A Substance Misuse Health Needs Assessment for the Residents of Hackney and City of London

December 2014
This report was commissioned from Solutions for Public Health (SPH) by City and Hackney Public Health, London Borough of Hackney. The contents are based upon the work undertaken by SPH, City and Hackney Public Health and stakeholders. November 2014
Contents

Executive summary ........................................................................................................................................ 5
Demography and influences on substance misuse ....................................................................................... 6
Substance misuse in Hackney and the City .................................................................................................. 6
Local services ............................................................................................................................................... 7
Evidence of effectiveness and cost-effectiveness ......................................................................................... 9
Recommendations ....................................................................................................................................... 10
1. Introduction and background .............................................................................................................. 13
   Aim and approach of the health needs assessment ................................................................................. 13
   Introduction ............................................................................................................................................. 13
   Substance misuse: national and local context ......................................................................................... 14
2. Needs estimates ....................................................................................................................................... 18
   Areas where data is available .................................................................................................................. 18
   Areas where little data is available ......................................................................................................... 20
3. Understanding the population ............................................................................................................. 22
   Demographics ......................................................................................................................................... 22
   Risk and protective factors for substance misuse .................................................................................... 31
   Summary of the key population indicators and risk factors that will determine health
   needs in relation to substance misuse in City and Hackney .................................................................. 46
4. Epidemiology of substance misuse .................................................................................................... 48
   Drug misuse ............................................................................................................................................. 48
   Alcohol misuse ......................................................................................................................................... 55
   Summary of key findings on public health indicators for drug and alcohol use ..................................... 65
5. Substance misuse services in Hackney and City of London ................................................................ 67
   Services for adults and older people in Hackney .................................................................................... 67
   Services for adults and older people in the City of London ................................................................ 73
   Expenditure on substance misuse services ............................................................................................. 76
   Summary of key findings on substance misuse services ......................................................................... 78
6. Substance misuse activity data for City of London and Hackney ................................................................ 80
   Profile of clients accessing treatment for drug misuse .......................................................................... 80
   Treatment outcomes ................................................................................................................................. 83
   Summary of substance misuse activity data ........................................................................................... 96
   Service specific user profile and activity data ....................................................................................... 97
   Profile of clients receiving alcohol treatment ....................................................................................... 105
   Alcohol screening ................................................................................................................................... 106
7. Substance misuse in children and young people ................................................................................. 108
   Data summary .......................................................................................................................................... 108
   Introduction .............................................................................................................................................. 109
   Prevalence of substance misuse in young people .................................................................................. 110
   Substance misuse services for young people in City and Hackney ....................................................... 111
   Profile of young people treated for substance misuse in Hackney ....................................................... 114
   Summary of key findings on substance misuse in children and young people ..................................... 115
8. Stakeholders views of substance misuse in City of London and Hackney ........................................... 116
   Areas of unmet need/gaps in service provision ..................................................................................... 116
   Challenges facing the service ................................................................................................................ 118
9. Literature review: Primary prevention interventions for substance misuse ........................................ 120
Question .......................................................................................................................... 120
Findings .......................................................................................................................... 120
Summary of findings ...................................................................................................... 128
Features of effective programmes .................................................................................. 129
Quality of the evidence and limitations ........................................................................ 129
Discussion and conclusions ............................................................................................. 129

10. Economic impact of interventions to prevent substance misuse ................................ 131
11. Conclusions and recommendations .......................................................................... 133
    Conclusions ...................................................................................................................... 133
    Recommendations ............................................................................................................ 133

12. Appendix 1: National guidance on substance misuse ........................................... 136
13. Appendix 2: Literature search strategy – primary prevention interventions for
    substance misuse ............................................................................................................ 138
14. Appendix 3: Themes identified in stakeholder interviews and workshop – Jan to March
    2014 .................................................................................................................................. 139
Executive summary

This report is an assessment of substance misuse needs in children and young people and adults in Hackney and the City of London. Health needs assessment is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities. This health needs assessment aims to inform the development of a commissioning strategy for substance misuse, on which commissioners would like to begin work in July 2014.

Solutions for Public Health (SPH) was commissioned to produce this substance misuse needs assessment by the London Borough of Hackney and the Corporation of the City of London.

The objectives were to:
- identify relevant national and local policy in relation to adult substance misuse provision
- identify the prevalence of common substance misuse conditions by Clinical Commissioning Group (CCG) locality &/or GP practice, including caseload for community teams in City of London and Hackney
- quantify proxy measures for the burden of drug and alcohol misuse in City of London and Hackney, for example deprivation, employment status, number of refugees and asylum seekers
- identify the current service provision in City of London and Hackney, including prevention, diagnosis, early intervention, treatment and recovery services
- understand through discussions with local providers if there are particular service users who only reach services at crisis point and ascertain reasons for lack of early intervention
- gain an understanding of any cultural barriers to accessing substance misuse care in relation to stigma and discrimination relevant to the City of London and Hackney population
- engage with service users to explore the patient perspective of existing services, to understand whether services are accessible and appropriate and to identify why patients may access services late
- understand the needs of carers and the services available to them
- map the provision of substance misuse services according to population need to identify any gaps in service and make recommendations to commissioners as to priorities for service development.

Nationally, drug misuse gives rise to between £10 billion and £18 billion a year in social and economic costs. The negative impact of drug use includes increased levels of crime, blood-borne virus infections, depression, unemployment and homelessness. Users may also receive custodial sentences resulting from possession of illegal substances or from crime committed to fund their habit. There is also the potential for serious consequences for the children of problem drug users.

There were around 1.2 million alcohol-related hospital admissions in England in 2010/11, and almost 15,500 people died from alcohol-related causes in 2010. Alcohol-related harm overall costs the NHS in England about £3.5bn a year. The impact of alcohol misuse encompasses
alcohol-related illness and injuries, domestic violence and crime, teenage pregnancy, and homelessness. The misuse of alcohol is a trigger to violent crime (44% of offenders convicted for violence have alcohol issues) and alcohol misuse is strongly linked to risk of reoffending. As alcohol has become more affordable, there has also been an increase in liver disease, which increased by 25% between 2001 and 2009 in the UK. Excessive drinking is a major cause of disease, accounting for 9.2% of disability-adjusted life years (DALYs) worldwide, the third most important cause after tobacco smoking and high blood pressure. Health inequalities result from alcohol-related harm.

**Demography and influences on substance misuse**

The populations of Hackney and the City of London are relatively young, with a higher proportion of adults aged 25 to 45 years old and a lower proportion of adults aged over 65 years than the England average. The Office for National Statistics estimates that the population of Hackney will increase from 247,182 to 271,844 or by 10% from 2011 to 2021 and that the resident population of City of London will grow over the same time period from around 7,400 to 12,000. The effect of these changes on drug misuse depends on rates of drug misuse in different age groups.

The ethnic make-up of City of London residents is similar to that for England, whereas the population of Hackney is more diverse. City of London and Hackney are also communities with a diverse range of religious faiths. Both of these factors influence the level of substance misuse in the local population and the delivery of preventive and treatment interventions. Some ethnic minorities show higher rates of substance misuse, while religious affiliation is associated with lower rates.

The rate of benefits claimants in the working age population for whom the main medical reason is alcoholism in Hackney is higher than both the London and England averages.

Hackney has a higher rate of households in temporary accommodation than the England average, and both City and Hackney have a higher proportion of overcrowded households than comparable London boroughs. There are also rising numbers of rough sleepers. These factors are associated with higher rates of substance misuse.

**Substance misuse in Hackney and the City**

There were 1,394 adults in treatment for drug misuse in 2012/13 in Hackney, an increase of 62 on the previous year. The number of adults in treatment in the City of London was 13, down from 17 the previous year. These are rates of 5.65 and 1.75 per thousand residents respectively, compared with 3.65 per thousand for England.

The estimated prevalence of use of opiates and crack cocaine and of drug injecting is higher in Hackney than in England and London, but similar to the ONS London Cosmopolitan local authorities.\(^1\) The prevalence rates for the City of London were similar to the London average and lower than the England average, apart from the prevalence of opiate and crack cocaine

---

\(^1\) Brent, Hackney, Haringey, Lambeth, Lewisham, Newham, Southwark
use which was lower than both London and England averages. There were fewer drug-related deaths registered in Hackney in the period 2010 to 2012 than in 2007 to 2009.

Alcohol-attributable crime rates have been falling in recent years in both Hackney and the City of London, but these remained higher than the England and London averages in 2011/12.

Nationally published modelled estimates based on data reported in the General Lifestyle Survey suggest that almost 8% of drinkers in Hackney and almost 9% of drinkers in City of London are higher-risk drinkers, which is higher than the London average. Estimates for binge drinking levels are much higher for the City of London resident population than for Hackney and for London as a whole. In 2012, more than 10,800 people in Hackney and the City of London were estimated to be dependent on alcohol and this number is expected to increase to over 11,500 by 2020. This does not include problem drinking by the City of London non-resident workforce.

Hospital admission rates related to alcohol misuse are higher than the London average in Hackney, but not in the City of London. Rates of ambulance call outs for alcohol-related illness during 2013 show that Haggerston ward had a higher call-out rate than the other Hackney wards.

In 2012, Hackney had the fourth highest alcohol-related mortality rate for males of any London borough; the alcohol-related mortality rate for females was similar to the London average. The numbers of alcohol-related deaths in the City of London are too few for valid statistical comparison.

Local services

Drug misuse services in Hackney include a community drug service, a drug intervention programme, a substance misuse service for young people, a blood-borne virus service, locally enhanced services in primary care and opiate substitution and needle/syringe services based in pharmacies. For people with alcohol misuse, there is screening in primary care and an alcohol recovery service. There is also a specialist addiction unit, residential detoxification and rehabilitation and a range of specialist clinicians and social workers, including a team who work with people on the street.

In the City, there are branches of Alcoholics Anonymous and Narcotics Anonymous, an Alcohol Recovery Centre, an Arrest Referral Service, needle exchange, the Club Drug Clinic, primary care teams and specialist advice teams.

In 2013/14, statutory agencies in City and Hackney spent £8.4 million on substance misuse services for young people up to 19 and adults, of which £7.7 million was direct service provision and £700,000 was commissioning and support costs. 94% of this is Council spending, mostly via public health budgets.

Analysis of the National Drug Treatment Monitoring System (NDTMS) data for those in treatment for drug misuse suggests that:

- the number of adults in treatment for substance misuse in Hackney and the City was broadly stable in 2012/13. The treatment population is gradually growing older
the most common ‘primary drug’ (the substance or substances that brought the client into treatment at the point of triage/initial assessment) for adults in drug treatment in Hackney since 2005/06 has been combined opiate and crack use
• completion rates for opiate and non-opiate clients in treatment in Hackney compare well with the NDTMS cluster\(^2\) average for opiate addiction, but less well for non-opiates
• re-presentation rates for opiate users in treatment in Hackney were higher than the NDTMS cluster average in 2012/13, but are falling
• there was a lower proportion of treatment-naive clients in treatment in Hackney than the cluster average in 2012/13. This may indicate that local services are failing to attract in new clients or those from under-served groups
• a larger proportion of clients in treatment had 4 or more previous treatment journeys compared to the England average in 2012/13. This may suggest that clients are exiting treatment prematurely, only to return subsequently
• a higher proportion of clients in treatment in Hackney were in the ‘very high’ complexity group, which may reflect failed previous treatment journeys and suggests that local services need to ensure that they are responding to other aspects of complexity, such as daily opiate use, crack use, injecting, alcohol use and housing problems
• a lower proportion of opiate users than the NDTMS would expect had stopped using opiates after 6 months of treatment as of 31 March 2013
• a lower proportion of non-opiate injecting drug users and crack cocaine users had stopped using drugs than the national average after 6 months of treatment.

Treatment costs per user for substance misuse are higher than average in Hackney and in the City. This may reflect differences in the number of people who are in contact with substance misuse services but who are not in treatment and who are therefore not reflected in the NDTMS data showing the numbers of service users, a higher cost treatment model, more complex cases, or lower efficiency or the allocation of financial costs. This merits further investigation. Drug and alcohol services are also more concentrated in the south of Hackney, whereas higher risk drinkers are more concentrated in the north.

Drug and alcohol misuse pose a significant risk to a young person’s physical and psychological health and development. However, there are no local prevalence figures for Hackney and the City. There are services targeted at young people with substance misuse and alcohol problems.

Stakeholders made several points about the service available in Hackney and the City:
• there is no specific service provision for young adults in the 19-25 years age group; adult substance misuse services were considered inappropriate for this age group
• there is very little direct work with children of parents who are substance misusers, a group are at higher risk themselves of becoming substance misusers. Stakeholders

also suggested that there is a lack of whole family work for managing children and young people with substance misuse problems

- the number of community-based alcohol detoxifications in City and Hackney was considered by stakeholders to be very low. There is currently nowhere to place alcohol clients who have a high social need and who are not self-caring, yet who would benefit from community detoxification
- there is little support available for drinkers in the ‘increasing risk’ (hazardous drinking) category in City and Hackney
- stakeholders reported that access to psychology services for people with substance misuse problems was limited
- older people with needs relating to substance misuse have particular problems. Some are long-term users of prescription medications, some older adults have cognitive problems secondary to substance misuse and some are part of an ageing cohort of injecting drug users
- challenges facing the service include excess demand, a lack of attention to education, outreach and preventive work, service fragmentation and lack of awareness of services available
- capacity within primary care could be increased to manage patients with substance misuse who fall below existing thresholds for referral to substance misuse services, for example drinkers in lower risk categories, ‘high’ cannabis users, and patients on long-term prescription medicines such as opiates or benzodiazepines.

There is guidance from NICE on substance misuse services, but little information on whether it is followed.

Evidence of effectiveness and cost-effectiveness

We conducted a literature review to explore the evidence base for the effectiveness and cost-effectiveness for primary prevention interventions for substance misuse (alcohol and drugs) across all age groups.

Systematic reviews suggest that comprehensive multi-modal programmes that include developing psychosocial skills and family involvement can reduce long-term drug and alcohol use in adolescents. The evidence to support mentoring and pre-school programmes for primary prevention of substance misuse is less clear.

The effectiveness of mass media campaigns and social media on their own in preventing or reducing substance misuse are not supported by the available evidence. Alcohol expectancy challenge\(^3\) and other interventions to prevent harmful alcohol and drug use in nightlife settings appear to be effective in college students and adults.

\(^3\) Interventions challenging alcohol expectancies have been developed as a means to reduce alcohol consumption. The expectancy challenge (EC) intervention was designed to illustrate the effects of alcohol-related expectancies through experiential learning in a group setting. An EC intervention typically includes the provision of beverages to groups of drinkers in a bar-like setting; some contain alcohol and others contain a placebo beverage, but the participants do not know the content of their drinks. Participants engage in activities that promote social interaction, and after time passes, participants are asked to evaluate whether other participants were drinking alcohol versus a placebo. Incorrect identification provides opportunities to consider the effects of alcohol attributable to expectancies.
The available evidence suggests that increasing the hours of sale by 2 hours or more increases alcohol-related harm.

The effects of the primary prevention interventions that appear to have a positive impact on substance misuse tend to diminish with time; this suggests that any such intervention should be ongoing rather than a one-off.

An intervention in primary care that combines universal screening by GPs followed by a 5-minute advice session for hazardous or harmful drinkers would be cost saving within 1 year. The lifetime return on investment for specialist substance misuse treatment for young people could be between £4.66 and £8.38 for every £1 spent. Structured treatment was also estimated to be cost effective in the short-term, with a return on investment of £2.50 for every £1 spent.\(^4\)

**Recommendations**

1. Consider more intensive outreach to engage with the large number of substance misusers who are not in contact with treatment services of any kind.

2. Address service fragmentation issues by considering the option of introducing a single substance misuse service. As a minimum, improve co-ordination and communication between drug and alcohol services and between different components of the individual services (such as Lifeline and the Specialist Addictions Unit), ensuring the use of a common assessment approach (e.g. strength-based assessment) and common care and recovery pathways.

3. Increase the level of provision available for young people, and increase the focus on educational and outreach interventions. For example, there is scope for better awareness and recognition of substance misuse issues amongst other professionals, e.g. Children’s Centre staff and health visitors, so that issues are identified and people/families referred to services early. There is also scope for more work to be done before young people get into difficulties, e.g. via schools, festivals and clubbing venues, and scope for more partnership work with Children’s Centres and schools.

4. Provide specific services for young people in the transitional age group of 19 to 24 years, either via increasing the upper age limit of existing young people’s services or by providing a dedicated service to meet the needs of this age group. Targeted consultation with service users and investigation of service provision in other boroughs should be undertaken to inform selection of the most suitable service model.

5. Review the existing approach to implementation of alcohol screening, which evidence reviews have shown to be cost-effective when carried out in association with a 5-

---

minute advice session (so-called ‘brief intervention’). Consider adopting a more targeted approach to screening in the local community, including the use of screening in hospital settings such as accident and emergency departments and inpatient settings.

6. Review the existing provision for alcohol withdrawal/detoxification services and explore the potential for providing community-based alcohol detoxification with GP support, including the availability of detoxification for people living in nursing/residential accommodation. This might include, for high-risk patients, a stepped care model involving hospital admission for the initial stage of detoxification followed by discharge into the community. As reported in the evidence review informing the NICE Guideline on Alcohol Use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence,\(^5\) interpretation of the evidence on cost-effectiveness of community versus residential alcohol detoxification is challenging. However, the evidence seems to suggest that more severe and less socially stable patients who misuse alcohol seem to fare better in inpatient (or more intensive treatment), whereas among married patients with stable accommodation, fewer years of problem drinking, and less history of treatment, outpatient (and less intensive) treatment yields more favourable outcomes than inpatient treatment.

7. Consider greater integration of support for patients with substance misuse problems into primary care, for example, considering the role of a GP with Special Interest in substance misuse to provide leadership, education, training and support to colleagues in primary care, developing an outreach model whereby every practice has access to a specialist drug and alcohol worker, and exploring the possibility of 1 practice providing substance misuse services on behalf of others.

8. Improve services and pathways for substance misusers with high social needs, including facilitating their access to housing and benefits advice and support.

9. Increase the level of service provision available for drinkers in the ‘increasing risk’ (hazardous drinking) category by, for example, providing interventions which help them to identify and understand the risk associated with their drinking behaviour and which support them in modifying their drinking behaviour.

10. Address existing problems with service access by exploring, for example, increasing service provision over the weekends to facilitate access by non-resident City workers and exploring ways of improving access to services by residents in the north of Hackney.

11. Ensure where appropriate the compliance of services with NICE guidance and other relevant clinical guidelines.

12. Investigate the variations in cost per service user between Hackney, the City and England.

---

\(^5\) Alcohol Use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence. The British Psychological Society & The Royal College of Psychiatrists, 2011.
13. Increase uptake of Improving Access to Psychological Therapies (IAPT) by people with substance misuse problems with a view to improving recovery rates from substance misuse.

14. Develop treatment pathways for people using new psychoactive substances/legal highs and those misusing prescription or over the counter medications.

15. Identify and review the medication requirements of older people on long-term prescriptions for potentially addictive medicines.

16. Review education and training needs of people working within the substance misuse services and provision to address this.

17. Ensure that all people working within substance misuse services are fully briefed on the range of services, including aftercare services, available to their clients and that they pass this information on, where relevant, to clients.

18. Work with Hackney’s diverse communities to understand their specific needs and identify how these communities can support and complement local prevention and treatment services.

19. Those receiving services and support for substance misuse should be regularly assessed for mental ill-health and provided with the appropriate support and treatment for these conditions.
1. Introduction and background

Aim and approach of the health needs assessment

The aim of this work is to produce a health needs assessment of the public health commissioned substance misuse need for adults, children and young people in the City of London and Hackney. Health needs assessment is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities. This health needs assessment aims to inform the development of a commissioning strategy for substance misuse which the commissioners would like to begin work on in July 2014.

Solutions for Public Health (SPH) were commissioned to produce this substance misuse needs assessment by the London Borough of City of London and Hackney. The objectives were to:

- identify relevant national and local policy in relation to adult substance misuse provision
- identify the prevalence of common substance misuse conditions, by CCG locality &/or GP practice to include caseload for community teams in City of London and Hackney
- quantify proxy measures for the burden of mental illness needs in City of London and Hackney (for example, deprivation, employment status, refugees and asylum seekers, drug and alcohol misuse)
- identify the current service provision in City of London and Hackney (prevention, early intervention, diagnosis, treatment and recovery services)
- through discussions with local providers, understand if there are particular service users who only reach services at crisis point and ascertain reasons for lack of early intervention
- gain an understanding of any cultural barriers to accessing substance misuse care in relation to stigma and discrimination relevant to the City of London and Hackney population
- engage with service users to explore the patient perspective of existing services, to understand whether services are accessible and appropriate and to identify why patients may access services late
- understand the needs of carers and the services available to them
- map the provision of substance misuse services according to population need to identify any gaps in service and make recommendations to commissioners as to priorities for service development.

Introduction

Nationally, drug misuse gives rise to between £10 billion and £18 billion a year in social and economic costs,6 99% of which is accounted for by problematic drug users. Across communities and society as a whole, the negative impact of drug use can include increased levels of crime, blood-borne viruses (Hepatitis B and C and HIV), depression, unemployment and homelessness.7 Users may also receive custodial sentences, resulting from possession of

---

6 The Centre for Social Justice (2013). NO QUICK FIX - Exposing the depth of Britain’s drug and alcohol problem.
illegal substances or from crime committed to fund their habit. There is also the potential for well recognised and serious consequences for the children of problem drug users, including the disruption of family life.²

The impact of alcohol misuse is widespread; it encompasses alcohol-related illness and injuries as well as significant social impacts including domestic violence and crime, teenage pregnancy, and homelessness. The misuse of alcohol is recognised as a trigger to violent crime (44% of offenders convicted for violence have alcohol issues) and alcohol misuse is strongly linked to risk of reoffending.⁸

As alcohol has become more affordable, there has also been an increase in liver disease, which increased by 25% between 2001 and 2009 in the UK. Alcohol-related liver disease accounts for over a third (37%) of all liver disease deaths.⁹ Excessive drinking is a major cause of disease, accounting for 9.2% of disability-adjusted life years (DALYs) worldwide with only tobacco smoking and high blood pressure as higher risk factors.¹⁰ Health inequalities are clearly evident as a result of alcohol-related harm. Department of Health analysis of Office of National Statistics data indicates that alcohol-related death rates are about 45% higher in areas of high deprivation, and liver disease represents one of the few diseases where the inequalities gap is increasing. These problems may be related to intoxication, regular excessive consumption or dependence.¹¹

Substance misuse: national and local context

National Context – Policy Drivers

Drugs
Drug Action Teams were established by the Government in 1995 to ensure the strategic coordination of local action on drug misuse.

The 2010 National Drug Strategy¹² ‘Reducing demand, restricting supply, building recovery: supporting people to live a drug free life’ sets out the Government’s approach to tackling drugs and addressing alcohol dependence, both of which are key causes of societal harm, including crime, family breakdown and poverty. It has 2 overarching aims:
- to reduce illicit and other harmful drug use
- to increase the numbers recovering from dependence.

This new approach is a shift towards a more integrated approach to commissioning public health outcomes, addressing the root causes and wider determinants of substance misuse.

---

⁸ Alcohol Strategy 2012 Home Office
¹¹ Department of Health (2009) Signs for Improvement: Commissioning intervention to improve alcohol-related harm London
The key principle is for drug and alcohol commissioners to work closely with all relevant partners in order to commission services based on outcomes.

The National Treatment Agency’s (NTA) Joint Strategic Needs Assessment (JSNA) support pack for commissioners (2011) sets out 4 principles within the National Drug Strategy 2010 to inform the commissioning of an integrated recovery orientated drug treatment system. The 4 principles promoting successful recovery journeys are:

1. recovery is initiated by maintaining and, where necessary, improving access to early and preventative interventions, and to treatment
2. treatment is recovery-orientated, effective and high quality
3. treatment delivers continued benefit and achieves appropriate recovery-orientated outcomes, including successful completions
4. treatment supports people to achieve sustained recovery.

Alcohol
In June 2007, the Department of Health and the Home Office jointly launched an updated government alcohol strategy, ‘Safe, Sensible, Social: The next steps in the National Alcohol Strategy’ which set out clear goals and actions to promote sensible drinking and reduce the harm that alcohol can cause.

The strategy aimed to sharpen the criminal penalties for drunken behaviour, review NHS alcohol spending, help more people who wanted to drink less, toughen enforcement for under age sales of alcohol, have public information campaigns, consult on pricing and support local strategies on alcohol.

In March 2012, the Coalition government published its strategy on alcohol. The alcohol strategy sets out proposals to ‘crack down on our ‘binge drinking’ culture’, ‘cut the alcohol-fuelled violence and disorder that blights too many of our communities’, and ‘slash the number of people drinking to damaging levels’.

The strategy includes commitments to:
- consult on a minimum unit price for alcohol
- consult on a ban on the sale of multi-buy alcohol discounting
- introduce stronger powers for local areas to control the density of licensed premises, including making the impact on health a consideration for this
- pilot innovative sobriety schemes to challenge alcohol-related offending.

---

15 Alcohol Strategy 2012 Home Office
In April 2013, the NTA for Substance Misuse was abolished and its key functions transferred into Public Health England; commissioning responsibilities for drug and alcohol services were transferred to Directors of Public Health (DsPH), based in local authorities.

**Local Context**

Strategic documents which have informed the prevention and treatment of drug and alcohol misuse in Hackney and City of London include:

- The Hackney Drug Strategy Refresh 2012-2014
- Drug and Alcohol Misuse: Adult Harm Reduction Strategy for City of London and Hackney 2013-16

The Hackney Drug Strategy Refresh 2012-2014\(^{16}\) sets out 3 key objectives, each with a set of key tasks to be undertaken over the period. These are:

- develop recovery-based treatment and relapse prevention services
- reduce drug-related offending and anti-social behaviour across the Borough
- develop effective interventions to reduce harm with young adults and communities around substance misuse.

The 2013 City and Hackney Drug and Alcohol Misuse Adult Harm Reduction Strategy\(^{17}\) has 7 objectives:

- provide and manage a strategic framework to address and promote harm reduction according to local need
- reduce the transmission of blood-borne viruses among people using drugs
- reduce drug related deaths of people from overdose
- minimise the harm to individuals from substitute prescribing
- minimise the harm to vulnerable groups
- minimise the harm to individuals from alcohol
- develop and sustain a knowledgeable, skilled and competent workforce.

The City of London Substance Misuse Partnership Commissioning Strategy, 2011\(^ {18}\) summarises the aims of the partnership as follows:

- ensure that the entire treatment system focuses on recovery and reintegration and on quality of services
- deliver timely and effective treatment, harm reduction and wraparound services to drug users resident in the City of London or homeless within its boundaries
- improve access to treatment and harm reduction services for hard to reach groups in the City
- seek and report on research and best practice evidence in order to assist commissioning and strategic decision making

---

\(^{16}\) Hackney Drug and Alcohol Action Team. Hackney drug strategy refresh 2012-2014


\(^{18}\) Institute of Public Care. City of London substance misuse partnership. Commissioning strategy, March 2011
• increase the number of problematic drug users in treatment by increasing access points and retention and reducing unplanned discharges
• focus on improving the quality of current services with robust clinical governance procedures
• continue to work closely with partners to maintain a strong system which can be accessed if necessary to provide assistance to problem drug users with dependent children.
2. Needs estimates

Needs estimates have been provided for opiate and/or crack users and those who drink alcohol who are at an increasing or high risk of problem drinking. Information has also been provided on cannabis, prescription/over the counter medication, legal emerging drugs and club drugs.

Areas where data is available

Opiates and Crack

Approximately 50% of projected opiate users (including opiate and crack users) are receiving treatment, and approximately 25% of projected crack users (who don’t use opiates) are receiving treatment.

Prevalence estimates\(^{19}\) suggest there were about 2,600 opiate and/or crack users in City & Hackney in 2011/12. The estimates suggest that about half of these use both opiates and crack.

In 2102/13 roughly 50% of opiate only, and roughly 50% of opiate and crack users were receiving treatment. Roughly 25% of crack only users were receiving treatment. (Source: NDTMS)

Table 1: Estimated drug use and number of clients in treatment

<table>
<thead>
<tr>
<th>Primary drug of choice</th>
<th>2011/2012 estimated drug use</th>
<th>Clients in treatment 2012/13</th>
<th>Coverage</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiates and crack</td>
<td>1282</td>
<td>674</td>
<td>52.6%</td>
<td>608</td>
</tr>
<tr>
<td>Opiates only</td>
<td>728</td>
<td>380</td>
<td>52.2%</td>
<td>348</td>
</tr>
<tr>
<td>Crack only</td>
<td>636</td>
<td>153</td>
<td>24.1%</td>
<td>483</td>
</tr>
</tbody>
</table>

Please note that the prevalence estimates are not very precise at the level of local authorities, with a 95% confidence interval of around 500.

Alcohol

Alcohol use can exist at unproblematic and problematic levels. Local Alcohol Profiles for England (LAPE) estimates use the 3 categories of low risk, increasing risk (or hazardous), and high risk (or harmful), as well as the separate category of binge drinking.

\(^{19}\) Also known as the “Glasgow Estimates”. *Estimates of the prevalence of opiate use and/or crack cocaine use (2011/12)*, Centre for Public Health, Liverpool John Moores University, April 2014 [http://www.nta.nhs.uk/facts-prevalence.aspx](http://www.nta.nhs.uk/facts-prevalence.aspx)
2% of projected high risk drinkers are known to GPs; 3% of projected increasing risk drinkers are known to GPs.

3% of projected harmful drinkers received treatment from the East London NHS Foundation Trust (ELFT) Alcohol Recovery Service. This is slightly more than are recorded on the GP register as high risk drinkers, and roughly 25% of those recorded on the GP register as increasing risk or high risk drinkers.

Table 2: Estimated and recorded level of alcohol consumption in City & Hackney

<table>
<thead>
<tr>
<th>Estimated number</th>
<th>Recorded on GP register</th>
<th>Coverage</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low risk</td>
<td>115,100</td>
<td>6176</td>
<td>5.4%</td>
</tr>
<tr>
<td>Increasing risk</td>
<td>28,300</td>
<td>955</td>
<td>3.4%</td>
</tr>
<tr>
<td>High risk</td>
<td>12,500</td>
<td>286</td>
<td>2.3%</td>
</tr>
<tr>
<td>Binge drinking</td>
<td>28,700</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

LAPE
GP register data provided by CEG, April 2014

There were 588 adults in alcohol treatment 2013/14.20

Table 3: Proportion of estimated and known high and increasing risk drinkers receiving treatment in City & Hackney 2013/14

<table>
<thead>
<tr>
<th>Adults receiving alcohol treatment in City &amp; Hackney 2013/14</th>
<th>Total</th>
<th>Of estimated population</th>
<th>Of those recorded on GP register</th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk only</td>
<td>588 (risk level not given)</td>
<td>4.7%</td>
<td>205.6%</td>
</tr>
<tr>
<td>Increasing and high risk</td>
<td></td>
<td>1.4%</td>
<td>47.4%</td>
</tr>
</tbody>
</table>

LAPE
GP register data provided by CEG, April 2014

Cannabis

Cannabis is the most commonly used illegal drug in the UK.21 The Crime Survey for England and Wales (CSEW) reports that 6.3% of people aged 16-59 had used cannabis in 2012/13. This provides a conservative estimate for cannabis use in City & Hackney of over 11,000 people.22

The Adult Psychiatric Morbidity survey suggests that 2.5% of the 16+ population is dependent on cannabis.23 This would give 5,300 people in City & Hackney. However, the report highlights

---

that its definition of ‘dependent’ has a much lower threshold than is recommended by ICD-10 and DSM-IV.24

A small but growing number of people receiving treatment are getting it for cannabis use, with 95 clients receiving treatment for cannabis as primary drug of choice in 2012/13 (NDTMS).

Figure 1: Number of clients receiving treatment for cannabis as primary drug of choice in City & Hackney over the last 8 years

Source: NDTMS

Cannabis also appears as the most common secondary substance for those offered treatment for alcohol issues by ARC. (26% of those offered treatment were using a secondary substance, of whom 52% were using cannabis as that substance.)

Areas where little data is available

The following substances do not have good local data on use or dependency. For context, sections have been quoted from the body of the main report to give a flavour of what is known.

Prescription Only Medication / Over the Counter Medicine

Data provided by Public Health England (PHE) indicates that 9% of Hackney’s treatment population (141 people) cite problems with prescription only / over the counter medication. Of these, 10% have no illicit drug use.

24Respondents were counted as dependent if they answered yes to any one of five given criteria, rather than the typical threshold of three.
The issue of addiction to prescription drugs has increased dramatically in the past few decades. Physical health problems and the long-term prescription of medication contribute to the development of substance misuse in older people.\(^\text{25}\) However, prescription drugs are now more widely available, through diversion of prescriptions and unregulated sales via the Internet. Deaths involving benzodiazepines (drugs which help alleviate anxiety and insomnia) and the painkiller, Tramadol, increased by 60% in the 5 years between 2007 and 2012. The Home Affairs Committee report noted that support and treatment for people who develop problems in relation to prescription-only or over-the-counter medicines would be provided by GPs, many of whom do not report to the National Drug Treatment Monitoring Service (NDTMS) and so it is difficult to obtain a clear picture of the scale of addiction to prescription medicines.\(^\text{26}\)

**Legal Emerging Drugs**

For the first time, the Crime Survey for England and Wales 2012/13 included questions on use of the legal emerging drugs, salvia and nitrous oxide, in the previous 12 months and found that: amongst adults aged 16 to 59, 2.0% reported taking nitrous oxide and 0.3% reported taking salvia in the last year; amongst young adults aged 16 to 24, 6.1% reported taking nitrous oxide and 1.1% reported taking salvia in the last year.

**Club Drugs**

‘Club drugs’ is a collective term for a number of different substances typically used by young people in bars and nightclubs, at concerts and parties. These drugs can be harmful, and heavy use can develop into a dependency.\(^\text{27}\) Despite the widespread use of club drugs, they are currently causing a treatment problem for relatively few people. There is no evidence to suggest they are replacing heroin and crack as drugs of dependency, but they can seriously harm the physical and mental health of users.

---


\(^{26}\) Home Affairs Committee, Ninth Report of Session 2012–13, Drugs: Breaking the Cycle, HC 184-I

3. Understanding the population

This section of the report describes the composition of the population and uses various indicators to identify population need in relation to substance misuse.

Throughout this section, where data are available, Hackney and City of London are compared with the ONS ‘London Cosmopolitan’ peer group of local authorities comprising: Brent, Hackney, Haringey, Lambeth, Lewisham, Newham and Southwark or in some instances Clinical Commissioning Groups (CCGs) considered by the ONS to have similar demographic characteristics.

Demographics

Age and sex profile

The Office for National Statistics (ONS)\(^{28}\) estimated the population of the London Borough of Hackney to be 252,119 in 2012 and the resident population of the City of London to be 7,604. This does not include the City’s non-resident working population.

Figure 2 and Figure 3 show the composition of the population of each of the 2 boroughs by age and gender. Hackney has a similar gender distribution to the England average with 50.4% of the population being female and 49.6% of the population male. The City of London has a higher proportion of males to females. Both the City of London and Hackney boroughs have a young population with substantially more adults aged 25 to 45 years than the England average. The proportion of older people (8% in Hackney and 10% in the City) is therefore much smaller than the national average. The overall balance of sexes in Hackney is 51% female and 49% male while the City of London’s resident population is 55% male and 45% female.

\(^{28}\) Office for National Statistics (ONS) Mid Year Estimates & 2012 interim sub-national population projections

ONS 2012
The ONS estimated the population of City of London and Hackney CCG to be 259,723 in 2012. The age structure of the CCG population is shown in Figure 4.
Ethnicity
Both boroughs are ethnically diverse; the City has a similar profile to England as a whole while Hackney has a large Black population. Figure 5 shows the composition of the populations of the 2 boroughs compared to the ONS London Cosmopolitan peer group and the England average.
The City of London has a higher proportion of the resident population from White ethnic groups but a lower proportion from Black and ‘Other’ ethnic groups compared to Hackney. Compared to the ONS London Cosmopolitan peer group, Hackney and City of London have a slightly higher proportion of the total population from White and ‘Other’ ethnic groups. The White population of Hackney included 6,029 Turkish, 5,216 Irish, 3,393 Polish, 474 Gypsy or Irish traveller populations at the time of the 2011 Census.

Figure 6 shows the percentage of the resident population in the wards in Hackney and in the City of London from Black and minority ethnic (BME) groups in 2011. It shows that the proportion of the population from BME groups varied at ward level in Hackney from over 60% in King’s Park ward to around 30% in Lordship ward.
The current JSNA for Hackney notes that White populations are particularly concentrated in the City and in the wards of Lordship, New River and Clissold in the north of Hackney. Higher proportions of Black people tend to be found in the east of Hackney, and in some other areas throughout the borough. There are concentrations of people of Asian ethnicity in the Leabridge, Hackney Downs and Cazenove wards, as well as in the east of the City. Populations of those who describe themselves as being of mixed or multiple ethnicities are more evenly distributed as a whole, making up less than 10% of the population in all Lower Super Output Areas.

Future population projections produced by the Greater London Authority (GLA) suggest that both the number and proportion of the resident population of the City of London and Hackney drawn from ethnic minority groups will increase in the years ahead. Figure 7 shows the projected change in the resident population of the City of London aged 0-19 years from 2011 to 2041 for the main categories of Black and ethnic minority groups.
Figure 7: Number of residents aged 0-19 years from Black and minority ethnic populations for City of London, 2011 to 2041

Figure 7 indicates that growth in the BME groups between 2011 and 2041 is likely to be highest in the Black Other, Other Asian and Other ethnic group categories. In total the number of residents aged 0-19 years in the City of London belonging to BME groups is expected to increase from 329 in 2011 to 580 by 2041, an increase of 76%.

Figure 8 shows the equivalent projections for the BME populations aged 0-19 years for Hackney between 2011 and 2041.

Figure 8: Number of residents aged 0-19 years from Black and minority ethnic populations for Hackney, 2011 to 2041

Source: GLA interim 2012 population projections
Figure 8 indicates that the populations of some ethnic minority groups in Hackney are expected to decrease between 2011 and 2041 and others are expected to increase. In particular the populations of Black Caribbeans, Black Africans and Bangladeshis are expected to decrease between 2011 and 2041, while the populations in the Black Other and Other ethnic group categories are expected to increase. In total the number of residents aged 0-19 years in Hackney belonging to BME groups is expected to increase from 38,607 in 2011 to 44,604 by 2041, an increase of 16%.

The Crime Survey for England and Wales (CSEW) found that adults from a White ethnic group generally had higher levels of any drug use than those from a non-White background (9.5% versus 5.4%).

A policy briefing in 2010 by the UK Drug Policy Commission reported that:
- cannabis is the most commonly used drug across all ethnic groups and age groups. Rates of Class A drug use are higher among people from White or mixed ethnic background than among other ethnic groups; lowest overall levels of drug use are reported by people from Asian backgrounds (Indian, Pakistani or Bangladeshi)
- men are more likely than women to use any illicit drugs in many ethnic groups, particularly among Asian, White and Chinese/Other groups, whereas Black and mixed race men and women have similar levels of use
- the types of drugs that cause individuals to seek help vary between different communities. Drug users from Black groups are most likely to seek treatment for crack cocaine and cannabis use, whereas the most common reason for seeking treatment among the Asian community is problematic use of heroin. Factors suggested as linked to high levels of cannabis use within Black communities include a perception that it is safe and less harmful than other drugs; a history of cannabis use within families; for Rastafarians, cannabis use is a spiritual act and part of the ‘culture’ of the movement.

BME communities may be at risk of drug use because they often live in disadvantaged and deprived areas, where drug markets thrive. A number of minority ethnic groups, particularly refugees and asylum seekers, face high levels of unemployment, isolation and social exclusion. Limited opportunities can lead to frustration, boredom and anxiety thereby increasing the likelihood of drug use.

Among some BME groups, particularly South Asians and the Chinese, high levels of stigma are attached to drug use and directed at both drug users and their families. This can lead drug users to hide the extent of their use, and levels of drug problems being underestimated. Peer pressure and influence are seen as important reasons why young people use drugs. Young people growing up under the influence of western culture and trends may seek to distance themselves from ‘traditional’ cultural values in order to ‘fit in’.

As reported in a recent review of the UK literature on ethnicity and alcohol, drinking patterns vary both between and within minority ethnic groups:

---

• most minority ethnic groups have higher rates of abstinence and lower levels of frequent and heavy drinking when compared with the British population as a whole and to people from White backgrounds. In general, studies suggest that abstinence and low levels of drinking among non-White ethnic groups are associated with a strong ethnic identity, strong family and local community ties, continuing links with the host country, and maintaining religious values.

• people from mixed ethnic backgrounds have high rates of current use and are less likely to abstain than people from non-White minority ethnic groups. People from mixed ethnicities also report relatively high rates of heavy and very heavy drinking compared with other non-White ethnicities. Differences between men and women for abstinence and frequent drinking are also less marked than for other minority ethnic groups.

• some research has shown that drinking patterns in second-generation minority ethnic groups may begin to resemble the drinking habits of the general population whereas drinking patterns among some first-generation minority ethnic groups resembles those from their country of origin.

• people of Black Caribbean ethnicity have higher levels of drinking than people from South Asian and Chinese ethnicities, but lower levels compared to people from White backgrounds and compared to the general population. They also have lower rates of alcohol-related mortality compared with people from White and South Asian backgrounds in the UK. Black African people have higher levels of drinking compared with most South Asian ethnicities, but lower rates of alcohol use than the general population and people from White backgrounds. They also tend to report rates lower than Black Caribbean people.

Stress associated with migration has also been linked with increased drinking levels in certain minority ethnic groups. The stress of moving to a new country can be affected by factors such as people’s access to employment and education opportunities, socio-economic status, peer influences and lifestyle choices.

Religion
There is evidence to suggest that religion is a protective factor for substance abuse. A review of nearly 40 studies found that people with higher levels of religious commitment were less likely to become involved in substance abuse.\textsuperscript{32} A US national study of 5,000 youths also found that those who both attend church weekly and report that religion is important to them are much less likely to engage in binge drinking, smoking or using marijuana. Relative to their peers, religious youths are less likely to engage in behaviours that compromise their health, suggesting that religious resources may serve as a potentially important and often overlooked ally in promoting health.\textsuperscript{33}


Figure 9 shows that there is a diverse range of religious faiths in the communities of Hackney and the City of London. Christianity is the faith of the largest number of people in both boroughs, but 14% of the residents of Hackney are Muslims and 6% are Jewish.

**Figure 9: Religious belief in City of London and Hackney compared to ONS London Cosmopolitan peer local authorities and England, 2011**

![Religious belief chart](chart.png)

Source: ONS Census 2011

The Hackney JSNA indicates that geographically, the largest Christian populations are in the City, the east of Hackney and in the north-west near Finsbury Park. Jewish populations are particularly clustered in northern wards of Hackney. Populations of Muslims are concentrated in the east of Hackney, around Finsbury Park, and in the east of the City. Those identifying as having no religion are more prevalent in the west and south of the area.

One very large and distinctive religious group within Hackney is the Charedi community, part of the Jewish orthodox community that has been an established part of the local population for many years. Work commissioned by the London Borough of Hackney estimated the size of the Charedi population in 2011 to be 17,587, accounting for 7.4% of the Hackney population. This constitutes the UK’s largest Charedi community and is centred on Stamford Hill, identified as an area covering the wards of Brownswood, Cazenove, New River and Springfield in the London Borough of Hackney, and Seven Sisters in Haringey. Work undertaken by City and Hackney PCT to explore the specific health needs of the local Charedi population has shown that alcohol consumption within the community appeared relatively low compared to the general population.

**Lesbian, Gay, Bisexual and Transgender (LBGT) communities**

Research shows that, across all age groups, LGBT people are significantly more likely to use drugs and/or binge drink alcohol compared to the general population; they are also more likely to be dependent on these substances than the general population. Comparison with

---

data from the British Crime Survey (2010/11) suggests that ‘the use of any drug in the last month’ is 7 times higher across all LGBT adults compared to the general population.\textsuperscript{35} The range of recreational drugs used by LGBT communities is wide and includes the misuse of prescription drugs and steroids. Recreational drug use, particularly of methamphetamine, has been associated with risky sexual behaviour that may contribute to HIV transmission in gay and bisexual men.

Little is known about the drug treatment needs of the LGBT communities living and working in City and Hackney. The 2010 Gay Men’s Sex Survey\textsuperscript{36} asked participants whether they were currently concerned about their use of a range of different drugs. Of the 427 respondents from City and Hackney, 9.4% reported being concerned about their drug use. which is slightly higher than the average for London (8.6%).

Recent research carried out by the London Boroughs of Lambeth, Southwark and Lewisham\textsuperscript{37} has explored drug use in sexual settings among gay and bisexual men. It noted that crystal methamphetamine, gamma-hydroxybutyrate (GHB) / gamma-butyrolactone (GBL), mephedrone and, to a lesser extent, cocaine and ketamine are the main drugs most commonly associated with use in sexual settings. These drugs are widely known to facilitate pleasure or euphoria, but are also associated with a range of harms. Particular concern has been raised regarding the role of crystal meth, GHB/GBL and mephedrone in sexual HIV or STI transmission risk behaviour. These drugs can facilitate long sexual sessions with multiple partners and the likelihood of STI transmission may be increased due to rectal trauma or penile abrasions. There are also harms associated with drug overdose, especially in relation to GHB/GBL, which is typically administered in small, carefully timed doses. Within the last 2 years there have been a number of drug related casualties among gay men in clubs or sex-on-premises venues in London.

**Risk and protective factors for substance misuse**

**Deprivation**

The Index of Multiple Deprivation 2010 produced by Department for Communities and Local Government (DCLG) combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area in England. Indices of Deprivation 2010 have been produced at Lower Super Output Area (LSOA) level, of which there are 32,482 in the country and 181 in City of London and Hackney.

The relationships between deprivation and illegal drug use have been highlighted in a number of research studies.\textsuperscript{38} The Advisory Council for the Misuse of Drugs report ‘Drug Misuse and the Environment’ (1998)\textsuperscript{39} stressed the following points:


\textsuperscript{36} Findings from the United Kingdom Gay Men’s Sex Survey 2010. Sigma Research 2010. Available at: http://sigmaresearch.org.uk/gmss/region/london


\textsuperscript{38} Drugs and poverty: A literature review. Published by Scottish Drugs Forum on behalf of the Scottish Association of Alcohol and Drug Action Teams. 2007
• deprivation is associated with the problematic use of particular drugs such as heroin and crack cocaine. Although problematic use of these drugs is not exclusively related to deprivation it is much more common among poorer people
• rather than deprivation being related to whether people have ever tried drugs or not, it is more likely to relate to a lower age of first use, progression to dependence, injecting drug use, risky use, health and social complications from use and to criminal involvement
• deprivation is linked most strongly with the extremes of problematic use and least with casual, recreational or intermittent use of drugs
• deprivation often means a user is less likely to get care and treatment
• the chances of overcoming drug problems are lower among people who are disadvantaged; they have fewer positive alternatives and less access to meaningful employment, housing etc.
• deprived areas often suffer from greater and more visible public nuisance from drug taking and supplying
• poorer areas with high unemployment levels can provide an environment where drug dealing becomes an established way of earning money. Deprived areas might, at community level, find it more difficult to deal with drug problems
• deprived people living in over-crowded and sub-standard accommodation are more likely to share injecting equipment and more likely to get hepatitis, HIV and tuberculosis.

In other words, while there is no correlation between whether people have ever tried illegal drugs (with the possible exceptions of heroin and crack cocaine) and deprivation, there is a clear link between problematic drug use and deprivation. This does not mean all problematic drug users come from deprived areas or backgrounds. It does mean that a disproportionate number do.

The association between alcohol misuse and deprivation is not as clear and in fact several studies show that the more deprived the neighbourhood, the lower the level of alcohol consumption.40

Figure 10 shows the level of deprivation in Hackney based upon the Index of Multiple Deprivation 2010 scores for Middle Level Super Output Areas in Hackney and the City of London.

---
40 Neighbourhood deprivation and alcohol consumption: does the availability of alcohol play a role? Pollack, Craig Evan; Cubbin, Catherine; Ahn, David; Winkleby, Marilyn. International Journal of Epidemiology, Volume 34, Number 4, August 2005, pp. 772-780(9).
Figure 10: IMD Scores for Middle Level Super Output Areas in Hackney and City of London, 2010

Figure 10 shows that areas of relatively high deprivation are present in different parts of Hackney, in contrast with the City of London which is much less deprived than Hackney.

**Poverty and unemployment**

Aspects of socio-economic deprivation such as overcrowding, unemployment, single-parent households, those with 3 or more children, and no access to a car are associated with the prevalence of substance misuse.\(^{41}\) Mental health problems and poor school performance are also associated with substance misuse.

Figure 11 shows the trend for Hackney and City of London in long-term employment for the 4 years between October 2009 and October 2013. It shows the percentage of the working age population (aged 16-64 years) that had been claiming Jobseeker’s Allowance for over 12 months.

---

Figure 11: Percentage of the working age population that have been claiming job seekers allowance for over 12 months for Hackney and City of London, October 2009 to October 2013

In Hackney, long-term unemployment rose steadily from October 2009 to a peak in May 2012 of almost 1.9%, but has declined since then. Long-term unemployment in the City of London has fluctuated over this period and rose steeply in the autumn of 2011, but has been relatively stable since then at around 0.6%.

Figure 12 shows that the percentage of the working age population (persons aged 16-64 years) of Hackney that were unemployed in the 12 months to September 2013 was not significantly different to that for London and the other local authorities in the ONS London Cosmopolitan peer group but was higher than the England average. Data on the unemployment rate for the City of London are not available.

Figure 12: Percentage unemployment October 2012 to September 2013

Source: NOMIS
Figure 13 shows the percentage of the population aged 16-64 years in Hackney, England and the ONS London Cosmopolitan peer group who were in employment in the 12 months to September 2013. It shows that Hackney had the second lowest percentage of people aged 16-64 years in employment out of the authorities in the London Cosmopolitan peer group and that the proportion of adults in employment in Hackney was significantly lower than the average for London and England as a whole. Data on the employment rate for the City of London are not available.

**Figure 13: Percentage employment October 2012 to September 2013**

![Employment Rate Chart](image)

Source: NOMIS

Figure 14 shows the proportion of people claiming Job Seekers Allowance in Hackney and in the City of London aged 16-24 years, 25-49 years, 50-59 years and 60 years and over in January 2014.
Figure 14: Job Seekers Allowance claimants by age group for Hackney and City of London compared to ONS London Cosmopolitan peer local authorities, January 2014

![Bar Chart](image)

Source: NOMIS

It shows that Hackney had similar proportions of JSA claimants in each age group to the other ONS London Cosmopolitan local authorities, but that the City of London had a higher proportion of claimants aged 50 years and over and a lower of proportion of claimants aged 16-24 years.

Figure 15: Claimants of Incapacity Benefit and/or Severe Disablement Allowance whose main medical reason is alcoholism: Persons, crude rate per 100,000, working-age population, August 2011

![Bar Chart](image)

Source: LAPE

Figure 15 shows, for August 2011, the number of claimants of Incapacity Benefit (IB) and/or Severe Disablement Allowance (SDA) whose main medical reason is alcoholism per 100,000 working age population. The rate of claimants with alcoholism in Hackney was the second highest amongst the ONS London Cosmopolitan local authorities and significantly higher than the average across all London local authorities and England. The figure for City of London was
not significantly different to the London and England averages but, due to small numbers, the confidence intervals are very wide.

**Educational achievement**

In young people, the risk of becoming a substance misuser will depend on the relationship between a number of possible risk factors, such as deviant attitudes and behaviours, and protective factors, such as parental support. The potential impact of specific risk and protective factors changes with age. For example, risk factors within the family have greater impact on a younger child, while association with drug-abusing peers may be a more significant risk factor for an adolescent. Given the complexity of the relationship between different risk factors, and problems associated with quantifying them at a local level, it is difficult to assess the risk of becoming a substance misuser amongst young people in City and Hackney compared with the rest of London and England. Factors within the local population which may be associated with an increased risk of substance misuse amongst young people in Hackney and City include poverty, unemployment, levels of children in care, educational achievement and school drop-out rates.

A recent youth risk behaviour survey in the US\(^{42}\) showed a negative association between substance misuse and academic achievement after controlling for sex, race/ethnicity, and grade level. Figure 16 shows the percentage of pupils achieving at least 5 GCSE grades A* to C in 2012/13. It indicates that a lower proportion of children in Hackney (79.6%) achieve at least 5 GCSE grades A* to C than the average for London (84.4%); however, GCSE point scores for Hackney were similar to the London average. 7% of young people aged 16 to 18 in Hackney are not in employment, education or training (NEETs) compared with 5.4% nationally.

---

**Figure 16:** Percentage of pupils achieving 5 or more GCSE grades A* to C, for Hackney and ONS London Cosmopolitan local authorities, 2013/13

[Graph showing percentage achievements by local authority]

Source: Department for Education

---

\(^{42}\) 2009 National Youth Risk Behavior Survey (YRBS), US
Temporary accommodation and homelessness

Figure 17 shows the trend for the period 2009/10 to 2012/13 in the number of households in temporary accommodation. It shows that Hackney had a much higher rate of households in temporary accommodation than the average for England, but a lower rate than some of the ONS London Cosmopolitan authorities, such as Haringey, Brent and Newham. The rate of households in temporary accommodation in Hackney has remained relatively stable over this period.

Figure 17: Households in temporary accommodation per 1,000 households, 2009/10 to 2012/13

There is strong evidence of a mutually reinforcing relationship between homelessness and substance misuse. An experience of homelessness increases the risk of substance misuse among previously abstinent people, while entering into substance misuse also increases the risk that someone will become homeless, and when someone is homeless and involved in substance misuse each problem compounds the other.43

Table 4 shows the number of applications for Hackney and the City of London that were processed under the homelessness provisions of the 1996 Housing Act in the first half of 2013/14. It shows that over the 6-month period, almost 450 (59%) applicant households were unintentionally homeless and in priority need. Over three-quarters of these households were from non-White ethnic groups.

Table 4: Applicant households dealt with under the homelessness provisions of the 1996 Housing Act for which decisions were taken between April and September 2013

<table>
<thead>
<tr>
<th></th>
<th>City of London</th>
<th>Hackney</th>
<th>Total</th>
<th>%</th>
<th>Number Non-White</th>
<th>Total</th>
<th>% Non-White</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Eligible, unintentionally homeless and in priority need</td>
<td>&lt;5</td>
<td>445</td>
<td>448</td>
<td>59%</td>
<td>340</td>
<td>446</td>
<td>76%</td>
</tr>
</tbody>
</table>

Table 5 shows the types of accommodation that were used to house homeless households in the period from April to September 2013. It shows that 35% of homeless households were accommodated in hostels and a further 32% in private sector accommodation.

Table 5: Homeless households accommodated by Hackney and City of London at the end of September 2013

<table>
<thead>
<tr>
<th>Type of Accommodation</th>
<th>City of London</th>
<th>Hackney</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Bed and breakfast</td>
<td>0</td>
<td>23</td>
<td>23</td>
<td>1%</td>
</tr>
<tr>
<td>2. Other nightly paid, privately managed accommodation</td>
<td>10</td>
<td>&lt;5</td>
<td>12</td>
<td>1%</td>
</tr>
<tr>
<td>a. Hostels (incl. reception centres and emergencies units)</td>
<td>0</td>
<td>602</td>
<td>602</td>
<td>35%</td>
</tr>
<tr>
<td>b. Women’s refuges</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>4. Private sector accommodation leased by your authority or leased or managed by a Registered Provider (RP)</td>
<td>0</td>
<td>542</td>
<td>542</td>
<td>32%</td>
</tr>
<tr>
<td>5. Directly with a private sector landlord</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>6. Within your own stock</td>
<td>0</td>
<td>220</td>
<td>220</td>
<td>13%</td>
</tr>
<tr>
<td>7. Within Registered Provider stock</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>8. Any other types of accommodation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

Source: DCLG Neighbourhood Analysis Division, December 2013

Rough sleepers
The Combined Homelessness And Information Network (CHAIN) report for 2012/13 reported on people seen sleeping rough by outreach services using CHAIN, in the outer London boroughs. The data for Hackney suggest that:

- there were 102 rough sleepers observed to be bedding down in Hackney
- this was an increase of 21 compared to the previous year
- there were 87 male and 15 female rough sleepers
- 41 rough sleepers were of UK nationality, but there were 33 from the Central and Eastern European (CEE) category including: Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia, Slovenia
- 36 had support needs for alcohol, 23 for drugs, 32 for mental health and 11 of these needed support for all 3.

The CHAIN report for 2012/13 for the City of London suggests that:
- there were 284 rough sleepers observed to be bedding down in the City of London
- this was the same number as the previous year
- there were 266 male and 18 female rough sleepers

---

44 Annual CHAIN report for outer boroughs 1 April 2012 to 31 March 2013, Broadway
• 158 rough sleepers were of UK nationality, but there were 78 from the Central and Eastern European (CEE) category including: Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia, Slovenia
• 35 had support needs for alcohol, 17 for drugs, 38 for mental health and 30 of these needed support for all 3.

Crime
The relationship between problem drug use and crime is complex. Substance misuse can be both a cause of crime and, in the case of illegal drugs, a crime itself. The evidence indicates that problem drug users are responsible for a large percentage of acquisitive crime, such as shoplifting and burglaries. It has been suggested that one-third to over a half of all acquisitive crime is related to illegal drug use and it is generally committed by dependent users of heroin and crack cocaine trying to pay for their drugs. However, drugs and crime are also linked in a number of other ways including:
• arrest of people who use or supply illegal drugs
• arrest of people who commit violent offences while under the influence of drugs, particularly alcohol. Drunkenness is associated with a majority of murders, manslaughters and stabbings and half of domestic assaults
• alcohol and drug-related driving offences
• violence involving drug dealers who may clash with rival gangs or be violent towards drug users who owe them money.

Those living in poverty are more likely than average to be victims of crime, suffering more home break-ins, vandalism or deliberate harm to their home or car or experiencing personal theft. Fear of crime is also greatest amongst the poorer people and the elderly, and this is linked closely to substance misuse.

As a direct consequence of the crime they commit, these problem drug users are highly likely to end up in the criminal justice system at some point. Some will serve community sentences, others will be sent to prison. In either case, the criminal justice system now compels them to confront their drug problems.

Crime and alcohol
Figure 18 shows the trend in alcohol-related recorded crimes per 1,000 population over the period 2008/09 to 2012/13, for Hackney compared to London and England. Alcohol-attributable crime rates fell between 2009/10 and 2011/12, but showed a slight increase between 2011/12 and 2012/13 and, throughout this period, remained higher than the England and London averages. However, crime rates are unadjusted for age, so the higher rates in Hackney relative to England may just reflect the younger demographic profile. Published alcohol-attributable crime rates for the City of London appear to be very high but

45 The economic and social costs of Class A drug use in England and Wales, 2003-04 in Measuring different aspects of problem drug use: methodological developments, Home Office online report 16/06; BCS 2007
do not reflect the fact that much of the alcohol-attributable crime committed in the borough is by non-residents. For this reason, data on the City of London have been excluded from the graphs.

Figure 18: Trend in alcohol-related recorded crimes crude rate per 1,000 population 2008/09 to 2012/13

Figure 19 shows the trend in violent crime attributable to alcohol over the same period. The rates of crime, and violent crime, attributable to alcohol in Hackney have been higher than for London and England over this period, but have shown a downward trend, except for a slight upturn between 2011/12 and 2012/13.

Figure 19: Trend in alcohol-related violent crime crude rate per 1,000 population, 2007/08 to 2011/12

Figure 20 shows the trend in sexual crimes attributable to alcohol for Hackney compared to London and England for the years 2008/09 to 2012/13. It shows that the sexual crime rate attributed to alcohol has remained higher in Hackney than in London and England, despite having fallen since 2008/09.

Figure 20: Trend in alcohol-related sexual crimes crude rate per 1,000 population, 2008/09 to 2012/13
Crime and drugs

Figure 21 shows the rate per 1,000 crimes for drug offences in Hackney between March 2007 and June 2013 compared with the Metropolitan Police area as a whole. It shows that drug offences in Hackney as a proportion of reported crimes rose steadily during 2007 and 2008 before peaking in 2009. Since 2009, the drug crime rate in Hackney has fallen to a level similar to that for the Metropolitan Police area as a whole.

Figure 21: Drug offences in Hackney & the London Metropolitan Police area recorded between 2007 and 2012, rate per 1,000 crimes

Source: Home Office
Figure 22 shows the drug crime rate per 1,000 population for the wards in Hackney during 2012/13 (equivalent data are not available for the City of London at ward level). Haggerston and King’s Park wards had the highest rate of drug crimes in 2012/13. Both wards had rates more than twice those of the other Hackney wards.

**Figure 22: Drug crimes rate per 1,000 population for Hackney wards, 2012/13**

Source: GLA Ward profiles

**Children and young people in contact with the criminal justice system**

Research has highlighted that young people in the youth justice system use illegal drugs earlier and in larger quantities than other young people.49 Figure 23 shows the number of children and young people in contact with the criminal justice system aged 10 and over in Hackney for the years 2010/11 and 2012 by age group. It shows that the number of children and young people in contact with the criminal justice system has reduced from more than 350 in 2010/11 to less than 200 in 2012/13. This reduction has been uniform across all of the age groups.

---

Figure 23: Number of children and young people in contact with the criminal justice system in Hackney, 2010/11 to 2012/13 by age group

Source: Ministry of Justice

Gangs
In Great Britain, 1% of men aged 18-34 years are gang members compared to 8.6% in Hackney. Information released by the Metropolitan Police in 2012 suggests that Hackney has over 20 established gangs, with membership ranging from 20 up to almost 100 members or associates.

A 2011 survey of young men (aged 18-34 years) in England, Scotland and Wales included 4,664 men, of whom 624 were from Hackney. This survey found that gang members were significantly more likely than non-members to have experienced psychosis, anxiety, alcohol dependence, drug dependence, anti-social personality disorder and suicide attempts.

Dual diagnosis
‘Dual diagnosis’ (sometimes called co-morbidity) is a term used to denote the presence of both mental health and substance misuse issues experienced by individuals.

It has, in the past, been used largely to describe individuals who have severe and complex substance misuse problems, and significant drug and/or alcohol addiction. However, good practice for CCGs would expect that the whole spectrum of care would be encompassed within a definition when applied to commissioning for the healthcare needs of a population, and therefore a ‘low threshold’ definition would be most appropriate.

According to mental health charity Mind:\footnote{MIND 2007}

‘Dual diagnosis is a common problem for both mental health services and drug and alcohol treatment services. It’s suggested that 30 to 50 per cent of people with mental health problems also have current drug or alcohol issues.’

‘It’s possible that as many as half to two-thirds of people who come into contact with drug or alcohol treatment services may also have some kind of mental health problem, although they will not necessarily have contact with mental health services.’

As indicated in the NICE guideline CG120,\footnote{NICE guideline, Psychosis with coexisting substance misuse: Assessment and management in adults and young people (CG 120), NICE, London, March 2011.} substance misuse among individuals with mental health disorders is associated with significantly poorer outcomes than for individuals with a single disorder. These outcomes include worsening psychiatric symptoms, poorer physical health, increased use of institutional services, poor medication adherence, homelessness, increased risk of HIV infection, greater dropout from services and higher treatment costs. Social outcomes are also significantly worse, including greater homelessness, a higher impact on families and carers, and increased contact with the criminal justice system. People with psychosis commonly take various non-prescribed substances as a way of coping with their symptoms; this amounts to harmful or dependent use in a third of people with psychosis. The outcome for people with psychosis and coexisting substance misuse is worse than for people without coexisting substance misuse, partly because the substances used may exacerbate the psychosis and partly because substances often interfere with pharmacological or psychological treatment.

Amongst Hackney residents undergoing structured alcohol treatment during 2012/13, 103 (equivalent to 30% of alcohol clients) were recorded as having dual diagnosis.

**Suicide**

Both substance misuse and untreated mental illness are associated with a greater risk of suicide. It is estimated that 16% of substance misusers (current misusers, not ever misusers) will take their own lives. Research shows that individuals with a dual diagnosis are at a further increased risk of suicide. Severe depression accompanied by substance misuse is one of the most frequent causes of suicide.\footnote{NICE guideline, Psychosis with coexisting substance misuse: Assessment and management in adults and young people (CG 120), NICE, London, March 2011.}

Hackney had a similar rate of mortality from suicide and injury undetermined in the period 2010 to 2012 to that for England, London and the other ONS London Cosmopolitan authorities. The City of London had a higher mortality rate from suicide and injury undetermined than both London and England but the small resident population makes this figure more difficult to interpret. In 2008/2010, there were 12.8 cases of suicide and injury undetermined per 100,000 population for Hackney (all ages); this rate fell to 8.1 per 100,000 in 2010-12 and remained at 8.0 in 2011-13. This is no longer statistically different from the London and England averages.

No local information could be found to indicate whether the rate of suicide involving substance misuse in Hackney and City residents is more than expected compared with London and national averages.
Summary of the key population indicators and risk factors that will determine health needs in relation to substance misuse in City and Hackney

- The resident populations of Hackney and the City of London are relatively young, with more adults aged 25-45 years and fewer adults aged over 65 years than the England average. The ONS estimates that the population of Hackney will increase from 247,182 to 271,844 or by 10% from 2011 to 2021 and that the resident population of City of London will grow over the same time period from around 7,400 to 12,000. These increases will not be uniform across the different age groups in the population. The ONS expects a reduction in the absolute number of people in the 10-29 years group and increases in both 0-9 years and 30-44 years age groups. Since 2008, more people have been moving into Hackney from other parts of the UK and overseas than have been moving out. The effect on drug misuse of these changes depends on rates of drug misuse in different age-groups.

- The ethnic make-up of the City of London’s resident population is similar to that for England, whereas the population of Hackney is more diverse. The ethnicity of Hackney’s population is similar to that of other local authorities in the ONS ‘London Cosmopolitan’ peer group, having a large Black population. City of London and Hackney are also communities with a diverse range of religious faiths. Some ethnic minorities are at greater risk of substance misuse, while religious engagement is protective. These factors will have implications for the level of substance misuse with the local population and for the delivery of preventive and treatment interventions.

- Little is known about the needs of the LGBT community in City and Hackney. However, 1 in 7 (14.6%) respondents from City and Hackney to the 2007 Gay Men’s Sex Survey reported being concerned about their drug use, which was higher than average for London (11.0%).

- Unemployment in Hackney has been falling in line with national trends and the latest data indicate that unemployment rates are similar to the London average and that of ONS London Cosmopolitan peer authorities. However, this is due to the rising population, and the absolute numbers of people not in work has remained constant.

- The rate of benefits claimants in the working age population for whom the main medical reason is alcoholism in Hackney was higher than both the London and England averages.

- Hackney has a higher rate of households in temporary accommodation than the England average. There is a strong association between poor housing and substance misuse. The rate of homelessness and overcrowding within City and Hackney is relatively high.

- In a 2012/13 survey of rough sleepers, Hackney had a 20% increase in the number of rough sleepers compared to the previous year. Almost a third of the rough sleepers were from Central and Eastern Europe. More than a third (36%) of all the rough sleepers had support needs for alcohol, 23 for drugs, 32 mental health needs and 11 support needs for all 3. Rough sleepers were more common in the City of London than in Hackney, and have a high prevalence of substance misuse.

- Alcohol-attributable crime rates have been falling in recent years in both Hackney and the City of London, but these remained higher than the England and London averages.

---

55 Brent, Hackney, Haringey, Lambeth, Lewisham, Newham, Southwark.
in 2011/12. Rates of drug crime in Hackney have also fallen in recent years, with most drug crime in 2012/13 taking place in Haggerston and King’s Park wards.

- Gang membership amongst young men is more common in Hackney than in England as a whole, with the Metropolitan Police believing that at least 20 gangs were operating in Hackney in 2012.
4. Epidemiology of substance misuse

Drug misuse

National prevalence
According to the 2013 Crime Survey for England and Wales (CSEW), the use of any illicit drug in the UK has fallen from 11.1% in 1996 to 8.2% in 2012/13, mainly due to a decline in cannabis use. Use of Class A drugs was lower in 2012/13 than at any time since 1996, due largely to declines in the use of hallucinogens (LSD and magic mushrooms), ecstasy and, in the last 4 years, cocaine.

The level of illicit drug use among men (11.0%) is twice as high as the level among women (5.4%). Men are also more likely than women to have used a Class A drug in the last year (3.7% in men vs. 1.5% in women). Presentations for problems with crack cocaine use continue to be high.

For the first time, the CSEW 2012/13 included questions on use of the legal emerging drugs, salvia and nitrous oxide, in the previous 12 months and found that: among adults aged 16-59 years, 2.0% reported taking nitrous oxide and 0.3% reported taking salvia in the last year; among young adults aged 16-24 years, 6.1% reported taking nitrous oxide and 1.1% reported taking salvia in the last year.

Applying these percentages to the population of Hackney and the City of London would suggest that around 1,912 people aged 16-24 years will have taken nitrous oxide in the last year and 345 people aged 16-24 years will have taken salvia in the last year. Similarly, around 3,700 people aged 16-59 years will have taken nitrous oxide in the last year and 554 people aged 16-59 years will have taken salvia.

‘Club drugs’ is a collective term for a number of different substances typically used by young people in bars and nightclubs, at concerts and parties. These drugs can be harmful and heavy use can develop into a dependency. Data collected since 2005/06 provide some information on the scale and nature of the problems associated with the more established club drugs – ecstasy, ketamine, methamphetamine, GHB/GBL and mephedrone. Despite the widespread use of club drugs, they are currently causing a treatment problem for relatively few people. There is no evidence to suggest they are replacing heroin and crack as drugs of dependency, but they can seriously harm the physical and mental health of users. Although only a small number of people have so far needed treatment for club drugs, the figure is gradually increasing. There is an inevitable time lag between first use and developing a dependency, so it is not yet clear how many more people may require treatment in future years.

Encouragingly, the club drug users who do need help tend to respond well to treatment. Unlike typical heroin and crack users, they often have the good personal resources – jobs, relationships, accommodation – that mean they are more likely to make the most of available support.

---

The issue of addiction to prescription drugs has increased dramatically in the past few decades. Physical health problems and the long-term prescription of medication contribute to the development of substance misuse in older people. However, prescription drugs are now more widely available, through diversion of prescriptions and unregulated sales via the Internet. Deaths involving benzodiazepines (drugs which help alleviate anxiety and insomnia) and the painkiller, Tramadol, increased by 60% in the 5 years between 2007 and 2012. The Home Affairs Committee report noted that support and treatment for people who develop problems in relation to prescription-only or over-the-counter medicines would be provided by GPs, many of whom do not report to the National Drug Treatment Monitoring Service (NDTMS) and so it is difficult to obtain a clear picture of the scale of addiction to prescription medicines.

### Older people and substance misuse

It is projected that in Europe and the UK, the number of people aged 65 years and over with a substance use problem or needing treatment will more than double between 2001 and 2020. This partly reflects the impact of the ageing population and longer life expectancy, however there is also some evidence that the current population of older people may drink relatively more alcohol compared to previous generations. In the older population aged over 65 years, men have a greater risk of substance use disorders relating to alcohol and illicit drugs, whereas women are at higher risk of psychotropic drug misuse.

There are a number of substance misuse issues that particularly affect older people. For example, they may use a combination of licit and illicit substances, as well as prescribed and over-the-counter medications taken under medical instruction. About one-third of people aged over 65 years in private households take 4 or more prescribed medicines daily. There can also be issues in correctly taking medications, for example taking food and/or drugs that interact or forgetting which medications they have taken. Failure to comply with prescribing instructions can result in a range of adverse effects such as tolerance, withdrawal symptoms and compulsive use in the long term. Changes in the body’s metabolism as people age can also leave older people more at risk from the harmful effects of substance misuse, for example, older people tend to show higher blood alcohol levels than younger people after drinking the same amount of alcohol.

The consumption of alcohol tends to follow a different pattern in older people. For example, the average alcohol weekly consumption in 2010 was 8.1 units for people aged 65 years and over, compared to 13.1 units in people aged 45-64 years. However, the proportion of males aged 65 years and over who consumed alcohol on 5 or more days in the last week in 2011 was 24%, compared to 16% across all age groups. The proportion of women aged 65 years and over who consumed alcohol on 5 more days was also higher at 13% (compared to 9% across all age groups). This suggests that while older people drink fewer units in a single session they drink more often over the course of a week.

---

One study of psychiatric illness and co-morbid substance misuse in primary care found a 27% increase in co-morbidity in the 75-84 years age group compared to an average of 62% with co-morbid psychiatric illness and substance misuse across all age groups. The increase was associated with dependence on licit substances such as benzodiazepines and was associated with delirium. There has also been an upward trend in hospital admissions for people aged over 60 years with alcohol-related mental health problems (e.g. Wernicke Korsakoff syndrome) between 2002 and 2012.

**Local prevalence of drug misuse in Hackney and City of London**

Estimates for the numbers and prevalence of opiate and crack cocaine users (per 1,000 population aged 15-64 years) for each local authority area are produced by the University of Glasgow to inform local service provision. Table 6 shows the estimated numbers of drug users in Hackney for the period 2004/05 to 2010/11, during which there has been an overall decline in the numbers of opiate and/or crack cocaine use. The number of injecting drug users has fluctuated over the same period. Evidence from 50 months of drug testing data (heroin and cocaine only) at Hackney Police stations from April 2007 to June 2011 showed a similar downward trend from 100 positive tests per month in 2008 to 67 positive tests per month in 2011.

**Table 6: Estimated numbers of drug users in Hackney, 2004/05 to 2010/11 (with 95% confidence intervals shown in brackets where available)**

<table>
<thead>
<tr>
<th>Drug</th>
<th>2004/05</th>
<th>2006/07</th>
<th>2008/09 (brackets)</th>
<th>2009/10</th>
<th>2010/11 (brackets)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiate and/or crack cocaine use</td>
<td>4,586</td>
<td>3,898</td>
<td>2,925 (2420 to 3404)</td>
<td>2,009 (1907 to 2570)</td>
<td>2246 (1907 to 2570)</td>
</tr>
<tr>
<td>Opiate use</td>
<td>2,909</td>
<td>2,656</td>
<td>1,939 (1642 to 2239)</td>
<td>1,795 (1521 to 2067)</td>
<td>1792 (1521 to 2067)</td>
</tr>
<tr>
<td>Crack cocaine use</td>
<td>3,969</td>
<td>2,982</td>
<td>1,932 (1576 to 2269)</td>
<td>1,926 (1456 to 2074)</td>
<td>1769 (1456 to 2074)</td>
</tr>
<tr>
<td>Injecting drug use</td>
<td>Per 378</td>
<td>680</td>
<td>N/A</td>
<td>435</td>
<td>549 (460 to 677)</td>
</tr>
</tbody>
</table>

Source: University of Glasgow and Liverpool John Moores University

Table 7 shows the estimated numbers of drug users in the City of London for 2010/11, with the number of opiate and/or crack cocaine users estimated as fewer than 50.

---

Table 7: Estimated numbers of drug users in City of London, 2010/11 (with 95% confidence intervals)

<table>
<thead>
<tr>
<th>Drug</th>
<th>2010/11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiate and/or crack cocaine use</td>
<td>46</td>
</tr>
<tr>
<td></td>
<td>(25 to 67)</td>
</tr>
<tr>
<td>Opiate use</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>(23 to 52)</td>
</tr>
<tr>
<td>Crack cocaine use</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>(26 to 61)</td>
</tr>
<tr>
<td>Injecting drug use</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>(8 to 23)</td>
</tr>
</tbody>
</table>

Source: University of Glasgow and Liverpool John Moores University

Figure 24, Figure 25, Figure 26 and Figure 27 show the estimated prevalence of opiate users, crack cocaine users, opiate and/or crack cocaine users, and injecting-drug users in Hackney compared with the other ONS London Cosmopolitan boroughs in 2010/11, alongside the averages for London and England. For all types of drug use, the estimated prevalence amongst the 15-64 years age group in Hackney was significantly higher than average for London and England. The prevalence rates for the City of London were not significantly different from the London average and were lower than the England average, apart from the prevalence of opiate and crack cocaine use, which was lower than both London and England averages.

Figure 24: ‘Glasgow’ estimates of opiate users per 1,000 population aged 15-64, 2010/11

Source: University of Manchester and Liverpool John Moores University
Figure 25: ‘Glasgow’ estimates of crack cocaine users per 1,000 population aged 15-64, 2010/11

Source: University of Manchester and Liverpool John Moores University

Figure 26: ‘Glasgow’ estimates of injecting drug users per 1,000 population aged 15-64, 2010/11

Source: University of Manchester and Liverpool John Moores University
Figure 27: ‘Glasgow’ estimates of opiate and crack cocaine users per 1,000 population aged 15-64, 2010/11

Source: University of Manchester and Liverpool John Moores University

Nationally estimated projections for the numbers of men and women aged 18-64 years dependent on drugs over the period 2012 to 2020 for Hackney and City of London are shown in Figure 28 and Figure 29. Please note that these figures are derived from the Adult Psychiatric Morbidity survey,63 which highlights that its definition of ‘dependent’ has a much lower threshold than is recommended by ICD-10 and DSM-IV64 and that the majority of those considered drug dependent by this measure are dependent on cannabis only.

For Hackney the number of adults dependent on drugs using this non-clinical threshold is predicted to rise by around 300, from 5,912 to 6,255 between 2012 and 2020 (equivalent to a rise of around 5%). The number of adults predicted to be dependent on drugs in the City of London is expected to increase from 221 in 2012 to 331 by 2020 (equivalent to a rise of around 50%).

---

64 Respondents were counted as dependent if they answered yes to any one of five given criteria, rather than the typical threshold of three.
Drug-related deaths

In 2012, the mortality related to drug misuse was lower for London (149 reported deaths equivalent to an age-standardised rate of 17.2 per million, 95% CI 14.4 to 20.0) than for England (1,356 deaths, equivalent to an age-standardised rate of 25.4 per million, 95% CI 24.1 to 26.8). The most common underlying cause of death in 2012 was from accidental poisoning, accounting for 73% (1,087 out of 1,496) of drug-related deaths in England and Wales. Deaths involving new psychoactive substances such as mephedrone increased from 29 deaths in 2011 to 52 deaths in 2012.  

There were 23 drug-related deaths registered in Hackney in the period 2010 to 2012, which was lower than the 31 deaths reported in the period 2007 to 2009. These figures relate to the numbers of deaths registered with drug misuse as a cause during the period in question; due

---

to the length of time it takes to complete a coroner’s inquest, it can take months or even years for a drug-related death to be registered.

**Blood-borne viruses**

People who misuse illicit substances are often at increased risk of contracting blood-borne viruses, including Hepatitis B (HBV), Hepatitis C (HCV) and Human Immunodeficiency Virus (HIV). HBV and HCV infections are major causes of chronic liver disease and liver cancer, and pose a significant challenge in terms of potentially preventable mortality and morbidity. The prevalence of both Hepatitis B and C varies markedly across the country and most infections are acquired through adult risk behaviour. In England and Wales, injecting drug use and male homosexual contact are the most frequently reported routes of transmission. Public Health England estimates that in the UK, 1 in 2 injecting drug users has contracted HCV, 1 in 6 has HBV and 1 in 100 has HIV. NICE recommends that anyone who is at regular risk (e.g. still injecting) should be tested and retested every 6 months.66

In addition to blood-borne viruses, bacterial infections remain a problem among people who inject drugs in the UK, with almost one-third reporting a symptom of a bacterial infection (such as a sore or an abscess) at an injecting site in the past year.

**Alcohol misuse**

**National prevalence of alcohol misuse**

The Institute of Alcohol Studies have reported that annual alcohol consumption in the UK has been estimated at 10 litres per capita for those aged 15 years and older and 8.3 litres per capita on average throughout the entire population in 2011.67 This forms part of a recent downward trend from a peak of 11.5 and 9.5 litres per capita respectively in 2004. However, there has been a long-term increase in UK alcohol consumption since 1975, when average annual consumption per capita was 9 litres for the UK population older than 15 years and 6.9 litres on average as a whole.

The ONS conducted a national survey on the nation’s drinking habits in 2012.68 This survey showed that in 2012, 58% of adults aged over 16 years in Great Britain (GB) drank alcohol in the week before being interviewed. This was a 2% reduction for both men and women compared with 2011. This continues the general decline in the proportion of adults drinking in GB since 2005. It also indicated that 11% of adults in GB were frequent drinkers (drank alcohol on at least 5 days in the week before being interviewed) in 2012. There were differences in frequent drinking between different sub-groups of the population:

- men were more likely to be frequent drinkers than women (64% vs. 52%)
- those in employment were more likely to be frequent drinkers than those who were unemployed/economically inactive (65% vs. 47% and 48% respectively)

---

66 NICE (2013) Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection NICE public health guidance 43
68 Office for National Statistics Opinions and Lifestyle Survey, Drinking Habits Amongst Adults, 2012
people from White ethnic groups were more likely to be frequent drinkers than those from ethnic minority groups (62% White, 33% Black or Black British, 19% Asian or Asian British).

Frequent drinking (drinking on 5 or more days in the week before interview) was more common in men than women and also more common with increasing age. The ONS Survey indicated that 5% of men and 2% of women aged 16-24 years were frequent drinkers, but this proportion increased to 23% for men and 14% for women in the 65 years and older age group.

In 2012 a quarter of adult drinkers were heavy drinkers. The ONS defined heavy drinking as consuming 8 units of alcohol for males and 6 units of alcohol for females on the heaviest drinking day during the week prior to interview for frequent drinkers who had consumed alcohol on 5 of the previous 7 days. Male drinkers (29%) were more likely to be heavy drinkers than female drinkers (21%), regardless of age.

Drinkers who smoked (25%) were more than twice as likely as those who did not smoke (11%) to be very heavy drinkers, regardless of how much they smoked. However, drinkers who were ex-smokers (13%) were more likely to be very heavy drinkers than those who had never smoked (9%). It is not clear whether people who have given up smoking reduce their drinking frequency, or whether smokers who reduce their drinking frequency then go on to give up smoking.

Tackling the impact of harmful and dependent drinking is a key public health priority. The National Treatment Agency for Substance Misuse has stated that alcohol misuse is linked to a range of health disorders, including high blood pressure, heart disease, stroke, liver disease, some cancers, and depression. There were around 1.2 million alcohol-related hospital admissions in England in 2010/11 while close to 15,500 people died from alcohol-related causes in 2010. Estimates suggest alcohol-related harm overall costs the NHS in England £3.5bn a year.

**Local prevalence of alcohol misuse in Hackney and City of London**

Nationally published modelled estimates for the proportion of people in different drinking risk categories are shown for Hackney and City of London in

Table 8, alongside the regional average. In Hackney, it was estimated that almost 25% of adults abstain from drinking compared with the London average of 22.4%; for City of London, the proportion of abstainers was estimated as lower, at less than 15%. The percentage of drinkers who engage in lower risk drinking was estimated to be around 75% for Hackney, which was similar to the London average, and around 70% for the City of London. 18% of Hackney drinkers (around 27,000 people) are estimated to be increasing risk (hazardous) drinkers compared with 21.7% of City drinkers (almost 1,300 people) and 19.7% of London drinkers. Almost 8% of drinkers in Hackney (more than 11,000 people) and almost 9% of drinkers in City of London (more than 500 people) are estimated to be higher risk drinkers, which is higher than the London average. The estimated numbers of binge drinkers is more than 25,000 for Hackney and almost 1,750 for the City of London.

---

Table 8: Number and percentage\(^{70}\) of drinkers in Hackney, City of London and London by risk group, 2011

<table>
<thead>
<tr>
<th>Risk Group</th>
<th>Hackney</th>
<th>City of London</th>
<th>London</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population aged 16 and over (GLA 2014)</td>
<td>205,104</td>
<td>7,171</td>
<td>6,832,119</td>
</tr>
<tr>
<td>Abstainers</td>
<td>24.8%</td>
<td>50,866</td>
<td>14.3%</td>
</tr>
<tr>
<td>Lower risk drinking (% of drinkers only)</td>
<td>74.2%</td>
<td>114,445</td>
<td>69.4%</td>
</tr>
<tr>
<td>Increasing risk drinking (also referred to as hazardous drinking) (% of drinkers only)</td>
<td>18.8%</td>
<td>27,763</td>
<td>21.7%</td>
</tr>
<tr>
<td>Higher risk drinking (also referred to as harmful drinking) (% of drinkers only)</td>
<td>7.8%</td>
<td>12,031</td>
<td>8.9%</td>
</tr>
<tr>
<td>Binge drinking (% of total pop)</td>
<td>13.4%</td>
<td>27,484</td>
<td>25.3%</td>
</tr>
</tbody>
</table>

Source: Local Alcohol Profiles for England (LAPE)

The likely distribution of male drinkers in Hackney who are in the increasing risk (hazardous) drinking category or higher is shown in Figure 30; this suggests that there is a higher concentration of heavier drinkers in the north of the borough. The likely distribution of female drinkers in Hackney who are in the increasing risk (hazardous) drinking category or higher is shown in Figure 31.

\(^{70}\) LAPE, 2009
Figure 30: Proportion of men who regularly drink 4 or more units of alcohol per day

Source: Hackney Acorn Wellbeing Model

Figure 31: Proportion of women who regularly drink 3 or more units of alcohol per day

Source: Hackney Acorn Wellbeing Model
Figure 32 shows the estimated number of adults in Hackney and the City of London, expected to have mild, moderate and severe alcohol dependency for the years 2012 to 2020. These projections have used the results of the Adult Psychiatric Morbidity Survey⁷¹ applied to ONS population projections for the 2 boroughs of Hackney and the City of London.

Figure 32: Estimated number of mild, moderate and severe cases of alcohol dependence for adults aged 18-64 years in Hackney & City, 2012 to 2020

![Graph showing estimated number of cases of alcohol dependence](image)

Source: PANSI

In 2012, more than 10,800 people in Hackney and the City of London were estimated to be dependent on alcohol and this number is expected to increase to over 11,500 by 2020. Among the dependent drinkers, the vast majority have mild dependency and only a small minority have moderate or severe dependency.

**Hospital admissions related to alcohol**

As shown in Figure 33, the number of alcohol-related hospital admissions⁷² per 100,000 population in Hackney has risen over the period 2008/09 to 2012/13; the rate was consistently higher than the London average which also increased over the same period. The rate of alcohol-related hospital admissions for the City of London showed a similar increase but was consistently lower than that for London as a whole.

---

⁷¹ Adult psychiatric morbidity in England, 2007: Results of a household survey, published by the Health and Social Care Information Centre in 2009

⁷² Alcohol-related conditions include all alcohol-specific conditions, plus those where alcohol is causally implicated in some but not all cases of the outcome, for example hypertensive diseases, various cancers and falls. The attributable fractions for alcohol-related outcomes used here range from between 0 and less than 1.0. For example, the alcohol-attributable fraction for mortality from pneumonia among men aged 75 years and over is 0.10 because the latest epidemiological data suggest that 10% of pneumonia cases among this population are due to alcohol. Outcomes where alcohol has a protective effect (i.e. the fraction is less than 0) are not included when the alcohol-attributable fractions are applied to mortality and hospital episode statistics data.
Figure 33: Age-standardised rate of alcohol-related admissions per 100,000 population for City of London, Hackney and England, 2008/09 to 2012/13

Source: HSCIC

Figure 34 shows the trend in alcohol-specific\textsuperscript{73} admissions for Hackney compared with London and England over the period 2008/09 to 2012/13, shown separately for men and for women. The rate of alcohol-specific admissions for men in Hackney was higher than the regional and national averages over this period; the rate for women was similar to the regional and national averages over the same period.

Figure 34: Rate of alcohol-specific hospital admissions (number per 100,000 population) for Hackney compared to London and England, 2008/09 to 2012/13

Source: LAPE

\textsuperscript{73} Alcohol-specific outcomes include those conditions where alcohol is causally implicated in all cases of the condition; for example, alcohol-induced behavioural disorders and alcohol-related liver cirrhosis. The alcohol-attributable fraction is 1.0 because all cases (100\%) are caused by alcohol.
Figure 35 and Figure 36 show the trend in alcohol-related admissions for Hackney and the City of London compared with London and England over the period 2008/09 to 2012/13, shown separately for men and for women. Alcohol-related admissions were higher for men than women in all years and were higher in 2012/13 than in 2008/09. The rate of alcohol-related admissions in Hackney is higher than both the England and London averages for men and for women, whereas the figures for the City of London are lower for both men and women.

Figure 35: Trend in alcohol-related hospital admissions for males (number per 1,000 admissions) for Hackney and the City of London compared to London and England, 2008/09 to 2012/13

Source: LAPE

Figure 36: Trend in alcohol-related hospital admissions for females (number per 1,000 admissions) for Hackney and the City of London compared to London and England, 2008/09 to 2012/13

Source: LAPE

---

Alcohol-attributable conditions include alcohol-specific conditions plus conditions that are caused by alcohol in some, but not all, cases (e.g. stomach cancer and unintentional injury). For these latter conditions, different attributable fractions are used to determine the proportion related to alcohol for males and females. A list of alcohol-attributable conditions with their ICD-10 codes can be found at: http://www.nwph.net/nwpho/publications/AlcoholAttributableFractions.pdf
Figure 37 shows the age-standardised emergency hospital admission rate for alcohol-related liver disease in City and Hackney CCG over the period 2010/11 to 2012/13, compared with selected London CCGs, and the London and national averages. The rates for City and Hackney CCG are lower than the London and national averages which contrasts with the higher rates of hospital admission for men in City and Hackney with alcohol-related conditions.

Figure 37: Age-standardised emergency hospital admissions for alcohol-related liver disease per 1,000 population, selected London CCGs, London and England, 2010/11 to 2012/13

Rates of ambulance call outs per 100 population aged 16-40 years for binge drinking during 2013 are shown for each of the Hackney wards in Figure 38, showing that Haggerston ward had the highest call-out rate and Springfield the lowest.
**Figure 38:** Rates of ambulance call outs per 100 population aged 16-40 years for binge drinking, by ward for Hackney, 2013

![Figure 38: Rates of ambulance call outs per 100 population aged 16-40 years for binge drinking, by ward for Hackney, 2013](image)

Source: GLA Ward Profiles

**Alcohol-related deaths**

Figure 39 and Figure 40 show the crude mortality rates for alcohol-related deaths for the boroughs in London for the year 2012. In 2012, alcohol-related death rates for both sexes in London were significantly lower than the England average. In 2012, alcohol-related death rates for males in London ranged from 44.9 per 100,000 in Harrow to 78.1 per 100,000 in Tower Hamlets (figures are not published for City of London and Kingston). Hackney had the fourth highest alcohol-related mortality rate of any London borough.

In 2012, alcohol-related death rates for females in London ranged from 18.6 per 100,000 in Barnet to 36.2 per 100,000 in Tower Hamlets (figures are not published for City of London and Kensington and Chelsea). Hackney’s rate was similar to the average for London.
Figure 39: Male alcohol-related death rates per 100,000 population, London boroughs, 2012

Source: Local Alcohol Profiles for England, based on ONS mortality data and population estimates
Figure 40: Female alcohol-related death rates per 100,000 population, London boroughs, 2012

Source: Local Alcohol Profiles for England, based on ONS mortality data and population estimates

Summary of key findings on public health indicators for drug and alcohol use

- Nationally, the 2013 Crime Survey for England and Wales (CSEW) suggests that the use of drugs in the UK has fallen over the last 15 years mainly due to a decline in cannabis use. However, use of recreational club drugs, legal highs and abuse of prescription medications is believed to be growing, although there is a relative paucity of data currently on these emerging drugs.
- Estimates of the prevalence of drug use in Hackney suggest that the prevalence of opiate use, crack cocaine use and injecting drug use is higher than the averages for England and London, but similar to ONS London Cosmopolitan local authorities. The prevalence rates for the resident population of the City of London were not significantly different from the London average and were lower than the England average, apart from the prevalence of opiate and crack cocaine use which was lower
than both London and England averages. Please note that this does not include the substance misuse in those who work but do not live in the City.

- There were fewer drug-related deaths registered in Hackney in the period 2010 to 2012 than in 2007 to 2009.
- People who misuse illicit substances are often at increased risk of contracting blood-borne viruses, including Hepatitis B (HBV), Hepatitis C (HCV) and Human Immunodeficiency Virus (HIV).
- The National Treatment Agency for Substance Misuse has stated that there were around 1.2 million alcohol-related hospital admissions in England in 2010/11 while close to 15,500 people died from alcohol-related causes in 2010. Estimates suggest alcohol-related harm overall costs the NHS in England £3.5bn a year.
- Nationally published modelled estimates suggest that almost 8% of drinkers in Hackney and almost 9% of drinkers in City of London are higher risk drinkers, which is higher than the London average. Estimates for binge drinking levels are much higher for the City of London resident population than for Hackney and for London as a whole; this does not include the non-resident workforce. In 2012, more than 10,800 people in Hackney and the City of London were estimated to be dependent on alcohol and this number is expected to increase to over 11,500 by 2020.
- Hospital admission rates related to alcohol misuse are higher than the London average in Hackney, but not in the City of London. They show a rising trend over recent years.
- Rates of ambulance call-outs for alcohol-related illness during 2013 show that Haggerston ward had a much higher call-out rate than the other Hackney wards. This figure includes non-residents requiring an ambulance while in Haggerston, and must be understood in the context of its large night-time economy.
- In 2012, Hackney had the fourth highest alcohol-related mortality rate for males of any London borough; the alcohol-related mortality rate for females was similar to the London average. The numbers of alcohol-related deaths in the City of London are too few for valid statistical comparison.
5. Substance misuse services in Hackney and City of London

Services for adults and older people in Hackney

This section briefly describes the current local service provision in Hackney and the City of London for adults who misuse illicit drugs. Service activity data is presented later in Section 5 of this report.

Drug misuse services

1. Community Drug Service (Provider = Lifeline)

The Community Drug Service is provided by Lifeline, a registered charity, from the purpose-built Elizabeth Fry Centre, in Tudor Grove in Hackney. The centre has been designed to provide active direct access engagement and triage and progression through to a range of recovery-based services that have been developed in consultation with the Hackney Drug and Alcohol Action Team.

Substance or alcohol misuse support can be accessed by telephone, secure messaging on the website, at daily open access drop-in clinics or by referral from a GP or other professional worker.

This service is the gateway to drug treatment services providing:

- open access drop-in
- structured support service
- 12-week group day programme
- aftercare service
- GP shared care
- women’s and families services
- stimulant treatment service
- opiate substitute prescribing
- needle exchange.

The drop-in is open daily from Monday to Friday at the Elizabeth Fry Centre, with evening sessions (up to 8.00 pm) on 2 evenings per week. The drop-in team can offer:

- advice and information
- assessment for treatment
- needle exchange
- health support and blood-borne virus testing from a specialist nurse.

There are also a variety of easy-access support programmes in the drop-in including:

- brief interventions and short-term support
- acupuncture
- pre-treatment support group
- cannabis group programme
- housing and benefits advice
- advice sessions on keeping safe and healthy (e.g. safe using, nutrition, smoking cessation).
Lifeline’s workers provide therapeutic support and help to develop a personalised recovery plan, as well as giving access to a range of other treatment services. These include:

- opioid substitution treatment for opiate users by on-site doctors
- day programme focusing on life-skills and self-development; relapse prevention; substance misuse and health; reducing offending behaviour
- specialist groups for crack use, cannabis use and other drug uses
- on-site counselling service, run by a full-time paid counsellor supported by a team of volunteers
- self-development activities including:
  - art group
  - choir
  - complementary therapies
  - football
  - reading group
  - drama group
  - free gym passes
  - mosaic-making
  - education, training and employment support
  - access to recreational and vocational training courses
  - access to mutual aid groups such as Narcotics Anonymous (NA) and Cocaine Anonymous (CA)
- specialist women’s service in a safe women-only environment
- family and parenting service for families which include problem drug users and people with children
- LGBT service.

Lifeline can also help find a residential detoxification and rehabilitation place, and give post treatment support including move-on to community training and development services when clients are ready to leave treatment.

2. Drug Intervention Programme (Provider = Westminster Drugs Project)

Westminster Drug Project (WDP) Hackney is a recovery support service for adults who are affected by drug and alcohol problems and have had involvement with the criminal justice system.

Their services are designed to help people leave the cycle of crime and substance misuse and regain control over their lives. WDP has a dedicated team of substance misuse practitioners who work across the London Borough of Hackney to identify and support drug and alcohol using offenders. They work closely with partners in the criminal justice system, health service and other agencies to provide a range of services to people who wish to receive advice, assessment and treatment for their drug and alcohol problems.

The services WDP offer include:

- Drug Interventions Programme (DIP), working in partnership with the police, probation and courts to identify and support substance misusing offenders
- assessment of people’s needs in relations to their drug and alcohol problems
- one-to-one key working sessions
• counselling and psychology interventions
• access to group work
• blood-borne virus (BBV) screening and immunisation
• rapid access to opiate substitute prescribing and onward referral to other specialist prescribing services
• assessment for detoxification and rehabilitation
• assessment for drug rehabilitation requirement (DRR) and alcohol treatment requirement (ATR)
• dedicated prison link worker offering support prior and post release from prison, liaising with prison teams to ensure a smooth transition into the community
• extended brief interventions for alcohol users
• dedicated women’s practitioner who works with all female service users, both in the community and in custody. The women’s practitioner has experience in working with women with complex issues, such as domestic violence, sex work and safeguarding
• support from trained practitioners for people with the ‘dual diagnosis’ of mental health and substance use problems
• access to housing, legal and debt advice, including support from a WDP housing practitioner who works with partners in the statutory, voluntary and private sectors to generate local solutions to improve the lives of homeless and poorly housed clients, assessing clients’ needs, exploring options, finding accommodation and linking in with longer-term support
• referral to aftercare services, including education, training and employment support
• access to mutual aid groups
• ongoing support to assist individuals in their progression in their recovery journey upon becoming abstinent.

3. **Blood-Borne Virus Service (Provider = East London NHS Foundation Trust)**

A nurse team providing a harm reduction healthcare service covering:
• safer drug and injecting advice
• testing for Hepatitis B, C and HIV
• vaccinations (Hepatitis A, Hepatitis B, influenza and tetanus)
• diagnosis and treatment of sexually transmitted infections
• emergency contraception and pregnancy testing
• screening for TB
• cervical cytology (smears)
• assessment for other general health problems and referral to appropriate agencies
• monitoring of Hepatitis, HIV and liver disease
• treatment for Hepatitis B and C and HIV through joint clinics
• screening and monitoring for alcohol-related health problems including liver disease.

4. **GP Shared Care Locally Enhanced Service (Provider = Hackney GPs)**

The shared care service was developed to support partnership working between primary care and Hackney specialist drug services in the provision of multi-disciplinary care to stable drug users, i.e. adult drug users who do not experience problems related to their drug use, who
will be stable and treatment compliant, having been titrated and stabilised by the Community Drug Service prior to the transfer of their care to primary care. General Practitioners work with Lifeline Hackney and other agencies to agree, and regularly review, a personalised Recovery Care Plan for each patient. The Recovery Care Plan sets out a personalised package of care based on the patient’s aspirations and capabilities, and is intended to enable him/her to build a lifestyle that promotes health and wellbeing, social and personal capital, as well as tackling drug dependence. Practices receive a monthly payment of £37.85 for every patient registered and seen monthly on the shared care scheme. During 2013/14, 19 practices in City and Hackney CCG had managed around 325 patients under the shared care scheme.

5. **Pharmacy Based Supervised Opiate Substitute Local Enhanced Service (Provider = Hackney Pharmacies)**

The daily supervised consumption of opiate substitutes is intended to stabilise service users on substitute medication in order to reduce craving and alleviate withdrawal (with take away cover doses when the Pharmacy is closed) by ensuring that each dose is correctly consumed by the service user it was intended for.

6. **Pharmacy Needle and Syringe Exchange Local Enhanced Service (Provider = Hackney Pharmacies)**

This service is offered by 7 community pharmacies in Hackney. It was developed because of the extensive evidence base which shows that syringe and needle exchange provision reduces the transmission of blood-borne viruses and other diseases associated with injecting drug use, thus reducing harm for the individual and the wider community.

**Alcohol misuse services**

7. **Grove Alcohol Recovery Centre (ARC) (Provider = East London NHS Foundation Trust)**

First point of contact for alcohol-related advice and support in the community offering advice, information, counselling and onward referrals.

ARC provides:
- speedy assessment
- specialist health check
- individual support and counselling
- support groups for drinking reduction, abstinence and family/friends
- community detoxification and aftercare
- advice and support
- evening appointments
- Polish language drop-in 11am-1pm Fridays.

ARC offer free training for professionals on request and can provide relapse prevention for individuals who may no longer be drinking but wish to access support to maintain their recovery. Through their liaison service they currently run a number of satellites across the area and may be able to offer an appointment at the individual’s GP. ARC satellites at local
GPs include: Heron Practice; Well Street Surgery; Lawson Practice; Shoreditch Park Surgery/Hoxton, Greenhouse Walk in clinic; Nightingale Surgery; Barton House Group Practice; Sorsby Surgery.

8. **Primary Care Alcohol Screening (Provider = Hackney GPs)**

In 2008, the Government issued a Direct Enhanced Service that required practices to screen new patients aged 16 years and over to identify any alcohol-related health issues they may have. NHS City and Hackney supplemented this service with a Local Enhanced Service to increase the identification of patients who have a specified long-term condition and are drinking at hazardous or dangerous levels. GPs are rewarded for identifying adult patients drinking at increasing or higher risk levels, and encouraged to consider referring dependent drinkers to Hackney specialist alcohol services. All City and Hackney practices offer this service.

**Combined drug and alcohol services**

9. **City & Hackney Specialist Addiction Unit (SAU)**\(^{75}\) *(Provider = East London NHS Foundation Trust)*

The SAU is a treatment service offering routes to recovery to adults over the age of 18 years who have complex drug and alcohol-related needs in the City and Hackney. Individuals can self-refer, as can professionals such as GPs, social services and mental health professionals.

The SAU works with people who:
- are using both drugs and / or alcohol dependently
- have physical and / or mental health problems
- are struggling with multiple social problems, debt, child care issues, unemployment
- are pregnant women
- are sex workers
- are homeless and spend their time in / or have a link to the City or Hackney
- have needs which cannot be met in primary care.

10. **Homerton Hospital Substance Misuse Midwife (Provider = Homerton University Hospital Foundation Trust)**

Provides or secures coordination of care for pregnant women who are misusing, or at risk of misusing drugs and alcohol, to safeguard the mother and foetus.

11. **Homerton Hospital Clinical Nurse Specialists (Provider = Homerton University Hospital Foundation Trust)**

---

\(^{75}\) Services for dual-diagnosis clients that were previously provided by the Specialist Addictions Unit are now being provided by a Complex Needs Service delivered by Lifeline. The change in delivery took place in April 2014.
Provides assessment, referral to services, discharge planning, detoxification and opiate substitute prescribing to inpatients; advice and assistance to manage substance misusing patients attending accident and emergency and other departments.

12. **Crisis residential care (Provider = Cranstoun City Roads)**

Residential care for clients in immediate danger and crisis when it would not be safe for them to remain in the community, with placements usually up to 21 days.

13. **Residential detoxification and rehabilitation (Providers = Spot Purchased)**

Residential rehabilitation that usually involves clients staying for weeks or months. There is normally a mixture of group work, counselling and other practical and vocational activities. Different providers have different approaches, for example therapeutic communities or those based on the 12-Step programme used by Alcohols Anonymous and Narcotics Anonymous. There is also residential treatment provision for specific groups, e.g. pregnant women, people with mental illness and substance misuse problems.

14. **DAAT Engagement and Move On Outreach Team (DEMO) (Provider = London Borough of Hackney)**

Works with street users, e.g. drinkers, drug users, sex workers, people begging and the homeless, to support them into treatment and, if they have dropped out of treatment, seeks to re-engage them with services.

15. **Substance Misuse Social Work Team (Provider = London Borough of Hackney)**

Provides information and advice on adult social care issues, and community care assessments and care management.

16. **Dual Diagnosis Assertive Outreach Worker (Provider = East London NHS Foundation Trust)**

Provides counselling to clients of the Community Drug Service / Community Alcohol Service / DIP / DEMO to mitigate unplanned exits and re-presentations to treatment services.

The full list of drug and drug and alcohol services, including voluntary sector agencies, can be found in the Hackney Drug and Alcohol Treatment services map available from [www.hackneydaat.org.uk](http://www.hackneydaat.org.uk).

Figure 41 shows the geographical location of the drug and alcohol misuse services in Hackney described in this section. It shows that the services are concentrated in the south of Hackney, while the problem drinkers are more concentrated in the north (as shown in Figure 30 and Figure 31).
Services for adults and older people in the City of London

1. Alcoholics Anonymous
Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking.

2. Alcohol Recovery Centre (ARC)
A consultant-led service for those seeking help with problematic alcohol use this includes individuals, families and carers. The service is recovery focused, helping people free themselves from dependence on alcohol. Services include:

- 1:1 work
- group programmes
3. **Arrest Referral Service**, provided by City of London Substance Misuse Partnership Enhanced Arrest Referral Scheme. It provides direct fast track referrals to drug and alcohol services and undertakes required assessments. Services are free and confidential and include:

- advice and Information
- referral to Day Programmes
- harm minimisation
- motivational techniques
- rehabilitation
- support into and during treatment.

Anyone arrested in the City of London will have access to this service. City residents arrested elsewhere will be referred to the City of London Arrest Referral Team. City residents are offered all of the above services plus follow up, through care and social care.

4. **City of London Needle Exchange Service**

This is a pharmacy-based needle exchange service provided by the City of London Substance Misuse Partnership and is available to anyone who needs to use a needle exchange service. This service is available from Boots Pharmacy in Cheapside.

5. **Club Drug Clinic – CNWL**

The Club Drug Clinic is a team of specialist doctors, nurses, counsellors and psychologists who are all experienced in helping people who have a problem with club drugs. Club drugs that people may experience problems with can include:

- GBL
- Ketamine
- Crystal Meth (and other amphetamines)
- Cocaine
- MDMA
- Mephedrone
- Legal Highs.

The clinic is based in Chelsea & Westminster Hospital. Services provided include:

- information and advice
- assessment of individuals’ problems and planning how to improve the situation
- medically assisted withdrawal from substances talking treatments, to help individuals make the changes they want and stick to them
- sexual health screening.

This service works with people from all backgrounds and sexualities and can help with the psychological, sexual, physical, relationship, housing and work problems related to club drug use.
6. **Cranstoun City Roads**

Cranstoun City Roads Crisis Intervention provides a specialist residential service for people in crisis related to their drug use. It is a place of safety for those whose lives are in danger of spiralling out of control and are at risk. Services provided include:

- 24-hour staffing, with 2 qualified nurses and 2 social care team members per shift
- health assessment and appropriate treatment
- detoxification and/or stabilisation
- additional support staff during the day
- one-to-one support sessions
- a group work programme tailored to help people cope with issues arising during this stage of treatment, including: health, education, harm reduction and relapse prevention
- complementary therapies and relaxation groups
- creative activities to stimulate and help rebuild confidence
- support addressing legal, financial and social difficulties arising from drug use
- crisis helpline.

7. **Narcotics Anonymous (NA)**

NA is a non-profit fellowship or society of men and women for whom drugs had become a major problem. Narcotics Anonymous is a completely voluntary organisation of recovering addicts who meet regularly to help each other stay clean. Membership is open to anyone with a drug problem seeking help, regardless of what drug or combination of drugs have been used, and irrespective of age, sex, religion, race, creed or class. The only requirement for membership is a desire to stop using drugs. The primary service provided by Narcotics Anonymous is the local meetings (held weekly). Meetings are facilitated by NA members. Other members may take part by talking in turn about their experiences of addiction and the recovery, strength and hope they've discovered through NA. On-line Skype meetings are also available.

8. **Health E1**

Nurse-led general medical practice for people who are sleeping rough or those in temporary or hostel accommodation in the Borough of Tower Hamlets and E1 (City of London). Services include:

- substance misuse clinics
- alcohol service
- mental health clinics
- home visits
- psychologist
- health visitors
- family planning
- blood clinics and Blood-Borne Virus Team
- new-patient health checks.
9. **The Neaman Practice**

GP-led medical practice for City of London residents who live within the surgery catchment area (see catchment area information). This type of service is the first point of contact for most medical services. Services and clinics provided at the surgery include:

- substance misuse service
- chiropody
- diabetes clinic
- baby clinic
- immunisation (travel, children and adults)
- repeat prescription service.

10. **Release**

Release is the national centre of expertise on drugs and drugs law – providing free and confidential specialist advice to the public and professionals. Release also campaigns for changes to UK drug policy to bring about a fairer and more compassionate legal framework to manage drug use in our society. Services provided include:

- national advice telephone helpline offering advice in relation to drugs and the law
- legal helpline offering advice to both professionals and the public on criminal matters; drugs classification; anti-social behaviour orders
- help and advice on legal issues pertinent to drugs users, such as travelling with prescribed controlled drugs
- help and advice on the impact of criminal convictions and cautions
- help and advice on drug use and its impact on driving requirements.

Advice can also be provided on other legal issues by providing details of other services. There is also a drugs helpline providing help, advice, information, support and referral to people affected directly and indirectly by drug use.

11. **Drinkline – The National Alcohol Helpline**

Drinkline is an advice and information line for anyone who wants more information about alcohol, local services that can help, or simply to talk about drinking and alcohol issues. Services provided include:

- free and confidential service
- details of local services
- leaflets, information and guides
- advice on how to reduce your drinking
- information provided to anyone who is worried about someone else’s drinking.

**Expenditure on substance misuse services**

In 2013/14, planned spend was £8.4 million on substance misuse services for young people up to 19 years of age and adults; £7.7 million on direct service provision, and £700,000 on commissioning and support costs. The council provides 94% of total funding, i.e. £7.9 million. Most of this council funding – £7.2 million or 90% – is via public health budgets.
Table 9: Expenditure on drug and alcohol services by London Borough of Hackney: Actual spend, 2013/14; Planned spend, 2014/15

<table>
<thead>
<tr>
<th>Service</th>
<th>2013/14 (Actual spend)</th>
<th>2014/15 (Planned spend)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug misuse in adults</td>
<td>£5,273,160</td>
<td>£5,417,860</td>
</tr>
<tr>
<td>Alcohol misuse in adults</td>
<td>£1,064,000</td>
<td>£1,074,000</td>
</tr>
<tr>
<td>Young people's substance misuse service</td>
<td>£217,000</td>
<td>£217,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£6,554,160</strong></td>
<td><strong>£6,708,860</strong></td>
</tr>
</tbody>
</table>

Source: Public Health Team, London Borough of Hackney
Table 10 shows spending on drugs and alcohol services in Hackney, the City, London and England. It indicates that spending per head of population on both services is low in the City compared with Hackney, London and England. In Hackney, spending per head on drug services is higher than in London and England, while spending on alcohol services is similar to London though higher than that for England.

We analysed the data further to investigate whether these differences reflected higher levels of demand. Data from the Adult Drug Profiles held by the NTDMS shows that there were 1,394 adults in treatment for drug misuse in Hackney in 2012/13. This suggests that the average annual spend (based on planned expenditure for 2013/14) per service user in treatment is about £3,700. There were 13 City residents in treatment, an average spend of about £3,200 per service user in treatment. In England in 2011/13, 193,575 adults were in treatment for drug misuse,\(^76\) giving an average annual spend per user of about £2,900. So spend per service user in treatment for drug misuse is higher than average in Hackney and in the City.

Corresponding data for alcohol services show that there were 491 adults in treatment for alcohol misuse in Hackney in 2012/13. This suggests that the average annual spend per service user in treatment for alcohol misuse is about £2,300. In England in 2012/13, 109,683 adults were in treatment for alcohol misuse, giving an average annual cost per user in treatment of about £1,900. Spend per service user in treatment for alcohol misuse is therefore higher than average in Hackney.

This picture may reflect differences in the number of people in contact with substance misuse services who are not in treatment and not reflected in the NDTMS data, a higher cost treatment model, more complex cases, lower efficiency or the allocation of financial costs. This merits further investigation.

**Summary of key findings on substance misuse services**

- Drug misuse services in Hackney include a community drug service, a drug intervention programme, a blood-borne virus service, locally enhanced service in primary care and opiate substitution and needle/syringe exchange services. For people

---

with alcohol misuse, there is screening in primary care and an alcohol-recovery service. There is also a specialist addiction unit, residential detoxification and rehabilitation and a range of specialist clinicians and social workers, including a team who work with people on the street.

In the City, there are branches of Alcoholics Anonymous and Narcotics Anonymous, an Alcohol Recovery Centre, an Arrest Referral Service, needle exchange, the Club Drug Clinic, primary care teams and specialist advice teams. In 2013/14, statutory agencies in City and Hackney spent £8.4 million on substance misuse services for young people (up to 19 years of age) and adults, £7.7 million on direct service provision and £700,000 on commissioning and support costs. 94% is Council spending, mostly via public health budgets.

In Hackney, spending per head on drug services is higher than in London and England, while spending on alcohol services is similar to London (though higher than that for England).
6. Substance misuse activity data for City of London and Hackney

This section brings together data on substance misuse activity within City of London and Hackney and for the residents of City of London and Hackney from a number of sources. These include data on those entering, leaving and in treatment for alcohol and drug misuse from the National Drug Treatment Monitoring Service (NDTMS) and data from local services provided by the Hackney DAAT.

At the request of the Hackney DAAT, we have not included any provisional NDTMS data for 2013/14 in this section, as these data may be subject to further revision.

Profile of clients accessing treatment for drug misuse

Data from the Adult Drug Profiles held by the NTDMS shows that there were 1,394 adults in treatment for drug misuse in 2012/13 in Hackney, an increase of 62 on the previous year. The number of adults in treatment in the City of London was 13, down from 17 the previous year. These are rates of 5.65 and 1.75 per thousand residents respectively, compared with 3.65 per thousand for England.

Figure 42 shows the age distribution of adults in treatment for Hackney for the years from 2005/06 to 2012/13.

Figure 42: Age profile for adults in drug treatment for substance misuse in Hackney, 2005/06 to 2012/13

Figure 42 shows that there has been a gradual shift towards a slightly older treatment population for substance misuse in Hackney. The proportion of adults in treatment aged 45 years and over in 2005/06 was 13%, but in 2012/13 this proportion had more than doubled to 27%. There has been a corresponding decrease in the proportion of adults in treatment aged...
under 35 years; this age group accounted for 69% of those in treatment in 2005/06, but 55% of those in treatment in 2012/13.

Figure 43: Ethnic distribution of adults in drug treatment in Hackney, 2005/06 to 2012/13

Figure 43 shows the ethnic distribution of adults in drug treatment in Hackney for the years 2005/06 to 2012/13. It shows that the proportion of adults in treatment from White ethnic groups has increased since 2005/05 from 63% to 67%, while the proportion from Black ethnic groups has decreased from 21% to 18% over the same period.

Figure 44: Primary drug for adults in drug treatment in Hackney, 2005/06 to 2012/13 (excluding ‘Others’ and ‘Unknown’)

Figure 44 shows that the largest group of adults in drug treatment in Hackney since 2005/06 has been opiate and crack users. The number of adults in treatment with opiates and crack cocaine as their primary drug increased from 479 in 2005/06 to 813 in 2008/09, before declining to 638 in 2011/12. The number of people in drug treatment with crack cocaine as
their sole drug has declined since 2008/09, falling from 301 in 2008/09 to 153 in 2012/13. The number of adults in treatment with cannabis as their primary drug has increased from 24 in 2005/06 to 95 in 2012/13.

Opiate and crack users were also the most commonly used primary drugs for people in treatment from the City of London. In 2012/13, 7 of the 13 people in treatment had opiates and crack cocaine as their primary drug.

**Figure 45:** Trend in length in treatment for adults in drug treatment in Hackney, 2005/06 to 2012/13

Figure 45 shows that there has been a slight increase in the proportion of adults in drug treatment for more than 2 years. This proportion was 25% in 2005/06 but increased to 29% in 2012/13.

Figure 46 shows the number of adults in treatment, the numbers in effective treatment and the number of completions for Hackney for the years 2005/06 to 2012/13. The numbers in treatment are only a fraction of the estimated 6,000 people with substance misuse problems in Hackney, indicating that around 4,500 people are not in treatment and may have unmet needs.

---

77 Treatment completions are the numbers of clients judged by their clinician to be no longer requiring structured drug treatment, free of their drug(s) of dependency and not using opiates or crack cocaine.
The number of adults from Hackney in treatment and in effective treatment has declined from a peak in 2008/09, although these numbers were higher in 2012/13 than in the previous year. The number of successful completions has remained relatively stable at around 200 per annum.

The NDTMS data shows that the number of adults in substance misuse treatment in the City of London has also declined from 33 in 2006/07 to 13 in 2012/13. Eleven of the 13 were in effective treatment in 2012/13 and there were 3 successful completions during the year.

### Treatment outcomes

Table 11 shows the completion rate for opiate and non-opiate clients for people in treatment in Hackney for the years 2010/11 to 2012/13. It shows that completion rates for both opiate and non-opiate users were lower in 2012/13 than in 2011/12.

<table>
<thead>
<tr>
<th></th>
<th>Opiate</th>
<th></th>
<th>Opiate</th>
<th></th>
<th>Non Opiate</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number in treatment</td>
<td>1061</td>
<td>991</td>
<td>1054</td>
<td>319</td>
<td>341</td>
<td>340</td>
</tr>
<tr>
<td>Completions</td>
<td>99</td>
<td>101</td>
<td>86</td>
<td>83</td>
<td>100</td>
<td>94</td>
</tr>
<tr>
<td>% Completions</td>
<td>9%</td>
<td>10%</td>
<td>8%</td>
<td>26%</td>
<td>29%</td>
<td>28%</td>
</tr>
</tbody>
</table>

Source: PHE Recovery Diagnostic Tool

Figure 47 shows the completion rates for opiate and non-opiate clients for Hackney compared to the NDTMS cluster average for the years 2010/11 to 2012/13.\(^{78}\)

---

\(^{78}\) NTDMS comparison methods will change for 2014/15. This report is written using the previous cluster system, where Hackney was in Cluster E, a cluster of 30 comparator areas including Camden, Islington, Lambeth,
For opiate users, the completion rates for Hackney were consistently higher than the NDTMS cluster average over this period, although the rates fell slightly in 2012/13 to come more in line with the NDTMS cluster average. For non-opiate users, the Hackney completion rates were consistently lower than the NDTMS cluster average over the same period and, compared with the previous year, the rates fell slightly in 2012/13. Provisional figures for the first 3 quarters of 2013/14 suggest that completion rates have improved since 2012, but scope remains to improve completion rates further.

Table 12 shows the number and proportion of successful completions (both opiate and non-opiate) by treatment provider for 2012/13 compared to baseline. It shows that Lifeline had 105 successful completions in the year, the Westminster Drugs project had 38, the Specialist Addiction Unit had 29, and the Hackney Substance Misuse Team had 8. In total there were 20 more completions in 2012/13 than in 2011/12. Lifeline is the only treatment provider that


The Substance Misuse Team are social workers/care managers employed by Hackney Council. They are co-located with the DAAT; previously they were based at the Hackney Service Centre (HSC).

They undertake Community Care Assessments (CCA) on clients referred for residential rehabilitation treatment. Following a CCA if client is eligible for treatment, the care managers will source out appropriate residential provider and write up a case presentation which is presented to the Care Panel for funding to be agreed/declined as appropriate.

They do not provide treatment; however the London NTA (now the London PHE) allowed the SMT in partnerships to report to the NDTMS at a time residential providers were not effectively reporting clients, some providers didn’t have NDTMS codes hence partnerships were losing number of clients being treated. Now that reporting problems have been resolved, it was decided and agreed with the NDTMS to exempt the SMT from reporting since July/August 2013.
substantially improved the number of successful completions in 2012/12 compared with baseline.
Table 12: Number and percentage of successful completions aged 18 years and above for Hackney by treatment provider, 2012/13 compared to baseline of 2011/12

<table>
<thead>
<tr>
<th>Number in treatment in the last 12 months (aged 18+)</th>
<th>Successful completions as a proportion of all in treatment (aged 18+)</th>
<th>Number of successful completions (Aged 18+, rolling 12 month data) – Latest month</th>
<th>Number of clients transferred - not in custody - latest 12 months</th>
<th>Number of clients transferred and continuing treatment in partnership</th>
<th>Number of clients transferred and resuming treatment outside of partnership</th>
<th>Percentage of all clients in treatment successfully transferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifeline</td>
<td>707</td>
<td>10.7%</td>
<td>76</td>
<td>105</td>
<td>111</td>
<td>44</td>
</tr>
<tr>
<td>WDP</td>
<td>429</td>
<td>9.6%</td>
<td>41</td>
<td>38</td>
<td>194</td>
<td>165</td>
</tr>
<tr>
<td>East London and The City Mental Health NHS Trust</td>
<td>327</td>
<td>9.8%</td>
<td>32</td>
<td>29</td>
<td>31</td>
<td>16</td>
</tr>
<tr>
<td>Hackney Substance Misuse Team</td>
<td>28</td>
<td>39.3%</td>
<td>11</td>
<td>8</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cranstoun</td>
<td>15</td>
<td>20.0%</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Charis Alcohol &amp; Drug Therapy Unit</td>
<td>&lt;5</td>
<td>50.0%</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Not available</td>
<td>&lt;5</td>
<td>50.0%</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Seventy4</td>
<td>&lt;5</td>
<td>0.0%</td>
<td>0</td>
<td>&lt;5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Quinton House</td>
<td>&lt;5</td>
<td>66.7%</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ANA</td>
<td>&lt;5</td>
<td>33.3%</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>New Roads</td>
<td>0</td>
<td>na</td>
<td>0</td>
<td>&lt;5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>BROADWAY LODGE</td>
<td>5</td>
<td>20.0%</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>RAPT</td>
<td>0</td>
<td>na</td>
<td>0</td>
<td>&lt;5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Gypnet Health</td>
<td>&lt;5</td>
<td>100.0%</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Action on Addiction</td>
<td>&lt;5</td>
<td>100.0%</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>St Mungo</td>
<td>22</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>BROADREACH HOUSE</td>
<td>&lt;5</td>
<td>25.0%</td>
<td>&lt;5</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Barnet, Enfield and Haringey Mental Health NHS Trust</td>
<td>&lt;5</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TTP</td>
<td>&lt;5</td>
<td>100.0%</td>
<td>&lt;5</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Salvation Army</td>
<td>5</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Camden and Islington Mental Health and Social Care</td>
<td>&lt;5</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Phoenix Futures</td>
<td>0</td>
<td>na</td>
<td>0</td>
<td>0</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Kenward Residential</td>
<td>0</td>
<td>na</td>
<td>0</td>
<td>0</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Compass</td>
<td>&lt;5</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
</tbody>
</table>

Source: NDTMS Successful Completions Provider Report, March 2013

Table 13 shows the re-presentation rates for both opiate and non-opiate clients for calendar years 2010 to 2012. It shows that while re-presentation rates for opiate clients decreased in 2012 compared to 2011, they remain higher than the NDTMS cluster average. Re-presentation rates for non-opiate clients have also declined in recent years and are now the same as the NDTMS cluster average.

Table 13: Number of completions and re-presentations for Hackney, 2010 to 2012 (calendar years)

<table>
<thead>
<tr>
<th></th>
<th>Opiate</th>
<th>Non Opiate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of completions</td>
<td>2010</td>
<td>2011</td>
</tr>
<tr>
<td>Of which, re-presented</td>
<td>20%</td>
<td>26%</td>
</tr>
<tr>
<td>NDTMS cluster average</td>
<td>22%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Source: PHE Recovery Diagnostic Tool
Figure 48 shows re-presentation rates for Hackney compared with the NDTMS cluster average over the period 2010 to 2012. Re-presentations for opiate users in the last 2 years of this period were higher than the NDTMS cluster average (24% vs. 19% in 2012); for non-opiate users, re-presentation rates were initially high compared with the NDTMS cluster average but have fallen year-on-year to reach the same level as the NDTMS cluster average in 2012. Provisional data for the first 3 quarters of 2013/14 suggest that re-presentation rates in Hackney have improved since 2012 and are now in the top quartile for the NDTMS cluster.

The DOMES report for the year ending 31st December 2012 noted that successful completion rates for opiate and non-opiate users continued to fall modestly for the third consecutive quarter and the rate of re-presentation to treatment for opiate users remained high. However, provisional part year data for 2013/14 suggests that re-presentation rates have decreased since 2012/13.

Figure 49 shows the average length of time in treatment for opiate users in Hackney compared to the NDTMS cluster average. Around two-thirds of opiate users in Hackney spend no more than 3 years in treatment. It shows that Hackney has a higher proportion of opiate users in treatment for less than a year than the NDTMS cluster average and a lower proportion in treatment for 6 years or longer. While it is a positive sign for opiate clients to spend less time in treatment, the fact that re-presentation rates for opiate clients are higher than the NDTMS cluster average may suggest that some clients are being discharged too early and are then re-presenting within 6 months.
Figure 49: Length of time in treatment for opiate clients, Hackney compared to NDTMS cluster average, 2012/13

![Graph showing length of time in treatment for opiate clients, Hackney compared to NDTMS cluster average.]

Source: PHE Recovery Diagnostic Tool

Figure 50 shows the length of time in treatment for non-opiate clients in Hackney compared to the NDTMS cluster average. It shows that the length of time in treatment for non-opiate clients in Hackney is similar to the NDTMS cluster average.

Figure 50: Length of time in treatment for non-opiate clients, Hackney compared to NDTMS cluster average, 2012/13

![Graph showing length of time in treatment for non-opiate clients, Hackney compared to NDTMS cluster average.]

Source: PHE Recovery Diagnostic Tool

Figure 51 shows the proportion of opiate and non-opiate clients who were not treatment naïve (first-time presentations) by complexity. It shows that for both opiate and non-opiate clients,
clients, Hackney has a smaller proportion of Very Low complexity cases and a higher proportion of Very High complexity cases, than the NDTMS cluster average.

**Figure 51: Case complexity for non-treatment naïve opiate and non-opiate clients in Hackney, 2010/11 to 2012/13**

Despite having a more complex case mix, Hackney has had a shorter average length of treatment than the NDTMS cluster average.

**Figure 52 shows the percentage of opiate and non-opiate clients in Hackney with previous treatment journeys in 2012/13 compared to the NDTMS cluster average.**

**Figure 52: Proportion of opiate and non opiate clients in treatment by previous treatment journeys, Hackney compared to NDTMS cluster average, 2012/13**
Figure 52 shows that in 2012/13 Hackney had a higher proportion of people in treatment for both opiates and non-opiates who had 4 or more previous treatment journeys. Having more unsuccessful journeys will add to complexity which may then lead to less successful outcomes.

The DOMES report indicated that the proportion of new presentations in Hackney that had accepted a Hepatitis B (HBV) vaccination in the period April to December 2012 was 38%. This was below the national average of 47%. However, the proportion that had accepted testing for Hepatitis C was 74% which was higher than the national average of 72%. For the City of London, the DOMES report for Q4 2012/13 indicates that only 25% of new presentations in the year had accepted a Hepatitis B vaccination, but 88% had accepted testing for Hepatitis C.

Table 14 shows the number and proportion of clients who were first-time presentations (treatment naïve) for the years 2010/11 to 2012/13.

<table>
<thead>
<tr>
<th></th>
<th>Opiate</th>
<th>Non Opiate</th>
<th>Opiate</th>
<th>Non Opiate</th>
<th>Opiate</th>
<th>Non Opiate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbers in treatment</td>
<td>1061</td>
<td>991</td>
<td>1054</td>
<td>319</td>
<td>341</td>
<td>340</td>
</tr>
<tr>
<td>Number in treatment who are treatment naïve</td>
<td>297</td>
<td>237</td>
<td>246</td>
<td>149</td>
<td>173</td>
<td>175</td>
</tr>
<tr>
<td>% who were treatment naïve</td>
<td>28%</td>
<td>24%</td>
<td>23%</td>
<td>47%</td>
<td>51%</td>
<td>51%</td>
</tr>
<tr>
<td>NDTMS cluster average</td>
<td>37%</td>
<td>34%</td>
<td>31%</td>
<td>59%</td>
<td>57%</td>
<td>55%</td>
</tr>
</tbody>
</table>

Source: PHE Recovery Diagnostic Tool

Table 14 shows that for both opiate and non-opiate clients Hackney has a lower percentage of treatment naïve clients than the NDTMS cluster average. One interpretation of this is that the services may not be attracting new clients into the treatment pathway. This might reflect changes in national patterns around service access, or it may mean that local services are not attractive or accessible for the treatment naïve.
Figure 53: Proportion of those in treatment in Hackney who were treatment naïve compared to NDTMS cluster average, 2010/11 to 2012/13

![Graph showing proportion of those in treatment in Hackney who were treatment naïve compared to NDTMS cluster average, 2010/11 to 2012/13.](image)

Source: PHE Recovery Diagnostic Tool

Figure 54 shows the completion rates for treatment naïve opiate and non-opiate clients for the years 2010/11 to 2012/13. It shows that over these 3 years, for opiate clients, completion rates for Hackney have been below the NDTMS cluster average. However, completion rates were higher than the cluster average for non-opiate clients.

![Graph showing completion rates for clients who were treatment naïve, Hackney compared to NDTMS cluster average, 2010/11 to 2012/13.](image)

Source: PHE Recovery Diagnostic Tool

Figure 55 shows the complexity groups for treatment naïve opiate and non-opiate clients in 2012/13. It shows a similar picture as that for non-treatment naïve clients, in so far as Hackney had a lower proportion of clients in the Very Low complexity group and a higher proportion of clients in the Very High complexity group. The Very High complexity group may include some individuals who have dropped out of treatment too soon in previous years.

![Graph showing complexity groups for treatment naïve opiate and non-opiate clients in 2012/13.](image)
The indicators of complexity in the treatment naïve users that were more commonly recorded in Hackney in 2012/13 compared to the England average were:
- daily use of opiates (18% in Hackney vs. 14% for England)
- daily use of non-opiates (14% vs. 7%)
- non-daily injecting (7% vs. 4%)
- crack use at start of treatment (28% vs. 11%)
- a housing problem or no fixed abode (38% vs. 22%).

Table 15 shows the completion rates for each complexity group for Hackney compared to the national average along with the percentage of the treatment population in each complexity group.

Table 15: Treatment population and completions by complexity groups (all clients), Hackney compared to national average, 2012/13

<table>
<thead>
<tr>
<th></th>
<th>V Low</th>
<th>Low</th>
<th>Med</th>
<th>High</th>
<th>V High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number in treatment</td>
<td>207</td>
<td>285</td>
<td>322</td>
<td>299</td>
<td>281</td>
</tr>
<tr>
<td>Number of completions</td>
<td>67</td>
<td>41</td>
<td>35</td>
<td>21</td>
<td>16</td>
</tr>
<tr>
<td>% completions of all in treatment</td>
<td>32%</td>
<td>14%</td>
<td>11%</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>% completions of all in treatment (national average)</td>
<td>43%</td>
<td>15%</td>
<td>9%</td>
<td>7%</td>
<td>5%</td>
</tr>
<tr>
<td>Distribution of treatment population</td>
<td>15%</td>
<td>20%</td>
<td>23%</td>
<td>21%</td>
<td>20%</td>
</tr>
<tr>
<td>Distribution of treatment population (national ave)</td>
<td>16%</td>
<td>24%</td>
<td>26%</td>
<td>20%</td>
<td>14%</td>
</tr>
<tr>
<td>Distribution of completions</td>
<td>37%</td>
<td>23%</td>
<td>19%</td>
<td>12%</td>
<td>9%</td>
</tr>
<tr>
<td>Distribution of completions (national ave)</td>
<td>45%</td>
<td>24%</td>
<td>16%</td>
<td>10%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Source: PHE Recovery Diagnostic Tool

Table 15 shows that, both for all clients, completion rates in 2012/13 were lower for the ‘Very Low’ complexity groups in Hackney than the national average. It also shows that Hackney had
a higher percentage of clients (20%) in the ‘Very High’ complexity group than the national average (14%).

Figure 56 and Figure 57 show the recorded outcomes for opiate users in Hackney at 6 months and 12 months after completing treatment. The first bar in Figure 56 gives the proportion of opiate clients who were using and not using the drug in the 28 days before they started treatment. The bottom section shows the proportion using at the start of treatment (dark orange) and the top section (light orange) shows the proportion of clients that were not using at the start of treatment. The next 4 bars show clients’ changes in opiate use by the time of the 6-month review. They fall into 1 of 4 categories based on the changes in levels of drug use: stopped, improved, unchanged and deteriorated. For clients who ‘stopped’, an upper and lower expected performance rate is displayed. Based on the complexity of clients in the local authority, it is expected that the proportion who stop using opiates will fall within this range. So if you are performing above the upper estimate you are exceeding your expected performance; if you fall below the lower rate you are performing below your expected performance.

**Figure 56: 6-month opiate outcomes in opiate clients reporting use and not reporting use at the start of treatment**

![Bar chart showing outcomes for opiate clients](chart.png)

Source: PHE Recovery Diagnostic Tool
Figure 57: Twelve-month opiate outcomes in opiate clients reporting use and not reporting use at the start of treatment

Source: PHE Recovery Diagnostic Tool

Figure 56 and Figure 57 show that the NDTMS have estimated that a smaller percentage of opiate clients in Hackney than expected had stopped using opiates at both 6 and 12 months after completing treatment.

Table 16 shows the treatment outcomes for non-opiate clients in Hackney at 6 months after treatment compared to the national average.

Table 16: Changes in drug use after 6 months of treatment, for non-opiate clients, Hackney compared to national average, 2012/13

<table>
<thead>
<tr>
<th></th>
<th>Stopped</th>
<th>Improved</th>
<th>Unchanged</th>
<th>Deteriorated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hackney</td>
<td>National</td>
<td>Hackney</td>
<td>National</td>
</tr>
<tr>
<td>Crack</td>
<td>46%</td>
<td>58%</td>
<td>13%</td>
<td>7%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>65%</td>
<td>66%</td>
<td>6%</td>
<td>10%</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>67%</td>
<td>59%</td>
<td>33%</td>
<td>10%</td>
</tr>
<tr>
<td>Cannabis</td>
<td>29%</td>
<td>36%</td>
<td>16%</td>
<td>18%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>28%</td>
<td>32%</td>
<td>11%</td>
<td>15%</td>
</tr>
<tr>
<td>Injecting</td>
<td>50%</td>
<td>63%</td>
<td>50%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Source: PHE Recovery Diagnostic Tool

Table 16 shows that a lower proportion of crack and injecting drug users in Hackney had stopped using after 6 months treatment compared to the national average. Also 11% of cannabis users and 17% of alcohol users in Hackney had deteriorated compared with 3% nationally.
Diagnostic and Outcomes Monitoring (DOMES)

The Q3 2012/13 DOMES report for Hackney indicates that there were 915 opiate drug users in effective treatment in Hackney during the year; an increase of 1.4% on the previous year. This trend was not reflected nationally where there was a reduction of 2.7% in the number of opiate users in effective treatment. For non-opiate users, the DOMES data indicates that 274 non-opiate users were in effective treatment in Hackney, an increase of 8.3% on the number the previous year. This constituted a larger increase than was seen nationally (2%). Both of these trends were described as positive in the Commentary to Support Local Performance in the DOMES report.

The DOMES report notes that successfully completing treatment without re-presenting within 6 months will be the key outcome indicator within the Public Health Outcomes Framework for drug treatment. For opiate users, Hackney’s recovery rate of 8.1% (84/1041) was noted as being outside the top quartile performance for similar partnerships, which ranged between 8.6% and 11.7%. In absolute numbers the number of opiate users completing treatment had been virtually unchanged for the previous 3 consecutive quarters, but the recovery rate had declined because the number in effective treatment had increased over this period.
Summary of substance misuse activity data

- There were 1,394 adults in treatment for drug misuse in 2012/13 in Hackney, an increase of 62 on the previous year. The number of adults in treatment in the City of London was 13, down from 17 the previous year. These are rates of 5.65 and 1.75 per 1,000 residents respectively, compared with 3.65 per 1,000 for England.
- The number of adults in treatment for substance misuse in Hackney and the City was broadly stable in 2012/13. The treatment population is gradually growing older.
- The most common ‘primary drug’ (the substance or substances that brought the client into treatment at the point of triage/initial assessment) for adults in drug treatment in Hackney since 2005/06 has been combined opiate and crack use.
- Completion rates for opiate and non-opiate clients in treatment in Hackney were slightly lower in 2012/13 than in 2011/12. They compare well with the NDTMS cluster\(^80\) average for opiate addiction, but less well for non-opiates.
- Re-presentation rates for opiate users in treatment in Hackney were higher than the NDTMS cluster average in 2012/13, but are falling.
- There were a lower proportion of treatment naïve clients in treatment in Hackney than the NDTMS cluster average in 2012/13. This might suggest that local services are failing to attract in new clients or those from under-served groups.
- A larger proportion of clients in treatment had 4 or more previous treatment journeys compared to the England average in 2012/13. This may suggest that clients are exiting treatment prematurely.
- A higher proportion of clients in treatment in Hackney were in the ‘Very High’ complexity group, which may reflect failed previous treatment journeys and suggests that local services need to ensure that they are responding to other aspects of complexity such as daily opiate use, crack use, injecting, alcohol use and housing problems.
- The average length of time in treatment in Hackney was less than for the NDTMS cluster average in 2012/13.
- A lower proportion of opiate users than predicted by the national average had stopped using opiates after 6 months of treatment as of 31 March 2013.
- A lower proportion of non-opiate injecting drug users and crack cocaine users had stopped using drugs than the national average after 6 months of treatment.

---

Service specific user profile and activity data

Community Drugs Service (CDS) – Lifeline
The CDS started 398 new treatment episodes in the year 2012/13, slightly below the target of 458, largely due to a slow-down in new referrals in the final quarter of the year. All new clients were offered Hepatitis B and Hepatitis C testing and a general healthcare assessment.

From April to December 2013, 86% of clients were in effective treatment. There were 273 adults in effective treatment in December 2013, 214 of whom were opiate users. There were 114 successful completions during the year, of which 56 were opiate users. Overall 91% of completions did not re-present within 6 months. Successful completions or onward referrals accounted for 75% of all discharges during the year.

Open access
The housing advisor saw between 3 and 18 individuals per month at once-weekly housing support sessions.

Stimulant treatment service
During 2012/13, 255 new stimulant users were taken on of whom 103 had a stimulant as their primary drug. During Quarter 4, 359 users were receiving a one-on-one service. There were 170 discharges during the year of which 101 (59%) were planned.

Vulnerable women’s service
At the end of the year there were 73 vulnerable women on the caseload: a significant increase from 26 in February 2012. There were 9 successful completions from this population during 2012/13, compared to 2 the previous year.

Counselling
The counselling service at Lifeline is provided by 1 full time (paid) counsellor and 5 volunteers. It typically sees around 40 service users each quarter and has a counselling session attendance rate of around 90%.

Education, Training and Employment (ETE)
The ETE service saw 141 new clients during the year. There were 48 clients supported into ‘meaningful activity’ and 21 supported into sustainable employment during the year.

Aftercare and activities to strengthen recovery
There were 74 referrals for linking into post-treatment support, from Lifeline, ARC and the SMT.
City & Hackney Specialist Addiction Unit

There were 273 new referrals of Drug and Alcohol Action Team (DAAT) clients during 2012/13 (including some out of area) of which 63% were male. Almost three-quarters (74%) were aged 26-41 years. Of these referrals, 160 (58%) were offered treatment.

There were 227 cases on the DAAT caseload at the end of Quarter 4 2012/13. Of these, 35% were aged 42-49 years. Most were from White ethnic groups, including Irish (5%), other White European (7%), as well as British (60%). Three-quarters (75%) had heroin as their primary drug, with crack/cocaine (10%) being the next most common primary drug.

There were 127 discharges of closed cases during the year, including 27 successful completions that were drug and/or alcohol free.

At the end of Quarter 4 there were 154 service users that had been on the caseload for 6 months or more.

There were 53 Drug Intervention Programme (DIP) referrals during 2012/13, of which 72% (38) were male. The majority (66%) were aged 35-49 years. Of the referrals to the service, 36 (68%) were offered treatment.

There were 38 cases on the active caseload at the end of Quarter 4, an increase from 21 cases at the end of the first quarter.

There were 18 discharges/closed cases from the service in 2012/12, including 2 deaths.

At the end of Quarter 4, there were 20 clients who had been on the caseload for 6 months or more.

Westminster Drugs Project – Drug Intervention Programme

There were 295 new treatment journeys into the service in 2012/13, more than the annual target of 216. The service believes that this was the result of better access to the service arising from a widening of the range of interventions on offer and delivering treatment to non-opiate/crack users and for problematic alcohol users.

Figure 58: Number of new treatment journeys at the Westminster Drug Project, 2012/13

75% of service users were in effective treatment in the period January to December 2013. There were 37 service users who successfully completed treatment drug free or with only occasional use in 2012/13. The quarterly numbers are shown in Figure 59.

**Figure 59: Number of clients successfully completing treatment drug free or with occasional use, 2012/13**

WDP Hackney performed well above the London average for all Arrest Referral Diagnostic Indicators (DIs) during 2012/13. It also managed to perform above the national average for the number triaged and referred for a modality then starting treatment within 6 weeks.

Heroin is the primary drug of choice with 67% of service users on the caseload reporting an opiate dependency. Crack cocaine is the second highest used drug at 17%. Powder cocaine and cannabis use account for 8% and 6% respectively.

A total of 560 clients were seen by WDP Hackney but did not come into structured treatment. Of these:

- 439 were seen under Required Assessment legislation
- 121 were seen on a voluntary basis
Specialist Midwife – Substance and Alcohol Misuse (SAAM)
Table 17 shows the number of women referred to the Substance and Alcohol Misuse (SAAM) specialist midwifery service for the years 2010/11 to 2012/13, broken down by age group. It shows that the total number of women referred to the SAAM service increased markedly in 2012/13 compared to the 2 previous years. Over 50% of women referred to the service are aged 25-34 years and there are a higher proportion of referrals of women in younger age groups (aged under 25 years) than of older age groups (aged over 35 years).

Table 17: Age profile of women referred to the specialist substance and alcohol abuse midwife, 2010/11 to 2012/13

<table>
<thead>
<tr>
<th>Age in years</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>Percentage</td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>Under 19 years</td>
<td>&lt;10 -</td>
<td>&lt;10 -</td>
<td>&lt;10 -</td>
</tr>
<tr>
<td>19-24 years</td>
<td>18 25%</td>
<td>14 18%</td>
<td>30 20%</td>
</tr>
<tr>
<td>25-34 years</td>
<td>37 51%</td>
<td>41 51%</td>
<td>88 59%</td>
</tr>
<tr>
<td>35-45 years</td>
<td>11 15%</td>
<td>17 21%</td>
<td>21 14%</td>
</tr>
<tr>
<td>Over 45 years</td>
<td>&lt;10 -</td>
<td>&lt;10 -</td>
<td>&lt;10 -</td>
</tr>
<tr>
<td>Not known</td>
<td>&lt;10 -</td>
<td>&lt;10 -</td>
<td>&lt;10 -</td>
</tr>
<tr>
<td>Total</td>
<td>73 100%</td>
<td>80 100%</td>
<td>149 100%</td>
</tr>
</tbody>
</table>

Source: Hackney Drug Action Team

Table 18 shows the ethnic origin of women referred to the SAAM service between 2010/11 and 2012/13. It shows that there were fewer women of Asian or mixed race origin than of Black or White ethnic origin.
Table 18: Ethnic origin of women referred to the specialist substance and alcohol abuse midwife, 2010/11 to 2012/13

<table>
<thead>
<tr>
<th>Ethnic Origin</th>
<th>2010/11</th>
<th></th>
<th>2011/12</th>
<th></th>
<th>2012/13</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percentage</td>
<td>Number</td>
<td>Percentage</td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>Asian</td>
<td>&lt;10</td>
<td>-</td>
<td>&lt;10</td>
<td>-</td>
<td>&lt;10</td>
<td>-</td>
</tr>
<tr>
<td>Black</td>
<td>24</td>
<td>33%</td>
<td>16</td>
<td>20%</td>
<td>40</td>
<td>27%</td>
</tr>
<tr>
<td>Mixed Race</td>
<td>&lt;10</td>
<td>-</td>
<td>&lt;10</td>
<td>-</td>
<td>22</td>
<td>15%</td>
</tr>
<tr>
<td>White</td>
<td>35</td>
<td>48%</td>
<td>48</td>
<td>60%</td>
<td>72</td>
<td>49%</td>
</tr>
<tr>
<td>Other ethnicity</td>
<td>&lt;10</td>
<td>-</td>
<td>&lt;10</td>
<td>-</td>
<td>&lt;10</td>
<td>-</td>
</tr>
<tr>
<td>Not stated</td>
<td>&lt;10</td>
<td>-</td>
<td>&lt;10</td>
<td>-</td>
<td>&lt;10</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>73</td>
<td>100%</td>
<td>80</td>
<td>100%</td>
<td>148</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Hackney Drug Action Team

Table 19 shows the substances used by women referred to the SAAM service in 2010/11 to 2012/13. It shows that a wide variety of substances were in use by women referred to the service. The most common drugs were cannabis, alcohol and crack cocaine.

Table 19: Substances used by women referred to the specialist midwife, 2010/11 to 2012/13. Note that more than 1 substance can be used by each woman

<table>
<thead>
<tr>
<th></th>
<th>2010/11</th>
<th></th>
<th>2011/12</th>
<th></th>
<th>2012/13</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Current user</td>
<td>Past History</td>
<td>Current user</td>
<td>Past History</td>
<td>Current user</td>
<td>Past History</td>
</tr>
<tr>
<td>Heroin</td>
<td>16</td>
<td>&lt;10</td>
<td>21</td>
<td>&lt;10</td>
<td>15</td>
<td>13</td>
</tr>
<tr>
<td>Crack cocaine</td>
<td>18</td>
<td>&lt;10</td>
<td>22</td>
<td>&lt;10</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Benzodiazepine</td>
<td>&lt;10</td>
<td>0</td>
<td>&lt;10</td>
<td>0</td>
<td>&lt;10</td>
<td>0</td>
</tr>
<tr>
<td>Cocaine</td>
<td>&lt;10</td>
<td>&lt;10</td>
<td>&lt;10</td>
<td>&lt;10</td>
<td>21</td>
<td>&lt;10</td>
</tr>
<tr>
<td>Methadone</td>
<td>16</td>
<td>0</td>
<td>21</td>
<td>0</td>
<td>16</td>
<td>&lt;10</td>
</tr>
<tr>
<td>Alcohol</td>
<td>19</td>
<td>&lt;10</td>
<td>20</td>
<td>&lt;10</td>
<td>58</td>
<td>10</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>0</td>
<td>0</td>
<td>&lt;10</td>
<td>&lt;10</td>
<td>&lt;10</td>
<td>&lt;10</td>
</tr>
<tr>
<td>Nitrates/poppers</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>LSD</td>
<td>0</td>
<td>0</td>
<td>&lt;10</td>
<td>0</td>
<td>&lt;10</td>
<td>0</td>
</tr>
<tr>
<td>Cannabis</td>
<td>36</td>
<td>&lt;10</td>
<td>32</td>
<td>&lt;10</td>
<td>66</td>
<td>18</td>
</tr>
<tr>
<td>Magic mushrooms</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>&lt;10</td>
<td>0</td>
<td>&lt;10</td>
<td>0</td>
<td>&lt;10</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Hackney Drug Action Team

45 of the 133 women currently misusing substances at the time of referral in 2012/13 were using more than 1 substance (15 women were referred based on previous history or due to their partner’s substance misuse).

Women are referred to the service from a wide variety of sources. The most common in 2012/13 were antenatal clinics (50 referrals) and the community midwifery service (43 referrals). The Public Health midwives were responsible for 20 of the 148 referrals in 2012/13.

Clinical Nurse Specialists – Homerton Hospital

The Homerton Hospital provides support to patients who are admitted to Homerton University Hospital with drug or alcohol problems. The service utilises clinical nurse specialists (CNS) who provide information and advice to patients attending accident and emergency
departments with drug or alcohol problems along with referral to specialist treatment services.

The CNS saw a total of 747 patients in 2012/13, an average of 62 patients a month. Three-quarters of contacts were recorded as Hackney residents (575), 8% came from Islington (61), 6% ‘out of borough’ (43), 5% ‘no fixed abode’ (41) and 3% from Tower Hamlets (20).

Three-quarters of CNS contacts in 2012/13 were male. One-fifth of CNS contacts were 35 years old or younger, 46% were aged 36-50 years, and 33% were over 50 years old.

Two-thirds of CNS contacts were ‘White British’. No other ethnic classification attained more than 7% (‘White other’), ‘Black British’ and ‘Caribbean’ only made up 7% of the contacts, and ‘Turkish’ only 2%. None of the CNS contacts defined themselves as ‘Pakistani’ or ‘Jewish’ – 2 significant ethnic communities in Hackney.

The CNS saw 85% of its contacts for alcohol-related ill-health, which may correspond with the onset of alcohol-related ill-health problems (e.g. liver disease). Methadone was reported as the primary substance by 8% of contacts, and 4% for ‘heroin’ and ‘opiates’ combined.

60% of patients were seen in the Acute Care Unit (ACU), 21% on the ward, 14% in accident and emergency departments and 5% as out-patients. The CNS has consistently seen over half its contacts in the ACU, however there was a drop in November and December 2012 when higher than average levels of out-patient contacts were reported.

68% of CNS contacts were not in contact with community services. Of those who were, 12% were with the Alcohol Resource Centre (ARC) and 6% with the Specialist Addiction Unit. No other single service accounted for more than 3% of all contacts.

78% of contacts reported not using a second substance. This is consonant with the high proportion of ‘primary alcohol’ contacts in that drug misusers are more likely to be using several substances. ‘Crack/cocaine’ was noted by 4% of contacts, and heroin by 3%.

Figure 61 shows the annual trend in the number of contacts seen by the CNS for all boroughs and for Hackney for the years 2010/11 to 2012/13. It shows that the number of contacts in 2012/13 was slightly lower than in the previous year both in total and for Hackney.
Alcohol Recovery Service (ARC)

The Alcohol Recovery Centre (ARC) is a specialist recovery oriented alcohol treatment service for adults over the age of 18 years, based in Hackney. The service is delivered by the East London NHS Foundation Trust and Lifeline Project LTD. Staff at ARC come from a variety of professional backgrounds and have expertise in alcohol treatment and recovery. The service aims to provide an accessible and high quality service to reduce alcohol-related harms to individuals, families and communities.

Data for the ARC service suggest that during 2012/13 the service received a total of 599 referrals during the year. Around 70% of referrals were for men. The 599 referrals resulted in 322 residents of City and Hackney being offered treatment during the course of the year. The remainder of referrals were either inappropriate, did not complete the assessment process, were not City and Hackney residents or were referred on to other services more appropriate for their needs. Around a quarter (26%) of those offered treatment were using a secondary substance (in addition to alcohol) at the time of their assessment. Cannabis was the most common secondary substance, and was used in just over half (52%) of all cases where there was a secondary substance.

The total number on the caseload for the ARC service increased each quarter, from 192 in Quarter 1 to 212 by Quarter 4. The age breakdown of the number on the ARC caseload each quarter is shown in Figure 62.
The number of placements for residential detoxification fell from 52 in 2011/12 to 30 in 2012/13. The majority of detoxification clients (90%) who completed then successfully transferred into the Abstinent Day Programme (ADP) or Residential Rehabilitation. Table 20 shows the number of residential detoxifications started and completed at the ARC during 2012/13.

Table 20: Number of residential detoxifications at ARC, 2012/13

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starts</td>
<td>30</td>
</tr>
<tr>
<td>Finishes</td>
<td>28</td>
</tr>
<tr>
<td>Completed</td>
<td>22</td>
</tr>
<tr>
<td>Self Discharge</td>
<td>&lt;10</td>
</tr>
<tr>
<td>Disciplinary</td>
<td>&lt;10</td>
</tr>
<tr>
<td>Therapeutic Discharge</td>
<td>&lt;10</td>
</tr>
</tbody>
</table>

Table 21 shows the number of discharges from the ARC service during each quarter of 2012/13 and the reason for discharge. It shows that there were 181 discharges during the year. The clients who had dropped out before completing treatment made up 66 (36%) of discharges and a further 36 (20%) were alcohol-free clients who had completed treatment. There were 37 clients (20%) who had reduced their alcohol to the levels of an occasional drinker.

Table 21: Number of discharges at ARC, 2012/13

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9</td>
<td>26</td>
<td>26</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>10-19</td>
<td>26</td>
<td>26</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>20-29</td>
<td>26</td>
<td>26</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>30-39</td>
<td>26</td>
<td>26</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>40-49</td>
<td>26</td>
<td>26</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>50-59</td>
<td>26</td>
<td>26</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>60-69</td>
<td>26</td>
<td>26</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>70-79</td>
<td>26</td>
<td>26</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>80-89</td>
<td>26</td>
<td>26</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>90-99</td>
<td>26</td>
<td>26</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>100</td>
<td>26</td>
<td>26</td>
<td>26</td>
<td>26</td>
</tr>
</tbody>
</table>

Source:ARC quarterly reports
Table 21: Discharges from the ARC service

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Year 2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incomplete - client died</td>
<td>0</td>
<td>0</td>
<td>&lt;10</td>
<td>0</td>
<td>&lt;10</td>
</tr>
<tr>
<td>Incomplete - dropped out</td>
<td>16</td>
<td>21</td>
<td>11</td>
<td>18</td>
<td>66</td>
</tr>
<tr>
<td>Incomplete - retained in custody</td>
<td>&lt;10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>&lt;10</td>
</tr>
<tr>
<td>Incomplete - treatment withdrawn</td>
<td>&lt;10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>&lt;10</td>
</tr>
<tr>
<td>Transferred - in custody</td>
<td>0</td>
<td>0</td>
<td>&lt;10</td>
<td>&lt;10</td>
<td>&lt;10</td>
</tr>
<tr>
<td>Transferred - not in custody</td>
<td>12</td>
<td>&lt;10</td>
<td>10</td>
<td>&lt;10</td>
<td>36</td>
</tr>
<tr>
<td>Treatment completed - alcohol free</td>
<td>13</td>
<td>&lt;10</td>
<td>&lt;10</td>
<td>&lt;10</td>
<td>36</td>
</tr>
<tr>
<td>Treatment completed - occasional user (alcohol)</td>
<td>15</td>
<td>&lt;10</td>
<td>&lt;10</td>
<td>&lt;10</td>
<td>37</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>58</td>
<td>41</td>
<td>40</td>
<td>42</td>
<td>181</td>
</tr>
</tbody>
</table>

Source: ARC quarterly reports

The drop-in centre at Tudor Grove was seeing an average of at least 100 clients per week during January to March 2013, for a range of interventions. This included at least 20 triage assessments per week, at least 15 health care checks per week, 30 to 40 brief interventions and extended brief interventions per week, as well as clients attending housing and welfare advice sessions. These Tier 2 activities are not included in the NDTMS data presented later in this report.

During Q4 ARC/Lifeline CDS had 77 clients attend for welfare advice, 54 of which had been subject to sanctions or had other stopping of benefits.

### Profile of clients receiving alcohol treatment

Data on adults in treatment for alcohol misuse in Hackney indicate that in 2013/14 there were a total of 588 people in treatment with alcohol as their primary drug, of whom 412 (70%) started treatment in 2013-14.  

Detailed demographic data is not yet available for this year, but in 2012/13, when there were 491 people in treatment, just over two-thirds of adults in treatment were male (341) and one-third were female (150). Only 8% of those in treatment were aged under 30 years, 15% were aged 55 years and over, with the majority (77%) being aged between 35-54 years. More than half of adults in treatment were White British (56%). Other White ethnic groups accounted for a further 21% of those in treatment (White Irish 7% and Other White 14%) with Black Caribbean, Black African or Other Black groups accounting for a further 15%.

58% of adults in treatment drank more than 20 units on a typical drinking day and 13% drank 40 or more units per week. Nearly half (45%) had drunk alcohol on each of the last 28 days. 48% were drinking in excess of 400 units per month and 11% were drinking in excess of 1,000 units per month. Of those misusing both drugs and alcohol, cannabis and crack cocaine were the most common adjunctive drugs.

---

82 NDTMS
30% of new presentations (103 adults) had dual diagnosis (alcohol misuse and a mental health disorder). 21% of new presentations (73 adults) had a housing problem; of these, 24 adults (7% of all new presentations) had an urgent housing problem. 31% of new presentations (107 adults) involved a parent living with children; a further 27% (91 adults) had contact with children but were not living with them.

**Alcohol screening**

As shown in Table 22, analysis of alcohol screening tests undertaken over the past 5 years in primary care in City and Hackney shows that, in Hackney, 948 people were identified as hazardous drinkers and a further 277 as harmful drinkers. In City, fewer than 10 hazardous and fewer than 10 harmful drinkers were identified. The numbers of people identified as hazardous or harmful drinkers through alcohol screening is significantly lower than the estimated numbers of people in Hackney and the City of London who are increasing risk or higher risk drinkers (as shown in Table 8).

<table>
<thead>
<tr>
<th>Borough of Residence</th>
<th>Intake within recommended limits (code 136L)</th>
<th>Hazardous alcohol use (code 136S)</th>
<th>Harmful alcohol use (code 136T)</th>
<th>% within recommended</th>
<th>% hazardous</th>
<th>% harmful</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of London</td>
<td>29</td>
<td>&lt;10</td>
<td>&lt;10</td>
<td>64.4%</td>
<td>15.6%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Hackney</td>
<td>6147</td>
<td>948</td>
<td>277</td>
<td>83.4%</td>
<td>12.9%</td>
<td>3.8%</td>
</tr>
</tbody>
</table>

Among Hackney residents who underwent an alcohol screening test, a higher proportion of tests were found to be positive amongst younger adults (particularly those aged 25 to 39 years), those from less deprived areas, those of White ethnicity, men, and people with no other morbidities. In contrast, a higher proportion of tests were undertaken amongst older residents (aged 50+ years), women, and people from more deprived areas. This picture is consistent with opportunistic screening being offered more frequently to women, older people and people from more deprived communities who are more likely to present to their GP surgery.

**Needle exchange**

There is a well established needle exchange programme in place in Hackney and the City to ensure injecting drug users have access to new injecting equipment as well as information and support from health professionals. Other health care needs such as sexual health, flu vaccination and advice on care of veins and other sites used to inject drugs are also addressed. There are 15 needle exchange sites in Hackney and 1 in the City of London.

The community drug service (CDS), primary care services and some pharmacies offer blood-borne virus testing and referral to treatment. Vaccination against HBV is also available through the CDS. In 2010/11, 33% of new presentations to CDS accepted a vaccination for HBV, close to the national average at 34% and slightly more than half of those who were offered a vaccination. 44% of new presentations to CDS accepted a test for HCV.
10 people began their treatment journeys in the City during 2010/11.

**Sex workers**
The most significant driver of the street sex work scene in Hackney is chronic addiction and its associated poverty, homelessness, criminality and mental health problems. Open Doors delivers outreach, clinical and case management services to women selling sex in both street and off-street environments in Hackney and the City. On average, Open Doors supports 50 women per month.

In 2010/11, opiate use decreased significantly among the Open Doors sex workers cohort with only 9% identifying themselves as primary heroin users and 24% as poly-drug users. 38% of street sex workers identified as primary crack cocaine users and 25% as alcohol and crack cocaine users.

Overall morbidity among street sex workers is high. In 2010/11, Open Doors supported 12 street-based sex workers with HIV and a small number of women diagnosed with TB. Primary care needs tend to be related to abscesses, cellulitis and skin infections. Tobacco and alcohol use are common.

Almost all sex work in the City is off-street. Very little is known about these sex workers and their health needs.
7. Substance misuse in children and young people

Data summary

About the data

All prevalence estimates are national. This is likely to underestimate the number of children and young people who misuse substances in City & Hackney, as Hackney’s high levels of deprivation and other wider determinants of health mean it has higher than average levels of substance misuse. Population numbers have been taken from the GLA’s projections for 2014.83

Prevalence estimates

11-15 year olds: 1,600 young people aged 11-15 years (12%) in City & Hackney are estimated to have taken drugs in the last year; 800 (6%) in the last month. 84 1,400 (10%) are estimated to have drunk alcohol in the last week. 85

16-24 year olds: 5,100 people aged 16-24 years (16.3%) in City & Hackney are estimated to have taken drugs in the last year; 1,600 (5.1%) are classified as frequent users. The most common substances used by young people were alcohol, cannabis, cocaine and amyl nitrate. 86 737 men (5%) and 332 women (2%) are estimated to be frequent drinkers (drinking on 5 or more days a week). 87

Referrals to services

There were 158 young people aged 13-19 years referred for drug treatment in Hackney in 2013/14. 88 There were 36 dealing referrals in the same age band in 2013/14. In both cases the majority of referrals were for males.

27 Hackney residents aged under 18 years were referred to Tier 3 young people’s substance misuse services in 2012/13. Young people in Tier 3 treatment made up only 4% of users (54) in treatment in Hackney in 2011/12. This is well below the national average benchmark of 9%. 89

---

83 GLA Population Projections 2012 Round, SHLAA, Borough SYA  
88 Source: London Borough of Hackney.  
89 NTA JSNA Support Pack local data for young people 2011/12.
Introduction

Drug and alcohol misuse pose a significant risk to a young person’s physical and psychological health and development. In particular the adolescent brain is known to be particularly susceptible to alcohol. By delaying the age at which young people start drinking, they are less likely to engage in health risk behaviours\(^90\) and to later become dependent on alcohol.\(^91\) The Government’s Chief Medical Officer recommends that no one aged 15 years or under should drink alcohol.\(^92\)

The consumption of alcohol by young people also has wider impacts on society, with alcohol consumption associated with violence, committing offences, absenteeism and exclusion from school, increased use of drugs and decreased use of contraceptives.\(^93\)

National and local evidence suggests that the majority of young people who misuse substances are likely to be using alcohol or cannabis, although current policy models are being challenged by the growth of the new psychoactive substances or ‘legal highs’ market. These are substances that have been synthesised to cause similar reactions to controlled substances\(^94\) and which are marketed as legal alternatives.

It is important that substance misuse is seen in the context of the wider children and family agenda and not in isolation, as the biggest influences on young people’s attitudes to substances are their parents and siblings. Substance misuse is interwoven with the issues of domestic violence and poor mental health including suicide, depression and disruptive behaviour disorders, and the presence of these issues together greatly increases the risks to children.

All children and young people are potentially at risk of misusing alcohol and or drugs. However, evidence suggests that young people in certain vulnerable groups are more at risk of misusing substances. Every Child Matters identified the following at-risk groups:\(^95\)

- children affected by parental drug use: the Hidden Harm Report in 2003 by the Advisory Council on the Misuse of Drugs\(^96\) estimates that there are between 250,000 and 350,000 children in England and Wales who have a parent with a drug problem. It is widely accepted that this is an underestimate.

\(^93\) Hackney Drug & Alcohol Team. Hackney Alcohol Harm Reduction Strategy 2010-1014.
\(^96\) Hidden Harm; Responding to the needs of children of problem drug users. Advisory Council on the Misuse of Drugs, 2003.
• persistent truants and school excludes: evidence tells us that children who fall into this category are much more likely to be involved with substances and so suitable provision should be put in place to support this cohort
• looked after children: these children are 4 times more likely to misuse substances than the general child population
• young people in contact with the criminal justice system: evidence tells us that this cohort report more substance use than any other vulnerable group
• other groups: homeless children and young people, those experiencing sexual exploitation, teenage mothers and those not in education, employment or training. All of these and the above groups are potentially all linked with other factors, such as living within the most deprived communities also being a factor.

Children may be affected by any number of these vulnerabilities and so this will likely increase their risk.

Prevalence of substance misuse in young people

Drugs
Findings from ‘Smoking, drinking and drug use among young people’\(^97\) in 2012 show that:
• estimated prevalence of drug use among young people aged 11-15 years has decreased
• older pupils are more likely to report ever taking drugs
• cannabis is the most widely used drug amongst pupils
• the frequency of drug taking is decreasing
• vulnerable pupils (those who truant or are excluded) are most likely to take drugs frequently.

The survey found that the prevalence nationally among pupils has declined since 2001. In 2012, 17% (29% in 2001) of pupils had ever used drugs, 12% (20% in 2001) had taken drugs in the last year and 6% (12% in 2001) in the last month.

An estimated 16.3% of young people aged 16-24 years used an illicit drug in 2012/13, compared to an estimated 8.2% of adults, and down from 19.3% in 2011/12. The most common drugs used by young people were cannabis powder, cocaine and amyl nitrate. For legal emerging drugs, 6.1% of young people aged 16-24 years had taken nitrous oxide in the last year (compared to 2.0% of adults aged 16-59 years) and 1.1% had taken salvia (compared to 0.3% of adults).\(^98\) In 2012/13 5.1% of young people aged 16-24 years were classed as frequent drug users (compared to 2.8% of adults).\(^98\)

Alcohol
The findings from ‘Smoking, drinking and drug use among young people’ in 2010\(^99\) suggest that:

---
• prevalence of alcohol use among young people aged 11-15 years has decreased
• older pupils are more likely to report ever drinking alcohol
• the mean amount of alcohol consumed by young people has varied from year to year with no clear trend
• young people’s drinking is influenced by the attitudes and behaviour of their families.

The survey found there has been a steady decline in the proportion of pupils who drink alcohol nationally: in 2012, 10% had drunk alcohol in the last week compared to 26% in 2003. Less than a half (43%) of school pupils said that they had drunk alcohol at least once in 2012; this compares to 61% in 2003. The proportion of young people aged 11-15 years who think drinking is acceptable for someone of their age has decreased (28% in 2012 compared to 46% in 2003).

A 2012 ONS Survey of the nation’s drinking habits found that 5% of men and 2% of women aged 16-24 years were frequent drinkers (drinking on 5 or more days in the week before the interview).100 In the 2012/13 Crime Survey for England and Wales, 11% of young people aged 16-24 years thought that it was acceptable for people of their own age to get drunk frequently, however 15% of young people aged 16-19 years thought that it was never acceptable to get drunk.98

Substance misuse services for young people in City and Hackney

Substance misuse services for young people in City and Hackney are provided separately to the adult services. There are 3 main reasons for the need for targeted service provision for young people:101

• there is a differing profile of drug use amongst younger people which is skewed toward cannabis and alcohol and is not likely to have reached an entrenched stage requiring the most intensive of interventions.
• substance misuse must be considered within the wider context of the needs, risks and services that are relevant to the young person, their families and peer networks.
• young people in Tier 3 treatment made up only 4% of users (54) in treatment in Hackney in 2011/12. This is well below the national average benchmark of 9% (NTA JSNA Support Pack local data for young people 2011/12).

Young Hackney

A specialist Young People’s Substance Misuse Service, commissioned by Public Health, is available through Young Hackney. The service is open to young people aged 19 years and under, but most cases are in the 14-17 years range. The substance misuse team within Young Hackney work across the borough with young people who have been referred to them.

The substance misuse team comprises a service manager/specialist worker and 4 practitioners, including 2 substance misuse workers, 1 outreach worker and 1 dealing interventions officer. Caseloads are typically about 45-50 young people at any one time.

100 Office for National Statistics Opinions and Lifestyle Survey, Drinking Habits Amongst Adults, 2012
The service takes a holistic approach and works with a range of partner services. For example, they do prevention work, work with offenders and work with social services to address the wide range of needs that a young person may have. The team’s involvement with young people varies from one-off sessions to longer periods of involvement; case management typically lasts between 4 and 16 weeks. About 75% of the team’s capacity involves 1:1 work between Tiers 1 and 3, but they also provide some set programmes and groups, for example a monthly one-off session for young people picked up with cannabis. The service also provides prevention sessions to more than 50 different schools, colleges and community groups, reaching more than 500 young people and professionals in 2012/13.

The baseline budget for the service in 2013/14 is £233,000, with almost all provided by public health.

Hackney Drug and Alcohol Action Team (DAAT)
The Hackney drug strategy refresh 2012-2014\(^{102}\) described the work that has been done to meet the promises made in the 2008-2012 drug strategy around working with young people. Table 23 is reproduced from this refresh document and sets out the promises made in the Drug Strategy (2008-2012) and the work that has been done to address these promises in the last 4 years:

<table>
<thead>
<tr>
<th>What we promised in the 2008-2012 drug strategy:</th>
<th>In the last 4 years we have:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Support outreach work and interventions with young people through delivery of training to frontline workers</td>
<td>DAAT Training programme provides bespoke training to frontline staff and to all services in screening and working with young adults with drug and alcohol problems</td>
</tr>
</tbody>
</table>
| 2. Support young people in the transitional age range (19-25 years) to access appropriate treatment and support through specific projects and information campaigns and develop pilot interventions to reduce drug dealing by young people | - DAAT provided regular substance misuse training at Hackney Community College and other locations  
- Young people’s leads identified in all services to work with under-25s  
- Accommodation for young adults with substance misuse/mental health issues developed with Supporting People |
| 3. Provide low threshold interventions to young people, including diversionary activities and peer-led support, targeting those at risk of becoming involved in drugs and crime | Young people’s substance misuse treatment provision redesigned to fit with Young Hackney model which encompasses work with children and young people in contact with the criminal justice system and gangs |
| 4. Enhance Hackney’s specialist treatment provision for young people using drugs/alcohol with a robust focus on cannabis dealing and use and ensure it reaches out to a range of young people reflective of the diverse local community | - Cannabis Support Group established in 2010 at Lifeline drug service  
- Further work to be developed in this area in 2012/13 with links to Sexual Health services, LGBT groups and clubs being targeted for improved join-up |
| 5. Support the development of a ‘Hidden Harm’ Strategy for Hackney to improve partnership work and provide effective | - Joint Working protocol agreed with Children’s Social Care in 2010 and workforce training rolled out since then  
- Families Service in place since April 2011 at Lifeline Drug |

| Support for substance misusing families and women including younger women | Service, 24 families engaged to date  
- 55 parenting sessions delivered and second roll-out of Parenting Programme underway  
- Peer-led support provided in parenting programme  
- Mayor of London’s Rape Crisis Support offered in conjunction with DAAT Women & Families support and worked with 36 women to date  
- Domestic Violence Team, Police, Children & Young People’s service have referred 164 clients to the Women & Families Service  
- Specialist Midwife for Substance and Alcohol Misuse (SAAM) service continues to work with women using drugs and alcohol during pregnancy: 83 women have been seen January 2011-January 2012 with more presenting with complex needs than was previously the case  
- Service users establish the Starbright Group |

| Deliver extended services to kin carers, carers and children of substance misusing parents and ensure that we have meaningful service user involvement for this group | - Carer’s Forum co-ordinated by DAAT  
- St Mungo’s Women’s Support Group providing self-help for women affected by substance misuse  
- Service users delivered training to social work professionals on working with statutory services when being a parent who uses drugs and alcohol  
- Service users won the Hackney Stars award for volunteers for their contribution in the development of the Joint Working Protocol with CSC |

| Develop clear alignment between our community based work and the treatment system with enhanced opportunities for dialogue with local communities | - 25+ BME groups engaged with a range of projects mostly around diversionary and drugs awareness work with young people within communities by DAAT trained community leads  
- Employment Support  
- Sheltered accommodation support |

**M-PACT**

M-PACT is a short intervention focusing on children and young people affected by parental substance misuse which uses a whole family approach and includes individual family assessment and group work with parents/ carers and with children. The overall aim of M-PACT is to support families to work together to manage how parental substance misuse has disrupted their lives. An evaluation of 13 M-PACT programmes that ran between 2006 and 2011 included a total of 64 families and found that:

- 60% of children thought that M-PACT had ‘definitely yes’ helped them to understand their parent’s drug or alcohol problem a bit more
- 78% of children thought that M-PACT had ‘definitely yes’ helped them to understand how addiction had affected their family
- over 80% of adults thought that M-PACT had ‘definitely yes’ helped them to understand how the parental substance misuse has affected their children and their family

---

103 M-PACT - [http://www.actiononaddiction.org.uk/For-Families/M-Pact-Programme.aspx](http://www.actiononaddiction.org.uk/For-Families/M-Pact-Programme.aspx)

• over 75% of adults reported that M-PACT had ‘definitely yes’ allowed their family to talk more openly and positively about the parental substance and how it has affected the family
• 68% of children reported that M-PACT had ‘definitely yes’ helped them to see that their parent’s drug or alcohol problem was not their fault
• 66% of children reported that M-PACT had ‘definitely yes’ helped them to think about how they can stay safe.

An M-PACT programme ran in Hackney from January to March 2014 as a pilot, with 5 families completing the programme. The potential for running another programme for these children/families later in the year is being explored.

Profile of young people treated for substance misuse in Hackney

Table 24 shows the number of children and young people referred for drug treatment in Hackney each quarter between January 2012 and March 2014.

| Table 24: Number of referrals, dealing referrals and mean age at referral for children and young people referred for treatment in Hackney between January 2012 and March 2014. |
|---|---|---|---|---|---|---|---|---|---|---|
| No. of referrals | 25 | 50 | 46 | 30 | 45 | 27 | 61 | 34 | 36 | 354 |
| Male | 20 | 39 | 33 | 24 | 43 | 24 | 51 | 26 | 30 | 290 |
| Female | <10 | 11 | 13 | <10 | <10 | <10 | 10 | <10 | <10 | 64 |
| Dealing referrals | <10 | 23 | 16 | <10 | 14 | <10 | 11 | 10 | <10 | 100 |
| Male | <10 | 20 | 14 | <10 | 14 | <10 | 11 | 10 | <10 | 93 |
| Female | <10 | <10 | <10 | 0 | 0 | 0 | 0 | 0 | <10 | 7 |

Source: Hackney Council

Table 23 shows that there were 171 referrals in the year 2012/13 and 158 in the year 2013/14. Overall, 82% of referrals are for males and 18% are for females. There were 58 dealing referrals in 2012/13 and 36 in 2013/14, of which over 90% were for males. The age range for all referrals was between 12-19 years and for dealing referrals between 13-19 years.

In 2012/13, a total of 27 Hackney residents under the age of 18 years were referred to Tier 3 young people’s substance misuse services, mostly via the Young Hackney Youth Justice Team or the Children and Family Service.\(^{105}\) The gender distribution was the same as that for adult clients entering the treatment services (male to female ratio of 3:1). 97% of those entering treatment in Tier 3 were aged 14 years or above at the time of referral; more than half were

\(^{105}\) National Drug Treatment Monitoring System, Young People Needs Assessment data 2012/13
aged 16 or 17 years. The ethnic distribution among young people entering treatment services was different to that of the adults in that only 19% were of White ethnic origin, and the remaining 80% were of Asian, Black or mixed ethnic origin. No information was available on the religion of young people entering treatment. The most commonly used substance among young people referred to the substance misuse service was cannabis; just over half were using cannabis alone and a quarter were using cannabis and alcohol.

For young people leaving the Tier 3 treatment system in 2010/11, 48% left after completing treatment and 33% were referred on to other services, including back to the referrer (46%), to targeted youth support (38%) and children’s mental health (15%). Of those completing treatment successfully, 37% were primary cannabis users and 11% were alcohol users.\(^{106}\)

**Summary of key findings on substance misuse in children and young people**

- Nationally, the prevalence of drug use and alcohol among young people aged 11-15 years has declined since 2001. The prevalence of young people aged 16-24 years using illicit drugs also decreased between 2011 and 2013.
- Groups that are more at risk of misusing substances include children affected by parental drug use, persistent truants and school excludees, looked after children, young people in contact with the criminal justice system, the homeless, those experiencing sexual exploitation, teenage mothers and those not in education, employment or training.
- National and local evidence suggests that the majority of young people who misuse substances are likely to be using alcohol or cannabis although the use of new psychoactive substances or ‘legal highs’ is an emerging issue.
- A key influence on young people’s attitude to substances is their parents and siblings. It is important that substance misuse is seen in the context of the wider children and family agenda.
- There were 171 referrals for drug treatment in Hackney in 2012/13 and 158 referrals in 2013/14. There were 58 dealing referrals in 2013/13 and 36 in 2013/14. In both cases the majority of referrals for males.
- 27 Hackney residents aged under 18 years were referred to Tier 3 young people’s substance misuse services in 2012/13.
- Young Hackney provides a specialist Young People’s Substance Misuse Service open to young people aged 19 years and under.
- The Hackney Drug and Alcohol Action Team (DAAT) included a number of objectives relating to working with young people in their 2008-12 drug strategy and outlined the work that has been achieved against these objectives in the 2012-2014 drug strategy refresh.
- 5 families in Hackney completed an M-PACT programme (for children and young people affected by parental substance misuse) in 2014. The potential for running another programme for these children/families later in the year is being explored.

8. Stakeholders views of substance misuse in City of London and Hackney

A combination of stakeholder interviews (telephone and face-to-face) and a half-day workshop were held between January and March 2014 to gather views from a range of stakeholders on substance misuse services in City and Hackney. Stakeholder participants included: staff, commissioners, members of the voluntary sector, service providers and service user representatives.

The following section provides an overview of the key findings from the stakeholder data-gathering exercise. It focuses on areas of unmet need and gaps in service provision, challenges facing the service, and the existing assets or resources in the local community that could be used to better meet the needs of City and Hackney residents in relation to substance misuse. A compilation of detailed stakeholder views is given in Appendix 3.

Areas of unmet need/gaps in service provision

Young people aged 19-24 years

It was reported that there is no specific service provision for young adults in the 19-24 year age group. Adult substance misuse services were considered by stakeholders to be inappropriate for this age group since the profile of drug use in young people is very different to that among adults. It was perceived that there was, therefore, a tendency to treat and discharge young people from substance misuse services before they reached the upper age threshold (19 years) of services for young people.

It was suggested at the stakeholder workshop that traditional funding created artificial boundaries around age and that shifting the age limit of young people’s services to 25 years might be a more appropriate way of meeting the needs of young adults. Another suggestion was to have people working jointly across children and adult services.

Children and families affected by substance misuse

It was reported that there is very little direct work with children of parents who are substance misusers, despite the fact that this group are at higher risk of themselves becoming substances misusers. Stakeholders also suggested that there is a lack of whole family work for managing children or young people with substance misuse problems. It was also reported that residential rehabilitation treatment for families seemed to be less available than in the past. Support for foster carers or kinship carers was identified as a possible way to help maintain looked after children placements and to reduce the risk of children going on to become substance misusers.

Alcohol detoxification

The number of community-based alcohol detoxifications in City and Hackney was perceived by stakeholders to be very low, although this could not be verified due to the lack of readily accessible local data on patients undergoing alcohol detoxification. Stakeholders also identified difficulties in accessing community detoxification for people living in nursing or residential homes.
GP stakeholders identified the opportunity to increase the provision of community alcohol detoxification, thereby helping to reduce the length of stay for patients who currently undergo hospital detoxification (including those found to be alcohol dependent on admission to hospital for reasons that may or may not be related to their alcohol consumption and who undergo detoxification prior to discharge). Improved communication between hospital and community services and the use of common treatment pathways in both sectors were highlighted as ways to improve support for patient undergoing alcohol detoxification and to prevent relapse. They would also reduce the potential for patients to be readmitted to hospital and so undergo repeated alcohol withdrawal (which can lead to cognitive impairment and brain damage).107

**Alcohol-dependent clients with high social need**

Stakeholders indicated that there is currently nowhere to place alcohol clients who have a high social need and who are not self-caring, yet who would benefit from community detoxification. They also perceived the need for better links between the substance misuse services and adult social care services, to enable the provision of more ongoing support for alcohol clients with high social needs, including older clients.

**Drinkers in the ‘increasing risk’ category**

A number of stakeholders indicated that there was little known support available for drinkers in the ‘increasing risk’ (hazardous drinking) category in City and Hackney (estimated to be around 36,000 in number). It was felt that more could be done to help people to understand the risk posed to themselves and others by their drinking behaviour and to provide support to enable them to modify this.

**Access to psychological therapy for people with substance misuse problems**

Stakeholders in both primary care and psychology services reported that access to psychology (IAPT) services for people with substance misuse problems was limited and that there were opportunities for joint working/collaboration between the substance misuse and psychology services to improve the range of services available. For example, it was felt that more could be done using psychological therapies to support people unable to modify their drinking behaviour independently. ‘High’ cannabis users were also identified as a group who are currently not served by the psychology services and for whom the GPs have no other treatment options.

**People with dual diagnosis of a mental health disorder and substance misuse**

During the stakeholder workshop, stakeholders highlighted the needs of a subgroup of people with mental health and substance misuse issues who are more likely to lead chaotic lifestyles and to need ongoing social support and supported housing. However, because of their chaotic lifestyles, they may not meet the referral thresholds or admission policies for the support available so they continue to use an enormous amount of resources from crisis response services.

**Older people with needs relating to substance misuse**

*Long-term users of prescription medications*

GP stakeholders highlighted the needs of older people who are long-term users of prescription medications, such as benzodiazepines for anxiety and/or depression, and codeine

---

and other opiate-based pain relief. The management of such patients should be reviewed in order to identify scope for reducing/modifying their medication. The size of this population is not currently known but could be identified via general practice information systems.

**Older adults with cognitive problems secondary to substance misuse**
There was felt to be a gap in provision/support for older people who have mild/moderate cognitive impairment secondary to substance misuse.

**The ageing cohort of injecting drug users**
Several stakeholders highlighted the needs of the ageing cohort of injecting drug users and the importance of ensuring that their needs continue to be met when they transfer from adult to older people’s services.

**Groups with difficulties accessing services**
A number of different groups were identified as having difficulties accessing services. These included: parents with childcare responsibilities who have difficulty accessing services due to service opening times and availability of childcare; City residents who work so are unable to access services during normal working hours; City residents who find it difficult to access services based on the east side of Hackney, so are more likely to not attend or drop out of treatment. People from some Black and ethnic minority communities may find it more difficult to access services due to attitudes which prevail within the local community.

**Homeless population**
Some stakeholders perceived that the lack of support services available for the homeless population, including the lack of temporary accommodation, meant that some of the more complicated, higher need cases moved out of the area to other boroughs.

**‘Emerging’ problems**
During both the interviews and the stakeholder workshop, it was clear that service providers did not feel adequately prepared for dealing with emerging problems in substance misuse such as the use of new psychoactive substances or so-called ‘legal highs’. Some stakeholders perceived that the profile of drug use is changing amongst the local population, but it was not clear that services were responding appropriately to these changes.

**Challenges facing the service**

**Demand versus supply**
Stakeholders felt that services are generally very over-stretched with high case loads which impacts on the ability for professionals to work effectively with service users, for example in promoting a recovery agenda. There is also limited capacity to undertake educational and outreach work to prevent substance misuse within different communities and with different age groups.

**Scope for early intervention/prevention**
Stakeholders highlighted the importance of education/outreach/preventive work. Existing substance misuse services in Hackney and City, including young people’s services, tended to focus on the treatment of clients at the higher end of the risk spectrum, with very limited capacity available for preventive activities. In relation to young people’s services, it was
suggested that the scope of the services could be extended to include more prevention and early intervention work including expansion of the capacity to do outreach work.

**Service fragmentation**

A number of stakeholders highlighted problems associated with the perceived ‘disparateness’ of services, with the associated risk that service users would be ‘lost’ when transferring between different components of the service, for example between Lifeline and the Specialist Addictions Unit. Some stakeholders felt that there would be benefits associated with the introduction of a single service with a common treatment pathway for drugs and alcohol.

It was also suggested that there are ‘old style’ ways of working in some areas, such as working with the different elements of dual diagnosis separately, whereas people with complex needs were felt to need more flexible and imaginative working.

**Capacity within primary care to manage substance misuse problems**

It was suggested that capacity within primary care could be increased to manage patients with substance misuse who fall below existing thresholds for referral to substance misuse services, for example drinkers in lower risk categories, ‘high’ cannabis users, and patients on long-term prescription medicines such as opiates or benzodiazepines. Suggested ways of doing this included education, training and support from clinical leads, drug and alcohol support workers attached to practices, and ensuring all practices operate within the substance misuse shared care system.

**Awareness of services available**

There was reported to be a lack of awareness amongst some service providers about the full range of aftercare services available to service users, despite the inclusion of information about such services in the Hackney and City of London service directories. It was considered that more could be done to promote uptake of aftercare services amongst service users by, for example, increasing awareness of aftercare services amongst service provider staff.
9. Literature review: Primary prevention interventions for substance misuse

Question

For substance misuse, which primary prevention interventions (for alcohol and drugs) are clinically and/or cost effective and for which populations?

Findings

We conducted a literature review to explore the evidence base for the effectiveness and cost effectiveness for primary prevention interventions for substance misuse (alcohol and drugs) in children and adults over the age of 18 years. This was not a systematic review seeking to identify and assess all the studies that have been published in this area, rather it was a rapid review of high-level evidence from health technology assessments, systematic reviews, meta-analyses and health economic studies that could be used to inform the delivery and targeting of interventions for substance misuse prevention in Hackney and City of London. Full details of the search strategy and inclusion criteria are given in the Appendix 2.

Evidence of effectiveness

We included 11 systematic reviews (SRs) and meta-analyses; 3 reviewed primary prevention strategies for children and adolescents, 4 focused on young people and 4 reviewed interventions for all age groups (see Table 25).


The interventions for children included: school-based, family or parental support programmes, mentoring of youth and community-based programmes. For adults, they included: college-based, community-based and social norms interventions that aimed to reduce substance use. Comparators ranged from no intervention, to minimally active interventions (such as general drug or alcohol education), and active interventions (such as in-person behaviour modification programmes). All included studies reported drug and alcohol use. Table 25 presents summary of the included studies.

**Children and adolescents**
Thomas et al 2013\(^{119}\) found that mentoring by peers or adults showed modest impact on the initiation of drug or alcohol use in adolescents, primarily from disadvantaged or minority groups. However the studies included in the review had some limitations; blinding of participants was not possible, as the interventions were explicitly about mentoring, and there was no statement about blinding of outcome assessors or data analysts. The randomised controlled trials (RCTs) included a high proportion of minority and disadvantaged adolescents; this means that the results may not be applicable to other adolescent populations. There is no evidence from studies at low risk of bias to show that the efforts of the organisations, the mentors and the associated community activities resulted in less alcohol or drug use.

Lemstra et al 2010\(^{120}\) concluded that comprehensive programmes that included anti-drug information with refusal skills, self-management skills and social skills training were the most effective programmes for long-term reduction of marijuana and alcohol use in adolescents (10-15 years). However there are limitations due to the studies included. There are variations in the clinical characteristics of the studies included and the risk that data were missed because only studies published in English were included. The authors did not report the quality of the individual studies.

Brown et al. 2007\(^{121}\) found a modest but consistent beneficial impact of drug prevention programmes on later use and level of use in rural populations. As well as publication bias, this review is likely to be out of date as the literature search was conducted over 7 years ago.

**Young people**
Ferri 2013\(^{122}\) assessed the effectiveness of mass media campaigns in preventing or reducing the use of or intention to use illicit drugs amongst young people and concluded that the available evidence does not allow conclusions about the effect of media campaigns on illicit drug use among young people. The included RCTs had a low overall risk of bias and the prospective cohort studies had overall good quality, apart from the description of loss to follow-up by exposure. The main limitation of the studies included in this review is the lack of comparability of some measures of outcomes and, more importantly, the unclear causal


relationship between the campaign size and its effect. This lack of clarity reduces the generalisability of results, i.e. it is still unclear which part of a campaign should be reproduced to achieve which results.

Norberg 2013\textsuperscript{123} evaluated the effectiveness of primary prevention programmes in preventing young people from using cannabis. The results suggest that primary prevention programmes may be able to deter young people from using cannabis, with statistically significant effect sizes ranging from trivial to extremely large. Universal multi-modal programmes appeared to outperform other programme types; however the quality of the included studies was poor. A meta-analysis was not feasible due to the marked heterogeneity of study design and measurement outcomes. An improvement in methodological and reporting quality of prevention trials would facilitate an appropriate quantitative analysis. The individual programme components assessed in this study were limited due to poor reporting of salient and important information. All included studies relied on self-reported cannabis use, which may not provide an accurate measure of cannabis use, although evidence has supported the validity of such self-reported data.

Scott-Sheldon 2012\textsuperscript{124} conducted a meta-analysis to examine the efficacy of alcohol expectancy challenge* (EC) interventions for college alcohol abuse prevention. The authors found that expectancy challenge interventions succeeded at reducing positive alcohol expectancies, the quantity of alcohol consumed, and the frequency of heavy drinking for as long as 1 month post-intervention. Reduction in the quantity of alcohol consumed and the frequency of heavy drinking was not sustained at longer follow-ups (i.e. up to 6 months post intervention). However, the review had several limitations; all the included studies had outcomes which involve self-reports, which are vulnerable to cognitive and social biases. Self-report is imperfect, but most researchers employed methods designed to optimise data quality. To optimise statistical power, primary analyses were restricted to assessments of expectancies and consumption measures at first post-intervention, typically 2 weeks after the receipt of the EC intervention. Thus, the findings are restricted to short-term outcomes and may not be replicated at longer follow-ups. Indeed, analyses at last assessment (among the 8 studies with multiple follow-ups) indicate that reductions in quantity of alcohol consumed and the frequency of heavy drinking were not maintained 2 months following the intervention.

* Interventions challenging alcohol expectancies have been developed as a means to reduce alcohol consumption. The expectancy challenge (EC) intervention was designed to illustrate the effects of alcohol-related expectancies through experiential learning in a group setting. An EC intervention typically includes the provision of beverages to groups of drinkers in a bar-like setting; some contain alcohol and others contain a placebo beverage, but the participants do not know the content of their drinks. Participants engage in activities that promote social interaction, and after time passes, participants are asked to evaluate whether other participants were drinking alcohol versus a placebo. Incorrect identification provides opportunities to consider the effects of alcohol attributable to expectancies.

Gates 2006\textsuperscript{125} reviewed the literature on the effectiveness of interventions delivered in non-school settings intended to prevent or reduce drug use by young people under 25 years. The authors concluded that there is a lack of evidence of effectiveness of the included interventions. Many of the studies lacked blinding and had high numbers of participants lost to follow up. There were too few studies for firm conclusions. No meta-analysis could be performed because the interventions were too heterogeneous to be combined meaningfully.

\textit{All ages}

Janssen 2013\textsuperscript{126} carried out a systematic review of the effectiveness of alcohol prevention interventions based on the principles of social marketing. The authors found that the effect of applying the principles of social marketing in alcohol prevention in changing alcohol-related attitudes or behaviour could not be assessed. This is because of the drawbacks of the included studies; not many studies used social marketing for alcohol misuse prevention and amongst those that did, there was lack of clarity on what social marketing entails.

CADTH 2012\textsuperscript{127} reviewed the evidence on the primary prevention of alcohol, marijuana or other illegal drug use in order to help inform a policy position on substance misuse prevention. The authors concluded that family, parental, and school-based educational programmes have shown a positive impact on substance misuse in children and adolescents. Social norms and other computer-based interventions may be effective in reducing alcohol misuse in adults. The overall quality of the studies, however, was poor. Many of these studies were underpowered and had follow-up times less than 6 months. Other limitations included lack of blinding, unclear allocation concealment, self-reported outcomes and loss to follow up exceeding 20%. The majority of the studies were conducted in the US. Considering the importance of the population characteristics and setting to the success of psychosocial interventions, the generalisability of these studies to the UK context should be carefully evaluated when developing policy options.

Bolier 2011\textsuperscript{128} assessed the effectiveness of interventions to prevent harmful alcohol and drug use in nightlife settings. They concluded that these interventions could effectively reduce high-risk alcohol consumption, alcohol-related injury, violent crime, access to alcohol by those under age, and alcohol service to intoxicated people. However, given the diversity and limited quality of the studies included and the possibility of publication bias, the authors’ conclusions may be over optimistic.


\textsuperscript{127} Cadth. Prevention strategies for substance misuse: a review of the clinical evidence (Structured abstract). Health Technology Assessment Database [serial on the Internet]. 2012; (4)

Table 25: Included systematic reviews/ meta-analysis at a glance

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>≤18 years</td>
<td>Any</td>
<td>Alternative/no programme</td>
<td>6 RCTs</td>
<td>All</td>
<td>All</td>
<td>All</td>
<td>Marijuana &amp; alcohol</td>
<td>All</td>
<td>Illicit drugs</td>
<td>Cannabis</td>
<td>Drugs</td>
<td>Alcohol</td>
<td>Alcohol</td>
</tr>
<tr>
<td>All ages</td>
<td>All ages</td>
<td>Any</td>
<td>Alternative/no programme</td>
<td>9 SRs, 2 RCTs</td>
<td>All</td>
<td>All</td>
<td>School-based</td>
<td>10-15 year olds</td>
<td>≤18 years</td>
<td>≤26 years</td>
<td>≤24 years</td>
<td>≤25 years</td>
<td>All ages</td>
<td>College age</td>
</tr>
<tr>
<td>All ages</td>
<td>All ages</td>
<td>Any</td>
<td>Knowledge/curriculum only</td>
<td>17 studies</td>
<td>All</td>
<td>All</td>
<td>School-based</td>
<td>≤18 years</td>
<td>≤18 years</td>
<td>≤24 years</td>
<td>≤25 years</td>
<td>All ages</td>
<td>College age</td>
<td>All ages</td>
</tr>
<tr>
<td>Marijuana &amp; alcohol</td>
<td>10-15 year olds</td>
<td>School-based</td>
<td>Alternative/no programme</td>
<td>6 RCTs</td>
<td>All</td>
<td>All</td>
<td>Media campaign</td>
<td>≤18 years</td>
<td>≤26 years</td>
<td>≤24 years</td>
<td>≤25 years</td>
<td>All ages</td>
<td>College age</td>
<td>All ages</td>
</tr>
<tr>
<td>Cannabis</td>
<td>≤18 years</td>
<td>Any</td>
<td>Alternative/no programme</td>
<td>22 studies</td>
<td>All</td>
<td>All</td>
<td>Any</td>
<td>School-based</td>
<td>All</td>
<td>All</td>
<td>All</td>
<td>All</td>
<td>Placebo</td>
<td>Before &amp; after design</td>
</tr>
<tr>
<td>Drugs</td>
<td>≤24 years</td>
<td>Non-school based</td>
<td>Alternative/no programme</td>
<td>23 studies</td>
<td>All</td>
<td>All</td>
<td>Non-school based</td>
<td>Social marketing</td>
<td>All</td>
<td>All</td>
<td>All</td>
<td>All</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>≤25 years</td>
<td>Social marketing</td>
<td>Alternative/no programme</td>
<td>25 RCTs</td>
<td>All</td>
<td>All</td>
<td>Social marketing</td>
<td>Social marketing</td>
<td>All</td>
<td>All</td>
<td>All</td>
<td>All</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>All ages</td>
<td>College based</td>
<td>Alternative/no programme</td>
<td>17 studies</td>
<td>All</td>
<td>All</td>
<td>College based</td>
<td>College based</td>
<td>All</td>
<td>All</td>
<td>All</td>
<td>All</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>All ages</td>
<td>On-premises (alcohol outlets)</td>
<td>Alternative/no programme</td>
<td>6 studies</td>
<td>All</td>
<td>All</td>
<td>On-premises (alcohol outlets)</td>
<td>On-premises (alcohol outlets)</td>
<td>All</td>
<td>All</td>
<td>All</td>
<td>All</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 26: Study findings

<table>
<thead>
<tr>
<th>Study</th>
<th>Intervention description</th>
<th>Outcomes</th>
<th>Authors’ conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHILDREN &amp; ADOLESCENTS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thomas 2013 SR Included 6 RCTs (5 USA, 1 Sweden)</td>
<td>Randomised controlled trials (RCTs) of mentoring in adolescents to prevent/reduce alcohol or drug use. The control in 3 studies was no intervention, 1 study had no control. Mentoring is defined as ‘a supportive relationship in which one person offers support, guidance and concrete assistance to the partner, based on the sharing of experience and expertise without expectation of personal gain by the mentor’.</td>
<td>4 RCTs provided evidence on mentoring and alcohol use. The 2 that could be pooled showed less alcohol use by mentored youth. 6 RCTs on mentoring and drug use were identified, 2 of which provided some evidence of the effect of mentoring in reducing drug use.</td>
<td>Very few well-designed studies evaluate the effects of mentoring on adolescent drug and alcohol use.</td>
</tr>
<tr>
<td>Lemstra 2010 SR Included 6 RCTs (USA)</td>
<td>Half of the studies assessed knowledge-based interventions and half assessed comprehensive-based programmes. All included studies, except 1, were interactive. Control groups were knowledge only, curriculum only, printed pamphlets and standard care. In half of the included studies the intervention was delivered by an external educator; in the remaining studies teachers and/or peers were used. 1 of the studies failed to describe the control group used. The length of the intervention varied considerably from 1 session to multiple sessions over a period of 3 years; half of the studies used booster sessions. Half of the studies assessed alcohol and marijuana use and the rest assessed alcohol usage alone; none assessed marijuana usage alone. Other assessed outcomes included knowledge and skills and the incidence of problem behaviours.</td>
<td>All studies combined (knowledge and comprehensive programme interventions) using a combined outcome measure (alcohol and marijuana use) reported a pooled MUR of 0.95 (95% CI 0.91 to 1.00) in comparison with control. In comparison with no exposure, comprehensive intervention programmes resulted in a mean absolute reduction of 7 days in marijuana use per month (MUR 0.93; 95% CI 0.92 to 0.94, range 6-8 days; 2 studies) and 12 days of alcohol usage (MUR 0.88; 95% CI 0.87 to 0.89, range of 11-13 days; 3 studies) Knowledge-only programmes resulted in a mean absolute usage of 2 days of alcohol usage per month (MUR 0.98; 95% CI 0.92 to 1.04, range 4-6 days; 2 studies). 1 study of a knowledge-based outcome assessed marijuana use.</td>
<td>Comprehensive programmes that included anti-drug information with refusal skills, self-management skills and social skills training. These were the most effective programmes for long-term reduction of marijuana and alcohol use in adolescents aged 10-15 years.</td>
</tr>
<tr>
<td>Brown 2007 SR School-based drug prevention programmes that included rural populations.</td>
<td>The authors found a modest but consistent beneficial impact of drug prevention programmes on later use as well as level of use. Regarding later drug use, the largest impact was on those who were not using at baseline and those exposed to an interactive programme; the results were much larger for</td>
<td>Evidence exists for a small but systematic beneficial effect of drug prevention programmes in rural settings. It is likely that these</td>
<td></td>
</tr>
</tbody>
</table>
marijuana and other drugs compared to alcohol or tobacco, while inhalant use was less affected than other drug categories. Regarding level of use, the impact was greatest 6 months after the trial ended, with diminishing effects thereafter. programmes have produced a mild reduction in new use of substances but have had little impact on those already using substances.

<table>
<thead>
<tr>
<th>YOUNG PEOPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ferri 2013</strong>&lt;br&gt;SR Included 23 studies (12 RCTs, 2 PCS, 6 ITS, 2 CBA)&lt;br&gt;one study was both RCT &amp; PCS&lt;br&gt;USA, Canada &amp; Australia</td>
</tr>
<tr>
<td>'Mass media is defined here as channels of communication such as television, radio, newspapers, billboards, posters, leaflets or booklets intended to reach large numbers of people and which are not dependent on person to person contact.'&lt;br&gt;Studies which assess a mass media campaign explicitly aimed at influencing people’s drug use, intention to use or attitude towards illicit drugs use were included.&lt;br&gt;<strong>Control intervention</strong>&lt;br&gt;1) No intervention; 2) Other types of communication interventions such as school-based drug abuse prevention programmes 3) Community-based prevention programmes; 4) Lower exposure to intervention; 5) Time before exposure to intervention. The RCTs had an overall low risk of bias and the PCS had overall good quality, apart from the description of loss to follow-up by exposure. Self-reported or biomarker-assessed illicit drug use was measured with an array of published and unpublished scales making comparisons difficult. Pooled results of 5 RCTs (N = 5470) show no effect of media campaign intervention (standardised mean difference (SMD) -0.02; 95% confidence interval (CI) -0.15 to 0.12). We also pooled 5 ITS studies (N = 26,405) focusing specifically on methamphetamine use. Out of 4 pooled estimates (2 endpoints measured in 2 age groups), there was evidence of a reduction only in past-year prevalence of methamphetamine use among those aged 12-17 years. Overall the available evidence does not allow conclusions about the effect of media campaigns on illicit drug use among young people.</td>
</tr>
</tbody>
</table>

| Norberg 2013<br>SR Included 28 studies representing 25 RCTs<br>USA, Australia, UK & Europe |
| Universal programmes<br>Targeted programmes: targeted towards gender, African/Mexican American, athletic participation, disease, and personality risk<br>The programmes were also classed as:<br>Uni-modal programmes: Those that adopted a single modality for prevention implementation.<br>Multi-modal programmes: The core components involved drug prevention programmes predominantly delivered through school curriculums with other programmes utilising, a CDrom intervention, a child-skills workshop, a motivational interviewing session, and a one-on-one health consultation. Parent and family-based intervention components were most commonly adopted in conjunction with these core components. Other additional components included peer involvement community leadership/mentoring, mass media coverage, and school community development. Universal programmes: 9 out of 15 had a significant finding (d= 0.08 to 5.26, Mdn= 0.36). 1 programme obtained substantially larger effect sizes than the others (d= 1.63 to 5.26, Mdn= 2.19). Excluding this study, the median effect size of the other significant findings reduced to 0.14. Targeted programmes: 6 out of 10 reported significant findings (d= 0.07 to 0.74, Mdn= 0.20) Uni-modal programmes: 9 of 14 reported significant findings (d= 0.09 to 0.74, Mdn= 0.20) Multi-modal programmes 6 of 11 reported significant findings (d= 0.07 to 5.26, Mdn= 0.68) Overall, the current study suggests primary prevention programming may avert cannabis use. Albeit reliable and discernible patterns for programme efficacy remain largely inconclusive, results of the current study indicate the importance of assessing the relative efficacy of all programme types and the interdependent relationship of programme type and individual programme components. Substantial work is needed to improve the methodological and statistical reporting quality of effectiveness trials. |

<p>| Scott-Sheldon 2012&lt;br&gt;MA&lt;br&gt;14 studies 919 interventions&lt;br&gt;USA |
| An expectancy challenge (EC) intervention typically includes the provision of beverages to groups of drinkers in a bar-like setting; some contain alcohol and others contain a placebo beverage, but the participants do not know the content of their drinks. Participants engage in activities that promote social interaction, and after time passes, participants are asked to evaluate whether other participants were drinking alcohol versus a placebo. Incorrect identification provides opportunities to consider the effects of alcohol attributable to expectancies. Compared to controls, EC participants reported lower positive alcohol expectancies, reduced their alcohol use, and reduced their frequency of heavy drinking (d+s ranged from 0.23 to 0.28). Within-group improvements in alcohol expectancies and consumption emerged for the EC group only; relative to their own baseline, EC participants reported lower positive alcohol expectancies, reduced their alcohol use, and reduced their frequency of heavy drinking (d+s range from 0.13 to 0.36). Supplemental analyses found improvements in specific alcohol expectancies (social, sexual, tension, and arousal) both between and within-group. The short-term effects of EC interventions on college student drinking are not maintained at follow-ups greater than 4 Overall, expectancy challenge interventions succeeded at reducing positive alcohol expectancies, the quantity of alcohol consumed, and the frequency of heavy drinking for as long as 1 month post-intervention. Quantity of alcohol consumed and the frequency of heavy drinking was not sustained at longer follow-ups (i.e., up to 6 months post intervention). |</p>
<table>
<thead>
<tr>
<th>Reference</th>
<th>Description</th>
<th>Key Findings</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gates 2006 SR</td>
<td>Intervention had to describe the effects of an alcohol prevention intervention developed according to 1 or more principles of social marketing. No limits were set on the age of the participants or on the kind of alcohol prevention intervention.</td>
<td>Intervention was based on motivational interviewing, education, or skills training. Most studies were controlled before-and-after design; the others were RCTs or time series quasi-experimental studies.</td>
<td>Preventive interventions, in nightlife settings, could effectively reduce high-risk alcohol consumption, alcohol-related injury, violent crime, access to alcohol by those under age, and alcohol service to intoxicated people, but more research was needed.</td>
</tr>
<tr>
<td>Included 17 studies (9 cluster &amp; 8 individually randomised studies USA, UK &amp; China)</td>
<td>The interventions studied included school-based curriculum, family or parental support programmes, mentoring of youth, and prevention programmes for children. In adults, it included web- or computer-based interventions, and social norms interventions that aimed to reduce substance use. Comparators ranged from no intervention, to minimally active interventions, such as assessment or general drug or alcohol education, and active interventions, such as in-person behaviour modification programmes.</td>
<td>Few studies were included, and some family interventions may have some benefit. Cost-effectiveness has not yet been addressed in any studies, and further research is needed to determine whether any of these interventions can be recommended.</td>
<td></td>
</tr>
<tr>
<td>All Ages</td>
<td>4 types of intervention: motivational interviewing or brief intervention, education or skills training, family interventions and multi-component community interventions.</td>
<td>1 study of motivational interviewing suggested that this intervention was beneficial on cannabis use. 3 family interventions (Focus on Families, Iowa Strengthening Families Programme and Preparing for the Drug-Free Years), each evaluated in only 1 study, suggested that they may be beneficial in preventing cannabis use. The studies of multi-component community interventions did not find any strong effects on drug use outcomes, and the 2 studies of education and skills training did not find any differences between the intervention and control groups.</td>
<td>Based on this review, the effect of applying the principles of social marketing in alcohol prevention in changing alcohol-related attitudes or behaviour could not be assessed. More research, with a good quality methodology, like using a randomised control trial and measuring short, medium, and long-term effects, is required on this topic. Policy implications are discussed.</td>
</tr>
<tr>
<td>Janssen 2013 SR</td>
<td>Intervention had to describe the effects of an alcohol prevention intervention developed according to 1 or more principles of social marketing. No limits were set on the age of the participants or on the kind of alcohol prevention intervention.</td>
<td>The 6 studies included showed associations for the application of social marketing techniques on alcohol-related attitudes or behaviour; 1 study relates to participation in a drinking event, 4 to alcohol drinking behaviour, 2 to driving a car while under the influence of alcohol, 2 to recognition of campaign messages or campaign logo, and 1 to awareness of the campaign. However, no associations were also found.</td>
<td></td>
</tr>
<tr>
<td>CADTH 2012 SR</td>
<td>The interventions studied included school-based curriculum, family or parental support programmes, mentoring of youth, and prevention programmes for children. In adults, it included web- or computer-based interventions, and social norms interventions that aimed to reduce substance use. Comparators ranged from no intervention, to minimally active interventions, such as assessment or general drug or alcohol education, and active interventions, such as in-person behaviour modification programmes.</td>
<td>2 SRs of family or parental support programmes provided evidence that these interventions can reduce substance use. Universal family-based programmes with educational and psychosocial components showed statistically significant positive effects across multiple outcomes of alcohol use. School-based programmes were evaluated in 2 SRs. Certain psychosocial or life skills programmes were reported to reduce the risk of alcohol misuse. The evidence was strongest for general programmes targeting multiple factors including misuse of drugs, tobacco, alcohol and antisocial behaviour. Skills-focused school programmes also showed statistically significant reductions in drug use compared to usual curriculum. A systematic review of educationally oriented pre-school programmes reported evidence that early childhood interventions improve health behaviours. 3 RCTs showed a lower risk of marijuana use when children reached adulthood, but mixed effects on other drugs or alcohol. The review authors found no consistent evidence of the impact of pre-school programmes on health services utilisation.</td>
<td></td>
</tr>
<tr>
<td>Boilier 2011 SR</td>
<td>Most of the included studies evaluated alcohol programmes; 2 assessed drug programmes. The alcohol studies evaluated 4 types of intervention: community, alcohol server, education, and policy. There was considerable diversity in the type of intervention. Most studies had a controlled before-and-after design; the others were RCTs or time series quasi-experimental studies.</td>
<td>17 studies were included in the review; 15 were alcohol-related and 2 were drug related. The total number of participants was not reported. 3 studies were given a quality score of 1 (low quality), and 2 scored 4 (high quality). Follow-up ranged from immediately after the intervention, to 4 years. Community: 4 studies, generally, showed that community interventions could reduce substance-related harm. There was a small effect associated with the behaviour of doormen when</td>
<td></td>
</tr>
</tbody>
</table>
noticing drug use (1 study). Community interventions were effective in reducing high-risk alcohol consumption, and alcohol-related injury from traffic accidents and assault (1 study); alcohol access by underage consumers (1 study); and alcohol service to intoxicated customers and violent crimes (1 study).

**Alcohol server:** From 6 studies, alcohol server interventions were effective in improving knowledge (4 studies) and improving self-reported server behaviour (2 studies). There were mixed effects on objective measures, including observed server behaviour, road accidents, blood alcohol level and drink driving.

**Education:** 2 studies reported small effects of educational interventions on negative attitudes to drugs and drinking behaviour. 4 of 5 studies reported that policy interventions were effective on alcohol serving; the other study reported no significant effect.

| Eligible studies needed to assess the impact of changes in the hours of sale on excessive alcohol consumption, related harms or both in jurisdictions where changes occurred. Included studies needed to have a comparison group or report comparison of prespecified outcomes before and after a change in policy related to hours of sale. Only studies conducted in high-income economies were considered. Studies that assessed short-term changes in alcohol availability and combined interventions were excluded. Where multiple outcomes were reported, those known to have the strongest association with excessive alcohol consumption (such as alcohol-related motor vehicle crashes) were selected. Included studies assessed the effects of increasing hours of sale versus not increasing hours of sale. All studies were of on-premises alcohol outlets. Studies were conducted in the UK, Iceland, and Australia. | 16 studies were included.

Studies of changes of at least 2 hours in hours of sale: 10 studies were included. 1 study was of greatest design suitability, 1 was of moderate design suitability and 8 were of least suitable design; all had fair quality of execution. 2 studies reported that an increase of at least 2 hours in the hours of sale resulted in decreased alcohol-related harms (injury and serious violent crime). 6 studies reported an increase in alcohol-related harms relative to the period before the increase in hours of sale. 1 study reported no effect. 1 study reported a non-significant increase in alcohol consumption associated with an increase in hours of sale.

Studies of changes of less than 2 hours in hours of sale: 6 studies (10 papers) were included. 3 studies (7 papers) were of greatest design suitability, 3 were of least suitable design and all were of fair quality of execution. Overall results suggested no consistent effects of changes of less than 2 hours on alcohol-related outcomes. 1 study of increased hours of sale reported increases in wholesale alcohol purchases, assaults and motor vehicle crashes. 2 studies reported small and inconsistent changes in alcohol-related outcomes (alcohol consumption, multiple alcohol-related causes of mortality and motor vehicle crashes) following extension of opening hours. 2 studies of increased hours of sale reported small and inconsistent changes in alcohol sales and consumption. | There was sufficient evidence to conclude that increasing hours of sale by 2 or more hours increased alcohol-related harms. There was insufficient evidence to determine whether increasing hours of sale by less than 2 hours increased excessive alcohol consumption and related harms. |

Hahn 2010

| SR | MUR – mean usage ratio; PCS – prospective cohort studies |
Hahn 2010\textsuperscript{129} assessed the effects of changes in the hours during which alcohol is served on excessive alcohol consumption and related harms. The authors concluded that there was sufficient evidence to conclude that increasing hours of sale by 2 hours or more increased alcohol-related harms. There was insufficient evidence to determine whether increased hours of sale of less than 2 hours increased excessive consumption and related harms. The review was well conducted and the studies included were of suitable design. Unpublished papers were excluded, therefore there is potential for publication bias.

**Evidence of Cost effectiveness**

We did not find any evidence to determine the cost effectiveness of primary prevention strategies for substance misuse.

**Summary of findings**

**Children and adolescents**

There was an overlap among the studies included in the selected systematic reviews.

The systematic review that reviewed mentoring by peers or adults showed a modest impact on the initiation of drug or alcohol use in adolescents primarily from disadvantaged or minority groups in the US. However the results may not be applicable to other adolescent populations.

School-based programmes were evaluated in 2 included systematic reviews. The review found that comprehensive programmes that included anti-drug information with family involvement, psychosocial and life skills were the most effective programmes for long-term reduction of marijuana and alcohol use in adolescents.

**Young people**

1 systematic review that assessed the effectiveness of mass media campaigns in preventing or reducing the use of or intention to use illicit drugs amongst young people found that the available evidence is inconclusive. A meta-analysis to examine the efficacy of alcohol expectancy challenge (EC) interventions for college alcohol abuse prevention found that this may be effective in the short-term. The authors of a review of non-school/college-based interventions to reduce drug use in young people concluded that there is no evidence for the effectiveness of the included programmes. Another SR found that multi-modal programmes may be useful in averting young people from using cannabis.

**All ages**

Janssen et al. found that the effect of applying the principles of social marketing in alcohol prevention could not be assessed because of the lack of clarity within the available studies of what social marketing entails. 1 well-conducted systematic review concluded that comprehensive programmes may have a positive impact on substance misuse in children and adolescents. 1 review found that interventions to prevent alcohol-related harm in nightlife

settings have a positive effect. Another review of the effect of increasing hours of alcohol sales by 2 hours or more found that this increased alcohol-related harm.

We did not find any evidence to determine the cost effectiveness of primary prevention strategies for substance misuse.

**Features of effective programmes**

The evidence suggests that comprehensive multi-modal programmes that involved families and included developing psychosocial skills may be effective in averting drug and alcohol use in adolescents. Alcohol expectancy challenge and other interventions to prevent harmful alcohol and drug use in nightlife settings also appear to be effective in college students and adults. The common features of these interventions include participants’ engagement and social interaction.

**Quality of the evidence and limitations**

The systematic reviews and meta-analysis included in this rapid review were methodologically robust; conducted a comprehensive literature search, screened and extracted studies according to explicit inclusion and exclusion criteria, and assessed the risk of bias of the included studies. However, all were limited by the quality of the included studies.

Many studies were underpowered to detect differences between groups. Almost all studies used self-reported substance use as an outcome measure, which may be influenced by social factors. Allocation concealment was often unclear. In clinical trials the lack of blinding has been associated with over-estimation of the intervention effects, however blinding is generally not possible with an intervention such as these studied. The statistical analysis did not always take into consideration clustering of participants (the fact that schools were randomised and not individual children).

The populations, interventions and their comparators were heterogeneous, which made drawing overall conclusions on effectiveness difficult.

**Discussion and conclusions**

There are numerous studies available that evaluate the effectiveness of programmes to prevent substance misuse in general adult and youth populations. The reviews suggest that comprehensive multi-modal programmes that include developing psychosocial skills and family involvement can have a positive effect on long-term drug and alcohol use in adolescents. The evidence to support mentoring and pre-school programmes for primary prevention of substance misuse is less clear.

The effectiveness of mass media campaigns and the principles of social media on their own in preventing or reducing substance misuse are not supported by the available evidence. Alcohol expectancy challenge and other interventions to prevent harmful alcohol and drug use in nightlife settings appear to be effective in college students and adults.
The available evidence suggests that increasing the hours of sale by 2 hours or more increases alcohol-related harm.

The effects of the primary prevention interventions that appear to have a positive impact on substance misuse tend to diminish with time; this suggests that any such intervention should be ongoing rather than a one-off.
10. Economic impact of interventions to prevent substance misuse

A desk-based exercise was conducted to identify the high-level economic impact of substance misuse primary prevention interventions. The intention was not to undertake a full economic assessment of the impact of any individual intervention, nor to perform any primary economic modelling. Instead the intention was to identify any interventions that have been subjected to a previous economic analysis which has been published in a peer-reviewed journal, and to identify any published tools for estimating the economic impact of intervention. However, no such evidence or tools were identified.

A different approach was therefore taken through the presentation of case studies for the estimated economic burden and potential economic case for investment in Hackney and City. We used 3 sources of information:

- The NICE costing reports produced alongside NICE clinical guidance have been used to assess the cost of substance misuse
- A 2011 Department of Health report which looked at the economic case for prevention by modelling the return on investment associated with intervention
- A 2011 Department of Education report on specialist drug and alcohol services for young people.

Alcohol misuse

Approximately 11,000 adults were expected to have mild, moderate or severe alcohol dependency in Hackney and City in 2014. The annual cost to the NHS of alcohol dependence has been estimated at £1,800 per person. This includes costs associated with hospital admissions, which have been estimated at around £1,450 for hospital admissions wholly attributable to alcohol and around £1,750 for hospital admissions partially attributable to alcohol. It has been estimated that, nationally, 86% of adults dependent on alcohol do not receive any intervention.

A 2011 Department of Health report calculated the return on investment for an intervention in primary care that combines universal screening by GPs of all patients (using the Alcohol Use Disorders Identification Test, AUDIT), followed by a 5-minute advice session for those who are identified as hazardous or harmful drinkers. The total cost of the intervention as an average across all those screened was £17.41 per person (2009/10 prices). The return on investment modelling suggests that such an intervention would be cost-saving within 1 year with a total return of £3.17 for every £1 spent. The projected return from year 6 onwards was estimated to be £1.18 for every £1 spent. The lower return over the longer-term is due to the assumption that the effectiveness of this intervention will decline over time.

---

133 UCLPartners Academic Health Science Partnership. Public mental health overview. October 2013
Substance misuse in young people
A total of 171 Hackney residents under the age of 18 years were referred to the young people’s substance misuse services in 2012/13; 158 were referred in 2013/14. The expenditure for 2013/14 for young people’s services was reported as £217,000.

The annual costs associated with young people misusing drugs and alcohol in the absence of treatment has been estimated at £179 per person in health care costs and £4,000 per person in crime related costs. The annual costs associated with adult substance misuse were estimated at between £21,300 and £45,100 per adult for non-problematic adult drug users; £550,388 to £958,848 per adult for problematic drug users and £173,090 to £238,397 per adult for alcohol abusers. This includes the cost of crime, poor health, premature death and lost output due to absenteeism and low employment levels.135

A 2011 Department of Education report on specialist drug and alcohol services for young people estimated that the lifetime return on investment for specialist substance misuse treatment for young people could be between £4.66 and £8.38 for every £1 spent. Structured treatment was also estimated to be cost effective in the short-term with a return on investment of £2.50 for every £1 spent. In this report specialist drug and alcohol treatment is defined as a planned medical, psychological or specialist harm reduction intervention aimed at preventing escalation of use or harm.135

11. Conclusions and recommendations

Conclusions

The misuse of drugs and alcohol is an important public health problem in Hackney and the City. The local population has higher than average indicators of need for substance misuse services, a higher estimated prevalence of both drug and alcohol misuse and higher rates of service use; these are concentrated in Hackney.

Service activity data show the service to be performing effectively, though there is room for improvement in rates of completion of treatment and cessation of misuse.

Consultation with stakeholders identified a number of different groups within the local population whose needs are perceived as not being met satisfactorily by local substance misuse services including service users with high social needs, people requiring alcohol detoxification, young people aged 19-24 years, ‘high’ cannabis users, people in the ‘increasing risk’ drinker category, older people on addictive long-term prescription medications and substance misusers needing access to psychological therapies.

Service challenges identified by stakeholders included ‘disparateness’ of existing services (with the potential for some service users to ‘fall through the net’) the potential to increase capacity within primary care to manage people with substance misuse problems and the current focus on treatment of service users at the expense of prevention and outreach interventions.

Review of the evidence on primary prevention identified numerous studies evaluating the effectiveness of programmes to prevent substance misuse in general adult and youth populations. The reviews suggest that comprehensive multi-modal programmes that include developing psychosocial skills and family involvement can have a positive effect on long-term drug and alcohol use in adolescents. The evidence to support mentoring and pre-school programmes for primary prevention of substance misuse is less clear.

Recommendations

1. Consider more intensive outreach to engage with the large number of substance misusers who are not in contact with treatment services of any kind.

2. Address service fragmentation issues by considering the option of introducing a single substance misuse service. As a minimum, improve co-ordination and communication between drug and alcohol services and between different components of the individual services (such as Lifeline and the Specialist Addictions Unit), ensuring the use of a common assessment approach (e.g. strength-based assessment) and common care and recovery pathways.

3. Increase the level of provision available for young people, and increase the focus on educational and outreach interventions. For example, there is scope for better
awareness and recognition of substance misuse issues amongst other professionals, e.g. Children’s Centre staff and health visitors, so that issues are identified and people/families referred to services early. There is also scope for more work to be done before young people get into difficulties e.g. via schools, festivals and clubbing venues, and scope for more partnership work with Children’s Centres and schools.

4. Provide specific services for young people in the transitional age group of 19-24 years, either via increasing the upper age limit of existing young people’s services or by providing a dedicated service to meet the needs of this age group. Targeted consultation with service users and investigation of service provision in other boroughs should be undertaken to inform selection of the most suitable service model.

5. Review the existing approach to implementation of alcohol screening, which evidence reviews have shown to be cost-effective when carried out in association with a 5-minute advice session (so-called ‘brief intervention’). Consider adopting a more targeted approach to screening in the local community, including the use of screening in hospital settings such as accident and emergency departments and inpatient settings.

6. Review the existing provision for alcohol withdrawal/detoxification services and explore the potential for providing community-based alcohol detoxification with GP support, including the availability of detoxification for people living in nursing/residential accommodation. This might include, for high-risk patients, a stepped care model involving hospital admission for the initial stage of detoxification followed by discharge into the community. As reported in the evidence review informing the NICE Guideline on Alcohol Use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence, interpretation of the evidence on cost-effectiveness of community versus residential alcohol detoxification is challenging. However, the evidence seems to suggest that more severe and less socially stable patients who misuse alcohol seem to fare better in inpatient (or more intensive) treatment, whereas among married patients with stable accommodation, fewer years of problem drinking, and less history of treatment, outpatient (and less intensive) treatment yields more favourable outcomes than inpatient treatment.

7. Consider greater integration of support for patients with substance misuse problems into primary care; for example, considering the role of a GP with Special Interest in substance misuse to provide leadership, education, training and support to colleagues in primary care, developing an outreach model whereby every practice has access to a specialist drug and alcohol worker, and exploring the possibility of 1 practice providing substance misuse services on behalf of others.

8. Improve services and pathways for substance misusers with high social needs, including facilitating their access to housing and benefits advice and support.

---

136 Alcohol Use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence. The British Psychological Society & The Royal College of Psychiatrists, 2011.
9. Increase the level of service provision available for drinkers in the ‘increasing risk’ (hazardous drinking) category by, for example, providing interventions which help them to identify and understand the risk associated with their drinking behaviour and which support them in modifying their drinking behaviour.

10. Address existing problems with service access by exploring, for example, increasing service provision over the weekends to facilitate access by non-resident City workers and exploring ways of improving access to services by residents in the north of Hackney.

11. Ensure where appropriate the compliance of services with NICE guidance and other relevant clinical guidelines.

12. Investigate the variations in cost per service user between Hackney, the City and England.

13. Increase uptake of Improving Access to Psychological Therapies (IAPT) by people with substance misuse problems with a view to improving recovery rates from substance misuse.

14. Develop treatment pathways for people using new psychoactive substances/legal highs and those misusing prescription or over the counter medications.

15. Identify and review the medication requirements of older people on long-term prescriptions for potentially addictive medicines.

16. Review education and training needs of people working within the substance misuse services and provision to address this.

17. Ensure that all people working within substance misuse services are fully briefed on the range of services, including aftercare services, available to their clients and that they pass this information on, where relevant, to clients.

18. Work with Hackney’s diverse communities to understand their specific needs and identify how these communities can support and complement local prevention and treatment services.

19. Those receiving services and support for substance misuse should be regularly assessed for mental ill-health and provided with the appropriate support and treatment for these conditions.
12. Appendix 1: National guidance on substance misuse

The table below lists the clinical guidance and public health guidance published by the National Institute for Health and Care Excellence that focuses on substance misuse. The inclusion of any recommendations specifically relating to children and young people, adults or older people within the guidance is indicated.

Table 27: Guidance published by the National Institute of Health and Care Excellence (NICE): substance misuse

<table>
<thead>
<tr>
<th>NICE guidance</th>
<th>Areas covered by recommendations</th>
<th>Recommendations specifically relating to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Children/Young people</td>
</tr>
<tr>
<td>Drug misuse: psychosocial interventions. CG51, 2007</td>
<td>• General considerations • Identification and assessment of drug misuse • Brief interventions and self-help • Formal psychosocial interventions • Residential, prison and inpatient care</td>
<td>No</td>
</tr>
<tr>
<td>Drug misuse: opioid detoxification. CG52, 2007</td>
<td>• General considerations • Assessment • Pharmacological interventions in opioid detoxification • Opioid detoxification in community, residential, inpatient and prison settings • Specific psychosocial interventions</td>
<td>No</td>
</tr>
<tr>
<td>Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people. PH4, 2007</td>
<td>• Identifying children and young people who are misusing or at risk of misusing substances • Joint working • Motivational interviews • Group-based behavioural therapy • Family-based programmes</td>
<td>Yes</td>
</tr>
<tr>
<td>Alcohol-use disorders – preventing the development of hazardous and harmful drinking. PH24, 2010</td>
<td>• Licensing • Resources for identifying and helping people with alcohol-related problems • Children and young people aged 10-15 years – assessing their ability to consent, judging their alcohol use, discussion and referral to</td>
<td>Yes</td>
</tr>
<tr>
<td>Appendix Title / Guideline</td>
<td>Description / Intervention</td>
<td>CG115, 2011</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------------------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. | Principles of care  
- Identification and assessment  
- Interventions for alcohol misuse | Yes | Yes | Yes |
| Alcohol-use disorders: physical complications. | Acute alcohol withdrawal  
- Wernicke’s encephalopathy  
- Alcohol-related liver disease  
- Alcohol-related pancreatitis | Yes | Yes | No |
| Interventions in schools to prevent and reduce alcohol use among children and young people. | School-based education and advice  
- Partnerships | Yes | No | No |
| Psychosis with coexisting substance misuse. | Principles of care  
- Recognition of psychosis with coexisting substance misuse  
- Primary care  
- Secondary care mental health services  
- Substance misuse services  
- Inpatient mental health services  
- Staffed accommodation  
- Specific issues for young people with psychosis and coexisting substance misuse | Yes | Yes | No |
13. Appendix 2: Literature search strategy – primary prevention interventions for substance misuse

**Databases searched:** Medline, Embase, PsycINFO and the Cochrane Library
**Search date:** 02.12.2013
**Search filters:**
- Health technology assessments, systematic reviews, meta-analysis and cost/economic studies
- English language
- Published from 2003 onwards

**Medline search strategy:**
1. Primary Prevention/
2. (primary adj2 prevent*).ti,ab.
3. prevent*.ti.
4. 1 or 2 or 3
5. exp Substance-Related Disorders/
6. Alcoholics/
7. (substance* adj3 (use* or misuse* or abuse* or addict* or dependen*)).ti,ab.
8. (alcohol* adj3 (use* or misuse* or abuse* or addict* or dependen*)).ti,ab.
9. (alcoholic or alcoholism).ti,ab.
10. ((drug* or heroin or opioid* or cocaine or amphetamine*) adj3 (use* or misuse* or abuse* or addict* or dependen*)).ti,ab.
11. 5 or 6 or 7 or 8 or 9 or 10
12. 4 and 11
13. limit 12 to "reviews (maximises specificity)"
14. limit 12 to ("economics (maximises specificity)" or "costs (maximises specificity)"")
15. 13 or 14
16. limit 15 to (English language and yr="2003 -Current"")
17.

**Inclusion criteria for identification of relevant studies**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publication type</td>
<td>Systematic review, meta-analysis, Economic study (any type) Absorbs were excluded where no clinical outcomes reported, or where the paper was a non-systematic literature review, editorial, letter, laboratory or animal study. Duplicate publications and studies published as abstract only (e.g. conference poster) were excluded. If multiple systematic reviews, meta-analyses or HTAs were found for a given population and intervention, and all the included studies overlapped between reports, then the most recent and methodologically sound report was included.</td>
</tr>
<tr>
<td>Patients</td>
<td>Children and adults over the age of 18 years</td>
</tr>
<tr>
<td>Intervention</td>
<td>Primary prevention intervention for substance misuse (alcohol and drugs)</td>
</tr>
<tr>
<td>Comparators</td>
<td>Any comparator</td>
</tr>
<tr>
<td>Outcome</td>
<td>Decrease substance misuse Decrease in substance abuse/misuse deaths Decrease health resource use (e.g. fewer emergency treatments, fewer missed days of work)</td>
</tr>
<tr>
<td>Language</td>
<td>English only</td>
</tr>
</tbody>
</table>

**Unmet needs – key groups whose needs are not well met by existing provision**

<table>
<thead>
<tr>
<th>Population</th>
<th>Unmet needs</th>
<th>Source</th>
</tr>
</thead>
</table>
| Young people in the transitional age group of 19 to 25 years | • No specific service provision for young adults aged 19-25 years. Adult substance misuse services are considered inappropriate for this age group since the profile of drug use in young people is very different to that in adults  
  • Young people’s hostels take people aged 16-24 years so might be a gap (in working with young people in hostels aged 19-24 years) as young people’s substance misuse services have a cut-off at 19 years  
  • Shifting the age limit of young people’s services to 25 years might be a more appropriate way of meeting the needs of young adults. | Workshop and Interviews  |
| Children and families affected by substance misuse | • Very little direct work with these children. Those in this group are highly likely to go on to have substances misuse issues later on  
  • Multi-agency working needs to happen at a strategic level as well, e.g. would be useful to have a hidden harm sub-committee  
  • No literature around Hackney about how to protect children from substance misuse or for the children affected  
  • Absolute need for programmes that work with the whole family and the children affected  
  • Rehabilitation residential treatment for families may be less available than in the past. Complex funding issues but real benefit for families  
  • Support for foster carers or kinship carers to help maintain placements and prevent children from going on to becoming substance misusers | Workshop and Interviews  |
| Young people (prevention work) | Huge demand for education/outreach work. Could expand the capacity to provide this | Interviews                  |
| Alcohol detoxification | • No community detox facility (only inpatient) that GPs are involved with/aware of  
  • May be gaps in the pathways and liaison between hospital and community services for dual diagnosis patients undergoing detox  
  • Missed opportunities when alcohol-dependent people admitted to hospital and given detox but discharged without ongoing support | Workshop and Interviews  |
<table>
<thead>
<tr>
<th>Substance misuse HNA, City of London and Hackney</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alcohol-dependent clients with high social need</strong></td>
</tr>
<tr>
<td>• More capacity required; could be via stepped care model (i.e. first few days in hospital with completion in community) and provision of community detoxification (supported by primary care)</td>
</tr>
<tr>
<td><strong>Drinkers in the ‘increasing risk category’</strong></td>
</tr>
<tr>
<td>• Nowhere to place people who are not self-caring. Needs to be better links with Adult Social Care</td>
</tr>
<tr>
<td>• Very high admission rate for people with alcohol issues</td>
</tr>
<tr>
<td><strong>Access to psychological therapy for people with substance misuse problems</strong></td>
</tr>
<tr>
<td>• People at lower end of alcohol misuse spectrum who need more support and can’t independently moderate their drinking behaviour</td>
</tr>
<tr>
<td>• Harmful, but non-dependent drinkers and cannabis users. Would not necessarily come into treatment but are ‘time bombs’</td>
</tr>
<tr>
<td><strong>People with dual diagnosis of a mental health disorder and substance misuse</strong></td>
</tr>
<tr>
<td>• They are more likely to lead chaotic lifestyles, need social support/supported housing but may not meet the ‘admission’ policy for this type of support so continue to use an enormous amount of resources from service providers picking them up in crisis</td>
</tr>
<tr>
<td>• Can fall between services or get batted between teams</td>
</tr>
<tr>
<td>• Cannabis users and mental health problems</td>
</tr>
<tr>
<td><strong>Older people with needs relating to substance misuse</strong></td>
</tr>
<tr>
<td>• Long-term users of prescription medications, e.g. benzodiazepines for anxiety/depression, opiates for pain relief. The size of this group is not known but could be identified easily via GP registers</td>
</tr>
<tr>
<td>• Older people with cognitive problems</td>
</tr>
<tr>
<td>• People in nursing homes who need detox</td>
</tr>
<tr>
<td><strong>Groups with difficulties accessing services</strong></td>
</tr>
<tr>
<td>• Limited crèche services for substance users with young children, e.g. for adults using treatment services</td>
</tr>
<tr>
<td>• Working adults</td>
</tr>
<tr>
<td>• Difficult for City residents to access treatment services in the east side of Hackney</td>
</tr>
<tr>
<td><strong>Homeless population</strong></td>
</tr>
<tr>
<td>• No services for the homeless population in City</td>
</tr>
<tr>
<td>• No temporary accommodation in City. Some complex cases will go to other boroughs</td>
</tr>
<tr>
<td><strong>‘Emerging’ problems</strong></td>
</tr>
<tr>
<td>• Legal highs – emerging problem which services are not ready to tackle</td>
</tr>
<tr>
<td>• Prescription drugs with high street value</td>
</tr>
</tbody>
</table>

Interviews

Workshop and Interviews

Workshop and Interviews

Workshop and Interviews

Workshop and Interviews

Workshop and Interviews

Workshop and Interviews
- Use of prescribed drugs in combination with alcohol on the rise
- Recreational drug users, e.g. club drugs in young people and cannabis smokers
- Concerns about club/street drugs, which GPs are anxious about managing

## Challenges facing the service

| Pathways | • The substance misuse services in Hackney involve separate services and treatment pathways for drugs and for alcohol, despite some services in the same building. Introduction of a single service for drugs and alcohol with common treatment pathways  
• Not a smooth enough service in terms of patient access/ follow-up. Tend to operate a ‘book an appointment’ type service and ‘back to you’ once patient seen. Services not as accessible as they could be, but better than before. Need to be more pro-active  
• Communication/liaison/pathways between hospital and community services, e.g. for dual diagnosis patients, for patients undergoing alcohol detoxification  
• No encouragement to move on long-term clients  
• Hepatitis B pathway not as robust as it could be  
• Pathways for young people reported to be complex | Workshop and Interviews |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathways for young people</td>
<td>• Complex pathway where people have to be referred to Young Hackney and then to the substance misuse team. Can be difficult to explain to young people</td>
<td>Interviews</td>
</tr>
</tbody>
</table>
| Structure of services | • Would like to look at the structuring/commissioning models of young people’s substance misuse services – at present providing a slim-line service with high demand and case loads  
• Would like to extend the focus of services to include more prevention and early intervention work  
• Could expand on the capacity to do outreach work and to cover all things, including smoking and alcohol use  
• Could expand on the capacity to work with drug dealers  
• Would be good to offer more satellite services for young people, e.g. in schools or Children’s Centres  
• No specialist substance misuse role currently within CCG  
• Old style ways of working, e.g. separating alcohol and other substance misuse – idea that have to work with the different elements of dual diagnosis separately | Interviews |
<p>| Capacity of services | Services generally very over-stretched with high case loads – impacts on ability to work effectively with service users, e.g. | Interviews |</p>
<table>
<thead>
<tr>
<th>in promoting a recovery agenda</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Thresholds for referral</strong></td>
<td><strong>Increase capacity within primary care to manage patients with substance misuse who fall below threshold for referral to any SM services, e.g. non-dependent drinkers, ‘high’ cannabis users, patients on long-term opiates/benzodiazepines</strong>&lt;br&gt;<strong>Possible ways of doing so include clinical lead/GP with special interest to provide education/training/support; drug/alcohol support workers attached to each practice (i.e. outreach of specialist team to primary care); ensuring all practices operate within substance misuse shared care system</strong></td>
</tr>
<tr>
<td><strong>Changing needs</strong></td>
<td><strong>Pattern of drug use amongst City residents has changed. Used to be predominantly homeless people, now more people who have stable housing/employed, and more alcohol than drug users</strong></td>
</tr>
<tr>
<td><strong>Prevention/early intervention</strong></td>
<td><strong>Response times – would help to be able to react quickly and get people at the right time before crisis</strong>&lt;br&gt;<strong>Scope for more promotion of positive view of ‘in recovery’. At present tend to work with high-end risk due to demand but this does not break the cycle. Have knowledge and desire to do more early intervention but very hard with the pressure of demand from high risk users</strong>&lt;br&gt;<strong>Scope for better awareness/recognition of substance misuse issues amongst other professionals, e.g. Children’s Centre staff and health visitors, so that issues are identified and people/families referred to services early</strong>&lt;br&gt;<strong>Scope for more work to be done before young people get into difficulties, e.g. in schools, festivals, clubbing</strong>&lt;br&gt;<strong>Scope to do more preventative work with City workers</strong></td>
</tr>
<tr>
<td><strong>Joint working/communication</strong></td>
<td><strong>Clear that knowledge about other local services is mixed. Some ‘silo working’ – need networking so that services know what else is available</strong>&lt;br&gt;<strong>Different funding streams and criteria can make it difficult for services to work together</strong>&lt;br&gt;<strong>Multi-agency working needs flexibility and willingness to work with/ across different cultures and models/ways of working</strong>&lt;br&gt;<strong>Workforce development – so that staff aware of the pathways/services available</strong>&lt;br&gt;<strong>Need 1 central point for data/provision of information to avoid people getting bombarded by information on individual services from a variety of different sources</strong>&lt;br&gt;<strong>Can be problems transferring between services</strong>&lt;br&gt;<strong>Links with mental health services</strong>&lt;br&gt;<strong>Aftercare is available but some workers not using the service or signposting to their clients. Aftercare should</strong></td>
</tr>
<tr>
<td>Appendixes</td>
<td>143</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Start at outset not after treatment has completed</strong>&lt;br&gt;• Lack of pro-active follow-up of people who attend accident and emergency departments with substance misuse issues</td>
<td></td>
</tr>
<tr>
<td><strong>Transitional service for young people aged 19-25 years</strong>&lt;br&gt;• Traditional funding creates artificial boundaries around age&lt;br&gt;• Could have people working jointly across children and adult services&lt;br&gt;• Could have service targeting young people aged 19-25 years&lt;br&gt;• Have services for young people at location that they will attend</td>
<td>Workshop and Interviews</td>
</tr>
<tr>
<td><strong>Family support</strong>&lt;br&gt;• There is a great need for family work and only limited capacity to provide it at present&lt;br&gt;• Scope for more partnership work with Children’s Centres in working with mothers/carers and young people&lt;br&gt;• Service users may be fathers, and may have children living in a different area who may stay with them. Needs to be taken into account, e.g. in relation to safe storage of medication at home</td>
<td>Workshop and Interviews</td>
</tr>
<tr>
<td><strong>Perceptions</strong>&lt;br&gt;• People who don’t see themselves as drug users in the traditional sense and won’t access services. How to help them?</td>
<td>Workshop</td>
</tr>
<tr>
<td><strong>Alcohol screening</strong>&lt;br&gt;Implementation of alcohol screening in A&amp;E departments locally as occurs in A&amp;E departments elsewhere</td>
<td>Workshop</td>
</tr>
<tr>
<td><strong>Specialised midwifery team</strong>&lt;br&gt;Need to expand specialised midwifery team to work with pregnant women with substance misuse issues</td>
<td>Interviews</td>
</tr>
<tr>
<td><strong>Domestic violence</strong>&lt;br&gt;Awareness in services about the interaction of substance misuse and domestic violence. Cases can be very complex and may, for example, need referral to anger management services instead of substance misuse services</td>
<td>Interviews</td>
</tr>
<tr>
<td><strong>Sex workers</strong>&lt;br&gt;Sex workers becoming more hidden and more difficult to identify and support</td>
<td>Interviews</td>
</tr>
<tr>
<td><strong>Dentistry</strong>&lt;br&gt;Facilitation of access to dentistry by substance misuse service clients (services are available but are not accessed by substance misuse clients when they need it, e.g. for acute/chronic pain)</td>
<td>Workshop</td>
</tr>
<tr>
<td><strong>Engaging with religious/ ethnic communities</strong>&lt;br&gt;• Engage with religious/ethnic communities to help/support people with substance misuse issues from within their own community.&lt;br&gt;• Good information in peoples preferred language&lt;br&gt;• ‘A10’ population coming to live and work in UK, usually from Central and Eastern Europe</td>
<td>Workshop</td>
</tr>
<tr>
<td><strong>Transient population</strong>&lt;br&gt;Normally live in another borough but have found temporary work/accommodation in Hackney. May not be able to access their usual substance misuse services</td>
<td></td>
</tr>
<tr>
<td><strong>Wider support</strong>&lt;br&gt;• More capacity needed in providing responsive benefits</td>
<td>Workshop and</td>
</tr>
</tbody>
</table>
advice service for clients

- Lack of jobs and employment. Some links with Job Centre Plus but not great relationships
- Appropriate housing
- Social care pathways need to be improved, especially for dependent alcohol users
- Social care aspects of those with long-term health problems
- No residential/nursing home accommodation in the City so people are placed out of area if need care home admission

**Assets/resources in the community**

The table shown here lists the local assets identified by attendees at the substance misuse workshop and interview participants.

<table>
<thead>
<tr>
<th>Area</th>
<th>Asset</th>
<th>Benefit</th>
<th>Source</th>
</tr>
</thead>
</table>
| Staff and ways of working | Skills and experience of staff | - Do have good resources and experienced staff in Hackney  
- Engaged, motivated and flexible workforce  
- Diversity of workforce that reflects the community | Workshop and Interviews |
| Volunteers | | - Contribute across a wide range of services/areas | Workshop |
| Service user involvement | | - Service user forums  
- Recovery champions | Workshop |
| Services | | - Solution-focused providers/services | Workshop |
| Joint working | | - Multi-agency work helps ensure referrals are appropriate and in getting people into services quickly. Also helps with sharing skills and experiences  
- Alcohol and drug services together so much more joint working, whereas in past users had to contact separate services  
- Some individuals/teams very good at multi-agency working and building links with other services  
- Integration of health and social care, e.g. Greenways, St Mungo’s  
- Good communication between services when they use the common assessment tool  
- Consultant with links to mainstream | Interviews |
<table>
<thead>
<tr>
<th>Individual services</th>
<th>Advocacy for all Hackney</th>
<th>Co-location of services</th>
<th>Outreach work</th>
<th>Training</th>
<th>Pharmacies</th>
<th>GPs</th>
<th>Workshops</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Funded by LBH, run by City and Hackney MIND in partnership with other voluntary organisations</td>
<td>Co-location of Hackney Ark and Lifeline helps with liaison between professionals and in working with families</td>
<td>Exploit existing outreach work/festivals</td>
<td>Access to free expert advice and training on a range of substance misuse issues for communities and professionals</td>
<td>Pharmacists that are enthusiastic to be engaged with public health issues</td>
<td>Capitalising on willingness of GPs, e.g. to support alcohol community detoxification</td>
<td>Workshops</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Co-location of Adult Social Care and City of London DAAT positive</td>
<td>SUOM – street outreach meeting – good partnership work between drug and alcohol treatment services and community safety with regard to balance of care and enforcement</td>
<td>Training available on how to talk to young people about substance misuse for youth groups, families, carers, mentors, health care professionals and providers</td>
<td>Social prescribing scheme</td>
<td></td>
<td>Workshops</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Workshop and Interviews</td>
<td>Workshop</td>
<td></td>
<td>Workshops</td>
</tr>
<tr>
<td>Alcohol Recovery Centre (ARC)</td>
<td>ARC day programme</td>
<td></td>
<td></td>
<td>Workshop</td>
<td></td>
<td></td>
<td>Workshops</td>
</tr>
<tr>
<td></td>
<td>Shows good partnership working between health and voluntary sector</td>
<td></td>
<td></td>
<td>Interviews</td>
<td></td>
<td></td>
<td>Workshops</td>
</tr>
<tr>
<td></td>
<td>Good service user involvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Workshops</td>
</tr>
<tr>
<td>BBV nurses</td>
<td>Blood-Born Virus nurses drop-in service</td>
<td></td>
<td></td>
<td>Interviews</td>
<td></td>
<td></td>
<td>Workshops</td>
</tr>
<tr>
<td></td>
<td>See people who won’t or can’t go to other services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Workshops</td>
</tr>
<tr>
<td>Building a Better Future</td>
<td>Week-long course free to service users, 3 times a year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Workshops</td>
</tr>
<tr>
<td>Carers centre and carers group</td>
<td>Emotional and practical support and information for families and friends</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Workshops</td>
</tr>
<tr>
<td>Children’s centres</td>
<td>Work around strengthening families and communities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Workshops</td>
</tr>
<tr>
<td></td>
<td>Welfare/housing and family support services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Workshops</td>
</tr>
<tr>
<td></td>
<td>Partnerships with schools</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Workshops</td>
</tr>
<tr>
<td>Organization</td>
<td>Description</td>
<td>Method</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis Skylight</td>
<td>Courses can be accessed for ex-homeless/homeless clients</td>
<td>Workshop</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DAAT employment lead</td>
<td>Good links with employers and training</td>
<td>Interviews</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEMO outreach team</td>
<td>Doing good work with chaotic and hard to reach people</td>
<td>Workshop and Interviews</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>Substance misuse courses. Good professional development calendar (DAAT)</td>
<td>Workshop</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foodbank</td>
<td>Good identification and partnership working</td>
<td>Workshop</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greenhouse</td>
<td>You can register with GP/housing benefits advice</td>
<td>Workshop</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I Care</td>
<td>Can create a support package for substance misuse clients</td>
<td>Workshop</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lee House</td>
<td>Employment and rehabilitation centre</td>
<td>Workshop</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifeline</td>
<td>Work with families and carers, including a group for people on long-term scripts</td>
<td>Workshop and Interviews</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M-PACT programme</td>
<td>Working with families where the parents have substance misuse issues. This has been running as a pilot but has now finished</td>
<td>Workshop and Interviews</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MIND</td>
<td>Provides advice and support to empower anyone experiencing a mental health problem</td>
<td>Workshop</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MOSAIC project</td>
<td>Recovery focused community arts project</td>
<td>Workshop</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mutual aid groups</td>
<td>Very large and diverse range of mutual aid groups – peer support</td>
<td>Workshop</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Hanbury Project</td>
<td>Emphasis on recovery</td>
<td>Interviews and workshop</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>‘Opendoors’</td>
<td>Sex workers service offers same day access</td>
<td>Interviews</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Work with offenders           | • Drug Interventions Programme (DIP)  
• Prison liaison work  
• Drug and alcohol worker who works with the police when people are arrested for alcohol/drug use  
• St Giles Trust – helping ex-offenders back into work | Workshop                |
| Recovery Centre               | Twice-weekly social clubs                                                                                                                                                                                     | Interviews              |
| Recovery Champions            | Meet and greet new clients and model recovery                                                                                                                                                                 | Interviews              |
| Specialist Addiction Unit     | • Deal with more complex cases  
• Links well into community services                                                                                                                                                                        | Interviews              |
| Specialist workers linked to GP surgeries | • City substance misuse service has a specialist worker co-located in a GP surgery  
• Specialist additions nurse linked to a GP practice | Interviews |
| St Mungo’s | • Working with complex needs  
• Social group at St Mungo’s | Workshop |
| Substance misuse midwife | Has improved outcomes and engaged women in treatment by identifying women and building a relationship with them | Interviews |
| Tudor Grove site | • Lots of activities including football team and onsite massage and acupuncture  
• Sessions from DAAT housing support officer and clinics from Citizens Advice Bureau | Interviews |
| Women-only days | At Tudor Grove and Mare Street sites | Interviews |
| Young Hackney | Holistic approach/unit structure. Providing services for young people, e.g. substance misuse, CAMHS, positive activities, family units, gangs | Workshop and Interviews |
| Youth Centres | Network of young people’s hubs (centres) and enthusiasm to have substance misuse workers involved | Workshop |