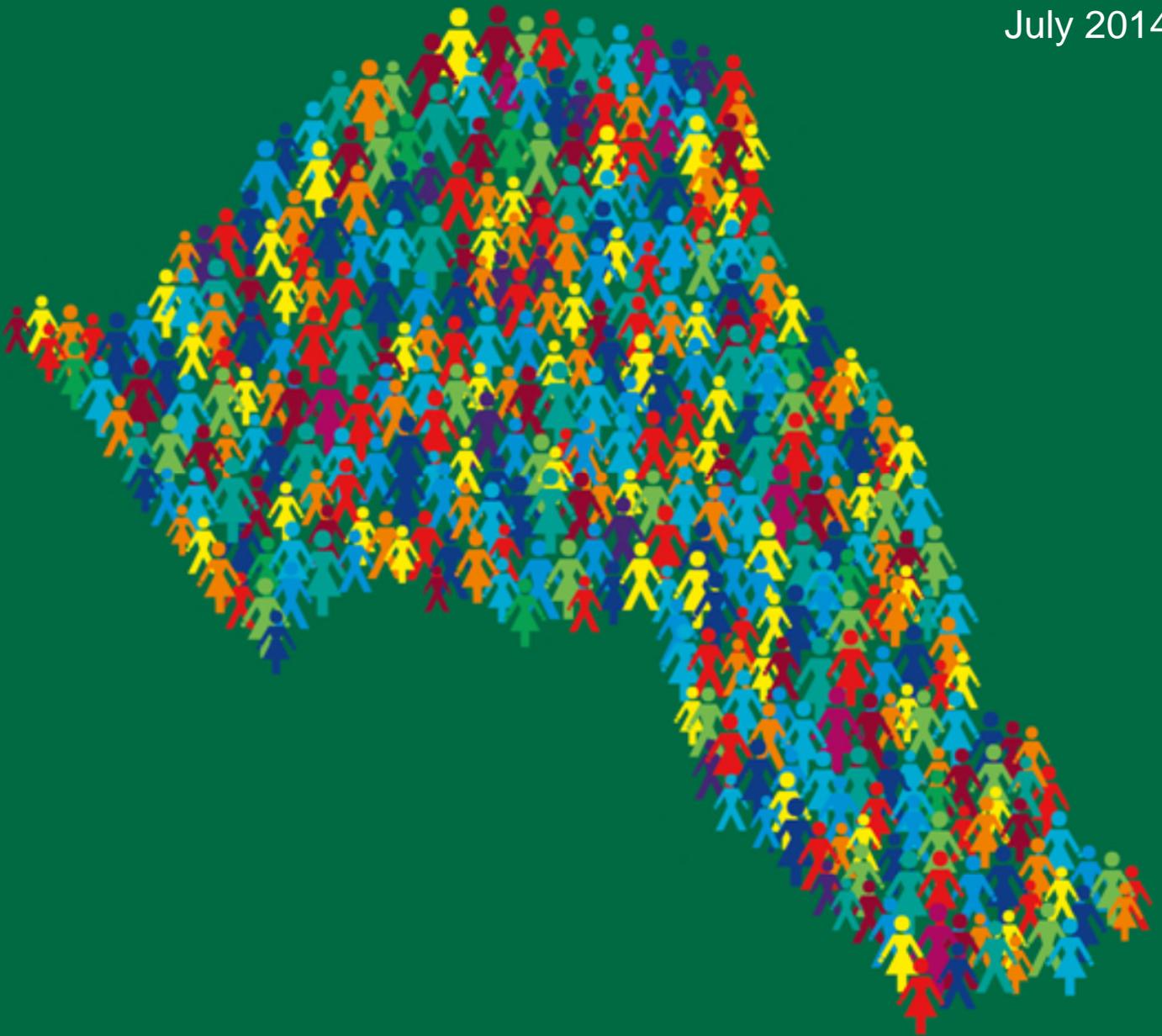


**CAMDEN PROFILE  
PUBLIC HEALTH INTELLIGENCE**

**Alcohol and Substance Misuse Needs Assessment**

First edition  
July 2014



## About this profile

### Purpose

This public health intelligence profile describes the patterns in alcohol and substance misuse prevalence and treatment in Camden.

This work will support and inform:

- London Borough of Camden Substance Misuse and Alcohol Misuse Commissioning Teams
- Camden and Islington Public Health Department

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### Further information and feedback

This profile was created by Harriet North and Tanya Khera-Butler (Public Health Information Analysts), David Clifford and Victoria Makepeace-Warne (Public Health Information Officers) and Minkyong Choi (Assistant Public Health Information Officer) with review by Dalina Vekinis (Senior Public Health Information Analyst).

For further information, please contact Harriet North

Email: [publichealth.intelligence@islington.gov.uk](mailto:publichealth.intelligence@islington.gov.uk)

Tel: 020 7527 1240

**We would also very much welcome your comments on these profiles and how they could better suit your requirements, so please do contact us with your ideas.**

## Recommendations and key messages

### Overview & recommendations

1. Review and make recommendations for the development of the drug treatment pathways, to improve effectiveness and value for money. Focus on improving access, engagement and outcomes for hard to reach and new cohorts of drug users, such as stimulant users and users of novel psychoactive substances.
2. Improve access to screening, appropriate interventions and outcomes for substance misusers who are at risk of contracting / have contracted a blood borne virus (BBV).
3. Work with health partners to improve response to substance misuse in primary care and acute hospitals – identify and implement integrated approaches to screening, prevention, treatment and recovery.
4. Develop and implement effective pathways for people with dual diagnosis (substance misuse and mental health)- focus on improved diagnosis and outcomes.
5. Review Locally Commissioned Services (pharmacy and primary care) to improve prevention and recovery outcomes for Camden residents.

### Key messages

#### Prevalence of drug and alcohol misuse

If estimates for London from the Crime Survey for England are representative of the Camden population, there may be over 15,000 Camden residents that used illicit drugs in 2012/13, including almost 6,000 using at least one Class A drug. Estimates suggest that Camden has one of the largest opiate or crack-using populations in London (2,350 people), including an estimated 840 injecting drug users, although cannabis and powder cocaine are likely to be the most widely used illicit drugs in the borough. If 11-15 year olds in Camden have the same rate of drug use as the national figures, almost 1,500 children would have used drugs ever, with 1,000 using drugs in the past year and 500 using them in the past month. Local survey data suggest that one third of children in year 10 have used illegal drugs. There are an estimated 29,700 binge drinkers and 12,100 high risk drinkers in Camden.

#### Treatment penetration in opiate and crack users

There were almost 900 people in treatment for opiate or crack use in March 2013, 38% of the population estimated to be using these drugs. An additional 377 people were in treatment in the past year (16% of estimated users).

#### Who is in treatment?

Camden's drug and alcohol treatment populations are older than the England average, with the exception of people in treatment for cannabis use, where 42% of clients are aged 15-24 years old (compared to 27% nationally). In Camden 70% of people in treatment for drugs and 65% in treatment for alcohol are men, which is similar to the national picture. Camden's treatment population is generally more ethnically diverse than the national average, reflecting the local population.

## Key messages continued

### Client complexity and compounding issues

When compared to the England average, Camden has a bigger proportion of drug clients who are classed 'very low complexity', 23% compared to 16% of clients in England. Completion rates are higher in less complex clients. A third of all Camden clients scored as very low complexity have completed treatment, however completion rates for this group are significantly lower than the Cluster average. It is not clear why completion rates are lower in this group. In Camden, the most common complexity factors for drug clients are housing problems or having no fixed abode.

For people in treatment for alcohol, unemployment was the most common compounding issue: 55% of the Camden treatment population were unemployed at the start of treatment. About 38% were also receiving care from mental health services for reasons other than substance misuse, higher than the England average of 21%.

### Treatment outcomes

There were just over 1,685 people in treatment for drugs and 738 people in treatment for alcohol in Camden in 2012/13. The size of the overall drug treatment population has remained stable since 2010/11. Of those in treatment for drugs, 70% are in treatment for opiates – a slight decrease (5%) since 2010/11. Opiate drug clients are less likely to complete treatment than non-opiate clients. However, rates of drug completion in Camden's non-opiate clients are significantly lower than the cluster. Treatment outcomes at six months in Camden were better than the national average for injecting drug users and amphetamine clients, but worse for crack, cocaine, cannabis and alcohol.

The re-presentation rates for drug treatment in Camden are not significantly different from the cluster. The proportion that have re-presented after treatment has decreased since 2010/11 for both opiate and non-opiate clients. In 2012, 6.7% of clients who had successfully completed treatment for alcohol represented within 6 months, this is lower than the England average of 10.2%.

In line with national trends, the case mix amongst opiate clients in Camden is changing over time: more clients have had longer drug careers, length of time in treatment is increasing and a smaller proportion of clients are new to treatment. The percentage of clients that have been in treatment for six or more years has risen from 19% in 2010/11 to 24% in 2012/13. The percentage of clients with 21+ year drug careers in 2012/13 was 41%, significantly higher than 31% in 2010/11. In Camden, as with the national picture, as more clients are in treatment for longer periods, it is less likely that they will complete treatment.

The majority of non-opiate clients have been in treatment for less than a year. Completion rates for non-opiate clients are higher in those that have been in treatment for less than two years (30% completed, compared to 8% in treatment for longer than two years).

During 2012/2013, 238 people in Camden successfully completed alcohol treatment (58% of all alcohol treatment exits). This was slightly lower than the England rate of 63%.

### Impact of alcohol & substance misuse

There are more deaths associated with or directly caused by alcohol (alcohol specific deaths) than deaths due to drugs in Camden. Between 2010-12, there were on average 18 alcohol specific deaths per year in Camden. There were two deaths specifically due to drugs in Camden in 2012.

## Key messages continued

### Impact of alcohol & substance misuse continued

Camden had higher than average rates of alcohol-specific hospital admissions in men and overall admissions for alcohol-attributable conditions. Unfortunately, we could not carry out analyses of local hospital data on drugs-related hospital admissions for this needs assessment due to lack of availability of data at this time.

Local analysis of crime data suggest that about a quarter of all crimes committed in Camden may have been linked to alcohol. This equates to about 8,300 crimes. Some crimes are more likely to be linked to alcohol than others: 95% of domestic incidents in Camden may have been related to alcohol.

Commissioners have expressed concern that clients of treatment services who are parents may be unlikely to disclose that they have children, for fear that Children's Services may become involved with their family. The number of referrals to Camden Children's Services that involved substance misuse in 2012/13 was lower than the number of parents using treatment services.

**Note:** As alcohol is not an illegal substance, the wider impacts of alcohol misuse are easier to quantify than drugs misuse.

# Understanding the data: data sources and definitions

## Prevalence of substance misuse

- Due to the nature of drug misuse, quantifying its prevalence is difficult. The National Treatment Agency, now a part of Public Health England, publishes prevalence estimates of opiate, crack, and injecting drug use by local authority.
- Estimates for other the use of drugs are only published at regional and national levels, as a part of the crime survey for England and Wales, and estimates of drug use among children are available through the Smoking, Drinking and Drug Use Among Young People in England survey. Both of these surveys cover self-reported drug use, and their estimates have been applied to the Camden resident population to create an estimate of the number of people using each drug locally.
- To support these figures, we have also received data from the Talk to Frank confidential advice service on the types of drugs that people discuss, by contact channel.

## Prevalence of alcohol misuse

- The prevalence of alcoholism is not published nationally, however the Local Alcohol Profiles for England present estimates of the prevalence of alcohol use, by the level of drinking (e.g. lower risk, increasing risk, and higher risk).

## Treatment

- The National Drug Treatment Monitoring System (NDTMS) publishes a range of statistics on the number of people in drug treatment programmes. This Needs Assessment has used NDTMS data on the demographic characteristics of people in treatment, by drug type, as well as information on the treatment needs, history, and outcomes of people in treatment
- Recovery diagnostic toolkit: this provides information for opiate and non-opiate client treatment outcomes at a local level. Data include length of time in treatment, length of drug career, representations and client complexity.
- The NDTMS is planning to publish in-depth profiles for alcohol treatment in the future. However for this Needs Assessment, data for alcohol treatment were taken from the Adult Alcohol Partnership Quarterly Performance Report, The Diagnostic Outcomes Monitoring Executive Summary (DOMES) 2013-2014 and the JSNA Support pack.

## Mortality and hospital-admissions

- As drug misuse is an illegal activity, and because there are fewer cases, there is little information available on drug-related mortality and hospital admissions.
- Information on alcohol-related and alcohol-specific mortality are taken from the Local Alcohol Profiles for England. Alcohol-specific cases are those wholly caused by alcohol use (e.g. alcohol poisoning or alcoholic liver disease), and alcohol-related cases also include those where alcohol is a contributing factor (for example high blood pressure and heart disease).

## Crime

- Again, because of the nature of drug misuse it is difficult to obtain accurate information on the number of crimes that are drug-related. Therefore in the crime section we only present information on crimes where alcohol was a factor.
- Information on these crimes were obtained from the Metropolitan Police. The figures were extracted from a live database which is updated as more details about a crime are obtained, so the numbers may be different in other publications.

## Key terms

Term	Definition
Career length	The length of time between the client's first reported drug use to the latest point of contact with the treatment system or if the client is still in treatment to the end of the financial year.
Complexity	This measure is assigned to each client based on a scoring system, this measures social and economic factors that will affect the client's likelihood of completing treatment. As opiate use is included as one of the complexity factors, the analysis is not split by opiate/non-opiate clients.
Length of time in treatment	The length of time that the client has spent continuously on their most recent treatment journey. This is calculated from the client's earliest triage to the latest discharge; unless client is still in treatment then it is calculated as end of the financial year.
Level of alcohol use	Alcohol use is defined by the number of units consumed per week; higher risk drinking is 35+ units a week for women and 50+ units a week for men, increasing risk is defined as 15-35 units a week for women and 22-50 units a week for men, and low risk drinking is $\leq 15$ units a week for women, and $\leq 22$ units a week for men.
National programme on substance abuse deaths (NPSAD)	A death where any of the following criteria are met at a completed inquest, fatal accident inquiry or similar investigation: one or more psychoactive substance directly implicated in death; history of dependence or abuse of psychoactive drugs; presence of controlled drugs at post mortem; or cases with deaths directly due to drugs but with no inquest.
Partnership clusters	The NDTMS groups drug treatment partnerships in to clusters, for opiate and non-opiate clients. These partnerships are created based on variables which predict treatment outcomes, including the number of previous treatment episodes, criminal justice referrals, and deprivation. They allow comparisons between local authorities with similar characteristics, which may be more suitable than comparing with geographic neighbours.
Previous treatment journeys	The total number of previous drug/alcohol treatment journeys the client has had anywhere in England.
Treatment completions and representations	These outcomes provide information on the proportion of clients that have successfully completed their latest treatment journey. Representations are those that have represented within 6 months of successfully completing treatment.
Treatment naïve clients	Clients that have not had a previous treatment journey anywhere in England.

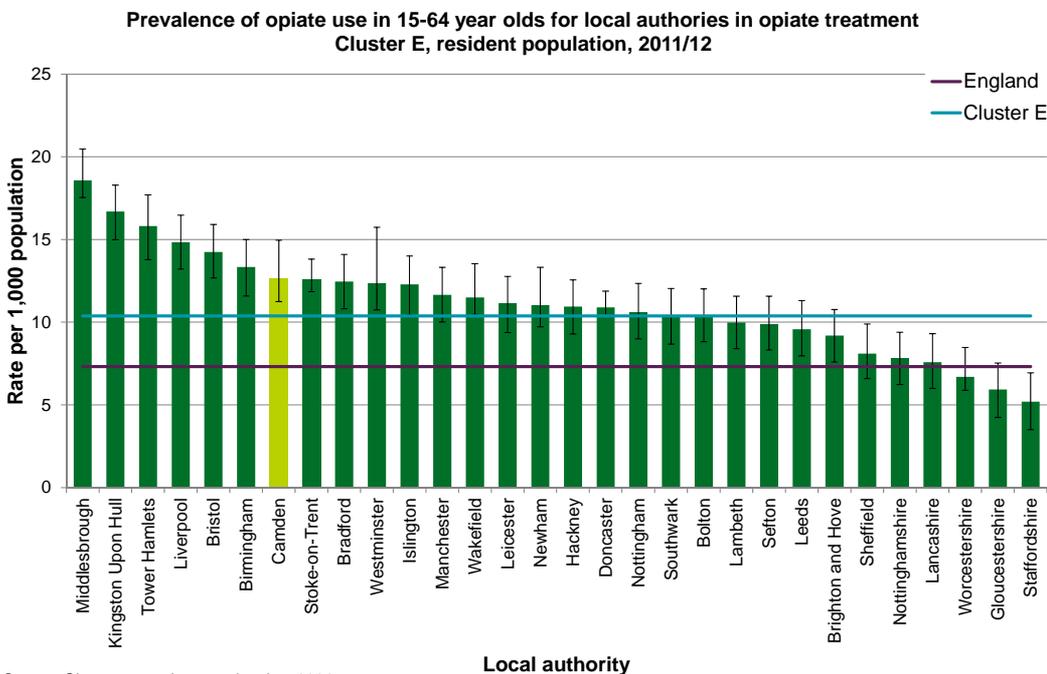
## Acronyms

Acronym	Definition
DIP	Drug interventions programme
NATMS	National Alcohol Treatment Monitoring System
NDTMS	National Drug Treatment Monitoring System
NFA	No fixed abode
NPSAD	National programme on substance abuse deaths (see Key terms for details)
TOP	Treatment Outcome Profile

# PREVALENCE

This section contains information on the estimated prevalence of people using different types of drugs and alcohol. Where possible, we present the data with comparators to show Camden’s level of need in context with other London boroughs and the national picture.

## Prevalence of opiate use in Partnership Cluster E

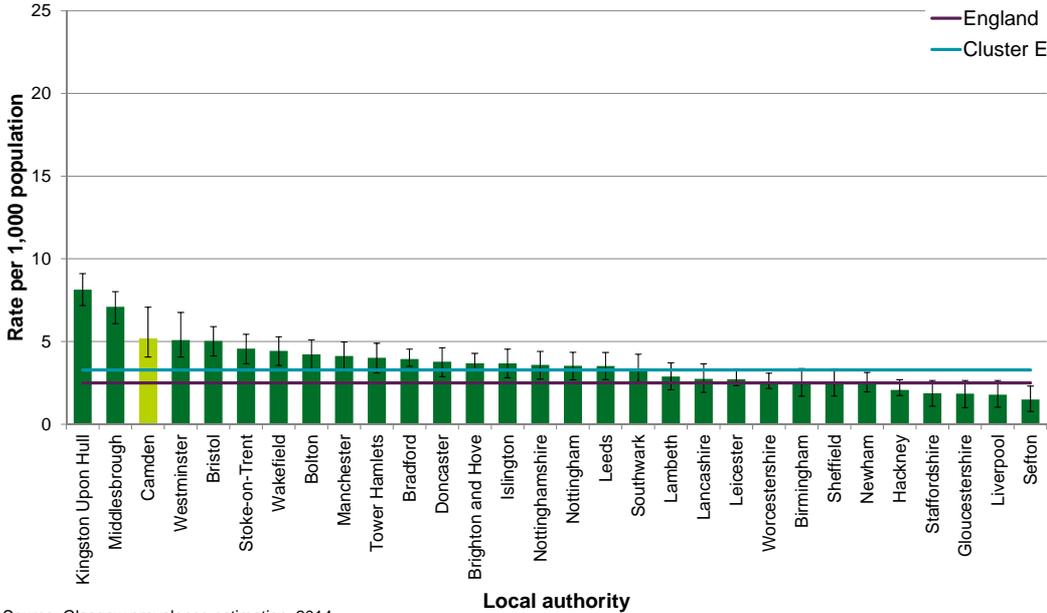


Source: Glasgow prevalence estimation, 2014

- English local authorities are grouped into clusters to allow for comparisons between areas of similar need.
- Camden is in Cluster E (the group with the highest need) for opiate treatment.
- In 2011/12 there were an estimated 2,060 opiate users in Camden (13 per 1,000 population). The estimated prevalence of opiate use in Camden was significantly higher than the Cluster average of 10 per 1,000 people.

# Prevalence of injecting drug use in Partnership Cluster E

Prevalence of injecting drug use in 15-64 year olds for local authorities in opiate treatment Cluster E, resident population, 2011/12



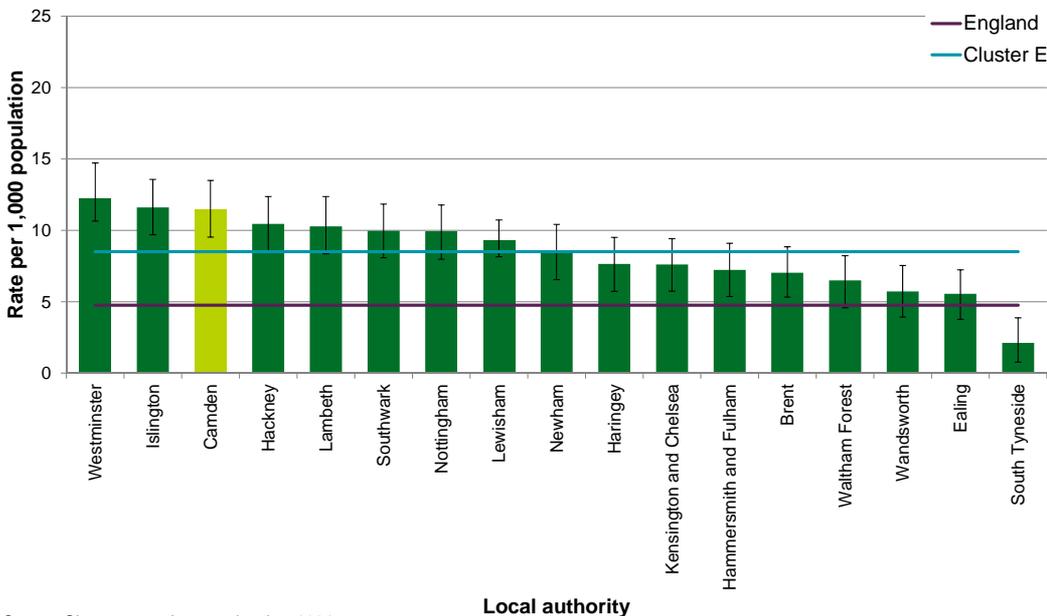
Source: Glasgow prevalence estimation, 2014

- There were an estimated 840 injecting drug users in Camden in 2011/12 (5 per 1,000 population). This was significantly higher than the Cluster average of 3 per 1,000 people.
- Injecting drug use has been shown here against the opiate drug treatment cluster, as heroin users account for the majority of injecting drug users in treatment.

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# Prevalence of crack cocaine use in Partnership Cluster E

Prevalence of crack cocaine use in 15-64 year olds for local authorities in non-opiate treatment Cluster E, resident population, 2011/12



Source: Glasgow prevalence estimation, 2014

- There are also clusters for non-opiate drugs, and again Camden is in Cluster E (the group with the highest need).
- In 2011/12 there were an estimated 1,860 crack cocaine users in Camden (12 per 1,000 population). The estimated prevalence of crack cocaine use in Camden was significantly higher than the Cluster average of 9 per 1,000 people.
- There are no local estimates published for other non-opiate drugs.

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## Estimated prevalence of other drug use

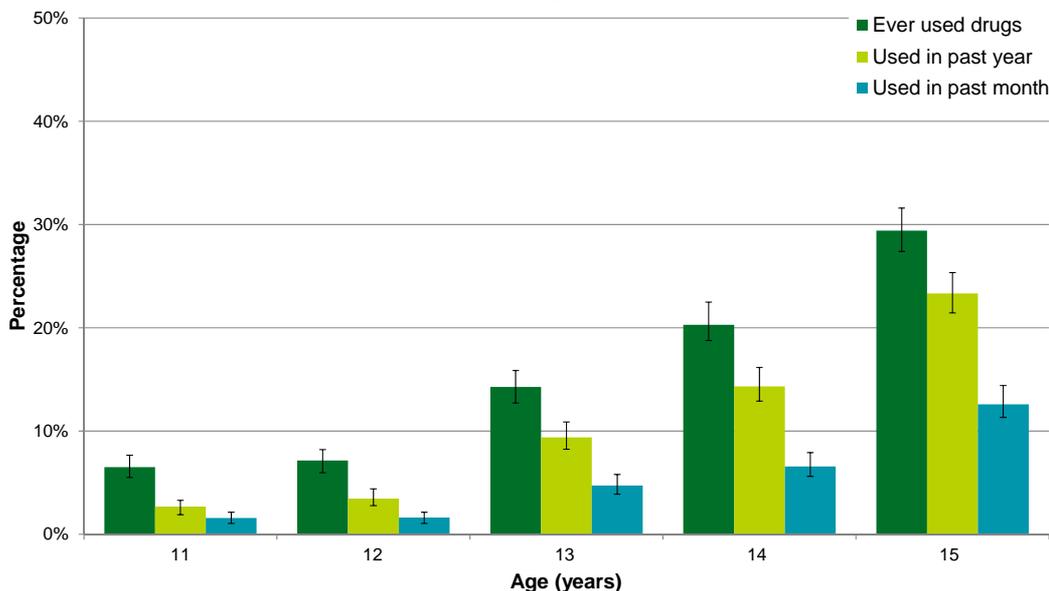
	London prevalence	Camden estimate
Powder cocaine	3.4%	5,190
Ecstasy	1.8%	2,740
Hallucinogens	0.6%	990
Amphetamines	0.5%	850
Cannabis	7.2%	11,060
Mephedrone	0.3%	540
Ketamine	0.6%	900
Amyl nitrate	0.8%	1,200

- The Crime Survey for England and Wales 2012/13 (CSEW)** includes the self-reported prevalence of illicit drug use among 16-59 year olds in the past year, by region. Applying these figures to Camden's population, it's possible to make an estimate of how many people in the borough use different illicit drugs:
  - The CSEW estimates that 10% of 16-59 year old Londoners use illicit drugs, which would suggest that over 15,000 Camden residents use illicit drugs, including almost 6,000 using at least one Class A drug.
  - The most widely used illicit drugs are cannabis and powdered cocaine.
  - However, the survey does not include an estimate of the frequency of drug use.
- Talk to Frank** is the national drug advice service which people can contact for support by phone, email, text, and online chat. The service collates national information according to the drug(s) mentioned in each contact, and figures from the service also highlight the relatively high prevalence of cannabis and cocaine use. Due to the sensitive nature of the calls personal data such as area of residence are not collected, so the figures discussed below are national level.
- Cannabis was the most frequently mentioned drug by service users by all four modes of contact. This included almost 22,000 calls in 2012/13, compared to 13,000 calls about cocaine use (the second highest).
- Heroin, Cathinones, and Alcohol also accounted for a large amount of contacts in the past year.

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## Drug use among young people

Proportion of young people that used drugs in the past month, year or ever, 11-15 year olds, England, 2012/13



Source: Smoking, Drinking, and Drug Use in Young People, HSCIC, 2013

- Overall, 17% of 11-15 year olds in England used some kind of drug and 11% used something other than volatile substances such as poppers and solvents in 2012/13 .
- Drug use increased with age, but with little variation by sex.
- If Camden children and young people had the same rate of drug use as the national figures almost 1,500 children would have used drugs, with 1,000 using them in the past year and 500 using them in the past month.

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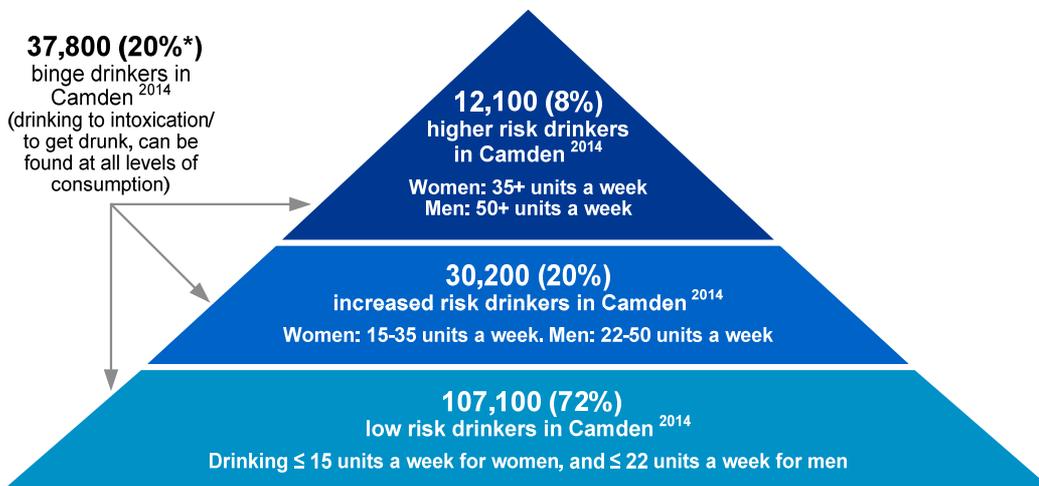
## Drug use among young people - the local picture

The Camden Health Related Behaviours Questionnaire, among a sample of Year 8 and 10 pupils in the borough, looks at a number of health behaviours, including alcohol and substance misuse:

- 12% of boys and 20% of girls in Year 10 reported drinking at least one unit of alcohol in the past week, though boys reported higher levels of consumption.
- In Year 10, White and Mixed ethnic groups were more likely to report that they consumed alcohol in the past week, (35% and 39% respectively), compared to 7% among Asian pupils and 15% among Black pupils.
- 71% of Year 10 boys reported not drinking at all, similar to previous years.
- 33% of Year 10 pupils have used an illegal drug, and 13% of Year 8 pupils. Within Year 10, drug use was highest among pupils from a Mixed ethnic background (53%) and lowest among Asian pupils (28%).
- 36% of Year 10 pupils reported being offered cannabis. This includes 50% of White pupils, and 52% of Year 10 boys - a decrease from 67% in 2010. 20% of Year 10 pupils said that they had used cannabis, the same for boys and girls.

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## Estimated prevalence of alcohol use



\* The prevalence of binge drinking is reported based on the whole population, other estimates of alcohol consumption are based on the population of drinkers.  
Source: Prevalence estimates have been made using the Office of National Statistics' population estimates for Camden, prevalence of drinking behaviours from the Local Alcohol Profile for Camden (2014).

- There are no published estimates of alcohol dependence by local authority, however the Local Alcohol Profiles for England (LAPE) include estimated prevalences of each level of alcohol use.
- LAPE estimate that, of people who drink alcohol, 8% of people are higher risk drinkers, and 20% of drinkers binge drink.
- There is currently no reliable estimate of the prevalence of dependent drinkers at local authority levels.

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## TREATMENT PENETRATION

This section contains information on the numbers of drug users in treatment and known to the treatment services in Camden, taken from the NDTMS, and compares these figures with prevalence estimates for substances where they are available.

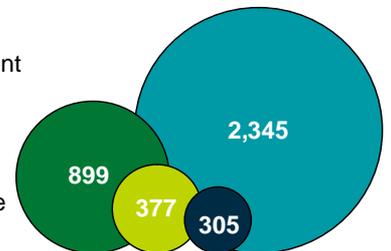
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### Treatment penetration: opiates and crack

These figures look at the extent of treatment penetration - i.e. how many of the estimated opiate and crack using population are currently in treatment, and how many others have been in treatment in the past year.

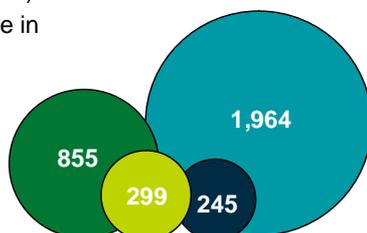
#### Opiate or Crack users

- There were almost 900 people in treatment for opiate or crack use (38% of the borough's estimated using population) in March 2013.
- An additional 377 were in treatment in the past year (16% of estimated users).



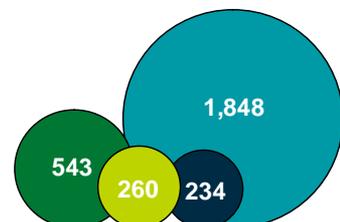
#### Opiate users

- There were 855 people in treatment for opiate use (44% of estimated opiate users) at the end of 2012/13.
- Almost 300 other people were in treatment for opiate use in 2012/13, leaving 40% of estimated users who were not in contact with the service this year.



#### Crack users

- Almost 550 people are currently in treatment for crack use, 29% of the estimated crack-using population.
- A further 14% of the estimated crack-using population were in treatment at some point in 2012/13.



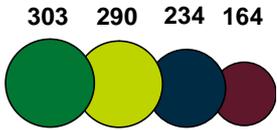
KEY:   
● In treatment, March 2013   
● In treatment last year   
● Known to treatment, but not treated last year   
● Estimated prevalence

Source: NDTMS, 2013; Glasgow prevalence estimation, 2014

# Treatment penetration: other drugs

## Cannabis users

- Over 300 people were in treatment at the end of March 2013, over 30% of cannabis users known to the treatment system.
- A further 29% were in treatment at some point in 2012/13.



## Cocaine users

- 109 people were in treatment for cocaine use in March 2013.
- This accounts for a quarter of cocaine users known to the treatment service.



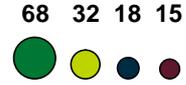
## Amphetamine users

- Almost 50 people were treated for amphetamine use
- This amounts to almost three-quarters of amphetamine users known to the treatment service.



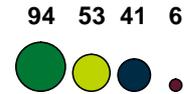
## Benzodiazepine users

- Over half of benzodiazepine users that were known to treatment services were in treatment at the end of March 2013.



## Other drug users

- There were 94 people in treatment for the use of other drugs.
- This accounts for about half of people known to use other drugs.



**KEY:**

-  In treatment, March 2013
-  In treatment last year
-  Known to treatment, but not treated last year
-  Clients in contact with Drug Interventions Programme, but not with the treatment system\*

Prevalence estimates are not published at local authority level for these drugs, so the number of clients in contact with the DIP team is used. However, these figures will inevitably be an underestimate as they miss drug users who have never contacted a treatment program.

Source: NDTMS, 2013.

## TREATMENT POPULATION PROFILE

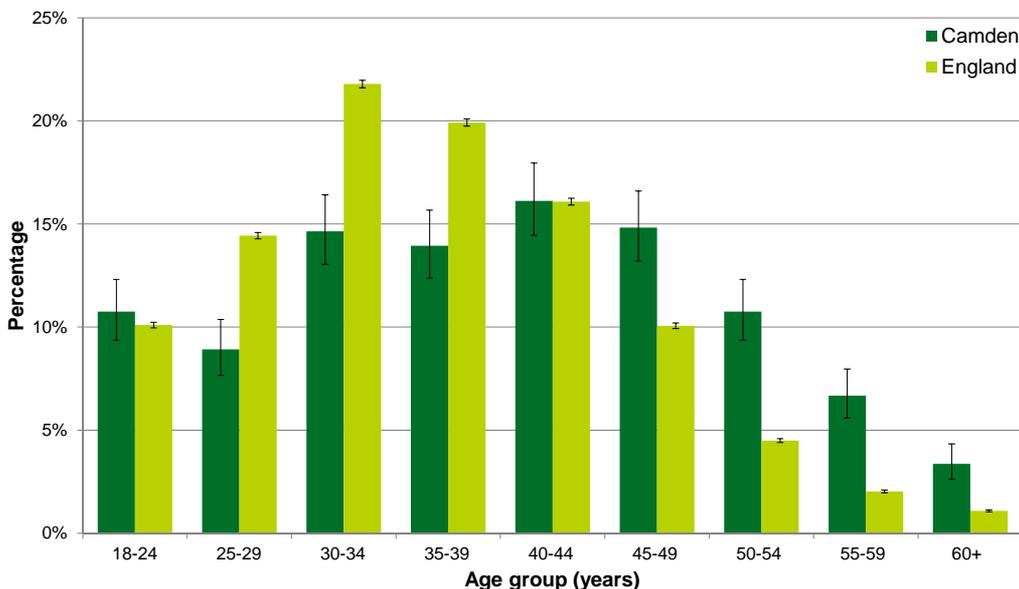
This section contains information on the demographics of the population in drug treatment.

We know from previous needs assessments that drug and alcohol misuse is more prevalent in some groups. For this reason, in this section we compare Camden’s treatment population to the national treatment population, rather than Camden’s resident population.

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## Treatment population profile: age and sex, drugs

Proportion of drug treatment clients by age, Camden resident drug client population, aged 18 and over, compared against England, 2012/13

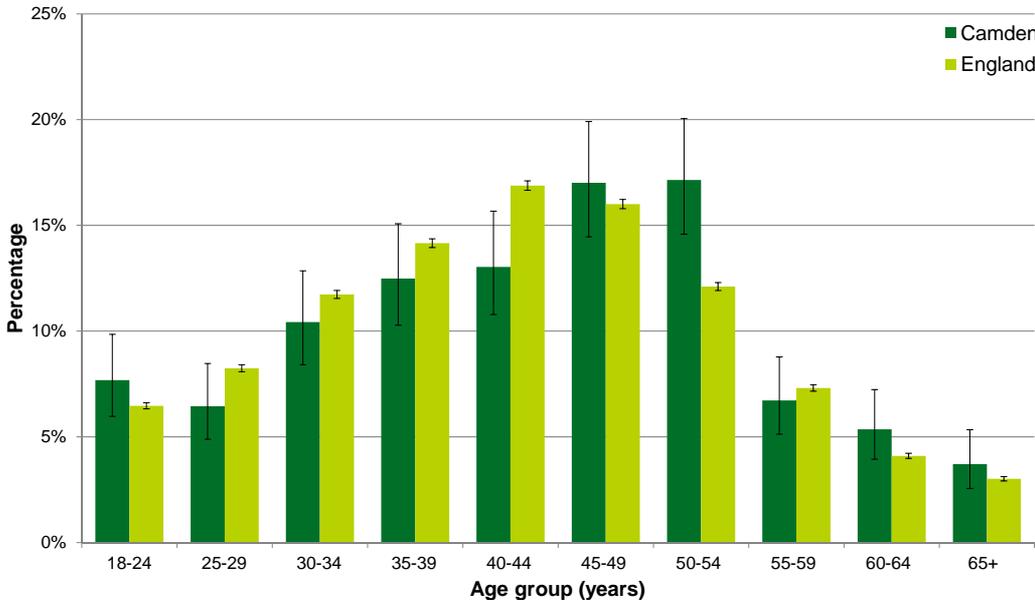


Source: Adult Partnership Quarterly Performance Report 2012 / 2013, Quarter 4 and NDTMS, 2012/13

- There were almost 1,690 people in treatment for drugs in Camden in 2012/13 (0.9% of the adult population).
- Camden’s drug treatment population was older than the England average, with the exception of people in treatment for cannabis use, where 42% were aged 15-24 years old (compared to 27% nationally).
- The Camden drug treatment population had a similar gender split to the national average. Across all drugs about 70% of people in treatment were men, locally and nationally.

## Treatment population profile: age and sex, alcohol

Proportion of alcohol treatment clients by age, Camden resident alcohol client population, aged 18 and over, compared against England, 2012/13



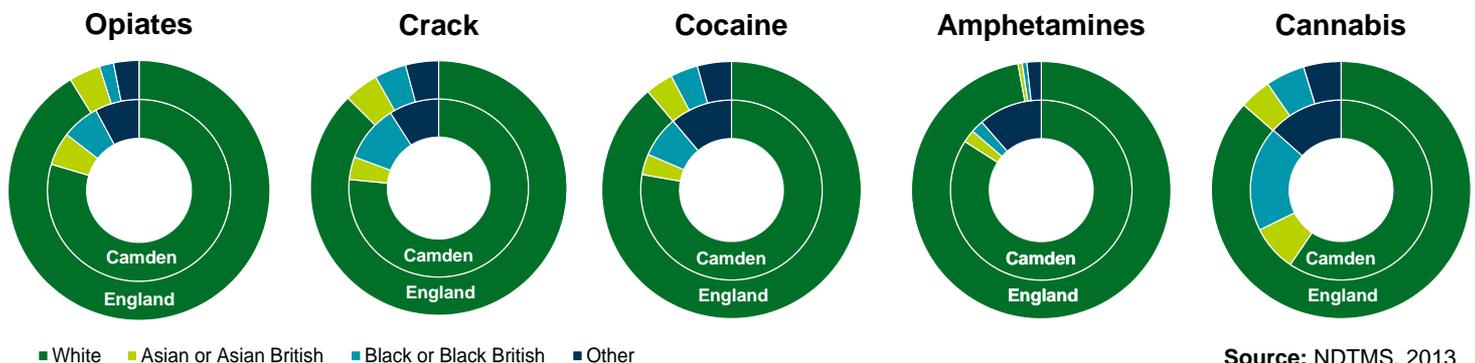
Source: Adult Partnership Quarterly Performance Report 2012 / 2013, Quarter 4 and NDTMS, 2012/13

- In 2012/13 there were 738 adults in alcohol treatment in Camden (0.4% of the adult population).
- The Camden alcohol treatment population had a similar age structure to England. However, there was a slightly higher proportion of Camden residents in treatment that were older (age 45 to 65+).
- About 65% of people in treatment for alcohol were men. This was same at a local and national level.

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## Treatment population profile: ethnicity, drugs & alcohol

- In 2012/13 Camden's drug and alcohol treatment population was generally more ethnically diverse than the national average. For most substances, a smaller proportion of people in treatment in Camden were White than the national average. For example, nationally 91% of people in treatment for opiate use were White, compared to 80% in Camden. The treatment population for alcohol was 81% White in Camden compared to 91% White nationally.
- This may reflect the greater ethnic diversity in Camden - 66% of Camden's population were White, compared to 85% of the national population.
- The charts below show the ethnic breakdown for five drugs where there was a significant difference between Camden and England's treatment populations. There was no significant difference between the ethnic groups in treatment for benzodiazepine use.



Source: NDTMS, 2013

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## COMPLEXITY & COMPOUNDING FACTORS

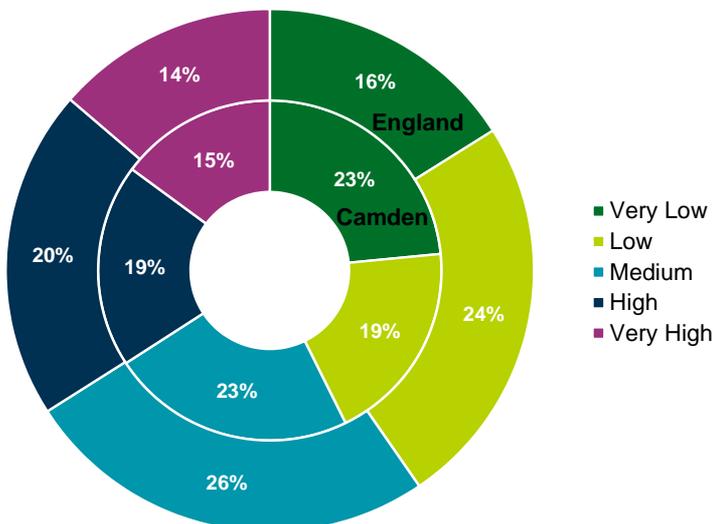
Many people in drug and alcohol treatment experience wide-ranging problems. This section looks at the overall level of complexity and prevalence of different complexity indicators in the drug treatment population. It also includes information on the prevalence of compounding factors in the alcohol treatment population.

**Note:** Overall complexity is only modelled for drug treatment clients (i.e. different complexity factors are weighted according to the impact they have on a client’s likelihood of completing treatment). New drug clients joining a treatment program are assessed to determine how complex their needs are based on the information in their Treatment Outcomes Profile (TOP), and are classified from very low to very high. There is no similar model for weighting complexity factors in alcohol misuse clients, but compounding factors are recorded at the start of treatment.

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## Complexity: overall complexity in all drugs clients

Distribution of treatment population by complexity, Camden resident clients and national clients, 2012/13



- In Camden, a similar proportion of drug clients were in each complexity group in 2012/13.
- The proportion of clients in the very low complexity group in Camden was significantly higher than the national average (23% vs. 16%, respectively). The distribution of complexity groups was otherwise similar to the national average.

# Complexity: interpreting the charts

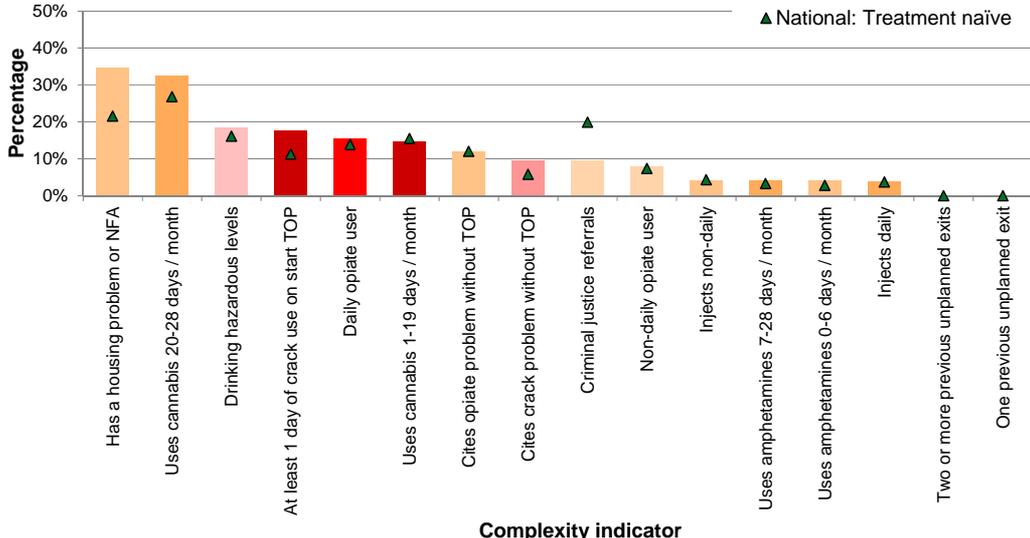
New clients complexity category	Complexity score	Existing clients complexity category	Complexity score
Pregnant	-5	Cocaine 1-3 days*	-5
In work 1-28 days*	-4	Cocaine 4-28 days*	-5
In education 1-28 days*	-2	In work 1-28 days*	-5
Physical health score >=12	-2	Pregnant	-5
Psychological health score >=11	-1	In education 1-28 days*	-3
Quality of life score >=12	-1	Physical health score >=12	-1
Cocaine 1-3 days*	0	Psychological health score >=11	-1
Cocaine 4-28 days*	0	Male	0
Cannabis 1-19 days*	1	Quality of life score >=12	0
Cannabis 20-28 days*	1	Amphetamines 1-6 days*	1
Amphetamines 1-6 days*	2	Cannabis 1-19 days*	1
Crack user (no TOP)	2	Amphetamines 7-28 days*	2
Current injector (no TOP)	2	Crack user (no TOP)	2
Housing problem	2	Cannabis 20-28 days*	3
Injector - non-daily	2	Crack 1-6 days*	3
Male	2	Crack 7-28 days*	3
Previous unplanned episode (1)	2	Housing problem	3
Crack 1-6 days*	3	Referral from Criminal Justice	3
Injector - daily	3	Current injector (no TOP)	4
Referral from Criminal Justice	3	Hazardous drinker	4
Previous unplanned episodes (2 or more)	5	Injector - non-daily	4
Amphetamines 7-28 days*	6	Injector - daily	5
Crack 7-28 days*	6	Previous unplanned episode (1)	5
Hazardous drinker	6	Previous unplanned episodes (2 or more)	10
Opiate user (no TOP)	13	Opiate user (no TOP)	13
Opiate use - daily	15	Opiate user - non-daily	14
Opiate user - non-daily	15	Opiate use - daily	15

- Clients are categorised into different levels of complexity based on their total complexity score.
- Complexity scoring is slightly different for new and existing (non naive) clients.
- As opiate use is a factor in the scoring, opiate and non-opiate clients are scored in the same way and results presented for all drug users together.
- The charts on the following pages show common complexity indicators in Camden.
- Indicators are weighted, and charts are shaded to reflect this. **Dark red** shows the most heavily weighted complexity indicators.

\* Refers to the number of days of work, education, or drug use in the past 28 days.

# Complexity: indicators in naïve clients

The percentage of treatment naive drug clients by complexity indicators, Camden's resident drug client population, 2012/13

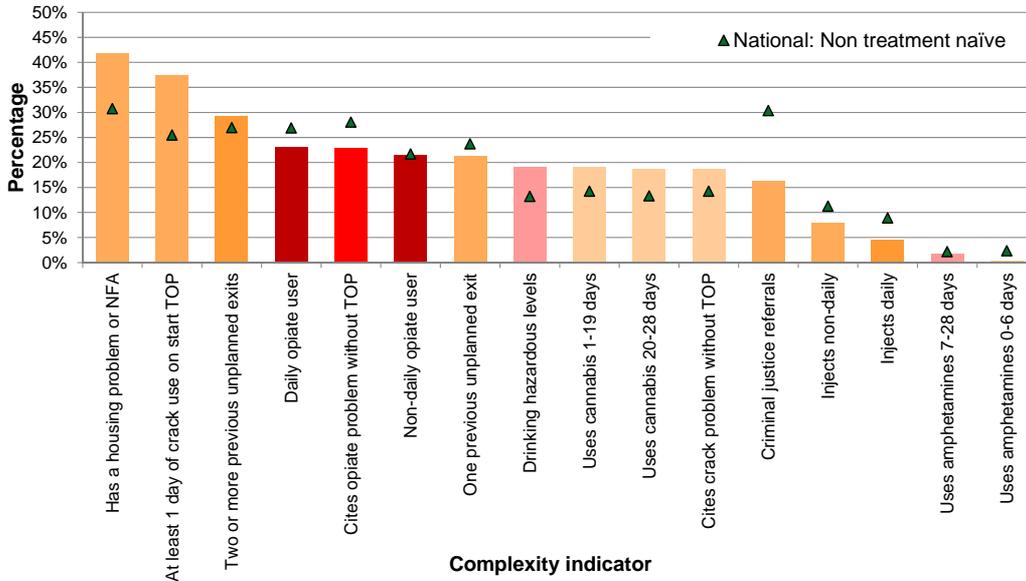


- The most common complexity factor for both the naive and non naive treatment clients was housing problem or no fixed abode. This was higher than the national average.
- For naive clients, the other common complexity factor was cannabis use (20-28 days per month). This was higher than the national average in Camden.

**Notes:** Complexity factors are coloured from red to yellow to reflect high to low complexity. Some complexity factors are not presented in the graph as no cases were reported. NFA = No fixed abode. TOP = Treatment Outcome Profile  
 Days represents the number of days that the client uses a drug per month.  
**Source:** Recovery Diagnostic Toolkit, 2013

## Complexity: indicators in non-naïve clients

The percentage of non-treatment naïve drug clients by complexity indicators, Camden's resident drug client population, 2012/13



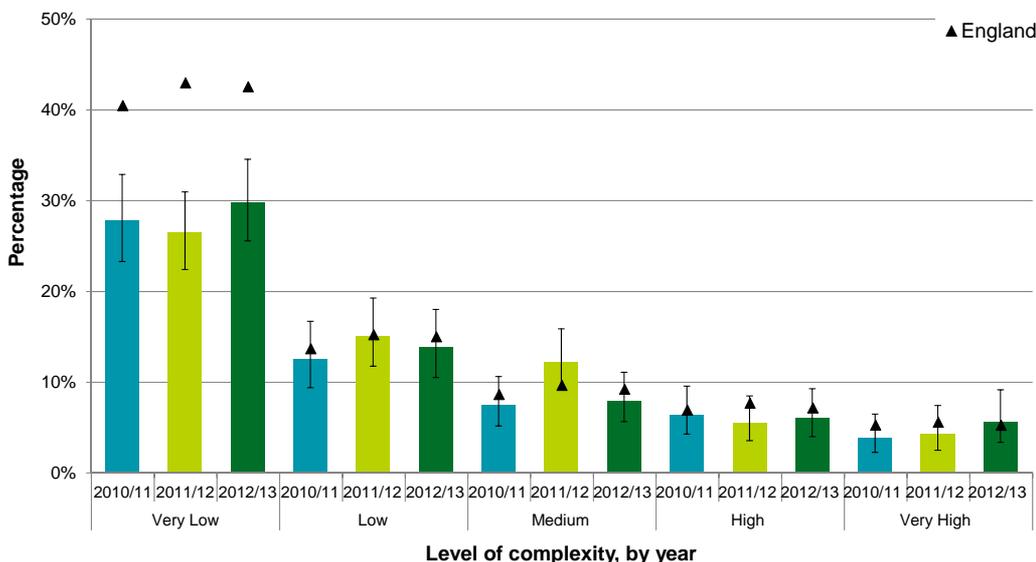
**Note:** Complexity factors are coloured from red to yellow to reflect high to low complexity. Some complexity factors are not presented in the graph as no cases were reported. **Source:** Recovery Diagnostic Toolkit, 2013

- For non treatment naïve clients, the most common complexity factor after housing problems was "at least 1 day of crack use per month at the start of TOP". This was higher than the national average.

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## Complexity: completion by all drug clients

Percentage of all clients that completed treatment by complexity, Camden drug client resident population compared against England, 2010/11 to 2012/13



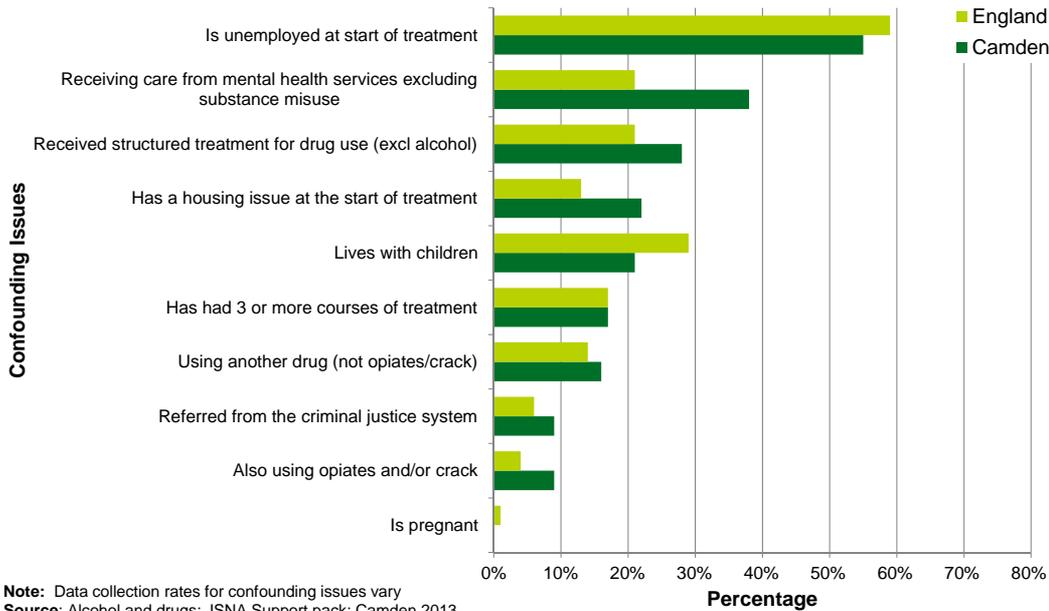
**Source:** Recovery Diagnostic Toolkit, 2013

- In 2012/13, just under a third of all Camden clients scored as very low complexity completed treatment. This was significantly lower than the England average (43%).
- As expected, completion rates were lower in more complex clients. Six per cent of very high complexity clients completed treatment in Camden, compared to 30% of very low complexity clients.
- There was little change in completion rates in any complexity group between 2010/11 and 2012/13.

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# Compounding issues: alcohol clients

**Compounding issues in the treatment population, Camden's resident alcohol treatment population, 2012/13**



**Note:** Data collection rates for confounding issues vary  
**Source:** Alcohol and drugs: JSNA Support pack: Camden 2013

- Unemployment was the most common compounding issue in the alcohol treatment population, with 55% of the Camden population being unemployed at the start of treatment, lower than the England average of 59%.
- About 38% were also receiving care from mental health services for reasons other than substance misuse, almost double the England average (21%).
- One in five also had a housing issue at the start of treatment, higher than England (13%).
- About 28% also received structured treatment for drug use (other than alcohol), higher than the country rate of 21%.

## TREATMENT OUTCOMES

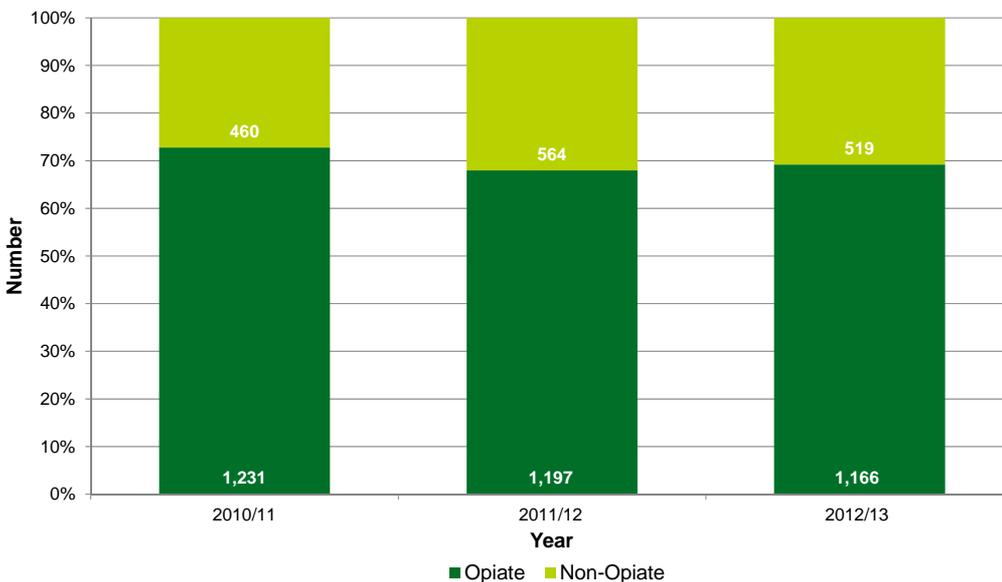
This section presents information on treatment outcomes for drug and alcohol clients, from the NDTMS and NATMS. It includes breakdowns of the reasons people leave treatment, numbers of people successfully completing treatment, changes in substance misuse at 6 and 12 months in to treatment, and patients representing to the service after completing treatment. It also includes information on the treatment careers of clients, including the length of treatment episodes and the number of previous treatment journeys that clients have had.

**Note:** Outcomes for drugs clients are compared with the relevant cluster where data are available, and national averages otherwise.

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## Treatment outcomes: numbers in drug treatment

The number of opiate and non-opiate clients in Camden, Camden's resident population, 2010/11 to 2012/13



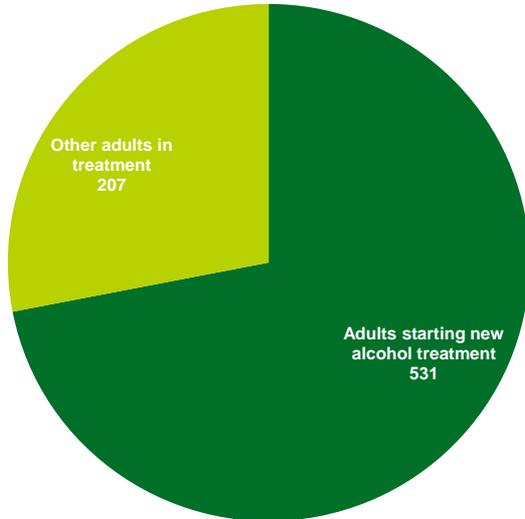
- In Camden 70% of drugs clients are in treatment for opiates.
- Between 2010/11 and 2012/13 the number of people in treatment for opiates in Camden fell by 5% from 1,231 to 1,166.
- Over the same period the number in treatment for non-opiates rose by 13% from 460 to 519.

Source: Recovery Diagnostic Toolkit, 2013

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## Treatment outcomes: numbers in alcohol treatment

The percentage of adults starting new alcohol treatment, Camden's resident alcohol treatment population, 2012/13



- During 2012/13, 72% of the Camden treatment population started a treatment journey during the period compared to 69% in England.
- 413 Camden adults left alcohol treatment within 2012/13. This represented 56% of the Camden treatment population which was lower than the England average of 63%.

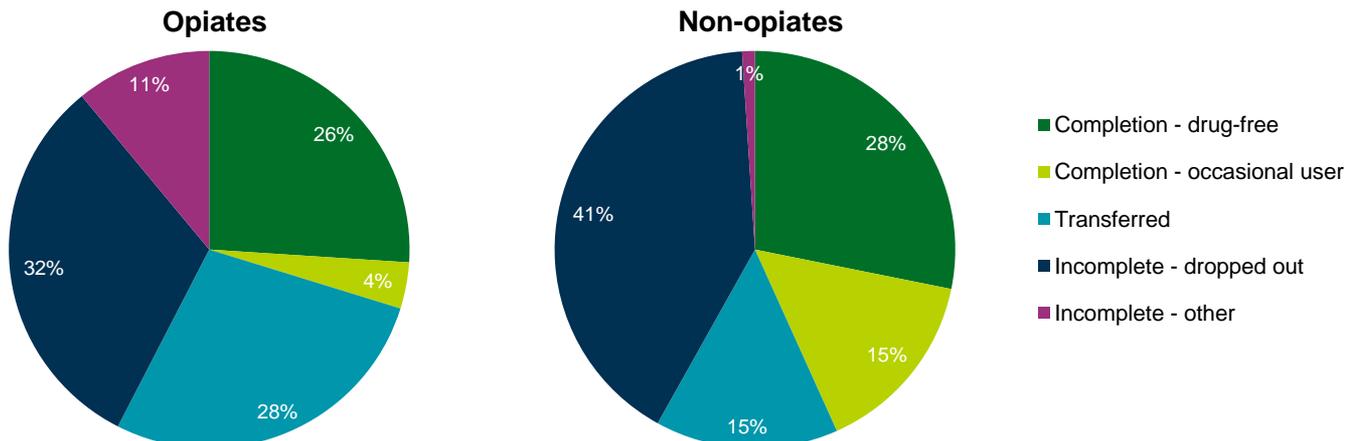
Source: Alcohol and drugs: JSNA Support pack: Camden 2013

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## Treatment outcomes: reasons for leaving treatment

The National Treatment Agency publishes the **reasons that patients leave treatment**; 26% of opiate drug treatment clients who left treatment in Camden in 2012/13 were drug-free, and 28% of non-opiate clients.

In the figures, below, 'transferred' predominantly includes people leaving treatment with no known destination and a very small percentage who have represented to another service and people now in custody; 60% of opiate users have left treatment without completing, compared to 34% of non-opiate clients.

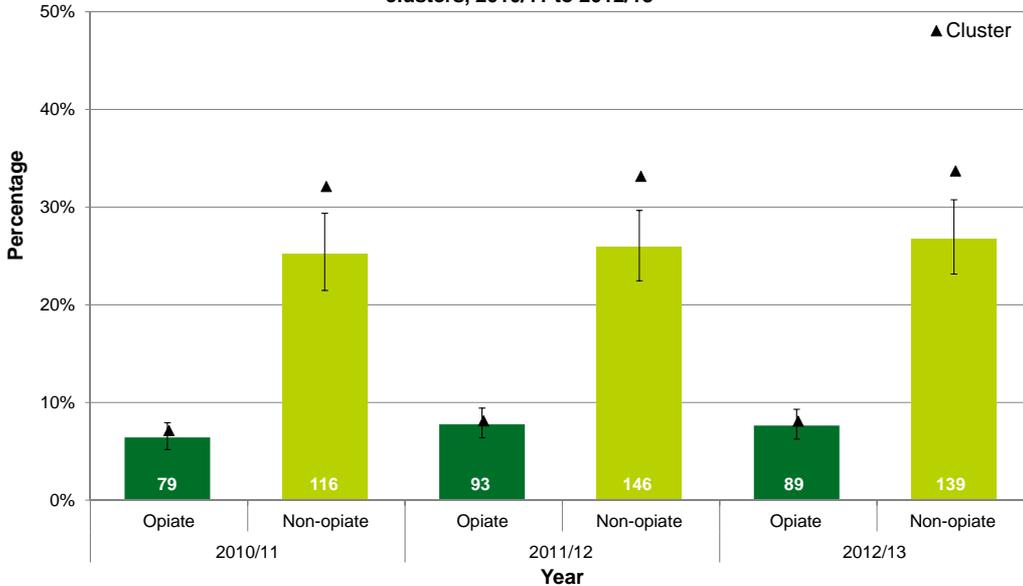


Source: National Treatment Agency, 2013

35

## Treatment outcomes: completion of drugs treatment

The percentage of opiate and non-opiate clients that completed treatment by year, Camden's drug client resident population compared against Camden's treatment clusters, 2010/11 to 2012/13



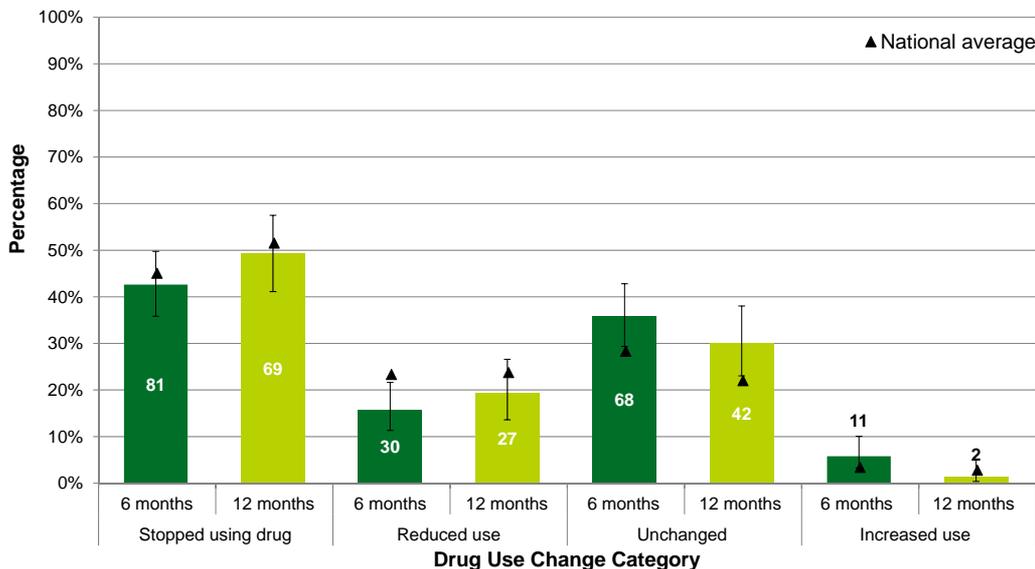
Source: Recovery Diagnostic Toolkit, 2013

- These charts look at **completion rates among all people in treatment.**
- Overall, non-opiate clients were more likely to complete compared to opiate clients. This is similar to England.
- In Camden, non-opiate clients consistently had significantly lower completion rates than the cluster. The proportion of non-opiate clients that completed increased by 2% from 2010/11 to 2012/13.
- The proportion of opiate clients that completed treatment stayed the same for the past two years and was not significantly different from the cluster.

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## Treatment outcomes: change in opiate use

Breakdown of opiate clients by 6 month and 12 month opiate outcomes, Camden's opiate client resident population, 2012/13



Source: Recovery Diagnostic Toolkit, 2013

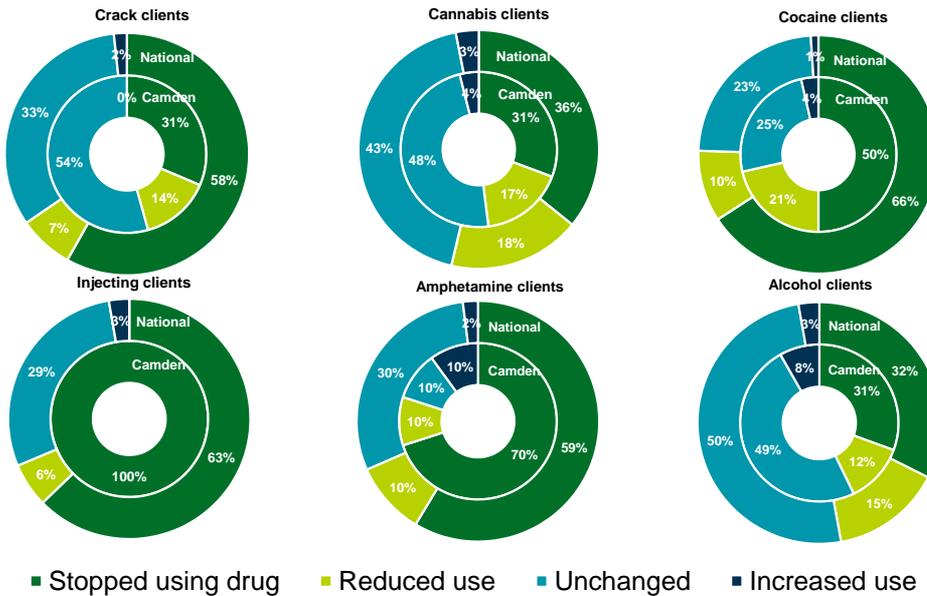
Note: Change in drug use is assessed using the 'Reliable Change Index', opiate clients' drug use must increase or decrease by at least 13 days from the start of

- 43% of opiate users had stopped use 6 months in to their treatment program, and 49% had stopped after 12 months, similar to the national average.
- The proportion of users whose drug use was unchanged 6 and 12 months into treatment was slightly higher than the national average.
- Few clients had seen a deterioration in drug use after 6 and 12 months.
- The pattern was similar when focusing specifically on crack use.

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## Treatment outcomes: Change in use, by drug

Breakdown of client outcomes at 6-months, by drug type, Camden's client resident population, 2012/13



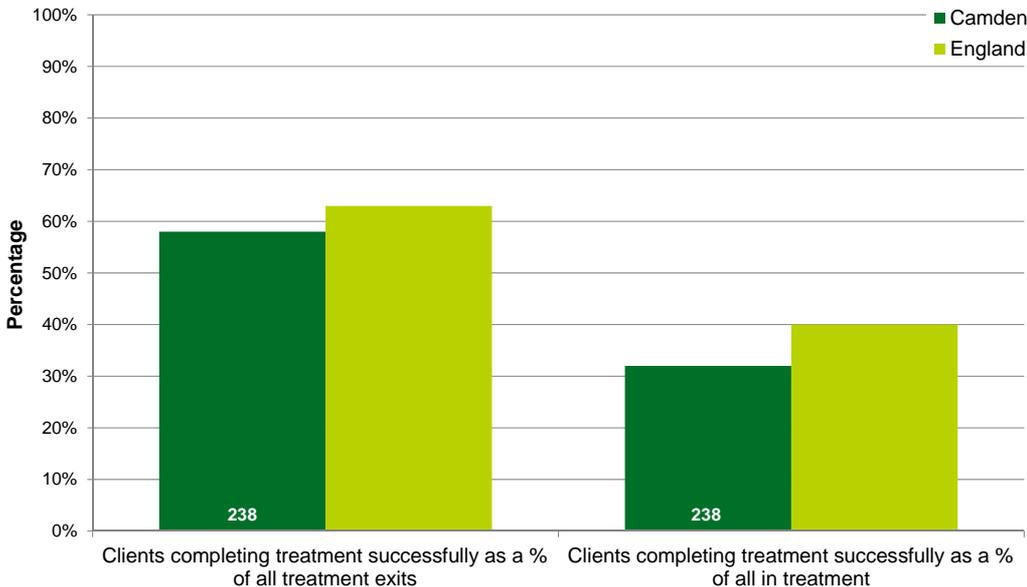
Source: Recovery diagnostic toolkit, 2013

Note: As with Opiates, change in drug use is assessed using the 'Reliable Change Index' with the boundaries ranging from eight days for Crack to 15 days for Injecting.

- In Camden, 100% of clients that were injecting at the start of treatment stopped by the time of the six month review. In addition, 70% of amphetamine clients had stopped. These proportions are higher than the national estimate, but should be interpreted with caution due to the relatively small number of clients.
- The proportion of Camden's treatment population that stopped using crack, cocaine, cannabis and alcohol at the six month review was less than the national estimate.
- There was also a higher proportion of amphetamine and alcohol clients that increased use in Camden at the six month review compared to the national estimate.

## Treatment outcomes: completion of alcohol treatment

The percentage of alcohol clients that successfully completed treatment, Camden's alcohol client population, 2012/13

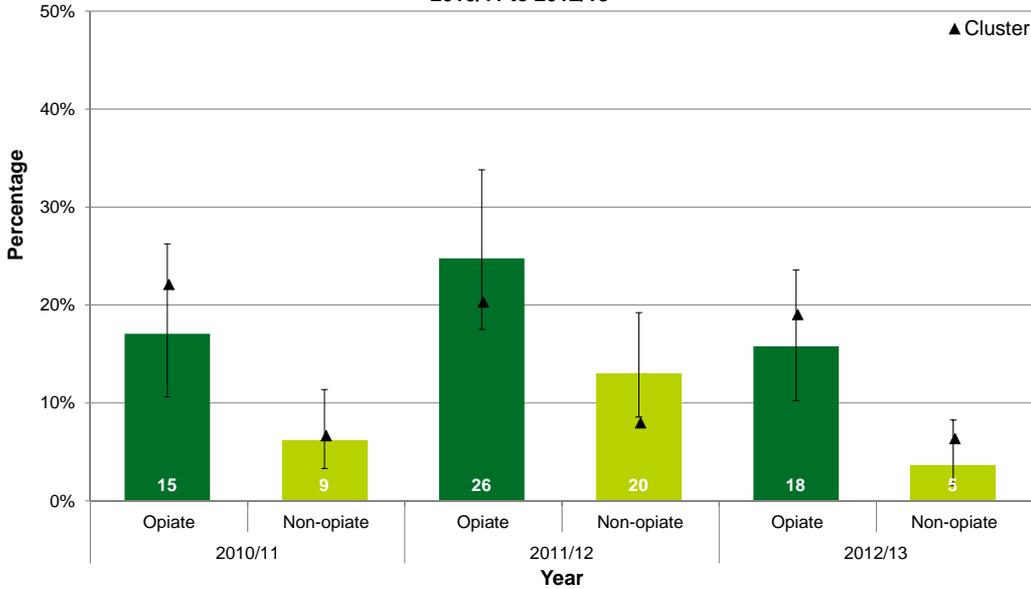


Source: Alcohol and drugs: JSNA Support pack: Camden 2013

- During 2012/13, 58% of all alcohol treatment exits were because a client had successfully completed.
- This successful completion rate was slightly lower than the England rate of 63%.
- Successful completion is when the individual has been discharged from treatment having met their care plan goals.

## Treatment outcomes: representations for drugs

The percentage of opiate and non-opiate clients that re-presented following completion of treatment by year, Camden's drug client resident population, 2010/11 to 2012/13



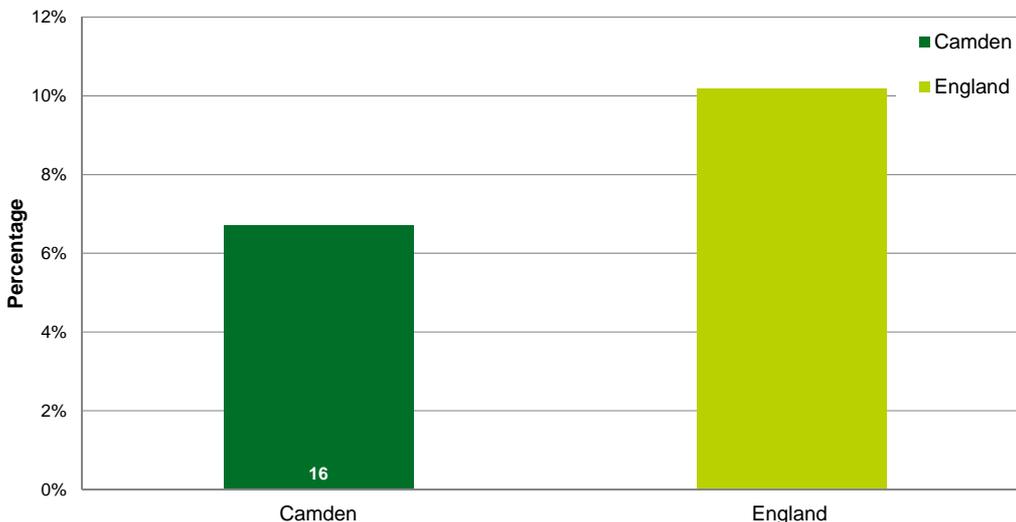
Source: Recovery Diagnostic Toolkit, 2013

- The re-representation rates in Camden were not significantly different from the cluster between 2010/11 and 2012/13.
- Overall, a higher proportion of opiate clients were likely to re-present compared to non-opiate users.
- Trends in re-representation rates are difficult to interpret due to the small numbers of clients re-presenting.
- The proportion that have re-presented after treatment may have decreased since 2011/12 for both opiate and non-opiate clients, although this is not a statistically significant decrease.

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## Treatment outcomes: representations for alcohol

Proportion of clients successfully completing treatment in 2012 and re-presenting within 6 months to the total successful completions, resident alcohol treatment population, Camden and England, 2012/13



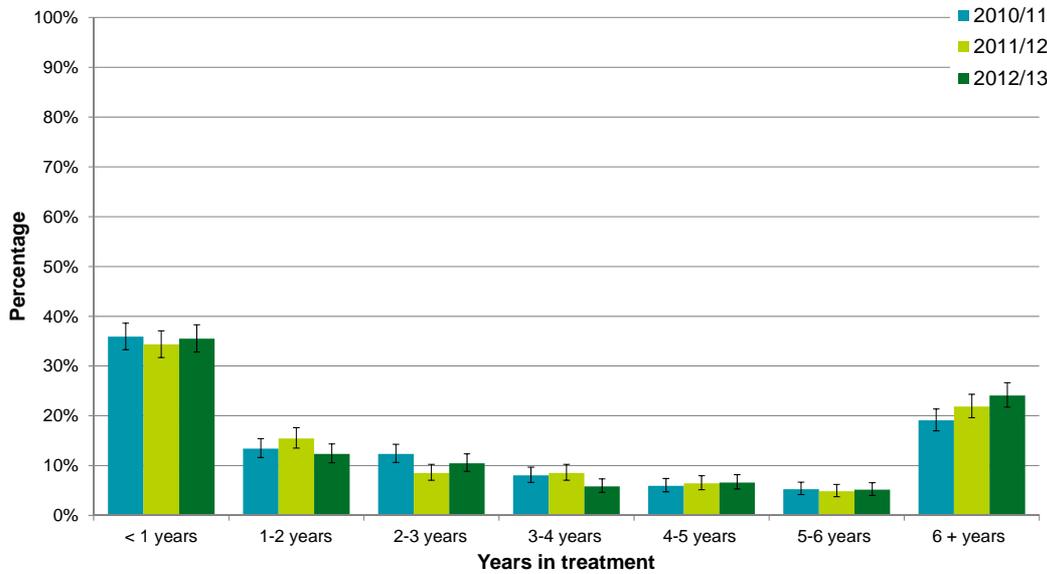
Source: Alcohol and drugs: JSNA Support pack: Camden 2013, DOMES 2013-2014 Q3

- 6.7% of clients who had successfully completed treatment in 2012 re-presented within 6 months. This was lower than the England average of 10% re-presenting.

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## Treatment outcomes: length of time in treatment for opiates

Percentage of opiate clients that were in treatment by length of treatment, Camden opiate client resident population, 2010/11 to 2012/13



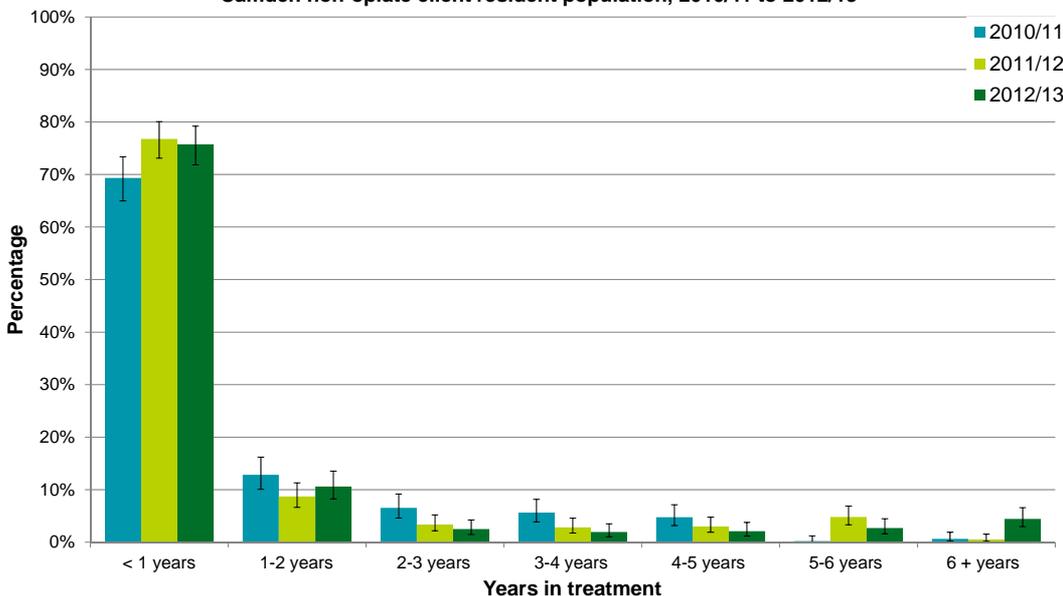
Source: Recovery Diagnostic Toolkit, 2013

- In Camden, as with the national picture, as more clients are in treatment for longer periods, it is less likely that they will complete treatment.
- The percentage of clients that had been in treatment for six or more years increased from 19% in 2010/11 to 24% in 2012/13.
- Conversely, the percentage of clients that had been in treatment for 1-2 years decreased from 20% to 16% in that period.
- Successful completion is highest for opiate clients that have been in treatment for under two years (about 10% of clients complete treatment). The completion rate for those in treatment six or more years is 1-2%.

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## Treatment outcomes: length of time in treatment for non-opiates

Percentage of non-opiate clients that were in treatment by length of treatment, Camden non-opiate client resident population, 2010/11 to 2012/13



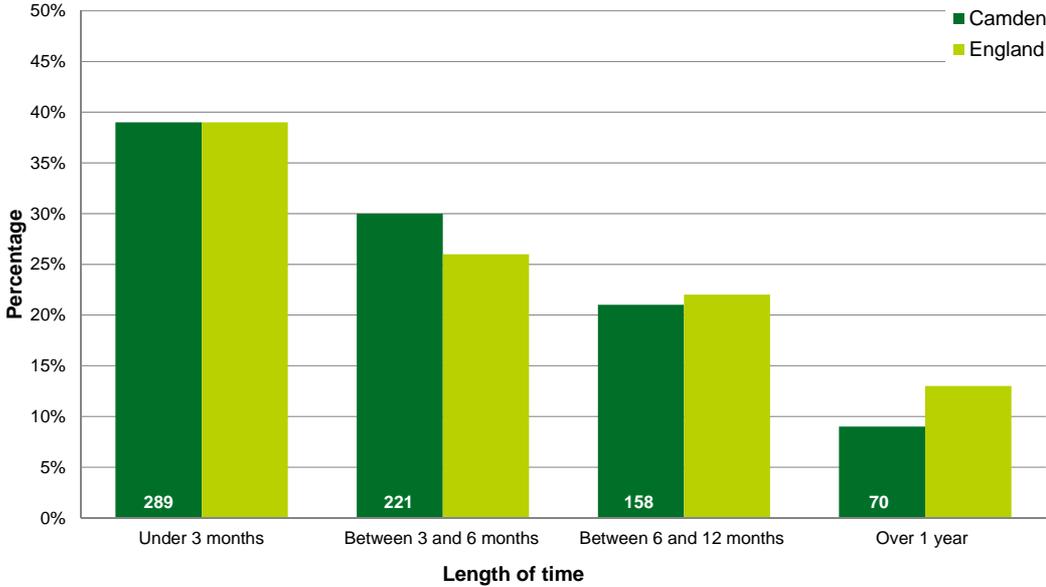
Source: Recovery Diagnostic Toolkit, 2013

- The majority of non-opiate clients had been in treatment for under one year.
- In 2012/13, completion rates for non-opiate clients were higher in those that had been in treatment for under two years (30%) than those that had been in treatment for more than two years (8%).

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# Treatment outcomes: length of time in treatment for alcohol

Percentage of clients that were in alcohol treatment by length of time in treatment, Camden's resident alcohol treatment population, 2012/13

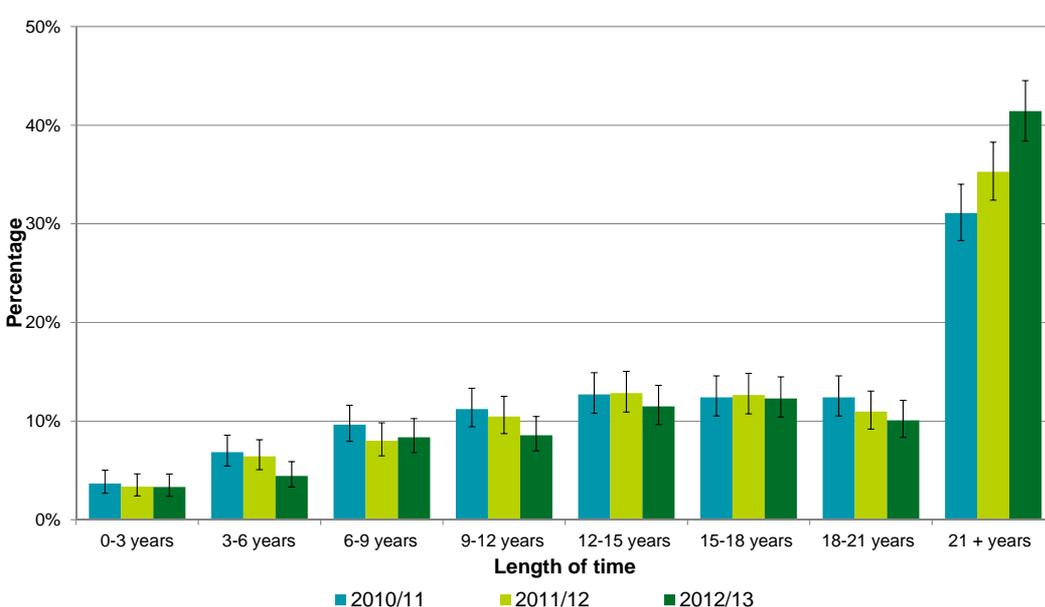


- On average clients spent 162 days in alcohol treatment in Camden compared with 183 days in England.
- Current recommendations are that adults should spend a maximum of 1 year in alcohol treatment. 9% of adults in alcohol treatment in Camden spent over 1 year in treatment, which is slightly better than the England average (13%).

Source: JSNA Support pack: Alcohol and drugs 2013 : Camden

# Treatment outcomes: length of drug career, opiates

Percentage of opiate clients that were in treatment by length of drug career, Camden opiate client resident population, 2010/11 to 2012/13

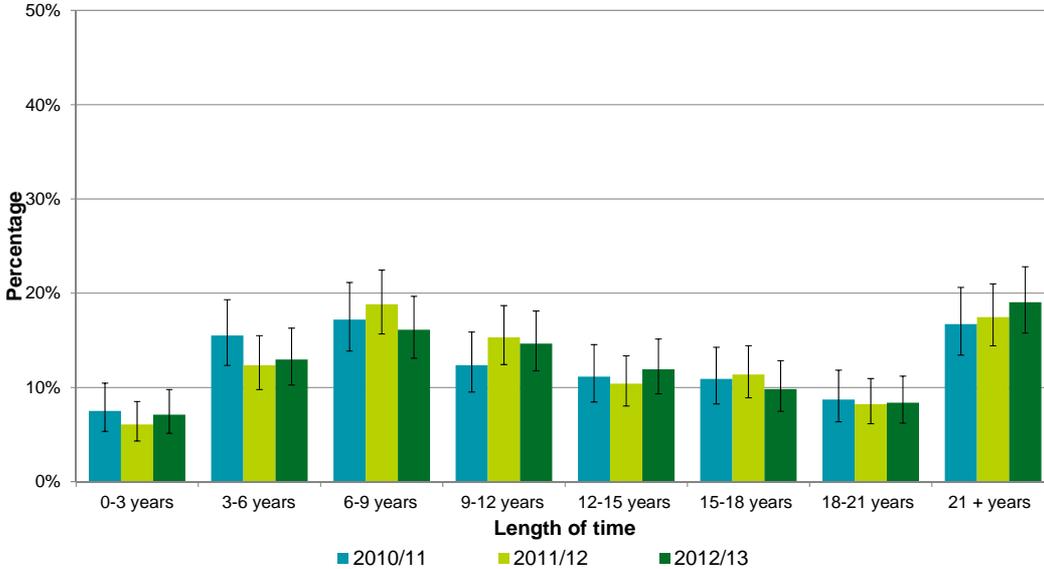


- There was a significantly higher percentage of clients with 21+ year opiate careers in 2012/13 in Camden compared to 2010/11 (41% and 31%, respectively).
- The percentage of clients with 21+ year careers was also significantly higher than Camden's opiate cluster average in 2012/13 (25%).
- The increase in numbers of clients with very long careers is in line with national trends. The number of new users are decreasing and so existing users that started using in the 1980s and 90s represent a higher proportion of the treatment population.
- Overall, there were higher completion rates for opiate clients that had shorter drug careers, however this trend is not significant.

Source: Recovery Diagnostic Toolkit, 2013

## Treatment outcomes: length of drug career, non-opiates

Percentage of non-opiate clients that were in treatment by length of drug career, Camden non-opiate client resident population, 2010/11 to 2012/13



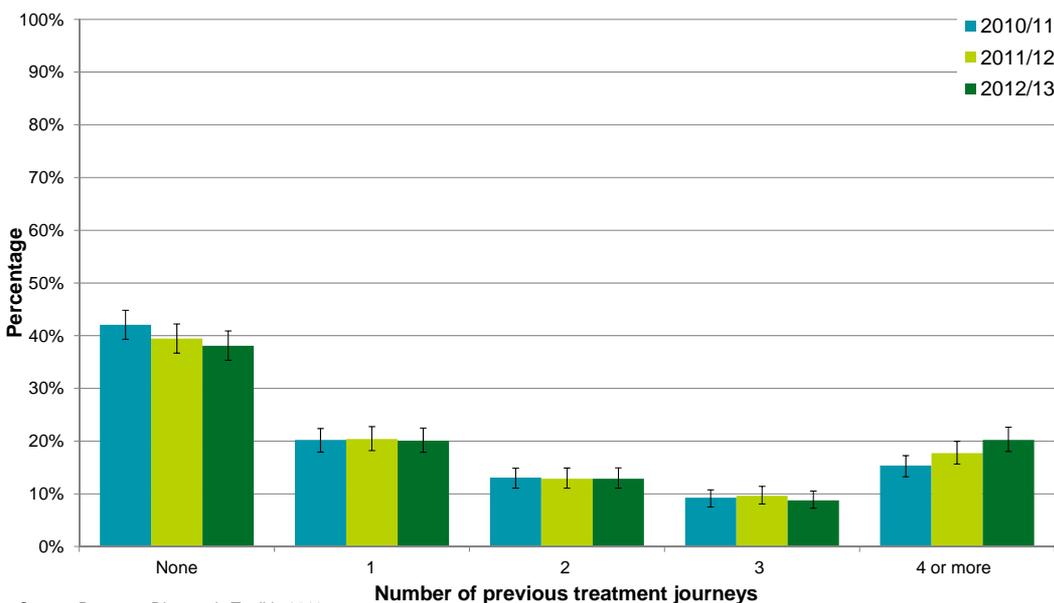
Source: Recovery Diagnostic Toolkit, 2013

- Compared to opiate client drug careers, there were similar proportions of non-opiate clients with different lengths of drug careers.
- The proportion of non-opiate clients that had had more than 21 year drug careers showed an increase with time, but this was not statistically significant.
- The breakdown of non-opiate clients by career length in 2012/13 in Camden was not significantly different to the non-opiate cluster.
- Completion rates showed little variation between different career length in non-opiate clients.

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## Treatment outcomes: previous treatment journeys, opiates

Percentage of opiate clients that were in treatment by number of previous treatment journeys, Camden opiate client resident population, 2010/11 to 2012/13



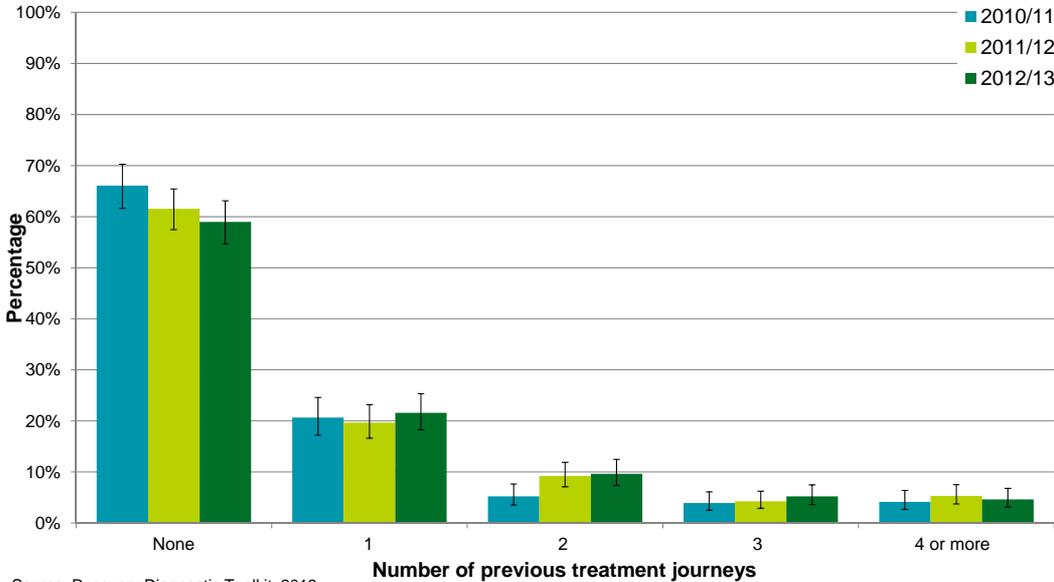
Source: Recovery Diagnostic Toolkit, 2013

- In 2012/13, 38% of opiate clients in Camden had had no previous treatment (444 people). This was significantly higher than the treatment cluster (33%).
- The proportion of clients with no previous treatment journeys decreased over time.
- Conversely, the proportion of clients with four or more treatment journeys rose from 15% in 2010/11 to 20% in 2012/13.
- Completion rates in Camden were similar for clients with no previous treatment journeys and those with more than one (around 8%).
- The national picture shows people are more likely to complete treatment if they have had no previous treatment journeys.

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## Treatment outcomes: previous treatment journeys, non-opiates

Percentage of opiate clients that were in treatment by number of previous treatment journeys, Camden opiate client resident population, 2010/11 to 2012/13



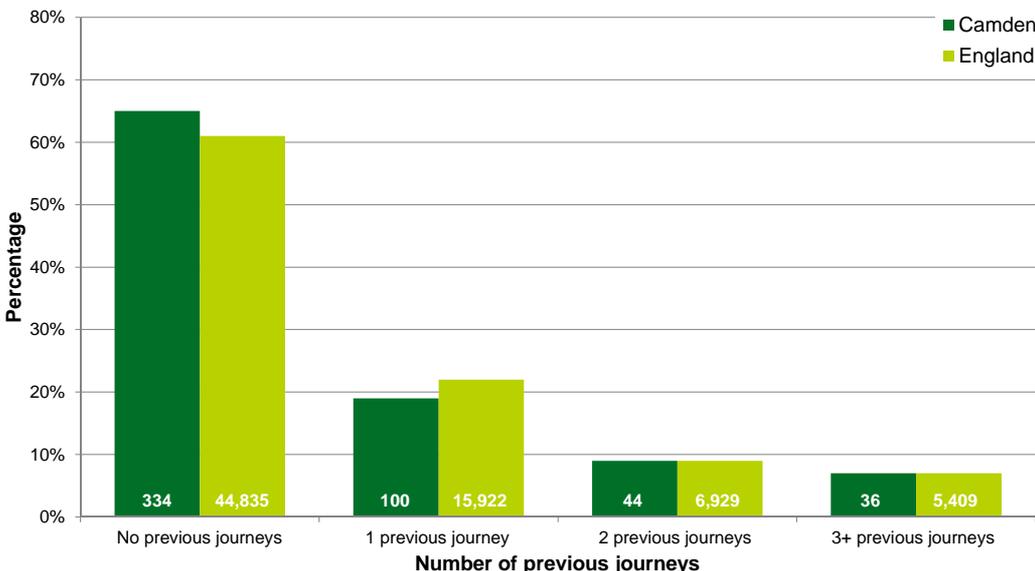
Source: Recovery Diagnostic Toolkit, 2013

- In 2012/13, 59% of non-opiate clients in Camden had had no previous treatment (306 people).
- The proportion of clients with no previous treatment journeys decreased over time, although this is not statistically significant.
- Completion rates in Camden were similar for non-opiate clients with no previous treatment journeys and those with more than one (around 30%).
- Camden is no different to the non-opiate cluster in both breakdown of number of previous treatment journeys and for completion rates.

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## Treatment outcomes: previous treatment journeys, alcohol

The number of previous treatment journeys of alcohol client's new presentations, Camden's resident alcohol treatment population, 2012/13



Source: Adult Partnership Quarterly Performance Report, Q4 2012/13

- Approximately two thirds (65%) of new client presentations in Camden during 2012/13 had no previous treatment journeys, which was slightly higher than the England average (61%).
- 19% of new client presentations in Camden had one previous treatment journey, which was slightly lower than the England average (22%).

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## IMPACT OF ALCOHOL & SUBSTANCE MISUSE

This section looks at the wider impacts substance misuse, including data on hospital admissions, mortality, crime and referrals to Children's Services. It combines information from the Local Alcohol Profiles for England, deaths data from the ONS and NPSAD, and information requested from the Metropolitan Police Service and Council Children's Services Team.

Information on the impacts of substance misuse is harder to obtain, because people are less likely to admit that an incident was drug-related.

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## Measuring the impact of alcohol and drugs

As alcohol is not an illegal substance, the wider impacts of alcohol misuse are easier to quantify than drugs misuse. The preceding chart and table show a summary of alcohol outcomes for Camden compared to the England average (for the full profile, see appendix).

Camden has **significantly worse rates** compared to the England average for:

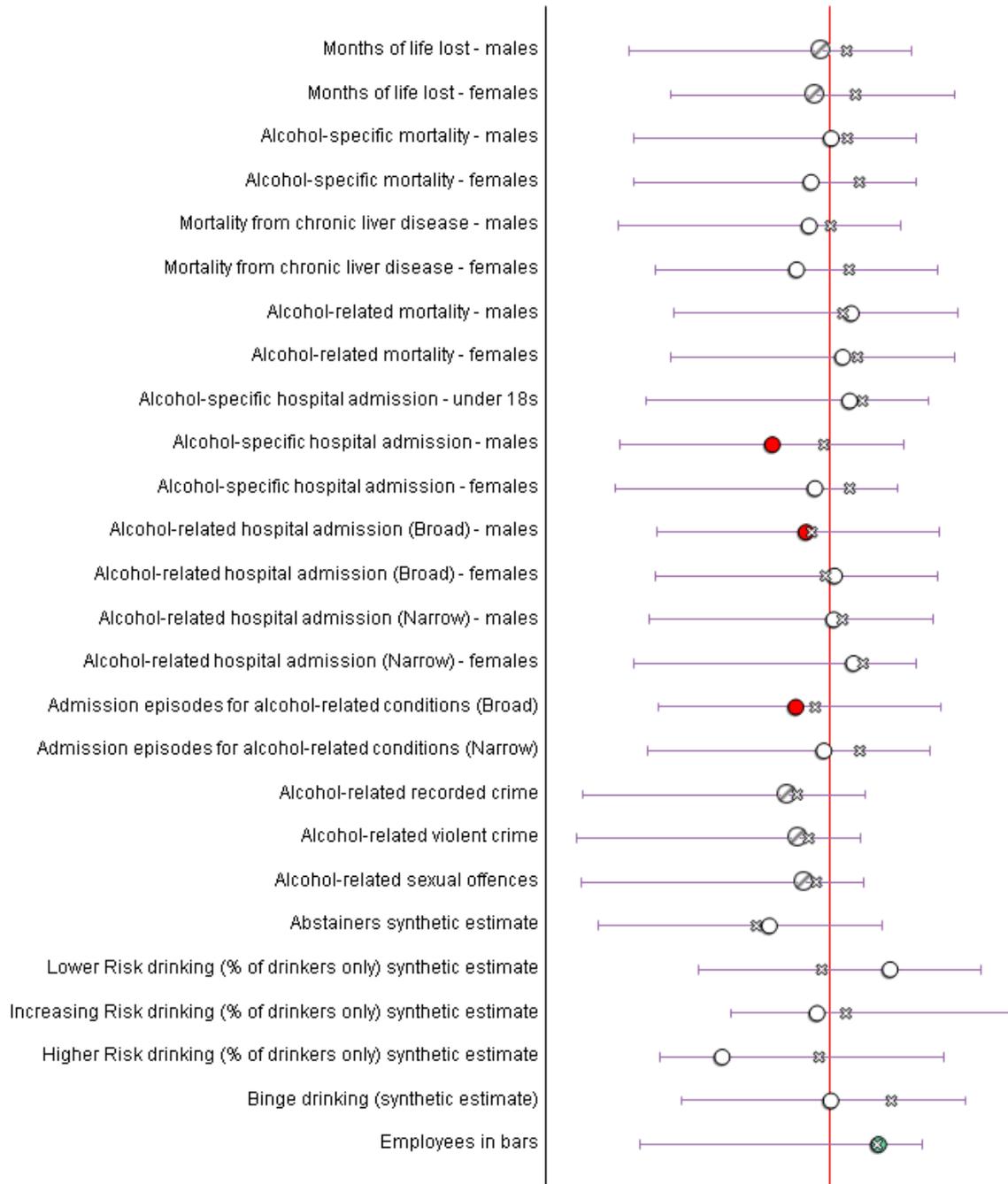
- Alcohol-specific hospital admissions in men
- Alcohol-related hospital admissions in men (broad definition)
- Admissions episodes for alcohol-related conditions (broad definition)

Camden has **significantly better rates** compared to the England average for:

- Percentage of all employees who work in bars

**Note:** broad definitions of alcohol specific hospital admissions and episodes includes primary diagnosis or any secondary diagnosis; narrow definitions include primary diagnosis or any secondary diagnosis with an external cause

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## LAPE Ranking

Rank of each alcohol outcome for Camden among local authorities in England and London (where 1 is the worst)

Alcohol outcome	Rank in London	Rank in England
Months of life lost - males	8	105
Months of life lost - females	2	78
Alcohol-specific mortality - males	10	122
Alcohol-specific mortality - females	2	74
Mortality from chronic liver disease - males	8	82
Mortality from chronic liver disease - females	4	56
Alcohol-related mortality - males	17	207
Alcohol-related mortality - females	14	179
Alcohol-specific hospital admissions - under 18 year olds	14	197
Alcohol-specific hospital admission - males	4	26
Alcohol-specific hospital admission - females	4	86
Alcohol-related hospital admission (Broad) - males	16	78
Alcohol-related hospital admission (Broad) - females	20	132
Alcohol-related hospital admission (Narrow) - males	13	121
Alcohol-related hospital admission (Narrow) - females	15	194
Admission episodes for alcohol-related conditions (Broad)	12	65
Admission episodes for alcohol-related conditions (Narrow)	3	118
Alcohol-related recorded crime	10	11
Alcohol-related violent crime	8	13
Alcohol-related sexual offences	6	20
Abstainers synthetic estimate	16	301
Lower Risk drinking (% of drinkers only) synthetic estimate	5	16
Increasing Risk drinking (% of drinkers only) synthetic estimate	15	177
Higher Risk drinking (% of drinkers only) synthetic estimate	2	3
Binge drinking (synthetic estimate)	7	145
Employees in bars	16	303

Key:	London quintile	Rank 1 - 6	Rank 7 - 13	Rank 14 - 19	Rank 20 - 26	Rank 27 - 33
	England quintile	Rank 1 - 65	Rank 66 - 130	Rank 131 - 195	Rank 196 - 261	Rank 262 - 326

## Deaths

### Alcohol

The rate of deaths in Camden that are attributable to alcohol or directly caused by alcohol (alcohol specific deaths) are in line with the national average. Camden had:

- 33 deaths in men and 21 deaths in women that were caused specifically by alcohol between 2010 and 2012.
- 40 deaths in men and 21 deaths in women were attributable to alcohol in 2012.
- 42 deaths in men and 27 deaths in women were caused by chronic liver disease (CLD) between 2010 and 2012. Rates of CLD correlate with levels of chronic alcohol misuse.

### Drugs

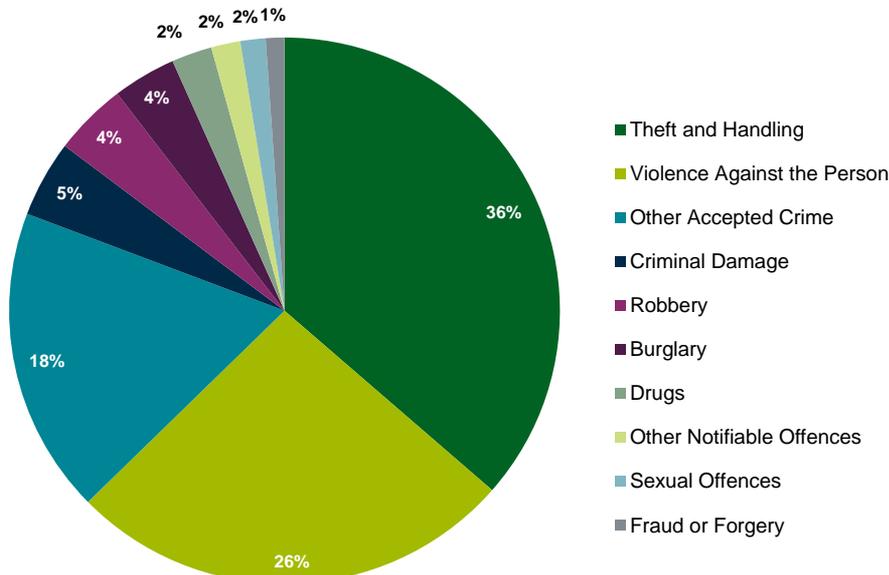
There were two deaths due to drugs (NPSAD definition) in Camden in 2012 (1.1 per 100,000 population). Local data are unavailable, but national data showed:

- The overall number of drug related deaths in England continued to decrease. There were 1,147 deaths in 2012, 35% fewer than in 2009.
- Over 70% of people who died a drug related death were men, 64% were under the age of 45 years and 63% were White. This is consistent with previous years.
- Accidental poisoning accounted for 68% of drug related deaths, similar to previous years.
- The proportion of drug related deaths in England that were due to heroin/morphine fell from 49% in 2009 to 30% of deaths in 2011, but increased to 35% in 2012. The inverse pattern is seen for methadone deaths, where the proportion of deaths from methadone increased between 2009-11 from 20% to 27% and fell to 23% in 2012.
- The most common principal substances in drug-related deaths were heroin/morphine (35%); alcohol-in-combination with other substances (34%); other opiates/opioid analgesics (27%); antidepressants (25%); hypnotics/sedatives (24%); methadone (23%); and cocaine (11%).

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## Crime: Types of alcohol-related crime

Breakdown of recorded crimes committed in Camden where alcohol may have been a factor, by type of crime, 2012/13

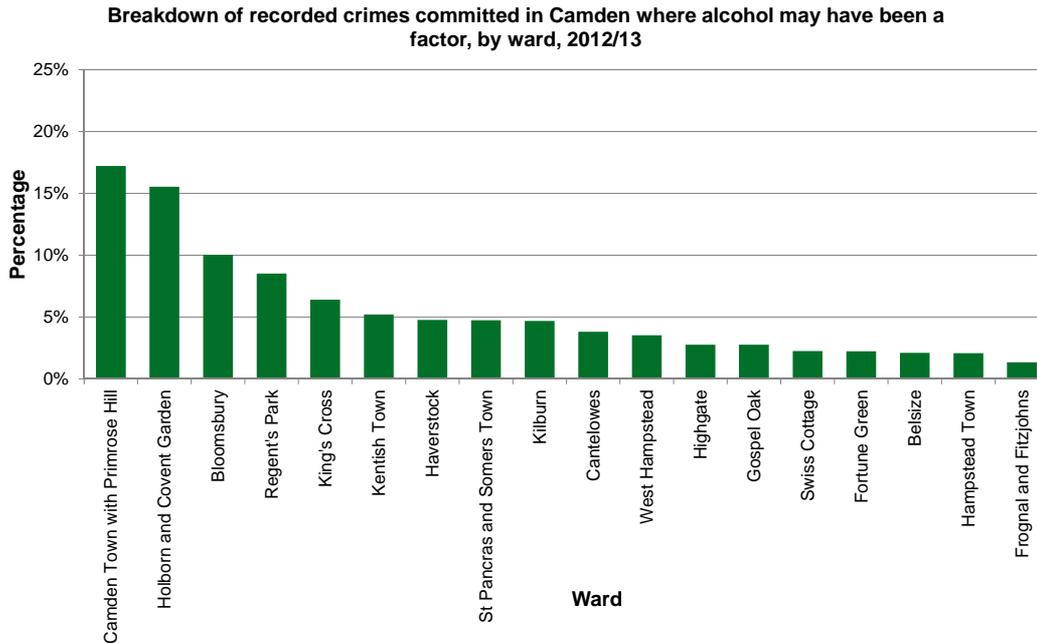


Source: Metropolitan Police Service, 2013

- In Camden about a quarter of all crimes in 2012/13 may have been linked to alcohol. This equates to about 8,300 alcohol related crimes.
- Among alcohol-related crimes, 36% were 'Theft and handling' offences, followed by 26% that were 'Violence against the person' crimes.
- 'Other accepted crime' is largely comprised of domestic incidents - 95% of domestic incidents may have been related to alcohol.
- Trends in alcohol-related crime, violent crime, and sexual crime are in the LAPE profile in the Appendices, which show that in 2012/13 there was a decrease in all crime and violent crime where alcohol was a factor.

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## Crime: Location of alcohol-related crime



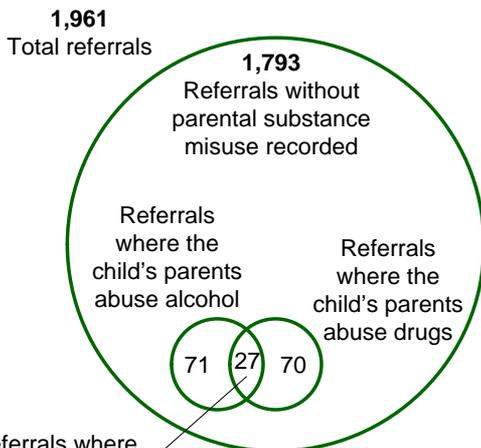
- In Camden, the wards Camden Town with Primrose Hill, Holborn and Covent Garden and Bloomsbury have the highest proportion of offences that may have been linked to alcohol.
- These wards correspond to those with the highest concentration of licensed premises.

**Note:** 180 offences with unknown ward are not included in this analysis. **Source:** Metropolitan Police Service, 2013

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## Children of people who misuse substances

### Referrals to Camden Children's Services, 2012/13



Referrals where the child's parents abuse alcohol & drugs

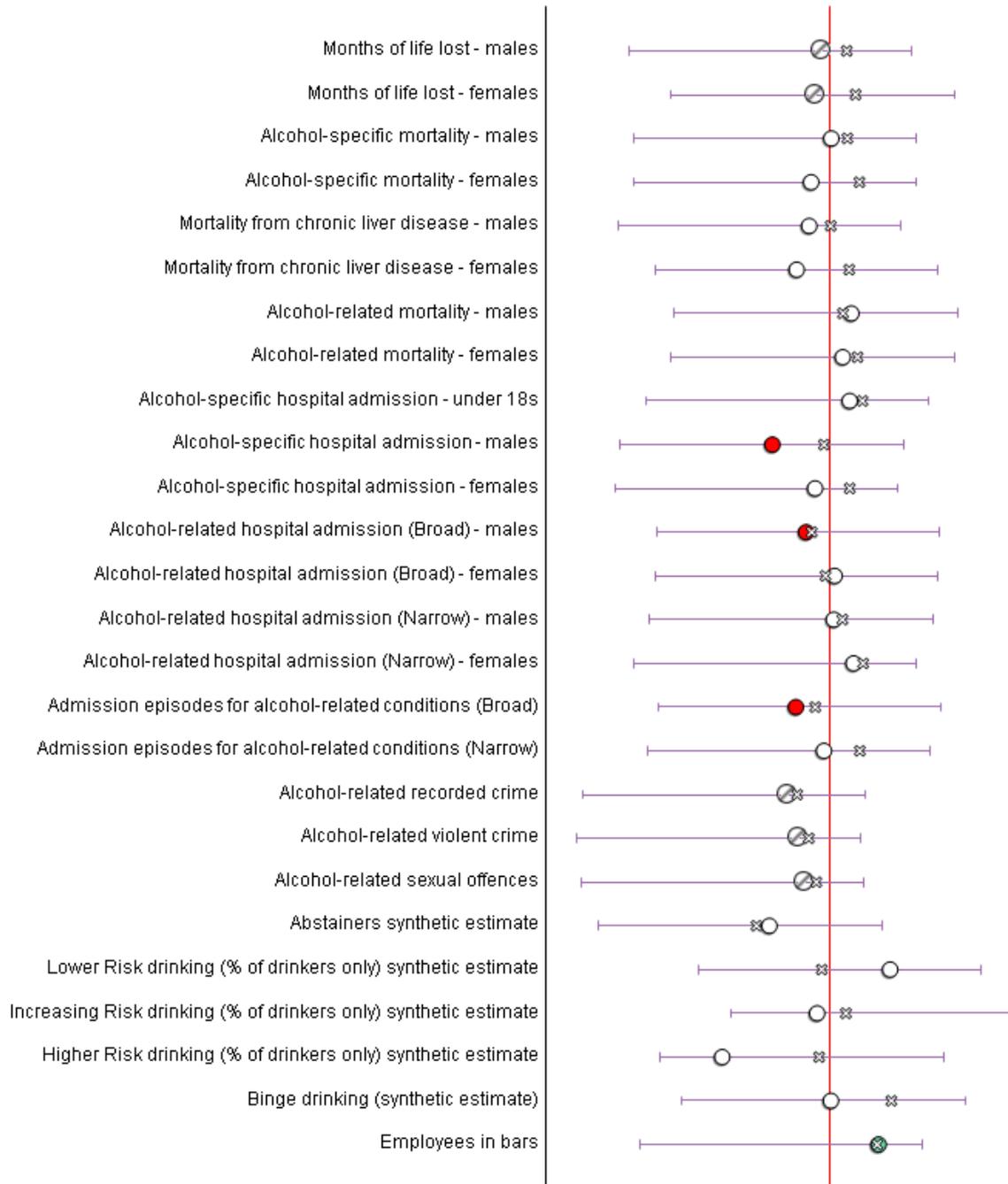
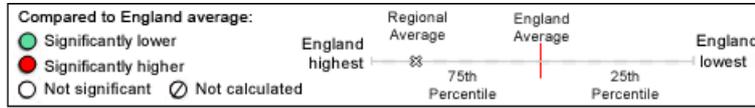
**Source:** Camden Children's service, 2014

- 512 (30%) adults in treatment in Camden live with children. This is similar to the England average. A further 198 (12%) adults in treatment are parents but do not live with any children.
- Commissioners have expressed concern that clients of treatment services who are parents may be unlikely to disclose this information, for fear that Children's Services may become involved in their family.
- We compared the number of substance misuse clients in Camden who had children with referrals data from Camden Children's Services. **The number of referrals that involved substance misuse is lower than the number of parents using treatment services.** **Note:** the same families may have been referred more than once over the year.
- In 2012/13, 168 referrals (8.6%) to Camden's Children's Services had parents misusing drugs, alcohol or both noted at the time of referral or within 90 days of referral. This is similar to referrals in 2011/12.
- **Alcohol misuse was the principal reason for needing a service in 27% (26) of referrals noting alcohol misuse.**
- **Drug misuse was the principal reason in 28% (27) of referrals noting drug misuse.**

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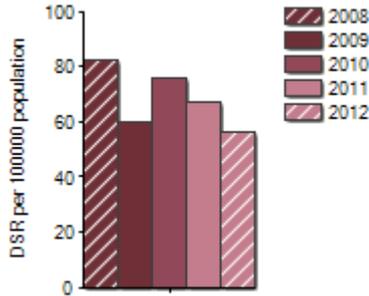
## APPENDICES

This section includes JSNA profiles and the LAPE profile for Camden.

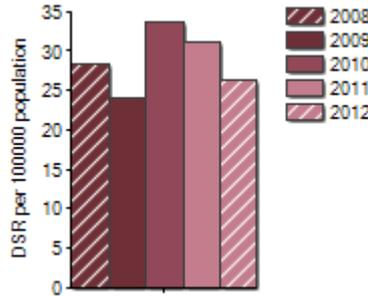




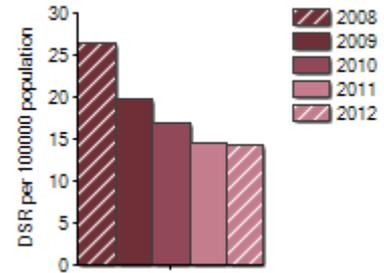
Alcohol-related mortality - males



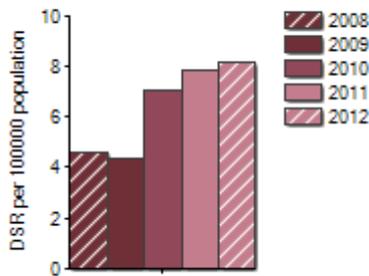
Alcohol-related mortality - females



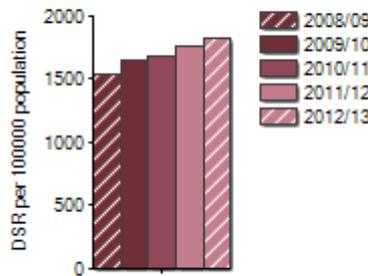
Mortality from chronic liver disease - males



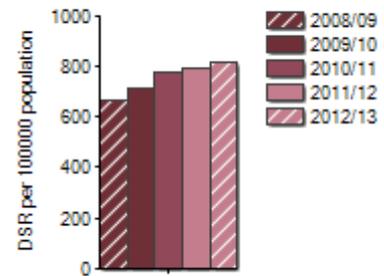
Mortality from chronic liver disease - females



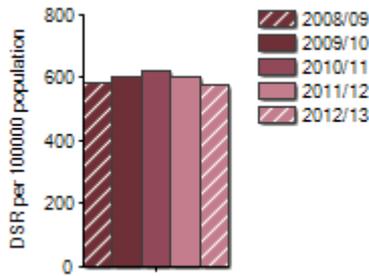
Alcohol-related hospital admission (Broad) - males



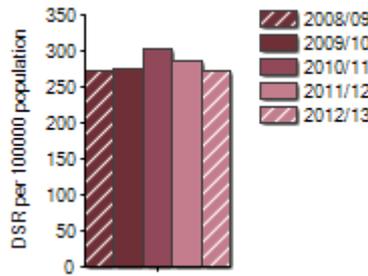
Alcohol-related hospital admission (Broad) - females



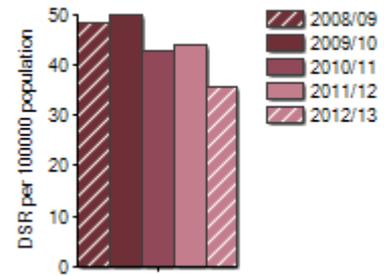
Alcohol-related hospital admission (Narrow) - males



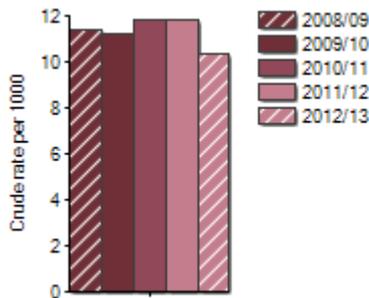
Alcohol-related hospital admission (Narrow) - females



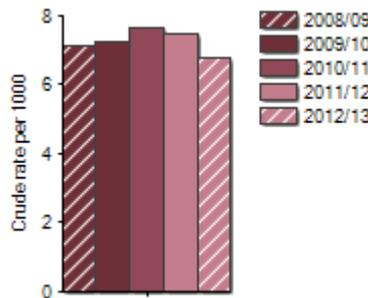
Alcohol-specific hospital admission - under 18s



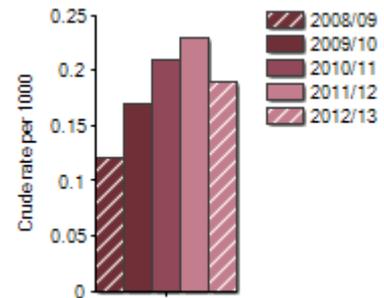
Alcohol-related recorded crimes



Alcohol-related violent crimes



Alcohol-related sexual offences



knowledge & intelligence team (north west)

Public Health England  
Room 2.09 2nd Floor  
Liverpool John Moores University  
Henry Cotton Campus  
15-21 Webster Street  
Liverpool  
L3 2ET

Tel:  
+44(0)151 231 4535  
Fax:  
+44(0)151 231 4552  
Email:  
[KITNorthWest@phe.gov.uk](mailto:KITNorthWest@phe.gov.uk)  
Website:  
<http://www.nwpho.org.uk>  
<http://www.gov.uk/phe>



ID	Indicator	Measure (a)	National Rank (b)	Regional Average
1	Months of life lost - males	12.3	222	10.2
2	Months of life lost - females	6.0	249	4.5
3	Alcohol-specific mortality - males	14.2	205	12.1
4	Alcohol-specific mortality - females	8.1	253	4.4
5	Mortality from chronic liver disease - males	18.8	245	15.5
6	Mortality from chronic liver disease - females	10.8	271	6.8
7	Alcohol-related mortality - males	56.6	120	59.1
8	Alcohol-related mortality - females	26.3	148	24.5
9	Alcohol-specific hospital admission - under 18s	35.5	130	29.8
10	Alcohol-specific hospital admission - males	768.8	301	529.0
11	Alcohol-specific hospital admission - females	260.9	241	188.1
12	Alcohol-related hospital admission (Broad) - males	1,818.4	249	1,784.1
13	Alcohol-related hospital admission (Broad) - females	812.8	195	842.3
14	Alcohol-related hospital admission (Narrow) - males	577.1	206	557.1
15	Alcohol-related hospital admission (Narrow) - females	272.7	133	260.1
16	Admission episodes for alcohol-related conditions (Broad)	2,312.7	262	2,147.5
17	Admission episodes for alcohol-related conditions (Narrow)	649.6	209	553.8
18	Alcohol-related recorded crime	10.3	316	9.0
19	Alcohol-related violent crime	6.8	314	5.7
20	Alcohol-related sexual offences	0.2	307	0.2
21	Abstainers synthetic estimate	21.3	26	22.4
22	Lower Risk drinking (% of drinkers only) synthetic estimate	71.7	311	73.4
23	Increasing Risk drinking (% of drinkers only) synthetic estimate	20.2	150	19.7
24	Higher Risk drinking (% of drinkers only) synthetic estimate	8.1	324	6.9
25	Binge drinking (synthetic estimate)	19.9	182	14.3
26	Employees in bars	1.0	24	1.0

Footnotes	Definition
Alcohol-specific	Alcohol-specific outcomes include those conditions where alcohol is causally implicated in all cases of the condition; for example, alcohol-induced behavioural disorders and alcohol-related liver cirrhosis. The alcohol-attributable fraction is 1.0 because all cases (100%) are caused by alcohol.
Alcohol-related	Alcohol-related conditions include all alcohol-specific conditions, plus those where alcohol is causally implicated in some but not all cases of the outcome, for example hypertensive diseases, various cancers and falls. The attributable fractions for alcohol-related outcomes used here range from between 0 and less than 1.0. For example, the alcohol-attributable fraction for mortality from pneumonia among men aged 75 and over is 0.10 because the latest epidemiological data suggest that 10% of pneumonia cases among this population are due to alcohol. Outcomes where alcohol has a protective effect (i.e. the fraction is less than 0) are not included when the alcohol-attributable fractions are applied to mortality and hospital episode statistics data.
Indicator value	The actual indicator value for the Local Authority as calculated in the definitions below.
Ranks	The rank of the local indicator value among all 326 Local Authorities in England. A rank of 1 is the lowest value Local Authority in England and a rank of 326 is the highest except for indicators 21 & 22 where the ranking is reversed (1 is the highest value and 326 the lowest).
Suppression	Where values in 'Trend Charts' and 'Data' are blank, data have been suppressed to prevent disclosure unless otherwise stated. For mortality data counts below 3 have been suppressed and for HES data, counts below 6 have been suppressed (HES counts of 0 do not require suppression). Further suppression has been applied to the datasets in LAPE to prevent disclosure through subtraction.

Knowledge & Intelligence Team (North West)

Public Health England Room 2.09 2nd Floor Liverpool John Moores University Henry Cotton Campus 15-21 Webster Street Liverpool L3 2ET	<p>Tel: +44(0)151 231 4535</p> <p>Fax: +44(0)151 231 4552</p> <p>Email: <a href="mailto:KITNorthWest@phe.gov.uk">KITNorthWest@phe.gov.uk</a></p> <p>Website: <a href="http://www.nwpho.org.uk">http://www.nwpho.org.uk</a> <a href="http://www.gov.uk/phe">http://www.gov.uk/phe</a></p>
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ID	Definition
1,2	Months of life lost- males/females - An estimate of the increase in life expectancy at birth that would be expected if all alcohol-related deaths among males/females aged less than 75 years were prevented. Knowledge and Intelligence Team (North West) from 2010-2012 England and Wales life expectancy tables for males and females (from Office for National Statistics), alcohol-related deaths from the Public Health Mortality File 2010-2012 for males/females aged less than 75 years and the Office for National Statistics mid-year population estimates for 2010-2012.
3,4	Alcohol-specific mortality- males/females - Deaths from alcohol-specific conditions, all ages, males/females, directly age-standardised rate per 100,000 population (standardised to the European standard population). Knowledge and Intelligence Team (North West) from the Public Health Mortality File for 2010-2012 and Office for National Statistics mid-year population estimates for 2010-2012.
5,6	Mortality from chronic liver disease- males/females - Deaths from chronic liver disease including cirrhosis (International Classification of Diseases, version 10: K70, K73-K74), all ages, males/females, directly age-standardised rate per 100,000 population (standardised to the European standard population). Knowledge and Intelligence Team (North West) from the Public Health Mortality File for 2010-2012 and Office for National Statistics mid-year population estimates for 2010-2012.
7,8	Alcohol-related mortality - males/females - Deaths from alcohol-related conditions, all ages, males/females, directly age-standardised rate per 100,000 population (standardised to the European standard population). Knowledge and Intelligence Team (North West) from the Office for National Statistics Public Health Mortality File for 2012 and mid-year population estimates for 2012.
9	Alcohol-specific hospital admission - under 18s - Persons admitted to hospital due to alcohol-specific conditions, under 18 year olds, crude rate per 100,000 population. Knowledge and Intelligence Team (North West) from hospital episode statistics 2010/11 to 2012/13. Office for National Statistics mid-year population estimates 2010, 2011 and 2012. Does not include attendance at Accident and Emergency departments.
10, 11	Alcohol-specific hospital admission - males/females - Persons admitted to hospital due to alcohol-specific conditions, all ages, males/females, directly age-standardised rate per 100,000 population (standardised to the European standard population). Knowledge and Intelligence Team (North West) from hospital episode statistics 2012/13. Office for National Statistics mid-year population estimates 2012. Does not include attendance at Accident and Emergency departments.
12, 13, 14, 15	Alcohol-related hospital admission - males/females - Persons admitted to hospital due to alcohol-related conditions (broad measure [primary diagnosis or any secondary diagnosis] and narrow measure [primary diagnosis or any secondary diagnosis with an external cause]), all ages, males/females, directly age-standardised rate per 100,000 population (standardised to the European standard population). Knowledge and Intelligence Team (North West) from hospital episode statistics 2012/13. Office for National Statistics mid-year population estimates 2012. Does not include attendance at Accident and Emergency departments.
16, 17	Admission episodes for alcohol-related conditions - Admission episodes for alcohol-related conditions (broad measure [primary diagnosis or any secondary diagnosis] and narrow measure [primary diagnosis or any secondary diagnosis with an external cause]), all ages, directly age-standardised rate per 100,000 population (standardised to the European standard population). Knowledge and Intelligence Team (North West) from hospital episode statistics 2012/13. Office for National Statistics mid-year population estimates 2012. Does not include attendance at Accident and Emergency departments.
18, 19, 20	Alcohol-attributable recorded crimes - Alcohol-related recorded crimes (based on the Home Office's former 'key offence' categories), all ages, persons, crude rate per 1,000 population. Knowledge and Intelligence Team (North West) from Office for National Statistics recorded crime statistics 2012/13. Office for National Statistics 2011 mid-year populations. Attributable fractions for alcohol for each crime category were applied where available, based on survey data on arrestees who tested positive for alcohol by the UK Prime Minister's Strategy Unit.
21	Abstainers synthetic estimate - Abstainers: Mid 2009 synthetic estimate of the percentage of abstainers in the population aged 16 years and over who report abstaining from drinking. Estimates were derived from a statistical model developed to estimate the percentage of abstainers, lower risk (as a percentage of drinkers), increasing risk (as a percentage of drinkers) and higher risk drinkers (as a percentage of drinkers) in local authority populations. The Local Alcohol Profiles for England 2012 refresh of this indicator (and included in subsequent refreshes of data) was generated using an enhanced methodology (see metadata for details) and care should be taken when comparing these with previous estimates.
22	Lower Risk drinking (% of drinkers only) synthetic estimate - Lower risk drinking (as a percentage of drinkers): Mid 2009 synthetic estimate of the percentage of drinkers in the population aged 16 years and over who report engaging in lower risk drinking (consumption of fewer than 22 units of alcohol per week for males, and fewer than 15 units of alcohol per week for females). Estimates were derived from a statistical model developed to estimate the percentage of abstainers, lower risk (as a percentage of drinkers), increasing risk (as a percentage of drinkers) and higher risk (as a percentage of drinkers) drinkers in local authority populations. The Local Alcohol Profiles for England 2012 refresh for this indicator (and included in subsequent refreshes of data) was generated using an enhanced methodology (see metadata for details) and care should be taken when comparing these with previous estimates.

Knowledge & Intelligence Team (North West)

Public Health England  
Room 2.09 2nd Floor  
Liverpool John Moores University  
Henry Cotton Campus  
15-21 Webster Street  
Liverpool  
L3 2ET

Tel:  
+44(0)151 231 4535

Fax:  
+44(0)151 231 4552

Email:  
[KITNorthWest@phe.gov.uk](mailto:KITNorthWest@phe.gov.uk)

Website:  
<http://www.nwpho.org.uk>  
<http://www.gov.uk/phe>



ID	Definition
23	Increasing Risk drinking (% of drinkers only) synthetic estimate - Increasing risk drinking (as a percentage of drinkers): Mid 2009 synthetic estimate of the percentage of drinkers in the population aged 16 years and over who report engaging in increasing risk drinking (consumption of between 22 and 50 units of alcohol per week for males, and between 15 and 35 units of alcohol per week for females). Estimates were derived from a statistical model developed to estimate the percentage of abstainers, lower risk (as a percentage of drinkers), increasing risk (as a percentage of drinkers) and higher risk (as a percentage of drinkers) drinkers in local authority populations. The Local Alcohol Profiles for England 2012 refresh for this indicator (and included in subsequent refreshes of data) was generated using an enhanced methodology (see metadata for details) and care should be taken when comparing these with previous estimates.
24	Higher Risk drinking (% of drinkers only) synthetic estimate - Higher risk drinking (as a percentage of drinkers): Mid 2009 synthetic estimate of the percentage of drinkers in the population aged 16 years and over who report engaging in higher risk drinking (consuming more than 50 units of alcohol per week for males, and more than 35 units of alcohol per week for females). Estimates were derived from a statistical model developed to estimate the percentage of abstainers, lower risk (as a percentage of drinkers), increasing risk (as a percentage of drinkers) and higher risk drinkers (as a percentage of drinkers) in local authority populations. The Local Alcohol Profiles for England 2012 refresh for this indicator (and subsequent refreshes of data) was generated using an enhanced methodology (see metadata for details) and care should be taken when comparing these with previous estimates.
25	Binge drinking (synthetic estimate) - Synthetic estimate of the percentage of adults who consume at least twice the daily recommended amount of alcohol in a single drinking session (that is, eight or more units for men and six or more units for women). Estimates produced for the Association of Public Health Observatories (2007-2008). Revised dataset published March 2011 and updated to Local Alcohol Profiles for England resources in April 2012. Please see Public Health Observatories Datasets for further information: <a href="http://www.apho.org.uk/resource/view.aspx?RID=91736">www.apho.org.uk/resource/view.aspx?RID=91736</a> .
26	Employees in bars - % of all employees - The number of those in employment in the beverage serving activities industry sector (Standard Industrial Classification 2007: 563), as a percentage of all in employment. Business Register and Employment Survey September 2012, Office for National Statistics from Nomis: <a href="http://www.nomisweb.co.uk">www.nomisweb.co.uk</a> .

Knowledge & Intelligence Team (North West)

Public Health England	Tel:
Room 2.09 2nd Floor	+44(0)151 231 4535
Liverpool John Moores University	Fax:
: Henry Cotton Campus	+44(0)151 231 4552
: 15-21 Webster Street	Email:
Liverpool	<a href="mailto:KITNorthWest@phe.gov.uk">KITNorthWest@phe.gov.uk</a>
L3 2ET	Website:
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Public Health  
England

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# Alcohol and drugs: JSNA support pack

Key data to support planning for effective young  
people's specialist substance misuse interventions

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**CAMDEN**

## SUPPORTING INFORMATION

This pack provides key performance information about young people (under the age of 18 years) accessing specialist substance misuse interventions in your area alongside national data for comparison. The data is taken from the National Drug Treatment Monitoring System (NDTMS) which, for young people, reflects specialist treatment for those with problems around both alcohol and drug misuse. Although the data provided in this pack focuses solely on specialist interventions, the emphasis within the young people's strand of the drug strategy (2010) is also on protecting young people by preventing or delaying the onset of substance use. Whilst the majority of young people do not use drugs, and most of those that do are not dependent, drug and alcohol misuse can have a major impact on young people's education, their health, their families and their long-term chances in life.

The 2010 drug strategy advocates for the provision of good quality education and advice to young people and their parents, and for targeted support to prevent drug or alcohol misuse and early interventions when such problems first arise. The data in this pack should therefore be considered as part of the wider health data that is available nationally and locally to support the strategy.

A key national resource is the Child and Maternal Health Observatory website (ChiMat) which provides information and intelligence about the health of young people at local authority level.

<http://www.chimat.org.uk/>

Evidence suggests that specialist substance misuse interventions contribute to improved health and wellbeing, educational attendance and achievement, reductions in the numbers of young people not in education, employment or training and reduced risk taking behaviour, such as offending, smoking and unprotected sex. The data in this pack provides a comprehensive overview of these specialist interventions.

## INVESTMENT

Funding for specialist substance misuse interventions is available via the Public Health Grant.

Additional funding for early interventions targeted at specific groups of young people deemed to be more at risk of escalating substance misuse is available through the Business Rates Scheme (formerly the Early Interventions Grant).

Local funding may be available, via the Police and Crime Commissioner, to provide substance misuse and youth crime prevention initiatives. This was previously allocated directly to Youth Offending Teams to support the YOT drugs worker.

Maintaining investment is important to ensure the continued availability of early identification, targeted support and onward referral as appropriate, as well as specialist interventions.

## VALUE FOR MONEY

A Department for Education cost-benefit analysis found that every £1 invested in specialist substance misuse interventions delivered up to £8 in long-term savings and almost £2 within two years.

Evidence indicates that investing in specialist interventions is a cost effective way of securing long-term outcomes, reducing future demand on health, social care and mental health services, and supporting the Troubled Families agenda.

## NUMBERS IN SERVICES

Local ● National ●

These figures reflect the number of young people in specialist substance misuse services in your area during 2011-12 and 2012-13, and as a proportion of the entire treatment population for the area. Also included is the number of young people who have received specialist treatment within a secure setting in the youth justice system.

Reporting to NDTMS by the secure estate began with Young Offender Institutions (YOI) in 2012-13 and has been rolled out to Secure Training Centres and Secure Children's Homes since April 2013. The figures for 2012-13 therefore only reflect those detained within the YOI estate and a partial picture of the total number of specialist interventions delivered to young people whilst in custody.



## YOUNG ADULTS IN YOUNG PEOPLE'S SPECIALIST SUBSTANCE MISUSE SERVICES

The data below shows the number and proportion of all over 18s in 'young people only' specialist substance misuse services.

Specialist services must deliver age-appropriate interventions and promote the safeguarding and welfare of children and young people. The partnership may wish to investigate why young adults (18-24s) are being offered support to address their substance misuse within the under-18s service. The needs of 18-24s are different to those of under-18s. Clear transitions and joint care plans with adult services will help under-18s who require on-going support beyond their 18th birthday.

Substances	Local		National	
	n	%	%	
Class A (Heroin & Crack)	1	1%	6%	
Stimulants (Cocaine, Ecstasy, Amphetamine, Not Crack)	7	8%	24%	
Cannabis & Alcohol	30	33%	26%	
Cannabis Only	39	43%	27%	
Alcohol Only	11	12%	16%	
Other Drug	2	2%	1%	

## REFERRAL SOURCES

Local National

Young people come to specialist services from various routes but are typically referred by youth justice; education; self, family & friends and children & family services. If your performance differs significantly from the national figure, you can use local NDTMS to identify shifts in the volume and sources of referrals. Changes in universal and targeted young people services may affect screening, referrals and demand for specialist interventions. There should be clear pathways between targeted and specialist services, supported by joint working protocols and good communication.

Referral Sources 2012-13	Local		National	proportions are of all referral routes
	n	%	%	
Youth Justice (incl the Secure Estate)	38	42%	34%	
Education Services	17	19%	24%	
Self, Family & Friends	6	7%	11%	
Children & Family Services	11	12%	10%	
Other Substance Misuse Services	0	0%	9%	
Health & Mental Health Services (excl A&E)	12	13%	7%	
Accident & Emergency	0	0%	1%	
Other	7	8%	3%	

## INTERVENTIONS DELIVERED AND LENGTH OF TIME IN SERVICES

Local National

This shows the time young people in your area spent receiving specialist interventions (latest contact). Young people generally spend less time in specialist interventions than adults because their substance misuse is not entrenched. However, those with complex care needs often require support for longer.

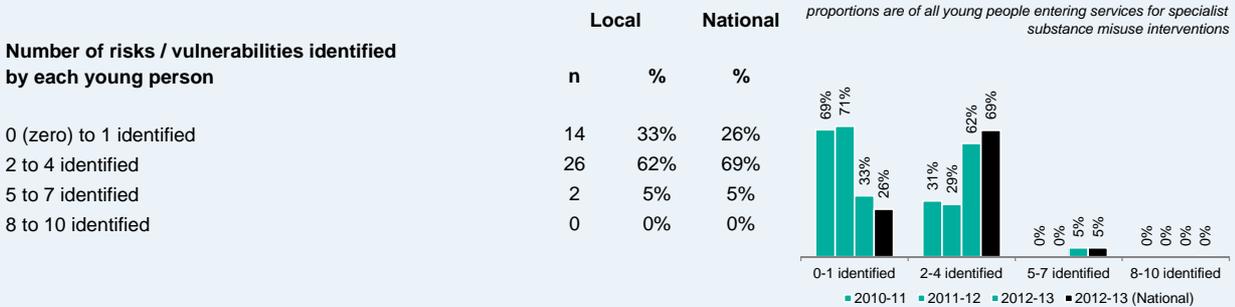
Young people have better outcomes when they receive a range of interventions as part of their personalised package of care. If a pharmacological intervention is required, it should always be delivered alongside appropriate psychosocial support.

Psychosocial interventions are a range of talking therapies designed to encourage behaviour change. In the below table, psychosocial interventions include family interventions and harm reduction as well as other specific psychosocial intervention types.

Length of time	Local		National	proportions are of all young people receiving specialist substance misuse interventions
	n	%	%	
0 (zero) to 12 weeks	23	26%	42%	
13 to 26 weeks	16	18%	31%	
27 to 52 weeks	19	21%	18%	
Longer than 52 weeks	31	35%	8%	
<b>Interventions</b>	<b>n</b>	<b>%</b>	<b>%</b>	
Pharmacological only	0	0%	0%	
Psychosocial only*	89	100%	97%	
Pharmacological plus psychosocial*	0	0%	1%	
Other intervention combinations	0	0%	1%	
No named interventions	0	0%	2%	
Multiple interventions	1	1%	54%	

The risk-harm profile identifies 10 key items to gauge the vulnerability of young people entering specialist substance misuse services. The higher the score, the more complex the need. Age of initiation is often the strongest predictor of the length and severity of substance misuse problems, the younger the age they start to use, the greater the likelihood of them becoming adult problematic drug users. The data below gives the age of young people in specialist services but not the age of initiation.

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



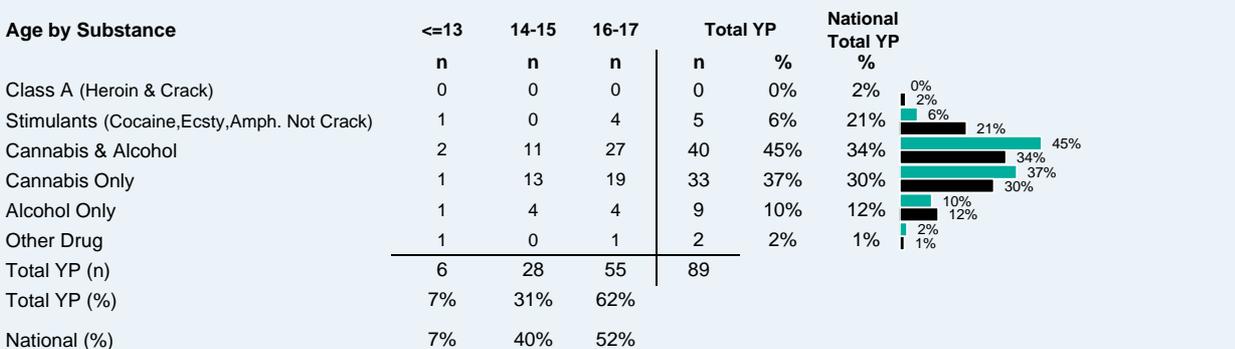
\*There are no safe drinking levels for under 15s and young people aged 16-17 should drink infrequently on no more than one day a week (CMO, 2009). This measure captures young people drinking on an almost daily basis (27-28 days of the month) and those drinking above 8 units per day (males) or 6 units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

<sup>U</sup> substances for young people includes alcohol.

PLEASE NOTE: owing to different methodologies used to calculate the numbers of risks and the number with each risk percentages may differ, this is because the numbers of young people entering this specialist provision will be slightly different owing to different eligibility criteria.

Sexual Exploitation	Local		National
	n	%	%
Young people entering services in 2012-13 who have stated that they are involved in sexual exploitation at start or exit	2	2%	4%

proportions are of all YP entering services for specialist substance misuse interventions



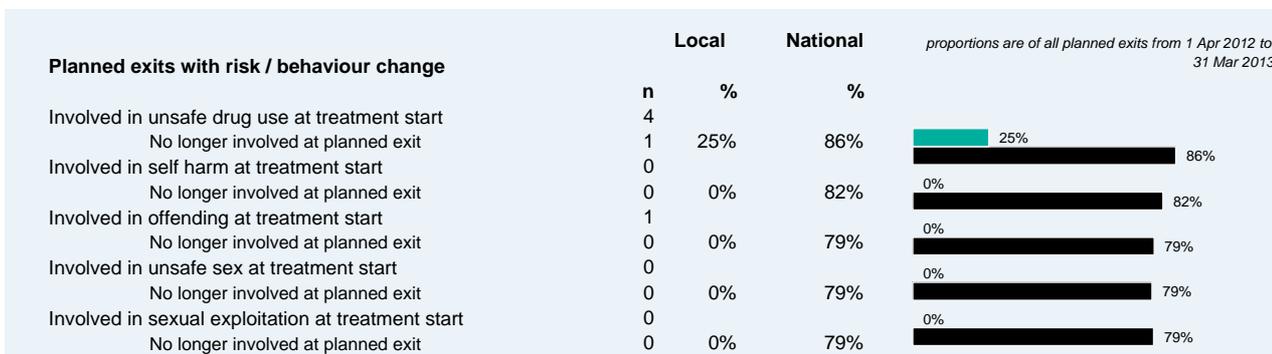
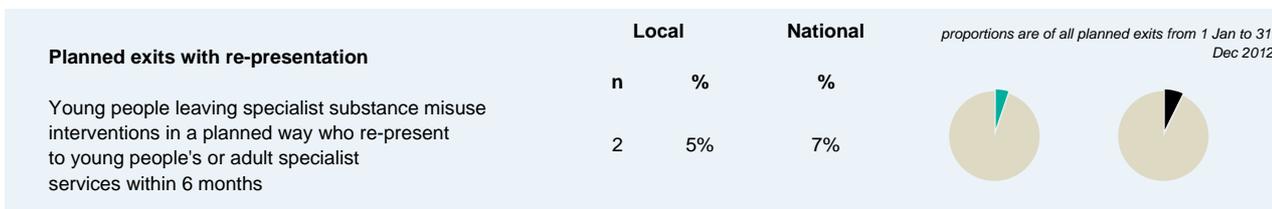
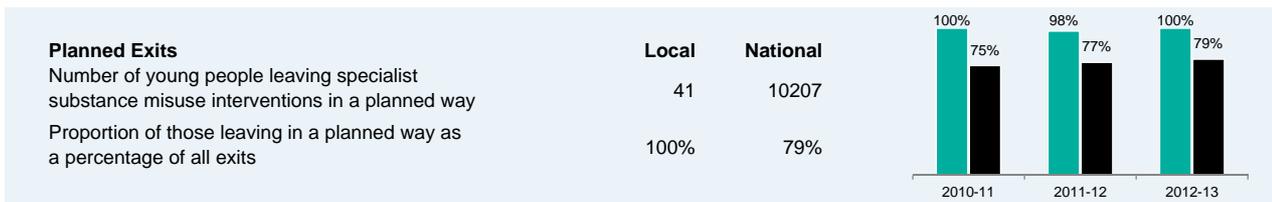
This section shows the number of young people who have left specialist interventions successfully and met the aims of their care plan during 2012-13. The graph on the right provides this information for the past 3 years and national figures are given for comparison.

Young people's circumstances can change, as does their ability to cope. If they re-present to treatment, this is not necessarily a failure and they should rapidly be re-assessed. A new care plan should identify what is likely to help them this time. This should include wider needs as substance misuse is unlikely to be their only problem and any reduction in substance misuse needs to be sustained by addressing other problems.

The re-presentation information is based on 2012-13 activity data. With the increased focus on outcomes, it is included to help with monitoring the effectiveness of specialist interventions and to ensure services provide demonstrable cost-effective outcomes and remain relevant to changing need. This is especially relevant for safeguarding investment in specialist services from sources such as the Public Health Grant, which has outcome-based conditions.

The behaviour risk change data reflects changes made while young people are engaged with specialist services. Not all of the risks identified here are substance specific, so if no change is noted it does not necessarily point to a failure of specialist services. The data should, instead, inform a review of the care pathways and joint working arrangements between specialist services and other children's and young people's support services.

Please note that there are methodological differences in how the data in this section has been calculated, and it is not comparable.



The data within this pack is based on young people accessing specialist substance misuse services in the community. Your local needs assessment can also provide further information about the needs of young people who are not in contact with young people's specialist substance misuse services to help assess if there is unmet need. Information about smoking, drinking and drug use below the threshold for a specialist intervention can be found at: <http://www.hscic.gov.uk/catalogue/PUB11334>

Please note that the percentages given in this pack are rounded to the nearest per cent. Totals may not add up to 100 due to rounding. Figures displayed here are based on annual report methodology and so may differ slightly from previously released figures in quarterly reporting or the needs assessment data

**RESTRICTED STATISTICS**

You are reminded that the data provided in this document are official statistics to which you have privileged access in advance of release. Such access is carefully controlled and is provided for management, quality assurance, and briefing purposes only. Release into the public domain or any public comment on these statistics prior to official publication planned for 4th December 2013 would undermine the integrity of official statistics. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including descriptions such as "favourable" or "unfavourable". If in doubt you should consult Malcolm Roxburgh or Jonathan Knight, via [EvidenceApplicationTeam@phe.gov.uk](mailto:EvidenceApplicationTeam@phe.gov.uk), who can advise. Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others who have not been given prior access and use it only for the purposes for which it has been provided. If you intend to publish figures from the JSNA after 4th December you must restrict all figures under 5 and any associated figures to prevent deductive disclosure.

The restricted status of this data will be lifted after the release of the Young People's Annual Report on 4th December 2013.



Public Health  
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# Alcohol and drugs JSNA support pack

Key data to support planning for effective  
drugs prevention, treatment and recovery

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**CAMDEN**

## SUPPORTING INFORMATION

This pack provides key performance and recovery outcomes information about your treatment system with national data for comparison. It presents data from the National Drug Treatment Monitoring System (NDTMS), the Treatment Outcomes Profile (TOP), the Drug Interventions Programme (DIP) and estimates of the prevalence of opiate and/or crack cocaine use. Although drug treatment services treat dependence for all drugs, heroin users remain the group with the most complex problems, so separate data is provided for them.

## KEY FACTORS INFLUENCING YOUR TREATMENT OUTCOMES

Data within this pack presents outcomes for clients during their time in treatment and also longer-term recovery outcomes. The outcomes achieved while in treatment can be demonstrated to be very good predictors of successful completion and non re-presentation especially housing and employment and abstinence from illicit drug use.

In addition the latest successful completion and non re-presentation rates are a very good indicator of future performance in the PHOF indicators 2.15i and 2.15ii (successful completion of drug treatment)

<http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/par/E12000004/ati/102/page/0>

### Key factors influencing your treatment outcomes 2012-13 compared to 2011-12

	Completions	Waiting times (proportion waiting under 3 weeks)	Non re-presentations
Opiate	◀▶ No Change	◀▶ No Change	▲ Up 9%
Non-opiate	▲ Up 1%		▲ Up 9%

## VALUE FOR MONEY

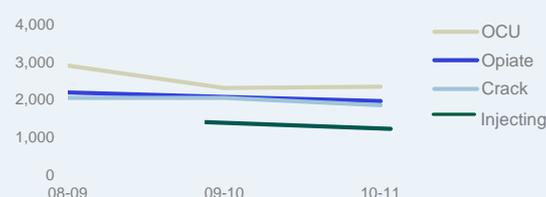
Drug addiction leads to significant crime, health and social costs. Evidence-based drug treatment reduces these and delivers real savings, particularly in crime costs, but also in savings to the NHS through health improvements, reduced drug-related deaths and lower levels of blood-borne disease. This strong value for money case was endorsed by the National Audit Office and is the foundation of central government's significant ongoing investment.

To help local areas assess the benefits this investment brings to them, a local Value for Money tool produced by PHE will be available in October/November. This includes estimated crime and health savings, including number of crimes prevented. Designed to be flexible, the tool also allows areas to consider the consequences of disinvestment in terms of increased crime and disorder, poorer health outcomes, increased risk to communities and poorer outcomes for families with multiple needs. These products are based on work that has been approved by senior economists in the Home Office and Department of Health.

## PREVALENCE ESTIMATES

The estimated number of opiate and/or crack users (OCU) and injectors in your area is set out below. Collectively, they have a significant impact on crime, unemployment, safeguarding children and welfare dependency.

Prevalence estimates (Aged from 15-64)	Local n	Rate per 1000	National n	Rate per 1000
OCU	2,345	13.01	298,752	8.67
Opiate	1,964	10.90	261,792	7.59
Crack	1,848	10.25	170,627	4.95
Injecting	823	4.56	93,401	2.71

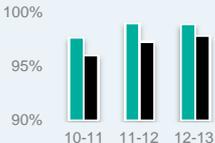


## WAITING TIMES

Local  National 

This data shows the number of drug users who waited less than three or more than six weeks to start treatment. Drug users need prompt help if they are to recover from dependence. Local efforts to keep waiting times low mean that the national average waiting time is less than one week. Keeping waiting times low will play a vital role in supporting recovery in local communities.

	Local	Proportion of all initial waits	National	Proportion of all initial waits
Adults waiting under three weeks to start treatment	605	99%	66,956	98%
Adults waiting over six weeks to start treatment	1	0%	439	1%



## TREATMENT ENGAGEMENT

When engaged in treatment, people use less illegal drugs, commit less crime, improve their health, and manage their lives better – which also benefits the community. Preventing early drop out and keeping people in treatment long enough to benefit contributes to these improved outcomes. As people progress through treatment, the benefits to them, their families and their community start to accrue. The information below shows the proportion of adults in your area in 2012-13 who have been in treatment for three months or more – a measure for effective treatment engagement.

Adults effectively engaged in treatment 2012-13	Local	Growth from 11-12	Proportion of treatment population	National	Growth from 11-12	Proportion of treatment population
Opiate	1125	-2%	96%	148,368	-3%	96%
Non opiate	474	-8%	91%	33,739	3%	88%
All	1599	-4%	95%	182,107	-2%	94%



## EMPLOYMENT

The data below shows the employment status of people starting treatment in your area in 2012-13. Being in work or undertaking meaningful activity is strongly associated with improved recovery outcomes, as is accessing education and training. However, the majority of people in drug and alcohol treatment will require significant support to address their education, training and employment needs and to get them job ready. The data below helps illustrate the scale of this challenge in your area. PHE will supply more information on this to support your needs assessment, in the form of treatment data matched with the Labour Market System (LMS) benefits data held by DWP. Joint working between your local treatment and education and employment support services (Jobcentre Plus and Work Programme providers) is key to meeting this challenge.

Employment status at the start of treatment	Local	Proportion of eligible clients	National	Proportion of eligible clients
Regular employment	385	9%	25,315	16%
Unemployed	2709	61%	90,704	58%
Long term sick or disabled	335	8%	17,147	11%



## IN TREATMENT OUTCOMES

The data below is drawn from the Treatment Outcomes Profile (TOP), which tracks the progress drug users make in treatment. This includes information on rates of abstinence from drugs and statistically significant reductions in drug use and injecting, and those successfully leaving treatment with secure housing and in work. Data from NDTMS suggests that clients who stop using illicit opiates in the first six months of treatment are almost five times more likely to complete successfully than those that continue to use.

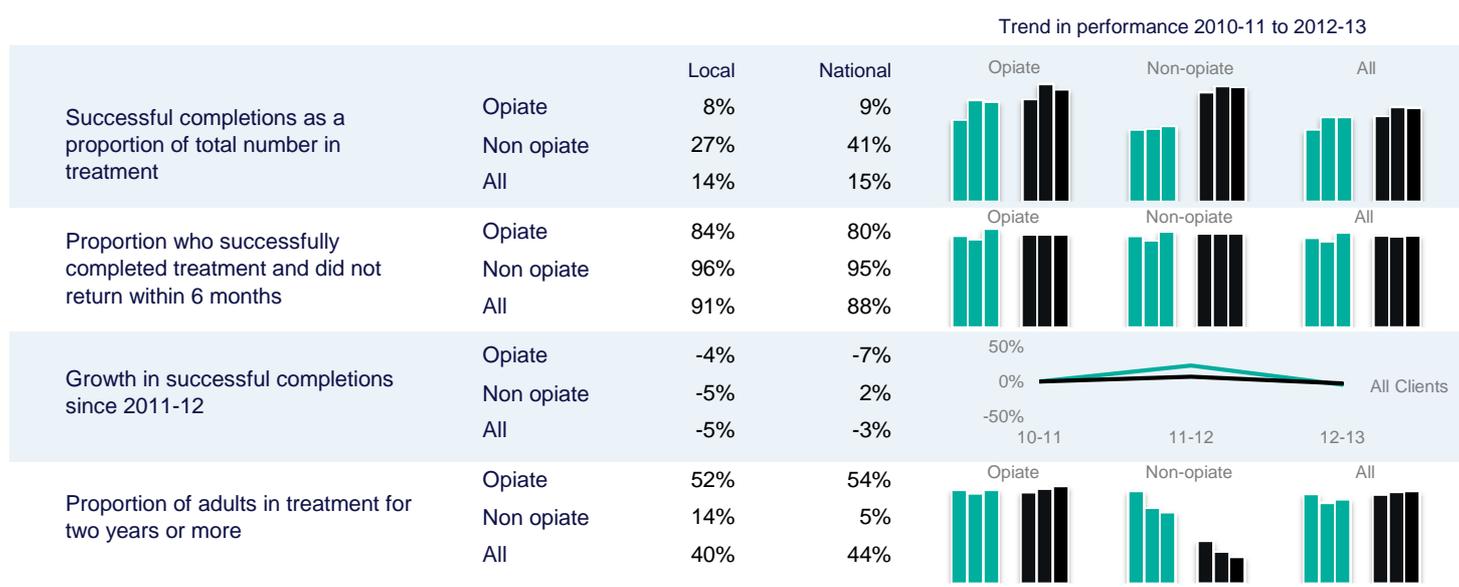


## SUCCESSFUL COMPLETIONS

Local National

The data below shows the proportion of drug users who complete their treatment free of dependence, the progress your area has made on people successfully completing treatment, and those successfully completing who do not relapse and re-enter treatment. The drug strategy asks local areas to increase the number of people successfully leaving treatment having overcome dependence. Although many individuals will require a number of separate treatment episodes spread over many years, most individuals who complete successfully do so within two years of treatment entry.

Also below is the proportion of adults who have been in treatment for more than two years – the data tells us that the likelihood of clients completing treatment and not re-presenting decreases the longer they remain in treatment over 2 years.



## RESIDENTIAL REHAB

The data below shows the number of adult drug users in your area who have been to residential rehab during their latest period of treatment (as a proportion of your whole treatment population and against the national proportion). Drug treatment mostly takes place in the community, near to users' families and support networks. Residential rehabilitation may be cost effective with someone who is ready for active change and a higher intensity treatment at any stage of their treatment, and local areas are encouraged to provide this option as part of an integrated recovery-orientated system.

	Local	Proportion of treatment population	National	Proportion of treatment population
Number of adults who attended residential rehab	133	8%	4,030	2%



## PRESCRIPTION ONLY MEDICINE/OVER THE COUNTER MEDICINE (POM/OTC)

Local  National 

People in treatment for prescription-only medicines (POM) or over the counter medicines (OTC), and drug users who have a problem with these as well as illicit drugs are presented below. Health and public health commissioners will want to understand local need in relation to misuse of and dependence on prescription and over-the-counter medicines, so that together they can commission appropriate responses.

	Local	Proportion of treatment population	National	Proportion of treatment population
Number of adults citing POM/OTC use	195	12%	27,842	14%
Illicit use	40	2%	4,603	2%
No illicit use	235	14%	32,445	17%
Total				

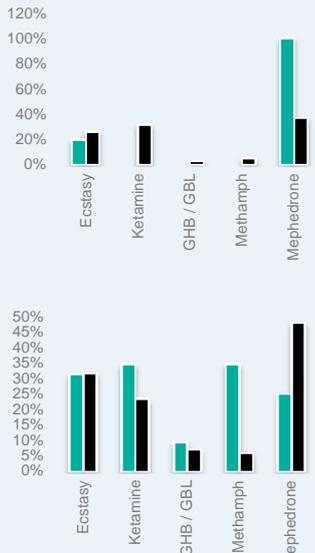


## CLUB DRUGS

Local  National 

The data below covers the main 'club' drugs reported by new treatment entrants who are also using opiates (first table) or using club drugs and other drugs but not opiates (second table). Opiate users still dominate adult treatment, and generally face a more complex set of challenges and are much harder to treat. Non-opiate-using, adult club drug users typically have good personal resources – jobs, relationships, accommodation – that mean they are more likely to make the most of treatment. From April 2013 NDTMS collected information on additional new psychoactive substances, and will report these next year.

	Local	Proportion <sup>1</sup>	National	Proportion <sup>1</sup>	
Number of adults new to treatment citing club drug use and opiate use	Ecstasy	1	20%	124	26%
	Ketamine	0	0%	150	32%
	GHB / GBL	0	0%	13	3%
	Methamphetamine	0	0%	25	5%
	Mephedrone	5	100%	175	37%
	Any club drug use <sup>2</sup>	5	1%	471	1%
Number of adults new to treatment citing club drug use (no additional opiate use)	Ecstasy	10	31%	966	31%
	Ketamine	11	34%	718	23%
	GHB / GBL	3	9%	218	7%
	Methamphetamine	11	34%	183	6%
	Mephedrone	8	25%	1,460	48%
	Any club drug use <sup>2</sup>	32	11%	3,070	12%



<sup>1</sup> Proportions of ecstasy, ketamine, GHB/GBL, methamphetamine and mephedrone as a percentage of any club drug use. Clients' citing the use of multiple club drugs will be counted once under each drug they cite. Therefore figures may exceed the total (labelled any club drug use) and proportions may sum to more than 100%.

<sup>2</sup> Any club drug use is a percentage of all new treatment entrants.

## BLOOD-BORNE VIRUSES AND DRUG-RELATED DEATHS

Local  National 

The data below shows the drug users in treatment in your area who have had a hepatitis B vaccination and current or past injectors who have been tested for hepatitis C. Drug users who share injecting equipment can spread blood-borne viruses. Providing methadone and sterile injecting equipment protects them and communities, and provides long-term health savings. Although local drug-related death data is not provided, understanding and preventing deaths is an important measure of how well your recovery-orientated drug treatment system is protecting people while increasing ambition.

	Local	Proportion of eligible clients	National	Proportion of eligible clients
Adults new to treatment eligible for a HBV vaccination who accepted one	175	33%	22,128	47%
Of those:				
the proportion who started a course of vaccination	13	7%	4,989	23%
the proportion who completed a course of vaccination	29	17%	4,403	20%
Previous or current injectors eligible for a HCV test who received one	447	58%	74,530	73%

## PARENTS AND FAMILIES

Local  National 

The data below shows the number of drug users in treatment who live with children; users who are parents but do not live with children; and users for whom there is incomplete data. This last item is included to help you consider the possible hidden population(s) of drug-dependent parents, or those with childcare responsibilities in contact with local treatment services. An estimated one in three of the English treatment population (64,862 people) has a child living with them at least some of the time.

	Local	Proportion of treatment population	National	Proportion of treatment population
Adults who live with children	512	30%	64,862	33%
Adults who are parents but do not live with any children	198	12%	41,532	21%
Adults with incomplete data	7	0%	4,691	2%

Proportion of adults in treatment who live with children



### RESTRICTED STATISTICS

You are reminded that the data provided in this document are official statistics to which you have privileged access in advance of release. Such access is carefully controlled and is provided for management, quality assurance, and briefing purposes only. Release into the public domain or any public comment on these statistics prior to official publication planned for 6th November 2013 would undermine the integrity of official statistics. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including descriptions such as "favourable" or "unfavourable". If in doubt you should consult Malcolm Roxburgh or Jonathan Knight, via EvidenceApplicationTeam@phe.gov.uk, who can advise. Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others who have not been given prior access and use it only for the purposes for which it has been provided. If you intend to publish figures from the JSNA after 6th November you must restrict all figures under 5 and any associated figures to prevent deductive disclosure.

The restricted status of this data will be lifted after the release of the Adult Drug Annual Report on 6th November 2013.



Public Health  
England

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# Alcohol and drugs: JSNA support pack

Key data to support planning for effective  
alcohol prevention, treatment and recovery

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**CAMDEN**

## SUPPORTING INFORMATION

The health harms associated with alcohol consumption in England are widespread, with around 9 million adults drinking at levels that pose some level of risk to their health. Because of the breadth of the problems, this pack provides a range of alcohol related data in relation to levels of harm and the local alcohol treatment system's response.

Using a range of key indicators, the pack aims to describe the extent of alcohol related problems at a local level using data from the Local Alcohol Profiles for England (LAPE).

To fully understanding how your local alcohol system is responding to these problems, locally and nationally held data can be used. Data relating to local areas' targeted alcohol interventions is not collected nationally, but should be available at a local level and a list of wider data sources is referenced below.

Key performance information about alcohol clients in your local treatment system are then presented, alongside national data for comparison. The data is taken from the National Drug Treatment Monitoring System (NDTMS) and relates to clients in England who are in treatment primarily for alcohol misuse. Detailed information relating to the methods used in calculating all data items in this pack is available in the supporting document 'Technical Definitions for the Alcohol Data'.

## INVESTMENT AND VALUE FOR MONEY

Funding through the Public Health Grant allows local authorities to commission Identification and Brief Advice (IBA) and specialist treatment for those with greater needs. Local authorities and Clinical Commissioning Groups can work together to identify potential additional funding for hospital based services via Clinical Commissioning Groups.

A 'Why Invest' document will be published alongside the JSNA packs to support the case for investment in alcohol prevention and treatment interventions.

## LOCAL DATA TO REDUCE ALCOHOL RELATED HARM AND COMPARISON GROUPS

The following three sections make data comparisons against a national benchmark and using a nearest neighbour approach. The nearest neighbour approach groups each local area with 15 other areas that are similar across a range of demographic, socio-economic and geographic variables. Utilising a nearest neighbour approach allows for like-for-like comparisons of areas and can reveal patterns in the data that would not otherwise be seen when only making comparisons against a national benchmark. It is therefore important to consider both national and nearest neighbour comparisons when interpreting your data.

All data has been divided in to four equal groups (quartiles) in order to allocate levels of harm. Quartile one, shown in dark green, is indicative of lower levels of alcohol related harm compared to the benchmark. Groups two and three indicate increasing levels of harm respectively, and areas in quartile four (shown in red) suggest areas have the highest levels of harm compared to the benchmark.

1 Least amount of harm      2 Lower harm levels      3 Higher harm levels      4 Most amount of harm

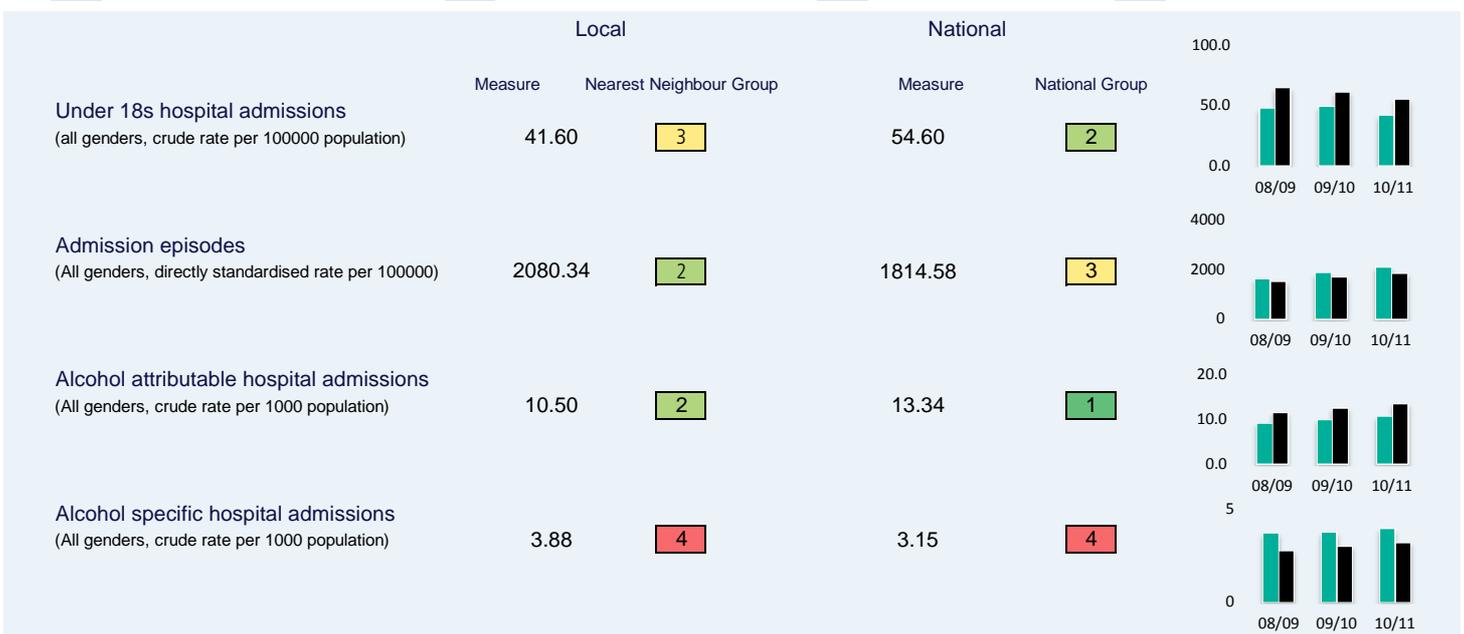
## HOSPITAL ADMISSIONS DUE TO ALCOHOL

Local ● National ●

The data reflects the general level of health harm from alcohol in the population. Hospital admissions can be a result of casual regular alcohol use above lower-risk levels as well as chronic heavy drinking in the population and is most likely to be found in increasing-risk drinkers, higher-risk drinkers, dependent drinkers and binge drinkers. High levels of alcohol specific admissions clearly indicate levels of alcohol misuse.

The rate of alcohol-related hospital admissions will be used as an indicator in the Public Health Outcome Framework. Some alcohol-related hospital admissions are specifically caused by alcohol while others are contributed to by alcohol (attributable).

1 Least amount of harm      2 Lower harm levels      3 Higher harm levels      4 Most amount of harm



## MORTALITY AND MONTHS OF LIFE LOST

Local ● National ●

The data reflects the level of chronic heavy drinking in the population and is most likely to be found in higher-risk drinkers and dependent drinkers. High rates of alcohol specific mortality and mortality from chronic liver disease are likely to indicate a significant population who have been drinking heavily and persistently over the past 10 – 30 years.

Whilst alcohol misuse is the primary cause of liver disease, obesity is a growing significant causal factor.

Broadly speaking alcohol attributable deaths make up around 3% of all deaths. Of these, about a third are alcohol specific deaths – e.g. from alcohol poisoning, alcoholic liver disease, alcoholic pancreatitis.

The remaining alcohol-attributable deaths are from conditions partially attributed to alcohol, roughly two thirds of which are from chronic conditions – e.g. Haemorrhagic stroke, Cardiac arrhythmias, Malignant neoplasm of oesophagus, with the remainder caused by acute consequences such as road traffic accidents or intentional self-harm.

**1** Least amount of harm      **2** Lower harm levels      **3** Higher harm levels      **4** Most amount of harm



The data reflects the level of crime linked to drinking in the population and is most likely to be found in binge drinkers, higher-risk drinkers and dependent drinkers.

Higher levels of alcohol-related recorded crimes and violent crimes are likely to be significantly linked to binge drinkers and the night-time economy. It is not possible to determine whether these drinkers are increasing risk, higher risk or dependent drinkers however they are obviously drinking problematically.



LOCAL DATA TO REDUCE WIDER ALCOHOL RELATED HARM

Primary and Secondary Care Data

NHS Health check

<http://www.healthcheck.nhs.uk>

Directed Enhanced Service (DES) for Alcohol

<http://www.alcohollearningcentre.org.uk/Topics/Browse/PrimaryCare/GPTemplates/>

Hospital Episode Statistics (HES)

<http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&category>

Accident and Emergency Data on violent incidents

[www.collemergencymed.ac.uk/asp/document.asp?id=4881](http://www.collemergencymed.ac.uk/asp/document.asp?id=4881)

Public Health Outcomes Framework

<http://www.phoutcomes.info/>

Wider Public Health Data

Local Area Profiles for England

[www.lape.org.uk](http://www.lape.org.uk)

Smoking, Drinking and Drug Use among Young People in England, Drinking: Adults Behaviour and Knowledge and Statistics on Alcohol

[http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalWorkAreas/Statisticalpublichealth/DH\\_4032542](http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalWorkAreas/Statisticalpublichealth/DH_4032542)

Health Profiles for England

[http://www.apho.org.uk/default.aspx?QN=P\\_HEALTH\\_PROFILES](http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES)

ONS Alcohol-related deaths in the United Kingdom 2000-2009

<http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Alcohol-related+Deaths>

Further Alcohol Treatment Data

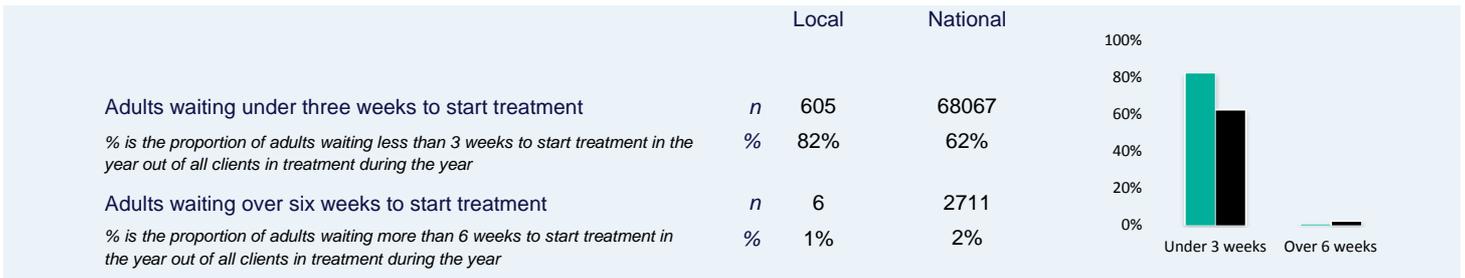
National Alcohol Treatment Monitoring System Performance Reports

<https://www.ndtms.net/Reports.aspx#>

## WAITING TIMES

Local ● National ●

This section provides information relating to the length of time clients waited to access alcohol treatment for the first intervention they received. People who need alcohol treatment need prompt help if they are to recover from dependency and keeping waiting times low will play a vital role in supporting recovery from alcohol dependency.

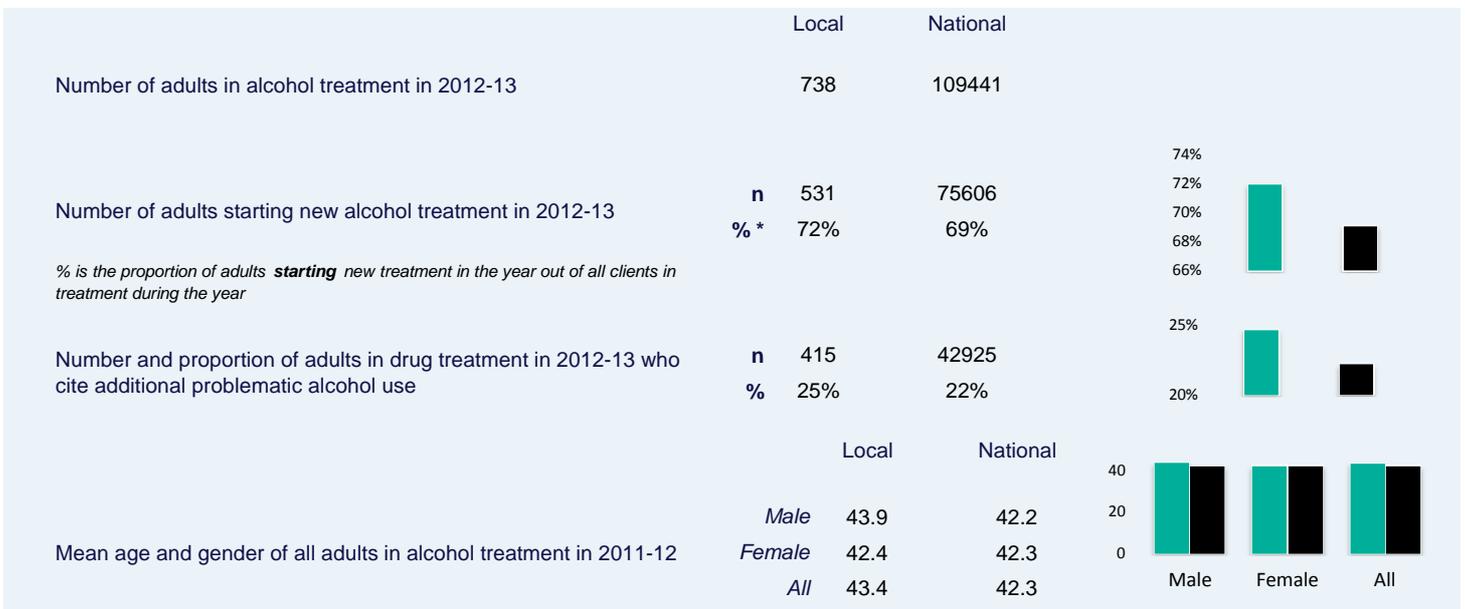


## DEMOGRAPHICS AND HEADLINE TREATMENT FIGURES

Local ● National ●

The national average age of clients in alcohol treatment is 42 and although there are more men than women in treatment, the age distribution for both genders is very similar.

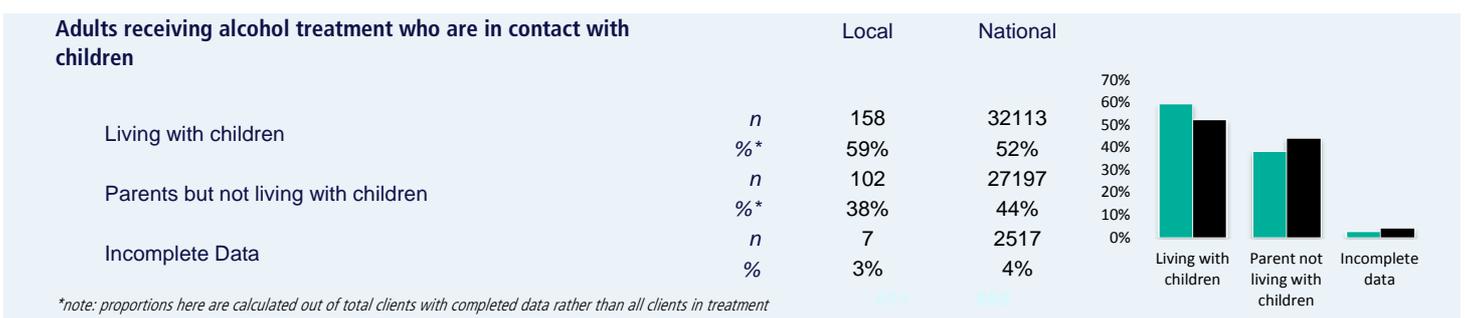
This section shows the number of people who were in alcohol treatment in 2012-13 and whether they commenced treatment in that year or were already in treatment at the start of it. A supplementary figure is provided which shows the number of people in drug treatment in 2012-13 who stated that alcohol was an adjunctive problematic substance to other primary drug use. These people are not included anywhere else in this report but will be receiving treatment for alcohol dependency as part of their drug treatment.



## SAFEGUARDING

Local ● National ●

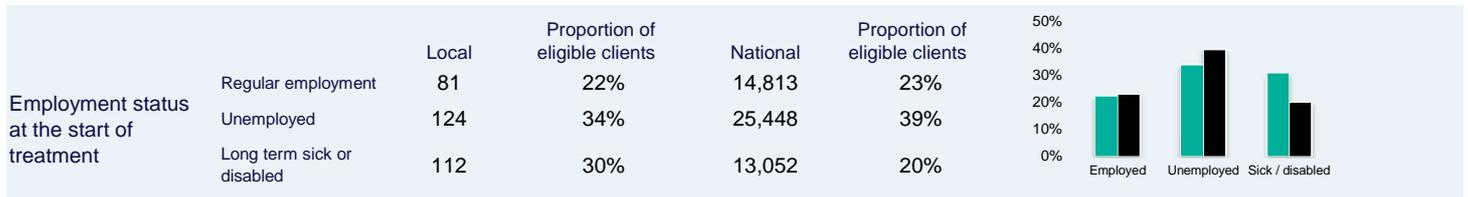
Approximately one in three of England's alcohol treatment population has a child living with them at least some of the time. The 2004 Alcohol Harm Reduction Strategy for England (Cabinet Office) estimated that 1.3 million children under 16 in England are affected by parents whose drinking is classified as either harmful or dependent. An estimated 2.6 million children (22%) in the UK are living with parents who are drinking hazardously and 705,000 (6%) are living with dependent drinkers (Manning, V. et. al. (2009) New estimates on the number of children living with substance-misusing parents: Results from UK national household surveys. *Journal of Public Health*, 9 (1), pp377-389).



## EMPLOYMENT

Local ● National ●

The data below shows the employment status of people starting treatment in your area in 2012-13. Being in work or undertaking meaningful activity is strongly associated with improved recovery outcomes, as is accessing education and training. However, the majority of people in drug and alcohol treatment will require significant support to address their education, training and employment needs and to get them job ready. The data below helps illustrate the scale of this challenge in your area. PHE will supply more information on this to support your needs assessment, in the form of treatment data matched with the Labour Market System (LMS) benefits data held by DWP. Joint working between your local treatment and education and employment support services (Jobcentre Plus and Work Programme providers) is key to meeting this challenge.



## DRINKING LEVELS AND ADDITIONAL SUBSTANCES USED

Local ● National ●

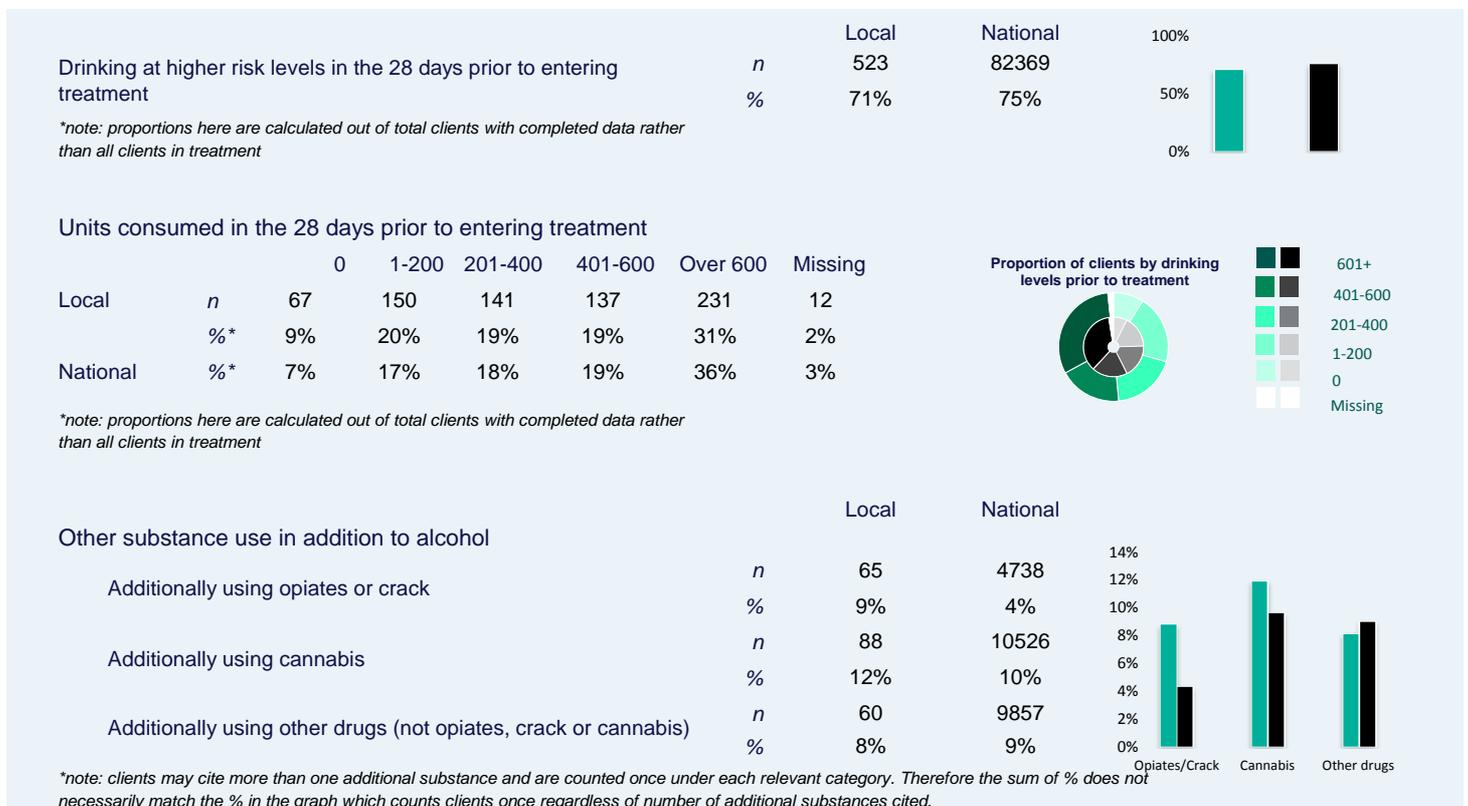
This section shows the number of people drinking at higher risk levels, the number of units consumed in the 28 days prior to treatment and the number of people using additional substances to alcohol.

Higher risk drinking is defined here as 'women drinking more than 140 units per month' and 'men drinking more than 200 units per month' and is in line with the Government's definition of weekly higher risk consumption levels (50 units per week for men and 35 units per week for women).

Drinking at higher risk levels increases the risk of alcohol related disease. For example, the risk of liver disease is increased by 13 times. Risk of coronary heart disease is increased by 1.7 times for men and 1.3 times for women.

Although the majority of clients cite using alcohol in the month prior to treatment, 9% nationally cite no alcohol use. There are several reasons why this could be the case: they may have been referred to treatment directly from the criminal justice system or they may be in treatment to maintain abstinence and relapse-prevention.

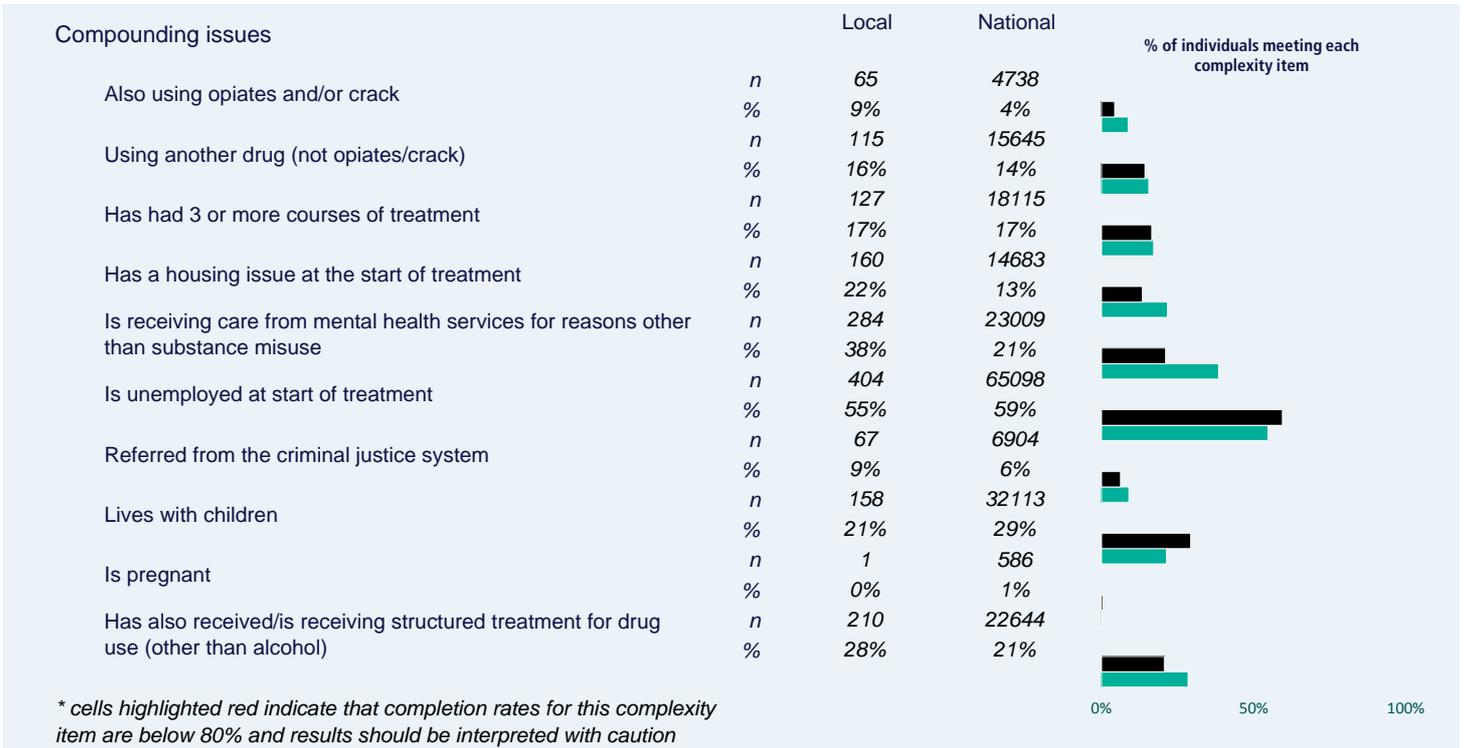
Additional use of opiates and crack are mentioned here as they are often used by clients with the most complex problems. Cannabis is also shown separately as it is the most common adjunctive substance cited by alcohol clients in treatment.



## COMPOUNDING ISSUES IN THE TREATMENT POPULATION

Local ● National ●

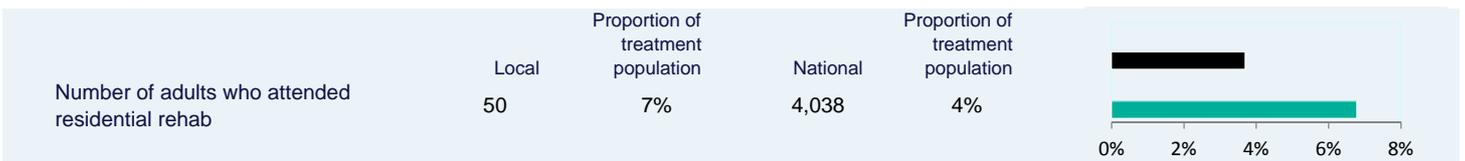
Many adults in alcohol treatment experience complex and wide-ranging problems. The 11 data items described below provide an overview of these. This is intended to give an impression of the additional characteristics of the people treated locally and identify issues which may warrant further investigation.



## RESIDENTIAL REHAB

Local ● National ●

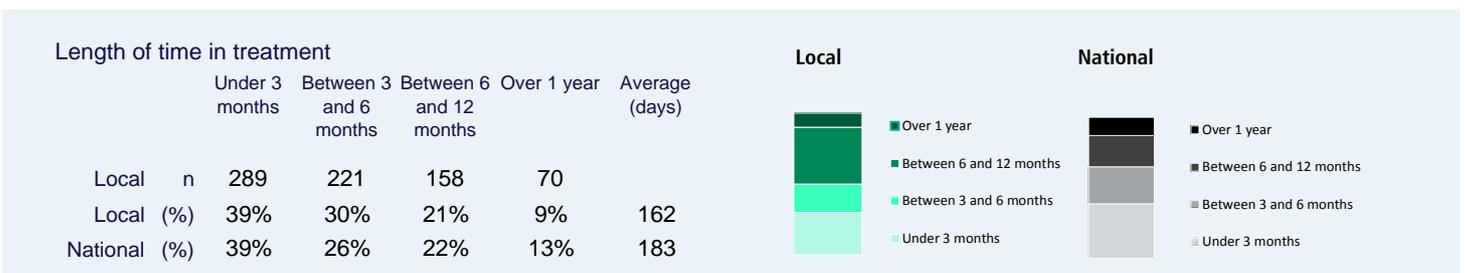
The data below shows the number of adult alcohol users in your area who have been to residential rehab during their latest period of treatment (as a proportion of your whole treatment population and against the national proportion). Structured alcohol treatment mostly takes place in the community, near to users' families and support networks. However, in line with NICE recommendations, a stay in residential rehab is appropriate for the most serious cases, and local areas are encouraged to provide this option as part of an integrated recovery-orientated system.



## LENGTH OF TIME IN TREATMENT

Local ● National ●

A course of alcohol treatment can involve one or more different types of intervention. The number of clients receiving each intervention type during their course of treatment is shown in this section. Clients may receive more than one intervention type during their treatment and are counted once for each type they receive. As a result percentages sum to greater than 100%. The most common type of interventions nationally are psychosocial interventions and other structured treatment.

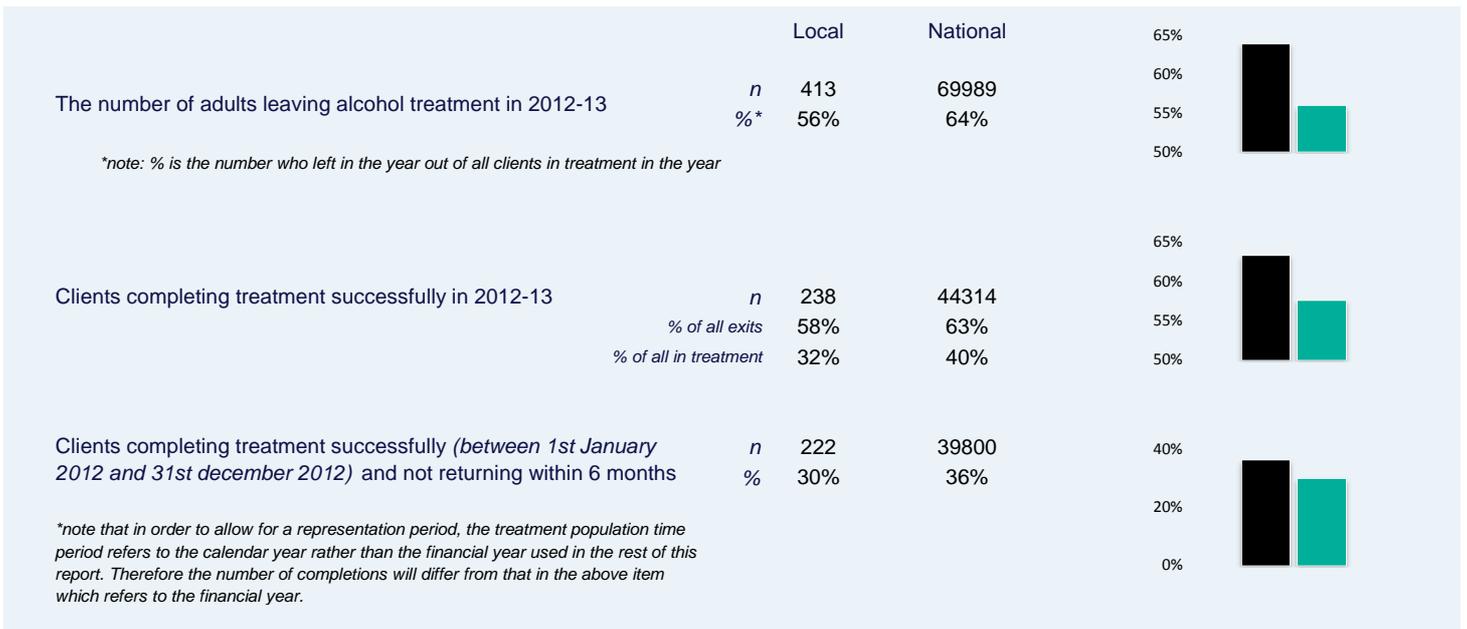


The following section relates to clients completing their period in treatment in 2012-13, and whether they completed successfully and did not return within 6 months.

The Government's alcohol strategy states that increasing effective treatment for dependent drinkers will offer the most immediate opportunity to reduce alcohol-related admissions and costs to the NHS. Although there is no single measure of effective treatment for alcohol dependency, the following data demonstrates how well the current system is working in treating those who are receiving structured treatment.

The length of a typical treatment period was around 6 months, although nationally 13% of clients remained in treatment for more than 1 year. Retaining clients for their full course of treatment is important in order to increase the levels of successful treatment completion and reduce rates of early treatment drop out. Conversely, having a high proportion of clients in treatment for more than a year may indicate that they are not moving effectively through and out of the treatment system.

The successful completions data provides an indication of the effectiveness of the treatment system in your area. A high number of successful completions and a low number of representations to treatment indicate that your treatment services are responding well to the needs of those in treatment.



Please note that the percentages given in this pack are rounded to the nearest per cent. Totals may not add up to 100 due to rounding.

**RESTRICTED STATISTICS**

You are reminded that the alcohol data provided in this document are official statistics to which you have privileged access in advance of release. Such access is carefully controlled and is provided for management, quality assurance, and briefing purposes only. Release into the public domain or any public comment on these statistics prior to official publication planned for 16th October 2013 would undermine the integrity of official statistics. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including descriptions such as "favourable" or "unfavourable". If in doubt you should consult Malcolm Roxburgh or Jonathan Knight, via EvidenceApplicationTeam@phe.gov.uk, who can advise. Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others who have not been given prior access and use it only for the purposes for which it has been provided. If you intend to publish figures from the JSNA after 16th October you must restrict figures less than 5 any any associated figures to prevent deductive disclosure.

The restricted status of this data will be lifted after the release of the Alcohol Annual Report on 16th October 2013.

### About Public Health Intelligence

Public health intelligence is a specialist area of public health. Trained analysts use a variety of statistical and epidemiological methods to collate, analyse and interpret data to provide an evidence-base and inform decision-making at all levels. Camden and Islington's Public Health Intelligence team undertake epidemiological analysis on a wide range of data sources.

### **FURTHER INFORMATION & FEEDBACK**

This Needs Assessment has been created by Camden and Islington's Public Health Intelligence team. For further information please contact Harriet North

**Email:** [publichealth.intelligence@islington.gov.uk](mailto:publichealth.intelligence@islington.gov.uk), **Tel:** 020 7527 1240

**We would also very much welcome your comments on these profiles and how they could better suit your requirements, so please contact us with your ideas.**

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