

JSNA Chapter: Drug and Alcohol Misuse in Havering

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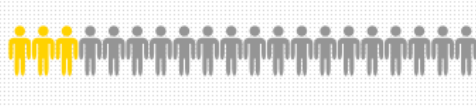
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1.0 Infographic Summary

RISK OF ILL HEALTH THROUGH ALCOHOL

20,808
Higher
Risk
Drinkers

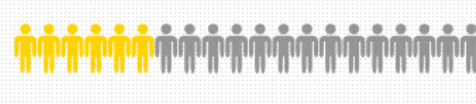


14%



4.2m

44,292
Increasing
Risk
Drinkers



29%



9.0m

88,840
Lower Risk
Drinkers



58%



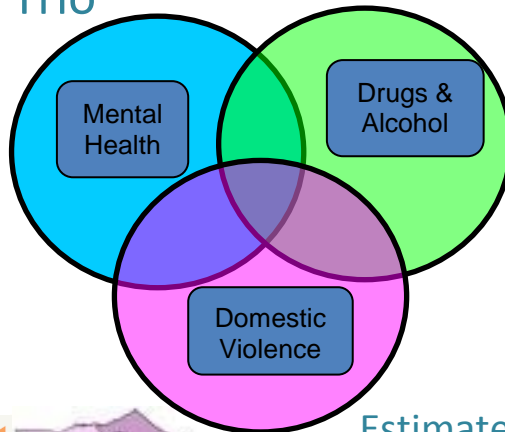
3.1m

COST OF ALCOHOL RELATED PROBLEMS TO THE LOCAL HEALTH

Toxic Trio



4% of all ambulance call-outs in 2012-13 were alcohol-related



Estimated 3,316 Dependent Drinkers; 852 Opiate & Crack Users in Havering



A typical heroin user spends around **£1,400 per month** on drugs (2.5 times the average mortgage)

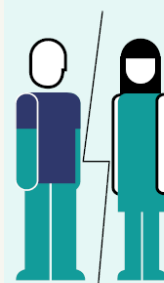


17% of road fatalities

Alcohol is implicated in around 17% of all road fatalities



Parental drug use is a risk factor in **29%** of all serious case reviews



Domestic violence and marital breakdown

Around 70-90% of Domestic Violence assailants report the use of alcohol or drugs



Every **£1** spent on drug treatment saves **£2.50** in costs to society

Every **£1** spent on young people's drug and alcohol interventions brings a benefit of **£5-£8**

2.0 Executive Summary

	Key Data	Considerations for Commissioners
Toxic Trio	<ul style="list-style-type: none"> The Toxic Trio of Mental Health, Drugs and Alcohol and Domestic Violence are cited as occurring in nearly 75% of serious case reviews where harm to a child has occurred; parental drug use is a factor in 29% of all serious case reviews Estimated 23,200 people in Havering have a common mental health condition There were 5,708 calls in 2013 to Havering police regarding domestic abuse 	Frontline staff working with Troubled Families should be trained in delivering Intervention and Brief Advice (IBA) and/or signposting clients experiencing drug or alcohol issues onto specialist services.
Prevalence of Alcohol Misuse in Havering	<ul style="list-style-type: none"> 3,316 estimated Dependent Drinkers 20,808 (14%) Higher Risk Drinkers – drink at very heavy levels which significantly increases the risk of damaging their health 44,292 (29%) Increasing Risk Drinkers – drink above the recommended level which increases their risk of damaging their health 88,840 (58%) Low Risk Drinkers – drink within recommended guidelines Havering ranks 11th out of 15 Local Authorities (1 being best) in the same deprivation bracket for deaths from Liver Disease at a rate of 15 per 100,000 The rate of mortality from chronic liver disease in women in Havering (6.67 per 100,000) is higher than that for London (5.83 per 100,000) 	<p>Only <i>estimates</i> are currently available on how many dependent drinkers there are in Havering – greater levels of screening using (e.g.) AUDIT C is required to establish better intelligence as to who would benefit from help into treatment.</p> <p>Ensure A&E services at BHRUHT adopt the ‘Cardiff model’ or equivalent to improve the recording of alcohol related harm (the who, when, where etc.)</p> <p>Work with Havering Clinical Commissioning Group (CCG) to implement the ‘last drink survey’ within A&E departments using a simple question, “Where did you buy your last drink from?”</p>
Amount of Alcohol Consumed / Binge Drinking	<ul style="list-style-type: none"> Just under 4% of 43,057 ambulance call-outs in 2012-13 in Havering had alcohol recorded as a primary or secondary contributing factor to the call-out 26% of people entering alcohol treatment in Havering consume more than 600 units of alcohol in the 28 days prior to treatment There were 21,802 alcohol-related 	There is currently a lack of robust intelligence on how many binge drinkers there are likely to be in Havering. Given the success of the night-time economy in the borough, such data would enable us to target resources more effectively to identifying and intervening early to minimise the harm caused by binge drinking.

	Key Data	Considerations for Commissioners
	<p>admissions to A&E in Havering</p> <ul style="list-style-type: none"> 761 alcohol-related hospital admissions as an inpatient in Havering were wholly attributable to alcohol 	<p>There are few services available to raise awareness of the harms caused by binge drinking to people engaging in Havering's night time economy. Increases in the numbers of frontline staff trained in delivery of Interventions and Brief Advice (IBA) may help.</p>
Specialist Alcohol Treatment Services	<ul style="list-style-type: none"> AUDIT C assessment has only been given to 771 patients out of a total 10,539 Health Checks 273 people were provided with specialist adult alcohol treatment in 2012-13 61% of those engaged in treatment were men 91% of those engaged in treatment were White British 65% of Havering clients waited less than 3 weeks to begin alcohol treatment compared with 62% nationally 	<p>Look to identify more people with alcohol problems and increase referrals into the community alcohol service by: -</p> <ul style="list-style-type: none"> <i>in general practice</i> – by including use of the Audit C screening tool in NHS health checks; and providing GPs with training regarding Audit C and IBA <i>in general practice</i> – work with GPs to better understand how and when they prescribe alcohol abstinence medication and encourage them to refer patients into specialist or recovery services <i>in hospital</i> – by commissioning a hospital liaison service and agreeing expectations of BHRHT regarding the identification of problem drinkers admitted and / or attending A&E
Alcohol Consumed by Children and Young People	<ul style="list-style-type: none"> 75% of respondents to Havering Young People's Survey on Smoking, Drug and Alcohol Use (269 responses) were aged 15 or under when they had their first alcoholic drink 45% of children aged 11-15 years surveyed in Havering declared they have ever had an alcoholic drink. Early age of drinking onset is associated with an increased likelihood of developing alcohol abuse or dependence in adolescence or adulthood; vulnerability to alcohol abuse is greatest amongst young people who begin drinking 	<p>Schools should be supported to provide high quality drug and alcohol education for all pupils; commissioners should consider the potential value of additional input from school nursing when the service is re-commissioned</p>

	Key Data	Considerations for Commissioners
	before the age of 15.	
Prevalence of Drug Misuse	<ul style="list-style-type: none"> • Havering's rate for drug use is 5.54 per 1,000 population, which is lower than the national rate of 8.40 per 1,000 population • Declared prevalence estimates from Liverpool John Moores University and Public Health England estimate that for Havering there are: <ul style="list-style-type: none"> ○ 852 Opiate and Crack Users in Havering ○ 712 Opiate Only ○ 693 Crack Only ○ 172 Injecting Users • 4.4% of 25-29 year olds nationally have taken powder cocaine • Havering has one of the highest proportion of powder cocaine users entering treatment in England • Nitrous Oxide (NO) use is a new and emerging trend; nationally 6.1% of 16-24 year olds have taken NO • 134 Disability Adjusted Life Years (DALYs) are lost annually in Havering through drug misuse • Estimated 1,100 people in Havering infected with Hepatitis C 	<p>Improve needs assessment and understanding of substance misuse locally</p> <p>Promote awareness of drug treatment services</p> <p>Regularly report waiting times to potential referrers to demonstrate the capacity of the service and the potential for a timely response</p> <p>Require providers to promote services to potential referrers e.g. GPs.</p> <p>Improve reporting from needle exchange services to improve this potentially useful source of information</p>
Prescription Only Medicines (POM) and Over-the-Counter medication (OTC)	<ul style="list-style-type: none"> • Of the 520 clients in drug treatment in Havering in 2011/12, 11.5% cited problematic use of prescription only medicines (POM) or over-the-counter medicines (OTC), slightly lower than the London average (12.6%) 	Commissioners need to establish more robust intelligence on POM and OTC usage
Specialist Drug Treatment Services	<ul style="list-style-type: none"> • There were 540 adults engaged in specialist drug treatment services in Havering in 2012-13; 268 Opiate users, 272 non-Opiate • 88% of Havering's drug treatment clients were White British • Successful completions for cannabis users in Havering are significantly lower (23.9%) than London (37.1%) • Needle exchange schemes are 	<p>Ensure treatment service involve families and carers in treatment, making use of behavioural couples therapy, in line with NICE guidance</p> <p>Support the recovery agenda by considering commissioning of recovery programmes as part of exit procedures from specialist services e.g. Recovery Café</p>

	Key Data	Considerations for Commissioners
	available at 9 pharmacies across the borough	<p>Consider whether use of alternative venues would reduce the stigma associated with attending substance misuse services.</p> <p>Further exploration and feedback from service users is required to determine why the completion rate for cannabis is so much lower in Havering</p>
Drug Misuse amongst Children & Young People	<ul style="list-style-type: none"> 74% of young people aged 13-19 years in Havering responding to the Havering Young People's Survey (2013) thought drugs are 'easy to get hold of' 29% have been offered drugs at school Cannabis was the top drug believed by young people to be used by young people in Havering, followed by cocaine and ecstasy 	Ensure all Multi-Agency Safeguarding Hub (MASH) partners are aware of provisions for carers and families of drug and alcohol users.
Specialist Drug Service for Children & Young People	<ul style="list-style-type: none"> In 2012-13 there were 63 young people aged under 18 years in specialist services Young people were in specialist substance misuse services for longer than the England average - 38% took 13-26 weeks compared with 31% in England 37% of young people cited Stimulants (cocaine, ecstasy and amphetamines) as their primary drug 	<p>Commissioners should ensure drugs and alcohol workers receive regular safeguarding training and actively engage with MASH and Multi-Agency Risk Assessment Conference (MARAC) procedures as required.</p> <p>Ensure treatment services link with Children and Young People social care services and the Troubled Families project.</p>
Parental Substance Misuse	<ul style="list-style-type: none"> 45% of adults receiving alcohol treatment in Havering who have contact with children are living with them; 52% are parents but not living with them There were 331 children in Havering living in homes where there is a parent/carer known to be engaging in drug or alcohol treatment 56% of drug using adults in Havering have responsibility for children 	The Troubled Families Initiative is essential to identify and support families experiencing substance misuse; all frontline staff in contact with children and families should be trained in delivery of Intervention and Brief Advice (IBA)

	Key Data	Considerations for Commissioners
Supporting the Recovery Agenda	<ul style="list-style-type: none"> Alcoholics Anonymous is particularly strong in Havering – it has 15 regular groups, each attended by 10-15 people 	Consider commissioning of recovery programmes as part of exit procedures from specialist services e.g. Recovery Café
'At Risk' Groups	<ul style="list-style-type: none"> Early intervention amongst children and young people to prevent drug and alcohol misuse issues is essential. However, there are vulnerable groups within Havering, who may require access to additional targeted services Drug and alcohol addiction is more likely in families where it is already present Children from lone parent families are more likely to engage in risky behaviour, including drug or alcohol misuse and smoking – 27% of children live in lone parent families in Havering 65% of people entering alcohol treatment and 63% of drug treatment were unemployed at the start of treatment Havering's rate of homeless households in temporary accommodation (6.43 per 1,000) is higher than that of England (2.54 per 1,000) but lower than London (12.02 per 1,000) Loneliness and social isolation is a key risk factor for substance misuse; Havering has the highest percentage of people aged 65+ (17.86%) than all of London (11.1%). Of these, it is estimated that 16,300 Havering residents aged 65+ were living alone in 2012. This is predicted to increase to 17,948 older people living alone by 2020 Older people are at increased risk of adverse physical effects of substance misuse, including dementia – there are an estimated 3,050 people in Havering with dementia 19% of prisoners report having alcohol problems when entering 	<p>There is currently an over-representation of White British service users accessing treatment (88% and 91% for drug and alcohol respectively) – further exploration is required as to why this is the case, and to ensure that the services commissioned meet the needs of various ethnic groups equitably</p> <p>The needs of prisoners in temporary custody require assessing</p>

	Key Data	Considerations for Commissioners
	prison	
Effective Use of the Criminal Justice System	<ul style="list-style-type: none"> • Estimated 30-50% of acquisitive crime is due to drug-using offenders • 42% of Havering burglary offenders tested positive for drug use compared to 23% in London • 44% of burglary offenders re-offended compared with 28% in London • There were 1,986 crimes attributable to alcohol in 2011-12 in Havering • 215 Offenders in Havering were tested under the Drugs Intervention Programme (DIP) • Integrated Offender Management (IOM) currently has 52 people on its caseload 	<p>Increased support for Testing on Arrest (ToA) and Conditional Cautioning (CC) as routes to treatment from the criminal justice system</p> <p>Adopt similar approaches as currently employed to identify drug misusers and engage them in treatment e.g. Alcohol Treatment Requirements (ATR) and Alcohol Arrest Referrals (AAR)</p>
Regulation in the Night Time Economy	<ul style="list-style-type: none"> • Havering has a vibrant night-time economy and was awarded Beacon status in 2009 • There are 585 licensed premises in Havering. 	<p>Continue with and build on existing schemes developed with the licensed trade to minimise risks associated with alcohol and the night-time economy</p> <p>Explore whether individuals identified by <i>'Banned from one, Banned from all'</i> and <i>'Yellow card'</i> schemes can be referred on to treatment services</p>
Financial Impact	<ul style="list-style-type: none"> • Havering spends £1.82million on specialist alcohol and drug services 	<p>The NTA's cost-effectiveness tool suggests that the Havering spend on community prescribing programmes is significantly higher than the national rate. An in-depth service review is required to ascertain where the costs are arising in order to improve value for money</p>

3.0 Introduction

3.1 Alcohol

Alcohol is widely used in socialisation and has an important role in both British culture and our economy. It is legal for anyone over the age of 18 to purchase alcohol, and for a child aged 5 to 16 years to drink alcohol at home or on other private premises¹. The Government's Alcohol Strategy² recognises that, in moderation, alcohol can have a beneficial effect on an individual's health and wellbeing, especially where it encourages sociability. Nonetheless alcohol causes significant harm.

The Government estimates that in a community of 100,000 people, each year²:

- 2,000 people will be admitted to hospital with an alcohol-related condition;
- 1,000 people will be a victim of alcohol-related violent crime;
- Over 400 11-15 year olds will be drinking weekly;
- Over 13,000 people will binge-drink;
- Over 21,500 people will be regularly drinking above the lower-risk levels;
- Over 3,000 will be showing some signs of alcohol dependence; and
- Over 500 will be moderately or severely dependent on alcohol.

To address this, the Government want to see an end to the availability of cheap alcohol and irresponsible drink promotions. The Government's Alcohol Strategy (2012)² is seeking industry support to change the culture around alcohol, aims to support individuals to make informed choices, and aims to improve treatment and recovery services, including services for offenders.

3.2 Drugs

Drugs are far more complex in their legality and impacts. They too cause significant harm, are often highly addictive and are frequently associated with escalating criminal behaviour³. Well known drugs such as heroin, crack cocaine, cannabis and ecstasy are clearly specified in the law as illegal and the associated harms are clearly evidenced. However, there are emerging trends in the misuse of prescription-only-medicines (POM), over-the-counter (OTC) medicines and various recreational drugs, or 'legal highs', which are as equally potentially harmful, but can currently be purchased lawfully.

The Government's National Drug's Strategy (2010)⁴ focuses on reducing demand for drugs, restricting supply and building recovery. It places an emphasis on shifting power and accountability to the local level through the introduction of Police and Crime Commissioners (PCCs), the reform of the NHS and the creation of Public Health England (PHE), as well as making it clear that individuals are responsible for their actions. The two key aims of the strategy are to reduce illicit and other

¹ Drinkaware. The Law on alcohol and under 18s. October 2013. Available on: <https://www.drinkaware.co.uk/check-the-facts/alcohol-and-the-law/the-law-on-alcohol-and-under-18s>

² HM Government (2012) *The Government's Alcohol Strategy*. London: The Stationery Office. Available on:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224075/alcohol-strategy.pdf

³ McBride, D.C. & McCoy C.B. The Drugs-Crime Relationship: an analytical framework. *The Prison Journal* 1993: 73;3; 257-278 Available on: <http://tpj.sagepub.com/content/73/3/257>

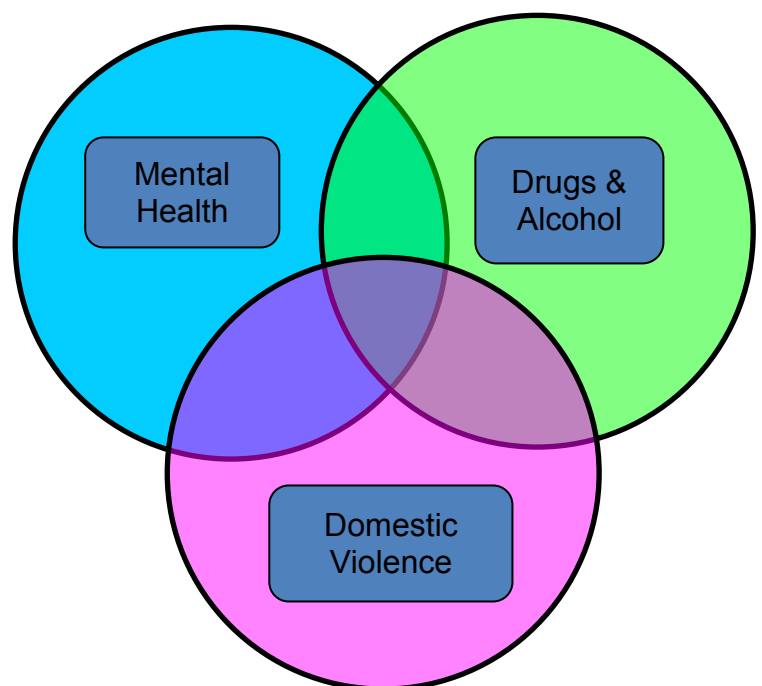
⁴ HM Government (2010). *Drug Strategy 2010: Reducing Demand, restricting supply, building recovery: Supporting people to live a drug free life*. London: HM Government. Available on: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118336/drug-strategy-2010.pdf

harmful drug use and to increase the numbers of people recovering from their dependence. To do this, the strategy encourages partnerships to develop and commission recovery focused services using a whole systems approach to support individual's holistic needs and not just their substance misuse needs, enabling them to leave treatment free from drug or alcohol dependence for good.

The pattern of drugs and alcohol use and the harms resulting are constantly changing whether it be the increasing use of novel 'legal highs' (including POM or OTC medicines) or the trend for 'preloading' with cheap alcohol at home before going out. Hence it is essential that we regularly review the needs of the population served and ensure that the response to those needs is still fit for purpose; maximising the benefit achieved within the budget available.

3.3 Toxic Trio and Troubled Families

Mental ill health, drug or alcohol abuse and domestic violence, or the 'Toxic Trio'⁵, have a complex inter-relationship that can play a significant part in families where harm to children has occurred. In nearly 75% of an in-depth sample of 40 serious case reviews examined in a recent study, the children lived in an environment where parents and carers were struggling with mental ill health and/or substance misuse and/or domestic violence^{6,7}. Parental drug use is a factor in around 29% of all serious case reviews⁷. In Havering, the number of children who are significantly harmed in these circumstances is extremely small – since 2009 six serious case reviews (SCRs) have been conducted⁸. However, the life chances of a small but significant number of children in Havering are adversely affected by one or a combination of 'toxic trio' factors.



The 'Troubled Families' initiative provides intensive support to families/households who:

- Are involved in crime and anti-social behaviour
- Have children not in school

⁵ Department of Health (2013). Health Visiting and School Nursing Programmes: supporting implementation of the new service model No.5: Domestic Violence and Abuse – Professional Guidance. Available on: https://www.google.co.uk/url?url=https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/211018/9576-TSO-Health_Visiting_Domestic_Violence_A3_Posters_WEB.pdf&rct=j&frm=1&q=&esrc=s&sa=U&ei=bsyVU-CEComk0QWWm4HIAg&ved=0CCAQFjAB&sig2=1-L7yS2VhlmOR_ftvNL4-g&usg=AFQjCNGTLFh-bNdHZq6pLQUzjkxVCL26g

⁶ Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebotham, P., Dodsworth, J. Warren, C. & Black, J. (2009). *Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-07* Department for Education, Research Report DCSF-RR129, London.

⁷ Brandon, M., Sidebotham, P., Bailey, S., Belderson, P., Hawley, C., Ellis, C. and Megson, M. (2012) *New Learning from Serious Case Reviews: a two year report for 2009-2011*. Department for Education, DFE-RR226, London.

⁸ London Borough of Havering (2014). *Havering JSNA Children and Young People Chapter* (2014). London Borough of Havering, Romford. Available on: <http://www.haveringdata.net/resource/view?resourceId=CYPPTwentyThirteenFourteen>

- Have an adult on out of work benefits
- Cause high costs to the public purse.

Focusing on the needs of the families who meet these criteria is a priority for Havering, and is central to the drug and alcohol agenda, preventing harm and increasing referrals into treatment wherever possible. Through a combination of aligning work programmes in the council, streamlining services and improving both systems and communication between discrete agencies it is envisaged that focusing on priority families will create sustainable change for children and families.

3.4 Purpose of this JSNA Chapter

This chapter of the JSNA provides decision makers in the various statutory and voluntary sector agencies involved in reducing the misuse of drugs and alcohol, and the harm resulting, with the best possible intelligence about the needs of the Havering residents.

To this end, it: -

- describes the harm caused to individuals, their families and the wider community.
- provides estimates of the number of people affected and who might benefit from effective prevention; treatment and rehabilitation.
- identifies communities and / or population groups with higher need on whom a greater proportion of services should be focused and / or different approaches should be employed
- outlines the cost to health; social care and criminal justice services
- compares the outcomes achieved in Havering with those in other areas and over time so our performance can be judged as good or bad; improving or worsening
- describes current service provision and the extent to which it matches local needs and reflects the evidence base and best practice guidance

Subsequently, recommendations are made as to how the local response can be further improved to achieve the objectives set out in: -

- The national alcohol strategy (2012)²:-
 - A change in behaviour so that people think it is not acceptable to drink in ways that could cause harm to themselves or others;
 - A reduction in the amount of alcohol-fuelled violent crime;
 - A reduction in the number of adults drinking above the NHS guidelines;
 - A reduction in the number of people “binge drinking”
 - A reduction in the number of alcohol-related deaths; and
 - A sustained reduction in both the numbers of 11-15 year olds drinking alcohol and the amounts consumed.
- The national drugs strategy (2010)⁴ *Reducing demand, restricting supply, building recovery: supporting people to live a drug free life* which seeks to reduce demand; restrict supply and support recovery for anyone who wishes a route out of dependency thereby: -
 - Reducing illicit and other harmful drug use;
 - Increasing the numbers recovering from their dependence.

This chapter starts by defining alcohol and drug misuse and outlining the scale of misuse problems in Havering.

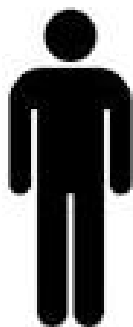
4.0 The Scale of Substance Misuse in Havering

4.1 Alcohol Misuse

4.1.1 What is Alcohol Misuse?

Current medical guidelines recommend that⁹:

Men should drink not regularly drink more than:



3 – 4 Units/day

Women should drink not regularly drink more than:



2 – 3 Units/day

In addition, it is also recommended to avoid alcohol for 48 hours, particularly after a 'heavy' drinking session, i.e. more than 3 to 4 units.

However, what constitutes a unit of alcohol is not particularly simple. Figure 4.1 shows the number of units in a range of alcoholic drinks, which is dependent on the percentage of alcohol in each drink by the volume of that drink – this is the ABV measure.

No. of Units = Strength (ABV) x Volume (ml) ÷ 1,000

	Standard glass of wine (175ml) 11.5% ABV 2 units		Large glass of wine (250ml) 12% ABV 3 units		Bottle of wine (750ml) 12% ABV 9 units
	Pint of strong lager or beer 5.3% ABV 3 units		Pint of normal strength lager or beer 3.5% ABV 2 units		Can of normal strength lager (500ml) 4% ABV 2 units
	Spirits double (50ml) 40% ABV 2 Units		Alcopop bottle (275ml) 5% ABV 1.4 units		Spirits single (25ml) 40% ABV 1 unit

Figure 4.1 Number of Units in an Alcoholic Drink¹⁰

For children, an alcohol-free childhood is recommended as the safest and healthiest option, or at the very least to delay consuming any alcoholic drink until at least 15 years old¹¹. If 15-17 year olds drink

⁹ NHS Choices (2013). *Alcohol Units* Available on: <http://www.nhs.uk/Livewell/alcohol/Pages/alcohol-units.aspx>

¹⁰ Source of image: <http://safecornwall.co.uk/what-we-do/alcohol/alcohol-units-whats-safe/>

¹¹ Draft Guidance on the Consumption of Alcohol by Children and Young People from the Chief Medical Officers of England, Wales and Northern Ireland. Available on: <http://www.google.co.uk/url?q=https://www.education.gov.uk/consultations/downloadableDocs/CMO%2520Guidance.pdf&sa=U&ei=RDELU53jBobb7AbmioGgBA&ved=0CB4QFjAA&usg=AFQjCNESXAE0eWHRSt4KIUPnkQBCz8KApA>

alcohol, it should be rarely, and never more than once a week. The main reasons for this recommendation are¹⁰:

- Early age of drinking onset is associated with an increased likelihood of developing alcohol abuse or dependence in adolescence and adulthood, and also dependence at a younger age.
- Vulnerability to alcohol abuse and dependence is greatest amongst young people who begin drinking before the age of 15.
- Children who begin drinking at a young age (typically below the age of 13) drink more frequently and in greater quantities than those who delay drinking, and are more likely to drink to intoxication.
- Initiation of drinking prior to age 14 has been shown to be associated with a number of risk factors including having experienced alcohol-related injuries, involvement in violent behaviours, suicidal thoughts and suicide attempts.
- Early onset of drinking is also associated with having more sexual partners and pregnancy, other substance abuse, employment problems and risky driving behaviours.
- Young people with alcohol use disorders may display structural and functional deficits in brain development compared with their non-alcohol using peers.
- Studies of these young people have shown that significant changes in brain structure accompany heavy drinking that can affect motivation, reasoning, interpersonal interactions and other brain functions.
- Heavy drinking during adolescence may affect normal brain functioning during adulthood.
- Young people who drink heavily may also experience adverse effects on the liver, bone, growth and endocrine development.

The law relating to children and alcohol states that¹²:

- It is illegal to give alcohol to children under 5 years of age.
- If you're 16 or under, you may be able to go into a pub or licenced premises that's primarily used to sell alcohol if you're accompanied by an adult. (However, this isn't always the case and it can depend on the premises and the licensable activities taking place there.)
- If you're 16 or 17 and accompanied by an adult, you can **drink** (but not buy) beer, wine or cider with a meal on a licenced premises.
- The police can stop, fine or arrest a person under 18 who is drinking alcohol in public.
- If you're under 18, it's against the law:
 - for someone to sell you alcohol
 - to buy or try to buy alcohol
 - for an adult to buy or try to buy alcohol for you
 - to drink alcohol in licensed premises, such as a pub or restaurant if you are not accompanied by an adult

It is illegal to give ANY alcohol to a child aged under 5 years of age

¹² NHS Choices (2013) Available on: <http://www.nhs.uk/chg/pages/2595.aspx> . Data cited from Reference 7 above.

4.1.2 How Many Adults Misuse Alcohol?

Just over 1 in 4 people (29%) in Havering drink at levels that put them at increased risk of ill health of such conditions as liver, mouth or breast cancer, pancreatitis and liver disease (see section 6.1 for further detail on the health harms of alcohol). This means that out of an adult population of around 170,000 people, just over 44,000 people drink at a level which puts them at increased risk of ill health. A further 14% of the Havering adult population (20,808 individuals) drink at a level which puts them at higher risk of serious health conditions. An estimated 15.99% of Havering's population abstain from alcohol (mid 2009 estimate)¹³.

Data from the Health Survey for England 2011¹⁴ showed that nationally:

- 86% of men and 80% of women said they had drunk alcohol in the last 12 months.
- Men and women in the youngest and oldest age groups were least likely to have drunk alcohol in the last 12 months.
- Men were also more likely than women to have drunk in the last week; 67% of men and 53% of women did so, including 18% of men and 10% of women who drank on five or more days in the week.
- 67% of men had drunk alcohol in the last week; this included 30% of men who did not exceed 4 units on any day that they drank, 17% who drank between 4 and 8 units, and 21% who drank more than 8 units on at least one day in the last week. 53% of women had drunk alcohol in the last week, including 25% who drank 3 units or less on the day drank most, 16% who had drunk between 3 and 6 units and 13% who had drunk more than 6 units.
- Among adults who had drunk alcohol in the last week, 55% of men and 53% of women drank more than the recommended daily amounts, including 31% of men and 24% of women who drank more than twice the recommended amounts. Drinking above recommended levels was highest among men aged 16-24 and women aged between 16 and 34, and lowest among men and women aged 75 and over.
- The majority of men who had drunk alcohol in the last week had drunk normal strength beer, cider or shandy (62%); a third had drunk wine (33%), and just over a fifth had drunk spirits (22%). In contrast, the majority of women had drunk wine (64%); a quarter had drunk spirits (26%), and a fifth had drunk normal strength beer, cider or shandy (19%).
- The proportions who drank fortified wines and alcopops were each very small, but consumption of these was concentrated in particular age groups: those aged 75 and over for fortified wine, and those aged 16-24 for alcopops.
- Assessment of average weekly alcohol consumption showed that 62% of men usually drank up to 21 units a week and 61% of women usually drank up to 14 units a week, the level of drinking defined as lower risk.
- Almost a quarter of men drank more than 21 units a week, at an increased risk level (24%), including 5% who drank more than 50 units (higher risk). Among women, 18% usually drank

¹³ Local Alcohol Profiles for England (LAPE) (2014). Local Authority Alcohol Indicators, 2014 Update. Mid 2009 synthetic estimate of the percentage within the total population aged 16 years and over who report in abstaining from drinking. Available on: http://www.lape.org.uk/downloads/LAPE_LA_Dataset_PHE_250414_FINAL.xlsx

¹⁴ Fuller, E. (2013) Chapter 6 – Alcohol Consumption. In: Craig, R. & Mindell (J. (Eds). *Health Survey for England 2012*. London: Health and Social Care Information Centre (HSCIC). Available on: <http://healthsurvey.hscic.gov.uk/support-guidance/public-health/health-survey-for-england/alcohol-consumption.aspx>

more than 14 units a week (increased risk), including 4% who drank more than 35 units (higher risk).

Figure 4.2 outlines the commonly used definitions for describing when consumption of alcohol becomes a problem and the corresponding number of people this equates to in Havering and England¹⁵.

Figure 4.2 Numbers of Higher, Increasing and Low Risk Drinkers in Havering¹⁶

Risk Level	Higher Risk Drinkers	Increasing Risk Drinkers	Low Risk Drinkers
Definition	<p>Drink at very heavy levels which significantly increases the risk of damaging their health and may have already caused some harm to their health.</p> <p>Men who regularly drink over 8 units per day and women who regularly drink over 6 units per day. Higher risk drinkers will have a higher alcohol tolerance, which may make them especially vulnerable to alcohol dependency.</p>	<p>Drink above the recommended levels which increases the risk of damaging their health.</p> <p>Men who regularly drink over 3 to 4 units per day and women who regularly drink over 2 to 3 units per day.</p>	<p>Drink within the recommended alcohol guidelines.</p> <p>Men who regularly drink no more than 3 to 4 units per day and women who regularly drink no more than 2 to 3 units per day.</p>
Havering	20,808 (14%)	44,292 (29%)	88,840 (58%)
England	2.6 million	7.4 million	25.9 million

Although somewhat confusing, an alternative (and sometimes interchangeable) set of definitions is also used to describe people drinking at levels which may harm their health. Figure 4.3 outlines the definitions for *hazardous*, *harmful* and *dependent* drinkers. Dependence on alcohol can be further subdivided into mild, moderate or severe dependency¹⁷. However, for the purposes of this chapter, the overall estimated number of dependent drinkers are stated in their total numbers, not further divided.

In Havering there are an estimated 3,316 dependent drinkers¹⁸



¹⁵ NICE (2011), Alcohol use disorders: the NICE guideline on diagnosis, assessment and management of harmful drinking and alcohol dependence. London, NICE. p11. Available on:

<http://www.nice.org.uk/nicemedia/live/13337/53190/53190.pdf>

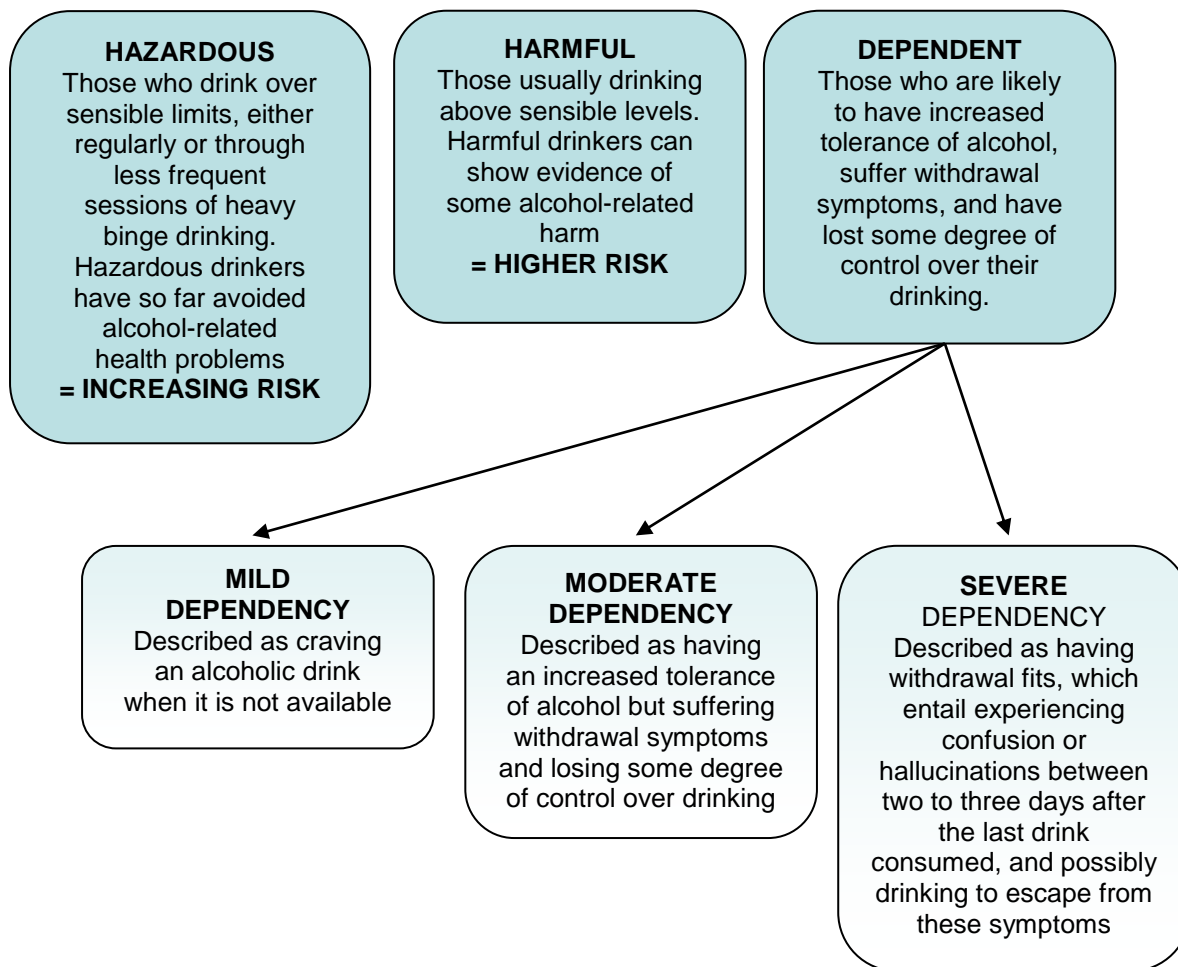
¹⁶ Alcohol Concern (2013). Available on: <http://www.alcoholconcern.org.uk/campaign/alcohol-harm-map>

¹⁷ 2020 Health (2011), From One to Many: The risks of frequent excessive drinking, p9. Available on:

<http://www.2020health.org/2020health/Publications/Publications-2011/From-one-to-many.html> Cited in Alcohol Concern Campaign Map⁸.

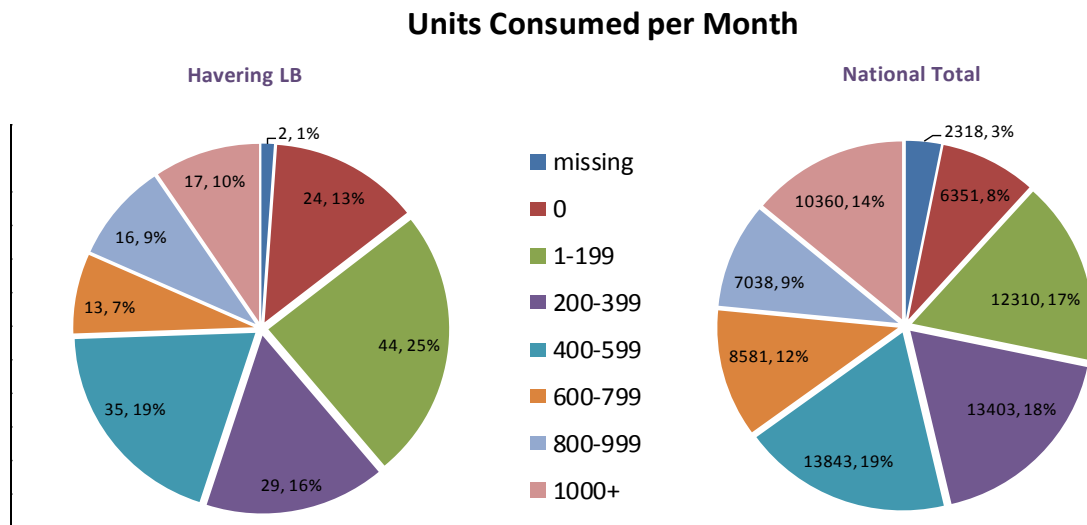
¹⁸ NTA (2012). *JSNA Support Pack for Strategic Partners. The data for alcohol*. London Borough of Havering. London: National Treatment Agency for Substance Misuse (now Public Health England).

Figure 4.3 Definition of Hazardous, Harmful and Dependent Drinking



One indication of the level of alcohol misuse in the borough is the number of units of alcohol consumed per month at the start of alcohol treatment. In Havering, new patients starting alcohol treatment were skewed towards lower volumes of alcohol consumption on presentation compared with the national average (Fig. 4.4). Around one quarter (25%) of new patients consumed up to 199 units in the last month compared with 17% nationally. At the other end of the spectrum, Havering had fewer clients than the national figure for consumption of exceedingly high units consumed – 10% of new patients consumed 1000 units or more in the last month compared with 14% nationally.

Figure 4.4 Pie Chart Showing Comparison between Havering and National Average Profiles of New Alcohol Treatment Journeys Grouped by Alcohol Intake.



4.1.3 How Many Children and Young People Drink Alcohol?

The health risks of excessive and prolonged use of alcohol usually begin in adolescence. The *Smoking, drinking and drug use among young people in England in 2012* survey¹⁹ is the latest in a series designed to monitor smoking, drinking and drug use among secondary school pupils across England aged 11 to 15 years. Data from this 2012 survey (published in 2013), in which over 7,500 children responded, showed that 43% of pupils had ever had an alcohol drink.

Key findings from the **national** survey are:

- 43% of pupils said that they had drunk alcohol at least once. This continues the downward trend since 2003, when 61% of pupils had drunk alcohol.
- Boys and girls were equally likely to have drunk alcohol.
- The proportion of pupils who had drunk alcohol increased with age from 12% of 11 year olds to 74% of 15 year olds.
- 10% of pupils had drunk alcohol in the last week. The prevalence of recent drinking has reduced significantly since 2003, when 26% of pupils had drunk in the last week, and is lower than in 2011 (12%). Similar proportions of boys and girls had drunk alcohol in the last week. The proportion increased with age from 1% of 11 year olds to 25% of 15 year olds.
- Pupils who had drunk in the last week had drunk an average (mean) of 12.5 units. Median consumption – which gives a more representative indication of how much pupils drink – was lower (8.0 units).
- Most pupils who had drunk alcohol in the last week had consumed more than one type of drink. Compared with boys, girls were less likely to have drunk beer, lager or cider, and more likely to have drunk, spirits, alcopops or wine. Both boys and girls consumed the majority of their alcohol intake in the form of beer, lager or cider.

¹⁹ Fuller, E. (ed) (2013) *Smoking, Drinking and Drug Use Among Young People in England in 2013*. London: Health and Social Care Information Centre (HSCIC). Available on: <http://www.hscic.gov.uk/catalogue/PUB11334/smok-drin-drug-young-peop-eng-2012-repo.pdf>

- 33% of pupils said that they had obtained alcohol in the last week. This continues the downward trend since 2004 when 49% said they had obtained alcohol in the last week. The most common ways of obtaining alcohol were to be given it by parents (19%), given it by friends (19%), to ask someone else to buy it (13%), or to take it from home (13%).
- Under half of pupils who drank alcohol (44%) said they bought it. Pupils who had bought alcohol had usually done so from friends (53%), someone other than family or friends (34%), off-licences (32%) or shops or supermarkets (24%).
- Pupils who drank alcohol were most likely to do so in their own home (54%), someone else's home (48%), at parties with friends (47%), or somewhere outside (18%). Since 2006, there has been an increase in the proportions who usually drink at home or in other people's homes or at parties with friends, and a reduction in the proportion drinking outside.
- Pupils were most likely to drink with friends of both sexes (57% of current drinkers), their parents (53%), brothers, sisters or other relatives (37%) or friends of the same sex (37%). Younger pupils were most likely to drink with family members, older pupils were most likely to drink with friends.
- Half (50%) of pupils who had drunk alcohol in the last four weeks said that they had been drunk at least once during that time. Although 61% said that they had deliberately tried to get drunk, 39% said they had not.
- Pupils are more likely to drink if they live with other people who drink alcohol. 83% who lived with no one who drank alcohol had never drunk alcohol, compared with 30% of pupils who lived with three or more drinkers.
- About half (52%) of pupils thought their parents didn't like them drinking, slightly more than the proportion who said their parents didn't mind as long as they didn't drink too much (47%). Few pupils (1%) said their parents let them drink as much as they liked. There was a strong relationship between pupils' drinking behaviour and their parents' attitudes to their drinking. 87% of pupils who felt their parents would disapprove of their drinking had never drunk alcohol, compared with 28% who thought their parents wouldn't mind as long as they didn't drink too much.
- There has been a fall in recent years in the proportion of pupils who think that drinking is acceptable for someone of their age. In 2012, 28% thought it was OK for someone of their age to drink once a week compared with 46% in 2003.
- Pupils were most likely to think that people of their age drink to look cool in front of their friends (77%), because it gives them a rush or buzz (68%), to be more sociable with friends (66%) or because their friends pressure them into it (61%).
- Pupils' beliefs about why people of their age drink alcohol vary according to whether or not they have drunk alcohol themselves.
- Pupils who had never drunk alcohol were more likely than those who had to think that people of their age drink because of social pressures: to look cool in front of their friends or because their friends pressure them into it.
- Pupils who have drunk alcohol are more likely than non-drinkers to believe that people their age drink to be sociable with friends or because it gives them a rush or buzz.

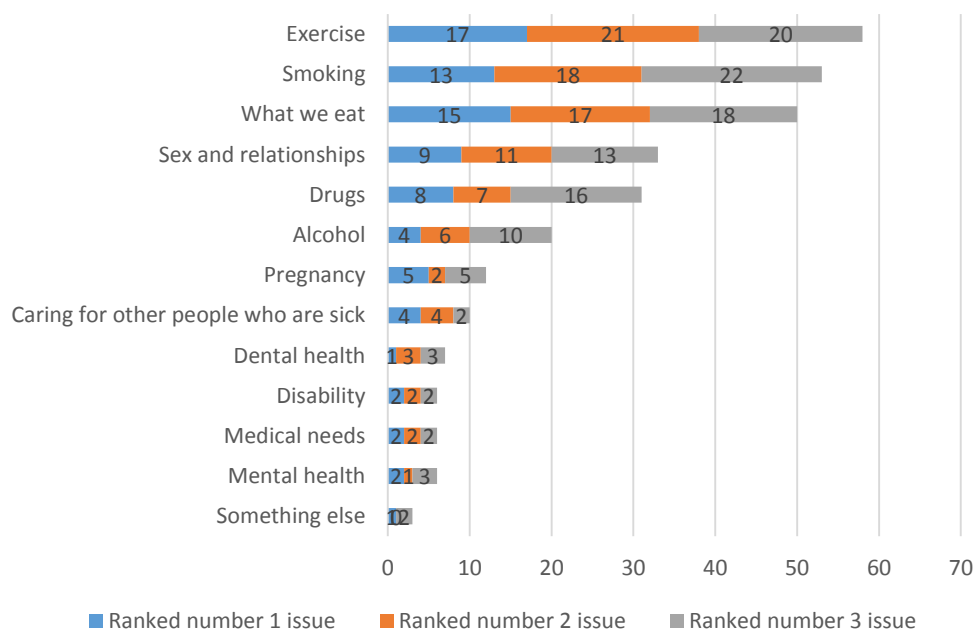
The latest data available to compare the percentage of young people who have ever had an alcohol drink in Havering with national figures is 2009. According to the Tell Us 4 survey in 2009, 45% of pupils answering the survey in Havering had drunk an alcoholic drink compared to 42% nationally, and 7% in Havering had been drunk once in the last month compared to 6% nationally²⁰. There are no further local prevalence figures for Havering, as the Tell Us Survey was ceased in 2009, so we can only use national prevalence estimates for 2010 onwards.

In 2009, the Tell Us 4 Survey showed 42% of young people aged 11-15 years nationally have ever had alcohol compared with 45% in Havering

In Havering, concern about both alcohol and drugs (prevalence of drug misuse is covered specifically in section 4.2.3) features highly in both adults and children’s perceptions as to what health issues are important. As part of a local survey of children resident and/or attending school in Havering, 108 children and young people²¹ responded to the question ‘what are the 3 most important health issues for young people in Havering’. ‘Exercise’ was the most commonly cited response, with drugs ranked 5th and alcohol ranked 6th in the list (Fig. 4.5). The same question was asked in a parallel survey of adults and of the 73 respondents, ‘what they eat’ was the top response, followed by ‘exercise’ with alcohol and drugs taking 4th and 5th places (Fig 4.6)²². Drugs were of relatively higher importance to young people than alcohol, whilst parents placed alcohol higher than drugs.

Figure 4.5 Young People’s Perceptions of 3 Most Important Health Issues in Havering

Young people: what are the 3 most important health issues for children and young people in Havering? (108 responses)



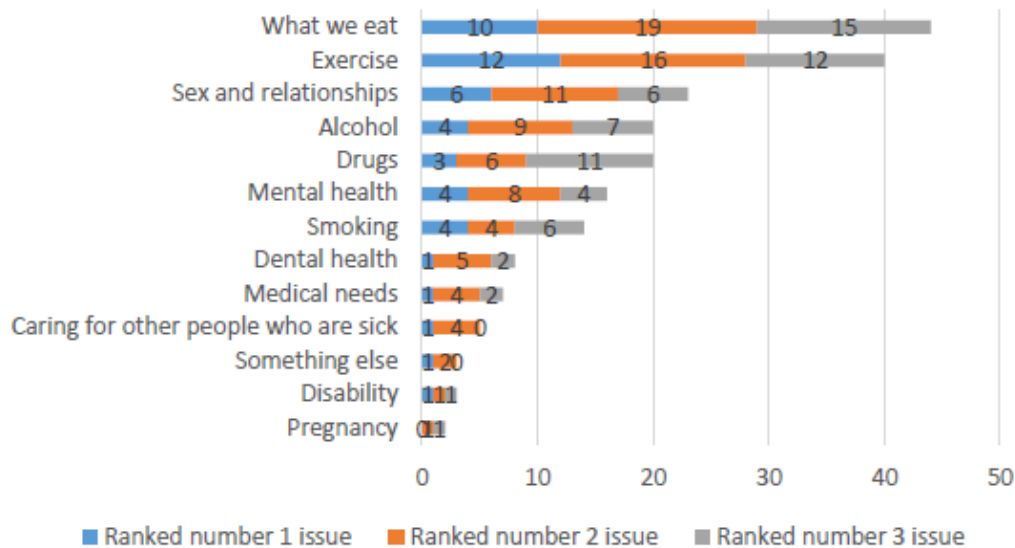
²⁰ Tell Us 4 Survey, Department for Schools, Education and Families, 2009. Cited in Havering JSNA 2010. Available on: <http://www.haveringdata.net/resource/view?resourceId=JSNAfulldocument>

²¹ Note that this is a very small sample size, and should therefore be treated with caution

²² Havering JSNA Children and Young People Chapter (2014). London Borough of Havering, Romford. Available on: <http://www.haveringdata.net/resource/view?resourceId=CYPPTwentyThirteenFourteen>

Figure 4.6 Adult's Perceptions of 3 Most Important Health Issues for Children in Havering

Adults: what are the 3 most important health issues for young people in Havering? (73 responses)

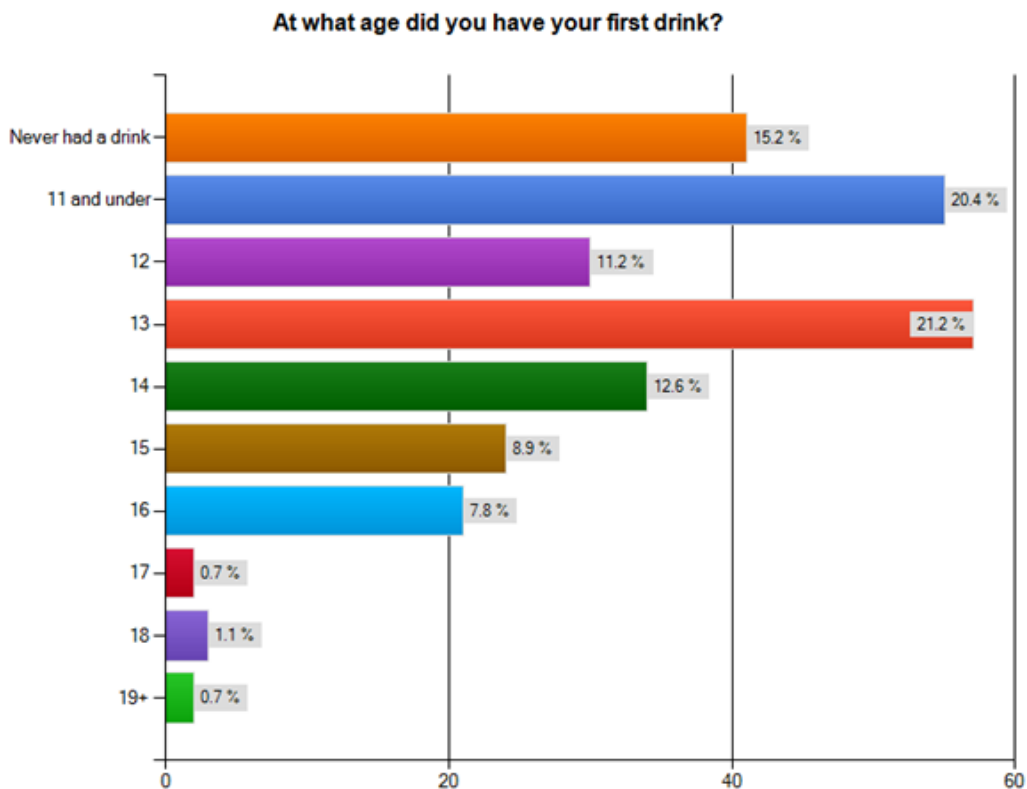


The Young People's Survey 2013, conducted by Young Addaction (the children and young people's local service provider) on behalf of Havering Council, collected the views on young people aged 13-19 years on Smoking, Drug and Alcohol use²³. The age distribution for respondents to this local survey was not heavily skewed to those who could legally purchase or drink alcohol – 25.1% of respondents were aged 18 or 19 years; 44.3% were aged 16 or 17 years and 30.6% were aged 12 to 15 years. However, out of 269 responses to the question of what age they were when they had their first alcohol drink, nearly 75% were aged 15 or under when they had their first alcoholic drink, and only 15% stated they had never had an alcoholic drink (Fig 4.7).

75% of Havering Young People were aged 15 or under when they had their first alcoholic drink. (2013 local Young Addaction survey of 13-19 year olds)

²³ Young Addaction (2013). *Drugs, Alcohol and Tobacco Use. The Young People's Survey 2013*. Romford, London Borough of Havering.

Figure 4.7 Age at which a young person in Havering had an alcoholic drink (n = 269)

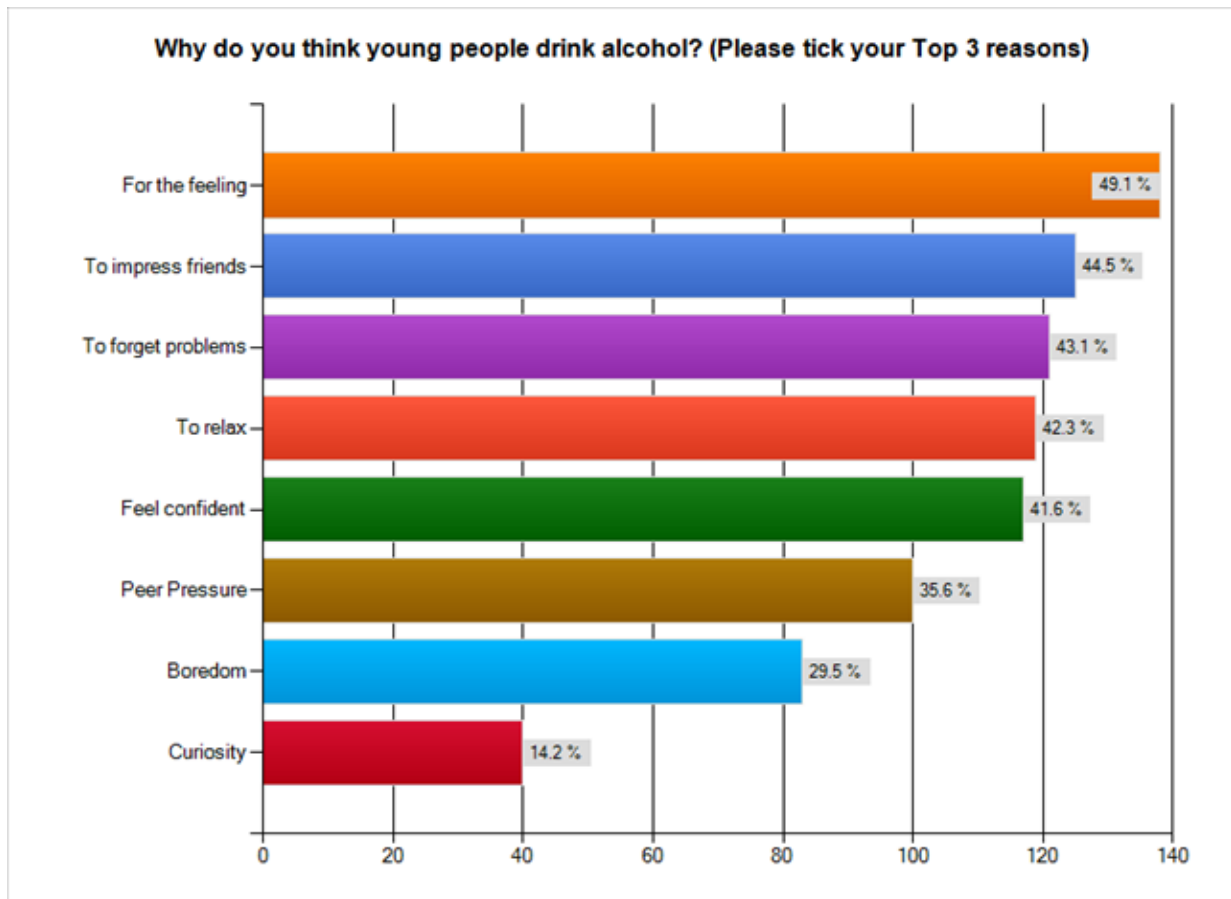


The key results from this 2013 survey amongst 13-19 year olds were:

- Of those who currently drank alcohol (224 young people)
 - 38.4% had a drink in the last week
 - 20.5% in the last 24 hours
 - 23.2% felt drunk in the last week
 - 10.7% felt drunk in the last 24 hours
- 63.4% found it very or fairly easy to purchase alcohol
- Of those who stated they buy alcohol (161 young people)
 - 25.5% bought from an off-licence
 - 21.1% bought from a supermarket
 - 13% bought from a pub or club
- Out of 217 people who said they drank alcohol (respondents were asked to pick their top 2 options)
 - 69.7% drank with a mixed group of friends,
 - 30.9% drank with friends of the same sex,
 - 29% drank with their parents
- Vodka was the most popular drink, with 26.7% of respondents saying this was their preferred alcohol drink, closely followed by Cider (19.8%) and Lager/Beer (19.4%)
- 53.3% said their parents didn't mind them drinking, as long as they didn't drink too much, compared with 8.4% who said their parents didn't like them drinking
- 10.4% hid their drinking from their parents
- 94.4% of the 214 respondents who drank alcohol said they did NOT want support to reduce their drinking

The reason people give for drinking alcohol varies with age. The 2013 Young People’s survey showed that out of 281 respondents, the top answer (49.1%) for why **young people** drink alcohol is ‘For the feeling’ followed closely by ‘To impress friends’ (Fig. 4.8). However, the number one reason *adults* give for drinking alcohol is socialisation, closely followed by liking the taste, then to relax or feel at ease. Drinking to get a ‘buzz’ or simply to ‘get drunk’ are often at the bottom of the list of reasons for adults.

Figure 4.8 Reasons Given for why Young People Drink Alcohol (n = 281)



4.1.4 Parental Alcohol Misuse

The number of children who are affected by/living with parental alcohol misuse at a local and national level is largely unknown. Data on rates of drinking during pregnancy are commonly based on self-reporting and therefore often unreliable as a result of poor estimation, poor recollection and the social stigma associated with heavy drinking during pregnancy. Maternal alcohol consumption levels are therefore often significantly underestimated. However, estimates suggest parental alcohol misuse is far more prevalent than parental drug misuse. Manning et al (2009)²⁴ carried out secondary analysis of five UK national household surveys. From this, they estimate that:

²⁴ Manning, V., Best, D., Faulkner, N & Titherington, E. (2009). New estimates of the number of children living with substance misusing parents: results from UK national household surveys. *BMC Public Health* 9: 377. Available on: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2762991/pdf/1471-2458-9-377.pdf>

- In 2004, around 30% of children under-16 years in the UK lived with at least one binge drinking parent, 8% with at least two binge drinkers and 4% with a lone (binge drinking) parent²⁵.
- In 2000, 22% lived with a hazardous drinker²⁶ and 6% with a dependent drinker²⁷.

Data from the JSNA Support Pack²⁸ shows that just under half of the adults in treatment for alcohol problems who have contact with children are living with them (Fig. 4.9). For those who do not live with their children, their problems with alcohol misuse nonetheless pose a significant safeguarding risk to these children.

Figure 4.9 Number of Adults Receiving Alcohol Treatment who are in Contact with Children

	Havering		England	
	Number (n)	%	Number (n)	%
Living with Children	77	45%	32,113	52%
Parents but not living with children	89	52%	27,197	44%
Incomplete data	<5	N/A	2,517	4%

As at October 2013, there were 331 children in Havering living in homes where there is a parent/carer known to be engaging in drug/alcohol treatment. In total, 157 parents were receiving drug / alcohol services from our main drug and alcohol service and a further 64 parents were receiving a specialist prescribing service²⁹.

4.2 Drug Misuse

4.2.1 The Law on Drugs

Unlike alcohol, which for the most part is legal for adults, and illegal to sell to anyone aged under 18 years, or to sell to someone already drunk, the law on drugs is more complex. Under the Misuse of Drugs Act 1971, drugs are categorised into three classes, A,B or C, broadly based on the degree of harm they cause to the individual user, or to society when they are misused (Fig. 4.10)³⁰. Class A are the most harmful.

²⁵ Binge drinking at least once in the week before interview and measured as per the UK Government definition (i.e. 6 or more units in a single drinking occasion for women and 8 or more units for men)

²⁶ Hazardous drinking: a pattern that increases the risk of harmful consequences to the user or others

²⁷ Identified using the Severity of Alcohol Dependence Questionnaire

²⁸ Public Health England (2013). *Alcohol and Drugs: JSNA Support Pack. Key data to support planning for effective alcohol prevention, treatment and recovery. The data for Havering*. London: Public Health England.

²⁹ Havering JSNA *Children and Young People Chapter* (2014). London Borough of Havering, Romford. Available on:

<http://www.haveringdata.net/resource/view?resourceId=CYPTwentyThirteenFourteen>

³⁰ UK Government (2014). *Drugs Penalties*. Available on: <https://www.gov.uk/penalties-drug-possession-dealing>

Key issues relating to the law are^{29,31}:

- It is an offence to:
 - unlawfully possess a controlled drug
 - possess a controlled drug with intent to supply it
 - unlawfully supply (sell, give, share) a controlled drug
 - allow premises you occupy or manage to be used for the smoking or use of drugs
- It is also illegal to give or share drugs amongst friends (this is considered as supplying) and it is illegal to consume drugs at home or allow anyone to use drugs in your home
- A person may be charged with possessing an illegal substance if they are caught with drugs, whether they're theirs or not.
- The police are allowed to tell the parent(s)/guardian(s)/carer(s) of a person under 18 years old if they have been caught with drugs
- The penalty will depend on:
 - the class and quantity of drug
 - where you and the drugs were found
 - your personal history (previous crimes, including any previous drug offences)
 - other aggravating or mitigating factors
- It is an offence to drive a motor vehicle whilst impaired through the use of drugs.
- Causing death by dangerous driving whilst under the influence of drink or drugs will result in a maximum 14-year jail sentence and a minimum 2-year driving ban.
- The legal penalties for 'drug rape' - where a person was raped, sexually assaulted or sexually coerced after being drugged or while under the influence of drugs - are the same as for any other kind of rape. A conviction for rape can mean up to life imprisonment.

Figure 4.10 Classes of Drugs and Penalties for Possession/Supply

Class	Drugs	Penalty for Possession	Penalty for Supply and Production
A	Powder Cocaine Crack Cocaine Ecstasy (MDMA) LSD Magic Mushrooms Heroin Methadone Methamphetamine (Crystal meth)	Up to 7 years in prison, an unlimited fine, or both.	Up to life in prison, an unlimited fine, or both.
B	Amphetamines Barbiturates Cannabis Codeine Ketamine Methylphenidate (Ritalin) Synthetic cannabinoids Synthetic cathinones (e.g. Mephedrone (a New Psychoactive	Up to 5 years in prison, an unlimited fine, or both. Police can issue a warning or an on-the-spot fine of £90 if you're found with cannabis.	Up to 14 years in prison, an unlimited fine, or both.

³¹ Know the Score (2014). *Drugs & the Law*. Available on: <http://knowthescore.info/drugs-facts/drugs-and-the-law>

Class	Drugs	Penalty for Possession	Penalty for Supply and Production
	Substance NSP) or methoxetamine)		
C	Anabolic Steroids Benzodiazepines (Diazepam) Benzylpiperazine (BZP) Gamma-Hydroxybutyric Acid (GHB) Gamma-Butyrolactone (GBL)	Up to 2 years in prison, an unlimited fine, or both (except anabolic steroids – it's not an offence to possess them for personal use).	Up to 14 years in prison, an unlimited fine, or both.
Temporary Class Drugs*	NBOMe (“N-bombs”) and Benzofuran compounds	None, but the police can take away a suspected temporary class drug	Up to 14 years in prison, an unlimited fine, or both.

*The government can ban new drugs for 1 year under a ‘temporary banning order’ while they decide how the drugs should be classified

Over the past few years, there has been an increase in the use and availability of new psychoactive substances (NPS). Although sometimes referred to as ‘legal highs’, they frequently contain substances that are not legal, and cannot be assumed to be safe. They are substances designed to produce the same, or similar effects, to drugs such as cocaine and ecstasy, but are structurally different enough to avoid being controlled under the Misuse of Drugs Act. ‘Legal highs’ cannot be sold for human consumption so they are often sold under the names of bath salts, research chemicals, plant food or advertised as ‘not for human consumption’ to get round the law. Legal highs are potentially a ‘gateway drug’ to other drug misuse, and their impact on particularly young people and the wider community needs to be considered.



The use of ‘legal highs’ includes an emerging trend for nitrous oxide as a party drug’. Although the use of nitrous oxide is not in itself illegal, it is illegal to sell to anyone under 18 if you believe they are going to inhale it. When inhaled, nitrous oxide can cause feelings of euphoria, dizziness and hallucinations and is becoming popular in bars and nightclubs as a ‘party drug’. Home Office Statistics for the 2012-13 Crime Survey showed that 6.1% of 16-24 year olds had taken nitrous oxide in the last year, and 2% of adults aged 16-59³². Just recently the council has reported a visible presence of cannisters and balloons being collected with street litter.

Emerging trends:
NO = Nitrous Oxide or Laughing Gas; 6.1% 16-24 year olds, 2% adults 16-59 have taken NO in the last year

³² Home Office (2013) *Drug Misuse: Findings from the 2012 to 2013 Crime Survey for England and Wales*. London: Home Office. Available on: <https://www.gov.uk/government/publications/drug-misuse-findings-from-the-2012-to-2013-csew/drug-misuse-findings-from-the-2012-to-2013-crime-survey-for-england-and-wales>

Over-the-Counter (OTC) and Prescription Only Medicines (POM) are another emerging trend, but there is unfortunately a lack of reliable local data – as a proxy measure, the number of clients entering treatment citing OTC or POM drugs as their drug of use is given in section 4.2.2 below. The following gives a definition of OTC and POM medication³³.

- Over-the-Counter (OTC) drugs can be sold directly to the customer without a prescription. Some OTC drugs are addictive nature, which if taken regularly over long periods can produce a physical dependence that will result in withdrawal symptoms if ceased. This particularly includes Codeine based analgesics such as³⁴:
 - Ibuprofen and Codeine (e.g. Nurofen Plus) and Paracetamol and Codeine (e.g. Solpadeine).
 - Some cough medicines (some types of Benylin) also contain Codeine
- Prescription Only Medication (POM), are drugs which are legally available only with a valid prescription from a prescriber and include most antibiotics and all antidepressants or antidiabetic medications. A pharmacist has to be on the premises for POM medicines to be dispensed, required by law. The medicine has been specifically prescribed for the patient holding the prescription, so it is considered safe for *only* the recipient to take. Drugs included as POM are high-strength painkillers such as Oxycodone and Tramadol, medications such as Sildenafil (Viagra) and Diazepam (Valium), and certain topical preparations such as corticosteroids. These medicines are often sold by drug dealers, especially those marked as "CD POM," (Controlled Drug, Prescription Only Medicine) which are controlled due to abuse risk such as Diconal, Temazepam, and Methadone.

4.2.2 The Prevalence of Adult Drug Misuse

According to the Crime Survey for England and Wales 2012-13³⁵, just over one third (35.9%) of adults aged 16 – 59 years and 36.7% of young people aged 16-25 years old have taken an illegal drug in their lifetime.

In Havering specifically, there are an **estimated** 852 Opiate and Crack Users (OCUs)³⁶. These prevalence estimates are based on statistical modelling of the numbers of users of each drug identified from the known drug-using population and underlying general population, also known as the Glasgow model. The models used a capture-recapture approach and multiple indicator model³⁷. Figure

35.9% of all adults aged 16-59 years and 36.7% of 16-25 year olds nationally have taken an illegal drug in their lifetime
(Crime Survey for England and Wales 2012-13)

³³ Wikipedia (2014). *Over-the-counter drug*. Available on: http://en.wikipedia.org/wiki/Over-the-counter_drug

³⁴ Action on Addiction (no date given). *Prescription / Over-the-Counter Drugs*. Available on: <http://www.actiononaddiction.org.uk/Treatment/About-Addiction/Prescription-Over-the-Counter-Drugs.aspx>

³⁵ Home Office (2013) *Drug Misuse: Findings from the 2012 to 2013 Crime Survey for England and Wales*. London: Home Office. Available on: <https://www.gov.uk/government/publications/drug-misuse-findings-from-the-2012-to-2013-csew/drug-misuse-findings-from-the-2012-to-2013-crime-survey-for-england-and-wales>

³⁶ Hay, G., Rael dos Santos, A., Worsley, J. (2014). *Estimates of the prevalence of opiate use and/or crack cocaine use (2011/12)* Liverpool John Moores University, Glasgow Prevalence Estimation Ltd., distributed directly to commissioners by Public Health England. Available on: <http://www.nta.nhs.uk/Estimates-of-the-Prevalence-of-Opiate-Use-and-or-Crack-Cocaine-Use-2011-12.aspx>

³⁷ Hay, G., Gannon, M., Casey, J. & Millar, T. (2011). *Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2009/10: Sweep 6 report*. Glasgow, Centre for Drug Misuse Research and Manchester, National Drug Evidence Centre.

4.11 outlines the estimated prevalence of adult (aged 15-64 years) drug users in Havering compared with England. Estimated Opiate and Crack use in Havering appears to be higher in younger adults. The rate for OCUs is highest amongst 25-34 year olds in Havering (7.70 per 1,000 population), compared with 5.41 per 1,000 in 15-24 year olds and 4.91 per 1,000 population amongst 35-64 year olds³⁸.

There are an estimated 852 Opiate and Crack Users (OCUs) in Havering

(PHE Prevalence Estimates 2014)



Figure 4.11 Prevalence of Drug Users in Havering

15-64 Years	Havering		National (England)	
	Number	Rate per 1,000	Number	Rate per 1,000
Opiate and Crack Users (OCUs)	852	5.54	293,879	8.40
Opiate only	712	4.63	256,163	7.32
Crack only	693	4.51	166,640	4.76
Injecting Users	206	1.34	87,302	2.49

Data from the Crime Survey for England and Wales (CSEW) (Fig. 4.12) show the percentages of illegal drug use amongst adults aged 16-59 years in 2012-13³⁹. In particular, young adults aged 16-24 were more likely to have taken drugs in the last year than older adults, and so a separate analysis is given for this age group. If these percentages are applied directly to the Havering population, (as the age profile for Havering is roughly similar to that of England as a whole), a **rough estimate** can be made for the number of users of each drug in these age ranges. These estimates are higher than the calculated estimate for prevalence used above, as they are based on age profiles only, not including direct evidence from the known drug-using population.

Please note – the Glasgow model estimates cited in figure 4.11 should be used by commissioners to plan their services as this represents a highly sophisticated modelling technique, providing the most accurate proxy for service demand as it bases its calculations on the known drug using population . The rough estimates provided in Figure 4.12 below is based on responses to the Crime Survey for England and Wales, and is intended to be representative of the 16-59 year old general population. Therefore, the rough estimates shown in Fig. 4.12 are much higher than the modelled estimates created by the Glasgow Prevalence Estimates.

³⁸ <http://www.nta.nhs.uk/Prevalence-estimates-2011-12.aspx>

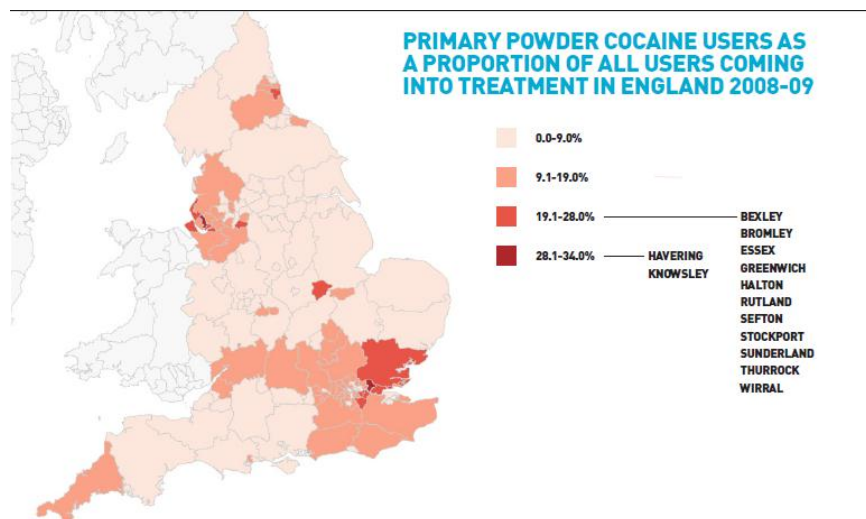
³⁹ Home Office (2013) *Drug Misuse: Findings from the 2012 to 2013 Crime Survey for England and Wales*. London: Home Office. Available on: <https://www.gov.uk/government/publications/drug-misuse-findings-from-the-2012-to-2013-csew/drug-misuse-findings-from-the-2012-to-2013-crime-survey-for-england-and-wales>

Figure 4.12 National Percentages of Illicit Drug Use Applied to Havering Population

Drug	Adults aged 16-59		Young people aged 16-24	
	National %	Havering Estimate (137,099 total)	National %	Havering Estimate (27,407 total)
Any illicit drug (excl. mephedrone)	8.2%	11,242	16.3%	4,467
Class A drug	2.6%	3,565	4.8%	1,316
Cannabis	6.4%	8,774	13.5%	3,700
Powder Cocaine	1.9%	2,605	3.0%	822
Ecstasy	1.3%	1,782	2.9%	795
Mephedrone	0.5%	685	1.6%	439
Ketamine	0.4%	548	0.8%	219

Of particular importance for Havering is the prevalence of powder cocaine. Data from the 2012-13 Crime Survey for England and Wales shows that powder cocaine is the second most commonly used drug (1.9%) by 16-59 year olds after cannabis (6.4%)⁴⁰. Powder cocaine use peaks among 25-29 year olds (4.4%) according to this survey. Havering in particular has very high levels of powder cocaine use. The most recent national study found the borough to have the highest proportion of powder cocaine users entering treatment in the country, as shown in Figure 4.13⁴¹. Whilst it is good that powder cocaine users are entering treatment, it is nevertheless far more beneficial to prevent them from taking up the habit in the first place.

Figure 4.13 Primary Powder Cocaine Users as a Proportion of all Users Entering Treatment in 2008/09



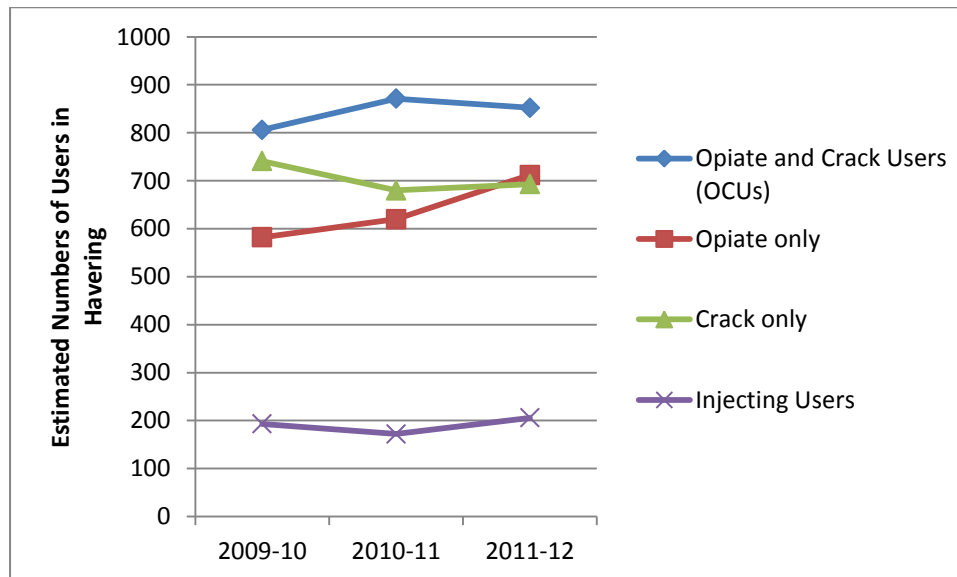
4.4% of 25-29 year-olds have taken powder cocaine

⁴⁰ Home Office, July 2013. *Drug Misuse: Findings from the 2012 to 2013 Crime Survey for England and Wales*. London: Home Office. Available on: <https://www.gov.uk/government/publications/drug-misuse-findings-from-the-2012-to-2013-csew/drug-misuse-findings-from-the-2012-to-2013-crime-survey-for-england-and-wales>

⁴¹ Powder Cocaine: *How the treatment system is responding to a growing problem*, NTA, 2010. Available on: www.nta.nhs.uk/uploads/ntapowdercocaine1march2010d.pdf

In line with the rest of England and Wales, heroin use in Havering is seen to be declining, if the numbers in treatment are viewed as an indicator (NDTMS Annual report, 2013⁴²; Havering Recovery Diagnostic Tool – Opiates, 2013). The national and local prevalence estimates published in April 2014 show a slight reduction in the estimated prevalence of Opiate and Crack Users (OCUs) in Havering from 2010-11 to 2011-12 (Fig 4.14)⁴³. However, these prevalence estimates also show a slight increase in the numbers of opiate only users, crack only and injecting users. The trend should be viewed with caution, however, as only 3 years' worth of data are used.

Figure 4.14 Change in Estimated Prevalence of Opiate and Crack Use(OCU), Opiate only, Crack only and Injecting Users from 2009-10 to 2011-12 in Havering



For cannabis, unfortunately we can only base prevalence estimates on extrapolations from national synthetic estimates; therefore the penetration figure is not robust. The Crime Survey of England and Wales puts national use of cannabis in the last month (at the time of the survey) for males and females aged 16-59 at 3.9%. The difficulty is the discrepancy between national and local prevalence, and the difference between recreational and problematic use.

Of the 520 clients in drug treatment in Havering in 2011/12, 11.5% cited problematic use of prescription only medicines (POM) or over-the-counter medicines (OTC), slightly lower than the London average (12.6%). Only 0.2% reported no additional illicit drug use, considerably lower than the London average (1.6%). This is interesting as it is (jointly with Slough) a lower rate than any other Drug and Alcohol Action Team (DAAT) area in England, except Rutland. DAAT teams are local teams set up within health organisations or local authorities specifically to commission and co-ordinate high quality drug and alcohol treatment programmes. Whilst it is conceivable that problematic use of POM/OTC drugs is very rare in Havering, it is important to urgently increase our understanding of local needs pertaining to these drug types, and developing services and pathways to meet those

⁴² Drug Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2012 to 31 March 2013: Public Health England

⁴³ Hay, G., Rael dos Santos, A., Worsley, J. (2014). *Estimates of the prevalence of opiate use and/or crack cocaine use (2011/12)* Liverpool John Moores University, Glasgow Prevalence Estimation Ltd., distributed by Public Health England.

needs. Of those clients citing use of POM/OTC drugs within the treatment services provided in Havering, all were prescription benzodiazepines and opioids.

Image enhancing and performance enhancing drugs are also increasing, particularly the use of steroids in gyms. Classified as a class C drug under the Misuse of Drugs Act (1971), steroids are to be sold by a pharmacist only with a doctor's prescription. It is legal to possess or import steroids for personal use only. However, injecting steroids (usually directly into muscle) carries its own risks, particularly from Human Immunodeficiency Virus (HIV), Hepatitis C and other infections, if dirty needles are used or needles shared. A recent report on BBC news highlighted that one specialist drug treatment provider, CRI, who also provide our services locally, as seen a 645% increase in the number of people accessing needle exchange schemes for steroid use, from 290 in 2010 to 2,161 in 2013⁴⁴.

In Havering, the exact numbers of needle packs given to steroid users needs investigating further, but early indications are that around 40% of just over 3500 needle exchange packs given out at fixed site needle exchanges may be for steroid use. However, as there is no specific treatment pathway for steroid users, it is difficult to establish the exact numbers of steroid users in the borough through established methodologies. Improvements are needed in local monitoring to ensure this trend is examined in more detail and addressed appropriately.

4.2.3 Prevalence of Drug Misuse in Children & Young People

Data from the *Smoking, drinking and drug use among young people in England in 2012* survey (published in 2013)⁴⁵, in which over 7,500 children aged 11-15 years responded, showed that:

- In 2012, the prevalence of illicit drug use was at similar levels as in 2011. 17% of pupils had ever taken drugs, 12% had taken them in the last year and 6% in the last month. These levels are the lowest measured since 2001, when the current method of measuring drug use was begun.
- The prevalence of ever having taken drugs increased with age from 7% of 11 year olds to 31% of 15 year olds. There were similar patterns for drug use in the last year (from 4% amongst 11 years olds to 24% amongst 15 year olds) and in the last month (from 2% to 13% in 11 or 15 year olds respectively).
- Of those pupils who had taken drugs in the last year, 75% reported only having taken one type of drug, and 25% had taken two or more.
- Boys and girls were equally likely to have ever taken drugs, and the same was true for drug use in the last year or in the last month.
- Pupils who had taken drugs in the last year were most likely to have taken cannabis (7.5%).
- 2% of pupils said that they usually took drugs at least once a month (this survey's definition of frequent drug use).
- In 2012, 28% of pupils had ever been offered drugs.

⁴⁴ BBC Newsbeat (2014). Six-fold increase in steroid users, says charity. Report by Catherine Burns, 9th April 2014. Available on: <http://www.bbc.co.uk/newsbeat/26890715>

⁴⁵ Fuller, E. (ed) (2013) *Smoking, Drinking and Drug Use Among Young People in England in 2013*. London: Health and Social Care Information Centre (HSCIC). Available on: <http://www.hscic.gov.uk/catalogue/PUB11334/smok-drin-drug-young-peop-eng-2012-repo.pdf>

- Drug use in the last year was strongly associated with other risky behaviours: smoking, drinking alcohol, truancy and exclusion from school.
- Pupils from minority ethnic groups were more likely to have taken drugs in the last year than White pupils.
- As in previous years of this survey, cannabis was the most widely used drug among 11 to 15 year olds; 7.5% of pupils reported taking it in the last year. This figure is similar to that seen in 2011 (7.6%), but continues the overall downward trend in prevalence of cannabis use since 2001.
- Class A drug use remained relatively rare among pupils; 2.2% reported taking one of the eight Class A drugs asked about in the last year. From 2001 to 2009, this proportion was around 4% but fell to 2.4% in 2010 and has remained at a similar level since.
- Use of volatile substances, such as glues, gases, aerosols and solvents, was reported by 3.6% of pupils in 2012, a similar proportion to 2011 (3.5%).
- 28% of pupils reported ever being offered any drug, a similar proportion as in 2011 (29%). Boys were more likely than girls to say they had been offered any drugs (30% of boys compared with 27% of girls).
- Pupils who had ever truanted or had been excluded from school were more likely to report usually taking drugs at least once a month than those who had never truanted or had never been excluded (10% compared with 1%). Also, pupils who had ever played truant or been excluded were more likely to report taking Class A drugs in the last year (9%) than those who had never truanted or been excluded (1%).
- Pupils who said they had taken drugs in the last year were asked on how many occasions they had taken drugs and how often, if at all, they usually did so. Figures for 2012 were broadly similar to those reported in previous years; 3% of all pupils said they had only ever taken drugs on one occasion, 3% said they had taken them on two to five occasions, 1% reported they had taken them on six to ten occasions, and 2% reported having taken drugs on more than ten occasions.
- Pupils were most likely to get helpful information from teachers (66%), parents (63%) or TV (60%). As in previous years, helplines were the source least likely to be found helpful by pupils (15%).

According to the Health & Social Care Information Centre⁴⁶, since 2001, there has been an overall decline in the prevalence of drug use among pupils. The proportion of pupils aged 11-15 years ever having taken drugs decreased from 29% in 2001 to 17% in 2012.

Locally, data from the Havering Young People's Survey (2013)⁴⁷ show that out of 281 responses to the survey 74% thought that illegal drugs were easy to get hold of in Havering. Although this is a relatively small sample size, and it is acknowledged there may be some selection bias in terms of the pupils choosing to take part, it is nevertheless considered to be sufficiently representative of the views of young people in the borough. Cannabis was the top drug believed to be used by young people in Havering, followed by cocaine and ecstasy (Figs. 4.15 and 4.16).

⁴⁶ Health & Social Care Information Centre (HSCIC) (2013). *Statistics on Drug Misuse: England 2013*. London, HSCIC. Available on: <http://www.hscic.gov.uk/catalogue/PUB12994/drug-misu-eng-2013-rep.pdf>

⁴⁷ Young Addaction (2013). *Drugs, Alcohol and Tobacco Use. The Young People's Survey 2013*. Romford, London Borough of Havering.

Figure 4.15 *Havering Young People's Perceptions of Main Drugs used by Young People Aged 13-19 years (n=290)*

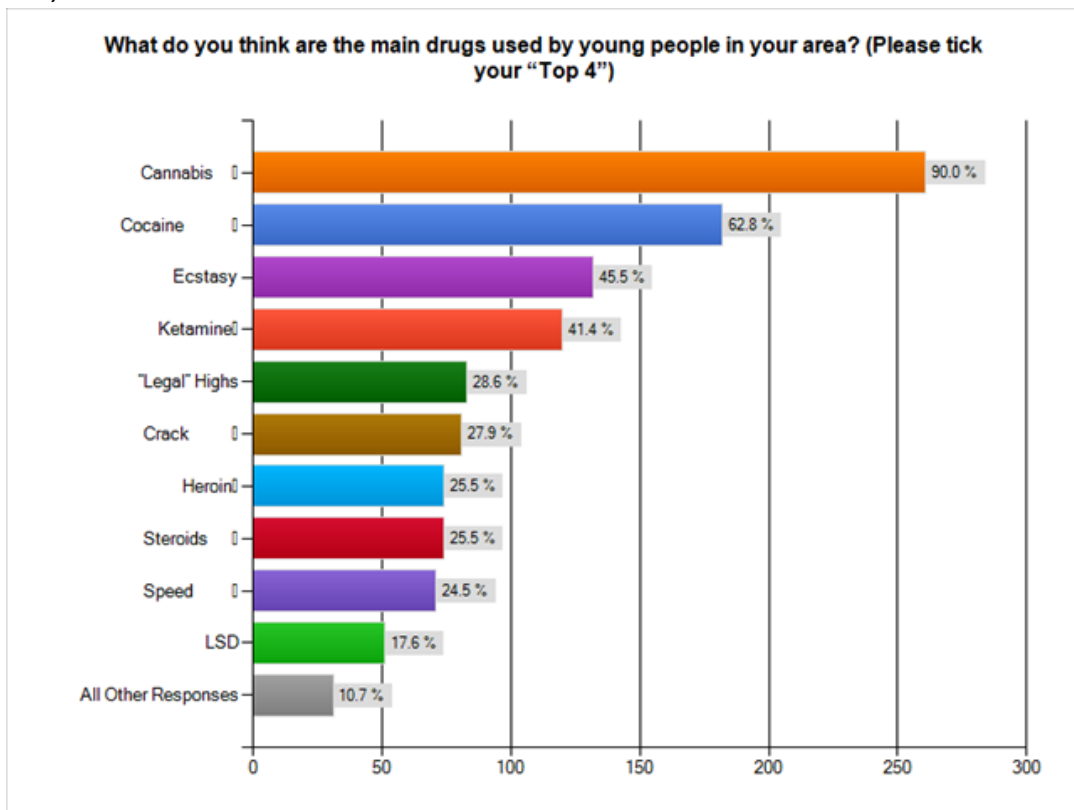
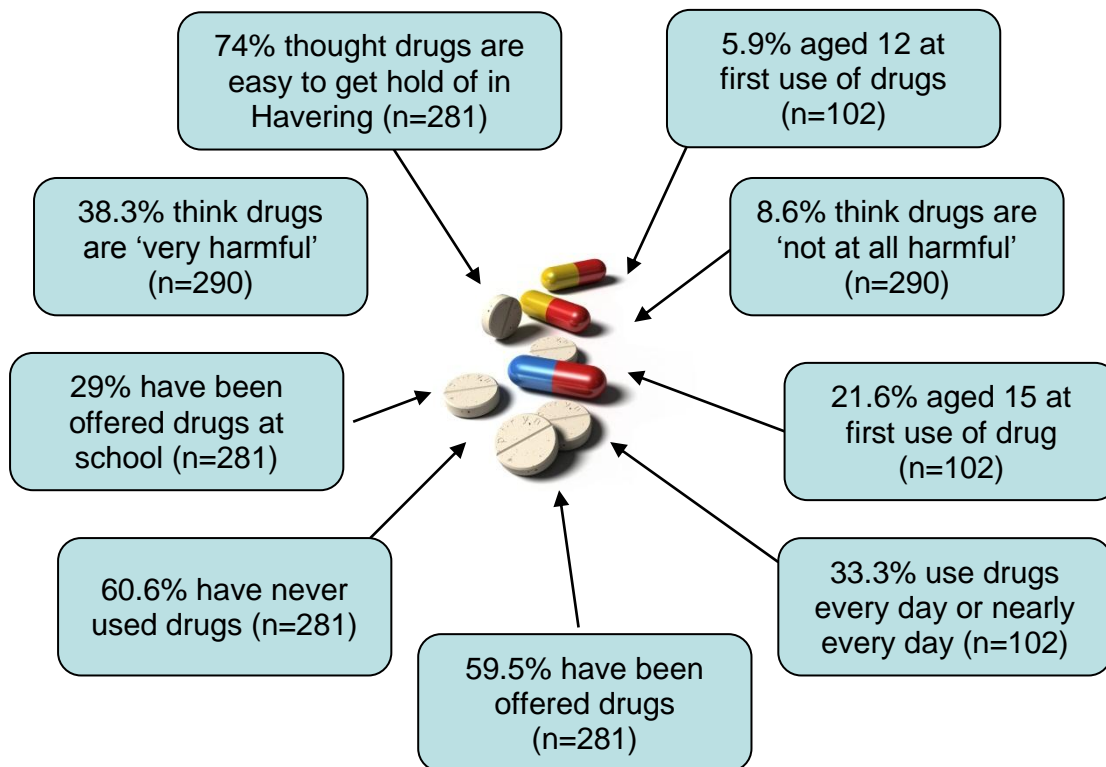
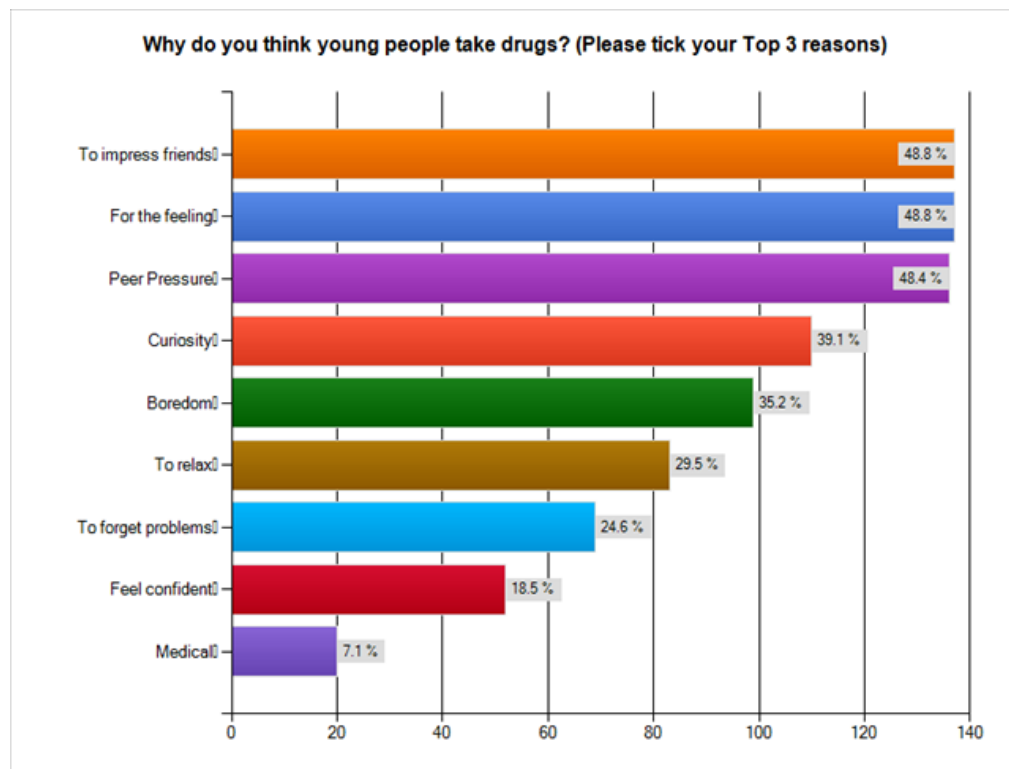


Figure 4.16 *Young People's Perceptions about Drug Prevalence and Use in Havering 2013*



The influence of friends and peer pressure is just as important as the feeling young people feel they get from taking drugs – nearly half of the 281 respondents to the question why they think young people take drugs cited impressing friends, for the feeling or peer pressure (Fig. 4.17).

Figure 4.17 Reasons Why Young People Use Drugs in Havering (n=281)



4.2.4 Parental Drug Misuse

Data from the JSNA support pack for partners shows that 56% of drug users in treatment in Havering in 2012-13 had responsibility for children, higher than the national average of 54% (Fig. 4.18)⁴⁸. In particular 40% of Havering parents in treatment for drug misuse were living with their children compared with 33% nationally.

Figure 4.18 Proportions of Drug Users in Treatment with Responsibility for Children

	Havering		England	
	Number (n)	%	Number (n)	%
Living with Children	242	40%	64,862	33%
Parents but not living with children	96	16%	41,532	21%
Incomplete data	<5	N/A	4,691	2%

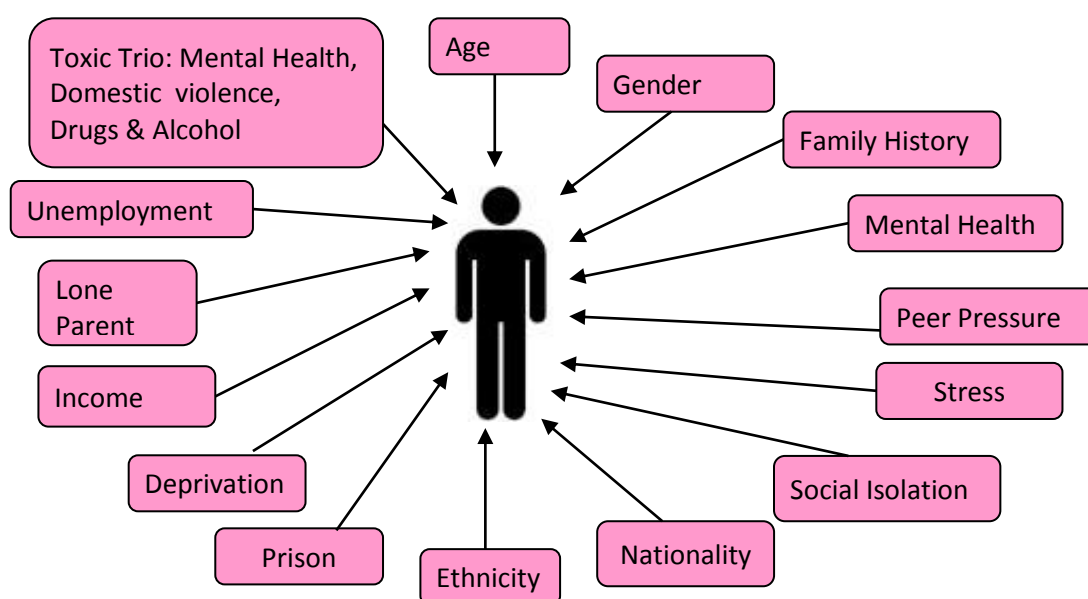
The following section examines the risk factors for developing drug and alcohol misuse problems to outline who is contributing to the figures outlined above.

⁴⁸ Public Health England (2013). *Alcohol and Drugs: JSNA Support Pack. Key data to support planning for effective drugs prevention, treatment and recovery. The data for Havering.* London: Public Health England.

5.0 Risk Factors for Drug & Alcohol Misuse

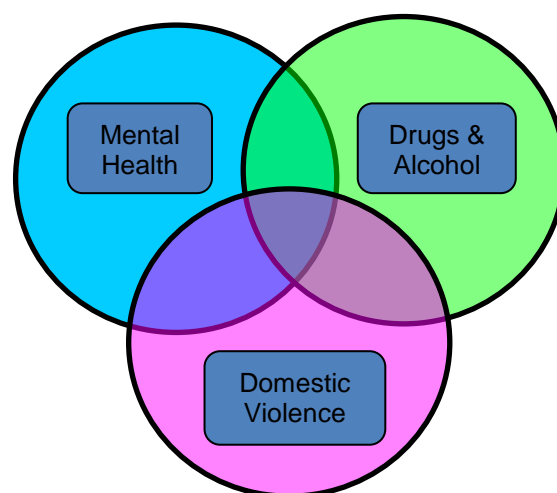
The following section explores in detail what the risk factors are for drug and alcohol misuse. It outlines who is most at risk of developing these problems, and therefore provides a guide for commissioners as to who should be targeted for specialist services – these may include advice or education on preventing substance misuse as well as areas for safeguarding, or opportunities to engage clients into treatment services. Fig 5.1 outlines the key risk factors; the remainder of the section covers these risk factors in more detail, giving the prevalence or impact for Havering residents where possible.

Figure 5.1 Risk Factors for Drug and Alcohol Misuse



5.1 Toxic Trio (Mental Health, Alcohol Misuse, Domestic Violence)

There is a clear association between having a mental illness and increasing risk of alcohol dependence⁴⁹ – if you drink too much, you put your mental health at risk. Conversely, if you have a mental health problem, you are more likely to drink at levels that put your health at risk. Similarly, there is a close inter-relationship between domestic violence and substance misuse, which both further impact mental ill health. Early identification of domestic abuse and/or mental health issues in substance misusers is highly important. Tackling this ‘toxic trio’ of issues is therefore a clear priority for Havering – the following section highlights the prevalence of mental health problems and domestic violence within the borough.



⁴⁹ Weaver, T., Madden, P., Charles, V., Stimson, G., Renton, A., Tyrer, P., Barnes, T., Bench, C., Middleton, H., Wright, N., Paterson, S., Shanahan, W., Seivewright, N. & Ford, C. (2003). Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. *British Journal of Psychiatrists* 183: 304-313.

Research by the Royal College of Psychiatrists showed that 44% of patients in contact with a Community Mental Health Team (CMHT) reported past-year problem drug use and/or harmful alcohol use³⁷. In addition, 75% of drug service and 85% of alcohol service patients had a past-year psychiatric disorder.

The National Service Framework for Mental Health⁵⁰ highlights that:

- unemployed people are twice as likely to have depression as people in work
- children in the poorest households are three times more likely to have mental health problems than children in well off households
- half of all women and a quarter of all men will be affected by depression at some period during their lives
- people who have been abused or been victims of domestic violence have higher rates of mental health problems
- between a quarter and a half of people using night shelters or sleeping rough may have a serious mental disorder, and up to half may be alcohol dependent
- some black and minority ethnic groups are diagnosed as having higher rates of mental disorder than the general population; refugees are especially vulnerable
- there is a high rate of mental disorder in the prison population
- people with drug and alcohol problems have higher rates of other mental health problems
- people with physical illnesses have higher rates of mental health problems.

Estimated
23,200 people in
Havering with a
common mental
health condition

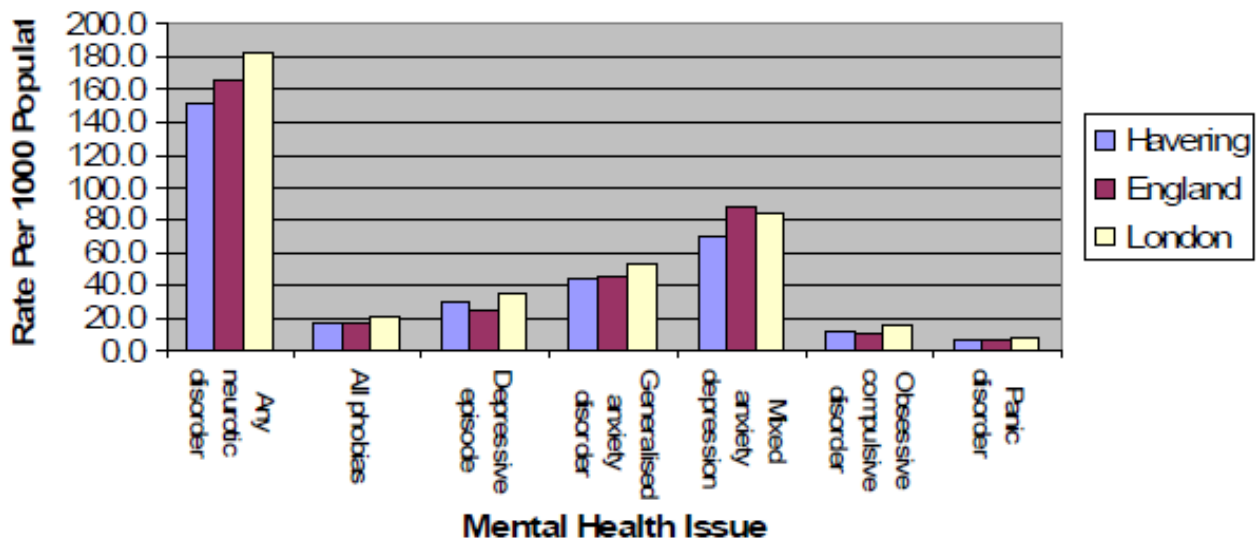
Alcohol problems are more common among people with more severe mental health conditions – alcohol can temporarily alleviate feelings of anxiety or depression. However, engaging in such ‘self-medication’ using alcohol to ‘numb’ feelings can also exacerbate underlying health conditions⁵¹. Evidence shows that people who consume high amounts of alcohol are vulnerable to higher levels of mental ill health and it can be a contributory factor in some mental illnesses, such as depression. In Havering, it is estimated there are around 23,200 people with a common mental health disorder, which includes anxiety, depression or obsessive compulsive disorder. Figure 5.2 shows the common mental health issues in Havering⁵².

⁵⁰ Department of Health (1999) *Mental Health: National Service Framework*, London, Department of Health.

⁵¹ Mental Health Foundation (2014). Available on: <http://www.mentalhealth.org.uk/help-information/mental-health-a-z/A/alcohol/>

⁵² North West Public Health Observatory 2008; Cited in JSNA Refresh 2010 – Disabilities, Mental Health and Learning Difficulties (2010), London Borough Of Havering, Romford. Available on: <http://www.haveringdata.net/resource/view?resourceId=JSNA Disability Learning Mental>

Figure 5.2 Common Mental Health Issues in Havering, London and England



There were 5,708 calls in 2013 to police in Havering regarding domestic abuse

Data from the Havering Community Safety Partnership (HCSP) Strategic Assessment (2013)⁵³ shows that domestic violence accounts for a third of all physical violence reported to and recorded by police in Havering, despite crime survey data nationally identifying a high level of underreporting. There were 5,708 calls to police in Havering regarding domestic abuse in the last 12-months, a rate of 24 calls per 1,000 residents (16th highest of the 32 boroughs in London). Over a third (35%) of those who sought police help were aged 20-30 years old. Given this age-group represents 13.8% of the total Havering population, this means that there is a significant over-representation (2 ½ times

more) of people aged 20-30. Of those who called the police reporting domestic violence, 21.9% were repeat victims (i.e. they had called the police at least twice in a 12-month period for domestic violence incidents).

Although there is generally a lack of robust national data on the use of alcohol and drugs and its association with domestic violence⁵⁴, a number of research studies have nevertheless demonstrated the link between domestic violence, alcohol and drugs, with up to 90% of assailants reporting the use of alcohol and drugs. Gilchrist et al, researching the characteristics of domestic violence offenders, found that 73% of perpetrators had been drinking at the time of the assault⁵⁵. In another study, 92% of domestic abuse assailants reporting use of alcohol or other drugs on the day of assault, although this was for relatively low numbers of perpetrators⁵⁶. A number of studies have

⁵³ Havering Community Safety Partnership Strategic Assessment 2013. London Borough Of Havering, Romford.

⁵⁴ Galvani, S (2010). *Grasping the Nettle: alcohol and domestic violence*. London: Alcohol Concern. Available on: https://www.google.co.uk/url?q=http://www.alcoholconcern.org.uk/assets/files/Publications/Grasping%2520the%2520nettle%2520factsheet%2520revised%2520June%25202010.pdf&sa=U&ei=bdpYU_O0HbSO7QbM9oGgCw&ved=0CCKQFjAC&usg=AFQjCNGQo5aiZ2JICbEKfaNx5CK6nPtaw

⁵⁵ Gilchrist, E., Johnson, R., Takriti, R., Weston, S., Beech, A. and Kebbell, M. (2003) *Domestic violence offenders: characteristics and offending related needs*, Findings, 217, London, Home Office.

⁵⁶ Brookoff, D., O'Brien, K.K., Cook, C.S., Thompson, T.D., Williams, C. (1997) 'Characteristics of participants in domestic violence assessment at the scene of domestic assault'. *Journal of the American Association*: 277 (17); 1369-1377.

found that the perpetrators use of alcohol, particularly heavy drinking, was likely to result in more serious injury to their partners than if they had been sober⁵⁷.

According to the British Crime Survey 25% of all women will experience domestic abuse at some point in their lifetime, which means there are potentially 30,000 domestic abuse victims currently residing in Havering. In addition, women who experience any type of sexual abuse in childhood abuse are roughly three times more likely than non-abused women to report drug or alcohol dependence⁵⁸.

However, it is essential that victims of domestic violence are able to report that a crime has occurred. The HCSP strategic assessment reports specifically that “We know from the British Crime Survey that that 19% of domestic violence victims report to the police, however, 23% will notify their general practitioner first. A study by the Royal College of General Practitioners (2012) found that 25% of domestic abuse victims first reported to their GP. Of more concern, the same study found that just 29% of GP’s in England felt comfortable in asking questions about suspected abuse and just 24% of GP’s said they would be prepared to make appropriate referrals.” It is therefore important that Havering Clinical Commissioning Group (HCCG) works with local GPs to ensure they are suitably trained and equipped to raise the issue of domestic violence and are aware of the referral pathways.

For children, emotional and mental health problems are associated either directly via their own substance abuse issues, or via parental misuse of alcohol or drugs. The ‘toxic trio’ of mental health, substance misuse and domestic violence have been found to be common features in nearly 75% of serious case reviews where harm to a child has occurred⁵⁹. This statistic was derived from an in-depth sample of 40 serious case reviews, in which the children lived in an environment where parents and carers were struggling with mental ill health and/or substance misuse and/or domestic violence⁶⁰. Toxic Trio issues are therefore key criteria, amongst others, used in the identification of families who would benefit from receiving intensive support via the Troubled Families initiative. Figure 5.3 demonstrates the geographical spread over the borough of such families, which largely corresponds to areas of deprivation within the borough (see also section 5.3). To date over 230 families in Havering have been identified through this initiative, which involves an intensive package of support tailored to each family’s individual needs.

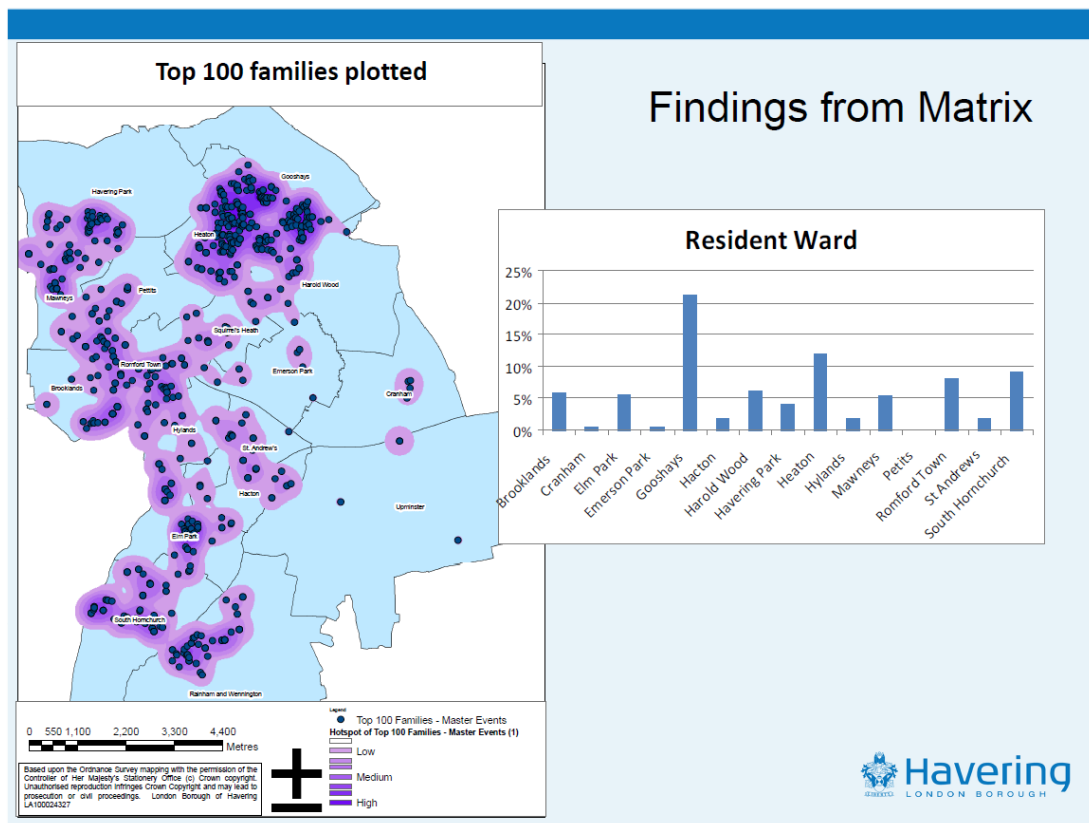
⁵⁷ Brecklin, L., 2002. The role of perpetrator alcohol use in the injury outcomes of intimate assaults, *Journal of Family Violence*, 17 (3), 185-196.

⁵⁸ Kendler, K.S., et al. (2000) "Childhood sexual abuse and adult psychiatric and substance use disorders in women: An epidemiological and co-twin control analysis". *Archives of General Psychiatry* : 57(10); 953-959. Available on: <http://archpsyc.jamanetwork.com/article.aspx?articleid=481660>

⁵⁹ Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebotham, P., Dodsworth, J. Warren, C. & Black, J. (2009). *Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-07* Department for Education, Research Report DCSF-RR129, London.

⁶⁰ Brandon, M., Sidebotham, P., Bailey, S., Belderson, P., Hawley, C., Ellis, C. and Megson, M. (2012) [New Learning from Serious Case Reviews: a two year report for 2009-2011](#). Department for Education, DFE-RR226, London.

Figure 5.3 Troubled Families by Ward in Havering



Of particular importance for many troubled families, but may also include other families in the borough, is the rising trend in gang culture, which has become entrenched in some of the most disadvantaged neighbourhoods in the UK⁶¹. Gang culture is a very recent phenomenon that is rapidly spreading from more disadvantaged boroughs, in which a small number of youths in a gang can have a significant impact on communities⁶². Home Office Data from 2006 suggested that up to 6% of 10 to 19 year olds belong to a gang⁶³. Although not exclusive to gang members, knife crime, violence and sexual exploitation are often synonymous with gang culture. In addition, anecdotal evidence suggests young people are being targeted locally to sell drugs for gangs, and some are running up large drugs debts. Further work is required to ascertain the true extent of the problem locally, but is a highly important issue, especially for young offenders.

Up to 6% of 10-19 year olds belong to a gang

⁶¹ The Centre for Social Justice (2009). *Dying to Belong: an in-depth review of street gangs in Britain*. Available on: <http://www.centreforsocialjustice.org.uk/publications/dying-to-belong>

⁶² HM Government (2011). *Ending Gang and Youth Violence A Cross-Government Report including further evidence and good practice case studies* Available on:

<http://www.google.co.uk/url?url=http://www.saferlondonfoundation.org/download.php%3Ffile%3Dgang-violence-detailreport.pdf&rct=j&frm=1&q=&esrc=s&sa=U&ei=rZStU-fRFKqC0AXcqoGYCQ&ved=0CC8QFjAE&sig2=6yR2FXDz59nYiKXCEAqHg&usg=AFQjCNHiXtswCck1A2cJT-fEc6vX91ZlZg>

⁶³ Sharp, C., Aldridge, J., Medina, J. (2009). *Delinquent youth groups and offending behaviour: findings from the 2004 Offending, Crime and Justice Survey*. London: Home Office p.39.

In addition, promoting good mental health in children and adults can help prevent alcohol misuse. Parenting programmes and prevention programmes for children can both help, particularly when problems are identified early.

5.2 Family History

Drug and alcohol addiction is more likely in families where drug and alcohol addiction is already present⁶⁴. In addition, children from lone parent families are more likely than those in two-parent families to engage in risky behaviour, including drug and alcohol misuse or smoking⁶⁵. Single parents often have lower incomes, greater degree of social isolation, fewer resources to help them cope with the stresses of daily life and in some cases find it harder to maintain discipline in the home. In 2011, 27.47% of children (whose parents claim child benefit) lived in lone parent households. This is similar to the number in England (27.4%), but lower than the number for London (33.29%).

27% of children in Havering live in lone parent families

Recent research in the US has found that whilst the gender of the lone parent does not impact on son's usage of drugs, drug use amongst daughters living with single fathers is higher than that of those daughters living with single mothers⁶⁶. In Havering, data from the 2011 census shows that 92.1% of lone parents are female and 7.9% are male (n = 570)⁶⁷. Many of these single fathers are likely to have daughters, and so the needs of single fathers are an important factor to consider when assessing families and offering the right support for potential drug-using behaviour.

Conversely, in families that exhibit a strong, cohesive relationship between adolescents and parents, the children are less likely to become involved in alcohol compared with those who do not have a close familial bond⁶⁸. Good family relationships, whether in single or two-parent families are therefore essential foundations for the prevention of substance misuse behaviour – this places even greater emphasis on the importance of the Troubled Families initiative to tackle parental or childhood substance misuse and halt the cycle of misuse.

The children of drugs users are more likely to be living in relative poverty. Moreover, parental substance misuse can reduce the parent's ability to provide practical and emotional care, which can have serious consequences, including exclusion or persistent absence from school⁶⁹. Children of drug- or alcohol-misusing parents more frequently report violence and/or 'parental disappearances from the home. In addition, inappropriate or excessive levels of caring by young people may prevent

⁶⁴ Substance Abuse and Mental Health Services Administration (SAMHSA) (2004). *Substance Abuse Treatment and Family Therapy. Treatment Improvement Protocol (TIP) No.39* Rockville, Maryland, USA. Available on: <http://www.ncbi.nlm.nih.gov/books/NBK64258/>

⁶⁵ Blum, R.W., Beuhring, T., Shew, M. L., Bearinger, L. H., Sieving, R. E., & Resnick, M. D. (2000). The effects of race/ethnicity, income, and family structure on adolescent risk behaviors. *American Journal of Public Health, 90*, 1879–1884.

⁶⁶ Hemovich, V. & Crano, W.D. (2009). Family Structure and Adolescent Drug Use: An exploration of single-parent families. *Substance Use Misuse 44*; 14: 2099 – 2113. Available on: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3075408/>

⁶⁷ Havering Data Intelligence Hub (2013). Population overview. Available on:

<http://www.haveringdata.net/profiles/profile?profileId=1136&geoTypeId=5&geoids=00AR#iasProfileSection4>

⁶⁸ Birckmayer, JD, Holder, HD, Yacoubian, GS, & Friend, KB. (2004). A general causal model to guide alcohol, tobacco, and illicit drug prevention: Assessing the research evidence. *Journal of Drug Education, 34*(2), 121-153.

⁶⁹ National Treatment Agency for Substance Misuse (NTA), *Parents with Drug Problems: How treatment helps Families*, London NTA, 2012. www.nta.nhs.uk/uploads/families2012vfinali.pdf

them from enjoying their childhood in the same way as other children. Young carers are particularly vulnerable to educational underachievement. It is estimated that 27% of all young carers of secondary school age are missing school or experiencing educational difficulties. This figure rises to 40% for young carers specifically caring for someone who misuses drugs or alcohol⁷⁰.

In Havering, there are now 443 children who were reported through the 2011 census to provide regular and ongoing care to a family member⁷¹. Although there are no direct data on the proportion of these young carers who care specifically for a family member who misuses alcohol or drugs, it is nevertheless a key consideration as to the health and wellbeing of young carers.

56% of drug using adults in Havering have responsibility for children

Compared to the national average, Havering has a slightly higher proportion of drug using adults with responsibility for children (56%) than the national average (54%)⁷². With an estimated 14% of all Havering adults thought to drink at levels which significantly increases the risk of damaging their health and at least 852 Opiate and Crack Users (OCUs), of whom 487 are likely to have responsibility for children, this represents a significant number of potential families who may need further assistance. Many of these are likely to already be known to social services. Relevant agencies therefore need to communicate effectively with each other to ensure families are offered the right support when potential drug and alcohol issues are identified.

5.3 Income, Deprivation and Employment

The effect of social disadvantage on both drug and alcohol misuse is complex. Socially disadvantaged groups are more likely to experience poverty, unemployment and homelessness which are associated with an increased risk of serious social and behavioural problems including alcohol and drug misuse. Data from the Health Survey for England (2012) showed that⁷³:

- 81% of men and 69% of women in the highest income quintile drank in the last week, compared with 51% of men and 39% of women in the lowest income quintile. There was a similar pattern for frequent drinking.
- Drinking was also related to area deprivation, measured by the Index of Multiple Deprivation (IMD). In the least deprived quintile, 77% of men and 62% of women had drunk alcohol in the last week, compared with 50% of men and 38% of women who lived in the most deprived quintile.
- Men and women in the highest equivalised household income quintile were most likely to drink at increased risk levels (31% of men, 25% of women); those in the lowest two income quintiles were least likely to do so (19% of men, 13% of women). There was no equivalent pattern for higher risk drinking.

⁷⁰ Dearden, C. & Becker, S. (2004). Young Carers in the UK: The 2004 Report.

⁷¹ Havering JSNA *Children and Young People Chapter* (2014). London Borough of Havering, Romford.

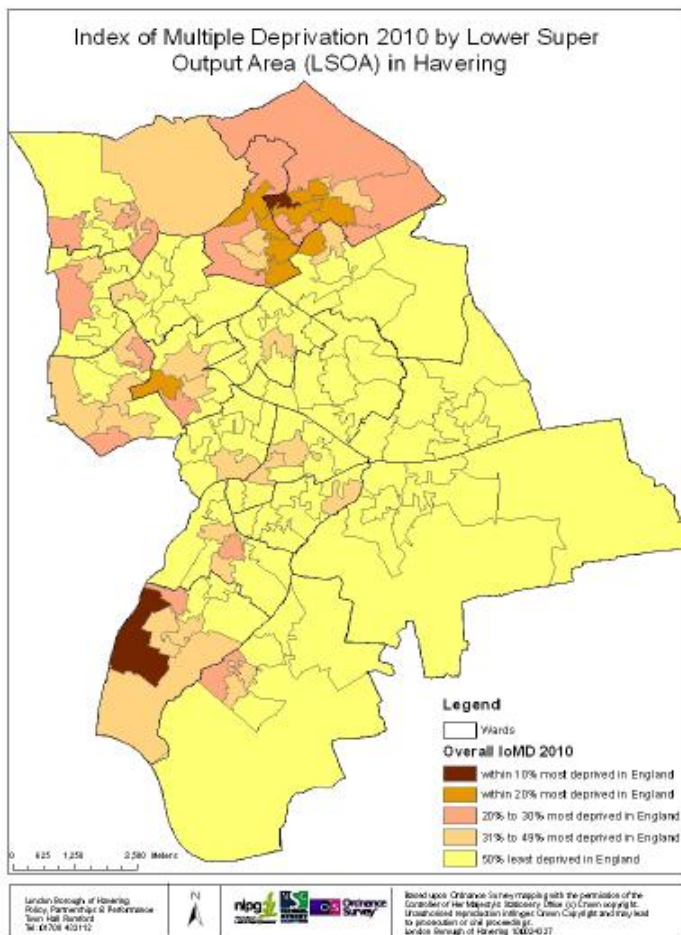
⁷² Public Health England (2013). *Alcohol and Drugs: JSNA Support Pack. Key data to support planning for effective drugs prevention, treatment and recovery. The data for Havering*. London: Public Health England.

⁷³ Fuller, E. (2013) Chapter 6 – Alcohol Consumption. In: Craig, R. & Mindell (J. (Eds). *Health Survey for England 2012*. London: Health and Social Care Information Centre (HSCIC). Available on: <http://healthsurvey.hscic.gov.uk/support-guidance/public-health/health-survey-for-england/alcohol-consumption.aspx>

- Similarly, men and women who lived in least deprived areas were most likely to drink at increased risk levels, and those in the most deprived areas less likely to do so. As with income, this pattern was not apparent among higher risk drinkers.

As a borough, Havering is ranked 177th out of 326 local authorities for deprivation (1 being most, 326 being least deprived). However, there are two small areas in Havering which fall into the top 10% of most deprived small areas in England (within Gooshays and South Hornchurch) (Fig 5.4). There are also 11 small areas in Havering falling into the top 20% of most deprived areas in England⁷⁴. When compared to other London Boroughs, Havering had a relatively small proportion of children living in poverty in 2009 (sixth smallest proportion of children living in poverty in London)⁷⁵. However 19.3% of children were still estimated to be living in poverty in Havering in 2009⁷⁶. These areas should therefore be targeted by statutory and voluntary sector agencies who may be able to offer intensive support to families in need.

Figure 5.4 Map of Deprivation in Havering



Havering is ranked 177th out of 326 local authorities for deprivation; 2 small areas in Gooshays and South Hornchurch fall into the top 10% of most deprived areas England

⁷⁴ Havering JSNA (2012). *Demographics Update*. London Borough Of Havering, Romford. Available on: <http://www.haveringdata.net/resource/view?resourceId=JSNAtwentytwelveDemographicsUpdate>

⁷⁵ Children in Poverty Intelligence Update, The Greater London Authority (2011). Available online at: <http://www.london.gov.uk/who-runs-london/mayor/publications/society/facts-and-figures/poverty>

⁷⁶ Children in Poverty Statistics, Her Majesty's Revenues and Customs (2009). Available online at: http://www.hmrc.gov.uk/stats/personal-tax-credits/child_poverty.htm

At the far end of the spectrum of deprivation, it is important to highlight the needs of those people who do not currently have a home. Havering has a higher rate of households in temporary accommodation than England, but lower than London (Fig. 5.5) – in Havering this equates to over 600 families in temporary accommodation in 2013 and a further 77 in hostel accommodation⁷⁷. Nationally, between a quarter and a half of people using night shelters or sleeping rough may have a serious mental disorder, and up to half may be alcohol dependent⁷⁸. Data from the Department for Communities and Local Government estimates there are only 2 rough sleepers in Havering (out of 543 estimated for London as a whole), but this data should be treated with caution⁷⁹. This needs further investigation to understand the issues of homeless and will be investigated in a future JSNA chapter.

Figure 5.5 Rate of Homelessness in Havering

Rate per 1,000	Havering	London	England
Homeless households in temporary Accommodation (2013)	6.43	12.02	2.54
Homeless households in bed & breakfast accommodation (2013)	N/A	0.67	0.20
Homeless households at home awaiting accommodation (2010)	N/A	0.33	0.17
Homeless households in hostel accommodation (2013)	0.78	0.59	0.20

Drug and alcohol problems can in themselves also result in downward social mobility by lowering educational achievement and increasing exposure to unemployment and incarceration (prison sentences)⁸⁰.

Conversely, young people from more advantaged backgrounds may use the freedom that relative affluence brings to seek out new and novel drug use experiences. In the US, the Panel Study of Income Dynamics⁸¹ found that young adults in the highest income, highest wealth, and highest parental education had at least twice the odds as those in the lowest socio-economic status (SES) categories of being current drinkers. In addition, the odds of marijuana use in the past year were consistently, significantly greater only among respondents in the higher income, higher wealth and higher parental education domains.

⁷⁷ Havering Data Intelligence Hub (2013). *Housing Overview*. Available on:

<http://www.haveringdata.net/profiles/profile?profileid=1133&geoTypeId=5&geoids=00AR#iasProfileSection2>

⁷⁸ Department of Health (1999) *Mental Health: National Service Framework*, London, Department of Health.

⁷⁹ Department for Communities and Local Government (2014). *Homelessness Statistical Release. Rough Sleeping Statistics England; Autumn 2013 Official Statistics*. London, DCLG. Available on:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/284074/Table_1_FINAL.xlsx

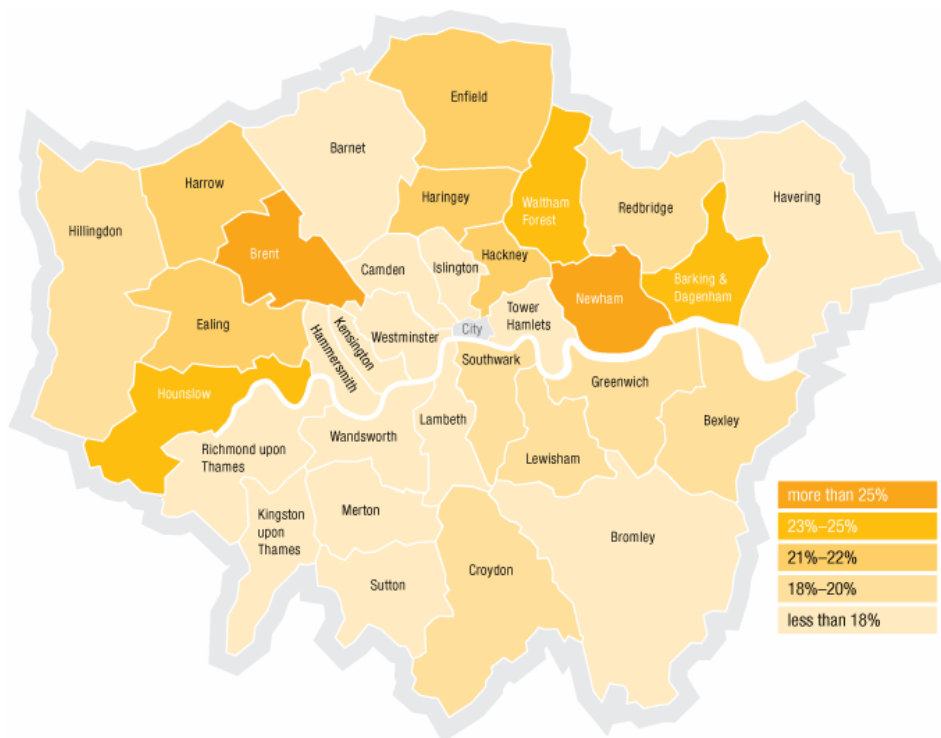
⁸⁰ Australian Government Department of Health (2004). *The Prevention of Substance Use, Risk and Harm in Australia: a review of the evidence*. Cited directly from: [https://www.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-publicat-document-mono_prevention-cnt.htm/\\$FILE/mono_prevention_ch6.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-publicat-document-mono_prevention-cnt.htm/$FILE/mono_prevention_ch6.pdf)

⁸¹ Patrick, M.E., Wightman, P., Schoeni, R.F., Schulenberg, J.E. (2012). Socioeconomic Status and Substance Use Among Young Adults: A Comparison Across Constructs and Drugs. *Journal of Studies on Alcohol and Drugs* 73: 5; 772-782. Available on: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3410945/>

As a borough, and despite some areas which experience significant levels of deprivation, Havering is relatively affluent compared with England and with many other London boroughs. Figure 5.6 shows the proportion of people in low-paid work by borough of residence: compared with the rest of London boroughs, less than 18% of residents in Havering are in low paid work. The median income in Havering in 2011 was £26,493, slightly higher than that of all Outer London boroughs (£26,327), and higher than the median income in England (£21,449)⁸². Around 2.6% of people were claiming Job Seeker’s Allowance January 2014⁸³.

Havering’s median income (£26,493) is higher than that of England (£21,449)

Figure 5.6 Proportion of People in Low Paid Work by Borough of Residence



Such relative affluence may make it more affordable to engage in regular or high level drinking behaviour. Anecdotal evidence from Young Addaction, Havering’s provider of young people’s drug and alcohol services, suggests that drinking and drug-taking behaviour is purportedly more prevalent amongst higher income groups in Havering; of particular concern is the practice of private parties in the home, in which parents have reportedly bought alcohol for their older children for such parties. This may include experimenting with new or emerging trends, such as that for inhalation of nitrous oxide (laughing gas). Subsequently these new patterns of drug use may be spread to other social groups. Caution should therefore be advised in making assumptions about income levels and substance misuse behaviour.

⁸² Office for National Statistics (2012). *Annual Survey of Hours and Earnings: 2011 Provisional Results*. Available on: <http://www.ons.gov.uk/ons/re/ashe/annual-survey-of-hours-and-earnings/2011-provisional-results--soc-2010-/2011-provisional-table-8.zip>

⁸³ Office for National Statistics. Available on: <http://www.ons.gov.uk/ons/interactive/theme-pages/index.html>

All things being equal, individuals in disadvantaged groups mis-using drugs are more likely to experience undesirable social consequences than more affluent peers who benefit from more supportive social and family networks and greater self- efficacy. It is therefore recommended that, whilst universal services are available for all those who need it, resources be targeted first and foremost to those experiencing inequality and disadvantage, whilst maintaining a comprehensive education and awareness programme for more advantaged groups with the means to seek self-help.

5.4 Age

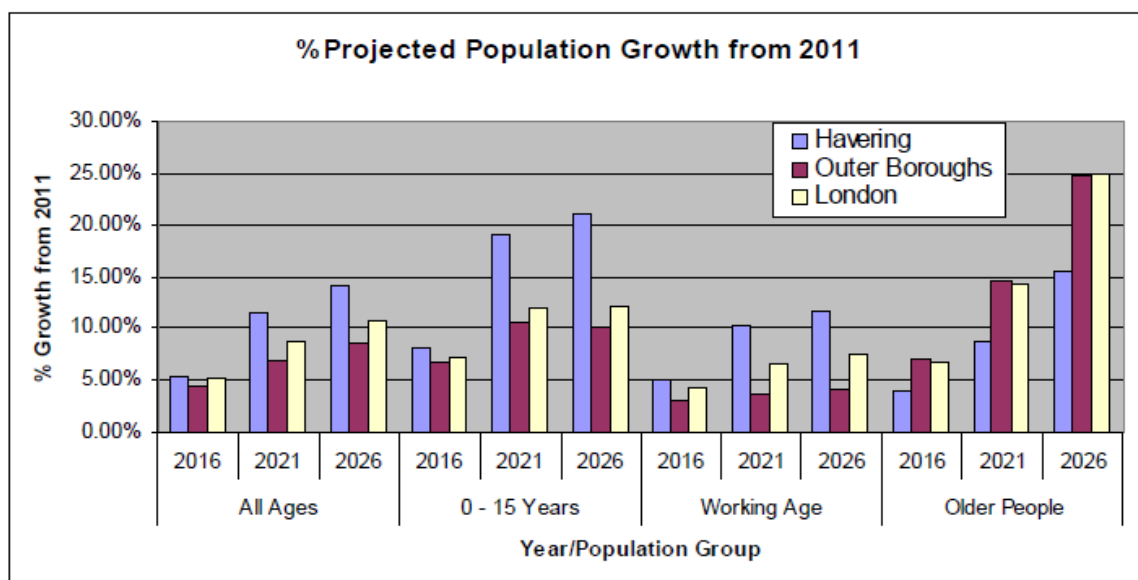
75% of Havering Young People (2013 survey) were aged 15 or under when they had their first alcoholic drink.

The earlier the age that a young person starts drinking alcohol, the more likely it is that they will develop alcohol-related problems in later life⁸⁴. Data from the Young People’s Survey (2013) (see section 4.1.3) showed that in Havering, 74% of respondents had their first alcoholic drink on or before they were 15 years old. Interventions that successfully establish healthy attitudes to drugs and alcohol in children and young people and thereby delay initiation are

likely to reduce harm and the need for treatment interventions in later life.

Havering is projected to have a much higher percentage increase in 0-15 year olds than the outer London boroughs and London by 2026 (Fig. 5.7). It will therefore be important to ensure that adequate resources are targeted to children and young people, for example via schools, youth work and young people’s activities and programmes to embed a preventative approach towards engaging in alcohol and drug taking behaviour.

Figure 5.7 Havering Population Projections from 2011 to 2026 compared with Outer London Boroughs and London as a whole



⁸⁴ O’Connell, M. E., Boat, T., & Warner, K. E., Eds. (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults, Institute of Medicine. Washington, DC: National Academies Press. Available on: <http://www.ncbi.nlm.nih.gov/books/NBK32775/>

More people under the age of 25 report getting ‘very drunk’ than any other adult age group⁸⁵ and around 50% of students drink more than the lower-risk guidelines⁸⁶. Under 25s are also the most likely to enjoy a night out in Romford, taking advantage of the borough’s vibrant night-time economy - Romford’s night time economy attracts some 11,000 – 15,000 18 to 25 year olds on Thursday, Friday and Saturday nights to big name venues such as Fiction, Yates, and Missoula. However, this age group also have the highest risk of being a victim of violent crime. There have been some good examples of how to make appropriate information easily accessible for young adults, such as Drinkaware’s “Why let good times go bad?” campaign and we expect to see more campaigns such as this in the future.

Drug use is more predominant amongst a slightly higher age group. Data from the 2012-13 Crime Survey for England and Wales shows that powder cocaine use peaks among 25-29 year olds (4.4%)⁸⁷. However, the use of legal highs may form a ‘gateway’ to more serious, and illegal, drug taking. Young people who may be sufficiently deterred from breaking the law by taking any class A,B or C drug could nevertheless wish to ‘experiment’ with legal highs to achieve the same ‘buzz’ whilst not getting into trouble with the police. Just because something is labelled as ‘legal’ doesn’t necessarily mean it’s safe though. Many of these legal highs can cause significant harm, particularly when mixed with alcohol or tobacco, and often contain substances which are illegal drugs. It is therefore essential to warn young people about the dangers of supposedly ‘legal’ highs and prevent them from progressing further into drug-taking behaviour.⁸⁸

However, misuse of alcohol or drugs (also known as substance misuse) is not just an issue for young people – it is also posing an increasing problem for older adults. The Royal College of Psychiatrist’s Report (2011) states that “because of physiological changes associated with ageing, older people are at increased risk of adverse physical effects of substance misuse, even at relatively modest levels of intake”⁸⁹. This may include a greater risk of dementia as an artefact of ageing, lower income, social isolation and stress (see section 5.5 for further details). Havering is an ageing population – the mean age of people living in Havering is 40.4 years, which is 4.8 years older than people living in London (35.6) or 1.8 years older than the national average⁹⁰. Havering also has the highest percentage of people aged 65 and over out of all the London Boroughs (Fig. 5.8) and is projected to increase further⁹¹.

⁸⁵ Matthews, S. & Richardson, A. (2005). *Findings from the 2003 Offending, Crime and Justice Survey: Alcohol-related Crime and Disorder*. Home Office Research Findings 261. Home Office, London.

⁸⁶ Gill, J.S. (2002) Reported levels of alcohol consumption and binge drinking within the UK undergraduate student population over the last 25 years. *Alcohol and Alcoholism* 37: 2; 109-120.

⁸⁷ Home Office, July 2013. *Drug Misuse: Findings from the 2012 to 2013 Crime Survey for England and Wales*. London: Home Office. Available on: <https://www.gov.uk/government/publications/drug-misuse-findings-from-the-2012-to-2013-csew/drug-misuse-findings-from-the-2012-to-2013-crime-survey-for-england-and-wales>

⁸⁸ Angelus Foundation. *Talking to your children about legal highs and club drugs: a parent’s handbook*. Available on: https://www.google.co.uk/url?q=http://www.adfam.org.uk/cms/docs/Angelus_Adfam_Parent_ClubDrug_Booklet.pdf&sa=U&ei=a3-IU7bQCqaN0AW1-IHgDw&ved=0CCAQFjAA&sig2=RuL5WpxD2PGj3YjsevDEQ&usg=AFQjCNEyDEESsBGfUzGBHKyOSMhB4CD0fw

⁸⁹ Royal College of Psychiatrists (2011) *Our invisible addicts*. College Report CR165. London RCP. Available on: <http://www.rcpsych.ac.uk/files/pdfversion/CR165.pdf>

⁹⁰ Havering JSNA (2014). *Demographics Update*. Available on: <http://www.haveringdata.net/resource/view?resourceId=DemographicsChapterJanuaryTwentyFourteen>

⁹¹ Havering Data Intelligence Hub (2013) *Population Overview*. Available on: <http://www.haveringdata.net/profiles/profile?profileId=1136&geoTypeId=5&geoids=00AR>

Figure 5.8. Percentage of People Aged 65+ in Havering, London and England (2011 Census)

	Havering	London	England
% of People aged 65+	17.86	11.10	16.44

5.5 Social Circumstances (Stress, Loneliness, Dementia, Peer Pressure)

People experiencing high degrees of stress, loneliness, bereavement etc. are at increased risk of engaging in harmful drinking and/ or drug misuse as a method of coping with the issues and problems occurring in their lives. This can apply to both young and old people – the following section outlines the issues for older people first, and then young people.

Social isolation among older people is an important public health issue that is associated with poor outcomes such as increased mortality and increased susceptibility to dementia⁹².

- Older people living alone can be an indicator of social isolation and may require more support from health and social care services
- Older people experience greater adverse outcomes as the result of drinking alcohol because of physiological changes associated with ageing – as a result they may experience greater incidence of dementia and/or more falls leading to fractures of the neck of the femur
- It is estimated that 16,300 Havering residents aged 65+ were living alone in 2012. This is predicted to increase to 17,948 older people living alone by 2020
- It is estimated that 3,760 people aged 65+ in Havering have depression. This is estimated to increase to 3,925 by 2015 and 4,146 by 2020⁹³
- It is estimated that around 3,050 older people in Havering have dementia, which is predicted to rise to 4,691 by 2030⁹⁴
- In 2011, there were approximately 560 users of learning disability services in Havering (of all ages), of which around 70 were aged 60 or older

Estimated 16,300 people in Havering live alone

Social care services supporting vulnerable people and older adults are recommended to ensure that frontline staff are aware of the potential for substance misuse amongst this population. In particular, they should be appropriately trained to raise the issue of alcohol intake and deliver brief interventions or advice on how to reduce intake to sensible levels in these circumstances.

Estimated 3,050 people in Havering have Dementia

⁹² Dickens, A., Richards, S., Greaves, C., Campbell, J. (2011) Interventions targeting social isolation in older people: a systematic review. *Journal of Public Health*, 11: 647.

⁹³ Projected Level of Need for Older People in Havering, POPPI, (2012). Available on: www.poppi.org.uk

⁹⁴ Havering JSNA (2012). *Supporting Vulnerable Adults and Older People*. London Borough of Havering, Romford. Available on: http://www.haveringdata.net/resource/view?resourceId=Supporting_Vulnerable_Adults_And_Older_People

For younger age groups, prevailing social norms and pressure to conform to certain behaviours can be particularly influential on young people. During the adolescent years, being accepted by peers is an important way that young adults understand themselves and find their identity. Peer pressure is particularly difficult for young people, where they may be singled out, teased or excluded from a group by not engaging in particular behaviours. Figure 5.9 gives some examples of the types of verbal peer pressure that can be experienced by young people, which have been developed from numerous research studies on peer pressure, and underpinned by the US Department of Health and Human Services advice on peer pressure^{95,96}. Education on how to resist peer pressure, and how to find acceptance amongst social peers without engaging in risky behaviours, is essential to improving the ages at which young people first experience alcohol and reducing drug-taking behaviours.

Figure 5.9 Peer Pressure Experienced by Young People



5.6 Gender & Pregnancy

A significantly higher percentage of people addicted to drugs and/or alcohol are male. Of the current 240,000 population in Havering, 52% are female and 48% are male. However, the gender of clients in the drug treatment system in Havering in 2012-13 features slightly higher proportion of males (75%)⁹⁷ than the national average (73%)⁹⁸, although this local proportion has reduced from 77% in

⁹⁵ Teen Alcohol Abuse (2009). *Peer Pressure Drinking*. Available on: <http://www.teenalcoholabuse.us/content/peer-pressure-drinking.html>

⁹⁶ US Department of Health and Human Services (2014). *The Cool Spot, Peer Pressure*. Available on: <http://www.thecoolspot.gov/pressures.asp>

⁹⁷ PHE (2013) *Partnership Adult Drug Performance Report 2012-13, Quarter 4 Havering (H02B)*

⁹⁸ PHE (2013) *National Adult Drug Performance Report 2012-13, Quarter 4*

2011-12 (Fig. 5.10). We also need to continue to check the appropriate availability and accessibility of our drug services for women. In terms of alcohol treatment, for 2012-13 the sex split in Havering was 61% male and 37% female (2% not stated), compared with a national 65% male and 36% female (rounding creating total above 100%). There is no notable difference between the national and local gender split.

Figure 5.10 Relative Proportions of Male and Females in Drug or Alcohol Treatment

% of clients in treatment	Drug Treatment		Alcohol Treatment	
	Men	Women	Men	Women
Havering	75	25	61	37
National	73	27	65	36

Drinking alcohol during pregnancy is also a significant risk factor specifically for women. Alcohol and substance misuse and domestic violence are key risk factors for perinatal mental health disorders; the perinatal period covers pregnancy and in the first year after birth⁹⁹. Around 1 in 10 women in London will experience some kind of perinatal mental health condition¹⁰⁰, and a proportion of these will arise from these risk factors of drug and alcohol misuse, or domestic violence.

Fetal alcohol spectrum disorders (FASD) are a group of conditions that can occur in a person whose mother drank alcohol during pregnancy. As alcohol is a toxic substance, alcohol in the mother’s blood passes through the umbilical cord to the baby, where it can harm the development of the baby. However, not every mother who drinks heavily during pregnancy has a baby with Fetal Alcohol Syndrome. It is also not know exactly how much alcohol is safe to drink during pregnancy, but heavy drinking and binge drinking are more likely to cause damage to the baby¹⁰¹.

The range of disorders include:

- Fetal Alcohol Syndrome (FAS)
- Partial Fetal Alcohol Syndrome (PFAS)
- Alcohol Related Neuro-developmental Disorder (ARND)
- Alcohol Related Birth Defects (ARBD)
- Fetal Alcohol Effects (FAE)

There were 313 reported cases of Fetal Alcohol Syndrome in England in 2012-13

Fetal Alcohol Syndrome Disorders (FASDs) are lifelong conditions that can have a severe impact on individuals and their families - leading to a wide range of difficulties including low IQ, memory disorders, attention disorders, speech and language disorders, visual and hearing defects, epilepsy and heart defects. They are caused entirely by drinking alcohol during pregnancy, and so are completely preventable.

⁹⁹ Korkodilos, M. (2014). *The health and wellbeing of children and young people in London: an evidence based resource*. Public Health England. Presentation given 31st March 2014.

¹⁰⁰ Greater London Authority (2014) *London mental health: The invisible costs of mental ill health*

¹⁰¹ Patient.co.uk (2014) Fetal Alcohol Syndrome. Available on: <http://www.patient.co.uk/health/fetal-alcohol-syndrome>

Data from the Health and Social Care Information Centre (HSCIC), Hospital Episode Statistics cite that there were 313 cases of Fetal Alcohol Syndrome (FAS) in England in 2012-13, plus several other diagnoses where maternal drug or alcohol use has affected the health of their fetus or newborn child (Fig. 5.11)¹⁰². The number of reported cases of FAS has increased dramatically from 2002-3 in which there were 128 cases reported in England¹⁰³. However, despite having these indicative figures, it is acknowledged that we do not have reliable information about the incidence of FASD across the whole of the UK, and it is likely that significant numbers of children are not diagnosed. FASD can be caused by mothers drinking even before they know they are pregnant; so preventing the incidence of these disorders is strongly linked to reducing the levels of heavy drinking in the population as a whole, and especially among women.

Figure 5.11 Number of Reported Cases of Fetal Health Being Affected by Maternal Drug or Alcohol Misuse in England 2012-13

Diagnosis	Number of Reported Cases
Maternal care for (suspected) damage to fetus from alcohol	29
Maternal care for (suspected) damage to fetus by drugs	231
Fetus and newborn affected by maternal use of alcohol	54
Fetus and newborn affected by maternal use of drugs of addiction	368
Fetal Alcohol Syndrome	313

In Havering, there were no known women entering alcohol treatment who were pregnant in 2011-12. Continuing to raise awareness of the need for women who are pregnant or trying to conceive to avoid alcohol, including by increasing the awareness of health professionals is a feature of the Government's Alcohol Strategy and will require local implementation.

5.7 Ethnicity

Research by the Joseph Rowntree Foundation shows that there is diversity both within and between ethnic groups in their use or misuse of alcohol¹⁰⁴:

- Most minority ethnic groups have higher rates of abstinence and lower levels of drinking compared to people from white backgrounds.

¹⁰² Health and Social Care Information Centre (2014). *Hospital Episode Statistics, Admitted Patient Care, England, 2012-13* Available on: <http://www.hscic.gov.uk/catalogue/PUB12566/hosp-epis-stat-admi-diaq-2012-13-tab.xlsx>

¹⁰³ BMA Board of Science (2007). *Fetal Alcohol Spectrum Disorders: A guide for healthcare professionals*. London: British Medical Association. Available on: https://www.google.com/url?q=http://nofasaa1.miniserver.com/~martin/PDF/BMA%2520REPORT%25204%2520JUNE%25202007.pdf&sa=U&ei=sWCIU7OtOsSsPeieglAM&ved=0CDcQFjAE&sig2=j6_WXN0PavUFS9tZmpf9Og&usg=AFQjCNHtkBbIAUN57qQP-X2nTgm7mdBeHQ

¹⁰⁴ Hurcombe, R., Bayley, M. & Goodman, A. (2010). *Ethnicity and Alcohol: a review of the UK literature*. The Joseph Rowntree Foundation, York. Available on: http://www.google.co.uk/url?q=http://www.jrf.org.uk/sites/files/jrf/ethnicity-alcohol-literature-review-summary.pdf&sa=U&ei=v9cdU9_SKY-ihgeCjIDgCg&ved=0CCcQFjAB&usg=AFQjCNHD9XQOVVXeM94J-C00ngUPo8iwmw

- Abstinence is high amongst South Asians, particularly those from Pakistani, Bangladeshi and Muslim backgrounds. But Pakistani and Muslim men who do drink do so more heavily than other non-white minority ethnic and religious groups.
- People from mixed ethnic backgrounds are less likely to abstain and more likely to drink heavily compared to other non-white minority ethnic groups
- People from Indian, Chinese, Irish and Pakistani backgrounds on higher incomes tend to drink above recommended limits.

Over time generational differences may emerge:

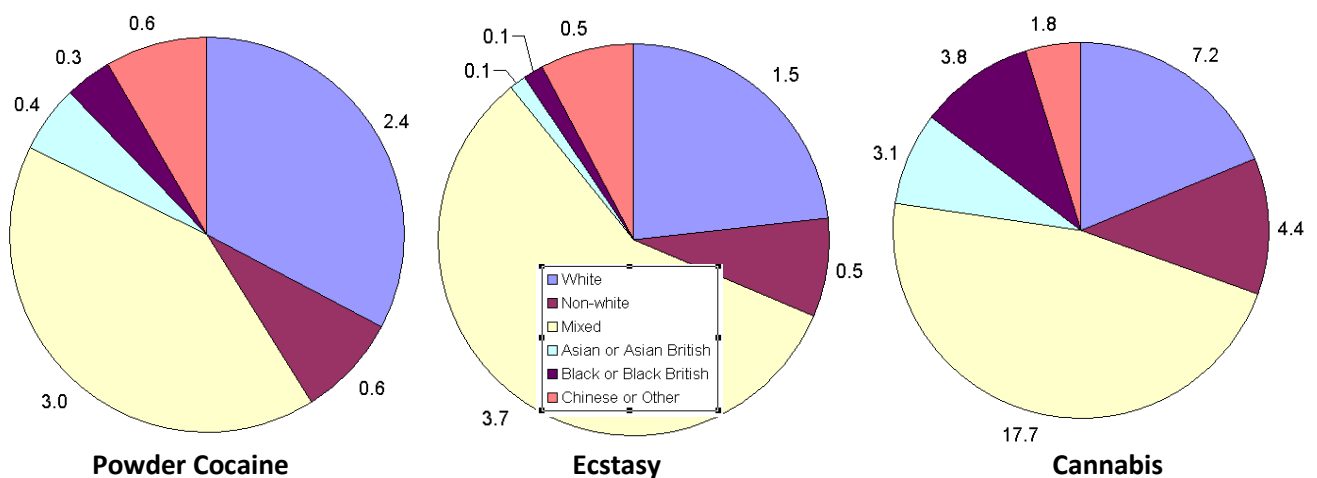
- Frequent and heavy drinking has increased for Indian women and Chinese men.
- Drinking among Sikh girls has increased whilst second generation Sikh men drink less than first generations. People from some ethnic groups are more at risk of alcohol-related harm
- Irish, Scottish, and Indian men, and Irish and Scottish women have higher than national average alcohol-related deaths in England and Wales.
- Sikh men are overrepresented for liver cirrhosis.
- People from minority ethnic groups have similar levels of alcohol dependence compared to the general population, despite drinking less

Services are reportedly not responsive enough:

- Minority ethnic groups are under-represented in seeking treatment and advice for drinking problems.
- Problem drinking may be hidden among women and young people from South Asian ethnic groups in which drinking is proscribed.
- Greater understanding of cultural issues is needed in developing mainstream and specialist alcohol services.

Drug-using behaviour is also sensitive to ethnicity. Data from the Crime Survey for England and Wales (2010-11) showed that 16-59 year olds from a mixed race background were relatively more likely to take powder cocaine, ecstasy or cannabis than other ethnicity groups (Fig. 5.12). However, it should be noted that there were far fewer actual numbers of mixed race respondents to the survey than white respondents.

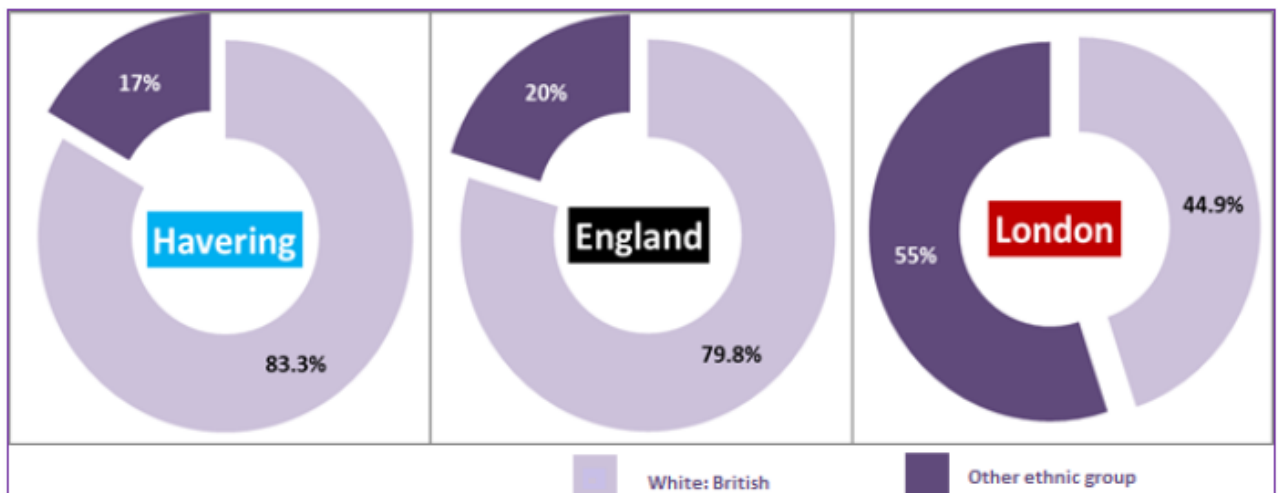
Figure 5.12 Relative Percentages of Drug use Amongst Ethnic Groups



Havering has a significantly lower percentage of ethnic minority groups than either London or England (Figs. 5.13 and 5.14)¹⁰⁵. However, this should not mask any potential differences in the way services respond to the needs of different ethnic groups – this is further explored in section 7, examining the treatment services available to people in Havering. For example, the research above identified people from Indian, Chinese, Irish and Pakistani backgrounds on higher incomes as tending to drink above the recommended levels.

There are 11,545 people from Asian backgrounds plus further 3,149 people from Irish or Irish traveller backgrounds living in Havering. Given the relative affluence of the borough compared with other London boroughs, it is highly likely that there will be a significant number of people within these groups who may be drinking above recommended levels. In addition, the report also states that second generation ethnic minorities may be drinking at levels more akin to the general resident population, and so their alcohol intake may be increasing.

Figure 5.13 Percentage of Majority and Minority Ethnic Groups in Havering, London and England (2011 Census).



¹⁰⁵ Havering JSNA (2014). *Demographics Update*. Available on: <http://www.haveringdata.net/resource/view?resourceId=DemographicsChapterJanuaryTwentyFourteen>

Figure 5.14 Ethnicity Profile of Havering Residents (2011 Census)

	Comparable Census 2011 Ethnic Groups	Population count	% of total havering population
White	White; English/Welsh/Scottish/Northern Irish/British	197,615	83.3%
	White; Irish	2,989	1.3%
	White; Gypsy or Irish Traveller	160	0.1%
	White; Other White	7,185	3.0%
Mixed	Mixed/Multiple Ethnic Groups; White and Black Caribbean	1,970	0.8%
	Mixed/Multiple Ethnic Groups; White and Black African	712	0.3%
	Mixed/Multiple Ethnic Groups; White and Asian	1,154	0.5%
	Mixed/Multiple Ethnic Groups; Other Mixed	1,097	0.5%
Asian	Asian/Asian British; Indian	5,017	2.1%
	Asian/Asian British; Pakistani	1,492	0.6%
	Asian/Asian British; Bangladeshi	975	0.4%
	Asian/Asian British; Chinese	1,459	0.6%
	Asian/Asian British; Other Asian	2,602	1.1%
Black	Black/African/Caribbean/Black British; African	7,581	3.2%
	Black/African/Caribbean/Black British; Caribbean	2,885	1.2%
	Black/African/Caribbean/Black British; Other Black	1,015	0.4%
Other	Other Ethnic Group; Arab	311	0.1%
	Other Ethnic Group; Any Other Ethnic Group	1,013	0.4%

Data Source: Census 2001 and 2011

5.8 Criminal Behaviour & the Criminal Justice System

Both alcohol and drugs play a significant part in crime and violent behaviour. There is a high prevalence among the offender population of drinking at higher risk levels, both among adults and young offenders – 19% of prisoners reported having alcohol problems when entering prison. This percentage is even higher for young adults entering prison (30%) and for women entering prison (29%)¹⁰⁶. In addition, with particular reference to the ‘toxic trio’ outlined in section 5.1, prisoners are more likely to suffer from more than one health problem at the same time (known as comorbidity), particularly mental health conditions. Addiction problems and severe mental disorders are particularly high in the prison population, most notably with antisocial personality,

19% of prisoners reported having alcohol problems when entering prison

¹⁰⁶ HM Inspectorate of Prisons (2010). *Alcohol services in prisons: an unmet need*. London: HM Government. Available on: http://www.google.co.uk/url?q=http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/thematic-reports-and-research-publications/Alcohol_2010_rps.pdf&sa=U&ei=T_YdU9v_K5Hy7AbI44HoBw&ved=0CDAQFjAA&usq=AFQjCNEsaDYRSPH3gHUAJeKJ3af1r7xiBg

schizophrenia, and bipolar disorders (Fig. 5.15)¹⁰⁷. Many of these may also be engaged in drug or alcohol misuse.

Figure 5.15 Prevalence of Mental Health Issues Amongst Prisoners Compared with the General Population

Percentages (%)	Sentenced Prisoners		General Population	
	Men	Women	Men	Women
Personality Disorder	64	50	5	3
Anxiety	21	32	8	9
Depression	33	51	10	12
Psychotic Disorder	7.7	14	1	0.5

In addition, amongst 18-24 year olds, 3 times as many men and twice as many women classified as 'binge' drinkers have participated in violent crime or group fights than 'regular' drinkers (Fig. 5.16)¹⁰⁸.

Figure 5.16 Prevalence of Offending for Those Aged 18-24, by Sex and Drinking Status

Percentages (%)	Binge Drinker			Other Regular Drinker		
	Men	Women	All	Men	Women	All
Any offence	49	22	39	21	8	14
Violent crime	25	3	17	7	1	4
Group fight in public place	22	2	15	6	1	3
Theft	16	4	11	10	3	6
Criminal Damage	7	<1	4	1	0	0

Estimated 30-50% of acquisitive crime due to drug-using offenders

Acquisitive crime, including residential burglary, theft of a motor vehicle, theft from a motor vehicle or robbery, is a strategic priority for the Havering Community Safety Partnership¹⁰⁹. It is estimated that 30-50% of such acquisitive crime is due to drug-using offenders¹¹⁰. Entry into the criminal justice system punishes offenders but can also be an opportunity to provide support to overcome alcohol and drug problems and prevent further offending.

¹⁰⁷ Reference provided by NHS England for Havering Crime and Disorder Committee, 17th October 2013. Available on: <http://democracy.havering.gov.uk/ieListDocuments.aspx?Cid=140&MID=2637#AI5826>

¹⁰⁸ Richardson, A., Budd, T., Engineer, R., Phillips, A., Thompson, J., Nicholls, J. (2003) *Drinking, Crime and Disorder*. London: Home Office. Available on: http://www.popcenter.org/problems/assaultsinbars/PDFs/Richardson_etal_2003.pdf

¹⁰⁹ Havering Community Safety Partnership Strategic Assessment 2013. London Borough Of Havering, Romford.

¹¹⁰ National Treatment Agency for Substance Misuse (2009). *Breaking the Link: The role of drug treatment in tackling crime*. London; NTA. Available on: http://www.nta.nhs.uk/publications/documents/nta_criminaljustice_0809.pdf

Figure 5.17 shows the re-offending rates for drug-misusing adults and the re-offending rates for juveniles from 2009-2011¹¹¹. Efforts to tackle dependency on drugs begun in prison should be continued on release. Testing on arrest and the placement of drug and alcohol workers in police custody suites can facilitate the timely assessment offenders and signposting to appropriate treatment services.

Figure 5.17 Havering Re-Offending Rates (Change from 2009-2011)

	2011	2010	2009	Change (2011 vs 2010)	Change (2011 vs 2009)	Rank of Rate 2011 (MPS 1 = worst)
Drug Misusing – Re-offending Rate	68.4	56.5	60.3	+11.9	+8.1	1*
Drug Misusing – Avg. Rate of Re-offences	3.77	4.09	2.81	-0.32	+0.96	18
Drug Misusing – Frequency Rate	2.58	2.31	1.69	+0.27	+0.89	6
Juvenile – Re-offending Rate	29.9	33.4	27.5	-3.5	+2.4	30
Juvenile – Avg. Rate of Re-offences	2.78	2.30	2.04	+0.48	+0.74	12
Juvenile – Frequency Rate	0.83	0.77	0.56	+0.06	+0.27	29

**Havering has the 5th smallest drug misusing cohort in London – 57 compared to an average of 231, therefore a small number of offenders can have a significantly adverse impact on the re-offending rate.*

In order to effectively commission services for those most at risk of drug and alcohol abuse, commissioners need to consider the interplay between the cause or effect. Some people identified at risk start misusing alcohol or drugs as a consequence of their personal or social circumstances. Others are at risk of other harms as a result of their drug-taking or alcohol consumption behaviour. The following section examines the impact that drug and alcohol misuse can have on individuals as well as Havering as a whole.

¹¹¹ Havering Community Safety Partnership Strategic Assessment 2013. London Borough Of Havering, Romford.

6.0 The Harms Caused by Drugs and Alcohol

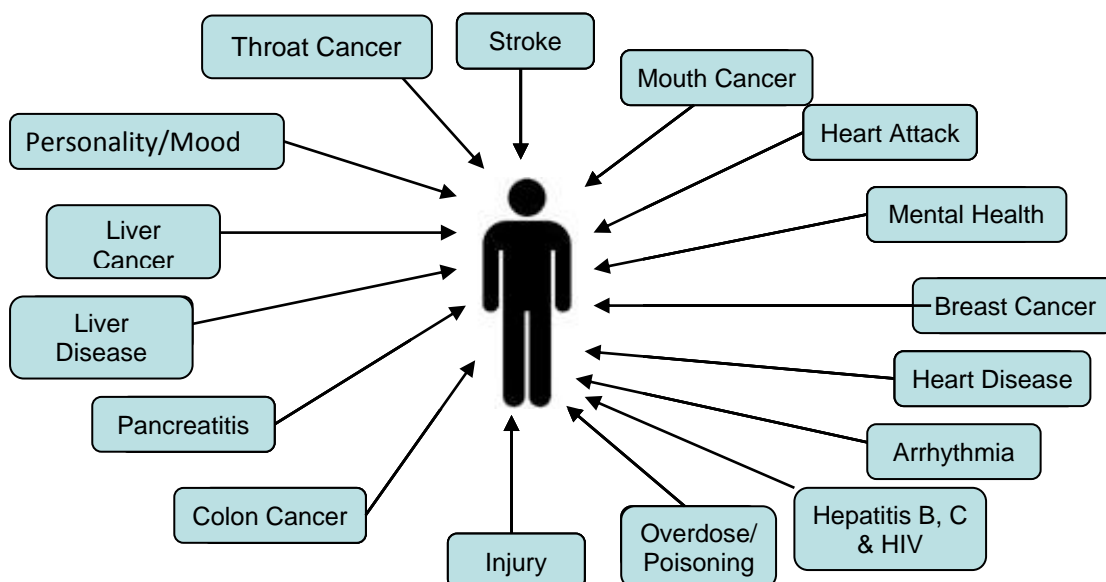
The harm caused by misuse of alcohol and drugs can come in many forms including premature death; violent crime; and family breakup. In this section we seek to describe the harm in terms of health; social; and criminal justice terms.

6.1 The Harms Caused by Drugs and Alcohol In Health Terms

Alcohol consumption is a contributory cause of more than 200 diseases including various cancers, cirrhosis of the liver, and stroke. Similarly, drugs can have a significant impact on health. Figure 6.1 depicts the range of health impacts that drugs or alcohol can have on an individual.

In most cases, the more alcohol consumed, the higher the risks of alcohol-attributable disease. The threshold at which the risk of ill-health is increased is relatively low, but the risk increases dramatically at higher levels such that most of the health harms related to alcohol are born by those engaged in heavy drinking, both regularly and irregularly. A significant proportion of such drinkers would be classed as dependent. Drugs, however, can have a significantly harmful, and in some cases fatal effect after just one use of the substance, though this is extremely rare. Inhalation of nitrous oxide, or laughing gas, for example, can cause unconsciousness or death from lack of oxygen. This occurs when the available oxygen for breathing is effectively pushed out by the nitrous oxide. The risk is greater if the gas is consumed in an enclosed space or if a plastic bag is used that covers both nose and mouth.

Figure 6.1 Health Impacts of Drugs and Alcohol



The following section outlines the harms from alcohol and drug use separately, but there are numerous joint impacts of both drugs and alcohol. In particular, and specifically for Havering which has a large proportion of powder cocaine users entering treatment in the borough compared with other boroughs across the UK, the combined effect of taking powder cocaine and alcohol together poses even greater physical and psychiatric risks. Whilst there are inherent risks in taking either

excessive alcohol or cocaine individually, the combined effect creates a third compound in the body, coca-ethylene, the risks of which include:

- greater risk of heart attack
- liver toxicity
- Coca ethylene increases dopamine release and can lead to sudden cardiac death
- respiratory problems
- stroke
- psychiatric problems
- spontaneous abortion and birth defects

Combined psychiatric effects include:

- more euphoric and rewarding leading to an increased high
- decrease in alcohol sedation or cognitive impairment
- increase in interpersonal and physical violence
- increase in sexual risk behaviours
- increase in impulsive decision making and decrease impact on memory and learning¹¹²

Another health impact affected by taking both drugs and alcohol is the incidence of sexually transmitted infections (STIs). The loss of inhibitions or control that can occur with drugs or alcohol can lead to increased risks in sexual behaviour and hence increased risk of sexual health infections. Commissioners are currently working to develop the workforce to increase frontline knowledge and expertise around sexually transmitted infections (STIs) and establish robust care pathways between Havering genito-urinary medicine (GUM) clinics and drugs and alcohol services. Prevalence of these issues in the drug and alcohol treatment populations are not systematically collected, and restrictive GUM clinic confidentiality is a piece of work requiring national attention.

6.1.1 Health Effects of Alcohol – short and long term

As well as the (usually) more pleasant effects of alcohol, including feelings of euphoria, or a ‘buzz’, alcohol is nevertheless a poison. As with most other toxins encountered by the body, it is the liver’s function to process toxins, but it has its limits – it takes around an hour for the liver to process one unit of alcohol. In the short term, drinking too much too quickly can cause acute effects on the body including¹¹³:

- slow down your brain functions so you lose your sense of balance –
 - this can often lead to accidental injury from falls or trips; in older people this may be a causal factor in fractures to the neck of the femur (hip fractures)
 - loss of inhibition may lead to more aggressive behaviour and injury may be sustained through fights
- irritate the stomach which causes vomiting and it stops your gag reflex from working properly – you can choke on, or inhale, your own vomit into your lungs.
- affect the nerves that control your breathing and heartbeat, it can stop both
- dehydrate you, which can cause permanent brain damage
- lower the body’s temperature, which can lead to hypothermia
- lower your blood sugar levels, so you could suffer seizures

¹¹² Cocaine and Alcohol: The hidden mixer. Alex Meikle. Glasgow Council on Alcohol. October 2006

¹¹³ Drinkaware (2014). *Check the Facts: Alcohol Poisoning*. Available on: <https://www.drinkaware.co.uk/check-the-facts/health-effects-of-alcohol/effects-on-the-body/alcohol-poisoning>

In the longer term, chronic sustained or heavy drinking can cause lasting damage, particularly liver disease, cirrhosis of the liver, cancers of the mouth, throat, breast, liver and colon and pancreatitis, stroke and heart disease amongst others. In Havering, the directly standardised rate of mortality from chronic liver disease is lower for men than the rate for both London and England, but the rate for women is higher than that for London (Fig 6.2).

Mortality from Chronic Liver Disease is higher for Women in Havering than London

Figure 6.2 Directly Standardised Rate per 100,000 Population of Mortality from Chronic Liver Disease 2010-2012 for Men and Women¹¹⁴

DSR per 100,000	Havering	London	England
Men	12.16	15.45	15.75
Women	8.74	6.77	8.33

The common causes of liver disease are alcohol, Hepatitis and obesity. In comparison with other local authorities in England (149 local authorities in total), Havering's rate of premature deaths from liver disease is relatively low – Havering ranks 42nd out of 149 local authorities with a rate of 15 deaths per 100,000 population. However, when Havering is compared with 14 other local authorities in the same deprivation bracket, Havering ranks 11th out of the 15 authorities (Fig. 6.3)¹¹⁵. The comparator local authorities include – Harrow, Barnet, Suffolk, Somerset, Poole, Bexley, Shropshire, Sutton, Solihull, Worcestershire, Staffordshire, (Havering), Swindon, Cheshire West and Chester, and Milton Keynes.

Figure 6.3 Premature Deaths for Liver Disease in Havering (rate per 100,000) compared with All Local Authorities (left) or with Similar Local Authorities (right) in the Same Deprivation Bracket



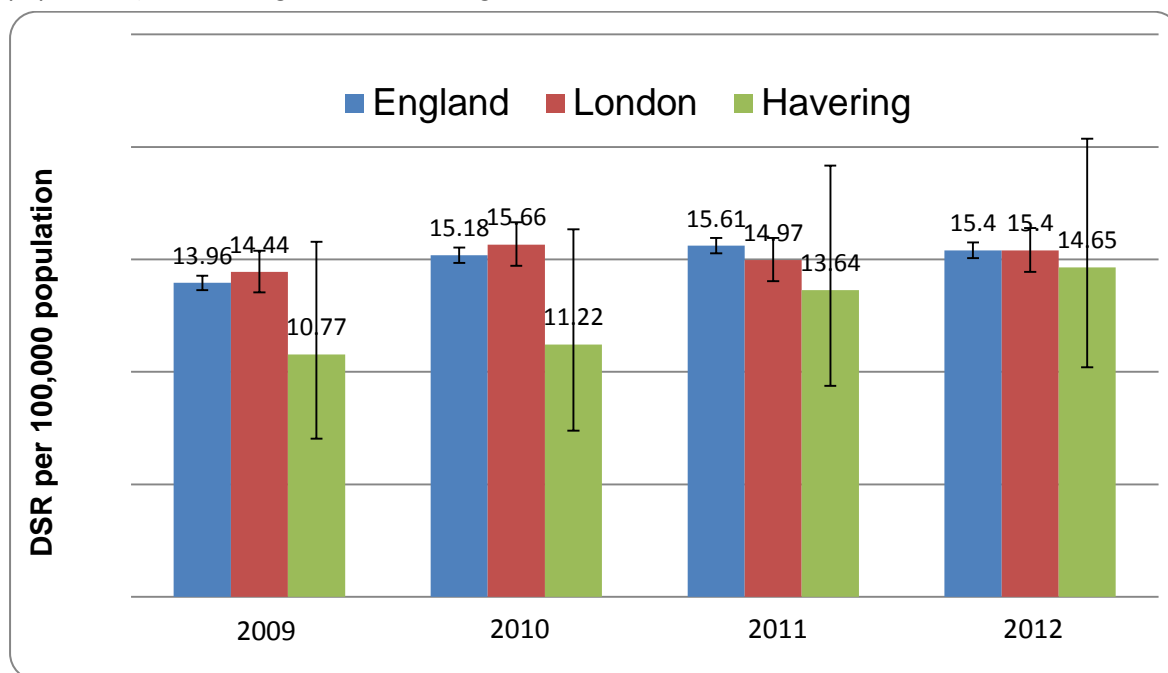
Common Causes of Liver Disease are Alcohol, Hepatitis and Obesity

¹¹⁴ Local Alcohol Profiles for England (LAPE). Local Authority Indicators Update (2014). Available on: http://www.lape.org.uk/downloads/LAPE_LA_Dataset_PHE_250414_FINAL.xlsx

¹¹⁵ Public Health England (2013). *Longer Lives: Mortality Rankings*. Available on: <http://longerlives.phe.org.uk/area-details#are/E09000016/par/E92000001>

In addition, the trend in premature mortality in Havering is increasing. Whilst in 2012 the rate for premature mortality from liver disease in Havering (14.65 per 100,000) was lower than that for both London and England (15.4 per 100,000), it has steadily increased from 10.77 per 100,000 in 2009 (Fig. 6.4)¹¹⁶.

Figure 6.4 Trend in Premature Mortality from Liver Disease (Age Standardised Rates per 100,000 population) in Havering, London and England 2009-2012



Prolonged and excessive alcohol consumption is also a major risk factor for cancer, along with smoking and poor diet. Havering's rate of cancer is worse than that for liver disease, ranking 77th out of 150 local authorities, with a rate of 148 deaths per 100,000 population. In comparison with similar local authorities in the same deprivation bracket, Havering has one of the worst rates for cancer, ranking 13th out of the 15 similar local authority areas (Fig. 6.5)¹¹⁷.

Whilst it is acknowledged that smoking is a major cause of cancer, in comparison with the similar local authorities in its group on the Public Health England 'Longer Lives' website¹¹⁸, Havering ranks 5th Highest for smoking rates out of the group of 15 local authorities. Therefore, it is not just smoking causing the high rate of cancer in Havering, and poor diet and excessive alcohol consumption are both major contributory factors.

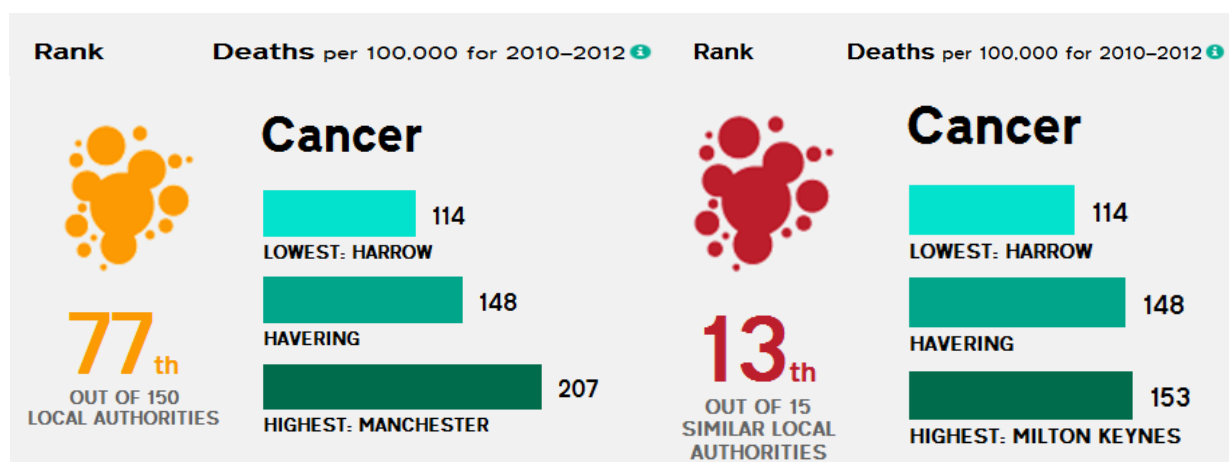
¹¹⁶ Health and Social Care Information Centre (HSCIC) (2013). *Dataset 1.7 Under 75 Mortality Rates from Liver Disease*. Available on:

www.indicators.ic.nhs.uk/download/Clinical%20Commissioning%20Group%20Indicators/Data/CCG_1.7_100768_D_V3.xls

¹¹⁷ Public Health England (2013). *Longer Lives: Mortality Rankings*. Available on: <http://longerlives.phe.org.uk/area-details#are/E09000016/par/E92000001>

¹¹⁸ PHE Longer Lives

Figure 6.5 Premature Deaths for Cancer in Havering (rate per 100,000) compared with All Local Authorities or with Similar Local Authorities in the Same Deprivation Bracket



Common Causes of Cancer are Smoking, Alcohol and Poor Diet

The impact of developing such conditions can be expressed in terms of life lost, either through living with disability as a result these conditions, or dying sooner than he or she would have been expected to live. Figure 6.6 shows that in Havering men lose more months of life due to alcohol than women, and these figures are better than those for London or England as a whole¹¹⁹.

Figure 6.6 Months of Life Lost Due to Alcohol Aged Less Than 75 Years (2010-12)

	Havering		London		England	
	Men	Women	Men	Women	Men	Women
Months of Life Lost <75 years	8.37	4.05	10.17	4.45	11.49	5.38

The impact of such conditions on a person’s life is captured through the Global Burden of Disease (GBD). The GBD study is a comprehensive regional and global assessment of the numbers of deaths and disability from major injuries, diseases and risk factors. The GBD uses 3 measures to quantify the harm caused by diseases, but also behaviours that increase the risk of that disease:

- YLL = Years of Life Lost – an estimate of the average years a person would have lived if he or she had not died prematurely¹²⁰
- YLD = Years Lived with Disability – the number of years lost due to disability from a health condition or its consequences¹²¹
- DALYs = Disability Adjusted Life Years – one lost year of ‘healthy life’

550 Years Lived in Disability (YLD) due to alcohol in Havering

¹¹⁹ Local Alcohol Profiles for England (LAPE). Local Authority Indicators Update (2014). Available on: http://www.lape.org.uk/downloads/LAPE_LA_Dataset_PHE_250414_FINAL.xlsx

¹²⁰ Gardner, J.W., Sanborn, J.S. (1990). Years of Potential Life Loss (YPLL) – what does it measure? *Epidemiology* 1: 4; 322 – 329. Available on: <http://www.ncbi.nlm.nih.gov/pubmed/2083312>

¹²¹ World Health Organisation (2014). *Health Statistics and Health Information Systems: Metrics: Disability Adjusted Life Year (DALY)*. Available on: http://www.who.int/healthinfo/global_burden_disease/metrics_daly/en/

Figure 6.7 shows the number of years of healthy life lost in Havering due to a range of lifestyle factors. Taking into account the whole of the Havering population, its age profile, prevalence of health conditions and estimates for the numbers of people engaging in unhealthy behaviours, 470 DALYs for alcohol and 134 DALYs for drug use are lost each year. Data are available for alcohol and drug dependency, but also conditions such as cirrhosis of the liver, which is to a great extent the result of alcohol and drug use.

DALYs due to cirrhosis of the liver in the UK increased by 60% in the 20 years from 1990 to 2010; over the same period DALYs for all causes fell by 8%. To a large extent this increase reflected the increasing harm resulting from alcohol use and Hepatitis C infection. Intravenous drug users make up a significant proportion of Hepatitis C cases.

Figure 6.7 Number of Disability Adjusted Life Years (DALYs) Attributable to Alcohol in Relation to Other Lifestyle and Behavioural Risk Factors in Havering



The development of certain conditions can either be wholly or partly attributable to alcohol:

- Alcohol-specific conditions include those conditions where alcohol is causally implicated in *all* cases of the condition; for example, alcohol-induced behavioural disorders and alcoholic liver cirrhosis. By definition, the alcohol-attributable fraction equals one because no cases would be expected to arise in the absence of alcohol.
- Attributable fraction values, or population attributable fractions, are the proportion of conditions that are attributable to exposure to a specific risk factor (such as alcohol) in a given population. In some cases, such as crime, alcohol-attributable fractions estimate the statistical association between measures of alcohol and crime, and not necessarily the causal association, and should therefore be distinguished from the disease specific alcohol-attributable fractions used for the hospital admission and mortality indicators¹²².

An alcohol-attributable fraction is the attributable fraction due to alcohol i.e. 1 = 100%, 0.25 = 25% of cases are attributable to alcohol.

Havering’s rate of mortality *specifically* related to consumption of alcohol is lower than the rate for both London and England for men, but slightly higher than the rate for London for women (Fig 6.8). Figure 6.8 shows the Directly Standardised Rate (DSR) per 100,000 population – direct standardisation is calculated by applying the rates that would be expected for a standard population to a local population in order to be able to make direct comparisons between similar population groups. Havering’s rate of conditions which are *attributable* to alcohol are higher for women in Havering than London¹²³.

Figure 6.8 Alcohol-specific and Alcohol-Related Mortality for Men and Women in Havering, London and England 2010-12

2008-2010 Mortality	Havering		London		England	
	Men	Women	Men	Women	Men	Women
Alcohol-Specific Rate	7.28	3.96	12.10	4.39	14.57	6.78
Alcohol-Related Rate	53.96	19.45	59.07	24.51	63.2	28.05

Alcohol mortality presents an interesting picture with significant gender differences. Of particular significance, male alcohol mortality rates are much higher than the rates for women (Figure 6.9). In 2012, there appears to be a slight drop in the alcohol-related mortality rate for women, but a slight

¹²² LAPE (2014). *User Guide: Local Alcohol Profiles for England*. Public Health England. Available on: http://www.lape.org.uk/downloads/LAPE%20User%20Guide_Final.pdf

¹²³ Local Alcohol Profiles for England (LAPE). Local Authority Indicators Update (2014). Available on: http://www.lape.org.uk/downloads/LAPE_LA_Dataset_PHE_250414_FINAL.xlsx

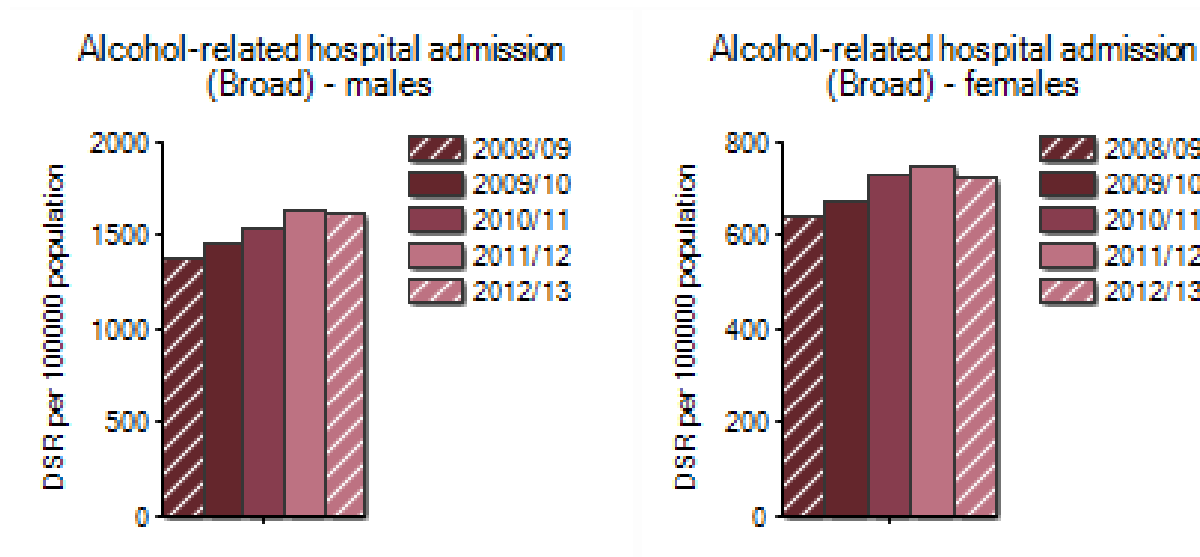
rise for men. Therefore, greater emphasis needs to be placed on the issue of men’s consumption of alcohol and its longer term, or chronic, effects.

Figure 6.9 Alcohol-Attributable Mortality Rates for Men and Women in Havering 2008-2012



Rates of hospital admissions recorded as specifically resulting from alcohol are better than the London and England averages for both males and females. Admissions that are more broadly ‘attributable’ to alcohol show a similar pattern for both men and women (Fig. 6.10). The ‘broad’ measure employed in the Local Alcohol Profiles for England (LAPE) includes a hospital admission where alcohol is implicated in the primary diagnosis or any secondary diagnosis, and does not include attendance only at A&E departments. Two examples of this would be i) a person admitted to inpatient wards with chronic liver disease (which is attributable to alcohol), or ii) a person admitted to A&E with a primary diagnosis of leg fracture, with a secondary diagnosis of acute alcohol intoxication¹²⁴.

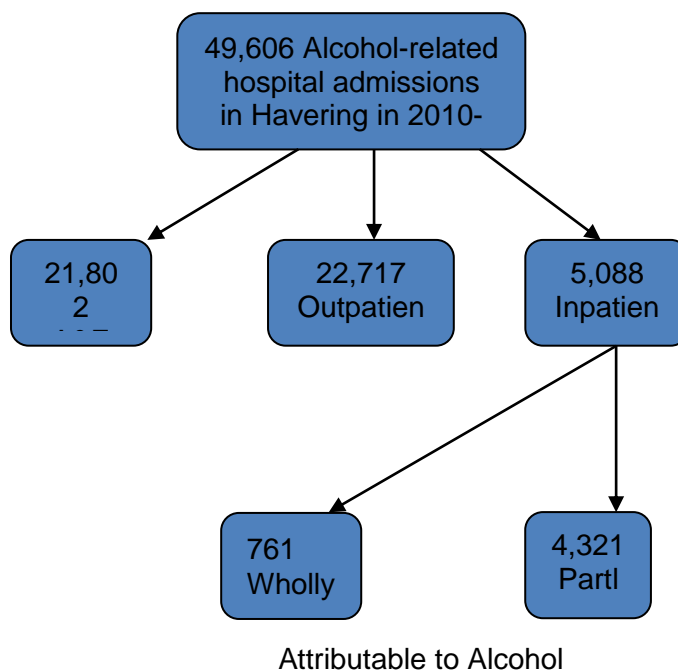
Figure 6.10 Alcohol-Attributable Hospital Admission in Havering 2008-2012



¹²⁴ The ‘narrow’ measure, now also included in the LAPE profile, counts only those hospital admissions where alcohol is a factor in the primary cause for attendance only

The overall rate of admissions has, however, increased by 8% from 2010/11 to 2011/12, more than both the regional average (7%) and the England one (4%)¹²⁵. Analysis of Hospital Episode Statistics (HES) data paints a similar picture, showing that there are still large, and increasing numbers of admissions for alcohol related harm per year¹²⁶. In Havering, there were just under 50,000 admissions to hospital for alcohol-related conditions in 2010-11(Fig. 6.11). Of these, 5,088 were for conditions serious enough to be admitted as an inpatient – 761 of these were wholly attributable to alcohol.

Figure 6.11 Estimated number of Alcohol-Related Hospital Admissions in Havering Wholly or Partly Attributable to Alcohol ¹²⁷



Havering’s rate of admissions to hospital with alcohol-specific conditions for children aged under 18 years are broadly similar to London and lower than the rate for England (Figs 6.12 and 6.13).

Figure 6.12 Under 18 years and All ages Admitted to Hospital with Alcohol-Specific Conditions

DSR ¹²⁸ per 100,000	Aged Under 18 years (Men and Women)	All Ages Men	All Ages Women
Havering	35.24	299.75	139.82
London	35.72	439.15	170.87
England	55.79	450.90	225.01

¹²⁵ LAPE (2012). Available on: <http://www.lape.org.uk/LAProfile.aspx?reg=h>

¹²⁶ Hospital Episode Statistics Data 2008-2011, collated by NHS ONEL informatics team.

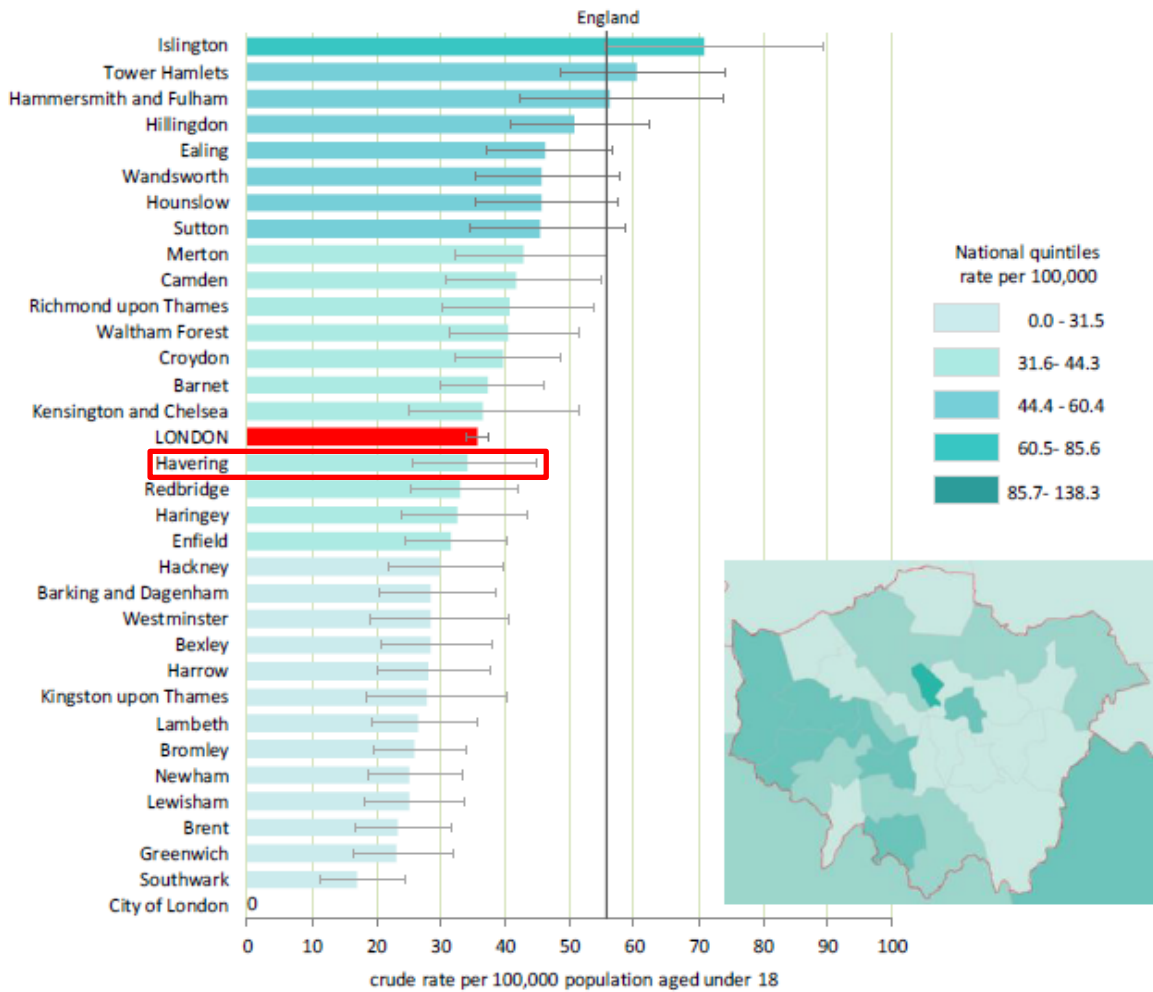
¹²⁷ Alcohol Concern (2013). Alcohol Harm Map. Havering Data 2010-11. Available on:

<http://www.alcoholconcern.org.uk/campaign/alcohol-harm-map>

¹²⁸ Directly Standardised Rate

Figure 6.13 Hospital Admissions Due to Alcohol Specific Conditions in Children and Young People Aged under 18 years, 2008-9 to 2010- 11

ALCOHOL ADMISSIONS*, London, 2008/9-10/11



Source: PHE Local Alcohol Profile (LAPE) data set using HES data. Map – PHE ChiMat using LAPE data
 * Hospital Admission (not A&E) due to alcohol specific conditions

6.1.2 Health Effects of Drugs

As with alcohol, there are both acute (short term) and chronic (long term) effects of drug-taking. In many cases the effects are altered or amplified when taken in combination with alcohol. Therefore, the health impacts of drugs should be considered alongside those of alcohol, as well as an individual substance misuse problem in its own right. Figure 6.14 gives an overview of the short and long-term effects of the predominant drugs used in Havering, and their effects when taken in combination with alcohol¹²⁹.

¹²⁹ National Institute on Drug Abuse (2014). *Health Effects (of commonly abused drugs)*. Available on: <http://www.drugabuse.gov/drugs-abuse/commonly-abused-drugs/health-effects>

Figure 6.14 Acute (Short-term) and Chronic (Long-term) Health Effects of Drugs and the impact when taken with alcohol

Drug	Acute Effect (Short Term)	Chronic Effect (Long Term)	In Combination with Alcohol
Cannabis	Heightened sensory perception; euphoria, followed by drowsiness/relaxation; impaired short-term memory, attention, judgment, coordination and balance; increased heart rate; increased appetite	Addiction: About 9 % of users; about 1 in 6 of those who started using in their teens; 25 to 50 % of daily users. Mental disorders: may be a causal factor in schizophreniform disorders ¹³⁰ (in those with a pre-existing vulnerability); is associated with depression and anxiety	Magnified tachycardia ¹³¹ and effect on blood pressure; amplified impairment of cognitive, psychomotor, and driving performance
Cocaine	Dilated pupils; increased body temperature, heart rate, and blood pressure; nausea; increased energy, alertness; euphoria; decreased appetite and sleep. High doses: erratic and violent behaviour, panic attacks	Addiction, restlessness, anxiety, irritability, paranoia, panic attacks, mood disturbances; insomnia; nasal damage and difficulty swallowing from snorting; GI problems; HIV	When combined, there is a greater risk of overdose and sudden death than either drug alone.
Meth-amphetamine	Enhanced mood; increased heart rate, blood pressure, body temperature, energy and activity; decreased appetite; dry mouth; increased sexuality; jaw-clenching	Addiction, memory loss; weight loss; impaired cognition; insomnia, anxiety, irritability, confusion, paranoia, aggression, mood disturbances, hallucinations, violent behaviour; liver, kidney, lung damage; severe dental problems; cardiac and neurological damage; HIV, Hepatitis	N/A
Ecstasy	Euphoria; increased energy, alertness, tactile sensitivity, empathy; decreased fear, anxiety; increased/irregular heartbeat; dehydration; chills; sweating; impaired cognition and motor function; reduced appetite; muscle cramping; teeth grinding/clenching; in rare cases—hyperthermia, rhabdomyolysis ¹³² , and death.	Impulsiveness; irritability; sleep disturbances; anxiety addiction.	N/A

¹³⁰ Schizophreniform disorders are mental health disorders where symptoms of schizophrenia are present within a one-month period, but not present for the full 6 months period required for a formal full diagnosis of schizophrenia

¹³¹ Tachycardia is a heart rate that exceeds the normal range. In general, a resting heart rate for an adult (over 15 years of age) of over 100 beats per minute is classed as tachycardia

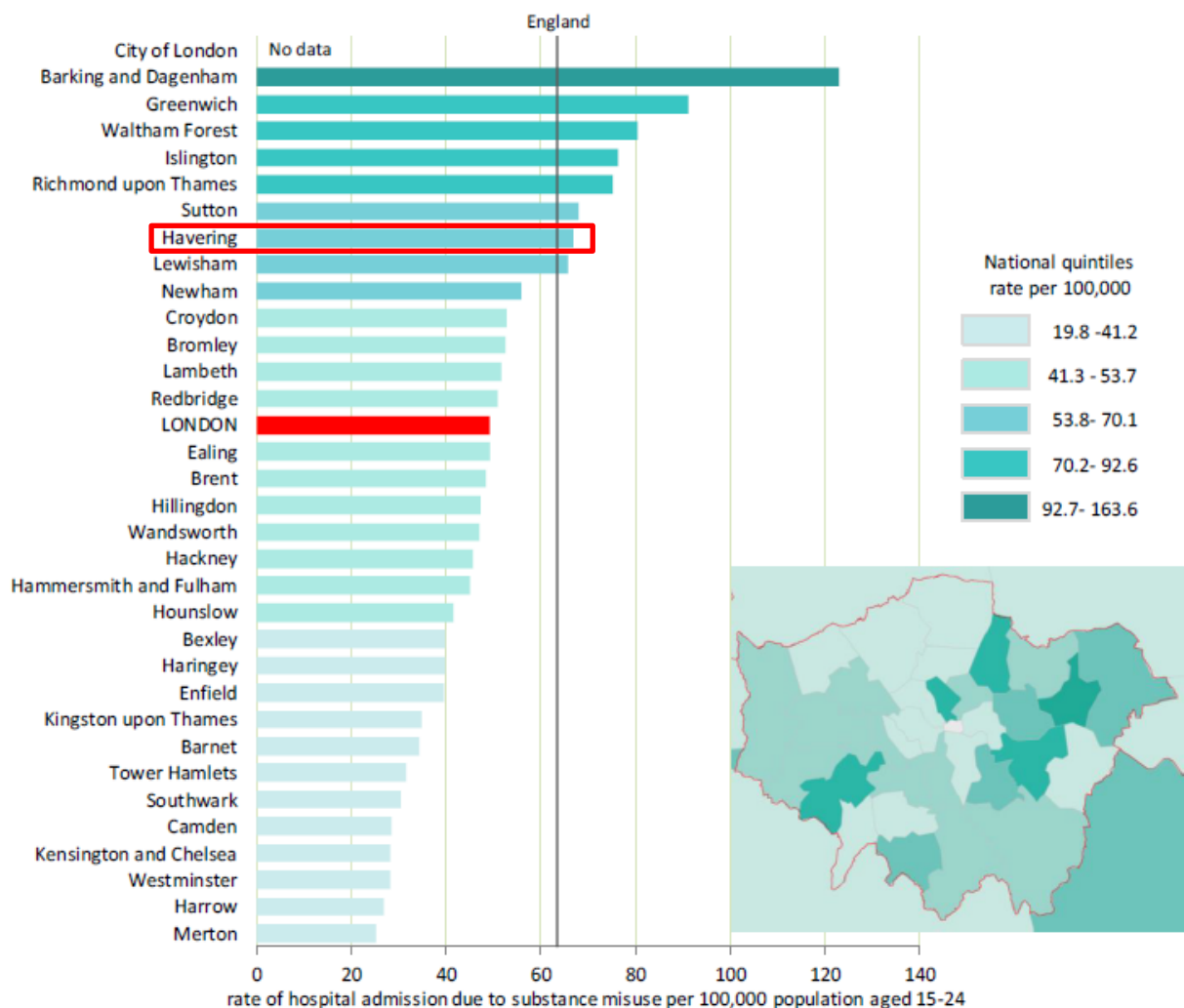
¹³² Rhabdomyolysis is a condition in which muscle tissues of the skeleton break down and these breakdown products, such as the protein myoglobin are released into the blood stream where it can cause damage to the kidneys and lead to kidney failure

Drug	Acute Effect (Short Term)	Chronic Effect (Long Term)	In Combination with Alcohol
Heroin / Opium	Euphoria; warm flushing of skin; dry mouth; heavy feeling in extremities; clouded thinking; alternate wakeful and drowsy states; itching; nausea; depressed respiration	Addiction; physical dependence; collapsed veins; abscesses; infection of heart lining and valves; arthritis/other rheumatologic problems; HIV; Hepatitis C	Dangerous slowdown of heart rate and respiration, coma, or death

Hospital admissions for children and young people aged 15-24 years are higher in Havering than the London average and slightly above the England average (Fig. 6.15). Commissioners should therefore consider preventing substance misuse by this age group as a high priority.

Figure 6.15 Hospital Admissions due to Substance Misuse in Young People Aged 15-24 years, 2008-2011

SUBSTANCE MISUSE, London, 2008-11



Deaths directly related to drugs in Havering are very rare. In general, deaths due to deliberate or accidental poisoning related to substance misuse most commonly occur in white unemployed males aged over 35, and opiates are the most common class of drug deemed to contribute to death. According to the latest St. George’s Hospital/ University of London drug-related death report

2012¹³³, Havering only had one single drug-related death (using the National Programme on Substance Abuse Deaths (*np-SAD*) definition¹³⁴) in 2011: this was the same figure as 2010. However, caution should be applied to the *np-SAD* statistics, as different recording and reporting methods may mean that other drug-related deaths are not being recorded specifically as a drug-related death. Based on this single death, the incidence rate for Havering is 0.52 per 100,000 population aged 16 and over in 2011, compared with an Eastern London rate of 1.11 per 100,000. For comparison, the highest rates of drug-related deaths in 2011 were in the following areas: City of Manchester (14.86); Blackburn, Hyndburn & Ribble Valley (13.35); Liverpool (11.37); and Blackpool & the Fylde (11.10). There are much lower reported rates of drug-related death in Havering than most other areas around England, and this is consistent whether using the *np-SAD* definition or the government's 2010 drug strategy definition.

However, the other health impacts of taking drugs can have much longer lasting effects, including mental health problems, liver and other cancers. The key health concern for injecting drug users is the risk of blood-borne viruses, particularly Hepatitis B virus (HBV), Hepatitis C virus (HCV), and Human Immunodeficiency Virus (HIV). Risks around this are aggravated by the sharing of injecting equipment, and this is a key driver of effective needle and syringe programmes. Health Protection Agency (HPA, 2012, now Public Health England (PHE)) estimates have suggested that 46% (38-54%) of people who inject drugs in Havering have Hepatitis C¹³⁵. An interactive template has been produced¹³⁶ by HPA that uses prevalence estimates of injecting drug use to provide an estimate of a total infected population of 1,100 (comprising 208 current IDUs, 686 ex-IDUs and 205 non-IDUs) in 2010. Of this 1,100 69% (814) were estimated to be RNA positive (symptomatic).

According to the Health Protection Agency (HPA, now PHE) over 1,100 individuals are estimated to be infected with Hepatitis C in Havering and the cost of treating those already identified is estimated to be more than £500,000¹³⁷. Predictions for 2015, based on statistical modelling from the previous history of the disease, suggest that Havering can expect an additional 12 cases of HCV, with an associated treatment cost of more than £100,000 (Fig. 6.16).

Estimated 1,100 people in Havering infected with HCV & a further 12 cases predicted for 2015

¹³³ Ghodse, H., Corkery, J., Claridge, H., Goodair, C., Schifano, F. (2012). Drug-related deaths in the UK Annual Report 2012. National Programme on Substance Abuse Deaths (*np-SAD*) International Centre for Drug Policy (ICDP) St George's, University of London, UK. Available on:

http://www.google.co.uk/url?url=http://www.sgul.ac.uk/research/projects/icdp/pdf/np-sad-13th-annual-report-2012.pdf&rct=j&frm=1&q=&esrc=s&sa=U&ei=eDyxU8qsEsTx0gW_3YD4Dg&ved=0CBoQFiAB&usq=AFQjCNGuHoCDsvQ9IeN1_JzMOGk5x9Ietg

¹³⁴ St. George's University of London National Programme on Substance Abuse Deaths. Available on:

<http://www.sgul.ac.uk/research/projects/icdp/our-work-programmes/substance-abuse-deaths/?searchterm=drugs%20deaths>

¹³⁵ Health Protection Agency, Health Protection Services and Microbiology Services. Hepatitis C among people who inject drugs: Local area estimates of prevalence to guide those who commission services in England. November 2012. London, Health Protection Agency.

¹³⁶ Commissioning template for estimating HCV prevalence by DAT and numbers eligible for treatment: Health Protection Agency July 2011.

¹³⁷ Health Protection Agency, (2012). *Hepatitis C in London: Annual Review (2011 data)*. Available on: http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317135974202

Figure 6.16 Estimates of Hepatitis C Prevalence, Burden, Treatment and Cost of Treatment By Drug Action Team (DAT) in London(2011 data)

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

The late diagnosis of HIV is common in Havering despite having the lowest incidence rate across London¹³⁸.

As well as the health implications from contracting HBC, HCV or HIV themselves, these blood borne viruses are also implicated in the development of particularly liver cancer and liver cirrhosis. Data from the Global Burden of Disease (GBD) study (2010) are shown in Figure 6.17.

Figure 6.17 Percentage of Liver Cancer or Liver Cirrhosis deaths associated with Hepatitis B or C Viruses¹³⁹

	Liver Cancer	Liver Cirrhosis
HBV	45%	30%
HCV	41%	40%

Estimated 172 injecting drug users in Havering (1.1 per 1,000); lower than national rate

Although much drug taking activity is illegal, treatment services are accessed by individuals who want to change their behaviour and as such are designed to facilitate rehabilitation and recovery. This is in line with the Government’s Drug Strategy (2010), which has recovery as a priority. Services endeavour to reduce injecting behaviour through

harm reduction advice and helping clients to change their approach to their use of opiates. There are numerous risks associated with injecting: vein damage and injection site infections, risks of contracting blood-borne viruses from sharing equipment, increased chance of overdose, visible scarring and social stigma. There are estimated to be 172 injecting drug users in Havering (a rate of 1.1 per 1000 compared with national rate of 2.7 per 1000)¹⁴⁰. In 2012-13, 56.7% of Havering primary opiate users (284) indicated current or previous injecting (161)¹⁴¹.

Drug treatment services utilise a tool known as the Treatment Outcome Profile (TOP). This measures change and progress in key areas of the lives of the people engaging in treatment, from current behaviours to quality of life¹⁴². Local TOP data suggests there were 6% (8 clients) reporting injecting as problematic at treatment start in Havering in 2012-13, and there were less than 5 clients still injecting at planned exit¹⁴³. A planned exit is one in which the client has successfully completed their course of treatment and leaves the treatment service with clear goals on how they will continue their recovery process or is transferred on to further required treatment. In Havering during 2012-

¹³⁸ HIV Epidemiology in London 2009 data – published September 2011

¹³⁹ Cowie, B., MacLachlan, J. (2013). The global burden of liver disease attributable to Hepatitis B, Hepatitis C, and alcohol: increasing mortality, differing causes (Reported by Levin, J. on http://www.natap.org/2013/AASLD/AASLD_38.htm

¹⁴⁰ Public Health England (2013). *Alcohol and Drugs: JSNA Support Pack. Key data to support planning for effective drugs prevention, treatment and recovery. The data for Havering.* London: Public Health England.

¹⁴¹ Havering Needs Assessment 2012-13 Bulls Eye Data (all in Treatment) v2: PHE

¹⁴² National Treatment Agency (2014) Treatment Outcome Profile. Available on: <http://www.nta.nhs.uk/healthcare-top.aspx>

¹⁴³ Havering TOP Exit Quarter 4 2012-13 report

13, a total of 10 injectors were in treatment: 63% of these were no longer injecting at review, compared with a national average of 60%⁵.

In order to minimise the potential spread of HBV, new users entering treatment are offered an HBV vaccination; similarly clients can also be offered a test for the presence of HCV (Fig. 6.18).

Figure 6.18 Percentage of Eligible Clients Offered an HBV Vaccination or HCV test in Havering Compared with National rates

	Havering		England	
	Number	%	Number	%
Adults new to treatment eligible for a HBV vaccination who accepted one	86	28%	22,128	47%
Of those: the proportion who started a course of vaccination	Less than 5	2%	4,989	20%
Of those: the proportion who completed a course of vaccination	50	58%	4,403	23%
Previous or current injectors eligible for a HCV test who received one	140	76%	74,530	73%

Tuberculosis (TB) is spread through transfer of saliva through coughing or direct contact; amongst drug users sharing of a crack pipe puts users at particular risk of TB. It is understood that tuberculosis (TB) is present in our current treatment population, however the exact numbers of TB cases are only available at a borough level due to the small numbers involved. Data from the TB annual report (2013) show that Havering had 27 new notifications of TB in 2012. Havering's rate of new TB cases is the fourth lowest out of all the London Boroughs, at 11.4 per 100,000, compared with a London rate of 41.9 per 100,000¹⁴⁴.

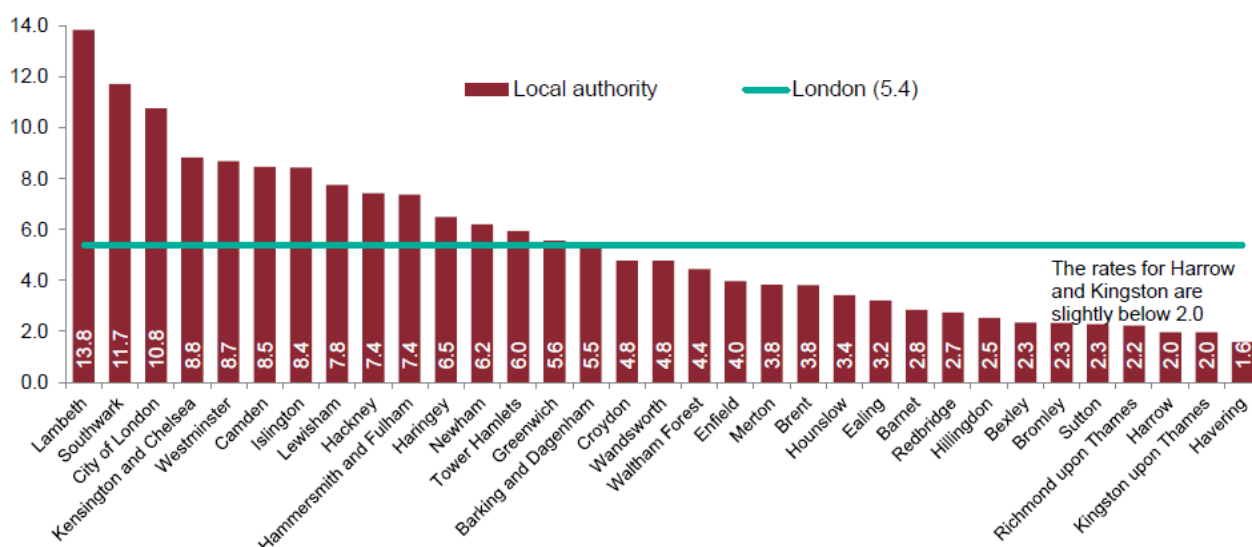
Havering has the 4th lowest rate of TB in London; 11.4 per 100,000

Havering also has the lowest rate of prevalence of HIV out of all the London boroughs – 1.6 per 1,000 residents aged 16-59 years compared with 5.4 per 1,000 in London as a whole (Fig. 6.19)¹⁴⁵. However despite the rate being so low, this does not mean that as a borough we should become complacent about the potential for HIV infection, nor for the health impacts of contracting HIV.

¹⁴⁴ Public Health England (2013). News Release: London TB Capital of Western Europe. Available on: https://www.google.co.uk/url?q=https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/231016/TB_2013_annual_report_London_press_release.pdf&sa=U&ei=SD8gU5PEINSu7AaEkIHQBQ&ved=OCD8QFjAF&usg=AFQjCNHgmHyHXSyrezVfclqTce-Rveg30g

¹⁴⁵ Public Health England (2013). *HIV Epidemiology in London: 2011 Data*. Available on: http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317138999825

Figure 6.19 Diagnosed Prevalence Rate of HIV (per 1,000 population aged 16-59 years) in London



Inhalation of nitrous oxide is a new and emerging trend in the borough. Estimates from the Crime Survey for England and Wales suggest that 2% of 16-59 year olds have taken nitrous oxide in the last year¹⁴⁶. The risks of using nitrous oxide include:

- Dizziness
- Affecting judgement, which might make a person act carelessly or dangerously
- Unconsciousness or death from lack of oxygen. This occurs when the available oxygen for breathing is effectively pushed out by the nitrous oxide. The risk is greater if the gas is consumed in an enclosed space or if a plastic bag is used that covers both nose and mouth.
- It can be hard to judge the amount to use safely – just enough to get a high but not so much to end up fainting, having an accident or much worse
- Severe vitamin B deficiency can develop with heavy, regular use of nitrous oxide. This can cause serious nerve damage, which leads to tingling and numbness in the fingers, toes and other extremities, and even to difficulties with walking, and to pains in the affected areas.

6.1% 16-24 year olds,
2% adults 16-59 have
taken Nitrous Oxide
nationally in the last
year

6.2 The Harms Caused by Drugs and Alcohol In Social Terms

While the impact of alcohol consumption and dependence on mortality and disease is substantial, there are also many social and economic burdens resulting from the effects of alcohol on individuals, families, workplaces, and society as a whole. This means that alcohol consumption and dependence have sizable impacts on many people other than the drinker. Among the most devastating effects

¹⁴⁶ Home Office (2013) *Drug Misuse: Findings from the 2012 to 2013 Crime Survey for England and Wales*. London: Home Office. Available on: <https://www.gov.uk/government/publications/drug-misuse-findings-from-the-2012-to-2013-csew/drug-misuse-findings-from-the-2012-to-2013-crime-survey-for-england-and-wales>

are insufficient fulfilments of roles; family problems, including divorce; problems with parenting at the family level; and lost productivity in the workplace. These effects add up to a staggering number of alcohol-attributable social costs.

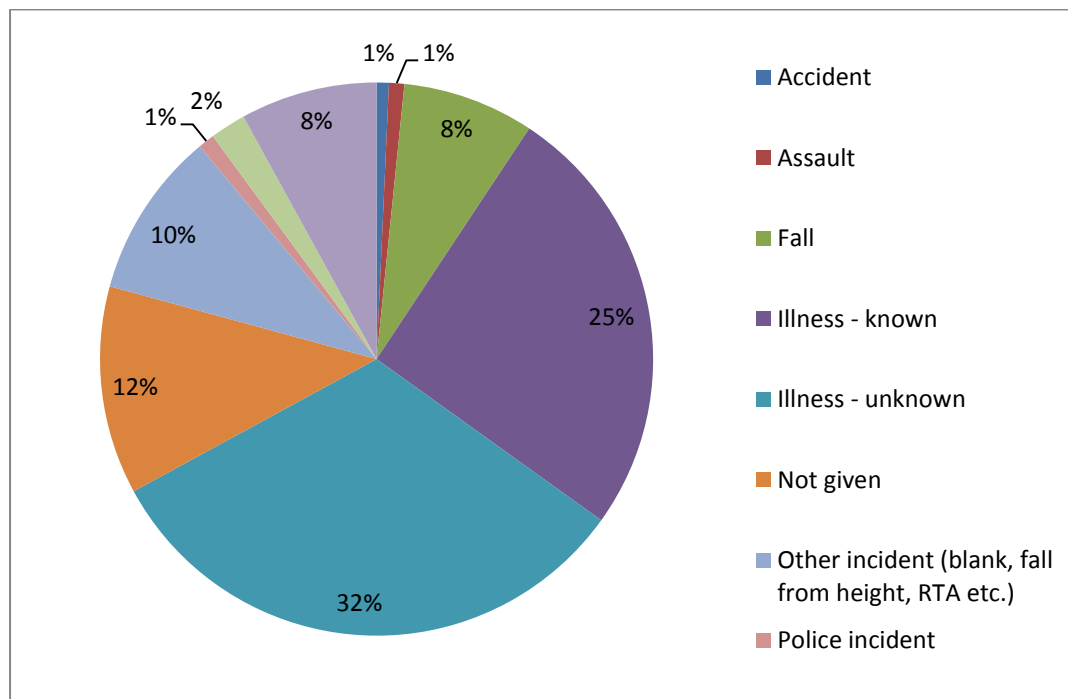
6.2.1 Impact on Emergency Services

Alcohol has an impact on the use of ambulance services. Data from the SafeStats website showed that in 2013 alcohol was recorded as a primary or secondary contributory factor on just under 4% of the total 43,057 call-outs in Havering. Just over one quarter of the call-outs related to alcohol were for 'Illness' known to be related to alcohol (Fig. 6.20). There is a higher number of recorded ambulance call outs related to alcohol in Romford Town, compared to other wards in the borough – just over a third of alcohol-related ambulance call-out were specifically for Romford Town.



Just under 4% of the total ambulance call-outs in 2012-13 were for an alcohol-related condition

Figure 6.20 Reason for Alcohol-related Ambulance Call-Out in Havering (2012-13)



The Public Health Outcomes Framework (PHOF) suggests that the number of people killed or seriously injured on England's roads (PHOF 1.10) has remained relatively static in Havering (Fig 6.21). However a percentage of these are likely to be due to alcohol. Nationally, in 2012, 16% of all road fatalities were due to drink-drive incidents¹⁴⁷. Although data from the London Ambulance Service

¹⁴⁷ Department for Transport website. Reported Road Casualties in Great Britain: 2012 Annual Report. Available at: <https://www.gov.uk/government/publications/reported-road-casualties-in-great-britain-main-results-2012>

described above suggests a very small number of ambulance call-outs related to alcohol for road traffic accidents in Havering specifically, there are nevertheless a small number of deaths per year from transport accidents. Havering's rate (0.63 per 100,000) is far lower than the rate for both London and England (Fig 6.22)¹⁴⁸.

Figure 6.21 Number of People Seriously Injured or Killed per 100,000 population 2009-12

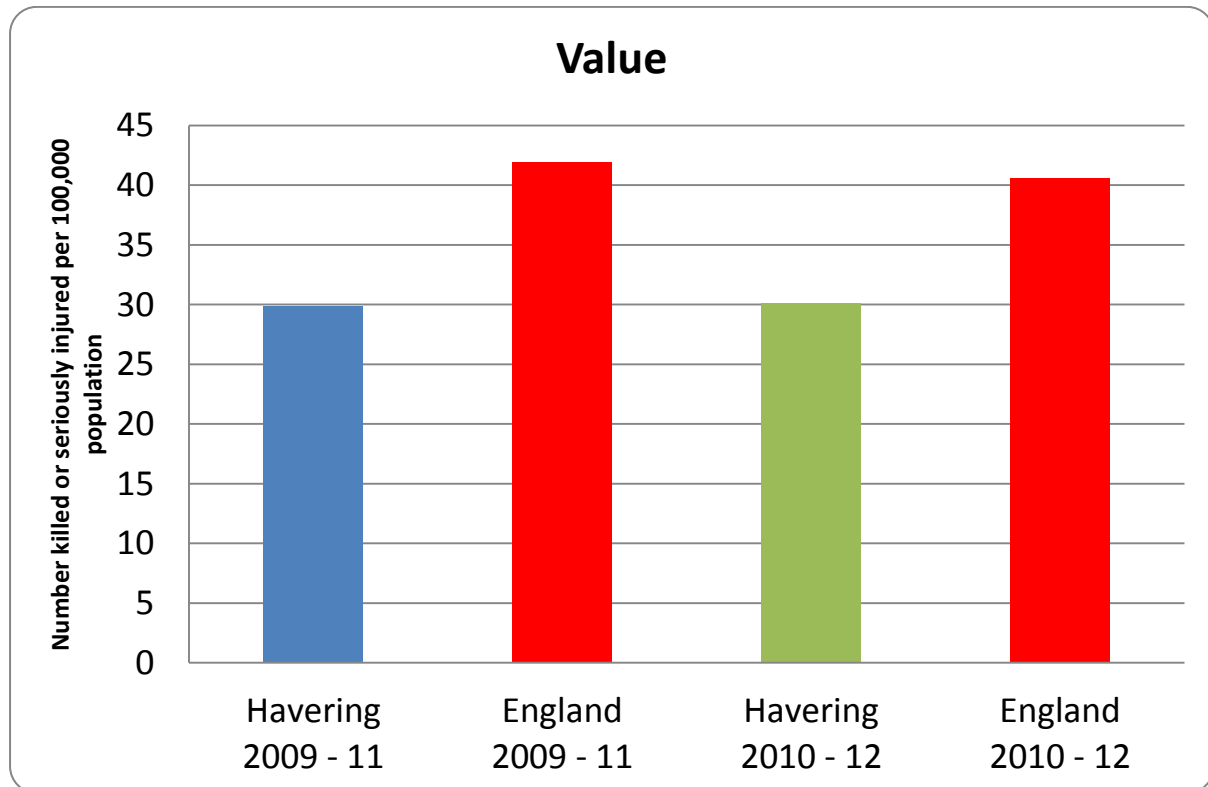
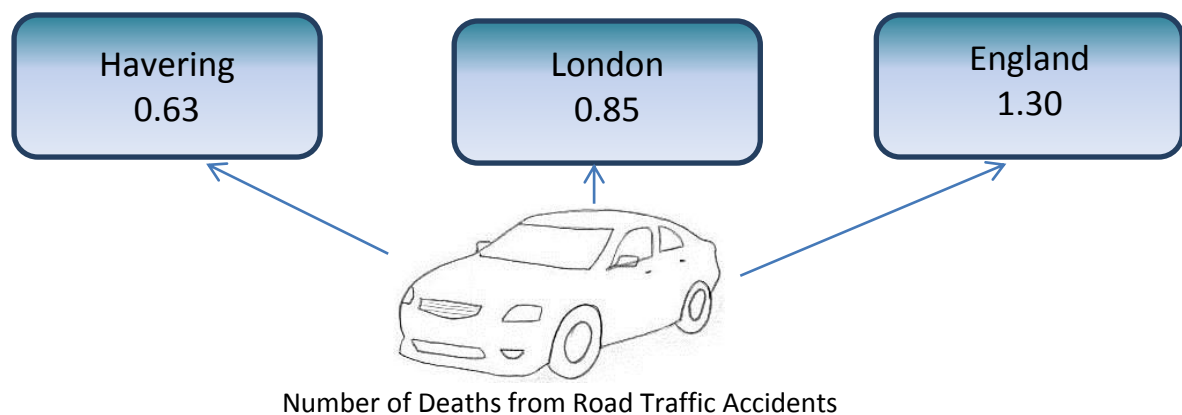


Figure 6.22 Deaths from Land Transport Accidents due to Alcohol, All persons, All Ages 2008-2010 (DSR per 100,000)



6.2.2 Safeguarding

Just under half (45%) of the adults in Havering in treatment for alcohol problems and 40% of those in treatment for drug misuse who have contact with children are living with them. Given the relative proportions of people in Havering, compared with the national average, in contact with drug or

¹⁴⁸ Local Alcohol Profiles for England (LAPE) (2013). Land Transport Mortality. Available on: http://www.lape.org.uk/downloads/LapeLADatasetNWPFO_01_08_12.xlsx

alcohol services with responsibility for children, safeguarding children is a priority for Havering. However, protecting children from the potential harms of substance misusing parents is just one aspect of safeguarding. The *Young Addaction Young People's Survey* (2013) outlined earlier in section 4.2.3 (Prevalence of Drug Misuse in Children & Young People) found that 74% of the 281 young people aged 13-19 years responding to this question thought that 'drugs were easy to get hold of'. This perception by young people in the borough indicates that protecting children from the direct harms caused by drinking alcohol or taking drugs themselves is also a priority.

In 2003 the Advisory Council on the Misuse of Drugs (ACMD) published its report "Hidden Harm" responding to the needs of children of problematic illicit drug users. The report identified 48 recommendations and 6 key findings as follows¹⁴⁹:-

- There are between 250,000 and 300,000 children of problem drug users in the UK – about one for every problem drug user
- Parental problem drug use can and does cause serious harm to children at every age from conception to adulthood
- Reducing the harm to children from parental problem drug use should become a main objective of policy and practice
- Effective treatment of the parent can have major benefits for the child
- By working together, services can take many practical steps to protect and improve the health and well being of affected children
- The number of affected children is only likely to decrease when the number of problem drug users decreases.

Havering's Local Safeguarding Children Board (LSCB) has 5 priorities, including addressing the 'Toxic Trio' of drugs and alcohol misuse, mental health and domestic violence (see also section 5.1):

- Ensuring the partnership provides an effective child protection service to all children ensuring that all statutory functions are completed to the highest standards.
- Monitoring the development and implementation of a multi agency early offer of help to children and families living in Havering.
- Monitoring the alignment and effectiveness of the partnership when working across the child's journey between universal, targeted and specialist safeguarding.
- Coordinating an approach to domestic violence, mental health and drug and alcohol abuse across the children and adults' partnership to ensure that families affected receive the right support at the right time.
- Ensuring that Havering Safeguarding Children Board communicates effectively with partners, children, young people and their families, communities and residents.

Havering's Troubled Families initiative is key to the success of tackling these 'Toxic Trio' issues – the local response to ensuring safeguarding is effectively implemented is further detailed in section 7.2.

¹⁴⁹ Home Office (2003). *Hidden Harm*. Advisory Council on the Misuse of Drugs. London: Home Office. Available on: https://www.google.co.uk/url?q=https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/120620/hidden-harm-full.pdf&sa=U&ei=-GUgU4iMH6-w7AbUp4BQ&ved=0CCQQFjAB&usg=AFQjCNGQQofkD-ECxrkmBkoj8Ew7QL9J3w

6.2.3 Crime Burden

Alcohol and drug misuse contributes to too many crimes. Almost a million (44% of the total) violent crimes are alcohol-related. Police.uk provides communities across England and Wales with street-level crime and anti-social behaviour information, including those occurring on or near a number of key public spaces, hospitals, nightclubs and supermarkets. The Government estimates that in a community of 100,000 people, each year:

- 1,000 people will be a victim of alcohol-related violent crime;
- Over 400 11-15 year olds will be drinking weekly;
- Over 13,000 people will binge-drink;

In terms of national legislation and available powers, the Government has doubled the maximum fine for persistently selling alcohol to a person under 18 to £20,000 and making it easier to close down premises found to be persistently selling alcohol to young people. The police also have powers to seize alcohol from young people under the age of 18 and can prosecute a further offence of persistently possessing alcohol in a public place.

The Government's Alcohol Strategy (2012) states that, "It is an offence, under the Licensing Act 2003, to knowingly serve alcohol to a drunk but there were only three convictions for this offence [in England] in 2010"¹⁵⁰. This could send a powerful message locally and local partners including the council and local licensed premises will need to work with the police to tackle the issue of serving alcohol to drunks. It will also include exploring how greater use can be made of existing legislative powers held by the council and police, and how test purchasing can support this. In addition, under these new Licensing Act powers, for the first time, local health bodies will be able to instigate a review of a licence. This means that a hospital that is regularly dealing with patients at A&E as a result of alcohol-related violence at a particular pub will now be able to instigate a review of the licence at those premises. If things do not improve, we would expect the premises to lose their licence. However, in order to effect this, it is essential that data is collected, particularly from A&E departments on where a person attending A&E for alcohol-related intoxication or injury bought their last drink from.

Local data is needed on where people attending A&E bought their last drink from

Havering is currently not performing as well as the England average (5.74 per 1,000 population) on alcohol-related recorded crime with 7.53 crimes per 1,000 population according to 2012-13 Home Office recorded crime statistics (Figure 6.23.)¹⁵¹. However, this rate compares favourably to the London figure which is currently 9.02 per 1,000 population. For violent crime attributable to alcohol, Havering records 4.38 incidents per 1,000 population, better than the London figure of 5.67 but slightly worse than the national average of 3.93 per 1,000 population¹⁵².

¹⁵⁰ HM Government (2012) *The Government's Alcohol Strategy*. London: The Stationery Office. Available on:

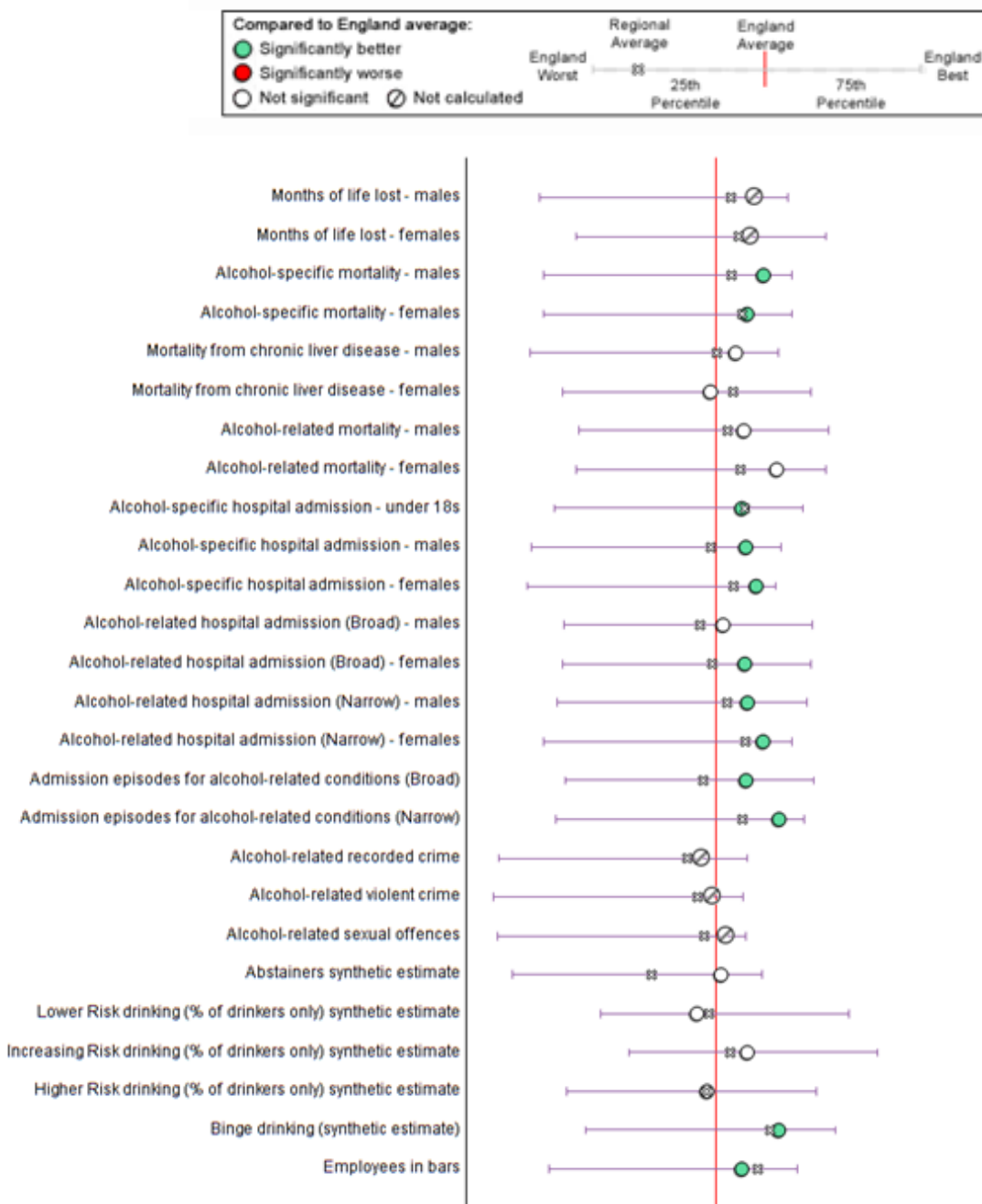
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224075/alcohol-strategy.pdf

¹⁵¹ Local Alcohol Profiles for England (LAPE). Local Authority Indicators Update (2014). Available on:

http://www.lape.org.uk/downloads/LAPE_LA_Dataset_PHE_250414_FINAL.xlsx

¹⁵² <http://www.haveringdata.net/profiles/profile?profileId=1126&geoTypeId=5&geoids=00AR>

Figure 6.23 Indicator profile for Havering from Local Alcohol Profile for England: snapshot downloaded May 2014 from www.lape.org.uk.



However, it should be noted that the 2014 Local Alcohol Profiles for England (LAPE) dataset, released 29th April 2014, contained a number of methodological changes from the 2012 dataset used previously. Firstly, the population estimates for this release are based on the Office for National Statistics (ONS) 2011 mid-year population census data. Secondly, the classification system for crime data has been altered (Fig. 6.24)¹⁵³. Therefore, any trend data relating to crime statistics cannot be directly compared with the 2012 dataset, and instead all trend data for the years 2008/09 onwards have been recalculated.

¹⁵³ Local Alcohol Profiles for England (2014). *User Guide: Local Alcohol Profiles for England 2014*. London: Public Health England. (Page 61) Available on: http://www.lape.org.uk/downloads/LAPE%20User%20Guide_Final.pdf

Figure 6.24 Offence Groupings for Alcohol-Related Recorded Crimes Indicator for LAPE 2014

Offence Groupings used in Previous Local Alcohol Profiles for England (LAPE)	New Office for National Statistics Crime Grouping
Violence Against the Person	Homicide
	Violence with Injury
	Violence without Injury
Sexual Offences	Sexual Offences* * no longer includes the categories of 'Exploitation of prostitution' and 'Soliciting for purposes of prostitution offences'. Therefore, figure for these offences are now not part of the dataset used to calculate the LAPE 2014 indicators.
Robbery	Robbery
Burglary	Domestic Burglary
Theft of a Motor Vehicle	Vehicle offences (also including 'Interfering with a motor vehicle offences')**
Theft from a Motor Vehicle	**' Interfering with a motor vehicle offences' were not previously included as part of the calculations for LAPE and for consistency these were also omitted in the 2014 dataset

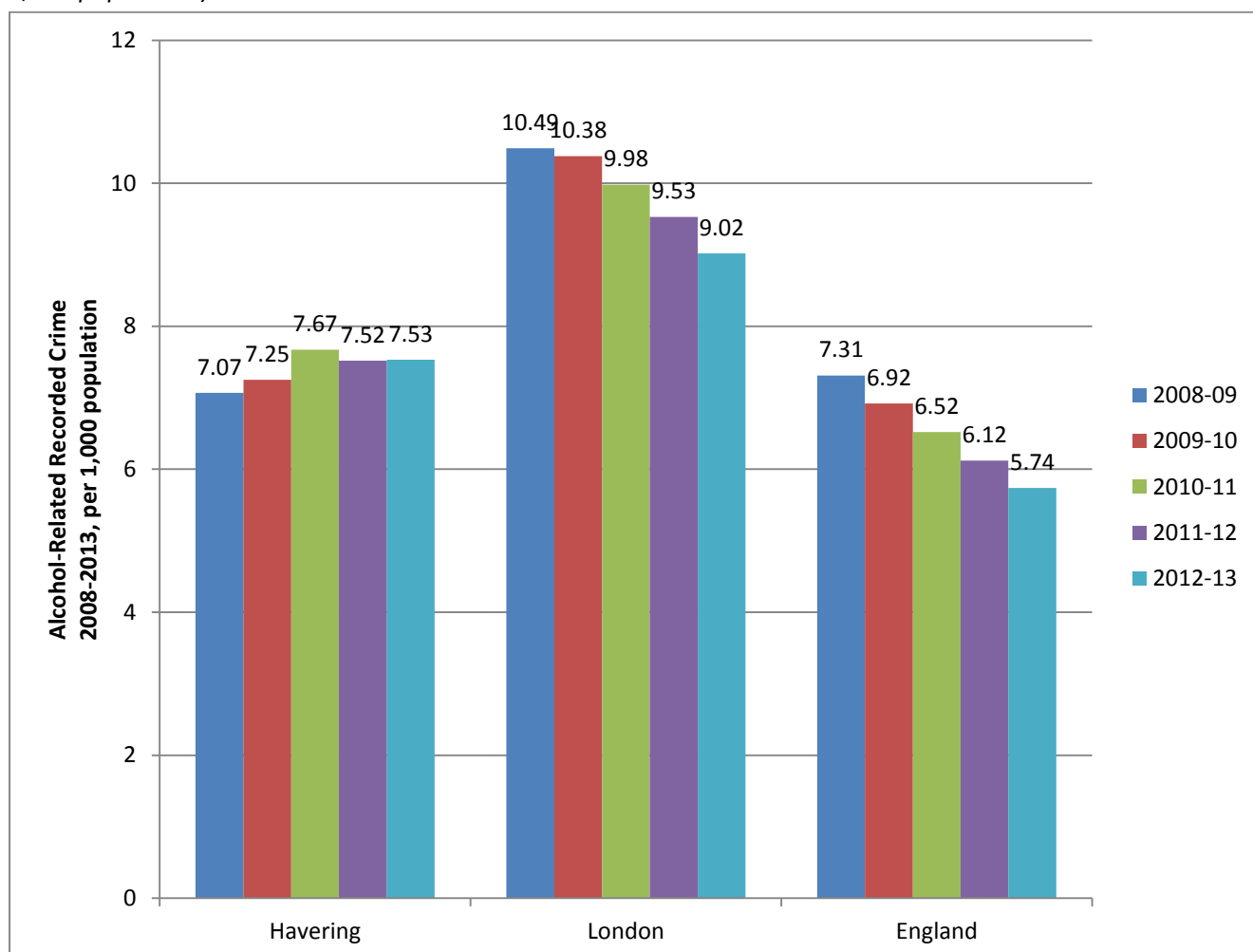
In 2012-13 there were 1,791 crimes attributable to alcohol in Havering (LAPE)¹⁵⁴, which accounts for just over 11% of total notifiable crime in the borough. Of these crimes attributable to alcohol, 1,043 were violent crimes – taking this as a proportion of all violent crimes (n = 3,515), this suggests that just under one third of all violent crimes in the borough are alcohol-related¹⁵⁵.

The trend for rates of alcohol related crime in Havering have countered regional and national trends over the past five years. Figure 6.25 shows there has been a steady decline in alcohol related crime and alcohol related violent crime in both London and England for consecutive years since 2008-09. However, during the same period Havering saw a rise from 2008-09 to 2010-11 before seeing a small reduction in 2011-12 and has remained steady in 2012-13. In addition, Havering's alcohol-related crime is lower than the London regional average, which may reflect the schemes and initiatives in place locally to ensure that Havering's night time economy is safe and thriving. It could also reflect the unusual demographic for a London borough (for example, higher proportion of older residents). However, the priority should be on reducing the rate of alcohol-related recorded crime towards England rates or lower.

¹⁵⁴ Local Alcohol Profiles for England (LAPE). Local Authority Indicators Update (2014). Available on: http://www.lape.org.uk/downloads/LAPE_LA_Dataset_PHE_250414_FINAL.xlsx

¹⁵⁵ Havering Community Safety Partnership Strategic Assessment 2013. London Borough Of Havering, Romford.

Figure 6.25 Trend in Alcohol-Related Crime for Havering, London and England 2008 – 2013 (rate per 1,000 population)



Havering’s rate of alcohol-related violent crimes are lower than the London average, but higher than the national average¹⁵⁶. The rate for alcohol-related sexual offences is lower than that for both London and England (Fig. 6.26).

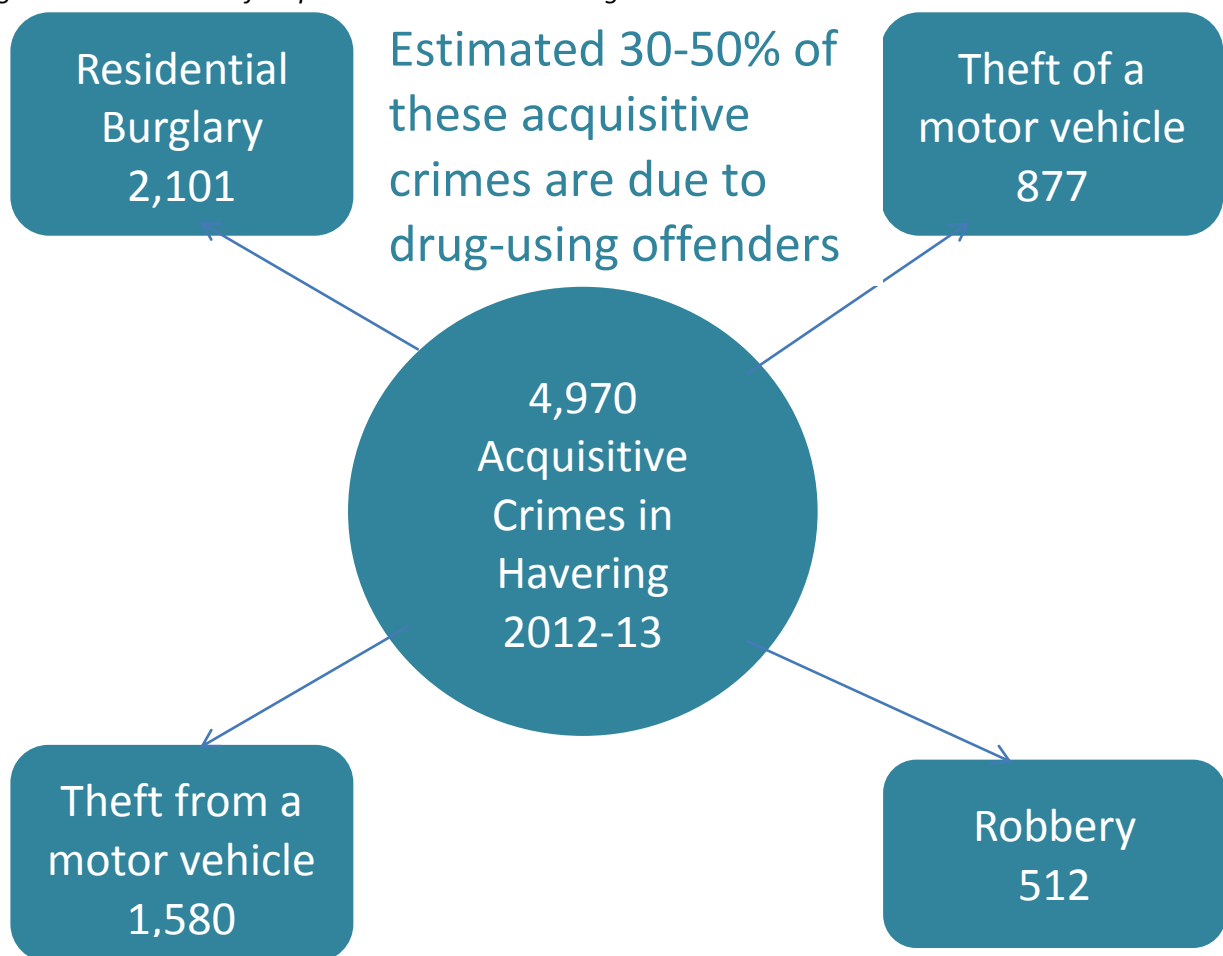
Figure 6.26 Rate of Recorded Crime Attributable to Alcohol (2012-13)(LAPE)

Crude Rate per 1,000	Havering	London	England
Alcohol-related recorded crimes (all)	7.53	9.02	5.74
Alcohol-related violent crimes	4.38	5.67	3.93
Alcohol-related sexual offences	0.10	0.15	0.12

¹⁵⁶ Local Alcohol Profiles for England (LAPE). Local Authority Indicators Update (2014). Available on: http://www.lape.org.uk/downloads/LAPE_LA_Dataset_PHE_250414_FINAL.xlsx

Acquisitive crime, including residential burglary, theft of a motor vehicle, theft from a motor vehicle or robbery, is a strategic priority for the Havering Community Safety Partnership¹⁵⁷ - it is estimated that 30-50% of acquisitive crime is due to drug-using offenders (Fig. 6.27)¹⁵⁸. Havering currently has the 7th highest rate of burglary rate and 4th highest theft of motor vehicle rate in London whilst the overall rate of acquisitive crime in Havering is twice the national average. Burglary and vehicle crime together account for 33% of all recorded crimes in Havering. In 2012/13 there were 4,970 acquisitive crimes in Havering¹⁵⁹. Although it is not possible to directly break this down into crimes identified as being committed by drug-using offenders, the National Treatment Agency (NTA) estimate that drug addicts commit between one third and half of all acquisitive crime¹⁶⁰. This means that for Havering in 2012/13 an estimated 1,657 to 2,485 acquisitive crimes were committed by drug-using offenders.

Figure 6.27 Numbers of Acquisitive Crimes in Havering 2012-13



¹⁵⁷ Havering Community Safety Partnership Strategic Assessment 2013. London Borough Of Havering, Romford.

¹⁵⁸ NTORS, (1999). *NTORS at One Year: The National Treatment Outcome Research Study*, 3rd Bulletin, London, Department of Health.

¹⁵⁹ Acquisitive crime defined as domestic burglary (residence), theft of a motor vehicle, theft from a motor vehicle and robbery (people and business). Data provided directly by Intelligence Analyst at Metropolitan Police Service, Havering Patrol Base (Romford) 24/10/13.

¹⁶⁰ National Treatment Agency for Substance Misuse. *Breaking the Link. The role of drug treatment in tackling crime*. London, NTA, 2009. Available on:

http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=2&cad=rja&ved=0CDYQFjAB&url=http%3A%2F%2Fwww.nta.nhs.uk%2Fuploads%2Fnta_criminaljustice_0809.pdf&ei=wSRxUvfjC6rA7Abdo4DACA&usg=AFQjCNGFySV EQebCDpGBteW4ei9AFsQWdA&bvm=bv.55617003,d.ZGU

In the last 12-months 215 offenders from Havering were tested under the Drugs Intervention Programme (DIP) across London, an increase from 162 (+33%) the previous 12-month period. Just fewer than a third of those offenders whose residence is Havering were arrested in Redbridge whilst between 7% and 14% were arrested in Hackney, Newham, Tower Hamlets, Waltham Forest and Westminster. Of the arrests 57% were for acquisitive crimes (trigger offences) and 23% for possession of drugs and/or possession of drugs with intent to supply¹⁶¹. The two main areas of note were with regard to young men using and/or supplying Class A substances in other boroughs and the high positive test rate for burglars from Havering offending elsewhere (predominantly neighbouring Redbridge).

Almost half of Havering offenders DIP tested across London in the last 12-months were aged 18-24 (101 offenders of which 34% tested positive for cocaine) and their main offence was possession and/or possession with intent to supply Class A substances. Of those individuals 90% were males, predominantly white British (73%) and arrested an equal number of times in Shoreditch, Ilford and Bethnal Green (Shoreditch and Brick Lane, near to Bethnal Green both have significant night time economies).

The proportion of Havering offenders yielding positive test results was in line with the regional average for all categories of crime with the exception of burglary. Havering burglars, offending outside Havering in the last 12-months, had a positive DIP test rate of 42% which is notably above the London average of 23%. Burglars from Havering tested were entirely male, predominantly described as White (85%) and aged 18-24 (70%). Those who yielded positive test results for cocaine were also predominantly within the 18-24 age group (60%) whilst the remainder were aged 30 and over. Ilford and Redbridge were the most common locations for their offending.

People who have already committed an offence are more likely to offend again. In Havering both the percentage of people who re-offend and average number of offences are lower than that for both London and England (Fig. 6.28)¹⁶². One of the methods of reducing re-offending rates is to offer additional support via Integrated Offender Management (IOM). IOM is a tool used by police and partners to tackle persistent offenders who keep committing crime. Havering currently has a caseload of 52 clients on the IOM panel, which is recommended to increase .

Integrated Offender Management currently has 52 people on its caseload

Figure 6.28 Re-Offending Levels in Havering and England 2011 (PHOF)

	Havering	London	England
Percentage of Offenders who Re-Offend	22.7% (501 persons)	26.9%	26.9%

¹⁶¹ Havering Community Safety Partnership Strategic Assessment 2013. London Borough Of Havering, Romford.

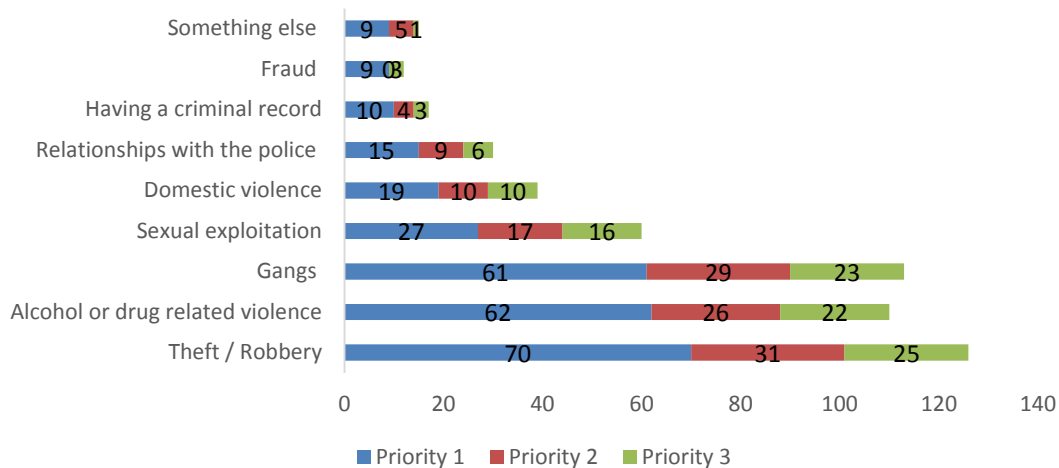
¹⁶² Public Health England (2014). Public Health Outcomes Framework, Wider Determinants of Health. Available on <http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000041/pat/6/ati/101/page/1/par/E12000007/are/E09000016>

Average Number of Offences per Offender	0.63	0.73	0.78
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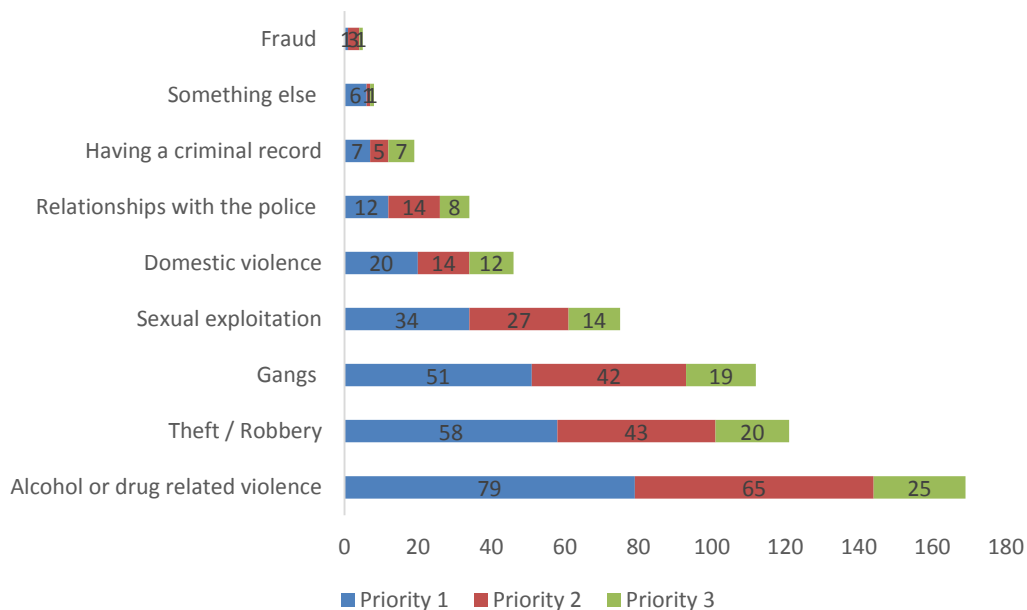
For both children and adults, alcohol or drug related violence features very highly in the three most important crime and safety issues affecting children and young people in Havering (Fig. 6.29)¹⁶³. This question was posed to both children and adults who responded to the borough’s ‘Pick Your Priorities’ survey undertaken in September 2013.

Figure 6.29 Perceptions of Children’s and Adult’s Top 3 Crime and Safety Issues For Children and Young People

Children: What are the 3 most important crime & safety issues for children / young people in Havering? (172 responses)



Adults: What are the three most important crime and safety issues for children and young people in Havering? (205 responses)

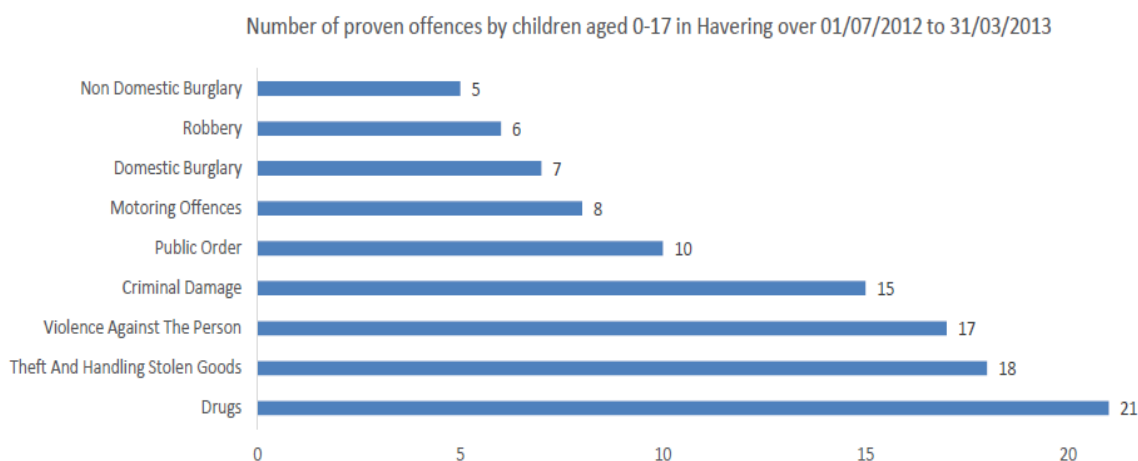


¹⁶³ Havering JSNA Children and Young People Chapter (2014). London Borough of Havering, Romford (Page 129). Available on: <http://www.haveringdata.net/resource/view?resourceId=CYPPTwentyThirteenFourteen>

In terms of gangs, as a risk factor for drug and alcohol misuse (see also section 5.1) , Havering currently has 18 young people under the age of 21 who have been identified as a gang nominal – 5 of these are over 18 years. This is very low compared with many other boroughs, but is worth monitoring regularly to make sure that the impact of any increases in gang culture does not impact negatively on our local communities. Gang culture is a very recent phenomenon that is rapidly spreading from more disadvantaged boroughs, in which a small number of youths in a gang can have a significant impact on communities¹⁶⁴.

Data from the Youth Justice Board shows that over the period 1st July 2012 to 31st March 2013, there were 235 proven offences committed by 127 children aged 0-17 resident in Havering. This represents less than 0.25% of children. Of these offences, 14 involved a breach of bail, conditional discharge or of a statutory order. Figure 6.30 shows that drugs offences represented the most common of the remaining 113 offences (18.6%), followed by theft and handling stolen goods (16%). Of the 127 young offenders, 77% were male (98 people) and 71% were white. Asian, black and mixed accounted for the remaining 23% of offenders; 8 did not have their ethnicity recorded¹⁶⁵.

Figure 6.30 Number of Proven Offences by Children Aged 0-17 years (01/07/12 to 31/03/13)



25

6.2.4 The Night Time Economy

Havering has a vibrant night-time economy; some 11,000-14,000 18-24 year olds visit some of Romford’s big name venues on a Thursday, Friday or Saturday night. Overall, Havering has 585 licensed premises, 51 of which are Club Premises Certificates (CPC) (Fig. 6.31). Therefore, as a major contributor to the income generation in the borough, it will be essential to work even closer *with* licensed premises to reduce the harms from drugs and alcohol, for example through the Safe and Sound Partnership.

¹⁶⁴ HM Government (2011). *Ending Gang and Youth Violence A Cross-Government Report including further evidence and good practice case studies* Available on:

<http://www.google.co.uk/url?url=http://www.saferlondonfoundation.org/download.php%3Ffile%3Dgang-violence-detailreport.pdf&rct=j&frm=1&q=&esrc=s&sa=U&ei=rZStU-fRFKqc0AXcqoGYCQ&ved=0CC8QFjAE&sig2=6yR2FXDz59nYiKIZCEAqHg&usg=AFQjCNHiXtswCck1A2cJT-fEc6vX91ZlZg>

¹⁶⁵ Havering JSNA *Children and Young People Chapter* (2014). London Borough of Havering, Romford. Available on: <http://www.haveringdata.net/resource/view?resourceId=CYPPTwentyThirteenFourteen>

Figure 6.31 Number of Licensed Premises in Havering 2012-13

	Premises Licenses	Club Premises Certificates
Licensed to sell or supply alcohol (On-sales only)	119	38
Licensed to sell or supply alcohol (Off-sales only)	208	-
Both on and off sales or supply of alcohol	123	13
Licences not permitted to sell or supply alcohol (Late night refreshment or entertainment only)	84	-
Total	534	51

A Club Premises Certificate (CPC) is a license for a members only club, such as a working man’s club, run by themselves, for themselves. Romford’s experience led to the development of a night time economy strategy. The strategy comprises a number of strands, including a police plan, an alcohol harm reduction strategy, a tourism and culture strategy, a licensing policy, and a community safety plan. The strategy takes a zero tolerance policy to theft, pickpocketing and any behaviour that causes offence to staff and customers. Havering continues to develop its strategy and acknowledges that change does not happen overnight – it has to be a long term commitment, with strong partnerships and member support.

Although there are clear benefits of a vibrant night time economy, on the minus side of the equation, there is nevertheless a culture of binge and excessive drinking, fuelled by such trends as stimulant mixes (e.g. vodka and red bull) to increase the ‘buzz’ and online games such as Neck Nomination (also known as Neknomination). Such online gaming highlights the influence that social media can have on risky behaviour such as drinking, and should be considered in any plans to tackle alcohol and drug misuse behaviours.

6.2.5 Impact on the Environment

Drug or alcohol misuse doesn’t just affect an individual, or their families – drug paraphernalia such as needles, syringes, crack pipes etc. can pose a significant health risk to people where this type of litter is dropped. Anecdotal evidence suggests that despite needle exchange programmes being delivered in only 9 out of 45 pharmacies across the borough as well as at Havering’s provider of drugs service, First Stop, needles and other drugs litter are found regularly at sites throughout Havering. More needle exchange schemes are therefore needed to ensure access is provided across the borough to minimise the potential harm. Havering council’s

Street Care team provide services to remove such drugs litter safely – recent reports from the team also suggest an increase in the number of nitrous oxide canisters being found as part of the litter clean-up in particularly Romford town centre. The council has a website available to report contaminated litter: <https://www.havering.gov.uk/Pages/OnlineForms/Contaminated-waste.aspx>

Needle exchange schemes are available at only 9 pharmacies across Havering

Broken glass from bottles of alcohol are also particularly dangerous. Havering has a policy of all licensed premises to use only polycarbonate glasses; however, this does not stop breakages from other glass bottles bought and drunk away from licensed premises, such as in parks or on the street.

6.3 The Harms Caused by Drugs and Alcohol In Financial Terms

Whilst the night time economy can provide much needed jobs and a thriving centre in which to socialise, alcohol-related crime and social disorder is estimated to cost the UK taxpayer around £21 billion per year (Fig. 6.32) and around £15.9 billion for drug misuse (Fig 6.33). For Havering the costs are estimated to be around £16.3 million or £85 per head of population. The recommendation to commissioners is therefore to maintain the vibrancy of the night time economy whilst reducing the harms caused by misuse of drugs and alcohol.



In 2010/11 the alcohol-related healthcare costs in Havering were £16.3m or £85 per head

Figure 6.32 Annual Costs to the Taxpayer for Alcohol-Related Harm



Figure 6.33 Annual Cost of Drug Addiction

The annual cost of drug addiction

Every year it costs society

£15.4bn

Any heroin or crack user not in treatment commits crime costing an average £26,074 a year

In 2011 the cost of deaths related to drug misuse was £2.4bn

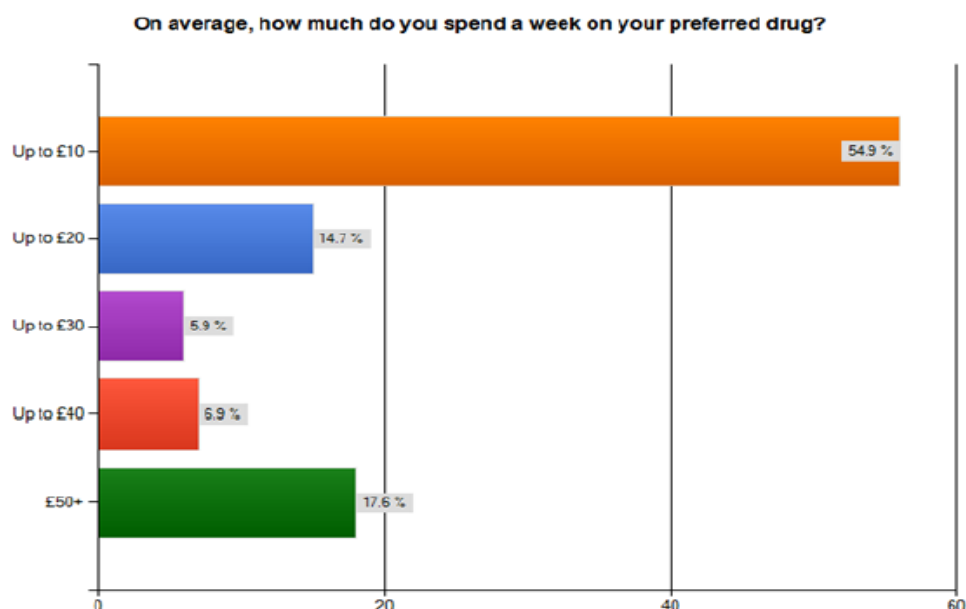
Every year drug misuse costs the NHS in England £488m

Annual cost of looking after drug using parents' children who have been taken into care is £42.5m

A full review of the services provided in Havering will be conducted in 2014, which will include appraisal of effectiveness and value for money; results of this will be added to this JSNA chapter when available.

However, the costs to the individual can be just as high. Data from Public Health England suggests that a typical heroin user can spend up to £1,400 per month, nearly 2 ½ times the average mortgage¹⁶⁶. An alcohol-dependent adult who may be drinking 35 units or more of alcohol a day, the equivalent of a bottle of vodka a day, could be spending £70 to £100 a week to fuel their dependency. For children, data from the Young People’s survey 2013 showed that of the 102 respondents, 17.6% spent £50 or more a week on their preferred drug (Fig. 6.34)¹⁶⁷.

Figure 6.34 Young People’s Spend on Preferred Drug (n = 102 respondents)



Havering currently spends a total of around £1.82 million on drug and alcohol services from community prescribing, structured day programmes and psychosocial interventions to inpatient treatment and residential rehabilitation, as well as wider programmes such as the Drug Intervention Programme (DIP) and housing/accommodation support for alcohol- or drug-using offenders. An outline of the services offered in Havering is given in section 7. Data from the National Treatment Agency’s Cost Effectiveness Tool (Fig 6.35)¹⁶⁸ shows that Havering spends a considerably higher percentage of its budget on community prescribing (41.4%) that the national average (30.6%).

Havering spends around £1.82million on drug and alcohol services

¹⁶⁶ Public Health England. *Alcohol and Drugs Prevention, Treatment and Recovery: Why invest?* London: Public Health England. Available on: <http://www.nta.nhs.uk/uploads/whyinvest2014.pdf>

¹⁶⁷ Young Addaction (2013). *Drugs, Alcohol and Tobacco Use. The Young People’s Survey 2013*. Romford, London Borough of Havering.

¹⁶⁸ National Treatment Agency (2012) Cost Effectiveness Tool (Havering). Available on: <https://www.ndtms.net/CETTool.aspx>

Figure 6.35 Expenditure for 2012-13 on Drug and Alcohol Services in Havering Compared with National Average Expenditure 2011-12

	Expenditure	Havering 2012-13 %	National 2011-12 %
Community Prescribing	£754,416	41.4%	30.2%
Structured Day Programmes	£100,000	5.5%	4.8%
Structures Psychosocial Interventions	£100,000	5.5%	7.7%
Other Structured Drug Treatment	£193,000	10.6%	9.0%
Inpatient Treatment	£28,000	1.5%	3.7%
Residential Rehabilitation	£71,660	3.9%	4.1%
Lower Threshold (formerly unstructured/Tier 2)	£181,720	10.0%	10.4%
Drug Interventions Programme (DIP)	£61,000	3.3%	12.1%
Prison-based drug treatment	£0	0.0%	9.3%
Commissioning System / Treatment Overheads	£152,395	8.4%	6.9%
Contingency / below the line	£181,000	9.9%	2.0%
Total	£1,823,191	100%	100%

7.0 The Local Response

It is vital that we provide effective treatment and recovery. The Government's Drug Strategy sets out how it is raising the ambition to support full recovery for those suffering from addiction, including alcohol. Increasing effective treatment for dependent drinkers will offer the most immediate opportunity to reduce alcohol-related admissions and to reduce NHS costs. Treating alcohol dependence, where successful, has also been shown to prevent future illnesses. Around 31,000 (33%) of adults in alcohol treatment are parents with childcare responsibilities. A further 20% are parents whose child lives elsewhere. Local treatment services and children's and family services are increasingly working together – as part of a wider team around the family – to identify and respond to alcohol-related problems. Evidence shows that Family Intervention Projects (FIPs) are effective in tackling these families' entrenched problems including a 34% reduction in drug and alcohol problems, 58% reduction in anti-social behaviour and over 50% reduction in truancy. Recovery goes beyond medical or mental health issues to include dealing with the wider factors that reinforce dependence, such as childcare, housing needs, employability and involvement in crime. The Government's Drug Strategy sets out how we are working with eight pilot areas developing approaches to paying for outcomes for recovery from drug or alcohol dependency.

7.1. Principles of Effective Treatment

There are a variety of evidence-based treatment programmes for both drug and alcohol misuse. The following extract is taken directly from the National Institute on Drug Abuse guide to effective treatment – these principles can be applied broadly to alcohol misuse as well as drug misuse¹⁶⁹. This section subsequently outlines what areas of treatment are currently being delivered in Havering.

1. Addiction is a complex but treatable disease that affects brain function and behavior. Drugs of abuse alter the brain's structure and function, resulting in changes that persist long after drug use has ceased. This may explain why drug abusers are at risk for relapse even after long periods of abstinence and despite the potentially devastating consequences.
2. No single treatment is appropriate for everyone. Treatment varies depending on the type of drug and the characteristics of the patients. Matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.
3. Treatment needs to be readily available. Because drug-addicted individuals may be uncertain about entering treatment, taking advantage of available services the moment people are ready for treatment is critical. Potential patients can be lost if treatment is not immediately available or readily accessible. As with other chronic diseases, the earlier treatment is offered in the disease process, the greater the likelihood of positive outcomes.
4. Effective treatment attends to multiple needs of the individual, not just his or her drug abuse. To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems. It is also important that treatment be appropriate to the individual's age, gender, ethnicity, and culture.
5. Remaining in treatment for an adequate period of time is critical. The appropriate duration for an individual depends on the type and degree of the patient's problems and needs. Research indicates that most addicted individuals need at least 3 months in treatment to significantly

¹⁶⁹ National Institute on Drug Abuse (2012). *Principles of Drug Addiction Treatment: A research-based guide (third edition)*. NIDA, USA. Available on: http://www.drugabuse.gov/sites/default/files/podat_1.pdf

reduce or stop their drug use and that the best outcomes occur with longer durations of treatment. Recovery from drug addiction is a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug abuse can occur and should signal a need for treatment to be reinstated or adjusted. Because individuals often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.

6. Behavioural therapies—including individual, family, or group counselling—are the most commonly used forms of drug abuse treatment. Behavioural therapies vary in their focus and may involve addressing a patient’s motivation to change, providing incentives for abstinence, building skills to resist drug use, replacing drug-using activities with constructive and rewarding activities, improving problem-solving skills, and facilitating better interpersonal relationships. Also, participation in group therapy and other peer support programs during and following treatment can help maintain abstinence.
7. Medications are an important element of treatment for many patients, especially when combined with counselling and other behavioural therapies. For example, methadone, buprenorphine, and naltrexone (including a new long-acting formulation) are effective in helping individuals addicted to heroin or other opioids stabilize their lives and reduce their illicit drug use. Acamprosate, disulfiram, and naltrexone are medications approved for treating alcohol dependence. For persons addicted to nicotine, a nicotine replacement product (available as patches, gum, lozenges, or nasal spray) or an oral medication (such as bupropion or varenicline) can be an effective component of treatment when part of a comprehensive behavioural treatment program.
8. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs. A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counselling or psychotherapy, a patient may require medication, medical services, family therapy, parenting instruction, vocational rehabilitation, and/or social and legal services. For many patients, a continuing care approach provides the best results, with the treatment intensity varying according to a person’s changing needs.
9. Many drug-addicted individuals also have other mental disorders. Because drug abuse and addiction—both of which are mental disorders—often co-occur with other mental illnesses, patients presenting with one condition should be assessed for the other(s). And when these problems co-occur, treatment should address both (or all), including the use of medications as appropriate.
10. Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse. Although medically assisted detoxification can safely manage the acute physical symptoms of withdrawal and can, for some, pave the way for effective long-term addiction treatment, detoxification alone is rarely sufficient to help addicted individuals achieve long-term abstinence. Thus, patients should be encouraged to continue drug treatment following detoxification. Motivational enhancement and incentive strategies, begun at initial patient intake, can improve treatment engagement.
11. Treatment does not need to be voluntary to be effective. Sanctions or enticements from family, employment settings, and/or the criminal justice system can significantly increase treatment entry, retention rates, and the ultimate success of drug treatment interventions.

12. Drug use during treatment must be monitored continuously, as lapses during treatment do occur. Knowing their drug use is being monitored can be a powerful incentive for patients and can help them withstand urges to use drugs. Monitoring also provides an early indication of a return to drug use, signaling a possible need to adjust an individual's treatment plan to better meet his or her needs.
13. Treatment programs should test patients for the presence of HIV/AIDS, Hepatitis B and C, tuberculosis, and other infectious diseases as well as provide targeted risk-reduction counseling, linking patients to treatment if necessary. Typically, drug abuse treatment addresses some of the drug-related behaviors that put people at risk of infectious diseases. Targeted counseling focused on reducing infectious disease risk can help patients further reduce or avoid substance-related and other high-risk behaviors. Counseling can also help those who are already infected to manage their illness. Moreover, engaging in substance abuse treatment can facilitate adherence to other medical treatments. Substance abuse treatment facilities should provide onsite, rapid HIV testing rather than referrals to offsite testing—research shows that doing so increases the likelihood that patients will be tested and receive their test results. Treatment providers should also inform patients that highly active antiretroviral therapy (HAART) has proven effective in combating HIV, including among drug-abusing populations, and help link them to HIV treatment if they test positive.

7.2 Adult Alcohol Services

The following section provides both best practice guidance recommended for the treatment of alcohol misuse disorders, and an overview of what services are currently provided in Havering in line with these recommendations.

7.2.1 Screening for Alcohol Dependence – Use of the NHS Health Checks Programme

In order to identify alcohol dependence it is first necessary to screen individuals for their level of harmful drinking behaviour. NICE Public Health Guidance 24 (June 2010)¹⁷⁰ recommends that, 'Commissioners should ensure their plans include screening and brief interventions for people at risk of an alcohol-related problem (hazardous drinkers) and those whose health is being damaged by alcohol (harmful drinkers). This includes people from disadvantaged groups.'

Screening tools such as AUDIT (Alcohol Use Disorders Identification Test) have been well evaluated and validated as an effective tool for detecting hazardous and harmful drinkers, particularly in primary care settings. Regarded as the gold standard, AUDIT can detect 92% of genuinely hazardous and harmful drinkers and excludes 93% of those who are not. AUDIT has been shown to be more sensitive than CAGE¹⁷¹ at picking up hazardous and harmful drinker, unless the CAGE tool is supplemented with two additional questions on maximum daily and total weekly consumption¹⁷².

¹⁷⁰ NICE Public Health Guidance 24 (June 2010). *Alcohol-use disorders: Preventing Harmful Drinking*
<http://guidance.nice.org.uk/PH24/Guidance/pdf/English>

¹⁷¹ CAGE is defined as "attempts to Cut back on drinking, being Annoyed at criticisms about drinking, feeling Guilty about drinking, and using alcohol as an Eye-opener"

¹⁷² Scottish Intercollegiate Guidelines Network (SIGN) Guideline 74 (September 2003). *The management of harmful drinking and alcohol dependence in primary care: A national clinical guideline.* [Available here.](#)

In addition, the screening tool chosen needs to be appropriate to the setting. In time-limited situations NICE Public Health Guidance 24 recommends using an abbreviated version such as AUDIT-C, AUDIT-PC, SASQ or FAST. In emergency care settings the recommended screening tool is FAST or PAT (Paddington Alcohol Test), whilst TWEAK and T-ACE are particularly effective for A&E or obstetric settings¹⁷³.

The key recommendations for screening from NICE are:

- Use AUDIT tool, or AUDIT-C/FAST if time limited in primary care settings
- When new patients register with a GP they should be asked about weekly and maximum daily alcohol consumption, or an appropriate screening tool should be used.
- Primary care workers should be alerted by certain presentations and physical signs, to the possibility that alcohol is a contributing factor and should ask about alcohol consumption.

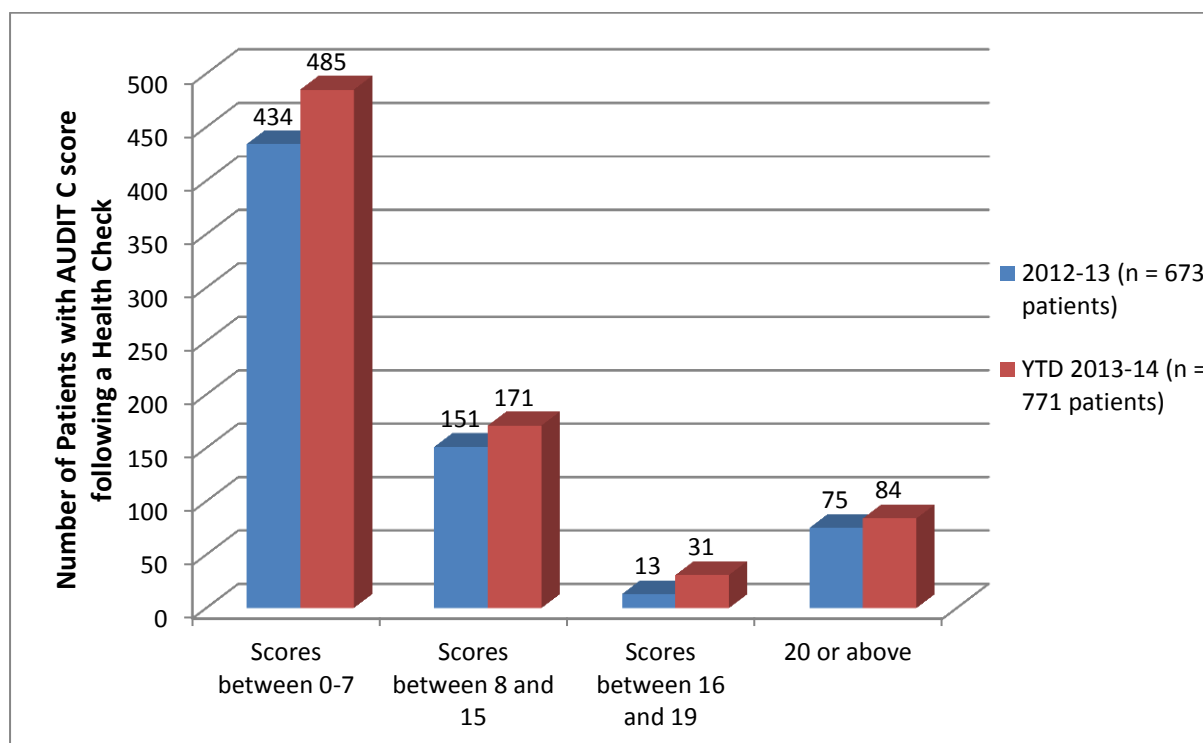
In Havering, out of 10,539 Health Checks offered to eligible patients in the borough in the year to date 2013-14, 4,497 Health Checks have been delivered, which represents a take-up of 39.9%. This is an improvement in overall numbers of checks taken up from 2012-13 in which 5,123 Health Checks were offered and 3,328 were actually delivered. However, not all patients who have taken up a Health Check have actually completed an AUDIT C evaluation. In 2012-13 a total of 673 patients completed an AUDIT C and in the Year to Date 2013-14, 771 patients completed an AUDIT C. Figure 7.1 shows the AUDIT C scores of these patients. The recommended course of action, developed by the World Health Organisation, for each range of scores is:

- Scores between 0 – 7 = Alcohol Education
- Scores between 8 – 15 = Simple Advice - focused on the reduction of hazardous drinking
- Scores between 16 – 19 = Simple Advice plus brief counselling and continued monitoring
- Scores 20 or above = Referral to specialist for further diagnostic evaluation for alcohol dependence

More people have been identified as potentially alcohol dependent and (possibly) referred on to specialist services in 2013-14 (84 people so far) than in 2012-13 (75). However, this still represents only 2% of the estimated 3,316 dependent drinkers in the borough, excluding those already in treatment.

¹⁷³ Health Collaborating Centre, commissioned by NICE. Available on:
<http://www.nice.org.uk/guidance/index.jsp?action=download&o=49007>

Figure 7.1 Number of Patients with AUDIT C Score following a Health Check in 2012-13 and Year to Date 2013-14



7.2.2 Effectiveness and Use of Interventions and Brief Advice (IBA)

Interventions and Brief Advice (IBA) have been shown to have a positive impact on alcohol consumption, mortality, morbidity, alcohol-related injuries, alcohol-related social consequences, and healthcare resource use and are effective for both men and women¹⁷⁴. Evidence shows that when delivered in certain settings, alcohol Interventions and Brief Advice (IBAs) have the ability to reduce hazardous and harmful alcohol in the population effectively¹⁷⁵. Screening and brief advice have been shown to save £58,000 per 1,000 people screened in doctors surgeries¹⁷⁶. It is expected that IBA would result in the reduction from higher risk drinkers (also known as harmful drinkers) to lower risk drinkers (also known as hazardous drinkers), in 250,000 men and 67,500 women each year. Higher risk and increasing risk drinkers who receive brief interventions are twice as likely to moderate their drinking 6 to 12 months after an intervention when compared to drinkers receiving no interventions at all¹⁷⁷.

¹⁷⁴ Jackson, R *et al.* (2010) Screening and Brief Interventions for Prevention and Early Identification of Alcohol Use Disorders in Adults and Young People SCHARR Public Health Collaborating Centre, commissioned by NICE. Available on: <http://www.nice.org.uk/guidance/index.jsp?action=download&o=49007>

¹⁷⁵ Heather, N., D., Godfrey, C.,C. Review of effectiveness of Treatment for Alcohol Problems, 2006. National Treatment Agency for Substance Misuse

¹⁷⁶ Alcohol Concern (2011). *Making alcohol a health priority – Opportunities to reduce alcohol harms and rising costs* Available on: <http://www.alcoholconcern.org.uk/assets/files/Publications/2011/Making%20alcohol%20a%20health%20priority-opportunities%20to%20curb%20alcohol%20harms%20and%20reduce%20rising%20costs.pdf>

¹⁷⁷ Wallace, P., Cutler, S. & Haines, A. (1988). Randomized controlled trial of general practitioner intervention with excessive alcohol consumption. *British Medical Journal*, 297, 663–668.

Brief interventions can reduce drinking by between 13% and 34% resulting in 2.9 to 8.7 fewer mean drinks per week with a significant effect on recommended or safe alcohol use¹⁷⁸. Effects of IBA persists for periods up to 2 years after intervention and perhaps as long as 4 years¹²⁵.

NICE Guidelines and the associated pathway for treatment options for alcohol-use disorders therefore recommend brief interventions (Fig 7.2)¹⁷⁹. However, evidence for the use of IBA within Havering is difficult to measure. In 2009, a programme of training in delivery of IBA was rolled out in the borough. Over 350 members of frontline staff from 60 different teams/agencies including, e.g.:

- Mental health services
- Substance misuse providers
- Social services
- Criminal justice
- Health
- Housing
- Children's services

A questionnaire was sent out to practitioners who had attended the training to assess the extent to which these activities were being implemented across the different agencies. Unfortunately the response to the questionnaire was quite low at 8%; only 19 of 238 potential returns were received, and the evaluation results should be treated with caution. Of these:

- 10 people (59%) stated that they offered brief interventions whilst the rest (41%) had not
- Reasons why practitioners had not offered brief interventions included:
 - 'I have not had cause to implement any brief interventions but I do have knowledge from this training to make reference to'
 - 'I will only need to use it if any of my counselling clients present with alcohol issues'
 - 'I currently do not work or come into contact with potential clients'
 - 'As at yet, I have not come across any clients who need this input'
- 8 people indicated that they had screened people while 10 had not.
- Estimated total numbers screened: 238
- Estimated total number offered brief intervention: 68
- The conversion rate of people whose screening had resulted in a brief intervention was 28%.

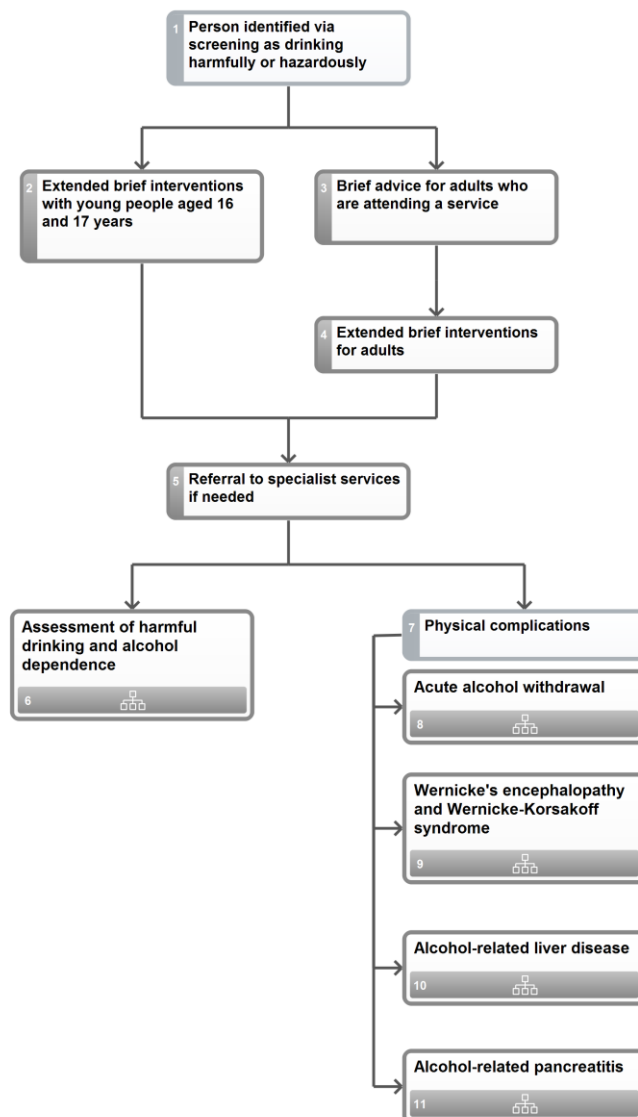
The key recommendations from the evaluation of the training programme were:

- Future IBA programmes need to focus on increasing the coverage and reach of people that could benefit from intervention.
- Develop minimum dataset for collating information on IBA to be implemented across all partner agencies. This will give a much clearer and developed knowledge of local drinking behaviour
- Offer training once every 3 years
- Develop baseline and evaluation criteria against which further ABI activity can be monitored

¹⁷⁸ Whitlock, E. P., Polen, M. R., Green, C. A., Orleans, T. & Klein, J. (2004). Behavioural counseling interventions in primary care to reduce risky/harmful alcohol use by adults: A summary of the evidence for the US Preventive Services Task Force. *Annals of Internal Medicine*, 140, 557–568.

¹⁷⁹ NICE (2013) Available on: <http://pathways.nice.org.uk/pathways/alcohol-use-disorders/brief-interventions-for-alcohol-use-disorders>

Figure 7.2 NICE Pathway for Brief Interventions for Alcohol-Use Disorders



7.2.3 Engagement in Alcohol Treatment Services

The London Borough of Havering currently commissions CRI (Crime Reduction Initiative) to deliver the services of the Community Alcohol Team, based in Ballard Chambers, 26 High Street, Romford, RM1 1RH Phone: 01708 747614; Freephone: 0800 652 5898. Services include:

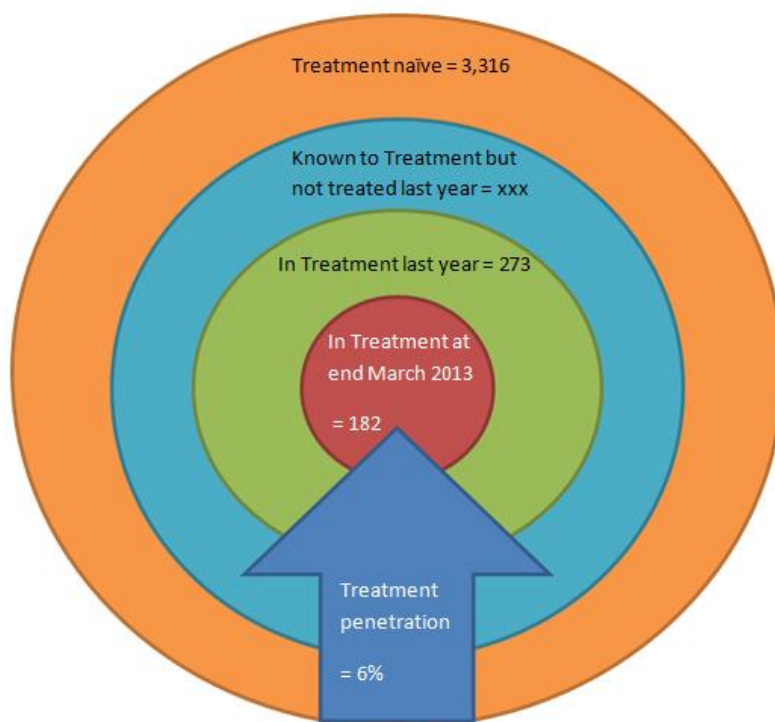
- Assessment and referral
- Induction programme
- Structured Day Programme
- Counselling
- Assertive outreach
- Community detoxification
- Assessment for residential rehabilitation
- Motivational interviewing.

Alcohol treatment, directly commissioned by the council, was provided to 273 service users in 2012-13 in total, of whom 182 were starting new treatment episodes¹⁸⁰. Of these 273 in treatment:

- 205 were assessed to be dependent drinkers,
- 16 were hazardous drinkers
- 19 were harmful drinkers
- 33 'safe' drinkers, referred into treatment through social services/probation to prevent relapse¹⁸¹

If the prevalence estimate of 3,316 dependent drinkers in Havering has remained constant, given that local treatment services saw 205 of them, this gives Havering a treatment penetration of 6% (i.e. 205/3316) (Fig. 7.3).

Figure 7.3 Treatment Penetration Rate for Havering Alcohol Treatment Services 2012-13



This is consistent with the penetration rate for Havering in 2011-12 (also 6%), however we have no current (2012-13) national comparison data. In 2011-12, the national penetration rate was 13%, suggesting that Havering is likely to be still relatively less effective than other areas at meeting the volume alcohol treatment needs of its population (Fig. 7.4).

¹⁸⁰ Public Health England (2013). *Alcohol and Drugs: JSNA Support Pack. Key data to support planning for effective alcohol prevention, treatment and recovery. The data for Havering.* London: Public Health England.

¹⁸¹ Personal communication with Community Alcohol Team Service Manager using Caseload Segmentation Tool (17/03/14).

Figure 7.4 Numbers in Alcohol Treatment Services 2011-12 to 2012-13

	2011-12	2012-13
Numbers provided treatment	268	273
Numbers starting new treatment episodes	180	182
Treatment Penetration Rate	6%	6%
National Treatment Penetration Rate	13%	-

Of the 273 service users accessing alcohol treatment, 255 engaged in community treatment¹⁸², and a further 18 accessed inpatient treatment only. Most of these 18 have funded their treatment by non-statutory means (London Borough of Havering paid for 10 individuals). Whilst this may not capture all activity where people are self-funding their treatment, many private clinics do report to NATMS/NDTMS¹⁸³.

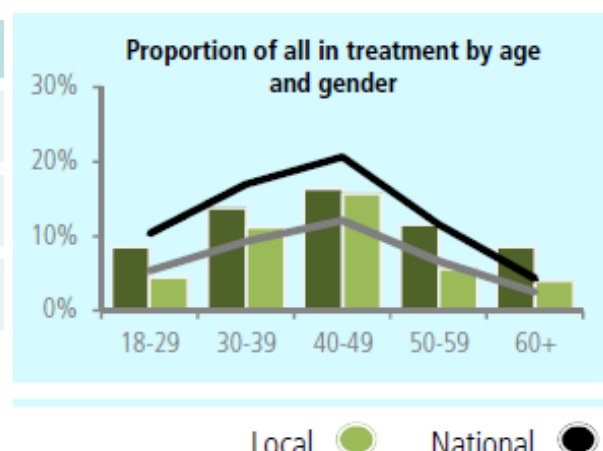
255 people treated in community alcohol treatment services; 18 treated as in-patients

61% men; 37% women engaged in treatment; 91% of clients were White British in 2012-13

In Havering, more men (61%) engaged in alcohol treatment than women (37%). There was also a higher percentage of white British clients in alcohol treatment services than any other ethnic group at 91%, which is greater than the proportion of ethnic minority groups currently residing in the borough (88%)¹⁸⁴. The mean age for men and women in alcohol treatment is slightly higher than the mean age nationally (Figure 7.5).

Figure 7.5 Mean Age and Gender of All Adults in Alcohol Treatment in 2011-12.

	Havering	National
Men	43.8	41.7
Women	42.7	42.0
All	43.4	41.8



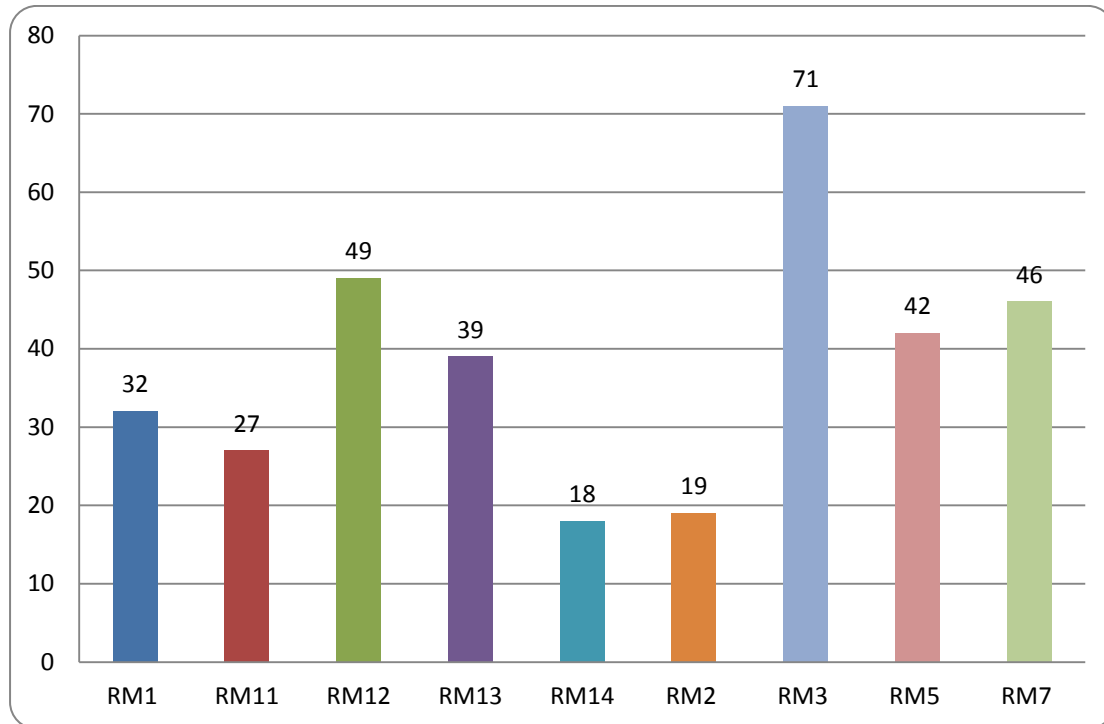
¹⁸² National Drug Treatment Monitoring System (NDTMS) (2014). Adult Alcohol Performance/Provider by Residence - 2012/2013, Quarter 4: Havering, CRI Havering Community Alcohol Team.

¹⁸³ Personal communication from London NDTMS manager

¹⁸⁴ Adult Alcohol Partnership Quarterly Performance Report 2012 / 2013, Quarter 4

The close correlation between deprivation and substance misuse is reflected in the area of residence from which clients present themselves for alcohol treatment. Figure 7.6 shows that Postcode RM3 (Harold Hill/Gooshays) is the most prevalent for alcohol treatment, followed closely by high needs of residents in Postcodes RM12 (Hornchurch/Elm Park), RM5 (Collier Row) and RM7 (Brooklands ward, west of Romford). Data referencing the postcodes RM4 and RM6 are suppressed due to very low numbers. Postcodes RM8, RM9 and RM10 are in neighbouring Barking & Dagenham, and RM15 in Thurrock.

Figure 7.6 Postcodes of clients referred to Alcohol Treatment Services in Havering (2010-13)



48% of clients presenting for alcohol treatment drank <600 units in the 28 days prior to treatment

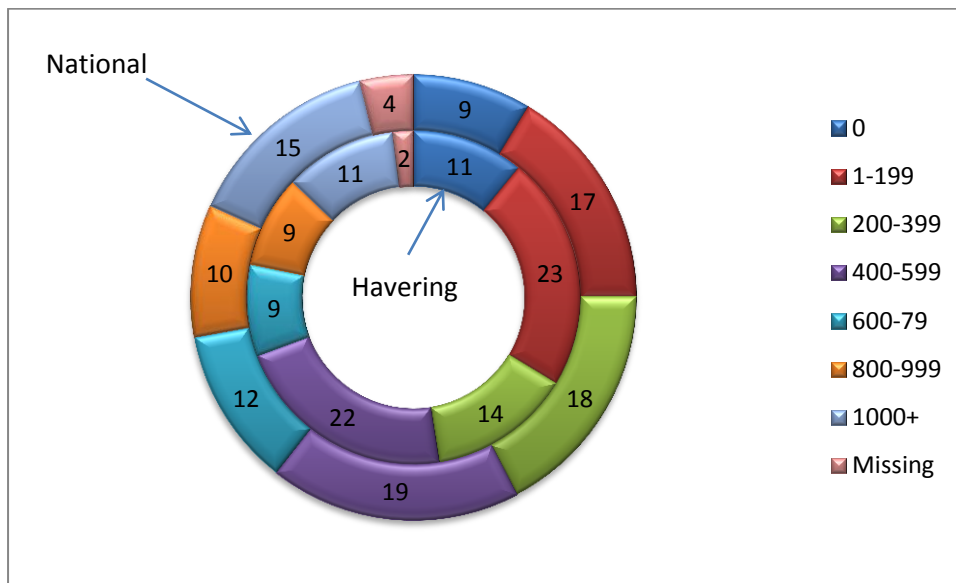
The percentage of people drinking at higher risk levels in the 28 days prior to entering treatment in Havering was 68%, lower than the national rate of 77% (Fig. 7.7)¹⁸⁵. A greater percentage of people entering treatment in Havering appear to be presenting with lower levels of alcohol intake – 48% present consuming less than 600 units of alcohol in the 28 days prior to treatment compared with 44% nationally. This apparent skewing of the patient population in Havering to ‘less complex’ clients is further supported by data on the number of clients presenting to treatment who cite using other substances

in addition to alcohol. In Havering, 3% of clients cite additionally using cannabis compared with 10% nationally, and 4% cite using other drugs (excluding opiates, crack or cannabis) compared with 9% nationally. This could be perceived as reflecting either:

¹⁸⁵ NTA (2012). *JSNA Support Pack for Strategic Partners. The data for alcohol. London Borough of Havering*. London: National Treatment Agency for Substance Misuse (now Public Health England).

- an inappropriate system set-up, meaning that fewer than expected high volume drinkers are accessing treatment,
- Havering’s demography of drinking is substantively different to other parts of the UK in terms of having fewer drinkers consuming over 600 units in the 28 days prior to entering treatment.

Figure 7.7 Units consumed in the 28 days prior to entering treatment (% Havering compared with National) (2011-12 data)

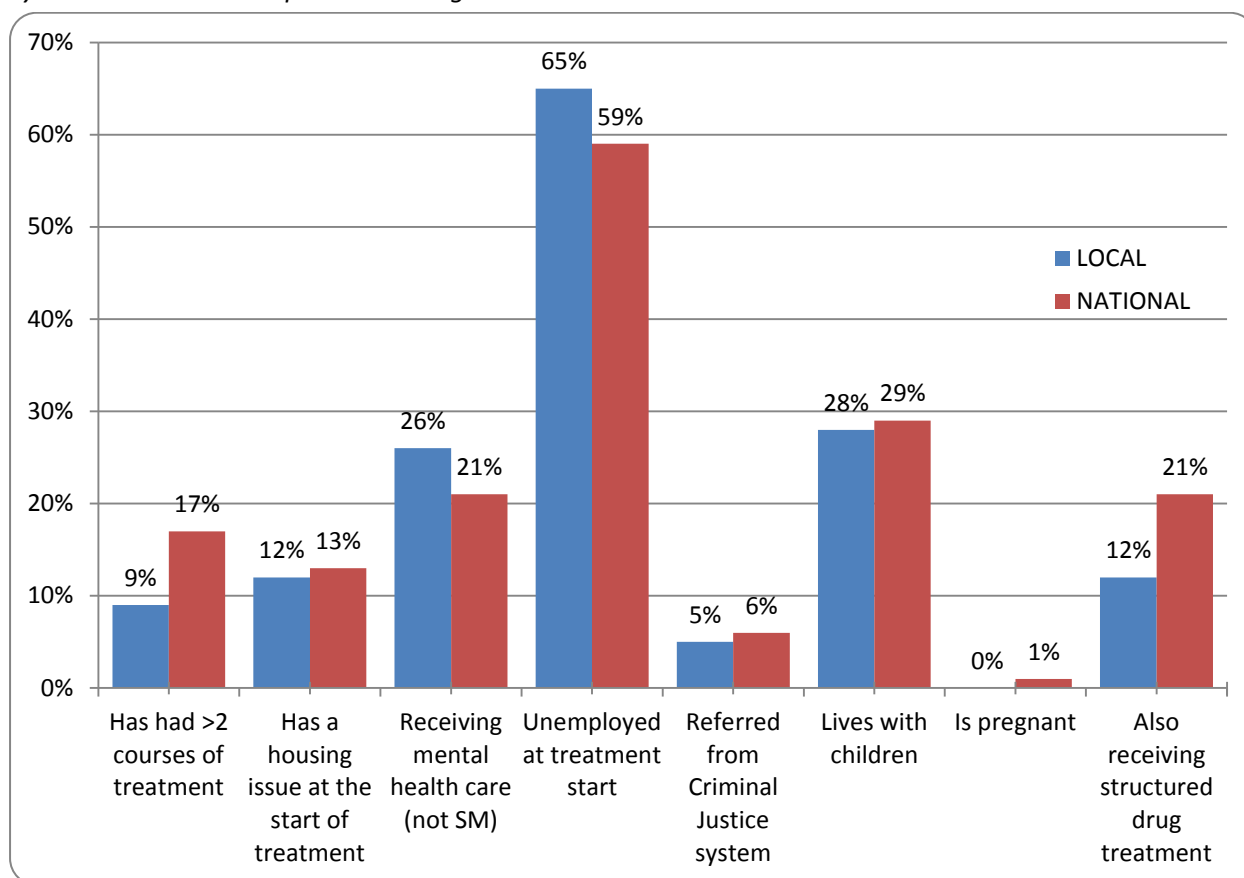


Nevertheless, 11% of new clients in Havering drank more than 1000 units of alcohol in the 28 days prior to treatment than the national figure (15%) – this represents an intake of 35 or more units of alcohol per day, the equivalent of around a bottle of vodka a day. In addition, although the majority of cite using alcohol in the month prior to treatment, 9% nationally and 11% in Havering cite no alcohol use. There are several reasons why this could be the case: they may have been referred to treatment directly from the criminal justice system or they may be in treatment to maintain abstinence and relapse-prevention.

Many adults in alcohol treatment experience complex and wide-ranging problems. The 11 data items described in Figure 7.8 provide an overview of these. When added together, these provide an overall score for each client. The higher the score, the more likely it is that the client has complex needs. Using this scoring system, this figure presents an overview of the complexity of Havering’s alcohol treatment population compared with the national figure. In terms of the compounding issues presenting in the alcohol service users in Havering, there are some notable differences with the national profile ¹⁸⁶.

¹⁸⁶ NTA (2012). *JSNA Support Pack for Strategic Partners. The data for alcohol. London Borough of Havering.* London: National Treatment Agency for Substance Misuse (now Public Health England).

Figure 7.8 Prevalence of Compounding Issues of Alcohol Clients in the Havering Alcohol Treatment System in 2012-13 compared with England.



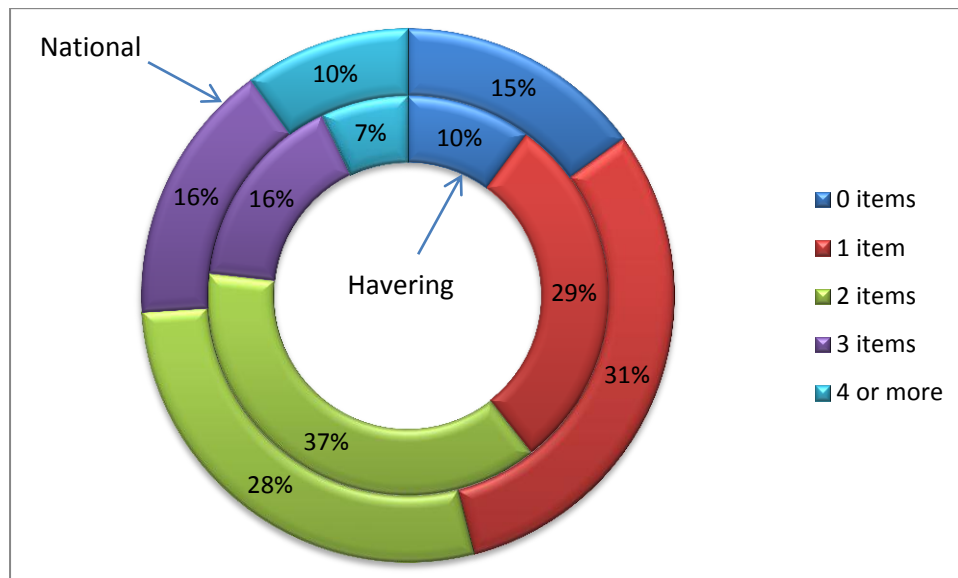
In 2012-13, proportionately fewer of Havering’s alcohol clients, compared with England, had 3 or more courses/episodes of alcohol treatment, and a smaller proportion were receiving structured treatment for drug problems in addition to alcohol. Proportions were notably higher in Havering than England for those receiving mental health services not related to substance misuse, and for those unemployed at treatment start. This is interesting in contrast with our understanding of Havering’s reportedly good levels of mental health and levels of employment: Havering has a significantly better directly standardised rate for hospital admissions for mental health 2009/10 to 2011/12 of 152 (per hundred thousand) compared with England average of 243¹⁸⁷. Havering’s rate of long term unemployment (8.8) is also significantly better than England (9.5) - crude rate per 1000 unemployed for 12 months or longer¹⁸⁸. We need to understand why the alcohol treatment cohort does not reflect this wider picture. It could be that a lack of early intervention with alcohol issues means that lifestyles have deteriorated significantly before issues are identified and referrals to services are made. Alternatively, perhaps local people are attempting to cope with problems with mental health and/or unemployment through alcohol use which then becomes problematic, and leads to referrals to services. Alternatively, since unemployment and mental health are linked, it could be that the alcohol linkage is with one or other, and the third factor follows by nature of the linkage.

¹⁸⁷ Havering Community Mental Health Profile 2013

¹⁸⁸ Havering Health Profile 2013: Public Health England

Data from the JSNA support pack for 2011-12 showed that 76% of Havering alcohol clients had 2 or fewer items on the complexity scores, compared with 74% nationally (Fig 7.9). However, the predominant number of complexity items was 2 for Havering (37%) compared with 1 nationally (31%).

Figure 7.9 Number of Complexity Items Scored in Havering Alcohol Treatment Clients Compared with National (2011-12 data)



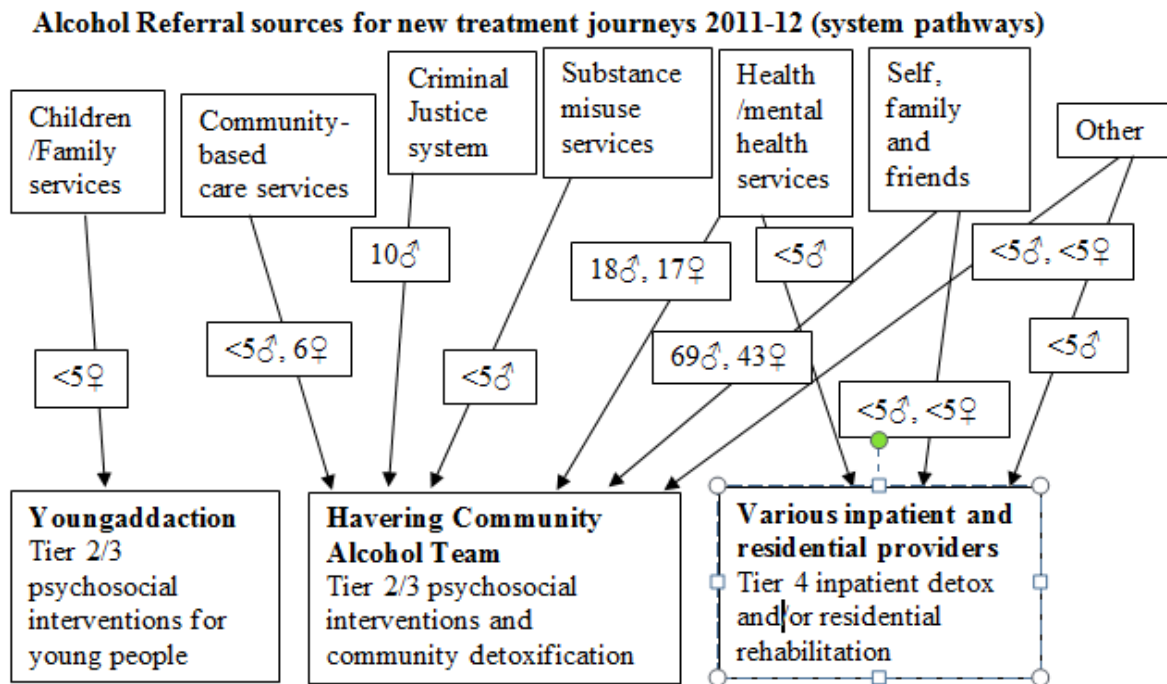
Dual diagnosis (comorbid mental health diagnosis) was present in 21% of clients receiving services during 2012-13¹⁸⁹. These contrasts with data from the JSNA support pack stating that 26% of alcohol clients were in touch with mental health services for reasons other than substance misuse: this is higher than the national average of 21%⁵. The notable greater proportion of alcohol/mental health dual diagnosis in Havering is interesting. Possible explanations include people with mental health issues self-medicating with alcohol either because of difficulties managing their illness/condition through the available mental health services. According to the 2012-13 data⁵, the proportion of alcohol clients referred from the Criminal Justice system was comparable with the national proportion at 5% (compared with 6% national average). In 2011-12, local intelligence that we have a high proportion of alcohol service users living with children was supported by NTA data in the JSNA support pack putting Havering's proportion at 40%, compared with a 32% national average. In 2012-13 however, Havering's proportion had reduced to 28%, and the national average had dropped to 29%. Efforts should be made to understand why this feature of the client group changed so dramatically. Perhaps interestingly the proportions of alcohol clients with a housing problem was stable at 12% in 2012-13 as it was in the previous year, consistently comparable with the national average of 13% (also stable from 2011-12 to 2012-13).

The referral sources for patients entering treatment services are given in Fig. 7.10. It is likely that many others presented to primary care and were not referred to specialist treatment for various reasons – GPs may have attempted to manage the alcohol use through Information and Brief Advice (IBA) under the Direct Enhanced Service (DES) contract, other clients may have used mutual aid

¹⁸⁹ Adult Alcohol Performance Report - 2012 / 2013, Quarter 4 Havering

groups such as Alcoholics Anonymous (AA). Furthermore, some individuals may be accessing treatment through private clinics.

Figure 7.10 Alcohol Referral Sources for New Treatment Journeys 2011-12



7.2.4 Mutual Aid and Recovery

The complex and cross-cutting issues associated with substance misuse necessitate an approach that goes beyond the treatment of the addiction. Issues around housing and employment/ education are important. Support from peers through mentors or sponsors and using the networks of mutual aid from organisations such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and SMART Recovery have been demonstrated to significantly strengthen the gains made in treatment and positive outcomes, particularly assisting people to remain in on-going control of their drug and/or alcohol use. AA in Havering is particularly strong since there are around 15 regular groups, each attended by around 10-15 people with around 80% of these being Havering residents. The anonymous nature of the group means that precise data is not generally available, however the estimates would suggest that between 120 and 225 Havering people with alcohol issues are attending. Some of these will have been previously, or indeed currently, engaging with the Havering Community Alcohol Team. The team routinely refers clients to AA when leaving treatment and encourages them to attend whilst they are receiving structured treatment.

7.2.5 Adult Alcohol Treatment Outcomes

The Government's alcohol strategy states that increasing effective treatment for dependent drinkers will offer the most immediate opportunity to reduce alcohol-related admissions and costs to the NHS. Although there is no single measure of effective treatment for alcohol dependency, the following data demonstrates how well the current system is working in treating those who are receiving structured treatment. Despite a low penetration rate for the numbers of dependent drinkers actually presenting for treatment (6% compared to 13% nationally), the quality of treatment services in terms of outcomes for individuals is relatively good in Havering.

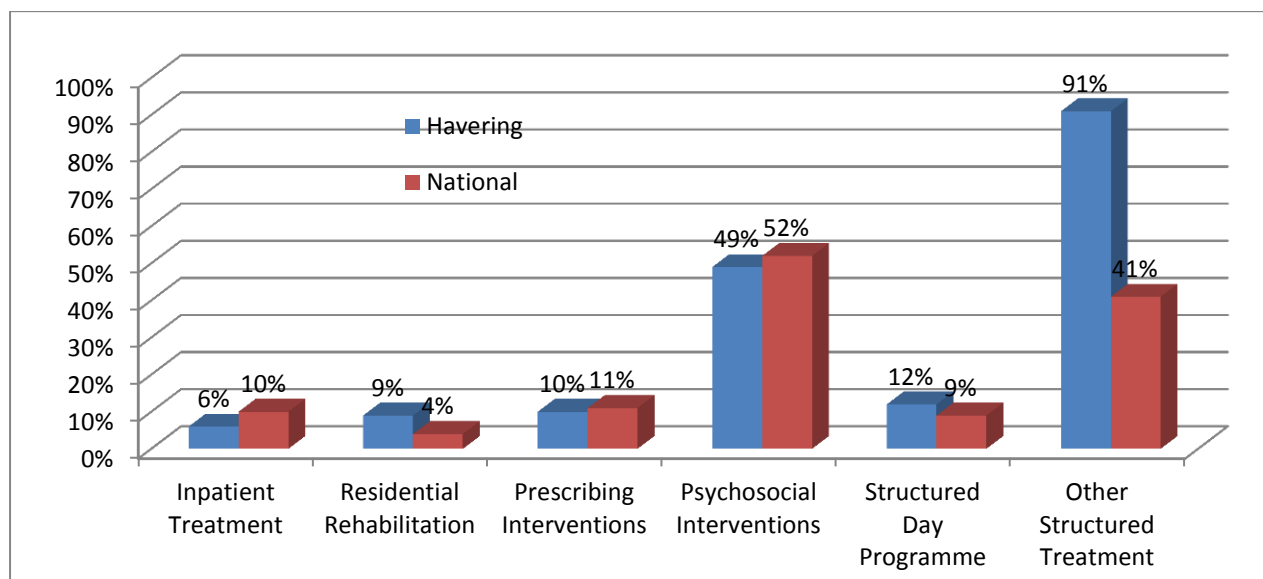
65% of Havering clients waited less than 3 weeks to begin alcohol treatment compared with 62% nationally

People who need alcohol treatment need prompt help if they are to recover from alcohol dependency and keeping waiting times low will play a vital part in supporting recovery. In Havering, 65% of adults waited less than 3 weeks to start treatment, compared with a national figure of 62%. However, the low penetration rate into treatment of alcohol dependency may to some extent explain why the waiting time is low.

Anecdotally, service user awareness of capacity challenges and therefore difficulties or delays getting into treatment may be suppressing self-referrals, and there may be similar challenges with GPs reluctant to refer to an agency known to be struggling to meet demand. Alternatively, there may be aspects of the service that are unattractive to service users. Co-location with drug services and the visage of the premises could also be off-putting. There have also been reports through professional communications and service user representatives of alcohol clients withdrawing from treatment because of mixed drug/alcohol treatment groups. Hospital liaison capacity has been lower than optimal, so that the referral pathway from Queen’s Hospital, Romford has not been effective.

Havering Alcohol Treatment clients received a greater percentage of residential rehabilitation (9%) compared with 4% nationally (Fig. 7.11). In addition, 91% of Havering clients received ‘Other Structured Treatment’ compared with 41% nationally.

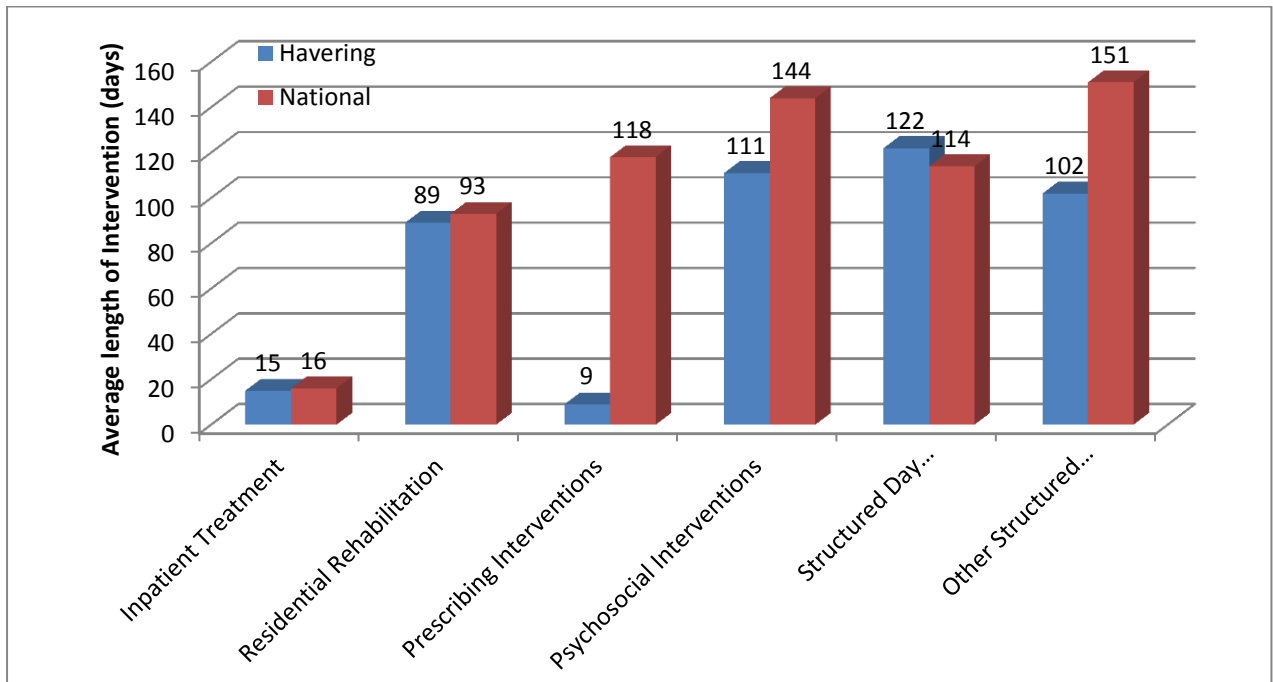
Figure 7.11 Treatment Interventions Received by Alcohol Clients 2011-12 in Havering compared with National



The length of a typical treatment period nationally was around 6 months, although nationally 17% of clients remained in treatment for more than 1 year. Retaining clients for their full course of treatment is important in order to increase the levels of successful treatment completion and reduce rates of early treatment drop out. Conversely, having a high proportion of clients in treatment for more than a year may indicate that they are not moving effectively through and out of the

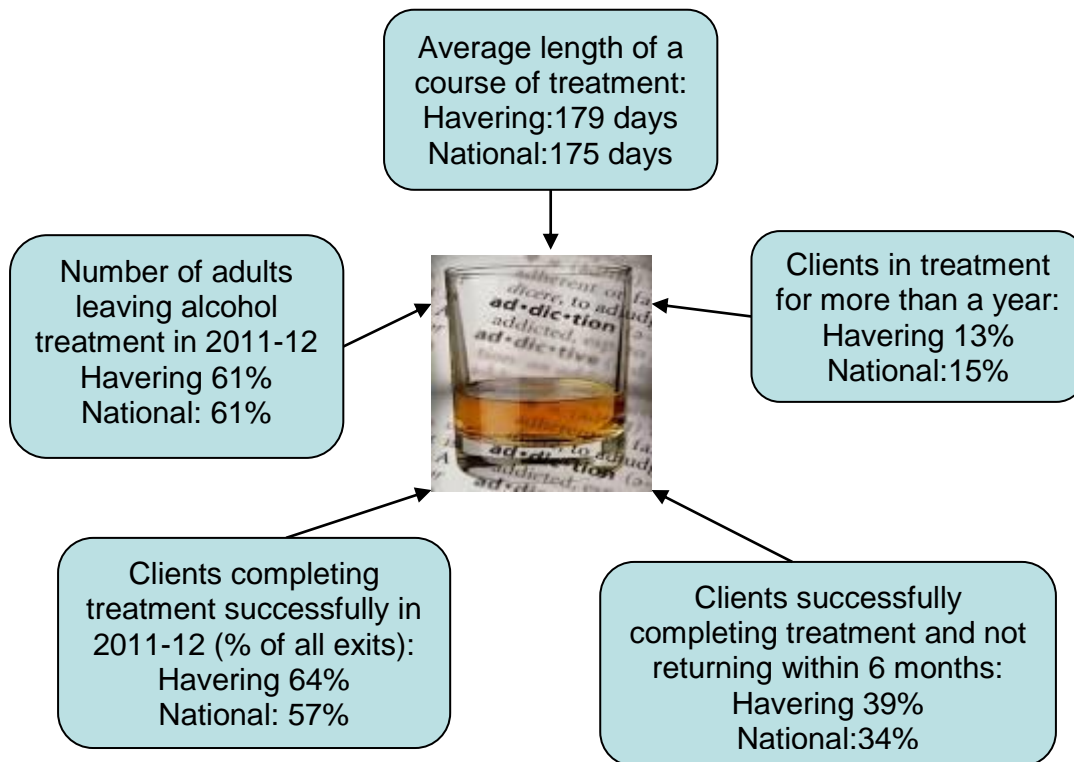
treatment system. In Havering, the longest average length of intervention was for a structured day programme at 122 days (just over 4 months) (Fig. 7.12).

Figure 7.12 Average Length of Intervention (days) in Havering Compared with National (2011-12)



Although Havering's average length of a course of treatment was slightly longer than the national average, those people attending Havering's alcohol treatment services were more likely to complete successfully and not return within 6 months (Fig. 7.13).

Figure 7.13 Havering's Proportion of Successful Completions of Treatment Compared to National (2011-12)



7.2.6 Medications Available

Further evidence of treatment for alcohol misuse disorders is available via the number of scripts for drugs specific ally for people aiming to achieve abstinence. There are three main medications available to GPs, which were prescribed to 190 people in Havering in the current year to date 2013-14¹⁹⁰:

- Acamprosate (brand name Campral) is used to help prevent a relapse in people who have successfully achieved abstinence from alcohol. It's usually used in combination with counselling. Acamprosate works by affecting levels of a chemical in the brain called gamma-amino-butyric acid (GABA). GABA is thought to be partly responsible for inducing a craving for alcohol. A course of acamprosate usually starts as soon as a person begins withdrawal from alcohol and can last for up to six months.
- Disulfiram (brand name Antabuse) can be used for people trying to achieve abstinence but are concerned that they may relapse, or if they've had previous relapses. Disulfiram works by deterring drinking by causing unpleasant physical reactions if they drink alcohol. These can include:
 - nausea
 - chest pain
 - vomiting
 - dizziness

¹⁹⁰ Information reproduced from NHS Choices, 2013. Available on: <http://www.nhs.uk/Conditions/Alcohol-misuse/Pages/treatment.aspx>

As well as alcoholic drinks, it's important to avoid all sources of alcohol because they could also induce an unpleasant reaction. Products that may contain alcohol include:

- aftershave
- mouthwash
- some types of vinegar
- perfume

When taking disulfiram a patient will be seen by their healthcare team about once every two weeks for the first two months, and then every month for the following four months

- Naltrexone, like acamprosate, can also be used to prevent a relapse or to limit the amount of alcohol someone drinks. It works by blocking the opioid receptors in the body, stopping the effects of alcohol. It's usually used in combination with other medicine or counselling. If naltrexone is recommended, it will also stop painkillers that contain opioids, such as morphine and codeine, from working. A course of naltrexone can last up to six months although it may sometimes be longer. Before being prescribed any type of medication to help treat alcohol misuse patients are required to have a full medical assessment which will include blood tests.

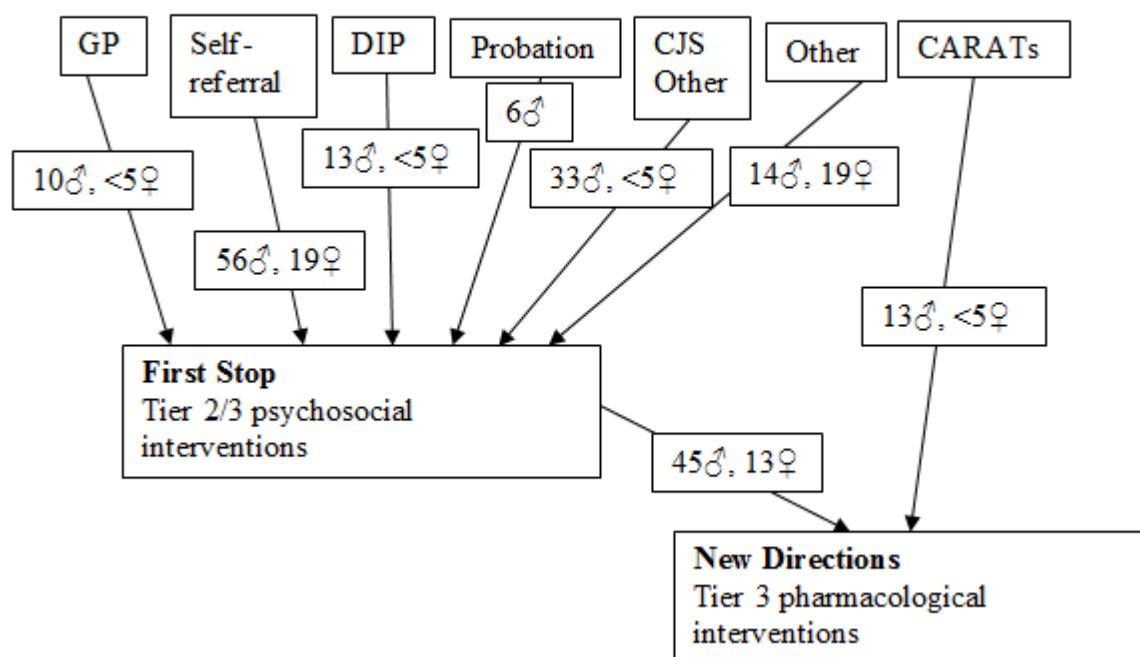
7.3 Adult Drug Services

Adult drug services are provided by 2 main providers. The referral sources into treatment are given in Fig. 7.14.

- First Stop, provided by CRI, Ballard Chambers , 26 High Street, Romford, RM1 1RH Phone: 01708 747614; Freephone: 0800 652 5898. Services include:
 - Assessment and care planning
 - One to one support and motivational interviewing
 - Advice, information and needle exchange
 - Referral onto statutory and voluntary agencies
 - Assertive outreach
 - Open access drop-in
 - Structured Day Programme
- New Directions, provided by North East London Foundation Trust (NELFT). Access to this service is by referral though First Stop only. Services include:
 - Substitute Prescribing
 - Community detoxification programmes
 - Onward referral for inpatient detoxification and residential rehabilitation
 - Counselling Health checks
 - HIV testing
 - Hepatitis B and C Testing
 - Hepatitis B immunisations.

Figure 7.14 Drug Treatment Referral Sources for New Patients (2011-12)

Drugs Referral sources for new journeys (2011-12 system pathways)



7.3.1 Engagement in Drug Treatment Services

When engaged in treatment, people use less illegal drugs, commit less crime, improve their health, and manage their lives better – which also benefits the community. Preventing early drop out and keeping people in treatment long enough to benefit contributes to these improved outcomes. As people progress through treatment, the benefits to them, their families and their community start to accrue. In total, there were 540 opiate and non-opiate drug users engaged in treatment in Havering in 2011-12¹⁹¹ (Fig. 7.15).

Figure 7.15 Number and Proportion of Adults Engaged in Drug Treatment 2012-13

	Havering			National		
	Number	Growth from 2011-12	Proportion of Treatment Population	Number	Growth from 2011-12	Proportion of Treatment Population
Opiate	268	↓ 1%	94%	148,368	↓ 3%	96%
Non-Opiate	272	↑ 29%	85%	33,739	↑ 3%	88%
All	540	↑ 12%	89%	182,107	↓ 2%	94%

¹⁹¹ Public Health England (2013) *Key data to support planning for effective drugs prevention, treatment and recovery: the data for Havering*. London, Public Health England.

75% of Havering's drug treatment clients were men

The gender of clients in the drug treatment system in Havering in 2012-13 features slightly higher proportion of males (75%)¹⁹² than the national average (73%)¹⁹³, although this local proportion has reduced from 77% in 2011-12.

Although it appears to be predominantly men requiring drug treatment services, it is important to continue to check the appropriate availability and accessibility of our drug services for women. In other words, are women not coming forward for treatment because the services are not designed / appropriate for them, or is it truly that men are more likely to take drugs and require treatment than women? It is therefore recommended that commissioners undertake equality impact assessment of service provision to ensure they are meeting local needs.

In 2012-13, the number of clients from ethnic minorities entering drug treatment in Havering was under-represented. There was a higher proportion of White British clients in drug treatment in Havering (88%) than the percentage of White British people residing in Havering (83.3%). Nationally 83% of drug treatment clients were White British (Fig. 7.16). More work therefore needs to take place to ensure that we are offering accessible and culturally sensitive and appropriate treatment for Black and Minority Ethnic (BME) populations in Havering.

88% of Havering's drug treatment clients were White British

Figure 7.16 Ethnicity Proportions for Havering, London and England

Ethnicity	Havering	London	England
White British	88%	69%	86%
Mixed	1%	3%	2%
Asian or Asian British	5%	14%	7%
Black or Black British	4%	10%	3%
Other	1%	4%	2%

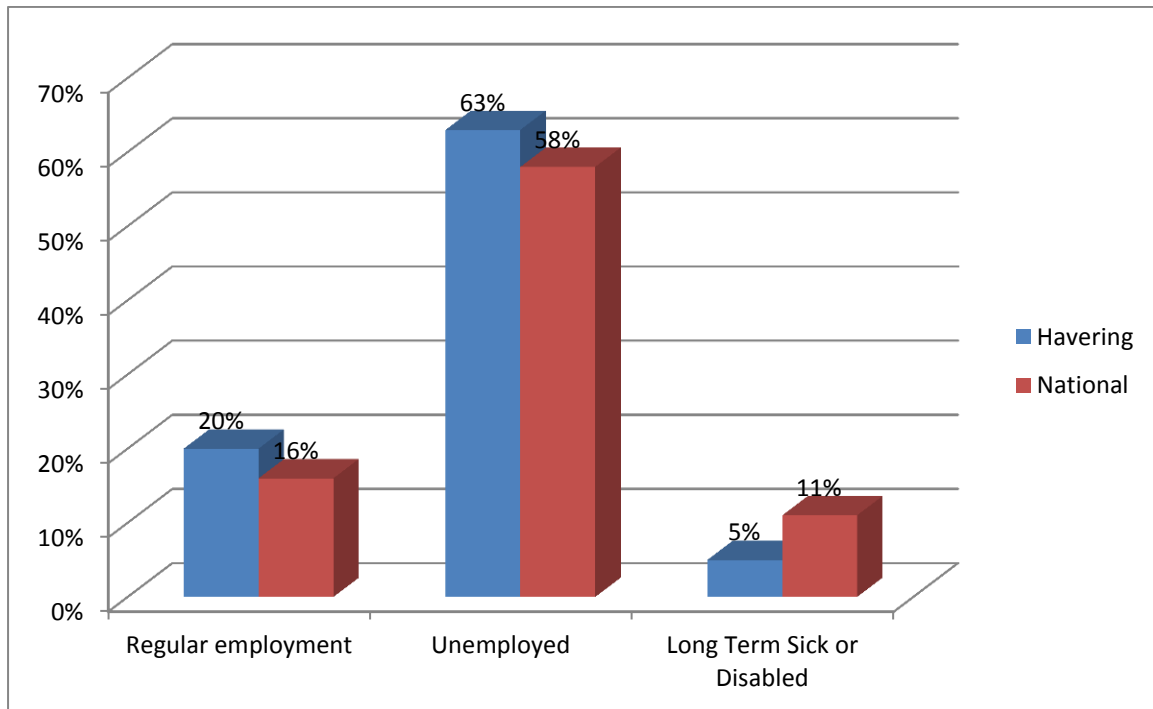
More people in drug treatment were unemployed at the start of treatment in Havering (63%) than the national figure (58%) in 2012-13 (Fig. 7.17)¹⁹⁴.

¹⁹² PHE (2013) Partnership Adult Drug Performance Report 2012-13, Quarter 4 Havering (H02B)

¹⁹³ PHE (2013) National Adult Drug Performance Report 2012-13, Quarter 4

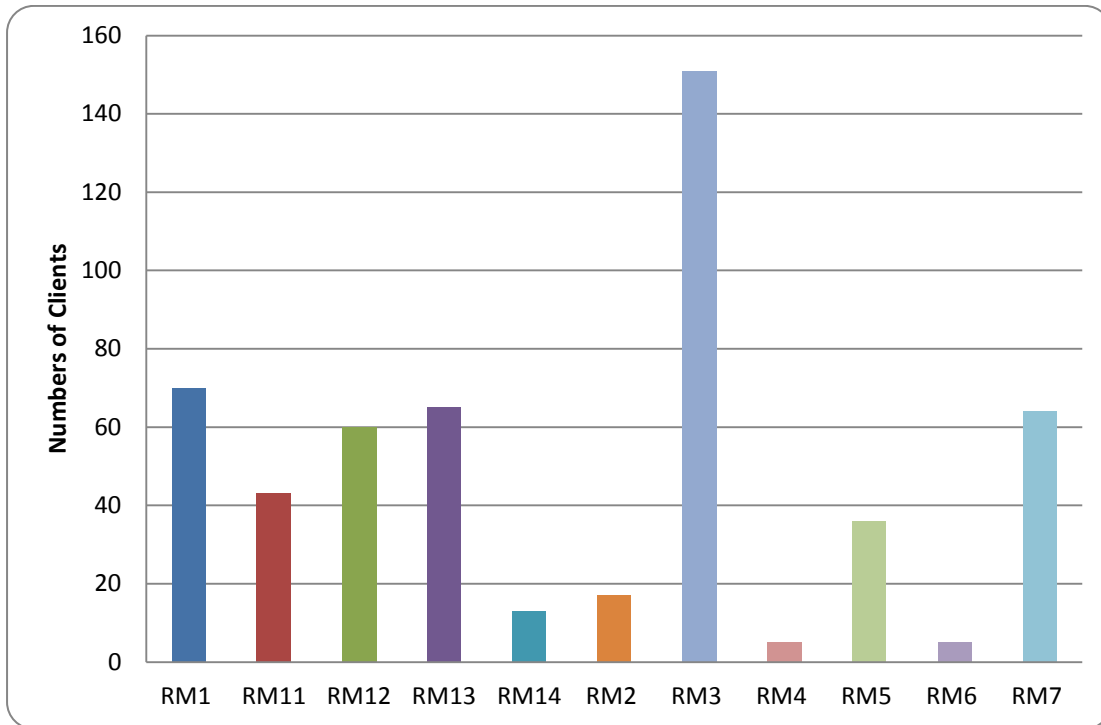
¹⁹⁴ Public Health England (2013) *Key data to support planning for effective drugs prevention, treatment and recovery: the data for Havering*. London, PHE.

Figure 7.17 Proportion of Drug Treatment Clients Employed, Unemployed or Long Term Sick or Disabled (2012-13)



Drug use is also highly correlated with deprivation – Postcode RM3 (Harold Hill/Gooshays) is the most prevalent area of residence for people entering drug treatment in Havering (Fig. 7.18). Data referencing the postcodes RM4 and RM6 are suppressed due to very low numbers. Looking beyond RM3, in terms of drug treatment, figure xi suggests treatment attenders are next highest in Romford Town (RM1), RM13 (Rainham), RM12 (South Hornchurch/Elm Park), and RM7 (Brooklands ward, west of Romford). It is not surprising these high referral areas correspond to the recognised pockets of deprivation around the borough. Where postcodes outside the Havering boundary or where values were lower than 5, these were not included in the chart.

Figure 7.18 Postcodes of Adult Clients referred to Drug Treatment Services in Havering (2010-13)



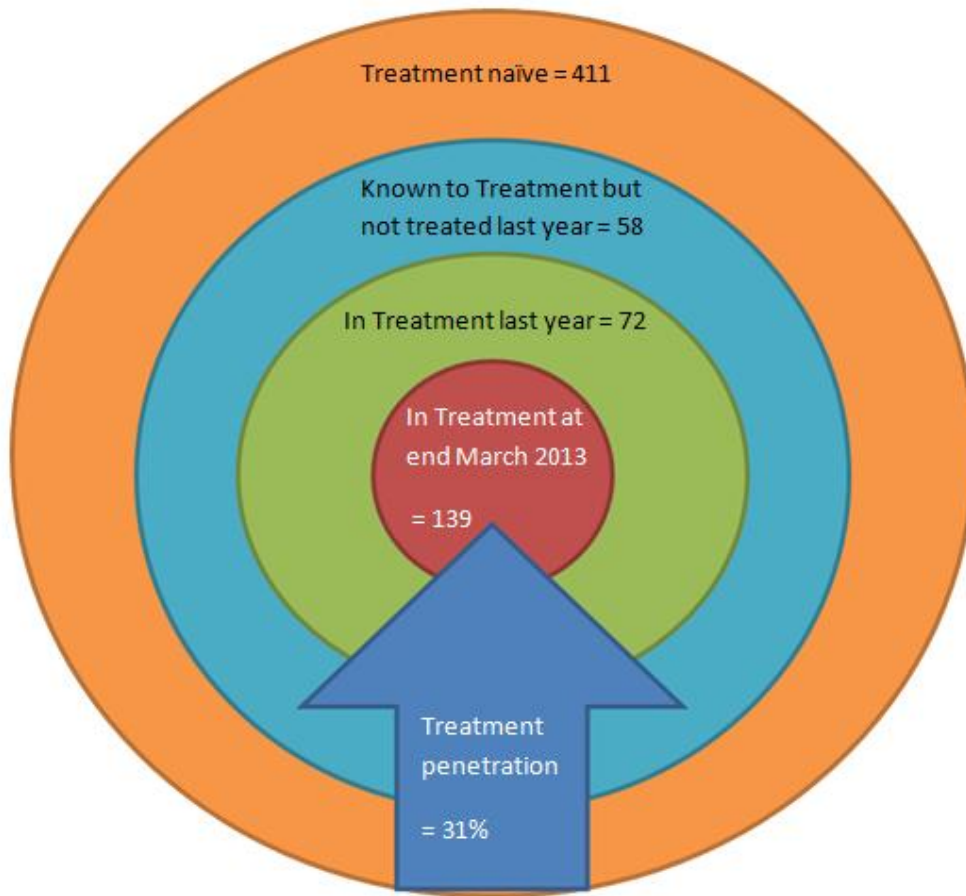
Given the nature and complexity of drug use, the following section examines the engagement in treatment by specific drug users: Crack and Cocaine, Heroin, Cannabis and Prescription Only Medication/Over the Counter (POM/OTC).

7.3.1.1 Crack and Cocaine

Where crack use is indicated it is almost always a secondary drug to heroin. The latest National Drug Evidence Centre (NDEC) prevalence estimates using the capture-recapture methodology suggests the number of crack users in Havering is 680 (95% Confidence Interval = 539 to 910). Per head of population, this represents a higher rate than neighbouring boroughs with a similar profile. NDTMS data shows that 211 (139+72) crack users presented to treatment in 2012-13, giving an annual treatment penetration of 31% - this is the same penetration as 2011-12 (Fig. 7.19). Additionally, there were 46 crack user individuals in contact with DIP (either prison or community) who were not in the treatment system.

It is recognised that crack is more prevalent in London boroughs than non-metropolitan areas; furthermore that areas with high levels of cocaine use are likely to have considerable crack prevalence. It is relatively easy to manufacture crack from powder cocaine. Unlike opiate misuse whereby treatment services can offer a pharmacological substitute, there is no such incentive for crack and cocaine. This presents a particular challenge in terms of improving treatment penetration. Criminal justice pathways represent a strong option to improve this, particularly following the roll-out of Testing on Arrest (ToA) from January 2013.

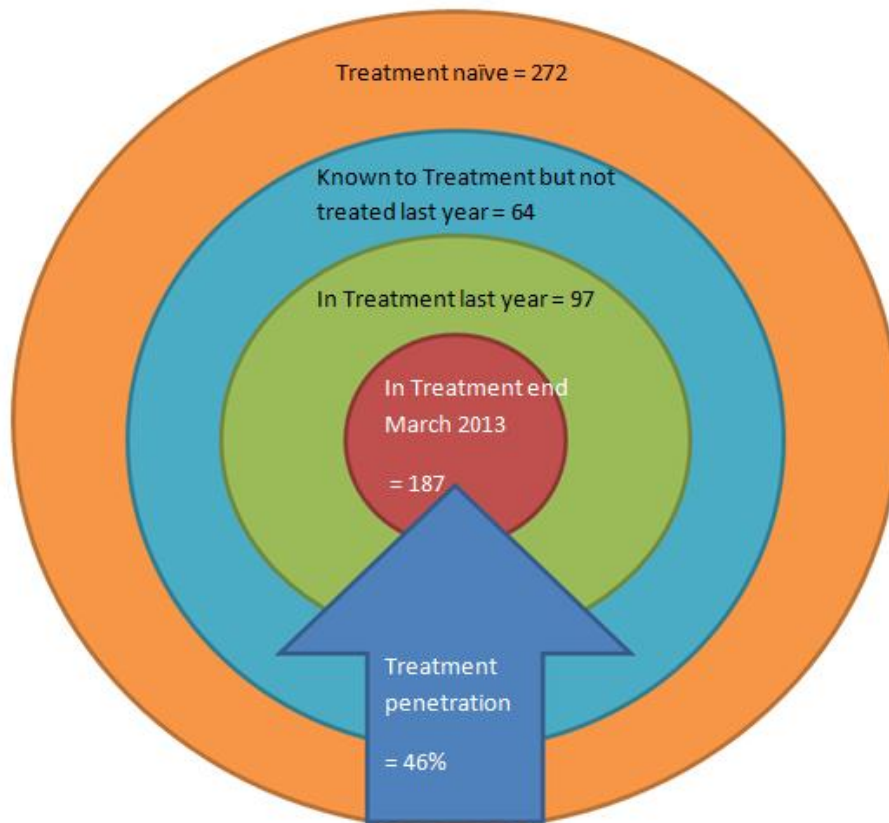
Figure 7.19 Treatment Bull's Eye Showing Proportions of Crack Users Engaging in Treatment During 2012-13



7.3.1.2 Heroin

The latest National Drug Evidence Centre prevalence estimates using the capture-recapture methodology suggests the number of opiate users in Havering is 620 (95% CI = 517 to 770). The number of opiate users presenting to treatment in 2012-13 was 284, giving an annual treatment penetration of 46% (Fig. 7.20). In addition there were 44 opiate users who were in touch with DIP services (either in prison or community) and not in engaged with the treatment system.

Figure 7.20 Treatment Bull's Eye Showing Proportions of Opiate (Heroin) Users Engaging in Treatment During 2012-13



7.3.1.3 Cannabis

In 2012-13 there were 96 primary cannabis users engaged in treatment in Havering. This was an increase from 2011-12 (83) but is still significantly lower than 2010-11 (143). Many drug users in treatment for other drugs of concern also use cannabis. Beyond opiates and crack/cocaine and alcohol, cannabis remains the drug most prevalent in those adults seeking services. Contemporary cannabis is a powerful drug with a spectrum of effects, and can exacerbate mental health conditions, negatively affect both motivation and relationships.

7.3.1.4 Prescription Only Medicine (POM)/Over-the-Counter (OTC)

Of the 540 clients in drug treatment in Havering in 2012-13, 9% (54 individuals) cited problematic use of prescription only medicines (POM) or over-the-counter medicines (OTC), much lower than the national average (17%). Less than 1% (3 individuals) reported using POM/OTC with no additional illicit drug use, considerably lower than the national average (2%)¹⁷. This latter statistic is interesting as Havering has the fourth lowest rate of any local authority area in England, ahead of Slough, Thurrock and Reading. Whilst it is conceivable that problematic use of POM/OTC drugs is very rare in Havering, it is more likely that we should urgently increase our understanding of local needs pertaining to these drug types, and developing services and pathways to meet those needs. Of those clients citing use of POM/OTC drugs, all were prescription benzodiazepines and opioids.

Data on prescription rates, volumes and GP surgery locations of benzodiazepines and opiates is in the process of being collated and this will inform a separate project to scope needs and develop a

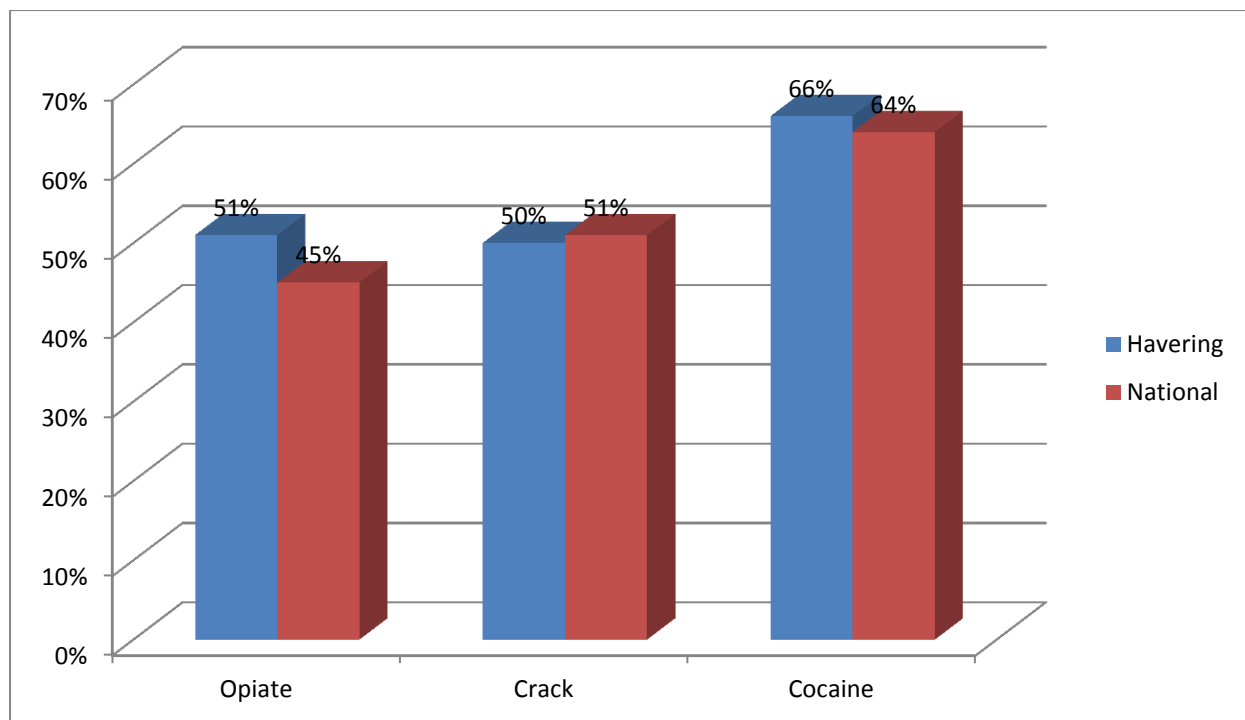
service response to dovetail with the integrated treatment system re-commissioning process planned for 2013/14.

7.3.2 Adult Drug Treatment Outcomes

Drug users need prompt help if they are to recover from dependence. In Havering, 99% of adults waited less than 3 weeks to start treatment. Local efforts to keep waiting times low mean that the national average waiting time is less than one week. Keeping waiting times low will play a vital role in supporting recovery in local communities.

Havering crack users levels of abstinence in treatment (50%) are broadly in line with the national average (51%), as evidenced by the Treatment Outcome Profile (TOP) data¹⁹⁵. In addition, there seems to be a gradual trend decline in the rate of crack abstinence in treatment over the past 3 years, however a converse trend improvement in significant reductions in use. Havering is performing better (51%) than the national average for abstinence in Opiate use (45%) (Fig. 7.21). Abstinence in treatment levels for cocaine are slightly higher in Havering (66%) than the national figure (64%). Twelve per cent of cocaine clients in Havering also demonstrated significant reductions in use, compared with 11% nationally, in 2012-13. These local figures have been relatively stable over the past 3 years.

Figure 7.21 Proportions of Drug Users Leaving Treatment Abstinent in Havering 2012-13



Havering is also performing better than the national average on the proportion of drug treatment clients who are no longer injecting at review following treatment, and re-engaging with work – 39% of Havering’s clients worked 10 or more days in the month before successfully completing treatment compared with 25% nationally (Fig. 7.22).

¹⁹⁵ Public Health England (2013). *Alcohol and Drugs: JSNA Support Pack. Key data to support planning for effective drugs prevention, treatment and recovery. The data for Havering.* London: Public Health England.

Figure 7.22 Treatment Outcomes Profile Results for Havering

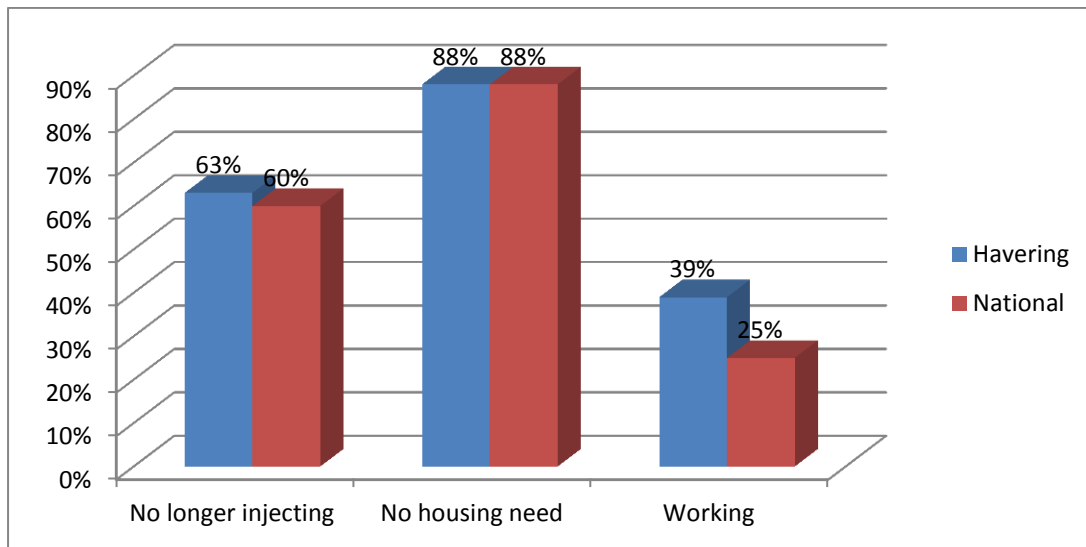
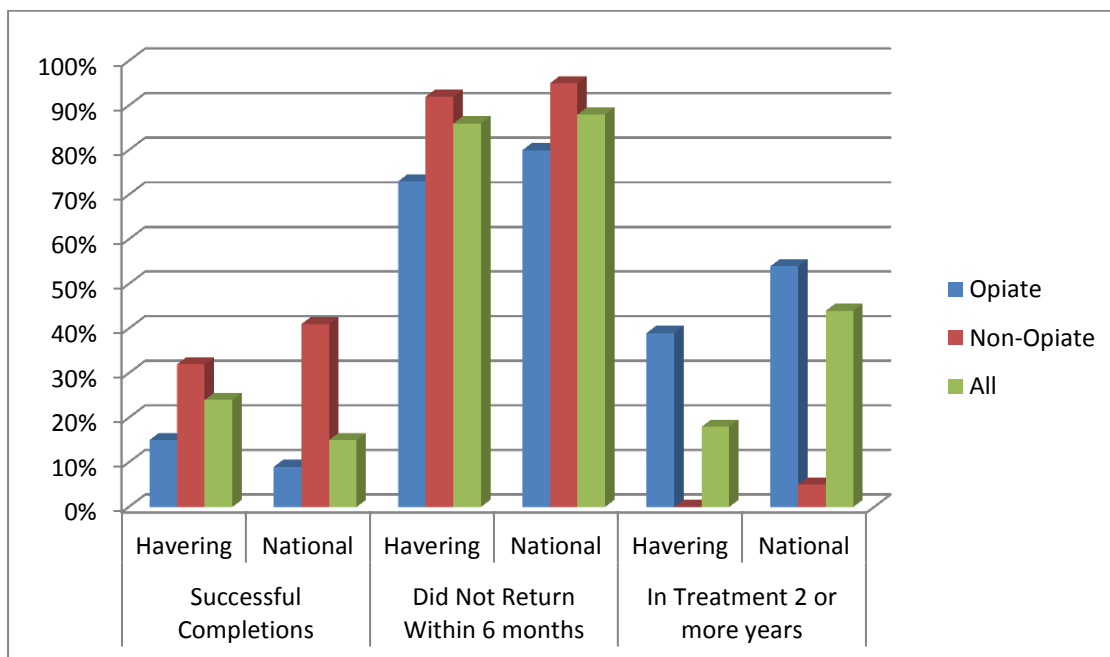


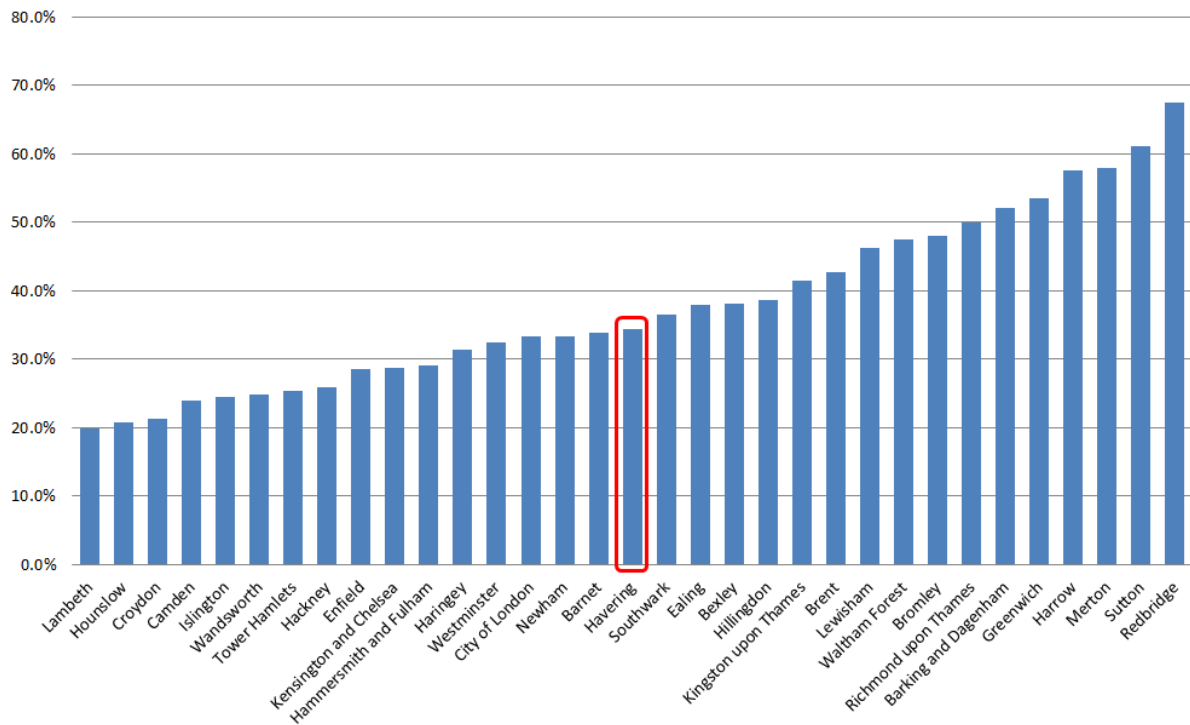
Figure 7.23 below shows the proportion of drug users who complete their treatment free of dependence, and those successfully completing who do not relapse and re-enter treatment. The drug strategy asks local areas to increase the number of people successfully leaving treatment having overcome dependence. Although many individuals will require a number of separate treatment episodes spread over many years, most individuals who complete successfully do so within two years of treatment entry. Also below is the proportion of adults who have been in treatment for more than two years – the data tells us that the likelihood of clients completing treatment and not re-presenting decreases the longer they remain in treatment over 2 years. Havering has fewer clients both Opiate and Non-opiate who spend more than 2 years in treatment than the national figure.

Figure 7.23 Successful Completions for Drug Treatment in Havering compared with National



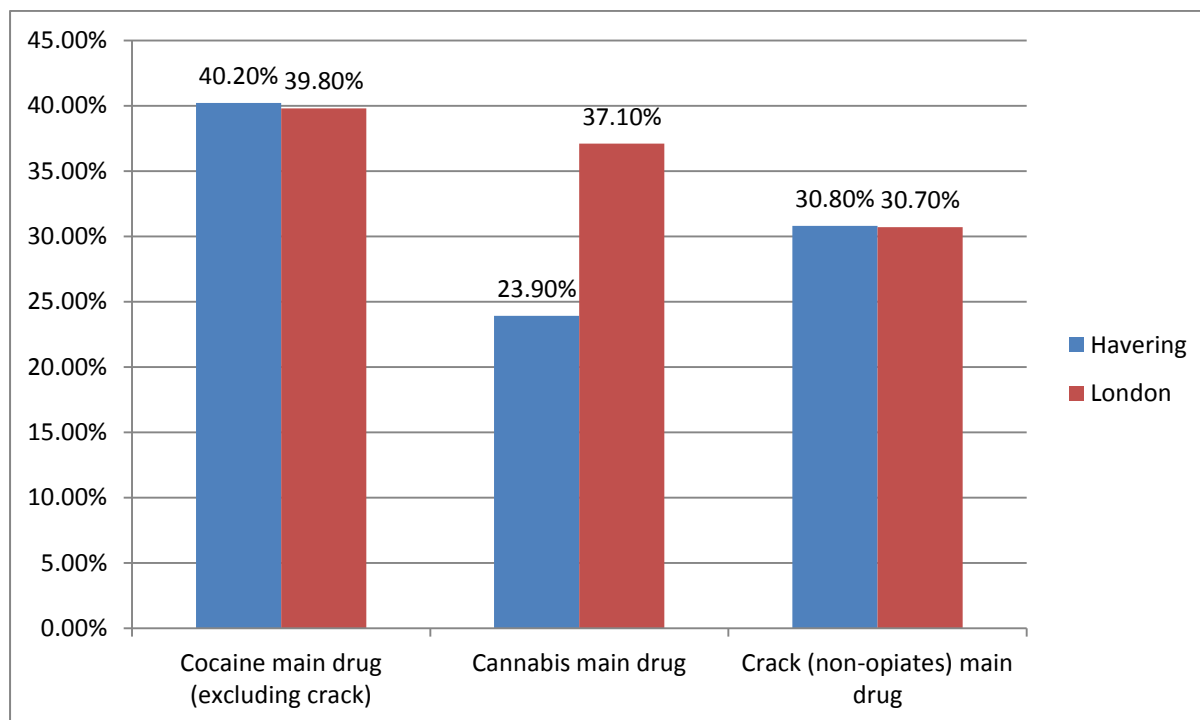
Compared with London, Havering is roughly in the middle of all London boroughs for successful completions of all non-Opiate and non-Crack clients (Fig. 7.24), i.e. we are not the worst performing, but we could do a lot to improve. Whether this is due to the quality of services provided or an artefact of the type of Cannabis user in Havering is unknown, and requires further exploration.

Figure 7.24 Successful Completions of all Non-Opiate and Non-Crack Clients in London



The percentage of successful completions by Havering patients is comparable to that of London for both Cocaine (excluding Crack) and Crack separately, but the successful completion rate for Cannabis is much lower (23.9%) than the London rate (37.1%) (Fig. 7.25).

Figure 7.25 Rate of Successful Completions for Cocaine, Cannabis or Crack in Havering 2012-13 Compared with London



In addition, it is a key feature of drug treatment services to offer relevant services (or enhanced referrals to external services) for blood-borne virus interventions: particularly vaccinations for Hepatitis B virus (HBV), and testing for Hepatitis C virus (HCV) and HIV. For much of 2012-13 the council has been running an effective ‘contingency management’ scheme to promote uptake of HCV testing for injecting drug users, and our testing for appropriate clients at the end of 2012-13 was 76%, which is slightly higher than the national average (73%). Contingency management (CM) is an evidence-based treatment intervention recommended by the National Institute for Health and Clinical Excellence (NICE). It is based on principles of behaviour modification and aims to incentivise and then reinforce changes in behaviour with the aid of vouchers, privileges, prizes or modest financial incentives that are of value to the client¹⁹⁶.

The contingency management scheme has also applied to HBV vaccinations, but the national evidence does not appear so favourable, especially when put in context of those who have been offered and refused vaccinations (nationally 30%, in Havering 38%), and those where no status has been recorded (nationally 3%, in Havering 20%). The data gap suggests that we in fact do not know how well we are performing, and we must address this recording practice as a priority to improve our intelligence on HBV activity.

¹⁹⁶ Public Health England (2014). *Contingency Management Scheme*. Available on: <http://www.nta.nhs.uk/CM%20Page.aspx>

7.4 Supporting the Recovery Agenda

The Government's Drug Strategy¹⁹⁷ makes a clear recommendation to support the recovery of drug users from their dependence. It states that, "Recovery involves three overarching principles—wellbeing, citizenship, and freedom from dependence. It is an individual, person-centred journey, as opposed to an end state, and one that will mean different things to different people. We must therefore, put the individual at the heart of any recovery system and commission a range of services at the local level to provide tailored packages of care and support. This means that local services must take account of the diverse needs of their community when commissioning services."

Following treatment completion, there are clear benefits for continuing to have engagement with peers and services, either through the commissioned aftercare provision or with mutual aid services. These can assist with relapse prevention and guide through reintegration, social networking and offer advice and support around a wide variety of relevant issues.

One provider offers aftercare, although by the provider's own admission uptake is relatively poor. It is reported that those leaving treatment are not motivated to return to those services/premises to receive aftercare as it is challenging to maintain a link to the memories that may be difficult, and may be concerns about exposure to other clients who may still be drinking, using or dealing. Feedback at Treatment Planning Group and provider performance meetings suggests a general feeling among the partnership that recovery resources are quite limited in Havering, and when clients are discharged from treatment there is a sense that they are left to their own devices. A challenge for commissioners is to find ways of building an effective recovery infrastructure which is separate but from but appropriately linked to the treatment system.

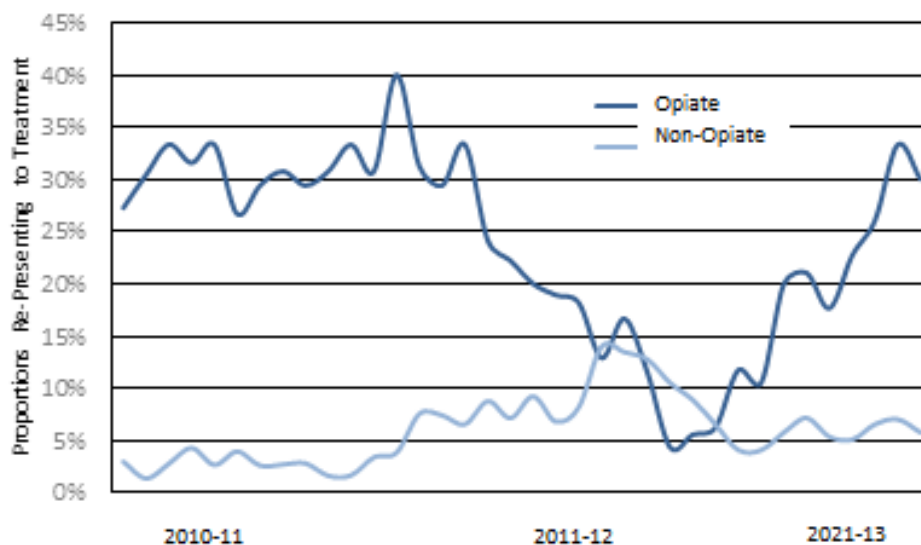
Re-representations are an important measure of the strength of recovery resources in an area. In 2012-13, 6 opiate clients returned to treatment in the second six-month period out of 20 successful completions in the first six-month period¹⁹⁸; furthermore 3 non-opiate clients returned to treatment in the second six-month period out of 52 successful completions in the first six-month period¹⁹⁹. The trend for re-presentation rates can be seen in figure 7.26.

¹⁹⁷ HM Government (2010). *Drug Strategy 2010: Reducing Demand, restricting supply, building recovery: Supporting people to live a drug free life*. London: HM Government. Available on: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118336/drug-strategy-2010.pdf

¹⁹⁸ Diagnostic Outcomes Monitoring Executive Summary Havering Quarter 4 2012-13

¹⁹⁹ Diagnostic Outcomes Monitoring Executive Summary Havering Quarter 4 2012-13

Figure 7.26. Trend in Re-presentation Rates (proportion of a 12 month rolling cohort successfully completing) from 2010-11 to 2012-13



Non-opiate performance has been reasonably stable throughout the 3 year period reported. Opiate performance in re-presentations improved (rate reduced) through 2010-11 and 2011-12 to lower rates than non-opiates but then rose again throughout 2012-13. Questions are now being specifically raised with providers regarding the clients re-presenting to see what can be learned and appropriately adjusted in practice. NTA London regional team has produced additional resources²⁰⁰ we are analysing as a wider Havering treatment partnership (including providers), to identify practical changes we can implement that will embed recovery and reduce re-presentations.

One of the current key challenges for substance misuse strategic leads is to commission services and resources that encourage and nurture recovery, in line with the ambition of the Government’s Drug Strategy (2010)²⁰¹. It highlights that one of the best predictors of recovery being sustained is through an individual’s ‘recovery capital’ – the resources necessary to start and retain recovery from drug and alcohol addiction²⁰². This includes ‘Social Capital’ – the resource a person has from their relationships (family, partners, children, friends and peers) and includes both support received and commitment and obligations resulting from relationships.

Throughout 2012-13, advice from the service users providing comments and feedback to commissioners has demonstrated there has been a clear user-led demand for a recovery café resource. This model offers an opportunity for networking and support for and by service users, volunteering and paid employment opportunities, learning new skills, providing a non-judgmental environment, affordable meals and beverages, whilst signposting clients onto relevant services, occasional special evening events, offer a safe/sober space where people can meet and socialise

²⁰⁰ Improving Recovery Orientation of Drug Treatment FINAL (NTA London, 2013)

²⁰¹ HM Government (2010). *Drug Strategy 2010: Reducing Demand, restricting supply, building recovery: Supporting people to live a drug free life*. London: HM Government. Available on: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118336/drug-strategy-2010.pdf

²⁰² HM Government (2010). *Drug Strategy 2010: Reducing Demand, restricting supply, building recovery: Supporting people to live a drug free life*. London: HM Government. Available on: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118336/drug-strategy-2010.pdf

with others in recovery. Beyond mutual aid, this development may represent an opportunity to focus the recovery support structures and processes in Havering around something that is independent of the treatment system yet commissioned by the partnership. Whilst undoubtedly a “bottom up” service development, this model has been effectively implemented in other DAAT areas (e.g. neighbouring Barking & Dagenham). Given the user-led demand for such a service, to build social capital and aid in recovery, commissioners should consider whether such a resource would be feasible in Havering.

Commissioners are also recommended to consider actively developing the mutual aid networks operating within Havering. Although as discussed previously, Alcoholics Anonymous is well-established in the borough, delivering some 15 regular groups, attended by 10-15 people per group, it is possible that the high demand for such voluntary organisations may reflect a lack of capacity within the current commissioned alcohol treatment service. Voluntary organisation such as Alcoholics Anonymous are highly respected, and receive ‘referrals’ from a wide variety of sources including commissioned providers. Other similar resources such as Narcotics Anonymous (NA) and Cocaine Anonymous (CA) also exist and we would be keen to foster their development and proliferation. However, not all programmes meet everyone’s personal preferences - the “Fellowship” and the 12 step philosophy, for example, is not universally appreciated, and we are looking at opportunities to develop a range of services which will meet individual’s diverse preferences, for example developing Self Management Addiction Recovery Training (SMART) Recovery in the borough.

SMART Recovery²⁰³ is a self-empowering addiction recovery support group where participants learn tools for addiction recovery based on the latest scientific research and participate in a world-wide community which includes free, self-empowering, science-based mutual help groups. The SMART Recovery 4-Point Program helps people recover from all types of addiction and addictive behaviours, including: drug abuse, drug addiction, substance abuse, alcohol abuse, gambling addiction, cocaine addiction, prescription drug abuse, and problem addiction to other substances and activities. SMART Recovery sponsors face-to-face meetings around the world, and daily online meetings.

In addition, being an effective family member and better delivering parenting roles is seen as an important channel in building ‘recovery capital’. NICE guidelines for psychosocial interventions for substance misuse²⁰⁴ clearly identify the benefits for all concerned of involving families and carers in the client treatment journey. The NICE guideline also discusses the benefit of behavioural couples therapy, which is shown to be often effective where there is one partner misusing substances and another who is not. For some individuals this means returning to rebuild relationships with family members to levels prior to addiction to drugs and/or alcohol, for others this means learning entirely new skill sets to be a productive positive parent.

There are significant and complex issues around relationships and responsibilities pertaining to children and adults connected with substance misusers²⁰⁵. Building strong links with local social care

²⁰³ www.smartrecovery.org

²⁰⁴ NICE (2007) Drug misuse: psychosocial interventions (clinical guideline). CG51

²⁰⁵ Templeton, L. & Copello, A. (2012) Adult Family Members Affected by a Relative’s Substance Misuse: A review of policy and guidance documents across the UK. UKDPC: London: ISBN 978-1-906246-36-5. Available on:

services, and to the Troubled Families project (which has locally identified parental drug and alcohol use as a flag), will be a key component in supporting families in their recovery from drug or alcohol addiction.

7.5 Specialist Drug and Alcohol Services for Children and Young People

Specialist services for Children and Young People in Havering are provided by Young Addaction. Based at Romford Youth Zone, 10, Hedley Court, Romford, it is open Monday to Friday 9am to 5pm, but is flexible in meeting young people anywhere in Havering and also offers evening and weekend appointments. Services provided encompass specialist advice as well as comprehensive awareness and education programmes working with schools:

- Support to schools in delivering drug education
- Outreach drug education to young people out-of-school and in community settings
- Prevention and early intervention work with young people excluded from or at risk of exclusion from school.
- Comprehensive assessment of substance misuse
- Advice and information to young people
- Support to young people whose parents have substance misuse problems.

There were 63 young people aged under 18 years in Specialist Services in Havering in 2012-13

Young people come to specialist services from various routes but are typically referred by youth justice; education; self, family & friends and children & family services (Fig. 7.27). By comparing the percentages of referrals from different statutory and voluntary sector agencies with the national percentages, it is possible to effectively monitor whether partner agencies are picking up children and young people with drug and alcohol issues and appropriately referring them on for treatment.

Figure 7.27 shows that self-referrals including referrals from family and friends are much higher in Havering (30%) than in England (11%). It appears, therefore, that access to substance misuse services in Havering is much more reliant on young people putting themselves forward for treatment, than relevant agencies making those referrals on their behalf. Commissioners should therefore consider what training is required by potential referral agencies, including education, youth justice teams, children and family services, workers with Troubled Families, and health and Child and Adolescent Mental Health Services (CAMHS), to ensure drug and alcohol issues are identified.

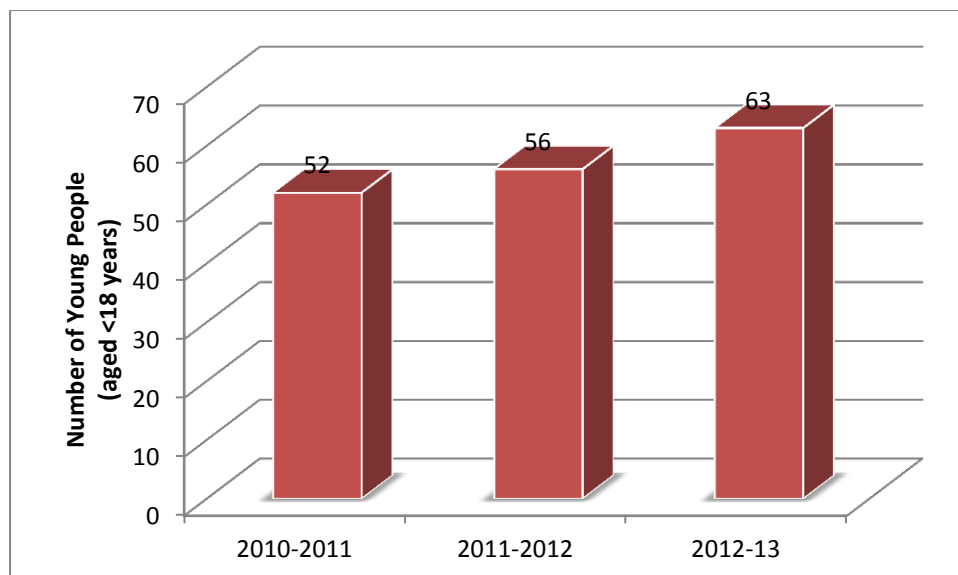
Whilst changes in universal and targeted young people services may affect screening, referrals and demand for specialist interventions, there should nevertheless be clear pathways between targeted and specialist services, supported by joint working protocols and good communication.

Figure 7.27 Referral Sources for Children and Young People into Specialist Treatment services in Havering 2012-13

	Havering		England
	Number	%	%
Youth Justice	19	29%	34%
Education	17	26%	24%
Self, family friends	20	30%	11%
Children and Family Services	5	8%	10%
Other Substance Misuse Services	<5	<5%	9%
Health and Mental Health Services	<5	<5%	7%
A&E	0	0%	1%
Other	0	0%	3%

In 2012-13, there were 63 young people aged under 18 years in specialist services in Havering (Fig. 7.28). Young people represented 9% of all adults and young people in specialist substance misuse services, the same as the national average of 9% and a reduction in proportion from 2011-12 (10%)²⁰⁶.

Figure 7.28 Trend in Number of Young People (aged under 18 years) Engaged in Specialist Treatment Services 2010-2013



Specialist services must deliver age-appropriate interventions and promote the safeguarding and welfare of children and young people. The needs of 18-24s are different to those of under-18s and

²⁰⁶ Public Health England (2013) *Key data to support planning for effective young people's specialist substance misuse interventions: the data for Havering*. London, Public Health England.

clear transitions and joint care plans with adult services will help under-18s who require on-going support beyond their 18th birthday. In Havering, there were less than 5 young people aged between 18-24 years who were supported within the Young People’s service (for Class A drug use (Heroin or Crack), Cannabis only or Alcohol only) which is designed for under 18s.

In terms of treatment outcomes, young people (aged under 18 years) generally spend less time in specialist interventions than adults because their substance misuse is not entrenched. In Havering, young people tend to spend longer in specialist services than the national average – the largest proportion (38%) spent 13-26 weeks in treatment compared with 31% nationally (Fig. 7.29). However, those with complex care needs often require support for longer.

Young people have better outcomes when they receive a range of interventions as part of their personalised package of care. If a pharmacological intervention is required, it should always be delivered alongside appropriate psychosocial support. Psychosocial interventions are a range of talking therapies designed to encourage behaviour change that focus on the psychological issues of an individual in the context of the social environment in which they are living. In Havering, 95% of young people entering specialist young people’s services received psychosocial interventions only – this is broadly in line with the national average of 97% receiving psychosocial interventions only.

Figure 7.29 Length of Time in Specialist Young People’s Substance Misuse Services in Havering and England 2012-13

	Havering		England
	Number	%	%
0 – 12 weeks	19	30%	42%
13-26 weeks	24	38%	31%
27-52 weeks	14	22%	18%
Longer than 52 weeks	<5	5%	8%

The risk-harm profile identifies 10 key items to gauge the vulnerability of young people entering specialist substance misuse services. These are:

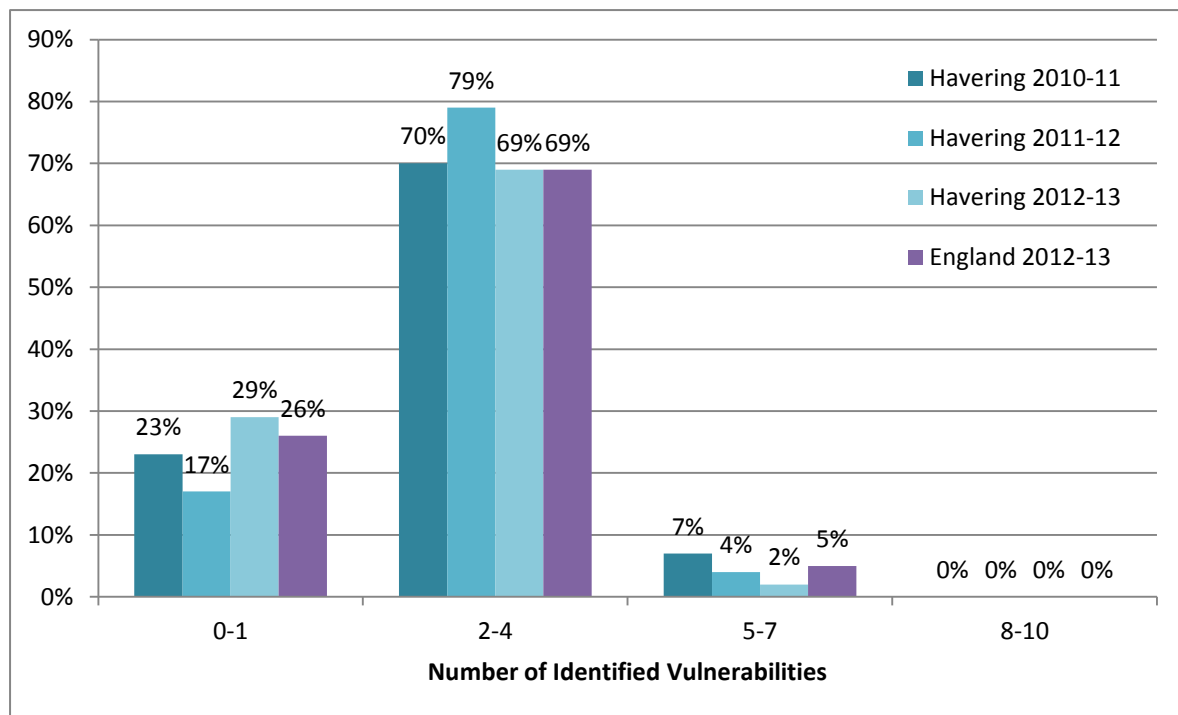
- Opiate and/or crack user
- Alcohol users ²⁰⁷
- Using 2 or more substances (including alcohol)
- Began using main problem substance (including alcohol) under 15
- NFA / unsettled housing
- Not in education, employment or training
- Involved in self harm
- Involved in offending

²⁰⁷ Note- There are no safe drinking levels for under 15s and young people aged 16-17 should drink infrequently on no more than one day a week (CMO, 2009). This measure captures young people drinking on an almost daily basis (27-28 days of the month) and those drinking above 8 units per day (males) or 6 units per day (females), on 13 or more days a month.)

- Pregnant and/or parent
- Looked after child

The higher the score, the more complex the need. Age of initiation is often the strongest predictor of the length and severity of substance misuse problems, the younger the age they start to use, the greater the likelihood of them becoming adult problematic drug users. Figure 7.30 gives the age of young people in specialist services but not the age when the young people first started using drugs or alcohol.

Figure 7.30 Number of Risks/Vulnerabilities Identified by Each Person in Havering Compared with England 2010-2013



Many young people receiving specialist interventions have a range of vulnerabilities. They are more likely to be not in education, employment or training (NEET), have contracted a sexually transmitted infection (STI), have a child, be in contact with the youth justice system, be receiving benefits by the time they are 18, and half as likely to be in full-time employment (Fig. 7.31). Universal and targeted services have a role to play in providing substance misuse support at the earliest opportunity, specialist services should be provided to those whose use has escalated and is causing them harm. There should be effective pathways between specialist services and children’s social care for those young people who are vulnerable and age-appropriate care should be available for all young people in specialist services.

Figure 7.31 Number of Young People (aged under 18 years) with Each Vulnerability Item in Havering and England 2012-13

	Havering		England
	Number	%	%
Opiate and/or Crack User	<5	<5%	2%
Alcohol Users	<5	7%	6%
Using 2 or more substances	27	64%	55%
Began using main problem substance under 15 years	35	83%	81%
No Fixed Accommodation / unsettled housing	<5	5%	3%
Not in education, employment or training (NEET)	0	0%	19%
Involved in self harm	<5	7%	12%
Involved in Offending	12	29%	43%
Pregnant and/or parenting	<5	<5%	3%
Looked After Child	5	12%	12%

The age range of young people in specialist services is given in Figure 7.32 and the primary drug misused in Fig.7. 33– Havering had more 16-17 years olds than the national figure.

Figure 7.32 Ages of Young People in Havering and England 2012-13

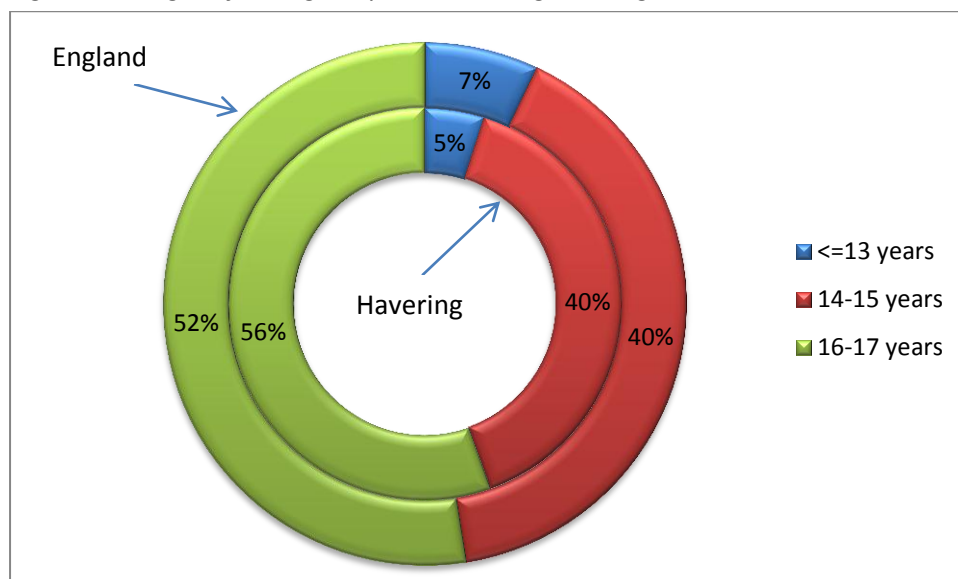
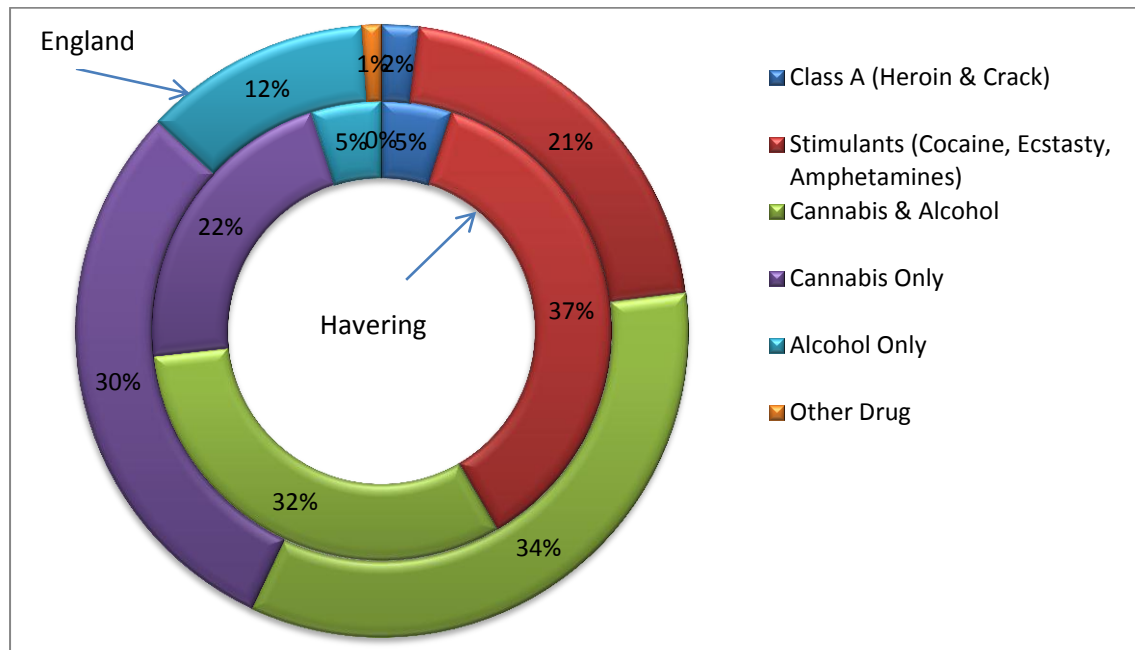


Figure 7.33 Primary Drug Misused in Young People’s Specialist Services in Havering and England 2012-13



A significantly higher percentage of young people engaged with specialist substance misuse services used stimulants – cocaine, ecstasy or amphetamines in Havering (37%) than the national figure (21%), which perhaps reflects the high usage of powder cocaine by older users in the borough.

7.6 The Social Response

Stopping, or using the Government’s Drug Strategy’s terminology ‘restricting’, the supply of drugs, particularly cocaine, will be essential in reducing the levels of drug misuse in Havering – the following section outlines how Havering is working in collaboration with departments and agencies across the council and other statutory and voluntary sector agencies across the borough. Both drug and alcohol misuse is a cross-cutting issue and requires co-ordination between relevant agencies.

7.6.1 Regulation of the Night Time Economy & Licensing

A number of initiatives have been taken to mitigate the harm, largely defined in crime and disorder terms, associated with alcohol misuse and/or the night time economy. Havering has a strong Community Safety Partnership (HCSP) comprising representatives from the local police, relevant health bodies (e.g. Havering CCG), voluntary sector and community groups. The aim of the HCSP is to raise awareness of crime reduction projects and initiatives, and increase the safety of residents and visitors to the borough. Fig. 7.34 outlines the range of initiatives currently being employed in Havering to minimise the impact of drug and alcohol misuse in the night-time economy.

Figure 7.34 Initiatives Delivered in Havering's Night Time Economy

Initiative	Description
Banned from One, Banned from All	Under the new scheme set up by the Havering Police and the council, anyone banned from one licensed premises for drink related disorder will be banned from them all
Yellow Card	Troublemakers under the influence of alcohol are being given 'yellow cards' and banned temporarily from Romford town centre.
Safe and Sound	Working with licensed premises and businesses to reduce the incidence of violence within the night time economy and crime and ASB within the town centre. The scheme has also been extended to Hornchurch High Street.
Alcohol Arrest Referral	A brief intervention with a detained person in a police custody suite and facilitating their referral into treatment or some other diversionary channel; plans to introduce this are in development in Havering
Legal Sales Testing	'Secret shoppers' approach to testing compliance with age of sales legislation
Safe Haven & Street Triage	Community Safety initiative to provide care to night-time revellers who have drunk to excess or experienced injury in the town centre, thereby avoiding a trip to local A& E services
Town Link Radios	Dedicated radios to link professionals or volunteers contributing to various aspects of crime or harm reduction in Havering's economic centres direct to police support
CCTV	Romford town centre is under CCTV surveillance to reduce anti-social behaviour by preventing or reacting quickly to incidents
Saturation Policies	Due to the cumulative impact of existing licensed premises; further applications for licences in St Andrews Ward Hornchurch and Romford will be refused other than in exceptional circumstances. ²⁰⁸
Designated Public Place Orders	The centre of Romford was the subject of a DPPO in 2004. Provisions in the Police & Criminal Justice Act 2001 ²⁰⁹ for dealing with alcohol-related crime disorder permitted the introduction of Designated Public Place Orders [DPPOs] at a local authority level to help the police deal with the problems of anti-social drinking in public places. While it is not an offence to consume alcohol within a "designated" area, the police have powers to control the consumption of alcohol within that place. Under recent proposals, DPPOs will be replaced by Community Protection Order (Public Space).

In addition, Havering's Licensing Strategy (2014) is key to encouraging safe and responsible drinking. The main actions in the refreshed strategy are:

- Reducing age-restricted sales, particularly in the vicinity of schools and colleges
- Controlling the availability of alcohol after pubs close to reduce anti-social behaviour
- Controlling street drinking

²⁰⁸ London Borough Of Havering: Statement of Licensing Policy

²⁰⁹ Home Office, 'Alcohol Consumption in Public Places: Designation Orders', National Archives

- Controlling cumulative impacts
- Reducing the level of drug use on licensed premises
- Licensing and planning regimes to be more joined up
- Having well-informed Licensing Sub-Committees
- Effective use of data to inform interventions
- Consistency in approach to tackling problems associated with licensed premises
- Having a Licensing Policy that is fit for purpose
- Reducing littering and urinating in the streets

In particular, through the planning and licensing process, the Council seeks to protect reasonable residential amenity in all of our town centres. The current form of Havering's night-time economy results in residents living near to pubs and clubs being disturbed by noise from amplified music, people congregating outside licensed premises, patrons leaving these premises in the early hours of the morning and other anti-social behaviour associated with excessive alcohol consumption, often over a large geographical area around our town centres. To minimise the impact on local residents, Havering has the following tools:

- *Development Policy DC23* – the Council will
 - encourage a range of complementary day and evening uses in the town centres
 - seek to manage the evening and night time economy and its impact on town centres and residents
 - discourage proposals that will result in a concentration of similar evening uses
- *Policy ROM8* – seeks to diversify the day and evening economy of Romford town centre, in particular, by encouraging more restaurants and seeking to reduce the concentration of licensed premises in South Street
- *Romford Town Centre Pavement Cafes Local Development Order (LDO)* - was adopted in January 2012 and allows pavement cafes within specified areas of the town centre where the lawful use of the premises is A3 (restaurants and cafes) or A4 (drinking establishments).
- *Compliance checks* are carried out by Local Authority licensing officers
- *Reviews of premises licenses* are submitted to the Licensing subcommittee for decision.

7.6.2 Effective use of the Criminal Justice System

In addition to the initiatives specific to the night time economy, Havering has a number of opportunities through the criminal justice system to minimise the impact of drug and alcohol misuse in the borough²¹⁰ (Fig. 7.35). These include projects or initiatives run by, or on behalf of, criminal justice agencies, but which all contribute to reducing crime or the fear of crime. Some of these initiatives are funded by the Mayor's Office Police And Crime unit (MOPAC).

²¹⁰ Havering Community Safety Partnership Strategic Assessment 2013. London Borough Of Havering, Romford.

Figure 7.35 Initiatives in Havering to Reduce Crime or Fear of Crime

Initiative	Description
Drug Intervention Project Panel (DIP)	Monthly panel meeting managing drug dependent offenders in Havering.
Alcohol Treatment Requirements	A community sentence available to the courts which provides access to treatment and support programmes for offenders where alcohol use is identified as a significant factor in offending. ATR's are also suitable for hazardous and harmful drinkers in certain circumstances; where alcohol is the dominant feature in the offending and the offender would benefit from treatment. Once the order is imposed by the courts the individual must agree to a treatment plan with probation and the treatment provider. This plan then sets out the level of treatment required throughout the order.
Conditional Cautions (Drugs)	Conditional Cautioning (CC) enables offenders to be given a suitable disposal without the involvement of the usual court processes. Where rehabilitative or reparative conditions (or both) are considered preferable to prosecution, CC provides a statutory means of enforcing them through prosecution for the original offence in the event of non-compliance. The key to determining whether a CC should be given - instead of prosecution or a simple caution - is that the imposition of specified conditions will be an appropriate and effective means of addressing an offender's behaviour or making reparation for the effects of the offence on the victim or the community.
Integrated Offender Management Panel (IOM)	Monthly panel to manage high crime causing offenders with complex needs using a range of multi-agency services.
Domestic Violence Intervention	Including Domestic Violence (DV) Forum; DV Perpetrators training for frontline staff for identifying and working with DV perpetrators; Havering Women's Aid; Independent DV Advocate (MOPAC funded)
Serious Youth Violence Panel	Specialist panel of experts formed to support youths engaged in serious violence to improve their life chances and outcomes by offering appropriate and directed support
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
Fathers' Project	A group programme to enable Fathers to address negative thinking and behaviour that impacts on families and children, and to encourage child centred parenting.
Food Project	To assist IOM service users to develop basic life skills and also help them to be effective in managing their food budget.
Football Project	Aimed at reducing re-offending through diversionary football activities, and the development of life skills and positive motivation.

Initiative	Description
Rent Deposit Scheme (MOPAC funded):	Funding emergency accommodation and access to the private rental sector for IOM clients unlikely to be housed by the Local Authority.
Survival Guide	An information booklet for those being released from Prison or new to the borough. It explains how to access help in key areas linked to risk of re-offending: Food, Shelter, Money and Health.
Women's Empowerment Programme	A 6 week programme for women service users consisting of information giving, signposting and contact with key services, targeting risk factors particularly relevant to women's offending.

Testing on Arrest (ToA) has been particularly effective in increasing the referrals into treatment (Fig. 7.36). ToA was introduced as part of the Drugs Act (2005)²¹¹, which included a provision to move the point at which a drug test may be carried out to post-arrest rather than post-charge. An individual will be tested on arrest where they fulfil all of the following conditions:

- are aged 18 or over
- are in police custody
- were arrested for a trigger offence or for an offence where a police officer of Inspector rank or above suspects specified Class A drug use was a causal or contributory factor.

Testing on Arrest enables us to identify adults misusing specified Class A drugs earlier in their contact with the criminal justice system, so that they may be steered into treatment and away from crime as soon as possible. It has also increased the volume of drug misusing arrestees identified – providing an opportunity to screen more people at some stage of their detention - and will ensure that those who misuse drugs but are not charged with an offence are nevertheless helped to engage in treatment and other programmes of help.

Figure 7.36 Impact of Introduction of Testing on Arrest

	April- Mar 2011/12	April –Mar 2012/13	Jan-October 2012	Jan-October 2013 (Testing on Arrest Commenced Jan to 2013)	% increase based on comparison data from 2012 to 2013
Number of Referrals/triage assessments	232	249	158	325	106%
Number Commencing Tier 3 Treatment	92	162	78	191	145%
Completing Tier Treatment	47	60	34	82	141%

²¹¹ HM Government (2005). Drugs Act 2005. London: HM Government. Available on: https://www.google.com/url?q=http://www.legislation.gov.uk/ukpga/2005/17/pdfs/ukpga_20050017_en.pdf&sa=U&ei=qWgpU4ifL5KThQfxjYDICA&ved=0CBsQFjAA&usg=AFQjCNFm8e1r48fUCBr-dq5_P_pYLLvAaQ

The council also offer a range of crime prevention services for Children and Young People. The aim of pre-crime prevention is to identify children and young people who are at high risk of offending and help them to avoid entering the Youth Justice System. The Youth Justice Board has developed a variety of programmes which are intended to achieve this aim.

On a local level, Havering has collaborations with various local and community organisations to divert young people from offending. One of the projects that work within Havering Youth Offending Service is the Youth Inclusion Support Programme (YISP). YISP work with young 8-13 year olds at risk of offending/anti-social behaviour, and their families. This is a voluntary service which aims to reduce risk of offending and increase protective factors in a young person's life.

Young people must have four or more risk factors and have two or more agencies concerned about them in order to qualify for referral. Referrals can be made by professionals or young people/parents/carers can self-refer.

7.6.3 Supporting Housing Needs

The lives of people with serious drugs problems can often be chaotic – housing can therefore often be the only stability there is. Stable accommodation can be the difference between staying in treatment and returning to crime and anti-social behaviour. In particular, evidence shows that those leaving drug treatment or custody without their housing needs being assessed and met are more likely to relapse and re-offend. Even those who are housed are likely to lose their accommodation if they do not receive the right support to sustain their tenancy. Statistics from the Audit Commission clearly establish the link between homelessness and drug misuse²¹².

- Three-quarters of single homeless people have a history of problematic substance misuse (rising to more than 80% of rough sleepers).
- More than 40% of single homeless people cite drug use as the main reason for homelessness, while two-thirds report increasing problem substance misuse after becoming homeless.
- Extensive research by Addaction (2005) found that 83% of substance misusers felt that stable housing was one of the most important support services required to help them stay clean.

Havering housing data shows that many clients face problems in securing safe, secure and stable accommodation - essential for many in making and sustaining long term positive changes. Two organisations, Family Mosaic and SHP are currently commissioned to provide housing and tenancy support .

Family Mosaic, which has been running for around 6 years, is funded to provide a tenancy sustainment service to stop the revolving door of losing tenancies. Their role is to ensure benefits are in place, help service users into education or employment etc., look at mental health, drug and alcohol, and child protection issues. Referral can be via any agency, including self-referral. There is a dedicated assessment officer to see if what the client needs is what Family Mosaic can provide; if a

²¹² Cited directly from Drug Interventions Programme (2008). *Housing Drug Users Factsheet*. Available on: <https://www.google.co.uk/url?q=http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Good%2520Practice/dip-housing-december-08.pdf&sa=U&ei=GnkpU4LzF8y3hAfwxIG4BA&ved=0CB4QFjAA&usg=AFQjCNGI7Jb4JAt71cQcBgi04hhPO6X0-w>

person qualifies, a support worker is provided to the client for up to 2 years, with more intensive contact in the beginning, decreasing as the client becomes more settled and self-sustaining. The service covers 16-65 year olds and includes local authority, owner occupied or privately rented housing (over 65s are provided support through older people's services within the local authority). Family Mosaic provide a rent deposit loan scheme and also lease properties in the Family Mosaic name. There are 13 properties for young people aged 16-24; 4 properties for drug and alcohol service users – tenants are assessed through a panel and have to have completed a detox or drug service programme to be eligible to apply for housing; after 6 months to 2 years of responsible tenant behaviour, Family Mosaic are able to offer a positive reference to the local authority to set them on the path of standard tenancies. The services Family Mosaic provides include:

- Support directly for young people
- Support for drug and alcohol users
- Support for clients with mental health difficulties
- Advice around debt management problems
- Medication service for young people who may have been evicted or left home (usually around 14/15 to 20 years old)
- Generic housing advice
- Private Sector Leasing (PSL) services, which involves up to 4 weeks intensive work setting up relevant benefits, getting in contact with partner agencies or sorting out furniture etc.
- Tenant involvement – provide training and survey customers to elicit their training needs, which should lead to greater employment. Family Mosaic's current targets centre on employment targets. Tenant involvement also includes trips to London to see museums, Party in the Park, Winter Wonderland and other Social inclusion activities
- Work closely with Troubled Families programme

SHP (previously called Single Homeless Project) works London-wide, and is the biggest provider of floating support in London. In Havering, the service is specifically focused on offenders, those at risk or those who have already offended. SHP take a holistic approach to clients, working with them for up to 2 years. Some come to the service because their primary need is housing and then drift away when their housing is addressed, and don't look at the other aspects that SHP could help with. SHP work with up to 33 clients in Havering at any one time as the service consists of only 2 ½ workers and limited advice surgeries. They work with anyone who has had a history of offending or at risk of offending. This floating support service includes:

- Housing in the right place
- Benefits
- Training/employment
- Registering with a GP
- Referral to mental health services
- Management of a rent deposit scheme, which was funded through MOPAC, for the criminal justice agencies in the borough, and feeds through the DIP panel and Community Safety
- Developing a support plan, focusing on issues of:
 - Motivation

- Mental health
- Substance misuse
- Physical health
- Social networks
- Relationships

SHP's role is to ensure a client is linked in with specialist agencies – and can make referrals on to the relevant agencies, acting as a broker for services. These include referrals to First Stop/Community Alcohol Team (CAT) and mental health assessments. Out of the general 33 clients only 2 or 3 don't have a problem with drugs or alcohol so this is a very important issue. In order for a client to get rent deposit scheme funding, SHP have to ensure they are engaged with First Stop and/or CAT. For example, if a client is coming out of prison they can be given two weeks in bed and breakfast accommodation during which time it is their responsibility to pick up their script from New Directions for treatment of withdrawal symptoms. If the client is following the conditions imposed during these two weeks they are then given a chance to find stable accommodation in the private rented sector. SHP get information from the CARATS team in prison to see whether the client engaged in voluntary drugs testing whilst in prison and/or made an effort to engage in drugs services.

7.6.4 Financial Strategies

There is a strong and well proven link between price and consumption of alcohol. Likewise easy physical access is associated with higher consumption - there is evidence of a link between the number of venues selling alcohol in one area and levels of harm, whether this is crime, damage to health, or harm to young people²¹³.

In recent years, the disparity in cost between on and off licence sales has led to a change in behaviour, with increasing numbers of people drinking excessively at home, including many who do so before they go on a night out, termed 'pre-loading'. In a recent study, around two-thirds of 17-30 year olds arrested in a city in England claimed to have 'pre-loaded' before a night out²¹⁴, and a further study found 'pre-loaders' two-and-a-half times more likely to be involved in violence than other drinkers²¹⁵.

In response, the 2012 national Alcohol Strategy included a commitment at the time to introduce a minimum unit price (MUP) for alcohol and to consult on a ban on multi-buy promotions in the off-trade (shops) which encourage customers to buy more alcohol than they intend. Currently, the Government is not intending to extend this ban to the on-trade (pubs, bars, restaurants etc.) which is described as '*a more controlled and regulated drinking environment*'. However, recent intelligence

²¹³ Popova, S., Giesbrecht, N., Bekmuradov, D. and Patra, J. (2009) Hours and days of sale and density of alcohol outputs: Impacts on alcohol consumption and damage: A systematic review. *Alcohol & Alcoholism*. Vol. 44, No. 5, pp500-516

²¹⁴ Barton, A. and Husk, K. (forthcoming) Controlling pre-loaders: alcohol related violence in an English night time economy. *Drugs and Alcohol Today*.

²¹⁵ Hughes, K., Anderson, Z., Morleo, M. and Bellis, M.A. (2008) 'Alcohol, nightlife and violence: the relative contributions of drinking before and during nights out to negative health and criminal justice outcomes', *Addiction*, 103 (1), pp 60-5.

suggests MUP for alcohol is not likely to take effect. Instead, the Government are looking at banning the sale of alcohol at a value less than duty plus VAT.

With regard to accessibility, the strategy includes commitments to give local authorities stronger powers to control the density of licensed premises and make health a licensing objective for this purpose. Local communities will be able to limit the density of premises where this is contributing to the major types of harm. Cumulative Impact Policies (CIPs) can already do this to tackle certain issues, but the statutory guidance on the Licensing Act 2003 will be amended to make clear that CIPs apply to both the on-trade and the off-trade. The burden of evidence on licensing authorities will be reduced to make it easier to introduce CIPs. In addition, there will be powers to restrict alcohol sales if late opening is causing problems.

From 25 April 2012, licensing authorities and local health bodies formally became 'responsible authorities' under the Licensing Act 2003, ensuring that they are automatically notified of an application or review, and can more easily instigate a review of a licence themselves. At the same time, new powers will make it easier to refuse, revoke or impose conditions on a licence by reducing the evidential threshold from 'necessary' to 'appropriate', thereby making it easier to challenge irresponsible businesses. The Public Health team, who are now a part of the council, has been nominated to review and make representations on licensing applications, and therefore have an opportunity to consider the wider health and wellbeing impacts of a licensed premises application.

8.0 What are the Gaps?

Examination of the key data required to build this needs assessment has provided a reasonable picture of the current situation in Havering. However, it has also revealed some important gaps in the current data and intelligence and areas where there appears to be unmet need. Figure 8.1 outlines the key gaps/areas which are as yet undefined or were not readily available. The remainder of this section explores in greater depth some of the key issues, drawing on national best practice guidance to offer solutions as to why some of these gaps remain in Havering.

Figure 8.1 Key Gaps and Unmet Need in Havering

Key Gap	What is Lacking?
Dependent drinkers accessing treatment	Only estimates are currently available on how many dependent drinkers there are in Havering – greater levels of screening using (e.g.) AUDIT C is required to establish better intelligence as to who would benefit from help into treatment.
Binge drinking prevalence	There is currently a lack of robust intelligence on how many binge drinkers there are likely to be in Havering. Given the success of the night-time economy in the borough, such data would enable us to target resources more effectively to identifying and intervening early to minimise the harm caused by binge drinking.
Minimising the harm from binge drinking	There are few services available to raise awareness of the harms caused by binge drinking to people engaging in Havering’s night time economy. Increases in the numbers of frontline staff trained in delivery of IBA may help.
OTC and POM intelligence	There is a current lack of robust intelligence on the numbers of people taking Prescription Only Medication (POM) and Over-the-Counter medicines (OTC).
Cost-effectiveness	The NTA’s cost effectiveness tool suggests that the Havering spend on community prescribing programmes is significantly higher than the national average rate. An in-depth service review is required to ascertain where the costs are arising in order to improve value for money.
Ensuring ethnic minorities access appropriate services	There is currently an over-representation of White British people accessing drug and alcohol treatment services (88%) compared with the numbers of BME Groups in Havering (83%)
Successful cannabis treatment completions	Successful completions for cannabis users in treatment in Havering are significantly lower (23.9%) than the rate achieved in London (37.1%). Further exploration, including outcomes analysis and feedback from service users is required to determine why this may be happening.
Young carers	How many young carers in Havering are required to care for a parent with drug or alcohol misuse issues?
Needs of prisoners; preventing re-offending behaviour	Havering does not have a statutory prison within its borders, but the needs of offenders are addressed through the links with the Family Mosaic and SHP programmes. However, the needs of Havering residents who may be temporarily in custody requires further in-depth exploration.

8.1 Screening and Brief Intervention

It is clear from the numbers of dependent drinkers currently in contact with local treatment services that only a small percentage of the estimated total numbers are actually being treated. In addition, although treatment services are indeed seeing clients within the target waiting time, the low numbers of people and low waiting times may also suggest that the services are not working to their full potential capacity. Identification of and encouragement for these people into treatment is therefore a priority.

NICE Clinical Guideline 115 (2007, updated 2011)²¹⁶ suggests that the some of the reasons why only 6% of the people identified with alcohol dependence issues enter treatment is due to an often long period between developing alcohol dependence and seeking help, and the limited availability of specialist alcohol treatment services in some parts of England. Additionally, alcohol misuse is under-identified by health and social care professionals, leading to missed opportunities to provide effective interventions. Therefore, without an opportunistic or planned discussion around alcohol misuse it is difficult to identify those who require further help.

A systematic review of studies (47 papers in total) that addressed screening and brief intervention found a number of barriers and facilitators – some of these facilitators are either not currently being delivered in Havering, or not being delivered to a sufficient extent (Fig. 8.2)²¹⁷.

Figure 8.2 Barriers and Facilitators to Engaging Patients in Screening and Brief Intervention

Barriers	Facilitators
<ul style="list-style-type: none"> • Lack of financial incentives • Lack of management support • Perceived lack of knowledge and confidence in imparting advice; practitioners were confused by, or unaware of current guidelines • Confusion around multiple definitions of alcohol measures and strengths • Receptionists did not have a positive attitude towards being involved in handing out screening questionnaires • A minority of health care professionals did not see the delivery of brief interventions as part of their role • Nurses were anxious not to misdirect advice • Some practitioners found the topic difficult to raise or were reluctant to ask patients about their drinking behaviour unless there are clear signs of risky behaviour • Clinical inertia found to be a barrier to 	<ul style="list-style-type: none"> • Carrying out screening or IBA in well-being clinics • Delivering the screening tool as part of a patient registration • Practice nurses delivering screening seen as having time to talk • GPs delivering screening/IBA seen as being more knowledgeable • Access to staff training, focusing on skills relevant to the appropriate detection and management of individuals at risk of heavy drinking • Delegating work such as handing out screening questionnaires saved time • Involving all relevant staff in discussions about health promotion programmes in primary care settings • Positive attitudes of junior doctors towards implementing screening and brief intervention

²¹⁶ NICE Clinical Guideline 115 (2011). *Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence*. London: NICE

²¹⁷ Johnson, M., Jackson, R., Guillaume., Meier, P. and Goyder, E. (2011) 'Barriers and facilitators to implementing screening and brief intervention for alcohol misuse: a systematic review of qualitative evidence', *Journal of Public Health*, 33 (3), pp. 412-21 Available on: <http://jpubhealth.oxfordjournals.org/content/33/3/412.long>

<p>implementing screening and brief advice, particularly in emergency departments</p> <ul style="list-style-type: none"> • Despite training, some professionals remain unmotivated or do not carry out interventions appropriately – this may be an organisational barrier • Individual characteristics associated with either a lower or higher likelihood of being approached by practitioners to discuss drinking behaviour leads in inequitable access • GPs reluctant to discuss drinking behaviour with young people as they felt they were more likely to grow out of the habit of hazardous drinking • Cultural differences in over-or under-reporting of alcohol intake and relative satisfaction with services 	<p>in acute settings</p> <ul style="list-style-type: none"> • Training was more acceptable to nurses when delivered by a nurse • Being receptive to training and committed to the aims of brief intervention • Patients need to be counselled as soon as possible after detection to facilitate intervention success • Patients prefer to discuss alcohol issues with their GP or nurse rather than a specialist • A good rapport is essential for discussing sensitive issues such as drinking behaviour
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8.2 Strategies for Encouraging People into Treatment

Alcohol Alert no. 81 from the National Institute on Alcohol Abuse and Alcoholism (NIAAA)²¹⁸ suggests that alcohol treatment can be delivered in a variety of settings and should be a routine component of healthcare. However, it is only when physicians are more comfortable with alcohol treatment options and gain experience of these that they will be more likely to identify people with alcohol-use problems. Behavioural treatment – changing a person’s expectations and behaviours about alcohol – has the best long-term effects, but combining medication with behavioural therapy has also had positive effects. Some of the strategies proposed in this article for promoting treatment seeking include:

- Because such a high proportion of people with unhealthy alcohol use—from risk drinking and abuse to dependence—go untreated, it may be advantageous to expand treatment to include other settings, such as primary care offices, emergency departments, and even community centers.
- Studies suggest that the majority of those with alcohol problems recognize the problem as much as a decade before they seek treatment, which implies there may be an opportunity for reaching patients earlier²¹⁹. Understanding the factors that influence people’s decisions to seek care and learning how to engage them will assist.
- Only 15 to 25 percent of people with drinking problems seek help from doctors, treatment programs, or MHGs²²⁰. Many do not use treatment services until they are forced to do so by a court, a family member, or an employer²²¹.
- People in alcohol treatment often have the most serious problems, such as comorbid health, mental health, and psychosocial problems. However, studies also show that 66–75% of risky

²¹⁸ NIAAA (2010) *Exploring Treatment Options for Alcohol-use Disorders* Available on:

<http://pubs.niaaa.nih.gov/publications/AA81/AA81.htm>

²¹⁹ Tucker, J.A., and Simpson, C.A. The recovery spectrum: From self-change to seeking treatment. *Alcohol Research & Health* 33(4):371–379, 2011.

²²⁰ Tucker, J.A. Natural resolution of alcohol-related problems. *Recent Developments in Alcoholism* 16:77–90, 2003. [PMID: 12638632](https://pubmed.ncbi.nlm.nih.gov/12638632/)

²²¹ Parhar, K.K.; Wormith, J.S.; Derksen, D.M.; and Beauregard, A.M. Offender coercion in treatment: A meta-analysis of effectiveness. *Criminal Justice and Behavior* 35:1109–1135, 2008.

drinkers do make positive changes, including reaching abstinence or stable moderation, on their own. People who resolve drinking problems on their own more commonly become moderate drinkers than those who receive treatment.

- Research suggests that a person's denial that he or she has a drinking problem is not a primary reason people do not seek treatment²²². One possible reason people do not seek treatment earlier is that both admitting to having an alcohol problem and seeking treatment remain stigmatized in society.
- Other barriers to treatment include a belief that the problem is not serious enough to warrant treatment.
- To remove barriers to treatment, programs are starting to view people with alcohol use disorders and their social networks as consumers of services who can choose among many available alternatives. Programs are making services more user friendly and attractive by providing convenient appointments, parking, and childcare. They also can offer treatment goals that do not necessarily require abstinence in the near term but allow for more gradual approaches to change.
- Some programs have gone a step further, offering "treatment on demand." Rather than working to change a person's motivations directly, these programs simply promote rapid treatment entry as soon as an individual's motivation shifts in favor of change.
- Another approach, the Community Reinforcement and Family Training (CRAFT) model, works to change the patient's environment to make a non-substance-using lifestyle more rewarding than one focused on drinking. In the CRAFT model, concerned significant others (CSOs) are the focus of the therapy instead of the substance abusers. CSOs receive training to change their interactions with the substance-using person, reducing their enabling behaviors and improving their communication strategies. Although originally designed for drug abuse²²³, it is now being used for all forms of substance abuse.

Research on facilitators and barriers to encouraging people into alcohol treatment showed that the CRAFT approach was more effective in engaging initially unmotivated problem drinkers into treatment (64%) as compared with the more commonly practiced Al-Anon 12-step programme (13%) and a Johnson Institute intervention to prepare for a confrontational family meeting (30%)²²⁴. Treatment Improvement Protocols on substance abuse²²⁵ shows how substance abuse treatment staff can influence change by developing a therapeutic relationship that respects and builds on the client's autonomy whilst at the same time making the practitioner a partner in the change process.

Interventions particularly focusing on families are relatively scarce in Havering – the Troubled Families initiative presents the best available option for giving families the support they need to

²²² Simpson, C.A., and Tucker, J.A. Temporal sequencing of alcohol-related problems, problem recognition, and help-seeking episodes. *Addictive Behaviors* 27:659–674, 2002. [PMID: 12201375](https://pubmed.ncbi.nlm.nih.gov/12201375/)

²²³ Meyers, R.J.; Miller, W. R.; Hill, D.E. & Tonigan, J.S (1998). Community reinforcement and family training (CRAFT): engaging unmotivated drug users in treatment. *Journal of Substance Abuse* Vol 10 (3); 291-308.

²²⁴ Miller, W. R.; Meyers, R.J.; Tonigan, J.S (1999). Engaging the unmotivated in treatment for alcohol problems: A comparison of three strategies for intervention through family members. *Journal of Consulting and Clinical Psychology*, Vol 67(5), Oct 1999, 688-697.

²²⁵ Miller, W.R. (1999). *Enhancing Motivation for Change in Substance Abuse Treatment*. US Department for Health and Human Services: Rockville, USA. Available on: http://books.google.co.uk/books?hl=en&lr=&id=L1Y7w_cwBwIC&oi=fnd&pg=PR7&dq=best+practice+engaging+unmotivated+substance+abuse+into+treatment&ots=q-RDa8UJvk&sig=Jf5rytebt3iszXVvZUZnL-ifKIA#v=onepage&q&f=false

tackle their issues, including drug and alcohol misuse. However, commissioners are also encouraged to consider other models of family-based drug and alcohol treatment during their process for commissioning future services.

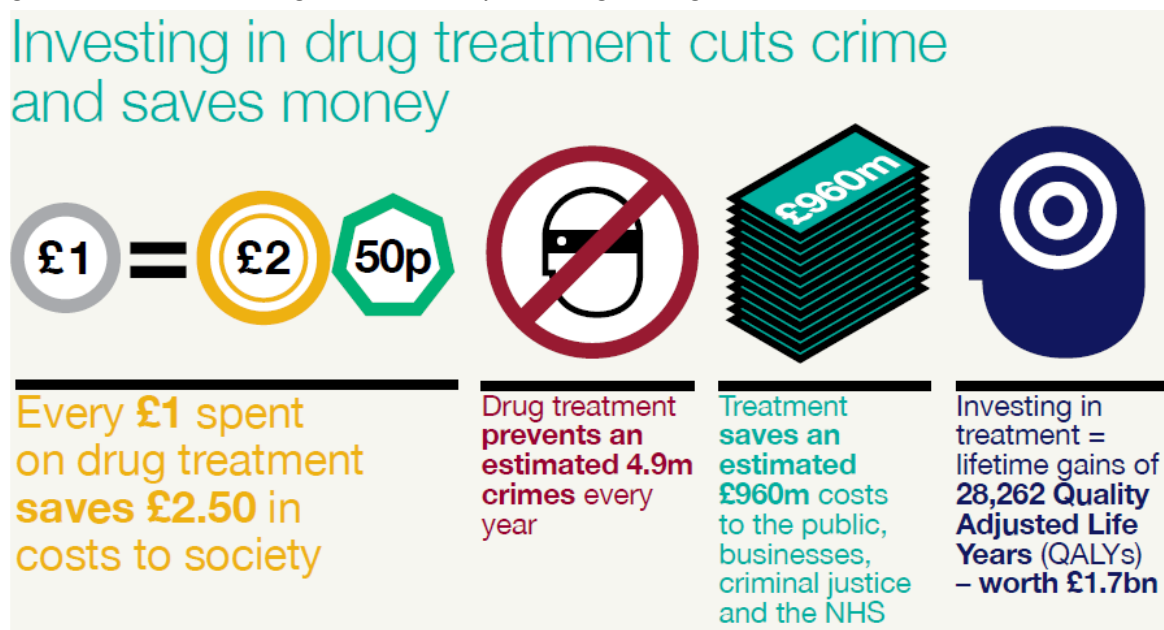
8.3 Value for Money?

Data from Public Health England show that investing in drug and alcohol services will save money and reduce crime (Figs. 8.3 and 8.4)²²⁶. For every £1 spent on drug treatment services, a potential saving of £2.50 can be made to society. Similarly, every £1 spent intervening early on young people’s drug and alcohol services can bring a benefit of £5-8 to society.

Figure 8.3 Potential Savings to be made by Investing in Alcohol Interventions



Figure 8.4 Potential Savings to be made by Investing in Drug Treatment



²²⁶ Public Health England. *Alcohol and Drugs Prevention, Treatment and Recovery: Why invest?* London: Public Health England. Available on: <http://www.nta.nhs.uk/uploads/whyinvest2014.pdf>

The National Treatment Agency’s (NTA) cost-effectiveness tool (outlined in section 6.3) showed that Havering spent considerably more of its total budget on community prescribing (41.4%) than the national average (30.6%) (although this is comparing 2011-12 national data with 2012-13 Havering spend). In addition, breaking this down into a cost per day basis shows again that Havering is spending considerably more per day on community prescribing than the national average cost for this kind of treatment (Fig. 8.5). Whether this is due to an artifact of local residents requiring a more complex treatment regime, supply and demand in the treatment system not working effectively, or local providers’ costs being significantly high is an issue requiring thorough examination. Therefore, an in-depth service review is required (and currently under development for commissioning) to ascertain how well our services are performing and where this disproportionate cost is arising. Future re-commissioning of services will need to take into account the Public Health Outcomes Framework (PHOF) and ensure that an ‘Outcomes’ approach is adopted by successful providers.

Figure 8.5 Cost Per Day (Unit Cost) of Interventions in Havering Compared with National Average Cost

	Havering	Top Quartile	National
Community Prescribing	£12.86	£5.12	£5.92
Structured Day Programmes	£29.08	£41.66	£27.88
Structures Psychosocial Interventions	£12.31	£12.31	£13.85
Other Structured Drug Treatment	£9.56	£26.81	£18.14
Inpatient Treatment	£300.20	£389.45	£413.06
Residential Rehabilitation	£84.39	£163.05	£162.37

9.0 Recommendations for Commissioners

The following section is divided into ‘themes’ used to define the priority areas of need for Havering. Commissioners are encouraged to consider these recommendations in terms of what could be commissioned collaboratively, or delivered in a partnership approach.

9.1 Prevention and Early Identification of At Risk Groups

- Continue to commission prevention focused drugs and alcohol services for children and young people: -
 - Work with Troubled Families initiative to identify and support families experiencing substance misuse (whether parental or child)
 - Support schools to provide high quality drug and alcohol education; consider the potential value of additional input from school nursing when the service is re-commissioned.
 - Work with other services to identify vulnerable young people e.g. young offenders, and their families and intervene early with effective support
 - Notwithstanding that it is legal, ensure that all stakeholders are aware of the potential harm of alcohol use in young people and encourage a lower threshold for intervention more in line with other forms of substance misuse.
 - Ensure timely access to specialist support for those at risk or showing signs of dependency
 - Ensure that all frontline staff with access to children and young people are adequately trained in alcohol Intervention and Brief Advice (IBA)
- Raise awareness of the harms caused by drugs and alcohol and encourage users into suitable treatment
 - Ensure all relevant frontline staff are trained in IBA, particularly those in contact with Troubled Families
 - Commission suitable outreach workers to engage with the night-time economy to identify and signpost people into treatment
 - Ensure good communication between statutory service providers to ensure that individuals experiencing any of the Toxic Trio of drug and alcohol misuse, mental health difficulties or domestic violence are supported or suitably referred to services where the harms from any of these issues can be addressed and minimised
 - Continue to commission Health Checks and support GPs to ensure that AUDIT C is administered as part of this check
- Improve needs assessment and understanding of substance misuse locally
 - Ensure A&E services at BHRUHT adopt the ‘Cardiff model’ or equivalent to improve the recording of alcohol related harm (the who, when, where etc.);
 - Work with Havering Clinical Commissioning Group (CCG) to implement the ‘last drink survey’ within A&E departments using a simple question, “Where did you buy your last drink from?”
 - Share the resulting information with partners to enable better targeting of public safety activity and support efforts through the licensing process to tackle poorly managed premises and stop the issue of further licences where localities are already saturated.

- Establish more robust local intelligence on Prescription Only Medication (POM) and Over-the-Counter (OTC) medicines usage
- Improve reporting from needle exchange services to improve this potentially useful source of information
- Seek to confirm the suspicion of significant steroid use and if so develop an appropriate response as dealing fosters criminality and use is associated with increased violence, including domestic violence as well as the usual health threats entailed in injecting drug use.
- Work with the CCG to better understand prescription of benzodiazepines and opioids locally and the extent to which this might increase the risk of dependency.
- Establish the health needs of offenders in short term custody
- Be alert to changing demography and how this might impact on the need for services
- Work with the criminal justice system to reduce the impact that drugs and alcohol have on offending behaviour and the health of offenders
 - Continue to commission services to respond to Alcohol Treatment Requirements and Conditional Cautioning for Drug Users
 - Sustain and improve upon the Integrated Offender Management Programme (IOM)
 - Implement Alcohol Conditional Cautioning with Criminal Justice partners
 - Commissioners should ensure the pathway between those testing positive on arrest (ToA) and compliance with drug or alcohol treatment is suitably implemented, and intelligence from this reported back
 - Ensure those at risk of, or experiencing domestic violence, are assessed for drug or alcohol misuse and referred into treatment
 - Continue to commission housing support services for ex-offenders to ensure their rehabilitation is facilitated by being in stable housing

9.2 Safeguarding

- Commission holistic support
 - Consider how to incentivise providers to focus beyond the achievement of short term treatment outcomes e.g. KPIs regarding employment, housing, education etc; representation rates;
 - Ensure links are in place with Jobcentres to increase referrals and / or improve support clients who's search for work is hindered by drug and / or alcohol problems
 - Ensure drugs and alcohol workers receive regular safeguarding training and actively engage with MASH²²⁷ and MARAC²²⁸ procedures as required.
 - Ensure all MASH partners are aware of provisions for carers and families of drug and alcohol users
 - Ensure treatment services link with Children and Young People social care services and the Troubled Families project.

²²⁷ For more information regarding [Havering's Multi Agency Safeguarding Hub \(MASH\)](#)

²²⁸ The Multi Agency Risk Assessment Conference is a monthly meeting where information is shared on high risk domestic violence cases between representatives of local police, probation, health, child protection, housing providers, probation, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sector.

- Ensure treatment service involve families and carers in treatment, making use of behavioural couples therapy, in line with NICE guidance
- Develop targeted young people's diversionary activities
- Explore and develop social media techniques to engage with young people to ensure they are aware of and minimise the harms from drugs and alcohol

9.3 Harm Minimisation

- Determine the contribution of GP shared care in an increasingly recovery focused service.
- Continue to commission needle exchange services and other interventions designed to reduce the harm entailed in injecting drugs. Look to increase the offer of Hepatitis B and subsequent engagement with treatment if needed.
- Ensure injecting users are offered and screened for Blood Borne Viruses (BBV) – HBV, HCV or HIV infection

9.4 Treatment for Drug Users

- Promote awareness of drug treatment services
 - Regularly report waiting times to potential referrers to demonstrate the capacity of the service and the potential for a timely response
 - Require providers to promote services to potential referrers e.g. GPs.
- Given there is no substitute to offer users of crack and cocaine, as is the case for opiates, treatment services can struggle to engage these users. It's therefore essential that alternative referral routes are maximised. The criminal justice system; specifically the opportunity to 'test on arrest' needs to be exploited to the full.
- Work with the CCG to ensure drug and alcohol services complement other mental health services and meet the needs of patients with dual diagnosis.
- Consider commissioning of recovery programmes as part of exit procedures from specialist services e.g. Recovery Café
- Ensure that specialist drug services raise awareness of, and work with, mutual aid or other voluntary groups specialising in promoting and sustaining recovery.

9.5 Treatment for Dependent Drinkers

- Look to identify more people with alcohol problems and increase referrals into the community alcohol service by: -
 - *in general practice* – by including use of the Audit C screening tool in NHS health checks; and providing GPs with training regarding Audit C and IBA
 - *in general practice* – work with GPs to better understand how and when they prescribe alcohol abstinence medication and encourage them to refer patients into specialist or recovery services
 - *in hospital* – by commissioning a hospital liaison service and agreeing expectations of BHRHT regarding the identification of problem drinkers admitted and / or attending A&E
 - *in the criminal justice system* – adopt similar approaches as currently employed to identify substance misusers and engage them in treatment e.g. Alcohol Treatment Requirements [ATR] and Alcohol Arrest Referrals [AAR]

- *in social care* – train staff in IBA and how to make referrals
- Consider whether use of alternative venues would reduce the stigma associated with attending substance misuse services.
- Regularly report waiting times to potential referrers to demonstrate the capacity of the service and the potential for a timely response
- Require providers to promote services to potential referrers e.g. GPs.
- Focus on support to clients successfully completing treatment to minimise representations
 - Seek to grow mutual aid capacity in the borough particularly regarding drugs
 - Build an effective recovery infrastructure separate from but linked to treatment services.
 - Consider the costs / benefits of a recovery café.

9.6 The Night Time Economy

- Continue with and build on existing schemes developed with the licensed trade to minimise risks associated with alcohol and the night-time economy: -
 - explore whether individuals identified by '*Banned from one, Banned from all*' and '*Yellow card*' schemes can be referred on to treatment services

10.0 Further Data Sources

Further data pertaining to both national data and Havering specifically can be found on:

- [Havering Data Intelligence Hub](#)
- [Havering JSNA Chapters](#)
- [Public Health England: Longer Lives](#)
- [Public Health England Drug Trends](#) (formerly National Treatment Agency (NTA))