Southwark
Drug and Alcohol Action Team

Needs Assessment 2011

Comprising of
Adult Drugs and Young people's updated assessments
And
Alcohol first full needs assessment

Safer Southwark Partnership: Southwark DAAT
Southwark Substance Misuse Needs Assessment 2011
Date: January 2011

Foreword

2010 has been a year of development for Southwark DAAT as it has worked to meet the twin challenges of poor performance and a reducing budget.

Southwark DAAT responded by implementing a number of strategies to address strategic planning, commissioning and delivery issues in both the short and the long term. Implementation of these strategies has led to improvement in performance and improved outcomes for service users.

- The DAAT Board and Joint Commissioning Group are meeting regularly with clear terms of reference and providing strategic leadership.
- The new Children and Young people's service was commissioned and started work in May.
- Alcohol hubs have been set up across the borough providing GPs with access to a professional specialist nursing service.
- Significant work has been undertaken to establish GP shared care as a key method of delivery for tier 3 treatment.
- We have trialled a new way of delivering Drug Rehabilitation Requirements using a pick and mix decision making model with Probation, the case manager and the client agreeing a personalised programme.

On the horizon there is a culmination of the remodelling of the adult treatment service.
This reconfiguration of the services will enable clients to access treatment easier and improve partnership working between all providers.

The 'Adult Alcohol Health Needs Assessment', 'Adult Substance Misuse' and Children and 'Young People's Substance Misuse' needs assessments have been performed in parallel and are presented together with shared recommendations.

The needs assessments combine epidemiological data collection with input from experts and service users. They quantify and describe the individuals drinking or misusing substances, summarise the impact of this behaviour and assess the services provided to reduce this impact, spanning primary prevention through to treatment and harm reduction.

The Needs Assessments are produced within the context of the new Drug Strategy *'Reducing Demand, Restricting Supply, Building Recovery'* and the Public Health White Paper *'Healthy Lives, Healthy People'*.

The 2010 - 2011 needs assessment has involved as wide a range of agencies, partners, clinicians, and service users as possible. It was decided this year to conduct a three way needs assessment covering drugs and alcohol for both adults and young people. As a result this needs assessment has one Executive Summary, chapters on each area and concludes with the key recommendations.

2011 – 2012 will be another testing year with significant budgetary cuts and a continued need to drive up performance with payment by results on the horizon the following year. All this will need to be delivered against the backdrop of rapid changes within the NHS and a national drug strategy to implement. Despite these challenges Southwark DAAT is committed to improving its service provision, improving performance and adopting a recovery focused approach to treatment and care.

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LIST OF ABBREVIATIONS

3BHCT	Three Boroughs Healthcare Team
AA	Alcoholics Anonymous
ATR	Alcohol Treatment Requirement
Blenheim CDP	Blenheim Community Drug Project
CA	Cocaine Anonymous
CAMHS	Child and Adolescent Mental Health Service
CDAT	Community Drug and Alcohol Team
CiC	Children in Care
CLA	Children Looked After
CQUIN	Commissioning for Quality and Innovation
CRI	Crime Reduction Initiative
DAAT	Drug and Alcohol Action Team
DIP	Drug Interventions Programme
DIRWEB	Home Office's DIP Data Management System
DNA	Did Not Attend
DWP	Department of Work and Pensions
ETE	Employment Training and Education
FIP	Family Intervention Project
GP	General Practitioner
HASS	Housing Assessment Support Service
HMP	Her Majesty's Prison
IAPT	Improving Access to Psychological Therapies
IOM	Integrated Offender Management system
JCG	Joint Commissioning Group
JCP	Jobcentre Plus
LAS	London Ambulance Service
LB	London Borough of ....
LES	Local Enhanced Service
LSOA	Lower Super Output Area
MA	Marijuana Anonymous
NA	Narcotics Anonymous
NDTMS	National Drug Treatment Monitoring System
NEET	Not in Education Employment or Training
NICE	National Institute of Clinical Excellence
NTA	National Treatment Agency
NWPHO	North West Public Health Observatory
ONS	Office National Statistics
PDU	Problematic Drug User
PTB	Pooled Treatment Budget
RARS	Resettlement Assessment and Referral Service
SDLA	Severe Disability Living Allowance
SILS	Southwark Inclusive Learning Service
SLAM	South London and the Maudsley NHS Foundation Trust
SMT	Social Services Substance Misuse Team
SPOT	Street Population Outreach Team
SUI	Serious Untoward Incident
TOP	Treatment Outcome Profile
YOS / YOT	Youth Offending Service / Team

Aims and Objectives

Aims
The aims of this needs assessment are to establish;

- A clear picture of local need.
- How this need can be met by the DAAT and service providers.
- To identify gaps in data and understanding of need to inform future needs assessments.

Objectives
These aims will be met by the following objectives;

- To review current treatment population and provision.
- Analyse and interpret local and national data, to identify current and emerging trends.
- To seek the views of service users, professionals and other stakeholders in relation to substance misuse and service provision in Southwark.
- To consider and plan how the new service will integrate with universal and targeted children and young people's services to facilitate earlier intervention and prevention in the area of substance misuse.
- To identify levels of need and where these are being and not being met.
- Identify barriers that exist in meeting these needs.
- To critically evaluate the efficacy and efficiency of existing substance misuse provision across Southwark.
- To review and highlight the impact of alcohol and substance misuse on carers, family, friends, young people and significant others and how services can meet these needs.
- To evaluate how far the Recovery model is utilised in Southwark and how this can be strengthened.

Data from a wide range of sources has been utilised to inform the Needs Assessment. Use of data focused on the national, regional and local levels.

We are grateful to the support of many partners in the gathering of this data. Our service providers, statutory bodies and agencies, the NTA, and the Southwark Service User Council and service users have all provided information, data, and opinions which have helped shape this report.

Thank you from
The Steering Group.

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SUMMARY of RECOMMENDATIONS

The findings of the assessments suggest the following key areas for prioritisation by the DAAT:

The number of people in effective treatment in Southwark has been declining in recent years. It is evident from the research carried out for this needs assessment that this does not reflect the level of need in Southwark. The largest single referral route into treatment is self referral in Southwark.

Carrying out the adult substance misuse needs assessment alongside the young people's needs assessment has highlighted the inter-generational nature of substance misuse and its associated impacts on different generations. Treatment services must recognise this if treatment is to have a lasting effect. This will be an area of focussed development in Southwark.

Outcome based commissioning is now widely accepted, the key now will be to ensure that outcomes and not just outputs are the key area of focus for treatment services.

Adult Alcohol:

1. Support the introduction of a minimum pricing scheme for alcohol.
2. Ensure continued development of Primary Care screening and brief advice (potentially through a Locally Enhanced Service), and continued development of community services including Primary Care alcohol hubs.
3. Link with KCH and GSTT to contribute to their work plans around alcohol screening and treatment in A&E and across the Acute sector.
4. Ensure that community services have the capacity to meet any additional referrals that may be generated by screening and brief interventions in other agencies.
5. Ensure that family support is available in treatment services both to improve effectiveness and to minimise barriers to women accessing services.
6. Investigate and address high rates of unplanned exits in community detox services.
7. Ensure that treatment services provide support or links into other services around housing, employment etc.
8. Ensure appropriate aftercare to prevent relapse (when aiming for abstinence).
9. Encourage a range of agencies to use identification and brief advice to contribute to a range of health and non-health outcomes (police, probation, workplaces, acute trusts etc), including potential use of DIP.
10. Link commissioned and non-commissioned services to ensure appropriate referrals and smooth flow of individuals between services (e.g. from Acute Trusts and probation into community services).
11. Contribute to further work to reduce alcohol related crime and violence through saturation areas, feedback to trade, and also individual level support utilising DIP and other alcohol specific services.

Adult drug misuse:

1. Improve numbers into and retained in effective treatment across all services.
2. The adoption of the Recovery remodel and reconfiguring of services to support this. This will see open access service provision for assessment across all services for all substances used (drugs and alcohol).
3. Increase the recognition of the intergenerational nature of substance misuse and tailor services to meet this. This will encourage early intervention (with referrals to the young people's substance misuse service for young people) and support to parents/carers

(with referrals to adult treatment services for adults) through increased and improved family interventions.

4.
5. Improve planned exits and outcomes for service users, which will be supported by the adoption of the Recovery model in services.
6. Recognise that service users have both underlying and consequential psychosocial support needs around substance misuse and reflect this in service development plans.
7. Improve assessment and access from the Criminal Justice System (Probation, DIP, DRR) by reviewing and improving current arrangements.
8. Re-commission current DIP service provision to support improvements to access and treatment outcomes as well as the recovery agenda.

Children and young person's substance misuse:

1. Increase the number of young people in treatment by:
   a. Increasing attendance by Children's Service staff and other identified agencies at the training provided by insight.
   b. Increasing referral routes from all services.
   c. Increasing the profile of the service in the Borough.
   d. Complete protocols and practice guidelines to ensure that pharmacological and residential substance misuse treatment services can be accessed where needed.

2. Implement the Family Therapy Trial.

Next steps

Following the publication of this needs assessment, and its approval by the Board of Southwark DAAT, action and treatment plans in each of the three areas will be drawn up ready for implementation from April 2011.

Alongside this process commissioning of services and the setting of the 2011-2012 budget will reflect the priorities and key recommendations contained within the needs assessment.
Final approval of the budget, treatment and action plans will be made by the Board in March 2011.

Southwark

Updated Drugs Needs Assessment

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Introduction

On the 8th December 2010 the new Drug Strategy was published setting out a different approach to addressing substance misuse.

> "This strategy sets out a fundamentally different approach to tackling drugs and an entirely new ambition to reduce drug use and dependence. It will consider dependence on all drugs, including prescription and over the counter medicines. It recognises that severe alcohol dependence raises similar issues and that treatment providers are often one and the same."[i]

The strategy has two overarching aims to:

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

The strategy recognises the importance of education and early intervention, the role of the family and the principle of Recovery for communities and individuals.

This needs assessment, in line with NTA guidance, will review existing data and information, map current service provision and profile service users and groups who do not access services. This will lead to an understanding of the unmet need which will be discussed by the expert group to form a gap analysis to evaluate and prioritise areas to be addressed.

The following methods and information sources were used for this needs assessment:

- Analysis of National Drug Treatment Monitoring System (NDTMS)
- Local treatment service data and impressionistic feedback
- Local performance data
- Previous existing local needs analysis data
- Discussion and knowledge from Expert Group
- Local Tier One service data and impressionistic feedback
- Safer Southwark Partnership Rolling Plan Refresh
- Southwark Substance Misuse Service User Council consultation.

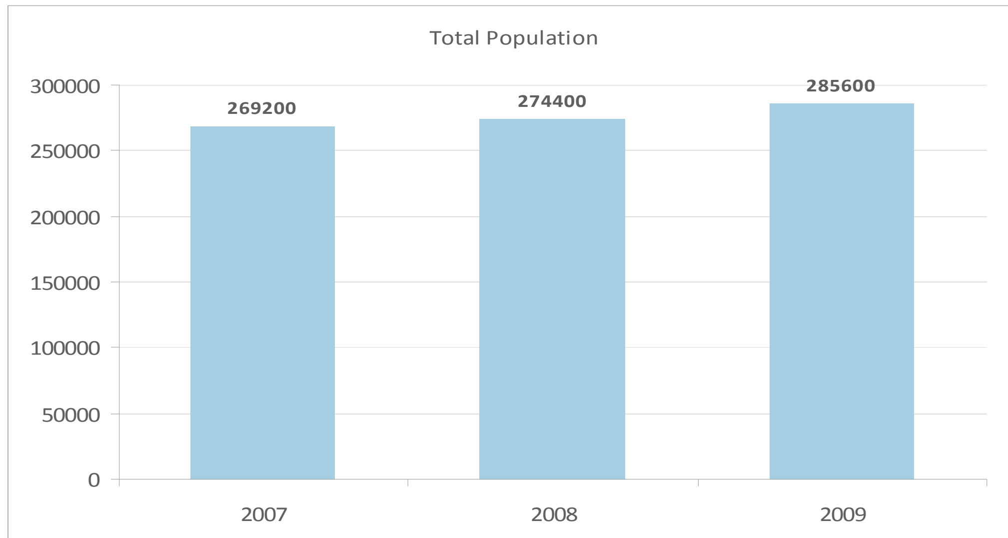
Last years needs assessment identified a number of areas where additional work and research would be carried out, this was an ambitious plan which was written before the change in the political landscape which has had an effect on the organisation and resources of the DAAT partnership agencies. This has resulted in some areas of work not being carried out on the scale that the needs assessment planned. However, this should not detract from the good work that has been carried out and the commitment that the DAAT has to improve treatment pathways and provision in Southwark.

This year Southwark DAAT decided to adopt the Recovery model of treatment and remodel services to facilitate this. This is a separate piece of work that is being carried out alongside the needs assessment but the needs assessment and resulting treatment plan will feed into this process and vice versa.

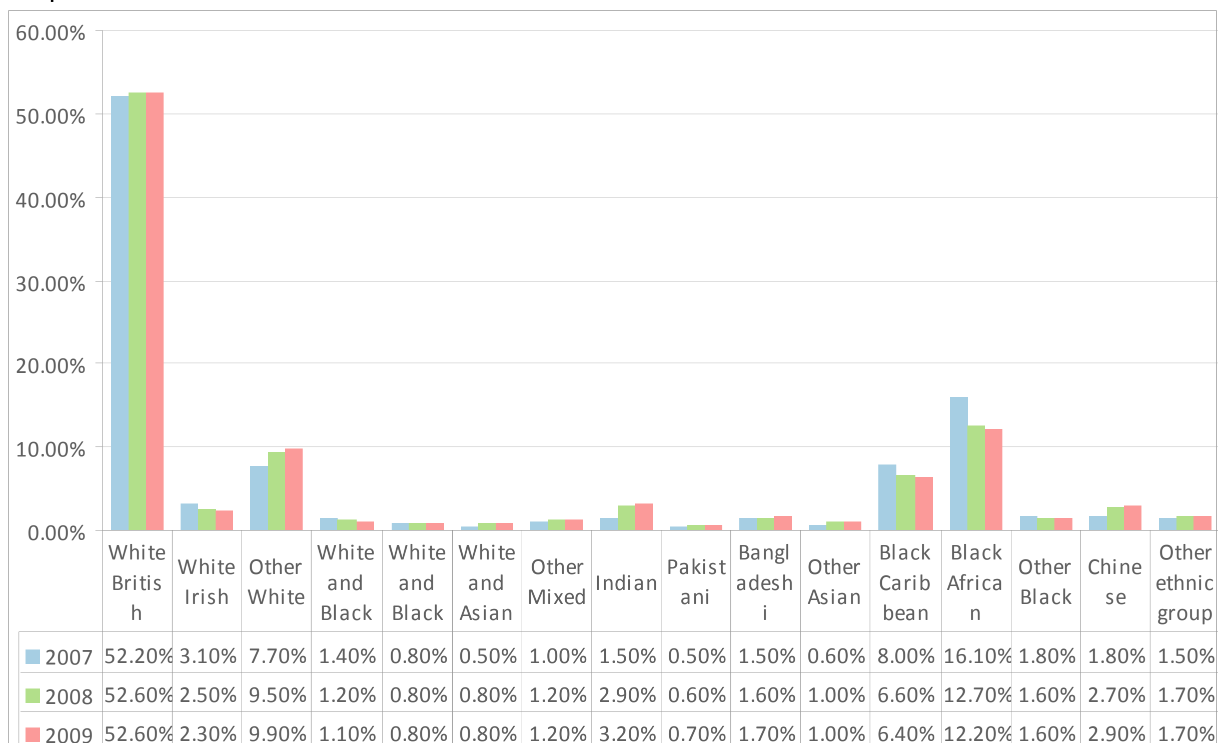
Demographics & Prevalence

There have been some changes in Southwark's population in 2009. Graph 1a shows the overall population of Southwark has increased from 274,440 in 2008 to 285,600 in 2009. Graph 1b shows there have also been changes to the ethnic demographics of Southwark with a slight increase in the "white British" population and an increase in the "white other" population of 2.2% which is generally held to be Eastern Europeans.

Graph 1 a



Graph 1b



Glasgow Estimate

The methodology used to establish the Glasgow estimate which is used by the NTA to estimate the prevalence of 'problem drug use' (defined as use of opiates and/or crack cocaine) both nationally and locally has been changed. This has resulted in a reduction of 956 in the Glasgow estimate of PDUs this year to 3417[ii], which the NTA believe is a more realistic estimate. They do, however advise that the new estimate cannot be compared with previous years. In relation to Southwark this is a more realistic estimate of drug use within the borough.

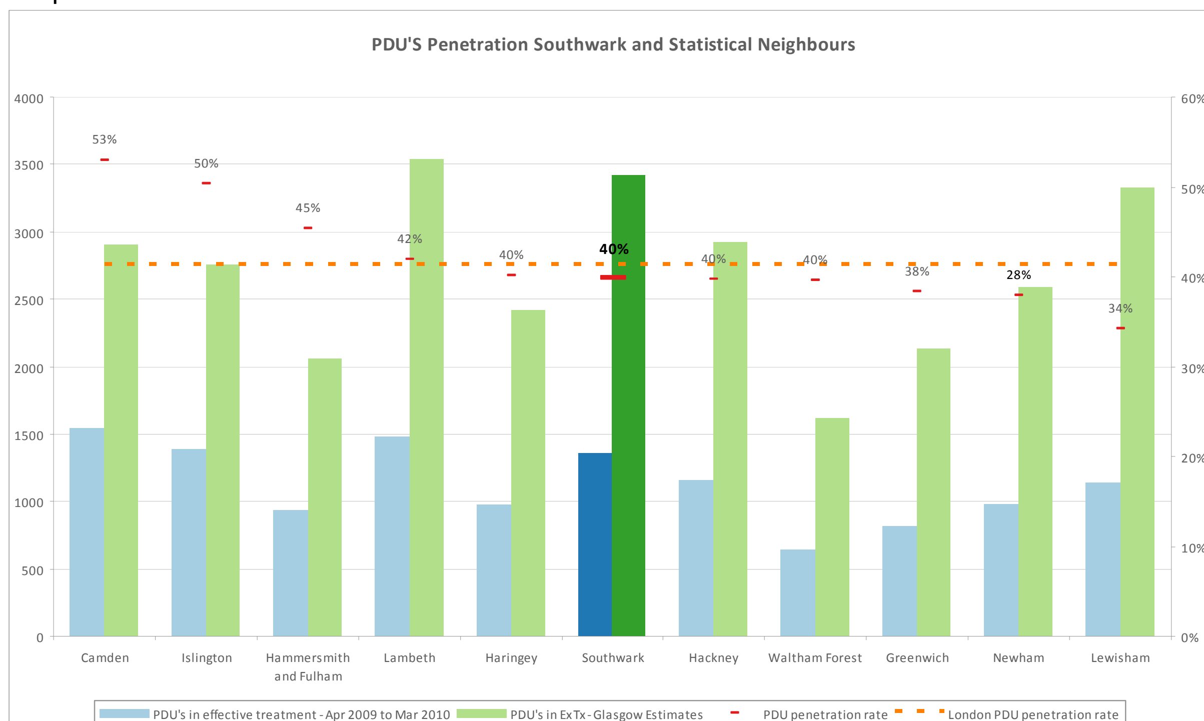
It should be noted, however, that the Glasgow estimate does not include non problematic drug users, such as powder cocaine and cannabis users. It is recognised in Southwark that these groups who are not covered by the Glasgow estimate do present issues which warrant treatment interventions.

The table below shows the estimated number of problem drug users aged between 15 – 64 for 2008/9 with associated 95% confidence intervals. The table also shows further breakdown of this estimate.

	Number	95% CI	
Problematic drug users (Age 15-64)	3,417	2,902	3,892
Opiate users	2,405	2,047	2,764
Crack users	2,356	1,898	2,834
PDUs 15-24	368	300	456
PDUs 25-34	1,215	9,61	1,486
PDUs 35-64	1,833	1,496	2,142

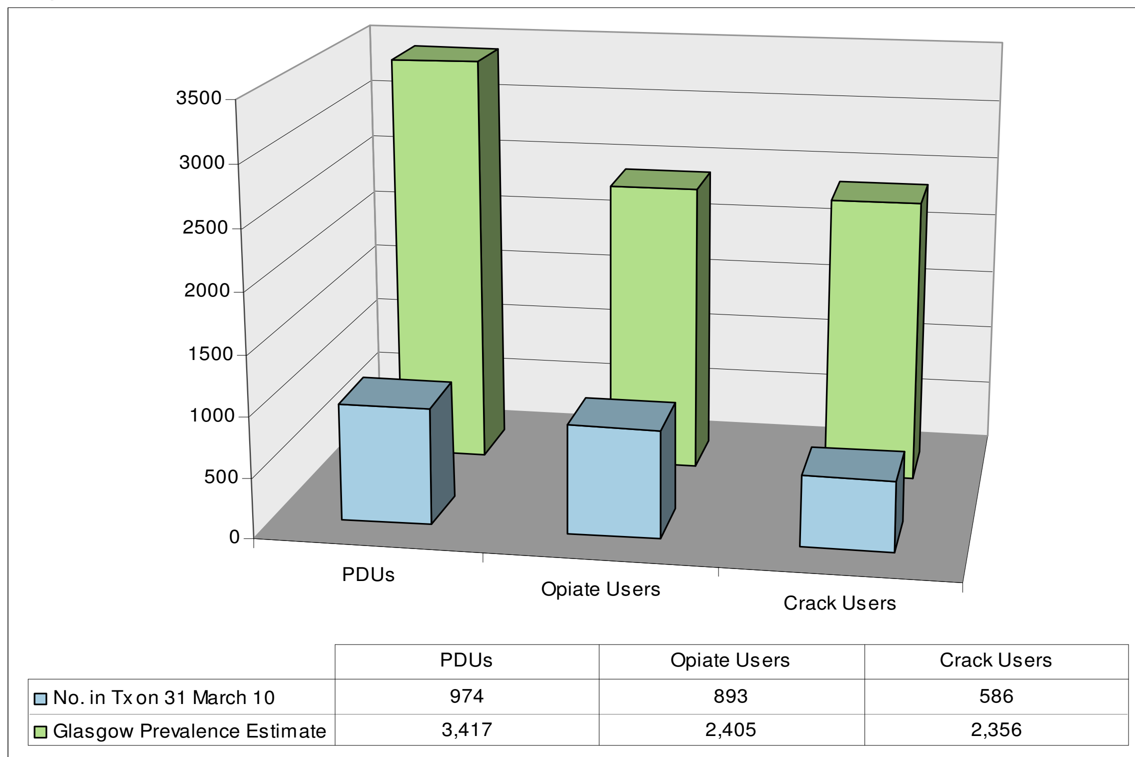
The graph 2a below shows the penetration rates for Southwark and its statistical neighbours. As the graph shows, Southwark's penetration rate compares favourably with its statistical neighbours and that there appears to be a trend in penetration rates with those boroughs with higher Glasgow estimates having lower penetration rates than boroughs with comparatively lower Glasgow estimates.

Graph 2a



Graph 2b shows that in Southwark penetration rates for opiate users are the highest at 37% with PDU and crack users penetration rates being 29% and 25% respectively.

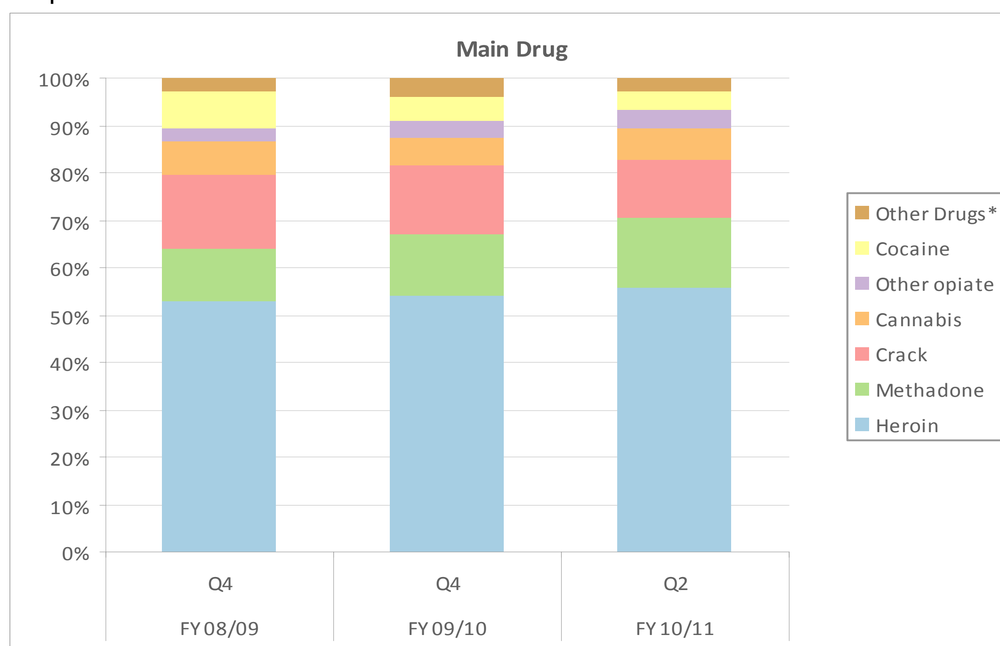
Graph 2b



	PDUs	Opiate Users	Crack Users
No. in Tx on 31 March 10	974	893	586
Glasgow Prevalence Estimate	3,417	2,405	2,356

Graph 2c shows that from NDTMS data, the reported main drug used by people in treatment is heroin. Previous needs assessments have established that polydrug use is the norm in Southwark, and other data in this year's needs assessment shows that polydrug use is the norm in Southwark.

Graph 2c



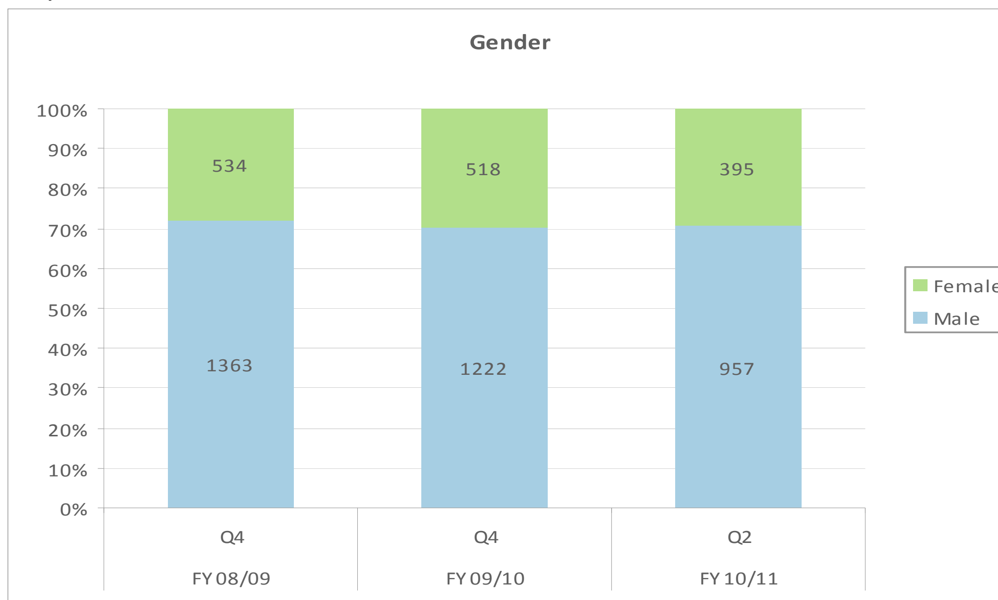
Treatment Data Analysis and Issues Arising

Gender

Graph 3a shows a breakdown by gender for all people in treatment; assuming 85% of those in treatment are PDUs and given the Glasgow estimates in 2008 provided a breakdown of the prevalence rates by gender (77% to 23% male to female ratio) the % of women in treatment is higher than the prevalence rate. With women making up 29.2% of the in treatment population, it would appear that being a woman is not a barrier to entering treatment. However, it should be noted that at the focus groups, it was voiced that there are barriers to women accessing treatment, particularly concerns around social services involvement where those accessing treatment were mothers, so this remains an area that could be improved through closer working links with social services.

Women do have higher rates of retention in treatment than men, which may be for a number of reasons, but does highlight a need for this to be explored further.

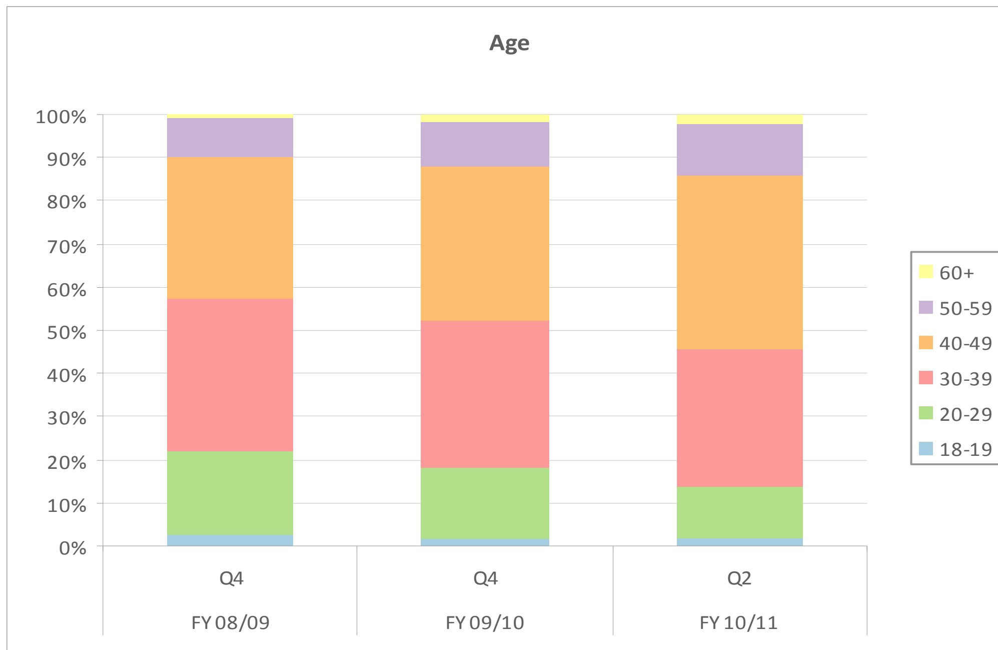
Graph 3a



Age

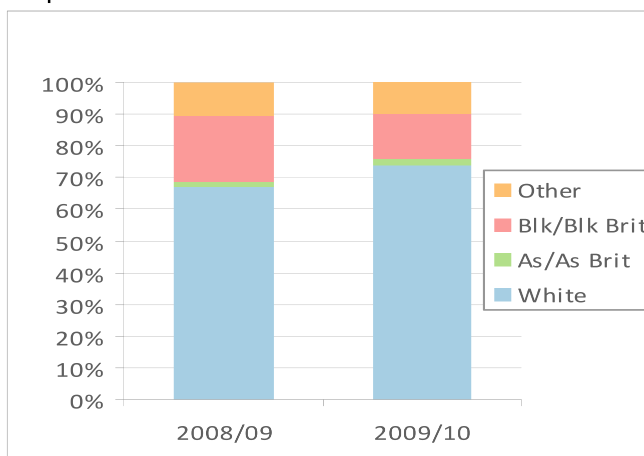
Graph 3b illustrates the aging nature of the treatment population in Southwark which is similar to recently published national findings. Graph 3B shows a reduction in the number of people in the 20-29 age band and an increase in the 40-60 age band, which if this is considered with the earlier findings of the main drug people are receiving treatment for as being heroin, we can see the emerging picture of less young people using heroin and crack cocaine.

Graph 3b



Ethnicity

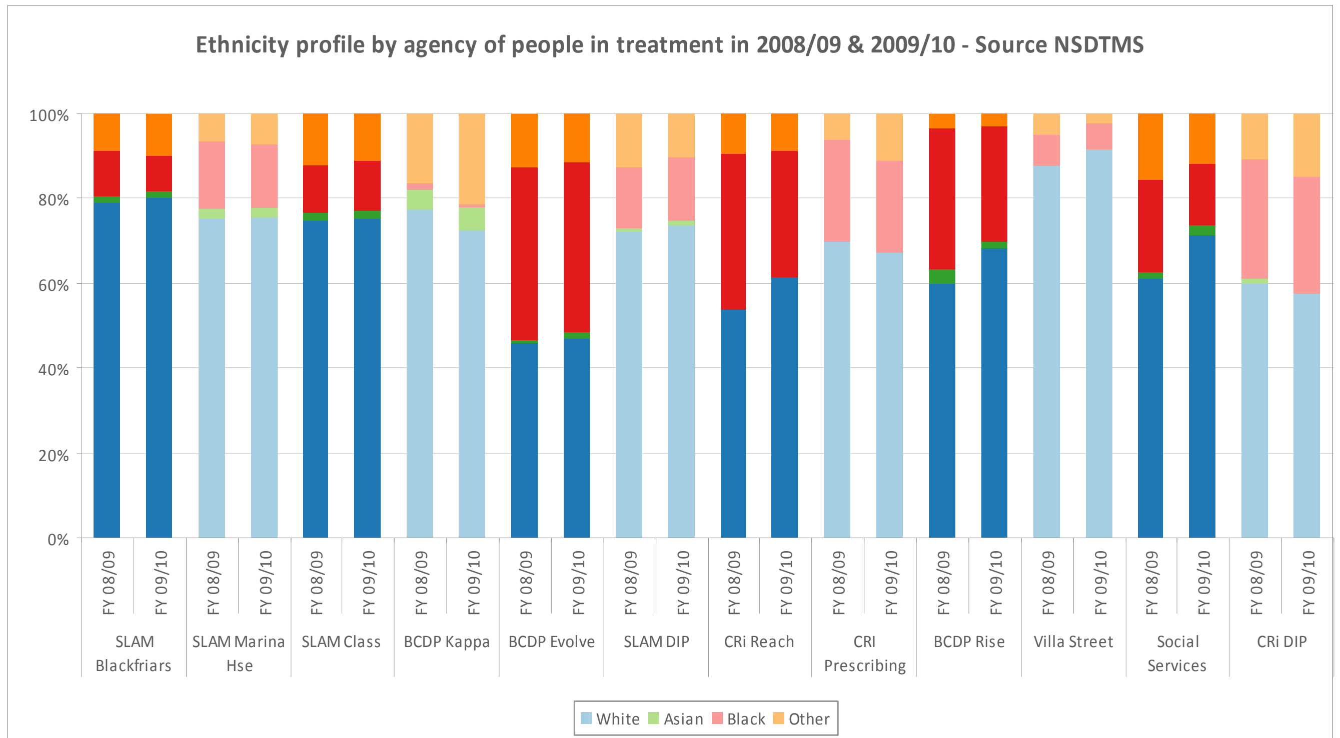
Graph 3c



Graph 3c below shows the ethnic breakdown of the treatment population in Southwark. It is evident that the percentage of ethnic minorities in treatment has decreased from 2008/9 to 2009/10. This may be connected in part at least, to the changes in the ethnicity of the overall population of Southwark as discussed earlier. However this is looked at in more detail by agency in Graph 3d below.

Graph 3d below shows a comparison between 2008/9 and 2009/10 ethnic breakdown of people in treatment by agency. It can be seen that a number of agencies have seen an increase in the number of "white" people in treatment with CRI Reach, BCDP Rise, Villa Street and Social Services being the most noticeable. These agencies have seen corresponding reductions in the number of people from ethnic minorities receiving treatment with a noticeable reduction from the "black" community. There have been some changes in the "other" ethnic minority groups with SLAM Blackfriars, SLAM Marina House, CRI prescribing and CRI DIP seeing increases in these groups. These changes may be due, in part, to the overall changes in the ethnic breakdown of the Southwark population, as there are some similarities, such as a increase in the "white" population, reported to be Eastern Europeans.

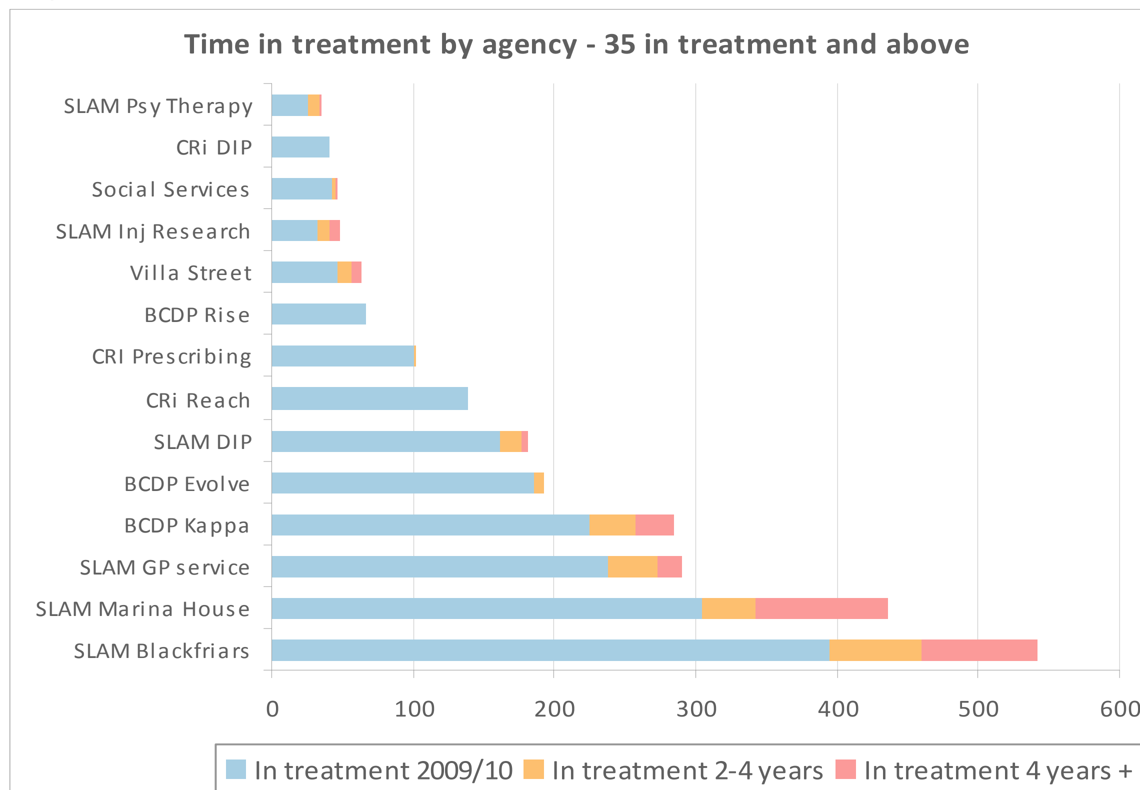
Graph 3d



Time in Treatment

Graph 3d below shows the number of clients who have been in treatment for between 2 and 4 years and how many have been in treatment for over 4 years. This information has been simplified to include only those agencies with more than 35 clients.

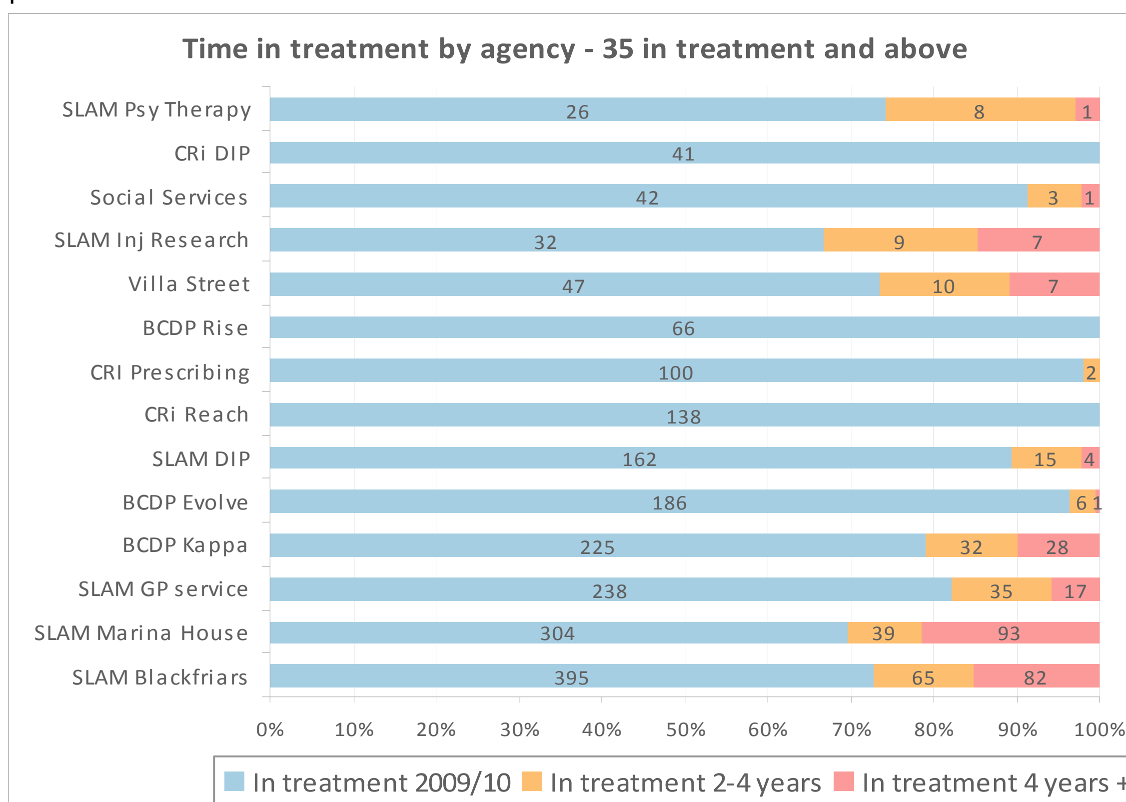
Graph 3d



From this information we can see that of 2,467 people in treatment 238 have been in treatment for 2-4 years, with 241 being in treatment for over 4 years. From discussions with service providers it is evident that some of these clients will be working and their substance misuse and/or treatment will have little impact on their lives. Locally there is an evidence based harm reduction culture. Services have been working to these principles for many years and although some opportunities for recovery and abstinence exist we are keen to develop these. We need to ensure that people are given opportunities to be involved in recovery activities even when on maintenance scripts.

In consultations, service users talked about being "parked up" on methadone prescriptions. This led to no expectations of exiting treatment and abstinence not being presented as a goal. Graph 3e below shows a breakdown of numbers in treatment for individual agencies, as can be seen, which could be seen as supporting this view. The specialist prescribing services that provide substitute opiate prescribing have the highest proportion of people in treatment for over 2 years, which would be expected as they see some of the clients with the most complex needs. This may be clinically appropriate that some of these clients have been in treatment for this length of time (i.e. dual diagnosis, heavily dependant drinkers on daily supervised consumption etc.).

Graph 3e



Views of service users

As part of the information gathering process for this needs assessment, two focus groups were held. The groups were asked to consider access to treatment, their experience of being within services and leaving treatment. The groups identified hostels as having a drinking and drug taking fraternity, and that alcohol was used by people who had been on drugs for a long period, often people in their 30s and older. The groups felt that the use of class A drugs was becoming less as fewer new drug users were using class A drugs; *"I don't think there's so many people now as there was 15 years ago starting on class As".*

At the focus groups there were discussions around the inter-generational nature of substance misuse and the multiple social needs that are often present. These were felt by those that attended the groups to be important issues for treatment services to recognise and focus on. The groups also discussed the impact of substance misuse on communities and these areas were identified as key issues locally;

- Antisocial behaviour *“people don’t really care anymore, that’s the impact”*
- Impact on families:
    - Families where parents have substance misuse often have young people who use drugs or drink
    - Parental addiction affects children
    - Young person addiction affects the whole family
    - Family substance misuse (normalising substance misuse and meaning that children grow up quickly) *“there’s a lot of families that use with their kids” ”especially the cannabis”*
    - Failure of “the system” to support children with family addiction, abuse, family breakdown
    - Lack of prevention work with children and young people

The groups also looked at treatment, including access to treatment and exiting treatment. This is a summary of the main points covered.

Access to treatment:

- Access is often at a crisis point, and sometimes this crisis is created to access treatment.
- A barrier for women is the fear that it will instigate social services investigations around children.
- The expectation that an individual will have to attend a day programme before being considered for residential treatment is seen as a barrier. An individual’s substance misuse and subsequent lifestyle is the reason they are seeking residential treatment and it is this lifestyle that means attending a day programme can be difficult.

Treatment services.

- Initial contact with services was seen as good.
- More support could be offered to those clients who may be “struggling”.
- Care plans were seen as good, shared with clients.
- Care plans could include other agencies, e.g. social services and housing.
- Harm reduction seen as being good.
- Lack of understanding and support from social services around what treatment services are available and how to work with parents and carers who have drug problems.
- There is a lack of alcohol services provided.
- Lack of family interventions.

Leaving treatment

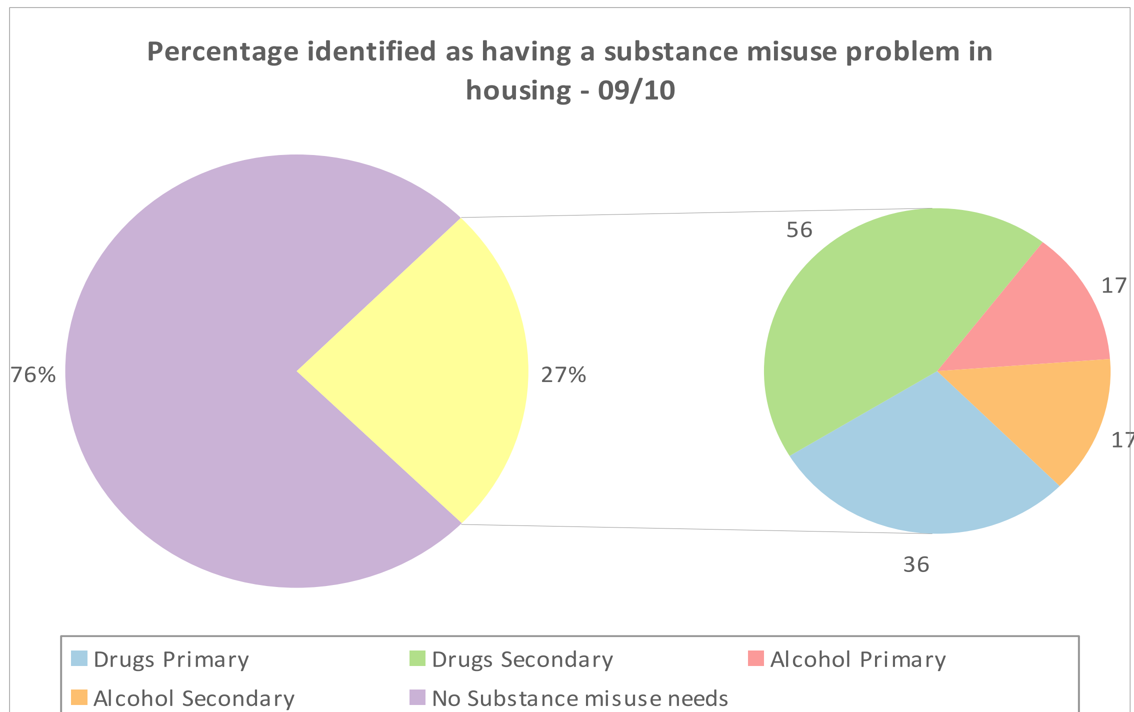
- This should be done in a planned way, with appropriate support. Often this is not planned for or discussed.
- Volunteering opportunities were seen as good; however there were barriers to employment and wider opportunities could be explored in volunteering/training/work sectors.

- Clients often need support with other issues such as legal and housing, this was not always available.

The Service User Council in Southwark is well established and forms an important part of all service development. The views of the SUC and individual service users are considered alongside other information and findings and sometimes represent perceptions and misperceptions of services, highlighting the need to improve information sharing and communication. The views of the SUC may also highlight shortcomings in the treatment system, support other findings and warrant further investigation. As with all views they should be considered in conjunction with data and information from other sources.

Access to Treatment

Southwark Housing; Resettlement Assessment and Referral Service
Graph 4a



This was an area of need highlighted in last year's needs assessment and though some progress has been made, data collection has not been improved. It is widely recognised that within Southwark's nine hostels and other supported housing accommodation there is a significant need to provide support and access to treatment services.

In a snapshot survey, conducted in April 2010 with Supporting People, Southwark DAAT questioned homeless hostel providers and other supported housing providers about drug and alcohol need within their projects.

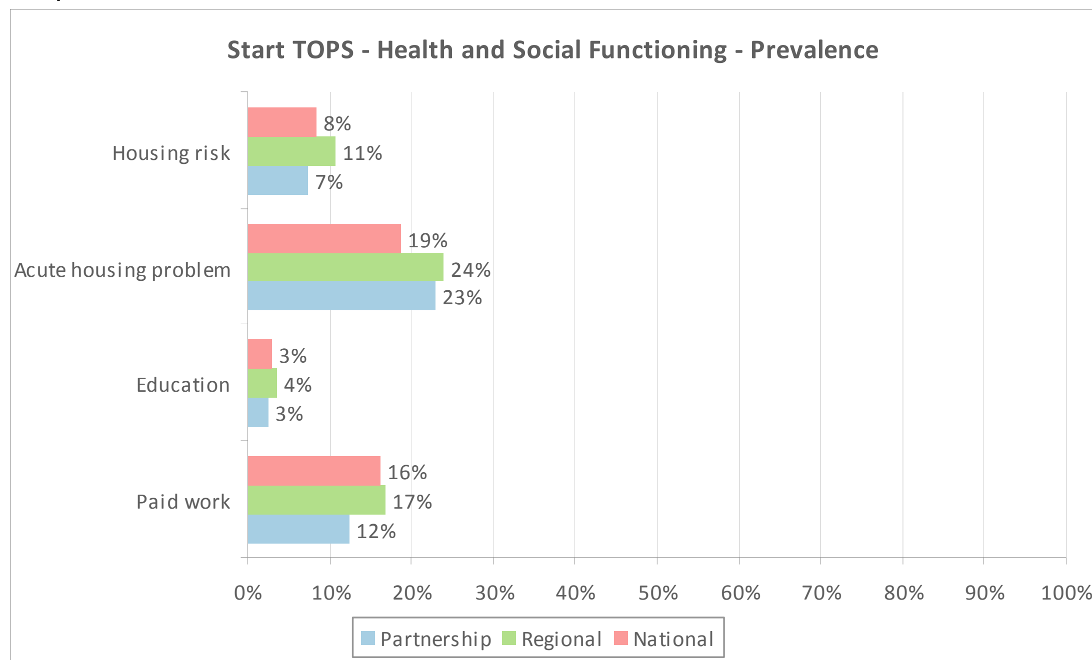
Seven homeless hostels and 349 residents were surveyed as part of this work. Of those 349 residents, 209 residents (60%) were assessed as having a drug or alcohol treatment need. Of the 349 residents surveyed;

- 115 (33%) of those reported having a crack and heroin need and 58 (17%) of those individuals also had problems with alcohol. 98 of this client group were reported as being in treatment.
- 52 (15%) people were reported as having an alcohol need only and 11 of these individuals were reported as currently receiving treatment.

- 42 (12%) of the 349 residents were reported as having non-PDU drug need and 11 of these individuals were reported as being in treatment.

TOPs data shown in Graph 4b below, shows that 23% of people starting treatment in Southwark identify themselves as having an acute housing problem, compared with 19% nationally and 24% regionally. It should also be noted that with the coming changes to housing law and benefits, people with substance misuse problems will be significantly affected both in their housing choices and their benefits.

Graph 4b



Probation Service

Last year's needs assessment highlighted work around data collection, building workforce capacity and development needs. Whilst work has been carried out with probation to increase substance misuse skills (including an away day and a satellite DIP service provided at the probation offices), it appears that there remains a treatment naive population in probation.

Last year's needs assessment estimated that within probation clients an estimated 38% of heroin using clients were treatment naive and an estimated 69% of crack/cocaine using clients were treatment naive. There was some discussion around the accuracy of these figures however it was agreed that there is a group who are known to probation and for various reasons such as not being at a stage where they recognise that their substance use is a problem, are not being referred to or accessing treatment.

Tables 5a – 5d below are from the Southwark DIY Probation report for the period from October 2009 to September 2010.

Table 5a

Drugs Misuse	Frequency	Percent
Not Known	403	24%
No	534	32%
Yes	719	43%

Total	1656	100%

Table 5b

	Total Offender Population		Drugs Misuse	
Alcohol Misuse	Frequency	Percent	Frequency	Percent
Not Known	2	0%	0	0%
Yes	533	32%	244	34%
No	1121	68%	475	66%
Total	**1656**	**100%**	**719**	**100%**

Table 5c

	Total Offender Population		Drugs Misuse	
Accommodation Needs	Frequency	Percent	Frequency	Percent
Not Known	2	0%	0	0%
Yes	423	26%	239	33%
No	1231	74%	480	67%
Total	**1656**	**100%**	**719**	**100%**

Table 5d

	Total Offender Population		Drugs Misuse	
ETE Needs	Frequency	Percent	Frequency	Percent
Not Known	1	0%	0	0%
Yes	558	34%	346	48%
No	1097	66%	373	52%
Total	**1656**	**100%**	**719**	**100%**

As can be seen, 43% of probation clients have a substance misuse need linked to their offending. This is higher than the London statistic of 38%. The number of offenders reporting issues in other areas was also greater than the total offender population. This was with alcohol (2% greater), accommodation (7% greater) and Education. Training and Employment (ETE) (14%). It is difficult to establish how often these needs are addressed without a full file audit, however a small file audit was carried out in relation to substance misuse need.

This year a sample file audit was carried out of approximately 400 Southwark offenders with a drug need related to offending, and of the 78 files sampled 53 were judged to have needs that would require a drugs assessment. This represents an estimated 68%.

Mr A.

Mr A was arrested for a violent offence and his pre sentence report outlined his history;

- Started using cannabis at the age of 10, heroin and crack cocaine at the age of 20
- In 1998 he self referred to a treatment programme and achieved abstinence which he maintained for 2 years.
- Relapse following deaths of a number of close relatives.
- Received prison sentences for various crimes, achieved abstinence in prison and attended various programmes.
- Mr A identified that he would benefit form a treatment programme consisting of psychological interventions and “void fillers” (meaningful activity, work etc)
- Pre sentence report suggested a custodial sentence.

- Mr A received a suspended sentence.

In discussion with senior probation staff this was recognised as a missed opportunity to engage MR A in treatment, as there was not a referral made for a drug assessment or DRR.

Drug Intervention Programme (DIP) Service

The DIP team have made progress this year in terms of improving the number of DIP clients who successfully enter treatment. However, the national data does not reflect this improving picture. A data audit has indicated that there are many discrepancies between local and national data and work is being undertaken to improve processes. Despite this, there is still attrition at every stage of the DIP process that needs to be addressed with a particular focus on increasing the number of DIP clients who get referred to treatment and reducing the number of clients who do not attend their treatment appointment after referral. Progress has been made to integrate DIP within the treatment system but further improvements are needed to ensure that clients that are referred from DIP are supported into structured treatment and leave in a planned way. Profiling work needs to be completed to identify any commonalities in clients who do not attend treatment and whether this is due to criminal justice clients' needs not being met by DIP and/or the treatment system.

Another key area of attrition is between the number of people testing positive for Heroin/Crack/Cocaine in police custody and the number who attend their required assessments with DIP. Analysis of the Drug Test Records from July 2009 to June 2010 highlighted that Southwark were providing inadequate coverage of the police custody suites in the borough. Therefore the arrest referral coverage is being extended to increase the number of clients who have their initial assessment whilst they are in custody and are therefore assessed at the earliest point in the Criminal Justice System. However, improvements are still needed to ensure clients who do not comply with the required assessment process are breached by the police and receive an appropriate penalty for their non-compliance.

We have continued to see a high number of non-Southwark residents coming through arrest referral and work with other boroughs has been undertaken to ensure out of borough repeat testers receive an assertive response by their borough of residence. However, since implementation of the cross borough protocol for DIP rapid returners, there have not been any referrals into Southwark from other boroughs for rapid returners. Analytical work needs to be completed to identify if this is due to rigidity of the criteria in this protocol.

The greatest success for the DIP team over the last year is improving the continuity of care for drug misusers leaving prison. Southwark have contributed to a new joint working protocol with HMP Holloway and local guidelines have also been implemented in the borough to ensure that clients leaving prison are escorted by DIP to their first treatment appointment. This work has resulted in an increase from December 2009 to well above the London and national average. There has been a slight dip in this recently, which appears to be due to changes in the prison procedures, but this will be closely monitored to ensure the previous levels are returned to.

Southwark is in the process of implementing a cross borough Integrated Offender Management (IOM) model which will see probation, Police, DIP service providers and Resettlement services (working across the 9 resettlement pathways) based in one location. The anticipated outcomes of this new joined up approach will address the attrition rates within DIP, an increase in the number of people accessing treatment from the Criminal Justice System and a reduction in reoffending and demand on the Criminal Justice System. This new approach is particularly important for Southwark as we have one of the highest 'new entrants to custody' figures in the region.

It is the DAAT's intention to re-commission the whole of the DIP to have it delivered by one service provider early next financial year. This should reduce the attrition at each stage of DIP and improve outcomes for clients by ensuring consistency through the process from arrest referral through to case management and into treatment. It is intended that the remodelled DIP will sit within an Integrated Offender Management model based in SLaM's Marina House. However, due to the delay in an IOM being formed, the DIP team have temporarily moved into the CRI REACH day programme premises which is allowing the staff to see clients in suitable accommodation to better meet the clients' needs.

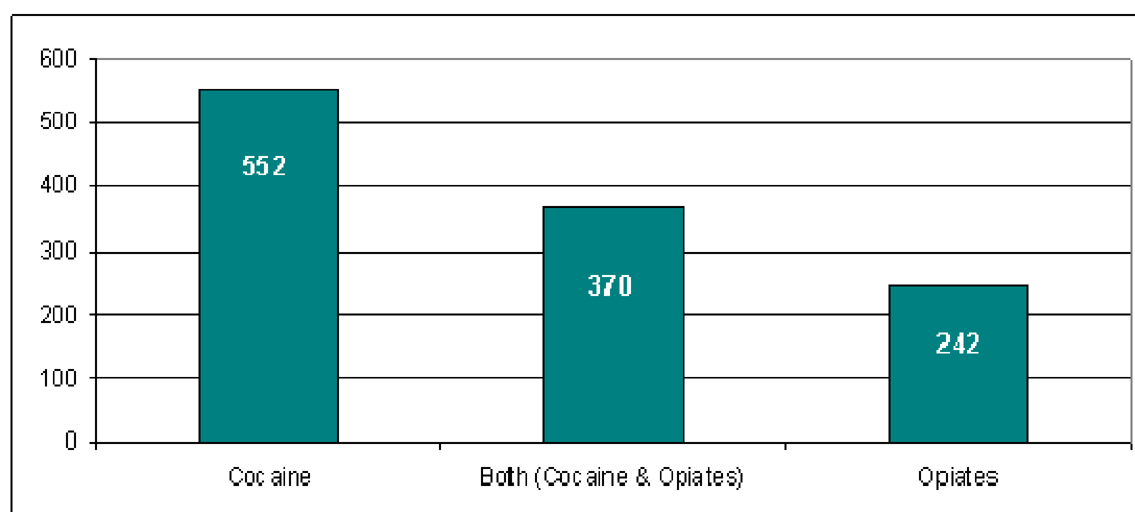
Further work also needs to be done with Probation to ensure drug misusing offenders are referred into appropriate treatment. A DIP worker is now based in the probation offices three days a week to assist with completing referrals into treatment for class A drug misusing offenders but take up of this service has been poor. From September to November only 14 offenders on Southwark Probation's caseload were referred to the DIP advisor and 4 of these were inappropriate referrals and not suitable for structured treatment.

4519 people have been tested for drugs upon their arrest, having been arrested for a trigger offence. Of these (and excluding 11 where there was no result), just over a quarter (25.8%) tested positively for some form of drug. (1164)

Of this number, the most common offence was theft (41.1%) with possession of drugs (19.4%) second.

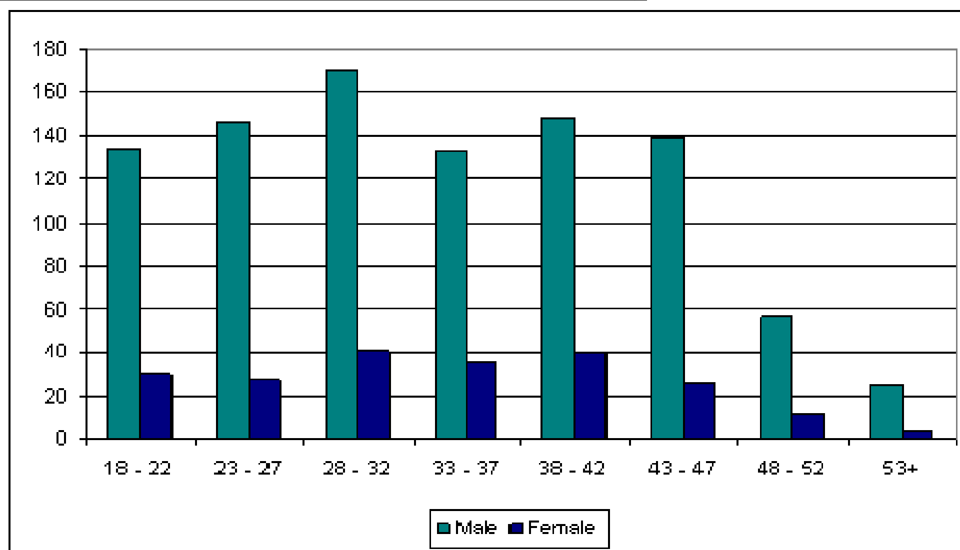
Table 6a

Crime Type	No offences	% positive arrests
Theft	478	41.1
Possession of drugs	226	19.4
Burglary	153	13.1
Production/Supply drugs	85	7.3
Handling stolen goods	62	5.3
Robbery	49	4.2
Theft of vehicle	29	2.5
Fraud	27	2.3
Non-trigger offence	22	1.9
Going equipped	17	1.5
Begging	16	1.4



Age Range	Asian or Asian British	Black or Black British	Chinese or Other	Mixed	Not stated	White	Grand Total
18 - 22	5	53	8	7		91	164
23 - 27	3	45	4	9	1	111	173
28 - 32	7	47	1	10	3	143	211
33 - 37	2	49	1	10	2	104	168
38 - 42	1	53	1	6	4	123	188
43 - 47	1	56	3	7	5	93	165
48 - 52		32	1	5		29	67
53+		12				16	28
Grand Total	19	347	19	54	15	710	1164

Age and gender of those who tested positively



18.3% of those who rested positively for drugs were female (213)

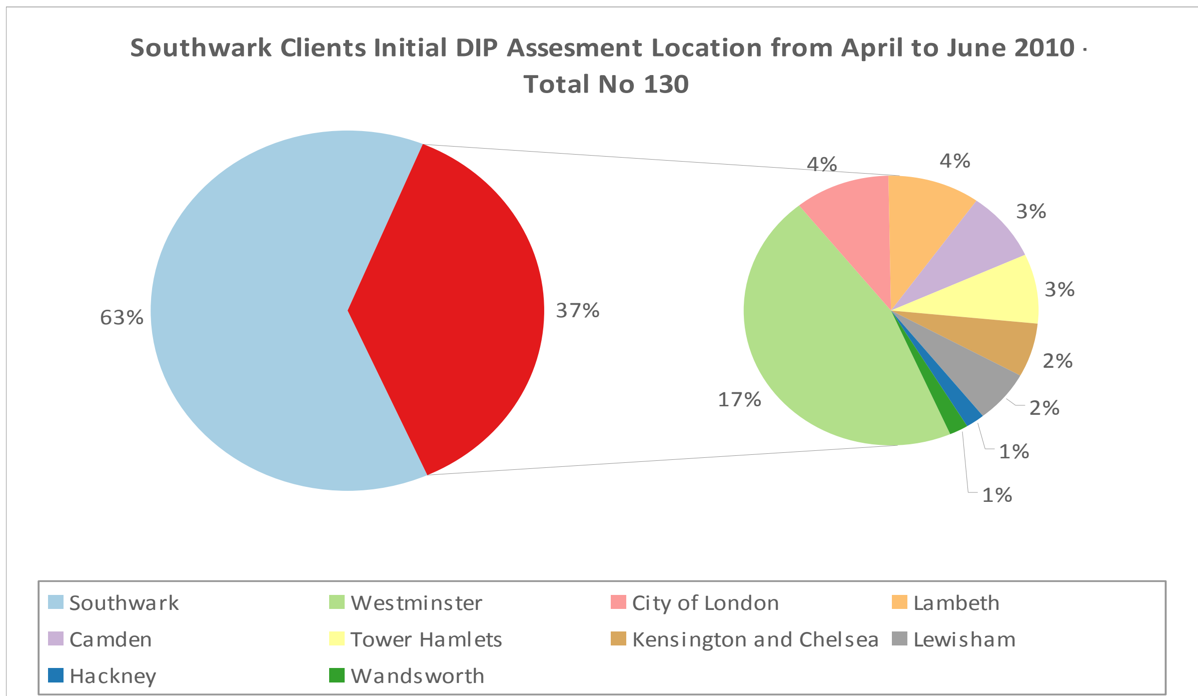
DAT of residence	No suspects	% total
Southwark	782	67.2
Lewisham	86	7.4
Lambeth	65	5.6
(blank)	58	5.0
Kent	25	2.1
Greenwich	22	1.9
Croydon	16	1.4
Essex	12	1.0
Surrey	12	1.0
Tower Hamlets	10	0.9
Wandsworth	10	0.9
Newham	9	0.8
Bromley	8	0.7
Westminster	6	0.5
Bexley	5	0.4
Hammersmith and Fulham	4	0.3
Haringey	4	0.3
Enfield	3	0.3
Hackney	3	0.3
Merton	3	0.3
Waltham Forest	3	0.3
West Sussex	3	0.3
Camden	2	0.2
Hounslow	2	0.2
Southampton	2	0.2
Barking and Dagenham	1	0.1
Buckinghamshire	1	0.1
City of London	1	0.1
Derby	1	0.1
Ealing	1	0.1
Hertfordshire	1	0.1
Islington	1	0.1
Middlesbrough	1	0.1
Milton Keynes	1	0.1

Over two thirds of those people who tested positively for drugs after their arrest in Southwark were Southwark residents, with the following two highest DAT's being Southwark's neighbouring boroughs.

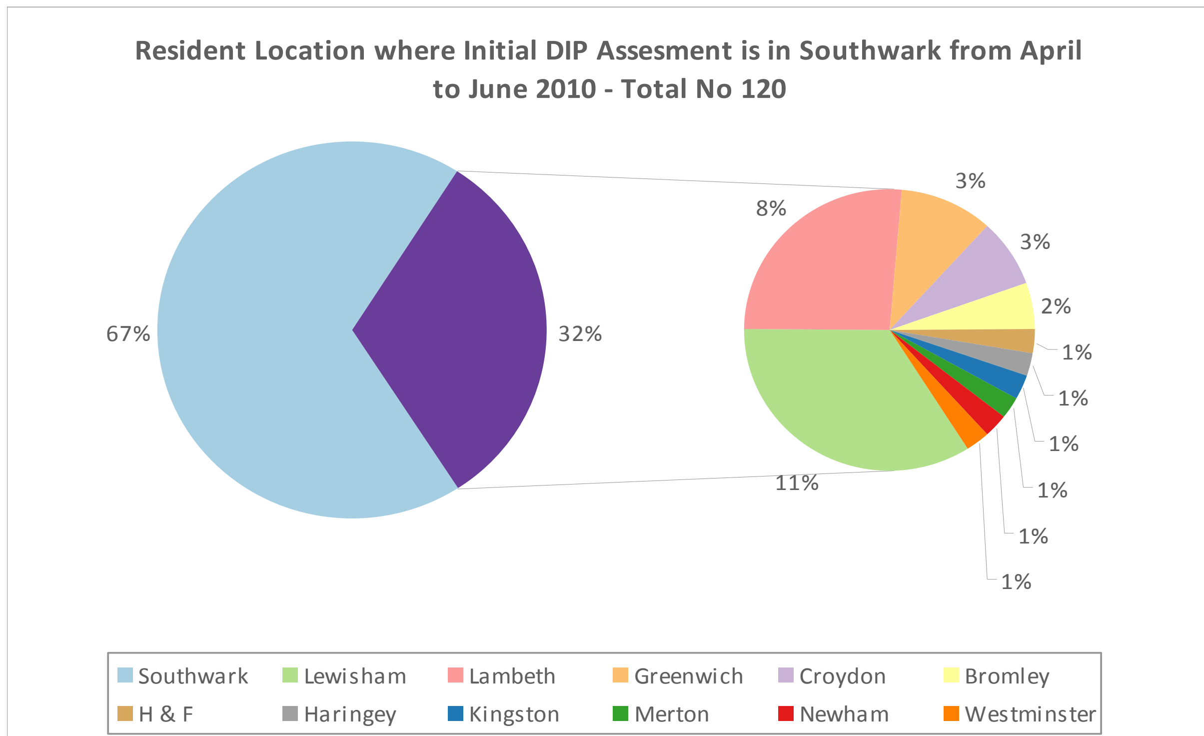
DIP Cross Borough Analysis

As can be seen from Graph 7a below (Southwark Clients Initial DIP Assessment Location from April to June 2010), there are comparatively high rates of cross borough offending for Southwark residents. 37% of Southwark residents who tested positive on arrest and were therefore eligible for a Required Assessment with the DIP team were arrested and dealt with at a police station outside of the Borough. The majority of these clients were arrested in the City of Westminster area.

Graph 7a



Similarly, (*Resident Location where Initial DIP Assessments is in Southwark from April to June 2010*), 32% of those arrested and dealt with at a Police station in Southwark are residents from outside of the Borough - the majority of these are from the neighbouring boroughs of Lewisham and Lambeth



The rate of ‘conversion’ from initial assessment to follow up assessment for Southwark residents (Chart: Southwark Clients Initial DIP Assessment Location and those who attend a follow up assessment from April to June 2010) is broadly similar irrespective of where the arrestee received their initial assessment (55%) There is a high rate of attrition for non-Southwark residents between the initial DIP assessment that takes place in Southwark and the follow up assessment that takes place in their borough of residence. 55% of Southwark residents arrested in Southwark attended their follow up assessment, compared to none of those clients arrested in Southwark but resident in our neighbouring boroughs (Chart: Resident Location where Initial DIP Assessment is in Southwark and those who attend a follow up assessment from April to June 2010).

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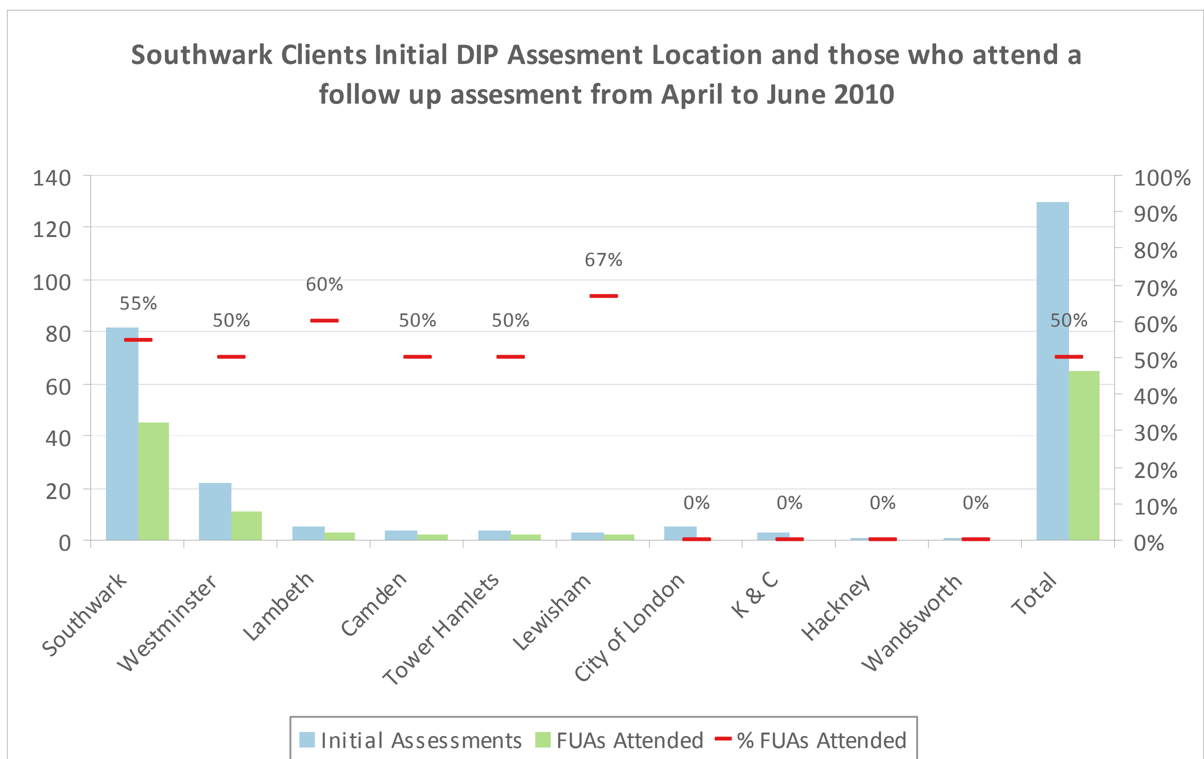
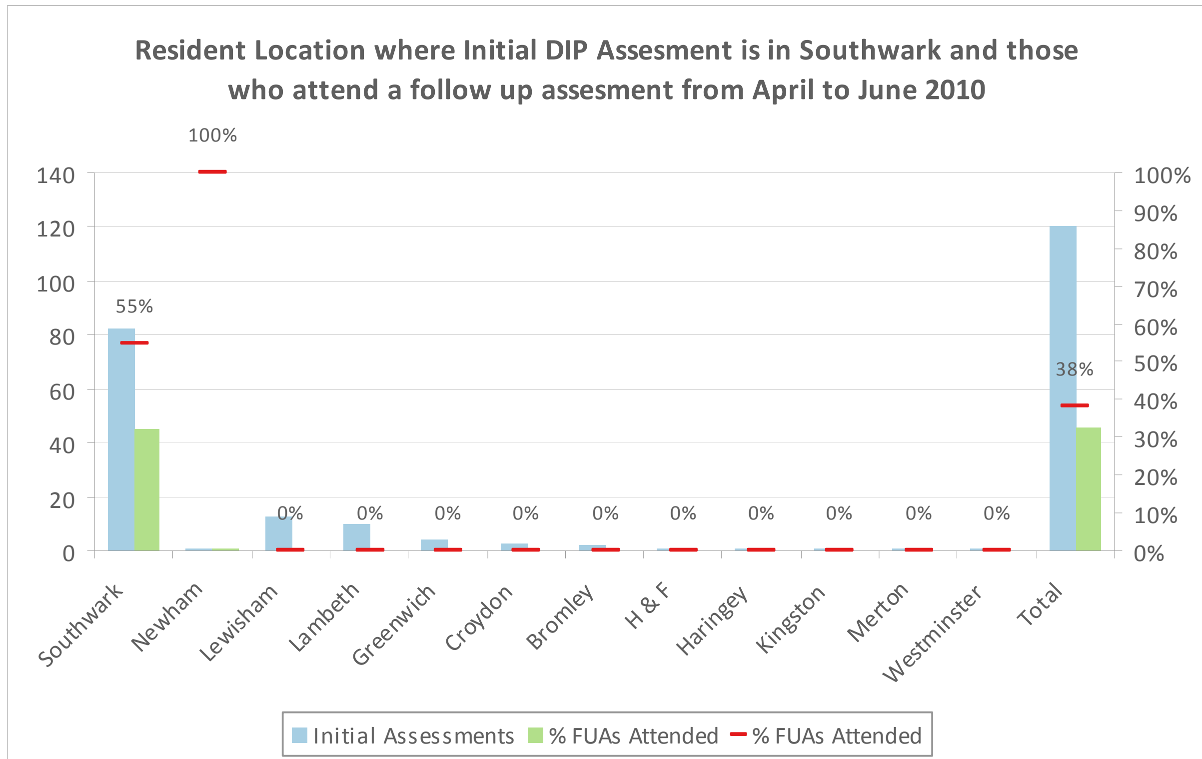
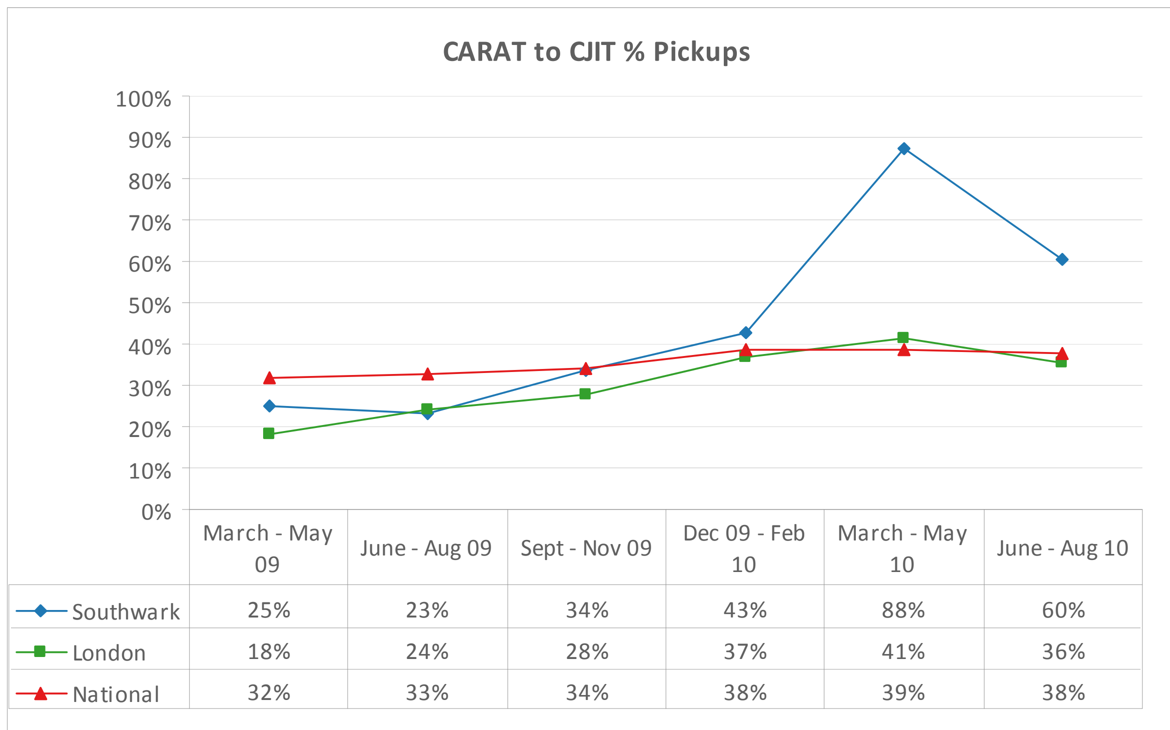




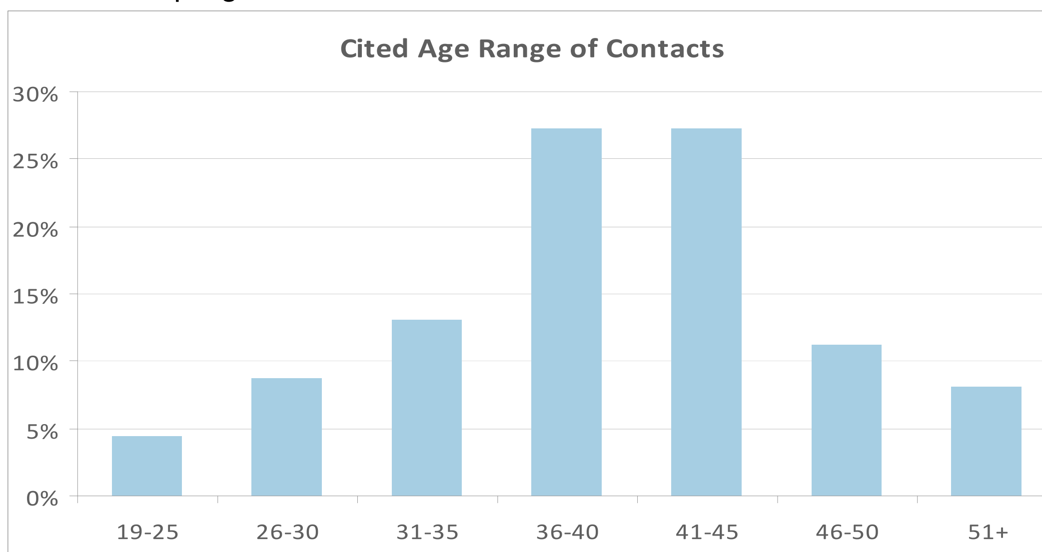
Prisons

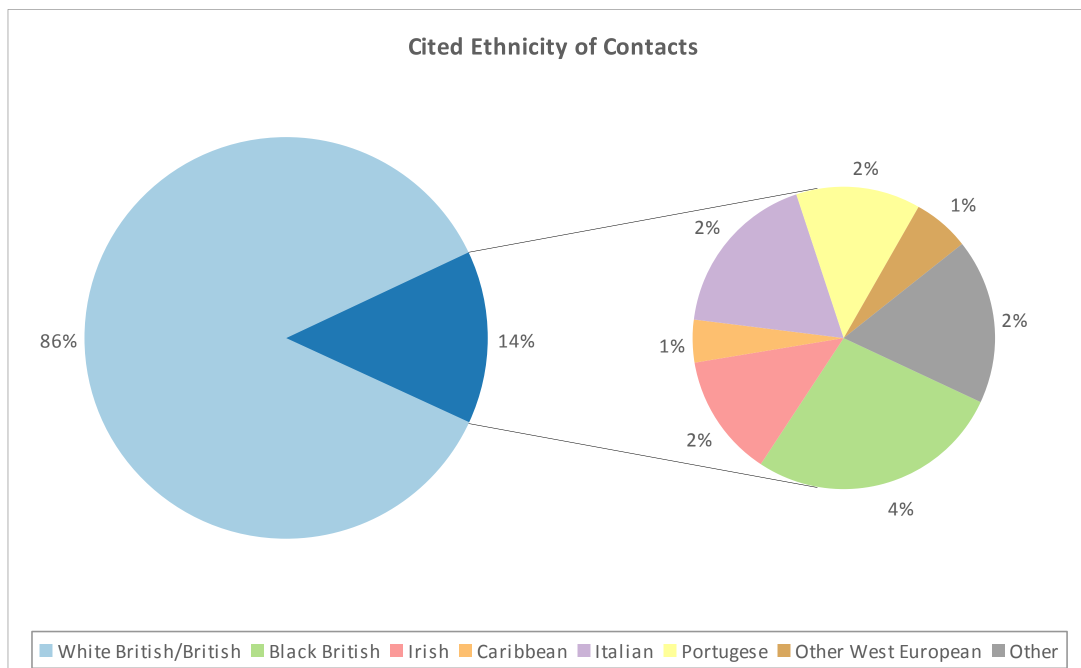
Prisoners from Southwark are placed in a range of prisons across the country and their substance misuse needs are addressed by the CARAT teams. On release they are referred and picked up by the CJIT and Southwark have made significant improvements in this area. However this does not necessarily mean that these individuals will access treatment, and it is recognised that some improvements could be made in this area.



Tier Two Services: Mobile Needle Exchange

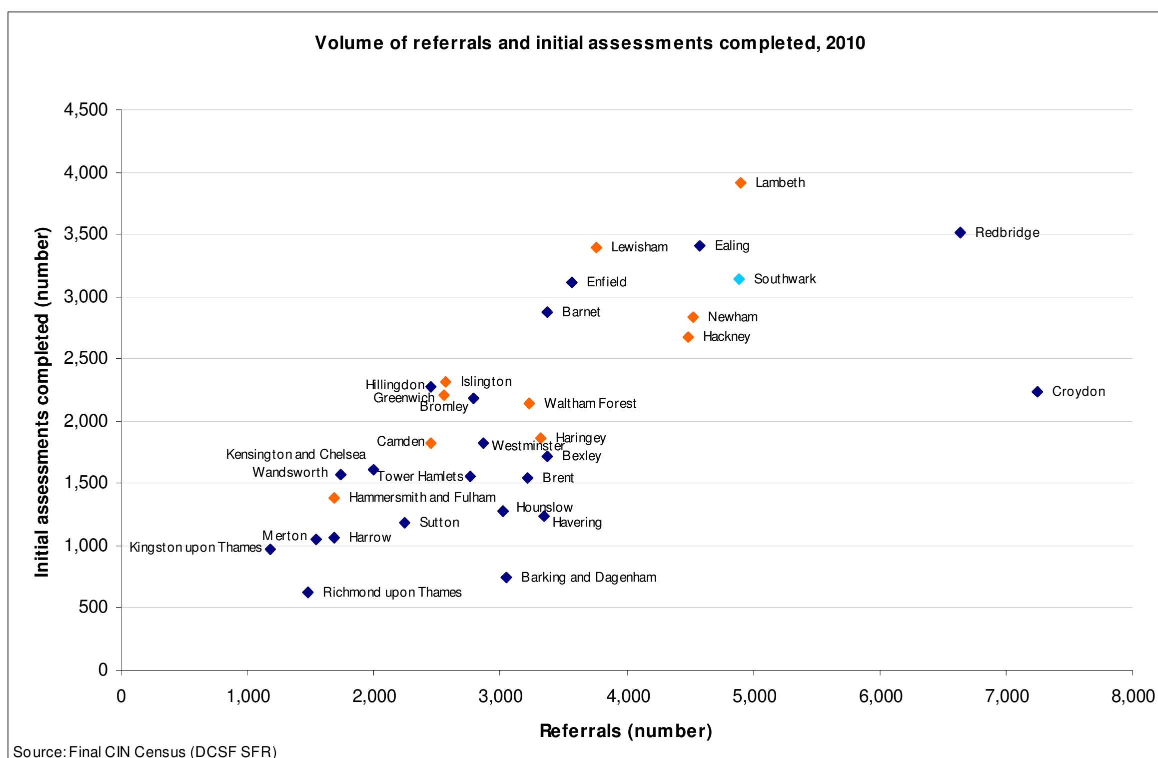
The mobile needle exchange service had 12,955 contacts in 2009/10.
Last year the needs assessment included results of a survey of service users of this service. 38% of whom said they were not in treatment. This was an area identified as needing improvement and a way of people accessing treatment. This year has seen work carried out by Kappa and the needle exchange bus to engage people to access residential treatment, which has included crisis admissions to City Roads to engage in stabilisation programmes.



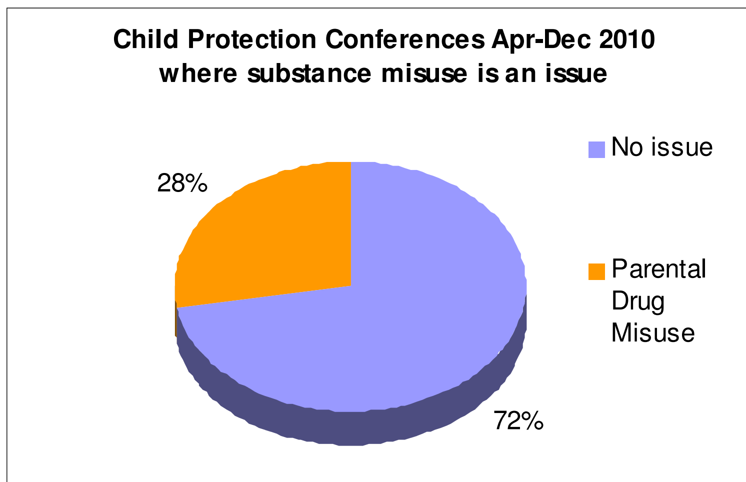


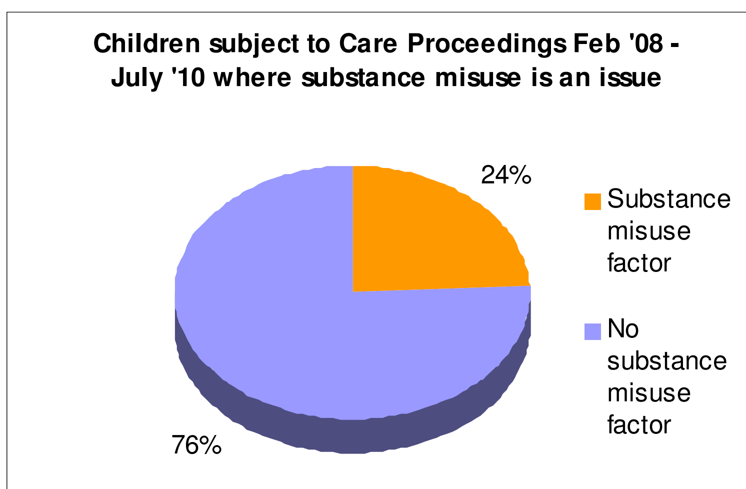
Children's Services / Substance Misusing Parents

Substance misuse can impact on families and young people also, more detail in this area is available in the Young people's Substance Misuse needs assessment. In Southwark 3,737 children were assessed by the local authority and recorded as being a child in need at 31 March 2010, which was an increase of 20.5% from 2009. This represented a rate of 677.4 per 10,000 children, which was nearly twice as high as the national rate of 341.3 per 10,000 children.



In the period April – December 2010 of the 497 Child Protection Conferences held 27% (137) had a parent with a substance misuse problem.





In the period February 2008 – July 2010 29 of 120 care proceedings 29 involved parental substance misuse. 12 of the 29 were cases where concerns arose prior to birth and the majority of the children were under 5.

In 2010 the new young person's substance misuse service, BCDP Insight, was launched. The service offers support to parents and carers and there are other family interventions available within Southwark. In addition to these, we are currently in the planning stages of a family therapy intervention which is described more fully in the young people's substance misuse documents.

Liaison ante-natal drug and alcohol service

The liaison ante-natal drug and alcohol service is a well established partnership service between SLaM, BCDP, maternity services and social services.

Pregnant women would be referred to either of the multidisciplinary Liaison Antenatal Drugs & Alcohol services at Kings College Hospital (Woodvine South) or St Thomas' Hospital (Woodvine North / aka LANDS) depending on where the woman is booked to give birth. Clinics are held in the antenatal Out Patient Departments of each hospital on a weekly basis.

Information from the Woodvine North service was provided for this needs assessment and data was extrapolated from records of referrals. The Associate Specialist in Addiction Psychiatry said that generally those attending with a primary opiate problem also used crack cocaine, but see it as secondary to the opiate. However for some women, they felt that both opiate and crack were equally problematic.

Figures from April 2009 - April 2010

Substance	Referred	Engaged
Primary Opiate problem (dependence) -	15	13
Heroin and Crack dependence	5	4
Crack only -	2	1
Cocaine powder -	2	2
Alcohol -	8	3
Cannabis -	5	3
Ecstasy/ketamine	2	2

The majority of those who did not engage either did not attend and were referred back to referrer or after discussions with referrer were deemed not suitable. This is a group who may benefit from support to access treatment.

Treatment Naive Research.

Last years needs assessment included a survey carried out by the Service User Council which looked at why people did not enter treatment. The findings found that a large proportion felt that treatment was unsuccessful, though it was unclear what was seen as unsuccessful. Also that they would manage their substance use issues themselves and that there were not services available for substances like crack. This perception that there are not services that cater for crack use highlights some of the misconceptions around what services are available, as there is a crack service in Southwark. This highlighted the need for a comprehensive and effective communication strategy. This could be linked to the new Recovery remodel.

Effective Engagement

Current Provision

Southwark has the full range of Tier 1 to 4 interventions as set out in Models of Care for Drug Misuse and Models of Care for Alcohol Misuse. These include services with a predominantly alcohol focus such as Foundation 66 (formerly ARP), those with a predominantly drugs focus (such as the Kappa Project) and those with a joint focus like the Community Drug and Alcohol Team at Blackfriars Rd.

Drugs
Tier 1 interventions include the provision of drug-related information and advice, screening and referral to specialist drug treatment.

Tier 2 interventions include provision of drug related information and advice, triage assessment, referral to structured drug treatment, brief psychological interventions, harm reduction interventions (including needle exchange) and aftercare.

Tier 3 interventions include the provision of community based specialist drug assessment and co-ordinated care planned treatment and drug specialist liaison.

Tier 4 interventions include provision of residential specialist treatment, which is care planned and care coordinated to ensure continuity of care and aftercare.

Alcohol
Tier 1 interventions include alcohol related information and advice, screening, simple brief interventions, and referral.

Tier 2 interventions include open access, non-care planned, alcohol specific interventions.

Tier 3 interventions include community based, structured care planned alcohol treatment.

Tier 4 interventions include alcohol specialist in-patient treatment and residential rehabilitation.

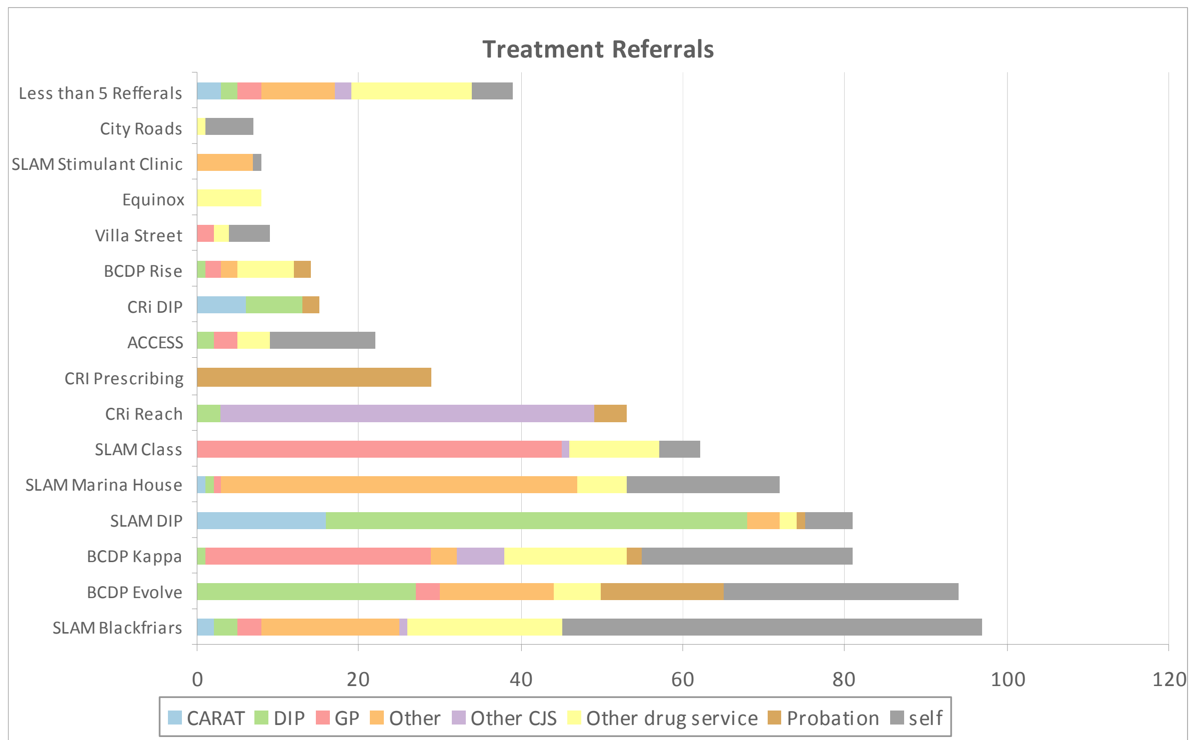
General Practitioners

There are now 25 GP practices (an increase of 4 from last year) who are signed up to the drug treatment LES. 19 are supported by a clinic on site by BCDP Kappa. Jointly they provide assessment, care planning and review, prescribing and keyworking. The others are supported by Kappa via a distance keyworking model - letter system. All clients can access other services at Kappa such as needle exchange, BBV nurse input, legal/housing/welfare advice and complementary therapies etc.. Kappa also run 2 prescribing clinics on site, one supported by SLaM and one by a GP.
All 49 Southwark GP Practices have a link primary care alcohol nurse and access to 10 hubs across the borough to refer alcohol clients for assessment, referral and detox and medium term interventions. The Primary Care Alcohol Nurses work jointly with GPs and local pharmacists to offer alcohol detox. F66 is also a hub which is supported by one of the nurses.

Community Pharmacies

18 Community Pharmacies are currently contracted to provide supervised dispensing of methadone and other related medication to substance misusers in Southwark. In some cases clients attend only when specialist drug treatment services are closed (e.g. weekends and public holidays). In others, the pharmacy provides all the clients treatment medication, on either a daily or weekly basis, depending on how stable the client is.
15 Community Pharmacies also provide needle and paraphernalia exchange services.

Referral routes



The largest single referral source is self referral representing 24% of all referrals in Southwark. The rest of the referral pathways (DIP, GP, Other, Other CJS, Other Drug service, Probation) have very similar rates circa 14% each with CARAT referring the lowest into treatment at 4%.

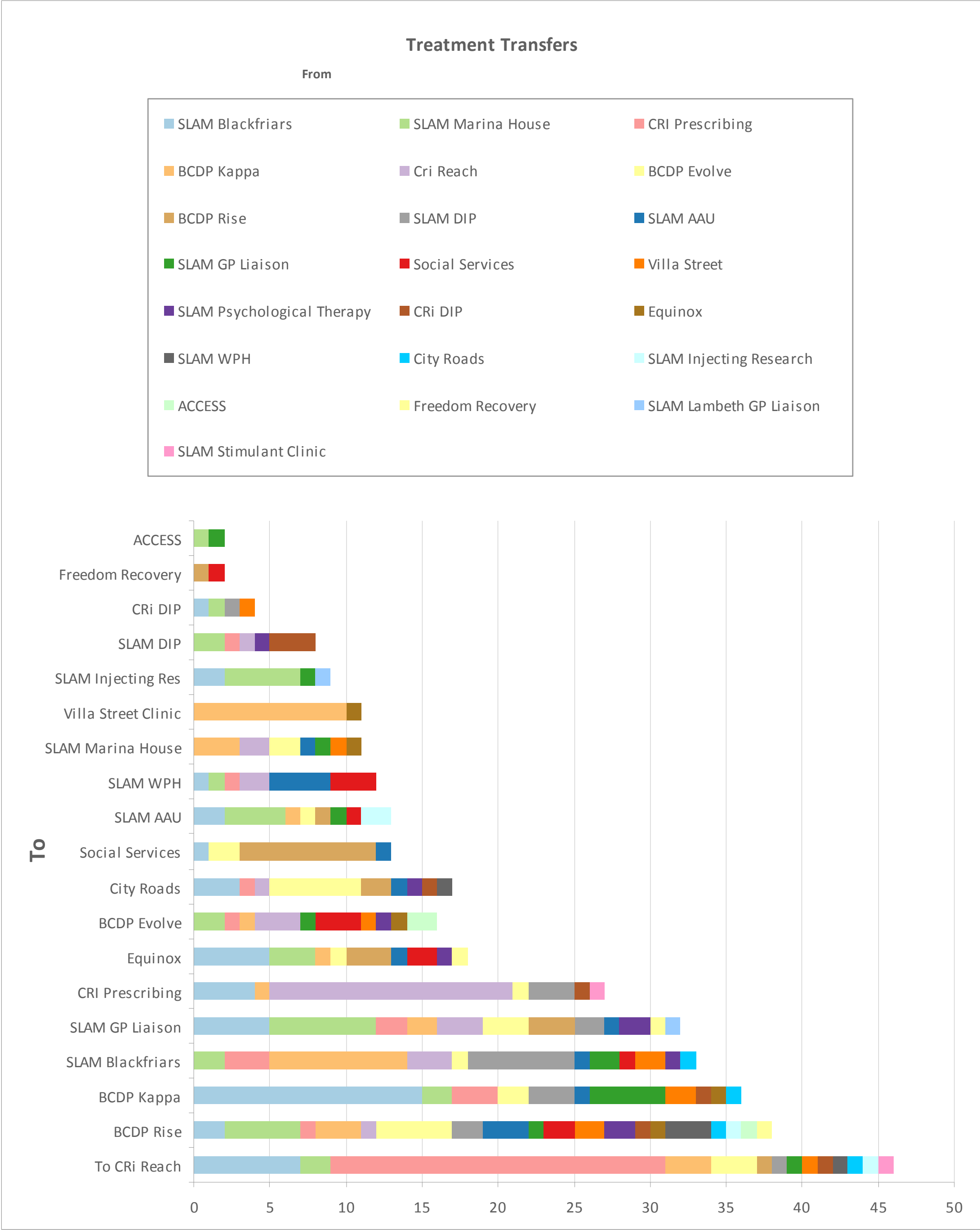
Having a majority of self referrals could indicate that most people enter treatment independently, or another explanation is that key workers are not clarifying how the client became aware of the service.

Slam Blackfriars have received the largest number of referrals overall; which is inline with historical perceptions of Southwark treatment system.

BCDP Kappa has a high percentage of GP referrals which demonstrates the strong links between Kappa and primary care. This numbers are likely to further increase with the implementation of the primary care strategy.

The majority of CARAT and DIP referrals are to SLAM DIP and Evolve. This is because all referrals into opiate treatment for clients leaving prison are currently referred initially to CDAT for rapid prescribing on the day of release and those suitable for shared care get referred on to Kappa from CDAT. There is likely to be an increase in referral rates directly to Kappa with the development of improved criminal justice pathways into treatment.

Transfer Data



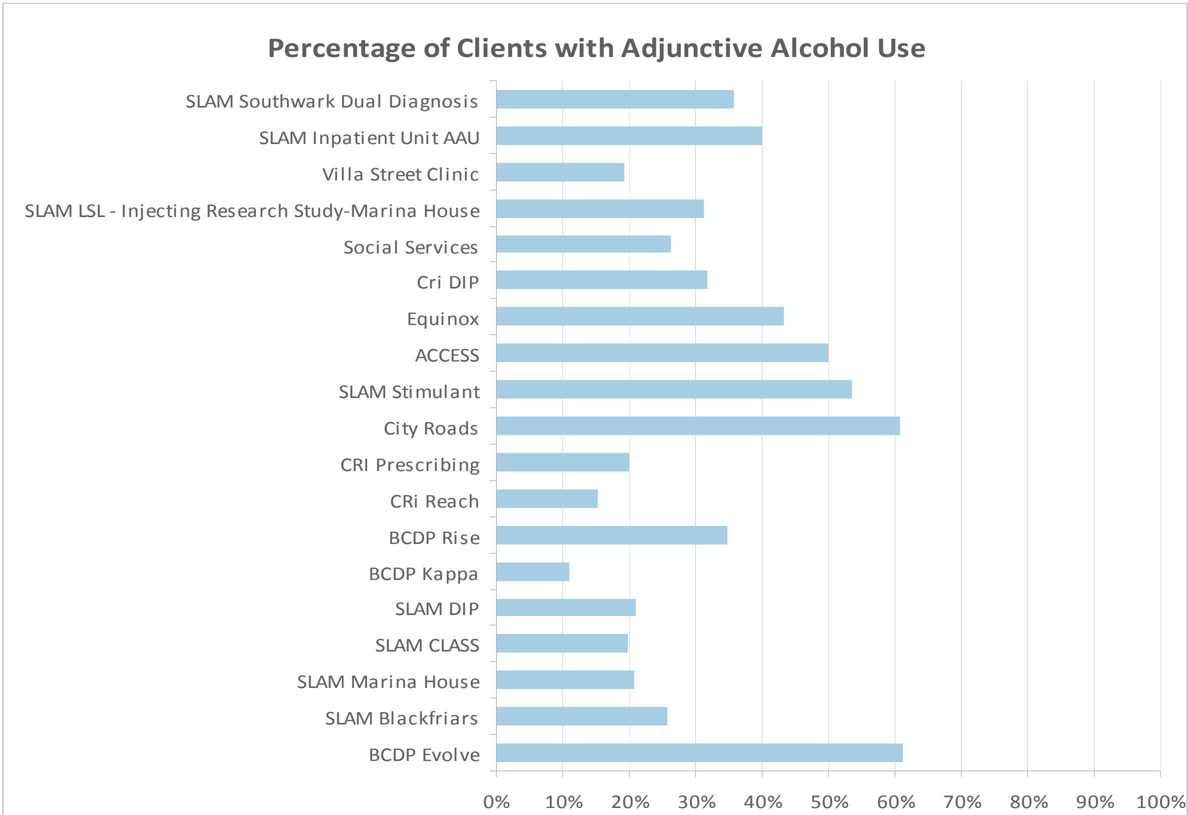
The graph above shows client movements / referral pathways around the treatment system from one agency to another. This highlights the complexity of Southwark's treatment system and the amount of movement between the services.

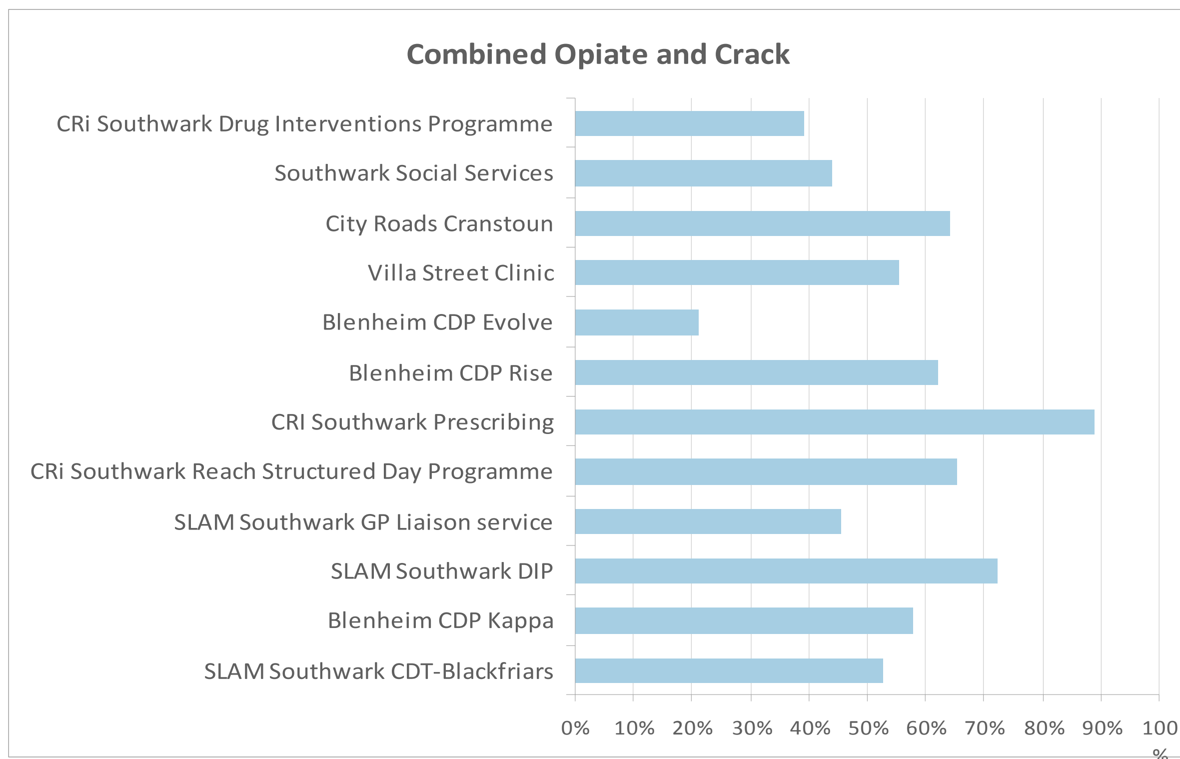
The high referral rate between Kappa and Blackfriars demonstrates the movement of complex primary opiate clients to Blackfriars and stable primary opiate clients to Kappa. This is a pathway that is being developed further and we would expect to see higher rates of referral between these services in the future as the primary care strategy becomes embedded.

If we exclude the high rate of referrals between CRi services BCDP Rise receives the highest number of referrals, from a range of different agencies. This is expected since the programme provides more structured treatment and we would expect this to be the service that clients would be referred to after they have reached some stability in their treatment plan. The majority of Rise clients would return to the agency that referred them. However, Rise appear to have high rates of referrals to Social services, for consideration of CCA funded services (including residential rehabilitation and abstinence based day programmes) showing that significant numbers of graduates from the day programme wish to continue a pathway of recovery.

Clients with Adjunctive Alcohol Use and Combined Opiate and Crack use.

As can be seen from the graphs below, adjunctive alcohol use and combined opiate and crack use are prevalent at all services, in some services this is over 50% of clients. These findings support the assertion in last year's needs assessment that polysubstance use is prevalent in Southwark.





Assessment and Care Planning

Southwark's needs assessment of 2009/10 proposed that this would be an area of investigation in 2010 and would also be part of the preparatory work for the Recovery remodel.

A file audit of assessment and care planning by service providers was carried out in 2010. The findings show that providers are doing care plans (some variance between services but as per DAAT Quality standards) with the clients covering the 5 domains (as per Models of Care, drug and alcohol use, physical and mental health, criminal justice and personal situation). Goals and a timeframe are agreed with the clients and they are offered a copy. The care plans are reviewed 12 weekly with the client. On the whole we were satisfied that assessments, risk assessments, care plans and reviews were happening. The main issues at 2 of the services was inconsistency in where information can be found in the electronic files and communication with other services.

Feedback was given to providers and where necessary they have agreed a plan of action on how to address issues. SLaM agreed to do an internal audit again and share the results with us.

Assessment and care planning will form an important part of the Recovery agenda, supporting people to improve their lives with an individualised care plan that looks at strengths as well as support needs.

Recovery

The goal of all treatment is for drug users to achieve abstinence from their drug – or drugs – of dependency.... too many drug users relapse, do not complete treatment programmes, or stay in treatment for too long before re-establishing their lives. The challenge for the new strategy is to maximise the impact of

treatment for those who receive it, seizing the opportunity treatment provides to reduce the harms caused to communities, families and individuals.

We will therefore work to develop more personalised approaches to treatment services, which have the flexibility to respond to individual circumstances. We will examine how we can best support those leaving and planning to leave treatment with packages of support top access housing, education, training and employment.[iii]

The remodel is a response to the need to

- Increase numbers into treatment
- Improve treatment available for both drug and alcohol users.
- Increase throughput
- Services will be come more flexible and able to address individualised needs of service users.
- We will Achieve National and local Targets
- Financial - the new model will deliver better value for money.
- Improved care pathways
- Closer working between agencies

The system will provide numerous points of entry both in primary and secondary care. Good care planning at the outset will allow users to be quickly placed in the part of treatment system that best addresses their need. Increased capacity in the shared care system will allow more users to access treatment at their local GP.

Implementation

The new model will incorporate all treatment staff into a single structure, with clear supervision and line management arrangements.

The new service delivery model will have 3 elements to the pathway; workers will not be limited to working in a single part of the pathway. Capacity within the model for flexibility and shifting resource to where there is greater need will be integral to the success of the new model.

The 3 pathway elements are: **Assessment and Treatment, Complex Care** and **Shared Care.** Recovery is the partnership's integrative and organising concept that binds these elements together as well as defining specific activities within each component. **Aftercare** is to be developed alongside these elements.

The new model will ensure those moving through the treatment system are not passed between or held up in different organisations – they will be a natural progression through the service.

The board will agree a set of measures by which to evaluate success.

Within the treatment partnership there is a need to:

- Develop Borough-wide training and supervision structures to facilitate staff to be competent to deliver psychosocial interventions within a recovery orientated system of care.
- Map current support options and identify gaps.
- Promote the range of specialist resources available in the Borough and highlight where there may be barriers to access.
- Evaluate all service developments with the aim of developing practice-based evidence to share and help foster a learning and dynamic culture in the partnership.

Psychological Therapies

Southwark residents have access to specialist psychology provision commissioned by NHS Southwark and provided by the South London and Maudsley Addictions services Community Drug and Alcohol Team. There are high rates of complex and underlying mental illness among those with entrenched drug and alcohol misuse and the psychology service provides intensive support to these patients. As a consequence an unmet need was identified as part of previous needs assessments whereby those with lower level of need for formal psychology based talking therapies were having restricted access to this support. In 2010 the DAAT took steps to improve access by both commissioning additional psychology within SLaM Addictions to meet this need as well as being part of a pan London initiative to pilot access to mainstream Improving Access to Psychological Therapies programme (IAPT) services for stable drug misusing patients from within Southwark – historically substance misuse was an exclusion criterion for IAPT. The pilot will be reviewed in Q1 2011/12.

Inpatient and Residential Rehabilitation Provision

The action plan from the 2010/11 Needs Assessment undertook to review residential and inpatient need with a view to redesigning the pathway and increasing residential rehabilitation placements for 2011/12. The inpatient referral coordinator assertively manages the gateway into inpatient treatment service by supporting clinical staff with their care planning to ensure best outcomes and value for money. Initial analysis of this data suggest that the majority of requests for inpatient treatment have an alcohol misuse component – either the referred client has a primary alcohol misuse issue and requires alcohol detoxification or the client is misusing both drugs and alcohol and requires a period of hospitalisation to stabilise their drug misuse and detoxify from alcohol, with few referrals for inpatient detoxification from illicit drugs alone. The current pathways do not seem to create demand for drug detox alone. The increased emphasis on recovery and abstinence, central to the remodelling of services currently taking place should address this and increase demand.

In 2009/10 there were 140 referrals to the Substance Misuse Care Management Team for a Community Care Assessment. This resulted in 73 residential rehabilitation placements - of these 60% had a drug misuse component.

Mutual Aid

An area that was identified for development was to raise awareness and access to mutual aid, 12 step groups such as Alcoholics Anonymous and Narcotics Anonymous. A series of workshops run jointly by AA and NA have been facilitated and have been attended by staff from hostels, treatment services and other agencies. Our aim is to comprehensively raise awareness of using the 12 Step fellowships as a realistic referral option across the substance use and homeless sector. Our hope is that workers attend meetings with or without clients to increase their awareness that these fellowships can work for their clients.

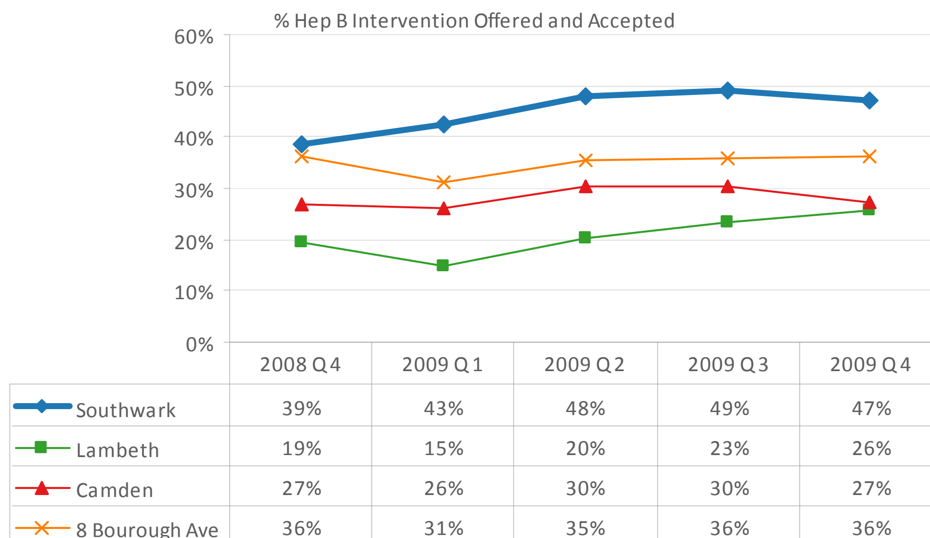
These workshops are followed up with a literature drop to the services represented on the day. So far we are reliant on the goodwill of both NA and AA to provide literature.

Harm Reduction

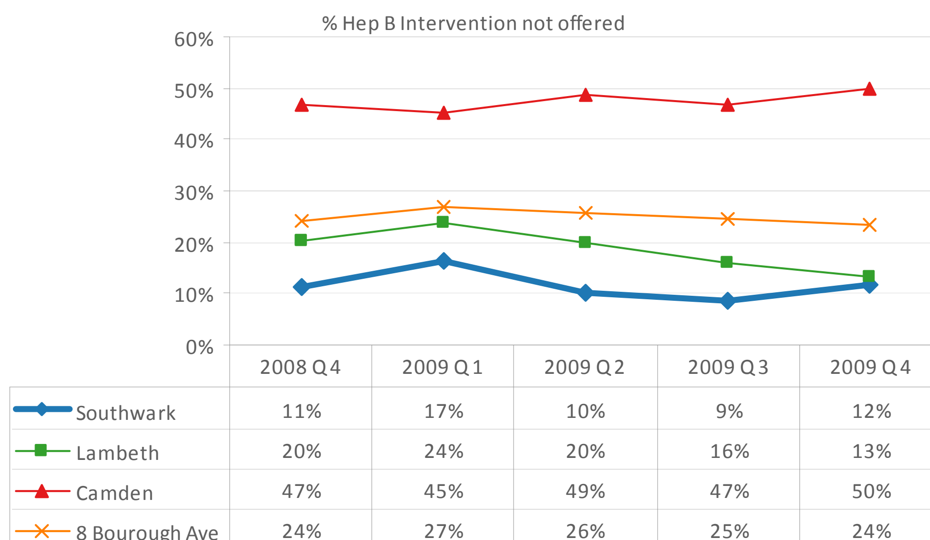
Hepatitis B and C interventions and healthcare assessments offered compare favourably with neighbouring boroughs and statistical averages.

Blood Born Viruses

Hepatitis B Virus Screening

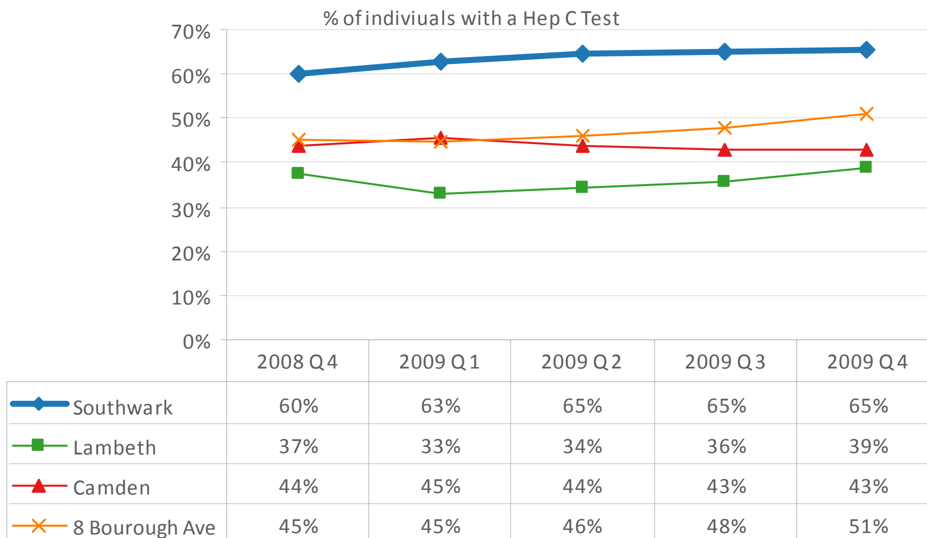


	2008 Q4	2009 Q1	2009 Q2	2009 Q3	2009 Q4
Southwark	39%	43%	48%	49%	47%
Lambeth	19%	15%	20%	23%	26%
Camden	27%	26%	30%	30%	27%
8 Bourough Ave	36%	31%	35%	36%	36%



	2008 Q4	2009 Q1	2009 Q2	2009 Q3	2009 Q4
Southwark	11%	17%	10%	9%	12%
Lambeth	20%	24%	20%	16%	13%
Camden	47%	45%	49%	47%	50%
8 Bourough Ave	24%	27%	26%	25%	24%

Hepatitis C Testing



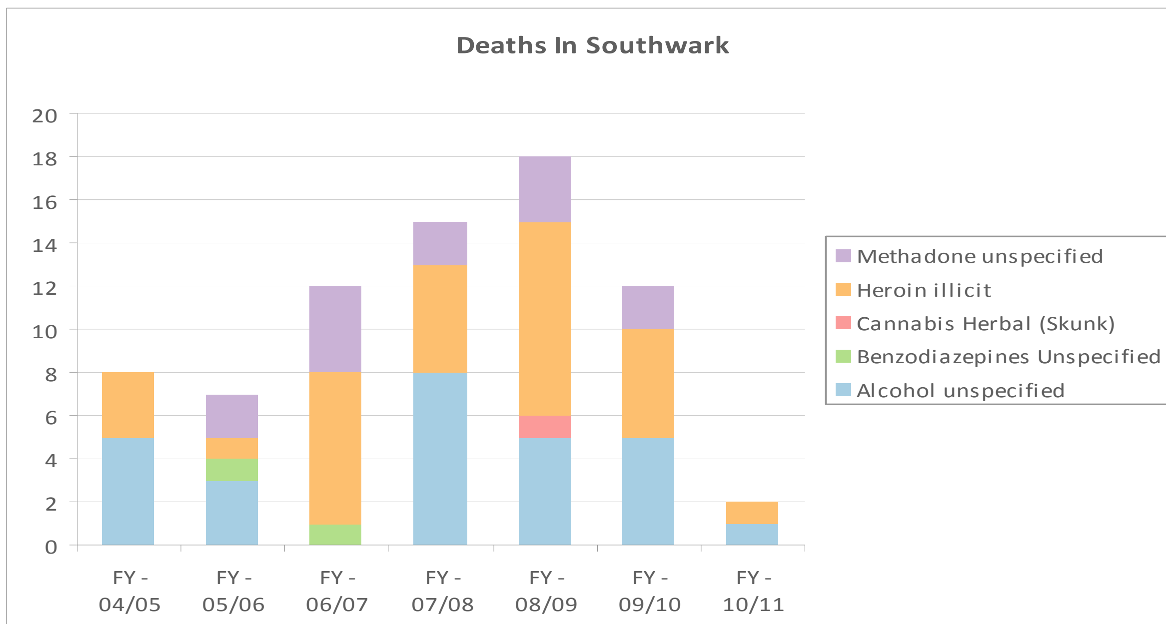
	2008 Q4	2009 Q1	2009 Q2	2009 Q3	2009 Q4
Southwark	60%	63%	65%	65%	65%
Lambeth	37%	33%	34%	36%	39%
Camden	44%	45%	44%	43%	43%
8 Bourough Ave	45%	45%	46%	48%	51%

Drug Related Deaths

Substance Misuse Related Deaths in Southwark

The collection of data on substance misuse related deaths is difficult due to possible reluctance of coroners to record deaths as related to substance misuse, coroners records only being kept as paper records and the lapse between the recorded death and availability of the information (6 months). Also these records will not record near misses and other information that would help to reduce deaths.

From NDTMS, 2009/10 saw a reduction in the number of deaths of people in treatment in Southwark from 2008/09. However, these recorded deaths could be unrelated to substance misuse, so provide limited information for the purposes of this needs assessment.



Families

In Treatment Parental Status

Blenheim have produced a report showing the profile of clients starting treatment in 2008/09 compared to those starting treatment in 2009/10 who have dependents.

42 people started treatment in 2009/10 who had dependents, double the number from last year. Just over half were female, a smaller proportion from last year. 7% were aged under 25, less than last year, but 40% were under 35, a much higher proportion than 2008/09 (29%). There is a smaller proportion of white and black people with dependents, but more Asian and mixed people. Just under two thirds were white, followed by 14% mixed. Housing is not such an issue this year with just 12% with a housing problem, half the rate from last year, when just under a quarter had a housing problem. Last year people starting treatment who had dependents were fairly spread amongst the borough. But this year, almost a third reside in Peckham, followed by Rotherhithe. A larger proportion of people had heroin or other opiates as their primary drug (55% compared to 48% in 2008/09) and a similar proportion had cocaine or crack cocaine as their primary drug.

Southwark Profile Data - Clients with dependents

	FY2008-09[1]		FY2009-10[2]	
	No.	**%**	**No.**	**%**
Gender				
Male	9	43%	20	48%
Female	12	57%	22	52%
Total	**21**		**42**	
Age				
18-24	2	10%	3	7%
25-34	4	19%	14	33%
35-44	10	48%	14	33%
45-54	5	24%	8	19%
55-64	0	0%	3	7%
Ethnicity				
White	14	67%	27	64%
Mixed	2	10%	6	14%
Asian/Asian British	0	0%	2	5%
Black/Black British	4	19%	5	12%
Other	1	5%	2	5%
Accommodation Need				
NFA- Urgent housing problem	0	0%	1	2%
Housing problem	5	24%	5	12%
No housing problem	16	76%	36	86%
Location				
Bermondsey	3	14%	0	0%
Borough & Bankside	2	10%	0	0%
Camberwell	3	14%	6	14%
Dulwich	2	10%	1	2%
East Dulwich	0	0%	1	2%
Herne Hill	0	0%	1	2%
Kennington	0	0%	2	5%
Nunhead & Peckham Rye	3	14%	0	0%
Peckham	1	5%	12	29%
Rotherhithe	1	5%	7	17%
South Eastern Head	0	0%	6	14%
Walworth	4	19%	6	14%
Not provided	2	10%	0	0%
Primary Drug				
Cocaine	3	14%	4	10%
Crack Cocaine	6	29%	13	31%
Heroin or other Opiates	10	48%	23	55%
Alcohol	0	0%	1	2%
Anti-depressants	0	0%	1	2%
Cannabis	2	10%	0	0%

1 - Data presented is for clients starting treatment between 01/04/2008 and 31/03/2009

2 - Data presented is for clients starting treatment between 01/04/2009 and 31/03/2010

The Family Intervention Programme (FIP) works with the families of young people who are offenders or at risk of offending. They are based in the YOS and in a recent snapshot of their cases identified 7 families where parental substance misuse was a considerable concern. This is a summary of 2 cases;

Family A:

- Couple with 7 children.
- Father is known to use Heroin but also dabbles in Crack Cocaine and Cannabis. He is on a methadone treatment programme.
- Still using illegal drugs along with the Methadone, he does not attend the counselling sessions that go along with the Methadone Treatment.
- The Parent is open and honest about his addiction and has disclosed that he supports his habit through crime.
- Uses some of the family's weekly benefits income to support his habit.
- Family have considerable debts and were at risk of eviction due to non payment of rent but this has now been resolved.
- 16 year old has also disclosed using skunk cannabis.

Family B:

- Mother is a lone parent who lives with her two sons aged 10 and 15.
- She is a victim of historical generational Domestic Violence and is now being victimised by her 15 year old son.
- She is known to smoke Cannabis and will smoke Cannabis with her eldest child and his friends.
- Her son says he is addicted to cannabis, consumes large quantities of alcohol and deals cannabis.
- When under the influence of substances will become abusive and violent towards mother and sibling.
- Mother is not in any treatment programme and quite clearly states that she does not have a problem with her Cannabis usage.

Southwark, in collaboration with SL&M and the Institute of Psychiatry, is in the planning stages of a family therapy trial with an application being currently considered by the Health Technology Assessment Programme (HTA) for research funding. It is to research the effectiveness and cost effectiveness of family therapy interventions against other treatment interventions. It is a multi centred project; London, Leeds, Newcastle and Surrey. London will involve Southwark, Lambeth and Greenwich.

The family interventions will focus on alcohol and cannabis use and will compare the family intervention with the usual tier 3 intervention with the young person. This will necessitate an evaluation of the current treatment provision provided by Insight as the control group.

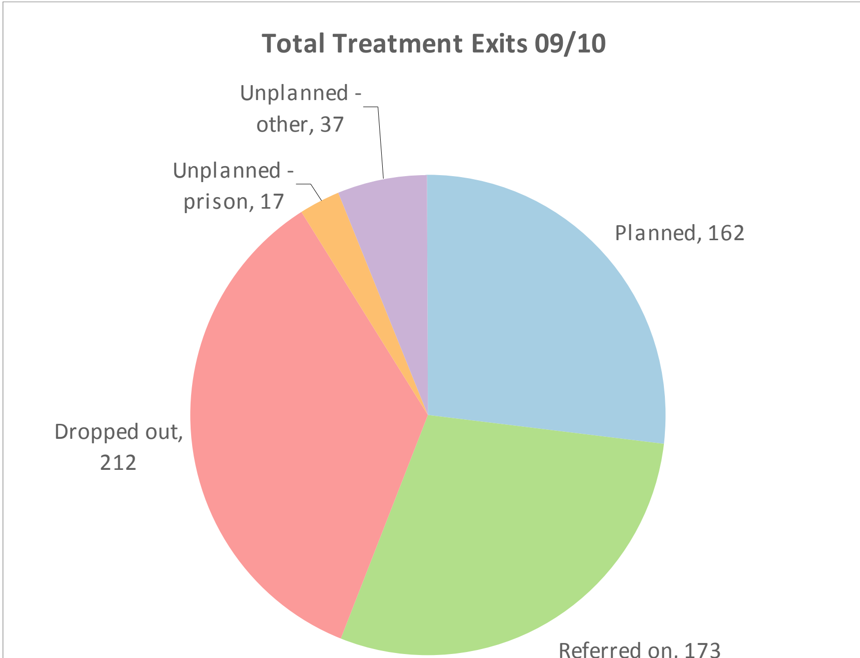
The aim of the intervention is to reduce substance use and enhance wellbeing. The length of the trial will be for approximately 2 years and in resource terms this will mean a family therapy team available to young people and an evaluation of the current tier 3 treatment provision. The trial will need to be coordinated and sufficient referrals will need to be made so this commitment will be sought from Children's Services and the DAAT

Treatment System Exits & Treatment Outcomes

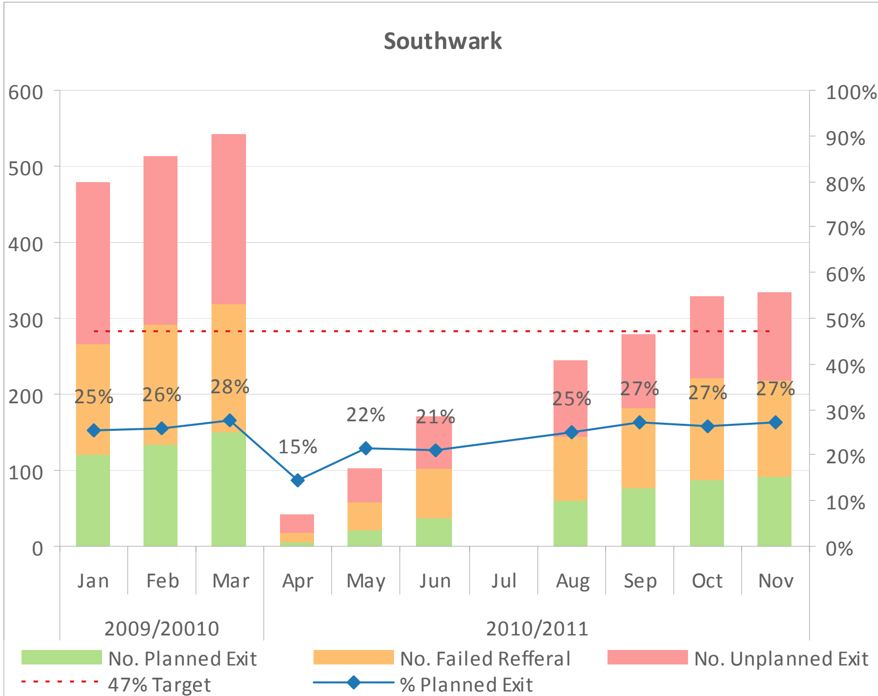
Treatment exits and outcomes were highlighted in the last needs assessment as a priority area for improvement. Though some progress has been made with providers to improve, this still remains an area of improvement in Southwark and as such remains a high priority.

Total Treatment Exits 2009/10

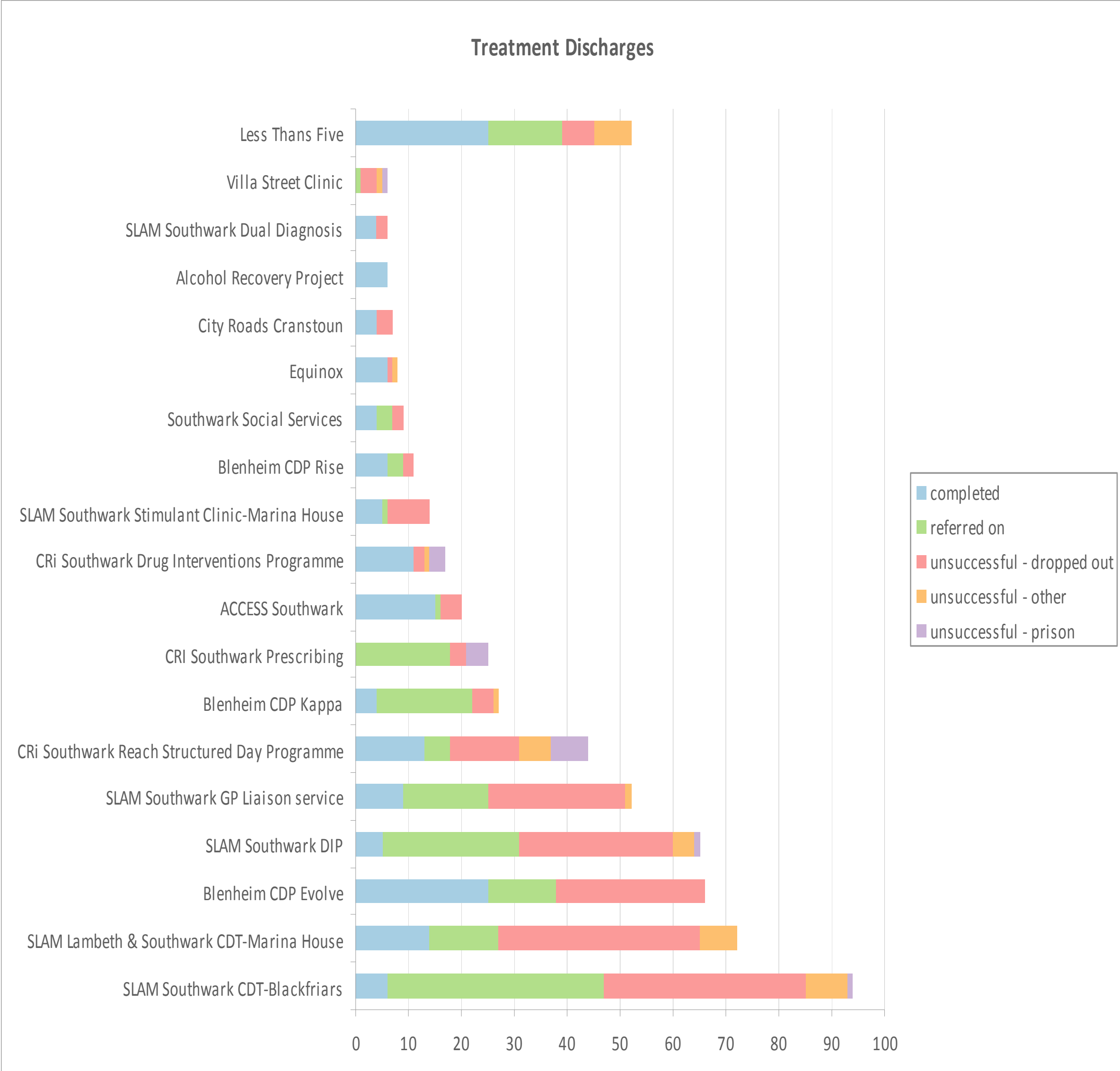
As shown in the graph below, of the total number of clients leaving treatment in 2009/10, 601, only 162 left in a planned way, which is 27%



Recent information shows some improvement after a dip in April, May and June but Southwark remains significantly below the target of 47%



Treatment discharges for individual services are shown below. SLAM services perform poorly in this area. This could be in part due to unique characteristics of clients of these services, however this remains an area of concern and will be looked at in 2011.

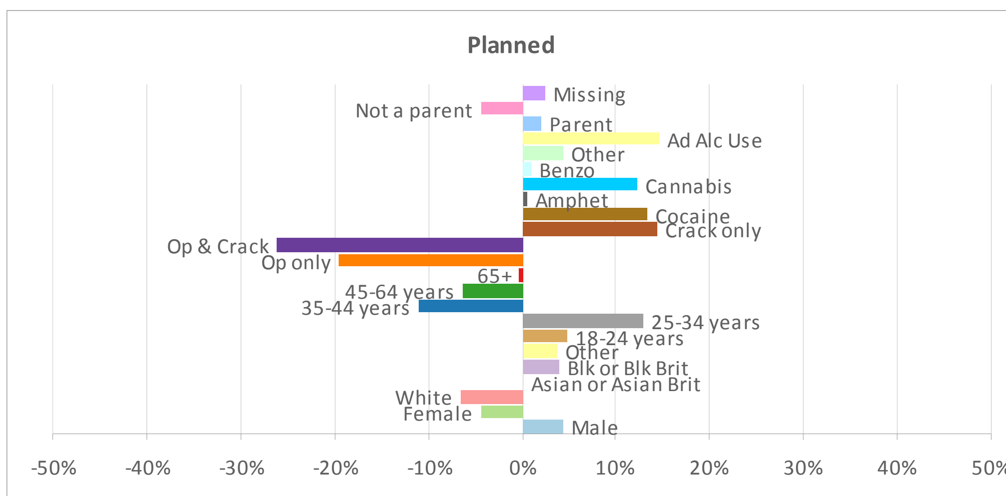


Planned exits

The following graphs compare the demographic profiles of those within treatment in 2009/2010, compared to the demographic profiles of those who left treatment during the year by:

- Planned exit
- At point of referral to another agency
- On dropping out of treatment
- Leaving treatment and entering prison
- Other unplanned exits from treatment
- Everyone leaving treatment

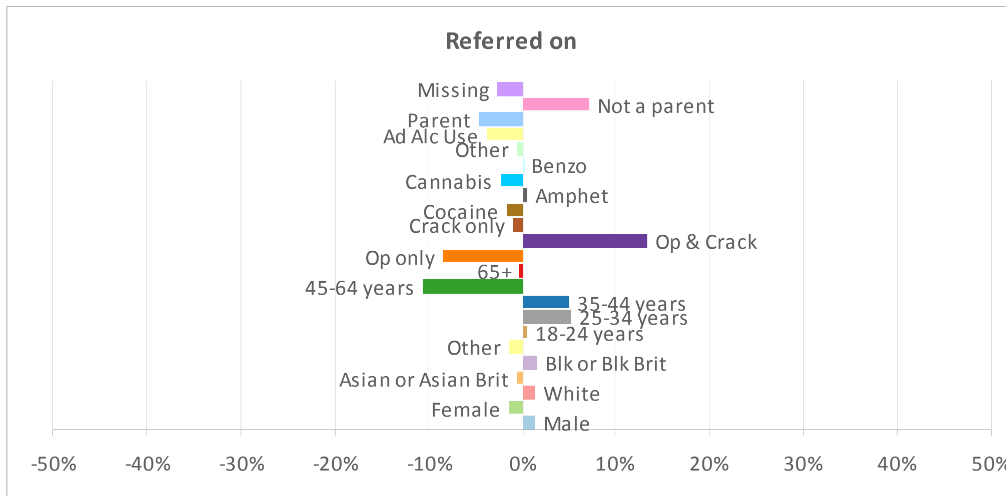
The higher the positive value then the more likely the client is likely to leave in this way, and the higher the negative value the less likely they are to leave in this way.



A total of 162 clients left treatment in a planned way.

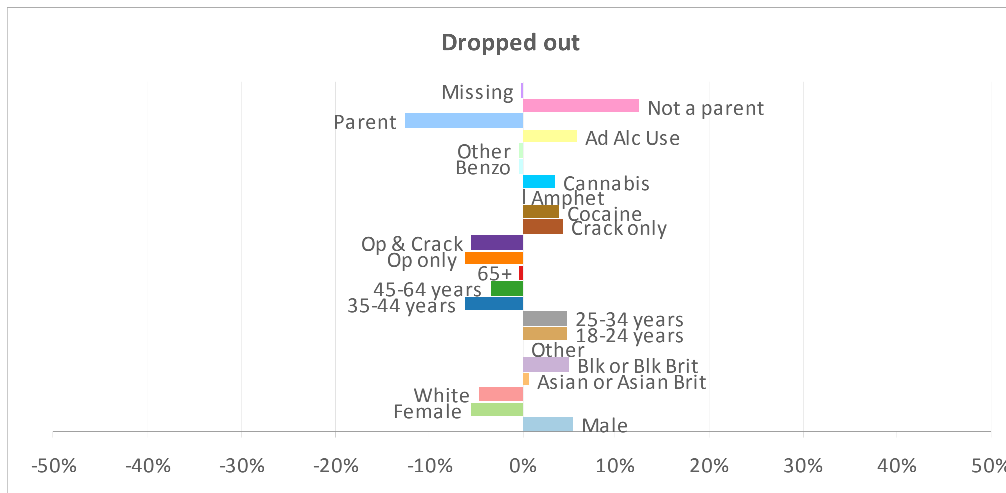
From this we can ascertain that the significant groups that leave in a planned way are cocaine, crack, and cannabis users, with adjunctive alcohol use, who are aged 25 to 34.

This shows more work is needed to aid the opiate, and opiate and crack clients, aged 35 to 44 to exit treatment in a planned way.

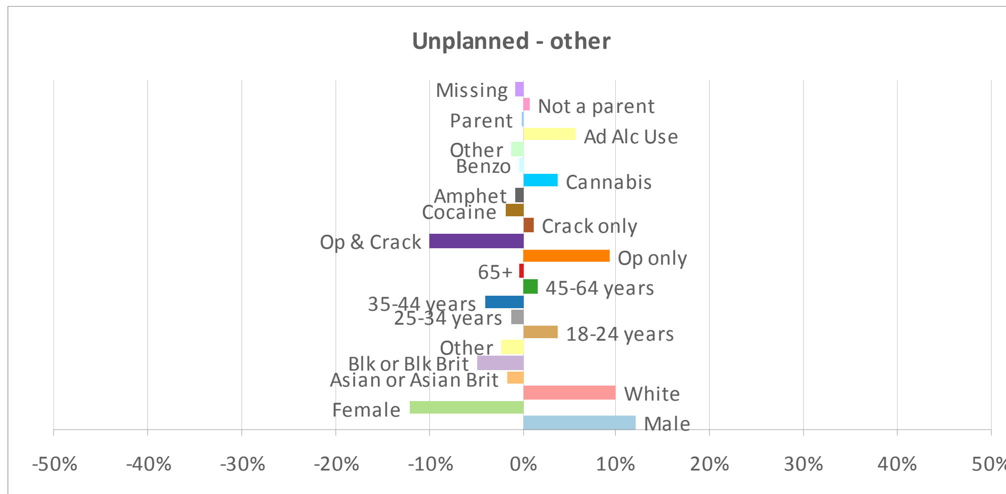


A total of 173 clients left treatment at the point of being 'referred on' in 09/10.

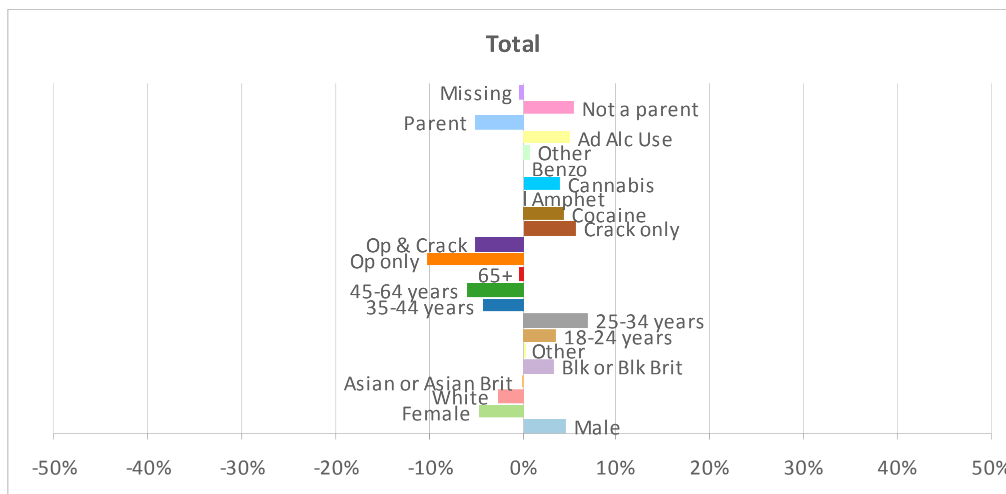
The significant group to leave treatment at the point of referral were the opiate and crack group. This is likely as the majority of failed referrals were from services that dealt with people with complex presentations i.e. poly substance use.



A total of 212 clients left treatment by dropping out. The only significant group that leaves treatment in this way are clients who are 'not a parent'. This could show that parenting is a driver to stay in treatment.



A total of 37 clients left treatment in an 'unplanned other' way which includes missing and not knowing why the client left treatment. Again as the number is relatively low the findings should be treated with care. The significant groups that leave treatment in this way are White Males, who use opiates.



601 people left Southwark's treatment system in 2009/10. This shows that Black British men aged 18 to 34 who use Crack, Cocaine, Cannabis with adjunctive alcohol use, who are 'not a parent' are more likely to leave treatment. White women, aged 35 to 64 who take opiates and opiates and crack who are parents are more likely to stay in the treatment. Overall there is no significant variance with the way people leave treatment or retain in treatment apart from the retention of opiate users.

Employment training and education. (ETE)

> “People in contact with drug and alcohol services face numerous issues that hinder their entry into employment including part- time and voluntary work. These include lack of skills, mental health problems, offending histories, multiple forms of deprivation and social stigmatisation of this group...... there is sufficient research to enable us to infer some of the key indicators of good practice”[iv]

ETE is key part of the Recovery agenda and for this needs assessment service providers were approached for information about how ETE informs treatment planning for individuals. Unfortunately the response was low. Last year’s needs assessment concluded that there were pockets of good practice; this appears to be the case currently. In discussions with Job Centre Plus and Southwark Volunteer centre, though they recognised that they did work with people with substance misuse problems, they do not record data on this systematically.

Southwark Volunteer Centre run a mental health supportive volunteering scheme and a work experience project, both of which have 5% of people with substance misuse problems. Part of the centre’s role is to support organisations to attract volunteers; this is done by training and support. They would welcome arrangements to link them with the planned Recovery remodel work.

The 2009/10 needs assessment proposed the re-instigation of the Social Inclusion Working Group in 2010, however due to reorganisation and resource constraints this was not possible. ETE is an integral part of the Recovery agenda, and as such will be looked at more closely in the remodel.

Both JCP and the Volunteer Centre felt that an increase in strategic networks and formalised working arrangements would be of benefit.

Data Collection and Reporting.

Contract and Performance Management

Over the last 13 months the DAAT has prioritised and established improved systems for data collection and reporting. Historically NHS Southwark has commissioned all treatment and harm minimisation services on behalf of the DAAT and has in place robust contract and performance management systems; during 2010/11 commissioning of DIP services transferred to community safety.

Over the last year it has become clear that from April 2012 funding for drug treatment will be based on treatment outcomes, specifically the number of people who leave treatment in a planned way. Southwark has performed poorly on this measure over the last two years and in February 2010 the Partnership developed and implemented an action plan to improve performance. As of November 2010 Southwark was the second worst performer in London at 27% for all drug misusing adults, ranking 144 out of 147 across England. The partnership agreed a target of 47% with the NTA for 2010/11 based on the London average for the previous financial year 2009/10.

A series of actions were put in place to improve performance with key actions including:

- **Improving understanding of reporting issues –** Data manager attended weekly meetings at services who have the highest impact on Southwark's overall performance, to improve front line workers' and managers' understanding of NDTMS technical issues regarding clients exiting and being referred to other agencies in the treatment system.
- **Improved governance and scrutiny –** The chairs of the JCG and DAAT board took a "hands on" approach to better understand the issues and drive improvements with key stakeholders. Improved performance reporting was put in place, particularly with regard to planned exits and Treatment Outcome Profile compliance, at the JCG and DAAT board.
- **Improved clinical pathways –** The establishment of a weekly joint provider meeting to discuss appropriate treatment interventions for clients and which treatment provider is most appropriate to meet their needs as well as overseeing the transfer of clients from one agency to another to ensure reported data matches the client's journey.
- **Improved Commissioning scrutiny –** development of bespoke analytical tools to improve scrutiny and performance management across a range of indicators. Monthly performance meetings within the commissioning team to consider individual agency

performance with the development of individual recovery plans where necessary. Regular meetings were held with senior managers from South London and Maudsley Blenheim CDP and CRi.

As part of the initiative to improve planned exits performance we have also worked with key providers to ensure more accurate reporting of TOPS information to ensure that we are meeting the 80% compliance threshold. There has been a marked improvement throughout the year from 67% in April 2010 to 83% in September 2010. In January 2011 the partnership received its first report showing progress for those who have exited treatment against the four key outcome indicators and we are keen to learn from this data.

Contract monitoring meetings

Following a reduction in staffing levels within the commissioning team within the PCT at the beginning of 2010/11, a review of contract monitoring meetings was undertaken. Previously in excess of twenty meetings were held each quarter. These have been replaced by more robust performance data gathering and analysis together with quarterly qualitative information reports from managers, monthly performance/improvement meetings with key agencies and half-yearly meetings with agencies to discuss wider issues. A gap has been identified and improvements of data collection and analysis of tier 2 activity is being developed and will be implemented from Q1 2011/12.

Monthly scrutiny of performance/activity data and spend on inpatients services across SLaM and third-sector providers is in place together with analysis of specialist out patients activity. The inpatient referral coordinator assertively manages the gateway into inpatient treatment service by supporting clinical staff with their care planning to ensure best outcomes and value for money.

Quarterly scrutiny of performance/activity data and spend on locally enhanced services within general practice and community pharmacy is in place together with analysis of specialist out patients activity. The primary care development manager assesses capacity across the whole system.

Commissioning Issues.

NHS Southwark commissions drug and alcohol services on behalf of the Safer Southwark Partnership. The DAAT has continued to commission a wide range of services for drug and alcohol misusers across all the tiers of models of care, from needle and paraphernalia exchange, mobile outreach, information and advice, prescribing services in secondary and primary care, structured psychosocial interventions as well as a range of inpatient and

rehabilitation service in both the statutory and third sectors, and independent providers including community pharmacy and general practice.

The PCT has continued to roll out the Substance Misuse Primary Care Strategy during 2010/11 specifically

- the consolidation of Southwark's Specialist Community Drug and Alcohol Services provided by South London and Maudsley NHS Trust onto one site (transfer some of the clinical teams at Marina House in Camberwell to Blackfriars Road, SE1) the creation of a range of satellite clinics to meet the needs of those unable to travel to the various treatment centres

- the creation of an Integrated Offender Management service (specialist health and social care treatment and enforcement provision)

- the creation of a range of satellite clinics to meet the needs of those unable to travel to the various treatment centres and the creation of specialist primary care based services for those with drug and alcohol problems.

Data audit

During 2010/11 the commissioning team undertook an audit of the data held on NDTMS and compared this to data held by local treatment agencies. This has reduced the historically inflated number of PDUs in effective treatment such that the numbers in effective treatment during 2009/10 more accurately reflect activity; the only caveat is that the 07/08 baseline may still be inflated since the audit focused on those clients who were on the 'open case load' at the time of the audit, and should have included all clients who have had an open case since the 2007/08 baseline was set.

The main evidence for this is shown by CRi DIP discharging circa 100 people all on one day in July 2008. If these clients had been discharged in the correct way, it is more than likely that some, if not all of the clients would have been discharge before the 2007/08 baseline had been set, and therefore they wouldn't have be included in this figure.

We are confident that this will not be an issue going forward as the NDTMS team have now developed a tool within the interface that uploads data to NDTMS.net that checks for this. We may continue with annual data audits to ensure figures truly reflect the numbers in treatment if this does not resolve the issue.

Conclusion and Recommendations

The number of people in effective treatment in Southwark has been declining in recent years. It is evident from the research carried out for this needs assessment that this does not reflect the level of need in Southwark. The largest single referral route into treatment is self referral in Southwark. Again, this does not reflect the level of need of people in contact with adult services, such as the criminal justice system. These points represent the challenge for Southwark in the coming year, how to facilitate meaningful referrals into treatment services from the services that people are in contact with and ensure people remain in treatment to have an impact on their lives and leave in a planned way.

Southwark welcomes the new approach that the drug strategy represents, coupled with the Recovery agenda, this will allow Southwark to develop services that address the multiple needs of people who are using substances that have a significant impact on their lives and the lives of others. This will mean remodelling services to make them accessible and allow them to work in a way that will mean treatment can be tailored to suit the needs of the individual and recognise that Recovery not only means an end to dependence on drugs but enables "drug misusers to build a lifestyle that promotes health and wellbeing, social and personal capital, as well as tackling drug dependence"[1]

Carrying out the adult substance misuse needs assessment alongside the young people's needs assessment has highlighted the inter-generational nature of substance misuse and its associated impacts on different generations. Treatment services must recognise this if treatment is to have a lasting effect. This will be an area of focussed development in Southwark.

Commissioning in Southwark moved towards an outcome basis, how will things be different after treatment? This must be further embedded and monitored in Southwark. This will mean looking at a range of areas of improvement in a person's life, and the TOPs data will help this monitoring. To use TOPS usefully, however, compliance must improve.

From the needs assessment the following recommendations emerged;

1. Improve numbers into and retained in effective treatment across all services.
2. The adoption of the Recovery remodel and reconfiguring of services to support this. This will see open access service provision for assessment across all services for all substances used (drugs and alcohol).
3. Increase the recognition of the intergenerational nature of substance misuse and tailor services to meet this. This will encourage early intervention (with referrals to the young people's substance misuse service for young people) and support to parents/carers (with referrals to adult treatment services for adults) through increased and improved family interventions.
4. Improve planned exits and outcomes for service users, which will be supported by the adoption of the Recovery model in services.
5. Recognise that service users have both underlying and consequential psychosocial support needs around substance misuse and reflect this in service development plans.
6. Improve assessment and access from the Criminal Justice System (Probation, DIP, DRR) by reviewing and improving current arrangements.
7. Re-commission current DIP service provision to support improvements to access and treatment outcomes as well as the recovery agenda.

Southwark

Alcohol Health Needs Assessment

January 2011

Kate Harvey
Public Health Specialty Registrar

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Many individuals have contributed to the needs assessment process. The author would like to thank all those who gave up their time to advise and support the needs assessment. Special thanks to Jacob Wheeler, Tony Lawlor, Melvin Hartley, Paul Collins, Francis Diffley, Julie Cuthbert, Alex Trouton, Karen Phillips and Gillian Holdsworth.

1. Introduction

- The 'Alcohol Health Needs Assessment' is being conducted alongside the 'Adult Drug and Children and 'Young People's Substance Misuse' needs assessments.

- The needs assessment aims to quantify the prevalence of alcohol related behaviours, the impact of alcohol on health in Southwark and assess the services provided to reduce alcohol related harm.

- This is being performed against a backdrop of:
  - Increasing affordability of alcohol relative to disposable income
  - Increasing consumption of alcohol within the home
  - An increasing national emphasis on alcohol related harm
  - Local population growth
  - A reconfiguration of the local services in Southwark

Two thirds of the population drink alcohol on a regular basis[v]. In Southwark this resulted in 75 deaths in 2008 and about 3262 hospital admissions. The 'collateral damage' caused by drinking has gained increasing attention since the term was coined by Liam Donaldson, Chief Medical Officer, in 2008[vi]. Such damage from 'passive drinking' includes the anti-social behaviour, crime and violence associated with drinking and the night time economy and the impact that alcohol has on families, work and school. This has been recently supported by a harm analysis study in the UK that found alcohol to be the most harmful drug overall, partly due to the high harm caused to others by alcohol use[vii].

This Health Needs Assessment aims to support alcohol harm reduction activities in Southwark by addressing the following points:

- A summary of how many people in Southwark are drinking at increasing and higher risk levels
- Quantification of how drinking alcohol affects peoples' health in Southwark (including deaths, hospital care and the treatment of alcohol use)
- The broader social and economic impacts of drinking alcohol in Southwark, i.e. the 'collateral damage' (including crime and disorder, impacts on families and risk taking behaviour)
- The evidence based actions that are recommended to reduce the harm caused by alcohol and address health and social inequalities arising from alcohol
- The local gaps in practice and priorities for action

There are three main ways of approaching health needs assessment[viii]:

1. An epidemiological approach describes the size of the problem and service use
2. A corporate approach aims to summarise the issue from the view of service users and professionals
3. A comparative approach considers observed practice against guidelines or examples.

As is common in health needs assessment, this report will incorporate all three approaches. The process was overseen by a needs assessment steering group (involving public health and the drug and alcohol action team) and the following events were held to gather wider contribution to the process:

- Data workshop (see Appendix 2)
- Expert group (see Appendix 3)

- Three Service user focus groups (see Appendices 4 and 5)

1.1 The national context

Alcohol related harm has been estimated to cost around £20 billion in England and Wales[ix], covering costs related to crime and disorder, the loss of work productivity and direct health costs to the NHS (the latter of these has more recently been estimated to total about £2.7 billion[x] based on 06/07 prices). Alcohol problems affect both males and females, all social classes and all age groups.

Current UK Government recommendations[xi] advise that:

- Adult women should not regularly drink more than 2–3 units of alcohol a day
- Adult men should not regularly drink more than 3–4 units of alcohol a day; and
- Pregnant women or women trying to conceive should avoid drinking alcohol. If they do choose to drink, to protect the baby they should not drink more than 1–2 units of alcohol once or twice a week and should not get drunk.

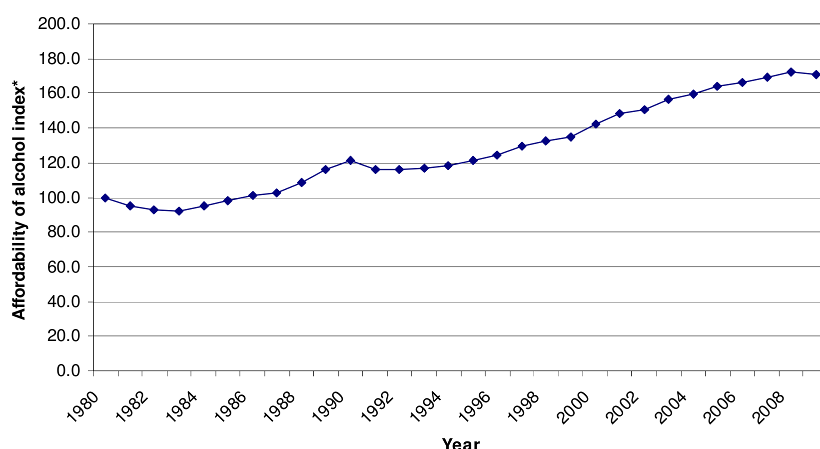
The 2004 National strategy to tackle alcohol related harm, 'Safe Sensible Social'[xi] covers health, alcohol-related crime and harm to children and young people due to alcohol. Key themes that have guided national policy and action in this area include:

1. Supporting people to make informed healthy choices (mass media and social marketing campaigns have run alongside partnerships with industry to improve unit and health information on labelling)
2. Creating an environment in which the healthier/responsible choice is the easiest choice (working with retailers and investigating the impact of pricing on alcohol consumption)
3. Providing support and advice for those most at risk of alcohol harm (developing medical student and GP skills in identifying potentially harmful drinking and provide brief interventions in a range of settings)
4. Effectively prioritised and delivered action on alcohol misuse (supporting PCTs in their commissioning and the use of appropriate targets)

The 2010 Drug Strategy, 'Reducing Demand, Restricting Supply, Building Recovery: supporting people to live a drug-free life', considers specialist treatment for severe alcohol dependency to be similar to treatment to drug dependency and therefore addresses both issues together[xii].

These policies have been developed against a backdrop of increasing affordability of alcohol over time compared to the price of other goods[xiii] (see Figure 1, below). If someone were to spend the same proportion of their disposable income on alcohol in 2009 they would get roughly 70% more alcohol for their money.

Figure 1: Affordability of alcohol since 1980



* Affordability of alcohol index compares the relative changes in the price of alcohol with changes in households' disposable incomes since 1980 (a value greater than 100 shows that alcohol is more affordable than it was in 1980).

Source: NHS Information Centre 2010[xiv]

Despite recommendations by the Chief Medical Officer[vi] and the National Institute of Health and Clinical Excellence to set a minimum price per unit[xv] this has not yet been done in England.

Other changes in alcohol consumption in the UK include a decrease in alcohol consumption outside of the home and an increase in alcohol consumption within the home. Total alcohol consumption in England has remained fairly steady since 2000[xvi].

1.2 The local context

This Needs Assessment is being developed to support the work of the Southwark Alcohol Steering Group, NHS Southwark and the Safer Southwark Partnership. Findings will be used to guide the re-development of an Alcohol Strategy and will provide those working in this field with a data resource.

Southwark has an estimated resident population of 285,600[xvii]. Like many London boroughs Southwark has a predominately young adult population compared to that of England. Approximately 43% of the Southwark population are aged 25 - 44 years old compared to 28% in England (and 72% of working age compared to 62% nationally).

The population of Southwark is growing and the resident population is expected to increase by more than a fifth to 355,200 by 2030[xviii]. Alongside this, there are significant developments that will have an impact on alcohol use and the night time economy including the Shard Development in Borough which will bring additional workers to the area and result in additional licensed premises.

2. Alcohol Use in Southwark

- In Southwark there are an estimated 35,265 to 42,459 people at increased risk, 11,026 to 13,918 people at higher risk and 35,030 to 53,133 people binge drinking (2009).
- There are an estimated 6348 dependent drinkers in Southwark.
- 2006 Health Survey for England estimates suggest that 45% of Southwark residents drink more than the recommended daily alcohol intake on one or more days of the week.
- Information on alcohol use in specific populations shows that rates of drinking are high amongst those with a housing need, those with diagnosed mental health problems and those known to the probation system.
- Alongside this, national survey data suggests that we can expect those of white ethnicity, men, under 65s and those employed in managerial and professional roles to drink more.
- Market segmentation can be used to breakdown the population into different categories of drinkers in order to target interventions appropriately. Care must be taken, however, when doing this as this technique can overestimate the population at increased or higher risk.

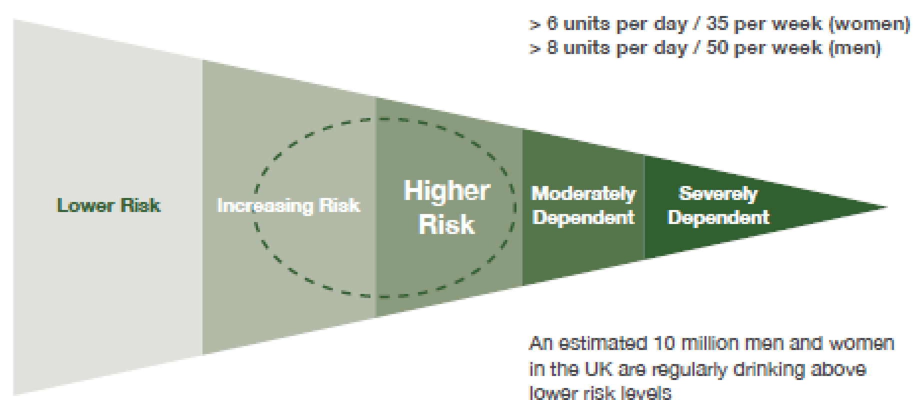
2.1 Measurement definitions

Government recommendations are that adult men should not regularly drink more than 3-4 units of alcohol a day and adult women should not regularly drink more than 2-3 units a day[xix]. It is also recommended that pregnant women do not drink and, if they decide to drink, limit themselves to 1-2 units a week and avoid getting drunk[xx].

Whilst a range of sources collect information on how much people drink, e.g. the number of units drunk in an average week and the amount drunk on the heaviest drinking day in the last week, there is little precise measure of consumption against the recommendations.

A further categorisation relates to clinical groupings of alcohol consumption. Hazardous or increasing risk drinking is defined as a pattern of drinking which brings about the risk of physical or psychological harm and harmful or higher risk drinking is defined as a pattern of drinking which is likely to cause physical or psychological harm. Substance dependence is defined by the International Classification of Diseases and related health problems (ICD-10) as a cluster of behavioural, cognitive and physiological phenomena that can develop after repeated substance use. This is shown on the diagram below.

Figure 2: Moving in and out of higher risk drinking



Taken from Alcohol Social Marketing Toolkit[xxi]

Synthetic estimates of the numbers needing services at each level can be created using the 'Rush Model'[xxii] (see section 7).

2.2 Drinking behaviour in Southwark

Mid 2005 synthetic estimates of drinking behaviour (Local Alcohol Profiles, NWPHO) suggest a lower proportion of the Southwark population was engaging in increased risk drinking in 2005 compared to England as a whole[xxiii]. This data is based on the application of national rates to local population details and must therefore be interpreted with caution. This assumes that the rates of increasing, higher risk and binge drinking have not changed since 2005.

Figure 3: Mid-2005 synthetic estimates of drinking behaviour in Southwark (16 years and over)

	Southwark		London %	England %
	%	People*		
Increased risk (95% confidence interval)	16.53 (15.00-18.06)	35,265 to 42,459	18.77 (17.33-20.14)	20.10 (18.42-21.77)
Higher risk (95% confidence interval)	5.30 (4.69-5.92)	11,026 to 13,918	5.10 (4.53 – 5.67)	5.03 (4.50-5.57)
Binge drinking (95% confidence interval)	18.44 (14.9-22.6)	35,030 to 53,133	14.3 (12.5-16.3)	20.1 (19.4-20.8)
Dependent **	2.7	6348	-	3.8

*Calculated using ONS mid-2009 population estimate of 235,100 persons aged 16 and over
** Local dependency estimates provided by National Treatment Agency

Source: ONS[xxiv] and NWPHO Local Alcohol Profiles for England[xxiii]

More local representative, but again slightly out of date, information about drinking behaviour relative to the Government's guidelines comes from the London boost of the Health Survey for England. Whilst surveys are known to suffer from under-reporting of alcohol misuse[xxv], under-representation from some groups including homeless or those in institutions and a lower response rate from problem drinkers they still provide the most accurate local data available.

Figure 4: Alcohol use on the heaviest day in the past week in Southwark

Southwark (2006)	Southwark		London
	%	Persons*	%
Did not drink in the past week	37.8 (30.2-45.3)	82446 to 123669	43.6 (41.5-45.7)
Up to 4 units (men) or 3 units (women)	17.2 (10.4-24.0)	28392 to 65520	20.7 (19.5-22.0)
Between 4-8 units (men) or 3-6 units (women)	17.0 (13.7-20.3)	37401 to 55419	16.3 (15.2-17.4)
More than 8 units (men) or 6 units (women)	28.0 (19.0-36.9)	51870 to 100737	19.3 (17.8-20.9)

* Range calculated from the 95% confidence interval of the % drinking at this level applied to the appropriate ONS mid-2006 population estimates (273 000 persons)

Source: LHO[Error! Bookmark not defined.] **and ONS**[xxvi]

It can be seen that drinking behaviour in Southwark does not differ significantly from the London average. The HSE did not find any significant difference between male and female drinking behaviour in Southwark although London and national data suggests that there is a higher prevalence of problem drinking amongst men than women.

2.3 Alcohol use in defined populations

Further information is available on alcohol use in defined populations.

2.3.1 Alcohol use measured by GPs

A Directed Enhanced Service is currently in place to incentivise GPs to screen new patients for alcohol use using a validated tool (either FAST or AUDIT is promoted in Southwark). Existing patients were screened for their alcohol use during the 2008/2009 period through the Locally Enhanced Service although this is not currently in place. In 09/10 only 48.6% of new registrations in Southwark were screened using a validated tool.

GPs record the number of harmful/hazardous drinkers or dependent drinkers and have found a much lower prevalence that would be expected.

Figure 5: Alcohol Use Screening in New GP Registrations (2009/10)

	2009/2010	
	Number	% (prevalence)
New registrations (age 16+)	33904	-
Screened (FAST, AUDIT C or AUDIT)	16492	-
Harmful or hazardous drinkers	531	3.22
Dependent drinkers	317	1.92

* % of those screened

2.3.2 Alcohol use amongst those known to the criminal justice system

Alcohol use amongst offending populations is known to be high and the 2010 Ministry of Justice Green Paper recognises that treatment for alcohol misuse is often the first step in reforming offenders[xxvii].

Police

51% of arrests are dealt with at the police station. It has been estimated that 31% of this population have a problem involving alcohol misuse[xxviii]. In Southwark there were 15,703 arrests in 2009/2010[xxix], suggesting an estimated 4868 individuals with a problem associated with alcohol.

Prisons

63% of sentenced male prisoners and 39% of female sentenced prisoners admit to hazardous drinking prior to entering prison, with half of these having a severe alcohol dependency[xxx].

Prisoners from Southwark are placed in a range of prisons across the country and their alcohol needs are addressed by the CARAT (counselling, assessment, referral, advice and throughcare) teams.

Probation

The impact of alcohol use on offending behaviour (criminogenic need) is recorded by the probation system. This only considers alcohol use in terms of its contribution to current and past offending behaviour and does not use a validated tool but may provide some indication of the needs of this population group although prevalence is likely to be underestimated.

It is estimated that 32% of the probation assessments between October 2009 and September 2010 identified a criminogenic need related to alcohol use. Amongst the group of offenders with alcohol needs (533 individuals) it was more likely to identify mental health issues and accommodation problems than in offenders with no recognised criminogenic need linked to alcohol[xxxi]. During the 2009/2010 period, Southwark issued 104 Alcohol Treatment Requirements (ATRs) to individuals on probation. Individuals are screened using the AUDIT tool and treatment plans are made by a service that Equinox provides on behalf of the London Probation Trust.

2.3.3 Alcohol use in those with a housing need

39% of clients in homeless projects are suggested to have an alcohol need, rising to 56% in day centres 54% in Direct Access hostels[xxxii].

Amongst rough sleepers, it is suggested that at least 25% are dependant on alcohol, with 63% reporting drug or alcohol use to be one of the reasons they first became homeless[xxxiii]. Amongst rough sleepers drug and alcohol use and dependency is associated with being homeless for a longer time[xxxiii].

Hostels regularly identify and support those misusing alcohol. Other housing services hold little information about alcohol need and identify only a small proportion of the population with an alcohol need. Between April 2009 and March 2010, only 7% of those in contact with the Southwark Resettlement Team were identified as having an alcohol need (3% of all clients had a primary alcohol need, 3% had a secondary alcohol need). Within resettled premises, only 28 individuals were identified as having a support need for alcohol.

2.3.4 Dual diagnosis (co-existing mental and substance misuse disorder)

Cheryl Kiping (Consultant Nurse Dual Diagnosis, South London and Maudsley NHS Foundation Trust) has provided the following information on the alcohol needs amongst those with mental health problems. It is clear that alcohol use is a significant problem for many people with mental health problems. Of those with a 'dual diagnosis' (co-existing mental and substance misuse disorder) evidence consistently indicates that alcohol is the substance most commonly used.

Alcohol is strongly associated with a range of mental health problems, in particular depression and anxiety and mental health risks, especially self harm and suicide, with up to 41% of suicides being attributable to alcohol[ix].

Studies have found that between 26% and 49% of mental health service users meet the criteria for harmful or hazardous drinking, with 9% to 15% being dependent on alcohol[xxxiv],[xxxv]. Local studies have suggested that 41% of mental health patients drink excessively (Camberwell based mental health service users)[xxxvi], with prevalence higher in inpatient psychiatric wards and forensic services than in community mental health services[xxxvii].

Although some people in contact with mental health services can and do access specialist alcohol treatment, many are unwilling or unable to do so. Local snapshots and case audits have identified between 19% and 31% of caseloads have been identified with problematic alcohol use[xxxviii]. It was identified that some care coordinators did not know about their patients' alcohol use.

The Mental Health Service for Older Adults found that in 2002/2003 13% of older adults (over 65) with a diagnosis of depression also had a diagnosis of alcohol dependence[xxxix].

Challenges relating to dual diagnosis service provision have been identified by the Consultant Nurse in Dual Diagnosis[xxxviii] as:

- A lack of focus on alcohol/dual diagnosis in pre-registration training of staff in all disciplines (a threat to the implementation of NICE guidance), compounded by the effect of disinvestment on training and supervision
- The view of some mental health staff that assessment and management of alcohol misuse as 'extra work' that should be the responsibility of alcohol services
- Mental health service users who do not view their alcohol use as problematic and do not want to access services
- The potential for service users to 'fall between the gaps' in the care pathway if reduced capacity affects acceptance criteria of different agencies
- Lack of clarity in care pathways for dual diagnosis clients, potentially compounded by NICE Guidance that recommends treating alcohol use before depression and anxiety
- Lack of mental health expertise amongst general alcohol service staff (no longer supported by dual diagnosis staff)
- Challenges for inpatient ward staff managing clients who become intoxicated (e.g. self-harm, violence, suicide risk)

There is work underway in the South London and Maudsley Foundation NHS Trust to advocate for the integration of identification (AUDIT) and brief intervention into core mental health services, with further training and sharing of best practice[xxxviii].

2.5 What do we know about people drinking alcohol in Southwark?

Little date is available to describe who in Southwark is at increasing or higher risk from their drinking behaviour. National data suggests that people drinking more than the recommended levels are more likely to be:

- Men (37% of men exceeded the recommended amount on at least one day of the past week compared to 26% women)[xl]
- Of white ethnicity (most other ethnic groups have higher rates of abstinence and lower rates of frequent and heavy drinking although there are exceptions to this, e.g. Sikh male populations have high rates of heavy drinking)[xli]. It is important to remember that there are often large variations within these populations.
- Under 65 (over 65s men were half as likely, and women a third as likely, to consume over the recommended daily amount at least once in the past week)[xl]
- Employed in Managerial and Professional roles and not in routine and manual roles (a difference that is particularly pronounced for women)[xl]
- Earning higher household incomes[xl]

Alcohol harm is not solely related to the amount of alcohol consume and it has been suggested that more affluent drinkers do not suffer the same alcohol related morbidity and mortality as more deprived drinkers[ix].

Social marketing techniques can be used to segment local populations based on their drinking behaviour and other characteristics into discrete groups that can be targeted in order to achieve change in drinking behaviour. Using the Alcohol Learning Centre market segmentation tool[xlii], eight segments describe increasing and higher risk drinkers. The segments that the Department of Health identifies as being of primary importance to focus on are 10, 12 and 13, with segments 8 and 9 being of secondary importance. Pen portraits of the primary segments are given below.

Segment 10
Segment 10 includes high numbers of pensioners, who are generally in poor health with conditions that include asthma, angina and heart problems. They have high acute hospital admissions. They often live alone and in local authority flats. As well as drinking beer and spirits, they are likely to smoke. They tend to read tabloids.

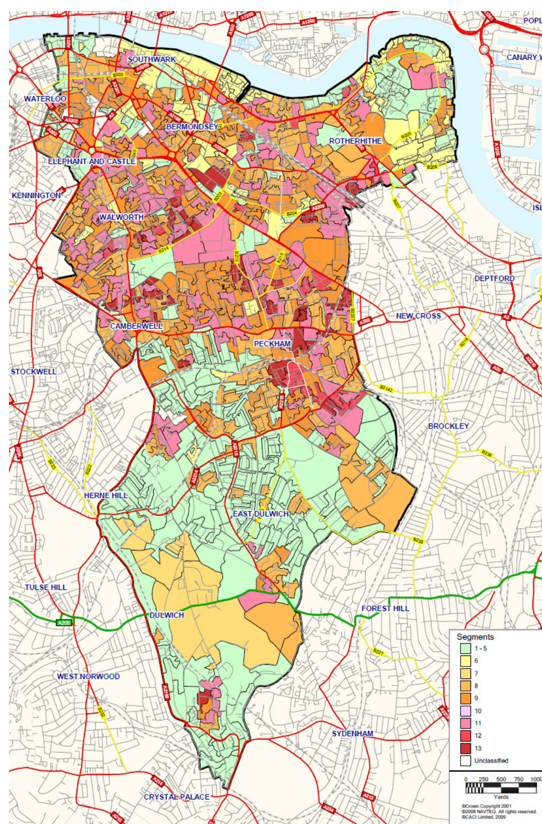
Segment 12
Segment 12 includes people with a broad range of ages, who are likely to live in terraces, often in former industrial areas. They generally have the worst levels of overall health, with asthma, cholesterol and heart conditions as well as high acute hospital admissions. They are likely to smoke and drink beer and lager, at home and in pubs. They tend to read tabloids.

Segment 13
Segment 13 includes young people in their 20s who have a very high rate of acute admissions. They are likely to live alone in local authority flats or hostels, be unemployed and some are single parents. They are likely to drink large amounts of both beer and spirits and to smoke. They tend to read tabloids.

Taken from www.alchollearningcentre.org.uk

The location of the segments in Southwark is shown on the map below. It can be seen that the majority of the population thought to be of Primary Importance are located in the North of the Borough but that segments are widely dispersed.

Figure 6: Social marketing drinking segmentation



Source: Alcohol Learning Centre Market Segmentation A3 Map[xlii]

This map indicates postcodes where the potential to influence drinking behaviour is high – this is not purely based on drinking behaviour but also includes assessment of responsiveness to marketing and media. For this reason, whilst the postcodes identified as priority areas are likely to reflect populations with higher propensity to problem drinking the maps should not be used to guide service configuration or commissioning. The segmentation uses HealthACORN, 2006/7 alcohol attributable hospital admissions data from the North West Public Health Observatory and 2009 TGI data.

It is also possible to consider which individuals are experiencing alcohol related harm. This work in currently underway in Southwark.

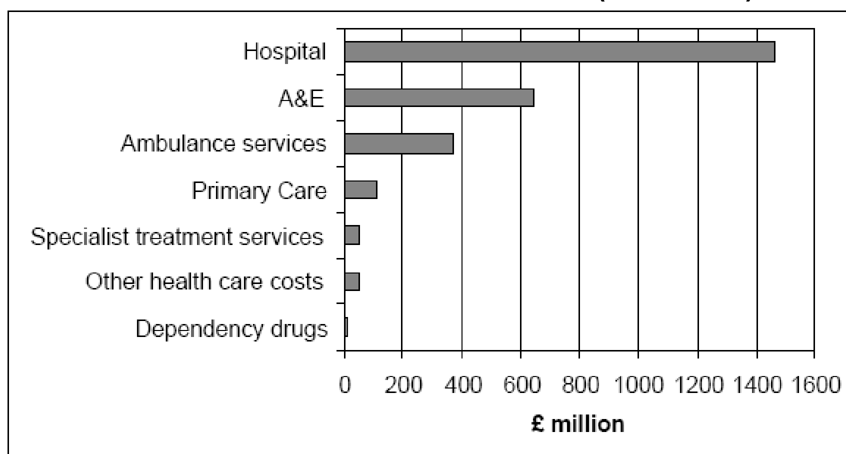
3. Health Impacts of Alcohol Use in Southwark

- Alcohol has a significant impact on the health of residents in Southwark. If all alcohol related deaths were prevented, life expectancy at birth in the Borough would increase by 10.9 months for men and 4.2 months for women.
- In 2008, 75 deaths in Southwark were attributable to alcohol. This represents a mortality rate similar to both the regional and national rates.
- Southwark experiences particularly high rates of male mortality from chronic liver disease when compared to both England and London.
- In 2008, there were 3262 alcohol related hospital admissions. This represents a significant cost to Southwark although the rate compares favourably with England and London averages.
- Alcohol specific hospital admissions can provide more information about who is experiencing alcohol related harm. Individuals being admitted for alcohol specific causes were more likely to be male (77% of admissions) and were predominantly white (70% of admissions), with most of these being white British. Rates of admission are particularly high in residents of Nunhead, Livesey, East Walworth and Cathedrals wards.
- Locally, it is difficult to assess the direct contribution of alcohol to the A&E consultation rate. Nationally, it is estimated that 12% of A&E visits are directly due to alcohol consumption. For Southwark residents, this would represent 2364 emergency admissions at a cost of approximately £4,871,143.
- 5.1% of all ambulance calls in 09/10 (2908 calls) were related to alcohol.

Alcohol has been shown to be causally related to over 60 different acute and chronic medical conditions, including cancer cardiovascular disease and obesity. Alcohol is a significant cause of morbidity and mortality but alcohol misuse is often masked by other conditions (e.g. gastrointestinal problems and insomnia), misdiagnosed or otherwise under-diagnosed.

The cost of treating alcohol related conditions in England has been estimated to be over £2.7 billion, with the highest costs being for hospital and A&E care (see below)[xliii].

Figure 7: Annual estimated cost of alcohol to the NHS (2006-2007)[xliv]



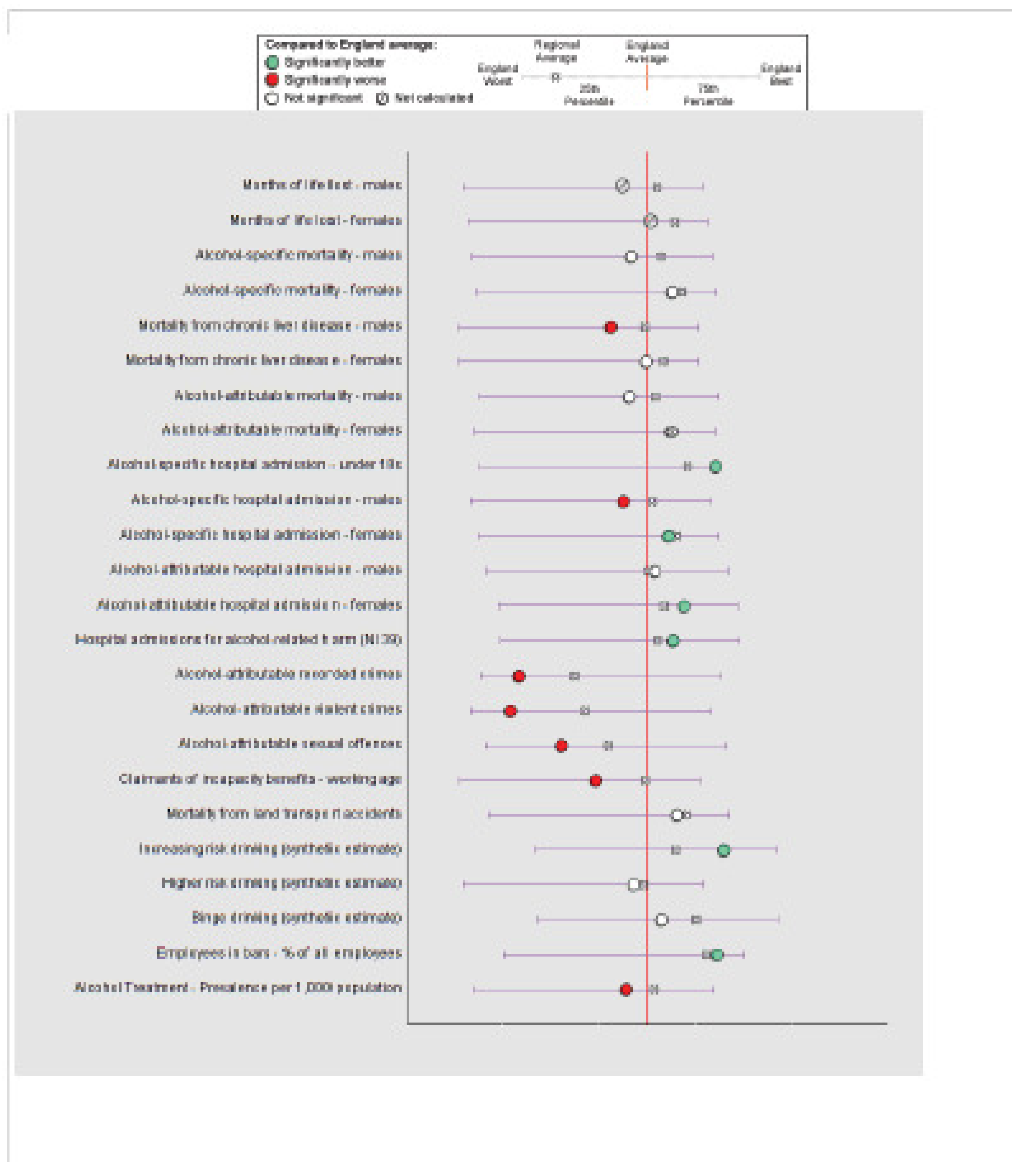
Source: Health Improvement Analytic Team 2008[xliii]

3.1 Health impacts of alcohol misuse in Southwark

The chart below compares the Southwark health impacts from alcohol to the average English and London experiences. Southwark has particularly high rates of alcohol related crime compared to the London and England averages and this is explored in more detail in Chapter 4.

A number of individual areas of health impact are explored in more depth in this chapter including alcohol attributable mortality, hospital admissions and A&E calls.

Figure 8: Profile of alcohol related harm for Southwark (compared to England and London)



Source: NWPHO[xxiii]

3.2 Alcohol related deaths in Southwark

3.2.1 Alcohol attributable mortality

75 deaths in Southwark in 2008 were attributable to alcohol (60 male deaths and 15 female deaths)[xlv]. This represents an age standardised mortality rate of 41.2 per 100,000 population for men and 12.7 per 100,000 for women (neither rate differs significantly from the London and England averages) and includes both those causes of death directly caused by alcohol and also a proportion of the deaths sometimes related to alcohol.

Alcohol attributable mortality in Southwark has remaining roughly constant since 2004. Nationally, there was a decrease in alcohol attributable mortality in 2009 that has been attributed to the impact of the recession[xlvi]. This is expected to reverse once the financial climate improves.

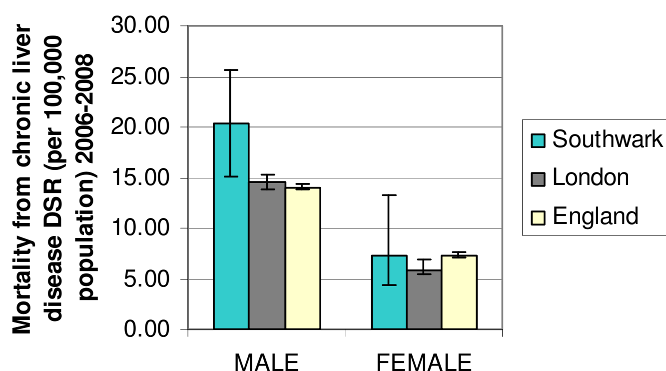
3.2.2 The impact of alcohol on life expectancy in Southwark

If all alcohol attributable deaths in those under 75 were prevented, life expectancy in Southwark would increase by 10.9 months for men and 4.2 months for women[xlv].

3.2.3 Mortality from chronic liver disease

Mortality from chronic liver disease is particularly high for men in Southwark compared to both London and England, as shown on the graph below. Women have much lower mortality from liver disease than men and experience similar rates to both London and England.

Figure 9: Mortality from chronic liver disease (06-08)



Error bars show 95% confidence intervals
DSR = Directly age standardised rate (i.e. controlling for age structures of the populations)

Source: NWPHO[xlv]

3.3 Alcohol related hospital activity in Southwark

As for mortality, hospital admissions due to alcohol use include conditions caused solely by alcohol use (e.g. mental and behavioural disorders due to the use of alcohol or ethanol poisoning) and also conditions that are only partially caused by alcohol use.

The main causes of alcohol related admission in Southwark for 2007/2008 (compiled by London Health Observatory and not available for 08/09) are shown below:

Figure 10: Alcohol related admission in Southwark (2007/2008)

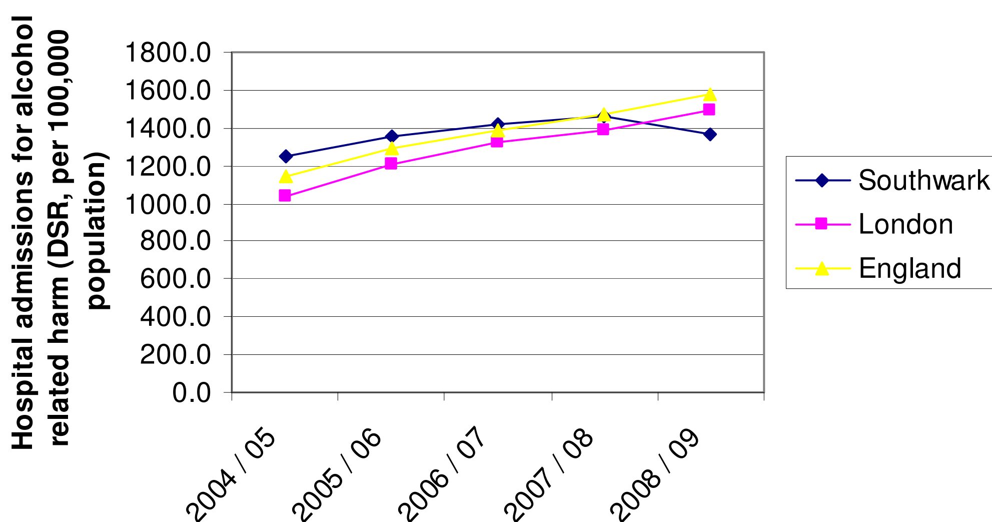
Dominant Diagnosis	Number of admissions (07/08)
Mental and behavioural disorders due to the use of alcohol	997
Hypertensive diseases	865
Cardiac arrhythmias	386
Epilepsy and status epilepticus	303
Alcoholic liver disease	158
Fall injuries	84
Chronic hepatitis/liver cirrhosis	76
Intentional self-harm/event of undetermined intent	70
Assault	65
Oesophageal varices	56
Spontaneous abortion	50
Ethanol poisoning	37
Malignant neoplasm of the breast	29
Malignant neoplasm of lip, oral cavity and pharynx	24
Chronic pancreatitis (alcohol induced)	23
Acute and chronic pancreatitis	23

Source: London Health Observatory[xlvii]

3.3.1 Alcohol related admissions (NI36 – admissions for alcohol related harm)

In 2008/2009 there were 3262 hospital admissions for alcohol related harm in Southwark. This represents a rate that is significantly lower than both London and England averages (1361.5 per 100,000 population vs 1489.9 and 1582.4 per 100,000 respectively). This is due to recent reductions in the rate of hospital admissions in comparison to England and London increases.

Figure 11: Alcohol related admissions (02/03 to 07/08)



Source: NWPHO[xlv]Error! Bookmark not defined.

3.3.2 Non-A&E alcohol related hospital admissions in Southwark

1415 men and 790 women were admitted to hospital (excluding A&E admissions) in Southwark with alcohol attributable conditions in 2008/2009[xlv]. Male admission rates are similar to England and London averages, but Female admission rates are significantly lower than both England and London.

Southwark has particularly high rates of age standardised admissions for alcohol specific conditions amongst males, at 485 per 100,000 populations (vs 398 per 100,000 for London and 379 per 100,000 for England)[xlv].

3.3.3 Alcohol related A&E activity in Southwark

Whilst data collection in A&E has been improved recently, coding problems with submitted data and lack of data from Kings A&E means that it is not possible to assess the local burden of A&E admissions due to alcohol. Nationally, it is estimated that 12% of A&E admissions are directly related to alcohol[xlviii].

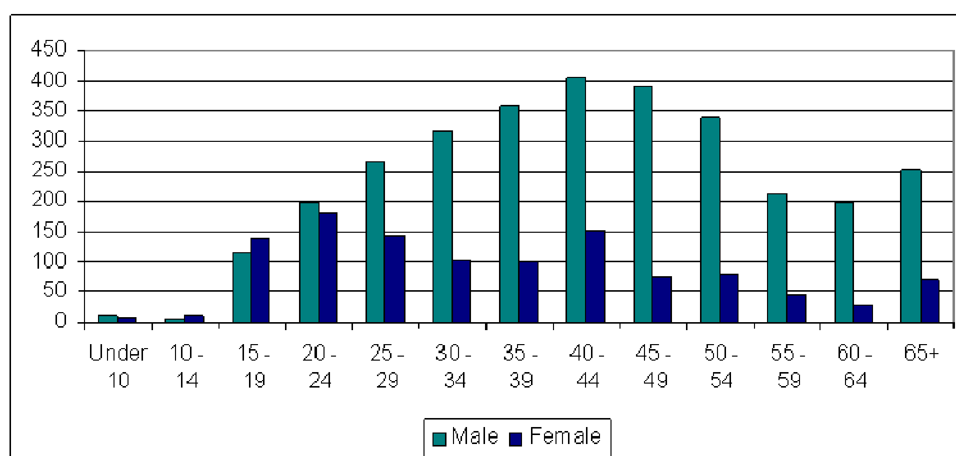
In Southwark there were 19,698 emergency admissions in 2009/2010 (patients aged 18 and over only). Applying National estimates, 12% of these admissions are directly related to alcohol representing 2364 emergency admissions at a cost of approximately £4,871,143[xlix].

There is still very poor data held on alcohol consumption prior to A&E visit and a recent audit at Kings suggests that an alcohol history was only recorded for 8% of patients[l].

3.3.4 Alcohol related ambulance service use in Southwark

Between April 2009 and March 2010 there were 2908 alcohol related ambulance calls in Southwark (5.1% of all calls). Examining the calls by gender and age it can be seen that males represent the bulk of the alcohol related calls, particularly amongst adults aged 30-50. This is consistent with the high levels of alcohol related male violent crime observed in Southwark (see Chapter 4).

Figure 12: London Ambulance Service alcohol related calls (April 09 – Sept 10)



Source: LAS

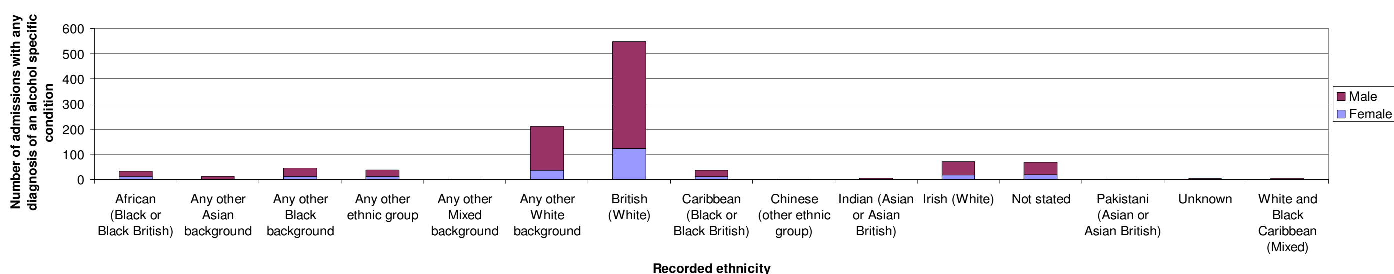
3.3.5 Who is admitted to hospital for alcohol specific causes?

Local data on alcohol specific admissions gives a picture of who is experiencing harm from alcohol use in Southwark.

Alcohol specific admissions are here defined as admissions that mention alcohol specific conditions in any of the diagnosis codes, as used by the North West Public Health Observatory.

In 2009/2010 there were more male admissions that female admissions (77% of admissions were for males). As shown on Figure 13, most admitted individuals were white (70%) with the majority of these being white British.

Figure 13: Alcohol specific admissions by ethnicity and gender (Southwark registered population, 09/10)



Source: HES

The alcohol specific admission rates per 1000 population in Southwark show that the white population in Southwark experience the highest rate of admissions. Other

Figure 14: Alcohol specific admission rates by ethnicity 2009/2010

	Admissions (2009/2010)	Population (000s) (2007)	Admission rate per 1000 population
White	829	152.1	5.45
Other	40	11	3.64
Black or Black British	117	41	2.85
Asian or Asian British	19	14.8	1.28
Mixed	7	6.4	1.09
TOTAL	*1084*	*225.2*	*4.81*

Source: ONS and HES

The admissions are drawn from a range of postcodes and, when grouping admissions by Ward and comparing admission rates (relative to Ward populations) it can be seen that there is a large variation, with Nunhead, Livesey, East Walworth and Cathedrals Wards having the highest admission rates.

Figure 15: Ward level admission rates for alcohol specific conditions (any diagnosis recorded) in Southwark (09/10)

Ward	2009 Population	Admissions (09/10)	Admissions per 1000 population
Nunhead	12005	72	6.00
Livesey	13654	77	5.64
East Walworth	13117	64	4.88
Cathedrals	15851	76	4.79
Brunswick Park	12281	56	4.56
Faraday	13488	55	4.08
Newington	14424	56	3.88
Camberwell Green	13868	52	3.75
South Bermondsey	12824	45	3.51
Peckham Rye	12896	43	3.33
Rotherhithe	12938	42	3.25
Grange	14803	47	3.17
The Lane	14473	42	2.90
Riverside	13475	39	2.89
Peckham	12066	31	2.57
Surrey Docks	12818	31	2.42
East Dulwich	11893	28	2.35
Chaucer	16132	36	2.23
Village	11019	22	2.00
South Camberwell	12230	21	1.72
College	11221	10	0.89

Source: GLA population estimates (2009) and HES

4. Social and Economic Impacts of Alcohol Use in Southwark

- The social and economic costs of alcohol in Southwark include:

  - Crime, including domestic violence (alcohol was related to 3101 crimes, April 09 to Sept 10)
  - Alcohol misuse has a significant impact on families, children and young people and Southwark Children's Services estimated that alcohol is involved in 30% of local care proceedings
  - Sexual health and unplanned conceptions
  - Accidents including road traffic accidents and fires.

- Economic costs of alcohol include loss of productivity and absence from work.

- Individuals who misuse alcohol are disproportionately likely to come into contact with some services, including the Criminal Justice System, Children's Services.

- Individuals who drink alcohol at increasing or higher risk levels, or are dependent on alcohol, are more likely to take unplanned absence from work.

- In Southwark, there are much higher rates of claiming Incapacity Benefit (IB) or Severe Disability Living Allowance (SDA) due to alcoholism than across England or London. In 2009, 400 individuals in Southwark were claiming IB / SDA due to alcoholism.

European estimates place the social cost of alcohol at between 1% and 3% of GDP, figures that exceed Government expenditure on social security and welfare and total roughly 25% of healthcare expenditure[li].

This section will consider the broader impact of alcohol use in terms of crime and disorder, domestic violence, impacts on children and young people, fires and road traffic accidents and impacts on work and productivity.

4.1 Crime and disorder

Alcohol is a major factor in many kinds of crime and the costs of alcohol related crime and disorder was estimated to cost £7.3billion in England in 2004[lii]. Police Superintendents suggest that alcohol is a factor in half of all crime[liii] and an All Party Group of MPs was advised by the British Medical Association[liv] that alcohol is a factor in:

- 60-70% of homicides
- 75% of stabbings
- 70% of beatings
- 50% of fights and domestic assaults

Alcohol misuse can also perpetuate offending behaviour and it is recognised that tackling these problems is often the first step in helping an offender to reform[lv].

Police figures may seriously underestimate the numbers of alcohol related crime as it has been estimated that less than a quarter of assaults recorded in emergency departments are

reported to police[lvi]. Work is currently underway in Southwark to improve the availability of data on alcohol use in assaults presenting to emergency departments.

Public perceptions of crime can be measured by CAD calls as these are made by members of the public when they have a crime issue that they wish to be resolved. From 2009/2010 to 2010/2011 to date there has been a 37.5% decrease in alcohol related CAD calls with particular decreases in Cathedral Ward (North West corner of the Borough) and The Lanes Ward (Central Southwark).

Continuing hot spots have been identified as:

1. Clink Street and surrounds (70 calls)
2. Peckham High Street (102 calls).

4.1.1 Alcohol related crime (excluding domestic violence)

Data from the Metropolitan Police suggests that 5.3% of all crime in Southwark was flagged as alcohol related[lvii] between April 09 and Sept 10.

Excluding domestic violence (see Section 4.2.2 for this data), 4.4% of crime was flagged as being related to alcohol in Southwark (2009/2010), a figure that varied by crime type as shown below. Violence, sexual offences and 'other notifiable offences' are the most likely crime types to be related to alcohol in Southwark.

Figure 16: The proportion of reported crimes related to alcohol in Southwark (excluding domestic violence) April 09 – Sept 10

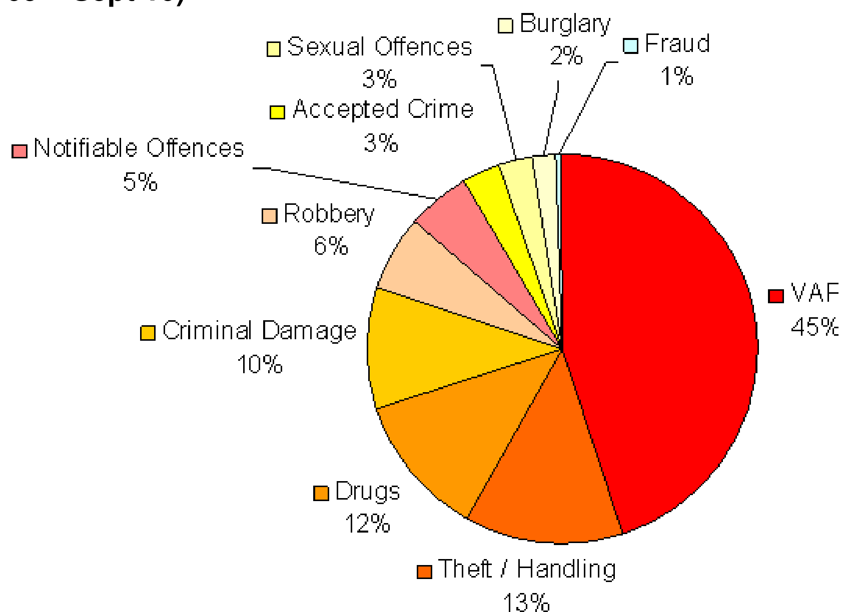
Non DV crimes

Major crime type	Alcohol involved	No alcohol	% alcohol related	Grand Total
Burglary	42	4728	0.9	4770
Criminal Damage	221	4094	5.1	4315
Drugs	267	6663	3.9	6930
Fraud or Forgery	13	1755	0.7	1768
Other Accepted Crime	67	1380	4.6	1447
Other Notifiable Offences	117	785	13.0	902
Robbery	142	2759	4.9	2901
Sexual Offences	65	445	12.7	510
Theft and Handling	288	17930	1.6	18218
Violence Against the Person	1005	8146	11.0	9151
Grand Total	**2227**	**48685**	**4.4**	**50912**

Source: Community Safety Partnership Service

The breakdown of the 2227 alcohol related crimes reported in Southwark between April 09 and Sept 10 is shown below. Violence accounts for almost half of all reported alcohol related crime.

Figure 17: Alcohol related reported crime (non-domestic violence) in Southwark (April 09 – Sept 10)



VAP = Violence Against the Person
Source: Community Safety Partnership Service

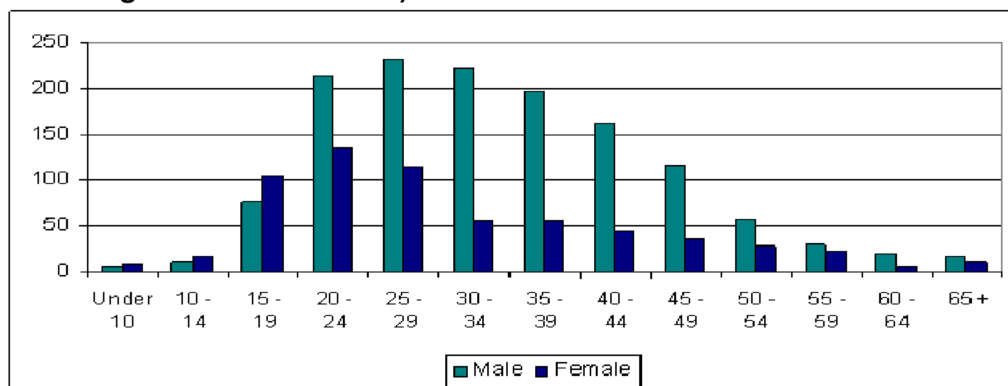
Suspected offenders of reported alcohol related crime (excluding domestic violence) in Southwark (April 09 – Sept 10) were most likely to be:

- Lone suspected offenders (78%, although 17% offended in a small group)
- Over 18 (the peak age of suspects was 20-24)
- Male (most strikingly, at the peak age of 20-24 there were almost six times as many male suspects as female suspects)

1897 individuals were reported as victims of alcohol related crime (excluding domestic violence) in Southwark between April 09 and Sept 10. Victims were most likely to be:

- Alone at the time of the incident (76.9% of victims) although 15% of victims were in a pair at the time of the incident
- Female if under age 20
- Male is over age 20 (most strikingly in the 30-34 year old age group, more than 4 times as many men as women were reported to be victims of crime, as shown on the chart below)

Figure 18: Age and gender of recorded crime in Southwark (April 09 – Sept 10; excluding domestic violence)



Source: Community Safety Partnership Service

4.2 Impacts on family relationships, children and young people

4.2.1 Parenting and child protection

Nationally, it has been estimated that between 780,000 and 1.3 million children are affected by parental alcohol problems[lviii]. Southwark Childrens' Services estimate that 30% of care proceedings involve alcohol.

4.2.2 Domestic violence

The links between domestic violence and alcohol (or more general substance misuse) are multiple and complex[lix] and relate to both the perpetrator and the victim. Perpetrators have reported that substance use increases during bouts of violence and note substance misuse issues pre-dating violence[lx]. Victims reporting substance misuse issues report that they began their problematic substance use following experience of domestic violence, often reporting that the link involved dulling both the physical and emotional pain[lx]. As such, it is suggested that women experiencing domestic violence are up to 15 times more likely to misuse alcohol[lxi].

7639 domestic violence crimes were reported in Southwark in between April 09 and Sept 10 although this will greatly underestimate the true incidence as it is estimated that only a third of domestic violence incidents are reported. Of reported incidents in this time period, 11.4% were flagged as being related to alcohol.

Violence and 'other accepted crime' (usually a domestic argument where no crimes are alleged or apparent) are the most common domestic crime types, as shown in the table below.

Figure 19: The proportion of reported domestic violence crimes in Southwark related to alcohol (April 09 – Sept 10)

DV crimes

Major crime type	Alcohol involved	No alcohol	% alcohol related	Grand Total
Burglary	0	16	0.0	16
Criminal Damage	65	295	18.1	360
Drugs	3	2	60.0	5
Fraud or Forgery	0	12	0.0	12
Other Accepted Crime	283	3697	7.1	3980
Other Notifiable Offences	19	116	14.1	135
Robbery	1	14	6.7	15
Sexual Offences	13	39	25.0	52
Theft and Handling	6	59	9.2	65
Violence Against the Person	484	2515	16.1	2999
Grand Total	874	6765	11.4	7639

Source: Community Safety Partnership Service

1268 individuals were recorded as victims of domestic abuse in Southwark between April 09 and Sept 10.

4.3 Sexual health and unplanned pregnancies

Alcohol is commonly reported as a contributing factor in sex without a condom, regretted sexual activity and sex with someone who would not normally be found attractive[lxii]. A link between alcohol consumption and both sexually transmitted infections[lxiii] and also teenage pregnancy[lxiv] has been suggested.

Whilst there has been a 27.4% reduction on the 1998 baseline rate of teenage conceptions, rates remain high and Southwark has the third highest rate across London and the seventh highest nationally (63.3 conceptions per 1000 amongst 15-18 year olds). 60-70% of teenage conceptions end in terminations[lxv].

4.4 Fires and Road Traffic Accidents

In 2009 there were 975 collisions involving one or more driver. Of these, alcohol was recorded as a contributory factor in 19 accidents (2%). Positive breath tests were only received in 13 of these incidents[lxvi].

The consumption of alcohol has long been suspected to be related to increased risk of fire in the home (usually due to cooking, careless handling or disposal of lit materials and falling asleep).

Across London, alcohol is suspected as a contributing factor in 5.3% of fires in homes (totalling 569 fires) since November 2008 when the National Incident Recording System was introduced[lxvii]. Toxicology tests find alcohol in the blood of fatal domestic fire victims at a higher rate than this (up to about 25% of victims) but in the past 10 years there have been few fatalities in Southwark with positive toxicology results for blood alcohol (only 4 since 2000).

4.5 Work, Absence and Worklessness

Alcohol related loss of productivity involves:

- Alcohol related absence
- The inability to work
- Premature deaths amongst people of economically active age

In total, alcohol related output losses to the UK economy are estimated to be up to £6.4bn a year[lxviii].

4.5.1 Alcohol and the workplace

It has been estimated that up to 17 million working days are lost in England through alcohol related absence, costing the UK economy about £1.5bn.

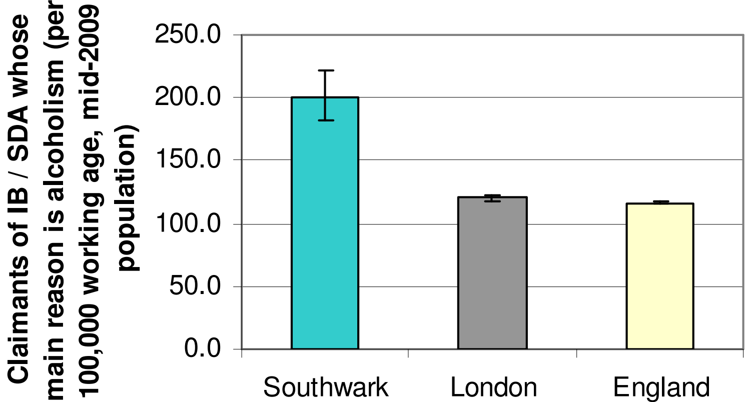
Alcohol is also related to productivity when at work and with a third of employees report having been to work with a hangover, and 15% report having been drunk at work, this may have a significant impact on productivity[lxix].

4.5.2 Alcohol and the inability to work

Recent research from the Department for Work and Pensions has, for the first time, provided estimates of the number of dependent drinkers receiving a range of benefits in 2008. Dependency is defined by a score of 20 or more on the AUDIT screening tool. The study estimates that 4% of all people in receipt of the Disability Living Allowance (DLA), Incapacity Benefit, Income Support or Job Seekers Allowance are dependent drinkers. Men are most at risk and the peak age for alcohol related problems is 54-44[lxx].

In Southwark, the rate of claiming Incapacity Benefit or Severe Disability Allowance due to alcoholism was much higher than the London and England averages, as shown on the graph below.

Figure 20: Rates of IB / SDA claimants per 100,000 working age mid-2008 population (August 2009)



400 individuals were registered as claiming Incapacity Benefit or Severe Disability Allowance due to alcoholism in August 2009.

5. Effective Interventions

- A range of interventions have been found to be effective, and cost effective, in reducing alcohol misuse, working both at the population and individual level.

- Screening in a variety of settings for alcohol use is important if the treatment base is to be broadened to include problem drinkers before they become help seekers. It is important to use a validated tool as relying on informal methods may miss the majority of increasing risk drinkers who have no obvious signs of alcohol related harm.

- There is no single ‘best buy’ package of interventions but suggested factors promoting effectiveness are:

    - Service user choice
    - A broad range of interventions on offer at a range of levels
    - Involvement of families and other close contacts

- Detailed evidence based Clinical Guidance in the management of harmful drinking and alcohol dependence has been provided by NICE. This should be followed by all services and monitored regularly.

Treatment for alcohol misuse is cost effective from a national perspective and for every £1 spent £5 is saved elsewhere[lxxi],[lxxii]. For the purposes of this document, the evidence of effectiveness for services will be broken down into:

1. Preventing harmful drinking
2. Identifying harmful drinkers
3. Reducing and targeting harmful drinking
4. Alcohol withdrawal and dependency

Reviewing the effectiveness of services requires clear definition of the goals and outcome measures. Traditionally, services have aimed to improve an individual’s quality of life[lxxi] but there may be a move nationally to consider abstinence as the primary outcome measure of success[lxxiii]. This review will consider both quality of life and abstinence outcome measures according to the evidence available.

The evidence base for services for ethnically diverse areas suggests that all services should be competent to meet the ethnic and cultural needs of local populations. There is a trade off between providing specific services for different groups and offering choice through a range of generic services so it may be more useful to find new ways of engaging with ethnic minorities as opposed to separate services. Women (apart from women who have been abused) generally do well in mainstream services provided co-morbidity needs are addressed[lxxi].

5.1 Preventing harmful drinking

NICE recommends population level approaches as a more effective, and more cost effective, way of reducing alcohol associated harm[lxxiv]. Full details can be found in the public health guidance, *Alcohol-use disorders: preventing the development of harmful and hazardous drinking*.
Such population level action is suggested to involve:

- Making alcohol less affordable (e.g. a minimum price per unit)

- Managing availability of alcohol so that it is less easy to buy (both through licensing and reviewing personal import allowances)
- Regulating advertising of alcohol (with a particular emphasis on children and young people).

5.2 Identifying harmful drinkers

Screening in a variety of settings for alcohol use is important if the treatment base is to be broadened to include problem drinkers before they become help seekers. It is important to use a validated tool as relying on informal methods may miss the majority of increasing risk drinkers who have no obvious signs of alcohol related harm.

NICE highlights the importance of ensuring that any organisation that regularly comes into contact with individuals at risk of harmful drinking screens for alcohol use. They specifically name health and social care, criminal justice and the community/voluntary sector in both NHS and non-NHS settings. Where population wide screening is not possible it is suggested that targeted screening, including particular patient groups or new GP registrations, is an alternative to general screening[lxxi,lxxiv]. Screening by trained individuals in all NHS commissioned services that come into contact with those at risk of alcohol misuse is recommended in NICE clinical guidelines[lxxvii].

A wide range of screening tools are available for use, some of which were originally developed for specific situations (e.g. AUDIT for primary care, FAST for emergency departments) and various adaptations of these tools have been made since. When selecting a tool it is important to consider the time available for screening and the likely prevalence of different levels of need (e.g. dependency vs increasing risk drinking). The AUDIT is, however, suggested to be the tool of choice in community settings[lxxi] although initial SIPS results suggest that FAST may be superior in primary healthcare settings[lxxv].

5.3 Reducing and treating harmful drinking

5.3.1 Brief interventions

NICE recommends providing brief interventions following identification of those at increased risk from their drinking. These interventions are generally either structured brief advice or extended brief interventions[lxxiv].

It is recommended that staff use recognized, evidence based packs with a short guide on how to deliver a brief intervention, a validated screening questionnaire, a visual presentation (to compare the person’s drinking levels with the average), practical advice on how to reduce alcohol consumption, a self-help leaflet and possibly a poster for display in waiting rooms[lxxiv]. Brief interventions have been shown to be cost effective although most of the research comes from a primary care setting.

Brief advice based on the FRAMES approach (feedback, responsibility, advice, menu, empathy, self-efficacy) is recommended. The advice should cover the potential harm caused by their level of drinking, reasons for changing the behaviour, including the health and wellbeing benefits, the barriers to change, outline practical strategies to help reduce alcohol consumption and lead to a set of goals[lxxiv].

For those not responding to brief intervention or advice, it is recommended that up to four extended brief interventions (20-30 minutes, based on a motivational interviewing approach) are provided, with referral for clients who need more specialist services. Such clients include those who show signs of moderate or severe alcohol-dependence, those who have failed to benefit from structured brief advice and an extended brief intervention and wish to receive further help for an alcohol problem or those who show signs of severe alcohol-related

impairment or have a related co-morbid condition (for example, liver disease or alcohol-related mental health problems)[lxxiv].

5.3.2 Further support

The National Treatment Agency (NTA) suggests that it is best to offer extensive treatments (over a long period of time) rather than intensive treatments (resource intensive in a short period of time) due to the variation in the course of alcohol problems over time. This is particularly true for individuals with chronic and severe alcohol related problems[lxxi].

To ensure the effectiveness of any activities it is essential that properly trained and competent staff deliver the interventions, following manuals or guidelines as outlined in the research base[lxxi].

In terms of individual treatments, there is no one ‘best value package’ but rather a range of interventions, some of which have a specific application but most of which are generally effective[lxxi]. There are a range of different treatment options offering a range of approaches that deliver equally good outcomes. Such approaches include intensive socially based therapies, less intensive motivationally based treatments, 12 step facilitation treatments, cognitive behavioural coping skills therapy, behavioural self control training and marital and family therapies. Service user choice in treatment improves outcomes[lxxi].

Inclusion of friends and family in treatment[lxxi,lxxvi], specifically suggested to involve:

1. Making the role played by the social environment as central and important as that played by individual factors
2. Broadening the base of treatment to see family as a legitimate unit for intervention, allowing the family member or other individual to become the focus of help either within a family-based intervention or as a service use themselves
3. Recognising a broader set of positive outcomes from treatment in addition to reductions in alcohol use (e.g. effects on family and the wider social context).

Some of these clients may be experiencing some degree of alcohol dependency.

5.4 Alcohol withdrawal and dependency

5.4.1 Planned care

The evidence on the management of alcohol use disorders (harmful drinking and alcohol dependence) has been reviewed in detail by NICE[lxxvii]. In the clinical guidance *Alcohol-use disorders: diagnosis and clinical management of alcohol related physical complications*. Evidence based recommendations for the delivery of care are provided in depth and a brief summary is provided in Appendix 1.

5.4.2 Unplanned Withdrawal

Advice on managing unplanned medical withdrawal suggests admission for those who are in acute withdrawal and with, or at high risk of developing, alcohol withdrawal seizures or delirium tremens or are under 16 years old[lxxix]. A lower threshold for admission is suggested for people who are vulnerable (for example, those who are frail, have cognitive impairment or multiple co-morbidities, lack social support, have learning difficulties or are 16 or 17 years)[lxxviii].

For people who are alcohol dependent but not admitted to hospital it is suggested that professionals should offer advice to avoid a sudden reduction in alcohol intake and information about how to contact local alcohol support services[lxxix].

Recommendations on treatment for alcohol withdrawal suggest that clinicians should:

- Offer pharmacotherapy to treat the symptoms of acute alcohol withdrawal as recommended
- Ensure that people with decompensated liver disease who are being treated for acute alcohol withdrawal are offered advice from a healthcare professional experienced in the management of patients with liver disease and
- Provide information for other patients being treated for acute alcohol withdrawal about how to contact local alcohol support services.

More specific guidelines exist for dosing and the management of a number of specific conditions including pancreatitis, alcohol related hepatitis, liver disease and Wernick's encephalopathy.

6. Services Provided for Adult Alcohol Use in Southwark

- Individuals misusing alcohol in Southwark have access to a range of services, operating through a range of organisations.

- NHS Southwark commissions services to treat adults with a primary alcohol need on behalf of the Drug and Alcohol Action Team (DAAT). Services funded by the DAAT include alcohol primary care hub activities including extended brief advice and community detoxification, community support programmes through Foundation 66, specialist alcohol treatment within South London and Maudsley (SLaM) specifically the Community Drug and Alcohol Teams, specialist out-patient clinics and inpatient detoxification units as well as residential rehabilitation programmes through a range of providers. Some of the other substance misuse services also provide support for individuals with an alcohol need – this will be expanded through the service remodel.

- Services funded through other routes include primary care (Directed Enhanced Services) activity (IBA), services within Kings College Hospital Trust, Guys and St Thomas' Hospital Trust, Criminal Justice (police, probation, CARAT teams) and a range of voluntary sector organisations.

- Taking a stepped care approach to the provision of care, an individual should be offered the least intrusive and least expensive intervention that is likely to be effective and only offering a more intensive alternative if treatment fails.

- It is essential that the full range of services available is well understood by all those involved in alcohol misuse prevention and treatment to avoid confusion and the unintended loss of people to the treatment system.

Southwark Services

The Drug and Alcohol Action Team (DAAT) funds some services to treat adults with a primary alcohol need through the pooled treatment budgets and supplementary PCT and council funding.

NHS Southwark commissions services to treat adults with a primary alcohol need on behalf of the Drug and Alcohol Action Team (DAAT). The DAAT funds some services to treat adults with a primary alcohol need through the Substance Misuse Pooled Treatment Budget as well as supplementary PCT and council funding.

In 2010/2011 5.3% (£506,071) of the total adult substance misuse service spend was allocated for primary alcohol misuse services. Many of the drug services will also support clients with their adjunctive alcohol use, further adding to the resource available.

These alcohol specific services include:

Tier 1: - Alcohol strategy work

Tier 2: - Foundation 66 direct access walk in
- St Mungos assertive outreach

Tier 3: - Foundation 66 counselling and structured day programme
- Primary care hub activities
(including extended brief advice and community detoxification)
- Specialist treatment within South London and Maudsley, SLaM
(specifically the Community Drug and Alcohol Teams,
specialist out-patient clinics and inpatient detoxification units)
- Residential rehabilitation programmes

Services funded through other routes include Directed Enhanced Services within General Practice as well as services within Kings College Hospital Trust, Guys and St Thomas' Hospital Trust, Criminal Justice (police, probation, CARAT teams) and a range of voluntary sector organisations.

Figure 21: Southwark Alcohol Services (DAAT and non-DAAT Funded)

	Service	Client Group
Tier 1 Non-substance misuse specific services	Social Services	Universal
	GPs / Primary Care / CMHTs / Other	Universal
	Generic Health Services	Universal
	Housing / Employment	Universal
	A&E	Universal
	Criminal Justice System	Universal
Tier 2 Services offering drop-in harm reduction interventions	Foundation 66 Elephant & Castle Shopfront	Primary Alcohol Users with or without any other substance use
	Hospital Liaison & Assessment Service (Kings College Hospital and Guy's & St Thomas' Hospital)	Any drug user; poly or single use including Alcohol
	Blenheim CDP Outreach Bus	Any drug user; poly or single use with or without Alcohol as non-primary drug
	Primary Care Alcohol Hubs	Alcohol users (with or without other drugs)
	St Mungos Outreach Service	Any DIP drug user (poly or single use including Alcohol) or Any Primary Alcohol user (with or without any other substance use)
	Three Boroughs Drug & Alcohol Team	
Tier 3 Services offering community-based specilaised substance misuse assessment & treatment	SLaM Community Drug & Alcohol Team	Any drug user; poly or single use including Alcohol
	Blenheim CDP KAPPA Service	Any drug user; poly or single use including non-primary Alcohol
	Foundation 66 Counselling Service	Poly drug users with Primary Alcohol
	Foundation 66 Day Programme	Primary Alcohol Users with or without any other substance use
	Blenehim CDP Rise Day Programme	Any drug user; poly or single use including Alcohol
	CRi REACH Day Programme	Any drug user under a DRR order; poly or single use including non-primary Alcohol
	Blenheim CDP Evolve Crack Service	Any stimulant user; poly or single use including non-primary Alcohol

	Service	Client Group
	Primary Care Alcohol Hubs	Alcohol users (with or without other drugs)
Tier 4 Services offering residential substance misuse treatment	Equinox Brook Drive	Any drug user; poly or single use including Alcohol
	SLaM Inpatient Services	Any drug user; poly or single use including Alcohol
	Social Services Care Management Team	Any drug user; poly or single use including Alcohol

Aftercare / **Holistic** / **Wrap-around Services**	Red Kite Employment, Training and Education	Any drug user; poly or single use including Alcohol
	Thamesreach Aftercare Accommodation	Any drug user; poly or single use including Alcohol
	Service User Council	Any drug user with experience of the Treatment system
	CRi Peer Advocacy Service	Any drug user with experience of the Treatment system

7. Current Service Provision Relative to Need

- Amongst individuals in treatment for alcohol use, 34.1% used a second substance, with cannabis being the most common substance, followed by cocaine.

- The number of assessments for alcohol treatment (Tier 3 and 4) performed in Southwark is similar to the number predicted by the Rush Model (based on an estimated prevalence of dependent drinking in Southwark of 2.7%).

- Local service provision in 2009/2010 involved less community detox and more short term residential detoxification (with less long term residential detox) than predicted.

- Treatment rates are highest amongst the white Irish population in Southwark, with lower rates than would be expected amongst the white British population.

- Women in treatment for primary alcohol problems were less likely to be in residential treatment then men (16.2% of women vs 23.1% of men were in residential treatment).

- The most common source of referrals into alcohol treatment is health and mental health services (43%), followed by substance misuse services (19%). Few referrals come from the criminal justice system (3%) and family services (1%) although these sectors will be in contact with clients with a high prevalence of alcohol misuse.

- There are low rates of planned exit for community prescribing (i.e. community detoxification services, with only 27% of clients leaving treatment in a mutually agreed planned way.

- Of the non-residential treatment modalities, structured day programmes achieve the highest rate of planned exits (70.4%).

It is important to distinguish between the different measures used when considering alcohol service provision.

Need refers to the capacity to benefit from alcohol services – i.e. how many people are drinking at increasing or higher risk levels and how many dependent drinkers are there.

Dependent drinkers who should be treated in a given year can be estimated as a proportion of the total number of all dependent drinkers. This does not represent the expressed demand or numbers in treatment.

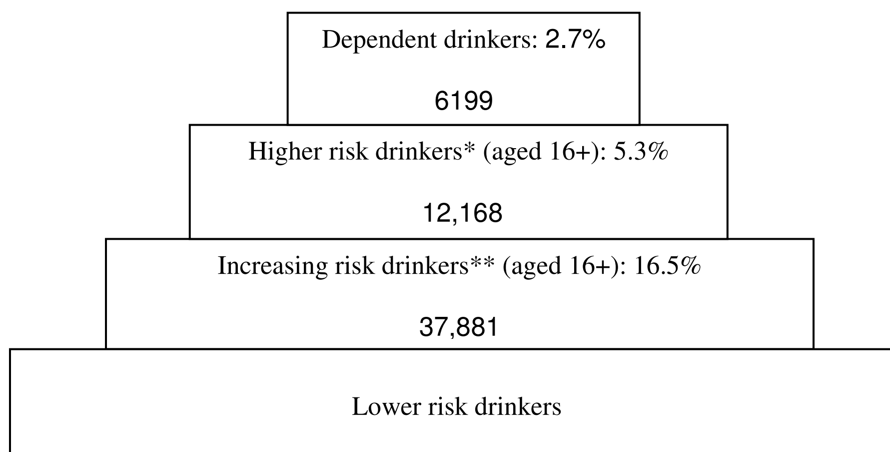
Treatment provision quantifies the services actually provided (this may be similar to demand although not everyone presenting may be appropriate for treatment).

7.1 Need

7.1.1 Drinking behaviour

The figures below summarise alcohol related health behaviour in the Southwark population aged 18 and over. This can be used to predict the adult alcohol service need.

Figure 22: Southwark alcohol related risk and dependency estimates (aged 18 and over)



* Men drinking over 50 and women drinking over 35 units a week
** Men drinking 22-49 and women drinking 15-34 units a week

All figures calculated based on extrapolated mid-2009 population estimate for Southwark (229,580 persons)

7.1.2 Hospital admissions

Hospital admissions data has identified the Wards with particularly high rates of alcohol specific hospital admissions (admissions with any diagnosis of an alcohol specific disorder) – see Section 3.3.5.

7.2 Predicted annual service use for dependent drinkers

It is suggested that 10%-20% of dependent drinkers should be treated in a given year[xxii]. The Department of Health has suggested that 10% is used in England and Wales[lxxx] which suggests that for Southwark (with an estimated 6199 dependent drinkers) 620 dependent drinkers required treatment in 2009.

The Rush model assumes that:
- 55% of patients require outpatient treatment
- 30% require day treatment
- 10% require short term residential treatment and
- 5% require long term residential treatment

In terms of aftercare, it is estimated that:
- 75% of outpatients
- 80% of day treatment
- 85% of short term residential and
- 70% of long term residential patients require aftercare

Applying this model to the local prevalence of depended drinking (2.7%, i.e. 6199 dependent drinkers), it can be estimated that in Southwark in 2009:

Tier 3 Services:
373 people required assessment
42 people required community detoxification
157 people required counselling or outpatient treatment (incl 20% drop out)
86 people required day treatment (incl 20% drop out)

Tier 4 Services:
29 people required short term residential treatment (detox) (incl 20% drop out)
14 people required long term residential treatment (rehab) (incl 20% drop out)
243 people required aftercare

7.3 Services provided for primary alcohol users in Southwark (2009/2010)

It is not possible to gather complete data on service provision across all tiers of alcohol services. Data is particularly sparse in terms of lower tier provision, with no reliable data on the provision of brief interventions in primary care.

Data on St Mungos assertive outreach for 09/10 is currently being sourced.

Data on Foundation 66 Tier 2 and aftercare provision cannot be separated as it is reported as combined activity figures.

In 2009/2010, 690 clients were in treatment. There were 399 new presentations to Tier 3 and 4 alcohol services and 364 total exits. The number of new presentations to alcohol services has fallen since 08/09. The total number of people in treatment for a primary alcohol problem, however, has increased as fewer people are being discharged.

The total number of new presentations that we have accurate data for during the year is shown in more detail below compared to the Rush Model service estimates. The number of assessments is taken as the number of new presentations.

Figure 23: Service provision in Southwark (observed vs expected)

	Expected (Rush Model Estimates) (2009)	**Observed New Presentations (2009/2010)**
TIER 1:	-	-
TIER 2:	-	-
TIER 3:		
Assessment	373	351
Community detox	42	15*
Counselling/outpatient	157	264**
Day treatment	86	22***
TIER 4:		
Short term residential	29	41
Long term residential	14	7
AFTERCARE:	243	281□

*** community prescribing**
**** structured psychosocial intervention or other structured treatment**
***** structured day programme**
□ **Includes both Tier 2 and aftercare provision**

Source: NDTMS Quarterly Report Q4 2009/2010

Initial interpretation of the service use data suggests that:

- The number of assessments performed is roughly similar to that predicted
- A smaller number of community detoxifications are occurring than are predicted
- There may be more counselling and outpatient service provision that predicted (although some of this may actually be day treatment), and conversely there may be less day treatment provision (although again this may be due to confusion between categories).
- There is more short term residential treatment being provided that predicted, with less long term residential treatment than predicted.

7.4 Access to services

When profiling service users for the 2009/2010 period it can be seen that treatment rates are highest for the White Irish population in Southwark, as shown on Figure 24. Treatment rates for the white British population are lower than would be expected given the high rate of hospital admissions for this group but the small numbers being considered mean that this data should be interpreted with caution and significance testing is necessary to aid interpretation.

The lower than expected treatment rate for the white British population in Southwark may also be due to the relatively high treatment rates for other drug amongst this group and it is necessary to compare this data to other drug treatment rates.

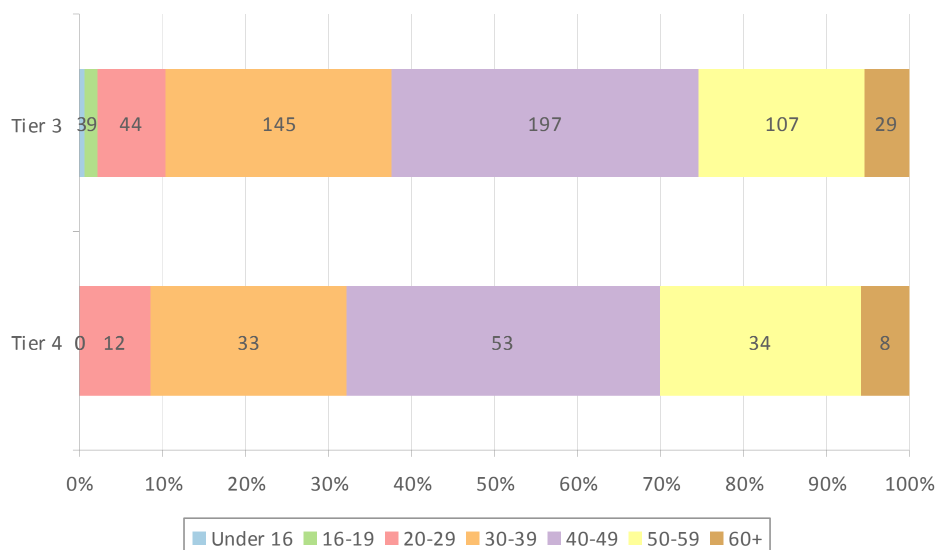
Figure 24: Treatment rates by ethnicity in Southwark (2009/2010)

Ethnicity	In treatment (09/10)	Population ages 18 and over	Treatment rate per 1000 population
White Irish	56	5,280	10.61
White & Black Caribbean	19	2,525	7.52
Other Black	23	3,673	6.26
Other	18	3,903	4.61
Other Asian	9	2,296	3.92
White British	472	120,759	3.91
Caribbean	28	14,693	1.91
Other White	42	22,728	1.85
Other Mixed	5	2,755	1.81
White & Black African	3	1,837	1.63
African	21	28,009	0.75
Pakistani	1	1,607	0.62
Indian	1	7,347	0.14
White & Asian	0	1,837	0.00
Bangladeshi	0	3,903	0.00
Chinese	0	6,658	0.00

Source: Data provided by DAAT analyst from NDTMS
(Ethnicity proportions applied to ONS mid-2009 over 18 population estimate for Southwark)

The age of clients in treatment (shown separately for tier 3 and tier 4 treatment) is shown below. As would be expected, individuals in residential treatment (tier 4) are generally older than those in lower tier treatment.

Figure 25: Age profile of clients in tier 3 and 4 treatment (2009/2010) (age at mid-point of treatment)



Source: Data provided by DAAT analysts from NTA needs assessment data

Modality of service use varied with gender, with women being less likely to be in residential treatment than men (only 16.2% of the women in alcohol treatment in 2009/10 were in residential or inpatient treatment, compared to 23.1% of men)[2]. This may be due to the reluctance of women to access more intensive services due to impacts on the family with potential care proceedings for children – an issue raised in the service user consultation.

Amongst clients in treatment for primary alcohol use, 34.1% used a second substance. Cannabis was the most common second substance used (14.2% of clients) with cocaine (6.9%), heroin (3.9%) and crack (3.9%) being next[2].

Service user consultation suggests that barriers to accessing services may exist for:

- Women with children (due to fear and potentially lack of understanding of care proceedings)
- Homeless (due to delays waiting to find secure housing before accessing treatment)

Drug services were viewed as being easier to access than alcohol services, with particular problems accessing residential services being expressed. It was also recognised that accessing services straight from hospital was common, particularly when clients were at crisis point.

GPs were seen as having a crucial role in terms of provision of services and referral into more specialist treatment although problems were cited included lack of consistency between GPs, GP awareness of services on offer, waiting times and refusal to prescribe to support community detoxification. Using nurses to provide the services with less of a wait was suggested.

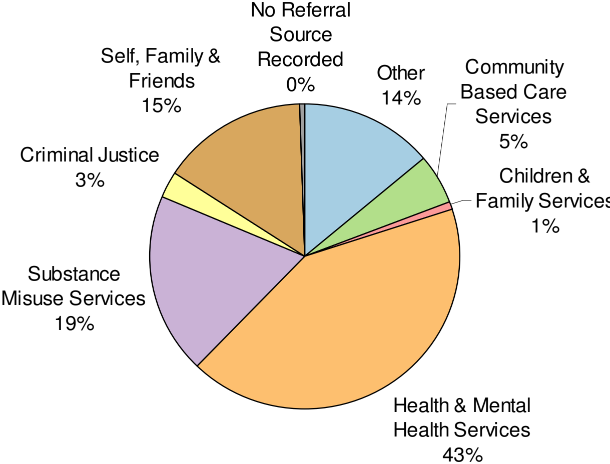
The lack of services at weekends was mentioned.
Ongoing aftercare, including drop in options, was viewed as being very important but often lacking.

7.5 Referral Sources

[2] Source: NDTMS Quarterly Report, Q4 2009/2010

The most common source of new referrals into alcohol services (based on the 860 referrals recorded by NDTMS is health and mental health services (43%) followed by substance misuse services (19%). Few referrals are recorded from criminal justice (3%) and children and family services (1%). This is shown on the figure below.

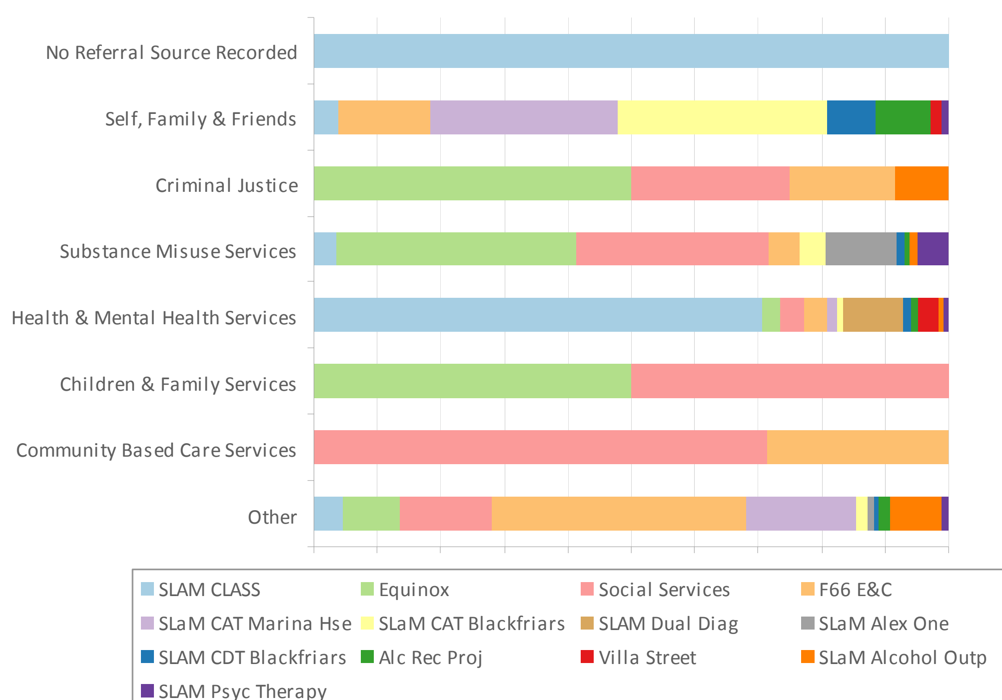
Figure 26: Alcohol treatment referral source (09/10)



Source: NDTMS (data provided by DAAT Data Analyst)

Criminal justice and children and family services tend to refer into Equinox or social services, as shown on the chart below.

Figure 27: Alcohol treatment referral source by provider (09/10)



7.6 Effectiveness of services

Effectiveness of alcohol services is measured as the client leaving treatment in a mutually agreed planned way. The effectiveness of different modalities of treatment provision is shown below. This considers all clients leaving treatment in the 2009/2010 period, regardless of the date that they entered treatment.

Figure 28: Service effectiveness by modality (2009/2010)

	Inpatient treatment	Residential rehabilitation	Community prescribing	Structured psycho-social	Structured day prog	Other structured
Interventions ended (n)	103	45	37	197	28	207
% with exit status recorded	99%	100%	100%	99%	96%	98%
% mutually agreed planned exit	81.4%	82.2%	27.0%	50.0%	70.4%	46.0%
% unplanned exit	13.7%	8.9%	56.8%	48.0%	29.6%	52.0%
% treatment withdrawn	4.9%	8.9%	16.2%	2.0%	0.0%	2.0%

Source: NDTMS Quarterly Report (Q4, 2009/2010)

This data suggests that:

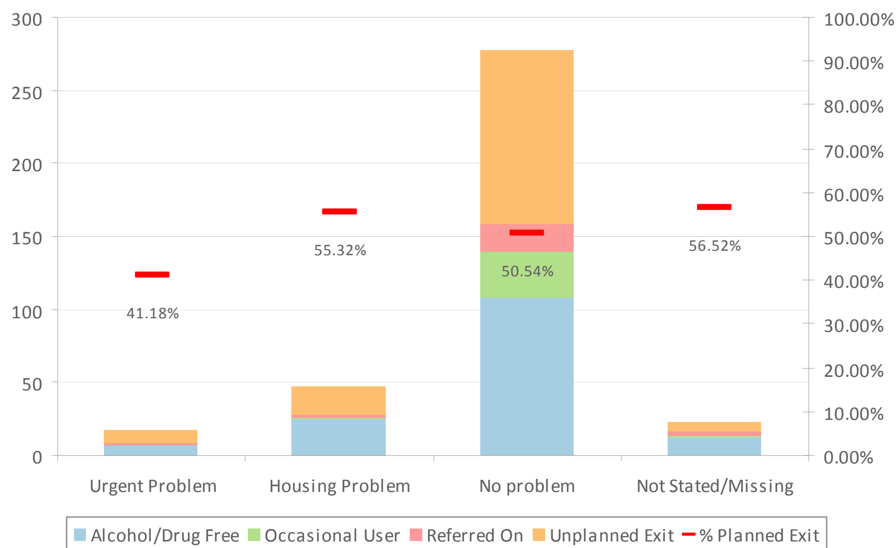
- There are low rates of planned exit for community prescribing (i.e. community detoxification services with follow-up care and support, with only 27% of clients leaving treatment in a mutually agreed planned way. Anecdotally, it has been reported that this is due to successful completion of the community detox with lower success rate for the follow up support.

- The numbers of community detoxes, however, are low with only 37 in 2009/2010
- The non-residential treatment modality that achieves the highest rate of planned exits is the structured day programmes (70.4%)

The planned exit rate for treatment provided in 2009/2010 does not vary with client accommodation status, as shown on Figure 29 below. The relatively small numbers suggest of clients with housing problems, however, mean that this data should be interpreted with caution.

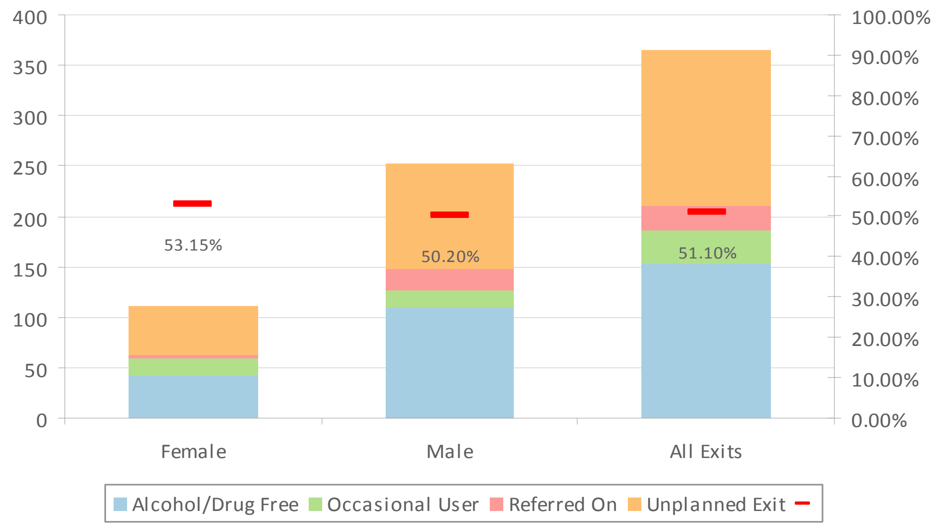
Analysis of the planned exit rate by age also suggests that rates of planned exit are similar across different age groups although again, there are relatively small numbers of clients in treatment at some ages.

Figure 29: Effectiveness of services by client accommodation status



Analysis of the rates of planned exit by gender suggest that there is a slightly higher rate of planned exit for women than for men, as shown below.

Figure 27: Effectiveness of Services by Gender



8. Recommendations

A number of alcohol specific recommendations for NHS Southwark, London Borough of Southwark and the Southwark drug and alcohol action team have emerged from the needs assessment process:

Population level action:

1. Advocate for the introduction of a minimum pricing scheme for alcohol

NHS and NHS commissioned services:

2. Continue to develop Primary Care screening and brief advice (potentially through a Locally Enhanced Service), and continue to develop community services including shared care and the Primary Care alcohol hubs
3. Link with KCH and GSTT to contribute to their workplans around alcohol screening and treatment in A&E and across the Acute sector
4. Plan to ensure that community services will have the capacity to meet any additional referrals generated by extended screening and brief interventions in other agencies
5. Work with treatment services to ensure that family support is available in treatment services both to improve effectiveness and to minimise barriers to women accessing services
6. Investigate and address high rates of unplanned exits in community detoxification services
7. Work with treatment services to ensure that clients receive appropriate referrals into services to address wider social needs including housing, and employment
8. Include aftercare in the service remodel to ensure that sufficient services are available locally

Work with other agencies:

9. Encourage a range of agencies to use identification and brief advice to contribute to a range of health and non-health outcomes (police, probation, workplaces, acute trusts etc), including potential use of DIP to address the alcohol needs of arrested individuals
10. Link commissioned and non-commissioned services to ensure appropriate referrals and smooth flow of individuals between services (e.g. from Acute Trusts and probation into community services)
11. Continue to work closely with police, community safety and other partners to support the ongoing work to reduce alcohol related crime and violence in Southwark. This should include advocating for and individual level support to reduce alcohol related reoffending (through DIP or other means) alongside work on saturation areas and feedback to trade.

Appendix 1:

Evidence Based Recommendations for the Management of Alcohol Use Disorders (Harmful Drinking and Alcohol Dependence)

The recommendations provided by NICE[lxxxi] include the following key points. These are heavily summarised so for more detail the full document should be referred to.

Care coordination and case management

- Care coordination as part of the routine care of all service users in specialist alcohol services (throughout care, including aftercare)
- Case management in Tier 3 services for people who are dependent and at risk of dropping out of treatment or with a history of poor engagement (throughout care, including aftercare), including engagement with family or significant others and other agencies involved in care

Goals of treatment

- The use of abstinence as a goal for those with alcohol dependence and those with severe co-morbidities, but without refusing treatment to clients who refuse to abstain and chose to moderate
- The use of moderation as a goal for those with harmful drinking or mild dependence without significant co-morbidity (and with adequate social support) unless the client has a strong preference for abstinence
- A harm reduction programme of care for those with severe alcohol dependence or harmful alcohol use with significant co-morbidities who refuse to work towards abstinence
- Recognition that abstinence may be a court requirement for some clients

Identification, assessment and ongoing measurement

- Assessment of risk and need by trained staff, using validated tools, to inform care planning
- Assessment and management of assisted withdrawal by staff competent in the diagnosis and assessment of alcohol dependence and withdrawal symptoms and use of appropriate drug regimes
- Brief triage, comprehensive assessment and assessment of co-morbid psychiatric problems as appropriate (with ongoing psychiatric assessment as treatment for alcohol misuse can result in psychiatric improvements)
- Use of breath alcohol, blood tests and cognitive functioning tests on an individual rather than routine basis

Assisted alcohol withdrawal

- For service users drinking >15 units per day, or scoring >20 on AUDIT, consider assessing for a community-based assisted withdrawal (varying according to the severity of dependence, social support and co-morbidities but with monitoring every other day at least) or specialist alcohol withdrawal if there are safety concerns
- Inpatient or residential assisted withdrawal if a service user meets one or more of:
    - Drinks over 30 units of alcohol per day
    - Has a score of more than 30 on the SADQ
    - Has a history of epilepsy, or experience of withdrawal-related seizures or delirium tremens during previous assisted withdrawal programmes
    - Need concurrent withdrawal from alcohol and benzodiazepines
    - Regularly drink between 15 and 20 units of alcohol per day and have: significant psychiatric or physical comorbidities (for example, chronic severe depression, psychosis, malnutrition, congestive cardiac failure, unstable angina, chronic liver disease) or a significant learning disability or cognitive impairment.
- A lower threshold for inpatient or residential assisted withdrawal should be considered for homeless people, older people, pregnant women.

Drug regimens for assisted withdrawal

- In community-based assisted withdrawal programmes, fixed-dose medication regimens should be used (starting with a standard dose that is not based on the level of alcohol withdrawal)

- In inpatient or residential settings fixed dose or symptom-triggered medication regimens can be used.
- All medication should be prescribed, dosed and administered according to guidelines
- For clients already using benzodiazapines, doses should be increased accordingly and inpatient withdrawal regimes should last for at least 2-3 weeks

Interventions to promote abstinence and relapse prevention

- Initial assessments for all people misusing alcohol should include motivational interventions
- Interventions promoting abstinence in community-based settings should be offered to all people who misuse alcohol
- More intensive structured community-based interventions should be offered to people with moderate and severe alcohol dependence who have very limited social support (for example, they are living alone or have very little contact with family or friends), complex physical or psychiatric co-morbidities or have not responded to initial community-based interventions
- Residential rehabilitation for a maximum of 3 months should be considered for people with alcohol dependence who are homeless
- All people seeking help for alcohol misuse should be given information on the value and availability of community support networks and self-help groups (for example, Alcoholics Anonymous or SMART Recovery) and helped to participate in community support networks and self-help groups by encouraging them to go to meetings and arranging support so that they can attend

Interventions for harmful drinking and mild alcohol dependence

- Harmful drinkers and people with mild alcohol dependence should be offered a psychological intervention focused specifically on alcohol-related cognitions, behaviour, problems and social networks
- Harmful drinkers and people with mild alcohol dependence who have a regular partner who is willing to participate in treatment should be offered behavioural couples therapy
- Harmful drinkers and people with mild alcohol dependence who have not responded to psychological interventions alone, or who have specifically requested a pharmacological intervention, should be considered for the use of acamprosate or oral naltrexone in combination with an individual psychological intervention or behavioural couples therapy
- When the needs of families and carers of people who misuse alcohol have been identified, guided self-help should be offered
- If the families and carers of people who misuse alcohol have not benefited, or are not likely to benefit, from guided self-help and/or support groups and continue to have significant problems family meetings should be considered

Interventions for moderate and severe alcohol dependence after successful withdrawal

- Acamprosate or oral naltrexone in combination with an individual psychological intervention or behavioural couples therapy should be considered for people with moderate and severe alcohol dependence who have completed a successful withdrawal
- Disulfiram in combination with a psychological intervention should be considered for people with moderate and severe alcohol dependence who have completed a successful withdrawal if the individual has a goal of abstinence but acamprosate and oral naltrexone are not suitable or if the individual would prefer disulfiram and understands the relative risks of taking the drug
- Benxodiazapenes should only be used for managing alcohol withdrawal (not for ongoing treatment for alcohol dependence), antidepressants and GHB should not be used
- If using acamprosate, treatment should be started as soon as possible after assisted withdrawal and continue for up to 6 months or longer for those benefiting (use should be stopped if drinking persists 4-6 weeks after starting the drug)
- If using oral naltrexone, treatment should be started after assisted withdrawal and continue for up to 6 months, or longer for those benefiting (again, use should be stopped if drinking persists 4–6 weeks after starting the drug)
- If using disulfiram, treatment should be started at least 24 hours after the last alcoholic drink consumed

Other recommendations for managing withdrawal

- For people who misuse alcohol and have comorbid depression or anxiety disorders, the alcohol misuse should be treated first as this may lead to significant improvement in the depression and anxiety

- Those who misuse alcohol and have a significant comorbid mental disorder, and those assessed to be at high risk of suicide, should be referred to a psychiatrist to make sure that effective assessment, treatment and risk-management plans are in place
- For comorbid alcohol and nicotine dependence, encourage service users to stop smoking according to NICE guidance[lxxxii]
- Follow NICE guidance[lxxxiii] on thiamine for people at high risk of developing, or with suspected, Wernicke's encephalopathy. In addition, offer parenteral thiamine followed by oral thiamine should be offered to people who are entering planned assisted alcohol withdrawal in specialist inpatient alcohol services or prison settings and who are malnourished or at risk of malnourishment (for example, people who are homeless) or have decompensated liver disease.
- People with Wernicke-Korsakoff syndrome should be offered long-term placement in supported independent living for those with mild cognitive impairment or supported 24-hour care for those with moderate or severe cognitive impairment

Appendix 2:

Notes from Needs Assessment Data Workshop

19th November 2010

Attendees:

Jonathon Joseph	Homeless Services and Resettlement
Clare Ansdell	Probation
Jacob Wheeler	Southwark DAAT Partnership
Bernie Casey	National Treatment Agency
Melvin Hartley	Southwark DAAT Partnership
Paul Collins	Southwark DAAT Partnership
Kate Harvey	Southwark PCT

1. **Probation Data:**

- Contacts are Robin Lattimer, Dezlee Dennis, Hermione Wright
- OASIS assessment performed on everyone in the supervised cohort and those receiving pre-sentencing reports (about 19,000 individuals plus about the same number in custody) – sometimes OASIS is repeated at different points e.g. pre-sentencing, at breach, review etc
- OASIS includes good information on substance misuse although alcohol has rarely been analysed in the past
- Fields of interest include:
    - In treatment?
    - Treatment naïve?
    - Demographics
    - Polydrug use
    - Alcohol use
    - Type of offense
- Can access a full data set if required (request from Robin Lattimer)
- Data on those with supervision orders <12 months will be on Diamond's system

Actions: **CA to provide a blank OASIS to JW**
PC, KH and JW to request data (provide spec)
PC and KH to investigate data from Diamond

2. **Housing Data:**

- Contact is Jonathan Joseph (resettlement)
- Resettlement team only hold data on alcohol and drug use when they impact on an individual's ability to hold a tenancy (based on self disclosure – no screening tool used)
- Only 'alcohol' or 'drug' use (no details)
- Individuals are referred for treatment if their need is severe (but timing rarely right as individuals are in crisis) – no earlier intervention
- Database holds information on about 2500 people (about half of single individuals are recorded as having substance misuse problems)
- Supports individuals once they have lost their home through their time in supported accommodation, treatment etc for up to two years
- Tenancy Services work with Council Tenants who are in arrears to help
- May have data on impact of substances?
- Housing register unlikely to hold useful information

Actions: **PC and KH to source data from JJ**
PC and KH to investigate tenancy services data

3. **NDTMS**

- Contact is JW

- Can look at those entering treatment, outcome, time in treatment, re-presentations and referral route
- Can analyse client groups (e.g. criminal justice clients)

Actions: **PC and KH to request data from JW**

4. <u>Primary Care Data</u>

- Contacts are Pat Roberts (PCT) or Frances Diffley (GP)
- Can look at variation by Practice
- Some lead GPs take specialist patients
- Shared care – can get data from Jacob
- KH has data on the LES and DES

Actions: PC and KH to investigate and request further data

5. <u>NTA value for money tool</u>

- Available from mid-Dec to look at scenario planning

6. <u>Policy scanning</u>

- Name documents

7. <u>Midwife data</u>

- KH to investigate

Actions: **KH to investigate**
PC and KH to analyse

8. <u>Other options</u>

- Case Studies
- LASS data
- A&E data

Actions: **PC and KH to investigate**

Appendix 3:

Notes from Needs Assessment Expert Group

Needs Assessment Expert Group Meeting
7th January 2011
Tooley Street

Name	Organisation
Gina Warilow	Foundation 66
Dionne Dennie	Foundation 66
Jenny Corless	SLAM
Jo Delaforce	Haven
Dionne Cameron	DAAT LBS
Carolyn Hart Taylor	DAAT LBS
Irina Andrade	CRI
Edward Dean	JCP
Jake Wheeler	Data Manager
Becca Walker	PCT
Tony Lawlor	PCT
Alberto P	BCDP
Sisa Madaka	SLAM CAHMS
Chris Saunders	Children's Services
Michelle Harris	Children's Services
Monika Ciurej	Children's Services
Jenny Brennan	Children's Services Youth Offending
Julie Cuthbert	NHS Southwark
Maria Moore	Foundation 66
Marilyn Major	SLAM
Colin Maclean	BCDP/Southwark DIP
Sarah Day	DAAT LBS
Alison Campbell	BCDP
Liz Legge	BCDP Rise Day Prog
Iain Gray	DAAT LBS
James Bell	SLAM

Introductions
PC and TL opened the meeting with house keeping information followed with a request for each attendee to introduce themselves and explain their role to the group. TL then explained the structure of the workshops.
The aim was to present the preliminary findings out of which a document would be produced.

The group were informed that they would be put into workshop groups to discuss what is working well, what is not working and identifying what the barriers are.

A definition of what a needs assessment was given: triangulate, qualitative and quantative data.

The new needs assessment is going to be about local prevention as well as provision and where gaps in the service provision exist the Expert Group's meeting aims to identify ways of providing an improved service.

PC informed the group that he has been liaising with various groups and stakeholders to get relevant information. He informed the group that February 2011 would be the timescale for the final version of the Needs Assessment document.

In response to being asked why a needs assessment document is being carried out this year, PC explained that it is a different world now and that a national strategy would now include drugs and alcohol. It would cover abstinence, personal responsibility, early intervention, and a key issue would be public health in England.

Definition
The current definition of what constitutes a problem drug user is changing. Southwark has significant issues with alcohol and cannabis use. Future funding of alcohol and drug treatment will be based on successful treatment, linked to exiting, so it is now about how people leave the service and if it is in a planned way and whether they are abstinent.

In terms of finances it is likely that some of our partners will face pressure so it is going to be a challenging period. We have to think about what we do with families but also the children in those families.

KH gave a summary of the problem stating that Southwark is no different to other boroughs apart from having higher levels of people drinking. This information was gathered by KH looking at social marketing data where statistics show that more people are dying who also fall under the categories of being in need of housing, are rough sleepers, are known to the criminal justice service and who may have mental health problems.

KH then showed the group hospital data that she has been using to get a better idea of the current situation. She ran through the admissions to the accident and emergency department and death statistics. The data revealed that Southwark has a higher level of people with liver disease, more people absent from work and more people experiencing incapacity or disability. A higher percentage of this was related to alcohol.

It was suggested that a broad range of interventions is now needed.
In terms of current service provision we need to look at numbers going into and out of treatment and the problem with links between services.

KH asked the group if they had come across other services that could be utilised for screening. In response it was found that Job Centres have done work in this area and referred people to services. Haven the centre for supporting those who have been raped or sexually assaulted provided data on alcohol related rape which is 47% higher than other boroughs.

IG informed the group that in terms of access to services, satellite services within hostels had been positive because many people in hostels who are in need of support are not in treatment.

Alcohol screening
●Primary Care Alcohol Hub: In terms of gaps in the service it was felt that some people were not aware of what a Primary Care alcohol hub is.

●GP's do screen new patients for alcohol use and will do a brief interview themselves or refer them for assessment to alcohol hubs.

●Nurses are available in pharmacy's to provide screening.

●Foundation 66 provides screening.

It was felt that early intervention is the most effective and that service provider staff members need to be aware of all the various services available and need to integrate. The PCT website has been re-launched to give clearer information about services.

Aftercare needs to be flexible for people's needs.

Data
Tops data was used and it revealed that cannabis was commonly used in Southwark; PDU's are mainly using it on a daily basis.

Crack and opiates are commonly used daily. The Tops data also revealed that this lifestyle was linked to health and social care aspects such as being at risk of losing their tenancy.

PC explained that the profile of someone could influence whether they would access services. For instance we have to consider if someone would access services if they are currently working. So we

need to look beyond the drug use and at the wider picture. At present there is a fairly consistent level of drug use taking place in Southwark. There is a 28% penetration rate across London

Southwark has one of the of the lowest penetration rates in London but it has reduced. The data came from different data sets and was then compared to get estimates, which is done by looking at the socio economic makeup.

JW then compared needs assessment information and exiting treatment. From the data he could determine what a client's most likely exit would be, those who tended to be referred on, those who would drop out or disengage. This was done by looking at criteria such as age, ethnic origin, gender etc.
Although the data suggested those in treatment would exit treatment in a planned way, group members disagreed.

In terms of the service users view of services

PC ran a couple of service user groups screening people with lots of cannabis use. It was clear that there was a problem with parents using cannabis while their children were present resulting in them thinking it was normal behaviour.
Service users felt that there was a lack of support for families unless they had reached crisis point. This view was especially felt by women. Also discussed was the effect of this working life and children's schooling. Parents were not aware of their rights within services and they felt that there needed to be more information about services available. People still remain in fear of accessing social services because of fear that children will be removed, rather than getting any support. The general feeling was that organisations need to be honest in accepting that some people are not aware of the service that they provide.

In terms of multiple services, there is a problem with people getting stuck within services and struggling to get treatment intervention.

Young People's Substance Misuse Preliminary Findings
Period **2009-10** People in treatment
Treatment for young people is different to adults because young people's needs are different. For young people brief intervention, approximately four sessions, is good as they do not keep coming back week after week.
National Treatment Agency can be referred to for more information on this area.

Current Performance
Youth Outreach Service (YOS)
Self referrals account for a couple and are increasing. Age of young person in treatment in Southwark ranges from 13-15 but no under 13's. Note after secondary school young people tend not to listen and instead become influenced by their peers, so early intervention is essential.

Workshop feedback

Group 1
Specialist Interventions and care through to recovery

What works well

- Day programmes-longer period of time provides structure with an outcome.
- User reaches stages which are celebrated and people then feel that they are moving forward.
- Counselling service, focusing on holistic needs and cognitive focus.
- Relapse prevention at day programme, stand alone group, peer support.
- Day programme can be a referral pathway to rehab
- Community detox
- Satellite services for adults and young people, (e.g. gang postcode issues)
- GP shared care and GP referrals into alcohol dependent services.
- Monitoring data (some services do not monitor as effectively)
- Volunteering as a form of meaningful activity
- Service user led services
- Working with theatre groups, so using artistic means to help support recovery.

What doesn't work well

What are other structured interventions that can support recovery (e.g. for after completing a day programme)

- Rehab
- Permission to record data means that data may not be accurate
- Liaison with services –problems around TOPS sharing information
- Focus on recovery is lacking in services currently harm minimalisation culture
- Need more services to support recovery. Lots in start and middle but hardly anything at the end of treatment journey.
- Need more focus on addressing holistic needs of users, e.g. the benefits, accommodation etc.
- Difficult to access counselling services
- Need more activities to fill time, some services aren't sensitive towards drug alcohol services
- ITEP work isn't enough. Service users can't maintain this when worker is not there.
- Working with continuous drinkers.
- Problem with talking about drugs and/or alcohol all day as this may make people want to use, so need other meaningful activities.
- Joined up planning with parental substance misuse and children's services planning.
- Tiers don't work for YP
- Lack of out of hours services e.g. evenings and weekends

Top priorities

- Middle to end of pathway-preparation for the end
- Focus on families and early prevention to prevent young people continuing onto adult services.

Group 2

Specialist interventions and care through to recovery

- Revisit YP and alcohol DIP assessment in the station-missing an opportunity at this stage
- Family, we should be thinking more about the whole situation
- YOT has a drugs worker so need to get specialist knowledge to the young people.
- Conflict regarding DUST and assessment etc.
- First contact is critical
- Good skills of staff
- FIP
- TAC –Team Around the Child

- Satellites
- When do you need a specialist?
- Training Assessment tool

Group 3

Exiting treatment relapse prevention and aftercare.

What works well

- Partnership holistic approach
- More in depth work in terms of aftercare
- Peer mentors to assist regarding transitions
- 12 step fellowships
- Peer support groups
- Training for peer mentors
- Counselling and psychology
- Family interventions

What doesn't work well

- Restricting appointments for aftercare to working hours
- Restricting access to aftercare
- Better co-ordination around exiting treatment
- Interagency approach
- Poor communications
- Discrimination against people with addiction difficulties
- Disconnected- systems-lack of continuity
- Multi agency work needed as part of aftercare
- Limited options for aftercare
- Time-services focused on working hours
- When exiting treatment more support is needed
- Regarding unplanned exits childcare is major issue

Top priorities

- Training for social services regarding service users
- Partnership aftercare
- Wider range of aftercare services
- Evening and weekend access
- Appropriate housing

Group 4

Identification-outreach difficult
Engagement –comes from service user not service, so how to motivate engagement.
SM illegal –society says must engage

Difficulty with cla
Diclosure
Adults/parents-conflict with services
Lack of knowledge
Of care services
Of SM services
Transition YP –adult

MH assessment only available after 6 months alcohol abstinence

Role legitimacy
Hand holding
Role Model

What works well?
Foundation 66
Outreach-other areas e.g. Insight
Holistic approach
Models of good practice in schools
Health huts
KAPPA
Brief assessments (needle exchange) etc.
YOS, SLAM

What doesn't work well
Schools –evidence base (Nat)
Provision of support to revolving door
Haven –connectivity links to services are not good
Accident and emergency do not make it a priority

Top Priorities
Sustained effort –e.g. hospital, A and E
Liaison
Finance consideration-what has maximum impact regarding model
Communication strategy
All in PCT strategy

Appendix 4:

Southwark Drug and Alcohol Service User Council Focus Group

24th November 2010

1. Southwark Profile

Key drug issues identified locally included:

- Alcohol also involving older middle aged people who have been on drugs for a long period of time (30/35 years old upwards)
- Alcohol – people meet up daily and sit outside drinking (e.g. Camberwell Green)
- *"Active addiction"* of Class A drugs and alcohol is seen around Camberwell/Dulwich and Camberwell Green
- Cannabis and alcohol in London Bridge, particularly with teenagers (of all ethnicity) drinking in public
- Cannabis was recognised as a major emerging problem *"The biggest problem I see is cannabis. Weed. Skunk... And it seems to be young boys, the odd girl... but young boys in groups and anti-social behaviour and drinking and puffing seems to go together" "nearly everyone smokes puff" "the cannabis thing it's just taken off" "it's all about image and status with young people and a lot of these young people... have had parents in addiction and their parents haven't provided for them so they've grown up really quickly and started to get into the same lifestyle... it's all image, they want this and they want that.."*
- Not many new people using Class A drugs *"there still is people but I don't think there's so many" "A lot of people on class A drugs are people who've been on it a long time" "I don't think there's so many people now as there was 15 years ago starting on Class As"*
- Dealing hot spots (for Class A drugs) identified included East Street, Camberwell Green, East Street, Wharf Road
- Dealers are also using MacDonalds and Bookies *"using MacDonalds... I've seen a lot of activity in MacDonalds" "the dealers are going up to the toilets and meeting people there. They're shutting them in the toilets" "and using Bookies a lot now" "you go past any Bookies you'll see a load standing outside these days. And you see the same faces from morning to night, all day until it closes"*

The impacts of substance misuse that the group discussed included:

- Antisocial behaviour *"people don't really care anymore, that's the impact"*
- Impact on families:
  - Families where parents have substance misuse often have young people who use drugs or drink
  - Parental addiction affect children
  - Young person addiction affects the whole family

"If a young person's getting involved in drugs it impacts on the whole family" "it's not just the person who's going through the addiction, the whole family goes through it with you"

Factors related to the start of substance misuse included:

- Family substance misuse (normalising substance misuse and meaning that children grow up quickly) *"there's a lot of families that use with their kids" "especially the cannabis"*
- Failure of "the system" to support children with family addiction, abuse, family breakdown
- Starting using alcohol and cannabis then moving on to other substances (speed, cocaine, crack, heroin)
- Peer pressure (especially with cannabis) and material requirements (clothes etc)

It was noted that dealers were getting younger and drugs were becoming more easily available.

2. Prevention

- Lack of prevention work with children and young people
- Should get ex-users into schools
- Youth clubs help
- Leaflets could be put in schools, GP surgeries, pharmacies, churches, supermarkets – these need to be specifically about drugs

3. Access into Treatment

- People only access services when they know they have a problem
- Often you have to be in crisis to get support (people have to put themselves in crisis, e.g. become homeless or get arrested)
- Barriers exist in particular for women due to the knowledge that treatment will start the social services process (there was support for this process but it was recognised as a barrier to women accessing treatment)
- Women need an individual social worker to guide them through social services issues and ensure that women are well informed (it is good to have social workers for children but many women do not know their rights and it was reported that some women had put their children up for adoption in situations where this was not necessary due to lack of understanding of the process)
- Few referrals were made from schools and social services
- Is it always necessary for individuals to take part in a day programme before accessing residential rehabilitation? Those most in need of residential programmes would be unable to attend a day programme as they are at crisis point

4. Treatment Service Provision and Quality

- Lack of alcohol treatment services (alcohol is often seen as less of a problem than drugs due to social acceptability and its legal status)
- Need for automatic referral service upon hospital admission for alcohol related cause (as with suicide and psychological support)
- Lack of drug services for young people and parents (some parents are not familiar with substance misuse)
- Services do not tackle substance misuse being passed on within families (e.g. children growing up with parents with substance misuse)
- Lots of services provided for teenage mums and pregnant women (both a good and bad thing)
- Women with infants in foster care find it hard to get support to stay busy
- Support for teenagers needs to be structured (e.g. YOT orders are good)
- Initial contact with services was seen as good
- More could be done to help those who were struggling (more key worker sessions or information on treatment alternatives)
- Social services have poor understanding of drug use and can make people feel uncomfortable
- Social services need to support the client as well as children
- Social service support around relapse could help support women in re-contacting services to seek help if they fear they are at risk of relapse
- The cuts may affect services, especially as it is already difficult to access peripheral services (e.g. holistic massage)
- Care plans are good as they are a joint effort and goals are flexible, shared and positive
- Shared care planning could incorporate social services and other agencies to ensure that there was understanding across the agencies and now conflicting advice and information/decisions
- Need more groups (rolling/drop in groups rather than 12 week programmes to help people become more comfortable in the environment without having to commit or feel pressured)

- Events or groups on offer are promoted during assessment and also by some staff and via a timetable poster in services
- Harm reduction is good as it does impact risk taking behaviour and some “wet hostels” are needed

5. Leaving Treatment

- Clients need ongoing structure and key worker links after the Care Plan was achieved
- Equally, treatment is a process that happens at individual client paces and cannot be rushed
- Treatment is often not seen as a process by providers (i.e. no exit plan was set and the emphasis is often on maintenance, e.g. using pharmacological treatment) and key workers can be shocked when clients suggested that they might want to work towards leaving treatment
- Too many people are “parked up” on prescriptions and the prescribing service does not always link with the reduction service to promote abstinence
- Long term outcomes are related to internal stability, growth, self esteem and goal setting
- Relapse prevention could be supported with multi-agency work to support all client needs, early interventions when at risk of relapse, continued aftercare support (left open), easier access into other support, ensuring that services will not be withdrawn immediately on relapse (e.g. residential treatment), more groups to build self-esteem and provide activity/distraction, relapse prevention being provided as standard (rarely done at present)
- Support during relapse is required to minimise the impact
- People need “something to do after treatment”
- There is a need for legal and housing support
- To access follow-up services clients often have to be clean for 2 weeks – is this always necessary?
- There are good links into volunteering, training etc but it is difficult to get back into work (and some barriers for training exist – e.g. some courses for specific populations including those with English as a second language)
- There is a lack of awareness of wider opportunities and voluntary sector organisations
- Apprenticeships within drug and alcohol services could build the workforce and offer employment opportunities
- More workshops in treatment places could be run by ex-service users, peer education programmes could be set up, apprenticeships are good

Appendix 5:

Alcohol Service User Focus Groups

Focus Group 1: 10th December 2010 (5 participants)

Southwark Need:
- Alcohol use is very visible in Southwark as people tend to congregate in parks
- Hostels have a real drinking and drug taking "fraternity"

Preventing People Drinking Excessively:
- Need to increase prices
- Should ban very high content alcoholic drinks
- It would be easier if alcohol was less widely available
- It would be useful to get advice and signposting in GP surgeries, parks, through police and wardens, housing and social services
- The social acceptability of alcohol encourages excessive drinking

Access to Services:
- People hear about alcohol services through GPs, word of mouth, outreach work
- More access points would help to improve treatment uptake (accessing alcohol treatment through any treatment facility was seen as *"great",* especially if this enabled provision of a 7 days a week service *"you've got the weekend and then what do you do? They cut your drip")*
- Barriers to access include homelessness (can link to time delays), lack of funding and bureaucracy
- It is easier to access drug treatment than alcohol treatment, particularly through Drug Rehabilitation Orders – there was a suggestion that money could be diverted from drug treatment into alcohol treatment

What Works Well?
- The services are staffed well and are supportive
- Individual motivation, when present, is the key determinant of success
- Foundation 66 is viewed positively

What Needs Improvement?
- Access into residential services, in some cases straight from GPs to prevent delay
- Having a medical part to community treatments would help
- Delays in housing can limit treatment *"3 weeks are quite long if you're taking brown every day"*
- Delays between assessment and first appointments can mean that people get lost
- Wardens and police often enforce and move people on without offering any support or signposting into services

Ongoing Care and Aftercare:
- Confidence and success is enhanced by voluntary work, courses, mentor and peer advocacy work – lots of post-treatment clients were suggested to volunteer for Crisis Christmas work
- Recognition of achievements (e.g. certificates etc) help
- Lambeth aftercare service contacts people proactively – this helps

Focus Group 2: 14th December 2010 (12 Participants)

Preventing People Drinking Excessively:
- Price – alcohol is too cheap
- Advertising affects drinking behaviour
- Availability – alcohol is available "*on every corner*", "*24 hours a day*" (e.g. the same shops that top up electricity keys all sell alcohol)
- No prevention campaigns really?

- GPs are not always helpful
- Wider awareness of warning signs of dangerous alcohol use and risks would help (e.g. in schools or individually through brief advice)

Access to Services:

- Access straight from hospital is common (including hospital detox following a crisis)
- There can be barriers to accessing community detox through GPs (e.g. GPs may not refer appropriately, services may not support alcohol addiction)
- It would help to be able to access brief services through nurses as well as GPs to avoid having to wait for so long
- Community detox can be accessed through Foundation 66
- Alcohol units are not widely known – it could be useful to be able to self refer to these
- More access points could help BUT it is important to ensure that everyone knows how/where to refer to avoid *"passing the buck"*

What Works Well?

- Brief intervention workers (but not if funded by cutting other services)
- Walk in services are good

What Needs Improvement?

- GPs are not always able to provide services themselves (e.g. prescribing)
- There is little consistency with GPs (hard to get same GP or same day appointment)
- Getting a care coordinator can take time
- Family support and support for the parents when combining treatment and social services processes would help, possibly with liaison workers to support whole family planning and strategies

Ongoing Care and Aftercare:

- Aftercare workers can be hard to get
- Confidence and success are enhanced by longer aftercare, "somewhere to go" as boredom is a problem, social support/group activities, AA (but not always liked), access to exercise facilities, specific groups or activities targeted at individuals after treatment
- The Sanctuary Club at Vauxhall offers a drop in facility

Young people's substance misuse
Updated needs assessment

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1. Introduction

2010 saw the re-commissioning of young peoples substance misuse treatment services in Southwark resulting in the establishment of a stand alone treatment service accessible to all young people in Southwark. This needs assessment will build on the previous needs assessment which highlighted the low numbers of young people accessing treatment and the fact that treatment services for young people were not well known or well advertised.

The publication of the 2010 Drug Strategy supports the emerging recognition in Southwark of the inter-generational nature of substance misuse and its impact on young people. This needs assessment will look at current provision, the data we have from various sources to identify need in this area and the views of young people to develop a treatment plan that will build on the work that has been carried out to date to address the substance misuse needs of young people in Southwark.

2. Socio-economic factors

Children living in poverty can experience negative effects on their life chances and opportunities: affecting their housing, health, education and in time employment.

In 1999 the British Government set an ambitious target to halve child poverty levels by 2010–11 and to eliminate it entirely by 2020. The government now intends to enshrine this pledge in legislation.

The borough of Southwark had a population of around 278,000 in mid-2008 with over one-fifth (22 per cent) of the population aged 0–19 years (60,600)[lxxxiv][lxxxv]. Southwark will continue to grow to anywhere up to 341,300 people by 2026 and the number of children is expected to grow to up to 82,000 by 2026[lxxxvi].

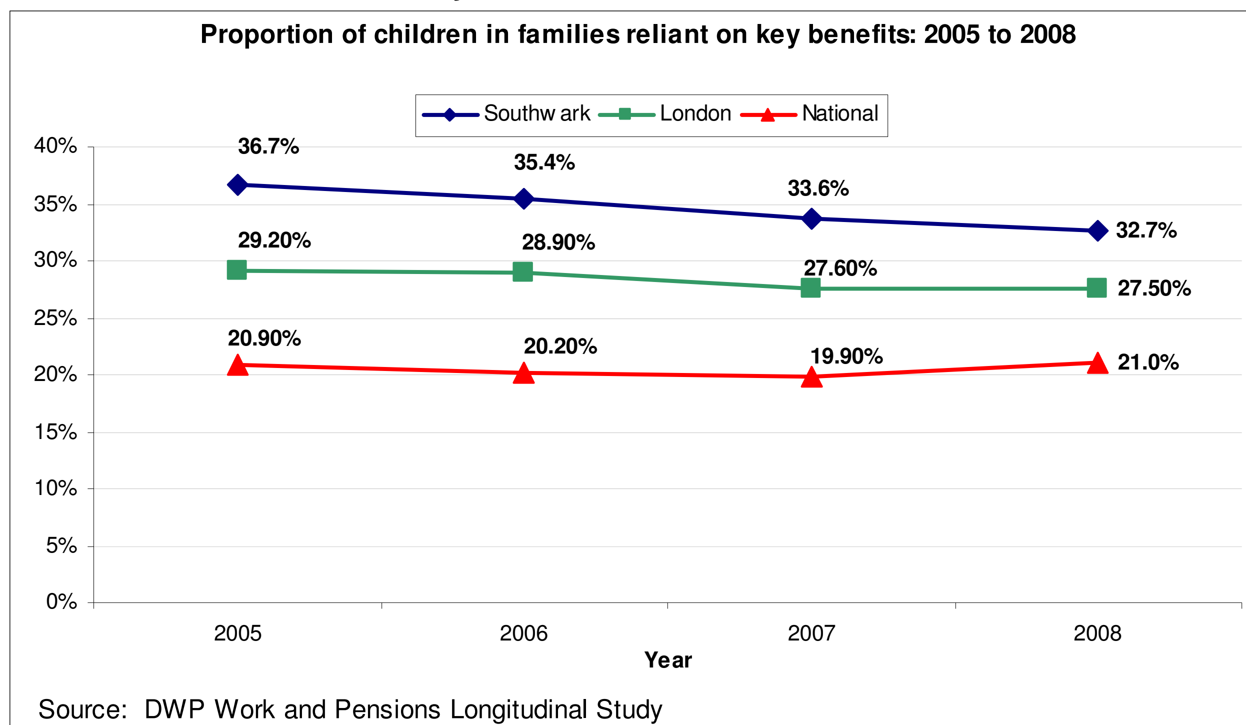
Southwark is a diverse and changing borough full of contrasts: affluent suburbs lie just minutes from some of London's most deprived areas. Southwark was ranked as the 26th most deprived borough in England (of 354) in 2007 and the 9th most deprived borough in London[lxxxvii]. Furthermore, according to the Child Wellbeing Index 2009, Southwark was ranked as having the 7th lowest level of child well-being in England and the 4th lowest level of child well-being in London[lxxxviii].

Worklessness and low pay have been identified as direct causes of poverty and with Southwark's high numbers of children living in families reliant on workless benefits as well as families on low incomes the poverty issue in Southwark is more evident and worrying. Just over two-fifths of lone parents were in employment in 2005 and the unemployment rate was relatively high in Southwark compared to other London boroughs.

Southwark also has a high proportion of families claiming a range of benefits particularly key benefits indicating the high level of lone parents, long-term and short-term sick people, families with disabilities and families with adults with no work that are resident in Southwark further demonstrating the high risk of child poverty in the borough. Southwark also has a high rate of teenage pregnancy and a relatively high number of young people not in education, employment or training further adding to the problem.

Based on figures published by the DWP, Southwark had 16,450 children living in families on key benefits in May 2008[lxxxix]. The claimant rate in Southwark was 32.7 per cent[xc], which was higher than the London and Great Britain rate of 27.5 and 21 per cent respectively. However, Southwark had a slightly lower proportion than the statistical neighbour average (34.2 per cent). Trend data shows that the rate of children living in workless households has decreased slightly since 2005, dropping 4% points between 2005 and 2008. In contrast, the national average has increased slightly in recent years.

Children in families reliant on key benefits 2005 to 2008



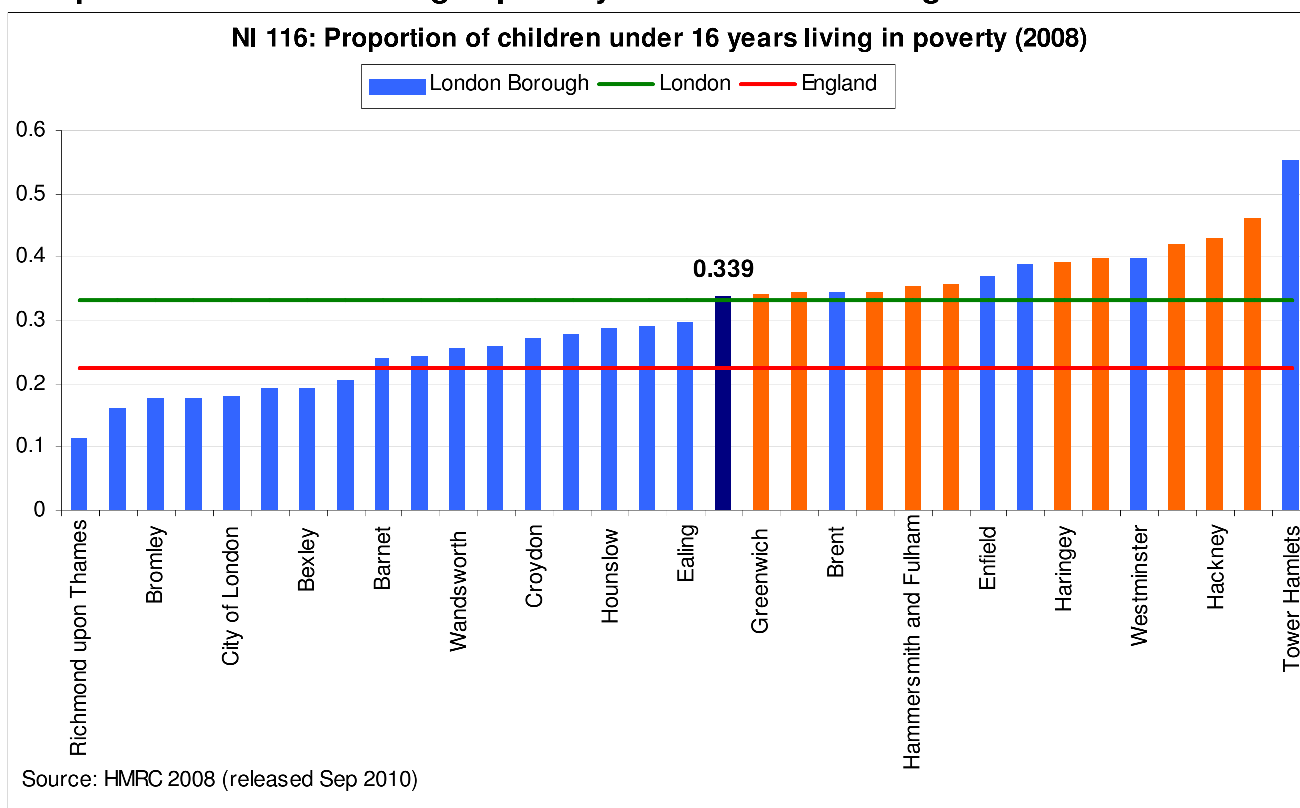
National Indicator for poverty (NI 116)

The National Indicator 116 (Proportion of children in poverty) measures the measures the proportion of dependent children[xci] in a Local Authority who live in households in receipt of out of work benefits or tax credits and where their reported income is less than 60 per cent of the contemporary national median. This takes into consideration both children from out of work families and children from in-work families where their equivalised income is less than 60% of the median.

Data published in September 2010 calculated that around one third of dependant children in Southwark were living in poverty in 2008 (n=17,335, 37.7%). This was a 3.8 percentage point decrease from 2007, and only 2.7 percentage points higher than the London average. Southwark's child poverty rate continued to be lower than the Statistical Neighbours average (38.4%) and was the lowest rate of all Statistical Neighbours.
Between 2007 and 2008 Southwark dropped from having the 11th highest rate of child poverty to the 16th highest rate (18th out of the 33 London Boroughs for this indicator and 333 out of 354 LAs nationally). Southwark decreased its rate of child poverty at a higher rate than both the London and National averages (which decreased by 1.5 and 0.8 percentage points respectively).

Despite the decrease between 2007 and 2008, this data is not reflective of any changes in the economy and unemployment rates that that have occurred between 2008 and 2010, and it is anticipated that more recent data will show a rise in the child poverty rate.

Proportion of children living in poverty 2008 London Boroughs



Source: HMRC 2008 (released Sep 2010)

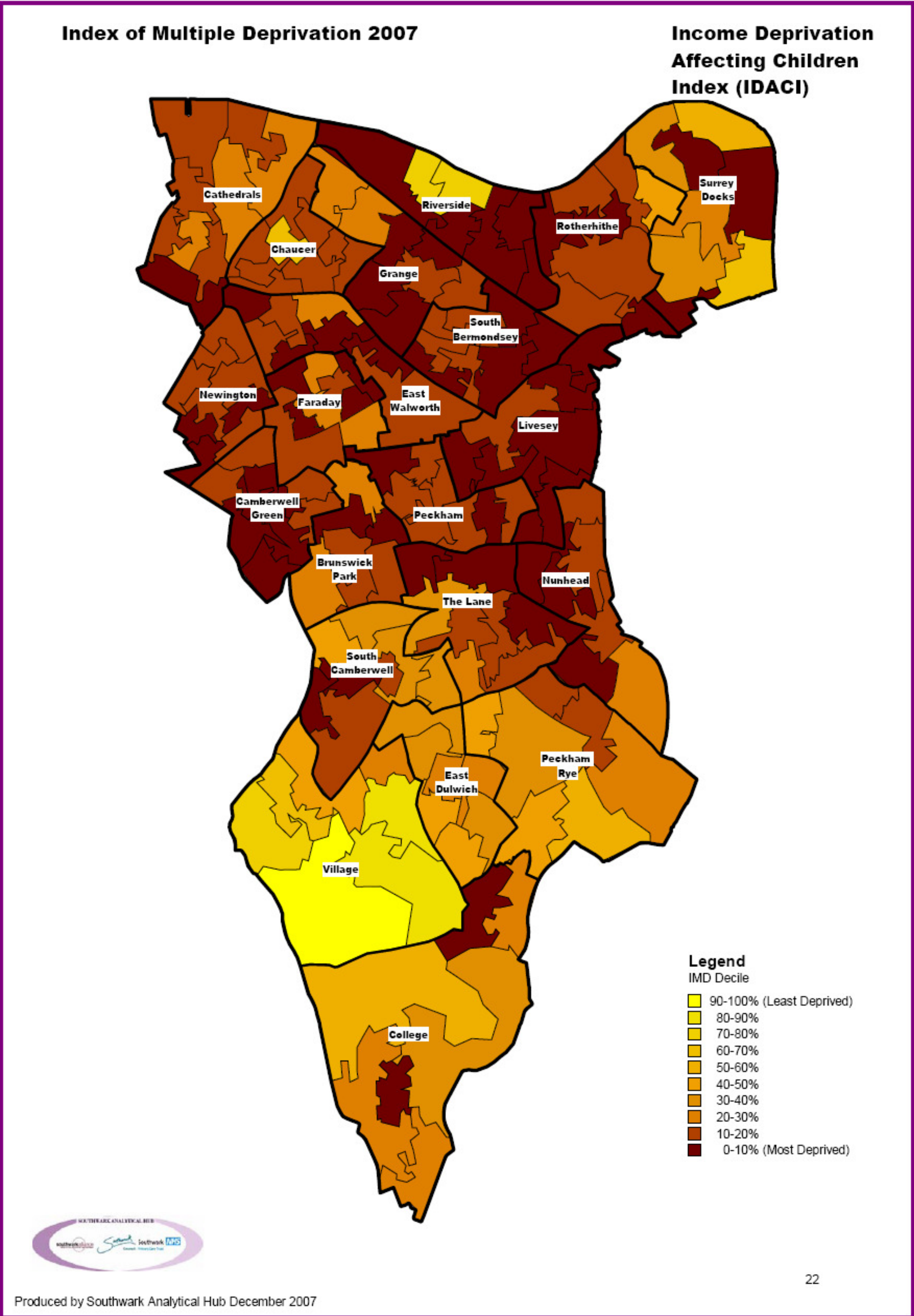
Income Deprivation Affecting Children (Lower Super Output Areas)

The income deprivation affecting children index (IDACI) from the Indices of Deprivation 2007 (ID2007) gives the proportion of children aged 0-15 years in an area who are in families living on low incomes. In practice, this is the proportion of families who are dependent on means-tested benefits (including any dependents of claimants). The benefits included in the count are Income Support, Income Based Job Seekers Allowance, Pension Credit, Working Tax Credit and Child Tax Credit (limited to those on low incomes), along with asylum seekers receiving support.

The Southwark picture shows that the most deprived LSOAs are concentrated in the centre and towards the north of Southwark with 35 per cent of LSOAs (throughout the borough) having children in families in income deprivation appearing in the most deprived decile. These were found in most wards except Village, Peckham Rye, Chaucer and East Dulwich. Village ward scores well with five out of seven LSOAs in the 60–100 per cent deciles, therefore less deprived than other areas in Southwark. College, East Dulwich, Peckham Rye, Surrey Docks and South Camberwell wards scored well compared to the other wards in Southwark with a greater proportion of LSOAs in these wards scoring between 30–70 per cent[xcii].

The highest deprivation was an LSOA in Rotherhithe, which had a score of 0.72, meaning 72 per cent of children lived in income deprived families. Those LSOAs in the most deprived decile in Southwark had between 48 per cent and 72 per cent of children living in families that were income deprived. The lowest level of income deprivation affecting children was an LSOA in Village ward where only 3 per cent of children were in income deprived families[xciii].

Income Deprivation Affecting Children Index (IDACI) for Southwark

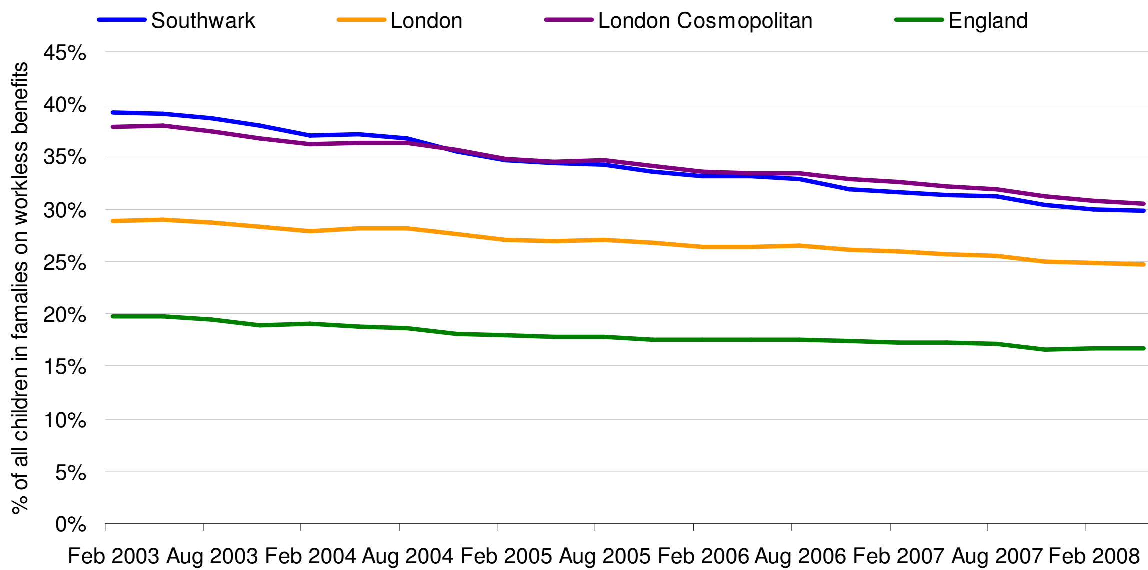


Children in workless households

Children in workless households, those households with no adults in work, face a very high risk of poverty relative to households that have one or more working parents. Working age households are defined as those containing at least one person of working age (16-59 years old for women and 16-64 years old for men).

This measure counts the number of children living in families reliant on workless benefits (i.e. job seekers allowance, income support). As of February 2008, around 30 per cent of dependant children lived in a workless household, which is a steady decrease from the 2003 figure of nearly 40 per cent. Southwark's figure is slightly lower than the London Cosmopolitan average for 2008 (31 per cent) but higher than the London average of 25 per cent.

Proportion of children in workless households, Southwark 2003–2008



Source: *DWP Information Directorate: Work and Pensions Longitudinal Study (latest data - May 2008)*

Children in overcrowded accommodation

Created by Performance, Information & Analysis
C. Kling
Sept 28th 2009

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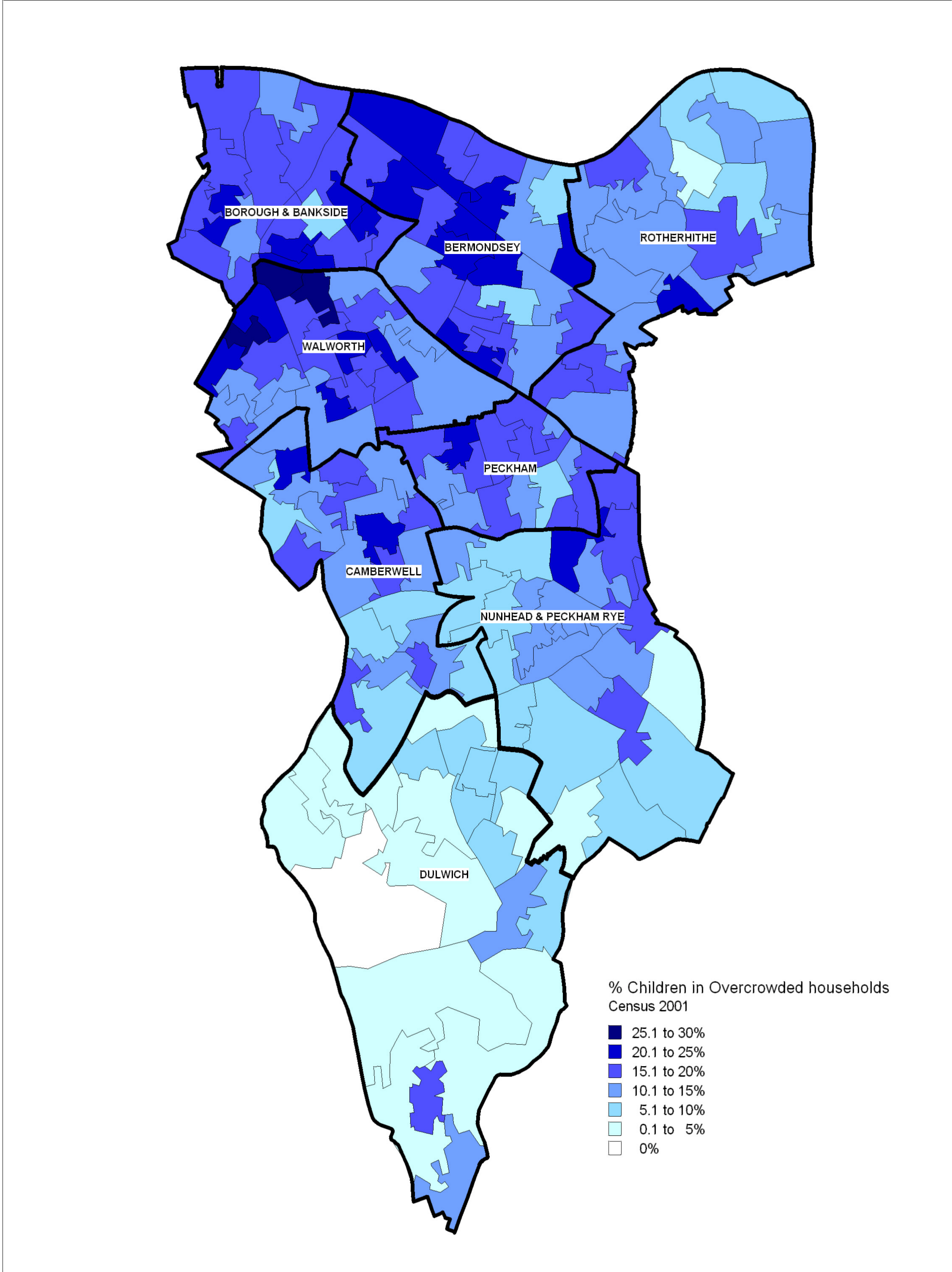
CHILDREN'S SERVICES

PROPORTION CHILDREN IN OVERCROWDED ACCOMMODATION (2001)



3. Substance Misuse Prevalence Analysis – Defining the population in need

Support needs: Blenheim data: 2008-10 financial years

Blenheim have produced a report showing the profile of clients starting treatment in 2008/09 compared to those starting treatment in 2009/10 who have dependents.

42 people started treatment in 2009/10 who had dependents, double the number from last year. Just over half were female, a smaller proportion from last year. 7% were aged under 25, less than last year, but 40% were under 35, a much higher proportion than 2008/09 (29%). There is a smaller proportion of white and black people with dependents, but more Asian and mixed people. Just under two thirds were white, followed by 14% mixed. Housing is not such an issue this year with just 12% with a housing problem, half the rate from last year, when just under a quarter had a housing problem. Last year people starting treatment who had dependents were fairly spread amongst the borough. But this year, almost a third reside in Peckham, followed by Rotherhithe. A larger proportion of people had heroin or other opiates as their primary drug (55% compared to 48% in 2008/09) and a similar proportion had cocaine or crack cocaine as their primary drug.

Southwark Profile Data - Clients with dependents

	FY2008-09[1]		FY2009-10[2]	
	No.	%	No.	%
Gender				
Male	9	43%	20	48%
Female	12	57%	22	52%
Total	**21**		**42**	
Age				
18-24	2	10%	3	7%
25-34	4	19%	14	33%
35-44	10	48%	14	33%
45-54	5	24%	8	19%
55-64	0	0%	3	7%
Ethnicity				
White	14	67%	27	64%
Mixed	2	10%	6	14%
Asian/Asian British	0	0%	2	5%
Black/Black British	4	19%	5	12%
Other	1	5%	2	5%
Accommodation Need				
NFA- Urgent housing problem	0	0%	1	2%
Housing problem	5	24%	5	12%
No housing problem	16	76%	36	86%
Location				
Bermondsey	3	14%	0	0%
Borough & Bankside	2	10%	0	0%
Camberwell	3	14%	6	14%
Dulwich	2	10%	1	2%
East Dulwich	0	0%	1	2%
Herne Hill	0	0%	1	2%
Kennington	0	0%	2	5%
Nunhead & Peckham Rye	3	14%	0	0%
Peckham	1	5%	12	29%
Rotherhithe	1	5%	7	17%
South Eastern Head	0	0%	6	14%
Walworth	4	19%	6	14%
Not provided	2	10%	0	0%
Primary Drug				
Cocaine	3	14%	4	10%
Crack Cocaine	6	29%	13	31%
Heroin or other Opiates	10	48%	23	55%
Alcohol	0	0%	1	2%
Anti-depressants	0	0%	1	2%
Cannabis	2	10%	0	0%

1 - Data presented is for clients starting treatment between 01/04/2008 and 31/03/2009

2 - Data presented is for clients starting treatment between 01/04/2009 and 31/03/2010

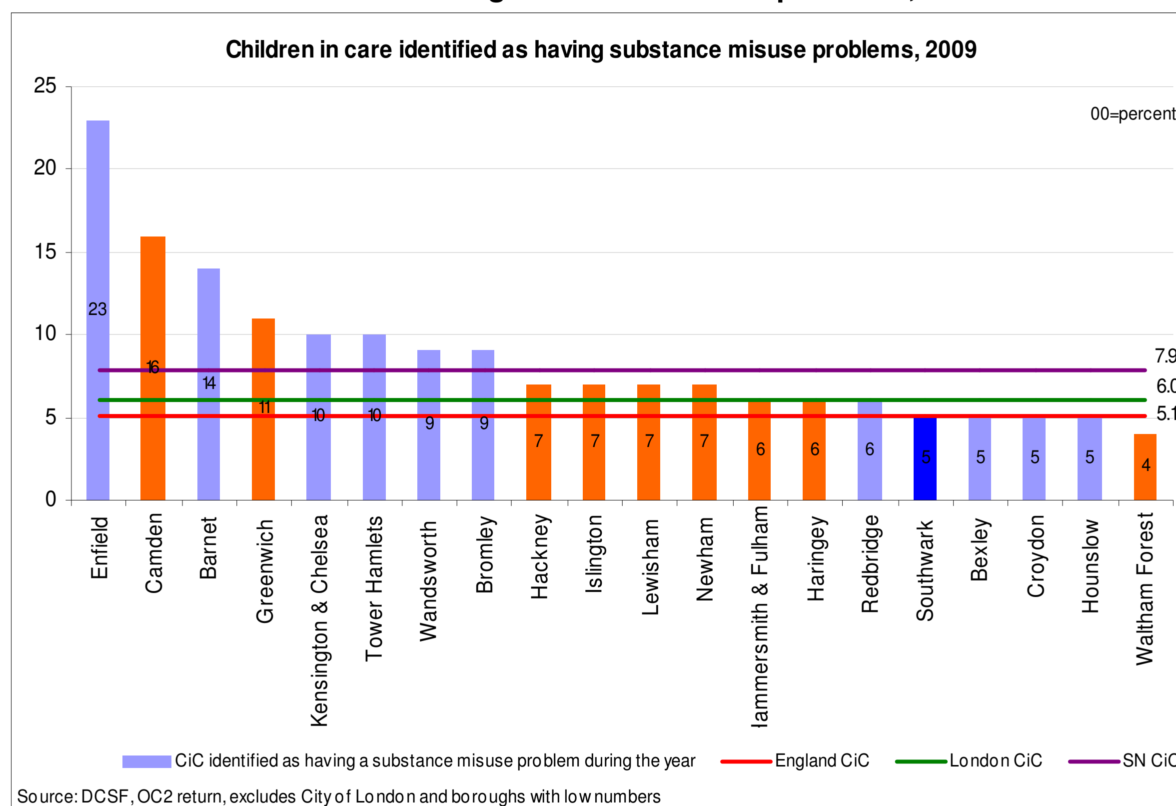
Children in care (CiC) with substance misuse[xciv][1]

The numbers of children in care identified as having substance misuse problems are small and the following should be interpreted with caution.

Of the 370 children in care at 30 September 2009 who had been in care for at least twelve months, 20 children (5%) were identified as having substance misuse problems, which was an increase from the previous 12 months. This was in line with the national (5.1%), London (6%) and lower than the statistical neighbour (7.9%) averages.

Southwark also had equal 2nd lowest proportion of children in care identified as having substance misuse problems out of the 20 London boroughs.

Children in care identified as having substance misuse problems, 2009

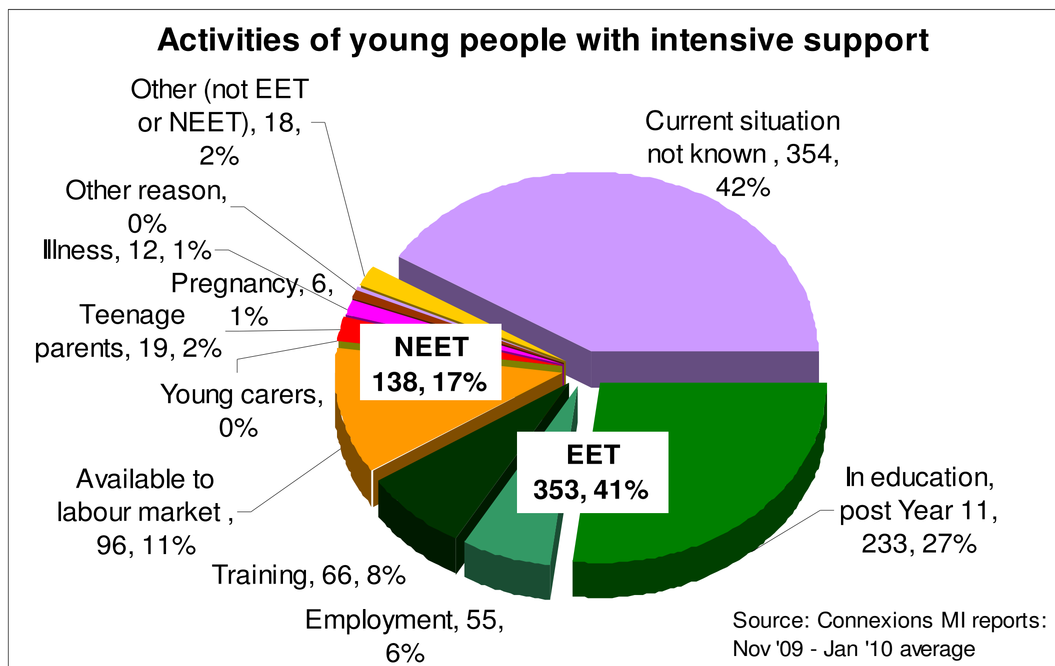


Connexions data

Central London Connexions produce monthly Management Information (MI) reports at a borough level. These are based on the cohort of young people aged 16 to 20 (or 25 if they have an LDD who have completed compulsory education. National indicator 117 (% of 16-18 year olds who are NEET) is defined as the average number over the 3 month period November to January of each year. Hence analysis has been produced for the 3 month average from November 2009 to January 2010 using the monthly MI reports.

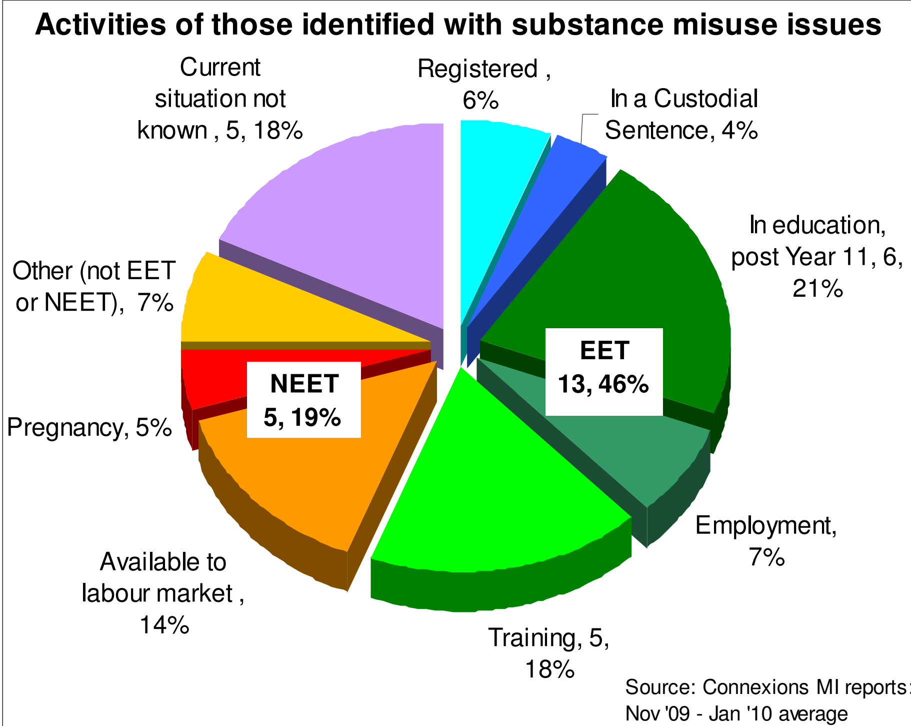
One of the reports shows the activity of those identified with support needs (categorised as minimum intervention, supported or intensive support).

Out of the cohort that Connexions contacted from November 2009 to January 2010, who had an intensive support need identified, two in five were in education, employment or training (EET), less than last year. 17% were classified as not in education, employment or training (NEET) compared to 14% last year and the situation of the remaining people was unknown.
This is a very similar pattern to those who have general supports needs but for young people with minimum intervention in the same period of time, only 3% were NEET and 78% were EET.

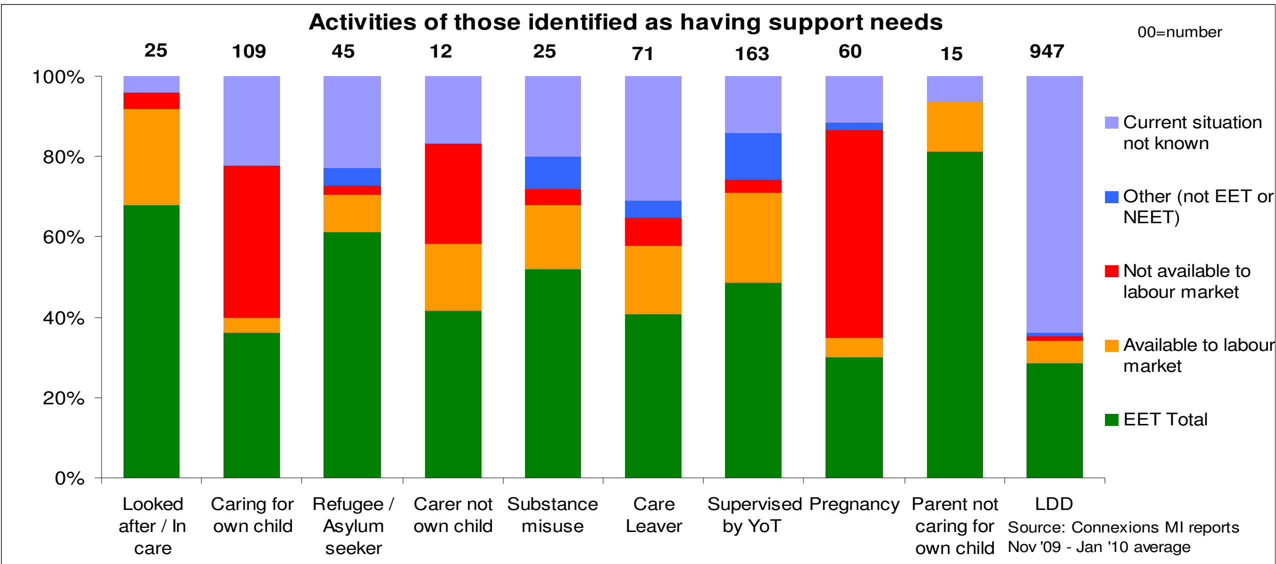


A further report shows the activity breakdown of those identified with individual circumstances. One of the circumstances identified is substance misuse. However, substance misuse is only recorded by Connexions Personal Advisors if they discover this about the young person. It is not statutory to ask about substance misuse, therefore the numbers recorded are likely to be lower than the reality.

An average of 28 young people were recorded in November 2009 to January 2010 as having substance misuse, 5 more than last year. Almost a half of these young people were in education, training or employment, double the proportion from last year, and almost one in five were NEET, the same as last year. The proportion who were NEET is slightly higher than those identified with intensive support needs, the same pattern as last year.



Comparing activity of those with substance misuse to the other categories of support, only 3 other categories have larger proportions of young people in education, employment and training than those with substance misuse issues. These are young people looked after/in care, refugee/asylum seekers and parents not caring for their own child. This is an improvement from last year where most other support categories had higher proportions of young people who were EET.



NEET

In December 2010, the wards of Peckham and Cathedrals had the highest numbers of young people who were NEET. The wards of Village and East Dulwich had the lowest (5 or less people).

Helping young people to access learning & work

Dec 2010
16-18 NEET Levels by Ward

Legend
Connexions Centres & Access Points
Thames
NEET: No. of Young People in Ward
0 - 5
6 - 15
16 - 25
26 +

Cathedrals 27
Riverside 8
Surrey Docks 7
Rotherhithe 18
Chaucer 10
Grange 17
East Walworth 13
South Bermondsey 13
Newington 9
Faraday 22
Livesey 19
Camberwell Green 13
Peckham 29
Brunswick Park 22
Nunhead 17
The Lane 15
South Camberwell 7
Peckham Rye 11
East Dulwich 5
Village 2
College 9

Cohort Data: CCIS data, 6-Dec-10; 1,705 clients in CLC - those without a valid postcode have been assigned the local centre's postcode.

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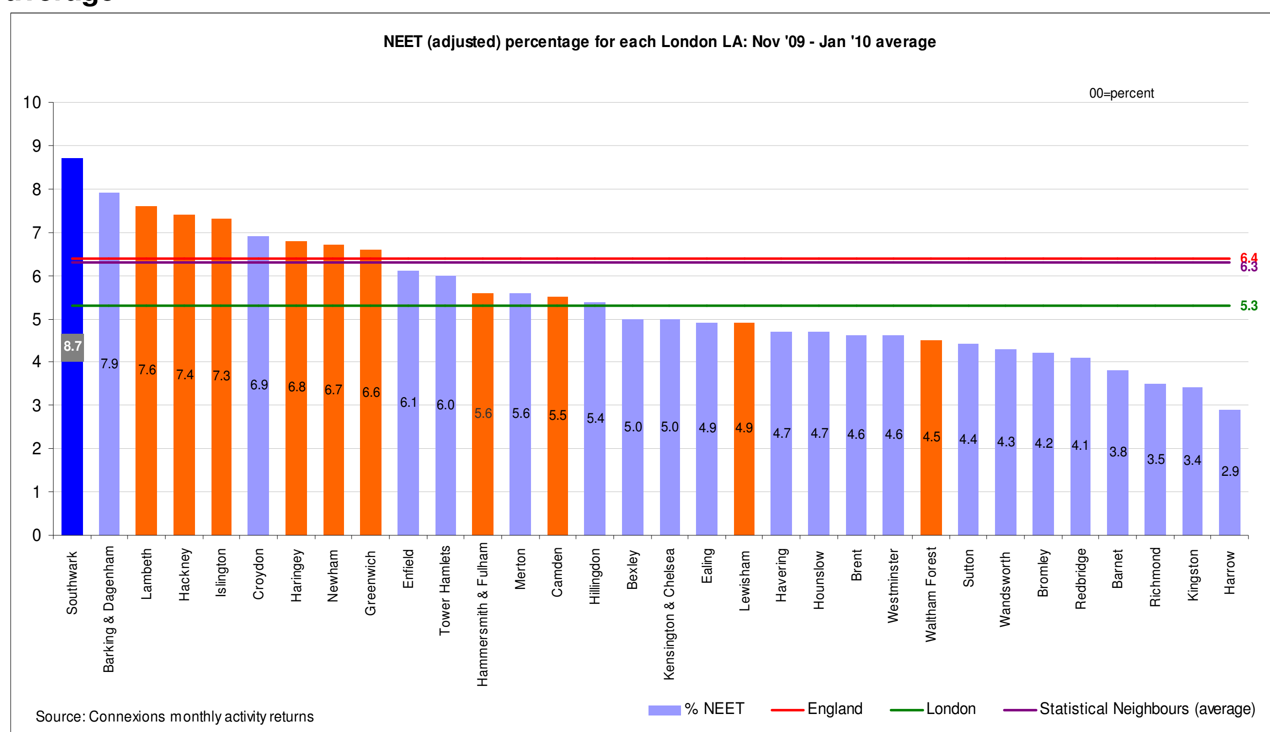
The Royal Borough of Kensington and Chelsea 100021668 (2010)

Date: 6-Dec-2010
Author: CLC MI Team
Status: Final
1:55,000

In November 2009 to January 2010, almost one in ten (8.7 per cent) of the whole 16 to 18 year old cohort were classified as not being in education, employment or training (294 young people). This is a slight improvement on last year's rate (8.8%) and a large decrease in the number of young people (there were 395 young people who were NEET in 2008/09). This was higher than the proportion of 16-18 year olds nationally (6.4 per cent), in London (5.3 per cent) and the Statistical Neighbour average (6.3 per cent)[xcv]. Southwark has the highest proportion out of the 32 London boroughs (which is a decline from the fourth highest proportion last year) and the 21st highest number of young people who are NEET[xcvi] (an improvement from twelfth last year).

The gap between England and Southwark widened slightly to 2.3 percentage points from 2.1 and Southwark now has the largest gap out of the 32 London boroughs (fourth largest last year).
The gap between the London average and Southwark was 3.4 percentage points, a decline from 3 percentage points last year (also the largest gap out of the London boroughs, fourth last year).

16-18 year olds who are NEET (adjusted figures), November 2009 – January 2010 average



Teenage Pregnancy

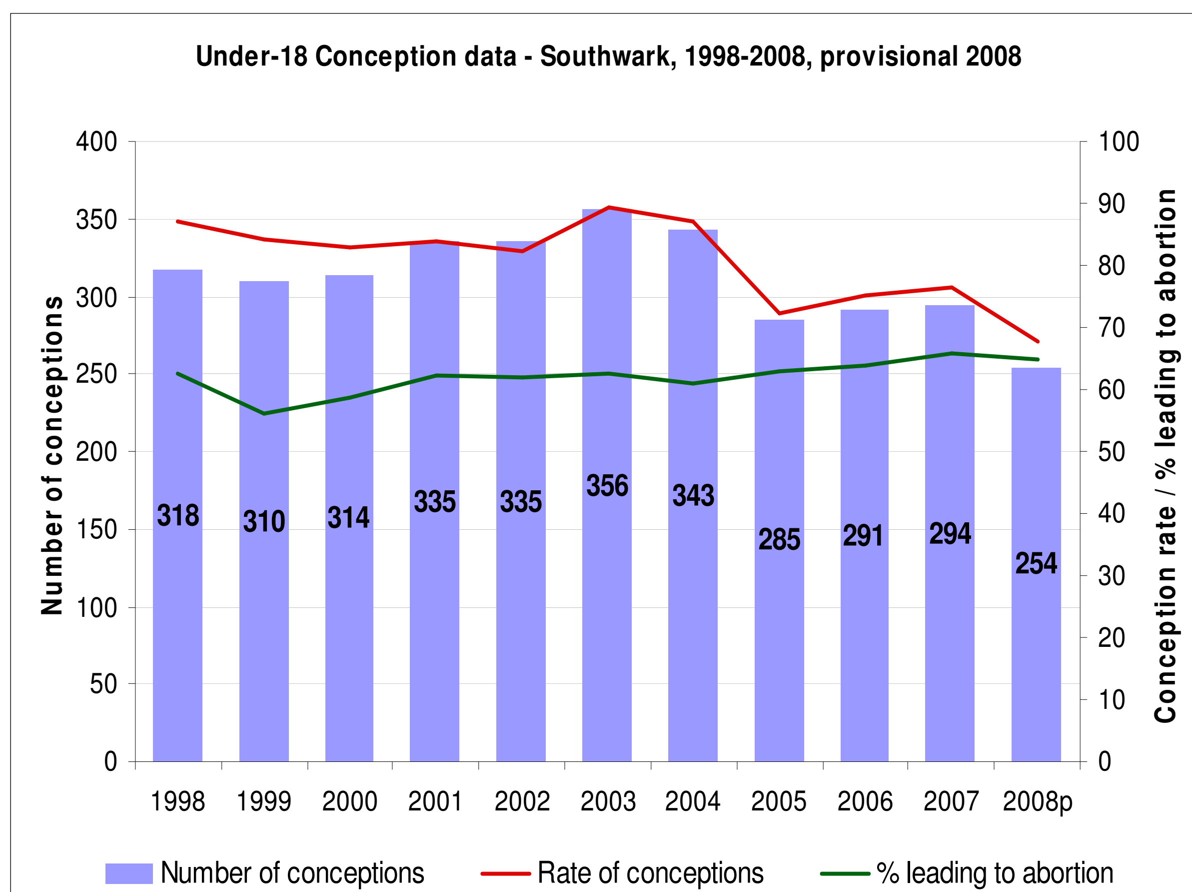
The Under-18 conception rate is a National Indicator (NI 112) and is defined as the change in the rate of under-18 conceptions per 1,000 girls aged 15-17 years resident in the area for the current calendar year, as compared with the 1998 baseline rate, shown as a percentage of the 1998 rate.

Provisional 2008 (Jan-Dec 2008)
Since 1998 to last year Southwark's conception rates have been the highest or second highest in the country except in 2005 where Southwark was third. Provisional 2008 data however shows that Southwark's overall rate of under-18 conceptions was

the lowest in the country yet at sixth highest and third highest in London. The overall rate has decreased from 76.6 per 1000 15-17 female population to 67.8 over the last year.

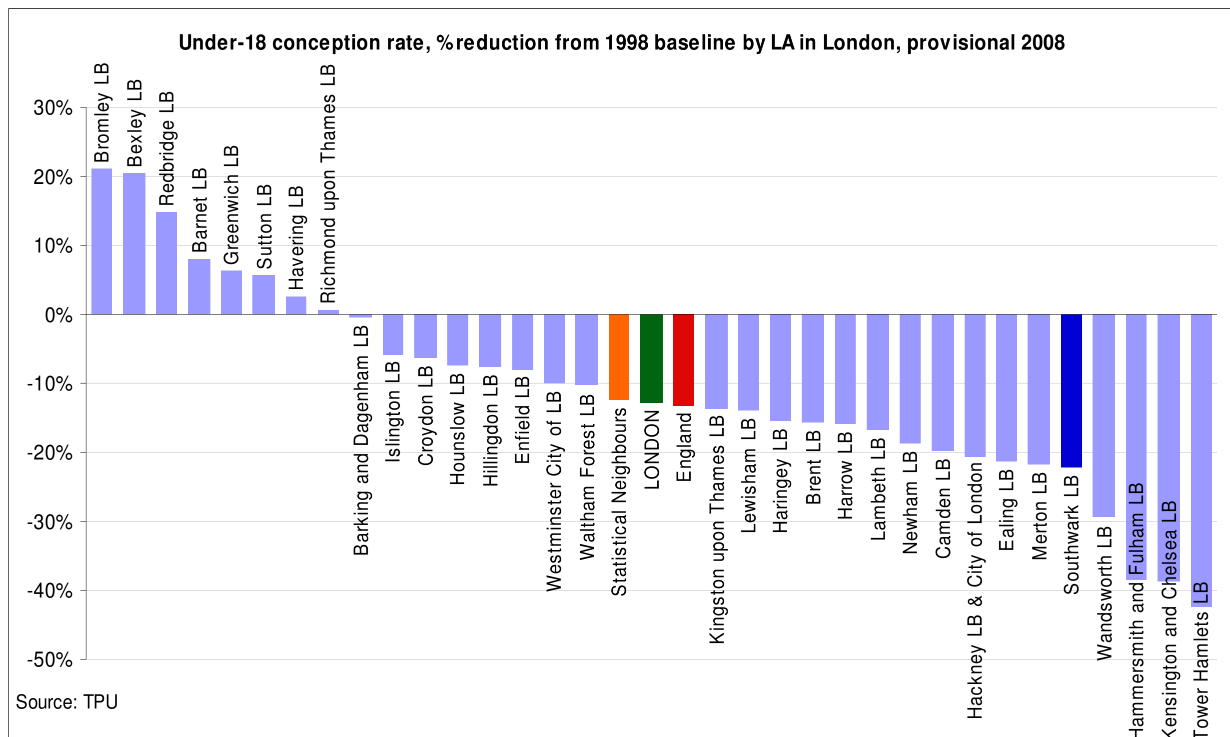
The conception rate has been declining at a steady rate nationally over the last nine years with a slight increase in 2007 and is not at 40.5. The rate has remained steady in London for the last five years, although is higher than the national rate at 44.5.

Southwark has the fourth highest number of conceptions out of the 32 London boroughs so has improved from 2007 where Southwark had the highest conception rate and the third highest number of conceptions of the 32 boroughs.
The proportion leading to abortion has remained steady over the years with a slight upward trend. In 2007 Southwark had reached the highest proportion leading to abortion over the last 10 years (66%) but this year is has fallen slightly to 65%.



Although the overall rate for Southwark is still high, Southwark had a greater reduction on the 1998 baseline of 22.2% compared to a reduction of 13.3% nationally and 12.8% for London.

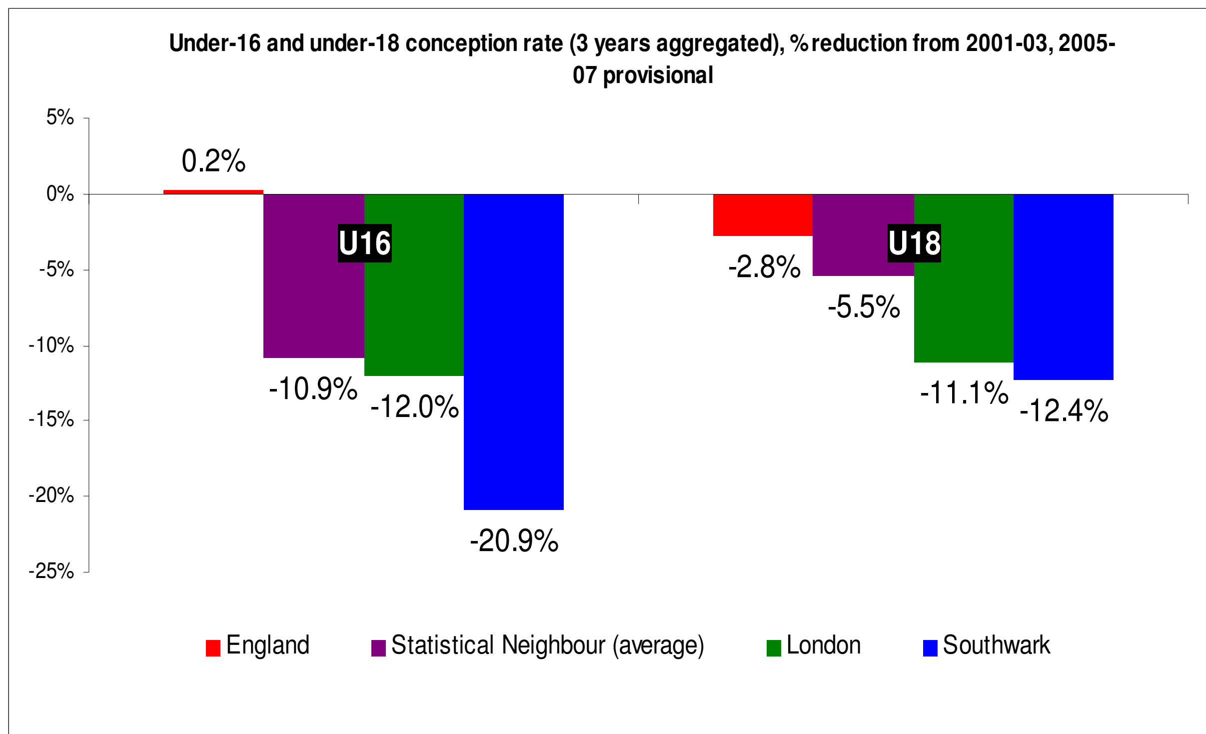
Of the 32 London boroughs Southwark had the 28th greatest reduction on the 1998 baseline and is in the top quartile of most improving LAs in the country.



Hotspot mapping produced by Public Health of teenage conceptions in Southwark 2006-2008 shows hotspots at the Acorn Estate, North Peckham Estate, Alvey Estate and Aylesbury Estate. However, there have been the addition of Rockingham Estate, Penrose Estate, Pelier Estate, Wyndham Estate, Southampton Way Estate, East Dulwich Estate, Pelican Estate, Lindley Estate, Kirby Estate and Pynfolds Estate.

Under 16s: Provisional 3 year annual conceptions: 2006-08

The conception rate for under 16 year olds in Southwark for 2006 to 2008 is 15.8 per 1,000 females aged 13 to 15, which is an increase from the previous 3 year rolling rate of 14.8. Southwark's rate had been steadily decreasing each rolling 3 year period since 2001 but this increase has widened the gap from the national average (which has remained the same as the previous 3 year rolling period).
The number of under 16 year olds conceiving in Southwark has also increased in 2006 to 2008 after having previously decreased each 3 year rolling period. In 2006 to 2008, the number of conceptions has risen to 179, which is 9 more than 2005 to 2007 but is 49 fewer conceptions than in 2001-03.
Southwark remain one of the London boroughs with the highest rate; out of 32 London boroughs, Southwark have the second highest rates of conception, with Lewisham having the highest. This is the same as 2005-07.

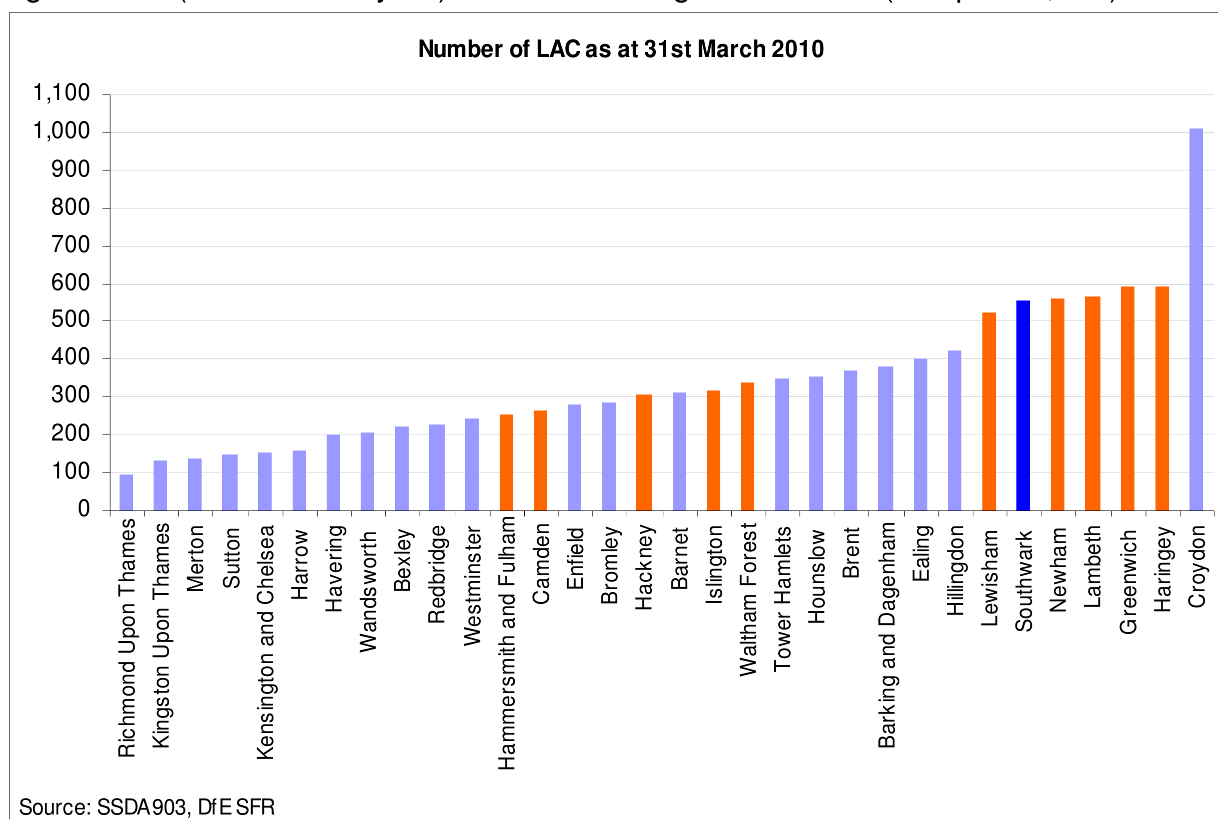


Further analysis can be carried out in the future using local Connexions data to highlight the characteristics of young people known to Connexions to be teenage parents or pregnant. This can be analysed to show those with more than one support needs, including substance misuse. However, substance misuse is only recorded by Connexions Personal Advisors if they discover this about the young person. It is not statutory to ask about substance misuse, therefore the numbers recorded are likely to be lower than the reality.

Children in care (CiC)

At 30 September 2009 there were 43,200 children who had been in care continuously for at least twelve months by English local authorities. Southwark accounted for nearly one per cent of these children (370 children in care (CiC)). Over two thirds (68.9%) of these children were of school age (255 children looked after). This was lower than the previous 12 months (395 CiC of which 290 were of school age at 30 September 2008).

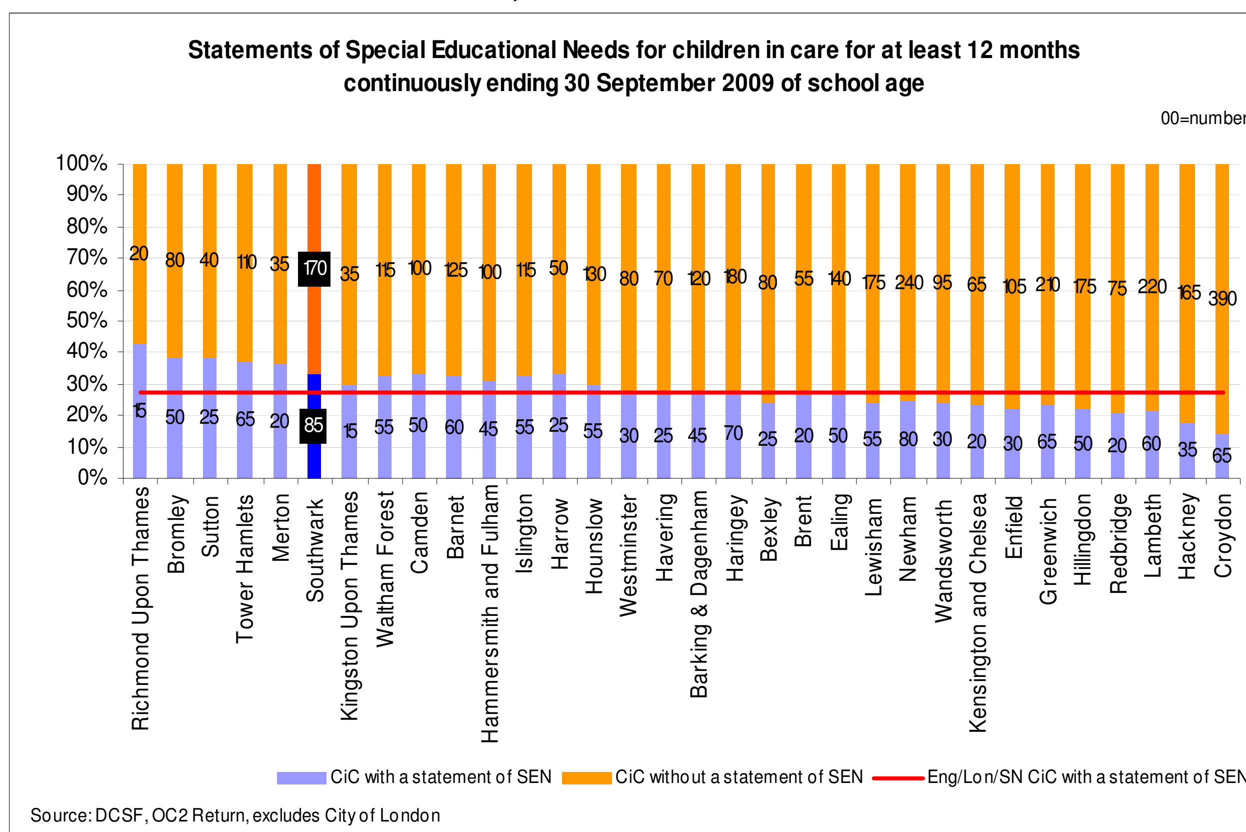
Southwark had 555 children looked after at 31 March 2010 (535 last year) and the 5th highest rate (same as last year) of the 33 boroughs in London (101 per 10,000).



In 2009, 34% of school aged children in care had a statement of Special Educational Needs (85 children in care), which was slightly higher proportion (32%) than in to 2008 but a lower number of children (90). Similar to 2008, this was higher than the proportion of children in care with statements nationally, in London and the statistical neighbours average (all 27%). Southwark had the 6th highest proportion of school aged children with a statement of SEN out of the 32 London boroughs (excludes City of London). This is higher than in 2008 where Southwark was ranked 9th highest.

Southwark children in care are almost 10 times more likely to hold a statement of special educational needs compared to all children. Just over three per cent of all school children in Southwark held a statement of SEN as at January 2009[xcvii]. This is also evident for national figures, London and the statistical neighbour average[xcviii].

Children in care with a statement of SEN, 2009



Source: http://www.dcsf.gov.uk/rsgateway/DB/SFR/s000852/index.shtml

Youth Offending

Safer Southwark Partnership Community Desk report on drugs, alcohol and young people (April 2007 – August 2009)

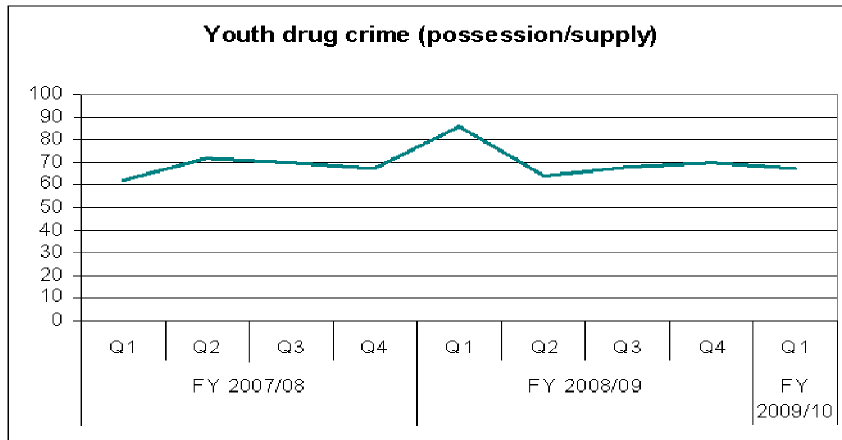
This report utilises CRIS data to try and understand the nature of drug and alcohol related offending in Southwark between April 2007 and August 2009.

The CRIS data was run through the Omnidata system to ensure consistency and accuracy.

Health data has been obtained from LASS (London Analyst Support Site (Ambulance), Guys Hospital (A & E) and the North West Observatories data re alcohol use has also been considered.

Time constraints have ensured that this report is not as detailed as it would ideally have been.

Performance
Southwark's performance regarding the use (both possession and supply) of drugs by young people is set out in the chart below. There was an increase of 6.3% (equating to 17 offences) when comparing FY2008/09 with the previous financial year. Levels have remained fairly steady since July 2008 (average of 60 – 65 per quarter



5.9% of possession of drugs is concerned with those aged 17 and under
19.1% of supply of drugs is concerned with those aged 17 and under

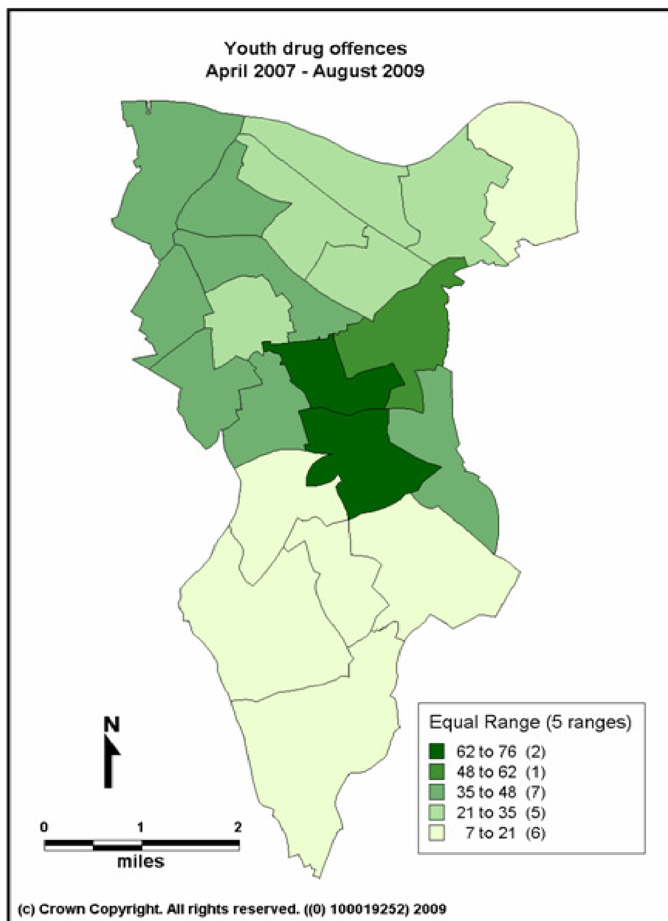
Types of drug

Type of drug	No.
Cannabis-Herbal	546
Crack Cocaine	38
Not stated	22
Cannabis-Resin	19
Cocaine	15
Heroin	14
Other	4
Designer Drug	3
Amphetamines	2
Cannabis Plant(s)	2
Multiple Drug Group	1
Grand Total	**666**

For this age group, the main 'drug of choice' is almost exclusively cannabis, with very few other types of drug used.

Alarmingly, the second highest type of drug used/sold is crack cocaine. A sample of these cases show that young people are typically selling this drug rather than using it. This obviously leads to other questions, such as where are they getting the drugs from, from who, and what kind of markets they are involved in.

Location



In terms of the possession/supply of illicit substances, the peak areas are to the centre and north of the borough, in Peckham, and to a slightly lesser extent in Livesey.

It must be remembered when using these figures that they are largely derived from police pro-active patrols, and may not necessarily be the true 'hotspots' for drug crime.

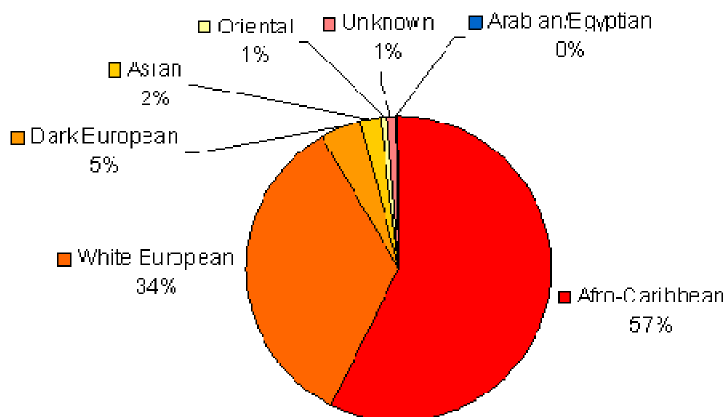
The table below shows each individual ward, and their totals for drug use/supply by young people. Peckham and the Lane (the two central wards) head the list, in terms of both use and supply. However, Chaucer and Cathedrals have comparatively high levels of young people supplying drugs.

Camberwell and Nunhead, as well as East Walworth (around Elephant and Castle) remain to be persistent areas of activity.

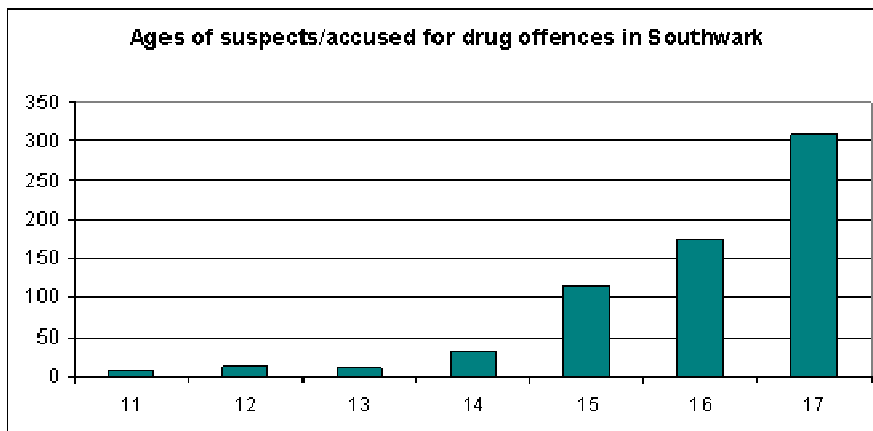
NAME	Drug Supply	Other offences	Possession	Grand Total
Peckham	13		63	76
The Lane	18		48	66
Livesey	8		41	49
Camberwell Green	1		39	40
Cathedrals	14		26	40
Nunhead	4		35	39
East Walworth	5		33	38
Brunswick Park	4	1	32	37
Newington	5		32	37
Chaucer	11		25	36
Faraday			28	28
Grange	1		24	25
South Bermondsey			23	23
Riverside	3		19	22
Rotherhithe	1	1	20	22
Peckham Rye	1	1	18	20
College	1	1	11	13
South Camberwell	2		11	13
Village	1		11	12
Surrey Docks			8	8
East Dulwich			7	7
Grand Total	93	4	554	651

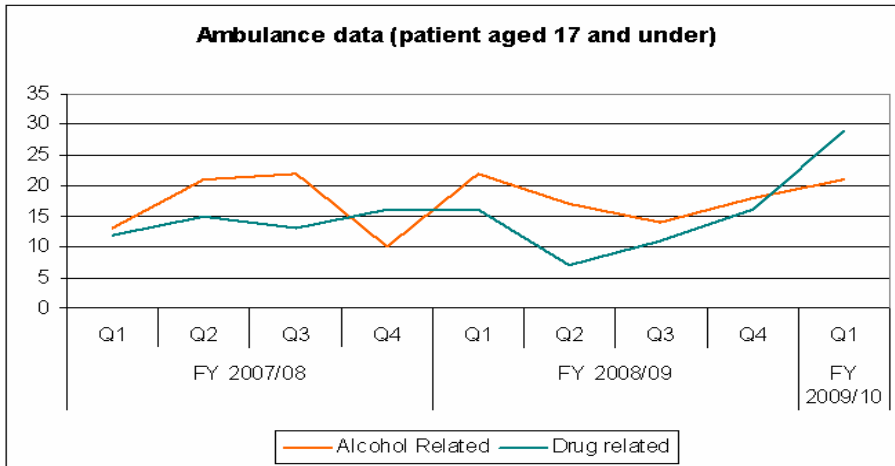
Victimology

Just 32 of the 666 total youth suspects for drug related offences (from both FY's) were female, with the remainder being male.



Afro-Caribbean and White European are the principal ethnicities, with few suspects derived from other backgrounds.



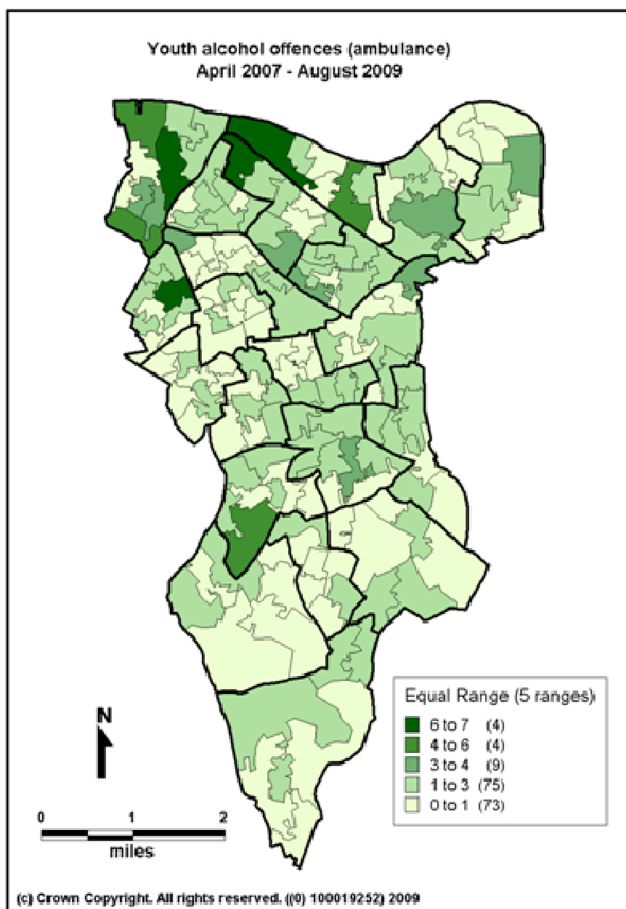


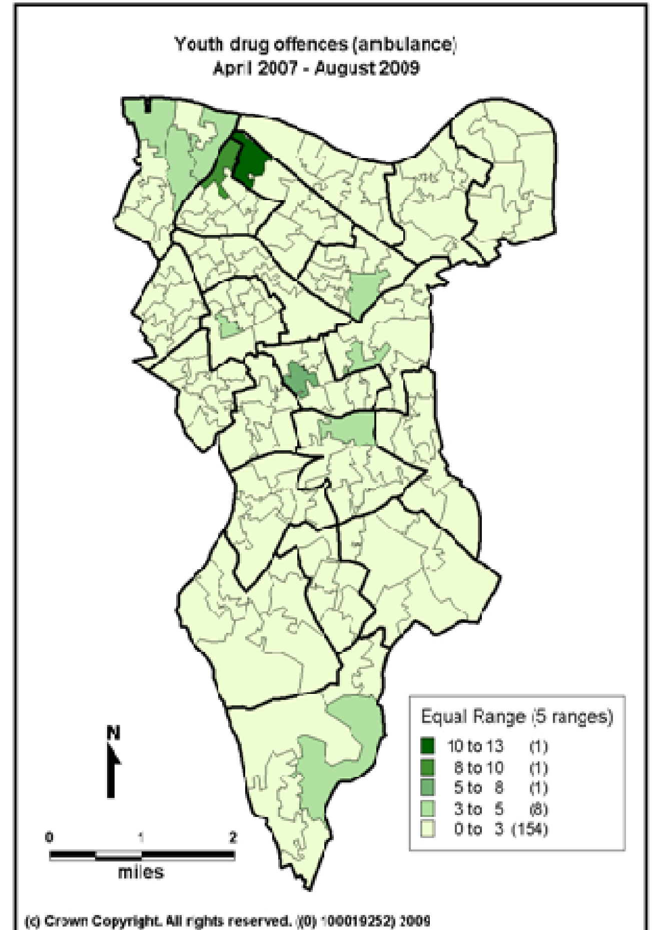
Alcohol related calls to patients aged 17 and under increased by 7.6% when comparing FY 2008/09 with the previous year (5). However, FYTD, there was an 11.1% decrease (4 calls).

Drug related calls to patients aged 17 and under decreased by 10.7% (6) when comparing FY 2008/09 with the previous year. However, there was a 71.4% increase FYTD (15 calls).

In most cases, the sole data given on the reporting system is 'overdose'. However, other symptoms include abdominal pains, psychiatric problems, and vomiting. In terms of alcohol calls, there were also a significant number of substance misuse cases (either drug overdose or solvent related) as well as indications of assault or accidental injury, such as lacerations, minor injury, pain and fainting/dizziness.

Location





It can be seen that in terms of ambulance data, the locations in which young people are recovered by the ambulance differs greatly from the overall police picture, and is possibly a more representative dataset.

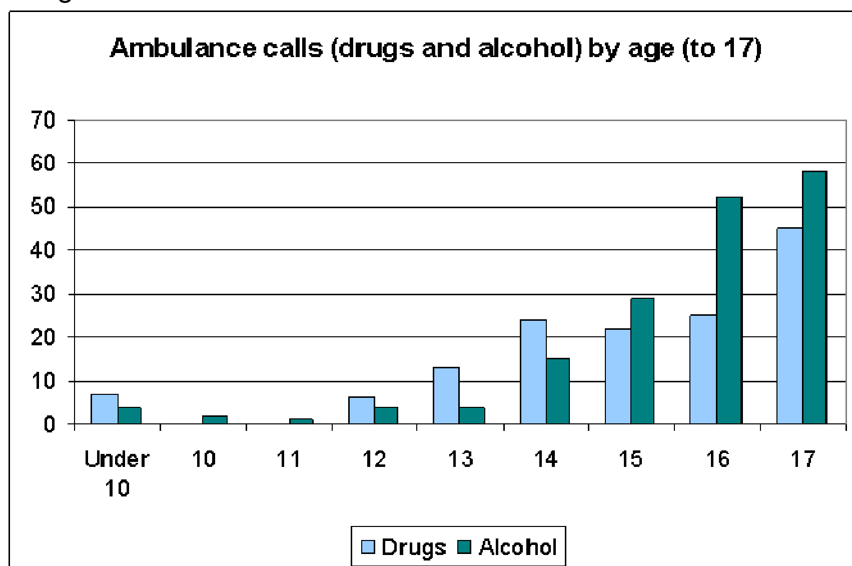
The areas of Peckham and the Lane have not reported significant numbers of young people needing ambulance assistance, however, the north of the borough, specifically Cathedrals Riverside and Grange (to the North West) have. This is likely concerned with the abundance of bars and nightclubs in this area, which young people may hope to gain admission to, and also parks, open space and the riverfront, which are traditional areas for young people to congregate.

In terms of drugs, the LAS were called to two areas far more than most, these being the LSOA's to the north of Grange and Chaucer. Located within this fairly tight area are London Bridge BR/LU (the busiest train station in Southwark) and Guys Hospital. These locations are both off Borough High Street, which houses much of the boroughs night-time economy.

Victimology

When considering drug related calls for this age group, females were by far the prevalent gender (72.3% of all calls). The peak age was 17.

59.8% of calls to this age group which were alcohol related concerned females, the peak age being 16.



Although perhaps unexpected, and certainly not reflecting the police recorded crime data, there are a number of reasons why females in this age group are more prevalent than males, these being:

1. Tolerance levels for females may be much lower than for males, owing to body mass
2. Females may be more likely to call for help than males, especially if they are in a group.

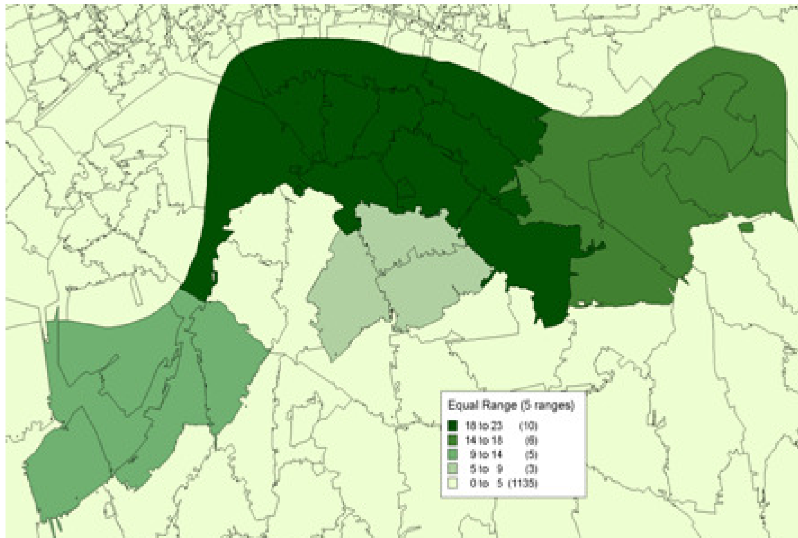
The Community Desk has recently been able to obtain data from St Thomas's hospital, concerning A & E admissions, whereby the patient has been assaulted. The data set is limited, and the exercise is very much in its infancy. Data obtained runs from March 2009 to August 2009. As yet, there is no method f determining whether an incident was related to alcohol or drugs.

Just over 9% (104) of A & E admissions to St Thomas's, where the patient was assaulted are concerned with young people aged 17 and under.

Most are head wounds (38.5%) with fists being the second commonest body part treated (35.6%).

Just under 75% of those admissions are males, with 29 cases being female. The most common ages (for both genders) is between 5-17 (70.2%)

It is possible therefore, that females of this age group may call for help, and summon an ambulance, whereas males may present themselves at A & E should they feel they need to.



When the entire data set was run, and maps created, it was evident that patients attended St Thomas's from many different boroughs, indeed counties, having chosen to come to Southwark for an evening in London.

Looking at this age group however, it is evident that the catchment area is much smaller, with patients almost exclusively from the north of Southwark and Lambeth boroughs, with very few patients from elsewhere.

Problematic drug users (PDUs) accessing treatment
Sourced from the Southwark Substance Misuse Needs Assessment (Adult) 2008/09

	% of PDU population	% PDU population in treament	% of age group in treatment as at 31st March 08	% not accessed tier 2,3,4 treatment	Most widely used drug of those in treatment	% in treatment using crack/opiates
15 to 24 year olds	9%	4%	10%	48%	cannabis	69% opiates 77% crack

Key Issues
Young people – 15 to 24 year-olds are the greatest users of cannabis but make up only 28% of all cannabis users in treatment.

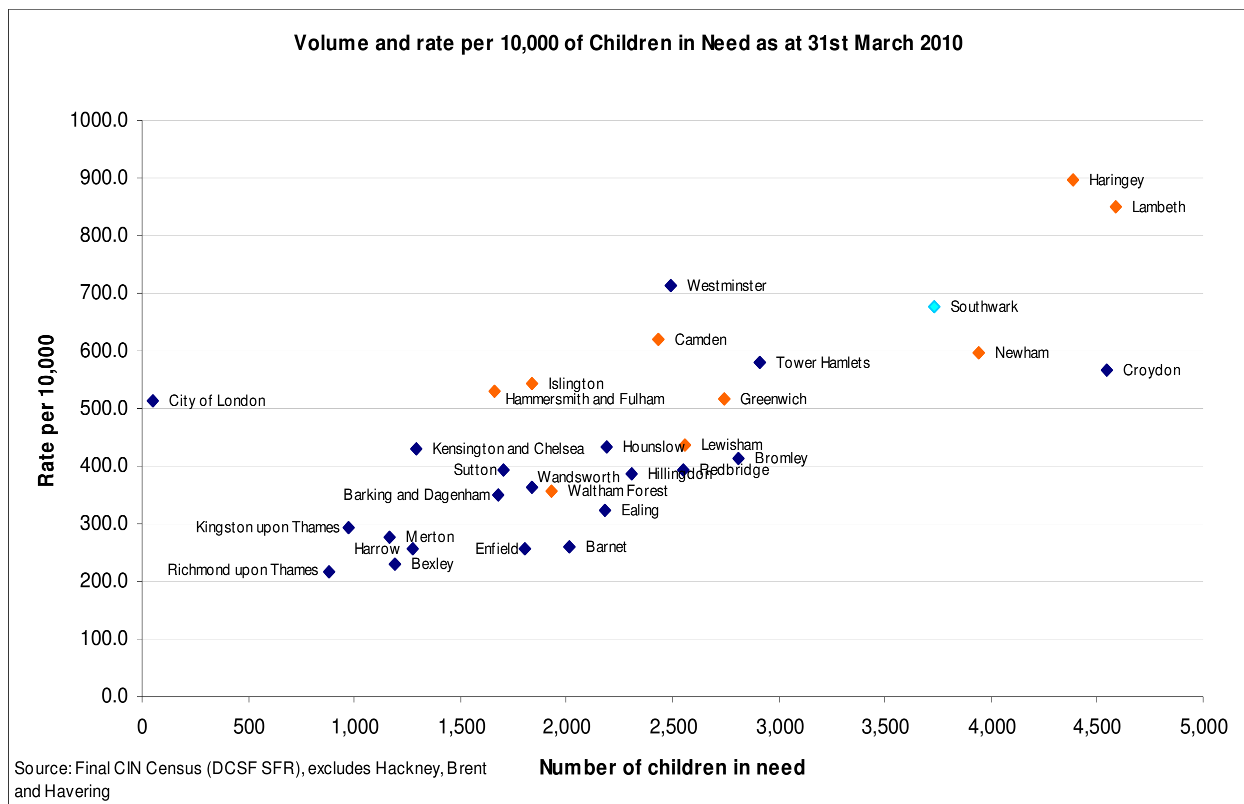
Social care

Children in need

Nationally, there were 375,900 children in need at 31 March 2010 of which Southwark accounted for 1.0% of children in need. In Southwark there were 3,737 children in need at 31 March 2010, which was an increase of 20.5% from 2009. This represented a rate of 677.4 per 10,000 children, which was nearly twice as high as the national rate of 341.3 per 10,000 children.

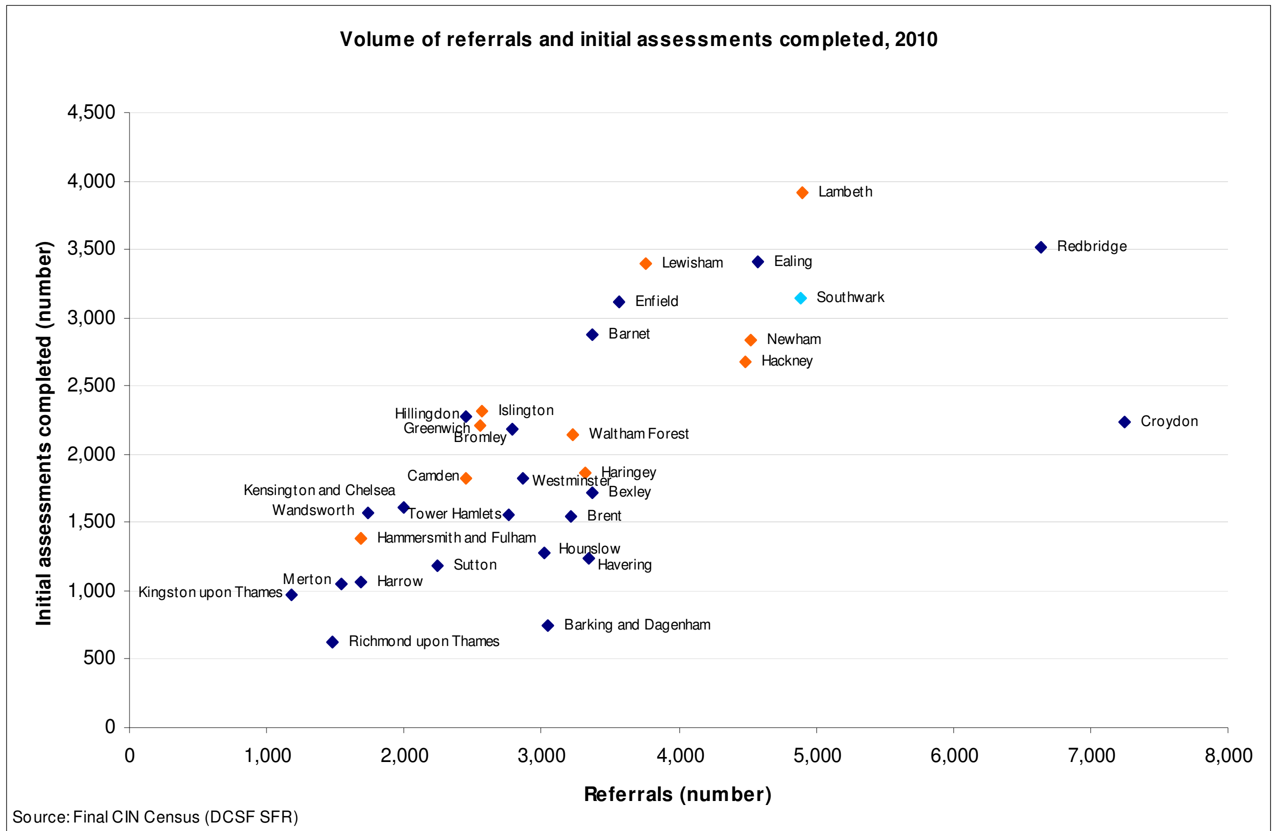
Southwark had the 5th highest number of children in need, improving from 2nd highest in the previous year and had the 4th highest rate per 10,000 children.

Volume and rate per 10,000 of Children in Need as at 31st March 2010



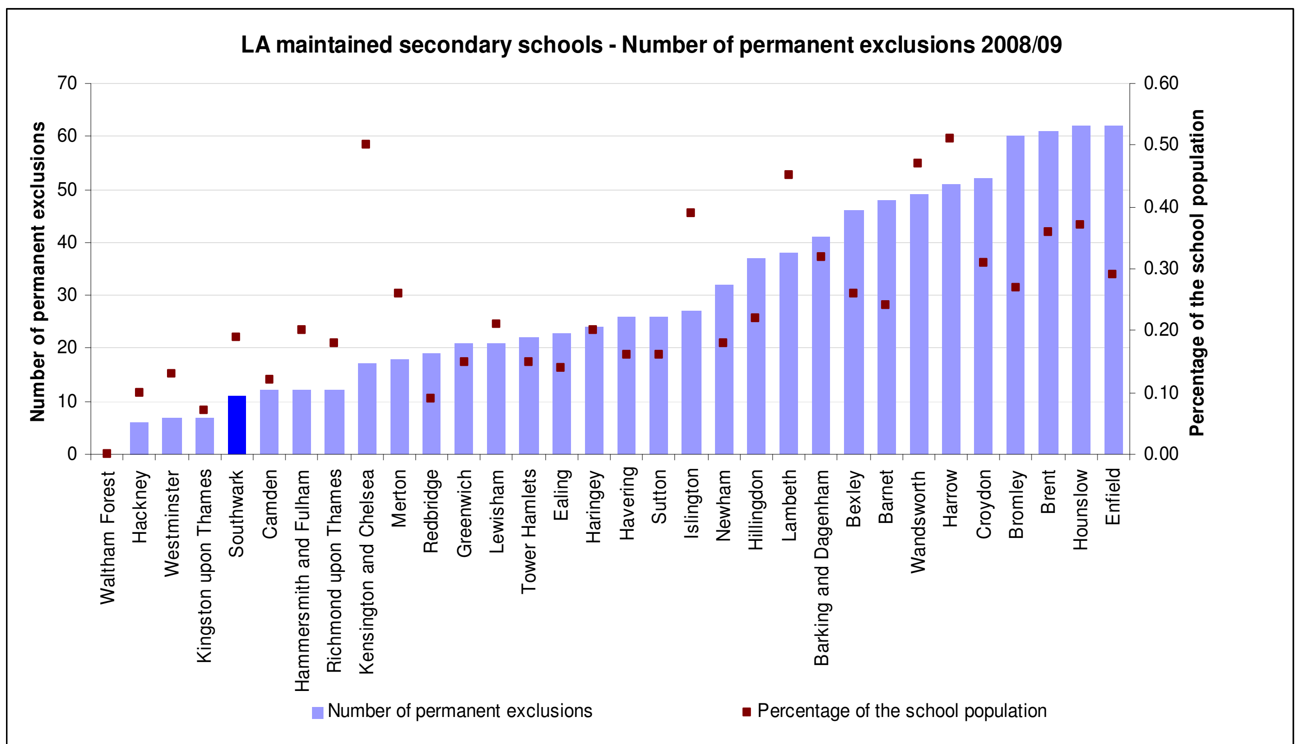
Source: Final CIN Census (DCSF SFR), excludes Hackney, Brent and Havering

Although there has been a slight decrease in the volumes of referrals and only a slight increase in initial assessments in 2010 we continue to have high levels compared to other London boroughs.

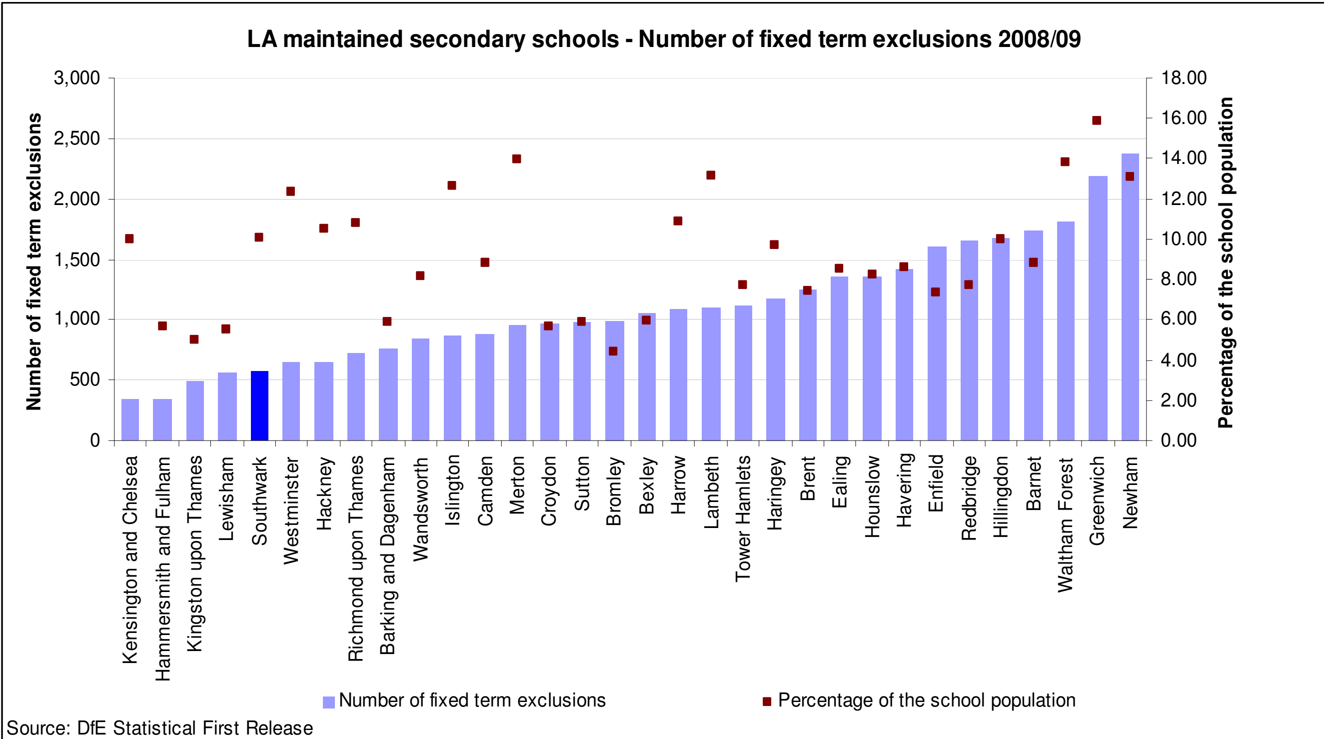


Exclusions

Southwark has the 5th lowest number of permanent exclusions out of the 32 London boroughs with 11 permanent exclusions in secondary maintained schools. This as a percentage of the school population is higher than England but lower than London. Out of the 32 boroughs in London this is the 19th highest.



In regards to fixed terms exclusions out of the 32 boroughs in London, Southwark has the 5th lowest number of fixed term exclusions (571 fixed term exclusions) in secondary maintained schools. However, as a percentage of the school population, it has the 11th highest fixed term exclusion rate (higher than England and London).



Source: http://www.education.gov.uk/rsgateway/DB/SFR/s000942/sfr22-2010la.xls

4. Young people in treatment recorded on NDTMS

Substance misuse

NTA data

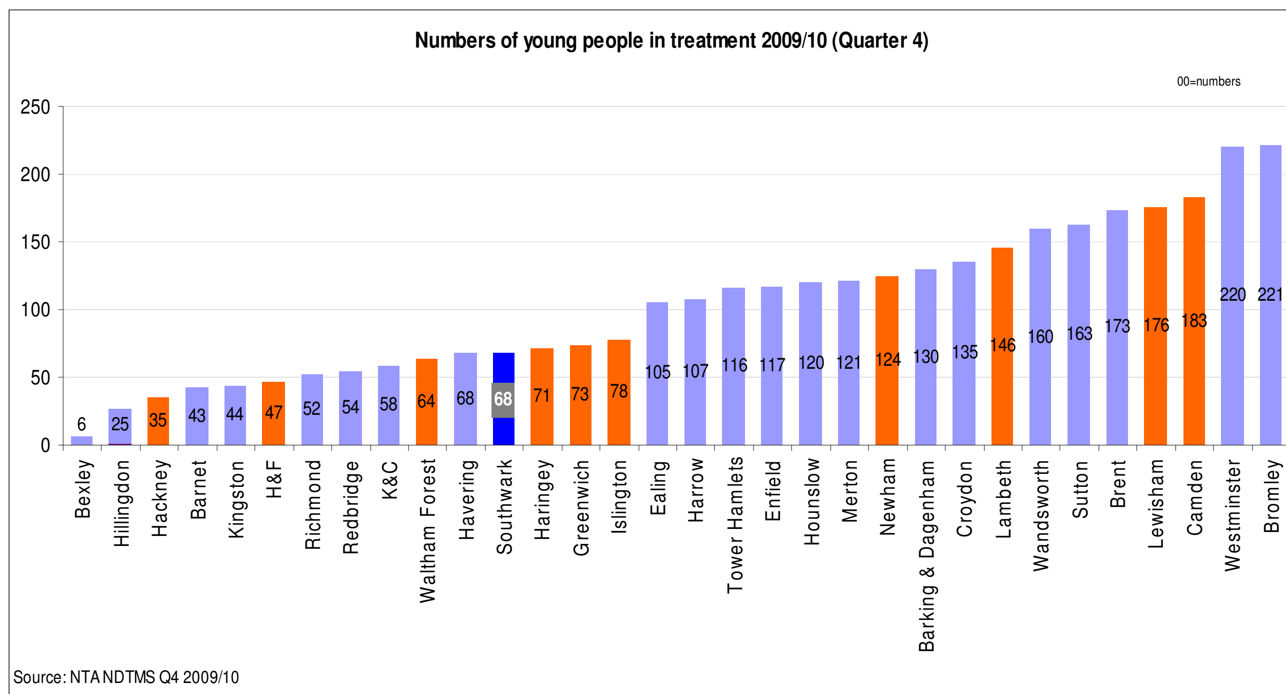
Using data released by the National Treatment Agency (NTA), comparisons between the agencies for those in treatment, referred and who had a treatment exit can be made. Figures have only been used if the number of people is more than 5. Southwark can be compared to its statistical neighbours and to London and national figures.

NTA quarter 4 data taken from the NDTMS was used for most charts. Where data was not available in quarter 4, the needs assessment data for 2009/10 from NTA was used. Quarter 4 data is cumulative from throughout the year so the figures for quarter 4 are also for year end.

More detailed analyses can be carried out in the future from the individual level dataset released by NTA. However, due to time limitations and a need to gain the knowledge required to properly interrogate the dataset, this has not been produced for this report.

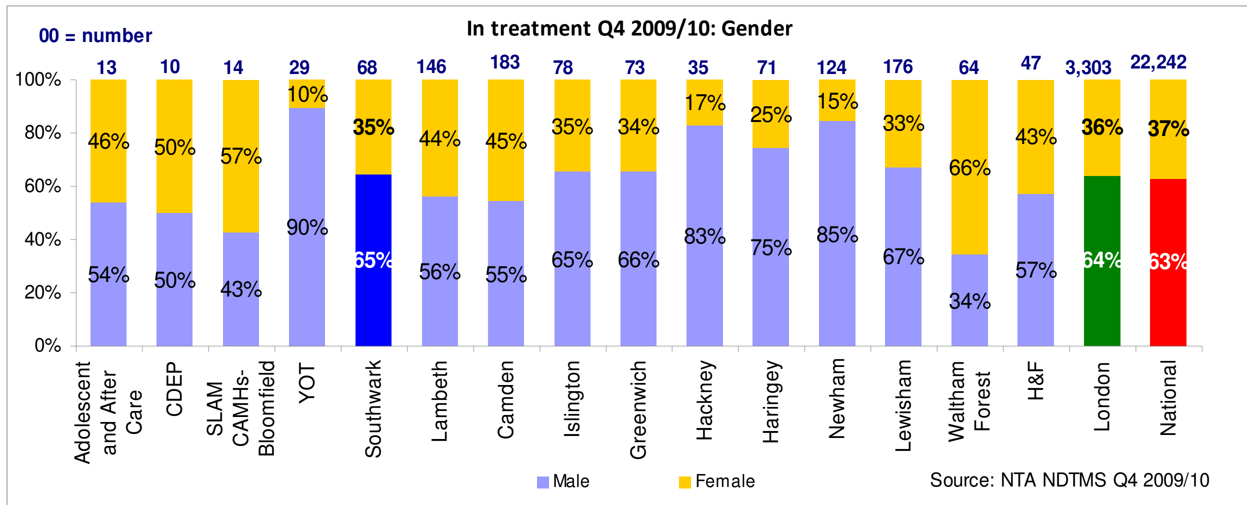
In treatment (2009/10)

Southwark had the twelfth lowest number of young people in treatment (68) in 2009/10 (at the end of quarter 4) out of all the London local authorities, compared to being eleventh lowest last year with 70 young people in treatment. Three of Southwark's statistical neighbours had lower numbers in treatment (the same as last year).



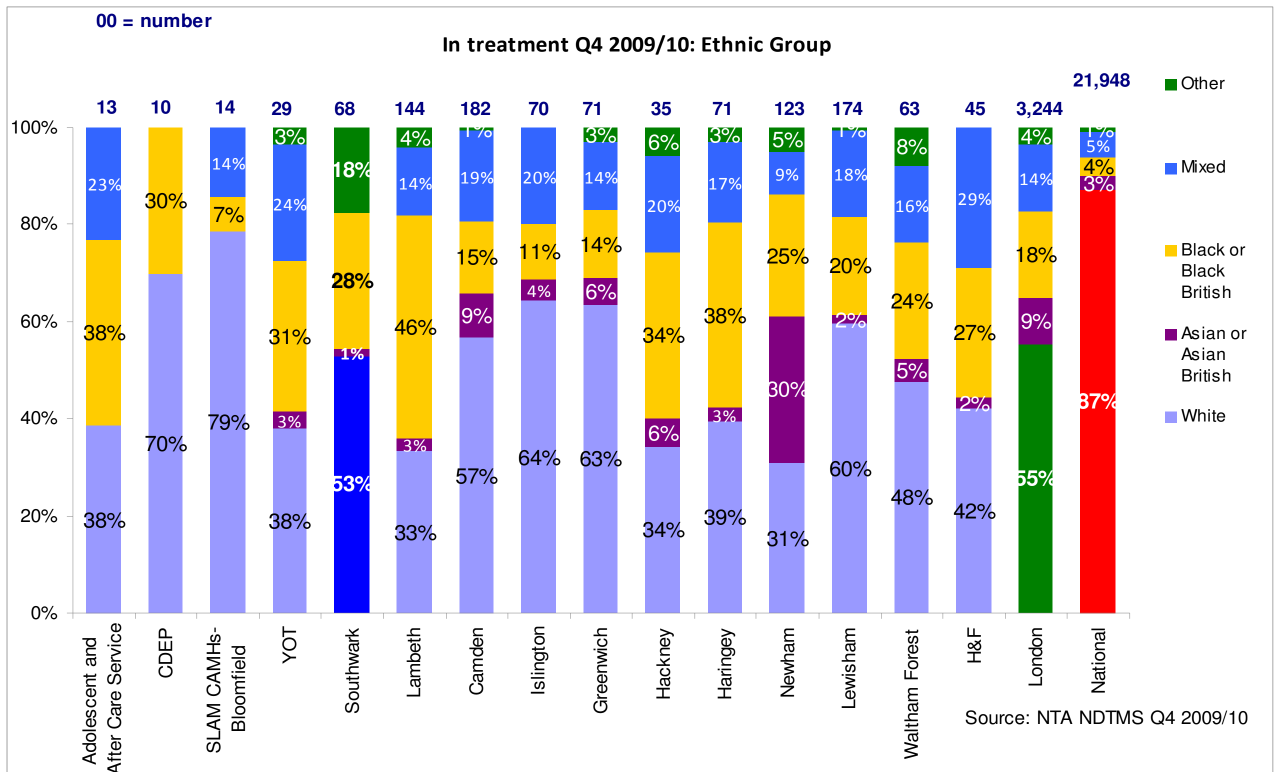
Gender

The Youth Offending Team (YOT) had the most people in treatment recorded (29) in 2009/10 out of the Southwark agencies and the largest proportion of males in treatment. The other agencies in Southwark had a more equal split, different to last year where the agencies had higher proportions of males than females. Almost two thirds of young people in treatment in Southwark were male compared to just over a half (51%) of the overall population of Southwark who are aged 13 to 17 who are male. This is lower than last year where almost three quarters of young people in Southwark were male. Southwark have a slightly larger proportions of males in treatment than London (64%) and England (63%).



Ethnicity

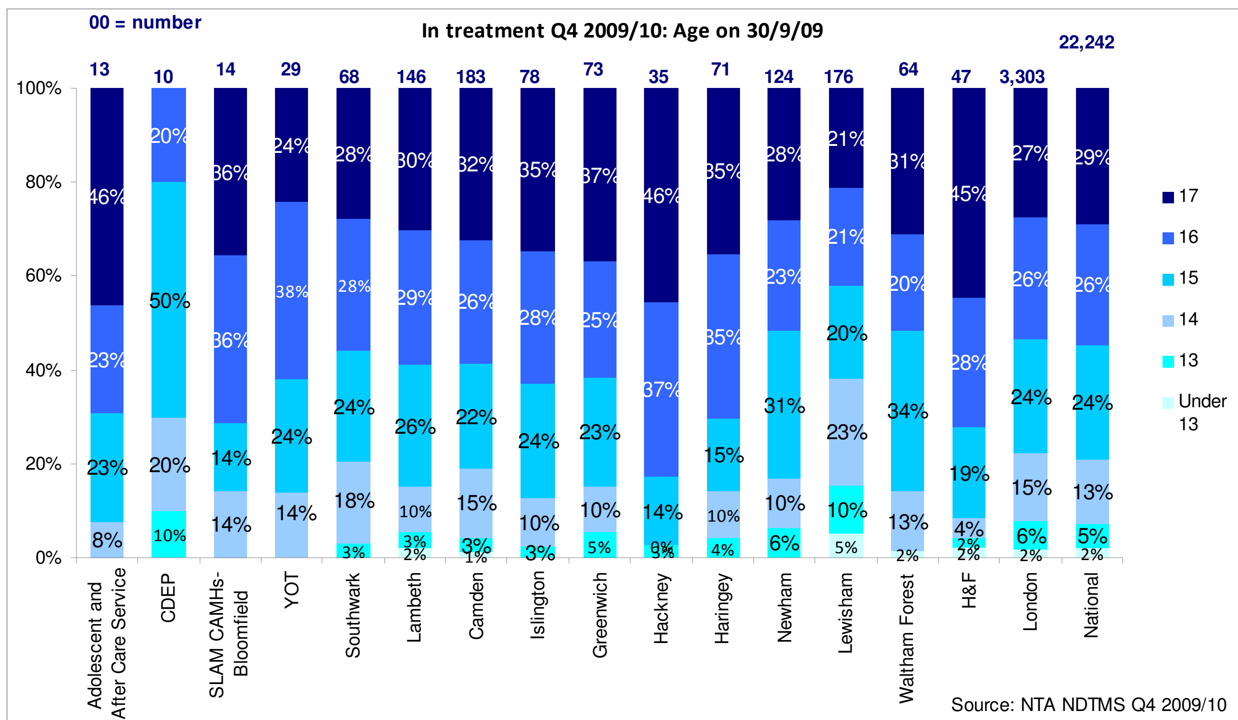
Not every person in treatment had an ethnic group recorded. For those that did have, the proportion of white people was lower than London in the Adolescent and After Care Service and the YOT but higher than London in the Community Drugs Education Project (CDEP) and the SLAM CAMHS (Bloomfield) where around three quarters of people in treatment were white. White people accounted for 55% of people in treatment in London. Nationally, almost 9 in 10 people in treatment were white. Just over a half of young people in treatment in Southwark were white compared to just under a half (49%) of the Southwark population of 10 to 17 year olds.
There is a lower proportion of Black or Black British young people in treatment (28%, slightly more than last year) compared to the population of Southwark who are aged 10 to 17 (a third, 34%).



Age

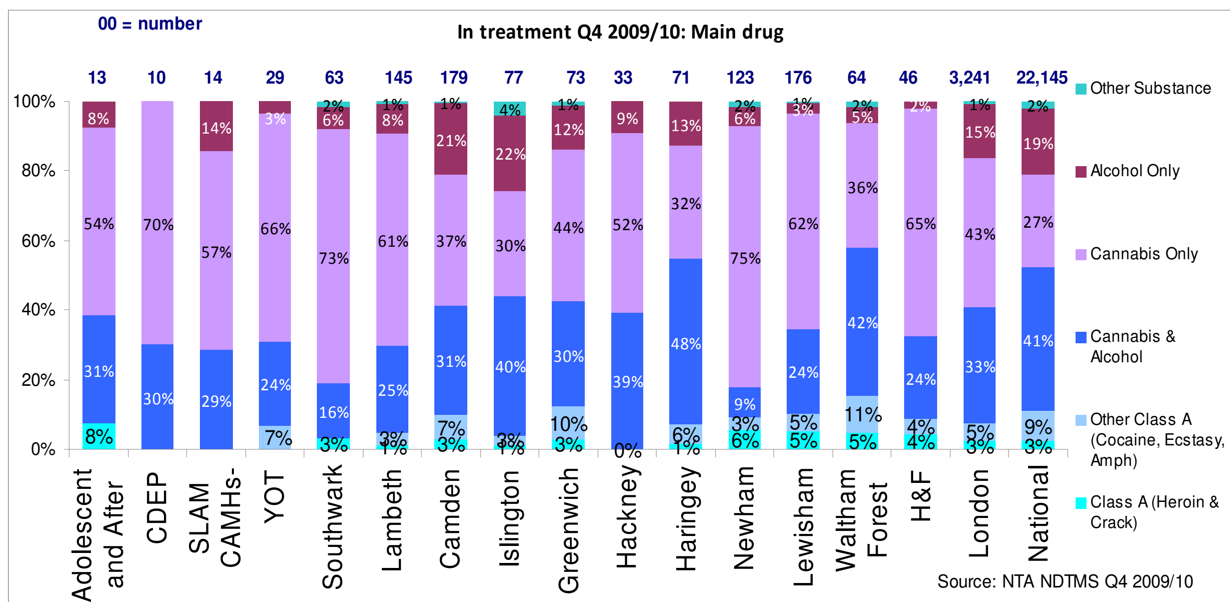
As was the case last year, none of the people in treatment in Southwark agencies were under 13. SLAM CAMHS (Bloomfield) and the YOT had similar age breakdowns, although the YOT had a higher proportion of younger people (38% of young people were aged 15 or under). The YOT still had a lower proportion of young people (aged 15 or under) compared to London (47%) and nationally (44%). All the young people in treatment at the CDEP were aged 16 or under whereas the Adolescent and After Care Service had an older age breakdown, with most people being aged 17.

The age breakdown of young people in treatment in Southwark is in line with the London and national age breakdown. In the 13 to 17 year old population of Southwark overall, there is an equal breakdown of each age.



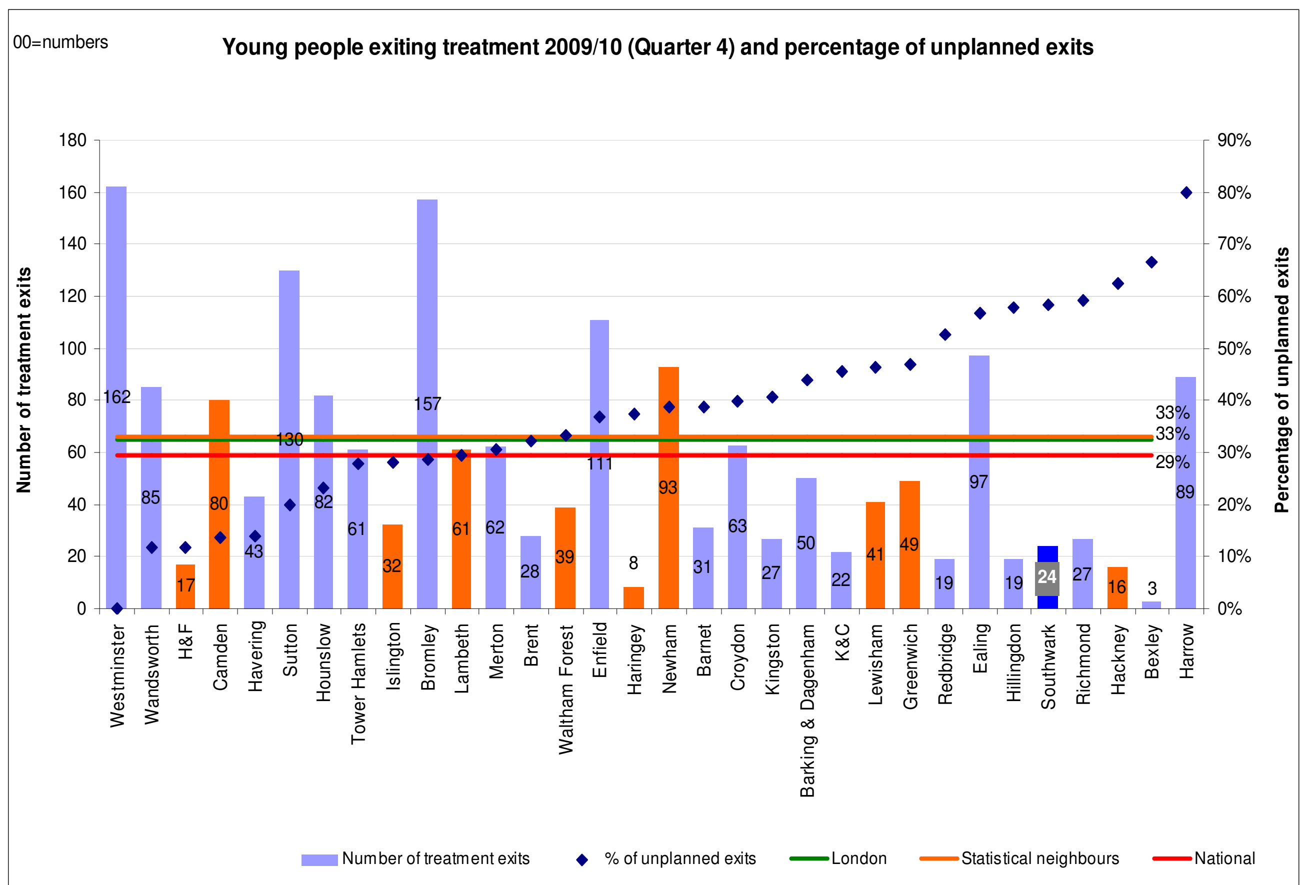
Substances used

Over half of young people in treatment in each Southwark agency have cannabis only as their substance, which is a higher proportion than London (43%) and England where only just over a quarter of people have this as their substance. Other than Newham, Southwark has the largest proportion out of the statistical neighbours of young people in treatment with cannabis only. Southwark has a much smaller proportion of young people with alcohol only (6%) compared to London (15%) and nationally (19%). Each Southwark agency has around a quarter to a third of young people in treatment with cannabis and alcohol misuse, which is the same as London. Southwark has 3% of young people with Class A misuse, which is the same as London and nationally.



Exiting treatment (2009/10)

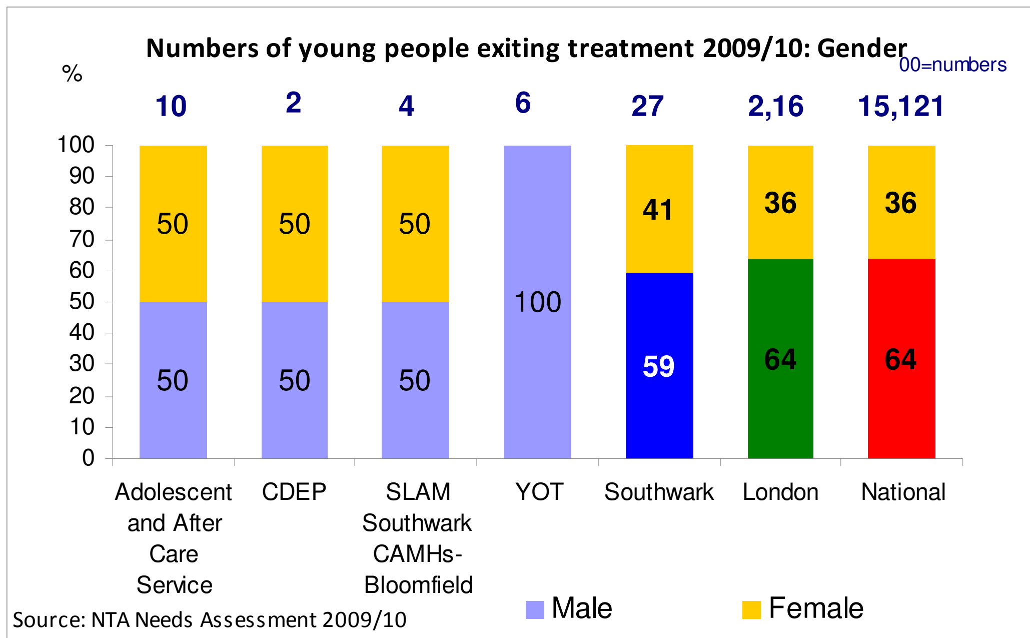
24 young people exited treatment by the end of quarter 4 2009/10 (one less than last year). This is a low number exiting compared to other London boroughs. As with last year, Westminster had the highest number of young people exiting treatment (162) and only seven boroughs had few exits than Southwark (five last year). Of all the young people exiting treatment in the year, Southwark had the fifth highest proportion of unplanned exits out of all the London boroughs (better than last year where Southwark had the highest). 58% of young people exiting treatment in Southwark left in an unplanned way (over three quarters did last year) compared to just under a third nationally and a third in London and the statistical neighbour average.



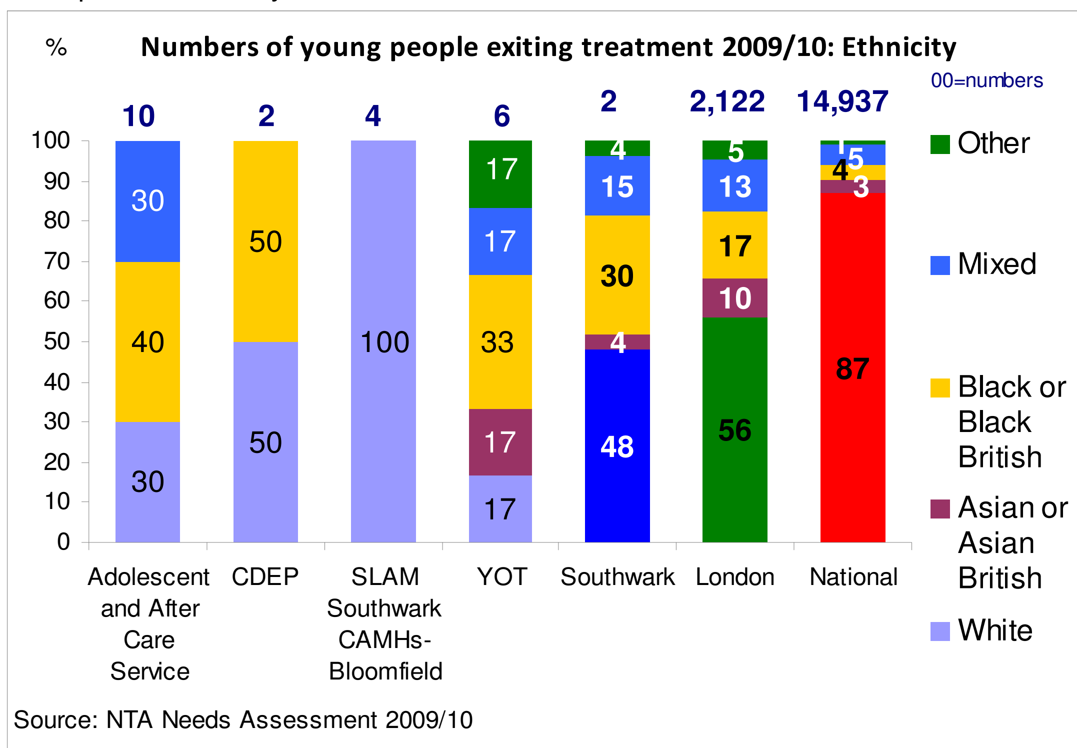
Source: NTA NDTMS Q4 2009/10

Looking at the needs assessment data released by the NTA for 2009/10, all of the six exits from the YOT were planned. However, all of the exits from the SLAM CAMHS Bloomfield were unplanned and 8 of the 10 exits from the Adolescent and After Care Service were unplanned.

The gender split for those exiting treatment in 2009/10 in London and nationally is about the same as those in treatment, as it is for Southwark's agencies. However for Southwark, the proportion of males exiting treatment is slightly lower than those in treatment (65% of those in treatment in 2009/10 were male whereas 59% of those exiting treatment were male). A higher proportion of males exited treatment in an planned way to an unplanned way (the opposite to last year). A lower proportion of females left treatment in a planned way however.

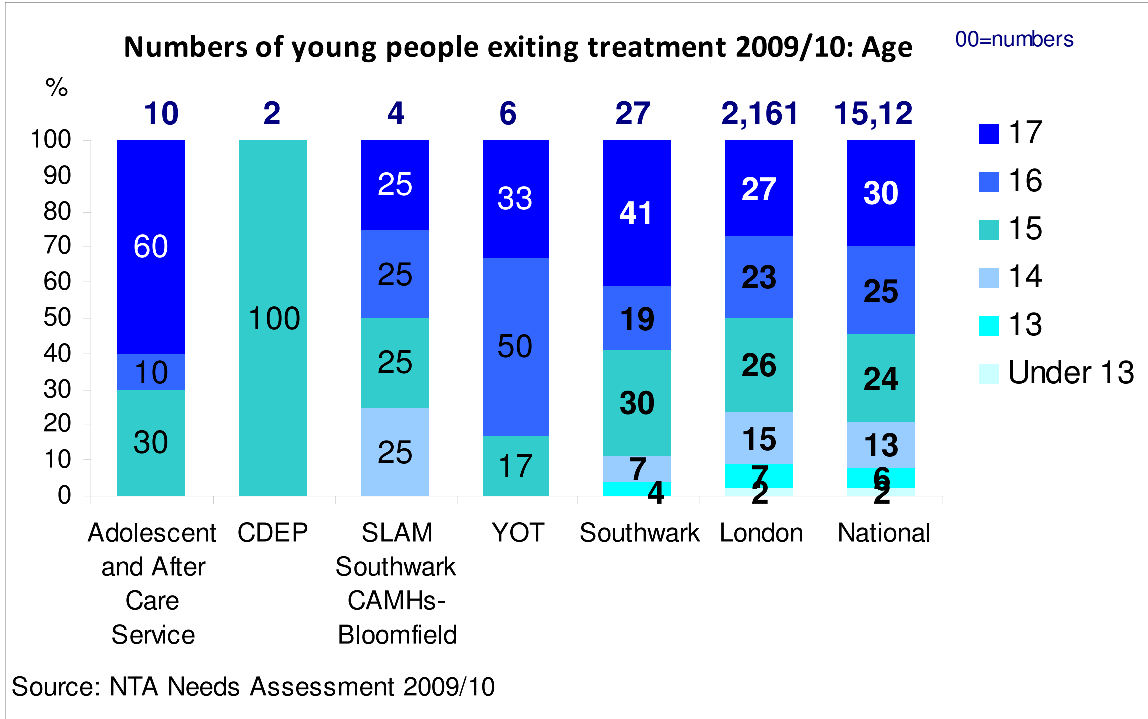


As with gender, the ethnic breakdown of young people exiting treatment nationally and in London is in line with those in treatment. Lower proportions of people exiting treatment from most of the Southwark agencies are white than those in treatment and slightly higher proportions are black. The same pattern applies for Southwark in general, and this follows the same pattern as last year too. The same proportions of young people exiting in a planned way are black as those exiting in an unplanned way but a larger proportion of those exiting in an unplanned way are white than those exiting in a planned way in Southwark. This is also the same pattern as last year.



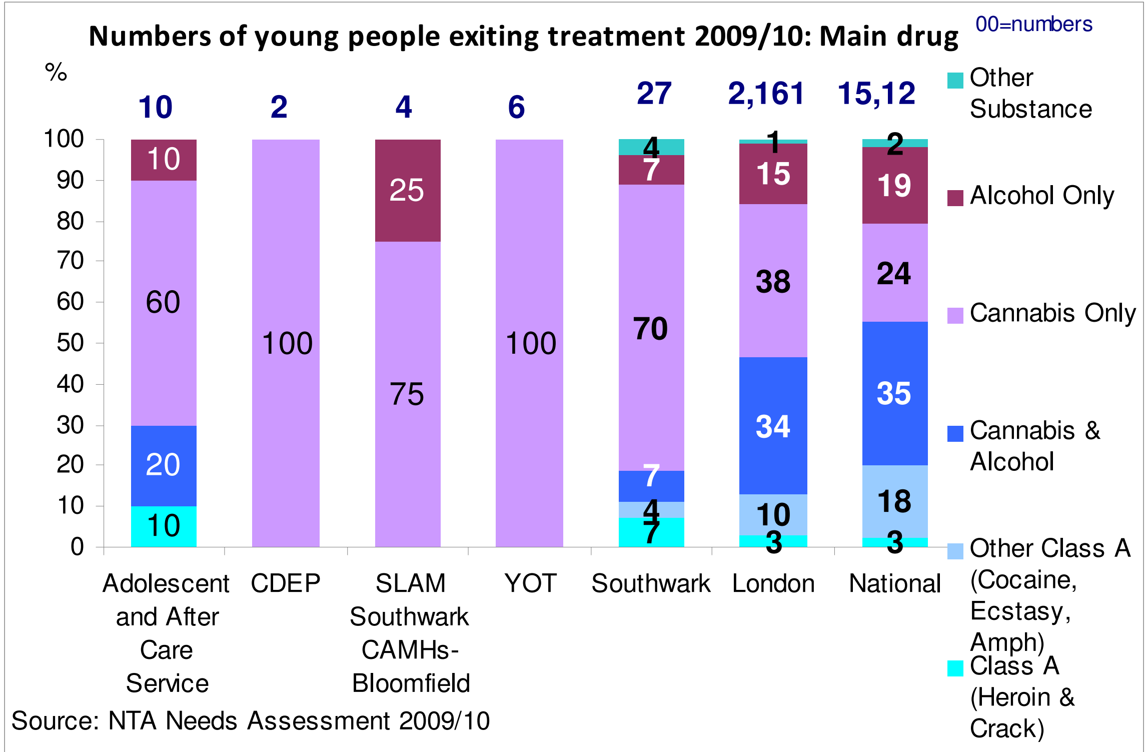
In London and nationally, the age breakdown of those exiting treatment in 2009/10 is about the same as those in treatment. In Southwark, 41% of those exiting treatment were aged 17 whereas only 28% of those in treatment were the same age.

As with young people in treatment, none of the people leaving treatment in Southwark agencies were under 13. A higher proportion of young people exiting the Adolescent and After Care Service were aged 17 than those in treatment.
Young people leaving treatment in a planned way were younger than those exiting in an unplanned way.



Source: NTA Needs Assessment 2009/10

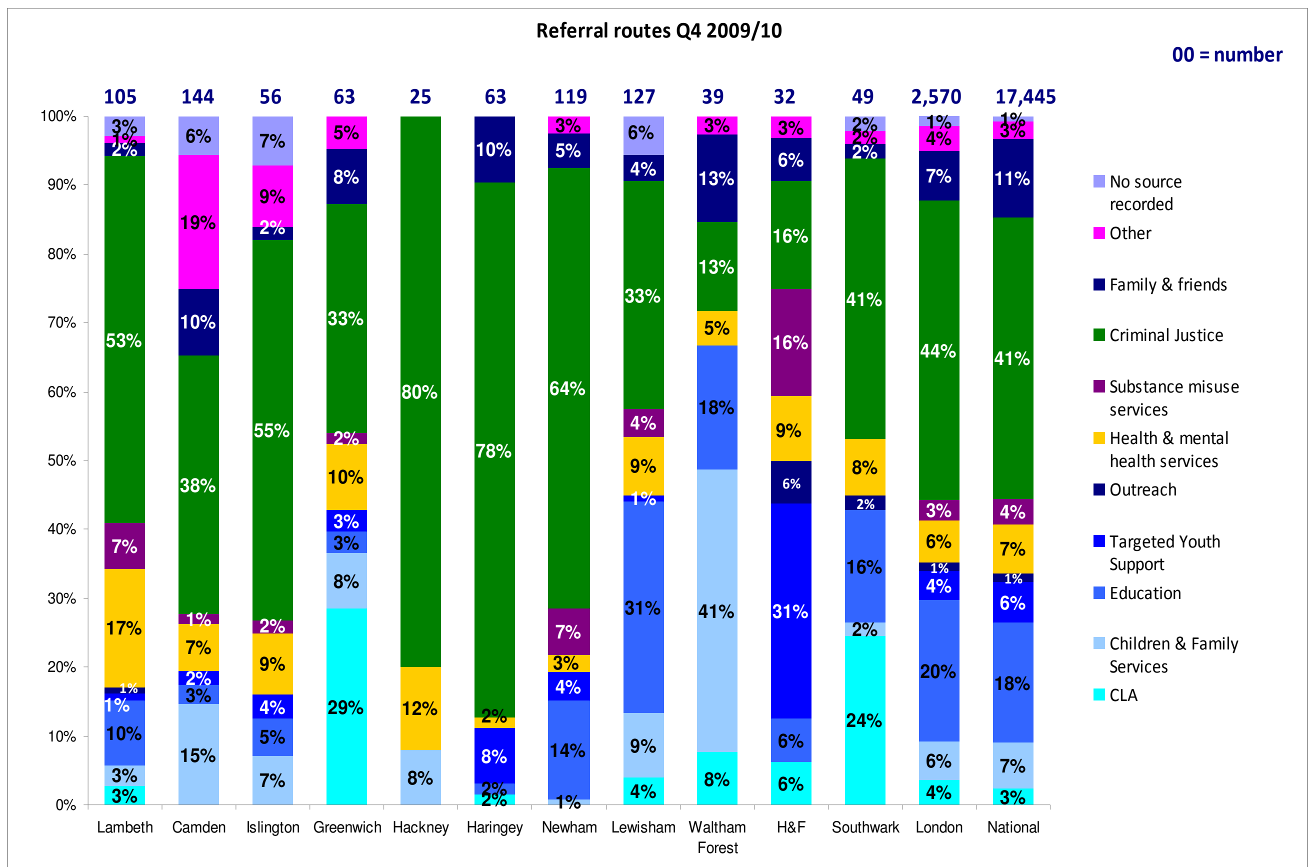
The patterns of those exiting treatment Southwark follows that of those in treatment in 2009/10, with the largest proportion of young people with cannabis only misuse. However, a higher proportion of those exiting had class A misuse to those in treatment (11% compared to just 3% in treatment).



Source: NTA Needs Assessment 2009/10

Referral routes into treatment (2009/10)

Almost a quarter of young people were referred into treatment from Children Looked After sources which is a much higher proportion than London and nationally (4% and 3% respectively). Most other sources of referral are in line with London and nationally except Southwark have a lower proportion of referrals from family and friends. Just over two fifths were referred from criminal justice sources, which is much more than last year where just a quarter were referred from this source, and puts Southwark more in line with the London, national and other statistical neighbour figures.



5. Current Treatment Provision

Blenheim CDP, Southwark Insight.

Southwark Insight, the stand alone young peoples substance missuue treatmnt service provided by Blenheim CDP is currently based at Cator Street, SE15, the service has a stable core team of 7 staff; with a small bank of sessional workers.

The service is currently working with 31 Tier 3 providing structured interventions for the young people. Due to various events and activities Insight currently have very high levels of contacts and tier 2 work with young people.

The service is working with CAMHS to develop a protocol for Tier 4 treatment access, needle exchange and prescribing.

The service has been raising its profile in Southwark, both with other agencies and Southwark young people (at events and on Reprezent radio). This work is leading to the building of working relationships and referral pathways with other services and providers.

Referral pathways are now established with the YOS and CLA and some satellites are being run in these services. Insight are also working with the Gateway project, a supported housing project for young people, running satellite clinics there.

Insight also provide young people specific basic drug awareness and screening/referral training. The aim of this is to ensure that all young people in Southwark will come into contact with a professional who will be able to engage them around their substance use and refer them to Insight if appropriate.

Cator Street was always viewed as a temporary venue, partly due to its location and associated gang issues. Blenheim CDP have secured a building near Elephant and Castle, on Amelia St. This is viewed as a relatively “neutral” area in relation to gangs and has good transport links across the borough. Work is planned to fit-out the premises to meet its aim of engaging with young people, offering other activities as well as information and treatment for substance misuse problems. It is expected this will be completed in spring 2011 and will have a high profile launch.

Family Interventions.

This years needs assessment for young people and adults has carried a strong recognition of the inter-generational nature of substance misuse and how this could be recognised in treatment provision. Southwark Insight do offer some support to parents and carers, however this does not reach the threshold of treatment. There are some family therapy provision within the borough, but this is often focussed on adult substance misuse or accessed through CAMHS (meaning the young person must also have a mental health problem).

The Family Intervention Programme (FIP) works with the families of young people who are offenders or at risk of offending. They are based in the YOS and in a recent snapshot of their cases identified 7 families where parental substance misuse was a considerable concern. This is a summary of 2 cases;

Family A:

- Couple with 7 children.
- Father is known to use Heroin but also dabbles in Crack Cocaine and Cannabis. He is on a methadone treatment programme.
- Still using illegal drugs along with the Methadone, he does not attend the counselling sessions that go along with the Methadone Treatment.
- The Parent is open and honest about his addiction and has disclosed that he supports his habit through crime.
- Uses some of the family's weekly benefits income to support his habit.
- Family have considerable debts and were at risk of eviction due to non payment of rent but this has now been resolved.
- 16 year old has also disclosed using skunk cannabis.

Family B:

- Mother is a lone parent who lives with her two sons aged 10 and 15.
- She is a victim of historical generational Domestic Violence and is now being victimised by her 15 year old son.
- She is known to smoke Cannabis and will smoke Cannabis with her eldest child and his friends.
- Her son says he is addicted to cannabis, consumes large quantities of alcohol and deals cannabis.
- When under the influence of substances will become abusibve and violent towards mother and sibling.
- Mother is not in any treatment programme and quite clearly states that she does not have a problem with her Cannabis usage.

Southwark, in collaboration with SL&M and the Institute of Psychiatry, is in the planning stages of a family therapy trial with an application being currently considered by the Health Technology Assessment Programme (HTA) for research funding. It is to research the effectiveness and cost effectiveness of family therapy interventions against other treatment interventions. It is a multi centred project; London, Leeds, Newcastle and Surrey. London will involve Southwark, Lambeth and Greenwich.

The family interventions will focus on alcohol and cannabis use and will compare the family intervention with the usual tier 3 intervention with the young person. This will necessitate an evaluation of the current treatment provision provided by Insight as the control group.

The aim of the intervention is to reduce substance use and enhance wellbeing. The length of the trial will be for approximately 2 years and in resource terms this will mean a family therapy team available to young people and an evaluation of the current tier 3 treatment provision. The trial will need to be coordinated and sufficient referrals will need to be made so this commitment will be sought from Children's Services and the DAAT.

6. Expert Group views.

The expert group met and discussed the preliminary findings of the needs assessment and also looked at current provision and what works well and areas where improvements could be made.

The expert group agreed that the main substances used by young people were cannabis and alcohol.

There was a strong recognition of the role of the family in substance misuse, both in its development and a in the importance of the family in addressing substance misuse. It was recognised that in some families substance misuse can be acceptable and that this impact on young people. The main view of the expert group was that services should be working to educate young people about substance misuse earlier than it seems they do at the moment, by working with young people still in primary education. This echoes the views of young people themselves.

The main points that came out of the group were;

- The young person needs to be seen in the context of being part of a family.
- Parental substance use impacts on young people, but there may be barriers to parents accessing treatment as they are concerned about social services becoming involved as they are parents.
- Training should be provided for staff around substance misuse, both in regard to adults and young people.
- Adult and young people’s services, including social services, should work more closely where needed.
- Substance misuse services, including those for young people, should have flexible and longer opening hours, young people should be supported to attend education and training, services that open only during office hours impact on education.

7. Young Peoples views and consultation.

For last years needs assessment, Reprezent radio carried out a consultation with young people in Southwark to gather their views on substance misuse in Southwark and how we could develop services to meet the need. The main points that emerged from this consultation was that the main drug used is cannabis, also alcohol is used and occasional reports of class A use and "pills". The consultation also highlighted the fact that the services that were available were not known to young people and that young people felt that education around drugs is not available in schools.

These findings are still relevant this year however Southwark Insight carried out a consultation with SILs pupils which have built on the previous findings. These are some of the comments from young people;

> *"I only smoke weed and I'm not going to do crack because I'm afraid"*
>
> *"Usually you start around 14 but I had my first weed at 7"*
>
> *"My mum used to give me lunch money but I was buying something else, I rather be high than eating"*
>
> *"When I was in mainstream (school), I new people that were having sniffs (referring to powder form cocaine), pills, they were smoking, having weed, being drunk. One student slipped and fall because she was so drunk"*
>
> *"I don't have sex if I'm drunk because I am not sure on myself" Some of the group felt there was a strong link "If you do a line and someone asks you to bend over you are more likely to do it"*

Focus groups were run in the SILS by BCDP Insight and the young people were asked at what age different substances were used by young people, these are results;

Age 12-14	**Age 14-16**	**Age 16-18**	**Age 18-24**
Alcohol	Alcohol	Alcohol	Alcohol
Cannabis	Cannabis	Cannabis	Cannabis
Solvents	Solvents	Magic Mushrooms	Magic Mushrooms
Cocaine (powder)	Cigarettes	Cigarettes	Tranquillizers
	Ecstasy	Ecstasy	Ecstasy
		Speed	Ketamine
		Cocaine	Cocaine & crack cocaine
			LSD
			Heroin

The young people also highlighted that drugs were often used at home; this was also something that adult service users highlighted.

> "*Everybody is smoking weed at home", "I remember when I was little that I used to smoke the end that they (family) left in the ashtray just to see how it was; except my mum tall the rest are smoking"*

8. Assessment of Workforce Coverage, Capacity and Training Needs

Southwark insight has the dual role of delivering substance misuse treatment to young people and supporting universal and targeted children's and young peoples services around substance misuse.

Blenheim CDP are an established substance misuse treatment provider and staff development is a priority in all their services. At Southwark Insight a skills audiot was carried out when the service was launched and training and resources have ensured that the staff team provide an up to date service.

To support universal and targeted children and young peoples Southwark Insight have developed a one day training package on basic drug awareness and referral to Southwark Insight. This is being delivered monthly, and after a slow start is becoming well attended. This is an area that would benefit from further development with staff from all children and young peoples services in Southwark having access to this training.

9. Key Findings / Priorities

The launch of a stand alone young peoples substance misuse service in Southwark, BCDP Insight, has meant that access to treatment and early intervention for young people has been significantly improved. However treatment figures do not yet reflect this and there remains some key areas where improvements could be made. This will be done by establishing the new service in the fit-for-purpose new premises adn continuing to raise the profile of the service. Work already done to establish referral pathways as will the delivery of training by Southwark Insight.

Cannabis and alcohol continue to be the substance most used by young people in Southwark and the strongest emerging theme from the needs assessment was the recognition of the inter-generational nature of substance misuse and how this can be recognised in addressing the issue.

- Increase the number of young people in treatment by:
    e. Increasing attendance by Children's Service staff and other identified agencies at the training provided by insight
    f. Increasing referral routes from all services
    g. Increasing the profile of the service in the Borough
    h. Complete protocols and practice guidelines to ensure that pharmacological and residential substance misuse treatment services can be accessed where needed.

- Plan and implement family therapy intervention pilot.

Appendix 1

In treatment (2009/10): NTA NTDMS Quarter 4 data

	Lambeth		Camden		Islington		Greenwich		Hackney		Haringey		Newham		Lewisham		Waltham Forest		H&F		Southwark		London		National	
In treatment 2009/10	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Gender																										
Male	82	56%	100	55%	51	65%	48	66%	29	83%	53	75%	105	85%	118	67%	22	34%	27	57%	44	65%	2116	64%	13950	63%
Female	64	44%	83	45%	27	35%	25	34%	6	17%	18	25%	19	15%	58	33%	42	66%	20	43%	24	35%	1187	36%	8300	37%
Total	**146**	**100%**	**183**	**100%**	**78**	**100%**	**73**	**100%**	**35**	**100%**	**71**	**100%**	**124**	**100%**	**176**	**100%**	**64**	**100%**	**47**	**100%**	**68**	**100%**	**3303**	**100%**	**22250**	**100%**
Ethnic group																										
White	48	33%	103	57%	45	64%	45	63%	12	34%	28	39%	38	31%	104	60%	30	48%	19	42%	36	53%	1797	55%	19117	87%
Asian or Asian British	4	3%	17	9%	3	4%	4	6%	2	6%	2	3%	37	30%	3	2%	3	5%	1	2%	1	1%	307	9%	662	3%
Black or Black British	66	46%	27	15%	8	11%	10	14%	12	34%	27	38%	31	25%	35	20%	15	24%	12	27%	19	28%	583	18%	841	4%
Mixed	20	14%	34	19%	14	20%	10	14%	7	20%	12	17%	11	9%	31	18%	10	16%	13	29%	12	18%	443	14%	1138	5%
Other	6	4%	1	1%			2	3%	2	6%	2	3%	6	5%	1	1%	5	8%					114	4%	190	1%
Total	**144**	**100%**	**182**	**100%**	**70**	**100%**	**71**	**100%**	**35**	**100%**	**71**	**100%**	**123**	**100%**	**174**	**100%**	**63**	**100%**	**45**	**100%**	**68**	**100%**	**3244**	**100%**	**21948**	**100%**
Age on 30th September 2008																										
Under 13	3	2%	2	1%											9	5%	1	2%	1	2%			58	2%	463	2%
13	5	3%	6	3%	2	3%	4	5%	1	3%	3	4%	8	6%	18	10%			1	2%	2	3%	200	6%	1176	5%
14	14	10%	27	15%	8	10%	7	10%			7	10%	13	10%	40	23%	8	13%	2	4%	12	18%	479	15%	2992	13%
15	38	26%	41	22%	19	24%	17	23%	5	14%	11	15%	39	31%	35	20%	22	34%	9	19%	16	24%	799	24%	5432	24%
16	42	29%	48	26%	22	28%	18	25%	13	37%	25	35%	29	23%	37	21%	13	20%	13	28%	19	28%	861	26%	5738	26%
17	44	30%	59	32%	27	35%	27	37%	16	46%	25	35%	35	28%	37	21%	20	31%	21	45%	19	28%	906	27%	6449	29%
Total	**146**	**100%**	**183**	**100%**	**78**	**100%**	**73**	**100%**	**35**	**100%**	**71**	**100%**	**124**	**100%**	**176**	**100%**	**64**	**100%**	**47**	**100%**	**68**	**100%**	**3303**	**100%**	**22250**	**100%**
Main drug																										
Class A (Heroin & Crack)	2	1%	5	3%	1	1%	2	3%			1	1%	7	6%	9	5%	3	5%	2	4%	2	3%	82	3%	562	3%
Other Class A (Cocaine, Ecstasy, Amph)	5	3%	13	7%	2	3%	7	10%			4	6%	4	3%	9	5%	7	11%	2	4%			158	5%	1940	9%
Cannabis & Alcohol	36	25%	56	31%	31	40%	22	30%	13	39%	34	48%	11	9%	43	24%	27	42%	11	24%	10	16%	1084	33%	9070	41%
Cannabis Only	89	61%	67	37%	23	30%	32	44%	17	52%	23	32%	92	75%	109	62%	23	36%	30	65%	46	73%	1390	43%	5918	27%
Alcohol Only	12	8%	37	21%	17	22%	9	12%	3	9%	9	13%	7	6%	5	3%	3	5%	1	2%	4	6%	498	15%	4238	19%
Other Substance	1	1%	1	1%	3	4%	1	1%					2	2%	1	1%	1	2%			1	2%	29	1%	417	2%
Total	**145**	**100%**	**179**	**100%**	**77**	**100%**	**73**	**100%**	**33**	**100%**	**71**	**100%**	**123**	**100%**	**176**	**100%**	**64**	**100%**	**46**	**100%**	**63**	**100%**	**3241**	**100%**	**22145**	**100%**
Injecting Status																										
Current											1	5%			1	1%			1	3%			5	0%	106	1%
Previous													1	1%	2	2%			1	3%	1	7%	14	1%	168	1%
Never	70	100%	3	100%	45	100%	36	100%	23	100%	21	95%	100	99%	105	97%	30	100%	27	93%	14	93%	1823	99%	13957	98%
Total	**70**	**100%**	**3**	**100%**	**45**	**100%**	**36**	**100%**	**23**	**100%**	**22**	**100%**	**101**	**100%**	**108**	**100%**	**30**	**100%**	**29**	**100%**	**15**	**100%**	**1842**	**100%**	**14231**	**100%**
GrandTotal	**146**		**183**		**78**		**73**		**35**		**71**		**124**		**176**		**64**		**47**		**68**		**3303**		**22242**	

	Adolescent and After Care Service		CDEP		Lambeth Drugs Education Team		SLAM CAMHs - Lambeth		SLAM - Lambeth & Southwark CDT-		SLAM Southwark CAMHs-Belgrave		SLAM CAMHs-Bloomfield		SLAM Southwark Psychological		Social Services		YOT		TP ACAPS - Lewisham		Southwark		London		National	
In treatment 2009/10	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Gender																												
Male	7	54%	5	50%	1	50%							6	43%			3	100%	26	90%	2	100%	44	65%	2116	64%	13950	63%
Female	6	46%	5	50%	1	50%	1	100%	1	100%	2	100%	8	57%	1	100%			3	10%			24	35%	1187	36%	8300	37%
Total	**13**		**10**		**2**		**1**		**1**		**2**		**14**		**1**		**3**		**29**		**2**		**68**	100%	**3303**	**100%**	**22250**	**100%**
Ethnic group																												
White	5	38%	7	70%	1	50%	1	100%	1	100%	1	50%	11	79%	1	100%	1	33%	11	38%	2	100%	36	53%	1797	55%	19117	87%
Asian or Asian British																			1	3%			1	1%	307	9%	662	3%
Black or Black British	5	38%	3	30%	1	50%							1	7%			1	33%	9	31%			19	28%	583	18%	841	4%
Mixed	3	23%									1	50%	2	14%			1		7	24%								
Other																			1	3%			12	18%	557	17%	1328	6%
Total	**13**		**10**		**2**		**1**		**1**		**2**		**14**		**1**		**3**		**29**		**2**		**68**	100%	**3244**	**100%**	**21948**	**100%**
Age on 30th September 2008																												
Under 13																									58	2%	463	2%
13			1	10%																	1	50%	2	3%	200	6%	1176	5%
14	1	8%	2	20%	1	50%							2	14%					4	14%			12	18%	479	15%	2992	13%
15	3	23%	5	50%	1	50%					1	50%	2	14%	1	100%	1	33%	7	24%	1	50%	16	24%	799	24%	5432	24%
16	3	23%	2	20%									5	36%					11	38%			19	28%	861	26%	5738	26%
17	6	46%					1	100%	1	100%	1	50%	5	36%			2	67%	7	24%			19	28%	906	27%	6449	29%
Total	**13**		**10**		**2**		**1**		**1**		**2**		**14**		**1**		**3**		**29**		**2**		**68**	100%	**3303**	**100%**	**22250**	**100%**
Main drug																												
Class A (Heroin & Crack)	1	8%							1	100%	1	50%			1	100%							2	3%	82	3%	562	3%
Other Class A (Cocaine, Ecstasy, Amph)							1	100%											2	7%					158	5%	1940	9%
Cannabis & Alcohol	4	31%	3	30%									4	29%			2	67%	7	24%			10	16%	1084	33%	9070	41%
Cannabis Only	7	54%	7	70%	1	50%					1	50%	8	57%			1	33%	19	66%	1	50%	46	73%	1390	43%	5918	27%
Alcohol Only	1	8%											2	14%					1	3%	1	50%	4	6%	498	15%	4238	19%
Other Substance					1	50%																	1	2%	29	1%	417	2%
Total	**13**		**10**		**2**		**1**		**1**		**2**		**14**		**1**		**3**		**29**		**2**		**63**	100%	**3241**	**100%**	**22145**	**100%**
Injecting Status																												
Current																									5	0%	106	1%
Previous			1	13%									1	14%									1	7%	14	1%	168	1%
Never	2	100%	7	88%	2	100%	1	100%	1	100%	1	100%	6	86%					7		2	100%	14	93%	1823	99%	13957	98%
Total	**2**		**8**		**2**		**1**		**1**		**1**		**7**						**7**		**2**		**15**	100%	**1842**	**100%**	**14231**	**100%**
GrandTotal	**13**		**10**		**2**		**1**		**1**		**2**		**14**		**1**		**3**		**29**		**2**		**68**		**3303**		**22242**	

Exiting treatment (2009/10): NTA NTDMS Quarter 4 data

Agency	Planned	% of planned exits	Unplanned	% of unplanned exits	Referred On	% referred on	Number of treatment exits
Westminster	148	91%	0	0%	14	9%	**162**
Wandsworth	73	86%	10	12%	2	2%	**85**
H&F	12	71%	2	12%	3	18%	**17**
Camden	69	86%	11	14%	0	0%	**80**
Havering	10	23%	6	14%	27	63%	**43**
Sutton	47	36%	26	20%	57	44%	**130**
Hounslow	62	76%	19	23%	1	1%	**82**
Tower Hamlets	38	62%	17	28%	6	10%	**61**
Islington	20	63%	9	28%	3	9%	**32**
Bromley	75	48%	45	29%	37	24%	**157**
Lambeth	41	67%	18	30%	2	3%	**61**
Merton	40	65%	19	31%	3	5%	**62**
Brent	19	68%	9	32%	0	0%	**28**
Waltham Forest	21	54%	13	33%	5	13%	**39**
Enfield	24	22%	41	37%	46	41%	**111**
Haringey	3	38%	3	38%	2	25%	**8**
Newham	45	48%	36	39%	12	13%	**93**
Barnet	10	32%	12	39%	9	29%	**31**
Croydon	33	52%	25	40%	5	8%	**63**
Kingston	13	48%	11	41%	3	11%	**27**
Barking & Dagenham	18	36%	22	44%	10	20%	**50**
K&C	9	41%	10	45%	3	14%	**22**
Lewisham	16	39%	19	46%	6	15%	**41**
Greenwich	22	45%	23	47%	4	8%	**49**
Redbridge	7	37%	10	53%	2	11%	**19**
Ealing	24	25%	55	57%	18	19%	**97**
Hillingdon	8	42%	11	58%	0	0%	**19**
Southwark	**9**	**38%**	**14**	**58%**	**1**	**4%**	**24**
Richmond	9	33%	16	59%	2	7%	**27**
Hackney	4	25%	10	63%	2	13%	**16**
Bexley	1	33%	2	67%	0	0%	**3**
Harrow	18	20%	71	80%	0	0%	**89**
London	**948**	**52%**	**595**	**33%**	**285**	**16%**	**1828**
Statistical Neighbours	**253**	**58%**	**144**	**33%**	**39**	**9%**	**436**
National	**7122**	**55%**	**3789**	**29%**	**1989**	**15%**	**12900**

Exiting treatment (2009/10): NTA NTDMS Needs Assessment data – total treatment exits

	Adolescent and After Care Service		CDEP		Lambeth Drug Education Team		SLAM CAMHS - Lambeth		SLAM Lambeth & Southwar		SLAM Southwa rk CAMHs-		YOT		TP ACAPS - Lewisha m		Southwark		London		National	
Total treatment exit	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Gender																						
Male	5	50	1	50	1	50	0	0	0	0	2	50	6	100	1	100	16	59	1377	64	9710	64
Female	5	50	1	50	1	50	1	100	1	100	2	50	0	0	0	0	11	41	784	36	5411	36
Total	**10**	100	**2**	100	**2**	100	**1**	100	**1**	100	**4**	100	**6**	100	**1**	100	**27**	100	**2161**	100	**15121**	100
Ethnic group																						
White	3	30	1	50	1	50	1	100	1	100	4	100	1	17	1	100	13	48	1185	56	12982	87
Asian or Asian British	0	0	0	0	0	0	0	0	0	0	0	0	1	17	0	0	1	4	212	10	481	3
Black or Black British	4	40	1	50	1	50	0	0	0	0	0	0	2	33	0	0	8	30	353	17	578	4
Mixed	3	30	0	0	0	0	0	0	0	0	0	0	1	17	0	0	4	15	271	13	748	5
Other	0	0	0	0	0	0	0	0	0	0	0	0	1	17	0	0	1	4	101	5	148	1
Total	**10**	100	**2**	100	**2**	100	**1**	100	**1**	100	**4**	100	**6**	100	**1**	100	**27**	100	**2122**	100	**14937**	100
Age on 30th September 2008																						
Under 13	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	49	2	313	2
13	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	100	1	4	141	7	871	6
14	0	0	0	0	1	50	0	0	0	0	1	25	0	0	0	0	2	7	323	15	2000	13
15	3	30	2	100	1	50	0	0	0	0	1	25	1	17	0	0	8	30	563	26	3682	24
16	1	10	0	0	0	0	0	0	0	0	1	25	3	50	0	0	5	19	498	23	3733	25
17	6	60	0	0	0	0	1	100	1	100	1	25	2	33	0	0	11	41	587	27	4522	30
Total	**10**	100	**2**	100	**2**	100	**1**	100	**1**	100	**4**	100	**6**	100	**1**	100	**27**	100	**2161**	100	**15121**	100
Main drug																						
Class A (Heroin & Crack	1	10	0	0	0	0	0	0	1	100	0	0	0	0	0	0	2	7	65	3	385	3
Other Class A (Cocaine,	0	0	0	0	0	0	1	100	0	0	0	0	0	0	0	0	1	4	213	10	2665	18
Cannabis & Alcohol	2	20	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	7	726	34	5335	35
Cannabis Only	6	60	2	100	1	50	0	0	0	0	3	75	6	100	1	100	19	70	813	38	3629	24
Alcohol Only	1	10	0	0	0	0	0	0	0	0	1	25	0	0	0	0	2	7	325	15	2828	19
Other Substance	0	0	0	0	1	50	0	0	0	0	0	0	0	0	0	0	1	4	19	1	279	2
Total	**10**	100	**2**	100	**2**	100	**1**	100	**1**	100	**4**	100	**6**	100	**1**	100	**27**	100	**2161**	100	**15121**	100
Injecting Status																						
Current	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	86	1
Previous	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11	1	136	1
Never	1	100	2	100	2	100	1	100	1	100	1	100	1	100	1	100	10	100	1680	99	13100	98
Total	**1**	100	**2**	100	**2**	100	**1**	100	**1**	100	**1**	100	**1**	100	**1**	100	**10**	100	**1694**	100	**13322**	100
GrandTotal	**10**	**100**	**2**	**100**	**2**	**100**	**1**	**100**	**1**	**100**	**4**	**100**	**6**	**100**	**1**	**100**	**27**	**100**	**2161**	**100**	**15121**	**100**

Exiting treatment (2009/10): NTA NTDMS Needs Assessment data – planned treatment exits

	Adolescent and After Care Service		CDEP		Lambeth Drug Education Team		SLAM CAMHS - Lambeth		YOT		TP ACAPS - Lewisham		Southwark		London		National	
Planned treatment exit	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Gender																		
Male	0	0	1	100	1	50	0	0	6	100	1	100	9	69	1034	64	7292	64
Female	2	100	0	0	1	50	1	100	0	0	0	0	4	31	587	36	4114	36
Total	**2**	100	**1**	100	**2**	100	**1**	100	**6**	100	**1**	100	**13**	100	**1621**	100	**11406**	100
Ethnic group																		
White	1	50	0	0	1	50	1	100	1	17	1	100	5	38	873	55	9789	87
Asian or Asian British	0	0	0	0	0	0	0	0	1	17	0	0	1	8	166	10	362	3
Black or Black British	0	0	1	100	1	50	0	0	2	33	0	0	4	31	259	16	430	4
Mixed	1	50	0	0	0	0	0	0	1	17	0	0	2	15	214	13	588	5
Other	0	0	0	0	0	0	0	0	1	17	0	0	1	8	82	5	119	1
Total	**2**	100	**1**	100	**2**	100	**1**	100	**6**	100	**1**	100	**13**	100	**1594**	100	**11288**	100
Age on 30th September 2008																		
Under 13	0	0	0	0	0	0	0	0	0	0	0	0	0	0	44	3	269	2
13	0	0	0	0	0	0	0	0	0	0	1	100	1	8	116	7	711	6
14	0	0	0	0	1	50	0	0	0	0	0	0	1	8	264	16	1591	14
15	1	50	1	100	1	50	0	0	1	17	0	0	4	31	411	25	2874	25
16	0	0	0	0	0	0	0	0	3	50	0	0	3	23	368	23	2723	24
17	1	50	0	0	0	0	1	100	2	33	0	0	4	31	418	26	3238	28
Total	**2**	100	**1**	100	**2**	100	**1**	100	**6**	100	**1**	100	**13**	100	**1621**	100	**11406**	100
Main drug																		
Class A (Heroin & Crack	0	0	0	0	0	0	0	0	0	0	0	0	0	0	44	3	279	2
Other Class A (Cocaine,	0	0	0	0	0	0	1	100	0	0	0	0	1	8	163	10	1919	17
Cannabis & Alcohol	1	50	0	0	0	0	0	0	0	0	0	0	1	8	549	34	4015	35
Cannabis Only	0	0	1	100	1	50	0	0	6	100	1	100	9	69	579	36	2651	23
Alcohol Only	1	50	0	0	0	0	0	0	0	0	0	0	1	8	268	17	2311	20
Other Substance	0	0	0	0	1	50	0	0	0	0	0	0	1	8	18	1	231	2
Total	**2**	100	**1**	100	**2**	100	**1**	100	**6**	100	**1**	100	**13**	100	**1621**	100	**11406**	100
Injecting Status																		
Current	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	62	1
Previous	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	0	92	1
Never	1	100	1	100	2	100	1	100	1	100	1	100	7	100	1279	99	9900	98
Total	**1**	100	**1**	100	**2**	100	**1**	100	**1**	100	**1**	100	**7**	100	**1286**	100	**10054**	100
GrandTotal	**2**	**100**	**1**	**100**	**2**	**100**	**1**	**100**	**6**	**100**	**1**	**100**	**13**	**100**	**1621**	**100**	**11406**	**100**

Exiting treatment (2009/10): NTA NTDMS Needs Assessment data – unplanned treatment exits

	Adolescent and After Care Service		CDEP		SLAM Lambeth & Southwark CDT-Marina		SLAM Southwark CAMHs-Bloomfield		Southwark		London		National	
Unplanned treatment e	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Gender														
Male	5	63	0	0	0	0	2	50	7	50	343	64	2418	65
Female	3	38	1	100	1	100	2	50	7	50	197	36	1297	35
Total	**8**	100	**1**	100	**1**	100	**4**	100	**14**	100	**540**	100	**3715**	100
Ethnic group														
White	2	25	1	100	1	100	4	100	8	57	312	59	3193	88
Asian or Asian British	0	0	0	0	0	0	0	0	0	0	46	9	119	3
Black or Black British	4	50	0	0	0	0	0	0	4	29	94	18	148	4
Mixed	2	25	0	0	0	0	0	0	2	14	57	11	160	4
Other	0	0	0	0	0	0	0	0	0	0	19	4	29	1
Total	**8**	100	**1**	100	**1**	100	**4**	100	**14**	100	**528**	100	**3649**	100
Age on 30th September 2008														
Under 13	0	0	0	0	0	0	0	0	0	0	5	1	44	1
13	0	0	0	0	0	0	0	0	0	0	25	5	160	4
14	0	0	0	0	0	0	1	25	1	7	59	11	409	11
15	2	25	1	100	0	0	1	25	4	29	152	28	808	22
16	1	13	0	0	0	0	1	25	2	14	130	24	1010	27
17	5	63	0	0	1	100	1	25	7	50	169	31	1284	35
Total	**8**	100	**1**	100	**1**	100	**4**	100	**14**	100	**540**	100	**3715**	100
Main drug														
Class A (Heroin & Crack	1	13	0	0	1	100	0	0	2	14	21	4	106	3
Other Class A (Cocaine,	0	0	0	0	0	0	0	0	0	0	50	9	746	20
Cannabis & Alcohol	1	13	0	0	0	0	0	0	1	7	177	33	1320	36
Cannabis Only	6	75	1	100	0	0	3	75	10	71	234	43	978	26
Alcohol Only	0	0	0	0	0	0	1	25	1	7	57	11	517	14
Other Substance	0	0	0	0	0	0	0	0	0	0	1	0	48	1
Total	**8**	100	**1**	100	**1**	100	**4**	100	**14**	100	**540**	100	**3715**	100
Injecting Status														
Current	0	0	0	0	0	0	0	0	0	0	2	0	24	1
Previous	0	0	0	0	0	0	0	0	0	0	5	1	44	1
Never	0	0	1	100	1	100	1	100	3	100	401	98	3200	98
Total	**0**	0	**1**	100	**1**	100	**1**	100	**3**	100	**408**	100	**3268**	100
GrandTotal	**8**	**100**	**1**	**100**	**1**	**100**	**4**	**100**	**14**	**100**	**540**	**100**	**3715**	**100**

Appendix 2

Substance misuse – taken from the OC2 guidance notes 2008-09 for the Outcome Indicators for Looked After Children

This guidance document has been written to support Local Authorities with the data collection in relation to substance misuse. It has also been updated to address some of the issues encountered in the first round of data collection. These are outlined in section 2 below.

1. Background information

The DCSF has lead responsibility for policy on preventing substance misuse among young people, particularly the most vulnerable.

Substance misuse and associated problems harm children and young people's welfare and prevent them from achieving their full potential. The strategic guidance document Every Child Matters: Change for Children – Young People and Drugs (2005) sets out proposals to ensure that every young person with increased vulnerability to developing substance misuse problems, has their substance misuse needs identified early on and receives an appropriate service or intervention to prevent the problems escalating.

Where should substance misuse needs be recorded?

Promoting the Health of Looked After Children guidance, DH (2002) sets out the requirement that every looked after child has a health assessment when they enter into care and that a health plan is set out stating how their health needs will be met. The guidance includes a chapter on young people and drugs as it is a key issue for consideration when assessing the health and wellbeing and safety of looked after children.

Councils have a duty to promote and ensure the wellbeing of all children who are looked after by them. This means that councils must put in place arrangements to ensure that every child who is looked after has

a His/her health needs fully assessed

b A health plan which clearly sets out how health needs identified in the assessment will be addressed, including intended outcomes for the child, measurable objectives to achieve the outcome, actions needed to meet the objectives, the person responsible for each action and timescales for achieving this

c His/her health plan reviewed

Information from the health assessment forms the health plan which is recorded within the child's Care Plan as part of the assessment, planning, intervention and review process for all looked after children. It is anticipated that problems with substance misuse will be identified as part of the heath assessment or, if concerns have come from a carer, addressed as part of the assessment. Proposed interventions will be recorded within the care plan and progress and outcomes of interventions identified at the review.

The Integrated Children's System framework captures all the information about individual children which is required for management or performance indicators on the review record from which relevant information is aggregated.

The health assessment should be carried out by a suitably qualified medical practitioner and should promote the current and future health of the child or young person who is looked after and not focus solely on the detection of ill health. Health assessments should cover a range of issues beyond those of physical health which include developmental health and emotional well being.

Increased vulnerability to substance misuse

Evidence suggests that children in care are four times more likely than their peers to smoke, use alcohol and misuse drugs. (Meltzer et. al. 2003). Looked after children and young people who have experienced parental drug and alcohol misuse may view excessive drugs and/or alcohol use as 'normal' (Ward and others 2003, Newburn and Pearson 2002).

Substance Misuse- what constitutes a problem?

The Health Advisory Service (HAS) report (1996) states 'one off and experimental use of drugs and alcohol cannot in itself be seen as indicative of having caused actual harm or being related to any personal disorder'. In other words the fact that a young person has taken a substance should not lead to the automatic conclusion that there is a problem or condition to be treated. However, it is essential to recognise that all substance taking by young people carries potential harm.

Recent guidance published by the National Institute for Clinical Excellence (NICE) offers the following definition of **substance misuse** as 'intoxication by – or regular excessive consumption of and/or dependence on – psychoactive substances, leading to social, psychological, physical or legal problems. It includes problematic use of both legal and illegal drugs (including alcohol when used in combination with other substances).

Drugs, alcohol and substances

In this guidance document, the term 'drug' is used to refer to any psychotropic substance, including illegal drugs, illicit use of prescription drugs and volatile substances. Young people's drug taking is often inextricably linked with the consumption of alcohol. Therefore the term 'substance' refers to both drugs and alcohol but not tobacco.

A Range of Interventions

Identification and assessment

The identification and assessment of substance misuse must take place within the context of the assessment of the young person's overall needs and not as a stand alone activity. Therefore the range of interventions made available to the young person should meet the holistic assessment of need. There are 3 possible options following the initial assessment process;

1. No need is identified but the assessment process is recorded

2. Need is identified and a care plan is agreed, substance misuse being one issue which the young person requires support with and can be provided by a generic practitioner.

3. Substance misuse is identified requiring an intervention from a specialist worker focussing on a substance misuse based care plan.

Wherever possible, support should be provided 'in house' by staff known to the young person i.e. social workers carers and other staff. This should include support for the identified substance misuse problem and other problems identified in the assessment.

What is an Intervention?

Intervention can include such activities as information, advice and guidance, brief interventions, positive activities, therapeutic support, targeted support including support with a range of problems which are causing the young person difficulties and may be exacerbating the young person's substance misuse i.e. family contact, placement stability, school attendance, emotional and mental health problems.

Interventions can cover a wide range of information, advice, support and services. The National Institute for Clinical Excellence (NICE) recently published guidance on 'community based interventions' to reduce substance misuse among vulnerable young people. Details of the guidance document can be obtained from www.nice.org

Some young people with more serious substance misuse problems will need more specialist services. These services should be well known to the Children's Services and clear referral protocols established between the department and the specialist agency.

2. Data collection and associated issues

The publication of substance misuse related data for the first time in 2006 – 07 highlighted the need for more clarity around a number of important issues. These include;

Looked After Children Under 10

Information on substance misuse should be collected from all children **regardless of age.** However, in line with understanding of treatment data which suggests that substance misuse problems develop from the age of 10 onwards, calculation of the national percentage of looked after children with substance misuse problems will be expressed from the number of LAC aged 10 – 17, rather than those aged 0 – 17.

Recording and Counting Process

The publication of substance misuse related data highlighted some anomalies in the data collection process. In some areas the numbers accepting or refusing interventions exceeded the numbers identified with problems.

For purpose of clarity, every young person identified with a drug or alcohol related problem should be recorded once, irrespective of the number of times they have been offered interventions over the 12 month period. The database will be amended to reject incidents where numbers do not add up thus allowing local authorities to recheck figures.

Placements outside the local authority area

The responsible authority is required to ensure that all looked after children receive a health assessment in line with statutory requirements, irrespective of where they are placed. It is expected that problems with substance misuse will be identified and/or addressed within the health assessment and actions recorded on the health plan within the Integrated Children's System.

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[lxxxix] Taken from DWP data released 20/1/10 and includes Job Seekers' Allowance, Income Support, Incapacity Benefit/Severe Disablement Allowance, or Pension Credit at May 2008
[xc] Rate is calculated as a percentage of all aged under 15 years from the 2007 Child Benefit Data, HMRC
[xci] Children are defined as individuals under the age of 16, plus 16-19 year olds in full time education.
[xcii] English Indices of Deprivation 2007: London Borough of Southwark, Analytical Hub, April 2008
[xciii] English Indices of Deprivation 2007: London Borough of Southwark, Analytical Hub, April 2008
[xciv] See Appendix 2 for the OC2 guidance notes for Looked After Children
[xcv] The statistical neighbour average includes the following boroughs: Waltham Forest, Camden, Lambeth, Lewisham, Islington, Hackney, Haringey, Newham, Greenwich and Hammersmith & Fulham
[xcvi] Excludes City of London due to low numbers of young people who are NEET
[xcvii] Source: School Census - DCSF published figures http://www.dcsf.gov.uk/rsgateway/DB/SFR/s000852/index.shtml Includes Nursery, Primary, Middle, Secondary, Independent and Special schools, Pupil Referral Units and City Technology Colleges
[xcviii] Refer to Table 1 in Appendix 1 for borough level detail for all children and Table 2 for headline figures for children in care