2017

Adult substance Misuse Health Needs Assessment

DR AALAA JAWAD

SUPERVISED BY AMANDA KILLORAN

LBM | London Borough of Merton Public Health

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1. EXECUTIVE SUMMARY

Aims

The adult substance misuse Health Needs Assessment (SMHNA) aims to provide analysis of current adult substance misuse needs and identify health inequalities and unmet needs to inform a strategic framework to redesign and develop substance misuse services for adults in Merton.

Methodology

Local, regional and national data was analysed for trends and summarised alongside national policy documents. Stakeholder engagement with service providers and partners was conducted through a multidisciplinary workshop and service user engagement was instigated through a focus group at a local community substance misuse service.

Merton patterns of alcohol consumption

The Chief Medical Officer (CMO) recommends drinking a maximum of 14 units a week, spread evenly over a few days with drink free days included in the week. Local prevalence estimates taken from the national Health Survey for England (HSE) found over half (59%) of the population are drinking at lower risk, consuming <14 units a week, however this is likely to be an underestimate. Almost a quarter of the population, are estimated to be drinking at increasing or higher risk and a study using Adult Psychiatric Morbidity Survey (AMPS) data from 2014 provided a refined estimate that 1,837 individuals in Merton are dependant drinkers in need of specialist assessment and treatment. The survey also found significant differences between the genders when looking at patterns in age with a consistently higher proportion of men drinking more than 14 units of alcohol per week in comparison to females throughout their lifetime. In both genders, the highest proportion of drinking above the recommended limit is in the 50's to early 70's, and is in line with local treatment population data that shows oldest age distribution among alcohol clients. This is alarming as they have potential increased health harms due to the likely accumulated medical conditions.

Although the less deprived tend to drinking more units of alcohol, more health harms and mortality are experienced by the more deprived, who tend to consume less units. This is commonly referred to as the alcohol harm paradox and a local survey result based on market system software in Merton clearly showed increased burden for health harms or disabilities related to alcohol or drugs in the east more deprived areas than in the less deprived west, highlighting the health inequality across the borough.

Alcohol related harm in Merton

Alcohol misuse has considerable health harms as measured by hospital admissions which may be directly caused by alcohol and are alcohol-specific, or where alcohol plays a role and is alcohol-related. The way the above harms are categorised may be broad, in that the primary or secondary diagnosis was recorded as an alcohol-related disease; or narrow where the primary diagnosis is alcohol-related disease, injury or condition, or the secondary diagnosis is an alcohol related external cause. Compared to neighbouring groups (15 other similar areas) PHE data found there are increased harms from narrow definitions of alcohol-specific and alcohol-related hospital admissions locally. Alcohol specific mortality in Merton was worse than the London average, and given the

paradox describe above it is likely worse in the east of the borough, identifying a need for increased resources in the east to overcome this.

Gender disparities were found in comparison to neighbouring groups where men in Merton experienced the highest amount of harm for alcohol admissions for mental and behavioural disorders, and admissions for intentional self-poisoning, whereas females experienced the highest amount of harm for admissions of alcoholic liver disease conditions (broad) and alcohol related cancer incidence, showing the need for more targeted mental health services for males, and a more medical prevention for females.

The negative impact of crime is also a measure of harm. Alcohol is implicated in both violent and impulsive crime as well as less serious crime such as noise disturbance, littering and anti-social behaviour that may impact an area significantly. The Crime Survey for England and Wales (CSEW) 2016 found that 40% of violent incidents the victim believed the offender(s) to be under the influence of alcohol, which amounts to 5,300 alcohol related crimes in Merton in the same year, a likely underestimate due to the exclusion of non-violent crime and underreporting of more minor crimes. To some extent this can be controlled through premises licensing and the creation of a cumulative impact zones in saturated areas to limit the number, and opening times, of drinking establishments present.

Merton patterns of drug misuse

Estimates of drug misuse from the CSEW found over a third of the 16-59 year old population have taken drugs at some point in their lifetime with cannabis being the most popular substance. An estimated 5,548 adults in Merton are more frequent users who have taken drugs in the last month. Of the 207 opiate clients in treatment most commonly presenting with crack cocaine (45%) as an adjunctive substance. The treatment population in Merton have larger proportion of opiate clients who use cocaine as an adjunct than nationally, as well as having a larger proportion of non-opiate clients using cocaine than in London or nationally. The high local popularity of cocaine both as an adjunct, in addition to as the primary substance being misused, shows a need for services to be aware of and have a strong pathway for treatment.

Drug related harm in Merton

Drug harms can range from death due to an overdose, a particular risk in opiate users, or preventable conditions such as bloodbourne infections. Nationally, there has been significant concern for the rising number of deaths in treatment, especially for opiate users, and a call to make the opiate antidote medicine naloxone more widely available as a preventative measure. Although the numbers of drug related deaths locally have previously fluctuated and numbers remain small, 2015-16 was the first year that they surpassed 1% of all deaths in the treatment, raising concerns that preventative measures such as naloxone need to be more widely adopted.

Harm reduction policies such as needle and syringe exchange programmes and vaccination can reduce the spread of bloodbourne infections. The proportion of new clients to treatment being vaccinated for blood borne viruses is poorer in Merton than nationally with less than a quarter (22%) of eligible clients accepting Hepatitis B Vaccination (HBV) and less than half completing the course. Similarly, over a quarter of previous, or currently injecting, clients in treatment eligible for the hepatitis C vaccination (HCV) did not received one indicating a lost opportunity for harm reduction.

Drug related harm from crime can be categorised as drug offences or acquisitive crime to fund substance misuse. The CSEW estimates 2,518 drug related crimes are committed annually in Merton

where in 19% of violent incidents the victim believed the offender(s) to be under the influence of drugs. Engaging offenders in treatment services is vital to prevent reoffending and potentially reduce crime rates.

Merton substance misuse treatment population

Nationally opiate clients form the largest group in treatment, although alcohol only clients form the largest group in Merton. The Merton treatment population consist of significantly fewer number of clients than the estimated population of alcohol and drug users presented and reasons for the poor penetration of treatment services into the substance misuse population may be due to limitations in accessibility or approachability of the service.

Consultations with service users identified that "*word-of-mouth*" remained the main way of finding out about services and more efforts can be made to inform and advertise about services. Stakeholders identified that the normal working hours services operated in were not reflective of their target population and they also emphasised the lack of targeted approach to ethnic minorities to cater for language and cultural differences.

Service users also argued the lack of childcare facilities limit mothers access to services and more effort to engage families is necessary. A PHE workshop held to discuss the roles of families in substance misuse highlighted that outcomes deteriorate when children are taken away. They reported although *"family member's lives are disrupted"* children are not represented in services and children may be exposed to potentially traumatic events early on or take on carer roles at a young age.

The main route by which referrals are made to treatment services were recorded as 'self, family and friends', and of great concern there has been a reduction in referrals from the criminal justice system for all substance groups. Merton refers a lower proportion of drug and alcohol clients from most criminal justice system referral pathways compared to the rest of London, which may result in an increased likelihood of untreated clients reoffending. Moreover, of the 66 substance misuse clients leaving prison in the Merton treatment population, only 9% successfully engaged in community-based structured treatment following release, and consultation with stakeholders revealed a perceived fragmentation of the criminal justice system leaving gaps in referrals and follow up.

Recovery factors

Housing, education, employment, and training are key factors in promoting and maintaining recovery. In Merton opiate users tend to report the highest percentage of urgent housing problems, which has implications on treatment outcomes and access to services without a fixed address.

Employment has been found to moderate drug use, whilst successful drug treatment improves the likelihood of achieving positive employment outcomes. In Merton over half of new presentations to drug services are unemployed or economically inactive clients, higher than the national proportion, and this is worse at treatment exit stressing an acute need to align treatment with opportunities to increase employment.

Consultation with service users about training during treatment highlighted the challenges faced by users who report they "*need to get the self-esteem to get out there and do stuff*" and a reliance on peer support to develop day to day functionality in the initial stages of recovery. 'Recovery champions' who have completed treatment and now work as recovery supporters were identified as

a protective factor for individuals who report "*for my recovery I feel I need to help others*", whilst providing an aspiration for those in the earlier stages of treatment.

2. AIMS

The SMHNA aims to provide analysis of current adult substance misuse needs and identify health inequalities and unmet needs.

It also intends to inform a strategic framework to redesign and develop services with updated evidence and policy guidance.

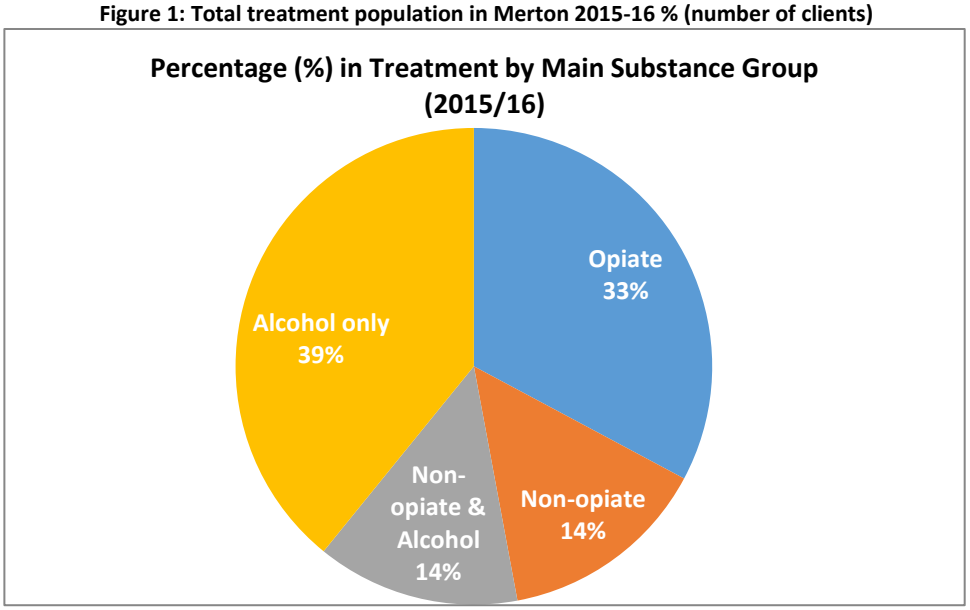
3. OBJECTIVES

- To provide a descriptive analysis of adult substance misuse needs in Merton to include patterns of substance misuse, health harms and hospital admissions, and impact on crime.
- To provide a descriptive analysis of local modifiable factors that contribute to treatment success including education, training, employment, and housing.
- To describe the extent of health inequalities or unmet needs in the substance misuse population
- To describe the policies and evidence base for adult substance misuse services

4. BACKGROUND

Merton has a total estimated drug population prevalence of 5,548 frequent users (defined as used in the last month) and a refined estimated alcohol population prevalence of 1,837 (defined as dependent drinkers in need of specialist assessment and treatment)[1]. In comparison, the total population of drug and alcohol clients in treatment was 631 in 2015-16 as displayed in Figure 1. The largest group in the population was alcohol only clients (39%), and the drug treatment population was split almost evenly between opiate and non-opiate clients (with or without alcohol misuse).

Figure 1: Total treatment population in Merton 2015-16 % (number of clients)



[1] Details of how estimates were calculated can be found in the relevant sections.

5. METHODOLOGY

5.1. General

Local, regional and national data was analysed for trends and summarised alongside national policy documents in the writing of this health needs assessment. Key data sets included those published by the National Drug Treatment Monitoring System (NDTMS) and the Local Alcohol Profiles by Public Health England (PHE). National surveys used included Crime Survey in England and Wales (CSEW) and Health Survey for England (HSE). Data sets were in turn explored for alcohol and drugs to give the local context.

Policy guidance was predominately obtained from two substantial evidence reviews published by PHE on alcohol harms and policy solutions, and drug treatment and recovery systems.

Stakeholder engagement was carried out through consultations conducted with service providers, partners, and users respectively. Service providers and partners were engaged through a multidisciplinary workshop delivered by London Borough of Merton (LBM) public health where providers were grouped with partners from all aspects of the criminal justice system, mental health services, National Health Service (NHS) trusts, primary care, pharmacists, Merton Clinical Commissioning Group, LBM substance misuse commissioning team, and service users in recovery.

Additional service user engagement was instigated through a focus group conducted with consent at a weekly group meeting where users in all stages of the treatment journey, in addition to carers, were present for the session.

Findings were presented in this report with recommendations to inform the adult substance misuse strategic framework for the London Borough of Merton Public Health team.

5.2. National policy and guidance documents

Commissioned by the Department of Health, Public Health England (PHE) were asked to carry out two extensive evidence reviews, the first on alcohol harms and policy solutions, and the second on drug treatment and recovery systems, with the intention of informing future policy. These documents, referred to in this SMHNA summarise the current evidence in the UK context, and offer policy options and the evidence base behind them.

The report on 'The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies' presents trends in alcohol consumption and summarises alcohol related health harms, impact on family, employment, and crime, as well as exploring alcohol control policies across the UK.

In comparison, 'An evidence review of the outcomes that can be expected of drug misuse treatment in England' explores the harms to individuals and society that drug treatment reduces, and compares treatment in England to international treatment systems. It also explores the impact of housing, employment, and deprivation on treatment outcomes before exploring what outcomes are most appropriate to measure success.

These reports were used at aids to extrapolate the local harms of substance misuse, identify areas where Merton was doing better or worse than the national picture, and explore polices that can be locally adapted.

5.3. National data sets and reports

Substance misuse services have a long history of structured data collection, and The National Drug Treatment Monitoring System (NDTMS) is the body that collects regular activity and performance data from all public drug treatment services in England. Local drug treatment agencies are required to submit reports on 'core data' monthly, and these reports are collated by NDTMS and used to report on a wide range of outcomes and indicators, both nationally and locally.

Reports published from NDTMS data set and used in this SMHNA include the quarterly Diagnostic Outcomes Monitoring Executive Summary (DOMES) which reports on recovery measures and associated variables and the annual PHE local trend reports, which focus on nine key areas of the dataset. We also used the PHE's Local Alcohol Profiles for England, which include data on alcohol health harms and admissions collected from a range of sources.

The datasets provided contextual information with national and regional figures that we were able to compare to the Merton figures to gain a better understanding of how the borough fits in with the national picture.

5.4. Table of key sources

Key source	Publisher	Commentary
The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies. 2016.	Public Health England	An extensive evidence review which provides an overview of alcohol related harm and analyses the evidence for possible policy solutions.
An evidence review of the outcomes that can be expected of drug misuse treatment in England	Public Health England	An objective assessment of the research evidence on what drug treatment outcomes are achievable and future needs.
Crime in England and Wales: year ending June 2016	Office for National Statistics	An annual survey that monitors the extent of crime in England and Wales and is used by the Government to evaluate and develop crime reduction policies.
Health Survey for England 2014	NHS digital (previously called Health and Social Care Information Centre)	A national survey that uses randomly selected postcodes to sample a proportion of the population on health and lifestyle behaviours through a mixture of interview and questionnaires.
Diagnostic Outcomes Monitoring Executive Summary (DOMES)	The National Drug Treatment Monitoring System	A quarterly publication which reports on recovery measures and associated variables.
Local Area Trend Reports for Merton, London, and Nationally	Public Health England	Datasheets constructed on the trends in drug and alcohol treatment profiles and outcomes at local authority, PHE Centre, and national level. It focuses on nine key areas from the Adult NDTMS National Statistics publication for 2015-16 as well as trend data from 2009-10 to 2015-16.
JSNA Support pack 2017-	Public Health	Data support packs that present local key

18- Key data **-Drugs** **-Alcohol**	England	indicators and recovery outcomes information and compare it to the national data. It presents 2015-16 data from NDTMS, the Treatment Outcomes Profile (TOP), drug and alcohol related death data, and hospital admission data. It aims to aid planning for effective drugs prevention, treatment and recovery in 2017-18.
JSNA support pack 2017-18: commissioning prompts **-Drugs** **-Alcohol**	Public Health England	Two separate documents produced to outline six principles, that should be consider in local plan development to achieve an integrated alcohol and drugs prevention, treatment and recovery system. The principles have prompts to help put them into practice.
Local Alcohol Profiles for England	Public Health England	Profiles present data collated from range of sources (including the Department of Health, Office for National Statistics, and the Home Office) on alcohol health harms, admissions, and other indicators.

6. POLICY CONTEXT

Alcohol

Polices for alcohol can be broadly divided into those that influence affordability, availability, or acceptability[2].

High grade evidence supports policies that reduce the affordability being the most effective, and cost-effective way of promoting prevention and health improvement for alcohol abuse. This could be through increasing taxation, or more specifically through minimum unit pricing, which has the additional benefit of targeting the heaviest drinkers who experience the greatest harm by ensuring the price is paid by the customer. Legal challenges on the grounds of impeding the free movement of goods that the Scottish government has faced have shown the resistance against implementation of this policy that has been recognised as being more effective than taxation at "protecting life and health… while being less restrictive of trade" (1).

Availability is largely impacted through licensing, and there is moderate evidence to show placing restrictions on the days and hours of sale and the types of alcohol available (e.g. alcohol by volume strength (%) restrictions) can reduce alcohol related harm and be effective in targeting those more at risk.

Finally, multiple stakeholders play conflicting roles in influencing the acceptability of alcohol. It can be influenced by an advertising ban, although complete bans have been hard to impose historically. The focus tends to be on education such as Identification and Brief Advice (IBA) as part of the treatment package. IBA involves a short screening questionnaire, followed by personalised advice

[2] Policy evidence based summarised from the presentation 'Alcohol Evidence Review' Alison Keating, Head of PHE London Alcohol and Drugs Team given at the Substance Misuse Commissioning Managers Forum, 13th January 2017.

and information given in a brief session, with the potential to link into other services where needed. It has been found to be most effective in primary care settings, and have a small to moderate benefit in emergency department settings.

Drugs

Due to the diversity of the substances encountered in drug treatment services, policies must reflect the changing treatment population. Policies may effect prevention, treatment, recovery, or a combination of the three.

Policies to prevent drug-related harms such as needle & syringe exchange to reduce the spread of bloodbourne viruses; provision of naloxone to prevent death by opioid overdose; and confidential testing for blood borne viruses and tuberculosis in this high risk population, are key to limiting the extent of health harms.

Treatment systems should have sufficient capacity to address the needs of the estimated local dependent population (to include community, specialist, and prison settings) and attract all potential service users. Additionally it is key that systems must have the ability to respond rapidly and effectively to changing patterns of alcohol and drug misuse, such as the increasing trend of New Psychoactive Substances (NPS, drugs that are designed to replicate the effects of other illegal substances (2)) and chemsex (the use of a combination of drugs before or during sex by men who have sex with men (3)).

It is widely recognised that key components in promoting and sustaining recovery, and potentially reduce drug-related crime, are housing, education, and employment. The Dame Carol Black Review, commissioned by the government to review how best to support benefit claimants with potentially treatable conditions, looked at how to sustain recovery in substance misuse to encourage claimants back into the workforce. The independent report concluded that the government should support benefit claimants with an addiction to recover by encouraging, but not mandating treatment services (4).

The policies most applicable and implementable in the Merton treatment population and substance misuse services will be explored in further detail in this report.

7. PATTERNS OF ALCOHOL CONSUMPTION

7.1. National guidelines

Drinking patterns can be influenced by socioeconomic and demographic disparities. National guidelines on what is considered an appropriate level of alcohol consumption is periodically reviewed, and in 2016 the Chief Medical Officer (CMO) issued new guidelines which provide the most up to date scientific information on what is considered low risk drinking to enable the public to make informed decisions about their own drinking.

The guidelines cover three recommendations:

Weekly drinking

For adults that drink regularly or frequently (most weeks) the guidance for males and females is to drink no more than 14 units a week on a regular basis. To keep the health risks from alcohol to a low level it is advised that the units are spread evenly over 3 or more days, as one or two heavy drinking

episodes a week increases the risk of death from long term illness, accidents, or injuries. Furthermore, the risk of developing a range of health problems, including strokes and cancer, proportionally increases as the amount of alcohol consumed increases, and so several drink-free days a week are advised to limit the harms.

Single occasion drinking episodes

For people who drink within the weekly guideline, or those who drink at higher levels, there are short term health risks associated with drinking too much or too quickly on a single occasion. Recognising this it is advised that during a single drinking occasion the total amount of alcohol consumed should be limited and consumed slowly, with food, or alternating with water. Additionally, the impaired judgement in a single drinking occasion can cause accidents resulting in injury (e.g head injuries, falls and fractures), misjudgement of risky situations, and loss of self-control (e.g. engaging in unprotected sex). These risks can be mitigated by avoiding risky places and activities, planning for the return journey home, and being with other known individuals. Young people, those at risk of falls, those taking medications that interact with alcohol, and individuals where alcohol exacerbates pre-existing physical or mental health problems are at a high risk of increased harms from a single drinking occasion.

Pregnancy and drinking

For pregnant women or those planning a pregnancy, the advice given is that the safest approach is not to drink alcohol at all to keep risks of long-term harm to the baby minimal. Women who consumed small amounts of alcohol in pregnancy, or before they were aware they were pregnant, are reassured that the risk of harm to the baby is small, but they are advised to avoid further drinking as the harm to the mother and the baby increases as the amount of alcohol consumed increases.

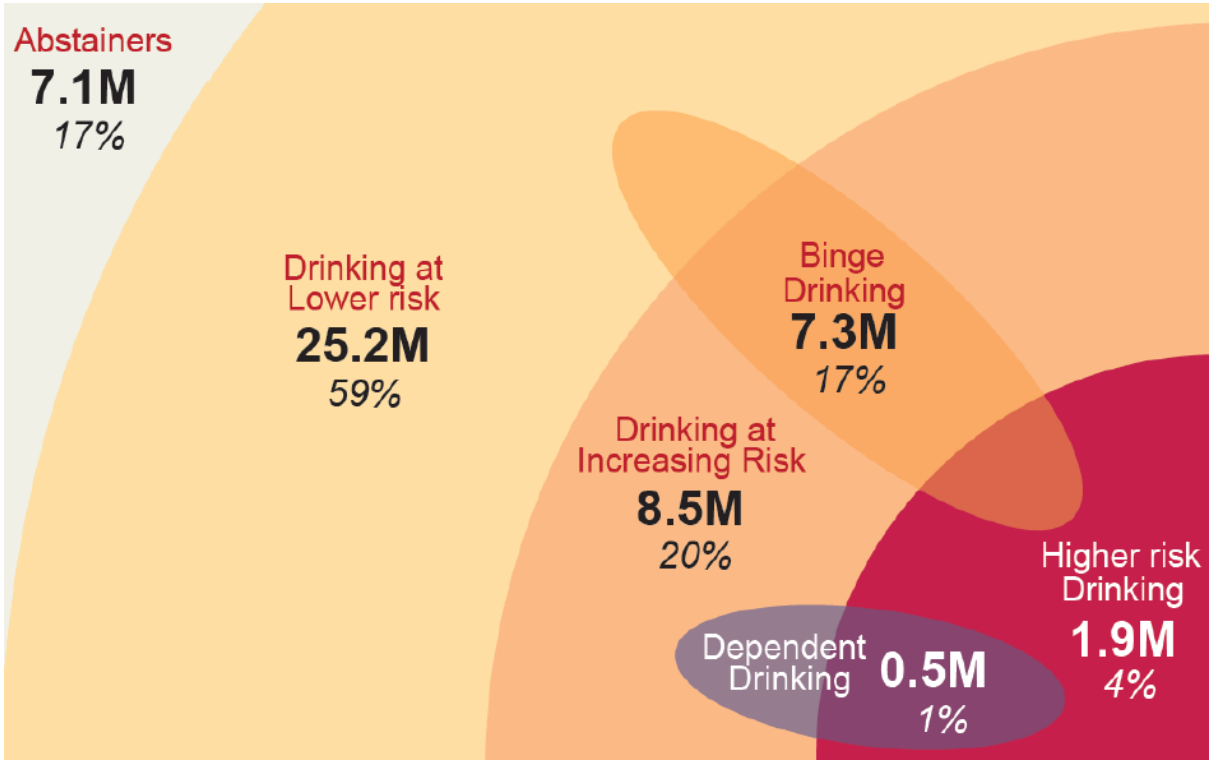
7.2. National patterns of alcohol consumption

7.2.1. Definition of levels of alcohol consumption

PHE provided updated estimates of the prevalence of alcohol consumption in England in their comprehensive review (5). The estimates are based on the national Health Survey for England (HSE) conducted in 2014. The survey uses a mixture of interview and questionnaires on a sample of the population randomly selected by postcode, to enquire about the type and frequency of beverages consumed. The standardised method for converting beverages to units has been agreed in UK surveys since 2007.

Data from the surveys was grouped as follows: in line with the CMO's guidelines under 14 units of alcohol per week was classified as **lower risk**, with **increasing risk** defined as up to 35 units per week for women and 50 units per week for men. The **higher risk** category included women drinking above 35 units and men drinking above 50 units per week. Additionally, **binge drinking** was defined as consuming over 6 units for women, and over 8 units for men, on the heaviest drinking day in previous week. Finally, using the results of the AMPS, a nationally-representative cross-sectional survey of individuals in private accommodation aged 16 or over, a **dependant** drinking group was categorised. The distribution of the population in England in these groups is depicted in **Figure 2** below.

Figure 2 The distribution of drinkers in England, 2014



The distribution highlights that the majority of the population (25.2 million) report drinking at lower risk, and targeted advice about single occasion drinking (binge drinking), drink-free days, and the increased risks of exceeding the number of units consumed would be the priority in this group. Of growing concern, a fifth of the population report drinking at increased risk, with a proportion of those individuals binge drinking, or being dependent drinkers. This group is exposed to greater health harms, and as the units consumed increases to the higher risk group, the harms also increase.

The binge drinking and dependent drinking groups, both of whom are exposed to greater risk of alcohol harms, identify a need to target associations of high volume risk drinking, e.g. mental health and drinking culture (to include serving portions, marketing offers, and the night time economy).

Furthermore, the limitations of such surveys in underestimating population level alcohol consumption, indicates that a greater proportion than represented above is drinking at increased risk and subsequently exposed to greater health harms. The reasons such surveys are likely underestimations is twofold. Firstly, the surveys target adults in private households, and so outreach to the groups that are likely to drink more, and may have a more chaotic lifestyle with less stable housing, are limited. Secondly, individual respondents are likely to underestimate what are considered socially undesirable behaviours, and may self-exclude irregular drinking occasions such as holidays in their estimates.

7.2.2. National trends in patterns of alcohol consumption

Given the limitations of survey data, in order to get a more holistic picture of alcohol consumption it is worth considering a less subjective measurement such as duty and tax records when describing national trends in alcohol consumption. The volume of alcohol sold nationally peaked in 2008 before slowly declining (calculated from Her Majesty's Revenue and Customs (HMRC) duty and tax receipts) and an increasing proportion of the population has emerged as abstinent from alcohol (17% of survey respondents reported being abstinent in the HSE 2014) (5). The juxtaposition between the

growing proportion of an abstinent population and the drinking population makes it difficult to interpret the fall in consumption since 2008 (5). Nevertheless, over 10 million people nationally have been identified as drinking at levels that increase their risk of health harms and so the case is made for public health actions, with reducing harmful drinking being one of PHE's priority areas (6). Outreach to engage individuals at risk is key, as nationally only a proportion of those with alcohol misuse will present to treatment, and after a peak in new presentations to treatment in 2013-14 there has been a gradual decline since (7).

7.3. Merton estimated levels of alcohol consumption

Based on the national figures presented above, and categorised by the same definitions, the local estimated prevalence of alcohol consumption was calculated using the ONS mid-year population estimate (Table 1). In line with the year the survey was conducted the 2014 mid-year population estimate of adults 18 years and over was 157,875 adults.

Table 1: Alcohol consumption prevalence in Merton

Alcohol consumption prevalence in Merton					
Consumption	Abstain	Lower risk	Increasing risk	Higher risk	Binge drinking
National prevalence (%)	17%	59%	20%	4%	17%
Local prevalence (persons)	26,839	93,146	31,575	6,315	26,839

The majority of adults in Merton consume alcohol. Over half are considered to be drinking at lower risk (<14 units weekly), although given the limitations of the estimates described above, a proportion of those individuals are likely grouped with the almost 38,000 individuals estimated to be drinking at increasing or higher risk. Another national study commissioned by PHE to provide updated estimates of the number of adults with alcohol dependence, analysed the AMPS 2014 in conjunction with two alcohol screening tools (Alcohol Use Disorder Test (AUDIT) and Severity of Alcohol Dependence Questionnaire (SADQ)) to provide refined 2014-15 point estimates at upper local authority level (8). The study provided the refined estimate that there were 1,837 adults in Merton with alcohol dependence in need of specialist assessment and treatment. This figure is strikingly different from the treatment population of 334 individuals known to alcohol services as alcohol only or non-opiate and alcohol clients in 2015-16 and the difference signifies an unmet need in Merton. Whilst the lower risk population would not necessarily need to engage with services and IBA would be a sufficient intervention, those at higher risk (drinking over 35 units for females and 50 units for men) and dependent drinkers would certainly be candidates. Better understanding of why treatment numbers are so much lower, taking into account the current outreach and penetration of services, as well as whether services have capacity to accommodate such numbers needs to be considered.

The 17% of the population who report binge drinking (single occasion drinking) are at increased risk of harm to themselves and others. In addition to the short term health harms explored above, binge drinking is associated with antisocial behaviour such as vomiting or urinating in the street, fights, noise, and littering that impacts local residents. Locally in Merton, the west of the borough has a thriving night-time economy, and individual residents, as well as resident organisations regularly complain of the impact of antisocial behaviour by intoxicated individuals and object to alcohol license applications. In comparison, residents in the more deprived east of the borough complain of street drinking and the antisocial behaviour associated with that. In both cases, binge drinking has

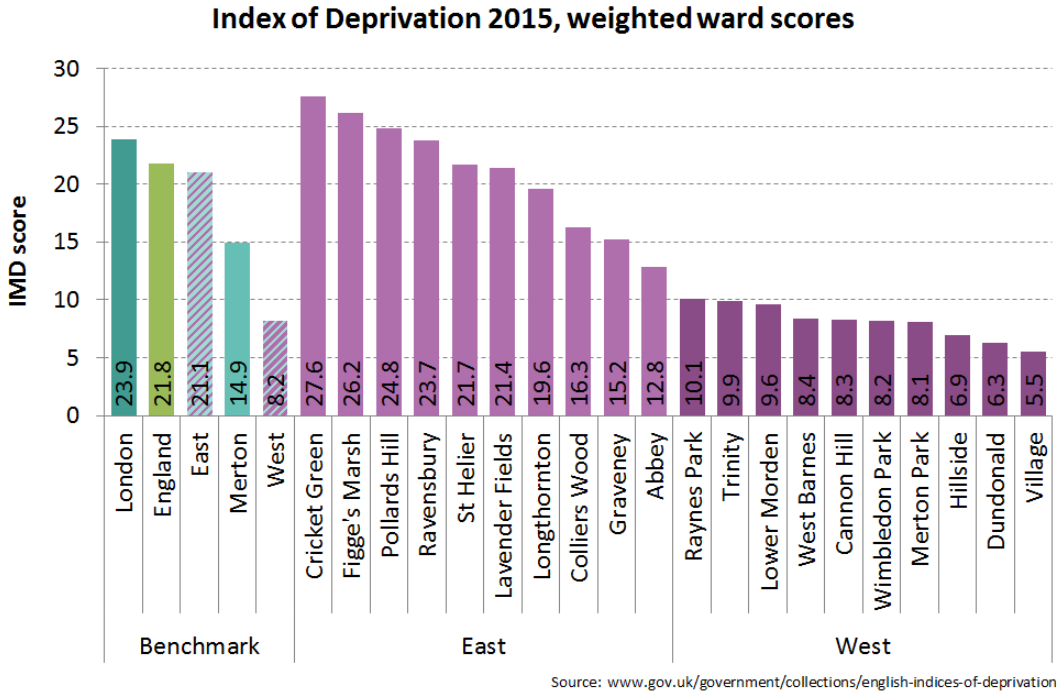
led to antisocial behaviour affecting local residents which will be explored further in this report. Sculpting the environment to limit this through planning and licensing, in addition to ensuing affected individuals receive appropriate screening, advice, and treatment where appropriate, is important in resolving the issue.

7.4. Patterns of alcohol consumption by social economic groups

The proportion of men and women who drink increases as neighbourhood deprivation decreases i.e. the highest rates of alcohol consumption are in the least deprived areas. However, the evidence indicates that lower socioeconomic groups are more likely to die or suffer from a disease relating to their alcohol use even though they often report lower levels of average consumption than their less deprived counterparts (5). Possible explanations for this phenomenon known as the alcohol harm paradox include drinking patterns such as increased binge drinking in lower socioeconomic groups; lower resilience; increased risk factors or co-morbidities; and differential access to healthcare.

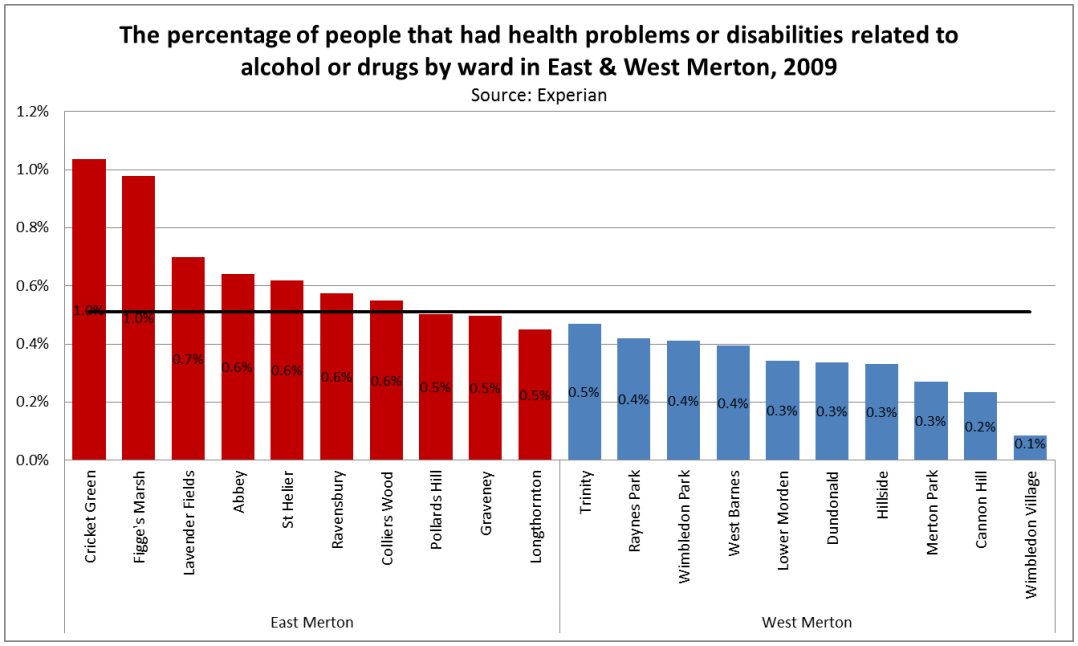
The spread of deprivation in Merton is shown in Figure 3 below. Indices are presented across the 20 electoral wards and highlighting the difference in deprivation between the east and west of the borough. Index of deprivation is calculated by weighing indicators across seven domains (income; employment; education, skills & training; health & disability; crime; housing and services; and living environment deprivation). Similarly, Figure 4 created from Experian data (local survey results based on a market software system) shows the percentage of people reporting health problems or disabilities related to alcohol across the Merton wards, which replicates the same pattern as seen with index of deprivation, with the more deprived wards reporting the highest percentage of alcohol related health harms. This uneven distribution of health harms, paradoxically not reflective of the amount of alcohol consumed indicates an unmet need in these areas and an increased burden of disease. To counter this appropriate resource allocation and adequate access to services combined with a focused preventative approach will help reduce the health inequalities across the borough.

Figure 3: Index of Deprivation across the London Borough of Merton



Source: www.gov.uk/government/collections/english-indices-of-deprivation

Figure 4: Distribution of health problems and disabilities related to alcohol and drugs by Merton ward



7.5. Age, gender and ethnicity

The HSE survey 2014 also found that there were gross disparities in alcohol consumption between ethnicities, as shown in Figure 5, and age as shown in

Figure 6. The national survey provides a good source of information as there is limited local data to demonstrate this.

The lowest proportion of abstinence was found in people identifying as white ethnicity (less than 10% of men and 15% of women remaining abstinent). Comparatively, approximately 40% of people identifying as black were abstinent, and the highest proportion of abstaining individuals identified as Asian in ethnicity, where this was even higher for females in comparison to males (55%).

Figure 5: The proportion of people who do not drink alcohol by race and gender (%), England 2014

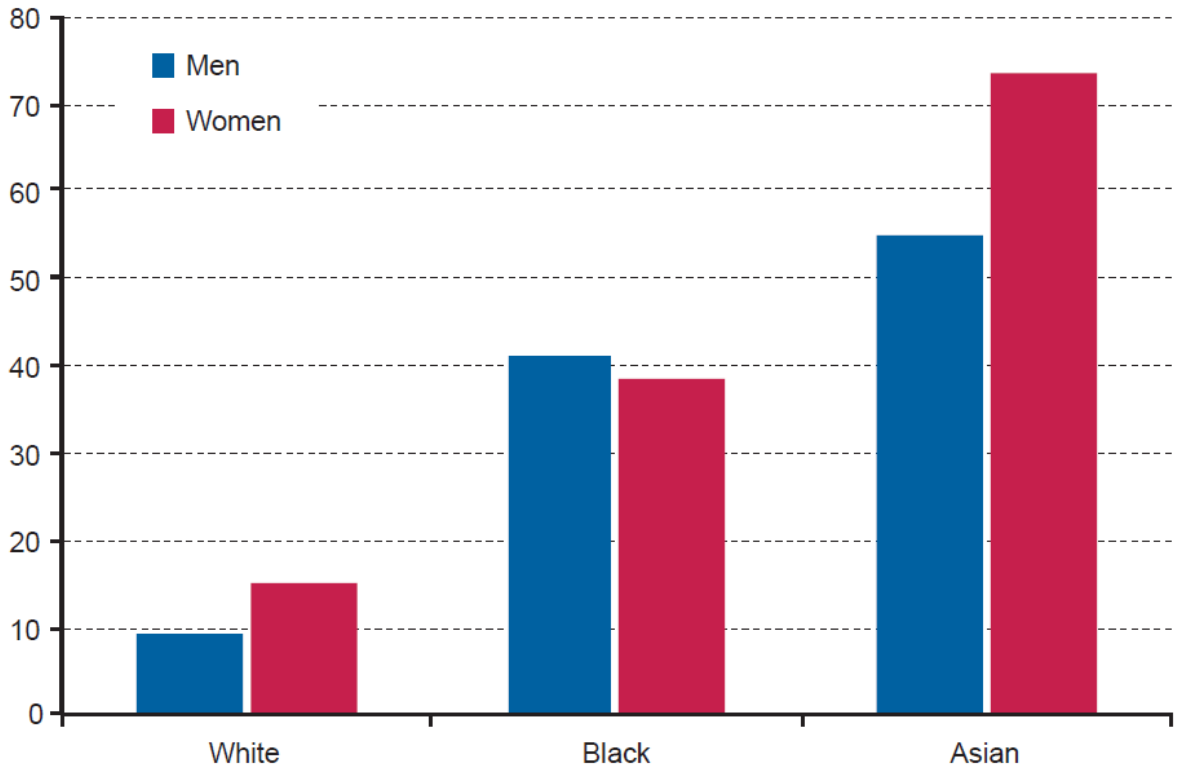
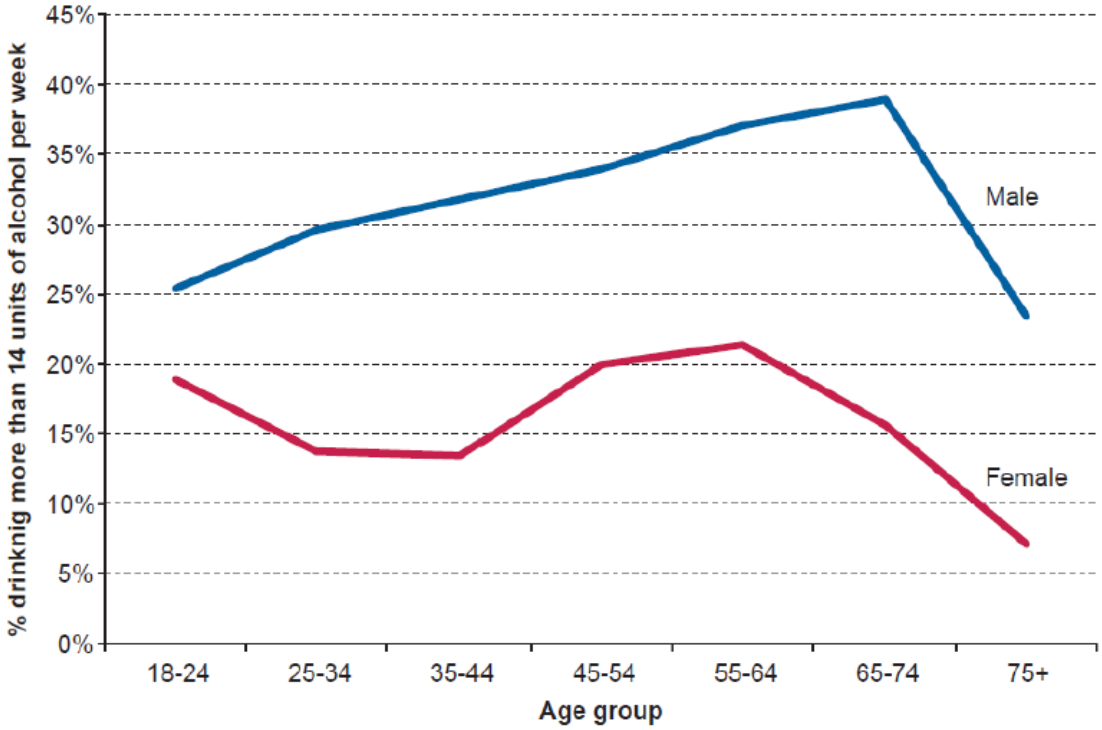


Figure 6: The proportion of adults drinking more than 14 units of alcohol per week by age and gender, England, 2014



8. Alcohol related harm in Merton

8.1. Alcohol attributable hospital admissions & mortality definitions

Alcohol misuse has considerable harms on an individual level, those around the individual, and at a population level. We will cover some of these harms in the following sections.

The health harms caused by alcohol can be grouped into conditions caused by alcohol, known as **alcohol-specific conditions**, and **alcohol-related conditions** where alcohol is implicated in some but not all cases of the condition. Hence, alcohol-related conditions naturally include all alcohol-specific conditions in addition to those where alcohol is not the only cause. To illustrate alcohol induced behavioural disorders is an alcohol-specific condition and would also be included in data on alcohol related condition, whereas hypertension (high blood pressure) can only be considered as an alcohol related condition as the harm attributed by alcohol is a fraction of the disease causation.

To gain more detail about admissions for alcohol-specific and alcohol-related conditions they can be further broken down into their **broad** or **narrow** definitions. As it would imply, **broad** measures include those where the primary or secondary diagnosis was recorded as an alcohol-related disease, injury or condition and is useful to measure the total burden alcohol has on the community and health services. In comparison, **narrow** measures are admissions where the primary diagnosis is recorded as an alcohol-related disease, injury or condition, or the secondary diagnosis is an alcohol related external cause. The narrow definition is less sensitive to changes in how diagnoses are recorded, enabling a fairer comparison of harm levels across time and place.

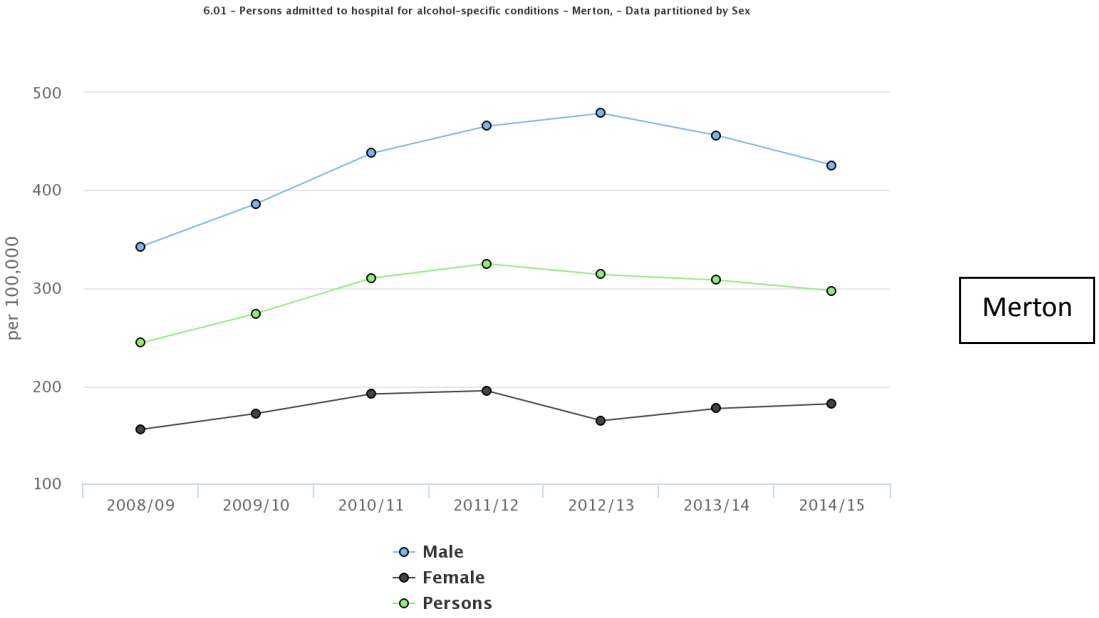
Mortality is similarly grouped with alcohol-specific mortality including all deaths where alcohol was the cause (e.g. alcoholic liver disease), and alcohol-related mortality which includes both deaths due to alcohol as well as those where alcohol played a role but was not the only casual factor (the fraction attribute to alcohol is taken into consideration).

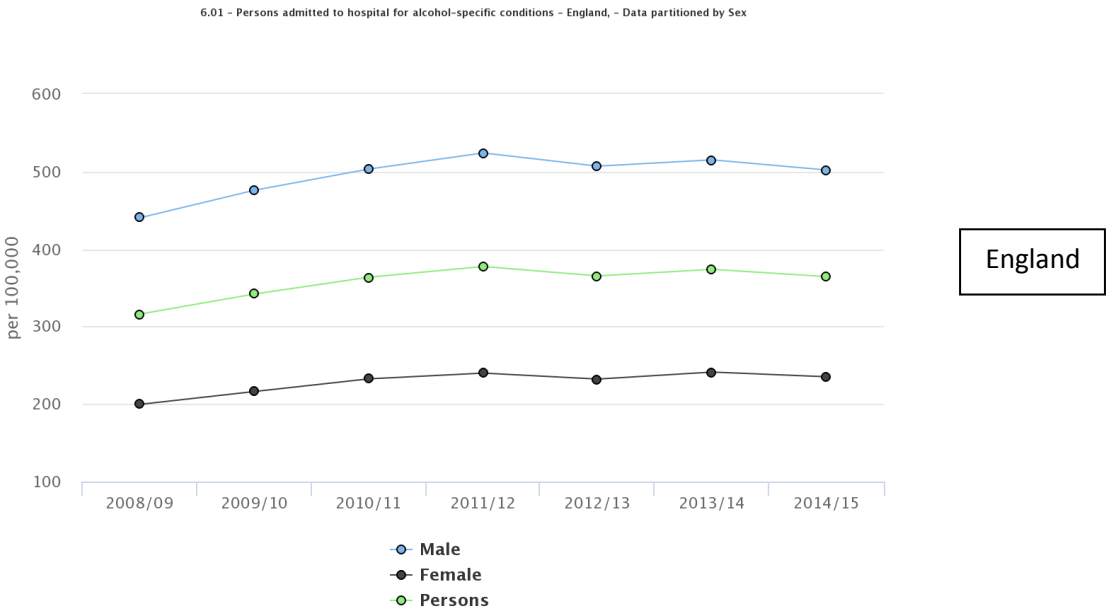
8.2. Trends and pattern of alcohol hospital admissions

Trends can be in comparison to London or national figures, as well as by comparing harms in neighbourhood groups that are categorised on a four-point scale (lowest, lower, higher, and highest). Neighbour groups are 15 other areas that are similar across a range of demographic, socio-economic and geographic variables.

In 2014-15 Merton had better values of hospital admissions for alcohol-specific and alcohol-related conditions than England, but had higher levels of harm than neighbouring groups for the narrow definitions of alcohol-related hospital admissions (9). This amounts to 398.8 persons admitted to hospital for alcohol-related conditions per 100,000 persons, indicating an increased burden of admissions locally in Merton.

Looking at this trend over time, the graphs below from the PHE Local Alcohol Profiles (10) show a clear peak in male admissions for alcohol specific conditions in Merton in 2013/14 that was not experienced nationally.



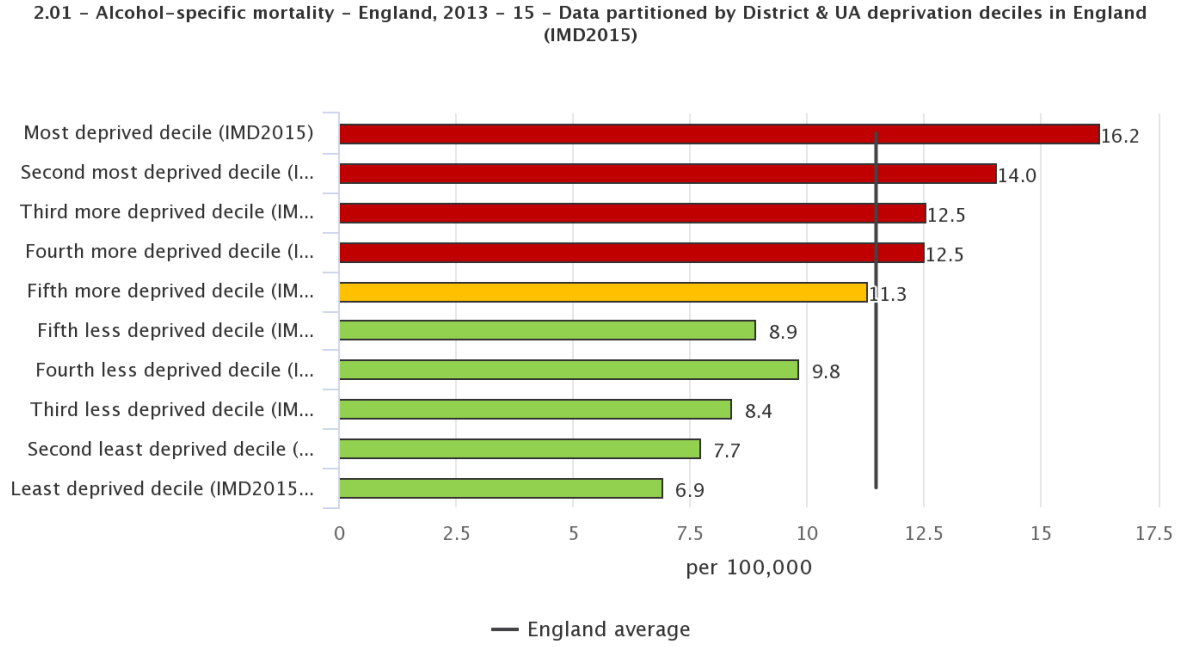


Gender disparities are further revealed with more detailed indicators, which highlighted that men experience the highest amount of harm compared to neighbouring groups for alcohol admissions for mental and behavioural disorders (124.2 per 100,000 admission episodes for mental and behavioural disorders due to use of alcohol), and admissions for intentional self-poisoning (21.8 per 100,000 admission episodes for intentional self-poisoning by and exposure to alcohol) (9). In comparison, females in Merton experience the highest amount of harm compared to neighbouring groups for admissions of alcoholic liver disease conditions (84.3 per 100,000 admission episodes for the broad definition of alcoholic liver disease condition) and alcohol related cancer incidence[3] (37.8 per 100,000 Incidence rate of alcohol-related cancer (9). These figures show that there is unmet need in both genders, with a need for more targeted mental health services that focus on prevention to cater for males, and a more medical approach for females which must be coupled with prevention to reduce the incidence of alcoholic liver disease and alcohol related cancer.

Alcohol specific mortality in Merton (10.2 per 100,000 European standard population) between 2013-2015 is similar to the England average (depicted below), but worse than neighbour groups and the London average of 8.7 per 100,000 European standard population. For alcohol-related mortality Merton has a similar rate to London (39.9 and 41.9 per 100,000 respectively), but fares worse than neighbour groups, where Merton clients experience the highest amount of harm for alcohol-related mortality (0.42 months of life lost due to alcohol). These figures shows that there is an increased mortality experienced in Merton due to alcohol, be it related or specifically, compared to neighbouring groups.

As illustrated below for England, the higher mortality rates are overwhelmingly experienced in the more deprived area which in Merton tend to be based in the east of the borough, where this is a lower IMD, and hence have increased need for targeted substance misuse services.

[3] Directly Age Standardised Rate of Alcohol related cancer incidence per 100,000 European Standard Population, calculated for 2012-14.



8.3. Alcohol related crime

In addition to the health harms posed by alcohol, crime associated with drinking may also harm the individual, the people around the individual as well as society as a whole. Alcohol is implicated in both violent and impulsive crime as well as less serious crime such as noise disturbance, littering and anti-social behaviour that may impact an area significantly (5). Crime may occur in public areas e.g. drinking establishments, and public places e.g. drink driving in vehicles, or in private areas, impacting victims known to the individual such as their partner or children (including domestic violence), or other drinkers and/or or non-drinkers in the area.

For public crimes, levels of public violence and disorder are associated with the number of pubs and clubs concentrated in an area and time of day. An increased number of premises are associated with increased levels of violence and public disorder, which are most likely to occur on weekend nights (5).

Due to the nature of offences ranging from very serious to less serious crimes, not all offences are recorded, and hence estimating the extent of crime is difficult. The CSEW found that in the year ending 2016 in 40% of violent incidents the victim believed the offender(s) to be under the influence of alcohol, the lowest proportion recorded in the last decade of survey's (11). Similarly, a recent local survey highlighted that an average of 41% of residents in Merton report being very worried or fairly worried about people being drunk and rowdy (12).

Using the local Merton data from the CSEW, there were a total of 13,251 crimes committed from October 2015- September 2016, 40% of which would amount to approximately 5,300 alcohol related crimes in the year, a likely underestimate of the extent to which alcohol impacts on the community.

Certain types of crime can be controlled through premises licensing and the creation of a cumulative impact zones in saturated areas to limit the number of additional licenses approved. Aligning

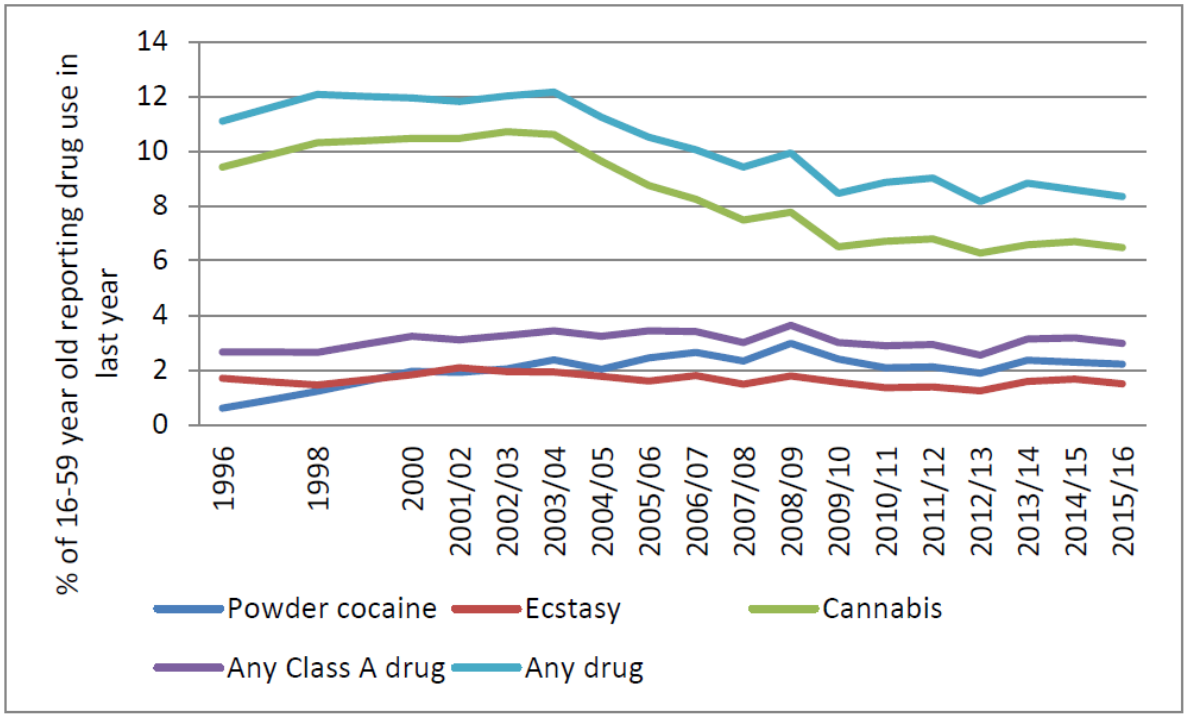
outreach services with crime time and date patterns may also reduce re-offences by having adequate staff that are able to refer clients from criminal services into substance misuse services.

9. Patterns of drug misuse

9.1. National estimates of drug misuse

The CSEW (13) also provides a source of data on national prevalence rates of drug misuse. As illustrated in Figure 7, 8.4% of the population report taking a drug in the last year with Cannabis being the most popular drug, and Class A drugs coming second. The percentage of individuals aged 16-59 reporting use of Class A drugs has remained stable over the past two decades, and there has been a decline in the percentage reporting any drug use.

Figure 7: Percentage of individuals aged 16-59 reporting use of illicit drugs in the last year (England and Wales)



9.2. Merton estimates of drug misuse

Local population estimates can be extrapolated from the national CSEW prevalence rates. Estimates of the number of adults in Merton using drugs are set out in Table 2 below and are calculated using the ONS mid-year population 2015 estimate of adults 16-59 years of age (129,034 adults).

Table 2: Estimates of drug use prevalence in Merton (adults 16 years and over)

Drug type		Drug use in the last year	
		National proportion of adults aged 16-59	Estimated proportion in Merton[4]
Any class A Dug			
Crack cocaine, cocaine, ecstasy (MDMA), heroin, LSD, magic mushrooms, methadone, and methamphetamine		3.00%	3,871
Any stimulant drug			
Powder cocaine, crack cocaine, ecstasy, amphetamines amyl nitrite, and methamphetamine		3.30%	4,258
Any drug taken			
Powder cocaine, crack cocaine, ecstasy, LSD, magic mushrooms, ketamine, heroin, methadone, amphetamines, methamphetamine, cannabis, tranquillisers, anabolic steroids, amyl nitrite, any other pills/powders/drugs smoked	Any drug (taken in last month)	4.30%	5,548*
	Any drug (taken in last year)	8.40%	10,839
	Any drug (taken in lifetime)	35.00%	45,162

*Taking drugs within the last month is used as a proxy to estimate the active drug population

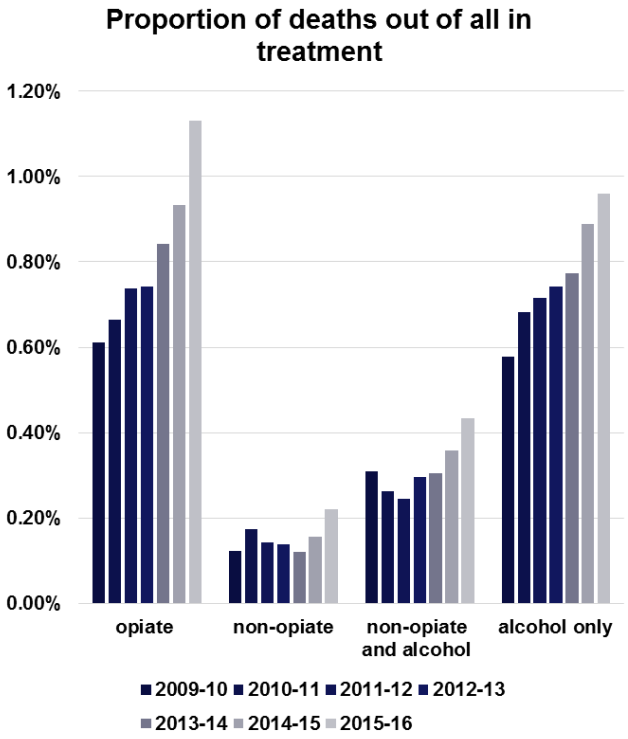
Whilst over a third of the 16-59 year old population have taken drugs at some point in their lifetime, a smaller proportion are more frequent users have taken drugs in the last month. The drug classification system attempts to risk assess harms from drugs and issue penalties correspondingly, with Class A drugs being considered the most harmful. The roughly 4,000 adults who have used Class A drugs in the last year would be the group of key concern to engage in substance misuse services to meet their needs and reduce harms and crime.

10. DRUG RELATED HARM IN MERTON

10.1. Trends in drug-related deaths

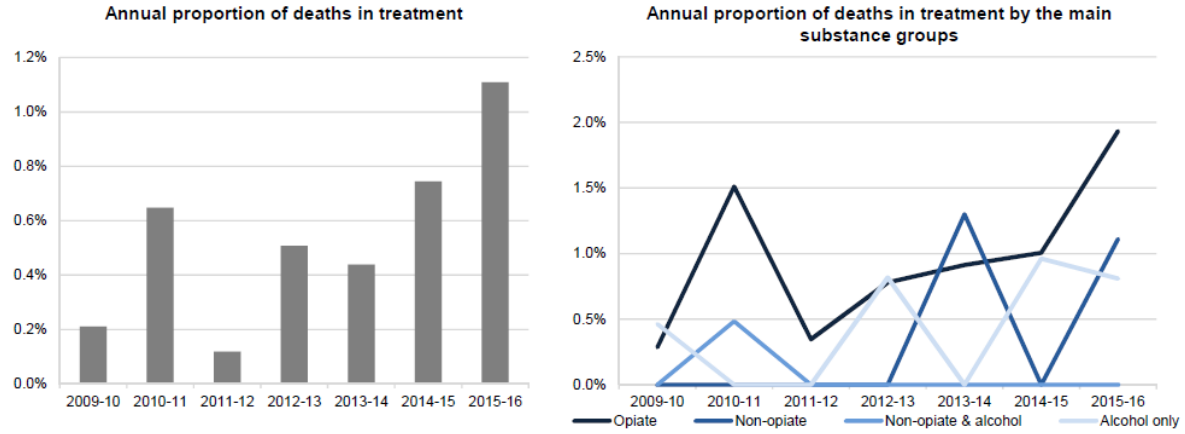
Opiate usage is associated with a substantial risk of premature death due to the side effects of the drug such as respiratory depression and hypoxia. Nationally, there has been significant concern for the rising number of deaths in treatment, especially for opiate users, which in England in 2015-16 surpassed 1% of all deaths in the treatment population (see Figure 8 below) (14). A report published by PHE exploring this concluded that the factors responsible for the increase in drug-related deaths are multiple and complex including an increase in the availability and purity of heroin: the ageing cohort of users with increasing co-morbidities and poor engagement with treatment services; and an increase in suicides (14).

Figure 8: Proportion of deaths in treatment by substance group for England



In comparison, the numbers of drug related deaths locally have previously fluctuated, and although the numbers remain small, 2015-16 was the first year that they surpassed 1% of all deaths in the treatment as show in Figure 9, most prominently due to the rise in opiate deaths (15) resonating with the PHE guidance to make the opiate antidote medicine naloxone more widely available as a preventative measure (14).

Figure 9: Annual proportion of deaths in treatment in Merton



10.2. Drug related crime

Drug related crime can be broken down in drug offences, including the trafficking or possession of drugs, crimes committed under the influence of drugs, and acquisitive crime to fund substance use.

The addictive nature of substance misuse and the significant cost of maintaining a supply provide a motivation for acquisitive crime; hence, treatment is associated with substantial crime reduction benefits (16).

The CSEW found that in the year ending 2016 in 19% of violent incidents the victim believed the offender(s) to be under the influence of drugs (13). This amounts to 2,518 crimes committed annually, however, this is also likely to be a gross underestimate due to the exclusion of non-violent crimes and poor reporting of certain crimes such as acquisitive crimes of small value. Good communication between substance misuse services and the criminal justice system with a clear referral and follow up process can improve engagement with services. A focus on improving treatment outcomes has been found to be key in preventing reoffending and thus reducing harms due to drug related crimes.

11. ADVERSE EFFECT ON CHILDREN & YOUNG PEOPLE

Substance misuse can lead to a chaotic lifestyle and have negative impacts on a user's family, impairing their ability to perform a family role and contribute to a functioning household.

Harms can range from financial to violent, and can result in children having exposure to a significant parental influence of substance misuse at an early age. To illustrate, a national UK survey found parents were the most important influence on children's attitude to alcohol (17) and children of parents with alcohol use disorder are more likely to develop it themselves later in life (5).

Furthermore, potentially traumatic events termed 'adverse childhood experiences' (ACE) can have a negative lasting impact on the health and wellbeing of the individual. Examples of such events include abuse, deaths of loved ones, or parental divorce; and strong links have been found between substance misuse and ACE. Data exploring this association from a national survey of almost 4,000 people in England in 2013 showed that the prevalence of health harming behaviours, such as substance misuse, increased with increasing levels of ACE (18).

11.1. Children in child protection

In 2015-16, there were a higher proportion of drug clients in treatment living with children locally (24%) than nationally (19%), of which 42% are female (10). These children may be exposed to substance misuse at an early age and are more likely to experience ACE than the general population. A workshop run by PHE called 'A family affair' 2016 explored the needs of families and children of substance misuse parents in particular. Talks highlighted the carer roles children often take on, the protective factor treatment provides, and the deterioration in outcomes when children are taken away from parents with substance misuse. Thus, services need to integrate support for children, whilst engaging a collaborative family approach.

12. MERTON SUBSTANCE MISUSE TREATMENT POPULATION

12.1. Numbers in treatment

General

Merton has one of the smallest substance misuse treatment populations in London. Table 3 shows that Merton has a lower proportion of opiate clients than London and nationally, and a larger proportion of alcohol clients than both in London and nationally,

Nationally opiate clients form the largest group in treatment, although there has been a reducing trend over time in the number of opiate clients, mirrored in London and Merton. In comparison, the largest substance misuse group in Merton are alcohol clients that made up 39% of the treatment population in 2015-16, and when reports of alcohol consumption in other substance groups in treatment are included, almost two thirds (61%) of the total treatment population reported alcohol

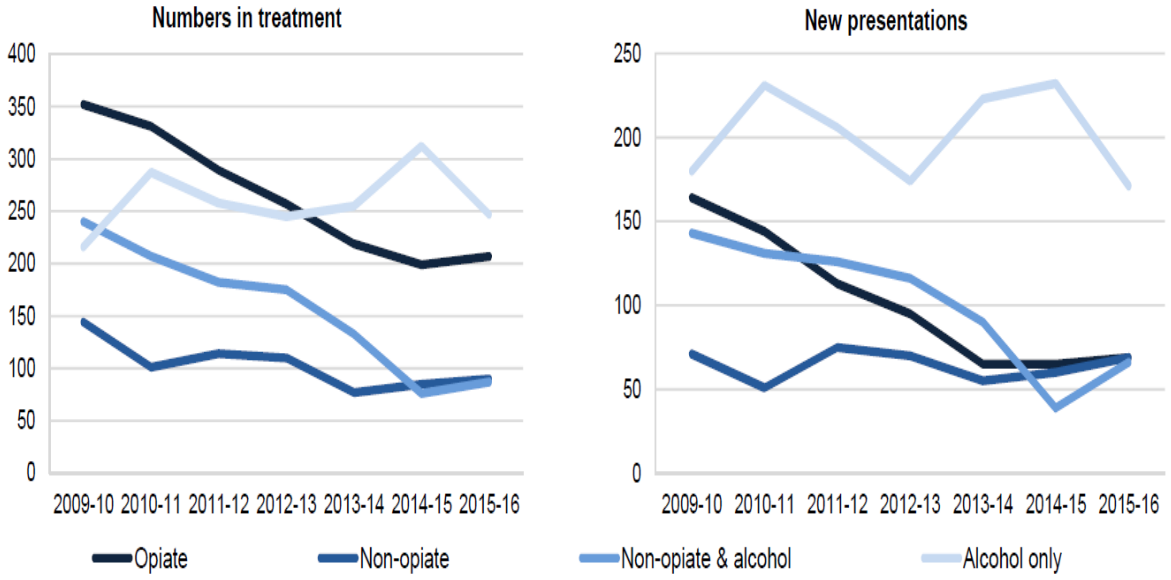
misuse (19) giving an indication of the scale of the cohort and representing an unmet need for prevention and support.

Table 3 Treatment population by substance group

Numbers in treatment	National	London	Merton (%)	Merton (Number of clients)
Opiate	52%	46%	33%	208
Non-opiate	9%	12%	14%	88
Non-opiate & Alcohol	10%	14%	14%	88
Alcohol only	29%	28%	39%	246
Total number of clients in treatment	288,843	44,124	631	631

Regarding the numbers of new presentations and numbers in treatment generally, after peaking in 2014-15, they have slightly declined in Merton (19) as shown in Figure 10, similar to the national decline.

Figure 10: Trends in numbers in treatment and new presentations to treatment by main substance group, 2009-2015



Penetration rate

Although the treatment population is a good indicator of service users, it does not necessarily give the full picture of substance misuse in Merton due to the limitations in how representative services are.

PHE commissioning prompts repeatedly encourage commissioned services to be inclusive and "target highest risk groups and be accessible to and attract all potential service users" which include women, LGBT individuals, men who have sex with men (MSM), parents of young children, young adults, people with co-occurring mental health conditions, and NPS and club drug users.

Substance misuse can result in chaotic and unstable lifestyles, and so the extent to which services have good outreach and engagement with users will define how representative the treatment population is. Overcoming limitations to accessibility and approachability of the service, particularly for the high risk groups described above, e.g. having good links with mental health services, offering

a crèche facility, or having extended opening times impacts on how likely potential users are to engage with the service.

To illustrate limitations in penetration, there has been national concern regarding the increasing prevalence across England (16) of new psychoactive substances (NPS) and club drug usage; however the numbers of new presentations to treatment for these drugs was negligible in Merton (20). A lack of standardised prevalence estimates makes it difficult to quantify the unmet need in the population. Experts at PHE report it is likely that club drug use is escalating locally in line with the national picture, but they suspect users are not presenting to services in Merton and so the treatment population data is not capturing club drug clients. This may be in part due to the lack of specialised services that have adapted to accommodate and be accessible to such users in other boroughs[5].

12.2. Merton estimates of opiate and crack users

Numbers of current opiate and crack cocaine users from treatment services have shown a declined in recent years, most prominently among younger people (16) and in Merton 15% of the treatment population in contact with the criminal justice system are opiate clients in comparison to 21.9% nationally (21).

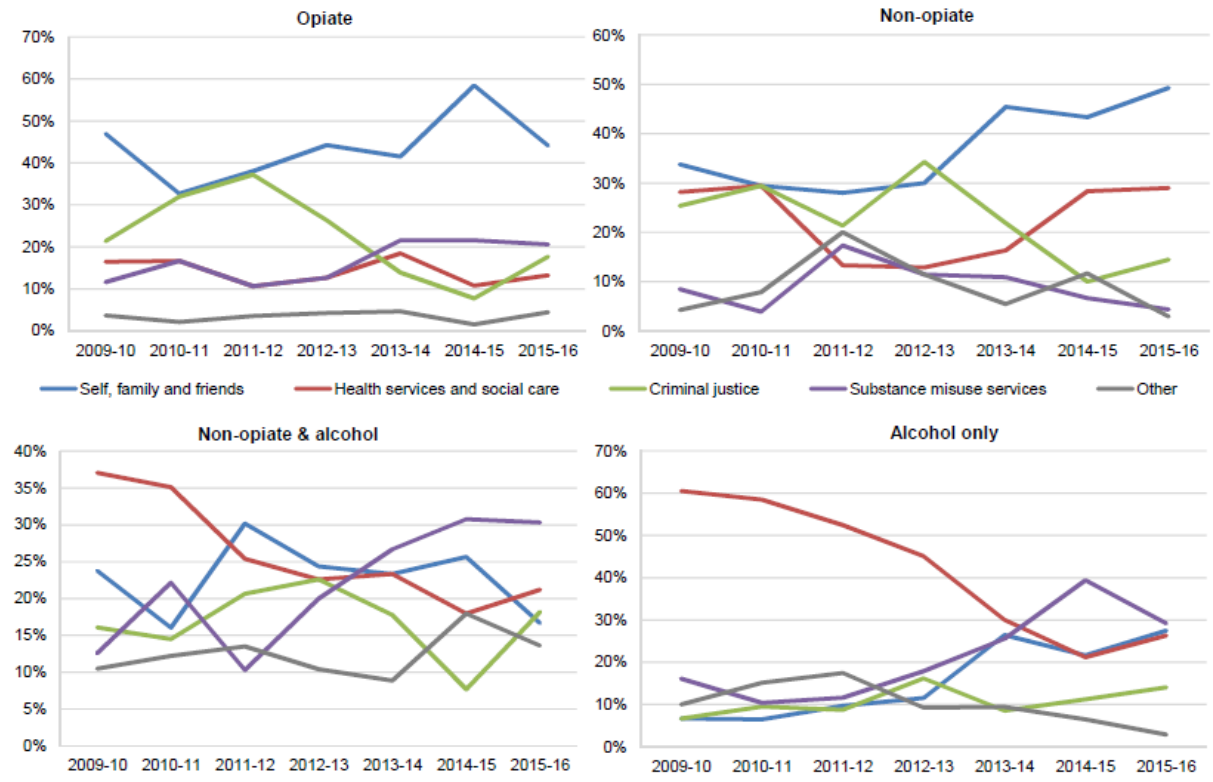
There are an estimated 2,968 cocaine users and 129 opiate users in Merton based on the CSEW national drugs prevalence and ONS mid-year estimate 2015 of 16-59 year olds in Merton (13). In contrast, the treatment services report 207 opiate clients in treatment in 2015-16 (20), most commonly presenting with crack cocaine (45%) as an adjunctive substance. The treatment population in Merton have larger proportion of opiate clients who use cocaine as an adjunct than nationally (19; 7), as well as having a larger proportion of non-opiate clients using cocaine locally (36%) than in London (28%) or nationally (30%) (22; 7; 23). The high local popularity of cocaine both as an adjunct, in addition to as the primary substance being misused, shows a need for services to be aware of and have a strong pathway for treatment.

12.3. Source of referrals

Almost half of all opiate referrals to treatment in Merton, London and nationally were by 'self, family and friends', as has been the trend since 2009-10 and almost a third of non-opiate and non-opiate & alcohol clients were referred by substance misuse services in Merton, an increasing trend since 2009-10. Additionally, there has been in an on-going reduction in the proportion of non-opiate and non-opiate & alcohol clients referred by health services as shown in Figure 11.

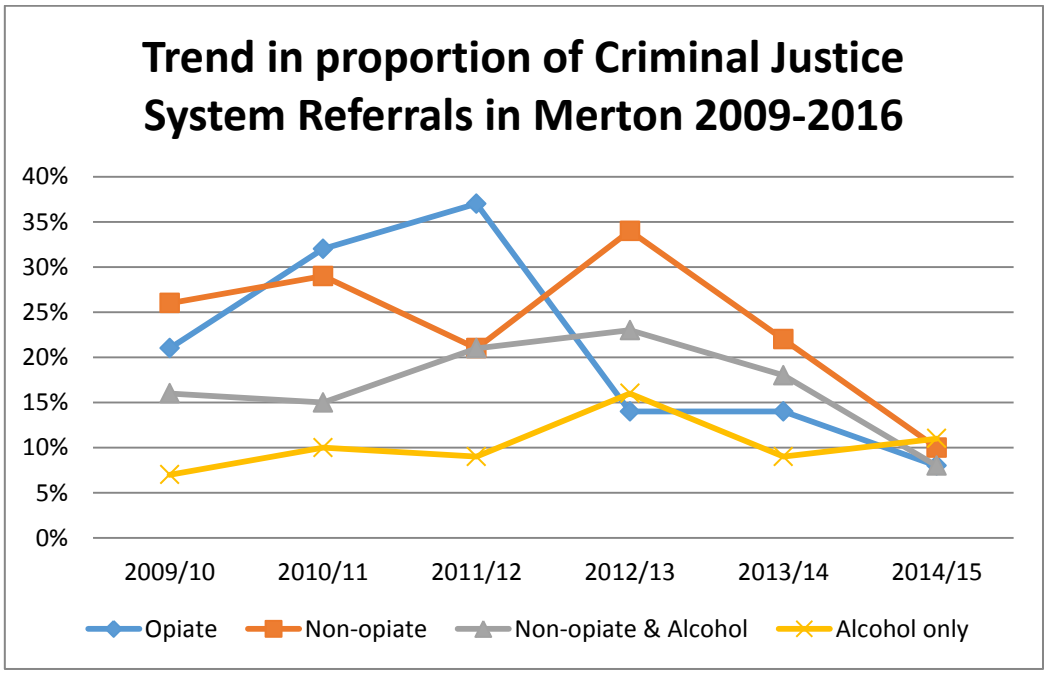
[5] Club Drug Clinic, Central and North West London NHS foundation trust. Available at: http://www.cnwl.nhs.uk/services/addictions-and-substance-misuse-services/club-drug-clinic-2/

Figure 11: Trends in source of referral into treatment for new presentations 2015-16



Of great concern, for all substance groups there have been reduced referrals from the criminal justice system as shown in Figure 12 (15).

Figure 12: Trend in proportion of Criminal Justice System Referrals in Merton



Criminal justice system referrals can be completed from the arrest referral team in police cell or court premises; by a probation manager in the community; by Counselling, Assessment, Referral, Advice and Throughcare (CARAT) workers in prison; or by other means.

Merton refers a lower proportion of drug and alcohol clients than London from all Criminal justice system referral pathways, with the exception of other (see Table 4). This is further exacerbated when broken down to drug only clients who receive less than half the London proportion of arrest referral clients (24). Areas such as probation where no referrals were received for drug clients in Merton seem unlikely, and indicate poor outreach and fragmentation of the referral service.

Table 4 Adapted from the Adult Community Treatment Map Summary 2015-16

Criminal Justice System Referrals	Arrest referral	Probation	CARAT	Other
National- All Clients	2%	3%	5%	4%
National- Drug Clients	3%	3%	8%	5%
National- Alcohol Clients	1%	3%	0%	1%
London- All Clients	5%	2%	3%	4%
London- Drug Clients	7%	2%	3%	6%
London- Alcohol Clients	1%	2%	0%	1%
Merton- All Clients	2%	1%	1%	6%
Merton- Drug Clients	3%	0%	1%	10%
Merton- Alcohol Clients	0%	1%	0%	2%

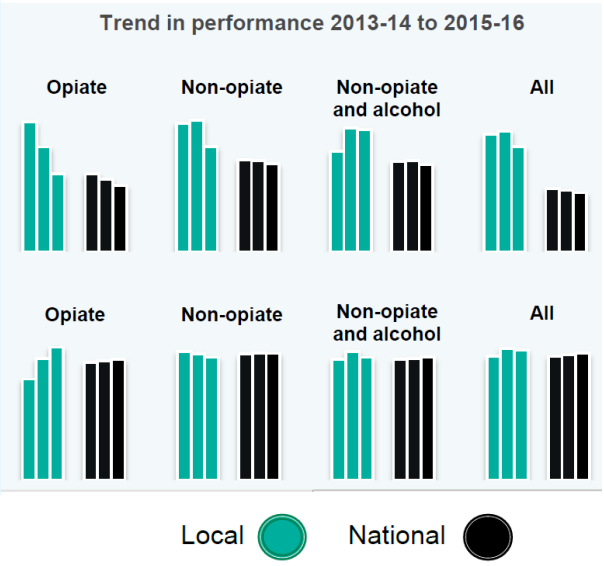
A clear trend of decreasing criminal justice system referrals is of great concern, as there is an increased likelihood of recommitting an offence if referral to substance misuse treatment services are inadequate, which has a knock on impact on the individual, their families, and the community.

12.4. Successful completions

What is considered to be a successful completion in variable. For alcohol clients, some would be expected to become abstinent, whilst others would be expected to moderate consumption, and for opiate clients this would not include those on opiate substitution therapy e.g. methadone. NDTMS uses the proportion of clients exiting in the year that successfully completed treatment and left in a planned way as the definition of successful completion. This is then assessed by longevity with a second indicator reporting the number of successful completions that didn't represent to treatment services within six months.

In Merton the proportion of all clients in treatment who successfully completed treatment and did not re-present within 6 months decreased for all substance groups, with the largest fall in non-opiate clients (from 49.4% to 47.5%) (21). The reduction in successful completions has been an on-going decrease in recent years as depicted below (20) and is similar to the falling rates in England. Of note, the London average shows a slight improvement in successful completions of treatment since 2009-10 which is not represented locally.

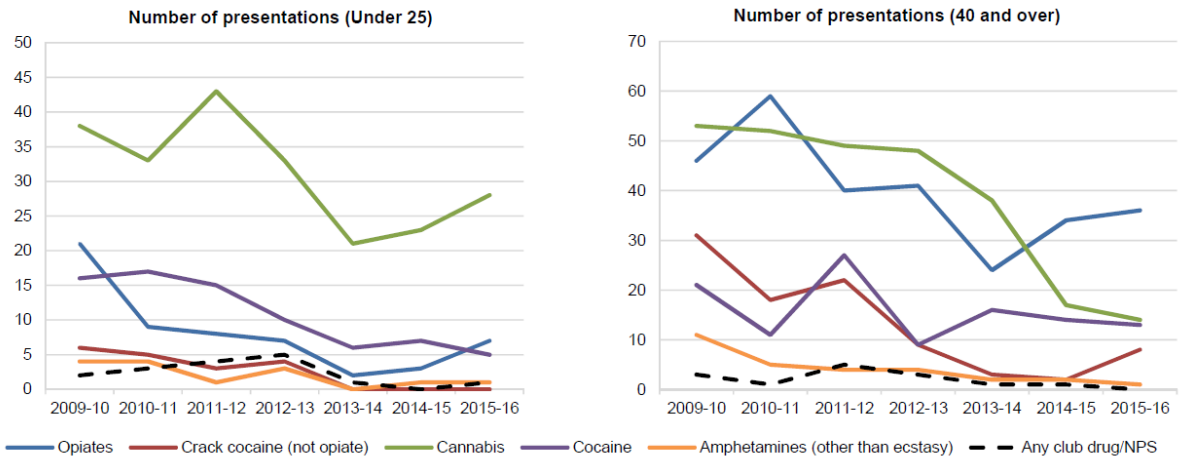
Successful completions as a proportion of total number in treatment	Local (%)	National (%)
Opiate	8.2	7
Non-opiate	48.9	40.8
Non-opiate and alcohol	49.4	35.3
All	27.1	15.2
Proportion who successfully completed treatment and did not return within 6 months[9]		
Opiate	90	81.6
Non-opiate	91.8	94.7
Non-opiate and alcohol	91.9	92
All	91.5	89.1



In Merton, over half of alcohol clients spent between 3-6 months in treatment, with 10% having an early unplanned exit similar to national proportions (9). Clients who have an early unplanned exit are more likely to represent to treatment, and may have increased complexity as discussed below.

Successful completions are a key indicator to measure both success of a service but also to be able to predict capacity and anticipate service users. There has been a reducing trend in the number of younger clients presenting to treatment in Merton for opiates as show in Figure 13. Additionally, drug misuse clients generally completed treatment in less than 2 years, with the exception of a proportion of opiate clients (16%) who remained in treatment for six years or more. Hence, there remains an ageing cohort of opiate users that have created a unique substance misuse treatment group which will have entrenched dependence, increasingly complex needs, and are likely to have had previous treatment journeys. PHE estimates that due to this treatment group, the expected the proportion of opiate clients who successfully complete treatment will continue to fall, resulting in a treatment subset that will be challenging to manage, and may require different outcomes as treatment end goals such as harm reduction as opposed to successful completion (16).

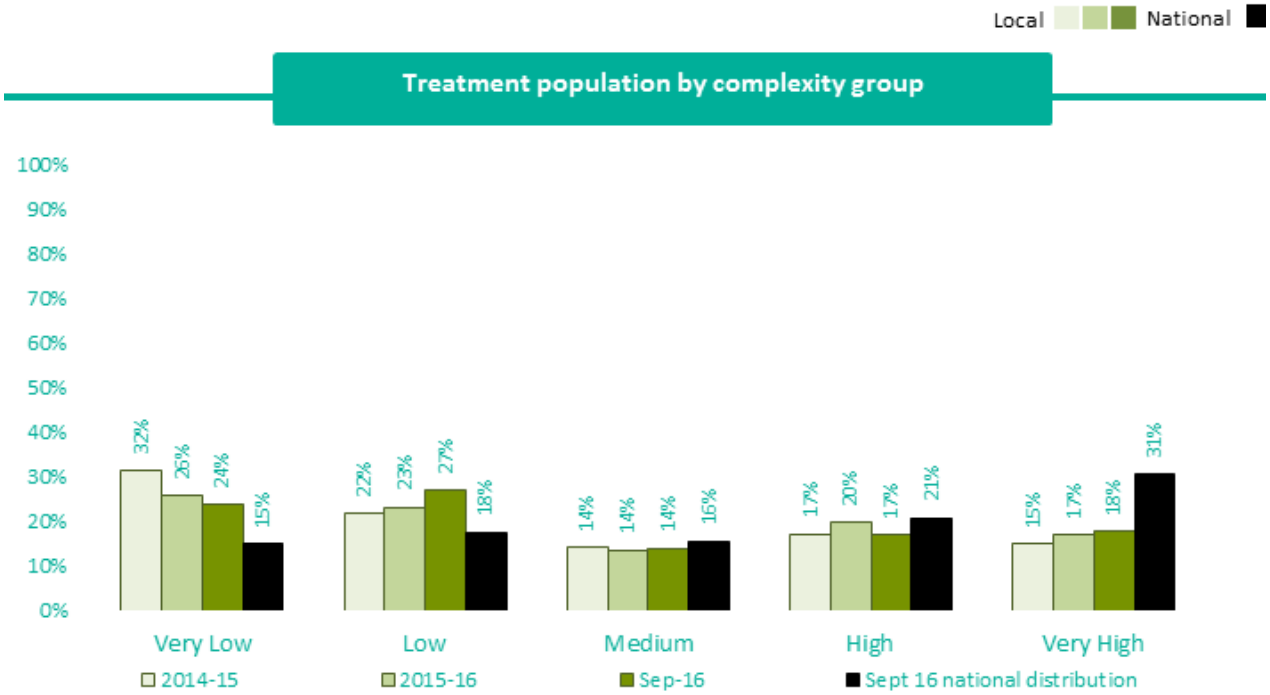
Figure 13: Trends in presenting substances of under 25 and 40 and over, Local Trends Report for Merton 2015-16



12.5. Complexity

The chances of clients successfully completing treatment is impacted by a range of factors which are labelled as 'complexity' and are categorised from very low to very high. Complexity includes substances used and frequency, as well as previous treatment journeys. Locally, there is a smaller proportion of very high complexity clients and higher proportions of very low and low complexity patients compared to national proportions as shown for opiate clients in Figure 14. This would mirror the generally higher than national successful completions, as the general treatment population in Merton is less complex. However, the 17% of very high complexity patients, likely to include the ageing opiate cohort discussed above present a challenging group which will have limited successful completions, and may need additional resource allocation, or to be assessed by a more fitting outcome measure.

Figure 14: Complexity of opiate clients in Merton compared to nationally



13. RECOVERY FROM TREATMENT

13.1. Housing problems

Homelessness has been implicated in starting substance misuse or worsening usage as well as reducing the motivation and willingness for change. Additionally, having no fixed address could reduce access to health and welfare services (16). Housing is a key factor in treatment outcomes and urgent housing problems and housing instability such as no fixed abode or homelessness are prevalent in the treatment population.

Opiate users tend to report the highest percentage of urgent housing problems, and that is the case both locally and nationally (9% and 13% respectively). Locally, after a peak in the number of new presentations reporting an urgent housing problem (10%) in 2014-15 this has reduced over the last year to 4%, remaining similar to the national proportion (3%) (15; 9). Substance misuse services

must have good links with housing associations to ensure that presentations with housing issues are promptly dealt with to increase treatment success.

13.2. Employment

There is a strong link between employment and successful drug treatment. The recent evidence review found the relationship works in two directions with successful drug treatment improving the likelihood of achieving positive employment outcomes, and employment moderating drug misuse (including increased periods of abstinence, reduced relapse, and improved engagement with drug treatment) (25).

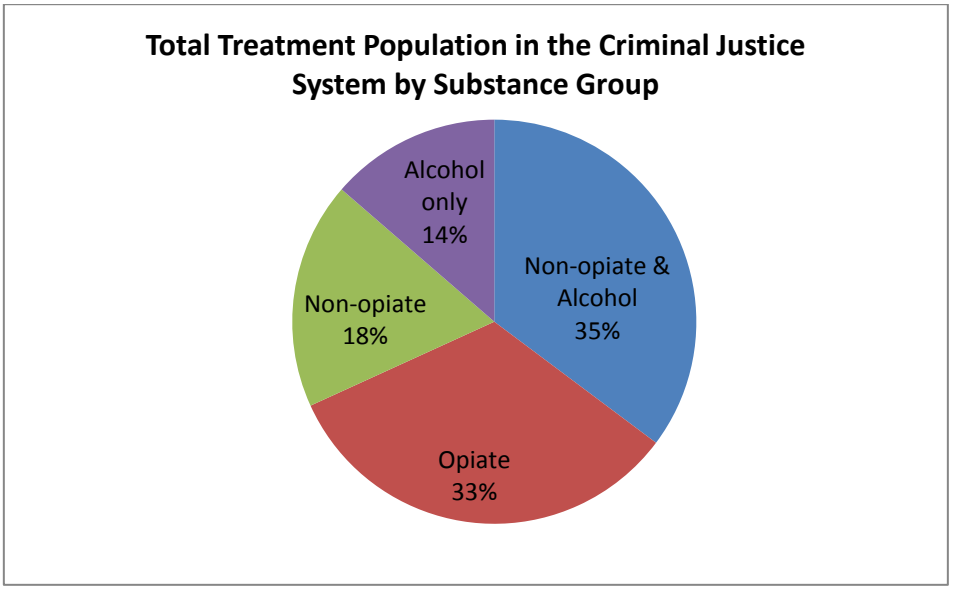
Over half of new presentations to drug services in 2015-16 were unemployed or economically inactive (57%), substantially higher than the national figure (14%) (20). This is exacerbated at treatment exit with 86% of unplanned exits and 66% of planned exits remaining unemployed. Similarly, well over half (61%) of alcohol clients were recorded as not working at treatment start, and there were no changes to this proportion at planned exit (9). This highlights a significant weakness in the provisions of substance misuse services in Merton, and an acute need to align treatment with opportunities to improve employment to continue to improve treatment outcomes.

13.3. Treatment population in the criminal justice system

The criminal justice system has a notable proportion of substance misusers, with 81% of adult prisoners reporting use of illicit drugs at some point prior to entering prison, and almost two-thirds reporting more frequent usage within the month before entering prison (26).

As described above, there has been a recent decline in referrals from all parts of the criminal justice system to substance misuse services in Merton, and the total treatment population in the criminal justice system is 15% (88 clients) as categorised in Figure 15. Whilst the proportion of opiate clients in treatment has remained stable between 2014 and 2016, there has been an on-going rise in the number of non-opiate & alcohol clients since November 2015, and a plateauing of a steep increase in alcohol only clients since April 2016. Additionally, the local proportion of alcohol clients in touch with the criminal justice system locally is almost double the national average (14.8% in Merton cf. 7.7% nationally) reiterating the local need to provide targeted initiatives for these clients (22).

Figure 15: Treatment population in the criminal justice system by substance group



It is vital to ensure clients have adequate access to substance misuse treatment services in the criminal justice system and effectively manage clients between custody and the community. Clients leaving prisons have a high risk of drug-related death in the first few weeks following release, as well as increase likelihood of relapse and reoffending (16). Of the 66 substance misuse clients leaving prison in the Merton treatment population, only 9% successfully engage in community-based structured treatment following release, compared to the national average of 30% (21). This low proportion indicates that services are fragmented and clients are slipping through the net between prison and the community. Strengthening this transition will improve outcomes for clients and reduce reoffending.

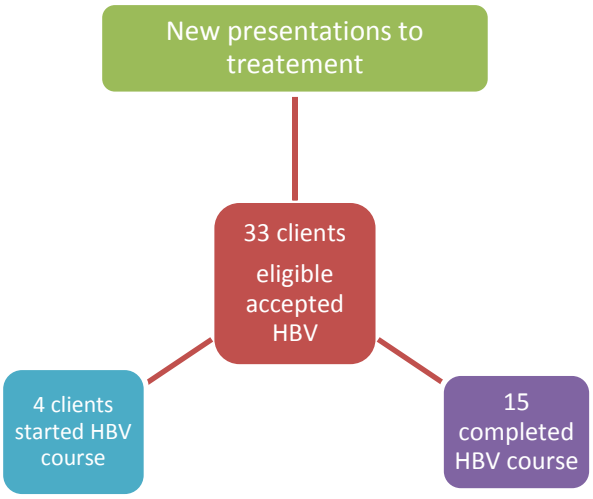
14. HARM REDUCTION

14.1. Blood borne viruses

In addition to the risk of death, other harms caused by substance misuse include the spread of infectious diseases. In particular, viruses transmitted by blood can be spread between injecting users sharing needles and other injecting equipment. Notably, the spread of the Human Immunodeficiency virus (HIV) and hepatitis blood borne viruses can be interrupted and prevented through harm reduction policies such as needle and syringe exchange programmes and vaccination. Currently, vaccination of injecting users for Hepatitis B and C is routinely available.

The proportion of new clients to treatment being vaccinated for blood borne viruses is poorer in Merton than nationally with only 22% of eligible clients accepting Hepatitis B Vaccination (HBV) and less than half of those subsequently completing the course as show below. Similarly, over a quarter of previous, or currently injecting, clients in treatment eligible for the hepatitis C vaccination (HCV) did not received one (20).

This is a lost opportunity for harm reduction, and substance misuse services efforts to engage clients to complete vaccination must be reviewed, as the consequences of injective individuals getting the disease are substantial.



15. AVAILABILITY AND REGULATION OF ALCOHOL IN MERTON

15.1. Policy context

As explored earlier, policy developments on reducing harms from alcohol have focused on three main influencers of alcohol consumption: affordability, availability, and acceptability (5). In Merton, the main approach used to decrease health harms is availability through licensing. Legal challenges faced by the governments trying to implement minimum unit pricing have resulted in local authorities being hesitant to impose this with no legal precedent, and so influencing affordability is more difficult. Acceptability is influenced by commissioning services which offer IBA.

To pursue a multidisciplinary partnership approach to policy implementation Merton has also recently been accepted onto the Local Alcohol Action Areas project set up by the Home office to tackle the harmful effects of irresponsible drinking.

15.2. Licensing in Merton

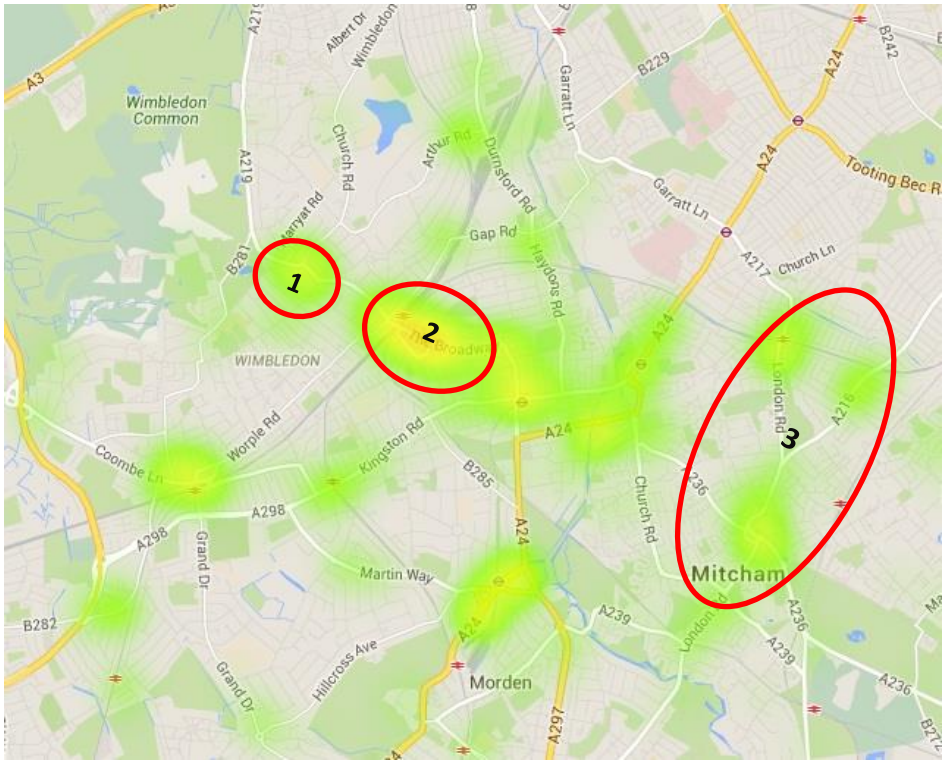
Responsible authorities regularly convene and discuss current license applications, reflections on recent applications, and key relevant topics in Merton. The local public health team triage all applications and negotiate the addition of key conditions that promote the licensing objectives: the prevention of crime and disorder, public safety, prevention of public nuisance, and the protection of children from harm. High priority conditions in Merton include those that promote the Challenge 25 scheme (a retailing strategy that encourages checking ID for anyone over 18 but looks under 25) and restrict alcohol by volume in off-licenses to limit sales of high strength alcohol.

Triaged applications in the public health team either negotiate recommended conditions to be added, or a representation is submitted to oppose the license at the councils subcommittee. Representations include data obtained from local Safestats, a postcode specific dataset that merges incidents reported from British transport police, London ambulance, and other sources.

The cumulative impact policy forms part of the Licensing Act of 2003 and identifies “the potential impact on the promotion of the licensing objectives of a significant number of licensed premises concentrated in one area” (27) hence the creation of cumulative impact zones (CIZ). There are three CIZ’s in Merton split between the east and west of the borough in areas of high saturation of licensed premises as show in Figure 16. They have different approaches, with west Merton CIZ’s

focusing on managing the vibrant night-time economy whilst limiting the harms, in comparison to the more deprived East Merton's CIZ targeting the high density of off-licenses which fuel the street drinking presence.

Figure 16: Alcohol Licenses heatmap and Cumulative Impact Zones (as of April 2016)



1. **Wimbledon Village Cumulative Impact Zone**
2. **Wimbledon Town Centre Cumulative Impact Zone**
3. **Mitcham Cumulative Impact Zone**

With availability being a key factor in alcohol consumption, licensing teams need to be aware of the impact of current and new licenses with regards to opening times and number of nearby premises.

16. Stakeholder engagement

16.1. Engagement with service users

General

To inform this SMHNA a focus group was run with services users and carers to get a better understanding of their requirements from substance misuse services. When asked about their priorities in a service "knowing about it" was felt to be the key obstacle with a lack of service visibility and health care professional awareness. They reported that word-of-mouth remained the main way of finding out about services and more efforts can be made to advertise at health services such as GP's, as well as more general locations such as gyms.

When asked what they would like a service to look like the role of peer experts or 'recovery champions' (those who have completed treatment locally and now work as recovery supporters) was unanimous, with service users requesting their presence throughout the treatment journey

from prevention to recovery. Furthermore, those present who were recovery champions highlighted that they felt helping others was a part of their own treatment journey.

"*For my recovery I feel I need to help others*"
(Female recovery champion, 01/03/2017)

Treatment journey and outcomes

When discussing the treatment journey, the conversation continued to focus on the recovery aspect with service users reiterating the value of peer support in creating a non-judgemental environment that enabled them to improve their self-esteem sufficiently to restore day-to-day functionality. Moreover, they felt they did not have an appropriate location to meet peers with.

"*We need somewhere to go*"
(Female service user, 01/03/2017)

Regarding what outcomes they felt would capture a good recovery service users reported quantitative and qualitative measures. It was felt education and housing would be important as quantitative measures, and for qualitative measures, family and relationships were identified both as an outcome, as well as being a source of information from which to obtain outcomes. Service users themselves felt "peace of mind" was the most accurate reflection of successful recovery.

Education, employment, and training

Discussions on education, employment and training outcomes highlighted the need for more diversity in skill training, including basic life skills.

"We need life skills to be able to get back to life"
*(*Male service user, 01/03/2017*)*

"*A lot of people have a lot of work-life ahead and need to get the self-esteem to get out there and do stuff*"
*(*Female service user, 01/03/2017*)*

When it was suggested that these services exist within the community, they reiterated they didn't feel able to attend mainstream services in their initial recovery, and would need to be with peers to feel comfortable attending as the service user below explained:

"I *would only be able to attend as a group with other people in recovery as I wouldn't have the self-esteem to do it alone. We just don't feel we are good enough… and the high anxiety levels will worry me that this might trigger me to drink so I would avoid it"*
(Female service user, 01/03/2017)

Families and carers

Families reported that for other family members impacted by the substance user, such as children, there was a scarcity of support services. This sentiment was also echoed by carers who felt that they were key to the individual succeeding in recovery but that they themselves lacked support and care,

even when this was impacting on their own health. At the PHE 'A family affair' workshop 2016, this was explored in detail and a member from Families Anonymous summarised this eloquently:

"Addicts get all the attention but live in their own bubble while family member's lives are disrupted and have the stigma, guilt, and shame is added to their lives"

Mothers also reported restrictions to service access due to limited childcare facilities which prevented them from fully utilising services. They also reported feeling frightened by social services and felt this was due to the fragmentation of services, and that if they were better integrated with substance misuse services it would be more reassuring.

16.2. Engagement with providers and other stakeholders

A local multidisciplinary workshop held with service providers, commissioners, and service users also informed the development of this SMHNA. The discussion was structured around the following three topics.

Improving access and treatment pathways

There were two main themes discussed which centred on access to services, including for ethnic minorities in Merton, and the need for partnership working between services involved in substance misuse.

To improve access to services it was felt that time and place was key with the need for evening clinics and weekend services to cater to users, and locations such as youth centres, estates, and one stop shops should be utilised to improve outreach. The high threshold for service entry was also identified as a barrier with limited resources being the main reason for this.
Service provisions catering to ethnic minorities were considered to be a weakness in services, with limited efforts made to raise awareness of prevention and overcome language and cultural barriers, particularly for the Polish and Tamil populations who were explicitly identified to be in need of better access to services.

The need for partnership working was identified between many stakeholders including community services, health services, criminal justice system, and others. The lack of communication across services was seen as a significant limitation in improving access and treatment pathways. Alcohol misuse was used as a case study to identify the lack of communication between police dealing with street drinkers in Mitcham, their recurrent admissions to accident & emergency, insufficient outreach work to engage them into treatment services and their GP having limited knowledge of their use of other services. It was suggested a primary care clinical lead be identified to allow services to link into GP practices and promote information sharing.

Prevention opportunities and routes to recovery

The larger context of primary prevention from a higher governmental level to "reteach society how to function" and develop family and social networks was identified, and the local context of suppression of basic development in addicts, particularly of those who begin at young age, makes it necessary to teach them how to function in, and be a member of society.

The secondary prevention of being able to identify the cycle pattern of users and create an awareness that prevents relapse and promotes recovery was the focus of the discussion. The role of recovery champions was identified as a protective factor for prevention for the individual whilst providing an aspiration for those in the earlier stages of treatment. Furthermore, the presence of recovery champions in groups and in their role as peer support creates a joint cycle awareness to enable members to support each other, create a social network, and recognise when members are in crisis. Services agreed that having a champion in every group activity they run would be effective and aid further clients recovery.

Tackling crime and antisocial behaviour relating to substance misuse

National changes in the criminal justice system, particularly the split of National Probation Services (NPS) from Community rehabilitation company (CRC) was recognised to have a significant impact on service delivery locally. The majority of substance misuse resource allocation and expertise was felt to have been disproportionally retained in CRC and lost in the NPS. In particular the awareness of local offers, services, and referral process is different between the services, e.g. the referral process for youth into the local Catch-22 service is well maintained in CRC but lost in the NPS.

A lack of communication between the two criminal justice system services was also reported to have created gaps in the service, with what was described as a 'pot luck' approach of being seen and followed up, e.g. patients being discharged into the community without follow-up teams being aware. The discussion highlighted the local responsibility to overcome these obstacles through a multidisciplinary approach with a closer, coordinated communication needed between mental health services, the criminal justice system, drug and alcohol teams (DAAT), and community services which are overseen by commissioners. The presence and visibility of senior prisons/courts members in community partnerships, and officers in local services was also identified as a way of promoting this.

The role of the criminal justice system in prevention and breaking the cycle of reoffending was explored, with the need for training and development being offered to teach those with short sentences "how to function in society". Additionally the role of appropriate housing on discharge was identified as paramount in maintaining rehabilitation. Officers reported concerns that for clients who are not engaging with the justice system, their role is limited to enforcement, but the treatment service stressed that working with people in the "pre-contemplative" mode is effective in the long term.

Finally, the need for licensing in tackling crime and antisocial behaviour was reviewed and the need for a consistent and coordinated message to be clearly communicated by the responsible authorities to licensing committees was considered the most effective way to clarify "the Merton standard" for licensing in the east and west of the borough.

17. KEY FINDINGS

General

- Merton has a total estimated drug population prevalence of 5,548 frequent users (defined as used in the last month) and a refined estimated prevalence of 1,837 dependent drinkers in need of specialist assessment and treatment
- There were 631 clients in treatment services, with the largest group being alcohol only clients (39%) a third being opiate clients, and approximately a third being non-opiate and non-opiate & alcohol clients. 15% (88 clients) are in the criminal justice system where the local proportion of alcohol clients is almost double the national average

Alcohol population

- Local alcohol prevalence estimates found almost a quarter of the population, amounting to 37,890 individuals are estimated to be drinking at increasing or higher risk
- There are gender disparities in patterns of alcohol consumption with consistently higher proportion of men reporting drinking more than 14 units of alcohol per week in comparison to females throughout their lifetime. In both genders, the highest proportion of drinking above the recommended limit is in the 50's to early 70's, and is in line with local treatment population data that shows alcohol clients tend to have the oldest age distribution
- Well over half (61%) of alcohol clients were recorded as not working at treatment start, and there were no changes to this proportion at planned exit

Alcohol harms

- Although the less deprived tend to drink more units of alcohol, more health harms and mortality are experienced by the more deprived, who tend to consume less units. The alcohol harm paradox places an unequal burden of disease on more deprived in the east of the borough
- There are increased harms from the narrow definitions of alcohol-related hospital admissions compared to neighbouring groups which is calculated to be 398.8 persons per 100,000 persons admitted to hospital for alcohol-related conditions, indicating an increased burden of admissions locally in Merton
- Alcohol specific mortality in Merton between 2013-2015 (10.2 per 100,000 European standard population) is worse than the London average of 8.7 per 100,000 European standard population
- Men in Merton experience the highest amount of harm in comparison to neighbouring groups for alcohol admissions for mental and behavioural disorders (124.2 per 100,000 admission episodes for mental and behavioural disorders due to use of alcohol), and admissions for intentional self-poisoning (21.8 per 100,000 admission episodes for intentional self-poisoning by and exposure to alcohol)
- Females in Merton experience the highest amount of harm compared to neighbouring groups for admissions of alcoholic liver disease conditions (84.3 per 100,000 admission episodes for the broad definition of alcoholic liver disease) and alcohol related cancer incidence (37.8 per 100,000 incidence rate of alcohol-related cancer)
- The Crime Survey for England and Wales 2016 found that in 40% of violent incidents the victim believed the offender(s) to be under the influence of alcohol, which amounts to 5,300 alcohol related crimes in Merton that year

- The cumulative impact policy from the Licensing Act of 2003 has resulted in the creation of three areas of license saturation split between the east and west of the borough. They have different approaches, with limiting restaurant licenses to manage the vibrant night-time economy in the west of the borough whilst the more deprived east of the borough limits off-license premises to control the street drinking presence

Drug population

- Over a third of the adult 16-59 year old population are estimated to have taken drugs at some point in their lifetime with cannabis being the most popular substance.
- There are an estimated 2,968 cocaine users and 129 opiate users in Merton based on the Crime survey for England and Wales national drugs prevalence and ONS mid-year estimate 2015.
- In comparison, there are 207 opiate clients in treatment most commonly presenting with crack cocaine (45%) as an adjunctive substance, and the treatment population in Merton has a larger proportion of non-opiate clients using cocaine than in London or nationally.
- There has been a decline in referrals from all parts of the criminal justice system to substance misuse services in Merton
- Of the 66 substance misuse clients leaving prison in the Merton treatment population, only 9% successfully engaged in community-based structured treatment following release, compared to the national average of 30%
- Over half of new presentations to drug services in 2015-16 were unemployed or economically inactive (57%), substantially higher than the national figure (14%) and was worse at treatment exit with 86% of unplanned exits and 66% of planned exits remaining unemployed

Drug harms

- There has been a rise in number of deaths in treatment, particularly for opiate users, and 2015-16 was the first year that they surpassed 1% of all deaths in the treatment locally and nationally
- There is poor vaccination of clients in Merton with less than a quarter (22%) of eligible clients accepting Hepatitis B Vaccination (HBV) and less than half of those subsequently completing the course. Additionally over a quarter of previous, or currently injecting, clients in treatment eligible for the hepatitis C vaccination (HCV) did not received one.
- An estimated 2,518 drug related crimes are committed annually in Merton as the Crime survey for England and Wales found 2016 in 19% of violent incidents the victim believed the offender(s) to be under the influence of drugs
- There were a higher proportion of drug clients in treatment living with children locally (24%) than nationally (19%) and these children may be exposed to substance misuse at an early age and are more likely to experience adverse childhood experiences than the general population

Stakeholders

- Stakeholder consultation identified limited service accessibility due to poor awareness of services, limited opening times, and poor outreach
    - Providers reported the fragmentation of the criminal justice system has created gaps in the service, with what was described as a 'pot luck' approach of being seen and followed up

    - It was noted that services were not adapted to overcome cultural and language barriers, particularly for the Tamil and Polish populations.
    - Families including children and other carers of substance misusers were felt to lack support, and limited childcare facilities restricted mothers from accessing services.
- 'Recovery champions' (those who have completed treatment locally and now work as recovery supporters) were identified as a protective factor for the individual whilst providing an aspiration for those in the earlier stages of treatment
- The need for partnership working was identified between many stakeholders including community services, health services, criminal justice system, and others. The lack of communication across services was seen as a significant limitation in improving access and treatment pathway

18. RECOMMENDATIONS

Recommendations to promote a partnership approach

1. Create a partnership approach with commitment and accountability to prioritise substance misuse across organisations
2. Ensure recovery champions have a voice in all partnership organisations
3. Develop a coordinated licensing approach by the responsible authorities
4. Strengthen links between substance misuse services, the criminal justice system, and mental health services
5. Develop links between substance misuse services and primary care

Recommendations to improve access to services

6. Improve outreach and accessibility of services for all potential or current substance misusers including users families and ethnic minorities
7. Promote the presence and involvement of recovery champions across services
8. Create a safety net for clients leaving prison to ensure continuity of care

Recommendations to reduce harms from alcohol and improve recovery from drugs

9. Improve awareness of alcohol misuse in all frontline services by providing adequate training in Identification and Brief Advice (IBA)
10. Engage health promotion dialogue about substance misuse
11. Ensure resources are adequately distributed to account for specific alcohol misuser needs
12. Increase uptake of harm prevention for bloodbourne infections in drug misuse clients
13. Promote client recovery though holistic treatment services that address employment and housing concerns

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