Croydon Drug and Alcohol Action Team

Drug and Alcohol Substance Misuse Needs Assessment 2013

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Croydon Drug & Alcohol Local Needs Assessment 2012

1 Introduction

Although the core function of this document is to facilitate the development of the treatment plan, this year the needs assessment is produced divergent from previous years. There are three reasons as follows:

- To inform the commissioning intentions and draft the Commissioning Strategy.
- To inform the re-tendering of the Drug and Alcohol treatment system in Croydon
- To facilitate the process of re-designing the partnership's recovery oriented treatment system.

Following on from the above, the areas of core information this document covers will include the overall treatment system from entry to exit complemented by specific topics that have an overarching impact on the partnership's treatment delivery.

2 Data Sources

Multiple data sources and various analysis methods have been used to produce the final analysis for this needs assessment. The main period used for this analysis is data gathered during 2011-12 but other periods prior to 2011-12 have been used due to accessibility issues of obtaining data to reflect similar time periods. Sources used are listed below:

- National Drug Treatment Monitoring System (NDTMS) – www.ndtms.net
- National Alcohol Treatment Monitoring System (NATMS) – www.ndtms.net
- Glasgow estimates for the prevalence of opiate and/or crack users (OCU)
- Local Alcohol Profiles for England (LAPE) – www.lape.org.uk
- Health and Social Care Information Centre (HSCIC) – www.hscic.gov.uk
- Health Protection Agency (HPA) – www.hpa.org.uk
- Drug Test Recorder (DTR) – Home Office
- Drug Interventions Programme web system (DIRWeb) – www.dirweb.co.uk
- Croydon Observatory – www.croydonobservatory.org
- Croydon JSNA - www.croydonobservatory.org
- Recovery Diagnostic Tool 2011-12 (RDT) Public Health (NTA) – www.ndtms.net

In order to achieve a comprehensive assessment, the analysis of various data sets have been used to best fit the partnership's potential unmet need of its' treatment population.

3 Executive Summary

- During 2011-12, Croydon spent £4,093,932 on substance misuse and the delivery of the Drug Intervention program jointly. In total 832 adults effectively engaged in treatment which accounts for -5% reduction from 2010-11. Planned treatment completions represented 33% of the total treatment exits compared to 43% in London and 47% nationally. The partnership's successful completions performance was recorded at 13% compared to national figures of 15%. The opiate

based completions were recorded at 9% and non-opiate based completions were recorded at 23% compared to 9% and 41% correspondingly for national performance.

- The estimated opiate and/or crack users (OCU) for Croydon is based on Glasgow University's prevalence figures for 2010/11 of 1676. The treatment penetration rate achieved during 2011-12 is 44%, an increase from previous year of 38%. This translates into nearly 732 people of the OCU population not accessing treatment during 2011-12. 23% of this population are identified to be DIP clients. The typical profile of Croydon substance misuse client is white, male aged between 30-49 years of age.
- Over 65% of people accessing treatment services are aged 35 and over. The ageing of the drug taking population has implications for the wider health needs and consequent provision of health services and links with public health programmes.
- Drug users from the Black and Minority Ethnic community in contact with treatment services represent 13% of the total treatment population.
- 74% of clients in treatment during 2011/12 listed opiates and /or crack as main problematic substance. Heroin is the main drug of use with crack being the secondary drug. Those coming from the criminal justice route via DIP are primarily testing positive for cocaine.
- Transmission of blood borne viruses remains a risk. Croydon's Hepatitis C prevalence is 53% and HIV prevalence 4.78%. Croydon reported 5 case of acute hep B during 2011. Although 54% of the treatment population are reporting never having injected, the prevalence figures for Croydon suggest that there may be an increasing trend of injecting drug users in this client group.
- There has been a decreasing trend in the number of alcohol clients accessing treatment over the last three years. The number of new referrals into treatment have also decreased. However, the hospital admissions related to alcohol has increased. The average percentage increase is approximately 16% since 2002-03. Croydon remains in the top quartile for high numbers of alcohol related hospital admissions in the London region.
- The number of criminal justice clients engaging in treatment appears to remain low with high attrition rates from referral to engagement in treatment.

4 National Policy

The 2010 National Drug Strategy 'Reducing demand, restricting supply, building recovery, supporting people to live a drug free life has two overarching aims -

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

This new approach is a shift for a more integrated approach to commissioning public health outcomes addressing the root causes and wider determinants of substance misuse. 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 NTA's support pack for commissioners (2011) sets out four principles within the National Drug Strategy 2010 to inform the commissioning of an integrated recovery orientated drug treatment system. The four 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

It is envisaged that this document will inform the commissioning intentions of the partnership and the re-tendering of the Croydon Treatment System during 2014-15.

5 Croydon Population

(*Croydon Observatory*)

Croydon is the largest Local Authority in London with a population of 363,400 as at March 2011. In the last ten years, the borough has seen an 8.4% increase, 1.3% higher than the national average.

Croydon is ranked 19th out of the 32 boroughs in terms of deprivation. The current employment rate is 70.7% (June 2012), above national and regional averages. The Job Seekers Allowance (JSA) claimant rate for the working age population in the borough is 4.5% (11,000 people – Sep 2012). Within this population group, the highest JSA claimant rate is for the 18-24 age group which equates to 2,715 residents.

Life expectancy in Croydon is 79 years for men and 82 years for women. The national figures are slightly less for men at 78 years and women at 82 years. Older people aged 65 years and over make up 13.8% of the Croydon population and people aged 85 years and over make up 1.9%. The projected increase of these proportions by 2030 is 16.27% and 2.9% respectively.

Croydon has approximately 147,000 dwellings with over 9% being council housing, 7% registered social housing and 83% private sector housing. House prices are approximately 50% above the national average. However, prices are less by over £100,000 compared to the average for Greater London which is £359,000 (June 2012).

Croydon's population is also very diverse. Black and ethnic minority residents make up almost 42% of the population and more than 100 languages are spoken.

Older people aged 65 years and over, make up 13.8% of the Croydon population and residents aged 85 years and over make up 1.9%. These proportions are projected to increase to 16.27% and 2.91% respectively by 2030.

6 Prevalence Estimates

Information on prevalence of opiate and / or crack cocaine use (OCU) is an essential part of the evidence used to assess the impact of interventions on the wider population. The research used to estimate the prevalence of OCU is based on data sources from Croydon and England. The University of Glasgow has been responsible for undertaking this research and the most recent estimates released are for the 2010/11 period.

The table below gives the estimates for each of the drug categories including injecting users and the rate per thousand of the population. The total 16-64 year old population for Croydon is 232,500. Also included in the table is the percentage rate for per thousand of population identified as OCU and injecting drug users.

	Number of users				Rate per thousand of population			
	Prevalence estimate 2010/11	Lower bound 95% CI	Upper bound 95% CI	Users %	Lower bound 95% CI	Upper bound 95% CI	London	National
OCU	1676	1185	2194	7.21%	5.10%	9.44%	9.62%	8.67%
Opiate users	1307	919	1694	5.62%	3.95%	7.29%	7.78%	7.59%
Crack users	1465	1265	1759	6.30%	5.44%	7.56%	7.30%	4.95%
Injecting	278	178	470	1.20%	0.77%	2.02%	2.12%	2.71%

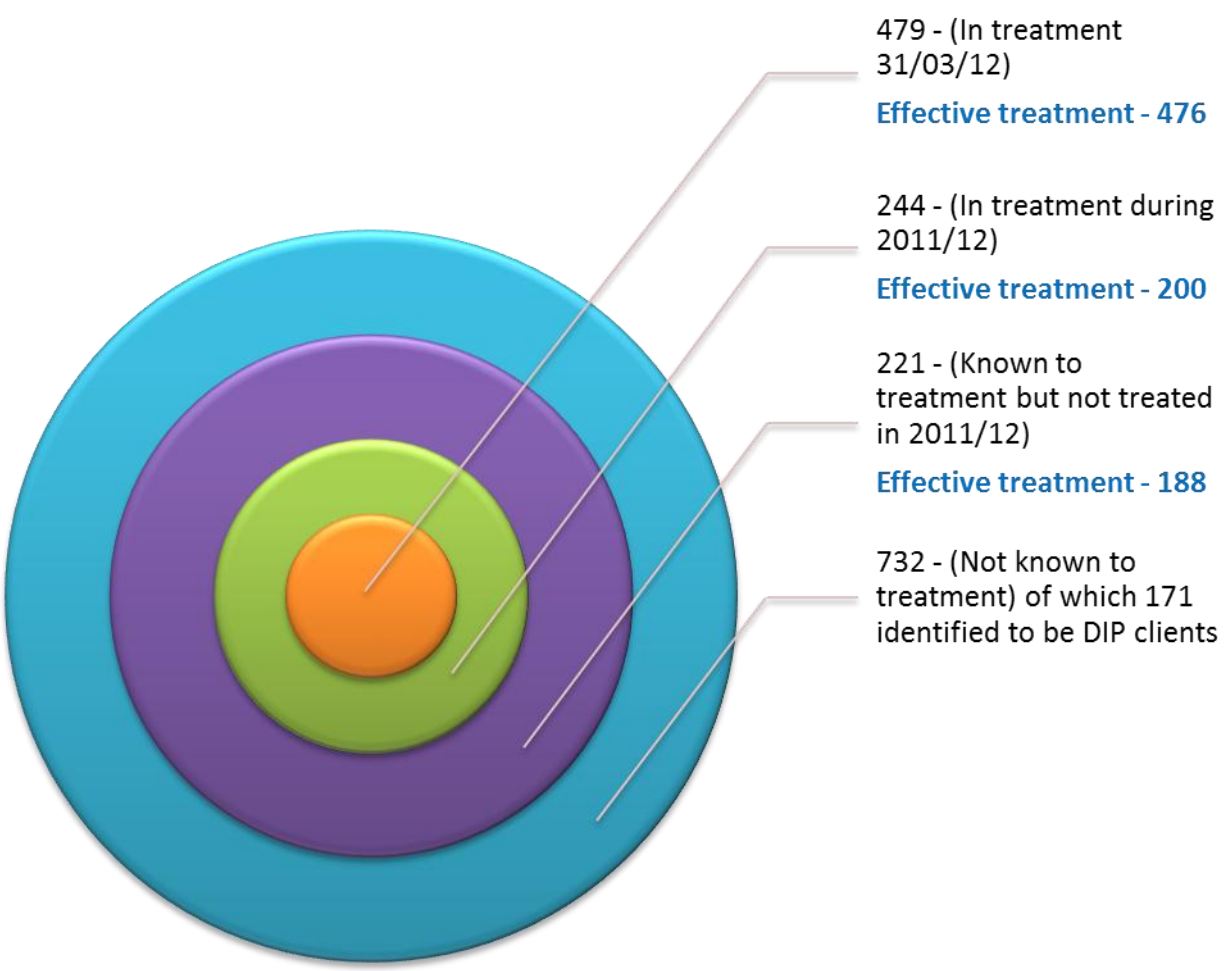
Croydon has lower average levels of OCU compared to London and England.

7 Treatment bulls eye

The treatment bulls eye was designed to illustrate the proportion of OCU clients engaged in structured treatment and those not engaged in structured treatment against the partnership's prevalence targets. The two main sources of data used for this calculation are the NDTMS (National Drug Treatment Monitoring System) and DIP (Drug Intervention Programme).

The bulls eye diagram below takes into account the 2011/12 data. Based on the recent prevalence estimate, summary of figures for our treatment population are:

- OCUs in treatment at the end of the financial year , 31st March 2012 - 479
- OCUs in treatment during the financial year 2011/12 - 244
- OCUs known to the treatment system but not treated during 2011/12 - 221.
- DIP clients (OCUs) identified as not known to treatment are – 171
- Total OCUs not known to treatment – 732 (this figure is the difference between the estimated prevalence and the sum of all the OCUs in treatment including those that are known to treatment but not treated during 2011/12.) This accounts for about 44% of the OCU population that are treatment naïve.



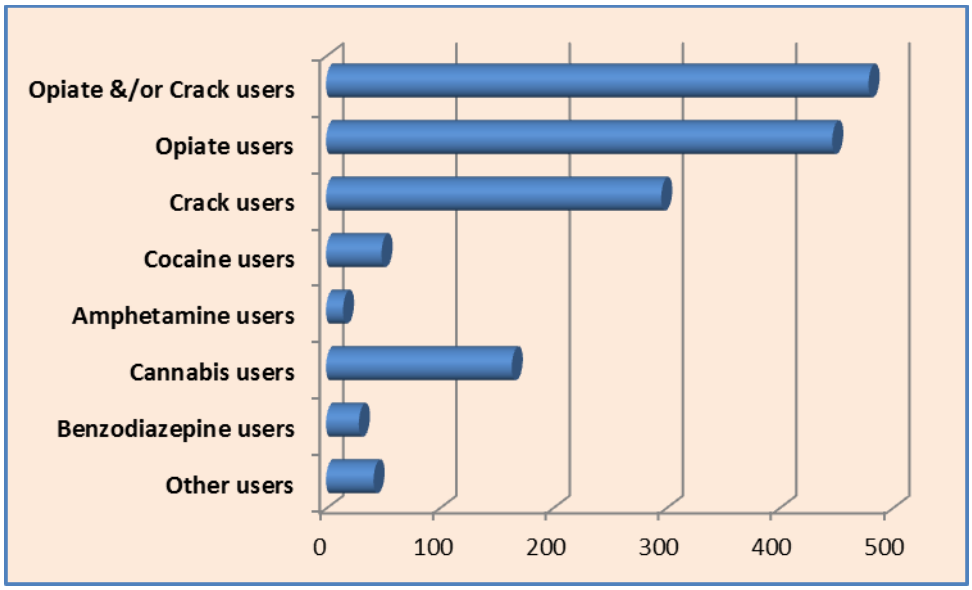
The table below shows the trend of treatment naïve clients for the last four years in the OCU, opiates only and crack only clients. It must be noted that the prevalence estimates during 2008-09 period was higher and numbers declined in 2009-10. Thus the proportion of treatment naïve clients (not known to treatment row in the table below) has been on a decreasing trend since 2008-09 but the numbers have increased during 2011-12.

	OCU				OPIATES				CRACK			
	2011-12	2010-11	2009-10	2008-09	2011-12	2010-11	2009-10	2008-09	2011-12	2010-11	2009-10	2008-09
In treatment YTD	479	491	524	490	447	453	486	433	296	332	309	322
off which are effective treatment	476	477	515	477	445	441	478	423	293	295	298	311
In treatment during the year	244	294	234	264	201	243	174	186	167	228	158	210
off which are effective treatment	200	243	173	180	169	199	127	137	138	164	118	137
Known to treatment but not treated duri	221	198	220	204	174	136	150	131	150	143	170	156
off which are effective treatment	188	138	152	150	146	95	112	100	129	92	113	100
Not known to treatment	**732**	**615**	**961**	**1549**	**481**	**504**	**493**	**877**	**852**	**771**	**807**	**1158**
Known to DIP	171	107	377	408	121	65	240	261	115	90	302	334
community	54	45	120	227	30	26	78	153	44	38	88	177
prison	120	66	285	234	94	41	181	147	71	56	235	201

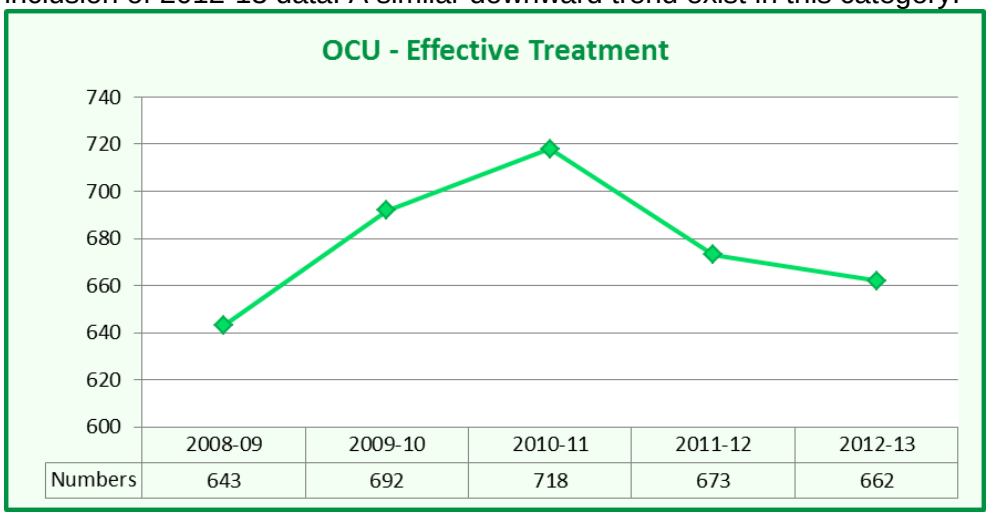
7.1 Penetration Rates

The penetration rates for treatment naïve clients during 2011-12 is around 44%, an increase from previous year's rate of 38%. However the penetration rates have been on a decreasing trend since 2008-09 when average rates were at an average of 60%.

Apart from the OCU population, also identified were a significant number of cannabis users. About 35% of the treatment population were identified to be cannabis users. This has been the average rate for cannabis users within the treatment system.
The chart below, gives an overview of the proportion of clients based on their presenting drug of use. This refers to the numbers in treatment at the end of 2011-12.



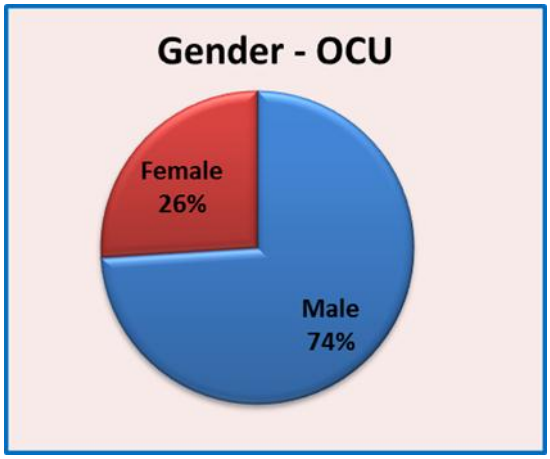
The graph below shows the number of OCU clients in effective treatment since 2008-09 with the inclusion of 2012-13 data. A similar downward trend exist in this category.

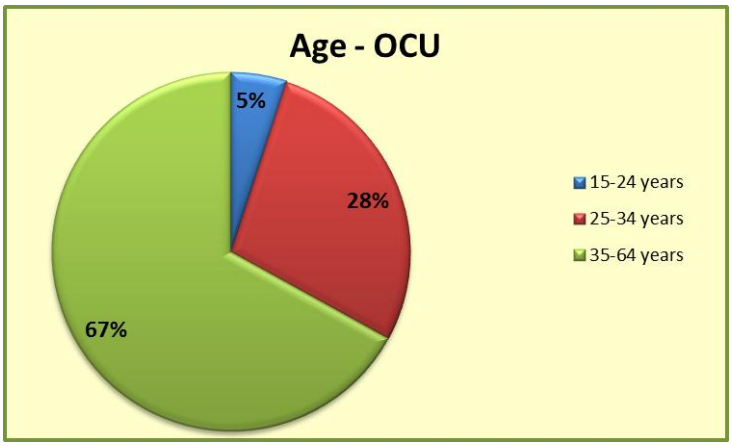


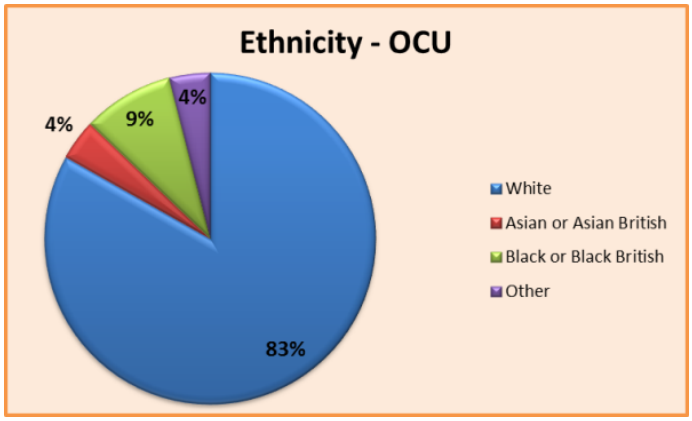
	2008-09	2009-10	2010-11	2011-12	2012-13
Numbers	643	692	718	673	662

7.2 OCU Demographics

The charts below show the profile of OCU clients in Croydon by gender, age group and ethnicity. As the charts indicate, the typical Croydon profile for this population is white, male between 35-64 years of age .







Key Consideration

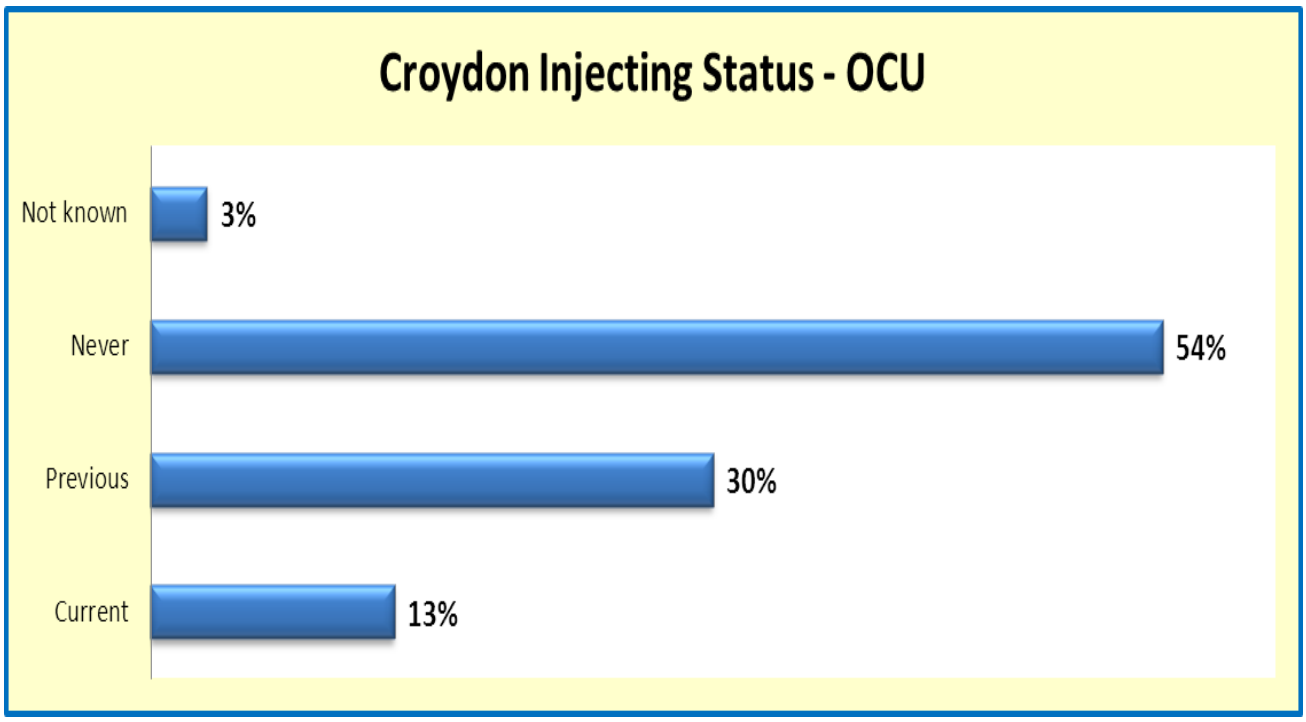
Given Croydon's demographic profile, it is expected that the representation of Black and Minority Ethnic community in contact with treatment services would be higher than the total 13%. The partnership will need to further explore this area of treatment engagement to identify if there is actually a gap in this area of representation.

8 Injecting Drug Users (IDUs) , Blood Borne Virus (BBV) Hep C, HIV

Preventing the spread of blood-borne viruses is a key outcome in the 2010 Drug Strategy. People who inject drugs (PWID) are vulnerable to a diverse range of infectious and communicable diseases, including HIV and Hepatit C. The Health Protection Agency (HPA) in collaboration with over 50 specialist agencies work with people who inject drugs throughout England, Wales and Northern Ireland to produce data on the prevalences of hepatitis C, hepatitis B and HIV. These figures are published in the HPA's Unlinked Anonymous Monitoring Survey of HIV and Hepatitis in Injecting Drug Users publication. The key findings from the November 2012 publication highlighted:

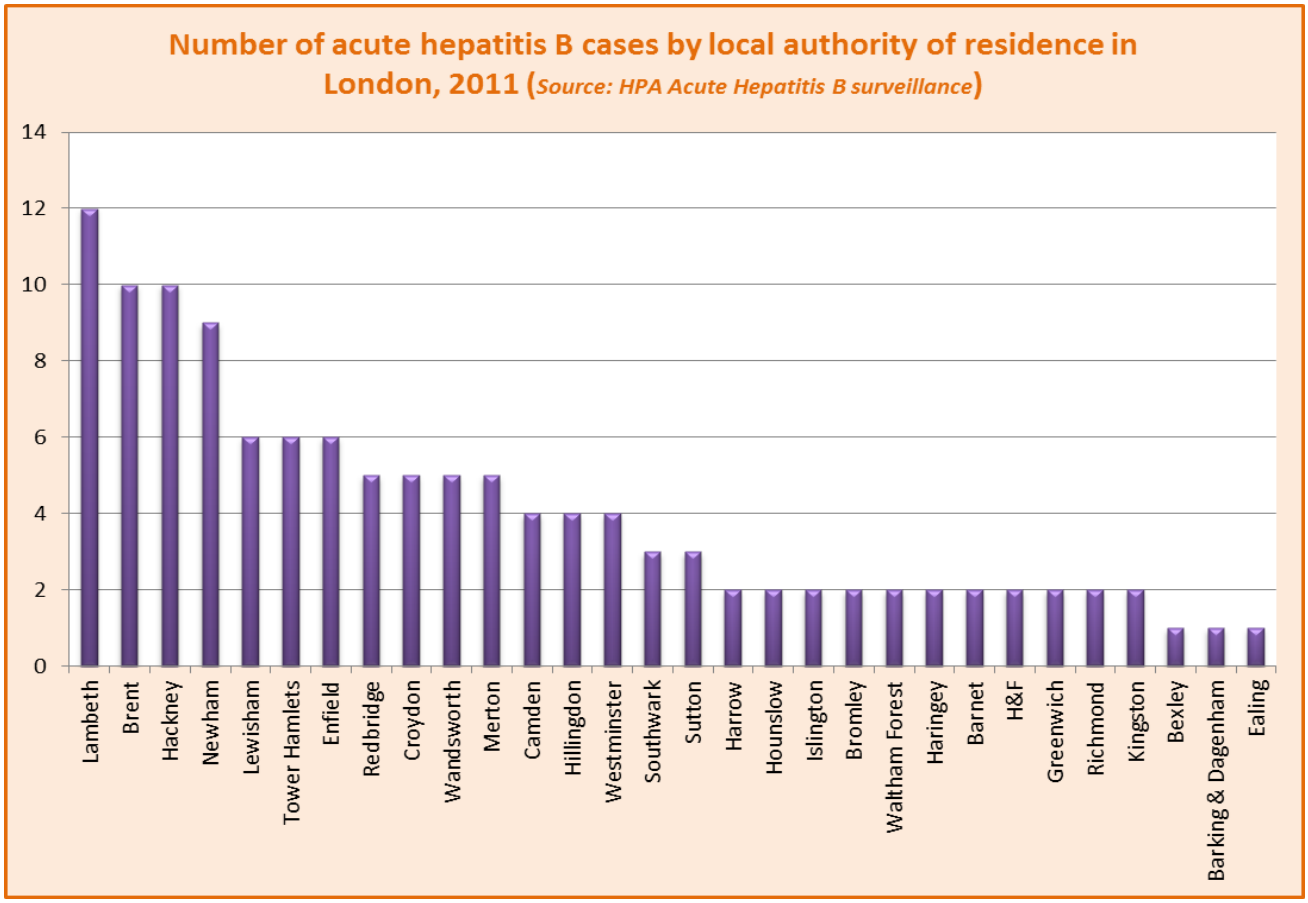
- Hep B infection among people who inject drugs has declined over the last decade. One in six people who inject drugs had never been infected with the Hep B virus in 2011.
- This decline most probably reflects the marked increase in the uptake of the Hep C vaccine among people who inject drugs. Targeting vaccination to this group needs to be maintained if the current low level of new infections is to be sustained.
- Around half of those who inject drugs in the UK have been infected with hepatitis C and around one in every 100 has HIV.
- Bacterial infections remain a problem among people who inject drugs, with almost one-third reporting a symptom of a bacterial infection at an injecting site in the past year.
- Needle and syringe sharing is lower than a decade ago, although around one-sixth of people who inject drugs continue to share needles and syringes.

The injecting drug users from the OCU population reveal that 54% of users reported never having injected as the chart below highlights.



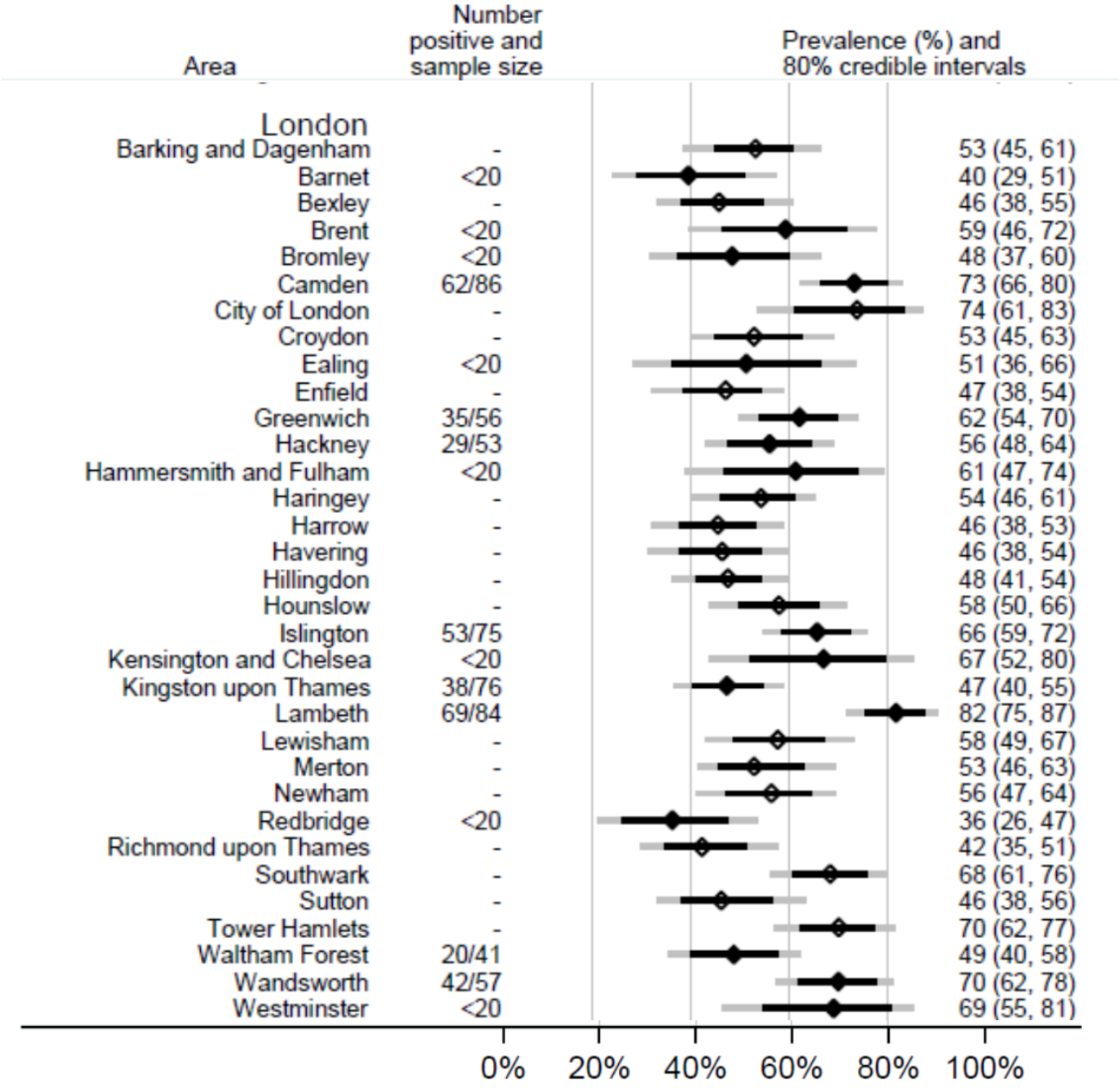
8.1 Hepatitis B

During 2011/12, 43% of the partnership's drug treatment population had Hep B vaccination. During 2011, Croydon reported 5 cases of acute hepatitis B. The high numbers recorded in London was in Lambeth with 12 cases as the chart below shows.



8.2 Hepatitis C

The Health Protection Agency (HPA) currently monitors the prevalence of Hep C antibodies among people who inject drugs (PWID) across England through the national Unlinked Anonymous Monitoring (UAM) Survey of PWID attending specialist drug services. The HPA with assistance from the NTA, has developed a means of estimating Hep C prevalence among PWID in each local partnership (Drug Action Team) area. However, these estimates only reflect the prevalence among PWID in contact with specialist services such as drug treatment services, needle and syringe programmes. Thus the prevalence among those who are not in contact with such services might be different. The method used in this process is undergoing further development to produce estimates with narrower confidence intervals in the future. Whilst these estimates are used cautiously, they can be viewed as being indicative of the likely prevalence of hepatitis C. They are presented with 80% credible intervals to give an indication of the plausible range of prevalence in each local area.
Estimates vary considerably across England, ranging from 17% to 82%.
The prevalence estimate for each area in the London region and its credible interval (confidence interval), are given in the table below. Croydon falls within the medium prevalence area where Hep C antibody prevalence is between 40% - 60%. Within this cohort, about half of PWID will be infected overall and majority of longer term injectors are likely to be infected with Hep C. However, most of those who have started injecting more recently are likely to be uninfected.



*The solid diamonds represent the sampled areas and the hollow diamonds the non-sampled. The dark grey bars around the estimates indicate 80% credible intervals, the light grey bars 95% credible intervals.*HPA November 2012*

It is estimated that nearly 58,000 people are infected with Hep C in London. The next table gives a breakdown of all the London partnerships by Drug Action Team area. Number of individuals with Hep C varies from 3,807 (Camden) to 77 (City of London). Croydon falls mid range in this cohort at 1,911 people estimated to be infected. The table below also gives estimated cost of treating and the annual cost of treating additional cases (with the assumption that 5% of people infected with Hep C are diagnosed each year). Along with this, the table also includes estimates of the future burden of disease.

Table 2: Estimates of hepatitis C prevalence, burden, treatment and cost of treatment by DAT in London[8]

DAT	Estimated total infected population	Estimated Burden in 2015			Estimated cost of treating those already identified	Estimated annual additional no. requiring treatment	Estimated annual cost of treating additional cases
		Mild/ Moderate liver disease	Cirrhotic or end stage liver disease	Died			
Barking & Dagenham	1,061	680	33	72	£529,429	11	£104,992
Barnet	1,984	1,271	62	135	£990,054	21	£196,339
Bexley	1,015	651	32	69	£506,779	11	£100,500
Brent	2,080	1,333	65	141	£1,037,866	22	£205,820
Bromley	1,716	1,099	54	116	£856,255	18	£169,805
Camden	3,807	2,439	120	258	£1,899,889	40	£376,769
City of London	77	49	2	5	£38,436	1	£7,622
Croydon	1,911	1,225	60	130	£953,939	20	£189,177
Ealing	2,163	1,386	68	147	£1,079,247	23	£214,026
Enfield	1,489	954	47	101	£743,227	16	£147,390
Greenwich	1,855	1,188	58	126	£925,515	20	£183,540
Hackney	1,971	1,263	62	134	£983,705	21	£195,080
Hammersmith & Fulham	1,696	1,087	53	115	£846,484	18	£167,867
Haringey	1,686	1,080	53	114	£841,249	18	£166,829
Harrow	1,161	744	37	79	£579,497	12	£114,921
Havering	1,100	705	35	75	£549,069	12	£108,886
Hillingdon	1,386	888	44	94	£691,533	15	£137,139
Hounslow	1,517	972	48	103	£757,212	16	£150,164
Islington	2,429	1,556	76	165	£1,212,311	26	£240,415
Kensington & Chelsea	1,624	1,041	51	110	£810,458	17	£160,723
Kingston upon Thames	928	595	29	63	£463,281	10	£91,874
Lambeth	3,154	2,021	99	214	£1,574,160	33	£312,173
Lewisham	2,133	1,367	67	145	£1,064,734	23	£211,149
Merton	1,284	823	40	87	£640,894	14	£127,096
Newham	1,680	1,076	53	114	£838,308	18	£166,246
Redbridge	1,521	975	48	103	£759,286	16	£150,575
Richmond upon Thames	982	629	31	67	£490,154	10	£97,203
Southwark	2,694	1,726	85	183	£1,344,441	28	£266,617
Sutton	1,028	659	32	70	£512,973	11	£101,728
Tower Hamlets	2,677	1,716	84	182	£1,336,182	28	£264,980
Waltham Forest	1,365	874	43	93	£680,980	14	£135,046
Wandsworth	2,187	1,401	69	148	£1,091,579	23	£216,472
Westminster	2,512	1,610	79	170	£1,253,871	27	£248,656
London	57,875	37,082	1,820	3,925	£28,882,994	611	£5,727,816

Data from the template is available on the HPA website, which was produced to help DATs and Health and Wellbeing Boards estimate the prevalence of hepatitis C in their local population (updated since the 2007 version which was estimated at PCT level). The template draws heavily on methods produced for estimating prevalence at a national level and on national and local projections of current and future morbidity. These estimates are naturally less accurate than national estimates due to limited data available at a local level. We are interested in receiving feedback on the utility of this template, as it is our aim to continue to develop this tool as new information and data become available. http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HepatitisC/

8.3 HIV

The HPA uses data from SOPHID (Survey of Prevalence HIV Infections Diagnosed) to show the local authorities (Las) in England where the prevalence of diagnosed HIV infection exceeds two adults (aged 15-59) per 1,000 population. In 2011, 58 LAs had a diagnosed prevalence above the two per 1,000 threshold. Of the 58, 30 of these Las were from London.

The table below shows the London boroughs where prevalence of diagnosed HIV infection exceeded two adults per 1,000 population (aged 15-59 years) in 2011.

Local Authority	Residents accessing HIV related care* (aged 15-59)	Estimated resident population in 1,000s** (aged 15-59)	Diagnosed HIV prevalence per 1,000 (aged 15-59)
Inside London			
Lambeth	3049	220.2	13.85
Southwark	2422	206.7	11.72
City of London	57	5.3	10.75
Kensington and Chelsea	950	107.6	8.83
Westminster	1345	154.6	8.70
Camden	1296	153.1	8.47
Islington	1266	149.9	8.45
Lewisham	1448	186.7	7.76
Hackney	1291	174.0	7.42
Hammersmith and Fulham	967	131.1	7.38
Haringey	1136	174.8	6.50
Newham	1336	215.0	6.21
Tower Hamlets	1112	186.8	5.95
Greenwich	928	166.5	5.57
Barking and Dagenham	629	114.9	5.47
Croydon	1094	228.7	4.78
Wandsworth	1055	221.1	4.77
Waltham Forest	764	171.9	4.44
Enfield	776	195.2	3.98
Merton	504	131.6	3.83
Brent	793	207.7	3.82
Hounslow	577	168.3	3.43
Ealing	719	223.4	3.22
Barnet	633	222.7	2.84
Redbridge	481	175.5	2.74
Hillingdon	439	173.3	2.53
Bexley	325	138.3	2.35
Bromley	428	182.8	2.34
Sutton	270	117.8	2.29
Richmond upon Thames	261	116.8	2.23

Data Sources
* SOPHID - Survey of prevalent HIV infections diagnosed 2011, Health Protection Agency.
** Office for National Statistics mid-2011 population estimate - latest available at time of publication.

Croydon falls midway in the prevalence rate compared to the relevant London boroughs as seen in the table above. The HPA recommends that routine HIV testing should be commissioned as a priority for all general medical admissions in high prevalence areas. The National Institute of Health and Clinical Excellence (NICE) guidance 2011, recommend expanding HIV testing in high prevalence areas. Amongst the series of recommendations, included were the consideration of offer for HIV test in drug dependency programmes and all patients reporting a history of injecting drug use.

Key Issue

Data recording of injecting drug users, blood borne viruses is currently poor and unclear. There needs to be more comprehensive information gathering in this category. A separate Harm Reduction needs assessment would benefit the overall treatment system provision and identify improved pathways for this client group.

Commissioning consideration

Services such as needle and syringe programmes, substitution therapy and safer injection advice are key to infection prevention and should be widely available.
These services should support entry into recovery focused drug treatment. Voluntary confidential diagnostic testing for Hep C and other blood-borne viruses should also be easily accessible.

9 Treatment System

The current adult drug and alcohol treatment system is mainly provided by South London & Maudsley NHS Trust (SLAM) and Foundation66. Over 95% of Croydon's treatment population is serviced by these two providers. Entry into the treatment system is mainly by self referrals.

9.1 Treatment Map

The treatment map is a graphical representation of the treatment pathways within the partnership available to clients. The purpose of mapping pathways is to identify the number of clients flowing into, out of and between services.

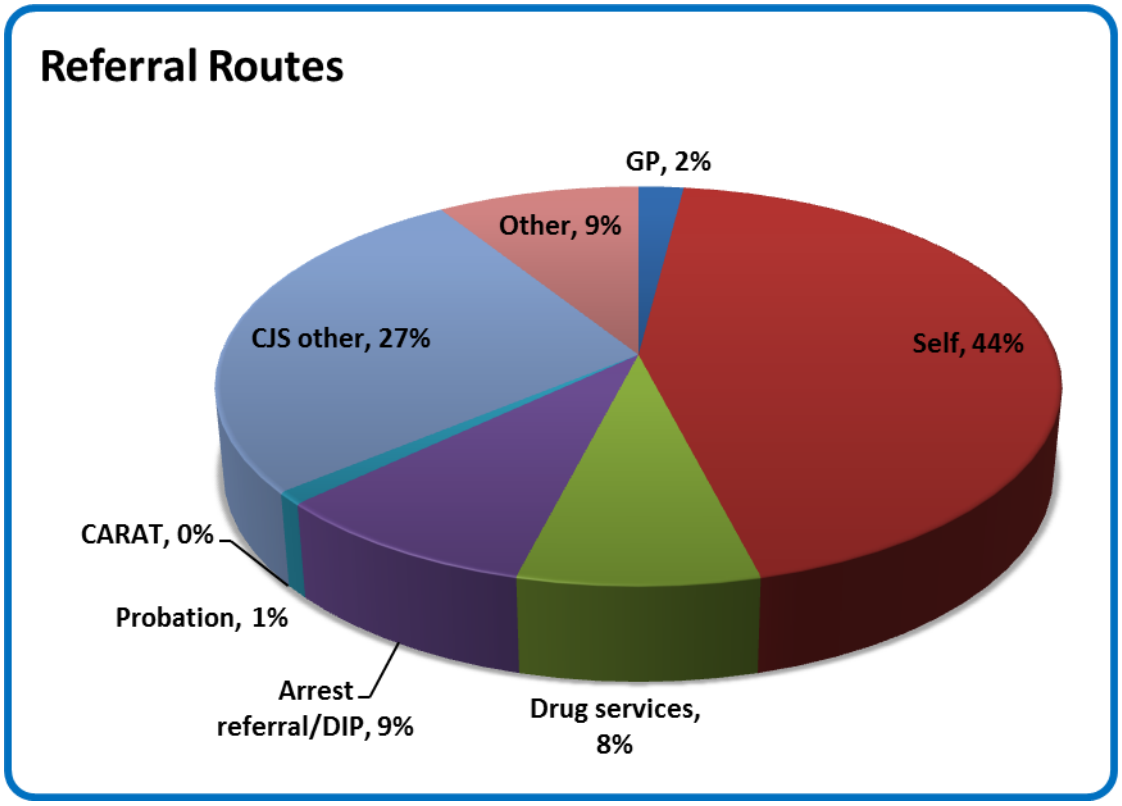
The full detail of the partnership's map is illustrated in the treatment map table. *(This table is not attached to this document due to the size of the map but is available on request.)*

Whilst reviewing the figures, please note that clients may access services of more than one agency, thus there may be duplicate counting. Thus the numbers showing in treatment during the year is not consistent to the other figures of numbers in treatment highlighted in other parts of this report.

The diagram below illustrates the overview of numbers referred into and exiting the treatment system during 2011-12. 462 new referrals were made into the treatment system, 1558 clients in treatment with 7% of those clients having been in the treatment system between 2-4 years and over 6% for over 4 years. Around 359 clients exited the treatment system which accounts for 23% of those in treatment during the year.

9.2 Referrals

The chart below shows the percentage breakdown of referral routes into the treatment system. Self referral accounted for 44% followed by 37% through criminal justice.



The table below gives the breakdown of referral sources for the last four years from 2008-09 to 2011-12. Self referral has always been the highest form of referral. There was a decreasing trend with self referrals but during 2011-12 referrals increased to 255. However, criminal justice referrals increased sharply during 2010-11 to 117 referrals and then fell to 64 referrals during 2011-12. This reflects the decrease in criminal justice clients engaging in treatment by about 47% which is a significant proportion.

ROUTE	2011-12	2010-11	2009-10	2008-09
GP	4	7	9	14
Self	255	186	215	221
Drug services	91	36	42	41
Arrest referral/DIP	32	37	139	75
Probation		5	3	13
CARAT	5	1	4	1
CJS other	64	117	34	51
Other	32	37	35	140
TOTALS	**483**	**426**	**481**	**556**

Out of the 483 referrals, 34% were unknown to the treatment system. This accounts for nearly 70% of clients coming into the system are known to the treatment system.

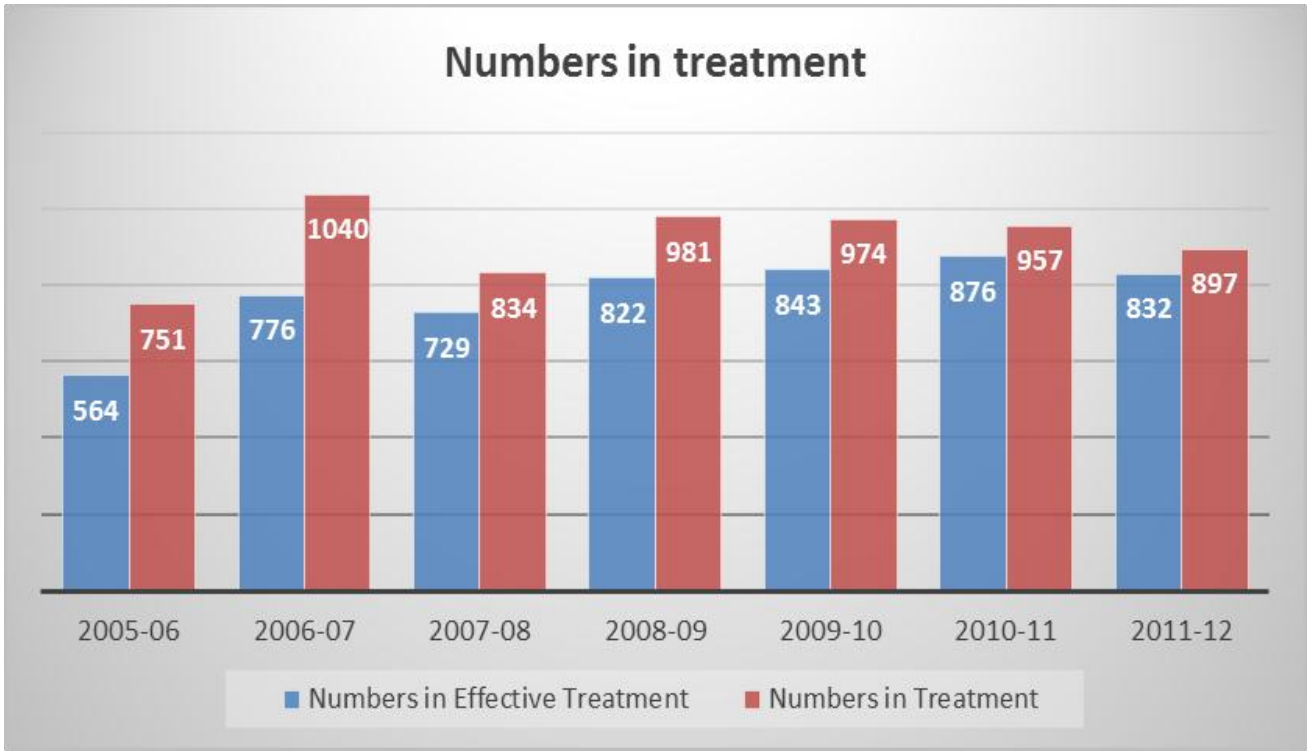
The table below shows the proportion of criminal justice referrals during 2011-12 for the various client groups as follows:

All clients	Non-opiate clients	Crack non-opiates	Crack main drug	Crack clients
23.4%	16.9%	28.8%	27.3%	32.1%

9.3 Numbers in Treatment

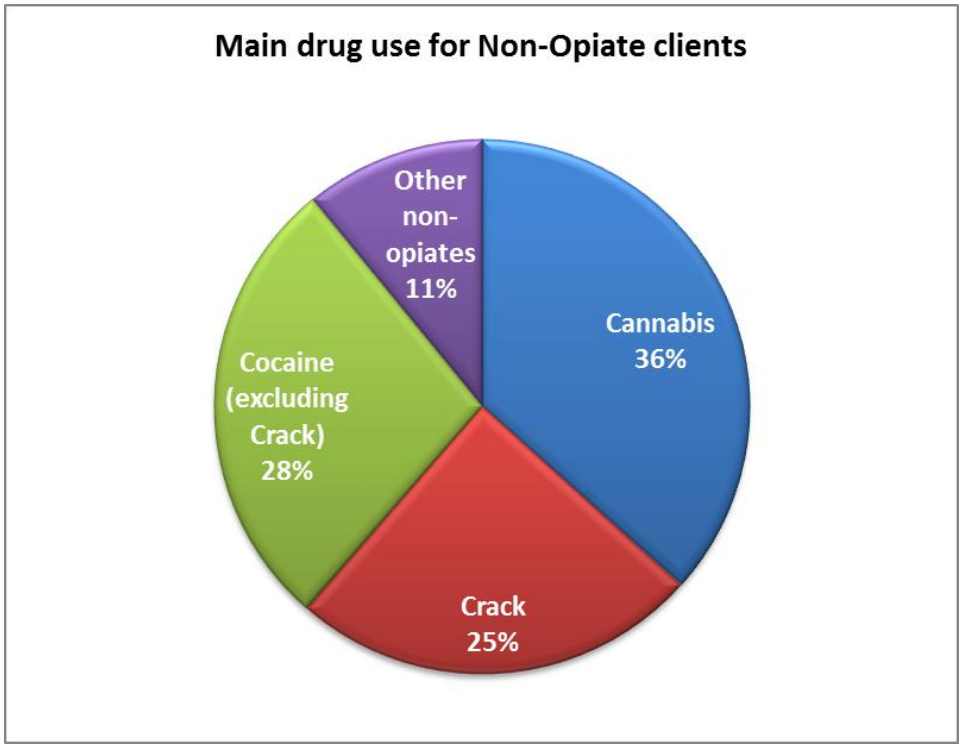
There has been a gradual rise in total numbers in treatment since 2005-06 as the graph below indicate. 2011-12 has shown a downward trend in the total numbers in treatment at the end of the financial year. This is also similar with the numbers in effective treatment. Effective treatment refers to the retention in treatment for 12 weeks or more or successful treatment completion within 12 weeks.

* (*The data below takes into account all client groups – OCUs & non-OCUs*)



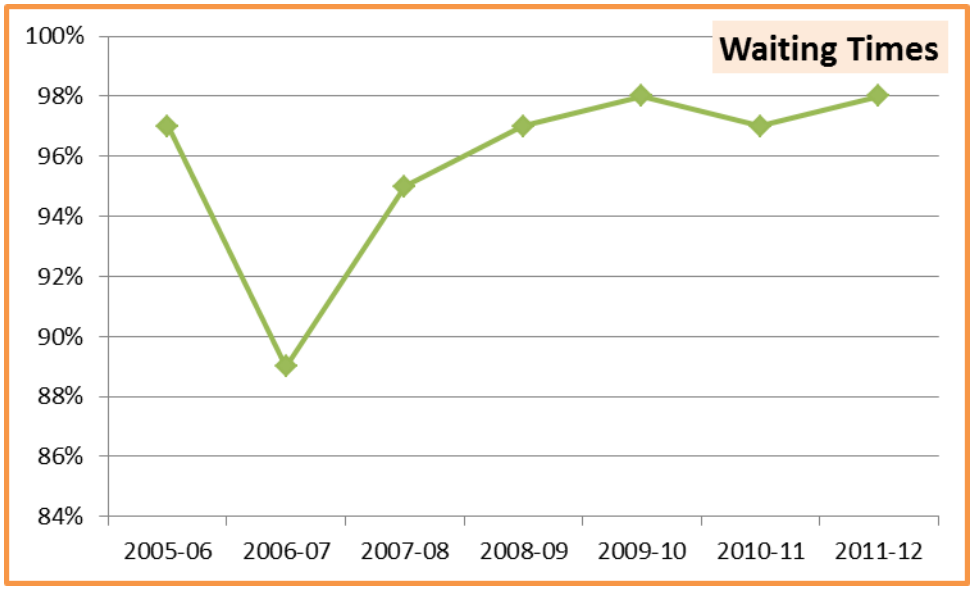
During 2011-12, the non-opiate clients accounted for 26% of the treatment population. Croydon has a low proportion of non-opiate clients compared to London (28%) but higher compared to National (19%).

The breakdown of main drug use for non-opiate clients in treatment during 2011-12 are highlighted in the chart below.



9.4 Waiting Times

Waiting times have remained consistently above the 95% target in the last four years as shown in the graph below. These waiting times refer to first treatment presentations.

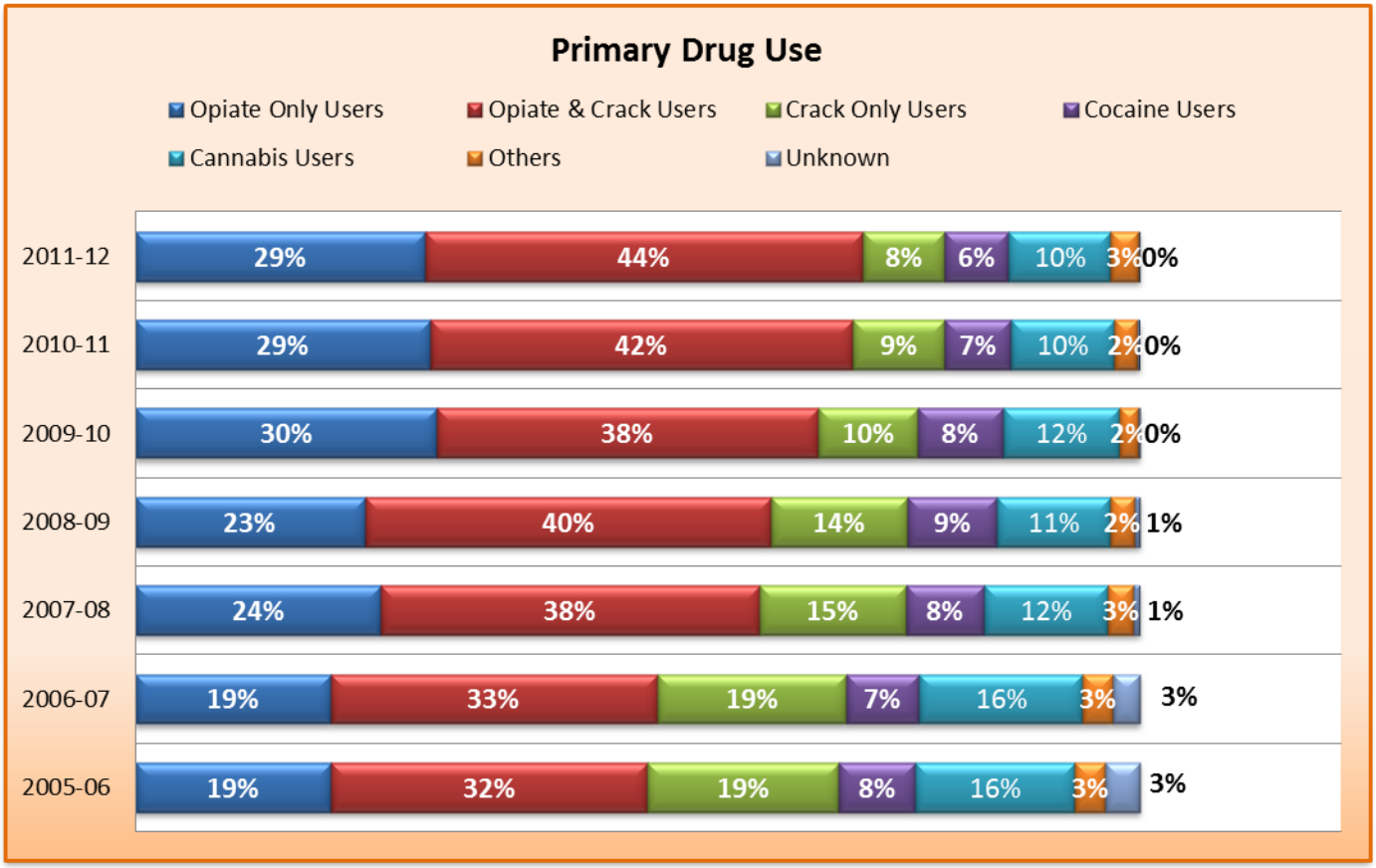


10 Demographics and Treatment Population

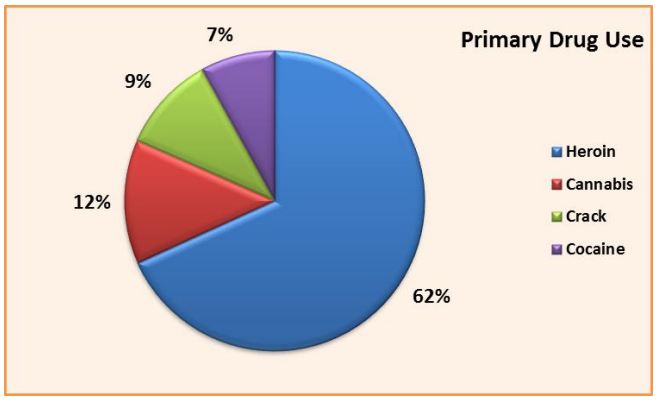
10.1 Drug Use

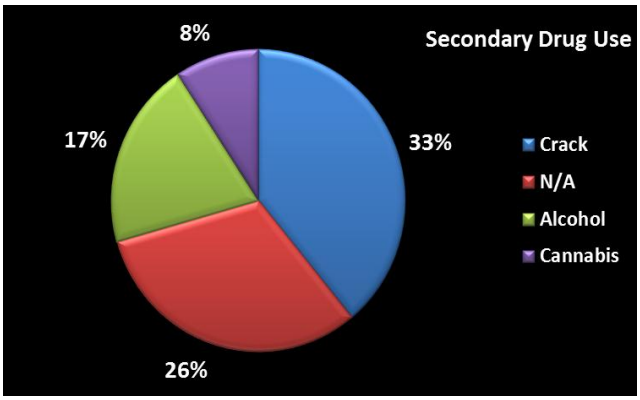
There has been an increasing trend with both opiate only users and opiate & crack users compared to the overall treatment population. Crack only users have decreased in proportion and so has cannabis

users. The graph below gives the overall trend in the primary drug use reported by clients since 2005-06. Thus although there has been a downward trend with the OCU population, the proportion of clients using opiate & crack has increased.



The next two graphs below give a further breakdown of main drug followed by secondary drug use. 62% of clients reported heroine as the main drug of use followed by 12% for cannabis. Crack was identified as the largest secondary drug of choice by clients at 33%.





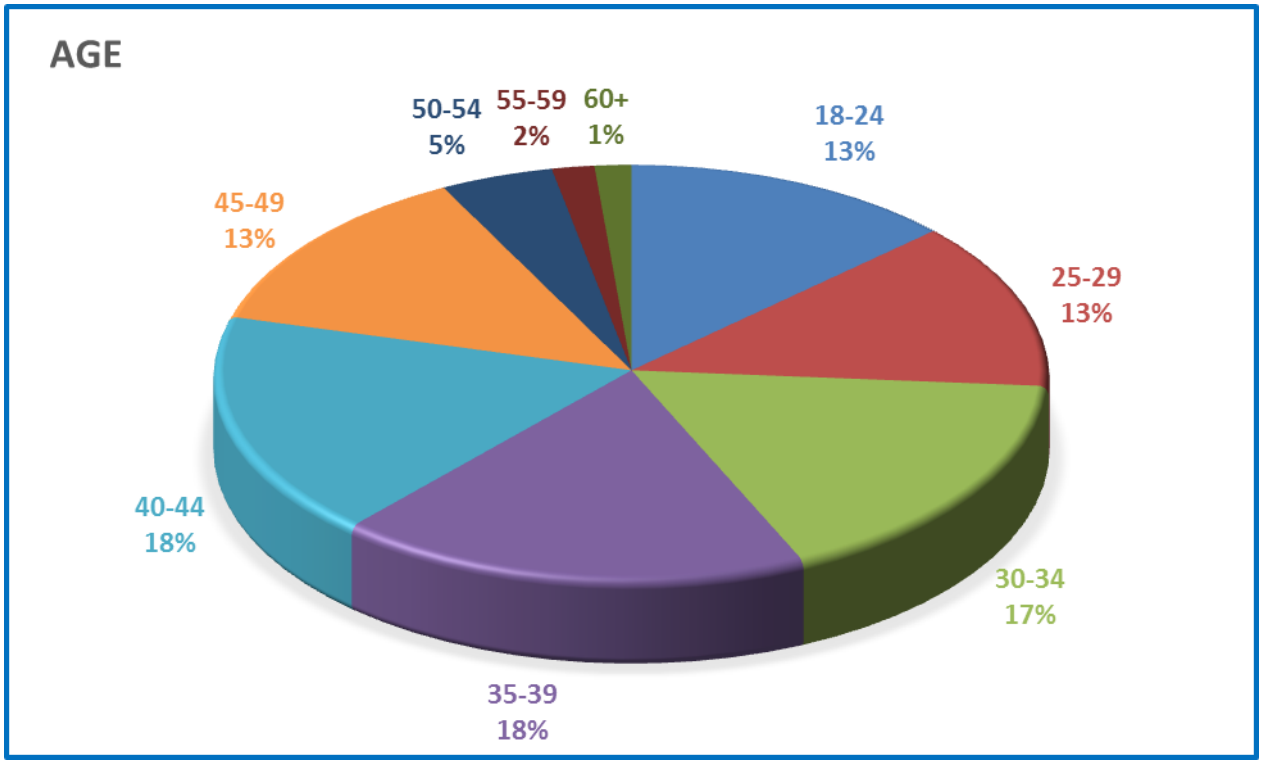
10.2 Gender

Croydon has lower proportion of women in treatment and the gender split has always been at an average of 75% male and 25% female.

10.3 Age

The predominant age range for clients in treatment in the partnership ranges between 30-44 years.

The chart below illustrates the age range of all clients in treatment during 2011-12 with further breakdown of the age range.



The main proportion of clients fall within the 18-44 years as the table below shows. However, there's a slight increasing trend between 45-49 years in the last 3 years. This could be a gradual shift for those who have been in treatment for over 3 years and now falling included in the older age range of above 45 years of age. Also there is a trend for increase in the 40-44 years age group in the next few years as the younger clients remain in treatment and do not leave the treatment system.

AGE	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
18-24	17%	18%	13%	15%	15%	13%	13%
25-29	15%	16%	16%	18%	18%	14%	13%
30-34	23%	19%	19%	16%	15%	18%	17%
35-39	23%	22%	21%	20%	20%	20%	18%
40-44	12%	14%	19%	18%	17%	17%	18%
45-49	6%	6%	8%	9%	10%	12%	13%
50-54	4%	3%	3%	2%	3%	4%	4%
55-59	1%	1%	2%	2%	2%	2%	2%
60+	1%	1%	1%	1%	1%	1%	1%

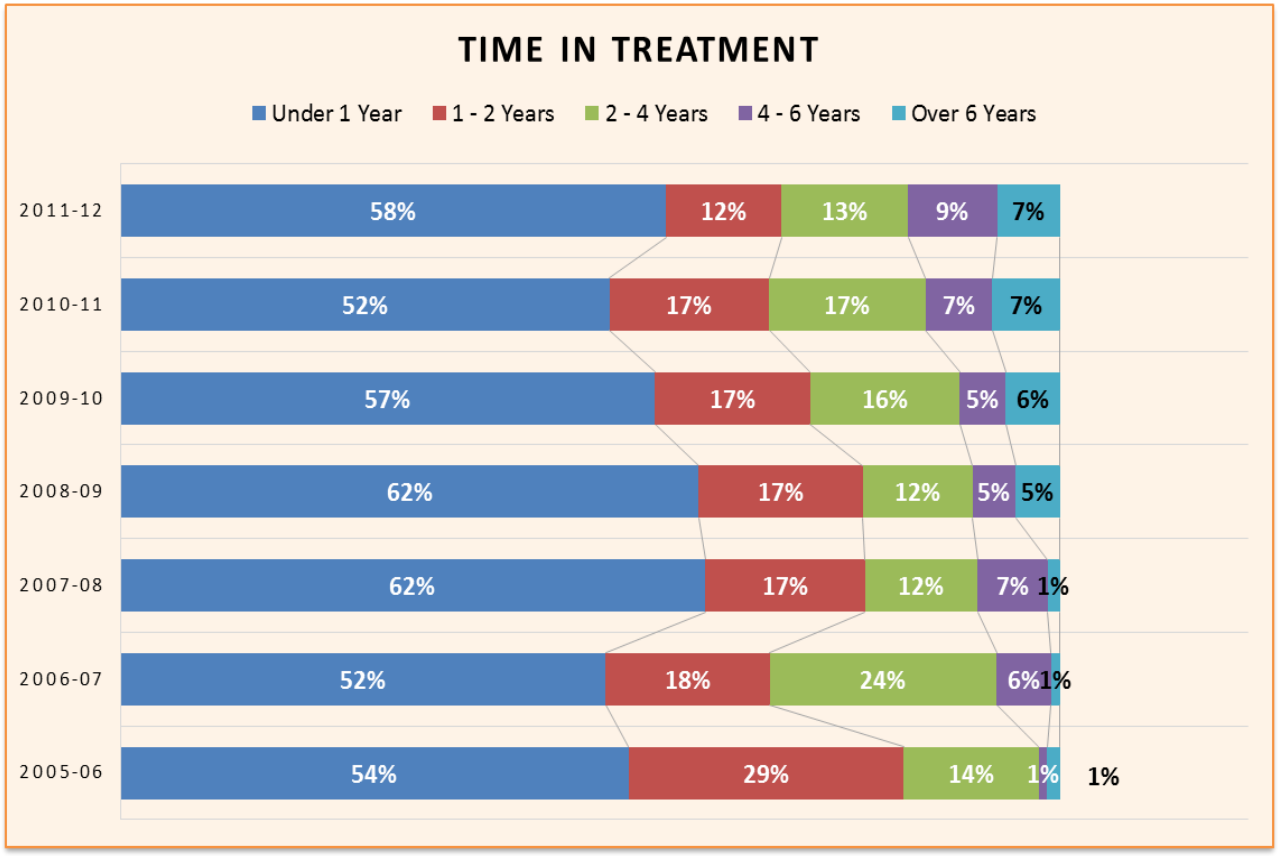
Treatment re-design consideration

The increasing ageing population of drug users highlights the range of health and social implications. This also means that the treatment service use is dominated by this group which means that treatment options for younger people in the 18-20 years age range will need to be attractive enough for the younger people to access.

10.4 Time in Treatment

Although in average about 55% of the partnership's treatment population remain in treatment within a year, the remaining clients in treatment remain for more than year up to over six years. The graph below shows the breakdown of clients in treatment from under one year to over six years since 2005-06. The proportion of clients being in treatment from 1-2 years has marginally decreased over the

years but further decrease to 12% from 17% is highlighted during 2011-12. There's been decrease in the 2-4 year time span from 24% during 2006-07 to 13% during 2011-12. However, the 4-6 years and over 6 years range seem to show a gradual increase of time spent in treatment.



Treatment re-design consideration

The increasing trend of clients being in treatment 4-6 years and over 6 years will need to be factored into the redesign of the treatment system to engage this client group with recovery oriented pathways.

10.5 Treatment Interventions

A client's treatment episode can contain one or a number of treatment interventions. The table below gives the breakdown of treatment interventions and proportion of clients receiving those interventions since 2005-06. Prescribing and structured day programme has primarily been the main interventions received by clients. However there has been a changing trend since 2005-06. In the last five years, prescribing (including key working) only was the main treatment for the partnership's service users. On average, about 35% of the treatment population were engaged in this intervention. During 2011-12, only 20% of treatment population received this intervention. Structured day programme only has also seen a steady decline over the years especially in the last couple of years. The proportion of clients engaged in structured day programme only during 2011-12 is 13% which is a decrease from 39% in 2005-06. There has been a steep increase in the combined intervention of prescribing and structured day programme in the last four years. The table below highlights the rate of increase since 2008-09 from 5% of the treatment population to 21% during 2010-11 and 29% in 2011-12. One of the factors contributing to the increase could be due to the integrated service contract jointly provided by SLAM and Foundation66 and the relocation of the Community Drug Service to Lantern Hall provided by Foundation66 and delivered side by side with the joint provision of the integrated drug treatment service.

Tier 4 interventions like residential rehabilitation and inpatient services has also seen a decrease in the last three years.

PATHWAYS	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
Prescribing (including key working) only	↓ 19%	↓ 23%	↑ 36%	↑ 37%	↑ 39%	↑ 36%	↓ 20%
Other structured intervention only	→ 4%	↑ 6%	↑ 7%	→ 5%	→ 4%	↓ 3%	↓ 2%
Psychosocial (including key working)	→ 3%	→ 2%	↓ 1%	↓ 1%	↓ 1%	↓ 1%	↑ 5%
Structured Day Programme Only	↑ 39%	↑ 33%	→ 28%	→ 26%	↓ 20%	↓ 18%	↓ 13%
Prescribing and Psychosocial	→ 2%	↓ 1%	↓ 1%	↓ 0%	↓ 1%	↓ 1%	↑ 4%
Prescribing and Structured Day Programme	↓ 2%	↓ 3%	↓ 5%	↓ 5%	→ 13%	↑ 21%	↑ 29%
Inpatient (including key working)	↑ 3%	→ 2%	↓ 1%	↓ 2%	↓ 1%	↓ 1%	↓ 1%
Residential Rehabilitation	↑ 3%	↑ 4%	↑ 4%	↑ 4%	↓ 2%	↓ 2%	↓ 2%
Prescribing and Inpatient (inc key working)	↓ 1%	↓ 1%	↑ 4%	↑ 4%	↑ 4%	↑ 4%	↓ 2%
Prescribing and RR (inc key working)	↓ 1%	↓ 1%	↑ 2%	↑ 2%	↑ 2%	→ 1%	↓ 1%
All Other Combinations	↓ 6%	↓ 5%	↓ 8%	→ 10%	→ 10%	↓ 9%	↑ 19%
No Pathway Recorded	↑ 18%	↑ 20%	↓ 4%	↓ 4%	↓ 5%	↓ 3%	↓ 2%

However, funding allocations have not seen much cost efficiencies in Tier 4 service interventions. The cost analysis report from last year shows the partnership spend in this area is nearly three to four times higher compared to the national spend. *(The cost analysis report from last year is available on request.)*

Key considerations

There is gap with data collection that prevents further analysis of the various treatment interventions and client profiling pertaining to treatment engagement.
Further mapping of treatment pathways and location of services will be useful to establish impact on treatment engagement and feasibility.
Mapping exercise will also need to take into account the cost effective tool analysis in regard to the value for money of current pathways and future re-design of service provision and pathways.

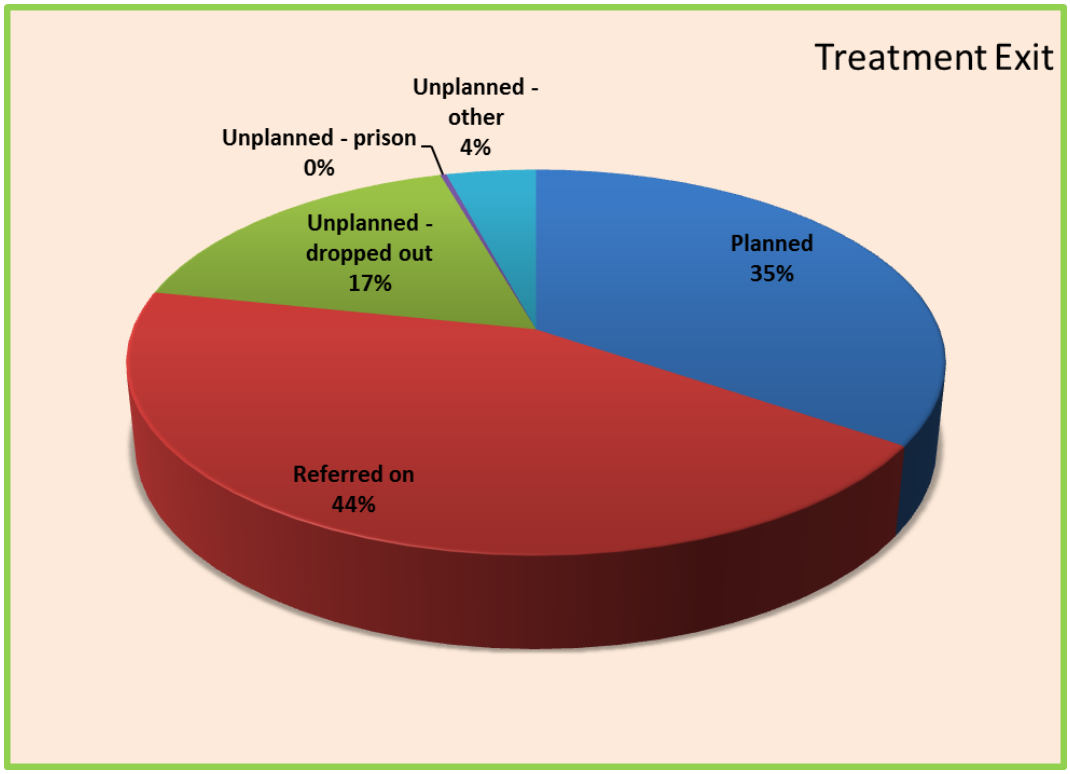
Commissioning consideration

Incorporate cost efficiencies of treatment delivery pertaining to treatment interventions.

11 Treatment Exits

Following on from the treatment entry, the treatment exit stage focuses on clients leaving the treatment system in a planned or unplanned way.

The chart below shows the percentage proportion of clients exiting the treatment system.



It must be noted that during 2011-12, a data migration exercise took place where exits were recorded as referred on and this partly contributes towards the high referred on status of 44%. *(Referred on means clients are transferred on to a different treatment provider for further treatment to continue client's treatment journey. At the same time, the "referred on" option is used when doing data migration exercises.)*

The table below shows the treatment exits in the last four years and the "referred on" category shows a sharp increase during 2011-12 for reasons stated previously.

Treatment exits	2008-09	2009-10	2010-11	2011-12
Planned	36%	26%	44%	35%
Referred on	0%	12%	25%	44%
Unplanned - dropped out	51%	52%	23%	17%
Unplanned - prison	6%	4%	3%	0%
Unplanned - other	7%	6%	4%	4%

11.1 Successful Completions

The section focuses on drug users completing treatment free of dependency who do not relapse and re-enter treatment. Data includes analysis taken from the NTA's Recovery Diagnostic Tool.

The national drug strategy drives to increase the number of people successfully leaving treatment having overcome dependency. Most individuals who complete treatment successfully do so within two years of treatment commencement.

The table below highlights the proportion of treatment population that has achieved successful completions and not represented within six months. Also included are those that have been in treatment for over two years and the growth rate since 2010-11.

Completions	Group	Local	National
Successful completions as a proportion of total number in treatment	Opiate	9%	9%
	Non opiate	23%	41%
	All	13%	15%
Proportion who successfully completed treatment and did not return within 6 months	Opiate	81%	80%
	Non opiate	89%	94%
	All	85%	86%
Growth in successful completions since 2010-11	Opiate	-31%	10%
	Non opiate	-36%	4%
	All	-33%	7%
Proportion of adults in treatment for more than two years	Opiate	36%	53%
	Non opiate	9%	6%
	All	28%	44%

Croydon has a low proportion of non-opiate clients (26%) compared to London (28%) and nationally (19%)

For their non-opiate clients, Croydon have a low successful completion rate compared with the national average

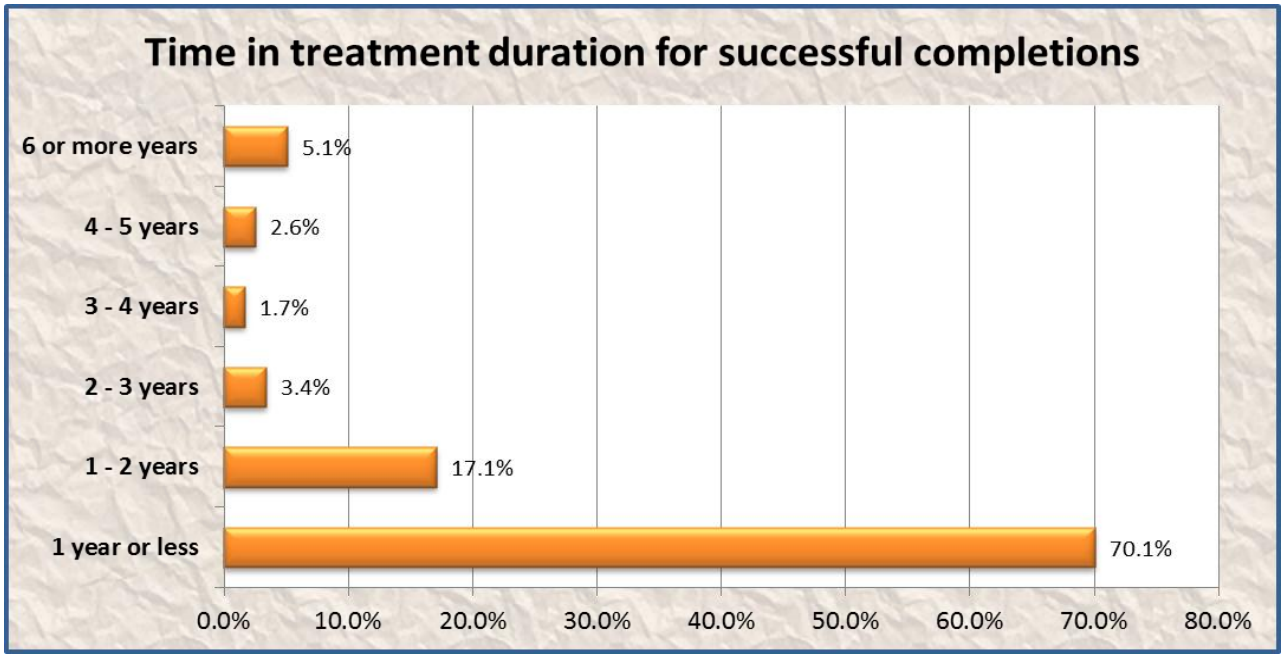
11.2 Non-opiate completions

The table below shows the successful completions for the partnership and region by drug group (non-opiates). Included for each of the drug group are the proportional figures for completions out of the total numbers in treatment for the partnership. The last column, shows the comparison between Croydon and the London region. The overall partnership's performance for successful completions is poor compared to London average.

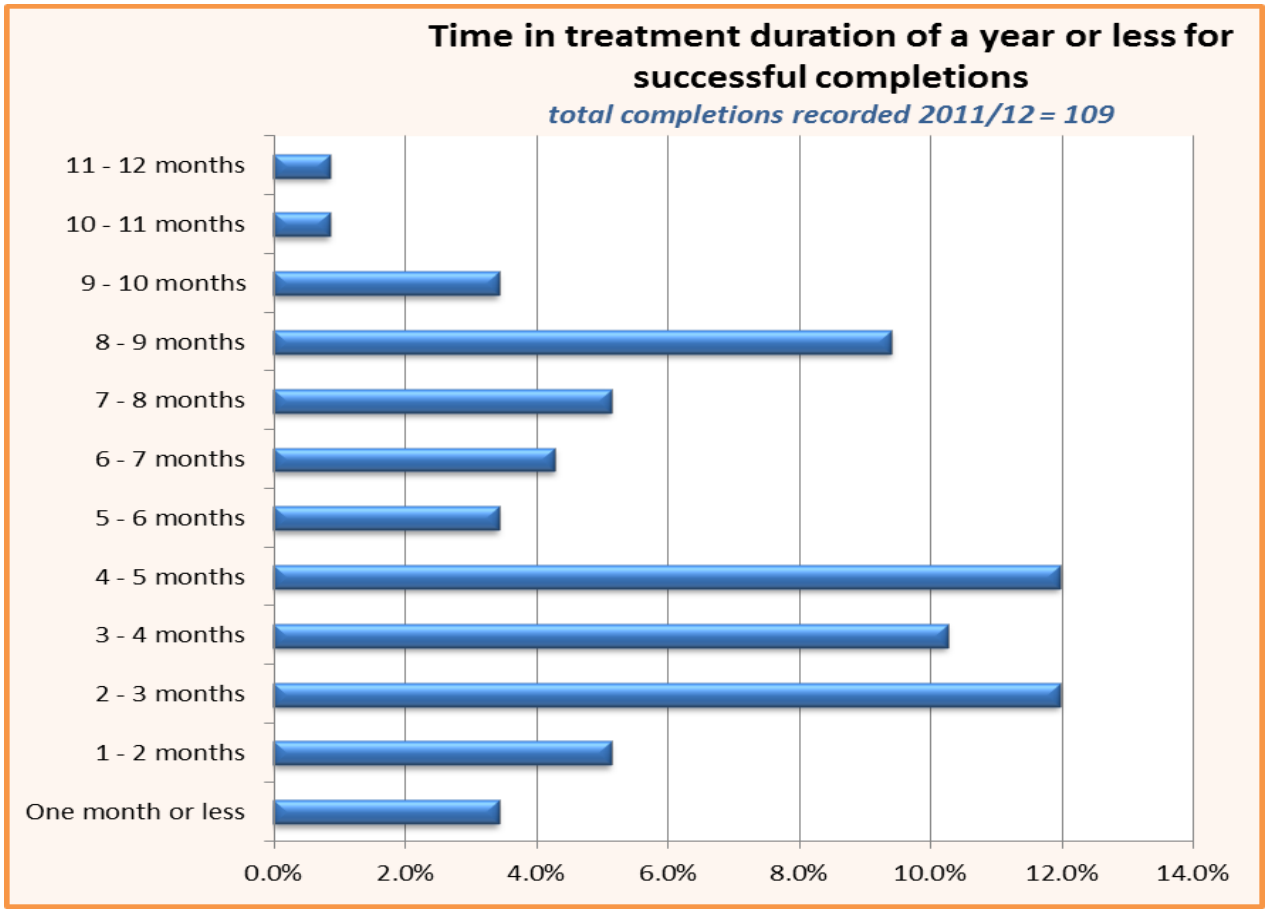
Drug group	Proportion of clients out of total numbers in treatment	Successful completions as a proportion of all in treatment		Comparison
		Croydon	London	
Non-opiates	26.7%	20.5%	34.9%	
Non-opiates and non-crack	18.8%	22.1%	36.5%	
Crack main drug (non-opiates)	6.0%	22.4%	30.1%	
Crack in any part of treatment journey (non-opiates)	8.0%	16.7%	30.6%	
Crack main drug	10.7%	14.8%	22.2%	
Crack in any part of treatment journey	52.4%	9.8%	13.3%	
Crack only drug	0.2%	50.0%	27.2%	

11.3 Length of time in treatment

Of the total successful completions, approximately 70% of those completions recorded clients being in treatment for the duration of one year or less. The chart below, shows the percentage breakdown of time clients have spent in treatment before successfully completing treatment.

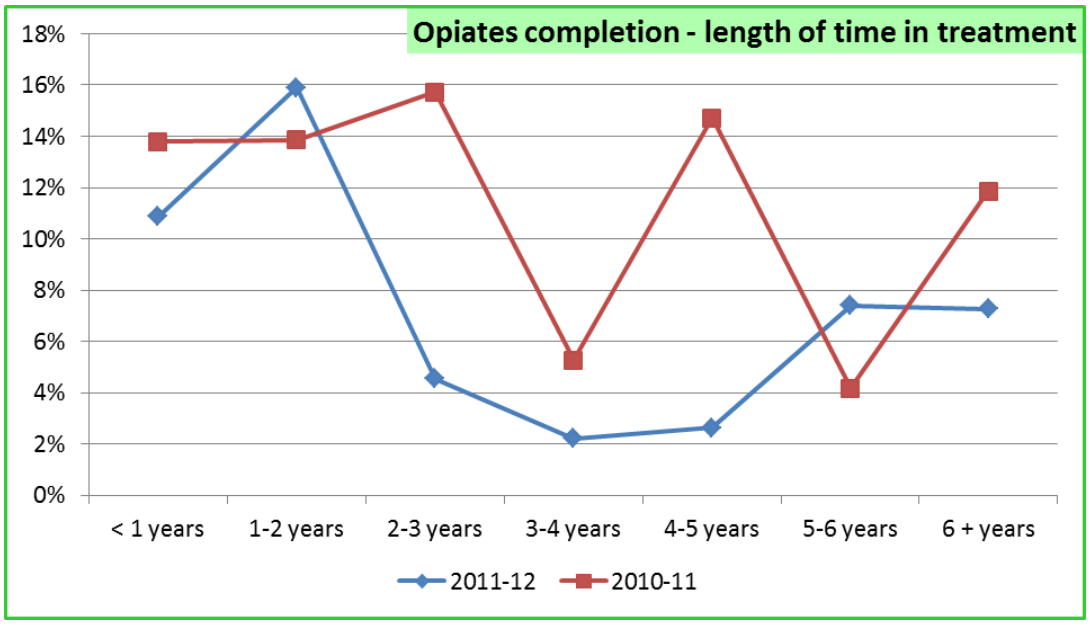


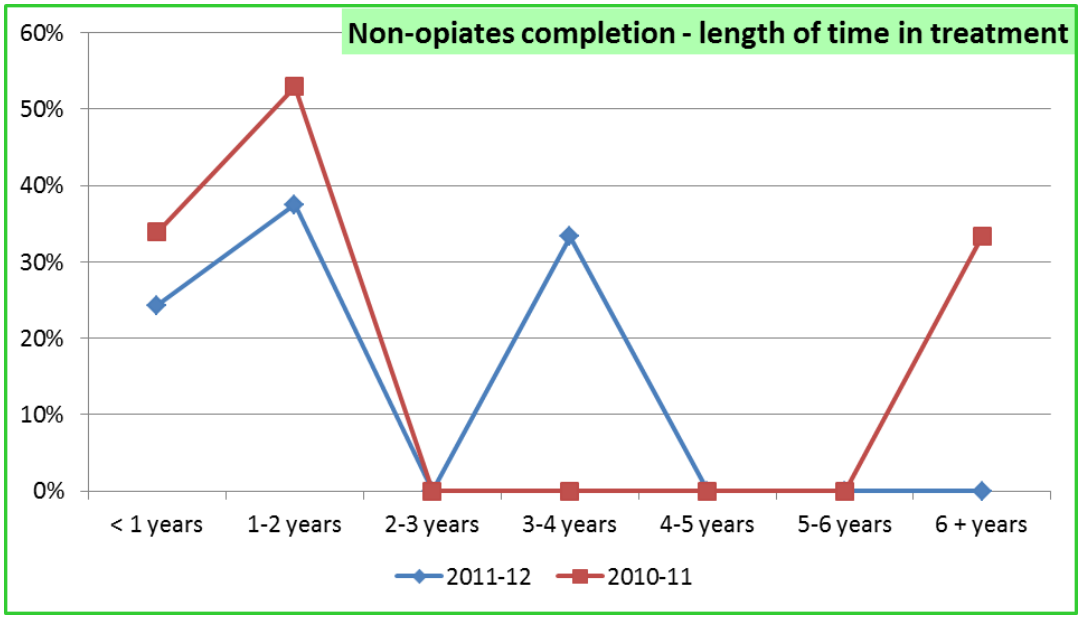
The next chart below gives the monthly breakdown of time spent during a year or less for those clients successfully completing treatment. A large proportion of clients fall within the 2-3 months and 4-5 months period and it is interesting to note the short period of time spent for large proportion of successful completions.



The next two charts show the time in treatment for opiate and non-opiate clients successfully leaving treatment. Opiate clients have better completion rates when longer in treatment compared to non-opiate clients. However, non-opiate clients have a higher completion rate at over 50% in the 1-2 year period gap.

The overall performance for opiate clients has fallen during 2011-12 except during the 1-2 year gap of being in treatment whilst performance for non-opiate clients has increased during 2011-12 in the 2-5 years in treatment period.





11.4 Treatment Naïve clients by length of stay in treatment

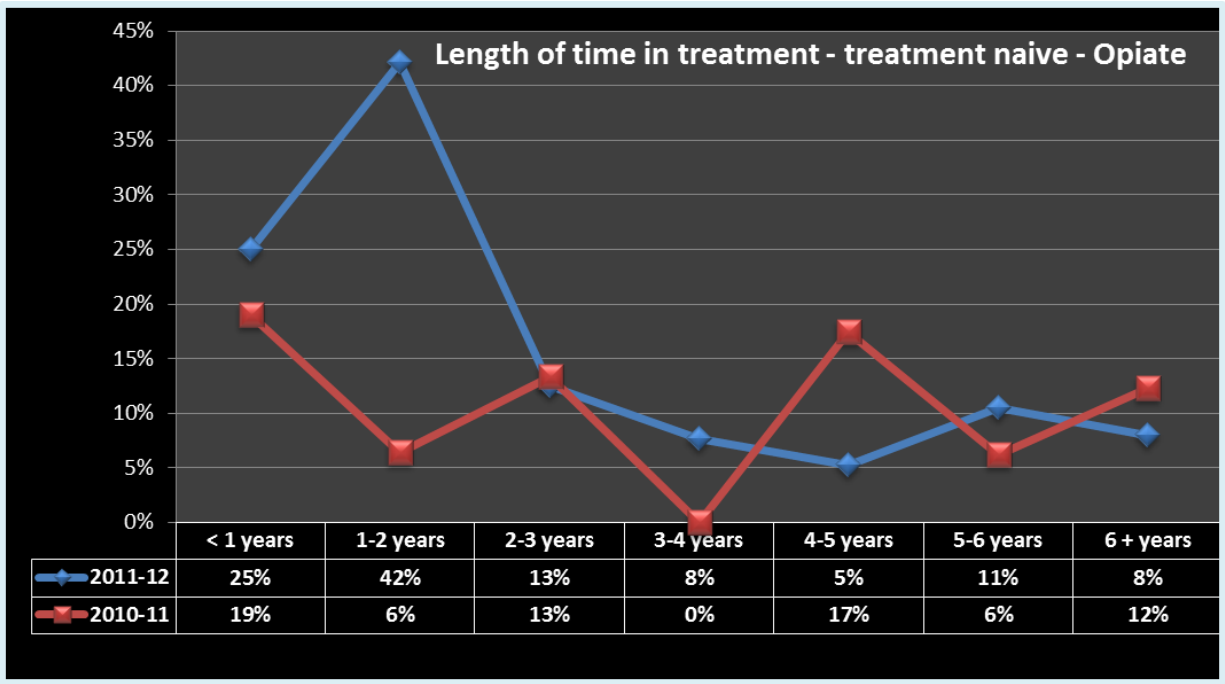
The tables and graphs below highlight the treatment completion rates for opiate and non-opiate clients that are treatment naïve including the length of time spent in treatment before treatment exit.

There's more activity for opiate clients than non-opiate clients although treatment naïve proportions are greater in the non-opiate client group. This is attributed to the fact that there has been a

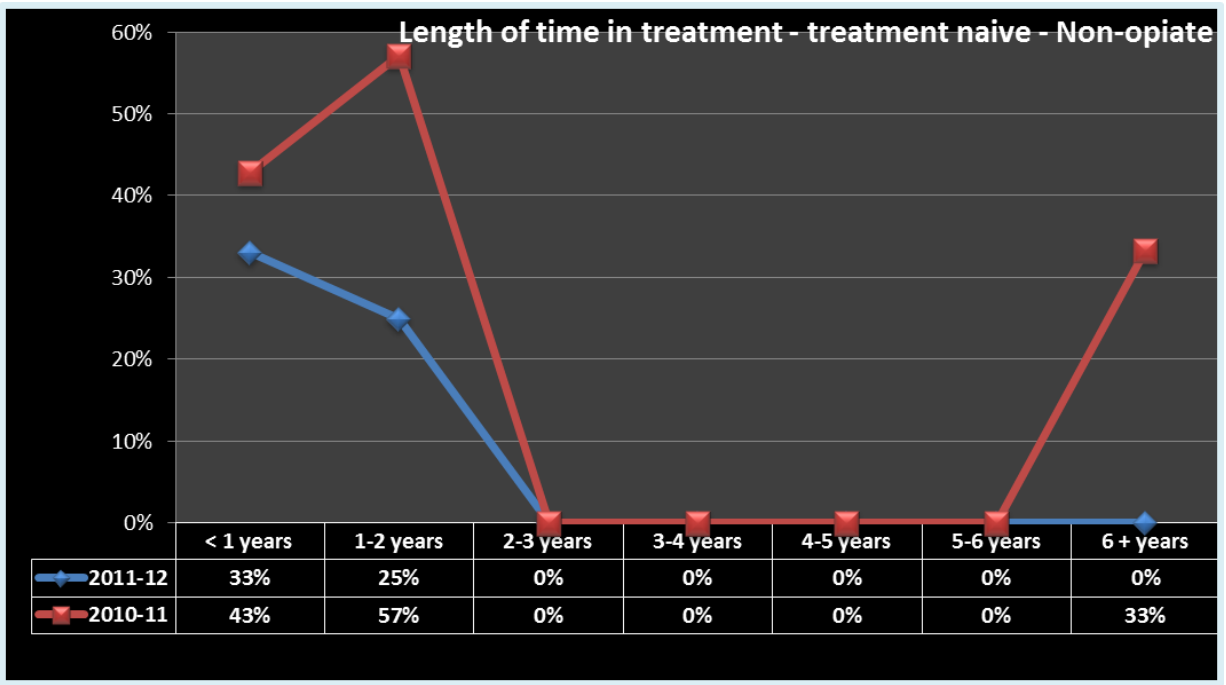
decreasing trend of treatment naïve clients in the opiate client group which is consistent with the ageing of this cohort.

Opiate clients: Nearly 42% of clients stayed in treatment between 1-2 years before exiting the treatment system successfully during 2011-12. This is a steep increase compared to 6% during 2010-11. There is a decreasing trend for longer time in treatment as the graph below shows during 2011-12 compared to 2010-11.

Non-opiate clients: activity for those in treatment between 1-2 years is much higher at 57% during 2010-11 compared to 25% during 2011-12. There was an increasing number of non-opiate clients remained in treatment for over 6 years before discharging successfully during 2010-12 at 33% of the treatment population. However this trend did not continue during 2011-12 as the figures show that no clients remained as long before being discharged.



	< 1 years	1-2 years	2-3 years	3-4 years	4-5 years	5-6 years	6 + years
2011-12	25%	42%	13%	8%	5%	11%	8%
2010-11	19%	6%	13%	0%	17%	6%	12%



	< 1 years	1-2 years	2-3 years	3-4 years	4-5 years	5-6 years	6 + years
2011-12	33%	25%	0%	0%	0%	0%	0%
2010-11	43%	57%	0%	0%	0%	0%	33%

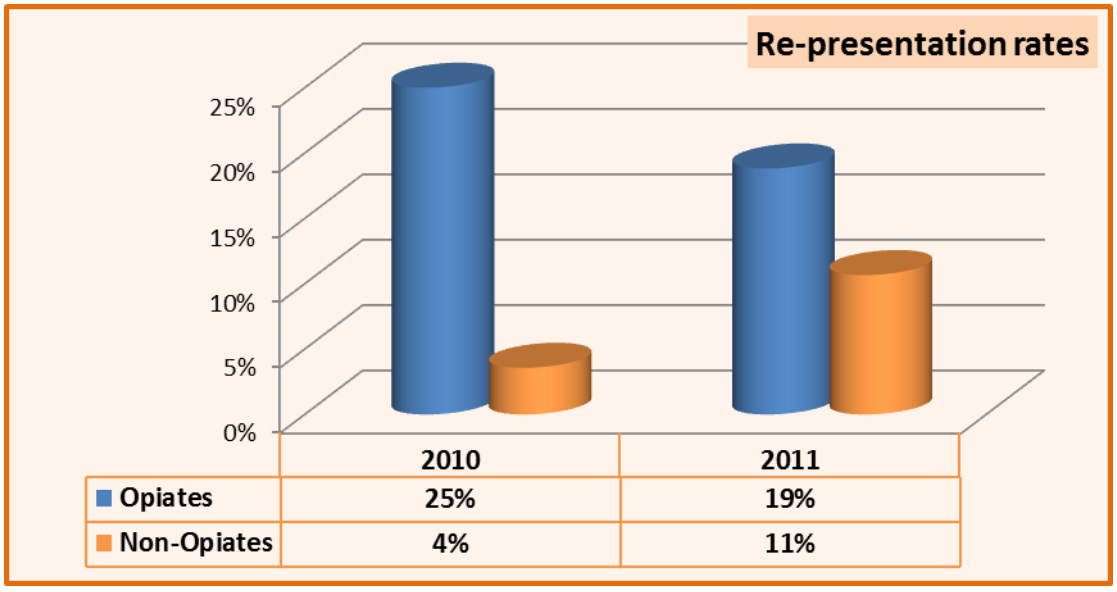
11.5 Re-presentation Rates

The tables below highlight the re-presentation rates for both opiate and non-opiate clients during 2010 & 2011. The re-presentation rates for opiate clients are higher than the non-opiate clients.

During 2011, the re-presentation rate for non-opiate clients increased from 4% to 11% and this is quite a steep increase from 2010. The cluster averages remain at 6% consistently which means that the partnership will need to look at all aspects of the non-opiate client group to improve performance.

OPIATES		
	2010	2011
Number of completions (calendar year)	88	85
Of which, re-presented	22	16
% re-presented following completion	25%	19%
% re-presented following completion (cluster average)	21%	21%

NON-OPIATES		
	2010	2011
Number of completions (calendar year)	84	75
Of which, re-presented	3	8
% re-presented following completion	4%	11%
% re-presented following completion (cluster average)	6%	6%



The graph above gives an overview of the comparison between opiate and non-opiate clients group for re-presentation rates during 2010 and 2011.

Key issues and considerations

The lack of data access does not provide for much comprehensive analysis in regard to client profiling and type of treatment interventions. There is an increasing trend of non-opiate clients in the partnership and successful completions are low for this client group compared to national and cluster averages with other partnerships.

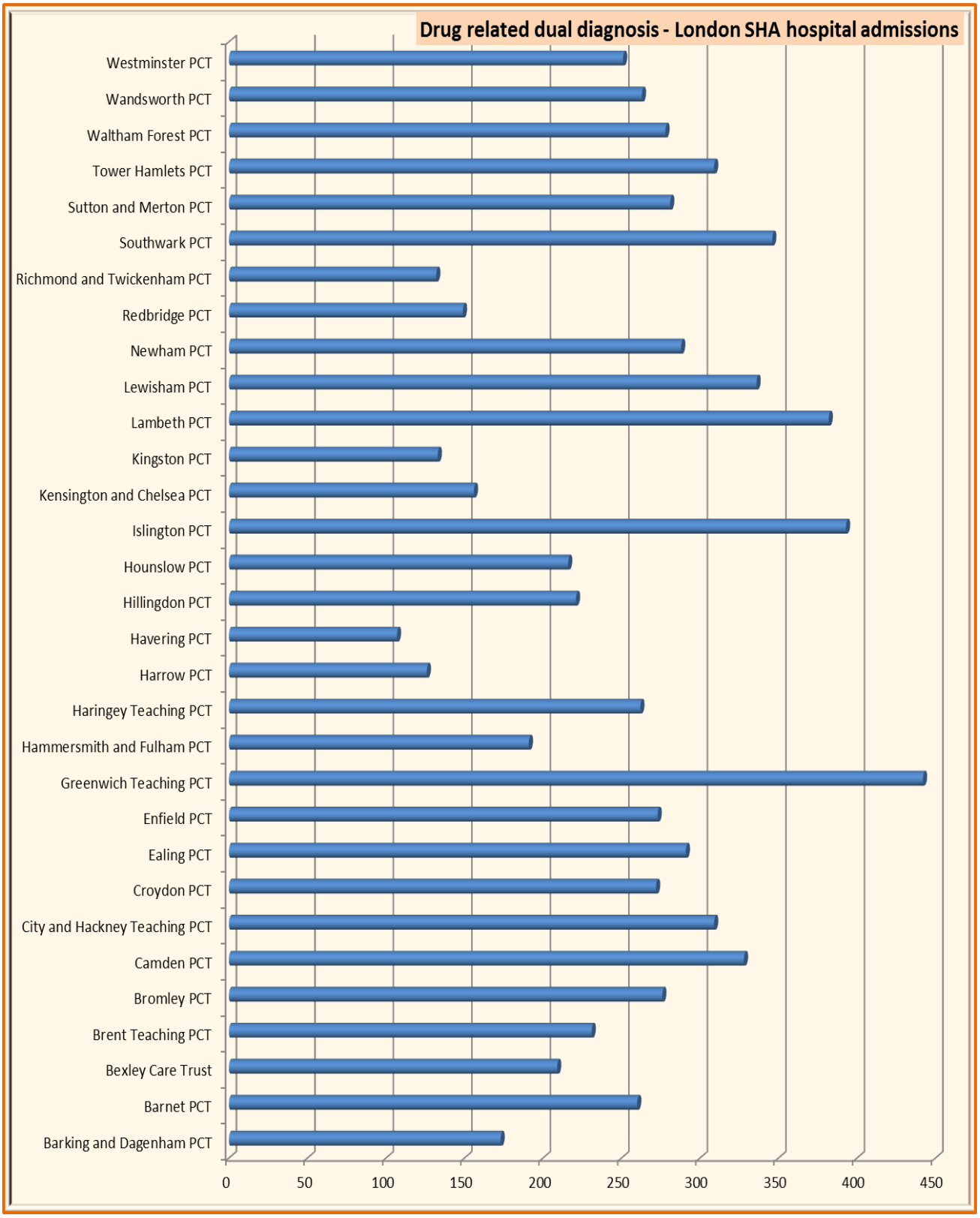
Treatment planning

The NTA's Recovery Diagnostic Tool provides further analysis and information in regard to clinical aspects of treatment planning and re-commissioning of services to fit the partnership's client profile. It is recommended that this tool is used to complete the treatment re-design and facilitate the re-commissioning of services.

12 Dual Diagnosis

During 2011/12, 27% of the treatment population had dual diagnosis issues. The NHS hospital admissions statistics reported 272 admissions were logged where there was a primary or secondary diagnosis of drug related mental health and behavioural disorders. This accounted for 3% of the total admissions recorded in the London Strategic Health Authority (London SHA) and Primary Care Trust at that time.

The chart below shows the numbers recorded in the London area.



13 Drug Related Poisoning

During 2011-12 Croydon had 39 cases of drug related poisoning. However, there isn't enough analysis to match how many, if any, of those cases were receiving treatment in the local partnership.

Key Issue & Gap

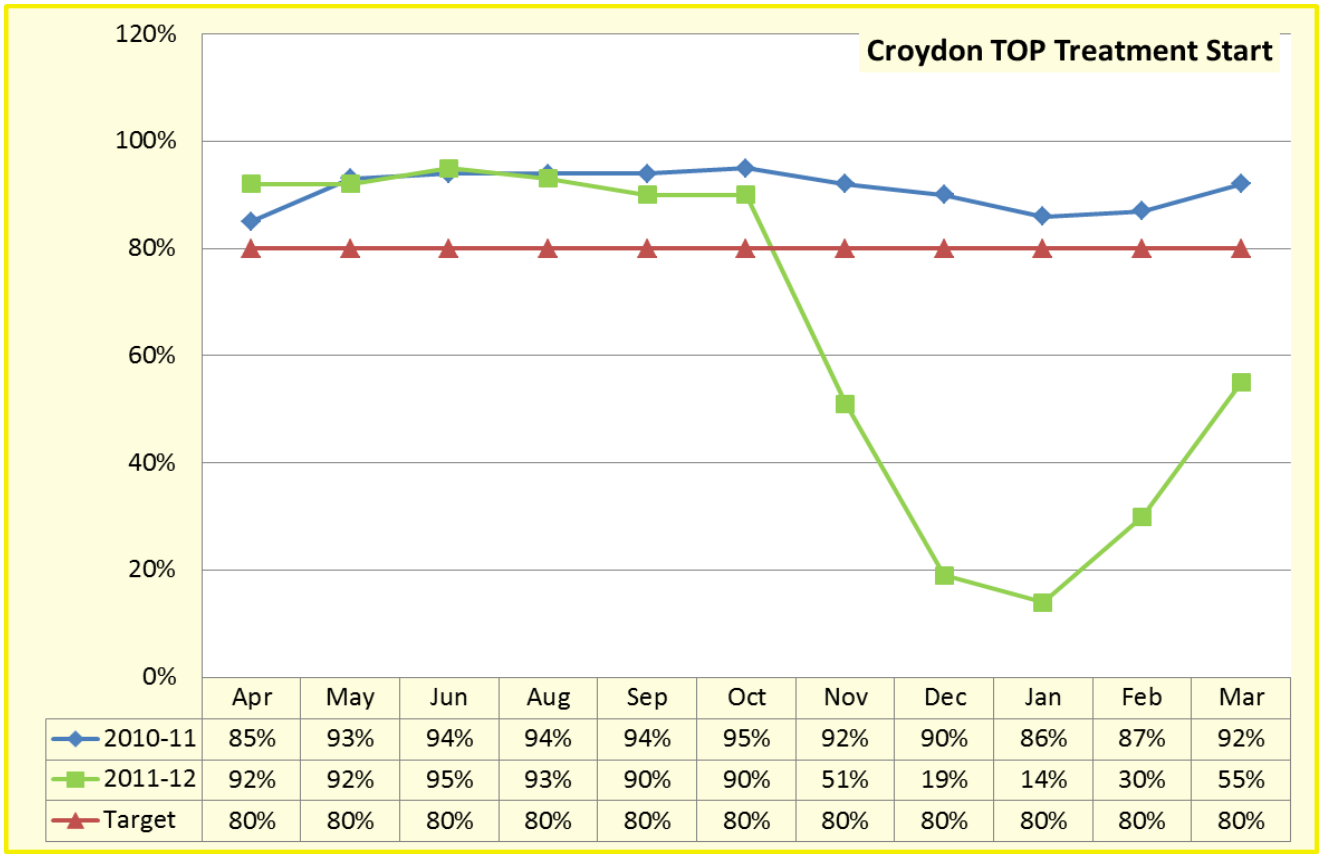
This again is an on going gap in the current service delivery where there is not much information gathered and monitored to identify clients at risk and to do any comprehensive analysis for this client group.

14 Treatment Outcome Profile (TOP)

TOP focuses on four key areas of substance use, injecting behaviour, criminal activity and health & social functioning. It is used to measure client progress from treatment commencement, review and after treatment completion.

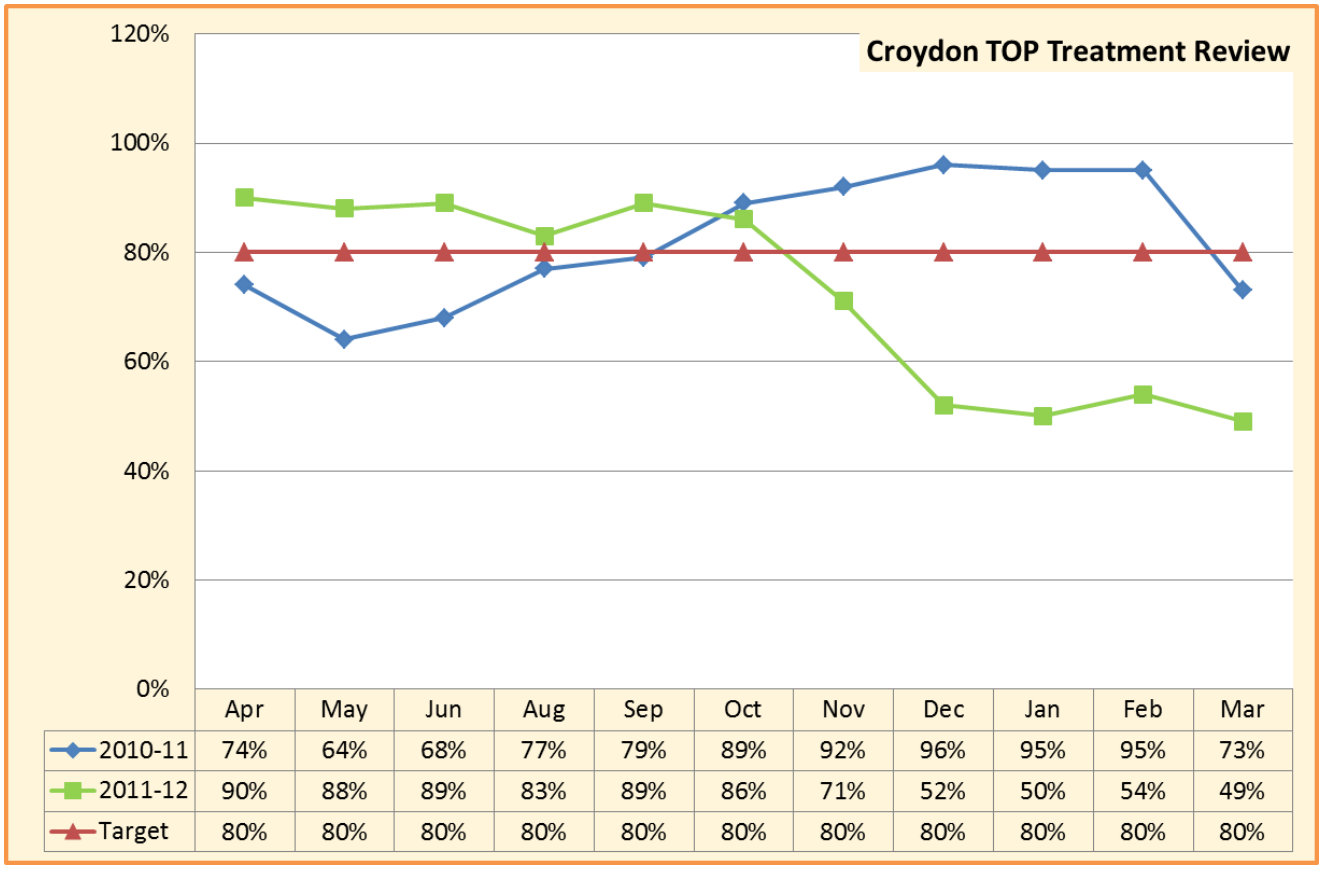
Unfortunately, Croydon's performance in this areas has taken a downward trend since the latter part of 2010-11 continuing on during 2011-12. The graphs below show the TOP performance for treatment start, review and exit during 2010-11 & 2011-12.

Treatment start – The average rate of performance during 2010-11 was 83.5% compared to 60% in 2011-12.



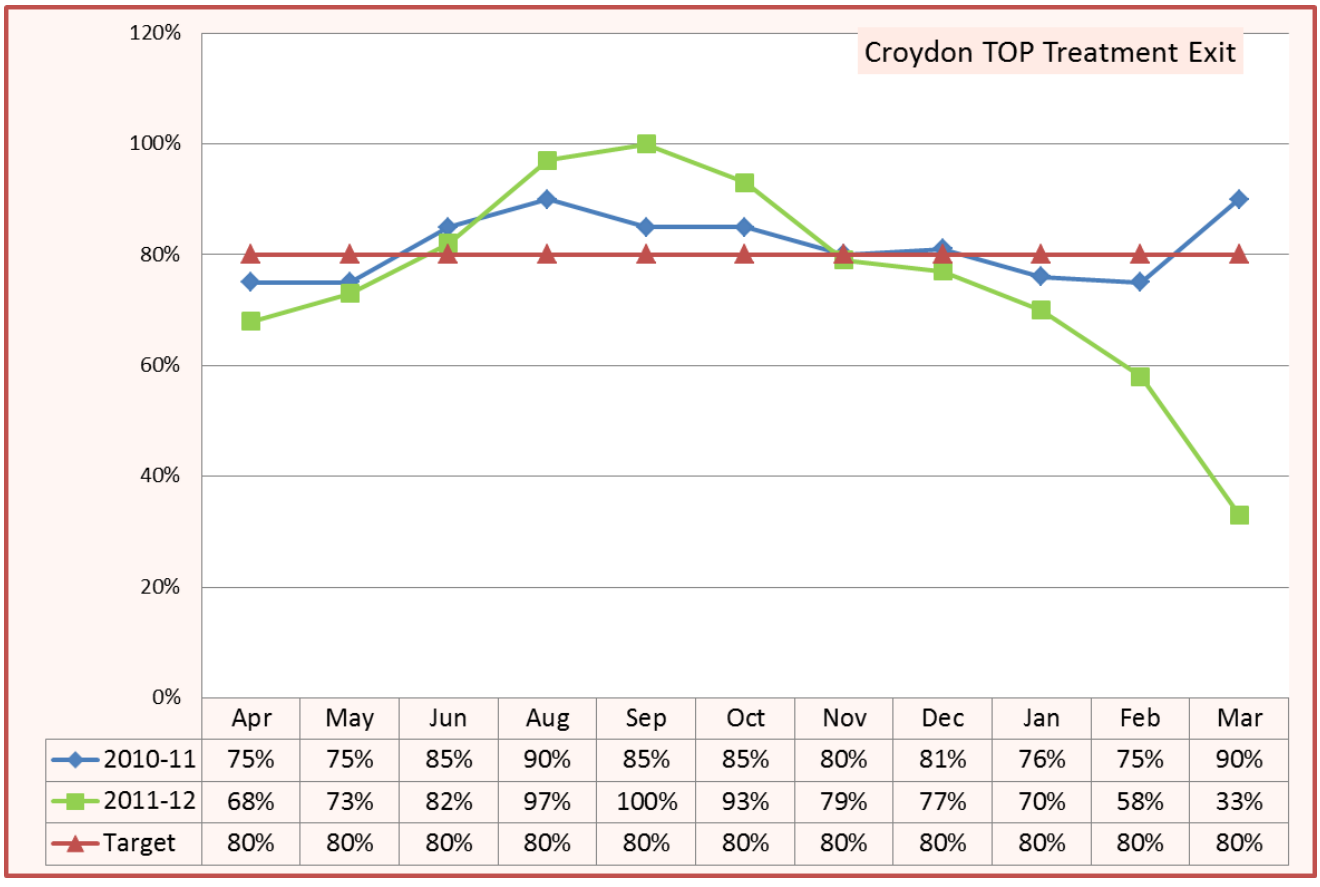
	Apr	May	Jun	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010-11	85%	93%	94%	94%	94%	95%	92%	90%	86%	87%	92%
2011-12	92%	92%	95%	93%	90%	90%	51%	19%	14%	30%	55%
Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%

Treatment Review – The performance of TOP review averaged at 75% during 2010-11 and 67% during 2011-12.



	Apr	May	Jun	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010-11	74%	64%	68%	77%	79%	89%	92%	96%	95%	95%	73%
2011-12	90%	88%	89%	83%	89%	86%	71%	52%	50%	54%	49%
Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%

Treatment Exit – The average rate of performance for TOP exit during 2010-11 was 75% compared to 69% during 2011-12.



	Apr	May	Jun	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010-11	75%	75%	85%	90%	85%	85%	80%	81%	76%	75%	90%
2011-12	68%	73%	82%	97%	100%	93%	79%	77%	70%	58%	33%
Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%

As a result of poor TOP performance below target, the detailed comprehensive analysis pertaining to progress of clients' substance use, injecting behaviour, criminal activity and health & well being is unavailable.

Key Issue

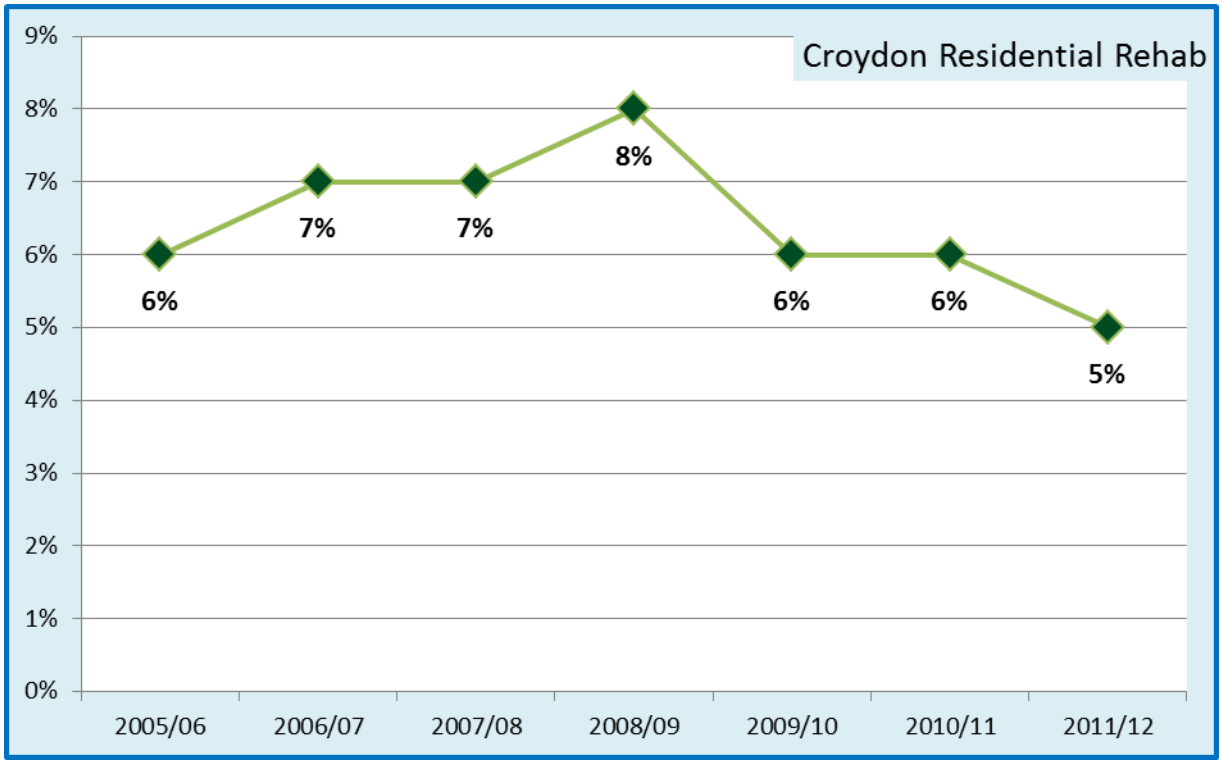
One of the contributing factors to poor TOP performance in the partnership has been due to the lack of clarity with treatment pathways for providers and this caused confusion in regard to which element of the treatment system was responsible in completing TOP start, review and exit. There are also issues with data recording and the migration of data from the CDA contract to the integrated service contract. As a result this has contributed confusion in recording client records and TOPs.

Commissioning consideration

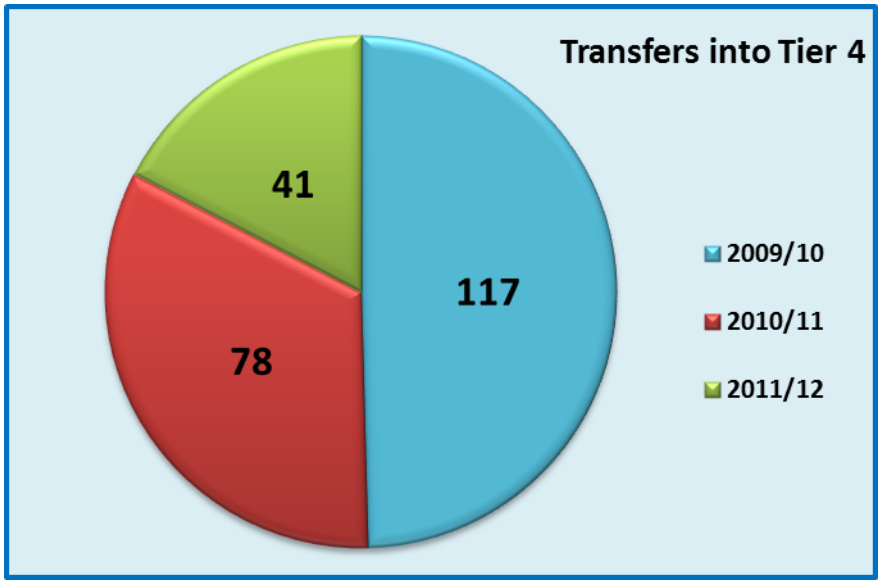
In re-designing and re-commissioning the treatment services for the partnership, it is recommended that a robust treatment system with clear pathways are implemented. It may also be useful to have a clear communication protocol so that all providers and their workforce are adequately informed of the partnership's processes for treatment delivery.

15 Residential Rehabilitation (Tier 4)

On average, about 6% of the treatment population in Croydon attend residential rehabilitation. The chart below, shows the percentage proportion of the partnership's treatment population since 2005-06 that have accessed residential rehab. The chart also highlights the downward trend of proportion of clients accessing this intervention.



There has also been a reduction in the number of clients being referred and transferred into Tier 4 services over the last couple of years. The chart below shows that since 2009-10, there has been a decreasing trend of clients being referred to Tier 4 treatment.



The cost analysis exercise also revealed that expenses for Tier 4 service provision does not provide value for money and expenditure is much higher compared to national and regional quartiles.

About 35% of clients entering Tier 4 treatment are reported to have completed treatment successfully.

There's also a gap in the after care provision for this client group which impacts on successful treatment completions for this client group.

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Commissioning consideration

In re-designing and re-commissioning the treatment services for the partnership, it is recommended that the partnership review the service provision for the Tier 4 layer in line with the cost analysis and explore cost effective methods and pathways of commissioning this layer of service delivery.

16 ALCOHOL

The recent statistical report released on 30th May 2013 by Health and Social Care Information Centre provides a reference point for health issues relating to alcohol use and misuse. It covers topics such as drinking habits and behaviours among adults (16 and over), school children aged 11 to 15, drinking-related ill health and mortality, affordability of alcohol, alcohol related admissions to hospital and alcohol-related costs. Full details of report can be obtained from below reference:

Statistics on Alcohol – England, 2013 (Publication date: May 30, 2013)
http://www.hscic.gov.uk/catalogue/PUB10932

Some of the key facts for England highlighted in the report are listed below

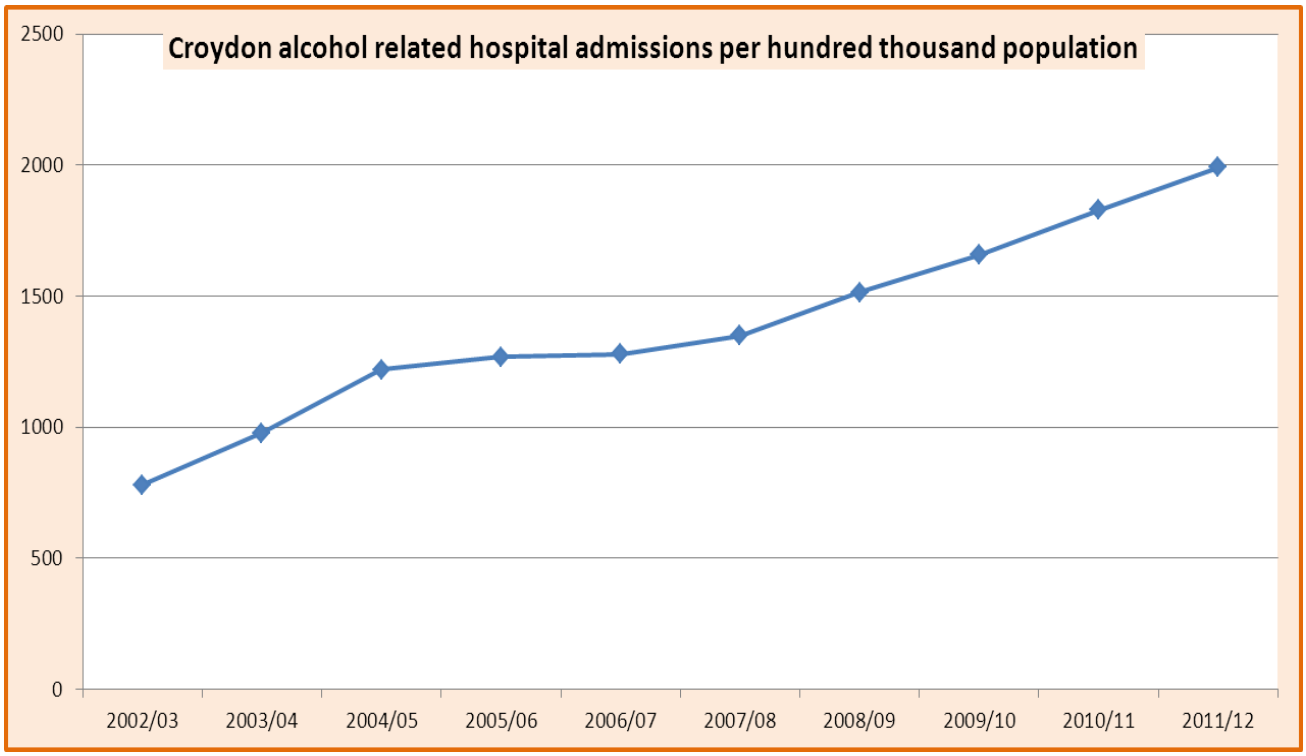
- 61% of men 72% of women in 2011 had either drunk no alcohol in the last week, or had drunk within the recommended levels on the day they drank the most alcohol. This was most common among men and women aged 65 or over.
- 64% of men drank no more than 21 units weekly, and 63% of women drank no more than 14 units weekly in 2011.

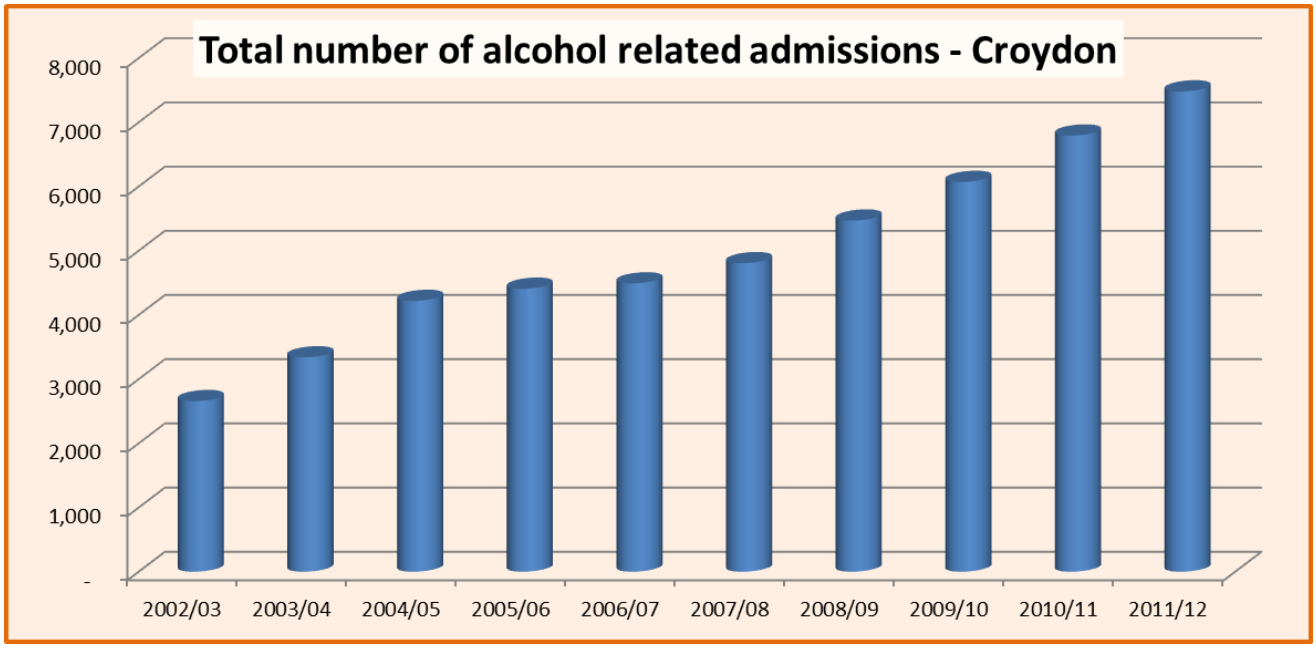
- In 2011/12 there were 200,900 admissions where the primary diagnosis was attributable to the consumption of alcohol compared to 198,900 admissions during the previous year 2010/11. Since 2002/03, there's been an increase of 41% for such admissions.
- In 2011/12, there were an estimated 1,220,300 admissions related to alcohol consumption where an alcohol-related disease, injury or condition was the primary reason for hospital admission or a secondary diagnosis (broad measure). This is an increase of 4% from 2010/11.
- In 2012, there were 178,247 prescription items prescribed for the treatment of alcohol dependence in primary care stings or NHS hospitals and dispensed in the community. This is an increase of 6% from 2011 (167,764). The Net Ingredient Cost (NIC) of these prescriptions was £2.93 million in 2012. This is an increase of 18% from 2011 at £2.49 million.

There are different data sources and methodologies used to estimate the drinking behaviours of the adult population for local areas. Thus data is not directly comparable with these different sources and estimated prevalence of particular behaviours may differ. The data and analysis for this section is taken from the NTA's JSNA pack for alcohol 2011-12 and from NATMS (treatment map), Hospital Episode Statistics (HES) and from Local Alcohol Profile England (LAPE).

16.1 Alcohol related hospital admissions

There were 7,481 alcohol related admissions during 2011-12. The rate per hundred thousand of the total population in Croydon pertaining to hospital admissions is 1,992. Since the 2002-03, there has been an increasing trend in admissions related to alcohol. The two graphs below, show the rate per hundred thousand of the population in Croydon and the increasing trend in number of admissions each year since 2002-03.





The table below shows the number of hospital related admissions in London by local authority during 2011-12. The green arrows are indicative of the those boroughs with higher quartile, amber arrows are those in the mid range and red arrows are those with lowest number of admissions recorded in London. Croydon remains in the higher quartile with second largest number of admissions (7,481) after Ealing recorded in the London region.

Local Authority	2011/12	Local Authority	2011/12
City of London	146	Hounslow	5,047
Barking and Dagenham	3,967	Islington	4,514
Barnet	6,775	Kensington and Chelsea	2,795
Bexley	4,780	Kingston upon Thames	2,847
Brent	6,060	Lambeth	4,824
Bromley	6,130	Lewisham	4,883
Camden	4,093	Merton	3,402
Croydon	7,481	Newham	5,518
Ealing	7,804	Redbridge	5,624
Enfield	6,268	Richmond upon Thames	3,103
Greenwich	4,756	Southwark	4,818
Hackney	3,852	Sutton	3,998
Hammersmith and Fulham	3,748	Tower Hamlets	3,685
Haringey	4,867	Waltham Forest	5,656
Harrow	4,295	Wandsworth	4,755
Havering	5,297	Westminster	4,086
Hillingdon	6,174		

16.2 Alcohol Related Deaths

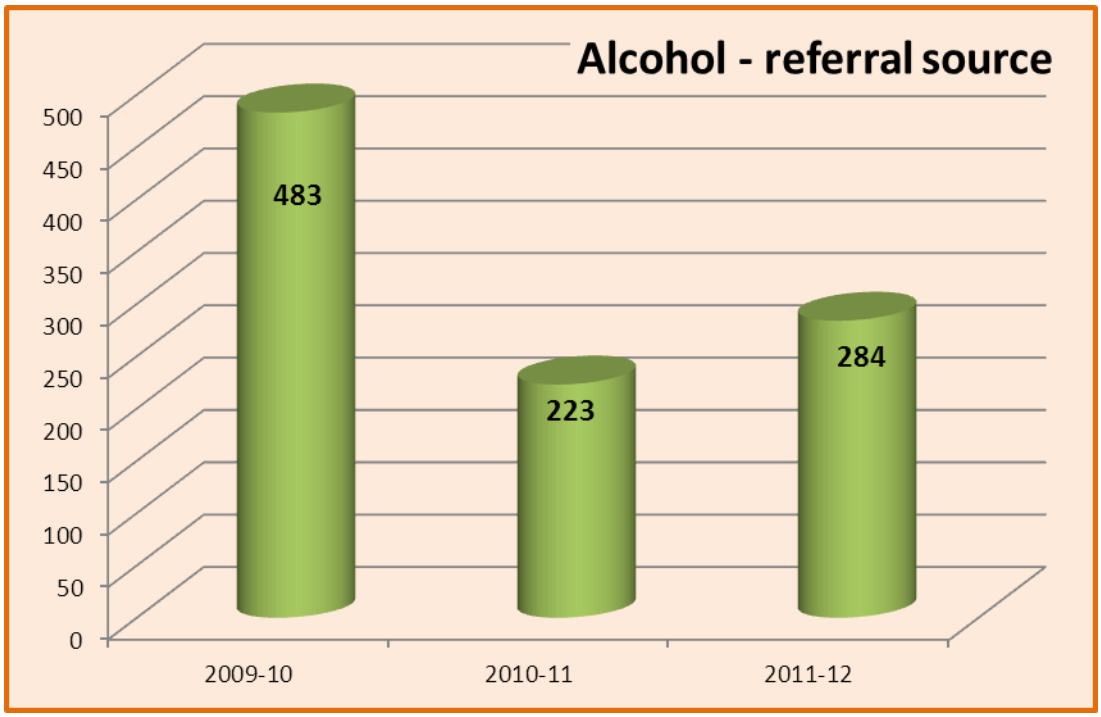
Between 2008-10 in Croydon, recorded alcohol related deaths were 51 for males and 27 for females. At the same time during the same period, 61 males and 39 females were also reported to have lost their lives due to chronic liver diseases.

16.3 Alcohol Prevalence Estimate

The age range for establishing prevalence of dependent drinkers is from 18-75 years of age. The estimated number of dependent drinkers in the partnership is 4,356 and the proportion of those in treatment is 11%.

16.4 Referrals into Treatment

During 2011-12 there were 284 referrals into alcohol treatment. The chart below shows the referral trend for the last three years.



Since 2009-10, the number of referrals have dropped and in 2011-12 there is a slight increase from 223 to 284 clients.

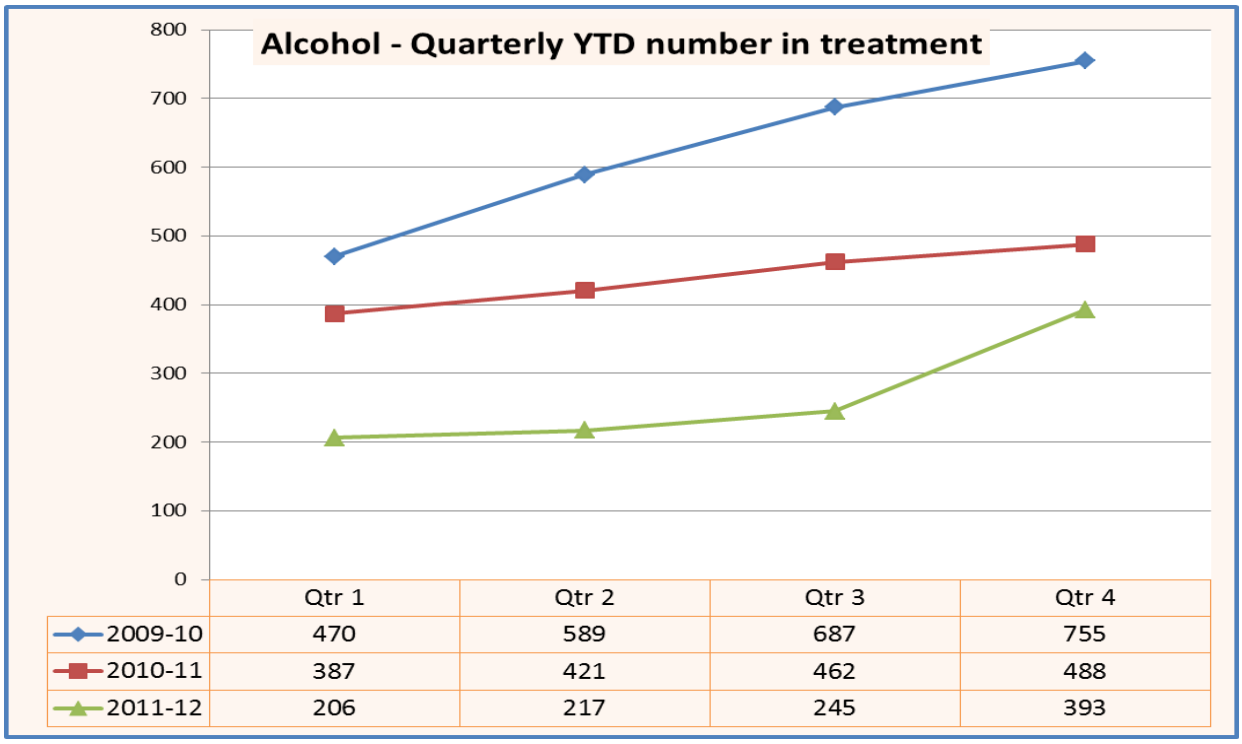
Self referrals account for the main referral route. There has been a slight increase in referrals coming from the substance misuse services during 2011-12 as seen in the table below. The referrals from "Health & Mental health services" has decreased considerably from 52 during 2009-10 to only 9 referrals during 2011-12.

REFERRAL SOURCE	2009-10	2010-11	2011-12
Community based services	18	8	6
Children & Family services	5	3	1
Health & Mental health services	52	28	9
Substance Misuse services	22	18	26
Criminal Justice Services	11	2	3
Self, Family and Friends	339	140	223
Other	18	20	9
No Referral Source recorded	18	4	7
Total	**483**	**223**	**284**

16.5 Demographics and Treatment

The total number of adults in alcohol treatment during 2011-12 were 407. The quarterly alcohol treatment data shows a decrease of numbers in treatment since 2009-10 at 755 clients recorded to be in treatment with a decreasing trend right up to 2011-12.

The chart below shows the quarterly numbers in treatment in the last three years.

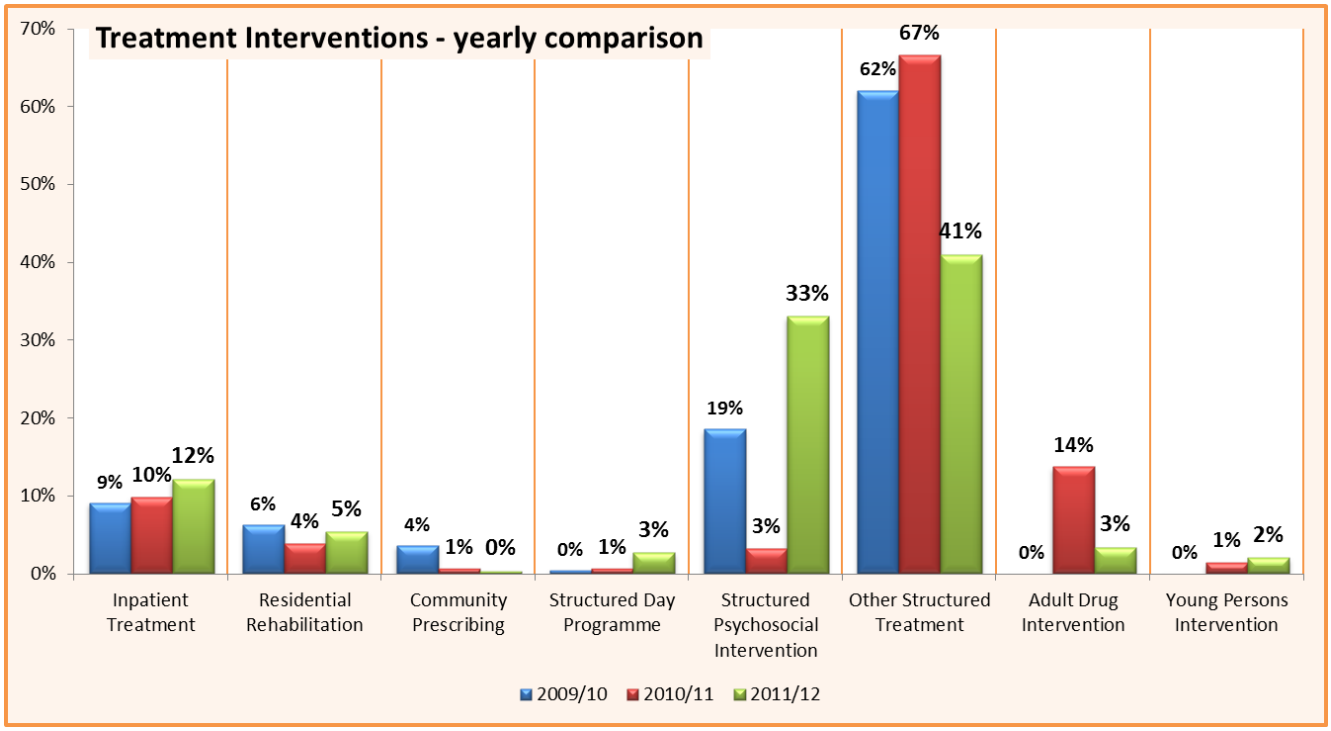


	Qtr 1	Qtr 2	Qtr 3	Qtr 4
2009-10	470	589	687	755
2010-11	387	421	462	488
2011-12	206	217	245	393

The number of adults in drug treatment that also cite additional problematic alcohol use were around 38% of the treatment population.

The average age of adults in treatment for both male and female is around 42 years of age with the largest proportion of clients being in the 40-49 years age group.

The main treatment intervention recorded is “other structured treatment”. The graph below, shows the breakdown of treatment interventions engaged in by clients during 2009-10, 2010-11 and 2011-12.



The recording of treatment interventions has improved during 2011-12 where other structured treatment fell to 41% from 67% of previous year and structured psychosocial intervention increased to 33% from 3%. There is still room for more improvement in recording alcohol treatment interventions.

16.6 Safeguarding

About one in three of the alcohol treatment population in England has a child living with them at some of the time. It is estimated that 1.3 million children under 16 are affected by parent whose drinking is classified as either harmful or dependent.

In Croydon, 47% of the treatment population have children living with them. The national proportion is around 32%.

8% of the treatment population are identified as parents not living with children which is lower than the national proportion of 24%.

16.7 Drinking Levels and Additional Substances Used

The Government's definition of weekly high risk consumption levels are 50 units per week for men and 35 units per week for women. The data in this section highlights drinking levels 28 days prior to entering treatment.

The partnership's proportion of clients drinking at high risk levels 28 days prior to entering treatment is 85% compared to national levels of 77%. The table below shows the proportion of clients reporting units consumed 28 days prior to entering treatment. Figures show both local and national levels for comparison. The partnership reflects clients consuming more alcohol in the high end levels compared to national proportions which are lower.

Units consumed	0	100-199	200-399	400-599	600-799	800-999	1000+	Missing
Croydon	↓ 7%	↓ 10%	↓ 10%	↓ 16%	↑ 19%	↑ 16%	↑ 23%	↓ 1%
National	↑ 9%	↑ 17%	↑ 18%	↑ 19%	↓ 12%	↓ 10%	↓ 15%	↑ 4%

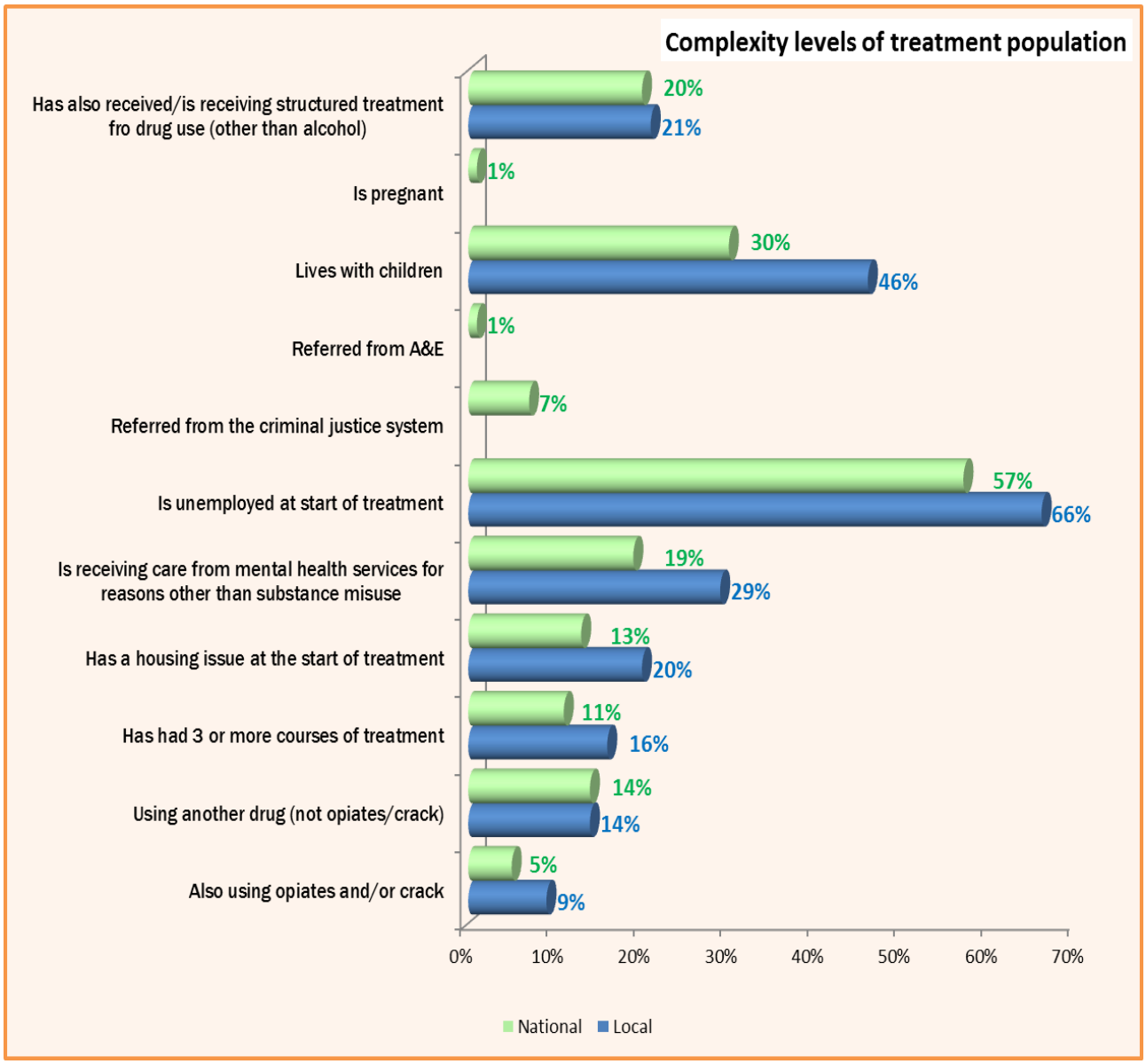
Clients may also cite more than one additional substance when reporting alcohol use. The table below shows the proportion for both local and national levels.

	Local	National
Additionally using opiates or crack	9%	5%
Additionally using cannabis	11%	10%
Additionally using other drugs (not opiates, crack or cannabis)	9%	9%

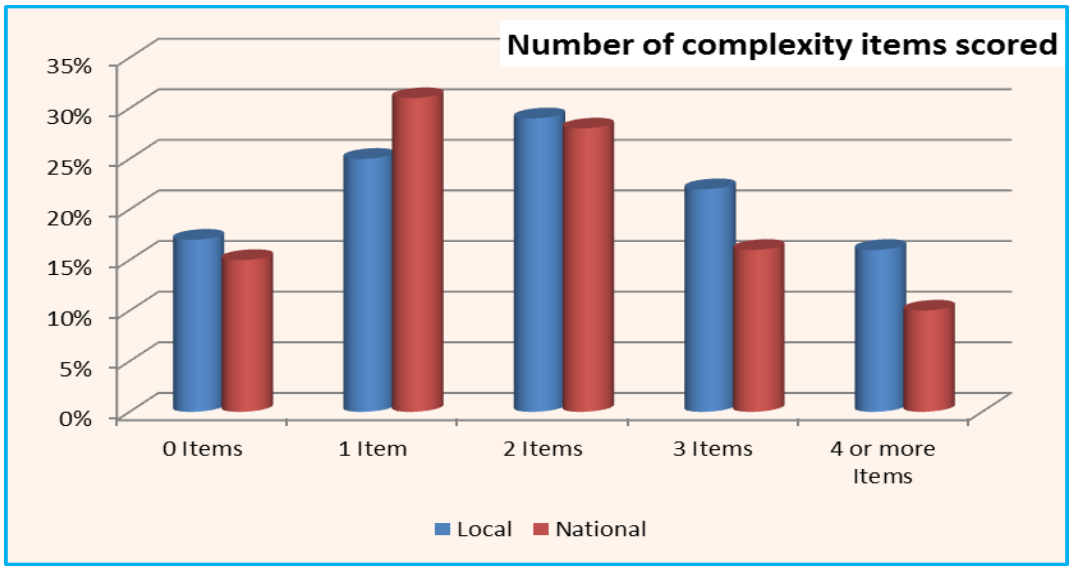
16.8 Complexity of Treatment Population

Adults in alcohol treatment experience wide-ranging problems. The complexity of alcohol treatment population is based on a scoring system of a set of data items to establish the proportion of complexity in local partnerships. Higher the score, more likely it is that the client has complex needs.

The graph below shows the percentage proportion of clients recorded in each of the complexity items scored. Also included are national figures for comparison.



In most of the items, Croydon scores higher than the national scores. The next graph below gives a breakdown of the number of complexity items combined. The partnership has greater proportion of clients that have recorded either 2, 3 or 4 and more complexity items at a time.



Key facts

Although the year to date numbers in treatment for alcohol clients show a decreasing trend in the last three years, the increasing trend in hospital admissions related to alcohol reveal that alcohol misuse is an issue in the borough.

17 Criminal Justice Interventions

The Drug Interventions Programme (DIP) identifies and engages with drug using offenders at the stages of arrest, sentencing, prison and post prison release. A detailed Criminal Justice needs assessment has been completed and distributed to the wider partnership. This includes the wider operational process from the time of arrest, drug testing to treatment uptake.

One of the main continuing challenges in regard to treatment uptake for this client group is the recording of engagement of clients into treatment from the point of referral after initial assessments. During 2011-12, of the total DIP referrals made into treatment, apparently only 14% of these referrals transferred into treatment engagement. The earlier challenges were attributed to data matching concerns between DIP and NDTMS but this only attributed to part of the issue. The wider problem has been the apparent attrition point between point of referral and clients turning up at the treatment service for engagement.

Also identified were the high rates of cocaine only users that have disengaged from treatment. A new pilot was started to tackle this issue. A new structured intervention keyworker was recruited to have a hands on approach to meet individual client needs within this group. As a result, retention of cocaine only users have shown improvement. This will be an on going pilot for the rest of this year 2013-14 and performance will be closely monitored.

Changes to DIP funding will now lead to partnerships bidding for the funding via the Mayor's Office of Policing and Crime (MOPAC). A major shift in service delivery will be for the partnership to implement Payment by Results (PbR) for this area of the Criminal Justice Interventions.

18 Personalisation

Putting People First (LGA, ADASS, NHS, 2007) made personalisation and personal budgets the cornerstone of policy in adult social care, meaning “every person across the spectrum of need, having choice and control over the shape of his or her support, in the most appropriate setting”. Local Authorities have subsequently committed that by 2013, all adults using community based social care service will have a personal budget. The national pilot programme for personal health budget was launched in 2009. From a total of over 70 pilot sites in England, Croydon and Southampton piloted for the substance misuse category. The final draft of the evaluation report was due to be released by November 2012. The findings and recommendations are currently embargoed and the DAAT hopes to release the final summary in the near future.

Croydon began recruiting people to the pilot in January 2011. 60 drug and/or alcohol users were recruited to the pilot, 30 of whom were given personal health budgets and 30 of whom would have their treatment and support delivered in the usual way. Further 8 people were recruited from the criminal justice group. A resource allocation system (RAS) was developed to promote a more objective and transparent way of determining the indicative personal health budget allocation for each individual.

18.1 Final reflections on the pilot

For all pilot participants, a modest personal budget added value to their lives and helped promote effective recovery to varying degrees. The extent of value added outstripped the monetary value of purchases. The diverse range of personal outcomes and spend seen in the pilot suggests a reasonable degree of success in achieving person centredness in the support planning process.

One of the benefits most frequently reported was improved self-confidence and self-esteem.

Whether positive longer-term outcomes are achieved by pilot participants will depend on many different factors, including the strength of individual resilience and motivation. However, both staff and participants succeeded in “thinking differently” in the pilot, opening new possibilities with infinite number of combination of supports, solutions and services. Recovery capital is potentially expansive to the types of interventions and support that substance misuse services can provide.

There are still some learning points arising from the pilot. An in depth evaluation including comparative outcome measurements will follow in reports to be published by the independent evaluation team in the near future during 2013.

Key facts and considerations

The DAAT has currently put aside £50K for use as personal health budgets. This is still work in progress in regard to funding allocations and the partnership is to explore further methodologies of implementing personalisation across the wider treatment planning system.

19 Service User Experience Questionnaire Result

During 2011/12, the annual service user questionnaire was carried out by the Service User Reps. In total, 75 completed forms were returned and the results are summarised below:

- Awareness of local substance misuse services – rise in numbers who heard about services through friends, GPs or criminal justice services.
- Choice of treatment – overall increase in those acknowledging satifsfaction with the choice of treatment offered.

- Care plans – reported increase in those receiving copies of care plans and care plan reviews.
- Hep B and Hep C – increase in numbers being offered Hep B vaccinations and Hep C tests.
- Increase in awareness about complaints procedures
- Increase in satisfaction that staff were willing to discuss any concerns or problems
- Increase in awareness about Service User Reps, their role and how they could help
- Increase in awareness about support for family and friends
- Drop in numbers wanting a peer mentor
- Drop in numbers who had filled out a TOP form, or had a TOP review.
- Factors influencing people to continue using services – two main popular factors were 'positive changes to life' and 'I need the treatment/service'.
- Reasons or factors influencing people to drop out – most popular were 'difficult to get there' and 'treatment/service is not helping.

General comments included:

- My own commitment works, been occasions where I have felt my voice was not important
- Better than it used to be
- Raised an issue in group about problems of environment of Tuesday pm testing (Lantern Hall) – things seem to have improved, security presence, sitting in group room with SUReps.
- Whatever happens, I need this service – it's a lifeline to me just now. Not just my script (which is important) but it provides me (in group and keywork) with a place of safety where I can be myself.
- My treatment has been first class from day one.
- Regardless of the cost cutting etc, that service is dreadful, especially the complaints procedure, which I have pointed out frerquently.
- They need to get more leaflets and information for family members that have a loved one that's on drugs and they don't know about it.
- Key workers never on time.

TOPs – 16 people responded they had filled out a form of which 5 said they had a TOP review and 9 said that this process has been helpful to them.

Personal budgets – produced a varied range of ideas as to how people would spend a personal health budget with bus fares as the main popular remuneration required. Included are other ideas such as training courses, clothes, family acitivities, counselling, housing, changing lifestyle.

Recommendations:

- Services to offer a focus on aftercare, community reintegration, move on support.
- Services to raise awareness of the usefulness of the TOP form and for practitioners to understand its importance as a marker for treatment progress and to use it as a recovery tool during their regular service user care plan reviews.
- Service User Reps to promote the benefits of peer support
- Service User Reps to be more visible at services to promote recovery
- Services to ensure their provision is reaching out to the diverse range of communities in Croydon.

20 Conclusion

Commissioning of substance misuse services should meet the diverse needs of the local substance misuse treatment population and in doing so this benefits the wider community. This is achieved in implementing a treatment system that is efficient, relevant and accessible to the substance misuse client group. Quality commissioning is also followed by robust performance management system.

This needs assessment has been limited by the quality of data currently available in Croydon. Thus the content of this assessment draws on information from multiple sources including NDTMS data submissions, qualitative observations by stakeholders and service user questionnaires. There are several areas in the partnership's treatment system that need further emphasis and the accessibility of data to comprehensively carry out analysis is not readily available to do real time monitoring.

As a result of the above, one of the key priorities for the partnership to consider is the possibility of implementing a system wide web based information management system to improve data accessibility and analysis. The electronic system will also facilitate robust performance and contract compliance monitoring.

The partnership has had several challenges in the last couple of years which has impacted on overall service delivery and performance outcomes. However in spite of these challenges, the partnership has maintained the continuity of the overall treatment delivery in meeting the needs of the current substance misuse population and performance has been at average levels.

Main key priorities to consider are:

- Explore treatment pathways for the increasing non-opiate client groups
- Further work is required to improve the intake of criminal justice clients and retention in treatment. This also extends to the continuing care for those clients coming out of prison.
- Improve service delivery and pathways to facilitate increase in successful treatment completions for both opiate and non-opiate client groups.
- Needle exchange activity is incomplete due to lack of consistent data collection and access to this area of information to do analysis. More work needs to be considered in this area of information gathering.
- After care provision is still an area that needs more work. This focuses on the National policy context of a recovery focused agenda for substance misuse treatment delivery.
- The personalisation and payment by result elements need to be factored into the overall treatment re-design process.