London Borough of Tower Hamlets Substance Misuse Needs Assessment 2013/14

Full Report
February 2014

Ottaway
Strategic Management

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1 Executive Summary

Overview

1.1 Conducting a Substance Misuse Needs Assessment is essential to treatment planning and commissioning as it reviews service demand, offers comparison to relevant regional and national baselines and assesses local partnership performance over time. This needs assessment has reviewed the needs of the Tower Hamlets' substance misusing population to support the Drug and Alcohol Action Team (DAAT) and its wider partnership to respond to future treatment demand.

1.2 The Tower Hamlet's Substance Misuse treatment system has developed over time and is now one of the largest treatment systems in London. Its performance has historically been strong although in recent years there has been a decline in outcomes. Presentations to borough treatment services are heavily opiate and crack focused, with much of the resources targeted to a complex and high need client group which needs to be managed through the treatment care pathway to effective recovery.

Approach

1.3 This needs assessment has been based on a range of desk research and data analysis, primary and secondary research and an assessment of service provision across the borough. The core data used to support the needs assessment was derived from the National Drug Treatment Monitoring System (NDTMS), which is critical to assessing both service need and performance and supports an understanding of treatment demand to inform substance misuse intervention priorities for local partnerships.

1.4 Additional operational data was available through Mi-Case and directly provided by services across the DAAT. Partnership data was also gathered and analysed that has supported the findings of this assessment.

1.5 Primary quantitative and qualitative research included:

- 200 Service Users surveys
- 45 interviews with practitioners and stakeholders
- 4 focus groups with 36 participants
- 64 stakeholders engaged in workshops and presentations

1.6 All emerging findings were also scrutinised by an independent steering group with representatives from the project team, Public Health England (PHE), Home Office (HO) and a DAAT Coordinator from an external authority.

Resources

1.7 In 2012/13 Tower Hamlets spent £9.5M on community based substance misuse treatment in the borough (based on the Pooled Treatment Budget and Council and PCT Funding, it does not include young people's services). All borough substance misuse services are commissioned and/or delivered by LBTH via the DAAT, the Drug Interventions Programme (DIP) and Children's Commissioning with annual funds for the DAAT (and DIP) in the region of £9.5m for 2013/14 which is derived from the PH Grant (£8.8m) and the Mayor's

Office for Policing and Crime (£613k for DIP). This funding commissions 25 services to address the treatment needs of local drug users.

Impact of commissioned services

1.8 There are a range of performance highlights which have emerged from the borough's treatment system. The key impacts of commissioned services are:

- The Borough's treatment penetration rate for opiate and/or crack users (OCU) is 34% (down 3% on the previous year). This is set against an estimated OCU population of 3,027.
- Women are under-represented in treatment in the community (at 20%) and are below the London and national rates of presentation.
- In 2012/13 there were 833 new entries into treatment, 2,154 people in treatment and 611 people exiting the treatment system
- Treatment providers with the highest volume of clients were Lifeline CDT with 857 (40%) clients, Tower Hamlets Specialist Addictions Unit (SAU) 339 (16%), Health E1 with 257 (12%) and NAFAS 149 (7%).
- Just over a third, 217 (36%) left treatment in a planned way, successfully completing treatment (accounting for 20% of the drug treatment budget) and 233 (38%) left in an unplanned way, majority of which dropped out of treatment.
- As a percentage of the numbers in treatment 9.3% opiate clients successfully completed treatment (compared to 9.8% London and 8.7% national average). However, in September 2013 this dropped to 5.1% (compared to cluster top quartile performance range, 8% to 10%).
- Thirty-four percent of non-opiate clients successfully completed treatment (compared to cluster top quartile performance range, 49% to 63%). In September 2012/13 this dropped further to 29.5%.
- Tower Hamlets has a prevalence rate of 17 per 1,000 aged between 18 and 64 OCUs, 15 for opiate users, 16 for crack users and 4 for injecting drug users (opiate use is twice as prevalent compared to London and national averages, whilst crack use is more than three times the national rate).
- OCUs in effective treatment make up almost the entire treatment population in Tower Hamlets which has ranged between 96% and 93% since 2008/09.
- North West Health Observatory figures indicate 30,810 at risk drinkers, with 9,168 consuming alcohol at higher risk and 16,382 binge drinkers.
- Alcohol admissions to the treatment system are growing in Tower Hamlets (with 470 alcohol referrals, 738 in treatment amongst providers and 432 treatment exits).
- Tower Hamlets is hitting a 50% successful completion rate for alcohol users with around half (46%) reporting unplanned exits.
- Alcohol is an increasing concern locally and one which the treatment system needs to address.

The Performance of the Partnership

1.9 In Tower Hamlets one in four clients in treatment (opiate and non-opiate) have very high complex needs (442), this is almost twice as many very high complex need clients compared to the national average (14%).

1.10 Tower Hamlets opiate treatment population falls into cluster E and non-opiate treatment population into cluster D. Clusters range from A to E, with A representing the least complex treatment populations and E the most complex. Therefore the borough's cluster comparators are the most complex opiate and the second most complex non-opiate Local Authority areas.

Opiate Clients

1.11 In September 2013 Tower Hamlets had 1,456 opiate clients in treatment, which is below cluster average placing Tower Hamlets mid-table for the size of its opiate treatment population. There has been a significant reduction in the number of opiate clients successfully completing treatment since October 2012, this means Tower Hamlets is ranked 6th lowest for the number of opiate successful from a position of 14th highest at the 2012/13 baseline.

1.12 In 2012/13 one in four opiate clients had a drug using career length that spanned over 21 years, similar to cluster average. However a high proportion (43%), have been in treatment for less than one year, higher compared to cluster average of 22% and the proportion of opiate clients that have had more than four previous treatment journeys is equal to 24% (higher compared to 19% cluster and national average) which has increased from one in five in the previous year. Whilst completion rates are broadly consistent with cluster average, this suggests a significant number of opiate clients are engaging and disengaging in treatment and as the number of previous attempts at treatment increase they are less likely to complete the next time they are in treatment.

1.13 The outcomes data suggests, in the past six months, there have been 46% less clients successfully completing treatment (138, 2012/13 baseline and 74, September 2013). The proportion of opiate clients re-presenting to treatment has fluctuated between 37% and 19% since 2010/11, with September 2013 showing 34% re-presentations.

Non-Opiate Clients

1.14 In September 2013 Tower Hamlets had 224 non-opiate clients in treatment, which is below cluster average and ranks Tower Hamlets 8th lowest for the size of its non-opiate treatment population. Non-opiate clients account for 13% of the total treatment population. In the past 6 months, 6% less non-opiate clients successfully completed treatment (70, 2012/13 baseline and 66, September 2013). In the latest reporting period there have been no re-presentations to treatment.

1.15 The distribution of non-opiate clients in treatment is broadly similar to cluster and national average, with the majority (59%) in treatment with no previous treatment journeys, however completion rates are much lower at 37%, compared to 47% cluster and 43% national average.

1.16 As a proportion of the numbers in treatment 5.1% opiate clients and 29.5% non-opiate clients successfully completing treatment in September 2013.

The Performance of substance misuse treatment providers

1.17 Tower Hamlets has numerous providers reporting into NDTMS, however the bulk of opiate clients are distributed amongst seven main treatment providers and non-opiate clients amongst five.

1.18 In September 2013 the number of opiate clients in treatment across the main providers ranged from 745 to 63, Lifeline CDT having the highest number of opiate clients in treatment and RAPT Day Programme the least. Compared to 2012/13 baseline the number of opiate clients in treatment has fallen with the majority of providers. Fewer opiate clients have been successfully completing treatment at each baseline period for all providers. The reduction in the number of opiate clients in treatment was proportionately less than the reduction in the numbers successfully completing, as a result successful completions as a proportion of the numbers in treatment show a stark decline in performance. In addition a high proportion of clients re-presented to treatment, one third of completions resulted in client re-presentations for Lifeline CDT and NAFAS and 28% for the Harbour Recovery Centre.

1.19 In the first 6 months of 2012/13 treatment exit outcomes show opiate clients dropping out of treatment far outweigh those successfully completing treatment. Collectively 11% left treatment in a planned way (successfully completing treatment). For all providers, with the exception of NAFAS, this ranged from 0% to 18%. NAFAS however achieved 72% planned exits. The proportion of unplanned exits resulted in almost 50% opiate clients dropping out of treatment; this is equal to 111 clients collectively.

1.20 Non-opiate clients ranged from 54 to 19, NAFAS having the highest and SAU the least. The number of non-opiate clients in treatment has increased slightly or remained the same across most providers. There were no re-presentations to treatment.

1.21 The treatment exit outcomes for non-opiate clients show higher proportion of planned exits with some providers, whilst equal for others in comparison to the proportions that dropped out of treatment. Overall the treatment outcomes for non-opiate clients are better compared with opiate clients with almost half leaving treatment having successfully completed.

The impact of Drugs and Alcohol in the community

1.22 A wider review of partnership data shows that drugs and alcohol has a significant impact on the borough in terms of health, crime, community safety. The borough has seen increasing levels of drugs and alcohol call outs made by the London Ambulance Service, the borough has also seen increasing levels for Alcohol related admissions to hospital 986 in 2002/03 rising to 2,577 in 2012/13 and almost tripling over this period.

1.23 There was an average of 256 drug offences per month in the borough, with peaks in the summer of 2012, there was a hugh spike of possessions convicted in June 2012, (associated with preparations for the Olympics). The numbers of drug trafficking offences (dealing) is lower and there has been a broadly consistent level of offences throughout this

period with a spike in October 2012. The Borough Police have targeted a dealer a day as part of a local campaign and during this period there was an average of 16 arrests a month

1.24 Tower Hamlets has a higher rate of recorded crime attributable to alcohol, greater than London and England; although this is falling it did see a rise in the estimate in 2009/10. With respect to violent crime Tower Hamlets also has a higher rate than London and England and once again this figure is declining broadly in line with the London and England profiles. The rate for sexual crime attributed to alcohol is however growing compared to London and England which are declining albeit very slowly. This is a concern but is likely to be affected by the club based night time economy emerging in the borough.

1.25 The impact and cost of drugs and alcohol on the borough is great and it is importance to engage these people in treatment and to work particularly with 'frequent flyers' of these services to ensure that treatment can be used to mitigate repeat incidents.

Primary Research Findings

1.26 A range of primary research was completed in developing this needs assessment. This included stakeholder interviews and workshops, a service user questionnaire completed by 200 respondents, four focus groups targeting opiate users, non-opiate users, women and alcohol treatment clients. The headline findings of these are set out below.

Stakeholder interviews

1.27 Interviews and workshops engaged over 50 practitioners and stakeholders in the borough. There were many themes which came out of these interviews however the main focus was:

- The treatment system lacks holistic planning and has evolved with additional services being added over time
- Heavy operational focus on opiates, low level of non-opiate engagement, but high complexity clients in deprived and challenging environment
- Volume of providers creates a situation where clients are held onto and transferred haphazardly, too many providers leading to duplication, lack of mutual value, some interagency miss-trust
- Critical need to address the 'disjointedness' of treatment provision and to consolidate a clear understanding of what everyone is doing.
- Clients are often not treatment ready particularly with respect to detox and rehab
- Low levels of treatment value from clients
- Low levels of recovery focus but a priority aim of the treatment system, pockets of good practice although these are often not shared
- An overwhelming positive commitment to improve the treatment system but a clear realisation amongst providers and stakeholders that whilst this will be opportunistic for the treatment system it is likely to be a threat to them

Service User Questionnaire

1.28 Throughout the survey and its findings there was a loyal sense of general support for the way the treatment system works from the 200 respondents who took the time to complete the survey:

- 96.0% think their substance misuse negatively impacts on their life

- 78% feel optimistic about their ability to reduce dependency
- 85.8% have a good relationship with their treatment providers
- 85.8% key worker skills and abilities in interpreting their needs are good
- 71.8% felt their treatment provider was good at meeting their needs
- 74.9% have a care/recovery plan and
- 80.6% of these worked on care/recovery plan with their key worker
- Going forward they prioritised:
  - After care
  - 'After/out of hours' services
  - Better service access across the borough
  - More and better counselling, psychosocial therapies, alternative therapies
  - More access to housing, detox, rehab and aftercare
  - Better information and communication about what's available

Service User Focus Groups

1.29 Four Focus groups were completed as part of this needs Assessment. There were a range of key findings that are set out in the main body of this report and in a separate focus group report. The main themes that emerge are set out below:

- Clients felt that there is a branding issue in local treatment as many have pre-conceived perceptions of services which stigmatise provision
- Their consistent view was that Drugs and Alcohol are a common part of life for many in the borough
- Focus groups felt there was an absence of commitment and operational structures to support client recovery
- Many felt that services are incoherent and need better integration, particularly with respect to drugs and alcohol
- Most clients experience unstable housing, poor public services access and more support for ETE
- Focus Group participants do not see GPs are being part of their care team and there is concern about the quality of care received from GPs
- Clients feel there is a desperate need for more effective aftercare and recovery support
- Treatment clients felt that services need to be more patient centred
- There were also strong arguments for more Peer involvement to support recovery

Conclusions [Key issues emerging from the assessment]

1.30 There are some clear issues for the treatment system to contend with, in particular:

- Reduction of successful completions achieved by the partnership
- Slowing down of new treatment entries across most providers
- Several bottlenecks in the system, in particular the borough's CDT
- General low levels of client readiness for the recovery journey
- Low levels of treatment compliance by clients (drop outs)
- Low levels of recovery capital in clients
- High levels of complexity and diversity within the system
- Some poor inter agency procedures and protocols to enable effective treatment transfers
- Specific operational issues within the DIP

- Clients in Shared Care arrangements in the borough tend to be stabilised but not benefiting from a strong recovery focus to their treatment

1.31 The role of shared care in the borough's treatment is strong with over 800 clients receiving their treatment in this way. Capacity to effectively support and treat clients in this shared approach suggests the need for a strong revamp. Particularly as this is affecting the capability of the Partnership to meet its successful completion targets set in the Public Health Outcomes Framework.

1.32 The difficulty in engaging clients and their lack of recovery capital prevents successful completions from emerging and fails to support clients to be treatment ready and to enable the associated benefits of recovery being realised. In short treatment needs to actually be provided and clients and practitioners need to better distinguish between the role of substitute prescription as a method of stabilisation/maintenance and structured treatment as a support to reducing and eventually stopping their drug use.

1.33 Diversity and the cultural needs of different clients are also key considerations for the borough. It is vital that prospective clients from all communities are at ease with entering the treatment systems either to maintain their substance misuse and or to begin a journey through to recovery. In Tower Hamlets there seems to be a far greater proportion of the former and far fewer of the latter.

Value for Money

1.34 Addressing Value for Money (VFM) and cost effectiveness is a relatively inaccurate science nonetheless the NDTMS have provided tools that can support a better understanding. The VFM tool estimates that if there were no provision for drug treatment this would have a cost to Tower Hamlets of £23.7m. However based on a budget of £4.2m over the spending review period there is a net benefit of £16.9m and a cost benefit ratio of 1: £2.82.

1.35 The large variation in subsidy per head of providers suggests varying cost in provision, varying numbers of clients in effective treatment and potential to rationalise some of these costs against need.

Recommendations

1.36 This needs assessment has identified a number of key priorities for the Tower Hamlets Treatment System, these are set out and addressed below:

- Develop a treatment system that meets the needs of the local community
- Develop a clear annual treatment plan
- Support the transition to an integrated drugs and alcohol service
- Better alignment of services and treatment activity
- Deliver more outcome focused treatment
- Improve the recovery capital of clients
- Develop more client facing services
- Rationalise the commissioning function and performance management of contracts
- Support the ongoing workforce development of treatment staff and stakeholders
- Use the procurement process to better clarify the roles and responsibilities and operational relationships between providers

- Better clarify the distinctions between shared care and structured treatment roles in the treatment system
- Utilise the procurement process to rebrand services

1.37 Aims of the Drug and Alcohol Treatment Service should be:

- To offer personalised opportunities for those using drugs and/or alcohol to move towards total cessation.
- To reduce the harm caused by substance misuse on the local community including contributing to a reduction in crime and anti-social behaviour
- To ensure that the principles of harm minimisation underpin the delivery of all interventions in order to improve the health and well-being of service users
- To deliver a non-judgemental and inclusive service which treats service users with dignity, respecting gender, sexual orientation, age, ethnicity, physical or mental health ability, religion, culture, social background and lifestyle choice
- To deliver services which are accessible, responsive and offer greater service user choice
- To improve the outcomes for children of service users by reducing the impact of drug and alcohol related harm on family life and to promote positive family involvement in treatment
- To facilitate a co-ordinated and holistic approach to recovery which emphasises the inclusion, or re-entry into society of service users by working with a range of local partner agencies
- To reduce the impact of drug and alcohol misuse on the wider public sector economy by promoting effective treatment and harm reduction responses in a range of settings including primary and community health care, mental health and criminal justice services
- To identify and safeguard vulnerable adults and children of adults who use the services

1.38 A key recommendation to the DAAT Board is the need to appraise options for future treatment provision. These options will be reviewed in detail in the service review report.

1.39 Strategic Recommendations:

- Maintain the management of drugs and alcohol treatment planning, commissioning and performance management through the DAAT team within the Council
- Establish evidence based commissioning and treatment planning by using this needs assessment and set appropriate targets and performance management tools for the borough's drugs and alcohol treatment system
- Maintain the priority of Substance Misuse Treatment Services through current and future changes to funding streams for Drugs and Alcohol misuse in Tower Hamlets
- Develop and maintain annual treatment plans which fit into the Public Health commissioning priorities to tackle addictions in the community
- The Tower Hamlets DAAT needs to maintain up to date data and to review performance against the 2014/15 treatment plan

1.40 Key Treatment Plan Priorities:

- Tower Hamlets has seen a slow decrease in opiate presentations over the last three years. However this does not address the wider treatment naive population. Opiate users should always be a priority group within substance misuse treatment provision

- Services will need to be maintained and strengthened for non-opiate and other problematic substance misuse
- There is a clear need to plan for and target the increasing emergence of alcohol.
- Increase the numbers of those entering the treatment system to maintain a steady client flow through
- Undertake a more dynamic approach to sourcing new clients and or targeting ex-clients who may now be treatment naive
- Maximise the number of clients in effective treatment, this is currently falling and may affect future service success and impact
- Develop programmes to increase the Recovery capital available to clients
- Work to address the recovery agenda and drive forward the increase in Successful Completions for the borough
- Establish a focus on addressing the long term clients i.e. clients who have been in the treatment system for over 6 years.

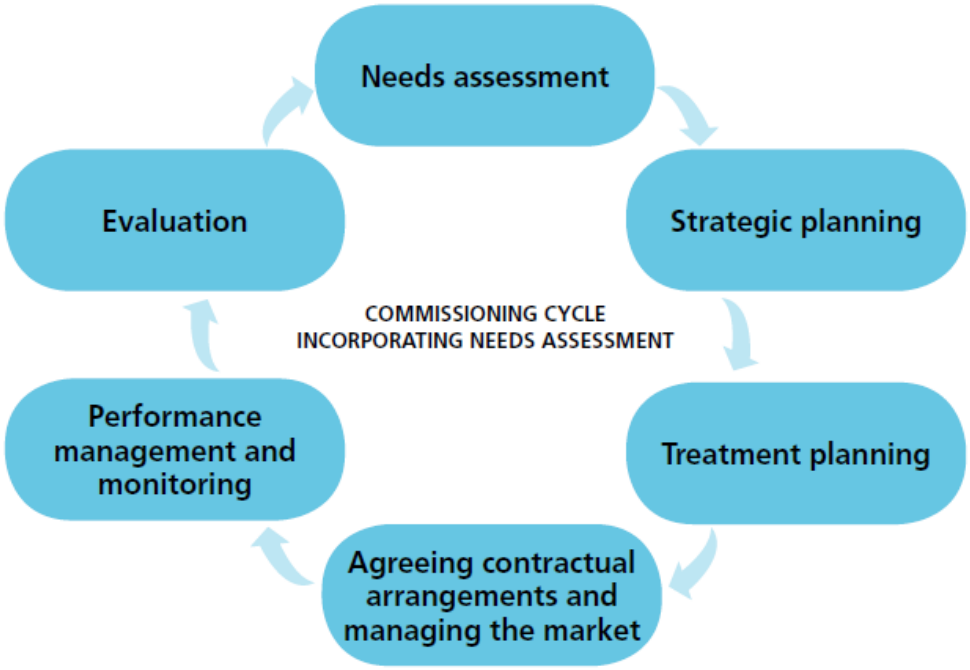
1.41 Operational Priorities

- Set targets for the treatment provision secured through the re-procurement exercise
- Define service scope and capacity to expand the community focus of the work and to provide beyond the traditional 9-5 operational model, extending to more evening and or weekend provision where feasible
- Redefine the Borough's Shared Care system to take account of the treatment/recovery needs of clients in particular those receiving their substitute prescribing from their GP
- Review and support aftercare and consider effective options to extend aftercare services
- Support providers to work with the 'assertive' outreach services within the DIP to support re-engagement and to engage new clients
- Target non-opiate and alcohol treatment provision with associated treatment options in particular psychosocial analysis, behavioural treatment and motivational interviewing.
- Review the role and provision of community detox
- Support clients readiness for treatment
- Enhance the key worker capabilities in the borough
- Implement a comprehensive and frequent review of client treatment and care plans both from a clinical and treatment perspective.
- Improved contract management, setting recovery focused delivery targets for each provider, in part this is already in the performance management of the providers but may need revisiting and reinvigorating.
- Clear fiscal controls with all providers in contract to support treatment system benefits and to guide/influence decision making
- Contracts to be set to secure a controlled and where possible reducing subsidy level and increasing cost benefit ratio regarding costs of crime as nominal targets.
- Review those parts of the treatment service where there are high levels of expenditure but which do not contribute to performance targets or indicator
- Develop Annual workforce development plan
- Work with partners to secure effective up to date data exchange on; A&E admissions, drugs and alcohol Hospital admissions, Ambulance service call outs and maintain a working review of Policing, drug and alcohol crime and Integrated Offender management (IOM) and Probation client data.

2 Introduction and context

2.1 A Substance Misuse Needs Assessment is an essential part of the treatment planning and commissioning cycle. In effect a needs assessment reviews the baseline demand for services in a local area, offers comparison to regional and national figures and assesses local partnership performance over a given period.

Chart 1: Commissioning Cycle (Commissioning for Recovery NTA 2010)



2.2 The commissioning of all adult substance misuse treatment provision is co-ordinated by Tower Hamlets DAAT and is based on an analysis of local substance misuse needs which informs a borough treatment plan. The last treatment plan was developed in 2010/11 thereafter the treatment plan activity is included in the DAAT Service Plan which is up to date.

Tower Hamlets Substance Misuse Strategy 2012-15

2.3 The strategy is a joint strategy developed in partnership between London Borough of Tower Hamlets, NHS East London & the City, the Metropolitan Police and the London Probation Service. The mission statement in the Strategy states that: 'In Tower Hamlets, we will support people and families to make healthy lifestyle choices; we will reduce harm to those at risk, and empower those who are addicted or dependent to recover. We will relentlessly bear down on the crime and anti-social behaviour associated with drug and alcohol misuse that impact on our communities.'

2.4 The strategy relies on a 'Three Pillars Approach', addressing:

- **Prevention and Behaviour Change**: including information, education, support to parents, health messages and communications

- **Treatment:** through screening and identification, assessment and care planning, effective treatment, after care and reintegration
- **Enforcement and Regulation**: including dedicated drug task force, integrated offender management, 'Dealer a Day' operations and licencing enforcement

2.5 The strategy sets out the broad framework for the drugs and alcohol intervention across the borough and identifies a range of priorities that address the themes listed above. The coordination of these functions makes the strategy a direct responsibility of Drugs and Alcohol Action Board and the day to day management within the safer communities' service in the Council, through community safety, licencing and the DAAT.

2.6 In addition, all providers are responsible for delivering drug treatment within the context of the National Drug Treatment Strategy to deliver increases in those:

- reducing their drug and alcohol misuse and those achieving abstinence
- reducing their offending, including repeat offenders
- improving health and well being
- reintegrating with education, training and employment, housing & other services

2.7 In 2012/13 the treatment budget was £9.5m (based on the Pooled Treatment Budget and Council and PCT Funding, it does not include young people's services). This included the borough's Tier 1-3 Treatment provision, DIP, Drugs and Alcohol Tier 4. In April 2013 all funding was transferred to the borough and all contracts novated to the DAAT. Now all borough substance misuse services are entirely commissioned and/or delivered by LBTH via the Drug and Alcohol Action Team (DAAT), the Drug Interventions Programme (DIP) and Children's Commissioning with annual funds for the DAAT (and DIP) in the region of £9.5m for 2013/14 which is derived from two funding streams:

- PH Grant (£8.8m which includes £865k for DIP) and
- Mayor's Office for Policing and Crime (MOPAC) (£613k for DIP).

2.8 Many of the contracts now managed by the DAAT have been historically 'rolled over', however there is now a clear priority to commence a re-procurement process to ensure that the contracts held by LBTH are set in line with the borough's procurement priorities. Therefore the re-commissioning of substance misuse contracts will be supported by the Needs Assessment and service reviews and a range of options will be developed which will be appraised and reported to the DAAT Board. From this position all contracts are due for re-tendered by the end of 2014/15.

2.9 The current Substance Misuse treatment provision in Tower Hamlets is delivered through a range of Tier 2 and 3 providers set out below:

- **Tower Hamlets Community Drug Team (CDT):** Providing Advice and information; substitute medication for heroin addiction; key work and group work; nurse appointments for healthcare assessments, testing for HIV, Hep B, C and immunisation and other services; including assessment for accessing inpatient detox and residential rehabilitation services. A range of Tier 2 services from advice and information, through harm reduction, needle exchange and general drug safety.

- **Specialist Addiction Unit (SAU):** A multidisciplinary service which provides structured drug treatment to adults with complex drug related needs, aside from these more focused psychosocial interventions the service also provided needle exchange and low threshold prescribing. These complex needs may be due to: Physical health, Mental health, Using a number of drugs including alcohol in a chaotic way and Pregnancy

- **ISIS (women's service):** Working with women over 18 and providing Advice and information; one-to-one counselling; key work; substitute medication for heroin addiction; needle exchange; nurse appointments for healthcare assessments, testing for HIV, Hep B, C; sexual health advice; parenting support and immunisation and other services; including assessments for inpatient detox and residential rehab.

- **Health E1 Homeless medical centre:** Medical centre for patients who are street homeless, in hostels or in other temporary/unstable accommodation in Tower Hamlets. These patients are offered full GP registration at the surgery. Primarily a general practice health service/out patient service– not a substance misuse service. In addition they provide additional services to other practices though needle exchange for patients, submission of NDTMS data

- **NAFAS:** Culturally sensitive 12 week day care programmes for drug users and their families including: support, aftercare, specialist addiction counselling, advice and fast-track referrals to specialist services.

- **Island Day Programme:** Structured abstinence-based day programme for drug and alcohol users following the 12 step model. The programme also offers one to one counselling and an aftercare programme

- **Harbour Recovery Centre:** Men only residential detoxification centre for noncomplex (non-injecting) opiate users aged 18-65 years requiring detox. Offering detoxification, group work programmes and counselling.

- **Tower Hamlets Community Alcohol Team:** Drop-in advice, information and assessments, community alcohol detoxification, group work, counselling, support for clients experiencing domestic violence and alcohol use, onward referral to further treatment and associated agencies, including residential detoxification/rehabilitation.

- **Changes programme:** delivered at the DIP this treatment contract delivers group work targeting clients from the criminal justice system.

- **Shared Care Team:** Coordinated within the CCG supports the Shared care of substance misusers (predominantly Opiate) across Primary care settings in the borough. A vast proportion of clients in the treatment system are in shared care particularly those who are prescribed by their GP. The Shared care team coordinates this role including the Local Enhanced Services for Drugs, Alcohol, Community Prescribing, Pharmacists and the GPs with Special Interest who prescribe in treatment settings.

- **DIP:** the borough's Drugs Intervention Programme coordinates the identification, assessment and referral into treatment for those emerging out of the criminal justice system. The programme makes referrals into treatment providers in the borough. The team includes Assertive Outreach, Criminal Justice workers, Prison Link Team, Integrated Offender Management, Treatment Referral, Restrictions on Bail and Court work, Arrest Referral Team

- In addition there are several other contracts not highlighted in specific Tier 3 work but including:

    - Specialist Midwife
    - Prison Link Team (sits within the DIP)
    - Dellow Centre Providence Row
    - Nacro (Substance Misuse Link Intervention Service)
    - Mind THN – Somali Link Worker Project
    - Blood Borne Virus (BBV) Team
    - Young People's Substance Misuse Service (Transitional programme)

2.10 It should be noted, that these arrangements are all subject to a re-procurement exercise in 2014/15. Therefore, this Needs Assessment also aims to set some baselines concerning the above providers to inform a service review to be utilised to inform the future commissioning plan.

3 Methodology

3.1 This needs assessment has been based on a range of desk research and data analysis, and includes primary and secondary research and an assessment of service provision across the borough.

3.2 The core data used to support this needs assessment has come from the National Drug Treatment Monitoring System (NDTMS) and the National Alcohol Treatment Monitoring System (NATMS), which are monitoring and performance management systems that produces annual needs assessment data sets against which treatment can be reviewed. Thus both NDTMS and NATMS are used, to assess service need and performance and to support an understanding of treatment demand to inform substance misuse intervention priorities for local partnerships.

3.3 Particular analysis from NDTMS and NATMS identifies:

- Prevalence of substance misuse in the community (Only OCUs – based on national and local estimates)
- North West London Public Health Observatory (NWPHO) Alcohol Consumption estimates and Local Alcohol Profiles for England (LAPE)
- Treatment mapping including referrals and presentation to treatment, including new treatment entries, those in effective treatment, treatment exits, successful completions
- Partnership and provider performance
- Profiles of treatment users and those in the treatment system, including age, gender, ethnicity, length of time in treatment, profile of primary, secondary and tertiary drug used employment status and housing needs and client complexity

3.4 Although, information derived from NDTMS and NATMS are critical to this process, much of this is retrospective and therefore historical. Nonetheless specific trends can be established which provide strong indicators of future treatment service demand to inform local partnership priorities. In the case of this Needs Assessment this data has been supplemented with additional partnership information.

3.5 Additional operational data has also been analysed using in particular the borough's Mi-Case system and has been supported by data from services across the DAAT.

3.6 Additional partnership data was also gathered and analysed that has supported to findings of this assessment, this has included NHS data (EMIS GP Data, BBV Data, Prescribing data, Hidden Harm, Hospital Admissions (drugs and Alcohol), Crime data, fear of crime data, Probation client information from Offender Assessment System (OASys), London Ambulance callout data and A&E admissions data. Much of this information describes the impact that drugs and alcohol related activity has with these bodies and embellishes the needs that are being presented by the wider community many of who have not entered the treatment system and hence who are not recorded on either NDTMS or NATMS.

3.7 Primary quantitative and qualitative research included:

- 200 Service User surveys
- 45 semi structured interviews of stakeholders and service providers
- 4 focus groups with 36 participants

- 64 partners and stakeholders engaged in workshops and presentations

3.8 A significant amount of data has been used to support the needs assessment was derived mostly from the NDTMS, which is central to assessing both treatment demand and performance.

3.9 However all sources were used to establish treatment demand to inform substance misuse intervention priorities for local partnerships. All emerging findings were also scrutinised by an independent steering group with representatives from the project team, PHE, HO and a DAAT Coordinator from an external authority.

Methodological notes:

University of Glasgow Prevalence Estimates and Methodology

3.10 Establishing needs is based on a series of factors as set out by the National Treatment Agency (NTA) Guidance for Needs Assessments. General opiate and crack user (OCU) treatment need is based on estimates generated by Glasgow University.

3.11 Problematic drug users classified by as those using opiates and crack places a disproportionally large burden on the substance misuse treatment services. The Glasgow University prevalence estimates used by Public Health England (formerly the NTA) set out the estimated number and prevalence rate of problematic drug use at local authority, regional and national levels. This needs assessment is using 2010/11 OCU estimates which is the latest available estimate from Glasgow University.

3.12 The Capture Recapture (CRC) process was used to provide the majority of local DAAT estimates. Essentially, this method estimates the "hidden" or "unknown" drug populations by assessing the overlap between known problematic drug users who appear in data sets (such as treatment data and criminal justice system data) and using this information to estimate the number who do not appear in any of the data sources. Once the hidden population is estimated, it is added to the total "known" population to provide an estimate of the whole population of problem drug users.

Service User questionnaire

3.13 This service user survey was supported by the borough's main T3 treatment providers who disseminated the questionnaires amongst their service users and collected the self-completion questionnaires and posted them using the Freepost addressed envelops provided. The questionnaire had 23 separate questions including 9 demographic sampling questions.

3.14 Essentially Section one of the survey sought to identify the substances being misused by the cohort, their length in their current treatment episode, how they were referred into treatment, and their service provider. Section two of the survey identified client perceptions of their substance misuse and their entry into treatment. Section three identified questions about the clients care plans. Section four of the survey asked questions about the client's perception of their treatment and their treatment provider. Section five asked questions about after care services and concluded with an open ended

questions offering the opportunity for the client to make comments about treatment provision in general.

Stakeholder Interviews

3.15 Interviews took place throughout November and December 2013 and there were people from different parts of the drugs and alcohol treatment services, partner agencies and concerned individuals who are keen to see effective and efficient interventions to address drugs and alcohol use and treatment in the borough.

3.16 To put these interviews in context it seemed that there was a range of different levels of understanding of people and stakeholders as to the issues that relate to drugs and alcohol and as to the different types of interventions and in particular treatment. Each clearly knew their area of expertise but as individuals and organisations coming to the Drugs and Alcohol treatment environment from differing positions and organisational priorities, they seem to want to have a greater sense of what collectively they were doing to address needs and to resolve the problems associated with drug and alcohol use.

3.17 Interviews ranged from between 30 and 40 minutes and several were made by phone although the majority were face to face, some were also met through provider monitoring meetings and group presentations and workshops.

• Andy Bamber	Head of Service for Safer Communities
• Rachael Sadegh	DAAT Coordinator
• Marc Edmunds	DAAT Commissioner
• Sarah Khalifeh	DAAT Administrator
• Noormuz Zaman	DAAT Engagement
• Cliff Askey	CDT
• Anna Hemmings	CDT
• Dayo Agunbiade	SAU
• Alex Verner	SAU
• Tarlok.Boyton-Singh	HRS
• Gabriella.Ndenecho	HRS
• Nuno Albuquerque	IDP
• Monica Geraghty	THCAT
• James Parker	RAPT
• Tohel Ahmed	NAFAS
• Harun Miah	NAFAS
• Paula McGranaghan	ISIS
• Gill Burns	Shared Care
• Anna Livingston	GP
• Richard Fragley	CCG Commissioner
• Chris Lovitt	Public Health LBTH
• Elizabeth Hamer	DIP
• Diane Monk	DIP
• Abdul Azad	DIP
• Andy Bamber	LBTH Service Head
• Somen Banerjee	Acting DPH
• Peter Buchman	GPwSI, Health E1
• Phil Greenwood	Dellow Centre
• George Gallagher	Young Peoples Service
• Mandie Wilkinson	Manager BBV Team

Focus Groups

3.18 In December 2013, four qualitative research focus groups took place amongst clients with experience of a range of Tower Hamlet drug and alcohol services, including ISIS, THCAT, CDT and NAFAS. The purpose of the research was to gain insights about individuals' knowledge and attitudes of services, and their resulting behaviour, in order to help to shape future commissioning decisions in the borough.

Focus Group Participants

3.19 There were a total of 36 residents of Tower Hamlets who participated in the four focus groups.

Focus group location	Total	Male	Female	BME
ISIS	10		10	4
THCAT	11	6	5	0
CDT	5	5		3
NAFAS	10	7	3	7
Total	36	18	18	

Focus Group Recruitment

3.20 The Tower Hamlets drug and alcohol services undertook the recruitment for the participants. They approached individuals known to the service and invited them to attend. This is a valid and common recruitment method for qualitative research given the sensitive subject and the defined purposes of the research to investigate experiences of drug and alcohol services in Tower Hamlets. It enables the exploration of individuals' knowledge, attitudes and behaviour. However, by 'hand-picking' participants whom services could readily contact and were willing to participant, not all people who take drugs and alcohol in Tower Hamlets had an equal chance of being selected. As a non-representative sample it is important to exercise caution about generalising the findings to the whole drug and alcohol using local population.

Focus Group Research scope

3.21 The research sought to explore those issues that affected participant's substance misuse behaviour, the motivators and barriers to seeking help, the experiences of treatment, recognised opportunities and challenges, expectations for the future and perceptions of wider societal attitudes. A discussion guide was prepared to help to guide the conversation. However, a discursive approach was adopted allowing participants to steer the conversation according to the issues relating to treatment that they felt were most important. As a result whilst the main topics were covered by all of the groups there was variation in the degree to which they were discussed.

4 Needs Assessment NDTMS Data Sets

4.1 Local authorities are encouraged to conduct an assessment of need each year which is aimed at assessing the degree of met and unmet need, as there are many reasons why need might be unmet.

4.2 According to the PHE Alcohol and Drugs Team, the needs assessment should identify the following:

- What works in open access and structured drug treatment services and what unmet needs are there across the system
- Where the system is failing to engage and retain people
- Hidden populations and their risk profiles
- Enablers and blocks to treatment pathways
- Relationships between treatment agencies and harm profiles

4.3 Ideally, the needs assessment should be used by the DAAT Board to:

- Inform the annual treatment plan
- Make evidence-based commissioning decisions
- Inform and develop the borough substance misuse strategy

4.4 By developing these areas, local authorities should develop a shared understanding of evidence-based need in relation to drug treatment services, to assist commissioning, treatment planning and the allocation of resources. The needs assessment is a systematic and strategic process designed to inform the Adult Treatment Plan (which sets out the partnership's strategy for service provision).

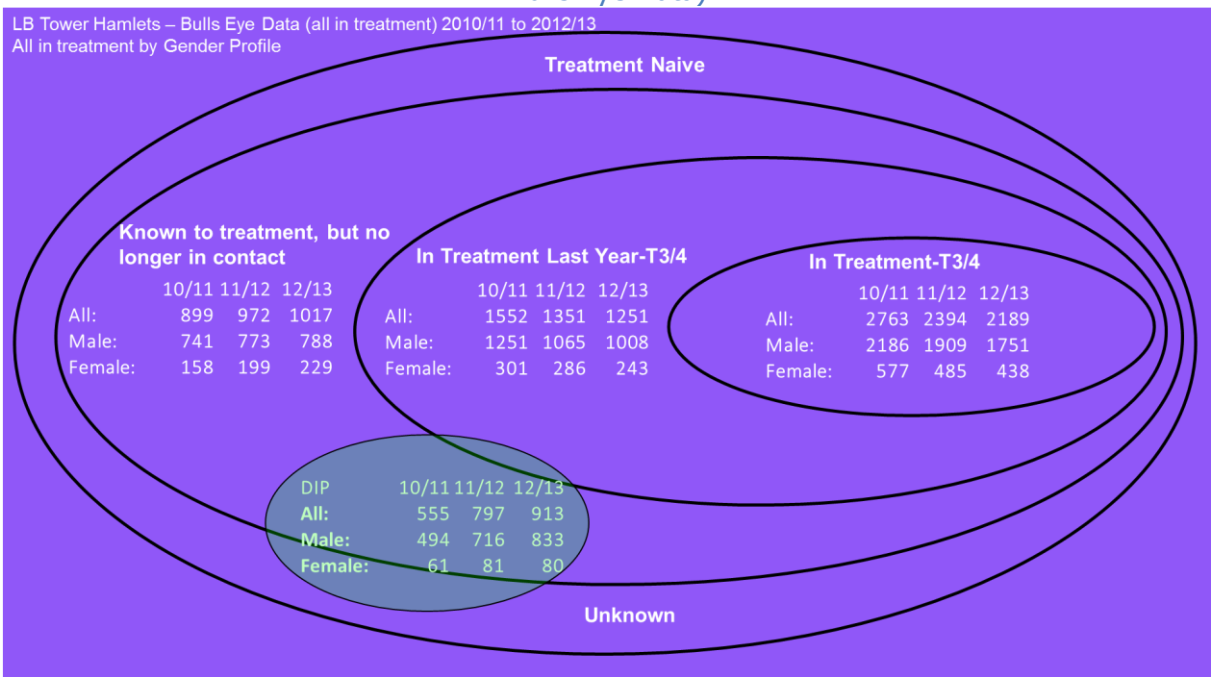
4.5 This substance misuse needs assessment has been developed in accordance with the NTA partnership guidance. In particular, information has been used which has come from the NDTMS data sets which highlights treatment engagement, trends and prevalence rates. This data has been used to develop and inform the treatment bull's-eye process and the treatment journey assessments – which are produced using a specified methodology to provide standardised assessments.

Treatment Bull's-eyes

4.6 The NDTMS provides data which can be used to estimate the size of local unmet need and is displayed as a treatment bull's-eye (similar to a Venn diagram). The bull's-eye has four circles, each of which represent drug treatment populations between 2009/10 and 2012/13.

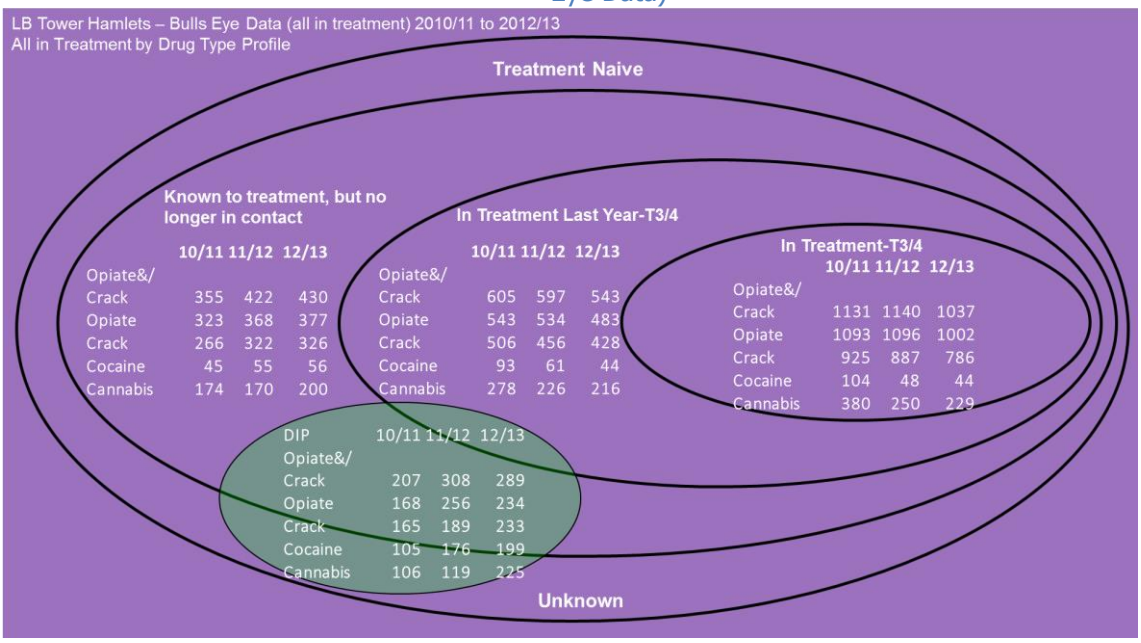
4.7 The data which generates the graphic represent the activities which treatment providers report as being delivered to clients resident in Tower Hamlets. This will largely highlight the work of the treatment providers in the borough. However, it will also include residents accessing services outside Tower Hamlets.

Chart 2: All in treatment clients by gender profile 2010/11 to 2012/13 (source: NDTMS Bulls Eye Data)



4.7.1 The chart above shows that over the past three years Tower Hamlets has seen a steady decline in the number of clients in treatment (all drugs episodes)– falling by 21% from 2,763 to 2,189 (between 2010/11 and 2012/13). Similarly, those counted in treatment last year essentially follows the same trend declining by 19% (301) over the same period (from 1,552 to 1,251). Correspondingly, there has been a 5% increase (118) in those users known to the treatment system but no longer in contact with it (from 899 in 2010/11 to 1017 in 2012/13). Also, drug using offenders in contact with DIP but not with the treatment system has increased dramatically (64%) over the same period (from 555 in 2010/11 to 913 in 2012/13). In summary, this shows a decline in those accessing treatment and an increase in those unknown to treatment in the borough over the last three years – which needs to be reversed to deliver the aims of the strategy.

Chart 3: All in Treatment by Drug Type Profile 2010/11 to 2012/13 (source: NDTMS Bulls Eye Data)



4.7.2 The chart above shows the main drugs reported by those presenting to services (and would typically represent the most problematic substances used by them). In 2012/13 there were a total of 2,189 clients in treatment (all drugs episodes) of which OCUs made up almost half (47%), however when adding together all opiate and all crack users this represents 81.5% of the borough's treatments system population.

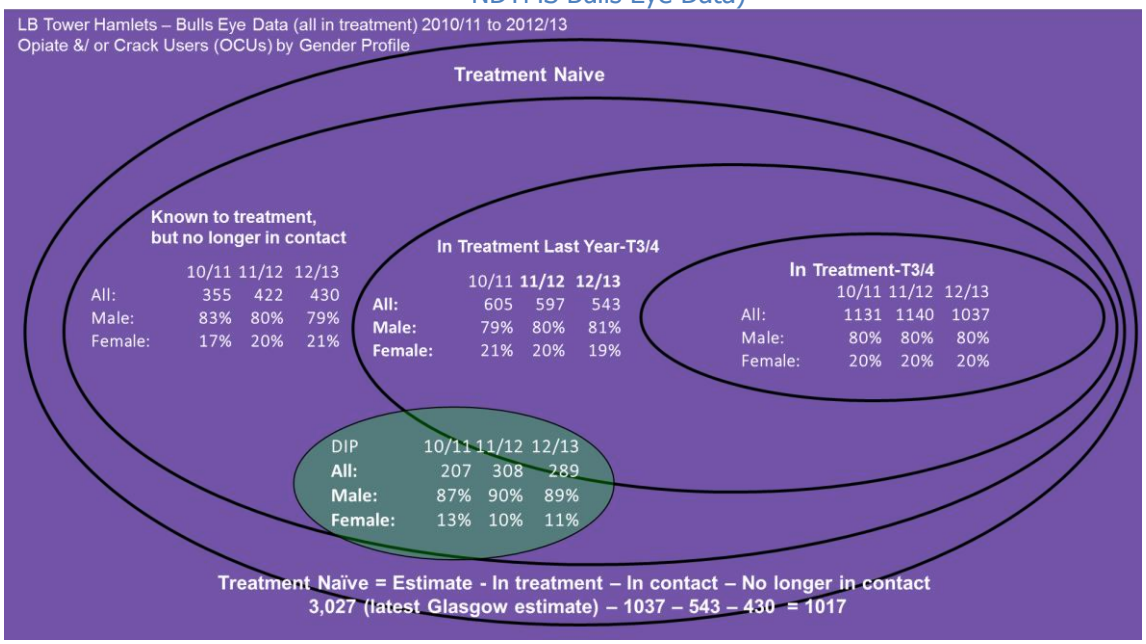
4.7.3 However, like the overall trend, there has been a steady decline (8%) in the numbers of OCUs in treatment in the borough over the past three years (falling from 1,131 in 2010/11 to 1,037 in 2012/13).

4.7.4 Those citing opiate drug use also fell (8%) by the same margin over this period (from 1093 in 2010/11 to 1002 in 2012/13). However, those accessing services and citing the use of crack dropped by a much faster rate (15%) from 925 in 2010/11 to 786 in 2012/13. Additionally, those reporting cocaine and cannabis use also fell significantly (by 58% and 40% respectively) over the three years. This pattern is further supported by data generated from the DIP which shows an increase in the number of clients known to DIP but are not known in the treatment system. OCUs known to DIP but not in treatment has increased from 207 in 2010/11 to 289 in 2012/13, this means there are 40% more clients known to DIP but not in treatment. Similarly in 2012/13 there are 39% more citing opiate drug use, and 41% more citing crack use known to DIP but not in treatment compared to 2010/11.

4.7.5 This suggests that although those with the most problematic substance misuse are still being targeted there would appear to be a disengagement from local services by potential service users. A key issue would appear to be the lack of treatment engagement by stimulant users evidenced by the large drops in the last three years of those accessing treatment and reporting crack and cocaine use as their primary drug use. This possibly highlights the lack of appropriate service provision for stimulant users, the data also suggests that this is particularly

evident with the reduced levels of engagement of DIP clients who are known to be using Crack Cocaine.

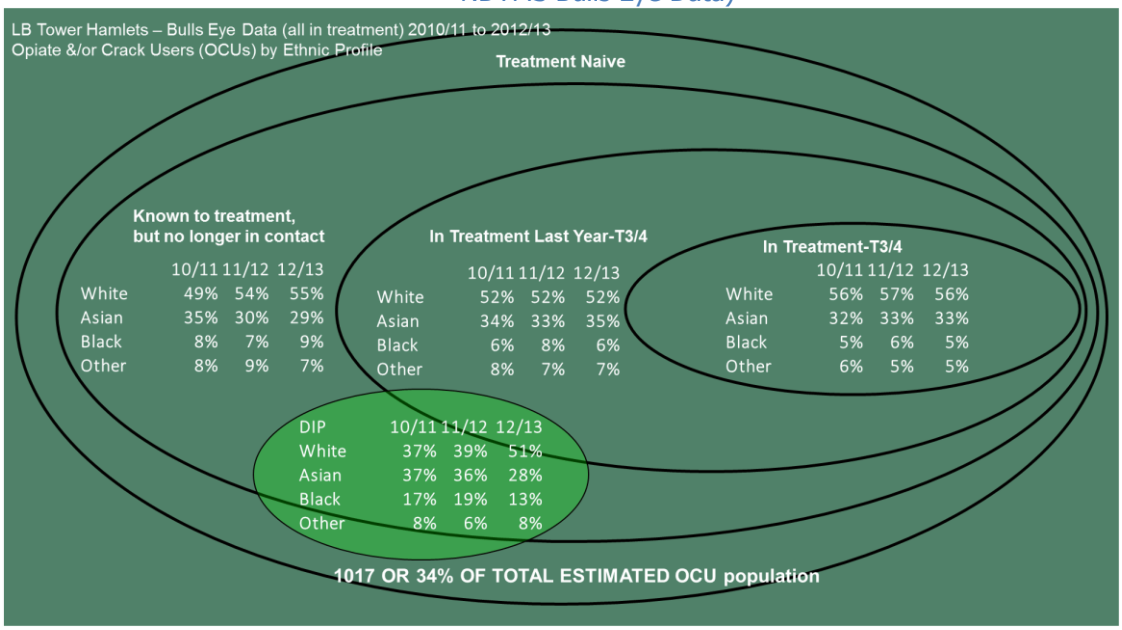
Chart 4: Opiate and/or Crack Users by Gender Profile 2009/10 to 2012/13 (source: NDTMS Bulls Eye Data)



4.7.6 In the past three years the male to female OCU ratio has remained consistently at 8:2 (20%). Female OCU representation in treatment is lower compared to London and national averages (at 26% and 28% respectively).

4.7.7 It is also possible to calculate the OCU treatment naïve population for 2012/13, in Tower Hamlets this was 1,017 (34%) from an estimated 3,027 OCUs. This suggests that the level of treatment naivety in the Borough's population has increased, compared 31% in 2010/11. However the calculation is based on 2010/11 estimates and as such may not reflect reducing level of OCUs nationally and regionally. Treatment naivety will be reviewed in detail below.

Chart 5: Opiate and/or Crack Users by Ethnic Profile 2009/10 to 2012/13 (source: NDTMS Bulls Eye Data)

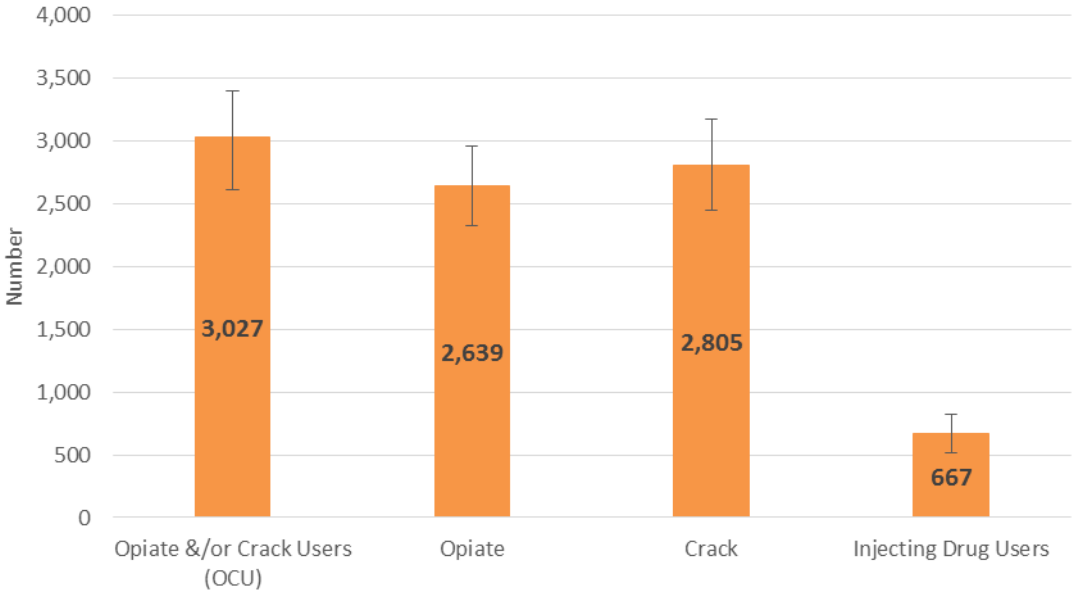


4.8 The chart above shows that in 2012/13 the majority (56%) of clients in treatment described themselves as White. Of the remainder, a third were Asian, and 5% were Black with a similar proportion stating 'Other'. This ethnic profile has remained broadly consistent over the past three years.

4.9 These findings suggest that whilst strong effort have been made to ensure a fully representative ethnic profile in treatment, the 56% of white in the treatment system is still larger than the 45% in the total population (2011 census). This would suggest that there needs to be more work focused on identifying and attracting BME groups into the local treatment system to ensure all needs are catered for. Indeed if the system had a stronger focus on non-opiate substance misuse these ethnic profiles are likely to better reflect the whole community.

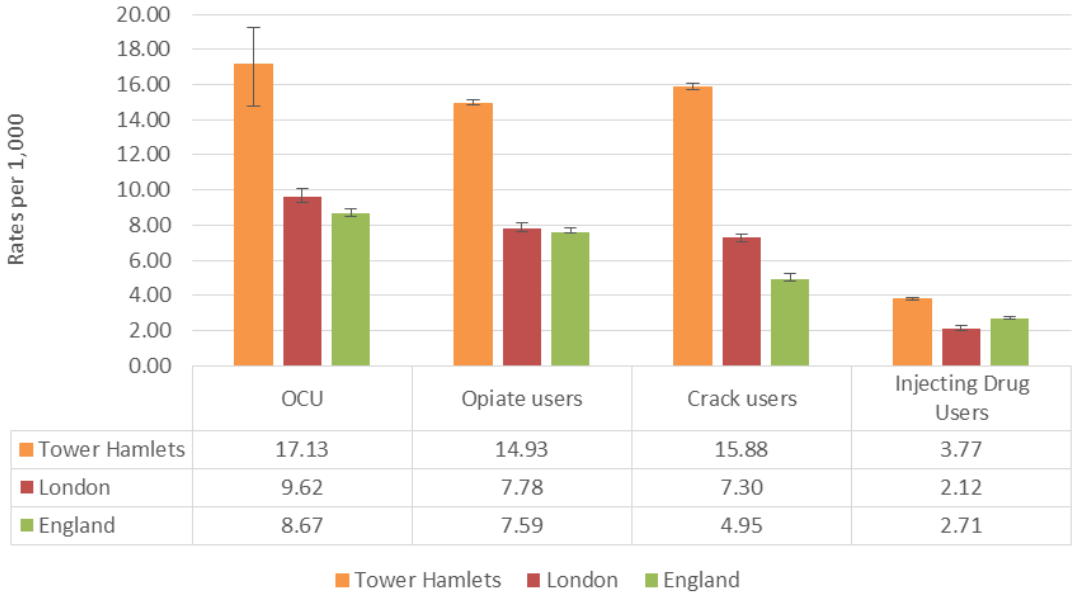
4.10 The chart below sets out the 2010/11 estimated number of problematic drug users in Tower Hamlets (n.b. these are the most recent estimates available and they include 95% lower and upper confidence intervals). There are an estimated 3,027 OCUs, 2,639 opiate drug users, 2,805 crack users and 667 Injecting Drug Users (IDU). Compared to 2009/10 estimates the most recent estimates suggests there has been a increase for all group with an increase in the OCU estimates by 13%, but this increase is proportionately higher in crack users (23%) than opiate users (9%), as well as an 11% increase in IDUs.

Chart 6: Estimated Number of OCUs, Opiate, Crack and Injecting Drug Users 2010/11 (source: NDTMS Prevalence Data)



4.10.1 The chart below shows the estimated prevalence rates per 1,000 populations[1], Tower Hamlets has an OCU prevalence rate of 17 per 1,000 (aged 18 - 64 years), 15 for opiate drug users, 16 for crack users and 4 for IDUs. On all counts, Tower Hamlets had significantly higher rates compared to London and England (for OCUs the prevalence rate was around two-fifths higher and for opiate and crack more than twice and three times the London and national averages).

Chart 7: Estimated Prevalence (rates per 1,000 residents) OCUs, Opiate, Crack and Injecting Drug Users 2010/11 (source: NDTMS Prevalence Data)



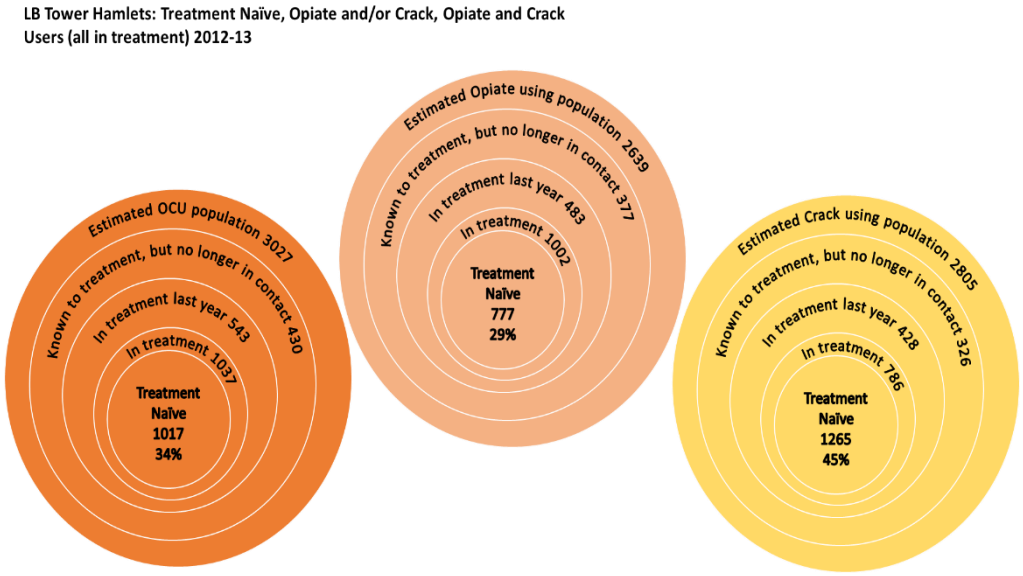
	OCU	Opiate users	Crack users	Injecting Drug Users
Tower Hamlets	17.13	14.93	15.88	3.77
London	9.62	7.78	7.30	2.12
England	8.67	7.59	4.95	2.71

4.11 The chart below illustrates the number and proportion of the treatment naïve population in Tower Hamlets. This equates to 1,017 OCUs, 777 opiate users and 1,265

[1] Population count: Tower Hamlets 147,700 – London 5,472,700 – England 34,467,000, Glasgow Prevalence Estimation 2010/11

crack users. As a proportion this shows 34% OCUs, 29% opiates and 45% crack users are not engaged with treatment services. Tower Hamlets has a similar proportion of treatment naïve OCUs compared to national estimates (36%) but is significantly lower than the regional estimate (41%). This is very positive as this means a higher percentage of the most problematic drug users are accessing treatment services in Tower Hamlets. Therefore Tower Hamlets is effective in attracting and engaging opiate and crack drug users into its treatment system. Essentially 7% more OCUs and 7% opiate and 5% more crack users are in treatment compared to London average.

Chart 8: Treatment Naïve 2012/13 (source: NDTMS Prevalence Data)



4.11.1 The table below shows the penetration rates of OCUs against the drug using population estimates, compared with London and national rates. In 2012/13 Tower Hamlets showed a penetration rate of 34% against the estimated number of OCUs. In London the penetration rate is lower at 31% and higher nationally at 41%. The penetration rate for opiate users was 38% and crack users 28%.

Table 2: OCU Penetration Rates, 2009/10 to 2012/13, with London and National Comparisons (source: NDTMS Bulls Eye/Prevalence Data)

Partnership	Tower Hamlets	London	National
2010/11 Estimated OCU Population (University of Glasgow)	3,027	52,623	298,752
2009/10 Estimated OCU Population (University of Glasgow)	2,683	51,445	306,150
2010/11 OCU Population compared to 2009/10	344	1,178	-7,398
Numbers of Opiate &/or Crack Users in treatment 2010/11	1131	17,948	128,982
OCU Penetration Rate 2010/11	37%	34%	43%
Numbers of Opiate &/or Crack Users in treatment 2011/12	1,140	16,789	122,712
OCU Penetration Rate 2011/12	37.7%	32%	41%
Number of Opiate &/or Crack Users in treatment 2012/13	1,037	16,276	119,763
OCU Penetration Rate 2012/13	34.3%	31%	40%
2012/13 Penetration rate variation from 2011/12	-3%	-1%	-1%
2012/13 Penetration rate variation from 2011/12	-4%	-1%	-1%

Treatment Journey Mapping Data

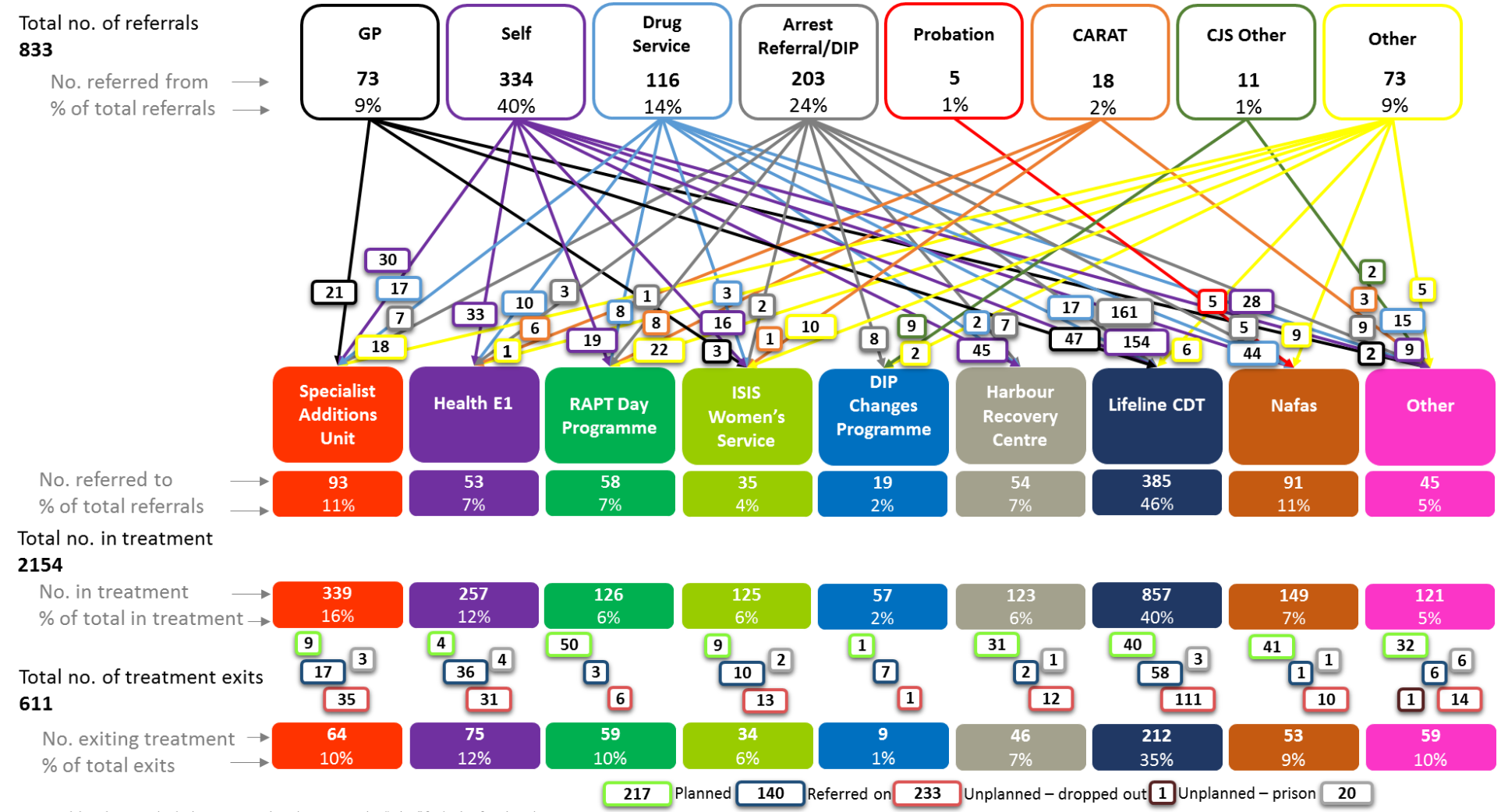
4.12 The two charts below show the extent of client treatment journeys, focusing on the main sources of referral, and those in treatment, transferring between agencies and exiting the system. In brief, the maps refer to those clients who have entered treatment, moved through and left the treatment system, in planned or unplanned way (agency transfers are shown separately).

4.13 In 2012/13 there were 833 referrals into treatment, 2,514 clients in treatment, 300 inter agency transfers and 611 treatment system exits[2]. Each of these element of the treatment journey are reviewed in detail below.

[2] This count of "in treatment" clients differs to that in the bull's-eye data, as a client could have attended more than one provider during 2012/13 period and are therefore counted for each treatment episode.

Chart 9: Treatment Journey Map 2012/13 (source: NDTMS Treatment Map Summary Data)

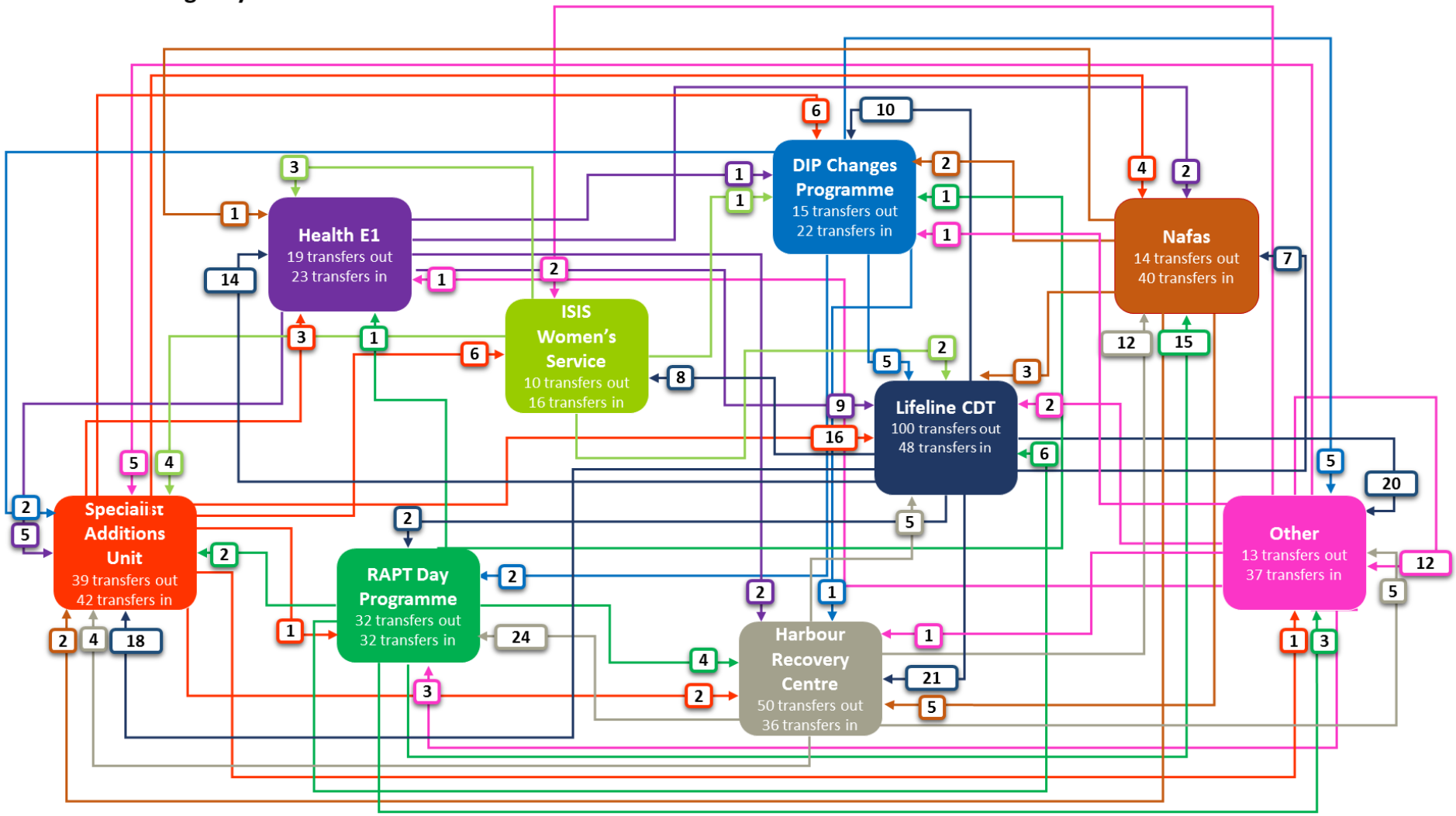
LB Tower Hamlets: Referrals routes into and exits from treatment 2012-13



Agencies with less than 19 individuals in treatment have been grouped in "other" for both referrals and treatment exits

Chart 10: Treatment Journey Map 2012/13 *(source: NDTMS Treatment Map Summary Data)*

LB Tower Hamlets: Agency transfers 2012-13



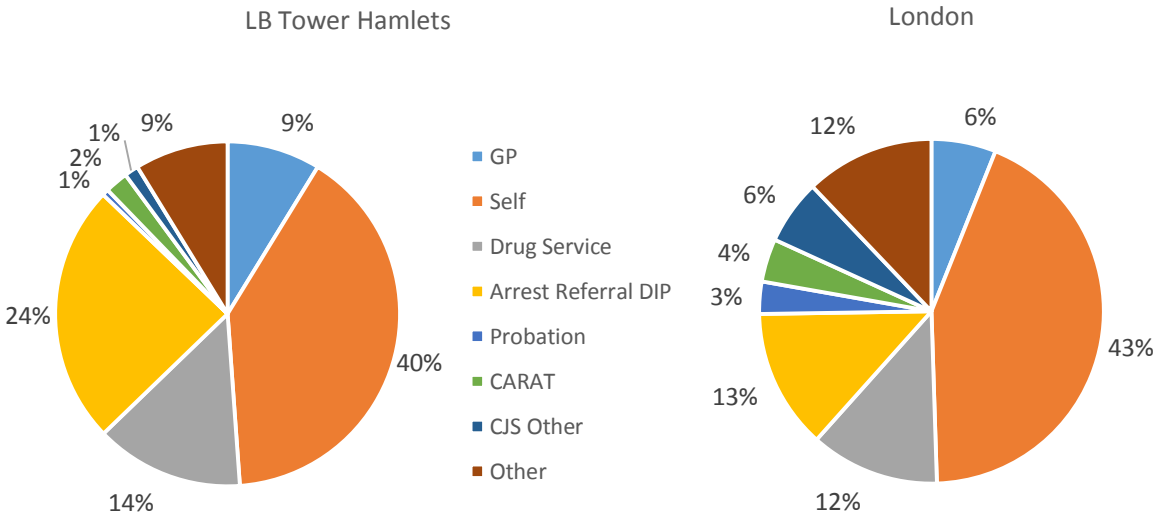
Referrals to treatment in 2012/13

4.14 In Tower Hamlets 833 clients were referred into treatment, of which a third (32%) were entering treatment for the first time. This was 11% lower than the London average of 43% and lower compared to the national average where 40% were entering treatment for the first time. The volume of referrals was similar to 2011/12, where 849 were referred to treatment.

4.15 The chart below shows the referrals into drug treatment by referral source for Tower Hamlets and London averages. The majority of referrals come from self-referrals to treatment, 334 (40%) slightly lower than the London average of 42% and consistent with the national average of 40%. Self-referrals are critical to treatment completions and positive outcomes, whilst there may be some people in the community that are treatment naïve the self-referral route suggests that those that do come to treatment this way do so because they want to and hence should be more responsive to treatment.

4.16 Referrals from the criminal justice system shows a combined 237 (28%) referrals, with 203 (24%) referrals from DIP, almost twice as much compared to London (13%) and almost 3 times as much compared to national average (9%), this is a positive reflection of the DIP in the borough. Referrals from GPs account for 9% of all referrals, one third more than London and national average. Referrals from "drug services" are referrals from out of borough services and are broadly consistent with London and national averages.

Chart 11: Referrals into Drug Treatment by Referral Source 2012/13 *(source: NDTMS Treatment Map Summary Data)*



4.17 Table 3 shows the distribution of the 833 referrals between the main drug treatment providers in Tower Hamlets. This shows the majority of almost half (46%) of the referrals are received by the Lifeline CDT. This is followed by the SAU and NAFAS, with 11% for both. The number and proportion of referrals remains consistent to 2011/12 referrals for the main drug treatment providers.

Chart 12: Clients Referrals to Main Drug Treatment Providers in 2012/13 *(source: NDTMS Treatment Map Summary Data)*

	Total Referrals	
Treatment Provider (2012/13)	n	%
Lifeline CDT	385	46%
Specialist Addictions Unit	93	11%
NAFAS	91	11%
Health E1	53	7%
Harbour Recovery Centre	54	7%
RAPT Day Programme	58	7%
ISIS Women's Service	35	4%
Changes Programme	19	2%
Total	833	
London	14482	
National	72525	

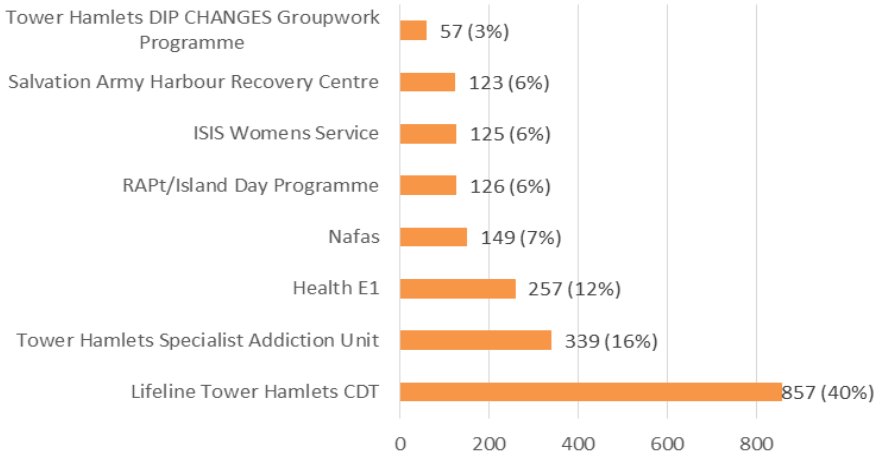
4.17.1.1.1.1.1.1

In treatment

4.18 In 2012/13 there were 2,154 clients resident in Tower Hamlets receiving treatment across 45 treatment agencies. If a client attended more than one treatment provider in 2012/13 they would be counted in each and therefore the "in treatment" total in this section of the needs assessment data will differ from that contained in the bull's-eye data which counts individuals only once in treatment irrespective of the number of treatment providers they attended. However this is not the case for Tower Hamlets and hence there is an anomaly in this data.

4.19 The chart below shows the numbers in treatment across the main treatment providers. This is broken down for the main treatment providers by numbers and as a percentage of the total 2,154 in treatment. This shows an overwhelming 40% of those in treatment are in Lifeline CDT, followed by 16% with the SAU.

Chart 13: Numbers in Treatment by Main Treatment Providers 2012/13 *(source: NDTMS Treatment Map Summary Data)*



Time in treatment

4.20 There are 562 clients that have been in treatment for 2 or more years, this amount to just over one in four. Of this number 289 clients in treatment between 2 and 4 years and 273 clients in treatment for more than 4 years.

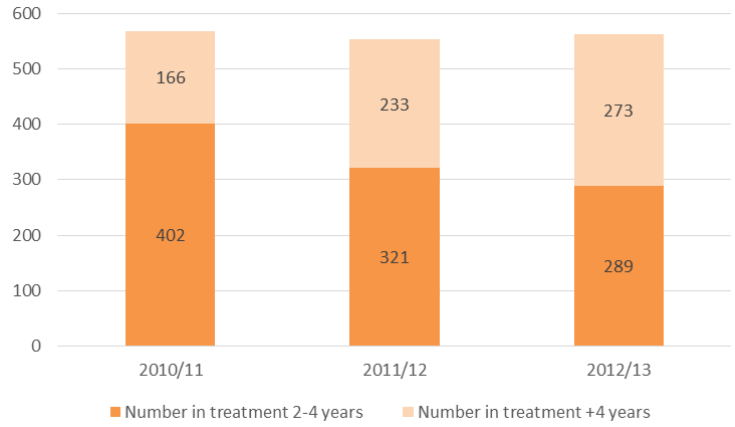
4.21 The table below shows the proportion of clients in treatment between 2 and 4 years has in the past 3 years reduced in Tower Hamlets from 16% in 2010/11 to 13% in 2012/13, across London this has increased from 11% in 2010/11 to 12% in 2012/13. Over the same period Tower Hamlets has seen a steady increase in the proportion of individuals in treatment for more than 4 years, from 7% in 2010/11 to 10% in 2011/12 and 13% in 2012/13, in London however this has remained constant at 9% whilst nationally this has increased from 15% in 2010/11 to 20% in 2012/13. Overall Tower Hamlets has seen the proportion of individuals in long term treatment increase at a greater rate. It is noteworthy to highlight the changeover of the main opiate service provider in 2008 from Addaction to Tower Hamlet CDT led to clients being recorded as new to treatment rather than having their treatment continued with another provider consequently the length of time in treatment is highly underestimated.

Table 3: Proportion in Treatment between 2-4 years and +4 years, 2010/11 to 2012/13
(source: NDTMS Treatment Map Summary Data)

	Total number in treatment	Number in treatment 2-4 years	% in treatment 2-4 years			Number in treatment +4 years	% in treatment +4 years		
			Tower Hamlets	London	National		Tower Hamlets	London	National
2010/11	2439	402	16%	11%	16%	166	7%	9%	15%
2011/12	2401	321	13%	10%	16%	233	10%	9%	17%
2012/13	2154	289	13%	12%	15%	273	13%	9%	20%

4.22 This suggests over this 3 year period a number of individuals in treatment between 2 and 4 years have continued to remain in treatment and now form part of the cohort in treatment for more than 4 years. More encouragingly however, the shrinking nature of those in treatment between 2 and 4 years suggest there is not the same volume of individuals who are crossing over the under 2 years in treatment threshold to between 2 and 4 year. The chart below shows the change in the number of clients in treatment over the past 3 years.

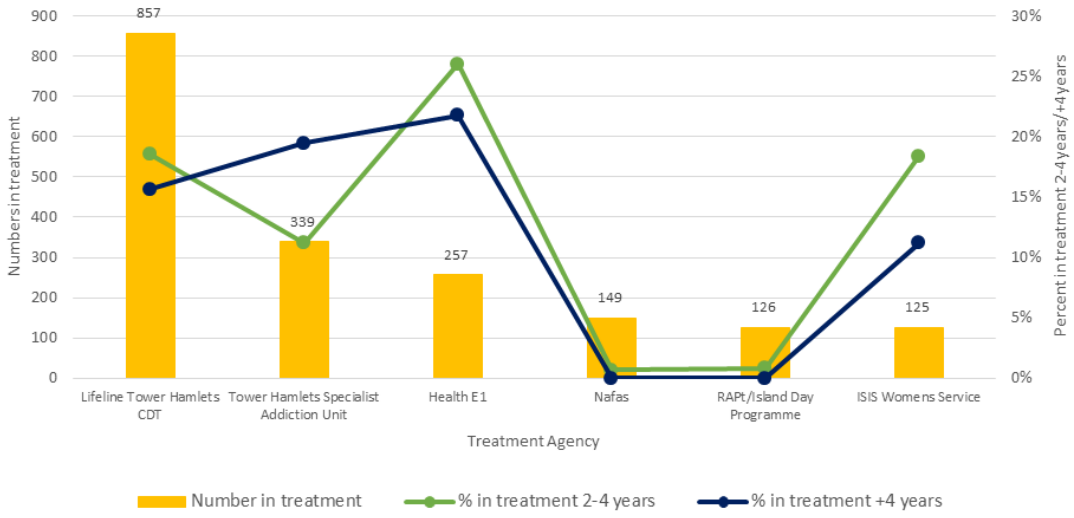
Chart 14: Clients in Treatment between 2-4 years and over 4 years 2010/11 to 2012/13
(source: NDTMS Treatment Map Summary Data)



4.23 Those in treatment between 2 and 4 years are in treatment with 6 agencies. Over half (159) of these clients are in treatment with Lifeline CDT, followed by almost one quarter (67) with Health E1 and 13% (38) with the SAU. Those in treatment for +4 years are in the main in treatment with 4 agencies in Tower Hamlets, and a further 3 out of borough agencies (however this amounts to 3 clients). Forty-nine percent (134) are in treatment with Lifeline CDT, followed by 24% (66) with SAU and 21% (56) with Health E1.

4.24 The chart below shows the agencies and the proportion of clients that have been in treatment between 2 and 4 years and more than 4 years as a proportion of their total numbers in treatment. Clients in treatment with Health E1 have the highest proportion of individuals in treatment between 2 and 4 years and more than 4 years (26% and 22% respectively). However this is to be expected given the nature of the complex needs of the clients that present to Health E1.

Chart 15: Time in Treatment 2-4 years and over 4 years as Proportion of Numbers in Treatment by Treatment Provider 2012/13 *(source: NDTMS Treatment Map Summary Data)*



In Treatment Transfers

4.25 In 2012/13, 300 clients were transferred between treatment providers. This means 14% of all clients in treatment were transferred between treatment providers within the Tower Hamlets system. The second treatment map above maps the flow of clients transferred in and out of treatment providers. The majority of referrals to other treatment providers were made from Lifeline CDT, 33%, followed by Harbour Recovery Centre, 17% and SAU, 13%. The majority of referrals were received by Lifeline CDT, 165, followed by SAU, 14% and NAFAS 13%.

Exits and completions

4.26 In 2012/13 there were 611 clients who left the drug treatment system. The table below sets out the treatment exit outcomes for these clients, by treatment provider and compares this to London and national averages. This shows there are more clients dropping out of treatment than those leaving in a planned way. There were 365 or 36% of all clients leaving treatment in 2012/13 left in a planned way, having successfully completed treatment drug free or as an occasional user (not included opiate or crack cocaine). This is 10% lower than the London average and 11% lower than the national average (46% and 47% respectively). Over one in three (38%) clients "dropped out" of treatment, this is 9% higher than the London average of 29% and 15% higher than the national average of 23%.

Table 4: Treatment Exit Outcomes *(source: NDTMS Treatment Map Summary Data)*

Provider (2012/13)	Planned		Referred on		Dropped out		Unplanned - prison		Unplanned - other		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Lifeline CDT	40	18%	58	41%	111	48%	0	0%	3	15%	**212**	**35%**
Specialist Addictions Unit	9	4%	17	12%	35	15%	0	0%	3	15%	**64**	**10%**
NAFAS	41	19%	1	1%	10	4%	0	0%	1	5%	**53**	**9%**
Health E1	4	2%	36	26%	31	13%	0	0%	4	20%	**75**	**12%**
Harbour Recovery Centre	31	14%	2	1%	12	5%	0	0%	1	5%	**46**	**8%**
RAPT Day Programme	50	23%	3	2%	6	3%	0	0%	0	0%	**59**	**10%**
ISIS Women's Service	9	4%	10	7%	13	6%	0	0%	2	10%	**34**	**6%**
DIP Changes Programme	1	0%	7	5%	1	0%	0	0%	0	0%	**9**	**1%**
Tower Hamlets Total	**217**	**36%**	**140**	**23%**	**233**	**38%**	**1**	**0%**	**20**	**3%**	**611**	**100%**
London	**5761**	**46%**	**2564**	**21%**	**3561**	**29%**	**128**	**1%**	**453**	**4%**	**12467**	**100%**
National	**30499**	**47%**	**15070**	**23%**	**14980**	**23%**	**833**	**1%**	**3009**	**5%**	**64391**	**100%**

4.27 The proportion of planned and unplanned treatment exit outcomes at a provider level shows a great level of variation. Where the RAPT Day Programme achieved 23% planned treatment exits and 3% unplanned "dropped out" treatment exits, Lifeline CDT achieved 18% planned treatment exits and 48% unplanned "dropped out" treatment exits. These treatment outcomes do reflect the complexities that clients present at individual treatment

providers and also reflects the point in the treatment journey that the provider works with these clients.

4.28 Summary of key findings from NDTMS Needs Assessment Data

- In the past three years Tower Hamlets has seen a downward trend in the number of clients in treatment, from 2,763 in 2010/11 to 2,394 in 2011/12 and more recently 2,189 in 2012/13.
- The number of OCUs in treatment have remained broadly consistent at 1,131 in 2010/11 and 1,140 in 2011/12, however in 2012/13 this has fallen to 1,037, 8% less compared to 2011/12.
- In 2012/13 there were 913 drug users known to DIP but not in contact with the treatment system. Thirty-two percent (289) OCUs, 26% (234) citing opiates and 26% (233) citing crack as main drug of choice.
- In the past three years the male to female OCU ratio has remained consistently at 8:2. Female OCU representation in treatment is lower in the borough compared to London 26% and national average, 28%.
- In 2012/13 just over half (56%) of clients in treatment identify themselves as White, one third identify themselves as Asian and 5% identify themselves as Black. The ethnic diversity of the treatment population is higher than London and national averages and is broadly reflective of the borough.

- Tower Hamlets has a prevalence rate of 17 per 1,000 aged between 18 and 64 OCUs, 15 for opiate drug users, 16 for crack users and 4 for IDUs. This is almost twice as much compared to London and national rate. Opiate drug use is twice as prevalent compared to London and national averages, whilst crack drug use rates are more than three times the national average.
- There are estimated to be 3,027 OCUs, 2,639 opiate drug users, 2,805 crack users and 667 IDUs. Tower Hamlets has a penetration rate of 34% against the estimated number of OCUs, as the number of OCUs in treatment have declined so has the penetration rate over the past three years. In London the penetration rate is lower at 31% and higher nationally at 41%.
- The penetration rate for opiate drug users is 38% and for crack drug users 28%.
- By deducting those OCUs in treatment or known to treatment over past two years from the estimated number of OCUs the treatment naïve population is calculated, this shows in 2012/13 there are 1,027 (34%), 777 (29%) opiate users and 1,265 (45%) crack users.
- Tower Hamlets has a lower than London and national treatment naïve population for all problematic drug users and this means Tower Hamlets is more effective at attracting and engaging OCUs, opiate and crack drug users into its treatment system, compared to London and national averages.
- NDTMS Treatment Map Data:
- 833 clients were referred into treatment, of which 268 (32%) were entering treatment for the first time, lower than the London and national average of 43% and 40% respectively. The majority of referrals are generated from self-referrals to treatment, 334 (40%) slightly lower than the London average of 42% and national average of 40%. Almost one quarter of

referrals are referred to treatment from DIP, twice as much DIP referrals compared to London and almost 3 times as much compared to national average.

- 2,154 clients resident in Tower Hamlets receiving treatment across 45 treatment agencies. The majority 40% of those in treatment are in Lifeline CDT.
- 562 clients that have been in treatment for 2 or more years, this amounts to just over one in four. Of this 289 clients in treatment between 2 and 4 years and 273 clients in treatment for more than 4 years. In the past three years Tower Hamlets has seen an increasing proportion of individuals that have remained in treatment for more than 6 years, from one in thirteen (7.7%) in 2010/11 to one in eleven (9.4%) in 2012/13.
- There were 300 clients transferred between treatment providers. This means 14% of all clients in treatment were transferred between treatment providers within the Tower Hamlets treatment system.
- 611 clients who left the drug treatment system. More clients dropped out of treatment than those leaving in a planned way. 217 (36%) of all clients leavening treatment in 2012/13 left in a planned way, having successfully completed treatment however 233 (38%) left in an unplanned way (dropped out).

5 Criminal Justice (DIP)

5.1 Unlike many Drugs Intervention programmes the DIP in Tower Hamlets is run in house and is firmly part of the borough's commitment to safer communities. Since its initiation the DIP in Tower Hamlets has grown into a comprehensive DIP function. Introduced in 2003, the DIP has been central to the Government's aims to reduce crime and re-offending. By placing drug workers at all stages of the Criminal Justice System (CJS), the Programme was able to identify, assess and refer drug using offenders (DUOs) into appropriate treatments and support services. This offered a planned and multi-agency supported route away from drug related crime and into treatment and sustainable recovery.

5.2 DIP was funded in its entirety by the Home Office until 2011 at which time, 66% of the funding was provided by the Department of Health (DoH) and the remaining 33% still provided by the HO. The DIP Main Grant had always been "ring-fenced" and remained so during 2012, when the HO devolved the responsibility for the funding streams of a number of crime reduction initiatives to MOPAC. Although still "ring-fenced" and a separate funding stream, this resulted in an 11% loss of funding for LBTH DIP in 2012/13.

5.3 In March 2013, MOPAC created the London Crime Prevention Fund (LCPF) which brought together the disparate funding streams into "one single-pot and the DIP remit was extended to cover all DUOs. Local Authorities were invited to "bid" for initiatives that would respond to local priorities to reduce crime. DIP applied for £613,000 that was awarded in entirety. This, combined with £860,000 received from the DoH, and £39,000 from the DAAT for the DRR Assessor, gives an overall budget of £1,512,000.

5.4 Current service priorities include:

- Work with partner agencies to progress the development and implementation of IOM
- Widen remit to include all substance misuse offenders including specific alcohol interventions e.g. Alcohol Treatment Requirement (ATR) assessments.
- Develop the service to offer interventions at the earliest point of identification within the CJS.
- Expansion of the Prison Link Service
- Deliver a coherent and uniformed response to the issue of prostitution
- Strengthen the effectiveness of the Outreach Team through the introduction of dedicated Enforcement Officers
- Introduce the changed service to all stakeholders and re-name the Identify, Assess and Refer Programme (IARP)

5.5 In addition, particular emphasis will be placed on: identifying individuals at the beginning of their drug related criminal careers; the ability to affect behaviour change for those unwilling to participate in treatment; sex workers (to contribute the Violence Against Women and Girls (VAWG) and Domestic Violence (DV) agendas) and the development and implementation of a co-located IOM Team.

5.6 The table below shows the profile of clients known to DIP but not in contact with the treatment system in Tower Hamlets set against drug type and broken down by gender,

ethnicity and age. This data is highly pertinent to the needs assessment in providing a better understanding of possible or potential treatment demand.

Table 5: Clients in Contact with DIP but not with the Treatment System 2012/13 *(source: NDTMS Bull's-eye Needs Assessment Data)*

	Opiate &/or Crack Users	Opiate Users	Crack Users	Cocaine Users	Amphetamine Users	Cannabis Users	Benzodiazepine Users	Other Drug Users
Gender								
Male	258	205	206	183	6	220	10	3
Female	31	29	27	16	0	5	3	0
Ethnic group								
White	142	119	117	91	4	71	9	2
Asian or Asian British	77	67	58	48	0	66	2	0
Black or Black British	35	20	31	32	1	39	1	0
Other	22	19	18	19	0	34	1	1
Age on 30th September 2011								
18-24 years	29	20	24	51	2	96	1	0
25-34 years	137	111	115	91	3	86	5	2
35-64 years	123	103	94	57	1	43	7	1
Total	**289**	**234**	**233**	**199**	**6**	**225**	**13**	**3**

5.7 In 2012/13 there were 913 DIP episodes of clients that had no contact with treatment services; this is an increase of 39% compared to 2010/11 where 555 DIP clients had not contact with treatment. Of these:

- The majority were male (89%)
- A third (31%) reported using opiate and crack
- A quarter (26%) reported using opiates
- A quarter (26%) reported using crack
- A quarter (25%) reported using cannabis.
- Just under half (45%) were White (with 26% Asian and 14% Black)
- Just under half (45%) were aged between 25 and 34 years
- Just under two-fifths (39%) entered treatment.

5.8 Clients in custody can be tested for drug use, this can happen in one of two ways, either where a client has committed a 'trigger' offence (an offence closely associated with the use of drugs) or on the Inspector's Authority (this can include a client that is already known to use drugs but may not have been arrested for a trigger offence). Tower Hamlet's has achieved the highest rate of positive drug tests carried out under the Inspector's Authority in six month reporting period between June 2013 and November 2013, of 94 drug tests using Inspectors Authority 53 tested positive given a positive test rate of 56%.

5.9 The Tower Hamlet's DIP has consistently achieved good positive test conversion rates in both instances, The November 2013 the Drug Testing Report set out in the two charts below shows Tower Hamlet's has achieved good positive test conversion rates for both trigger offences and Inspectors Authority. This performance is encouraging and evident of

good working relationships between the DIP custody team and the police, particularly with the introduction of targeted tested.

Table 6: DIP Monthly Report (Drug Testing - Trigger Offences) November 2013 (source: Met Police, DIP Intelligence & Information Management)

TRIGGER OFFENCES	Pre TT Monthly Average 2011/12	Monthly Average 2012/13	Nov	Oct	Sept
Number of successful tests	221	146	142	151	111
Number not tested (TT)	/	\	55	41	37
Number of refused tests	/	\	2	2	2
Number of aborted tests	/	\	0	0	0
Total number of positive tests	71	54	66	74	39
% tested positive	**32%**	**37%**	**46%**	**49%**	**35%**

Table 7: DIP Monthly Report (Drug Testing – Inspector Authority) November 2013 (source: Met Police, DIP Intelligence & Information Management)

INSPECTOR'S AUTHORITY	Nov	Oct	Sept
Total number of tests for non-trigger	16	18	15
Number of refused tests	0	0	0
Number of aborted tests	0	0	0
Total number of positive tests	9	13	6
% tested positive	**56%**	**72%**	**40%**

5.10 The table below sets out the quarterly treatment uptake of DIP referrals in 2012/13, this shows the uptake of treatment is good and on average 64% of new DIP referrals start treatment within 6 weeks. This is 9% more than the London average and similar to the national. In terms of performance this places Tower Hamlet's DIP in the 3rd quartile range (note: the DIP referrals in quarter 3 and 4 were low due to data reporting issues between local and national databases, local data suggest there were 106 DIP referrals in quarter 3 and 109 in quarter 4, 2012/13. This has since been resolved and referrals are being reporting at higher rate). Essentially the DIP in the borough is a referral body; it does not provide treatment. However in passing their clients onto treatment providers the DIP works to support the client in treatment for a minimum of 12 weeks, in some cases for longer depending on the client's needs. Nonetheless they can only influence treatment outcomes rather than manage them.

Table 8: Treatment Uptake of DIP referrals 2012/13 (source: NDTMS DIP Quarterly Summary Report Data – Quarters 1 to 4, 2012/13)

2012/13	Total DIP Referrals	New DIP Referrals	New DIP Referrals Starting Treatment			
			Tower Hamlets		London	National
Quarter	*n*	*n*	*n*	*%*	*%*	*%*
1	116	95	62	62%	57%	61%
2	104	86	55	64%	54%	63%
3	48	42	23	55%	54%	63%
4	38	32	22	69%	56%	64%
Total	**306**	**255**	**162**	64%	55%	63%

5.11 The table below shows the treatment activity of those clients referred in 2012/13, compared to the London and national average performance. This shows just under one quarter of opiate clients in treatment are referred by DIP (a higher proportion compared to London average of 17% and national average of 16%) while only 8% of the non-opiate treatment population are referred by DIP, lower compared to London and national average (17% and 16% respectively). Overall in Tower Hamlets one in five clients in treatment has been referred by the DIP.

5.12 Analysis of the outcomes for opiate clients, non-opiate and all clients in 2012/13, as a proportion of the total number of DIP clients in treatment showed 5% of DIP clients left treatment successfully, 3% below London and 2% below national average. A higher proportion of 38% non-opiate DIP clients left successfully, 2% above London average but 8% below the national average of 46%. Whilst the numbers are low, the combined opiate and non-opiate successful completions show the DIP performs at a rate that is 50% below London and national averages.

5.13 Further analysis of the number of completions shows significant levels of re-presentations for opiate DIP clients in Tower Hamlets, 59%. This is twice the amount compared to London average (30%) and higher still compared to national average (24%). Similar re-presentation levels are seen for non-opiate DIP clients, 17% in Tower Hamlets compared to 7% London average and 6% national average. The overall impact this has on all DIP client leaving treatment is almost half have re-presented within 6 months of successfully leaving treatment.

Table 9: Treatment Activity of Clients Referred by DIP (rolling 12 month period) 2012/13
(source: NDTMS DIP Quarterly Summary Report Data)

			Tower Hamlets	London	National
Number of DIP clients in treatment and proportion of treatment population	Opiate users	n	334	324	24,356
		%	23%	17%	16%
	Non opiate users	n	16	1271	5,732
		%	8%	14%	15%
	All	n	350	5006	30,088
		%	21%	16%	16%
Successful completions given as a number and as a proportion of total DIP clients in treatment (i.e. as reported above)	Opiate users	n	18	303	1,688
		%	5%	8%	7%
	Non opiate users	n	6	458	2,649
		%	38%	36%	46%
	All	n	24	761	4,337
		%	7%	15%	14%
Number of successful completions in first 6 months of 12 month rolling period and proportion of these who re-present to treatment within 6 months	Opiate users	n	17	192	1,076
		%	59%	30%	24%
	Non opiate users	n	6	200	1,339
		%	17%	7%	6%
	All	n	23	392	2,415
		%	48%	18%	14%

5.14 The Partnership/Police Force Area DIP Report for 2012/13 shows an additional measure of performance on crime and re-offending. The table below shows Tower Hamlets has a higher number of trigger offence rates, of 23 per 1,000 residents compared to London average, of 20 per 1,000 and higher still compared to national average of 14 per, 1000 residents. However estimates of proven re-offending for drug using offenders' shows Tower Hamlets has better outcomes with a lower rate of re-offending, this is 21% compared to London average (26%) and national average (28%).

Table 10: Crime and re-offending (Drug Using Offenders) 2012/13 (source: NDTMS DIP Quarterly Summary Report Data)

2012/13	Tower Hamlets		Police Force Area		National	
Trigger offence rate/1000 population	23		20		14	
Early estimates of proven re-offending for drug using offenders	501	21%	6976	26%	37601	28%

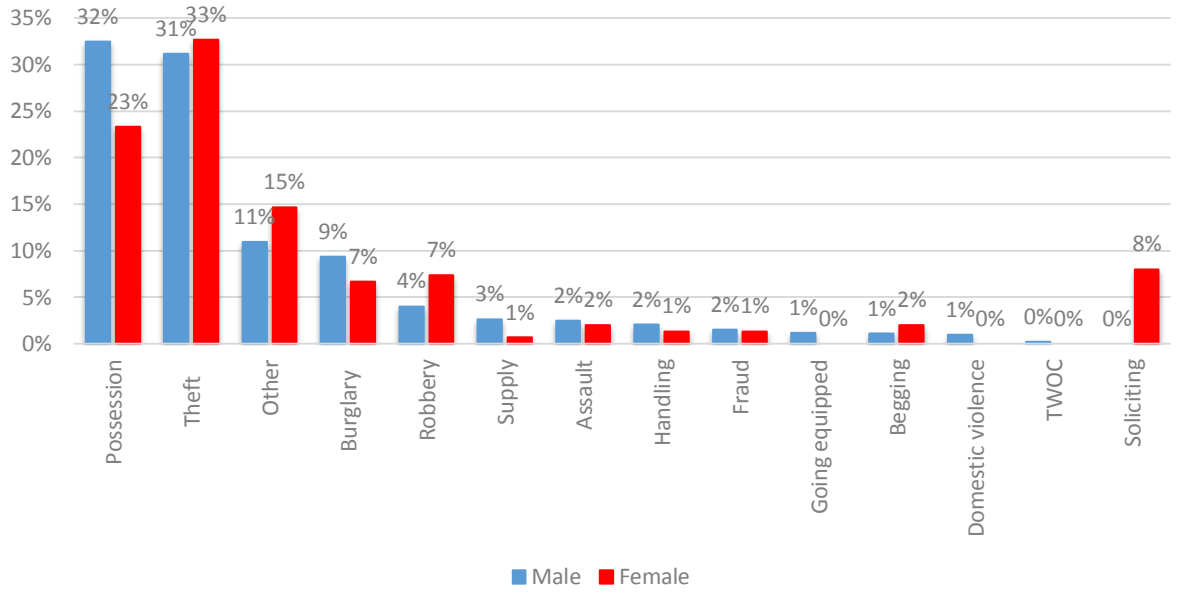
Mi-Case DIP Data Review

5.15 DIP records client activity on the local data management system Mi-Case and as the DIP is not a treatment provider Mi-Case data builds a picture of how clients engage with DIP in

Tower Hamlets. There were 1161 clients in contact with DIP in 2012/13 of which 86% were male and 14% female. From the initial screening of these clients just over half were Required Assessments (RA) Initial Assessments and 9% RA Follow-Up Assessments. Thirty-six percent of the initial screenings were categorised as 'other' and 78% of 'other' were in contact with DIP though being released from prison and 16% from outreach.

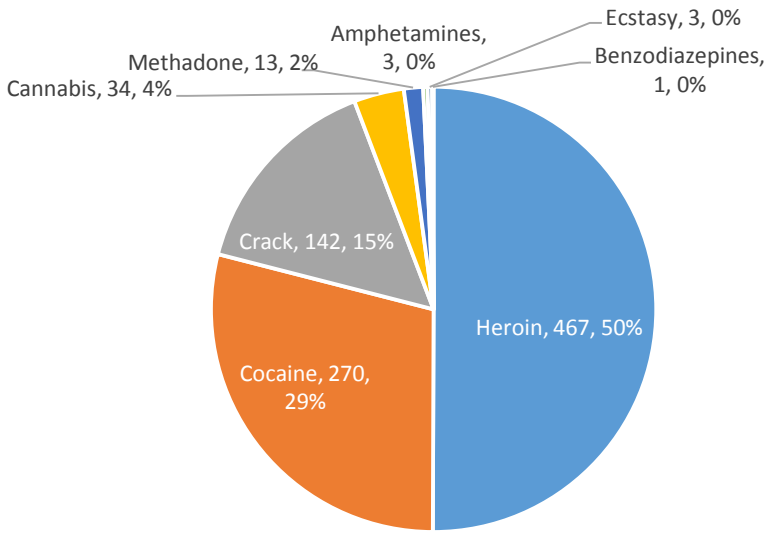
5.16 The charts below compare the distribution of offences between male and female clients in contact with DIP. This shows the type of offences are broadly consistent between male and females and involved mainly possession and theft, with possession being more prevalent in male clients and theft more so in female clients. However the chart also shows that 8% of offences recorded for women involved soliciting. The breakdown of theft categories show that 26% of female client offences involved shoplifting compared to 19% for male.

Chart 16: Recorded Offences for Clients in Contact with DIP 2012/13 *(source: DIP Mi-Case Data)*



5.17 Not all clients in contact with DIP were recorded as drug users, the data shows drug use was cited in 80% (993) of clients in contact with DIP. This is still high proportion of drug use reported by clients committing offences that are strongly associated but not exclusively with substance misuse. The chart below shows that half of the clients cited heroin as their main drug and 15% citing crack. This indicates of those citing drug use two thirds are problematic drug users. As this data has only taken the main drug it is likely a high proportion are using both opiate and crack. A significant proportion 29% cited the use of cocaine.

Chart 17: Main Drug Use Cited by Clients in Contact with DIP 2012/13 *(source: DIP Mi-Case Data)*



5.18 1,044 clients accepted an intervention and a care plan was agreed with 494 clients. The remaining 655 did not agree to a care plan and the main reason for almost half was clients being transferred to prison prior to care plan or to the DIP where they reside. There was also a significant proportion of 22% that did not attend the appointment.

5.19 There were 277 recorded referrals into treatment. Clients were referred to fifteen different treatment providers. In the main these referrals were to Tier 3 structured treatment but also to Tier 4 treatment which included residential rehabilitation. The majority, 71% were referred into CDT. However as this is taken from the DIP recorded data it does not enable verification of these clients engaging with the services or their treatment outcomes.

5.20 It is clear a large number of clients are in contact with DIP and evidence of established links with a variety of criminal justice settings. A crude estimate of attrition based 1,054 clients recorded as requiring an intervention suggests around half are not referred to treatment and this estimate takes account of and discounts those transferred to prison prior to agreeing a care plan, with no further intervention status and signposted to other services.

6 Tier 4 Treatment Provision

6.1 Tower Hamlets' Tier 4 Panel comprises of six representatives from the Council and its key providers (i.e. DAAT Commissioning Manager, DIP Manager and SAU (Consultant Psychiatrist) and service managers from THCAT, CDT, and the Harbour Recovery Centre). The panel meets on a bi-weekly basis to assess applications from local residents for drug and alcohol Tier 4 funding (i.e. residential detoxification and rehabilitation treatments) that are deemed to require specialist and intensive Tier 4 support. The panel also considers DRR Referral's directed from the Court.

6.2 All Community Care Assessment (CCA) and DRR applications are sent to the DAAT in advance of the meetings and circulated to the panel members. At the panel meetings each application is then discussed and assessed by the panel to establish if the Tier 4 treatment identified would be beneficial to the applicant (given their treatment history, current substance misuse problems and any particular circumstances).

6.3 Regardless of the decision, the applicant is informed by letter of the Panel's expectations and/or reasons. While engaged in Tier 4 treatment reports on progress are provided to the panel by the provider along with recommendations for further treatment if deemed necessary. Successful applicants who subsequently have unplanned exits are then barred from making future applicants to the panel for six months.

6.4 Before November 2013 drug and alcohol applications for Tier 4 funding were reviewed separately with the Tier 4 panel assessing applications from drug misusers and THCAT with all responsibilities for applications relating to alcohol. However, this was considered disjointed and imbalanced. Since this time, all substance misuse applications are processed via the panel to provide clear oversight of the decision making process and fiscal control. The total funding available for residential detoxification and rehabilitation for 2013/14 is in the region of £1m.

6.5 The two charts below map the Tier 4 treatment provision for clients in Tower Hamlets during 2012/13. The Tier 4 treatment starts, in treatment population and exits are mapped in the first chart, whilst the second maps the transfer of client into and out of Tier 4 treatment. The chart below shows in 2012/13, 105 clients started Tier 4 treatment, of this 79 clients were referred to Harbour Recovery Centre (HRC), equal to 75% of all treatment starts. HRC is an in borough Tier 4 treatment providers and focuses on residential detox. HRC offers a self-referral pathway to treatment which is novel as this has been designed to provide local people easy access detoxification. Essentially this service is in part Tier 3 and in part Tier 4 although strictly speaking it is a Tier 4 provision that is managed by the Tier 4 panel. In the case of HRC they are in a DAAT contract and are funded to provide locally based residential detoxifications. There are 8 beds in the unit; 6 are via the DAAT contract and 2 are spot purchases by the borough's Tier 4 panel.

6.6 The numbers in treatment across all Tier 4 treatment providers for this period was 198; the providers with a minimum of four clients in treatment are displayed whilst those with less than four have been grouped into 'other' (this consisted of 41 clients amongst 23 treatment providers – a significant proportion of which were residential rehabilitation services). HRC

had 120 clients in treatment this is equal to 62% of the total Tier 4 treatment population. Action on Addictions (Cloud House) had 12 (6%) and clients in 'other' amounted to 21%.

6.7 The chart also shows the Tier 4 treatment exit outcomes, in total for this period there were 124, of this 61 (49%) left treatment in a planned way (proxy for successfully completed treatment), this is higher compared to London average (42%) and significantly higher than the national average (33%). However 24% (30) clients left treatment in an unplanned way, this is higher than London average (19%) and almost twice as much compared to the national average (13%). A further 7% (9) were referred on and 19% (24) were still in treatment. The level of planned exits in 2012-2013 have dropped by 16% compared to 2011-12.

6.8 It follows that as the majority received treatment in HRC the vast majority that exited left from HRC as well, 71 clients and 57% of all exits. The breakdown for HRC shows that half of the exits (36) were planned exits from treatment, equal to 51% of all HRC treatment exit outcomes. A further 19 (27%) left treatment in an unplanned way and only 3 (4%) were referred on.

6.9 On the basis of proportionality the successful treatment outcomes vary greatly from 20% successful completion rate with Broadway Lodge to 100% with Broadreach House, it is important to note the numbers are particularly low and this map does not take account of those clients that may have re-presented within 6 months.

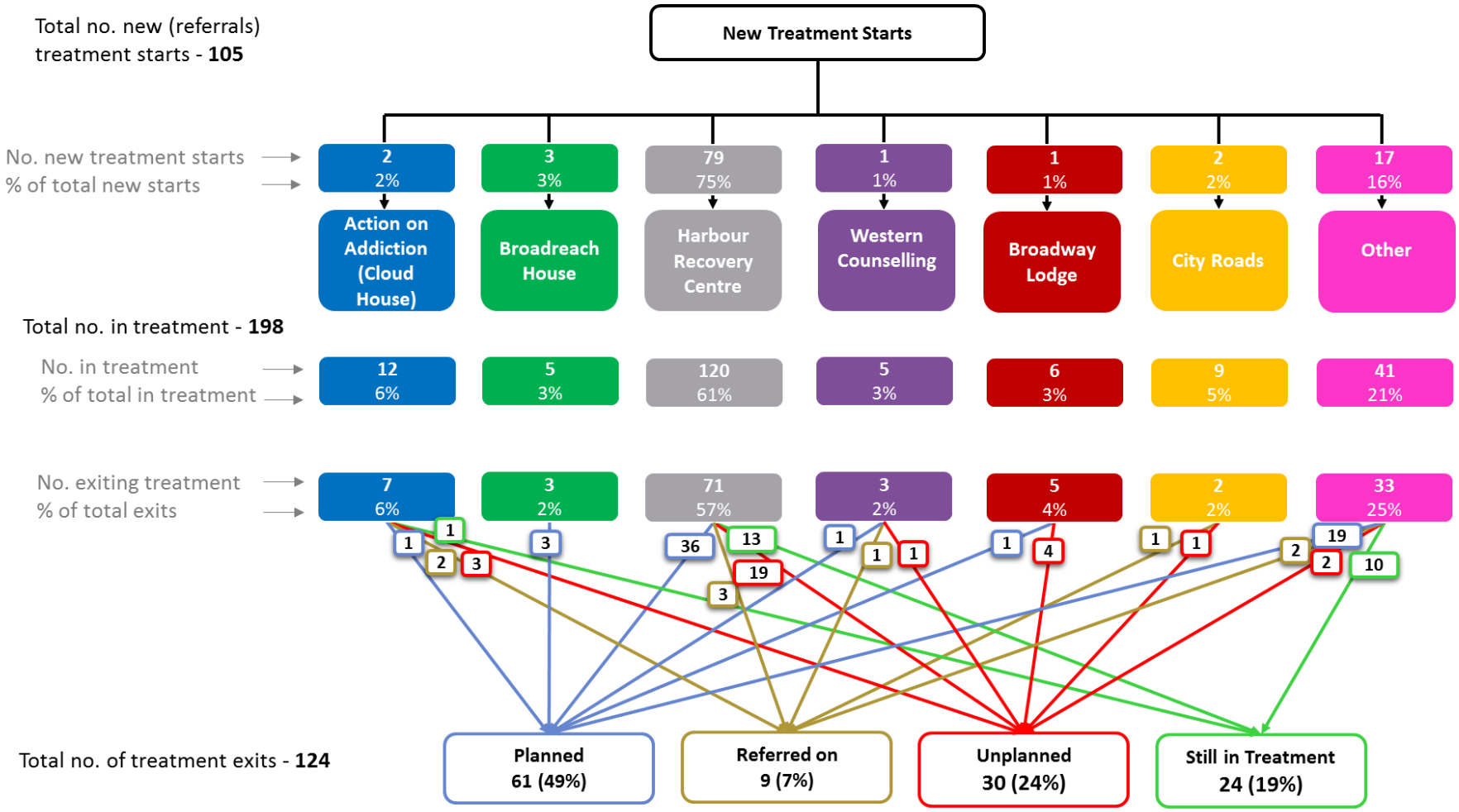
6.10 The second treatment map, maps the transfers into Tier 4 treatment and transfers out of Tier 4 treatment. The top section shows the treatment providers that transferred clients into Tier 4 treatment. It is interesting to note a significant proportion 19 clients (16%) were referred to Tier 4 treatment by Tier 4 treatment providers, (all Tier 4 treatment providers are in filled colour boxes). The remaining transfers into Tier 4 treatment providers were through the main treatment providers, the majority through CDT (58, 50%).

6.11 The middle section maps which Tier 4 treatment provider these clients were transferred to. This shows 58% were transferred to HRC. Transfers into HRC originated from 7 sources including Tier 4 treatment providers. Twenty-two percent were referred to a number of Tier 4 treatment providers grouped in 'other' and include residential rehabilitation.

6.12 The last section maps transfers out of Tier 4. This shows 77 clients were transferred from Tier 4 treatment in 2012/13 with 75% transferred to CDT (Tier 3 treatment provider) The remaining quarter were transferred to another Tier 4 treatment provider, including residential rehabilitation.

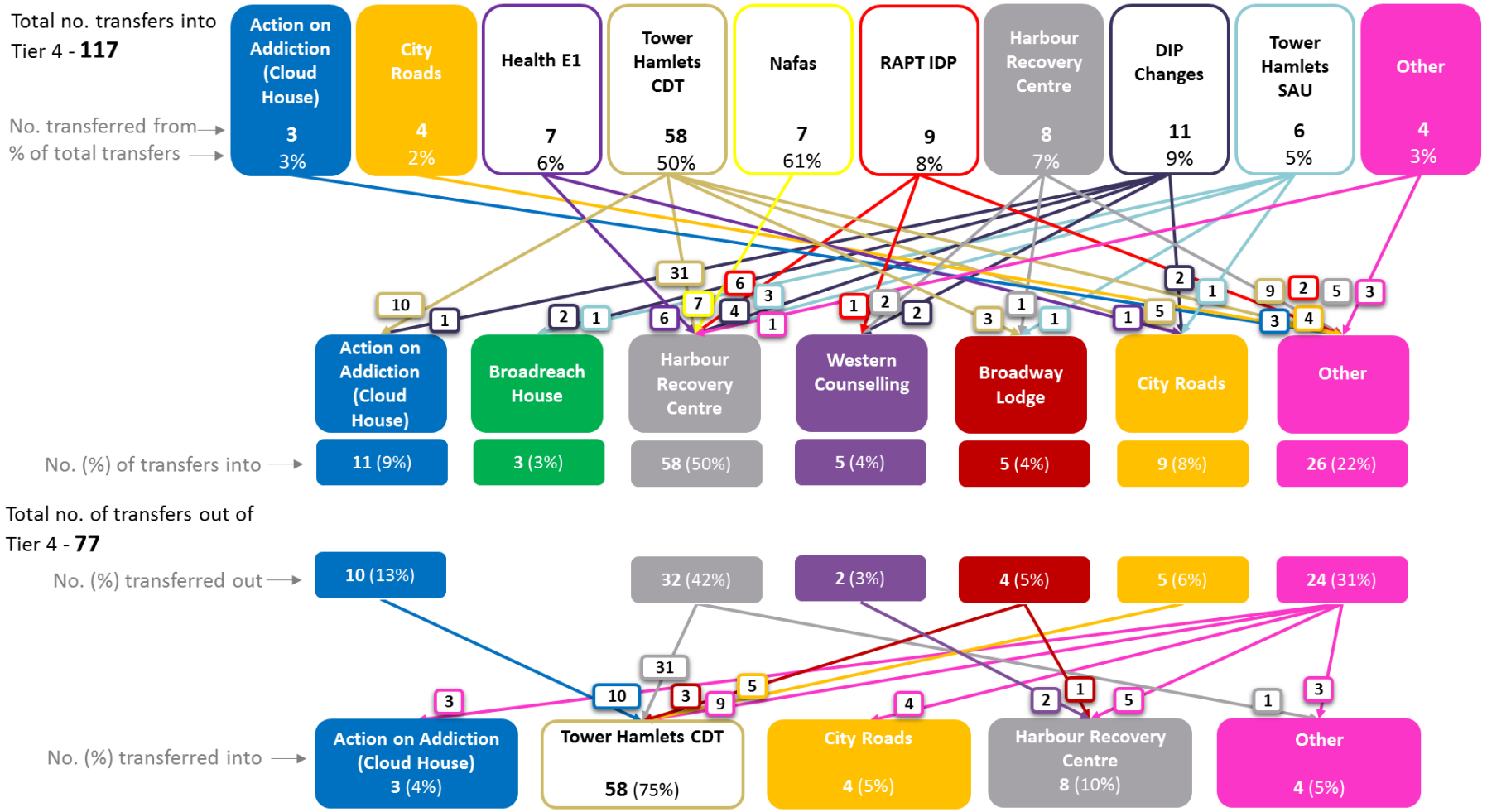
6.13 It is also critical to stress that a key component of successful Tier 4 interventions is the delivery of appropriate recovery support, within the borough more is needed to support recovery and in particular to address the longer standing recovery capabilities of clients exiting treatment.

Chart 18: New Starts into and Exits from Treatment (Tier 4) 2012/13 (Source: Tier 4 Treatment Map Needs Assessment Data)



Agencies with less than 4 clients in treatment have been grouped in "other" for both referrals and treatment exits

Chart 19: Transfers into and Transfers out of Treatment (Tier 4) 2012/13 (Source: Tier 4 Treatment Map Needs Assessment Data)



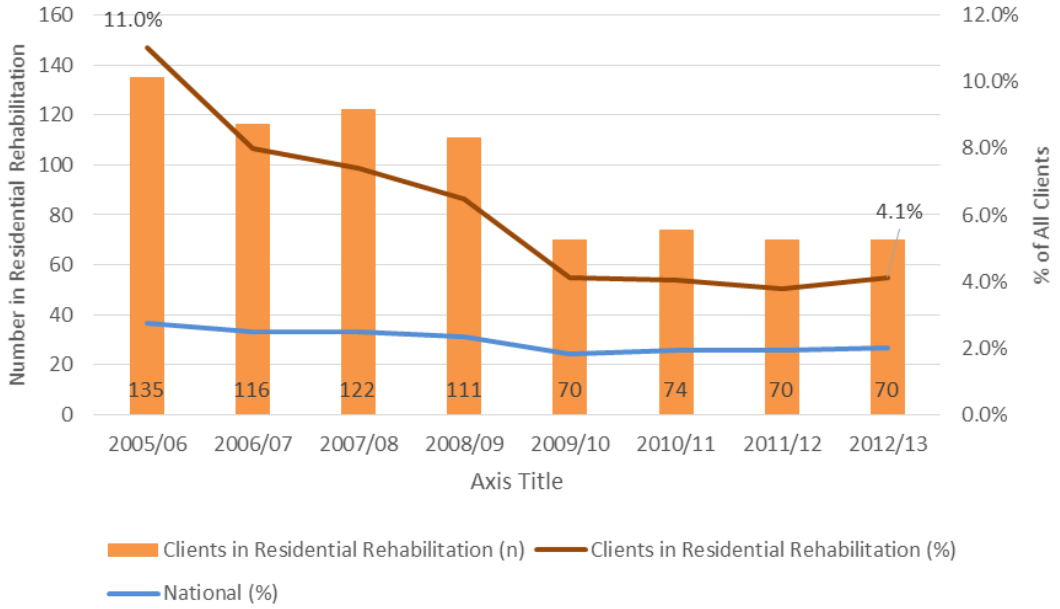
6.14 The data suggest clients transfer into Tier 4 include transfers from Tier 4 to Tier 4 and transfers out of Tier 4 and again into Tier 4. This strongly indicates clients undertake multiple Tier 4 treatment episodes. At this stage without more detailed client information this needs assessment cannot comment if this is an appropriate use of Tier 4 provision. It does however seem clear the use of Tier four provision is high and there are high levels of unplanned exits, which would suggest that clients need to be made more treatment ready to benefit from this opportunity.

6.15 In 2012 the National Treatment Agency confirmed that residential rehabilitation is an integral part of any treatment system, a vital option for some people requiring treatment and that it should therefore be easily accessible to anyone who needs it[3]. The chart below shows the number and proportion of clients with residential rehabilitation as part of their latest treatment journey compared to the national average between 2005/06 to 2012/13. This shows that Tower Hamlets in the former years of this period has over four times the proportion of clients in residential rehabilitation compared to the national average, since 2009/10 in Tower Hamlets this has reduced in both absolute and proportionately to around 4%; however in this period Tower Hamlets has remained consistently higher than the national average.

6.16 Residential Rehab clients as a percentage of those clients in treatment are set out in the chart below. This shows the trend in the take-up of residential rehab whilst the rate has declined in the proportion of clients in residential rehab, it still remains higher than the national average. This confirms in Tower Hamlets, Tier 4 treatment is accessible and forms part of treatment system.

[3] The Role of Residential Rehab in an Integrated Treatment System, NTA 2012

Chart 20: Residential Rehab 2005/06 to 2012/13 *(Source: Tier 4 Treatment Map Needs Assessment Data)*



6.17 Tier 4 inpatient detox and residential rehabilitation is an expensive treatment option but a necessary treatment provision for many clients. In order for Tier 4 treatment to be effective and to achieve success clients require preparation and stabilisation prior to entering treatment and critically a comprehensive package of recovery and aftercare support. Across London there were 580 Tier 4 treatment starts in 2012/13, in Tower Hamlets there were 105, equal to 18% of all Tier 4 treatment starts across 32 London Boroughs and has the highest proportion compared to other London comparable opiate cluster DAATs. Many DAATs use Detoxification and Rehabilitation sparingly. Indeed many are also able to work with clients to achieve drug free treatment completions in the community.

7 Additional Drugs and Alcohol data Sources

7.1 This section identifies data from a range of key DAAT partners from the Health and the Criminal Justice sectors. Essentially this data supplements treatment data to support an assessment of drugs and alcohol activity in the community. To this end this section identifies health incidents as a result of alcohol or drug misuse and drug offending crime rates, ambulance service callouts and the profile of substance misuse attributable to clients of the probation service. There are also other key data sets which at this stage are not available to this needs assessment, however the data available does provide a context for treatment needs and profiles those incidents associated with drugs and alcohol misuse which add to the understanding of needs in the borough.

Health Data

7.2 In developing this needs assessment some potentially useful data was either not available or not researched. This included substance misuse information from NHS walk-in centres, A&E department presentation data, minor injuries units, and gynaecology, midwifery and antenatal services. Community mental health, inpatient, dual diagnosis services and GP practices all come into contact with drug and alcohol users and sometimes collect potentially useful statistics on those who may not be in the formal treatment data provided by NDTMS. Essentially this provides a greater understanding of the alcohol and drugs misusers who are not presenting to treatment.

7.3 The following health and "other" data would also help treatment planning and highlight some of the services treatment naïve clients are accessing:

Needle exchange data – data on needle exchange services operating in Tower Hamlets is currently unavailable. Needle exchange is provided through the Borough's pharmacies, however this data is not systematically recorded and hence any data held is deemed unreliable. A full picture of needle exchange activity is a strong indicator of opiate and injecting profile in the community. Indeed whilst being a harm minimisation action (tier 2 service) analysing needle exchange activity in the borough would embellish the understanding of the level of injecting in the community.

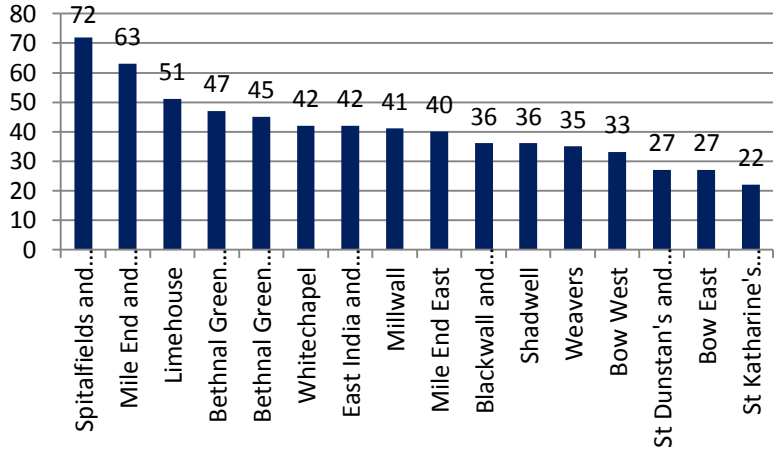
General practice research database (GPRD) - contains data on more than 3 million randomly sampled patients in GP practices across England. It includes demographic profiles, clinical diagnoses, drugs prescribed and immunisation details. It is good as a comparison tool for incidence/prevalence in the general population with NDTMS/local data sources. This data has not been available to this needs assessment although Public health colleagues could advise on accessing and making use of this rich data in the future.

7.4 'Other' areas of key health related data could include:
Prescribing analyses and cost data (PACT) - records all prescriptions issued within a Clinical Commissioning Group (CCG) area. This identifies those clients accessing opiate substitute prescriptions outside of the usual shared care practice. This information has been collected and is available in section 13 of this assessment.

London Ambulance Service Callouts

7.5 The following information has been collated from the London Ambulance Service for drug related ambulance callouts for Tower Hamlets. In the period April 2012 to September 2013 there were 677 drugs related call outs/incidents attended by London Ambulance Service. The table below shows the ward from which these callouts originated.

Chart 21: Tower Hamlets Ambulance Service Callouts by Ward *(Source: LAS Apr 12-Sep13)*



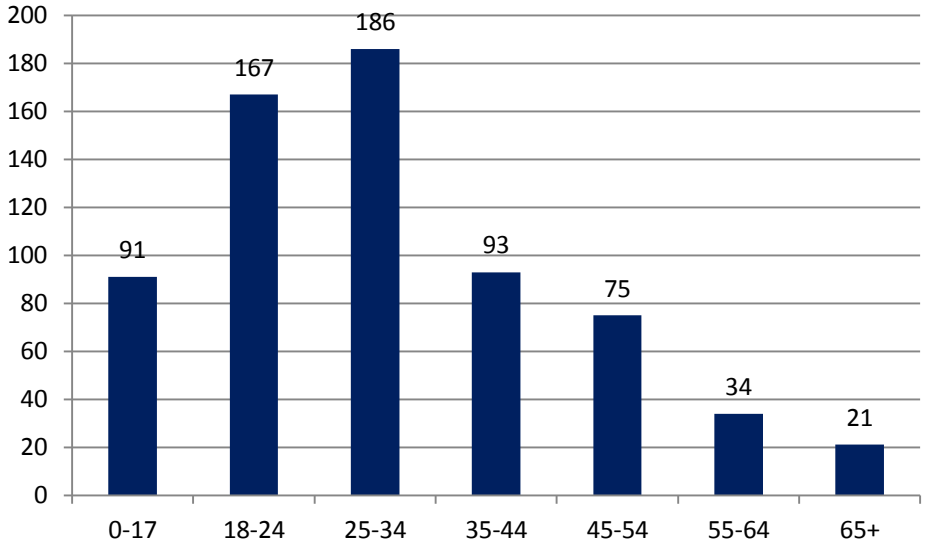
7.6 The wards with the highest callout over this period were Spitalfields and Banglatown, Mile End and Globe Town, Limehouse, and Bethnal Green South and North. The lowest call outs were from Bow East and St Katherine's and Wapping.

Table 11: LAS Drug Callouts in Tower Hamlets by Incident *(Source: LAS April 2012 to Sept 2013)*

Incident	Count
Accident	10
Assault	4
Cardiac problem	1
Day case appointment	1
Fall	2
Fire incident	1
Illness - known	124
Illness - unknown	133
Not given	112
Obstetric	1
Other incident	35
Police incident	3
Psychiatric problems	35
Self-harm	200
(blank)	
Grand Total	**662**

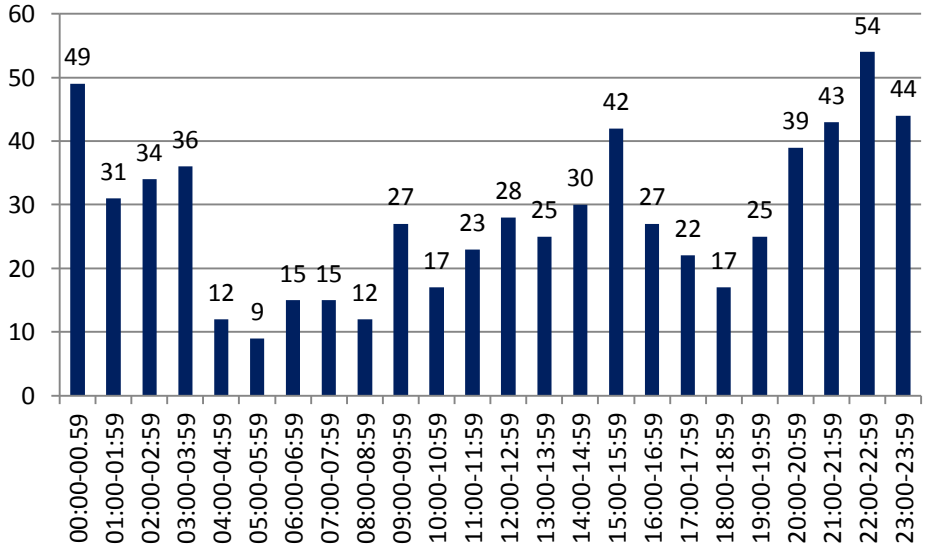
7.7 In terms of specific illness descriptions 219 were for drug overdose in this period (which seems very high), 78 were alcohol related and 35 poisoning, 26 were for Psychiatric problems (diagnosed and undiagnosed)

Chart 22: Tower Hamlets Ambulance Services Drugs callouts by age *(Source: LAS 2012/13 2013)*



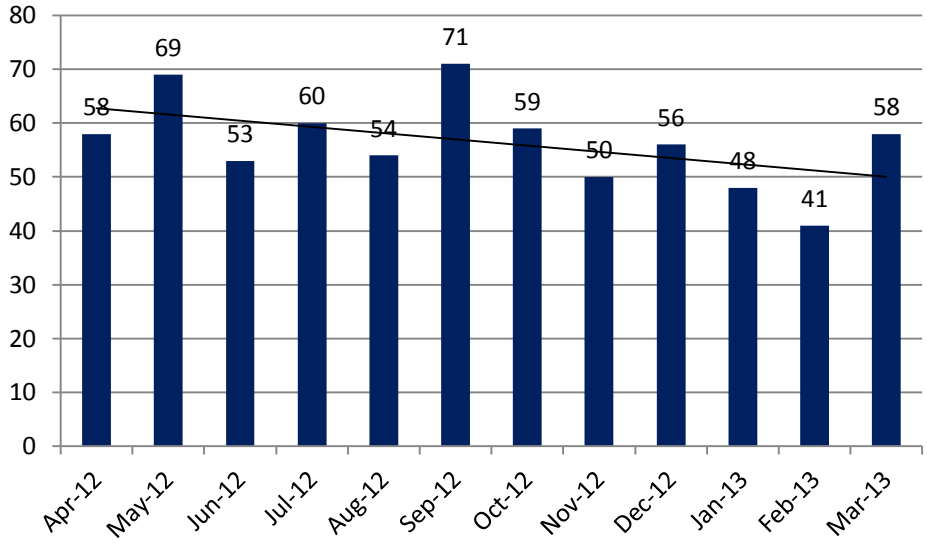
7.8 The chart above shows the volume of drug related callouts by age. It is clear from this data that the groups with the highest level of Ambulance callouts for a drug related cause (often overdose) was the 25-34 age group, followed by the 18-24 year old group.

Chart 23: Tower Hamlets Ambulance Service Drug Call outs by time of day *(Source: LAS 2012/13)*



7.9 The chart above shows that the overwhelming majority of drugs callouts are in the period between 8.00pm and 2.00am, although there seems to be an odd variance between 3pm and 4pm.

Chart 24: Tower Hamlets Ambulance Service Drug Call outs by month of year *(Source: LAS 2012/13)*



7.10 The chart above shows a pretty even distribution across the year but with higher levels of Drug related callouts in the summer months with additional peaks during October 2012 and December 2012. Overall the trend line shows that in this period the levels were declining.

7.11 Unlike alcohol callouts the numbers of drug overdose call outs are smaller in number, and include some associated alcohol related callouts. Closer examination of the LAS dataset confirms that there were 677 Drug Overdose callouts for the period between April 2012 and March 2013. This seems a high figure and one which suggests a level of concern that the DAAT needs to address. Ninety percent of these callouts took the patient to the Royal London Hospital and 78 or 12% were deemed violent.

Criminal justice data

7.12 This needs assessment has analysed relevant partner data sets from various partners within the CJS. The section below describes the overall position of Tower Hamlets in terms of drug related offences, within the context of antisocial behaviour and disorder, and drugs offences. Further data is provided by the probation service through its OASys reporting system.

Tower Hamlets strategic assessment priorities

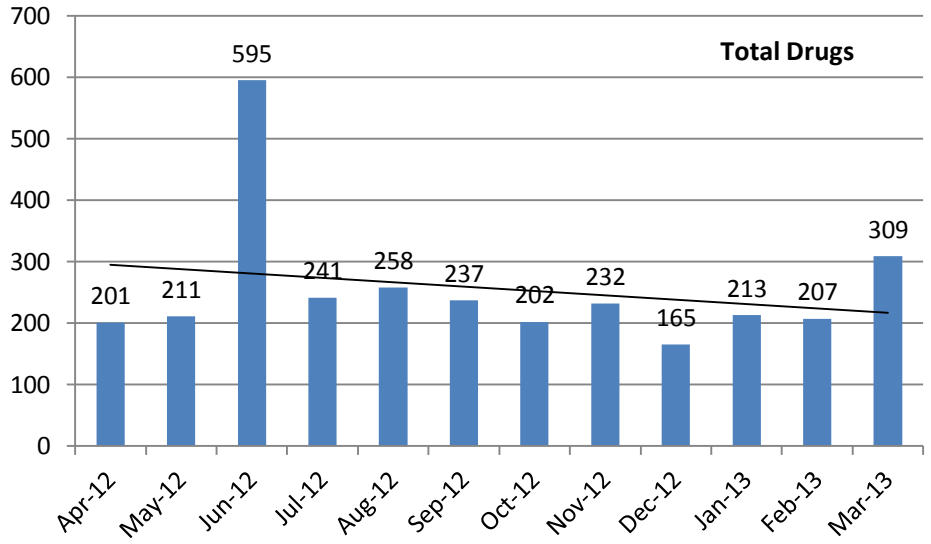
7.13 In headline policy terms, Tower Hamlets strategic assessment priorities for crime and disorder reduction focus for 2013/14 has been:

- Alcohol and Drug related crime
- Anti-Social Behaviour
- Burglary (residential)
- Domestic Violence
- Youth Violence (including knife crime)

Drug Offences (iQuanta)

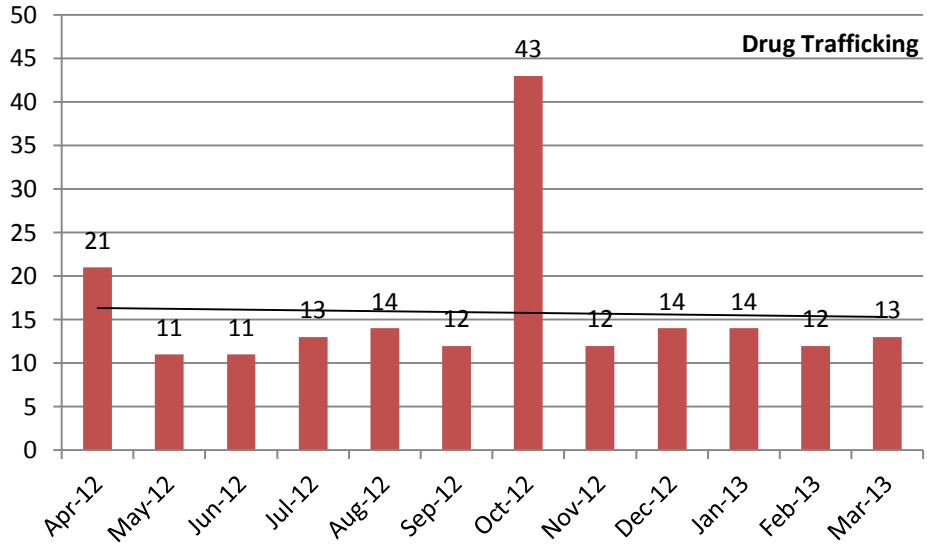
7.14 The data below is taken from the Metropolitan Police's iQuanta database. It describes drug offences, possession and trafficking crimes recorded in the period between April 2012 and Sept 2013.

Chart 25: Tower Hamlets Total Drug Offences *(Source: LASS April 2012 – September 2013)*



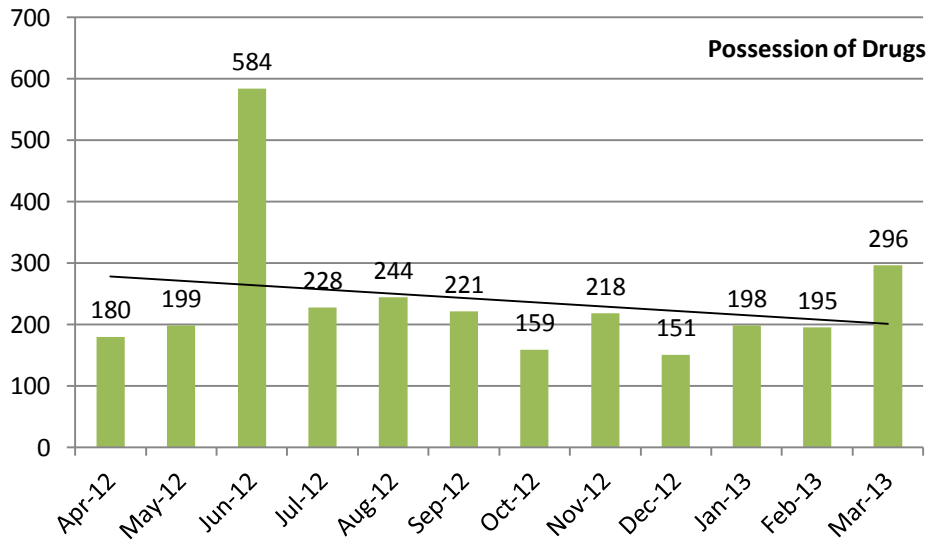
7.15 Over this period there has been an average of 256 drug offences per month in the borough, with peaks in the summer of 2012, although showing a decline in general through to March 2013. Indeed the trend line above shows a level of decline over this whole period from just under 300 to just over 210 per month, although this is in part caused by the hugh spike of possessions convicted in June 2012.

Chart 26: Tower Hamlets Drug trafficking *(Source: LASS April 2012 – September 2013)*



7.16 Whilst the level of drug trafficking (dealing) is much lower there has been a broadly consistent level of trafficking offences throughout this period with a spike in October 2012. The Borough's Police have targeted a dealer a day as part of a local campaign. The average number of arrests per month was 16 in 2012/13.

Table 12: Tower Hamlets Drug Possession *(Source: LASS 2012/13)*



7.17 The chart above shows that arrests for possessions are by far the dominant volume of all drugs related arrests and quite closely reflects the all drug offences chart. However the trend shows that arrests for possession are in a slower rate of decline and the average number of monthly arrests for possession was 240 over this period.

Probation Service Data (Offender Assessment System OASys)

7.18 The data below comes from the Probation Service's OASys. This system measures the scores of probationers and classifies their assessments into a range of categories of client need/risks. For the purposes of this Needs Assessment data has been taken for the period 1st October 2012 to 30th September 2013. The table below identifies specific needs of the clients on the OASys system in Tower Hamlets. In this period there were 1,324 clients on the system.

Offence category

7.18.1 The Gender profile of those on the system is set out in the table below. This identified 36% men and 27% women as having drug using needs.

Table 13: Tower Hamlets Probation client by Gender and Drug Use October 12 to September 2013

Row Labels	Count of Gender	Sum of Drugs	% of Drug Users
Female	129	35	27%
Male	1193	427	36%
Not known	2	2	
Grand Total	**1324**	**464**	

7.19 The tables below show the offence categories of those with drug needs. This shows a broad range of offences and in some cases more than one offence was committed by the same client.

Table 14: Tower Hamlets Probation client offence categories by Drugs Need October 2012 to September 2013

Row Labels	Count of Offence	Sum of Drugs	% of Drug Users
Burglary	70	47	**67%**
Criminal Damage	23	7	30%
Drug Offences	189	110	**58%**
Fraud and Forgery	82	8	10%
Indictable Motoring Offences	11	1	9%
Other Indictable	105	28	27%
Other Summary Offences	69	16	23%
Robbery	103	64	**62%**
Sexual Offences	57	15	26%
Summary Motoring Offences	70	5	7%
Theft and Handling	139	63	45%
Violence Against the Person	405	100	25%
(blank)		0	
Grand Total	**1323**	**464**	

7.20 It is interesting that the highest proportion of Probation Clients using drugs by offences relates to Burglary (67%), Drug offences (58%) and Robbery (62%). This is a similar offending profile to those clients in contact with DIP.

7.21 The two charts below show the dispersal of probationers as distributed across the borough's wards by drugs and alcohol misuse. These show the localities are broadly consistent between drugs and alcohol misusing probation clients, Mile End East, Bethnal Green and East India with the largest proportions and St Katherine's and Wapping with the least for both drug and alcohol misuse. This may reflect the fact that treatment provision is located in the west of the borough and not in areas like Mile End East and East India in the east of the borough.

Chart 27: Tower Hamlets Drugs misusing Probationers by Ward October 2012 to September 2013

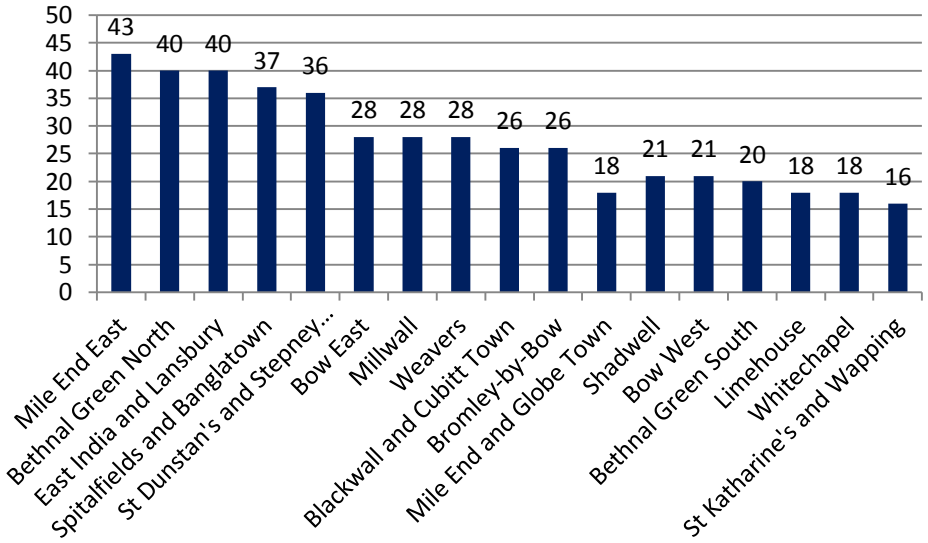
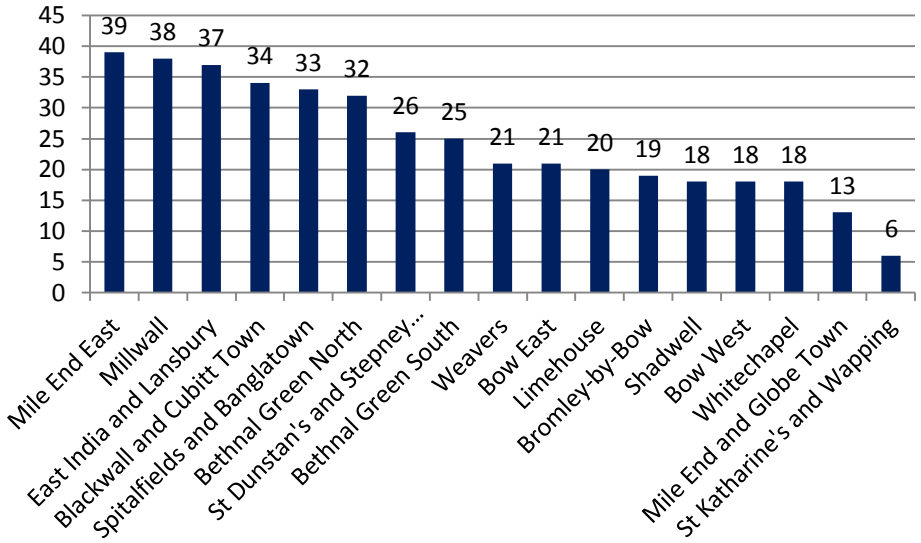


Chart 28: Tower Hamlets Alcohol misusing Probationers by Ward October 2012 to September 2013



7.22 The charts below show a higher level of ethnic diversity for Drugs needs than Alcohol needs which will reflect cultural backgrounds.

Chart 29: Tower Hamlets Probation clients' Ethnicity with Drugs needs

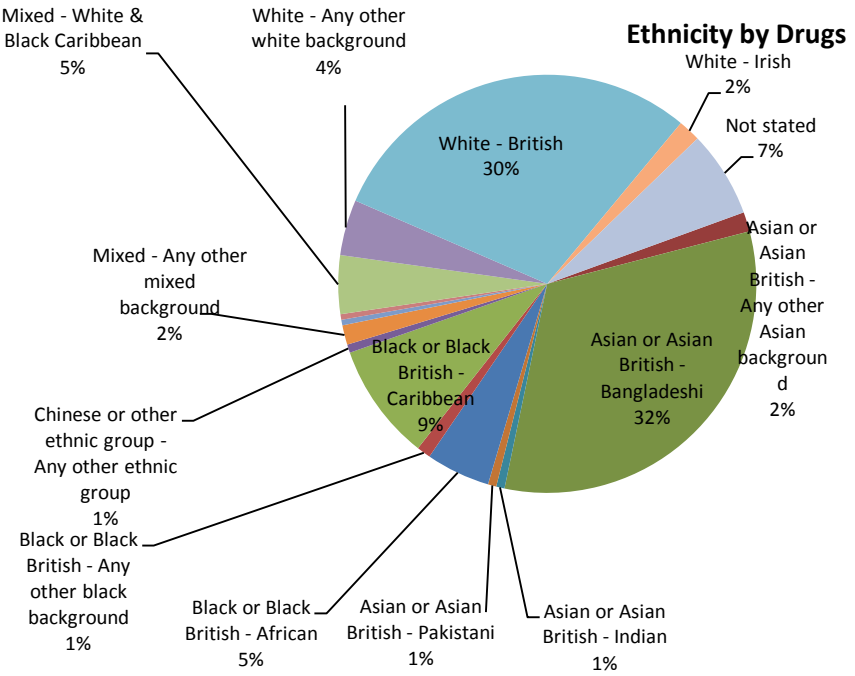
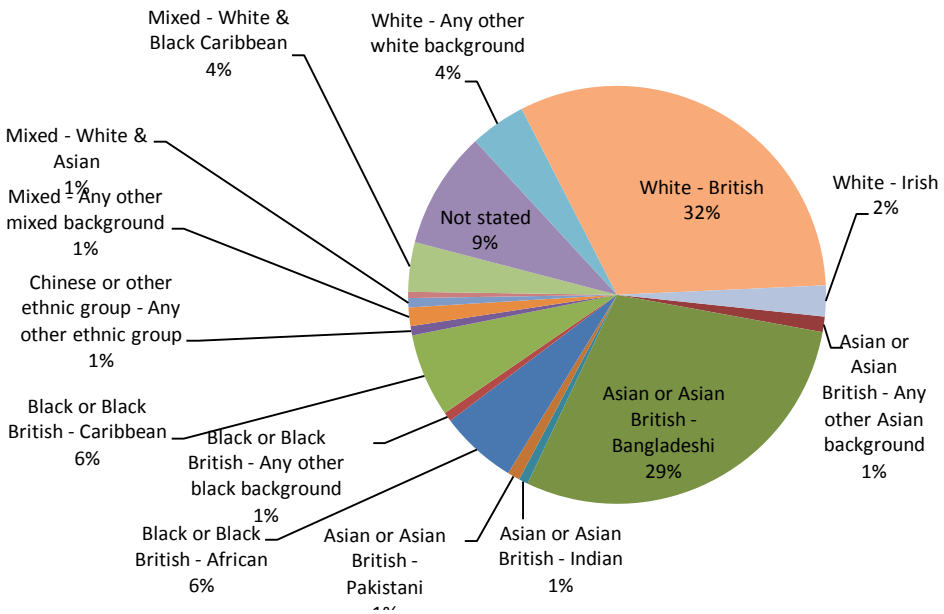


Chart 30: Tower Hamlets Probation clients' Ethnicity with Alcohol needs



Summary of additional data

7.23 Data from the Borough's Health Services, the Ambulance Service, the Police and the Probation Service enriches the understanding of the range and breath of drugs and alcohol abuse in the borough and in many ways demonstrates the impact drugs and alcohol has on Tower Hamlets.

7.24 What is useful to this and future needs assessment is the establishment of reporting agreements and data sharing between the DAAT key partner services in Health, the Police, the Ambulance Service and Probation. These are the key players although moving forward data could also be accessed from the Fire Service, Housing and Social Services and other local authority departments.

7.25 However a wider review of partnership data shows that drugs and alcohol has a significant impact on the borough in terms of health, crime, community safety. The impact and cost of drugs and alcohol on the borough is great and it is importance to engage these people in treatment and to work particularly with 'frequent flyers' of these services to ensure that treatment can be used to mitigate some of repeat incidents:

- There were 677 Drug Overdose call outs during 2012/13
- The average volume of Drug overdose callouts by the London Ambulance Service in Tower Hamlets in the 2012/13 period was 56 per month
- The wards with the highest callout rates over this period were Spitalfields and Banglatown, Mile End and Globe Town, Limehouse, and Bethnal Green South and North. The lowest callouts were from Bow East and St Katherine's and Wapping
- 90% of these callouts took the patients to the Royal London Hospital and 78 or 12% were deemed violent

- There was an average of 256 drug offences per month in the borough, with peaks in the summer of 2012, there was a hugh spike of possessions convicted in June 2012, (associated with preparations for the Olympics)
- The numbers of drug trafficking offences (dealing) is lower and there has been a broadly consistent level of offences throughout this period with a spike in October 2012.
- The Borough Police have targeted a dealer a day as part of a local campaign.
- Possessions dominate the volume of all drug related arrests, however the trend shows that arrests for possession are in a slower rate of decline and the average number of monthly arrests for possession was 240
- 36% of male probationers and 27% of female probationers are identified as having drug using needs.
- The highest offences carried out by Probation Clients using drugs were Burglary (67%) Robbery (62%) and Drug offences (58%), consistent to the offending profile of clients in contact with DIP.

8 Alcohol

8.1 Alcohol is a growing component of Tower Hamlet's treatment system. Increasingly substance misuse treatment providers are seeing more alcohol presentations. The NTA have advised of the need to include alcohol within a substance misuse needs assessment. To this end this needs assessment has analysed the National Alcohol Treatment Management System (NATMS) data held on alcohol treatment and has used the treatment mapping information to produce a comprehensive treatment map.

8.2 LBTH's Alcohol Service Provision is set out below:

Tier 1 Health Promotion specialists/ services able to deliver low level interventions

- Alcohol advice and information.
- Targeted screening and assessment for those drinking in excess of DOH guidelines on sensible drinking and for those who may need alcohol treatment.
- Provision of simple brief interventions for hazardous and harmful drinkers.
- Referral of those requiring more than simple brief interventions for specialised alcohol treatment.

Tier 2 THCAT/DAT/A&E Nurses alcohol role/GPs

- Alcohol advice and information.
- Targeted screening and assessment for those drinking in excess of DOH guidelines on sensible drinking and for those who may need alcohol treatment.
- Provision of simple brief interventions for hazardous and harmful drinkers.
- Referral of those requiring more than simple brief interventions for specialised alcohol treatment.
- Partnership or 'shared care' with specialised alcohol treatment services.

Tier 3 THCAT/IDP

- Comprehensive substance misuse assessment, care planning and review for all those in structured treatment, often with regular key working sessions as standard practice.
- Community care assessment and case management of alcohol misusers a range of evidence-based prescribing interventions, in the context of a package of care, including community-based medically assisted alcohol withdrawal (detoxification) and prescribing interventions to reduce risk of relapse.
- A range of structured evidence based psychosocial therapies and support within a care plan to address alcohol misuse and to address co-existing conditions, such as depression and anxiety, when appropriate.
- Structured day programmes and care-planned day care (e.g. interventions targeting specific groups)
- Liaison services, e.g. for acute medical and psychiatric health services (such as pregnancy, mental health or a hepatitis services) and social care services (such as child care and housing services and other generic services as appropriate).

Tier 4 LBTH Inpatient detox via THCAT

- Comprehensive substance misuse assessment, including complex cases when appropriate care planning and review for all inpatient and residential structured treatment.

- A range of evidence-based prescribing interventions, in the context of a package of care, including medically assisted alcohol withdrawal (detoxification) in inpatient or residential care and prescribing interventions to reduce risk of relapse.
- A range of structured evidence-based psychosocial therapies and support to address alcohol misuse.
- Provision of information, advice and training and 'shared care' to others delivering Tier 1 and Tier 2 and support for Tier 3 services as appropriate.

Treatment Journey Mapping Data

8.3 The diagrams in the following two charts map client alcohol treatment journeys in 2012/13. Similar to the treatment map for drug using clients, focusing on the main sources of referral, those in treatment, those transferring between agencies and those leaving the system. There were 470 referrals into treatment, 738 in treatment (amongst providers), 70 transfers between agencies and 432 exits from the treatment system. Each of these elements of the treatment journey will be reviewed in further detail below.

8.4 In 2012/13 there were 470 alcohol referrals, this is an increase of 8% compared to 2011/12 where 433 were referred. The majority of 34% were referrals from self, family or friends nationally this was 41%, followed by 27% from health, mental health services equal to the national average and 13% from criminal justice system higher than national average of 8%. In 2011/12 there were similar proportion of referrals from self, family or friend (35%), 8% more from health and mental health services and fewer referrals from criminal justice system (5%).

8.5 Female referrals to treatment are low in Tower Hamlets making up 22% (103) compared to 35% nationally. The proportion referred from the various referrals routes shows slightly higher proportion of female referrals from health and mental health services (30%) compared to males (27%) and higher proportion of females referred from self, family and friends (38%) compared to males (34%). Fewer female referrals came from criminal justice system (6%) compared to males (15%).

Chart 31: Treatment Journey Map 2012/13 (source: NDTMS Alcohol Treatment Map Summary Data)

LB Tower Hamlets: Referrals routes into and exits from treatment (alcohol) 2012-13

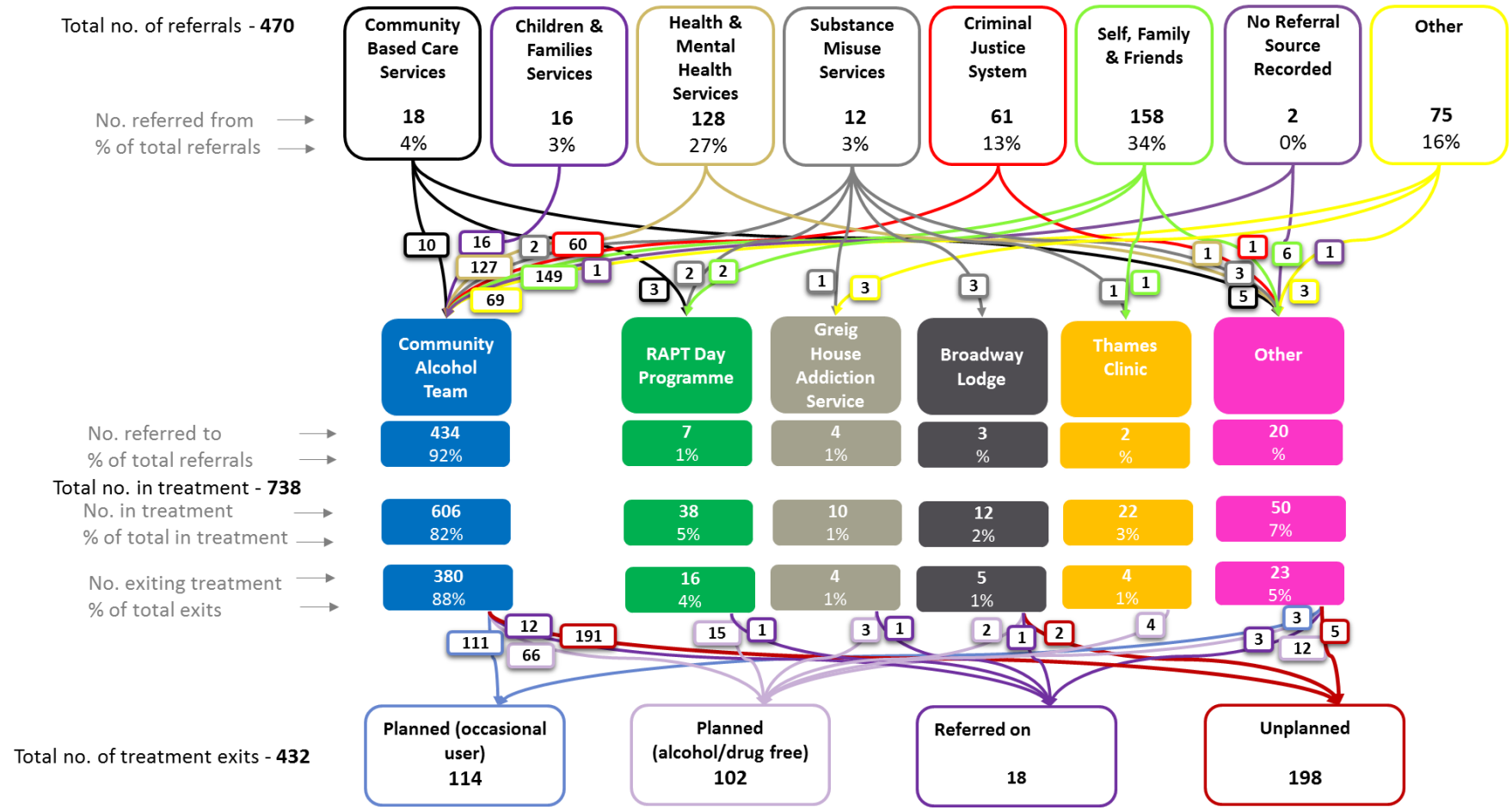
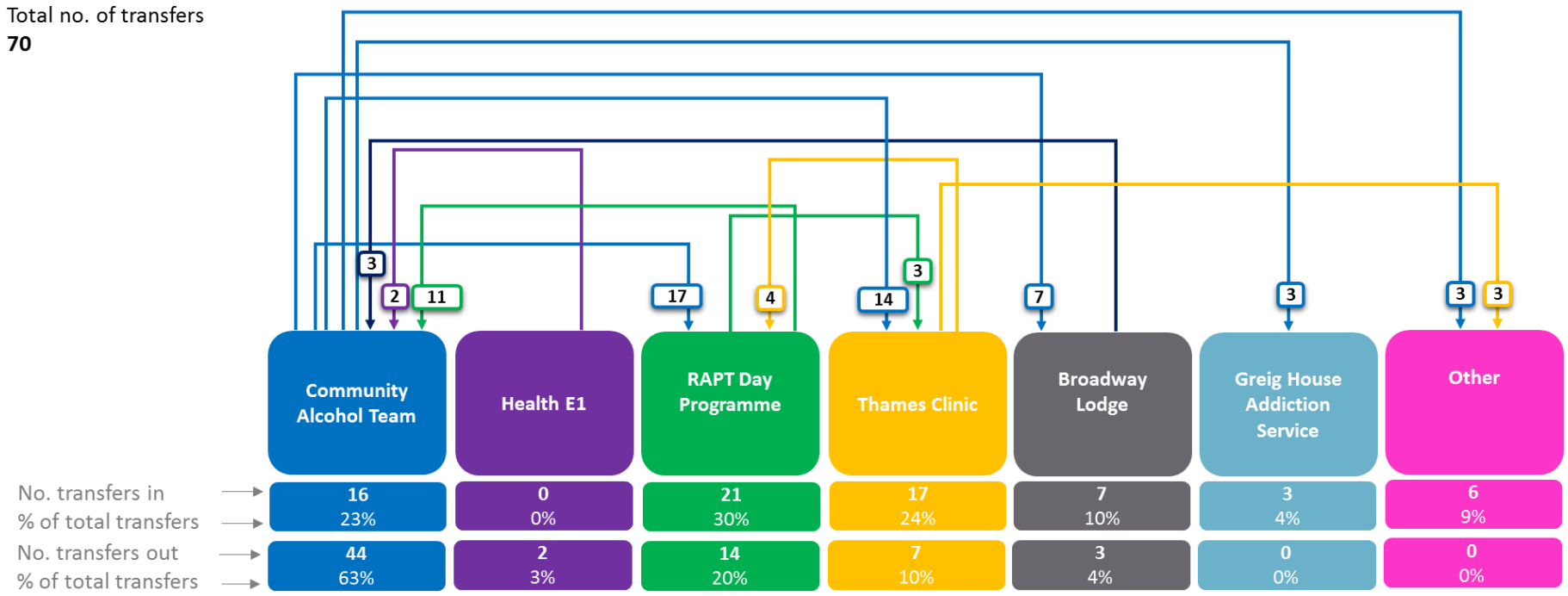


Chart 32: Treatment Journey Map 2012/13 (source: NDTMS Alcohol Treatment Map Summary Data)

LB Tower Hamlets: Transfers to and from treatment agencies (alcohol) 2012-13



8.6 The in treatment transfers of clients is particularly low with 70 transfer in 2012/13 although higher compared to 2011/12 where 49 transfers took place. Eleven percent are transferred as a proportion of the total treatment population, as treatment for primarily alcohol use is delivered THCAT it is to be expected that there would be fewer transfers within the Tower Hamlet's treatment system.

8.7 There were 645 clients in treatment in 2012/13 (partnership level data is not equal to the number in treatment at provider level due to multiple counting of clients who received treatment in more than one agency), of this 136 were female clients, accounting for 27% of the treatment population, as expected this is higher compared to the male, female ratios for drug treatment.

8.8 The chart above also shows the range of treatment exit outcomes. This shows half (216) of the treatment exit outcomes resulted in clients successfully completing treatment, with 26% leaving alcohol free and 24% leaving as occasional users. The proportion of successful treatment exit outcomes in Tower Hamlets is lower compared to national average of 61% (35% leaving alcohol free and 24% leaving as occasional users). There is an almost equal amount at 46% (198) of clients for whom treatment exit outcomes resulted in unplanned exits, this is higher compared to 33% nationally.

8.9 It is important to assess how many people, out in the community, have an alcohol issue and hence may require treatment services. The only methodology currently being employed is the use of synthetic estimates generated from by LAPE. The estimate generates a percentage profile for a local area, balanced by existing treatment patterns to assess the range of potential alcohol users and an indication of the level of need; this is compared to England as a whole.

8.10 A clear focus of the estimation tool is to review the categories of alcohol abstainers, low risk drinkers, increasing risk drinkers, higher risk drinkers and binge drinkers. The table below shows in Tower Hamlets there is a higher proportion of 'abstainers' compared to the England average, 28.6% and 16.5% respectively. For those 'lower risk drinkers', those at 'increasing risk of drinking' and 'higher risk drinking' Tower Hamlets has a similar profile to the England average. Tower Hamlets has half the proportion of 'binge drinkers' (10.9%) compared to the England average (20.1%).

Table 15: Estimation tool (Source: Local Alcohol Synthetic Estimates for England 2012/13 Needs Assessment)

	Tower Hamlets			England		
	% of Total Population aged 16+	Lower 95% CI	Upper 95% CI	% of Total Population aged 16+	Lower 95% CI	Upper 95% CI
Abstainers	28.6	20.5	34.4	16.5	11.1	20.6
	% of Drinking Population aged 16+	Lower 95% CI	Upper 95% CI	% of Drinking Population aged 16+	Lower 95% CI	Upper 95% CI
Lower Risk Drinkers	73.4	49.5	90.9	73.3	51.1	86.4
Increasing Risk Drinking	20.5	10.1	40.4	20	10.8	38.5
Higher Risk Drinking	6.1	1.8	21	6.7	2.4	21.8
Binge Drinking	10.9	9.7	12.3	20.1	19.4	20.8

8.11 In Tower Hamlets it is estimated the total 16 and over populations is 210,494. Of this 60,201 are abstainers and therefore leaving an estimated 16 and over drinking population of 150,239. The chart below has been calculated using the aged 16 and over mid-2012 ONS population estimates as set out in these synthetic estimates to calculate the number of people that fall into the different drinking profiles.

Chart 33: Estimated Number of Drinkers mid-2012 Tower Hamlets Population (Source: Local Alcohol Synthetic Estimates for England 2012/13 Needs Assessment)

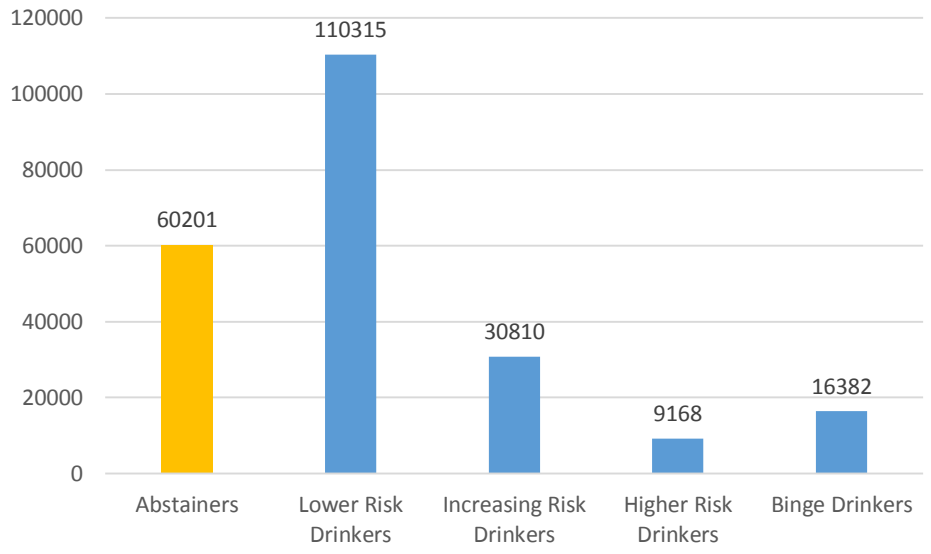
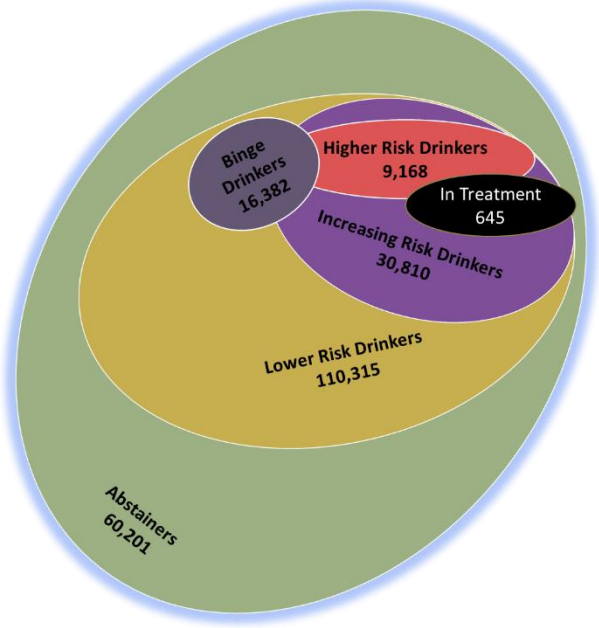


Table 16: Estimation tool (Source: Local Alcohol Synthetic Estimates for England 2012/13 Needs Assessment with ONS population profile 2012)

	Estimate
Abstainers	60,201
	% of Drinking Population aged 16+
Lower risk Drinkers	110,315
Increasing Risk Drinking	30,810
Higher Risk Drinking	9,168
Binge Drinking	16,382

8.12 Using the mid-2012 ONS aged 16 and over population estimates for Tower Hamlets the profile of the alcohol drinking population is set out in the chart below. Inserted into the chart is the number of alcohol treatment clients in the system during 2012/13.

Chart 34: LAPE Synthetic Estimates Converted to mid-2012 Tower Hamlets Treatment Population *(Source: NDTMS & ONS Population Estimates)*



8.13 What this suggests is that there is a very large proportion of low risk drinkers (110,315). Nonetheless there is a significant volume of increasing risk drinkers at 30,810 and 9,168 higher risk drinkers. Clients in treatment however is low at 645 compared to the proportion of potential need set out in these synthetic estimates.

Admission Episodes for Alcohol Attributable Conditions (previously NI 39)

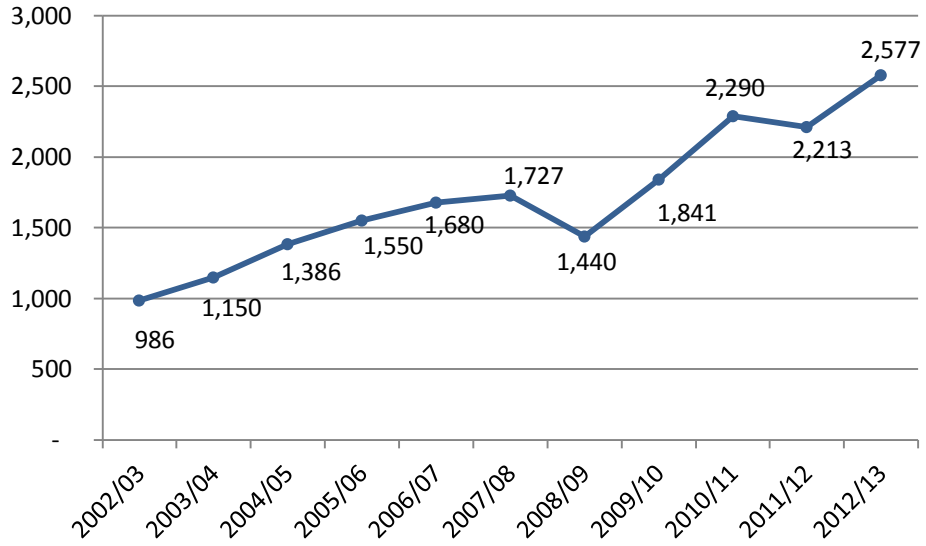
8.14 The rate of admission episodes for alcohol attributable conditions is measured per 100,000 population using Hospital Episode Statistics (HES). The rate of alcohol related admissions

are calculated using international best practice by the North West Public Health Observatory; it is calculated in several stages:

(1) Identification of hospital admissions with alcohol related diagnosis
(2) Estimating alcohol attributable admissions
(3) Standardised rate calculation.

8.15 The rate of admission episodes have increased nationally and regionally. The rates for Tower Hamlets have also followed a similar trajectory as set out in the chart below.

Chart 35: Tower Hamlets Admission Episodes for Alcohol Related Conditions (previously NI39) 2002 to 2013 *(Source: NWLPHO)*



Source: NWPHO

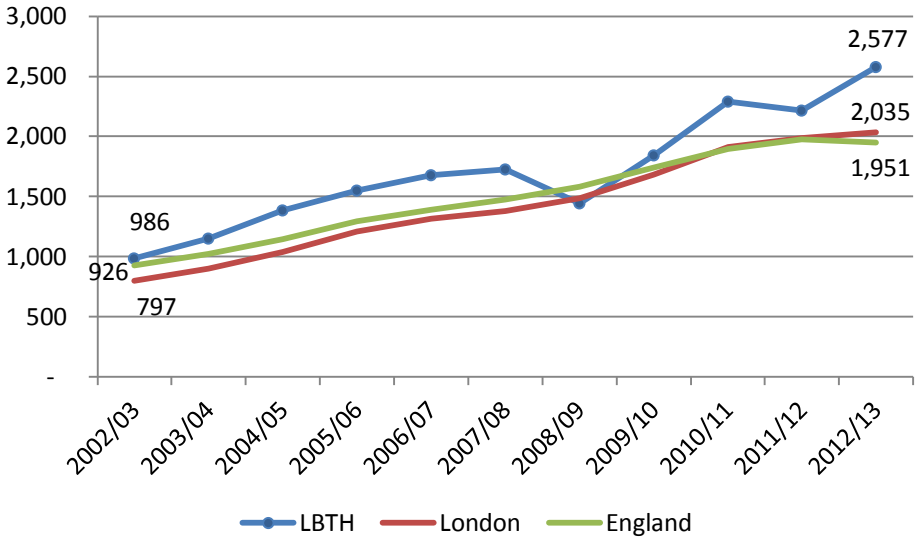
8.16 This shows the rate of alcohol attributable admission episodes have risen significantly since 2002. The last recorded rate in 2012/13 showed an increase to 2,577 alcohol attributable admissions, note, these figures also include others who have been admitted because of someone else's alcohol inebriation i.e. victims of RTAs

8.17 Looking more closely at the trends for alcohol attributable admission episode rates from 2002/03 to 2012/13 the following is evident:

- Tower Hamlets has fluctuated below and above the average rate of alcohol related admissions for London and England, but currently is significantly higher.
- The rates of alcohol related admissions have risen sharply since 2008/09 and now at the highest levels since 2002/03.
- What is abundantly clear is that there is a growing trend and this raises real concerns for the Borough's alcohol strategy.
- It should be noted that the volatility of change in percentages of admissions makes it harder to plan services. The basic trend line is however growing and this growth is consistent in the analysis of NWHPO data used for this needs assessment.

8.18 The chart below confirms that the Tower Hamlets rate of hospital admissions for alcohol has grown since 2003 as has been the case in London and England. However the Tower Hamlets rate is above that of London and England and has been consistently so since 2002/03 apart from 2008/09 when the rate dipped below that of London and England.

Chart 36: Standardised Hospital Admission Episodes for Alcohol Attributable Conditions (previously NI39) 2002 to 2013 LBTH, London and England *(Source: NWLPHO)*



8.19 It is important to consider the rates of hospital admissions for alcohol specific conditons and alcohol attributable conditions for males and famles in Tower Hamlets. Alcohol (for conditions that are wholly related to alcohol, for example liver disease or alcohol overdose) which for male and female admissions shows a general upward trend since 2006/7. The rate was calcuated at 590 per 100,000 admissions to hospital for males and 208 per 100,000 hospital admissions for females in 2010/11. The rates of alcohol attributable hospital admissions (alcohol sepcific plus conditions thate are caused by alcohol in some way, but not all cases, for example stomach cancer or unintentional injury). The rate for males was calculated at 1,859 per 100,000 and 916 per 100,000 in 2010/11. Both measue do not include attendance at A&E departments.

8.20 This shows a marked difference in the rate of male and female admissions, in both measures the rate is more than twice as prevelant in males than in females. The rate of admissions for males with alcohol specific and alcohol attribuatble conditions compare signifincaltly worse to the national avearge whilst the female rate of admissions in both alcohol specific and alcohol attributable shows not significant difference. Primary care data from the Tower Hamlets CCG was not covered in this needs assessment but would provide the detail and analysis to target interventions for alcohol related hospital admissions, in particular for men.

Chart 37: Recorded crime attributable to alcohol: Persons, all ages, crude rate per 1000 population *(Source: LAPE - NWLPHO)*

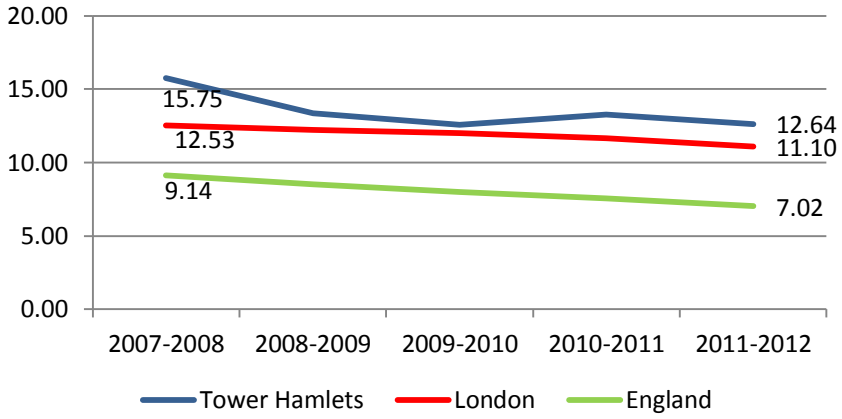


Chart 38: Violent crime attributable to alcohol: Persons, all ages, crude rate per 1000 population *(Source: LAPE - NWLPHO)*

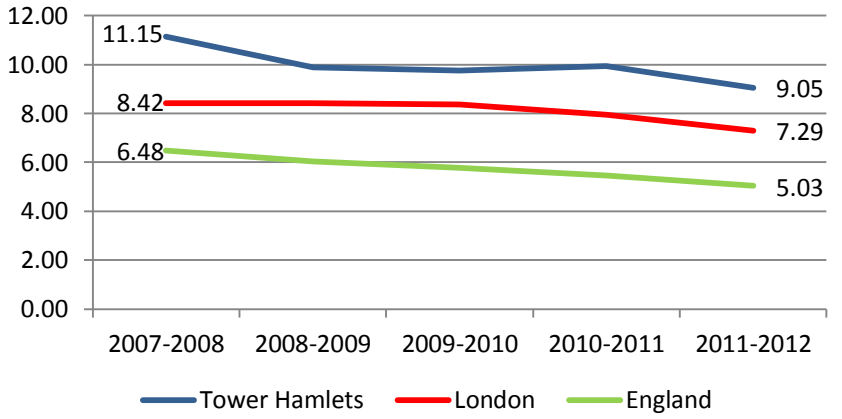
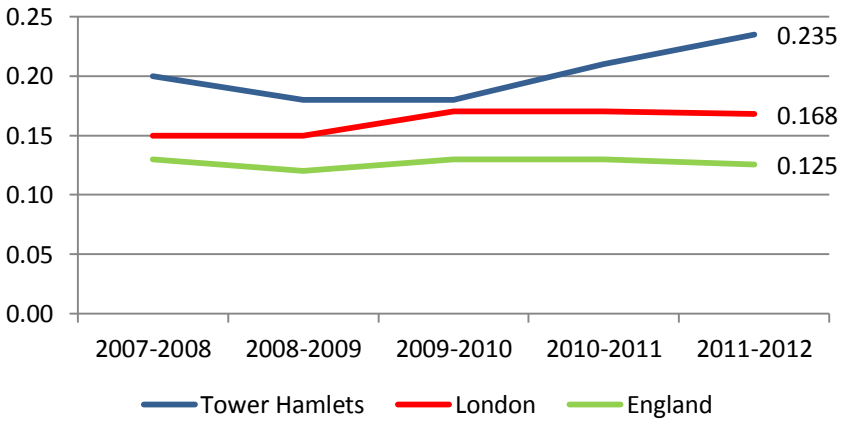


Chart 39: Sexual crime attributable to alcohol: Persons, all ages, crude rate per 1000 population *(Source: LAPE - NWLPHO)*



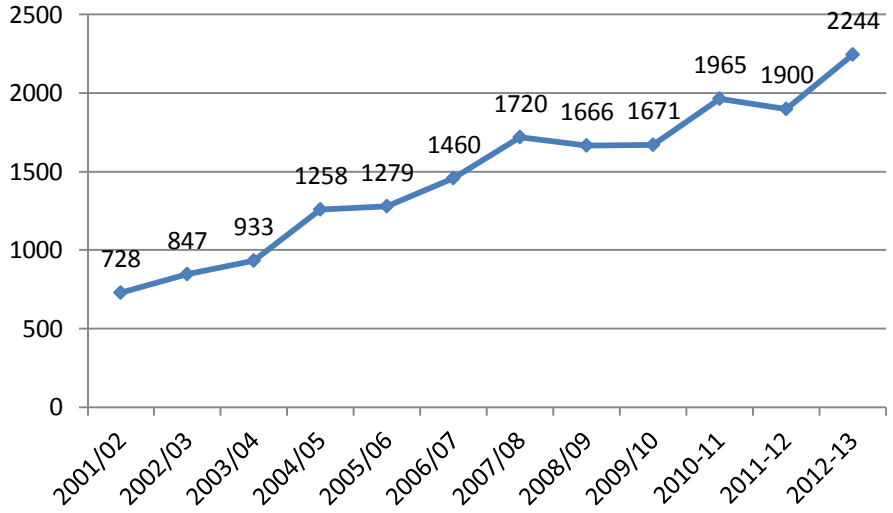
8.21 The three charts above show the calculated estimates for the crime attributable to alcohol: Persons all ages crude rate per 1000 population. These are estimated by the Local Alcohol

Profile for England developed by the North West Public Health Observatory. Interestingly Tower Hamlets has a higher rate of recorded crime attributable to alcohol, greater than London and England; although this is falling it did see a rise in the estimate in 2009/10. With respect to Violent Crime Tower Hamlets also has a higher rate than London and England and once again this figure is declining broadly in line with the London and England profiles. The rate for sexual crime attributed to Alcohol is however growing compared to London and England which are declining albeit very slowly. This is a concern but is likely to be affected by the club based night time economy emerging in the borough.

Tower Hamlets Ambulance Service Alcohol related Callouts

8.22 The following information has been collated from the London Ambulance Service for alcohol related callouts. The chart below shows the trend in the steady rise in alcohol related callouts to the London Ambulance Service in the last 12 years.

Chart 40: Tower Hamlets LAS Callouts 2001/02 to 2012/13 *(Source: London Ambulance Service Data)*



8.23 The LAS report for the period April 2012 to March 2013 shows there were 2,244 alcohol related callouts/incidents attended. The table below shows the gender profile of these calls and the two charts show where these callouts originated from and the age profile of callers.

Table 17: Gender of London Ambulance Alcohol Callouts: Tower Hamlets – 2012/13 *(Source: London Ambulance Service Data)*

Gender	Total	%
Male	1579	70.4%
Female	637	28.4%
Un recorded	28	1.2%
Total	2244	

Chart 41: London Ambulance Service Tower Hamlets Alcohol callouts: Ward 2012/13

(Source: London Ambulance Service Data)

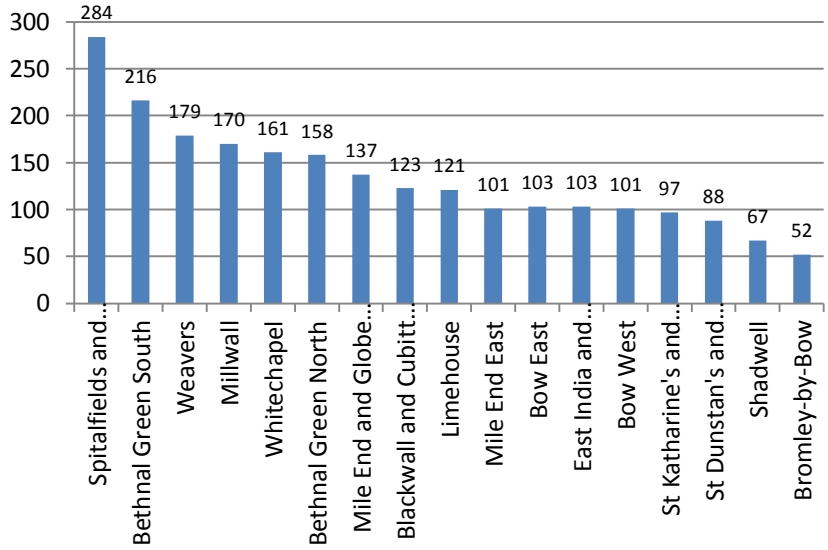
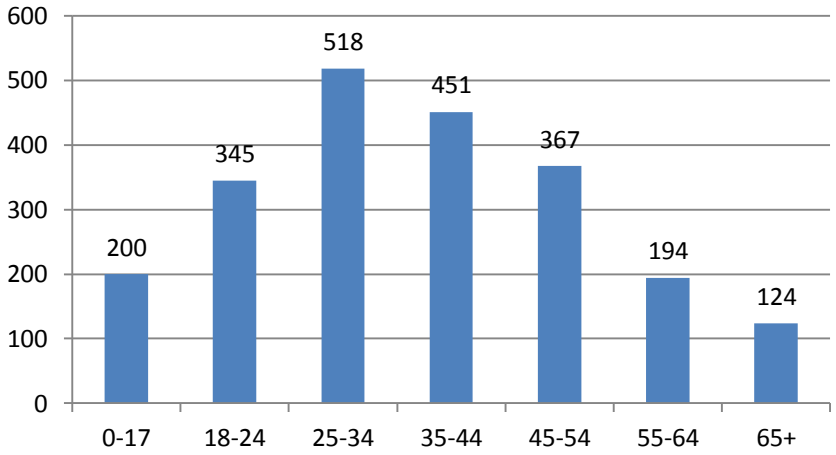


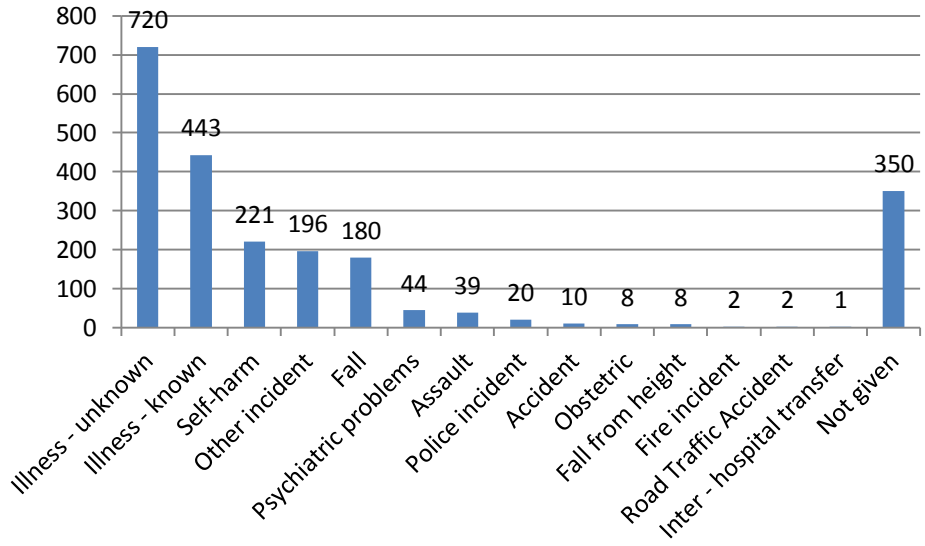
Chart 42: London Ambulance Services Tower Hamlets Alcohol callouts by age 2012/13

(Source: London Ambulance Service Data)



8.24 It is clear from this data in 2012/13 the highest number of callouts originated from Spitalfields and Banglatown, followed by Bethnal Green South. The age groups with the highest level callouts for an alcohol related cause were in the 25-34 age group, followed by the 35-44 and the 45-54 age group and the 18-24 age group.

Chart 43: London Ambulance Service Tower Hamlets Alcohol Call outs by type of incident 2012/13 *(Source: London Ambulance Service Data)*



8.25 Unlike drugs callouts the number of alcohol overdose call outs are far higher. Eighty-six percent of callouts resulted in patients being taken to the Royal London Hospital. 133 or 5% were Violent Assault descriptions.

Lack of clients moving into Treatment

8.26 The data we see in the tables above show an increasing trend in alcohol related admissions to Hospital and an increasing trend in alcohol related Ambulance callouts. This suggests a worsening set of presentations to the Health service. This also is compounded by the fact that there is a far lower proportion entering the treatment system and clearly this is a reflection of the treatment naive population in the Borough's high risk drinkers. Essentially there are problem drinkers in the borough that are not presenting to treatment and the overwhelmingly likely reason is that people do not believe they have a problem. Indeed this situation is consistent with other parts of the country where high risk drinkers simply do not feel they have an alcohol problem and they do not present for treatment until the problem becomes more serious for them, even life threatening.

8.27 This needs assessment focused on Tier 3 treatment data that was available through NATMS. Whist there is evidence that would suggest brief interventions that are set outside of the Tier 3 alcohol treatment system are likely to be most cost effective. This is currently being achieved through hospital A&E and the criminal justice settings. In Tower Hamlets the focus has been on seeking to address the numbers in treatment and should continue to maximise the potential and extend this provisions to a wider spectrum of settings including hostels, social services, primary care, hospitals etc.

8.28 Summary of Alcohol Needs Assessment data

- In 2012/13 there were 470 referrals into treatment, 738 in treatment (amongst providers), 70 transfers between agencies and 432 exits from the treatment system
- Female referrals to treatment are low in Tower Hamlets making up 22% (103) compared to 35% nationally

- Half (216) of the treatment exit outcomes resulted in clients successfully completing treatment, with 26% leaving alcohol free and 24% leaving as occasional users.
- Tower Hamlets there is a higher proportion of 'abstainers' compared to the England average, 28.6% and 16.5% respectively. For those 'lower risk drinkers', those at 'increasing risk of drinking' and 'higher risk drinking' Tower Hamlets has a similar profile to the England average. Tower Hamlets has half the proportion of 'binge drinkers' (10.9%) compared to the England average (20.1%)
- Alcohol admissions to the treatment system are growing in the borough.
- The rate of alcohol related admissions have increased nationally and regionally. The rates for Tower Hamlets have also followed a similar trajectory rising in 2012/13 to 2,577.
- Tower Hamlets has fluctuated below and above the average rate of alcohol related admissions for London and England, but currently is significantly higher.
- The rates of alcohol related admissions have risen sharply since 2008/09 and are at the highest levels since 2002/03.
- Tower Hamlets has a higher rate of recorded crime attributable to alcohol, greater than London and England; although this is falling it did see a rise in the estimate
- Violent Crime rates in Tower Hamlets are higher than London and England and once again this figure is declining broadly in line with the London and England profiles
- Sexual crime attributed to Alcohol is however growing compared to London and England which are declining albeit very slowly. This is a concern but is likely to be affected by the club based night time economy emerging in the borough
- Between April 2012 and March 2013 there were 2,244 alcohol related London Ambulance Service callouts/incidents attended
- High risk drinkers still present a significant concern for the borough and the increasing volume of increasing risk drinkers should alert services to a potentially growing problem.

9 Service User and Stakeholder Engagement 2013

9.1 This section summarises the findings of a range of primary research activities completed as part of this needs assessment. This included:

- Service User Questionnaire
- Stakeholder interviews
- Focus Groups
- Partnership Workshop on 17th December

Service User Questionnaire

9.2 In total 300 questionnaires were distributed as part of this exercise and 200 were returned which represents just over 67% of the sample. Indeed based on the number of clients in treatment in 2012/13 (2,154) 200 returns represents 9.2% of the total treatment population.

Survey respondents' profile

9.3 The profile of respondents showed that 73.2% were male, 26.8% female; the age profile was spread relatively evenly with 3.5% (18-24), 37.2% (25-23), 34.3% (35-44), 18% (45-54) and 6.4% (55-64). 18.8% stated they had a disability, of which 64.2% stated mental ill health. The ethnic profile of respondents showed 44.2% White British, 24.4% Bangladeshi and 11% White other. 44.8% were Christian and 26.4% Muslim and 17.2% no religion. 89.5% were heterosexual, 3% were pregnant or within 26 weeks of having given birth, 79% were neither married nor in a civil partnership.

Substance misuse

9.4 The substances used by those responding to the survey were:

- Opiate and Crack users (78%),
- Alcohol users (39%),
- Cannabis (19%),
- Cocaine (8%)
- Diazepam (5%),
- Amphetamines (3%)

9.5 Respondent's current treatment duration was:

- Less than a month (22%),
- More than a month and less than 6 months (19%),
- Between 6 months and a year (16%),
- Between 1 and 2 years (13%),
- Over two and less than 4 years (13%)
- and over 4 years (17%).

9.6 Question Three shows the referral source for each client in the survey. The high level of self-referrals, 43.1% is in line with the NDTMS data, followed by Drugs services with 22.7% and GPs with 18.2%. The table below shows the breakdown of all referral sources.

Table 18: Q3. How were you referred into treatment?

How were you referred for treatment?		
Answer Options	**Response Percent**	**Response Count**
Self-Referral	43.1%	78
GP	18.2%	33
Drug Services	22.7%	41
Arrest Referral (DIP)	6.6%	12
Probation	6.6%	12
CARAT	0.0%	0
Other Health Services	7.2%	13
Other Criminal Justice Services	1.7%	3
Other	7.2%	13

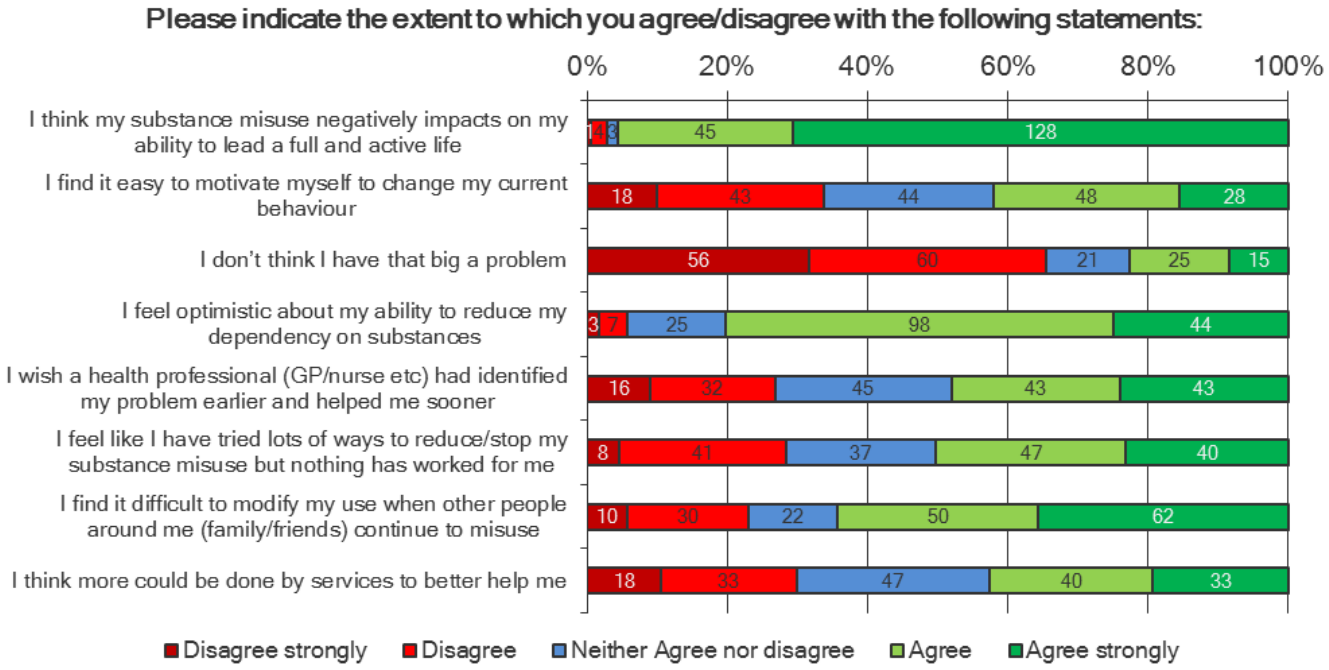
9.7 Question Four identified the respondent's treatment provider.

- 32.6% were with CDT
- 16.3% with Health E1
- 12.5% from SAU
- 12% NAFAS
- 10.3% ISIS
- 9.2% IDP and
- 6% THCAT

9.8 Reasons for seeking treatment were defined in the survey and responses to these definitions were:

- 74% to improve my health
- 62% to enjoy more the company of my family/children/friends
- 46% to help the chances of living longer
- 46% to reduce the stress it causes on my family/partner/children
- 37% to improve my ability to work
- 30% to stop getting into trouble with the police
- 25% to gain more money

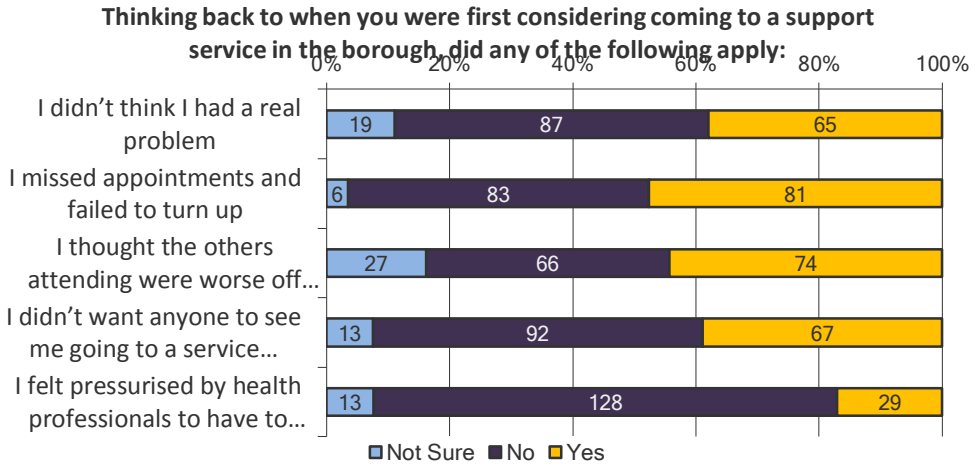
Chart 44: Q6. Please indicate the extent to which you agree or disagree with the following statements



9.9 The highest levels of agreement (96%) came from the statements 'I think my substance misuse negatively impacts on my ability to lead a full and active life' and 78% from 'I feel optimistic about my ability to reduce my dependency on substances'. The highest levels of disagreement came from the statements 'I don't think I have that big a problem' with 64% disagreeing, and 'I find it easy to motivate myself to change my current behaviour' with 34% disagreement.

9.10 Question Seven gave respondents the chance to think back to when they entered treatment to see if any of the following applied.

Chart 45: Q7. Thinking back to when you first considering coming to a support service in the borough, did any of the following apply:



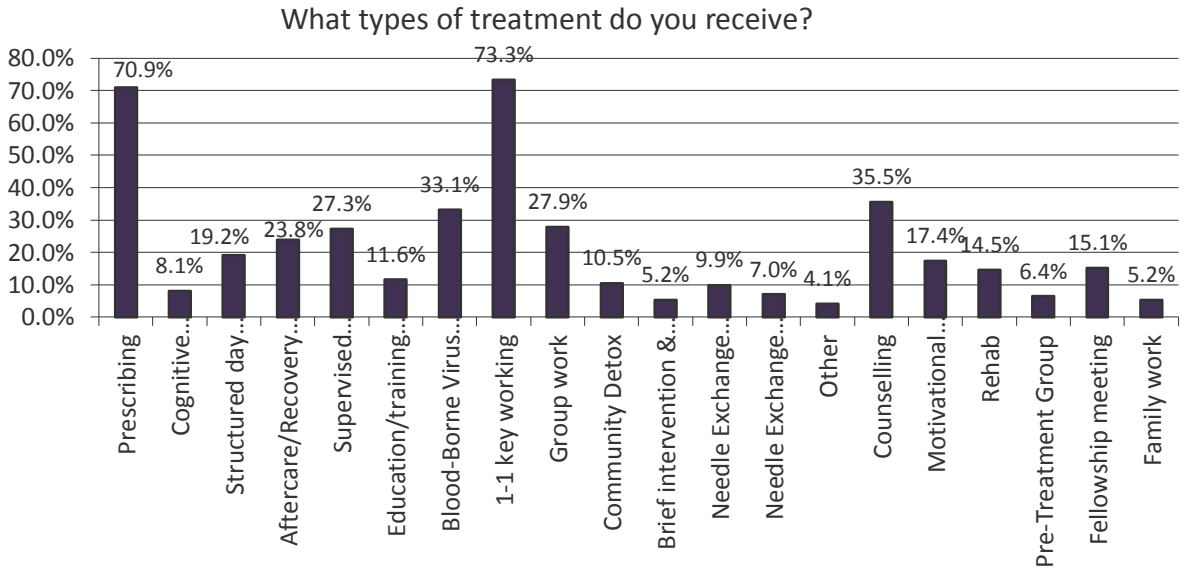
9.11 In all questions there was a majority who felt these things did not apply to them. Indeed there were similar responses to the first four statements. Interestingly only 17% felt they were pressurised by health professionals to have to come.

9.12 Section Three of the survey sought to identify the use of care/recovery planning to support clients in their treatment journeys. The following responses were received:

- 74.9% of respondents have a care/recovery plan, 14.0% did not and 11.2% were not sure.
- 80.6% (100) who said they had a care plan said they completed their care/recovery plan jointly with their key worker, 6.5% (8) said no and 12.9% (15) were not sure.
- 42.2% have a copy of their care plan, 42.97% do not and 14.9% were unsure.
- 59.6% said their care/recovery plan has been reviewed in the last 3 months, 23.7% said it hadn't and 17.1% were unsure.
- 70.7% said their care/recovery plan had positively contributed to their treatment, 8.7% that it hadn't and 20.7% were unsure. Some respondents were keen to state that their care/recovery plan provided focus, offers goals and helps record achievement and progression.
- 66.9% said they had been given choices about treatment options available to them in the borough, 18.3% said they had not and 14.8% were unsure.

9.13 Question Fourteen asked clients what services they currently receive from a menu of provision

Chart 46: What types of treatment have you received



9.14 71.8% stated their current or most recent treatment was good, 25.4% average and 2.8% said it was poor.

9.15 85.8% stated their relationship with their provider was good, 11.9% average and 2.3% poor. This is a very positive result for all providers.

9.16 85.4% stated their treatment provider's skills and abilities in interpreting their needs was good, 14.6% average, and none stated they were poor. 166 of the respondents took the time to make a statement in support of their workers, key workers and case workers.

9.17 82.5% rated their treatment provider's support for them as good, 15.8% stated they were average and 1.8% stated they were poor.

9.18 79.2% stated their treatment experience has helped to change their drug and or alcohol use, 8.7% stated it had not and 12.1% stated not really.

9.19 33.1% stated they had had access to after care services such as support for education, training and employment, 51.7% stated they had not and 15.1% were unsure.

9.20 41.6% stated that they had benefitted from after care services, 26.2% stated they had not and 32.2% stated they were not sure.

9.21 21.7% stated there were other services that would benefit their treatment currently not provided by the borough, 32.1% stated they were not and 46.3% were unsure.

Survey findings

9.22 Essentially the survey has provided a strong set of returns confirming the general support clients have for the way services are run. Service Users that responded are supportive of current treatment providers; indeed supporting their providers in this way shows a positive relationship and commitment to working on this relationship. Several respondents were engaged with multiple providers at any one time reflecting the local treatment system structure and highlights difficulty ensuring effective and sequenced treatment inputs. From a presentation perspective the high level of alcohol use also describes the volume of alcohol drinking in association with other substances.

9.23 The key reasons for accessing treatment concerned health and relationships – which reflect personal issues rather than semi-coerced/coerced referral mechanisms (more focus could be placed on increasing coerced referral mechanisms via the CJS rather than a high reliance on self-motivation and self-referral processes – this also highlights a potential skill deficits of drug workers in not being able to engage more difficult and unmotivated clients)

9.24 Most respondents reported a number of issues (e.g. missing service appointments, not perceiving themselves as having a substance misuse problem and concern over knowing other service users) which hindered their engagement with services following initial referral. This suggests a treatment system with rigid procedures, poor assessments and initial service engagement and poor internal communications between providers.

9.25 A quarter (25%) of respondents were not aware that they had care/recovery plan in place and over half (57%) did not have a copy. Care/recovery plan reviews were reported as infrequent (40%) and a third (33%) not fully aware of all the treatment choices available in the borough. Just over a quarter (28%) of respondents reported their treatment as

average or poor – despite most (86%) considering themselves as having a good relationship with their provider.

9.26 Two-thirds (67%) of respondents reported having no access to aftercare with just over a fifth (22%) with limited or no knowledge of recovery services. This may reflect the different positions clients are within the treatment system. Equally this suggests that service users are not clear about alternative options for treatment and/or alternative provision. Some felt there needed to be better after care, employment support, community and in patient detox in the borough, alternative therapies, Counselling, Rehab, Housing, life skills employment and training, one to one buddy systems and mentor schemes. There was a predominance of references to detox which for many seems to be their favoured solution.

9.27 In proposing areas for improvement clients recommended the importance of after care, 'out of and after hours' services and better cross partnership service access across the borough. Moreover clients identified the need across the system for greater levels of counselling, psychosocial therapies, alternative therapies, and better information and communication about what's available.

Stakeholder interviews -Key findings

9.28 A range of findings emerged through the interviews to support this needs assessment. It is clear that they are important issues for those interviewed and to this end the key finding have been clustered below:

Strategic considerations

- There is a general sense that the borough's drugs and alcohol work lacks holistic planning and that it has evolved over time and is not now fit for purpose
- Concerns that there are low levels of Tier 1 and 2 activity commissioned
- Heavy operational focus on opiates, low level of non-opiate engagement, but high complexity clients in deprived and challenging environment
- Several felt that services and activities currently feel fragmented, with a lack of effective coordination, awareness and often poor communications and information and no true sense of partnership
- Lack of effective cross partnership communication,
- An overwhelming positive commitment to change but a clear realisation amongst providers and stakeholders that whilst this will be opportunistic for the treatment system it is more likely to be a threat to them.
- Commitment to better support drugs and alcohol treatment provision and to widen local referrals which many felt were in need of reinvigorating

Inter-agency working

- The partnership has a strong guiding aim to support the health and mental well-being of the clients both through and at the end of their care process
- Real local problems associated with training, education and employment
- Desperate need for supported housing for drugs and alcohol service users.

Operational issues

- Whilst policies and procedures are in place there remains a lot of confusion in the way to transfer clients from service to service
- Volume of providers creates a situation where clients are held onto and transferred haphazardly, too many providers leading to duplication, lack of mutual value, some interagency miss-trust
- Clients are often not treatment ready particularly with respect to detox and rehab
- Clients place low levels of value on the treatment they receive
- Providers feel that some of their counterparts are not able to deal with clients and hence they are reluctant to transfer
- Critical need to address the 'disjointedness' of treatment provision and to consolidate a clear understanding of what everyone is doing.

Information management

- Performance management is reliant on the Mi-Case system. Many providers are dissatisfied with this system in terms of its design and utilisation.
- The DAAT needs information management systems that are trusted and reported accurately
- There needs to be better clarity for providers over the reporting mechanisms of the DAAT in particular the use of Mi-Case and its transfer of data to NDTMS
- Managing the wide range of partnership inputs is critical to the support of the achievement of the partnership

Aftercare and recovery

- Extremely low levels of recovery skills and capital amongst treatment clients.
- Real concerns over access to housing, social services and other main service providers that could help and support client recovery
- Low levels of recovery focus and priority action for the treatment system, pockets of good practice although these are often not shared

Focus groups - Summary Findings

9.29 This summary provides an overview of the findings drawn from across the four focus groups completed in December 2013, with female clients from ISIS, Opiate, Alcohol and Non-opiate clients. The insights from these participants have been analysed and structured around 10 core thematic areas.

Prevalence

9.30 Everyone who participated felt strongly that substance misuse is a common part of life for many people living in Tower Hamlets. The area is seen to have more people using drugs and alcohol, and for them to be more freely available, and accepted, than in other locations. This is felt to because Tower Hamlets is a deprived place with high density, poor quality housing stock, many long-term unemployed and a transient population. Alcohol misuse is reported to happen openly on the streets across the Borough, including amongst young people who are obviously under-aged. Several people reported that there is a wide range of drugs available, and that they are priced more cheaply than elsewhere, reflecting their poor quality. The perception is that the drugs market is controlled by local dealers.

Awareness and signposting of services

9.31 The participants generally felt that awareness of services is low amongst the population and that the availability of a range of treatment options is only known once people have already 'entered' the system. There is a strong desire for much greater promotion of services to take place across the Borough, with specific suggestions that GP surgeries, pharmacies, schools, churches and mosques, libraries and other public places should advertise the services. It was suggested that key professionals and community leaders should be provided with training to ensure what options there are and what signposting is appropriate.

9.32 It was proposed that it would be clearer to have a single name for all services and if there was a single 'entry' point and central telephone number that could signpost people to the relevant specific service.

9.33 Those participants, who had experienced a range of different services, often stretching back many years, showed greater understanding of provision and were knowledgeable about where different services are based and what they offer. The majority of participants were only aware of the service with whom they were in contact and perhaps one other.

9.34 Participants noted that it seems to be difficult to attract younger people to use services and they feel that this may be because they are both at a different stage in their addiction journey (and therefore less weary of its consequences) but also that they are potentially less aware of what is available generically and specifically for their age category.

9.35 The use of acronyms as the names of services was seen to be a barrier to people recognising and understanding what help was available.

9.36 There is recognition that substance misuse is less acceptable, and openly discussed and addressed amongst the Bangladeshi community that awareness amongst this community is

likely to be much lower. There is a concern that this will impact on help seeking behaviour from this community.

Public attitudes

9.37 Participants feel that because of their substance misuse that the general public, and even the medical professionals that they encounter at GP surgeries and at the hospitals, judge them and in some cases treat them with contempt. Participants feel that addictions are poorly understood and because of perceptions of self-responsibility and blame that they are seen to be undeserving of help and support.

9.38 The Bangladeshi and other BME communities are seen to have much greater levels of stigma and shame associated with substance misuse. This is seen as a worrisome barrier to people being able to seek help and support. There were no apparent issues with participants having preconceptions about drug and alcohol services, and it was not reported that some were more or less suitable for BMEs. The exception is ISIS that is widely seen to be for women with substance misuse who are sex workers.

Integrated approach

9.39 Participants talked emphatically about the challenge of modifying their drug and alcohol behaviour when they also had to manage poor quality and unstable housing tenures and the absence of employment and training opportunities. A more integrated service that also seeks to address a wider range of life challenges would be welcomed. In the absence of closer co-ordination, and access to housing support and training and employment opportunities it is felt that their outcomes are likely to continue to be limited.

Treatment

9.40 People generally report having a mixed experience of treatment. Whilst some were positive about their experience, the majority were more critical, with concerns that services fall short of helping them to achieve their goals. Several participants pointed out that they know people, often including themselves, who have been through treatment numerous times with limited success. As a consequence, there is a general concern that treatment services aren't working as effectively as they could be to help people change their behaviour.

9.41 However, people also recognised their own agency and responsibility, and are aware that they are very complex and deep-rooted problems that the services are needing to address.

9.42 Concerns about treatment 'success' are greatest for the CDT and ISIS group participants, who have a particular worry about high on-going use of methadone. The THCAT group were more positive about treatment being successful and as the NAFAS group had more first-timers they were more hopeful about its impact as they waited to see what outcomes they would achieve.

9.43 There were mixed experiences about Key Workers, with some reporting very positive relationships, whilst others felt more ambivalent, or critical about the staff they knew. Participants recognise that it can come down to chemistry and be subjective, but there

were concerns about whether there were appropriate professional standards and training provided to ensure consistent high quality provision.

9.44 A couple of participants would like to see treatment cater for substance misusing couples so that can have mutually supportive packages of care. For them, the involvement of a loved-one was seen to be critical to their long-term success.

9.45 A couple of participants also requested help be made available for wives/partners/mums who act as principal carers. It is felt that if they received training about addiction and understood the care pathways that they could further enhance their positive supporting role.

Recovery focus

9.46 Each focus group discussed their ultimate behaviour goal, and all stated they wanted to achieve abstinence. However, there is some doubt about whether this is the focus of services. Several feel that there is too great a focus on harm-minimisation rather than a genuine commitment and structuring of services to achieving a total recovery.

9.47 The strongest frustration and disappointment is amongst the opiate-using participants. With many having been maintained on their current dose of methadone for years, they express their dissatisfaction that they are not receiving greater support to achieve abstinence. Several reported that their Key Workers are rarely proactive about taking action to further reduce their dependencies.

9.48 It was felt that by regularly reviewing goals, and being actively involved in their own care planning that a greater focus on recovery could be achieved.

After care

9.49 Many people stated that successful longer-term outcomes are limited because of the absence of appropriate after-care once a formal treatment programme has ended. Current programmes are seen to stop too suddenly and have restrictive conditions which they feel makes them unable to be flexible to the on-going needs of the individual. There was strong support for after-care being available for as long as the individual deemed it to be necessary. For some this was seen to perhaps only be for a transitional phase, and for others this may require it to be available for years. The reassurance of help being available if it was needed was often the 'safety-net' that people were looking for. It was suggested that the after-care provision needs to include support after-hours and at weekends.

Patient centred care

9.50 Amongst some, there is concern about the extent to which the current treatment service is set up to put clients at the centre of the design and delivery of support. Not many people report feeling that they are listened to, and that they believe they are receiving a service that has been designed to be relevant and suitable to meet their needs. Instead, people feel that the service is delivered according to what the 'textbooks' say rather than close analysis of their individual story. Fewer than half were aware of their care plans, and several reported that they had not been involved in their planning. Participants feel that services need more work to feel as though they have patients at the centre. The THCAT

service users were more positive about the extent to which the service was responsive and centred around their needs.

Shared care with GPs

9.51 Across the four groups participants do not see GPs are being part of their care team and there is concern about the quality of care received by GPs. Few participants feel they have a supportive relationship with their GP. Many feel instead that their behaviour is judged and that as a consequence their wider health needs are not being met. For opiate users there is also general confusion about what, if any, role the GP should be having in their treatment.

Peer involvement

9.52 There is universal support for the involvement of peers in the delivery of treatment services and after-care. It is felt that the peers offer a unique perspective given their familiarity with what it is like to live with substance misuse. Many people make suggestions as to how peers could offer greater help and support, including for example by acting as chaperones to appointments, by paying informal house visits, by providing after-hours support and by being available on the telephone.

Productive / diversion activities

9.53 Participants feel that their chances of successful treatment would be raised if they were provided with the opportunity to participate in a range of 'normalising' activities to help them to rebuild positive relationships with other people and with their local community. Across the groups many spoke about the isolating impact of being a substance misusers and the fact that it had left them with little confidence to participate in 'ordinary' day to day pursuits such as visiting a library, or sitting in a café. It was suggested that there be a companion programme, which could be undertaken by peer workers, whereby they are taken out to gain the confidence to undertake routine tasks.

Housing and employment

9.54 It is felt there is an important need for treatment services to co-ordinate more closely with housing to ensure that service users are being provided with the best opportunities to successfully complete their treatment, obtain and maintain recovery. The current system is seen to work against the attainment of successful outcomes because service users are regularly housed in hostels with substance misuse is prolific, or returned to their homes amidst old negative acquaintances.

9.55 Many participants are eager to gain employment as they see this as a vital component of having more normalised lives. They would like greater support to acquire work and more opportunities to undertake training. It is seen to be especially difficult for those with a criminal record to otherwise have any work prospects.

9.56 In summary these focus group insights are helpful in gaining a user perspective on the local treatment system. Whilst care should be taken generalising the findings to reflect the views of the whole drug and alcohol using local population, these responses have enabled a better picture of the views of local service users.

Partnership Workshop Findings 17th December 2013

9.57 At the Partnership Workshop held on 17th December, participants from across the treatment system were broken into three groups addressing Shared Care, day programmes/services and DIP and Criminal Justice. Each of these groups were asked to discuss three simple questions, what works well, what doesn't work well and what can be improved. The points raised below are from the group discussions by the participants at the workshop, are set out in the table below.

Question	Shared Care	Day Programmes /Services	DIP/Criminal Justice Clients
What works well	• Patients have regular contact with primary care. • Normalisation of drug treatment – some patients only need attend primary care to see satellite worker and for prescribing, i.e. don't need to go to a place labelled a "drug treatment service".	• Access to individual programme dependent on need – interventions, days, times that are flexible. • Wide range of options. • Services offering range of courses that can build upon recovery capital and support ETE • Abstinence focused activities • Clients are able to access programmes / an activity at other services is good as it may facilitate engagement at other services in borough rather than clients being resistant to transfer. • Wrap around satellite services such as Nacro provide practical support. This is an advantage that this is available in commissioned services. • External satellite provision in drug services – facilitates engagement. Sharing expertise • Tier 4 panel & treatment preparation Group – accessible, demonstrates effective joint working. • Peer supporters in services – inspirational for clients. Positive role models. • Multi- agency approach – Drug/alcohol services working jointly with CSC as an example – Family approach	• Prison release work via DIP – indicated by the increasing number of referrals to the treatment system from DIP directly and via DRR. • Good liaison work between DIP and the rest of the Treatment System which was considered to have improved in the last couple of years. • Changes Group and the referrals into the Treatment System and the extension of involvement with Drug Using Offenders (DUOs) • The identification of Domestic Violence and Hidden Harm via the CJS and processing via DIP. • Probation's influence on client housing needs and access to HOST and allocated housing workers and hostel places. • High positive drug test rates and number of new DIP referrals that start treatment.
What doesn't work well	• No one seems to know or agree what Shared Care means. • Seems ok for some patients, especially those with satellite clinics in GP practices, but other patients have to go to CDT, then go to GP for a prescription. Others don't (because they get	• Services focus on their individual targets / need rather than focusing on partnership • Confusion about pathways in borough. Key workers/clients unfamiliar about range of services within Tower Hamlets and what each service can offer. This contributes to inappropriate referrals and delays to accessing treatment	• No Needle Exchange based at the DIP – not all levers in place to assist engaging DUOs into more structured treatment. • Prison Exit Team generate a high number of unsuccessful referrals as clients are believed to be 'prepared' to say what is required to access Harbour Recovery Centre (HRC).

Question	Shared Care	Day Programmes /Services	DIP/Criminal Justice Clients
	prescribed at ISIs/CDT/DIP).	• Minimal multi- agency work. Agencies should collaborate more to support client need • Minimal joint care plans between agencies. • Joint work between drug/ alcohol agencies and CSCX could be improved • Qualitative work not recognised	• Low levels of ATRs and DRRs being processed by the Courts resulting in low treatment take up. • Low levels of probation referrals into the Treatment system with DRRs and ATRs considered only one aspect of probation work. Wide acknowledgement that much more could be done by probation in identifying DUOs who could benefit from referral to structured treatment services. • Poor referral levels of non-dependent users into the treatment system. • Use of Tier 4 services inadequate for those receiving DRRs. • Poor levels of support provided by DIP prior to treatment take up. Seen as key to generating positive/successful outcomes. • DIP clients are not treated the same as non-DIP clients and are not fully integrated. • Access to prescribing is not adequate for DIP clients
How could it be improved for the patients/clients	• CDT/Shared Care to do alcohol as well as drugs. • Integration of a dual diagnosis function within CDT/Shared Care. • Improved access to one-off specialist opinions from, e.g. SAU. • Make best use of the community assets available. • GPs happy to do whatever they are commissioned to do – if needs not being met by current arrangements, commission it differently.	• Integrated drug / alcohol services • Improved joint working /satellite provision within services • Borough wide induction available to all frontline staff • Services need to "unpick" and review current delivery and consider new approaches/ joint working / targeting and promotion • Single access point for assessment • Pathway reviews	• Introduce bail conditions (e.g. Caution Plus Scheme) for non-dependent DUOs following arrest. • Ensure that DUOs who receive Tier 4 interventions are better supervised and those who drop out or have unplanned exits are returned to court for sentencing • Prison Release Team needs to be more joined up with community based services prior to prisoner release (e.g. prescribing and housing) for those not on license. • Referral of DUOs needs to be better sequenced via improved assessments and therefore referral to the HRC should only follow once offenders have engaged with community based services and not vice-versa.

Question	Shared Care	Day Programmes /Services	DIP/Criminal Justice Clients
			• Develop wraparound services for DUOs to improve engagement in structured treatment services. • Understanding of the roles and responsibilities of the whole treatment system, including the role DIP plays • A comprehensive reporting system that captures and demonstrates the work of the DIP team with clients prior to treatment and through treatment, as DIP does not report on NDTMS

Summary

9.58 The findings from these pieces of primary research have been used to support this needs assessment and they have, in particular, been used to influence some of the points raised in section 13, 14 and in the recommendations to this needs assessment.

10 Partnership Performance

10.1 This section sets out the drug treatment profile, harm minimisation and the overall trend in the partnership performance of Tower Hamlets, and to assess how well the partnership is fulfilling the recovery agenda in terms of treatment outcomes as well as the effective engagement of clients in treatment.

Drug Treatment Profile

10.2 The treatment profile data is taken from the quarter 4, 2012/13 Partnership Green Report, this data is aggregated up from partnership figures uploaded to NDTMS and therefore may differ from figures used elsewhere in this report.

Gender, Age and Ethnicity

10.3 In 2012/13 there were 1694 adults in drug treatment, of this 332 (20%) were female clients and 1362 (80%) male clients. The female population is under-represented in treatment and lower than the London average (26%) national average (28%). Almost half of the clients in treatment during 2012/13 were aged 30-39. Compared to the Tower Hamlets population aged 18 to 65 (Census 2011) clients in the 20-24 and 25-29 age group are the most under re-presented in treatment whilst those in the age groups ranging from 30 to 49 are significantly over-represented. There are around twice the number of 35-39 and 40-44 year olds in the treatment population compared to the total population of Tower Hamlets. The majority 43% of clients in treatment were White British, higher than the total population of 31%. Thirty percent were Bangladeshi which is similar to the total population.

Drug Use

10.4 Of the 1694 clients in treatment 83% were using a second drug and 59% were using a third drug. NDTMS allows up to three drugs to be recorded in a single treatment episode, it is possible that clients are using other substances as well. A significant 81% of treatment population is made up of primary opiate users. Crack was being used by the majority as a secondary drug (66%). Cannabis and Alcohol use as secondary or third drug was also prevalent.

Harm Reduction

10.5 Harm reduction in Tower Hamlets is co-ordinated through the SAU Blood Borne Virus (BBV) team and covers the majority of treatment services with the exception of alcohol treatment services and those clients in shared care. The team also address the wider complex physical health needs of clients in drug treatment. In tower Hamlets the BBV team have established referral pathways into all three Hospitals. Clients are tested and where diagnosed clients are treated for sexually transmitted diseases. Joint HIV clinic are held with the Royal London Hospital.

Injecting Status

10.6 Performance data taken from the quarter 2, 2012/13 DOMES Report shows in the first 6 months of 2013/14 there were 411 clients with an injecting drug use status. Of this 11% were injecting at the time of starting treatment and 17% had a history of previously injecting drug use.

Hepatitis B

10.7 The provision of Hepatitis B vaccinations in Tower Hamlets seems to have a good converge. In the first six months of 2013/14 there were 301 clients eligible for Hepatitis B vaccinations. The percentage of clients offered and accepting an intervention is slightly lower compared to the national average, 41.5% in Tower Hamlets compared to 43.9% nationally. Within this group a significantly higher proportion started (38.4%) and completed (44.8%) a course compared to the national average (18.8% and 15.5% respectively). Where clients are diagnosed with Hepatitis B to stop the spread of infection the BBV team extend their testing and treatment to partners and children.

Hepatitis C

10.8 Every client who has been recorded as either currently or previously injecting should be assessed to see whether they should be offered a Hepatitis C test. In the first 6 month of 2013/14 there were 679 eligible clients of this 91% received a HCV test, significantly higher compared to 73% nationally. Nationally the uptake of Hepatitis C treatment is low at around 3%, in Tower Hamlets the uptake of treatment is 10%[4]. In Tower Hamlets all clients that test positive are routinely screened, high risk group clients are routinely screened every 6 months.

Client Complexity

10.9 Clients usually present to treatment with various needs in addition to treatment for substance misuse. Clients are grouped into levels of complexity based on needs, including their employment and housing status, their physical and psychological health, all of which will significantly affect their chances of successfully completing treatment. In Tower Hamlets one in four clients in treatment (opiate and non-opiate) have very high complex needs (442), this is almost twice as many very high complex need clients compared to the national average (14%). At the other end of the spectrum of complexity, Tower Hamlets has a 9% very low complex need clients (155), lower compared to 16% nationally. In Tower Hamlets very high complex need clients have a 6% completion rate, which is slightly above national completion rate of 5%. Clients with very low complexities have more recovery capital, however the rate of successful completions are worse at 34% compared to 53% nationally. There seems to be room here for LBTH to increase their lower complexity successful completions, after all they seem to be better compared to the national average in addressing high complexity clients. This would be critical in increasing successful completions overall.

Comparisons with Cluster Model

10.10 DAAT partnerships across England have been clustered according to complexity and fall into one of five groups for both opiate and non-opiate clients in treatment, clusters range from A to E, with A representing the least complex treatment populations and E the most complex. Tower Hamlets opiate treatment population falls into cluster E and non-opiate treatment population into cluster D.

10.11 There are 30 local authority partnerships that fall into opiate cluster E. In the September 2013 reporting period the number of opiate drug users in cluster E ranged from 1,000 to

[4] Data provided by Tower Hamlets BBV Team

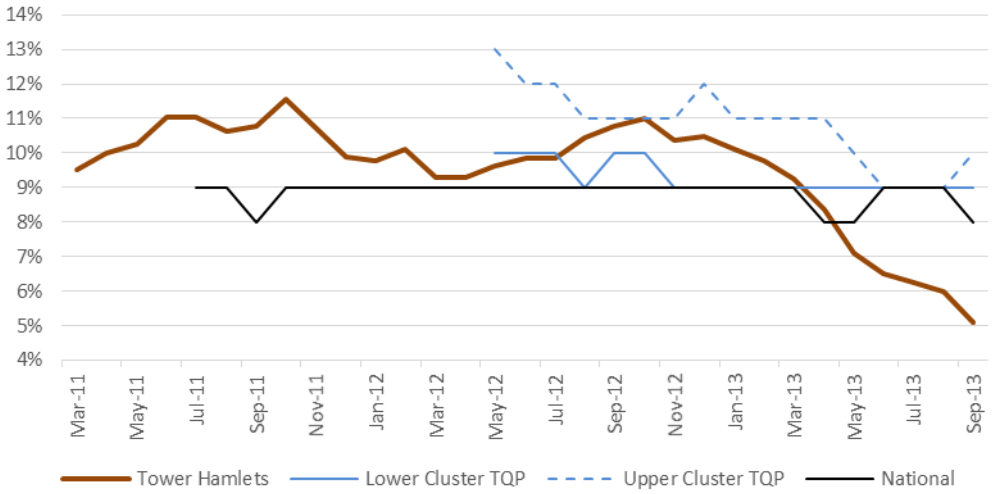
5,144 with an average of 1,831. Tower Hamlets has 1,456 which is below cluster average and places Tower Hamlets mid-table for the size of its opiate drug using population in treatment. Non-opiate cluster D has 35 partnerships and treatment populations range from 1,565 to 118, with an average of 437. Tower Hamlets has 224 which is below cluster average and ranks Tower Hamlets 8th lowest for the size of its non-opiate drug using population in treatment.

10.12 The change in the size of the opiate treatment population from 2012/13 baseline to September 2013 in Tower Hamlets has seen since 2012/13 a 2% reduction in the size of its opiate treatment population and a 7% growth in its non-opiate treatment population.

Successful Completions

10.13 Clients that leave the treatment system drug free or occasional drug users are recorded as successful completions. The number of successful completions achieved amongst cluster E partnerships range from 426 to 52. Tower Hamlets has seen a significant reduction in the number of successful completions since October 2012. In the past six months there have been 46% less clients successfully completing treatment (138, 2012/13 baseline and 74, September 2013). This set against a 2% decline in the number of opiate clients in treatment means the impact is more significant on the measure of successful completions as a proportion of the numbers in treatment, which currently stands at 5.1%, compared to 9.3% in 2012/13.

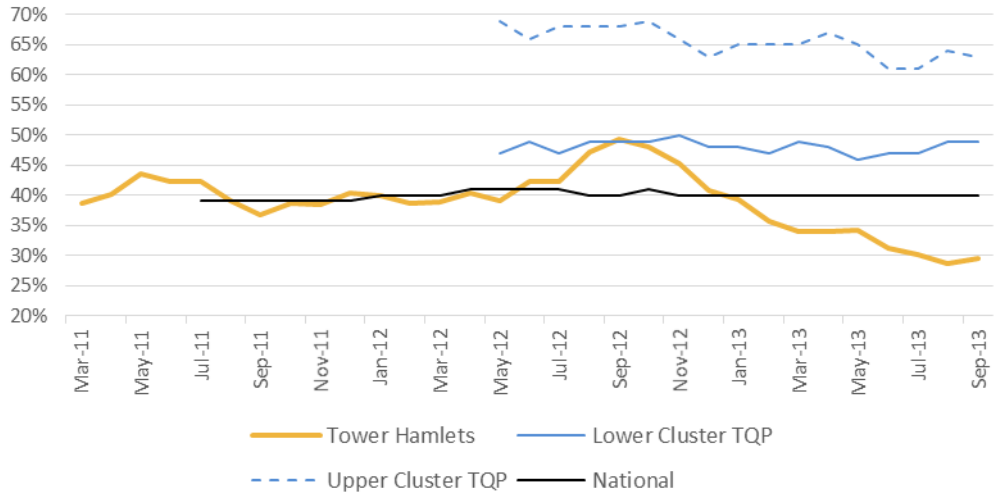
Chart 47: Tower Hamlets Opiate % Successful Completions 2010/11 baseline to September 2013 *(Source: NDTMS Successful Completions Partnership Performance September 2013 Data)*



10.14 The chart above compares the trend in the proportion of opiate clients in treatment that successfully complete treatment compared to cluster E top quartile performance range and national average. The top quartile performance range is the range required to be in the top 25% of partnerships in the cluster, with the upper end of the range showing the performance of the best performing partnership in the cluster. This also means Tower Hamlets is now performing outside of the cluster top quartile performance range, 9% to 10%, as well as the national average of 8%.

10.15 Successful completions amongst cluster D partnerships range from 728 to 56. Tower Hamlets has seen a decline in the number of non-opiate successful completions since around the same time as the reduction in opiate successful completions. In the past six months there has been 6% less non-opiate clients successfully completing treatment (70, 2012/13 baseline and 66, September 2013). This set against a 9% increase in the number of non-opiate clients in treatment has the same implication as described for the opiate measure of successful completions as a proportion of the numbers in treatment, expect the performance is impacted less by the growth of the non-opiate treatment population and decline in the number of successful completions, which currently stands at 29.5% compared to 34% in 2012/13. This also means Tower Hamlets continues to perform outside of the cluster top quartile performance range, 49% to 63%, as well as the national average, 40.3%. This can be seen in the chart below.

Chart 48: Tower Hamlets Non-opiate % Successful Completions 2010/11 baseline to September 2013 (Source: NDTMS Successful Completions Partnership Performance September 2013 Data)



Re-presentations

10.16 The quality of a successful completion is measured against the proportion that re-present to treatment within 6 months of successfully leaving treatment. This is calculated by taking the number of clients successfully completing treatment in the first half of a 12 month period and then monitored for re-presentations to treatment in the latter 6 months of the same reporting period. The proportion of opiate clients re-presenting to treatment has fluctuated between 37% and 19% since 2010/11, with the latest performance showing 34% re-presenting. This is significantly higher compared to the cluster top quartile performance range of between 13% and 10%. The level of re-presentations in non-opiate clients has been maintained at a much lower level than for opiate clients, with 0% in the September 2013 reporting period.

Treatment Exit Outcomes

10.17 Clients that drop out of treatment, or enter treatment and then decline further support or do not transfer into continued treatment within 21 days of being discharged have a detrimental effect on the treatment systems ability to produce the expected or desired

outcomes. The proportion that drop out of treatment in Tower Hamlets far outweighs the numbers that successfully leave treatment.

10.18 In the first six months of 2012/13 the percentage of opiate and non-opiate clients successfully leaving treatment successfully was significantly lower compared to the comparative clusters. For opiate clients this was 14% compared to 28% cluster average and for non-opiate clients 52% compared to 66% cluster average. Better treatment exits outcomes were achieved in the first six months of 2012/13 with a higher percentage of both opiate and non-opiate clients leaving successfully compared to cluster average. Whilst 44% opiate treatment exit outcomes resulted in clients dropping out, significantly worse compared to 33% in first six months of 2012/13. Non-opiate clients that dropped out proportionately less, 23% and similar compared to first six months of 2012/13.

10.19 Whilst overall there were more clients that left treatment in 2013/14 the general increase in the volumes dropping out of treatment will continue to have an impact on the successful completions rates, as it is likely a good proportion of those may have re-presenting to treatment. The proportions of successful transfers into continued treatment are a measure of a positive treatment exit outcomes. In Tower Hamlets the proportion of clients that are transferred are low, this added to the fact that those that do transfer a high proportion are not picked up indicates negative treatment exit outcomes.

Length of Time in Treatment

10.20 Data from the Recovery Diagnostic (RDT) Report also evidences the relationship between successful completions and length of time in treatment and previous treatment journeys. In Tower Hamlets 43% of opiate clients in treatment have been in treatment for less than one year, higher compared with cluster 22% and similar to national average of 45%. Tower Hamlets has a higher completion rate for this group 15% compared to cluster and national average (11% and 10%). One in ten have been in treatment for 6 years and more, significantly lower compared to the cluster, 22% and nationally, 13%. This group of clients have slightly lower outcomes rates compared to cluster and national average (5%, 6% and 6% respectively).

10.21 The length of time in treatment for non-opiate clients is similar to cluster and national average with the majority, 87% in treatment for less than one years. The completions rates are lower at 36%, compared to cluster and national average (44% and 41% respectively). It is worth noting this is simply an indication of the length of time a client has been in continuous treatment and the low completion rates are a result of the proportion of clients that have had a number of previous unsuccessful attempts at treatment.

10.22 In Tower Hamlets almost one in four opiate clients have a drug using career length that spans over 21 years, this has increased from one in five in 2010/11 and a general upward trend can be seen in the percentage of clients with career lengths of more than 12 years. Opiate clients with career lengths between zero and three years account for 3%. This distribution is similar to cluster and national averages. Tower Hamlets has a higher proportion of non-opiate clients with career lengths between zero and three years, 13%

compared to cluster and national average, 9% and 8% respectively. Those with career lengths of over 21 years account for 14%, this is similar to cluster and national average.

10.23 In 2012/13 one in four (24%) opiate clients had 4 or more previous treatment journeys, higher compared to 19% cluster and national average. Opiate clients 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, with those who have four or more previous treatment journeys having the poorest outcomes. Tower Hamlets, however has a 10% completion rate for clients with 4 or more previous treatment journeys compared to 6% cluster and 7% national average. There were 26% in treatment with no previous treatment journeys, less compared to cluster, 33% and nationally 32%. The completion rates are similar with cluster and national average.

10.24 The distribution of non-opiate clients in treatment is broadly similar to cluster and national profile, with the majority 59% in treatment with no previous treatment journeys, however completion rates are much lower at 37%, compared to 47% cluster and 43% national average.

Criminal Justice Clients

10.25 In quarter 2, 2013/14 just over one quarter (382) of the opiate treatment population consists of clients referred to treatment through the criminal justice system. For this group of clients 3.7% successfully completed drug treatment as the proportion of this treatment population, slightly lower than the rate for the whole opiate treatment population (5.1%), compared to cluster E partnership performance this sits outside the cluster top quartile performance range, 7% to 11%. There are fewer criminal justice non-opiate clients in treatment, 27 which equals 12% of the total non-opiate treatment population. For this group there is a higher proportion that successfully leave treatment, 40.7% compared to 29.5% for the whole non-opiate treatment population, however this remains outside of cluster top quartile performance range of 50% to 72%. In the September 2013 reporting period there have been no criminal justice clients re-presenting to treatment.

Clients Living with Children

10.26 In the same period a third (474) opiate clients in treatment were living with children, clients are considered to be 'living with children' if they report at any point in their treatment journey that they live with at least one child[5]. This means one third of all opiate clients in treatment live with children, as a proportion 8% have successfully left drug treatment, this is a higher proportion compared to the whole opiate treatment population (5.1%) and on par with national performance of 8.3%. One in five that leave opiate treatment re-presents to treatment within 6 months, similar to national average (19%). There are 61 non-opiate clients in treatment living with children and this would account for 27% of the whole treatment population. Compared to the total non-opiate treatment population a similar proportion of 31.1% successfully left treatment, but significantly lower proportion compared to the national average of 41.7%. There were no clients who re-presented to treatment, nationally 5.5% re-presented to treatment.

[5] 2013/14 Diagnostic and Outcomes Monitoring Executive Summary Report (DOMES) Guidance, NDTMS

10.27 The borough previously employed a Hidden Harm consultant that has completed a range of work which is set out below:

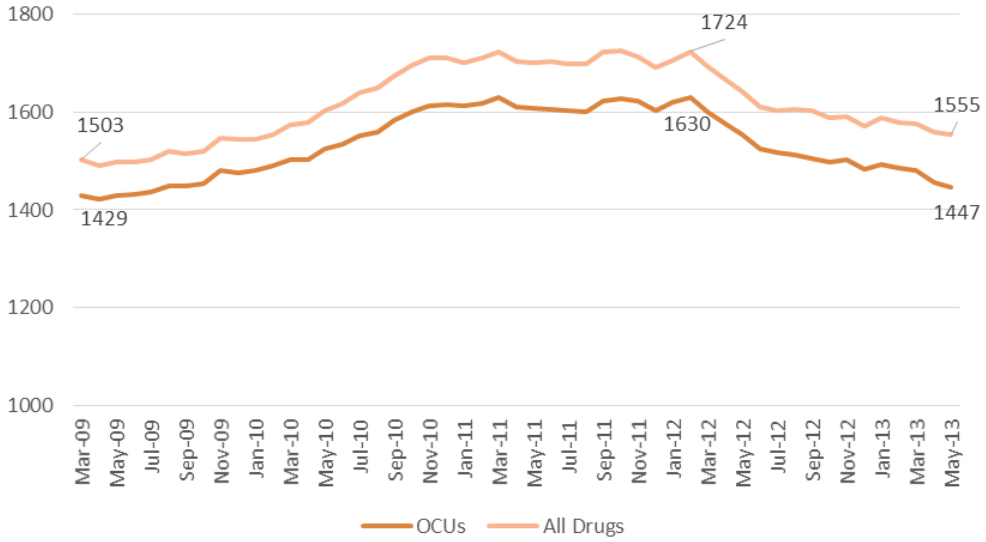
- Hidden Harm Handbook
- Integration of Breaking the Cycle within substance misuse treatment services (satellites, referral pathways)
- Moving Parents and Children Together (MPACT) in conjunction with Hackney DAAT working with IDP to deliver family focused Group work
- Developing the 'Dads project'
- Developing provisions and support for carers
- 5 Step Model (for carers and families)
- Links with Children's Centres and supporting Overland Children's Centre where all staff have received substance misuse training as part of a pilot
- Training for Children's Social Care staff to increase awareness of substance misuse
- Improved partnership working and pathways between DAAT services and Children's Social Care
- Work with the Young Carers Team to highlight the profile of children affected by parental substance misuse
- eCAF / CAF training delivered at treatment services

Effective Treatment

10.28 It is important to point out that the total number in treatment differs to the numbers "in effective" treatment, as the former is a count of anyone in treatment for any length of time, the latter is a count of those clients that have been retained in treatment for a minimum of 12 weeks (measure of effective engagement in treatment) or completed successfully within this time. In 2012/13 there were 1,273 new treatment journeys recorded, 88% were OCUs, however the number of OCUs entering treatment was 22% less compared to the previous year. New treatment journeys in the first 6 months of 2013/14 compared to the first 6 months of 2012/13 shows an increase in OCUs and non-OCUs clients entering treatment.

10.29 The chart below shows the trend in the number of OCUs and all drug users in effective treatment, from 2008/09 baseline to May 2013. Between 2008/09 to 2009/10 the graph shows a growth in the size of the treatment population, since 2010/11 this has shown a steady decline with numbers falling to 2008/09 levels. The highest numbers in effective treatment were achieved in February 2012 with 1,630 OCUs and 1,724 all drug users. Comparing 2012/13 numbers in effective treatment to the previous year shows 7.6% less OCUs and 7% less all drug users in effective treatment.

Chart 49: Numbers in Effective Treatment OCUs and All drug 2008/09 – May 2013 *(Source: NDTMS OCU and All Drugs Data)*



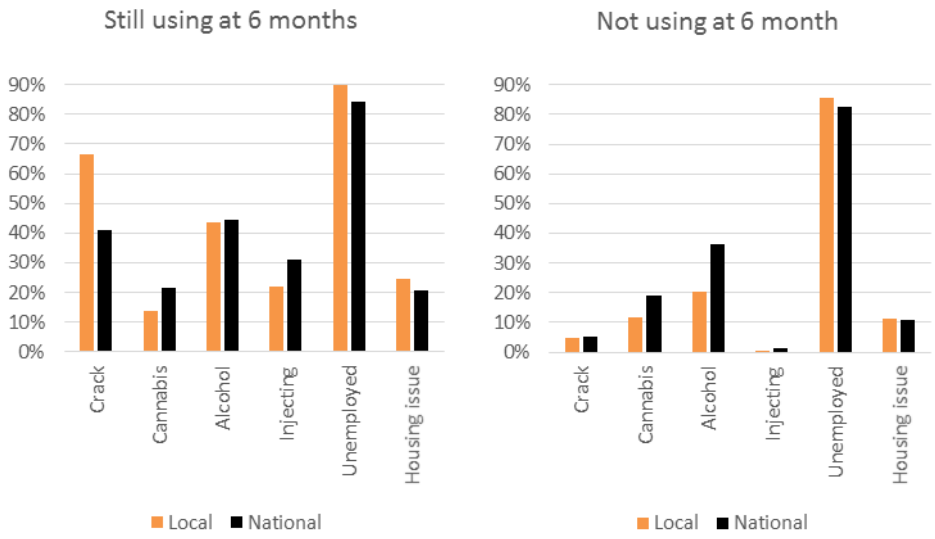
Opiate 6 and 12 Month Outcomes

10.30 The 2012/13 RDT data on the 6 and 12 month opiate outcomes of opiate users (this includes opiate and crack users) showed for Tower Hamlets 37% of opiate clients had stopped using at six months, within the expected performance range (36% to 48%) but lower compared to 45% national average. whilst it is likely more clients will stop by 12 month review in Tower Hamlets, 39% stopped using which is outside the expected range (42% to 55%) and significantly lower than 52% national average.

10.31 The 6 month crack outcomes of opiate clients that are also using crack show 45% of clients had stopped using at 6 months and 39% at 12 months. Whilst these clients are likely to be more complex than opiate only clients, crack abstinence for this group are worse compared to national average at 6 and 12 months (50% and 57% respectively).

10.32 The chart below shows the drug use and social functioning of opiate clients comparing opiate using who are and are not using at 6 months. This shows outcomes for those still using opiates are worse in all domains compared to those who stopped using opiates at 6 months. Most notably 66% were using crack at 6 months compared to 41% nationally. Unemployment is faced by almost all clients using at 6 months, 90% and 25% reporting housing issues. The percentage of clients not using that reported unemployment was 82% and housing issues 11%. Drug use and social functioning have a negative impact on successful completions and longer term recovery.

Chart 50: Drug Use and Social Functioning Behaviour of Opiate Clients Using/Not Using at Six Months 2012/13 *(Source: NDTMS Recovery Diagnostic Toolkit Data)*



10.33 Generally, clients who have stopped or improved should have an increased health score, whereas those who have deteriorated or remained unchanged are less likely to have made any positive change to their health or quality of life score. In Tower Hamlets the improvements in health and quality of life show for opiate clients that have stopped or improved an increased score whilst those who deteriorated showed a negative score.

10.34 The proportion of non-opiate clients that stopped using all drugs were higher compared to the national average, with the exception of cocaine. In particular abstinence from crack use was reported by 73% compared to 58% nationally and 72% abstinence from alcohol compared to 32% nationally. Drug use and social functioning for non-opiate clients at 6 months showed 7% still using crack at 6 months which was higher compared to 4% nationally but for all other drugs and alcohol Tower Hamlets reported lower proportions. Seventy-five percent reported unemployment (70% nationally) and 24% reported a housing issue (14% nationally).

11 Provider Performance

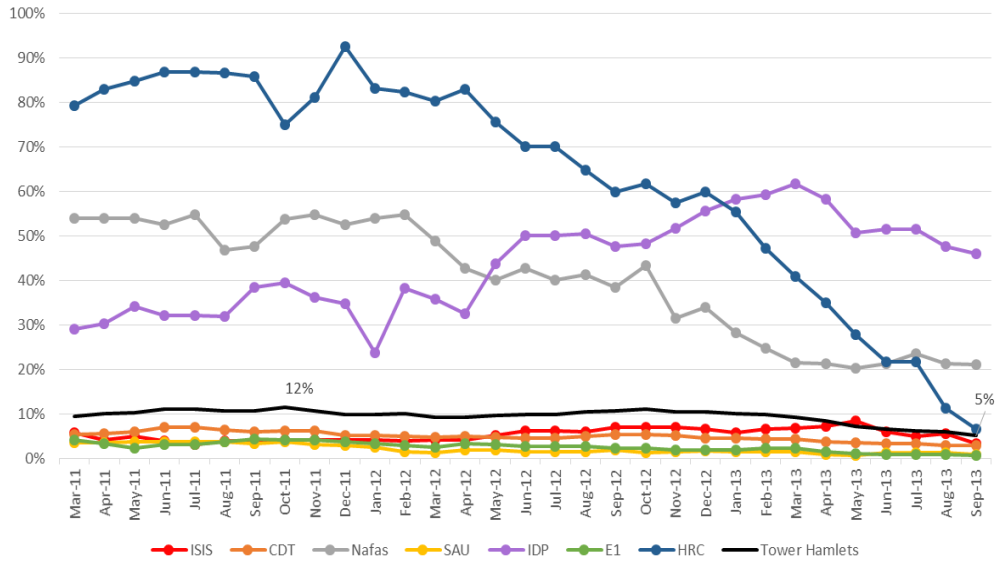
11.1 This section does not attempt to benchmark or compare the performance of providers as it is recognised in a treatment system each provider offers different treatment to clients with different levels of client complexities and who are at different stages of their treatment journey. Tower Hamlets has numerous providers reporting into NDTMS, however the bulk of opiate clients are distributed amongst seven main treatment providers and non-opiate clients amongst five.

11.2 In the latest 12 month reporting period (September 2013) the number of opiate clients in treatment across the main providers is varied and ranges from 745 to 63. CDT have the highest number of opiate clients in treatment and IDP the least. Similarly the number of non-opiate clients in treatment across the main providers vary and range from 54 to 19, NAFAS has the highest and SAU the least. Compared to 2012/13 baseline the number of opiate clients in treatment has fallen with the majority of providers, whilst the number of non-opiate clients in treatment has increased slightly or remained the same across most providers.

Successful Completions

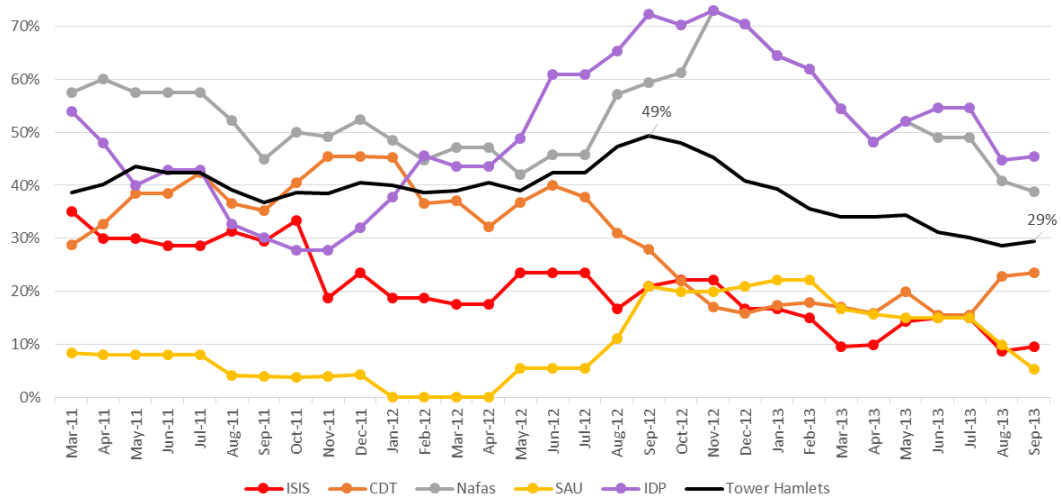
11.3 Successful completions as a proportion of the treatment population is a key measure in gauging the level of throughput in treatment, this is particularly important for those with large number of opiate users in their treatment service. The chart below shows the trend in the proportion of clients successfully completing treatment since 2010/11 baseline for the main opiate treatment providers. Tower Hamlets overall partnership performance is represented by the black line. The reduction in the number of opiate clients in treatment was proportionately less than the reduction in the numbers successfully completing, as a result successful completions as a proportion of the numbers in treatment show a stark decline in performance.

Chart 51: Proportion of Opiate Successful Completions by Treatment Provider 2010/11 baseline to September 2013 *(Source: NDTMS Provider Successful Completions Data)*



11.4 The chart below shows the proportion of non-opiate clients successfully completing treatment. IDP, NAFAS and CDT have been the main contributors (with the highest number of successful completions) to the higher levels of performance. As these providers have experienced significant reductions in the numbers completing treatment, with CDT experiencing this since July 2012 and IDP and NAFAS since December 2012 the overall partnership performance declined. However the chart also indicates a growth in successful completions in the last 2 months for ISIS, CDT and IDP.

Chart 52: Proportion of Successful Completions by Treatment Provider 2010/11 baseline to September 2013 *(Source: NDTMS Provider Successful Completions Data)*



Re-presentations

11.5 The September 2013 reporting period showed the majority of opiate clients that re-present to treatment left NAFAS, 17 clients (32% re-presentation rate), HRC had 13 (28%) and CDT with 12 (33%). For non-opiate clients, none re-presented to treatment.

Treatment Exits

11.6 The number and proportion of treatment exit outcomes for the first 6 months of 2013/14 show with the exception of NAFAS (who achieved successful completions at a rate of 72%), all providers' successful completion or planned exit rates ranged between 0% and 18%. A significant percentage of outcomes resulted in unplanned exits with the majority of opiate clients dropping out of treatment; this is equal to 111 opiate clients collectively between these providers (with the exception of NAFAS, 0%).

11.7 The treatment outcomes for non-opiate clients show the proportion of clients successfully completing were higher with some providers whilst equal for others in comparison to the proportions that dropped out of treatment. Overall the treatment outcomes for non-opiate clients are better compared with opiate clients with almost half leaving treatment having successfully completed.

11.8 Similarly the volume of transfers for opiate and non-opiate clients into continued treatment with other providers is low as is the proportion that successfully transfers and continues treatment. Whilst opportunities for clients successfully completing will vary between

providers the level of opiate and non-opiate clients that drop out of treatment is a feature for the majority of providers.

11.9 Treatment exit outcomes also include clients that were transferred to custody, for these providers a total of 28 opiate clients were transferred to custody of this 12 were recorded by CDT which was 16% of CDT's total exits. Proportionately fewer non-opiate clients were transferred to custody; the majority transferred to custody were recorded by NAFAS, which was 17% of NAFAS's total exits.

11.10 Provider level performance including client complexities and 6 and 12 month outcomes is covered in further detail in the Service Review.

12 VFM and Cost Impact of Services

12.1 Assessments of treatment cost and value are needed to support a comprehensive understanding of how a treatment system is set up and how it works. At present in Tower Hamlets there is a service review exercise which is running concurrently with this needs assessment. This service review is at a point where more detailed financial and performance data is necessary to more comprehensively assess value for money.

12.2 Some data is however currently available and this is analysed and reported below, other data particularly that from other local DAATs and London wide benchmarks are needed to support a better comparison of cost, impact and hence value. To this end a more detailed VFM review will be reported separately to the DAAT and will form part of the service review exercise, and will include cost comparisons with other similar DAATs.

12.3 Nonetheless this section reviews key value for money issues and uses the VFM Tool provided by the NDTMS. This section will also review the cost of particular services and compare these with local records of performance. We have also completed a subsidy per head of outcome benchmarking across the partnerships based on those in effective treatment. More work could be done to assess the cost impact in terms of real time local Prescribing and NHS costs and compare these to national benchmarks however there are other key data sets that are needed to enable this form of comparison.

VFM tool NDTMS

12.4 The NDTMS has established a VFM tool which essentially calculates the cost impact of drugs and alcohol to the borough if treatment services were not available. To this end NDTMS has developed a model for partnerships which looks at the value of the intervention in terms of the cost to society of not treating substance misuse. Initially the model was established to review the period of the Spending Review from 2012-15 and for this exercise the baseline was set at 2012/13. The model can review previous and future benefits of treatment (with the latter based on trends in service engagement over the last six years) to establish a strategic cost-saving estimate based on service provision and what this has saved the public purse in terms of crime, health and other societal costs which would have been generated by OCU's over the period of the model.

12.5 Specific partnership data from the NDTMS is inputted to the model. This data includes:

- Numbers in effective treatment
- Those in effective treatment in one year
- Numbers of successful completions for those in effective treatment
- Number of unsuccessful completions for those in effective treatment
- Sustaining recovery rate for those in effective treatment
- Clients sustaining recovery (based on re-presentation rates)

12.6 This is then computed against the estimated cost impact of crime and health interventions both in terms of direct costs and real term costs. A second computation is done to estimate the crime cost savings and natural benefits in real terms as well as the estimated health cost savings and natural benefits in real terms, and total estimated cost savings and natural benefits. This is then used to identify the net benefit when these aforementioned

cost savings are netted off against the total estimated spend during the period of the spending review in real terms and adjusted for market forces.

12.7 The first figure of real note is the estimated cost of the harm (cost to public services) during 2012/13 if no problematic drug users were treated for their addiction in real terms, which for Tower Hamlets is calculated at £23.7m. This demonstrates a significant potential cost locally and shows a high level of negative financial impact.

12.8 The estimated spend over the 2012/13 review period for Tower Hamlets is £4.2m adjusted for area costs, which comes from the direct treatment budget. The total benefit accrued through this expenditure is estimated at £16.9m. A net benefit is then calculated which shows the cost savings netted off against spend, which for the borough is £12.7m. From this point an estimated cost benefit ratio is calculated which is 1:2.82 in other words this means that the model calculates that for every £1.00 spent on the local drug treatment system £2.82 is gained in total benefits to the locality.

Table 19: LBTH Drug Treatment VFM Tool Summary Report 2012/13

Cost item over spending review 2012 period (2011/12 - 2014-2015)	Amount
Estimate amount of total harm if no PDU were treated (2012/13 baseline)	£23.7m
Total estimate spend (adjusted for market forces)	£4.2m
Total Benefits accrued	£16.9m
Total net benefit (Net benefit=Total benefit-spend)	£12.7m
Estimated cost benefit ratio	01:2.82
i.e. for every £1 spent £2.82 is gained in total benefits	£2.82

12.9 Essentially this VFM tool seeks to identify the value that is accrued locally by having an effective drug treatment system in the borough. What it confirms is that Tower Hamlets is providing value, however comparative authorities delivering similar services are attaining higher cost values in the realm of 1:3.50 and as high as 1:5.00. This would suggest that the borough is a high spending treatment service with a more complex client base and hence lower levels of cost impact to the community.

Subsidy per head benchmarking

12.10 The table below sets out a simple method for local benchmarking, by calculating the subsidy per outcome. The approach is a basic mathematical calculation of subsidy which can be compared year on year to identify performance and act as a barometer of value. The approach is based on calculating the number of achieved performance measures to generate a per head benefit based on the 2012/13 budget allocated to each treatment provider and the partnership as a whole. The outcomes used for this calculation are based on NDTMS performance data 2012/13 to date and totalises the number of clients in treatment (all drugs).

Table 20: LBTH 2012/13 Subsidy per head of beneficiary for provider and partnership.

Contract Name:	Provider:	Total budget allocation to service 2012/13	Numbers in treatment (2012/13)	Subsidy per head of NIET
Community Drug Team (CDT)	Life Line	£737,377.00	857	£860.42
Community Alcohol Team	RAPt	£600,000.00	606	£990.10
Specialist Addiction Unit	ELFT	£1,195,172.00	339	£3,525.58
Island Day Programme	RAPt	£353,077.00	126	£2,802.20
Changes Programme	RAPt	£56,000.00	57	£982.46
Harbour Recovery Centre	Salvation Army	£503,607.00	123	£4,094.37
Nafas	Nafas	£490,267.00	149	£3,290.38
ISIS	Compass	£292,892.00	125	£2,343.14
Health E1 Specialist Substance Misuse Provision		£122,000.00	257	£474.71
Total		**£4,350,392**	1874	£2,321.45

12.11 It should be noted that the subsidy levels cannot be compared as each treatment provider is responsible for very different work, with staff and treatment budgets. However this does serve as a useful benchmark which can be compared in future years to assess the growth and or reduction in this subsidy level. The partnership benchmark is based on all partnership costs as set out within the 2012/13 budget; which excludes DAAT operating costs and other funding for commissioned services (i.e. Tier two services and additional treatment spend for Tier 4 and aftercare).

12.12 However this does show a clear disparity in cost base and in the numbers of clients in effective treatment. Interestingly some providers are being asked to provide for their clients in a disproportionate way and in many cases their work helps clients at different points in their recovery journey. For example CDT have many new clients in treatment and their work in association with the Shared Care provision is quite different from some of the recovery based treatment services where there are fewer clients who are potentially easier to work with at the latter parts of their treatment journeys. This point needs to be resolved and the DAAT Board should be mindful that they are getting VFM for the work they are commissioning.

12.13 In addition to the main treatment providers in the table above there are also a number of support providers, some of whom provide direct treatment support and others who act as referral agencies providing brief interventions and some preparatory treatment support.

Table 21: LBTH 2012/13 unit cost for additional support contracts

Contract Name:	Provider	Allocated budget	New client contacts	Unit cost
Dual Diagnosis Service	ELFT	£165,170	2880	£57.35
Specialist Addiction Unit (BBV)	ELFT	£125,202	475	£263.58
Specialist Midwife	Barts	£43,347	49	£884.63
Dellow Centre	Providence Row	£40,000	75	£533.33
Intensive Substance Misuse Link Service	Nacro	£36,934	245	£150.75
Alcohol Nurse Specialist Service	Barts	£100,000	121	£826.45
Young Person's Provision T3	Life Line	£25,000	12	£2,083.33
Somali Project	MIND	£40,000	272	£147.06
Total		£410,483	1249.00	£328.65

12.14 It is clear from the provision described above that there are some higher levels of expenditure that provide services to clients within the treatment system, namely, the Dual Diagnosis service and the BBV services contracted through ELFT. In addition there are providers who deliver a wider range of activity much of which is based on supporting clients to enter the treatment system and to be referred onto 'main treatment provision', others provide alternative support for clients from particular segments of need in the borough. This is evident in contracts with the Dellow Centre, NACRO, Alcohol Nurse Specialist, Specialist midwife, Young People's transitionary project and the Somali substance misuse project.

12.15 In addition the DAAT also funds a number of Local Enhanced Services for Alcohol, Drugs, Shared Care coordination and the Community Pharmacy contract. These services are contracted via the CCG and they supplement direct treatment of clients in some cases in Tier 3 treatment but also through brief interventions, wider health support and through specific IBA programmes. This amounts to over £560,000 worth of additional contracts.

12.16 Finally the borough also funds a Tier 4 programme which utilises a budget of over £1.2m. Collectively this gives the Borough a treatment budget of £6,520,875 and based on the 1,874 in treatment (as registered by NDTMS) this provides a subsidy levels of £3,479.66. This figure is based on local data and acts as a potential VFM benchmark

12.17 A 'similar' comparison has been done by reviewing the budgets set for London Boroughs in 2012/13 (based on their pooled treatment budget) and using the numbers in treatment in this period for each partnership. What this shows is that there are some sizeable cost variances between boroughs in their treatment budget allocations and their outcomes to treatment. This is set out in the table below.

Table 22: London DAAT Unit Costs based on 2012/13 Pool Treatment Budgets and numbers in treatment

	2011/2012	baseline 11/12		2012/13	baseline 12/13		Cost
All	PTB	NIT	Unit	PTB	NIT	unit	Variance
Tower Hamlets	£5,409,337	1851	£2,922	£5,489,256	1489	£3,687	£765
Westminster	£4,949,780	1470	£3,367	£4,779,583	1140	£4,193	£826
Southwark	£5,157,681	1543	£3,343	£4,943,374	1122	£4,406	£1,063
Newham	£4,202,963	1220	£3,445	£4,167,814	998	£4,176	£731
Hackney	£4,543,556	1318	£3,447	£4,404,309	1054	£4,179	£732
Camden	£4,993,657	1753	£2,849	£4,384,198	1166	£3,760	£911
Islington	£4,925,952	1343	£3,668	£4,486,331	1040	£4,314	£646
Lambeth	£5,431,791	1832	£2,965	£5,307,468	1098	£4,834	£1,869

12.18 What this shows is that across London from 2011/12 to 2012/13, DAATs are reducing their numbers in treatment against this pooled treatment budget cost base. It should be noted that some of these treatment systems were re-commissioned in 2012/13 which will have had an effect on outcomes particularly those in treatment. This happened in Southwark, Lambeth and Newham's treatment system has also recently gone out to tender.

Summary

12.19 Like is not being compared with like in many of these assessments of VFM and more detailed work is needed to support the service review process being carried out in conjunction with this needs assessment. Nonetheless there are some clear indicators that can be gleaned from these 'comparisons'. These are:

- Service budgets are disproportionate to client through put and client need
- Services have different positions in the treatment pathway for clients and their support and delivery should be funded proportionately to their role in the treatment system
- Massive variation in subsidy per head of providers suggests varying cost in provision, varying numbers of clients in effective treatment and potential to rationalise some of these costs against need.
- The cost variance between boroughs in London is significant
- Tower Hamlets is an expensive treatment system with much of its spend targeting treatment activity which has less direct bearing on treatment outcome
- Baselines for cost comparisons are difficult given the widely varying treatment offered by different providers
- More information is needed to make clear comparisons between the performance of providers
- From a partnership perspective Tower Hamlets needs to assess how its cost base is made up and review what can be done to ensure greater value for money. This would assess management systems, direct treatment spend, indirect treatment spends, recovery focused spending and the targeting of expenditure to address complexity and need.

12.20 To this end some key recommendations emerge including:

- Improved contract management, reviewing and re-setting recovery focused delivery targets for each provider
- Contracts to be set to secure a controlled and where possible reducing subsidy level and increasing cost benefit ratio regarding costs of crime as nominal targets.
- Review those parts of the treatment service where there are high levels of expenditure but which do not contribute to performance targets or indicators , this would need to be reviewed in the context of risk/clinical governance as well as recognising that some services contribute less to targets and more to risk management, safeguarding and clinical governance.

13 Key issues emerging from the Needs Assessment and Service Reviews

13.1 The Tower Hamlets treatment system is one of the largest in London. This needs assessment has reviewed the need for drugs and alcohol services and treatment in the borough and the delivery capability and impact of the local substance misuse treatment system and its component parts. There is clear evidence that the borough has a large opiate dominant client base and this is reflected in the range of interventions service users benefit from in the borough. Services are dominated by males who represent the majority (80%) of service users and there is a strong ethnic reflection of the borough's diverse community. A significant proportion of clients have been within the borough's treatment system for many years and others have been in and out of treatment on many occasions. Essentially the opiate client base is growing older nonetheless there is evidence that this cohort whilst diminishing slightly is still providing a steady presentation of new clients with high levels of complexity and need but equally high attrition and service re-presentation rates.

13.2 There is similarly a steady stream of alcohol treatment clients coming into services and with the high number of hostel beds (c 1,300) in the borough this need is not going to change. Alcohol is widely consumed across the borough and in terms of problematic use there is significant evidence of high levels of poly drug use that is accompanied with excessive alcohol use. The use of non-opiates particularly cannabis and skunk is extremely high, although with much lower presentations to treatment, in many respects these drugs appear quite normalised in the borough. Finally there is a strong and growing club scene in the borough with associated party drugs and 'legal highs', however some of this is imported drugs activity from visitors to the borough.

13.3 The main operational focus of the DAAT in Tower Hamlets is to set treatment priorities and to commission services for drugs and alcohol misusers in structured treatment and to help providers to support clients to meet the target of full recovery. To support this, it is critical that treatment interventions are completed successfully by clients. It is recognised that this is more difficult to achieve with a complex client group but it is nonetheless a stated priority nationally and long term funding is dependent to this achievement. This is a pivotal performance criterion for the DAAT and is clearly stated in Tower Hamlets Substance Misuse Strategy 2012-15.

13.4 This needs assessment has shown that the borough treatment system whilst extensive and reliant on wider partnership inputs does not seem to operate systematically. Historically, as a structure, the treatment system has emerged over time rather than having been planned holistically. From a needs perspective there is clearly a priority on clients who use opiates and crack and there is a strong criminal justice link with a quarter (25%) of DIP referrals into treatment and a large number of clients either in or have been in the criminal justice system. Whilst there is skill and capability within the partnership there are low levels of non-opiate treatment, although data suggests that prevalence is strong. Alcohol is a clear treatment priority – despite the Public Health estimates indicating high levels of abstinence in the borough.

13.5 There are some clear issues for the treatment system to contend with, in particular:

- A reduction of successful completions achieved by the partnership
- Slowing down of new treatment entries across most providers
- Key bottlenecks in the system, in particular the borough's CDT
- Generally low levels of client readiness for the recovery journey
- Low levels of treatment compliance by clients (drop outs)
- Low levels of recovery capital in clients
- High levels of complexity and diversity within the system
- Some poor inter agency procedures and protocols to enable effective treatment transfers
- Specific operational issues within the DIP and borough Shared Care arrangements

13.6 In short the treatment system has had different services appended to it over time (for seemingly good reasons) but has not benefitted from being systematically planned. A solid attempt to reconfigure the treatment system started in 2011 but was thwarted in its progress by a desire to hold contracts as they were until the transfer of services from the PCT to the Council.

13.7 However, the time is now right to address the structure of the treatment system, to review the policy and treatment priorities of the DAAT Board and to assess the most effective model of provision for Drugs and Alcohol services in the borough. This needs assessment contains a wealth of data that should help contextualise this work and define services to inform a re-procurement process in 2014/15.

13.8 Diversity and the cultural needs of different clients are also key considerations for the Borough. It is vital that prospective clients from all communities are at ease with accessing the treatment systems to receive assistance and help for their substance misuse and to start recovering. In Tower Hamlets there seems to be a far greater proportion of the former and far fewer of the latter, this may well be a reflection of how the treatment system is designed but also a reflection of the value placed on treatment by its service users. Indeed for some the perceived range of treatment options is a good way to accommodate these different needs. However, this is also a concern, for while many factors determine funding of drugs and alcohol services, it is the achievement of successful completions which is a key measurement and in particular completed journeys to drug free (opiate) and reduced use exits, a proxy for successful completions and hence recovery. Thus, it is critical that the whole treatment system can increase its overall number of successful completions and begin to support local people to change their lives and reduce or cease their use.

LBTH Shared Care

13.9 The borough has a strong record of Primary Care provision and there is a strong commitment to maintain it at the core of drug and alcohol activity and to support the wider medical needs of the borough patients. Shared Care is central to the current Tower Hamlets substance misuse strategy.

13.10 Shared care also supports the treatment of clients through enhanced primary care provision delivered via 90 borough GPs. Historically in the borough there has been a clear primary care focus to health care for local people and this has resulted in support of drugs and alcohol treatment by local GPs

13.11 In addition to Shared Care, the DAAT funds 3 GPs with Special Interest in Drugs and Alcohol (GPWSI). These GPWSIs are based on 1 full time equivalent (10 sessions); however there are 14 GPs who support this commission on a rota, if required. GPWSIs also prescribe at two providers, CDT and ISIS and are also based in the DIP prescribing to its client group, after comprehensive assessment and prior to referral to CDT for treatment. These GPWSIs provide ten service sessions per week which equates to just over 500 sessionsper year (or about £340 per session). In addition, further GP provision is provided via Health E1 which supports general practice primary care provision for the homeless and residents of Hostels around the Whitechapel area of the borough. This provision is both within Shared Care and is funded directly by the DAAT.

How the system works for enhanced care:

13.12 In Tower Hamlets there are Local Enhanced Services (LES) for both alcohol and drugs activity in a primary care setting (which operates alongside an extensive range of enhanced care health priorities in the borough). Across the borough there are very large patient lists in most practices, with a total of 290,940 residents registered on EMIS. Additional payments are made to GPs to deliver the Enhanced Services (on top and beyond their normal activities).

13.13 These services include:

Drugs Interventions

- Consultations
- Prescribing
- Identification and Brief Advice
- BBV referrals
- Hep C referrals
- Onward referral to other Primary, community and secondary care services
- Co-ordination of care with a keyworker based within CDT or Isis and a dispensing pharmacist

Alcohol interventions

- Audit C Screenings
- Brief Alcohol Advice
- Patient Advised
- Brief Advice
- Extended Alcohol Advice
- Patient referred to alcohol services
- Patients referred to specialist alcohol services
- Patients referred to community alcohol services

13.14 Monitoring data provided by the Shared Care coordinator as part of their monitoring capability includes data on patients prescribed with opiate substitutes and drug therapies for the 2nd Quarter 2013/14. The data also addresses patients prescribed Opiate Substitutes and Drug Therapy between July and Sept 2013 and High Dose Opiate Substitutes by GP Network between July and Sept 2013, this is set out by GP network across the borough in the charts below.

Chart 53: Patients prescribed Opiate Substitutes and Drug Therapy recorded by GP Network between July and Sept 2013

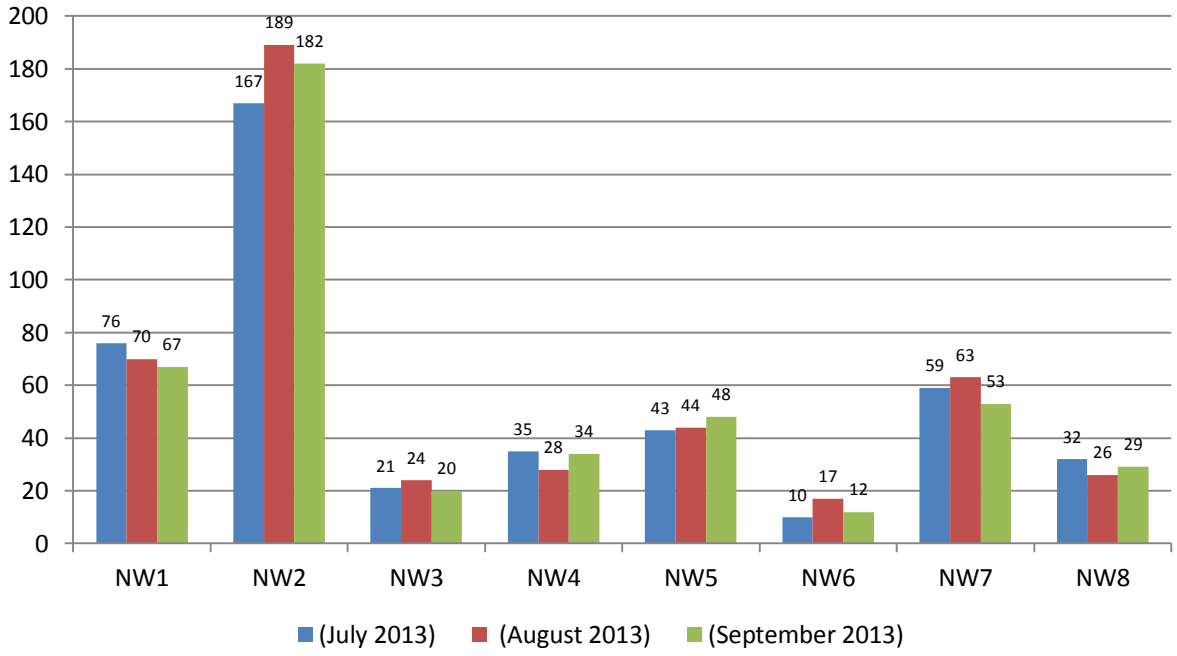


Chart 54: All Patients prescribed Opiate Substitutes and Drug Therapy between July and Sept 2013

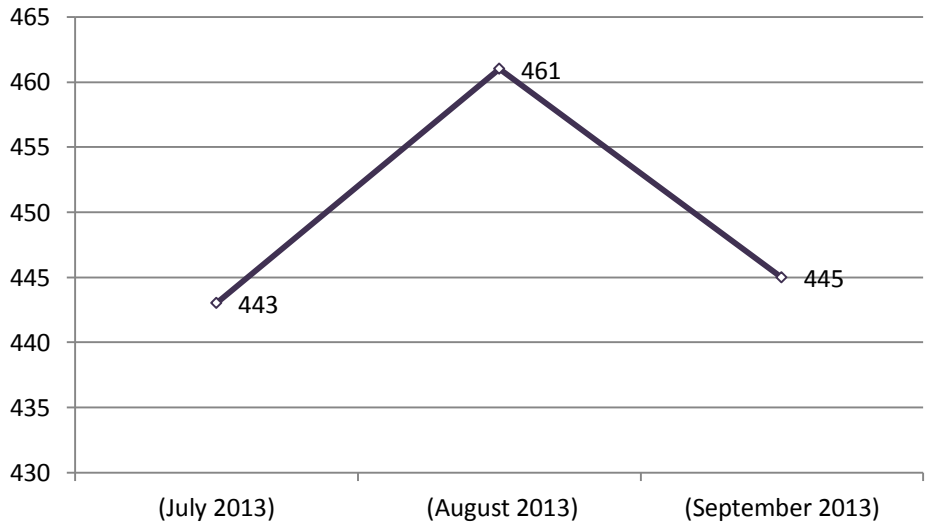
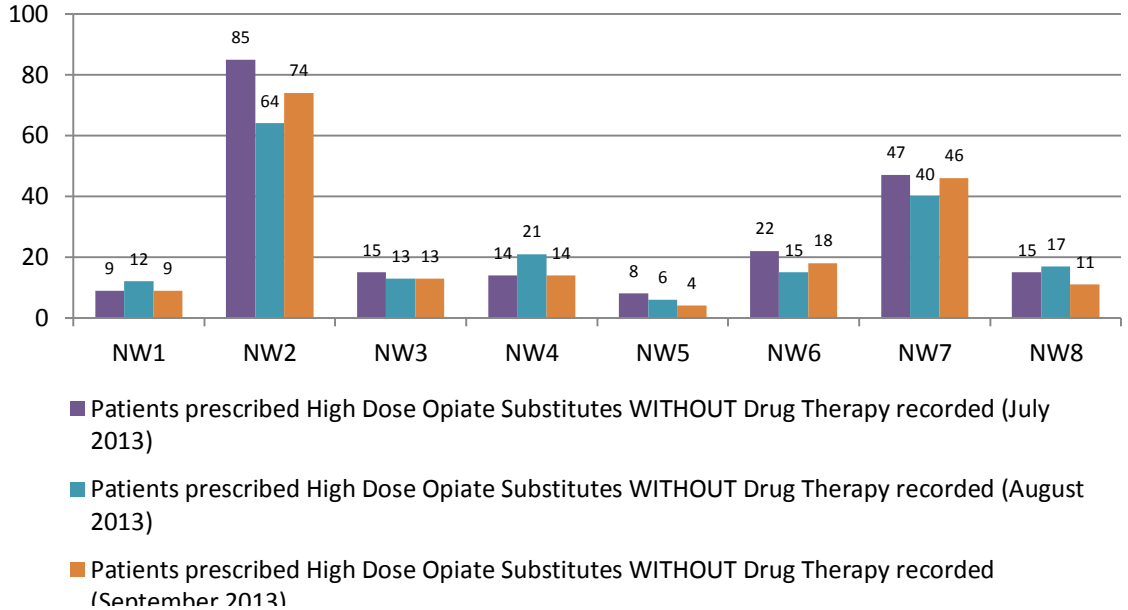


Chart 55: Patients prescribed High Dose Opiate Substitutes by GP Network between July and Sept 2013



13.15 Shared Care monitoring systems also include data held on the screening for Alcohol misuse, using the Audit C Assessment. Across the 290,940 patients on the GP lists there were 10,735 Audit C's done in Quarter 2 in the borough. This would suggest that over 40,000 are carried out per year.

Table 23: Tower Hamlets: Alcohol Enhanced Services Quarter 2 2013-2014 Positive Audit C Outcomes and interventions

Tower Hamlets: Alcohol Enhanced Services Quarter 2 2013-2014 Positive Audit C Outcomes	Total	% of total Audit C's
Alcohol AUDIT-C done Q2 in total	10,735	
Alcohol AUDIT-C done Q2 % of total list size	3.7%	
Positive AUDIT-C Q2 (Score ≥5 men, ≥4 women)	2,101	19.6%
Women, hazardous drinking (Score: 4-7)	693	33.0%
Women, harmful drinking (Score 8 or more)	136	6.5%
Men, hazardous drinking (Score: 5-7)	712	33.9%
Men, harmful drinking (Score: 8 or more)	560	26.7%
Interventions	**Total**	**% of total Audit C's**
Brief Alcohol Advice (Codes: 8CAM,9k1A)	3745	34.9%
Patient Advised (Code: 8CAM)	3687	34.3%
*Brief Advice (Code: 9k1A)	190	1.8%
Extended Alcohol Advice (Code: 9k1B)	8	0.1%
Patient referred to alcohol services (Codes: 8HkG, 8H7p)	51	0.5%
Patients referred to specialist Alcohol services (Code: 8HkG)	6	0.1%
Patients referred to community alcohol services (Code: 8H7p)	45	0.4%

13.16 The table above sets out the levels of Audit C Screening done in quarter 2, 2013/14. Across the 290,940 patients on the GP lists there were 10,735 Audit Cs done in Quarter 2 in the borough. Of this 19.6% were positive (2,101) of whom 33% were hazardously drinking women, and 6.5% harmfully drinking women and 33.9% hazardously drinking men and 26.7% harmfully drinking men (560). From an interventions perspective just under 35% were given brief alcohol advice, 34.3% have general patient advice and 1.8% as part of an intervention and Brief Advice (IBA). Extended alcohol advice was given to 8 (0.1%) and 51 were referred to alcohol services, 6% to specialist alcohol services and 45 referred to community alcohol services.

13.17 The shared care data in the charts and tables above come from OST coded activity where a template has been used, which is filled in manually by practice managers. However the Share Care Team lead suggested that this represents little more than half of the activity which took place according to the specification in each quarter. This suggests a level of under reporting. Indeed whilst this may well be the case another way of assessing the level of performance would be via the payment activity generated by this work. This shows that there were 5,772 Alcohol Audit-C completed in Q2 that generated a Direct Enhanced Service (DES) Payment and 2,196 that generated a LES payment. In total this comes to 7,968 Audit C's which triggered payments. This conflicts with the 10,735 Audit 'C recorded on EMIS and shows there is more activity carried out than paid for.

13.18 For the last 10 years paper based systems have been used to claim and pay for GP Drugs and Alcohol activity which has taken place through manual submissions of data copied out by practice managers every three months (attendance dates, meds, key worker details etc.). Colleagues' state that patient consultations are time consuming and frequent and prescribers often would write in free text rather than use the template on the computer for speed. Prescriptions issued are another form of hard data and the numbers are very different in total and by practice. However at the time of drafting this part of the assessment prescribing data was not available.

13.19 This data situation is likely to improve next quarter when payment will be based upon EMIS search only. However, there will inevitably be some under – recording and hence under payment and activity levels may appear to drop. Reviewing the efficacy and value of services is a priority for the CCG and for general practices in the borough. This component of service provision within the DAAT is a critical factor for the care and treatment of drugs and alcohol clients. It is important that the DAAT are both clear about what they are purchasing and what they expect from this funding. Moreover that they are in the best position to ensure that the care delivered by the GP Practice, pharmacies and the key worker in the treatment provider is collectively effective The role and function of Shared Care therefore needs to be better defined and clarity between all parties is critical to the ongoing success of this critical part of the borough's treatment system.

Prescribing Services

13.20 An EMIS search OST prescriptions of Tower Hamlets patients registered with their practice on 3rd April 2013 showed 879 people (728 men and 151 women) were prescribed by Tower Hamlets practices in the last year. This does not include GPWSI scripts given in ISIS/DIP/CDT or those who had moved practice or out of the area and not had a prescription in the current practice. This shows a high level of GP prescribing and a high number of clients in shared care.

13.21 However at its operational level there are some concerns about the shared care process. Tower Hamlets' shared care model is not as rigorously defined as other shared care models as it represents primary care targeted to clients in the treatment system, who are formally on the NDTMS as either an ISIS or CDT client. Essentially CDT and ISIS start these clients' structured treatment and provide initial triage and comprehensive assessments and the GPs take care of their prescribing requirements. However there are a variety of different ways in which these clients access their prescriptions. Some clients get their prescriptions via the GPs and see a key worker from CDT in surgery, others get their prescriptions through GPWSI and see their key worker at CDT and others get their prescriptions with GPs in surgery and who see key workers at CDT. In many cases clients start their prescriptions before they are seen by a key worker and this creates the need for catch up. Also the time available to see clients in practices is limited even in those eight surgeries where there is a satellite treatment offer.

13.22 This situation does seem confusing and the model essentially does not engender strong recovery capability and focus – as it appears to just hold patients in a state of maintenance with little direct coordination by treatment providers. Indeed the rates of successful completion for these clients are poor with a low level of between 3%-5% of successful completions in the last 24 months. Indeed given the number of clients in Shared Care this is having a large negative impact on successful completions across the partnership.

13.23 Another concern about the treatment engagement through GPs is that there seems to be nowhere for people to go who are not 'chaotic or high end users of opiates or alcohol'. The vast majority of health interventions to support lower level drugs and alcohol misuse are delivered within the Primary Care setting and few clients are referred into services that provide for non-opiates and alcohol treatment. This may be due to the stigmas and fears clients have about existing treatment providers and or the GP's judgement of the inappropriateness of this referral into treatment. It may be simply that GPs are not comfortable with pushing people into the structured treatment system or that they feel those services are set up for a more complicated client group. It may also be because they don't feel these services are effective. However examination of GP Audit C referrals into treatment at 2.4% of all screenings appears to indicate a low rate of referral given the high need identified in the Audits.

13.24 For a large proportion of opiate clients in the Tower Hamlets shared care 'model' there is little evidence of clients progressing through recovery. Clearly they are receiving supported care and maintenance of their addictive behaviours through community prescribing. The typical model of shared care is one that supports clients that are in a stable condition and as such eases their treatment through the familiarity and support of their GPs. Essentially, the Tower Hamlets system relies on a joint care package between the GP who prescribes

and provides health care, community pharmacists who monitor pick-up of medication and supervise consumption where necessary and community treatment providers who support with effective structured treatment for their clients. However the seemingly lower capacity to effectively support and treat clients in this shared approach suggests the need for a strong revamp. This is even more pressing given that this is affecting the capability of the Partnership to meet its successful completion targets set in the Public Health Outcomes Framework. The difficulty in engaging with clients and their apparent lack of recovery capital inhibits successful completions from emerging and fails to support clients to be treatment ready. In short treatment actually needs to be provided and clients and practitioners need to better distinguish between the values of substitute prescription as a method of stabilisation/ maintenance and structured treatment as a support programme to reduce and eventually cease their drug use.

13.25 Essentially the Shared Care model needs to better support the recovery aspiration of the DAAT and the DAAT needs to be clear about what it wants from this shared care arrangement. In addition there needs to be better access and referrals to services and to maintain the monitoring of prescribing activity in the borough. Future contracts should at the least specify the following information needs:

- Numbers clients in Shared care
- Numbers of Drugs and Alcohol clients seen by GPs
- Clients prescribed substitute medication by GPs
- Levels of prescribed drugs being prescribed by GPs
- GPs to upload patients on to NDTMS, where clients are not seen in treatment system but who are prescribed nonetheless
- Numbers of drugs and alcohol clients referred to structured treatment
- Contact frequency and drug worker inputs of clients in shared care
- Clients in Shared Care in effective treatment
- Clients in shared care achieving recovery drug free
- Clients formerly in Shared Care re-presenting to treatment with 6 months of exit

DIP

13.26 The DIP in the borough has emerged as the main referral and support agency for substance misusing offenders in the borough, who are or have been in contact with the criminal justice system. In Tower Hamlets the DIP operates as a referral agency for drug treatment. To this end, it undertakes an initial triage and comprehensive assessments and where necessary, ensures that clients are prescribed to support their stabilisation in the community before moving them onto treatment providers across the borough. Their main recipient providers are CDT and ISIS and to some extent NAFAS. There is a clinical interface with the Treatment providers and they then follow and monitor the progress of their referred clients for the 6 to 12 weeks of their treatment.

13.27 The DIP is funded from the Public Health budget with additional resources contributed from MOPAC. Whilst like many other DIPs nationally, the DIP was previously a Tier 3 provider, however this status changed three years ago and there is no appetite to review

its current role in the treatment system, especially since almost a quarter of all referrals into the system come via the DIP.

13.28 However a component function within the DIP that could be more effectively utilised across the whole treatment system is the assertive outreach team. It would seem that their operational capability needs to be better co-ordinated with providers in the treatment sector both to develop new treatment entries, secure better completions from all appropriate prospective and re-engaging those who drop out of treatment.

Other Key issues influencing the Treatment System in Tower Hamlets

Successful completions

13.29 A significant factor for the DAAT as evident through this needs assessment is the decline in successful completions achieved by the partnership over the last year or so. Tower Hamlets has seen a reduction in the number of opiate successful completions since October 2012 which means Tower Hamlets was ranked 6th lowest for the number of successful completions in September 2013 across its cluster E comparators, from a position of 14th highest at 2012/13 baseline. (There are 30 partnerships in cluster E of which 8 are in London)

13.30 The outcomes data suggests in the past six months there have been 46% less clients successfully completing treatment (138, 2012/13 baseline and 74 September 2013). This set against a 2% decline in the number of opiate clients in treatment means the impact is more significant on the measure of successful completions as a proportion of the numbers in treatment, which currently stands at 5.1%, compared to 9.3% in 2012/13.

13.31 Arguably, the fall in successful completions could be a reflection of the lower numbers accessing treatment, but a critical question is what is happening to those clients that are in treatment and the impact their treatment is having on their ability to successfully complete. The needs assessment has already addressed the high volume of Opiate clients in Shared Care and their low level of successful completions but it would seem that the diminution of successful completions is evident across all providers.

Bottlenecks in the treatment system

13.32 There are several bottlenecks in the treatment system. There is a potential bottleneck in the transfer of DIP clients into structured treatment. It would seem that with the requirement for effective prescribing of these clients there is an equal need to ensure that they undergo strong triage and comprehensive assessments. Essentially this work should be done by the provider who is maintaining their treatment, particularly from a clinical perspective. However due to a range of issues including prison release and the relatively chaotic presentation of DIP clients there is a need to complete these assessments and to prescribe (when needed) at the DIP and then pass these clients on to their continuing treatment provider.

13.33 The key bottleneck to the treatment system is the role currently carried out by the Community Drugs Team (CDT). Essentially this service seems to be massively overworked with over 850 clients in the treatment system and with many of those in Shared Care, where there are clear confusions and systemic failures in enabling clients to progress onto

recovery. Many of these clients are chaotic in their substance misuse and whilst they are not with SAU they are in a community treatment environment which is founded on GP prescribing and community treatment support both at CDT and 8 of the borough's satellite surgeries.

Client readiness to treatment

13.34 Interestingly through the review of the TOPS data and interviews with providers it is clear that in many cases there is a generally low level of client readiness for the recovery journey. In many instances clients are not engaged in pre-treatment support but directly access treatment providers; this is particularly the case for the Harbour Recovery Centre. This service tends to deal with non-injecting opiate using Bangladeshi clients, who are seeking detoxification as a way, in part to appease their families and to demonstrate their willingness to tackle their substance misuse. However the level of re-presentation from this group is high and providers even call their own service a 'Harbour Holiday'. In effect the client undertakes a residential detoxification (i.e. 10 to 21 days) away from their families, extended lifestyles and the pressure that this presents. In some cases these detoxifications are successfully completed but evidence from focus groups is that these clients are often targeted by dealers when back in the community. This situation is compounded, as many of those leaving the centre do not have the protective skills to avoid re-using thus indicating a low level of recovery readiness. On one level this could be considered as a wasted resource, for whilst the treatment is sound and successful, it is not being utilised in a way in which long term positive outcomes are achievable. Potentially more could be spent on getting clients ready for detox and to get them prepared to maximise its benefits. There are also issues relating to the sequencing of this invention which does not appear to compliment further treatment, which could be better managed via the Tier 4 Panel.

Treatment Compliance

13.35 Across the treatment system there are relatively low levels of treatment compliance by clients. In short many start treatment but make unplanned exits, or in other words they drop out. Just under two-fifths (39%) dropped out of their treatment modalities in 2012/13, which is higher than those who completed their treatment in a planned way. This essentially means that the treatment system is fighting a losing battle, for with just under 40% of their client base dropping out only 60% of clients are left to work with - with the target of successful completions being attempted with a diminished pool of potential clients. In short the DAAT has to achieve a much higher level of success against a smaller number of clients, when 4 out of 10 are likely to disengage from treatment and drop out. Therefore treatment compliance is critical and effort needs to be made to better engage and sustain clients into and through treatment. Furthermore, it should be noted, that these clients have accessed treatment only to then drop out and arguably after much of the hard work has been done. Better utilisation of outreach functions could support a reduction in dropped out clients, additionally providers need to make more efforts to retain clients in treatment and the treatment offer needs to provide more options particularly psychosocial treatment and needs to be better structured to secure this goal.

Recovery Capital

13.36 Another concern is the low level of recovery capital across large swathes of the treatment population in the borough. The Inter Ministerial Group on Drug's report 'Put Recovery First'

states: 'No longer, therefore, will addicts be "parked" on methadone or similar opiate substitutes without an expectation of their lives changing. We must ensure all those on a substitute prescription engage in recovery-driven support to maximise their chances of being free from any dependency as soon as is practicable and safe.' The Advisory Council on the Misuse of Drugs defines the domains of recovery capital as:

- Social capital outcomes (support from and obligations to related to family and group relationships)
- Human capital outcomes (health and well-being, aspirations, educational achievements etc.)
- Physical capital outcomes (tangible assets such as property and money)
- Cultural capital outcomes (values, beliefs and attitudes linked to social conformity and the ability to fit into dominant social behaviours).

13.37 Poor recovery capital tends to go hand in hand with complex clients, however what is critical is the need to build this recovery capital. Health is a strong focus of the Tower Hamlets interventions as is some support provided for housing, education, training and employment and general recovery support with benefits and debt. Pockets of this work are in place and when offered are valued by clients and providers alike but these resources, via the NACRO contract are limited to a single advice worker operating across the borough's treatment sector. It is crucial that all have the ability to universally engage and benefit from these interventions. Increasing this work stream would have a beneficial impact on treatment provision and outcomes. Recovery support should be a priority given its role as a key ingredient within the holistic journey to full recovery.

Complexity

13.38 As has been mentioned there are high levels of complexity and diversity within the Tower Hamlets treatment system. In many respects some of the varying needs of these clients have been identified and built into the treatment system. However whilst the targeted provision for particular communities and localities with defined needs is both relevant and evidenced there is a corresponding negative impact in that services are stigmatised as only being for those with high complexities. Indeed some new clients, particularly those with lower service needs, feel their behaviour has yet to reach the extremities being presented by some clients. The perception that 'I'm not that bad and the services are not for me', is something that needs to be challenged. Additionally there are some services which are seen as only being for certain people and certain groups. Service users can come in 'all shapes and sizes' and we know that many do not come to treatment willingly. Nonetheless treatment providers need to address their services to accommodate all these needs and to engage the client effectively into treatment and to give them the best chance they have to address their substance misuse and to make full recoveries. Moreover, it is critically important that these targeted services operate within clear guidelines and have the treatment skills and accreditation proportionate to their work. Additionally the commissioners of services need to address the development of recovery capital and to support this in much the same way to improve the health and well-being of long term substance misuse clients.

Awareness of provision across the sector

13.39 Although, many of the treatment providers had been working with each other for many years (which is positive), information gleaned through interviews showed many were unclear what other providers in the Treatment system did and some also held pre-conceived views of the other services. As such, there is a need to rationalise services and to create greater support for treatment transfers between providers and to clarify what the providers do, what they stand for and how they contribute to the borough's treatment system and different client's recovery/care plans.

Volume of providers

13.40 There are over 23 separate contracts in the borough's treatment system, which brings with it levels of duplication, additionality, over-provision, poor alignment and some internal competition. The treatment system could be better configured through a procurement exercise that designs a holistically treatment system, with the component parts better aligned and with a workforce better allocated to address client need. To this end, there would need to be recognition of the roles, skills, experience and quality of staff and to support this with effective workforce development. Provision within this envelope of services needs to be flexible and adaptable to need and should be based on high quality key working, one to one and group work, flexibility to respond to different presentations and a commitment to support clients on their journey to drug and alcohol free recovery.

Recovery Focus to treatment of Long term clients

13.41 The Recovery Orientated Drug Treatment Expert Group led by Professor John Strang has issued a new report on Medications in Recovery. In this there is a strong focus on the timing and content of treatment reviews. Guidance has now been set out in this report and is on HPE's drugs and alcohol website. The group's advice makes clear that:

- care planning, with its on-going and planned reviews of specific goals and actions, should be part of a phased and layered treatment programme
- a strategic review of the client's recovery pathway will normally be necessary within three months (and no later than six months) of treatment entry, and will then usually be repeated at six-monthly intervals
- strategic review should always revisit recovery goals and pathways (to support clients to move towards a drug-free lifestyle)
- drug treatment should be reviewed based on an assessment of improvement (or preservation of benefit) across the core domains of successful recovery

13.42 In his foreword to the report, Professor Strang says: "Review is both an integral and on-going part of every contact with a patient, and a periodic opportunity to step back and more thoroughly review the interventions being provided and the individual patient's response to them." Care Plan reviews and clinical reviews are a clear mechanism that the borough's treatment system should use to enhance the recovery orientation and this should also be applied to long term clients who are essentially not moving through the treatment system.

14 Priorities for improvement in service and outcomes

14.1 All Drugs and Alcohol needs assessments analyse data that identifies the range of demand for services in the community and assesses the delivery of treatment. However unless a needs assessment is focused on addressing improvement it is not meeting one of its primary objectives. Moreover needs assessments provide an evidence base for treatment planning, however this needs assessment has also reviewed the state of the treatment system locally and is therefore able to provide evidence of service impact and future provision.

14.2 To this end this needs assessment has identified a number of key priorities for the Tower Hamlets Treatment System, which are set out and addressed below.

Developing a treatment systems that meets the needs of the local community

14.3 There are many aspects of the treatment system that currently either prevent or fail to achieve effective treatment for the borough's treatment clients and potential clients. It is clear that there are experienced professionals and providers in the treatment system and the success of the past is testament to their work. However, what is evident is that the treatment system is now not functioning as well as it did and is declining in its ability to deliver effective outcome orientated treatment. Whilst there are clear skills held within the borough in terms of clinical, medical, community treatment, key work, specialist expertise and strong commitment to supporting the client, there are inherent problems with the local system which have been identified by the assessment. There is scant evidence of a treatment system working harmoniously to achieve maximum outcomes for clients. Equally the treatment system is fragmented with a wide range of Tier 3 providers with an array of associated referral/support and specialist interventions funded by the DAAT. From this backdrop, it is clear that the borough's treatment system has to meet the needs of the local community. Some key issues and priorities which need to be considered are set out below.

14.3.1 A **clear annual treatment plan** agreed by the DAAT and shared with providers. This would better define the priorities within the treatment system and support greater clarity of what is expected of the providers within it.

14.3.2 A transition to **integrated drugs and alcohol services** addressing opiates, non-opiates and alcohol. The drugs services are largely opiate focused and this needs to be better balanced with engagement of non-opiate clients. Currently there are high levels of non-opiate use and addiction in the community and this is supported and treated through commissioned services. There is evidence that non-opiate users believe that the treatment provision in the borough is not designed to cater for their needs as they are less chaotic than those using opiates. However there are also high levels of poly drug use and high risk drinking in the borough. Establishing an integrated approach would go a long way to better addressing all presented needs and in doing so generate additional service capacity.

14.3.3 There needs to be **better aligned services** to enable effective treatment and to support planned pathways to recovery. There are seemingly high numbers of clients that are in maintained states of drug use, through substitute prescriptions. This has

seemingly led to many clients still using on top of their methadone and even in some cases storing their methadone. It is clear that getting a substitute prescription is a target that drives all opiate users, whether they want to stabilise or recover. However their reliance on using methadone in this way whilst stabilising their addiction and in all probability reducing their impact on crime is not treating or helping them to move forward in their lives. For many this will be virtually impossible and these clients if stable could benefit from effective Shared Care. Alternatively some are treatment ready and are committed to their personal journey to fulfil their treatment and successfully complete. However in the borough there are high levels of drop outs, attrition and re-presentation into treatment across the partnership – which begs the question about treatment readiness of clients and the recovery capital they possess. Treatment clients are clearly being transferred from one provider to another and whilst this is part of the planned care pathway for the client there seems to be a general lack of clarity of the roles and responsibility between providers in the partnership.

14.3.4 To this end the treatment system needs to be realigned to address the entry into the system, the stabilisation of clients, getting clients treatment ready, working with clients who are starting their journeys, reviewing their treatment needs, counselling and therapy, controlled reduction, detoxification, rehabilitation, group work, recovery support and after care. Along this journey there is a clear requirement to support the psychosocial needs of the client and to address their motivation and goals. The DAAT needs to establish a new structure for treatment in the borough that addresses these needs and allocates clear roles and responsibilities across the partnership to best use expertise and to provide a treatment offer that effectively engages with clients to support them towards minimising their use and complete cessation/abstinence.

14.3.5 The treatment system also needs to improve its performance and **deliver more outcome focused treatment**. The decline of successful completions and the lower numbers of referrals into treatment, with a correspondingly lower level of exits suggests that the treatment system needs to be reinvigorated to be more dynamic and driven in its pursuit of better performance. Numbers in treatment are slowly reducing however the performance of providers is in decline and this needs to radically change to get the borough back to its strong performance levels in 2011. However, not much has seemingly changed since 2011 and the client group is broadly constant so one would expect the partnership to deliver against national and cluster norms and achieve between 8% and 10% successful completions as a proportion of those in treatment – as it has done previously.

14.3.6 **Improving Recovery Capital** is a critical component to successfully completing treatment and moving clients to full recovery. What is clear is that many clients in the borough have diverse and highly complex needs. This scenario is not likely to change in the immediate future and whilst this is a worry for the treatment system, it is critically important that providers and commissioners work to increase levels of recovery capital amongst its clients. This should be assessed through key working. Health, social, physical and cultural capital are important and the treatment system needs to work with partners to build this capital and thus support their clients to get

the most from the treatment system. Client's health and well-being is supported through the strong clinical and medical support afforded by the borough's primary care system. However there should be an enhanced focus on the physical, social and cultural capital of the borough's clients. Currently some providers seem to be better equipped to support this than others, however this needs to be more universally available to all clients.

14.3.7 Whilst the treatment system is targeted to the client there needs to be a greater emphasis on **client facing services** and the drive to offer a care plan which is structured and recovery orientated. Evidence from primary research conducted suggested that the treatment system needs to be more client orientated and focused. Whilst there were high levels of client satisfaction with services, procedures and protocols need to be more orientated to engage with clients and to give them a sense that they are at the centre of their treatment, throughout their treatment. Only in this way can one begin to address the high levels of drop outs in the system, although whilst it is recognised that some of these drop outs will occur their numbers can be decreased with more client focused provision. Many of those that participated in the focus groups felt some services were lacking in their focus on clients and whilst there is strong evidence of peer support, mentoring and peer engagement there was a sense that there needs to be a more positive support for clients particularly in the early stages of their treatment journey. Some provision was seen as medically driven, functional, restrictive and in some cases inflexible, other provision particular those at the 'latter' end of the treatment spectrum were more personalised, client focused and as a result seen as more supportive.

14.3.8 A clear consideration in the development of a treatment system that is based on needs is the corresponding benefit to the **rationalisation of commissioning** functions and the **performance management** of contracts. For example if services are better set out in a more focused, integrated and planned way there is every likelihood that the commissioning function would be better placed to effectively monitor and oversee the delivery of cross partnership performance. Currently there are a large number of contracts that are commissioned by the DAAT. The treatment system if procured to meet local needs would need fewer providers but rather build a comprehensive treatment function which is intuitive, capable to react effectively and responsive to clients. All contracts currently have performance targets which are reviewed quarterly (RAG). However many of these targets are currently not being met. Targets need to be broken down to units of delivery which contribute to the partnership treatment plan. This needs assessment suggests that targets should be in place for all providers and they should measure; new treatment entries, those in effective treatment, successful completions and the reduction of representations and drop outs. These should be standard measurements and reviewed monthly. In addition specific provider targets could be established where appropriate but these would need to be agreed locally with commissioners and monitored accordingly. In some cases these will relate to one off actions/events and the implementation and

delivery of specific operational activity. The development of the provider dashboards should assist in this.

14.3.9 **Workforce Development**: The quality of local drugs and alcohol services is generally a reflection of the skills, experience and knowledge of the staff working within them. Whilst the Borough's treatment system needs to be re-procured it is equally important that the workers and volunteers working in it have the right experience, skills and knowledge to perform and hence they need to be supported in developing the right blend of skills and competencies. This is the responsibility of the DAAT and service providers and its importance should not be overlooked. The treatment plan should identify the training and development priorities of the partnership annually and set a programme of development that can be funded and supported across the partnership. Workforce development needs to be both skills and knowledge based and providers need to commit to release staff and to engage in activity that should benefit the partnership as a whole and hence the clients being served by it. This should also help to retain qualified staff in the borough.

14.3.10 **Clarity of the roles and responsibilities** and operational relationships of different players and partners within the treatment system is vitally important. On this basis there is a need to define the treatment system in a way in which all parties are fully aware of their roles within the system and their responsibilities both to clients and the other partners in the borough.

14.3.11 There needs to be better clarity about the treatment roles of **shared care and structured treatment** in the borough. It is clear that there is a place for a shared care model in the borough but it is equally apparent that there needs to be proper assessment of clients before they are brought into that scheme. Most shared care systems ensure that primary care access and support is easily available for clients and particularly those that are better stabilised and those that can be better treated in a familiar primary care setting. Correspondingly structured treatment provision needs to be able to work within a primary care environment to provide effective treatment and to meaningfully support clients through their recovery journeys. This is the essential basis of the national drug strategy and shared care needs to play its part in this goal. Many in the current shared care 'model' are not progressing through treatment and are simply accessing local GP provision and obtaining prescriptions and not actively participating in the treatment.

14.3.12 The Treatment system in the borough needs to commit to implementing a comprehensive level of **care and treatment planning reviews** for all its clients with clinical support where this is needed and in particular to review the shared care clinical and treatment work for long term opiate clients.

The case for Treatment Service Procurement?

14.4 The way forward for the Boroughs procurement of treatment services is set out in the Tower Hamlet's Service Review report.

15 Recommendations

15.1 This Substance Misuse Needs Assessment has highlighted a range of information and research data about the needs of different treatment clients presenting to services in Tower Hamlets. The key focus of the needs assessment has been to review the existing usage of treatment services in the borough. Problematic drug users remain the primary focus for treatment provision and Tower Hamlets has commissioned services to broadly address the needs of these clients. Referrals into services are being channelled in a variety of ways with self-referral still being the strongest route. However referral pathways need to be built with all potential sources and this should reinvigorate the DAAT.

15.2 Across those in treatment, opiate users are the most prevalent, although there is an increasing volume of alcohol presentation. A high proportion of Tower Hamlets' service clients use opiates as their main drug of choice. Assessment indicates that problematic alcohol use is an increasing concern locally as well as being a strong secondary substance to Opiates and other drugs. However it is clear that there are still levels of unmet need with a sizeable proportion of OCU and high risk Alcohol users not entering the system.

15.3 It is also the view of this needs assessment that cannabis is a high use drug (particularly if crime/possessions rates are taken into consideration) although there are low levels of presentation to services. In some case the use of cannabis is almost as normalised as the use of alcohol. The strong levels of opiate and crack presentations in the borough have always been a priority and this would have masked other substances which are prevalent in the community. Legal highs have also been stated as a significant concern locally, although there is little evidence in the current treatment system of addressing this emerging problem. In short non-opiate pathways into treatment need to be reviewed to increase this component of the treatment system.

15.4 Problematic alcohol use is increasing both as a primary and secondary drug of choice and the implementation of the borough's alcohol strategy is a high priority to meet the increasing potential need for services. However the contrast between those estimated to have an alcohol problem and those in treatment is great. The low level of presentation against estimated need suggests a level of treatment naivety which needs to be challenged.

15.5 As with all forms of substance misuse, many people are reluctant to seek treatment. Barriers to accessing services are well-known and service providers must work to address and mitigate these. In part services need to be more integrated to address drugs and alcohol treatment needs.

15.6 Aims of the Integrated Drug and Alcohol Treatment Service should be:

- To offer personalised opportunities for those using drugs and/or alcohol to move towards total cessation.
- To reduce the harm caused by substance misuse on the local community including contributing to a reduction in crime and anti-social behaviour
- To ensure that the principles of harm minimisation underpin the delivery of all interventions in order to improve the health and well-being of service users

- To deliver a non-judgemental and inclusive service which treats service users with dignity, respecting gender, sexual orientation, age, ethnicity, physical or mental health ability, religion, culture, social background and lifestyle choice
- To deliver services which are accessible, responsive and offer greater service user choice
- To improve the outcomes for children of service users by reducing the impact of drug and alcohol related harm on family life and to promote positive family involvement in treatment
- To facilitate a co-ordinated and holistic approach to recovery which emphasises the inclusion, or re-entry into society of service users by working with a range of local partner agencies
- To reduce the impact of drug and alcohol misuse on the wider public sector economy by promoting effective treatment and harm reduction responses in a range of settings including primary and community health care, mental health and criminal justice services
- To identify and safeguard vulnerable adults and children of adults who use the services

15.7 The Tower Hamlet's partnership between its providers and with other statutory agencies has been well established but there is a current opportunity to revamp these relationships and to build a stronger set of local commitments to drugs and alcohol. It is on this basis that the following recommendations and treatment plan priorities are made:

Strategic Recommendations:

- Maintain the management of drugs and alcohol treatment planning, commissioning and performance management through the DAAT team within the Council
- Establish evidence based commissioning and treatment planning by using this needs assessment and set appropriate targets and performance management tools for the borough's drugs and alcohol treatment system
- Maintain the priority of Substance Misuse Treatment Services through current and future changes to funding streams for Drugs and Alcohol misuse in Tower Hamlets
- Develop and maintain annual treatment plans which fit into the Public Health commissioning priorities to tackle addictions in the community
- The Tower Hamlets DAAT needs to maintain up to date data and to review performance against the 2014/15 treatment plan

Key Treatment Plan Priorities:

- Tower Hamlets has seen a slow decrease in opiate presentations over the last three years. However this does not address the wider treatment naive population. Opiate users should always be a priority group within substance misuse treatment provision
- Services will need to be maintained and strengthened for non-opiate and other problematic substance misuse
- There is a clear need to plan for and target the increasing emergence of alcohol.
- Increase the numbers of those entering the treatment system to maintain a steady client flow through
- Undertake a more dynamic approach to sourcing new clients and or targeting ex-clients who may now be treatment naive
- Maximise the number of clients in effective treatment, this is currently falling and may affect future service success and impact

- Develop programmes to increase the Recovery capital available to clients
- Work to address the recovery agenda and drive forward the increase in Successful Completions for the borough
- Establish a focus on addressing the long term clients i.e. clients who have been in the treatment system for over 6 years.

Operational Priorities

- Set targets for the treatment provision secured through the re-procurement exercise
- Define service scope and capacity to expand the community focus of the work and to provide beyond the traditional 9-5 operational model, extending to more evening and or weekend provision where feasible
- Redefine the Borough's Shared Care system to take account of the treatment/recovery needs of clients in particular those receiving their substitute prescribing from their GP
- Review and support aftercare and consider effective options to extend aftercare services
- Support providers to work with the 'assertive' outreach services within the DIP to support re-engagement and to engage new clients
- Target non-opiate and alcohol treatment provision with associated treatment options in particular psychosocial analysis, behavioural treatment and motivational interviewing.
- Review the role and provision of community detox
- Support clients readiness for treatment
- Enhance the key worker capabilities in the borough
- Implement a comprehensive and frequent review of client treatment and care plans both from a clinical and treatment perspective.
- Improved contract management, setting recovery focused delivery targets for each provider, in part this is already in the performance management of the providers but may need revisiting and reinvigorating.
- Clear fiscal controls with all providers in contract to support treatment system benefits and to guide/influence decision making
- Contracts to be set to secure a controlled and where possible reducing subsidy level and increasing cost benefit ratio regarding costs of crime as nominal targets.
- Review those parts of the treatment service where there are high levels of expenditure but which do not contribute to performance targets or indicator
- Develop Annual workforce development plan
- Work with partners to secure effective up to date data exchange on; A&E admissions, drugs and alcohol Hospital admissions, Ambulance service call outs and maintain a working review of Policing, drug and alcohol crime and Integrated Offender management (IOM) and Probation client data.

16 Appendix 1: Glossary of Abbreviations

ATR	Alcohol Treatment Requirement
BBV	Blood Borne Virus
CCA	Community Care Assessment
CCG	Clinical Commissioning Group
CDT	Community Drug Team
CJS	Criminal Justice System
CRC	Capture Recapture
DAAT	Drug and Alcohol Action Team
DIP	Drug Interventions Programme
DOH	Department Of Health
DRR	Drug Rehabilitation Requirement Order
DUO	Drug Using Offender
DV	Domestic Violence
ETE	Education, Training and Employment
GPRD	General Practice Research Data
GPWSI	General Practitioner with Special Interest in Drugs and Alcohol
HO	Home Office
HRC	Harbour Recovery Centre
IDU	Injecting Drug User
IOM	Integrated Offender Management
LAPE	Local Alcohol Profiles for England
LAS	London Ambulance Service
LBTH	London Borough of Tower Hamlets
LCPF	London Crime Prevention Fund
MOPAC	Mayor's Office for Policing and Crime
NATMS	National Alcohol Treatment Monitoring System
NDTMS	National Drug Treatment Monitoring System
NTA	National Treatment Agency
NWPHO	North West London Public Health Observatory
OASys	Offender Assessment System
OCU	Opiate and/or Crack User
PACT	Prescribing Analysis and Cost Data
PCT	Primary Care Trust
PHE	Public Health England
SAU	Specialist Addictions Unit
THCAT	Tower Hamlets Community Alcohol Team

VAWG	Violence Against Women and Girls
VFM	Value for Money