



Bromley Clinical Commissioning Group



THE LONDON BOROUGH

www.bromley.gov.uk

BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT

2017

Drug Misuse in Adults

For more information visit www.bromley.gov.uk/JSNA or contact
JSNA@bromley.gov.uk

THIS PAGE HAS BEEN LEFT BLANK INTENTIONALLY

Contents

Executive Summary.....	4
Introduction.....	6
Causes and Patterns of Drugs Misuse	8
Epidemiology of Drug Misuse.....	9
Crime Survey for England and Wales.....	9
Prevalence Estimates- Bromley compared to region and nation.....	10
Prevalence of Over the Counter and Prescription Only Medication.....	17
New Psychoactive Substances and Club Drugs	18
Treatment Population	19
Not in Treatment Population.....	30
Impact on Health and Wellbeing	32
Mental Health (Dual Diagnosis)	33
Morbidity: Blood Borne Infections	36
Hospital Admissions.....	39
Mortality	45
Socioeconomic Impact	52
The Social Return on Investment in Local Drug Treatment Services	52
Crime.....	53
Health and Care Costs	53
Children and Families.....	54
Social Services, Housing and Benefits	55
The Treatment and Management of Drug Misuse	58
Treatment Pathways.....	60
Intervention Type and Setting Delivered	60
Treatment Outcomes	65
Prison Release and Transfer to Treatment.....	70
Early Unplanned Exits	71
Residential Rehabilitation	71
Appendix.....	73
Data Sources and Definitions.....	73
References.....	75

Executive Summary

Bromley has the **7th lowest estimated rate of Opiate and/or Crack** use in the region and **lower overall rates of drug use** compared to the regional and national average.

However the estimated consumption rate for **Opiate and/or Crack use in young people** in Bromley (age 15-24) is **higher** than the regional or national average. Rates of combined **Opiate and/or Crack use** are also rising in **the older population** (age 35-64).

The rate of **hospital admissions for substance misuse in young people** in Bromley is **significantly higher** than the national and regional average. The rates for young people are **increasing more steeply in Bromley** than across London or England as a whole.

Hospital admission rates for substance misuse in Bromley **positively correlate** with levels of **socioeconomic deprivation**. In contrast there is **no observable link** between **drug-related death rates and deprivation** in Bromley.

The **rate of drug-related deaths in Bromley** is lower than the regional local authorities in the same socioeconomic deprivation bracket and among the **lowest in the region**

There were a total of **50 drug-related deaths in Bromley** between 2012 and 2016.

The **average age** at the time of death was 47 years. **67%** of local drug-related deaths were classified as **accidental poisonings**, compared to 55% nationally.

Whilst the **illicit use of drugs in Bromley is increasing**, the **number entering treatment is decreasing**. **Opiate users** still dominate adult treatment, these clients generally face a **more complex** set of challenges and it is **more challenging** to achieve positive and sustainable outcomes.

The **estimated level of unmet need** (those with problematic substance misuse but not currently in contact with treatment services) **in Bromley is much higher** than the England average. It is estimated that **63%** of drug users in Bromley **are not known to treatment services**, ranking Bromley **second highest in the region**.

Of those in **contact with treatment services** in Bromley nearly **50%** of clients are **age 40+**, this is slightly **higher than the national average**. The age profile of clients newly presenting to treatment has also shifted to an older population.

In 2016/17 there were **100 children known to be living** with people misusing drugs in Bromley who had presented to substance misuse services for the first time in that period.

The proportion of **clients who engaged with treatment** following **referral from prison** is **lower in Bromley** than the national average (29% compared to 33%).

Bromley has a **higher proportion** (37%) of new clients presenting with a **co-occurring mental health condition** (dual diagnosis) **compared to England** (24%). **Half** of all **women** who present new to treatment, for **non-opiate or non-opiate and alcohol misuse**, have a co-occurring mental health condition.

16% of all people presenting to drug treatment services in Bromley cited a problem with **prescription only or over the counter medication** (POM/OTC) this is similar to the national average (15%)

Only **11%** of new clients in Bromley, who were eligible for hepatitis B vaccination and accepted to be vaccinated, actually **started a course of vaccination**.

Of those completing treatment with a planned exit in Bromley, the **number in full time work had increased by 32%** (compared to when they entered treatment) this is considerably higher than the national average increase (16%).

17% of all drug treatment clients in Bromley **successfully completed treatment** compared to 15% in England. **Locally** the current **treatment drop-out rate is lower** than the national average (12% in Bromley compared to 17% nationally). **Men were more likely to drop-out early** across all substance groups both locally and nationally.

Opiate clients have the **lowest proportion of successful completions** compared to rates for the other substance groups (**8% in Bromley**, 7% nationally). In Bromley the rates of opiate users achieving abstinence within 6 months is currently the same as the national average (39%). **Women** in Bromley presenting to treatment for **opiate use** had **higher successful completion rates** compared to men (12% compared to 6%).

Introduction

The World Health Organisation defines substance misuse as the use of a substance for a purpose not consistent with legal or medical guidelinesⁱ.

In the UK illegal drugs are classified, according to the harms they are considered to cause, into three main categories; A, B or C. Class A drugs are considered to be those which can cause the most harm.

Table 1

Class	Drug
A	Crack cocaine, cocaine, ecstasy (MDMA), heroin, LSD, magic mushrooms, methadone, methamphetamine (crystal meth)
B	Amphetamines, barbiturates, cannabis, codeine, methylphenidate (Ritalin), synthetic cannabinoids, synthetic cathinones (e.g. mephedrone, methoxetamine), ketamine
C	Anabolic steroids, benzodiazepines (diazepam), gamma hydroxybutyrate (GHB), gamma-butyrolactone (GBL), piperazines (BZP), khat

Adapted from UK Drug Classificationsⁱⁱ

Drug misuse is recognised as a major public health issue in the UK.

It is estimated nationally, that drug supply gives rise to £10.7 billion a year in social and economic costs – of which, £6 billion, is attributed to drug- related acquisitive crimeⁱⁱⁱ. Drug misuse is both a cause and consequence of wider factors including; physical and mental ill-health, and wider determinants. Harms caused by drug misuse are far reaching and affect lives at every levelⁱⁱⁱ.

A recent review of the evidence of patterns of drug misuse and treatment outcomes in England was undertaken as part of the development of the new national Drug Strategy 2017^{iv}. The review identified a range of patterns in substance misuse and their impact that are evident or emerging in England:

- The proportion of people in treatment with entrenched dependence and complex needs, particularly older heroin users, will increase. Evidence shows it is challenging to support those with complex needs and a long treatment history to achieve recovery, consequently the rates of successful treatment completion will continue to fall.
- The number of deaths related to drug misuse has risen significantly over the last 20 years, and particularly rapidly in the last 3 years. Older heroin users

(those aged 40 and over who may have started using heroin in the 1980s and 1990s) who now have multiple health conditions, are more susceptible to overdose. Drug misuse deaths in those in treatment for opiate dependency are predicted to continue to rise rapidly, due to overdoses and deaths from long-term conditions.

- There are reports of increasing problems of misuse and dependence associated with some prescription and over-the-counter medicines. The use of new psychoactive substances (NPS) is also increasing, and is a particular problem in prisons. New patterns of drug use and health risk behaviour are also becoming established including NPS used by injection, and drugs used alongside high-risk sexual behaviour ('chemsex').

These trends are likely to influence the future harms and costs of substance misuse in England and impact on the effectiveness and outcomes of local substance misuse harm reduction, treatment and recovery services.

This report will focus on drug misuse in adults and aims to draw on the latest available statistics to provide a profile of the patterns and trends in drug use in the population of Bromley and make regional and national comparisons.

Analysis and recommendations will be provided to inform the planned reprocurement of substance misuse services for adults, children and young people in Bromley in 2018.

Details of the patterns, impact and treatment of alcohol misuse in Bromley can be found in the "Alcohol" section on p. 246 of the JSNA 2016:

<https://bromley.mylifeportal.co.uk/media/20397/final-report-jsna-2016.pdf>

A review of patterns of substance misuse in children and young people and the impact of parental substance misuse can be found in the Child Wellbeing Needs Assessment 2016:

<http://cds.bromley.gov.uk/documents/s50045892/Child%20wellbeing%20needs%20assessment%20for%20Review%2028.09.16.pdf>

Causes and Patterns of Drugs Misuse

Problem drug use is viewed as a medical condition in the UK, and there is neurobiological evidence to suggest that this is the case. There are both genetic and social risk factors for drug misuse, which are most potent in combination.

Most people start taking illicit drugs in their teens and early twenties, with most reducing or stopping use as they move into adulthood. Dependency on opioids tends to start a few years after first use.

Dependency causes long-lasting changes in the brain, which cause tolerance, craving and withdrawal. As a result it is a chronic condition, characterised by periods of remission and relapse.

Drug use and misuse tend to be clustered; for example, areas of relatively high social deprivation have a higher prevalence of illicit opiate and crack cocaine use and larger numbers of people in treatment. The association between social factors and illicit drug use is reciprocal; drug misuse can cause social disadvantage, and socio-economic disadvantage may lead to drug use and dependence. Social factors can also moderate drug treatment outcomes. Unemployment and housing problems have a marked negative impact on treatment outcomes and exacerbate the risk that someone will relapse after treatment. Addressing the wider issues of health inequality and social exclusion are therefore fundamental to improving treatment outcomes^{iv}.

Epidemiology of Drug Misuse

Drug use is widespread but addiction is concentrated



2.7 million adults used an illegal drug in the past year

294,000 heroin and crack users in England

40% of prisoners have used heroin

1,200,000 affected by drug addiction in their families – mostly in poor communities

Adapted from Public Health England^v

Because of the illicit nature of drug misuse, direct counts for the number of opiate and /or crack cocaine users (OCU) are not readily available through administrative datasets. Instead indirect techniques are used to provide estimates of prevalence.

There are currently two sources of prevalence information: the Crime Survey for England and Wales (CSEW)^{vi} and estimates of problematic opiate use and crack cocaine use for England (2014-15)^{vii}.

Crime Survey for England and Wales

According to the 2016/17 CSEW, 1 in 3 (34.2%) adults aged 16 to 59 and 35.7% young adults aged 15-24 years had used a drug at some point in their lives (10.8 million people and 2.2 million people respectively)^{vi}.

Around 1 in 12 (8.5%) adults aged 16-59 in England and Wales had taken an illicit drug in the last year^{vi}. This equated to around 2.8 million people, and was similar to the 2015/16 survey (8.4%).

Around 1 in 5 (19.2%) young adults aged 16 to 24 in England and Wales had taken a drug in the last year (CSEW, 2016/17). This proportion was more than double that of the wider age group, and equates to 1.2 million people. The level of drug use was similar to the 2015/16 survey (18.0%)^{viii}.

The drug most cited as ever used was cannabis^{vi}. However cannabis use is lower than a decade ago and rates have been stable since 2009-10^{vi}. Estimates of ecstasy use among those aged between 16-24 years have increased and are currently similar to levels a decade ago (4.5% in 2015-2016 compared with 4.3% in 2005-2006)^{vi}.

The 2016/17 survey estimated that in the last year 7.6% of adults aged 16 to 59 had taken a prescription-only painkiller not prescribed to them for medical reasons, similar to the estimate of 7.4 per cent in the 2015/16 survey^{viii}.

While use of new psychoactive substances among the general population is low (0.7% of 16-59 year olds reported having used a new psychoactive substance in 2015-2016), they continue to appear rapidly on the market, and use among certain groups is problematic, particularly among the homeless population and in prisons. In addition, there is emerging use of image and performance enhancing drugs (including intravenous use); and use of multiple drugs ('poly-substance misuse').

Prevalence Estimates- Bromley compared to region and nation

These estimates bring together datasets available at a local and national level. For further information on the methodology, follow the link below

<http://www.cph.org.uk/wp-content/uploads/2017/09/Estimates-of-the-Prevalence-of-Opiate-Use-and-crack-cocaine-use-2014-15.pdf>.

Table 2

Number of Drug users (Rate per 1000 adult Population) 2014/15			
	Opiate &/or Crack Users	Opiate	Crack
Bromley	1221 (5.96)	870 (4.24)	837 (4.08)
London	52487 (8.87)	40750 (6.89)	39226 (6.63)
England	300783 (8.57)	257476 (7.33)	182828 (5.21)

Source: National Treatment Agency, 2017^{ix}

Bromley has lower estimated rates of opiate and or crack use than London and England in all categories (**Table 2**). The number of people using drugs in all

categories has increased since the last estimates in 2011/12. The local trend is similar to the national trend but not regional, where the numbers have fallen in all categories (**Table 3**). It is estimated that three quarters of the population using OCU and crack and two thirds of opiate users in Bromley are currently not in treatment.

Table 3

Difference between 2014/15 and 2011/12 estimates			
	Opiate &/or Crack Users	Opiate	Crack
Bromley ↑	104	56	87
England ↑	6,904	1,313	16,188
London ↓	-2,498	-3,168	-854

Source: PHE Adults- drugs commissioning support pack 2018/19 & National Treatment Agency, 2017

Bromley has the 7th lowest rates (out of 33 boroughs) of estimated combined opiate and or crack use in the region (**Figure 1**), as well as the 5th lowest estimated rates of opiate use (**Figure 2**) and crack use in the region (**Figure 3**). Although the rates of drug use are significantly below the region and national average, Bromley fares worse than two of the four local authorities in the region in a similar socioeconomic deprivation bracket (Merton, Sutton, Harrow, City of London).

Figure 1

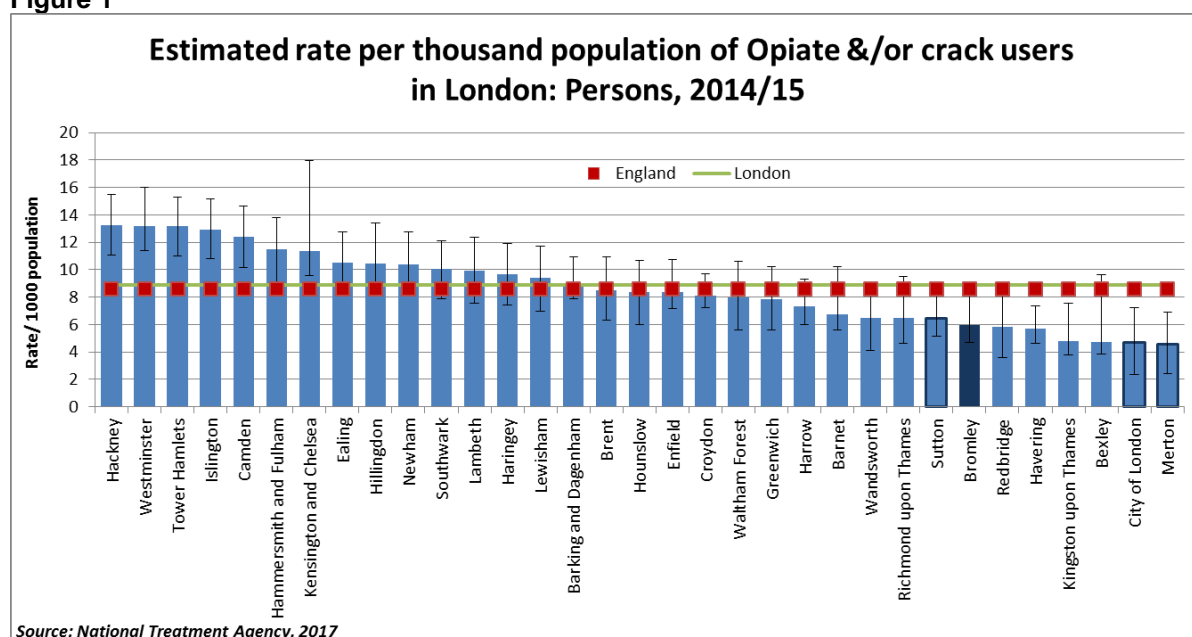


Figure 2

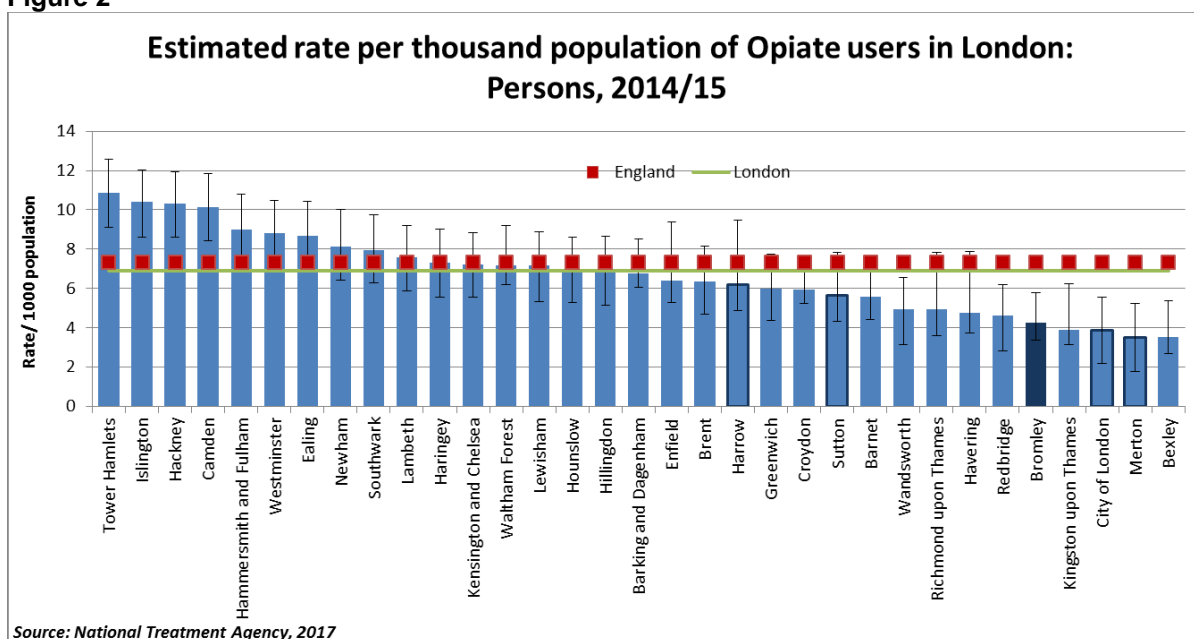
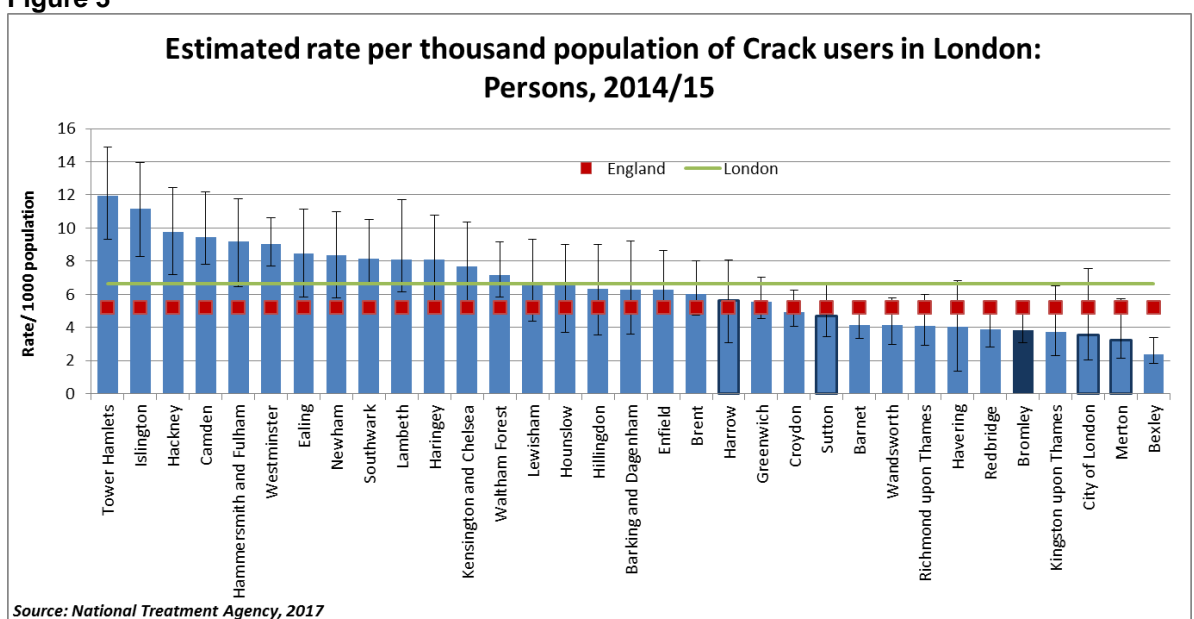


Figure 3



Demographic characteristics- Age

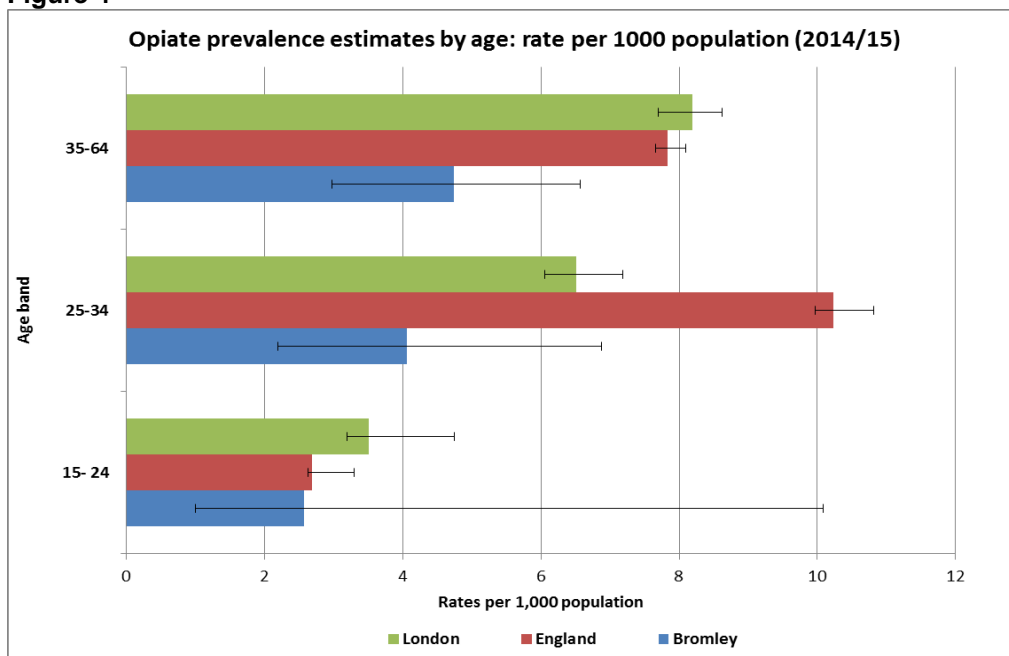
In England and Wales, younger people were more likely to take drugs than older people^{vi}. The level of any drug use in the last year was highest among the youngest age groups in England and Wales; 16.5% of 16 to 19 year olds and 21.2% of 20 to 24 year olds reported any drug use in the last year^{vi}. Levels of drug use then decreased as age increased, from 11.4% of 25 to 29 year olds to 2% of 55 to 59 year olds^{vi}.

There is no local information on combined drug use by age; the data available splits drug use by the different categories (opiate and/or crack users and opiate users but no data on crack use).

The estimated rates of opiate consumption in 15-24 year olds is similar in Bromley to that in London and England whereas opiate consumption rates in the older age groups are lower in Bromley in comparison to national and regional figures (**Figure 4**). The wide and overlapping confidence intervals are indicative of the small numbers.

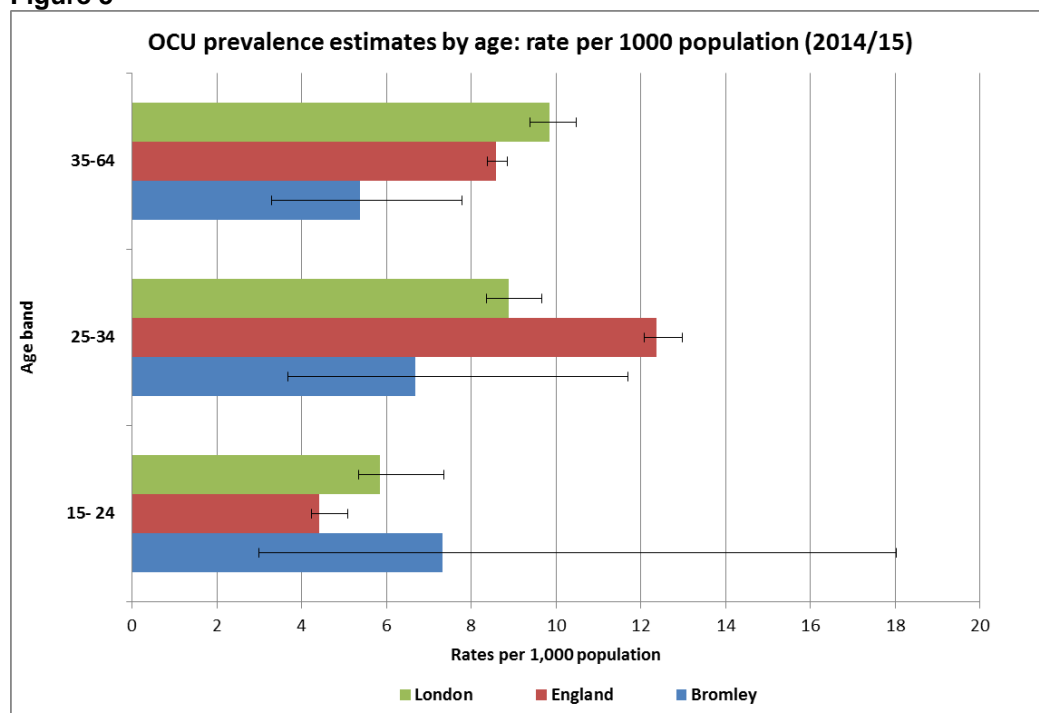
For combined opiate and/or crack use rates (**Figure 5**), the estimated consumption rates are actually higher in Bromley's young people (age 15-24) than the regional or national average.

Figure 4



Source: *National Treatment Agency, 2017*

Figure 5



Source: National Treatment Agency, 2017

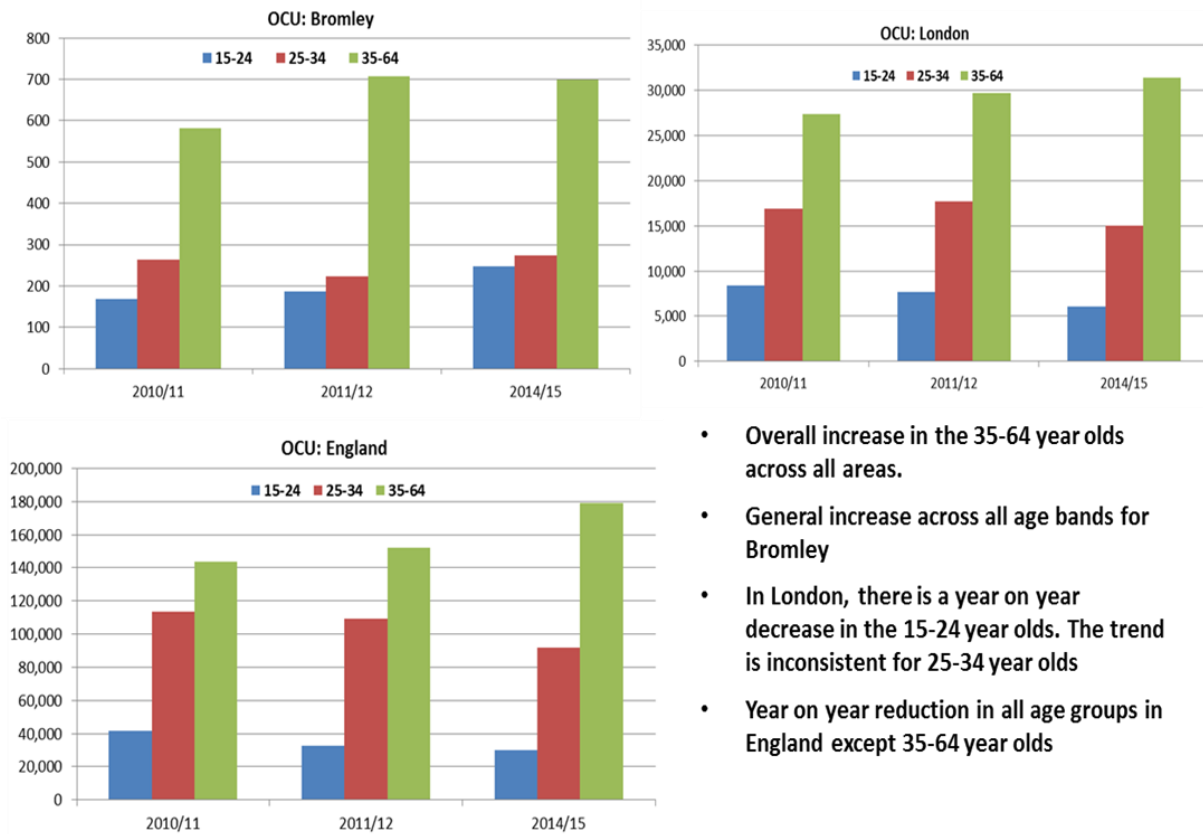
Analysis of trends in prevalence rates over time show an overall increase in the estimated number of older drug users (**Figure 6**).

In England, there has been a significant increase in those aged 35 and over who use opiates and or crack, rising from 130,628 in 2010-11 to 163,180 in 2014-15. A large proportion of heroin/opiate users in treatment in 2016-17 will have started using heroin in the epidemics of the 1980s and 1990s and are now over 40 years of age, having been using heroin for a significantly long period of time^x. The long term use significantly impacts on the burden of disease (particularly increasing complexity of cases with long term conditions) and mortality. Evidence shows that the aging cohort contributed to the worsening trend of drug related death ratesⁱⁱⁱ. Drug related deaths are discussed later in the report.

In Bromley, the estimated prevalence of opiate and or crack users in those aged 35-64 years in 2014/15 (609) is slightly lower than the previous estimates (707, 2011/12), (**Figure 6**).

Figure 6

Estimated Number of Opiate &/or Crack Users by Age band (2014/15)



- Overall increase in the 35-64 year olds across all areas.
- General increase across all age bands for Bromley
- In London, there is a year on year decrease in the 15-24 year olds. The trend is inconsistent for 25-34 year olds
- Year on year reduction in all age groups in England except 35-64 year olds

Source: National Treatment Agency, 2017.

Demographic characteristics- Gender

National statistics show that men were more likely to take drugs than women. Around 1 in 9 (11.5%) men aged 16 to 59 had taken any drug in the last year, compared with 1 in 18 (5.5%) women^{vi}.

The estimated levels of male opiate users in Bromley is about four times the estimated rates for females, whilst it's about three times in the region and the nation (Table 4).

Table 4: The estimated number and (rate per 1000 population) of Opiate users by gender: 2014/15

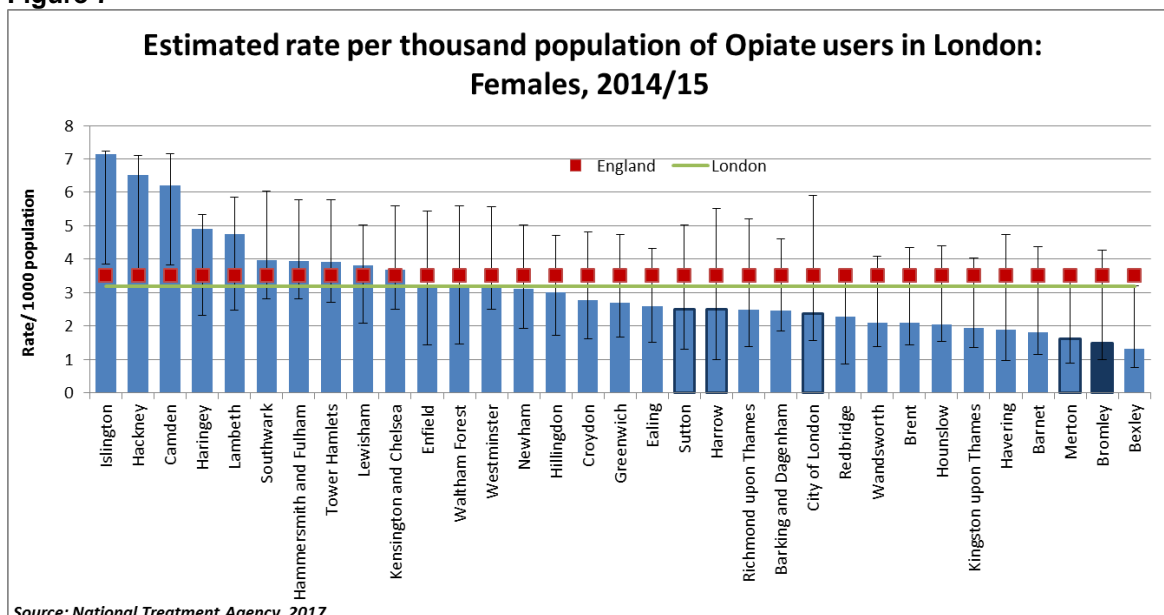
	Female	Male
Bromley	158 (1.49)	712 (7.18)
London	9427 (3.19)	31323 (10.58)
England	61682 (3.51)	195794 (11.18)

Source: National Treatment Agency

In the 2016/17 CSEW, nationally, men were more than twice as likely to report using cannabis in the last year as women (9.0% of men, compared with 4.2% of women)^{vi}. Men were almost three times more likely than women to take powder cocaine (3.3% compared with 1.3%) and were also twice as likely to have taken ecstasy (1.7% compared with 0.9%) in the last year^{vi}. Unfortunately at a local level, drug use analysis by gender is only available for opiate use and not the other categories of drug. So we are unable to make comparisons of the local gender profile for users of other types of drugs.

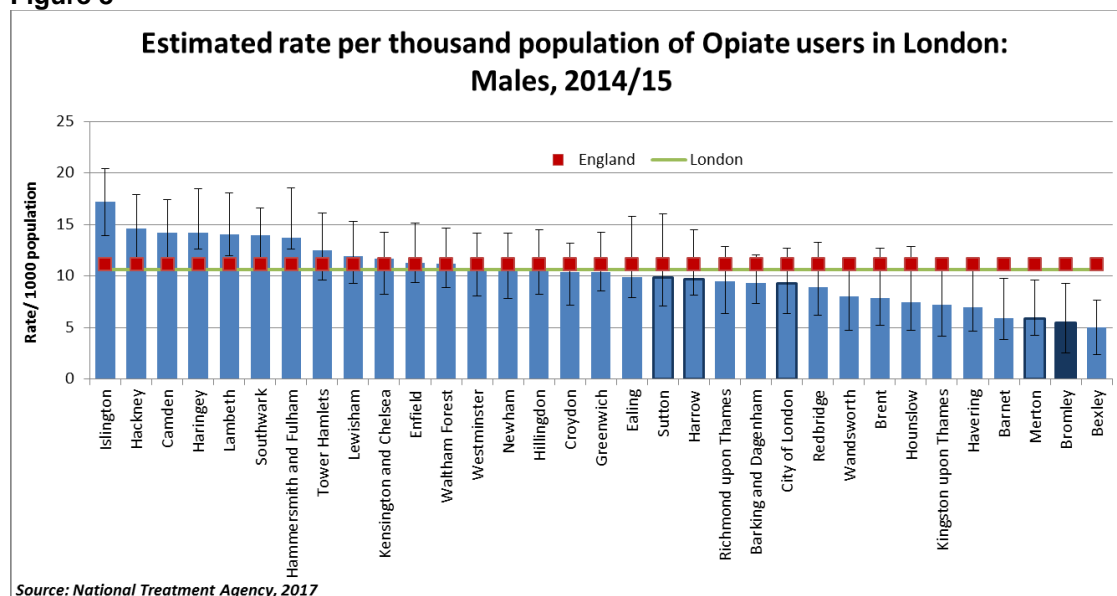
Figure 7 and 8 shows that Bromley has the second lowest rates of opiate use in women and men in the region. Bromley rates are lower than the four local authorities in the region in a similar socioeconomic deprivation bracket (Harrow, Merton, Sutton and City of London). The wide over lapping confidence intervals are worth noting, indicative of the small numbers behind these data and the indeterminate statistical significance.

Figure 7



Source: National Treatment Agency, 2017

Figure 8



Prevalence of Over the Counter and Prescription Only Medication

Addiction to prescription-only medicines (POMs) and over the counter medicines (OTC) has become an increasing problem in recent years^{ix}. OTC/POM drugs come under four main groups:

- Benzodiazepines and z-drugs, prescribed mainly for anxiety (benzodiazepines only) and insomnia
- Opioid and some other pain medicines, both prescribed and bought over-the-counter
- Stimulants, prescribed for ADHD or slimming
- Some OTC cough and cold medicines, and anti-histamines and stimulants.

There are distinct but overlapping populations using these medicines:

- Those who use prescription and OTC medicines as a supplement or alternative to illicit drugs, or as a commodity to sell
- Those who overuse prescription or OTC medicines to cope with genuine or perceived physical or psychological symptoms
- Those for whom the prescribed use of a medicine inadvertently led to dependence, sometimes called involuntary or iatrogenic addiction.
- Whilst there is evidence in the USA of a very substantial rise in the misuse of opioid analgesic medication and heroin use, there is currently no evidence of this gateway into heroin and other illicit substance use in England. It is however important that opioid prescribing levels are monitored to ensure they remain proportionate to need and that there are measures in place to prevent and treat dependence.

16% of all people presenting to drug treatment services in Bromley cited a problem with prescription only or over the counter medication (POM/OTC). Of these, 11% cited illicit use ¹ and 5% are presenting to treatment for non-illicit use ^{xi}. The proportion of people citing POM/OTC use in Bromley is similar to England (15%). Of the 15% citing use in England, 12% were illicitly using while 3% were non-illicit ²users.

New Psychoactive Substances and Club Drugs

Club drugs and New Psychoactive Substances (NPS) bring together a number of different substances typically used by people in bars and nightclubs, at concerts and festivals, before and after a night out.

The definition of NPS and Club Drugs has evolved over the years, reflecting the rapid and constant change in the characteristics of the drugs that are encompassed by the definition and the way in which they are used. A UK report in 2015 cited the following definitions^{xii}:

NPS are those substances that are deliberately designed to mimic the effects of controlled drugs while at the same time “designed” to be outside the scope of the Misuse of Drugs Act.

Club drugs are those controlled drugs (primarily used on the club/dance/festival scene) that are cause for growing concern (older drugs causing newer problems) either because of increasing acute incidents (such as MDMA/PMA) or their association with longer term, chronic conditions (such as GHB/GBL, ketamine and methamphetamine).

NPS can be further sub-divided into 4 main groups^{xii}:

1. Synthetic cannabinoid receptor agonists (SCRAs) – traded under names such as; Clockwork Orange and Black Mamba. The chemicals in these drugs act on the brain in a similar way to cannabis.
2. Stimulant-type drugs – The effects of these drugs replicate those experienced with amphetamine and MDMA. Examples of these NPS include; BZP, mephedrone, MPDV, NRG-1 and Benzo Fury.
3. Hallucinogenic NPS – Examples include; Bromo-Dragonfly, 25i-NBOMe & methoxyetamine
4. Opiates – there is some evidence of opiate type NPS, such as kratom, available in Europe but currently no evidence of significant use in the UK.

¹ Using Prescription only medicine to supplement the abuse of traditional illicit drug use and/or complement the effects of illicit drug use

² Addiction to prescription only medicine and taking prescription only medicine for reasons, or in ways or amounts not intended by the prescriber

The 2015/16 CSEW showed that some behaviours make it statistically significantly more likely that an individual will have used an NPS in the last year such as; alcohol consumption, visited a night club and evening pub or bar visit^{vi}.

The populations citing NPS/club drug use can also be split into two distinct groups; i) those also using opiates and ii) those citing NPS/club drug use and possibly other drugs but not opiates. Non-opiate using club drug users typically have good personal resources- job, relationships, accommodation- that means they are more likely to make the most of treatment^{xi}. In contrast a UK report recently described the profile of a NPS user as; a vulnerable young person, living in a socio-economic deprived environment (possibly on the streets or in the prison population), too young to be on the club drug scene and with little disposable income but who now has access to easily available (supposedly legal) substances with which to get intoxicated^{xii}.

Among the club drug users in Bromley citing opiate use (who were new to treatment in 2016/17), Mephedrone was the commonly used drug. While among those with no additional opiate use, Ecstasy (60%) was the drug most commonly used followed by NPS other (40%). Of those citing NPS other, 20% was predominantly cannabinoid and 20% others^{xi}. The data is subject to small numbers year on year random variation and disclosure controls which inhibit further analysis.

Among the club drug users in England citing opiate use (who were new to treatment in 2016/17), NPS other (69%) was the most commonly used drug, which was dominated by cannabinoids (42%) and other (18%). Among the club drug users with no additional opiate use, the three top most cited drugs were; Ecstasy (32%), NPS other (29%) and Ketamine (21%).

Both nationally and locally, the club drug users with or without opiate use, citing NPS other, also mainly cited Cannabinoid predominant drugs followed by other category.

Treatment Population

This section describes the characteristics of people who were in structured drug treatment in 2016-17. These services are a key part of drug treatment and recovery systems. The section includes a profile of all those in treatment and then goes on to describe the characteristics of specifically those who were new to treatment³ in that year. This doesn't include any information on the population of drug users who are not receiving treatment. The potential level of unmet need in the population who are not in contact treatment services is discussed further later on.

In 2016/17, there were 279,793 people aged 18-99 attending structured treatment for drug misuse in England, 28% (78,663) of them were new to treatment in this period.

³ Mix of individuals at their first point of contact with treatment system and those previously known to the service who are representing for further treatment.

In 2016/17, 460 clients attended drug treatment services in Bromley, 50% (231) were new to treatment in this period. The proportion of clients who were new to treatment is considerably higher in Bromley compared to the national average, however, it is indeterminate the proportion of clients re-presenting to service and those at first point of contact.

Table 5 shows that the most common reason for seeking treatment, both locally and nationally, is opiate use.

Over half of those in treatment nationally (52%, 146,536) were misusing opiates. This proportion is higher in Bromley with 66% (304) of clients in Bromley seeking treatment for opiate misuse.

The proportion of clients seeking treatment for opiate use is slightly lower in those who were new to treatment in 2016/17 in Bromley (53%) but this is still the predominant substance type for which treatment is sought. The proportion of those clients new to treatment in Bromley who sought help for non-opiate or non-opiate and alcohol misuse is considerably larger than in the total treatment population in Bromley (47% of the new to treatment population compared to 34% in the total treatment population).

Table 5: Numbers in treatment and new presentations by main substance group 2016/17

Bromley	In treatment Total		New presentations	
	Number	%	Number	%
Opiate	304	66	122	53
Non-opiate only	62	13	43	19
Non-opiate & alcohol	94	20	66	29
All	460		231	

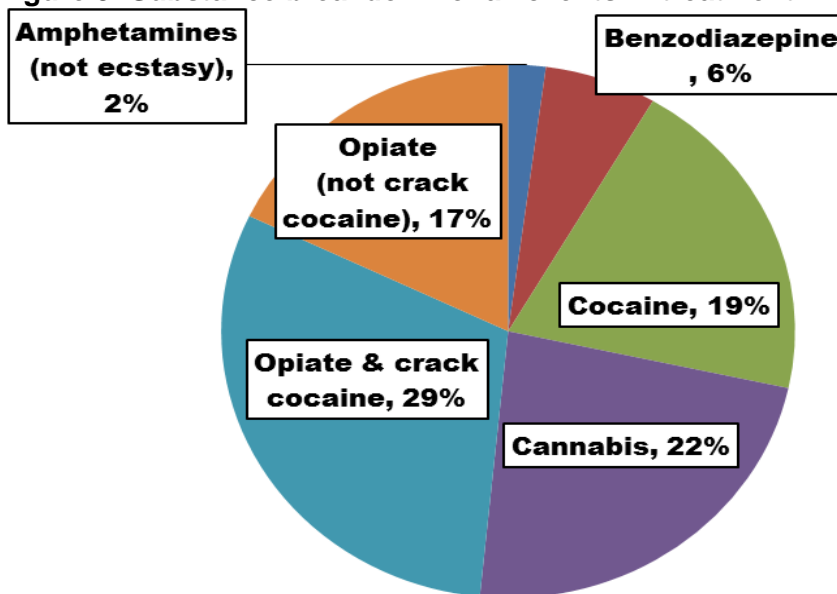
England	In treatment		New presentations	
	Number	%	Number	%
Opiate	146,536	52	43,142	55
Non-opiate only	24,561	9	16,775	21
Non-opiate & alcohol	28,242	10	18,716	24
All	279,793		78,633	

Source: National Drug Treatment Service, 2017

Drug use profile

Individuals may present to treatment citing problems with more than one substance (including alcohol). However, clients that are in treatment for alcohol only are excluded from this analysis. The adjunctive substances clients present to treatment with differ by the main drug groups. Opiate clients in Bromley tend to present with crack cocaine, making crack cocaine the biggest adjunctive substance (29%). Non-opiate clients accessing treatment in Bromley, either alone or in conjunction with alcohol, tend to present with cocaine and cannabis misuse. **Figure 9** shows substance use profile of all clients in treatment in Bromley in 2016/17.

Figure 9: Substance breakdown of all clients in treatment in Bromley: 2016-17



Source: NDTMS Trend Report, 2016-17

Treatment population trends

The number of clients in contact with treatment services has fallen gradually for both Bromley and England as shown in **Figures 10** and **11**. The data presented combines all three main substance groups- opiate, non-opiate and alcohol and non-opiate only. Alongside the reduction in the number of clients in treatment, there is a downward trend in the number of new clients entering treatment (**Figure 12** and **13**).

Figure 10

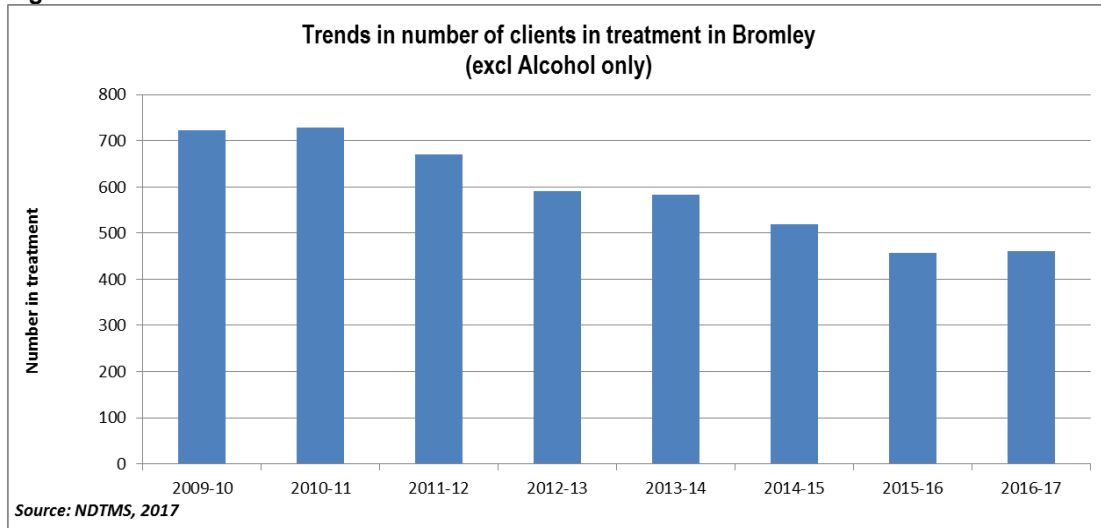
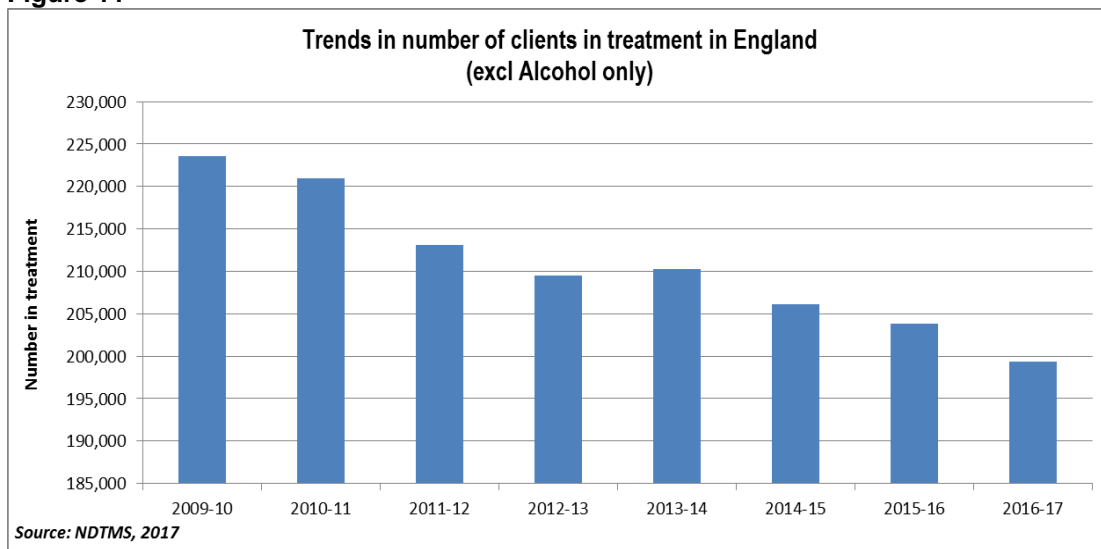


Figure 11



The spikes and troughs in the number of new clients entering treatment in Bromley follow a similar pattern to the England trends (**Figure 12 and 13**).

Figure 12

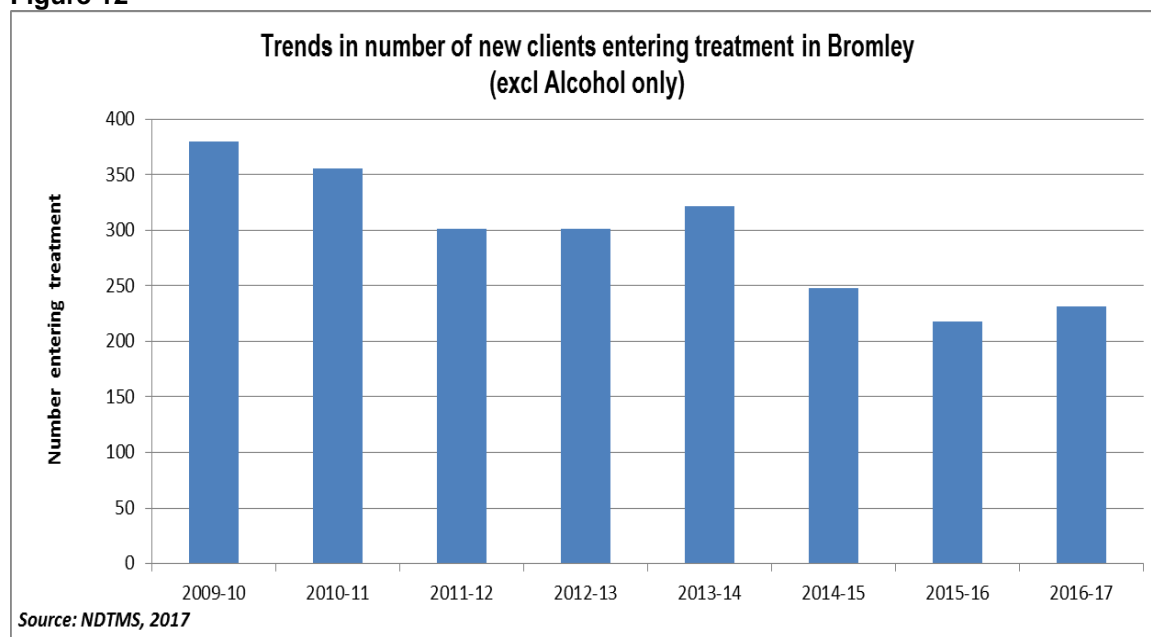
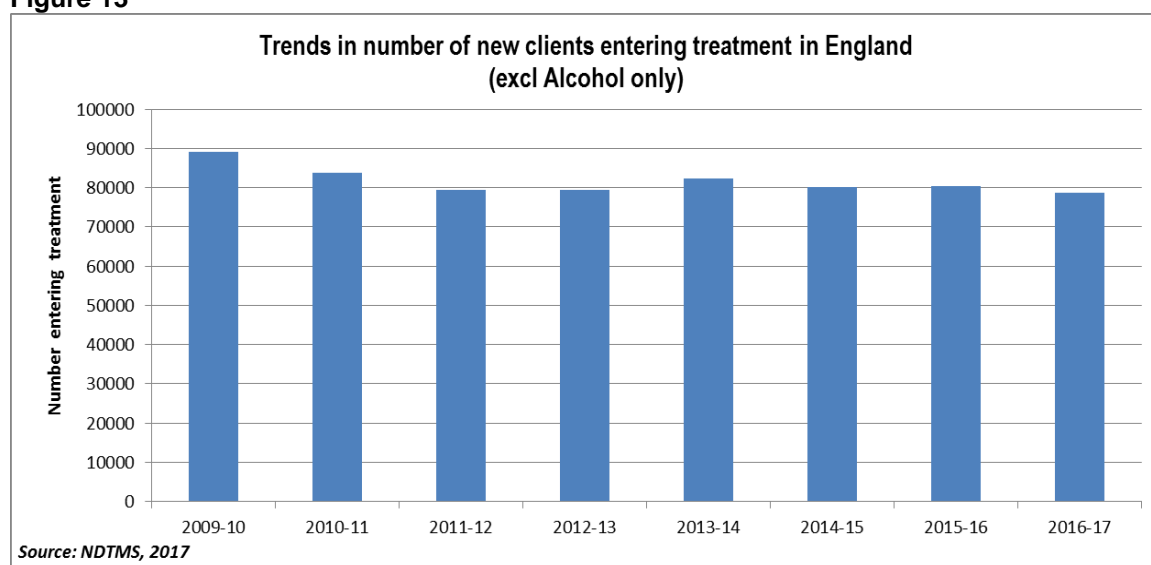


Figure 13



Treatment Population Profile: Age

On average individuals are most likely to start using drugs in their late teens and early twenties.

The age distribution of individuals in treatment mirrors the patterns seen in the prevalence estimates, presented earlier (**Figures 4 and 5**).

The pattern of age distribution across the drug treatment population in Bromley is similar to England with the peak age group being 30-39 years. However the treatment population in Bromley appears to be slightly older on average compared to England. Nearly 50% of clients in treatment in Bromley are age 40+ compared to 44% in England. (**Figure 14**)

Figure 14

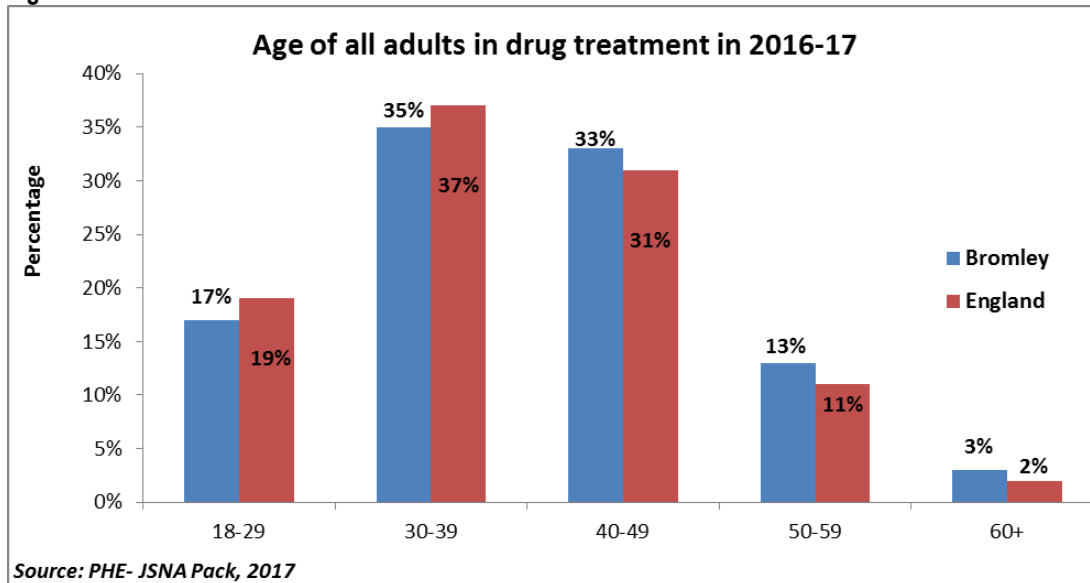
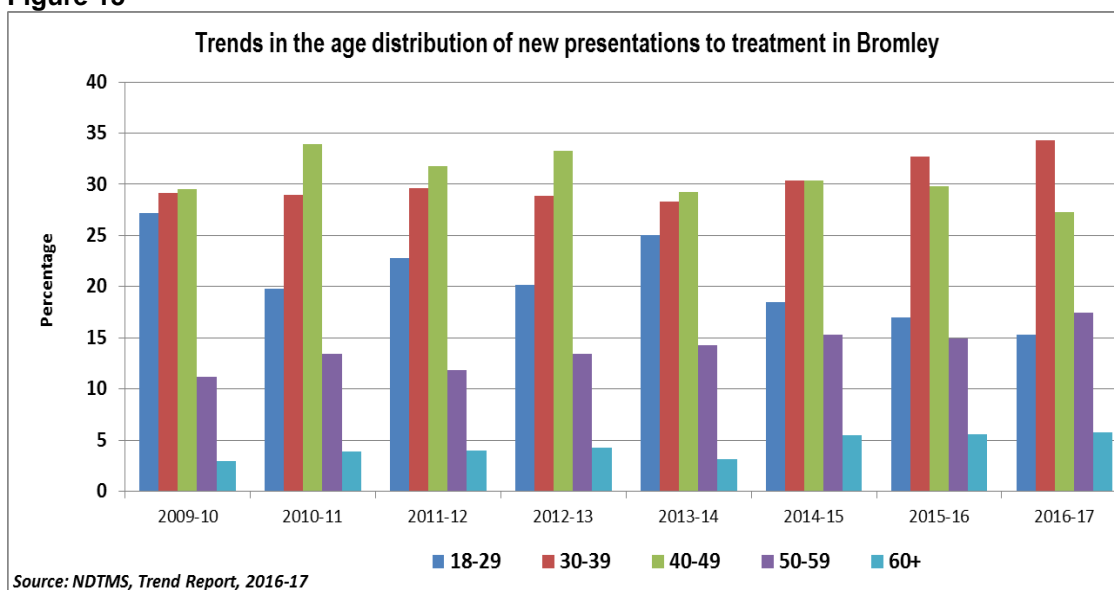


Figure 15 shows the trends in the age distribution of new presentations to treatment from 2009-10 to 2016-17 in Bromley. This indicates that the age profile of those presenting new to treatment in Bromley has shifted to an older population. There has been an overall decrease in the proportion of people presenting new to treatment aged 18-29 and an overall increase in the proportion of people age 50-59 and 60+.

This reflects the national trend which has seen a 27% increase in the number of clients aged 45 and over presenting new to treatment and a corresponding decrease of 38% in the numbers of those under 30 presenting to treatment.

Figure 15



Treatment Population Profile: Gender

In Bromley, there were 460 adults in drug treatment services in 2016/17; of which two thirds (68%) were male, compared to three quarters (73%) in England. The gender split varied depending on the presenting substances both locally and nationally. Nationally, women make up 27% of adults in drug treatment, lower than Bromley at 32%. Women presenting to treatment often experience poor mental health, domestic violence and abuse, which may impact upon their recovery, and they are more likely to be carers of children (JSNA support Pack, 2018/19).

Treatment Population Profile: Geographical analysis

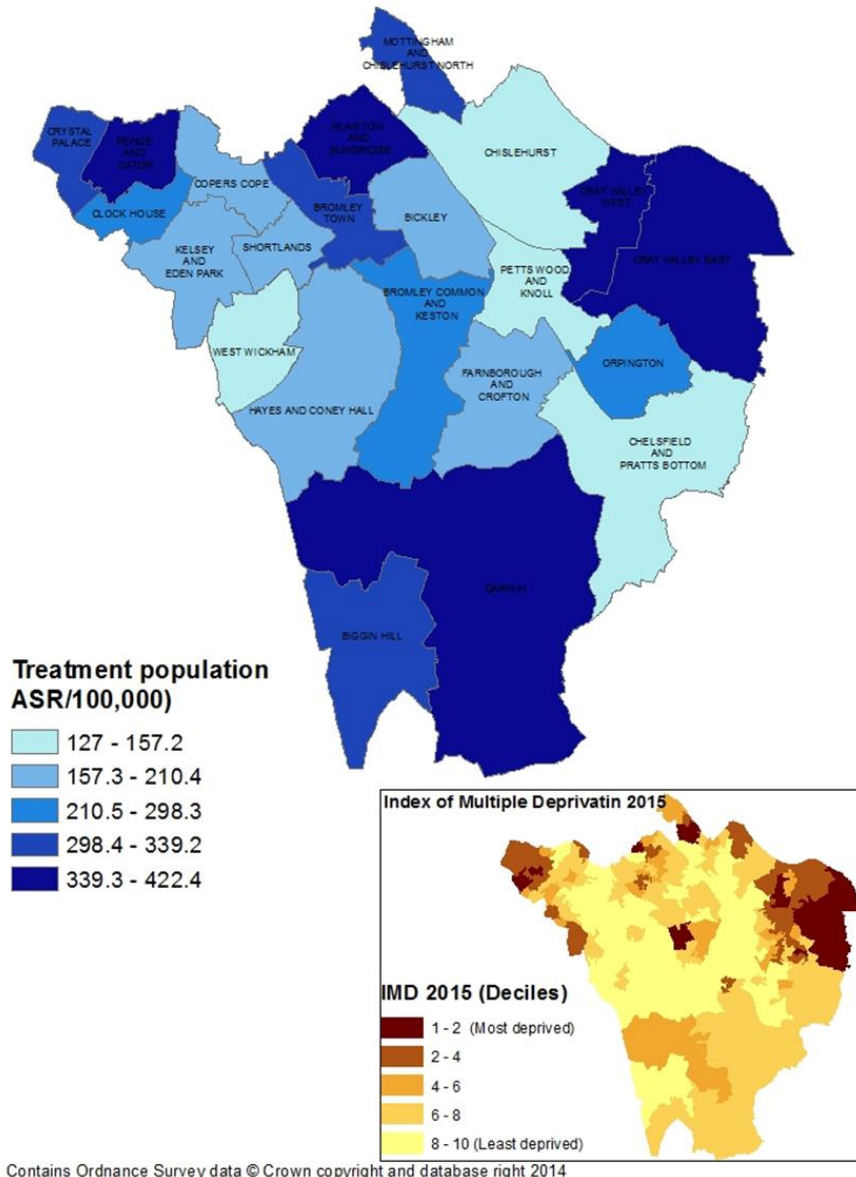
The relationship between deprivation and illegal drug use has been highlighted in a number of research studies. Evidence shows that deprivation is associated with the problematic use of particular drugs such as heroin and crack cocaine. Although the use of these drugs is not exclusively related to deprivation, it is much more common among people living in deprivation^{xiii}.

In Bromley the majority of clients in treatment in 2016/17 were living in the more deprived areas of the borough (**Map 1**). The map depicts the rates of treatment access across the wards in Bromley. In terms of the actual numbers of clients accessing treatment in 2016/17 the greatest number were living in the Crays, Penge and Cator, Crystal Palace and Mottingham and Chislehurst North.

Rates were highest in the Crays, Penge and Cator and Plaistow and Sundridge in the north and Darwin in the south of the borough. It should be noted that this doesn't represent a geographical analysis of the entire population of people currently misusing drugs in Bromley. It only represents those that had accessed and were receiving treatment in 2016/17. Further work is needed to better understand the unmet need amongst drug users in the population of Bromley who are not accessing services.

Map 1

Rate of people in treatment for drug abuse per 100,000 population by ward of residence (2016/17)



Treatment population with prior convictions

Table 6 presents the proportion of treatment clients with a prior conviction. The cohort is comprised of all clients in treatment at that point, but also includes clients who were in treatment at any point within the preceding year. Non-opiate and alcohol users contributed the highest number of clients with a prior conviction in Bromley in contrast to England, where opiates represented the highest group. However there were similar proportions of non-opiates, with 1 out of 3 clients both locally and nationally having a prior conviction.

Opiates had the lowest number of clients with a prior conviction in Bromley, representing 23% of the opiate treatment population in Bromley. England had higher proportions of opiate clients with a prior conviction compared to Bromley. Drug use coupled with prison sentence compounds the person's chances of recovery and re-integration into society. There is a need for continued work to engage with prison services.

Table 6

Number and proportion of clients in the treatment population in 2012 with convictions in the two years preceding treatment				
	Bromley		England	
	number	%	number	%
Opiate	31	23%	14,646	32%
Non-opiate	47	20%	13,164	21%
Non-opiate and alcohol	50	36%	9470	36%
All	128		22649	

Source: PHE- PCC Support Pack, 2017

New to Treatment Population Profile: Gender and Ethnicity

Half (50%) of the drug treatment population in Bromley in 2016/17 were new to treatment compared to 39% of the national drug treatment population. Gender wise in Bromley, 53% of the males in treatment were new compared to 43% of the females.

The majority (84%) of new presentations to drug treatment in Bromley self-reported as White British, this is in keeping with the general ethnic profile of the borough. In line with the majority presenting, 93% of clients also reported UK as their country of origin. In terms of sexuality, 3% of the new presentations to Bromley drug treatment services self-reported as Gay, Lesbian or Bi –Sexual. 15% of the clients entering treatment self-reported as having at least one disability. It is important that treatment services in Bromley are able to adapt to the needs of these client groups.

Predicting the future treatment population

As part of its evidence review for the new National Drugs Strategy, Public Health England produced estimates of the size and characteristics of the drug treatment population in England over the next 4 years (to 2020)^{iv}.

- Overall, it is projected that the number of people in treatment for opiate misuse will fall over the next four years, with fewer people starting treatment than leaving, particularly those new to treatment.
- The proportion of opiate users, both in and out of treatment, aged 45 and over will continue to increase and this will have significant implications for their health and mortality risks. Drug treatment will need to respond to a range of age-related, long-term health conditions (which may be exacerbated by other drug use and smoking) and actively support referrals for primary and specialist care.
- As treatment services become more widely populated by those with entrenched drug use it is predicted that overall, the rate of completions for opiate users is likely to fall and local areas should take this into account when considering setting any performance target. It is much harder to effect behaviour change with people who have very entrenched patterns of use and their likelihood of achieving positive outcomes are greatly diminished when compared to opiate users who engage after a shorter period of use
- Overall, it is projected that the number of non-opiate users in treatment will remain relatively stable over the next four years, as has been the case in recent years.
- It is projected that the age profile of non-opiate clients will not change that much over the next four years, with the majority of presentations continuing to come from the under 35 age group.
- Changes may be seen in the types of non-opiate substances that individuals are presenting for, with a rise in the use of NPS and the decline seen over the last 10 years in benzodiazepine and crack cocaine presentations
- NPS will attract new populations to using drugs and the development of new referral pathways and partnerships to reach new and emerging groups of users will be essential. As will staff with the competences to work with new users and patterns of use.
- While drug treatment services should always have high aspirations for all people in treatment, it is important that expectations are also realistic and reflect different populations in treatment, with very different likelihoods of success.

Route into treatment

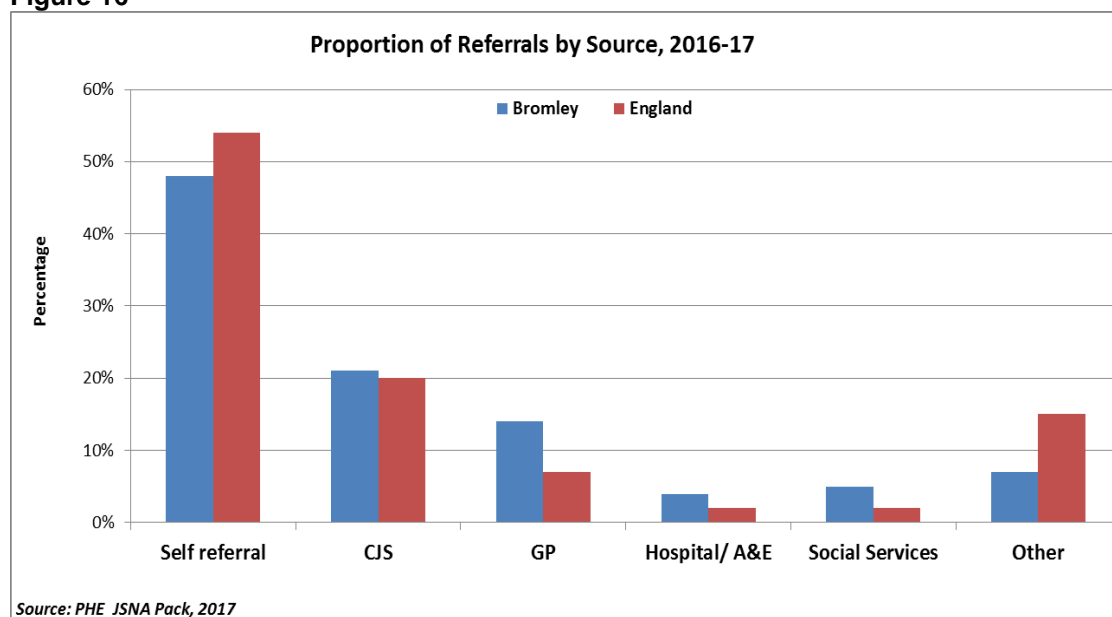
There are various possible sources of referral into treatment services

The most common source of referral for all drugs clients in both Bromley and England was referrals from self, family and friends. The second most common source of referrals was the Criminal Justice system (CJS) both locally and nationally. The proportion of referrals from “other” sources is higher nationally than in Bromley (15% compared to 7% respectively).

The groupings used in **Figure 16** and **Figure 17** differ as the trend data is grouped slightly differently to the data for the current year in the data source.

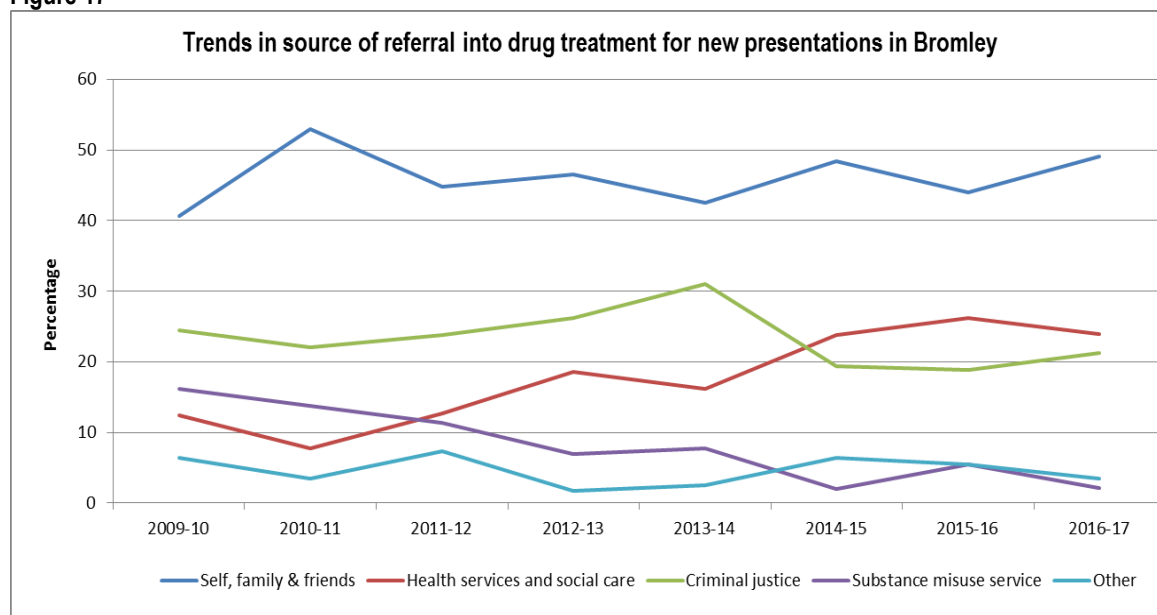
Trends show that self, family and friends still contribute greatly to referrals into treatment services. This means that the local community is a huge asset in improving service penetration in the high prevalence communities. The proportion of referrals through the health services and social care has generally increased while referrals from other substance misuse services⁴ have seen a complete year on year reduction since 2009-10 (**Figure 17**).

Figure 16



⁴ Substance misuse services refers to any referral from another substance misuse service; including out of area substance misuse services or internal referral between agencies in the same area.

Figure 17



Source: NDTMS Trend Report, 2016-17

Not in Treatment Population

Table 7 below presents the estimated proportion of drug users by substance group currently not in treatment. This gives an indication of unmet need in Bromley compared to England. Bromley has a higher estimated rate of individuals not in treatment for all substance groups compared to England.

Table 7: Percentage drug users not in treatment by substance group

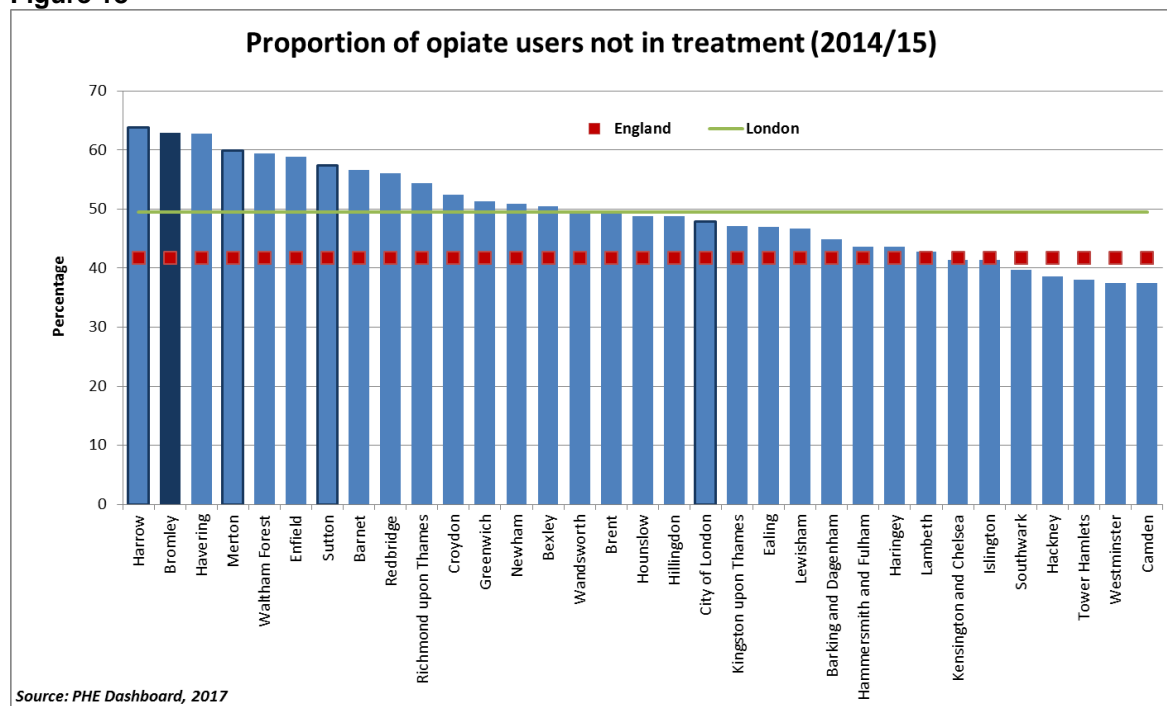
Percentage unmet need, 2014/15			
	Opiate &/or Crack	Opiate	Crack
Bromley	75	66	76
England	50	43	62

Source: PHE- JSNA Support Pack, 2018/19

Of note is the juxtaposition between the comparably low estimated prevalence of opiate use in Bromley (Figure 2) and the higher rates of substance users not in treatment (Table 7 and Figure 18). The estimated number of opiate and or crack users and the rate of unmet need, together, could have a significant impact on crime, unemployment, safeguarding children and long term benefit reliance.

Data shows that 63% of drug users in Bromley are not known to treatment services (**Figure 18**). With this rate, Bromley ranks second highest in the region, comparable to the second lowest rates of Opiate use, lower than areas in the same national socioeconomic deprivation bracket. Bromley levels of unmet are second to only one LA in the region. In addition, Bromley ranks 14th out of 15 local authorities in England in the same socioeconomic deprivation bracket on proportion of unmet need in opiate users; where 1 is the lowest. Further work is planned to identify and profile drug users who are not in treatment in Bromley in order to inform strategies to target and successfully engage those in need of treatment.

Figure 18

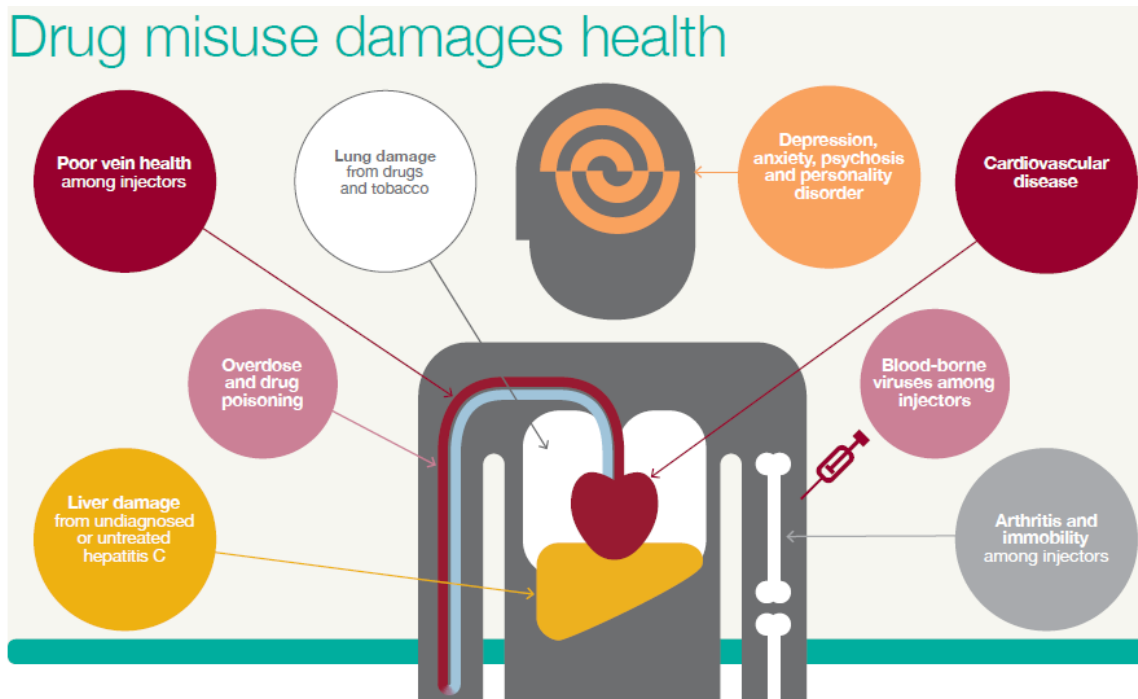


Source: PHE Dashboard, 2017

Impact on Health and Wellbeing

Drug misuse can have a wide range of short and long term, direct and indirect effects on physical and mental health effects. The nature of these effects are often dependant on a multitude of factors, for instance; the specific drug or combination of drugs used, how they are taken, quantity taken, the person's underlying health, social factors and environmental factors^{xiv}.

Whilst people who misuse any type of illicit substance are at risk of health harms and even death, the most harmful effects of drug misuse are seen among opioid users. These include increased risk of death from overdose, increased risk of infection with blood-borne viruses (HIV, hepatitis B and hepatitis C), high levels of depression and anxiety disorders, social problems such as disrupted parenting, unemployment and homelessness, and increased participation in the acquisitive crime required to fund the habit.



Adapted from Public Health England^v

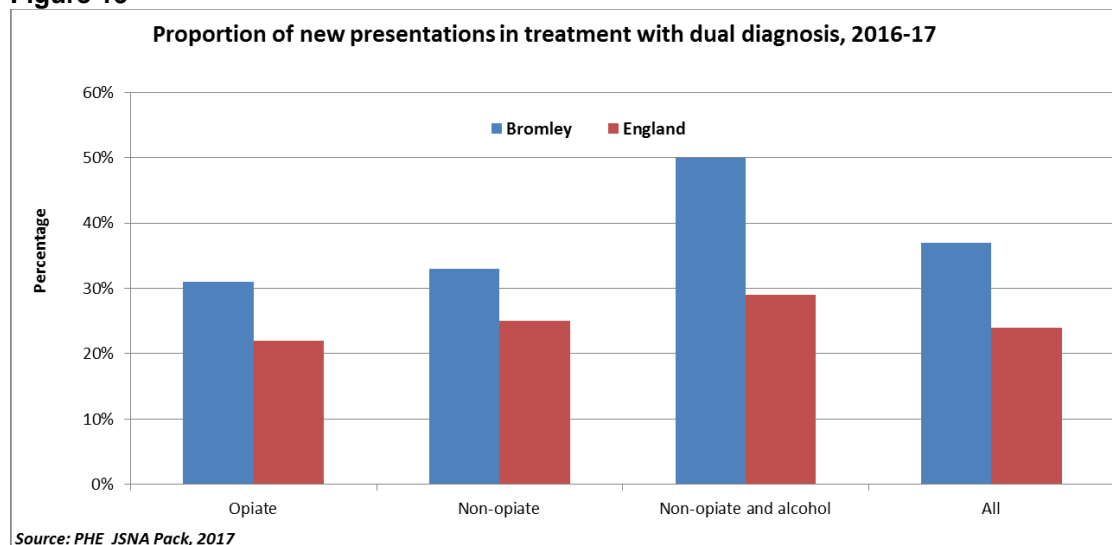
Mental Health (Dual Diagnosis)

Drug misuse is common among people with mental health problems and the relationship between the two is complex. Evidence shows that up to two thirds of people in drug services experience mental health problems^{xv} and that people with co-occurring conditions have an elevated risk of other health problems and premature mortality^{xv}.

Psychiatric comorbidity is common in drug misuse populations, with anxiety and depression generally common and antisocial and other personality disorders more prevalent than in the non-user population^{xvi}. Drug misuse disorders complicated by other comorbid mental disorders have been recognised as having a poorer prognosis and being more difficult to treat than those without comorbid disorders^{xvii}.

Figure 19 presents the proportion of clients entering treatment in 2016-17 who were also receiving care from a mental health service for reasons other than substance misuse. It is worth noting the incompleteness of reporting on dual diagnosis as well as the variation across partnerships in how dual diagnosis is defined in practice. With that said, Bromley seems to have higher proportions (37%) of new clients with a co-occurring mental health condition compared to England (24%). Analysis by substance group in Bromley shows that a similar proportion (around a third), of the new client group presenting for either opiate or non-opiate misuse were also receiving care from mental health services. However this proportion is higher in those who present for treatment for both non-opiate drug misuse combined with alcohol misuse. Half of new clients in this group were also receiving care from mental health services. The reasons behind the differing proportions of dual diagnosis clients in different treatment groups are likely to be complex.

Figure 19



Source: PHE JSNA Pack, 2017

13% of new clients with missing or incomplete dual diagnosis status. Variation across partnerships in definition and recording of dual diagnosis

Figure 20 shows further analysis of the new presentations to treatment with a co-occurring mental health condition by substance group and gender. Overall, the proportion of women who are new to treatment and have a co-occurring mental health condition is higher than that in men both locally and nationally. (44% of all women in Bromley presenting new to treatment had a co-occurring mental health condition and compared to 33% of all men) and(nationally (the national proportions are 31% of all women and 22% of all men new to treatment have a dual diagnosis). Of note in Bromley, is the fact that half of the women new to treatment for non-opiate and non –opiate and alcohol presented with a dual diagnosis.

Figure 20

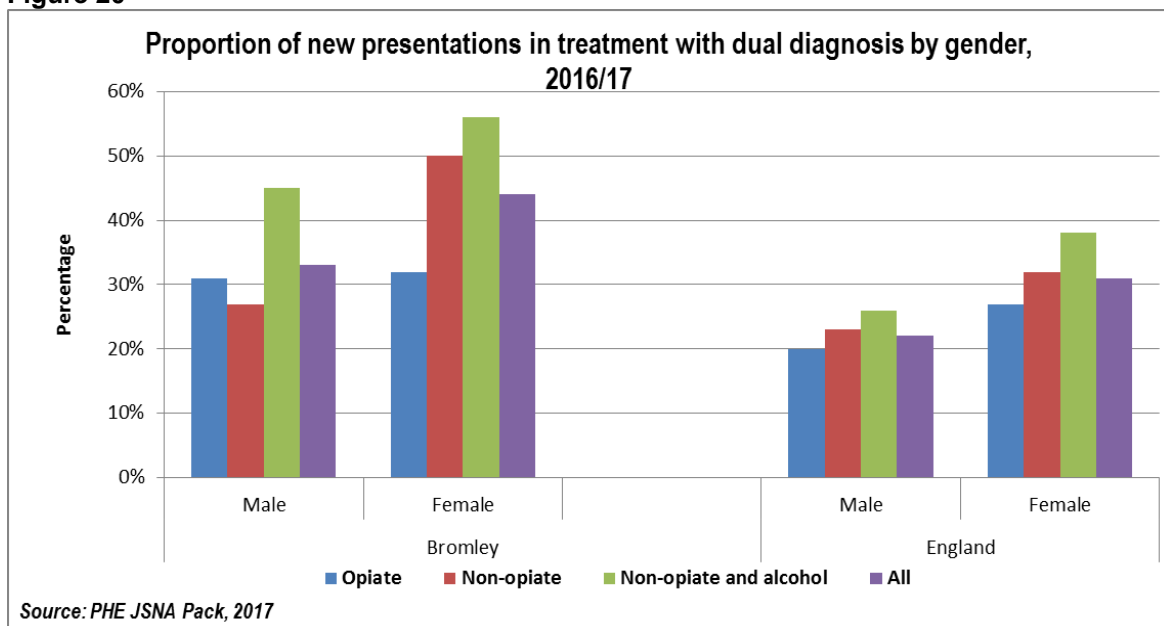


Figure 21 shows rates of dual diagnosis in Bromley compared to other London boroughs. This measure is indicative of levels of co-existing mental health problems in the overall drug treatment population and doesn't account for levels of co-existing substance misuse and mental health problems in the wider population not currently in contact with services. Bromley has the fifth lowest rates in the region, and significantly lower rates than the London average. When compared to other boroughs in the region with similar socioeconomic deprivation levels, Bromley rates are still lower.

Figure 21

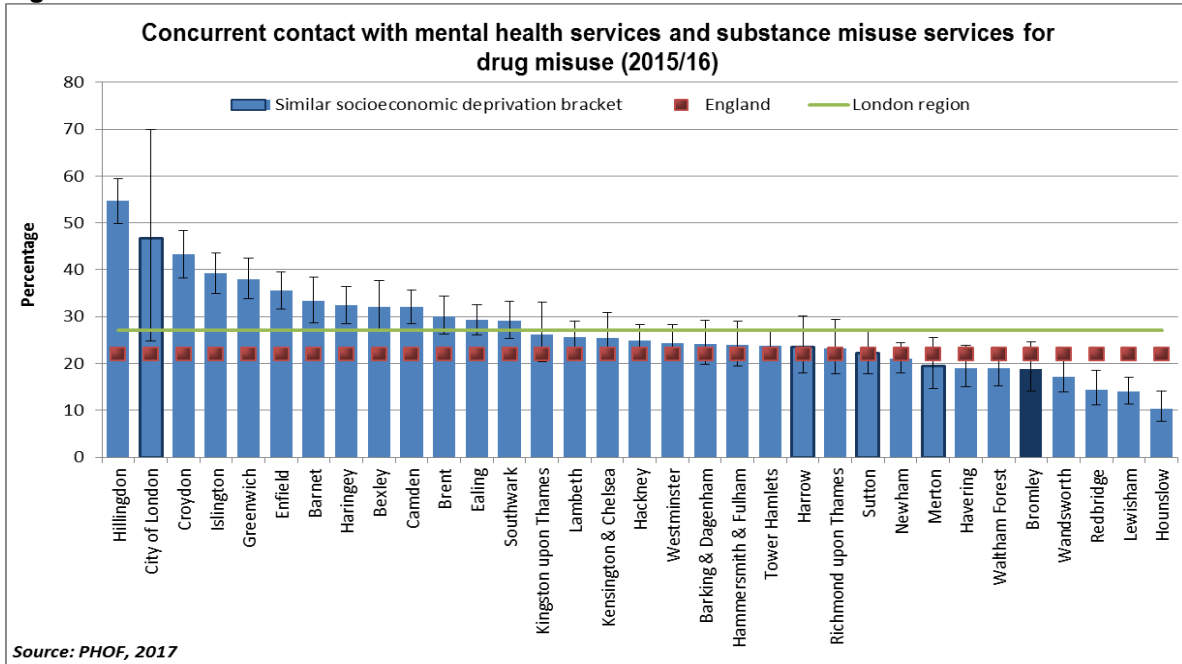
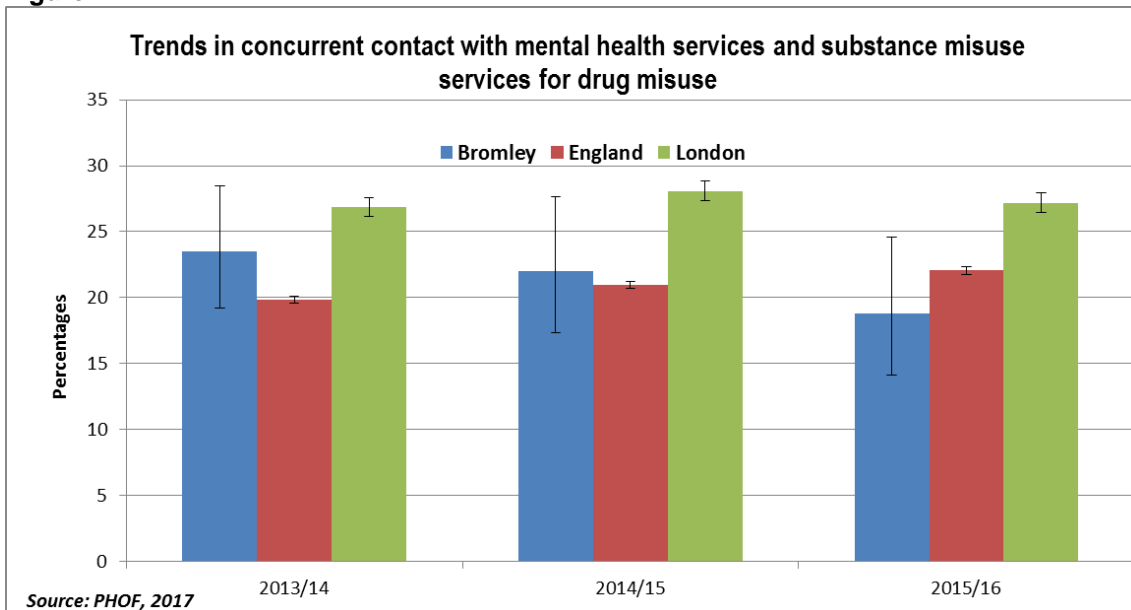


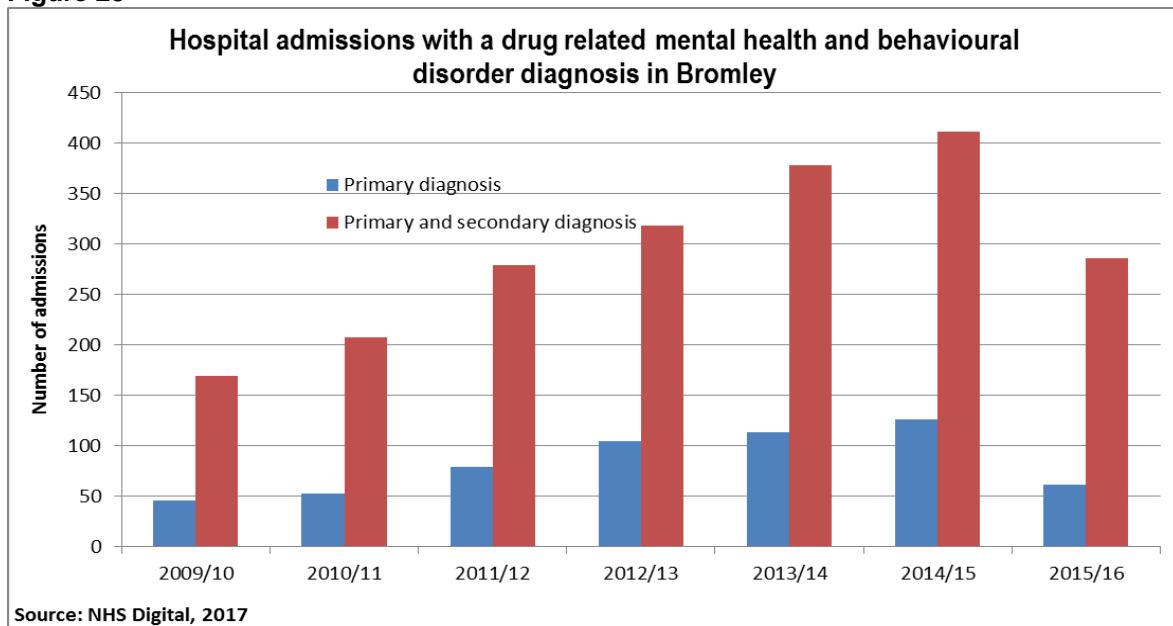
Figure 22 shows a downward trend of the proportion of people in concurrent contact with mental health services and substance misuse services in Bromley in contrast with the upward trend regionally and nationally. The wide overlapping confidence intervals in Bromley are indicative of the small numbers. However, in 2015/16, Bromley had significantly lower rates of clients in concurrent contact with mental health and substance misuse services than the regional average.

Figure 22



In 2015/16 there were 286 hospital admissions in Bromley for drug related mental health and behavioural disorders (including primary and secondary cause of admission). **Figure 23** shows that, the number of admissions for drug related mental health and behavioural disorders in Bromley and were increasing year on year up until the latest recording period where rates fell for the first time in 5 years. It is worth noting that, admissions don't represent counts of patients, as a person may have more than one admission a year.

Figure 23



Morbidity: Blood Borne Infections

Injecting drug users are at great risk of blood borne infections such as Hepatitis C and HIV, due to poor and non-sterile injecting techniques. Sharing injecting equipment is the single biggest factor in blood borne virus transmission among individuals who use and inject drugs and it elevates mortality risk. Providing opioid substitution therapy (OST), sterile injecting equipment and antiviral treatments is crucial in action to protect the users and their communities, and to provide long-term health savings.

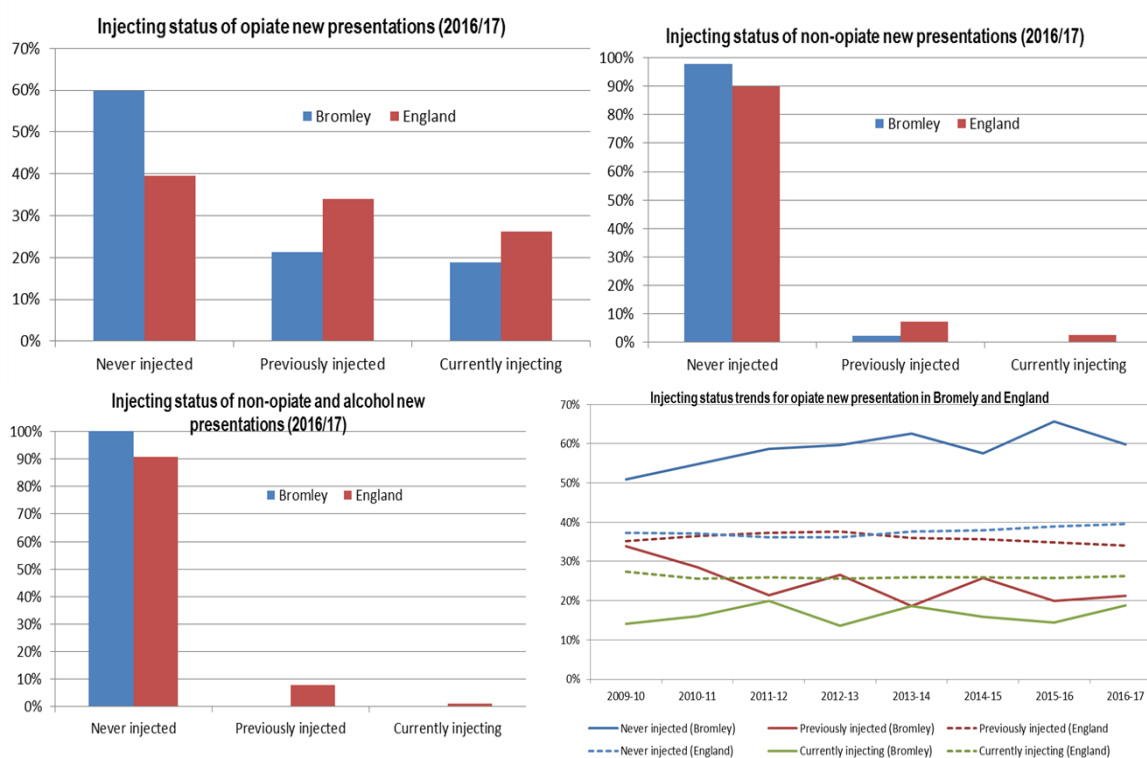
There are also concerns that some NPS are injected. This appears to be linked to members of three distinct populations: those who only use NPS but do so frequently; older drug users who appear to be supplementing or switching from established drugs that are prepared for injection; and those engaging in chemsex. A frequent pattern of NPS injecting among all these groups represents a significant concern for blood born virus transmission and health damage^{iv}.

The majority of clients entering treatment have never injected drugs. However, among clients that reported injecting drug use, there is a variation between substance groups. Opiate clients were more likely to report injecting drug use

compared to all other substance groups (**Figure 24**). Bromley has higher proportions of clients presenting to treatment having never injected drugs compared to England in all substance groups (**Figure 24**).

Trends show consistently higher proportions in Bromley of new presentations reporting never having injected drugs and lower proportions in all other categories compared to England (**Figure 24**). The majority of non-opiate clients who inject are likely to be individuals using methamphetamine and mephedrone (Local Area Trend Report, 2016/17). Due to disclosure controls on small numbers, it is not possible to present detailed analysis.

Figure 24



Source: NDTMS Trend Report, 2017

HIV

HIV levels remain low but the risks of transmission in those injecting drugs remain.

In the UK, around 1 in 100 people who inject drugs is living with HIV. Most have been diagnosed and will be accessing HIV care. However, the diagnosis often occurs at a late stage among injecting drug users^{xviii}. Once diagnosed the uptake of HIV related care, including anti-retroviral therapy, is relatively high.

The level of HIV infection and the uptake of HIV related care among those injecting image and performance enhancing drugs is similar to that among those injecting psychoactive drugs.

Statistics show that over the last decade, around 1% of Bromley residents diagnosed with HIV and are accessing care probably acquired the infection through injecting drug use compared to 2% in England. On average, 40% of all adults diagnosed with HIV in Bromley are diagnosed late.

Hepatitis C and Hepatitis B

Hepatitis C remains the most common infection among people who inject drugs, 90% of all cases of Hepatitis C diagnosed in the UK occur as a result of injecting drugs. Around 2 out of every five people who inject psychoactive drugs, such as heroin and mephedrone, are living with hepatitis C; half of these infections are undiagnosed. About 1 in 20 of those who inject image and performance enhancing drugs, such as anabolic steroids, are living with hepatitis C^{xvii}.

Hepatitis B is now rare, but vaccine uptake needs to be sustained. In the UK, around 1 in every 200 people who injected psychoactive drugs is living with hepatitis B infection. About three quarters of people who inject psychoactive drugs report taking up vaccines against hepatitis B, but the uptake level is no longer increasing. Vaccine uptake is much lower among people who inject image and performance enhancing drugs^{xviii}.

Due to the elevated risk of blood borne infection in this population, injecting drug users accessing treatment for substance misuse are tested for Hepatitis B and C and, if appropriate, vaccinated.

In 2016/17, 52% of new presenters to drug services in Bromley eligible for a hepatitis B vaccination accepted one, compared with the national average of 39%. It is worth noting that the vaccination conversion and completion rate in this treatment population is very low. Only 11% of those who accepted to be vaccinated actually started a course of vaccination and furthermore, only 12% of those completed a course of hepatitis B vaccination.

During the same period (2016/17), 79% of previously or currently injecting clients in treatment in Bromley received a Hepatitis C test, as compared with the national average of 83%. Nationally, there are similar proportions of men (83%) and women (84%) receiving hepatitis C tests, while in Bromley; more women (81%) received the test in comparison to men (77%) in 2016/17.

Drug users with Long term conditions

Statistics on drug users with long term conditions is not readily available through administrative datasets; although it is known that they often have health and mental health problemsⁱⁱⁱ. In early 2014, the medical records of ten out of twelve patients who had died from drug related causes in the previous 12 months in Bromley were examined. It was found that half of these patients had one or more significant medical conditions – asthma, Chronic Obstructive Pulmonary Disease, ischaemic heart disease and alcohol-related problems, some had a history of depression, and a smaller proportion had been in contact with services for their drug use.

Hospital Admissions

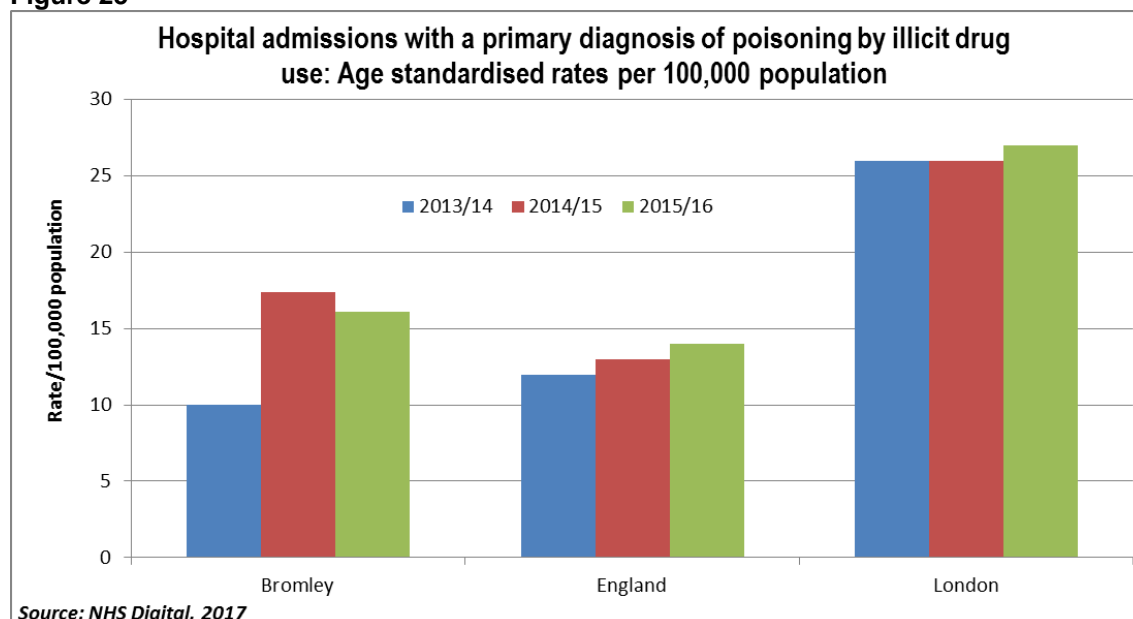
As well as being a key issue for secondary care, hospital admissions due to drug poisoning can be an indicator of future deaths. Evidence shows that people who experience non-fatal overdoses are more likely to experience a future fatal overdose^{xix}.

In 2016/17, hospital admission rates⁵ for drug poisoning in Bromley were significantly lower than the national rate at 22.3/100,000 and 52.3 per 100,000 respectively. These include admissions where drug poisoning was the primary or secondary cause of admission and also includes poisonings by “other opioids” which may include poisonings by non-illicit or prescribed opioids.

Figure 25 presents admission trends with a primary diagnosis of poisoning by illicit drug use. These rates are not comparable to the 2016/17 data because of the exclusion of admissions with a secondary diagnosis of drug poisoning, meaning that it isn't a complete picture of illicit drug poisoning inpatient activity in Bromley. That said, the rates in Bromley are erratic over the last three years, in contrast to the upward trends in England and London. It is not known if the difference seen within and between the geographies is statistically significant.

⁵ All persons, crude rate per 100,000 (PHE- JSNA Support Pack, 2018/19)

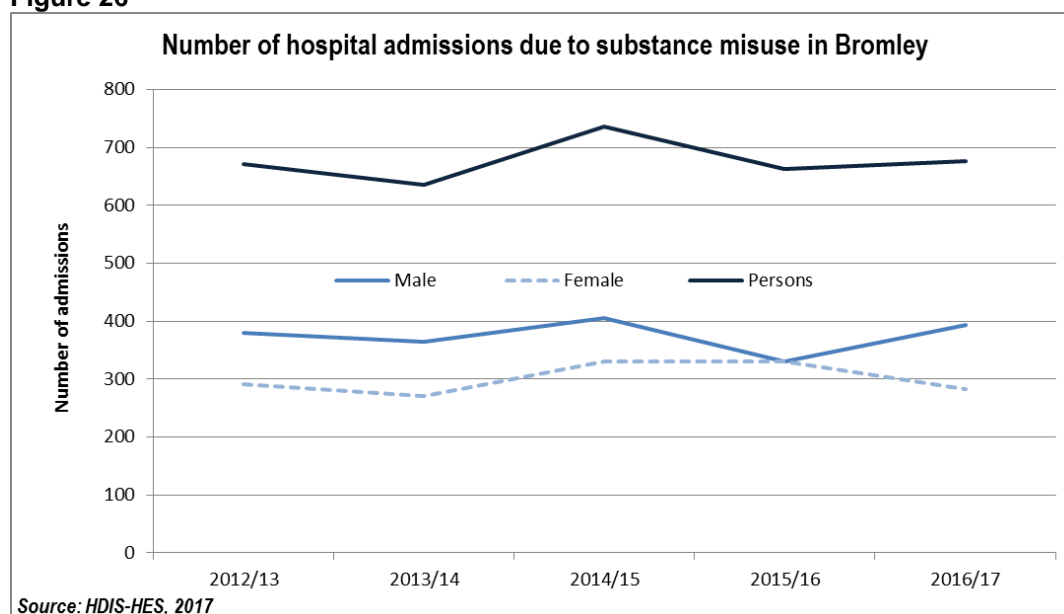
Figure 25



Hospital admissions: age and gender

Local data indicates that, in 2016/17, there were 677 admissions with a primary or secondary diagnosis of drug misuse⁶ in Bromley 15 years and over. Admissions in men were 1.3 times those in women.

Figure 26

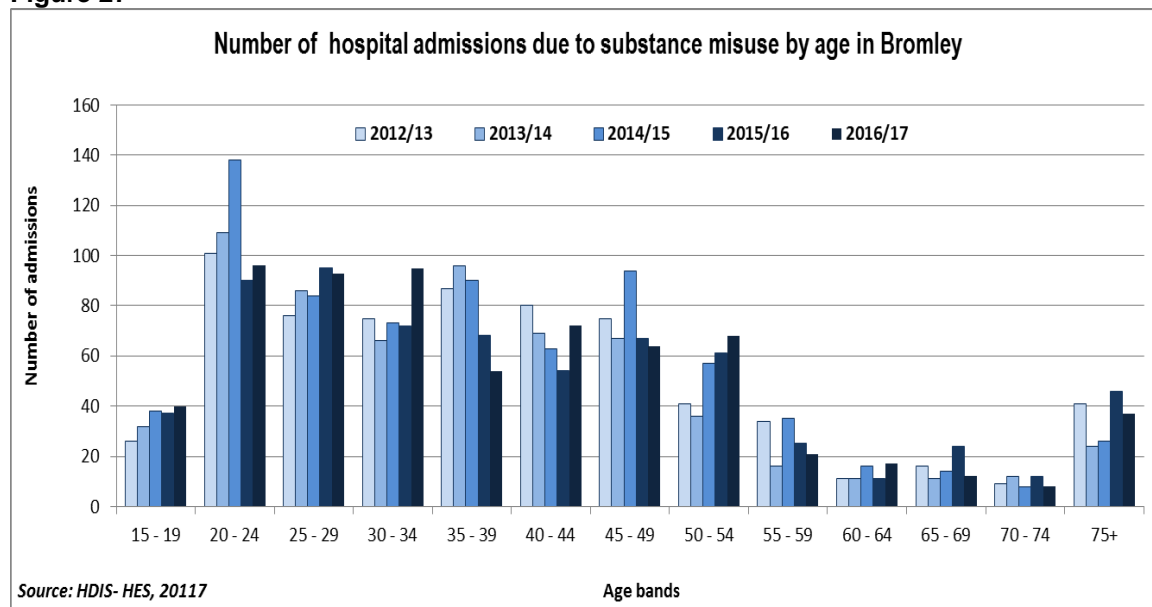


Analysis of local hospital episodes data shows that rates of hospital admissions for substance misuse are highest in young people. The high rate in the under 25s is

⁶ For Further information on relevant ICD-10 codes refer to Table 2 in the Appendix

particularly driven by those aged 20-24 years (**Figure 27**). The numbers of admissions across the age groups follow varied trends, with some groups going up (15-19 years, 25-29 years and 50-54 years) while others are erratic or reducing (35-39 years and 55-59 years).

Figure 27



Comparative and trend analysis (in **Figure 28 and 29**) shows that Bromley has significantly higher rates of hospital admission rates for substance misuse in young people 15-24 years old⁷ than England and London and data shows a worsening trend. The rate in Bromley is worse than all the London boroughs in the same socioeconomic deprivation bracket (Merton, Sutton and Harrow). Although hospital admission rates in young people are increasing year on year; nationally and regionally, the increase in Bromley is steeper (**Figure 29**).

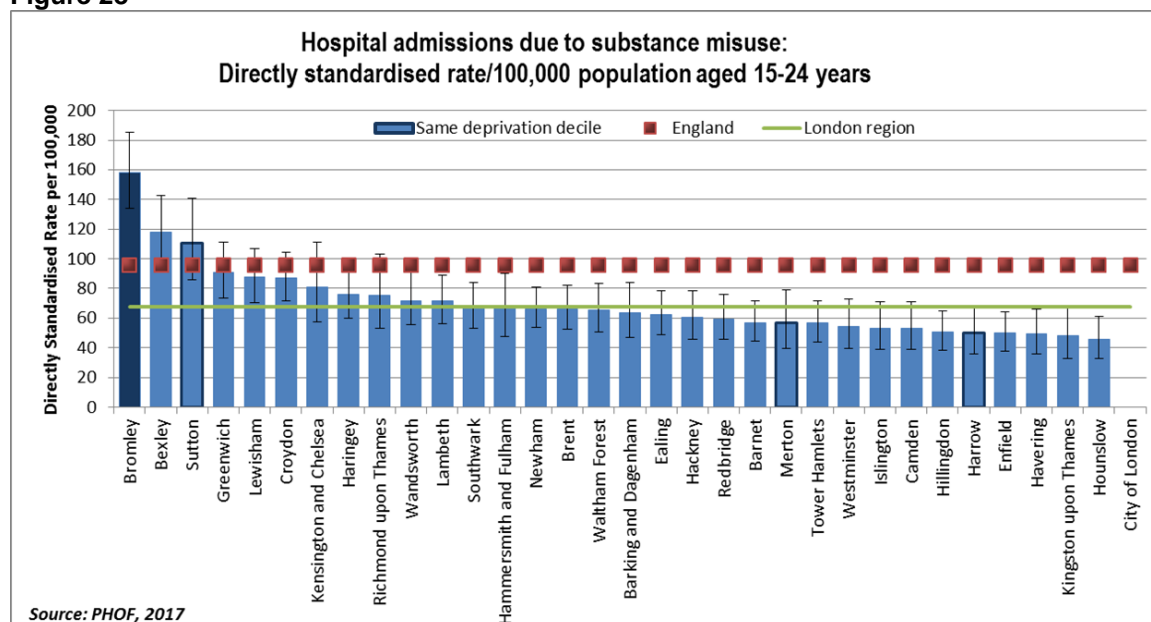
The estimates of the prevalence of opiate and crack use in Bromley, previously presented in this report (**Figure 6**), show that the rates of use of these types of substances in young people is relatively low. However the estimates suggest an upward trend in this age group which may be contributing to the high volume of inpatient activity for substance misuse in this cohort in Bromley.

Among young people, drug use is linked to increased likelihood of a range of adverse experiences and behaviour including; truancy, exclusion from school, homelessness, time in care and serious or frequent offending^{xi}.

Further investigation of this increasing trend in hospital admissions for young people will be undertaken as part of the refresh of the new Children and Young People's Health Needs Assessment early in 2018.

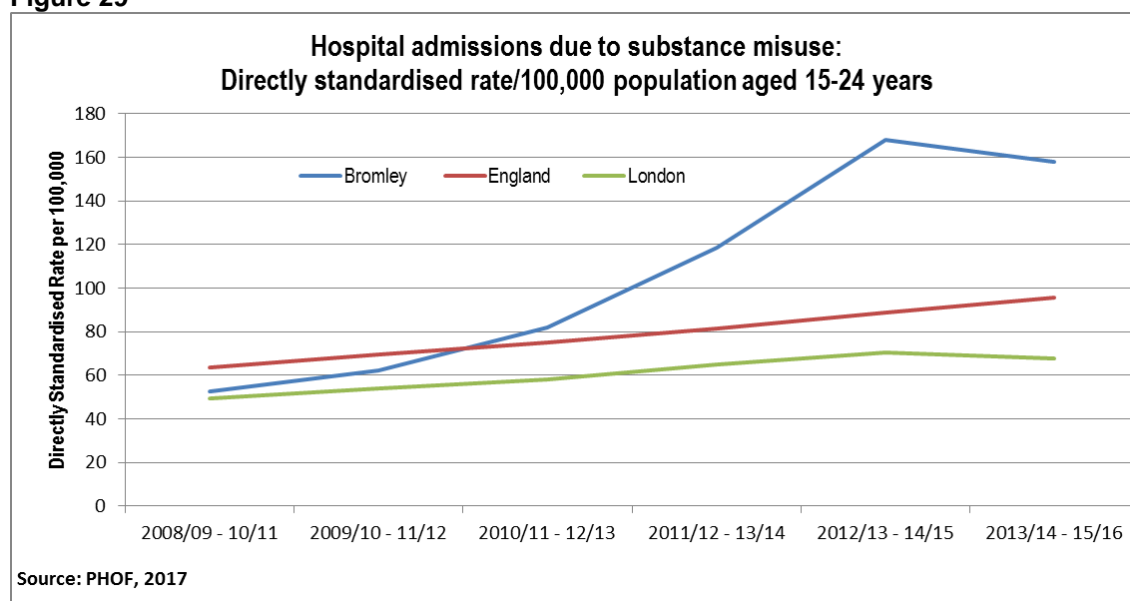
⁷ This statistic doesn't include admissions related to alcohol; it is specifically related to the misuse of drugs and other substances.

Figure 28



Including Mental and behavioural disorders due to use of tobacco but excludes alcohol

Figure 29

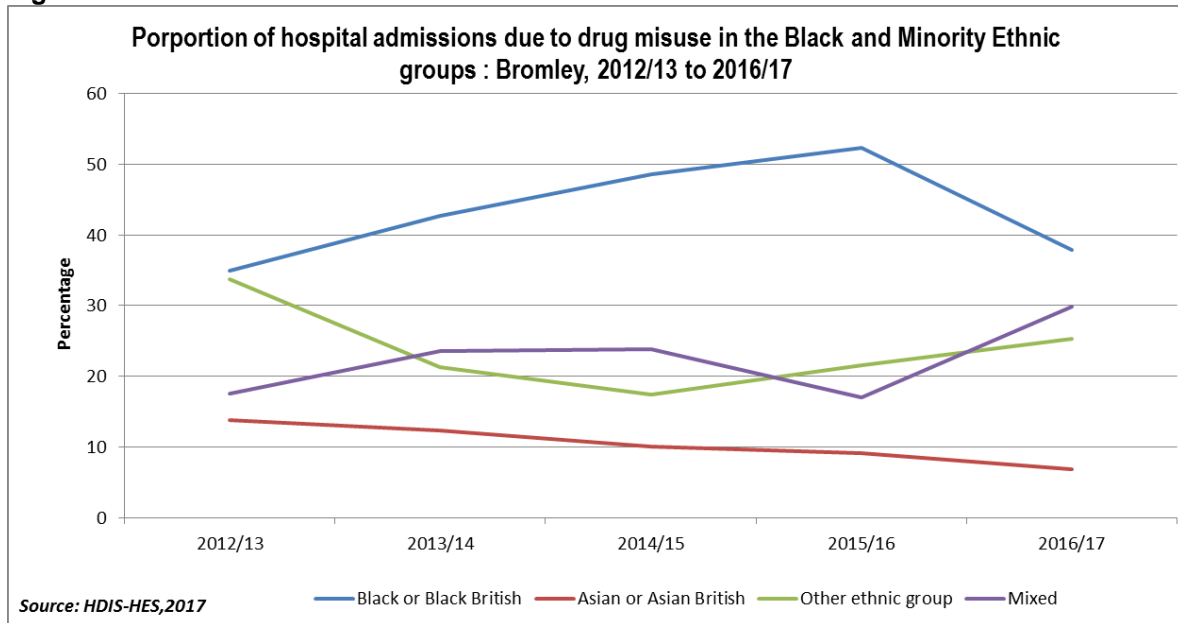


Including Mental and behavioural disorders due to use of tobacco but excludes alcohol

Ethnicity

In keeping with the general ethnic profile of Bromley, between 75% - 80% of hospital admissions are among the White British. The data for White British is excluded from **figure 30** below to allow for visibility of the difference within and between the other groups. **Figure 30** shows the proportion of hospital admissions in the Black and Ethnic Minority groups. There has been a year on year increase in drug misuse admissions for people from Black or Black British background as shown in **Figure 30** until the 27% reduction in the latest period. Admissions for Asian or Asian British are the lowest and have followed a steady downward trend, whilst the mixed and “other ethnic group” are erratic. The analysis does not allow for standardised comparison.

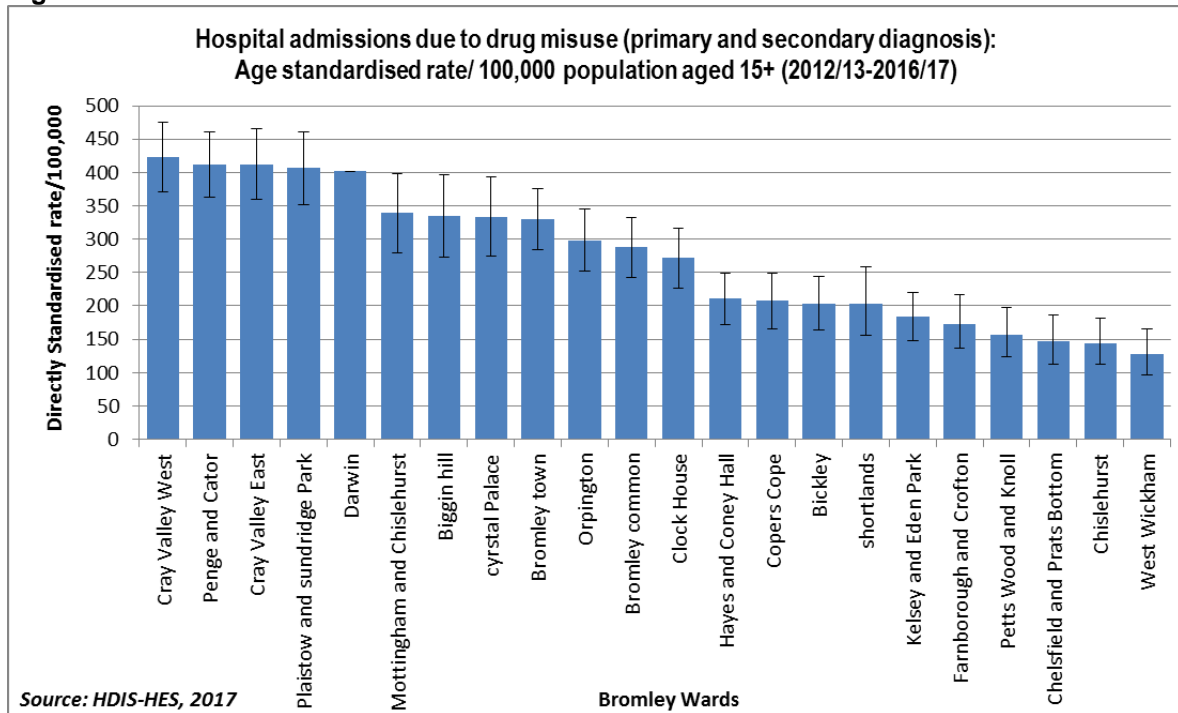
Figure 30



Geographical differences

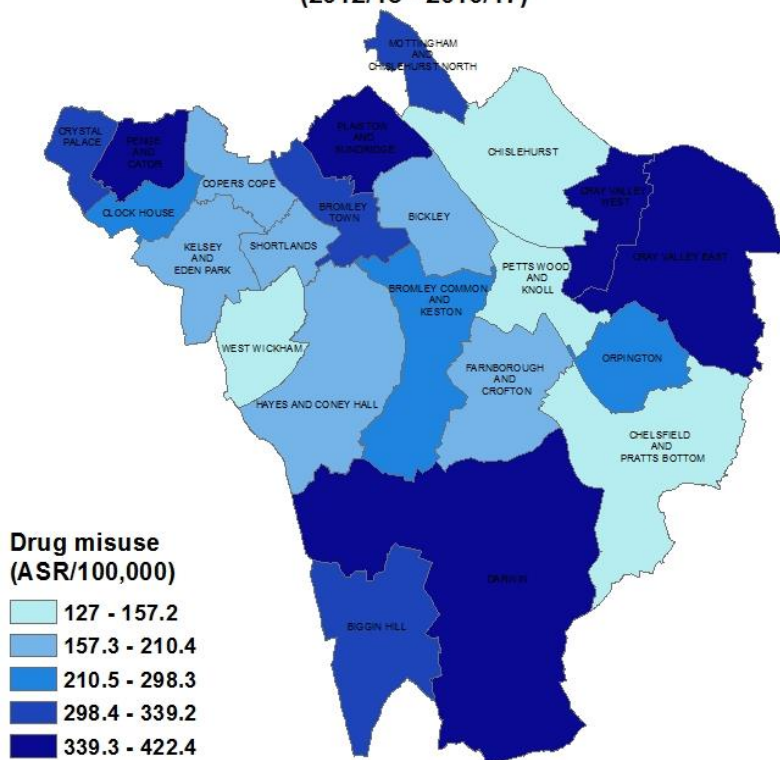
It has been shown that rates of hospital admission due to drugs correlate strongly with area deprivation. In Bromley, the most deprived wards have the highest rates of hospital admissions as shown in **figure 31** and **map 2**. There is a statistically significant difference between the 4 wards with the highest rates of hospital admissions and 10 wards with the lowest rates as shown in the figure below. It is worth noting that the wards with the highest rates of admissions for substance misuse are home to some of the most vulnerable people in Bromley, who experience poorer health outcomes and have significantly lower life expectancy than the average for Bromley.

Figure 31



Map 2

**Hospital admissions due to drug misuse
(primary and secondary diagnosis):
Age standardised rates/100,000 population aged 15+
(2012/13 - 2016/17)**



Contains Ordnance Survey data © Crown copyright and database right 2014

Mortality

Drug use and drug dependence are known causes of premature mortality. In 2016, there were 3,744 drug related deaths in England and Wales. There has been a dramatic increase in drug related deaths year on year since 2012 and mortality rates are now the highest since comparable records began in 1993.

The factors driving this increase are multiple and complex^{iv}:

- Deaths involving heroin have more than doubled from 2012 to 2015.
- Whilst drug poisoning deaths now account for 1 in 6 deaths amongst people aged 20-30, there has also been a significant rise in drug related deaths in the older cohort of drug users (age 30-70).
- It is likely that many more deaths are occurring in people who are aging, long term users of heroin who are more susceptible to the risk of drug overdose due to their worsening health.
- Other factors include increasing suicides, increasing deaths among women, an increase in poly-drug and alcohol use, and an increase in the prescribing of some medicines.
- Deaths caused by new psychoactive substances are also increasing. It is likely that NPS deaths may be under-reported because they may not be tested for during post-mortems as widely or comprehensively as other drugs.

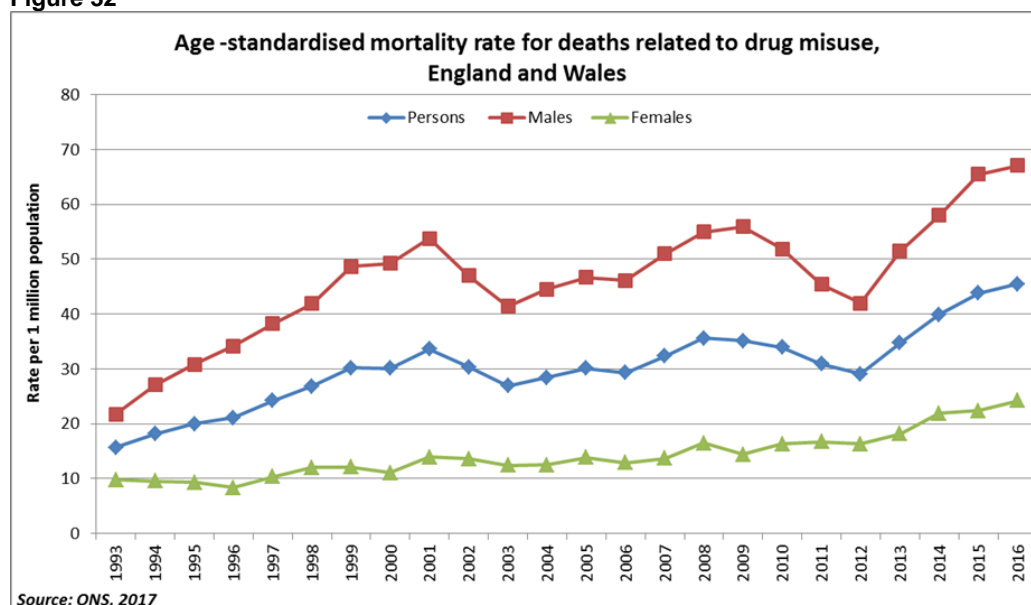
Mortality data are currently presented for two distinct groups, those where the underlying cause is:

- drug abuse/dependence on an illegal drug, and
- drug poisoning involving a controlled drug (legal or illegal).

Deaths from opioids may be counted in either group, depending on whether death was due to a drug-related condition or whether it was due to overdose or poisoning. The second category includes many other drugs, including those that are prescribed, such as Tramadol and anti-depressants.

Age-standardised death rates for drug misuse in England and Wales have increased since 1993, with peaks in 2001 and 2008, and another increase from 2013. Deaths in males have increased by 87% since 1993 and by 19% for women (**Figure 32**).

Figure 32



Deaths due to drug poisoning in England have showed a similar trend; with a peak in 2009, a fall until 2012, and a year on year increase from 2013. Of the 3,744 drug poisoning deaths (involving both legal and illegal drugs) registered in 2016 in England and Wales, over two thirds were in males. Female drug misuse deaths have increased steadily from 2009, and by 52%, from 459 in 2012 to 697 in 2016. In 2016, males aged 40 to 49 years had the highest mortality rate from drug misuse, followed by males aged 30 to 39 years.

Heroin and morphine remain the substances most commonly involved in drug poisoning deaths. 1209 deaths involved heroin or morphine in 2016; a steady rise from 579 deaths in 2012. Deaths involving tramadol have fallen, with 184 deaths in 2016. However, this is still double the number seen in 2009 (87 deaths). Deaths related to the misuse of cocaine and benzodiazepines have continued to rise nationally and there have been recent increases for some new psychoactive substances, like synthetic cannabinoids (often referred to as SCRA^s)^{xx}.

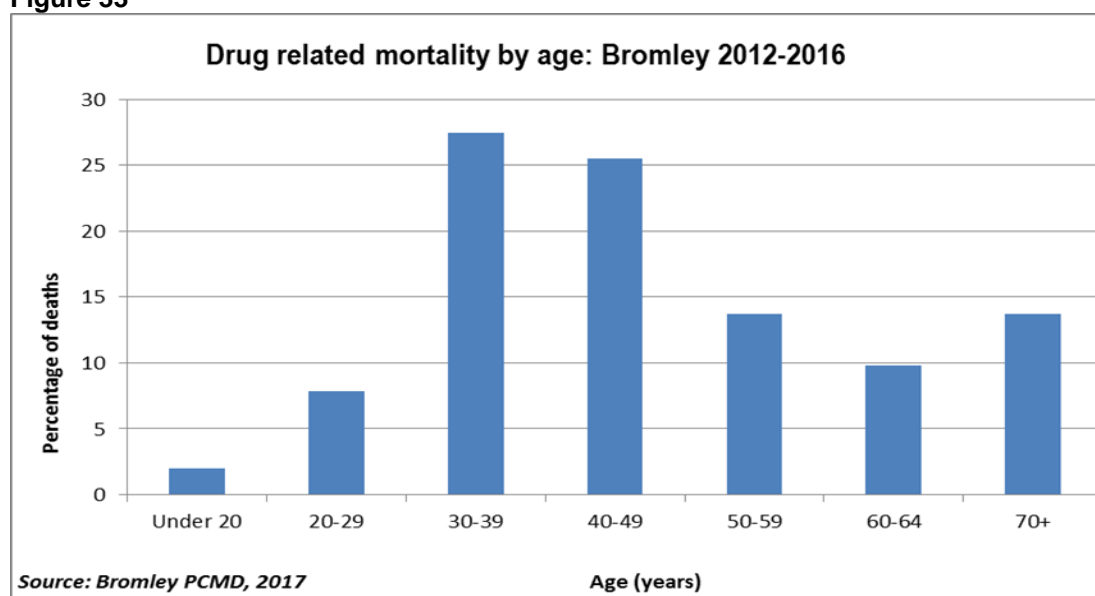
Deaths in Bromley

In Bromley, there were a total of 50 drug-related deaths between 2012 and 2016. The local data should be treated with caution due to the small number of observed deaths. The data has been aggregated over a five year period to increase events to levels which are more meaningful statistically and allow for easier illustration of underlying trends.

Demographic profile: Age and gender

Of the 50 drug related deaths in Bromley in 2012 and 2016, 57% were men. In terms of age, the highest proportions of drug-related deaths were among those aged 30-39 years (27.5%); and 40-49 years old (25.5%), (**Figure 33**). However, gender analysis by age shows the highest number of deaths in women, was in those aged 50-59 years and in men, those aged 30-39 years. The average age at the time of death was 47 years, ranging from 15 to 94 years old, and was 32 to 36 years less than the average life expectancy for men and women born in Bromley.

Figure 33

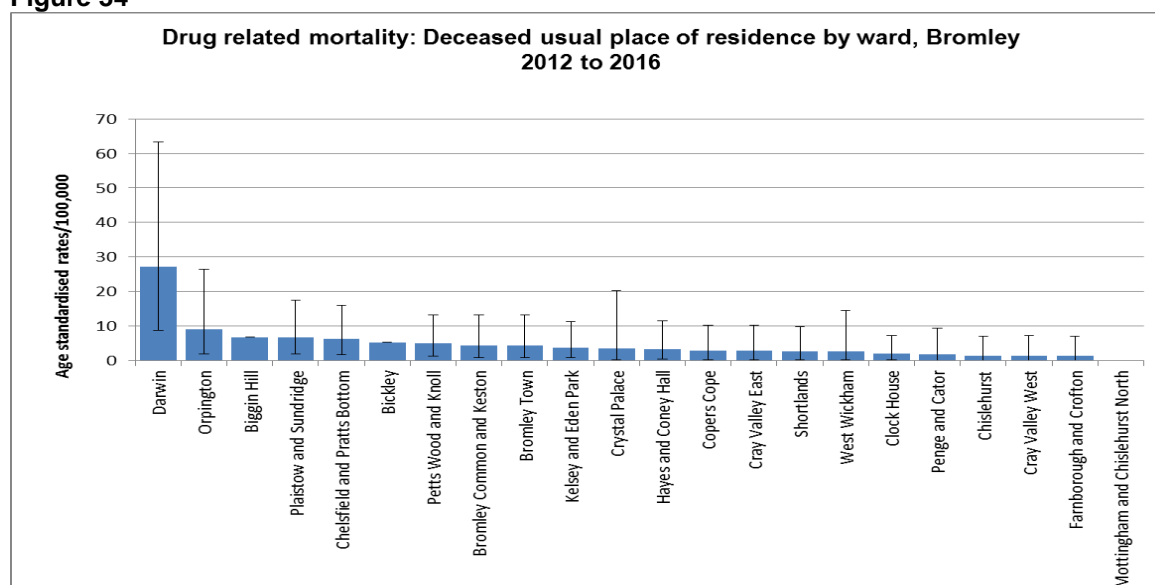


Place of Residence

Geographical analysis by usual place of residence shows that the highest mortality rate was found in Darwin (27.2 deaths per 100,000 population). There is no observable link between drug related death rates and deprivation in Bromley (**Figure 34**). Wards with relatively high deprivation scores have low mortality rates (Mottingham & Chislehurst, Cray Valley West and Penge & Cator) and at the same time also having high rates (Orpington). Due to the small numbers, Bromley rates have wide confidence intervals; meaning there is likelihood that the variation between wards is not precise estimate of the true underlying value, apart from the

difference between the ward with the highest rates (Darwin) and the ward with the lowest rates (Mottingham and Chislehurst North).

Figure 34



Cause of Death

Table 8 shows drug related deaths in Bromley by the underlying cause of death. Accidental poisonings contribute hugely to the proportion of drug related deaths in both males and females both locally (67%) and nationally (55%). In 2016, 82% (1561) male deaths and 72% (501) female deaths were due to accidental poisoning in England and Wales. Due to small numbers in Bromley, deaths for 5 years combined have been considered. In 2012/16, 69% (20) male deaths and 64% (14) female deaths were due to accidental poisoning.

Table 8: Drug related deaths 2012 to 2016

Drug related underlying cause of death by ICD-10 codes	% of deaths
Mental and behavioural disorders due to drug use (excluding alcohol and tobacco)	4
Accidental poisoning by drugs, medicaments and biological substances	67
Intentional self-poisoning by drugs, medicaments and biological substances	20
Poisoning by drugs, medicaments and biological substances, undetermined intent	10
Assault by drugs, medicaments and biological substances	-

Source: Bromley Primary Care Mortality Database, 2017

Trends

Local numbers are too small to analyse for trends in deaths from individual drugs.

Figures 35 and **36** show that nationally & regionally drug-related death rates have increased consistently since 2011/13. However in Bromley the trend is more erratic. There was a consistent rise in drug-related deaths between 2010/12 and 2012/14, in line with national and regional trends. However this was followed by a drop in local rates from 2013/15 to 2014/16. It is worth noting that Bromley rates are very erratic due to the relatively small number of drug-related deaths occurring each year, making it difficult to establish the overall direction of travel without smoothing these variations by analysing data over a longer time period.

Figure 35

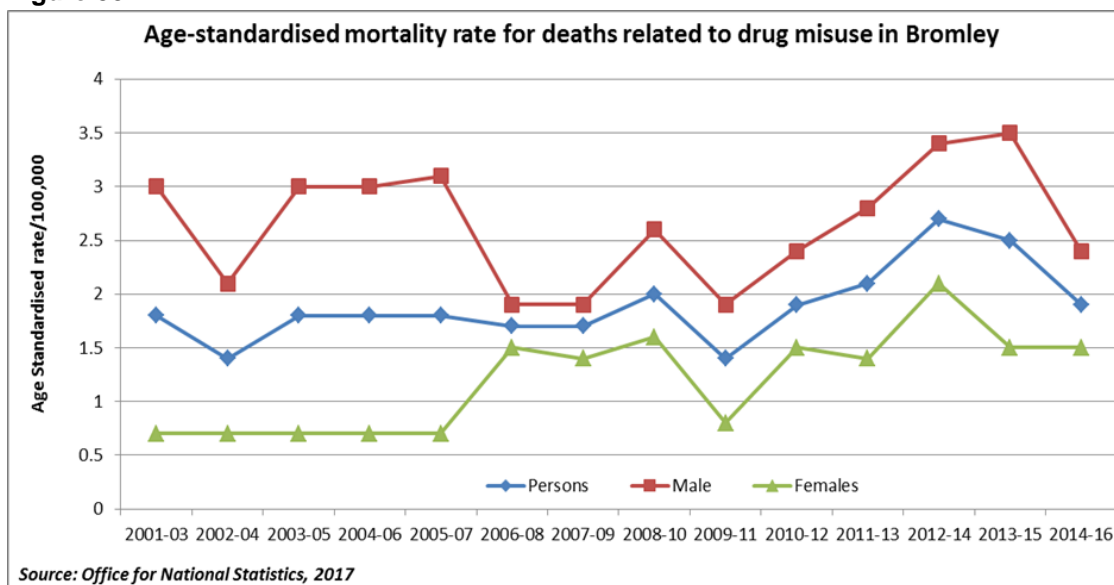
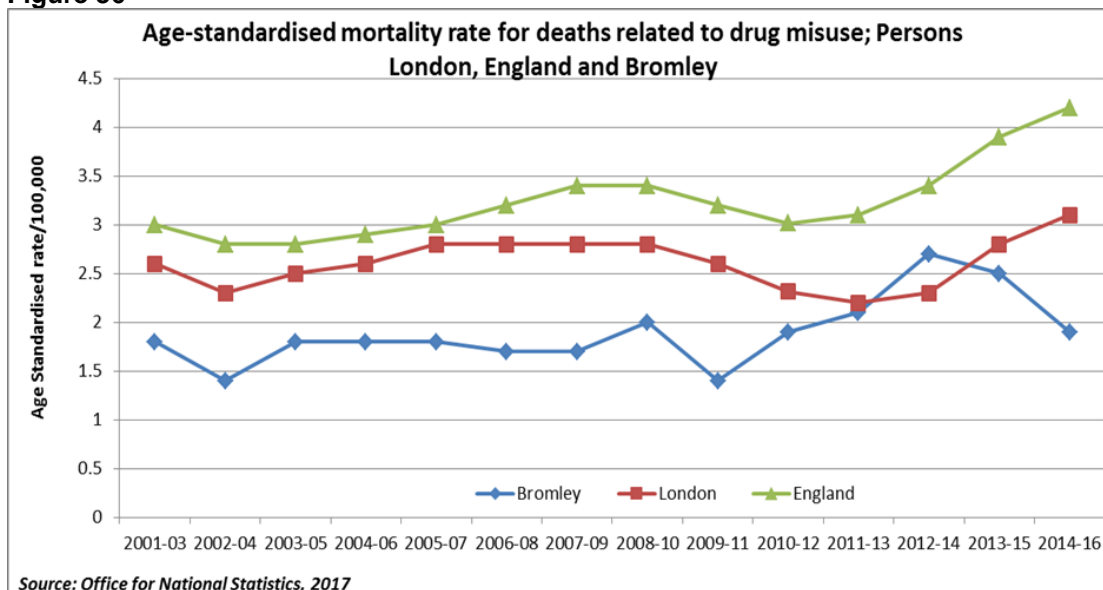


Figure 36



Mortality: deaths in those not engaged in treatment

For many drug users, engaging in treatment is the catalyst for getting the medical help they need to address their physical and mental health problems. Getting drug users into treatment services is a challenge but is central to saving lives^{xxi}. The majority of drug misuse deaths in England occur among people who are not in treatment, and evidence shows that being in treatment is protective against the risk of mortality. Modelling shows that drug treatment in England prevented an average of 880 opioid-related poisoning deaths each year between 2008 and 2011^{xxi}. However every year, a small percentage of clients die while they are in contact with the treatment system.

Figure 37 provides a ratio comparing the observed number of deaths among adults in treatment over a three year period to the expected number if the local authority experienced the same age specific mortality rates as the whole drug treatment population in England. The ratio in Bromley is lower than expected and is among the lowest in the region, even lower than local authorities in the same socioeconomic deprivation bracket in the region (Harrow, Merton, Sutton). This shows that services in Bromley are contributing to reducing the risk of death amongst those clients that engage in treatment. The wide overlapping confidence intervals are indicative of small numbers and there is likelihood that the differences seen are not a precise estimate of the true underlying value.

Figure 37

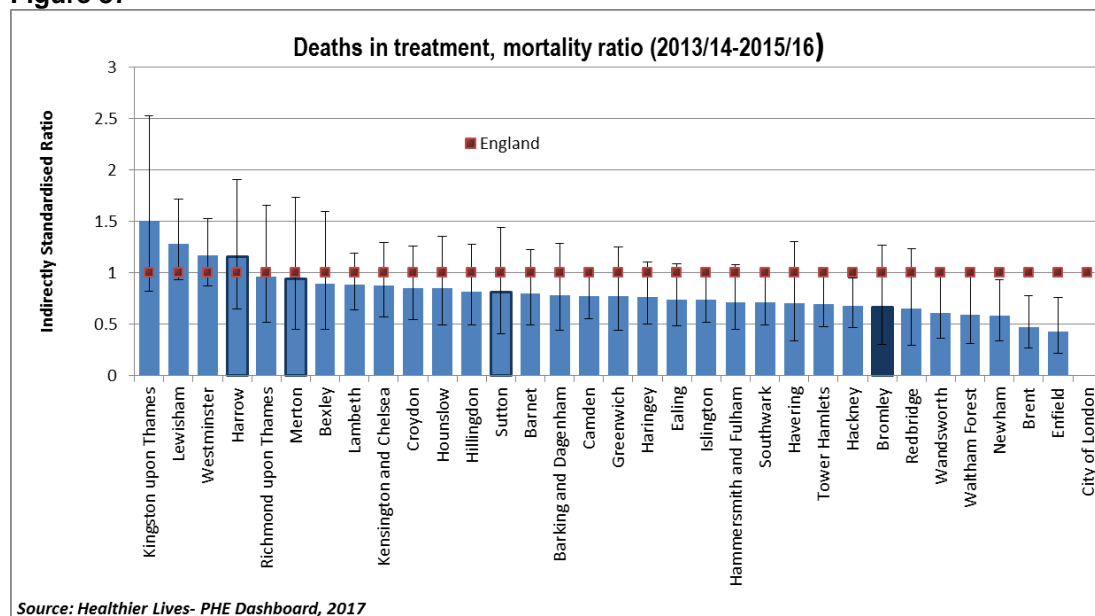
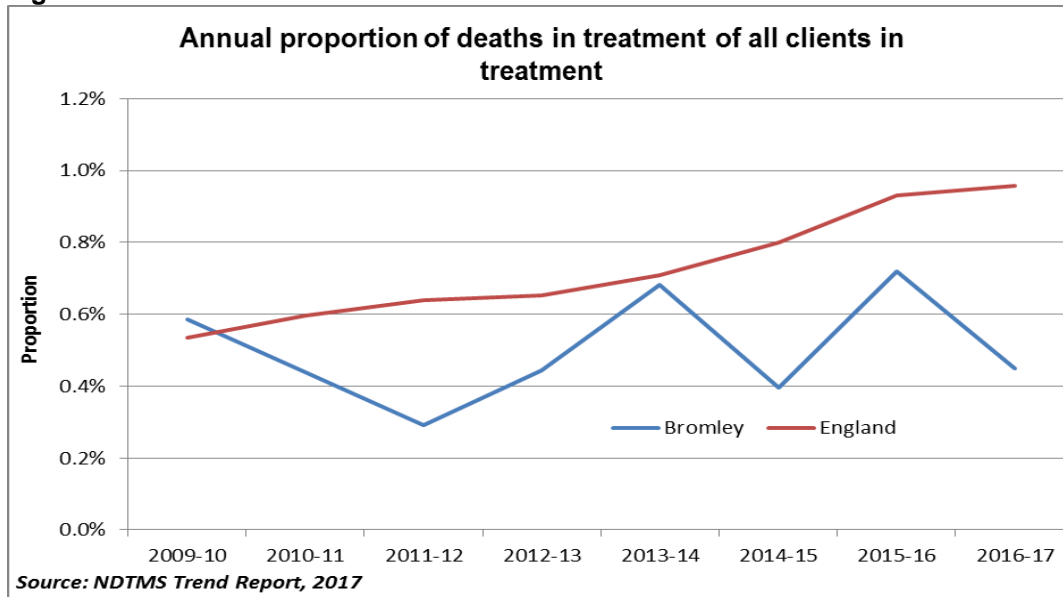


Figure 38 shows proportion of deaths in treatment of all the client population. National trends show there has been an increase in the proportion of deaths in treatment from 0.5% in 2009-10 to 1.0% in 2016-17. The rates in Bromley have consistently remained below the England average since 2009-10. However it should be noted that due to the small numbers, Bromley rates are very erratic and have wide confidence intervals. Although the death rates are low locally and nationally, every death is a tragedy which is potentially preventable and one which can have devastating and far reaching impacts.

Figure 38



Socioeconomic Impact

Today, drug misuse and dependency is associated with a range of harms including poor physical and mental health, unemployment, homelessness, family breakdown and criminal activity. The health and wellbeing of family members and carers can also be affected. Heroin and cocaine are associated with the majority of social costs associated with drug misuse^{iv}. People with heroin dependence usually develop a tolerance through daily use, which can result in an expensive addiction and a motivation to commit acquisitive crime. It was estimated in 2009 that adult drug users not in treatment typically spent £94/£231 (median/mean) a week in current prices on drugs and 40% of all acquisitive crime was drug-related^{iv}. It is further estimated that, any heroin or crack user not in treatment commits crime costing an average £26,074 per year in England.

As well as the social and economic impact on the individual, drug misuse causes a substantial economic burden to society and including costs to the health and care system and criminal justice system.

The annual cost of drug addiction

Every year it costs society

£15.4bn

Any heroin or crack user not in treatment commits crime costing an average £26,074 a year

Every year drug misuse costs the NHS in England £488m

Annual cost of looking after drug using parents' children who have been taken into care is £42.5m

Adapted from Public Health England^v

The Social Return on Investment in Local Drug Treatment Services

Investment in drug treatment can substantially reduce the economic and social costs of drug-related harm. Recent estimates suggest that the net cost-benefit ratio for evidence-based drug treatment in England is £1:£2.50, indicating that for every £1 spent on drug treatment services there is a net economic benefit to society of £2.50^{iv}.

Public Health England have produced estimates for local areas on the social return on investment (SROI) of local drug treatment services. The following provides a summary of some of the estimated gross cost-savings accrued to the borough of Bromley and its residents as a result of drug treatment provision in 2016/17.

Crime

Six billion of the social and economic cost of drug supply in England and Wales is attributed to drug-related acquisitive crime such as burglary, robbery shoplifting etc. Drug-related and drug-enabled activities are key drivers of both new and traditional crime: the possession of illicit substances; the crimes committed to fund drug dependence; the production and supply of harmful substances perpetrated by serious and organised criminals alongside drug market violence associated with human trafficking and modern slavery. Drugs can also play a part in facilitating child sexual exploitation and abuse and the illicit use of drugs in prisons is a driver of rising violence, self-harm and suicideⁱⁱⁱ.

It is estimated that, any heroin or crack user not in treatment commits crime costing an average £26,074 per year in England.

PHE estimate that a total of 33,951 crimes were committed in Bromley due to drug use in 2016/17 but drug treatment prevented approximately a further 6500 crimes being committed in the borough.

This reduction in crime has been estimated to be equivalent to a saving of over £2.4 million to the Bromley economy (the estimated socio-economic impact of the crimes avoided).

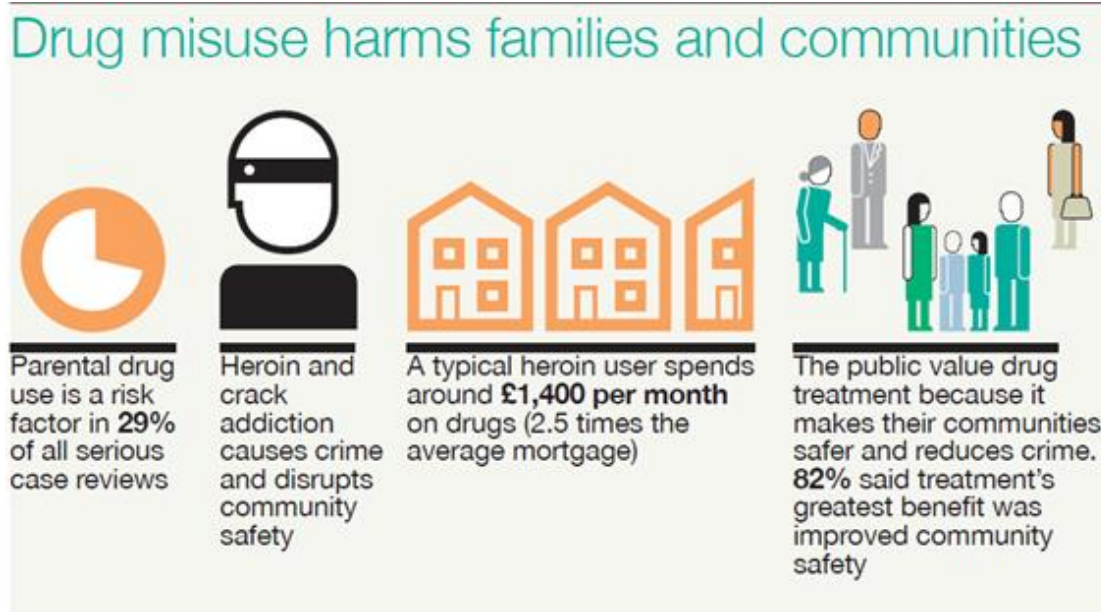
For more information about the methodology used to calculate these cost/benefits please refer to the full SROI tool and guidance document available here:

<https://www.ndtms.net/ValueForMoney.aspx>

Health and Care Costs

The cost of drug misuse to health services in England including; primary care, emergency departments, inpatient care, community mental health, and inpatient mental healthcare, is estimated at £488 million per year^v. The cost of healthcare alone for adult drug users not in structured treatment is estimated to be £5,380 per person per annum. Healthcare costs are estimated to fall by 31% when drug users are in treatment^{iv}.

Children and Families



Adapted from Public Health England^v

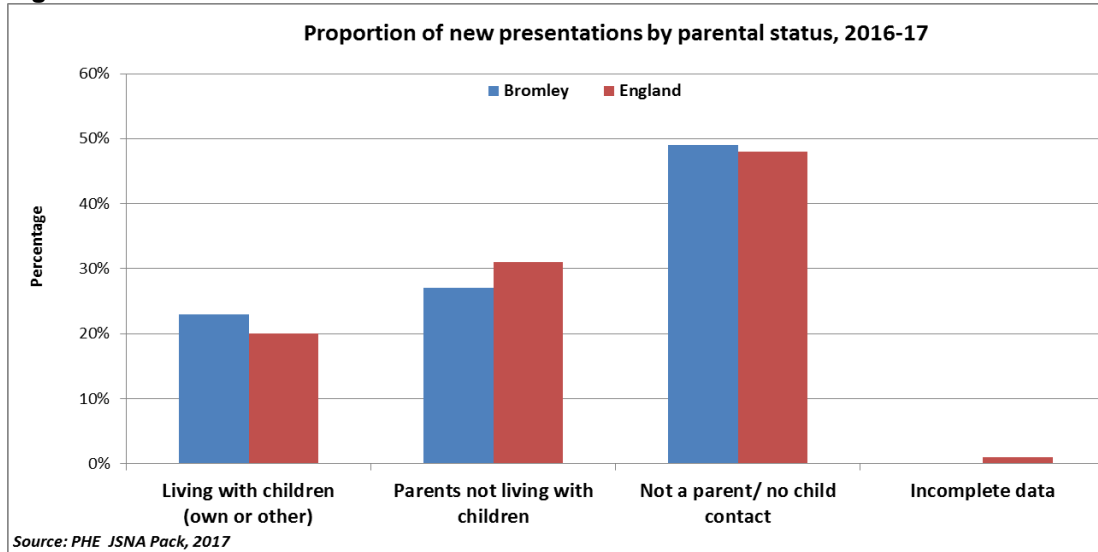
Substance misuse can reduce a parent's ability to provide care. The effects on the child can include neglect, educational problems, emotional difficulties and abuse. Children and young people can do little to protect themselves from the effects of parental substance misuse and can suffer emotional distress, neglect or physical injuryⁱⁱⁱ.

The annual cost to the family members and carers of heroin and/or crack cocaine users is estimated to be £2 billion. The evidence considers the costs of being a victim of crime, lost employment opportunities and health service use, as well as financial support given to relatives^{iv}. While use of opioids does not necessarily impact on parenting capacity, registration on UK child protection registers for neglect has been correlated strongly with parental heroin use, and parental problem drug use has been shown to be one of the commonest reasons for children being received into the care system^{xxii}.

Figure 39 shows that majority of people entering treatment were neither parents nor had contact with children (49% Bromley and 51% England). However, Bromley has a higher proportion, compared to England, of people entering treatment who live with children (23% and 20% respectively).

There were 100 children in Bromley living with drug users who entered treatment services in 2016/17. Many of these families may require specialist support to help them stabilise and strengthen and protect their children from harm. This will have implications for health and social care services in Bromley who must work together to provide effective, whole-family responses for those in treatment who have parental responsibilities.

Figure 39



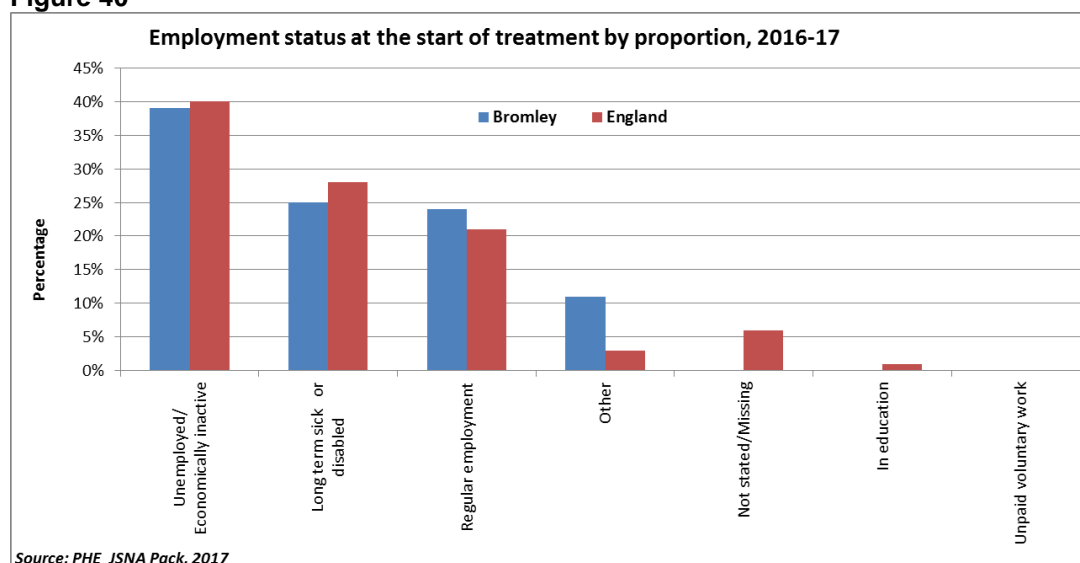
Social Services, Housing and Benefits

Social factors, including housing and employment and deprivation, are associated with substance misuse and these social factors moderate drug treatment outcomes. Lost productivity and unemployment increase with the severity and duration of drug misuse.

Unemployment has a marked negative impact on treatment outcomes and exacerbates the risk that someone will relapse after treatment. It is therefore important to provide longer- term employment support, including in-work support to help people maintain employment^{iv}.

Figure 40 below shows self-reported employment status at the start of treatment in 2016-17. The majority of the clients reported unemployment or economic inactivity in Bromley (39%) and England (40%) at the start of their treatment. Bromley had higher proportions (24%) of those reporting being in work compared to England (21%) and lower proportions reporting long term sick (25% and 28% respectively). The high proportion of people in regular employment contributes to improved chances of better treatment outcomes for local clients.

Figure 40



Employment status amongst drug treatment clients is also reviewed during treatment and at exit. Analysis of the data shows that, of the number of new entrants in Bromley self-reporting not working at the start of treatment, at the time of review, had reduced by 11% while the number in full time work had increased by 32%. At planned exit, the number reporting not in work had reduced by 17% and those reporting being in full time work had increased by 32%. These figures are favourable in comparison to the national average where the number of new clients self-reporting not working at the start of treatment, on review had reduced by 3% while the number in full time work had increased by 16%. At planned exit, the number reporting not in work had reduced by 6% and those reporting being in full time work had increased by 23%. It is of note that, of the clients dropping out of treatment in Bromley, 88% (86% in England) were not in work at the start and remained out of work. Improving job outcomes is key to sustaining recovery and requires improved multi-agency responses.

Housing and homelessness

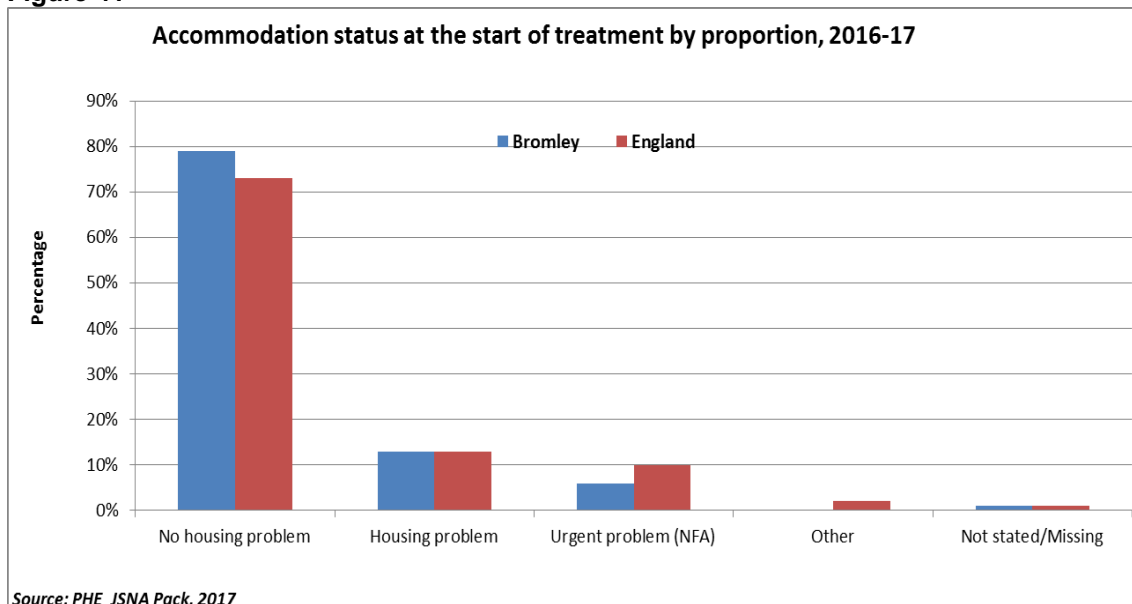
Evidence suggests that the relationship between substance misuse and homelessness is complex with both being mutually reinforcing. Homelessness is often compounded by substance misuse, as well as poor physical and mental healthⁱⁱⁱ. Substance misuse among homeless people is strongly associated with economic marginalisation, social isolation and mental health problems. Substance misuse, in itself, is not a necessary or sufficient condition for homelessness to occur as other factors appear to be involved^{xxiii}.

Figure 41 shows self-reported housing status of adults at the start of treatment. Bromley has a higher proportion (79%) of clients reporting no housing problem

compared to England (73%) and contrariwise a lower proportion (6%) of clients reporting an urgent housing problem at the start of treatment compared to England (10%). There are similar proportions (13%) of new clients reporting a housing problem. Evidence shows a safe stable home environment enables people to sustain their recovery.

These data should be interpreted in line with the overall number of decisions taken on homelessness applications in the area⁸. Bromley has a higher rate of decisions taken compared to England at 9.1 per 1,000 households and 5.0 per 1,000 households respectively. Engaging with local housing and homelessness agencies can help ensure that the full spectrum of homelessness is understood and picked up: from statutorily homeless, single homeless people and rough sleepers to those at risk of homelessness.

Figure 41



⁸ Data specific to drug users is unavailable

The Treatment and Management of Drug Misuse

Investing in drug treatment cuts crime and saves money



Adapted from Public Health England^v

The main aims of treatment are:

1. Harm reduction – preventing or reducing negative health and social consequences of drug use, including infections and overdose.
2. Maintenance oriented treatments – reducing an individual’s level of drug use, mainly by substitute prescribing.
3. Abstinence-oriented treatments – reducing drug use with the ultimate aim of abstinence, using a range of interventions including detoxification, psychosocial interventions and residential rehabilitation.

Drug treatment has been evaluated across a wide range of outcome measures, including drug use, abstinence from drug use, drug injecting, overdose, health and mortality, crime, social functioning included employment, housing, family relations, and the perceptions of service users about their recovery status. The breadths of these measures reflect the broad range of benefits anticipated from drug treatment.

The general principles of treatment are that; no single treatment is appropriate for all individuals, treatments should be accessible and begin when and where the service user presents, and there should be the capacity to address multiple needs. It is also accepted that treatments will change over time. Research suggests that treatment does not need to be voluntary to be successful, and is ethical when given as an alternative to other penal sanctions^{xiv}.

A recent evidence review made the following comparisons between drug treatment outcomes in England and those in other countries, according to the scientific literature in England^{iv}:

- The treatment penetration rate (60%) is among the highest reported

- Access to treatment (97% within three weeks) is comparable to other countries
- The rate of drug injecting among all 15-64 year olds (0.25%) is relatively low
- The rate of drop out from treatment before three and six months (18% and 34%, respectively) is comparable to the literature (28% on average)
- England has a very low rate of HIV infection among the injecting drug user population (1%), which compares favourably internationally. The rate of HCV infection (50%) is also lower than several other countries with available data. The rate of stopping injecting at 3, 6 and 12 months, is comparable with, or better than, the scientific literature
- Successful completion of treatment rates for non-opiate drug users, who only receive psychosocial interventions, have increased from 14% in 2005/6 to 37% in 2014/15 for non-opiate drug and alcohol users, and from 13% in 2005/6 to 42% in 2014/15 for users of non-opiate drugs alone

The evidence review also pointed to two key areas where there were opportunities for improvement in outcomes in comparison to evidence in the scientific literature and international comparisons:

- The rate of illicit opiate abstinence after three and also six months of treatment in England (46% and 48%, respectively) points to relatively poorer performance in comparison with the literature (56% on average)
- The drug-related death rate in England (34 per million in 2013) is substantially lower than in the USA but considerably higher than elsewhere in Europe

Key factors influencing recovery

Helping people to overcome drug dependence is a core function of the local drug treatment system.

When engaged in and completing treatment, people use fewer illegal drugs, commit less crime, improve their health, and manage their lives better. This makes a real contribution to community safety. The data below shows the proportion of drug users who complete their treatment free of dependence, the progress made on people successfully completing treatment, and those successfully completing who do not relapse and re-enter treatment.

Although drug treatment services treat dependence for all drugs, opiate users remain the group with most complex problems. In Bromley, opiate and/or crack cocaine users (OCUs) make up the overwhelming majority of clients in treatment, followed by users of cannabis and cocaine.

Treatment Pathways

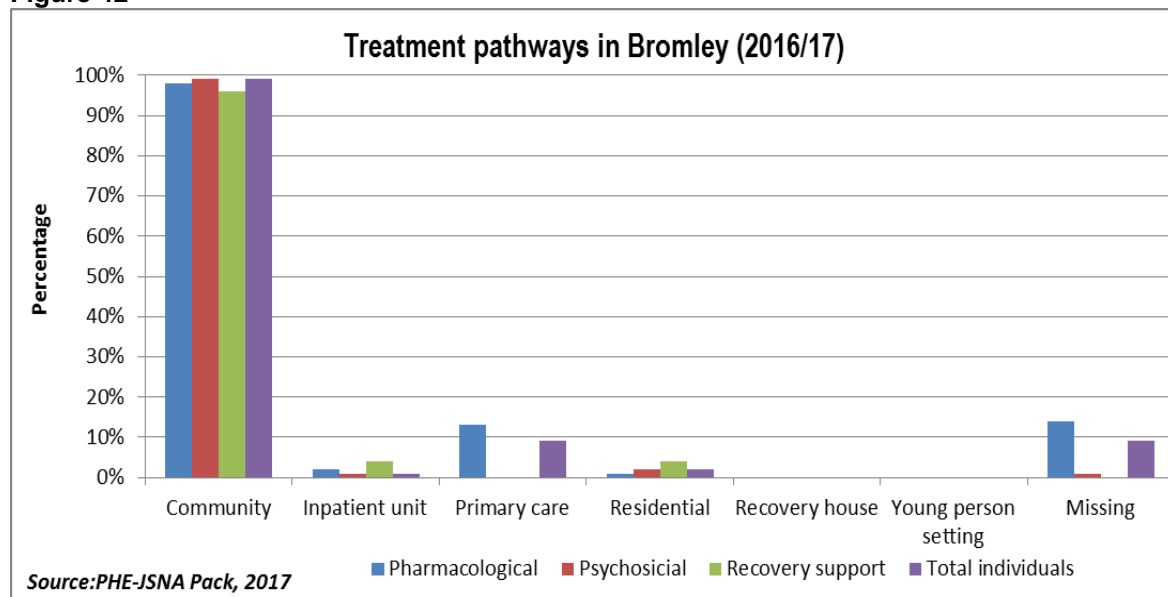
Analysis by substance group shows that in Bromley, the most common pathway in to treatment pathway for opiate clients was 'Prescribing & Psychosocial' with 95% of the referred clients attending. There were 23 clients who successfully completed this pathway at a successful completion rate of approximately 8%. Given the borough's opiate user profile, the expected successful completion rate is 5%. The most common pathway for non-opiate clients was 'Psychosocial only' (88%), with 36% of clients on this pathway successfully completing, compared with an expected 41% successful completion rate.

Intervention Type and Setting Delivered

We know that the types of interventions delivered to service users will have an impact on their achievement of recovery outcomes.

Figure 42 shows the numbers of people in Bromley receiving treatment via different available pathways. Bromley practice is in line with what is known about effectiveness, in that prescribing-only is much less effective in achieving sustained abstinence than when combined with psychological support.

Figure 42

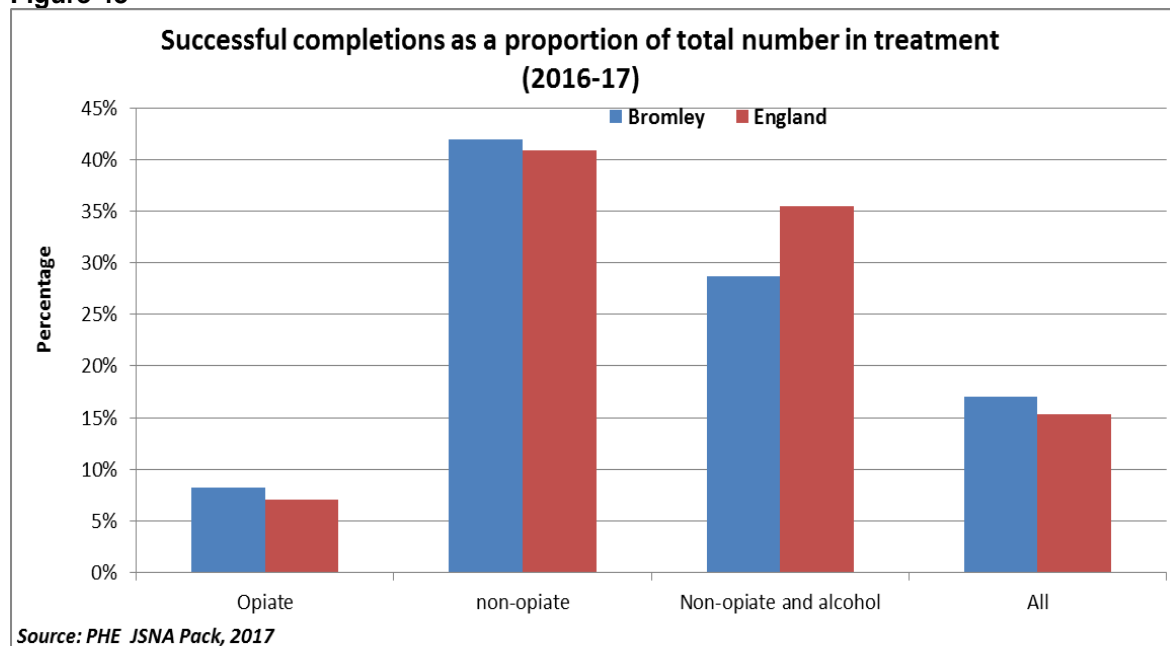


Successful completion

Figure 43 below shows the number of drug users who completed their drug treatment successfully (free of drug(s) of dependence) as a proportion of the total number in treatment for 2016/17. In that time period, 17% of all drug treatment clients in Bromley successfully completed treatment compared to 15% in England. Opiate clients have the lowest proportion of successful completions compared to rates for the other substance groups. Locally, 8% of opiate clients successfully completed treatment compared to 7% nationally. In contrast, 42% of non-opiate and 27% of non-opiate and alcohol clients successfully completed treatment in the same time period in Bromley. This compares to 41% and 36% respectively in England, showing a higher rate in non-opiate and alcohol clients in England compared to Bromley.

It is noteworthy that women in Bromley presenting to treatment for opiate use had higher successful completion rates (12%) compared to the local men (6%) in the same category.

Figure 43



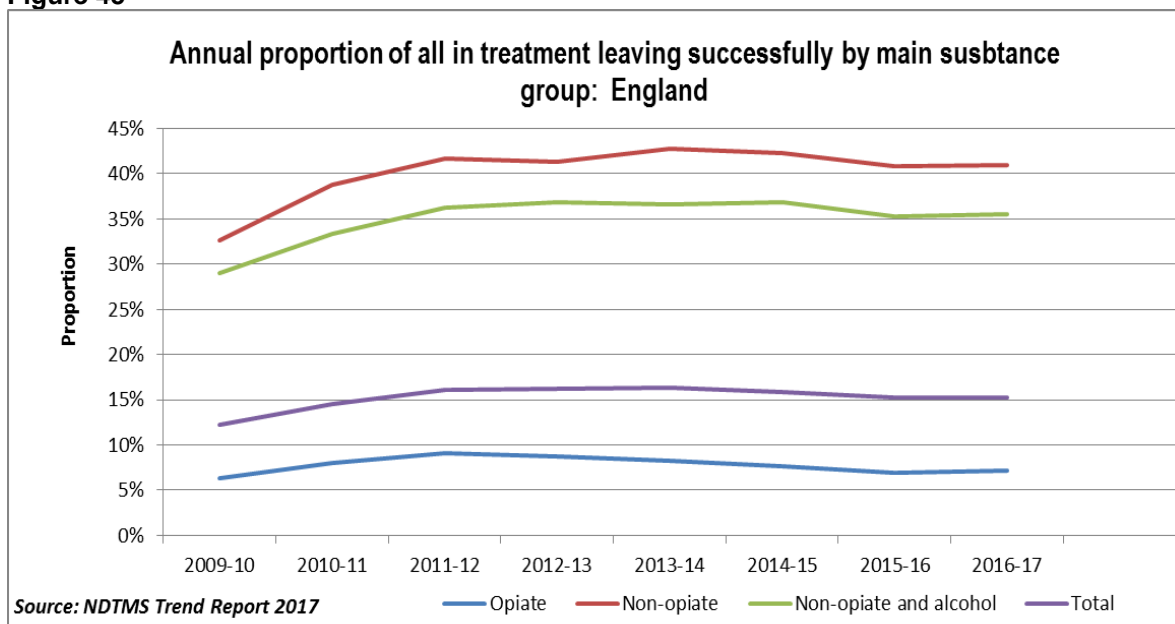
Successful completion trends

In England, the number and proportion of individuals completing treatment free of dependence have increased from 2009-10 to a peak in 2013/14 and has since fallen (**Figure 44** and **45**). Opiate clients have the lowest proportion of successful completions compared to rates for the other substance groups, while non-opiates consistently have the highest completion rates. There are similar patterns of change across the different substance groups (**Figure 45**).

Figure 44



Figure 45



In Bromley, the number and proportion of individuals completing treatment free of dependence have not followed a consistent pattern. There was a fall in 2011 from a peak in 2009-10 and then peak again in 2013/14 only to fall again (**Figure 46** and **47**). Opiate clients have the lowest proportion of successful completions compared to rates for the other substance groups, while non-opiates consistently have the highest completion rates. The rates in non-opiates and non-opiates and alcohol are very erratic and possibly contribute to the overall local successful completion trends (**Figure 47**).

Figure 46

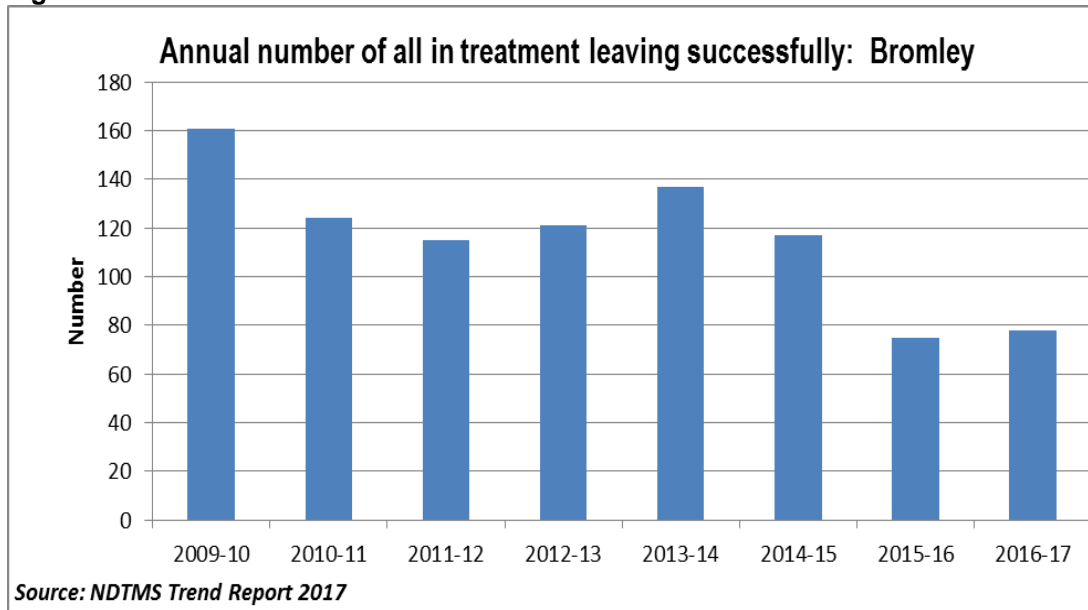
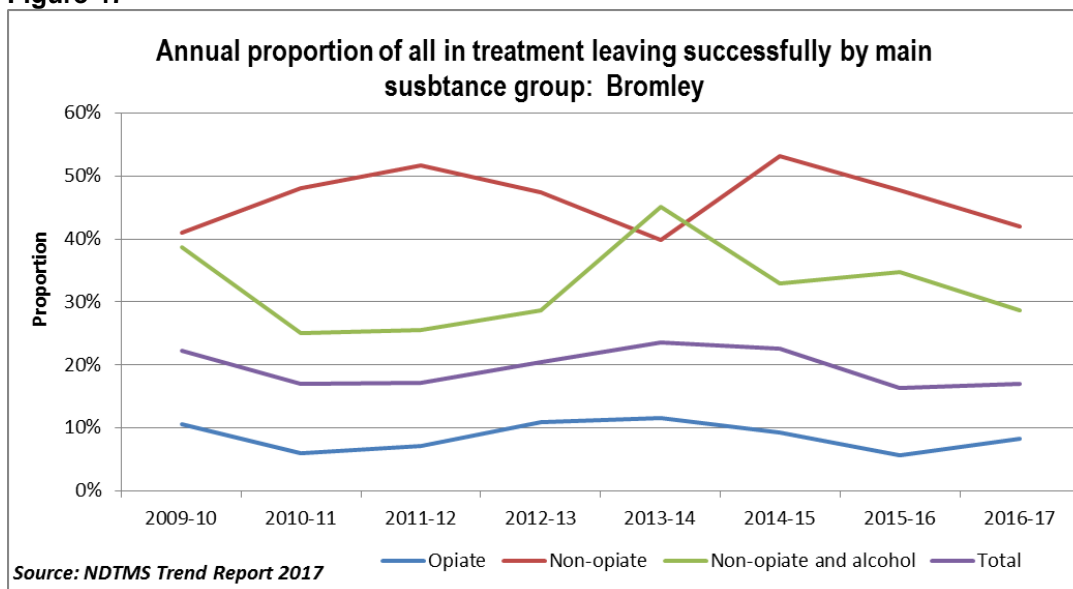


Figure 47



Successful completion and not representing

The proportions of opiate and non-opiate clients in Bromley who successfully complete treatment and do not relapse and re- enter treatment also show no overall trend. The local rates have wide and overlapping confidence intervals, which are indicative of the small numbers and there is likelihood that the variation is not a precise estimate of the true underlying value (**Figure 48 and 49**).

Figure 48

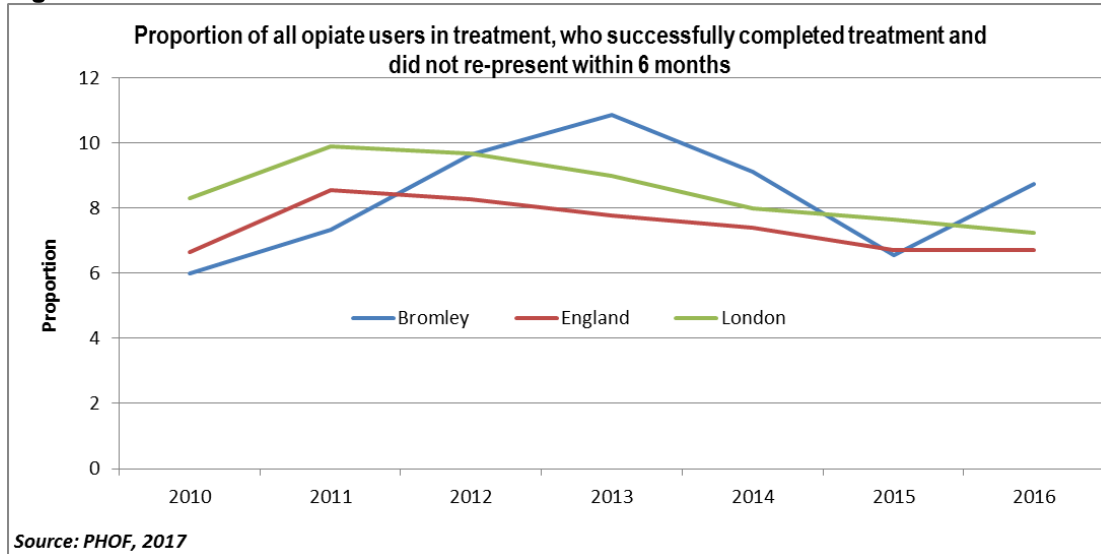
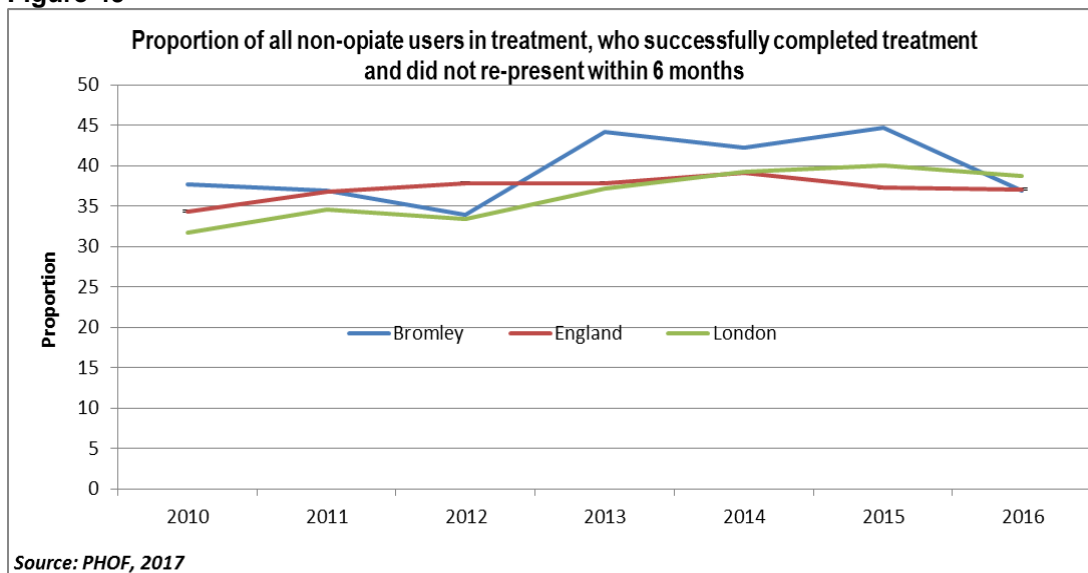


Figure 49



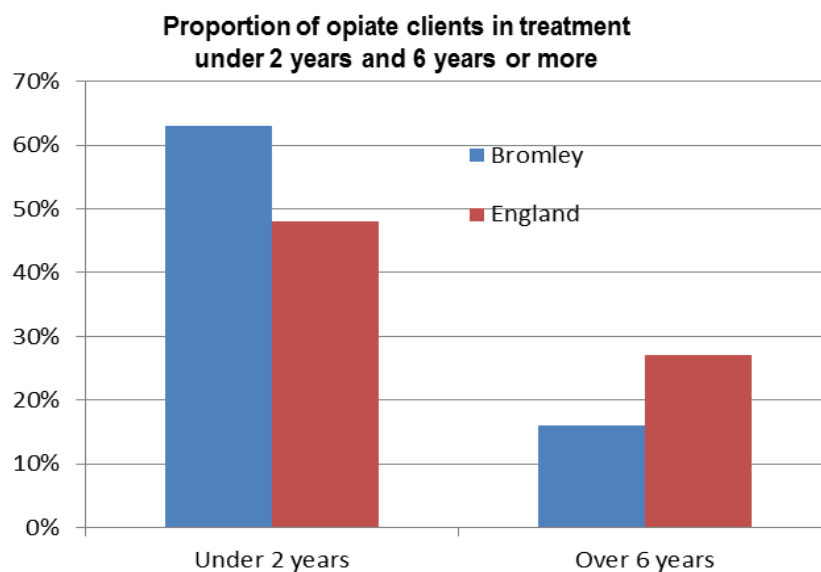
Length of time in treatment

Although many individuals will require a number of separate treatment episodes spread over many years, most individuals who complete successfully do so within two years of treatment entry. Clients that have been in treatment for long periods of time (six years or over for opiate clients and over two years for non-opiate clients) are most likely to be entrenched users who will find it harder to successfully complete treatment. Current data shows that opiate clients who successfully complete within two years of first starting treatment have a higher likelihood of achieving sustained recovery. Data also shows that non opiate clients are more likely to successfully complete treatment within two years.

In Bromley, there was no record of non-opiate clients in treatment for two years or more compared to the 3% in England. And only 1% of clients using both opiates and alcohol were in treatment for two years or more in Bromley compared to 4% in England.

For opiate clients, the majority also were in treatment under two years; 63% in Bromley (compared to 48% in England). Conversely, Bromley has lower proportions of opiate clients staying in treatment 6 years or more compared to England at 16% and 27% respectively (**Figure 50**).

Figure 50



Source: PHE- JSNA Support Pack, 2017

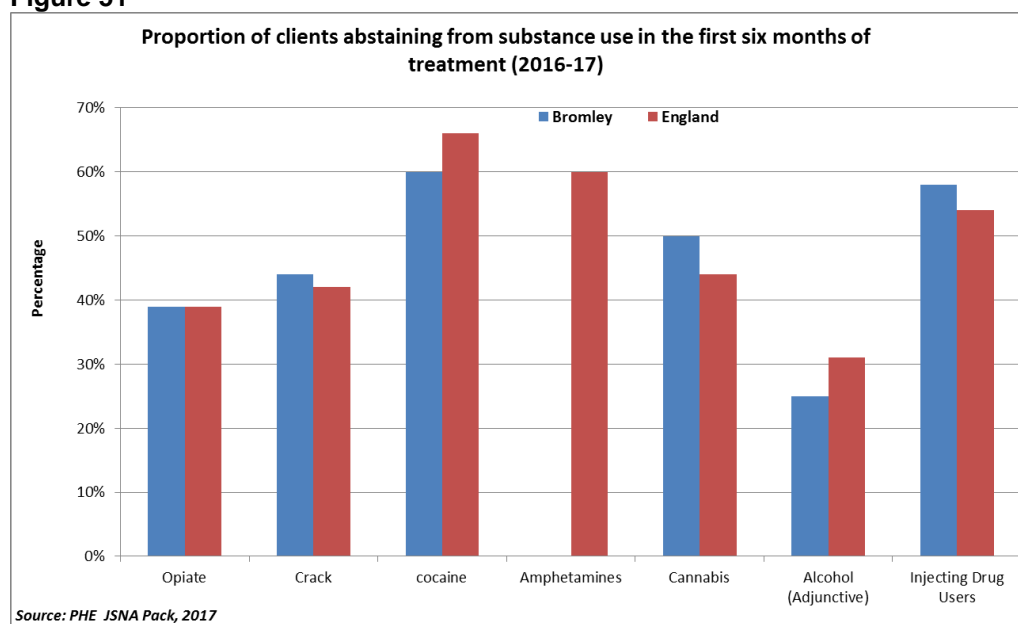
Treatment Outcomes

Treatment Outcomes at 6 Months

Figure 51 presents data drawn from the Treatment Outcomes Profile (TOP), which tracks the progress drug users make in treatment. Data from NDTMS suggests that clients who stop using illicit opiates in the first six months of treatment are almost five times more likely to complete successfully than those who continue to use.

Clients presenting with cocaine had the highest abstinence rates, both locally (60%) and nationally (66%), followed by injecting drug users (58% and 54% respectively). Bromley had similar proportions to England of opiate users achieving abstinence within 6 months (39%).

Figure 51



Analysis of data on abstinence in the first 6 months by substance and gender shows a varied picture. Where men achieved better abstinence levels for some substances (opiate, cocaine and injecting drug use) and women achieved higher levels on others (crack, cannabis and alcohol as the adjunctive drug). It is worth noting that no women injecting drugs were found to be abstinent in the first 6 months (**Figure 52**). Women presenting to treatment often experience poor mental health, domestic violence and abuse, which may impact upon their recovery. Unfortunately there is no data to ascertain trends by substance and gender.

Figure 52

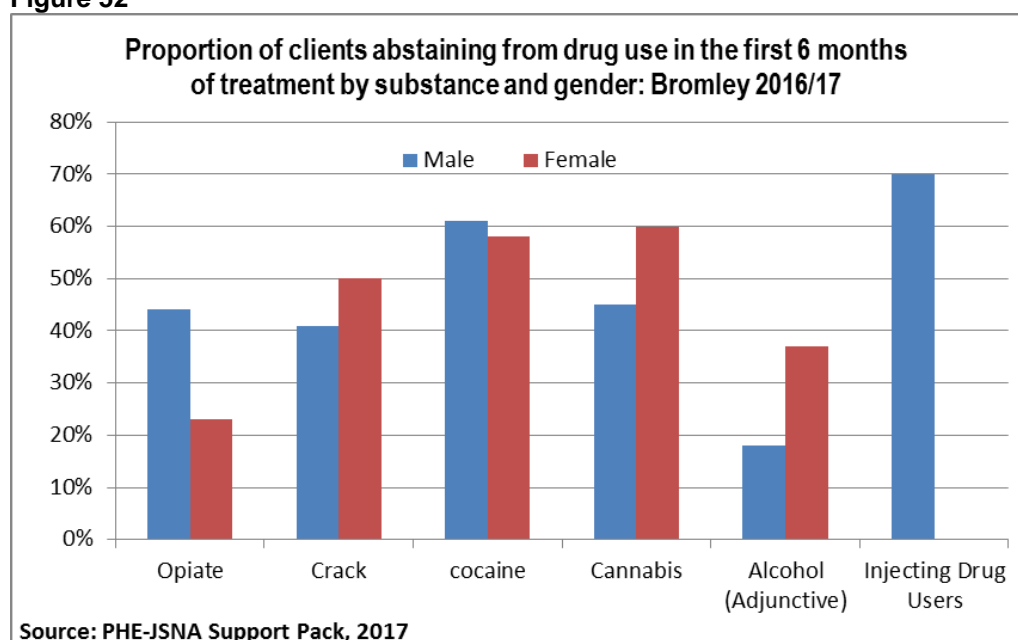
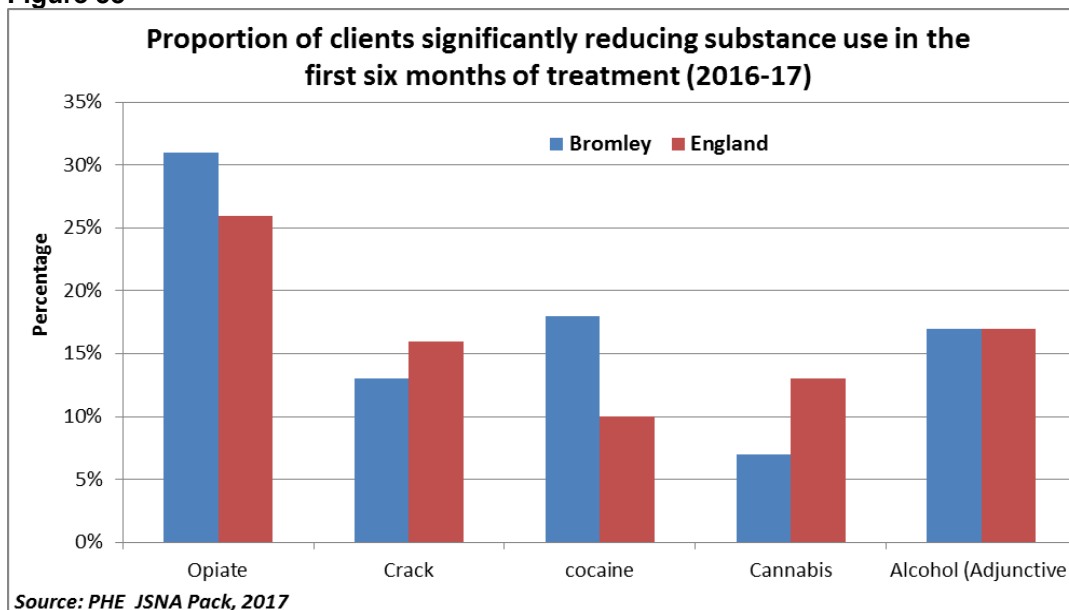


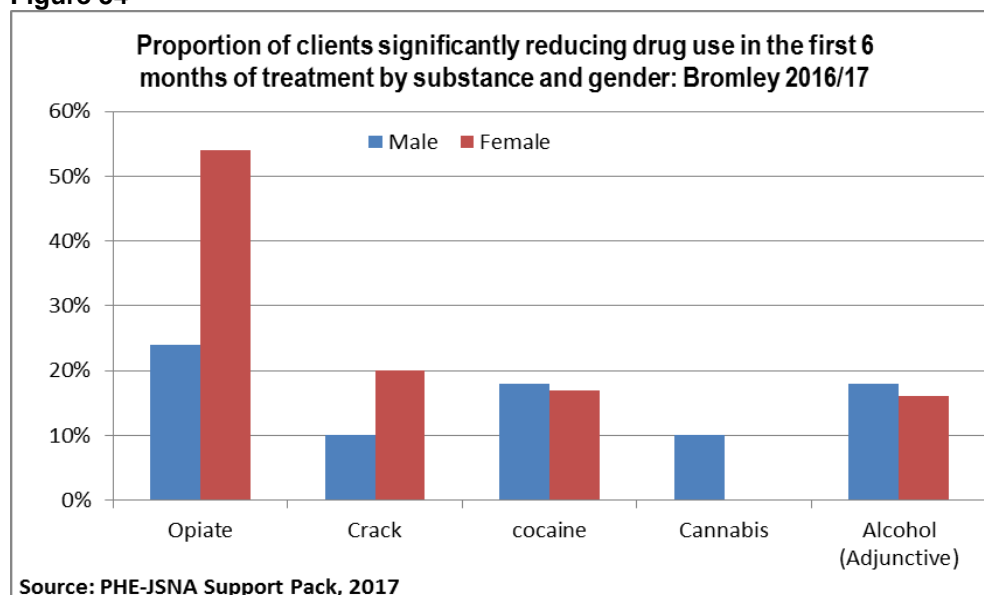
Figure 53 shows proportions of clients significantly reducing drug use in the first six months by the problem drug. Although opiate clients have the lowest successful completion rates, they have the highest proportions of significant reductions both locally (31%) and nationally (26%). This may be indicative of the complex problems in this group and the work involved overcoming addiction. Higher proportions of the clients presenting with cocaine locally (18%) than nationally (10%) reported significant reduction. However, among the cannabis clients and crack clients, England had higher proportions (13%, 16%) than Bromley (7%, 13%) respectively. Bromley had similar proportions to England among clients presenting with alcohol as an adjunctive drug (17%).

Figure 53



Analysis of the same data by substance and gender locally shows a varied picture. Where men achieved better reduction levels for some substances (cocaine, cannabis and where alcohol as an adjunctive drug) and women achieved higher levels on others (opiate and crack). It is worth noting that no women injecting drugs were reported in this category (**Figure 54**). Unfortunately there is no data to ascertain trends.

Figure 54



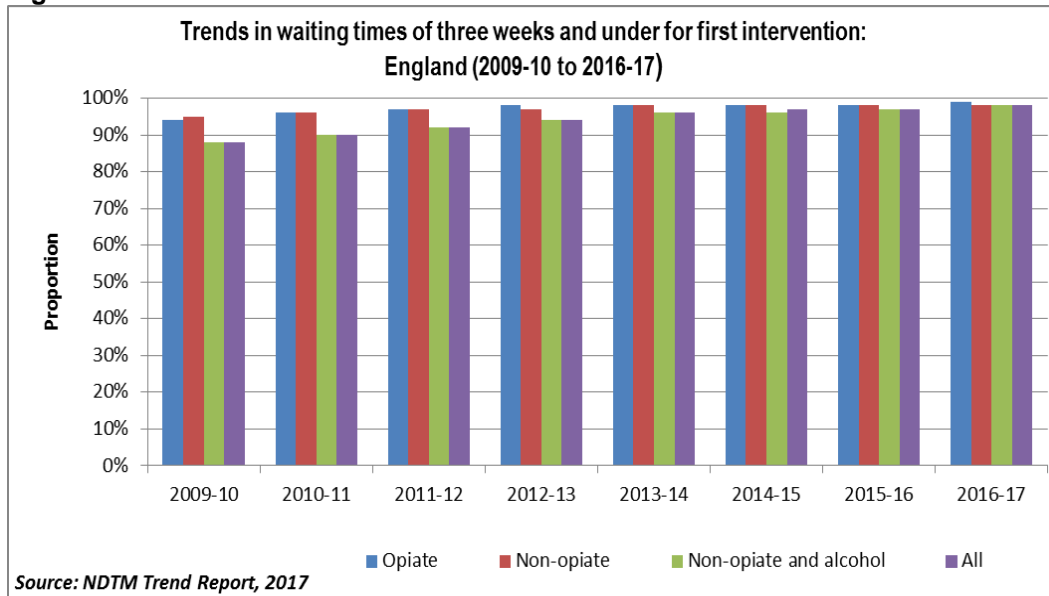
Waiting times

Drug users need prompt help if they are to recover from dependence. Local efforts to keep waiting times low means that the national average waiting time is less than one week. Keeping waiting times low plays a vital role in supporting recovery and ensuring that substance misuse treatment is accessible for all of those who need it.

Figure 55 & 56 shows that opiate clients, both locally (96%) and nationally (99%), had the highest proportion of individuals experiencing short waiting times defined as waiting three weeks or less from being identified as having a treatment need to being offered an appointment to start an intervention.

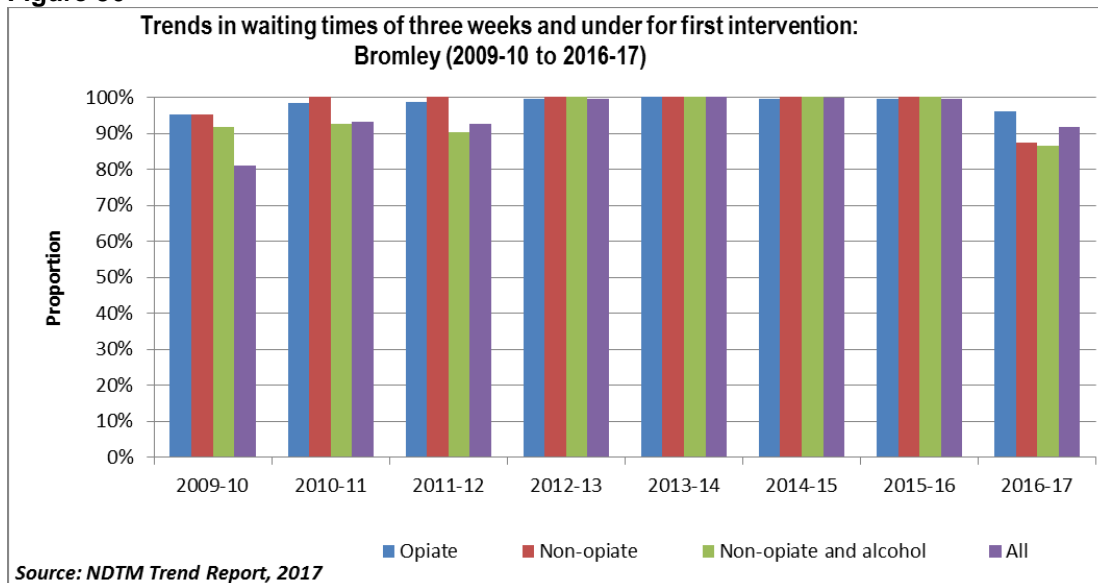
Figure 55 presents trends in the proportion of individuals experiencing short waiting times in England. Overall, the proportion waiting three weeks or less has increased across all substance groups since 2009-10 to 2016-17, with 99% of opiate clients in the most current year waiting 3 weeks or less to start an intervention. The largest improvements in waiting times have been seen in individuals presenting with problematic non-opiate and alcohol use. Among this group, the proportion waiting less than 3 weeks to start an intervention has risen from 88% in 2009-10 to 98% in 2016-17.

Figure 55



Overall in Bromley, the proportion of people experiencing short waiting times has been increasing across all substance groups since 2009-10 until recently. Non-opiate and alcohol clients were the most affected by the longer waiting times with a 13% reduction between 2015/16 and 2016/17 (**Figure 56**).

Figure 56

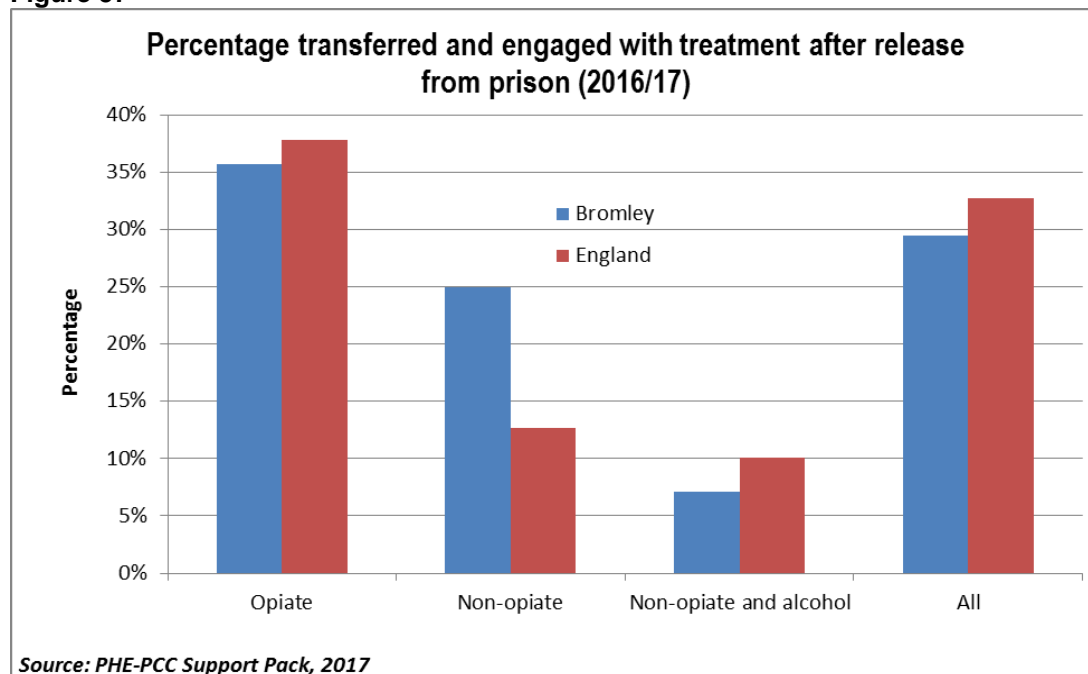


Prison Release and Transfer to Treatment

Figure 57 shows the percentage of individuals in 2016-17 who at the point of release from prison were transferred to a community treatment provider for structured treatment interventions and other support and were successfully engaged.

A total of 15 HMP prisons transferred clients to drug treatment in Bromley for structured treatment interventions and other support in 2016/17. Of those transferred, 29% successfully engaged with services in Bromley compared to 33% in England. Both locally and nationally, there were higher numbers and proportions of transfers and engagement among opiate clients. There are no prisons within Bromley borough; Bromley residents are remanded all over the country which could impact on timely and successful transfer of individuals released from prison into treatment service.

Figure 57



Early Unplanned Exits

When engaged in treatment, people use less illegal drugs, commit less crime, improve their health, and manage their lives better – which also benefits the community. Preventing early drop out and keeping people in treatment long enough to benefit contributes to these improved outcomes. As people progress through treatment, the benefits to them, their families and their community start to accrue. Unplanned exit or early drop out refers to adults entering treatment who left in an unplanned way before 12 weeks commonly.

Locally the current treatment drop-out rate is lower than the national average (12% in Bromley compared to 17% nationally). Locally, there were higher drop-out rates among clients presenting with opiate abuse at 20%. In England, the rate was highest among those presenting to treatment for non-opiate drug abuse at 18%. Analysis by gender shows that men were more likely to drop-out early across all substance groups both locally and nationally.

Residential Rehabilitation

Drug treatment mostly takes place in the community, near to drug users' families and support networks. However residential rehabilitation may be cost effective for someone who is ready for active change and a higher intensity treatment at any stage of their treatment, and this option is encouraged as part of an integrated recovery-orientated system.

With that said, only a small number and proportion of users were in residential rehabilitation during the latest period of treatment. In Bromley, 2% of the adult population in drug treatment attended residential rehabilitation compared to 3% nationally. Local data shows that there were more men in attendance.

What this means for residents in Bromley:

Substance misuse is a complex area. Individuals with substance misuse problems may also have other difficulties including mental health problems, poverty, relationship issues, family breakdown, unemployment and involvement with the criminal justice system. In Bromley, there is also the challenge of an aging population of opiate users with multiple physical health problems and entrenched use.

Bromley residents require specialist substance misuse services that can respond to the changing nature of substance misuse in the borough. The contract for existing substance misuse services for adults and young people in Bromley are due to expire later in 2018. A new service specification has been designed (incorporating the findings of this needs assessment) and new services will be commissioned to come into effect in December 2018.

The new service will be presented with a number of local challenges to address including the following:

- To increase numbers of individuals in treatment
- To find innovative ways of working with older opiate users with more complex needs
- To respond to the emerging needs of individuals using NPS and over the counter/prescribed medications
- Develop strategies to prevent drug related deaths
- To engage with problematic alcohol users who may be treatment naïve

A primary focus for the new service will be the identification and engagement of substance misusers. Partnership working with a range of key partners in the borough will be essential in supporting more individuals into treatment. This will include joint working with the Criminal Justice Services, Hospitals, LBB services including Children's Services, Community Health Services, the Voluntary Sector and Primary Care.

Aftercare and Reintegration has been cited as important for sustained recovery. The new service will offer wraparound support and on-going contact as well as pathways to specialist education, housing and employment support and advice.

It is anticipated that the integrated treatment system will provide a holistic service to support successful and sustained recovery for those who misuse substances in Bromley. Improved partnership working and early identification and referral will improve outcomes and treatment completion rates.

Appendix

Data Sources and Definitions

In order to understand mortality and morbidity due to drugs for Bromley, local PCMD and Hospital Episodes Statistics extracts have been used.

The **Primary Care Mortality Database** (PCMD) provides a list of all deaths recorded as drug poisoning. PCMD collates deaths by place of death, CCG of residence and date of death. The underlying cause of death is recorded for all deaths in the PCMD using the World Health Organisation's (WHO) International Classifications of Diseases version 10 (ICD 10). The relevant codes are listed in a **table 10** in the appendix.

This definition of drug deaths includes accidents, suicides and assaults involving drug poisoning, as well as deaths from drug abuse and drug dependence. It does not include other adverse effects of drugs (for example anaphylactic shock). Deaths are included where one of the ICD-10 codes shown in the Table is the underlying cause of death.

Due to various organisation and regulation changes, access to datasets (**Coroner records** and **GP clinical records**) that complement the PCMD extract is no longer possible. The absence of those datasets eliminates the soft intelligence around drug related deaths which is vital in prevention strategies.

The **Hospital Episodes Statistics** (HES) extract pulls together inpatient and day patient hospital admissions for drug poisoning. The **primary** and **secondary** cause of admission is recorded for all admissions in the HES using the World Health Organisation's (WHO) International Classifications of Diseases version 10 (ICD 10). The relevant codes are listed in a table in the appendix.

Primary diagnosis is defined as the main condition treated or investigated during the relevant episode of healthcare, and where there is no definitive diagnosis, the main symptom, abnormal findings or problem.

Secondary diagnosis describes those conditions that co-exist at the time of admission, or develop subsequently, and that affect the patient care for this current episode of care. Clinicians record up to 19 secondary diagnoses.

Other Sources:

- **Crime Survey for England and Wales**
- **National Drug Treatment Monitoring system**
- **Public Health England Commissioning Support Pack 2018/19**
- **Public Health England JSNA support Pack, 2018/19**
- **Public Health England Police and Crime Commissioners support pack, 2018/19**
- **Public Health Outcomes Framework**

Data caveats for consideration

The report specifically focuses on drug misuse to the exclusion of alcohol. However, CGL is contracted to offer a combined drug and alcohol treatment and support service for Bromley residents. Therefore data presented in this report has been cleansed of alcohol and thus may differ from the routine data sources listed above.

The definition of drug related deaths does not include every death that involved drugs, for example, transport accidents where the driver was under the influence of drugs are excluded.

In common with most other mortality statistics, figures for drug-related deaths are presented for deaths registered in a particular calendar year, rather than deaths occurring each year. Due to the length of time it takes to complete a coroner's inquest, there can be a considerable delay between when the death occurred and when it was registered. The local data can be influenced by geographical variations in registrations delay.

Hospital admissions for alcohol related and alcohol specific conditions have been excluded from the discussion of this report as this report specifically focuses on drugs misuse. These hospital admissions will be included in a separate report specific to alcohol.

Table 9

Underlying Cause of Death : Drug related Deaths	
ICD- 10 Code	Description
F11-F16,F18-F19	Mental and behavioural disorders due to drug use (excluding alcohol and tobacco)
X40-X44	Accidental poisoning by drugs, medicaments and biological substances
X60-X64	Intentional self-poisoning by drugs, medicaments and biological substances
Y10 -Y14	Poisoning by drugs, medicaments and biological substances, undetermined intent
X85	Assaults by drugs, medicaments and biological substances

References

- ⁱ World Health Organisation (WHO). *Lexicon of alcohol and Drug Terms* Published by the World Health Organisation. (1994). [online] Available at: http://www.who.int/substance_abuse/terminology/who_ladt/en/ [Accessed 13/11/2017].
- ⁱⁱ Alere. (2017). *UK drug classifications*. [online] Available at: <https://www.aleretoxiology.co.uk/en/home/support/drug-classifications.html> [Accessed 14/11/2017].
- ⁱⁱⁱ HM Government. (2017). *2017 Drug Strategy*. [online] Available at: <https://www.gov.uk/government/publications/drug-strategy-2017> [Accessed 13/11/2017].
- ^{iv} Burkinshaw, P., Anders, P., Knight, J., Eastwood, B., Musto, V., White, M. and Marsden, J. (2017). *An evidence review of the outcomes that can be expected of drug misuse treatment in England*. [online] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/586111/PHE_Evidence_review_of_drug_treatment_outcomes.pdf [Accessed 7/12/2017].
- ^v Public Health England. (2014). *Alcohol and drugs prevention, treatment and recovery: why invest*. [online] Available at: <http://www.nta.nhs.uk/uploads/why-invest-2014-alcohol-and-drugs.pdf> [Accessed 15/11/2017].
- ^{vi} Office for National Statistics. (2017). *Crime in England and Wales: year ending June 2017*. [online] Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/crimeinenglandandwales/june2017> [Accessed 24/01/2018].
- ^{vii} Public Health England. (2017). *Opiate and crack cocaine use: prevalence estimates for local populations*. [online] Available at: <https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates-for-local-populations> [Accessed 15/11/2017].
- ^{viii} Office for National Statistics. (2016). *Crime in England and Wales: year ending March 2016*. [online] Available at: <https://www.ons.gov.uk/releases/crimeinenglandandwalesyearendingmar2016> [Accessed 24/01/2018].
- ^{ix} National Treatment Agency for Substance Misuse. (2017). *Addiction to medicine: an investigation into the configuration and commissioning of treatment services to support those who develop problems with prescription-only or over-the-counter medicine*. [online] Available at: <http://www.nta.nhs.uk/facts-prevalence.aspx> [Accessed 15/11/2017].
- ^x Knight, J., Brand, P., Willey, P. and Van der Merwe, J. (2017). *Adult's substance misuse statistics from the National Drug Monitoring Service (NDTMS)*. [online] Available at: <https://www.ndtms.net/Publications/downloads/Adult%20Substance%20Misuse/Adult>

[-statistics-from-the-national-drug-treatment-monitoring-system-2016-17.pdf](#)

[Accessed 24/11/2017].

^{xi} Public Health England (2017). *Adults - drugs commissioning support pack 2018-19: key data. Planning for drug prevention, treatment and recovery in adults.* [online] Available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/647095/Adult_drug_commissioning_support_pack_2018-19_-_key_data.pdf [Accessed 15/12/2017].

^{xii} Shapiro, H. (2015). *Not for human consumption: an updated and amended status report on new psychoactive substances (NPS) and 'club drugs' in the UK.* [online]

Available at: <http://www.drugwise.org.uk/wp-content/uploads/not-for-human-consumption.pdf> [Accessed 15/12/2017].

^{xiii} DrugWise. (2017). *Is drug use mainly in deprived areas?* [online] Available at:

<http://www.drugwise.org.uk/is-drug-use-mainly-in-deprived-areas/> [Accessed 20/12/2017].

^{xiv} National Institute on Drug Abuse. (2017). *Treatment Approaches for Drug Addiction.* [online] Available at:

<https://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction> [Accessed 15/12/2017].

^{xv} Public Health England. (2017). *Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers.* [online] Available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf [Accessed 7/12/2017].

^{xvi} Crome, I.B. (2006). *An epidemiological perspective of psychiatric comorbidity and substance misuse: The UK experience/ example in Baldacchino, A and Corkery, J.* *Journal of Comorbidity: Perspectives across Europe*, (ECCAS Monography No 4), 45-60 [Accessed 4/12/2017].

^{xvii} Marsden, J. (2000). *Psychiatric symptoms among clients seeking treatment for drug dependence: intake data from the National Treatment Outcome research study.*

The British Journal of Psychiatry, 176, 285-289. [online] Available at: <https://www.ncbi.nlm.nih.gov/pubmed/10755078> [Accessed 4/12/2017].

^{xviii} Public Health England. (2017). *Shooting up: infections among people who injected drugs in the UK, 2015.* [online] Available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/567231/Shooting_Up_2016_Update.pdf [Accessed 6/12/2017].

^{xix} Stoope, M.A., Dietze, P.M. and Jolley, D. (2009). *Overdose deaths following previous non-fatal heroin overdose: record linkage of ambulance attendance and death registry data.* *Drug and Alcohol Review*, 28, 347-352. [online] Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19594787> [Accessed 15/12/2017].

^{xx} Public Health England: National Intelligence Network (2016). *Drug health harms – national intelligence*. [online] Available at: <http://www.nta.nhs.uk/uploads/national-intelligence-network-on-drug-health-harms-021215.pdf> [Accessed 15/12/2017].

^{xxi} Fenton, K. (2017). *Health Matters: Preventing drug misuse deaths-public health matters*. [online] Available at: <https://publichealthmatters.blog.gov.uk/2017/03/01/health-matters-preventing-drug-misuse-deaths/> [Accessed 7/12/2017].

^{xxii} National Institute for Health and Care Excellence (2007). *Drug misuse in over 16s: opioid detoxification*. [online] Available at: <https://www.nice.org.uk/guidance/cg52> [Accessed 15/12/2017].

^{xxiii} Pleace, N. (2008). *Effective services for substance misuse and homelessness in Scotland: evidence from an international review*. [online] Available at: <http://www.gov.scot/Resource/Doc/233172/0063910.pdf> [Accessed 12/12/2017].