

WALTHAM FOREST DRUG ACTION TEAM
SUBSTANCE MISUSE NEEDS ASSESSMENT
STRATEGIC SUMMARY
JANUARY 2008



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1. INTRODUCTION

- 1.1 Waltham Forest is an outer London borough with a projected population of some 226,000. Chingford lies to the north of the borough, the central area is Walthamstow and to the south are the areas of Leyton and Leytonstone.
- 1.2 National Insurance registrations reveal that a number of transient communities are arriving in the borough at a rapid rate. Local research, carried out by the Council and the PCT in 2007, suggests that migration into the borough by Eastern European (A8) nationals has been very high and has resulted in an additional 21,000 residents, not accounted for in the official population projection.
- 1.3 The borough has not shared fully in London's economic prosperity. Regional growth industries have not developed at the same pace in Waltham Forest as they have done elsewhere. The borough suffers from a skills deficit and is poorly represented in the higher employment groups. Low skilled residents tend to be concentrated in the centre and south of the borough.
- 1.4 Ethnic and religious diversity are key features of the borough and the Black and Minority Ethnic (BAME) population proportion is set to grow over the next 10 years. Importantly, there is an unequal spatial distribution across the three areas of the borough. Essentially the north has an older, less ethnically diverse population whilst the south has a younger very ethnically diverse population. The central area is characterised as a mixed area with wards offering clusters of one or two of the main BAME groups found in the borough.
- 1.5 BAME communities continue to experience various forms of social inequality. Life expectancy is lower in the centre and south of the borough than it is in the north. Regional data for diabetes and coronary heart disease suggest poorer health outcomes for people from Asian and Black African background. Similar patterns could be expected in Waltham Forest. Furthermore, in the period 2003-2006 performance by all BAME groups at GCSE level indicates that they are attaining lower grades than the same ethnic groups across London as a whole and, with the exception of Chinese children, the gap is greater than it is for white children.
- 1.6 Although in the period 2000-2005 there was a significant decrease in the number of households accepted as homeless, the vast majority of existing homeless households are still from BAME communities. Spatially this is significant because BME communities tend to be located in far higher numbers in the south and centre of the borough than in the north. The

centre and the south of the borough are also characterised by a higher churn than the north. This is likely to be exacerbated by the coming of the Olympics to the south of the borough as it is anticipated that this area will become home to an influx of people involved in the construction of the Olympic Park. Being an Olympic Borough will bring direct investment, including the redevelopment of the Eton Manor area, and additional benefits include allocations to the new housing in the Olympic Village, as well as volunteering, training and employment opportunities, particularly in construction at the new facility in Leyton. However, the new populations this development will bring, including temporary and permanent residents from diverse backgrounds, will require accessible and targeted services, publicity of services and outreach.

- 1.7 Residents in the south and the centre of the borough are also likely to suffer from higher levels of crime because crime is more spatially concentrated in those areas of the borough.

2. PURPOSE AND DIRECTION OF OUR STRATEGY

- 2.1 The Council and other strategic partners are presently engaged in fulfilling their obligations concerning the place-shaping agenda as set out the recent White Paper (“Strong and Prosperous Communities”). The place-shaping process involves a focus on developing the economic, social and environmental well-being of the local community and the local area, and it is in this strategic context that our local drug strategy sits.
- 2.2 The vision for a sustainable community in the borough is characterised around three cornerstone principles:
 - The need to reduce risks and inequalities foreseeable in the borough’s projected future demographic profile;
 - The need to increase residents’ prospects for generating wealth, and;
 - The need to ensure that those with the economic power to move out of the borough choose to remain.
- 2.3 The vehicle for putting into place actions necessary to achieve the borough’s preferred sustainable community scenario is our Local Area Agreement.
- 2.4 Our drug strategy complements these cornerstone principles in that it aims to ensure a sustainable reduction in drug-related harm. Specifically it seeks to ensure that: fewer people develop drug problems; that we can intervene early to prevent and reduce harms caused by drugs to those most at risk; that those who do have drug problems receive the effective

- treatment and support they need; and that communities are relieved of drug-related crime and anti-social behaviour.
- 2.5 We consider effective drug treatment for those that need it is seen as the most evidence-based way of reducing demand for illegal drugs. As such it is therefore integral to improving health and well being of users and their families, including children, as well as to tackling drug-related crime and anti-social behaviour.
 - 2.6 We will target drug treatment at drug-using offenders and drug users who are parents as well as those people with drug problems who self-refer to services. We will also seek to develop alternatives to specialist treatment provision for those whose drug of choice is cannabis.
 - 2.7 Treatment will be delivered through three high-quality service hubs offering access to treatment. Each service hub will specialise in a particular aspect of community-based treatment and will offer additional structured intervention; all three will offer access to residential treatment. They will be located in the centre of the borough for maximum accessibility. We recognise, however, that transport links from the north of the borough are comparatively poor and so we will improve access to interventions for those living in the north by developing satellite provision there.
 - 2.8 We will continue to develop and integrate wraparound support services as part of our effective treatment offer to users. Focusing on housing and worklessness provision delivered through mainstream partnership mechanisms we aim to improve a range of health and social outcomes. We will use Department of Health Vital Signs to inform and develop local operations plans and target setting to determine and manage these improvements.
 - 2.9 The number of drug users recorded as being in effective treatment is one of the proposed indicators in our Local Area Agreement.

3. PROJECTED DEMAND FROM OPIATE/CRACK USERS

- 3.1 We have used the DIP positive test data for 2006/07 and combined it with the Glasgow prevalence data and data provided by the NTA in order to project demand for services. Positive test data indicate that 87% of the cohort had used crack/cocaine and 60% had used opiates.

Modality	Demographic Characteristic				
	Male	Female	Asian	Black	White
	1500	300	200	600	1000
Open Access	1300	200	150	500	850
Harm Reduction	500	200	100	100	500
Community Treatment	950	250	150	300	750
Residential Treatment	25	25			

Calculations to project the number of clients, including the number of PDUs who are retained in effective treatment have been made using the Effective Treatment Audit Worksheets provided by the NTA for the purpose of % change ambition setting for 2008-2011. Using this data, Waltham Forest PCT has agreed a target of a 6% percentage increase (533 clients) as the trajectory for 2008-9. The first two quarters of 2008-9 will see the bedding in of two significant new services in the treatment system, namely the Tier 2/3 Service and the Abstinence-based day programme. Following this bedding in, and the accompanying integration into the treatment system, ambition for 2009-10 has been set higher at 12%.

- 3.2 We anticipate that with the development of our new open access service targeting stimulant users we will see a rise in the number black drug users moving into treatment in 2008/09.
- 3.3 The likelihood of women accessing treatment will also depend on the offer we are able to make and to that end we will have to develop our partnership with Children Services to ensure that the safeguarding arrangements that are in place are widely understood and that progress is made in supporting child care and other needs.
- 3.4 We aim to consolidate the links we have made with the Pakistani community through community based research, our Muslim Drug Education Forum and peer education project to ensure that appropriate information and knowledge is fostered in that community to enable those that need treatment to access it.
- 3.5 Our understanding of the demand from the local LGBT community has been developed through further community based research. Indications are that access to treatment is very much mediated through primary care, and specifically GPs. Demand is also likely to be influenced by the extent to which services address the different nature of drug use identified by that community and publicise their expertise in doing so.

4. KEY FINDINGS OF THE NEEDS ASSESSMENT

- 4.1 The estimate of the number of opiate and/or crack users in the borough stands at 1814. Primary opiate and crack users have accounted for some 88% of class A drug users in treatment over the past 3 years. We therefore estimate a total Class A drug using population of some 2,100.
- 4.2 Bulls-eye data for 2006/07 indicate 634 opiate/crack users in treatment with a further 360 known to the system but not in treatment during that time, suggesting that 55% of opiate/crack users in the borough are known to the DAT. Our bulls-eye data comprise NDTMS submissions from all treatment providers and could not be broken down by agency. Given the acknowledged inaccuracies of one provider's submissions to NDTMS, our ability to draw robust conclusions from the bulls-eye has been somewhat compromised.
- 4.3 The needs assessment illustrated that our treatment system is characterised by a low rate of inter-agency referral between community-based providers. Moreover, the way in which services in Waltham Services have registered on NDTMS does not demonstrate the movement between modalities within individual agencies and so the vast majority of service users appear to be in receipt of single episodes of treatment, contradicting the anecdotal assertion of providers. Levels of service user satisfaction with individual service providers have increased significantly.
- 4.4 The treatment system has improved its effectiveness in meeting the needs of opiate users, which is to be expected with the investment seen in the statutory service and improvements in prescribing practice following the appointment of a full-time consultant for the borough. In particular, the rate of drop out of white male opiate users has reduced. Similarly, and following work within the Pakistani community in the borough, retention of Asian users is higher than the borough average.
- 4.5 Data from 2006/07 indicate, however that we have seen poorer outcomes for female drug users, even discounting the Qalb Project's data, which is worrying.
- 4.6 Similarly from 2006/07 data, attrition rates and outcomes for stimulant users and to some extent by implication black users remain unsatisfactory. The absence of a genuine open access service for stimulant users continues to remain the most glaring area of unmet need.
- 4.7 Additional key findings in the needs assessment concern the lack of involvement of GPs in referring users into treatment. Local research amongst the LGBT community indicates that many are most likely to seek help from this source rather than one of the specialist services in the

borough. They are unlikely to be alone in this regard. In addition, an increase in presentations from A8 countries has implications for the accessibility of our services.

- 4.8 Publicity of services and entry points to the system was found to be inadequate, particularly by service users and carers. This contention is congruent with service provider concerns that they are not reaching new users effectively.

5. IMPROVING OUTCOMES FOR USERS

- 5.1 Clinical governance, by which we mean the systematic approach to monitoring and continuously improving the quality of clinical interventions, is seen by the PCT and other partners as being fundamental to improving the impact of drug treatment across all treatment outcome domains. We will utilise the opportunity provided by the publication of 2007 Clinical Guidelines to ensure that clinical interventions accord to best practice. We will also review the competencies of those involved in commissioning and performance management of drug treatment in the borough.
- 5.2 We are in the process of implementing a programme of user and carer involvement in commissioning and service development and anticipate that this will have an extremely positive impact upon the treatment system's ability to respond effectively to the multiple needs that the majority of users have.
- 5.3 We will work in partnership with local providers to improve access for our local workforce to excellent continuing professional development opportunities. These opportunities will include access to existing networks in statutory health and social care. We will also explore the feasibility of setting up a borough-based or cross-borough network to develop specialist training and coaching opportunities.
- 5.4 We will use the opportunity afforded by rationalising our provision over three service hubs to implement fully our plans to create a peripatetic response to health inequalities, including blood borne virus transmission, amongst drug users in the borough. We will target established injectors and work with them to minimise the initiation of others, and act as educators to reduce risks from overdose. We will seek to improve the quality and coverage of pharmacies as conduits for harm reduction information, advice and practical support. Furthermore we will implement comprehensive health checks for users including TB screening and sexual health in those checks.

- 5.5 We will use the present commissioning process to rationalise and improve social support to those in aftercare, building on the improvements initiated in structured treatment.
- 5.6 We will exploit recent re-structuring in the Council to build upon initial progress in bringing together the drug treatment and worklessness agendas in the borough. We will also utilise the inclusion in the LAA of NI 40 to improve the housing-related component of our offer to problem drug users. Both of these initiatives will build on the gains in structured treatment and deliver improvements in offending behaviour and community safety.

6. PRIORITIES FOR DEVELOPMENT IN 2008/09

Auditing the clinical governance system and integrating this work with that presently underway in relation to NICE guidance will form a key priority for the partnership over the coming months. This priority relates closely to our workforce and user/carer development ambitions and together these will underpin service development in the coming year.

We will establish our open access service hub in a central location within the borough, enabling us for to offer a comprehensive and attractive service to crack users.

We will develop pathways into treatment from our most deprived neighbourhoods through the borough's neighbourhood management teams in those areas. We will ensure that the most vulnerable individuals and families in those areas are enabled to access appropriate interventions speedily and with the support of others.

We will make changes to the extent to which services inter-refer where appropriate and ensure that services reflect through appropriate NDTMS registration the treatment journey their users undergo. Community-based treatment will be further enhanced by the implementation of our housing and worklessness priorities.

Harm reduction services will be radically improved by the full implementation of our existing plans to develop a peripatetic NHS team working across all agencies in the borough.

We will market extensively our new treatment provision both generally within the borough and through more targeted means, referring to those communities identified as being at greatest risk in our needs assessment.