

Redbridge Substance Misuse Recovery Strategy 2017-2020

*“To reduce substance misuse and addiction across the
lifespan of Redbridge residents”*



Ambitious for Redbridge

Contents	Page
Foreword	3
Introduction	5
Link to corporate strategy and vision	14
The Current situation: national and local picture	16
Developing this strategy	25
What we want to do? Objectives & Deliverables	29
Measuring Success	32
Glossary	33
Action plan	37
Appendices	42

Foreword

All Councils are tasked with implementing national policies and strategies to preventing substance use, minimising the harm caused by substances and helping people to stop taking them. Substance misuse does not happen in a vacuum, there are frequent links to a range of other factors such as mental health, crime and homelessness. Addiction to/dependence on substances (licit/illicit, medicines and other products) with dependence potential and abuse liability will affect individuals, families and communities in a variety of ways.

This Substance Misuse Recovery Strategy is a plan deployed towards achieving *Redbridge Health and Wellbeing Strategic vision 2017-2020* where:

"All people in Redbridge are able to live long, happy and independent lives in good health as we pursue good health outcomes through economic, social and environmental policy, and develop a health and care system that is focused on prevention, delivered close to home, integrated and co-ordinated, and seeks maximum value for money"

The plan incorporates data-driven analysis of local substance use trends, participation from front line staff and managers across the health and social care system and importantly the varying experience of local service users whose expertise around care locally contributed to shaping this strategy. We designed our planning process to achieve the aims of health and wellbeing as it relates to substance misuse and addiction. Over the course of three months with diverse stakeholder attendance- community, providers, clinicians and patients' partners- fashioned this plan. Furthermore, Council departments, such as the Department of Children and Families through providers engaged recipients of substance misuse services to determine gaps in the delivery of service and the maximization of increasing scarce resources.

The plan provides an overview of the overarching strategies to ensure Redbridge remains the safest borough in London, which are the following:

- Coordination and oversight: The implementation of a streamlined system of care, referral and communication process
- Continue to work across local health and social care footprint: to ensure a reduction in substance related deaths, treat and build recovery capital of local residents affected by substance- related addiction; and support recovery through economic participation.
- Enforcement: Enforcement partners increase community engagement and leveraging of services
- Employment: Referrals to existing employment programme opportunities, barrier remediation, and job readiness services
- Monitoring and evaluation

This strategy commits to evidence based activities as well as focusing on interventions that address the obvious manifestations of substance misuse, approaches to prevent the elevated level of substance misuse amongst residents addressing underlying determinants

G. Xavier.

.....

Gladys Xavier RN FFPH

On behalf of Redbridge Substance Misuse Treatment Oversight Group

Members of Redbridge Treatment Oversight Group are from:

- London Borough of Redbridge (Peoples Directorate and Civic Pride & Enforcement)
- Barking, Havering and Redbridge CCG's
- FUSION, North East London Foundation Trust
- R3, East London Foundation Trust
- Blenheim, East London Foundation Trust
- P & S Chemist
- Barking Havering and Redbridge NHS Foundation Trust
- CRC Probation Service
- Metropolitan Police, Redbridge Command
- Public Health England
- Penrose Criminal Justice Service

Special thanks to Andrew Hardwick and Ikenna Obianwa for developing the strategy

1.0. Introduction

This Substance Misuse Recovery Strategy has been agreed by all local partners and articulates the council's commitment to challenge the root causes of addiction with a view to ending chemical dependency and changing the lives of residents of Redbridge. It is developed to successfully navigate through a period of unprecedented changes in substance misuse prevention, treatment and recovery field. It also sets out a clear and ambitious vision for reducing harm, building recovery capital through the utilisation of key community assets and embracing opportunities currently available locally and beyond.

The concept of recovery now lies at the core of both Substance Misuse and Mental Health Service¹. Recovery for the purposes of this strategy is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. It is commonplace to find that recovery means different things to different people. In this strategy, it is a broad and complex journey that individuals must take, much wider than substance misuse alone and will necessarily take many forms including; reducing risk taking, overcoming dependence and improving health, improving quality of life and becoming personally fulfilled.

This strategy comprises of:

- a summary of key policy documents that have influenced this strategy;
- a summary of key points from prevention (primary, secondary and tertiary) data sets that form a baseline for which stakeholders have committed to improve; and
- agreed priorities that arose from analysis of these data sets, engagement with patients and stakeholders with the substance misuse system

1.1. What is Substance misuse?

Substance misuse is the harmful use of substances (like drugs and alcohol) for non-medical purposes. The term "substance misuse" often refers to illegal drugs. However, legal substances can also be misused, such as alcohol, prescription medications, caffeine, nicotine and volatile substances (e.g. petrol, glue, paint). Using drugs for unwarranted reasons is substance misuse. Using drugs as a means to learn how to cope with stress or even live life is also substance misuse.

A 'substance' is taken to include controlled drugs unlawfully held, alcohol, prescription only medicines, over the counter medications, volatile substances (e.g. solvent in glues, propellants in aerosols and amyl nitrates [poppers]), herbal remedies and currently licit substances known to have psychotropic effects, often called 'legal highs'. The term 'Misuse' (or 'Use') highlights the consequences of dependency on these substances and implies no judgement on the behaviour of residents or patients or clients.

Dependency or addiction ('persistent, compulsive dependence on a behaviour or substance') is the eventual consequence of substance misuse. Addictions are generally considered to be of two forms:

- A. Substance addiction (e.g. alcohol addiction, drug misuse or smoking); and

¹ Sheedy, C.K and Whitter, M (2009). Guiding Principles and Elements of Recovery-Oriented Systems of Care: What do we know from the research? *Journal of Drug Addiction, Education and Eradication* 9(4), pp.225-285

B. Process addictions (e.g. gambling, shopping, eating or sexual activity).

This strategy focuses on substance addictions (apart from smoking²) however it also recognises that process addictions may be due to consequences of substance misuse. Irrespective of the form of addiction, they have several defining components:

- continued engagement in a behaviour despite adverse consequences;
- diminished self-control over engagement in the behaviour;
- compulsive engagement in the behaviour; and
- An appetitive urge or craving state prior to engaging in the behaviour.

The convergence of gambling disorder, substance use disorders and mental illness is increasingly been understood by practitioners.

1.2. What is the impact of Substance misuse?

The impact of substance misuse is far-reaching. Their consumption and related issues have a strong relationship with a multitude of other outcomes for individuals, families, communities, agencies and society. While death is the most serious harm related to substance misuse³, its impact on individuals are summarised in table 1⁴:

Table 1: Impact of Substance Misuse on Individuals

Substance	Impact on health and mortality on individuals
Alcohol	<ul style="list-style-type: none"> • Stroke • Depression and anxiety • Cancer of the mouth, throat, oesophagus or larynx • Breast cancer in women • Heart disease or irregular heartbeat • High blood pressure • Liver cirrhosis and liver cancer • Pancreatitis • Reduced fertility • Harm to unborn babies
Drugs	<ul style="list-style-type: none"> • Depression, anxiety, psychosis and personality disorder • Poor vein health among injectors • Cardiovascular disease • Lung damage from drugs and tobacco • Overdose and drug poisoning • Blood-borne viruses among injectors • Liver damage from undiagnosed or untreated hepatitis C • Arthritis and immobility among injectors

Source: PHE (2014)⁴

² Smoking in Redbridge is addressed in the Redbridge Tobacco Strategy.

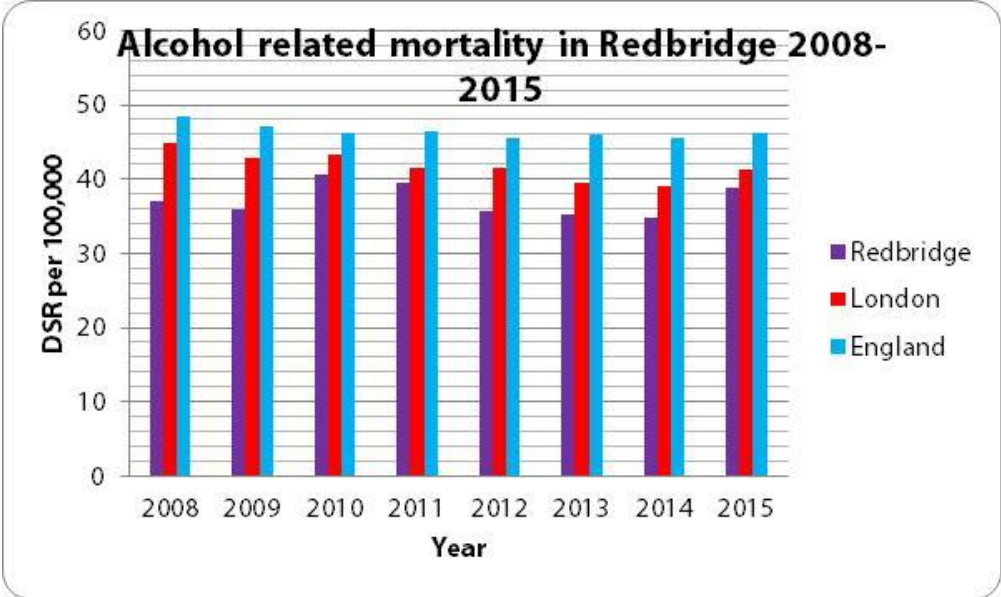
³ Advisory Council on the Misuse of Drugs (2016). *Reducing Opioid-Related Deaths in the UK*. London: ACMD

⁴ Public Health England (2014). Alcohol and drugs prevention, treatment and recovery: why invest? Accessed online from

It is important to consider that alcohol consumption and related harm increase steeply from the ages of 12-20 years⁵. Regular alcohol use, binge drinking and other risk-taking behaviours such as smoking, substance misuse and risky sexual behaviour emerge in adolescence (period of transition from childhood to adulthood) and there is evidence that these behaviours tend to cluster together⁶. Stable and protective childhoods remain critical factors in the development of resilience to health-harming behaviours in England⁷.

Alcohol related mortality in Redbridge has marginally reduced from 40.7 per 100,000 in 2010 to 38.8 per 100,000 in 2015

Graph 1: Trend of alcohol related mortality in Redbridge, 2008-2015



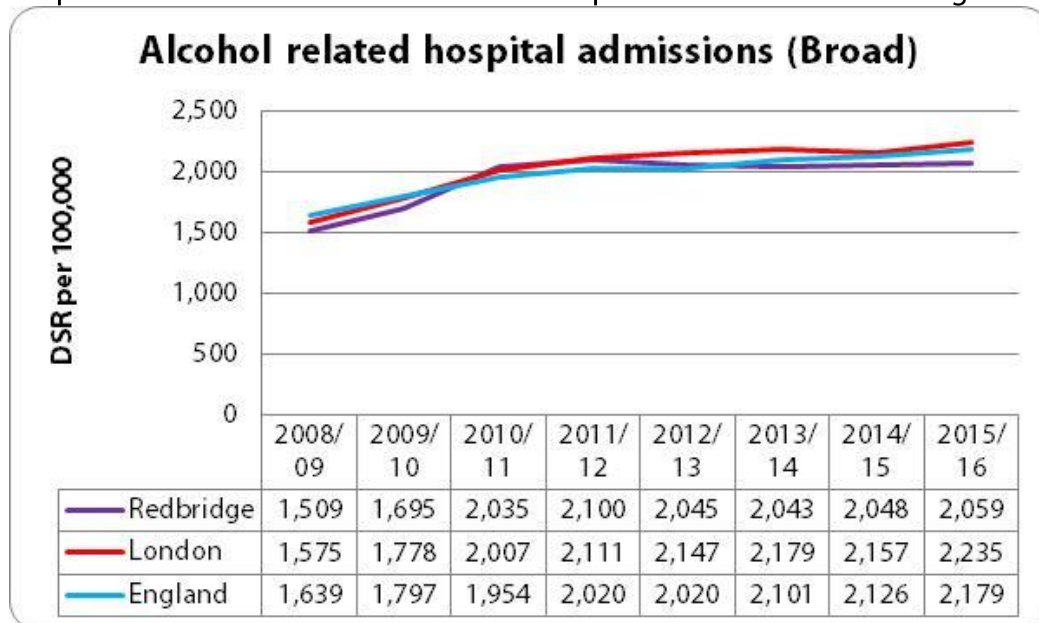
Source: LAPE 2017

Social-psychological variables influence substance misuse behaviours. This may involve developmental, personality, affect and cognition, conditioning or learning and familial factors. It is important to bear in mind that decreasing the impact of the consequences of substance misuse (illness) on the person, the family and society is also considered part of prevention. Prevention also includes reduction of stigma and consequence of barriers to treatment.

Hospital admissions data reflects the general level of health harm from alcohol in the population. It can be a result of casual regular alcohol use above lower-risk levels as well as chronic heavy drinking in the population and is most likely to be found in increasing-risk drinkers, higher-risk drinkers, dependent drinkers and binge drinkers. The broad alcohol related (i.e. partially attributable to alcohol) hospital admissions increased from 2,035 per 100,000 in 2010/11 to 2,059 per 100,000 despite being less than London and England averages. Alcohol-related mortality and morbidity are high in socioeconomically disadvantaged populations compared with individuals from advantaged areas.

⁵ NHS Information Centre (2008) *Statistics on Alcohol: England*
⁶ Wiefferink CH, PetersL, Hoesktra F, et al. (2006) . Clustering of health-related behaviours and their determinants: possible consequences for school health interventions, *Prev Sci*, 7pp. 127-49
⁷ Bellis, MA; Hughes K, Leckenby N; Perkins, C. and Lowey, H (2014). National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England *BMC Medicine* 12(72)

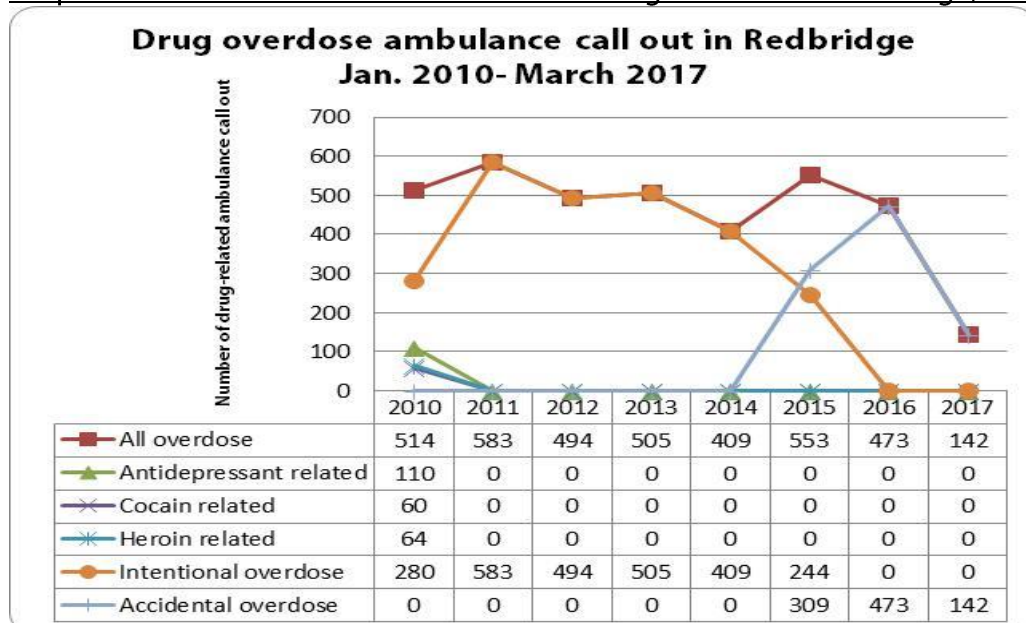
Graph 2: Trend of broad Alcohol related hospital admissions in Redbridge



Source: LAPE 2017

A drug 'overdose' is the usually inadvertent consumption of an excessive and amount of a substance leading to harm. An analysis of local drug overdose ambulance call outs show decline across all drug overdose however, it is important to note that accidental overdose commenced in 2015. This may be due how data is coded.

Graph 3: Trend of Ambulance call-outs from drug overdose in Redbridge, 2010-2017



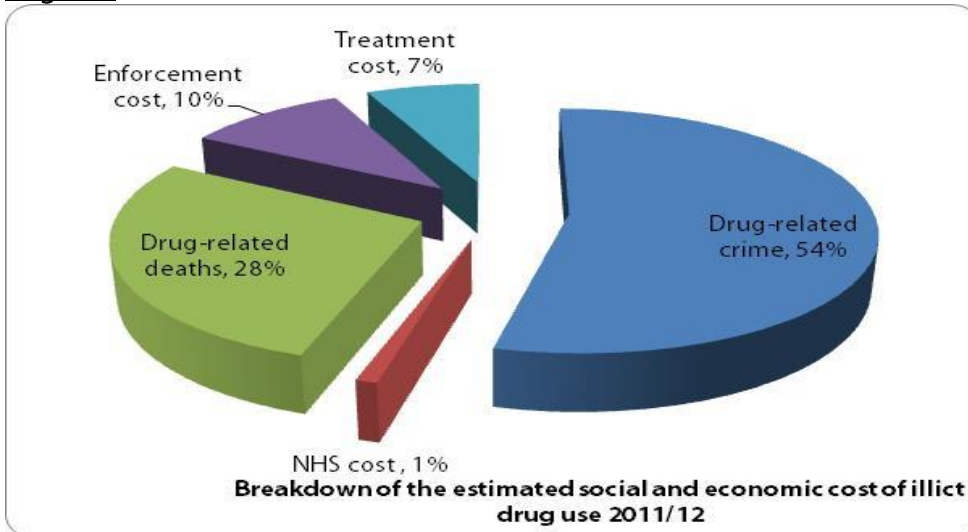
Source: Safestats, (2017)

The other impacts of substance misuse on families and communities include:

A. Socioeconomic cost

Heroin and cocaine are associated with the majority of social costs associated with drug misuse. The Home Office suggest that the cost of illicit drug use in the UK is £10.7bn (or £11.4bn in 2015/16 prices)

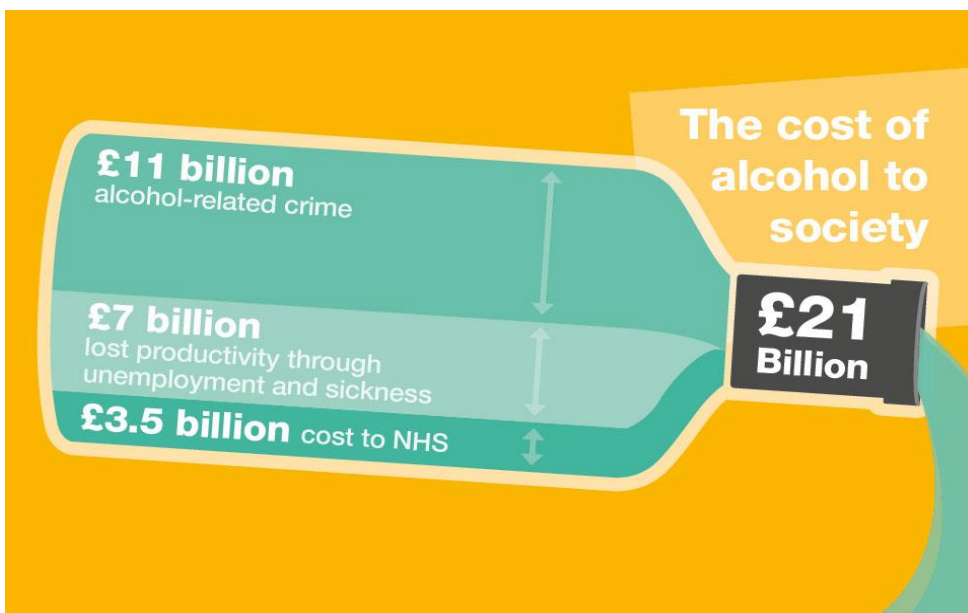
Chart 1: Breakdown of estimated economic and social cost of illicit drug use in England



Home Office, 2013⁸

These costs are an underestimate given drug related harm is far more costly than captured⁸.

Her Majesty’s Government alcohol strategy estimated that alcohol-related harm costs England society £21bn annually (this excludes estimates for economic cost of alcohol misuse to families and social networks)⁹.



PHE (2016)¹⁰

⁸https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/586111/PHE_Evidence_review_of_drug_treatment_outcomes.pdf

⁹The Government Home Office (2012), The Governments alcohol strategy, Home Office, March 2012. Available at: <https://www.gov.uk/government/publications/alcohol-strategy>

¹⁰<https://www.gov.uk/government/publications/health-matters-harmful-drinking-and-alcohol-dependence/health-matters-harmful-drinking-and-alcohol-dependence>

This impact clearly goes beyond health carrying heavy financial burden: £3.5bn in direct costs to the NHS. It remains a national commitment to continue improving recovery rates for both drug and alcohol treatment and to reduce health-related harms, HIV, hepatitis, tuberculosis transmission and drug-related deaths. This action was included with the Public Health England's Annual Plan 2015/16.

B. Criminal justice system

Substance misuse is associated with crime but the relationship is complex. Levels of drug use are high among offenders, with the highest levels of use reported among the most prolific offenders¹¹. Some people are criminalised directly through their drug use. In a culture in which legal drug use is deeply embedded, experimental or casual use of illegal drugs finds different motivations. Cannabis possession has accounted for around two-thirds of all recorded drug offences every year since 2005-06¹². Opiate and crack users are more likely to commit crime such as shoplifting and burglary to secure funds for drug use.

Substance misuse is also a serious threat to the security of the prison system, the health of individual prisoners and the safety of prisoners and staff. According to HM Inspectorate of Prisons, NPS-specifically, synthetic cannabis-are a problem in many prisons and a very serious threat to the safety and security of some¹³

C. Domestic violence and parental substance misuse

Alcohol is a factor in half of all incidents of domestic violence nationally, with many perpetrators having consumed alcohol prior to the assault according to Public Health England. Parental alcohol misuse is strongly correlated with family conflict and with domestic violence and abuse. This poses a risk to children of immediate significant harm and of longer-term negative consequences. Alcohol plays a part in 25 to 33% of known cases of child abuse¹⁴

D. Local authority housing

Local authorities are obliged to give re-housing priority to people who are vulnerable and homeless. For substance misusers, a safe, stable home environment better enables them to sustain their recovery whilst insecure housing or homelessness threatens it. Like all authorities in the United Kingdom, Redbridge does not give re-housing priority to people simply because they misuse substances.

Key triggers of homelessness amongst substance misusers are: leaving the family home at an early age (including chaotic living conditions with parents); leaving local authority care; a traumatic experience; a relationship breakdown and criminal activity resulting in a custodial sentence.

1.3. Who is affected by substance misuse?

There is no such thing as a 'typical' substance user as people experiment with or use substances at different points in their life for many different reasons. Everyone has the potential to misuse substances. All substance misuse is potentially harmful and most types of use carry health risks. Some methods of use are more harmful than others, for example, intravenous use, as this can lead to the transmission of blood

¹¹ Morgan, N. (2014). 'The heroin epidemic of the 1980s and 1990s and its effect on crime trends – then and now'. Research Report 79

¹² Office for National Statistics (2014). 'Deaths related to drug poisoning in England and Wales, 2013' Available at http://www.ons.gov.uk/ons/dcp171778_375498.pdf [accessed 7 December 2015]

¹³ <https://www.justiceinspectors.gov.uk/hmiprison/wp-content/uploads/sites/4/2015/12/Substance-misuse-web-2015.pdf>

¹⁴ <https://www.gov.uk/government/publications/health-matters-harmful-drinking-and-alcohol-dependence/health-matters-harmful-drinking-and-alcohol-dependence>

born disease such as HIV and Hepatitis. Furthermore, some patterns of use are more harmful than others, these include:

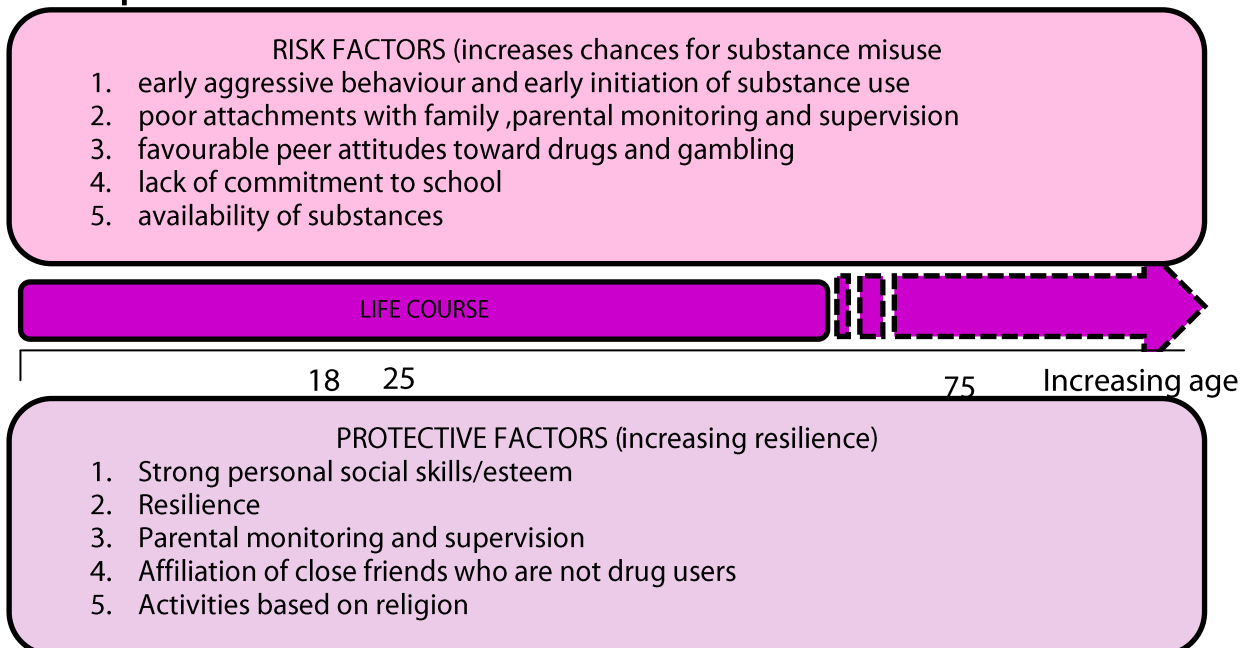
- Dependent use - A compulsion to continue to use a substance in order to feel good or avoid feeling bad. When this is done to avoid physical discomfort it is known as physical dependence, when it is used to avoid anxiety or mental stress or promote stimulation or pleasure, it is known as psychological dependence.
- Combination use - The use of more than one substance, for example, use of drugs and alcohol or the use of more than one drug.
- Chaotic and unrestrained use - Linked with combination use or bingeing on a single drug until the supply runs out or exhaustion or heavy intoxication prevents further use

The effects of the substance misuse will vary according to:

- the individual;
- the physical and psychological state-including whether the individual is on prescribed drugs for mental health problems;
- the substance used and the methods of use;
- the circumstances in which the substance is used; and
- where use takes place and the presence of other people at these times

Addiction is not typically the result of an issue in an individual's life; it is rather from a complex interaction of biological predisposition, environmental factors and influences, drug choice and delivery method.

Risk and protective factors – across the life course:



Source: George, Sheena, Art Dyer, and Phyllis Leven (2003)¹⁶

Risk and protective factors - at the personal, family and social level - can affect individuals at different developmental stages of their lives particularly during formative major life transitions. In the early years of life, these factors are inextricably linked with healthy child development¹⁷. Alongside the main formative life course

¹⁶ http://www.edu.gov.mb.ca/k12/cur/physhlth/frame_found_gr11/rm/5_su.pdf

¹⁷ <https://www.redbridge.gov.uk/media/1875/annual-public-health-report-15-16.pdf>

transitions, substance misuse can also be triggered at any point throughout life by adverse events such as traumatic events, relationship breakdowns, conflicts, interpersonal losses, legal problems or financial concerns. The ability to effectively cope (and therefore avoid problems such as substance misuse) will depend on the individual's level of 'capital', which will largely reflect the degree to which protective factors are or have been present in that individual's life.

Certain populations most at risk of substance misuse: These are presented below in order of the strength of the evidence.

Young people and troubled family history: Experiences during childhood can affect health throughout the life course (Adverse Childhood Experiences (ACEs))¹⁸. Children who experience stressful and poor quality childhoods are more likely to adopt health-harming behaviours such as substance misuse in later life and the more ACEs a child is exposed to, the more likely they are to develop problems¹⁹.

Individuals living in deprived areas: Deprivation and social exclusion are likely to have an impact on the initiation and maintenance of substance misuse²⁰. People living in more deprived areas are more likely to have entrenched and complex needs and to be frequent substance users, as well as potentially lack access to resources and opportunities to help improve their personal and social capital.

Individuals with mental health issues: Co-existing mental health and substance use problems may affect 30-70% of those presenting to health and social care settings. However, although there are clear associations between mental health and substance misuse, causality is not always clear.

Offenders: Offenders and ex-offenders generally experience greater health inequalities, social exclusion and risk of substance misuse. Prisoners report higher levels of substance misuse: 44% report drug misuse and 31% report alcohol misuse, compared to 8.6% and 22% respectively in the general population.

Individuals in substance misuse recovery: While successful completion of treatment is an important outcome for individuals who have accessed substance misuse services, relapse is often a threat. Individuals in recovery post-treatment are at risk of relapse and other associated risks such as substance-related death.

Domestic violence: As well as links to the perpetration of domestic violence, substance misuse can be a response to domestic violence and can increase vulnerability to violence, for example where substances are used as a coping mechanism for people in violent relationships¹⁵.

Men: are more likely than women to use substances and to die from using substances¹⁶. Approximately 62% of increasing and higher risk drinkers and 76% of frequent drug users are male (Drinkaware, 2015b) (Home Office, 2014).

¹⁸ Bellis, M.A., Lowey, H., Leckenby, N., Hughes, K. and Harrison, D., (2014). Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population. *Journal of public health*, 36(1), pp.81-91

¹⁹ Bellis, M.A., Lowey, H., Leckenby, N., Hughes, K. and Harrison, D., 2014. Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population. *Journal of public health*, 36(1), pp.81-91

²⁰ Hall, D.M.B and Elliman D.,(2006). *Health for all Children 4th Edition*. Oxford: Oxford Medical Publications

Older people: Over 50% of increasing and higher risk drinkers are over 35, with the highest rates in the 45-64 age group locally. Many older people use alcohol as their main substance

Ethnicity: Adults from a white background in Redbridge are more likely to have participated in illicit substance taking in the last year compared to other ethnic groups.

Sexual orientation: Lesbian, Gay, Bisexual and Transgender (LGBT) individuals have significantly higher rates of substance misuse than their heterosexual counterparts, with the highest rates amongst males²¹. The sexualised use of crystal meth, mephedrone and GHB/GBL is now the greatest threat to MSM health and wellbeing²².

1.4. Redbridge Substance Misuse Treatment Oversight Group

In April 2013, commissioning drug and alcohol misuse treatment services became the responsibility of local authorities.

The Redbridge Substance Misuse Treatment Oversight Group (RTOG) acts as the executive body for the local partnership. It has overall responsibility for ensuring the successful delivery of the treatment outcomes. Its vision is to ensure that *local people who need help due to substance misuse accesses timely, effective treatment services and build recovery capacities shaped by themselves but supported by local services*. This collaborative care approach to achieving and maintaining recovery is an important principle governing all stakeholders within the substance misuse system in Redbridge.

Partnership is crucial to successful implementation of this strategy. Work has started already on a range of proposed actions led by this Treatment Oversight Group, which meets quarterly and will be tasked with developing a more detailed implementation plan and monitoring outcomes

²¹ Hunter LJ, Dargan PI, Benzie A, *et al* (2012) Recreational drug use in men who have sex with men (MSM) attending UK sexual health services is significantly higher than in non-MSM *Postgraduate Medical Journal* Published Online First: 03 January 2014

²² <http://www.davidstuart.org/DavidStuart-HIVN13.1.pdf>

Ambitious for Redbridge

»
Increase
FAIRNESS
and respond to
the aspirations of
our Borough

1

We want to make sure everyone has a fair chance to succeed.

- Target resources to reduce poverty and inequality
- Tackle the root causes of social problems early
- Equip people with high quality education and skills
- Ensure sustainable growth and local opportunities

»
EMPOWER
our communities
to help shape our
Borough and the
services
we deliver

2

We will make sure that there is a meaningful conversation about how we deliver services.

- Place communities at the heart of decision making
- Help residents to be more resilient
- Embrace technology to change the way we communicate
- Improve internal communications to all Council employees

»
IMPROVE
quality of life and
civic pride amongst
our communities

3

We will ensure that Redbridge continues to be a place of choice to live.

- Create civic pride of a clean and safe borough for families
- Promote dignity and independence in our services
- Increase learning opportunities and access to work and training
- Maximise opportunities to build homes and regenerate town centres

»
TRANSFORM
our Council in tough
times to be dynamic
and responsive to
the challenges of
the future

4

We will find innovative solutions to provide the best services at the lowest cost.

- Internal redesign of services to do things better
- Partnership working with residents, third sector and businesses
- Use technology to improve delivery
- Change the culture of the Council to encourage employees to improve the way we work



The Corporate Strategy provides the vision and priorities for Redbridge. They are the top of the golden thread that links the work of individual employees to the vision **Ambitious for Redbridge**.

The Redbridge Substance Misuse Recovery Strategy will link to the Corporate Priorities in the following ways:

Corporate Priorities	How will the Substance Misuse Recovery Strategy contribute?
Increase fairness and respond to aspiration	<ul style="list-style-type: none"> • Variety of different threshold access points and range of service interventions including cultural specific ones, fast access to prescribing • flexible opening hours • Early interventions including recovery interventions • Advocacy functions
Empowering communities	<ul style="list-style-type: none"> • Clear lines of accountability and governance arrangements • Continuity of care including integrated aftercare • Care coordination i.e. information sharing, joint assessment/care planning, moving-on planning, shared care with GPs, partnership working with mainstream services • Systematic service user involvement and peer support and self-management including harm reduction
Improve quality of life and civic pride	<ul style="list-style-type: none"> • Early interventions and support to families and carers • Reduce availability of substances • Protect children, young people and Families from the harmful effects of substance misuse
Transform our Council	<ul style="list-style-type: none"> • Integration of service delivery • Commissioning approach oriented around pathway delivery and person-centred • Access to specialist clinical expertise and academic support • Partnership working with generic health and social care services

Vision

“Healthy, safe, and drug-free environments that nurture and assist all Redbridge residents to thrive”

2.0. The Current Situation: the National and Local picture

In England, alcohol misuse is the biggest risk attributable to early mortality, ill health and disability for those aged 15 to 49 years, for all ages it is the fifth most important. Public Health England estimates that the proportion of people in treatment with entrenched dependence and complex needs will increase and the proportion who successfully completes treatment will therefore continue to fall. In all, 288,843 individuals were in contact with drug and alcohol services in 2015-16; this is a 2% reduction on last year. Of these, 138,081 commenced their treatment during the year, with the vast majority (97%) waiting three weeks or less. PHE and NHSE emphasises the need for commissioners and providers across mental health and local authority public health substance misuse services to work in close collaboration to deliver shared outcomes for local residents.

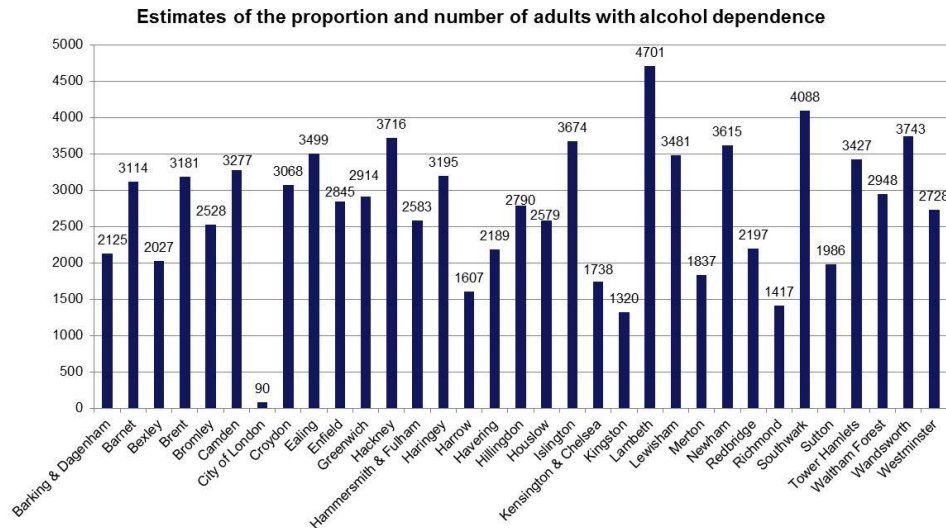
In recent years, there have been substantial increases in the number of people dying in the UK where illicit drugs are reported to be involved in their death. According to the Home Office, new psychoactive substances were involved in 204 deaths in the UK in 2015, an increase of 25% from 163 deaths in 2014²³. Also in the same year (2015), there was an estimated 167,000 working years lost due to alcohol alone in England; more working years were lost to alcohol than the ten leading causes of cancer death combined²⁴.

Alcohol prevalence rates in London

There are varying proportions of dependent drinkers in London. City of London has the least prevalence and Lambeth has the highest alcohol prevalence in London. Redbridge has the highest prevalence when compared with Havering and Barking & Dagenham boroughs.

²³ <https://www.gov.uk/government/news/psychoactive-substances-ban-6-months-on-almost-500-arrests-and-first-convictions>

²⁴ Public Health England (2016). *Working Years of Life Lost due to Alcohol*. London: PHE



PHE (2017)

2.1. Epidemiology of substance misuse in Redbridge

The data reported in this section are based on numbers provided by sources from Public Health England, ONS and NDTMS. The types of data examined include:

- magnitude (the number of people affected),
- prevalence (substance use rates), trends (change in rates over time), and
- comparison data (with other boroughs, per gender and age, etc.).

Data are organised by substance, and then by age group. The format reflects a pattern or relationships between substance use and adverse outcomes. Both use and outcomes are influenced by intervening variables, such as risk and protective factors, reflected in the logic models. Thus, this document reflects the logic model and presents information in the following order:

- Substance (the magnitude of the problem; the drug of choice).
- Consequences (the effects of use, misuse and abuse of a substance on quality-of-life: health, mortality, crime, dependence, and accidents).
- Consumption Patterns (prevalence, use patterns).
- Intervening Variables (risk/protective factors, and other mediating resources)

Demography profile

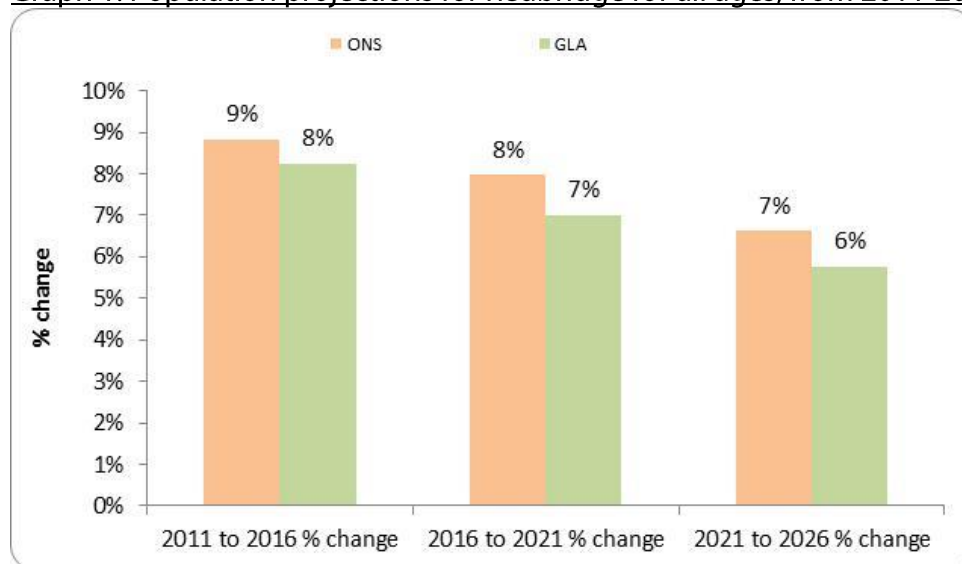
Redbridge is one of the outer north east London boroughs and is bordered by Waltham Forest to west, Newham to the south, Barking and Dagenham and Havering to the east and West Essex to the north. Known as a 'leafy' suburb, parts of the borough enjoy some of the best living environments in London, with around a third of the borough, particularly to the northwest, designated as green belt land. The borough comprises of 21 wards. Those in the south have inner-city characteristics, whereas the wards in the northwest tend to be more affluent.

Redbridge is a relatively affluent borough, although pockets of deprivation and significant health inequality exist between different neighbourhoods within Redbridge. Redbridge has an ethnically diverse population, with 62% population from Black, Asian and Minority Ethnic groups. This is significant as the overall drug

use is lower among minority ethnic groups than among the White population²⁵. The number of people resident in Redbridge is increasing, in 2015, it increased by 3,800 (1.28%) which is more than the national average²⁶.

Over the next 10 years, we anticipate further significant change in our population in regards to size and diversity due to migration.

Graph 1: Population projections for Redbridge for all ages, from 2011-2026



Source: ONS 2014 based sub-national population projections; GLA 2015 round of demographic projections - Long term trend-based projections

Our current diversity commits us to continuous improvement and responsiveness of substance misuse services to minority communities as a long-term process, and has over the years been given local strategic consideration rather than being treated as an 'add-on' to services' core activities²⁷.

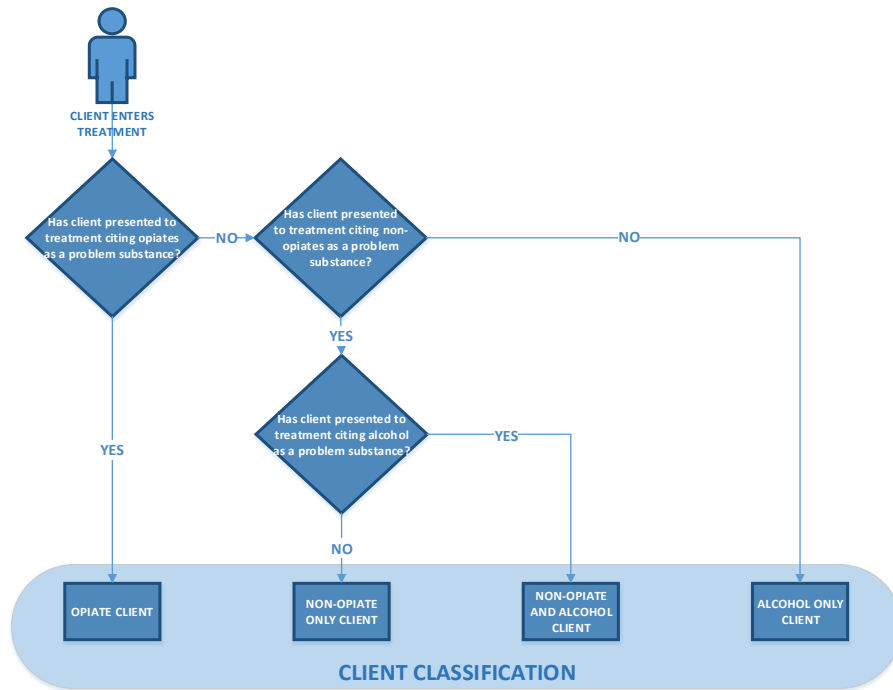
Substances in Redbridge

Individuals presenting to treatment services are categorised by the substances they cite as problematic at the start of treatment. Local treatment services show alcohol, opiates, and a combined crack cocaine and opiate as the drugs most in use by adults in treatment. This is shown below:

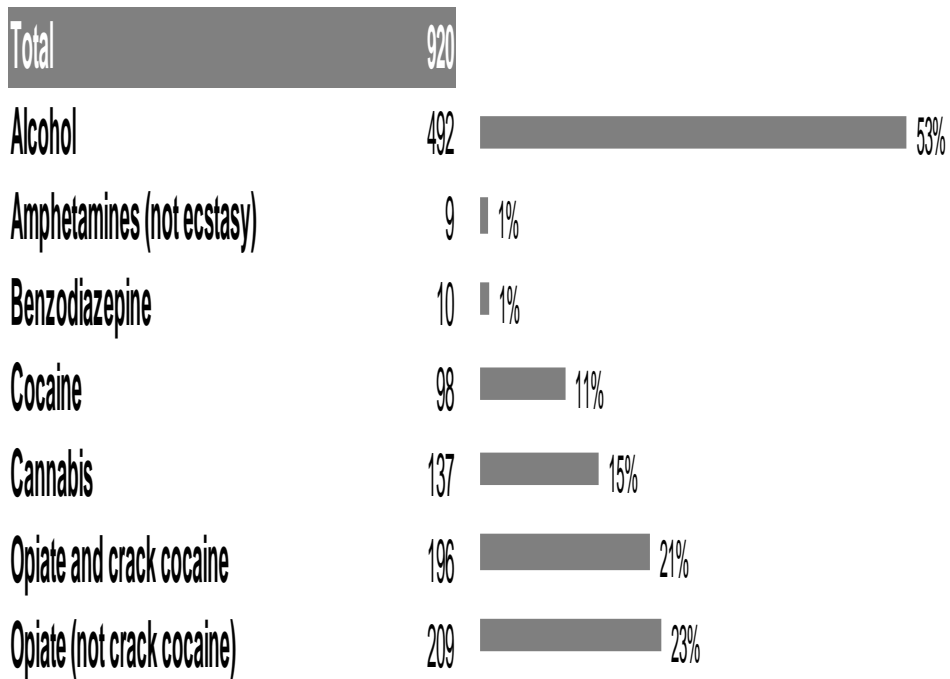
²⁵ UK Drug Policy Commission (2010). Drugs and diversity: Ethnic minority groups learning from the evidence [http://www.ukdpc.org.uk/wp-content/uploads/Policy%20report%20-%20Drugs%20and%20diversity%20ethnic%20minority%20groups%20\(policy%20briefing\).pdf](http://www.ukdpc.org.uk/wp-content/uploads/Policy%20report%20-%20Drugs%20and%20diversity%20ethnic%20minority%20groups%20(policy%20briefing).pdf)

²⁶ London Borough of Redbridge, (2016). *Annual Public Health Report: Growing up in Redbridge 2015/16*. Ilford: Redbridge Local Authority

²⁷ Fountain, J (2006). Issues surrounding drug use and drug services among the South Asian communities in England. Lancaster: UCLAN

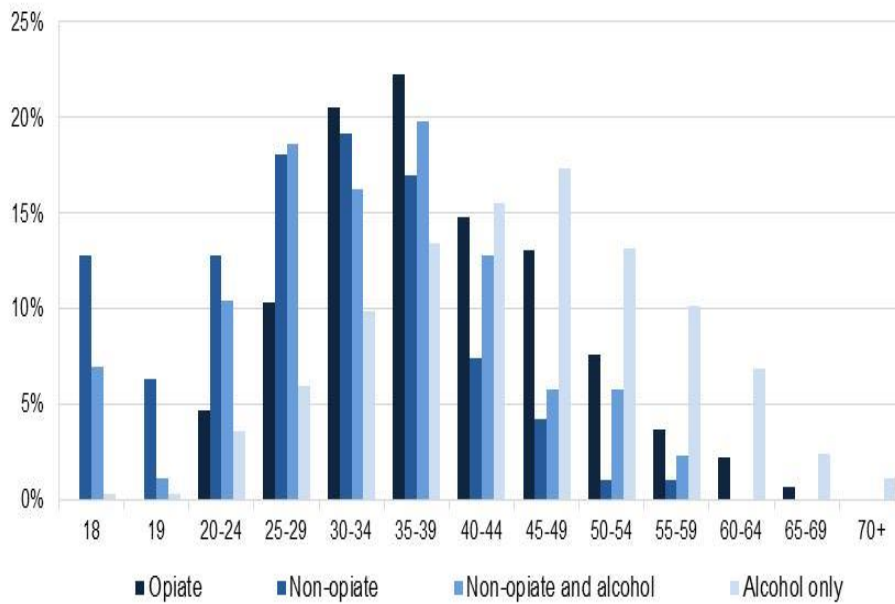


Substance breakdown of all clients in treatment 2015-16



Source: NDTMS

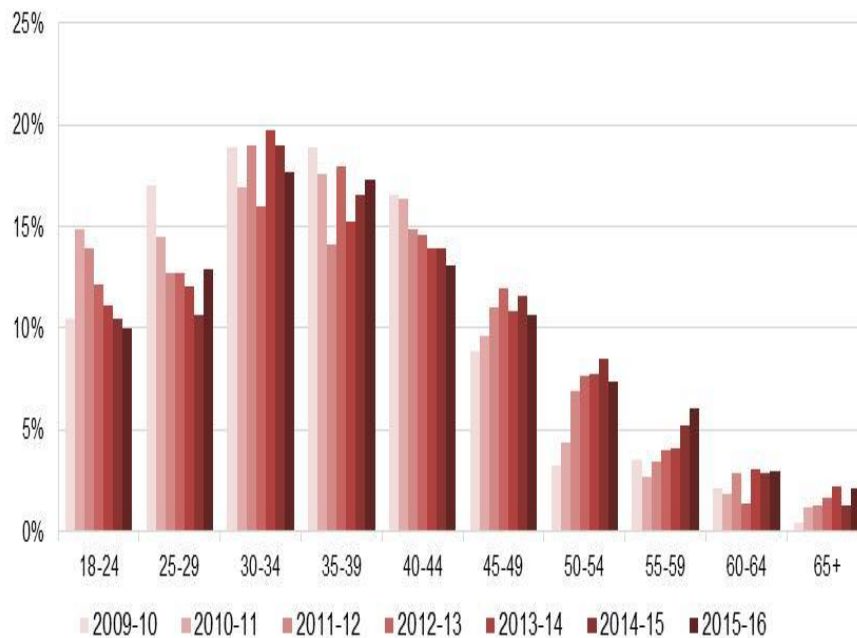
Age distribution of all clients in treatment 2015-16



Source: NDTMS

This graph shows that opiates are the drugs most taken by 35-39 year olds while non-opiates are more taken by 18 year olds. Alcohol is the drug most misused by the treatment population age group from 20-24 to 70+

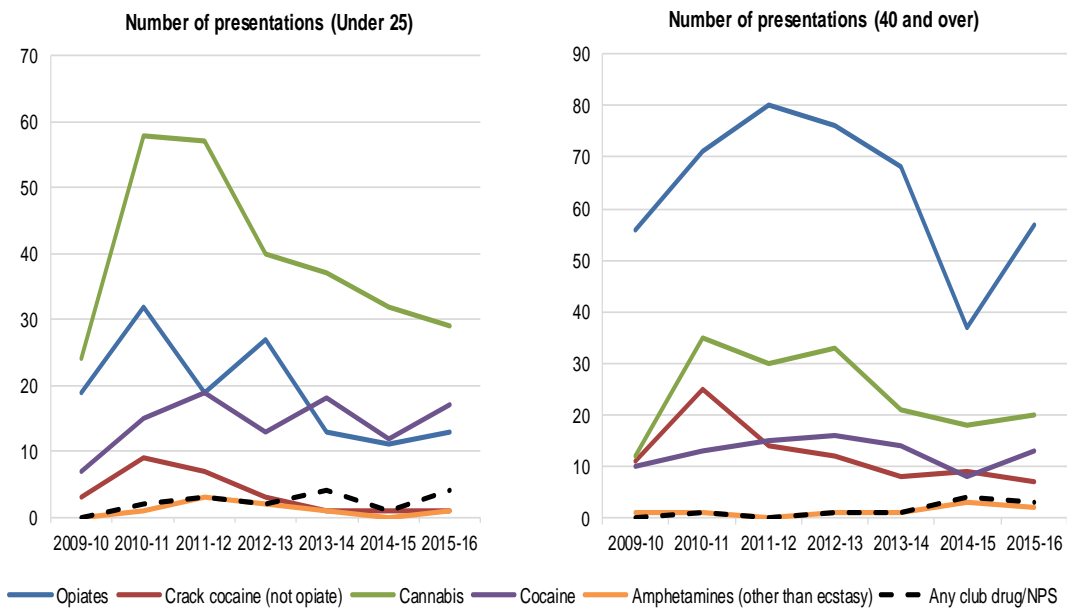
Trends in the age distribution of new presentations to treatment



Source: NDTMS

There has been an increase in opiate, cocaine and cannabis presentations since 2009-10 for those 40 and over.

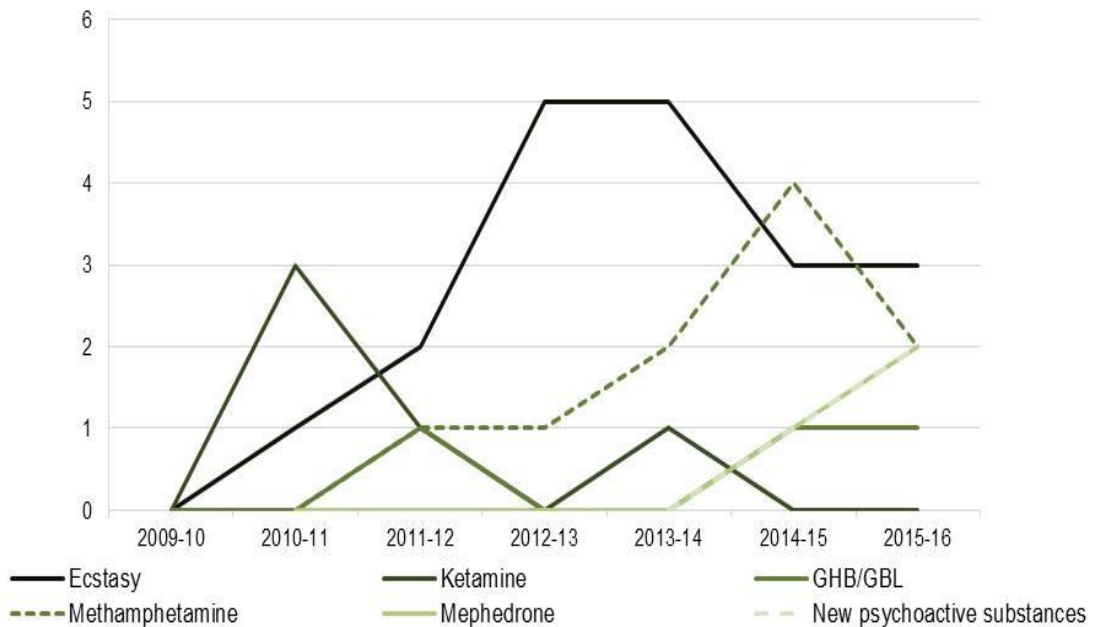
Trends in presenting substances of under 25 and 40 and over



Note: Totals will be greater than the number of new presentations due to some individuals presenting to treatment with more than one problematic substance (including alcohol).

Source: NDTMS

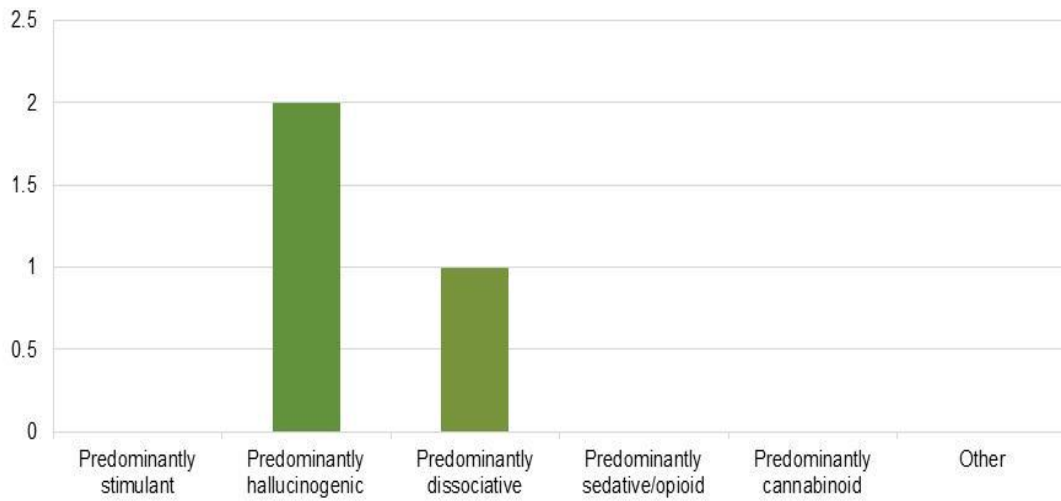
Trends in number of new presentations to treatment citing club drug use



Source: NDTMS

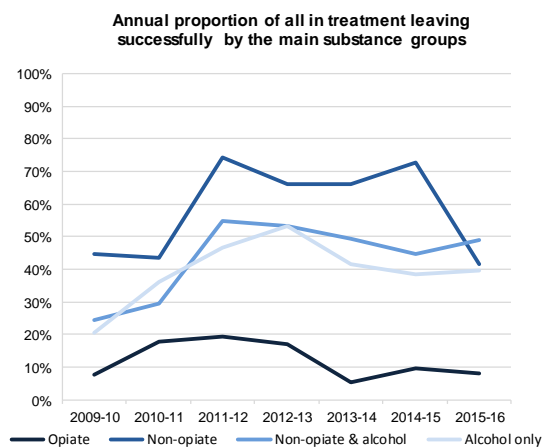
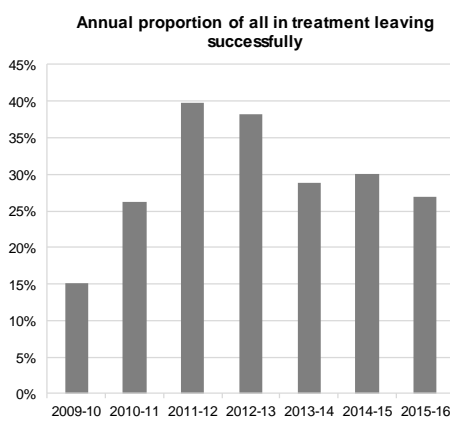
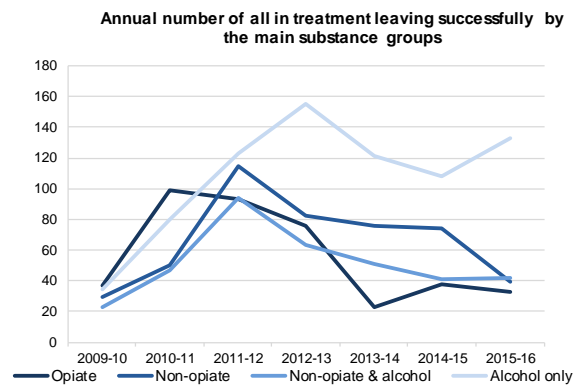
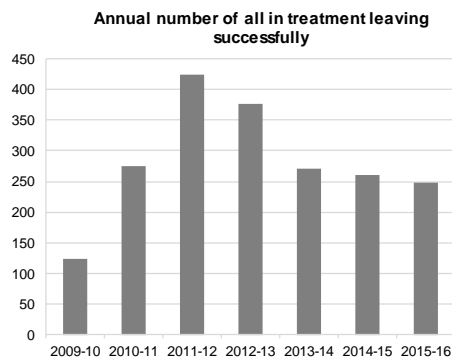
There is a rising Mephedrone and a stabilised Ketamine use in the borough. However, not recorded is N₂O whose canisters have been reported in schools and at the back of our local treatment centre. These drugs are predominantly hallucinogenic.

New psychoactive substance breakdown of new presentations to treatment 2015-16



Source: NDTMS

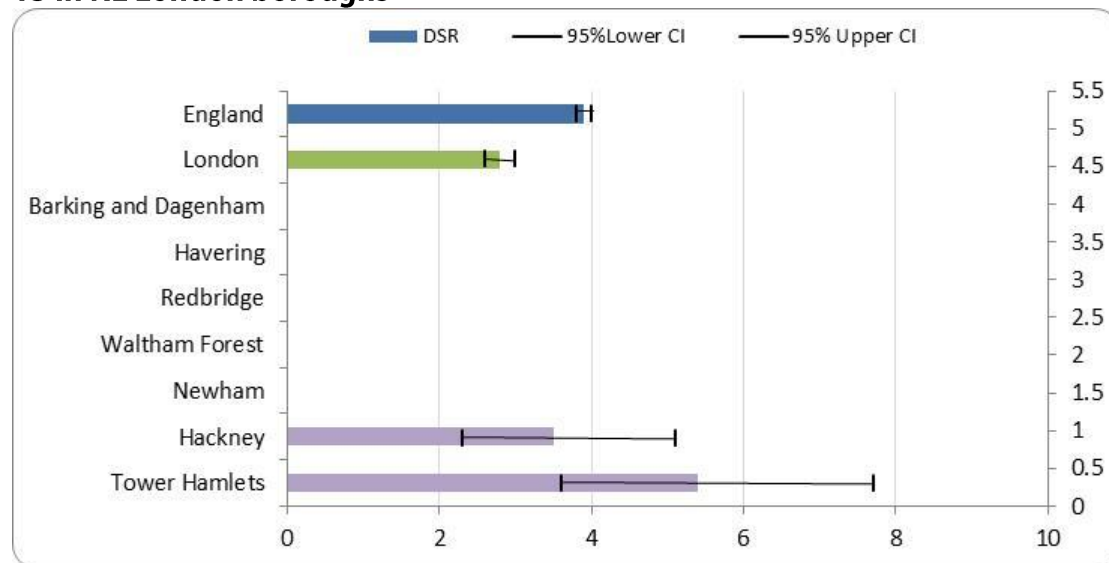
Trends in successful completions of all clients in treatment



Source: NDTMS

Treatment completion has generally reduced from 2009 to 2016.

Deaths from drug misuse (directly age-standardised rate per 100,000), 2013 - 15 in NE London boroughs



Source: Office of National Statistics (ONS)

Deaths from drug misuse are statistically insignificant.

2.2. How is Substance misuse being addressed nationally?

Substance misuse represents an important public health problem that impacts both individuals and society on many levels. Her Majesty's Government is responsible for setting the overall strategic approach to reducing drug harms and it retains some reserved powers. The legal framework relating to the misuse of drugs, including the *Misuse of Drugs Act 1971* (Her Majesty's Government, 1971), is reserved to the HM Government, however some areas of policy including health, education, housing and social care only apply to England.

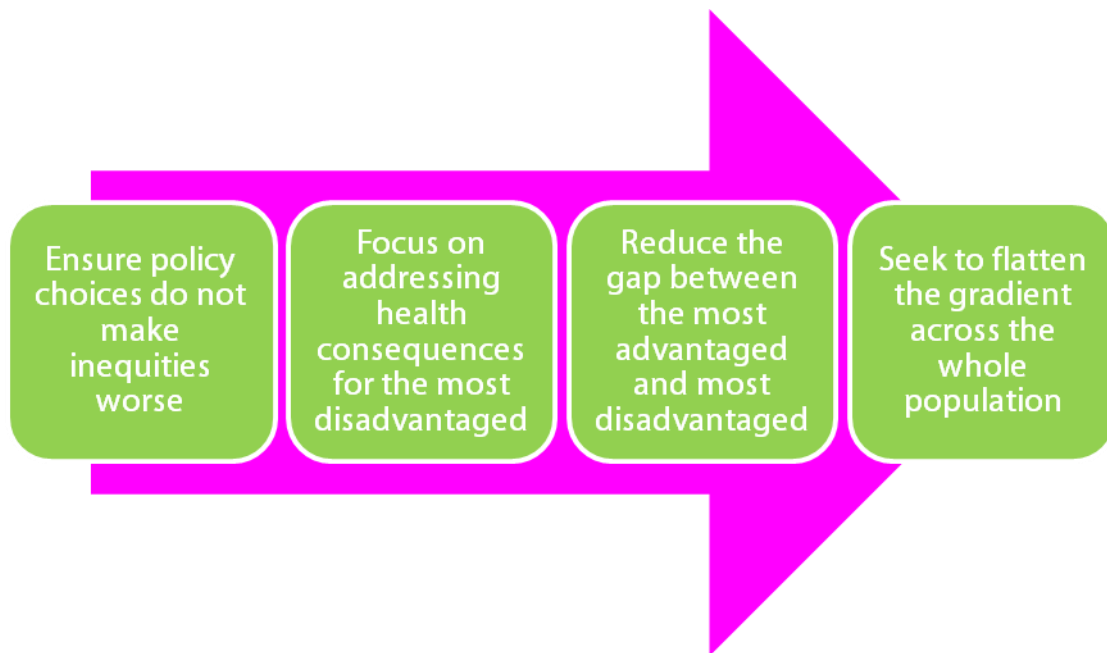
The drug strategy *reducing demand, restricting supply, building recovery: supporting people to live a drug free life* (Her Majesty's Government, 2010), has two overarching aims of: reduce illicit and other harmful drug use; and increase the numbers recovering from their dependence. *HM Government's Alcohol Strategy, 2012* focuses on irresponsible drinking and recommends closer working with the drinks industry and support for individuals to make informed choices about responsible drinking and reducing the numbers of people drinking to excess. Appendices provide a summary of policy context for substance misuse.

2.3. What works in addressing substance misuse?

Public Health England recently published an evidence review of what works in the control of alcohol²⁸ which presents two conceptual frameworks highlighting determinants; drivers and moderators of alcohol related harm; vulnerability and health outcomes.

Redbridge has long taken an incremental approach to reducing inequities and this Substance Misuse strategy will follow similar approach.

²⁸ Public Health England (2016). *The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review*. London: PHE



Prevention in substance misuse includes health promotion and prevention of disorders which not only aims to increase well-being by, for example, reducing inequities and building social capital, but also seeks to reduce incidence, prevalence, recurrence and time spent with symptoms, prevent relapses, delay recurrence and reduce the severity of symptoms.

What is the cost effectiveness/return on investment?

Commissioning prevention especially in school setting saves money, recoups £50 for every £1 spent. Additionally, commissioning specialist interventions with individual packages of care-planned support, which can include medical, psychosocial or specialist harm-reduction interventions where every £1 invested saves £1.93 within two years and up to £8.38 long term²⁹

According to the National Institute of Care and Health Excellence (NICE), stopping people using drugs can save money by:

- Reducing the crime associated with drug use (estimated at £445,000 over the lifetime of someone who takes drugs).
- Reducing the overall number of people who take or who inject drugs (the cost of providing health services to someone who injects drugs costs an estimated £35,000 or more over their lifetime).
- Preventing the transmission (and subsequent treatment costs) of blood-borne viruses.
- Reducing the number of hospital accident and emergency departments (and subsequent hospital bed-days) attendances for injection-site infections³⁰.

²⁹ PHE, (2016). Young people's drug, alcohol and tobacco use: Joint Strategic Needs Assessment (JSNA) support pack

³⁰ NICE (2014). Local Government Briefing: Tackling Drug Use. [Accessed online] on the 23 November <https://www.nice.org.uk/guidance/lgb18/resources/tackling-drug-use-60521153145541>

3. Developing this strategy

Substance misuse is a complex problem influenced by policies, systems, and environments, and its prevention requires changes across a range of community settings. Many of these settings are not necessarily part of the health and social care system; however they continue to evolve at a pace faster than the local health and social care system. The strategic planning process was conducted within the framework of broader Council planning initiatives and with the recognition of other Council strategies in the process of completion or completed.

Our approach at developing this strategy started with the acknowledgement that there is no “silver bullet” for reducing substance misuse. It was based on flexibility and responsiveness to community needs rather than a top-down prescription for change. This life course, collaborative, multi-setting approach has meant that we also considered a set of effective approaches to develop tailored, context-specific health and social interventions based on local community needs and capacity

By developing this strategy through participation of varied communities, groups and individuals in the selection and implementation of multi-setting substance misuse prevention, treatment and recovery interventions, we aim to create and sustain momentum toward a long-term reduction of substance misuse in our local resident population.

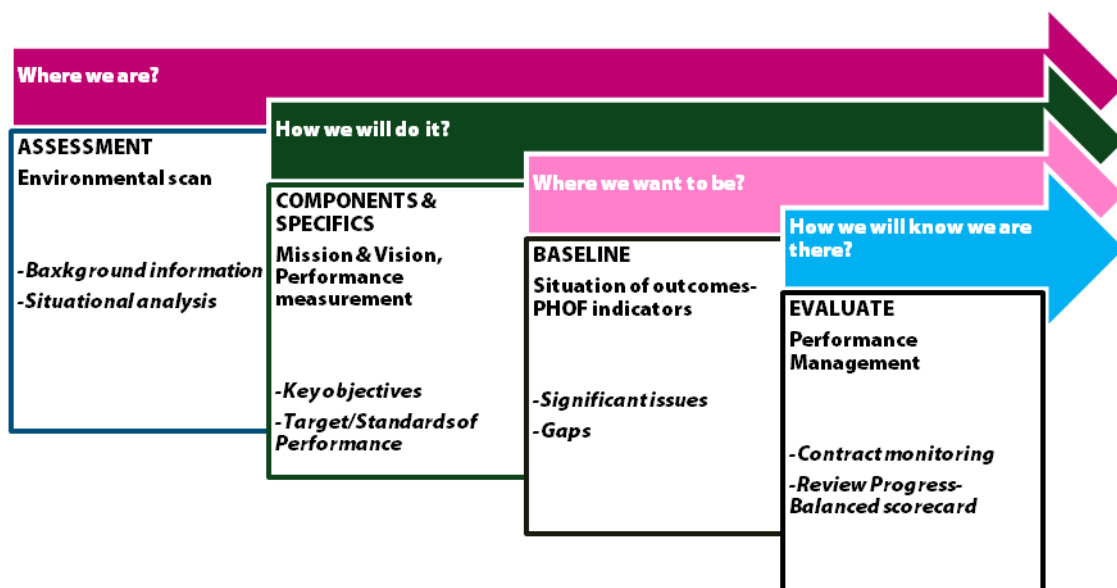
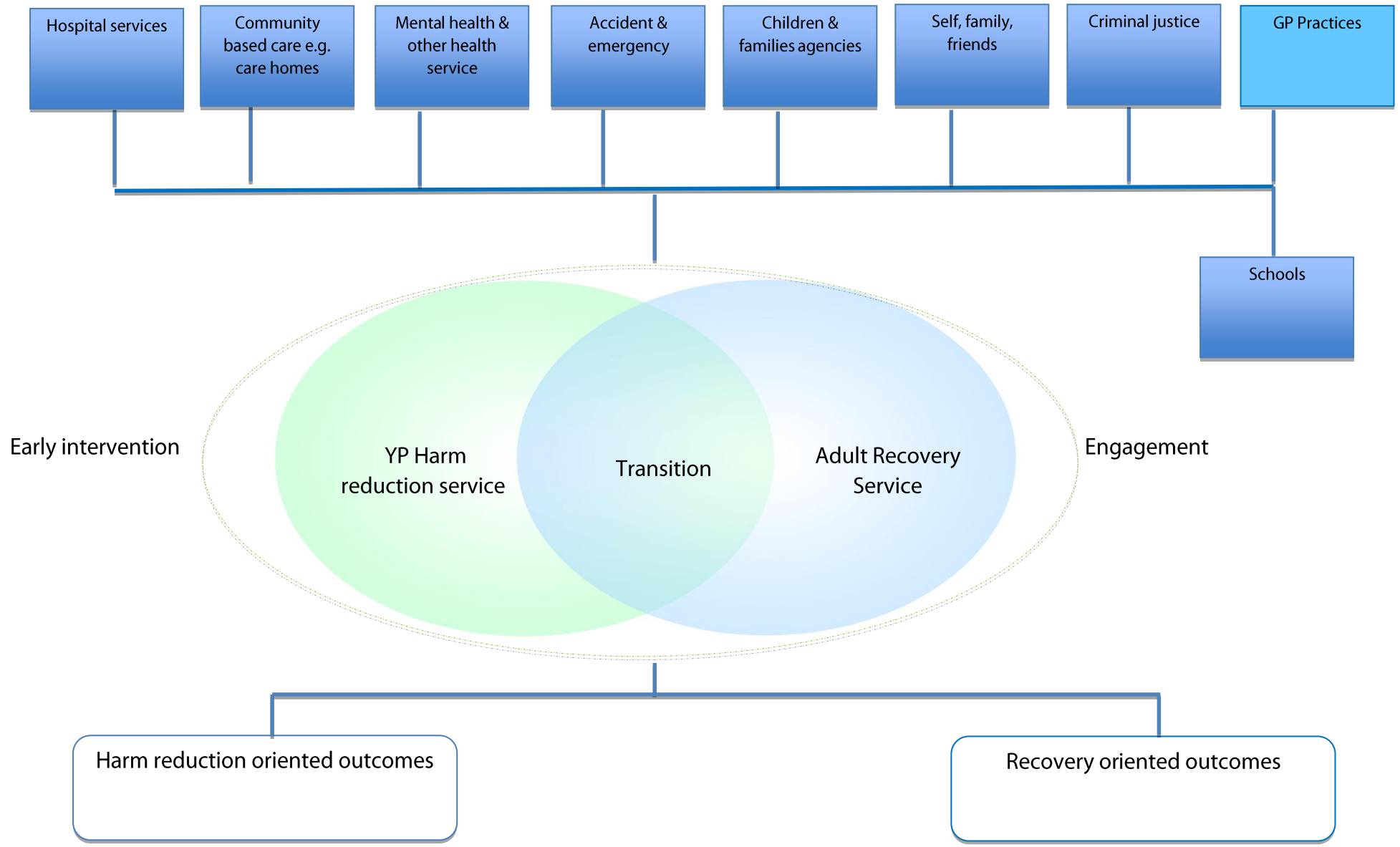


Figure 1: Process of substance misuse recovery strategy

3.1. Building on what we are already doing

In accordance with national standards, there have been necessary changes to local service delivery, including less focus on keeping individuals in treatment and more emphasis on ensuring that they leave services substance-free. Redbridge had opted for an integrated approach to substance misuse service delivery with a commissioned service going on stream from May 2015.

This integrated approach is essential as stakeholder organisations (and systems) in substance misuse comprise of separate, but interconnected components which play complementary roles in order to accomplish patient outcomes of recovery or harm reduction. The fulfilment of system outcomes necessitates co-operation and collaboration among and between the various parts of the stakeholder organisations.



Redbridge Substance Misuse local services

3.2. Strategic alignment and a need for multi-agency, multi-setting response

All Council continue to experience changes given the national policy direction, notwithstanding aligning this Substance Misuse Recovery Strategy and deploying associated resources to support delivery of Redbridge's Local plans, NHS targets and other strategic plans will maximise efficiencies and deliver service effectiveness and bring the best results in terms of addressing the complex social issues that contribute to and arise from problematic substance misuse.

In our view, it is imperative that local agencies work closely together to address substance misuse related issues and need. Irrespective of equally changing provider landscape, we are remain committed to commissioning a range of treatment and care services that work together effectively as an integrated system to help local residents to stop using substances, re-establish their lives, and to realise their potential in terms of health, education, skills, parenting and employment.

3.3. Engaging our stakeholders

Embarking upon an assessment of young people and adult substance abuse in Redbridge alone does not fully depict the nature, and why this challenge exists in our local area. Stakeholder engagement and collaboration remain deeply embedded in our process of innovation and the development of our solutions particularly in key challenging and dynamic areas.

The objectives of engagement were identified as:

- Increased awareness and understanding of current substance misuse service provision
- Increased understanding of our stakeholders priorities, needs, concerns and perceived environment
- Ensuring we maximised opportunities to work together and leverage support to achieve our strategy and objective

Methods

Three focused sets of activities were conducted to solicit feedback and information from stakeholders: an online questionnaire adapted from PHE Alcohol CLeaR tool (called Substance Misuse CLeaR) was sent to senior managers within the system, a series of interviews with frontline staff across the health and social care system related to substance misuse, and focus group discussions with service users were held.

Results and Findings

Please see appendices for a few of the results from the Substance Misuse CLeaR tool and findings generated the strategic priorities which were put to a stakeholder workshop.

4. What we want to do? Objectives & Deliverables

4.1. Our Strategic Aim

"To reduce substance misuse and addiction across the lifespan of Redbridge residents," and its vision was, "Healthy, safe, and drug-free environments that nurture and assist all Redbridge residents to thrive."

The objectives to be met by this strategy are:

1. Reducing the number of Redbridge residents drinking at harmful levels and misusing drugs
2. Contribute to the reduction in the availability and use of substances in the borough, especially for people engaged with the Criminal Justice System
3. Reduce the health, social and economic harms caused by substance misuse locally, for both the individual user and wider society
4. Promote recovery by ensuring those exiting treatment are free of substance dependence, do not represent at treatment services and are effectively reintegrated into society

To achieve these objectives, we would ensure the following are delivered by:

- A new recovery service better aligning clinical, therapeutic and recovery outcomes for adults. This service must synergistically provide care with young people service and together embed transition arrangements and a families approach.
- Streamline all pathways with primary and secondary care services, including social care (rehabilitation and recovery), especially safeguarding vulnerable children, young people and adults
- Strengthen primary care delivery by working with GP Practices and community pharmacies
- Strengthen and maintain quality of service provision³¹

4.2. Our Strategic approach

Redbridge takes a life-course perspective to addressing substance misuse locally. This is because the causes of inequalities are complex and known to be determined by social, economic and environmental conditions that people experience and live in. This perspective recognises the structural, social and cultural contexts in which residents live and work. In doing so it reflects the importance of our early years and how it impacts on a range of other health and social issues. This strategy recognises the impact of adverse childhood events and their relationship to the development emotional, behavioural and mental health issues, including the development of substance misuse. Supporting children, young people and their guardians/parents will therefore continue to be an important part of our strategy in the coming years (see APhR 2015/16).

4.3. Our Priorities

Achieving the higher- level national outcomes of increasing healthy life expectancy and reducing differences in life expectancy and healthy life expectancy between communities in Redbridge remain the primary drivers of these priorities. The Council will continue to:

³¹ Public Health England (2015). Quality governance guidance for local authority commissioners of alcohol and drug services accessible from < <http://www.nta.nhs.uk/uploads/quality-governance-guidance-for-local-authority-commissioners-of-alcohol-and-drug-services.pdf>>

- Drive improvements of wider factors that affect health and wellbeing, and health inequalities
- Ensure people are helped to live healthy lifestyles, make healthy choices and reduce health inequalities
- Ensure our population's health is protected from major incidents and other threats, while reducing health inequalities
- Reduce numbers of people living with preventable ill health and people dying prematurely, while closing the gap between communities

STRATEGIC PRIORITY 1: Inform, educate and empower communities to change social norms and community conditions that facilitate substance misuse. or PREVENTION & EARLY INTERVENTION

- Raise awareness of substances related harm targeting communities- professionals, young people and wider population
- Strengthen voluntary groups to response to substances misuse
- Utilize social marketing to target those most a risk of exposure to substance misuse and promote national campaigns
- Supporting resilience in young people to remain free from substances or delay substance use.
- Identification and assessment of at risk groups/population

STRATEGIC PRIORITY 2: Promoting healthy and Safe Community Environments or CONTRIBUTING TO SAFE & HEALTHY COMMUNITIES

- Using existing evidence to reduce availability of substances, especially alcohol
- Establish a multiagency information sharing and information governance system
- Establish safer environment for vulnerable young people and adults

STRATEGIC PRIORITY 3: Responsive System of Care through a coordinated, accessible and comprehensive system of evidence based service RESPONSIVE SYSTEM OF CARE

- Ensure structured and unstructured treatment is accessible to all clients in both adults and young people's service to achieve treatment completion and prevent substance related deaths
- Scale-up blood borne viruses screening and treatment
- Strengthen pathways across the substance misuse system e.g. with primary care, A&E, mental health, detoxification and rehabilitation
- Improve engagement and treatment steps with offenders who attend the adult treatment service in order to reduced crime and reoffending
- Reduce access barriers to services

STRATEGIC PRIORITY 4: Support individuals in making informed choices about their health and remaining free from all substances SUPPORT RECOVERY

- Promote the mental, physical wellbeing of all patients in treatment service;
- Facilitate education or employment in patients in recovery
- Raise capacity to be active in family and community life

4.4. Our Actions

The principles that Prevention works! Treatment is effective! and Recovery attainable!, are from the evidence base behind behavioural health prevention, early intervention, treatment and recovery services which continue to be the cornerstone to better outcomes for local people with, or who are at risk, for substance misuse including those with coexisting mental health conditions.

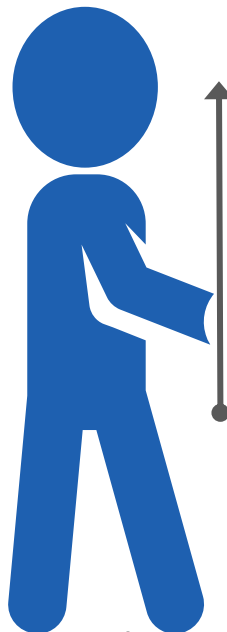
Delivering on our strategy is a partnership commitment to:

- Quality in every aspect of the service system;
- Collaborative, integrated and accessible services;
- Person-driven services without fear of prejudice or discrimination;
- Individualised community based services and supports meeting people where they are:
 - Accountability through performance measures and outcomes.
 - Transparent evidence-based practices and policies

CLOSE THE DEAL

WHAT OUR RESIDENTS NEED?

Support resident to delay, reduce and halt substances; treat dependency and support recovery



WHAT COMMISSIONERS and PROVIDERS MUST DO?

Deliver on all strategic priorities within the timeframe.

Commitment from Redbridge Partnership (See appendix for detailed year on year action plan)

5. Measuring Success

As part of delivering a responsive system of care, we seek to scale-up activities around blood borne virus control to achieve elimination. We will know we have gotten there by continuous monitoring and evaluating all that we do.

5.1. Gathering evidence

An essential requirement for strategies promoting people-centred and integrated care services is the gathering of evidence and learning to justify and support implementation. Our focus will be on the ongoing monitoring of progress within a framework that includes specific and measurable objectives. Attention will be given to understanding the extent to which each of the four interlocking strategic priorities are being met and, as council seek to implement reform, identify the technical obstacles to progress and support managers and leaders to make effective adjustments so that progress can be sustained.

5.2. Monitoring

A key action for commissioners will be to develop and maintain systems that monitor outcomes. The complexity of people-centred and integrated care services as a strategy means that monitoring will be needed at several levels: at the micro-level to examine whether citizens are receiving more people-centred care that is coordinated around their needs; and at the meso- and macro-levels to assess whether care is being reoriented towards people-centred and integrated health services, and an enabling environment is being created.

Monitoring of people-centred and integrated care will be led by local leadership and designed to reflect local-specific system institutional processes adapting to local needs and contexts.

Monitoring provides important opportunities to improve how our local system functions. Data does not only provide a basis for problem solving and decision-making by stakeholder leadership, but is also a way of continuous engagement with communities, promoting accountability for both commissioners and providers through disclosure of performance and strengthening services. Monitoring processes will not simply focus on average levels of performance, but will rather analyse leading and lagging performances, and will be employed in ways that promote learning and accountability. This first step in achieving this is ensuring all agencies with the substance misuse system sign up to Redbridge information sharing protocol

5.3. Maintaining quality measures

The monitoring of local data on the coverage of substance misuse services, outcomes, as well as indicators to assess equitable distribution and the social determinants of health, is important in supporting the aspirations to achieve strategic priorities as outlined in this strategy.

It is meant to stimulate learning and change across organisational practices. Consequently it is important for agencies to adopt and use a set of indicators that reflects the main elements of Redbridge strategy for person-centred and integrated care in substance misuse services delivery.

A reasonable range of indicators have been selected by Public Health England and the local Council which has been validated and used in a standardized and consistent way. Further details on these quality measures and indicators is given in the support document that accompanies this strategy

5.4. Learning and evaluation

There is a growing knowledge about the building blocks of people-centred and integrated health services, as set out in the four strategic priorities of this strategy, less is known about how to effectively implement complex service innovations though on going learning from Redbridge HUB-HASS model will provide a template. In many parts of London, there are continued uncertainties about how different strategies to strengthen people-centred and integrated care will work out. Locally, we will understudy ongoing efforts to generate local evidence while proceeding with reforms as seen in the council's flagship HUB and HASS model.

Glossary

SUBSTANCE MISUSE	Definition
Drugs	Clients presenting to treatment with opiates or non-opiates as their main, second or third drug recorded at any episode during any treatment journey. Service users will be grouped in this category if there is any drug cited, including alcohol.
Alcohol Only	Clients presenting to treatment in with alcohol as their only problem substance.
Structured Treatment	Structured drug and alcohol treatment consists of a comprehensive package of specialist drug- and alcohol-focused pharmacological, psychosocial and other interventions that follows a comprehensive assessment of need and is delivered according to a recovery care plan that is regularly reviewed with the client. The interventions are delivered sequentially or concurrently, mainly in the community (including primary care) but also in residential, inpatient unit or prison settings
Non-Structured Treatment	Non-structured interventions refer to information, advice and other services related to substance misuse provided in general and open-access services. Anyone can access non-structured interventions, usually without referral from another agency, and they are often a first point of contact for alcohol and drug users. Examples include needle and syringe programmes, drop-ins, alcohol health workers in acute hospitals, identification and brief advice (IBA) and recovery support interventions. Non-structured interventions can be delivered alongside structured treatment, though they can also act as a gateway to structured treatment.
STRUCTURED TREATMENT	
Pharmacological	<p>Medication prescribed for one of four main reasons.</p> <ol style="list-style-type: none"> 1. <u>Assessment and stabilisation</u>: prescribing of a receptor agonist (e.g. methadone), or partial agonist (e.g. buprenorphine), or other pharmacotherapy specific to substance misuse, to stabilise use of illicit drug(s), following and alongside continuing appropriate assessment. It also includes re-induction onto opioid substitution treatment prior to prison release, in the limited circumstances where this is appropriate. 2. <u>Maintenance</u>: prescribing of substitute medications under a stable dose regimen to medically manage physiological dependence and minimise illicit drug use. It may be provided to support achieving or sustaining medication assisted recovery. 3. <u>Withdrawal</u>: prescribing of an agonist or partial agonist or other medication, usually up to 12 weeks (or 28 days as an inpatient), to facilitate medically-supervised assisted withdrawal and to manage withdrawal symptoms. Prescribing of benzodiazepines and/or other medication for the management of alcohol withdrawal. 4. <u>Relapse prevention</u>: prescribing medication for relapse prevention support (e.g. naltrexone as part of opioid relapse prevention therapy, or naltrexone, acamprosate or disulfiram as part of alcohol disorder relapse prevention therapy).

Psychosocial	All psychosocial interventions provided, whether integral or additional to, or provided in the absence of, a pharmacological intervention. Interventions include: motivational interventions, contingency management, family and social network interventions, cognitive and behavioural based relapse prevention interventions, evidence-based psychological interventions for co-existing mental health problems, psychodynamic therapy, 12-step work, counselling (BACP accredited) and any other intervention based on established psychological models/theories that have an evidence base, and that is undertaken by a worker with the required competences with adequate supervision and clinical governance arrangements.
Inpatient treatment	Occurs in an inpatient unit which provides assessment, stabilisation and/or assisted withdrawal with 24-hour cover from a multidisciplinary clinical team who have had specialist training in managing addictive behaviours. The clinical lead in such a service comes from a consultant in addiction psychiatry or another substance misuse medical specialist. The multi-disciplinary team may include psychologists, nurses, occupational therapists, pharmacists and social workers. Inpatient units are for those alcohol or drug users whose needs require supervision in a controlled medical environment
Residential rehabilitation	A structured treatment setting where residence is a requirement and where people receive multiple interventions and support in a coordinated and controlled environment, normally comprising both professionally delivered interventions and peer-based support, as well as work and leisure activities. Although such programmes are usually abstinence based, prescribing for relapse prevention or medication assisted recovery are also options. Residential programmes are often aimed at people who have had difficulty in overcoming their dependence in a community setting and may also deliver an assisted withdrawal programme that qualifies as a 'medically monitored' inpatient service and meets the standards and criteria of the Specialist Clinical Addictions Network. This level of support and monitoring of assisted withdrawal is most appropriate for individuals with lower levels of dependence and/or without a range of associated medical and psychiatric problems.
NON-STRUCTURED TREATMENT	
Recovery support	Examples include: peer support involvement, facilitated access to mutual aid, family support, parenting support, housing support, employment support, education and training support, supported work projects, recovery check-ups, evidence-based psychosocial interventions to support substance misuse relapse prevention, evidence-based mental health focused psychosocial interventions to support continued recovery, complementary therapies, and any other recognised recovery activity or support intended to promote and maintain a service user's recovery capital, which is not captured by an individual type or combination of types above. For a more detailed explanation of 'recovery support', please see: _____
Needle and	Needle and syringe programmes (NSPs) supply needles and syringes,

syringe programmes	and other equipment, for people who inject drugs. They also provide advice and information to reduce the harms caused by injecting, access to BBV testing, vaccination and treatment services, access to drug treatment, and other health and welfare services (including condom provision).
Outreach	Outreach work is a method of delivering interventions in settings external to a service's usual site. Outreach is not an intervention in and of itself. Outreach interventions can be focused on changing the behaviour of individuals or supporting communities to develop strategies to minimise collective harm
Advice and Information	Advice and information services provide factual information on substance misuse and treatment. The advice and information can be conveyed in a variety of ways, e.g. verbal, written, audio-visual, in person or over the telephone. Topics typically covered are: potential psychological and physical implications of substance misuse, guidance on how to reduce or stop misusing safely; harm reduction information and guidance; and where to get help.
Outpatient attendance - consultant's services	A face-to-face, follow-up appointment with a hospital consultant with regard to alcohol and/or drug issues.
Alcohol Health Worker	Alcohol health workers are specialist staff working in hospital (usually nurses) who identify and work with patients drinking at levels that may impact or have already impacted their health.
GP advice about alcohol	Brief advice on alcohol management delivered by a GP.
GP screening and brief Intervention	GP universal screening of patients for individuals with increasing or high-risk drinking, followed by a five-minute advice session for those who screen positive.

A. Classification of Substances

Class A	Class A/B	Class B	Class B/C	Class C	Not Classified
Any Cocaine 1.Powder cocaine 2.Crack cocaine	Any Amphetamine <ul style="list-style-type: none"> • Amphetamine • Methamphetamine 	Cannabis	Tranquillisers	Anabolic steroids	Amyl nitrite
Ecstasy		Ketamine			Glues
Hallucinogens 1.LSD 2.Magic mushrooms		Mephedrone			
Opiates 1.Heroin 2.Methadone					

Notes on drug types

'Any Class A drug' comprises powder cocaine, crack cocaine, ecstasy, LSD, magic mushrooms, heroin and methadone, plus methamphetamine'

'Any stimulant drug' comprises powder cocaine, crack cocaine, ecstasy, amphetamines and amyl nitrite, plus methamphetamine and mephedrone

'Any drug' comprises powder cocaine, crack cocaine, ecstasy, LSD, magic mushrooms, ketamine, heroin, methadone, amphetamines, methamphetamine, cannabis, tranquillisers, anabolic steroids, amyl nitrite and any other pills/powders/drugs smoked and mephedrone.

Action Plan

Strategic Objectives	Actions	Timescales (indicate start dates) April 2017-March 2019								Means of verifiable indicators (MoV)	Responsible lead
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
STRATEGIC PRIORITY: Prevention and early intervention											
Shift in culture to promote positive alcohol lifestyle choices and a reduction in drug misuse	<ul style="list-style-type: none"> Raise awareness of substances related harm targeting communities- professionals, young people and wider population 									PHOF Evaluation reports Contract monitoring reports	Providers Commissioners
	<ul style="list-style-type: none"> Strengthen voluntary groups response to substances misuse 									Training report	Commissioners
	<ul style="list-style-type: none"> Utilize social marketing to target those most a risk of exposure to substance misuse and promote national campaigns 									<Discussion>	Commissioners Council and provider communication teams
	<ul style="list-style-type: none"> Supporting resilience in young people to remain free from substances or delay substance use. 									<Discussion>	Commissioners (Young people)
	<ul style="list-style-type: none"> Identification and assessment of at risk groups/population 									JSNA APHR	Commissioners
STRATEGIC PRIORITY: Contributing to safe and healthy environments											
Reduce the health, social and economic harms caused by substance misuse, for both the	<ul style="list-style-type: none"> Using existing evidence to reduce availability of substances, especially alcohol 									Participation in pan-London review via LSTHM/UCL Alcohol Licensing application record	CB Licensing lead

Action Plan

individual user and wider society	<ul style="list-style-type: none"> Establish a multiagency information sharing and information governance system 									Information sharing protocol agreed	Commissioners (AH/IO)
	<ul style="list-style-type: none"> Establish safer environment for vulnerable young people and adults 									Record of licensing representations	
STRATEGIC PRIORITY: Responsive System of Care											
Reduce the number of people drinking at harmful levels and misusing other substances	<ul style="list-style-type: none"> Reduce access barriers to services 									Annual High Street Drinkers Evaluation Report	
	<ul style="list-style-type: none"> Ensure structured and unstructured treatment is accessible to all clients in both adults and young people's service to achieve treatment completion and prevent substance related deaths 									NDTMS Quarterly Reports- Provider/DOMES	
	<ul style="list-style-type: none"> Scale-up blood borne viruses screening and treatment 									PHOF NDTMS Quarterly Reports	
	<ul style="list-style-type: none"> Strengthen pathways across the substance misuse system e.g. with primary care, A&E, mental health, detoxification and rehabilitation 									Operational pathways endorsed by leadership #Meetings & minutes	

Action Plan

<p>Contribute to the reduction in the availability and use of substances for people engaged with Criminal Justice systems</p>	<ul style="list-style-type: none"> Improve engagement and treatment steps with offenders who attend the adult treatment service in order to reduced crime and reoffending 									<p>NDTMS reports Contract monitoring data</p>	<p>Contract team Commissioners</p>
<p>STRATEGIC PRIORITY: Support recovery</p>											
<p>Promote recovery by ensuring those exiting treatment are free of substance dependence, do not re-present at treatment services and are effectively reintegrated into society</p>	<ul style="list-style-type: none"> Promote the mental, physical wellbeing of all patients in treatment service; 									<p>Contract monitoring data NDTMS reports</p>	<p>CCG Primary care- GPs/Pharmacies Commissioners (AH/IO) Providers</p>
	<ul style="list-style-type: none"> Facilitate education or employment in patients in recovery 									<p>Contract monitoring data NDTMS reports</p>	<p>Provider JSP Commissioners</p>
	<ul style="list-style-type: none"> Raise capacity to be active in family and community life 									<p>Contract monitoring data</p>	<p>Provider Commissioners</p>

NB: This action plan is guided by Redbridge HWBS, Commission intentions from People Directorate

Appendices

A. Priorities and Measures

Strategic Priority	What objective is met?	Related Measures
Responsive system of care	Reduce the number of people drinking at harmful levels and misusing drugs	#of young people reached during awareness sessions #of new treatment cases (adult & young) Successful completion of alcohol treatment Successful completion of drug treatment
Contributing to Safe and healthy communities	Reduce the health, social and economic harms caused by substance misuse, for both the individual user and wider society	Alcohol related admissions to hospital Alcohol related re-admissions to hospital Drug related admissions to hospital Drug related re-admissions to hospital Domestic violence rates Drug related deaths Blood borne viruses prevalence and incidence
Prevention and early intervention	Shift in culture to promote positive alcohol lifestyle choices and a reduction in drug misuse	Mortality from liver disease (under 75s) Estimated harmful drinkers Estimated drug users Estimated underage drinkers Estimated binge drinkers
Support recovery	Promote recovery by ensuring those exiting treatment are free of substance dependence, do not re-present at treatment services and are effectively reintegrated into society	Successful completion of alcohol treatment Successful completion of drug treatment Access to employment Access to accommodation Active family life
Responsive system of care	Contribute to the reduction in the availability and use of substances for people engaged with Criminal Justice systems	# of people entering prison with substance misuse issues not previously known to community treatment provider(s) #engaged with treatment provider(s)

Acknowledgments

Integrated Strategy and Commissioning would like to thank the following Gladys Xavier, Andrew Hardwick, Ikenna Obianwa, Tajinder Bhatia, Camille Barker, Aisha Baig, Emma Burke, Rachel Penny, Helen Anthony, Dr. Syed Altaf-Akhtar, Dr Naomi Oliver, Mandie Wilson, Basharat Hameed, Jennifer Allen, Jennifer Fletcher-Simms, Doreen Grant, Siobhan White, Mark Duncan, Valerie Scanlan, Andrew Farquharson, Shaheen Bhatia, Helen Chitty, Claire Donnelly, Sonia Lynch, Michele De-Sousa, Chris Ma, Ed Chaplin, John Richards, Stephen Crane, Stephen Jones, Linda Ross, Oge Chesa, Dr Raj Kumar, Dr Paul Kooner, Dr Mehul Mathukia, Dr Kanagasundrem Aynkaran. We would like to thank members of the Redbridge Treatment Oversight Group for their continued enthusiasm to improve health and wellbeing for service users.

