# Chapter 7: Strengthen the Role & Impact of Ill Health Prevention: Lifestyle related Morbidities

## Alcohol Misuse

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### Introduction

Alcohol is one of the three biggest lifestyle risk factors in the United Kingdom alongside smoking and obesity. In England, 9 million adults drink at levels that increase the risk of harm to their health, and 1.6 million adults show some signs of alcohol dependence.[1] Drinking more than the recommended limits on a regular basis increases the risk of a range of chronic diseases as well as psychological ill-health, and is also associated with a range of social problems such as violent crime, domestic violence and lost working days.

The annual cost of alcohol related harm to society is in the UK is estimated at 21bn, with 11bn relating to crime, 3.5bn to the NHS and 7bn in lost productivity. There are also significant costs relating to looked after children and other safeguarding interventions. Alcohol related hospital admissions cost Ealing 14.7m in 2008/9. [2]Locally, Ealing saves an estimated £18 million a year as a result of their investment in drug and alcohol treatment services[3], calculated by the PHE value for money tool, which is an evidence based calculation tool that utilises local crime and health statistical data to analyse the impact on spend on drugs and alcohol treatment. This tool has been validated by PHE's knowledge and intelligence team and is a recognised measure of value for money.

#### Policy Guidance

The current national alcohol strategy published in 2012[4] identifies the following as priority areas for intervention:

- Ending the availability of cheap alcohol and irresponsible promotions.
- Ensuring that local areas are able to tackle alcohol-related problems locally.
- A challenge to the beverage industry to be responsible in the production, sale and promotion of alcohol.
- Support for individuals to make informed choices about healthier and more responsible drinking, so it is no longer considered acceptable to drink excessively.

Locally, the Ealing Local Authority and Clinical Commissioning Group (CCG) have aligned the following strategies to address alcohol related harm in the borough: Ealing Licensing Strategy [5] Ealing Alcohol Strategy[6] and the Ealing CCG Out of

[1] Alcohol and drugs prevention, treatment and recovery: Why Invest?: PHE 2013

[2] The NHS Confederation January 2010 produced in association with the Royal College of Physicians, Briefing: *Too much of the hard stuff*: what alcohol costs the NHS

[3] Value for Money Tool: National Drug Treatment Monitoring System, PHE www.NDTMS.net

[4] HM Government (2012): *The Governments Alcohol Strategy.* Available at https://www.gov.uk/government/publications/alcohol-strategy

[5] Ealing Council: Licensing Act 2003; Statement of Licensing Policy 2012

Hospital Strategy[7]. The National Institute for Health and Clinical Excellence (NICE) has also developed three evidence based guidance documents addressing alcohol related problems [8] .[910] Ealing services provide interventions in line with NICE guidance and Models of Care for Alcohol Misusers (MoCAM) 2006[11].

## Level of Need in Ealing

To assess the level of alcohol misuse need in Ealing, Local Alcohol Profiles for England (LAPE)[12] and local service data were analysed. Ealing's rates for various indicators were compared with those of its statistical neighbours (Brent, Croydon and Enfield)[13], London and England. Trend analysis for specified comparators was also carried out and presented on bar charts where appropriate.

### Alcohol Consumption

### Lower, increasing and high risk drinking[14]

Seventy four percent of the Ealing population aged 16 and over are engaged in lower risk drinking while nearly a fifth (19%) are engaged in increasing risk drinking and 8% in higher risk drinking. These rates are not significantly different from the statistical neighbours', London's and England's averages.

### Binge Drinking[15]

Twelve percent of the Ealing population aged 16 and over is engaged in binge drinking. The rate is higher when compared to its statistical neighbours (with the exception of Enfield), however below the London and England averages (Figure 1)

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[6] Ealing Alcohol Strategy: 2013- 2016

[7] Ealing Clinical Commissioning Group: Better Care, Closer to Home: *Our three year strategy for co-ordinated, high quality care out of hospital;* 2012-2015

[8] NICE Public health guidance 24 (2010)

[9] NICE guidelines [CG115]

[10] NICE clinical guideline 100 (2010)

[11] DH/National Treatment Agency for Substance Misuse (2006): Models of care for Alcohol Misusers

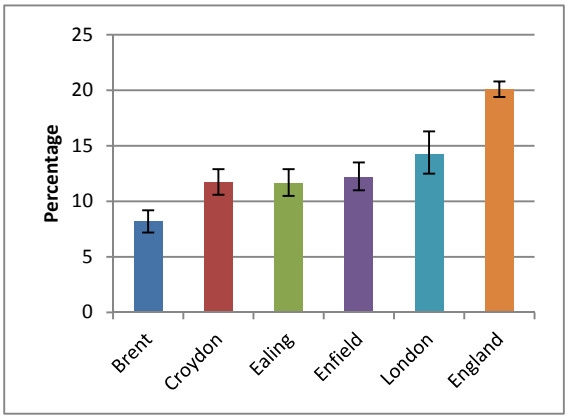
[12] http://www.lape.org.uk/

[13] Comparator authorities – which have similar profiles across a number of measures: www.cipfastats.net/resources/nearestneighbours/profile.asp?view=select&dataset=england

[14] Increased-risk or 'hazardous' drinking is regularly drinking 22-50 units of alcohol a week (adult men), or 15-35 units a week (adult women).

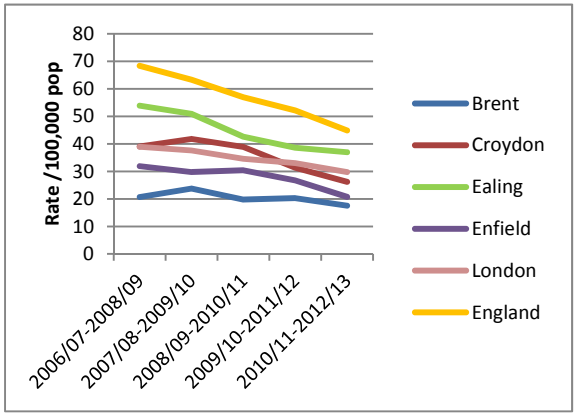
[15] Binge drinking involves drinking a large amount of alcohol in a short space of time - eight units in a day for men and six units in a day for women.

Figure 1: Percentage of the population aged 16 years and over who report engaging in binge drinking (2007-2008)




*Source: Local Alcohol Profiles for England*

Figure 2: Persons aged under 18 admitted to hospital with alcohol-specific conditions: Persons (2006/07-2012/13).




## Hospital Admissions

Admissions to hospital due to alcohol specific conditions[16] for persons aged below 18 years show a declining trend. In 2010/11 – 2012/13 there were 85 admissions as compared to 114 in 2006/07 – 2008/09.The Ealing rate has consistently remained lower than England's average but higher than the London's and other statistical neighbours' averages (Figure 2).

The rate of male admissions due to alcohol specific conditions in Ealing rose between 2008/09 and 2011/12. There has been a decline since 2011/12. It has remained consistently higher than the statistical neighbours', London's and England's averages. A total of 879 males were admitted in 2012/13 (627/100,000 population) (Figure 3). The females' rate over the five year period remained lower than the England average. In 2012/13, 291 women were admitted in hospital with alcohol specific conditions (187/100,000 population).

## Admissions due to alcohol related conditions

The rate of male admissions due to alcohol related conditions[17] has significantly declined from 655/100,000 population in 2008/09 to 617/100,000 population in 2012/13 (Measures are presented in line with LAPE and Public Health Outcomes Framework reports (using the 'Narrow measure as of 2014[18]). However the rate has consistently remained higher than the statistical neighbours', London's and

[16] Alcohol-specific outcomes include those conditions where alcohol is causally implicated in all cases of the condition; for example, alcohol-induced behavioural disorders and alcohol-related liver cirrhosis. The alcohol-attributable fraction is 1.0 because all cases (100%) are caused by alcohol.

[17] Alcohol-related conditions include all alcohol-specific conditions, plus those where alcohol is causally implicated in some but not all cases of the outcome.

[18] counts only the fraction alcohol attributable associated with the diagnosis in the primary position or alcohol-related external causes recorded in secondary diagnosis fields

England's averages (Figure 4). The female rate has remained higher than the London average, but lower than England's (Figure 5).

Figure 3: Admitted to hospital with alcohol-specific conditions: Males, all ages

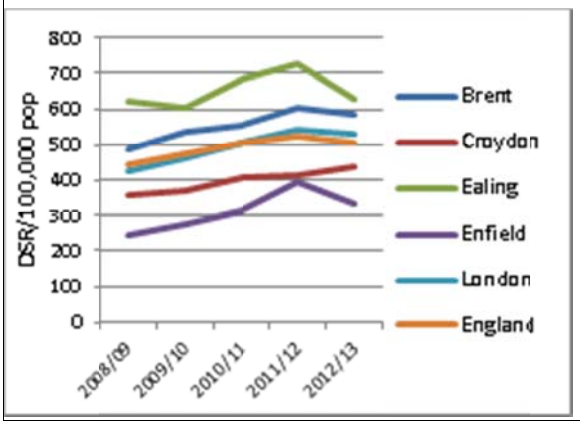
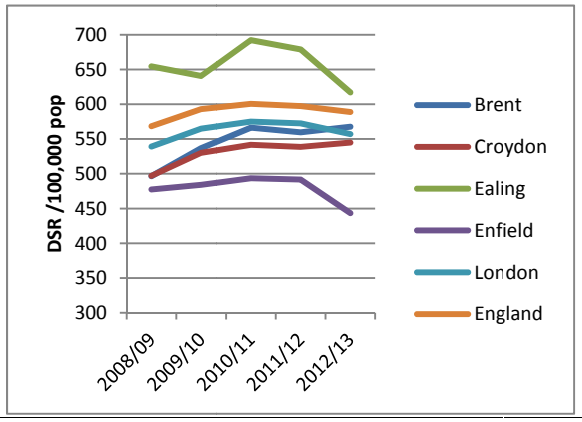



Figure 4: Admitted to hospital with alcohol-related conditions: males, all ages




*Source: Local Alcohol Profiles for England*

Figure 5: Admitted to hospital with alcohol-related conditions: Females, all ages

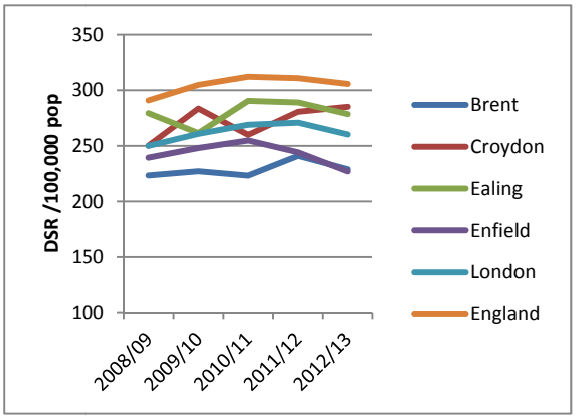
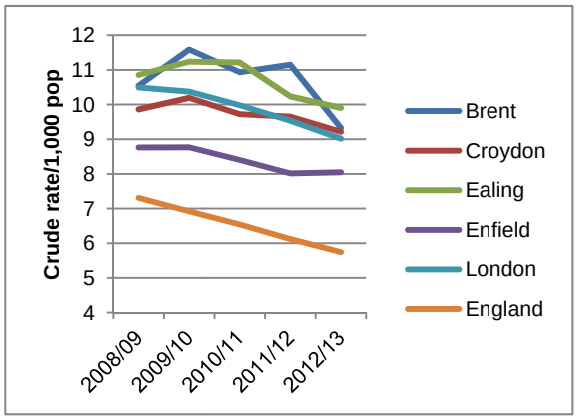



Figure 6: Alcohol-related recorded crimes: Persons, all ages




*Source: Local Alcohol Profiles for England*

## Alcohol Related Crimes

The rates of alcohol related recorded crimes in Ealing have been consistently higher than the London's and England's averages. However there has been an overall slight reduction since 2008/09. In 2012/13, 3361 cases were recorded which is equivalent to a rate of 10/1,000 population compared to 3460 cases (11/1,000 population) in 2008/09 (Figure 6).

Rates of alcohol related violence crimes in Ealing have remained stagnant over the five year period though higher than the England average. In 2012/13, 2170 cases

were recorded, equivalent to a rate of 6.4/1,000 population which was higher than the England average (3.9/1000 population).

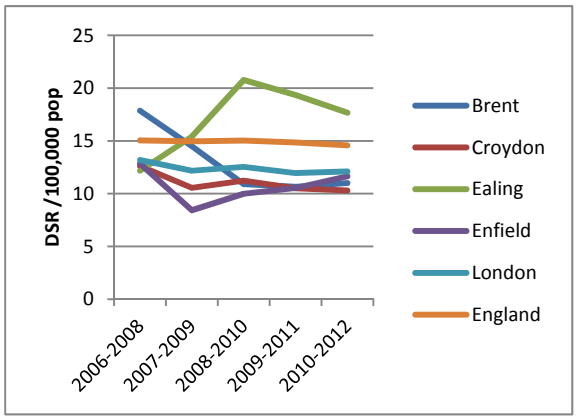
Rates of alcohol related sexual crimes in Ealing rose between 2008/09 and 2011/12. There was reduction between 2011/12 and 2012/13. However the rates have been consistently higher than the England average. In 2012/13, 48 cases were recorded in Ealing which equates to rate of 13/100,000 which was higher than the England average (12/100,000).

## Alcohol Specific & Related Mortality[19]

### Alcohol Specific Mortality

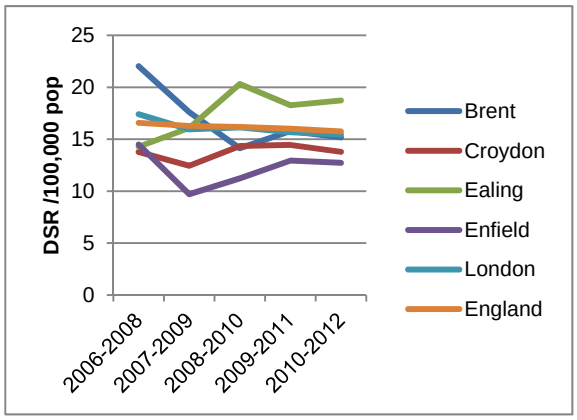
Ealing's male alcohol specific mortality rose from 12/100,000 population in 2006-2008 to 18/100,000 population in 2010-2012 and was consistently higher than the London and England average. The rates have been higher than that of statistical neighbours since 2007-2009 (Figure 7). The rate for women appears to be rising but still remains below the England average. In 2010-2012 there were 21 cases reported equivalent to 5/100,000 population.

Figure 7: Alcohol-specific mortality: Males, all ages




*Source: Local Alcohol Profiles for England*

Figure 8: Mortality from chronic liver disease: Males, all ages




### Chronic Liver Disease Mortality

Chronic liver disease mortality rate has been rising since 2006-2008. In 2010-12, 69 cases were reported in Ealing. This was equivalent to a rate of 19/100,000 population which was higher than the statistical neighbours', London's and England's averages. Among females the rates have been lower but there was notable rise between 2009-2011 and 2010-2012 (4.7 to 6 /100,000 population).

[19] Alcohol-specific mortality includes deaths caused by conditions where alcohol is causally implicated

## Alcohol Related Mortality[20]

The alcohol related mortality rate among males in Ealing has been declining since 2008. However there was a slight increase between 2011 and 2012 (64/100,000 to 69/100,000 population). The rate remains higher than the statistical neighbours', London's and England's averages. The female mortality rate has also been declining but there was a slight increase between 2011 and 2012 (23/100,000 to 26/100,000 population).

## Local Service

### Alcohol Related Ambulance Service Call Outs Ealing, 2013/14

In 2013/14, 2,717 alcohol related ambulance call outs were made from Ealing. The highest number of calls were from the Ealing Broadway ward (276) while Hobbayne (44) had the least calls. Most ambulance call outs concerned males aged 40-59 years (951). Among females most of the calls were by those aged 20-29 years (156).

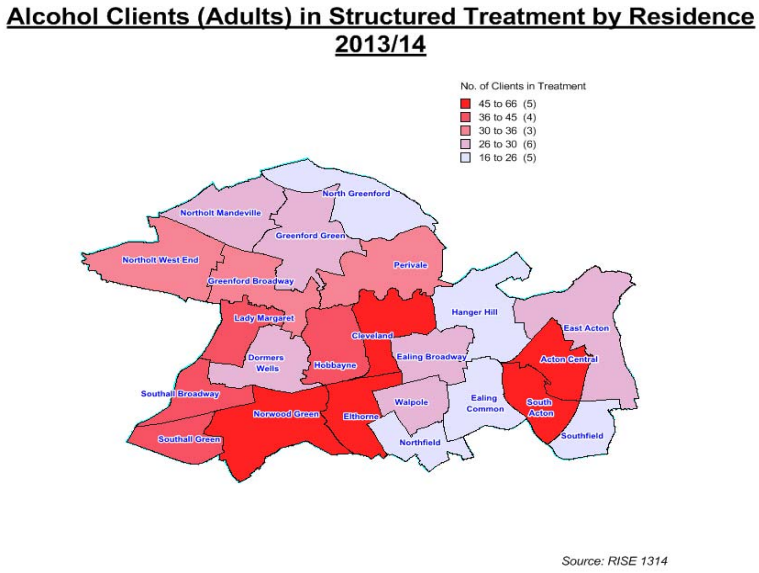
### Adults in Structured Treatment for Alcohol use[21]

The majority of adults in Ealing undergoing alcohol misuse treatment in 2013/14 were adults aged 35-44 years (33%), of these 698 were male, and 251 female. The highest number of presentations to alcohol treatment by ethnicity came from White and Asian/Asian British background. The least presentations came from those with a mixed background (white and black African, and white and Asian). The demographics of those accessing services is largely representative of the borough's population. Geographically the largest number of adults in treatment were from Hobbayne Northolt, Southall and Dormers Wells wards, (Figure 9):

[20] Include all alcohol-specific conditions, plus those where alcohol is causally implicated in some but not all cases.

[21] Adults in structured treatment for alcohol who have identified alcohol as a problematic substance in either primary or secondary fields. NB: this is exclusive of tier two IBA interventions

Figure 9: Adults in treatment for alcohol use in Ealing by Ward, 2013/14[22]




*Source: Ealing RISE alcohol service*

**Adults accessing structured treatment for alcohol use with children**[23]
In 2012/13, 40% of all adults accessing structured treatment for alcohol use were parents. 19% of those had children living with them, whilst 21% were parents who had other contact arrangements with their children.

**Successful completions from Alcohol treatment (Adults)**
Ealing recorded better successful alcohol treatment completion rates from community treatment than the national average throughout 2013/14 (Table 5).

Table 5: Alcohol Successful completions Q1-Q4 2013/14

| | Quarter one 2013/14 | Quarter two 2013/14 | Quarter three 2013/14 | Quarter four 2013/14 |
|---|---|---|---|---|
| Ealing | 40.6% | 39.9% | 43% | 49.3% |
| England | 36% | 35.8% | 36.6% | 37.5% |

**Young People in Alcohol Misuse Treatment**
A total of 74 young people aged 14-19 years in Ealing were in treatment for alcohol use in 2013/14. The majority were males (44). Young people from the Black Asian Minority Ethnic groups (BAME) had a higher rate of entry to treatment services as compared to the White group (Table 6).

[22] Non identifiable data: partial postcodes. Some wards may be under/over represented due to partial postcodes which overlap more than one ward. Further analysis is planned for final version.

[23] Alcohol identified as primary substance only

Table 6: Young people in treatment for alcohol use in Ealing by ethnicity (Crude Rate), 2013/14

| Gender | Number in Treatment | Population | Rate/100,000 |
|---|---|---|---|
| Male | 21 | 27950 | 75.1 |
| Female | 52 | 51100 | 101.8 |
| **Ethnicity** | | | |
| White | 21 | 27950 | 75.1 |
| BAME | 52 | 51100 | 101.8 |
| **Total** | **74** | **79100** | **94.0** |

## Current Interventions

The integrated multidisciplinary RISE service, delivers drug and alcohol treatment to adults in Ealing. RISE are a consortium of providers lead by CRI[24], working with CNWL NHS trust[25], EACH[26], Build on Belief, Intuitive Recovery and TSBC[27]. Rise currently provide a variety of clinical and psychosocial interventions summarised in the table below:

Table 7: Ealing RISE alcohol interventions

| | | | |
|---|---|---|---|
| • Assessment | • Recovery Planning | • Group Work | • ETE support |
| • Parental Assessment | • Counselling (individual & families) | • Psychology | • Floating housing support |
| • Community Detoxification for Alcohol | • Clinical Interventions (including opiate substation therapy | • Street Outreach | • Criminal Justice Interventions (arrest referral, integrated offender management, ATR/DRR) |
| • GP Alcohol Clinics | • Hospital In-reach | • GP Shared Care Scheme | • Fixed site and pharmacy needle exchange |
| • BBV Screening | • Hepatitis C Vaccination | • Training to partner agencies | • Volunteer and Mentoring Training and Placements |

There is a service user led 'Recovery Social club' situated in the heart of West Ealing which operates at weekends and some evenings providing access to peer led mutual aid groups such as Narcotics anonymous and Alcoholics Anonymous.

For individuals presenting with more complex needs, inpatient medically assisted detoxification and residential rehabilitation is also being made available. In 2013/14 approximately 139 residents were admitted to inpatient detoxification and 81% completed successfully. Approximately £370,000 was spent and the cost per week ranged from £854 for low complexity, to £1,505 for medium complexity and £2,205 for high complexity.

[24] Crime Reduction Initiatives
[25] Central North West London NHS trust
[26] Ethnic Alcohol Counselling Hounslow
[27] The Small Business Consultancy

In 2013/14 approximately 25 residents were granted places for residential rehabilitation and 60% completed successfully. The overall budget was around £334,236. The average cost for one week's stay in a residential rehabilitation unit is £1,000 and funding is approved for approximately 12 weeks.

Separate substance misuse services are commissioned in Ealing for under 18's. Ealing Council also provide IBA (Identification and brief advice) training for alcohol across key stakeholders.

The budget for drug and alcohol services, including the integrated RISE service, young people's services and inpatient detoxification/residential rehabilitation placements for 12/13 and 14/15 were just over £5.5m.

## Identified needs and intervention gaps

The following key unmet needs have been identified from data analysis and evaluation of current interventions as above:

- High rates of alcohol related ambulance call outs, hospital admissions, alcohol related mortality and chronic liver disease mortality present a challenge to Ealing. This suggests that the synthetic estimates (model-based figures commissioned by the DoH) of increasing risk and high risk drinking rates may be underestimating the level of alcohol related harm in the Borough.

- Higher than regional and England level of recorded crime, particularly violent crime indicates a gap in interventions to target alcohol related crime.

- Locality level data sources (such as data from probation and the new community rehabilitation company, safeguarding teams, hospital admission data, antisocial behaviour event data and GP data) require joint mapping.

## Recommendations for Commissioners

1. The high levels of alcohol related ill health; crime and consumption indicate that funding for integrated treatment services must be maintained to address demand and need.

2. Develop further the robust partnership working with hospitals, recommend enhancement of existing hospital in-reach team via LA commissioned services and the CCG to further address hospital admissions and mortality rates.

3. Stakeholder analysis and further mapping is recommended to increase identification of target areas to identify increasing risk and higher risk drinkers and plan services accordingly to improve accessibility.

4. Extend IBA training to key partners throughout the borough and ensure mechanisms are in place to record delivery.

5. High levels of alcohol related crime indicate that criminal justice elements of the integrated RISE model must adapt to meet this need.

6. Work with RISE to support criminal justice re-modelling to extend alcohol arrest referral in custody suites.

7. Identify alcohol users amongst existing probation cohort where alcohol is indicated as a criminogenic factor and embed offender focused interventions.

8. Co-ordinate different data sources to ensure needs are met and also to develop intelligence to inform licensing policy and reviews.

# Drug Misuse

*Lead author: David Suen*

## Introduction

Drug addiction and misuse leads to significant economic and social costs, affecting society in many debilitating ways[28]. From the impact of crime on local communities, health effects on users, collective impact on families to the damaging effect of international organised crime. Drug misuse can manifest in ill health, sickness and ultimately premature death. A considerable number of those who misuse drugs are unable to attain or sustain full time employment. The economic effects of drug misuse is significant, it impacts on: absenteeism, lost or impaired productivity and risk of accidents.

According to research by Public Health England (PHE), problem drug use costs society £15.4 billion a year[29], this can be broken down into:

- Deaths related to drugs misuse, £2.4bn
- Cost to the NHS in England, £488m
- Drug misusing parents' children who have been taken into care, £42.5m
- Class A drug-related crime, £13.9 billion
- Heroin or crack users not in treatment commit crime costs £26,074 a year

Drug misuse is associated with significant public health harms which can be divided in 2 main areas. The first is *communicable diseases*, where approximately 10% of all HIV infections worldwide occur via injecting drug use. Current or former Injecting Drug Users (IDU) are especially susceptible to hepatitis C. NICE estimates that the combined crime and healthcare costs of each IDU can add up to £480,000 over their lifetime[30]

The second harm is *premature death*; heroin users have a higher risk of premature death from drug overdose, especially among those using injections.[31] Deaths from drug misuse account for as many deaths as road traffic accidents among men. Studies have shown that addicted prisoners are at increased risk of drug-related death in the weeks immediately after release.[32,33]

Drug misuse treatment in Ealing is guided by the following policy documents:

[28] Ruth Lupton et al, (2002) A rock and a hard place: drug markets in deprived neighbourhoods, Home Office Research Study 240.
[29] Christine Godfrey et al, (2002) The economic and social costs of Class A drug use in England and Wales, 2000. Home Office Research Study 249.
[30] NICE (2009) Needle and syringe programmes: providing people who inject drugs with injecting equipment, NICE public health guidance 18
[31] Romina L Gaston et al (2009) Can we prevent drug related deaths by training opioid users to recognise and manage overdoses? Harm Reduction Journal 2009, 6:26 doi:10.1186/1477-7517-6-26
[32] Department of Health (2010) The Patel Report: Prison Drug Strategy Review Group.
[33] Merrall EL et al (2010) Meta-analysis of drug-related deaths soon after release from prison. Addiction, 2010 Sep; 105(9):1545-54. Epub 2010 Jun 23.

- **National drug strategy**, sets out the government's approach to tackling societal harm associated with drugs and addressing alcohol dependence[34]
- **NICE guidance**[35] and **Clinical Guidelines**[36], which are the foundation of the recovery focused treatment system.
- **Building Recovery in Communities** (BRiC)[37], a national framework for increasing the recovery orientation of local treatment systems.
- **Joint Prevention Strategy For Adults** 2012-2016[38], considers the options for prevention to improve the health and wellbeing of adults in Ealing.
- **Ealing CCG Better Care, Closer to Home 2012-15** 2012-15[39], looks to increase joint working and co-ordination between health and social care systems, improve access to primary care services, co-ordinate packages of care for patients with long term conditions, and improve support to patients being discharged from hospital.
- **Integrated Offender Management**[40] (IOM), a framework for partner agencies to ensure offenders whose crimes cause most harm locally are managed in a co-ordinated way.
- **Drugs Intervention Programme** (DIP) focuses on breaking the cycle of crime and drugs by providing opportunities for drug misusing offenders to access treatment at all points of contact within the criminal justice system.

## Level of need in Ealing

The Prevalence of Opiate and/or Crack Users (OCU) was 13.0 per 1,000 in 2010/11, this has been reduced to 10.9 for 2013-14[41]. The downward trend is also reflected nationally and may be due to older long term drug users having higher mortality rates, successful treatment exits of the treatment cohort, a shift away from class A drugs to New Psychoactive Substances (NPS)[42]. The treatment penetration rate for this group is at 43%, this means that there is still significant amount of work to be done to engage those who are treatment naïve. In terms of the gender split the penetration rate is 42% for men 51% for women.

### Socio-demographic factors

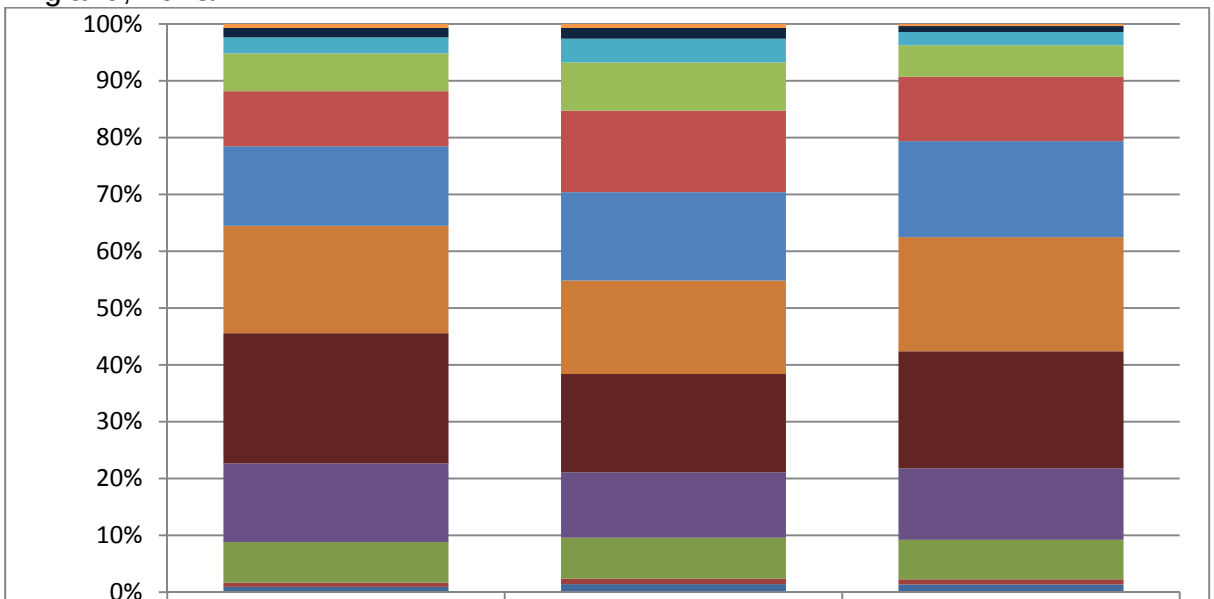
Socio-demographic variables such as age, education, ethnicity and occupational status have been found to be an important risk factor in substance misuse[43] because they have a considerable impact on dependence, morbidity and mortality in the general population. The treatment population profiles for age (

[34] Home Office, Drug Strategy: Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life., 2010
[35] http://guidance.nice.org.uk/CG51
[36] www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf
[37] National Treatment Agency for substance misuse, Building Recovery in Communities (BRiC), 2011.
[38] Ealing Joint Prevention Strategy for Adults 2012-2016
[39] Ealing Clinical Commissioning Group: Better Care, Closer to Home: Our three year strategy for co-ordinated, high quality care out of hospital; 2012-2015
[40] Home Office and Ministry of Justice, Integrated Offender Management Key Principals, 2010.
[41] Public Health England, Drug data: JSNA support pack, Key data for planning for effective drugs prevention, treatment and recovery in 2015-16, 2014.
[42] Office of Science and Technology, Foresight Drugs Futures 2025? The Scenarios, 2005
[43] Swendsen, J. et al., Socio-demographic risk factors for alcohol and drug dependence: the 10-year follow-up of the national comorbidity survey. Addiction. 2009, 104(8): 1346–1355.

Figure 1) shows that Ealing has a higher proportion of 25-29 year olds than regional and national averages and in terms of ethnicity (In terms of gender balance for those in treatment, males account for 83% of the treatment cohort which is marginally higher than London and nationally. An area that needs to be focused on is that of the removal of barriers to encourage more women into treatment services.

Figure 2) there is a lowe percentage of white British in the treatment population than regional and national measures although this group is still the largest in the borough. Those falling within the Asian Ethnicities (Indian, Pakistani, Bangladeshi) account for the second most prevalent group.

Figure 1: Age profile of drugs misuse treatment population, Ealing, London & England, 2013/14

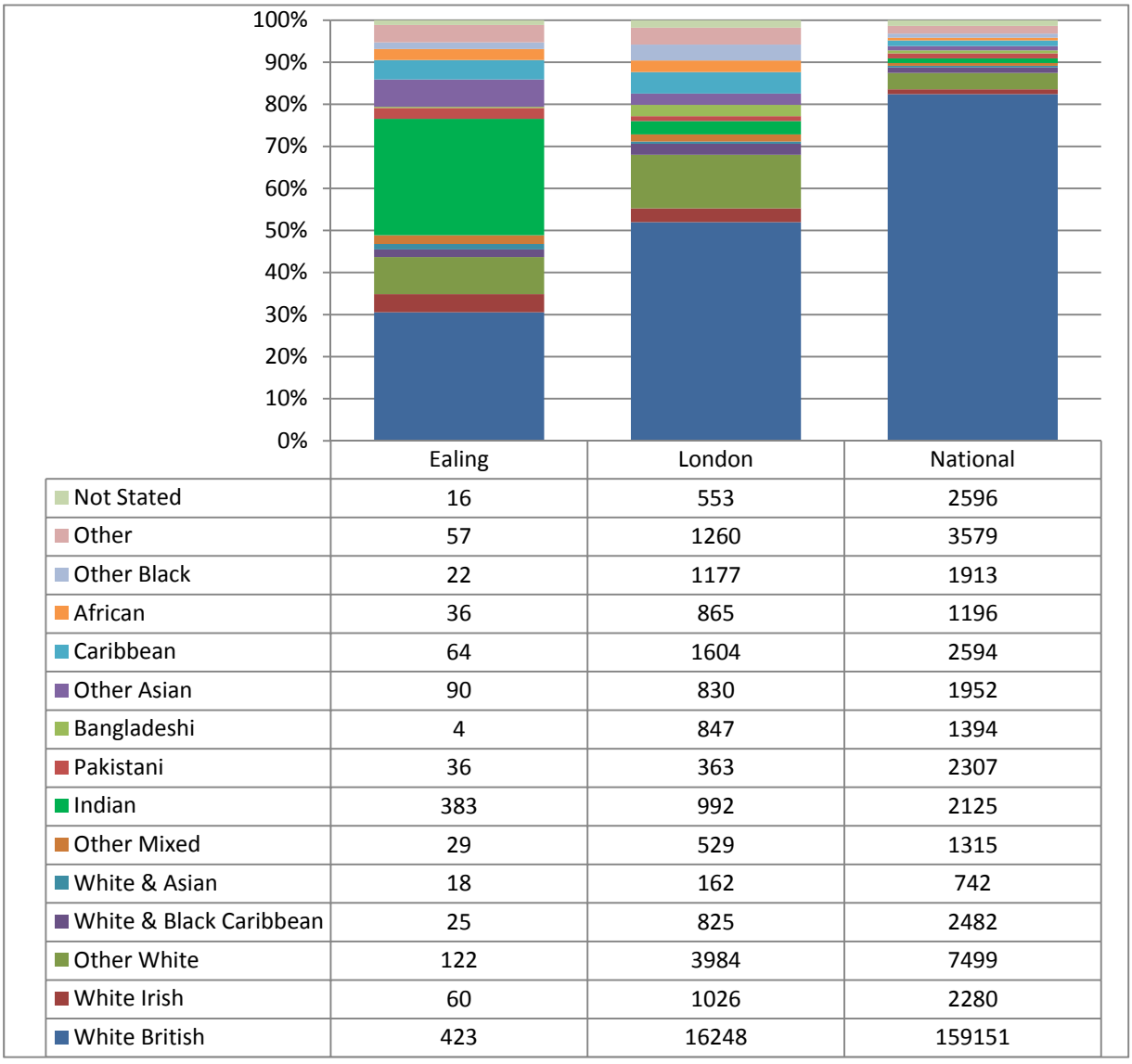



| | Ealing | London | National |
|---|---|---|---|
| 65+ | 10 | 227 | 734 |
| 60 – 64 | 23 | 589 | 2019 |
| 55 – 59 | 39 | 1298 | 4509 |
| 50 – 54 | 92 | 2666 | 10704 |
| 45 – 49 | 134 | 4478 | 21884 |
| 40 – 44 | 194 | 4862 | 32624 |
| 35 – 39 | 262 | 5139 | 38803 |
| 30 – 34 | 317 | 5408 | 39761 |
| 25 – 29 | 192 | 3602 | 24319 |
| 20 – 24 | 99 | 2250 | 13429 |
| 19 | 10 | 309 | 1731 |
| 18 | 13 | 437 | 2608 |

*Source: NDTMS Green Report 13-14*

In terms of gender balance for those in treatment, males account for 83% of the treatment cohort which is marginally higher than London and nationally. An area that needs to be focused on is that of the removal of barriers to encourage more women into treatment services.

Figure 2: Ethnicity of drugs misuse treatment population, Ealing, London & England, 2013/14




| | Ealing | London | National |
|---|---|---|---|
| Not Stated | 16 | 553 | 2596 |
| Other | 57 | 1260 | 3579 |
| Other Black | 22 | 1177 | 1913 |
| African | 36 | 865 | 1196 |
| Caribbean | 64 | 1604 | 2594 |
| Other Asian | 90 | 830 | 1952 |
| Bangladeshi | 4 | 847 | 1394 |
| Pakistani | 36 | 363 | 2307 |
| Indian | 383 | 992 | 2125 |
| Other Mixed | 29 | 529 | 1315 |
| White & Asian | 18 | 162 | 742 |
| White & Black Caribbean | 25 | 825 | 2482 |
| Other White | 122 | 3984 | 7499 |
| White Irish | 60 | 1026 | 2280 |
| White British | 423 | 16248 | 159151 |

*Source: NDTMS Green Report 2013-14*

**Error! Reference source not found.**shows the self-reported housing status of adult clients at the start of treatment. In 2012/13, 15% had a housing problem. A safe, stable home environment enables people to sustain their recovery, on the on the

hand insecure housing or homelessness threatens it. Addiction and homelessness do not exist in isolation; people experiencing both are likely to have a range of needs cutting across health and social care, substance use and criminal justice.

Table 1: Accommodation status at the start of treatment, Ealing drug misuse clients, 2012/13

| Accommodation status at the start of treatment | Local | Proportion of eligible clients |
|---|---|---|
| Urgent problem | 76 | 12% |
| Housing problem | 97 | 15% |
| No housing problem | 468 | 73% |
| Other | 4 | 1% |
| Not stated/Missing | 0 | 0% |

*Source: NDTMS Green Report 13-14*

**Impact on local population**

Treatment engagement is paramount because when people are engaged in treatment, they use less illegal drugs, commit less crime, improve their health, and manage their lives better, resulting in wider societal benefits. The information in Table 2 shows the proportion of adults in Ealing in 2013-14 who have been in treatment for 3 months or more, this is a measure for effective treatment engagement.

In 2013-14 the rate of growth dropped by 3%, whereas the non-opiate users rate grew by 3%. The percentages given are as a proportion of all clients in treatment in 2013-14. Growth is shown comparing the numbers in effective treatment in 2013-14 compared to the same number in 2012-13. The downward trend of opiate users reflects the general rates of growth across England. To be defined as in effective treatment a client must have started structured interventions and been retained for at least 12 weeks or, if retained for less than 12 weeks, had a successful completion from treatment.

Table 2: Treatment engagement, Ealing drug misuse clients, 2012/13

| Adults effectively engaged in treatment 2013-14 | Local n | Growth from 12-13 | Proportion of treatment population | National n | Growth from 12-13 | Proportion of treatment population |
|---|---|---|---|---|---|---|
| Opiate | 996 | -3% | 93% | 146,001 | -2% | 95% |
| Non opiate | 300 | 3% | 93% | 35,477 | 5% | 88% |
| All | 1,296 | -2% | 93% | 181,478 | 0% | 94% |

*Source: NDTMS Green Report 13-14*

**Blood-Borne Virus (BBV)**

Table 3 shows the drug users in treatment who have had a hepatitis B vaccination and current or past injectors who have been tested for hepatitis C. Drug users who share injecting equipment can spread BBVs. Provision of methadone and sterile

injecting equipment protects individuals and communities, and provides long-term health savings. In Ealing, 71% of service users received screening against a national average of 80%. Ealing public health and RISE have co-produced an action plan to address this performance which is monitored monthly.

Table 3: Drug users in treatment who have had a hepatitis B vaccination and current or past injectors who have been tested for hepatitis C, 2013/14.

| Drug users | Ealing | Proportion of eligible clients | National | Proportion of eligible clients |
|---|---|---|---|---|
| **Adults new to treatment eligible for a HBV vaccination who accept one** | 347 | 69% | 20,803 | 43% |
| **Of those:** | | | | |
| **- Proportion started a course of vaccination** | 41 | 12% | 5,384 | 26% |
| **- Proportion completed a course of vaccination** | 71 | 20% | 6,668 | 32% |
| **Previous or current injectors eligible for a HCV test who receive one** | 270 | 71% | 79,001 | 80% |

*Source: NDTMS Green Report 13-14*

## Parents with children

An estimated 1 in 3 of the English treatment population (64,862 people) has a child living with them at least some of the time. The Department for Education estimates that parental drug use is a factor for around a third of the 120,000 most troubled families. Average household size is increasing, and one in five Ealing families who have dependent children have three or more of them. In 2012/13 RISE supported 342 substance misusing parents who lived with their children, representing 17% of the entire caseload. Ealing rates of successfully helping parents to recover are much higher than national averages[44].

## Dual diagnosis

Dual diagnosis can be broadly defined as the co-existence of mental health and substance misuse problems. The use of non-prescribed drugs and alcohol can make mental health symptoms worse and trigger acute illness relapse, the converse is also true. Research suggests that between 22 and 44% of adult psychiatric inpatients also have problematic drug or alcohol use, up to half being drug dependent[45]. Similarly psychiatric disorders may lead to harmful or dependent substance use. It can be difficult to determine with certainty the precise nature of this relationship, resulting in the 'chicken' and 'egg' syndrome, which often affect the quality and nature of care that is given.

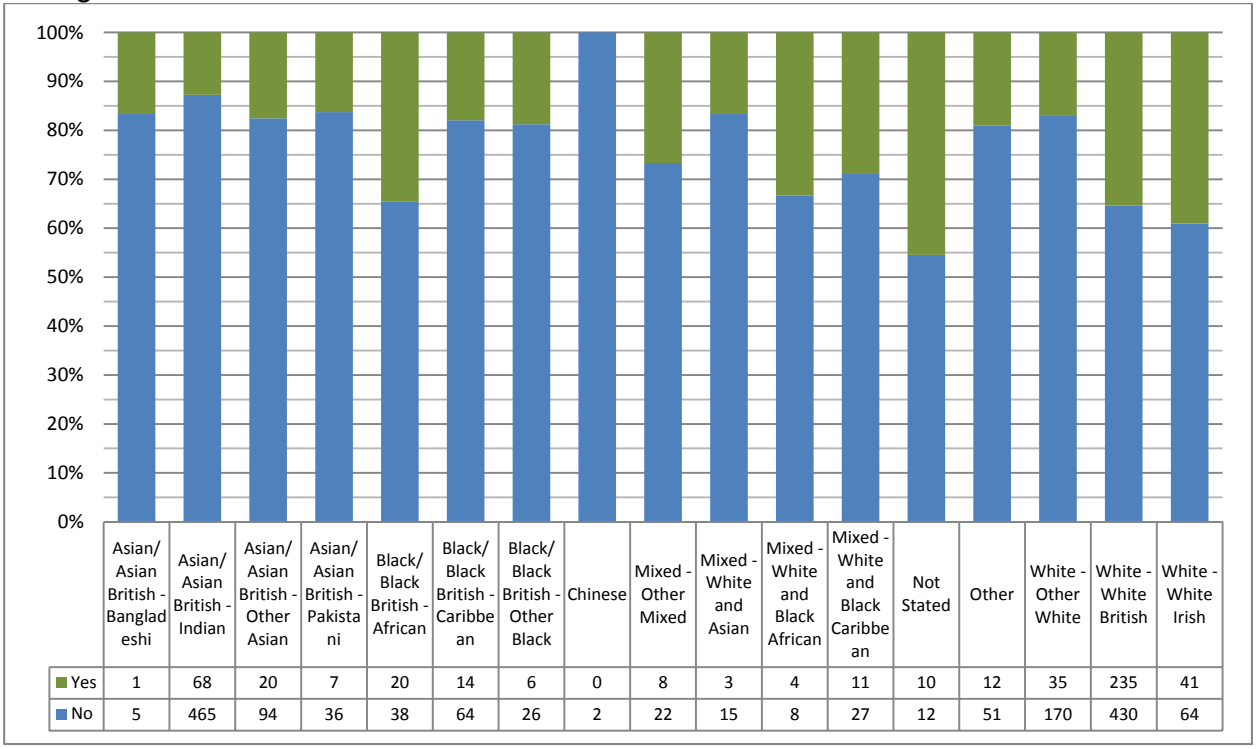
Historically, mental health services have evolved separately from drug and alcohol services. The majority of staff working in mental health services are not trained to assess and treat substance misuse. Since substance misuse is so prevalent among mental health service users, simple prevention and treatment interventions for harmful substance use need to be part of the core skills of mental health practitioners, with appropriate support provided by drug and alcohol practitioners.

[44] Diagnostic Outcomes Monitoring Framework Executive Summary (DOMES), Public Health England, 2013/14.

[45] Weaver et al. Co-morbidity of substance misuse and mental illness collaborative study. Imperial College of Science, Technology and Medicine. 2002.

In Ealing 24% of service users presented to drug and alcohol treatment services with dual diagnosis, 35% were female and 65% were male. The highest prevalence was amongst the White Irish, White British and Black African ethnicities.

Figure 3: Drug users in treatment reporting mental health problems (n= 2,024), Ealing, 2013/14




| | Asian/ Asian British - Bangladeshi | Asian/ Asian British - Indian | Asian/ Asian British - Other Asian | Asian/ Asian British - Pakistani | Black/ Black British - African | Black/ Black British - Caribbean | Black/ Black British - Other Black | Chinese | Mixed - Other Mixed | Mixed - White and Asian | Mixed - White and Black African | Mixed - White and Black Caribbean | Not Stated | Other | White - Other White | White - White British | White - White Irish |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Yes | 1 | 68 | 20 | 7 | 20 | 14 | 6 | 0 | 8 | 3 | 4 | 11 | 10 | 12 | 35 | 235 | 41 |
| No | 5 | 465 | 94 | 36 | 38 | 64 | 26 | 2 | 22 | 15 | 8 | 27 | 12 | 51 | 170 | 430 | 64 |

*Source: RISE 2013-14*

**Treatment Outcomes**

The data in Table 4 is drawn from the Treatment Outcomes Profile (TOP), which tracks the progress drug users make in treatment. This includes information on rates of abstinence from drugs and statistically significant reductions in drug use and injecting, and those successfully leaving treatment with secure housing and in work. Data from NDTMS suggests that clients who stop using illicit opiates in the first 6 months of treatment are almost 5 times more likely to complete successfully than those that continue to use.

Abstinence is defined as the number and proportion of clients who reported using opiates, crack cocaine, powder cocaine, amphetamines, cannabis or alcohol (adjunctive) respectively at the time of their start TOP that have stopped using by the time of their treatment review TOP, in 2013-14. Ealing performances above the national abstinence rates in all but 2 substances, cannabis and alcohol (adjunctive).

In addition to those achieving abstinence, TOPS also measures those who significantly reduce their substance misuse. Ealing performs above national, with significant reduction rate across all substances with the exception of Crack and Cocaine.

Table 4: Impact of drug use, Ealing and England, 2013/14

| | Abstinence | | | Significant reductions in use | | |
|---|---|---|---|---|---|---|
| | Local | | National | Local | | National |
| Opiate | 136 | 47% | 42% | 77 | 26% | 25% |
| Crack | 82 | 65% | 50% | 10 | 8% | 12% |
| Cocaine | 28 | 70% | 65% | 2 | 5% | 11% |
| Amphetamines | 0 | | 51% | 0 | | 18% |
| Cannabis | 25 | 32% | 36% | 24 | 31% | 25% |
| Alcohol (adjunctive) | 15 | 21% | 35% | 18 | 26% | 18% |

*Source: NDTMS Green Report 13-14*

As per Table 5, Ealing has excellent treatment outcomes when compared against national figures for the following areas:

- Injecting use - For clients who reported having injected in the last 28 days on their treatment start TOP, the number and proportion who reported no days of injecting at review. The data is then split by gender.
- Housing need - For clients who reported a housing issue on their treatment start TOP, the number and proportion of clients who successfully completed treatment who didn't report a housing problem at the end of treatment. The data is then split by gender.
- Employment -The number and proportion of clients who successfully completed treatment reported working at least 10 days of paid work in the last 28 days at the time of their exit TOP. The data is then split by gender.

Table 5: Treatment outcomes Ealing and England, 2013/14

| Injecting use, housing need and employment | Local | | Gender split (M/F) | National | | Gender split (M/F) |
|---|---|---|---|---|---|---|
| Adults no longer injecting at review | 33 | 79% | 77% / 86% | 4,913 | 57% | 57% / 55% |
| Adults successfully completing treatment no longer reporting a housing need | 80 | 92% | 91% / 95% | 4,605 | 88% | 88% / 88% |
| Adults working ten or more days in the month before successfully completing treatment | 93 | 30% | 33% / 19% | 7,028 | 27% | 31% / 16% |

*Source: NDTMS Green Report 13-14*

**Successful completions**

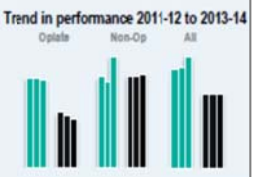
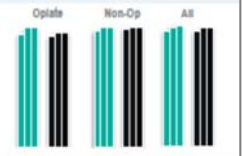
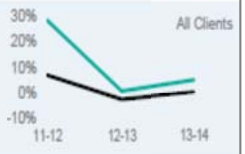
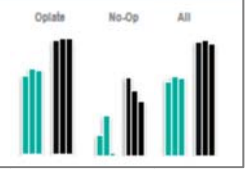
Successful completions are defined as those leaving treatment free of problematic substances and not re-presenting to treatment within 6 months of discharge which is indicative of sustained recovery. Table 6 below illustrates Ealing performance in comparison to national rates

The drug strategy asks local areas to increase the number of people successfully leaving treatment having overcome dependence. Although many individuals will require a number of separate treatment episodes spread over many years, most individuals who complete successfully do so within two years of treatment entry. Also below is the proportion of adults who have been in treatment for more than two years – the data indicates that the likelihood of clients completing treatment and not re-

presenting decreases the longer they remain in treatment over 2 years. Ealing performance is better than the national average.

Table 6: Drug users successfully completing treatment, Ealing & England, 2013/14

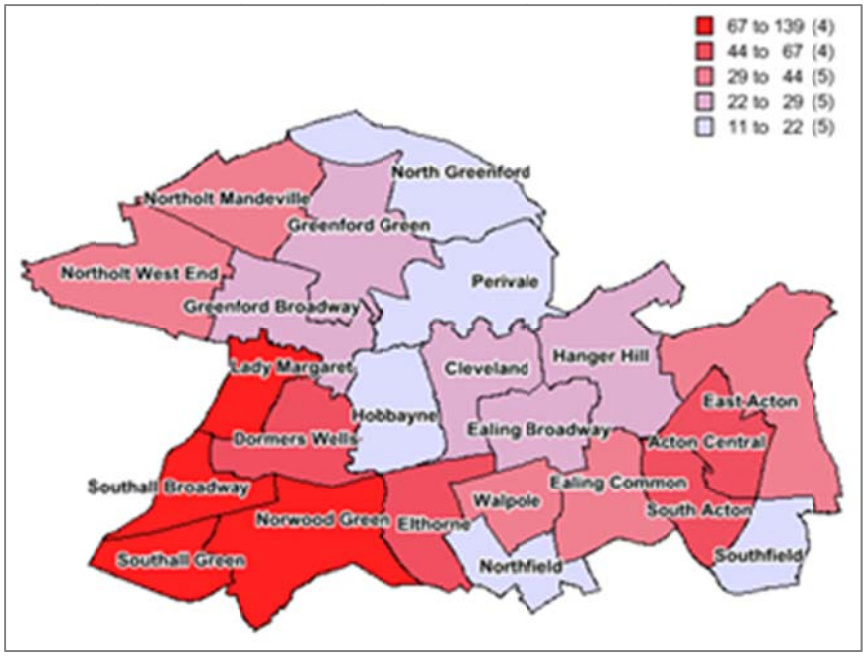
Local ● National ●

| | | Local | Gender split (M/F) | National | Gender split (M/F) | Trend in performance 2011-12 to 2013-14 |
|---|---|---|---|---|---|---|
| Successful completions as a proportion of total number in treatment | Opiate | 14% | 14% / 15% | 8% | 8% / 9% |   |
| | Non opiate | 50% | 46% / 61% | 41% | 42% / 40% | |
| | All | 23% | 21% / 30% | 15% | 15% / 15% | |
| Proportion who successfully completed treatment and did not return within 6 months | Opiate | 85% | 85% / 86% | 81% | 80% / 85% |   |
| | Non opiate | 94% | 93% / 98% | 95% | 95% / 95% | |
| | All | 90% | 89% / 94% | 89% | 88% / 90% | |
| Growth in successful completions since 2012-13 | Opiate | -6% | Gender split not available in 2012-2013 | -7% | Gender split not available in 2012-2013 |   |
| | Non opiate | 19% | | 7% | | |
| | All | 5% | | 0% | | |
| Proportion of adults in treatment for two years or more | Opiate | 39% | 39% / 37% | 53% | 52% / 58% |   |
| | Non opiate | 0% | 0% / 0% | 4% | 4% / 6% | |
| | All | 30% | 31% / 25% | 43% | 41% / 48% | |

*Source: Treatment Outcome Profile (TOP)*

*Non opiate (powder cocaine or stimulants) users in treatment* are found in and around Southall as indicated in red (Map 1), this is consistent with previous data as it shows relatively high drug use in areas of deprivation.

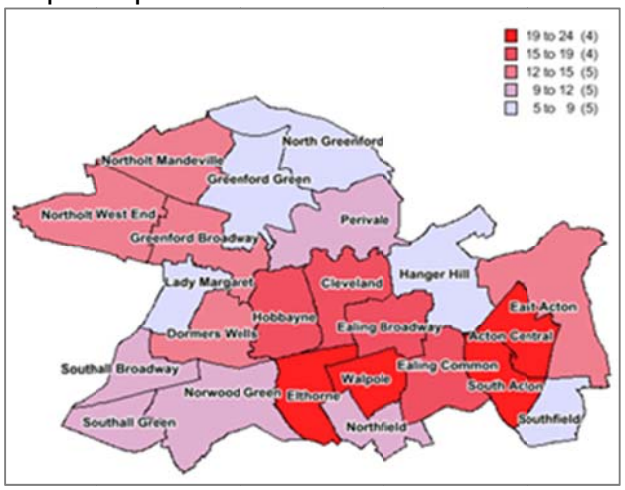
Map 1: Non opiate users in treatment




*Source: NDTMS 2013-14*

*Opiate users in treatment* are clustered around the middle of the borough as indicated in red (Map 2).

Map 2: Opiate users in treatment



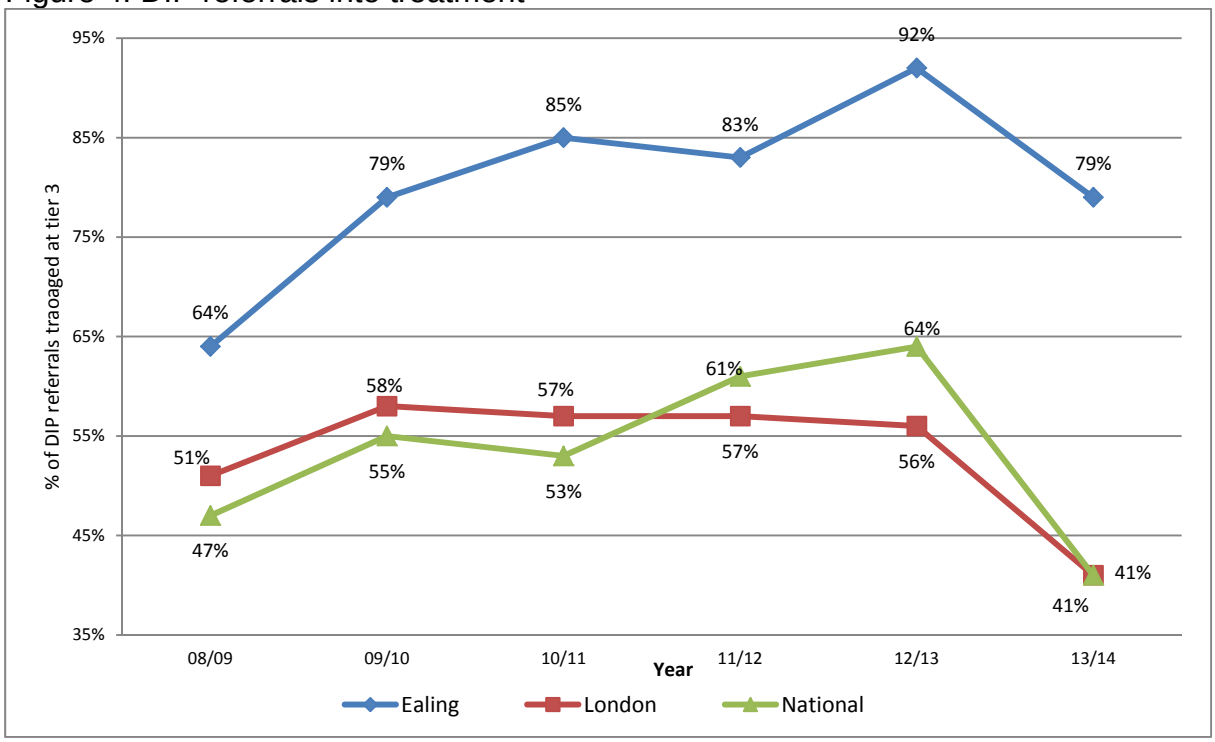

*Source: NDTMS 2013-14*

**Drug Misuse and Crime**

Between one-third and a half of acquisitive crime is estimated to be drug related. Research which matched anonymised data from the Police National Computer

(PNC) and NDTMS showed that the total number of crimes committed almost halved following the start of treatment153. The Drug Interventions Programme (DIP) is a key part of the United Kingdom's strategy for tackling drug abuse. It aims to engage drug-misusing offenders involved in the Criminal Justice system in formal addiction treatment and other support, thereby reducing drug-related harm and reducing offending behaviour. Figure 4 shows the uptake from DIP referrals continues to significantly outperform both regional and national averages, the latest data showing 79% of individuals referred to treatment go onto commence treatment.

Figure 4: DIP referrals into treatment




*Source: NDTMS*

## Related cost implications

An inquiry by the National Audit Office showed that treatment delivers value for money for the taxpayer. It cited the Home Office research finding that every pound spent on treatment delivered £2.50 worth of benefits to society, mostly by cutting crime but also in reduced health and social costs154. In Ealing the costing savings

equate to £3.80 for every £1 invested in treatment services. The figure of £3.80 was provided to us by PHE. They engaged with economists from the Department of Health and the Treasury to work out this figure.

## Current Interventions in Ealing and asset analysis

Drug addiction is treatable, a range of options are available, that address the medical, psychological and social needs of users which balance pharmacological and psycho-social interventions. Treatment seeks to help users recover and to enable them to become free of dependency. It also supports users to become active citizens - take responsibility for their children, earn their own living and keep a stable home. Therefore treatment is the first step on the road to recovery. Drug and alcohol treatment in Ealing has been fully integrated since 2012. For a full asset analysis and details of treatment interventions, please see the alcohol chapter which details the services delivered by the integrated drug and alcohol treatment system.

## Identified needs and intervention gaps

### Dual diagnosis

The prevalence of co-existing mental health and substance use affects between 30% and 70 % of those presenting to health and social care services in Ealing. Mental health and substance misuse problems are major public health and social issues. They are regularly encountered in the general population but are more apparent in health and social care settings.

### Khat

On 24th June 2014, Khat was re-classified as a class C substance, affecting availability and legal status. The recent Khat ban has resulted in a very slow uptake of treatment. In 2013-14 only 8 people presented for treatment and they were all men from either Asian or Black backgrounds. Services have been asset mapping and utilising joint outreach to engage with communities affected by the re-classification of Khat.

### Sex working

A study[46] of how women exit prostitution identifies nine barriers, with the most common ones being criminal convictions, alcohol and drug abuse and a lack of access to safe and appropriate accommodation. The proportion of the treatment population reporting sex working was 14 people and this was predominately females (79%) who are were aged between 25-34 (57%) and from a white ethnic background (57%).

### No Recourse to Public Funds (NRPF)

[46] Bindel, J. et al, (2012) Breaking down the barriers: A study of how women exit prostitution. Eaves and London South Bank University.

In recent years there has been an increase of adults that have NRPF. NRPF applies to a person who is subject to immigration control, does not have the right to work and has no entitlement to welfare benefits, public housing or asylum support. This group is mostly of working age (99%), South Asian (73%) and use opiates (72%). There is a limitation of treatment options for this group due to their status and risks of overdosing, and double prescriptions (due to the fact that we cannot verify their identity they can go get double prescribed which could mean the drugs are sold on the black market or they can overdose)

## Recommendations for Commissioners

1. The impact of drug misuse is wide ranging, affecting health, crime, the economy and wider society. The gains made from treatment need to continue so that they can come into fruition. Therefore funding for the integrated treatment services must be maintained and sustained to address demand and need.
2. Ensure commissioning and operational approaches address the issue of dual diagnosis across the treatment system by working in partnership with the CCG and mental health providers to review current arrangements and develop a strategic approach for 15/16.
3. Work in partnership with surrounding boroughs to ensure that sex workers are able to access treatment and have a route out of prostitution.

4. Conduct a comprehensive needs assessment of substance misuse via engagement with key stakeholders (service users, CCG, criminal justice partners and others), and extension of data sources, to scope the impact of emerging issues, such as NPS.
5. To engage with the Transforming Rehabilitation agenda to ensure effectiveness of the integrated treatment system and alignment with the new Community Rehabilitation Companies.
6. Establish clear treatment pathways for those with NRPF and follow up with an annual audit to assess impact.