London Borough of Harrow

Rapid Substance Misuse Needs Assessment

The Centre for Public Innovation

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Our mission is to improve the outcomes of services for their users, with a particular emphasis on the most disadvantaged.

Contents

Glossary

ABRD	Alcohol-related brain damage
ASB	Anti-social behaviour
ATR	Alcohol Treatment Requirement
COPD	Chronic obstructive pulmonary disease
DRR	Drug Rehabilitation Requirement
HCV	Hepatitis C virus
HBV	Hepatitis B virus
MPS	Metropolitan Police Service
NPS	Novel psychoactive substance
OCT	Opiate substitute therapy
OCU	Opiate and crack user
OST	Opioid substitute therapy
OTC	Over-the-counter (medicine)
PHOF	Public Health Outcomes Framework
POM	Prescription only medicine
WDP	Westminster Drug Project

1. Background

This rapid substance misuse needs assessment seeks to provide an overview of issues relating to drug and alcohol misuse and treatment in Harrow for the adult population. A separate needs assessment prepared for Harrow in 2021 sets out need in relation to children and young people.[1]

The purpose of the needs assessment is to provide an up-to-date picture of overall levels of need in relation to drug and alcohol use in Harrow along with the identification of any gaps in service delivery.

This needs assessment is intended to be used to inform the Supplemental Substance Misuse Treatment and Recovery Grant application to the Office for Health Improvement and Disparities. Given the short timescale in undertaking the rapid needs assessment, the findings set out in this report should be taken as an initial impression, and a starting point for a more in depth review of the picture locally.

2. Methodology

This rapid needs assessment utilised a blend of qualitative and quantitative data techniques. The methods used are described below.

2.1 Stakeholder consultation

The scope of the stakeholder interviews was limited due to time constraints. Interviews included key stakeholders with an interest in the adult drug and alcohol treatment system. Interviewees were conducted with:

1. Head of Service, Harrow and Barnet, London Probation Service,
2. Substance Misuse Commissioner Brent (covering Harrow temporarily),
3. Former Harrow Commissioner (substantive post) (currently seconded to City of London),
4. Principal Officer Community Safety & Serious Violence Co-ordinator, Harrow
5. Service Manager & Operations Manager, WDP treatment service (two interviews),
6. Chief Executive, Build on Belief.

[1] Elnaiem A., Children and Young People's Substance Misuse Needs Assessment, 2021. (Unpublished draft).

Three other key services were contacted but did not respond to requests for interview in the timescale within which the needs assessment was undertaken: Metropolitan Police, Alcohol nurse specialists, Psychiatric liaison service at Northwick Park hospital, and members of the Ealing Hospital alcohol team.

2.2 Quantitative data

The approach for this rapid evidence review comes from several open sources.

For comparisons between the London Borough of Harrow (known as 'Harrow' thereafter) and England, the review utilizes open-source data from the 'Adult Drug Commissioning Support Pack: 2022-23: Key Data' and 'Adults Alcohol Commissioning Support Pack: 2022-23: Key Data' for alcohol misuse. Comparisons are made for one year's data (2019-20) in Harrow and England (also called 'national').

For comparisons over time, data derived from 12 years (2009-10 to 2019-20) was accessed directly from: https://www.ndtms.net/ViewIt/Adult

Using this dataset, comparisons with London were also included in the analyses. Caution in some of the interpretations is required as there can be low numbers reported in sub-categories which may fluctuate over time. In addition, due to the relatively small numbers in Harrow, no significance testing was undertaken. Additional open-source data was derived from: https://fingertips.phe.org.uk/ and the Office for National Statistics.

A final source of data for the review was existing secondary analyses of crime trend data from the Metropolitan Police Service (MPS) and the Public Attitude Survey between 2012 and 2019 from the Mayor's Office for Policing and Crime. For trends in drug-related crime patterns, we deployed a Generalized Linear Mixed Model (GLMM) for recorded drug offenses weighted for resident population by ward between 2013 and 2017. A GLMM approach was also deployed to assess trends in Public Perceptions of drug-related crime between 2012 and 2019.

Additional analysis of data

Where data allows, trends in Harrow are compared to wider trends across London as a whole. Further analysis was undertaken to determine the extent of any correlation between rates of a given variable in Harrow and across London. Data regarding the extent of correlation are therefore independently arrived at and are not taken from existing datasets (e.g. NDTMS).

NDTMS data is used in conjunction with other datasets to derive estimates of prevalence and unmet need for both drug and alcohol treatment. Using multiple data sources including NDTMS and criminal justice data (prison and probation) it is possible to deploy capture-recapture (CRC) methodologies (Chao, A. (1987). Estimating the population size for capture-recapture data with unequal catchability. Biometrics, 783-791.) To assess the overlap across multiple data points to derive an estimate of the total drug misusing population and this method has been used for some indicators in this report. The data used for this section of the report has been derived from the methodological approach outlined in Hay, G. (2000). Capture–recapture estimates of drug misuse in urban and non-urban settings in the North East of Scotland. Addiction, 95(12), 1795-1803.

3. Current adult service provision

This section sets out an overview of the current adult drug and alcohol treatment system.

3.1 Description of drug and alcohol treatment service in Harrow

3.1.1. Adult substance misuse treatment service

The adult treatment service for Harrow is delivered by one provider (Westminster Drug Project – hereafter WDP) for both drug and alcohol misuse. The service is delivered from 44 Bessborough Rd, Harrow, which is close to the shopping centre and local transport connections.

The service has continued to operate throughout the pandemic and has adapted to provide online support where possible. The service is getting back to a more hybrid model of face to face delivery and online support.

Service offer

The service provides a range of components that would be expected within an effective service and includes:

- Receipt of referrals form a range of sources including self-referral
- Information, advice and assessment
- Drop-in and open access
- Co-ordination of needle and syringe programme – in-house and via pharmacies
- Community based detoxification
- A range of substitute prescribing options including Buvidal (long acting opioid substitution therapy) and prescriptions that support alcohol detoxification and relapse prevention
- Support for GP shared care
- Assessment and access to inpatient detoxification and residential rehabilitation services
- Advocacy, liaison and joint work with housing support services
- Group work (including women's group)
- Health assessments, testing/vaccination for blood borne viruses, liaison with specialist hepatology
- Smoking cessation support
- Keywork and counselling

- Housing and benefits support
- Facilitated access to mutual aid
- Sub-contracted weekend social support (via Build on Belief)
- Liaison with criminal justice partners
- Education, training and employment support
- Dedicated Family & Carer's practitioner who provides one to one support and also facilitates the Families & Carer's group
- Liaising with criminal justice partners, children and adult services and community and mental health teams

Staffing

An addictions specialist doctor is contracted three days a week to the service and clinical supervision is provided by the organisation's medical director. In addition, there are two nurses, one of whom is a non-medical prescriber.

WDP attend weekly meetings with the psychiatric liaison team at Northwick Park hospital to review admissions and referrals. WDP report a good partnership approach/relationship with mental health services and attend monthly dual diagnosis meetings at Bentley House (Community Mental Health Team).

The WDP counselling service is staffed by volunteer counsellors who are supervised, WDP-wide, by a qualified psychotherapist.

There are no clinical psychologist posts in the service. Previously there was a reflective practice session which considers the psychosocial interventions the team delivers.

The remaining drug workers are qualified or working towards qualification to NVQ Level 3.

3.1.2 Pan-London Inpatient Detoxification Consortium

Harrow's contribution (~£19,000) to the pan-London inpatient detoxification consortium is part of a wider commitment from all London boroughs towards the running costs of the new specialist inpatient provision at Guys & St Thomas' hospital. The service is intended to address the gap in complex inpatient detoxification provision in London for those with co-occurring physical and mental health needs such as:

- severe alcohol and/or polydrug dependence
- diagnosed severe and enduring mental health illness
- a history of multiple detoxifications and relapse
- alcohol-related liver disease
- alcohol-related brain damage (ABRD)
- chronic obstructive pulmonary disease (COPD)

There is a per night cost to London local authorities who access the resource (£250). The unit has not been accessed or any bed spaces used for clients from Harrow.

There is no waiting list for this provision – it can be accessed as required and the criteria are flexible if bedspaces are available. It is not clear why the resource has not been utilised for clients from Harrow. This should be followed up by commissioners to ensure Harrow service users receive access to this high/complex need provision for its most vulnerable alcohol or drug users and make use of a provision which is part funded by the borough.

3.2 Financial information

From the financial information provided, the core contract for WDP in 2021/22 was £1,696,000. An additional £180,000 one-off universal drug treatment grant in 2021-22 and ~£19,000 inpatient detoxification grant (Office for Health Improvement and Disparities) which contributed to a pan-London inpatient treatment service at Guys & St Thomas' hospital, bringing it to a total of £1,895,000 for adult drug and alcohol treatment.

The proposed use of the additional grant funds in 2021/22 increased the staff and resource of WDP as follows:

Universal funding (180k)

- 1 x harm reduction worker, focussing on health and wellbeing – in part on criminal justice clients, blood borne viruses, access to naloxone, needle exchange, supporting transition from prison/community – developing respiratory health treatment pathways
- 1 x 'at risk adult' outreach worker – co-located in adult social care to support staff to identify and refer into treatment. Strengthen links with criminal justice, ASB team and housing
- 20k residential rehab – for 'release to placement' for criminal justice clients

- 1 x criminal justice senior practitioner – to develop criminal justice pathways, improve partnership with mental health and learning disability teams and release to placement clients

Inpatient detoxification funding (~19k)

- Inpatient detoxification (medically managed) pan-London consortium arrangement

4. Analysis of quantitative data

This sections explores a range of data that describe demand and service delivery in relation to substance misuse. Data for drugs and alcohol are explored separately.

4.1 Drugs

4.1.1 Drug treatment demand – activity

Over 12 years from 2009-10 to 2019-20 there was a broadly stable picture of presenting treatment demand (using the total number of people in treatment) from 2009/10 to 2013/14, and thereafter a declining trend until 2018/19 (with a sharp uptick in demand noted in 2020/21).

The data indicates annual increases in the numbers of adults in treatment in Harrow in 2020-21 from 2019-20 for all drug types including a 72% increase in non-opiate presentations (from 50 to 85). There were also annual increases for presentations to treatment for non-opiates and alcohol (120 adults reported to NDTMS in 2020-21 from 105 in 2019-20) and for alcohol-only presentations (from 160 in 2019-20 to 225 in 2020-21). Data is set out at Table 1 below.

Table 1: Adults in Treatment, Harrow 2009-10 to 2020-21

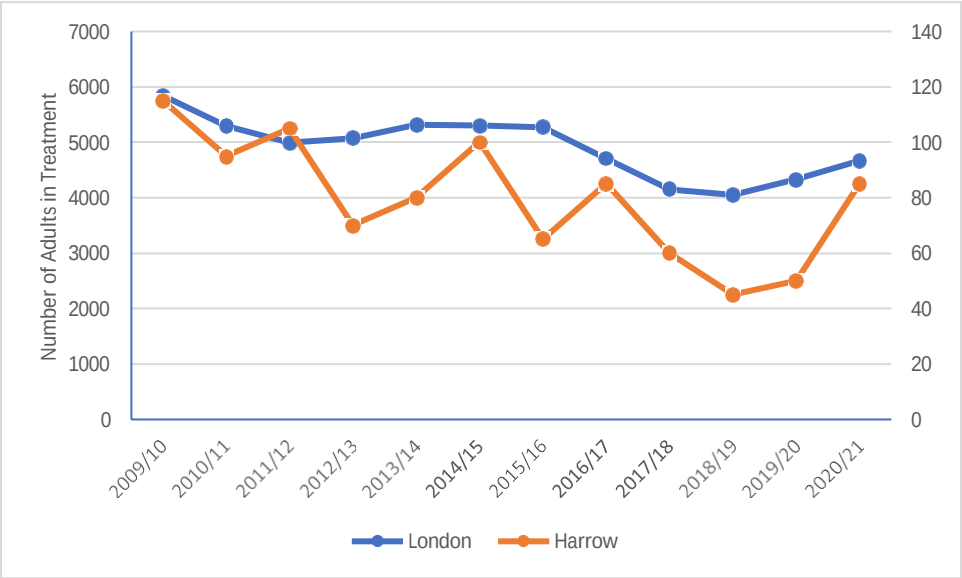
Substance Category	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Opiate	410	380	405	400	385	360	295	255	210	210	215	260
Non-opiate only	115	95	105	70	80	100	65	85	60	45	50	85
Alcohol only	240	250	250	235	290	265	250	280	210	160	160	225
Non-opiate & alcohol	120	130	155	140	170	140	105	130	125	105	105	120

(Source: OHID ViewIT)

Based on 12 years of historical data, a forecast model suggests an overall declining trend in treatment demand from 2020 (although the wide confidence intervals suggest caution in the interpretation of these estimates).

Trends in non-opiate presentations since 2009/10 are set out at Chart 1 (below).

Chart 1: Trends in Non-Opiate Presentation, Harrow compared to London, 2009-10 to 2020-21



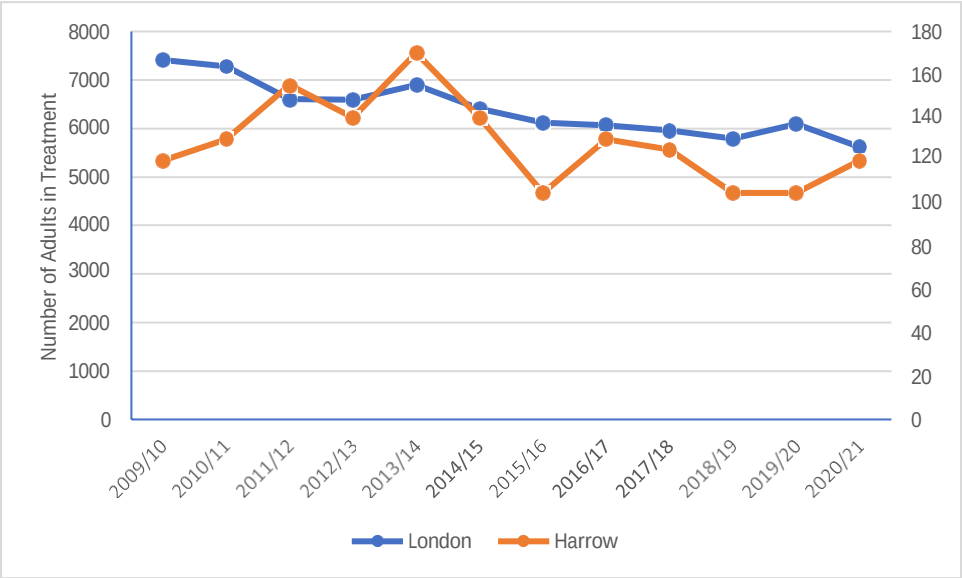
(Source: OHID ViewIT)

The uptick in adult presentations for non-opiate use can be shown in the chart above, which arrests a general decline in reports from 2016-17. Note that there is a strong correlation in the trend in non-opiate presentations between Harrow and London (r=0.77)[2].

Chart 2 sets out data in relation to alcohol and non-opiate presentations since 2009/10.

[2] Independently calculated using open source data and not calculated by OHID.

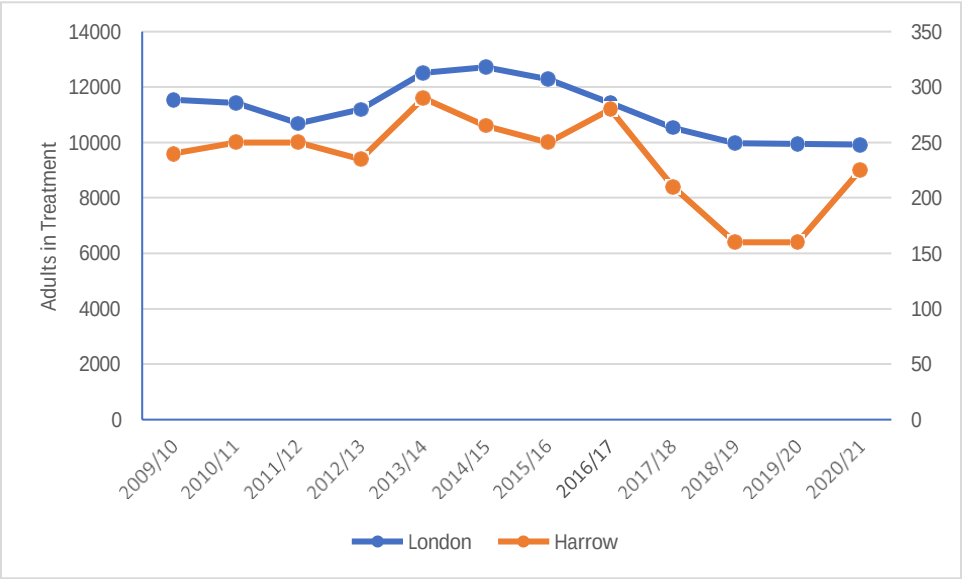
Chart 2: Trends in Alcohol and Non-Opiate Presentation, Harrow compared to London, 2009-10 to 2020-21



(Source: OHID ViewIT)

Analysis of the data at Chart 2 indicates that there is a weaker and moderate correlation between reports of non-opiate and alcohol presentation in Harrow compared to London between 2009/10 and 2020/21 (r=0.45).

Chart 3: Trends in Alcohol-Only Presentation, Harrow compared to London, 2009-10 to 2020-21



(Source: OHID ViewIT)

Analysis of the data at Chart 3 indicates that there is a strong (r=0.8) correlation between reports of alcohol-only presentations in Harrow compared to London between 2009-10 and 2020-21

4.1.2 Profile of those in treatment

This section explores the profile of those in drug treatment in Harrow, looking at longer-term trends (over 12 years) where data allows.

Age and Gender

Between 2009-10 and 2019-20, there was a stable picture in relation to the age profile of those in drug treatment with a slight increase in treatment demand for clients aged 50 and over from 21% in 2015/16 to 25% in 2020/21. Full data regarding age of adults in treatment is set out at Table 2.

Table 2: Age-Ranges of Adults in Treatment, Harrow 2009-10 to 2020-21 (at treatment start)

Age Group	2009/ 10	2010/ 11	2011/ 12	2012/ 13	2013/ 14	2014/ 15	2015/ 16	2016/ 17	2017/ 18	2018/ 19	2019/ 20	2020/ 21
Number												
18-29	230	190	190	170	190	170	120	140	100	85	85	120
30-49	505	515	540	495	540	505	445	445	365	300	320	400
50+	150	155	190	175	195	190	150	170	145	130	130	170
TOTAL	885	860	920	840	925	865	715	755	610	515	535	690
Percentage												
18-29	26%	22%	21%	20%	21%	20%	17%	19%	16%	17%	16%	17%
30-49	57%	60%	59%	59%	58%	58%	62%	59%	60%	58%	60%	58%
50+	17%	18%	21%	21%	21%	22%	21%	23%	24%	25%	24%	25%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

(Source: OHID ViewIT)

There has been a broad decline in the number and percentage of adults in treatment aged between 18 and 29 years from 2009-10 (26%, n=230 of all people reported in treatment) to 85 (16%) in 2019-20. It should be noted that there has been an increase in the number of people aged 18 to 29 years reported in treatment in 2020-21 (120) compared to the previous year (85). In comparison, the proportion of people in treatment between 2009-10 and 2020-21 aged 30-49 can be shown to be stable ranging between 57-62% during this time. Proportionally, there has been a small increase in the proportion of adults in treatment ranging from around one-fifth of the treatment population (2011-12 until 2015-16) to around one-quarter (2016-17 onwards).

The data indicates slightly higher levels of male presentations to drug treatment in Harrow (75%) relative to national figures (71%). There is however broad concordance in the gender split by drug type

when comparing Harrow to the national picture, apart from higher male representation in Harrow for opiate users (80%) compared to England (72%) [2020-21 data].

Over the 12 year period for which data was examined, there was a stable picture of presenting needs by sex (that is that proportions of male to female clients remained largely the same).

Data indicate that there is a higher proportion of younger people aged 18-29 in Harrow in drug treatment (22%) relative to England (16%) [2020-21 data]. Females are more likely to present to treatment aged 18-29 years (28%) compared to England (20%) [2020-21 data].

Ethnicity

Data regarding the ethnicity of adults in treatment since 2009/10 is set out at Table 3.

Table 3: Ethnicity of Adults in Treatment, Harrow 2009-10 to 2020-21 (at treatment start)

Ethnicity	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Number												
White	500	490	530	515	555	525	435	435	355	310	315	365
Mixed/Multiple ethnic group	35	35	45	40	45	45	45	40	40	20	25	35
Asian/Asian British	145	150	150	155	185	170	140	165	135	120	130	185
Black/African/Caribbean/Black British	95	105	115	75	70	60	45	65	50	45	45	65
Other ethnic group	25	15	15	15	20	10	5	10	5	5	5	10
TOTAL	800	795	855	800	875	810	670	715	585	500	520	660
Percentage												
White	63%	62%	62%	64%	63%	65%	65%	61%	61%	62%	61%	55%
Mixed/Multiple ethnic group	4%	4%	5%	5%	5%	6%	7%	6%	7%	4%	5%	5%
Asian/Asian British	18%	19%	18%	19%	21%	21%	21%	23%	23%	24%	25%	28%
Black/African/Caribbean/Black British	12%	13%	13%	9%	8%	7%	7%	9%	3109%	9%	9%	10%
Other ethnic group	3%	2%	2%	2%	2%	1%	1%	1%	1%	1%	1%	2%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

(Source: OHID ViewIT)

There has been a notable increase in the number of reports to treatment services in Harrow from Asian or Asian British people (reaching 185 in 2020-21). Proportionally, there has been a stable picture by ethnicity for other black and minority ethnic groups. For white people in treatment, there has been a

steady increase in numbers 2018-19 (310) to 2020-21 (365) although, as a proportion, the overall total fell from 62% in 2018-19 to 55% in 2020-21.

35% of new presentations to drug treatment in 2020-21 in Harrow were White British. This compares to a rate nationally of 80%. There is a notable difference in the proportion stated to be 'Indian' (10% of all new presentations in Harrow, compared to 1% in England).

Over the 12 year period for which data was examined the data indicates that there has been a proportional decrease in 'White' clients from 2019/20 to 2020/21 and a steady increase in the proportion of 'Asian' clients noted (18% in 2011/2012 to 28% in 2020/21)

Employment

In Harrow for 2020-21, there is a higher proportion of reports of people designated as unemployed (59%) compared to nationally (50%); in contrast, there was a lower proportion of people recorded in Harrow as long term sick or disabled (9%) compared to 21% nationally.

Over time (12-year period) some fluctuations in the proportion of Harrow clients in employment were seen, although no discernible trends were noted.

Housing

For 2020-21 there is broad concordance between housing needs at the start of treatment in Harrow and national figures such that 73% of clients in drug treatment in Harrow report no housing issue compared to 77% nationally. In addition, for people who successfully completed treatment but no longer reported a housing need, this figure reached 90% of Harrow clients in 2020-21 compared to 83% in England.

There has been a stable picture concerning housing needs, although it can be noted that there has been a proportional doubling in reports of clients with housing problems (7% in 2018/19 to 14% in 2020/21).

Parental Status

In Harrow in 2020-21, there were a lower proportion of clients recorded as 'parents not with children' (15%) compared to nationally (22%). There was a higher proportion of people in treatment who were reported as 'not a parent - no contact with children' (67% in Harrow compared to 60% nationally).

Over 12 years, there has been a broadly stable picture of need by parental status, with an increase in the proportion of people stating they are not a parent and not living with children increasing from 2014/15 (47%) to 61% in 2020/21. In comparison, there has been a proportional decline in reports of 'not a parent

and living with children' from a peak of 16% in 2013/14 to 4% in 2020/21. There has also been a steady increase in those characterised as 'parent not living with children' from 2009/10 (5%) to around a quarter (20%) of all reports from 2015/16 – 2019/2020, thereafter a drop to 15% was noted.

4.1.3 Routes into treatment

In 2020-21, more referrals for 'new' presentations were made from social services (11%) relative to the rate in England (3%); note however a lower proportion from 'self' referrals in Harrow (43%) compared to England (59%). Harrow reports a higher level of 'other' referral routes for new presentations (28%) compared to 16% nationally suggesting possible differences in approaches to coding/data entry. It is not possible to provide additional detail on the nature of the 'other' group from the open source data that was available when preparing this needs assessment. It is recommended that further exploration of these referral routes is undertaken locally.

With regard to criminal justice referrals, in 2020-21, a higher proportion of referrals were noted from Community Rehabilitation Companies in Harrow (38%) compared to 6% in England; in contrast, a lower proportion of referrals were made from prison (32%) in Harrow compared to 56% nationally.

For people entering treatment via Criminal Justice Integrated Teams, a higher proportion of clients in Harrow had been arrested for acquisitive crimes (39%) compared to the national rate (30%). In contrast lower rates were recorded in Harrow for drug-related crimes (10% v 18% in England) and 'other' offense types (22% in Harrow v 29% in England). It should however be noted that Harrow reported a higher rate of 'inconsistent' codes (21%) compared to 9% in England, possibly suggesting issues with data recording (2020-21 data). Further work is therefore required to explore data coding at a local level. This could involve an audit of how data is currently captured locally regarding criminal justice pathways and how staff are recording the data or where they are receiving this information from.

For prison leavers in 2020-21, Harrow reported a lower rate of people transferred to a community treatment provider for structured treatment and who successfully engaged at a rate of 14% locally compared to the national rate of 40%.

4.1.4 Drug Treatment Demand

Drug use

Comparing trends in demand for drug treatment over the last 12 years, there is a strong correlation between Harrow and London opiate use (r=0.93) – that is to say that trends in demand for opiate treatment in Harrow mirror wider trends across London as a whole. Note that numbers in Harrow declined annually from 2010/11 to 2017/18 with a steady rise with an uptick in numbers reported in 2020/2.

Over a 12 year period there was a moderately strong correlation in non-opiate use between Harrow and London (r=0.77) meaning some correspondence with non-opiate use in Harrow when compared to London as a whole. The data indicates a fluctuating pattern in the numbers presenting to Harrow services over time (for non-opiates) including an increase in treatment demand from 2018/19.

Over the 12 years for which data was examined, taking all substances reported, there is a broadly stable picture of presenting need, while noting however a declining trend in presentations from opiates (not crack cocaine) from a peak in 2012/13 of 24% to 14% in 2020/21.

Rates of unmet need are higher for Harrow for the OCU population (79%) relative to the national rate (53%); unmet need is also higher for opiate only (78% in Harrow versus 47% nationally) and crack-cocaine (72% in Harrow versus 58% nationally) which suggests a large potential demand for treatment services in the borough.

The proportion of people in treatment in 2020-21 for prescription-only medicine/over-the-counter medicine (POM/OTC) in Harrow (4%) corresponds exactly with the rate nationally (4%).

In Harrow in 2020-21 there were no cases reported of people 'new' to treatment accessing treatment for NPS/club drugs compared to 4% in England. For any club/NPS drug use Harrow reports a slightly lower rate in 2020-21 (6%) compared to England (8%).

Injecting status

In Harrow for the 12 years for which data was analysed, there has been a consistent picture in patterns of injecting use, with the majority of people in treatment never known as injecting drug users.

Smoking

For all drug users by type of substance used, in Harrow there was a lower proportion of people reported to be tobacco smokers (40%) compared to the national rate of 65% of those in treatment.

Mental health

For people in treatment during 2020-21, there is concordance in the level of co-occurring mental health and substance misuse conditions in Harrow (62%) when compared to the rate nationally (63%).

4.1.5 Interventions Received

For people in receipt of opioid substitute therapy (OST) intervention in Harrow for 2020-21 a lower proportion of people were receiving a Buprenorphine intervention (18%) when compared to the national rate (27%). Engagement with the provider by commissioners would be required to understand the reasons for this differential rate.

For people receiving OST, a larger proportion received methadone maintenance in Harrow in 2020-21 (65%) compared to the national rate of 57%.

In Harrow in 2020-21 a higher proportion of eligible people were offered naloxone (39%) compared to the rate for England (28%). In addition, for opiate adults in treatment in 2020-21, Harrow reports a higher rate (8%) that have been administered with naloxone relative to England (3%).

In Harrow in 2020-21 a higher proportion of people were eligible for an HBV vaccination and accepted one (48%) compared to a rate of 29% in England. Similarly there was a higher proportion of people who were eligible for an HCV test and who accepted one in Harrow (50%) compared to 41% nationally.

4.1.6 Treatment Outcomes

Between 2009-10 and 2019-20, the proportion of clients completing treatment in Harrow has fluctuated, declining from 2013/14 until 2015/16, after which increases were once again noted. The proportion of clients who dropped out of treatment peaked in 2017/18 (44%) and has reduced thereafter.

Successful completions (as a proportion of total number in treatment) in 2020-21 show that in Harrow 19% of clients successful completed compared to 14% nationally. The data indicates that this is driven by higher rates of successful completions noted for non-opiate users (44% in Harrow compared to 36% nationally).

Comparing the proportion of all people in treatment who successfully completed treatment and did not re-present within six months (PHOF C19a/C19b) there is broad concordance between rates in Harrow and national figures:

- opiate users (7% as the proportion of the treatment population in Harrow compared to 5% in England), and
- non-opiate users (31% as the proportion of the treatment population in Harrow compared to 33% in England) [2020-21 data].

For those people who left treatment in an unplanned way before 12 weeks, the rate was lower for Harrow (9%) relative to England (16%) holding across all drug types (opiates, non-opiate, and alcohol and non-opiate).

In 2020-21, the proportion of adults with opiate problems in treatment for under two years was recorded at 64% which compares to a rate of 46% for England; by way of comparison, the proportion of adults with opiate problems in treatment for six years or more was notably lower in Harrow for 2020-21 (16%) compared to nationally (27%). Note also that the length of time in treatment for adults with non-opiate problems for two years or more in Harrow in 2020-21 was 8% compared to 3% in England.

The rate of abstinence from selected drugs at six month review (in 2020-21) is higher in Harrow relative to England for most substances:

- cannabis (51% abstinent in Harrow versus 42% nationally),
- crack (61% abstinent in Harrow versus 48% nationally), and
- abstinent using opiates (67% in Harrow versus 51% nationally.

Only cocaine users had a lower abstinent rate in Harrow (56% compared to 69% nationally).

4.1.7 Drug-Related Offending

The rate of drug-related offending as measured by MPS data shows a declining trend (Odds Ratio 0.9855) in Harrow between 2013 and 2017, which is consistent with trends seen across London as a whole (Sondhi and Leidi[3]). The level of offending was determined examining monthly MPS data and

[3] Sondhi A. et al. (forthcoming), Small Area Estimation Study Examining the Relationship between Violence and Drug Offences in London.

then deploying a Generalized Linear Mixed Model to examine trends at ward level which were extrapolated to across all London boroughs.

From the Public Attitude Survey between 2012 and 2019, the largest increase across London in the public's perception of drug-related crime was noted in Harrow (Odds Ratio 1.33) [Sondhi *et al.*, 2021[4]].

4.2 Alcohol

4.2.1 Patterns of alcohol consumption

The proportion of adults who abstain from drinking alcohol in Harrow is very close to that of England (16.7% of the population compared to England 16.2%). In comparison, there is a lower proportion of people in Harrow who are recorded as drinking over 14 units of alcohol a week (10.9% in Harrow compared to 22.8 in England) [2015-2018].

4.2.2 Prevalence estimates and rates of unmet need for alcohol treatment

The need for specialist alcohol treatment in Harrow was estimated at 9.3 per 1,000 local population compared to 13.7 nationally. Similar high rates of unmet need can be seen across Harrow (81%) and England (82%).

Over the 12-year period for which data was examined, there was also a moderately strong relationship (r=0.80) between Harrow and London for alcohol treatment demand, with a sharp rise in presenting need from 2019/20 following a notable drop in demand from 2016/17 to 2018/19. It may be possible to hypothesize, in the absence of other more obvious explanations, that there may be consistent factors or issues driving the need for alcohol treatment across London are driving need in Harrow also.

4.2.3 Hospital admissions due to alcohol

Hospital data captures a range of issues in relation to alcohol consumption and its associated harm. This section explores a range of metrics as reported by hospitals for residents of Harrow.

Data for all ages hospital admissions for an alcohol-specific condition indicates a significantly lower rate (per 100,000 of population) recorded in Harrow in 2019-20 (539 95% Confidence Interval [CI] 510-570)

[4] Sondhi, A., Leidi, A., & Gilbert, E. (2021). A Small Area Estimation Method for Investigating the Relationship between Public Perception of Drug Problems with Neighborhood Prognostics: Trends in London between 2012 and 2019. International Journal of Environmental Research and Public Health, 18(17), 9016.

compared to England (644 95% Confidence Interval [CI] 642-646). In comparison there was also a significantly higher rate per 100,000 for 2019-20 for alcohol-related conditions using a broad definitions (1,904 in Harrow, 95% CI 1847-1963) compared to England (1,815, 95% CI 1811-1818).

Harrow reported significantly higher rates compared to England for the following alcohol-related admissions:

- Alcohol-related cardiovascular disease (Broad) for females (283 per 100,000, 95% CI 253-315 compared to 239 per 100,000, 95% CI 237-241 in England) and males (1,835 per 100,000, 95% 1751-1921 compared to 1,482, 95% CI 1477-1487 nationally)

Non-significant changes were noted for:

- Alcohol-related unintentional injuries (Narrow) for females (15.4 per 100,000, 95% CI 9.2 – 24.3 compared to 13.7 per 100,000, 95% CI 13.2-14.1in England) and males (109.3 per 100,000, 95% 90.5 – 130.7 compared to 95.8, 95% CI 94.6-97.0 nationally.) [2019-2020 data].

Significantly differential rates were noted by gender for alcoholic liver disease (Broad) with Harrow reporting lower rates for females (35.5 per 100,000, 95% CI 25.6-48.0 compared to 89.3, 95% CI 88.2-90.5 in England), but higher rates for males (230.3 per 100,000, 95% CI 202.6-260.8 compared to 191.8, 95% CI 190.1-193.5 in England).

Similarly, lower rates were noted for mental and behavioural disorders due to the use of alcohol (Narrow) where females in Harrow reported a non-significant lower rate of 37.3 per 100,000, 95% 27.6-50.1 compared to 45.3, 95% CI 44.5-46.1 nationally. In comparison, males in Harrow reported a significantly higher rate of admissions (125.8, 95% CI 106.1-148.1) compared to males nationally (103.8, 95% CI 102.6-105.1). [2019-2020 data]

Data for Harrow indicates significantly lower rates of alcohol-related admissions for intentional self-poisoning by and exposure to alcohol (Narrow) for both females (21.2 per 100,000, 95% CI 13.7-31.4 versus 52.8, 95% CI 51.9-53.6 nationally) and males (7.7 per 100,000, 95% CI 3.6-14.2 in Harrow compared to 39.7, 95% CI 38.9-40.4 in England).

The incidence rate of alcohol-related cancer using the latest available data from 2016-2018 combined was shown not to be significantly lower in Harrow for females (30.1 per 100,000, 95% CI 24.5-36.6 compared to 36.8, 95% CI 36.4-37.2 nationally). However the difference for males was shown to be

significantly different (31.4 per 100,000, 95% 25.2-38.6 v 39.2 in England, 95% 38.8-39.7). [2019-2020 data].

4.2.4 Alcohol-Related Mortality

Data for Harrow indicates significantly lower mortality rates that are alcohol-specific at a rate of 5.8 per 100,000 (4.1-7.9 in Harrow compared to 10.9 95% CI 10.7-11.1 in England). The data also indicates significantly lower rate related to chronic liver disease (6.3 per 100,000, 9.5 CI 4.5-8.6 in Harrow compared to 12.2 in England), and alcohol-related mortality (27.0 per 100,000, 95% CI 20.6-34.7 in Harrow compared to 35.8, 95% CI 35.8-38.2 in England).

4.2.5 Routes into treatment

A lower proportion of clients new to alcohol-only treatment were recorded as a 'self-referral' in Harrow (40%) compared to nationally (63%). Referrals via 'other' referral routes were noted to be twice as high in Harrow (26%) compared to England (13%). By contrast, Harrow recorded a higher proportion of referrals by GP (17%) compared to national figures (8%).

In 2020-21 there was only one referral from a Criminal Justice Intervention Team into Harrow specialist treatment compared to 3% nationally. In addition, out of four referrals for Harrow residents who had left prison into alcohol-only treatment, only one person subsequently engaged (compared to 13% nationally).

4.2.6 Profile of those in treatment

Age and gender

There were a higher proportion of males in alcohol-only treatment in Harrow in 2020-21 (68%) compared to England (58%). The age profile however for people in alcohol-only treatment are broadly similar with Harrow residents slightly less likely to be aged 50-59 (22% compared to 26% in England), and slightly more proportionally aged 60-69 (14% in Harrow compared to 10% in England).

Ethnicity

28% of new presentation to alcohol treatment in Harrow in 2020-21 were reported as White British. This compares to 83% nationally. There was a notable difference in those of Indian ethnicity (21% in Harrow compared to 2% nationally) and 'other Asian' (at 15% in Harrow and 1% nationally).

Other ethnic categories for new presentations are:

- 'Other White' (8% in Harrow compared to 5% nationally),
- White Irish (5% in Harrow to 1% nationally),
- Black African (4% in Harrow compared to 1% nationally),
- Black Caribbean (3% in Harrow to 1% nationally),
- Mixed White – Black Caribbean (2% in Harrow to 1% nationally),
- Pakistani (3% in Harrow to <1% nationally).

Parental status

For 'new' presentations to treatment in 2020-21 a slightly higher proportion were recorded as 'parents living with children' (29% in Harrow compared to 22% in England) and 'not parent - no contact with children' (62% in Harrow compared to 55% in England). In comparison, there was a lower proportion of people recorded as a 'parent not with children' in Harrow (8% to 18% nationally).

Employment

A higher proportion of new presentations for treatment in Harrow during 2020-21 were recorded as being unemployed or economically inactive (50%) compared to England (41%). By contrast, there was a lower rate of people recorded as long-term sick or disabled (9% in Harrow) compared to England (18%).

Housing

A higher proportion of people reported as a new presentation during 2020-21 with a housing problem (15% in Harrow) compared to England (7%).

4.2.7 Alcohol Treatment Demand

Alcohol use

Alcohol presentations peaked at 66% of the total treatment population in 2016-18 but declined in the three years afterward to 59% in 2020/21.

Data for clients presenting for alcohol-only treatment in 2020-21 and screened using the Severity of Alcohol Dependence Questionnaire shows broad similarities between Harrow and England for mild dependency (29% in Harrow compared to 27% in England) and moderate dependency (21% in Harrow compared to 20% in England).

By comparison a lower proportion of clients in Harrow reported a severe alcohol dependency (9% in Harrow) relative to England (20%). (It should be stated that in Harrow there was a slight difference in the proportion of people not stated or known (39%) compared to England (32% - including missing or incomplete data)).

In 2020-21, only one person from Harrow received treatment in residential treatment compared to 2% of the national population in alcohol-only treatment.

Smoking

There was a lower rate of tobacco use among people starting alcohol-only treatment in 2020-21 in Harrow (28%) compared to England (43%).

Mental health

There was a slightly lower rate of new presentations for treatment in Harrow during 2020-21 who were recorded as having mental health treatment needs (58%) compared to England (64%).

4.2.8 Treatment Outcomes

In 2020-21 there was a lower level of early unplanned exits for clients in alcohol-only treatment in Harrow (6%) relative to England (13%). In comparison, there was a higher percentage of people reported to be in treatment for between one and two years in Harrow (16%) compared to England (10%).

Based on all treatment exits and the average days in treatment, Harrow residents are less likely to be in treatment for less than three months (20%) compared to England figures (35%).

At the point of a planned exit from alcohol-only treatment, Harrow residents report a higher degree of abstinence from alcohol (69%) compared to the rate for England (53%).

Comparing alcohol consumption at the start of treatment with the planned exit, the average reduction in drinking days is similar for Harrow residents (8.4 fewer drinking days) compared to national figures (8.5 fewer drinking days).

For people who left treatment successfully, Harrow residents report a slightly lower rate of successful treatment outcomes as a proportion of the treatment system (30%) relative to England (37%).

As a proportion of all people in treatment, who successfully completed treatment and did not re-present within 6 months (PHOF C19c), Harrow reports a slightly lower rate (30%) compared to England (35%). It is not evident from the data that was available why there is a lower rate of successful treatment and 6 month re-presentation rates. While this issue certainly warrants further investigation, it was not possible to explore this issue during the period of this rapid needs assessment.

4.3 Drug and alcohol-related deaths

Data was explored into drug and alcohol-related deaths in the borough.

The data indicates relatively low levels of drug-related deaths (1993 to 2020) compared to other London boroughs.

The number of annual deaths related to drug poisoning registered each year between 1993 and 2020 shows that, for Harrow, the number of deaths each year is less than 10 (apart from 14 in 2005, 11 in 1998 and 10 in 1997).

Changes in deaths to drug poisoning can be shown to be moderately correlated with outer London (r=0.39) and with London as a whole (0.56). The rate, when weighted for the 100,000 resident population, is 2.5 in the period 2018-2020 which is largely consistent with previous years.

Drug poisoning deaths by males have declined to 2.6 per 100,000 population (2018-2020) from 4.1 per 100,000 (2015-2017). Comparative rates could not be calculated for females (due to low numbers).

There were two deaths related to drug misuse in 2020, down from a peak of 10 in 2005. The changes in deaths to drug poisoning can be shown to be weak-moderately correlated with outer London (r=0.28) and with London as a whole (0.42). Due to the small numbers reported, it was not possible to calculate rates weighted by the resident population.

There was a lower proportion of deaths in the drug treatment population in Harrow for 2020-21 (0.6%) compared to England (1.3%).

A similar picture can be shown for deaths in alcohol treatment in 2020-21 for Harrow residents (two people or 0.88% of the treatment population compared to 1.39% nationally).

5. Stakeholder consultation

Given the limited number of interviews that were undertaken, the findings have been set out by stakeholder. The views of each stakeholder are set out below.

5.1.1 Brent substance misuse commissioner

The current commissioner has been overseeing the Harrow treatment service contract whilst the substantive post-holder has been seconded to the City of London pan-London substance misuse programme.

The commissioner noted that his priority over the last two years has been to keep the treatment system in Harrow running through the pandemic. This has mainly been achieved by the service going online. He recognises that this was a vital adaptation however does not suit all service users, particularly those with more complex needs, and isolated and vulnerable people.

In relation to the commissioning function in the borough, he commented that there is no joint commissioning group or partnership involvement in prioritising, planning, and commissioning services. Therefore it was his opinion that co-ordination and development of partnership involvement is needed going forward.

The commissioner had no overall concerns about the treatment service which he noted provides a full range of treatment interventions. It was his view however that criminal justice linkages and pathways – particularly in relation to continuity of care between prison and community treatment – need to be improved. He also stated that mental health support for substance misuse clients needs to be improved as mental health service thresholds mean that many substance misuse clients with lower level mental health issues do not have their needs met. It was his view therefore that a more holistic mental wellbeing model is needed.

The commissioner's recommendation on priorities for the system (both locally and in terms of the aims of the national drug strategy) would be to improve the outreach function i.e. that WDP further develop partnerships with external services and referral sources and build protocols and pathways that will engage more service users – particularly those in probation and health provision.

5.1.2 Former Harrow commissioner (substantive post), currently seconded to City of London.

The former commissioner reiterated the comments of the current commissioner in relation to the absence of a partnership structure for planning and commissioning drug and alcohol treatment. The former commissioner noted that there had been a significant cuts to funding for drug and alcohol treatment over several years until 2021/22 – with a loss of over £500,000 to the treatment system which has had the effect of diminishing staff resources and the capacity of the service.

It was the view of the former commissioner that, within their resources, WDP are working with key partner agencies such as probation, mental health services, adult social care and so forth. She however recognises this may not be reflected in the outcome data, particularly for 'continuity of care', prison referrals engaging in treatment. She also recognises the 'penetration' rate (i.e. the proportion of OCU's in treatment) in the service is low.

The former commissioner reported that blood borne virus testing and vaccination are performing well and that WDP has effective links with Northwick Park Hospital hepatology department. She also stayed that the weekend service provided by Build on Belief is well received by service users, providing a wide range of activities and social networking activities.

The former commissioner was of the opinion that the building from which WDP operates is too small and in many ways holds the service back. This restriction means that WDP have to seek out suitable satellite locations to deliver support which can be difficult to identify.

5.1.3 Principal Officer Community Safety & Serious Violence coordinator

The role of this stakeholder is to coordinate anti-social behaviour officers responding to lower level offending, plus serious violence which often incorporates exploitation of vulnerable individuals by organised criminals. A multi-agency response and management system is used.

The interviewee highlighted the issue of 'cuckooing' that exists locally – that is taking over the properties of vulnerable people (including those dependent on drugs/alcohol) for the purposes of drug dealing, hiding weapons and so forth. He noted that this issue has increased significantly over the pandemic, from one or two cases a year previously to eleven in the latest year. The increase is understood to be due to the 'business model' moving inside during lockdown as it would be too obvious

dealing on the street at times when all the public were indoors. As dealing moved indoors anti-social behaviour linked to the business increased due to increase in 'traffic' to the property.

The principal officer's team has contact with the WDP treatment service and have worked closely in the past when street drinking was an issue. Generally, any enforcement action is accompanied by an outreach and engagement approach to enable people to access support for their underlying issues, which might include problematic drinking or drug use.

Before the pandemic there were known street drinking areas (e.g. Wealdstone) which were targeted – these have not re-emerged so far. The interviewee noted that there are some 'seasonal pockets' when the better weather arrives which are monitored by the team.

The main night time economy area is Harrow High Street, and to a lesser extent Wealdstone. There are 'street pastors' who patrol the area, and who can refer individuals to treatment services if appropriate. There is also a Harrow Pubwatch, and Business Improvement District with whom the anti-social behaviour officers have contact.

The interviewee noted that multiple agencies can convene quickly when issues are identified and there are reportedly good working relationships between agencies. The WDP service manager is a member of the serious violence panel which meets regularly to discuss and respond to individuals who are considered to be at 'high risk'.

The relationship between the substance misuse treatment service and the principal officer's team is such that they can make contact when necessary and seek advice or plan joint work. The principal officer noted however that it may be the case that the anti-social behaviour officers could benefit from some training from WDP around basic drug and alcohol awareness and a full understanding of what the treatment/recovery system can deliver as well as expected outcomes.

5.1.4 Service Manager & Operations Manager, WDP treatment service

The representatives from WDP provided an overview of how the service is delivered. They noted that the service has adapted during the pandemic and continues to deliver using a largely online model. The transition back to a hybrid model of online and face-to-face services has now commenced.

From the range of partner organisations discussed it is evident WDP are represented at key partners' meetings where safeguarding adults and children are discussed and in mental health services in the

community and at Northwick Park Hospital. Furthermore, they liaise and work alongside housing support and other recovery enhancing services.

Areas identified from the interviews of particular interest to commissioners and in need of further investigation and development are described below.

Criminal justice pathways

Whilst WDP recognises improvements are needed to engage criminal justice clients in treatment, efforts have been made to develop and make the pathways work. The new senior criminal justice practitioner role connects with Wormwood Scrubs but has not been allowed access to actually be in the prison. Prison referral data is checked to identify individuals for follow up. Three way meetings with prison, probation and WDP as well as link-up meetings directly with probation take place.

At the time of interviews a new satellite location for WDP to deliver a service from within the probation service building was being agreed. It is envisaged this will improve engagement as service users will access at the same time and place as probation appointments.

Court cover is not provided currently however there may be a possibility of negotiating a cross-borough arrangement.

WDP representatives noted that there is no treatment service presence at the police custody suite in Wembley since the pandemic however the police can directly book an appointment with the service where required.

Workforce caseloads

Drug workers' caseloads have increased and currently stand at around 60-70. Ideally WDP would like average caseloads to be 35-40.

Not all cases are structured treatment – they can include pre (engagement stage) and post treatment (recovery). Where staff carry complex cases flexibility of caseload is managed.

The WDP representatives noted that drug workers have to juggle their time between delivering group work, keywork, administration and liaison (amongst other tasks). It was reported that, inevitably, the quality of intervention received on a one-to-one basis will suffer when workers are stretched. It was therefore suggested that an additional specialist group worker to re-establish and run group work

would enable the generic drug workers to manage caseloads better and provide more intensive keywork where needed – this could include assertive engagement into treatment.

Female clients

Female service users can request a same sex key worker/practitioner which is particularly important for women who may feel reluctant to access male dominated services, and/or who have experienced abuse. WDP is working toward providing Trauma Informed Practice workshops which will complement the mental health training sessions already available.

A women's group ran pre-pandemic with female practitioners which WDP representatives felt needs to be reinstated. The group mainly provided peer-to-peer support and health and wellbeing services with no set programme. Numbers previously were between five and ten, but have dwindled.

WDP staff stated that the proposed additional specialist group worker (as noted above) could include development and promotion of womens' space/sessions.

Links with primary care

GP shared care is available for stable service users on a prescription in the borough. Satellite sessions at GP surgeries have stopped since the pandemic and service users are seen at the treatment centre. It was reported that it is important to re-establish the GP based sessions to ensure service users benefit from a primary care based service. The treatment service continues to liaise with the GPs in the scheme.

WDP attend GP practice forums in Harrow and can discuss cases with GPs however time is tight in this forum. GPs have started to phone to discuss how to support patients with benzodiazepine dependence. GPs are recognising benzodiazepine dependence issues but are not necessarily confident in dealing with treating the dependence and reportedly some don't realise it is problematic to stop prescribing abruptly. WDP recognise there is a need to train GPs and are reported that they are happy to develop this training offer.

Outreach

Key to the operation of the service going forward is its ability to deliver outreach to engage more individuals in treatment and to develop well used and simple pathways into the service. Given the small size of the service in terms of its staff resource and its building, WDP representatives reported that outreach to sources of referrals is key to delivering on the Government's Drug Strategy aim to increase numbers in treatment.

WDP are currently looking at potential outreach to hostels and what the service users' needs might be.

The service already has links with the Genito-Urinary Medicine clinic. WDP work with a small number of sex workers who are highly vulnerable, at risk and female and provide intensive engagement and support needs.

A new adult safeguarding post was funded from 2012/22 drug treatment grant (see finance section) which was intended to be co-located with adult social care/safeguarding however the local authority has not so far provided a space which has impeded closer working between the teams.

Funding has been offered for an Eastern European specialist post but WDP have had problems recruiting to it. Representatives from WDP indicated that it may be possible to widen the brief to a wider minority community specialist. The funding has currently however not been used.

Inpatient detoxification and residential rehabilitation

WDP hold a budget for inpatient and residential provision to be used where needed. It appears most, if not all placements are made to WDPs own inpatient and residential service at Passmore's House in Essex.

In addition to the core contract funded provision Harrow has contributed £19,000 to a pan-London inpatient detoxification service at Guys & St Thomas' hospital which has been unused. It may be beneficial for commissioners to consider how best to meet the varied needs of more complex service users to make best use of the funds available for this high cost/low volume component of the treatment system and look at the various options available, especially in the light of the Government target to provide residential provision to 2% of the treatment population (the baseline figure for Harrow is 1.1%).

WDP building

WDP's treatment and recovery service is delivered from a residential house which, although well situated, is considered by staff to be too small for the treatment service, with particular limitations in the ability to deliver group work. The lease on the property runs until September 2023. WDP are looking for locations to run groups in sites elsewhere. It was noted that moving to new premises may well have cost implications.

5.1.5 Head of service, Harrow and Barnet, London Probation Service

From a probation service perspective there is considerable development needed to improve the take up of drug and alcohol treatment for probation clients.

The interviewee from probation highlighted in particular that Drug Rehabilitation Requirements (DRR) and Alcohol Treatment Requirements (ATR) issued by courts to Harrow residents are at a very low level, and this has decreased further over the period of the pandemic. The interface between probation and the treatment service was described as patchy – sometimes with insufficient information received from the treatment service for probation reports on DRR/ATR clients.

There is a prison-specific worker based at WDP but this has not resulted in an increase in continuity of care engagement (i.e. links between prison and community treatment) treatment and therefore performance regarding this target remains low. The probation representative felt that pre-release preparatory work may improve engagement rates but that staff resourcing may be an issue with the interviewee noting a staff sickness issue that impacted on the concerns for probation clients.

Consistent with what was reported by WDP (see above) it was noted that there is no court-based drug workers to complete DRR/ATR assessments. This therefore creates a delay when assessments are needed. It was noted that drug users from multiple boroughs are dealt with in the court and that therefore a cross-borough arrangement might work better.

The representative from probation was aware of a full range of treatment options on offer but also noted that, within the probation service and client group, there is a perception that inpatient provision and residential rehabilitation is almost impossible to access and the criteria for it is high meaning that service users do not try to access it. There is also a perception that mental health services for substance use clients is difficult to access as disputes occur around where the 'primary diagnosis' sits (i.e. mental health lead or substance misuse lead). There is an appetite within probation to contribute to further development of protocols/pathways to address this.

In terms of the skills of the probation service workforce some joint training between the treatment service and probation service might be helpful to ensure basic drug/alcohol awareness and a full understanding of services available and protocols between the two services.

For younger probation clients in the 18-24 age range within the probation system, a form of over-the-counter drug misuse has been noticed by the probation team which can lead to offending behaviour

and dependence problems. 'Lean' is codeine based cough medicine mixed with fizzy drinks and sweets. Codeine is an opioid and becomes addictive with regular use.

5.1.6 Chief Executive, Build on Belief

Build on Belief run weekend services in Harrow for people who are in recovery from their substance use. They provide an interactive, service user/peer run form of mutual aid. The services are open access and offer a wide range of activities loosely based around the 'five ways to well-being'. They do not offer formal therapeutic interventions but are a socially based befriending service designed to complement the existing structured treatment system.

In Harrow they are sub-contracted by WDP to provide the weekend service. They are also working at Northwick Park Hospital (under a separate contract to the local authority) to support service users with dual diagnosis (that is those who have co-morbid mental health conditions).

Build on Belief provide an online service with over 35 workshops a week: these include peer support, book club, cookery, yoga, mindfulness, and many others, as well as a 'bricks and mortar' based service at the WDP building. The online service was developed in response to the pandemic and works well for particular groups such as women with child caring responsibilities, socially anxious people who don't feel comfortable accessing in person groups, and those who are IT literate and online. However, the online experience does not suit everyone – for some the cost of broadband is the barrier that excludes them, rather than cost of equipment.

The main issue identified for the borough in terms of the Build on Belief provision is the WDP building which is so small that it makes it hard to run groups. Only six to eight people can fit in to the space available at one time. The representative from Build on Belief noted that they could expand their provision with current staffing but the limitation is space.

6. Recommendations

Following on from the evidence set out above the following recommendations have been made:

1. Further consultation and data analysis to improve this initial, limited, needs assessment should be undertaken to gain a better understanding of the drug and alcohol needs of the borough. This should include (but not be limited to) consultation with police, psychiatric liaison at Northwick Park, alcohol care team at Ealing Hospital, mental health services, primary care providers, pharmacies as well as collation and analysis of wider datasets.
2. The commissioning function for substance misuse should be strengthened in order to support the treatment system to recover from the pandemic restrictions, to work on improving the interface between services and monitor the performance and impact of new funding.
3. The strengthened commissioning function should be involved in the development of a drug strategy partnership which involves key partners in coordination and planning and which contributes to commissioning decisions.
4. WDP should re-establish 'in person' services including group work and at satellite locations where possible to ensure that those with more vulnerability and complexity can access support.
5. WDP should re-establish the GP based shared care sessions to ensure service users benefit from a primary care based service, thereby freeing up space at the treatment service.
6. Consideration should be given to employing a group work specialist post for WDP to focus on the development of group work including a gender specific and trauma informed womens' group. Recruitment of such a post would free up the capacity of other drug workers enabling them to better manage caseloads and provide more intensive support to those in most need.
7. A deep dive investigation/audit should be undertaken into criminal justice links and pathways[5] – particularly in relation to continuity of care between prison and community treatment. Within this deep dive, commissioners should monitor the impact of investment and new posts in terms of activity and NDTMS outcomes.
8. WDP should further develop outreach partnerships with external services and potential referral sources, building pathways that will engage more service users in treatment.

[5]Guidance: Continuity of care for prisoners who need substance misuse treatment. An audit toolkit and guidance on data recording, for prison and community treatment providers and commissioners. https://www.gov.uk/government/publications/continuity-of-care-for-prisoners-who-need-substance-misuse-treatment

9. Commissioners should review inpatient detoxification and residential rehabilitation funding and placements to fully understand the spend on these two treatment components and consider how to move towards the national target of 2%.
10. The building from which WDP operates is considered to be too small and therefore potentially holds the service back. Furthermore, the lease ends in 2023. The limitations of the building restricts delivery of the commissioned service and means that WDP must seek out suitable satellite locations to deliver support. Commissioners should consider how to support the service in the short term to find satellite locations and allow co-location desk space in local authority services. In the medium term commissioner should liaise with WDP about plans for the end of the current lease and identification of a new fit for purpose building with appropriate capacity.
11. WDP should address the training needs of partner agencies such as probation services, the anti-social behaviour team and GPs around drug and alcohol awareness generally. Specific issues such as prescribed medicines dependence awareness for GPs should also be addressed.
12. Commissioners, WDP and key partners (such as the probation service) should consider the possibility of shared coverage of police custody and court settings using a cross-borough arrangement. This could increase referrals into treatment and improve DRR and ATR rates.
13. WDP should address the need to provide support and training for its workforce in relation to reflective practice to develop skills in the psychosocial interventions the team deliver.