DRUGS AND ALCOHOL USE IN EALING

ADULTS

JUNE 2019

Ealing
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CONTENTS

1. INTRODUCTION

Around 1 in 12 (8.5%) of adults aged 16 to 59 in England and Wales had taken an illicit drug in the last year[1]. Not all these people will go on to develop problems with their drug use. A smaller number of people who continue using drugs, experience difficulties because of their use. This type of problematic drug use has a profound impact on individuals, families and local communities, and places a substantial burden on the demand for health, social care, and criminal justice services. The associated shame and stigma surrounding substance misuse often delays people finding help and means some groups remain hidden or harder to engage for longer.

Alcohol is the most widely available and legal drug with a considerable cost to society (Box 1).

Box 1: Harms of alcohol in the UK

- Over 10 million people drink at levels that increase their risk of health harm.
- Alcohol is now the leading risk factor for ill-health, early mortality and disability in 15 to 49 year olds in England.
- More working years are lost to alcohol than the 10 most frequent cancer types combined.
- Liver disease has seen a 400% increase between 1970 and 2008
- Annually, there are now over 1 million hospital admissions relating to alcohol, half of which occur in the lowest three socio-economic deciles.
- Alcohol-related harms are often suffered by other people as alcohol is associated with social consequences such as loss of earnings or unemployment, family or relationship problems and crime and disorder.

Source: Public Health Burden of Alcohol & the Effectiveness and Cost-Effectiveness of Alcohol Control Policies 2016

Treatment services are increasingly working with people who have experienced several **Adverse Childhood Experiences (ACE)** and trauma. Problematic drug and alcohol use is often a symptom or coping mechanism for something far deeper. This means recovery is often complex and relapse is frequent. The revised (July 2017) UK guidelines on clinical management for drug misuse and dependence recommend drug treatment services

[1] Drug Misuse: findings from the 2016 to 2017 Crime Survey for England and Wales: Home Office

recognise the 'high levels of trauma exposure in substance misusers' and create an emotionally and physically safe space as part of this **trauma-informed practice**, supporting the individual through strengths and resilience-based practice. There are four main **enablers for recovery**, and treatment services support people to build on their strengths and develop these aspects of their lives to enhance stability and freedom from dependence.

- Human capital: health & wellbeing, knowledge, skills and experience
- Social capital: family, friends & relationships
- Cultural capital: a sense of identity and values that link to social integration
- Physical and economic capital: housing, money, education, training and employment.

While treatment attempts to support people with the complex issues driving their problematic use, there is a strong focus on **harm minimisation** work to help reduce risk and keep people safer. This work has become more imperative with recent increases in drug related deaths and the emerging threat of heroin markets adulterated with stronger substances like fentanyl (50-100 times more potent than morphine), and fentanyl analogues, including carfentanil.

2. NATIONAL AND LOCAL POLICY CONTEXT

NATIONAL DRUG STRATEGY

Four Strands:

- Reducing demand
- Restricting supply
- Building recovery
- Global action

2 main overarching aims:

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

Progress assessed through six Public Health Outcomes Framework (PHOF) measurements

Successful completion of drug treatment – opiate users

Successful completion of drug treatment – non-opiate users

Successful completion of alcohol treatment

Deaths from drug misuse

Adults with substance misuse treatment need who successfully engage in community-based structured treatment flowing release from prison

Admissions episodes for alcohol related conditions

DAME CAROL BLACK REVIEW

Independent review to determine the best approach for supporting benefit claimants with potentially treatable conditions.
Recommended further exploration into ways people addicted to drugs and alcohol can be helped to find work and improved joined-up working between work and health services.
Led to planned trials of Individual Placement Support (IPS) programmes in drug and alcohol settings. Ealing's IPS service is live for 3.5 years from January 2019.

MODERN CRIME PREVENTION STRATEGY

Strategy describes how the impact of drugs on crime and disorder can be mitigated through:

- Treatment – care pathways into and from the criminal justice system
- Prevention – confidence, resilience and effective decision-making skills' programmes and brief interventions in health, criminal justice and social care services

- Enforcement – policing interventions in hotspot areas accompanied by wider community initiatives including outreach.
- Alcohol as a driver for crime – improving local intelligence sharing e.g. health data to support licensing decisions; increasing court-imposed sobriety orders; and cumulative impact policies.

ROUGH SLEEPING STRATEGY

The government has committed to halving rough sleeping by 2022 and ending it by 2027. The strategy is backed by a £100 million of funding and Ealing has received some of this money under the Rough Sleeper Initiative, which covers the cost for a complex needs outreach worker to increase the number of rough sleepers into treatment with dedicated assessment slots at RISE, improving their chances of maintaining their housing placements.

The strategy has three strands: Prevent; Intervene; and Recover:

Prevent

- Funding for a range of pilots including support for people leaving prison & for care leavers with complex needs
- Review of current legislation around Rough Sleeping including the Vagrancy Act to prevent discrimination against homeless people.
- Research to inform work around particular cohorts e.g. LGBT community.
- Process for learning from any deaths or incidents of serious harm of people who rough sleep.
- Work around improving the affordability of the private rented sector to prevent homelessness.

Intervention

- An additional £45 million to continue the Rough Sleeping Initiative with money for additional bed spaces and staff.
- £17 million to support the development of Somewhere to Stay Pilots and additional funding for rough sleeping care navigators.
- Additional money for mental health and substance misuse support along with money from NHS England to finance targeted health services for rough sleepers.
- A frontline training programme covering issues including Spice, modern slavery, domestic abuse and effective support for LGBT people.
- Funding to support non-UK nationals sleeping rough
- Additional funding for StreetLink to support the community to make referrals of rough sleepers to outreach teams

Recovery

- Range of schemes to support building and delivering new homes for people who sleep rough.
- Tenancy sustainment schemes to support rough sleepers in their homes
- Homelessness experts to work in every Jobcentre Plus.

EALING CORPORATE PLAN – FUTURE EALING

The council has three new priorities for the borough.

- **Genuinely affordable housing**

Working with landlords to improve renting in the borough; continuing house building and estate regeneration programmes; demanding that homes in the borough are of a good quality and safe to live in; and helping to tackle homelessness.

- **Opportunities and living incomes**

Continuing to find ways to attract investment and jobs by maximising regeneration opportunities such as Crossrail, as well as helping young people reach their potential.

- **A healthy and great place**

Working with residents to keep them physically active, well and independent; helping those who need care to live better lives; encouraging sport and leisure; and striving to improve our air quality and reduce crime.

https://www.ealing.gov.uk/downloads/download/233/corporate_plan

Residents are physically and mentally healthy, active and independent

As part of transformation outcome 4 (residents are physically and mentally healthy, active and independent), Ealing is attempting to reduce the alcohol related hospital admission rate. There are several activities sitting underneath this target:

- increase the number of people in alcohol treatment
- increase the use of the AUDIT (alcohol screening tool) in primary care health checks to identify more people amongst the 40-74 age range drinking at increased risk or dependently and provide with information and brief advice or onward referral to RISE (Ealing's integrated drug and alcohol treatment system.)
- increase the number of people across the borough trained up as Making Every Contact Count (MECC) trainers to increase the opportunities for conversations about alcohol.
- increase the number of organisations working in Ealing signed up to the Healthy Workplace Charter, offering support to employers around their HR response to alcohol issues amongst their workforce.

SAFER EALING STRATEGY 2017-2021

The Safer Ealing Partnership reviewed its strategy and ways of working in the light of Future Ealing. The partnership approach covered several ways of working to support the overall Future Ealing outcome of a place where crime is down and Ealing residents feel safe, with a **focus on tackling vulnerability,**

building confidence and resilience through promoting early intervention and prevention.

The partnership approach uses intelligence, and information sharing to support problem identification, solving and targeting, and champions **integrated commissioning** as the most effective way of working to deliver positive and sustainable behaviour change for vulnerable and at-risk groups. The Safer Ealing Partnership strategy and action plan informed the allocation of local resources from the Mayor's Office of Police and Crime (MOPAC) London Crime Prevention Fund and enabled local commissioners to develop the Women's Wellness Zone.

EALING HEALTH & WELLBEING STRATEGY

Ealing's Health & Wellbeing Strategy has the following main aims:

- create opportunities to sustain good mental and physical health for children and adults at every stage of life
- reduce health inequalities by improving outcomes for neighbourhoods and communities experiencing poor health
- enable people of working age to participate as fully as possible in working and community life, to improve the health and economic outcomes for them and their households
- enable everyone to be healthy and independent for as long as possible, helping to prevent or delay the need for social and acute care.

The Strategy aims to tackle the following key issues:

- lifestyle factors that contribute to major health conditions such as diet, exercise, smoking and alcohol consumption;
- Ealing's major health conditions that contribute to the burden of ill health: cancers, diabetes and mental illness
- the control that residents can exercise over their own health and their ability to self-manage long term conditions
- neighbourhoods and population groups experiencing, or at greater risk of, poor health the quality of life for older people and their carers
- the wider determinants of health – issues such as deprivation, children living in poverty, poor housing and exposure to crime.

Reducing alcohol hospital admissions is one of the strategy's high-level outcomes

EALING ALCOHOL CLEAR

Alcohol CLeaR is a Public Health England tool to help partnership areas to assess local arrangements and delivery plans for reducing alcohol-related harm. The tool also helps to identify opportunities for further development. Ealing completed the process to inform the JSNA and new substance misuse strategy, and identified the following challenges, opportunities and priorities:

Top 3 challenges	• Increasing access to alcohol treatment at RISE & the number of successful completions for residents with primary alcohol needs. • Ensuring effective joint working by RISE and children's services to deliver high quality interventions for families affected by problematic alcohol use. • Finding a way to bridge the gap between MECC and specialist treatment – how do we deliver an alcohol IBA programme with no identified money?
Top 3 opportunities	• Developing a bid for the Government's Innovation Fund to support local work and thinking around hidden harm provision. • Developing Public Health's role and influence in licensing decisions and the development of the Night Time Economy Strategy. • Supporting the growth and development of Ealing's Women's Wellness Zone providing multi-disciplinary interventions for women with complex needs.
Top 3 priorities going forwards	• Re-establish a structured day programme (within the current budget) at a neutral site. The previous programme had provided effective aftercare for people with alcohol treatment needs away from the 2 chaotic treatment hubs. • Work in partnership with children's services to develop a joint working protocol accompanied by a joint training programme for staff across both disciplines and a co-located worker in Children's Services. • Further develop the alcohol clinic model in primary care so it delivers more effective support and earlier intervention to residents with alcohol needs away from the main treatment hubs.

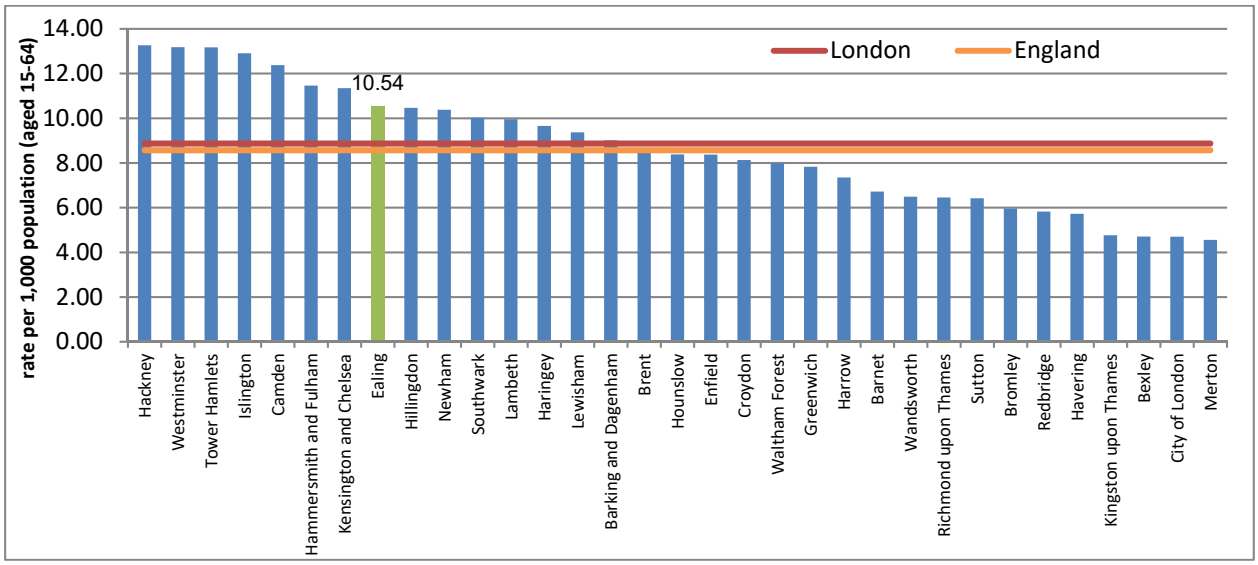
3. LEVEL OF NEED IN EALING

DRUGS

PREVALENCE OF OPIATE AND/OR CRACK USERS (OCU) IN EALING

- There are an estimated 2,464 opiate and/or crack users (OCUs) based on 2014/2015 (mid-point) Glasgow Prevalence Estimation. This is a 4.6% drop in the estimated number of OCUs in 2011/12 (down from 2,583).
- Across London the estimated number of OCUs dropped by 4.5% (down from 54,985 in 2011/12 to 52,487 in 2014/15). Meanwhile, across England the estimated number of OCUs rose by 2.3% (up from 293,880 in 2011/12 to 300,783 in 2014/15).
- The prevalence rate in Ealing is 10.54 per 1,000 people (aged 15-64), which is higher than the average across London (8.87 per 1,000) and compared to England as a whole (8.57 per 1,000) (Figure 1).
- This ranks Ealing 104th out of 153 counties and unitary authorities across England (with the 1st having the lowest rates).

Figure 1: OCU Prevalence Rate per 1,000 population (aged 15-64) in 2014/15



Source: Glasgow Prevalence Estimation (released Sep 2017)

- At the end of March 2019, Liverpool John Moores University published a report on the estimates of the prevalence of crack cocaine and opiate use for 2016-17.
- The table below shows the estimated number of opiate and crack users (OCUs) across Ealing, London and England, and then breaks these down into opiate and crack users and compares the most recent prevalence data with the previous estimates for 2014/15 which were released in September 2017.

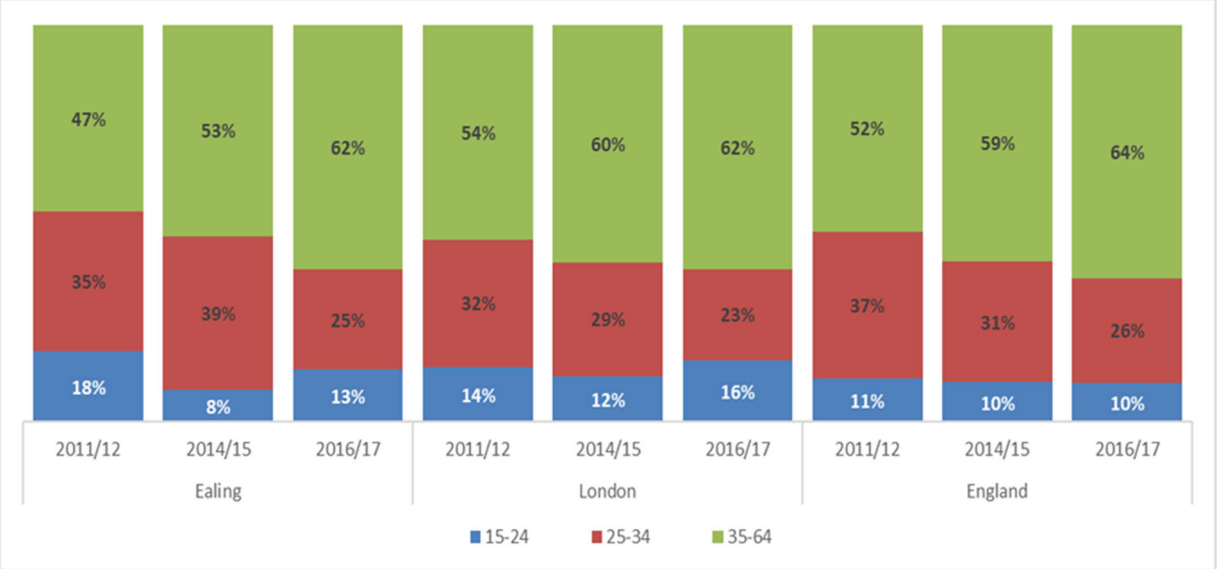
- London has seen a significant change in the prevalence of both opiate and crack users: the number of opiate users is increasing, and the number of crack users is decreasing. These changes are reflected in Ealing's prevalence estimates.

Figure 2: Estimates of Opiate and Crack Cocaine Use Prevalence: 2016/17

	OCU	Difference between 2014/15 & 2016/17	Opiates	Difference between 2014/15 & 2016/17	Crack cocaine	Difference between 2014/15 & 2016/17
Ealing	2,419	-45	2,099	70	1,441	-84
London	56,299	3,812	43,823	3,073	36,116	-3,110
England	313,971	13,188	261,294	3,818	180,748	-2,080

Source: Liverpool John Moores University Prevalence Estimation 2016/17 (released March 2019)

Figure 3: Estimated proportion of OCUs – Age Profile 2011/12, 2014/15 & 2016/17, Ealing, London and England



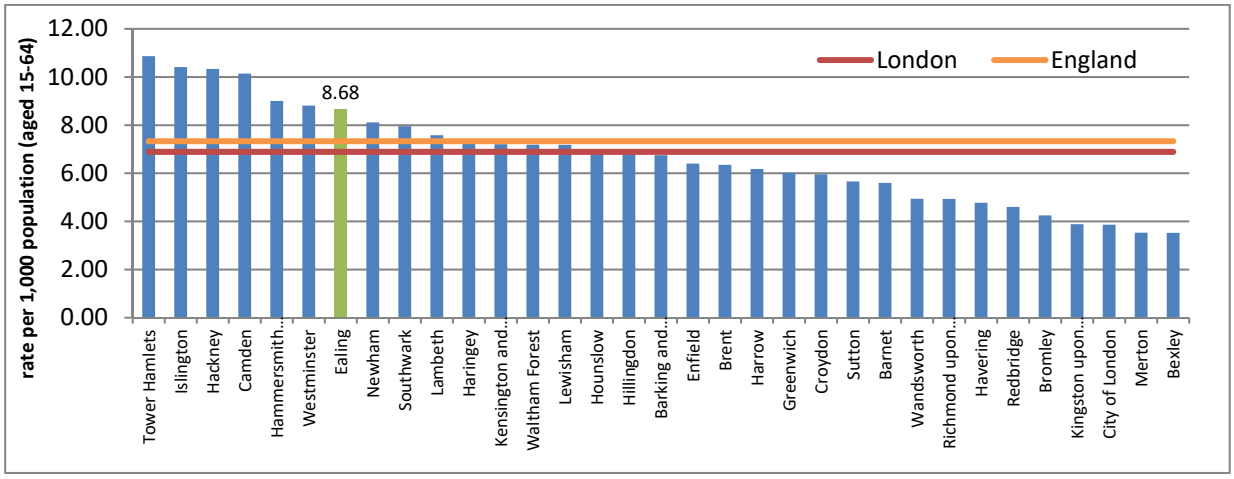
Source: Glasgow Prevalence Estimation 2011/12 (released 2014), 2014/15 (released 2017) & 2016/17 (released 2019)

- Figure 3 shows the changing age profiles for opiate and crack users (OCUs) for Ealing, London and England over the last 3 sets of prevalence estimates (2011/12, 2014/15 & 2016/17)
- Older OCUs in the 35-64 age range across all 3 areas are increasing with each set of prevalence data.

PREVALENCE OF OPIATE USE

- There are an estimated 2,029 opiate users based on 2014/15 (mid-point) Glasgow Prevalence estimation. This is a 9.3% drop on the estimated number of opiate users in 2011/12 (2,236).
- Across London the estimated number of opiate users fell by 7.2% (down from 43,920 in 2011/12 to 40,750 in 2014/15). However, across England the estimated number of opiate users increased by 0.5% (up from 256,160 in 2011/12 to 257,480 in 2014/15).[2]
- The prevalence rate in Ealing is 8.68 per 1,000 people (aged 15-64), higher than the average in London (6.89 per 1,000) and compared to England as a whole (7.33 per 1,000), but this is not a statistically significant difference (Figure 3).

Figure 4: Opiate Use Prevalence Rate per 1,000 Population (aged 15-64) 2014/15



Source: Glasgow Prevalence Estimation (released Sep 2017)

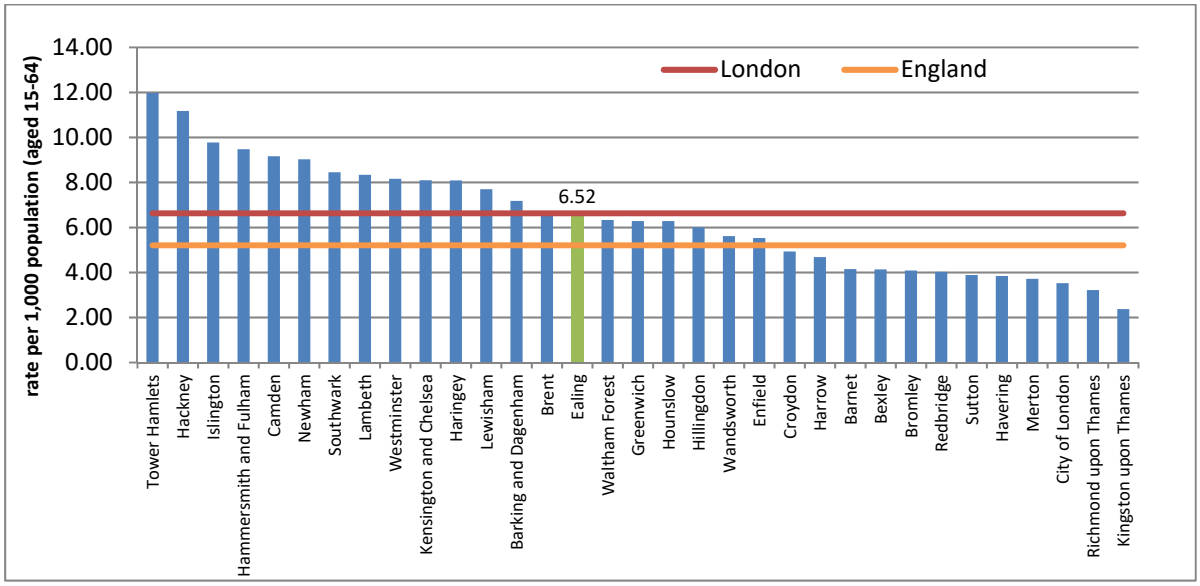
PREVALENCE OF CRACK USE

- There are an estimated 1,525 crack users based on 2014/15 (mid-point) Glasgow Prevalence estimation. This is a 13.4% increase on the estimated number of crack users in the previous year (up from 1,320 in 2011/12).

[2] Numbers of London and England users have been rounded to the nearest 5.

- Across London the estimated number of crack users fell slightly by 2.1% (up from 40,080 in 2011/12 to 39,230 in 2014/15). Meanwhile, across England the estimated number of crack users rose by 8.9% (up from 166,640 in 2011/12 to 182,830 in 2014/15).[3]
- The prevalence rate in Ealing is 6.52 per 1,000 people (aged 15-64) higher than the average for London (6.63 per 1,000) and significantly higher compared to England as a whole (5.21 per 1,000).

Figure 5: Crack Use Prevalence Rate per 1,000 Population (aged 15-64), 2014/15



Source: Glasgow Prevalence Estimation (released Sep 2017)

TREATMENT PENETRATION

- Public Health England measures the effectiveness of treatment systems by comparing how many crack and drug users the treatment system has managed to engage in effective treatment against the prevalence figures for the area modelled by the University of Glasgow. In 2016/17 there were 940 people in treatment for opiate and/or crack use, representing 38% of the estimated number of OCUs in Ealing. This is similar to treatment penetration levels across London (37%) but significantly lower in comparison to England as a whole (49%).
- The table below sets out the OCU treatment penetration levels over the past three years.

[3] Numbers of London and England users have been rounded to the nearest 5

Figure 6: OCU Treatment Penetration Rates, 2014/15 to 2016/17 - Ealing, London and England

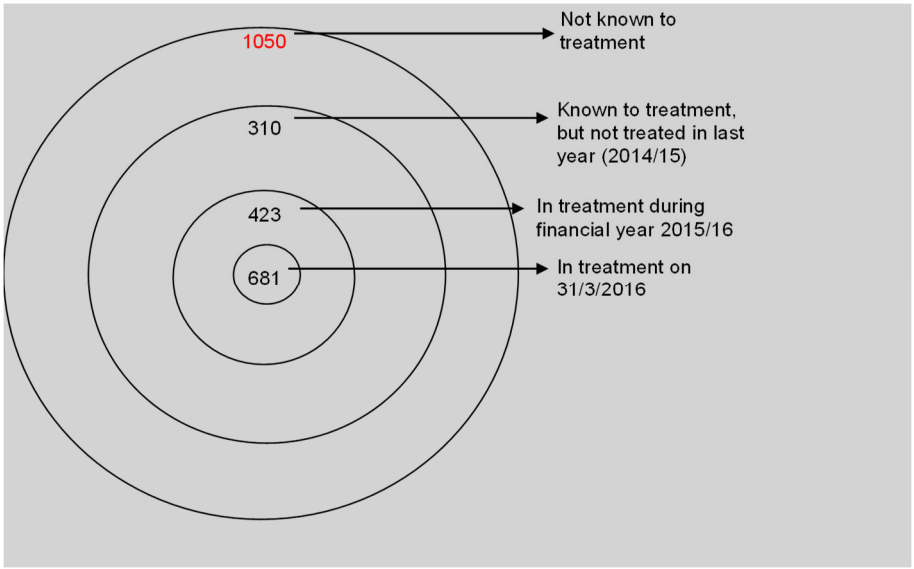
OCU Treatment Penetration	Ealing	London	National
2014/15 estimated OCU population	2,464	52,487	300,783
2011/12 estimated OCU population	2,583	54,985	293,879
Change in estimated OCU population (2014/15 to 2011/12)	-119	-2,498	6,904
% Change in estimated OCU population (2014/15 to 2011/12)	-4.6%	-4.5%	2.3%
Number of OCU's in treatment 2016/17	940	19,431	146,536
OCU treatment penetration 2016/17	38%	37%	49%
Number of OCU's in treatment 2015/16	1063	20,441	149,807
OCU treatment penetration 2015/16	43%	39%	50%
Numbers of OCU's in treatment 2014/15	1086	21,456	152,964
OCU treatment penetration 2014/15	44%	41%	51%
2016/17 OCU treatment penetration level variation from 2015/16	-5.0%	-1.9%	-1.1%

Source: Glasgow Prevalence Estimation Released 2014/15 (released Sep 2017) & PHE, Local Area Trend Report 2016/17 (NDTMS data)

TREATMENT NAÏVE

- Treatment naïve people are those using drugs who have never been in treatment anywhere in England and are a measure of Ealing's unmet need.
- It is estimated there are 2,464 OCUs in Ealing. As there are 1,414 individuals known to treatment (the three inner rings in Figure 5 below), we can estimate that 1,050 OCUs have not had any contact with the structured treatment system over the last two years. These estimated 1,050 OCUs are treatment naïve and equate to 43% of the local OCU population - this is a lower level of unmet need when compared to London (46%) but higher when compared to England as a whole (39%).

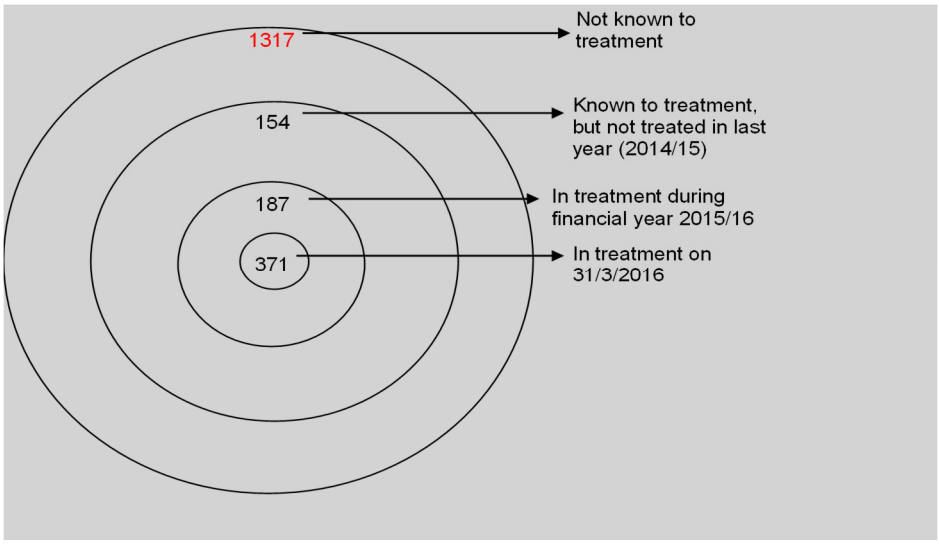
Figure 7: Treatment Naïve OCU



Source: NDTMS Bulls Eye Data 2015/16

- It is estimated there are 2,029 opiate users in Ealing. Using the same calculation as above, there are an estimated 1,317 opiate users who are treatment naïve, equating to 65% of the estimated local opiate population - this is a lower level of unmet need when compared to London (75%) and higher when compared to England as a whole (59%).

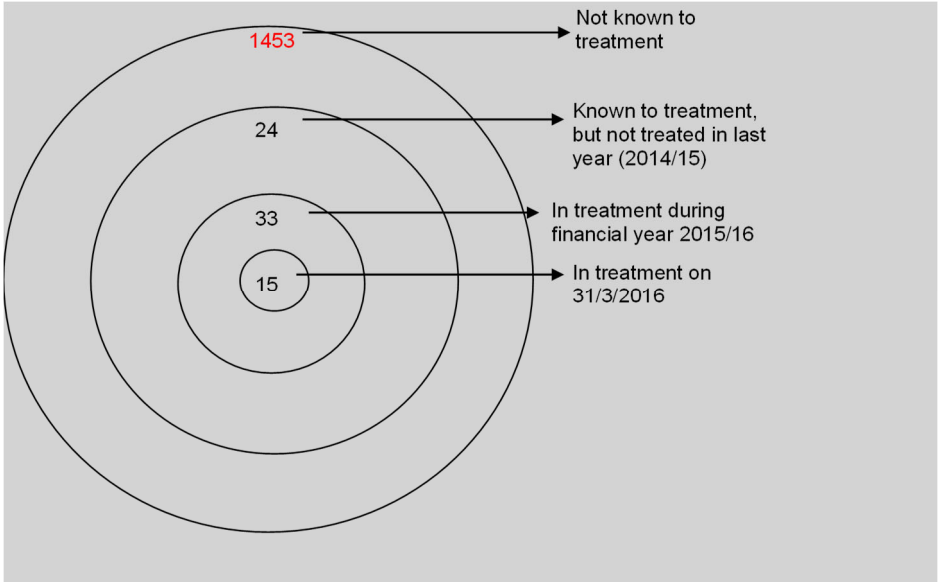
Figure 8: Treatment Naïve Opiate Users



Source: NDTMS Bulls Eye Data 2015/16

- It is estimated there are 1,525 crack users in Ealing. Using the same calculation as above, there are an estimated 1,453 crack users that are treatment naïve, equating to 95% of the estimated crack users in Ealing. This is higher when compared to London's rate of unmet need (93%) but similar to England as a whole (96%).

Figure 9: Treatment Naïve Crack Users



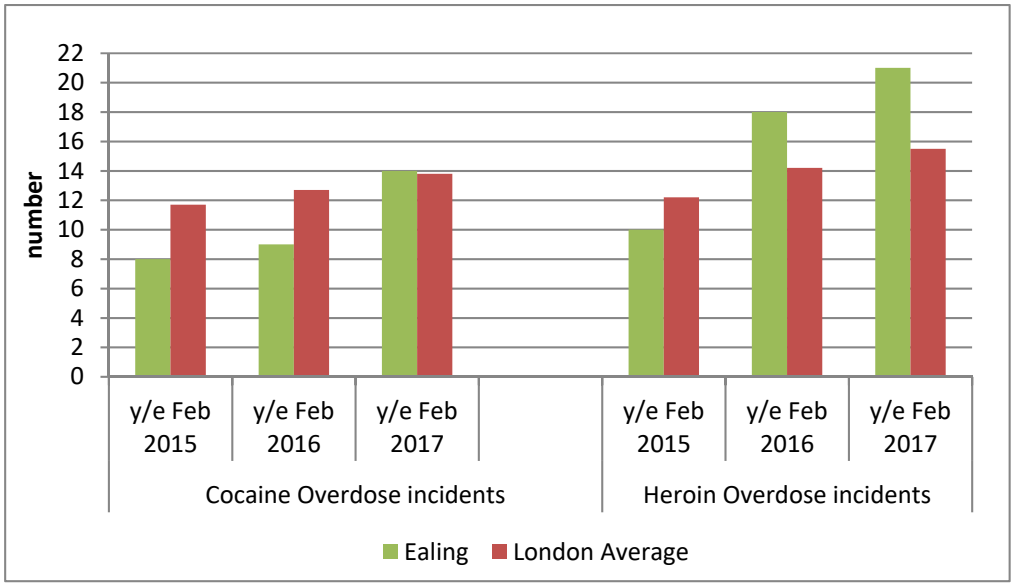
Source: NDTMS Bulls Eye Data 2015/16

OVERDOSES, HOSPITAL ADMISSIONS AND DRUG-RELATED DEATHS

LONDON AMBULANCE SERVICE (LAS) DRUG OVERDOSE INCIDENTS ATTENDED

- In the three-year period between March 2014 and February 2017 there were 80 incidents where the LAS had attended to someone suffering from a cocaine or heroin drug overdose; the same figure compared to the average across London (also 80 incidents).
- In the 12-month period ending February 2017, there were 14 incidents relating to cocaine overdose, (a 36% increase compared to the previous 12 months) and 21 incidents relating to heroin overdose (14% increase compared to the previous 12 months.)
- The chart below shows the number of cocaine and heroin overdose incidents attending by the LAS, compared to the London average.

Figure 10: LAS - Drug Overdose Incidents Attended, March 2015 – Feb 2017



Source: London Ambulance Service Monthly Dispatches and Incidents Report (London Datastore, 2017)

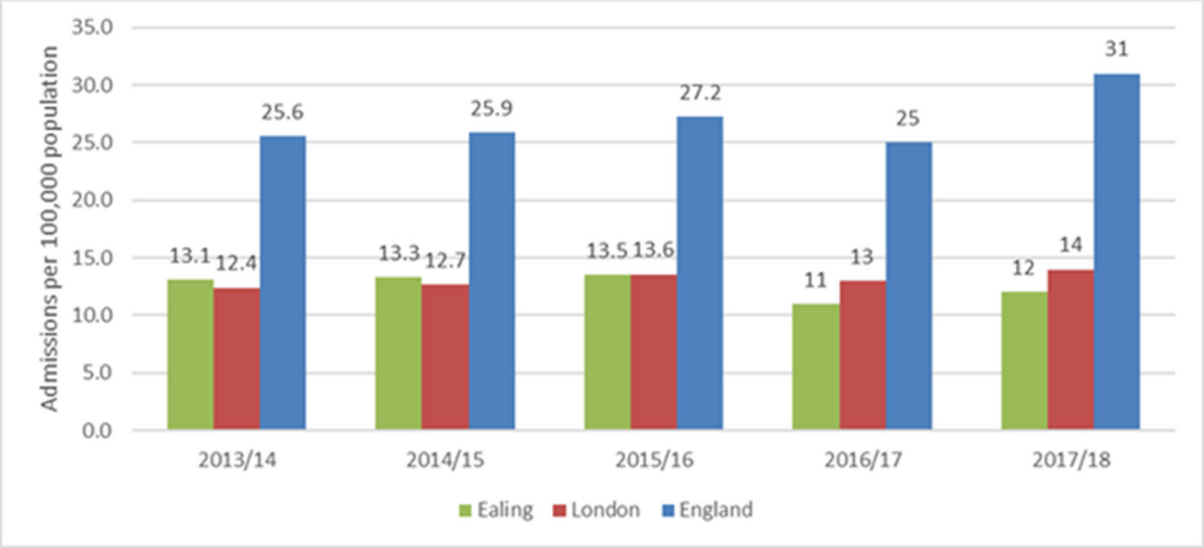
HOSPITAL ADMISSIONS DUE TO DRUG POISONING[4]

- Drug poisoning admissions can be an indicator of future deaths. Evidence shows that people who experience non-fatal overdoses are more likely to experience a future fatal overdose[5].
- As Figure 11 below shows, the hospital admissions rates for drug poisoning in Ealing are significantly lower than the national figures.

[4] This indicator includes poisonings by 'other opioids', which may include poisonings by non-illicit or prescribed opioids.

[5] PHE Drugs JSNA support pack: key data

Figure 11: Hospital admissions for drug poisoning



Source: Statistics on Drugs Misuse, NHS Digital

DRUG RELATED DEATHS: NATIONAL PICTURE

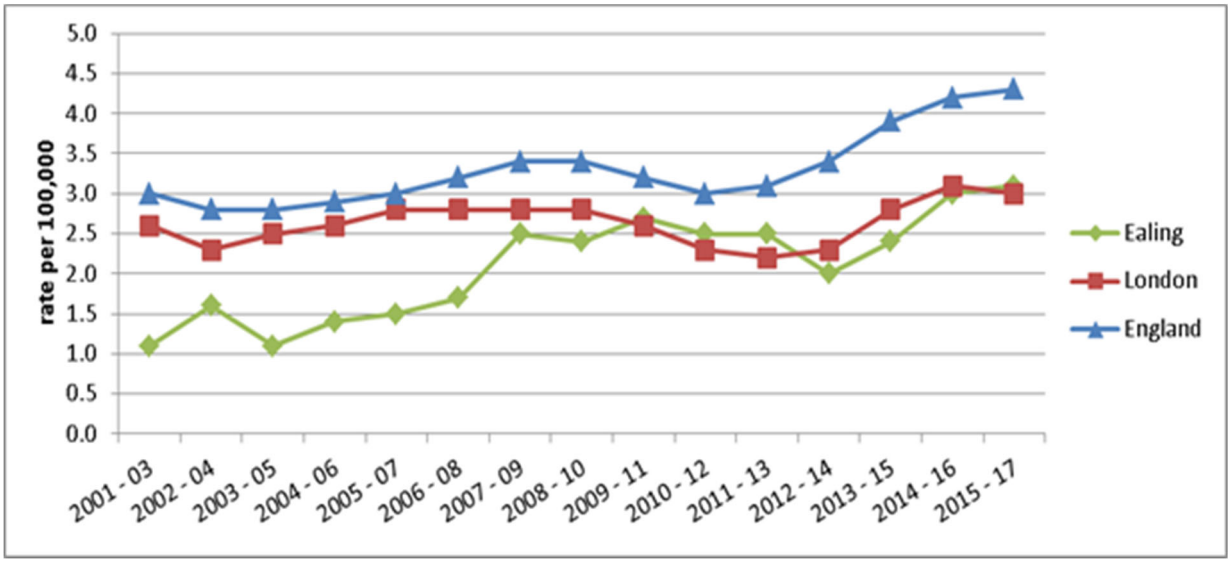
- There were 3,756 deaths relating to drug poisoning registered in England & Wales in 2017 (rate of 66.1 deaths per 1 million population) which is similar to the rate in 2016.
- Two-thirds of these drug-related deaths were related to drug misuse.
- Males' mortality rate decreased from 91.4 deaths per 1 million population in 2016 to 89.6 in 2017.
- The female mortality rate increased for the eighth consecutive year to 42.9 deaths per 1 million population; neither changes were significant. However, twice the number of women died by suicide compared to men, which is a concerning trend.
- The North East had a significantly higher rate than all other English regions; London had a significantly lower rate.
- Deaths involving cocaine and fentanyl continued to rise while deaths related to new psychoactive substances halved in 2017.
- The average registration delay for deaths relating to drug misuse has increased from last year in both England & Wales and it is important to remember these statistics cover the year a death was registered rather than when it occurred, with registration sometimes taking up to two years.

DEATHS FROM DRUG MISUSE: EALING, LONDON & ENGLAND

- The diagram below compares the National, London and Ealing registrations of drug-related deaths from the ONS dataset.
- **There is an upward trend** across all three datasets and figures are now at the highest rates since records began.

- There are several reasons for these increases. The opiate population is ageing and has acquired some severe physical health co-morbidities because of long using histories; poverty; poor diet, exercise, and housing conditions; incarceration; and/or a history of homelessness.
- There are other street drugs available which have led to groups of deaths in certain areas and the presence of fentanyl and other synthetic opiates is an increasing concern. Ealing has a drug alert monitoring system which targets a comprehensive range of partners with intelligence and harm minimisation advice if concerns are raised about fentanyl or other life-threatening drugs or contaminants in the supply chain.
- The economic downturn and austerity in England has had an impact on people's socio-economic circumstances, including income, jobs and housing, which has an impact on people's physical and mental health, which may be contributing to increased deaths due to drug overdose, suicide and long term physical health conditions.
- Austerity has also had an impact with reductions in drug and alcohol treatment provision due to budget cuts. This has often impacted on treatment systems' outreach capacity, which means users outside the treatment system, who are most at risk, are not seeing outreach workers as regularly as they used to for initial engagement and vital harm reduction work, including overdose prevention. Ealing used to have a team of six outreach staff and now has two workers to cover the entire borough, lead on community engagement work, and undertake all the assertive treatment re-engagement work for those who've recently dropped out of treatment at RISE.

Figure 12: Drug Related Deaths – Ealing, London & England



Source: Office for National Statistics (ONS), Aug 2018

DEATHS KNOWN TO THE LOCAL TREATMENT SYSTEM – EALING'S SERIOUS INCIDENT PANEL

- Ealing examines any alcohol or drug related deaths of residents either currently or previously known to the RISE treatment system to see whether there are any lessons to be learnt and noticeable themes or patterns. The meetings are multi-agency discussions and held twice a year with a range of partners including: lead clinicians from RISE; the West London NHS Trust; the prescribing and substance misuse leads from the CCG; Public Health; Mental Health Commissioner; Community Safety; Police; and Ealing's Rough Sleeping Street Outreach team.
- Since September 2015 until October 2018, these meetings have examined 60 deaths (17 women and 43 men), looking for any emerging issues which necessitate a strategic policy response or changes to current commissioning. The meetings also track a series of actions designed to improve local practice and strengthen care pathways and joint working. There are delays with formal cause of death notices from the coroner, and these can sometimes take up to two years to finalise. Consequently, it isn't possible to list the cause of death for all 60 case discussions. However, it is useful to look at some of the recurrent issues and emerging trends.
- The service users were predominantly older (40-70) and had long histories of drug and alcohol misuse, with frequent episodes of disengagement. Their physical health had deteriorated, and a substantial number of the deaths occurred in hospital due to Chronic Obstructive Pulmonary Disease (COPD) or liver disease. The considerable number of deaths due to physical health problems highlighted the need to establish or strengthen pathways with Ealing General Hospital Departments, especially A&E, Respiratory, & Gastrointestinal Departments.
- Following on from some of these case discussions, RISE now runs a joint Hepatology clinic at Ealing Hospital for RISE service users with serious alcohol related liver problems.
- This older client group also face difficulties when they require residential alcohol detoxification. Most of the commissioned services struggle to accommodate service users over 65 with increasingly frail physical health and this issue requires a specialist treatment response with residential detox services finding a way to address this gap in the market with the support of commissioners.
- A review of some of the deaths within the GP shared care setting, has led to RISE auditing the caseload and making sure any residents with more complex needs are moved back into the main treatment hubs where they will receive more clinical input and enhanced access to the full range of recovery support. It has also led to reviewing some of the current operating procedures to make sure increased alcohol use is picked up through regular blood testing and there are clear pathways into alcohol detoxification treatment where required.

  Several cases were known to both RISE and the West London Mental Health Trust, and these discussions have clarified the need for closer working between the two organisations and robust information sharing. A series of actions to support this closer

working have been identified and agreed by the partnership and are referenced in the Trust's co-existing mental health and substance use strategic action plan as well as in the recommendations in this JSNA chapter and are monitored in the action plan for the Serious Incident Panel.

RECOMMENDATIONS

Monitor Ealing's alcohol and drug related deaths and continue with the development of Ealing's Serious Incident Panel where these deaths can be discussed, and any lessons learnt are shared amongst the wider partnership. This includes supporting the development of joint investigations where individuals are known to both RISE and the West London NHS Trust's services.

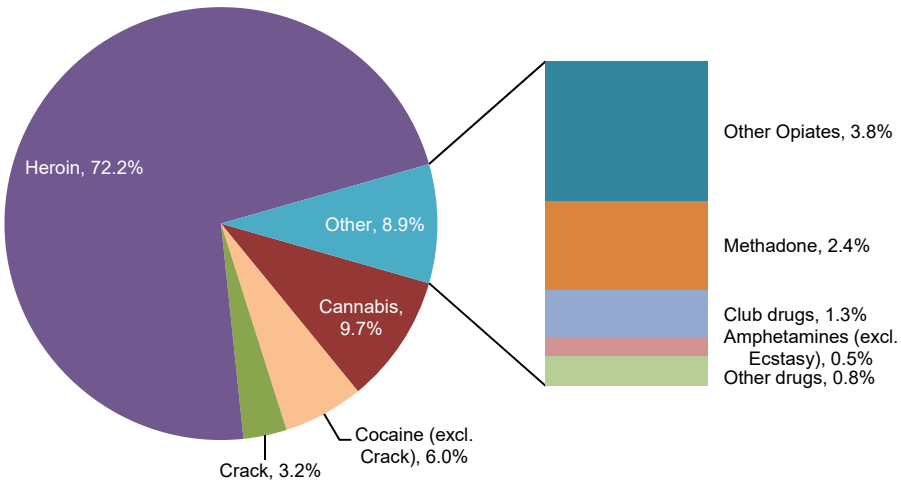
Develop a fentanyl action plan to protect vulnerable service users and reduce the risks of overdose and drug-related deaths should fentanyl appear in the local drug market supply chain.

4. TREATMENT OUTCOMES

PRIMARY DRUG USERS

- In 2016/17, there were 1765 adults (aged 18 and over) in RISE's integrated drug and alcohol treatment in Ealing, with 1,060 people in treatment for primary drug use (60%) and the remaining 705 (40%) in treatment with a primary alcohol need.
- From the 1,060 primary drug users, the majority were heroin users (72.2%), followed by cannabis users (9.7%), and cocaine (6.0%). The remainder were using other opiates, amphetamines (excluding ecstasy), methadone and other drugs such as prescription drugs, club drugs, benzodiazepines, and hallucinogens.

Figure 13: Primary Drug Users in Treatment

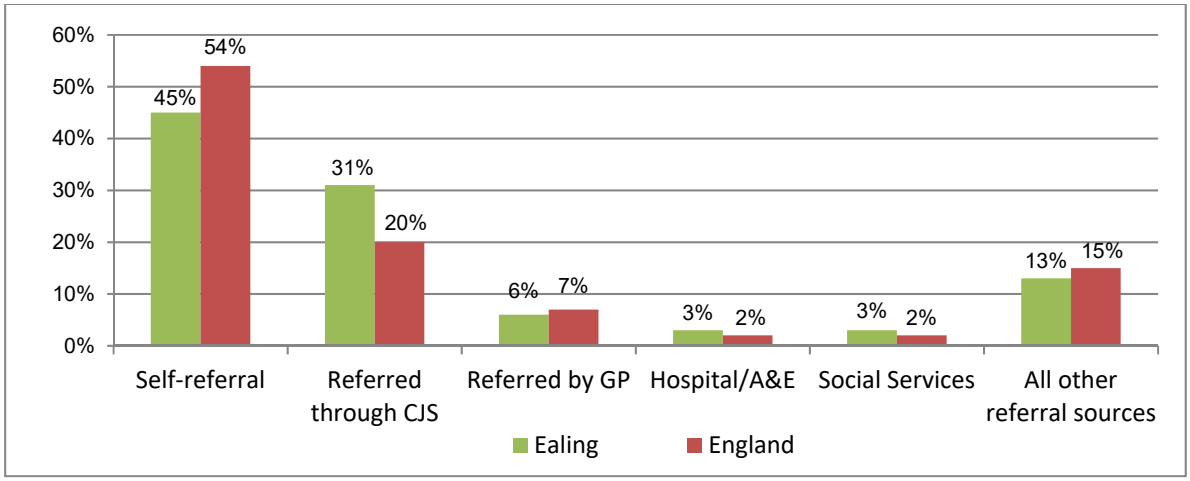


Source: Ealing RISE Data, 2016/17

ROUTES INTO TREATMENT

- The chart below shows the routes into drug treatment in 2016/17. These give an indication of the levels of referrals from criminal justice and other sources into specialist treatment. 'Referred through CJS' means referred through a police custody or court-based referral scheme, prison or the probation/CRC service.
- In Ealing, there were 520 referrals to treatment in 2016/17: the majority of these were self-referrals (45%). This is lower than the national average for self-referrals: 54%. Referrals through CJS were the second highest with 31%, compared to only 20% nationally.

Figure 14: Proportion of referrals by source – 2016/17



Source: PHE Adults – Drugs commissioning support pack 2018/19: key data (published 2017)

ETHNICITY OF DRUG USERS IN TREATMENT

- Ealing has a very diverse treatment population. RISE's local data shows roughly equal numbers of Asian (Indian & other) and White British drug and alcohol users presenting new to treatment in 2016/17. This was when the Southall treatment hub was fully operational.
- These figures changed during 2017/18 when the Southall treatment hub was closed for the year.
- The table below shows all new presentations to RISE's treatment system by ethnicity for 2016/17 & 2017/18.

All new presentations	Local		Proportion of new presentations		Proportion of new presentations by gender			
					2016/17		2017/18	
	2016/17	2017/18	2016/17	2017/18	Male	Female	Male	Female
Asian – Indian	228	165	24%	21%	93%	7%	88%	12%
Asian – other	76	65	8%	8%	93%	7%	94%	6%
Black - African	30	19	3%	2%	77%	23%	63%	37%
Black - Caribbean	47	46	5%	6%	79%	21%	70%	30%
Black – other	21	9	2%	1%	95%	5%	56%	44%
Mixed	53	58	6%	7%	72%	28%	69%	31%
Other/Not stated	41	34	4%	4%	76%	24%	75%	25%
White – British	311	270	32%	34%	70%	30%	70%	30%
White – Irish	53	40	6%	5%	77%	23%	67%	33%
White - other	103	83	11%	11%	81%	19%	81%	19%

- Figure 15 shows the difference in the number of new presentations from the Asian communities during 2016/17 & 2017/18. The lack of a treatment hub in Southall during 2017/18 had a particular effect on the number of new opiate presentations.

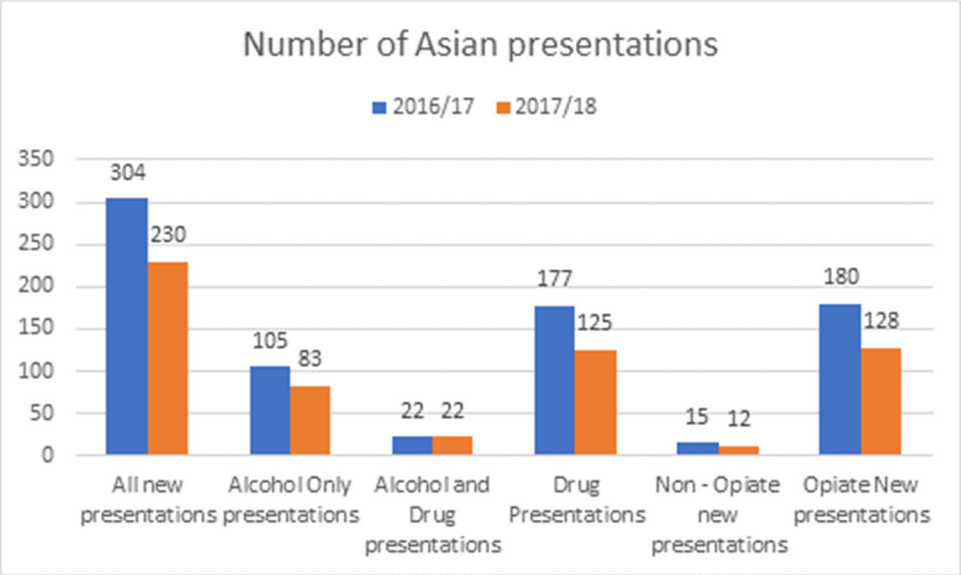


Figure 15: Number of Asian presentations to RISE treatment in 2016/17 & 2017/18

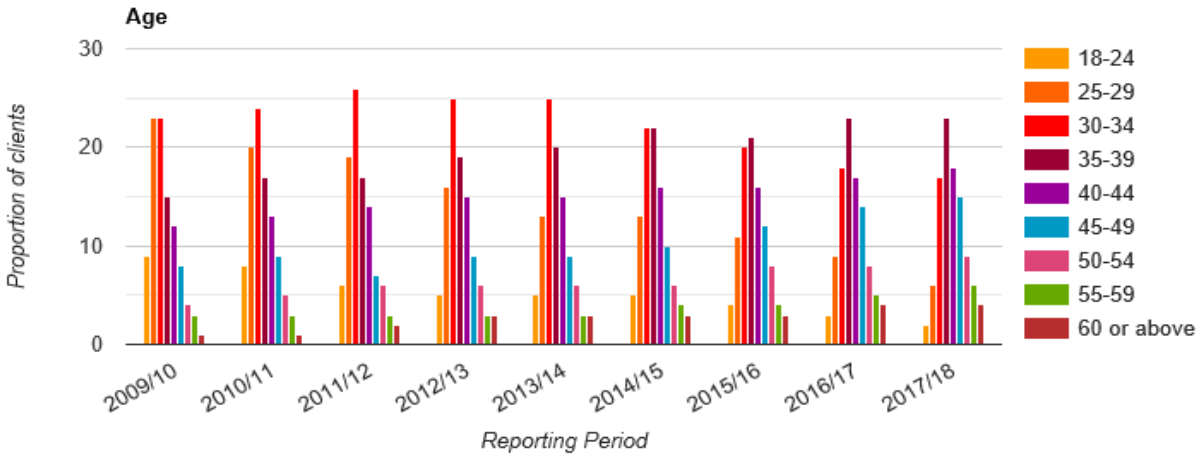
AGEING OPIATE TREATMENT POPULATION

- A report by the Advisory Council on the Misuse of Drugs (ACMD) June 2019 examined the issue of an ageing opiate population in England and highlighted the following findings:
  - the number of opiate users over 40 years old in treatment has increased from approximately 25,000 in 2006 to more than 75,000 in 2018
  - the number of opiate users in treatment under the age of 30 has decreased from approximately 60,000 to around 13,000 in the 12 years to 2017/18

- ageing drug users are less likely to have access to the resources they need to manage the complex needs of this group
- the death rate for opioid users increases the older the user

- Ealing's opiate treatment population mirrors this picture and the number of opiate users requiring treatment for a range of co-occurring physical health needs is increasing. These service users are becoming increasingly difficult to place in residential rehabilitation services as they have mobility issues and require nursing care which many providers are unable to accommodate.

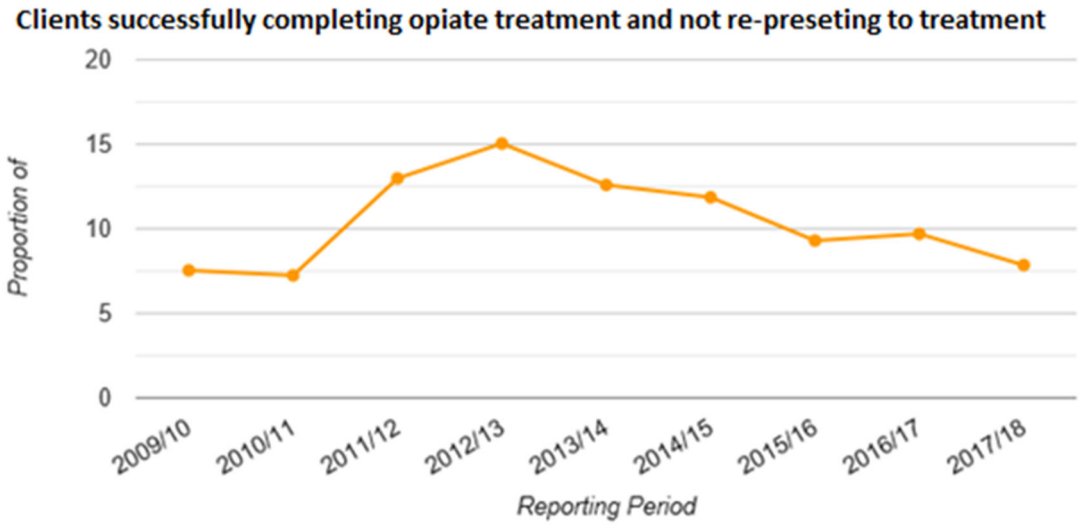
Figure 16: Age profile of opiate users in Ealing's treatment population by year

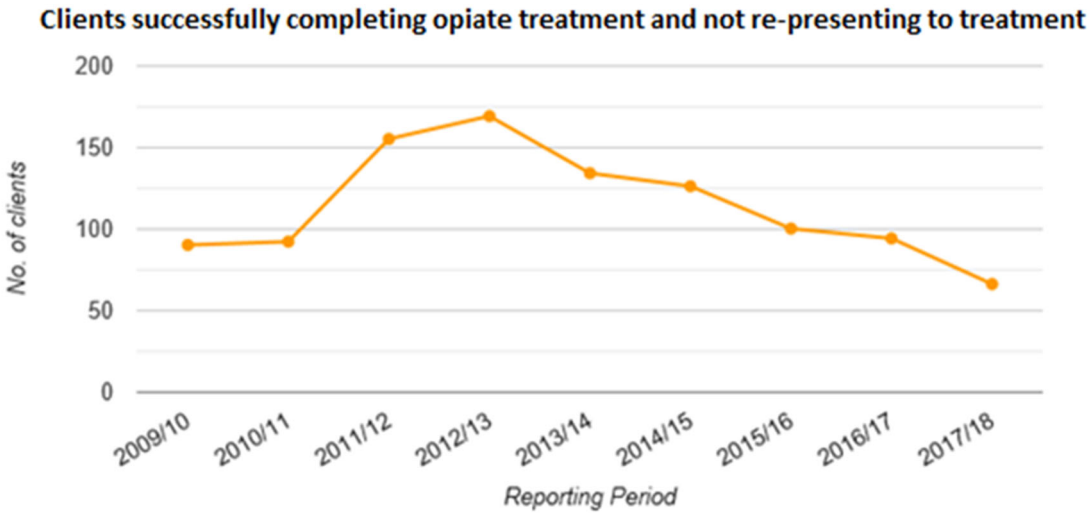


Source: NDTMS

OPIATE TREATMENT OUTCOMES

- Ealing's opiate successful completions dipped in 2017/18, tallying with the period when the RISE Southall treatment hub was closed. During 2017/18 RISE dropped out of the top quartile of partnerships achieving high numbers of successful completions for opiate users for the first time.
- There has been a decline in successful completions in opiate treatment locally since 2012/13. This may be because of the treatment system changing during this period to an integrated drug and alcohol treatment system. This often resulted in an initial increase in alcohol referrals into treatment because more money had been spent on drug treatment prior to this time.

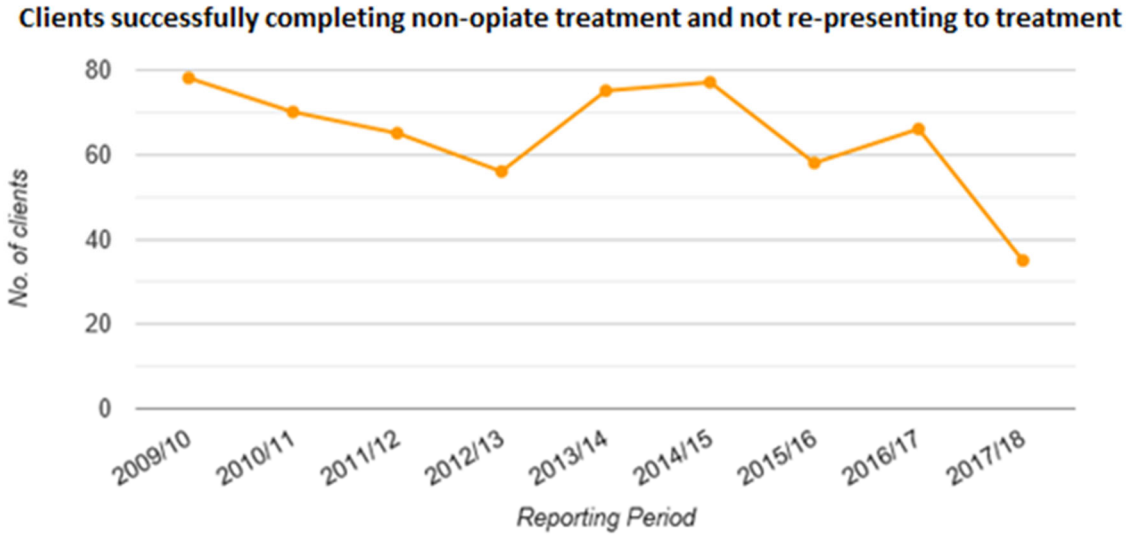


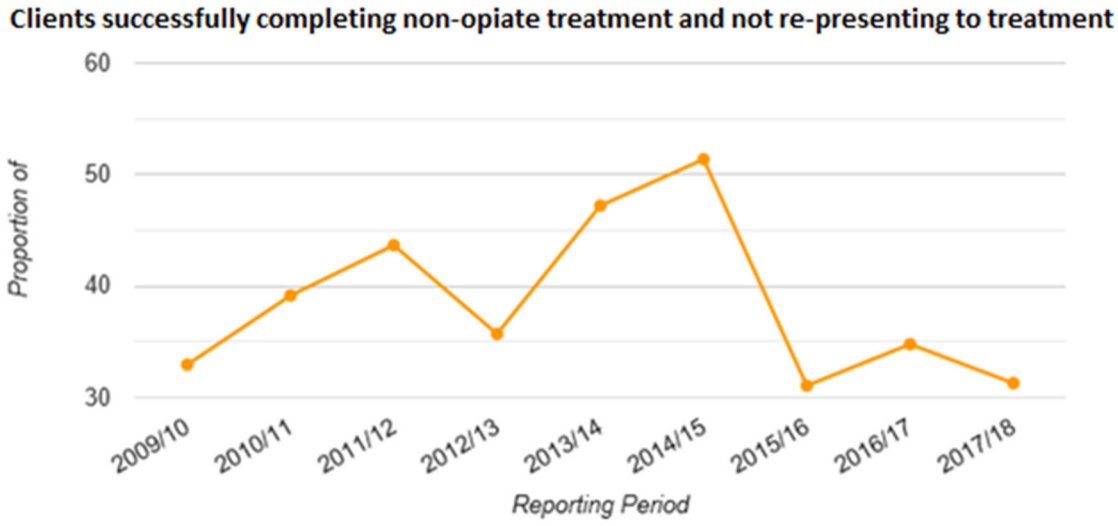


NON-OPIATE TREATMENT OUTCOMES

- Ealing's treatment system has struggled to attract non-opiate users into treatment and the numbers have remained small. Non-opiate numbers in treatment have been dropping: 140 in 15/16; 100 in 16/17; & 66 in 17/18. Successful completion numbers have also been low when compared with other treatment systems: 58 in 15/16 (31%); 66 in 16/17 (34%); & 35 in 17/18 (31%).
- RISE is developing a non-opiate action plan to address the small numbers in treatment & have visited several services within Cgl's portfolio to look at different approaches, including Newham. They will be targeting criminal justice partner agencies focusing on cannabis & cocaine users & looking at Rehabilitation Activity Requirements (RARs.) There are also plans to discuss partnership working with the local sexual health service, including exploring the option of a satellite service targeting chemsex users. The sexual health service has started delivering a satellite service at RISE's West Ealing hub and there is a strong working relationship between the Women's Wellness Zone and the sexual health service on Southall Broadway. However, there are currently no drug and alcohol satellite sessions within the sexual health service.

- Finally, RISE also intends to look at local employers and linking referrals in through a unique pathway, separate from the current treatment hubs.





RECOMMENDATIONS

Develop effective partnership working with sexual health services to increase screening for problematic drug and alcohol use and to deliver joint initiatives to provide support and treatment to specific groups including men who have sex with men and engage in Chemsex.

Develop and deliver a non-opiate action plan to increase the numbers of non-opiate users accessing treatment and achieving positive outcomes

5. ALCOHOL

PREVALENCE OF ALCOHOL USE

- Over the period 2011-2014, there were 33.9% of Ealing residents (aged 18+) who didn't drink alcohol – this is significantly higher than figures for London (24.3%) and England (15.5%). The data does not have any further detail beyond borough level.
- Ealing also had a lower proportion of the population in the high-risk drinker and binge drinker groups (18.9% & 12.0% respectively), but the differences in comparison to London and England are not statistically significant. (Figure 16)

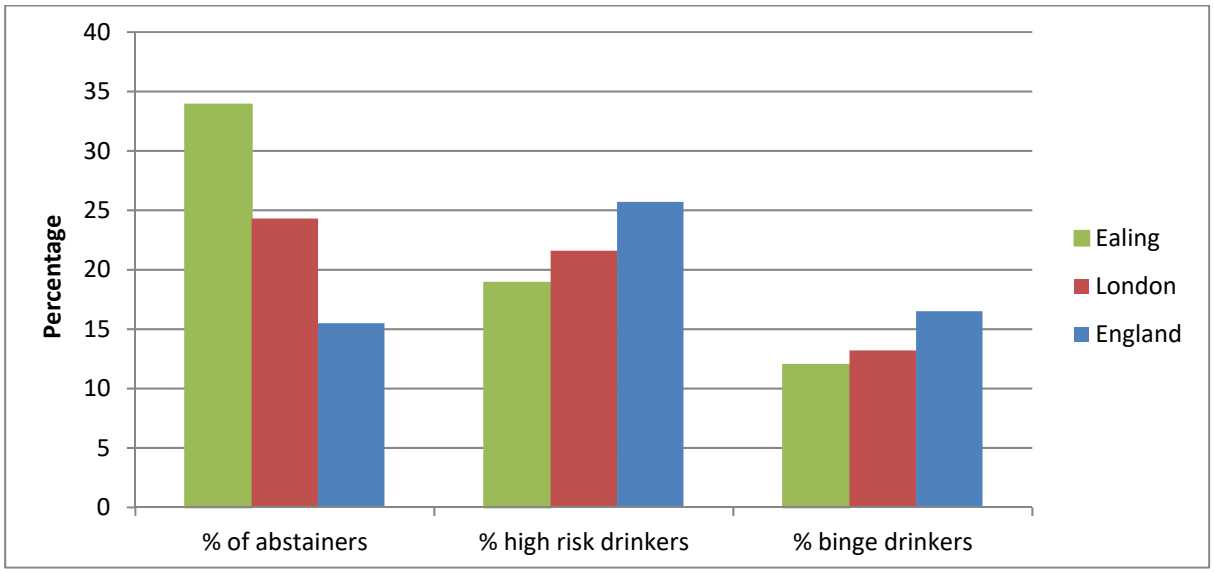
Dependent Drinker: characterised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequences (e.g. liver disease or depression caused by drinking).

Harmful/high-risk drinking: defined as a pattern of alcohol consumption causing health problems directly related to alcohol. This could include psychological problems such as depression, alcohol-related accidents or physical illness such as acute pancreatitis. Drinking 35 units a week or more for women. Drinking 50 units a week or more for men

Hazardous drinking/increasing risk drinking: pattern of alcohol consumption that increases someone's risk of harm. Drinking more than 14 units a week, but less than 35 units a week for women. Drinking more than 14 units a week, but less than 50 units for men

Binge drinking: usually refers to drinking lots of alcohol in a short space of time or drinking to get drunk

Figure 17: Prevalence of alcohol use



Source: Calculated by Public Health England: Risk Factors Intelligence (RFI) team using data from the Health Survey for England, 2011-2014 (Local Alcohol Profiles for England, 2017)

- Figure 18 shows the estimated number of dependent drinkers (aged 18+) living in Ealing, who are potentially in need of treatment. This is based on estimates developed by Sheffield University for Public Health England and the table was developed for Ealing as part of the PHE deep dive work on alcohol.
- At the time this data was provided, estimates were only available up to 2014-15 and therefore the last estimate is repeated in 2015-16 and 2016-17. This is then presented as a percentage of the overall adult population. Finally, the rate of unmet need is calculated and shown in the last box. This is the estimated number not in treatment as a proportion of the total dependent drinking population.

Figure 18: Local Alcohol Prevalence and unmet need

	Ealing			
	2013-14	**2014-15**	**2015-16**	**2016-17**
Estimated number of dependent drinkers in need of treatment	3,497	3,499	3,499	3,499
Rate of dependent drinkers among adult population (as a percentage)	1.33%	1.34%	1.34%	1.34%
Rate of unmet need	79%	75%	74%	80%

- In Figure 19, Ealing's rates of dependent drinkers and unmet need are compared to the national percentage in 2014-15 and those for Ealing's 15 nearest neighbours.
- Nationally in 2014/15 around 4 out of 5 people with a need for specialist treatment were not in contact with treatment. This shows Ealing's ability to engage dependent alcohol users in the local treatment system is comparable with both national rates and those of our nearest statistical neighbours.
- PHE has analysed the loss of alcohol users across the National treatment system and discussed their findings with local partnerships as part of a National alcohol deep dive exercise. Their findings are summarised in this report. https://www.gov.uk/government/publications/alcohol-treatment-inquiry-summary-of-findings/phe-inquiry-into-the-fall-in-numbers-of-people-in-alcohol-treatment-findings

Figure 19: Comparison between local and national prevalence and unmet need

	Ealing	Benchmark	
		National	Nearest neighbours
Rate of dependent drinkers among adult population 2014-2015	**1.34%**	**1.39%**	**1.30%**
Rate of unmet need 2016-17	**80%**	**82%**	**82%**

- Since this data was compiled for the alcohol deep dive exercise, the University of Sheffield has published new prevalence rates for dependent drinkers (November 2018.) Ealing's estimated number of dependent drinkers remains fairly consistent with 3,488 in 2015 and 3,387 in 2016.

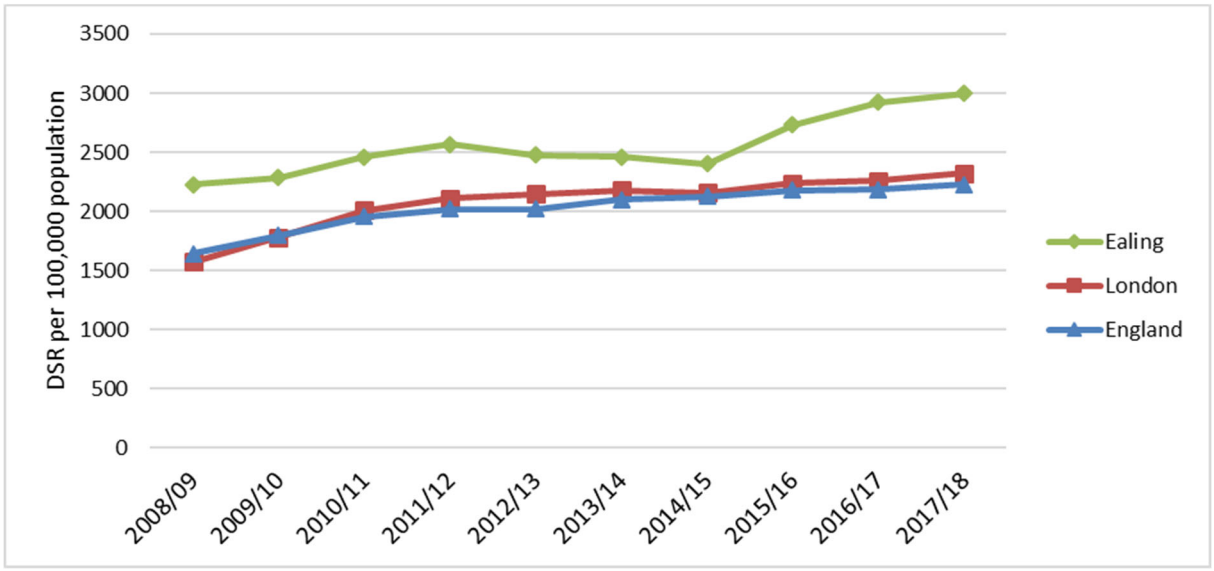
ALCOHOL-RELATED HOSPITAL ADMISSIONS

- Ealing has consistently **higher rates of hospital admissions, compared to England and London**. A substantial proportion of these hospital admissions are due to alcohol-related conditions. In 2018, **Ealing had the highest rate of hospital admissions due to alcohol-related cardiovascular disease in the whole of England (Figure 20)**.
- The Healthier Lives: Alcohol and Drug Profiles have used the number of alcohol related hospital admissions in each area as a measure of alcohol related dependence at a local level. This measure is included as an indicator in the Public Health Outcomes Framework (PHOF).
- The "broad" measure counts hospital admissions where the primary diagnosis or any secondary diagnosis has an alcohol attributable fraction. The broad measure shows there were 7,218 alcohol related admissions in 2015-2016 with a rate of 2,733 per 100,000, worse in comparison to London (2,179 per 100,000) and England (2,235 per 100,000). In Ealing the rate for both men and women is significantly worse than London and England.
- **Ealing's hospital admission rates continue to rise**, and the partnership is analysing the data further to see if there are any patterns in the demographics, which might help to design specific interventions within the current budget constraints. Figure 21 shows the hospital admission rates by patient postcode.
- The hospital liaison team has been reduced from a 7 day a week service to a five-day service covered by two nurses. They work inside Ealing Hospital delivering brief and extended interventions as well as targeting alcohol related hospital admissions and frequent attenders, providing seamless co-ordination with RISE's community provision. They are part of the recently restarted and restructured frequent attenders' monthly meeting at A & E, which includes psychiatric liaison, London Ambulance, and the CCG care

coordinators. This work aims to reduce admissions by developing multi-disciplinary care plans to address unmet needs.

- The NHS 10-year plan talks about the importance of Alcohol Care Teams (ACTs) and mentions additional funding for areas such as Ealing, who are struggling to reduce their high level of admissions. *Over the next five years, those* ***hospitals with the highest rate of alcohol dependence-related admissions will be supported to fully establish ACTs*** *using funding from their clinical commissioning groups (CCGs) health inequalities funding supplement, working in partnership with local authority commissioners of drug and alcohol services. Delivered in the 25% of worst affected hospitals, this could prevent 50,000 admissions over five years.*
- The hospital liaison team used to have money for a dedicated assertive outreach worker connected to the hospital team. Their role was to actively engage service users on release from hospital into RISE, either through collecting the person from their home and taking them to either of the treatment hubs or connecting them in through their nearest primary care setting. The loss of this role does affect the team's ability to successfully transfer service users into treatment after they've left hospital.

Figure 20: Hospital admissions for alcohol related conditions (Broad)



Source: Calculated by Public Health England: Risk Factors Intelligence (RFI) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates (LAPE, 2019)

Figure 21: Hospital Admissions for alcohol-related cardiovascular disease (broad) (males, all ages) 2017/18 (DSR per 100,000)

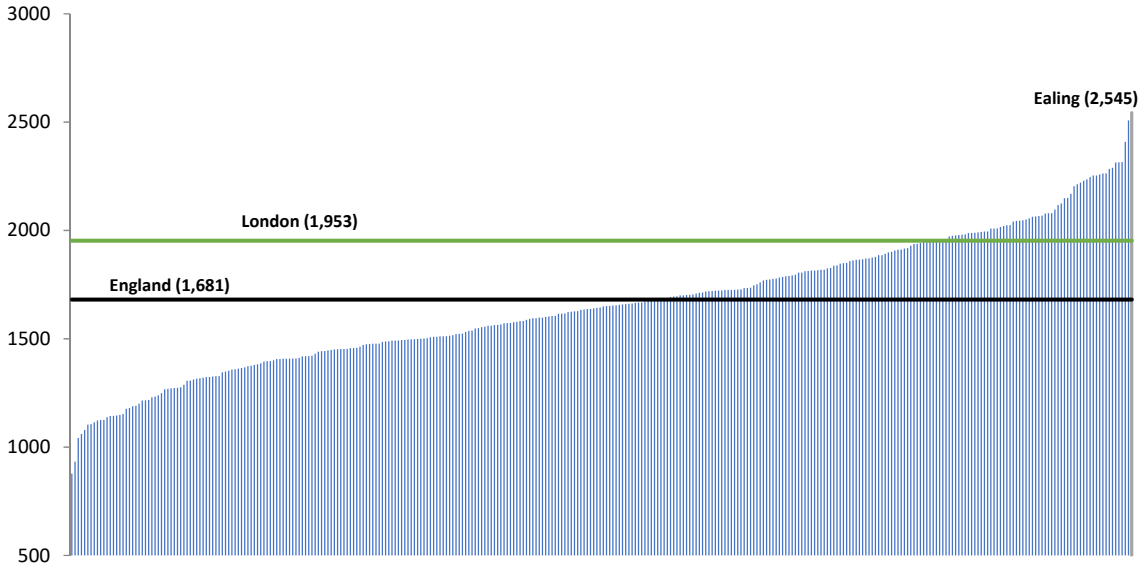
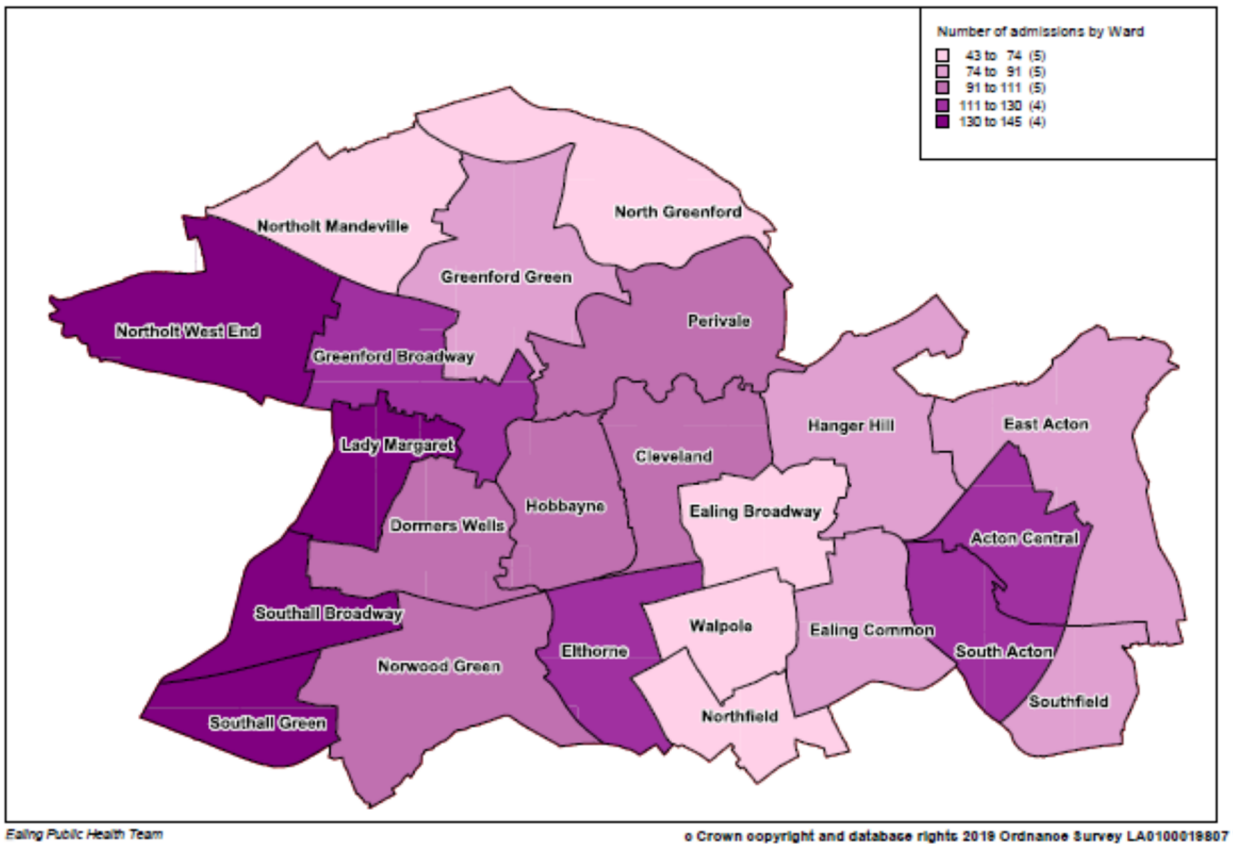


Figure 22: Hospital admission rates by patient postcode



RECOMMENDATIONS

Ealing will analyse the data around hospital related admissions in more detail to see if there are any patterns in the demographics, which might identify how best to design the most effective interventions within the current budget constraints.

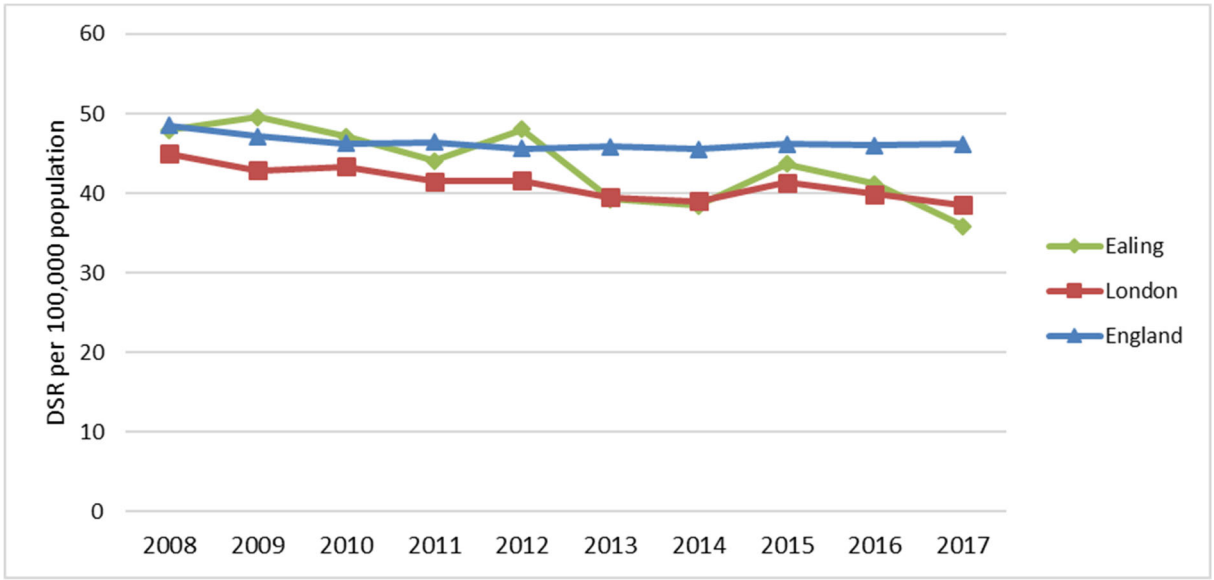
Ealing will discuss the analysis with a round table discussion of local partners to agree the best way forward on tackling alcohol hospital admissions, with a focus on prioritising a whole system and pathway approach to tackling alcohol misuse

The Ealing Partnership will be discussing plans to deliver on the promise of Hospital Alcohol Care Teams outlined in the NHS 10-year plan

ALCOHOL RELATED DEATHS

- In 2016, there were 109 alcohol related deaths with a mortality rate of 41.2 per 100,000 population. This is statistically similar to London and England (39.8 and 46.0 per 100,000 population respectively) (Figure 22).
- More men (78) than women (31) died from alcohol related conditions, with the mortality rate for men at 62.1 per 100,000 and for women 23.0 per 100,000. Ealing has similar rates to London and England averages.

Figure 23: Alcohol related mortality rates (per 100,000)



Source: Calculated by Public Health England: Risk Factors Intelligence (RFI) team from the Office for National Statistics (ONS) Annual Death Extract Public Health Mortality File and ONS Mid Year Population Estimates (LAPE, 2019)

6. TREATMENT POPULATION

ALCOHOL

IMPACT OF SERVICE REDUCTION ON EALING'S ALCOHOL TREATMENT OUTCOMES

- Ealing has identified some issues affecting successful alcohol treatment completion rates due to recent changes to the local integrated drug and alcohol treatment system, and these are picked up in the stakeholder interviews and highlighted later in the recommendations.
- These changes were driven by budget reductions which meant RISE had to re-configure its treatment system to accommodate the loss of over a third of its income. This resulted in reducing the consortium by one partner and over 27 full-time staff along with the loss of two buildings, including the abstinence space at EACH. The treatment system had been designed to provide a clear progression through treatment and exit via the structured day and aftercare programme in a less chaotic and abstinent space.
- Having a structured day programme in an abstinence space was particularly attractive to alcohol users completing community or residential detoxification and then looking for a group work programme with counselling to support their resettlement back in the community. They did not want to go back to the RISE hubs and mix with many service users in the early phase of their treatment journey as this made maintaining their recovery harder.
- There is also a concern amongst some of the alcohol service users that the 2 main hubs are very identified with opiate and other drug users who they could not necessarily identify with, particularly when they are in the early and most chaotic phase of treatment engagement. This issue is picked up in several of the stakeholder interviews. EACH had a long history in the borough, particularly as a specialist alcohol provider, and this particular expertise was also lost within the consortium, along with the provider's reputation amongst alcohol users and the crucial 'word of mouth' recommendation.
- The PHE analysis of the national reduction in alcohol numbers and successful completions, found the partnerships who had bucked this trend, had alcohol specific posts in their integrated treatment systems along with dedicated alcohol pathways. RISE has recruited an alcohol specialist worker to develop some of this partnership work targeting older people and carers using a community development/outreach model.

RECOMMENDATIONS

Re-configure the treatment service to offer flow through the system, with the delivery of a group work programme from an abstinence space at the end of treatment. Provide alternative premises to address the loss of the abstinence-based building as a venue for delivering the latter part of RISE's structured day programme. This will be outlined in the new service specification.

Develop targeted work with carers and older people drinking either dependently or at increasing risk through developing local partnership work with Southall Community Alliance, and the Carers' Trust.

DECLINE IN EALING'S ALCOHOL TREATMENT POPULATION

- Figure 24 shows the decline in the number of alcohol only presentations across Ealing's treatment system, and how the treatment penetration rate for alcohol users has been affected by the recent financially driven changes to the treatment system. This is also reflected in the other local treatment presentation rates, where the reduction in numbers entering the treatment system is even more marked than the London and national figures.

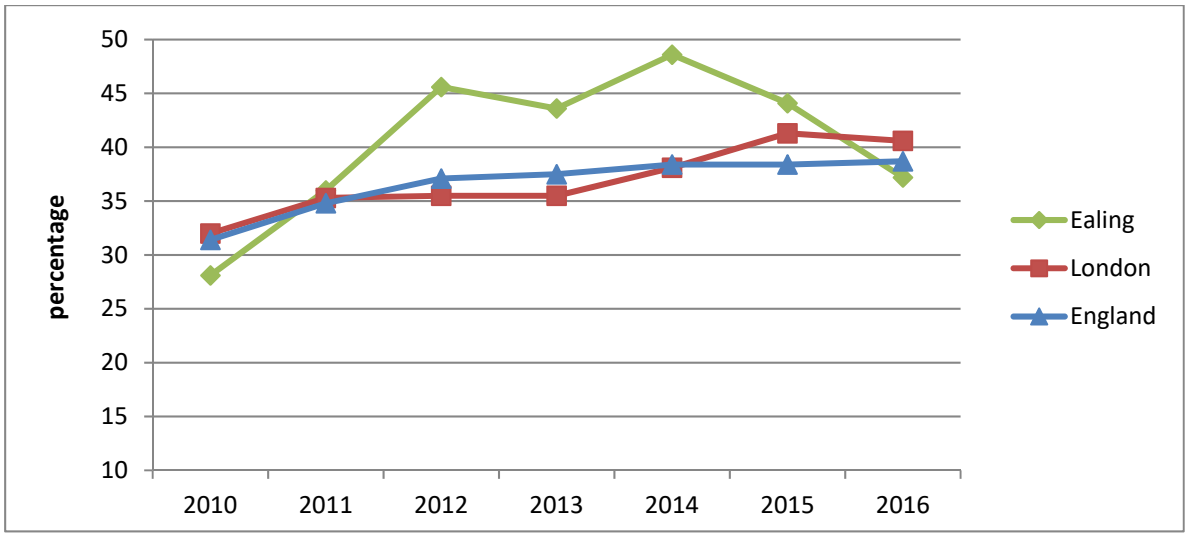
Figure 24: Decline in alcohol only presentations

		2013-14	2014-15		2015-16		2016-17		% change from 13-14 to 16-17
		(n)	(n)	% Change	(n)	% Change	(n)	% Change	
Local	Number of alcohol only presentations	404	507	25%	479	-6%	344	-28%	-15%
National		65,110	61,404	-6%	57,723	-6%	52,583	-9%	-19%
Centre		8,786	8,566	-3%	8,178	-5%	7,549	-8%	-14%
Local	Number of other presentations (not including alcohol only clients)	654	694	6%	759	9%	520	-31%	-20%
National		82,348	80,242	-3%	80,358	0%	78,633	-2%	-5%
Centre		15,737	14,936	-5%	14,237	-5%	13,446	-6%	-15%

- In 2016-2017, there were 551 people in treatment citing alcohol as their primary drug of choice, and 212 successfully completed treatment (38.5%)[6]. This is a slight improvement on the previous year, when 36.4% of people in alcohol treatment successfully completed. This figure is also very similar to the national average (39.0%).
- Figure 25 below shows Ealing had a significantly higher percentage of successful completions for alcohol between 2012 and 2015 with higher rates than the London and National averages. Ealing dropped below the London and National average successful completion rates and some of the reasons for this are discussed in the earlier prevalence section and stakeholder interviews.
- Figure 26 includes the alcohol successful completion rate for 2018/19, and the treatment system has started to increase the rate for the first time since the funding reductions. The alcohol treatment population in 2018/19 is still predominantly dependent drinkers with complex needs.

[6] *Source: NDTMS Partnership Successful Completions Reports (generated Dec 2017)*

Figure 25: Proportion of successful completions of treatment (those who successfully completed treatment and did not re-present within 6 months)



Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the National Drug Treatment Monitoring System (LAPE, 2017)

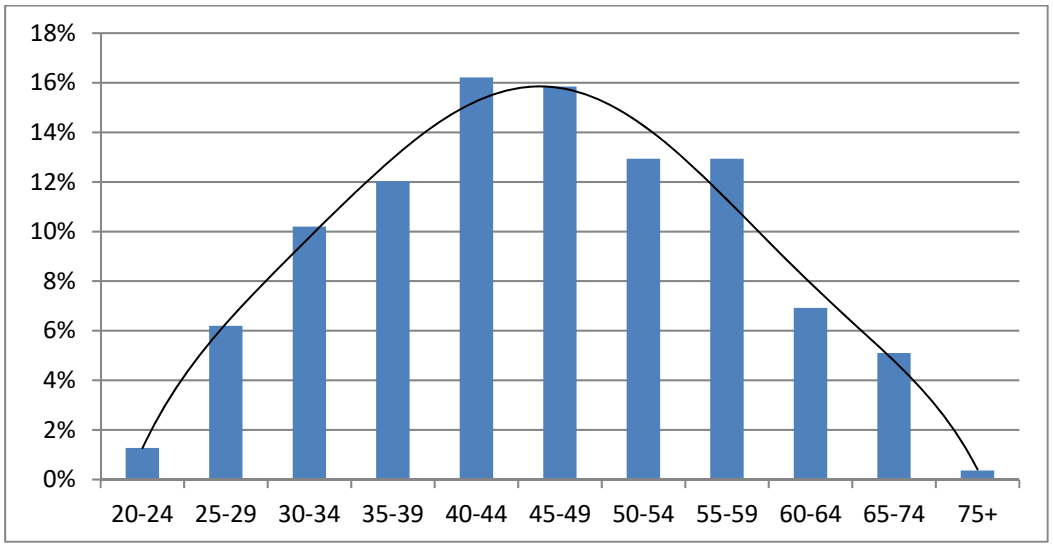
Figure 26: Ealing Alcohol Successful Completions

PRIMARY ALCOHOL USERS IN TREATMENT BY GENDER AND AGE

- In total there were 549 people in treatment with primary alcohol use in 2016/17. Almost three quarters (74%) of all alcohol users in treatment are men, with women representing 26%.

- The age profile of alcohol users in treatment is relatively old, with almost three in five (58%) aged 40-59. Most alcohol users are in the 40-49 age group, making up nearly a third (32%) of all alcohol users in treatment. This can be seen in Figure 26 below.

Figure 27: Age Profile by Primary Alcohol Use

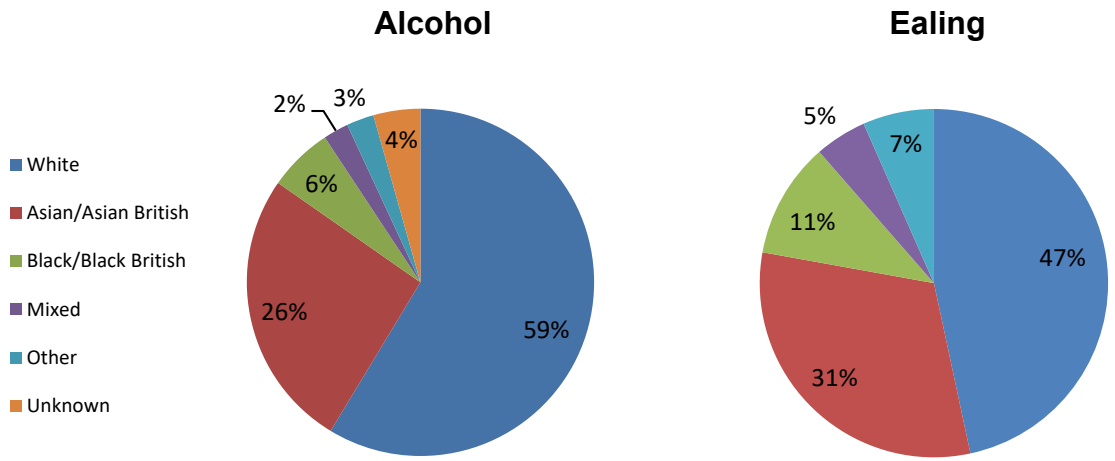


Source: NDTMS, Adult Partnership Activity Report, 2017

PRIMARY ALCOHOL USERS IN TREATMENT BY ETHNICITY

- Figure 28 shows the ethnic profile of Ealing's population and compares this to the alcohol treatment population. The percentage of residents from the white community in the alcohol treatment population (59%) is higher than the percentage of white residents amongst Ealing's population (47%).
- However, there is an under representation of alcohol treatment numbers amongst the Asian populations, accounting for 26% compared with the percentage of Asian residents in Ealing's population (31%).

Figure 28: Ethnic Profile, Ealing Population, Treatment Population by Primary Alcohol Use - 2016/17



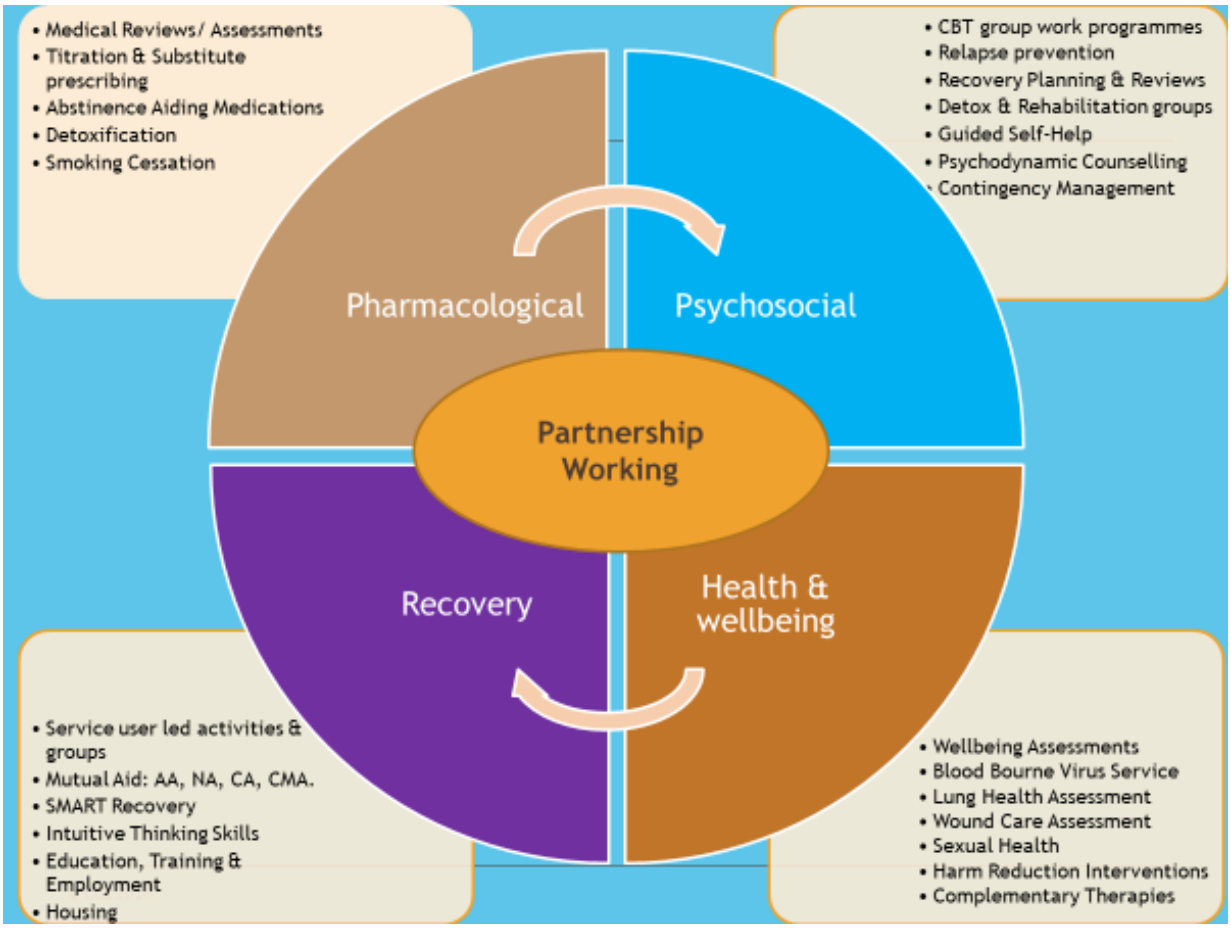
Source: NDTMS, Adult Partnership Activity Report, 2017 & GLA population projections ethnicity trend 2015 (LTM for 2017)

7. CURRENT INTERVENTIONS & ASSETS

EALING'S INTEGRATED ADULT DRUG AND ALCOHOL TREATMENT SYSTEM, RISE (RECOVERY INTERVENTION SERVICE EALING)

- RISE provides a community drug and alcohol treatment service for Ealing residents over 18 who are having problems with their drug and alcohol use. The service provides a range of intensive community-based support, clinical treatment and rehabilitation services that are designed to meet residents' needs and support their family and friends. Each recovery plan is co-produced with the service user and regularly reviewed.
- RISE services are delivered within a recovery focused framework, with harm minimisation underpinning all interventions. Lower threshold support consists of: needle exchange, naloxone distribution & overdose prevention; safer injecting advice; Blood Borne Virus (BBV) screening; and alcohol screening. Evidence based specialist treatment is NICE compliant and adheres to the UK guidelines on clinical management of drug misuse and dependence.

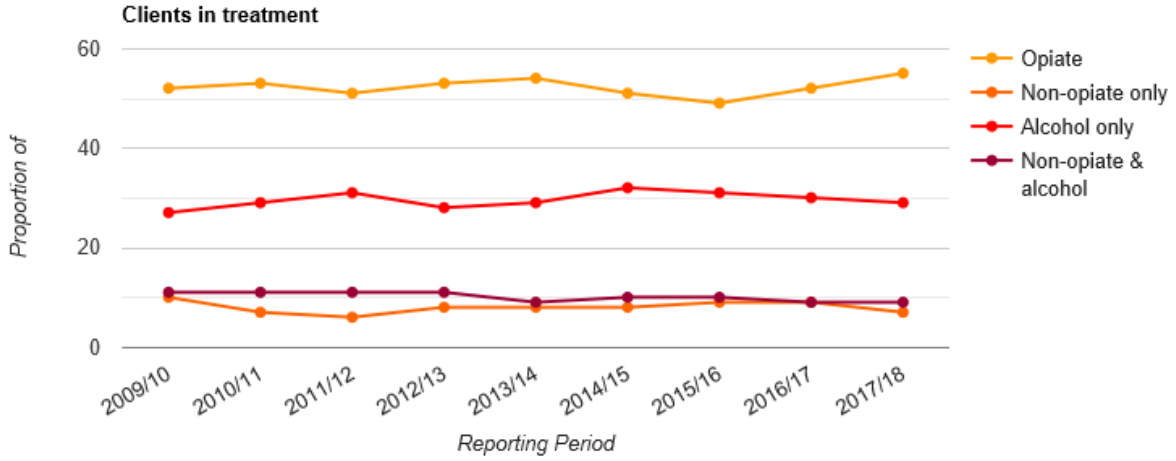
Figure 29: RISE's treatment offer



EALING'S CURRENT TREATMENT SYSTEM

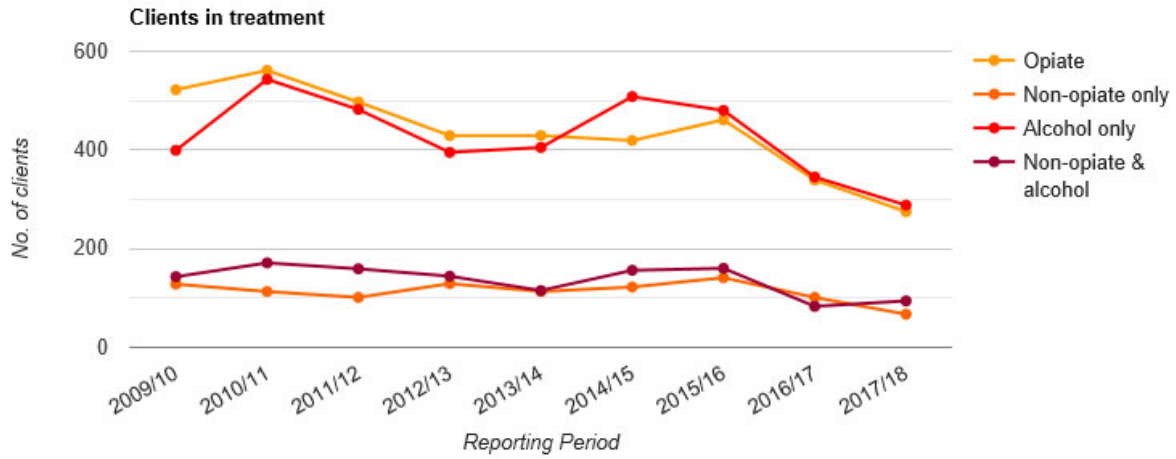
- The graph below shows the proportion of the different cohorts in Ealing's current treatment system.
- Ealing is still a predominantly opiate based treatment system, accounting for over 50% of the treatment population with alcohol only users making up for 30% of the treatment population.

Clients in treatment - Ealing - All in Treatment



- The graph below shows the number of new presentations in the treatment population by year and cohort.
- The numbers of opiate users are declining each year, and this is reflected in National data, with an ageing opiate population which is not being replaced with a new, young generation of opiate users.
- The number of new alcohol treatment presentations has reduced since 2015/16, which corresponds with when the reduced funding started to take effect and Ealing reduced the number of providers in the RISE consortium. The loss of an alcohol specialist agency, EACH, along with the loss of their abstinence space is a factor behind this decline in alcohol numbers.

Clients in treatment - Ealing - New Presentations



CURRENT FINANCIAL CONTEXT AND ITS IMPACT ON THE TREATMENT SYSTEM

- The current adult community drug & alcohol treatment contract (RISE) has been reduced by 40% over the last 2 years. This has been due to the following: reductions imposed by central government to the public health grant; locally agreed Council budget reductions; and the loss of substance misuse related funding from the Mayor's Office for Police and Crime (MOPAC) and the Better Care Fund. These reductions in the overall budget of the integrated drug and alcohol treatment system have had a significant impact on service delivery.
- Financial reductions to the budget have resulted in some distinct loss of service. There is no longer a discreet carers' offer at RISE, which used to have a dedicated worker running a support group and delivering a range of other interventions and community outreach work. This work has been transferred to the Carers' Trust who hold the contract for delivering carers' support work across the borough. RISE has delivered some work in partnership with the Carers' Trust and intends to extend this offer through a dedicated alcohol and non-opiate worker. This post will deliver satellite sessions at the Carers' Trust to identify those who may be drinking as a coping mechanism because of the demands associated with their caring role. This worker will also have a focus on older people drinking at increased risk or dependent levels, connecting into several older people services across the borough including Neighbourly Care.
- RISE also lost two dedicated education, training & employment leads, who supported service users in identifying appropriate job, volunteering and course opportunities. RISE has built connections with the different work programmes and DWP to fill this gap. The two new WLA individual placement and support staff starting in 2019/20 and based in the treatment hub will address this gap in the current treatment system.
- The loss of the better care fund from the CCG resulted in RISE's alcohol hospital liaison service losing one nurse and a community outreach worker. The service is now staffed by two nurses and can no longer provide a seven day a week service, which means some vulnerable service users are being missed and it is more difficult to ensure the successful transfer of people leaving hospital into community drug and alcohol treatment.
- The RISE consortia had to be reduced by one provider who crucially ran the abstinence based structured day programme. Removing this abstinence space from the local offer meant Ealing lost a building where service users in the later stages of their treatment journey felt they had a safe space away from the chaotic main hubs. The hubs deal with service users in the early phase of treatment engagement including those using the peer support part of RISE, Bob (Build on Belief), which targets those who do not yet feel ready for structured treatment at the West Ealing hub. It is not possible to zone this building or the Southall hub and anecdotal RISE and partner feedback suggests this has had an impact on the engagement and retention of the following service user groups: those coming back to the community from residential rehabilitation; returning abstinent from prison; drinking at higher risk levels who are committed to stabilisation or abstinence whilst they engage with structured treatment; and those continuing their treatment journey after

community or residential detoxification. The loss of this abstinence space is a gap which needs to be addressed and is currently something the provider and commissioner are working hard to resolve within the current budget constraints. It is certainly one of the main reasons, alongside the reduction in keyworker time, the alcohol successful completions have fallen since the financial savings started to bite.

- The cuts have also meant the treatment system has had to change its overall delivery model, with a move away from more 1:1 based treatment provision, to delivering more treatment in group settings or Pods. Increased caseloads because of fewer staff mean it is no longer possible to offer as much individual keyworker time and this does have an impact on the time available to build a therapeutic relationship or alliance with individual service users.
- Demand for the service has not reduced in line with the budget and if pressure continues to mount on the treatment system, the local partnership will have to consider operating a waiting system because further reductions in staff will lead to unsustainable increases in caseloads. If a certain number of service users do not complete their structured treatment each month, it will be dangerous to take any more people onto the caseloads, resulting in waiting times for treatment.
- This is the situation RISE has been dealing with over the last 2 years. The decrease in spend has had a direct correlation on performance for the adult community-based treatment service. The restructure across both 2015/16 & 2016/17, with the additional loss of the criminal justice team and the two Better Care Funded posts in the alcohol hospital liaison team in 2017/18, has meant there has been little time for RISE to consolidate or assimilate the new ways of working and revised service model.
- The reduction in the overall budget has also had an impact on RISE's ability to provide prevention and early intervention work across the borough because the staff team has shrunk considerably with the loss of over 30 staff.
- RISE was also affected in 2017/18 by the unforeseen and **unplanned closure of the Southall site** due to problems with signing off the building work at the new and current hub, the Saluja Clinic. RISE had given notice on their old Southall site at Featherstone Terrace on the assurance the new site was ready but the move to the new site was put back each month. In the end, the site was out of operation for almost a year. This had a significant impact on treatment performance as there was no alternative satellite hub in Southall and all treatment operated out of the West Ealing hub. Many service users would not travel from Southall for treatment and numbers and outcomes dropped significantly during the yea, particularly for opiate users. Consequently, when looking in more detail at local treatment performance data, this chapter has used 2016/17 data because this is more indicative of the service's performance level. The closure of the Southall hub has clearly shown the treatment service needs a hub in this area which can deliver clinical interventions including titration.

- The contract for the new treatment system starts on April 1st 2020. The reduced budget will continue but Ealing wants to ensure a level of stability for service users by letting a longer contract; 5 years with the option to extend for a further two.

RECOMMENDATIONS

Maintain titration at the Southall Hub to consolidate retention in treatment for drug and alcohol users living in the Southall area.

Commission the new drug and alcohol treatment system with a long contract to support stability

EALING SUBSTANCE MISUSE TEAM

- The social work team, based in the Council, provide the Care Act assessments and design placements for residents whose treatment needs cannot be met by the locally commissioned treatment system.
- The team monitor and review these placements which are either in other treatment services or residential rehabilitation settings.
- There have been substantial pressures on this budget since 2015/16 and the team are exploring the use of treatment packages to address the reduction in the residential rehabilitation budget. These could include pre-tox groups, motivational sessions, 10 day detoxes, 6-week structured day programme then onward referral to the West London Alliance Individual Placement Support Service delivered by WDP. This will maximise the dwindling Tier 4 placement budget and provide smooth transitions through treatment for individual service users.

EALING'S SUPPORTED HOUSING PATHWAY

- Ealing has several supported housing projects available to residents with drug and alcohol related problems ranging from high support needs project, St Mungo's Broadway 65, to floating support provided by EACH.
- There are two dedicated drug and alcohol supported housing projects delivered by Equinox: Churchfield Road & Cherington Road. Churchfield Road is for people who are currently using illegal drugs and/or alcohol but have expressed a strong motivation to change and who need additional support to engage in treatment services and reduce their substance use and the harm caused by this. Cherington Road is designed for people who have used illegal drugs and/or alcohol in the past and who now need additional support to remain abstinent. This includes people who are currently engaged in

community-based treatment services or have been through a residential detox or rehabilitation programme.

EASY: EALING'S YOUNG PEOPLE'S DRUG AND ALCOHOL TREATMENT SERVICE

- EASY is Ealing's support service for young people using drugs and/or alcohol aged 18 and under. The team is made up of experienced drug and alcohol workers who specialise in working with young people and take the service out to meet young people wherever they feel most comfortable.
- The service aims to reduce and stop young people using drugs and alcohol, through early intervention, prevention and targeted education, advice, guidance, training, assessment and treatment.
- The team consists of 2 part-time Young People Recovery Workers and one part time YP Tier 2 Substance Misuse and Outreach Worker. The EASY staff also work closely with RISE's Young Adult Link Worker (YALW), who focuses on the 18-25 year old group.
- The YALW offers appointments in convenient secure locations across Ealing because some clients find it difficult to get to RISE, (flexible working helps to keep clients engaged in treatment), and because it's not always appropriate to see service users from this vulnerable group within the RISE treatment hubs.
- The YALW like the EASY staff tries to involve the family in the service user's recovery, with parents receiving support around building healthy relationships with their child, which helps retain clients in treatment and leads to better treatment outcomes.
- https://www.changegrowlive.org/young-people/easy-project-ealing

DUAL DIAGNOSIS ANONYMOUS

- Dual Diagnosis Anonymous (DDA) is a self-help organisation for people with co-occurring mental illness and substance misuse issues.
- Dual Diagnosis Anonymous uses the traditional 12 steps of AA and Narcotics Anonymous but adds an additional five steps. The programme acknowledges both illnesses, accepts help for both conditions, understands the importance of a variety of interventions, combines illness self-management with peer support and spirituality, and works the program by helping others.
- DDA runs two meetings every week in Ealing and are a self-help organisation and social enterprise. The groups also welcome and extend support to families and friends, as well as health care providers and other interested parties.
- https://www.ddauk.org/

MUTUAL AID

- Ealing has a range of local mutual aid meetings including Alcoholics Anonymous (AA); Narcotics Anonymous (NA); Cocaine Anonymous (CA); and SMART Recovery groups.
- These provide additional crucial support for people in recovery and are often in the evenings or at weekends.

EACH

- EACH provides a range of services in Ealing including: floating support, the Jasmine Project (a counselling support service for women with complex needs), and one-to-one counselling support.
- They continue to provide a day programme, but no longer as part of RISE, which means the cost of sessions are covered on a spot purchase arrangement from the Ealing Substance Misuse Team's placement budget.
- http://www.eachcounselling.org.uk/

WEST LONDON ALLIANCE INDIVIDUAL PLACEMENT SUPPORT SUBSTANCE MISUSE SERVICE

- This contract is due to go live in Spring/Summer 2019 and will be delivered by WDP.
- RISE will have one education training and employment specialist placed within the treatment hubs providing access to jobs and accompanying support for people with drug and alcohol treatment needs.
- The employment specialist will be working closely with prospective employers to source local jobs and to provide the necessary additional support to help RISE service users stay in their job. They will also support service users with their benefits to make sure they are receiving everything they're entitled to and can be better off through employment.

RECOMMENDATIONS

Support the integration of the West London Alliance substance misuse Individual Placement Support Service delivered by two WDP workers placed at RISE and include this service as part of the overall package of care for service users.

WOMEN'S WELLNESS ZONE (WWZ)

- Ealing's Women's Wellness Zone is a women's one stop shop service commissioned to support women with complex needs in accessing a range of specialist services, empowering them to make healthy choices and achieve positive outcomes across several domains.

- The multi-agency approach helps women with at least three of the following needs: mental health; offending behaviour; domestic abuse and/or sexual violence; substance misuse; and those sex working or trafficked.
- The core team consists of 4 staff from partner voluntary sector agencies: two substance misuse/sex work/offender specialists (CGL); 1 Independent Domestic Violence Advocate - IDVA (Hestia); & 1 mental health worker (CAPE). There is also a range of support from other agencies via in-reach sessions including the Minerva Project and Each's Jasmine Project.
- The WWZ offers the following: proactive integrated case management including psycho-social interventions focusing on relationships and attitudes; assertive outreach identifying & providing support to sex workers on the street & in brothels; peer mentoring, user involvement & volunteer scheme; support around parenting & access to local programmes & childcare provision; housing, benefit & debt advice; health & wellbeing support including access to smoking cessation, sexual health, & GP registration; and access to local education, training and employment schemes.
- https://www.changegrowlive.org/content/womens-wellness-zone-ealing?gclid=EAIaIQobChMIl5ntmb6p4AIV1fhRCh1nGgUGEAAYASAAEgLrcPD_BwE

CRANSTOUN MEN & MASCULINITIES PROGRAMME

- Cranstoun successfully bid for Big Lottery money to develop their Men & Masculinities programme across Ealing and Hounslow. They will deliver a Domestic Violence and Abuse intervention programme with perpetrators (heterosexual male to female) including those attending a substance misuse or mental health treatment.
- The model of intervention supports recovery while addressing Intimate Partner violence and abuse and consists of a rolling 24-week group work programme for men with an accompanying women's support service to promote the safety of women and children. The women's support worker will be based at the Women's Wellness Zone when she's working with Ealing service users. The programme will last for 3 years and the group work programme is due to start in March/April 2019.

RECOMMENDATIONS

To support the integration of Cranstoun's Big Lottery funded Men and Masculinities programme for men perpetrating abuse in their relationships into the wider Ealing partnership. This will also involve embedding the accompanying women's support service and dedicated worker into the Women's Wellness Zone.

PRIMARY CARE

ALCOHOL PROVISION IN PRIMARY CARE

- The Ealing Standard, the Quality Framework for Primary Care 2017/18 to 2020/21, aims to support primary care with the necessary investment to drive improvements in the health and wellbeing of Ealing's population, improve the quality of care for patients, and sustain general practice for the future. The Standards have been coproduced with the Council of Members before approval by the Governing Body.
- Standard 12 (Prevention Proactive Care) covers primary care work around Health Checks for patients aged between 40-75 years old and alcohol screening for all new adult patients. Practices are encouraged to use reports/alerts generated by SystmOne to encourage GPs/Nurses to take a more systematic approach (i.e. more inclusive of all datasets to considering measuring) when performing opportunistic screening of patients – beyond just the formal NHS Health Check programme.
- Primary Care collects data around alcohol screening for both Health Checks for the 40-75 year olds and for all new adult patients.
- The data (2016/17) on alcohol screening as part of the NHS Health Checks showed some practices reported fewer alcohol screens as part of the health checks. Public Health wants to look at this data more closely to analyse why some practices are not providing alcohol screening and to compare this with data on new patients accessing primary care and whether they are also not being screened for alcohol use. It would make most sense for the RISE alcohol clinics to be delivered from primary care practices who are delivering more alcohol screening.
- From the 2016/17 NHS Health Check data, there were 392 patients (3%) with a raised AUDIT score (4008, 35% had no test). Five of these 392 were referred to RISE and 168 had a brief intervention for excessive alcohol consumption (6 offered but declined). 1100 (10%) patients were flagged as brief intervention for alcohol.

RISE'S GP SHARED CARE MODEL

- RISE's GP shared care model delivers joint treatment to people with problematic drug use via a GP working in partnership with RISE's community drug and alcohol workers. The service is available for services users who are stable on their substitute prescription.
- There were 154 people receiving treatment through the GP shared care scheme (Ealing RISE data at the beginning of August 2018.) This number fluctuates during the year and the current capacity can accommodate 245 service users. These service users are primary opiate users and since this is a declining population across Ealing, London and Nationwide, RISE is in the process of reviewing the primary care model.

REVIEW OF GP SHARED CARE

- The current model involves joint work with 11 surgeries across the borough, with 5 surgeries connected into the RISE West Hub and 6 surgeries aligned with the East Hub in Southall. In 2015/16, RISE were working with 18 surgeries before the funding reduction.
- The staff covering these surgeries are a mixture of nurses and recovery workers and travelling across the borough to the different surgeries does present a challenge after reductions in the overall staffing quota.
- 5 of the surgeries have only 4 to 8 service users, and three of these are only able to offer 10 places maximum at any given time. The review will look at where and how the model is currently operating, consider whether these smaller surgeries represent the best value for money with RISE's reduced staff team, and think about how best to deliver alcohol interventions in primary care.

RISE GP ALCOHOL PILOTS

- The attempt to pilot two alcohol surgeries at Greenford and Hillcrest within the shared care model has not proved successful in its current format. There are several factors: the lack of time the alcohol lead can spend in the surgery promoting the clinic; confusion at one of the surgeries with patients being advised to attend the RISE walk-in clinic rather than book an appointment at the surgery; and a lack of clarity over the process for booking alcohol clinic appointments.
- RISE will consider how to increase the alcohol offer within primary care as part of the overall GP shared care review. RISE has difficulties accommodating those drinking at increased risk into the two main treatment hubs and primary care feels a more attractive venue for working with this client group.
- Some of these service users will be working so any attempt to engage them through the primary care setting would have to take this into account and would require an early evening clinic option as part of the overall treatment offer.

POTENTIAL OPPORTUNITIES FROM THE GP SHARED CARE REVIEW

- The GP shared care review offers opportunities for RISE to consider several potential developments:
  - Opiate detoxification in primary care
  - Offering alcohol specific clinics, marketed separately, with some evening provision to target those drinking at increased risk before they become dependent and entrenched.
  - Review the current RISE staffing model for primary care to reduce loss of staff time in travel and to improve the relationship between RISE and individual practices through consistent staffing.
  - Deliver a more structured service for Hep B & C and COPD screening in primary care in partnership with the local surgery staff.

- Include the Women's Wellness Zone service users in the shared care model to deliver a one stop shop prescribing service.

RECOMMENDATIONS

Review and reconfigure RISE's GP shared care model bearing in mind the reductions in the opiate using population, the need to deliver primary care alcohol interventions and the Women's Wellness Zone service users.

Review RISE's primary care model to address alcohol interventions for those drinking at increased risk who do not want to come to the main treatment hubs. This will encompass learning from the two pilot primary care alcohol clinics.

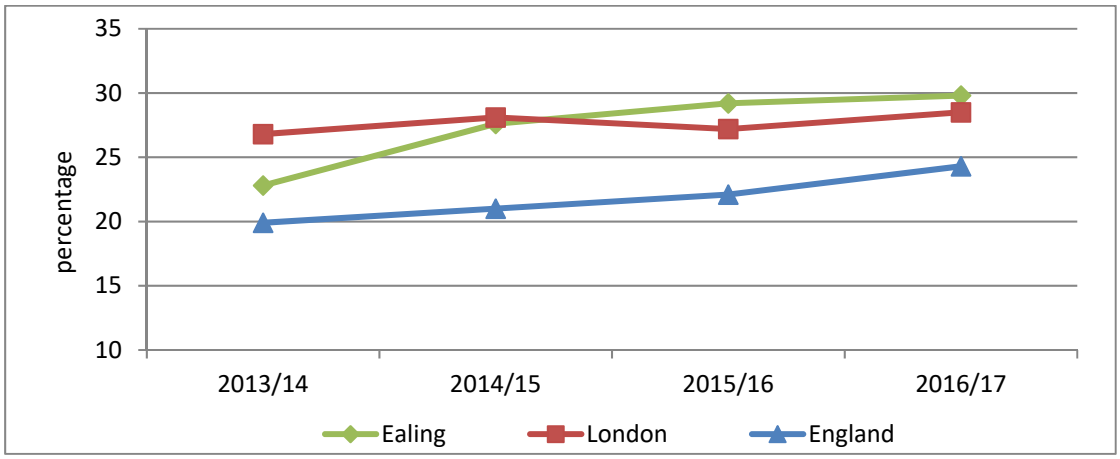
Analyse data on the level of AUDIT screening within Ealing NHS Health Checks, and for new patients in primary care collated for the Ealing Primary Care Standard. Use this data to inform where to target RISE's future primary care alcohol clinics and to improve performance around alcohol screening and Health Checks across primary care.

8. COMPLEXITY OF TREATMENT: VULNERABLE GROUPS

CO-EXISTING SUBSTANCE USE AND MENTAL HEALTH

- In 2016/17 in Ealing, there were 153 people with dual diagnosis (29.8% of new presentations in substance misuse treatment), which is a significantly higher proportion than the national figure of 24.3%. Figure 30 below shows the rising trend for Ealing over the last four years. This shows the proportion of people who, when assessed for drug treatment, were receiving treatment from mental health services for reasons other than substance misuse.
- The measure is indicative of levels of co-existing mental health problems in the drug treatment population. However, it should not be regarded as a comprehensive measure of co-existing mental health as it only captures whether a person is receiving mental health treatment at a given point in time and does not consider the majority of RISE service users who either have no official mental health diagnosis or do not meet the threshold for secondary care. As such, it is likely to be a significant under-estimate of the co-existing needs of the cohort of service users, many of whom have experiences of Adverse Childhood Experiences and trauma.

Figure 30: Co-existing substance misuse and mental health issues



Source: Co-existing substance misuse and mental health issues profile (NDTMS, 2017)

- In 2017/18, 46% of all new presentations to drug treatment were recorded as having a mental health need. Only 60% of these were receiving treatment for their mental health.
- In 2016/17, there were 89 people in alcohol treatment who also had contact with mental health services. This equates to 26.2% of new presentations in treatment, statistically similar to the national figure of 22.7%.
- In 2017/18, 48% of the alcohol treatment population were recorded as having a mental health need, 77% of these were receiving treatment for their mental health.

PARTNERSHIP WORKING BETWEEN RISE AND WEST LONDON NHS TRUST

- Ealing RISE is working in partnership with the West London NHS Trust to deliver more effective interventions for shared service users. The Trust has developed their co-existing mental health and substance use strategy and works with RISE and other West London treatment providers to deliver and monitor an accompanying action plan through a multi-disciplinary steering group which also includes commissioning leads.
- The West London NHS Trust Co-Existing Mental Health and Substance Use Strategy has 8 principles:
  - Equity of access to mental health services for those with co-existing alcohol and drug problems
  - Alcohol and drugs assessment should form part of the core assessment
  - Substance use needs should be addressed in the care plan
  - Service users should be offered interventions to address substance use
  - Families, carers and significant others affected by substance use should be offered support
  - Information sharing protocols will be in place to enable effective joint working between services
  - All staff should be competent in the recognition, assessment and treatment of individuals with co-existing mental health and substance use needs

- The Trust will support the Co-Existing Mental Health and Substance Use Governance Committee to monitor compliance and effectiveness against the strategy

- The shared action plan has initially focused on:
  - mapping current services across the two disciplines and any inclusion/exclusion criteria
  - clarifying what stepped care for those with co-existing mental health and substance use issues would ideally look like and who should deliver which components of the stepped care and criteria for escalation.
  - Compiling a joint training plan across both disciplines drawing on expertise across the mental health and treatment provision.
  - Delivering several shared areas of work including: joint investigations of shared service user deaths and the dissemination of lessons learned; consistent attendance of multi-disciplinary meetings to discuss shared cases; facilitated access to case management systems to support information sharing to manage risk; and investigating the possibility of shared student placements and secondments for staff.

RECOMMENDATIONS

Address gaps in local partnership working to more effectively support residents with co-existing mental health & substance use. This will involve ensuring appropriate information sharing with WLNHS Trust having access to RISE's case management system, CRIiS through the primary care mental health team, SPA, and the recovery team. RISE will have access to RIO on site at the main treatment hub. This partnership work around shared cases will be enhanced by regular and consistent WLNHS Trust attendance at RISE's multi-disciplinary team meetings to enrich case discussions and robust risk management. The West London NHS Trust is currently reviewing the IAPT offer in Hammersmith and Fulham, working closely with the treatment system to ensure improved access for substance misuse service users. RISE will be involved in this work through the Trust's co-existing mental health and substance use steering group and will be looking to adopt similar pathways in Ealing.

CRIMINAL JUSTICE

- Acquisitive crime and drugs are inextricably linked, with crime committed by people whose drug use has become an addiction. Their offending often escalates to keep up with the rising cost of their drug use. Estimates suggest that drug misusers commit between a third to a half of all acquisitive crime. Some also support their use through low-level dealing or prostitution.

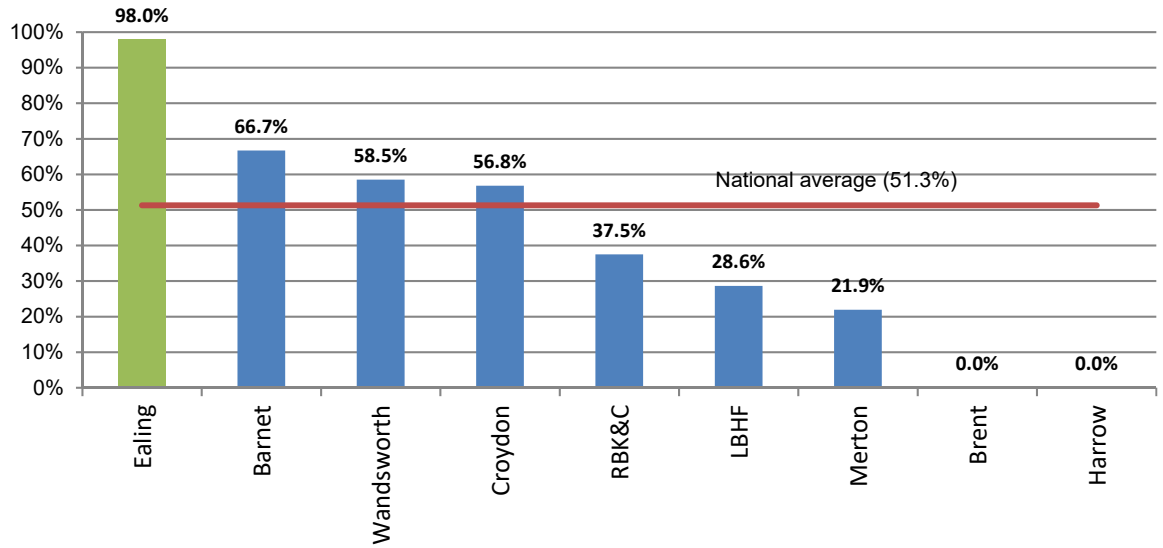
REFERRALS FROM THE CRIMINAL JUSTICE SYSTEM

- PHE provides data on the proportion of people in contact with the criminal justice system that are referred to and start a structured treatment intervention. This is an assessment

of referrals from the criminal justice system to community treatment, from community treatment to prison treatment and from prison to community treatment that engage in treatment interventions.

- The quarter 4, 2016/17 DOMES report shows that almost all (98.0%) of people in contact with the criminal justice system, were referred to community treatment, a considerably higher proportion of criminal justice system referrals into treatment compared with just over half (51.3%) nationally. The chart below shows the proportion of criminal justice system referrals into community treatment, comparing Ealing with the national average and comparable London local authorities with similar opiate using populations.

Figure 31: Referrals from Criminal Justice System to Structured Community Treatment in 2016/17



Source: NDTMS, DOMES Report, Quarter 4 2016/17

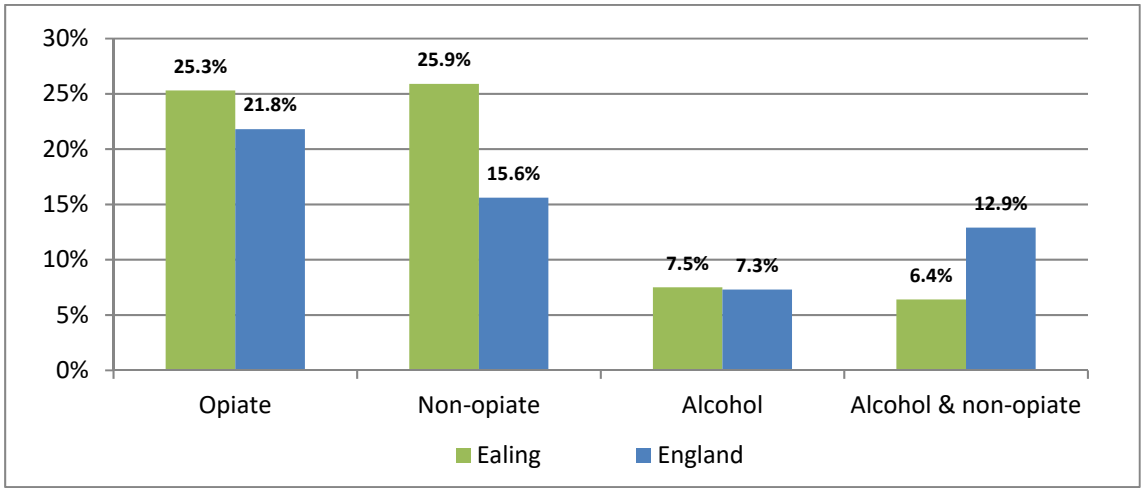
- More than one in four (25.7%) were transferred from prison to community treatment compared to one in ten (29.8%) across England.

CONTACT WITH THE CRIMINAL JUSTICE SYSTEM

- In 2016/17 there were a total of 332 service users in contact with the criminal justice system. The majority (71.4%) citied the use of opiate drugs, followed by non-opiate only drugs (13.3%), alcohol only (12.3%) and alcohol & non-opiate drugs (3.0%). Those citing opiate drug use and in contact with the criminal justice system represent 25.3% of the total treatment population citing opiate use, higher than the national average (21.8%).
- When it comes to non-opiate drug users in contact with the criminal justice system, Ealing's proportion is even higher than across England (25.9% versus 15.6%). The percentage of alcohol users is similar to the national figure. However, the proportion of alcohol and non-opiate users in contact with the criminal justice system are significantly less compared to the national average.

- The chart below shows the proportion of the total treatment population that are in contact with the criminal justice system by substance grouping, compared to the national average.

Figure 32: In contact with the Criminal Justice System by Substance Groupings, 2016/17



Source: NDTMS, DOMES Report, Quarter 4 2016/17

RISE'S CRIMINAL JUSTICE TREATMENT DELIVERY

- The MOPAC funding for RISE's dedicated criminal justice team ended in 2016/17. The Safer Ealing Partnership decided to allocate their Crime Prevention Funding to three new projects, one of which is the Women's Wellness Zone.
- This means RISE's criminal justice work has been mainstreamed into the recovery teams based at the two treatment hubs with all recovery workers having some service users known to the CRC or the NPS on their caseloads. There is one recovery worker with a continued Criminal Justice specialism who covers the prison engagement work and maintains RISE's partnership working with criminal justice agencies. His caseload is entirely criminal justice focused. Each quarter, there are approximately 120 criminal justice clients in the treatment system.
- The CJ specialist RISE worker has recently trained Probation Officers at the local justice area Magistrates Courts (Ealing and Uxbridge) to carry out their own Alcohol Treatment Requirement (ATR) assessments at Court on the first appearance. The main aim of this new initiative is to reduce the number of Court appearances and to prevent individuals from failing to attend their appointments whilst on bail. RISE plan to roll this process out to include Drug Rehabilitation Requirements (DRRs) assessments.
- RISE staff are trying to develop other treatment orders with the CRC and are looking at how to use Rehabilitation Activity Requirements (RARs) more effectively, particularly for targeting the non-opiate cohort.

- Ealing no longer has an arrest referral service based in the police custody suite. Anyone testing positive following a drug test is no longer required to attend a drug and alcohol assessment. This has been replaced by a voluntary assessment process.
- RISE and the police are discussing the introduction of a conditional cautioning scheme. A Conditional Caution is issued if an offender admits the offence and accepts the condition(s). A Conditional Caution differs from a simple caution as there are certain conditions that must be complied with to avoid prosecution for the offence committed. These conditions would involve attendance at RISE or the Women's Wellness Zone for treatment sessions.

RECOMMENDATIONS

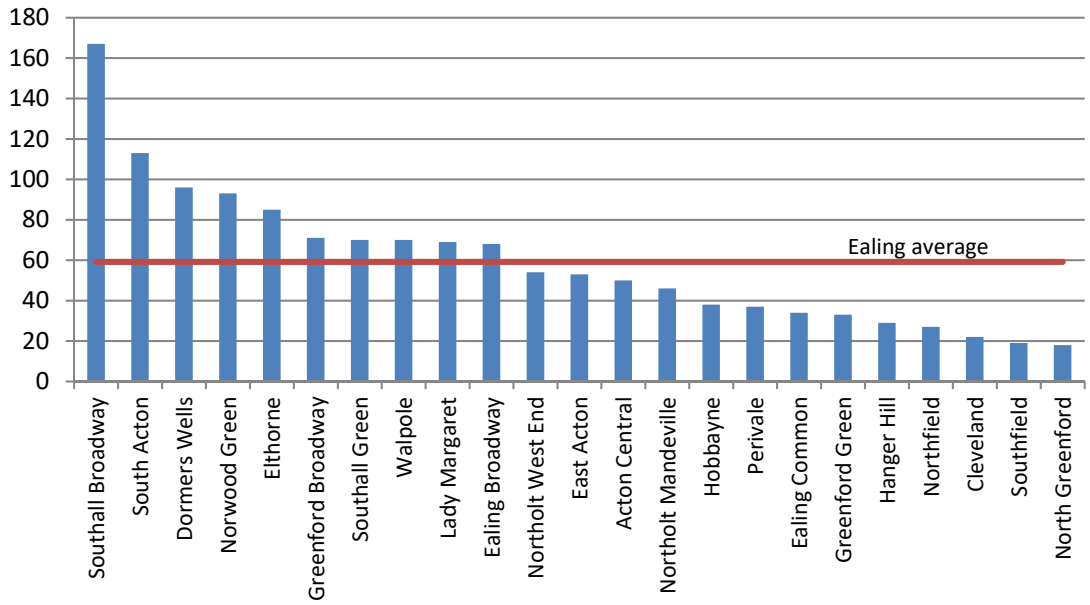
Improve partnership engagement from criminal justice agencies to support treatment outcomes. This will include improving use of community orders and developing pathways into treatment through conditional cautioning.

MET POLICE DRUG RELATED OFFENCES

- In 2016/17 there were a total of 1,362 drug related offences across Ealing[7], a reduction of 5% compared with the previous year (down from 1,435 in 2015/16). Across London there was an 8% drop in drug related offences (down from 41081 in 2015/16). In 2016/17, 89% involved possession of drugs, 9% drug trafficking and 1% other drug offences in Ealing, broadly similar to the London profile of drug offences.
- The chart below shows the percentage of drug related offences by wards in 2016/17. There was a total of 160 offences with an average of 59 offences per ward. There were 167 offences in Southall Broadway, representing 12% of the total drug related offences, followed by South Acton with 113 offences (8% of the total). Dormers Wells and Norwood Green added 7% each to the total number of drug related offences (96 & 93 records respectively), while the smallest number of these offences was recorded in Southfield (19) and North Greenford (18).

[7] *Source: MET Police Service, Recorded Crime Data (London Data Store), 2017*

Figure 33: Drug Related Offences, Ealing wards, 2016/17



Source: MET Police Service, Recorded Crime Data (London Data Store), 2017

WOMEN

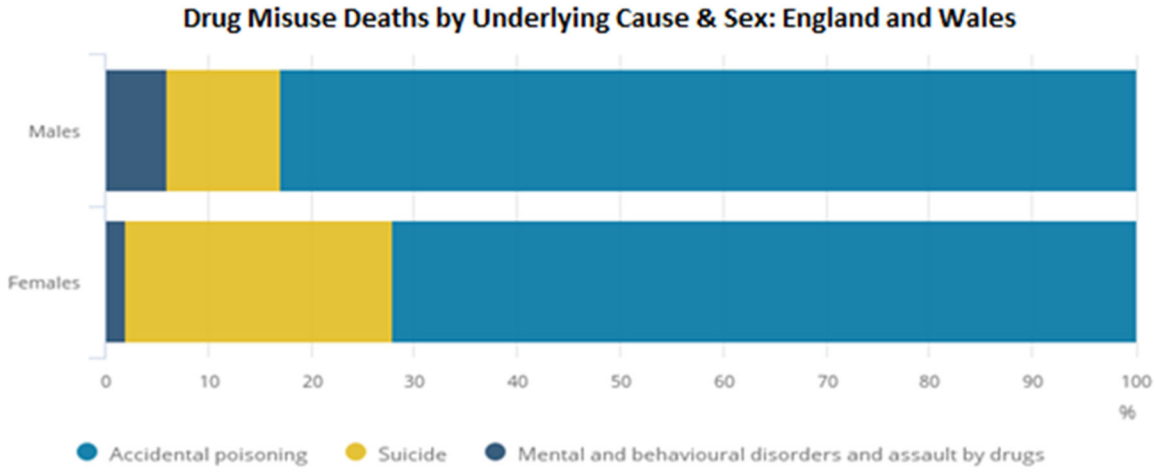
DIFFICULTIES ENGAGING WOMEN IN LOCAL TREATMENT SERVICES

- Ealing's treatment system has had difficulties in engaging the levels of women seen in other London treatment systems, and this issue was picked up in the last substance misuse needs assessment. RISE's treatment system is markedly different from the National average with an 80:20 male to female split, compared to 70:30 nationally.
- It is also concerning to see how the number of women entering the treatment system and achieving a successful treatment outcome has declined over the last two years, and the funding cuts seem to be further disproportionately affecting women.

REDUCED OUTCOMES FOR WOMEN WITH COMPLEX NEEDS

- In 2015/16 there were 501 women entering treatment, but this dropped to 399 in 2016/17. In 15/16, 121 women (24%) achieved a successful completion from drug and alcohol treatment with 118 leaving treatment without a positive outcome (23%). This compared to 80 achieving a successful completion (20%) in 2016/17 and 112 leaving without a successful treatment completion (28%).
- Where domestic abuse and sexual violence had been recorded, none of these women achieved a successful completion and if mental health was a contributing factor, the performance was declining here too. In 2015/6, where women presented with co-occurring mental health needs, 40 achieved a successful completion (76%) and 12 left treatment without a positive outcome. In 2016/17, 28 women with dual diagnosis left with a positive outcome (35%) but 50 did not.

- Most of the Southall women with substance misuse needs involved in street-based sex work were not moving from engagement with outreach workers into structured treatment. The funding cuts had reduced the number of outreach workers and had an impact on the amount of intensive support available to each service user. These statistics suggested poorer outcomes from Ealing's treatment system were more likely for women managing higher levels of complexity and trauma.
- These are compounded by some issues highlighted in the National data. Drug misuse deaths amongst women are rising faster than those amongst men. While most people who die because of drug misuse are men, in 2016, female drug misuse deaths rose by 8%, compared with a rise of 2% for men. Two years before they rose by 23%, compared with a rise of 14% amongst men. In 2017, the ONS reported twice the proportion of women died by suicide compared to males.



Source: Office for National Statistics

- There was a widespread perception that the configuration of the treatment system with two service delivery hubs, neither of which could be zoned or closed off for women only provision, posed some real problems for engagement and retention of female service users. They were concerned about attending treatment at the same time and in the same space as their male perpetrators and often 'voted with their feet', dropping out of structured treatment, further increasing their level of vulnerability.

THE WOMEN'S WELLNESS ZONE

- The stark inequalities facing women with drug and alcohol treatment needs along with other complex needs resulted in a local commissioning strategy to develop Ealing's women's one stop shop, the Women's Wellness Zone described in the assets and services section. Appendix 4.

HOUSING & HOMELESSNESS

- The data below shows the self-reported housing status of adults when they started treatment. A safe, stable environment is crucial to enable people to engage with treatment and then sustain their recovery.
- Ealing has the same issues as other London boroughs with the current housing crisis. There is not enough social housing to meet local need and therefore most drug and alcohol users are unlikely to get access to a Council or Housing Association tenancy. Most will have to use the private sector, and many will be unable to afford these rents with the current benefit cap. This means either trying to find enough work to avoid the cap and be eligible for working tax credit or relocating out of London.
- Under the two Public Health Outcomes Framework statutory homelessness measures, Ealing has elevated levels for **eligible homeless people not in priority need**. Ealing has the highest levels in London and is the 9th worst in the country per 1000 households. This refers to the number of households that have presented themselves to the local authority but under homelessness legislation have been deemed to be not in priority need. Most of the people that fall under this cohort are single homeless people which includes people with drug and alcohol treatment needs. Ealing also has high levels of **households in temporary accommodation** in comparison with National levels. These are homeless households in temporary accommodation awaiting a settled home. London make up the 12 highest scoring areas in the country and Ealing is 12th.

EALING'S DRUG AND ALCOHOL SUPPORTED HOUSING PATHWAY

- The local supported housing pathway has also experienced reductions although two new drug and alcohol projects went live in 2016/17. These Equinox projects provide supported housing for two groups of people: those still experiencing drug and alcohol problems but motivated to change and use the local treatment system; and those who have achieved abstinence but need some additional support before they're ready to move on into their own tenancy.
- The stakeholder interviews with supported housing providers and the manager of the rough sleeping outreach team, highlighted a difficulty in maximising places in these two housing projects and the wider supported housing pathway. There had been voids and so the supported housing providers had established a Project Move-On meeting to try to ensure no one relapsing or requiring move-on either through the supported housing pathway or into their own tenancy becomes homeless (NFA) because the system wouldn't be flexible enough to adapt to their changing needs. The meetings needed regular attendance from RISE's management to enhance partnership working by providing a clear picture of a service user's engagement and commitment to their treatment programme.

RECOMMENDATIONS

Improve movement through the supported housing pathway for substance misuse service users, along with communication between recovery workers & housing support workers to prevent relapse and maximise treatment engagement. This will be managed through the Move On meetings attended by supported housing providers, RISE and the manager of St Mungo's Ealing Street & Community Outreach Team

EALING ROUGH SLEEPERS

- Ealing has received funding from the Ministry for Housing, Communities and Local Government (MHCLG) to deliver a series of actions to tackle the levels of rough sleepers in the borough and support resettlement activity.
- The additional money has enhanced the St Mungo's outreach team and RISE will be providing specific assessment slots to support access and engagement with drug and alcohol treatment. Rough sleepers will also be introduced to the peer support and recovery services delivered by Bob at the service user café to support treatment engagement and for harm reduction work.

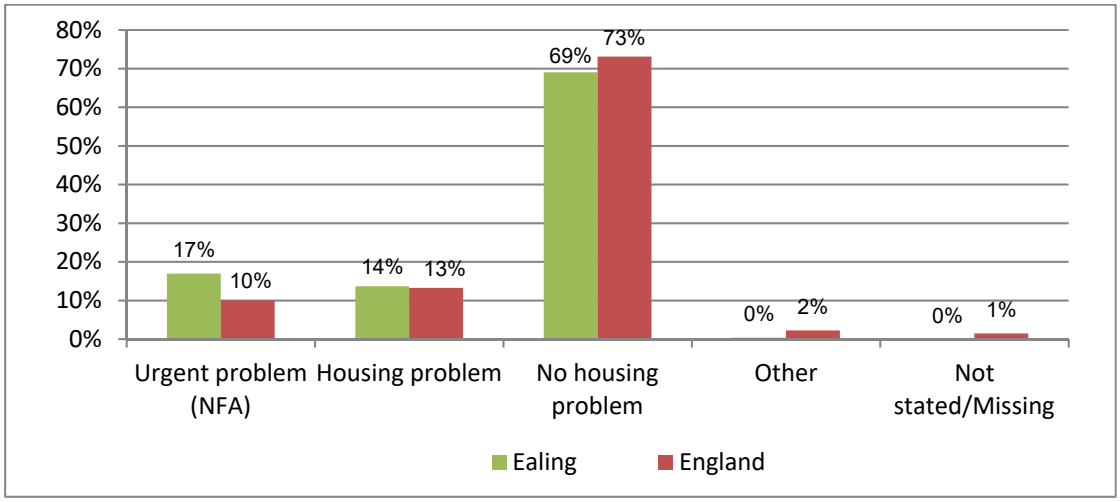
RECOMMENDATIONS

To develop an effective pathway into treatment for Ealing's rough sleeping population through the work of the central government funded Rough Sleeping Initiative programme.

HOUSING STATUS AMONGST EALING'S TREATMENT POPULATION IN 2016/17

- In 2016/17 in Ealing, there were 88 adults in treatment with an urgent housing problem (NFA)[8] (17%), higher than the national proportion of 10%.

Figure 34: Accommodation status at the start of treatment by proportion – 2016/17



Source: PHE, Drug commissioning support pack – key data 2018/19 (published 2017)

[8] NFA – No Fixed Abode

- Overall the number of decisions taken by the local authority on homelessness applications in 2016/17 was 1,387[9], which represents a rate per 1,000 households of 10.5. This is more than double the national rate of 5.0.
- In the same period, 28 adults successfully completed treatment and no longer reported a housing need. This equates to 78% of adults successfully exiting the treatment system who had a housing problem at the start of their treatment journey, but no longer reported a housing need when they exited treatment successfully. The England average is higher at 84%.

SMOKING

- There are high levels of smoking prevalence in Ealing's treatment population which corresponds with findings from research studies. The table below reproduces the smoking rates amongst residents starting treatment between April 1st 2018 and December 31st 2018. These figures are then compared with new treatment presentations across drug and alcohol services nationally during the same period.

Smoking Prevalence amongst Ealing treatment starts (April 1st -December 31st 2018)

	Year to date		National
	(%)	(n)	(%)
Opiate	72.6%	114/157	70.8%
Non-Opiate	69.2%	9/13	61%
Alcohol	56.5%	52/92	46.2%
Alcohol & Non-Opiate	71.9%	23/32	64.1%

(n) = client indicated smoking in at least 1 of the 28 days prior to starting treatment / clients starting treatment in the year to date (01/04/2018 to 31/12/2018)

Data Source: ***Diagnostic Outcome Monitoring Summary (DOMES) Quarter 3 2018-2019, PHE***

- Historically, there have been anxieties amongst both treatment staff and service users that attempting to stop smoking whilst trying to reduce or achieve abstinence from drugs and/or alcohol will have a negative impact on treatment outcomes. Current research has demonstrated that stopping smoking at the same time as entering drug and alcohol treatment does not undermine drug and alcohol treatment outcomes and may improve them. McKelvey, Thrul and Ramo (2017)[10] examined research studies looking at the impact of smoking cessation on treatment outcomes

[9] *Source: https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness (PHE, Drug commissioning support pack – key data 2018/19.*

[10] *Source: https://www.ncbi.nlm.nih.gov/pubmed/27816663*

Impact of quitting smoking and smoking cessation treatment on substance use outcomes: An updated and narrative review: McKelvey, Thrul and Ramo (2017)

between 2006 and 2016 and identified 24 relevant studies. 46% reported a solely positive impact; 17% reported solely null impact; 33% reported mixed positive; and 4% reported mixed negative. No studies reported increased substance use because of smoking cessation work.

- Mendelsohn and Wodak (2016)[11] summarised the common myths associated with smoking cessation for drug and alcohol service users and the appropriate response drawing on available research in the table below.

MYTH	**RESPONSE**
Smoking is a lower priority than other drugs	Those who are alcohol or drug dependent and smoke are far more likely to die prematurely from a smoking-related disease than from their primary drug problem
Smoking relieves stress	Smoking actually increases stress levels overall. Much of the apparent calming effect of smoking is due to the relief of the nicotine withdrawal.
Quitting smoking will undermine recovery from other drugs	Quitting smoking generally improves drug or alcohol treatment outcomes
It is best to stop one drug at a time	Concurrent treatment of nicotine and other drugs is preferred wherever possible and increases the success rates overall
Quitting causes massive weight gain	The average weight gain is only 2-3 kg over a five-year period, compared with those who smoke. Some quitters gain considerably more weight; however, one in five lose weight or stay the same.
The withdrawal symptoms will be unbearable	Withdrawal symptoms can usually be controlled with optimal use of stop-smoking medications and behaviour change strategies

- Mendelsohn and Wodak (2016) also collated information from research about how smoking interacts with drugs and alcohol to amplify some health risks further amplifying the case for combining smoking cessation work with drug and alcohol treatment.

Alcohol	• Nicotine and alcohol each enhance the enjoyment of the other through their common action in the reward pathway, where both trigger the release of dopamine. • Drinking alcohol increases the urge to smoke, partly due to the disinhibiting effects of alcohol and conditioned association of the two behaviours. • Smoking increases the urge to drink and is a risk factor for relapse to alcohol after alcohol treatment.

[11] *Source: https://www.ncbi.nlm.nih.gov/pubmed/27610446*

Smoking cessation in people with alcohol and other drug problems: Mendelsohn CP, Wodak Am A (2016).

	• Smoking counters the sedative and cognitive effects of alcohol and reduces the severity of alcohol withdrawal. • Long-term quit rates are low, especially in heavy drinkers.
Opiates	• Users of opiates and opioid agonists (e.g. methadone, buprenorphine) have the highest smoking rates (>85% smoke). • Methadone may increase the reinforcing effects of cigarettes. People who use methadone smoke more heavily in the four hours after each dose. • Nicotine attenuates some side-effects of methadone such as sedation and reduced attention. • Opiate users have high levels of psychiatric comorbidity and stress and may use smoking as an anxiolytic or antidepressant. • Most opiate users are interested in quitting smoking, but long-term quit rates are very low.
Cannabis	• About 50% of adults with cannabis-use disorders are currently smoking tobacco. • Two out of three users combine cannabis with tobacco ('mulling'), which can lead to nicotine dependence and cigarette smoking. • Quitting both together is recommended as continuing to use cannabis can make quitting tobacco harder. • Cannabis and tobacco have similar withdrawal syndromes and the combined symptoms may be more severe. • Behavioural strategies used for tobacco can also help reduce or stop cannabis.
Stimulants (e.g. cocaine, meth/amphetamine)	• More than 80% of people who use stimulants smoke tobacco. • Cocaine administration increases cigarette smoking and nicotine use increases the severity of cocaine use. • Nicotine withdrawal (quitting smoking) is associated with reduced cravings for stimulants. • A recent study has found that quitting smoking during stimulant treatment improved smoking abstinence and did not undermine stimulant outcomes.

RECOMMENDATIONS

To incorporate smoking cessation work into the new drug and alcohol treatment contract to improve treatment outcomes and overall physical health outcomes for Ealing residents with drug and alcohol problems

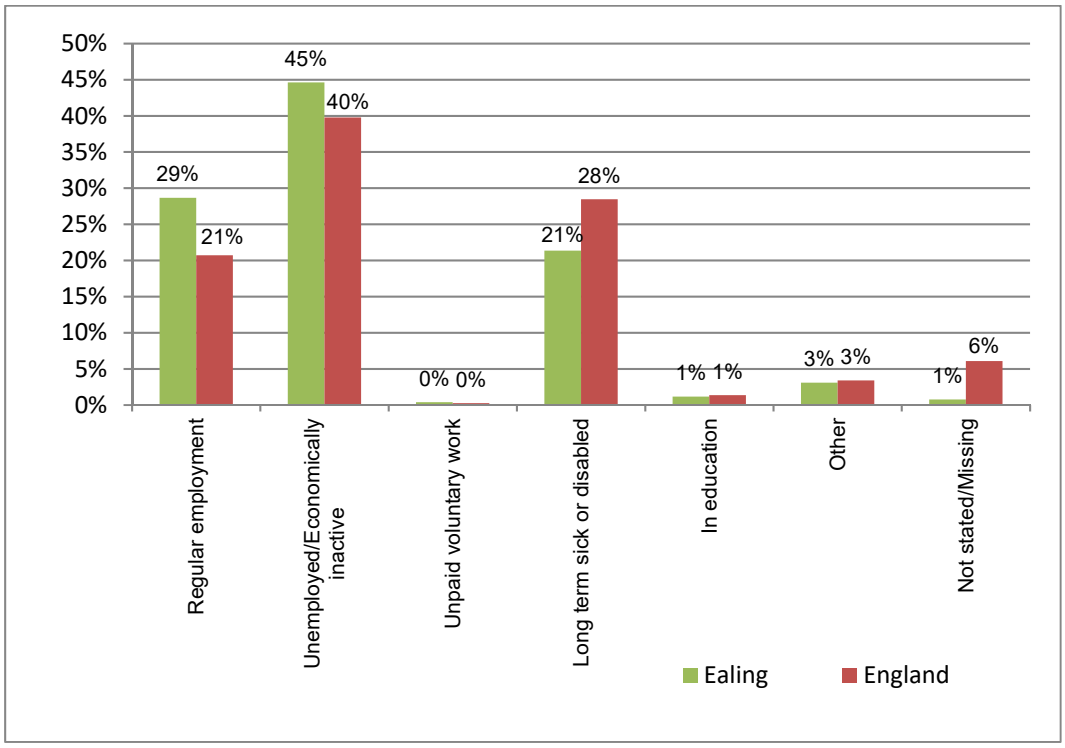
UNEMPLOYMENT

- The data below shows the self-reported employment status at the start of treatment in 2016/17. Improving job outcomes is key to sustaining recovery and requires improved multi-agency responses with Jobcentre Plus and Work and Health programme providers.
- In 2016/17 in Ealing, most people entering the treatment system were unemployed (45%), whilst 29% were in regular employment. The third largest group were the long-term sick or disabled (21%). Nationally, 40% of people starting treatment were unemployed, 28% long-term sick or disabled, whilst 21% had employment.

EMPLOYMENT PROJECTS IN EALING

- RISE used to have two specialist education, training and employment (ETE) posts as part of the treatment system before the reduction in overall funding. These workers helped to deliver some of the wrap-around support necessary to improve and sustain individual treatment outcomes.
- The West London Alliance recently commissioned an Individual Placement Support (IPS) employment service for drug and alcohol users. As part of this new contract, Ealing will have two specialist ETE posts integrated into the treatment team. They will be helping service users identify their employment goals and supporting them on their journey to acquire a job. This is a tailor-made employment service for drug and alcohol users delivered by WDP and going live in Ealing from April 2019.
- The project will sit alongside other ETE programmes RISE service users are eligible to apply for including: Twinings' IPS scheme for people with lower level mental health needs including anxiety and depression; and the Shaw Trust's Work & Health Programme commissioned by the West London Alliance for people with health conditions or a disability, unemployed for more than two years, or for those at specific disadvantage in the labour market.

Figure 35: Employment status at the start of treatment by proportion, 2016/17



Source: PHE, Drug commissioning support pack – key data 2018/19 (published 2017)

BLOOD-BORNE VIRUSES (BBVS)

- The data below shows the drug users in treatment in Ealing (2016/17), 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 blood-borne viruses. Providing opioid substitution therapy (OST) and sterile injecting equipment and antiviral treatments protects them and communities, as well as providing long-term health savings.
- RISE has developed a series of initiatives to increase the rate of BBV testing including BBV awareness weeks, highlighting the issue and testing across the treatment system with promotional drives in the service user forums.

Figure 36: Hepatitis B vaccination and current or past injectors who have been tested for hepatitis C in 2016/17

+ **Hepatitis B**	Ealing		England	
	Number	% of eligible clients	Number	% of eligible clients
Adults new to treatment in 2016/17 eligible for a HBV vaccination who accepted one	248	58%	20,856	39%

Of those:				
the proportion who started a course of vaccination	48	19%	3,484	17%
the proportion who completed a course of vaccination	45	18%	4,299	21%
Hepatitis C				
Previous or current injectors in treatment in 2016/17 eligible for a HCV test who received one	267	80%	77,432	83%

Source: PHE, Drug commissioning support pack – key data 2018/19 (published 2017)

HEPATITIS C TREATMENT

- Recent developments in hepatitis C treatment have resulted in improved treatment options from the two previous medications: pegylated interferon (a weekly injection) and ribavirin (a capsule or tablet). The new hepatitis C medications have been found to make treatment more effective, are easier to tolerate, and have shorter treatment courses and include simeprevir, sofosbuvir and daclatasvir.
- Using these latest medications, NHS England is hoping more than 90% of people with hepatitis C may be cured. The NHS is committed to expanding treatment options and accessibility and has committed to eliminating Hepatitis C at least five years earlier than the World Health Organisation goal of 2030.
- RISE has direct access to these treatments through St Mary's Operational Delivery Network (ODN) and a Hepatitis C nurse offers clinics at RISE providing people with their medication on site to improve uptake of the new treatments. RISE's staff promote testing along with information about the effectiveness and relative ease of the new Hep C treatment regimens as many service users are still unaware of the recent changes.
- PHE and NHS England (NHSE) have organised a national 'patient reengagement' exercise to find previous service users who tested positive to see if they are currently infected with the HCV virus and would benefit from curative HCV treatment.

PARENTAL SUBSTANCE MISUSE

- In 2016/17, there were 344 new presentations for alcohol treatment and 56 of these (16%) were living with children under the age of 18. This was lower than the national average of 25% for the same year. In total, there were 97 children in Ealing living with alcohol clients entering treatment in 2016/17.

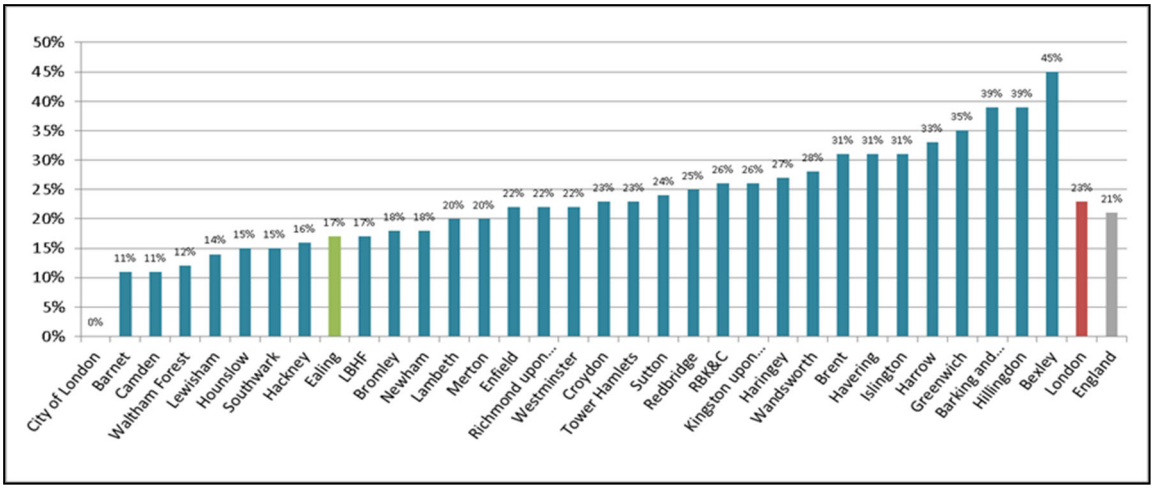
- In the same year amongst the new presentations to treatment, there were 35 people in drug treatment living with children under the age of 18, which was 7% of the new drug treatment cohort, lower than the national average of 20%. 126 (26%) were parents but weren't living with their children, compared to 31% nationally. 67% of the new presentations to drug treatment at RISE were not parents compared with 48% nationally.
- Data from the PHE parental substance misuse toolkit, shows Ealing identifying fewer risk factors associated with problematic drug and alcohol use at children in need assessments than the London and National average.
- Currently, there is no Ealing joint working protocol to support partnership work around hidden harm, and work has started to address strengthening care pathways between adult treatment and children and family services. The current training offer for children and family services around substance misuse also needs revisiting to ensure children's practitioners understand the local adult treatment offer and pathways into treatment. There also needs to be a similar training package for the RISE treatment staff to ensure they fully understand the changes under the Brighter Futures' programme, and the referral pathways into children's services.

Figure 37: Ealing Children in Need Risk Factor Data

	Risk factors identified in CIN assessments	
	Alcohol	***Drugs***
Ealing	***10.1%***	***9.5%***
Regional Average	***12.7%***	***14.2%***
National Average	***18.0%***	***19.7%***

- In 2016/17 the Recovery Intervention Service Ealing (RISE) had a lower treatment penetration rate (17%) compared to London (23%) and England (21%) with alcohol dependent parents. Figure 38 below shows Ealing's performance in comparison with the other London boroughs.

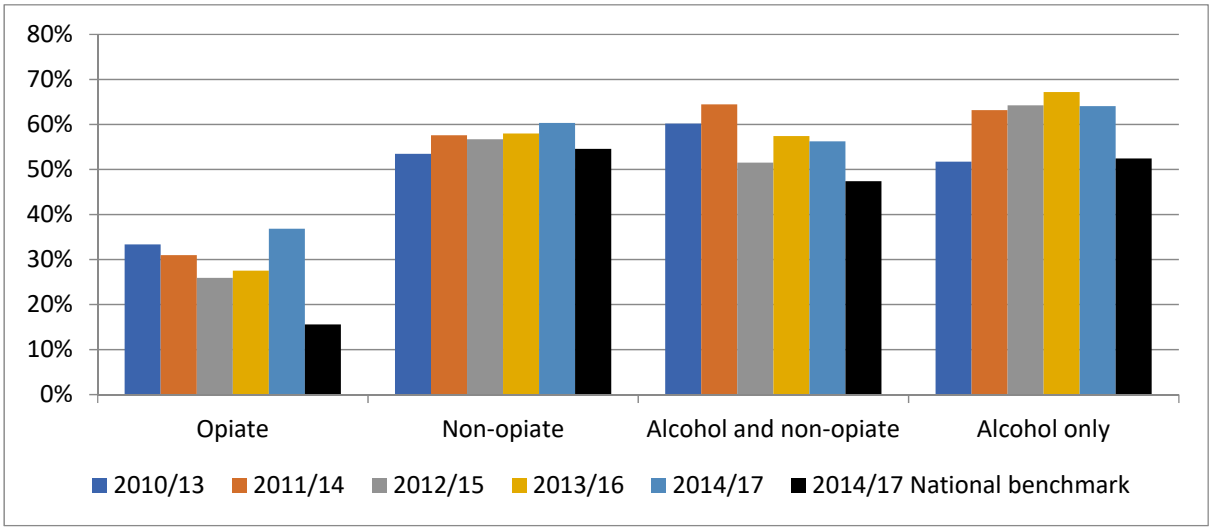
Figure 38: Adults with an alcohol dependency who live with children - % of treatment needs met 2016/17, comparing Ealing's performance with the rest of London



Source: PHE, Dependant alcohol & drug use: prevalence and treatment data, 2018

- When RISE provides parents with drug and alcohol treatment, the overall rate of successful completions is higher for this cohort than the overall completion rates at RISE. In the treatment years 2014/17, parents achieved a successful alcohol completion rate of 64.1% compared to Ealing's alcohol successful completion rate of 39% in 2016/17. Parents in treatment for opiates over the same three-year period achieved a 36.8% successful completion rate in comparison with RISE's 9.9% opiate successful completion rate in 2016/17.
- Figure 39 shows the percentage of successful completions from treatment in three year periods from 2010/13 to 2014/17. This NDTMS data includes successful completions for both parents who do not live with their children and adults who live with children.

Figure 39: Percentage of successful completions



- CQC recently inspected Ealing's looked after children's health services and highlighted some issues for Ealing's adult treatment system in their report, raising concerns about the lack of professional curiosity in the case files:

> *Although Ealing RISE substance misuse services electronic client records are good; those same records did evidence a lack of professional curiosity and responsive multi-disciplinary and multi-agency information sharing. This is true of both the adult substance misuse service and the young person's service. This is a missed opportunity to improve and build a comprehensive knowledge base regarding children and young people in the care of adult service users who can lead sometimes chaotic lifestyles which put those vulnerable young people at risk. A multi-agency approach to information sharing is integral to managing risk and the safety of vulnerable children and young people.*

- After this report, RISE audited 127 service users with a safeguarding module open. They found 36 cases which they defined as 'safeguarding not being managed effectively' and developed an action plan to address the issues covered in the audit and the CQC report. The plan covers the following:
    - Staff training sessions around safeguarding and professional curiosity covering the findings from an internal audit & the CQC report delivered by RISE safeguarding leads. EASY (the young people's drug and alcohol treatment service) staff will have their own team building session.
    - Mandatory monthly supervision sessions with the clinical psychologist to specifically focus on safeguarding practice
    - Multi-disciplinary team meetings to have a focus on safeguarding and Think Family practice as part of these wider discussions.
    - Team meetings to discuss expected standards around: Parental Needs Assessments; Urine Screening & blood alcohol content (BAC) requirements in line with RISE policy; expectations of a recovery worker when taking over a service user from another staff member's caseload; & joint working with children's services.
- RISE are also now part of Ealing's Multi-Agency Safeguarding Hub (MASH) to further address the CQC concerns about '*responsive multi-disciplinary and multi-agency*

information sharing' and improve partnership working between children and families and adult treatment.

RECOMMENDATIONS

Improve the communication and joint working between children's services and RISE by:

developing a hidden harm joint working protocol between the two disciplines with reference to the forthcoming revised PHE guidance and roll this out with joint training and workshops.

Exploring the possibility of placing a RISE worker in children's services.

Delivering substance misuse training to Ealing's children's services as part of Ealing's SCB's overall training offer.

Providing weekly safeguarding surgeries at RISE delivered by children and families staff

Delivering home visit training to RISE staff to increase their understanding of what to look for when on a home visit.

PEOPLE WITH NO RECOURSE TO PUBLIC FUNDS (NRPF)

- In the previous substance misuse JSNA, stakeholders raised a strong concern about the number of service users with no recourse to public funds. This poses problems for treatment workers since these service users are not entitled to any housing or benefit support. It's also difficult for them to obtain employment without a recognisable address or employment history. Service users can access community-based treatment but can't apply for residential rehabilitation because they are not eligible for funding under the Care Act. Ealing, because of its proximity to Heathrow and its diverse population (particularly in the west of the borough), has particular issues with these types of clients presenting to services.
- RISE analysed treatment data since 2015/16 to look at the number of NRPF service users in treatment. All the service users were living in Southall and nearly all were of Indian descent. During 2016/17 to 2018/19, there were 11 new presentations to treatment who had not been in treatment with RISE before – 6 were alcohol users and all were Indian males. The RISE outreach worker covering the Southall area, is seeing smaller numbers of NRPF service users and thinks this is due to them moving to other areas to find work. There are more alcohol dependent than heroin dependent service users in this new cohort of NRPF, which includes those in treatment and those only accessing harm reduction interventions through outreach sessions.
- RISE recruited an additional drug and alcohol outreach worker in Autumn 2018 til the end of the financial year. They were embedded in the St Mungo's Outreach Team as part of

Ealing's Rough Sleeper Initiative Programme. The project will continue in 2019/20 with a St Mungo's complex needs worker and Public Health will be tracking this work to see if it brings any new NRPF service users into drug and alcohol treatment as part of the local work to support rough sleepers into accommodation.

Figure 40: NRPF service users accessing RISE

	2015/16	2016/17	2017/18	2018/19
New presentations	31	34	36	25
Gender	100% male	100% male	100% male	100% male
Drug	30 opiate; 1 alcohol	33 opiate; 1 alcohol	34 opiate; 2 alcohol	23 opiate; 2 alcohol
Country of origin	31 Indian; 1 Nepalese	33 Indian; I Nepalese	33 Indian; 1 Algerian; I Nepalese; 1 Sri Lankan	23 Indian; I Nepalese, I Sri Lankan
Total NRPF treatment population	44	56	74	48
Drug	43 opiate; 1 alcohol	55 opiate; 1 alcohol	72 opiate; 2 alcohol	46 opiate; 2 alcohol
Country of origin	43 Indian; 1 Nepalese	54 Indian; 1 Nepalese	71 Indian; 1 Algerian; I Nepalese; 1 Sri Lankan	45 Indian; 1 Algerian; I Nepalese; 1 Sri Lankan

Source: RISE data

9. EMERGING TRENDS

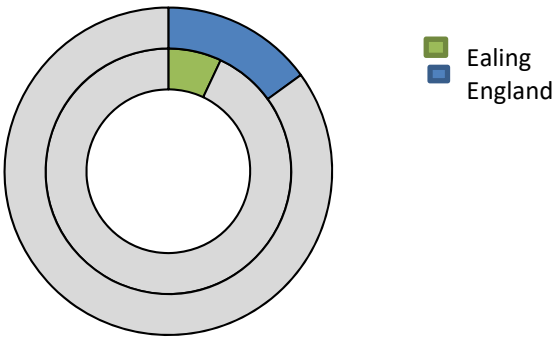
USE OF DRUGS TO TOP UP PRESCRIBED MEDICATION

Prescription only medicine/Over-the-counter medicine (POM/OTC)

- People in treatment for prescription-only medicine (POM) or over-the-counter medicines (OTC) and drug users who have a problem with these as well as illicit drugs, are presented in Figure 36 below. In 2016/17 in Ealing, 7% of people in treatment (89 individuals) cited use of POM/OTC, lower than the national proportion of 15%.
- RISE works closely with GPs requiring specialist support and advice to treat patients with prescription and over the counter addictions. However, the treatment system with its current reduced capacity is not able to take referrals for this group from primary care, which probably explains the lower than National average. Arguably, RISE is not the best place to treat these residents as they are unlikely to feel comfortable in the very busy treatment hubs.

- Stakeholders highlighted pain medication as an area of concern, with use escalating beyond original doses and patients remaining on medication for long-term chronic pain conditions rather than for short periods to treat acute pain. Research shows prescribing opiate and other pain medication for long-term chronic pain is counter-productive and is merely producing another group of dependent users. Stakeholders also raised concerns about local pain clinics with some patients leaving these specialist clinics (after referral from their GP) with even higher levels of medication. They also cited pregabalin and gabapentin as growing concerns. GPs initially didn't realise the dependency risks and were prescribing relatively freely until patients have started to become dependent on these drugs.
- The CCG are trying to tackle this prescribing issue by flagging alerts on people's files, but when patients do want to come off, there aren't the appropriate services to send them to. Clearly, a referral to RISE is not a suitable response nor is it likely to be successful for this client group.
- Ealing needs to do some further research to establish the real scale of this issue and audit the levels of pain prescribing across primary care. This data will then inform any potential pilot project, which will require additional funding. Public Health England is undertaking a public health evidence review of available data and published evidence on the problems associated with some prescribed medicines, including:
    - dependence
    - short term discontinuation syndrome
    - longer term withdrawal symptoms
- The review is due to publish its findings in 2019 and there are concerns England may be facing a crisis which has so far remained relatively hidden in relation to the levels of pain and antidepressant prescribing. Ealing will look closely at any recommendations coming from this research as well as their own data audit to determine the best approach to tackle the issue locally. It may be possible to fund interventions on an invest to save basis.

Figure 41: Proportion of treatment population citing POM/OTC use in 2016/17



Source: PHE, Drug commissioning support pack – key data 2018/19 (published 2017)

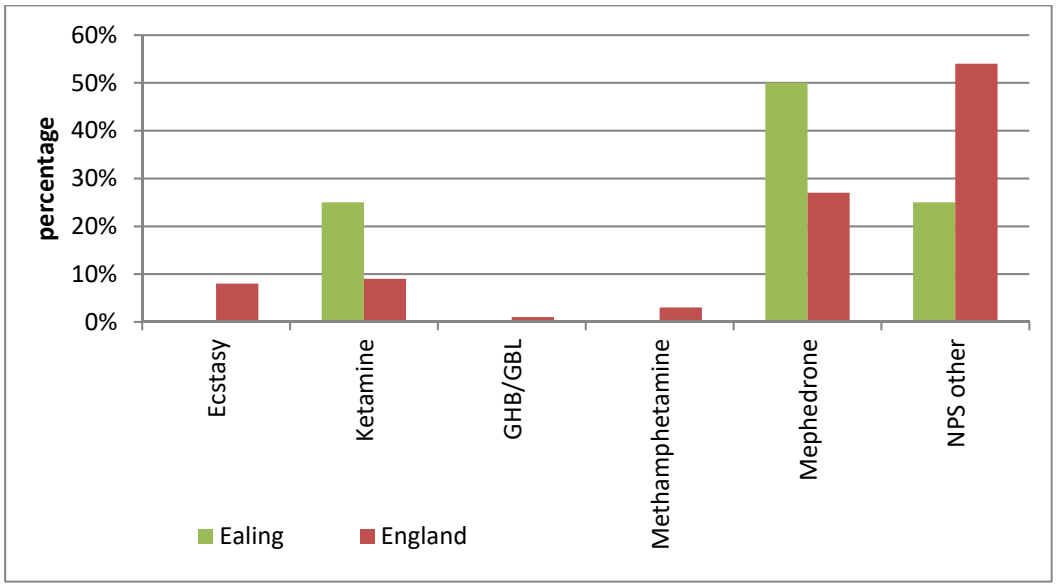
RECOMMENDATIONS

Work with the CCG to address the lack of an appropriate intervention for primary care patients with dependency to pain medication, initially prescribed for chronic pain relief.

NPS AND CLUB DRUGS

- The data below covers the main new psychoactive substances and 'club' drugs reported by new treatment entrants who are (1) also using opiates (Figure 41) or (2) using NPS/club drugs and perhaps other drugs but not opiates (Figure 42). Opiate users still dominate adult treatment, and generally face a more complex set of challenges which mean their treatment journeys can be longer, more fractured and complex. Non-opiate using, adult club drug users typically have better social capital, which mean they are more likely to maximise the benefits from a treatment system at a quicker pace.
- In 2016/17 in Ealing, there was a very small number (4) of adult users citing club drug use and opiate use, so in comparison to the national data, any differences are not statistically significant.

Figure 42: Proportion of club drug use and opiate use of those citing use at treatment start (opiate use) – 2016/17

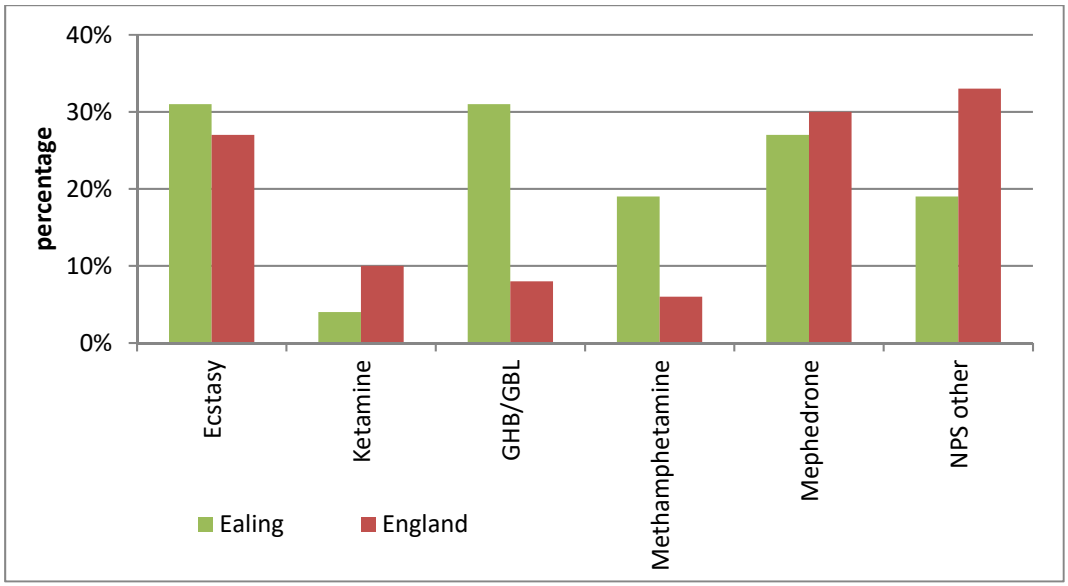


Source: PHE Adults – Drugs commissioning support pack 2018/19: key data (published 2017)

- In 2016/17 in Ealing, there were 26 adult users in total citing club drug use and no additional opiate use. Due to the small numbers in question, in comparison to the England data, any differences are not statistically significant.
- Men who have sex with men are a cohort who use some of these club drugs as part of the Chemsex phenomenon, where they have sex while under the influence of stimulant drugs including methamphetamine, mephedrone and GBL/GBH. These drugs are frequently administered through injection (slamming) and this group require harm minimisation and safer injecting advice as well as referral pathways into treatment and recovery.
- Many will use sexual health clinics in Soho but Ealing needs to make sure where men are using their local sexual health services, they are able to receive drug and alcohol treatment advice and support. RISE needs to work with the sexual health clinics locally to

establish partnership work and an appropriate referral pathway into treatment for those men requiring additional treatment support.

Figure 43: Proportion of club drug use and opiate use of those citing use at treatment start (no additional opiate use) – 2016/17



Source: PHE Adults – Drugs commissioning support pack 2018/19: key data (published 2017)

10. PERCEPTIONS OF STAKEHOLDERS, SERVICE PROVIDERS AND SERVICE USERS

HEALTHWATCH SERVICE USER FEEDBACK

- To provide some objective feedback about RISE's treatment offer, Healthwatch's Patient Experience Officer visited RISE several times over a few weeks in February 2018 and spoke to service users in the waiting area to hear about their experiences with the treatment system. After asking service users for an overall star rating of the service, Healthwatch asked them to "tell us more about your experience". Each comment was uploaded to Healthwatch's Online Feedback Centre, where up to five themes and sub-themes can be applied to the comment. Depending on the content of the comment it may have one or more themes attached to it. For each theme applied to a review, a positive, negative or neutral 'sentiment' is given.
- Healthwatch spoke to thirty-five service users who gave their reviews a Star Rating, where between 1-3 stars is a negative rating and 4-5 stars is positive. The results from the May report are produced below:

Total Number of Interviews	Positive Responses	Negative Responses	% of Positives
35	28	7	80%

- The positive ratings were due to the quality of the support and the attitude of the staff working at RISE. The negative ratings raised several key themes: problems due to the staffing level including multiple changes of keyworker; the waiting time between initially engaging with the service, completing the comprehensive assessment, and starting treatment; and cancellation of appointments due to staff shortages & sickness.
- These quotes cover some of the concerns service users identified:

It's gone downhill, the service used to be better when it was in Southall. I had only one key worker, she understands me, knows my history and felt confident with her. Now I have different key workers every time and sometimes they changed without telling me. She called sick often.

The reason I gave 3 is because there is no consistency with the key worker. One day you explain your situation with one key worker the next time you have a different and you keep repeating yourself again and again. They don't know you, so they can't build a relationship and that does not help.

To be honest it's not good as it used to be, they keep changing key workers all the time.

I have been using the service for a while and have relapsed a few times. The advice is there but the key worker keeps changing

Today is my first visit and it took me 2 months to get this appointment.

Waiting for an assessment it's a bit long, other than that once you are in the system its fine.

- These quotes are typical of the positive feedback:

It's very supportive, helpful and caring. My key worker, she is very nice and the support is really good. You just need to take all advice on board.

They are very helpful, friendly. I am trying to quit drinking, the support has been great.

My experience so far has been positive, it's a service that is really important to have it. It has helped me through my drug addiction.

It's excellent service, I have used similar service elsewhere but this is the best. The staff are nice, helpful, well-equipped and with many resources.

STAKEHOLDER INTERVIEWS

- Several stakeholders were interviewed to provide more qualitative data about the impact of recent reductions in funding and to identify any potential gaps and unmet needs in the current treatment system.
- The commissioner interviewed the following stakeholders:
    - The CCG clinical lead for substance misuse
    - RISE's Clinical Service Coordinator
    - RISE outreach worker based in Southall
    - RISE's deputy service manager
    - Build on Belief's Service User Involvement Lead
    - Ealing's Joint Mental Health Commissioner
    - Consultant Psychiatrist, Ealing Primary Care Mental Health Team
    - Ealing Safer Communities' Operations Manager
    - Consultant Psychiatrist, Ealing Primary Care Mental Health Team
    - Ealing Street & Community Outreach Team Manager, St Mungo's
    - Project Manager, 65 Broadway, Supported Housing, St Mungo's

- Service Manager, Equinox Supported Housing
- Ealing's Substance Misuse Team Manager (social work team based in the Council)
- Ealing's Children's Safeguarding Lead
- RISE Service User Engagement Forum

- The interviews and group discussions raised the following themes:

CHANGES TO RISE'S ASSESSMENT PROCESS

- Since these interviews took place, RISE has changed the process for entering treatment. They had tried a new system after the funding was substantially reduced to manage the assessment process with fewer staff and to reduce the high DNA rate for assessments. However, creating welcome pods with a follow-up appointment for a comprehensive assessment, created an additional barrier to accessing treatment, and a long wait between the first group discussion about RISE's treatment offer and the assessment appointment.
- They are now operating a drop-in and appointment system and have finetuned this process to provide additional front-end assessment slots at the start of the week when footfall is heaviest and service users were having to be turned away due to a lack of capacity.
- The regular changes of keyworker described by several service users continue to be a challenge for RISE with staff turnover and some inevitable reorganisation of caseloads when the Southall hub was unavoidably closed for almost 12 months from April 2017 until March 2018 because of issues with the building work at the new premises. The loss of the dedicated criminal justice team in September 2017 also resulted in some movement of service users across different caseloads as staff left or moved to new roles away from RISE.

CONCERNS ABOUT THE ALCOHOL PATHWAY

- Several stakeholders raised concerns about how reductions in funding had affected the alcohol pathway. They noted a decline in numbers accessing alcohol treatment alongside a reduction in successful completions. RISE's clinical service coordinator and the service user involvement lead both felt the loss of the structured day programme at EACH and the abstinence base had had a market impact on alcohol users accessing the service.
- They had both experienced alcohol users looking for treatment leaving the two treatment hubs at RISE either early on in their treatment journey or not making it beyond the assessment process, because they felt the service was more designed for drug users. This point was picked up by both the CCG clinical lead and the Consultant Psychiatrist in the West London NHS Trust's Ealing Primary Care Mental Health Team, who both had examples of alcohol service users who felt RISE didn't offer them the treatment space they required.

- Stakeholders felt EACH's historical reputation as an alcohol specialist had helped some service users engage with treatment through word of mouth recommendation. The loss of the abstinence space meant the treatment system no longer had a clear exit point and a building which felt more welcoming to alcohol users. EACH also provided counselling through a diverse staff team and was able to offer therapeutic interventions across several community languages with a strong reputation amongst BAME service users.
- Several stakeholders and service users raised concerns about the length of the alcohol detoxification pathway and whether this could not be concertinaed to prevent service users from dropping out or losing motivation.

IMPACT OF FUNDING CUTS ON THE TREATMENT SYSTEM DESIGN

- Several interviewees spoke about how the treatment system had been designed to ensure a flow through treatment, meaning someone could come in through the two main chaotic hubs, use the Bob recovery community to support treatment engagement and then exit through the structured day programme and aftercare offer at EACH's abstinence-based building.
- The funding reductions changed the treatment model and running abstinence-based groups at the main West Ealing hub had not worked. The social work team found it particularly difficult to use the RISE aftercare offer for service users coming back from residential detoxification and rehabilitation – it felt too unsafe, and meant they had to look at paying for placements outside of the borough or spot purchase EACH's structured day programme.
- There was a consensus having Bob located in the main West Ealing hub had been a positive result from the funding reduction. However, many of the attendees at the RISE service user forum spoke of Bob as a separate service and felt frustrated that it didn't feel as integrated as it could be. They spoke about wanting a Bob presence in the waiting area, a meet and greet function, so service users would be introduced to Bob right from the start of their treatment journey rather than finding out about it much later.

RECOMMENDATIONS

Integrate the Bob peer support service more effectively into RISE by exploring a meet and greet function in the waiting area and encouraging service users known to Bob but are not accessing structured treatment, to engage with RISE.

DIRECT IMPACT OF A REDUCED STAFF TEAM

- Several stakeholders spoke about the impact on caseloads now the treatment system had fewer staff (30 less) and yet the demand had not reduced. Some caseloads had gone as high as 70 plus at different points, particularly when the service had been hit by elevated

levels of sickness and bereavement last Winter. The caseloads are tightly monitored to ensure they are not operating beyond a clinically safe level and if the numbers reach this threshold, the treatment system will have to consider operating a waiting list.

- These reductions to the staff team also pose significant issues for delivering home visits either to parents to ensure effective safeguarding measures are in place, for reengagement work, or for visiting service users who are housebound. This is resource intensive and time consuming, involving two staff visiting a service user's home. The RISE Clinical Service Coordinator spoke about the dilemma of assessing housebound service users because although the service has the capacity to deliver an assessment, it simply isn't possible to continue visiting the resident at their home to deliver treatment long-term within the current staffing restrictions.
- The reduction in the staff team also has a direct impact on RISE's ability to deliver partnership working through satellite provision at other services, and both the outreach worker and service user involvement lead felt this had had a detrimental impact on the service's ability to engage with different client groups. The Safer Communities' Operations Manager acknowledged how much RISE's 2 outreach workers are stretched across such a large borough, and this inevitably meant certain areas of Ealing, like Greenford, have been more neglected.
- The reduction in staff numbers has had an impact on service delivery from the Southall site. After the funding cuts, titration for Southall service users was moved back to the West Ealing hub because there weren't enough clinicians to deliver the service across two sites. This had an impact on opiate users which was further exacerbated when the Southall hub had to close due to unanticipated delays with the building work at the new hub at the Saluja clinic. This meant the Southall service users had to move their entire treatment, not just titration, to the main Ealing hub.
- The outreach worker spoke about the impact of this move: Southall service users do not travel down the Uxbridge Road to West Ealing. They don't leave Southall. Most homeless clients won't travel on buses – they have no money and can't afford it. Prior to the hub closing, they could walk to the Southall site, be offered a cup of tea, feel more relaxed and have their assessment on a drop-in basis getting them into the service rapidly and with dignity. The 'welcome pods', which were adopted to help manage the flow into treatment with fewer staff and to reduce the DNA rate, appeared to discriminate against vulnerable homeless clients and sex workers. Several stakeholders mentioned the impact - asking vulnerable service users to attend a welcome pod and then to come back on another day for an assessment appointment increased the barriers to treatment.
- After the Southall hub at the Saluja Clinic opened in Spring 2018, RISE moved titration back to Southall from May 2018 and there is now a strong consensus across the treatment system, that this must be maintained.

- Several stakeholders spoke about the lack of robust partnership working between the West London NHS Trust and RISE. There was a consensus that as resources had become more tightly squeezed, both organisations had found working closely more of a challenge. Concerns were expressed about the lack of partnership work with IAPT and the sense that the service was unlikely to accept referrals from RISE service users.
- Several key areas were discussed: information sharing across both treatment systems to most effectively manage risk and support service users with dual diagnosis; effective multi-disciplinary working and shared case management; joint investigations into shared service users' deaths; and effective maximisation of scarce resources through shared training opportunities, and student placements.

THE LOSS OF PREVENTION AND EARLY INTERVENTION

- Several stakeholders spoke about the funding cuts' impact on prevention and early intervention work, including the service's capacity to offer alcohol identification and brief advice (IBA) or provide training for other disciplines to supplement this work, such as probation, pharmacists, and primary care staff. Stakeholders felt Making Every Contact Count (MECC) training had bridged some of this gap but there was not the capacity within Public Health to provide the focus on alcohol at both MECC level and the next stage through training on alcohol IBA work across the partnership.
- RISE's deputy service manager spoke about the pressure on the service to target their limited resources on primarily delivering specialist treatment to those with entrenched substance misuse issues. This meant there was little or no capacity for prevention and early intervention work although this work would ironically remove the pressure on the specialist treatment provision later.
- RISE needed the wider health and social care system to encourage those residents drinking at increased risk levels to engage with primary care and to use on-line resources, where appropriate, to help manage the front door of the treatment system. RISE staff repeatedly expressed concerns about effectively gatekeeping the treatment system with limited resources.
- RISE has access to Breaking Free Online, which provides psychosocial interventions compliant with NICE guidance aimed at helping people who want to reduce their drinking or drug use to less harmful levels or those who need to stop completely because their dependence has become severe. The service is considering how to improve access to this resource and how other online resources can address some of the loss of early intervention work.

RECOMMENDATIONS

Promote the use of on-line and self-help cognitive behavioural therapy digital responses to reduce drug and alcohol harms boosting the local early intervention offer. Explore all options including the Sustainability and Transformation Plan's prevention programme & Ealing MECC delivery to develop local alcohol IBA training beyond primary care.

ROBUST HIDDEN HARM WORK

- Several stakeholder interviews referred to fragmented partnership working between children's services and RISE. There have been substantial changes at RISE over the last two years, and children's services have been through a major reshaping exercise with the Brighter Futures programme. Without an effective joint working protocol and shared training programme, staff across both disciplines were unconfident about the referral pathways and service offer.
- RISE staff were unsure where to refer parents who didn't meet the safeguarding thresholds but required some additional family support. Ealing's safeguarding lead felt substance misuse had been lost in some of children's services' restructure and whilst domestic abuse had received a thorough focus, drugs and alcohol work had reduced with the loss of funding for a dedicated worker in the SAFE team and the end of a multi-disciplinary casework panel which RISE attended.
- This echoed the view expressed at a workshop around hidden harm as part of the alcohol CLeaR self-assessment. Several staff mentioned there were family meetings but no clearly defined and followed process for sharing recovery and family plans when both services are working with a family. This led to misunderstandings about RISE's treatment offer and what the service was attempting to deliver.

PAIN MEDICATION

- The CCG clinical lead for substance misuse raised concerns about the hidden group of users who require medication for pain but then end up with escalating use in mistaken attempts to treat long-term chronic pain with opiate based medication. She spoke about pain clinics being part of the problem locally as they are still very prescription heavy and not really using psychosocial approaches, citing one patient she referred because of concerns about the level of prescribing who left the clinic on even greater amounts of medication.
- RISE has not been taking these patients from GPs, and there are clear resourcing issues as to why this is not feasible or indeed appropriate. She felt a medication audit within primary care would help to gain a better understanding of the issue within Ealing.
- If the CCG looked at this from the perspective of invest to save, she felt there was the potential to then design a pilot intervention which would provide a more appropriate approach for supporting this dependent groups of patients.

RECOMMENDATIONS

Work with the CCG to address the lack of an appropriate intervention for primary care patients with dependency to pain medication, initially prescribed for chronic pain relief.

11. EVIDENCE OF WHAT WORKS: QUALITY & GOVERNANCE

CLINICAL GUIDELINES ON DRUG MISUSE & DEPENDENCE, UPDATED 2017

The guidelines are for UK clinicians providing drug treatment for people who misuse drugs or are dependent on drugs. They are based on current evidence and professional consensus on how to provide treatment for most service users, in most instances. Commissioners and providers have a responsibility to develop services that enable the application of the guidelines.

They cover the essential key elements of treatment provision:

- The needs of all drug users must be assessed across the following four domains:
  - Drug and alcohol misuse
  - Health
  - Social functioning
  - Criminal involvement
- Risk to the individual and affected children and adults should be assessed & reviewed
- Everyone receiving structured treatment should have consented to their recovery care plan & this should be reviewed regularly.
- A named keyworker should develop and review the care plan in partnership with the service user and may deliver elements of care.
- Drug testing can be a useful tool in diagnosis and assessment and in monitoring compliance and treatment outcomes.
- Treatment involves providing a range of psychosocial treatment and support interventions and is not just prescribing.
- Providing support for general health and wellbeing is crucial and requires working in partnership with primary and secondary care services
- Treatment services delivered through co-production with users and carers can create environments which address stigma and promote a sense of positivity and hope.

ALCOHOL EVIDENCE REVIEW 2016

This review was commissioned by the Department of Health and Social Care, which asked Public Health England to provide an overview of alcohol-related harm in England and possible policy solutions. It provides a broad summary of the types and prevalence of alcohol-related harm, as well as presenting evidence for the effectiveness and cost-effectiveness of alcohol control policies.
https://www.gov.uk/government/publications/the-public-health-burden-of-alcohol-evidence-review

Reflecting three key influencers of alcohol consumption: price (affordability); ease of purchase (availability); and the social norms around its consumption (acceptability), an extensive array of policies have been developed with the primary aim of reducing the public health burden of alcohol. This review evaluates the effectiveness and cost-effectiveness of each of these policy approaches:

- Taxation and price regulation
- Regulating marketing
- Regulating availability
- Promoting information and education
- Managing the drinking environment
- Reducing drink driving
- Brief interventions and treatment
- The policy mix

DRUG EVIDENCE REVIEW, 2017

The review provides an objective assessment of what drug treatment outcomes are achievable and compares outcomes in England to the evidence and to other drug treatment systems. It reviews the impact of housing problems, unemployment and social deprivation on treatment engagement and outcomes. The review also considers how drug treatment will need to be configured to meet future need and recommends an appropriate set of measures or indicator for treatment evaluation.

https://www.gov.uk/government/publications/drug-misuse-treatment-in-england-evidence-review-of-outcomes

England's treatment system is strong in relation to the following areas:

- the treatment penetration rate (60%) is among the highest reported internationally;
- access to treatment (97% within three weeks) is comparable to other countries;
- the rate of drug injecting among all 15-64 year olds (0.25%) is relatively low;
- the rate of drop out from treatment before three and six months (18% and 34%, respectively) is comparable (28% on average)
- England has a very low rate of HIV infection among the injecting drug user population (1%), which

compares favourably internationally.

The review identified the following as areas for improvement:

- the rate of illicit opiate abstinence after three and also six months of treatment in England (46% and 48%, respectively) points to relatively poorer performance in comparison with the literature (56% on average)
- the drug-related death rate in England (34 per million in 2013) is substantially lower than in the USA but considerably higher than elsewhere in Europe

The review also references changes in drug use patterns citing increasing problems of misuse and dependence associated with some prescription and over-the-counter medicines and the use of novel psychoactive substances (NPS) (particularly in prisons). There are new patterns of drug use and health risk behaviour including NPS administered by injection, the use of image and performance enhancing drugs (IPED) and drugs used alongside high-risk sexual behaviour ('chemsex').

NICE QUALITY STANDARDS, AND GOOD PRACTICE GUIDELINES

- NICE Quality standards for drug use disorders QS23
- NICE Quality standards for alcohol dependency and harmful alcohol use QS11
- NICE Technology Appraisal 114 (Methadone and Buprenorphine for the Management of Opioid Dependence)
- NICE Clinical Guidance 51 (Drug Misuse: Psychosocial interventions)
- Routes to Recovery: Psychosocial Interventions for Drug Misuse - a framework and toolkit for implementing NICE-recommended treatment interventions (commissioned by the National Treatment Agency (NTA) from the British Psychological Society (BPS)

- NICE Technology Appraisal 115 (Naltrexone for the Management of Opioid Dependence)
- NICE Clinical Guidance 52 (Drug Misuse: Opioid detoxification)
- NICE Clinical Guidance 100 (Alcohol use disorders: Diagnosis and clinical management of alcohol-related physical complications)
- NICE Clinical Guideline 115 (Alcohol use disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence)
- NICE Public Health Guidance 24 (Alcohol use disorders: Preventing harmful drinking)
- Drug misuse prevention: targeted intervention NICE guideline [NG64] Feb 17
- Good Practice in Harm Reduction (NTA 2008)
- NICE Public Health Guidance 18 (Needle and syringe programmes: providing people who inject drugs with injecting equipment)
- NICE Clinical Guidance 110 (Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors)
- NTA Models of Care for the treatment of adult drug misusers 2002 and update 2006
- Models of Care for Alcohol Misuse 2006 (MOCAM)
- Supporting and Involving Carers – Best Practice Guidance (NTA, 2008)
- NICE alcohol use disorders pathways
- NICE drug misuse pathways
- Neptune Guidance on the Clinical Management of Acute and Chronic Harms of Club Drugs and Novel Psychoactive Substances
- Essential standards of quality and safety – guidance about Compliance (Care Quality Commission, 2010)
- CQC Specialist Substance Misuse Providers' Handbook

CASE FOR INVESTING IN DRUG AND ALCOHOL TREATMENT

- The annual costs of alcohol and drug misuse to society are significant. Estimates show that the social and economic costs of alcohol related harm amount to £21.5bn, while that of illicit drug use costs £10.7bn. These include costs associated with deaths, NHS, crime and, in the case of alcohol, lost productivity.[12]

[12] Drug misuse costs 10.7bn: PHE (2017) An evidence review of the outcomes that can be expected of drug misuse treatment in England. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/586111/PHE_Evidence_review_of_drug_treatment_outcomes.pdf

Alcohol misuse 21.5bn: PHE (2016) The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies An evidence review. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/583047/alcohol_public_health_burden_evidence_review.pdf

- Investing in drug and alcohol treatment saves money and reduces individual and community harms. Providing well-funded drug and alcohol services is good value for money because it cuts crime, improves health, and can support individuals and families on the road to recovery.
- Specialist interventions for young people work delivering improvements in health and wellbeing, educational attainment, decrease absence from school or training and offer protection from risky behaviours. These all save money: young people's drug and alcohol interventions result in £4.3m health savings and £100m crime benefits per year.[13]
- Alcohol treatment reflects a return on investment of £3 for every £1 invested, which increases to £26 over 10 years. Drug treatment reflects a return on investment of £4 for every £1 invested, which increases to £21 over 10 years.[14] If just a 7-10% reduction in the number of young people continuing their dependency into adulthood is achieved, the lifetime societal benefit of treatment could be as high as £49-159m. This equates to a potential £5-£8 benefit for every £1 invested.
- Investing in alcohol treatment saves money:
    - Identification and brief advice in primary case can save the NHS £27 per patient per year[15]
    - Hospital alcohol care teams reduce the demand for hospital services. The return on investment can be £3.85 for every £1 invested
- Investing in drug harm reduction saves money:
    - £22k-£41k a year for every prevented case of hepatitis C treatment
    - £10k-£42k a year for every prevented case of HIV treatment
    - Reduced spending on A & E attendance and hospital stays for injecting site injuries and infections[16]

[13] Frontier Economics (2011) Specialist drug and alcohol services for young people: a Cost Benefit Analysis. Department for Education. Retrieved from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/182312/DFE-RR087.pdf

[14] These figures are taken from PHE's alcohol and drug treatment commissioning tool for local authorities

[15] PHE (2016) Local Health and Care Planning: Menu of preventative interventions. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/565944/Local_health_and_care_planning_menu_of_preventative_interventions.pdf

[16] PHE (2016) Local Health and Care Planning: Menu of preventative interventions. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/565944/Local_health_and_care_planning_menu_of_preventative_interventions.pdf

NICE (2014) Costing statement: Needle and syringe programmes Implementing the NICE guidance on Needle and syringe programmes (PH52). Available at: https://www.nice.org.uk/guidance/ph52/resources/costing-statement-pdf-69237469

12. RECOMMENDATIONS

PREVENTION & EARLY INTERVENTION

1. To enhance substance misuse work within Ealing's Primary Care setting	
Recommendation for Commissioners	Monitor data on the level of AUDIT screening within Ealing NHS Health Checks, and monitor data on alcohol screening of new patients in primary care. Use this data to inform where to target future primary care alcohol clinics provided by the drug & alcohol service and to improve performance around alcohol screening for new patients and Health Checks in line with the Primary Care Standard.
Recommendations for Providers	Review the drug & alcohol treatment service's primary care model to address alcohol interventions for those drinking at increased risk who do not want to come to the main treatment hubs. This will encompass learning from RISE's two pilot primary care alcohol clinics.
2. Increase the use of digital interventions	
Recommendations for Providers	Promote the use of on-line and self-help cognitive behavioural therapy digital responses to reduce drug and alcohol harms extending the local early intervention offer and providing additional support for those with increased levels of recovery capital.
3. Deliver alcohol IBA training beyond primary care in Ealing	
Recommendations for Commissioners	Explore all options including the NW London CCG prevention programme & Ealing MECC delivery to develop local alcohol IBA training

EFFECTIVE & QUALITY TREATMENT PROVISION

4. Adjust the current treatment system to increase positive outcomes and movement through the system	
Recommendations for providers	Re-configure the treatment system to offer flow through, with the delivery of a **group work programme** from an abstinence space at the back-end of the treatment system. Provide alternative premises to address the loss of the **abstinence-based building** as a venue for delivering the structured day programme. Review and reconfigure RISE's **GP shared care model** bearing in mind reductions in the opiate using population and the need to deliver more alcohol interventions from primary care, particularly for those drinking at increased risk. Develop and deliver a **non-opiate action plan** to increase the numbers of non-opiate users accessing treatment and achieving positive outcomes. Maintain **titration at the Southall Hub** to consolidate retention in treatment for service users living in the Southall area. Integrate the Bob peer support service more effectively into RISE by exploring a meet and greet function in the waiting area and encouraging service users known to Bob but not accessing structured treatment, to engage with RISE.
Recommendations for Commissioners	Commission the new drug and alcohol treatment system with a long contract to support stability, as well as a service specification that is informed by this JSNA. To incorporate **smoking cessation work** into the new drug and alcohol treatment contract to improve treatment outcomes and overall physical health outcomes for Ealing residents with drug and alcohol problems Work with the CCG to address the lack of an appropriate intervention for **primary care patients with dependency to pain medication**, initially prescribed for chronic pain relief.
5. Strengthen local partnership work to prevent drug and alcohol related deaths	
Recommendations for Commissioners	Monitor Ealing's alcohol and drug related deaths and continue with the development of **Ealing's Serious**

	Incident Panel where these deaths can be discussed, and any lessons learnt are shared amongst the wider partnership. This includes supporting the development of **joint investigations** where individuals are known to both RISE and the West London NHS Trust's services. Develop a **fentanyl action plan** to protect vulnerable service users and reduce the risks of overdose and drug-related deaths should fentanyl appear in the local drug market supply chain.
6. Strengthen local partnership working to improve outcomes for people with drug and alcohol problems	
Recommendations for commissioners & provider	**Address gaps in local partnership working to more effectively support residents with co-existing mental health & substance use.** This will involve ensuring appropriate information sharing, with WLNHS Trust having access to RISE's case management system (CRIiS) through the primary care mental health team, SPA, and the recovery team. RISE will have access to RIO on site at the main treatment hub. This partnership work around shared cases will be enhanced by regular and consistent WLNHS Trust attendance at RISE's multi-disciplinary team meetings to enrich case discussions and robust risk management. The West London NHS Trust is currently reviewing the IAPT offer in Hammersmith and Fulham, working closely with the treatment system to ensure improved access for substance misuse service users. RISE will be involved in this work through the Trust's co-existing mental health and substance use steering group and will be looking to adopt similar pathways in Ealing. **Improve the communication and joint working between children's services and the drug & alcohol treatment system by:** • developing a hidden harm joint working protocol between the two disciplines with reference to the forthcoming revised PHE guidance and roll this out with joint training and workshops. • Exploring the possibility of placing a treatment worker in children's services. • Delivering substance misuse training to Ealing's children's services as part of Ealing's Safeguarding Children's Board's overall training offer.

	• Providing weekly safeguarding surgeries in the treatment service delivered by children and families staff • Delivering home visit training to treatment staff to increase their understanding of what to look for when on a home visit. • Adding the treatment service to the MASH hub **Integrate new partnerships into the treatment system** Support the integration of the West London Alliance substance misuse **Individual Placement Support Service** delivered by two WDP workers placed at RISE and include this service as part of the overall package of care for service users. Support the integration of Cranstoun's Big Lottery funded **Men and Masculinities programme** for men who perpetrate abuse in their relationships into the wider Ealing partnership. This will also involve embedding the accompanying women's support service and dedicated worker into the Women's Wellness Zone.
Recommendations for providers	**Improve movement through the supported housing pathway for substance misuse service users, along with communication between recovery workers & housing support workers to prevent relapse and maximise treatment engagement.** This will be managed through the Move On meetings attended by supported housing providers, treatment and the manager of St Mungo's Ealing Street & Community Outreach Team **Deliver targeted interventions to reach specific groups** Develop targeted work with **carers and older people** drinking either dependently or at increasing risk through developing local partnership work with Southall Community Alliance, and the Carers' Trust. Develop an effective pathway into treatment for Ealing's **rough sleeping population** through the work of the central government funded Rough Sleeping Initiative programme. Develop effective partnership working with **sexual health services** to increase screening for problematic drug and alcohol use and to deliver joint initiatives to provide support and treatment to specific groups including men who have sex with men and engage in Chemsex.

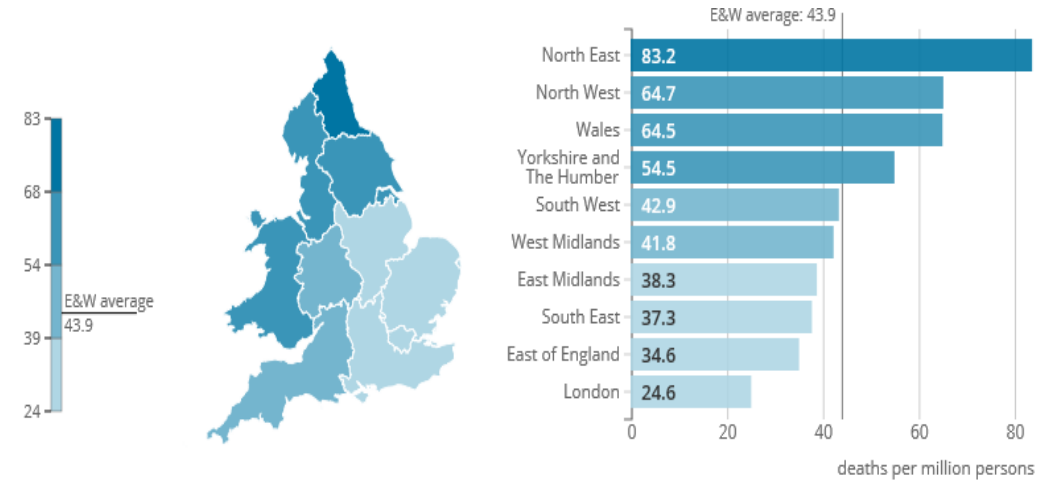
ENFORCEMENT & REGULATION

7. Strengthen partnership work with licensing	
Recommendations for commissioners	Develop Public Health's partnership work with licensing with a specific focus on off licenses and saturation in neighbourhoods adversely affected by health inequalities linked to poverty and exacerbated by alcohol misuse. (Alcohol CLeaR recommendation) Engage in the development of Ealing's Night Time Economy Strategy to ensure there are alternative options available to local people wanting to socialise and enjoy what Ealing has to offer without alcohol. (Alcohol CLeaR recommendation)
8. Strengthen partnership working with criminal justice agencies	
Recommendations for providers	Improve partnership engagement from criminal justice agencies to support treatment outcomes. This will include improving use of community orders and developing pathways into treatment through conditional cautioning.
9. Strengthen the treatment agencies' relationship with the local community	
Recommendations for providers	Develop an open day schedule to improve community understanding about treatment and build stronger links between the treatment agencies and residents.

APPENDIX 1

NATIONAL DATA ON DRUG-RELATED DEATHS

DEATHS RELATED TO DRUG-POISONING IN ENGLAND AND WALES: 2017 REGISTRATIONS



Source: Deaths related to drug poisoning in England and Wales: 2017 registrations

ONS 'DEEP DIVE' INTO DRUG-RELATED DEATHS

- In August 2018, the Office for National Statistics (ONS) published an experimental 'deep dive' study commissioned by Public Health England, into a sample of 115 drug misuse deaths. The sample included both suicides and unintentional overdose deaths.
- The study was commissioned in the context of concern at the surge in the number of drug-related deaths in England, Scotland & Wales over the last four years, now at their highest ever levels. The rate for England in 2016 increased to 44.1 deaths per million population from 42.9 deaths per million in 2015. This was a rise of 3% and an increase to 2,383 deaths. The number of deaths in 2016 was over three times higher than those recorded in 1993, when the time series began. There has been a sharp rise in the number of deaths since 2012, with 2013, 2014 and 2015 showing the largest year-on-year rises in numbers.
- The most common characteristics of the sample (not necessarily occurring together) were that the deceased was white, single or divorced, living alone, unemployed, and had a prior history of drug use and/or mental health issues. The deceased was most often found having already died.
- It is already known that around three-quarters of drug misuse deaths are male. In line with other reports, the findings suggest a vulnerable, at-risk population engaging in

unsafe drug-taking practices such as taking drugs alone and consuming multiple types of drugs alongside alcohol.

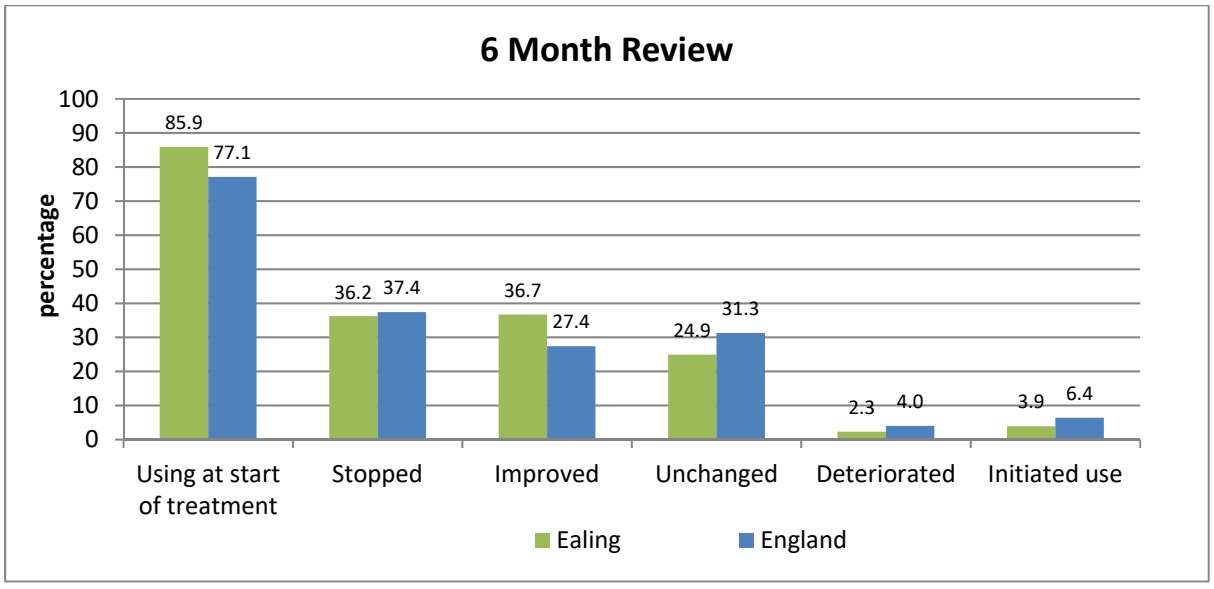
APPENDIX 2

DRUG TREATMENT OUTCOMES – MORE DETAIL

OPIATE OUTCOMES 6-MONTH REVIEW

- In the period from Oct 2016 to Sep 2017 in Ealing, there were 206 opiate users included in this analysis.
- Of these, 85.9% (177) reported using opiates sometime during the 28 days prior to treatment start, the remaining did not use opiates prior to treatment. Of those 177 using prior to treatment the change in use is reported in the figure below.
- This shows 36.2% (64) stopped using at the 6-month review, and this proportion is within the expected performance range (29.3% lower and 43.5% upper) but lower than the national average.
- The remaining 113 opiates users reported the following outcomes: 36.7% improved use (reduction in the amount being used), higher than the national average; 24.9% reported no change in use; and 2.3% deteriorated in their use. In addition, 3.9% (8) initiated use, lower compared to the national average (Figure X). Therefore, in total there were 121 still using at the 6-month review and 85 that were not.
- The average number of days using reduced from 24.2 prior to treatment to 7.5 at the 6-month review, which is a day lower than the national average (drop from 22.3 to 8.6 days).

Figure 1: Opiate Outcomes at 6 Month Review Oct 2016 – Sep 2017



Source: NDTMS Recovery Diagnostic Tool Kit 2016/17, released Sep 2017

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CRACK OUTCOMES (IN OPIATE USERS), 6-MONTH REVIEW[17]

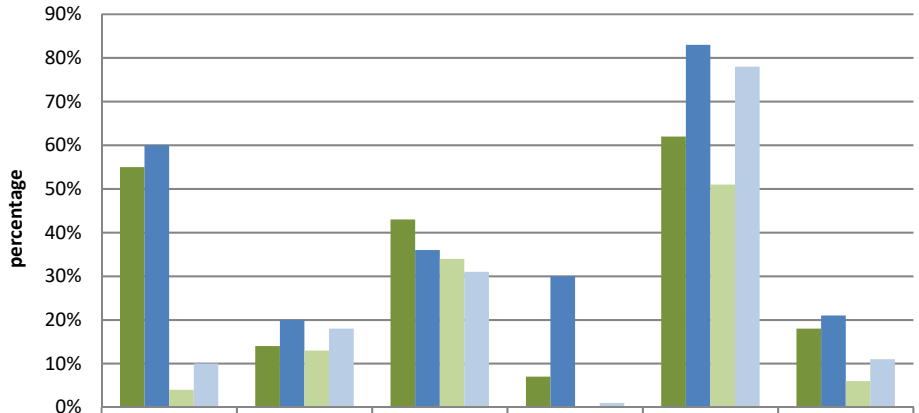
- There were 120 opiates users who also cited the use of crack. Of these 91.7% (110) reported using crack sometime during the 28 days prior to treatment start; the remaining 10 did not use crack prior to treatment.
- The following outcomes for opiate users also using crack were achieved at the 6-month review: 46.4% stopped crack use, exceeding the expected performance range (25.7% lower and 43.4% upper range) and above the national average (35.8%); 20.0% reported improved use - lower than the national average (18.8%); and 28.2% reported no change locally, whilst nationally this figure was 38.6%. A further 5.5% deteriorated, lower than the national average (6.8%).
- An additional 1 person (0.8%) initiated use, whilst the national average was 5 people (4.2%). Therefore, in total there were 60 opiates users still using crack at the 6-month review.
- The average number of days using reduced from 15.2 prior to treatment to 5.3 at the 6-month review, lower than the national average (15.3 days prior to treatment and 8.1 days at 6 months review).

USING BEHAVIOUR

- The chart below shows the drug use, housing and employment situation of those 121 opiate users who continued to use at the 6-month review (darker shade of green), and the 85 who had stopped using opiates at 6-month review (lighter shade of green) during Oct 2016 – Sep 2017.
- Across all domains of drug use, unemployment and housing issues, the outcomes are greater for those not using than outcomes for those still using opiates.
- In Ealing, outcomes in both groups are broadly better or similar to the national average. For those who stopped using opiates, significantly fewer reported using crack (4% compared to 55%), as well as fewer using cannabis and alcohol, and fewer reported being unemployed (51% compared to 62%), with less than half reporting a housing issue (6% compared to 18%)

[17] *Source: NDTMS Recovery Diagnostic Tool Kit 2016/17, released Sep 2017*

Figure 2: Using Behaviour at 6 Month Review, Ealing & England, Oct 2016 – Sep 2017



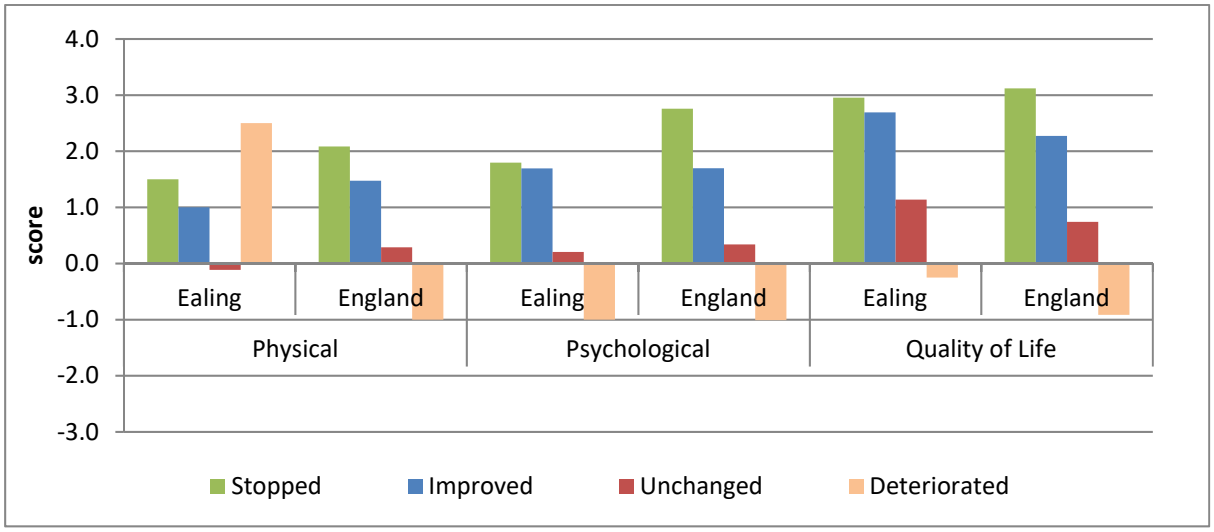
	Crack	Cannabis	Alcohol	Injecting	Unemployed	Housing issue
Still using opiates at 6 months :Ealing	55%	14%	43%	7%	62%	18%
Still using opiates at 6 months :England	60%	20%	36%	30%	83%	21%
Not using opiates at 6 months :Ealing	4%	13%	34%	0%	51%	6%
Not using opiates at 6 months :England	10%	18%	31%	1%	78%	11%

Source: NDTMS Recovery Diagnostic Tool Kit 2016/17, released Sep 2017

IMPROVEMENTS IN HEALTH/QOL

- Based on the changes made to drug use at the 6-month review, health and quality of life outcomes for opiate users are reported across those who stopped, improved, were unchanged, or who deteriorated in their use.
- The outcomes are assessed in relation to physical health, psychological health and quality of life. A value above zero indicates there has been an increase in the health and/or quality of life of opiate users in that category, whereas a value below zero indicates the health and/or quality of life in that category has fallen.
- The chart below shows, as expected, the scores are better for those who stopped or improved, whilst those who have deteriorated or remained unchanged report less positive change to their health or quality of life.

Figure 3: Improvements in Health and Quality of Life, Ealing (at 6-month review)



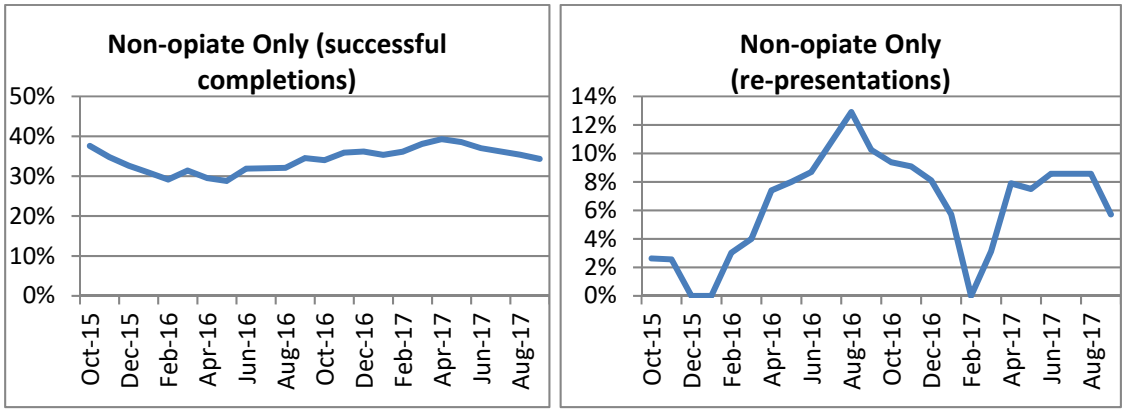
Source: NDTMS Recovery Diagnostic Tool Kit 2016/17, released Sep 2017

NON-OPIATE TREATMENT OUTCOMES

- In 2016/17, there were 168 people in treatment citing the use of non-opiate drugs, representing 9% of the total treatment population[18]. Over this period there were 100 people new to treatment citing the use of non-opiate drugs.
- In 2016/17, 64 successfully completed treatment, representing 38.1% as a proportion of all non-opiate drug users in treatment. This performance sits below the top quartile range for comparative local authorities with similar substance using populations to Ealing (43.1% lower and 62.2% upper performance range). In comparison to the previous year, the proportion of successful completions has risen by 6.7% (31.4% in 2015/16).
- The quality of successful completions is measured against the proportion that re-present to treatment within six months of successfully leaving treatment.
- In 2016/17 those who left treatment between April 2016 and September 2016 are assessed for re-presentation to treatment services. In 2016/17 there were a total of 3 re-presentations as a proportion of successful treatments - representing 4.6% and placing Ealing lower than the national figure of 5.5% for non-opiate re-presentations in the same period.
- The charts below show successful completion and re-presentation performance between Oct 2015 and Sep 2017.

[18] *Source: PHE: Local Area Trend Report 2016-17 - Ealing*

Figure 4: Non-opiate Successful completion and re-presentation performance



Source: NDTMS Partnership Successful Completions Reports (generated Dec 2017)

EXIT REASONS

- Of those new to treatment, 12.8% had an early unplanned exit from treatment[19], lower than 16.9% across England[20].
- The table below sets out the treatment exit reasons for those who left treatment in 2016/17.[21] This shows that half (49.6%) of non-opiate exits from treatment resulted in people leaving treatment successfully and 43.4% dropped out of treatment.

Non-opiate: Treatment Exit Reason (2016/17)	n	%
Treatment completed - drug/alcohol-free	40	31.0%
Treatment completed - occasional user (not heroin or crack)	24	18.6%
Incomplete - dropped out	56	43.4%
Transferred - in custody	5	3.9%
Transferred - not in custody	3	2.3%
Transferred - not in custody (within 21 days of end of month)	1	0.8%

Source: NDTMS Partnership Successful Completion and Re-presentation Report, 2017

6-MONTH REVIEW

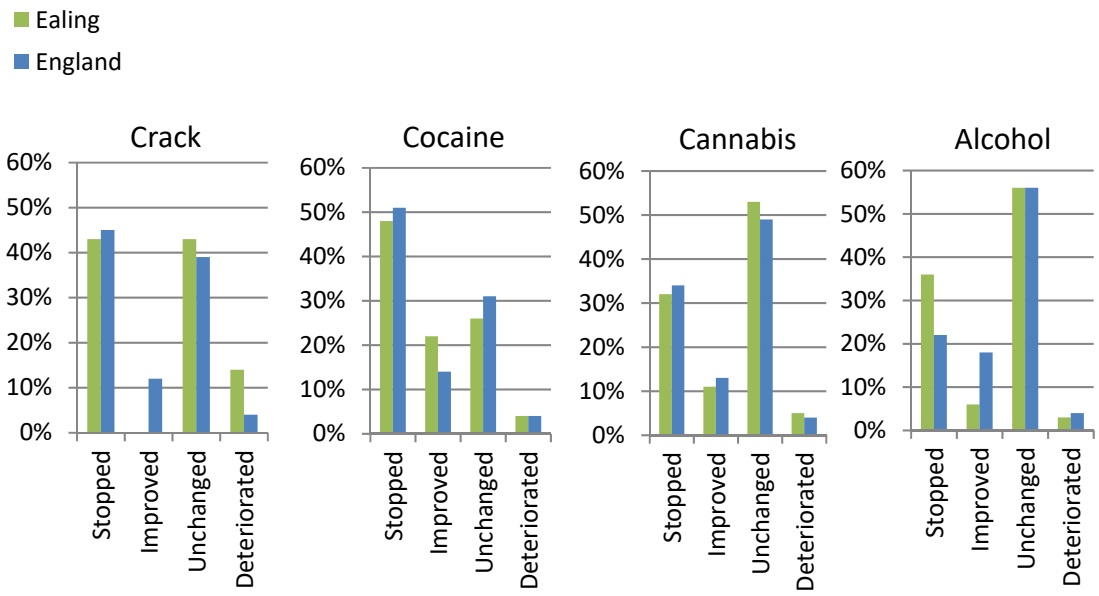
[19] Clients newly presenting to treatment in the latest 12 months (set 3 months back) who were left treatment (not treatment completed) before being retained for 12 weeks.

[20] Source: NDTMS, DOMES Report, Quarter 4 2016/17

[21] Note; this data is taken from the monthly Partnership Successful Completions Report and figures may vary (successful completions reports are live reports and may not take account of changes in data reported retrospectively).

- In 2016/17 there were 117 non-opiate users within this cohort. Of this the majority were using cannabis (32.5%), followed by alcohol (30.8%), cocaine (23.1%), crack (12.0%), amphetamines (1.7%) and there were no injecting drug users.
- The outcomes of non-opiate users at the six-month review can be seen in the chart below by the non-opiate substance used.
- Compared to the national average, in Ealing a lower proportion of crack users (43%) reporting using crack sometime during the 28 days prior to starting treatment had stopped using at the 6-month review (nationally this was 45%). The proportion of cocaine and cannabis users that stopped was also lower than the national average: for cocaine 48% of users stopped compared to 51% in England, whilst for cannabis, the stopping rate was 32% versus 34% nationally. Meanwhile, a greater proportion of alcohol users (36%) stopped using compared with 22% national average.
- Compared to the national average, in Ealing a greater proportion of cocaine users (22%) improved use (that is reduced the number of days they were using by more than the reliable change boundary). Nationally, 14% of cocaine users improved use.
- When it comes to the use of crack, cannabis and alcohol, Ealing saw lower levels of improvement than those seen across the country, but as the numbers of these users are low, this is not a statistically significant difference.
- RISE is developing a non-opiate action plan to increase the numbers accessing treatment and the number of successful outcomes. The plan will try to increase treatment uptake from criminal justice clients through the use of conditional cautioning and delivering treatment orders through Rehabilitation Activity Requirements (RARs).

Figure 5: Non-opiate Outcomes at 6 Month Review 2016/17

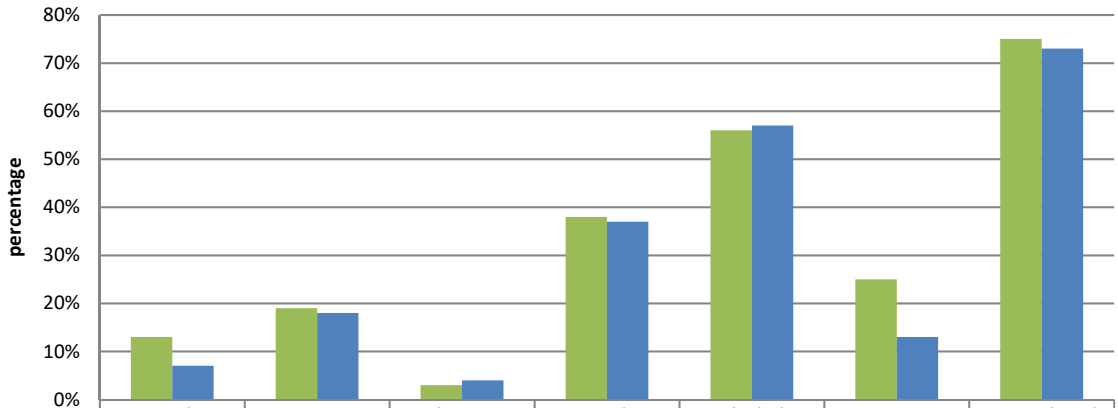


Source: NDTMS Recovery Diagnostic Tool Kit 2016/17, released Sep 2017

USING BEHAVIOUR (NON–OPIATES)

- The chart below shows the drug use, housing and employment situation of non-opiate users at the six-month review, during 2016/17.
- This shows amongst Ealing's non-opiate users, a greater proportion of crack, cocaine and cannabis users were still using at the 6-month review, compared with the national average. Only the proportion of Ealing alcohol users still drinking after 6 months was lower than the England average, by 1% (56% and 57% respectively).
- The proportion of non-opiate users reporting housing issues (25%) are around double compared to the national average (13%). Three quarters (75%) in Ealing reported being unemployed at the 6-month review, which is above the national average (73%).

Figure 6: Using Behaviour at 6 Month Review, Ealing & England, Oct 2016 – Sep 2017



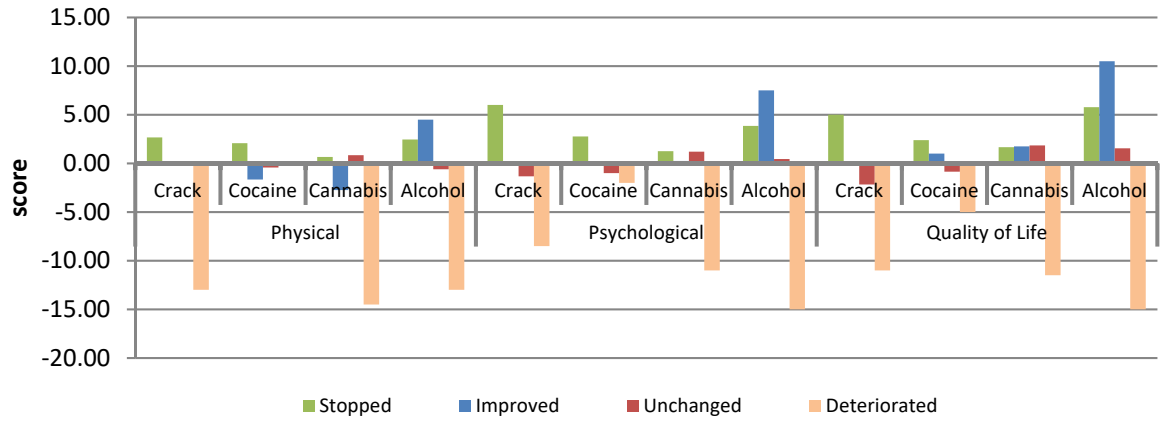
	Crack	Cocaine	Amphetamines	Cannabis	Alcohol	Housing issue	Unemployed
Ealing	13%	19%	3%	38%	56%	25%	75%
England	7%	18%	4%	37%	57%	13%	73%

Source: NDTMS Recovery Diagnostic Tool Kit 2016/17, released Sep 2017

IMPROVEMENTS IN HEALTH/QOL

- Based on the changes made to drug and/or alcohol use at the 6-month review, health and quality of life outcomes for non-opiate users are reported across those who stopped, improved, reported no change or deteriorated in their use.
- The outcomes are assessed in relation to physical health, psychological health and quality of life. A value above zero indicates there has been an increase in the health and / or quality of life of non-opiate users in that category, whereas a value below zero indicates the health and/or quality of life of non-opiates in that category has fallen.
- The chart below shows, as expected, the scores are better for those who stopped or improved. However, those who have deteriorated or remained unchanged report less positive changes to their health or quality of life.

Figure 7: Improvements in Health and Quality of Life, Ealing (at 6-month review)



Source: NDTMS Recovery Diagnostic Tool Kit 2016/17, released Sep 2017

APPENDIX 3

ALCOHOL TREATMENT OUTCOMES – MORE DETAIL

ALCOHOL TREATMENT OUTCOMES

This section looks at the treatment outcomes for those who are in treatment for alcohol use only and does not include those who use both alcohol and drugs. Service users that do use both alcohol and drugs will fall under the opiate or alcohol & non-opiate groupings. Therefore, the number of alcohol only users will appear smaller.

In 2016/17 in Ealing there were 553 alcohol users in treatment, 62% (344) were new to treatment that year, just below the national average (65%). This is a large drop from 674 people in treatment in 2015/16 in Ealing, when 479 (71%) were new participants.

SUCCESSFUL COMPLETION RATE

In 2016/17, 217 people in Ealing completed alcohol treatment successfully. That represents 39% of the treatment population and is similar to the National level (40%).

Males were slightly more successful in completing treatment than females (41% versus 34%).

EXIT REASONS

The table below sets out the treatment exit reasons for those who left treatment in 2016-2017. This shows over half (56.4%) of alcohol exits from treatment resulted in people successfully completing treatment, with 35.5% dropping out of treatment.

Table 1: Alcohol Treatment Exits, Ealing, 2016/17[22]

[22] The number of people who exited treatment in 2016/17 and some of these people may have re-presented within the same year

Alcohol: Treatment Exit Reason (2016/17)	n	%
Treatment completed - drug/alcohol-free	156	40.7%
Incomplete - dropped out	136	35.5%
Treatment completed - occasional user (not heroin or crack)	60	15.7%
Transferred - not in custody	10	2.6%
Transferred - in custody	5	1.3%
Incomplete - client died	7	1.8%
Transferred to another partnership	4	1.0%
Incomplete - treatment commencement declined by client	3	0.8%
Incomplete - treatment withdrawn by provider	2	0.5%

Source: NDTMS Partnership Successful Completions Report, March 2017 (generated Dec 2017)

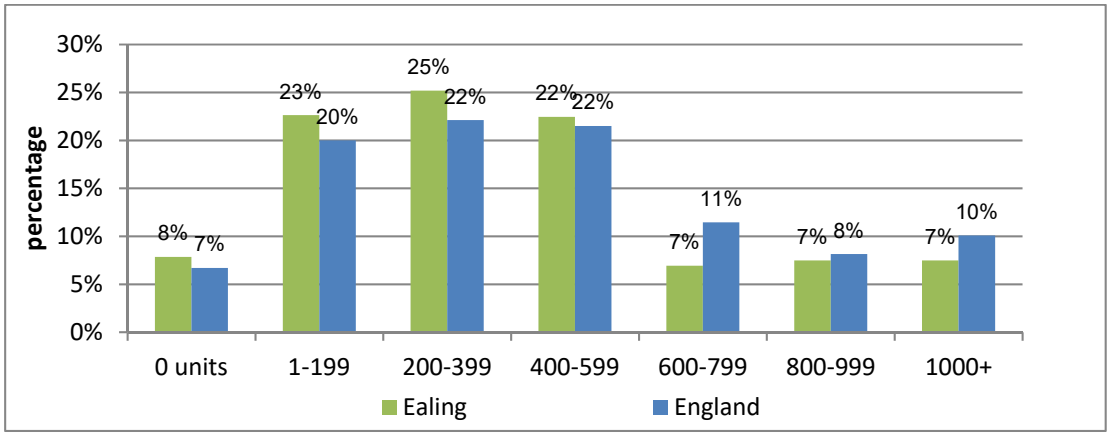
USING BEHAVIOUR

ALCOHOL UNITS CONSUMED

There is a strong association between levels of consumption and severity of dependence, but they are not the same for everyone. In general, women are likely to become dependent at lower levels of consumption than men. Consumption is based on drinking levels over the 28 days prior to assessment. Some adults may appear in the lowest category if they have stopped or reduced consumption prior to treatment (for example in hospital or prison).

Figure 11 indicates the number of units consumed at the start of treatment. This shows around 78% consumed between 1 and 599 units of alcohol at the start of treatment, proportionately more in comparison to the national average (71%). However, this also shows that more than a fifth (21%) had consumed 600 and more units of alcohol at the start of treatment, compared to a higher figure of 29% nationally.

Figure 1: Alcohol Units Consumed at Start of Treatment 2016/17 (28 days period)



Source: Recovery Diagnostic Tool Kit 2016/17, NDTMS (Released Sept 2017)

ALCOHOL AND NON-OPIATE TREATMENT OUTCOMES – MORE DETAIL

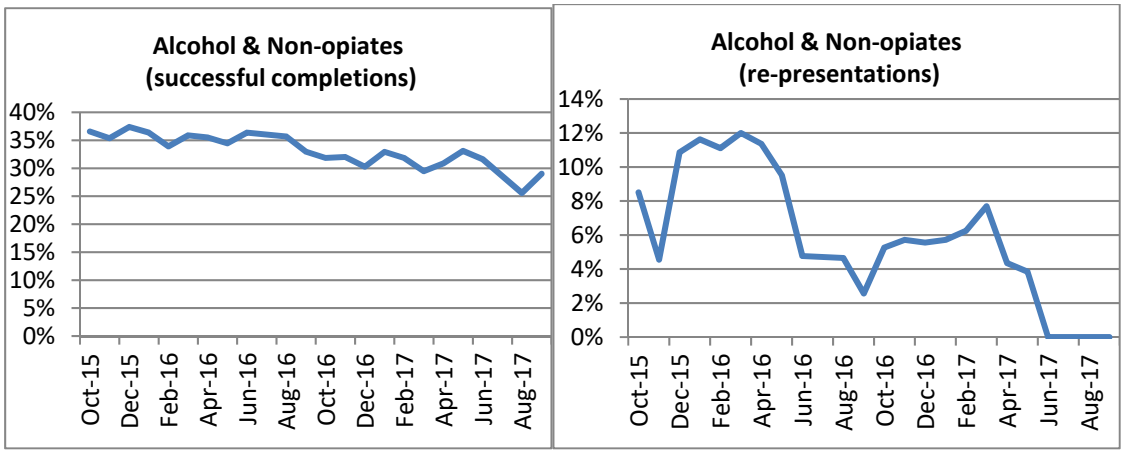
In 2016/17, there were 156 people in treatment citing the use of alcohol and non-opiate drugs, representing 8.6% of the total treatment population. Over this period there were 81 people new to treatment citing the use of alcohol and non-opiate drugs[23].

In 2016/17, 46 successfully completed treatment (either drug or alcohol free or as an occasional user, not including opiate or crack use), representing 29.5% as a proportion of all alcohol and non-opiate drug users in treatment. This performance is significantly below the national figure of 35.8% for the same period. In comparison to the previous year, the proportion of successful completions has fallen by 6.4% (35.9% in 2015/16).

SUCCESSFUL COMPLETION RATE

The quality of successful completions are measured against the proportion that re-present to treatment within a six month period of successfully leaving treatment. In 2016/17 those who left treatment between April 2016 and September 2016 are assessed for re-presentation to treatment services. This shows that in 2016/17 there were a total of 2 re-presentations, equating to 7.7%, lower than the proportion of 12% in 2015/16. Nationally, the proportion of alcohol & non-opiate users who successfully completed treatment in the first 6 months in the last year and re-presented within 6 months, has also dropped, from 8.5% in 2015/16 to 8.2% in 2016/17. The charts below show successful completion and re-presentation performance between 2015/16 and 2016/17.

Figure 2: Alcohol and Non-opiate Successful Completion and Re-presentation Performance, Ealing Oct 2015 – Aug 2017



[23] *Source: NDTMS Partnership Successful Completions Reports (generated Dec 2017)*

Source: NDTMS Partnership Successful Completions Reports (generated Dec 2017)

EXIT REASONS

Of those new to treatment (81), 9 people (11%) had an early unplanned exit from treatment,[24] compared to 17% across England[25]. The table below sets out the treatment exit reasons for those who left treatment in 2016/17.[26] This shows over two in five (42.6%) of alcohol and non-opiate exits resulted in a successful completion, whilst 46.3% dropped out of treatment.

Table 2: Alcohol and Non-Opiate Treatment Exits, Ealing, 2016/17 (YTD)

Alcohol and Non-opiate: Treatment Exit Reason (2016/17)	n	%
Incomplete - dropped out	50	46.3%
Treatment completed - drug/alcohol-free	28	25.9%
Treatment completed - occasional user (not heroin or crack)	18	16.7%
Transferred - in custody	2	1.9%
Transferred - not in custody	4	3.7%
Transferred to another partnership	2	1.9%
Incomplete - client died	1	0.9%
Incomplete - treatment withdrawn by provider	1	0.9%
Transferred - not in custody (within 21 days of end of month)	2	1.9%

Source: NDTMS Partnership Successful Completions Report, March 2017 (generated Dec 2017)

COMPLETION RATES BY ALCOHOL UNITS CONSUMED

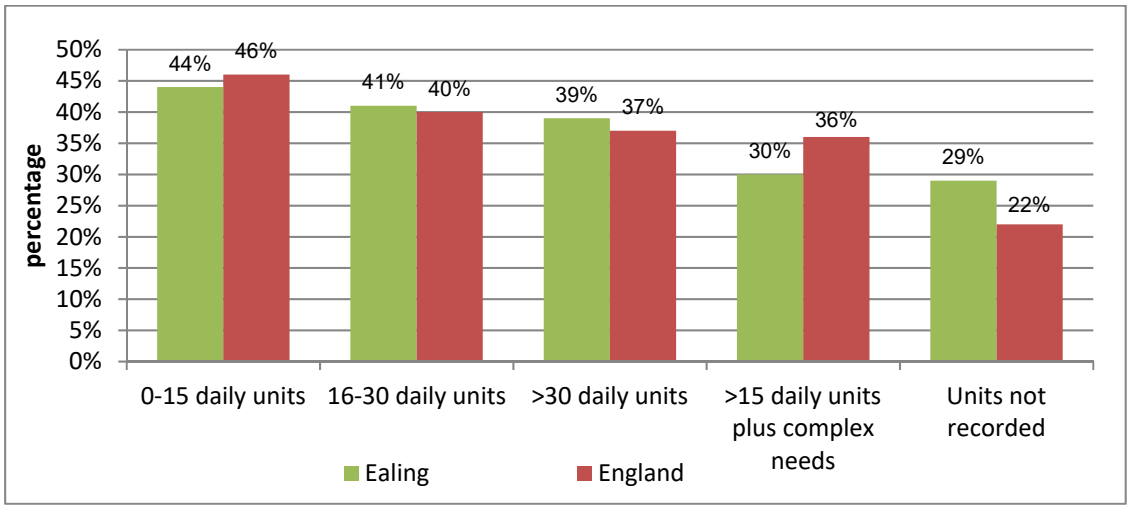
The figure below shows the breakdown of successful completions among different drinking levels in 2016/17. The most successful Ealing outcomes were amongst people in alcohol only treatment, consuming 0-15 daily units at the start of their treatment (44%), which is similar to the national result of 46%. The lowest success rate was in the group drinking more than 15 daily units, with complex needs (30%), whilst the England average for this group was lower at 36%.

[24] Clients newly presenting to treatment in the latest 12 months (set 3 months back) who were left treatment (not treatment completed) before being retained for 12 weeks.

[25] Source: PHE – Drug Data – commissioning support pack, key data 2018/19 (published in 2017)

[26] Note; this data is taken from the monthly Partnership Successful Completions Report and figures may vary (successful completions reports are live reports and may not take account of changes in data reported retrospectively).

Figure 3: Successful completions among alcohol only clients by daily consumption reported at the start of treatment – 2016/17

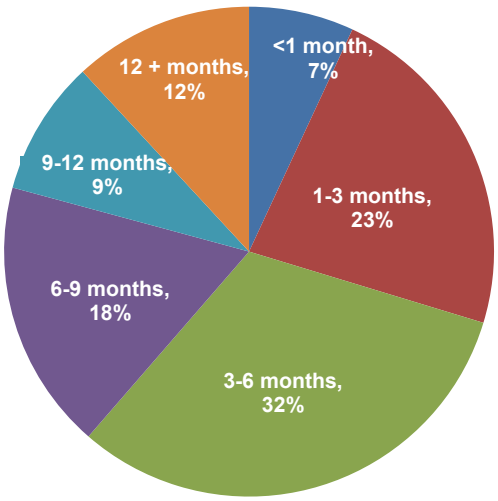


Source: PHE Adults – alcohol commissioning support pack 2018/19: key data (published 2017)

LENGTH OF TIME IN TREATMENT (ALCOHOL ONLY)

The majority have been in treatment for less than one year, with those in treatment for 1-3 months representing 23%, in treatment for 3-6 months representing 32% and 6-9 months representing 18%. Successful completion rates peak with services users that have been in treatment between 3-9 months. In comparison to the national results, Ealing achieved better or very similar completion rates among those in treatment for any length of time. 47% successful completion rates for those in treatment between 1-3 months (nationally, 39%) and 35% successful completion rates for those in treatment under 1 month (nationally, 23%).

Figure 4: Length of Time in Treatment – 2016/17

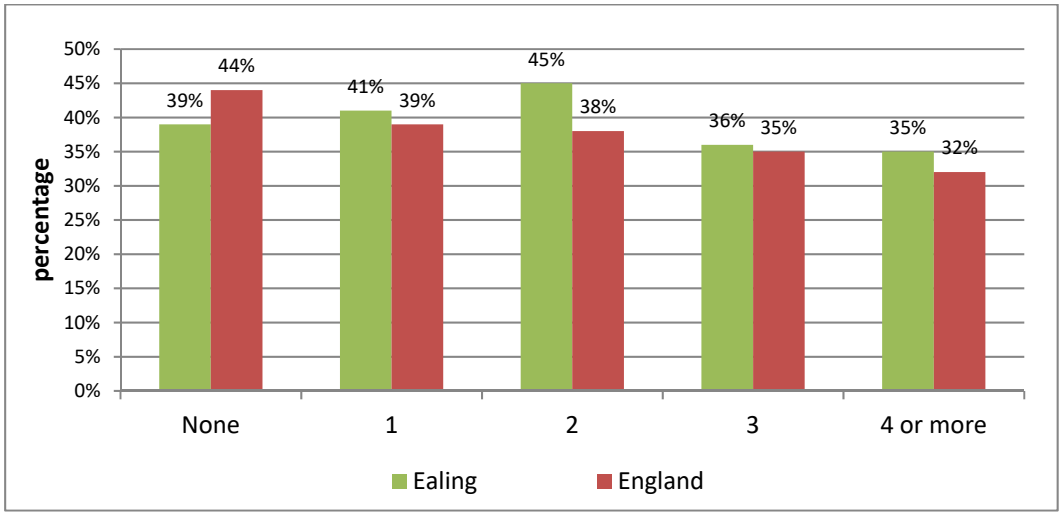


Source: Recovery Diagnostic Tool Kit 2016/17, NDTMS (Released Sept 2017)

PREVIOUS TREATMENT JOURNEYS

Around two in five (41%) had no previous treatment journey and nearly one in seven (15%) people in treatment have had 4 or more previous treatment journeys compared to 13% nationally. People who have had previous treatment journeys tend to be less likely to successfully complete the next time they are in treatment. This decreases further with each additional attempt. However, the likelihood of successful completions for clients who have had no previous treatment journey is almost 1.5 times greater than those with 4 or more journeys. In Ealing, however, the completions rates are better among service users with one or more treatment journeys when compared with the National rate.

Figure 5: Completion Rates by Number of Previous Treatment Journeys



Source: Recovery Diagnostic Tool Kit 2016/17, NDTMS (Released Sept 2017)

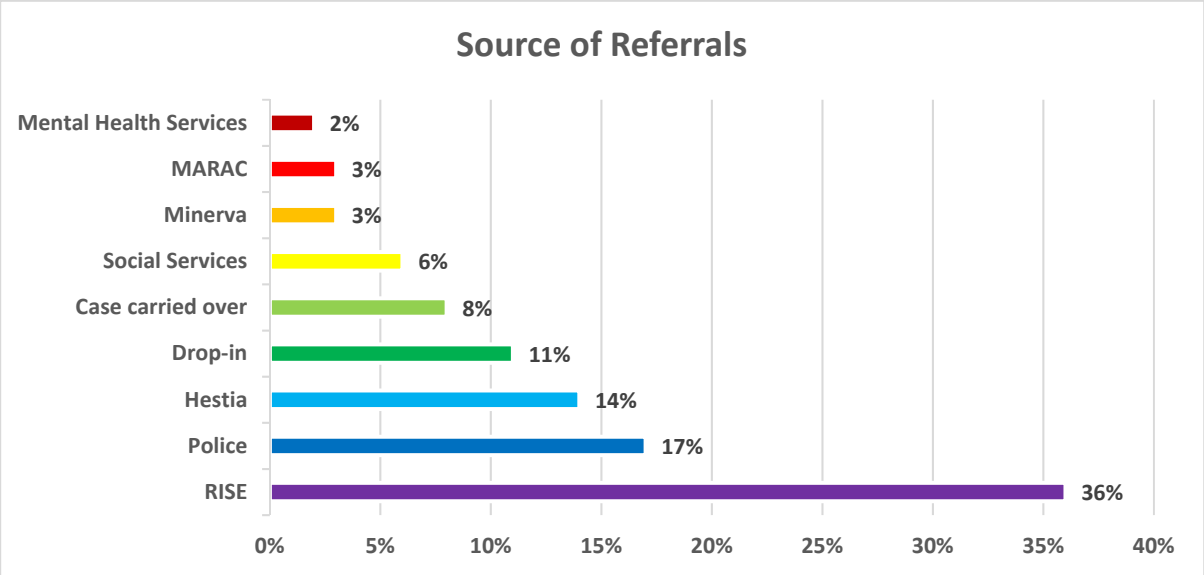
APPENDIX 4

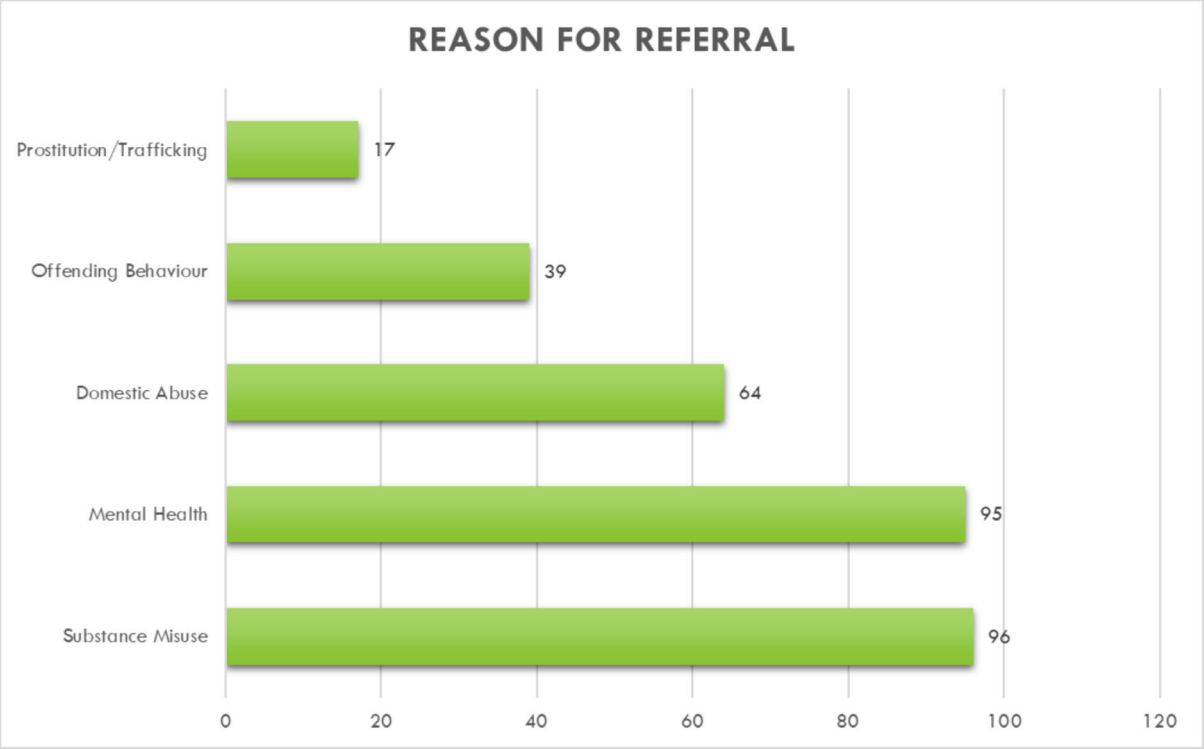
THE WOMEN'S WELLNESS ZONE PERFORMANCE INFORMATION

- The service started in November 2017 and moved to its dedicated premises in April 2018. The following key findings are taken from the first year's annual review report produced by the Safer Ealing Partnership's senior analyst:

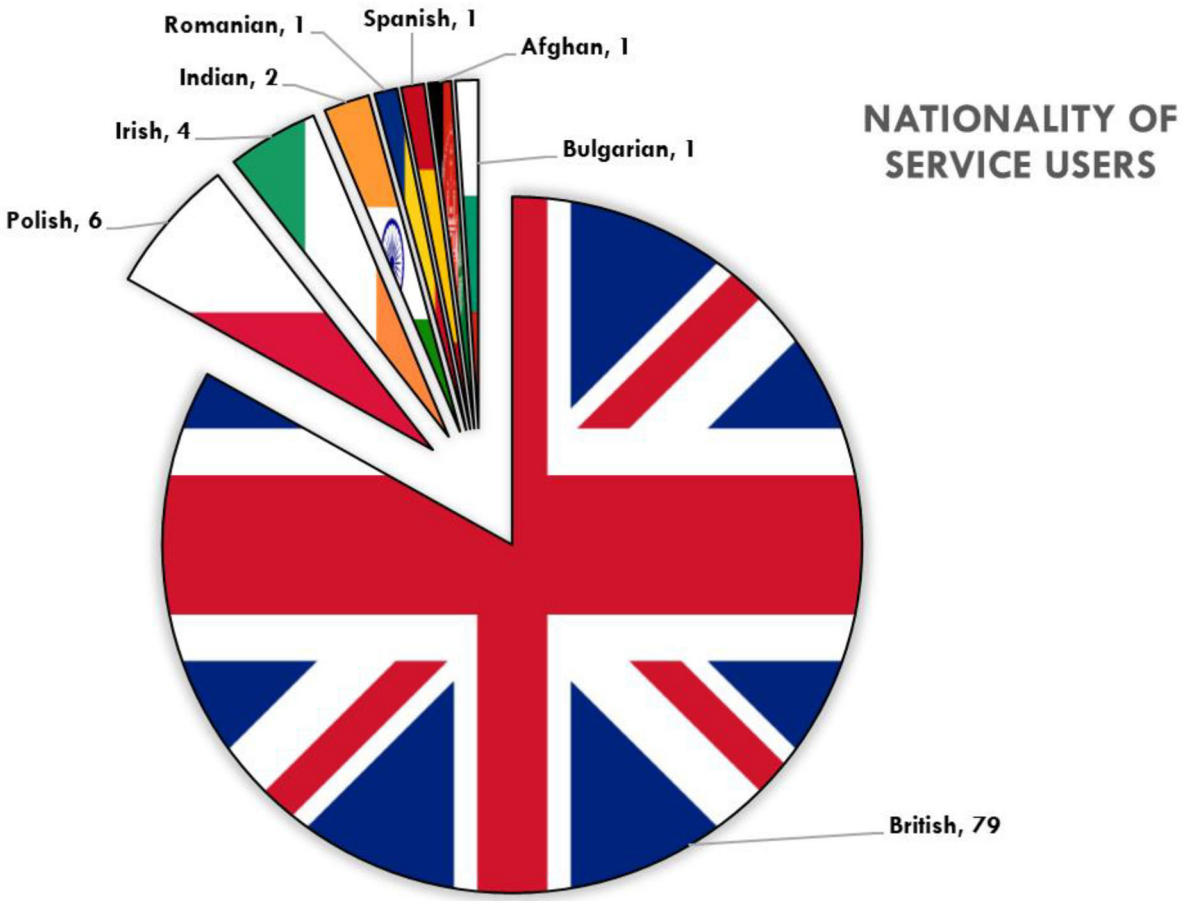
  - There have been 106 referrals between November 2017 and October 2018.
  - Most referrals came from RISE.
  - The minimum age of Service Users was 18 and the maximum age was 71. The most common age was 33.
  - The majority of Service Users were White British.
  - 80% of Service Users were registered to a GP.
  - 65% of women were experiencing problems in three areas and 14% had problems in four areas out of the five criteria for referral: substance misuse; offending behaviour; mental health; domestic abuse and/or sexual violence; and sex working or trafficked.
  - Mental health and substance misuse were the most common reason for referrals.
  - Improvement was seen for Service Users regarding eight out of the ten performance indicator categories of accommodation, support networks, mental health, domestic abuse, empowerment and self-esteem, physical health, substance misuse and education, training and employment.

WOMEN'S WELLNESS ZONE REFERRAL SOURCES & REASON FOR REFERRAL

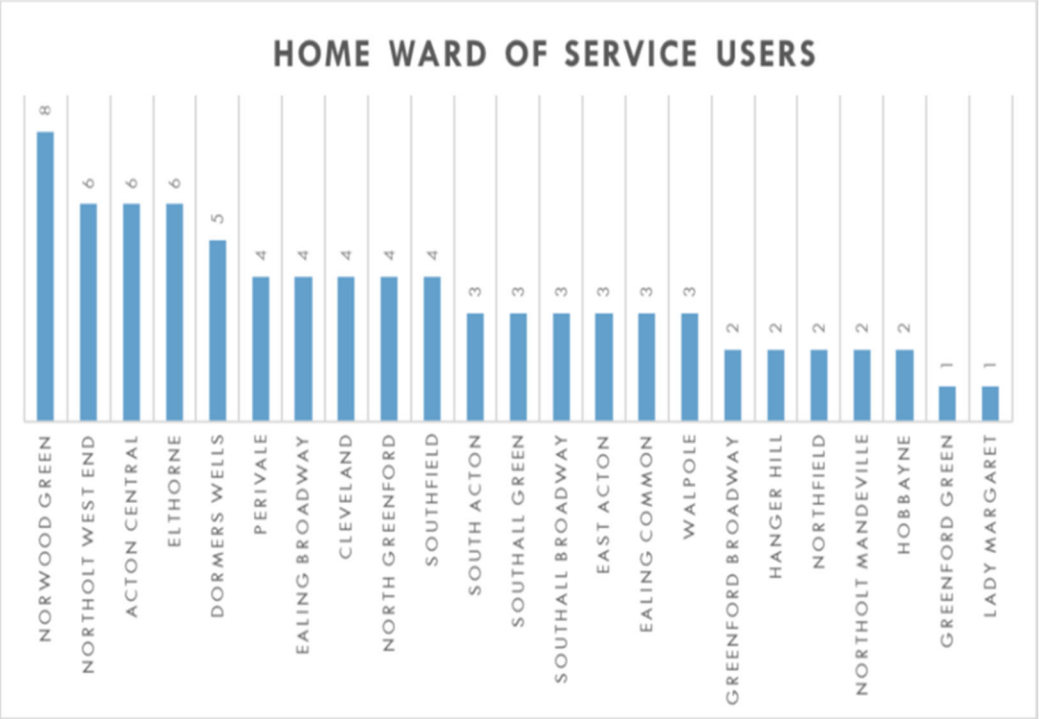




Ethnicity	Number
White - British	53
Asian/ Asian British - Indian	11
White - Other White	9
White - Irish	5
Mixed/ multiple ethnic group - White and Black Caribbean	4
Black/ African/ Caribbean/ Black British - Caribbean	4
Black/ African/ Caribbean/ Black British - African	3
Asian/ Asian British - Other Asian	1
Asian/ Asian British - Pakistani	1
Other ethnic group - Any other ethnic group	1
Mixed/ multiple ethnic group - White and Black African	1
Grand Total	**93**



HOME WARD OF THE SERVICE USER

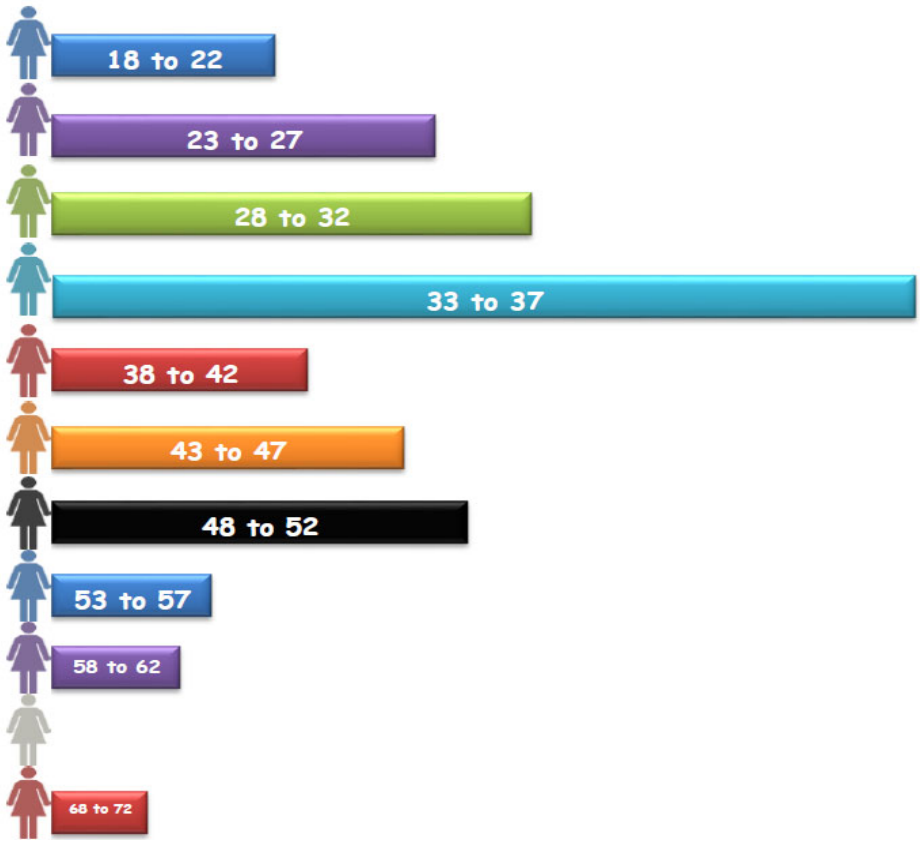


DRUG USE, MENTAL HEALTH & PARENTING AMONGST THE WWZ COHORT

- Over half of the women on the caseload used drugs – 57 out of 107. Heroin was the most common drug of choice accounting for 56%, followed by Cocaine (20%) and Cannabis (19%) and Methadone (5%) and Aerosols (5%). The main method of drug use was smoking (76%), followed by sniffing (16%). 60% of the women used drugs daily. Of the 57 women who take drugs, 33 (58%) used more than one drug. Just over half of the women were taking prescribed medication. 69% of the women drank alcohol and of those, 40% drank daily.
- 83% of the service users were described as having mental health problems, with depression as the most commonly identified need. Over half of the women were at risk of harm from others, with domestic abuse mentioned as being the most common risk. In relation to self-harm and suicide, information was available for 98 women, and of those 17 were described as self-harming or suicidal. 42% of women were the parent/caregiver for children under the age of eighteen. However, only 15% live in the same household as the children. 8 of the 103 women were pregnant while working with the WWZ.

SERVICE USERS' AGE

- Data was available for 103 women and their date was taken at the point of referral. The youngest was 18 and the oldest was 71. The average age was 37 and the most common age was 33. There were no service users in the 63 to 67 age category.



WOMEN'S WELLNESS ZONE PERFORMANCE FRAMEWORK

To increase the number of women by 10% accessing substance misuse treatment in Ealing from a baseline of 2016/17 which will be available from local data after March 31st 2017. This will help to address the lack of women currently in Ealing's treatment system with an 80:20 male to female ratio.

Data source: local RISE treatment data corroborated by NDTMS

To increase the number of street- based sex workers moving from engagement with the service to accessing structured treatment. 1st year will be the baseline year.

Data source: local RISE treatment data corroborated by NDTMS

To achieve positive treatment outcomes for 30% of women in contact with the one stop shop. The service cohort will be the most complex women with multiple issues. RISE is currently achieving 20% successful completions with all women in treatment for 2016/17 so an increase of 10% with the most complex cohort seems a realistic target.
Data source: local RISE treatment data corroborated by NDTMS

To reduce the number of repeat MARAC presentations for women in contact with the women's one stop shop measured by the number of MARAC presentations over the previous 12 months for each woman.
Data source: MARAC

60% of women in contact with the project report a decrease in risk of harm. Measured through Safer Lives assessment tool at beginning and end of engagement, client feedback mechanisms including group meetings, complaints, and satisfaction surveys.
Data source: WWZ database

To achieve positive change across at least 3 domains of the STAR outcome tool for 80% of women engaged with the service for over 6 months.
Data source: WWZ outcome tool & corroboration with TOPs scores for women with SM treatment needs.

80% of women accessing the one stop shop will engage with health services.
Data source: WWZ case database

To pursue enforcement activity against 25% of Ealing resident male perpetrators to provide women with time and space to focus on their health, wellbeing, & support needs.
Data source: Ealing Council's Safer Communities team and local police's data stored by the Safer Ealing Partnership analytical team.