IMPROVING COMMISSIONING
AND SERVICE DELIVERY:

HARINGEY ADULT DRUG TREATMENT NEEDS ASSESSMENT

WORKING DOCUMENT FEBRUARY 2011

DRAFT

Includes restricted statistics – Please do not circulate or release into public domain

CONTENTS

Executive Summary 4
Key findings 5

1. Introduction 9

2. Background 11
Objectives 15
Problematic drug use/drug misuse 16
Need and unmet need 17
Treatment outcomes 17

3. Methodology 18
Exclusions 18
Validity and quality of performance data 18
Expert group 19

4. Prevalence of problem drug use and profile of PDUs in tier 1/2 22
Drug use amongst women sex workers – SHOC contacts 22
Migrant sex workers needs assessment and SHOC Migrant Impact Fund project evaluation 24
BUBIC contacts 24
Generic health services 27
Ambulance call outs and drug overdoses 27
Inpatient hospital admissions 28
North Middlesex Accident and Emergency data 29
Criminal justice system 30
Probation 30
Crack and crime 39
Harm reduction 40

5. Prevalence of opiate and/or crack use and engagement with treatment 41
Treatment bullseye 44

6. Profile of population in tier 3-4 structured drug treatment 45
Drug use 46
Gender 47
Age breakdown 48
Ethnicity 50
Smaller communities 51
Nationality 52
New migrants 53
Geographical breakdown 53
Housing need 57
Parental drug use 58
Dual Diagnosis 62

7. The needs of family and friends 65

8. Treatment effectiveness 67
Effective treatment - current performance 68
Successful treatment exits 69
Exits case studies 71
Summary of care plan audit findings 74
Care pathways - to be updated 76

DRAFT

Tier 4 – abstinence based residential programmes 80
Treatment outcomes 84
Summary of the Service User Survey 2009 90

9. Employment and training needs 93

Existing national research 94
Haringey profile 96
Employment status in local drug treatment population 96
Employment and skills survey 99

The cost of drug use and the benefit of treatment to be updated 105

Reference 108

Acknowledgements:

The author of this document gratefully acknowledge the contribution of our partner agencies in providing data and information for the assessment:

Community Safety Team Haringey Council
Haringey DAAT Board
Haringey Guarantee
Haringey Probation
Haringey Teaching Primary Care Trust
North Middlesex Hospital

Particular thanks are due to Haringey drug treatment agencies and service user and carer representatives in guiding us to the right questions, providing a great insight and support improving our commissioning and the treatment provision. They are:

BUBIC (Bringing Unity Back into the Community)
CRI (Crime Reductions Iniatitive)
DASH (Drug Advisory Service Haringey)
Dual Diagnosis Network
Eban
R.I.S.E
HUG (Haringey User Group)
SHOC (Sexual Health On Call)

Author: Mia Moilanen

DRAFT

EXECUTIVE SUMMARY

Drug use cuts across a broad spectrum of social issues. Most problematic drugs are crack and opiates with most impact to society and the individual. Those most vulnerable to problematic use are likely to live in deprived areas, suffer from ill mental health, live in poor housing conditions and be involved in other criminal activity.

The profile of clients in drug treatment in Haringey is no different. A large minority (28%) come to treatment via the criminal justice system. A third of drug treatment clients have mild or severe mental health issues. The geographical patterns of drug use follow the patterns of deprivation. A large number of clients in drug treatment have housing issues or are homeless. A vast majority, three quarters, of clients have no paid work. Problematic drug use is both a symptom and the cause of wider social, economic and psychological issues. Underneath the most complex cases can lie sexual abuse, post traumatic stress disorders, domestic violence, parental drug misuse, low level of educational attainment and so on.

Year on year we have identified a high demand for drug treatment which includes low threshold support on health, and structured treatment and support for full recovery and social integration. However, drug treatment alone is not enough. As acknowledged by the recent Marmot review 'Fair society, healthy lives', in order to tackle health inequalities action is required on all social determinants of health involving, central and local governments departments, and third and private sector: "if conditions in which people are born, grow, live, work and age are favourable, and more equally distributed, then they will have more control over their lives in ways that will influence their own health and health behaviours, and those of their families (Marmot et al: 2010:12).

This document outlines the findings of a needs assessment for adult drug users in Haringey, a London Borough which hosts some of the most deprived areas in the country[1]. It follows and expands upon a series of yearly assessments done in the last six years. The main purpose of this document is to inform the yearly drug treatment plan for 2011-12 which outlines how the local pooled drug treatment budget for adults is commissioned. The document is for commissioners, the National Treatment Agency, Haringey DAAT partners, treatment providers and service user and carer representatives.

Local and national evidence base on drug treatment needs is extensive. This needs assessment looks at the latest available data for 2009-10 to assess the prevalence of illicit drug use, compare profiles of drug users in treatment against those problem users outside treatment, and assess the effectiveness and outcomes of treatment. Most of the analysis is based on secondary data from the National Drug Treatment Monitoring System, drug treatment agencies, health services and criminal justice agencies alongside with existing research and national guidance.

[1] According to the Haringey Joint Strategic Needs Assessment (Haringey Council: 2008), index of multiple deprivation in 2007 ranked Haringey as the 18th most deprived borough in England and the 5th most deprived in London, behind Tower Hamlets, Hackney, Islington, and Newham.

DRAFT

Key findings

A brief summary of prevalence and penetration levels in the community

The latest prevalence estimate of crack and opiate users for Haringey is 2420[1] and the rate per 1000 population is higher than London overall (Hay et al: 2010). A significant majority use crack (73%; 1771). The estimate for opiate users is slightly lower with 1590. This, alongside with drug treatment data, suggests that a poly use of crack and opiates is common, a trend by no means unique in comparison to rest of London. Against the prevalence, a majority (59%) of crack and opiate users in Haringey have accessed drug treatment thus leaving a treatment naïve population of around 1000. There are no prevalence estimates for other drug users as the definition of problematic and recreational use is hard to determine, but for comparison, Haringey treatment agencies saw 1418 drug users in treatment during 2009-10.

The characteristics of met and unmet need, attrition, and treatment outcomes

In 2009-10 there was little change in the profile of clients in drug treatment in comparison to the previous year (Haringey DAAT: 2010). Women made up a quarter of the population, a proportion on par with national and regional averages. At least 60 different nationalities were represented in treatment and a vast majority were non white British (64%) – a need for culturally competent and language resourced workforce is evident. Cultural competence was also highlighted in workshops with drug treatment agencies which aimed to understand the reasons for drop outs. Young adult population seeking drug treatment are more likely to use cannabis, and the estimated prevalence of crack and opiate use is far lower amongst ages 15-24 in comparison to 25-34 (370 and 1307 per 100 000 population respectively). Conversely older clients in treatment report that their crack or opiate use was likely to begin when they themselves were young adults, aged between15-24.

Problem drug use follows the patterns of deprivation and neighbourhoods where other social problems are more prevalent, from high number of burglaries to poor low educational attainment. Haringey residents who seek treatment are likely to come from the more deprived and densely populated east - the highest concentration is found in super output areas located in Seven sisters, Bruce Grove and Northumberland Park wards. Accordingly, the key drug services are based in the first two with Northumberland ward only a short distance away from Bruce Grove.

Mental health

High prevalence of mental health issues is also evident, especially amongst some black and minority ethnic groups, younger users and drug users in the criminal justice system. Almost third (30%) of the local treatment population are assessed with dual diagnosis. Accordingly, Haringey DAAT commissions the Dual Diagnosis Network and Eban Counselling service. However it is recommended that further work should

[1] 2008-9 estimates by the University of Glasgow. The associated confidence intervals are 2,051 and 2,788

DRAFT

go in to assessing how treatment services meet the needs of clients with more severe issues, and whether there are sufficient pathways to appropriate psychological services.

Parental substance misuse

Local analysis shows that in 2009-10 financial year a little less than a half of clients in drug treatment had children (47%). However, a majority of parents (64%) did not live with their children at the time when they commenced their latest treatment episode. National Treatment Agency for Substance Misuse (2010) report show that Haringey's rate was one of the highest in London. This could be either due to the higher prevalence of parents with drug issues in the borough or a better engagement with local services. The number of children living with clients in treatment is not recorded accurately and therefore data quality should be a priority for the local agencies

Treatment outcomes

Comparisons between client demographic characteristics, drug use and the length of time in treatment show that; women are more likely to leave treatment successfully in comparison to men; black British and 'other' ethnicity groups also fair better, and crack, cocaine or cannabis using clients are more successful than those who use opiates or crack and opiates combined. However, differences by client characteristics are not necessarily directly correlated to treatment outcomes. Other confounding factors may be far more significant. Indeed, NTA's successful treatment completions guidance (NTA:2009)[1] concluded that client characteristics have less to do with outcomes than service specific issues such as organisational functioning or therapeutic relationship between a client and their keyworker. During 2010 Haringey DAAT and the main drug treatment agencies set out to explore the key issues behind the reasons for clients dropping out by looking at a sample of anonymous client files in each service. As expected, this uncovered very complex cases and issues varying from problems with housing, domestic violence, mental health, childhood trauma, to self harm or loss of family member. It is clear that no one single measure is likely to improve drop outs but what can make a difference is a flexible client led approach to recovery, as well as competency, both organisational and individual, in creating positive partnerships across mental health, social care, mutual aid and voluntary organisations for the client to reach full recovery. Early signs of disengagement should be promptly addressed and treatment options reviewed.

Treatment outcome data for 2009-10 suggests there is improvement during the first year in treatment in all the four domains - substance misuse, injecting behaviour, criminal activity and health and social functioning. However, the outcome findings for 2009-10 should be treated with caution as data completeness for reviews was less than 80%[2]. Also, outcomes are not monitored after treatment. This highlights the importance of improving the validity and reliability of treatment outcome tool data, as well as monitoring whether those who leave treatment successfully present into treatment again.

DRAFT

---

[1] NTA (2009) Towards Successful Treatment Completion. NTA London www.nta.nhs.uk/publications/documents/completions0909.pdf

[2] 80% is the threshold set by the NTA whereby data is only published for each partnership once the data completeness reaches this percentage.

Employment

A vast majority of drug users (75%) in treatment are unemployed with a large number claiming work related benefits[1]. Drug users in the Probation service also have higher education, training and employment needs in comparison to the overall Haringey Probation population (43% and 32% respectively). National literature alongside with a local survey suggest that drug users face multiple barriers which are linked to criminal records, lack of work experience or interrupted work histories, lack of educational and occupational qualifications, literacy and numeracy problems, fear of relapse and issues with housing. Organisational barriers include employer discrimination and ineffective links between drug and employment services (Drugscope:2008) although in Haringey treatment agencies have good links with the main employment provision through a six weekly forum. In the local survey, career advice, help with CVs with computer skills training was required by most. Only a small minority (4%) thought ETE support should start in aftercare stage. This confirms the importance of work related activities being part of treatment and recovery. Work in itself can have intrinsic therapeutic value (South N. et al:2001). Staged re-introduction to employment, volunteering opportunities and the joint working between services is also crucial (Cebulla et al: 2004). On the other hand the therapeutic benefits of work are unlikely to be achieved by unsustainable and poor quality low paid work. As concluded by the Marmot review on health inequalities (2010), jobs need to be sustainable and offer a minimum level of quality, to include not only a decent living wage, but also opportunities for in-work development, the flexibility to enable people to balance work and family life, and protection from adverse working conditions.

Harm reduction to be updated February 2011

Treatment system mapping and the care pathways in operation to be updated February 2011

Information gaps and areas of further investigation

Haringey needs assessment process is ongoing. During 2011 Haringey DAAT will assess the cost benefit of local treatment provision once the NTA's value for money tool is launched. The alcohol needs assessment draft will be ready for consultation in February 2011. More work will concentrate on understanding the impact of the combined powder cocaine and alcohol use to local health services. Haringey DAAT will also monitor whether the number of clients who leave treatment successfully return to the system within a year.

Agencies should focus on completing the treatment outcome data and improve the data quality on the number of children who live with clients in drug treatment in order to accurately estimate the number of children affected by parental problem drug use.

On a general note, over reliance on quantitative data, however statistically reliable or valid, has a danger of simplifying issues and implying there are causal relationships

[1] Estimated 2160 in 2006-7(DWP:2008)

DRAFT

when real causes or correlations lie elsewhere. Since there is a raft of quantitative data available on drug treatment it would be useful for any future needs assessment also to use the techniques associated with qualitative research. This will help to explore issues fully. Qualitative information should not be seen as 'soft' data since it can provide useful contextual information and provide explanations as was shown by the workshops on drop outs done in 2010.

DRAFT

1. INTRODUCTION

Haringey Drug and Alcohol Action Team (DAAT) commissions the publicly funded drug treatment services in the borough. A needs assessment is the evidence base which informs the yearly drug treatment plan completed by all local teams in England and Wales in charge of the pooled drug treatment budget (PTB). 'Drug treatment', albeit a very medical term, describes a multitude of interventions which are designed to help individuals to recover i.e. to reduce or stop their drug use, improve their health and psychological well being, and provide support in their reintegration back into mainstream society. The treatment/recovery interventions vary from hepatitis B vaccinations to counselling, substitute prescribing, and residential rehabilitation to housing, employment and training support. The overall aim of the yearly treatment plan is to develop and improve the drug treatment provision so that it meets local need with better use of resources. It is important that services respond to local changes in drug use, changing social issues alongside with new research and policies, and reflect the diversity of Haringey. To respond to changes effectively the needs assessment is ongoing. Therefore this document will outline all the preliminary key findings but further work will be done throughout the treatment planning cycle, where deemed necessary.

Needs assessment is a form of evaluation aiming to find out '*merit, worth, or value (of interventions) in terms of improving the social and economic conditions of different stakeholders.'* (GSR:3). It is a systematic way of collating and analysing data to inform decision making and commissioning. The purpose is to identify the target population and their needs and also explore how well needs are currently met. Whilst acknowledging that needs differ by areas, groups and individuals, this evidence base should help to prioritise those needs in order to respond the issues posed by illicit drugs most effectively.

Much of the process and methodology is based on the National Treatment Agency for Substance Misuse (NTA)[1] guidelines on methods and components of an effective needs assessment for adult drug treatment (NTA:2007 and 2009). As per the NTA guidance (2009), this needs assessment aims to tie in with wider policies and guidance, including the Joint Strategic Needs Assessment for local strategic partnerships, Equalities Impact Assessment and guidance from The National Institute for Clinical Evidence (NICE), amongst others.

Service users and families are at the heart of the process. As recognised by the NTA and emphasised in the health sector, needs assessments provide '*ideal opportunities for engaging with specific communities, gathering evidence from and about them, and utilising an evidence-based approach to effect service changes and improvements with their full involvement'* (Cavanagh S. Chadwick K:2005:6). This year the carer and service users will be involved once preliminary findings are done. Their role is to appraise and evaluate the findings, and provide recommendations to the subsequent treatment plan. Also, in addition a service user survey completed in

[1] The National Treatment Agency for Substance Misuse (NTA) is a special health authority within the NHS, established by Government in 2001 to improve the availability, capacity and effectiveness of treatment for drug misuse in England. More information available from www.nta.nhs.uk

DRAFT

February and focus groups form part of the assessment from where they can contribute to specific issues. Both are designed and conducted jointly by representatives from treatment agencies, service users and commissioners.

Personalisation agenda currently piloted by the NTA, is a new approach which gives service users even more control over their treatment by giving them a personal budget to purchase services for themselves. Following the results of the pilot, Haringey DAAT is currently exploring how to adopt this into their commissioning.

DRAFT

2. BACKGROUND

There is a large amount of national evidence on the need and effectiveness of drug treatment. The current soon to be updated Models of Care (NTA: 2006) for drug treatment, which brings together the evidence, can be the starting point for a local needs assessment (NTA: 2007). The effectiveness of the specific harm reduction[1] and drug treatment interventions[2] outlined in the Models of Care is well established and monitored nationally through the National Drug Treatment Monitoring System (NDTMS).

Although this is now the sixth local needs assessment done by the DAAT, due to national targets and close monitoring by the National Treatment Agency for Substance Misuse, the local treatment framework or priorities have been based on a national agenda set by National Drug Strategy, the National Treatment Agency or National Institute of Clinical Excellence (NICE) amongst others.

Previous national policies have focussed on crack and opiate use since they are widely seen as being most harmful to the individual and the community. Subsequently, local needs assessments and treatment planning has centred around crack and opiate use. As a consequence there are gaps in our local knowledge about the specific needs of other drug users and alcohol misuse.

Key consideration should also be given to the new drug strategy '*Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life'* released in December 2010. The new strategy intends to build on the success of drug treatment to ensure more people are tackling their dependency and recovering fully (HM Government: 2010). Also relevant are the Public Health White Paper '*Healthy Lives, Healthy People: Our strategy for public health in England* along with the move of the NTA into the new national Public Health Service, and the NHS White '*Paper Equity and excellence: Liberating the* NHS'. There is also a recently published '*Drug Interventions Programme (DIP) Operational Handbook'* (2010) for managing drug using offenders into treatment. The document clarifies the governance and process of DIP; which in turn include identification, assessment and case management; available housing and housing support; establishing support networks (families, crisis support, peer support); developing life skills & route back to employment.

Recovery capital

New treatment models will build on what drug users already have rather than just focusing on their deficits, building recovery capital. The national drug strategy (HM Government: 2010) segments this capital into social, physical, human and cultural which in turn are defined as:

[1] eg. needle exchange, hepatitis C & B testing, advice and information
[2] eg. substitute prescribing, residential rehabilitation, counselling

DRAFT

- Social capital – the resource a person has from their relationships (e.g. family, partners, children, friends and peers). This includes both support received, and commitment and obligations resulting from relationships;
- Physical capital – such as money and a safe place to live;
- Human capital – skills, mental and physical health, and a job; and
- Cultural capital – values, beliefs and attitudes held by the individual

Research has shown that recognising a persons possession of or access to, such skills, resources and assets can be indicative of a persons capacity to overcome problematic drug use (Daddow, Broome: 2010). Granfield and Cloud identify these variables as ‘the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from alcohol or drug problems’ (sited in Daddow, Broom:2010: 62). They suggest that people who have access to recovery capital are better able to address problem drug use than those who do not.

The concept of recovery capital highlights that successful drug treatment is heavily reliant on social circumstances: on housing situation; support from friends and family; and employment and training opportunities, factors generally linked to social deprivation and ill health (Marmot et al: 2010). Whilst the pooled drug treatment budget cannot fund all these activities directly, they are crucial to outcomes and cost effectiveness of treatment. A key consideration is the input of other partner agencies and the effectiveness of generic recovery services in supporting the individuals during and after treatment. Furthermore the money spent on drug treatment should not be undermined by the lack of support from mainstream services. The NTA guidance (NTA:2009) highlights the need to steer away from seeing treatment as a linear journey. Accordingly, social integration, including employment, should be a consideration throughout treatment, not after.

DRAFT

Funding

Planned public sector cuts are also a key consideration. After a 16 per cent cut[1] in the two years between 2008-9 and 2010-11, the pooled treatment budget will have a small reduction in 2011-12. The pooled drug treatment budget will be part of the ringfenced public health budget. All funding related to drugs, including funding previously held by the Home Office is pooled and overseen by the Department of Health. The change in funding structures and the implementation of the recovery agenda will provide opportunities but inevitably the cuts throughout the public sector will pose a risk to the sustainability of recovery and social reintegration

Research studies on the overall societal cost of illicit drug use suggest that providing drug treatment makes economic sense. A Home Office study published in 2002 estimated that total social costs (for the types of costs see appendix 1) of class A drug use, when untreated, equate to “£6,564 per year averaged over all Class A drug users, £35,456 for problem drug users”. (Godfrey et al: 2002:55). In public sector, this cost is borne by health services, criminal justice system, social care, and payments by employment and housing benefits. Another, National Treatment Agency commissioned study on outcomes, ‘Drug Treatment Outcomes Research study (DTORS)’, found that ‘the net benefits of structured drug treatment were estimated to

[1] In 2008-9 the pooled treatment budget was £3,466,001 which was reduced to £3,324,476 in 2009-10. The budget for the current financial year, 2010-11, was £2,907,731.

be positive, both overall and at the individual level in around 80 per cent of cases, with a benefit-cost ratio of approximately 2.5:1'(Davies et al:2009). Experience of drug use is widespread and public opinion firmly supports investment in drug services: 77 per cent of us believes it is a sensible use of government money (Daddow, Broome: 2010:3)

Payment by results

As part of a commitment to recovery, a key action from the Drug Strategy 2010 is the development of pilots to test new approaches to the commissioning and delivery of drugs recovery systems that reward achievement of outcomes. During 2011, the NTA will support a series of pilots to implement a Payment by Results (PbR) approach to recovery for individuals who are drug dependent. The aim is to give incentives and reward providers that support individuals, including those in contact with the criminal justice system, to recover from their drug dependence, resulting in clear outcomes for the individual, their families and communities.

Targets

Performance against key targets has also been one of the driving factors for the yearly treatment plans. However, national targets are now facing abolition or changes, the focus on crack and opiate users in tier 3-4 structured drug treatment – as opposed to more low threshold support and inclusion of other illicit drugs – can potentially be better redirected at specific local needs, say alcohol users and social needs (eg. employment and training needs, or support with family issues).

Local service provision

There are number of drug treatment and relevant support options available for Haringey residents. Support ranges from advice and information, needle exchanges to counselling, residential rehabilitation and social reintegration services. The Drug Intervention Programme, an intervention for drug using offenders, is delivered by CRI. Haringey DAAT also commissions support for friends and family of drug users. The table 1 shows the main treatment and support available in each service. More information about all drug services is available from www.haringey.gov.uk.

DRAFT

Table 1: Drug and Alcohol services in Haringey

Service need	BUBIC	DASH	Dual	Eban	Haringey Aftercare	WDP Structured Day Programme	HAGA	Involve	SHOC	RISE	COSMIC	Chrysalis
Access to GP prescribing		●										
Access to rehab and detox		●					●	●				
Advice and information	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol support							●	●				
Children and young people (up to age 21)								●			●	
Complementary therapies		●		●	●			●		●		
Counselling				●			●					
Crack specialist support	●			●								
Domestic violence support							●		●			
Employment and training support	●				●					●		
Ex-users peer support	●						●			●		
Group work	●	●	●	●	●	●	●	●		●		●
Hepatitis B and C and HIV testing and Hep C immunisation		●	●	●	●				●			
Needle exchange		●		●	●			●	●			
One-to-one support	●	●	●	●	●	●	●	●	●	●		
Open access support (no referral needed)	●	●		●			●	●	●		●	●
Overdose advice	●	●	●	●		●	●	●	●			
Substitute prescribing for heroin or opiate users		●										
Counselling for family and friends				●								
Advice and info for family and friends	●	●	●	●	●	●	●	●	●	●	●	●
Women only groups		●		●	●		●		●		●	

Source: Haringey Drug and alcohol service directory. Available from: www.haringey.gov.uk

DRAFT

Purpose

The overall purpose of the needs assessment in 2010-11 is to improve the understanding of local need for people who experience problems with illicit drug use. At the same time this evidence base aims to reflect local priorities as well as changes in national policies, including: the focus on outcomes; the personalisation agenda; decentralisation of decision making to the local level; and take into account the impact of cuts in the public sector overall.

The main aims of the needs assessment are to inform the adult drug treatment plan for 2010-11 which in turn will improve current adult drug treatment provision in Haringey. The plan should ensure:

- there is a sufficient range of tier 2 engagement interventions (harm reduction and open access provision) for adult drug users and act effectively as the gateway for more new service users to access structured tier 3 and 4 drug treatment and recovery services
- tier 3 and 4 drug treatment responds to the needs effectively
- that outcomes of treatment are improved and supported by tier 1/recovery agencies (relevant agencies outside treatment) [1].

Objectives

The first stage of the needs assessment aims explore the overall prevalence of drug misuse in 2009-10 and where in Haringey the problems are concentrated, outcomes of treatment, and estimate the cost of not providing treatment for people to whom drug use is a problem. The objectives are to:

1. Identify the prevalence and profiles of drug users in contact with tier 1/2 services (inc criminal justice, health services, Job Centre Plus (demographic characteristics, location)
2. Identify how to make services accessible/attractive for those not in contact with the treatment system (service user survey and focus groups Jan 2011)
3. Identify if the structure of the current treatment system matches local need
4. Identify the geographical patterns of drug use in Haringey
5. Identify the number and needs of parents who are in treatment linking in with the Child Poverty Needs Assessment by Haringey Council
6. Identify outcomes of treatment (exit workshops, TOP)
7. Identify if there are specific groups that treatment provision fails to reach or for whom treatment outcomes are less successful
8. Estimate the cost of not providing support against the unit cost of treatment
9. Identify data gaps and areas for further investigation
10. Explore what existing recovery capital service users have and how to maximise this (ETE survey and survey/focus groups)
11. Evaluate findings and prioritise actions for the DAAT strategic and treatment plan

[1] This includes: open access services; employment and training services; family and carer support; tailored services for more marginalised groups (i.e. out of hours services); outreach and satellite services; specialist services for young adults and services that meet the needs of Haringey's diverse population (e.g the Somali community and khat) and cannabis users.

DRAFT

Initially the aim was to map prevalence data from tier 1 agencies and map that against those in treatment but due to the lack of data it was not feasible with the current resources. However more detailed geographical analysis was done on the current treatment population. Glasgow University have produced overall estimates for crack or opiate users by borough but there are no such estimates for other problem drug users partly because the definition of problematic and recreational use is harder to determine than with other drugs.

Haringey DAAT also completed an additional employment needs assessment during 2009-10, findings of which will be included in this document.

The second stage will focus on problematic alcohol use and gaps in knowledge identified by the Alcohol Needs Assessment 2009 conducted by the Haringey Public Health team at the NHS Haringey. Work is to conclude February 2010.

Scope and exclusions

The remit of this needs assessment is illicit and problematic drug use, for Haringey residents aged 18 and over who would benefit of some intervention or treatment addressing their drug use and other related needs. The focus is on prevalence in financial year 2009-10. A separate needs assessment and treatment plan is being done concurrently conducted for ages under 18.

This excludes recreational drug use focussing on harmful use where drug or alcohol use has resulted in unemployment, hospital admissions or A & E visits, or criminal activity.

Problematic drug use/drug misuse

The NTA Models of Care document (NTA: 2002) defines drug misuse as:

> *"drug taking that causes harm to the individual, their significant others or the wider community. By definition, those requiring drug treatment are drug misusers…misuse as illegal or illicit drug taking or alcohol consumption that leads a person to experience social, psychological, physical or legal problems related to intoxication or regular excessive consumption and/or dependence. " (p:3)*

Problematic substance misuse is often a symptom of social, economic and/or personal problems. Many use a combination of drugs, including alcohol. However, whilst acknowledging the harm caused by alcohol, tobacco and prescription drugs they are outside the scope of this assessment. Alcohol is included if a secondary drug of choice.

In practical terms, and for data collection purposes, this document looks at the needs of individuals in contact with drug treatment and harm reduction services (tiers 2-4), those arrested for trigger offences and tested positive for illicit drugs, or individuals who have been in contact with tier 1 mainstream services for their drug use (eg. overdose ambulance call out) or their drug use has otherwise been identified an issue (eg. inability to get work through an employment agency because of illicit drug use).

DRAFT

Need and unmet need

The need is broadly defined as health and social needs which are indirectly or directly a result of, or lead to, illicit drug use. The different types of need are defined in the Models of Care (NTA: 2006) as:

- harm reduction
- health
- structured treatment[1]
- other low threshold support such as advice and information
- training & employment
- housing
- carers (family and friends)

Needs relating to employment, training and housing can have a great impact on successful and sustainable treatment outcomes. The pooled treatment budget cannot fund these activities but they should be part of the needs assessment, planning and strategic activity.

Treatment outcomes

What constitutes a successful outcome is subjective and varies between individuals and organisations. For some the key is to stop drug use altogether but for others it can be anything from improvement in family relationships to full time employment and better health. The treatment outcome tool introduced by the NTA defines outcomes by reduction in crime and drug use, better psychological and physiological health, stable housing and employment. Since the NTA's definition was constructed in consultation with a variety of key stakeholders, both professionals and service users alike, and data on those outcomes is readily available, the same definition is used here. However this does not mean that other outcomes are less valid. For example, voluntary and non paid work, which are not listed in the treatment outcome tool, are arguably important measures of success.

DRAFT

[1] This includes the following interventions as defined by the National Treatment Agency: Residential Rehab, detox, counselling and psychological support, structured day programmes,

3. METHODOLOGY

The methodology is broadly based on the NTA guidance (NTA: 2007, 2009, 2010). Due to the resource constraints the data collection heavily relies on routinely collected secondary data from local services and the National Drug Treatment Monitoring System. The exceptions are the local service user satisfaction survey and focus groups and the employment needs survey.

The analysis focuses on prevalence in 2009-10 financial year where data for that period was available. The treatment planning and funding cycle is relatively short and done year on year, hence it is appropriate to use prevalence as opposed to long term trends or predictive methods. It should be noted that there has been changes and improvements in the service provision during the current financial year following the priorities set in the treatment plan. Any significant changes from last needs assessment and comparisons to 2009-10 data are indicated throughout.

NTA research and NICE clinical guidelines alongside other research in the drugs field are evidenced throughout the needs assessment and treatment planning process to ensure Haringey DAAT commissioning is done following best practise and up to date evidence.

However, since methods of data collection and analysis vary in different sections, additional notes are included in each section or in the footnotes where appropriate.

DRAFT

Exclusions

Young people under 18 are excluded from this project as the budget and the plan that it informs is for adult drug users only.

Validity and quality of performance data

Most quantitative data is from secondary sources which has been collected routinely for different purposes. Although a by-product, most data has not been collected for research nor needs assessment purposes. The selection of data items and data definitions are often predetermined by performance monitoring objectives and targets. Some information may reflect performance or targets, or the geographical location of the organisations. Comparisons are also problematic as the data collection is not co-ordinated by the same organisation: definitions and data collection methods differ by source. Also, the data has not been collected by individuals with relevant research experience and skills. This is significant as data can vary depending on who asks the question, how and for which purpose. Nevertheless, the combination of different sources, including qualitative input from our experts (see below) will give an indication on the degree and the nature of unmet need. This report is also sent back to the respective data sources to be checked. This

is to ensure the accuracy of the analysis and that any caveats, which may not be apparent in the data, are taken into account.

Expert group

For the reasons outlined above, it is important that the secondary quantitative data is supplemented and validated by other sources. Stakeholder input is instrumental to this process. As recommended by Hooper and Longworth (2002) the process should include those who care about the issues, know about the issues and those who make decisions.

During the previous assessments the aim has been to involve stakeholders from the very beginning of the process, including defining the objectives and the process. This year the process is different since the state of flux in national policy, information requirements and targets pose some limitations to what we can, or is useful to, investigate. Also, there is a risk of 'consultation fatigue' and therefore it was not judged appropriate nor necessary to repeat the same method of consultation every year. This year the consultation is done at the end of the process to ensure:

- the analysis accurately reflect what happens across services
- Key stakeholders have the opportunity to identify key areas for further investigation
- There is a representative of each key partner agencies or groups who act as a link to the respective organisations/groups

The function of an expert group is to bring together representatives from key groups, including representatives from service users and carer groups, Public Health, Community Safety, Probation, Housing and Job Centre Plus, and drug treatment services. An expert group is not a fixed group with fixed objectives and fixed membership. This membership changes according to different objectives depending on the 'expertise' or decision making level required.

DRAFT

The main aims of expert groups are to ensure that:

- the analysis accurately reflect what happens across services
- the needs of service users and their families remain the focus of the assessment and the subsequent treatment plan
- Key stakeholders have the opportunity to identify key areas for further investigation
- There is a representative of each key partner agencies or groups who act as a link to the respective organisations/groups

The ‘experts’ will be consulted after the first draft of needs assessment is complete with the existing groups, Treatment Task Group which includes service providers, Joint Commissioning Group, DAAT service user and carer groups, and the DAAT Board who make final decisions on funding. Separate meetings will be arranged where necessary to ensure all key stakeholders have a say. Findings will also be appraised by the joint commissioning group who has representatives from key partner agencies, with meeting scheduled in February 2011.

Peer led research project

Gold Standards Team, a research organisation run by ex users is currently conducting a study across four areas, including Haringey, on drug diversion. Although the focus is on subutex and the levels of street dealing, some of the questions in their survey around access to treatment will be helpful for our needs assessment. Haringey DAAT was also given the opportunity to add five local questions in to the survey. Preliminary findings are included in the harm reduction section, see page…

Presentation of data

All charts and percentages exclude non responses or missing values in data. However the response rate and the missing values are indicated in the charts or chart headings or footnotes.

Care plan audit

Care planning is one of the key elements of good quality treatment. A comprehensive care plan is vital to a successful treatment journey packaging the several types and sequences of treatment, as well as the wrap around support that may be required. This written agreement between a client and a keyworker outlines the treatment goals, who will do what towards achieving them, and by when (NTA:2009).

The findings from the previous audit are included in this document. A new revised audit is underway and all Haringey drug treatment agencies are to report findings back to the DAAT by 29th January 2011. These findings will also be part of the needs assessment to inform the treatment plan 2010-11. The audit criteria and the methodology are available on request.

DRAFT

Ethical approval

Ethical approval for the ongoing needs assessment was given by the Haringey Council Research Governance Framework in August 2009 and the governance panel was provided with the details of the employment survey in June 2010.

DRAFT

4. PREVALENCE OF DRUG MISUSE AND PROFILE OF USERS IN TIER 1/2

As mentioned in section 3 of this document, the needs of drug users have been widely researched on a national level. The aim of this section is therefore to understand the prevalence of harmful drug use and the profile of users locally.

The data was gathered from tier 2 services (low threshold substance misuse specific support), generic health services and the criminal justice system. As the data is not identifiable it is not possible to establish how many are not in contact with drug treatment services already.

The assumption is that those who use opiates and crack need structured drug treatment inclusive of recovery packages, for example housing and employment support. Those who use other illicit drugs may not need structured drug treatment but the fact that they have been in contact with criminal justice system or health services for the reasons linked with their drug use means that their use is harmful and some form of support is likely to be beneficial.

DRAFT

Drug use amongst women sex workers – SHOC contacts

SHOC (Sexual Health on call) provides support, outreach and clinical services, for female sex workers, working on and off street across Haringey and Enfield. Services include tier two low threshold support for drug users, including advice and information, needle exchange, sexual health and contraception services, including testing for blood borne viruses, and referrals to structured drug treatment. According to SHOC's annual report covering 09-10 financial year, they were in contact with 226 women through 'off' street outreach, women working in a premises and 156 through 'on' street outreach or at one of the two drop-ins' collectively known as the Haringey Working Women's Project. (WWP)

Overall the number of women seen was 382 which is an increase from 317 in 08-09. While the numbers of women attending the WWP remained the same, the numbers seen on outreach to 'off' street premises rose due to increased outreach halfway through the year. Of the 382 women 137 lived in Haringey, 58 in Enfield and 88 reported living in Greater London.

Since the decommissioning of SHOC's specialist in house drug treatment service they have worked in partnership to provide a fast track satellite session based at DASH and staffed by SHOC's Senior Drug Worker. This has proved invaluable to a small number of women but cannot be extended due to staff resources.

264 women were new to SHOC overall but this was largely in the 'off' street group, 173 and 91 women seen at the WWP. A large number of the 91 however have only

ever been seen on street outreach not utilised SHOC's other services and are unlikely to engage with drug treatment or other low threshold services.

90 of the women attending the WWP were known drug users[1] which represents 58% of all women 'on street'. The vast majority (83% n=75) used crack and more than half (n=52, 57%) heroin with the majority using a combination of substances including a combination of crack, heroin (or methadone) and alcohol.

Records show that nearly a third (30% n=27) of this group have been in drug treatment which leaves a substantial number not accessing treatment. However, SHOC themselves provide brief interventions which reduce drug use and stabilise women's lives and are very appropriate for crack users. Housing and domestic violence has been identified as a key barrier to engagement with treatment services.

A large number of women seen by SHOC are migrant sex workers who are not identified with drug use. However, this represents a significant challenge to the service in order to support the women adequately due to language barriers and their distrust of 'authority'. SHOC attempted to overcome these problems by the employment of a bi-lingual worker who has proven very successful in building relationships with the women. This element of service provision will come to an end in March 2011 unless further funding is found.

As shown in table 2, a little over half of women working on street were over 30 years of age, and there was no one under 18 years identified as a street sex workers. Those aged 20-25 made up a fifth of the client group (19%). The proportion of younger women working on premises is higher than those on the streets, ages 20-25 represented around third (34%) of the group. Those over 30 years of age represented a little less than a half (45%).

DRAFT

Table 2: SHOC clients age breakdown 2009-10 financial year

Age	on street	%	off street	%
Under 18	0	0%	0	0%
18 – 19	8	5%	7	3%
20 – 25	29	19%	77	34%
26 – 30	34	22%	41	18%
31 – 40	38	24%	50	22%
40+	47	30%	51	23%
Total	156	100%	226	100%

Source: SHOC annual report 2009-10

There were further differences between women working on and off street related to their ethnicity groups. A large minority of women working on the streets were white British with 41 per cent. Whereas a vast majority working in premises were identifies as European and 'other' (69%). See table 3.

[1] SHOC report notes that '*Included in the 90 drug users are 9 of which data is not available of which drugs they use. However, we believe this to be Heroin, Crack or both but this is not substantiated'* .

Table 3: SHOC clients ethnicity breakdown 2009-10

Ethnicity	on street	%	off street	%
White British	64	41%	43	19%
Black British	19	12%	13	6%
White Irish	3	2%	1	0%
European & Other	47	30%	155	69%
African Caribbean	4	3%	1	0%
African	5	3%	1	0%
Asian	1	1%	5	2%
Mixed Race	13	8%	7	3%
Total	156	100%	226	100%

Source: SHOC annual report 2009-10

Migrant sex workers needs assessment and SHOC Migrant Impact Fund project evaluation

SHOC has provided crucial support for the sex working women in Haringey for several years but not enough is known about their needs. As part of the Migrant Impact Fund, in 2009 Haringey DAAT commissioned a needs assessment and an outcome evaluation project for migrant women sex workers to be completed by an independent evaluator/research organisation. The full report will be finalised by February 2011 and available on request.

DRAFT

BUBIC contacts

BUBIC (Bringing Unity Back into the Community) is a mutual aid community support service set up in partnership with ex-service users who provide support, advice and guidance for people affected by drug use, predominantly crack users. They hold weekly peer support sessions around Haringey, conduct active outreach services through which referrals are made to mainstream services (the tier 3 and 4 structured treatment) provide one-to-one support for clients in the community and a re-engagement service for those who drop out of treatment. As a mutual aid service BUBIC offers an alternative to a formal drug treatment setting where people do not need to have their details recorded in order to receive support. Crack use is often linked with paranoia and initially personal questions can risk engagement.

There were a total of 849 attendances in 2009 -10 financial year for BUBIC sessions, including 50 newcomers from which 24 people had an initial assessment and 18 of them referred to mainstream treatment. There were also 123 contacts through satellite outreach in police stations, courts, libraries and the local college CONEL, and an additional 305 through assertive outreach where members of BUBIC seek out drug users in the community, streets, stairwells etc. The vast majority of their contacts (73%) reported being from black ethnic background. The ethos of BUBIC does not fit with the monitoring guidelines which government funded services are currently

subject to. Hence it is not possible to obtain exact figures on the number of individuals engaging with BUBIC.

This year, however, the organisation repeated a second round of questionnaires which their clients filled in on a voluntary basis. This snapshot provided some useful indicative results although we cannot generalise these findings due to the small self selected sample[1]. This exercise has been planned to be repeated twice in any financial calendar year and that will help to monitor these findings.

There were 31 responses overall, although not all forms were completed fully. 55% were male and 16% were women, although 29% did not comment on their gender. A little over half of the clients (51%) were over 35 years of age and 41% identified themselves as black Caribbean, and the second largest group, almost one fifth (19%) were White British and 13% were Greek Cypriot.

Main drugs which had caused, or were causing, them most problems were crack, alcohol, heroin and cannabis (50%, 16%, 11% and 7% respectively)[2]. However, the data also show that majority of the clients are using more than one drug simultaneously.

Chart 1: Snapshot of BUBIC clients April – May 2010 - treatment needs[3]

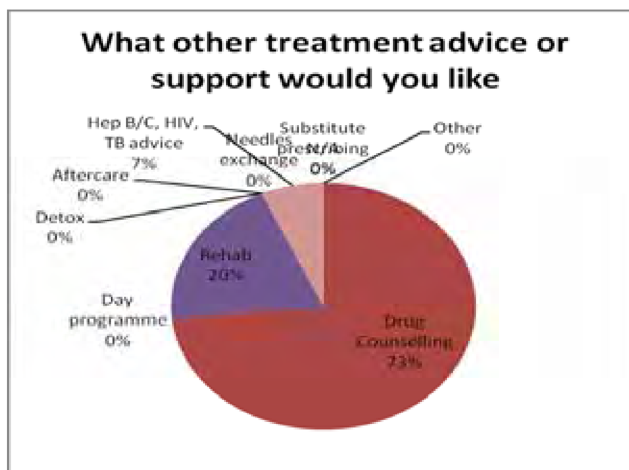
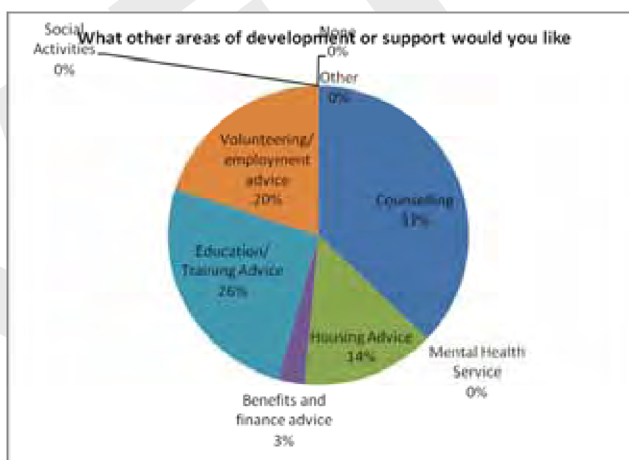


Chart 2: Snapshot of BUBIC clients April – May 2010 - other support needs



Source: BUBIC

DRAFT

Nearly half said they were currently using drugs, therefore a significant portion are likely to be ex users or did not want to disclose their drug use. Also friends and families of drug users attend BUBIC sessions. A fifth (20%) were not accessing any other drug treatment services. Those who did were more likely to be at Eban (35%),

---

[1] As opposed a demographically representative sample done by randomised sampling, or as may be more appropriate in this context, representative of the different personal or social circumstances that are important to cover with this client group (eg. whether they've been in treatment.). This can be achieved by purposive sampling.

[2] Skunk and cocaine powder by 7% each. Other drugs were ketamine 2% and 1% was defined as 'other'.

[3] This value was missing from 50% of questionnaires

DASH (19%) or DIP (16%). It should be noted however that DIP and EBAN are currently located in the same building as BUBIC.

The respondents did identify areas of further treatment support, including drug counselling, detox, rehab and day programme, as well as other areas outside drug treatment such as housing advice, education and employment, see charts 1 and 2.

None of this data fully reflects the work and the contacts made by outreach and other activities. BUBIC sessions are classified by the NTA model as tier 2 as they do not offer structured treatment. However, the number of PDUs attending BUBIC does not automatically equate to unmet structured treatment need. Mutual aid is a proven means of recovery in its own right and BUBIC has been recognised to be doing valuable and effective work in the community and in supporting crack users, especially from the black African and black Caribbean communities. In 2007 BUBIC won the London Tackling Drugs Changing Lives team award for the innovative work that they do.

BUBIC services can help reduce or stop harmful drug use and support service users to move on to more stable lifestyle. This work is at risk of being undermined by the fact that BUBIC does not report to the NDTMS or officially undertake TOP. A full outcome evaluation would be useful in order to fully establish how well they meet the needs of their service users, and how many individuals attend their services.

DRAFT

Generic health services

Data for this section was obtained from the London Ambulance, North Middlesex A & E and the Haringey TPCT on Hospital Episode Statistics (HES). Haringey TPCT is currently not required to collect data from GPs specifically on substance misuse. Because of resource and time constraints it was impractical for the DAAT to seek information from individual GP practices.

Health services are potentially a rich source of information, especially helpful in estimating numbers who would benefit from harm reduction services such as overdose advice. Robust data would help to identify the number and the demographics of the population potentially hidden from drug services.

Unfortunately illicit drug use information is mostly contained in a free text format. For example drug data from A & E on overdoses and self-harm are mostly categorised as 'unspecified drugs' and the information cannot be extracted without looking through client's notes. The ambulance callouts recorded as 'drug overdose' or 'drug use' may relate to – and most often do – suicide attempts or self harm involving prescribed or over-the-counter drugs. Also, the same person can appear in the statistics more than once. The data collection methods, data items, priorities and the frequency of recording substance misuse vary by organisation. Substance misuse related cases can also be hidden under other diagnosis such as 'vomiting' or 'fall'.

Ambulance call outs and drug overdoses

In 2009-10 there were 589 ambulance calls were made for drug overdoses[1]. The vast majority are related to prescription or over-the-counter drugs such as anti-depressants and painkillers. This compares with 1355 alcohol related calls in the same period. When excluding self-harm, which is more likely to have been cause by non illicit use, the number of overdoses are halved (300)

Previous needs assessments have identified that around 10% of drug overdoses relate to illicit drug use through the free text notes[2], although the scale of illicit use was likely underrepresented due to inconsistency in recording and possible differences in staff's ability to identify illicit use. Of the illicit drug use related calls in 2008-9 the vast majority of the illicit drug related calls mentioned heroin (39%) cannabis and cocaine use (21% and 27% respectively). Crack was mentioned in 7 records (10%). Alcohol featured heavily in all drug use related records, and may have been a more significant factor for the call was made. For example a fall may be due to the amount of alcohol used rather than drug use.

[1] Source: London Analysts Support Site
[2] London Ambulance Service was no longer able to provide this data for 2009-10.

DRAFT

Inpatient hospital admissions

In 2009-10 there were 85 Haringey residents admitted to a hospital with a diagnosis of mental and behavioural disorders due to illicit drug use[1] or poisoning[2]. Many had a multiple diagnosis as well as repeat admissions relating different substances. As shown in table 4, when looking at all the records use opiates and cocaine were the most likely causes for the admissions (59% and 19% respectively). A half (54%) had a further diagnosis of 'dependence syndrome, followed by 'harmful use' (33%). Similar to other health services data, the prevalence of alcohol related admissions is significantly higher in comparison: a total of 528 residents were admitted for a mental and behavioural disorder due to alcohol in the same period.

Table 4: Hospital admissions due to drug use in 2009-10, mental and behavioural disorders and poisoning due to drug use

Hospital admissions by diagnosis	n	%
opiates	89	59%
cocaine	28	19%
hallucinogens	*	*
stimulants	*	*
sedatives or hypnotics	*	*
multiple drug use and use of other	18	12%
Poisoning or exposure to narcotics	9	6%

Source: Hospital episode statistics. NHS Haringey

DRAFT

No one single five year age group were represented significantly more over others, however over half of the age groups were between in their 20's or 30's (59%) with biggest five year group somewhere between 35-39 (20%). A quarter (29%) were women. The largest group, 39 per cent, were white British following by any other white (19%) and black Caribbean (14%)[3].

---

[1] The query on inpatient hospital admissions (by patients) was created using ICD codes F10-F11, mental and behavioural disorder due to named substances, but excluding tobacco. If a record had more than one diagnosis with F10 codes only the first one was taken into account. F10 diagnosis is not necessarily their primary diagnosis. Also further substance related diagnosis can include one of the following: amnesic syndrome, dependence syndrome, harmful use, other mental & behavioural disorder, psychotic disorder, residual and late-onset psychotic disorder, unspecified mental & behavioural disorder, withdrawal state, withdrawal state with delirium. The individual records were identified from NHS ID but from 104 records this data was missing, therefore there may be duplications. For patients who were admitted more than once in 2009-10, the data relates to the latest admission.

[2] Diagnosis include: X42 - Accidental poisoning by and exposure to narcotics and psychodysleptics[hallucinogens], not elsewhere classified, X62 - Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified and Y12 - Poisoning by and exposure to narcotics and psychodysleptics[hallucinogens], not elsewhere classified, undetermined intent

[*] Data suppressed for data protection

[3] The percentages for ethnicity relates to 79 records, 7% (6) ethnicity values was missing or not stated.

North Middlesex Accident and Emergency data

North Middlesex A & E reported a total of 86 attendances relating to illicit drug use in 2009-10. In comparison, the number of alcohol related attendances recorded in the same period was 452. The description of the substances involved are mostly recorded in the free text field, therefore the majority are defined as unspecified. Almost half of clients (48%) came from N17, north east of Haringey, where the hospital is located.

DRAFT

Criminal justice system

This section presents the prevalence of drug use and charts the drug user profiles in the criminal justice services in Haringey. The link between acquisitive crime and drug use is well established although the relationship is more complex than simply drug use being funded through crime. Both can stem from difficult social and individual circumstances. Criminal activity can start before the drug use and thus becomes part of the associated lifestyle (Seddon: 2000, NTA: 2009). Re-offending rate is likely to be higher for class A poly drug users in comparison to Class B and/or C drugs in the four weeks before custody (Ministry of Justice: 2010).

A study on '*Changes in offending following prescribing treatment for drug misuse*' further consolidates the evidence that drug treatment works to reduce crime (Millar, Jones et al:2008). Drug use related offences such as theft[1] fell by almost half when the individuals were in drug treatment programmes. The study included around 1,500 opiate and crack cocaine users who had recently offended and started drug treatment. Reductions were evident for a range of drug-associated crimes: violence more than halved, as did crimes including fraud, drug possession and prostitution. Half of the individuals committed no follow-up crime at all, and those who did commit further offences did so at the same rate as before treatment. What is not conclusive however is which factors in 'drug treatment' work. If similar support packages which includes keyworking, counselling, employment and housing support amongst others were given to other offenders the results may be the same.

Probation

A large proportion of people on Probation use drugs some of which is identified as problematic and linked to the risk of re-offending. In 2009-10, a little less than third (29%, n=441) of Haringey Probation clients were assessed with drug misuse, of whom a quarter were placed on drug rehabilitation requirement[2] (19%, n=83)[3]. More recent data shows that the drug misusing population was little over third (34%) of the total offender population, although the cohort is smaller in size (n=418 out of 1213), in the year leading to September 2010[4]. The percentages between the two cohorts are not significantly different and therefore more recent figures have been used in the following section.

DRAFT

---

[1] Home Office defines the offences associated with drug use, the 'trigger offences' as: Theft, robbery, burglary, taking motor vehicle or other conveyance without authority, handling stolen goods, going equipped for stealing etc., possession of controlled drugs or possession of controlled drug with intent to supply fraud and begging

[2] The programme if part of a Community Order or a Suspended Sentence Order. This might involve counselling, substitute prescribing or attending a day centre. Clients on DRR are tested regularly to monitor the use of drugs.

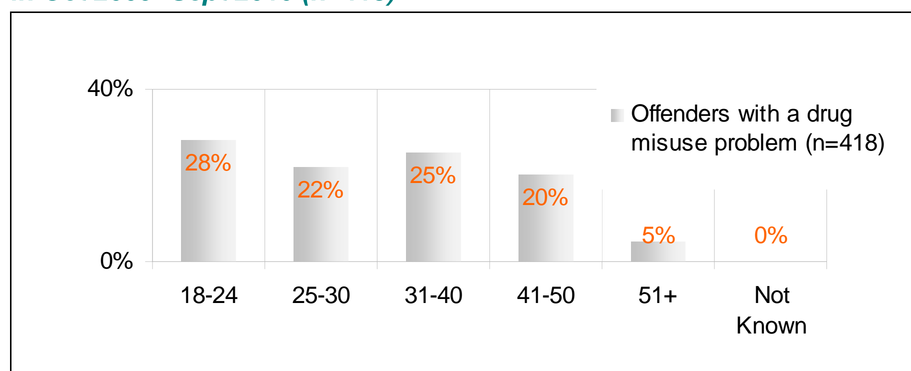
[3] This is out of the total 1535 Haringey Probation clients who had a full OASys assessment. There were a total of 1838 people on OASys assessments are only carried out with all young offenders and adults serving more than 12 months: adults serving less than 12 months are not covered by the OASys data. Data source: Haringey Borough Profile 2009/10: Community - London Probation Trust

[4] Data released by Haringey Probation Service November. Figures correct as at 10 November. 2009-10 figure is from a London Probation Service report on Drug misuse.

Probation profile and drug misuse

The proportion of women and age groups are very similar to Haringey Probation client group as a whole[1]. Only a small minority (10%) of the group identified with drug misuse were women. This group is fairly young with half of clients under 30 years of age and the largest group aged between 18-24 (28%) (see chart 3). Probation clients are younger in comparison to the drug treatment population.

Chart 3: Profile of Haringey Probation clients with drug need by age. Clients assessed in Oct 2009- Sept 2010 (n=418)



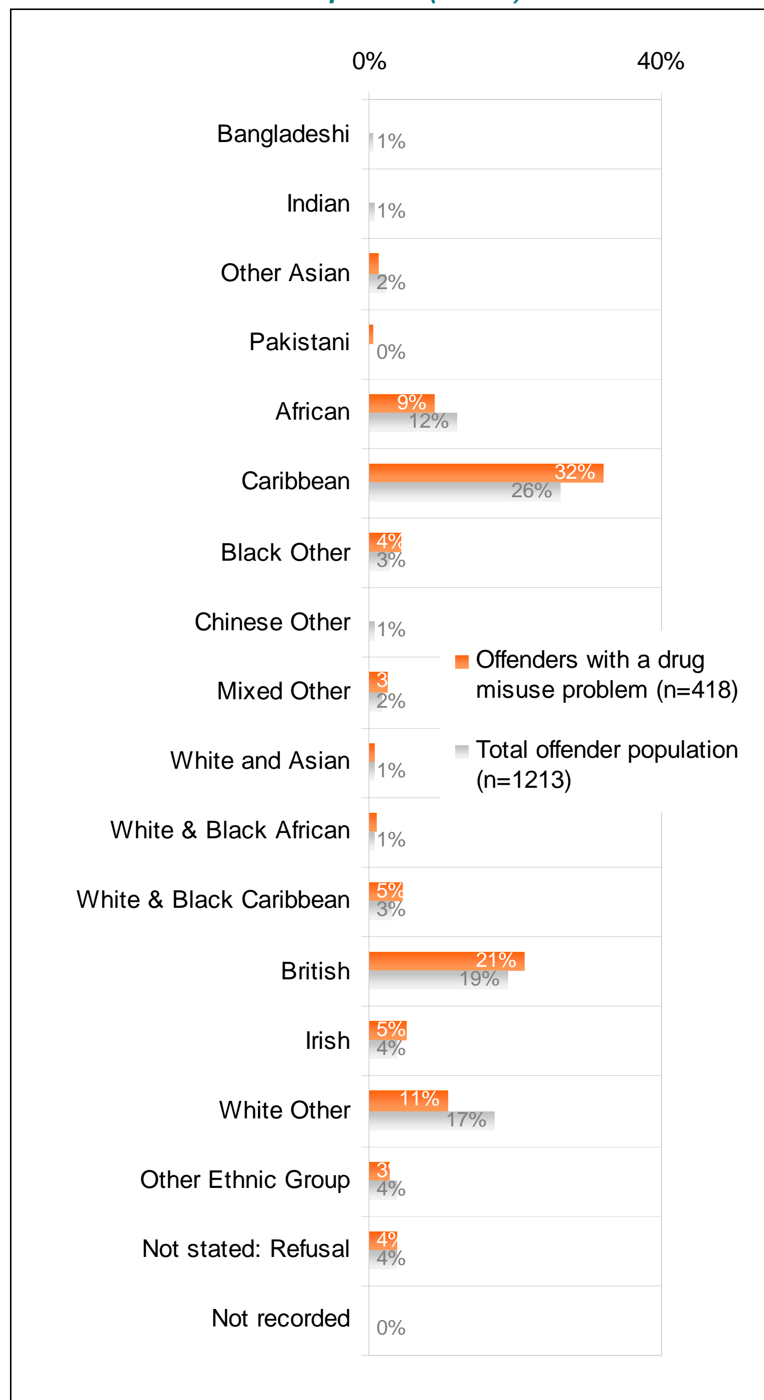
Source: Haringey Probation Service

Black Caribbean are the largest ethnic group, representing third (32%) of the drug misusing population. They are also overrepresented in comparison to the overall Probation population (26%) and the Haringey population as a whole (10% - Census 2001). White British are second largest group (21%), a proportion which is on the similar level to the total Probation population but significantly under represented when comparing to overall Haringey population (45%).

DRAFT

[1] Of the 1213 Haringey Probation clients, 13% (n=159) were women. 52% (n=633) were ages 18-30.

Chart 4: Profile of Haringey Probation clients with drug need by ethnicity. Clients assessed in Oct 2009- Sept 2010 (n=418)



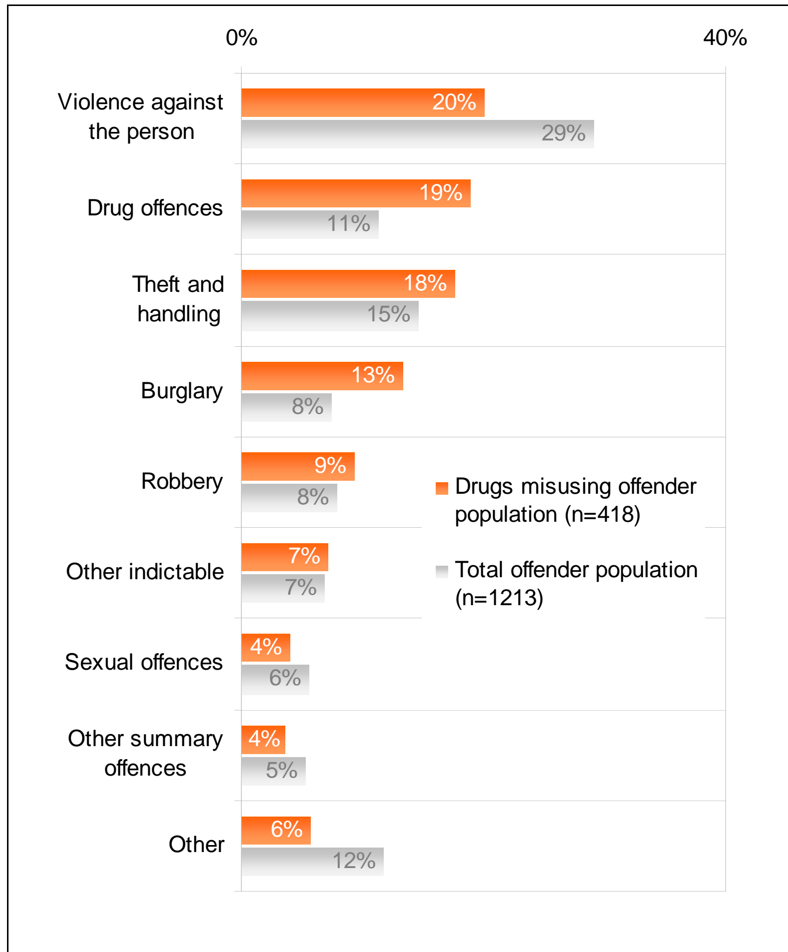
Source: Haringey Probation Service

Unfortunately the breakdown by drugs is not available for 2009-10. However, Haringey 2008-9 needs assessment found that majority of drug use, which was deemed as problematic rather than recreational, related to crack cocaine, cannabis and heroin use, the former being the most prevalent.

Offences

The most frequent offences in this cohort were violence against the person (20%, n=84), drug offences and (19% n=79) and theft & handling (18%, n=74). As shown in chart 5 violence against the person is lower than amongst the total Haringey Probation offender population. Offences often associated with drug misuse, and defined as acquisitive crime or 'trigger offences', are only slightly higher than is characteristic amongst the total Haringey Probation population.

Chart 5: Profile of Haringey Probation clients with drug need by offence category. Clients assessed in Oct 2009- Sept 2010 (n=418)



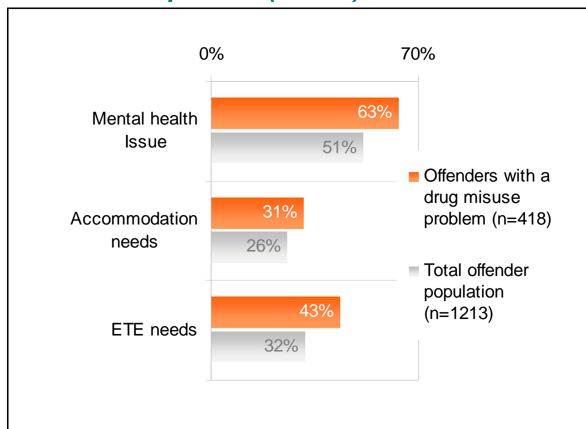
Source: Haringey Probation Service

Probation workers should be aware when assessing clients that violent offenders may have an underlying crack drug problem (NTA:2010:36).

Social needs

Probation assessments uncover a high level of need relating to mental health, housing, education, employment and training. These needs are proportionally higher amongst the drug misusing population. See chart 6.

Chart 6: Profile of Haringey Probation clients with drug need by mental health, accommodation and employment, training and education needs. Clients assessed in Oct 2009- Sept 2010 (n=418)



Source: Haringey Probation Service

A majority (63%) were assessed as having a mental health issue. This is in line with national research collated by the Mental Health Foundation which estimates the prevalence amongst prisoners with mental health issues around 70%[1]. In contrast, between one in four and one in six amongst the overall UK adult population will experience mental health problems at any given time[2], depending on definitions. Mental health issues are more common amongst BME groups who are also over represented amongst offenders[3]. Although direct comparisons are difficult due to different definitions of mental health issues and confounding factors such as deprivation. What is clear however is the perpetuating cycle of disadvantage amongst offenders who are affected by multiple issues from substance misuse, unemployment, housing needs, and mental health issues, to other socioeconomic factors relevant in Haringey which has the second highest numbers of self reported mental health illness in London (Klynman: 2010).

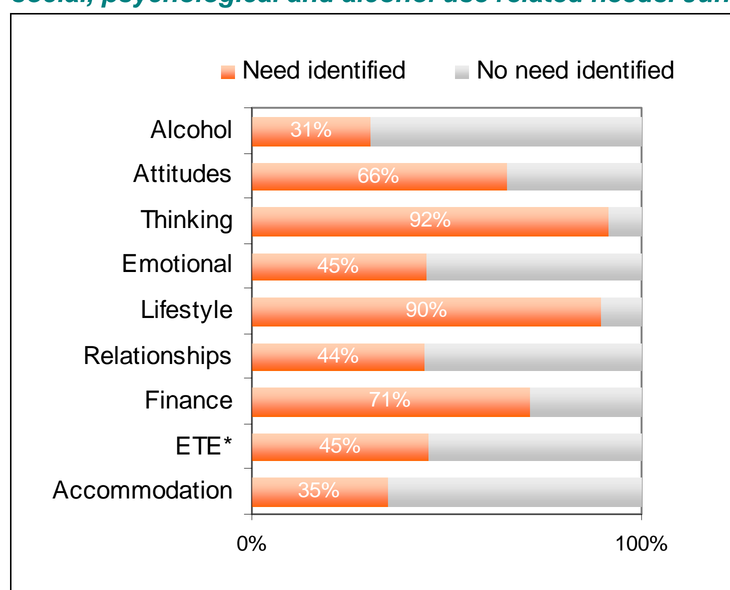
DRAFT

A further breakdown of the specific needs in this population is available from the London Analysts Support Site on assessments made between the period of July 2009 to Jun 2010. Again a third (33% n=242) of assessments made in this period 2010 indicated a drug related need[4]. Needs related to deficits in 'thinking' are prevalent in 92 per cent of this group. This refers to cognitive deficits' - the offender's application of reasoning, especially to social problems, inability to see other people's perspectives and consider consequences of their own behaviour, ultimately

[1] Mental Health Foundation quoting statistics from www.mentalhealth.org.uk/information/mental-health-overview/statistics/
[2] London Health Observatory and Mind quoting an ONS survey on the 2000 psychiatric morbidity survey of adults living in private households in Great Britain Available from: http://www.lho.org.uk/LHO_Topics/Health_Topics/Diseases/MentalHealthPrevalence.aspx and www.mind.org.uk/help/research_and_policy/statistics_1_how_common_is_mental_distress#prevalence
[3] Haringey Mental Health Needs Assessment. Available from:
[4] Due to a different query done by LASS the sample size is smaller than that for the 2009-10 financial year. Metadata by LASS explains that OASys ' measures the risk of harm that the offender poses, and also identifies the criminogenic needs of the offender. These are needs that the offender has, that are directly linked to their offending behaviour and hence addressing these needs is linked to reducing the likelihood of reoffending. This information is used by the offender manager to make sentencing proposals, and develop and maintain the sentence plans'.

increasing the risk of re-offending[1]. The lifestyle which is linked to reoffending - how they spend their time and who they mix with - is also an issue to a vast majority (90%). The economic factors and the financial security also plays a role in almost three quarters of the drug misusing offenders. See chart 7. As is clearly evident, there are numerous issues amongst Haringey residents in Probation who misuse drugs - from emotional and cognitive problems to issues with alcohol, relationships and personal finances. Intensive and comprehensive support is required to ensure full recovery and rehabilitation.

Chart 7: Profile of Haringey Probation clients with drug need assessed with further social, psychological and alcohol use related needs. June 2009 July 2010 (n=242)



Source: London Analysts Support Site

*Employment, training and education

DRAFT

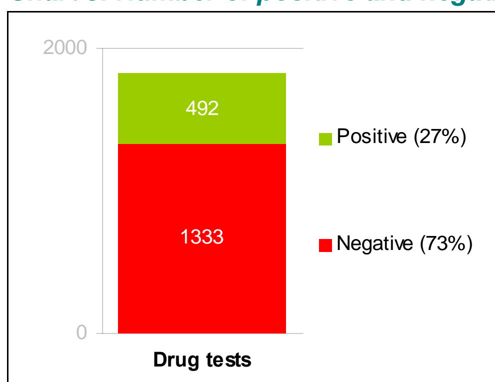
Test on arrest data

A third (27%) of Class A drugs tests[2] done on arrest in 2009-10 were positive (see chart 8). This follows the trend from previous years, both in Haringey and across London. Drug testing is mandatory for all arrests for acquisitive crime.

[1] As defined in National Probation Service Briefing 2005: Available from: www.probation.homeoffice.gov.uk/files/pdf/Briefing%2026.pdf

[2] This is 27% of all successfully completed tests.

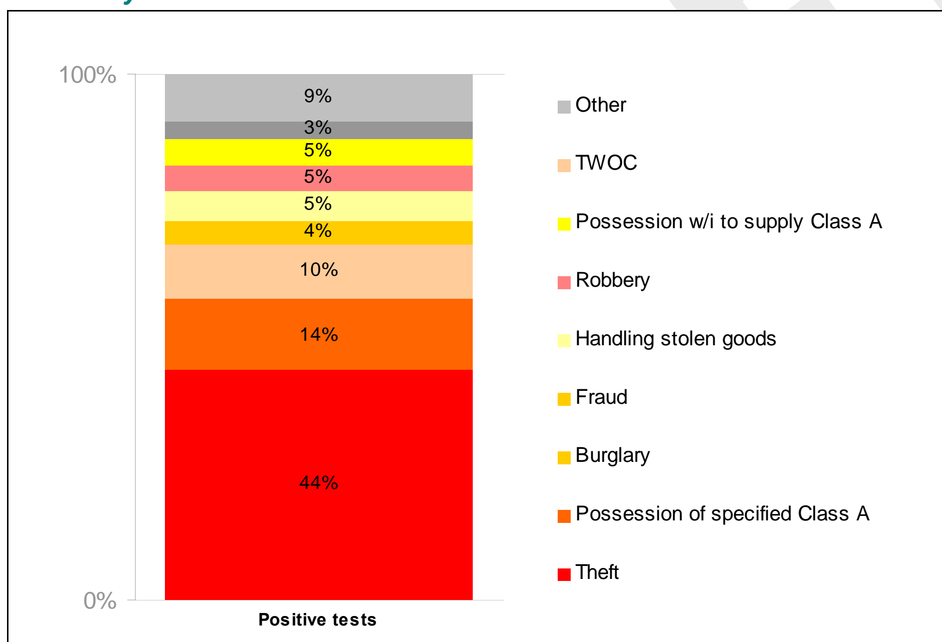
Chart 8: Number of positive and negative drug tests on arrest. Haringey 2009-10



Source: Drug Interventions Programme Haringey

The main offence type for arrestees who tested positive was theft making up almost half of all offences (n=215, 44%), followed by possession of Class A drug (n=67,14%) and burglary (n=51, 10%). See chart 9.

Chart 9: The percentage of positive drug tests by offence type. Haringey 2009-10 financial year.



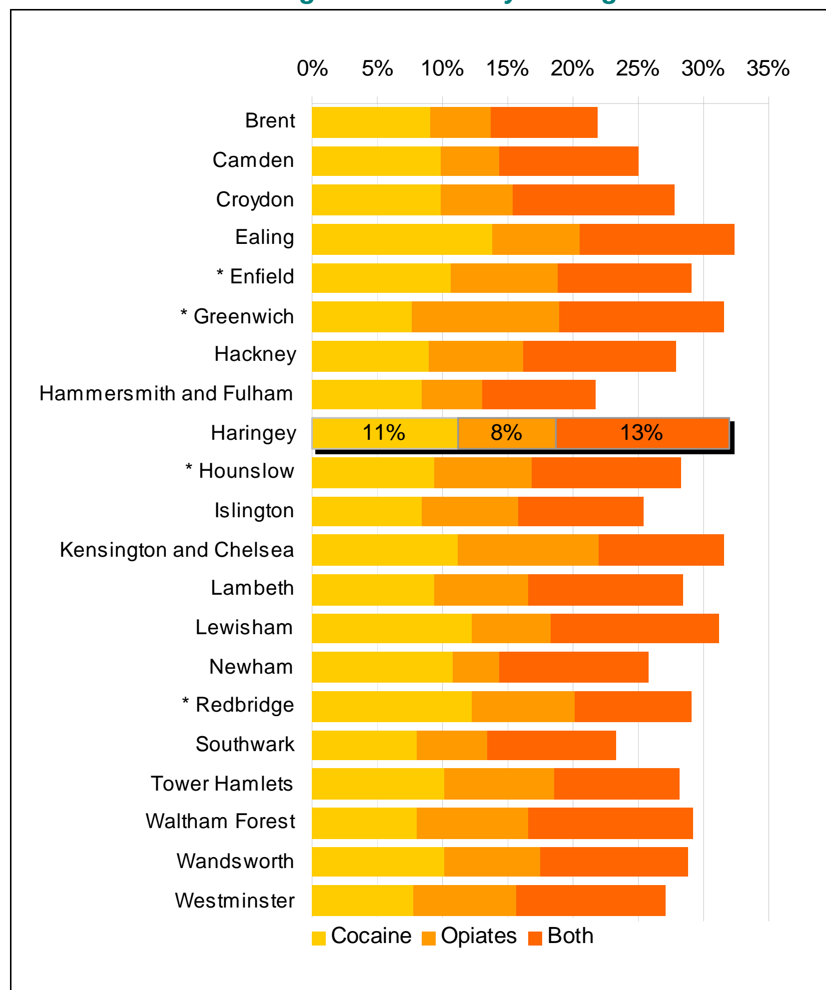
Source: Drug Interventions Programme Haringey

The largest group, almost half, tested positive for cocaine or crack (n=224,46%), nearly third for both heroin and crack or cocaine (n=148, 30%), and a quarter (n=120, 24%) for heroin only.

Comparison to other London boroughs shows Haringey with one of the highest proportion of positive tests in the last three months leading to March 2010. Haringey

also had the highest proportion of positive tests for both crack and cocaine (13% of all tests). See chart 10.

Chart 10: Profile of drug tests results by borough Jan-March 2010.

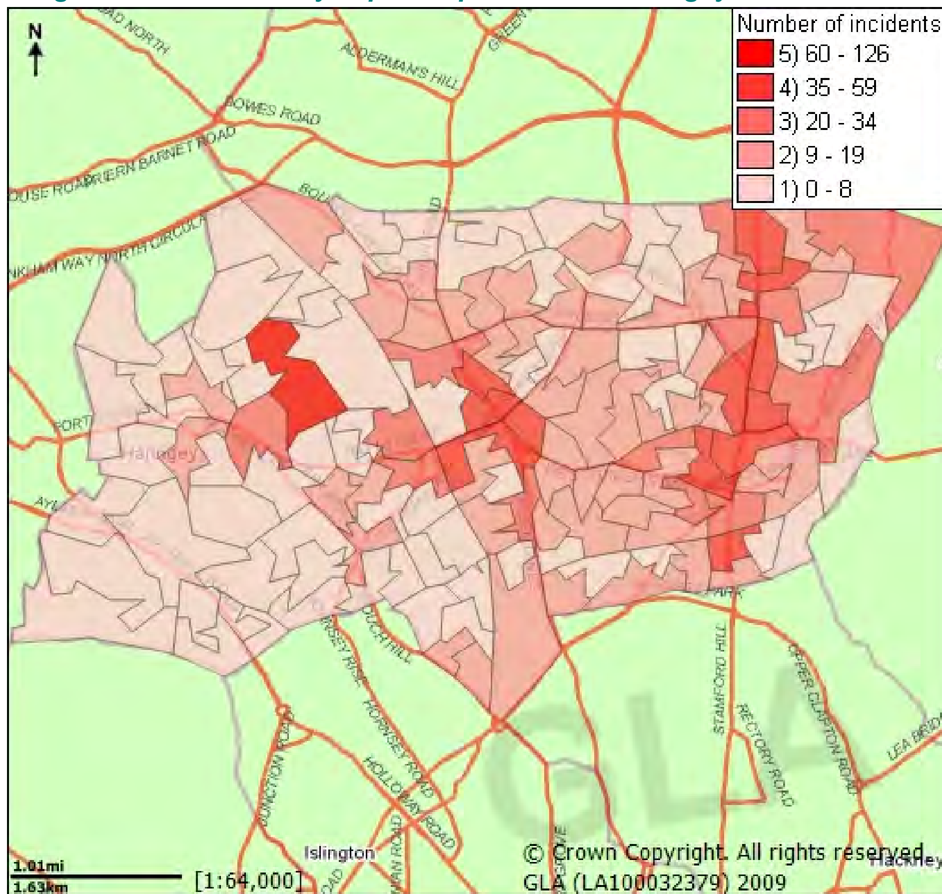


Source: London Analyst Support Site
** Phase three DIP boroughs*

Locations of drug offences and reported incidents

Drug offences, including possession and trafficking, is indicative of police operations and priorities. However, in conjunction with other datasets it is a useful indicator for prevalence of drug use. Recorded drug offences are more prevalent in the east side of Haringey, as reported by the London Analysts Support site. Although the superoutput area with the highest number of offences is located in the west, this is clearly linked to police activities since the Alexandra Palace area includes a large venue which holds music events etc and a park.

Drug offences 2009-10 by super output areas in Haringey



Source: London Analysts Support site

DRAFT

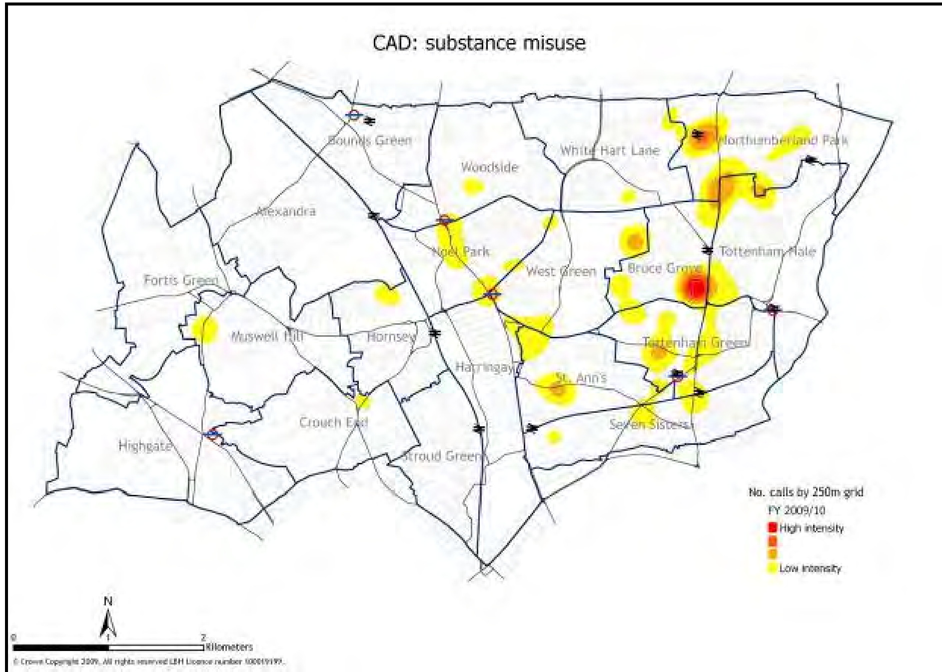
Geographical locations of substance misuse incidents

According to the latest Haringey Strategic Assessment, the highest number of CAD calls relating to substance misuse[1] in 2009-10 were received from Northumberland Park, Tottenham Green and Bruce Grove wards, concentrated specifically along the High Road N17 at Northumberland Park, Lansdowne Road and Philip Lane. The top 11 wards for substance misuse calls are all in the east. See map… These calls indicate where residents perceive drug use or dealing[2] occurs. Substance misuse made up 5.6% of all CAD disorder calls.

[1] The Demand and Resource Information System (DARIS) database records 999 calls to the police.[1] The following analysis is based on all calls requiring police action on incidents relating to disorder through the Computer Aided Dispatch (CAD) system. The calls can come from the public, either via '999' ('emergency' calls) or by directly contacting the police station ('ordinary' calls), from police officers on the street or from the London Ambulance or Fire Services ('radio' calls). Calls can also come from Intruder Alarm Company monitoring stations ('alarm' calls).

[2] There is a separate category for street drinking and the 'substance misuse' category is generally accepted as referring to drug use/abuse. It should be noted that these incidents are perceived to be related to substance use, a perception which may not be accurate.

Map.. Substance misuse CAD calls. Haringey 2009-10



Source: Haringey Strategic Assessment 2010

Crack and crime

The link between problem drug use and crime is complex. The Haringey DIP Needs Assessment for 2009/10 showed that there are more offenders testing positive for cocaine based drugs, either on its own or in combination with an opiate. That indicates that crack and/or cocaine powder, is more prevalent in the criminal justice system in Haringey than opiates. These findings are supported by the NTA report: Crack use in London (2010).

DRAFT

Harm reduction

To be updated February 2011

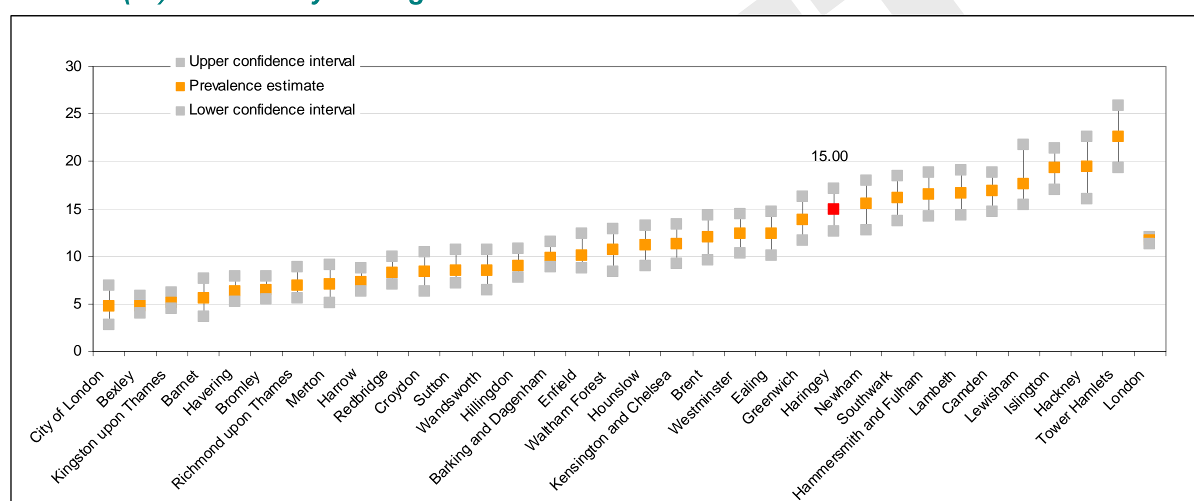
DRAFT

5. PREVALENCE OF OPIATE AND/OR CRACK USE AND ENGAGEMENT WITH TREATMENT

Latest estimates show that there are around 2420[1] opiate and/or crack users between ages 15-64 in Haringey (Hay et al: 2010)[2]. The definition 'problem drug user', used as term for crack and opiate users, indicates that anyone using these drugs are causing harm to themselves and the community, and consequently, are in need of drug treatment.

Although the data is not directly comparable due to the changes in methodology, the prevalence has gone down since the 2006-7 data sweep, from 2822[3], and not only in Haringey but across London (Hay et al 2010)[4]. The rate of 15 per 1000 population is 10th highest in London (see chart 11) and higher than the London overall rate.

Chart 11: London PDU rates per 1,000 population aged 15 to 64 with 95% confidence intervals (CI) - 2008/09 by borough



Source: Glasgow University prevalence estimates (Hay et al: 2010)

[1] The associated confidence intervals are 2,051 and 2,788

[2] The estimates were derived using two indirect measurement techniques: the capture-recapture method (CRC); and the multiple indicator (MIM) method. These methods are described in detail in Hay et al., 2006 and Hay et al., 2007a.

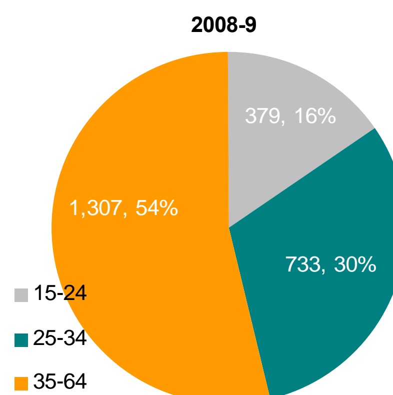
[3] The associated confidence intervals are 2,246 and 3,376. The smaller interval range in 2008-9 indicates that there is more confidence in the latest estimate.

[4] From 74,822 to 62769, although the decrease is not statistically significant. The decrease in London will be due in part to the exclusion of population density as an indicator.

Prevalence by age

National Treatment Agency reports that there has been a reduction in the number of younger people 18-24 seeking treatment for crack and opiates use (NTA:2009), suggesting that new generation is less likely to get involved in problem use. Similarly, the prevalence of crack and opiate use amongst the age group 15-24 is much lower than those aged 25-34, see chart 12.

Chart 12: Haringey PDU prevalence by age groups in 2008-9 and 2006-7 per 100 000 population



PDUs in treatment

In the last financial year (2009-10) Haringey had 972 problem drug users in effective treatment[1]. This suggests that potentially a significant number, somewhere between 1 079 and 1 816, were not in effective treatment or in contact with drug treatment at all.

Crack and opiate use versus combined use

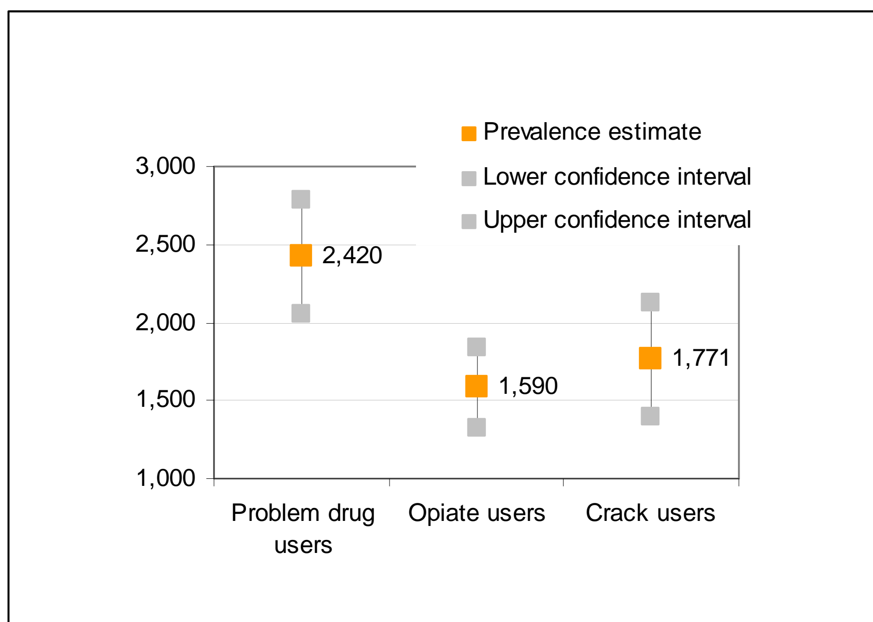
The chart 13 below shows the prevalence estimates in three categories, for crack and opiate users, those who use crack but not opiates, and those who use opiates only[2]. Combined use of crack and opiates is more prevalent. The estimate for crack only use is higher than for opiates, however confidence intervals indicate that the difference is not statistically significant. Furthermore the wider confidence interval range with crack use suggests that this estimate is less accurate than that for opiates.

A relatively large proportion of service users in Haringey present to treatment with crack cocaine as their primary or secondary problem drug. Crack use is also prominent amongst offenders testing positive. It has been acknowledged, nationally and locally, that services were in the past better equipped to deal with opiate use. In response to this Haringey commissioned a specific stimulant service Eban in September 2007.

[1] Figures published on www.ndtms.net
[2] This does not include other drugs they may be using alongside crack or opiates.

DRAFT

Chart 13: PDU prevalence and crack and/opiate use aged 15-64, Haringey 2008-9



Source: Hay, Gannon et al. (2010)

DRAFT

NTA's Drug Strategy Priorities report, for the 12 month period prior to Aug 2010 show that the proportion of crack users in effective treatment in Haringey is slightly up from the previous year with 36% (from 32%) but lower than the London average of 36%.

Table 5: Crack user prevalence and the proportion engaging in effective treatment (1st July 2009 to 30th June 2010) Haringey and London

Crack	Glasgow "Smoothed" Crack Estimate	No. of crack clients in effective treatment	% in effective treatment Haringey	% in effective treatment London
Lower Estimate	1397	645	46	50
Point Estimate	1771	645	36	38
Higher Estimate	2125	645	30	31

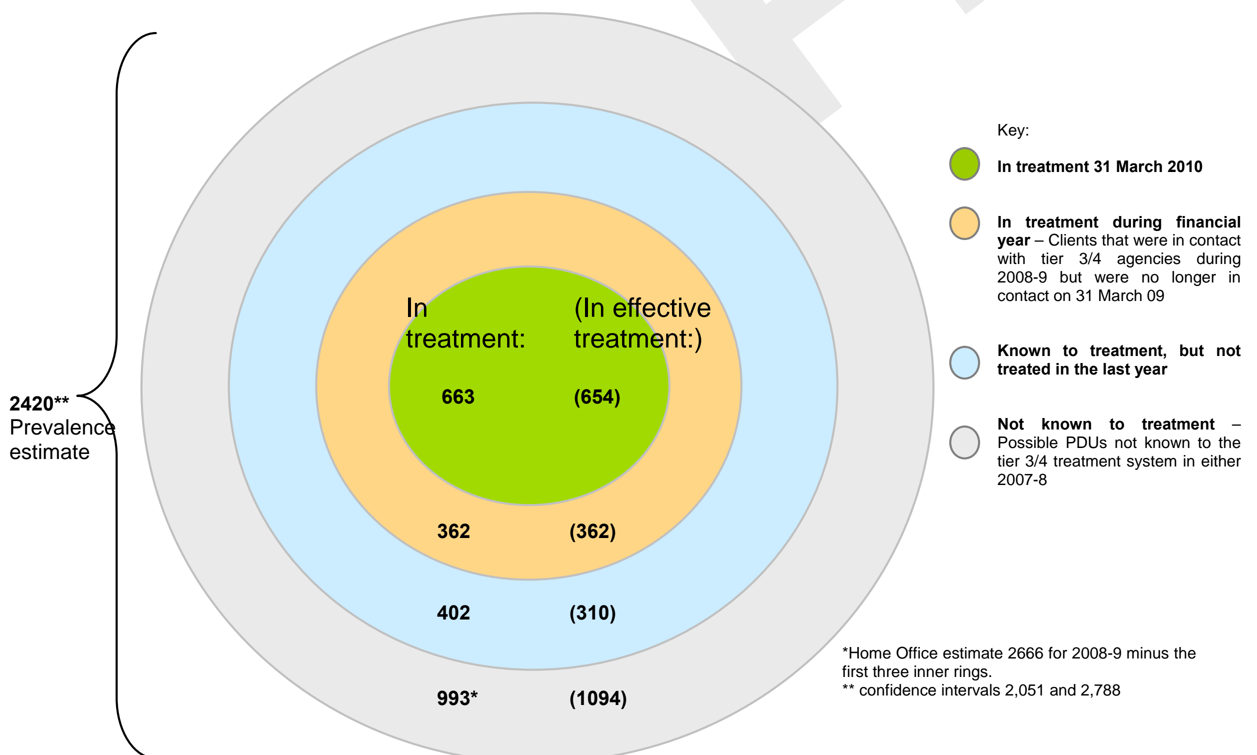
Source: www.ndtms.net *: Drug Strategy priorities data - restricted statistics*

Treatment bullseye

NTA's treatment bullseye methodology compares the prevalence figures on crack and/or opiate use, the figures produced by the Glasgow University (Hay, Gannon et al:2010), and the comparisons to the proportion of drug users who are, or have been, in treatment (see diagram 1). Around 993 opiate and/or crack users are not in contact with structured treatment provision, as shown in the bullseye, diagram 1. Although not directly comparable due to more rigorous prevalence figures for 2008-9, previous needs assessment identified a higher number in treatment naïve with 1253. The NTA's bullseye methodology shows that a majority (59%) of crack and opiate users in Haringey have accessed drug treatment and over a half (55%) have been in effective treatment (by 31 March 2009-10).

It is arguable whether everyone who uses crack or opiates requires structured treatment. Many BUBIC clients may have their needs met at their workshop sessions, as shown by their mini survey. On the other hand more reliable data from health services, including primary care, hostels and BUBIC and needle exchange may show up more people in need of structured treatment.

Diagram 1: Treatment bullseye: prevalence of opiate and/or crack users in Haringey in and outside of treatment



Source: NDTMS (www.ndtms.net : Needs Assessment data - restricted statistics)

DRAFT

6. PROFILE OF POPULATION IN TIER 3-4 STRUCTURED DRUG TREATMENT

This section outlines the profiles of Haringey adult drug treatment population in 2009-10. In addition to demographic profiles, it includes information on drug use, housing, parental status, dual diagnosis and geographical locations. Some comparisons to London averages are also made. Although the regional average hides significant variances across London, it does provide a way of checking if Haringey services reach to different groups is on par with London. As Haringey is a very diverse borough, it is important to know if our treatment population is responding to the this. Although demographic data and patterns of drug use tells us very little about their actual needs, barriers, or what works, comparisons to other population profiles can point us to those who do not access services and where further investigations should be made.

In 2009-10 financial year the overall number in treatment was 1418[1]. The total number of problem drug users in Haringey, including under 18s, in effective treatment was 953[2]. The number of all adults in effective treatment was 1242.

There are two different sets of statistics presented in this section - one provided by the University of Manchester for the NTA and another by the Haringey DAAT using NDTMS raw data[3]. They include two different cohorts but both are referred to as the 'treatment population'. The University of Manchester figures were used mainly for national and London comparisons. Their cohort is 699 individuals aged 18 and over assessed for their treatment journey[4], excluding those already in treatment who started their treatment prior to 31 March 2009.

The analysis by the Haringey DAAT contains a wider group. It includes 1349 individuals aged 18 and over who were in treatment during 2009-10 financial year[5]. This cohort was used to validate and expand on the University of Manchester figures: analyse profiles of everyone accessing treatment services; provide more detailed breakdown on variables like ethnicity; and seek information on accommodation, parental and dual diagnosis status.

DRAFT

---

[1] Figure accurate as at Dec 2010.

[2] Figure accurate as at October 2010 report. This includes Haringey residents who used opiates and/or crack who either stayed in treatment for 12 weeks or completed treatment (discharge reason was 'treatment completed' or 'treatment completed drug free'. Figures published on the www.nta.nhs.uk in October.

[3] Raw data refers to cleaned up unattributable data provided by the London NDTMS team. It includes all Haringey residents in drug treatment, including treatment agencies outside Haringey.

[4] 'Treatment journey' includes multiple episodes of treatment as long as there were less than three weeks between each episode.

[5] The figure is slightly different to the 1418 reported in www.ndtms.net restricted statistics site due to a differing query method. The local query relates to individuals who were triaged for structured drug treatment in financial year 2008-9 and those who continued their treatment in the year with a triage date prior to 1st April 2008. The cohort includes Haringey residents 18 years and over, the age indicated is the age at the mid point of the financial year. They may have attended any service in England who report to the NDTMS. For individuals with multiple treatment episodes the data relates to their latest treatment episode. For further information on NDTMS definitions see www.nta.nhs.uk

It should be noted that some data on variables such as postcodes are not always recorded for each client on the NDTMS. Missing data can therefore skew the results as the data is not randomly sampled. However data quality on attributes such as age, ethnicity and gender are complete in most records. There are also additional interventions for all drug users (needle exchange, peer support, aftercare etc.) which are not shown here because NDTMS only records activity in tier 3/4 structured treatment.

Drug use

Table 6 shows the regional comparisons of the treatment population by drug type. The patterns of drug use remain fairly unchanged from 2008-9. Vast majority use crack and/or opiates (72%). The proportion of crack only users was around the same as for opiates only[1]. Opiate only use in Haringey was slightly lower than in London overall, and much more so in comparison to the national average. Whereas crack only use was higher locally (19% against 13% in London). Mixed use of both was at the same level with London and this type of use forms the majority, a third, of all drug use. NTA's report on crack use in London highlighted that the mixed use of both is common with primary crack users using heroin to ease the come down from crack and primary heroin users simply widening their patterns of use (NTA: 2010).

Table 6: Breakdown of main drug of choice in treatment, regional and national averages, new clients in treatment 2009-10 (Haringey n=699)

Overall drug group	Opiate	Crack	Opiates and Crack	Other stimulant	Cannabis	Benzodiazepines	Other
Total	20%	19%	33%	7%	19%	0%	1%
London	25%	13%	36%	12%	11%	1%	2%
National	42%	5%	27%	12%	12%	1%	2%

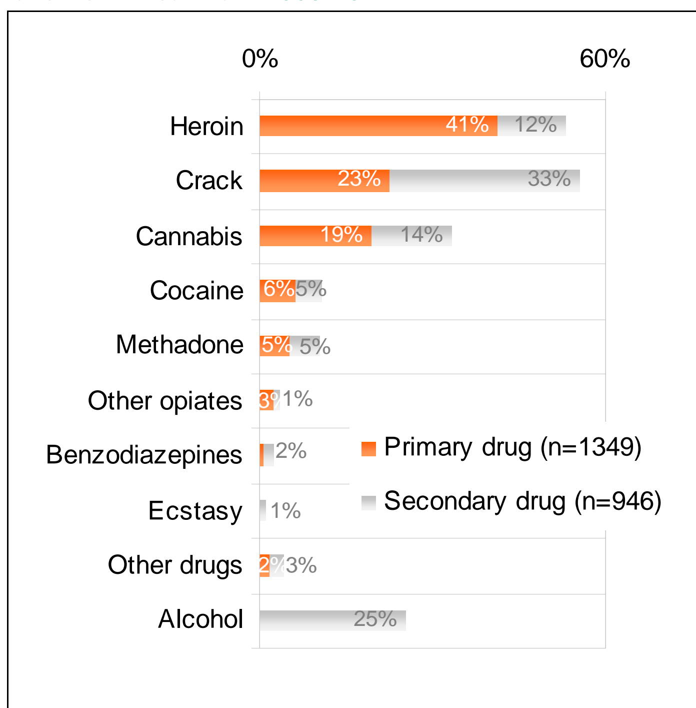
Source: www.ndtms.net *(Quarterly reports - restricted statistics)*

DRAFT

[1] Presenting Substance – the primary substance that individuals have presented with at triage. Clients have been counted only once and appear hierarchically based on their presenting substances, with opiates and crack counted first. If an individual presented with either opiates or crack as the primary or adjunctive substance they have been counted in one of the first three categories below. All other substances have been categorised by primary drug.
Opiates only – clients who state opiates as a primary or adjunctive substance but not crack at triage
Opiates and Crack – clients who state opiates and crack as primary or adjunctive substances at triage
Crack only – clients who state crack as a primary or adjunctive substance but not opiates at triage

A breakdown of primary and secondary drugs[1] for all clients in treatment shows that service users are still more likely to report heroin (41%), as their primary drug than crack (23%). Crack is however used by more clients overall with a large proportion (33%) reporting it as their secondary drug. Little over tenth (12%) reported heroin as their secondary drug. Alcohol and cannabis are the most prevalent secondary drugs after crack (25% and 14% respectively).

Chart 14: Drug use by primary and secondary drug. All clients in treatment 2009-10



Source: Haringey DAAT NDTMS analysis

The vast majority of people in Haringey report the use of more than (70%) one drug. Far more heroin users reported secondary crack use in comparison to the frequency of crack users reporting secondary heroin use[2]. Even with the introduction of Eban, a specialised service for crack users, there is little change in the overall drug use by the treatment population. This suggests that those service users previously attending other services have relocated to Eban which provides treatment more tailored for their needs, thus freeing the capacity at DASH, the main prescribing service to see more opiate users.

Gender

In the last financial year, the percentage of women new to treatment was the same as London overall. They represented a quarter of the new starters and all clients in treatment during the same period (24% and 25% respectively). A study published in 2005, and a more recent report both by the NTA (NTA:2005 and NTA:June 2009) alongside with comparisons with local datasets suggests women are not significantly under represented in drug treatment. London Health Observatory analysis in 2006 for

---

[1] 30% did not report a secondary drug or data was not recorded
*'Total other' includes drugs that were reported only by 10 clients or less during the year. NDTMS does not accept alcohol as a primary drug
[2] Well over half (58%) of those reporting heroin as their primary drug used crack. Whereas a third (32%) of those who reported crack as their primary drug stated heroin for their second drug of choice. Overall out of the 639 service users who reported heroin as their main drug of choice 81% reported a secondary drug of choice. Out of the 357 service users who reported crack as their main drug , 75% reported a secondary drug of choice.

DRAFT

Women in London went as far as to suggest that 'there are more women in treatment than might be expected' (London Health Observatory:2006:4). They are less likely to access treatment through the criminal justice system or report heroin as their main drug. Women in London are more likely to receive counselling and exit treatment successfully. However there are more deaths amongst drug using women that might be expected. (LHO:2006).

Table 7: NTA gender breakdown in Haringey, with comparisons to regional and national averages. New clients in treatment 2009-10 (Haringey n=699)

Area	Male	%	Female	%
Haringey	576	76%	191	24%
London	12952	76%	4303	24%
National	62522	76%	20697	24%

Source: www.ndtms.net *(Needs assessment data - restricted statistics)*

In line with the observatory's somewhat contradictory findings, local expert group representatives reported in 2009-10 that women do however face significant barriers to drug treatment. Childcare and stigma are major issues. Women may fear loosing the custody of their children if seeking help for their drug use[1].

There are other improvements that have been made to accommodate women better in Haringey, such as women only sessions now provided in all treatment services. However the ratio of women have remained around the same year on year, at least since the introduction of the NDTMS in 2004.

Age breakdown

In comparison to the rest of the country, London has a young population. East of Haringey, where most of the treatment population comes from, has a even younger population compared to west of Haringey and London overall (Haringey Council:2009). Yet the NDTMS age breakdown shows a slightly higher proportion of over 35 year olds in treatment in comparison with both regional and national figures, as shown in table 8.

Table 8: Treatment population and age breakdown by region 2008-9, new clients in treatment

Age	Under 25	%	25 - 34	%	35+	%
Haringey	90	13%	266	38%	343	49%
London	2479	15%	6235	38%	7666	47%
National	15402	19%	34195	43%	30146	38%

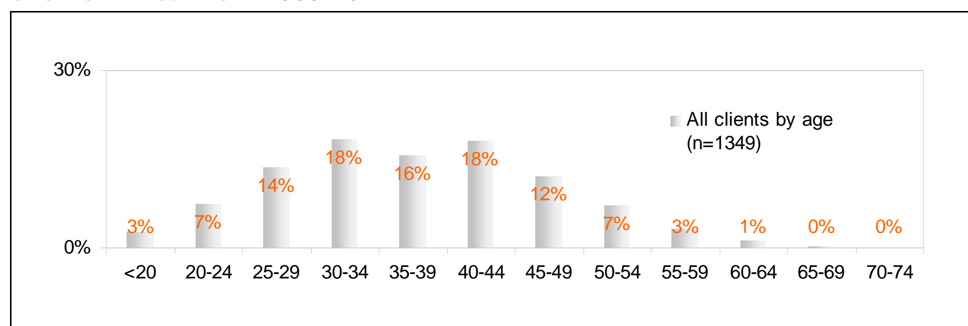
Source: University of Manchester[2]

[1] Findings from the needs assessment expert group, August 2009. Similar issues were also uncovered in the needs assessment meetings in the previous year.
[2] Cohort 584

DRAFT

A further breakdown of the total treatment population in chart 15 shows that the distribution for age groups between 25-49 are fairly equally distributed with the highest number of clients being between 30-34 and 40-44 years of age.

Chart 15: Treatment population in structured treatment in Haringey by age group. All clients in treatment 2009-10.

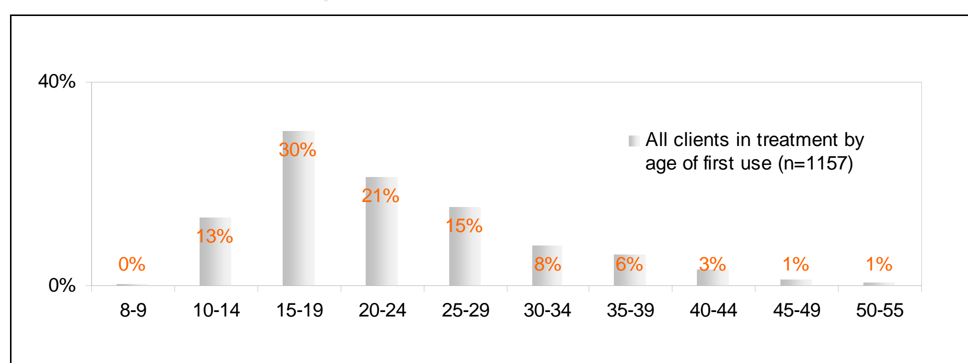


Source: Haringey DAAT NDTMS analysis

The first drug of choice differs between age groups with younger people reporting mainly cannabis. For example, over a half (56%) of all young adults in treatment aged 18 to 24 reported cannabis as their first drug of choice, but less than fifth (16%) reported heroin, and only around tenth (9%) crack. The crack and opiate primary use amongst this group is even lower than in the previous year (23% and 13% respectively in 2008-9). The use of crack and heroin increases significantly when clients are older. Heroin and crack use is notably more prominent already amongst clients in the next age group, between 25-29 (40% and 16% respectively in comparison to cannabis with 29%).

This, alongside the reported age of first use, see the chart 16 below, indicates that early prevention is key. 43 per cent of clients had used the drug they subsequently sought treatment for before their 20th birthday. Nearly two-thirds (65%) first experimented or started before their 25th birthday[1].

Chart 16: Treatment population in Haringey by age of first use of primary drug. All clients in treatment 2009-10



Source: Haringey DAAT NDTMS analysis

[1] Value for first age of use was missing from 14% of the records. Percentages relate to records where value was indicated, in a total of 1157 records.

DRAFT

Previous years expert group discussions with providers and service users suggests structured treatment may by inappropriate for the 18-24 age group. Young people may not feel their use is problematic at this stage. Interventions that focus on activities, skills and education and employment, with drug issues addressed by brief interventions, may be more effective. Therefore redefinition of what constitutes 'effective treatment' for this group may be useful. Ages 18-24 are also prominent in the criminal justice system. Therefore joint working with other partner agencies and departments in Haringey Council may be more effective in order to improve the engagement and outcomes for this group.

Ethnicity

Haringey is a very diverse borough with almost over a third of the population born outside UK (31%) and nearly half come from minority ethnic backgrounds (Haringey Council: 2009) .

Table 9 shows that overall, Haringey treatment provision attracts more clients from black ethnicity groups than London average. White ethnicity is slightly less prominent in Haringey than in London overall.

Table 9: Treatment population and ethnicity breakdown by region. New clients in treatment 2009-10 (Haringey n=683)

Area	Mixed %	Asian %	Black %	White %	Other %
Haringey	6%	5%	29%	54%	3%
London	7%	10%	15%	64%	3%
National	3%	4%	4%	83%	1%

Source: www.ndtms.net *(Needs assessment data - restricted statistics)*

DRAFT

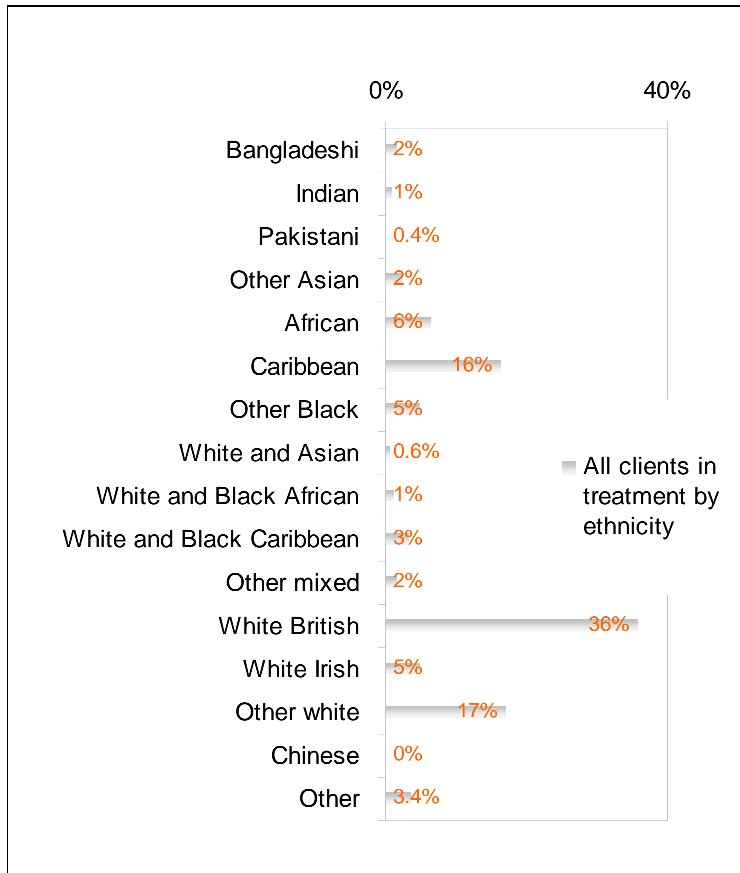
White British, other white and black Caribbean are the largest ethnicity groups in treatment (35%, 17% and 13% respectively). The 'other white' category is likely to include Turkish, Turkish Cypriot, Polish, Kurdish, Greek and Greek Cypriot as they are known to be some of the largest ethnicity groups in Haringey.

Although some black and minority ethnic groups are over represented in treatment as well as in the criminal justice system, as shown in the geographical breakdown on page 52 most drug treatment clients live in the more deprived and densely populated east.

In general, care should be taken when making conclusions from ethnicity data, especially because problem drug use carries a particular stigma. It should be noted that it is not the ethnicity that determines problem drug use but it stems from and is interlinked with wider social as well individual circumstances. Also, the 16 Office of National Statistics ethnicity categories used by the NDTMS provide limited information on specific groups that may be more affected by drug misuse[1].

[1] Ethnicity information is problematic in terms of gaining a better understanding of underserved communities, or estimating the prevalence of problematic drug use amongst particular groups. This is partly due to the limitations of the ONS definitions but also because ethnicity as a case definition is generally problematic, i.e. ethnic origin or ethnicity is self defined and a relatively complex term. It does

Chart 17: Haringey Treatment population by ethnicity. All clients in treatment 2009-10 (n=1308[1])



Source: Haringey DAAT NDTMS analysis

DRAFT

Smaller communities

Although not evident in the ethnicity statistics, according to the reports from DASH, both the Kurdish, Turkish and Cypriot communities as well as the Somali community have issues around drugs. The more legally "acceptable" nature of khat makes it more difficult to tackle the issues of drugs in that community. Both communities experience language and cultural barriers and neither are confident about approaching services for help. This made the role of the two BME workers previously commissioned by the DAAT helpful in securing the confidence of their respective communities. According to DASH, without the very varied and innovative outreach work, particularly working with the cafes in Green Lanes these communities are unlikely to come forward and engage with any mainstream services. The workers succeeded in generating awareness and increasing people's confidence and understanding of drugs and treatment.

---

not automatically signify homogenous groups who share similar problems. Ethnicity information per se says little about the underlying issues and care should be taken when making correlations or drawing conclusions based on this data, especially in the context of illicit drug use or other types of crime so as not to misrepresent or stigmatise certain groups. Further information on ONS ethnicity categories is available at www.statistics.gov.uk

[1] 3% of ethnicity values missing from records (41 out of 1349)

Due to the nationally set performance indicators and the reductions to the pooled treatment budget, the posts for the BME workers were no longer viable from 1st of April 2009. This has raised the concern that the diverse needs of the diverse Haringey population will now be harder to meet.

Nationality

The diversity of Haringey and its drug treatment population is also demonstrated by the large number of nationalities in treatment. Sixty different nationalities were reported in 2009-10, however over tenth (14%) did not disclose their country of origin. The vast majority were, however, from the UK (72%). See table 10.

Irish, Italian, Turkish, Iranian, Jamaican and Polish nationalities were the largest nationalities after British, although still counting only between two to three per cent of the total each.

The inevitable issue arising from such a variety of nationalities is language barrier, a concern also reported by local services, which hinders effective intervention. Even with a translator, if they are available, the therapeutic input can be undermined by using translators who are not familiar with drug treatment or have no counselling or keyworking background. Therefore it is important to have a culturally competent workforce with variety of language skills to match the treatment population. Whilst it would not be possible to have all the required language skills within the existing workforce, it is important that the recruitment takes into consideration the largest nationalities, especially Italian, Turkish, Farsi, and Polish speakers.

Table 10: Treatment population in Haringey 2009-10 by country of origin

Country name	Total	%
United Kingdom	852	72%
Ireland	34	3%
Italy	34	3%
Turkey	27	2%
Iran, Islamic Republic of	22	2%
Jamaica	20	2%
Poland	19	2%
Algeria	14	1%
Cyprus	10	1%
France	10	1%
Greece	10	1%
Other[1]	134	11%
Total	**1186**	**100%**
Data not stated	163[2]	14%

Source: Haringey DAAT NDTMS analysis

DRAFT

[1] Includes 49 nationalities of which less than 10 reported.
[2] 14% out of the total of 1349 did not disclose their nationality or the value was missing

New migrants

In the last year's expert group meetings an increase in the number of new migrants in need of substance misuse services was raised as an issue. Although the numbers are relatively low, the proportion of Polish as the third largest nationality suggests that there may be emerging substance misuse issues within the newly arrived community. The local outreach team from BUBIC also raised the issue over increasing crack use and homelessness amongst the new migrants.

Local concerns have, however, mainly centred around alcohol use, and the issues have been discussed in many forums including the local Alcohol Strategy Group. There is also ongoing research on street drinking focussing on this group. However the underlying problems are wider than alcohol or drug use. As the report 'Beyond Boundaries' (Mills K. et. al: 2007) concluded, homelessness, unemployment and under utilisation of skills are the most significant problems facing them.

The Beyond Boundaries report also found that the drugs used by this group are usually not heroin or crack. Hence low threshold drug related support is more likely to meet their needs. Furthermore the focus should not be on the drug services but on a multi-agency approach that can tackle the complex issues migrants face. The report also acknowledged the difficulty in obtaining accurate data with the risk of exaggerating substance misuse without firm evidence. This in turn can have a negative impact on the community relations with the local population.

Geographical breakdown

Problematic drug use mirrors deprivation alongside with higher levels of crime, unemployment, inequalities in health and antisocial behaviour. The highest concentration of treatment population is found in the east of the borough. The three super output areas with highest density are located in Seven sisters, Bruce Grove, Northumberland Park wards. DAAT commissioning is now more in line with the need geographically with more services, including needle exchanges, located in the north east of the borough. However, the location of services is likely to skew the figures since demand is likely to seem higher in places where services are more available.

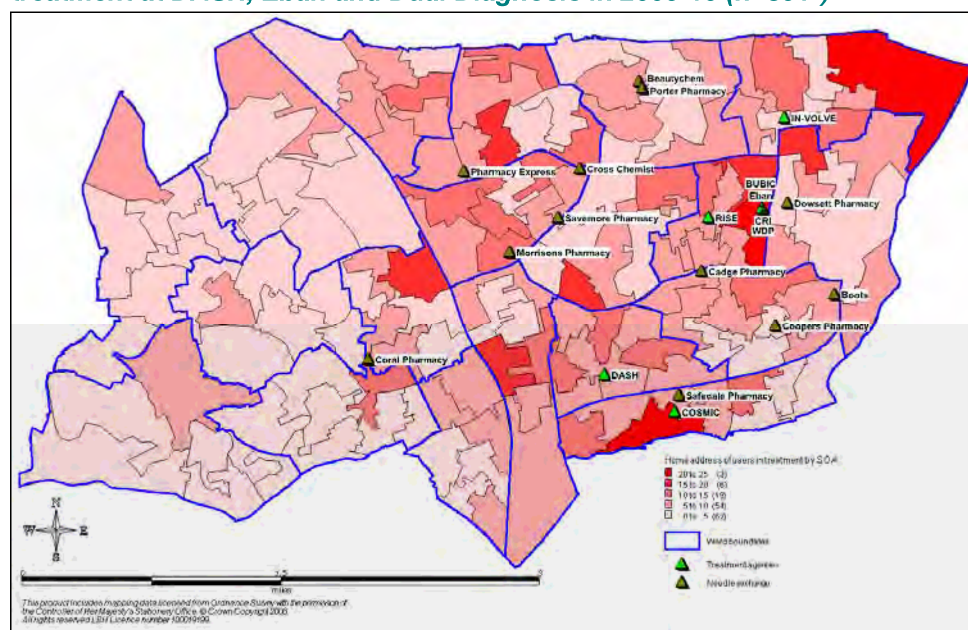
Some of the highest density areas are similar to those identified by the vulnerable localities index[1] which combines a variety of data sources from burglary to educational attainment, as well as the latest indices of income deprivation (2007), see maps…. Although this in itself does not prove correlation or causality it is clear that prevalence of social issues and deprivation alongside with drug problems is more prominent in the eastern parts of the borough. The map .. shows the number of all clients in treatment at one of the three agencies, DASH, EBan and Dual

[1] Source: Haringey Strategic Assessment. Vulnerable localities index is used to predict areas where breakdowns in community cohesion might occur by identifying priority neighbourhoods. These areas display disproportionate criminality alongside high levels of deprivation and demographic factors. The index uses the following data: Burglary in a dwelling (geocoded CRIS records FY2009/10), Criminal damage in a dwelling (geocoded CRIS records FY2009/10), Income deprivation (MOSAIC 209 postcode data IMD 2007), Employment deprivation (MOSAIC 2009 postcode data IMD 2007), Educational attainment below 5 GCSEs or equivalent at grades A - C (Census key statistics K13 table Qualification and Students) standardised with population data of young people ages 15-24, and location of individuals engaged with Youth Offending Service (YOS)

DRAFT

Diagnosis. The second map presents the geographical prevalence of crack and opiate users only. As is evident, there is very little difference between the two. Map… includes GP practises to identify priority surgeries that may be helpful to get involved in, for example, engagement and harm reduction work.

Map 1: Drug treatment population by super output area of residence. All clients in treatment at DASH, Eban and Dual Diagnosis in 2009-10 (n=891[1])

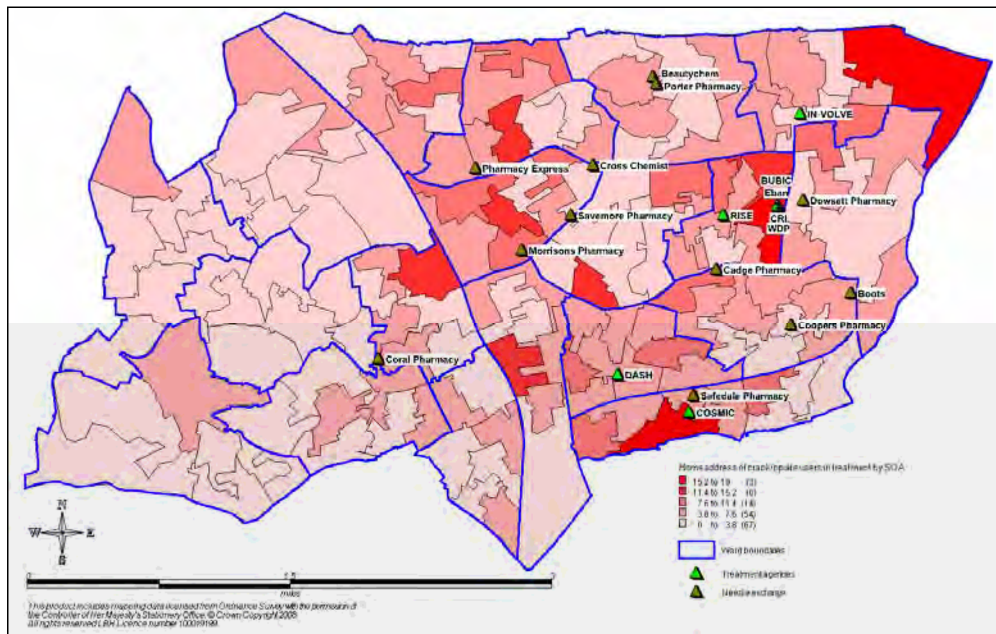


Source: Haringey DAAT NDTMS analysis

DRAFT

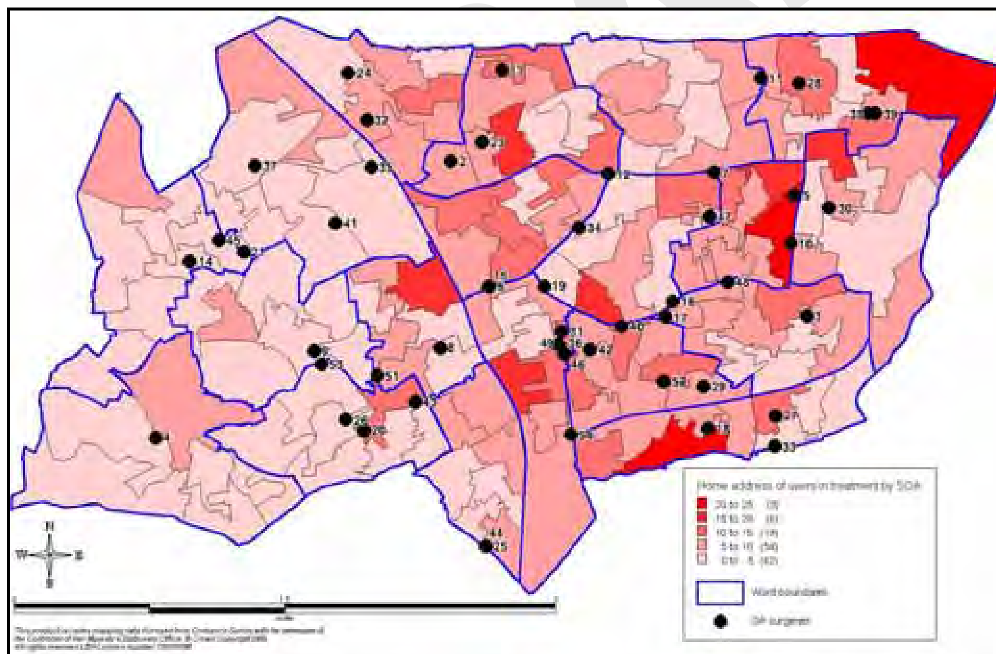
[1] The data set includes Haringey residents in drug treatment 2009-10 aged 18 who had their full postcode recorded. This represents 66% of the total treatment population. It was not possible to retrieve this data from CRI for their treatment population but may include clients who transferred from CRI during the year. The representativeness of the sample with SOAs data was compared to the overall treatment population during. There were no differences for more than 3% percentage points between the two cohorts in their demographic profiles - age, ethnicity, gender, or primary drug of choice. Therefore the sample population, even without CRI data and some postcodes missing, is broadly representative of the treatment population. It was not possible to get SOA level data from tier 4 agencies (residential rehabilitation and inpatient detox). If clients latest episode was at a tier 4 agency, the SOA was retrieved by using the data from the referring agency or the local agency prior to starting tier 4. For data protection reasons agencies mapped the postcode data into superoutput areas before data was provided for the DAAT.

Map 1: Drug treatment population by super output area of residence. Crack and opiate users in treatment at DASH, Eban and Dual Diagnosis in 2009-10 (n=662[1])



Source: Haringey DAAT NDTMS analysis

Map : Drug treatment population by super output area of residence with GP practises. All clients in treatment at DASH, Eban and Dual Diagnosis in 2009-10 (n=891)

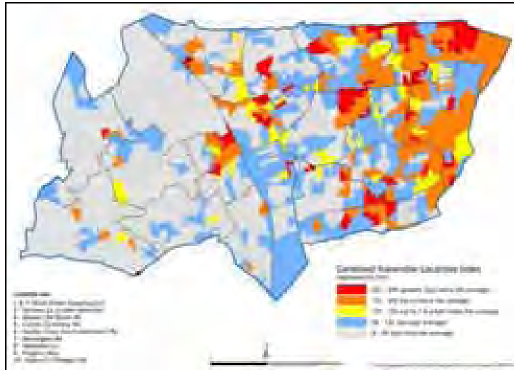


Source: Haringey DAAT NDTMS analysis

Key:

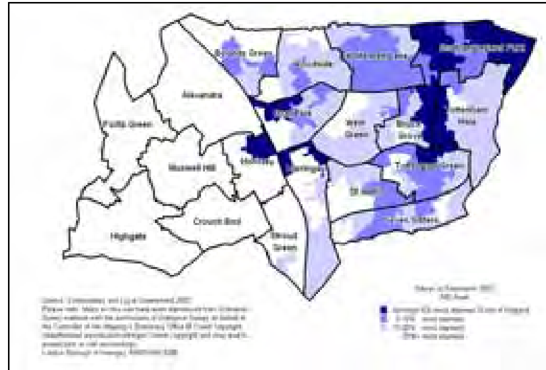
No.	GP surgery	No.	GP surgery
1	Dr J S Rohan	28	Tottenham Health Centre
2	Morum House Medical Centre	29	Dr J K Ikwueke
3	Tynemouth Road Health Centre	30	Dowsett Road Surgery
4	Highgate Group Practice	31	The Surgery
5	Charlton House Medical Centre	32	Evergreen House Surgery
6	The Surgery	33	Dr R Singh
7	The Morris House Medical Practice	34	Dr A T M Hoque
8	Dr I A K Sardar	35	Dr D Prasad
9	Dr E Greenbury	36	Dr A Sampson
10	Bruce Grove Primary Care Health Centre	37	Grosvenor Road Surgery
11	Somerset Gardens Family Health Care	38	Dr K Nagarajah
12	Westbury Medical Centre	39	Dr D K Suri
13	Arcadian Gardens NHS Medical Centre	40	West Green Road Surgery
14	Queens Avenue Practice	41	The Alexandra Surgery
15	Dr E N Obineche	42	Aarogya Medical Centre
16	Dr K Sivasinmyananthan	43	Allenson House Medical Centre
17	Dr P Das Gupta	44	New Stroud Green Health Centre
18	Dr D K Kundu	45	Rutland House Surgery
19	Havergal Surgery	46	The Old Surgery
20	The Christchurch Hall Surgery	47	Broadwater Farm Community Health Centre
21	Dukes Avenue Practice	48	JS Medical Practice, Lawrence House
22	Stuart Crescent Health Centre	49	Dr A U K Raja
23	Stuart Crescent Health Centre	50	Laurels Neighbourhood Practice
24	Bounds Green Group Practice	51	The Vale Practice
25	The 157 Medical Practice	52	The Laurels Medical Practice
26	Crouch Hall Road Surgery	53	Queenswood Practice
27	Dr S Caplan	54	The Greens Medical Practice

Map : Vulnerable localities index[1]



Source: Haringey Strategic Assessment 2010 – Community Safety

Map : Indices of deprivation 2007



Source: Haringey Council

Housing need

Adequate and appropriate housing is an important component of recovery and social integration - be it supported accommodation or housing in a location away from environments associated with drug use and life before treatment. Housing problems were reported by over a third (36%) of people entering treatment. 16 per cent were identified as urgent with no fixed abode.

Table 11: Treatment population and accommodation need in Haringey. All clients in treatment 2009-10 (n=1159[2]*)*

Accomodation need	Total	%
NFA - urgent housing problem	157	16%
Housing problem	203	20%
No housing problem	809	80%

Source: Haringey DAAT NDTMS analysis

DRAFT

Housing problems have, and continue to be, raised as one of the key issues by Haringey service users and service providers alike[3]. One of the reported problems has been the lack of knowledge and sensitivity around problem drug use by mainstream services. This has lead to inappropriate offers on housing in environments that pose risk to successful treatment outcomes.

[1] Priority areas are largely located in the east of the borough. Northumberland Park and Tottenham Hale figure strongly (12 and 7 OAs respectively) but Noel Park ward was particularly significant as it contains three out of the top ten most vulnerable OAs and it's the only ward to have a crime rate greater than double the borough average. However it is important to note that both Noel Park and Tottenham Hale contain major shopping centres and busy transport interchanges and all three wards have the highest volumes of LBH stock in the borough (Haringey Strategic assessment 2010:17)

[2] 13% of housing status value missing, 180 out of the total 1349.

[3] As per focus groups done in the previous years exploring gaps in services. This was also highlighted as one of the key issues in the expert group meeting in August I2009.

Parental drug use

National research suggests that a significant number of children, around a quarter, are on the child protection register as a result of parental substance misuse (ACMD:2003) with some quoting figures that are even higher - between 50 and 90 per cent of families on social workers' child care caseloads (SCIE:2005). Parental misuse often leads to a lack of practical and emotional care for children (Bancroft, Wilson et al: 2004). However, studies on parental substance misuse often fail to fully explore the other associated social factors. (Social Care Institute for Excellence: 2005, Bauld L et al: 2010). Furthermore, a recent literature review by the Joseph Rowntree Foundation concluded that there is very little research on the impact of father's drug use on children or where both parents have a dependency (Bauld L et al: 2010).

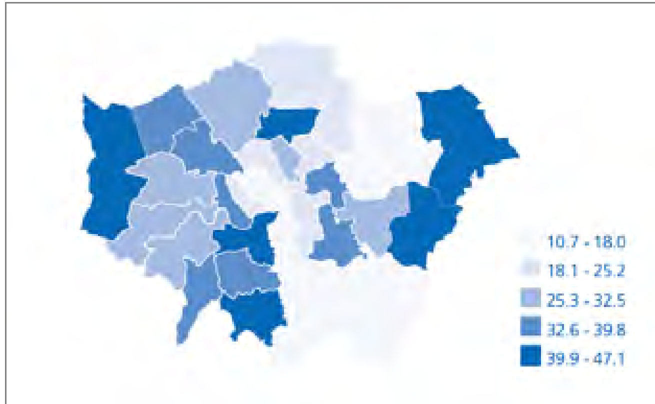
The Advisory Council of Misuse of Drugs recognised the importance of addressing parental substance misuse, the '*hidden harm*', in the report published in 2003 (ACMD:2003). The report stated that the number of children affected will only decrease if parents receive appropriate support and treatment. Following from that the latest drug strategy states that 'prevention must start early. Extra support in the first years of life can reduce the risks from a range of problems. The NHS and PHE, when established, will have a key role to play' (HMG:2010:9). It outlines a number of new initiatives including Family Nurse Partnerships programme aimed at improving parental capacity of mothers and fathers within potentially vulnerable families, through intensive and structured support from early on in the pregnancy until the child is two years old.

Local picture

A relatively high proportion of Haringey residents in drug treatment are parents in comparison to other London boroughs, according to a report by the National Treatment Agency for Substance Misuse (2010). Haringeys' rate was one of the highest in London. Rates in inner London are generally lower than those in outer London. This could mean however that local services are more successful in engaging parents in treatment. On the other hand it can also be an indication that a higher number of parents use drugs problematically contributed by high levels of social and economic deprivation in Haringey. Please see the map … for a geographical analysis on parents in drug treatment in London.

DRAFT

Percentage of parents in drug treatment by London Boroughs (n=4970)



Source: National Treatment Agency for Substance Misuse (2010) ***Adult Drug Treatment in London 2008/09:*** *Analysis of the National Drug Treatment Monitoring System (NDTMS). NTA*

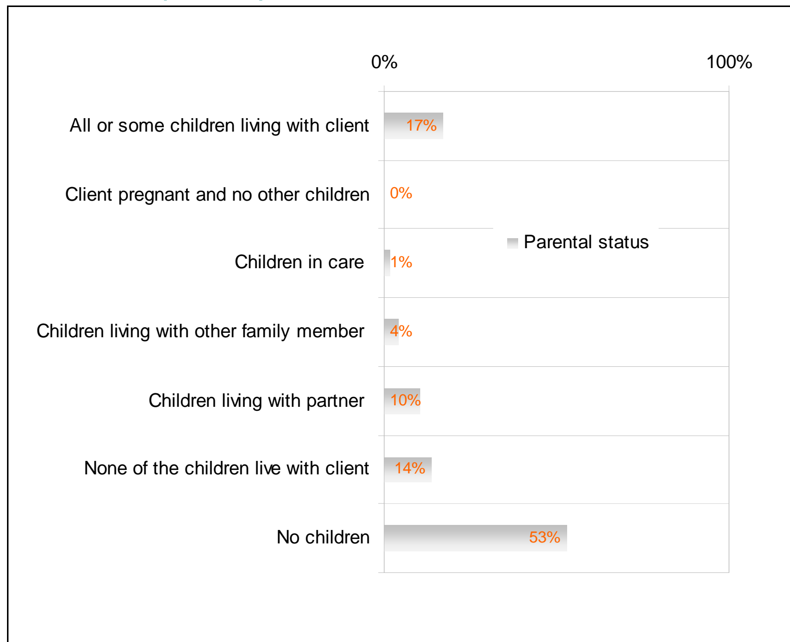
Local analysis shows that in 2009-10 financial year a little less than a half of client in drug treatment had children[1] (n=576, 47%)[2]. However a majority of parents did not live with them (n=366, 64%) at the beginning of their latest treatment episode. See chart below for a full breakdown of parental status in 2009-10.

DRAFT

[1] NDTMS definition for a child is anyone under 18 years of age. Definition for a parent status includes biological parents, step parents, foster parents, adoptive parents and guardians. It should also include de facto parents where an adult lives with the parent of a child or the child alone (for example, clients who care for young on siblings or grandchildren) and have taken full or partial parental responsibilities. However it should be noted that not every worker has necessarily recorded this information exactly according to these definitions affecting the reliability of this data.

[2] The percentages relate to 1226 records where parental status was recorded. 9% (n=123) of all records (n=1349) the status was either missing or defined as 'other'. 'Other' category was excluded from percentage calculations as it is not possible to ascertain this to mean parental relationship or whether they are in contact or live with any children.

Chart : Parental status[1]. Haringey residents in drug treatment between April 2009 and March 2010 (n=1226).



Source: National Drug Treatment Monitoring System (NDTMS) dataset

A little over half of all women had children (55%)[2]. The proportion of men with children was slightly lower with 44 per cent[3]. Women were also more likely to live with their children than men (42% and 33% respectively but this may be a usual pattern when both parents no longer live together). Treatment agencies also report the number of children under 18 that live in the same household as the client at least 1 night a week. The client does not necessarily need to have parental responsibility for the children. The data quality on this item is not sufficient to provide any conclusive figures but the total number of children reported in 2009-10 was 771[4]. Nevertheless the number of children affected by parental use, whether on not they currently live with their parents, is likely to be much higher than the number of parents since many will have, or live with more than one child. Also there may be reluctance to disclose this information for the fear of risking the custody of children. There may also be barriers to access treatment. The Social Care Institute for Excellence, amongst others, recognises that parents who need help are worried about losing their children (2005). Representatives of the local service users in drug

---

[1] Due to the change in coding from April 2009, old parental values and the new codes were mapped into the overarching categories. No children also includes a value 'not a parent' since that is the value that replaced 'no children'. Children living with client includes also all and some of the children living with client. Children not living with client includes children living with partner, other family member, or in care. More information about NDTMS definitions available from: www.nta.nhs.uk

[2] 170 out of 380 of women who disclosed their parental status or where parental status was not recorded as 'other'.

[3] 406 out of 918 of men who disclosed their parental status or where parental status was not recorded as 'other'.

[4] Data quality issues related to the mismatch between parental status and the number of children. For example a large number of parents, 116 in total, who initially reported not living with their children, reported a living in the same household with children. Also those a number of clients reporting living with children have not disclosed their parental status.

DRAFT

and alcohol treatment in Haringey also believe that a number of women may be absent from treatment due to childcare difficulties and the fear of being stigmatised.

The response to parental drug and alcohol misuse

The key recommendations by the ACMD (2003) for reducing the 'hidden harm' were to ensure that:

- drug or alcohol use is routinely assessed and recorded by maternity units, children services, child and adolescent mental health services, with respect to confidentiality but enabling accurate assessment
- there are better integrated local resources and services
- child protection policies include parental drug or alcohol misuse
- identification and management of substance misuse issues is included in staff training, assessment and case management procedures, and inter-agency liaison
- schools have clear policies and training to identify substance misuse in the family and a designated person with skills to deal with children affected
- drug and alcohol agencies provide accessible and effective support for parents and their children, either directly or through good links with other relevant services
- the training of staff in drug and alcohol agencies includes a specific focus on learning how to assess and meet the needs of clients as parents and their children
- all non-statutory organisations dedicated to helping children or problem drug or alcohol users carefully consider whether they could help meet the needs of the children of problem drug or alcohol users.

Current service provision

Support for children of substance misusing parents is equally as important as getting parents into treatment. National research has shown that children often do not know where to seek professional help, and that the quality of help is mixed. Children need non-judgemental support, and someone to talk to without feeling they need to take responsibility and make any decisions about their circumstances (Gorin:2004).
A local service called COSMIC is commissioned to provide parental support but they also help the children. For parents they provide support on parenting issues; improving communication between adult and child; children's behaviour; how to play with children; how to listen to children and keeping children safe. The workers can offer advice and support when there are problems in the family. For children they offer play and/or counselling sessions that allow them time and space to explore their feelings through painting, clay, drama, craft and other activities. The Children's and Young People Service at the local authority has also employed a parental substance misuse worker to signpost families to the appropriate services, such as COSMIC. However, COSMIC's funding is at risk due to wider public sector funding cuts.

Substance misuse in pregnancy

Substance misuse in pregnancy risks not only the health of the unborn child but also the mother. A Confidential Enquiry into Maternal Deaths in 2007 found that 8% of

DRAFT

deaths were substance misuse related. The impact on the unborn child or child can include low birth weight, preterm delivery, sudden infant death syndrome, neonatal abstinence syndrome and fetal abnormalities (Prentice 2007, National Treatment Agency for substance misuse, quoted in North Middlesex University Hospital Audit report).

In November 2010, North Middlesex University Hospital completed an audit on the management and outcomes for women who use drugs in pregnancy. The hospital has been running a specialist clinic for this patient group since 2006 and their work is supported by the drug treatment agencies. Of the 28 patients sampled, a majority (61%) had children with only half (53%) living with them. A majority were unemployed (89%), over a quarter had a mental health issues (28%), and a large minority (42%) had previously been involved with social services.

Most women had a GP who the most likely referral source (75%) with only a very small number coming via a drug treatment agency or social services. Of the 18 toxicology tests made in the antenatal period 61% of women tested positive, with more than a half for more than one drug (mostly for opiates). Hep C is not a routine test for pregnant women unlike testing for Hep B and HIV. The audit recommended this should be done for all women who present as intravenous drug users, as this was found not to be the case for everyone identified in the sample.

As for the outcomes, the average birth weights were within a normal range but a third of babies required treatment for neonatal abstinence syndrome. A majority (72%) were discharged with their mother and others went to foster care. Referral for social services was made for all in the sample. All but one referral was prior to birth. Substance misuse service was involved with fifth (21%) of the cases.

DRAFT

Dual Diagnosis

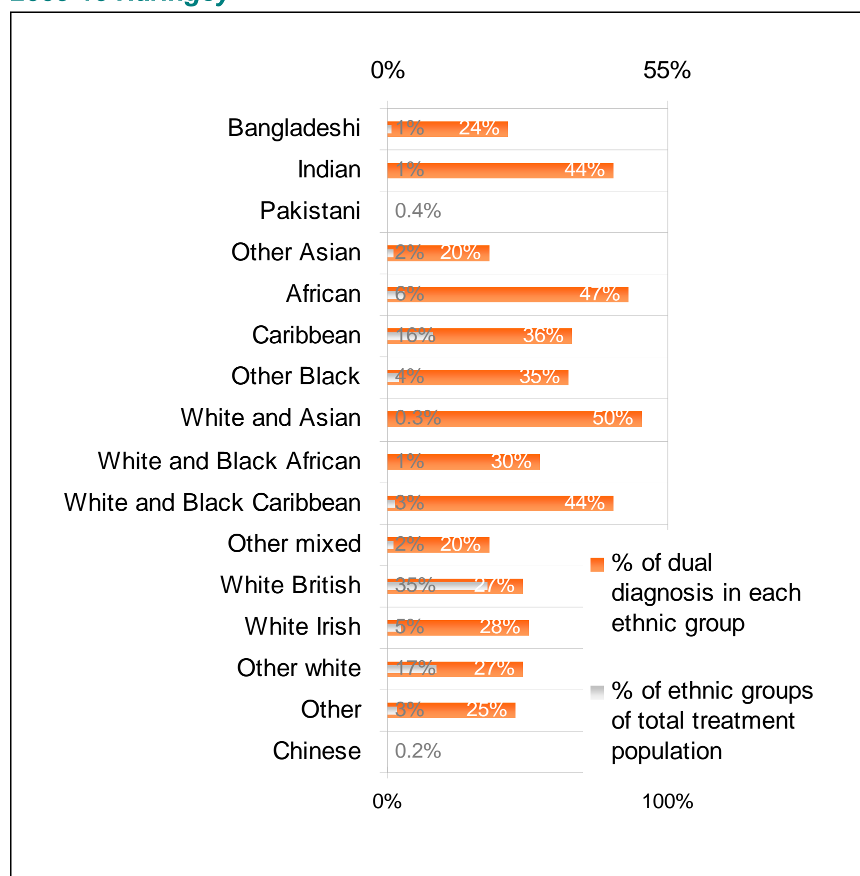
Dual diagnosis is a term used for individuals who experience problems with mental health as well drug or alcohol use. Studies have highlighted a relatively high prevalence of mild and moderate mental health problems in drug treatment population, with half of problem drug users reporting lifetime depression (Strathdee et al., 2002 cited in NTA 2010). Recent research project by the Royal Society of Arts (RSA) found that majority of their sample population experienced general anxiety, sleep deprivation and suffered from low self esteem and depression. Accordingly those who received help for these particular issues as part of their drug treatment strengthened their chances for recovery (Daddow, Broome: 2010). Haringey DAAT commissions Dual Diagnosis Network service who are specialised in treating this particular group.

Almost a third (30%) of Haringey clients in 2009-10 were identified with dual diagnosis[1]. Over a quarter of women had some form of mental health issues, a proportion slightly lower compared to men (30%). Differences between ethnicity groups were starker as shown on the chart 18. A larger proportion of clients in their twenties had dual diagnosis (37%[2]) than any other age group. This compares to, for

[1] 347 out 1175 clients in drug treatment - for whom dual diagnosis status was complete. Of the total 1349 clients, dual diagnosis status missing in 13% of the records (174).
[2] 89 out 239 of clients aged 20-29 who had dual diagnosis data recorded. Data was missing from 16% of the records (45 out of 284)

example, to a quarter of people (26%)[1] aged 30-39. Dual diagnosis was most prevalent amongst black and mixed white and black Caribbean ethnic groups, for example 37% of black Caribbean clients in comparison to 27% of white British. The main drugs are also different to the total treatment population. Prevalence of dual diagnosis is highest amongst primary cannabis users (68%), followed by cocaine (40%) and crack and (34%). These findings are not surprising considering most younger clients use cannabis, and the east of Haringey where most clients come from is more deprived and diverse than the west. 27% of Haringey Super Output Areas (SOAs) are amongst the 10% most deprived in the country. These SOAs are concentrated in the east of the borough mainly in White Hart Lane and Northumberland Park. The population in the east is also younger than the west (Haringey Council 2010).

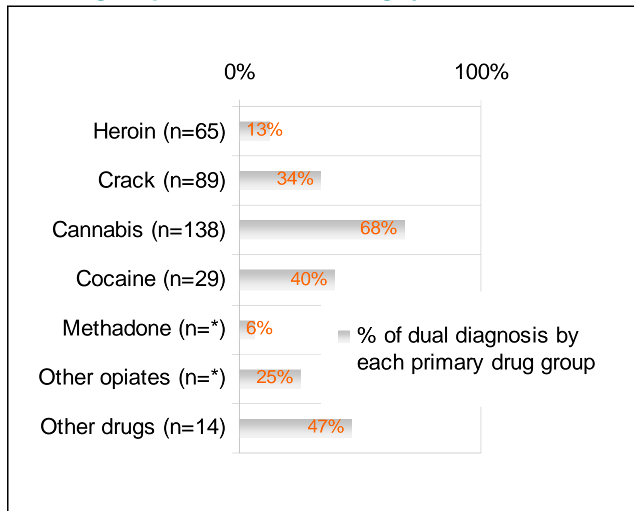
Chart 18: Drug treatment population with dual diagnosis by ethnicity, 2009-10 Haringey



Source: NDTMS raw data

[1] 105 out 405 of clients aged 30-39 who had dual diagnosis data recorded. Data was missing from 13% of the records (53 out of 458)

Chart 19: Drug treatment population – prevalence of dual diagnosis by ethnic groups. 2009-10 Haringey

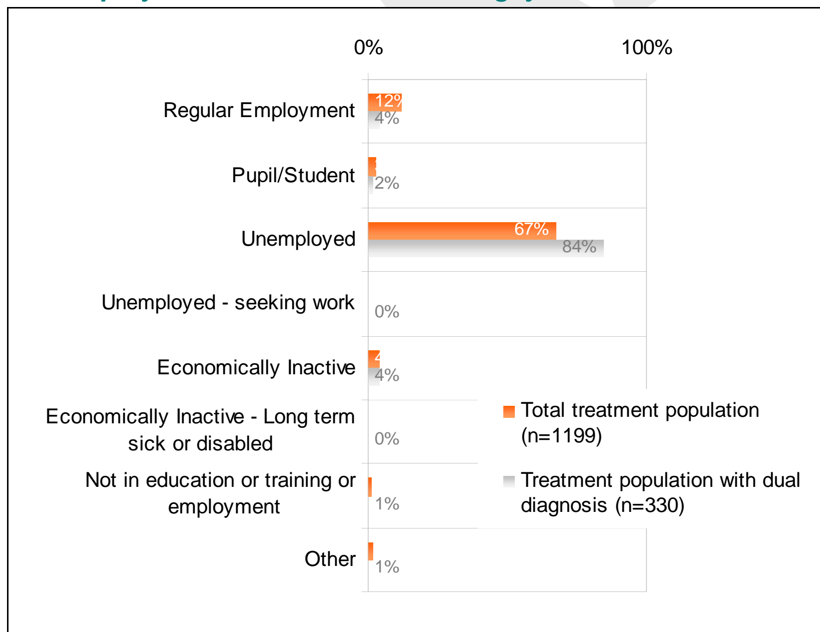


Source: NDTMS raw data
* Data suppressed for data protection

Similar to probation data on mental health needs, a larger proportion of clients who are referred from criminal justice system have a dual diagnosis, 25% in comparison to, for example, self referrals with 14%[1].

People with dual diagnosis were also less like to be in regular employment in comparison to the overall treatment population, 4% against the 12% respectively.

Chart 20: Drug treatment population – population with dual diagnosis and employment status. 2009-10 Haringey



[1] Standard variation between different referrals sources is very high (35%), and therefore comparisons to Haringey average for dual diagnosis is not relevant.

7. THE NEEDS OF FAMILY AND FRIENDS

The DAAT recognises that for many service users, friends and family are an important factor in recovery. Services have made much progress around the issues and also provide services for family and friends of both, drug and alcohol users. The work is based on current national guidance and the ongoing needs assessment which began in 2007. While some aspects of the work continue to move forward there remain a number of gaps that still need addressing. A key risk is the loss of a DAAT post with a specific remit to develop work with friends and family.

As well as services offering advice and information, there are two specific support services for family and friends – a counselling service and Chrysalis. Carers can also access the Council's carers assessments. For 2009/10 the DAAT has no data on the numbers of family and friends who are supporting drug users in Haringey and need support for themselves. The primary source for this data would be the treatment agencies but no systematic, regular mechanism exists for collecting and reporting this information. The local practise was to give out information to all clients about the support available for the client's family and friends.

Chrysalis is a support service for friends and family

Due to the low uptake the service was changed in September 2010 from a support group to a learning/self support group with a series of structured workshops that run over a 13 week period. The subjects covered include overdose awareness, what treatment is and a friend and families role as well as a visits to a residential detox. The purpose of this development is to encourage family and friends to learn more about drug and alcohol related issues with a view to a more self-empowered approach to managing their own issues. Since the change 13 new members up to January 2010 have attended the workshops.

Carers assessments

This is an assessment undertaken on behalf of the council, available to any carer who has a family member receiving a service funded by the council. Having been assessed as suitable a carer can access a range of local generic support services and financial support, which could be used to help access a family member in rehab.

The low number of assessments may demonstrate a reluctance of Friends and family to have an assessment linked to the council, or a general failure themselves as carers. However it has been recognised that generally services have not encouraged users to promote to their cares any form of assessment or support form drug agencies.

In 2010 a new friends and family signposting/assessment form was developed and a referral guide for staff created. During 2011 these new tools will be rolled out supported by a series of training and awareness raising sessions, which will be run by family and friends themselves. The DAAT will monitor the number of forms being completed.

DRAFT

Mutual aid and awareness raising

Volunteers have been attending drop-in sessions at the Visitors Centre at Pentonville Prison each month targeting the families visiting from Haringey since Autumn 2010. Contact has also been made with solicitors who are another potential source of information to family and friends. Family and friends have produced their own newsletter trying to reach out to the wider community to highlight the services of Chrysalis in particular. Newsletters have been distributed to various community venues including public transport. Friends and family have done 2 awareness raising sessions with GPs

Increasing involvement of the family and friends in commissioning

Due to the nature of the issues faced by many friends and family they are keen to see new services for them but find it hard to commit to working with the DAAT on a structured regular basis. They are also making an active choice to develop initiatives independently from the DAAT i.e. running stalls in libraries, visiting prisons. It is hoped that during 2011 they will develop their own support group.

Childcare

This continues to be a problem for family and friends who cannot attend support services because they have a young child. The issues around childcare are two fold. For a service such as Chrysalis there is no crèche facility. However, some family and friends have said that even if there were a crèche they would not bring their non-substance misusing child to a service in the first place.

DRAFT

8. TREATMENT EFFECTIVENESS

According to *Towards Successful Treatment Completion* produced by the NTA which combines evidence from a large number of other studies and data sources, variations in treatment effectiveness are more to do with how treatment agencies deliver their services than client's attributes (NTA:2009). For example, a therapeutic relationship with the keyworker is a stronger determinant of successful treatment completion than the age of the service user.

Nevertheless there are groups that fair better in treatment than others. This section provides information on treatment effectiveness as defined on page 16. We investigate pathways in to treatment, levels of successful completions, standards of care planning and outcomes of treatment. The majority of the figures are provided by the NTA with University of Manchester. Engagement and treatment completions are compared by particular client attributes. Those attributes are however unlikely to be directly linked with any outcomes. Other confounding factors such as stable housing conditions and employment status are likely to be more significant but such analysis is not available from the NTA at the moment.

A specific Treatment Outcome Tool (TOP) measures developments in physical, mental wellbeing and social reintegration and criminal involvement.. This tool was introduced in 2007 by the NTA and all drug treatment agencies are required to complete it for each client at the start of treatment, during care plan reviews and on exit, and where possible, after treatment. Findings from the data are provided at the end of this section but they should be viewed with caution. In 2009-10 the proportion of TOP completions on reviews and exits was around 50-60%. Although much of the data matches with London averages the local analysis does not provide conclusive evidence. Therefore the analysis presented here should be interpreted as indicative and treated with caution. It should also be acknowledged that the outcomes have been completed in discussion with different key workers to measure individual progress, and not done by independent researchers – for example the question relating to quality of life is subject to a considerable degree of variation and subjectivity. A copy of the tool is in appendix 2.

As mentioned earlier, the impact of social reintegration services on treatment effectiveness needs to also be taken into consideration.. Royal Society of Arts report on the national drug policy in 2007 concluded that social exclusion was a major factor in problem drug use (RSA: 2007). Users are likely to be excluded further from the mainstream society if they have to seek help for all their social and health needs from specialist drug services. RSA especially recommended that GPs and pharmacists involvement should be reinforced. RSA also found that nationally the access to 'talking therapies' was inadequate.

Support after treatment is also important. In 2010 Haringey DAAT re-commissioned a specific aftercare service R.I.S.E which includes support on employment and training. RISE works closely with Haringey Guarantee a council funded generic ETE service as well as voluntary sector employers local . An evaluation of how this service impacts on the effectiveness and outcomes is recommended:

DRAFT

Performance and TOP data time periods

The figures which relate to performance are for the latest data available in September 2010. Some analysis is based on the rolling 12 month period prior to September 2011, and some for the year to date, April to September 2010 period, each measure depending on how frequently and in which format it is reported by the NTA. Treatment Outcome Tool TOP data is for the 2009-10. The periods of data are different to that of the prevalence which focuses on 2009-10 financial year since it is more meaningful to look at the most recent performance data following any changes in the 2010-11 financial year.

Effective treatment - current performance

An effective treatment measure is defined by the NTA as a percentage of service users using opiates and/or crack who have been in treatment over 12 weeks or have successfully completed drug free under if treatment is under 12 weeks[1]. The data used here is for the latest 12 month period up to June 09.

Haringey failed to reach this target last year and is unlikely to succeed this year because of the number of new clients coming in to drug treatment has dropped. The actual ratio of clients in effective treatment has not changed significantly[2]. In fact, 86% per cent of new drug treatment clients were in effective treatment in the second quarter of 2010-11 in comparison to 79% in 2008-09 and 83% in 2009-10.

The number of new clients stalling should be viewed in the light of the fact that from 2003-4 to 2008-9 the numbers in treatment increased by 82%, Haringey PDU prevalence estimate is down (see page ..) and the NTA reports on a reduction of crack and opiate use nationally amongst younger users. The rapid increase in people in drug treatment should decrease the demand and could partly count for the fall in new clients coming to treatment.

Number of drug users in treatment between 2004-5 and 2009-10

2003-4	2004-5	2005-6	2007-8	2008-9	2009-10
807	1022	1182	1308	1468	1418

Haringey's current performance is higher than London average with 87% of all clients in effective treatment against 83% (for crack and opiate users 86% against 83%).

[1] There was also a change in the definition of this target from April 2009- those clients who use crack and/or opiates are counted as being in effective treatment only if they leave treatment drug free. This will further impact on our ability to meet this target. Previously 'treatment completed' discharge reason was part of the effective treatment definition. For more information on the methodology see guidance on the NTA website www.nta.nhs.uk.

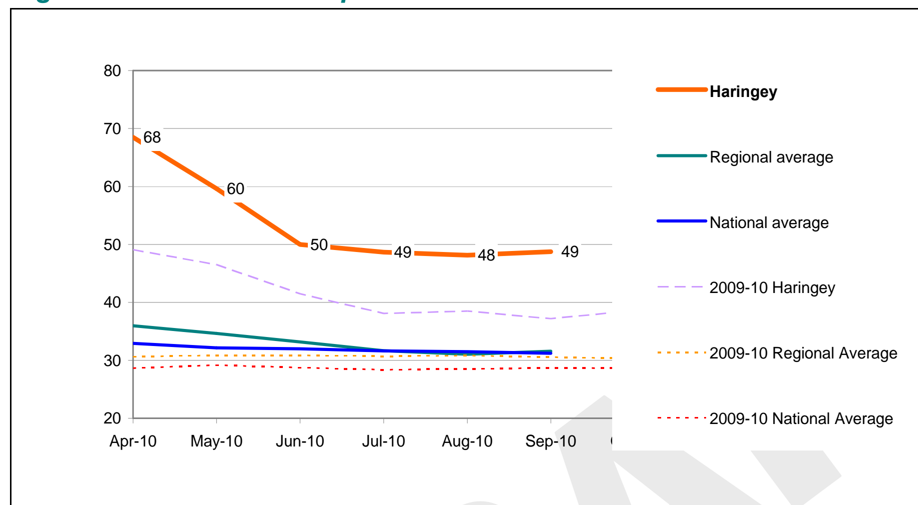
[2] between the two latest 12 month periods July 07 to June 08 and July 08 to June 09

DRAFT

Successful treatment exits

Haringey is above London average and has improved successful treatment exits, ie client leaving treatment as planned and, if using opiates or crack, drug free. However, the figures are slightly inflated due to aftercare clients transferring from tier 3 to tier 2 in April due to a change in service provision. The charts 21-22 compare successful treatment exits to London and national averages in 2009-10 and 2010 April to September.

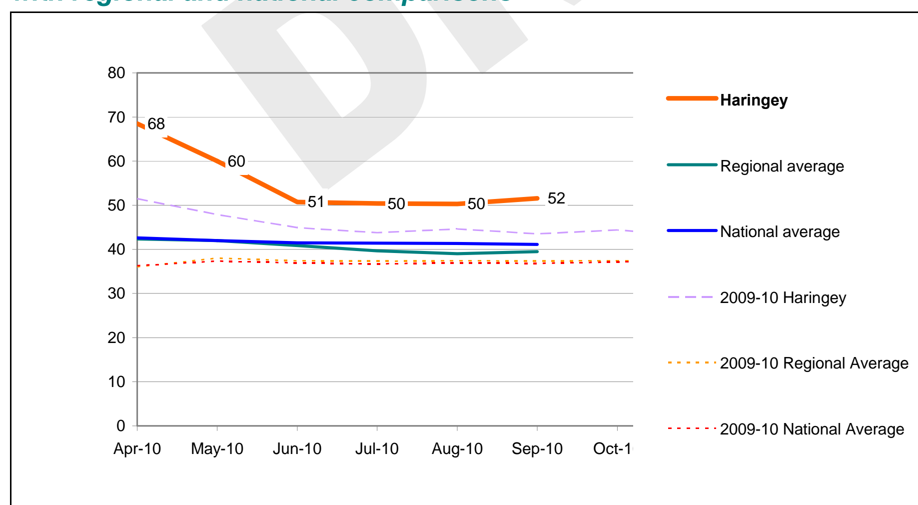
Chart 21: Successful exits (%) for PDUs in Haringey in April to Sept 2009 and 2010 with regional and national comparisons[1]



Source: Treatment exit trend tool report month 6 - 2010. NTA

DRAFT

Chart 22: Successful exits (%) for all adults in Haringey in April to Sept 2009 and 2010 with regional and national comparisons[2]



Source: Treatment exit trend tool report month 6 - 2010. NTA

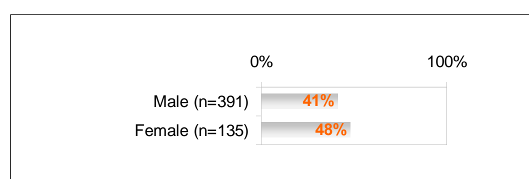
[1] In 2009 Haringey had 349 exits between April and September of which 180 were successful.
[2] In 2009 Haringey had 317 exits between April and September of which 138 were successful.

Differences in successful exits by client groups

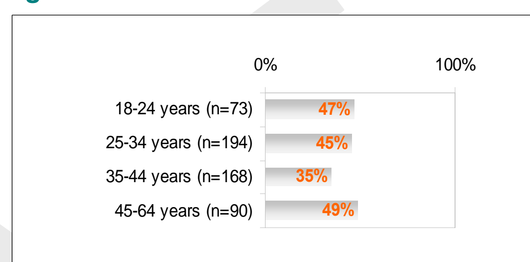
Comparisons between client demographic characteristics, drug use and the length of time in treatment show that; women are more likely to leave treatment successfully in comparison to men; black British and 'other' ethnicity groups fair better, and crack, cocaine or cannabis using clients are more successful than those who use opiates or crack and opiates combined. However the differences can be due to other confounding factors as there may not be any correlation between the success of someone's treatment with their demographic grouping. It seems that alcohol use which accompanies drug use does not impact on successful treatment exit. People who have been in treatment for more than six months are also more likely to have a planned discharge. See chart 23.

Chart 23: Successful exits by client characteristics 2009-10 (total exits n=526)

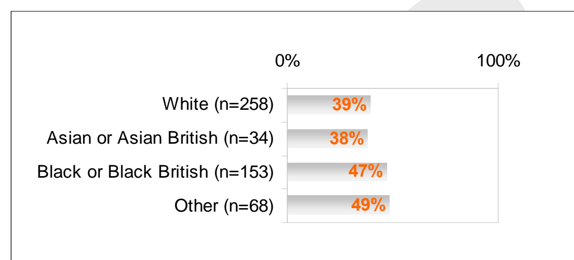
Gender



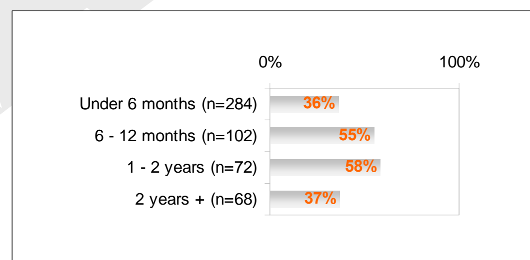
Age



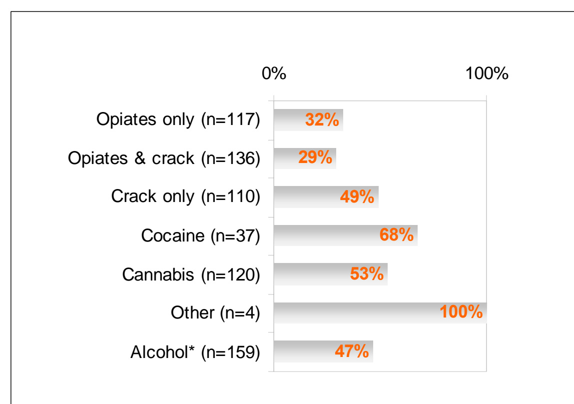
Ethnicity groups



Length of time in treatment



Drugs



Source: www.ndtms.net (restricted statistics – Treatment exits 2009-10 v2)

DRAFT

Exits case studies

Background

Much of the local information currently used for commissioning is quantitative secondary data mostly gathered via NDTMS and other performance monitoring tools. This data, although valuable, is limited since it does not give explanations or provide any contextual information. Relying on quantitative data, however statistically reliable or valid, has a danger of simplifying issues and implying there are causal relationships when real causes or correlations lie elsewhere. For example, in the previous needs assessments a larger proportion of clients between ages 18-24 have had poorer outcomes but this is not evident in the latest data. This is likely to do with the age itself being less significant than say unemployment or lack of training or skills or other issues prevalent with people who drop out of treatment. The implications for commissioning is that it may be more effective to target clients who have poor educational background or who have been unemployed for a long time rather than focus particular intervention on, say, younger clients.

The purpose of exits workshops

The DAAT and four of the local tier 3 agencies, DASH, Eban, CRI and Dual Diagnosis conducted exits workshops in each agency to look at more closely clients who had dropped out. These workshops were designed to widen the understanding of the contributing factors and to investigate issues that may hinder client's recovery. The exercise was also an acknowledgement of the complexity of the circumstances of each individual clients and client groups and the complex demands it poses on drug services.

Methodology

A random sample of anonymised client files from each agency were presented in each workshop and their treatment journey and information was discussed in detail by the managers of the services and DAAT representatives.

DRAFT

Findings

As expected, the sample uncovered very complex cases, issues varying from mental health, childhood trauma, to self harm or loss of family member. It is clear that no one single measure would be able to improve drop outs. However, improvements can be made, either by the commissioners or the services themselves, varying from improved information about or better links with other services or organisations such as community groups or legal services.

Housing

Housing was identified as a key issue at least in two cases. One of the clients had engaged intensively with a service but after a year while housing was still unresolved, he dropped out. Another client managed to secure temporary accommodation and conversely the commitment to treatment dropped due to gaining housing in another borough. The treatment agency in question was unable to contact the client once they had relocated. The recommendation to agencies is to ensure transfer is fully

finalised before relocation. This should enable the referring agency to chase the appropriate receiving organisations to check if the transfer has been successful.

Overall, treatment agencies did seem to do all that was in their, albeit limited, power to help clients obtain appropriate accommodation. For example, Eban's keyworker had hand delivered documentation with the client to the housing department, written several letters and was actively chasing up the issue.

Mental health

Mental health issues were evident in vast majority of cases ranging from severe, eg. psychotic episodes, self harm, post traumatic stress disorder and suicide attempts, to milder depressive episodes. Although not necessarily the cause for dropping out, it is clear that mental health issues are prevalent. Links with mental health services are not established enough since one agency had experienced a great difficulty in convening a case conference with a client who was clearly a risk to self and others.

Domestic violence

There were also clients reporting or assumed to be the perpetrator and/or a victim domestic violence. Whilst Hearthstone offers support for victims in Haringey the difficulty lie in perpetrators not being able to access counselling if no offence has been recorded.

Break up in the family and access to children

Children often featured in case notes with clients either living with children or having lost contact or legal access to their children. One client experienced difficulty in obtaining legal support to advance his case. Family breakdown was mentioned in many case notes, and in at least with one client this clearly lead to missed appointments. For one client a loss of a family member had been the crisis point which was a trigger for treatment, but a tragic loss of another member in the family combined with a severe deterioration in health took his treatment journey for the worse, and client eventually died.

Service specific issues

If a client has build up a good relationship with a keyworker a change can risk their engagement. At least in one of the cases a client started missing out appointments as soon their keyworker changed and eventually they dropped out. It is also evident that services are unlikely to be able to deal with culturally specific issues, such as post traumatic stress disorder, evident at least with one client who had lived in a war torn country before moving to Britain.

A clear sign of disengagement was evident in the number of missed appointments or clients turning up late with various excuses which, according to DASH, was sometimes deliberate so that the script would not be stopped whilst the clients was able to avoid proper engagement. Whilst agencies were actively chasing the client both by phone and letters, it may be that another approach should be considered with clients who are this chaotic and clearly starting to disengage. For example, Dual

DRAFT

Diagnosis Network did several home visits to re-engage clients before they had dropped out.

Recommendations

Although there are plans are already in place to address issues that came out of the workshops the following lists the key actions or issues to monitor

- Cultural competence - Training on cultural competence and understanding of different backgrounds would be helpful for staff alongside with a comprehensive directory of different community centres or organisations that can help or refer to appropriate services eg, for people suffering from post traumatic stress disorder.

- Mental health – agencies need to ensure mental health issues are addressed appropriately, be it a referral to dual diagnosis or other support organisations. With clients at risk, it is crucial commissioners are alerted to ensure case conferences happen in a timely fashion, relevant agencies are involved and issues are communicated to the appropriated level. Psychology may be a gap in services, in particular couple's therapy and anger management

- Reaction to early signs - Once client starts missing appointments there should be a prompt review of treatment options, including the intensity of current appointments, and actions before contact is lost altogether.

- DAAT and commissioners should continue to build links with housing departments to ensure clients recovery is not at risk for the lack of appropriate housing.

- DAAT and services should work together closely with other organisations dealing with family support.

- A change in keyworker should be prepared with care making sure the handover is done with clients full participation and both the existing and the new keyworker work together to ensure smooth transition.

- The services all agreed it would be helpful to compile a comprehensive list of relevant support services for staff. This should include voluntary sector providers, especially those representing the diverse communities in Haringey, and mental health services and who to contact when. Further pathway training on Eban counselling and IAPT (Improving access to psychological therapies) should also be ongoing. Routes to appropriate legal advice should also be made available (eg. Release)

DRAFT

Summary of care plan audit findings

Care planning is one of the key elements of good quality treatment. A comprehensive care plan is vital to a successful treatment journey packaging the several types and sequences of treatment according to the person's needs. This written agreement between a client and a keyworker outlines the treatment goals, who will do what towards achieving them, and by when (NTA:2009).

In line with the current national drug strategy and the NTA's increasing emphasis on recovery and re-integration, it is crucial that all care plans address treatment goals all the way to the discharge and beyond, and look at the client's wider needs, including housing and employment needs.

Three yearly local care plan local audits have been undertaken since 2007/8. The purpose is for the agencies to use the audit in their service and workforce development, share best practise, and help the DAAT to improve standards locally.

This summary is based on care plan audits completed in 2010 by the four Haringey treatment agencies: DASH, Eban, Dual Diagnosis and CRI[1]. Overall, albeit there were some differences between agencies, the results suggest that care plans are not in line with the recovery agenda. Social needs, which include employment and skills, or discussion about discharge and what happens after clients leave treatment, are not sufficiently evidenced in the care plans.

Key findings

This summary is based on care plan audit reports from four Haringey treatment agencies: DASH, Eban, Dual Diagnosis and CRI. A total of 128 service user records and care plans were audited across agencies. In their respective reports large number of actions to improve care planning has already been identified. However these were the key findings across agencies:

Section 1 – Proportion with a care plan, client's signature, review date and legibility

- 6% of clients sampled did not have a care plan. This is in contrast with 1% currently reported by the NDTMS where a care plan start date is recorded.
- Introduction of RiO in 2008 and move to paperless workplace was an issue for DASH and Dual. This meant that a large proportion of care plans at DASH were not signed by clients. Also, a care plan review dates cannot be recorded on RiO.

---

[1] Full report with the design and specification is available from Haringey DAAT. A total of 128 service user records and care plans were audited across agencies. When assessing the findings it should be noted that the audit involved examining solely the paperwork that relates to care planning. Individual contact with a member staff and their client may be rich in detail and cover all aspects that make a successful care plan, many of which that may not have been recorded in the forms. However by consistency in recording we can ensure the consistency in standards. Training of staff is another way to ensure that the standards and the quality of care are the same across agencies and should also be emphasised in agency specific and DAAT wide plans.

DRAFT

Section 2 – Care plan goals

- Vast majority (89%) of care plan goals were deemed SMART with plans addressing one or more key domains (drug and alcohol use, physical and psychological health, social needs, and needs relating to reduction in criminal involvement) with most following directly what had been identified in the assessment process (92%).

Section 3 – Addressing the four domains

- Substance misuse related needs were addressed in almost every plan (99%) and followed by an appropriate intervention
- Physical and psychological needs were addressed in vast majority (85%) of plans and followed by an appropriate intervention (85%)
- Social needs (employment, housing, relationships with family and friends etc) were addressed in vast majority (85%) of plans and followed by an appropriate intervention (85%).
- In comparison to the other domains, criminal behaviour which relates to drug use is still an issue not considered in care planning. Although this was more prominent in Eban's and CRI 's samples

Section 2 - Discharges and TOP

- There was a large discrepancy addressing discharge plans between agencies
- In only half of the care plans TOP commencement was clearly evidenced
- Review and exit TOP was evidenced in little over third
- The results suggest that TOP is still not used as part of the care planning.

Recommendations

The audit findings were discussed at the clinical governance group and agreed as follows:

- Since respective agencies already have comprehensive actions plans following the audit, and TOP and recovery agenda is part of the overall Adult Drug Treatment Plan 2010-11[1] there is no need for a further action plan.

- Audit for 2011 is to be in line with the recovery agenda and outcomes (ie focus on social needs, TOPs and discharge planning, and breaking down the social needs categories further)

DRAFT

[1] Summary document available from: http://www.haringey.gov.uk/index/community_and_leisure/crime_reduction/drugs_and_alcohol_action_team.htm

Care pathways - to be updated

The treatment diagram on page 66 shows the treatment journeys that relate to structured tier 3 treatment and clients in local treatment agencies captured via the NDTMS. Tier 2 is not covered by the NDTMS so the treatment pathways cannot be mapped in their entirety. Also, this diagram does not include tier 4 services, except for inpatient detox and crisis centre City Roads commissioned by the Haringey DAAT but located in Islington. A separate diagram was produced for tier four on page 69.

The majority, almost half of all clients (46%) self refer. Criminal justice is the main referral agency counting almost third of all referrals (31%). Drug services themselves count for tenth of referrals, as do 'other' category which includes several statutory agencies such as A & E, employment and psychological services, and family and friends and so on[1]. Only 1 per cent of service users were referred by GPs. The low referral rate has been identified in the previous needs assessments. It may be that many more GPs do signpost to drug services but clients report self referrals when they eventually present to drug treatment. Nevertheless a formal referral process is not fully established. Currently sixteen GP surgeries are part of shared care scheme, a scheme that involves GPs in drug treatment with the help of the referring drug treatment agency. This existing relationship with GPs should help in accessing more clients via GPs.

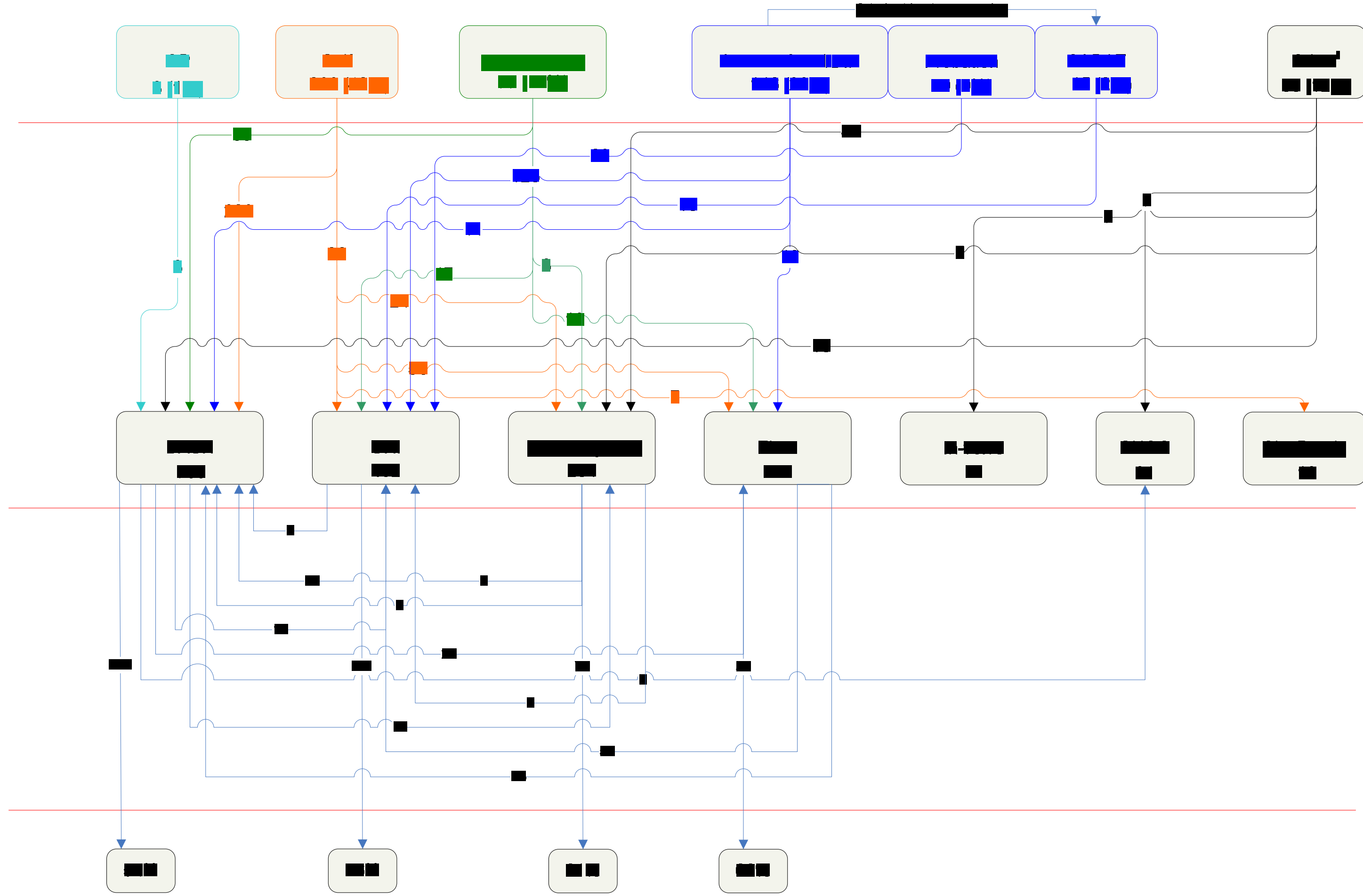
The diagram also shows the onward referrals between drug treatment agencies. Movement in general is higher than previous years and agency transfers are up by 75%[2]. Much work has gone to improve pathways and make sure treatment agencies work together better. It is important that clients are presented with all the treatment options available in Haringey.

DRAFT

[1] The referral categories on NDTMS are: Self , GP, Drug service statutory, Arrest Referral/DIP, service non-statutory, Other, Probation, Drug Rehabilitation Requirement – formally Drug Treatment and Testing Order (DTTO), CARAT/Prison (Care And Rehabilitation And Through-care), Psychiatry services, Connexions, PRU CLA - Children Looked, Sex Worker Project, Hospital, Psychological Services, Relative, Concerned other, Community Alcohol, Outreach, Job Centre Plus, Social Services, Education Service, Community care assessment, Accident and Emergency, Employment Service, Syringe Exchange

[2] From 110 agency transfers in 07-08 to 192 in 08-09

Diagram 3: Treatment pathways for tier 3 in 2008-9



[2] NDTMS

referral source categories include: Connexions, PRU CLA - Children Looked, Sex Worker Project, Hospital, Psychological Services, Relative, Concerned other, Community Alcohol, Outreach, Job Centre Plus, Social Services, Education Service, Community care assessment, Accident and Emergency, Employment Service, Syringe Exchange

Tier 4 – abstinence based residential programmes – to be updated

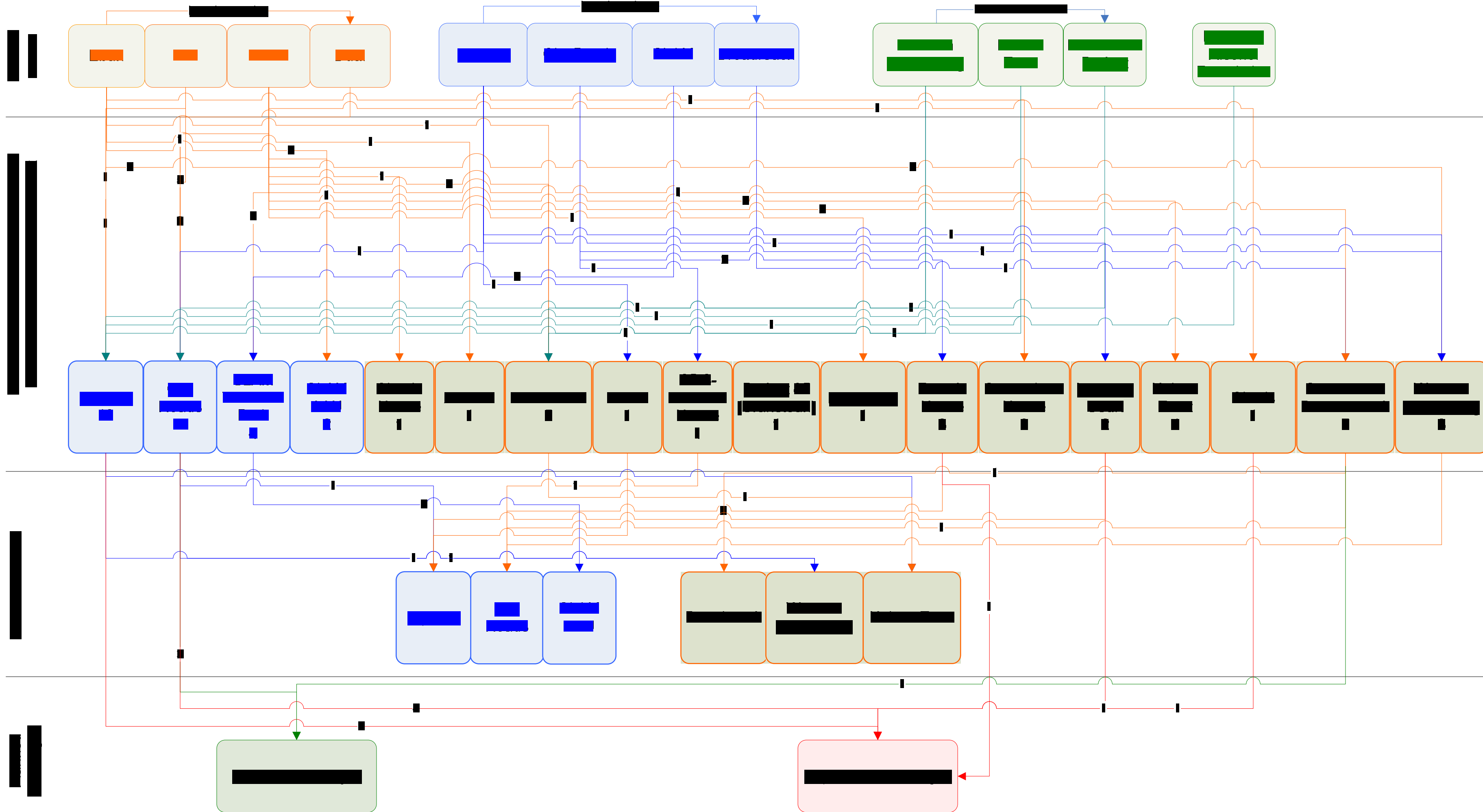
Extensive amount of work was done in the Haringey DAAT needs assessment during 2007[1] on tier 4 effectiveness. The DAAT sets a target for tier 4 admissions based on 10% of the treatment population requiring inpatient services, this target has not been met and there has been an underspend for the Tier 4 budget and there is a risk that the same will happen this year. In the first six months of this financial year there have been only 46 assessments out of 67 referrals, out of which 42 clients had their funding agreed.

The diagram 1 shows the pathways to tier four as shown on the NDTMS, based on the figures provided by the NTA. DASH is the local agency commissioned to co-ordinate tier four referrals and placements for Haringey residents. Although the NDTMS shows that the largest number come through DASH there is a significant number who seem to come via other agencies, including other residential providers outside Haringey. Hence the pathway diagram is not fully accurate. DASH care co-ordination role also means that they do reviews while clients are in tier 4 treatment and care co-ordinate them once treatment has finished.

Inpatient provision was re-commissioned in Haringey from April 2010. A local inpatient service was opening covering residents within five surrounding boroughs. The unit tailors its services to local need, offering both stabilisation and detoxification of any problematic substance misuse, work with clients with complex needs, pregnant women, crack users, and poly drug users alike. A full business case/needs assessment was completed in 2005 which concluded that a local unit would create both benefits in terms of cost and effectiveness. Having one central facility should also help with smooth transition to rehab or other appropriate post detox treatment. Before people with complex needs had to wait for placements which often jeopardised their engagement.

[1] Haringey DAAT (2007) Improving commissioning and service delivery - Needs assessment for Haringey DAAT adult drug treatment plan 2008-2009. Available from Haringey DAAT.

Diagram 2: Treatment pathways for tier 4 in 2008-9



Treatment outcomes

There is no one simple recipe to a successful treatment outcome. Who does well and why can depend on multiple factors, from levels of motivation, personal relationships, lack of housing, mental health to the level of trust between the client and their keyworker. A qualitative study in 2009 (Webster, O'Connor et. al) acknowledged the complexity of drug users needs and the unpredictability of outcomes, and consequently the demand for more flexible approach to meeting those needs. The study also found that clients had varying capacity to deal with underlying issues that lead to drug taking, such as childhood trauma. However, a flexible individually tailored treatment which can tap into multiple interventions and services, including services outside drug treatment which address those underlying issues, can lessen this unpredictability.

Treatment outcome profile (TOP) tool was developed by the NTA to measure benefits from treatment in four key areas; drug use, criminal behaviours, risky injecting behaviour and social and physical functioning. As well as to inform performance and commissioning, TOP was designed to work as a clinical tool to follow individual client's outcomes at different stages of treatment.

The rate of TOP completions for reviews and on exits has improved from 2008-9, from a third to 50-60 per cent[1] in 2009-10. However, in order to provide conclusive evidence, the completion rate should be at least 80%. It should also be noted that the cohort in each stages of treatment is slightly different and does not follow the same group of individuals throughout treatment. This means the cohort at the start of treatment includes all individuals who started treatment in 2009-10. The cohort indicated as '1-4' years will have had their TOP done in 2009-10 but their journey would have started prior to 2009-10. Some longitudinal analysis comparing outcomes for the same cohort is however given for substance misuse, housing and injecting behaviour[2]. However, outcomes are not monitored after treatment which means there is no evidence of the long term evidence impact of treatment.

Prevalence of drug use

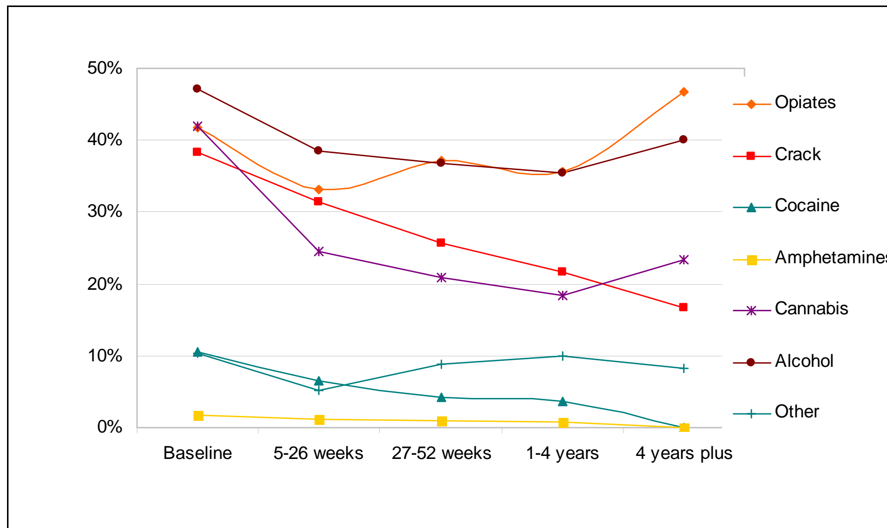
For any reduction is drug use, treatment seems to be most effective in the first six months – between the start TOP and the latest review completed between 5-27 weeks of treatment. Only the prevalence of crack use dropped steadily, by over a fifth, between all the cohorts up to four years of treatment and beyond. Opiate use starts to rise after the six month review however this can be expected since most opiate users in treatment are likely to be on a methadone script. The chart 24 also suggests that the proportion of alcohol and cannabis users increases after one year in treatment. This indicates that either the two substances replaces other drug use or treatment is less effective for clients using cannabis and alcohol.

---

[1] In the treatment start the completion rate was 88% with total of 606 valid responses. But already in the first review the completion rate is 52% with a total of 408 valid responses. The number of valid responses also decreases at each stage as client leave treatment so for the cohort with reviews done in 4 years in treatment the number of valid responses is 60.

[2] This type of analysis was not available for any other domains by the University of Manchester

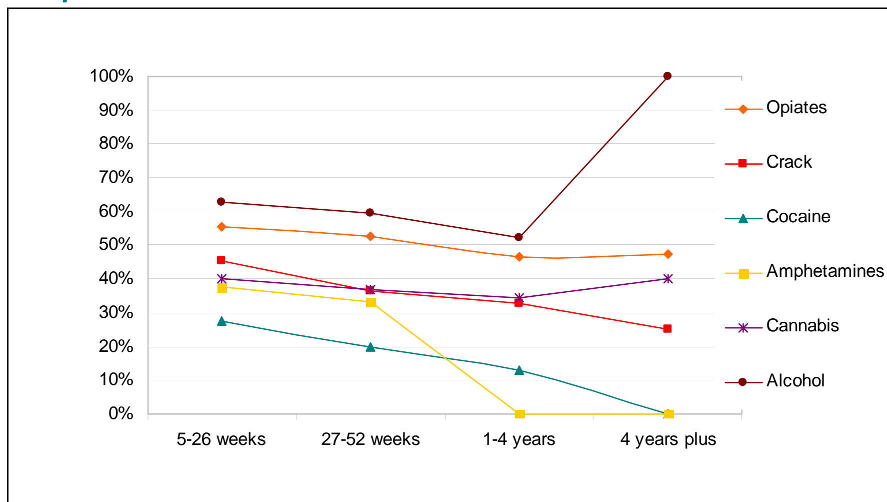
Chart 24: Prevalence of substance misuse (% at each stage of treatment) for TOPs completed in 2009-10



Source: www.ndtms.net restricted statistics – needs assessment data

Longitudinal analysis on substance misuse trends which makes comparisons to treatment start for the same group of clients[1] shows similar trends. Again alcohol and cannabis use increase after first year of treatment however opiate use stays the same as oppose to increase in the previous chart 25.

Chart 25: Prevalence of substance misuse (% at each stage of treatment) - comparisons of the same cohort between treatments start and reviews



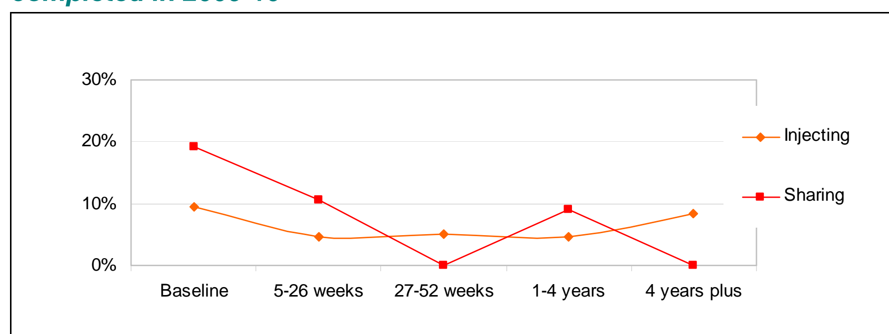
Source: www.ndtms.net restricted statistics – needs assessment data

[1] This analysis compares client treatment start data collected at triage by NDTMS to data which is later collected on the same clients at their Treatment review TOP. Therefore, it is making comparisons between what clients presented to treatment with against what they report on their review TOP (NTA needs assessment guidance 2009-10 page 51).

Injecting behaviour

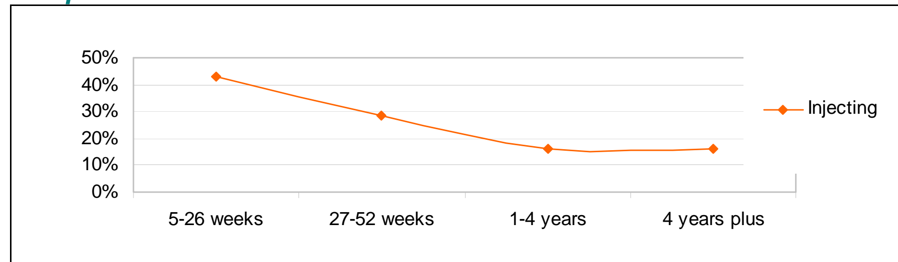
There appears to be very little change in injecting prevalence between the groups however sharing drops sharply as soon as treatment starts with a slight increase in between 1-4 years. However when looking at injecting trends for the same cohort throughout treatment periods, injecting does reduce significantly, by 27 percentage points (see chart 27)

Chart 26: Prevalence of injecting and sharing (% at each stage of treatment) for TOPs completed in 2009-10



Source: www.ndtms.net restricted statistics – needs assessment data

Chart 27: Prevalence of injecting and sharing (% at each stage of treatment) comparisons of the same cohort between treatments start and reviews



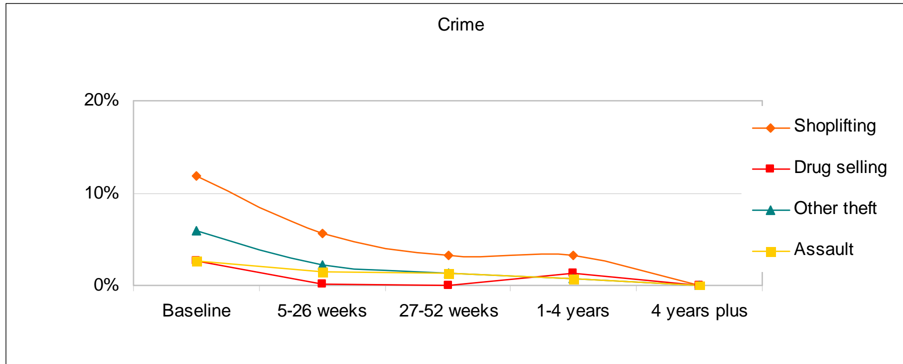
Source: www.ndtms.net restricted statistics – needs assessment data

Criminal behaviour

Shop lifting, drug selling, other theft, and assault decreases as soon as treatment starts. Drug selling and assaults, which are much less prevalent drug related crime types in comparison to theft go down almost completely except for drug selling which seems to start again after one year. It should be noted that the self reported crime is likely to be underreported, since the prevalence data at treatment start is lower than would be expected, especially when comparing to the number referred through the criminal justice system[1].

[1] For example, needs assessment data shows that 28% of clients were referred from criminal justice agencies in Haringey (Source: Treatment Map Summary data).

Chart 28: Crime prevalence (percentage) - all outcome reviews completed 2009-10 by time in treatment

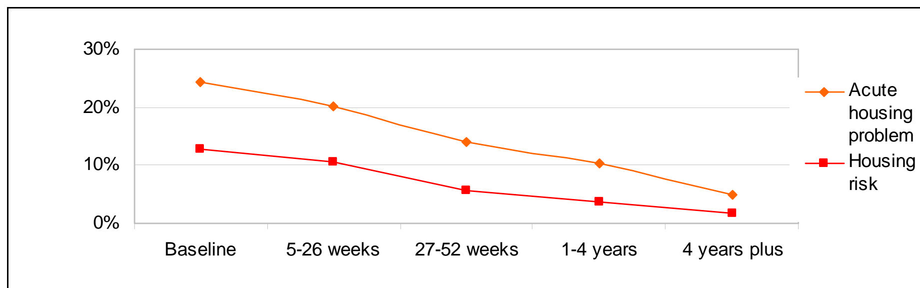


Source: www.ndtms.net restricted statistics – needs assessment data

Housing issues

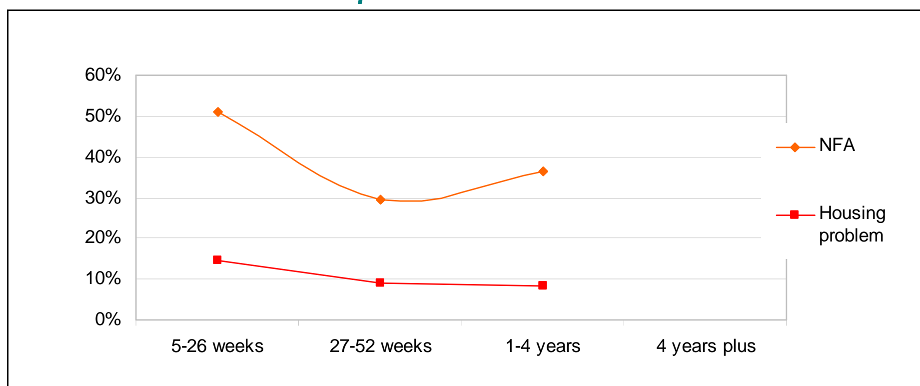
The data suggests that housing problems decrease once clients enter drug treatment. Acute housing problems decrease steadily between groups. Longitudinal analysis for the same groups of clients shows more drastic improvement in NFA status, 21 percentage points in the first year but rising again in the subsequent reviews.

Chart 29: Prevalence of housing problems - all outcome reviews completed 2009-10 by time in treatment



Source: www.ndtms.net restricted statistics – needs assessment data

Chart 30: Prevalence of housing problems - comparisons of the same cohort between treatments start and subsequent reviews

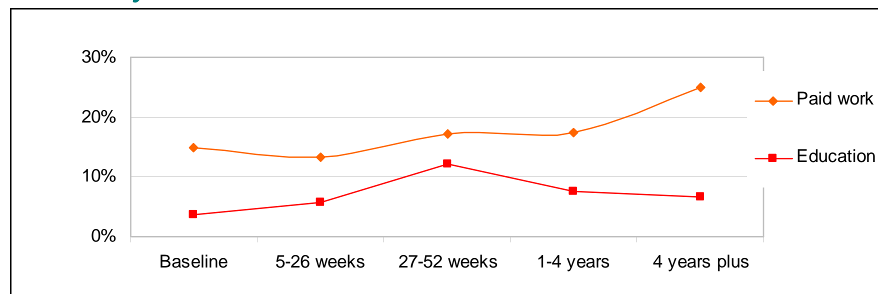


Source: www.ndtms.net restricted statistics – needs assessment data

Education and paid work

Prevalence of paid work starts to increase for clients who have been in treatment for 26 weeks or more. The proportion of clients in education improves in the first year cohorts but decreases in the subsequent groups.

Chart 31: Prevalence of education and paid work- all outcome reviews completed 2009-10 by time in treatment

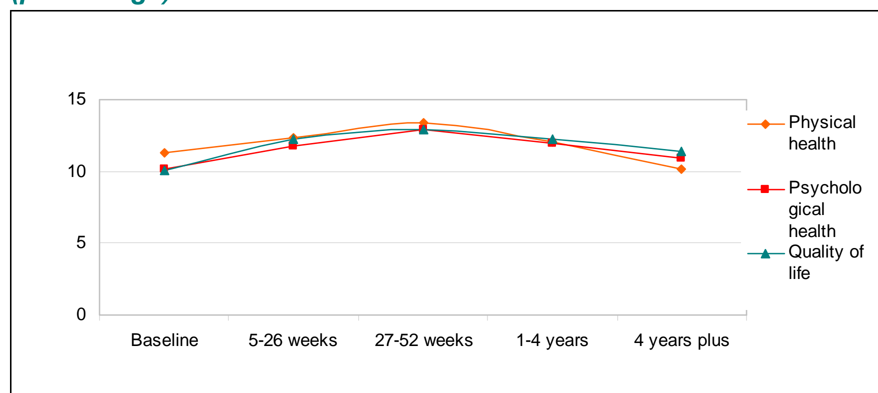


Source: www.ndtms.net restricted statistics – needs assessment data

Physical and social functioning

Of all the domains measured by the treatment outcome tool, these three, physical and psychological health and quality of life, are probably the hardest to compare between clients and stages of treatment. The interpretation of the questions and scales are likely to vary significantly. The chart 32 shows some improvement in the mean average scores in the first year of treatment but declines again after.

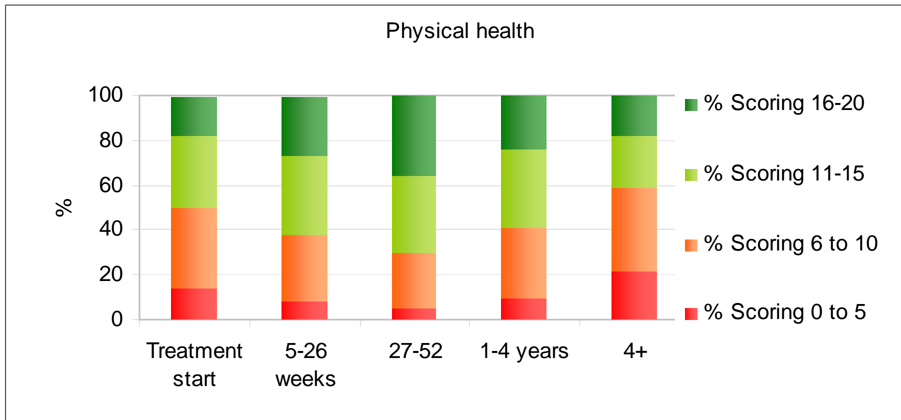
Chart 32: Physical and psychological health, and quality of life- prevalence (percentage) at each outcome review in 2009-10



Source: www.ndtms.net restricted statistics – needs assessment data

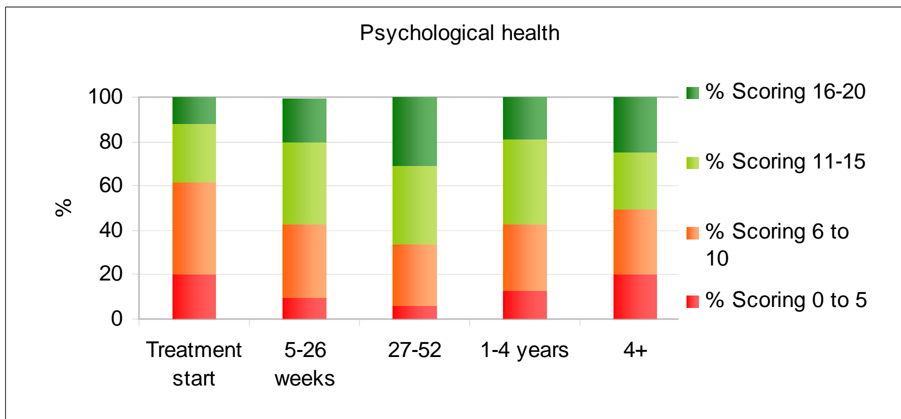
However, some variation is evident from the following charts (33-35) which present the percentage of clients reporting different scores for each period. The percentage of clients scoring higher than 11 for all three domains increase during the first year of treatment albeit the changes are within 10 percentage points.

Chart 33: Percentage of clients in different TOP score groups - rating their physical health in treatment 2009-10



Source: www.ndtms.net restricted statistics – needs assessment data

Chart 34: Percentage of clients in different TOP score groups - rating their psychological health in treatment 2009-10



Source: www.ndtms.net restricted statistics – needs assessment data

Chart 35: Percentage of clients in different TOP score groups - rating their quality of life in treatment 2009-10

Source: www.ndtms.net restricted statistics – needs assessment data

Key findings

The data for 2009-10 suggests that outcomes in all the four domains - substance misuse, injecting behaviour, criminal activity and health and social functioning - improve during the first year in treatment. There is little improvement in the prevalence for each domain for people who have been in treatment longer than a year.

However, the outcome findings for 2009-10 should be treated with caution as data completeness for the reviews less than 80%[1]. This highlights the importance of improving the validity and reliability of treatment outcome tool data.

Summary of the Service User Survey 2009

Haringey user group does an annual satisfaction survey. The final report on the latest survey and focus group findings is finalised by Feb 2011. Findings are used, where possible, to inform the detailed treatment plan for 2011-12 as well as each treatment agency specific improvements.

The previous survey completed in February 2010 survey was the 3rd survey conducted with users of Haringey's drug and alcohol treatment services. The survey areas were defined by service users who also compiled the questions, with the support of the DAAT. It was conducted between November and December 2009. 105 surveys were returned – representing some 10% of the total number of people in treatment at that time. Most of the surveys were completed by users of DASH. However the response also showed that users were receiving services from a number of services simultaneously. Half of respondents had been in treatment over a year and a quarter were relatively new clients.

The data was analysed by the DAAT and the report was written by the lead for service user involvement at the DAAT. This summary contains some of the key findings, recommendations, conclusions and some detail on how the survey for 2010 is being developed.

Key findings

Key working

Over a half had only had one key worker the whole time they had been in treatment and a large majority, 80%, were either happy or very happy with their key workers.

Harm reduction

75% of respondents who were injecting said that they were not using needle exchange. The injecting heroin using population also seemed to be less aware of

[1] 80% is the threshold set by the NTA whereby data is only published for each partnership once the data completeness reaches this percentage.

harm reduction than users of other drugs, which again is very concerning. Overall many would like to receive more training around first aid and overdose awareness.

Reception areas at the service, making complaints and waiting times for treatment

More that 90% of respondents said they were either happy or very happy with the reception areas and how welcoming their service appeared. They suggested improvements could be made around the time it takes to be seen by staff and their knowledge and helpfulness. They also cited the attitude of other clients which could be improved.

In relation to making complaints users generally were aware of how they would do this if they needed to.

The survey found users in Haringey did not have to wait long to be assessed for treatment with over 90% of users having to wait for 3 weeks or less for their assessment. For those who required a script over 80% of those received their script within 3 weeks of assessment.

Care plans

Over 75% of clients who said they had a care plan were either happy or very happy with the level of involvement they had in its development. This is an improvement on previous surveys. The issue with the care plans this time was the subjects discussed at the care plan meetings. Issues including education, skills and employment were far less frequently discussed at the care plan reviews than other standard subjects like the client's health.

The profile of respondents

There was an even gender balance completing the survey - although not proportionate to the treatment population overall - with just slightly more men than women. The highest number of respondents came from the 45-54 age range – just over 30 per cent of respondents. As 40 per cent of respondents were White British with Caribbean being the next largest group with 12%. However, the ethnic groups such as the eastern European and the Somali community did not feature in the survey. This is likely to be related to the format of the survey being a paper questionnaire in English only.

The final questions of the survey were around drug use, which drugs respondents had been using and for how long. Here the respondents entered several drugs including alcohol even though they were asked about the main drug that they seeked treatment for. This suggests that the assumption of everyone having a 'primary drug' is not how clients perceive their drug problems and recording should reflect that. However overall the drug used by the highest number of respondents was crack followed closely by heroin. Given the proportion of the people who fell into the 45-54 age range it is not surprising that well over half the respondents had been using drugs for over 10 years.

Recommendations

There are a number of lessons learnt both around the process of conducting the survey and the content of which many were taken forward into the 2010 Survey:

- Adopt a system orientated approach rather than a process owned by the DAAT or service users
- Use a steering group to direct the survey and ensure all stakeholders have a voice
- Ensure that both quantitative and qualitative data are collected
- Ensure the survey is accessed by the diverse communities of the borough – particularly where English may be a language barrier

In addition there are some key areas where more work needs to be done:

- Consider review of training offered to users around first aid and overdose awareness
- Clients are happy with the welcome at service but some aspects require attention including
    - a) period of time it takes to be seen by a key worker and
    - b) the knowledge and helpfulness of staff
    - c) effects of other users' behaviour

- Check with service users if there are any issues regarding needle exchanges
- Continue development of service users feeling part of development of their care plan.

One of the many benefits for the service users who took part in delivering the survey was that they became very empowered during the course of the survey's development. They not only went on training to support their understanding of the purpose of consultation but they were able to use what they had learnt to frame the survey itself and take greater ownership of the project. In terms of personal development this is a valuable achievement for the individuals and the DAAT and demonstrates the benefits of service user involvement for the treatment system as a whole. It is important that this element is maintained in future survey work.

9. EMPLOYMENT AND TRAINING NEEDS

> *Work provides a sense of responsibility, personal value, independence, security, dignity and stake in society*
> (Phillips C et al 1992 quoted in South N et al:2001)

Employment is not only a desired outcome of drug treatment but it can have intrinsic therapeutic value during recovery. A thematic review from 2001, looking at evidence mainly from US, supports the importance of work as part of treatment. It also protects from social exclusion and furthers reintegration. (South N. et al:2001). The latest Drug Strategy 2010 (HM Government 2010) places emphasis on full recovery for which employment is key. Along with housing, training and employment both aid, and are an indicator of, successful treatment outcomes. Estimated 267 000 people in England in receipt of out of work benefits are dependent on opiates or crack cocaine. This represents just over 6.6 per cent of those accessing main benefits (Bauld, Hay: 2008). Hence there is a strong commitment to address the employment needs and community re-integration by the National Treatment Agency and the Department of Work and Pensions. This was demonstrated by the creation of Jobcentre Plus Drugs Co-ordinators and national pathway pilots in 2010 and the roll out during 2011 of a joint NTA/JCP working protocol.

The Marmot Review (2010) on health inequalities recognised that work is a determinate of good health and of critical importance for reducing health inequalities. However, jobs need to be sustainable and offer a minimum level of quality, to include not only a decent living wage, but also opportunities for in-work development, the flexibility to enable people to balance work and family life, and protection from adverse working conditions that can damage health. Patterns of employment both reflect and reinforce the inequalities in health, or what the review defines as the 'social gradient in health'. The term is used to describe the parallels of lower social status with poor health whilst recognising that the relationship is a gradual one – the implication being that inequalities are not erased by focussing only on the poorest. There are also serious inequalities of access to the labour market. Rates of unemployment are highest among those with no or few qualifications and skills, people with disabilities and mental ill-health, those with caring responsibilities, lone parents, those from some ethnic minority groups, older workers and, in particular, young people. When in work, these same groups are more likely to be in low-paid, poor quality jobs with few opportunities for advancement, often working in conditions that are harmful to health. Many are trapped in a cycle of low-paid, poor quality work and unemployment.

The cuts in public sector are likely to impact on the number of jobs and education placements available. Therefore it is imperative that the right support is available for people in drug treatment at the right time. The concepts within the Coalition Governments Big Society strategy could offer drug user in recovery more opportunities to volunteer and develop mutual aid/social enterprises; however they may yet again face barriers linked to the stigma of their substance misuse and past offences.

This section provides literature review findings with some local statistics. A local survey was also conducted between June and July 2010 to further explore need: the barriers; type of support drug treatment providers should provide; the support required from mainstream employment services; and at which stage of treatment.

Existing national research

Research findings outlined in the Drugscope's (2008) response to the welfare reform suggests that the main barriers to employment for problem drug users include literacy and numeracy problems, lack of educational and occupational qualifications, lack of work experience or interrupted work histories, CV gaps, requirements to disclose health problems and criminal records, fear of relapse and the need to renegotiate benefits if things go wrong, and restrictive pharmacy dispensing of substitute drugs like methadone. Organisational barriers include employer discrimination and ineffective links between drug and employment services. Drugscope sites a Scottish survey of employers that uncovered significant negative attitudes towards those with a history of substance use or those on a methadone programme: *"70 per cent were 'absolutely certain they would not employ someone on a methadone programme' (although one third said they would employ someone recovering from a substance misuse problem". (Drugscope:2008:5)*

A qualitative study by the National Centre for Social Research (Cebulla et al: 2004) on perceptions and readiness to employment highlighted the importance of staged re-introduction to employment and the joint working between services. The participants, both alcohol and drug users in or after treatment, recognised the importance of employment for their recovery with its material and social benefits. Motivation to work was there however drug users were more sceptical about whether a current user could hold down a job. Current or ex drug users job aspirations were relatively modest and realistic. Drug users were seeking to do vocational training and look for unskilled or semi-skilled manual work. Drug users were more likely than alcohol users to be concerned about employers' attitudes towards someone with their history. Being a qualitative study based on 30 participants it is not feasible to generalise this to Haringey treatment population. However, the study provides useful in-depth and contextual information on the drug users attitudes to work.

UK Drugs Policy Commission research report (2008) provided two specific recommendations for commissioners to improve employment: adequate volunteering, training and job placement opportunities, and friends and family support. The same report also cites studies on employers reluctance to employ someone with drug misuse history - only a quarter of employers would do this without reservations. While employers are more willing to support existing staff who have developed drug problems, the concerns in employing someone new include the risk of relapse, illicit use in the workplace, concerns about time lost while attending treatment, possible links to criminality and untrustworthiness. To tackle this the report recommends a universal risk assessment tool to be used by all employers. (UKDPC: 2008).

Problem drug users are often disadvantaged in other ways, by homelessness, offending history or for having mental health issues. Studies on other socially excluded groups are important too. For example, a study by the social Exclusion Unit found that fewer than four in ten employers would employ someone with mental health issues (ODPM:2004). A study by the Department of Work and Pensions states

that unemployment amongst certain groups with criminal record is very high (Metcalf, Anderson et al: 2001). Although it is likely that the lifestyle that comes with problem drug use, lack of qualifications, lack of literacy skills and other factors add to the cycle of disadvantage.

Add findings from the latest DWP report and pilot draft

Employability

Considering the employers attitudes and the degree of worklessness amongst problem drug users, the term 'employability' is a concept that warrants further inspection. For drug users basic employability skills can be lacking for the years spent outside working environments. CBI (Confederation of British Industry's) defines employability as "A set of attributes, skills and knowledge that all labour market participants should possess to ensure they have the capability of being effective in the workplace – to the benefit of themselves, their employer and the wider economy (CBI:2007:11)". The term also refers to less quantifiable and harder to learn skills that form an important part of someone's employment prospects. All jobs are different but different organisations, including CBI, have identified some universal attributes that are important for someone's success at obtaining and succeeding in employment. The diagram 3 illustrates the CBI's vision, developed in consultation with a large number of employers, of key competencies required for a job. Positive attitude is at the core of employability and underpins the other seven key competencies. This is also echoed by the by Learning and Skills Network whose study found that enthusiasm/commitment is on par with literacy, communication and numeracy skills as the four 'deal breakers' when assessing employability (Villeneuve-Smith: 2005). A recent survey conducted by the CIPD (Chartered Institute of Personnel and development) found that interpersonal skills and communication skills are most important when recruiting new employees (2009).

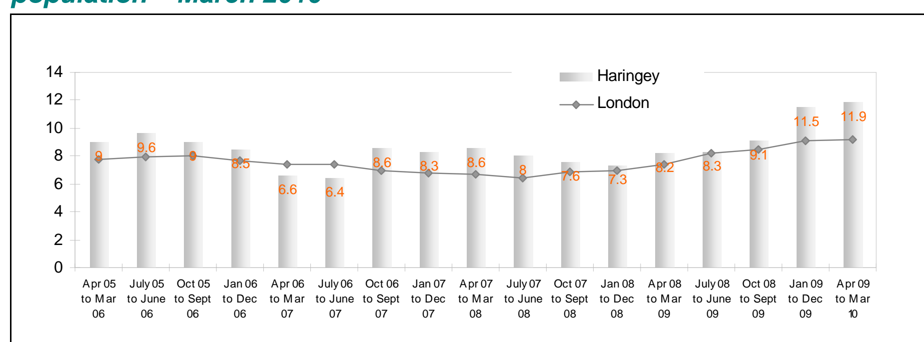
Diagram 3: Key employability attributes by CBI

Source: CBI 2007

Haringey profile

The trend in Haringey unemployment[1] shows a steady increase per 1000 population since 2008. The rate is currently higher than London for the latest 12 month period (11.9 and 9.2 respectively – per 1000 population). See chart 36. A large proportion of Haringey Council employees live locally and the cuts to the Council grant and inevitable redundancies is likely to impact these figures adversely. Haringey's incapacity benefit claimant rate due to mental illness is also higher than London, 24.40 per 1000 working age population in comparison to 32.60 in London[2].

Chart 36: Unemployment rate; Aged 16-64 Haringey and London April 2005 per 1000 population – March 2010



Source: Office of National Statistics

Employment status in local drug treatment population

A large number of people in drug treatment are unemployed or claiming work related benefits. In 2009-10, vast majority of Haringey treatment clients were unemployed (67%[3]). Only 15% reported regular employment or study. See chart 37.

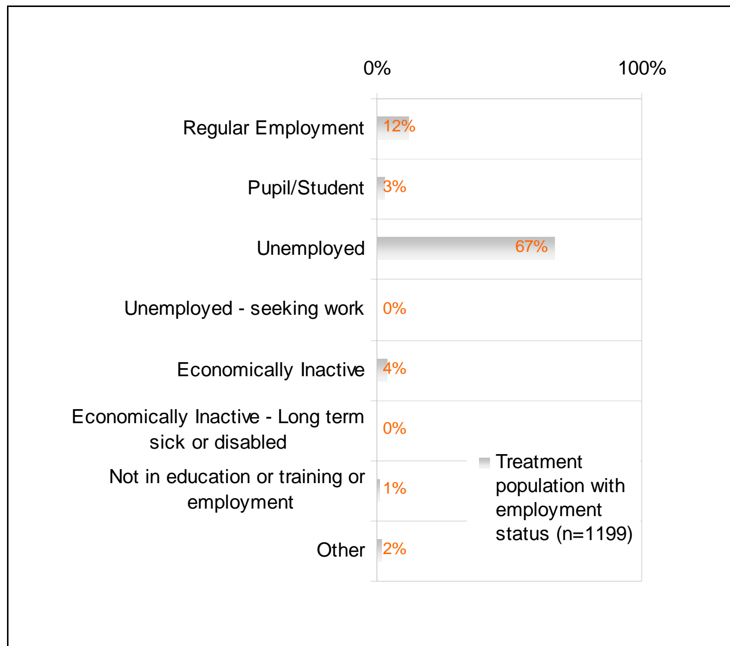
---

[1] These figures are statistical estimates that relate to measurement of worklessness. More specifically, the data includes information from the Annual Population Survey (information on the number and percentage of people who are employed, economically active, and economically inactive) and Model-based Unemployment Estimates (statistically modelled data, which show the number who are unemployed and the unemployment rate as a percentage of the economically active population (for more information go to www.statistics.gov.uk/default.asp)

[2] Source: Health Needs Assessment Toolkit available from: http://hna.csl.nhs.uk/

[3] 1199 out of 1349 had their employment status recorded. Values were missing from 11% of the records (n=150)

Chart 37: Employment status in drug treatment population. Haringey 2009-10



Source: National Drug Treatment Monitoring System

Similarly the treatment outcome tool data for the same period shows that at the start of treatment only 15 per cent had any paid work in the last 10 then days[1]. From the cohort who had a planned exit in 2009-10, the same proportion, 15 per cent, had had paid work in the last 10 days[2]. Only 10 per cent of clients with an unplanned exit had any paid work. TOP only records paid work however clients may have gained voluntary placements which arguably should count towards successful outcomes, especially in the current financial climate.

Department for Work and Pensions report in 2008 (DWP:2008) showed that a notable proportion of people on work related benefits are problem drug users. Table 17 shows the population estimates of problem drug users accessing welfare benefits in Haringey and percentages in comparison to London overall. Although Haringey prevalence seems slightly lower in comparison to London averages[3] the numbers highlight the need to include employment and skills development as a key priority and potential savings in the benefit bill since Haringey had estimated 2160 problem drug users claiming one or more main benefits.

[1] 90 out of 606 new clients in 2009-10 who had a TOP completed at the treatment start.
[2] The cohort is not an exact match of the treatment start cohort. Also the TOP data is either from exit TOP, and if it was not completed, data is from their latest completed TOP which could be their start TOP.
[3] No confidence intervals supplied with the data.

Table 12: Estimates of people on main benefits who are problem drug users in Haringey 2006-7

Type of benefit	Total no. of PDU benefit claimants	PDU % of all benefits claimants in Haringey	% of PDUs on main benefits in London
Job seekers allowance	530	6.78	9.43
Income support	1,180	7.07	9.20
Disability living allowance	200	3.28	3.39
Incapacity benefit	700	6.04	7.08
Main benefits[1]	2,160	7.22	9.02
Total PDUs	2690		

Source: Department of Work and Pensions (DWP) 2008

Kinesis findings from group sessions

Kinesis, the former local employment and training service for drug and alcohol users, conducted focus groups for their clients at the end stages in the service in 2006. The findings uncovered need to emphasise life skills from early stages of treatment. The issues raised in the groups were less about the lack of specific qualifications or work experience but more about confidence and skills relating to competencies people with more traditional education career trajectories and education might take for granted. Key support needs were about:

- Life management skills
- Adapting to new situations
- Dealing with triggers and challenges in a new situation, for example the nine to five routine
- Increasing self-respect and self-care, eg by paying attention to nutrition and doing exercise
- Building up confidence and self-esteem

Some of the key issues when starting training and getting back to employment were:

- Fear of not knowing how to perform in a new job
- Fear of the unknown
- Wanting to run away
- Fear of ‘Looking like an idiot’
- Lacking ‘people skills’
- Others not being friendly
- Not having the skills or enough experience

---

[1] For the purpose of this study a combined ‘main benefits’ group was constructed which referred to individuals in receipt of one (or more) of the following benefits: Disability Living Allowance (DLA); Incapacity Benefit (IB); Income Support (IS); Jobseeker’s Allowance (JSA); or Severe Disablement Allowance (SDA).

- Being judged
- Frustration about doing it wrong and failing.
- Fear of being forced into something
- Potential conflict of back-to-work model with recovery model which is about getting well in mind, body & soul. Holistic recovery-based activity such as Wheels of Recovery was sited as a good example

The support thought to be very helpful were:

- Regular as well as informal contact with Kinesis for updates how client were doing. It is important to be able to talk to someone if feeling anxious, having a contact for any concerns, anxieties, and both good and bad experiences
- Support to build up confidence and self esteem
- A support similar to 12-step programme that could be used to compare how you can make progress through a system and gradually move forward to resolve all the accumulated problems and baggage. It would be useful to adapt the 12-step process to build up confidence and self-esteem
- Creating personal strategies and building blocks to get to the point where one can move on
- Different time scales of support – short, medium & long term e.g. 1 months, 6 months, 1 year – all are crucial stages in sustaining and retaining employment
- Having a dedicated sponsor or mentor
- Well done, off you go' messages – it's important to acknowledge and celebrate transition and achievement
- The clients also pointed out that this was no quick fix situation and too much pressure at the beginning might jeopardise the clients progress. Some job agencies might put too much pressure on getting a job rather than finding out what you really want to do. Long term planning and support is helpful

Employment and skills survey

The main aim of the local survey conducted in June-July 2010 was to corroborate existing evidence outlined above and to test that evidence against the local client group. The questionnaire (see appendix 3) set out to explore: the level of employment related skills, abilities and confidence; the main barriers; specific support needs and the appropriate interventions, and current employment status and qualifications. The survey design was based on the literature review outlined above, existing Labour Force Survey (2009). It was developed together with the local employment forum which is represented by the Job Centre Plus, Drug Advisory Service Haringey, Eban, Haringey Guarantee, R.I.S.E (Resettlement. Independence. Stability. Enterprise) and Haringey Probation. The Department of Work and Pensions also added separate questions at the end of the questionnaire. The survey which received 51 responses was tested by service users at R.I.S.E.

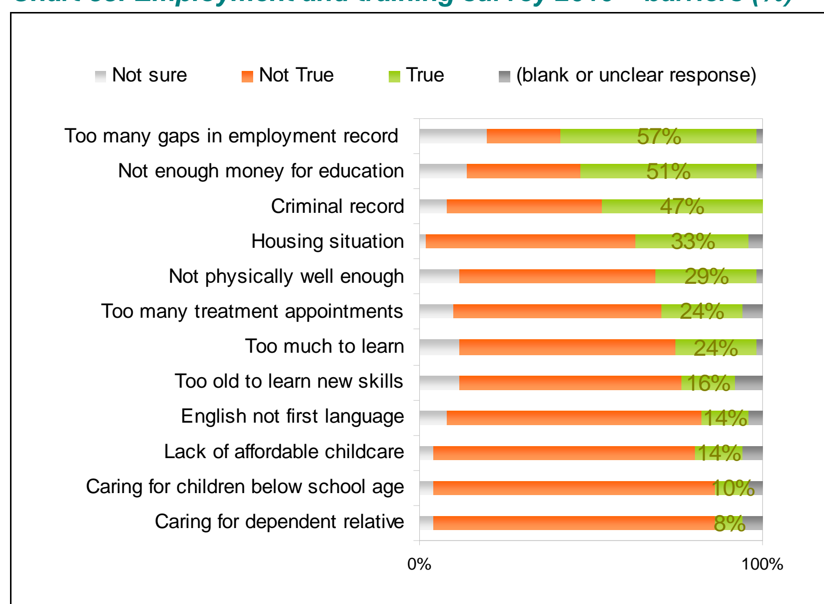
Barriers to employment

Gaps in employment record was a barrier for small majority (57%) of respondents (See chart 38). Half (51%) sited lack of money for education and a criminal record (47%). Many faced multiple barriers with vast majority (73%) listing more than two. For a third (33%), their housing situation posed a problem and for a quarter (24%) it was treatment appointments which restricted their employment prospects and the feeling that there would be too much learn before they could get the job they wanted.

Childcare and the caring of children or dependent relatives was an issue for a small minority but this may have been different if the ratio of women respondents was higher. English as a second language was a barrier for 14 per cent.

Free text comments mainly featured mental and physical health issues but a cost of rent, ageism, substitute prescribing appointments and a pressure from friends to continue with old lifestyle were mentioned.

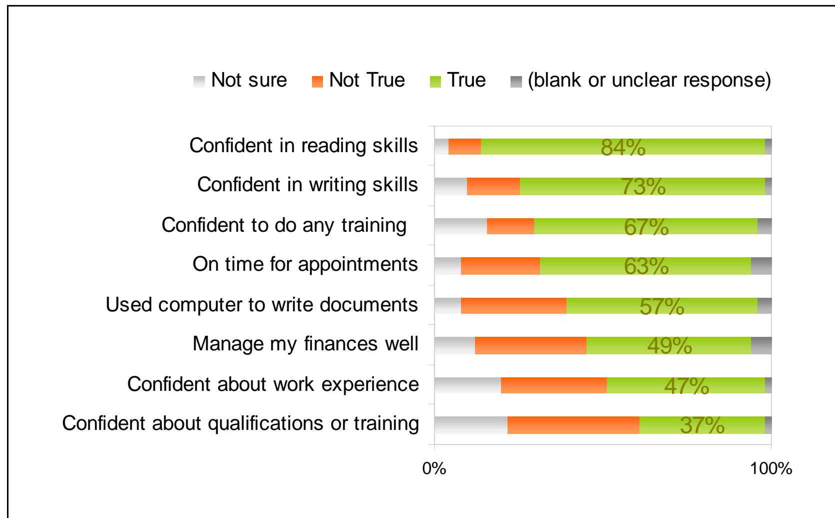
Chart 38: Employment and training survey 2010 – barriers (%)



Skills and abilities

Overall, the respondents self assessment of their skills and abilities was positive. Most were uncertain about their qualifications and training (61%). Half doubted their experience and the ability to manage their own finances. The confidence in reading (84%) and writing skills (73%) was there for a vast majority but this is likely to be skewed due to the survey format being a paper questionnaire.

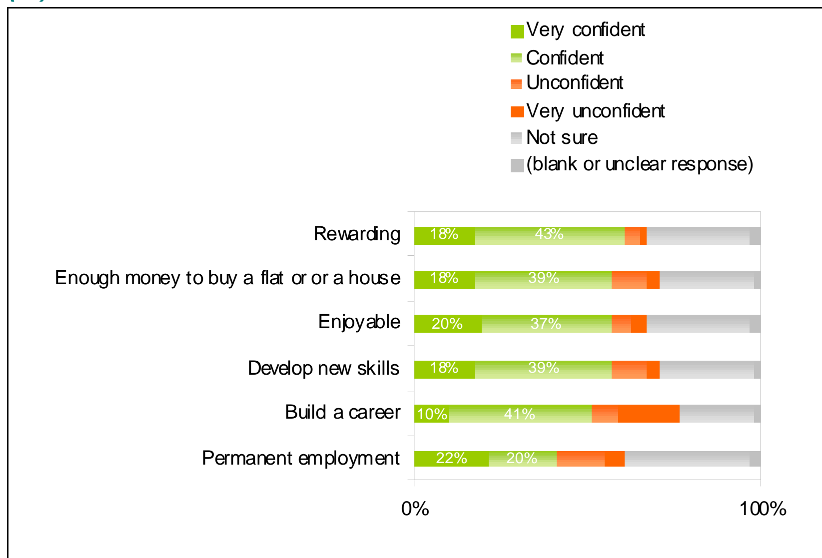
Employment and training survey 2010 – confidence in skills and abilities (%)



Confidence in future job prospects

A set of questions were included to measure the level of confidence respondents had in their future job prospects. More than half were confident or very confident about being able to find a job which was either enjoyable, rewarding, where they could develop new skills, build a career, and earn enough money to buy a flat. On the other hand they were least confident about gaining permanent employment. See chart 39.

Chart 39: Employment and training survey 2010 – confidence in future job prospects (%)



Support needs

Help with finding a job was required by a majority of respondents, especially career advice and applying for courses (61% and 63% respectively). More than half (55%) needed help with CVs. Computer skills training were required by most (57%). Writing and reading, numeracy, confidence building, English language support and business work skills was thought to be helpful by a large minority (see chart 40). Better access to voluntary and unpaid was seen as helpful by a small majority (57%), and a half (49%) believed access to part time work would be beneficial. Once in employment, majority thought regular contact from a professional and a mentor talk through any issues would be valuable.

For most questions around support needs around fifth of respondents were unsure what type of support would be helpful. This may indicate that they are unaware of the options available and what would help them individually thus further highlighting the need for career advice.

An open question was posed to provide the respondents an opportunity to encapsulate what they felt was the most important form of support. Some responses related to practical support such as start up money, travel pass, driving license, help with getting own tools, childcare and help with matching skills and experience to a particular job. Regular contact with a keyworker or a member of staff and peer mentors were also mentioned regularly. Training courses were also brought up several times. A few required emotional support such as confidence building, anger management and support from friends.

Chart 40: Support needs

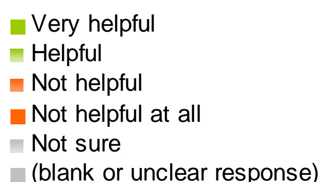


Chart 40.1: Job search support

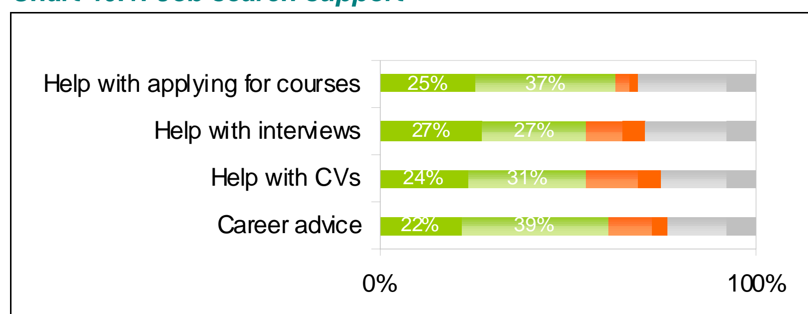


Chart 40.2: Skills and training support

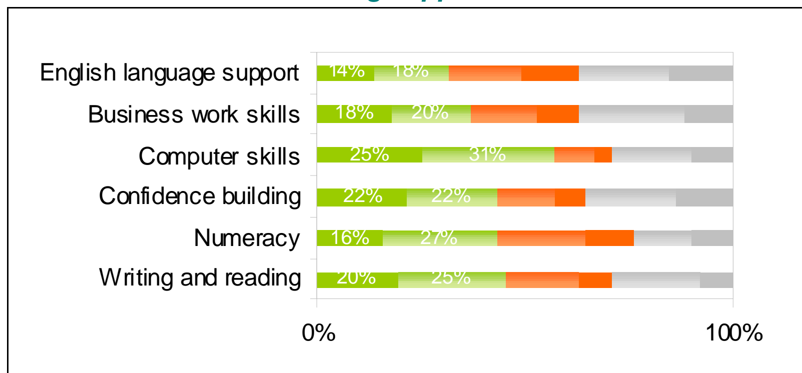


Chart 40.3: Flexible working and work experience

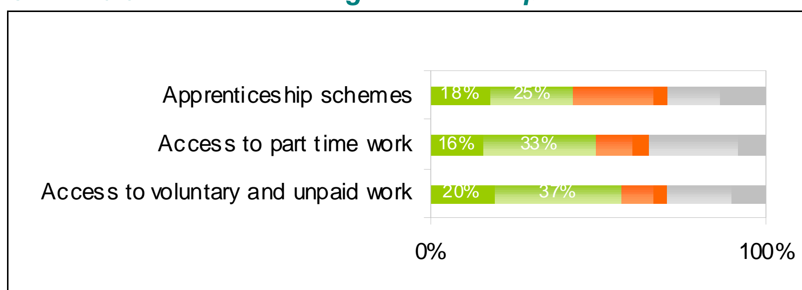
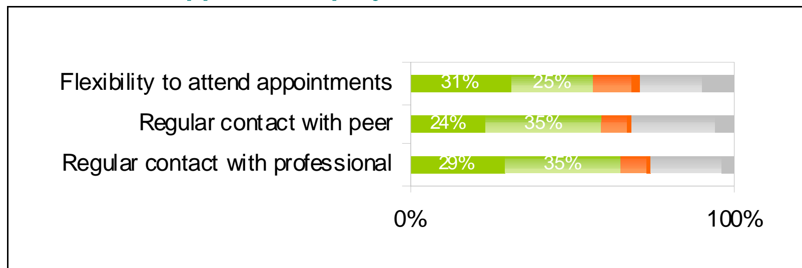


Chart 40.4: Support in employment



The timing of employment and training support

Opinions on when is the best time to start employment support varied from the start of treatment (24%) to end of treatment (20%) with most agreeing that the right time was different for each clients (35%). Only 4% thought it should start once clients were in aftercare, which supports the idea of employment support being offered in conjunction or as part of drug treatment and not after.

Current employment status and qualifications

Comparable to other datasets three quarters of respondents (75%) had not had any paid work in the previous week. 14% had never had any paid work. A fifth (18%) did not have any formal qualifications, but 14% did not respond to this question.

Majority (61%) were positive that they would work in the future; with around tenth considering the prospect of working was probable.

Profile of respondents

Most completed questionnaires were from DASH (30) and hence responses are weighted more towards their client group. Although a small sample, the responses came from a diverse groups broadly similar to the overall treatment population in 2009-10 by age and ethnicity groups (eg. 35% White British which is the same proportion as the overall treatment population). The gender ratio was also around the same as the overall treatment population (31% against 27%). The time in treatment also varied. Most used crack and opiates (45% and 43% respectively) followed by alcohol (39%).

Overview of local services

R.I.S.E is a local service for people aged 18 and over who are working towards being drug and alcohol free after treatment and looking for meaningful activity. They also provide access to social and vocational, training and volunteering opportunities. Cranstoun's Skills for Life Programme located in Islington offers a specialist education, work placement and employment service to people affected by drug and alcohol misuse. They offer career coaching, workshops (CV design, job searching, completing application forms, job interviews, psychometric testing and many more), training courses, social activities (such as gardening, cooking, health & fitness) and one to one support. R.I.S.E offers ETE introduction sessions in generic treatment services. During an 8 week pilot with JCP, Eban had in house sessions from a JCP advisor and it was noted that this was a major help for accessing employment.

Generic services

There are two Job Centre Plus offices in Haringey, located in Wood Green and Tottenham. Haringey Guarantee is a special local programme for Haringey residents currently not in employment and not in full-time education. The service assists residents overcome barriers to sustained employment and provide Information, advice & guidance and one-to-one sessions focussed supporting residents into sustained employment. Haringey Guarantee provides:

- One-to-one information, advice and guidance in returning to and remaining in work, delivered from various offices across the borough
- Benefits advice and how welfare benefits and working tax credits may be affected when starting work
- A full range Condition Management Programme available through the NHS
- Voluntary work placements with local employers and Haringey Council
- Access to other Council frontline services
- SIA Security training
- CSCS Card and Construction training
- Social Care Level 2 qualification
- Food Hygiene Level 2
- Guaranteed job interviews with local employers and Haringey Council
- In-work support and careers advice for up to 6 months

A full directory of local employment and training services is available from:
http://www.haringey.gov.uk/index/jobs_and_training.htm

THE COST OF DRUG USE AND THE BENEFIT OF TREATMENT - TO BE UPDATED

Awaiting for NTA's value for money tool

A Scotland based study estimated that vast majority (96%) of the total social and economic cost is attributed to problem drug use and only 4 % to recreational drug use (EMCDDA:2010).

Drug treatment does however reduce the impact and cost significantly. A recent study on Drug Treatment Outcomes Research study (DTORS) found that 'the net benefits of structured drug treatment were estimated to be positive, both overall and at the individual level in around 80 per cent of cases, with a benefit-cost ratio of approximately 2.5:1'(Davies et al:2009)[1]. Their estimate of the total net saving in health and social care services and offences in comparison to the cost of drug treatment over 51 week period per year was £7,301 for each problem user.

[1] Davies L, Jones A., Vamvakas G, Dubourg R. and Donmall M. (2009) *The Drug Treatment Outcomes Research study (DTORS): Cost-effectiveness analysis 2nd Edition*
Available from: www.homeoffice.gov.uk/rds/pdfs09/horr25c.pdf

Appendix 1 – Examples of typology of social costs of class A drug use

Group – Bearer of Cost	Examples of cost
Users	Premature death Loss of quality of life – mental and physical health; relationships; etc. Impact on educational achievement, training opportunities etc. Excess unemployment and loss of lifetime earnings
Families/carers	Impact on children of drug users Transmission of infections Intergeneration impact on drug use Financial problems Concern/worry for users Caring for drug users or drug users' dependants
Other individuals directly affected	Victims of drug driving; drug-related violence; drug related crime Transmission of infections from drug users
Wider community effects	Fear of crime
Environmental aspects of drug markets – needles, effects of drug dealing in community etc .	
Industry	Sickness absence Theft in the workplace Security expenditure to prevent drug-related crime Productivity losses Impact of illicit markets on legitimate markets
Public sector expenditure	Health care Criminal justice expenditure Social care services Social security benefits

(Source: Godfrey et al:2002:6)

Appendix 2 – Treatment Outcome Tool

Treatment Outcomes Profile

Client ID: ________ D.O.B. (dd/mm/yyyy): __ / __ / ____ Name of keyworker: ________

TOP interview date (dd/mm/yyyy): __ / __ / ____

Gender: M ☐ F ☐

Treatment stage: Treatment start ☐ Review ☐ Treatment exit ☐ Post-treatment exit ☐

Section 1: Substance use (Please use NA only if information is not disclosed or not answered.)

Record the average amount on a using day and number of days substances used in each of past four weeks

	Average		Week 4	Week 3	Week 2	Week 1	Total
a Alcohol		units/day	0–7	0–7	0–7	0–7	0–28
b Opiates		g/day	0–7	0–7	0–7	0–7	0–28
c Crack		g/day	0–7	0–7	0–7	0–7	0–28
d Cocaine		g/day	0–7	0–7	0–7	0–7	0–28
e Amphetamines		g/day	0–7	0–7	0–7	0–7	0–28
f Cannabis		spliffs/day	0–7	0–7	0–7	0–7	0–28
g Other problem substance?		g/day	0–7	0–7	0–7	0–7	0–28

Name……………………………

Section 2: Injecting risk behaviour (Please use NA only if information is not disclosed or not answered.)

Record number of days client injected non-prescribed drugs in past four weeks (If no, enter zero and 'N', and go to section 3)

	Week 4	Week 3	Week 2	Week 1	Total
a Injected	0–7	0–7	0–7	0–7	0–28

b Inject with needle or syringe used by someone else? Yes ☐ No ☐

c Inject using a spoon, water or filter used by someone else? Yes ☐ No ☐

Enter 'Y' if any yes, otherwise 'N'

Section 3: Crime (Please use NA only if information is not disclosed or not answered.)

Record days of shoplifting, drug selling and other categories committed in past four weeks

	Week 4	Week 3	Week 2	Week 1	Total
a Shoplifting	0–7	0–7	0–7	0–7	0–28
b Drug selling	0–7	0–7	0–7	0–7	0–28

c Theft from or of a vehicle Yes ☐ No ☐

d Other property theft or burglary Yes ☐ No ☐

e Fraud, forgery and handling stolen goods Yes ☐ No ☐

Enter 'Y' if any yes, otherwise 'N'

f Committing assault or violence Yes ☐ No ☐ Enter 'Y' or 'N'

Section 4: Health and social functioning (Please use NA only if information is not disclosed or not answered.)

a Client's rating of psychological health status (anxiety, depression and problem emotions and feelings)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good 0–20

Record days worked and at college or school for the past four weeks

	Week 4	Week 3	Week 2	Week 1	Total
b Days paid work	0–7	0–7	0–7	0–7	0–28
c Days attended college or school	0–7	0–7	0–7	0–7	0–28

d Client's rating of physical health status (extent of physical symptoms and bothered by illness)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good 0–20

Record accommodation items for the past four weeks

e Acute housing problem Yes ☐ No ☐ Enter 'Y' or 'N'

f At risk of eviction Yes ☐ No ☐ Enter 'Y' or 'N'

g Client's rating of overall quality of life (e.g. able to enjoy life, gets on well with family and partner)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good 0–20

© National Treatment Agency for Substance Misuse, 2007

TOP v1.1 August 2008

Appendix 3 – Employment, training and education questionnaire

JOBS, SKILLS AND TRAINING
SERVICE USER EMPLOYMENT QUESTIONNAIRE

Introduction

This questionnaire is for people in drug or alcohol treatment in Haringey. The main purpose is to find out about the key support needed to improve your employment opportunities. The aim is to identify the barriers to employment and how to overcome issues that may stop people from getting back to work or staying in employment.

The questionnaire has two parts. Part 1 – Employment and training needs and support - is divided into eight sections, all of which start with a short description of what the questions are for. Part 2 – Drug and Alcohol use and Jobcentre Plus (page 11) - is only for service users who are currently claiming work related benefits, or have claimed them at any point in the past. The aim of part 2 is for the Jobcentre Plus to find out more about why you have or have not disclosed your drug use to Jobcentre Plus and what would encourage you to do so. This is to make sure Jobcentre plus can offer everyone the support available to them.

It should take you around 30 minutes to complete the questionnaire.

How will the information be used

The information in part 1 will be processed and analysed by the Drug and Alcohol Action Team, who fund the drug and alcohol treatment services in Haringey. The findings will be used in our employment and skills support plan. To find out about the key findings and what happens next, the summary report will be available in your treatment agency by Dec 2010. Or you can contact the DAAT team on 020 8489 6909 or email mia.moilanen@haringey.gov.uk. Part 2 was designed by the Department of Work and Pensions and the data is analysed by their research department.

The more responses we get the more reliable the information will be. Your answers are very useful and will help us to make services better for you. **Please note that completing this questionnaire is entirely voluntary**. You do not have to answer any of the questions if you do not want to.

Confidentiality

All responses will be treated as confidential and in accordance with the Data Protection Act (1998). No individual questionnaire responses or data will be passed on to other agencies. The overall analysis of the information will be included in final reports and used only for the purposes stated above. If you need help to complete this questionnaire from a member of staff at the treatment service, the existing confidentiality agreement between you and the service applies. They will not pass any of the information you have given on to a third party.

Please leave the completed questionnaire in the designated box located at the reception of your treatment agency.

1. Skills and abilities

This section lists some of the key skills and abilities which can be useful for getting a job. The aim is to find out how you feel about your own skills and abilities.

Please **tick √ one box in each row** that shows if the statement is true or not.

	True	Not true	Not sure
I am confident in my writing skills	☐	☐	☐
I am confident in my reading skills	☐	☐	☐
I have used the internet to find information about jobs	☐	☐	☐
I can use a computer to write documents	☐	☐	☐
I generally manage my finances well and know roughly my weekly or monthly budget	☐	☐	☐
I am usually on time for appointments	☐	☐	☐
I feel confident that I have the qualifications or training to get a job I want	☐	☐	☐
I feel confident that I have the work experience to get a job I want	☐	☐	☐
I feel confident to do any training I need to get a job	☐	☐	☐

2. Barriers to employment

This section is about barriers or issues that may prevent you from getting work.

Please **tick √ one box in each row** that shows if the statement is true or not.

	True	Not true	Not sure
Lack of affordable childcare stops me from getting employment or going back to education or training	☐	☐	☐
I feel that I am too old to learn new work skills	☐	☐	☐
I feel that I have too much to learn before I can get the job I want	☐	☐	☐
I feel that my chances for getting a job are limited since English is not my first language	☐	☐	☐
I don’t have enough money to go back to education or training	☐	☐	☐
My housing situation affects my ability to get a job	☐	☐	☐
I find it difficult to look for work since I care for children below school age	☐	☐	☐

Barriers to employment (continued from the previous page)

Please **tick √ one box in each row** that shows if the statement is true or not.

	True	Not true	Not sure
I find it difficult to look for work since I care for a dependent adult relative	☐	☐	☐
I think my criminal record affects my ability to get a job	☐	☐	☐
I have too many gaps in my employment record	☐	☐	☐
I don't feel physically well enough to work	☐	☐	☐
I have too many treatment appointments to get a job	☐	☐	☐

Other barriers or issues: (Please write down what they are in the box below)

3. Your confidence regarding work

This section asks **how confident you feel** about your chances regarding work opportunities.

Please rate your chances of getting:
(Please **tick √ one box in each row** depending on how confident or unconfident you feel)

	Very confident	Confident	Not sure	unconfident	Very unconfident
a job that that gives you permanent employment?	☐	☐	☐	☐	☐
a job where you can develop your skills?	☐	☐	☐	☐	☐
a job where you can build a career?	☐	☐	☐	☐	☐
a job that you enjoy, at least partly?	☐	☐	☐	☐	☐
a job that you find rewarding, at least partly?	☐	☐	☐	☐	☐
a job which gives you enough money to buy a flat or a house?	☐	☐	☐	☐	☐

4. Support needs

This section asks about general employment support needs. Below is a list of services that may help you to get or keep a job.

Please rate how helpful or unhelpful they are by **ticking** √ **one box in each row**.

4.1 Job search support	**Very helpful**	**Helpful**	**Not sure**	**Not helpful**	**Not helpful at all**
Career advice to help you identify a job best suited to you	☐	☐	☐	☐	☐
Help with completing CVs and job application forms	☐	☐	☐	☐	☐
Help with preparing for interviews	☐	☐	☐	☐	☐
Help with applying for courses or training	☐	☐	☐	☐	☐

Other (please specify on the line below):

___

4.2 Skills and training support	**Very helpful**	**Helpful**	**Not sure**	**Not helpful**	**Not helpful at all**
Writing and reading	☐	☐	☐	☐	☐
Numeracy	☐	☐	☐	☐	☐
Confidence building	☐	☐	☐	☐	☐
Computer skills	☐	☐	☐	☐	☐
Business work skills	☐	☐	☐	☐	☐
English language support	☐	☐	☐	☐	☐

Other (please specify on the line below):

___

4.3 Flexible working and work experience	**Very helpful**	**Helpful**	**Not sure**	**Not helpful**	**Not helpful at all**
Better access to voluntary work or unpaid work experience	☐	☐	☐	☐	☐
Access to part-time work	☐	☐	☐	☐	☐
Apprenticeship schemes	☐	☐	☐	☐	☐

Other (please specify on the line below):

___

4.4 Support once in employment	**Very helpful**	**Helpful**	**Not sure**	**Not helpful**	**Not helpful at all**
Regular contact with a professional to talk through any issues regarding your employment	☐	☐	☐	☐	☐
Regular contact with a peer or a mentor to talk through any issues regarding your employment	☐	☐	☐	☐	☐
Flexibility from employer to attend treatment appointments	☐	☐	☐	☐	☐

Other (please specify on the line below):

____

4.5 If you had to choose only one form of support to help you get a job, what would that be?

Please write down in the box below. If **you are already working please leave this box blank.**

4.6 If you had to choose only one form of support to help you stay in your current job, what would that be?

Please write down in the box below. If you are **not** currently working please leave this box blank.

5. The timing of employment and training support

This section seeks information about the appropriate timing of employment support when people are in drug or alcohol treatment.

At what stage of drug or alcohol treatment do you think employment and training needs should be discussed for the **first** time between the client and the key worker?

Please **tick** √ **only one box**.

- ☐ At the beginning of treatment when a care plan[1] is being developed
- ☐ In the first care plan review (normally after three months from treatment start)
- ☐ Once the person is about to finish treatment
- ☐ Once client is in an aftercare service[2]
- ☐ The right time is different for each client
- ☐ Other (Please specify): ______________________________

6. Current employment, qualifications and skills status

Questions in this section seek information about your current employment status and qualifications.

6.1. Did you do any paid work in the last week 7 days ending last Sunday either as an employee or as self-employed?

- ☐ Yes
- ☐ No

6.2. Have you ever in your life had paid work, apart from casual or holiday work or the job you are waiting to begin? Please include self-employment or government schemes.

- ☐ Yes
- ☐ No

---

[1] 'a care plan' is a plan all clients in drug or alcohol treatment should have. It normally includes clients overall treatment goals, and the types of support they will have during treatment.

[2] Aftercare service is where clients are normally referred to after they complete treatment for additional support

6.3. Thinking of the 4 weeks ending last Sunday were you looking for any kind of paid work at any time in those 4 weeks?

☐ Yes

☐ No

6.4. In the four weeks ending Sunday did you do any of these job search activities?

Please **tick** √ **all that apply**:

☐ visit a Jobcentre/Jobmarket or Training and Employment Agency Office

☐ visit a Careers Office

☐ visit a Jobclub

☐ have your name on the books of a private employment agency

☐ answer advertisements in newspapers, journals or on the internet

☐ study situations vacant columns in newspapers, journals or on the internet?

☐ apply directly to employers

☐ ask friends, relatives, colleagues or trade unions about jobs

☐ wait for the results of an application for a job

☐ do anything else to find work (Please state what you did below)

____

6.5. Do you have qualifications from:

Please **tick** √ **all that apply.**

☐ school, college or university?

☐ training or courses connected with work?

☐ government schemes?

☐ an apprenticeship scheme?

☐ having been educated at home, when you were of school age?

☐ I have no formal qualifications

☐ I don't know if I have any qualifications

☐ other (Please specify): ______________________________

6.6. Do you think you will work in the future?

Please **tick** √ **only one box**.

- ☐ Definitely will work in the future
- ☐ Probably will work in the future
- ☐ Probably not work in the future
- ☐ Definitely not work in the future
- ☐ Don't know / Can't say

7. Any other comments on employment and skills support

Please write down any other issues regarding employment, skills and training that you think are important.

8. About you

This final section asks some questions about you, for example, your age and ethnicity, the time you have been in drug or alcohol treatment and your first drug of choice. The purpose of this is to ensure that we have responses from a wide range of people. This in turn helps us to ensure that services are designed for a wide range of people. It also helps to identify how support needs may differ between different groups. For example, clients who have recently started treatment may have different support needs in comparison to those who have been in treatment for longer. These questions are **not** used to identify you as a person.

8.1. How long have you been in drug or alcohol treatment? If you have been in treatment before please state the length of your latest treatment period. Please **tick** √ **only one box**.

- ☐ Less than three months
- ☐ Three to six months
- ☐ Between six months to a year
- ☐ Over a year
- ☐ Over two years
- ☐ Not sure/Can't say

8.2. Are you male or female? Please **tick** √ **only one box**.

- ☐ Male
- ☐ Female

8.3. What is your age group? Please **tick** √ **only one box**.

- ☐ 18-24
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55+

8.4. Do you consider yourself to be a disabled person? Please **tick** √ **only one box**.

- ☐ Yes
- ☐ No
- ☐ Not sure

8.5. What do you consider to be your ethnicity group? Please **tick √ only one box.**

White
- ☐ British
- ☐ Greek Cypriot
- ☐ Eastern European
- ☐ Kurdish
- ☐ Other White (Please specify): ____________________
- ☐ Irish
- ☐ Turkish Cypriot
- ☐ Turkish
- ☐ Other European (Please specify): ____________________

Asian
- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ East African Asian
- ☐ Any other Asian (Please specify): ____________________

Black or Black British
- ☐ Black British
- ☐ Black Caribbean
- ☐ Black African
- ☐ Any other Black (Please specify): ____________________

Mixed
- ☐ White and black African
- ☐ White and Black African
- ☐ Any other Mixed (Please specify): ____________________

Chinese or any other
- ☐ Chinese
- ☐ Any other ethnic group (Please specify): ____________________

8.6. What drug(s) did you/do you currently use on a regular basis?
Please **tick √ all that apply.**

- ☐ Alcohol
- ☐ Amphetamines
- ☐ Benzos
- ☐ Cocaine
- ☐ Crack
- ☐ Heroin
- ☐ Other opiates
- ☐ Cannabis
- ☐ Methamphetamine
- ☐ Other (Please specify): ____________________

Thank you very much for completing the part 1. If you are currently claiming or have claimed benefits please continue to next page. Please leave the completed questionnaire in the designated box located at the reception of your treatment agency.

9. Drug and Alcohol use and Jobcentre Plus

This final part of the survey is for service users who are **currently claiming benefits**, or **have claimed them at any point in the past**.

The aim is to find out more about why you have or have not disclosed your drug or alcohol use to Jobcentre Plus and what would encourage you to do so. When an individual discloses their drug or alcohol use to the Jobcentre it enables Jobcentre staff to direct them to the specific programmes and additional assistance that is available to them.

All responses will be treated as confidential and in accordance with the data protection act. **Your benefits will not be affected in any way**.

The responses to this survey will be compiled into a report, which will be made available to you through your treatment provider. No one will be able to identify you from this report Please leave this survey with your treatment provider once you have completed it.

9.1. Do you now, or have you in the past, claimed benefits from Jobcentre Plus?

Please **tick** √ **only one box**.

☐ Yes – now

☐ Yes – in the past but not now

☐ No – never

9.2. If **yes**, which benefit(s) do you/did you claim?

Please **tick** √ **all that apply**

☐ Jobseeker's Allowance (JSA)
☐ Incapacity Benefit (IB)
☐ Employment and Support Allowance (ESA)
☐ Income Support (IS)
☐ Disability Living Allowance (DLA)
☐ Severe Disablement Allowance (SDA)
☐ Other (Please specify): ____________________

9.3. Have any/did any Jobcentre staff ever ask you if you were using drugs or alcohol?

☐ Yes
☐ No

9.4. Have you disclosed / did you disclose your drug or alcohol use to the Jobcentre?

☐ Yes
☐ No

9.5. If **yes**, why did you disclose your drug or alcohol use? Please **tick** √ **all that apply**

☐ Personal adviser asked me and I wanted to be honest
☐ Wanted to access employment services for drug or alcohol users eg. progress2work or progress2work-LinkUP
☐ Needed to explain why I missed an appointment
☐ Needed to explain why I couldn't do certain kinds of jobs
☐ Other (Please specify in the box below):

9.6. If **no**, why have you/did you not disclose your drug or alcohol use? Please **tick** √ **all that apply**

☐ Personal adviser never asked
☐ Worried it might affect my benefits
☐ Lack of privacy in the Jobcentre – worried other people might overhear
☐ Worried the Jobcentre might tell the police
☐ Worried I might lose my children if the Jobcentre told social services
☐ Worried about being stigmatised by Jobcentre staff
☐ Other (Please specify in the box below):

9.7. What do you think would encourage you or other drug or alcohol users to disclose your drug use? Please **tick √ all that apply**

- ☐ More privacy in the Jobcentre
- ☐ Assurance that the Jobcentre won't pass this information on eg. to police and social services
- ☐ Greater awareness of the support Jobcentre Plus can give drug or alcohol users eg. special employment schemes for stabilised users
- ☐ Greater flexibility for drug or alcohol users eg. if on Jobseekers Allowance (JSA) not having to sign-on every fortnight, or being able to sign on at your treatment provider's building
- ☐ Other (Please specify in the box below):

9.8. Do you have any other comments about the issue of disclosing drug or alcohol use to Jobcentre Plus?

Thank you very much for completing the questionnaire.
Please leave the completed questionnaire in the designated box located at the reception of your treatment agency.

Reference

Bancroft A. Wilson S. et al (2004) *Parental drug and alcohol misuse: Resilience and transition among young people.* Joseph Rowntree Foundation. Available from: www.jrf.org.uk/bookshop/eBooks/1859352499.pdf (Last accessed 6 Jan 2009)

Bauld L. Hay G.(2008) *Population estimates of problematic drug users in England who access* DWP benefits: A feasibility study Paper No 46. DWP. Available from: *http://research.dwp.gov.uk/asd/asd5/WP46.pdf*

Cavanagh S. Chadwick K. (2005) *Health needs assessment: A practical guide*. NICE. Available from: www.nice.org.uk/media/150/35/Health_Needs_Assessment_A_Practical_Guide.pdf

CBI (2007) *Time well spent: Embedding employability in work experience.* CBI Available from: http://www.cbi.org.uk/pdf/timewellspent.pdf

Cebulla et al. (2004) *Returning to Normality: Substance Users' Work Histories and Perceptions of Work* in Br J Soc Work.2004; 34: 1045-1054

CIPD (2009) *Annual survey report 2009: Learning and development.* CIPD. Available from: http://www.cipd.co.uk/NR/rdonlyres/FFC9C11E-20A6-4E30-9F50-8E58BC9FFA1B/0/Learnanddevsur2009.pdf

Davies L, Jones A., Vamvakas G, Dubourg R. and Donmall M. (2009) *The Drug Treatment Outcomes Research study (DTORS):* Cost-effectiveness analysis. 2nd Ed. Home Office Research Report. London: Home Office.Available from: www.homeoffice.gov.uk/rds/pdfs09/horr25c.pdf

ECMDDA (2010) *The state of the Drugs Problem in Europe. Annual Report 2010*. Luxemburg: European Monitoring Centre for Drugs and Drug Addiction. Available from: http://www.emcdda.europa.eu/publications/annual-report/2010

Daddow, R, Broome, S. (2010) Whole person recovery: A user-centred systems approach to problem drug use. London. RSA. Available from: http://www.thersa.org/projects/whole-person-recovery

Department for Work and Pensions (2008) Government Office Region tables in the '*Population estimates of problematic drug users in England who access DWP benefits: A feasibility report'*. DWP Working Paper No 46.

Drugscope (2008) *Welfare Reform and Problem Drug Use: Briefing Note* . Available from: http://www.drugscope.org.uk/OneStopCMS/Core/CrawlerResourceServer.aspx?resource=E7E5C417-6E90-4C7E-A400-E860B51DB04D&mode=link&guid=985dc75ae9b3430bb646a01be4a3078d

ECMDDA (2010) *The state of the Drugs Problem in Europe. Annual Report 2010*. Luxemburg: European Monitoring Centre for Drugs and Drug Addiction. Available from: http://www.emcdda.europa.eu/publications/annual-report/2010

Godfrey, C., Eaton, G., McDougall, C. and Culyer, A. (2002) *The economic and social costs of Class A drug use in England and Wales, 2000.* Home Office Research Study 249. London. Home Office. Available from: www.homeoffice.gov.uk/rds/pdfs2/hors249.pdf

Gorin S. (2004) *Understanding what children say about living with domestic violence, parental substance misuse or parental health problems.* Joseph Rowntree Foundation. Available from: www.jrf.org.uk/bookshop/details.asp?pubID=599. (Last accessed 6 Jan 2009)

GSR (2007) *The Magenta Book: guidance notes for policy evaluation and analysis.* Government Social Research Unit. Available from: http://www.gsr.gov.uk/downloads/magenta_book/Chap_1_Magenta.pdf

Haringey Council (2009) Borough key statistics: Ethnicity Birthplace and religion. Available from: http://www.haringey.gov.uk/index/news_and_events/fact_file/statistics/census_statistics/census_statistics_keystats/keystats_borough.htm#ethnicity)

Haringey Council (2008) *Towards Joint Strategic Needs Assessment in Haringey: The core dataset August 2008*. Available from: http://www.haringey.gov.uk/jsna_executive_summary_and_chapter_1_introduction.pdf

Haringey Council (2010) *Facts and figures: Statistics.* Available from: http://www.haringey.gov.uk/index/news_and_events/fact_file.htm

Haringey Community Safety Team (2010) *Haringey Strategic Assessment.* Haringey Council. Unpublished.

Haringey DAAT (2010) *Adult drug treatment plan 2010-11 Part 1: Strategic summary, needs assessment and key priorities.* Available from: http://www.haringey.gov.uk/index/community_and_leisure/crime_reduction/drugs_and_alcohol_action_team.htm

Hay G, Gannon M. et al. (2010). *Estimates of the prevalence of opiate use and/or crack cocaine use (2008/09) London Region.* Home Office. Available from: http://www.nta.nhs.uk/uploads/ln[0].pdf
(Last accessed: 27 Oct 2010)

HM Government (2010) *Drug strategy 2010 Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life*. Home Office. Available from: www.homeoffice.gov.uk/drugs/drug-strategy-2010

Hooper and Longworth (2002) cited in Effective Interventions Unit (2004) *Needs assessment: a practical guide to assessing local needs for services for drug users.* Edinburgh: Scottish Executive Effective Interventions Unit, Substance Misuse *Available from:* http://www.scotland.gov.uk/Resource/Doc/26487/0013530.pdf

Klynman, N (2010) *Mental Health Needs Assessment*. NHS Haringey. Available from: http://www.haringey.gov.uk/mental_health_needs_assessment.pdf

London Health Observatory (2006) *Women drug users in London: an investigation into prevalence, drug using patterns and treatment issues*. LHO. Available from: 2006http://www.lho.org.uk/Download/Public/11245/1/London%20women%20report%20final.doc

Marmot M. et al :2010 *The Marmot Review : Strategic Review of Health Inequalities in England post-2010. Executive Summary.* Available from : www.ucl.ac.uk/marmotreview

Metcalf H., Anderson T. and Rolfe H. (2001) *Barriers to employment for offenders and ex-offenders* (DWP Research Report No 155) Leeds: CDS

Millar T. Jones A. et al (2008) Changes in offending following prescribing treatment for drug misuse Research briefing: RB35 NTA.

Mills K et. al. (2007) *Beyond Boundaries: offering substance misuse services to new migrants in London.* University of Hertfordshire.

Ministry of Justice (2010) *Compendium of reoffending statistics and analysis: Ministry of Justice Statistics bulletin.* Ministry of Justice. Available from: http://www.justice.gov.uk/compendium-reoffending.htm

NTA (2009) *Annual Report 2008-9*. NTA. Available from: http://www.nta.nhs.uk/publications/documents/nta_annual_report_08-09_(2).pdf

NTA (2010) *Drug Treatment 2009-10 in the London Region (NDTMS).* London. NTA. Available from:
www.nta.nhs.uk/uploads/lo.pdf

NTA (2006) Models of care for treatment of adult drug misusers: Update 2006. NTA

NTA (2007) *Needs assessment guidance for adult drug treatment.* Available from: www.nta.nhs.uk/areas/treatment_planning/docs/nta_needs_assessment_guidance.pdf. (Last accessed: 15 Jan 2008)

NTA (2009) Towards Successful Treatment Completion. NTA London www.nta.nhs.uk/publications/documents/completions0909.pdf

NTA (2009) *Undertaking needs assessment: Drug treatment - Recovery and reintegration in the community and prisons.* NTA . Available from: www.nta.nhs.uk/areas/treatment_planning/treatment_plans_2010_11/needs_assessment_2010_11.pdf. (Last accessed: 16 Sept 2009)

NTA (2009). *Breaking the Link: The role of drug treatment in tackling crime*. London: National Treatment Agency for Substance Misuse.

NTA (2010) *Crack use in London: Analysis of the National Drug Treatment System (NDTMS) and other data sources.* London: National Treatment Agency for Substance Misuse.

ODPM (2004) Mental Health and Social Exclusion: Social Exclusion Unit Report. (now Communities and Local Government). Office of Deputy Prime Minister. Available from:
http://www.communities.gov.uk/publications/corporate/mentalhealth

Royal Society of Arts (2007) Drugs – facing facts: The report of the RSA Commission on Illegal Drugs, Communities and Public Policy. Available from: *www.rsadrugscommission.org*.

Seddon T. (2000). Explaining the Drug–Crime Link: Theoretical, Policy and Research Issues. *Journal of Social Policy,* 29 , pp 95-107

UKDPC (2008) *Working towards recovery: Getting problem drug users into jobs.* UK Drugs Policy Commission. Available from:
http://www.ukdpc.org.uk/resources/Working_Towards_Recovery.pdf

Villeneuve-Smith F. (2008) *Employablity Skills Explored:.* Learning and Skills Network presentation. Learning and Skills Council. Available from:
http://www.lsneducation.org.uk/files/EmployabilityWriteUp.ppt

Webster M. O'Connor W et. al. (2009) *The Drug Treatment Outcomes Research Study (DTORS):Qualitative Study.* Available from:
http://www.homeoffice.gov.uk/rds/pdfs09/horr26c.pdf