Adults Drug and Alcohol Health Needs Assessment

Berkshire Unitary Authorities

2015

Contents

Executive Summary

What is the purpose of the needs assessment?

The adult's drug and alcohol needs assessment has been undertaken on a Berkshire-wide scale. It has identified treatment demand and service provision for substance misuse and has drawn upon comparisons between local authorities (LAs) across Berkshire. This is beneficial for future treatment and service planning and commissioning.

The results of the assessment have been summarised under the following headings; population, substance misuse prevalence, harm and treatment, treatment outcomes and service provision.

What are the key results of the assessment?

Population

Berkshire has a generally affluent and middle-aged population however it is interspersed by areas of much younger populations and areas with higher deprivation. Berkshire has a relatively small Black Ethnic Minority (BME) population but, like both age and deprivation, contains areas that go against this trend. Reading and Slough have much younger populations than the average Berkshire pattern along with more areas with a higher level of deprivation. Slough also has a higher BME population, predominantly Asian/Asian British.

Substance misuse prevalence

The drug prevalence indicator included shows the estimated drug user rates by LA. These rates are grouped into 4 categories: opiate and/or crack (OCU), opiate, crack and injecting users. Overall rates of drug use were notably highest in Reading and Slough when compared to the rest of Berkshire and to national figures.

Alcohol prevalence is shown using binge drinking population estimates and higher risk drinking population estimates. It is, however, difficult to draw conclusions from this data due to its date of publication (2007-2009). Furthermore as the data is based on modelled estimates with very wide confidence intervals, the reliability of the results should be examined with caution. This has highlighted the need for more up-to-date, relevant and accurate data as demonstrated in the Bracknell Forest Council Public Health Survey 2014.

Harm

Harm can be presented in a variety of ways, the severity of which differs greatly across Berkshire. When broken down by gender, males appear to fair worse than females for both alcohol related mortality and alcohol specific

mortality. This is also true for admissions to hospital for alcohol-related conditions. Alcohol specific admissions and readmissions are broken down by Clinical Commissioning Group (CCG) area. Only NHS South Reading CCG and NHS Slough CCG are similar to the national average for admissions for alcohol specific conditions, the rest are significantly lower. For alcohol specific readmissions within 30 days of discharge the only area that is significantly higher than the national average is NHS North & West Reading CCG. Considering that alcohol specific admissions are significantly lower than the national average in NHS North & West Reading CCG their readmission rate is surprisingly high.

Drug mortality rates at local level are missing for Reading, West Berkshire and Wokingham as they have not yet been reported and numbers for the remaining 3 LAs are small in statistical terms. Similarly hospital admissions due to poisoning by illicit drugs appear to be low.

Alcohol related crime rates are also included within this chapter, of which Reading and Slough are significantly higher than the national average on the 3 indicators shown (alcohol related recorded crime, alcohol related violent crime and alcohol related sexual crime).

Direct measures of dual diagnosis (mental health and substance misuse) are unavailable, although figures are shown for the percentage of people who have concurrent contact with mental health services and substance misuse services. For drug misuse services, this proportion of concurrent contact is statistically significantly highest in Slough, West Berkshire and RBWM and lowest in Wokingham and Reading (although not statistically significantly different to the South East and England average). For alcohol misuse services this proportion is highest in Reading and lowest in Wokingham, of which Wokingham is statistically significantly lower than the national average.

Treatment, treatment outcomes and service provision

This chapter has been broken down by numbers in treatment, outcomes whilst in treatment and successful treatment completions.

Numbers in treatment vary across Berkshire depending on the substance used. Bracknell Forest has a much higher percentage of people in alcohol treatment and non-opiate drug treatment, while the remaining 5 LAs have a higher percentage of people in opiate treatment.

Gender and ethnicity have both been compared to numbers in treatment. Overall, it appears that BME populations are underrepresented across Berkshire. When compared to gender, West Berkshire has the highest percentage of females in treatment with Bracknell Forest having the lowest.

Complexity levels of people in treatment can have an effect on treatment outcomes. The higher the complexity score the higher the risk that a client will not have a successful treatment outcome. Reading, followed by West Berkshire and Slough, have the highest proportion of people in treatment with

‘very high’ and ‘high’ complexity levels. When compared to completion rates, Bracknell Forest has completion rates that are lower than the national average for people in treatment with low complexity scores. This is the same for people in West Berkshire and Wokingham with low and medium complexity scores.

Whilst in treatment, the number of people with a record of a course of Hepatitis B vaccinations (HBV) and a Hepatitis C test (HCV) is recorded and made available on the National Drug and Treatment Monitoring System (NDTMS). The total number of eligible clients with a record of completing a course of HBV vaccinations is below the national average in all areas except for Reading and Slough. In addition the total number of eligible clients with a record of a HCV test is marginally lower than the national average in Bracknell Forest and considerably lower in RBWM.

The proportion of people in treatment who are also in contact with the criminal justice system has also been reported. This has been broken down by substance. Of note is that Reading has a much higher rate than both Berkshire and the England average for opiate users. Reading also has a slightly higher rate for alcohol users, along with RBWM and West Berkshire. In addition West Berkshire has a particularly higher rate for alcohol and non-opiate users than the national average.

The proportion of people spending 2 or more years in treatment was slightly higher in 2012/13 than it was in 2008/9 in all 6 LAs across Berkshire. Of particular interest is the percentage growth in the number of people spending 6 or more years in treatment between 2008/9 and 2012/13. This percentage increase is highest in Reading, West Berkshire and Wokingham.

Successful completions have been presented using two indicators: successful completions as a proportion of all in treatment and successful completions as a proportion of all in treatment who did not represent within 6 months (drug misuse only), allowing for a more reliable picture of success. Reading shows the highest percentage of successful completions for both people in treatment for non-opiate substances and for non-opiate and alcohol, although one of the lowest successful completion rates for people in treatment for opiates. Bracknell shows the highest number of completions for opiates and Wokingham shows the highest for alcohol. When drug misuse completion rates are presented through the successful completions who did not represent within 6 months indicator the highest percentages for opiates can be seen again in Bracknell Forest. This is also closely followed by Slough, which, using the successful completions indicator is less apparent. For non-opiates, this was again highest in Slough.

In terms of tier 2 support, it appears that provision for people who drink more than the recommended daily allowance but, for whatever reason, would not be classed or targeted as problem drinkers, could be further developed. Although recent NICE guidance has recommended the use of Nalmefene for those who are still consuming more than 7.5 units per day (for men) and more than 5 units (for women) 2 weeks after initial assessment, it should be noted

that this has limitations. Nalmefene needs to be prescribed alongside psychosocial interventions and should be part of an alcohol pathway. Clarity with funding of Nalmefene locally is also yet to be confirmed.

Budgets and return on investment

The budgets for drug and alcohol treatment have been presented in this needs assessment. Bracknell Forest and Wokingham receive the lowest, with Reading and Slough receiving the highest. It should be noted that the structure of spend for each of these budgets is not clear and therefore further analysis would be needed in order to ensure that budgets are appropriate to each LA.

Return on investment for drug treatment data shows that Reading has a particularly low return at £3.26 for every £1, compared to West Berkshire, which has a return on investment of £5.90.

Approximate budgets show the overall spend on substance misuse services across Berkshire but further financial analysis could be required as very little is known about the breakdown of spending in each LA.

Recommendations

This Berkshire-wide drug and alcohol needs assessment has explored the current need for substance misuse related services and service outcomes in each of the 6 LAs across the county. From this analysis a set of recommendations has been derived:

- More data is required around alcohol prevalence and how alcohol consumed. Similar data to that gathered in the Bracknell Forest Public Health Survey in each LA would benefit service and campaign planning (*page 15 onwards*).

- Nalmefene should be available to high risk drinkers (after relevant screening and consultation) in combination with psycho social support, as recommended by NICE guidance (*page 55*).

- More ‘tier 2’ support for people drinking over the recommended daily limit but not consuming enough to be highlighted as needing specialist treatment. This will help to drive down hospital admissions (*page 54*).

- More comprehensive and standardised reporting of ‘Tier 2’ services that already exist and numbers using tier 2 services would highlight demand and help to commission future tier 2 services (*page 54*).

- More support for at home drinkers and casual drug users and continued alcohol awareness campaigns.

- Further exploration of A&E attendances and alcohol related hospital admissions (*page 27 onwards*).

- Improved data collection on co-morbidity of substance misuse and mental health problems, as well as further information about available services (page 35).

- Improve reach of opiate initiatives in opiate populations (*page 43*).

- Provide more clarity on the breakdown of spend into different service areas. This would allow for standardisation and comparison (*page 58*).

Chapter 1: Population

Population structure

Each Health Needs Assessment (HNA) has to define its geographical scope. This HNA covers the county of Berkshire. Berkshire is divided into 6 LA areas; Bracknell Forest, Reading, Slough, Royal Borough of Windsor and Maidenhead (RBWM), West Berkshire and Wokingham. Data is most often available at a LA level, but where viable has also been given at a Berkshire level.

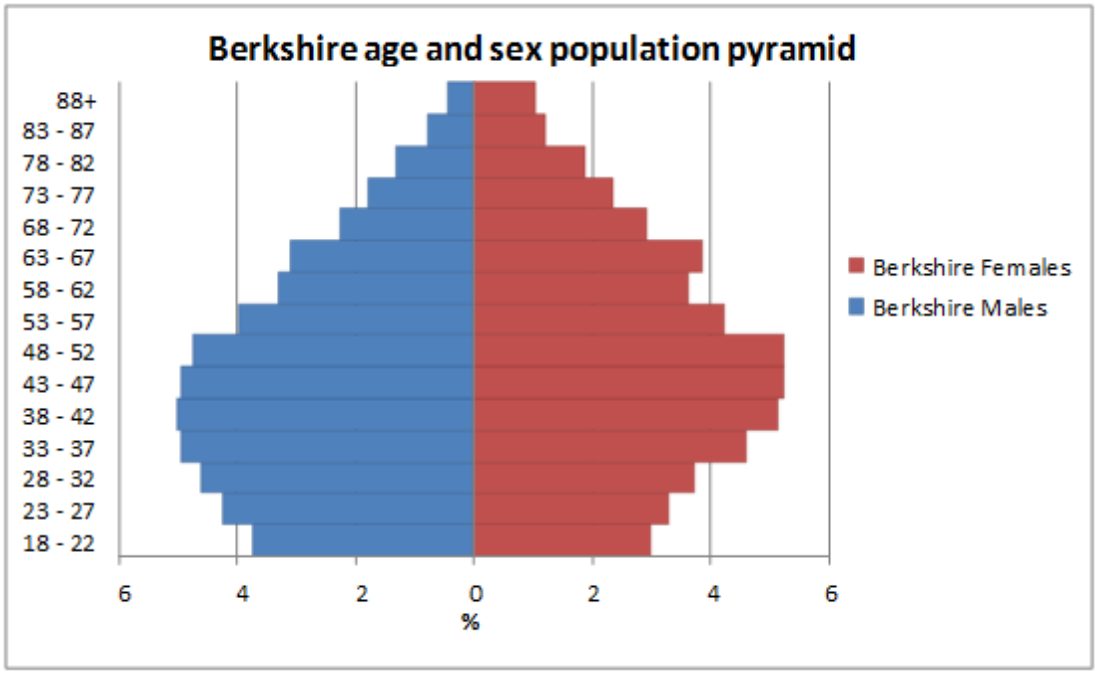
The population demographics of an area are likely to have an impact on the health outcomes of that area. This is no different when it comes to drugs and alcohol.

Figure 1. Map of Berkshire showing the 6 Local Authority areas.

Berkshire Demographics

As displayed in figure 2, Berkshire shows a ‘middle heavy’ population structure. In percentage terms, the population has many more 33 – 57 year olds than the England average. As a consequence of this ‘middle heavy’ population, Berkshire has by comparison less younger and older people.

Figure 2. Berkshire 18+ age and sex population pyramid.



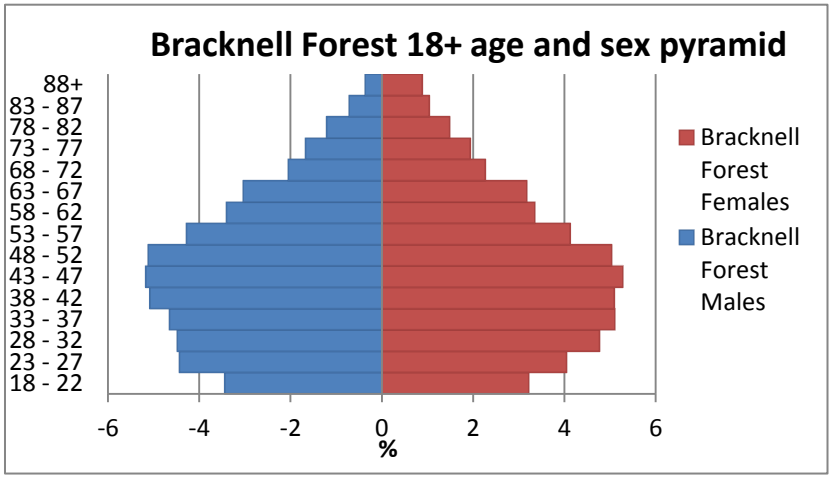
Source: mid-year population estimates, 2013, Office for National Statistics

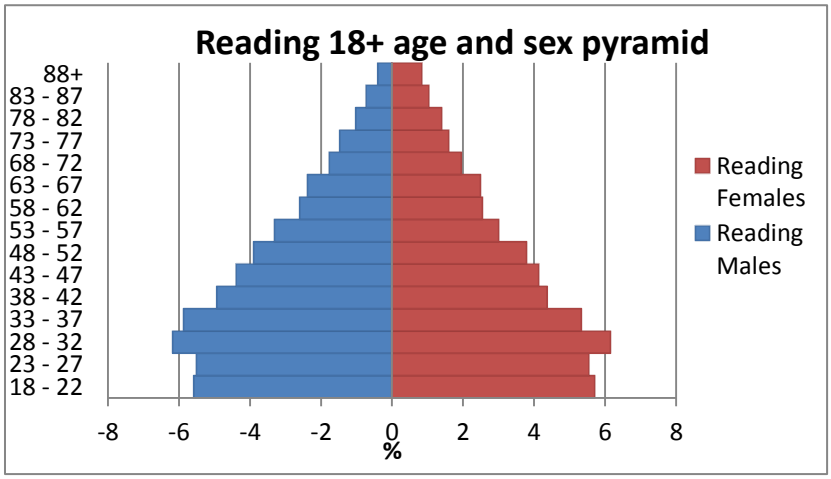
It is important to take into account the varied population profiles that exist within Berkshire. The six LAs show diversity in their individual population structures. This diversity is presented in figure 3.

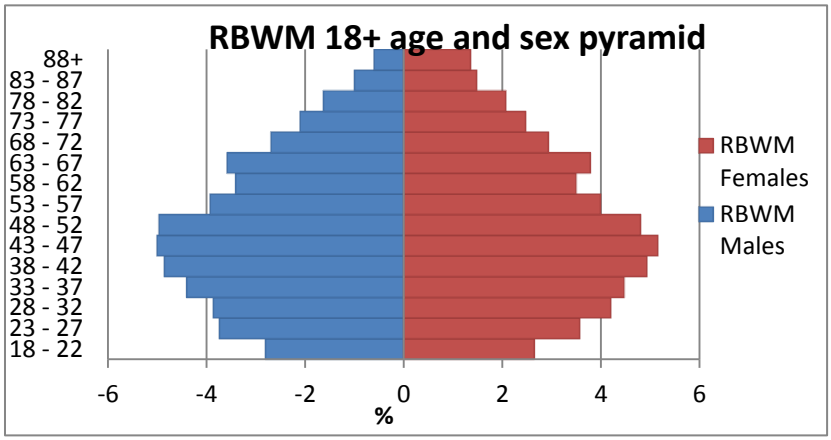
Figure 3 shows that Reading varies from the Berkshire population pyramid the most as it has a much greater proportion of younger adult residents. This is likely to be partly explained by the location of local universities. Slough differs from the Berkshire population by having a very large 28-37 population and a very small 38-57 population. The other LAs have a more typical Berkshire population structure.

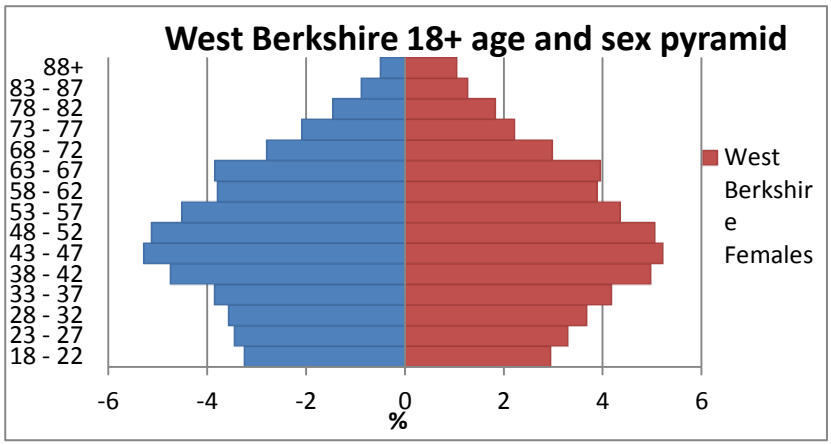
The structure of a population is likely to have an impact on how drugs and alcohol are used in an area.

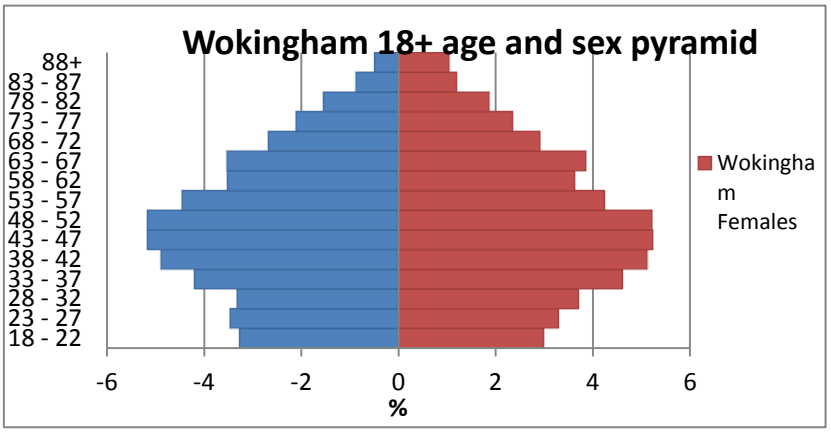
Figure 3. 6 Local authorities of Berkshire 18+ age and sex population profiles.

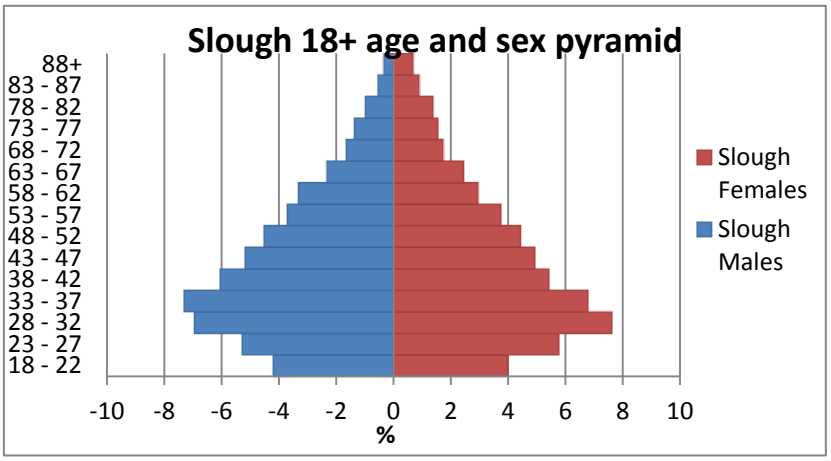












Source: mid-year population estimates 2013, Office for National Statistics

Bracknell Forest has a considerably smaller adult population than the other LAs (table 1). The average LA population is 111,948. Population size can have an effect on service requirements for a population. The Berkshire LAs are far smaller than the average County area; therefore some data is liable to be less accurate due to the smaller population.

Table 1. 18+ population by area.

Indicator	18+ population
Bracknell Forest	89,178
Reading	124,171
Slough	104,010
RBWM	113,296
West Berks	119,664
Wokingham	121,369
Berkshire	**671,688**

Source: mid-year population estimates, 2013, Office for National Statistics

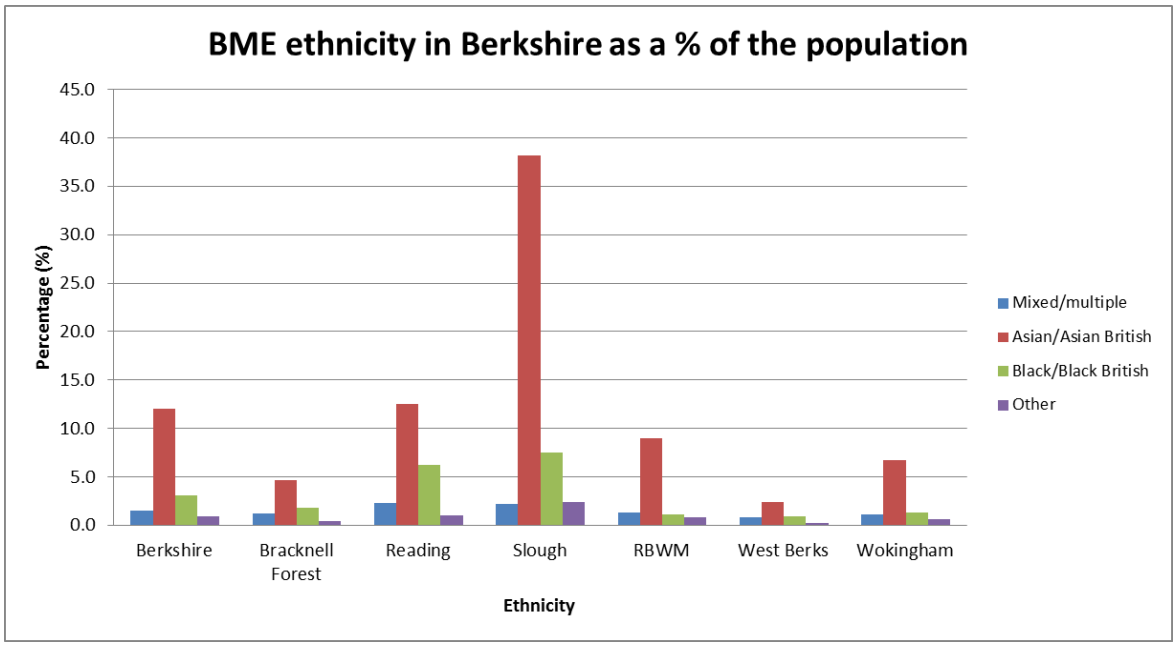
Ethnicity

Over 15% of the Berkshire population is from a BME background. The majority of ethnic minority population come from the Asian/Asian British community.

Different ethnic groups have different relationships with drugs and alcohol. This will be explored later in the report.

Figure 4 shows that the distribution of ethnic minority groups is not even, with Slough having a far larger Asian/Asian British population than the other LAs. The next largest BME population is in Reading. The other LAs have a smaller BME population, with Bracknell Forest and Wokingham having by far the smallest.

Figure 4. BME resident population in Berkshire by local authority.



Source: 2011 Census

Socioeconomic deprivation

Berkshire has very few areas of deprivation in comparison to the national picture. However it does have 23 Lower super output areas (LSOAs) that fall within the 20% most deprived areas nationally (table 2). These more deprived areas are mainly focused around Slough and Reading, with only 1 LSOA outside of these LA areas in West Berkshire. Socioeconomic deprivation is linked with higher incidence of substance misuse. Therefore it may be expected that there will be a much larger prevalence in these areas than their neighbouring areas with far less or no areas in the 20% most deprived.

Table 2. Number of LSOAs by LA that fall in the 20% most deprived nationally.

Local Authority	Number of LSOA in 20% most deprived (IMD)
Bracknell Forest	0
RBWM	0
Reading	12
Slough	10
West Berkshire	1
Wokingham	0

Source: Department for Communities and Local Government 2011

KEY POINTS

Berkshire has a ‘middle heavy’ population, with far more middle aged residents than younger and older.

Reading has a higher younger population. This could be due to the location of universities.

Slough differs from the Berkshire population by having a very large age 28-37 population and a very small age 38-57 population.

Slough has a far larger Asian/British Asian population than other Berkshire LAs

Berkshire has 23 LSOAs that fall within the 20% most deprived areas national. 12 of these are in Reading and 10 are in Slough.

Chapter 2: Substance prevalence

Prevalence, in this instance, refers to the number of cases of substance misuse in a local area. This is split broadly into drugs and alcohol, with more specific divisions in each. This is important to understand as it is pivotal in service planning and evaluation.

Drug prevalence

Definition
OCU: Opiate and/or crack cocaine users

OCU avoids double counting when estimating the prevalence of drug misuse within a population. Other estimates such as opiate users, crack users or injecting users are estimates of more specific usage. Using OCU gives an estimate of the total number of people using drugs in a population and is more accurate than simply adding up all of the known opiate and crack users as they can often be the same people.

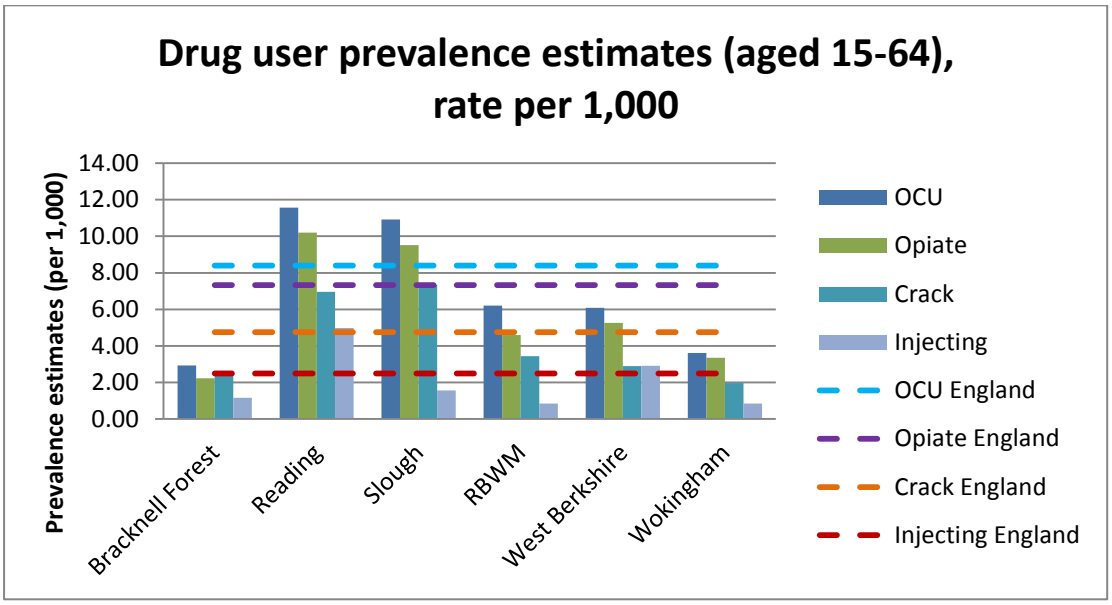
Prevalence estimates in figure 5 show that there is a higher rate of OCU users in Reading and Slough than any other of the LAs in Berkshire at 11.7 and 10.91 per 1000 population respectively. This is almost double the rate of the Royal Borough of Windsor and Maidenhead (RBWM) and West Berkshire and approximately four times the rate of Bracknell Forest and Wokingham. It is also higher than the England average of 8.4 per 1000 population. While we must be cautious as these prevalence rates are modelled estimates, they do suggest increased need for drug services in Reading and Slough.

Healthier Lives data (Public Health England) shows that, when compared to 152 counties and LAs across England, Bracknell has the second lowest estimated number of OCU and Wokingham has the fourth lowest.

The rate of injecting users is highest in Reading (4.98 per 1000). Bracknell Forest , Slough, RBWM and Wokingham all show rates below 2 per 1000 population, which is slightly lower than the England average of 2.49. West Berkshire shows a similar rate to the England average at 2.92.

Again using Healthier Lives data, when compared to all counties and local authorities across England, Wokingham has the seventh lowest estimated rate of injecting of opiates and/or crack while RBWM has the eighth lowest. In comparison, Reading has the 12th highest injecting rate. Reading is the worst in it's socioeconomic comparative group for this indicator. A socioeconomic comparative group comrpises of local authorities with a similar level of socioeconomic deprivation (Healthier Lives: Alcohol and Drugs, Public Health England).

Figure 5. Drug user prevalence estimates, aged 15-64, rate per 1000 population (2011-12).



Source: Public Health England, 2014

Alcohol prevalence

Definition

Confidence intervals: give an estimated range of values which is likely to include an unknown population parameter. The wider the range between the lower and upper confidence intervals, the more uncertain we are about the precision of the unknown parameter.

Higher risk drinking: consuming more than 50 units of alcohol per week for males and more than 35 units of alcohol per week for females.

In a society where social drinking has become a cultural norm it is important to ensure that initiatives are in place to prevent harmful levels of alcohol being consumed as this can affect the health of the public and increase pressure on health and social services.

Higher risk drinking and binge drinking can not only have impacts on short term health and social outcomes, for example crime rates, but can also initiate the development of long term health conditions, such as liver conditions, heart failure and some types of cancer, later on in life (NHS Choices, 2014). This can not only have serious consequences for the individual but also increases pressures on services in terms of both capacity and costs. Across England approximately £21 billion is spent on healthcare, crime and lost productivity costs due to alcohol misuse every year (Alcohol Concern, 2014).

Although the health impacts of higher risk drinking and binge drinking often don't present until later life, it is vital to reduce the volume of alcohol consumption now to avoid high pressure in the future.

Table 3 should be treated with extreme caution as the confidence intervals around the data is incredibly wide – suggesting poor quality data or small sample size. With this in mind table 3 shows that Reading had the highest percentage of self-reported higher risk drinkers in 2009, with Slough and Wokingham showing the lowest percentages. The remaining 3 LAs show a similar percentage to both the South East average and the England average. It should be noted that Reading is the only LA in Berkshire with a University, therefore the student population will be higher than in other areas. This could contribute to the higher percentage seen in Reading, with a 'drinking culture' often being associated with student lifestyle. Deprivation may also be a factor influencing this result, however this does not reflect the picture in Slough and again comes back to the quality of the data.

Table 3. Percentage within the drinking population (aged 16+) who report engaging in higher risk drinking (2009)- modelled estimates.

Local Authority	Percentage who report engaging in higher risk drinking	Lower 95% CI	Upper 95% CI
Bracknell Forest	6.86	2.31	22.18
West Berkshire	6.73	2.37	21.91
Reading	7.50	2.68	22.39
Slough	6.31	2.29	20.95
Windsor and Maidenhead	6.73	2.22	21.01
Wokingham	6.29	2.03	20.47
South East	6.75	2.36	21.59
England	6.75	2.38	21.77

Source: Local Alcohol Profiles for England, Public Health England, 2013

Definition

Binge drinkers: people who consume at least twice the daily recommended amount of alcohol in a single drinking session (that is 8 or more units for men and 6 or more units for women).

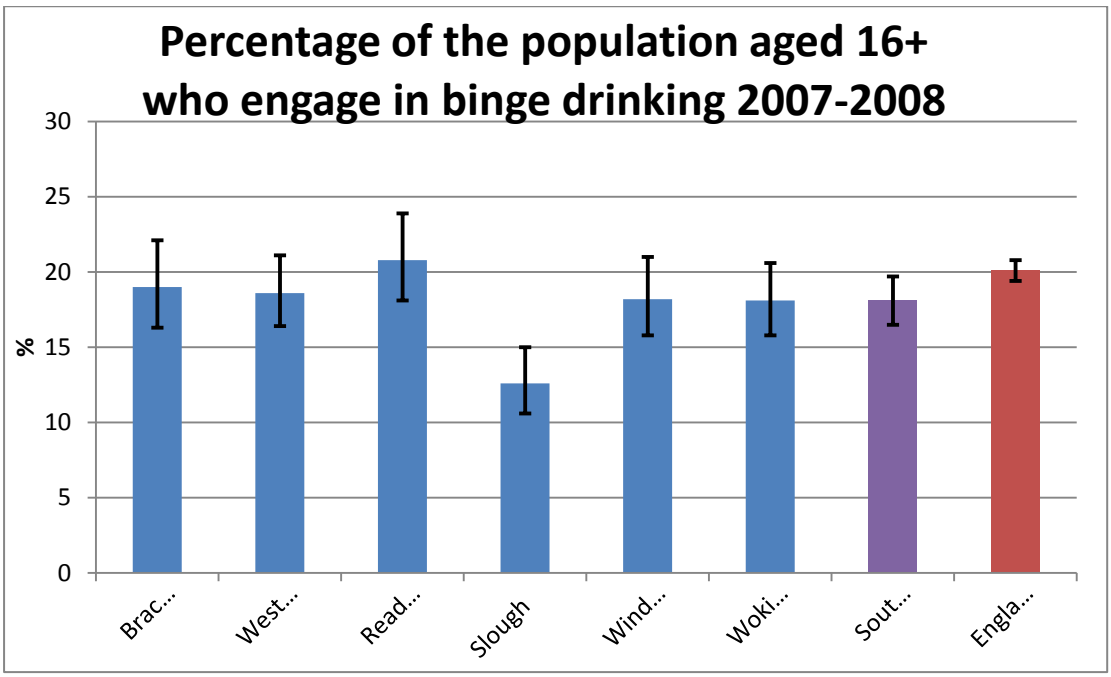
Figure 6 shows a fairly constant proportion of binge drinkers across Berkshire. Slough has the lowest percentage in the county (12.6%) and is significantly lower than both the South East and England averages, with Reading showing a slightly higher percentage than the England average (20.8% compared to 20.1%), although this is not significant.

A possible reason for the lower percentages of both higher risk drinkers and binge drinkers in Slough could be due to the large BME population. Slough

has a much higher Asian/Asian British community than the other LAs in Berkshire, therefore these lower figures could be as a result of religious choices. Binge drinking and higher risk drinking could genuinely be lower within this community or it could be a result of under-reporting due to the social stigma attached to religious values and consumption of alcohol.

The year of publication must be noted when presenting this data, with binge drinking percentages showing figures from 2007-8 and higher risk drinking percentages showing figures from 2009. Caution should also be taken as both table 3 and figure 6 are self-reported and could be subject to bias. The lack of recent data is an issue nationally when looking at drinking behaviour.

Figure 6. Percentage of population aged 16+ who report engaging in binge drinking (2007-8).



Source: Local Alcohol Profiles for England, Public Health England, 2013

Alcohol prevalence in the Bracknell Forest Health and wellbeing survey

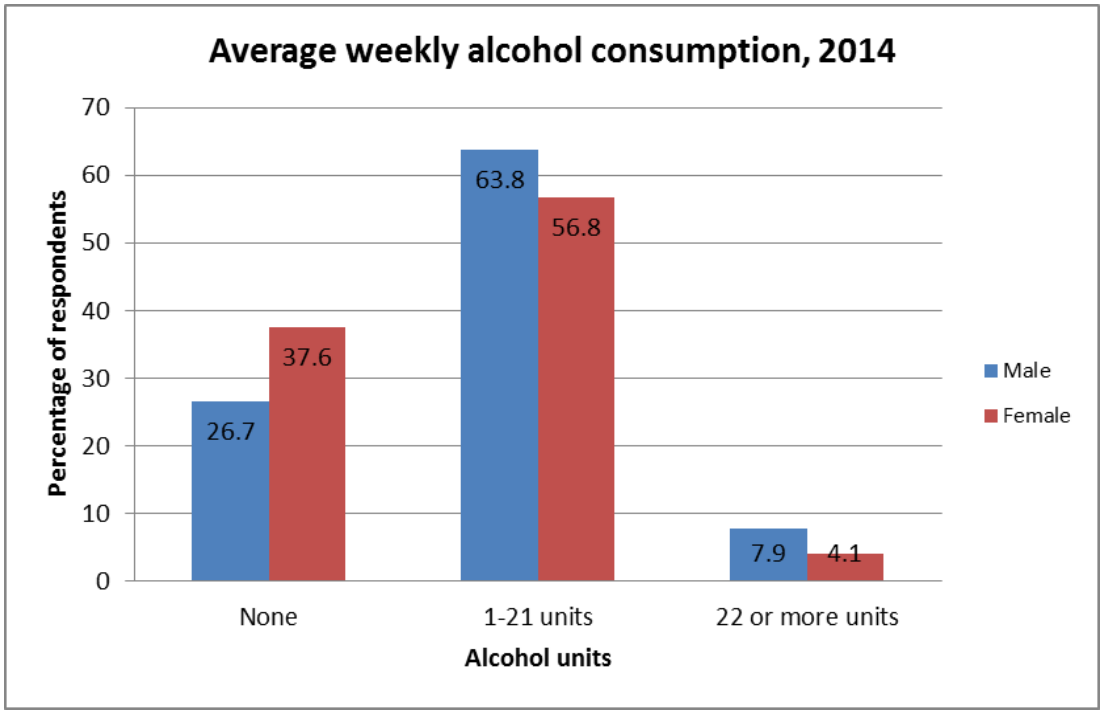
The lack of up to date and accurate data has been addressed in Bracknell Forest. The 2014 the Bracknell Forest health and wellbeing survey was undertaken to evaluate the health and wellbeing of residents. The survey used a sufficiently large sample to ensure representative and accurate data.

Part of the survey looked at alcohol consumption. This included both average weekly consumption and frequency of binge drinking. The Bracknell Forest health and wellbeing survey provided more up-to-date data for alcohol consumption behaviours than that in the Local Alcohol Profiles for England. This method of collecting data should be considered by other LAs in Berkshire.

Figure 7 shows average units consumed per week. The proportion of females that said that they do not consume alcohol was significantly higher than the proportion of males. In line with this, the proportion of males who said that they consume over the recommended levels was almost double that of females (7.9% vs 4.1%).

Potentially due to religious practices or personal choice, respondents from BME backgrounds were more likely than those from white backgrounds to say that they don't consume alcohol at all (42.1% vs. 30.6%). However, this difference was driven by differences amongst BME males (44.5% vs. 23.2%) rather than females and in fact BME and white female respondents were equally likely not to drink any alcohol (37.4% and 39.0% respectively).

Figure 7. Average weekly alcohol consumption in Bracknell Forest, 2014.



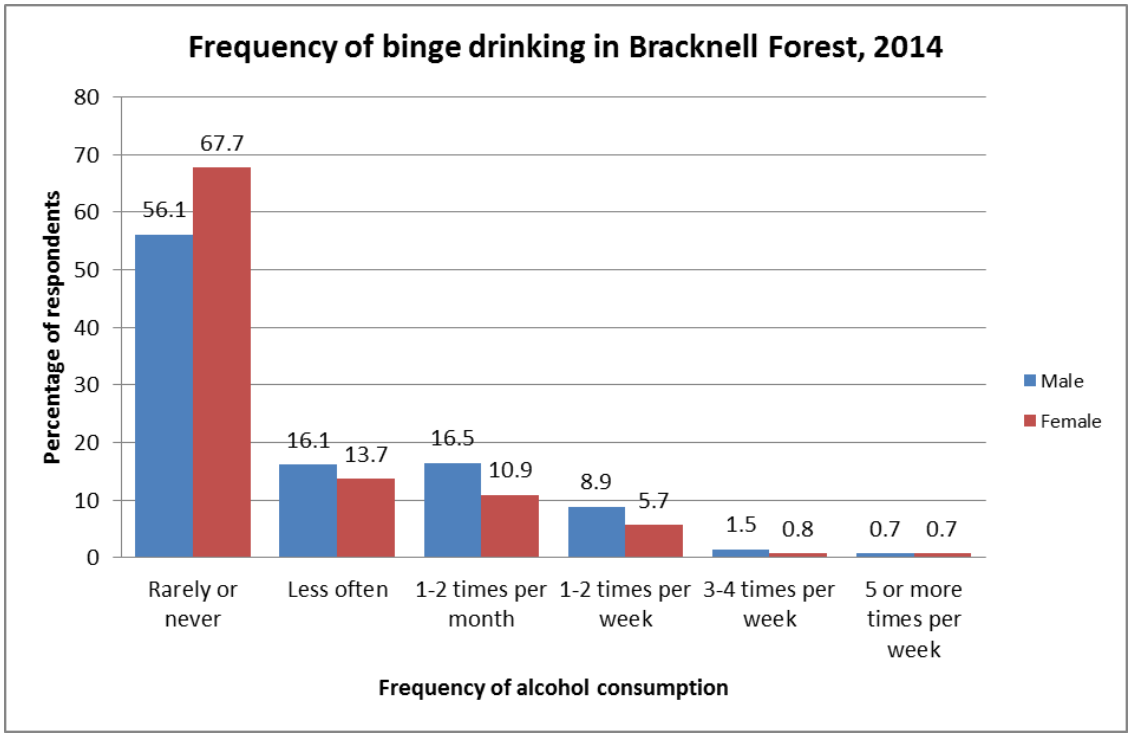
Source: Bracknell Health and Wellbeing Survey 2014, Qa Research

Figure 8 presents local binge drinking data. Consistent with figure 7 females were more likely than males to say that they rarely or never consumed 6 or more units in one sitting. Males were more likely than females to say that they consumed more than 8 units in one sitting 1-2 times per month or more often than this.

Additionally, amongst females, no difference in the proportion of BME respondents and those from white backgrounds that indicated they binge drink '1-2 times per week' or more often was recorded . However, this was not the case amongst male respondents where those from white backgrounds were more likely to binge drink.

Bracknell Forest survey data estimated that Bracknell Forest has a binge drinking rate of 23%.

Figure 8. Frequency of binge drinking in Bracknell Forest, 2014.



Source: Bracknell Health and Wellbeing Survey 2014, Qa Research

The Bracknell Health and Wellbeing survey has provided a number of advantages. It provided recent data and used a representative sample that allows for generalisations about the wider Bracknell Forest population. The data was also mapped by ward which has enabled targeted interventions and campaigns, such as the 'What's In Your Glass?' Drinkaware campaign.

KEY POINTS

Data shows that prevalence of OCU users was highest in Reading and Slough. This may be due to the higher number of deprived areas in these two LAs but it is surprising considering the lower aged population. OCU users *tend* to be older.

Reading had the highest proportion of binge drinkers and high risk drinkers across Berkshire.

Slough had the lowest percentage of self-reported binge drinkers and the second lowest percentage of self-reported higher risk drinkers. This could relate to the high number of Asian/British Asian residents in this area and the social stigma attached to this.

While alcohol prevalence data has been included, it remains out of date (2008/9). There is a clear gap in this data; a gap that in Bracknell Forest has been filled through Bracknell Forest Health and Wellbeing Survey 2014.

Ward level data allows mapping and targeting of services.

Chapter 3: Harm

Drug and alcohol related harm can take many forms. Although admission to hospital and mortality are the two aspects that spring to mind when discussing substance misuse, it is important to also consider a wider range of related harm. The relationships between substance misuse and mental health and substance misuse and crime are also considered as both still cause a level of harm to both the individual and to the community as a whole.

Drug mortality

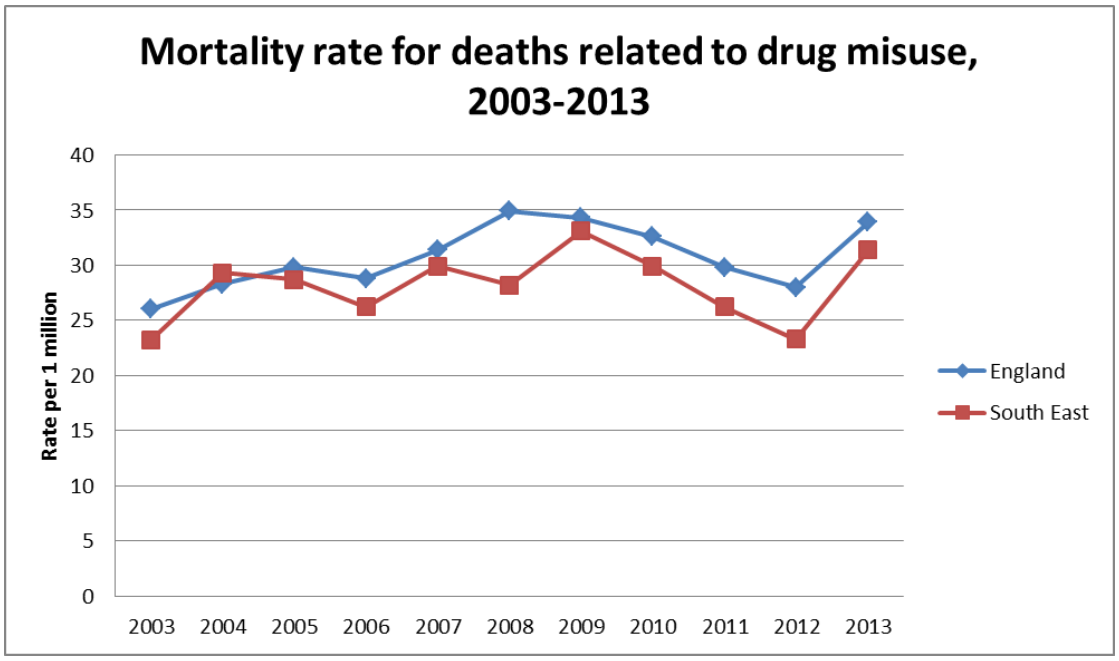
Drug use, and in particular drug dependence, is known to increase the rate of premature mortality. Nationally, nearly 1 in 7 deaths in people aged between 20 and 40 in 2013 were due to drug poisoning (Office for National Statistics, 2013). Accidental drug poisoning remains the most frequent cause of drug misuse death across all age groups (National Programme on Substance Abuse Deaths, 2013).

Data in figure 9 is shown at regional and national level. The South East average showed a similar trend to the national average between 2003-2013. Rates for deaths related to drug misuse appear to have steadily increased in England and the South East since 2003, with rates dropping down in 2012 but rising back up again in 2013. Despite this pattern, the fact the rate is per 1 million it is hard to draw a definitive trend from this data.

Definition

***Mortality rate for deaths related to drug misuse:** includes (a) deaths where the underlying cause is drug abuse or drug dependence, and (b) deaths where the underlying cause is drug poisoning and where any of the substances controlled under the Misuse of Drugs Act 1971 are involved (Office for National Statistics, 2013).

*Figure 9. Number of deaths and age-standardised mortality rate for deaths related to drug misuse, in South East and England, deaths registered between 2003–2013.**



Source: Office for National Statistics, 2014

Table 4 shows drug death rates at local level across Berkshire. From the data provided it appears that RBWM has the highest rate of drug deaths. However it should be noted that data for Reading, West Berkshire and Wokingham is not shown as Coroner's have been able to report these jurisdictions to the programme.

While the impact of these deaths to families and local communities is significant, the numbers are small in statistical terms and do not readily lend themselves to a valid, comparative analysis. An increase or decrease of 1 death could have a large influence on results. Therefore, conclusions should be drawn with caution.

*Table 4. Reported death rate per 100,000 for the Drug and Alcohol Action Team (DAAT) area for cases' usual area of residence.**

	Bracknell Forest	Reading	Slough	RBWM	West Berkshire	Wokingham
Drug death rate per 100,000	1.09	-	1.86	3.42	-	-

Source: National Programme on Substance Abuse Deaths, 2013

**It has to be acknowledged that there are some distinct differences between the definition of drug-related death used by NPSAD and that of "drug misuse" employed by Government departments to monitor trends in the effectiveness of the Government's Drug strategy. Whilst the main source of information for the Office for National Statistics is the medical certificate of death, supplemented by part V of the Coroner's Inquisition form, NPSAD receives detailed information from inquests with reports from various sources (including toxicology) to the Coroner to determine the cause of death and thus the verdict. Both sources of data are needed to obtain a fuller understanding of the nature of drug-related mortality in England, and the UK as a whole. (NPSAD, 2013).*

Alcohol mortality

Definition

Alcohol related mortality: deaths from alcohol related conditions (partially attributable conditions- appendix 1).

Alcohol specific mortality: deaths from alcohol specific conditions (wholly attributable conditions- appendix 1).

Haemorrhagic stroke: a stroke caused by a burst blood vessel in the brain.

Cardiac arrhythmias: abnormal heart rhythms

(User Guide: Local Alcohol Profiles for England, 2014)

Alcohol related deaths account for approximately 3% of deaths nationally. Approximately 1/3 of this 3% are deaths specific to alcohol, for example alcoholic liver disease or alcoholic poisoning. The remaining 2/3 are deaths where alcohol is a contributory factor. Examples of where alcohol contributes, at least in part, to mortality include haemorrhagic stroke (caused by a burst blood vessel in the brain), cardiac arrhythmias, self harm and road traffic accidents (Public Health England, 2014).

Figure 10 shows that the rate of alcohol related mortality in both males and females in all 6 LAs is comparable to the England average. The rate for males is higher than it is for females across Berkshire. It should be noted that due to small numbers confidence intervals are wide.

Figure 10 (i) Rate of alcohol related mortality in males across Berkshire, per 100,000 population, 2013.

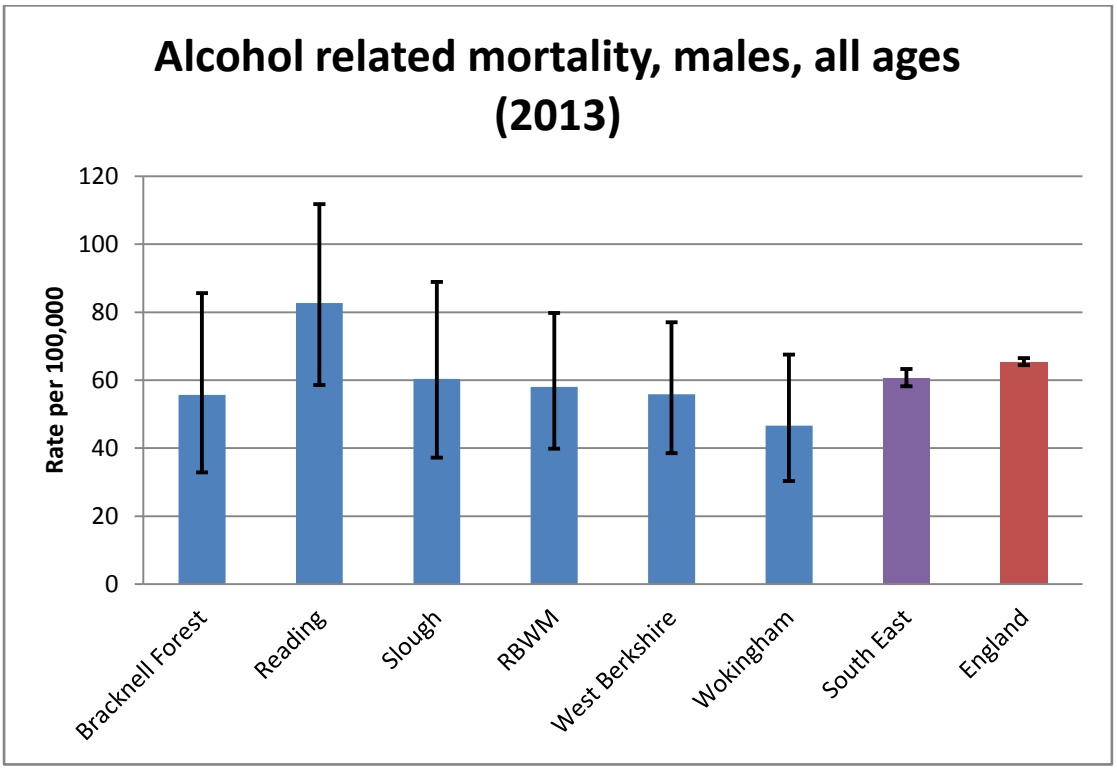
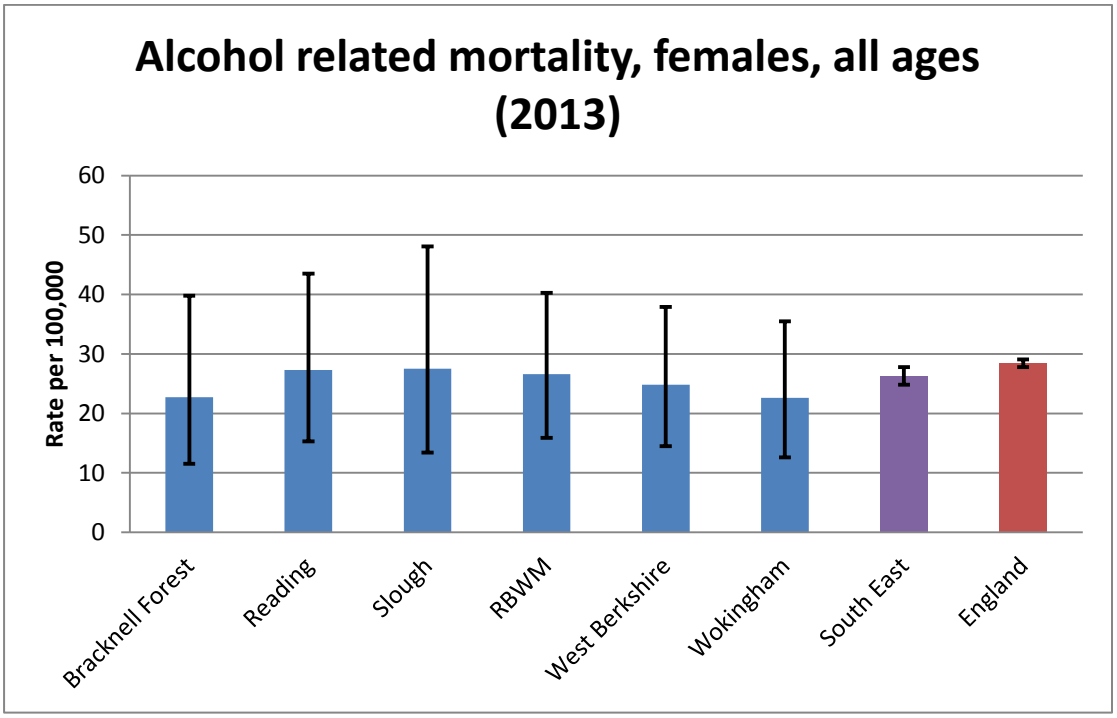


Figure 10 (ii) Rate of alcohol related mortality in females across Berkshire, per 100,000 population, 2013.

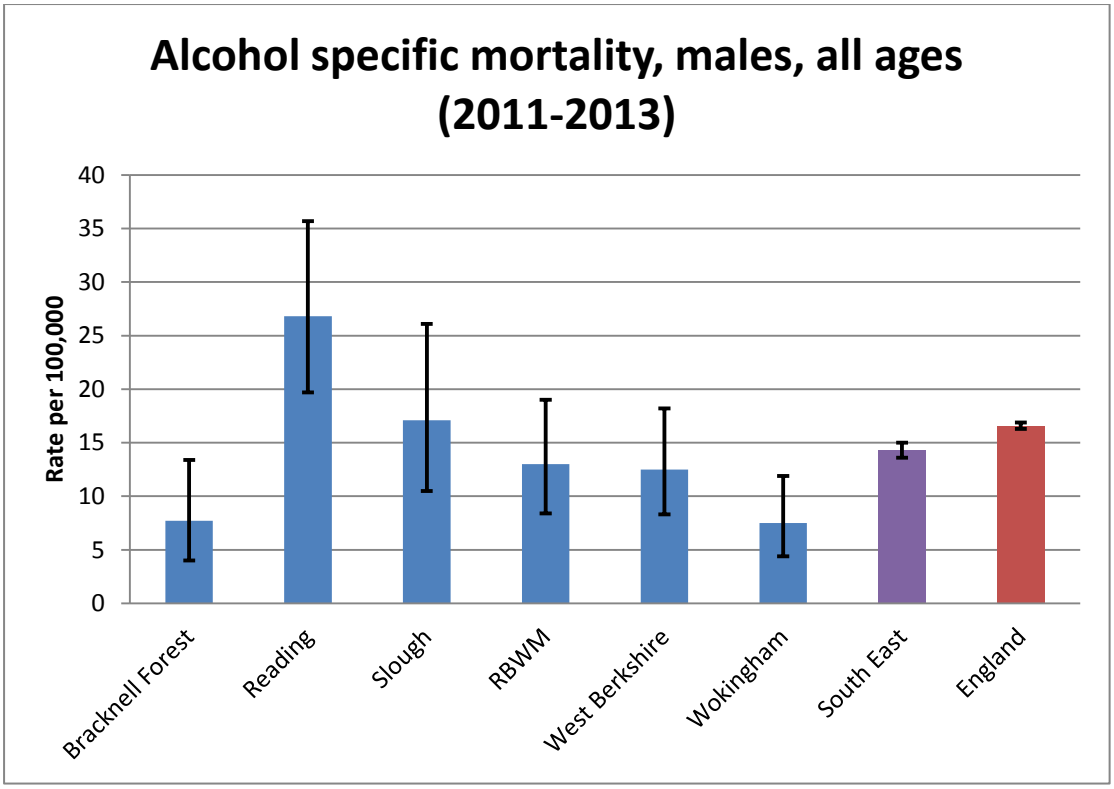


Source: Local Alcohol Profiles for England, Public Health England, 2015

Alcohol specific mortality for males (figure 11i) is above the statistically significantly higher than the national average in Reading. Slough, West Berkshire and RBWM show similar rates to the England average whilst Bracknell Forest and Wokingham are significantly lower.

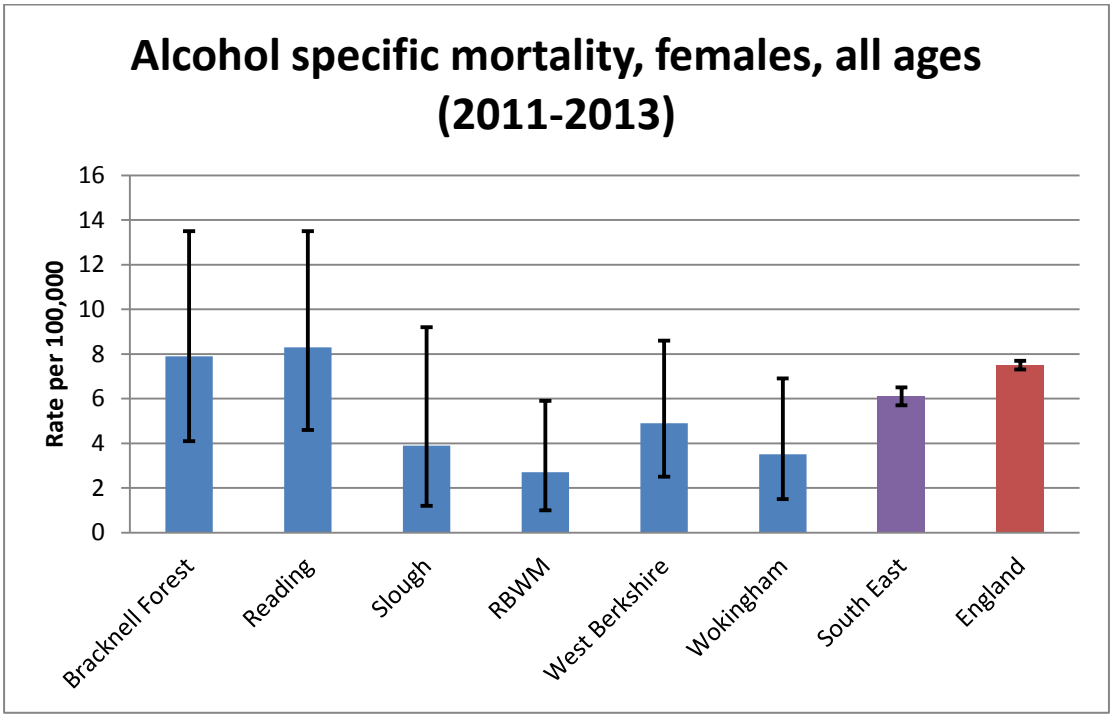
For women (figure 11ii), alcohol specific mortality is on the whole lower than for males. All rates are comparable to the national average with the exception of Wokingham and RBWM which are statistically significantly lower. Particularly of note is the rate for Bracknell Forest females which appears disproportionately high when compared to males, although confidence intervals are large and this is not statistically significantly different to the England average.

Figure 11(i): Rate of alcohol specific mortality in males across Berkshire, per 100,000 population, 2011-2013.



Source: Local Alcohol Profiles for England, Public Health England, 2015

Figure 11 (ii): Rate of alcohol specific mortality in females across Berkshire, per 100,000 population, 2011-2013.



Source: Local Alcohol Profiles for England, Public Health England, 2015

Hospital admissions for alcohol

Definition

Hospital admissions for alcohol-related conditions

Broad measure: Admissions to hospital where the primary diagnosis or any of the secondary diagnoses are an alcohol attributable code (Appendix 1), for the year 2012/13. Children aged less than 16 years were only included for alcohol-specific conditions and for low birth weight (Appendix 1). For other conditions, alcohol-attributable fractions were not available for children.

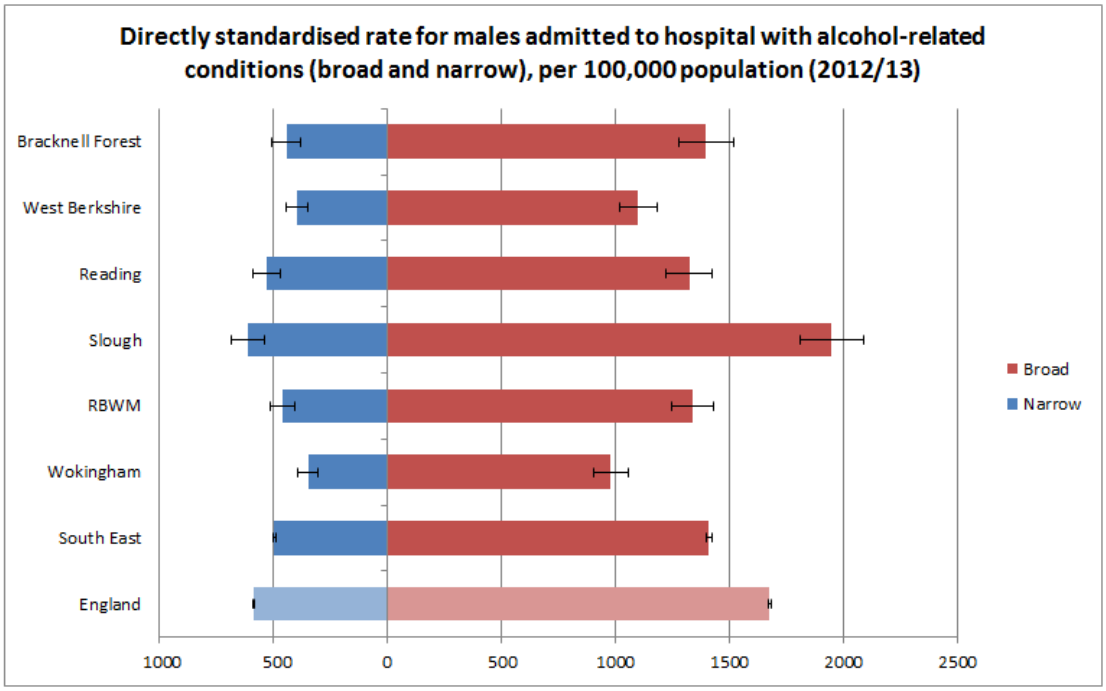
Narrow measure: Admissions to hospital where the primary diagnosis is an alcohol-attributable code (Appendix 1) or a secondary diagnosis is an alcohol-attributable external cause code (Appendix 1), for the year 2012/13. Children aged less than 16 years were only included for alcohol-specific conditions and for low birth weight (Appendix 1). For other conditions, alcohol-attributable fractions were not available for children.

(User Guide: Local Alcohol Profiles for England, 2014)

Males have far more admissions to hospital than females (figure 12). Wokingham has the lowest rates of hospital admissions for both males and females while Slough has the highest. Slough is the only authority with indicators above the national average. Although not statistically sound, given the alcohol prevalence data presented previously, Reading performs fairly well in relation to male and female hospital admissions.

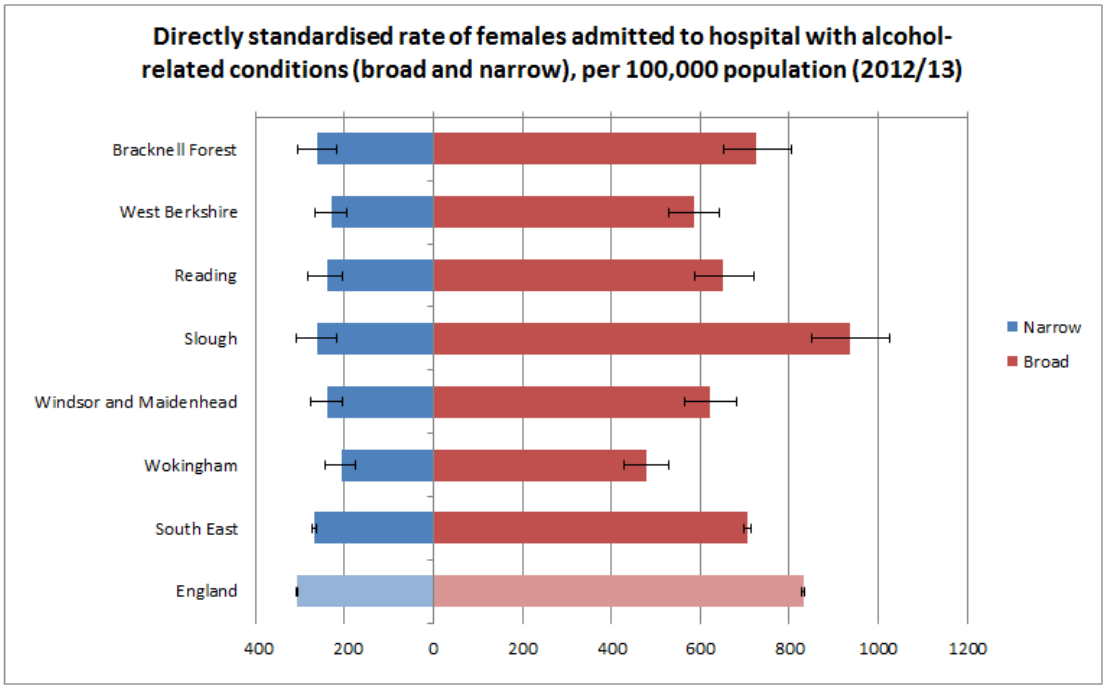
When comparing the 6 Berkshire LAs to 152 counties and LAs, Wokingham has the lowest rate of alcohol related admissions per 100,000 population, West Berkshire has the third lowest, Bracknell the sixth and RBWM the eighth (Public Health England, Healthier Lives).

Figure 12(i): Directly standardised rate of males admitted to hospital with alcohol-related conditions (broad and narrow), per 100,000 population (2012/13).



Source: Local Alcohol Profiles for England, 2014

Figure 12(ii): Directly standardised rate of females admitted to hospital with alcohol-related conditions (broad and narrow), per 100,000 population (2012/13).



Source: Local Alcohol Profiles for England, 2014

Alcohol specific hospital admissions

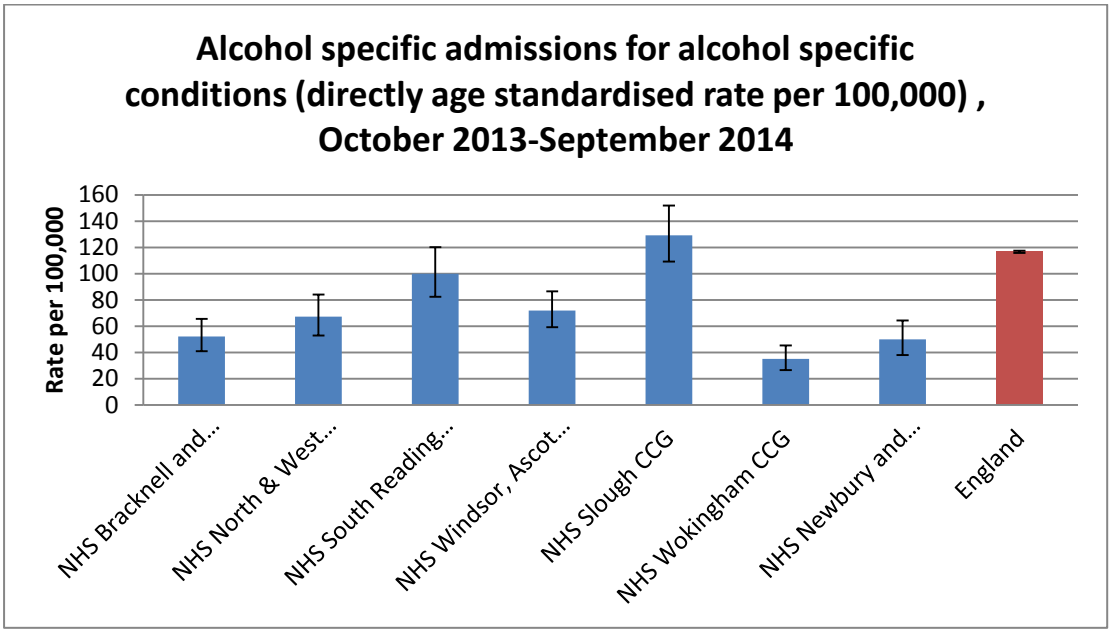
Definition

Alcohol specific admissions for alcohol specific conditions: admissions for conditions wholly attributable to alcohol (appendix 1).

Alcohol specific hospital admissions are measured when the condition is wholly attributable to alcohol.

Figure 13 shows that Slough CCG and South Reading CCG areas are comparable to the national average for alcohol specific admissions. All other areas are significantly lower than the national average (where lower is better).

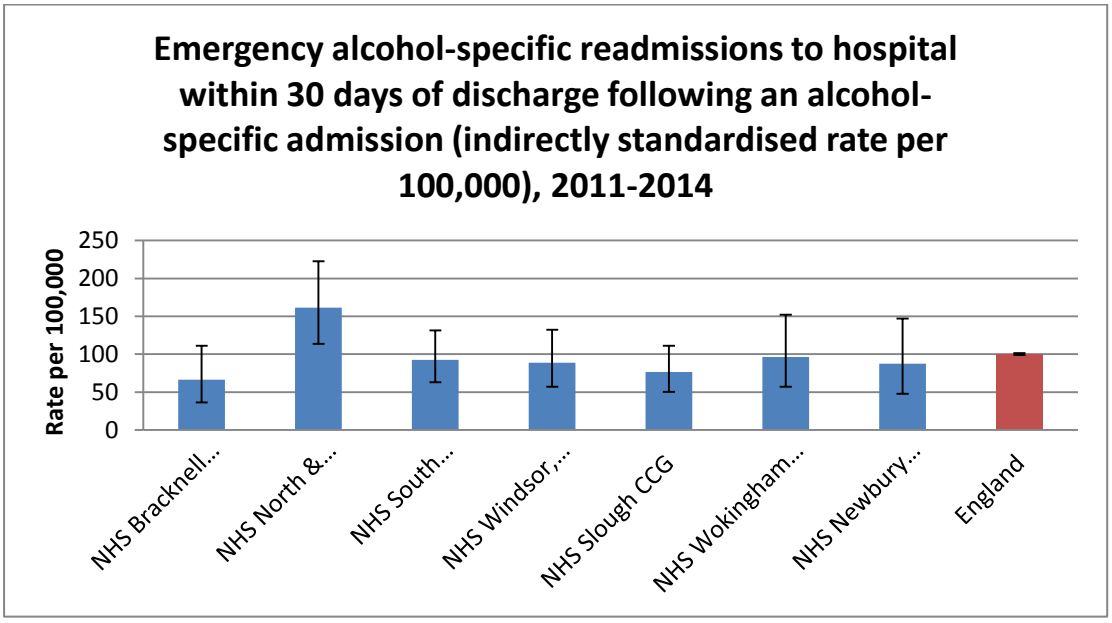
Figure 13. Alcohol specific admissions for alcohol specific conditions, October 2013- September 2014.



Source: Indicator Portal, Health and Social Care Information Centre, 2015

As seen in figure 14, for emergency alcohol specific readmissions to hospital within 30 days of discharge all CCG areas are similar to the national average except for North and West Reading CCG, which is statistically significantly higher at 161.1 per 100,000 population. This does not compare with their admission rates for alcohol specific conditions, which are significantly lower than the national average.

Figure 14. Emergency alcohol specific readmissions to hospital within 30 days of discharge following an alcohol specific admission, 2011-2014.



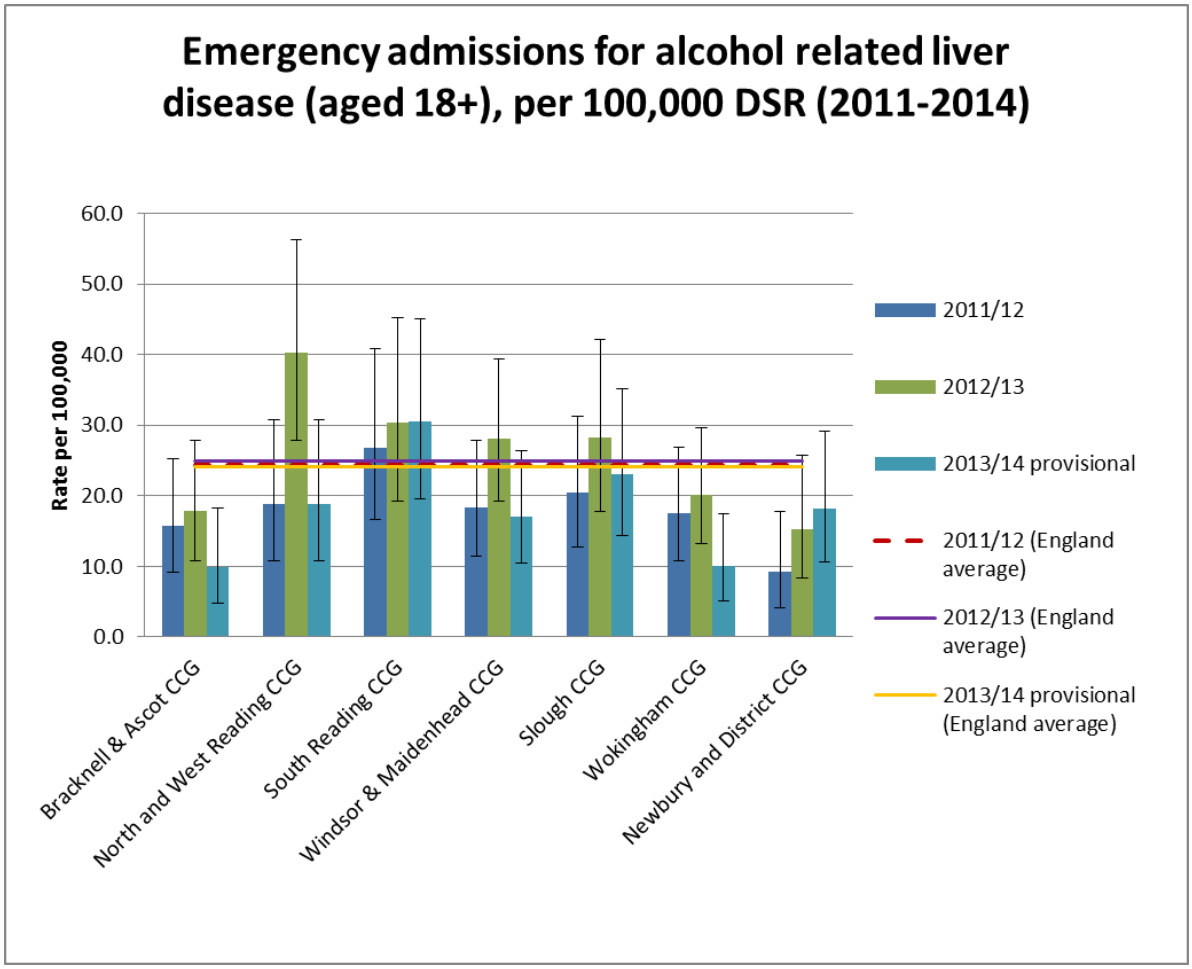
Source: Indicator Portal, Health and Social Care Information Centre, 2015

Figure 15 shows emergency admission rates for alcohol related liver disease. The only rate that has been statistically significantly higher than the national average over the last 3 years is North and West Reading CCG area in 2012/13. Provisional data for 2013/14 shows that both Bracknell and Ascot CCG area and Wokingham CCG area were statistically significantly lower than the national average.

Since 2011/12 rates in the Newbury and District CCG area and South Reading CCG area appear to have increased with Newbury and District CCG area rates doubling in this period, although again none of these figures are significantly higher than the national average. The remaining 5 CCG areas showed a peak in rates in 2012/13 and have all decreased slightly since then.

The interpretation of this data should be treated with caution due to the small numbers of admissions. This makes the data liable to change. An example of this is North and West Reading CCG, which doubles from 2011/12 to 2012/13 and then halves between 2012/13 and 2013/14 (provisional). In addition, confidence intervals are fairly wide, highlighting the possibility of wide variation from the data shown.

Figure 15. Emergency admissions for alcohol related liver disease, directly standardised rate for over 18s per 100,000 population.*



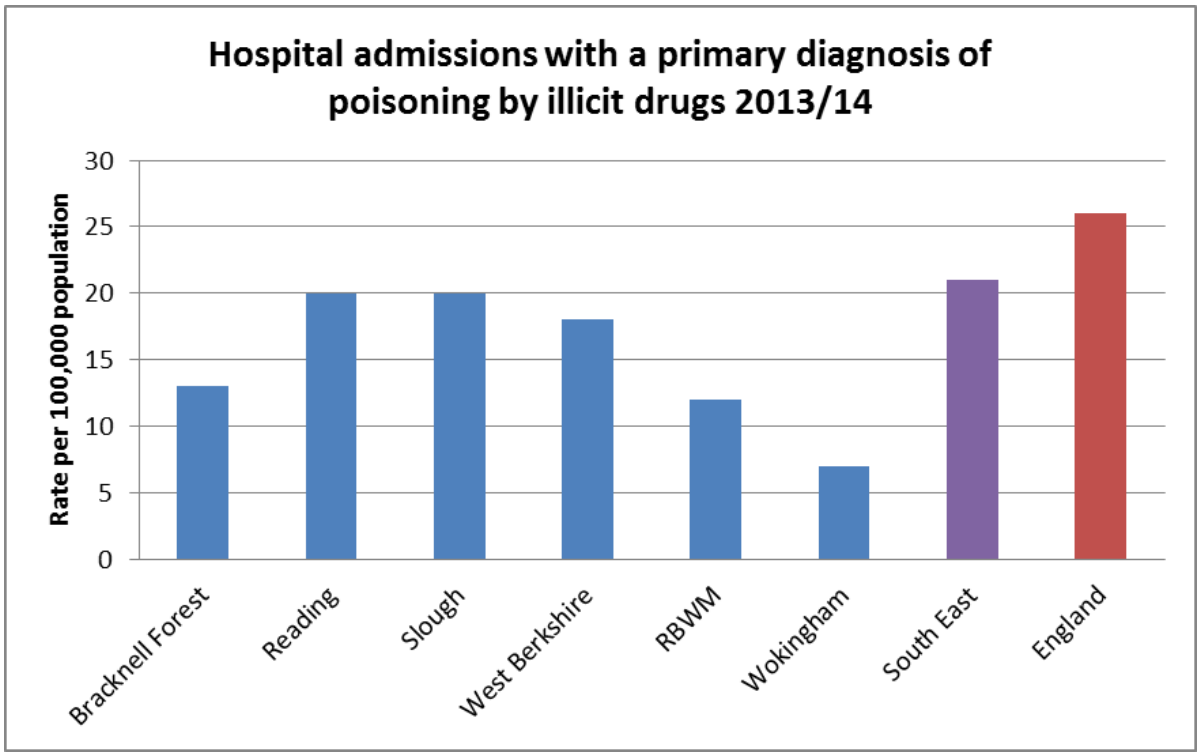
Source: Health and Social Care Information Centre, 2015

**Admissions' refers to the total number of emergency finished admission episodes. Please note that these data should not be described as a count of people as the same person may have been admitted on more than one occasion.*

Hospital admissions for drug use

The rate of hospital admissions for poisoning by illicit drugs is lower than both the South East average and national average in all 6 LAs (figure 16). Reading and Slough show the highest rates followed by West Berkshire, which appears to be disproportionately high when compared to drug prevalence data presented previously. However the small numbers should be considered when analysing this data.

Figure 16. NHS hospital admissions with a primary diagnosis of poisoning by illicit drugs[4], by Local Authority, 2013/14.



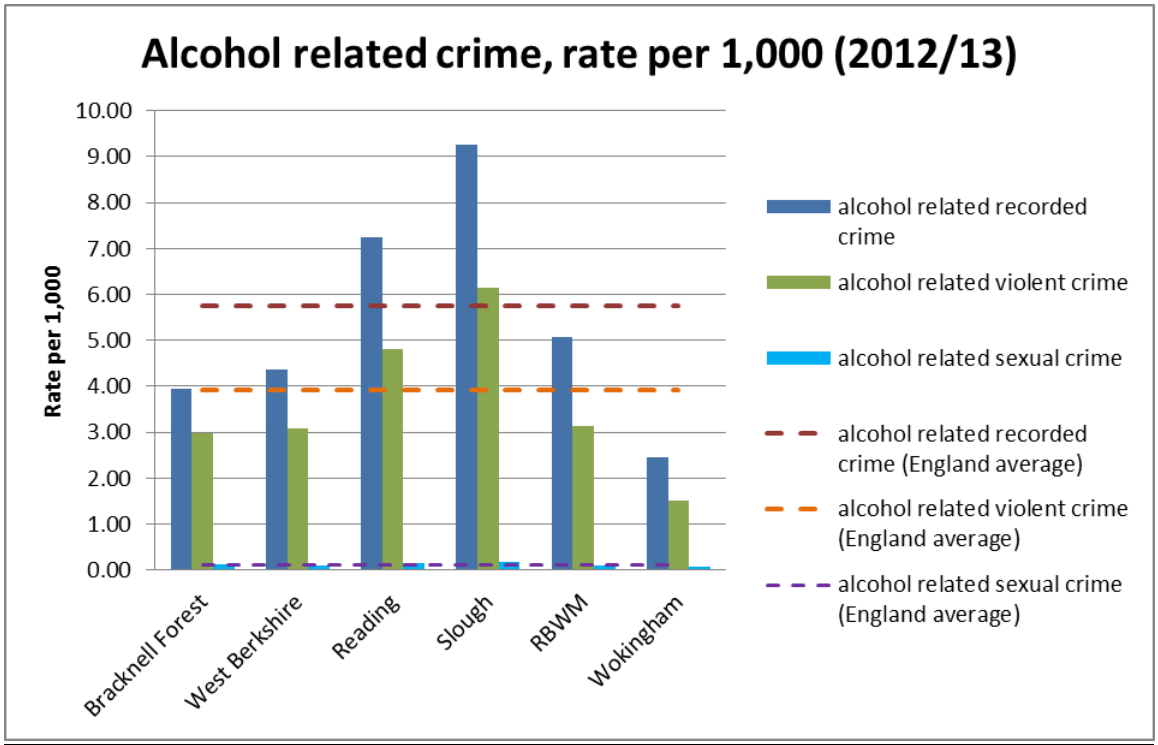
Source: Hospital Episode Statistics, Health and Social Care Information Centre

Crime

Figure 17 shows that Slough has the highest rate for alcohol related recorded crimes, sexual crimes and violent crimes within Berkshire, all of which are above the national average. This is followed by Reading in which all 3 indicators are again above the national average. It is therefore suggested that focus is needed in Reading and Slough on the prevention of alcohol related crime.

Alcohol related sexual crime rates remain low across all of Berkshire, with all LAs showing similar rates to the national average.

Figure 17. Alcohol related crime rates per 1000 population across Berkshire, 2012/13.

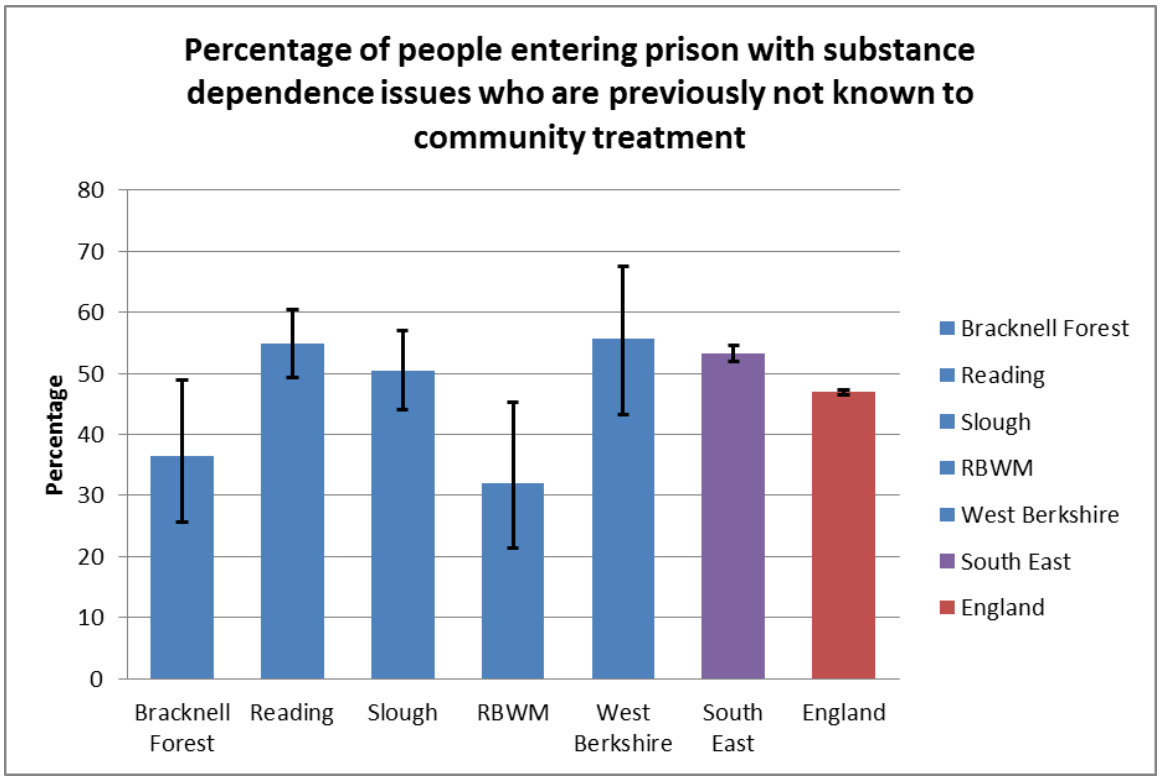


Source: Local Alcohol Profiles for England, 2014

**Alcohol related crime rates include 6 offences: violence against a person, sexual offences, robbery, burglary dwelling, theft of a motor vehicle and theft from a motor vehicle. Alcohol related violent crimes and alcohol related sexual crimes are therefore included in alcohol related recorded crime rates.*

Figure 18 shows the percentage of people entering prison with substance misuse issues who are not previously known to treatment services. Reading is the only area with a percentage statistically significantly higher than the England average while RBWM is statistically significantly lower than both the South East and the England average. Bracknell Forest is statistically significantly lower than the South East average but similar to England. The remaining LAs are similar to both. Wokingham has not been included in figure 18 as data is currently not available on the Public Health Outcomes Framework. This is due to small numbers.

Figure 18. Proportion of people assessed for substance dependence issues when entering prison who then required structured treatment and have not already received it in the community, 2012/13.



Source: Public Health Outcomes Framework, 2012/13

Mental health and substance misuse

Direct indicators of dual diagnosis are currently largely unavailable. However, mental health problems are very common among those in treatment for substance misuse.

Definition

Dual diagnosis: a person received a dual diagnosis when they have a severe mental illness and substance misuse is present.

Direct measures of dual diagnosis are unavailable. Figures are available for the percentage of people who have concurrent contact with mental health service and substance misuse services. Any interpretation of these figures should be considered with care as it is likely that they are as much of an indicator of the robustness of pathways between substance misuse and mental health services as they are rates of dual diagnosis in an area.

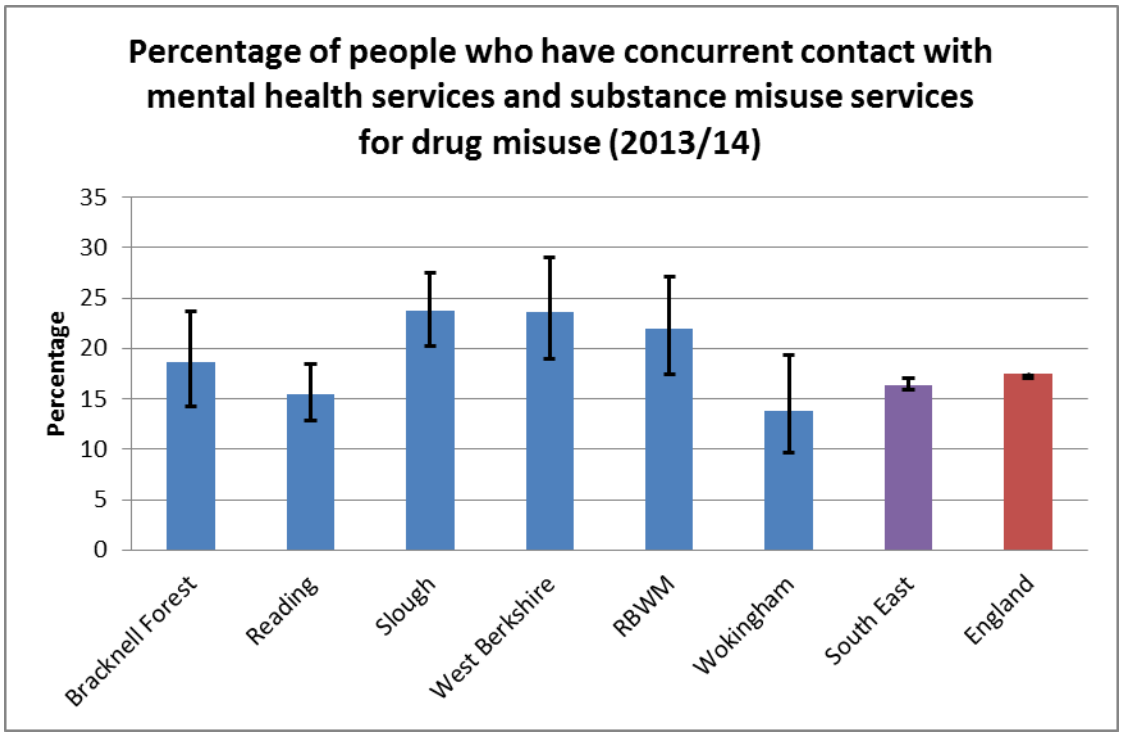
Although dual diagnosis is usually given to people who are misusing substance and have a severe mental illness, this indicator may include common mental health disorders as well. It's also important to remember that

dual diagnosis data can be easily influences by recording practices in individual areas.

Discussions with DAAT leads has shown that people who have concurrent contact with services find it hard to access specialist mental health treatment whilst substance misuse is an issue. It is often expected that a person is treated for substance misuse prior to being treated for mental illness.

Higher concurrent contact is generally seen as being better, however further information is however required to understand the differences in areas. Figure 19 shows that Slough, West Berkshire and RBWM have the highest proportion of people who have concurrent contact with mental health services and drug misuse services, of which all 3 areas are statistically signficantly higher than both the South East and England average. Reading is particularly low especially when considering high concurrent contact for those with alcohol misuse, however it still remains similar to the South East and national average.

Figure 19. Number of individuals who received treatment at a specialist drug misuse service and were currently in receipt of treatment from mental health services for a reason other than substance misuse at the time of assessment, as a proportion of all individuals in specialist drug misuse services, 2013/14.

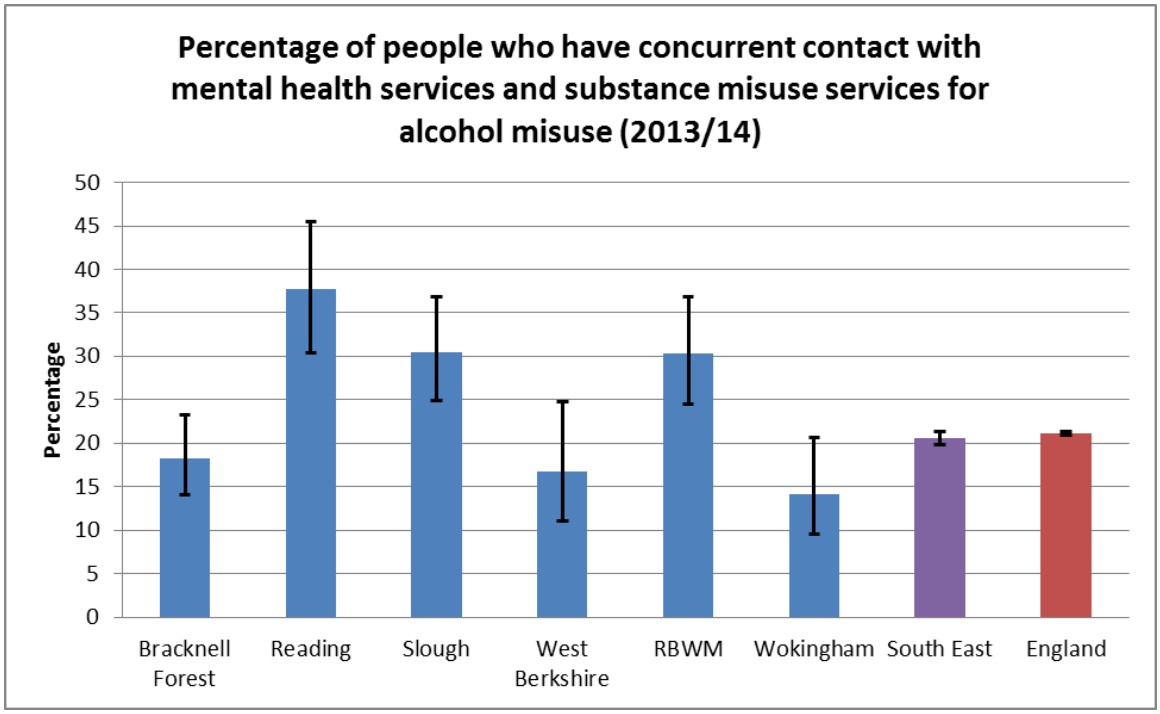


Source: Public Health England, 2014

Similar to concurrent contact for drug misuse higher rates in figure 20 are considered better. Again Slough and RBWM show a statistically significantly higher proportion of people who have concurrent contact with mental health services and alcohol misuse services than the South East and England

average. Unlike with drug misuse services, however, West Berkshire is not significantly different, but instead Reading is. Wokingham is similar to the South East but statistically significantly lower than England.

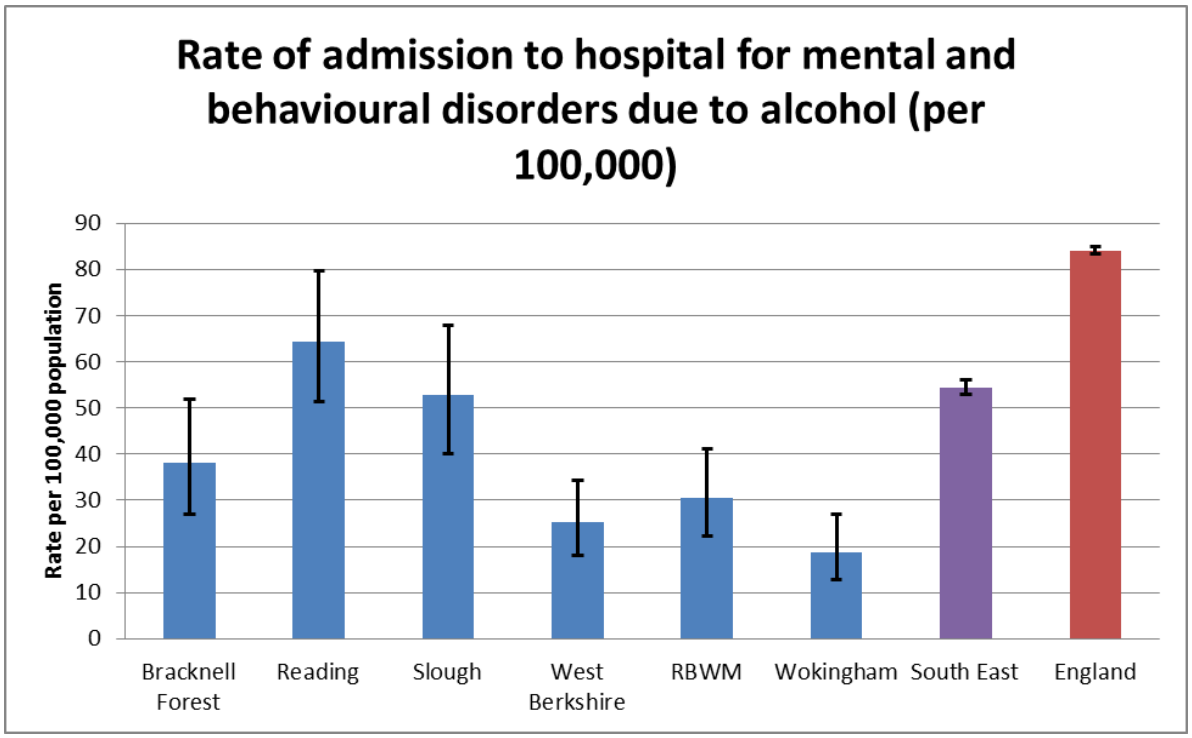
Figure 20. Number of individuals who received treatment at a specialist alcohol misuse service and were currently in receipt of treatment from mental health services for a reason other than substance misuse at the time of assessment, as a proportion of all individuals in specialist alcohol misuse services, 2013/14.



Source: Public Health England, 2014

All 6 LAs are statistically significantly lower than the England average for hospital admissions for mental health and behavioural disorders due to alcohol (figure 21). Only Reading and Slough are similar to the South East average with the remaining 4 LAs statistically significantly lower.

Figure 21. The number of admissions involving a primary diagnosis of a mental or behavioural disorder due to alcohol, per 100,000 population (age standardised), 2013/14.



Source: Public Health England, 2014

Latest data from the Public Health England JSNA Support Packs (2015/16) shows the percentage of DAAT clients who are currently receiving care from mental health services for reasons other than alcohol misuse:

- 18% in Bracknell Forest
- 35% in Reading
- 31% in Slough
- 17% in West Berkshire
- 30% in RBWM
- 14% in Wokingham

Reading, Slough and RBWM all show rates that are higher than the national average of 21%. This demonstrates the complexity of the needs that clients entering into treatment services have.

KEY POINTS

Drug misuse death rates are low in Berkshire. Data for Reading, West Berkshire and Wokingham is currently missing.

Both alcohol related mortality and alcohol specific mortality rates are higher for males than they are for females across Berkshire.

Alcohol specific mortality rates for males are statistically significantly higher than the England average in Reading and statistically significantly lower in Wokingham and Bracknell. Wokingham, along with RBWM, is also statistically significantly lower for female rates.

Males have more admissions to hospital for alcohol related conditions than females. Wokingham has the lowest rates of hospital admissions for both males and females while Slough has the highest.

North & West Reading CCG area have a hospital admission rate for alcohol specific conditions that is significantly lower than the national average. For readmissions within 30 days, however, this area is statistically significantly higher.

Provisional data shows that hospital admission rates for alcohol related liver disease were statistically significantly lower than the national average in both Bracknell and Ascot CCG area and Wokingham CCG area during 2013/14.

Reading and Slough show the highest hospital admission rates for drugs followed by West Berkshire. West Berkshire appears disproportionately high when compared to drug prevalence data presented previously. This could potentially be explained by low reach rates (lowest for opiates in Berkshire).

Reading and Slough are significantly higher than the national average for all 3 crime related indicators.

Reading is the only LA that is significantly higher than the England average for the proportion of people entering prison with a substance misuse issue who are not previously known to treatment services. RBWM is statistically significantly lower than both the South East and England averages.

West Berkshire, RBWM and Bracknell Forest are all statistically significantly higher than the regional and national average for the proportion of people who have concurrent contact with mental health services and drug misuse

services.

Wokingham is statistically significantly lower than the England average for the proportion of people who have concurrent contact with mental health services and alcohol misuse services.

Reading has a low proportion of people who have concurrent contact with mental health services compared to those in contact with mental health services and alcohol misuse services.

All LAs in Berkshire are lower than the England average for the rate of hospital admissions for mental and behavioural disorders due to alcohol.

Chapter 4: Treatment, treatment outcomes and service provision

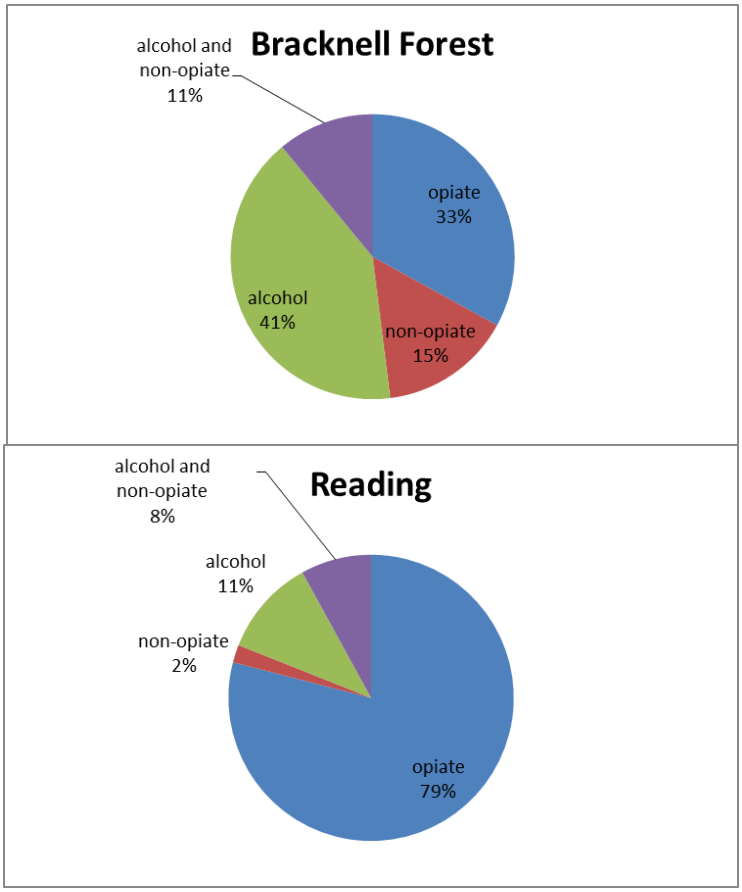
All in treatment

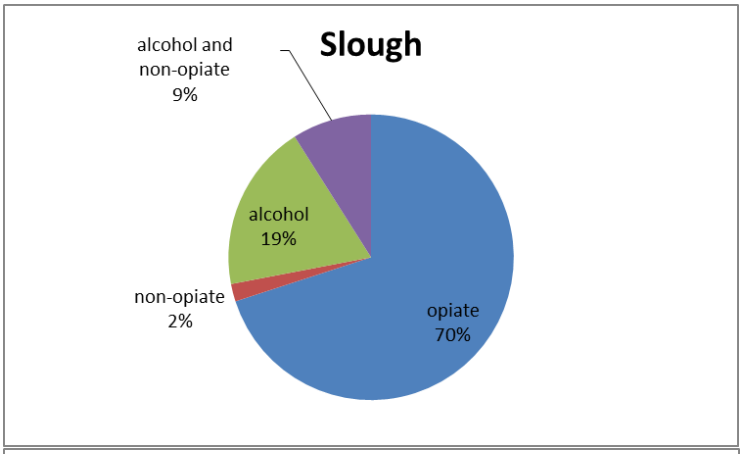
From figure 22 we can see that in comparison to other Berkshire LAs Bracknell Forest has a much higher percentage of it's in treatment population accessing treatment for alcohol (41%). The remaining 5 LAs range from 11 – 31% for treatment for alcohol. This further highlights the unreliability of alcohol prevalence data, which does not present Bracknell as having a particularly excessive higher drinking population.

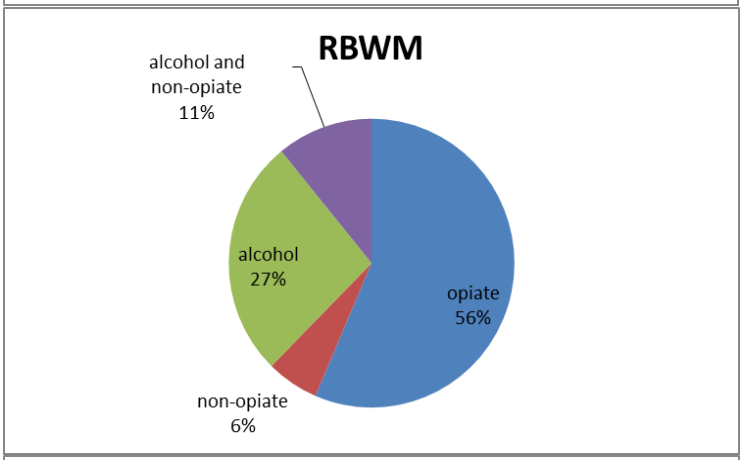
Bracknell Forest also shows a higher percentage of people in treatment for non-opiate drugs than the other LAs in Berkshire. The remaining 5 LAs have a considerably larger percentage of people in treatment for opiates, with Reading being the highest for this. This reflects the estimated prevalence figures for opiate users.

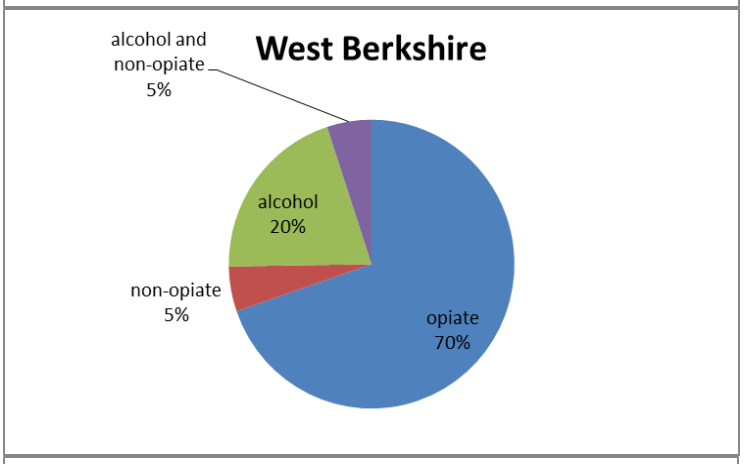
The high percentage of non-opiate and alcohol users in Wokingham, Bracknell Forest and RBWM could be explained by relative affluence when compared to Reading and Slough.

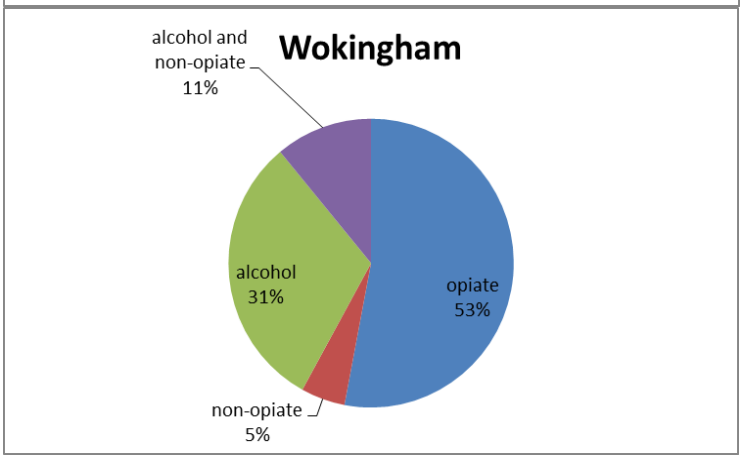
Figure 22. Percentage of all in treatment, year to date.











Source: Adult Partnership Activity Reports, PHE, Q2 2014/15

Table 5 makes the Bracknell Forest anomaly more apparent. Bracknell Forest has around 3 times more people in alcohol treatment per 100,000 population than Reading. This could be due to how different LAs proportion their drug and alcohol spending. For example Bracknell Forest spend more than Reading on alcohol treatment.

Table 5. Alcohol treatment rates per 100,000 population.

	Bracknell Forest	Reading	Slough	RBWM	West Berkshire	Wokingham
People in alcohol treatment per 100,000	158	53	98	85	55	58

Source: Adult Partnership Activity Reports, PHE, Q2 2014/15 & Mid-year population estimates 2013, ONS

The rate of people in opiate treatment compared to the estimated opiate using population (reach rate) varies by area, as shown in table 6. Bracknell Forest has the smallest gap between those in treatment and the estimated population. Slough and Reading have the largest gap in numerical terms; however Wokingham has the largest gap in percentage terms. These calculations should be used with caution as they are being plotted against an estimated prevalence figure.

Table 6. Opiate estimated prevalence, treatment population and reach rate.

	Bracknell Forest	Reading	Slough	RBWM	West Berkshire	Wokingham
People in opiate treatment per 100,000	124	397	360	180	191	100
Estimated opiate drug user population per 100,000	223	1020	951	460	526	335
% in opiate treatment compared to estimated (reach rate)	56	39	38	39	36	30

Source: Adult Partnership Activity Reports, PHE, Q2 2014/15 & Mid-year population estimates 2013, ONS

There is currently no data for non-opiate prevalence estimates, therefore the rate of treatment reach for non-opiates cannot be shown.

BME drug treatment population

Table 7 shows the proportion of BME people in drug treatment in comparison to the general population. It is clear that BME populations are underrepresented in drug services in Berkshire. This gap is proportionately largest in Bracknell Forest and Wokingham.

Table 7. BME service population for drugs in comparison to overall population

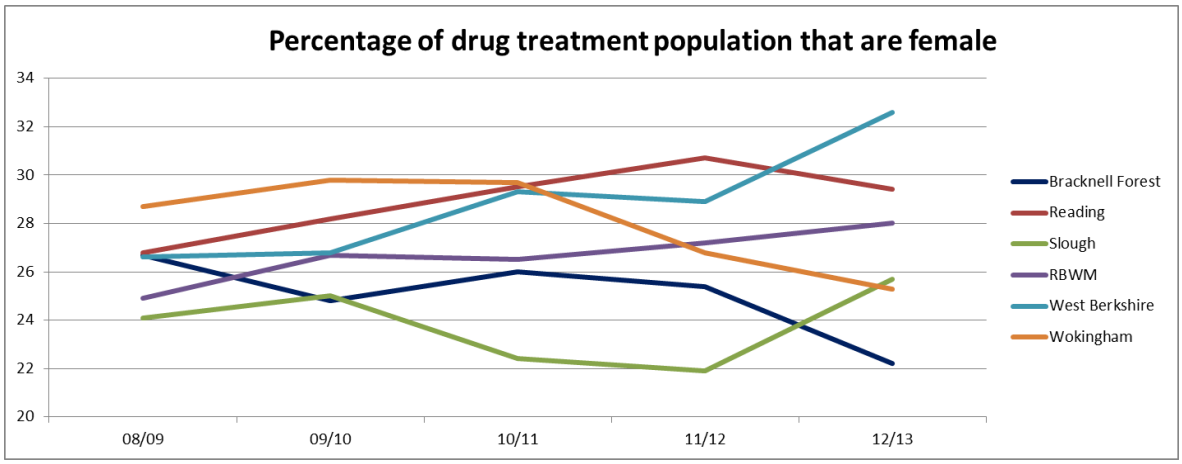
	12/13 BME service population (%)	18+ (%) population BME
Bracknell Forest	2.2	10.9
Reading	14.3	23.3
Slough	36.6	50.8
RBWM	6.2	13.2
West Berkshire	1.9	5.4
Wokingham	2.7	11.6
England	10.5	14.6

Source: National Drug Treatment Monitoring System 'View It' data

Female drug treatment population

Figure 23 shows the percentage of people in drug treatment who are female over time. Most recent data shows that West Berkshire has the highest percentage with Bracknell Forest having the lowest. Rate has remained fairly constant over the past 5 years, with Bracknell Forest showing the largest decline, followed by Wokingham. The remaining 4 LAs have seen a slight increase, with West Berkshire showing the largest increase.

Figure 23. Percentage of drug treatment population that are female.

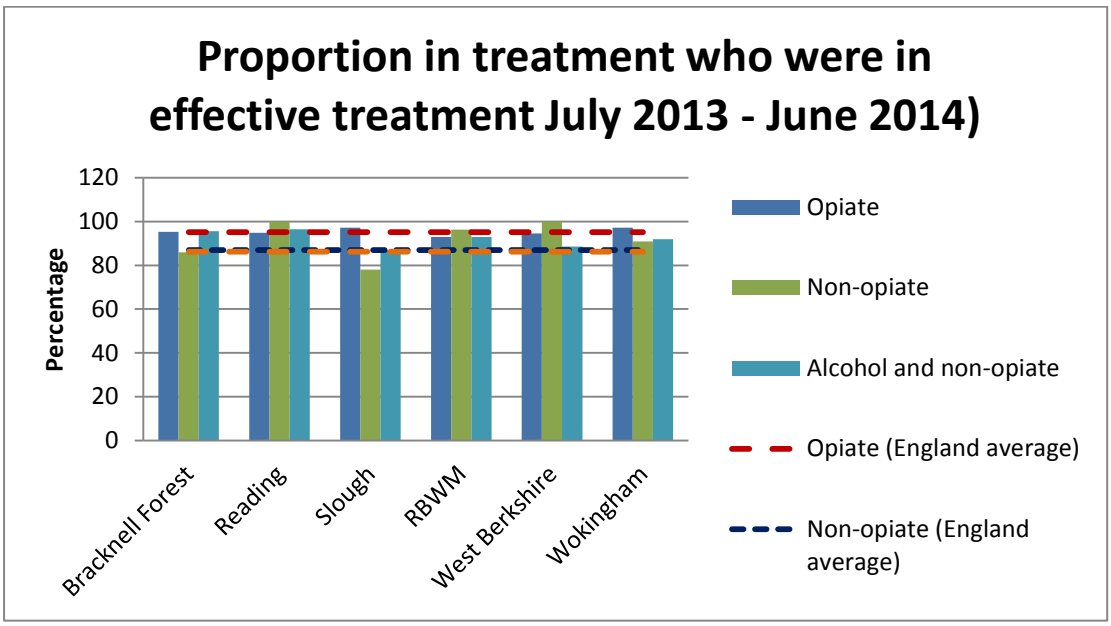


Source: National Drug Treatment Monitoring System 'View It' data

Effective treatment

Those in effective treatment for opiate, non-opiate and alcohol and non-opiate is fairly consistent across Berkshire and is comparable to the national average (figure 24). People in non-opiate treatment in Slough have the lowest rate of effective treatment, however numbers of people in non-opiate treatment are small so fluctuation is to be expected.

Figure 24. Proportion of clients in effective treatment (1/7/13 – 20/6/14).



Source: Diagnostic Outcomes Monitoring Executive Summary, 2014/15

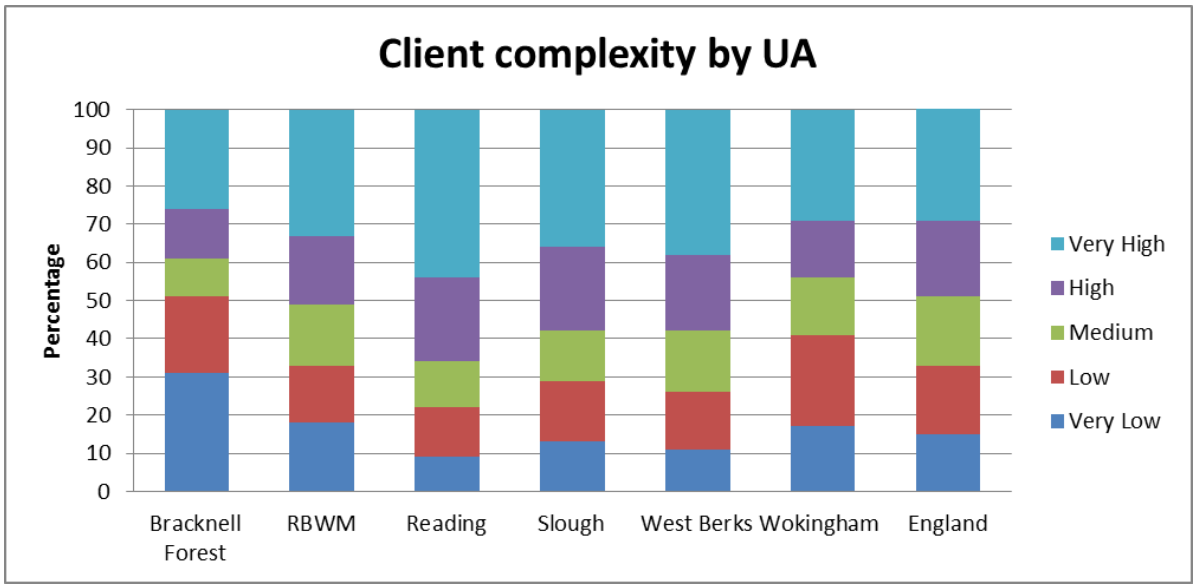
Client complexity

Client complexity is calculated using a case mix statistical model to segment clients according to complexity and predicted successful outcomes e.g. abstinence and moving onto stable accommodation. The following factors influencing outcomes were analysed to develop a risk scale;

1. Abstinence from problem substance
2. Injecting cessation
3. Housing problem resolution
4. Self-reported improvement in quality of life
5. Successful completion of treatment
6. Non-representation within one year

The higher the score the higher the risk a client would not achieve a successful outcome. Figure 25 shows how client complexity differs between LAs. Reading followed by West Berkshire and Slough have the highest proportion of 'very high' and 'high' complexity levels.

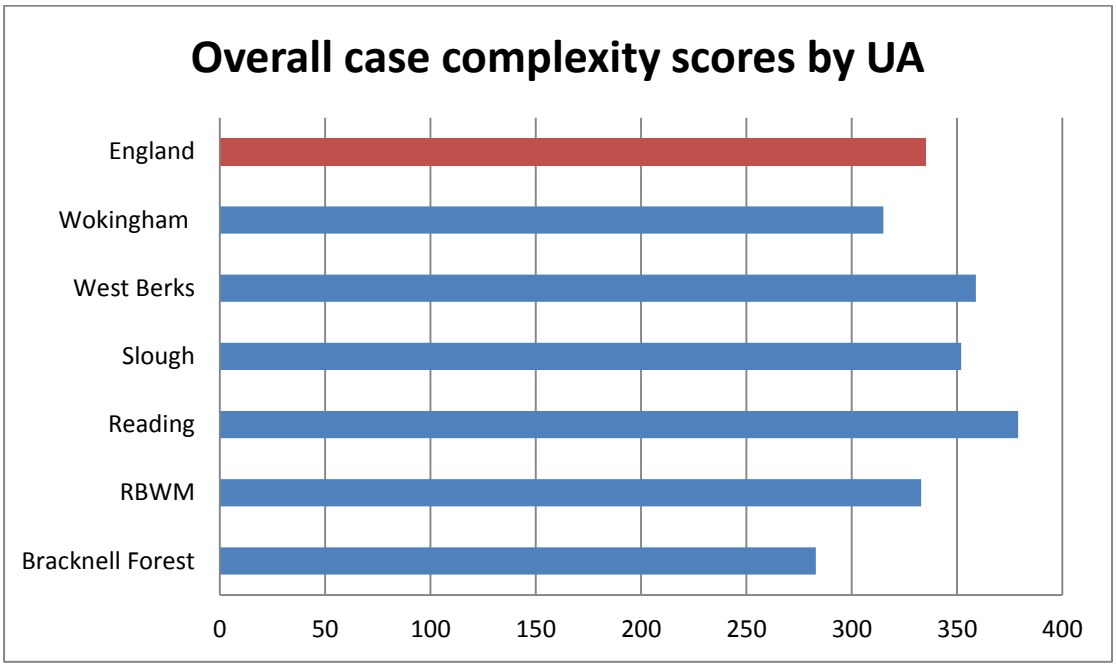
Figure 25. Proportion of clients who fall within each of the 5 complexity levels for each LA.



Source: VFM/CET tool

Figure 25 gives a detailed breakdown of each complexity level in each LA, whereas figure 26 gives a simplistic representation of overall complexity burden in each LA. It is important to note that this is a ranking of complexity and is not a true reflection. Figure 26 was calculated by assigning each LA with a points scale (1-5) for each of the 5 levels of complexity. Reading and West Berkshire have the highest overall client complexity followed by Slough. Bracknell Forest has the least complex client population according to this data.

Figure 26. Overall case complexity score by LA.



Source: Adapted from VFM/CET tool

Table 8 shows completion rate by varying complexity levels at LA level. General performance is good; however certain completion rates should be highlighted. Bracknell Forest has low completion rates of very low complexity considering the good performance across other complexity levels. West Berkshire and Wokingham are considerably lower than Berkshire and the England average for low and medium complexity.

Table 8. Percentage of successful completions by complexity level across Berkshire, 2013/14.

	Very Low	Low	Medium	High	Very High
Bracknell Forest	40	25	29	13	10
RBWM	47	29	31	7	9
Reading	55	22	11	11	4
Slough	58	30	24	16	7
West Berkshire	55	12	9	12	4
Wokingham	50	12	10	6	9
England	46	21	15	9	5

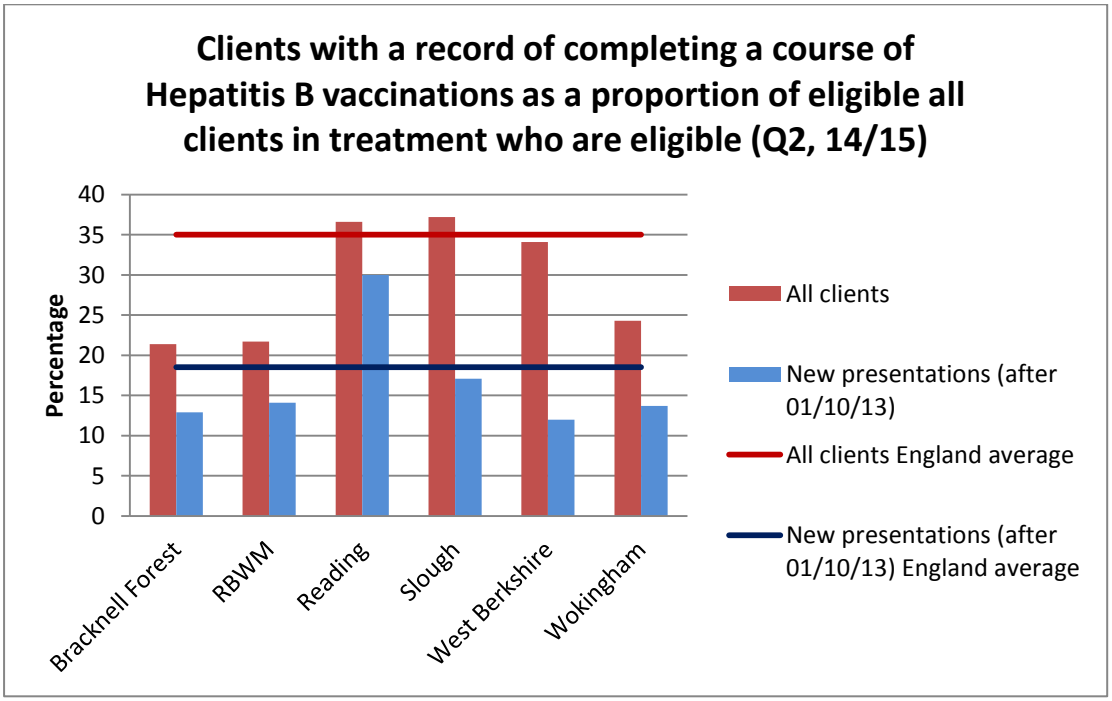
Source: Adapted from VFM/CET tool

Blood-borne viruses

Whilst, as would be expected, all areas in figure 27 show a higher percentage of all eligible clients having received a course of Hepatitis B vaccinations (HBV) as opposed to the percentage of new clients who are eligible for vaccinations the difference between the two groups is highest in Slough and West Berkshire.

The number of clients with a record of completing a course of HBV vaccinations as a proportion of the total number of clients in treatment is below the national average in all LAs except Reading and Slough.

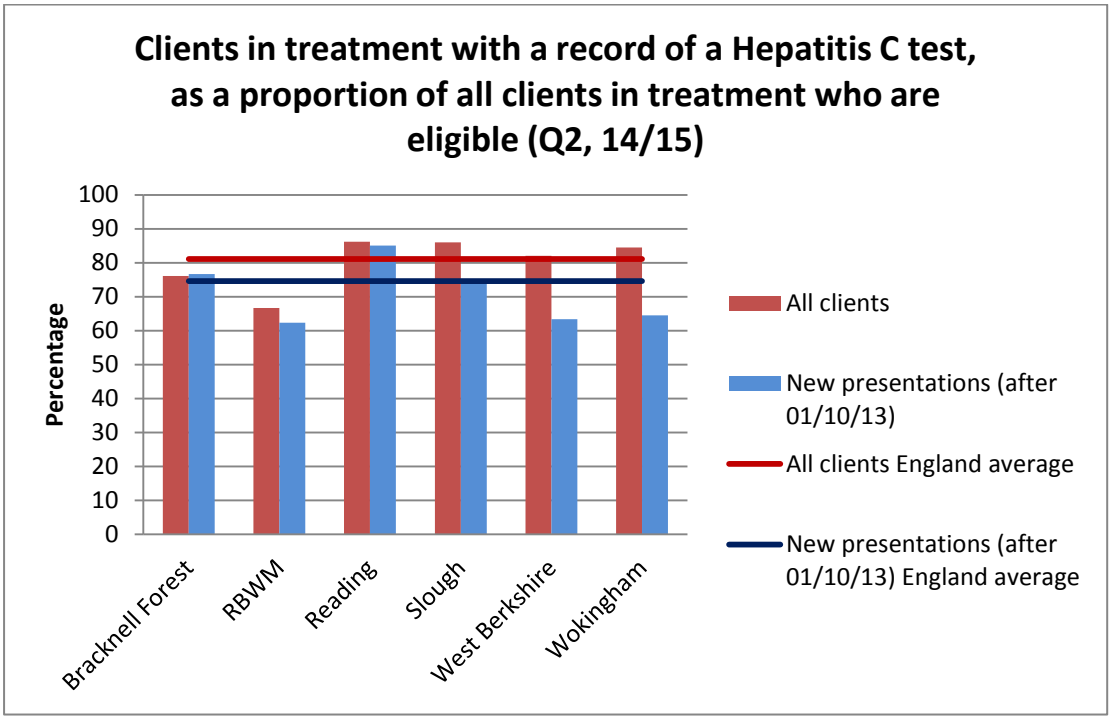
Figure 27. Clients with a record of completing a course of HBV vaccinations as a proportion of eligible clients in treatment.



Source: National Drug and Treatment Monitoring System, 2014

Again, all areas in figure 28 show a higher percentage of all eligible clients having received a HCV test as opposed to the percentage of new clients who are eligible for vaccinations, except for Bracknell Forest which shows a slightly higher percentage of new clients than all clients. The difference between the two groups is highest in Wokingham and West Berkshire.

Figure 28. Clients with a record of a HCV test as a proportion of all clients in treatment who are eligible.

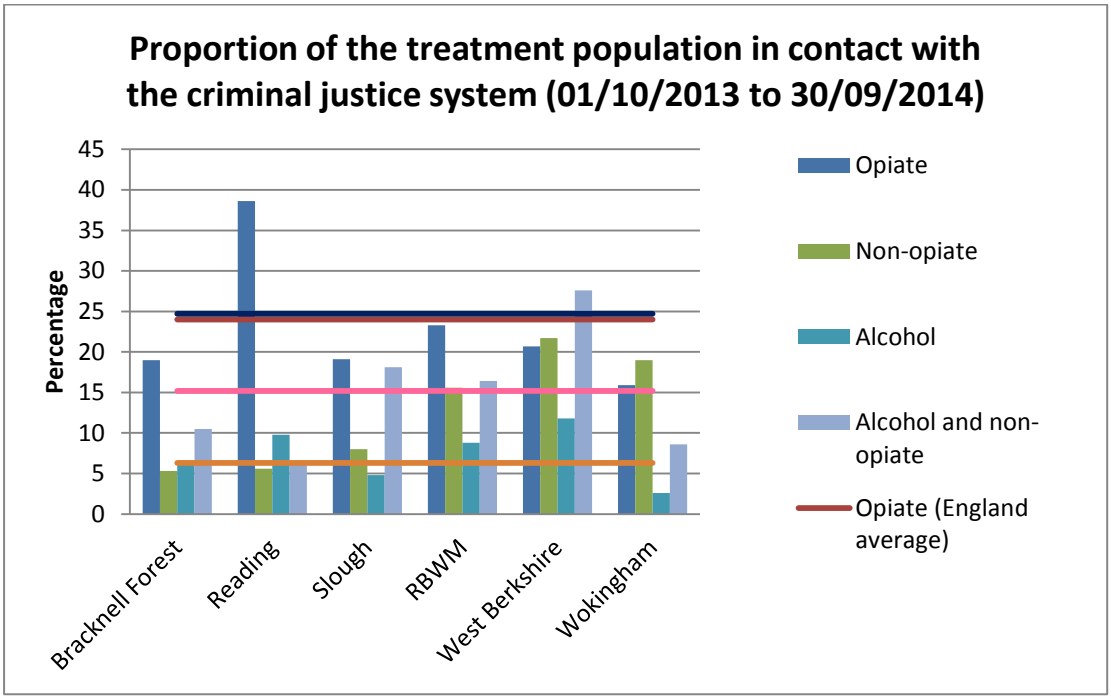


Source: National Drug and Treatment Monitoring System, 2014

Substance misuse treatment and the criminal justice system

The proportion of treatment population for opiates in contact with the criminal justice system in Berkshire is below the national average for all LAs, with the exception of Reading which shows a much higher rate (figure 29). Reading, RBWM and West Berkshire have a higher proportion of people in treatment for alcohol who are in contact with the criminal justice system. Slough, RBWM and West Berkshire have a higher proportion of people in treatment for alcohol and non-opiate who are in contact with the criminal justice system.

Figure 29. Proportion of the drug and alcohol treatment population in contact with the criminal justice system across Berkshire.

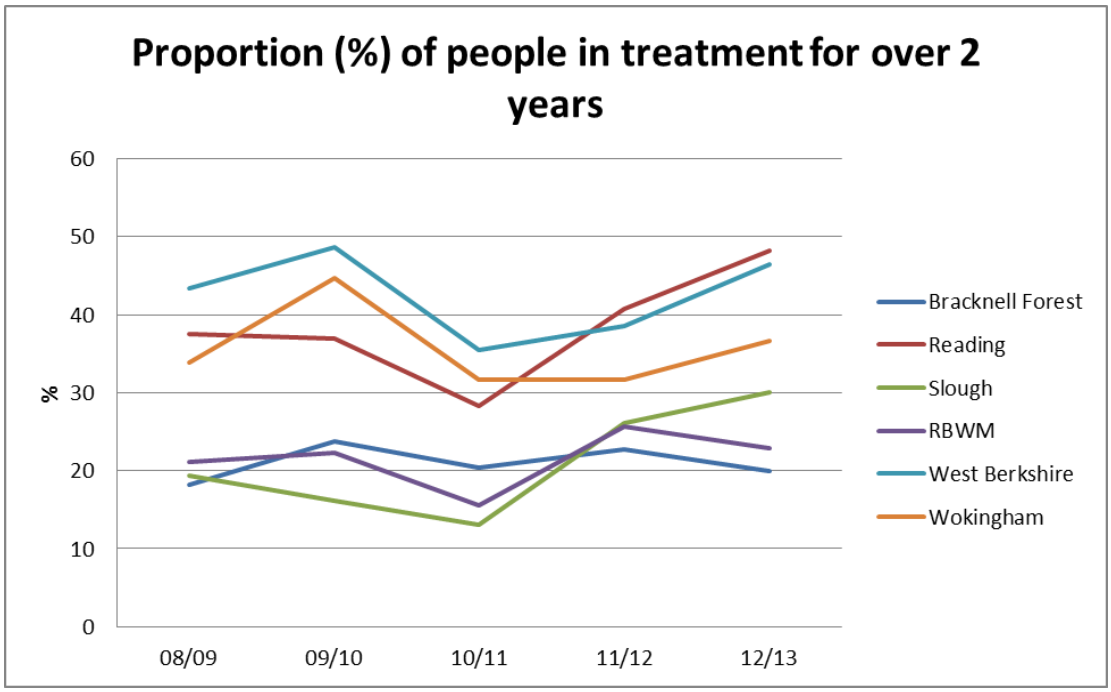


Source: Diagnostic Outcomes Monitoring Executive Summary Q2, 2014-15

Length of treatment

People in drug treatment are spending longer in treatment in 12/13 compared to 08/09. Whilst the figure 30 shows a small increase, the most notable increase is in those in treatment for longperiods of time. Table 9 shows the growth in percentage terms of those in treatment for over 6 years. Increases of particular note are in West Berkshire, Reading and Wokingham. Whether or not this data is cumulative is unknown.

Figure 30. Average years in treatment across Berkshire.



Source: NDTMS 'View it' data, 2014/15

Table 9. Percentage of people in treatment for over 6 years 2008/09 and 2012/13.

% of people in treatment (over 6 years)		
Local Authority	**08/09**	**12/13**
Bracknell Forest	0	4.3
Reading	1.2	12.9
Slough	0	2.5
RBWM	0	2.7
West Berkshire	0	13.4
Wokingham	0	9.3

Source: National Drug and Treatment Monitoring System 'View It' data, 2014/15

Successful completion of drug treatment

Definition

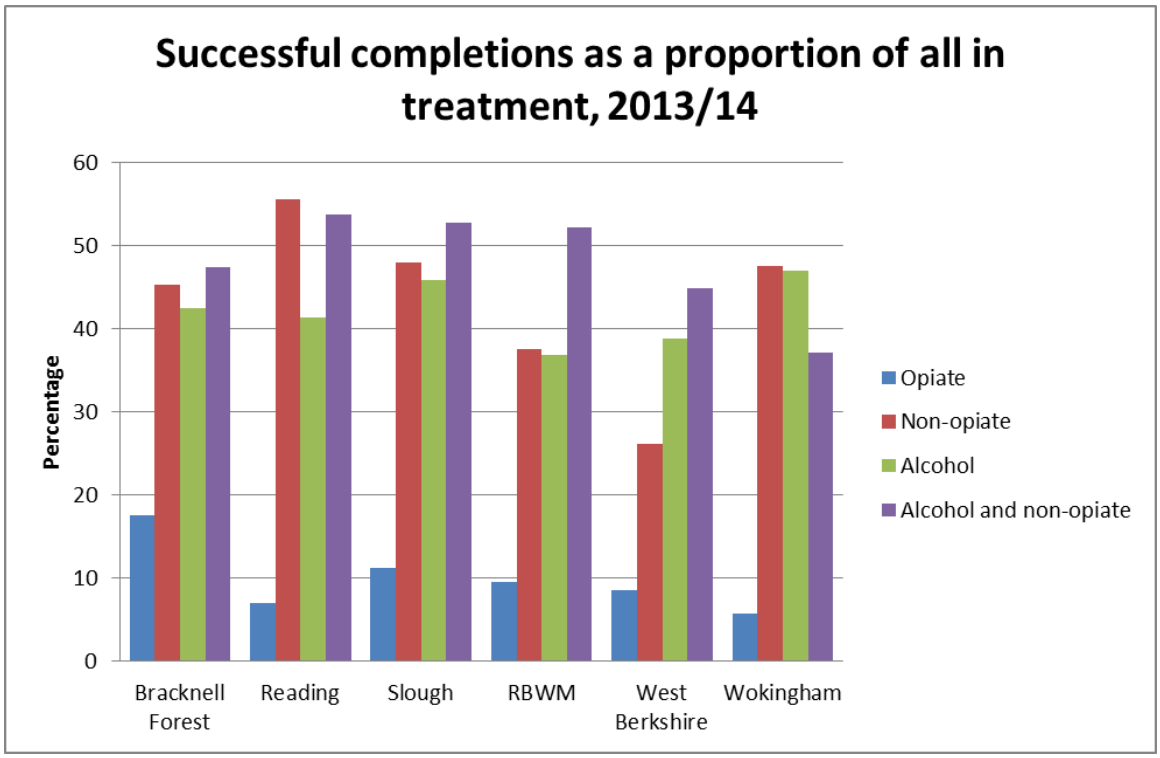
Successful completion: leaving drug treatment in a planned way.

Figure 31 shows that Reading has the highest percentage of successful completions for non-opiate drug treatment in Berkshire, whereas West Berkshire has the lowest.

For successful completions of opiate treatment, Bracknell Forest shows the highest percentage. It should be noted that Bracknell Forest also shows the highest opiate completion rate in its comparative socioeconomic decile (Healthier Lives: Alcohol and Drugs, Public Health England). Wokingham shows the lowest, followed by Reading. Reading also has the highest number of people in opiate treatment per 100,000 therefore this low completion rate should particularly be highlighted.

For alcohol and non-opiate successful completions Reading, Slough and RBWM show the highest rates in Berkshire, while Wokingham shows the lowest. Wokingham shows the highest percentage of alcohol treatment successful completions, followed by Slough. RBWM shows the lowest, at approximately 10% less than Wokingham.

Figure 31. Successful completions as a proportion of all in treatment across Berkshire, 01/10/13-30/09/14.



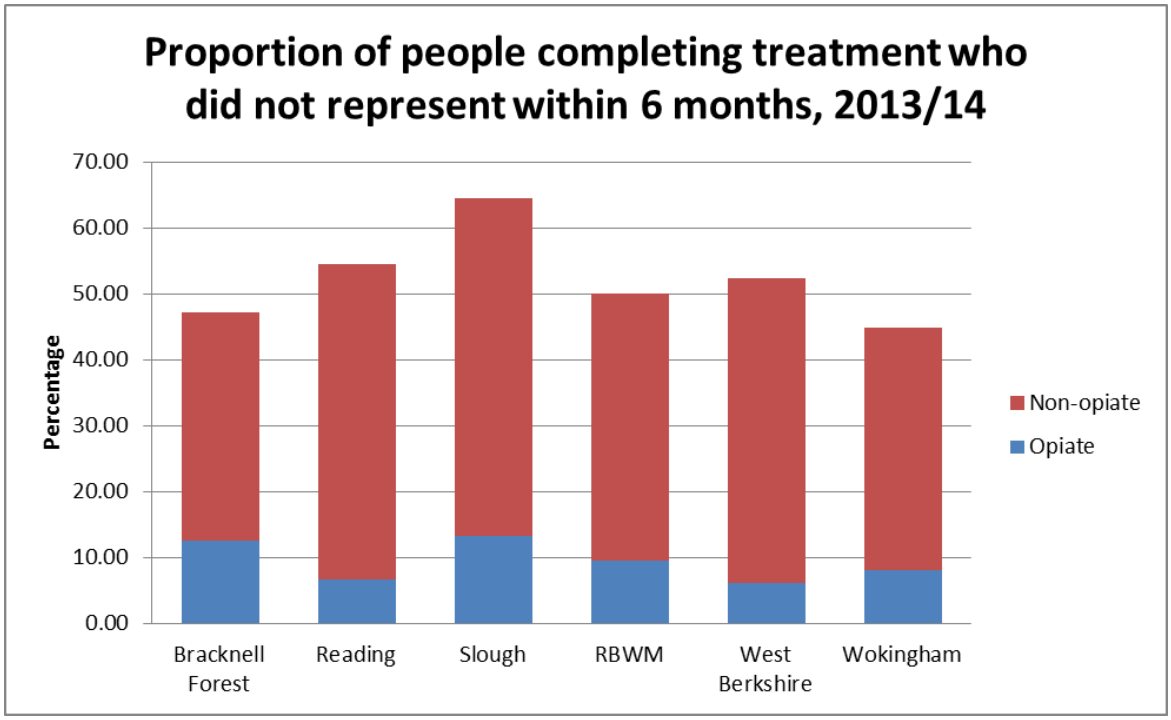
Source: Adult Partnership Activity Report, PHE, Q2 2014/15

In order to see a more successful outcome, data has also been included for the proportion of people successfully completing drug treatment who did not represent within 6 months (figure 32). This data does not show alcohol completions. It should also be noted that figure 32 shows actual percentages. It is not a cumulative of both non-opiate and opiate treatment completion.

Each of the LAs are above the national average for the percentage of people completing non opiate drug treatment who did not represent within 6 months, with the exception of Wokingham, which is slightly lower. Slough and Reading show the highest proportion of successful completions who did not represent, with Slough being statistically significantly higher than the England average.

For opiates, this percentage is higher than the national average in all LAs except for Reading and West Berkshire. Slough and Bracknell Forest show the highest proportions of people completing opiate treatment and not representing, with both LAs being statistically significantly higher than the England average. Again, Reading shows a low proportion considering that it has the highest number of people in treatment for opiate drugs in Berkshire.

Figure 32. Percentage of people completing drug treatment who did not represent within 6 months across Berkshire, 2013/14.



Source: Diagnostic Outcomes Monitoring Executive Summary, Q2 2014/15

Definition

Top quartile range for comparator LAs: there are 32 local authorities in each group. The top quartile is the performance of the eight best authorities in that group.

Table 10 shows the comparisons between Berkshire LAs and the top quartile range for comparator LAs for opiate and non-opiate completions not representing within 6 months. Those highlighted in red are completion rates below their top quartile range for comparator LAs. Both Wokingham and RBWM are lower than this range for both opiate and non-opiate completions not representing within 6 months.

Table 10. Percentage completing treatment who did not represent within 6 months (With top quartile range for comparator LA) (%)

	Opiate	Non-opiate
Bracknell Forest	12.6 (9.93 - 14.38)	34.6 (46.88 - 57.03)
Reading	6.7 (8.43-11.44)	47.8 (41.71-56.70)
Slough	13.3 (10.14-16.15)	51.3 (41.71- 59.67)
RBWM	9.5 (10.90-16.15)	40.6 (42.72-55.77)
West Berkshire	6.1 (9.92-14.38)	46.3 (42.72-59.67)
Wokingham	8.2 (10.57-16.15)	36.7 (42.72-55.77)

Source: Diagnostic Outcomes Monitoring Executive Summary, Q2 2014/15

Tier 2 service provision

Feedback from 4 of the 6 LAs highlights that there is a need for further tier 2 provision, aimed at people who are drinking over the recommended daily limit or using an inappropriate amount of drugs but are not deemed as needing specialist, intense treatment. Feedback from DAAT teams is shown below.

In West Berkshire any resident that requires information for their own or for another person's substance misuse can access support via numerous partnership agencies, for example, GPs, voluntary sector, West Berkshire Housing, Adult and Children and Young People's services, health providers (dentists, pharmacies etc) and via the West Berkshire internet site.

In Bracknell Forest the tier 2 service is the Local Area Screening and Referral services (LASARs). These services are responsible for screening, assessing and referring people into structured treatment. As part of this role they offer harm reduction information and advice, deliver brief interventions to people to support them to reduce their use while they are waiting to be referred into structured treatment. Some people choose not to be referred on but have been provided with all the relevant information and advice in order for them to make informed choices.

During 2013-14, Slough Treatment Services supported 156 alcohol clients and 202 substance misuse clients who did not receive structured treatment.

This caseload demonstrates that these clients need low level interventions to support the individual with their recovery. This support is equally as important with outcomes such a harm reduction leading into better quality of life.

RBWM also agree that there is more room for alcohol related prevention work within the community. Brief intervention training has been delivered to GPs and some work is being undertaken with social care. RBWM have a large number of people who are welcomed into the DAAT service but may only require short term brief interventions or extended brief interventions. Often these are alcohol clients and DAAT actively encourage people to come at that early stage but recording of these clients is something DAAT and SMART have been aiming to improve.

Nalmefene

From our analysis of available services a particular gap stands out in provision. Very little exists to support people who drink more than the recommended daily allowance, but (for whatever reason) would not be classed or targeted as problem drinkers. It is recommended that more support be available to ‘at home drinkers’ whether web based or via brief interventions.

Recent NICE (National Institute for Health and Care Excellence) guidance has endorsed the use of Nalmefene for ‘problem drinkers’ who are still consuming more than 7.5 units per day (for men) and more than 5 units per day (for women) 2 weeks after an initial assessment. This may well have a place in the treatment of problem drinkers, although some limitations still exist; Nalmefene needs to be prescribed alongside psychosocial interventions and should be part of an alcohol pathway. Furthermore it needs to be clarified who is paying for it at a local level.

This is not yet available in Berkshire, but could go a long way towards reducing the harm and the burden that ‘problem drinking’ causes locally. Full NICE guidance is available by searching:

‘Nalmefene for reducing alcohol consumption in people with alcohol dependence.’

KEY POINTS

Bracknell Forest has a considerably higher percentage of people in alcohol and non-opiate treatment while the other 5 LAs have a much higher opiate treatment percentage.

Bracknell Forest has the highest reach rates for opiate users, there is a 26% difference between Bracknell Forest and Wokingham.

Slough has the highest proportion of very high and high complexity levels. In addition both Slough and Reading have the highest overall client complexity levels whereas RBWM has the lowest.

BME groups are underrepresented in services.

West Berkshire has the highest proportion of women in drug treatment.

The number of clients with a record of completing a course of HBV vaccinations as a proportion of the total number of clients n treatment is below the national average in all LAs except Reading and Slough.

Records of a Hepatitis C test have increased in Bracknell Forest.

Reading has a far higher proportion of opiate treatment population in contact with the criminal justice system that the other 5 LAs.

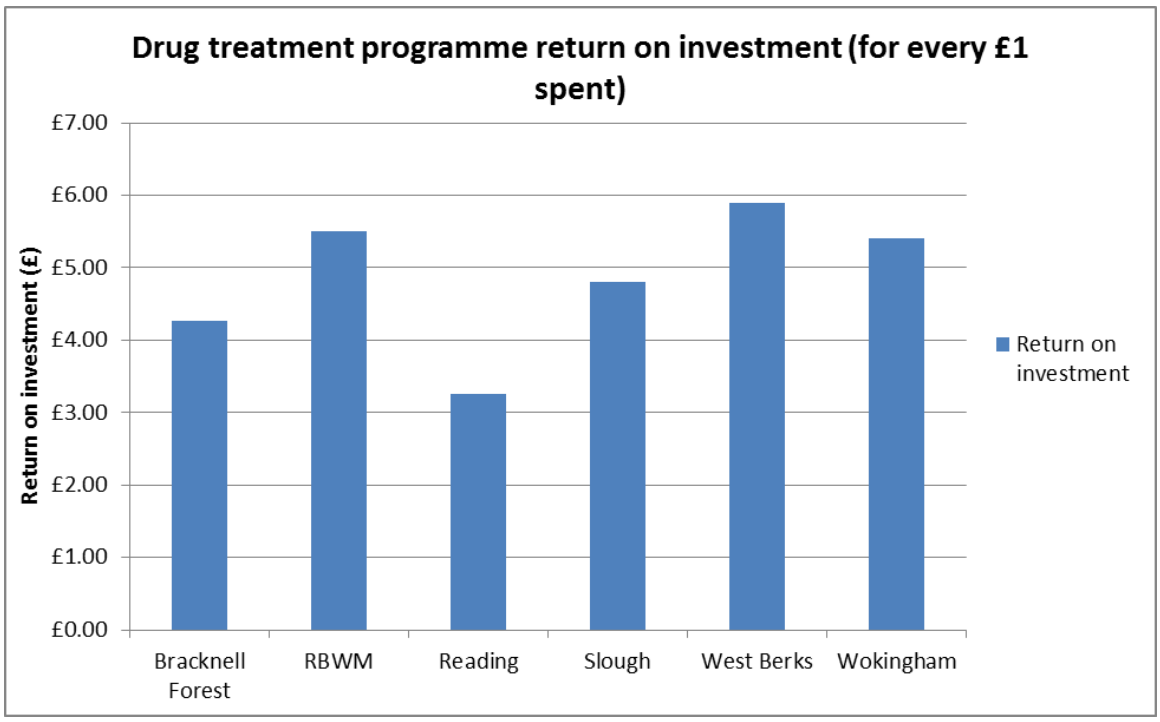
Reading has the lowest successful completion rate for opiate drug treatment but has the highest number of people in opiate treatment.

Wokingham has the lowest proportion of people successfully completing non-opiate drug treatment and not representing in 6 months.

Chapter 5: Budgets and return on investment

Figure 33 shows for every pound spent on drug services in 2012/13 the estimated return on that investment (savings that are made by treating drug users against a scenario where drug users were not treated). The estimate is calculated by using actual spending in 2012/13 against estimated treatment savings. Each of the Berkshire LAs have a ROI over £4 for every £1 spent. This is with the exception of Reading which is closer to £3. ROI tools must be treated with caution as the savings are purely estimates and cannot be verified as they are modelling for a situation that will not actually happen (no drug users receiving treatment).

Figure 33. Drug treatment programme ROI (return on investment) (per £1 spent).



Source: VFM tool - National Drug and Treatment Monitoring System, 2014

Table 11 shows the relative yearly DAAT budgets by LA. The budgets can be broken down, as with many of the stats in this document, into three categories. Reading and Slough have by far the largest budgets. This is followed by West Berkshire and RBWM, with Bracknell Forest and Wokingham having the smallest budgets. On the whole this compares with need, but there are exceptions.

It should be noted that each budget is spent differently depending on each LA. Spending in each LA in relation to the drug/alcohol split is unknown. A full budget breakdown for each LA would be needed for further analysis.

Table 11. Current substance misuse service budgets across Berkshire.

	Budget
Bracknell Forest	£846,600
Reading	£2,347,000
Slough	£2,296,748
RBWM	£1,100,000
West Berkshire	£1,100,000
Wokingham	£622,000

Source: Berkshire Drug and Alcohol Action Teams

The summary table in figure 34 is a useful way to look at the different LA DAATs. However it should be noted that comparison removes relative numerical context. The 1-6 system goes from 1 which is the highest value to 6 which is the lowest value. The summary table offers an overview of factors by local authority.

Figure 34. Comparison summary table.

	Bracknell Forest	RBWM	Reading	Slough	West Berkshire	Wokingham
Budget	5	3	1	2	4	6
18+ Pop	6	4	1	5	3	2
Est. drug user pop	6	3	1	2	4	5
Number in treatment	5	4	1	2	3	6
% completing treatment	2	3	5	1	6	4
Higher rate drinkers	2	3	1	5	4	6
Alcohol specific admissions	4	3	2	1	5	6

Source: Collated from data shown previously

KEY POINTS

Reading shows a particularly low return on investment at £3.26.

Reading has the highest budget allocation in Berkshire. However further information of budget breakdown would be needed to ensure that budget meets service demand.

Recommendations

This Berkshire-wide drug and alcohol needs assessment has explored the current need for substance misuse related services and service outcomes in each of the 6 LAs across the county. From this analysis a set of recommendations has been derived:

- More data is required around alcohol prevalence and how alcohol consumed. Similar data to that gathered in the Bracknell Forest Public Health Survey in each LA would benefit service and campaign planning (*page 15 onwards*).

- Nalmefene should be available to high risk drinkers (after relevant screening and consultation) in combination with psycho social support, as recommended by NICE guidance (*page 55*).

- More 'tier 2' support for people drinking over the recommended daily limit but not consuming enough to be highlighted as needing specialist treatment. This will help to drive down hospital admissions (*page 54*).

- More comprehensive and standardised reporting of 'Tier 2' services that already exist and numbers using tier 2 services would highlight demand and help to commission future tier 2 services (*page 54*).

- More support for at home drinkers and casual drug users and continued alcohol awareness campaigns.

- Further exploration of A&E attendances and alcohol related hospital admissions (*page 27 onwards*).

- Improved data collection on co-morbidity of substance misuse and mental health problems, as well as further information about available services (page 35).

- Improve reach of opiate initiatives in opiate populations (*page 43*).

- Provide more clarity on the breakdown of spend into different service areas. This would allow for standardisation and comparison (*page 58*).

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Appendix 1.

Local Alcohol Profiles for England 2014

Appendix 1. Updated alcohol-attributable fractions used to calculate alcohol-specific and alcohol-related hospital admission and mortality

Condition	ICD10 code(s)	0-15		16-24		25-34		35-44		45-54		55-64		65-74		75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Wholly attributable conditions																	
Alcohol-induced pseudo-Cushing's syndrome	E24.4	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Mental and behavioural disorders due to use of alcohol	F10	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Degeneration of nervous system due to alcohol	G31.2	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Alcoholic polyneuropathy	G62.1	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Alcoholic myopathy	G72.1	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Alcoholic cardiomyopathy	I42.6	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Alcoholic gastritis	K29.2	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Alcoholic liver disease	K70	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Alcohol-induced acute pancreatitis	K85.2	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Alcohol-induced chronic pancreatitis	K86.0	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Fetal alcohol syndrome (dysmorphic)	Q86.0	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Excess alcohol blood levels	R78.0	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Ethanol poisoning	T51.0	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Methanol poisoning	T51.1	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Toxic effect of alcohol, unspecified	T51.9	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Accidental poisoning by and exposure to alcohol	X45	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Intentional self-poisoning by and exposure to alcohol	X65	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Poisoning by and exposure to alcohol, undetermined intent	Y15	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Evidence of alcohol involvement determined by blood alcohol level	Y90	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Evidence of alcohol involvement determined by level of intoxication	Y91	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Partially attributable conditions - Chronic conditions																	
Infectious and parasitic diseases																	
Tuberculosis	A15-A19	0.00	0.00	0.30	0.19	0.33	0.17	0.34	0.21	0.35	0.22	0.35	0.20	0.31	0.14	0.22	0.11

Local Alcohol Profiles for England, 2014: User Guide

Condition	ICD10 code(s)	0-15		16-24		25-34		35-44		45-54		55-64		65-74		75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Malignant neoplasm of:																	
Lip, oral cavity and pharynx	C00-C14	0.00	0.00	0.53	0.38	0.44	0.35	0.44	0.42	0.46	0.43	0.47	0.40	0.40	0.31	0.29	0.24
Oesophagus	C15	0.00	0.00	0.58	0.49	0.61	0.48	0.61	0.53	0.63	0.53	0.63	0.51	0.60	0.45	0.52	0.38
Colorectal	C18-C20, C21	0.00	0.00	0.16	0.11	0.18	0.12	0.18	0.13	0.19	0.14	0.19	0.13	0.17	0.11	0.13	0.11
Liver and intrahepatic bile ducts	C22	0.00	0.00	0.15	0.11	0.17	0.11	0.17	0.12	0.18	0.13	0.18	0.12	0.16	0.10	0.12	0.11
Larynx	C32	0.00	0.00	0.35	0.25	0.39	0.23	0.39	0.28	0.41	0.29	0.41	0.27	0.36	0.21	0.28	0.17
Breast	C50	0.00	0.00	0.00	0.12	0.00	0.13	0.00	0.14	0.00	0.15	0.00	0.14	0.00	0.12	0.00	0.11
Diabetes mellitus																	
Diabetes mellitus (type II)	E11	0.00	0.00	-0.04	-0.20	-0.04	-0.21	-0.04	-0.22	-0.04	-0.22	-0.03	-0.22	-0.04	-0.20	-0.03	-0.15
Diseases of the nervous system																	
Epilepsy and Status epilepticus	G40-G41	0.00	0.00	0.32	0.22	0.35	0.20	0.35	0.24	0.37	0.25	0.37	0.23	0.33	0.18	0.24	0.15
Cardiovascular disease																	
Hypertensive diseases	I10-I15	0.00	0.00	0.22	0.26	0.25	0.17	0.25	0.30	0.27	0.31	0.27	0.25	0.23	0.09	0.15	-0.06
Ischaemic heart disease	I20-I25	0.00	0.00	-0.10	-0.10	-0.10	-0.08	-0.10	-0.10	-0.10	-0.10	-0.10	-0.09	-0.11	-0.07	-0.10	-0.02
Cardiac arrhythmias	I47-I48	0.00	0.00	0.15	0.10	0.17	0.11	0.17	0.12	0.18	0.13	0.18	0.12	0.16	0.10	0.12	0.11
Haemorrhagic stroke - Mortality	I60-I62, I69.0-I69.2	0.00	0.00	0.18	0.25	0.20	0.22	0.20	0.27	0.21	0.28	0.22	0.26	0.19	0.19	0.15	0.13
Haemorrhagic stroke - Morbidity		0.00	0.00	0.20	-0.11	0.22	-0.14	0.23	-0.11	0.24	-0.10	0.24	-0.12	0.21	-0.16	0.17	-0.15
Ischaemic stroke - Mortality	I63-I66, I69.3-I69.4	0.00	0.00	0.01	-0.09	0.02	-0.14	0.02	-0.09	0.03	-0.08	0.04	-0.10	0.01	-0.16	0.00	-0.14
Ischaemic stroke - Morbidity		0.00	0.00	0.00	-0.06	0.01	-0.07	0.01	-0.06	0.02	-0.06	0.03	-0.07	0.00	-0.07	-0.01	-0.06
Oesophageal varices - Mortality	I85	0.00	0.00	0.70	0.64	0.73	0.62	0.74	0.68	0.76	0.69	0.76	0.66	0.70	0.58	0.55	0.57
Oesophageal varices - Morbidity		0.00	0.00	0.44	0.31	0.47	0.41	0.48	0.38	0.50	0.40	0.50	0.41	0.44	0.42	0.33	0.51
Respiratory infections																	
Pneumonia	J10.0, J11.0, J12-J15, J18	0.00	0.00	0.12	0.07	0.14	0.06	0.14	0.08	0.15	0.08	0.15	0.08	0.13	0.05	0.10	0.03
Digestive disease																	
Unspecified liver disease - Mortality	K73,	0.00	0.00	0.70	0.64	0.73	0.62	0.74	0.68	0.76	0.69	0.76	0.66	0.70	0.58	0.55	0.57

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Condition	ICD10 code(s)	0-15		16-24		25-34		35-44		45-54		55-64		65-74		75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Unspecified liver disease - Morbidity	K74	0.00	0.00	0.44	0.31	0.47	0.41	0.48	0.38	0.50	0.40	0.50	0.41	0.44	0.42	0.33	0.51
Cholelithiasis (gall stones)	K80	0.00	0.00	-0.25	-0.17	-0.28	-0.17	-0.28	-0.19	-0.30	-0.19	-0.30	-0.18	-0.27	-0.16	-0.21	-0.14
Acute and chronic pancreatitis	K85, K86.1 (excl. K85.2)	0.00	0.00	0.35	0.17	0.39	0.14	0.40	0.20	0.43	0.21	0.43	0.18	0.35	0.12	0.20	0.10
Pregnancy and childbirth																	
Spontaneous abortion	O03	0.00	0.00	0.00	0.08	0.00	0.08	0.00	0.11	0.00	0.11	0.00	0.00	0.00	0.00	0.00	0.00
Low birth weight	P05-P07	0.05	0.05	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Partially attributable conditions - Acute conditions																	
Unintentional injuries																	
Road/pedestrian traffic accidents - Mortality	§	0.00	0.00	0.42	0.25	0.46	0.22	0.39	0.22	0.41	0.23	0.28	0.14	0.16	0.07	0.06	0.03
Road/pedestrian traffic accidents - Morbidity		0.00	0.00	0.28	0.17	0.31	0.15	0.26	0.15	0.27	0.15	0.19	0.09	0.11	0.05	0.04	0.02
Poisoning - Mortality	X40–X49 (excl. X45)	0.00	0.00	0.32	0.18	0.37	0.17	0.37	0.20	0.40	0.19	0.38	0.14	0.26	0.08	0.12	0.04
Poisoning - Morbidity		0.00	0.00	0.14	0.08	0.17	0.08	0.16	0.09	0.18	0.08	0.17	0.06	0.12	0.04	0.05	0.02
Fall injuries - Mortality	W00-W19	0.00	0.00	0.32	0.18	0.37	0.17	0.37	0.20	0.40	0.19	0.38	0.14	0.26	0.08	0.12	0.04
Fall injuries - Morbidity		0.00	0.00	0.14	0.08	0.17	0.08	0.16	0.09	0.18	0.08	0.17	0.06	0.12	0.04	0.05	0.02
Fire injuries - Mortality	X00-X09	0.00	0.00	0.32	0.18	0.37	0.17	0.37	0.20	0.40	0.19	0.38	0.14	0.26	0.08	0.12	0.04
Fire injuries - Morbidity		0.00	0.00	0.14	0.08	0.17	0.08	0.16	0.09	0.18	0.08	0.17	0.06	0.12	0.04	0.05	0.02
Drowning - Mortality	W65-W74	0.00	0.00	0.32	0.18	0.37	0.17	0.37	0.20	0.40	0.19	0.38	0.14	0.26	0.08	0.12	0.04
Drowning - Morbidity		0.00	0.00	0.14	0.08	0.17	0.08	0.16	0.09	0.18	0.08	0.17	0.06	0.12	0.04	0.05	0.02
Other unintentional injuries - Mortality	Rest of 'V' series §§	0.00	0.00	0.32	0.18	0.37	0.17	0.37	0.20	0.40	0.19	0.38	0.14	0.26	0.08	0.12	0.04
Other unintentional injuries - Morbidity		0.00	0.00	0.14	0.08	0.17	0.08	0.16	0.09	0.18	0.08	0.17	0.06	0.12	0.04	0.05	0.02
Intentional injuries																	
Intentional self-harm - Mortality	X60-X84, Y87.0 (excl. X65)	0.00	0.00	0.32	0.18	0.37	0.17	0.37	0.20	0.40	0.19	0.38	0.14	0.26	0.08	0.12	0.04
Intentional self-harm - Morbidity		0.00	0.00	0.14	0.08	0.17	0.08	0.16	0.09	0.18	0.08	0.17	0.06	0.12	0.04	0.05	0.02

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Condition	ICD10 code(s)	0-15		16-24		25-34		35-44		45-54		55-64		65-74		75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Event of undetermined intent - Mortality	Y10-Y34, Y87.2 (excl. Y15)	0.00	0.00	0.32	0.18	0.37	0.17	0.37	0.20	0.40	0.19	0.38	0.14	0.26	0.08	0.12	0.04
Event of undetermined intent - Morbidity		0.00	0.00	0.14	0.08	0.17	0.08	0.16	0.09	0.18	0.08	0.17	0.06	0.12	0.04	0.05	0.02
Assault - Mortality	X85-Y09, Y87.1	0.00	0.00	0.32	0.18	0.37	0.17	0.37	0.20	0.40	0.19	0.38	0.14	0.26	0.08	0.12	0.04
Assault - Morbidity		0.00	0.00	0.14	0.08	0.17	0.08	0.16	0.09	0.18	0.08	0.17	0.06	0.12	0.04	0.05	0.02

§ = V021-V029, V031-V039, V041-V049, V092, V093, V123-V129, V133-V139, V143-V149, V194-V196, V203-V209, V213-V219, V223-V229, V233-V239, V243-V249, V253-V259, V263-V269, V273-V279, V283-V289, V294-V299, V304-V309, V314-V319, V324-V329, V334-V339, V344-V349, V354-V359, V364-V369, V374-V379, V384-V389, V394-V399, V404-V409, V414-V419, V424-V429, V434-V439, V444-V449, V454-V459, V464-V469, V474-V479, V484-V489, V494-V499, V504-V509, V514-V519, V524-V529, V534-V539, V544-V549, V554-V559, V564-V569, V574-V579, V584-V589, V594-V599, V604-V609, V614-V619, V624-V629, V634-V639, V644-V649, V654-V659, V664-V669, V674-V679, V684-V689, V694-V699, V704-V709, V714-V719, V724-V729, V734-V739, V744-V749, V754-V759, V764-V769, V774-V779, V784-V789, V794-V799, V803-V805, V811, V821, V830-V833, V840-V843, V850-V853, V860-V863, V870-V878, V892. §§ = V01, V090, V091, V099, V100-V109, V110-V119, V120-122, V130-132, V140-V142, V150-V159, V160-V169, V170-V179, V180-V189, V191-V193, V20-V28: 0.1–0.2; V290-V293, V30-V38: 0.1–0.2; V390-V393, V40-V48: 0.1–0.2; V490-V493, V50-V58: 0.1–0.2; V590-V593, V60-V68: 0.1–0.2; V690-V693, V70-V78: 0.1–0.2; V790-V793, V800, V801, V806–V809, V810, V812–V819, V820, V822–V829, V834–V839, V844–V849, V854–V859, V864–V869, V879, V88, V890, V891, V893–V899, V90-V94, V95-V97, V98-V99, W20-W52, W75-W84, W85–W99, X10-X19, X20-X29, X30-X33, X50-X57, X58, X59, Y40-Y84 Y85, Y86, Y88, Y89

Source: User Guide: Local Alcohol Profiles for England, PHE, 2014