

# Substance Misuse Needs Assessment

## Tower Hamlets

**March 2023**

Produced by The Centre for Public Innovation in collaboration with LB Tower Hamlets and the Tower Hamlets Combatting Drugs Partnership, March 2023

The Tower Hamlets Combatting Drugs Partnership (CDP) is a multi-agency forum formed to implement the Government's national From Harm to Hope strategy locally. The CDP's purpose is to work together with partners to combat illegal drugs and the harm they cause in the community.

The Centre for Public Innovation is a Community Interest Company that provides research, training, support and advice in the fields of health, social care, criminal justice and community development. CPI's mission is to improve the outcomes of services for their users, with a particular emphasis on the most disadvantaged.

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# Foreword

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## Mayor Lutfur Rahman

I am pleased to introduce the new Tower Hamlets Substance Misuse Needs Assessment, which sets out the current need around drug and alcohol use in the borough, the range of services we have in place, and any gaps that the council and our partners can fill.

Our priority is to reduce the harm caused by drugs and alcohol to residents and communities, and to make sure our borough is safe for everyone who lives, works, or visits Tower Hamlets. We know that our residents are concerned about drug-related activity, and that drug and alcohol misuse can have a far-reaching and devastating impact on our communities.

Through the substance misuse needs assessment, our aim is to make sure that anyone affected by addiction, substance misuse, or the associated harms is offered the support they need.

This needs assessment presents the views of both residents and community organisations following engagement with groups that regularly see the negative effects of drug and alcohol use. We have included information from a range of services and needs, covering both the health and community impacts of drug and alcohol use.

This needs assessment shows that we have a high level of need around drugs and alcohol, and that people with drug and alcohol problems in Tower Hamlets have a relatively complex set of additional problems. It also shows that we have an ageing group of people that have used addictive drugs for many years and need intensive support.

We have comprehensive outreach, treatment, rehabilitation and recovery programmes to meet this need. However, there is more we can be doing to meet the needs of our community, and to improve long-term outcomes.

We will be working closely with our new Combatting Drugs Partnership to take the recommendations forward and incorporate them into the refresh of our drugs strategy, with a focus on improving treatment and recovery outcomes.

Tackling the causes and effects of substance misuse continues to be challenging, but this needs assessment will help us combat drug-related crime and provide world-class recovery services for those who need it. In turn, we hope to increase the health, wellbeing, safety and security for everyone who calls Tower Hamlets home.

**Mayor Lutfur Rahman, April 2023**



# Glossary

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ASB	Anti-social behaviour
BBV	Blood borne viruses
CGL	Change, Grow, Live
CAMHS	Child and Adolescent Mental Health Services
CDP	Combatting Drugs Partnership
DfE	Department for Education
DHSC	Department of Health and Social Care
DIP	Drugs in Partnership / Drug Interventions Programme
DRR/ATR	Drug rehabilitation requirement/alcohol treatment requirement
ELOP	Expanded Learning Opportunity Programme
HMPPS	His Majesty's Prison and Probation Service
ICS	Integrated Care Service
IOM	Integrated Offender Management
LAC	Looked After Children
LOC	Local Outcome Comparator
MoJ	Ministry of Justice
MPS	Metropolitan Police Service
NDTMS	National Drug Treatment Monitoring System
NEET	Not in Education Employment or Training
OHID	Office of Health Inequalities and Disparities
PSHE	Personal Social and Health Education
RA	Required assessment
SMIT	Substance Misuse Investigation Team
THEO	Tower Hamlets Enforcement Officer
TOP	Treatment Outcome Profile
YOS	Youth Offending Service

# 1. Executive Summary

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This needs assessment sets out the need around drug and alcohol misuse in Tower Hamlets; to inform the work of the Tower Hamlets Combating Drugs Partnership, local substance misuse strategy, planning of services and commissioning decisions. The needs assessment provides evidence on the impact of substance misuse on the population of Tower Hamlets, the level of need for a range of substance misuse services, and the range of interventions in place to address this need. The needs assessment looks at both adult and children and young people's substance misuse related needs (both illicit drugs and alcohol).

The report is not an evaluation; it has not been designed or resourced to assess the quality or impact of existing services.

The needs assessment has been produced by CPI who were commissioned by LBTH and worked alongside Tower Hamlets public health, substance misuse team, drug and alcohol commissioners, and the wider Combating Drugs Partnership to produce the needs assessment. Assessing need around substance misuse should be an ongoing process.

The needs assessment takes a broad, comprehensive view across the wide range of needs relating to substance misuse, and the complex arrange of interventions in place. This document is based on the latest available public and publishable data as of January 2023. Additional work will subsequently look in more detail at some of the issues highlighted. In particular, the impacts of the pandemic are still felt by services that support those with substance misuse needs; and further insight is required to fully capture this.

## 1.1 Findings

### 1.1.1 The impact of substance misuse and levels of need

#### *Alcohol misuse*

Despite high rates of alcohol abstinence, Tower Hamlets has high levels of need around alcohol-related harms. These appear to be concentrated among men and among White and Other ethnic groups. There is high unmet need for alcohol treatment (comparable to elsewhere in London).

- There has been a notable increase in the percentage of Tower Hamlets adults who binge drink on their heaviest drinking day, to 19.5% in 2015-18. This is higher than the rate for London and nationally. Similarly, the proportion of Tower Hamlets residents who reported drinking 14 or more units per week increased to 22% in 2015-18 (contrasting with a downward trend nationally).

- Hospital admission rates for residents for alcohol-specific conditions have declined since 2018-19 but have historically been higher than rates for England and London.
- Data on emergency hospital admissions show that alcohol-related harms are higher among men, those aged over 50, and those from White, Other and Black ethnic groups.
- It is estimated that 85% of those who may require support for alcohol dependency are not accessing this support. This is similar to the national rate of 82%.

### *Drug misuse*

Tower Hamlets sees substantial need around drug dependency, which is more common among men and those of White ethnicity (as shown by hospital admissions). Homeless households see particularly high levels of need around drug use. While numbers in treatment have fallen, there is no indication that this is due to reduction in need related to illicit drug use. Opioid prescriptions are higher in Tower Hamlets than elsewhere in North-East London.

- Residents and professional stakeholders consider drug use, and associated drug dealing, to be widely prevalent in the borough; many raise particular concerns around the use of nitrous oxide.
- Deaths from drugs have fluctuated over time but have recently (from 2017 onwards) seen a slight increase and now correspond with the rate for London. (Very small numbers in these data indicates some caution in the interpretation of the data: these changes could be due to chance or to changes to recording).
- Hospital admissions for drug poisoning (a wider measure of drug-related health impact) in Tower Hamlets are just over half that of the national rate.
- Hospital emergency admissions data suggest that drug related harms are concentrated among males (who account for 63% of admissions) and among people of White ethnicity (who account for around half of the admissions, while admissions from the Bangladeshi community represent around a fifth of admissions).
- Tower Hamlets has consistently had the highest rates of opioid prescriptions (per patient) in North East London. These are likely not 'illicit' drugs, nonetheless this suggests a need to review the reasons for these high prescription levels.
- Among newly homeless households in Tower Hamlets with identified support needs, a higher proportion have need relating to drugs or alcohol than is the case across London; suggesting particularly high substance misuse need among homeless people locally. 11.4% of newly homeless have a need around drugs (vs 3.1% across London). 4.3% have an alcohol-related need compared to 2.4% across London.



### ***Characteristics of the adult population requiring specialist drug and alcohol treatment***

Tower Hamlets has high levels of need for drug and alcohol treatment, with estimates of the prevalence of opiates and crack use among the highest in London. This population is ageing and has a complex set of intersecting needs. A greater proportion of people with drug and alcohol problems in Tower Hamlets also have serious housing or mental health need, than is the case elsewhere.

#### **Prevalence and numbers in treatment:**

- The estimated prevalence rate of opiate and crack users in Tower Hamlets is higher than the rates for England and London. Rates of opiate only and crack only use are also higher in Tower Hamlets than for London.
- Tower Hamlets has the highest total number of people in treatment in London for 2020-21 (1,945) and one of the highest rates of treatment demand when weighted for resident population (10.1 per 1,000 of population).  
Nearly two thirds (65%) of the treatment population are opiate users while 16% are alcohol users (2020-21)

#### **Substances used by those in treatment:**

- The number of opiate users in treatment has declined since 2011-12. This mirrors trends seen nationally. Estimates of the percentage of opiate and crack users *not* in treatment in Tower Hamlets show an upward trajectory indicating a greater proportion of drug users not accessing treatment.
- The number of people in Tower Hamlets accessing treatment for alcohol peaked in 2013-14 and decreased thereafter.
- There has been a recent increase (from 2019 onwards) in non-opiate users in treatment. The second-highest drug in terms of numbers of people in treatment was for Cannabis, with 46% of users in Tower Hamlets using Cannabis. This may suggest that there is a growing need to support users of non-opiate drugs.

#### **Wider needs of those with drug and alcohol problems:**

- A growing proportion of the treatment population is aged 50 years and above (23% in 2020-21). This ageing cohort reflects trends nationally and indicates higher need around physical and mental health.

The gender and ethnic make-up of the treatment population appears consistent with levels of need in the borough, as indicated by metrics such as hospital admissions. The majority of those in treatment are male (76% male versus 24% female). White service users form 58% of the treatment population, 30% are of Asian/Asian British heritage and 7% Black/African/Caribbean/Black British.

### *Substance misuse and children and young people*

- There has been a significantly declining trend in the hospital admissions rate for alcohol-specific conditions for young people under 18 in Tower Hamlets; as is the case elsewhere across London. Hospital admission rates for those aged between 15 and 24 years due to substance misuse are lower in Tower Hamlets than the rate for England.
- A local survey of school pupils indicates that 15% of boys and 21% of girls at secondary school had ever had a drink. The survey indicates that 11% of boys and under 10% of girls have reported ever having taken drugs.

### *Characteristics of the children and young people's treatment population*

- The number of young people in specialist treatment has decreased from 200 in 2014-15 to 70 in 2019/20. 3,048 young people received some form of intervention from Safe East of whom 97% (2,952) required only a brief intervention.
- Nearly two thirds (63%) of young people in treatment were in mainstream education however a quarter (25%) were recorded as Not in Education, Training or Employment.
- No young people were in treatment for opiates or crack cocaine. Most were in treatment for less health harmful drugs such as cannabis (93%) or alcohol (57%). Solvent use has increased and is now reported by over a fifth (21%) of young people in treatment.

#### **1.1.2 Early intervention**

An appropriate set of services are in place to provide information and advice to young people regarding risks around drug and alcohol misuse. On-line and in person screening and brief intervention services are in place to engage and assess local adults about alcohol consumption, to provide support for those drinking at non-dependent level.

#### *Early intervention services for adults*

- Alcohol screening is available in Tower Hamlets for local adults. This is consistent with guidance regarding effective early intervention. In 2021-22 over 49,000 adults received an alcohol screening in primary care.
- Additional screening is available online via the Drinkcoach website.

### *Early intervention services for children and young people*

- Safe East provide intervention and outreach to local young people with over 6,000 young people attending sessions that they delivered (sessions also were in relation to sex and relationships and tobacco as well as substance misuse).

#### **1.1.3 Evidence based treatment and recovery services**

A comprehensive drug and alcohol treatment service provided in Tower Hamlets, balancing pharmacological and psychosocial interventions is present in line with best practice guidance. The offer splits treatment workers across substance categories and includes focused on the needs of specific communities. There are currently issues with the capacity of the system, with treatment workers carrying very large caseloads.

A low proportion of those in treatment are 'treatment naïve', while a growing proportion of clients, particularly opiate users, remain in treatment for over six years. Routes into treatment are primarily from friends and family; the proportion of referrals from CJS routes has declined recently. Outcomes from treatment vary by substance, and for opiates in particular they have declined over the last decade.

Surrounding the core treatment service, a range of recovery services are offered to enable clients to embed their recovery and again the range of recovery groups aligns well with national standards. Opinion among service users and wider stakeholders varies on the quality of routes into treatment currently. Innovative services are in place to address wider needs – such as health issues related to NOx use. P-RESET provide an innovative primary care annual health check for adults in treatment.

#### *Adult treatment and recovery services*

- There is an appropriate set of interventions in place to meet need; which are in line with relevant guidelines:
  - The RESET treatment service provides outreach and referral, treatment and recovery services to the local population and began operation in 2016. The service was re-commissioned in 2019 with a change in provider for RESET treatment.
  - RESET Outreach provision aims to engage drug and alcohol users into structured treatment while also providing information about harm reduction and brief advice thereby supporting individuals prior to accessing treatment.
  - RESET Treatment provide a comprehensive range of interventions including pharmacological and psychosocial interventions. The range of provision is consistent with guidance for substance misuse provision.

- RESET Recovery provides a range of support interventions to aid service users through treatment and post-treatment.
- P-RESET is a primary health based service that provides Shared Care and health checks for service users in treatment.

### Complex needs

- There is comparative complexity among the cohort of people in treatment in Tower Hamlets, compared with elsewhere. A greater proportion of Tower Hamlets' treatment population is designated as "very high risk" compared to a comparator group of authorities (at 38% and 30% respectively). Levels of housing need, co-occurring Crack Cocaine use both indicate this increased complexity.
- The cohort in treatment show greater complexity and risk behaviours than in comparator areas. Opiate users in Tower Hamlets who are still using at six months are more likely to be exhibiting a range of higher-risk behaviours than their peers in comparator areas, including: more likely to have used crack (74% compared to 64%); cannabis (22% v 17%); alcohol (29% v 27%), and much more likely to have a housing issue (41% in Tower Hamlets compared to 27% nationally).

### Service outcomes

- Rates of successful completion from treatment among opiate users have been in decline for a number of years and now stand at 3%. The decline is statistically significant. Statistical analysis shows this decline mirrors trends regionally and nationally, suggesting the decline is driven by national and London-wide factors rather than being locally specific.
- However, the opiate completion rate of 3% locally is slightly lower than the rate of 5% seen among statistically similar comparator areas. Meanwhile, there are fewer re-presentations in Tower Hamlets than in comparator areas
- Alcohol successful completions dropped significantly from 2020 and now stand at 21%. This compares to 37% for Tower Hamlets' comparator group of areas. Data is not available to explain the drop in completions.
- While the majority of the treatment population are in treatment for under one year (53%), 15% have been in treatment for over 6 years. Those in treatment for over six years are all opiate users. The proportion in treatment for over 6 years is similar to that among comparator areas.
- 5% of treatment exits were due to the death of a client. Rates of death were highest for opiate users (8%).

- Tower Hamlets service users are more likely to leave treatment with a continued acute housing need, particularly for opiate users. 8.8% of Tower Hamlets opiate users have a housing need at end of treatment, versus 4.4% nationally across England.
- Within the first 12 weeks, a higher proportions of service users had an “unplanned exits” compared to England, for both opiate (18.0% v 16.4%) and alcohol users (13.6% v 12.9%). This may suggest that improving experience at the ‘front door’, particularly for opiate and alcohol clients, could result in greater proportions of presenters remaining in treatment for at least 12 weeks.

### *Children and young people’s drug and alcohol treatment*

- Local treatment for young people is provided by Safe East which offers an integrated substance misuse and sexual health service. This is in line with good practice that advocates integrating young people’s specialist treatment into wider services for young people.
- The emphasis of the work is on motivational interviewing and harm reduction which is also consistent with recognised treatment provision for young people.
- 90% of young people successfully completed treatment in 2019-20. Successful treatment rates have increased steadily (for instance were 67% in 2018-19).
- The majority of young people (60%) remain in treatment for up to 26 weeks. A small minority (13%) are in treatment for over one year.

### *Views of service users and stakeholders*

- A total of thirty-five professional stakeholders within the drug and alcohol system, twelve VCS organisations who work with residents in wider ways, and nine service users were interviewed to gather their views on treatment provision. Additionally a residents survey captured the viewpoints of over 150 residents.
- The residents survey found that residents considered GPs, self-referral to RESET treatment services, or online information were the best ways to get help with drug and alcohol issues. It also showed support for a range of interventions – from public information campaigns and education in schools, to improved pathways into treatment and
- Service users reported multiple effective pathways into treatment including from health and criminal justice agencies. Most were positive about the treatment service and that it was meeting their needs, albeit that some were not clear about what was available to them. Service users felt that the service could be better promoted.
- Professional stakeholders were aware of the high number of vacancies in RESET and recognised the pressures that this put on staff.

- Some professional stakeholders and some representatives from local community organisations reported perceived barriers for some communities in terms of accessing support for drug and alcohol use. These barriers were reported as both stigma within the community, lack of community awareness of specialist services, and lack of cultural awareness of services.
- Nox use was widely cited as an issue by professional stakeholders who felt that this was a growing problem among local communities. Stakeholders also reported widespread use of cannabis and that the needs of this client group needed to be addressed.

#### **1.1.4 Drug and alcohol related crime and ASB**

There is widespread recognition of and concern with the scale of the substance misuse issue in the borough, among residents and professionals. Crime data shows that a high level of recorded crimes around dealing and possession of drugs in Tower Hamlets. Cannabis was the highest volume drug seizure, followed by Cocaine and Heroin. Crimes related to supply of Heroin and Crack are more likely to be concentrated in the West of the borough, while Cannabis and Cocaine supply is more distributed.

A range of criminal justice interventions are in place to tackle crime, and many of these support drug and alcohol users within the criminal justice system into treatment. The proportion of those in prison who are transferred to the community has fallen over the past decade, which recent ADDER initiatives have sought to address.

##### ***Levels of drug related crime and ASB***

- Data from the local Drugs Profile shows that Cannabis was the highest volume substance seized, followed by Cocaine and Heroin. Over 90% of opioids within the crime data were Heroin.
- Drug possession offences are highest in Spitalfields & Banglatown and St. Peter's wards. Drug trafficking offences were highest in Spitalfields & Banglatown and Whitechapel wards.
- Drug-related crime is concentrated among certain areas of the Borough. The distribution of offences for the supply of Crack Cocaine and of Heroin are particularly focused in the West of the borough (near to Aldgate and Shoreditch), while Offences

related to supply of Cannabis and of Cocaine tend to be more evenly distributed across the Borough.

- Tower Hamlets had four wards in which over 100 drug-related ASB warnings had been issued.
- Analysis of data regarding drug related offences over time suggests a link between drug possession and theft indicating that drugs are driving crime more widely in the borough.

### ***Responding to drug and alcohol-related crime and ASB***

The prevalence of drug-related crime and therefore drug using offenders has led to the delivery of a complex landscape of services including Operation Continuum and other police operations, Throughcare, custody provision and IOM case officers (local authority provided for offenders) and a range of initiatives seeking to address substance misuse related ASB (such as the SMIT, Community MARAC and Safer Community Officers).

### ***The effectiveness of provision for offenders***

- The extent to which Tower Hamlets residents assessed by DIP are then taken onto the caseload has fluctuated over time, and overall the rate can be shown to be lower than rates across London.
- The proportion of people who leave prison who then successfully engage in treatment services (“continuity of care”) has fallen substantially since 2017, and is now lower than the national rate. However, this metric has increased in the last two years, at the time when the ADDER programme has been in place.
- Class A users consistently made up around a quarter of Integrated Offender Management clients.

### ***Views of residents and professional stakeholders on substance misuse, crime and ASB***

- A survey of residents of Tower Hamlets in 2019 indicated that nearly half (46%) believed drunken behaviour was a problem while nearly two thirds (67%) were concerned about the sale or use of illicit drugs.
- A (non-representative) survey of 167 residents developed as part of this needs assessment indicated that:
  - 72% of respondents were concerned about Nox and 70% were concerned about cannabis. 66% were concerned about alcohol.
  - When asked to cite the substance that is the biggest issue locally, the most common response given was Nox.

- That survey also showed that
- Local professional stakeholders were clear about the link between crime and the supply of Class A drugs locally.
- Professional stakeholders felt that the need for drug and alcohol services was 'huge' and that the treatment population was a complex one to manage.
- There was some confusion among local stakeholders about the range of services that are available locally and the pathways between these services.

## 1.2 Conclusions and recommendations

### 1.2.1 System-Level Conclusions

A number of conclusions have been reached that relate to the functioning of the system as a whole and how the various aspects of the treatment system and wider service landscape relate to one another.

*Tower Hamlets sees relatively high need around drugs and alcohol, and meets this with a complex set of services and interventions.*

1. Tower Hamlets has a higher estimated prevalence of opiate and crack use, and the largest cohort in treatment across all of London. The cohort of opiate users is ageing and displays comparatively high levels of complexity and additional needs (relative to England as a whole).
2. There is some indicative data that needs around alcohol are increasing.
3. As a result, a complex system has been put in place with a number of interventions seeking to identify, support different groups with a diverse set of needs. Despite simplifications, the system remains complex.

*Overall, some system outcomes have declined gradually over time, as has been the case across London and other areas.*

4. While there has been a long-term downward trend with regard to successful completions among opiate users, and to the number of people in treatment, these trends closely parallel London-wide and national trends. The trend is therefore most likely to be due to the substantial reduction in funding made available nationally for drug and alcohol services. Other indicators of performance have improved or remained relatively static – particularly for non-Opiates.
5. The data included in this needs assessment do not show specific time points when need, or in the extent to which needs are met, have markedly changed during the past decade.



### ***Need for improved lines of communication between, and reduced duplication within, parts of the system***

6. The service landscape has grown increasingly complex, particularly with the recent addition of ADDER funded roles. These additional services and posts serve a valuable role; however the complexity of the landscape has created a degree of confusion amongst stakeholders – including those working with drug and alcohol users.
7. There is a need to strengthen lines of communication between parts of the system – in particular between staff in local authority teams (such as Through Care) and RESET. For instance, staff at RESET were not clear about the roles of the prison workers and there was some lack of clarity between Through Care workers and the RESET about lines of accountability and client management.
8. The complex service landscape has created a situation whereby there are a growing number of handovers between teams (for example: custody team -> Through Care -> RESET). Multiple handovers of client has the potential to create more points for clients to drop-out/disengage.
9. The handovers are not consistently supported by joint care management of clients (for instance while Through Care team members support clients while they are in receipt of treatment at RESET, the former do not appear to consistently attend meetings with the latter to discuss these clients).

### ***System incentives and priorities need to be aligned to long-term outcomes***

10. Different parts of the system operate to different incentives and priorities, due to the complexity of the system. This has the potential to be sub-optimal for client outcomes – for instance some teams are measured by referring clients into RESET, rather than by what treatment outcomes clients go on to achieve. This creates an incentive to direct clients into RESET with less emphasis on the treatment outcomes.
11. Aligning system priorities of different services, to ensure a joined-up approach to outcomes and support, could lead to benefits for service users.

### ***Need for increased capacity in RESET/treatment***

12. Much of the drop in system outcomes (particularly successful treatment rates) appears to be associated with operational issues - including significant issues in staff capacity at RESET. This is an issue currently experienced by most treatment providers nationally.

13. The team is not fully staffed and is experiencing ongoing problems with recruitment. This has resulted in caseloads of over 80, which are often more than double the level that is recommended.<sup>1</sup>
14. There is not equity in case load of staff across the system – caseloads of over 80 in RESET are not mirrored by other teams such as Through Care. This suggests that there may be a benefit from distributing capacity more evenly across the system as a whole.

***Need to interrogate the cultural competency of the wider drug and alcohol system.***

15. The ethnic make-up of the population in structured treatment has remained stable over time and mirrors the ethnic break-down of emergency hospital admissions; this may suggest the system is equitably engaging different ethnic groups in treatment.
16. However, a number of stakeholders (both professional and from the community) raised the issue of the cultural competency throughout the system of services for people with drug and alcohol need.

### **1.1.2 System-level recommendations**

**Recommendation 1** *The CDP should undertake a systems-mapping exercise to identify all linkages and pathways into treatment:*

- *The mapping should assess the volume of clients in each part of the systems map to identify key pressure points,*
- *The systems map should identify numbers of handovers clients are receiving,*
- *The systems map should set out roles, responsibilities and remits for each element of the service system,*
- *Systems map should identify which service elements overlap and lead to co-working of clients.*

**Recommendation 2:** *The CDP should reconfigure pathways and system as needed in light of the mapping exercise.*

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<sup>1</sup> As set out in the Dame Black's Review of Drugs report, Part 2.

**Recommendation 3:** *Following the systems-mapping, the CDP should co-develop a system-wide plan for ensuring appropriate capacity in treatment and for improving recruitment and retention of the specialist treatment workforce.*

**Recommendation 4:** *Recognising ongoing problems with recruiting treatment workers the CDP should work with providers to develop and implement a drug and alcohol recruitment and retention strategy for the borough.*

**Recommendation 5:** *The CDP should carry out a review of the cultural competency of all elements of the treatment system (outreach, treatment and recovery), identifying best practice and setting out recommendations for change where necessary.*

### 1.2.3 Service-Level Conclusions

In addition to the conclusions that relate to the working of the system as a whole, a number of conclusions have also been drawn with regard to specific service delivery elements. These are set out below.

1. Data on alcohol consumption above recommended levels indicates that, contrary to the national trend, local rates are increasing. This suggests the need for more information to local residents on safe levels of drinking.

**Recommendation 6:** *CDP partners should:*

- (a) *develop a strategic approach to alcohol prevention in the borough and*
- (b) *consider undertake an information campaign aimed at local communities that sets out safe levels of alcohol consumption and highlights local services.*

2. Referring stakeholders report that people who they refer in to treatment often struggle to access an appropriate treatment offer. A higher proportions of service users had “unplanned exits” locally within the first 12 weeks compared to England, for both opiates and alcohol. Together these suggest that capacity issues are affecting the treatment service’s ability build appropriate relationship with new clients.

- a. **Recommendation 7:** *Referring teams should work with RESET to review protocols for new entrants into treatment, and identify ways to improve jointly managed handovers (between referring and treatment services) and ensure that clients are supported through referral, assessment and prescription.*

3. There has been a long-term decline in the successful treatment rate among opiate users. This, along with the ageing nature of the opiate using cohort (and therefore a likely increase in their complexity) is a matter that should be explored to understand whether any changes can be made in the support offered to this group to improve treatment outcomes. Specifically this should address ongoing prescribing practice to understand whether current approaches align with national guidance and best practice.

**Recommendation 8:** *A review should be undertaken of RESET treatment OST practice to determine whether current practice aligns with national guidance and best practice.<sup>2</sup> The review should seek to determine whether current practice is in line with all aspects of national guidance and whether there are any areas that could be enhanced/improved.*

**Recommendation 9:** *The CDP should explore what interventions are needed to address the needs of ageing opiate users and whether a specific offer is required for older, entrenched, long-term users.*

4. The increase in deaths among opiate users, while possibly a product of chance, nonetheless warrants further scrutiny to ensure that the CDP and all parties fully understand whether there are any underlying factors that can be addressed to better protect service users.

**Recommendation 10:** *A multi-agency forum meets to review drug related deaths. Additional capacity should be allocated to the forum to enable a "deep-dive" to be conducted of deaths over the last year to enable full scrutiny of all circumstances relating to the deaths. Lessons learned from the deep dive should be shared with commissioners, RESET, other partners (as appropriate) and the CDP.*

5. Of homeless people with support needs, the proportion with *drug or alcohol need* is higher in Tower Hamlets than elsewhere. This indicates a clear need to ensure that links and pathways are available for the homeless population to ensure that they can access treatment

**Recommendation 11:** *The CDP should look into housing provision for those who use drugs and alcohol, and seek to ensure appropriate provision is in place.*

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<sup>2</sup> See: <https://www.gov.uk/government/news/phe-launches-opioid-treatment-quality-improvement-programme>

6. Professional interviewees suggested there appears to be a growing problem with Nox misuse among young people; which treatment services have not yet responded to. It is likely that Nox users would benefit from a brief intervention approach akin to the cannabis group that is about to be set up.

***Recommendation 12:** The CDP should undertake a review to understand what intervention can be offered to NOx users, reviewing the evidence-base for what works with this client group.*

***Recommendation 13:** Following on from the review (above), and dependent on the evidence that emerges, CDP members should consider developing a pilot service for Nox users in the financial year 2023-24. This will require developing referral pathways from a range of other partners including (but not limited to) RESET outreach, DIP, Safe East and the hospital and community navigators.*

7. A B12 Pathway has been developed at the Royal London hospital for Nox users but that this has not been integrated into the wider delivery landscape. Work should be undertaken to ensure that this pathway is fully integrated into the wider substance misuse treatment system.

***Recommendation 14:** The CDP should engage with stakeholders at the Royal London Hospital to understand the operation of the B12 Pathway and how its operation can be linked into the wider treatment system.*

8. The P-RESET service provides a valuable and important function but appears to be under-utilized reaching only 42% of those who would potentially benefit from the service. Work should be undertaken to understand how levels of engagement can be improved.

*a. **Recommendation 15:** P-RESET should audit data on health checks to understand whether there are certain clients/characteristics of service users who are failing to utilize the health checks. As a result of the audit, where necessary, the offer should be amended to better engage service users.*

9. There is a working protocol between ELFT and RESET which provides clarity on how clients with co-morbid substance misuse and mental health issues should be managed. However specific groups of clients do not appear to be well served and some stakeholders suggested that there is at times an expectation (contrary to national guidance) that alcohol users are abstinent before they can be supported for mental health needs.

***Recommendation 16:** ELFT and RESET should revise the current protocol regarding working with clients with a dual diagnosis to better reflect national*

*guidance. We understand that a refresh is due in March 2023 so this should be used as an opportunity to align practice with national guidance.*

10. Prescriptions data suggest that Tower Hamlets has among the highest rates of opioid prescriptions across North East London. While this is a different issue to the use of illicit drugs, it warrants further investigation.

**Recommendation 17:** *CDP should work with NEL ICS Medicines Management team to understand the reasons for high opioid prescription and explore initiatives manage this.*

#### **1.2.4. Ongoing insight and analysis about substance misuse**

Finally, it is important to note that the process of gathering insight around substance misuse is an ongoing process. This Needs Assessment has gathered our knowledge of the picture across the system at the current moment in time. It has identified areas which would warrant further investigation, to inform future action.

**Recommendation 18:** *An ongoing programme of insight work should look into particular areas as highlighted in this report. Immediate priorities include:*

**18a)** *Analysis to support the 'system mapping' (Recommendation 1 above). This should include whole-system mapping of demand, capacity and flows – referrals into, and exits from, the range of services across treatment, outreach, CJS etc. If possible this analysis should look at handovers and where people "drop out".*

**18b)** *Additional analysis focusing on those who exit treatment within 12 weeks. This should look at the demographic, substance use, and contextual characteristics of the cohort; it should also investigate which pathways they have come through, to identify areas for improvement.*

**18c)** *A deep-dive to understand those who remain in treatment for a long time over 5 years: to understand the characteristics of this cohort, and what personal, service and wider factors determine the likelihood of remaining in treatment.*

**18d)** *Analytical support to recommendation 10 above – to conduct a "deep-dive" to be conducted of deaths over the last year; to identify lessons learned and enable full scrutiny of all circumstances relating to the deaths.*

**18e)** *A deep-dive to look at healthcare impacts of drug use; particularly to look into where in the health system people 'present' with drug issues (primary care, acute, mental health), whether this differs according to in-treatment vs treatment naïve, and whether this health data indicates and trends in drug use locally.*

## 2. Background and Context

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### 2.1 About the needs assessment

This needs assessment is intended to inform the work of the newly formed Combating Drugs Partnership in terms of the future substance misuse strategy, planning of services and commissioning decisions. It seeks to support the delivery of the Tower Hamlets Partnership Substance Misuse Strategy (2020-2025) (see 2.2.2 below).

The needs assessment has been produced by CPI who were commissioned by LBTH, with contributions from Tower Hamlets public health, substance misuse team, drug and alcohol commissioners, and wider Combatting Drugs Partnership. The needs assessment looks at both adult and children and young people's substance misuse related needs (both illicit drugs and alcohol).

This report is a needs assessment. This means the report seeks to investigate and understand what the impact of substance misuse is on the population of Tower Hamlets, the level of need for a range of substance misuse services, and the range of interventions in place to address this need. The report is not an evaluation; it has not been designed or resourced to assess the quality or impact of existing services.

Assessing need around substance misuse should be an ongoing process. This document is based on the latest available public and publishable data as at January 2023. Additional work will be required to look in more detail at some of the issues highlighted, and recommendations are made for ongoing needs assessment priorities. In particular, the impacts of the pandemic are still felt by services that support those with substance misuse needs; and further insight is required to fully capture this.

This report begins with background and strategic context. Chapter 3 sets out the methodology followed. Chapter 4 then characterises the impact of drugs and alcohol in Tower Hamlets, and seeks to understand the need for drug and alcohol services. Following this are sections that assess the interventions put in place to meet this need, aligned to each of the Tower Hamlets Substance Misuse Strategy's strategic priorities, namely:

1. Early intervention and prevention,
2. Effective evidence-based treatment and recovery support,



3. Reducing drug and alcohol related crime and anti-social behaviour through enforcement and regulation.

## 2.2 Strategic landscape

This section briefly sets out the strategic landscape for drug and alcohol treatment, both in Tower Hamlets and England as a whole.

### 2.2.1 National strategy

In 2021, the UK Government published its 10-year drugs strategy, '[From Harm to Hope: a 10-year drugs plan to cut crime and save lives](#)' following Dame Carol Black's Independent Review of Drugs ([Parts 1 & 2](#)). The Dame Carol Black review has been influential in pushing the drug treatment agenda forward, articulating unmet need and gaining Government backing including a considerable increase in funding for drug and alcohol treatment.

The 10-year drug strategy has three strategic priorities:

1. **'Break drug supply chains'**: reduce drug availability by targeting supply chains.
2. **'Deliver a world-class treatment and recovery system'**: rebuild treatment services following significant disinvestment; promote integration of drug treatment, health and criminal justice services.
3. **'Achieve a generational shift in demand for drugs'**: reduce demand for drugs by applying 'tougher and more meaningful consequences' to deter use, delivering education programmes in schools and supporting at risk families.

From the spending review funds announced by the Government, DHSC will invest an extra £533m via OHID grants to local authorities, to be spent on community-based *drug and alcohol* treatment services over a three-year period. NHS England are investing £21m in prison-based mental health and substance misuse treatment. The commitments made include a treatment place for every offender with an addiction.

MoJ/HMPPS have committed to invest £120m over three years to support the strategy objectives and those in the [Prison Strategy White Paper](#) which proposes prisoners will be assessed on arrival in prison for drug and alcohol addictions, allowing prison staff to make comprehensive plans for their recovery from day one. Upskilled staff will provide a full range of drug and mental health treatment both inside and outside of prison – including the use of abstinence-based treatment. The increased community drug treatment capacity aims to be able to respond to criminal justice priorities set out in the [Sentencing White Paper](#), including increased use of community sentences with a requirement for drug treatment and alcohol treatment.

Drug or alcohol dependence often co-exists with other health inequalities. The strategy promotes better integration of services to make sure that people's physical and mental health needs are addressed to reduce harm and support recovery.

Prevention of substance use is a key element of the government's ambition to reduce the demand for drugs. The factors placing young people at risk of substance use are complex and often inter-related. The most effective and sustainable approach to reducing demand i.e. primary prevention of alcohol and other drug misuse, in young people is building the resilience of young people through giving them a good start in life, the best education possible and keeping them safe, well and happy.

The Government commits to delivering school-based prevention and early intervention, delivering and evaluating mandatory relationships, sex and health education to improve quality and consistency, including a clear expectation that all pupils will learn about the dangers of drugs and alcohol during their time at school.

The Government's White Paper, [Swift, Certain, Tough](#) (consultation responses currently in analysis stage), proposed escalating consequences for drug possession including: mandatory drugs awareness courses, random drug testing (and expansion of drugs tested for on arrest), passport and driving licence confiscation, wearable drug monitors and exclusion orders prohibiting attendance of particular venues.

Local partnerships and accountability are key to the delivery of the ambitions set out in the national drug strategy. Success relies on local partners working together on these long-term ambitions. To ensure a common set of standards and quality the Government are:

1. Requiring each local area to have a strong partnership<sup>3</sup> that brings together all the relevant organisations and key individuals.
2. Introducing a new framework of national and local outcomes to inform progress and drive clear accountability.
3. Developing and implementing a set of [commissioning quality standards](#) to support transparency and accountability between all partners and layers of government, and improvement support.

### 2.2.2 Tower Hamlets

Tower Hamlets has a Partnership Substance Misuse Strategy for the period 2020-2025.

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<sup>3</sup> [Guidance](#) is available to outline the structures and processes through which local partners in England should work together to reduce drug-related harm.

The strategy sets out three priority areas:

1. Early intervention and prevention,
2. Effective evidence-based treatment and recovery support,
3. Reducing drug and alcohol related crime and anti-social behaviour through enforcement and regulation.

The strategy states that the primary focus is “on drug and alcohol use that causes the most harm to individuals and communities”. The strategy addresses the needs of both adults and young people.

The strategy sets out the high-level priorities for action and is supported by annual detailed delivery plans.

### **2.2.3 Project ADDER**

While not a national strategy, the national Project ADDER programme has had significant bearing on responses to drug misuse in Tower Hamlets. Project ADDER is targeted at a small number of areas; since July 2021 it covers two areas in London: Tower Hamlets and Hackney. Project ADDER is a programme that seeks to co-ordinate law enforcement activity as well as utilising diversionary schemes to get drug using offenders into treatment.

The programme seeks to ensure that more people get effective treatment, with enhanced treatment and recovery provision, including housing and employment support, and improved communication between treatment providers and courts, prisons, and hospitals.

The programme has the following aims:

- to reduce drug-related death
- to reduce drug-related offending
- to reduce the prevalence of drug use
- sustained and major disruption of high-harm criminals and networks involved in middle market drug/firearms supply and importation

While originally scheduled to run to March 2023, Project ADDER is now intended to run until 2025.

## 3. Methodology

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A range of methodological components were used for this needs assessment. Details of these are set out below.

### 3.1 Qualitative Data

#### 3.1.1 Professional stakeholders

For the 'wider professional stakeholder' interviews, in total, 35 professional stakeholders were interviewed. Interviews took up to 45 minutes.

A local contact list was compiled in October by the project team, comprising staff from a wide range of organisations within Tower Hamlets, including community safety, criminal justice agencies, primary health, mental health, housing, social care, and voluntary sector organisations.

Interviews covered perceptions on a range of themes relating to substance misuse, including: effectiveness of treatment services; whether provision meets demand; effectiveness of integrated responses and care pathways; unmet need; gaps in provision.

Between early November and the start of December 2022, stakeholders from across Tower Hamlets were interviewed in one-to-one video or telephone calls. The interviews were shaped around a semi-structured pro forma of questions, designed to probe:

- The **effectiveness of integrated responses and care pathways**– including the extent to which specialist treatment links in with other services.
- Whether current provision meets **demands**, and any areas of **unmet need** – including whether there are groups of people not accessing services.
- **Potential gaps in future provision**, and views on what future services should look like.

Those who agreed to be interviewed included:

- Council staff, housing and strategic managers working with people more vulnerable to developing substance misuse problems and those most at risk – including representatives from the Housing Options service (working with hostel users), rough sleeping support service, a specialist in hidden harm, and a safeguarding team leader.

- Criminal justice partners: primarily police and probation perspectives – including those managing Project ADDER, working in the local custody suite and gangs unit, and probation officers in the Tower Hamlets Probation Delivery Unit (PDU).
- Wider healthcare stakeholders: covering primary care, clinical leads (P-RESET/RESET), and mental health service commissioners.

In addition to professional stakeholders from a range of community organisations were interviewed. These were:

1. ELOP (LGBT Mental Health & Wellbeing)
2. Barnardo's
3. Coffee Afrik
4. Outside Edge Theatre Company
5. Elatt College
6. Canaan Project
7. Providence Row
8. We Are Spotlight
9. East London Mosque
10. Osmani Trust
11. Streets of Growth
12. 2 x Substance Misuse community activists

### **Limitations**

The qualitative data reflects the subjective views of a limited number of people consulted. As such views may be partial and should not be assumed to be conclusive statements of fact, but are rather the perceptions of those consulted.

### **3.1.2 Service users**

A total of nine people (eight men and one woman) took part in semi-structured interviews about their experiences of, and views about, RESET recovery services in Tower Hamlets. These service users were made up of a: group who attend a regular service user forum; a number who were approached by the Reset BRIC Team Leader and asked to participate in an interview. As such they cannot be said to be a cross-section of clients and form a self-selected sample of views.

Three one-to-one interviews were conducted by phone.

A group consultation with six people attending a service user forum took place at the Alma Centre in Spitalfields.

Participants in one-to-one interviews all had past experience of using RESET services. One also attended the service user forum. Another had become a recovery support worker after receiving support himself. Between them, these people had experience of heroin use, alcohol use, and gambling addiction. They were all in their 40s.

At the group consultation all the participants were men aged between 30 and 70 years old. They were equally divided between British South Asian, White British and North African heritages. They included drug and alcohol users. Two had very recently been referred to the service while the others had a long-term connection, in some cases over years.

### *Limitations*

The service users who were consulted constitute a self-selected sample (i.e. consists of those who came forward and who were willing to participate in the consultation process). The sample does not therefore represent a cross-section of the views of service users across the population of those engaged in specialist treatment. The sample also only represents those who are currently or who had recently left treatment. The sample does not therefore include the views of the treatment naïve (those who have never engaged in treatment) or those who are not currently in treatment.

Interviews were conducted over just two weeks. The fact that one man attended two interviews indicates that some voices may dominate.

## **3.2 Quantitative Data**

### *Note on quantitative data*

A variety of data sources were used in the preparation of this needs assessment (these are described below). The most contemporaneous data available at the time of the fieldwork were used in the preparation of this report. In some cases the most recently available data are somewhat historic – for instance some data on health conditions and levels of drinking are only available up to 2018. More historic data should be treated with caution as they will not capture more recent trends and developments and so may not therefore provide the “true” picture with regard to a given issue. On the whole, the older the data, the more cautions should be used in the reading of results from the data.

Note also that much of the data either coincides with the period of the Covid-19 pandemic or was published soon after the pandemic. As such some of the data is unlikely to have captured the full extent of the impact of the pandemic on issues relating to drug and alcohol misuse. Future data is likely to provide a better guide to the medium to long-term impact of Covid and substance misuse.

### 3.2.1 Data analysis

#### *National Drug Treatment Monitoring System*

The data used for analysis in this report came from several complementary sources focusing on drug treatment statistics reported to the National Drug Treatment Monitoring System (NDTMS) and accessed through open-source resources provided by OHID<sup>4</sup>. NDTMS is a national public health surveillance system that collates activity data on individuals from specialist drug and alcohol services in prison and the community. NDTMS<sup>5</sup> collects information on individual needs, a description of the treatment received, and summary information on the outcomes of their treatment.

One outcome measure used in substance misuse treatment is the Treatment Outcome Profile (TOP) which is completed on adults at treatment start and six-month intervals, and finally at discharge.<sup>6,7</sup> Therefore, the information can be based on data captured up to a year before, although publication times have been reduced.

NDTMS data forms the basis of this Health Needs Assessment, although it is also used in conjunction with other datasets to derive, for instance, estimates of prevalence and unmet needs. Using multiple data sources including NDTMS and criminal justice data (prison and probation) it is possible to deploy capture-recapture methodologies provided by OHID and as developed by the University of Glasgow<sup>8</sup> to derive an estimate of the total drug misusing population and this method has been used for some indicators in this report<sup>9</sup>. NDTMS data for this report is largely focused on open sources held as part of the ViewIT<sup>10</sup>. Information held on ViewIT was the preferred data source as it included more recent information up to 2020/2021, in comparison the 'Adults - drugs commissioning support pack 2022-23: key data' only includes snapshot data up to 2018/19.

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<sup>4</sup> OHID Adults - alcohol commissioning support pack 2021-22: key data. Planning for alcohol harm prevention, treatment, and recovery in adults and <https://www.ndtms.net/ViewIt/Adult>.

<sup>5</sup> NDTMS is a national standard applicable to all ages and is accredited by NHS Digital and the Information Standard (Section 250 of the Health and Social Care Act 2012). The dataset comprises extracts from each service provider based on an individual entering specialist drug and alcohol treatment. Where multiple episodes exist (for example, if an individual leaves and reappears at the same treatment provider, or if a person accessed more than one service) the additional episode is also captured and is defined as a 'treatment journey'.

<sup>6</sup> TOP is a separate dataset that reviews substance use and other needs based on the last 28 days. Information collected by NDTMS requires a validation process and is considered 'Official Statistics'

<sup>7</sup> Marsden J, Farrell M, Bradbury C, Dale-Perera A, Eastwood B, Roxburgh M, Taylor S. Development of the Treatment Outcomes Profile. *Addiction*. 2008 Sep;103(9):1450-60. doi: 10.1111/j.1360-0443.2008.02284.x. PMID: 18783500.

<sup>8</sup> Chao, A. (1987). Estimating the population size for capture-recapture data with unequal catchability. *Biometrics*, 783-791.

<sup>9</sup> Hay, G. (2000). Capture-recapture estimates of drug misuse in urban and non-urban settings in the north east of Scotland. *Addiction*, 95(12), 1795-1803.

<sup>10</sup> <https://www.ndtms.net/ViewIt/Adult>

As data are collated from a variety of sources, there are differences in comparison areas. Therefore, this report will include comparisons with statistical neighbours, the London region, and national (England) figures. Comparator data for some treatment service metrics utilises Local Outcome Comparator (LOC) which have been prepared by OHID. The LOC compares each area to 32 areas that are similar in terms of the complexity of their clients, with different LOCs for opiate, non-opiate and alcohol populations.

### *Crime Figures*

This Needs Assessment incorporates summary information on crime that has been drawn from the MPS's local Drugs Profile 2021, which was created for the inception of Project ADDER. While the detailed data are sensitive and cannot be included, summary of the issues has been incorporated.

Additionally, this NA assesses the extent of drug-related crime over 24 months and use of historical data by examining Metropolitan Police figures of recorded crime in Tower Hamlets.

Further detailed analysis was undertaken using open-source datasets accessed at ward level from monthly police recorded crime counts by offence category for five years from 2013 to 2017 (before COVID and to counting rule changes).

Separate analysis was undertaken using a Generalized Linear Mixed Model (GLMM), creating a monthly series using an integer from 1 to 60 representing consecutive months in a temporal sequence of five years and was used to estimate the time trend of the crime rates. A borough-by-month sequence was also created as an interaction term [also known as 'effect modifier'] that allowed for a different time trend between boroughs. This term yields an individual estimate of the time trend for each borough.

### *Terminology*

Throughout this report the term "significant" is used in its statistical sense (statistically significant) and refers to where a relationship between variables are not due to chance. As such, where data is "increasing" this means that the upward change is related to the variables in question and is not occurring at random.

### **3.2.2 Resident survey**

A short survey was prepared to gather the views of local residents. A copy of the survey is set out at the Appendix.

A short survey was designed to examine public perceptions of drug and alcohol use within Tower Hamlets. The survey was distributed via a number of sources including: the Policy and Improvement Team, the Strategies and Communities Team within Tower Hamlets; Tower



Hamlets Health Watch; the Safer Wards Forum and a number of local community groups and organisations.

In total 167 responses were received to the survey.

### *Limitations*

Given the level of responses this does not constitute a statistically significant sample of the local population. The results should therefore not be assumed to be a full cross-sectional view of local residents but is rather an ad hoc snapshot view of a self-selected group of local residents.

### **3.2.3 Comparison data**

Tower Hamlets has been compared to 32 areas (called Local Outcome Comparators) that are most similar to them in terms of the complexity. There will be different groups of local outcome comparators for opiate, non-opiate and alcohol population. This approach is similar to the 'nearest neighbour' method but is predicate on the treatment population's complexity as opposed to the broader similarity between the resident populations across local authorities.

## 4. The impact of substance misuse and levels of need

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This section seeks both a) to understand the impact of drug and alcohol misuse in Tower Hamlets and b) to understand levels of need for interventions to tackle substance misuse and related issues. Separate sections look at the impact of alcohol on the local population and the impact of drugs. Further data then explores the profile of those people who require specialist drug and alcohol treatment. Data is looked at separately for children and young people.

### 4.1 Alcohol misuse

#### *Key findings:*

- There has been a notable increase in the percentage of Tower Hamlets adults binge drinking on their heaviest drinking day to 19.5% in 2015-18. This is higher than the rate for London and nationally. Similarly, the proportion of Tower Hamlets residents who reported drinking 14 or more units per week increased to 22% in 2015-18. This contrasts with a downward trend nationally.
- Hospital admission rates for residents for alcohol-specific conditions have declined since 2018-19 but have historically been higher than rates for England and London.
- Data on emergency hospital admissions show that alcohol-related harms are higher among men, those aged over 50, and those from White, Other and Black ethnic groups.
- The most common alcohol-related primary diagnosis leading to an emergency admission is *Mental and behavioural disorders due to the use of alcohol*.
- It is estimated that 85% of those who may require support for alcohol dependency are not accessing this support. This is higher than the national rate of 82%.

#### 4.1.1 The effects of alcohol misuse

This section explores a range of datasets that cover various facets of harm caused by alcohol.

Alcohol-related harm is largely determined by the volume of alcohol consumed and the frequency of drinking occasions. The risk of harm is directly related to levels and patterns of consumption<sup>11</sup>. There can be a considerable lag between alcohol consumption and alcohol-related harms, particularly for chronic conditions where the lag can be many years. In January

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<sup>11</sup> Room, R. (1996). Alcohol consumption and social harm—conceptual issues and historical perspectives. *Contemporary Drug Problems*, 23(3), 373-388; Rehm, J. (2011). The risks associated with alcohol use and alcoholism. *Alcohol Research & Health*, 34(2), 135.

2016, the Chief Medical Officer issued revised guidance on alcohol consumption, which advises that, to keep to a low level of risk of alcohol-related harm, adults should drink no more than 14 units of alcohol a week. Harm can be short-term and instantaneous, due to intoxication, or long-term from continued exposure to the toxic effect of alcohol or from developing dependence. Alcohol is a causal or contributory factor in more than 200 medical conditions including circulatory and digestive diseases, liver disease, a number of cancers and depression<sup>12</sup>.

### 4.1.2 Levels of alcohol consumption

The data below explores alcohol consumption in Tower Hamlets to understand the size of the population who may be drinking at rates that impact on their health.

**Figure 1 Percentage of adults binge drinking on heaviest drinking day, 2011-14 to 2015-18, Tower Hamlets, London, England Percentage**



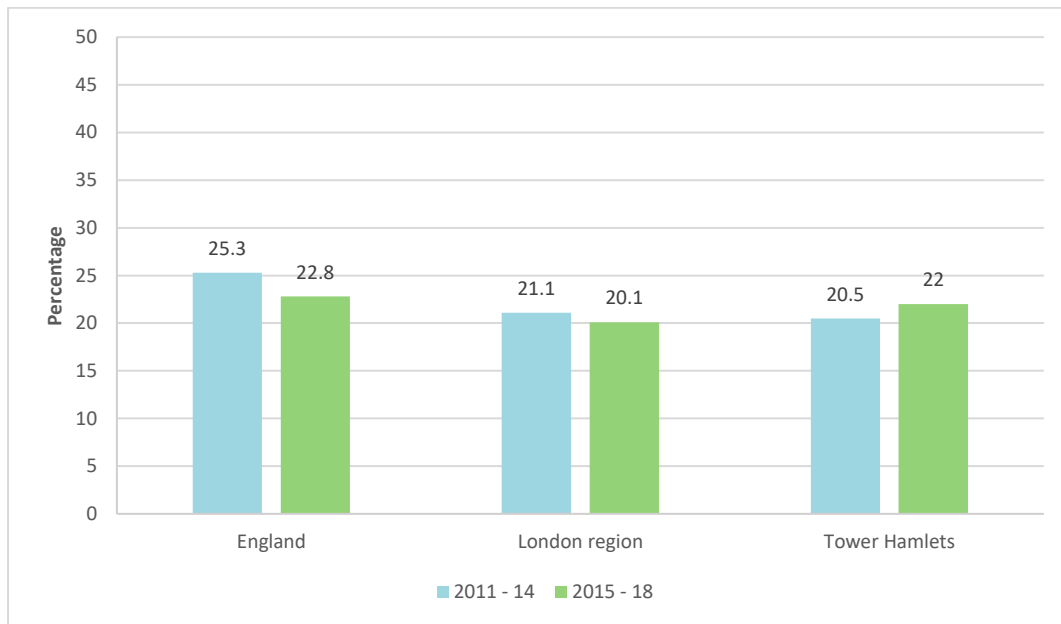
(Source: OHID, Fingertips)

There has been a notable increase in the percentage of Tower Hamlets adults binge drinking on their heaviest drinking day from 2011-14 (11.9%) to 2015-18 (19.5%). The most recent figures show a level of binge drinking higher than in London and nationally. The difference in binge drinking in Tower Hamlets between 2015-2018 can be shown to be statistically significant compared to London and England.

Figure 2 sets out the percentage of adults in the borough who are drinking at levels higher than recommended (14 units per week).

<sup>12</sup> WHO 2018 – alcohol fact sheet. <https://www.who.int/news-room/fact-sheets/detail/alcohol>

**Figure 2 Percentage of adults drinking over 14 units of alcohol a week, 2011-14 to 2015-18, Tower Hamlets, London, England Percentage**



(Source: OHID, Fingertips)

There has been an increase in Tower Hamlets residents who reported drinking 14 or more units per week, from 20.5% in 2011-14 to 22.0% in 2015-18. This rise is in contrast to decreases in drinking patterns across London and nationally. By far the majority of those drinking above 14 units per week will *not* require structured treatment but may benefit from a lower-level intervention (discussed below). The difference between Tower Hamlets, London and England of such risky drinking levels are however, not statistically significant.

Data about those who may require support for alcohol dependency is set out at Table 1. (This data is derived from modelling which *estimates* level of need based on a range of available data. As such the data should be read as indicative rather than an actual measure).<sup>13</sup>

**Table 1 Prevalence estimates and rates of unmet need for alcohol treatment in Tower Hamlets and England**

Area	Local rate per 1,000 of the population	Unmet need (%)
Tower Hamlets	14.2	85%
England	13.7	82%

(Source: Office for Health Improvement and Disparities, Adult Drug Commissioning Support Pack: 2022-23: Key Data. Planning for drug prevention, treatment and recovery in adults)

<sup>13</sup> For more information on the modelling see:

[https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fassets.publishing.service.gov.uk%2Fgovernment%2Fuploads%2Fsystem%2Fuploads%2Fattachment\\_data%2Ffile%2F969030%2Festimates\\_of\\_alcohol\\_dependent\\_adults\\_2018-19.ods&wdOrigin=BROWSELINK](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fassets.publishing.service.gov.uk%2Fgovernment%2Fuploads%2Fsystem%2Fuploads%2Fattachment_data%2Ffile%2F969030%2Festimates_of_alcohol_dependent_adults_2018-19.ods&wdOrigin=BROWSELINK)

There is a slightly higher rate per 1,000 in the prevalence in Tower Hamlets (14.2) compared with nationally (13.7), and a somewhat higher level of unmet need (85%) compared to 82% in England. The differences are not statistically significant.

### *What this tells us*

The data set out above indicates clearly that there is a cohort of alcohol users in Tower Hamlets who would benefit from some form of intervention. The data suggest this cohort may be growing in the borough.

Data on binge drinking shows that this issue is more pronounced in Tower Hamlets than in England or London. By far the majority of binge drinkers will not need structured treatment, but may benefit from some form of lower level intervention (such as a Brief Intervention). There is clearly therefore a need in Tower Hamlets for information on safe levels of drinking. This is substantiated by the data on adults drinking over 14 units which similarly indicates a clear need for clear health messages among the fifth of the population who are drinking above recommended levels.

While data on unmet need for dependent drinkers is an estimate (and therefore open to interpretation) the message is very clear – that there is a sizeable population who would benefit from alcohol treatment and by far the majority of people who would benefit from this service are not doing so.

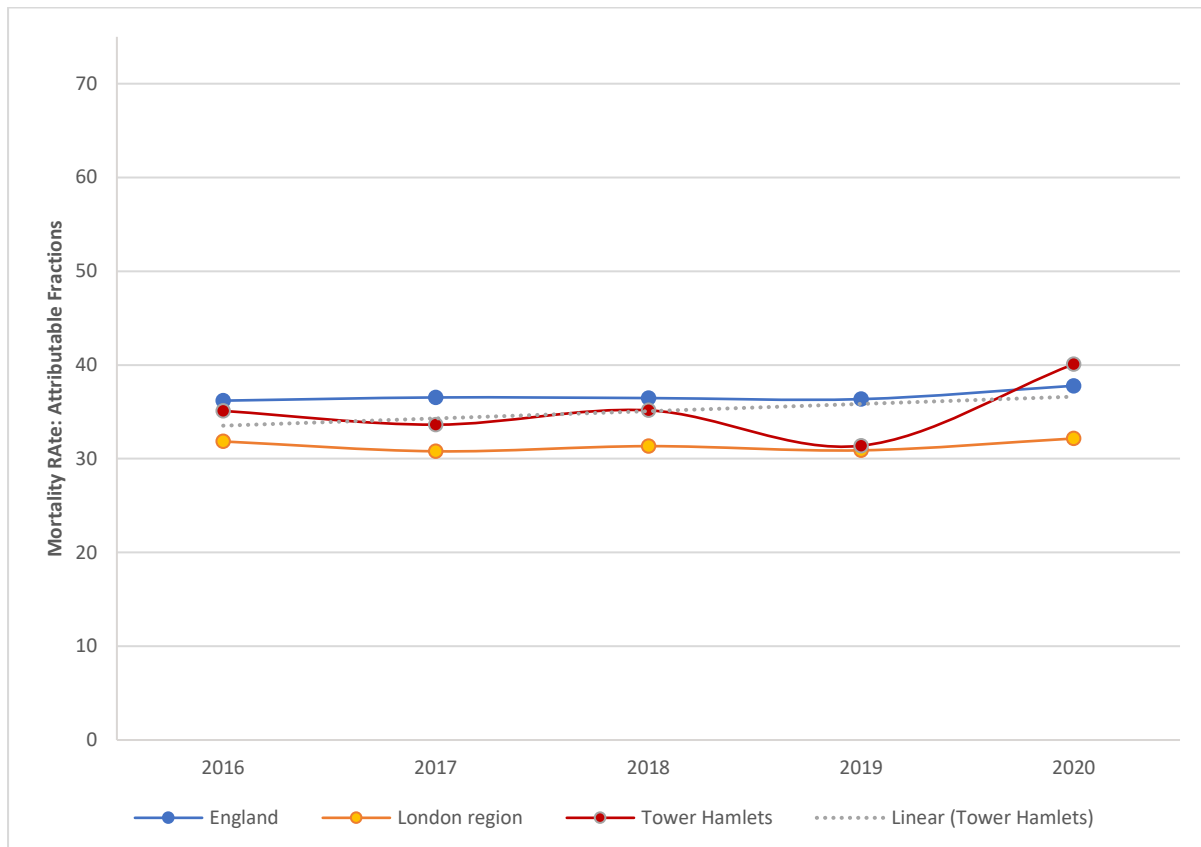
### **4.1.3 Alcohol harm**

Data about a range of alcohol-related health harms are set out below.

#### *Alcohol-related Mortality*

Data on alcohol-related mortality are set out at Figure 3.1. The data measures the upper end of adverse health effects – that is, measuring the relatively small number of people who die as a result of alcohol consumption.

Figure 3.1 Alcohol-related mortality (Persons), 2016 to 2020, Tower Hamlets, London, England Hospital Mortality Rate



(Source: OHID, Fingertips)

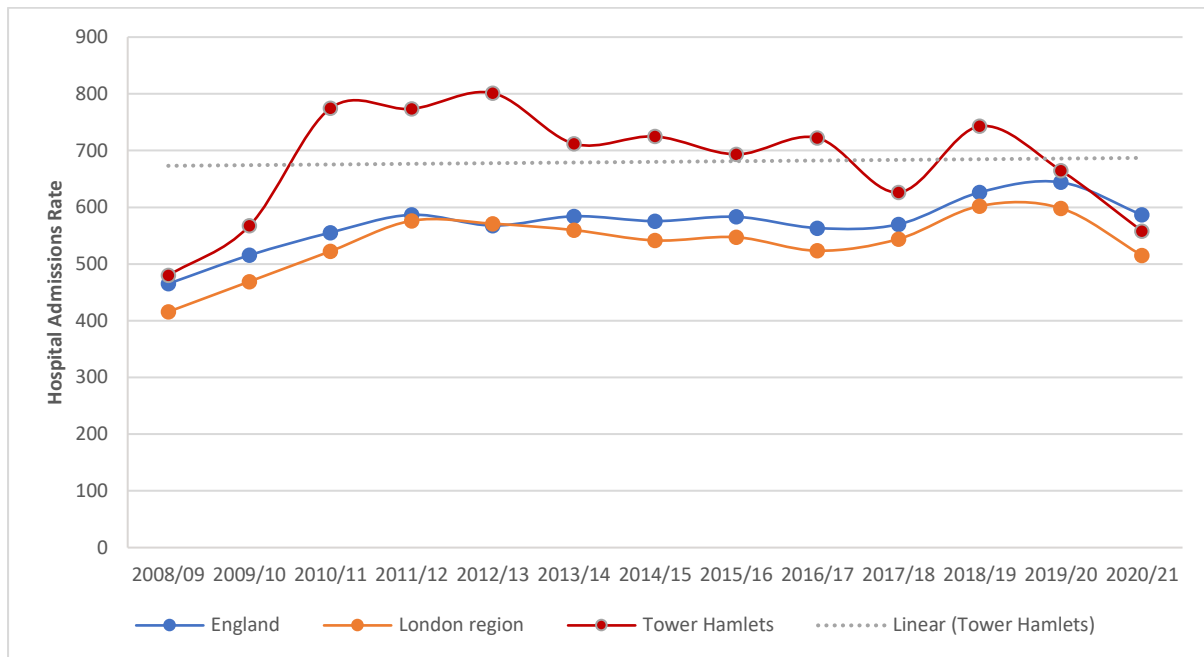
There has been a slight uptick in the alcohol-related mortality rate (which may possibly be a function of the impact of the Covid pandemic) among Tower Hamlets residents from 2019 to 2020, although the overall trend is suggested to be flat and small numbers mean that there is no statistically significant change over time noted. Rates are consistent with national and London-wide rates with no significant difference between rates reported in Tower Hamlets and in London or nationally.

### Hospital Admissions

Data for alcohol admissions is set out at Figure 3.2. This data covers a larger population than the data for mortality rates (above) and therefore gives a wider picture of impact. Data is conditional on hospital coding which may explain the variance and that rates are likely to have been impacted by the Covid pandemic.

Figure 3.2 sets out data in relation to alcohol-specific admissions: that is, conditions that are wholly caused by alcohol. The data therefore indicates the most problematic levels of drinking and the impact of alcohol dependency.

**Figure 3.2 Admission episodes for alcohol-specific conditions (Persons), 2008-09 to 2020-21, Tower Hamlets, London, England Hospital Admissions Rate**

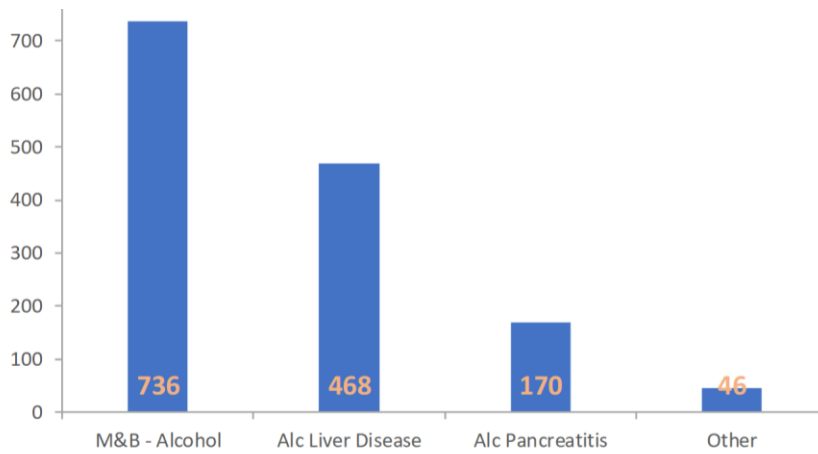


(Source: OHID, Fingertips)

The hospital admissions rate for alcohol-specific conditions in Tower Hamlets has fluctuated over time but can be shown to be broadly higher than in London and nationally until 2018-19, when the admission rate dipped notably (which may be a function of the Covid pandemic or of hospital coding). The overall linear trend in admissions, however, is broadly flat although there is a significant reduction in the admission rate for Tower Hamlets from 2018/19 (when there was also a significantly higher rate of hospital admissions in Tower Hamlets compared to London and nationally).

Figure 3.2a, below, sets out the level of emergency admissions that are directly related to alcohol misuse. The most common primary diagnosis for an emergency admission for alcohol is due to Mental and behavioural disorders due to the use of alcohol. This accounts for over half of all admissions at 52%.

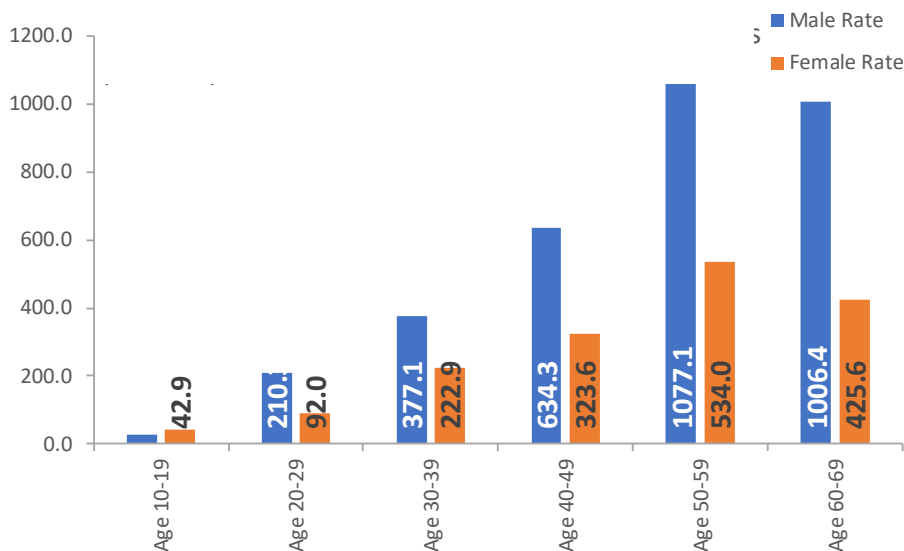
**Figure 3.2a Emergency Admissions where Alcohol-related cause is the primary diagnosis; 2019-2022**



(Source: Hospital Episode Statistics)

The breakdown of admissions due to alcohol is shown below, first by gender and age (fig 3.2b), then by ethnicity (fig 3.2c). Males account for the majority (68%) of emergency admissions due to alcohol, with an overall rate of 441 per 100,000 for males and 218 per 100,000 for females. The age bands of 50-59 and 60-69 show the highest rate of admissions in both males and females.

**Figure 3.2b Emergency Admissions where Alcohol-related cause is the primary diagnosis; rate per 100,000 residents by age and gender, 2019-2022**

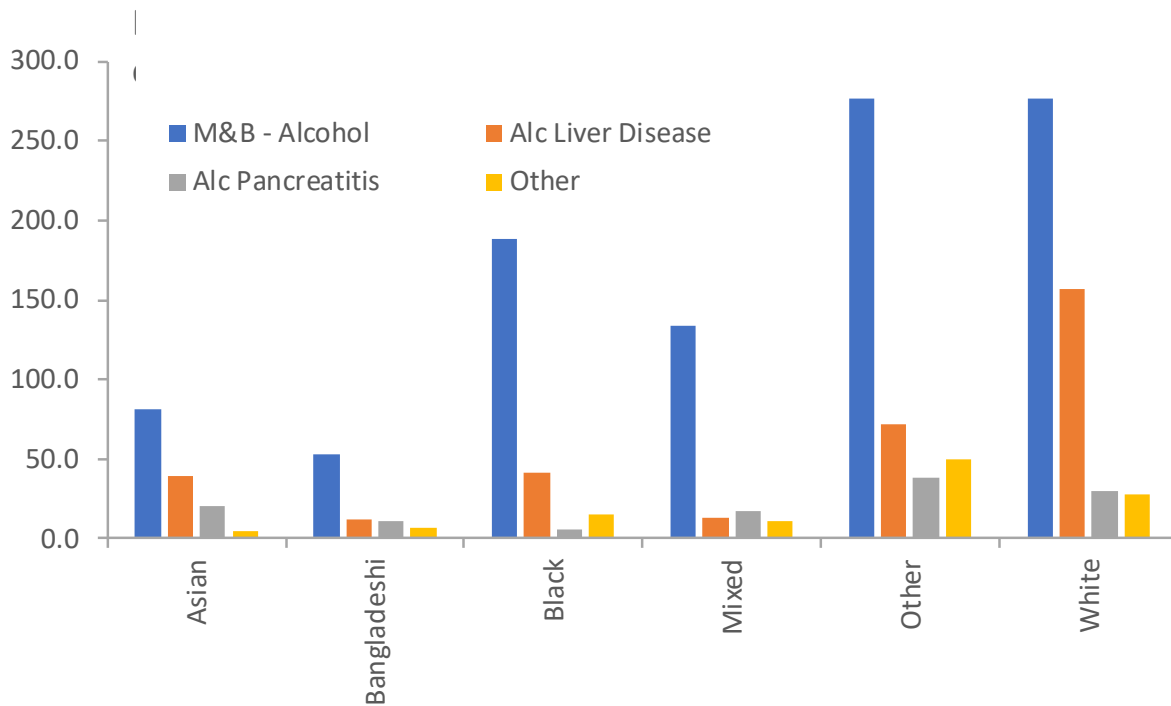


(Source: Hospital Episode Statistics)



The rate of admissions for alcohol-related conditions are highest among White and Other ethnic groups, and are lowest among Bangladeshi and Other Asian groups. This suggests that harmful drinking may be more concentrated among these groups; though issues with accurate coding of ethnicity must be considered.

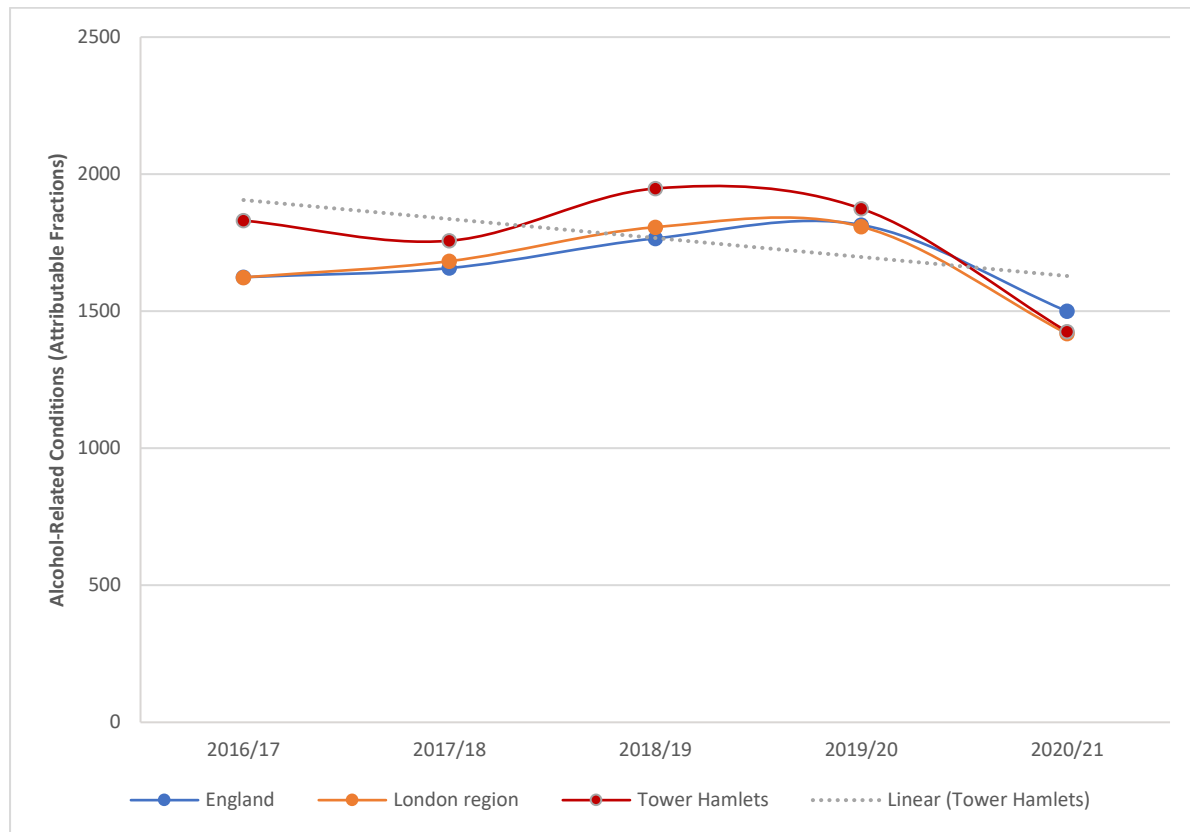
**Figure 3.2c Emergency Admissions where Alcohol-related cause is the primary diagnosis: rate per 100,000; by cause and ethnicity, 2019-2022**



Source: Hospital Episode Statistics. Note "Asian" includes all non-Bangladeshi Asian ethnic groups.

Data for the broader measure of alcohol-related conditions are set out below. The alcohol-related conditions refer to a wider range of health conditions where a proportion of the health impact (often relatively small) can be attributed to alcohol consumption. The indicator is constructed using "attributable fractions", which estimate what proportion of admissions could be said to be due to alcohol, based on the conditions for which patients are admitted, and the known contribution that alcohol makes to each condition. As such the rates are modelled estimates of the overall burden of alcohol at population, largely related to lower- or moderate-level drinking.

**Figure 3.3 Admission episodes for alcohol-related conditions (Broad) (Persons), 2016-17 to 2020-21, Tower Hamlets, London, England Hospital Admissions Rate using attributable fractions**



(Source: OHID, Fingertips)

The hospital admissions rate for alcohol-related conditions in Tower Hamlets (using a broad definition) had been higher in Tower Hamlets than nationally and in London, but declining since 2018-19 to near parity with the overall linear trend in admissions slowly declining (a non-significant change). The decline in 2020-21 is likely due to overall decline in admission rates due to the pandemic – rather than changes to the burden of alcohol locally.

**What this tells us**

While it is likely that some of the data set out above has been affected by the Covid pandemic (potentially limiting access to hospital for treatment for instance) the data indicates that there is a cohort within the population whose health is being adversely affected by heavy alcohol consumption – for instance alcohol-specific hospital admissions have (until recently) consistently been above national and London rates. More generally, alcohol continues to cause a substantial burden to overall health of a large part of the population, as the admissions for alcohol-related conditions show. The overall picture is one of a population in which alcohol continues to have a negative impact on health and health outcomes.

## 4.2 Drug misuse

### *Key findings:*

- Deaths from drugs have fluctuated over time but have recently (from 2017 onwards) seen a slight increase and now correspond with the rate for London. Very small numbers in these data indicates some caution in the interpretation of the data: these changes could be due to chance.
- Hospital admissions for drug poisoning (a wider measure of drug-related health impact) in Tower Hamlets are just over half that of the national rate.
- Hospital emergency admissions data suggest that drug related harms are concentrated among males (who account for 63% of admissions) and among people of White ethnicity (who account for around half of the admissions, while admissions from the Bangladeshi community represent around a fifth of admissions)
- Tower Hamlets has consistently had the highest rates of opioid prescriptions (per patient) in North East London. These are likely not 'illicit' drugs, nonetheless this suggests a need to review the reasons for these high prescription levels.

### 4.2.1 The effects of drug misuse

Drug misuse can cause a range of health-related problems, including:

- mental health problems such as anxiety, depression, psychosis, personality disorder and suicide,
- lung damage,
- cardiovascular disease,
- blood-borne viruses,
- liver damage from undiagnosed and untreated hepatitis C virus (HCV) (which is particularly high among people who inject drugs),
- arthritis and immobility among injectors,
- poor vein health in injectors,
- sexual risk taking and associated sexually transmitted infections (STIs),
- overdose and drug poisoning.

This section explores data in relation to health harms caused by drugs.

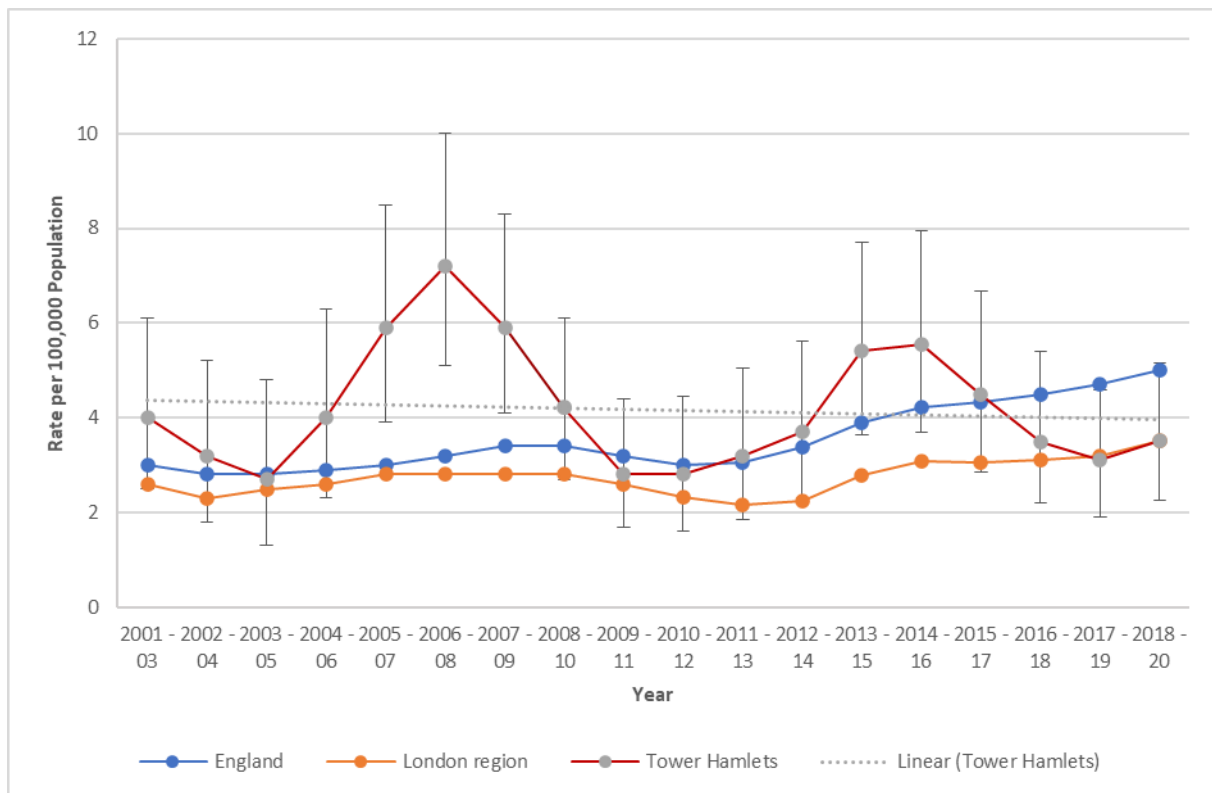
## 4.2.2 Drug-related harm

### Drug-Related Deaths

A key metric for understanding the impact of drugs is in relation to deaths caused by drug misuse.<sup>14</sup>

Data for Tower Hamlets, compared to London and national rates, are set out at Figure 4.

Figure 4 Deaths from drug misuse (Persons), 3-year intervals, Tower Hamlets, London and England, 2001-3 to 2018-20 (with confidence intervals)



(Source: NDTMS, OHID Fingertips)

Adjusting for the size of the resident population, the trend in drug-related deaths in Tower Hamlets has fluctuated since 2001-3, with two peaks in 2006-8 (where Tower Hamlets mortality rate was higher than London and nationally) and between 2013-17, noting however that there are wide confidence intervals suggesting that changes in the numbers of death are likely due to random variation (i.e. not due to change in the underlying risk of mortality).

The most recent deaths from drug misuse (2017 onwards) can be shown to track trends across London closely. There is a weak relationship between rates of deaths from drug misuse in Tower Hamlets compared to London ( $r=0.27$ ) and no relationship with trends

<sup>14</sup> Drug misuse deaths are defined as a death where the underlying cause is drug abuse or drug dependence or any of the substances involved are controlled under the Misuse of Drugs Act 1971.

across England ( $r=0.02$ ), suggesting mortality rates are affected by factors that are potentially locally specific and which are not driving drug deaths elsewhere in the country.

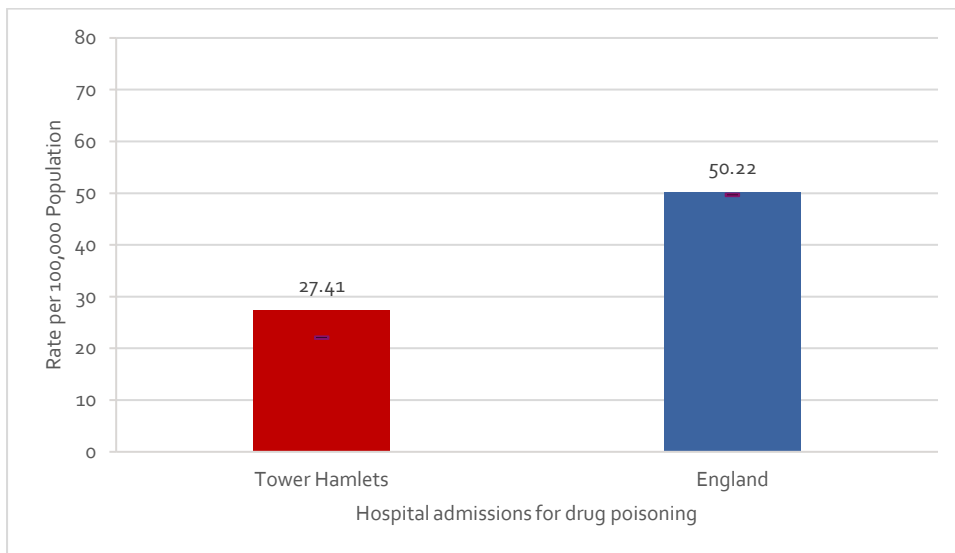
### Ambulance call-outs

Between 2019 and 2021 there were over 1,400 Ambulance call-outs where the “illness” was cited as drug overdose. The wards with the highest levels of call-outs were Bethnal Green, Spitalfields and Banglatown, and St Peter’s.

### Hospital Admissions

Data with regard to hospital admissions for drug poisoning are explored below.<sup>15</sup>

**Figure 5 Hospital admissions for drug poisoning, Tower Hamlets and England, 2020-21 weighted by the resident population (100,000)**



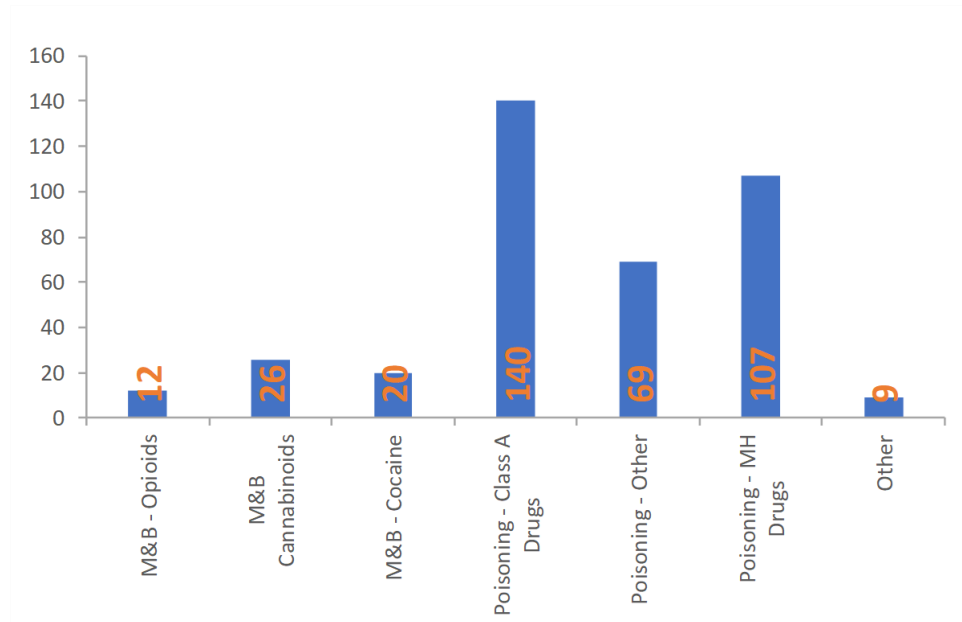
(Source: Office for Health Improvement and Disparities, Adult Drug Commissioning Support Pack: 2022-23: Key Data. Planning for drug prevention, treatment and recovery in adults)

The hospital admissions for drug poisoning in Tower Hamlets (27.41 per 100,000) can be shown to be just over half that of the national estimate (50.22 per 100,000).

The most common primary diagnosis for an emergency admission relating drugs is poisoning with Class A drugs. This accounts for nearly a third of all admissions at 36.5%. Hospitalisation related to other drugs, or to Mental and Behavioural reasons (related to Cannabinoids, Cocaine or Opioids) makes up a smaller proportion of admissions, mirroring national trends.

<sup>15</sup> This is a wider measure of drug misuse and includes drug poisoning that is not related to drug misuse (albeit that drug misuse makes up around two-thirds of drug poisonings). For details see: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2020#drug-misuse-in-england-and-wales>

**Figure 6a Hospital emergency admissions where drugs are primary diagnosis; rate per 100,000; Tower Hamlets 2019-2021.**



(Source: Hospital Episode Statistics).

As the charts below show, emergency admissions due to drugs vary by age and gender. Males account for 63% of overall admissions. Among females, rates of admission are highest among younger age bands 20-29. Among males, higher rates of admissions in age bands, 20-29 and 50-59 years (figure 7a). White ethnicities account for around half of the admissions, while admissions from the Bangladeshi community represent around a fifth of admissions (figure 7b).

**Figure 7a Hospital emergency admissions where drugs are primary diagnosis; by age and gender; rate per 100,000; Tower Hamlets 2019-2021.**

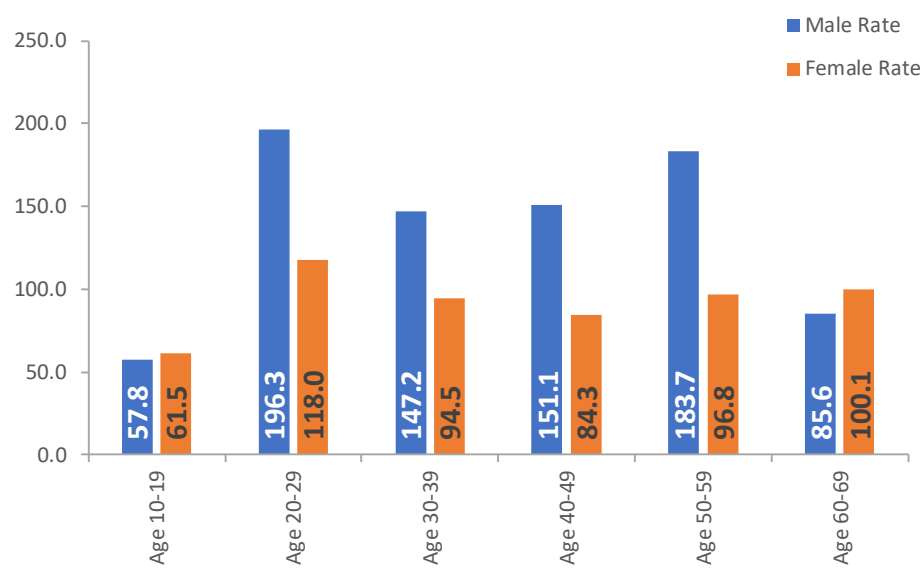
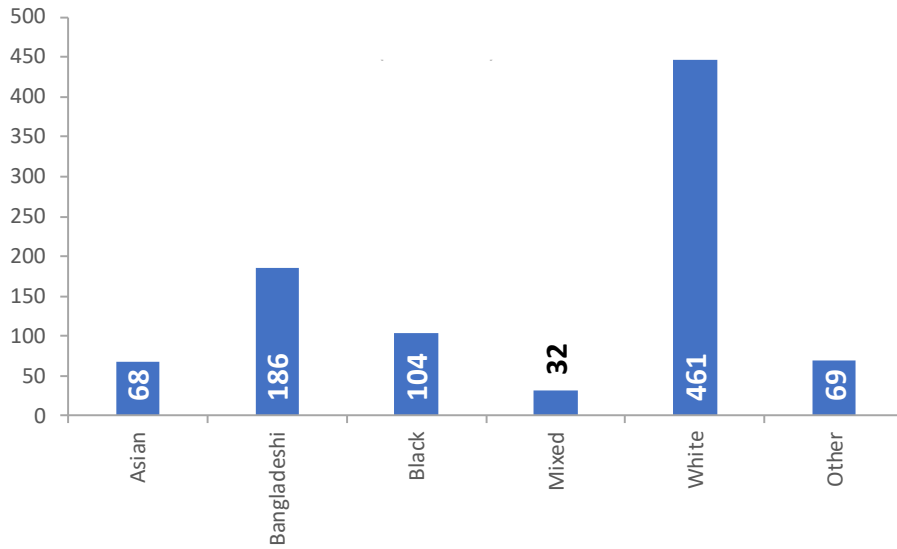


Figure 7b: Hospital emergency admissions where drugs are primary diagnosis; by ethnicity; Tower Hamlets 2019-2021.

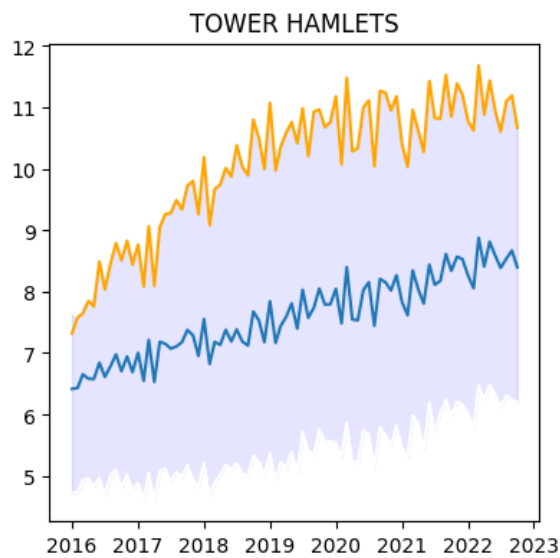


(Source: Hospital Episode Statistics)

**Prescription opioid use**

Data at Figure 8 sets out levels of non-illicit prescription opioid use in Tower Hamlets.

Figure 6 Number of unique persons ordering opioids per month (Rate per 1,000)



= Rate for North East London
  = Rate for Tower Hamlets
  = Range (max to min rate) for North East London

The data at Figure 8 demonstrates that the rate of patients ordering opioids each month increased for all places from Jan 2016 to Oct 2022. The data also indicates that Tower Hamlets has the highest rate of prescription opioid use in North East London.

The data at Figure 8 will include patients who clinically need to be on opioids and therefore the data does not therefore necessarily indicate problematic prescription opioid use. In the absence of data looking into individual patient condition's, it is not possible to say to what extent the opioid use described is clinically appropriate for the patient and to what extent it points to an issue of dependence.

#### **What this tells us**

While data on drug related deaths necessarily relates to a small number of individuals (and is therefore liable to significant shifts) it remains the case that in Tower Hamlets there are consistently a number of drug-related deaths in Tower Hamlets. This suggests that, like elsewhere, Tower Hamlets has a cohort in the population with very high levels of need and vulnerability some of whom are either not accessing treatment or who are dying in treatment despite the support provided.

Data on drug poisonings suggests that levels are lower than in England, which may suggest good practice to control drug misuse. However, there is a cohort in the population who are misusing drugs to the extent that it requires hospital admission.

## **4.3 Adults requiring specialist drug and alcohol treatment**

### **Key findings**

- The estimated prevalence rate of opiate and crack users in Tower Hamlets is higher than the rates for England and London. Rates of opiate only and crack only use are also higher in Tower Hamlets than for London.
- Tower Hamlets has the highest total number of people in treatment in London for 2020-21 (1,945) and one of the highest rates of treatment demand when weighted for resident population (10.1 per 1,000 of population).  
Nearly two thirds (65%) of the treatment population are opiate users while 16% are alcohol users (2020-21).
- The number of opiate users in treatment has declined since 2011-12. This mirrors trends seen nationally. Estimates of the percentage of opiate and crack users *not* in



treatment in Tower Hamlets show an upward trajectory indicating a greater proportion of drug users not accessing treatment.

- The number of people in Tower Hamlets accessing treatment for alcohol peaked in 2013-14 and decreased thereafter.
- There has been a recent increase (from 2019 onwards) in non-opiate users in treatment. The second-highest drug in terms of numbers of people in treatment was for Cannabis, with 46% of users in Tower Hamlets using Cannabis. This may suggest that there is a growing need to support users of non-opiate drugs.
- A growing proportion of the treatment population is aged 50 years and above (23% in 2020-21). This ageing cohort reflects trends nationally and indicates higher need around physical and mental health.
- The gender and ethnic make-up of the treatment population appears consistent with levels of need in the borough, as indicated by metrics such as hospital admissions. The majority of those in treatment are male (76% male versus 24% female). White service users form 58% of the treatment population, 30% are of Asian/Asian British heritage and 7% Black/African/Caribbean/Black British.

The data in sections 4.1 and 4.2 (above) shows general levels of impact of drugs and alcohol on the population of Tower Hamlets as a whole. This section looks specifically at the size and profile of the local population in need of specialist drug and alcohol treatment.<sup>16</sup>

#### 4.3.1 Prevalence of opiate and crack misuse

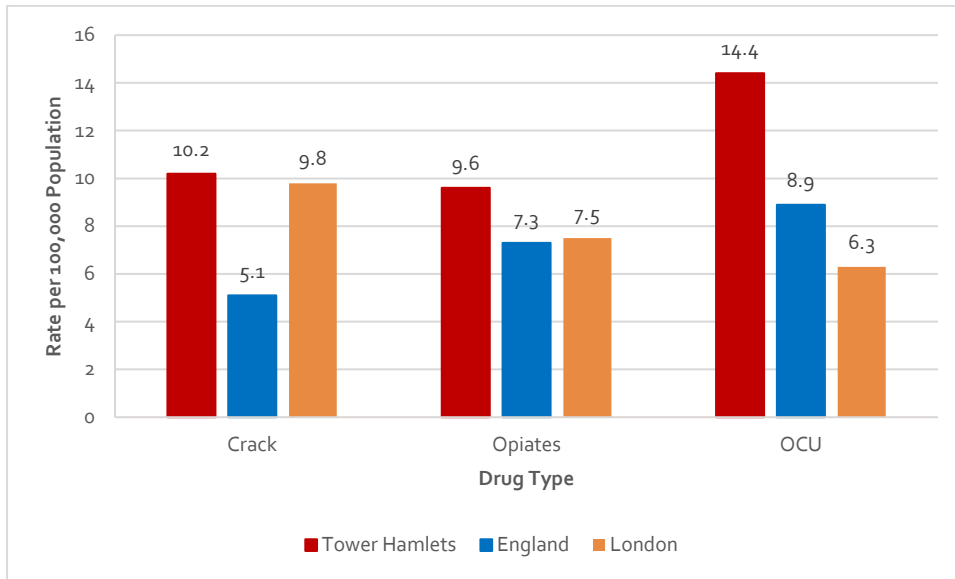
Data at Figure 9 sets out the estimated population of opiate and crack users (OCUs) in Tower Hamlets, London and England (expressed as a rate per 100,000 of the population). OCUs are those who use both opiates *and* crack. This data is set against those who use just opiates or just crack.

This is an estimated prevalence level derived from the modelling of data and is not a direct measure of need. As such the data should be treated as indicative rather than as a precise measure.

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<sup>16</sup> Note that prevalence estimates are largely based on 2016-17 data and are currently being updated. This means that there is as “lag” in the data and that the estimates throughout should be treated with a degree of caution due to this lag.

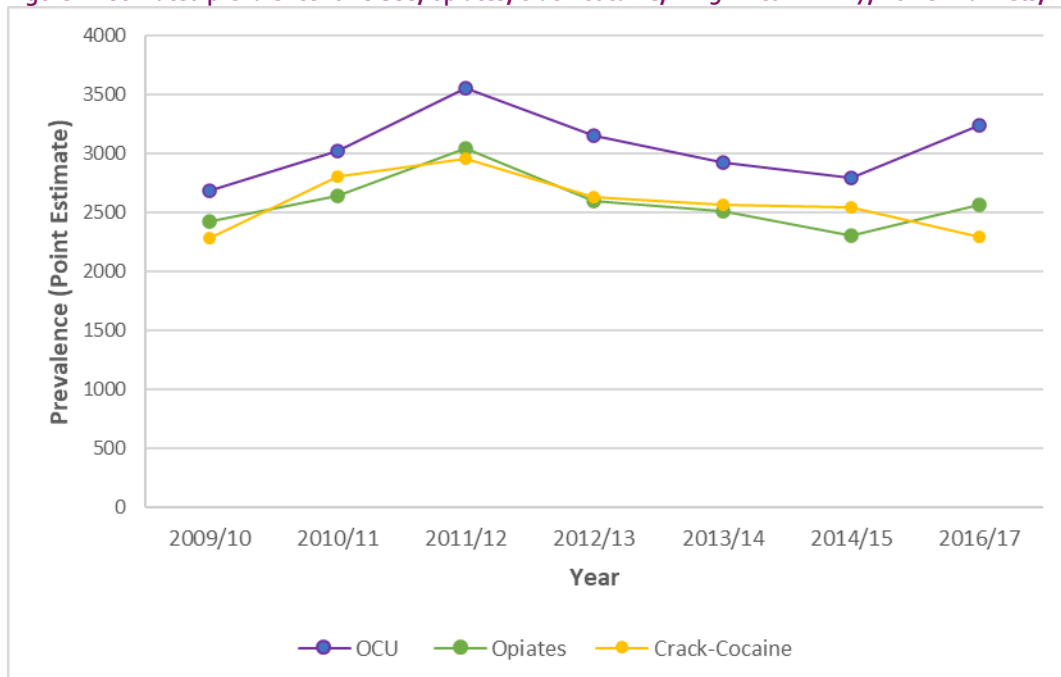
Figure 7 Estimated prevalence for OCUs, opiates, crack-cocaine, 2016-17, Tower Hamlets, London and England, weighted by the resident population (100,000)



(Source: Office for Health Improvement and Disparities, Adult Drug Commissioning Support Pack: 2022-23: Key Data. Planning for drug prevention, treatment and recovery in adults)

Across all drug types, it can be shown that, after adjusting for the resident population, the rate of drug use for OCUs, crack, and opiates are all higher than London and England estimates. Although there is close similarity between the crack-cocaine rate (10.2 in Tower Hamlets, 9.8 for London), there is disparity between the OCU rate (14.4 in Tower Hamlets and 6.3 in London). (The historic nature of the data – from 2016/17 – means that the data should be used with some caution). The point above regarding the estimated nature of the data should also be recollected when looking at these figures.

Figure 8 Estimated prevalence for OCUs, opiates, crack-cocaine, 2009-10 to 2016-17, Tower Hamlets, London



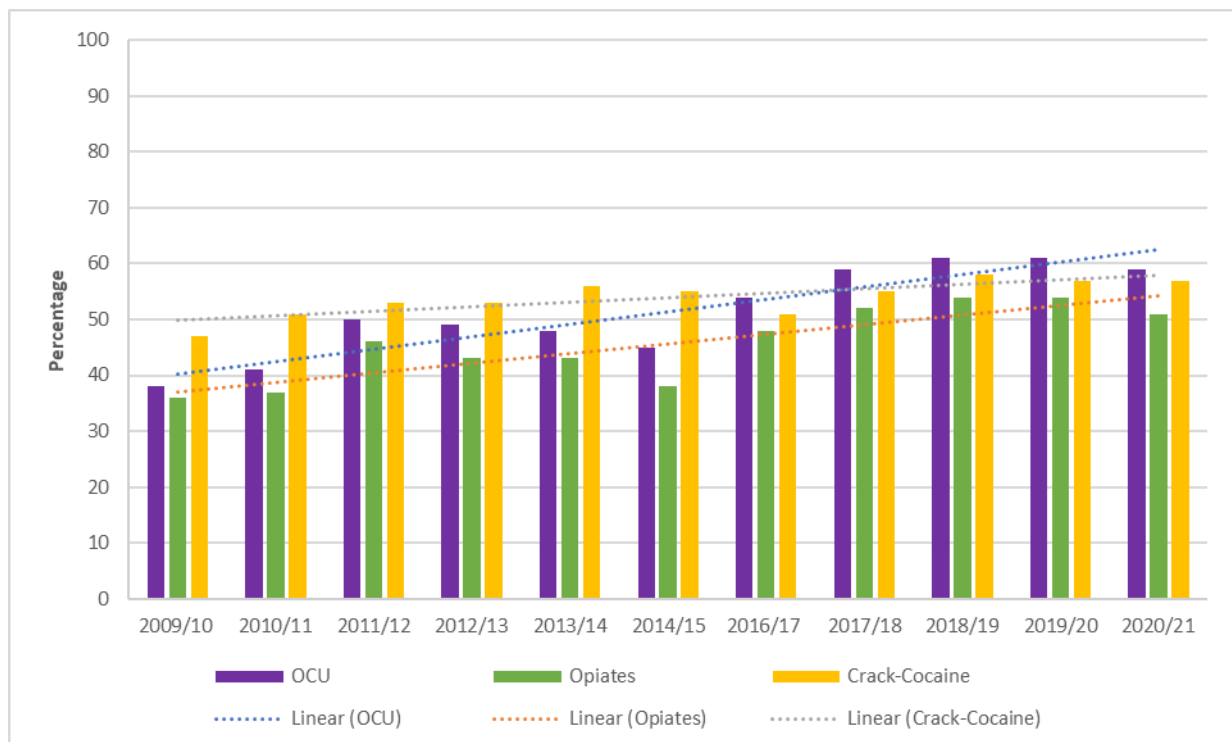
(Source: NDTMS, ViewIT)

There was a peak in the estimated prevalence for OCUs (n=3,561), opiates (n=3,047) and crack-cocaine (n=2,955) in 2011-12. There was an uptick in the estimated prevalence of OCU and opiates from 2014/15, compared to a commensurate drop in the estimate for crack-cocaine misuse. Note that these prevalence estimates are modelled; and are only available up until 2016-17.

What the data tells us therefore is that there is consistently a cohort of individuals who are using both opiates and crack and that the numbers were rising in the last period when the estimate was carried out. While there is a population of crack only users, the numbers in this group appear to be declining in the most recent years for which estimates are available.

Based on these modelled estimates of prevalence, and on numbers receiving treatment, it is possible to estimate the level of “unmet need” i.e. numbers of people who require treatment, who are not in treatment. Data at Figure 11 gives an indication of the level of unmet need for OCUs in Tower Hamlets, presented as a percentage (total estimate/people reported in treatment) in Tower Hamlets. Note that since 2016-17, modelled estimates of prevalence are not available and have been extrapolated forward, meaning particular caveats are required on estimates of unmet need since 2016-17.

Figure 9 Estimated levels of unmet need for OCUs, opiates, crack-cocaine, 2009-10 to 2020-21, Tower Hamlets



(Source: NDTMS, ViewIT)

The data shows the percentage of OCUs who are not in treatment versus the estimated total number of OCUs in Tower Hamlets which is based on extrapolated data last provided as a point estimate based on 2016-17 data. The broad trend for all OCU drug types (albeit with a shallower trend for crack-cocaine use) is for an increase in the unmet need for OCUs, opiates and crack cocaine. In 2020/21 the majority of OCUs, opiate and crack users were determined as not being in treatment. The declining numbers in treatment over this decade (see 4.3.2 below) suggest the reason for this trend.

#### ***What this tells us***

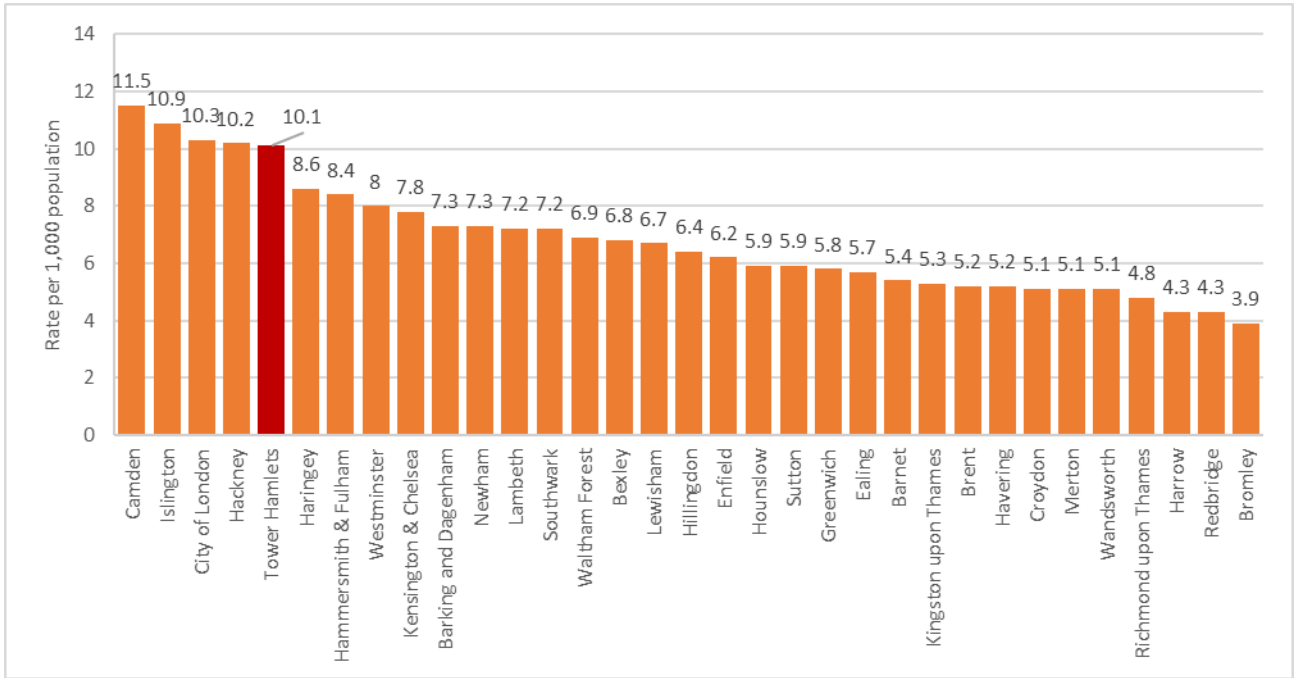
While data on OCU prevalence rates are estimates (and not therefore wholly accurate measures) there is a consistent picture of a sizeable local OCU population. Furthermore, there are larger numbers of crack only and opiate only users. This clearly indicates a pronounced need for specialist treatment for Class A drug users in the borough. Other data indicates that there is an ongoing need to engage with Class A drug users with prevalence rates for OCUs and opiate users increasing (and a modest downward trend in the rate of crack users). There is therefore no evidence of a dwindling need among Class A users. With higher levels of unmet need the data indicates rather that more people could benefit from treatment than do at the current time.

### **4.3.2 Adult treatment population**

This section explores the size of the adult treatment population in Tower Hamlets.

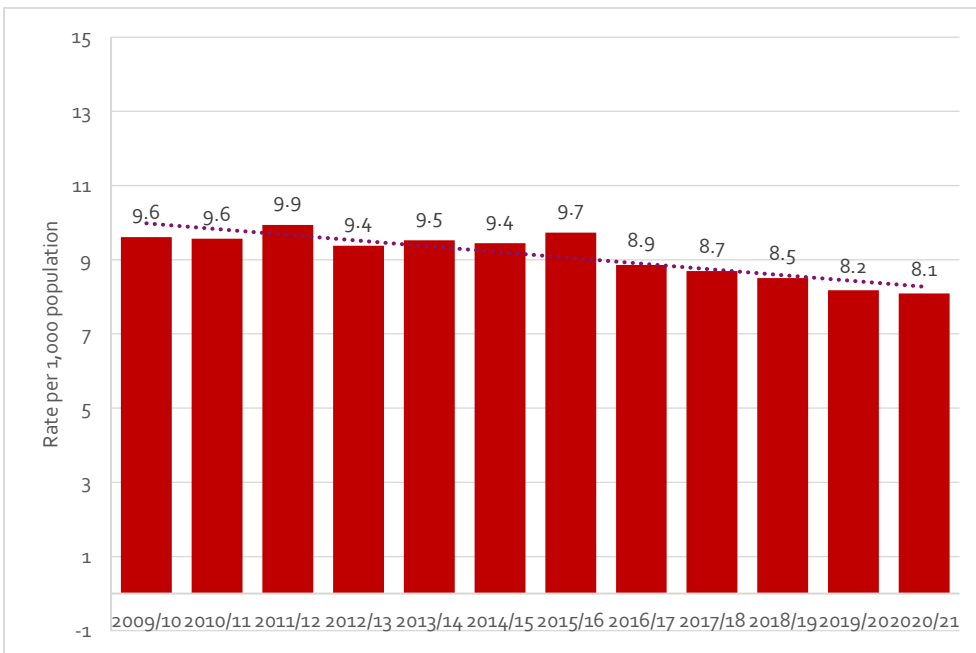
Figure 12 looks at the Tower Hamlets treatment population in comparison to other local authorities in London (expressed as both an absolute number and as a rate per 1,000 of population).

**Figure 10 Treatment population of London boroughs rate per 1,000 population (2020/21)**



The data at figure 12 shows that Tower Hamlets has the fifth largest number of people in treatment in London for 2020-21 (1,945) and one of the highest rates of treatment demand when weighted for resident population (at 10.1 per 1,000 population). The rate per 1,000 population for Tower Hamlets can be shown to be higher than the comparable estimates for London as a whole (6.2) and for England (7.6).

Figure 11 Trends in the rate per 1,000 population of people in treatment, Tower Hamlets, 2009-10 to 2020-21

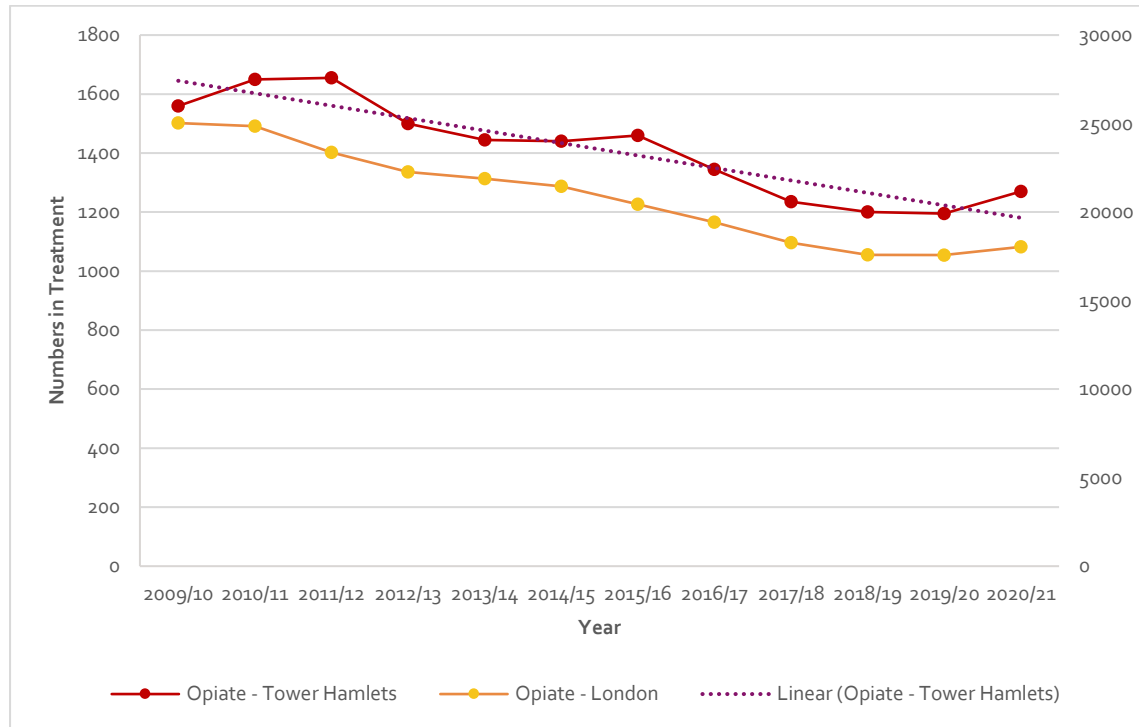


There is a shallow and non-statistically significant decline over time in the rate per 1,000 population of people in Tower Hamlets who are in treatment from a peak of 9.9 per 1,000 on 2011-12 to 8.2 per 1,000 in 2019-10.

**Treatment population by substance**

Figure 14 shows the numbers in treatment for opiate use in Tower Hamlets and in London.

**Figure 12 Opiate users in treatment, 2009-10 to 2020-21, Tower Hamlets, London**

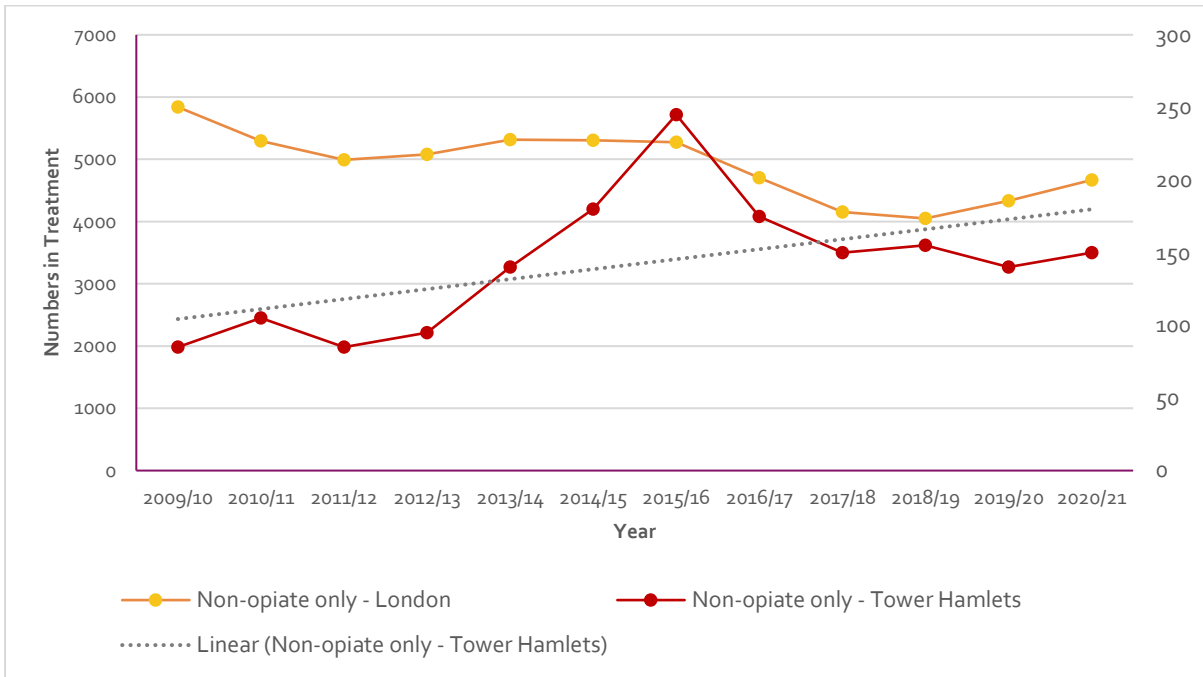


(Source: NDTMS, ViewIT)

The number of opiate users in treatment as measured by NDTMS has significantly declined from a peak in 2011-12 (1,655 users) to 1,270 in 2020-21, which can be shown as a broadly declining trend. There is a very strong correlation in numbers of opiate users in treatment in Tower Hamlets and across London ( $r=0.95$ ), suggesting that the factors which are determining this trend are not specific to Tower Hamlets. The period of decline in numbers runs parallel to the period in which there were cuts to funding in treatment services across London. The data may therefore depict the shrinking capacity of treatment services in Tower Hamlets and elsewhere rather than a drop in actual demand (albeit that this can only be inferred). An alternative explanation might be that opiate users are becoming more difficult to engage in treatment services hence the corresponding decline in numbers.

Data for non-opiate users in treatment is set out below.

Figure 13 Non-Opiate users in treatment, 2009-10 to 2020-21, Tower Hamlets, London



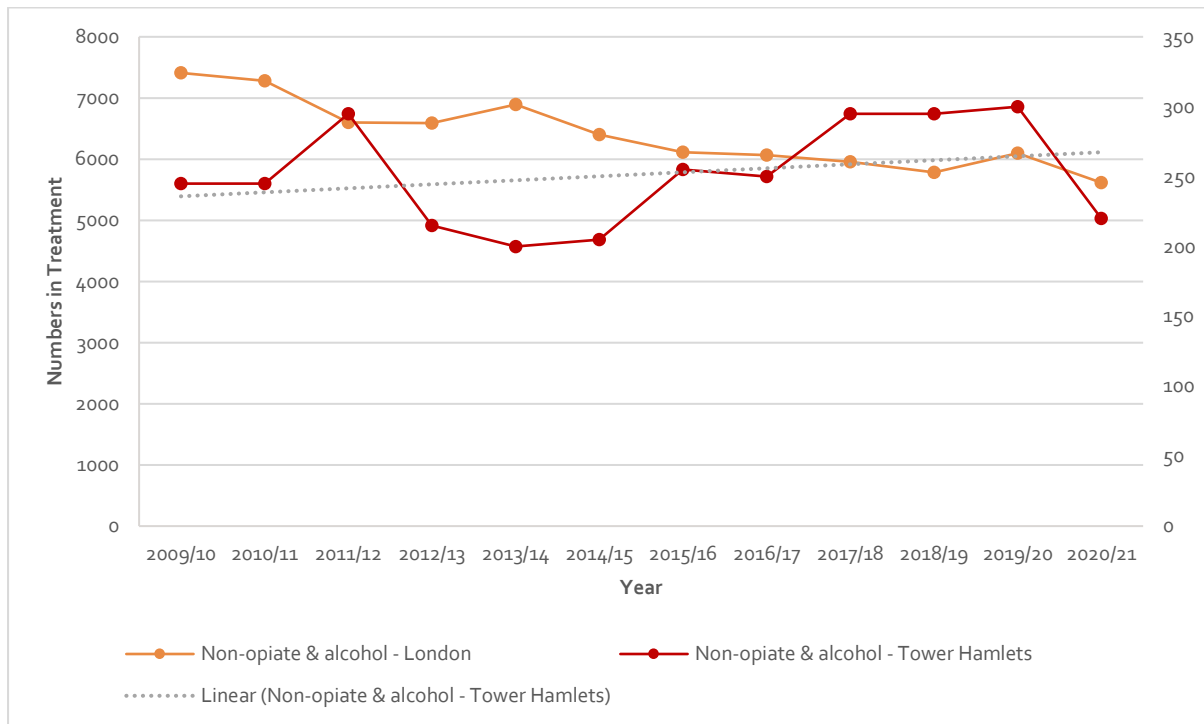
(Source: NDTMS, ViewIT)

The second-highest drug in terms of numbers of people in treatment was for Cannabis, with 46% of users in Tower Hamlets using Cannabis (this is higher than the proportion in Hackney). In Tower Hamlets, there was a peak in service users accessing treatment for non-Opiates in 2015-16 (n=180), with an overall trend of increasing the demand for services. In comparison, there was a weak negative correlation between the number of non-opiate users accessing services in Tower Hamlets with the rest of London ( $r=-0.19$ ), suggesting other local factors may have greater salience in determining the level of access to treatment services.

(There is no clear explanation from the data for the spike in presentations in 2015/16 and the corresponding fall thereafter, nor the more recent increase).

Data for the non-opiate and alcohol treatment population is set out at Figure 16.

Figure 14 Non-Opiate and alcohol users in treatment, 2009-10 to 2020-21, Tower Hamlets, London



(Source: NDTMS, ViewIT)

There has been some fluctuation in the number of presentations to treatment for Tower Hamlets, with an overall trend of a slight, non-significant increase in presentations from 2009-10 to 2020-21. There is a moderately weak negative relation between reports of non-opiate and alcohol treatment demand in Tower Hamlets with London ( $r=-0.31$ ). This suggests that the numbers accessing treatment among non-opiate and alcohol users is likely independent of London-wide trends.

Figure 17 below sets out data for the alcohol only treatment population.



Figure 15 Alcohol-only users in treatment, 20 09-10 to 2020-21, Tower Hamlets, London



(Source: NDTMS, ViewIT)

There has been some fluctuation in the number of reports of people in Tower Hamlets accessing treatment for alcohol-only problems, peaking in 2013-14 (n=505). Overall, from 2009-10 to 2020-21, there was a slight and non-significant decrease in the level of reporting of alcohol-only problems across the borough during this time. In contrast with other substances, numbers of people with an alcohol-only issue is moderately correlated with London-wide trends (r=0.57).

**What this tells us**

While the data indicates a reduction in numbers of opiate users in treatment, this does not suggest a drop in need for opiate treatment. As mentioned above, this is more likely to be related to changes in the capacity of treatment services. Moreover, the OCU estimate data would also imply that there is no downward trend in need for opiate treatment.

The recent increase (from 2019 onwards) in non-opiate users in treatment may suggest that, over and above the need for OCU and opiate treatment, there is a growing need to support users of other drugs.

Data on alcohol only clients, while on a downward trajectory, does not necessarily indicate a drop in need. Data at Table 1 indicated the majority of those who are alcohol dependent are

not in treatment. Therefore, despite the downward trend, the actual picture is likely to be of an ongoing pronounced need for alcohol treatment.

### *Socio-Demographic Indicators*

This section explores the profile of adults in drug and alcohol treatment in Tower Hamlets. The socio-demographic characteristics of people in treatment can be determined by examining NDTMS reports with the data set out below.

#### **Age and Sex**

The age of the adult treatment population is set out at Table 2.

**Table 2 Adult profiles: Age - All in treatment at the start of a treatment episode, 2009-10 to 2020-21, by age and substance type, Tower Hamlets, Percentage (%)**

	09/10	10/11	11/12	12/13	13/14	14/15	16/17	17/18	18/19	19/20	20/21
<b>ALL</b>											
18-29	25	22	20	18	17	15	16	14	15	15	14
30-49	64	66	67	68	67	69	68	67	64	63	64
50+	11	11	13	14	16	16	16	18	21	22	23
<b>OPIATE</b>											
18-29	26	22	19	16	14	10	10	7	6	6	6
30-49	67	70	72	74	75	77	77	77	74	72	70
50+	7	8	9	10	11	13	14	16	20	23	24
<b>NON-OPIATE</b>											
18-29	41	48	38	42	39	44	47	43	33	39	29
30-49	47	43	56	47	54	50	49	49	53	52	61
50+	12	10	6	11	7	6	4	9	13	10	11
<b>ALCOHOL</b>											
18-29	15	10	13	12	13	13	12	16	22	19	17
30-49	60	57	55	58	53	54	54	49	46	48	50
50+	25	33	32	30	34	32	34	34	33	33	33
<b>NON-OPIATE &amp; ALCOHOL</b>											
18-29	29	27	31	30	35	29	33	31	36	35	33
30-49	61	63	56	57	53	59	55	57	54	53	55
50+	10	10	14	14	13	12	12	12	10	12	12

(Source: NDTMS, ViewIT)

The proportion of people in treatment who are aged 18-29 has declined from a peak in 2009-10 of 25% to 14% in 2020-21. The balance of people aged 30-49 years has stayed broadly stable at around 63-69%. In contrast, the percentage of people aged 50 or over has more than doubled from 11% in 2009-10 to 23 in 2020-21. This reflects an ageing population of

opiate users which has increased from 7% in 2009-10 to 23% in 2020-21 which is a trend seen nationally. In comparison, the percentage of non-opiate users aged 30-49 has increased from 47% in 2009-10 to 61% in 2020-21 (including a notable spike in reports from 52% in 2019-20). Alcohol-only, and non-opiate and alcohol users are consistently represented at the same or similar levels (noting some annual fluctuations).

The gender of the treatment population is set out below.

**Table 3 Adult profiles: Sex - All in treatment at the start of a treatment episode, 2019-20, Tower Hamlets, Percentage**

	19/20 (%)
Male	76
Female	24

(Source: NDTMS, ViewIT)

The proportion of female service users are at around one-quarter (24%) having risen from around a fifth in 2016-17.

## Ethnicity

Data regarding the ethnicity of the adult treatment population is set out at Table 4.

**Table 4 Adult profiles: Ethnicity - All in treatment at the start of a treatment episode, 2009-10 to 2020-21, Tower Hamlets, Percentage**

	09/10 (%)	10/11 (%)	11/12 (%)	12/13 (%)	13/14 (%)	14/15 (%)	15/16 (%)	16/17 (%)	17/18 (%)	18/19 (%)	19/20 (%)	20/21 (%)
White	61	61	60	60	60	59	57	58	58	59	58	58
Mixed/Multiple ethnic groups	4	4	4	5	5	6	6	6	6	6	5	5
Asian/Asian British	28	28	27	28	27	28	29	28	27	26	29	30
Black/African/Caribbean/Black British	6	6	7	6	7	7	8	7	8	8	7	7
Other ethnic groups	2	2	2	1	1	1	1	0	2	1	1	1

(Source: NDTMS, ViewIT and Office for National Statistics, Population Estimates by ethnic group and religion Research Report)

There is a broadly stable picture of presenting treatment demand by ethnicity. White service users form around 58% of the treatment population with Asian/Asian British at 30%.

Without ethnicity-specific estimates of 'need', we cannot say that the differences in the ethnic profile of the treatment population and the wider population represent inequities in access to services between different ethnic groups). National data from APMS shows that certain ethnic groups, particularly Asian groups, are less likely to use illicit drugs. So it is likely that there is differential need between population groups, which may be one reason for the differences between the treatment cohort and the overall borough population.

## Religion

**Table 5 Adult profiles: Religion - All in treatment at the start of a treatment episode, 2020-21, Tower Hamlets, Percentage**

	2020/21 (%)
None	30
Christian	29
Muslim	20
Unknown	17
Other	4
Decline	1

(Source: NDTMS, ViewIT)

The most frequently reported religion reported by service users was Christian (27-29%), followed by Muslim (20-29%). No religion was stated by 30 and 4% of service users.

## Sexual Orientation

Data regarding sexual orientation of the treatment population are set out below.

**Table 6 Adult profiles: Sexual Orientation - All in treatment at the start of a treatment episode, 2020-21, Tower Hamlets, Percentage**

	2020/21 (%)
Heterosexual	88
Not stated	5
Gay/Lesbian	4
Bisexual	2
Client asked and did not know or is not sure	1
Other	0

(Source: NDTMS, ViewIT)

Most service users in treatment were reported to be heterosexual (88-93%).

## Parental Status

Data on the parenting status of those in treatment is set out at Table 7.

**Table 7 Adult profiles: Parental Status - All in treatment at the start of a treatment episode, 2009-10 to 2020-21, Tower Hamlets, Percentage**

	09/10 (%)	10/11 (%)	11/12 (%)	12/13 (%)	13/14 (%)	14/15 (%)	15/16 (%)	16/17 (%)	17/18 (%)	18/19 (%)	19/20 (%)	20/21 (%)
Parent living with children	15	15	15	14	14	15	14	14	15	14	13	17

Not a parent and living with children	20	20	20	20	21	21	19	15	9	7	6	6
Parent not living with children	11	15	15	14	16	14	12	17	25	26	26	21
Not a parent and not living with children	53	51	50	51	50	50	55	54	52	53	54	56

(Source: NDTMS, ViewIT)

There has been a notable drop in the proportion of service users reported as 'not a parent and living with children' from around one-fifth of all reports from 2009-10 to 2015-16, which may be a function of the changing age patterns of people in treatment (away from a younger cohort). Commensurately, there has been an increase in reports stating that a person is a parent but not living with children (from 12% in 2015-16 to 21% in 2020-21). The most frequent response for service users was not a parent and not living with children, reaching 56% of all reports in 2020-21.

## Housing

The housing status of the treatment population is set out at Table 8.

**Table 8 Adult profiles: Housing - All in treatment at the start of a treatment episode, 2020-21, Tower Hamlets, Percentage**

	09/10 (%)	10/11 (%)	11/12 (%)	12/13 (%)	13/14 (%)	14/15 (%)	15/16 (%)	16/17 (%)	17/18 (%)	18/19 (%)	19/20 (%)	20/21 (%)
No problem	69	72	73	71	68	68	73	69	64	73	69	68
Housing Problem	17	14	13	16	19	20	18	23	24	16	20	21
Urgent Housing Problem	13	13	13	11	11	10	7	6	11	11	12	11
Other	1	1	0	1	3	2	2	2	1	1	0	0

(Source: NDTMS, ViewIT)

There is a consistent picture of the nature of housing needs among service users in treatment. The majority of service users have been reported to have no housing problem (from 64% in 2017-18 to 73% in 2011-12 and 2018-19). Similarly, around one-fifth of people in treatment report some housing issue, with around one in ten reporting an urgent need for housing.

**Table 9 Adult profiles: Housing - All in treatment at the start of a treatment episode, 2020-21, Tower Hamlets, London and England Percentage**

	09/10 (%)	10/11 (%)	11/12 (%)	12/13 (%)	13/14 (%)	14/15 (%)	15/16 (%)	16/17 (%)	17/18 (%)	18/19 (%)	19/20 (%)	20/21 (%)
<b>No Problem</b>												
England	79	80	80	80	80	81	80	80	80	80	81	83
London	73	74	75	75	76	76	75	75	74	76	78	77

Tower Hamlets	69	72	73	71	68	68	73	69	64	73	69	68
<b>Housing Problem</b>												
England	13	13	13	12	12	12	11	11	11	11	11	12
London	16	15	14	14	13	14	14	14	15	14	14	15
Tower Hamlets	17	14	13	16	19	20	18	23	24	16	20	21
<b>Urgent Housing problem</b>												
England	6	6	7	7	7	7	7	7	8	8	7	6
London	9	9	9	9	9	9	9	9	9	9	8	7
Tower Hamlets	13	13	13	11	11	10	7	6	11	11	12	11
<b>Other</b>												
England	2	1	1	1	1	1	1	2	2	2	0	0
London	1	2	1	2	2	2	2	2	2	2	0	0
Tower Hamlets	1	1	0	1	3	2	2	2	1	1	0	0

Relative to London and England, Tower Hamlets residents are more likely to report having a housing problem including an urgent housing need.

### **What this tells us**

The data on age suggest that the specialist treatment population is slowly evolving, becoming older (with nearly a quarter now aged 50 years or over). This indicates that services need to evolve to respond to the needs of a population who are likely to have a range of co-morbid health needs and complications.

The data on ethnicity shows that the ethnic make-up of the cohort of people in treatment is similar to the ethnic make-up of emergency admissions for drugs. As in other inner London boroughs, people of white ethnicity make up a larger majority of those in treatment, compared to the overall borough populations. There are a number of potential explanations for this. As the emergency admissions suggest, It cannot be assumed that all ethnic groups have the same level of need for treatment, and data from the APMS nationally suggest that people of Asian ethnicity are less likely than those of White or Black ethnicity to use illicit drugs.<sup>17</sup>

The data on housing status indicates a link between substance misuse and housing with a tenth of service users reporting an urgent housing problem and one in five a housing problem. Tower Hamlets also includes a higher rate relative to London and England of housing needs (including acute levels of need). This evidences the need to link substance

<sup>17</sup> [Illicit drug use - GOV.UK Ethnicity facts and figures \(ethnicity-facts-figures.service.gov.uk\)](https://www.ethnicity-facts-figures.service.gov.uk)

misuse services to housing and accommodation services, recognising that recovery will be affected by lack of stable accommodation.

### 4.3.3 Substance use of treatment population

This section explores the substances used by those in treatment. Table 10 provides an overview, dividing the treatment population into opiate, non-opiate (only) and alcohol groups.

**Table 10 Adult profiles: Substance Misuse Need- All in treatment at the start of a treatment episode, 2009-10 to 2020-21, Tower Hamlets, Percentage**

	09/10 (%)	10/11 (%)	11/12 (%)	12/13 (%)	13/14 (%)	14/15 (%)	15/16 (%)	16/17 (%)	17/18 (%)	18/19 (%)	19/20 (%)	20/21 (%)
Opiate	68	72	69	67	63	63	62	63	59	59	61	65
Non-opiate only	4	5	4	4	6	8	10	8	7	8	7	8
Alcohol only	18	13	15	20	22	20	16	17	20	19	17	16
Non-opiate & alcohol	11	11	12	10	9	9	11	12	14	14	15	11

(Source: NDTMS, ViewIT)

Around two-thirds of the treatment population (59-72%) were reported to be users of opiates, with around one-fifth (13-22%) reported as users of alcohol only.

In 2020-21 a low proportion of people in treatment reported as users of club drugs and new psychoactive substances (no more than 1% of any substance reported using Ecstasy, GHB, Ketamine, Mephedrone, Methamphetamine and New Psychoactive). Over the last 10 years no more than 1% of the treatment population have reported use of club drugs.

**Table 11 Adult profiles: Substance Misuse Need Selected Substances- All in treatment at the start of a treatment episode, 2009-10 to 2020-21, England, London and Tower Hamlets, Percentage**

		09/10 (%)	10/11 (%)	11/12 (%)	12/13 (%)	13/14 (%)	14/15 (%)	15/16 (%)	16/17 (%)	17/18 (%)	18/19 (%)	19/20 (%)	20/21 (%)
Opiate and crack cocaine	E	15	15	13	13	13	13	14	17	18	18	19	16
Opiate and crack cocaine	L	23	23	22	20	19	18	18	20	21	21	21	21
Opiate and crack cocaine	TH	40	45	43	36	32	33	32	37	31	30	36	35
Opiate (not crack cocaine)	E	23	21	20	19	18	18	17	16	15	13	13	12
Opiate (not crack cocaine)	L	16	15	14	13	12	12	11	10	9	8	8	9
Opiate (not crack cocaine)	TH	18	14	15	14	15	15	13	12	10	9	9	11

crack cocaine)													
Crack cocaine (not opiate)	E	3	3	3	2	2	2	2	3	3	3	4	3
Crack cocaine (not opiate)	L	35	35	31	27	22	21	21	23	24	23	21	22
Crack cocaine (not opiate)	TH	6	7	9	6	5	7	9	10	6	6	7	5
Cannabis	E	20	20	21	21	21	20	20	20	20	19	20	21
Cannabis	L	25	26	27	27	26	26	25	25	25	24	25	26
Cannabis	TH	21	24	27	21	24	25	27	27	27	25	26	25
Cocaine	E	10	10	10	10	10	11	12	13	14	15	16	15
Cocaine	L	14	14	13	14	14	14	14	15	16	16	17	14
Cocaine	TH	9	8	7	6	9	12	10	7	9	13	14	11
Alcohol	E	59	61	63	63	64	63	62	60	60	60	59	60
Alcohol	L	56	58	59	61	62	61	61	61	62	62	61	59
Alcohol	TH	51	47	52	57	57	52	50	50	61	61	56	50

E = England, L = London, TH = Tower Hamlets

Although there is a shallow decline in OCU need, the rate of treatment demand in Tower Hamlets is higher than across London and nationally. For opiate only use, the level of treatment demand is consistently lower in Tower Hamlets than England, but is higher than across London (from 2011-12). Crack cocaine use whilst higher than England, is notably lower than London-wide figures. Rates of treatment demand increased from 2012-13 and is largely in line with London figures. Cocaine needs in Tower Hamlets has risen since 2016-17 but is lower than London and national figures (apart from 2014-15 in comparison to England). As expected given the profile of the borough, the level of demand for alcohol interventions is lower in Tower Hamlets (with the exception of a period between 2017 and 2019).

## Injecting

The injecting status of clients is explored at Table 12.

**Table 12 Adult profiles: Injecting Behaviour - All in treatment at the start of a treatment episode, 2020-21, Tower Hamlets, Percentage**

	Tower Hamlets 20/21 (%)	London 20/21 (%)	Engalnd20/21 (%)
Never previously injected	82	86	81
Previously injected	11	9	11
Currently injecting	7	5	7

(Source: NDTMS, ViewIT)

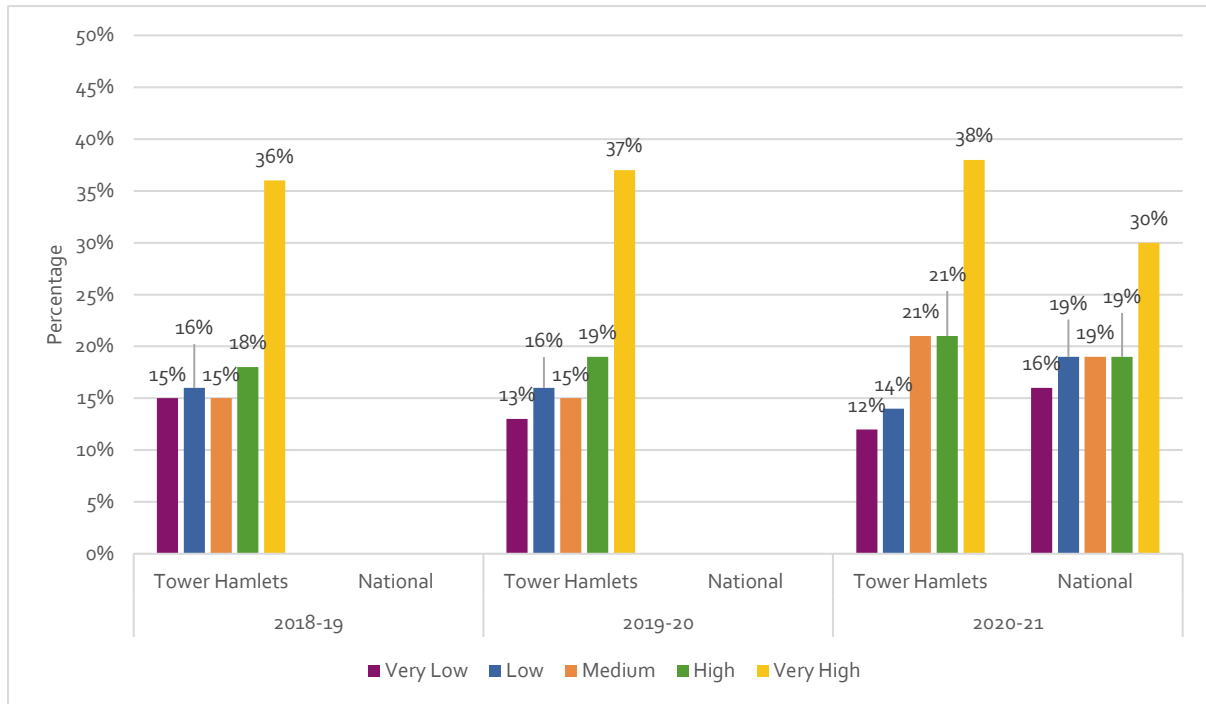


Most service users report no previous history of injecting (at 82%) at levels broadly consistent with London and national figures.

### Client Complexity

The following section looks at the treatment profile in terms of client complexity (as defined by OHID) and includes all opiate, non-opiate and alcohol clients.

**Figure 16 Treatment Complexity, Tower Hamlets and Local Outcome Comparator areas, 2018-19 to 2020-21 (data for LOC for 2020-21 only)**



(Source: OHID, Recovery Diagnostic Toolkit)

Tower Hamlets' entire treatment population can be shown to be less likely to be 'lower-risk' than in comparator areas ('very low' risk 12-15% compared to 15% in comparator areas; 'low' risk 14-16% compared to 19% nationally); broadly in line for 'medium' risk (15-21% in Tower Hamlets, relative to 19% nationally); but more likely to be a 'very high' risk (36-38%) relative to nationally (30%).

#### **What this tells us**

The data substantiates conclusions drawn earlier about the ongoing need to support and engage opiate users in the borough who continue to make up the majority of the treatment population. The alcohol treatment population has declined somewhat (as a proportion of the total treatment population) but the evidence indicates a need for greater numbers to access treatment for alcohol misuse (i.e. the drop is not due to a drop in need).

The data on opiate users indicates a high level of complexity with 38% designated as “Very high risk” (a proportion that is higher than for the comparator areas). (See Figure 18).

#### 4.3.4 Alcohol-only treatment population

This section sets out data with specific reference to the alcohol treatment population to better understand this sub-group of the treatment population.

##### *Demographic profile*

The demographic profile of the adult treatment population is set out at Table 13.

**Table 13 Socio-Demographic Characteristics of Tower Hamlets residents in alcohol-only treatment at treatment start, 2009-10 to 2020-21, Percentages**

	09/10 (%)	10/11 (%)	11/12 (%)	12/13 (%)	13/14 (%)	14/15 (%)	15/16 (%)	16/17 (%)	17/18 (%)	18/19 (%)	19/20 (%)	20/21 (%)
Male	71	70	79	78	73	72	71	74	65	63	67	69
Female	29	30	21	22	27	28	29	26	35	38	33	31
18-29	15	10	13	12	13	13	12	16	22	19	17	15
30-49	60	57	55	58	53	54	54	49	46	48	50	49
50+	25	33	32	30	34	32	34	34	33	33	33	36
White	79	80	74	73	77	75	71	71	68	71	68	65
Mixed/Multiple ethnic groups	2	3	6	6	4	5	5	6	6	5	3	4
Asian/Asian British	10	8	10	10	9	11	12	10	12	14	17	18
Black/African/Caribbean/Black British	6	5	7	9	8	9	12	13	12	9	10	12
Other ethnic groups	2	3	3	1	1	0	0	0	3	0	2	2

(Source: NDTMS, ViewIT)

The ratio of male-to-females accessing services has remained essentially constant at around 70 (male):30 (female).

Age profiles show mild fluctuations in the percentages of people accessing treatment, with a slight decline in people aged between 30-49.

There has been a decrease in the proportion of people accessing services from a White ethnic group (from 79-80% in 2009-10 and 2010-11 to 65% in 2020-21). In contrast, there has been an increase in the proportion of people with an Asian/Asian British heritage from 8-12% between 2009-10 to 2017-18 to 18% in 2020-21. As stated earlier, in the absence of data in relation to specific ethnic groups it is not possible to say whether the data indicates whether there are ethnic differentials in access or in needs being met.

### *What this tells us*

The data on alcohol-only clients indicates a slightly different population profile to drug users – for instance the slightly younger predominant age range. This suggests that the alcohol treatment cohort are somewhat distinct from drug (particularly opiate) users. While minority ethnic groups are represented in the alcohol treatment population, it is not possible to determine whether there are ethnic differentials in access or in needs being met.

## 4.4 Vulnerable adults

### *Key findings:*

- Research indicates that half of homeless people will experience substance misuse issues. Data for Tower Hamlets indicates 99 new rough sleepers in July to September 2022. A further 30 people were living on the streets.
- Among newly homeless households in Tower Hamlets with identified support needs, a higher proportion have need relating to drugs or alcohol than is the case across London; suggesting particularly high substance misuse need among homeless people locally. 11.4% of newly homeless have a need around drugs (vs 3.1% across London). 4.3% have an alcohol-related need compared to 2.4% across London.
- Research suggests very high prevalence of drug and alcohol use among women involved in prostitution. Around 50 clients are currently being supported by specialist services for women involved in prostitution in Tower Hamlets.

This section seeks to explore the needs of specific groups of adults who are known to have heightened vulnerability in relation to substance misuse issues.

### 4.4.1 Statutory homeless

Under the Homelessness Reduction Act (2017) local authorities have a number of duties in relation to homelessness, these are:

- **Prevention duty:** Local authorities owe prevention duties to help stop households at risk of homelessness losing their accommodation.
- **Relief duty:** If a household is homeless, the local authority owes them a relief duty to provide some sort of accommodation.
- **Main duty:** The main homelessness duty to provide accommodation (which until 2018 was the only statutory duty owed to homeless households) comes into effect when the relief duty has failed and accommodation has not been secured.

Data for Tower Hamlets for the period January to March 2022 indicates that of the 124 households with support need owed a homelessness duty 48 (38.7%) had a drug dependency need and 18 (14.5%) an alcohol dependency need. Drug dependency accounted for 11.4% of all support needs (compared to a London rate of 3.1%) and alcohol dependency 4.3% of all needs (compared to a London rate of 2.4%).

#### 4.4.2 Rough sleepers

Research in 2015 by Bramley *et al*<sup>18</sup> indicated that half of homeless people in England experience substance misuse. Research by Gill *et al*<sup>19</sup> indicates that half of rough sleepers, a specific sub-cohort of the homeless, could be defined as alcohol dependent, of whom 36% were severely dependent. 16% of hostel residents were alcohol dependent with 10% severely dependent.

Guidance issued by the charity [Homeless Link](#)<sup>20</sup> in 2019 sets out a number of key considerations when working with the homeless in relation to drug and alcohol treatment:

- Effective care planning – understanding the needs of service users holistically therefore understanding their physical and mental health and any substance misuse issues.
- Providing advocacy – advocating for the homeless population to ensure that they can access and receive the care and support that they need.
- Promoting harm reduction – providing health messages that can minimize harms from drug and alcohol consumption until such a time as when homeless people are prepared to engage with treatment.
- Store and administer naloxone – naloxone temporarily reverses the effects of opioid overdose; the guidance is that homeless services should be trained in identifying the signs of overdose and how to administer naloxone.
- Refer to drug treatment – identifying the appropriate pathway into local treatment services and making onward referral.
- Embrace partnership working – proactively engaging with and collaborating with organisations that can offer specialist services to homeless people (therefore including working collaboratively with substance misuse treatment services).

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<sup>18</sup> Bramley, G., Fitzpatrick, S., Edwards, J., Ford, D., Johnsen, S., Sosenko, F. & Watkins, D. (2015) *Hard Edges: Mapping Severe and Multiple Disadvantage*. (London: Lankelly Chase Foundation).

<sup>19</sup> Gill, B., Meltzer, H., & Hinds, K. (2003), The prevalence of psychiatric morbidity among homeless adults, *International Review of Psychiatry*, Vol. 15, No. 1-2, pp. 134-40.

<sup>20</sup><https://www.homeless.org.uk/sites/default/files/site-attachments/Supporting%20people%20who%20use%20drugs%20in%20homelessness%20services%20v2.pdf>

## Rough sleeping in Tower Hamlets

Tower Hamlets has seven hostels for homeless people, housing 450 people.

The government’s rough sleeping snapshot in autumn 2021 identified 28 people sleeping rough in the borough on a single night in the autumn.<sup>21</sup>

Data on levels of rough sleeping are set out at Table 14.

**Table 14 Tower Hamlets rough sleepers, July – September 2022**

Volumes	Rough sleepers	Change from last period	Change on same period last year
<b>New rough sleepers (RS) (all)<sup>22</sup></b>	<b>99</b>	<b>+59</b>	<b>+75</b>
New RS with no second night out	68	+52	+55
New RS with a second night out but not living on the streets	29	+6	+19
New RS joining living on the streets population*	2	+1	+1
<b>Living on the streets (LOS) (all)<sup>23</sup></b>	<b>30</b>	<b>+4</b>	<b>+15</b>
LOS – transferred from new RS*	2	+1	+1
LOS – known	27	+3	+13
LOS – RS205+	1	0	+1
<b>Intermittent rough sleepers<sup>24</sup></b>	<b>65</b>	<b>+26</b>	<b>+16</b>
<b>Total</b>	<b>192</b>	<b>+88</b>	<b>+105</b>

Chain Quarterly Report, July – September 2022

The data at Table 14 indicates that 21% of those in drug and alcohol treatment in Tower Hamlets have a “Housing problem” and 11% an “Urgent Housing Need” indicating a high level of homelessness and unstable accommodation among the local treatment population. Moreover, these rates have been fairly stable for the last 10 years.

<sup>21</sup> <https://www.gov.uk/government/statistics/rough-sleeping-snapshot-in-england-autumn-2021/rough-sleeping-snapshot-in-england-autumn-2021#regional-maps>

<sup>22</sup> A new rough sleeper is defined as someone who has not been contacted by outreach teams rough sleeping before the period.

<sup>23</sup> Living on the streets is defined as those who have had a high number of contacts over three weeks or more which suggests they are living on the streets.

<sup>24</sup> Intermittent rough sleepers are defined as people who were seen rough sleeping before the period began at some point and contacted in the period, but not regularly enough to be “living on the streets”.

A report on hard to manage hostel clients produced for Tower Hamlets Council<sup>25</sup> identified 97 hostel residents with “No Current Recovery Potential” (designated as older residents with substance misuse and mental health issues who are difficult to manage in the borough’s mainstream hostel provision). 81.5% of this client group had a pattern of drug misuse and 52% had problems with alcohol misuse. 81% had been through multiple local hostels with an average of just over 3 hostel placements per person.

The scale of substance misuse amongst the homeless population was described by one professional stakeholder: *“We have a huge problem with substances in hostels – drugs are a main support need, together with alcohol. And there are people at different levels of substance misuse within one provision, and that doesn’t work in my opinion”*.

### **Services provided**

The rough sleeping and homeless population are one of the key groups that the Providence Row outreach element of RESET target.

More recently Tower Hamlets received a Rough Sleeper Drug and Alcohol grant to help engage rough sleepers into treatment. The funding has been used to employ Assertive Engagement Workers to engage rough sleepers engaged in substance misuse related ASB and support them into treatment.

This work is delivered separately to the work delivered by Providence Row (as part of RESET) as described above.

In addition, three Hostel Relationship Managers are employed by the council. The focus of these posts is to work with the hostel staff and residents as well as supporting local residents. Their work includes helping to manage the most problematic clients who often have additional vulnerabilities due to substance misuse-related issues.

For those working with rough sleepers in Tower Hamlets, there was praise for the *“new model of outreach and navigation – the navigator team appeared last year, and those services are so valuable. That emphasis on engaging people, spending time to get people to reach a point to enter structured treatment or harm reduction, is great”*. But stakeholders also referenced the lack of staffing capacity at RESET: *“In RESET Outreach there are two workers to cover the whole borough, and that’s for everyone, not just rough sleepers. The Navigator service,*

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<sup>25</sup> “Report on a Housing Related Support Review for Tower Hamlets Council: Better meeting the needs of hard to manage hostel clients”, M. Ward, March 2019.

*specifically for rough sleepers, do a fantastic job, but they'd be busy if there were 10 more navigators! If you want an effective navigation through care service, you need more staff".*

### **Additional services for rough sleepers**

Asked what substance misuse provision should look like in an ideal world, one interviewee identified the need for a more personalised approach to the large hostels: *"They really should have a RESET worker allocated to each hostel provision. It was a route we were going down until they started to lose staff. Makes sense that hostels have at least one allocated named person, who go in for in-reach – particularly for large hostels".*

Some stakeholders felt that abstinence-based provision needed to be made available again locally. *"The Project ADDER worker is working hard with complex people to get them into rehab. An issue raised on numerous occasions is the fact that those working on the ground might get people into rehab, but where do they go after that? If they go back to hostels or unstable housing they'll relapse".*

### **4.4.3 Women involved in prostitution**

Research by Jeal *et al* notes that, "Sex work is frequently linked with problematic drug use and drug-dependent sex workers typically work on the street, experiencing the greatest risks to health compared with the general population<sup>26</sup>". The use of drugs impacts on the wider health outcomes of women involved in prostitution, "underpins their excess morbidity" and is also related to their risk-taking behaviour. Use of drugs can have the effect of trapping women as they are caught in a cycle of prostitution to feed their drug use.

In a separate study, Jeal *et al* identifies that, of a group of 71 women involved in prostitution who were interviewed, all reported drug or alcohol dependency problems, 22% had shared needles in the last week and 59% had shared injecting equipment<sup>27</sup>.

Jeal *et al* state that mental health conditions often act as a barrier to women involved in prostitution accessing substance misuse treatment. Experience of violence and abuse (common among women involved in prostitution) can lead to post traumatic stress disorder (PTSD) which, if un-resolved, acts as a barrier to accessing treatment services.

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<sup>26</sup> Jeal *et al*, Drug use in street sex workers (DUSSK) study protocol: a feasibility and acceptability study of a complex intervention to reduce illicit drug use in drug-dependent female street sex workers, *BMJ Open*, 2018.

<sup>27</sup> Jeal N., Salisbury C., A health needs assessment of street-based prostitutes: cross-sectional survey, *J Public Health (Oxf)* 2004 Jun;26(2):147-5

### *Services for women involved in prostitution*

Tower Hamlets has a Prostitution Partnership which adopts a MARAC-like (i.e. multi-agency) approach to supporting sex workers.

A local project has also been commissioned – Beyond the Streets - to support local women involved in prostitution.

The service offers one-to-one support to women.<sup>28</sup> The support is described as “holistic” and encompasses both practical support as well as emotional support. It adopts an assertive outreach approach in which support workers and volunteers identify and engage women on the streets where they are working.

The manager of the project reported that they are working with around 50 women of whom “around 90%” were described as having a substance misuse issue. (This prevalence would align with the findings from Jeal *et al* set out above). The women use drugs to deal with trauma, mental health and as response to the ongoing trauma of the work that they do.

All women are given an assessment which includes addressing substance misuse needs. The assessment process is “women-led” and so is done at a time and pace that suits them and supports their engagement.

It was reported that Beyond the Streets work well with RESET and the DIP team to support women into treatment as required (moreover, supporting women into substance misuse services is a KPI for the organisation). There is also an ADDER Women’s Pathway co-ordinator who works with this cohort.

#### *What this tells us*

Data on vulnerable adults indicates that there are a population of homeless and rough sleepers and people living on the streets, many of whom are likely to have drug and/or alcohol issues (as indicated in the research cited earlier). The proportion of those who are homeless and have a drug or alcohol need is higher in Tower Hamlets than elsewhere. The data therefore indicates a clear need to ensure that links and pathways are available for the homeless population to ensure that they can access treatment, while taking into account the additional vulnerability they have from a lack of stable accommodation.

Data on women involved in prostitution indicates a small but not insignificant group of people who are also likely to have drug and alcohol needs, again pointing to the need to

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<sup>28</sup> Note that the service does not support women who work on premises but this is to be explored in 2023.



ensure that services are available to this group and which takes into account their vulnerability.

## 4.5 Views of stakeholders

### *Key findings:*

- Drug use was considered to be very widely prevalent in the borough along with associated drug dealing. Particular concerns were raised around the widespread use of nitrous oxide.
- Representatives from local community organisations reported perceived barriers for some communities in terms of accessing support for drug and alcohol use. These barriers were reported as both stigma within the community, lack of community awareness of specialist services, and lack of cultural awareness of services.
- Stakeholders suggested that members of some local communities seek support through community means (such as mosques) rather than approaching specialist services.

### 4.5.1 Community stakeholders

Local community groups were consulted to understand the perspective of communities in Tower Hamlets. The views of these community groups are set out below. The views cannot be taken as being representative of the entire communities that they represent, or of the Tower Hamlets population as a whole. They are the viewpoint of a small number of community leaders from within those groups, however they give some useful points for consideration.

The views are set out in relation to key themes identified.

#### *Perceptions of stigma*

Although substance misuse was acknowledged as a taboo for the Islamic community it was also reported that the community has become more receptive to managing such issues in recent years. It was reported that there is a stigma attached to the issue and there is a need to make it easier for the community to access support. An interviewee from the Somali community felt that people from the Somali community were reticent to engage with statutory services as they felt that they were being judged when they did attend.

#### *Perceived cultural barriers*

It was reported that cultural barriers were believed to exist in relation to some communities accessing services. These barriers included language and cultural sensitivity.

Community stakeholders emphasised the need for services to be culturally sensitive and use culturally appropriate methods to address substance misuse issues. A stakeholder from one organisation used to refer to NAFAS, which was a culturally sensitive service (Bengali-led organisation) offering 12 weekday care programmes for drug users and their families. The stakeholder did not feel that there is an equivalent service currently and that consequently problems and misuse are often hidden and not being addressed.

### *The role of local community organisations*

A number of community representatives stated that members of the community they work with on occasion seek advice from them for help with substance related issues.

It was reported that Imams are often contacted to get advice on family substance misuse from a religious perspective and will signpost to specialist services. Contact is normally made by a family member rather than the user themselves. Often the person contacting refers to drugs generally rather than a specific drug type. Alcohol, crack cocaine and cannabis were reported as often being misused.

### *Drug dealing*

Representatives from a community organisation described the borough as a “haven” for Class A drug use and dealing, particularly crack cocaine and heroin whilst also recognising issues in relation to cannabis and nitrous oxide.

### *Drug use*

As highlighted elsewhere in this report, nitrous oxide use was described as “rampant” within the local community.

Some stakeholders perceived that there was increasing demand for “party drugs” caused by affluent people either living in the borough or visiting for work (e.g. Shoreditch, Canary Wharf and Liverpool Street) as being an issue, with local people supplying. It was felt that local people are often dealing to raise funds to pay for their own habit. (There is a lack of quantitative data to substantiate these views).

‘Lean’ was also described as being prevalent - this is a recreational drug prepared by mixing prescription strength cough or cold syrup containing codeine and promethazine with a soft drink. Lean was considered to be well embedded among young people (18 – 25 years old) in the community, with a feeling that it is culturally acceptable and the impact of its use are not seen as serious. Recently among young people the use of nitrous oxide has increased a lot with little understanding of its health effects. Education is required to address these uses.

Finally, it was noted that substance misuse is often linked to strong cultural traditions and cultural acceptances – for instance the use of Khat which is an established cultural tradition for many social situations.

### *Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ+) community*

A stakeholder from a local LGBTQ+ organisation stated that substance misuse is a major issue for their community, particularly in relation to clubbing drugs such as cocaine.<sup>29</sup> They also referred to the issue of chemsex<sup>30</sup> in the community. They also felt that there was a lot of hidden alcohol drinking - particularly at home. Some of this use was attributed to the inability of members of the community to cope with such issues associated with family, culture and faith. Substance misuse also comes up increasingly early for young people and is often seen by them as a way of managing their circumstances.

They stated that young LGBTQ+ people they were working with had a different drug mix usage. The use of nitrous oxide was particularly high amongst 15 – 18 year olds.

It was reported that members of the community do not feel that specialist services are “friendly” or reflective/understanding of the needs of the community. It was stated that members of this community should be offered the ability to see a worker from their community. Instead, members of the community do not routinely access substance misuse services and, when people do access specialist services, it was often late when they were in crisis.

#### *What this tells us*

There is a consensus among community stakeholders that there appear to be some perceived cultural barriers that may be influencing the extent to which some communities are accessing services. All representatives indicated there was some need for substance misuse treatment within their community and therefore that this may not be catered for due to the perceived barriers that exist. The data indicates the role of community groups as key interlocutors, providing means by which people from communities are seeking help rather than through statutory and commissioned services.

<sup>29</sup> Some independent research is available which substantiates this view. London Friend, an LGBTQ+ charity point to data from the Crime Survey for England and Wales that indicates that drug use in the past year amongst gay and bisexual men is three times higher (33%) than use amongst heterosexual men (11.1%). For lesbian and bisexual women use is more than four times as high (22.9%) than for heterosexual women (5.1%). See: <https://londonfriend.org.uk/official-data-confirms-lgb-drug-use-much-higher-than-heterosexuals/>

<sup>30</sup> “Chemsex” is an umbrella term that captures use of methamphetamines, GBL/GHB, mephedrone – plus a range of other novel substances which are not captured in data elsewhere.

The other key message from community sources is the sheer availability and levels of use of a range of drugs.

## 4.6 Substance misuse and children and young people

### *Key findings:*

- There has been a significantly declining trend in the hospital admissions rate for alcohol-specific conditions for young people under 18 in Tower Hamlets. This is consistent with trends both nationally and across London.
- Hospital admission rates for those aged between 15 and 24 years due to substance misuse are lower in Tower Hamlets than the rate for England.
- A local survey of school pupils indicates that 15% of boys and 21% of girls at secondary school had ever had a drink.
- The survey indicates that 11% of boys and under 10% of girls have reported ever having taken drugs.

This section addresses the needs of children and young people as well as the health impact of drug and alcohol use.

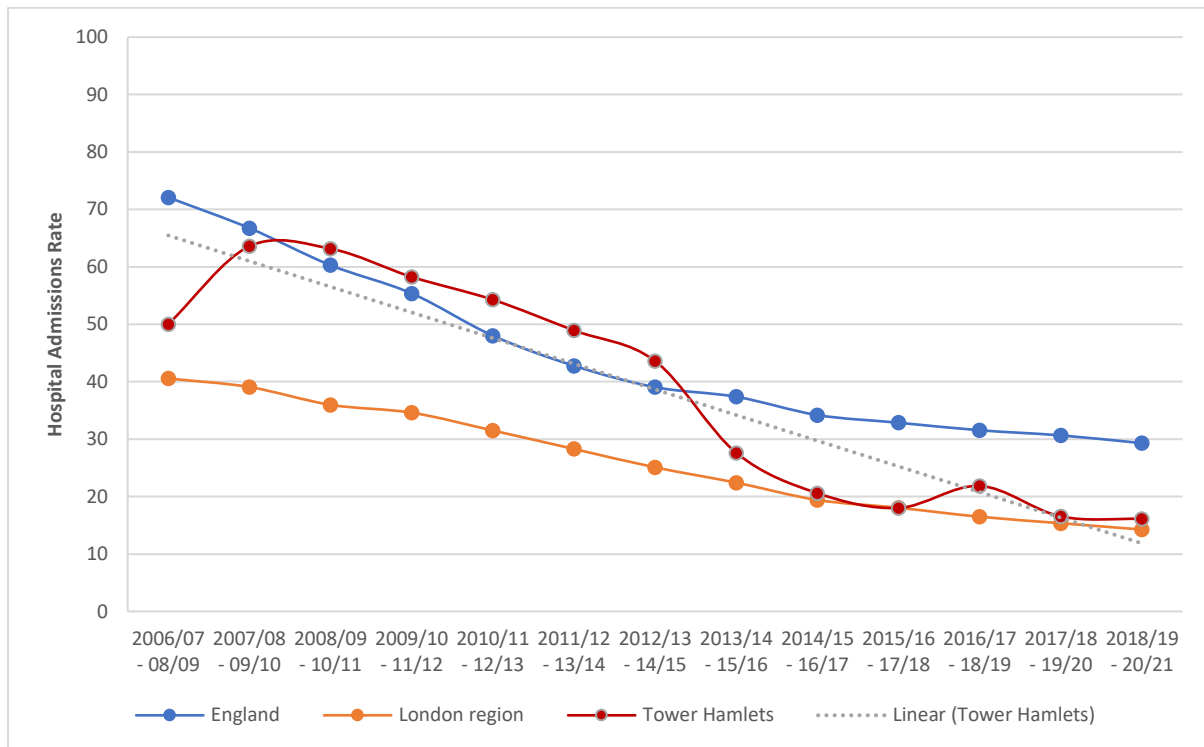
### 4.6.1 The health impact of drugs and alcohol on young people

As is the case for adults, there are a range of metrics that describe the degree of health harms caused to young people by drugs and alcohol. These are explored below.

#### *Hospital admissions*

Data for alcohol-related hospital admissions provide another means by which to understand the health impact that alcohol is having locally. (As per other hospital data set out in this report coding issues may affect the quality of the data).

Figure 17 Admission episodes for alcohol-specific conditions - Under 18s (Persons), 2006-07 to 2020-21, Tower Hamlets, London, England Hospital Admissions Rate

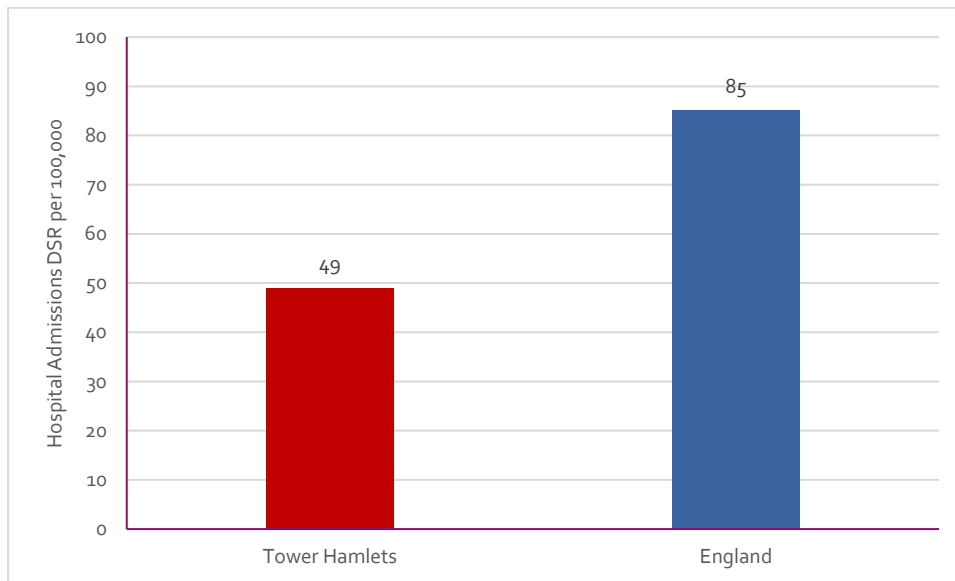


(Source: OHID, Fingertips)

There has been a significantly declining trend in the hospital admissions rate for alcohol-specific conditions for young people under 18 in Tower Hamlets, with a drop in reported admissions from 2012-13 (and despite a small spike in admissions during 2016-17 to 2018-19). This trend is consistent across London and nationally, suggesting that reductions in the borough are aligned with national trends (that is, the causes that are driving down rates nationally are also operating locally). The data does not indicate what these factors might be.

Data at Figure 20 explores hospital admission rates for those aged between 15 and 24 years due to substance misuse, again taking into account coding of hospital data and also the very low numbers of young people for whom data is recorded (the data is given as a rate per 100,000).

**Figure 18 Hospital admissions due to substance misuse (15-24 years) for Tower Hamlets and England, 2017-18 to 2019-20, Directly Standardised Rate (DSR) per 100,000 15-24-year-olds**



(Source: Young people substance misuse commissioning support pack 2022-23: Key data)

The DSR of hospital admissions from 2017-18 to 2019-20 due to substance misuse for young people aged 15-24 years is significantly lower in Tower Hamlets (49) compared to national rates (85).

***What this tells us***

The data for alcohol admissions for young people shows a very clear, ongoing and downward trend over a number of years. This would seem to suggest lower levels of alcohol consumption among young people – or at the least, drinking occurring at levels that do not necessitate a hospital admission. The lower rate of substance misuse admissions which, very tentatively, may indicate a lower need among young people (given that adult rates of admission in contrast were higher than the national rate). While the overall trend is downward, there are different communities of young people in the borough (for instance those living at home and students living away from home) and a range of different ethnic and cultural groups with different attitudes towards drugs and alcohol. The overall trend data does not identify need within specific sub-groups of young people and it is possible that, among some groups, need is increasing and that there are groups of young people in the community with high levels of need.

## 4.6.2 Young people’s perceptions of drugs and alcohol

This section seeks to ascertain the views of young people in Tower Hamlets with regards to the use of drugs and alcohol.

A survey of schools, (Pupil Attitude Survey) carried out in 2022, explored the views of young people. The survey is delivered through schools in the borough and there are separate versions for both Primary and Secondary schools.<sup>31</sup> The survey focuses on pupils’ views and experiences about learning, health and well-being, staying safe and plans for the future. Specific questions address attitudes towards and use of alcohol and drugs.

This section provides an overview of the findings from the secondary school survey.

### *Alcohol*

Pupils were asked about their use of alcohol. All respondents to the survey were aged under 18 years and so this data represents a snapshot of under-age drinking in the borough.

**Table 15** Have you ever had an alcoholic drink - a whole drink or a sip? (% by gender and ethnicity) (n=256)

	Yes (%)	No (%)
Boys	15%	72%
Girls	21%	73%
Other	43%	14%
White	63%	23%
Mixed	47%	40%
Asian/Asian British	7%	84%
Black/Black British	15%	62%
Other	31%	56%

Higher rates of lifetime prevalence were found for girls (21%) compared to boys (15%). White school pupils report the highest rate of lifetime alcohol use (63%), with Asian/Asian British the lowest at 7%. Many pupils of Asian/Asian British heritage will be from the local Bangladeshi community where alcohol consumption is haram, thus the differential drinking rates are not unexpected.

<sup>31</sup> The Pupil Attitude Survey captured the views of 1,516 pupils from 21 primary schools and 271 secondary school pupils from four secondary schools. Note that all schools in the borough were invited to participate meaning that the schools that engaged are a self-selected minority and may not therefore be a representative sample.

The data from the survey indicated that, while one in three children have tried alcohol, few (under 10%) have had alcohol in the preceding month.

## Drugs

Young people were asked about their use of drugs.

**Table 16 Have you ever taken drugs? (% by tender and ethnicity) (n=255)**

	YES (%)	NO (%)
Boys	11%	83%
Girls	<10%	85%
Other	14%	43%
White	<10%	86%
Mixed	19%	69%
Asian/Asian British	10%	84%
Black/Black British	0%	85%
Other	13%	88%

Similar rates of lifetime prevalence in the use of drugs were found by sex across boys (11%) and girls (10%). Mixed (19%) and Other ethnic groups (13%) reported the highest lifetime prevalence rates relative to other groups.

Young people were asked specifically about use of cannabis. The results are set out at Table 17.

**Table 17 If you have taken drugs, how often have you taken any of the following drugs in the last 4 weeks? Cannabis (e.g. Skunk, Hash, Weed etc.) (% by gender and ethnicity) (n=224)**

	Never	Not in the past 4 weeks	Once or twice	Three or more times	I have never taken drugs
Boys	57%	<10%	0%	<10%	35%
Girls	72%	0%	0%	<10%	26%
Other	40%	0%	0%	20%	40%
White	67%	0%	0%	<10%	27%
Mixed	69%	0%	0%	<10%	23%
Asian/Asian British	64%	<10%	0%	<10%	31%
Black/Black British	67%	0%	0%	0%	33%
Other	63%	<10%	0%	<10%	25%



Low levels of recent cannabis use were identified among pupils. (The results are obscured somewhat by the style of question which includes 'never' and 'I have never taken drugs').

Young people were asked to indicate whether they had taken any other drugs.

**Table 18** If you have taken drugs, how often have taken any of the following drugs in the last 4 weeks? Solvents, glue or gas (to inhale or sniff, like Laughing Gas/Nitrous Oxide etc.) (% by gender and ethnicity) (n=202)

	Never	Not in the past 4 weeks	Once or twice	Three or more times	I have never taken drugs
Boys	57%	<10	0%	0%	38%
Girls	64%	<10	0%	<10	28%
Other	67%	0%	0%	0%	33%
White	66%	<10	0%	0%	28%
Mixed	62%	0%	0%	<10	31%
Asian/Asian British	62%	<10	0%	<10	33%
Black/Black British	60%	0%	0%	0%	40%
Other	50%	<10	0%	<10	33%

There is a low level of recent solvent use among students with some indication of use amongst girls (<10%), mixed, Asian/Asian British and Other groups.

There was a low level of recent use for “other” drug types<sup>32</sup> and legal highs.

**What this tells us**

Data from the Pupil Survey indicates that a small cohort of young people of school age are already experimenting with alcohol and drugs. It is not the case that these young people will require substance misuse treatment, but it is nevertheless the case that early experimentation is an issue of concern and warrants some form of intervention to prevent further experimentation or more ongoing use. (A little under 10% of young people report using alcohol three or more times). As such there is evidence for the need for ongoing health and harm reduction messages to young people in the borough.

As may be expected young people are more likely to report use of alcohol than drugs. Where young people had taken a drug, this was most likely to be cannabis. This aligns with data

<sup>32</sup> Cocaine, LSD, heroin, crack, speed, magic mushrooms, Ecstasy, GHB

(presented later) that indicates that cannabis use is the most drug likely to be used by those in treatment.

### 4.6.3 Young people's access to drugs and alcohol

Data from Trading Standards provides further insight into experimental drug and alcohol misuse in Tower Hamlets. While the data by no means gives reliable figures for levels of experimentation with alcohol and other substances it does however give an indicative picture of the extent to which young people are seeking out these substances.

#### *Test purchasing*

Tower Hamlets council undertakes test purchasing on the basis of intelligence received, where information has been provided that a retailer has been selling to under-age young people. Intelligence is often provided by members of the public. Operations are carried out every couple of months with one product checked per retailer where intelligence has been provided (i.e. the test purchasing is carried out just for alcohol or tobacco for instance).

Data on test purchasing is set out below.<sup>33</sup> A failure means that the young person has been sold the item in question.

**Table 19 Alcohol test purchases 2018 - 2022**

Year	Alcohol					
	Total No. of Test Purchases <sup>34</sup>	No. of Test Purchases for alcohol	No. of Failures (sales)	% Failure Rate	No. of Prosecutions	Total Fines
2018/19	277	42	1	2.3%	0	0
2019/20	154	32	0	0	0	0
2020/21	8	8	4	50%	11	£2,222
2021/22	83	14	6	42.8%	16	£11,557

The data above indicates that there is a test purchase failure rate of 43% indicating that a number of local retailers have been selling alcohol to young people locally, a steep increase since 2018/19 (no test purchase operations were carried out during the Covid pandemic).

<sup>33</sup> Note that test purchasing figures dropped significantly in 2020/21 because of the pandemic. The data for this year should therefore be read with caution.

<sup>34</sup> Note that test purchases are also carried out for tobacco, vapes, knives and fireworks. The data set out is just for alcohol test purchases.

### Nitrous oxide

Trading Standards also carry out seizures for nitrous oxide (colloquially known as “Nox”). While Nox is not illegal, it can only be sold with reference to certain specific purposes – for instance for sale to the catering trade (to use in aerosols) and in healthcare. Therefore, retailers who do not have obvious links to those sectors where Nox is permitted can have their stock seized by Trading Standards officials (on the assumption that the Nox is being sold for its psychoactive effects, which is prohibited in law).

Data for Nox seizures in Tower Hamlets is set out below.<sup>35</sup>

**Table 20 Seizure of Nox canisters by Tower Hamlets trading standards**

	2018	2019	2020	2021	2022
Nox canisters	-	576	5,088	6,984*	5,749 <sup>§</sup>

\*29 1.4kg nitrous oxide cylinders

§ 39 650grams nitrous oxide cylinders and 44 1.4kg nitrous oxide cylinders

The data indicates a rise in Nox seizures since 2019 (with no seizures in 2018). While the data may be indicative of the focus put on this issue in the council, it nonetheless describes a situation in which substantial amounts of Nox are being sold by local retailers. This data will not capture on-street dealing of Nox, such as balloons outside of night club, and is therefore by no means fully indicative of Nox use locally.

#### **What this tells us**

The data on Nox seizures, while it should be treated very tentatively, is indicative of a demand for nitrous oxide in Tower Hamlets. The increase in seizures appears to show a strong demand for Nox among local residents (albeit that this may be due an enforcement focus in recent years rather than accelerating demand).

## 4.6.4 The children and young people’s treatment population

### **Key findings:**

- The number of young people in specialist treatment has decreased from 200 in 2014-15 to 70 in 2019/20.
- 3,048 young people received some form of intervention from Safe East of whom 97% (2,952) required only a brief intervention.

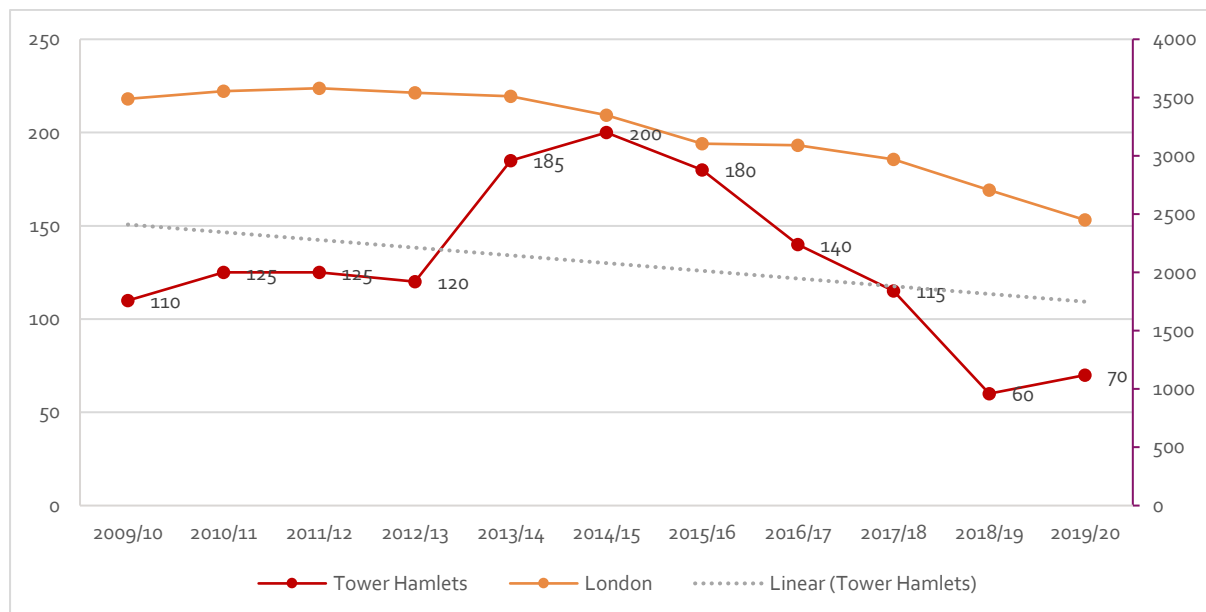
<sup>35</sup> Necessarily seizure data cannot be wholly attributed to use by young people, however stakeholders consulted for this needs assessment repeatedly associated Nox use with local young people. As such the assumption is made here that most Nox is being purchased by young people.

- Nearly half (47%) of young people in treatment were aged 14 or 15 and the same proportion were aged 16 or 17.
- Nearly two thirds (63%) of young people in treatment were in mainstream education however a quarter (25%) were recorded as Not in Education, Training or Employment.
- No young people were in treatment for opiates or crack cocaine. Most were in treatment for less health harmful drugs such as cannabis (93%) or alcohol (57%). Solvent use has increased and is now reported by over a fifth (21%) of young people in treatment.

This section sets out data regarding the children and young people’s treatment service.

### Numbers in Treatment

Figure 19 Numbers of young people in treatment, Tower Hamlets and London, 2009-10 to 2019/20



(Source: ViewIT. Note data for 2020/21 are not available at the time of reporting)

There was an increase in the number of young people accessing treatment, reaching a peak in 2014/15 (n=200). After that, the numbers decreased significantly to 70 in 2019/20. Overall, the linear trend is a shallow decline, and the trend is moderately correlated ( $r=0.54$ ) with presentation numbers across London. As per the size of the adult treatment population, the data does not indicate that the drop in numbers is associated with a drop in need – that is, the data does not indicate that fewer young people require treatment. The drop may be associated with cuts in treatment budgets and the corresponding drop in the capacity of treatment services. Other possible explanations are that young people are not willing to

access treatment services or that they do not perceive their use of drugs to be problematic and therefore do not wish to access specialist treatment services.

A breakdown of young people accessing the service in 2020-21 is set out at Table 21.

**Table 21 Young people engaging with Safe East (substance misuse only) (2020-21)**

	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Actual	Actual YTD
Total number of young people receiving interventions	563	495	1236	754	3048
Total number of young people receiving brief interventions	333	389	1115	1115	2952
Total number of young people receiving pharmacological interventions and/or structured interventions	157	93	121	121	492
No of Tier 3 individuals in treatment	55	28	22	21	82

The data shows that, in 2020-21 a total of 3,048 young people received some form of intervention from Safe East of whom 97% (2,952) required only a brief intervention while 2.6% (82) required an episode of structured treatment. The data therefore indicates that only a very small number required specialist treatment intervention and that, by far the majority had any substance misuse needs addressed through a limited and short-term response (i.e. a brief intervention).

### **Socio-Demographic Indicators**

The profile of the young people’s treatment population is explored below.

**Table 22 Selected socio-demographic profiles at treatment start, Tower Hamlets 2019/20, percentages**

	19/20 (%)
<b>Age</b>	
Under 14	7
14-15	47
16-17	47
<b>Sex</b>	
Male	36
Female	64

(Source: ViewIT. Note data for 2020/21 are not available at the time of reporting)

Just under half (47%) of young people in treatment in 2019-20 were aged 14-15 and 16-17 years. There are clear differences by gender with twice as many females accessing treatment as males, a pattern that has been consistent over the last 10 years.

The gender ratio has changed from a high of 86% male, and 14% female in 2013-14 to 64% male, and 36% female in 2019-20.

**Table 23 Selected socio-demographic profiles at treatment start, Tower Hamlets 2019/20, percentages**

Ethnicity	Local (n)	Proportion of all in treatment (Tower Hamlets)	Proportion of all in treatment (England)
White British	7	11%	73%
Other White	2	3%	4%
Not Stated	0	0%	3%
Caribbean	1	2%	3%
White and Black Caribbean	5	8%	3%
Other Mixed	1	2%	2%
African	3	5%	2%
Other Asian	0	0%	1%
Other Black	2	3%	1%
Pakistani	1	2%	1%
Missing/Incomplete	0	0%	1%
Other	2	3%	1%
White and Asian	1	2%	1%
Bangladeshi	38	59%	1%
White and Black African	0	0%	1%
Indian	0	0%	1%
White Irish	1	2%	0%
Chinese	0	0%	0%

(Source: Young people substance misuse commissioning support pack 2022-23: Key data)

The largest group in treatment for young people under 18 years is Bangladeshi (59%). Caution is advised in interpreting these findings due to the comparatively low numbers reported in treatment.

Data on their employment status is set out at Table 24.

**Table 24 Employment Status, Tower Hamlets 2019/20, percentages**

	19/20 (%)
Mainstream education	63
Alternative education	13
Not in employment or education or training (NEET)	25

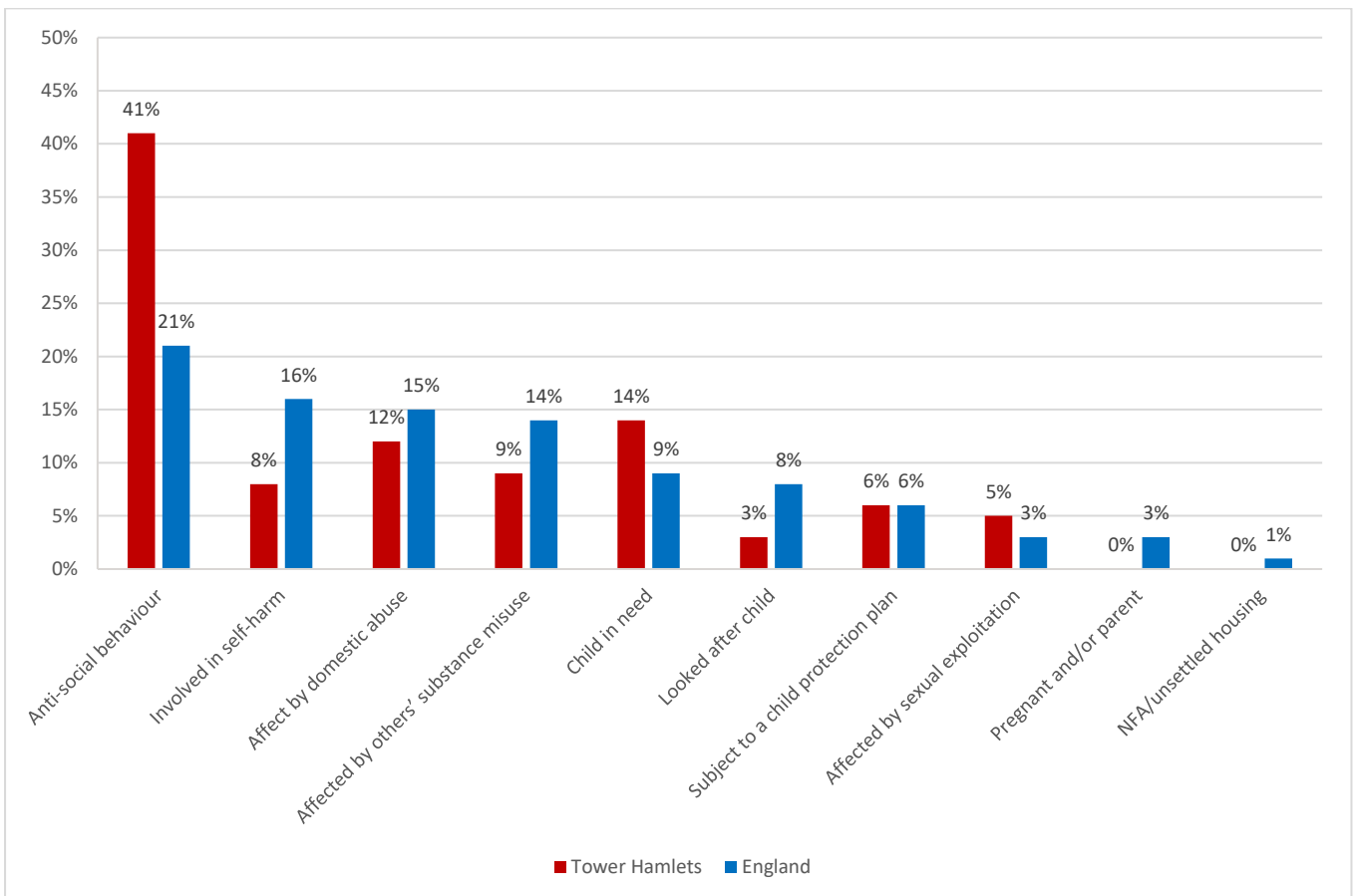
Apprenticeship or training	0
Employed	0
Persistent absentee or excluded	0
Economically inactive - health issue or caring role	0
Voluntary work	0

(Source: ViewIT. Note data for 2020/21 are not available at the time of reporting)

The majority of young people in treatment were reported to be in mainstream education (63%). A quarter of young people were not in employment, education or training (NEET) indicating a potential vulnerability among this cohort. The NEET cohort has grown from 11% in 2016-17.

Data on the wider vulnerabilities of the young people is set out at Figure 22.

**Figure 20 Young people (under 18) in treatment with wider vulnerabilities for Tower Hamlets, 2020-21**



(Source: Young people substance misuse commissioning support pack 2022-23: Key data)

For young people in treatment with wider vulnerabilities, Tower Hamlets residents were more likely to report being subject to anti-social behaviour (41%) compared to nationally (21%); being a child in need (14% in Tower Hamlets, 9% in England) and being affected by sexual exploitation (5% in Tower Hamlets, 3% in England). Conversely, Tower Hamlets





Heroin	0	0	0	0	0	0	0	0	0	0	0
Nicotine (adjunctive use only)	23	16	16	29	65	50	42	57	61	50	57

(Source: ViewIT. Note data for 2020/21 are not available at the time of reporting)

A large majority of young people accessing treatment report using cannabis (reaching 92-93% from 2018-19 to 2019-20), with over half (57-58%) from 2018-19 also reported the use of alcohol. As an adjunctive substance, nicotine use was also used in over half of all reports from 2016-17 (reaching 61% in 2017-18). There has been a notable increase in the percentage of young people reporting using solvents from 2017-18 (17-21%).

### **What this tells us**

The data indicates the almost universal use of cannabis among young people in treatment. The data highlights multiple drug use – with over half of young people also reporting alcohol use.

There has also been a pronounced increase in solvent usage (0% in 2013-14 to 21% in 2019-20). This suggests a very strong increase in the use of other drugs – most likely Nox<sup>36</sup> (given that this was highlighted as an issue by stakeholders).

An important finding is the complete absence of the use of crack and heroin for the period for which data was available. This is strongly indicative of a generational shift in the use of Class A drugs and is in contrast to the large proportion of opiate and crack users in the adult treatment population. While some young people may go on to use these drugs the data indicates that they have not started consumption prior to the age of 18. This mirrors a trend recognised nationally with fewer young people using Class A drugs compared to older generations.

## **4.6.6 Treatment Processes**

This section explores data in relation to treatment processes for young people.

**Table 26 Referral pathways, Tower Hamlets percentage known to drug treatment services 2009/10 to 2019/20**

	09/10 (%)	10/11 (%)	11/12 (%)	12/13 (%)	13/14 (%)	14/15 (%)	15/16 (%)	16/17 (%)	17/18 (%)	18/19 (%)	19/20 (%)
Education	38	33	16	17	42	39	39	32	14	22	25
Youth/Criminal justice	25	33	47	28	13	45	48	53	64	44	50
Social care	6	11	11	6	3	3	4	5	7	22	13
Self, family and friends	6	6	0	0	3	3	4	0	7	11	13
Health services	6	11	11	6	3	3	4	0	0	0	0

<sup>36</sup> Nitrous oxide is captured as its own code in NDTMS but this is then subsumed within the “solvent” category of drugs.

Substance misuse	19	6	16	44	35	3	0	11	7	0	0
Other	0	0	0	0	0	3	0	0	0	0	0

(Source: ViewIT. Note data for 2020/21 are not available at the time of reporting)

A large proportion of referrals for specialist drug and alcohol treatment comes from the criminal justice system (50% in 2019-20, reaching 64% in 2017-18). Between one-fifth and one-quarter (22-25%) since 2018-19 referrals come from education. No referrals were made from health services from 2016-17 onwards (with no referrals were made in the last five years for which data were available).

### *What this tells us*

The data indicates a strong link between the criminal justice system and treatment. Conversely while the majority of young people reported being in mainstream education, this was not the primary route into treatment.

## 4.6.7 Vulnerable young people

### *Key findings:*

- Young offenders are known to have increased risk of substance misuse. The rate of new entrants to the youth justice system in Tower Hamlets is double the national rate.
- 8% of Looked After Children were identified as having a substance misuse issue. This is over double the national rate of 3%.
- 5% of suspensions from school in Tower Hamlets were reported to be associated with drugs and alcohol, higher than the national rate of 3%.

This section explores data in relation to a number of key groups of young people who are known to be at greatest risk of developing problematic use of alcohol and drug use.

NICE identify key risk factors for young people as<sup>37</sup>:

- mental health problems
- being sexually exploited
- engaged in commercial sex work
- being lesbian, gay, bisexual or transgender
- Not in Employment Education or Training (NEET)
- excluded from school or who truant regularly

<sup>37</sup> Drug misuse prevention: targeted prevention. NICE Guideline NG64 (2014).

- families or carers use drugs
- looked after or who are care leavers
- in contact with youth offending services

The literature states, "The more risk factors young people have, the more likely they are to misuse substances"<sup>38</sup>. NICE states that the vulnerable include:

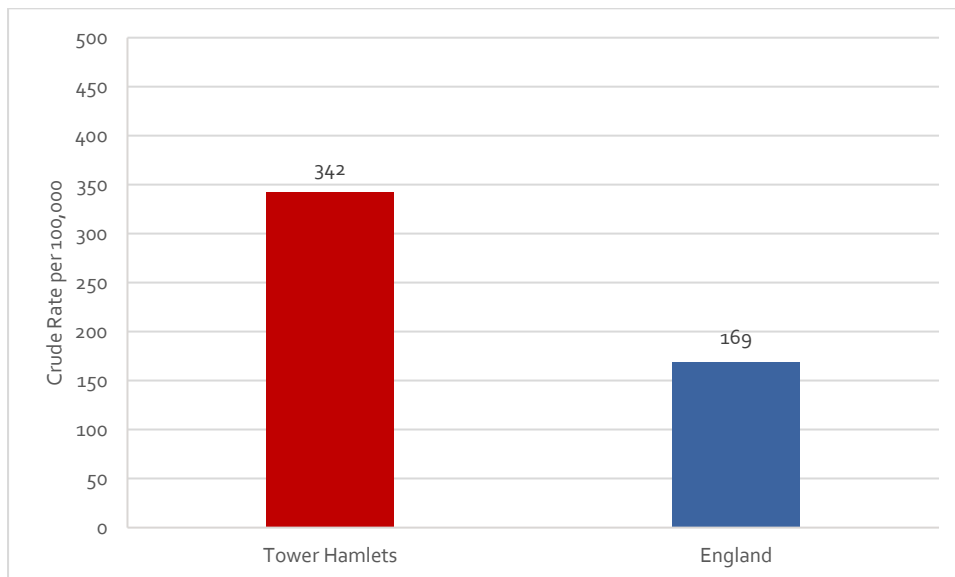
- in multiple groups of need (i.e. more than one of the factors set out above)
- whose personal circumstances put them at risk
- who use drugs on an occasional basis
- are already excessively using another substance such as alcohol<sup>39</sup>

### *Young offenders*

Young people known to youth offending services are known to be a cohort who are vulnerable to substance misuse.

Data at Figure 23 shows the rate of first-time entrants to the youth justice system for Tower Hamlets and England.

**Figure 21 First-time entrants to the youth justice system - Under 18s for Tower Hamlets and England, 2020**



(Source: Young people substance misuse commissioning support pack 2022-23: Key data)

<sup>38</sup> Young People – substance misuse JSNA support pack. p.5.

<sup>39</sup> NICE Guideline, p.12.

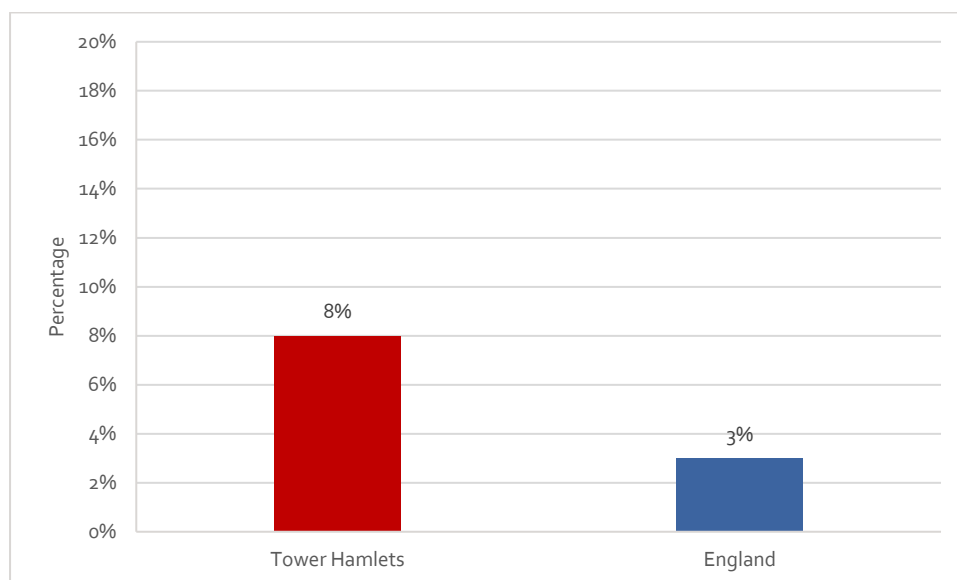
The crude rate per 100,000 population of first-time entrants to the youth justice system for those under 18s for 2020 was double that of the national rate (342 per 100,000 in Tower Hamlets compared to 169 per 100,000 in England). The difference can be shown to be statistically significant.

### *Looked After Children (LACs)*

Children and young people who are looked after are known to be a group with a higher risk profile in relation to substance misuse<sup>40</sup>.

Data at Figure 24 shows the proportion of LACs who were identified as having a substance misuse issue.

**Figure 22 Children looked after for at least 12 months identified as having a substance misuse problem Tower Hamlets and England, 2020-21, Percentage**



(Source: Young people substance misuse commissioning support pack 2022-23: Key data)

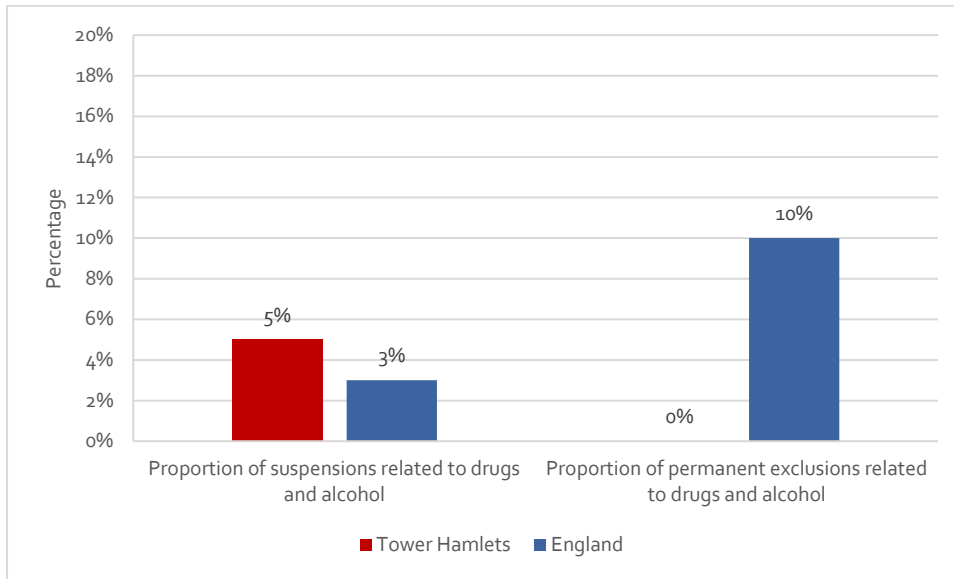
The percentage of children looked after for at least 12 months identified as having a substance misuse problem in 2020-21 was more than double the national rate (8% in Tower Hamlets compared to 3% in England). Of those in Tower Hamlets, 41% received a substance misuse intervention compared to 44% nationally.

### *School exclusions*

Data was explored in relation to suspensions and exclusions from schools in Tower Hamlets in relation to substance misuse.

<sup>40</sup> See NICE guideline [NG64] - <https://www.nice.org.uk/guidance/NG64/chapter/Recommendations#assessment>

**Figure 23 Suspensions and permanent exclusions from school related to drugs and alcohol for Tower Hamlets and England, 2019-20**



(Source: Young people substance misuse commissioning support pack 2022-23: Key data)

Suspensions from school for drug and/or alcohol-related issues in 2019-20 were higher in Tower Hamlets (5%) relative to England (3%). In comparison, there were 0% permanent exclusions for drugs and/or alcohol in Tower Hamlets compared to one in ten nationally (10%). The local approach to exclusions is supported managed moves which is the most likely explanation for the difference from the rate in England.

**What this tells us**

The data on referrals into treatment from criminal justice agencies indicates the crucial link between these services. Given that Tower Hamlets has a higher rate of first-time entrants to the youth justice system than national rates, this highlights the importance of this engagement mechanism as it will be a key conduit by which to direct vulnerable young people into treatment. The data may also indicate that a cohort of young people are using drugs to cope with adverse factors in their life and are subsequently then being picked up by criminal justice agencies. The data may therefore highlight earlier vulnerability in their lives (albeit that this conclusion is somewhat conjectural).

The data also highlights the vulnerability of LACs, nearly one in ten of whom report a substance misuse problem. This again highlights the importance of engaging local groups of vulnerable young people.

## 4.6.8 Views of stakeholders

### *Key issues:*

- Local stakeholders reported widespread drug use among young people with early onset experimentation with alcohol (aged 14 and above) and use of nitrous oxide.
- Stakeholders reported young people becoming involved in drug dealing and drug-related crime.
- Emphasis was placed on the need for appropriate education for young people to share key messages about drug and alcohol use.
- Local professionals working with children felt that Covid and the associated lockdowns had exacerbated substance misuse issues among young people.

Local stakeholders were consulted to understand their views regarding young people's use of alcohol and drugs. The views cannot be taken as representative of entire communities or groups and so should be considered as being useful points for consideration. The views are set out below.

### *Drug and alcohol use among young people*

Stakeholders stated that alcohol use is an issue, particularly from 14 years onwards (that is, school years 7,8 and 9). The age group have community exposure to cannabis (i.e. it is readily available and used in the wider community) but appear not to participate themselves.

It was suggested that the behaviour of young people is heavily shaped by adult behaviour; especially parental drinking, which some professional stakeholders reported seeing an increased use during Covid.

There was a perception that drug use among young people had recently seen a large increase recently in relation to Nox and spice use. Young people were also reported to vape, but do not always know what substance they are actually vaping. (There is little corroborating quantitative evidence to substantiate this view).

Stakeholders from a number of community organisations emphasised that drug use is often the symptom of something happening in the young person's life which needs to be addressed.

### *Drug-related crime*

A number of community representatives expressed the opinion that young people were involved in dealing cannabis. It was the view of a number of interviewees that involvement in substance misuse was therefore exposing some young people to the criminal justice system through involvement with gangs and knife crime.

Other stakeholders noted that despite wealth within the borough (e.g. Canary Wharf) there were high levels of poverty and, in some cases, the wealth was fuelling the substance misuse trade. They felt therefore that there was a need to connect with the young people who are often the most vulnerable undertaking both drug dealing and consumption.

### ***The role of education***

Stakeholders placed great emphasis on the need for education, highlighting the risks associated with substance misuse, that it's not "normalised" as well the implications of being caught with illegal substances. They emphasised that education should begin in primary schools and be a standard part of the school curriculum. In contrast staff felt that many young people saw substance misuse as normal behaviour.

### ***Availability of services for young people***

Some stakeholders expressed the view that, where services were in place, these did not necessarily cater for young people. For instance statutory services' operating times did not adequately take account of when services were really needed: substance misusers sleeping patterns often meant that their average day did not start until about 3/4pm when statutory services were winding down. This was thought to put a lot of pressure on the police who have to pick up substance misuse and other issues as they were the only statutory service constantly available. Some stakeholders therefore stated that the focus should be on outreach, going to the communities rather than operating from centralised locations. (There is not corroborating quantitative evidence to support this view).

### ***Impact of Covid***

It was a belief among some stakeholders that domestic abuse and substance misuse had increased during lockdowns – with more drug and alcohol use affecting families. *"The pandemic escalated family issues. But services responded appropriately, and we all knew we couldn't keep doing things the same way – so for example we adjusted substance misuse training, which used to do face to face. We made it more interactive online. We all had to learn very quickly - how to identify safeguarding online was tricky, but we had to learn that".*

### ***Role of safeguarding and early intervention activities***

Funding streams like Project ADDER, which has included the funding of a social worker, is helping to solve some of the entrenched problems for those working in safeguarding. *"In the past if a case involved just alcohol and no abuse, we would tend to redirect to GPs – asking them to put a person in touch with addiction support. And we were pretty sure nothing ever happened in the majority of cases as GPs are stacked up. But when we got Project ADDER funding for a social worker it meant that we have someone who tries to make contact with each case directly and robustly, and get them into treatment services. Also that person takes on safeguarding*

*where addiction is a key aggravating factor, be it perpetrator or victim. A perpetrator with addiction will, for example, go to their mum's house and rob them - so if we can get them to address addiction, wider risk is greatly reduced."*

Some stakeholders highlighted the loss of particular interventions: specifically the M-PACT (Moving parents and children together) programme, which did not run between 2020 to 2022. The licence provider was unable to develop an online version of the programme. This was a major challenge: *"we used to deliver this accredited programme around keeping parents and children together - so substance misuse using parent accessing RESET would be able to get this support, and we would encourage the whole family to join the 9 week evening programme. It worked well, but we couldn't develop it online. Prior to that we had been getting a lot of referrals but that died down. Recently we began delivering the programme again. But it was so hard to get referrals, as we had to re-establish links with children's social services and re-establish our team. It really did affect family work, with not a lot of referrals coming in".*

A pilot project around the repeat removal of children from mothers is just about to start, looking at a trauma informed approach around those mothers who have children taken off them due to substance misuse. A person is coming in-post soon *"for a year or so. Just going through checks. They'll look at partnership work around that, to prevent and focus on the trauma. RESET will be involved. Looking at counselling, and contraception etc. We used to have similar project eight or nine years ago called Nightingale, but that cost a lot."* Another project mentioned for praise is the Women's Criminal Justice worker, funded by Project ADDER, looking at alternatives to prison for women who are offending. *"That has huge implication on families and children".*

## **4.7 Analysis and summary: Need and Impact**

### **4.7.1 Alcohol**

Despite high rates of alcohol abstinence, Tower Hamlets has high levels of need around alcohol-related harms. Data at Figure 1 and 2, for instance, indicates that Tower Hamlets has a higher level of binge drinking, and of drinking over 14 units per week, than the rate for London and England. Furthermore, while the rate of people drinking at increased levels has decreased in London, it has increased in Tower Hamlets. While there may be a section of the community who are abstinent, many other adults in the borough are drinking at levels that may harm their health.



The data for various health harms caused by alcohol substantiates this picture. Alcohol-related mortality (Figure 3) indicates an increase from 2019 onward. However, hospital admission rates (for both alcohol-specific and wider measures) show an overall downward trajectory – see Figures 4 and 5. Several issues with hospital data – such as coding practices or impact of the pandemic on hospitalisations – may explain this discrepancy. (Albeit that these downward trends may be due to how data are coded or the impact of the Covid pandemic on hospital admissions).

As with the rest of England, Tower Hamlets has high numbers of adults who may be alcohol dependent but whose needs for treatment are not met. Only 14% of the adult population who would benefit from treatment are in receipt of such support (Table 1, and which compares to the rate in England of 13.7%). Though this is an estimate, it does clearly indicate that the majority of those who would benefit from treatment are not in treatment.

In summary, the data for alcohol clearly indicates a high level of need, high unmet need, and therefore the ongoing need for interventions for those drinking above recommended levels as well as those who are dependent.

#### 4.7.2 Drugs

Data at Figure 9 (based on historic data from 2016-17) shows that Tower Hamlets has a high rate of OCU, crack and opiate use with an OCU rate of 14.4 per 100,000 population (compared to a rate of 6.3 in London and 8.9 for England as a whole). This aligns with the views of local professional stakeholders who described the borough as having a significant issue with levels of Class A drug use. While relying on the projection of historic estimates (which are somewhat prone to error) the OCU prevalence rate in Tower Hamlets were (in 2016) increasing as was the rate of opiate use (albeit that crack rates were declining). (See Figure 10). Similarly there was an (estimated) upward trajectory in the estimated level of unmet need for OCUs, opiate and crack (with a small recent decline in 2020-21) (Figure 11).

In summary, there is substantial unmet need for drug treatment for Class A drug users in the borough, despite the fact that the borough has the largest treatment population in London (see Figure 12). While a comprehensive treatment system has been put in place (described later in this report), this is not meeting the needs of all Class A drug users in the borough: like elsewhere, many of these users are not previously engaged in treatment nor are they currently in treatment.<sup>41</sup>

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<sup>41</sup> Unmet need will include a mix of the treatment “naïve” (those who have never been in treatment) and those who are not currently in treatment but who have had previous treatment episodes.

### 4.7.3 Drug and alcohol treatment population

Tower Hamlets has the largest total treatment population in London with 1,945 adults in treatment in 2020-21 (Figure 12). It also has the fourth largest treatment population in London as a rate per 1,000 of population (at 10.1).<sup>42</sup> Crudely expressed, Tower Hamlets has a bigger issue to address than most other authorities in London.

The size of the treatment population (Figure 13) is on a downward trajectory in terms of the numbers of opiate users in treatment (from a high of over 1,600 in 2011-12). While this mirrors a similar downward trajectory across London as a whole, there is nothing that implies that this decline is due to a drop in need for treatment. Rather, and as discussed above, the data appears to indicate that conversely there are growing levels of Class A treatment need.

The alcohol treatment population has also declined over the past decade (albeit at a shallower rate) (Figure 17).

It is likely therefore that the drop in the treatment population across all group of substances is not due to a decline in the number of people needing specialist treatment, but is more likely linked to budget cuts to local treatment services, which have led to reduction in capacity and corresponding shrinking of the treatment population. The treatment budget has roughly halved since 2012. This data would tend to substantiate this conclusion.

The profile of the treatment population shows clearly how the proportion of those aged 50 and above in treatment are increasing. Table 2 shows that in 2010/11 this age group made up 11% of the treatment population, while now make up nearly a quarter (23%). This suggests the presence of an ageing cohort of opiate users, which may partly explain the growing cohort of service users who have been in treatment for six years or more (now making up 15% of the treatment population).

The issue of the ageing OCU population is not limited to Tower Hamlets but is a well-recognised phenomenon across England. The ageing population will exert an additional pressure on local services as they are likely to have a range of complex co-morbid health (physical and mental health conditions) and social care needs that will need to be addressed in addition to their drug use.

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<sup>42</sup> While the City of London also has a higher rate per 1,000 this is something of an anomaly given a very small resident population.

## 5. Early intervention

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### *Key findings:*

- Alcohol screening is available in Tower Hamlets for local adults. This is consistent with guidance with regard to effective early intervention. In 2021-22 over 49,000 adults received an alcohol screening in primary care.
- Additional screening is available online via the Drinkcoach website.

This section seeks to explore issues in relation to drugs and alcohol that are the precursor stages to dependency, where an individual may require specialist support or help: it looks at impacts and at the range of services that are in place to address problems at this stage.

### 5.1 Early intervention services for adults

#### 5.1.1 What works

There is a clear and well-developed evidence-base for the range of provision that should be in place to intervene to support adults with drug and alcohol misuse prior to the issue becoming such whereby it will require specialist treatment.

#### *Pathways*

Commissioning Quality Standards set out that, "People working in other services are offered training to provide services to people affected by problem drug or alcohol use, including:

- basic screening to identify problem alcohol or drug use
- advice and harm reduction interventions
- referral to appropriate services."<sup>43</sup>

Partners who have a role to play include: schools and youth services, community services, healthcare, housing services, criminal justice agencies, employment services and adult and children's social care.

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<sup>43</sup> <https://www.gov.uk/government/publications/commissioning-quality-standard-alcohol-and-drug-services/commissioning-quality-standard-alcohol-and-drug-treatment-and-recovery-guidance> See 3. Whole and integrated system approaches

### *Identification and Brief Advice (IBA)*

Many drinkers are motivated to try to reduce their alcohol consumption. A desire to be healthier, concern expressed by others and reducing the costs are some of the motivations towards change<sup>44</sup>.

IBA for alcohol use as recommended by NICE<sup>45</sup> should be delivered in all adult health, social care, and criminal justice settings. PHE guidance<sup>46</sup> also recommends that IBA is provided in all appropriate primary and secondary healthcare settings. There should be clear pathways<sup>47</sup> for those who may be dependent on alcohol and require structured treatment.

### **5.1.2 Early intervention services for adults**

A range of services are available for adult residents who may be drinking at elevated levels that may impact on their health. These services are not for those who are drinking at dependent levels and are not intended to serve this group of drinkers.

#### ***P-RESET***

P-RESET is a primary care drug and alcohol service provided by the Tower Hamlets GP Care Group. It is the brand name of the primary care drug and alcohol service commissioned by the local authority and also delivers Shared Care and annual health checks on alcohol dependent, opiate and crack users.

The early intervention component of P-RESET offers all adults in Tower Hamlets an AUDIT-C<sup>48</sup> alcohol screening assessment. Where necessary a full AUDIT screen can be carried out where the score from AUDIT-C indicates potentially hazardous levels of drinking.

Patients can receive either brief advice or an onward referral into RESET for treatment as required.

Table 27 sets out AUDIT-C screening undertaking in primary care.

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<sup>44</sup> Beard E, Brown J, Kaner E, West R, Michie S. Predictors of and reasons for attempts to reduce alcohol intake: A population survey of adults in England. PLoS One. 2017 Mar 9;12(3)

<sup>45</sup> <https://www.nice.org.uk/guidance/ph24>

<sup>46</sup> <https://www.gov.uk/government/publications/local-health-and-care-planning-menu-of-preventative-interventions>

<sup>47</sup> <https://www.gov.uk/government/publications/developing-pathways-for-alcohol-treatment/developing-pathways-for-referring-service-users-from-secondary-care-to-specialist-alcohol-treatment>

<sup>48</sup> AUDIT-C asks three questions in order to identify people who are drinking at harmful or hazardous levels.

**Table 27 AUDIT-C screening activity**

	Q1	Q2	Q3	Q4	Total
19-20	13,870	14,950	13,739	13,726	56,285
20-21	-	8,919	10,216	10,096	29,231
21-22	12,847	13,250	11,847	11,129	49,073
22-23	14,105	16,048	13,047	NA	43,200

The data at Table 27 indicates that P-RESET is delivering alcohol screening at volume to the local population with over 49,000 screenings carried out in the period 2021-22 and over 43,000 delivered by January 2023 (meaning that last year’s total is likely to be surpassed).

### **Drinkcoach**

In addition to the primary care offer Humankind are commissioned to deliver their Drinkcoach service. Drinkcoach is an online alcohol test (using the AUDIT alcohol screening tool). Local residents can anonymously go online to carry out a quick assessment of their alcohol consumption and whether it is within safe parameters.

The Drinkcoach service will direct anyone who scores above 20 (and therefore which may indicate possible dependency) to the RESET treatment service.

Drinkcoach also carry out three campaigns a year to promote safer drinking. These campaigns occur during Freshers’ week (aimed at students), in the lead up to Christmas and in the New Year.

### **What this tells us**

Services are in place to address issues with alcohol consumption that fall beneath the threshold of dependency and therefore the need to access specialist treatment. Most people who are drinking at above recommended levels will require this support and not specialist treatment. Data on screening carried out in primary care indicates widespread roll out of this service to the adult population. This offer has been strengthened by an online offer which means that numbers screened in Tower Hamlets are larger than the population screened in primary care.

## 5.2 Early intervention services for children and young people

### *Key findings:*

- Safe East provide intervention and outreach to local young people with over 6,000 young people attending sessions delivered (Sessions also were in relation to sex and relationships and tobacco as well as substance misuse).

This section sets out early intervention services for young people in Tower Hamlets.

### 5.2.1 What works

Schools equip children and young people with the knowledge, skills and attributes that they need to keep themselves healthy and safe and prepared for life and work, through the effective delivery of personal, social and health education. In September 2020, Relationships Education (in primary schools), Relationships and Sex Education (RSE) (in secondary schools), and Health Education (in both) became statutory<sup>49</sup> and included specific reference to drug, alcohol and tobacco education.

In 2021 the PSHE Association published its evidence review, guidance and lesson plans<sup>50</sup> which provides a comprehensive guide on effective teaching of drug and alcohol education within a broader PSHE (personal, social, health, economic) curriculum, and fully covers the drug and alcohol content specified in the statutory requirements for Health Education.

Key recommendations emerging from the evidence are:

- Take a whole school approach – drug and alcohol education and prevention is just one aspect of a wider whole-school approach which promotes healthy and positive friendships between children and young people, a positive relationship with the school, and that create links between the school and the local community.
- Teach age-appropriate knowledge regarding substance use, alongside development of personal and social skills and attitudes relating to substance use.
- Ensure provision of selective pastoral interventions for pupils at higher risk of or already involved in substance use.
- Have a clear and fair policy towards substance use outlining the response to substance-related incidents and take a balanced approach to substance-related

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<sup>49</sup> Department for Education, 2019. Relationships education, relationships and sex education (RSE) and health education

<sup>50</sup> Available at: <https://pshe-association.org.uk/drugeducation>

incidents which aims to keep the pupil in school, whilst ensuring health promotion and involvement of appropriate support services, such as young people's drug services, health and social services and/or counselling.

Schools should situate drug and alcohol education alongside related topics that can contribute to development of resilience and build on protective factors, such as:

- Healthy lifestyles and health-related decisions.
- Managing risks and personal safety.
- Mental health and emotional wellbeing.
- Forming and maintaining positive relationships.

The PHSE Association evidence review also describes how teachers should talk to children and young people about drugs and alcohol, teaching strategies and appropriate teaching at different stages (years).

## 5.2.2 Early intervention services for young people

### *Safe East*

Safe East is the integrated young people's substance misuse and sexual health service. While providing structured treatment (see Section 5) it also provides a range of early intervention activities.

Safe East attend school assemblies and go into youth centres to provide information about drugs and alcohol. Where needed they also provide workshops in schools for groups of young people where there are greater concerns.

In the year 20/21 Safe East provided the following early intervention and outreach services:

- 290 outreach sessions targeted at vulnerable young people.
- 1,767 young people attended outreach sessions.
- 2,010 referrals into service as a result of outreach<sup>51</sup>.
- 398 sessions delivered in relation to sex and relationship education, substance misuse and tobacco<sup>52</sup>.
- 6,642 young people attending sessions delivered in relation to sex and relationship education, substance misuse and tobacco.

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<sup>51</sup> The data does not indicate why there appears to be more young people referred into the service than attended an outreach session.

<sup>52</sup> Note therefore that this will include workshops where substance misuse was not covered.

### *What this tells us*

There is a clear commitment in Tower Hamlets to providing information about drugs and alcohol to young people. Moreover, this information is provided by expert parties – i.e. the local young people’s treatment service. The approach adopted in Tower Hamlets is consistent with national guidance in that it situates substance misuse among wider health behaviours. The data indicates that substantial numbers of young people are receiving some information about drugs and alcohol and in a manner that fits with best practice.

## **5.3 Analysis and Summary: Early Intervention**

Services are in place to engage and assess local adults in relation to alcohol consumption in order to provide support for those drinking at non-dependent levels. The alcohol screening provided by local GPs and the innovative use of an online platform (Drinkcoach) enable borough residents a means to assess their alcohol consumption at a time and through a mechanism which suits them. Both services provide routes into RESET who are able to provide Brief Interventions (i.e. short time-limited support for non-dependent drinkers) as well as a route into structured treatment. Data from P-RESET indicates that the AUDIT screening service is well used with 49,000 screenings carried out in the year 2021-22. (See Table 27). The data set out in Section 4.1 clearly indicates an ongoing issue of a large proportion of the population drinking at higher than recommended levels. It is therefore crucial that these early intervention services are retained to engage with this population and to improve the adverse health impacts as shown in the hospital data (as also seen in Section 4.1).



## 6. Evidence based treatment and recovery services

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### *Key findings:*

- There is an appropriate set of interventions in place to meet need; which are in line with relevant guidelines:
  - The RESET treatment service provides outreach and referral, treatment and recovery services to the local population and began operation in 2016. The service was re-commissioned in 2019 with a change in provider for RESET treatment.
  - RESET Outreach provision aims to engage drug and alcohol users into structured treatment while also providing information about harm reduction and brief advice thereby supporting individuals prior to accessing treatment.
  - RESET Treatment provide a comprehensive range of interventions including pharmacological and psychosocial interventions. The range of provision is consistent with guidance for substance misuse provision.
  - RESET Recovery provides a range of support interventions to aid service users through treatment and post-treatment.
  - P-RESET is a primary health based service that provides Shared Care and health checks for service users in treatment.
- There is comparative complexity among the cohort of people in treatment in Tower Hamlets, compared with elsewhere. A greater proportion of Tower Hamlets' treatment population is designated as "very high risk" compared to a comparator group of authorities (at 38% and 30% respectively). Levels of housing need, co-occurring Crack Cocaine use both indicate this increased complexity.
- The cohort in treatment show greater complexity and risk behaviours than in comparator areas. Opiate users in Tower Hamlets who are still using at six months are more likely to be exhibiting a range of higher-risk behaviours than their peers in comparator areas, including: more likely to have used crack (74% compared to 64%); cannabis (22% v 17%); alcohol (29% v 27%), and much more likely to have a housing issue (41% in Tower Hamlets compared to 27% nationally).
- Rates of successful completion from treatment among opiate users have been in decline for a number of years and now stand at 3%. The decline is statistically significant. Statistical analysis shows this decline mirrors trends regionally and

nationally, suggesting the decline is driven by national and London-wide factors rather than being locally specific.

- However, the opiate completion rate of 3% locally is slightly lower than the rate of 5% seen among statistically similar comparator areas. Meanwhile, there are fewer representations in Tower Hamlets than in comparator areas
- Alcohol successful completions dropped significantly from 2020 and now stand at 21%. This compares to 37% for Tower Hamlets' comparator group of areas. Data is not available to explain the drop in completions.
- While the majority of the treatment population are in treatment for under one year (53%), 15% have been in treatment for over 6 years. Those in treatment for over six years are all opiate users. The proportion in treatment for over 6 years is similar to that among comparator areas.
- 5% of treatment exits were due to the death of a client. Rates of death were highest for opiate users (8%).
- Tower Hamlets service users are more likely to leave treatment with a continued acute housing need, particularly for opiate users. 8.8% of Tower Hamlets opiate users have a housing need at end of treatment, versus 4.4% nationally across England.
- Within the first 12 weeks, a higher proportions of service users had an "unplanned exits" compared to England, for both opiate (18.0% v 16.4%) and alcohol users (13.6% v 12.9%). This may suggest that improving experience at the 'front door', particularly for opiate and alcohol clients, could result in greater proportions of presenters remaining in treatment for at least 12 weeks.

This section explores the specialist drug and alcohol treatment services that are provided in Tower Hamlets for adults.

## 6.1 Adult drug and alcohol treatment - what works

The delivery of adult specialist treatment services are set out in the Commissioning Quality Standards (referred to in Section 5.1) and in Drug misuse and dependence: UK guidelines on clinical management<sup>53</sup> ("Orange Book Guidelines"). The Orange Book sets out information on "Essential elements of treatment" as well as the delivery of pharmacological and psychosocial elements of treatment. It gives further guidance on relationship to the criminal

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<sup>53</sup> <https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management>

justice system and the wider health needs of those in specialist treatment (for instance the management of blood borne viruses).

Commissioners and providers should strive to locate drug and alcohol treatment services within an integrated health system which is coordinated to improve service users' access to healthcare services including for example wound care, sexual health, dental health, pain management, mental health, and cardiovascular health.

NICE Guidelines set out best practice in relation to harm reduction for people who inject drugs.<sup>54</sup> Commissioners and providers of drug and alcohol treatment services should ensure people who inject drugs have access to a suitable range and quantity of injecting equipment, to advice and information on blood-borne viruses and other infections, and advice on safer ways of taking drugs.

Services to support recovery on an ongoing basis help to prevent relapse by supporting the service user practically and/or emotionally and help build 'recovery capital' such as internal resources or supportive social networks. The evidence base for recovery support is growing<sup>55</sup>.

Services that support recovery include, but should not be restricted to:

- Peer support and mutual aid: People in treatment having access to a range of peer-based recovery support options, including 12-step (e.g., Alcoholics Anonymous, Narcotics Anonymous), SMART Recovery and other community recovery organisations. Substance misuse treatment providers should improve sustained recovery outcomes (including abstinence) by actively encouraging service users to engage with mutual aid.<sup>56</sup>
- Peer mentoring and support<sup>57</sup> should be integral to local service delivery. Support for education, training, and employment: Good connections between local training and employment agencies and treatment providers are crucial. As is engagement with local employers to make the case and address negative preconceptions and stigma about employing people with a history of alcohol or drug dependence.

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<sup>54</sup> <https://www.nice.org.uk/guidance/ph52>

<sup>55</sup> Advisory Council on the Misuse of Drugs. Recovery from drug and alcohol dependence: an overview of the evidence, London: ACMD; 2012

<sup>56</sup> PHE (2013) A briefing on the evidence-based drug and alcohol treatment guidance recommendations on mutual aid. [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/669047/Mutual-aid-briefing.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/669047/Mutual-aid-briefing.pdf)

<sup>57</sup> <https://www.gov.uk/government/publications/service-user-involvement-in-alcohol-and-drug-misuse-treatment>

- Recovery 'cafes', centres or groups that provide safe, drug free, meeting space, socializing and activities.

## 6.2 Adult treatment services

This section sets out the treatment and related services in place in Tower Hamlets

Adult treatment in Tower Hamlets is provided by RESET. The RESET service is made up of three distinct elements:

- *Outreach and Referral*: to identify and engage adults who might benefit from structured drug and/or alcohol treatment.
- *Treatment Service*: providing specialist treatment services.
- *Recovery*: service to provide ongoing support to embed the changes made through treatment and to prevent relapse.

More detail on each element is set out below.

The stated aim of the RESET treatment system (i.e. the totality of the offer across all three elements) is to support and enable service users to become free from substance dependency and to sustain long-term recovery, while reducing the harm associated with drug and alcohol misuse.

The RESET service began operation in 2016. Prior to this there had been a less unified local service system with over 18 providers of various substance misuse and treatment activities. The structure of the local treatment system was changed to the current model, due to a combination of funding reductions and a need to address confusion and duplication arising from a number of different providers (both users and stakeholders reporting confusion on where to refer/access treatment).<sup>58,59</sup> The approach adopted by RESET therefore aims to simplify by providing a single front-door to treatment.

Specifically, the RESET service aims to:

- Reduce risky behaviours associated with drug and alcohol misuse (for instance addressing injecting),

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<sup>58</sup>

<https://democracy.towerhamlets.gov.uk/documents/s86212/5.2a%20Substance%20Misuse%20Commissioning%20Part%201.pdf>

<sup>59</sup>

<https://democracy.towerhamlets.gov.uk/documents/s67606/9.1a%20DAAT%20Commissioning%20Intentions%20Update.pdf>

- Reduce any exploitation that is associated with drug and alcohol misuse (such as sexual exploitation),
- Reduce child and adult safeguarding risks,
- Reduce drug and alcohol-related crime and anti-social behaviour,
- Improve the health and wellbeing of those in treatment (both physical and mental health),
- Improve the number of individuals recovering from their drug and alcohol misuse.

### **6.2.1 Outreach and referral**

The outreach and referral service is provided by Providence Row (a local homelessness charity).

The outreach service seeks to:

- Encourage drug and alcohol users to access and engage structured treatment provided by the other elements of the RESET service (see below).
- Provide outreach to identify and engage those who would benefit from structured treatment,
- Provide harm reduction support and advice to both service users and professionals.

The service is based at Providence Row's building in Wentworth Street, E1 and so clients are able to access the wider services provided by Provide Row. The focus of much of its work is outreach into the community (rather than expecting clients to engage via Providence Row premises).

The service comprises:

- 0.5 FTE manager,
- 2 FTE outreach workers,
- Needle exchange co-ordinator.

Staff stated that recruitment has been an issue, for instance they have been unable to recruit a co-ordinator post whose role would be to co-ordinate the activities of the different workers.

The service operates its outreach function widely and seeks to engage diverse groups ranging from students at local universities (at Freshers events), a range of local community groups, through to local rough sleepers. The process of engagement can vary – providing one-off information to some people, whereas with others it can take months of engagement and conversations to get them to access treatment. Outreach can be complicated as a proportion of the homeless population in Tower Hamlets (who are a key target group) have

no links to the borough. The service can therefore work with them, and they end up in treatment in other boroughs.

Needle exchange is provided onsite at Providence Row and combines provision of equipment (needles and syringes), naloxone distribution with harm reduction advice.

The service also employs four RESET Navigators (funded through Project ADDER funds) whose role is to focus on rough sleepers. The intention of these workers is to focus (in the first instance) on 120 named rough sleepers and then to work with other rough sleepers as the initial cohort engage in treatment.

The rough sleepers are provided with intensive support to help them engage in the local treatment service and access inpatient detoxification and residential rehabilitation if desired.

### **6.2.2 Treatment service**

The RESET treatment service is currently (since late 2019) delivered by Change Grow Live (CGL). The scope of the service is defined as:

“RESET Treatment Service is a service for residents of Tower Hamlets who are aged 18 years and over who are concerned about their own or someone else’s drug taking and drinking behaviour. This includes legal and illegal drugs, novel psychoactive substances (known as “legal highs”) and misuse of over the counter and prescribed medicine.”

The treatment service provides the following interventions:

- Pharmacological interventions,
- Medical and non-medical prescribing,
- Opioid maintenance,
- Opioid detoxifications,
- Medications: relapse prevention, opioid overdose, for the reduction of alcohol consumption,
- Psychosocial interventions,
- Support and preparation for residential rehabilitation,
- Dual Diagnosis support (support for service users with co-morbid mental health needs),
- Harm reduction support: including advice as well as a needle and syringe programme,
- Blood Borne Virus and Sexual health screening, and
- Family, significant other and carer support.

As with all drug and alcohol treatment services, RESET operate a consent-based model meaning that service users must consent to engage in their treatment (including those who are subject to Community Orders).

The service operates from a number of locations with the main service located on the Whitechapel Road. Treatment staff are broadly assigned a specific cohort of service users:

- Alcohol care,
- Non-opiate care,
- Opiate care.

A number of specific posts have been employed using Project ADDER funding, specifically:

- 2 x recovery workers for criminal justice clients
- 1 x non-medical prescriber for criminal justice clients

The offer varies by client group, for instance with opiate clients supported by non-medical prescribers (who are in turn supported by specialist doctors working under a consultant psychiatrist).

At present vacancies are a significant issue in the treatment service and a number of posts remain unfilled. At the time when the needs assessment was prepared there were 20 vacancies across the core service and Adder funded roles. The vacancies have been driven by staff turnover, as well as the development of new posts that it has not been possible to fill. The vacancies cover a cross-section of roles including:

- Team leaders,
- Recovery worker,
- Homeless workers (including Team leader)
- Harm reduction worker,
- Alcohol worker,
- Opiate worker,
- Dual diagnosis worker,
- Hospital liaison worker,
- Specialty doctor,
- Clinical psychologist.

There is therefore a wide spread of skills and competencies among the vacancies including specialised roles (such as doctor and clinical psychologist).

While national data are not available, there are widespread reports among drug and alcohol treatment providers across England on problems with recruiting staff. The issue with vacancies is therefore not a purely local one but is a factor in many treatment services. While additional monies have been put into drug and alcohol treatment across England this has had the effect of treatment services “competing” with one another to recruit staff. This issue is likely to be particularly pronounced in London given the close clustering of so many treatment services and providers.

There has been ongoing activity to recruit to these posts. Recruitment issues have been further exacerbated by delays in Disclosure and Barring Service checks which means, even when recruited, it can take several months to get a new recruit in post.

The net effect of the vacancies means that treatment workers are carrying a caseload of up to 90 clients each (for opiate and alcohol workers). Dame Carol Black states that, “Good practice suggests a caseload of 40 or less, depending on complexity of need” and that, “high caseloads reduce the quality of care provided and the effectiveness of treatment”<sup>60</sup>. Parts of the current system are therefore running with caseloads double those that are considered to be acceptable.

The service accommodates requests for interpreters where needed. Some staff members are Bengali speakers and clients can request to receive care by those who speak Sylheti. Cultural flexibility is adopted in the offer of treatment -for instance users can be given scripting flexibility to travel for religious festivals.

Other aspects of the treatment system include:

- Blood borne viruses (BBV): all staff members are trained about BBVs and clients are screened for BBVs at assessment and then again at every 12 months (where they remain in treatment. Vaccinations for Hepatitis B are offered and links are in place with the Hepatitis C Trust who provide links into Hep C treatment provision in the NHS.
- Naloxone: all staff have received training in relation to naloxone (a medicine that reverses the effects of opioids and can therefore be used to counteract an opioid overdose). Service users are also given information regarding naloxone and its use (not just opioid clients). Training is also provided by RESET to wider professionals based in the community.

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<sup>60</sup> Review of drugs part two: prevention, treatment, and recovery, Dame Carol Black, 2021, See section 3.1.



- Needle exchange: all staff are trained in needle exchange issues and a needle exchange is offered by the service both at its main hub and via a satellite service. The RESET needle provision therefore supplements pharmacy-based provision.
- Rough sleeper provision: four workers and a team leader have been funded to provide additional support to rough sleepers. At the time of the fieldwork for the needs assessment only one post had been recruited.
- Think Family worker: a worker has been assigned to work with pregnant women and who liaises with local specialist midwives.
- Criminal Justice workers: RESET employs two workers to specifically work alongside criminal justice clients, working with the DIP team to support this client group. (At the time this report was prepared, both posts were vacant).
- Chemsex worker:<sup>61</sup> a dedicated (non-opiate) worker supports chemsex clients, liaising with local sexual health services.
- Hospital liaison worker: a worker is based at the Royal London hospital to engage and work with alcohol clients. A second post is being recruited.
- Inpatient detoxification and residential rehabilitation: most clients who require detoxification will be supported to do so in the community. Those requiring inpatient detoxification are reviewed at a panel chaired by the Senior Commissioning Manager for Substance Misuse in Tower Hamlets council following an assessment by RESET. The panel holds the budget for Tier 4 provision.

### *Cannabis Group*

There are plans to begin a cannabis group in early 2023. The cannabis group has been developed in recognition of several factors. Firstly, while cannabis users are welcome in most groups (which are not substance specific) cannabis users see their needs as very different from the OCUs who will tend to predominate. Secondly, the current groups tend to provide support over a period of around 16 weeks whereas cannabis users can benefit from a brief intervention over just a few weeks. Thirdly cannabis users are either often young people (who may not wish to access existing groups) or are in employment. The new group will therefore seek to support these groups who have not traditionally accessed RESET. Finally, feedback from mental health services indicated a cohort of people using cannabis which was impacting on their m&b.

The group will offer a brief intervention style delivery over five to six weeks. It will not be abstinence based and will provide health messages and harm reduction advice.

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<sup>61</sup> A BMJ article defines chemsex as "intentional sex under the influence of psychoactive drugs, mostly among men who have sex with men". "What is chemsex and why does it matter?" BMJ 2015;351:h5790. ,

## 6.2.3 Treatment Processes

This section explores various elements of the treatment process to understand the operation of drug and alcohol treatment in the borough.

### Referral Source

Table 28 sets out the source of referrals for clients in treatment.

**Table 28 Adult profiles: Referral Source – All in treatment at the start of a treatment episode, 2009-10 to 2020-21, Tower Hamlets, Percentage**

	09/10 (%)	10/11 (%)	11/12 (%)	12/13 (%)	13/14 (%)	14/15 (%)	15/16 (%)	16/17 (%)	17/18 (%)	18/19 (%)	19/20 (%)	20/21 (%)
Self, family & friends	42	36	40	44	43	45	49	48	43	49	59	49
Health services and social care	20	26	23	21	21	22	20	24	31	24	18	31
Criminal justice	17	23	21	21	20	18	18	12	12	14	17	9
Substance misuse service	12	10	11	7	8	7	6	12	7	3	2	2
Other	9	4	6	8	8	8	6	4	7	10	5	9

(Source: NDTMS, ViewIT)

**Table 29 Adult profiles: Referral Source – All in treatment at the start of a treatment episode, 2009-10 to 2020-21, Tower Hamlets, London and England Percentage**

	09/10 (%)	10/11 (%)	11/12 (%)	12/13 (%)	13/14 (%)	14/15 (%)	15/16 (%)	16/17 (%)	17/18 (%)	18/19 (%)	19/20 (%)	20/21 (%)	21/22 (%)
<b>Self, family &amp; friends</b>													
E	40	39	41	42	45	47	51	55	58	62	65	61	59
L	40	40	43	43	43	43	45	46	49	53	56	51	50
TH	42	36	40	44	43	45	49	48	43	49	59	49	47
<b>Health services and social care</b>													
E	21	21	21	22	22	22	20	18	18	16	15	15	18
L	20	20	20	20	21	22	23	24	25	25	25	22	28
TH	20	26	23	21	21	22	20	24	31	24	18	31	34
<b>Criminal justice</b>													
E	20	20	20	19	18	17	16	15	14	13	13	12	13
L	18	18	16	18	17	16	15	16	14	12	11	9	10
TH	17	23	21	21	20	18	18	12	12	14	17	9	10
<b>Substance misuse service</b>													
E	13	14	13	11	10	9	8	7	6	4	4	1	4
L	15	15	14	11	11	10	8	7	6	4	4	1	5
TH	12	10	11	7	8	7	6	12	7	3	2	2	3
<b>Other</b>													
E	6	6	6	5	5	5	5	5	4	4	4	10	6
L	7	7	7	8	8	8	8	7	6	5	5	16	8
TH	9	4	6	8	8	8	6	4	7	10	5	9	5

E = England, L = London, TH = Tower Hamlets

Around half (49%) of all referrals were reported from self, family and friends.

There were wide fluctuations in reports from other referral routes, including health and social care services (reaching 31% in 2020-21). Criminal justice reports have also fluctuated, reaching the lowest reported level in 2020-21 at 9% (which may be due to the pandemic

which would necessarily have impacted on this source of referrals but might also be indicative of changes in how local criminal justice services operate or local priorities). It is likely that recent investments – via ADDER funding – will likely increase levels of criminal justice referrals.

Relative to England and London, the proportion of Health and Social Care referrals in Tower Hamlets has notably increased in 2019-20. Referrals from the CJS exceeded England and London-wide figures in 2017-18 but has remain broadly similar before and after that date.

### Treatment Length

Data on the length of time adults spent in treatment is set out at Table 30. Substance misuse is generally accepted as being a chronic condition consisting of episodes of treatment (often multiple episodes) and relapse. Treatment is therefore often considered to sit in a framework that situates substance misuse alongside other chronic conditions (such as hypertension). Research suggests that *“patients receiving 3 months or more of treatment in long-term residential and outpatient treatment demonstrated significantly better outcomes with respect to lower rates of illicit drug use and improvements in several additional areas of behavioral functioning (e.g., employment, criminality) at the 12-month follow-up relative to patients with treatment durations of less than 3 months”*. Moreover, *“Regarding outpatient methadone maintenance services, however, it was not until patients had remained in treatment for 12 months or longer that they demonstrated significantly greater reductions in illicit drug use behaviors at follow-up than patients who dropped out of treatment prior to 12 months.”*<sup>62</sup>

**Table 30 Adult profiles: Length of time in Treatment – All in treatment at the start of a treatment episode, 2009-10 to 2020-21, Tower Hamlets, Percentage**

	09/10 (%)	10/11 (%)	11/12 (%)	12/13 (%)	13/14 (%)	14/15 (%)	15/16 (%)	16/17 (%)	17/18 (%)	18/19 (%)	19/20 (%)	20/21 (%)
Under 1 Year	62	58	60	59	59	60	60	60	62	58	57	53
1 to 2 Years	17	15	15	13	13	12	12	11	11	14	12	14
2 to 4 Years	12	16	14	12	12	12	11	10	8	9	11	12
4 to 6 Years	5	5	6	9	9	6	6	7	6	5	5	5
Over 6 Years	5	6	6	6	6	10	10	12	13	14	14	15

(Source: NDTMS, ViewIT)

Most people in treatment reported accessing services for less than one year (53-62%). There has been a broadly stable picture across all periods, although there has been a steady decline in people reporting being in treatment for under one year from 62% in 2017-18 to 53% in 2020-21.

<sup>62</sup> The Continuing Care Model of Substance Use Treatment: What Works, and When Is “Enough,” “Enough?”, Proctor and Herschman, Psychiatry J. 2014; 2014: 692423.

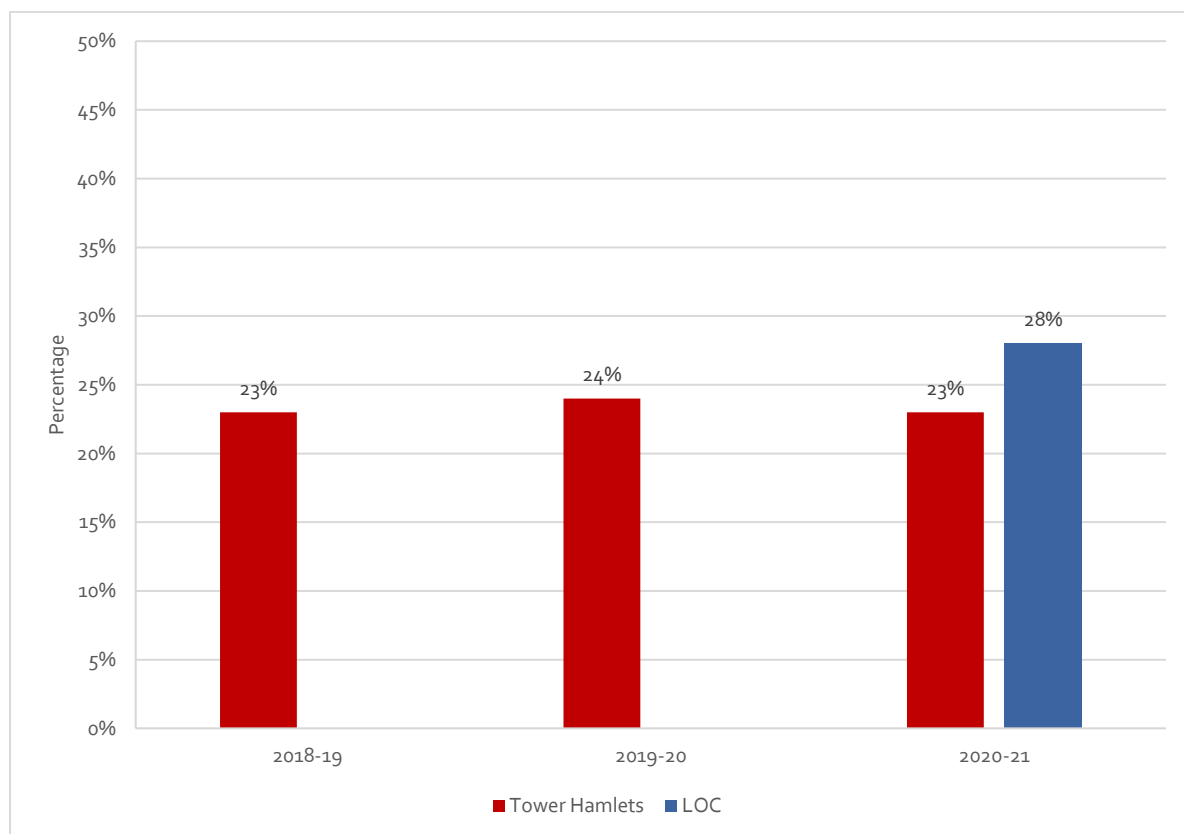
Data at Table 30 on the proportion of those in treatment for over six years should be read mindful of the fact that the treatment service was recommissioned in 2019. When the contract was changed there was a significant cohort of clients who transferred over who had been in treatment for longer than five years. As such the current proportion of clients in treatment for over six years is a function of the legacy of previous treatment provision.

Further analysis (data set out in the Appendix) indicates that less than half of all opiate users stayed in treatment for less than one year. For opiate users, there also has been an increase in the proportion of accessing services for six years or more, from 9% in 2013-14 to 23% in 2020-21.

Figure 26 below compares Tower Hamlets against the Local Comparator Group (LOC) areas which OHID have benchmarked the borough against.

As noted in section 3.2.3, Tower Hamlets has been compared to 32 areas (called Local Outcome Comparators) that are most similar to them in terms of the complexity.

**Figure 24 Treatment Population by Length of time in treatment (>=6 years), Tower Hamlets and LOC, 2018-19 to 2020-21 (data for LOC for 2020-21 only)**



(Source: OHID, Recovery Diagnostic Toolkit)

23% of Tower Hamlets' opiate-using population was reported to be in treatment for six or more years, compared to 28% of the LOC treatment population. This suggests that Tower Hamlets performs slightly better than its peers.

### *What this tells us*

The information above indicates that there is a comprehensive drug and alcohol treatment service provided in Tower Hamlets. Consideration has been given to all key aspects of the treatment pathway according to best practice guidance – engagement and referrals, treatment and recovery – with a range of appropriate interventions offered across each element of the system.

Within the treatment service there is a balance between pharmacological and psychosocial interventions, enabling the treatment episode to be structured to best meet the need of the client. There is a split of treatment workers across alcohol, opiate and non-opiate clients, meaning that workers can develop expertise and knowledge with regard to their particular discipline. The core offer has been added to with a number of additional posts that seek to address the needs of specific communities and groups – such as those in the criminal justice system and those who engage in chemsex. This indicates an appreciation of the diverse range of needs. The service also evidently seeks to address wider health issues, as per national guidance, for instance through the screening for BBVs.

However, there are issues with the capacity of the system, with treatment workers carrying very large caseloads, a number of posts vacant and issues with recruiting new staff.

Referral data indicates that nearly half of referrals are from clients and their friends and family. Criminal justice referrals are dropping (as a proportion). It may be the case that recent ADDER investment in a series of criminal justice pathways improves the rate of engagement from criminal justice agencies; the ADDER pathways are too recent to have an impact on the data here. There may also be some 'legacy' effect of the pandemic on referrals from these sources.

A growing proportion of clients remain in treatment for over six years (Table 30). Further analysis set out at the Appendix shows that the rise is driven by opiate users, nearly a quarter (23%) of whom have been in treatment for this length of time. Most users of other substances are supported for less than one year (for instance 82% of alcohol only clients). Tower Hamlets does better with regard to this metric than comparator areas (Figure 26).

Given that the issue is predominantly among opiate users, it is likely that this represents a cohort who are in receipt of opioid substitution treatment and so maintain contact with treatment in order to obtain methadone or other medications. The ongoing prescribing of

medication is recognised as a valid means to support some clients who may not wish to become entirely abstinent and so can be maintained and monitored. It does necessarily however create some pressure on treatment services by retaining them on caseload.

## 6.2.4 Recovery

The RESET recovery service is also provided by CGL.

The recovery service offers a range of support initiatives to aid service users through their treatment and post-treatment. The recovery offer includes:

- Brief intervention for relapse prevention,
- Accommodation support,
- Education, training and employment support,
- Family support and couples support,
- Mutual Aid,
- Peer-led recovery support,
- Complementary therapy.

Counselling is offered by a number of volunteer student counsellors.

A comprehensive range of group sessions are run throughout the week aimed at different groups of service users:

- Abstinent Peer Support,
- Acupuncture,
- Alcohol pre-detox,
- Alcohol Extended Brief Intervention,
- Alcohol Treatment Requirement group (combined with Drug Rehabilitation Requirement),
- Arts and crafts,
- Creative Writing,
- Mutual Aid,
- Preparing for rehab,
- SMART recovery,
- Wellbeing, and
- Women's group.

Peer mentors were previously in place to provide additional support but these have largely been lost during Covid and have not been replaced.

The recovery service is primarily based at the Alma, a building in Spelman Street, E1 that was adapted specifically to become a base for recovery. No group work currently takes place outside the Alma (i.e. other satellite locations are not used).

### 6.2.5 P-RESET

P-RESET is name of the primary care drug and alcohol service commissioned to deliver shared care and annual health checks on alcohol dependent, opiate and crack users.

P-RESET provides:

- Shared Care: GPs provide Opioid Substitution Therapy (OST) in partnership with RESET.
- Health checks: the service provides primary care annual health checks for RESET opiate and crack users alongside alcohol dependent clients. Clients can also be referred into smoking cessation services as required. The health check is a holistic assessment that explores a number of areas including: smoking, lung health (via the MRC Breathlessness Scale), alcohol screening (using AUDIT), blood pressure checks, cervical screening, assessing Body Mass Index as well as the provision of flu vaccines and Covid vaccines/boosters. (Data regarding health checks is set out later in this section).

Data for the health checks are set out below.<sup>63</sup>

**Table 31 P-RESET health checks for drug and alcohol clients**

Year	Eligible clients	Activity
19-20	755	319
20-21	819	96
21-22	856	187

Eligible clients for health checks are opiate, crack and alcohol dependent clients. The data at Table 31 shows the number of health checks carried out. (There are various components of the health check which are not all carried out in a single session and so the data does not reflect the entirety of activity undertaken.)

<sup>63</sup> Note that activity was partly suspended during Covid and so data reflects this drop.

The data at Table 32 indicates that a low proportion of the eligible population are accessing health checks – for instance in 2021-22 only around a fifth (21.8%) of clients had a health check. In 2019/20 a rate of 42% was achieved.

Prior to 2019 P-Reset was achieving its targets for health checks. The service was adversely affected by the pandemic but as shown at Table 31, the service is once again improving and reaching a greater proportion of clients.

P-Reset has employed new health check and alcohol support workers who are working closely with surgeries in three out of the four localities in Tower Hamlets. Recruitment is currently underway for a further worker. Plans are also under discussion to reach those patients who have not yet engaged with general practice.

Data regarding the number of clients being supported by P-RESET Shared Care service is set out below.

**Table 32 P-RESET Shared Care**

	Number of clients in Shared Care			
	Q1	Q2	Q3	Q4
19-20	228	228	234	239
20-21	218	202	196	190
21-22	191	203	203	207

The data indicates a steady rate of clients supported in primary care by P-RESET with an average of 201 for the last full year an average of 201 clients were being supported in the community.

***What this tells us***

A range of recovery services are offered to enable clients to embed their recovery and again the range of recovery groups aligns well with national standards.

The addition of primary care support is an innovative feature of the local system. While GP Shared Care is operated in many parts of the country (and again is considered to be good practice) Tower Hamlets additionally provides health checks. This extends the local offer and ensure that the holistic health needs of clients can be met. While this is a very positive offer, numbers accessing this service appear to be lower than they could be and so the service would benefit from greater levels of engagement. The pandemic and staffing levels in Primary Care have been significant factors on the completion of all sections of the health check.



## 6.2.6 Other services

### *Pathways from the Royal London Hospital*

An alcohol worker is based at the Royal London Hospital who provides linkages to the specialist treatment service. A gap has been identified by local stakeholders with regard to a substance misuse liaison worker at the Royal London. Local professionals feel that a substance misuse liaison role to provide expertise on the management of drug misuse for patients in the hospital and to create links into treatment services. Work is underway to address this gap.

### *B12 Pathway*

The Royal London Hospital has recently developed a B12 Pathway. This intervention is specifically designed to address the needs of Nox users.

Frequent and heavy Nox use inhibits the absorption of vitamin B12 in the human body (which cannot be naturally produced in the body and must be taken in via diet). Nox use can lead to neurological deterioration and nerve damage by depriving the body of vitamin B12<sup>64</sup>. The effects of this (if not too pronounced) can be managed by providing injections of vitamin B12.

The Royal London B12 Pathway receives referrals from the Hospital Navigator and Community Navigator teams and A&E department. Those who are assessed as vitamin B12 deficient will receive injections three times a week. Some young people supported by the Hospital Navigator service will also receive wider holistic support.

The B12 Pathway is not well known among local services. Safe East and RESET appeared to be unaware of the existence of the pathway.

### *Mental health*

For individuals with co-occurring mental health and substance misuse needs additional barriers exist to accessing and engaging in substance misuse services.

The Dame Carol Black review (referenced at Section 2.2.1) notes that, "Many people with drug dependence also have a mental health problem. Such individuals are often passed from one service to the other, excluded from mental health services until they resolve their drug problem, and excluded from drug services until their mental health problems have been

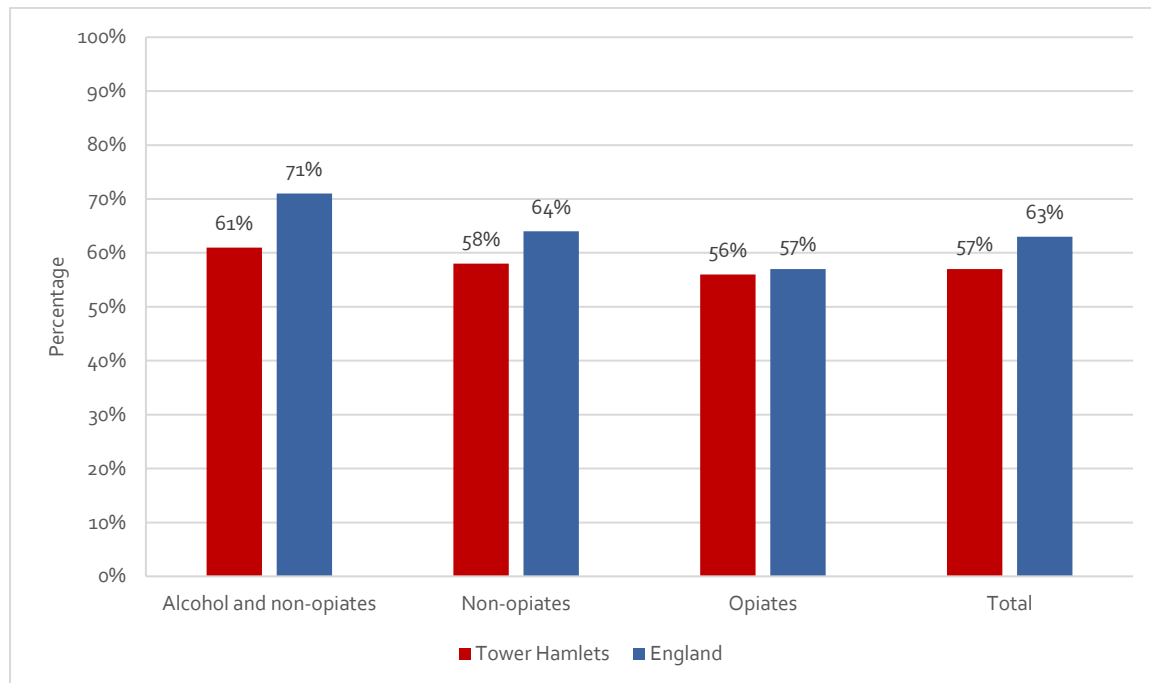
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<sup>64</sup> Note that this damage does not occur when Nitrous Oxide is used in a clinical environment as it is used in conjunction with oxygen which mitigates the effects of the N<sub>2</sub>O consumption.

addressed.”<sup>65</sup> She further notes that, for many people, mental health and trauma lie at the heart of their drug and alcohol misuse. There is therefore great stress placed in her report on effective links between substance misuse treatment and mental health services.

Data regarding the mental health needs of the treatment population is set out at Figure 27.

**Figure 25 Adults in drug treatment with a mental health treatment need, Tower Hamlets and England, 2020-21**



(Source: Adult Drug Commissioning Support Pack: 2022-23: Key Data)

For alcohol and non-opiates, the rate at which clients in treatment in Tower Hamlets have a comorbid mental health need is slightly lower than England’s figures. The rate of co-occurring mental health need for opiates can be shown to be broadly similar for Tower Hamlets (56%) and England (57%).

Issues in relation to the support offered to those with co-morbid drug and alcohol and mental health needs (commonly referred to as Dual Diagnosis) were highlighted during the stakeholder consultation.

Practitioners reported ongoing problems working with clients with a dual diagnosis. As a stakeholder from rough sleeping services stated: *"It's very frustrating when have someone in the hostel who's dual diagnosis. Have a 'chicken and egg' thing with mental health... get people*

<sup>65</sup> Independent Review of drugs part two: prevention, treatment, and recovery, Dame Carol Black, Section 3.11 - <https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery#rebuilding-services>

saying 'if they're self-medicating they can't come through our pathways' as using substances is a no-no".

A clinical lead remarked, those actively abusing substances or alcohol continue to have difficulty accessing mental health services: *"they're declined access until they're stable. But we're working hard with everyone to think how to bridge the gap. So if someone has a chaotic lifestyle, meaning they can't have psychological work, a lot can still be done around harm reduction and crisis management. We'd like to see more services commissioned with co-existence of SM and mental health taken into account. Need to see more willingness to provide solutions. GPs are hitting a wall. And while many can be managed in Primary care, when a GP needs more expertise sometimes there is a gap"*.

### **Working with clients with a Dual Diagnosis**

In recognition of high levels of co-morbid needs, RESET employ a dual diagnosis nurse (the post was vacant at the time when the field work for the needs assessment was taking place) to support this client group.

To support the work with clients with a dual diagnosis a protocol (dated March 2021) is in place between RESET and ELFT.

The protocol sets out four broad categories of dual diagnosis:

- Severe mental illness and substance dependence,
- Severe mental illness and non-dependent yet harmful misuse of substances,
- Non-severe mental health problems and substance dependence,
- Non-severe mental health problems and non-dependent yet harmful misuse of substances.

The protocol states: *"the service user's mental health and drug misuse can be very changeable"* and therefore that ongoing assessment and a person-centred approach to patient management is required.

For each of the four "typologies" of dual diagnosis a concomitant approach to management is set out (indicating who should be the lead organisation, how care should be managed and how the organisations should work alongside one another).

While the protocol sets out a very clear and structured framework for co-working between ELFT and RESET, in relation to alcohol dependent clients, the protocol states that:

“Once the service user has completed an alcohol detoxification and is abstinent then RESET can make the referral to ELFT Mental Health Services” (our emphasis added).

This expectation (that the client is abstinent from alcohol) runs contrary to current guidance on working with clients with a dual diagnosis. NICE guidelines currently state that services should: “not exclude adults and young people with psychosis and coexisting substance misuse from age-appropriate mental health care because of their substance misuse”<sup>66</sup>.

### **What this tells us**

The information above indicates that wider issues around substance misuse are being explored locally.

The B12 Pathway is a very innovative response to what appears to be a much localised issue (Nox use) and its introduction is to be welcomed. Data was not available on numbers of clients accessing this service but this should be monitored to give an idea of the impact of Nox use locally.

The mental health protocol indicates that key parties (i.e. the specialist treatment and mental health services) are aware of both the high levels of co-morbidity among the clients that they work with and therefore the need to collaborate effectively to better support clients. While it is welcome to see the protocol in place it does not fully reflect national guidance with regard to requiring alcohol clients to be abstinent.

## **6.3 Adult treatment service outcomes**

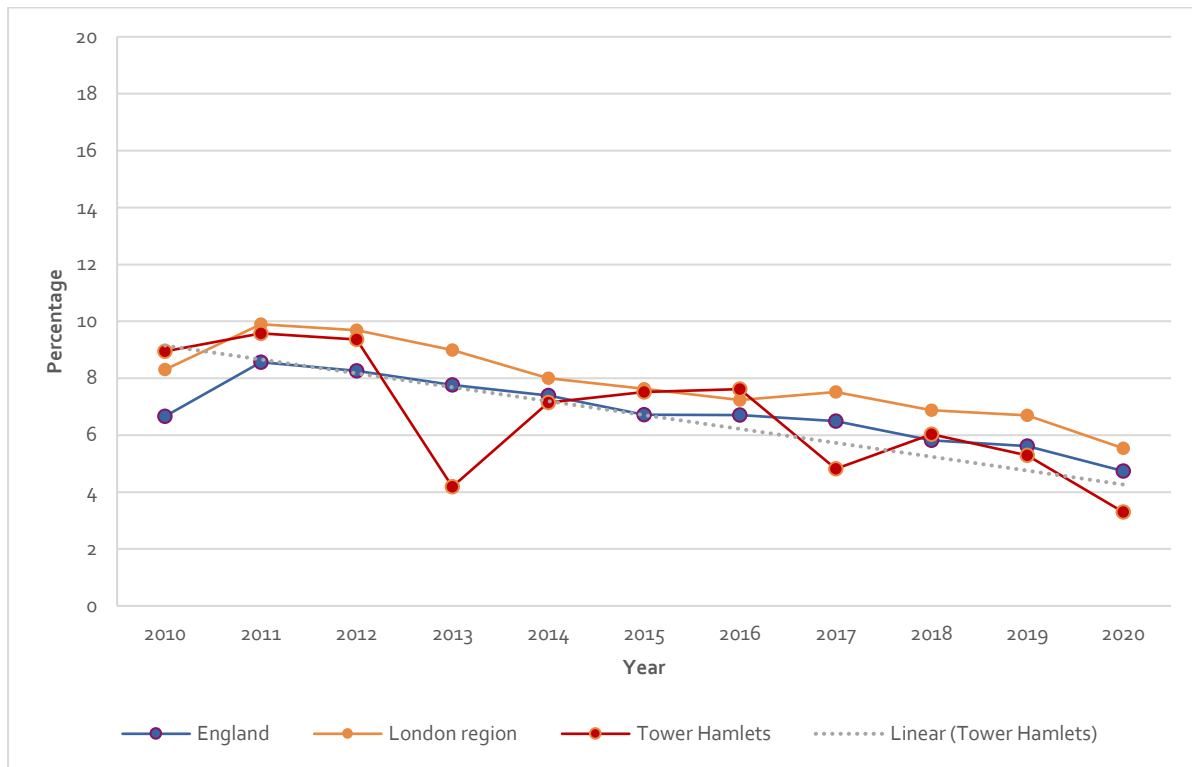
### **6.3.1 Successful completions**

Treatment outcomes for opiate users are set against the London and national rates at Figure 28<sup>67</sup>.

<sup>66</sup> Coexisting severe mental illness and substance misuse, Quality standard [QS188], 20 August 2019

<sup>67</sup> Note that there is a technical definition of “successful completion”, specifically: The number of adults that successfully complete treatment for opiates in a year and who do not re-present to treatment within 6 months.” For further details see: <https://fingertips.phe.org.uk/search/opiate%20drug%20users#page/6/gid/1938132924/pat/159/par/Ko2000001/ati/15/are/E92000001/iid/90244/age/168/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1>

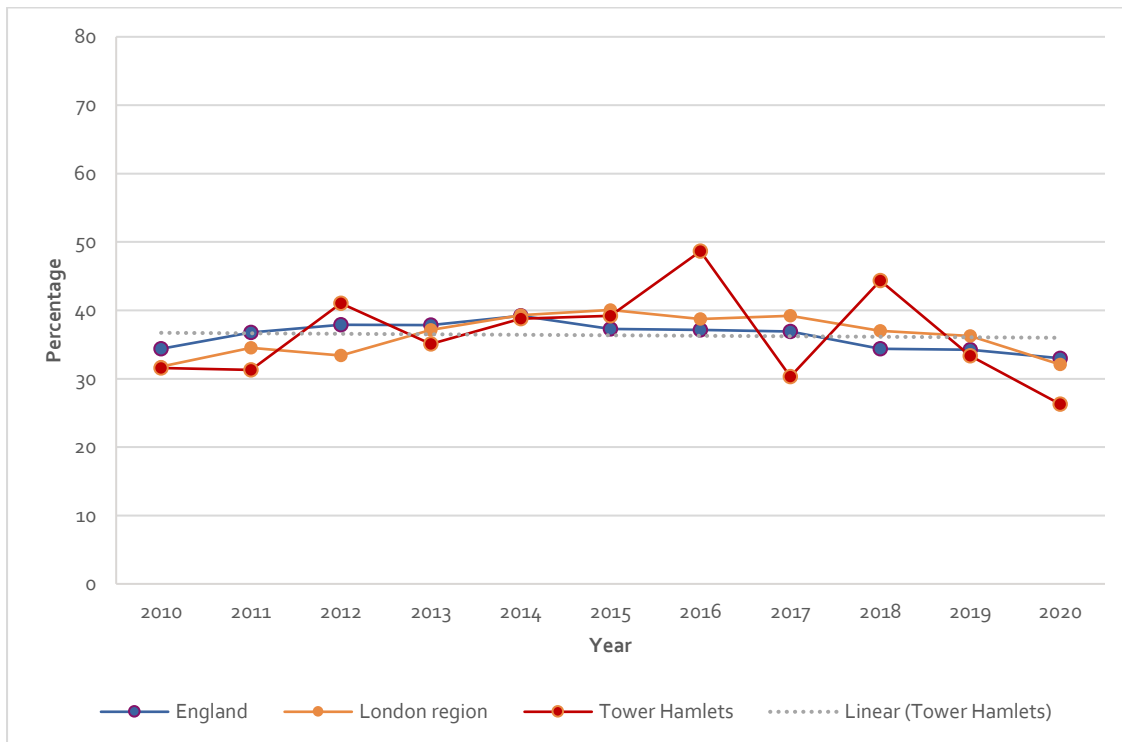
Figure 26 Successful completions from treatment (opiate users), Tower Hamlets, London and England



(Source: NDTMS, Fingertips)

Despite the variation in reported successful completions from treatment for users of opiates, the general trend for Tower Hamlets residents is one of a statistically significant decline (the dotted line). The trend can be shown to be similar across London and in England. A moderately strong relationship exists between successful completion rates in Tower Hamlets with London ( $r=0.68$ ) and England ( $r=0.66$ ). This suggests that the factors affecting successful completion rates for opiate users may be non-specific to Tower Hamlets, i.e. this trend may be influenced by wider factors.

Figure 27 Successful completions from treatment (non-opiate users), Tower Hamlets, London and England<sup>68</sup>

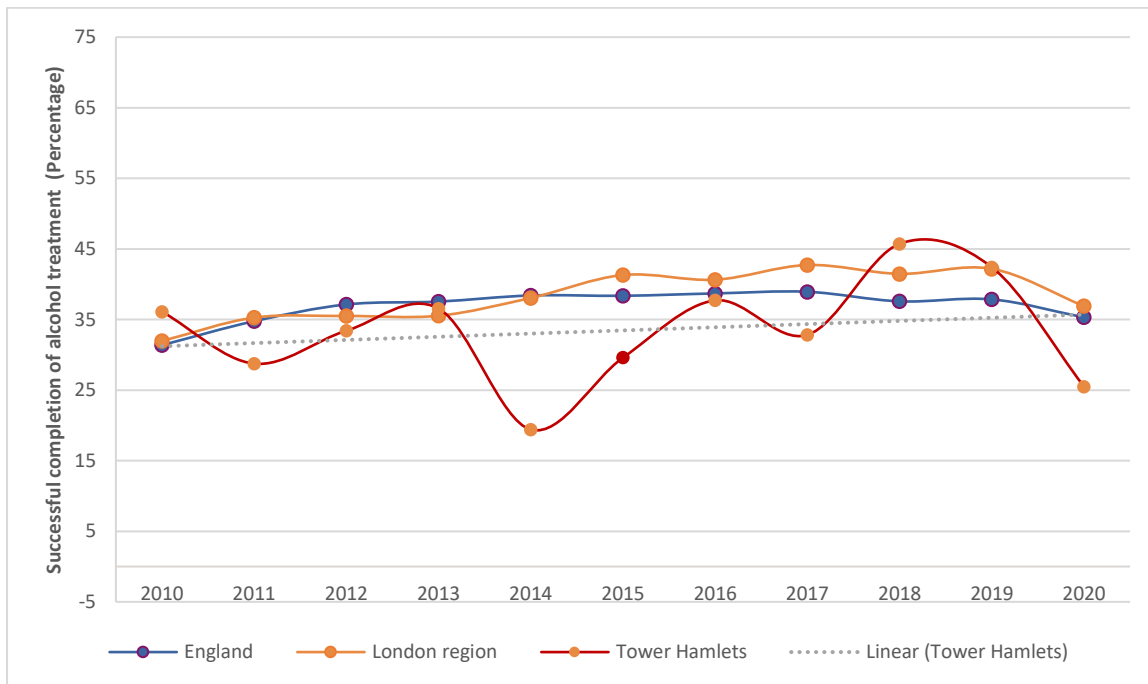


(Source: NDTMS, Fingertips)

The variation in successful completions for non-opiate users from treatment in Tower Hamlets can be shown above (orange line), although the broad trend is flat, although there has been a sharp, significant fall in completions from 2018. There exists a similar, albeit weaker, relationship in the trends with the relationship between Tower Hamlets successful completions and London ( $r=0.48$ ), and England ( $r=0.40$ ) shown to be moderately strong.

<sup>68</sup> Note that this uses the same definition with successful treatment defined as no re-presentation within 6 months.

Figure 28 Successful completion of alcohol treatment (percentage), 2010 to 2020, Tower Hamlets, London, England Percentages<sup>69</sup>



(Source: OHID NDTMS, Fingertips)

There have been notable fluctuations in the successful completion rate for Tower Hamlets residents in alcohol treatment. The successful completion rate surpassed or equalled London and national figures between 2018 and 2019 but dropped significantly in 2020 (although the overall trend is not significant). The data does not indicate why this might be the case. This is potentially related to how service provision was amended during Covid with possible knock-on effects for treatment outcomes. Other explanations are also possible including change (the change in pattern is a random one), that local data collection/coding is at issue, or that changes have been made to service provision which are responsible.

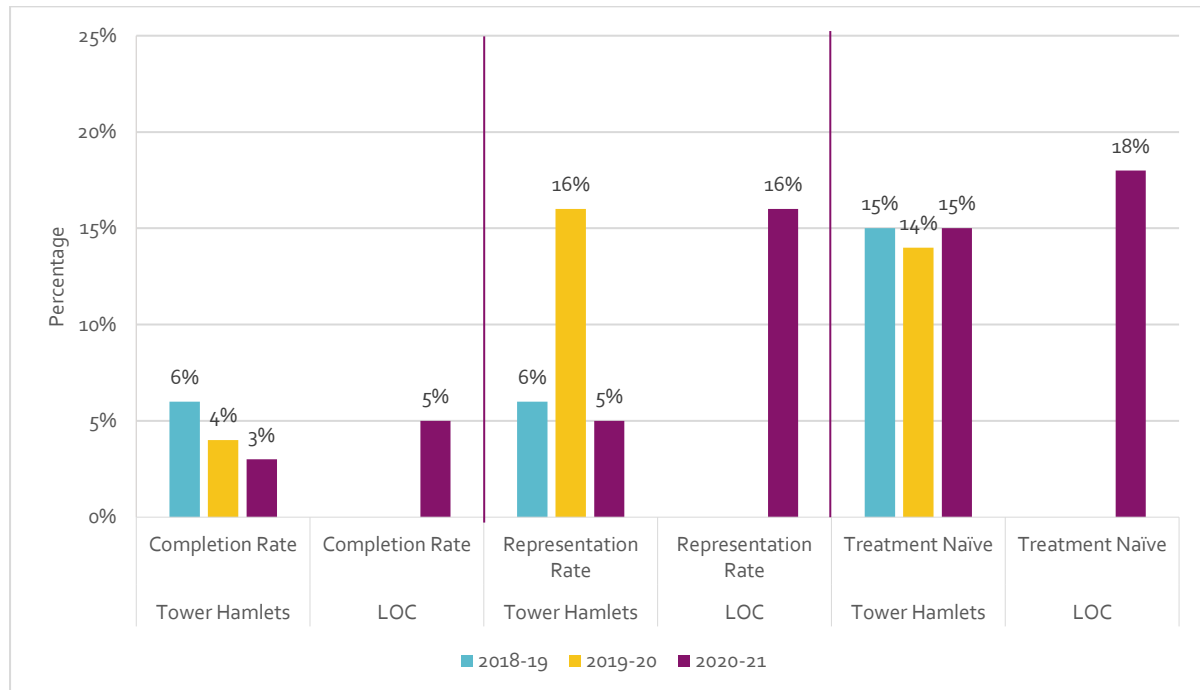
<sup>69</sup> Note again the use of no re-presentations within 6 months as the basis of success.

## Comparative Treatment Completion rates

This section compares treatment outcomes across the LOC group (see Section 3.2.3).

### Opiate Users

Figure 29 Completion, Re-presentation rates and Treatment Naïve rates, Tower Hamlets and LOC, 2018-19 to 2020-21 (data for LOC for 2020-21 only)



(Source: OHID, Recovery Diagnostic Toolkit)

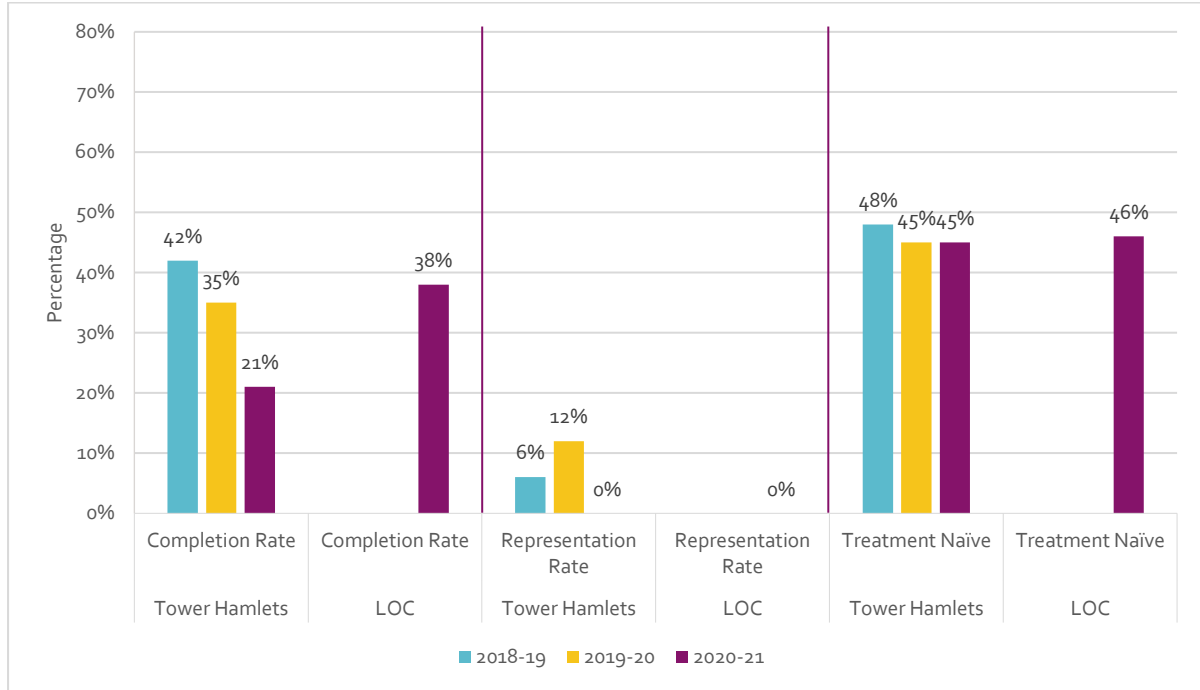
The completion rate in Tower Hamlets has declined annually from 6% in 2018-19 to 3% in 2020-21 (which compares to a completion rate of 5% for the LOC). There has been some fluctuation in the re-presentation rate in Tower Hamlets, fluctuating from 5-6% to 16% in 2019-20. The estimated rate for those who are treatment naïve (those who have never accessed drug or alcohol treatment) is slightly lower in Tower Hamlets (14-15%) relative to the LOC (18% in 2020-21). This means that there is a (slightly) lower proportion of people who would benefit from specialist treatment but who have not accessed treatment in Tower Hamlets than in the comparator group. This is generally indicative of effective and proactive engagement work that means that the treatment naïve are being identified and engaged.



## Non-Opiate Users

Comparisons are made against the LOC for non-opiate users at Figure 32.

**Figure 30 Completion, Re-representation rates and Treatment Naïve rates, Tower Hamlets and LOC, 2018-19 to 2020-21 (data for LOC for 2020-21 only)**



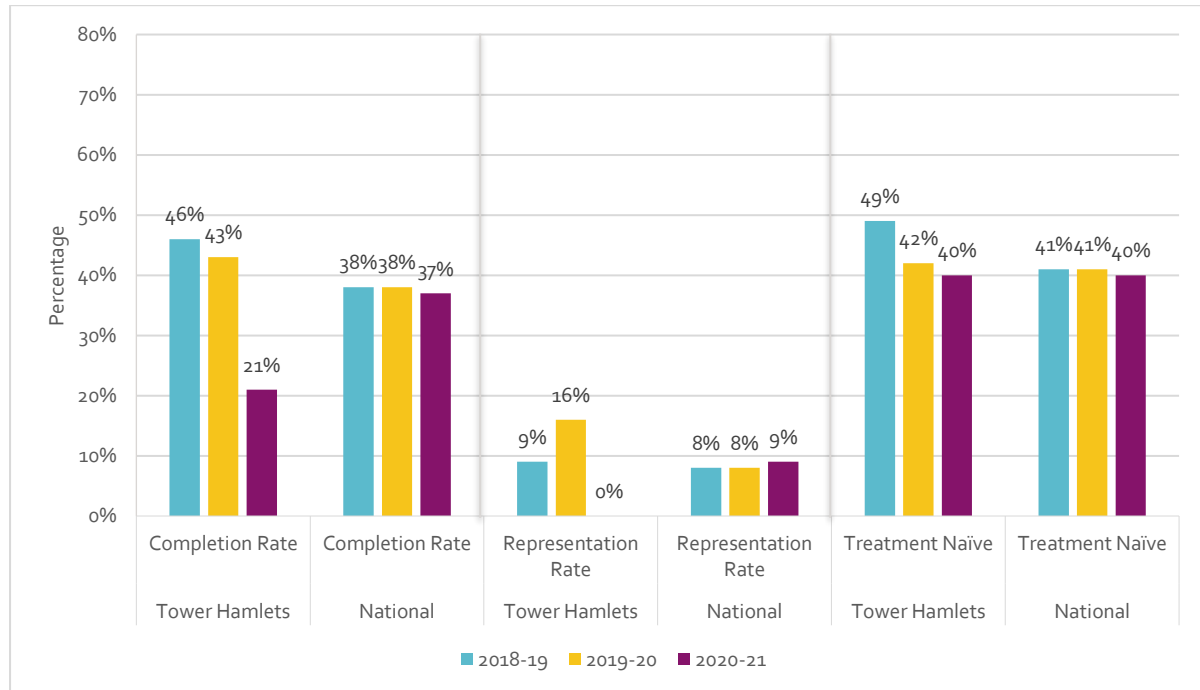
(Source: OHID, Recovery Diagnostic Toolkit)

The completion rate for non-opiate users has been steadily declining from 42% in 2018-19 to 21% in 2020-21, compared to 38% in the LOC. The re-representation rate is 0% in Tower Hamlets, which aligns with the national figures. Similarly, the treatment population for non-opiate users is around 45-48%, broadly concordant with national estimates (46%).

## Alcohol

Comparisons against the LOC for alcohol users are set out at Figure 33.

**Figure 31 Completion, Representation rates and Treatment Naïve rates, Tower Hamlets and LOC, 2018-19 to 2020-21**



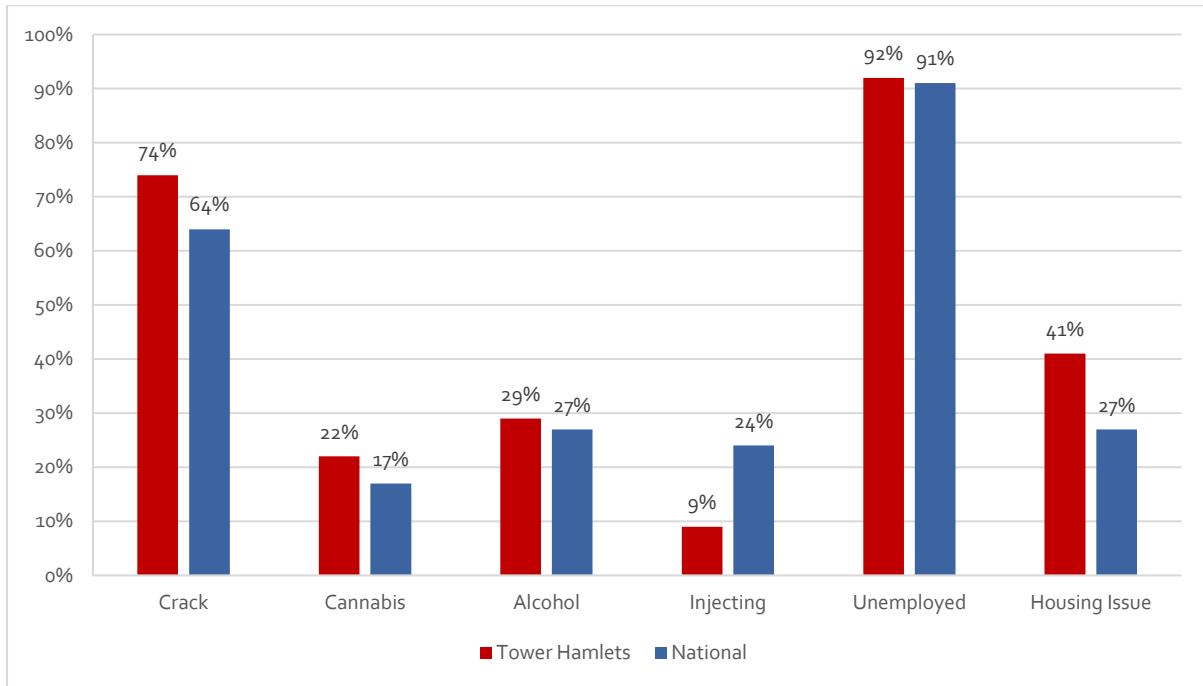
(Source: OHID, Recovery Diagnostic Toolkit)

There has been a broadly declining completion rate for alcohol-only clients in Tower Hamlets, from 46% in 2018-19 to 21% in 2020-21 (compared to a stable picture nationally at around 37-38%). Representations have fluctuated from 16% in 2019-20 to 0% in 2020-21. The treatment naïve population for alcohol-only clients in Tower Hamlets declined from 49% in 2018-19 to 40% in 2020-21, which is in line with national figures (40%).

### Factors that affect Treatment Completion

The following section examines the factors that are associated with treatment completion at six-month review based on TOP measures for opiate and non-opiate users (data for alcohol clients were not available).

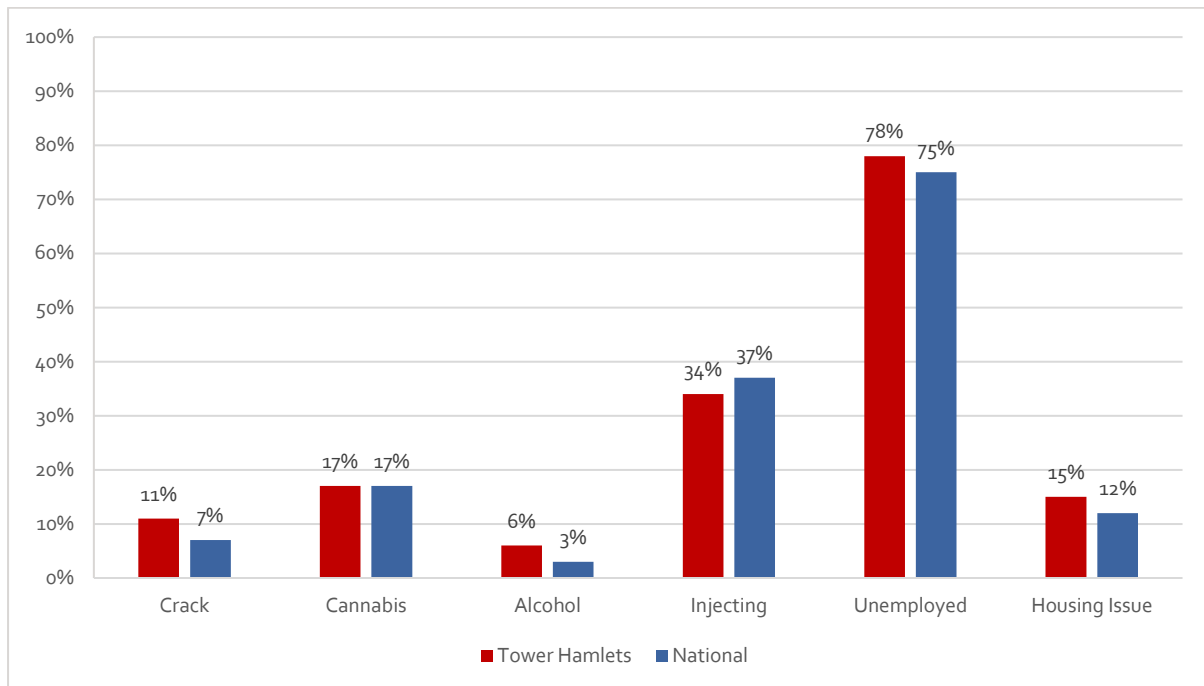
**Figure 32 Drug use and social functioning of opiate clients who still use opiates at six months, Tower Hamlets and national (England), 2018-19 to 2020-21**



(Source: OHID, Recovery Diagnostic Toolkit)

For opiate users who are still using opiates at six months, Tower Hamlet’s clients were less likely to report injecting drugs (9% compared to 24% nationally) but were shown to include higher-risk behaviours, including: more likely to have used crack (74% compared to 64% nationally); cannabis (22% v 17%); alcohol (29% v 27%). Other social functioning measures such as having a housing issue (41% in Tower Hamlets compared to 27% nationally).

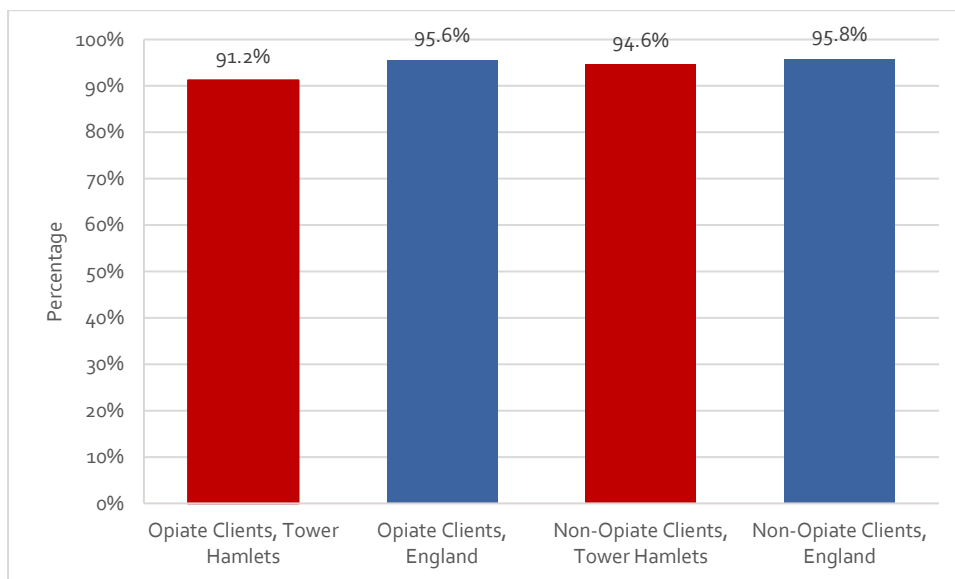
**Figure 33 Drug use and social functioning of non-opiate clients who still use non-opiates at six months, Tower Hamlets and national (England), 2018-19 to 2020-21**



(Source: OHID, Recovery Diagnostic Toolkit)

There are broad similarities between substance use and social functioning needs for non-opiate users at the six-month review, with slightly higher crack (11% v 7%) and alcohol use (6% v 3%). For social functioning needs, non-opiate users in Tower have only a slightly increased unemployment (78% v 75%) and housing needs (15% v 12%).

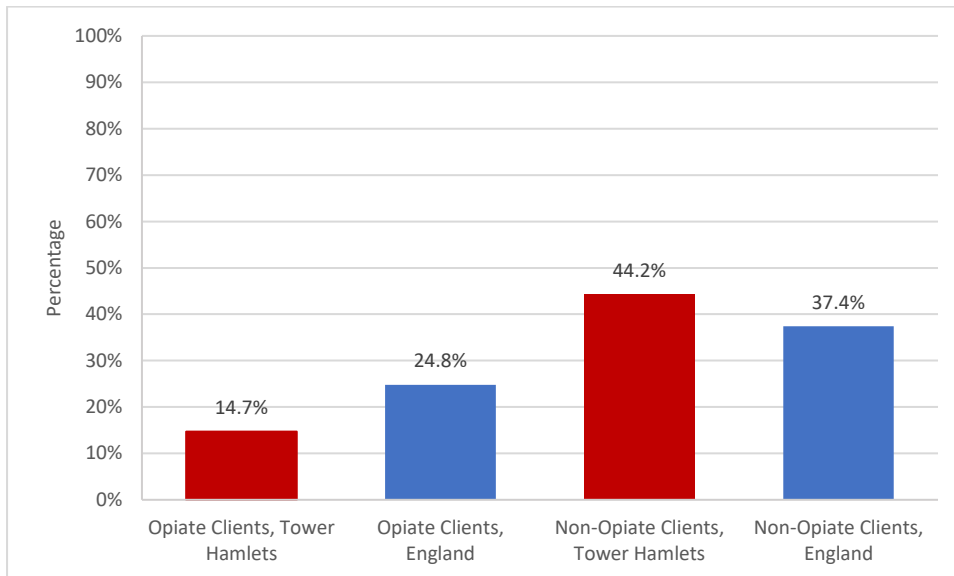
**Figure 34 Housing outcomes at successful completion of treatment, Percentage**



(Source: DOMES Diagnostic Report Quarter 2 2022-23)

Tower Hamlets residents are more likely to leave treatment with a housing need, compared to national average, particularly for opiate users. Figure 36 shows the proportion of people leaving treatment with successful housing outcomes, from which we can deduce how many still have housing need upon leaving treatment. 8.8% of Tower Hamlets opiate users have a housing need at end of treatment, versus 4.4% nationally across England; for non-opiates the comparative figures are 5.4% and 4.2%.

**Figure 35 Employment outcomes\* at successful completion of treatment, Percentage**



(Source: DOMES Diagnostic Report Quarter 2 2022-23: \* defined as working for at least 10 or more days in last 28 at exit)

There are notable disparities by drug type concerning employment outcomes. For Tower Hamlets residents, a higher proportion of non-opiates were employed (44.2%) compared to England (37.4%). In comparison, opiate users in Tower Hamlets were reported to be working at around half the level (14.7%) of their England counterparts (24.8%)

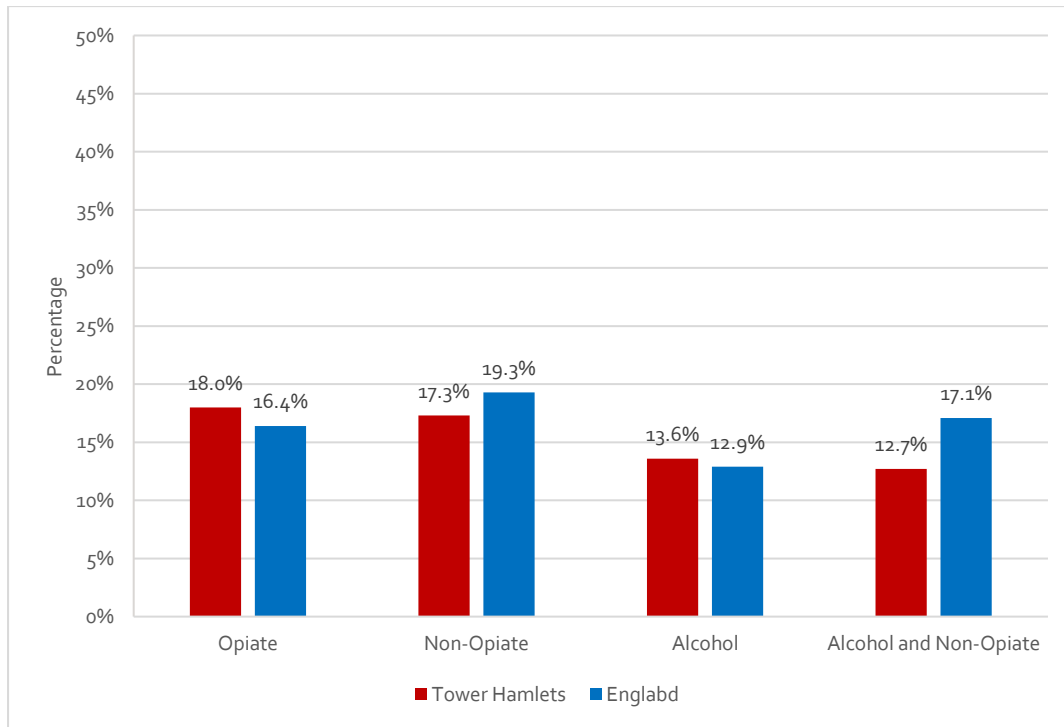
**Table 33 Treatment Outcome at Six Month Review, Tower Hamlets 2015-16 to 2020-21, for opiate users**

Treatment outcome	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)	2020/21 (%)
<b>Opiate Users</b>						
Abstinent	35	28	33	33	30	45
Improved	30	23	27	25	23	24
Unchanged	33	44	37	39	45	31
Deteriorated	2	5	2	2	3	2
<b>Opiate users who also use Crack Cocaine</b>						
Abstinent	34	24	31	27	26	34
Improved	24	18	31	24	23	22
Unchanged	39	53	33	44	45	41
Deteriorated	3	3	6	5	6	3

(Source: NDTMS, ViewIT)

For opiate users (using opiates only), over two-thirds (69%) were reported to be either abstinent or have improved. For opiate users who also use crack cocaine, this figure is slightly lower at 59%. Other substances are not included in this analysis due to the relatively small numbers reported.

**Figure 36** Proportion of new presentations who had an unplanned exit or transferred and not continuing a journey before being retained for 12 weeks, Tower Hamlets and England, 01/07/2021 to 30/06/2022



(Source: DOMES Diagnostic Report Quarter 2 2022-23)

Slightly higher proportions of unplanned exits were noted for Tower Hamlets residents who were opiate (18.0% v 16.4%) and alcohol users (13.6% v 12.9%) compared to England. In contrast, non-opiate users and alcohol (17.3% early exit for Tower Hamlets residents compared to 19.3% in England) and non-opiate users (12.7% in Tower Hamlets compared to 17.1% in England). This may suggest that improving experience at the ‘front door’, particularly for opiate and alcohol clients, could result in greater proportions of presenters remaining in treatment for at least 12 weeks.

### Treatment exits

This section sets out the status of clients at the point when they leave (exit) the treatment service.<sup>70</sup> See Table 34.

**Table 34 Adult profiles: Treatment Exits – All in treatment at the start of a treatment episode, 2020-21, Tower Hamlets, Percentage**

	Tower Hamlets 20/21 (%)	London 20/21 (%)	England 20/21 (%)
Successful completion	38	52	50
Dropped out/left	33	30	33
Transferred – not in custody	13	9	6
Transferred – in custody	10	3	4
Treatment declined	1	2	2
Died	5	3	3
Prison	0	0	1
Treatment withdrawn	0	00	

(Source: NDTMS, ViewIT)

Successful completion rates for Tower Hamlets (38%) can be shown to be lower than London (52%) and national figures (50%). In the latest year, 5% of those exiting treatment did so on the basis of dying while in treatment. This is an increase in mortality on previous years. The data does not indicate why this increase occurred. (The rate of death for opiate users is 8% while that of alcohol users was 4%).

There are several potential explanations for the change in death rate, including: random variation in the numbers of deaths; better follow up and recording may have identified more 'deaths (which may in other years have been misclassified as 'dropped out'); changes to mortality risks faced during the pandemic; or changes to services during the pandemic. At present the data cannot indicate which of these factors is most likely to explain the increase in deaths: a full audit is recommended.

#### What this tells us

The data indicates very variable levels of successful treatment completions with clear divisions between types of substances used. Successful completion rates for opiate treatment are lower than the comparator group, albeit by only two percentage points.

Data shows that opiate users are more likely than their peers in other areas to be exhibiting a range of factors that is likely to negatively affect their treatment (Figure 34). As such it can

<sup>70</sup> Note that this data uses a different definition than that used above at Section 6.3.1 – a successful completion here is at the point of exit (and does not include re-presentations at 6 months). As such it should be considered to be a separate measure of treatment outcomes.

be concluded that opiate users in Tower Hamlets appear to be more complex and vulnerable than opiate users in other (comparable) areas.

The data at Figure 31 shows that only 15% of those in treatment are “treatment naïve” (i.e. have not had previous episodes of drug treatment). This is fitting with earlier data showing an ageing opiate population that is largely made up of those who have had previous treatment episode and who have relapsed. This may explain the higher death rates for opiate clients (albeit that the change may be due to change or to other factors also). Moreover, the opiate population relative to nationally, can be shown as higher-risk clients which would affect the type and nature of the interventions offered (e.g. require greater intensity of support).

## 6.4 Views of service users and professional stakeholders

### *Key findings*

- A total of nine service users were consulted to gather their views on treatment provision.
- Service users reported multiple effective pathways into treatment including from health and criminal justice agencies.
- Service users were broadly positive about the service and that it was meeting their needs, albeit that some were not clear about what was available to them.
- Service users felt that the service could be better promoted.
- Professional stakeholders were aware of the high number of vacancies in RESET and recognised the pressures that this put on staff.
- Some professional stakeholders felt that barriers existed in relation to certain communities accessing the service and that more needed to be put in place to engage the diverse communities in the borough.
- Nox use was widely cited as an issue by professional stakeholders who felt that this was a growing problem among local communities.
- Stakeholders also reported widespread use of cannabis and that the needs of this client group needed to be addressed.

Nine individuals with lived experience of treatment were interviewed to understand their perspective on the effectiveness of treatment. The limited numbers of interviewees means that the views set out do not constitute a cross-section of views and must therefore be read as a self-selecting minority. The sample also represents a group of service users who had effectively participated in treatment. As such their views may not be representative of the wider treatment community.



### 6.4.1 Referrals

Three participants had been given information about RESET by A&E staff following hospital admission. One of these contacted RESET himself after his admission, with strong encouragement from their partner, and received a call back and an assessment for support within two hours. Another of the three received information about RESET twice, firstly in A&E and then after being sectioned (under the Mental Health Act). An older service user had very recently been referred by the A&E specialist nurse at the Royal London. The nurse gave him the information about RESET, he was referred very quickly and received a fast response.

All those who had been referred by the hospital spoke very highly of the support and signposting they had received there in connection with their referral.

A recent service user had been referred by the police after arrest for possession of drugs. In his case the referral was mandatory. The response from RESET was very quick and he had had an initial assessment within weeks.

### 6.4.2 Meeting needs

Service users were at different stages of their recovery and this influenced their understanding of how their needs had been met.

- Two past service users felt their needs had definitely been met in respect of their substance misuse. They found the service friendly, approachable, and non-judgemental and the meetings were sociable. Both had felt welcomed and understood in meetings. Online meetings had suited them.
- Two service users in the group were unclear about what their needs were exactly or how they would be met. The practitioner facilitating the service user forum was able to explain to them some of the psychosocial support that they could expect, as well as options such as free gym membership and a walking group.
- One service user with 25 years of treatment expressed a contrasting view. He felt that the type of service provided by RESET was 15-20 years behind best practice and that it lacks a human touch through being a manualised programme.

### 6.4.3 Accessing prescription and waiting times

There was some discussion between two long-standing former heroin users about difficulties and delays in getting a prescription for Subutex, Suboxone, or methadone, especially since the closure of the Mile End Hospital Drugs and Alcohol service. They suggested that, if people feel desperate, they may be tempted to seek out a dealer rather than wait for the prescription. However, as one participant observed "*if you are prioritising your recovery, it is*

*better to wait for, or chase, the script [prescription] which lasts for longer than a bag [of heroin bought from a dealer] anyway". There was a feeling that the process of getting a prescription should be quicker to make the most of the window of motivation when people most needed support. "Once you are in you will get scripted; it's just the waiting time".*

#### **6.4.4 Barriers**

There were some perceived barriers to receiving a service, although the service itself and its delivery was appreciated by nearly all participants.

- Participants felt that the service was not advertised enough, or at all, so there may be people in need who are not aware of the help that is available to them.
- The timings of meetings and sessions was thought by some to be an issue. Meetings were said to be within usual daytime working hours.<sup>71</sup> One man said he could simply tell his employer he had a private appointment, and that he worked from home anyway so could adjust his working hours to fit appointments in. Online sessions meant that a working mother could more easily attend during the working day or fit around childcare responsibilities.

#### **6.4.5 Covid**

Covid-19 restrictions meant that services went online, and several remain online. There are also face-to-face and hybrid services and for some participants the online element has been beneficial.

Three service users stated that Covid restrictions had increased their alcohol or cocaine use to a level where it had become highly problematic and led either to a hospital admission or an arrest. In the group, all participants were keen to regard that period as something they had put behind them and which they did not wish to speak about in detail.

There were reports that dealers had gone online during the lockdowns, making home deliveries rather than being street based.

#### **6.4.6 Progression**

One participant in the focus group had progressed to AA meetings and was attending two a day. None of the other participants had arrived at a point where they felt able to attend AA

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<sup>71</sup> Note this is a misconception; there are in fact sessions available outside of working hours within RESET treatment.

or similar groups. One man had negative perceptions of AA meetings and preferred the sociable atmosphere of meetings at RESET.

### **What this tells us**

The views of service users must be read mindful of the fact that this was not a representative sample of users. With this caveat in mind, the data indicates that effective referral pathways are in place into the service and that users felt that the service understood and was responding to their needs. There appears to be some sense that the service could be better advertised and that this would in turn help increase referrals further. Consideration also needs to be given to delivering groups outside of traditional working hours.

## **6.5 Views of stakeholders**

A range of stakeholders were consulted to gather their views on local treatment services and the need for treatment services. Details of those interviewed are set out at Section 2.1.1. The views of professional stakeholders represent the opinion of those consulted and therefore represent personal views which give useful points for consideration.

### **6.5.1 Capacity of RESET**

A recurrent perception among stakeholders was how stretched RESET is in terms of staff vacancies. *"They're completely understaffed – they struggle to retain and recruit, which impacts on waiting times. .... That impacts on service delivery in hostels, wait times to be assessed, to be scripted, social prescribing, for example."*

Stakeholders acknowledge that efforts are ongoing to fill the gaps in staffing: *"it's not through lack of will on their part – managers are desperate to recruit... they're always recruiting, but they struggle to get people to stay"*.

It was the view of some stakeholders that the impact of staff shortage on the delivery model was being felt across the system. Some felt that elements of the wider system are not designed in a way that takes into account challenges in the treatment service. One interviewee said: *"People wait weeks for assessments. Project ADDER funding has been spent to get people into treatment services, so we have staff going out seeing adults who are saying they want to engage, and we link them to the service... but then RESET are just not ready to meet them. And it makes whole cycle of change go backwards – people feel rejected"*.

### 6.5.2 Supporting local communities

Some professional stakeholders commented on need and stigma among local communities. One observed, *"I get so many police reports about young Bengali men using crack, heroin or drinking, but they don't want to know about drug and alcohol services due to the stigma"*.

Another stakeholder reported that the needs of South Asian/Bangladeshi community have *"traditionally always been a challenge for services – even 20 years ago there was specific chaotic mental health issues, and chaotic drug use, it's a really complex picture around culture"*. Another said, *"culturally it can be quite difficult for people to engage with specific services, as they come up against shame and disapproval"*.

A healthcare practitioner felt that, when asked about unmet need, the main priority is how the service can better deal with *"access, diversity and all the populations in the borough. A lot of work is needed around how to find out and target patients who don't engage. Certain ethnicities are more reluctant due to stigma. We have large Somali and Bangladeshi populations, some very poor as well, and a young population. It's amazing how diverse the area is. We need culturally sensitive services - with workers familiar with needs and substances certain groups use"*.

Cultural competency was raised by two interviewees, one of whom said: *"we need to talk to Somali community about Khat and understand what specific needs people have, rather than assume it's the usual substance misuse issues"*.

Other stakeholders felt the service makes appropriate efforts in relation to inclusion of different groups. Client feedback collected by the service does not highlight cultural competency as a key issue of concern among users (though this feedback only pertains to those who manage to access the service). Some RESET staff speak community languages and services can be offered in such a way as to take into account their cultural and religious need.

### 6.5.3 Nox (Nitrous Oxide)

Nox was cited as a serious and growing problem by multiple stakeholders who were interviewed. It was the view of interviewees that while use is starting among those aged 14 and 15 years, it extends into early adulthood and was said to be common among those in their twenties. (There is no quantitative data that corroborates levels of Nox use by age). While sometimes used in isolation it is also used in conjunction with cannabis or alcohol.

Nox is readily available via local retailers (as outlined earlier) as well as online. Nox can be purchased via social media such as SnapChat where dealers can be contacted. There are also

commercial operations with sophisticated marketing and branding operations who target young people – for instance Fast Gas<sup>72</sup> and Smartwhip<sup>73</sup>.

Multiple stakeholders who were consulted reported seeing or knowing about widespread use of Nox among young people and described that it was being widely used by local residents. Whilst there are no data (currently) available that can quantify levels of use several stakeholders reported that, such are levels of use, that Nox-associated litter has become an issue in itself (for instance the canisters that are used to dispense Nox). Professionals working with young people were particularly aware of the issue and felt that its use was largely normalised among younger generations.

Stakeholders regularly commented that there appears to be a prevailing belief among young people that Nox is “harmless”. (We were unable to consult with young people as part of this needs assessment and ascertain their views on the impact of Nox). Stakeholders reported that they were seeing young people in their twenties who were suffering adverse consequences of Nox use – these range from pins and needles through to loss of sensation in limbs.

Staff in RESET were aware of the growing issue of Nox use and had begun discussions with some partners in order to formulate a response.

Tower Hamlets has already responded to the growing issue of Nox by introducing a borough-wide Public Safety Protection Order.

#### **6.5.4 Cannabis**

Some stakeholders felt that there was insufficient support for adult cannabis users. As one stakeholder said: *“RESET are committed to developing something, but it (cannabis use) is so widespread... and sometimes it’s not about treatment: it’s about lifestyle, peers. And that sort of pathway isn’t as clear cut as saying come in to talk to us about your cannabis use for an hour once a week, and we’ll help you stop”*.

#### **6.5.5 Young people**

While Safe East provide a service to those aged up to 19 years, a number of stakeholders were of the opinion that young people in their twenties did not want to access RESET for substance misuse support. They reported that RESET is perceived to be a service for older people and opiate users. Moreover, young people (who are using cannabis and Nox) are

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<sup>72</sup> <https://fast-gas.com/>

<sup>73</sup> <https://smartwhip.com/>

unlikely to believe that the drugs they are using are harming them – particularly when compared to heroin use. As such, a number of interviewees reported that young people were refusing to enter treatment if RESET was the only option being presented to them. As one stated, *“There is no way young people will attend a RESET group session.”* (In the absence of consultation with young people it is not possible to corroborate this view).

### 6.5.6 Need for treatment

Interviewees indicated that the need for drug and alcohol services is *“huge”*: police interviewees flagged the scale of the Tower Hamlets drug using population, high complexity and pressures on waiting times as key issues to tackle: *“the numbers of drug users is so vast, especially in the west, where we have most hostels. We have transient populations, and Class A users, meaning that it’s a really big beast to tackle. But within what RESET can deliver, they do it very well – best I’ve seen”*.

Another stated, *“We’ve had recent issues – in that we can arrest drug dealers ‘til the cows come home, and put them away, but unless we deal with who they’re selling to and the markets... well there are so many vulnerable people, and it’s a seller’s market, so that attracts people to our area. And that heightens the pressures locally”*

#### **What this tells us**

A very strong theme from professional stakeholders who were consulted was the capacity issues of RESET. Section 6.2 set out the number of vacancies in the organisation and the absence of these staff has evidently been noted by wider professionals working in Tower Hamlets.

Another issue that emerged was engagement with local communities in the borough and a sense that certain communities face increased barriers, including stigma, to accessing treatment.

Echoing data elsewhere in this report, there was a very clear sense that Nox use is a growing issue locally and one that is not being adequately addressed. There was a very strong sense that Nox use is having an impact on the health of local people but that services had not yet responded to this need.

## 6.6 Children and Young People's Drug and Alcohol Treatment

### *Key findings:*

- Local treatment for young people is provided by Safe East which offers an integrated substance misuse and sexual health service. This is in line with good practice that advocates integrating young people's specialist treatment into wider services for young people.
- The emphasis of the work is on motivational interviewing and harm reduction which is also consistent with recognised treatment provision for young people.
- 90% of young people successfully completed treatment in 2019-20. Successful treatment rates have increased steadily (for instance were 67% in 2018-19).
- The majority of young people (60%) remain in treatment for up to 26 weeks. A small minority (13%) are in treatment for over one year.

This section looks at treatment provision and the effectiveness of treatment for children and young people.

### 6.6.1 What works

The key message in addressing the needs of children and young people is that they are a distinct group of clients in themselves, that their needs are distinct and that they must be supported in ways that differ from the adult treatment population.

The literature stresses the importance of building provision around young people, stressing the importance of understanding young people as a distinct cohort: "Children are not small adults and the adult definitions of substance misuse are inadequate in capturing the developmental aspects of substance misuse in young people."<sup>74</sup>

Given this, PHE state need for services to adopt an approach that recognize the strengths and assets of young people, which treat them with respect and as agents of change and which help to build:

- Resilience,
- Life skills,
- Ability to make better choices and to deal with difficulties.<sup>75</sup>

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<sup>74</sup> Practice Standards for Young People with Substance Misuse Problems, Royal College of Psychiatrists (2012). p.5

<sup>75</sup> Specialist substance misuse services for young people: A rapid mixed methods evidence review of current provision and main principles for commissioning, Public Health England (2017), p.11.

Young people's specialist drug and alcohol interventions should include evidence-based psychological, psychotherapeutic or counselling-based techniques to help young people change their behaviour and lifestyles, and to improve their coping skills.

Standard pharmacological approaches, which are normative practice in the treatment of adults, were not identified in the literature as of significant relevance to young people. This is due in part to the fact that by far the majority of young people will not have a need that requires a pharmacological approach. Ahuja *et al* state that, "Pharmacotherapy should only be initiated with extreme caution after thorough assessment."<sup>76</sup>

Recognising that substance misuse is often related to multiple vulnerabilities PHE recommend that, ideally, services for young people understand and tackle multiple vulnerabilities as part of their approach.

Given this, PHE guidance indicates that treatment approaches offer "integrated services that deliver targeted interventions to young people at risk of developing problems with substance misuse alongside specialist services, particularly with identified vulnerable groups with specific risk factors"<sup>77</sup>. As such, PHE stress the need for multi-agency responses with robust joint working arrangements. In particular it states the need to engage with and provide seamless transition to services including:

- CAMHS,
- Child Sexual Exploitation and abuse support services,
- Youth offending teams,
- Sexual health services.

### 6.6.2 Treatment services

The local young people's treatment service is Safe East and is provided by the charity Compass-UK.

The service is described as integrated health and wellbeing service and offers support in relation to substance misuse and sexual health. The service works with those aged 10 to 19 years (with the offer extending to those aged up to 25 years for specific groups including those who are in the care system, have a special educational need or who have a disability).

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<sup>76</sup> Engaging young people who misuse substances in treatment, Ahuja A., Crome I., Williams R., *Current Opinions in Psychiatry* 26, p.339.

<sup>77</sup> Specialist substance misuse services for young people: A rapid mixed methods evidence review of current provision and main principles for commissioning, Public Health England (2017), p.18.



In relation to its substance misuse offer the service provides:

- One-to-one support,
- Educational sessions,
- Targeted group work,
- Workshops,
- Advice and guidance,
- Harm reduction advice and information, and
- Tailored support.

The service is based in the Spotlight Youth Centre.

The team consists of:

- 3 x FTE practitioners,
- A team leader,
- An outreach worker, and
- 2 x sexual health nurses.

Substance misuse treatment is largely offered on a one-to-one basis as it was recognised that many young people do not feel comfortable disclosing in a group environment. The service is intentionally based at a youth centre in order that the young people do not feel any stigma in engaging with their service.

Much of their work is made up of delivering motivational interviewing and harm reduction work. Should a young person require prescribing (for instance for opiate user) then links exist with the adult treatment service (RESET) who can offer prescribing and medicines management. (While the pathway is available on paper, in practice, numbers requiring prescribing have in reality been nil since the start of the contract).

The service undertakes other work including work with schools, delivering PSHE sessions for local schools and delivering interventions with young people in schools as required. They also provide workshops in schools as required. In addition to work with schools they engage young people via local youth centres.

The service links in with other relevant services as required:

- Young people can be referred to CAMHS for any mental health needs (albeit many young people in the service are already known to CAMHS).

- Staff from Safe East work with the Youth Offending Service and attend their service twice a week. The Youth Offending Service screen their client for substance misuse issues and refer into Safe East as required. The process has been made as seamless as possible as Youth Offending staff can book appointments with the substance misuse worker on the days that they attend the Youth Offending service.

In addition to working with young people the service also engages with parents of the young people in treatment, offering workshops for parents (albeit that these workshops are not offered regularly).

**What this tells us**

The current configuration of young people’s specialist treatment aligns with guidance on delivering specialist treatment via integrated services (in the case of Tower Hamlets, alongside sexual health). Moreover the service appears to have clear and links with other key who work with vulnerable young people – particularly youth offending and mental health services.

Also consistent with guidance is the focus on motivational interviewing and harm reductions, approaches that recognise that working with substance misuse in young people requires a different approach to that of adults.

**6.6.3 Treatment effectiveness**

Data on the outcomes of the treatment are set out below.

**Table 35 Treatment outcomes, Tower Hamlets percentage known to drug treatment services 2014/15 to 2019/20**

	09/10 (%)	10/11 (%)	11/12 (%)	12/13 (%)	13/14 (%)	14/15 (%)	15/16 (%)	16/17 (%)	17/18 (%)	18/19 (%)	19/20 (%)
Successful completion	69	65	65	76	74	84	78	71	63	67	90
Dropped out/left	8	18	12	12	11	8	13	18	26	17	10
Referred on	8	6	12	6	4	8	4	6	5	0	0
Treatment declined	8	6	6	0	11	0	0	0	0	17	0
Prison	0	0	0	0	0	0	0	0	0	0	0
Other	8	6	6	6	0	0	4	6	5	0	0

(Source: ViewIT. Note data for 2020/21 are not available at the time of reporting)

There has been a steady increase in the proportion of successful completions from 63% in 2017-18 to 90% in 2019-20, with a concomitant decrease in the proportion of young people

reported as dropping out of treatment during this time (from 26% in 2017-18 to 10 in 2019-20).

Data on length of time spent in treatment is set out at Table 36.

**Table 36 Length of time in treatment, Tower Hamlets percentage known to drug treatment services 2014/15 to 2019/20**

	09/10 (%)	10/11 (%)	11/12 (%)	12/13 (%)	13/14 (%)	14/15 (%)	15/16 (%)	16/17 (%)	17/18 (%)	18/19 (%)	19/20 (%)
Under 12 Weeks	36	36	46	48	45	46	37	29	36	33	20
13 to 26 Weeks	45	48	46	35	29	32	29	39	32	33	40
27 to 52 Weeks	14	12	8	17	18	15	26	21	23	25	27
Over 53 Weeks	5	4	-	-	8	7	9	11	9	8	13

(Source: ViewIT. Note data for 2020/21 are not available at the time of reporting)

There has been a steady decline in the proportion of young people reported in treatment for under 12 weeks from 46% in 2014-15 to one-fifth of all cases (20%) in 2019-20. The modal length of treatment in 2019-20 was 13-26 weeks (40%). There has been a slight uptick in the proportion of young people in treatment for over one year (53 weeks), from 9% in 2017-18 to 13% in 2019-20. Section 4.6 indicates that the large majority of young people in treatment are users of cannabis (93% in 2019/20). It is not therefore clear why there is a cohort of young people in treatment for over a year as cannabis use is usually managed through motivational interviewing and harm reduction messages. The data may therefore be indicative of a small cohort of young people with very pronounced needs. It is not clear however why this cohort is increasing in size and further investigation is required.

***What this tells us***

The data clearly indicates a very high level of successful completions, and that successful completion rates have been improving over time. This would tend to indicate that treatment is being effectively and successfully delivered.

The proportion of young people in treatment over a year raises some questions about whether the complexity of some clients is increasing as it is unusual for young people to be retained in treatment for this length of time (another feature which distinguishes young people’s treatment from that of adults).

## **6.7 Analysis and Summary: treatment and recovery services**

### **6.7.1 Treatment services**

A comprehensive treatment system has been put in place that covers engagement, treatment and recovery treatment. In particular, an outreach service that has been put in place to engage different groups in the population to support their engagement in treatment. This recognizes the high levels of unmet drug and alcohol need (see Section 4) and seeks to directly address this problem.

Within the structured treatment service there is a comprehensive offer with tailored responses to different client groups (for instance recognising the different needs of opiate and alcohol users). The service has sought to address wider needs and vulnerabilities –for instance links with mental health, BBV provision, and the needle exchange provision. The service is continually evolving in ways to try and meet the needs of local drug and alcohol users – see for instance the development of the cannabis group which will begin in early 2023.

Structured treatment is complemented by a suite of recovery initiatives that both aid treatment and embed recovery.

As is the case elsewhere, treatment outcomes have been declining in recent years mirroring reductions in funding. Current high vacancy rates within treatment service are causing problems, primarily that caseloads for workers are far in excess of what is recommended. This necessarily impacts on the ability of the service to deliver effective treatment to clients. These recruitment issues and high caseloads are not unique to Tower Hamlets; in the light of additional funding for drug and alcohol services, demand for staff is high around the capital and beyond. RESET have made ongoing efforts to recruit to vacant posts but the effectiveness of this has been limited by the demand for skilled treatment workers. Commissioners should consider whether any further local action, investments or initiatives can be taken to address the caseload or recruitment challenges.

### **6.7.2 Treatment outcomes**

While a comprehensive service is in place, the data on successful completions shows a very clear downward trend in relation to successful completion rates for opiate users and which is similar to rates for London and England. Figure 28 shows a long-term decline in the proportion completing successfully, down from around 10% in 2012 to 3% for the most recent period for which data was available. The decline closely parallels rates in England and London and the local comparator group which tends to indicate that the decline is associated

with factors outside of the local area (i.e. issues that are operating at national and regional levels such as the ageing nature of OCUs). However, given the ongoing decline there is value in reviewing how opiate services are delivered, in particular OST provision, to see whether any improvements can be made to this aspect of the service.

Successful completion rates for non-opiate users have also dropped recently but are much better (at around 28%). Alcohol completion rates dropped in 2019 (see Figure 29) but this is possibly associated with the pandemic and is not part of a long-term trend. Ongoing monitoring is warranted to determine whether rates improve back to historic levels.

### **6.7.3 Deaths**

Table 41 (see Appendix 2) indicates that 8% of opiate users died while in treatment. This may be linked to the ageing OCU population described earlier in this report – as opiate users age, they will have increasingly complex health needs and, very commonly, a range of co-morbid health conditions. It is possible that the deaths are associated with other health issues. In order to better understand what the key driving factors are, in addition to the regular review of drug-related deaths that is already carried out, a further deep dive should be undertaken to develop a robust picture of factors associated with local opiate deaths.

### **6.7.4 Health checks**

P-RESET provide an innovative primary care annual health check for adults in treatment to enable a more holistic assessment of their health to take place. This approach enables service users to engage with local primary care services as well as ensuring their wider health needs can be properly assessed. Take-up rates of the service are low (working with around a fifth (21.8%) of eligible clients in 2021-22) meaning that the service is not enjoying the kind of impact that it could have. (See Table 31 for data). Service provision is likely to have been impacted by recruitment and resourcing challenges in primary care. Consideration should be given to how the service is promoted among clients and what engagement strategies could be used to improve take-up rates.

### **6.7.5 Nitrous oxide**

The data gathered from stakeholder interviews points to a growing issue with the consumption of Nox among young people – both those who are served by the Safe East service (up to 19) and those in their twenties (and who would therefore fall under the remit of RESET).

A number of frontline workers who were interviewed reported regularly coming into contact with young people reporting adverse effects from Nox, while stakeholders more widely

reported high levels of visibility of Nox use and its associated litter. Services do not appear to have responded to the Nox (other than as an ASB and trading standards issue). The development of the B12 Pathway at the Royal London that has been specifically put in place to manage the effects of Nox consumption, but it is not linked into wider treatment and other services (other than Hospital and Community Navigators). Most stakeholders were unaware of the operation of this service.

Given the perceived size of the problem there would be value in local services developing Nox pathways to identify and direct users into support (particularly the B12 clinic). This should be complemented by the development of a Nox group in the treatment service to offer brief advice and harm reduction messages (akin to the proposed approach for the cannabis group) to provide a treatment offer to this cohort.

## 7. Drug and alcohol related crime and ASB

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### *Key findings:*

- Data from the local Drugs Profile shows that Cannabis was the highest volume substance seized, followed by Cocaine and Heroin. Over 90% of opioids within the crime data were Heroin.
- Drug possession offences are highest in Spitalfields & Banglatown and St. Peter's wards. Drug trafficking offences were highest in Spitalfields & Banglatown and Whitechapel wards.
- Drug-related crime is concentrated among certain areas of the Borough. The distribution of offences for the supply of Crack Cocaine and of Heroin are particularly focused in the West of the borough (near to Aldgate and Shoreditch), while Offences related to supply of Cannabis and of Cocaine tend to be more evenly distributed across the Borough.
- Tower Hamlets had four wards in which over 100 drug-related ASB warnings had been issued.
- Analysis of data regarding drug related offences over time suggests a link between drug possession and theft indicating that drugs are driving crime more widely in the borough.

Drug and alcohol misuse are significantly associated with both crime and anti-social behavior. This section seeks to explore the relationship between and impact of substance misuse on crime and ASB in Tower Hamlets.

### 7.1 Levels of drug related crime and ASB

#### 7.1.1. Type of drugs and alcohol-related crime

Data from the Metropolitan Police Service (MPS)'s drug profile for the Central East BCU (Tower Hamlets and Hackney) shows that during April 2019-March 2021:

- Cannabis was the highest volume drug seizure, followed by Cocaine and Heroin.
- The vast majority of class-B drugs on crime reports were cannabinoid; and cannabis is mentioned on about 1 in 8 police intelligence reports (at a similar level across Tower Hamlets and Hackney)
- The most common stimulants within the crime records were cocaine and crack cocaine.
- Over 90% of opioids within the crime data were Heroin.

- A smaller proportion of crime reports related to Empathogens (ecstasy/MDMA), sedatives, or psychedelics.

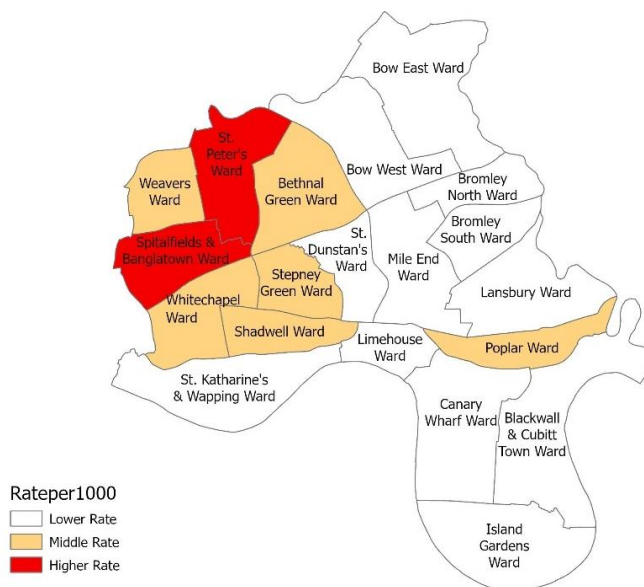
### 7.1.2 Distribution of drug-related offending

Data from the Metropolitan Police Service (MPS)'s drug profile for the borough shows that high levels of drug-related ASB call-outs in Tower Hamlets.

It was possible to explore the extent of drug-related crime over 24 months and use of historical data by examining Metropolitan Police figures of recorded crime in Tower Hamlets. These reports were provided at ward level and adjusted for the size of the resident population (per 1,000).

Data for drug possession offences are set out Map 1.

**Map 1 Drug Possession Offences recorded by the Metropolitan Police last 24 months, Rate per 1,000 population**

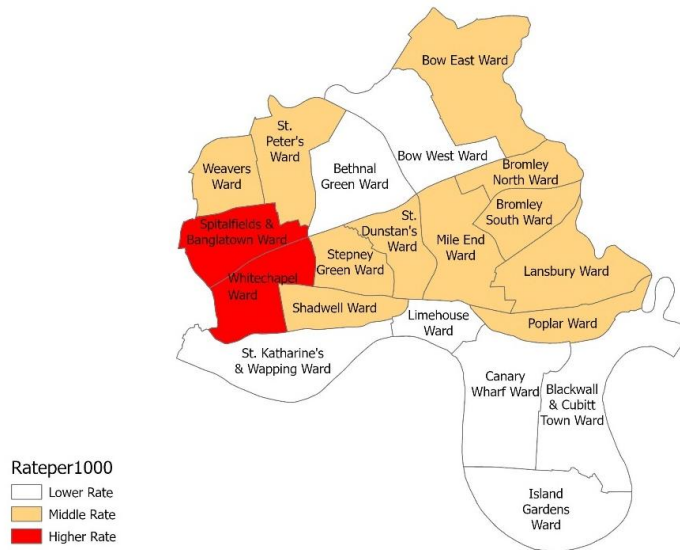


(Source: London Datastore)

For drug possession, the crime rate per 100,000 based on a two-year average shows the highest quintile reports are in Spitalfields & Banglatown (42.1 per 1,000) and St. Peter's (37.0 per 1,000) wards (Map 1).

**Map 2 Drug Trafficking Offences recorded by the Metropolitan Police last 24 months, Rate per 1,000 population**





(Source: London Datastore)

For drug trafficking, there is a similar picture with Spitalfields & Banglatown (8.1 per 1,000) and Whitechapel (6.6 per 100,000) wards represented in the highest quintile (Map 2). Data from the MPS's Drug Profile (not shown) shows that distribution of offences for the supply of Crack Cocaine and of Heroin are particularly focused in the West of the borough (near to Aldgate and Shoreditch), while Offences related to supply of Cannabis and of Cocaine tend to be more evenly distributed across the Borough.

### 7.1.3 Associations with drug possession and drug trafficking

Additional analyses examined the association of other crime types with drug possession and drug trafficking. The aim of this approach is to assess whether drug-related offending moves in similar ways to other offence types over two time periods. The first being the immediate 24 month period, and a longer time period since April 2010. This allows us to suggest possible associations between offending types and drug-related offences. The results of the analysis are set out at Appendix 3.

Positive associations with drug possession and some crime types such that, as drug possession offences increase, other crime types also increase. The data suggests a negative association between drug possession and violent offences, although the relationship between trafficking and Violence Against The Person is notably weaker than possession. Note these analyses are correlations (using time-series regression analyses); they cannot be taken to indicate causation.

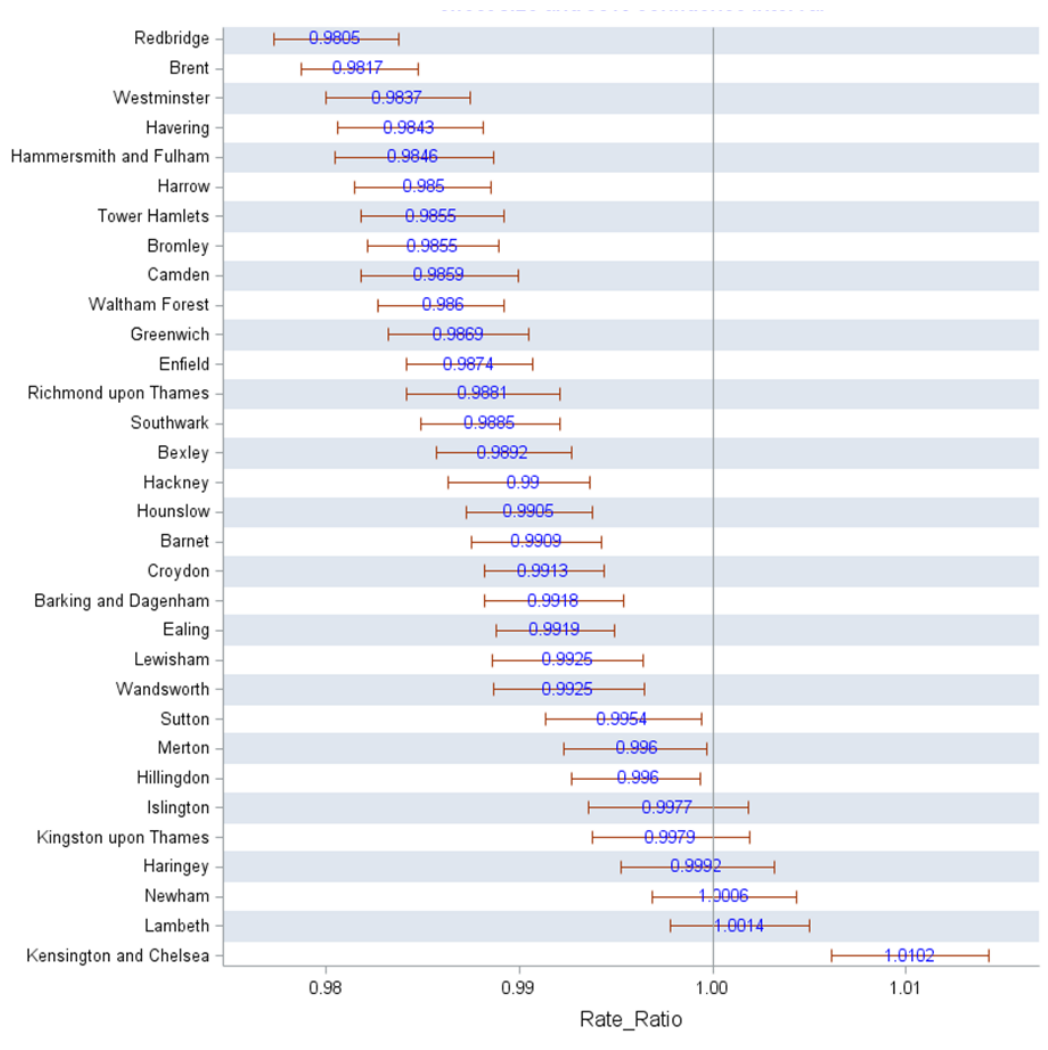
For both drug-related crime types (drug possession and trafficking), these measures were modelled using linear regression against all other recorded crime types to determine which, if any, crime types are significantly associated with it. Over the longer time frame statistically

significant results for possession, with robbery and shoplifting were shown to be negatively associated with drug possession, whilst shoplifting and other theft were shown to be significantly associated with increases in possession (in other words, as drug possession increases so does incidents of theft from the person and other theft). For drug trafficking, the only statistically significant factor identified was a negative association with robbery (such that as drug trafficking increases, robbery decreases).

**Time-trend analysis**

Academic research has investigated the change in levels of crime; this analysis has been re-run for this report as set out in Figure 39. The analysis used data from the original study, which was available for change between 2013-2017. This time-trend analysis suggests that Tower Hamlets had the seventh-largest decrease in drug-related crime across London during the period 2013-17.

**Figure 37 Drug-Related Offending Rate 2013-2017, time trend by borough: effect size and 95% confidence interval**



### *What this tells us*

The analysis of data regarding drug related offences over time indicates that there appears to be a correlation between drug possession and certain offences – such as that, as the number of people arrested for possession rises, so do levels of some crimes, but that there was a negative association between drug possession and violence. The link between drug possession and theft indicates that drugs are driving crime more widely in the borough.

Time trend analysis indicates that drug-related crime appears to be reducing in Tower Hamlets which suggests that the range of interventions in place (and described below) is having some effect on levels of drug-related crime.

## **7.2 Responding to drug and alcohol related crime and ASB**

### *Key findings:*

- The prevalence of drug-related crime and therefore drug using offenders has led to the delivery of a complex landscape of services including Operation Continuum and other police operations, Throughcare, custody provision and IOM case officers (local authority provided for offenders) and a range of initiatives seeking to address substance misuse related ASB (such as the SMIT, Community MARAC and Safer Community Officers).

Given both the prevalence of drug and alcohol-related crime and ASB and the concern it raises among local residents, a complex landscape of initiatives has evolved to respond to the issues raised. The key interventions are described below.

### **7.2.1 Project ADDER**

While not an intervention in itself Project ADDER, a funding stream from the government, has proven to be crucial to local responses to issue in relation to drug misuse in the borough.

Project ADDER is a partnership between the police and the local authority with the aim of reducing the impact of substance misuse in the area through a mix of enforcement activities and treatment and support for drug users. Funding of £1 million per annum has been allocated to Tower Hamlets. Project Funding was initially allocated up until March 2023 but supplementary funding will now be in place up until 2025. (Albeit that police ADDER funding tapers from 2023 onwards).

### **7.2.2 Operation Continuum**

Operation Continuum is an operation led by the MPS police that was established in Tower Hamlets to tackle drug dealing and to make neighbourhoods safer by undertaking

investigation and enforcement activities. It is led by the MPS (specifically the Central East BCU which covers both Tower Hamlets and Hackney) in conjunction with the local authority and housing associations.

Operation Continuum undertakes intelligence-led operations that respond to reports of drug dealing, drug use and associated criminality in the Central East BCU.

In the year 2021-22 112 arrests were made under Operation Continuum, £598,000 in cash seized and 132 weapons recovered.

### **7.2.3 Local authority initiatives**

A range of local authority initiatives have been put in place to deal with crime, ASB and the effects of crime related to substance misuse. This section seeks to set out the range of interventions that exist.

#### ***Policing***

Tower Hamlets council has funded a number of police officers to be based in the borough to ensure a visible police presence locally.

While funded by the council, the police operate within the wider BCU and can be extracted as required by policing demands (i.e. these additional posts do not necessarily solely serve Tower Hamlets).

#### ***Drug and alcohol users***

The following initiatives are in place to work with drug and alcohol users who are in contact with aspects of the criminal justice system.

#### **Throughcare (DIP)**

The Throughcare team (commonly referred to locally as the DIP) is a team of six practitioners, including two funded through ADDER, who aim to increase engagement of criminal justice clients with treatment services. The team assess clients referred to them and refer on to RESET as required. They also provide a range of additional interventions including brief interventions and harm minimisation advice, providing reports to courts and aiding the monitoring of breaches (that is, determining whether those clients who have been court mandated to access drug or alcohol treatment do so). Interventions are also delivered to address offender's criminogenic behaviour.

The service does not provide any clinical interventions (such as prescribing) which is held by RESET. Clients are therefore "shared" with RESET with Throughcare workers providing input alongside RESET recovery workers.

## **Custody Team**

Tower Hamlets has had a longstanding service that covers local police custody and courts.

In Bethnal Green custody suite a team will engage with anyone arrested and who has tested positive for drug use. (The team engage offenders from outside of Tower Hamlets). The service is provided seven days a week, 7am to 10pm, 364 days a year.

Those in custody will be provided with harm minimisation advice and, if a Tower Hamlets resident, will be passed on to the Throughcare team. The Throughcare team will pick up the client for further assessment and will “hold” them until they can be engaged in treatment (provided by RESET).

In addition to the coverage at Bethnal Green custody suite the team also provide coverage at court six days a week, carrying out assessments, setting Restrictions on Bail and fast-tracking Alcohol Treatment Requirements and Drug Rehabilitation Requirements.

## **Integrated Offender Management (IOM) Case Officers**

Two IOM Case Officers are employed to co-ordinate multi-agency work with local offenders who are on the IOM caseload which is made up of statutory probation cases aged 18 years and over. They therefore liaise with police, probation, housing and education, employment and training providers.

The IOM case officers are non-criminal justice workers (that is, they are not employed by the police or probation) and who can offer case management and support, providing agile support to help prevent the offender slipping into crisis which may then trigger their offending behaviour. They can therefore provide advocacy and mediation as well as linking offenders to a range of services and charities.

It was indicated that the majority of the IOM caseload are drug users, with high levels of cannabis and Nox usage. Some Class A drug use was reported but this was largely focused on those offenders aged 40 years and above. Many have engaged in drug dealing and, in some cases, violent offending also (often linked to drug dealing). In recognition of the substance misuse needs of this cohort, two substance misuse workers were added to the team funded through ADDER.

In Quarter 1 of 2022-23 there was an average IOM caseload of 108 clients per month of whom 23 were Class A drug users. Of the 23 Class A users 14 were in treatment.

### **Prison workers**

Over 50% of prison releases into Tower Hamlets were from HMP Thameside. As such two ADDER prison link workers have been employed to meet all Tower Hamlets residents in Thameside to support them with the return back to the community following their release. The workers create links to the RESET treatment service. An additional 2.5 workers cover releases from other prisons into the borough.

Once released from prison the clients are picked up by the Throughcare team (described above) who will work with the client alongside RESET.

### **Women's criminal justice pathway worker**

A women's criminal justice worker has been funded through Project ADDER monies to provide a seamless link into treatment for female offenders, linking women from criminal justice agencies into the community. The role provides case management and an element of additional support for the women.

### **ADDER Social Worker**

A dedicated social worker has been funded through ADDER to assess police Merlins<sup>78</sup> to identify clients who would benefit from support in relation to substance misuse issues. Clients can be referred directly into RESET.

### **ADDER Probation link worker**

A role has been employed to liaise between treatment services and probation, co-locating and working from probation offices in order to improve communication and co-ordination between substance misuse and probation services. Probation clients with a substance misuse need are identified and it can be made a condition of their license that they engage with the Throughcare team. In addition, the worker is informed as to whether a client fails to engage in treatment and therefore needs to be breached.

### ***Substance misuse related ASB***

The following initiatives seek to address substance misuse related ASB.

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<sup>78</sup> "Merlin" is the MPS IT application where officers are able to record details on vulnerable children and young people and adults that they encounter.

## **Community MARAC**

A Community MARAC<sup>79</sup> is in place to identify and respond to high risk ASB. Those on the MARAC can be either victims or perpetrators of ASB. Referrals are made into the service by a range of agencies including the police, housing providers, ASB officers and others.

The panel is made up of a range of agencies including: housing, adult social care, RESET, police, victim support services and ASB workers. The panel scrutinises whether any agencies are already working with the individual and what package of support can be put in place to address the ASB. Support is offered to try and help the individual to sustain their tenancy. In the case of perpetrators ASB tools and powers can be used to enforce engagement.

## **Specialist Substance Misuse Investigation Team (SMIT)**

The SMIT team provide outreach to engage with those who use drugs, particularly those who are treatment naïve. The service seeks to engage with those who are known to be causing ASB and where this is associated with drug or alcohol misuse. The individuals flagged up can be identified by other ASB services or the police. The SMIT team engage with the individual. A voluntary appointment can be made with treatment services but the team can also stipulate/mandate that they engage with local treatment services (utilising Community Protection Warnings or Community Protection Notices). They also provide harm reduction information and advice.

Once engaged, clients are referred on to the Throughcare team and subsequently on to treatment in RESET.

## **Safer Community Officers**

The Safer Community Officers work as a rapid response team to quickly engage with ASB as alerted to them by local residents and rapidly address the issue. Much of the work of the team is in relation to drug dealing. Members of the team are allocated specific geographic patches to ensure that they retain detailed local knowledge.

## **Tower Hamlets Enforcement Officers (THEO)**

A team of enforcement officers, geographically based, are employed by the council who carry out a range of enforcement and engagement activities. The aim of the team is to provide a visible presence in the borough in order to reassure communities that ASB-related issues are being addressed. The team have delegated powers from the police and can make referrals into treatment as required.

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<sup>79</sup> Note that Community MARAC is distinct from the domestic abuse MARAC which also adopts a similar multi-agency approach.

### **Anti-Social Behaviour Team**

This is a dedicated team who focus on complex and serious ASB cases and carry out investigations in order to support victims. The team use specialist legal powers to resolve ASB cases and focuses its efforts on few known hotspots.

### *Services for young people*

In addition to the services described above, a number of specific local interventions are in place for young people. While these seek to address wider vulnerabilities they are known to engage with young people using drugs.

### **ADDER Community Navigators**

The community navigators are a team dedicated to working with young people (18 plus) who are known to be involved in the criminal justice system. Clients for instance are often either on a court order or are on a post-prison license order.

Many clients are referred from Probation and the community navigators are able to provide a more youth-work style package of support than more traditional criminal justice services (such as probation). The cohort of young people receiving support were described as largely male, with significant numbers of Bangladeshi young men. Many have come into contact with the criminal justice system due to drug dealing offences.

The community navigators are largely made up of youth workers who are able to adopt a family-centred, trauma informed approach to working with young people (that is, recognising that they may be victims of trauma in their childhood).

All young people engaged by the community navigators are screened using ASSIST-Lite.<sup>80</sup> This is then followed by motivational advice and harm reduction advice as required determined by the outcome of the assessment. While young people can be offered an onward referral to RESET (for structured treatment) most young people were reported as not wishing to engage with this service.

In the first six months of 2022-23 the Community Navigators had worked with 61 new clients and there was an average total of 45 clients per month. In this period one client supported was a Class A drug user whilst an average of 17 per month were cannabis users. One referral was made in this period to specialist treatment.

### **ADDER Hospital navigators**

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<sup>80</sup> ASSIST-Lite is a short substance misuse screening tool for those aged 18 plus and covers: alcohol, tobacco, cannabis, stimulants, sedatives, opioids and other (non-prescribed) psychoactive substances.



The hospital navigators work with victims of violence aged 18 to 24 years who are being treated in the Royal London hospital. Not all the clients that are supported are Tower Hamlets residents.

The service aims to work with young people at a “teachable moment” – that is, at a point they are prepared to consider some of the life choices that they have made which may have resulted in their being the victim of violent. To help contextualise this, a member of staff stated that around 80% of the young people that they work with have either been injured as a result of a “drug deal gone wrong” or are involved in “postcode wars” in relation to drug dealing.

As with the community navigators, all of the young people that they support are screened using ASSIST-Lite to determine substance misuse. It was reported that the young people they work with commonly use cannabis, Nox, vapes and edibles.

Young people are supported with the aim of preventing their readmission to hospital, reducing the risk of retaliation attacks and, if from Tower Hamlets, are linked to a community worker who can provide a range of support. The service will also liaise with other services on behalf of the young person as appropriate (such as police, adult social care, colleges, GPs and local charities).

In the period April to October 2022 the Hospital Navigator team had engaged with 95 young people (under 17) from in Tower Hamlets; 15 were identified as having a substance misuse need

### **Nitrous Oxide Possession Public Safety Protection Order**

As noted at Section 6.5.3, in response to growing concern around levels of Nox use locally, the council has put in place a Public Safety Protection Order to address the issue. This requires that anyone found in possession of Nox can be ordered to surrender possession of this to an authorised person and issued with a formal warning or a Fixed Penalty Notice.<sup>81</sup>

The Protection Order is accompanied by a local awareness campaign – No Laughing Matter – which aims to discourage children and young people from using Nox and giving parents information to enable them to talk to their children.<sup>82</sup>

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<sup>81</sup> Note that stronger enforcement measures cannot be used as, under the Psychoactive Substances Act of 2016, it is not an offence to possess or use Nox. Therefore its use is not illegal as is the use of various other novel psychoactives.

<sup>82</sup>

[https://www.towerhamlets.gov.uk/lgnl/community\\_and\\_living/community\\_safety\\_\\_crime\\_preve/Nitrous\\_Oxide\\_No\\_laughing\\_matter.aspx](https://www.towerhamlets.gov.uk/lgnl/community_and_living/community_safety__crime_preve/Nitrous_Oxide_No_laughing_matter.aspx)

## 7.3 The effectiveness of provision for offenders

### Key findings:

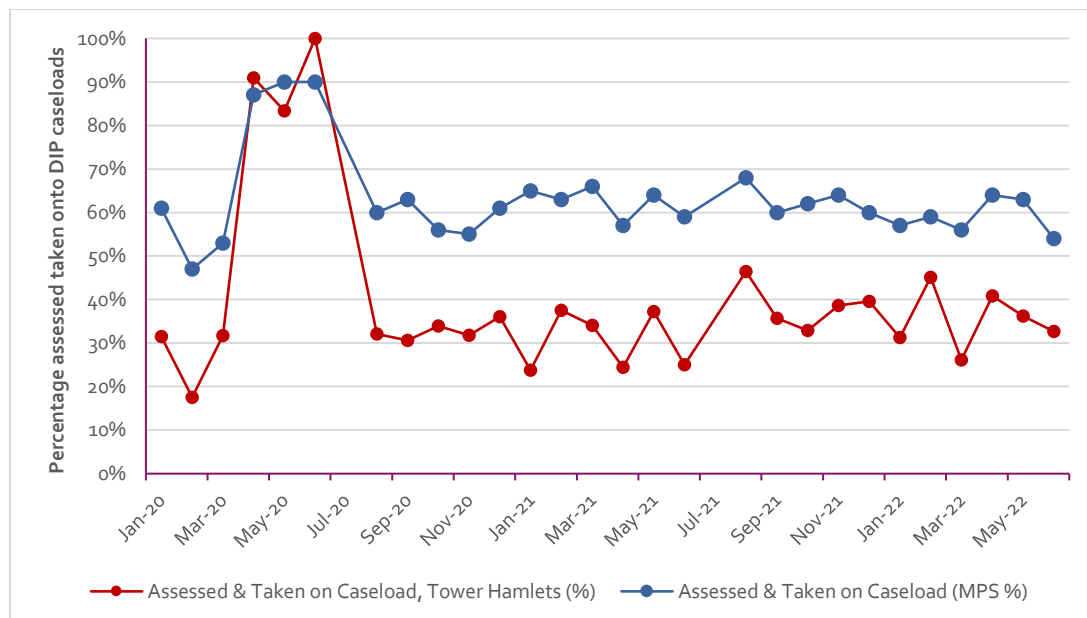
- The extent to which Tower Hamlets residents assessed by DIP are then taken onto the caseload has fluctuated over time, and overall the rate can be shown to be lower than rates across London.
- The proportion of people who leave prison who then successfully engage in treatment services (“continuity of care”) has fallen substantially since 2017, and is now lower than the national rate. However, this metric has increased in the last two years, at the time when the ADDER programme has been in place.
- Class A users consistently made up around a quarter of Integrated Offender Management clients.

This section sets out data with regards to the operation of some of the various schemes set out above.

### 7.3.1 Drug Intervention Programme (DIP)

The extent to which offenders who are assessed are taken on to the DIP caseload is set out below.

Figure 38 Percentage of people assessed taken onto DIP caseload, Tower Hamlets and London (Metropolitan Police), Jan 2020 to Jun 2022



(Source: Tower Hamlets CSP)

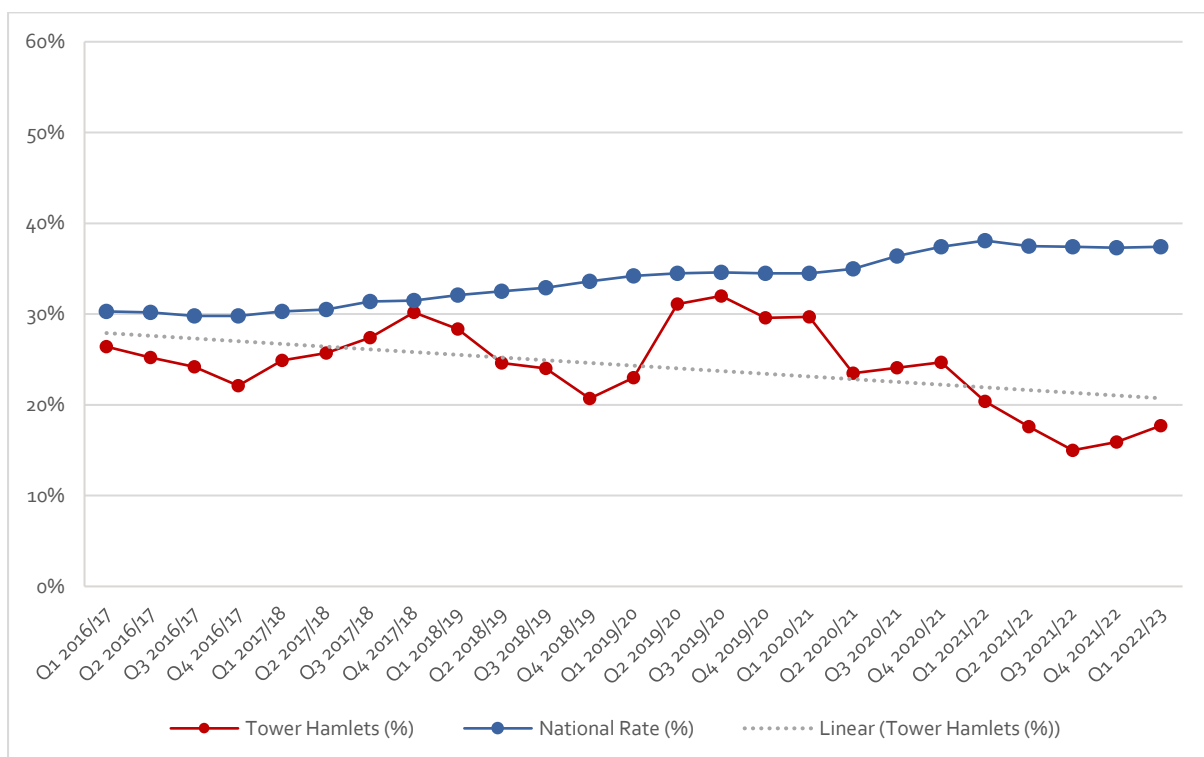
The extent to which Tower Hamlets residents assessed by DIP who then are taken onto the caseload has fluctuated over time, and overall the rate can be shown to be lower than rates

across London. It is not clear from the data whether this is due to clients being moved on to RESET (and therefore captured by data from that service) or whether local DIP provision tends to take on a lower proportion of clients than elsewhere.

### 7.3.2 Prison release

Data is set out below for the proportion of prisoners leaving prison who engage with community-based treatment. This is not a measure of the work of the current team but is given to indicate the historic picture of how well prisoners have engaged in treatment following release.

Figure 39 Treatment engagement following Prison Transfer to Community, 2016-17 to 2022-23 (Quarter 1)



(Source: Tower Hamlets CSP)

Measuring the extent to which offenders engage with community treatment services shows that from 2016-17 to 2022-23 (Quarter 1), Tower Hamlets residents engaged with services at a lower rate than England. The broad trend for Tower Hamlets can also be shown to be slightly decreasing over time. Locally this trend was reported as due to data recording rather than being a true reflection of engagement rates. Moreover the data issue has recently been rectified meaning that it is likely that, in the future, the trend will see a pronounced change.

### 7.3.3 Integrated Offender Management (IOM)

Data at Table 37 sets out information on the clients held by the IOM team.

**Table 37 Caseload of Integrated Offender Management (IOM) Team, April to October 2022**

IOM Team	Apr	May	Jun	Jul	Aug	Sep	Oct
Caseload in Community	63	67	73	66	71	79	51
Caseload In Prison	39	40	43	50	45	39	20
<b>Total</b>	<b>102</b>	<b>107</b>	<b>116</b>	<b>116</b>	<b>116</b>	<b>118</b>	<b>71</b>
Community Class A users on caseload	21	22	26	23	27	30	23
Community Class A users in treatment	15 (71%)	12 (55%)	15 (58%)	15 (65%)	15 (56%)	22 (73%)	17 (74%)

(Source: Tower Hamlets CSP)

The average IOM caseload between April and October 2022 was 107, with between one-fifth and one-quarter (average n=23) being Class A drug users. The number and proportion of Class A users on the caseload who were in treatment ranged from 12 (55%) to 22 (73%).

### 7.3.4 Community Navigators

Data regarding substance misuse needs for the Community Navigator clients are set out below.

**Table 38 Community Navigator Caseload, February to October 2022**

Community Navigator Caseload (Feb - Oct)	Cannabis	Heroin	Alcohol	Nitrous Oxide	Unknown
Case Closed	30	1			
Live Cases	48	2	1	1	8
Referrals					
Referral to ETE	27				
Referral to Housing	7				
Referral to GP/Medical/Mental health	2				
Referral Benefits	2				
Referral Drug/alcohol	1				
Referral to other	6				

(Source: Tower Hamlets CSP)

The majority of cases held by the community navigator between February and October 2022 were for cannabis (48 live cases and 30 cases closed).

The Community Navigator service directed a large proportion of young people on to other services of which the largest number had been referred to ETE services (n=27). Only one referral was made into drug/alcohol treatment.

### 7.3.5 Probation

Data from Probation indicates the extent of drug misuse among those supported by this service.

Of 1,396 Probation clients in Tower Hamlets 693 (49.6%) were assessed as having a need in relation to drug misuse. Of the Probation clients on a community order 46.3% were assessed as having a drug need, while among custodial clients the rate was 57.8%.

#### *What this tells us*

The data on those receiving treatment in prison being transferred to community treatment shows a clear downward trajectory which is diverging from the overall national rate. This issue has been identified as due to issues around data recording. Changes have subsequently been made which should mean that a more positive picture than that set out at Figure 41 emerges. In addition there has been additional investment in prison workers which should improve engagement rates further.

Data from the IOM service indicates that a high proportion of their clients on the community caseload are Class A drug users thereby demonstrating the link between repeat offenders and drug use. The data therefore indicates the importance of clear links between IOM and local treatment services.

Data from the Community Navigator service highlights the extent of cannabis use in particular among young people. While not all of these young people will benefit from treatment, it underlines the strong links between vulnerability and drug use.

## 7.4 Views of stakeholders on crime and ASB

### *Key findings:*

- A survey of residents of Tower Hamlets in 2019 indicated that nearly half (46%) believed drunken behaviour was a problem while nearly two thirds (67%) were concerned about the sale or use of illicit drugs.
- A (non-representative) survey of 167 residents developed as part of this needs assessment indicated that
- 72% of respondents were concerned about Nox and 70% were concerned about cannabis. 66% were concerned about alcohol.
- When asked to cite the substance that is the biggest issue locally, the most common response given was Nox.

This section sets out the perceptions of the impact of drugs and alcohol across a range of stakeholder groups in Tower Hamlets with particular reference to crime and ASB.

## 7.4.1 Resident's perceptions

### *Tower Hamlets Annual Resident's Survey*

Tower Hamlets Council regularly surveys its residents in relation to a range of subject matters. The survey in 2019 asked residents specifically about drug and alcohol issues; this is the latest date at which these topics were included (the 2021 survey did not include questions on this topic). Data was available from the 2019 survey in relation to attitudes towards perceptions of drug and alcohol related issues. The results are set out at Table 39.

**Table 39 Residents Survey (2019)<sup>83</sup>**

		2019 %
People being drunk or rowdy in public places	A very big problem	13%
	A fairly big problem	33%
	Not a very big problem	43%
	Not a problem at all	8%
	Don't know	1%
People using or dealing drugs	A very big problem	29%
	A fairly big problem	38%
	Not a very big problem	25%
	Not a problem at all	6%
	Don't know	2%

When asked about drunken behaviour nearly half of residents (46%) considered this to be a problem.

When asked about the use of sale of illicit drugs, nearly two thirds (67%) of respondents indicated that it was a problem.

### *Survey of residents*

A short survey was designed to examine public perceptions of drug and alcohol use within Tower Hamlets. The survey was distributed via a number of sources including: the Policy and Improvement Team, the Strategies and Communities Team within Tower Hamlets; Tower Hamlets Health Watch; and a number of local community groups and organisations.

<sup>83</sup> Note that this was the period for which the most recent data were available. The survey was suspended during the pandemic.

In total, 167 residents responded to the survey. The survey sample is non-representative and self-selected. It is not therefore a statistically valued cross-section of views of the local population and should be taken as an ad hoc sample of residents.

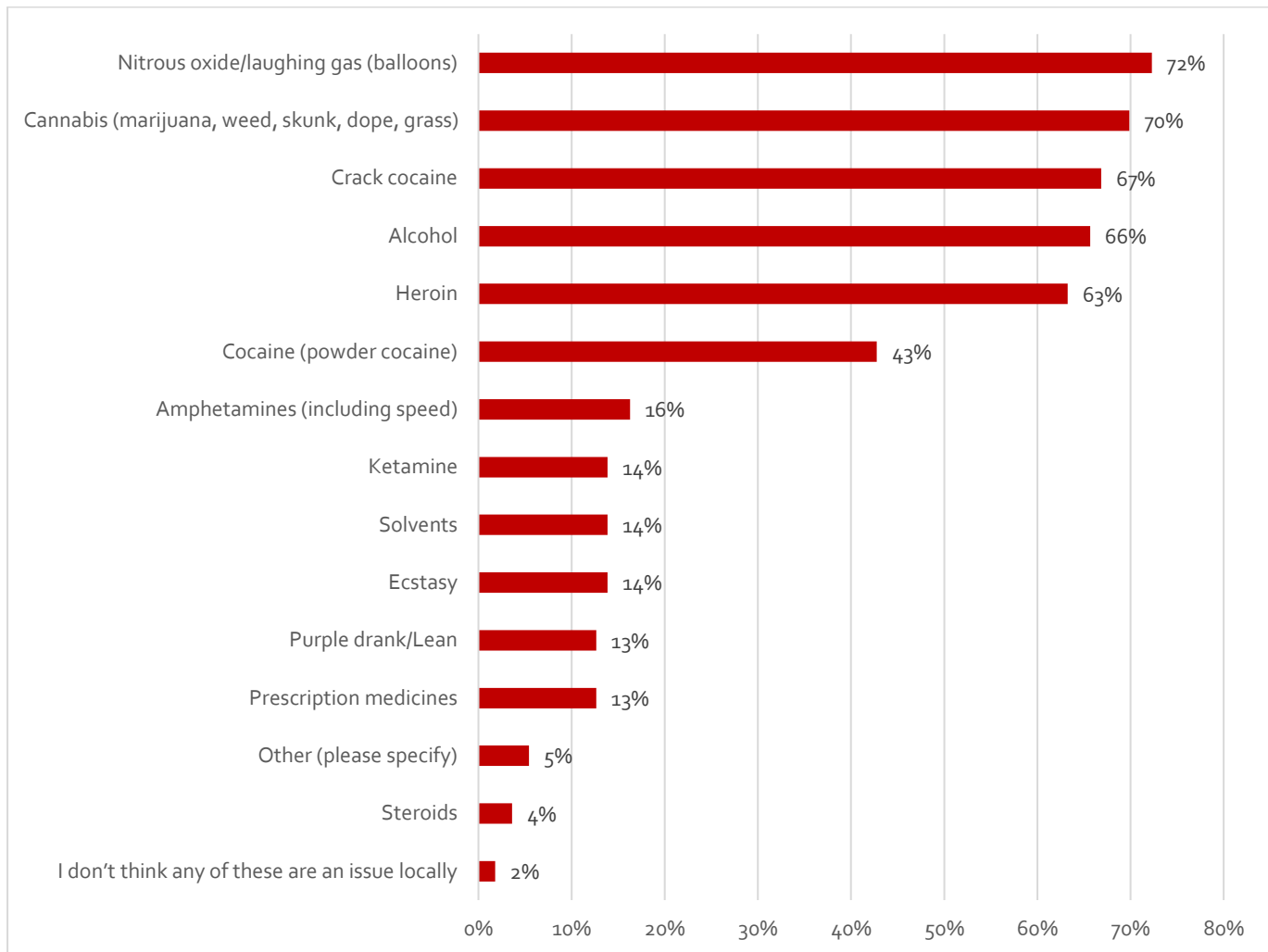
Of the respondents, 48% were Male and 46% were Female with 6% preferring not to say. Almost two thirds, 68% stated they were White (including Irish and any other white background), 9% Bangladeshi, 6% Somali and 6% stated they preferred not to say. A further 6% stated they were of Black or Black British background whilst 5% stated they were of Other Asian background.

There were no notable differences between gender or ethnicity in the findings of the survey.

### **Drug and alcohol misuse in Tower Hamlets**

Residents were asked what substances they have any particular concerns about. Nitrous oxide (72%), cannabis (70%), crack cocaine (76%), alcohol (66%) and heroin (63%) are the top five substances that residents were most concerned about. The full results are shown in Figure 42.

**Figure 40 Substances that are considered a problem locally (CPI survey)**



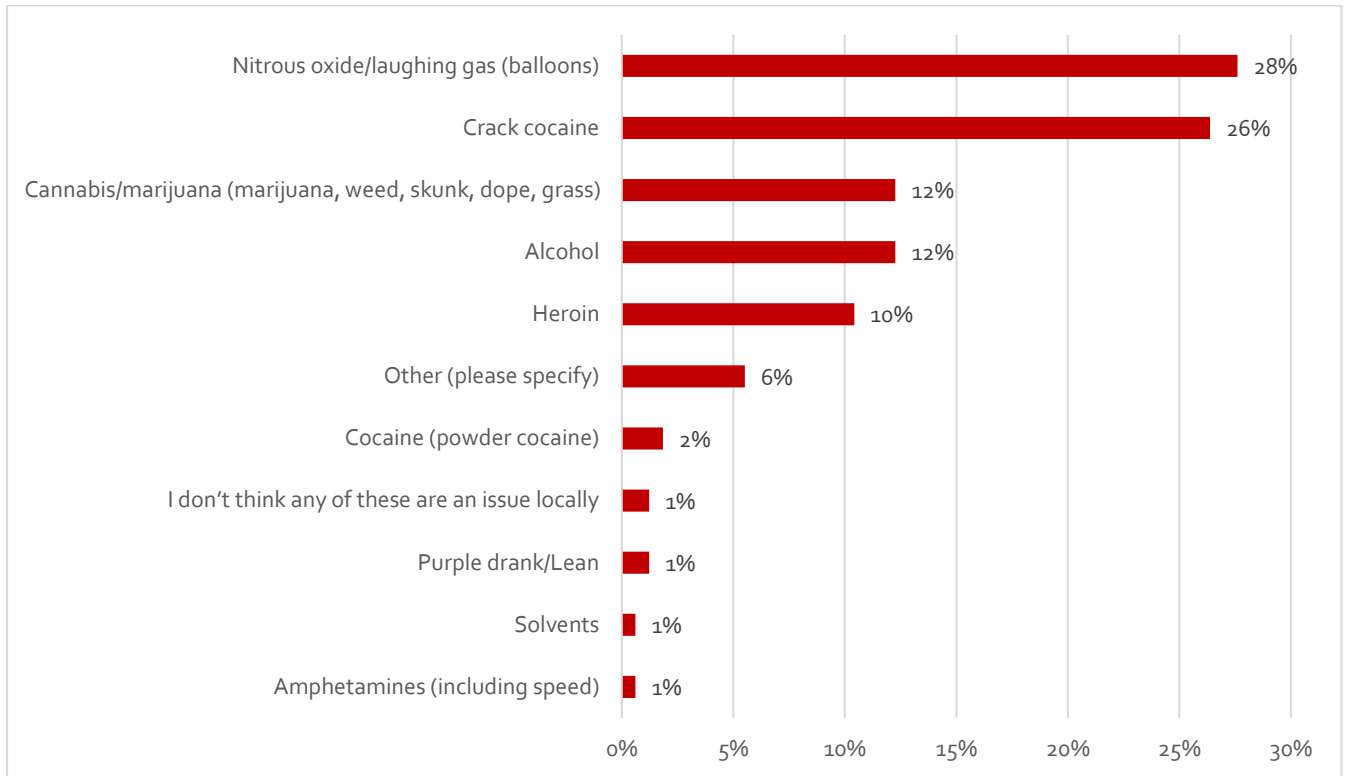
Base=166 (totals equal more than 100% as resident could select more than one option).

It is worth noting that those substances that cause greatest concern (alcohol, cannabis and nitrous oxide) tend to be the most noticeable to the wider community: alcohol and nitrous oxide are readily identified through rubbish/detritus (such as nitrous canisters) and cannabis is easily noticed from its smell. As such it is possible that the community are reporting back on what they notice the most rather than what impacts them the most.

Residents were then asked to single out which substance is the biggest issue locally. Nitrous oxide (28%, n=45) and crack cocaine (26%, n=43) are cited as the two biggest issues locally.

**Figure 41 Which substance is the biggest issue locally? (CPI survey)**





Base=163.

### *What this tells us*

While the survey does not represent a statistically significant cross-section of views of residents in Tower Hamlets, the data does give an indication that, among respondents, there were widespread concerns about drug and alcohol misuse. Concerns about drug misuse were however more pronounced. Respondents were particularly concerned about Nox which is not featured in local treatment services.

## 7.4.2 Views of professional stakeholders

### *Key findings*

- Local professional stakeholders were clear about the link between crime and the supply of Class A drugs locally.
- Professional stakeholders felt that the need for drug and alcohol services was significant and that the treatment population was a complex one to manage.
- There was some confusion among local stakeholders about the range of services that are available locally and the pathways between these services.

A range of professional stakeholders were asked to explore various aspects of the relationship between substance misuse and crime and ASB and how well local services were addressing these issues.

The criminal justice system, as it pertains to substance misuse treatment and support, is a complex network of roles and responsibilities across multiple agencies, both statutory and non-statutory. A range of perspectives from policing, local authority, probation and youth justice were gathered.

As with other sections setting out interview data, the information given should be seen as providing useful insight and points for consideration.

### **Links between substance misuse and crime**

Police interviewees explained how they believed that, locally, there is a strong link between violent crime and the supply of Class A and Class B drugs, together with other risks such as exploitation of young people and vulnerable adults. Operation Continuum was developed as a partnership approach to tackle crime, disorder and violence linked to the street based drug markets. Gangs Taskforce South and the partnerships formed via Project ADDER have brought together various police teams, council enforcement teams, drug treatment services and harm reduction outreach workers - with joint operations being organised in targeted drug hot spots, to use a mixture of enforcement and engagement approaches which would be initiated following enforcement action.

### **Impact of lockdown**

The impact of Covid on drug markets and drug use was explored in the interviews. Stakeholders reported that there appeared to be little change in how markets operated from a policing perspective: *"Just before COVID started a test purchase operation began, where undercover officers bought from drug dealers. We ran that operation all through COVID, and also as the pandemic restrictions were ending, so we saw the impact of the pandemic over the long term. And the key takeaway was not a lot changed. Tower Hamlets footfall remained quite high during lockdown. Homeless users didn't go away, they were still there, but with extra provision around temporary housing. Substance misusers still needed to find money to fund it, so we still had begging, thefts, ASB".*

### **Links into treatment**

Police interviewees stressed that their role is far from just enforcement and has been for some time – they look at demand and supply, but crucially ways to link people into treatment and interventions to impact on people's substance misuse drivers: *"Drugs crime can't be solved with enforcement alone. So we're looking at referrals into treatment: whether that's a*

*vulnerable person on the street referred by an officer; or testing of people coming into custody". Another added that, "We're pushing that agenda, referring into drugs workers".*

Police interviewees stressed there were good working relationships locally, but staffing in substance misuse services was a critical issue for joint working and delivery. *"Capacity is an issue... ADDER plans when formulated didn't put a lot of resource into drugs treatment, and we need more resilience – as we're getting more people into treatment via enforcement, but haven't the level of capacity to take people in".* This may suggest a need to invest further in capacity in the treatment system.

Lack of capacity in RESET impacted on partnership working, particularly when the police tried to increase referrals into the service. One example given was where a police operation involved contacting known drug users or people whose phone numbers appeared in police investigations, texting them with information on drug treatment. This was said to have not been as successful as it could have been partly down to RESET not having capacity: *"Some drug workers have 90-plus case files, so they lack capacity for innovation and trying something new".*

### **Lack of clarity regarding pathways**

A theme that emerged from a number of interviews was the confusion around the various pathways of support that exist locally for offenders with a substance misuse need. As one interviewee remarked: *"ADDER will take a while to settle down, but this authority got on top of it quickly – and worked out quick pathways, and there are some really good pathways - IOM, TTG, navigators. But when you add in Probation national commissioned providers ... and commissioned pathways to meet needs... So you go from a couple of really defined pathways to an embarrassment of riches, and then end up splitting the pot, and no-one can quite understand who they should be referring to."*

A stakeholder reported that *"Probation colleagues say it's actually quite confusing which pathways are on the go, and which are DIP and which are RESET".*

One healthcare practitioner stated that the continually changing commissioning landscape means that partners have to *"keep meeting people to learn of new initiatives and teams. For example, the public health team updated me on mental health, and we told them about our service offer and training we could provide."*

A lack of clarity about pathways was shared by professionals working in the treatment system who were interviewed. Both stakeholders from RESET and from the various local authority initiatives reported that staff do not understand (or know about) all the interventions that are being delivered across the borough and how these integrate with one

another. This situation was felt to have become more pronounced following the employment of a range of posts using Project ADDER funding. It was not clear from the interviewees that stakeholders working in the system had been informed about the introduction of new posts, what the purpose of these posts were and how they were intended to dovetail into existing structures, teams and pathways.

A number of professionals working in the treatment system reported a sense of duplication of provision and also a lack of clarity about the boundaries between services: for instance not all staff working in treatment could explain the exact demarcation between the work of the Through Care team (employed by the local authority) and RESET. Another commonly reported area of duplication was between the work of the RESET outreach team and the more recently employed Assertive Engagement Workers (who it was felt were seeking to engage with the same target group as the outreach team). It was felt that this lack of clarity was affecting how services were delivered as wider professionals were not clear who they were meant to be linking in with.

The range of services has led to some confusion about who ultimately “owned” a client and held accountability for the individual. An example given on several occasions was ambiguity about who “held” a criminal justice client when they are being supported by both the Through Care and RESET teams. In such a case, it was not clear which service was responsible for both treatment engagement and outcomes.

The development of multiple roles created numerous handover points for clients as they pass through the system— for instance from prison workers, to Through Care to RESET. The concern was raised that this led to groups of clients being engaged by multiple workers, being handed over from one to another (and so having to tell their story again) and with a lack of clarity about who “owned” the client. At a simple operational level, multiple handovers creates more opportunities for service users to disengage.

Finally it was felt that the incentives between services were not always well aligned. Some local authority services were reported to have KPIs that encouraged high levels of referrals into the treatment system. However this was done regardless of the capacity of RESET to manage the numbers of clients coming in (as explored at Section 6.2).

Some interviewees stated that the system as a whole was not working fluidly, but had a tendency to push clients through to the most stretched part of the service (i.e. treatment services). Other stakeholders conversely reported that they were being held to account for client treatment outcomes when their role was not treatment but about engagement and outreach.

### *Client handover*

Given the range of services that are delivered in the borough it was noted by professional stakeholders that this leads to multiple handovers – that is, clients having to be transferred from one service into another. One person said we are “Assessing clients to death. Separate assessments across the system”. Concerns were raised that the handover points were problematic as this can create confusion with lack of clarity about who is managing a client, as well as potentially creating opportunities for clients to disengage.

### *What this tells us*

The data set out above indicates that there is widespread recognition of the scale of the substance misuse issue in the borough and that professional stakeholders were aware of the impact that drug use is having. There was also clear acknowledgement that a broad range of responses are in place to respond to the issue of drugs, drug-related crime and ASB. However there was a sense that the response was not wholly co-ordinated and that the system, having evolved rapidly, could be reconfigured to clarify pathways and lines of accountability in order to maximise the efforts of all partners.

## **7.5 Analysis and summary: drug and alcohol related crime and ASB**

### **7.5.1 Drug-related crime**

Data from the Metropolitan Police indicates that drug related offending is not evenly distributed across the borough. As shown at Map 1, drug possession offences are clustered in the west of the borough (St Peter’s Ward and Spitalfields and Banglatown), as are drug trafficking offences (Map 2) (Spitalfields and Banglatown and Whitechapel). Further analysis of the data indicates that drug possession is correlated with a wider set of crimes, such as that, as drug offences increase, so do some other incidents of crime. A correlation exists between drug possession and theft.

### 7.5.2 Resident's perceptions

Data from local residents however underlines that drugs (and alcohol) are widely perceived to be a significant issue locally across the borough. In the Tower Hamlets Resident Survey nearly a third (29%) of respondents thought that drug use and dealing was "A very big problem" and over two thirds (67%) of local people considered it to be a problem. (See Table 39). Local people consider drugs to be a bigger issue than alcohol with 46% of people saying that alcohol use was a problem locally (also Table 39).

Data from the survey that was developed for this needs assessments reflects the emerging evidence about Nox: 72% said that they were concerned about Nox (followed by cannabis at 70%). (See Figure 42). The majority of respondents were also worried about Class A drug misuse – for instance 63% were concerned about heroin use. (See also Figure 42).

Interviews with representatives from various community groups highlighted the widescale availability of drugs in the area and the impact that it was having on their communities.

### 7.5.3 Responding to drug-related crime and ASB

A complex array of services have been developed to respond to drug and alcohol related crime and ASB. Such is the focus that local ASB teams largely have a focus on addressing the impact of alcohol and drugs (rather than more "traditional" manifestations of ASB such as noise and inconsiderate neighbours). A sophisticated system of services seeks to address the multiple manifestations of the problems created, with pathways between the various services and into the treatment service (where required). This is in addition to and supplements ongoing police work through Operation Continuum.

Tower Hamlets received substantial funding through Project ADDER which has enabled the funding of a range of posts to address drug related crime and offending. While a number of ADDER areas used funding to reintroduce links between police custody and treatment, Tower Hamlets had retained this functionality, meaning that the ADDER funds were used to invest in other, additional means by which to engage and support those in the criminal justice system with substance misuse needs. This has led to a further proliferation of activity in the borough aimed at addressing drug and alcohol use. It appears however that the rapid roll-out of such a comprehensive range of activities has meant that some stakeholders lack clarity about how the system operates, what pathways are in place, and which service should lead on supporting certain clients.

## 8. Conclusions and Recommendations

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### 8.1 Conclusions and recommendations

Based on the data and analysis set out in this report a number of conclusions have been drawn. The conclusions relate to:

- Systems-level (i.e. the operation of the totality of services working with drug and alcohol users in Tower Hamlets), and
- Service-level (i.e. the operation of individual services).

The conclusions are set out by level along with associated recommendations.

#### 8.1.1 System-Level Conclusions

A number of conclusions have been reached that relate to the functioning of the system as a whole and how the various aspects of the treatment system and wider service landscape relate to one another.

*Tower Hamlets sees relatively high need around drugs and alcohol, and meets this with a complex set of services and interventions.*

17. Tower Hamlets has a higher estimated prevalence of opiate and crack use, and the largest cohort in treatment across all of London. The cohort of opiate users is ageing and displays comparatively high levels of complexity and additional needs (relative to England as a whole).
18. There is some indicative data that needs around alcohol are increasing.
19. As a result, a complex system has been put in place with a number of interventions seeking to identify, support different groups with a diverse set of needs. Despite simplifications, the system remains complex.

*Overall, some system outcomes have declined gradually over time, as has been the case across London and other areas.*

20. While there has been a long-term downward trend with regard to successful completions among opiate users, and to the number of people in treatment, these trends closely parallel London-wide and national trend. The trend is therefore most likely to be due to the substantial reduction in funding made available nationally for drug and alcohol services. Other indicators of performance have improved or remained relatively static – particularly for non-Opiates.

21. The data included in this needs assessment do not show specific time points when need, or in the extent to which needs are met, have markedly changed during the past decade.

### ***Need for improved lines of communication between, and reduced duplication within, parts of the system***

22. The service landscape has grown increasingly complex, particularly with the recent addition of ADDER funded roles. These additional services and posts serve a valuable role; however the complexity of the landscape has created a degree of confusion amongst stakeholders – including those working with drug and alcohol users.
23. There is a need to strengthen lines of communication between parts of the system – in particular between staff in local authority teams (such as Through Care) and RESET. For instance, staff at RESET were not clear about the roles of the prison workers and there was some lack of clarity between Through Care workers and the RESET about lines of accountability and client management.
24. The complex service landscape has created a situation whereby there are a growing number of handovers between teams (for example: custody team -> Through Care -> RESET). Multiple handovers of clients has the potential to create more points for clients to drop-out/disengage.
25. The handovers are not consistently supported by joint care management of clients (for instance while Through Care team members support clients while they are in receipt of treatment at RESET, the former do not appear to consistently attend meetings with the latter to discuss these clients).

### ***System incentives and priorities need to be aligned to long-term outcomes***

26. Different parts of the system operate to different incentives and priorities, due to the complexity of the system. This has the potential to be sub-optimal for client outcomes – for instance some teams are measured by referring clients into RESET, rather than by what treatment outcomes clients go on to achieve. This creates an incentive to direct clients into RESET with less emphasis on the treatment outcomes.
27. Aligning system priorities of different services, to ensure a joined-up approach to outcomes and support, could lead to benefits for service users.

### ***Need for increased capacity in RESET/treatment***

28. Much of the drop in system outcomes (particularly successful treatment rates) appears to be associated with operational issues - including significant issues in staff capacity at RESET. This is an issue currently experienced by most treatment providers nationally.



29. The team is not fully staffed and is experiencing ongoing problems with recruitment. This has resulted in caseloads of over 80, which are often more than double the level that is recommended.<sup>84</sup>
30. There is not equity in case load of staff across the system – caseloads of over 80 in RESET are not mirrored by other teams such as Through Care. This suggests that there may be a benefit from distributing capacity more evenly across the system as a whole.

***Need to interrogate the cultural competency of the wider drug and alcohol system.***

31. The ethnic make-up of the population in structured treatment has remained stable over time and mirrors the ethnic break-down of emergency hospital admissions; this may suggest the system is equitably engaging different ethnic groups in treatment.
32. However, a number of stakeholders (both professional and from the community) raised the issue of the cultural competency throughout the system of services for people with drug and alcohol need.

### **8.1.2 System-level recommendations**

**Recommendation 1** *The CDP should undertake a systems-mapping exercise to identify all linkages and pathways into treatment:*

- *The mapping should assess the volume of clients in each part of the systems map to identify key pressure points,*
- *The systems map should identify numbers of handovers clients are receiving,*
- *The systems map should set out roles, responsibilities and remits for each element of the service system,*
- *Systems map should identify which service elements overlap and lead to co-working of clients.*

**Recommendation 2:** *The CDP should reconfigure pathways and system as needed in light of the mapping exercise.*

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<sup>84</sup> As set out in the Dame Black's Review of Drugs report, Part 2.

**Recommendation 3:** *Following the systems-mapping, the CDP should co-develop a system-wide plan for ensuring appropriate capacity in treatment and for improving recruitment and retention of the specialist treatment workforce.*

**Recommendation 4:** *Recognising ongoing problems with recruiting treatment workers the CDP should work with providers to develop and implement a drug and alcohol recruitment and retention strategy for the borough.*

**Recommendation 5:** *The CDP should carry out a review of the cultural competency of all elements of the treatment system (outreach, treatment and recovery), identifying best practice and setting out recommendations for change where necessary.*

### 8.1.3 Service-Level Conclusions

In addition to the conclusions that relate to the working of the system as a whole, a number of conclusions have also been drawn with regard to specific service delivery elements. These are set out below.

11. Data on alcohol consumption above recommended levels indicates that, contrary to the national trend, local rates are increasing. This suggests the need for more information to local residents on safe levels of drinking.

**Recommendation 6:** *CDP partners should:*

- (c) *develop a strategic approach to alcohol prevention in the borough and*
- (d) *consider undertake an information campaign aimed at local communities that sets out safe levels of alcohol consumption and highlights local services.*

12. Referring stakeholders report that people who they refer in to treatment often struggle to access an appropriate treatment offer. A higher proportions of service users had “unplanned exits” locally within the first 12 weeks compared to England, for both opiates and alcohol. Together these suggest that capacity issues are affecting the treatment service’s ability build appropriate relationship with new clients.

- a. **Recommendation 7:** *Referring teams should work with RESET to review protocols for new entrants into treatment, and identify ways to improve jointly managed handovers (between referring and treatment services) and ensure that clients are supported through referral, assessment and prescription.*

13. There has been a long-term decline in the successful treatment rate among opiate users. This, along with the ageing nature of the opiate using cohort (and therefore a likely increase in their complexity) is a matter that should be explored to understand whether any changes can be made in the support offered to this group to improve treatment outcomes. Specifically this should address ongoing prescribing practice to understand whether current approaches align with national guidance and best practice.

**Recommendation 8:** *A review should be undertaken of RESET treatment OST practice to determine whether current practice aligns with national guidance and best practice.<sup>85</sup> The review should seek to determine whether current practice is in line with all aspects of national guidance and whether there are any areas that could be enhanced/improved.*

**Recommendation 9:** *The CDP should explore what interventions are needed to address the needs of ageing opiate users and whether a specific offer is required for older, entrenched, long-term users.*

14. The increase in deaths among opiate users, while possibly a product of chance, nonetheless warrants further scrutiny to ensure that the CDP and all parties fully understand whether there are any underlying factors that can be addressed to better protect service users.

**Recommendation 10:** *A multi-agency forum meets to review drug related deaths. Additional capacity should be allocated to the forum to enable a "deep-dive" to be conducted of deaths over the last year to enable full scrutiny of all circumstances relating to the deaths. Lessons learned from the deep dive should be shared with commissioners, RESET, other partners (as appropriate) and the CDP.*

15. Of homeless people with support needs, the proportion with *drug or alcohol need* is higher in Tower Hamlets than elsewhere. This indicates a clear need to ensure that links and pathways are available for the homeless population to ensure that they can access treatment

**Recommendation 11:** *The CDP should look into housing provision for those who use drugs and alcohol, and seek to ensure appropriate provision is in place.*

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<sup>85</sup> See: <https://www.gov.uk/government/news/phe-launches-opioid-treatment-quality-improvement-programme>

16. Professional interviewees suggested there appears to be a growing problem with Nox misuse among young people; which treatment services have not yet responded to. It is likely that Nox users would benefit from a brief intervention approach akin to the cannabis group that is about to be set up.

**Recommendation 12:** *The CDP should undertake a review to understand what intervention can be offered to NOx users, reviewing the evidence-base for what works with this client group.*

**Recommendation 13:** *Following on from the review (above), and dependent on the evidence that emerges, CDP members should consider developing a pilot service for Nox users in the financial year 2023-24. This will require developing referral pathways from a range of other partners including (but not limited to) RESET outreach, DIP, Safe East and the hospital and community navigators.*

17. A B12 Pathway has been developed at the Royal London hospital for Nox users but that this has not been integrated into the wider delivery landscape. Work should be undertaken to ensure that this pathway is fully integrated into the wider substance misuse treatment system.

**Recommendation 14:** *The CDP should engage with stakeholders at the Royal London Hospital to understand the operation of the B12 Pathway and how its operation can be linked into the wider treatment system.*

18. The P-RESET service provides a valuable and important function but appears to be under-utilized reaching only 42% of those who would potentially benefit from the service. Work should be undertaken to understand how levels of engagement can be improved.

- a. **Recommendation 15:** *P-RESET should audit data on health checks to understand whether there are certain clients/characteristics of service users who are failing to utilize the health checks. As a result of the audit, where necessary, the offer should be amended to better engage service users.*

19. There is a working protocol between ELFT and RESET which provides clarity on how clients with co-morbid substance misuse and mental health issues should be managed. However specific groups of clients do not appear to be well served and some stakeholders suggested that there is at times an expectation (contrary to national guidance) that alcohol users are abstinent before they can be supported for mental health needs.

**Recommendation 16:** *ELFT and RESET should revise the current protocol regarding working with clients with a dual diagnosis to better reflect national*

*guidance. We understand that a refresh is due in March 2023 so this should be used as an opportunity to align practice with national guidance.*

20. Prescriptions data suggest that Tower Hamlets has among the highest rates of opioid prescriptions across North East London. While this is a different issue to the use of illicit drugs, it warrants further investigation.

***Recommendation 17:*** *CDP should work with NEL ICS Medicines Management team to understand the reasons for high opioid prescription and explore initiatives manage this.*

# Appendices

## Appendix 1: Length of time in treatment

Table 40 Adult profiles: Length of time in Treatment by specified substance - All in treatment at the start of a treatment episode, 2009-10 to 2020-21, Tower Hamlets, Percentage

	09/10 (%)	10/11 (%)	11/12 (%)	12/13 (%)	13/14 (%)	14/15 (%)	15/16 (%)	16/17 (%)	17/18 (%)	18/19 (%)	19/20 (%)	20/21 (%)
<b>Opiates</b>												
Under 1 Year	52	47	50	43	43	42	42	42	43	38	39	37
1 to 2 Years	19	18	16	17	17	16	15	12	14	16	13	16
2 to 4 Years	17	21	18	17	17	18	16	16	13	14	16	17
4 to 6 Years	6	6	8	13	13	10	10	12	10	9	8	8
Over 6 Years	6	8	8	9	9	15	16	18	21	23	23	23
<b>Non opiates</b>												
Under 1 Year	76	76	82	84	84	94	92	89	93	90	89	90
1 to 2 Years	12	14	6	11	11	3	6	9	7	10	7	7
2 to 4 Years	6	5	6	5	-	3	-	-	-	-	4	3
4 to 6 Years	-	-	-	5	-	-	-	-	-	-	-	-
Over 6 Years	-	5	6	-	-	-	-	-	-	-	-	-
<b>Alcohol</b>												
Under 1 Year	81	93	83	92	92	93	92	92	91	86	80	82
1 to 2 Years	17	7	13	4	4	7	7	7	9	11	14	13
2 to 4 Years	2	2	3	3	3	1	1	-	1	3	6	5
4 to 6 Years	-	-	-	-	0	-	-	-	-	-	-	-
Over 6 Years	-	-	-	-	-	-	-	-	-	-	-	-
<b>Non Opiates and Alcohol</b>												
Under 1 Year	88	86	81	91	91	90	88	88	90	88	88	84
1 to 2 Years	4	8	14	7	7	10	8	10	8	10	8	14
2 to 4 Years	4	2	3	2	2	-	2	2	2	2	3	2
4 to 6 Years	2	2	2	-	-	-	-	-	-	2	-	-
Over 6 Years	-	2	2	-	-	-	-	-	-	-	-	-

## Appendix 2: Treatment exits

Table 41 Adult profiles: Treatment exits by specified substance - All in treatment at the start of a treatment episode, 2009-10 to 2020-21, Tower Hamlets, Percentage

	09/10 (%)	10/11 (%)	11/12 (%)	12/13 (%)	13/14 (%)	14/15 (%)	15/16 (%)	16/17 (%)	17/18 (%)	18/19 (%)	19/20 (%)	20/21 (%)
<b>Opiates</b>												
Successful completion	34	31	29	28	18	26	27	18	22	24	17	19
Dropped out/left	33	30	39	41	43	33	41	38	50	51	49	31
Transferred - not in custody	15	26	16	16	21	22	16	29	12	12	20	25
Transferred - in custody	5	8	10	11	10	13	12	12	12	9	11	17
Treatment declined	3	0	2	0	1	0	0	0	0	0	0	0
Died	2	1	2	2	2	3	2	2	4	3	3	8
Prison	1	2	1	0	0	0	0	0	0	0	0	0
Treatment withdrawn	4	3	2	2	5	4	2	1	0	2	0	0
Other	3	0	0	0	0	0	0	0	0	0	0	0
<b>Non opiates</b>												
Successful completion	57	62	67	50	65	90	83	63	57	62	50	58
Dropped out/left	43	31	22	50	24	11	11	22	38	29	36	25
Transferred - not in custody	0	8	11	0	12	0	3	11	0	5	9	8
Transferred - in custody	0	0	0	0	0	0	3	4	5	5	5	8
Treatment declined	0	0	0	0	0	0	0	0	0	0	0	0
Died	0	0	0	0	0	0	0	0	0	0	0	0
Prison	0	0	0	0	0	0	0	0	0	0	0	0
Treatment withdrawn	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
<b>Alcohol</b>												
Successful completion	40	76	56	48	49	31	61	47	60	74	60	58
Dropped out/left	27	8	28	45	41	58	26	36	35	22	36	33
Transferred - not in custody	28	8	8	2	4	5	9	17	2	2	4	4
Transferred - in custody	0	0	0	2	2	3	2	0	2	2	0	0
Treatment declined	2	5	5	2	3	2	2	0	0	0	0	0
Died	0	3	3	0	2	2	0	0	2	0	0	4
Prison	0	0	0	0	0	0	0	0	0	0	0	0
Treatment withdrawn	2	0	0	2	0	0	0	0	0	0	0	0
Other	2	0	0	0	0	0	0	0	0	0	0	0
<b>Non opiate and alcohol</b>												
Successful completion	42	64	63	62	56	44	62	52	60	68	44	53
Dropped out/left	29	20	28	31	32	48	24	29	35	26	41	42
Transferred - not in custody	19	8	6	3	4	8	10	16	3	3	11	0

Transferred - in custody	0	4	0	0	4	0	3	3	3	3	4	5
Treatment declined	3	4	3	0	0	0	0	0	0	0	0	0
Died	0	0	0	0	0	0	0	0	0	0	0	0
Prison	0	0	0	0	0	0	0	0	0	0	0	0
Treatment withdrawn	3	0	0	3	4	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0

(Source: NDTMS, ViewIT)



## Appendix 3: Associations with drug possession and drug trafficking

Table 42 Associations between recorded crime types with Drug Possession and Drug Trafficking, last 24 months and since April 2010

	Correlation (last 24 months)	Correlation (Since April 2010)
Arson and Criminal Damage	-0.18	0.07
Burglary - Business and Community	-0.16	0.02
Burglary - Residential	0.35	-0.09
Possession of a Weapon	-0.07	-0.15
Public Order	-0.02	-0.40
Robbery	-0.005	-0.08
Sexual Offences	-0.44	-0.29
Shoplifting	-0.31	-0.49
Other Theft	-0.40	0.32
Theft from Person	-0.39	0.28
Vehicle Offences	-0.29	-0.13
Violence against the Person	-0.44	-0.36
Fraud and Forgery		0.45
<b>Drug Trafficking</b>		
Arson and Criminal Damage	-0.38	0.07
Burglary - Business and Community	0.03	-0.11
Burglary - Residential	-0.12	-0.02
Possession of a Weapon	0.36	-0.05
Public Order	0.13	-0.15
Robbery	-0.12	-0.24
Sexual Offences	-0.30	-0.13
Shoplifting	0.13	-0.32
Other Theft	-0.01	0.04
Theft from Person	-0.15	-0.25
Vehicle Offences	-0.13	-0.05
Violence against the Person	-0.09	-0.10
Fraud and Forgery		0.24

(Source: London Datastore)

## **Appendix 4: Tower Hamlets Drug and Alcohol Misuse Resident Survey**

Tower Hamlets Council is currently undertaking work to understand more about the impact of drug and alcohol misuse within the local area and to better understand local people's concerns about drugs and alcohol.

The consultation is being undertaken by an independent third party research organisation called the Centre for Public Innovation.

As a resident of Tower Hamlets we are interested to hear your opinion about the misuse of drugs and alcohol. We would very much appreciate it if you could answer this short survey which will take approximately 10 minutes to complete.

If you would prefer, a paper version is available by emailing: [Jennifer.bier@cpic.org.uk](mailto:Jennifer.bier@cpic.org.uk)

The survey is completely anonymous and contains no information that can be used to identify you.

Many thanks for your help.

In this survey, by drug misuse we mean the:

- consumption of illicit/illegal drug
- use of drugs not prescribed by a doctor or healthcare professional
- misuse of drugs that have been prescribed (for instance using prescribed drugs for recreational purposes).

### Drug and alcohol misuse in Tower Hamlets

1. Are you concerned about alcohol misuse by other people in Tower Hamlets?
  - a. Very concerned
  - b. Slightly concerned
  - c. Not concerned
  - d. Don't know
2. Are you concerned about drug misuse by other people in Tower Hamlets?
  - a. Very concerned
  - b. Slightly concerned
  - c. Not concerned
  - d. Don't know
3. Would you say that misuse of any of the following is a problem locally? (Tick all that apply).
  - Alcohol
  - Cannabis (marijuana, weed, skunk, dope, grass)
  - Heroin
  - Crack cocaine
  - Cocaine (powder cocaine)
  - Prescription medicines
  - Ecstasy
  - Purple drank/Lean
  - Amphetamines (including speed)
  - Nitrous oxide/laughing gas (balloons)
  - Steroids
  - Solvents
  - Ketamine
  - I don't think any of these are an issue locally
  - Other

If you ticked Other, please specify in the box below.

4. Which would you say is the biggest issue locally? (Tick one).
- Alcohol
  - Cannabis/marijuana (marijuana, weed, skunk, dope, grass)
  - Heroin
  - Crack cocaine
  - Cocaine (powder cocaine)
  - Prescription medicines
  - Ecstasy
  - Purple drank/Lean
  - Amphetamines (including speed)
  - Nitrous oxide/laughing gas (balloons)
  - Steroids
  - Solvents
  - Ketamine
  - I don't think any of these are an issue locally
  - Other

If you ticked Other, please specify in the box below.

5. To what extent would you agree with the following statement?: "Drug misuse is a growing problem in Tower Hamlets."
- Strongly agree
  - Agree
  - Neither agree nor disagree
  - Disagree
  - Strongly disagree
  - Don't know/I don't have an opinion
6. To what extent would you agree with the following statement?: "Alcohol misuse is a growing problem in Tower Hamlets."
- Strongly agree
  - Agree
  - Neither agree nor disagree
  - Disagree
  - Strongly disagree
  - Don't know/I don't have an opinion

1. What do you think are the priority areas that the Council and their strategic partners should be addressing in relation to drug and alcohol misuse in Tower Hamlets?
  - a) Interventions in schools
  - b) Harm reduction initiatives (e.g. Needle and syringe programmes; information on safer drug use)
  - c) Increased policing/ presence (PCSOs)
  - d) Stricter licensing of off-licenses
  - e) Reducing the number of licensed premises in the borough
  - f) Stricter licensing of on-premises
  - g) Creation of controlled drinking zones
  - h) Improved pathways to treatment
  - i) Information and public health campaigns
  - j) Other – Please specify
  
2. If you had any concerns about drugs and alcohol for you or a family member, what would be the easiest way for you to get help?
  - a) Self-referral into the treatment service (RESET Treatment)
  - b) Contact your GP
  - c) Go to a pharmacy
  - d) Contact the local hospital
  - e) Access online information
  - f) Access telephone support services
  - g) Other (please specify).

### Impact of drug and alcohol misuse on the quality of your life

7. On a scale from 1 to 10 - where 1 is no effect and 10 is a total effect on your quality of life, to what extent is your quality of life affected by drug and alcohol misuse of others?

[1] = no effect on quality of life .... [10] = total effect on quality of life

8. If drug and alcohol misuse of others has an impact on your quality of life, what are the things that are affecting you? (Tick all that apply).
  - Fear of crime – including drug dealing
  - Fear of violent crime
  - Fear of gangs

- Domestic Abuse
- Public drug consumption
- Street drinking
- Rowdy behaviour
- Anti-social behaviour (such as noise, public urination)
- Littering (discarded drink containers or drug paraphernalia)
- Other

If you ticked Other, please specify in the box below.

### Impact of drug and alcohol misuse on your family

9. Are you negatively affected by the drug or alcohol use of anyone in your family?

- Yes
- No
- Don't know

10. If you are affected, could you tell us what the impact has been?

- Domestic abuse
- Family/ relationship difficulties
- Mental wellbeing
- Education
- Employment
- Finances
- Housing/ accommodation
- Other (Please Specify)
- 

1. What is your month and year of birth? \*

Month [select month/open field text]

Year [select year/open field text]

Prefer not to say

2. What is your ethnic group?\*

White

English, Welsh, Scottish, Northern Irish or British

Irish

Gypsy or Irish Traveller

Roma

Any other White background, write in

Mixed or Multiple ethnic groups

White and Black Caribbean

White and Black African

White and Asian

Any other Mixed or Multiple background, write in

Asian or Asian British

Indian

Pakistani

Bangladeshi

Chinese

Any other Asian background, write in

Black, Black British, Caribbean or African

Caribbean

Somali

Other African

Any other Black, Black British or Caribbean background, write in

Other ethnic group

Arab

Any other ethnic group, write in

Prefer not to say

**3. Do you have any physical or mental health conditions or illnesses lasting or expected to last 12 months or more?\***

Yes

No

Prefer not to say

**4. What is your sex?\***

Female



Male

Prefer not to say

**5. Is the gender you identify with the same as your sex registered at birth?\***

Yes

No, write in gender identity

Prefer not to say

**6. Are you currently pregnant or did you give birth in the last twelve months?**

Yes

No

Prefer not to say

**7. What is your legal marital or registered civil partnership status?\***

Never married and never registered a civil partnership

Married

In a registered civil partnership

Separated, but still legally married

Separated, but still legally in a civil partnership

Divorced

Formerly in a civil partnership which is now legally dissolved

Widowed

Surviving partner from a registered civil partnership

Prefer not to say

**8. What is your religion?\***

No religion

Christian

Buddhist

Hindu

Jewish

Muslim

Sikh

Any other religion, write in

Prefer not to say

**9. Which of the following best describes your sexual orientation?\***

Straight/Heterosexual

Gay or Lesbian

Bisexual

Other sexual orientation, write in

Prefer not to say

**10. Do you look after, or give any help or support to, anyone because they have long-term physical or mental health conditions or illnesses, or problems related to old age?\***

No

Yes, 9 hours a week or less

Yes, 10 to 19 hours a week

Yes, 20 to 34 hours a week

Yes, 35 to 49 hours a week

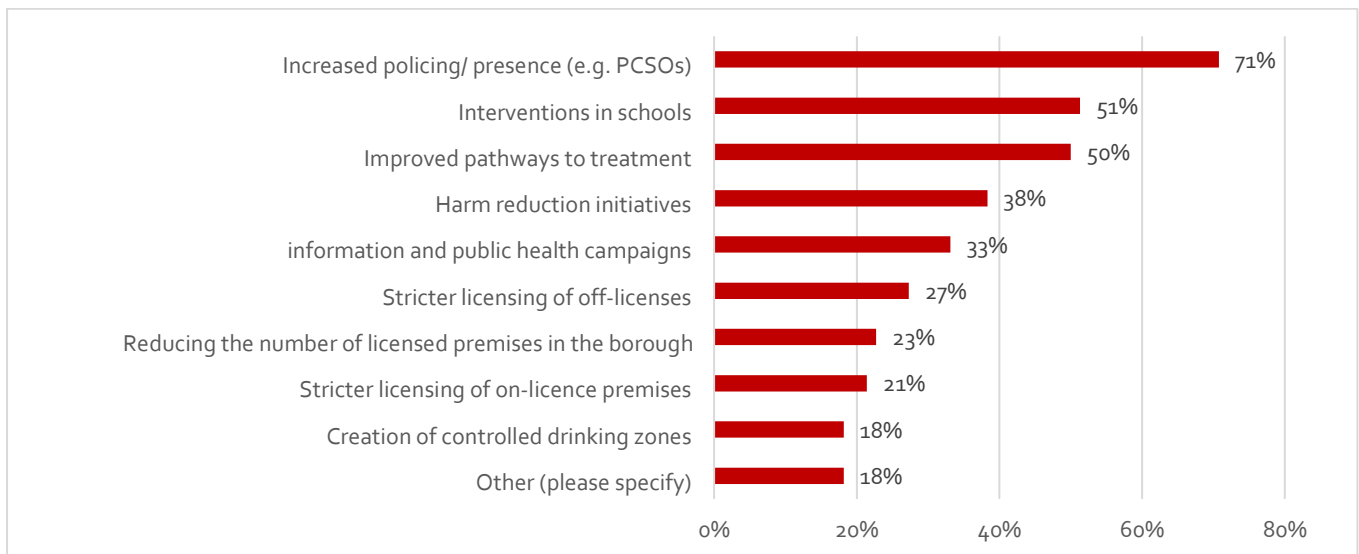
Yes, 50 or more hours a week

Prefer not to say

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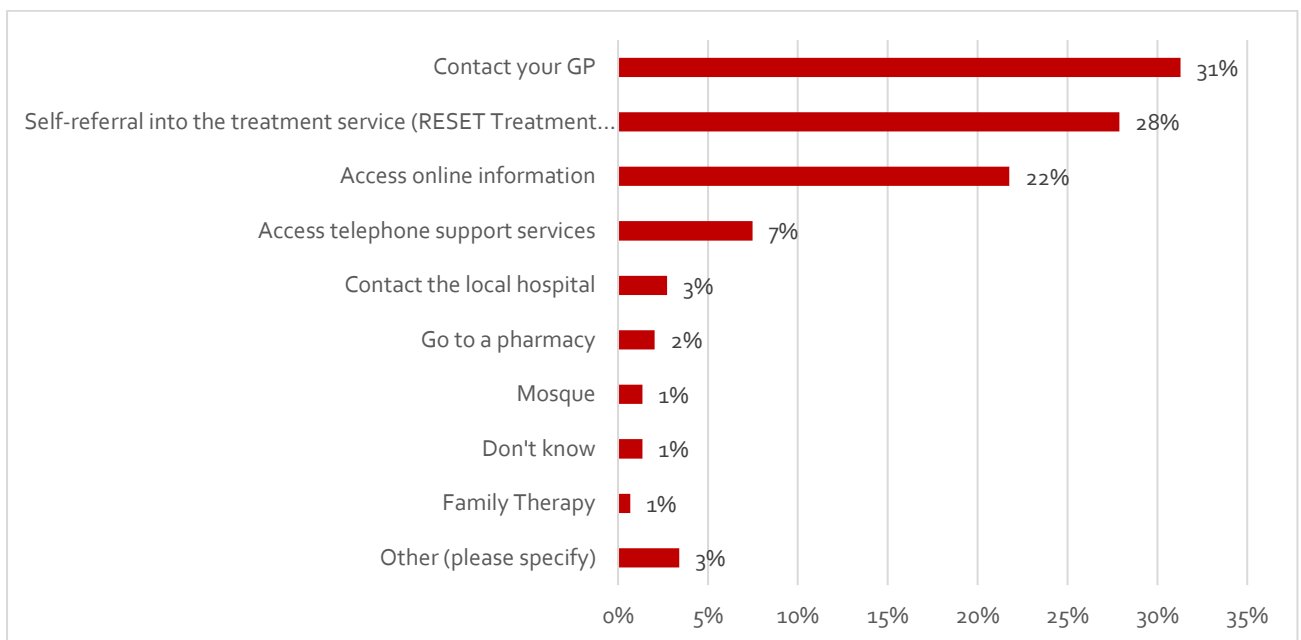
## Appendix 6: Survey Results

Figure 42 Priority areas that the Council and their strategic partners should be addressing in relation to drug and alcohol misuse (CPI survey)



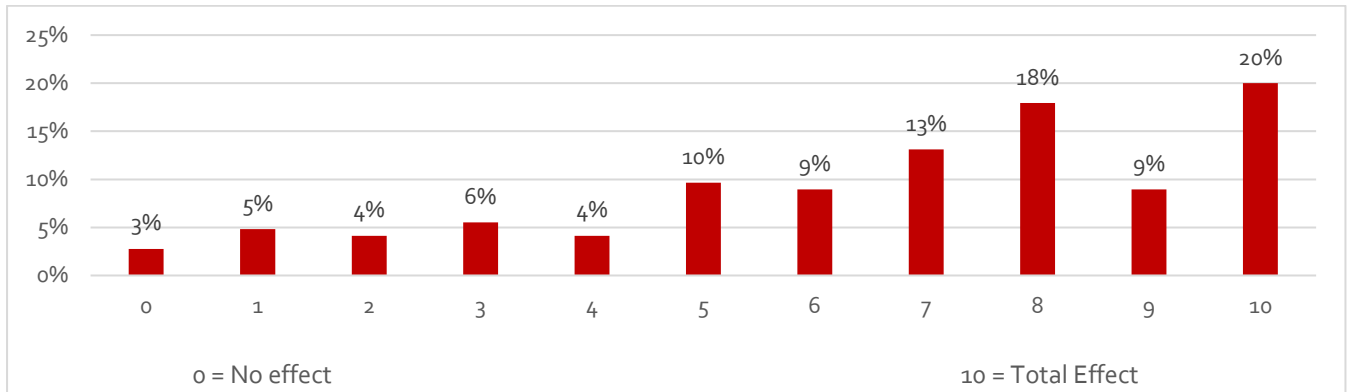
Base=154 (totals equal more than 100% as resident could select more than one option).

Figure 43 Easiest way for residents to get help if they have a concern about drug and alcohol misuse for themselves or a family member (CPI survey)



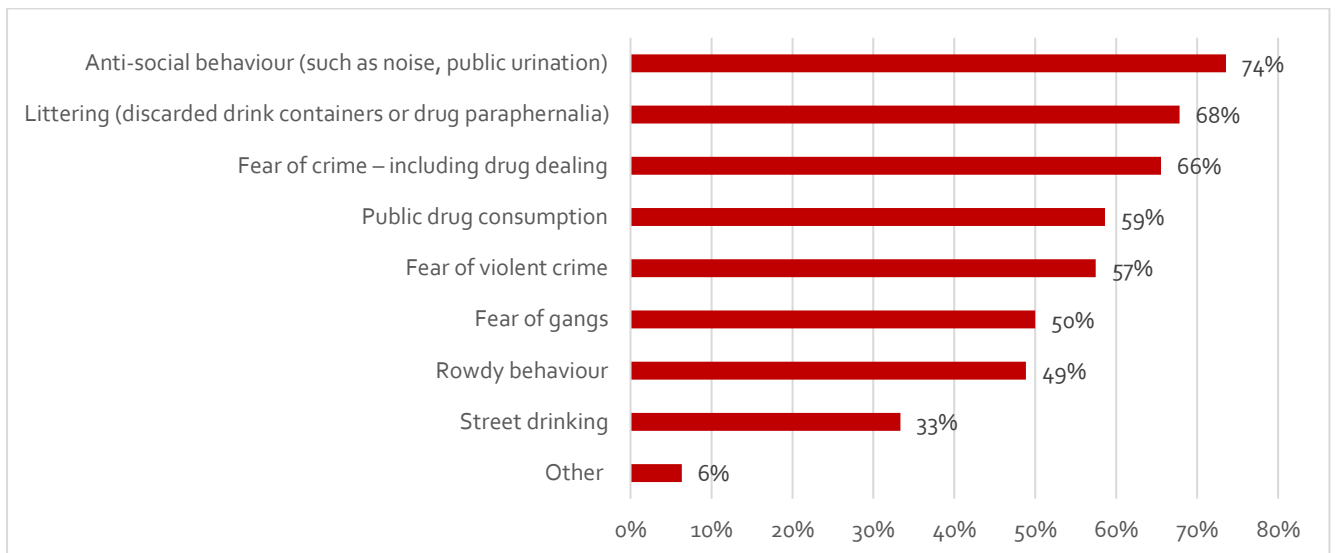
Base=147.

**Figure 44 Perceptions of the extent to which quality of life is affected by drug and alcohol misuse of others, 0-10 (CPI survey)**



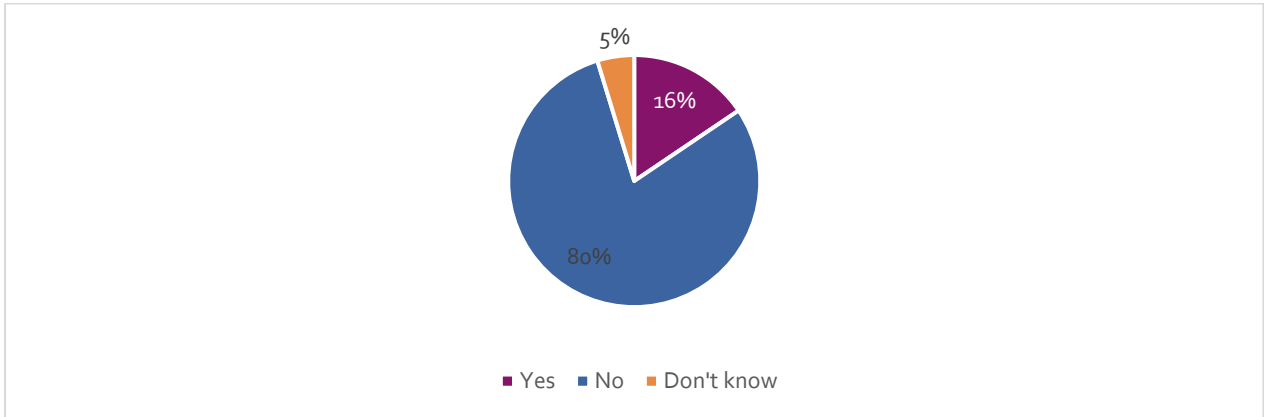
Base=147.

**Figure 45 Perceptions of which aspects of drug and alcohol misuse are having an effect on people's lives (CPI survey)**



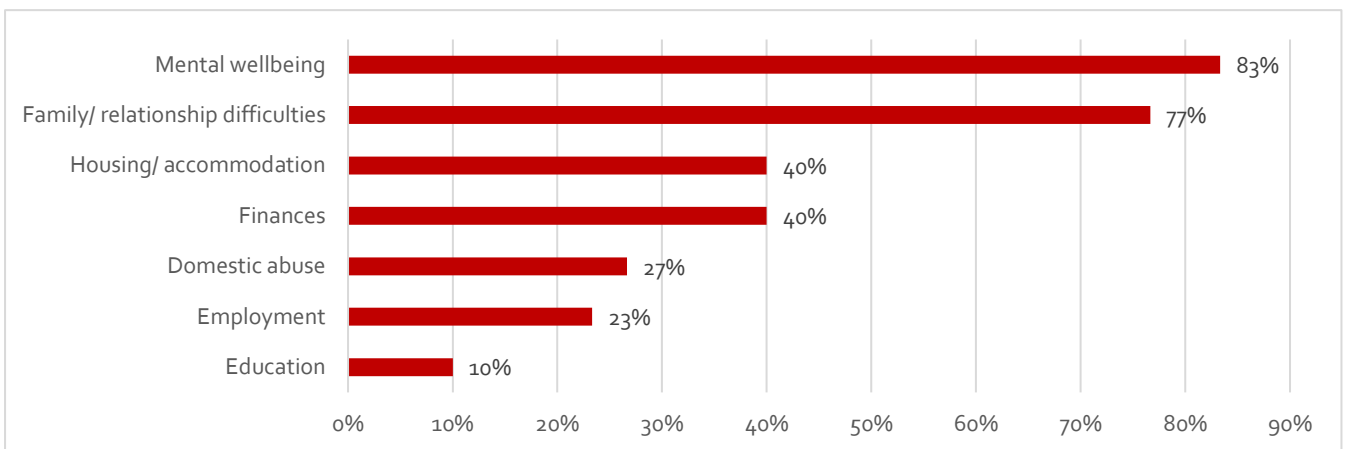
Base=147 (totals equal more than 100% as resident could select more than one option).

**Figure 46 Percentage of respondents that have been negatively affected by the drug misuse in the family? (CPI survey)**



Base=148.

Figure 47 Impact on those residents who are negatively affected by drug misuse in their family (CPI survey)



Base=30 (totals equal more than 100% as resident could select more than one option).