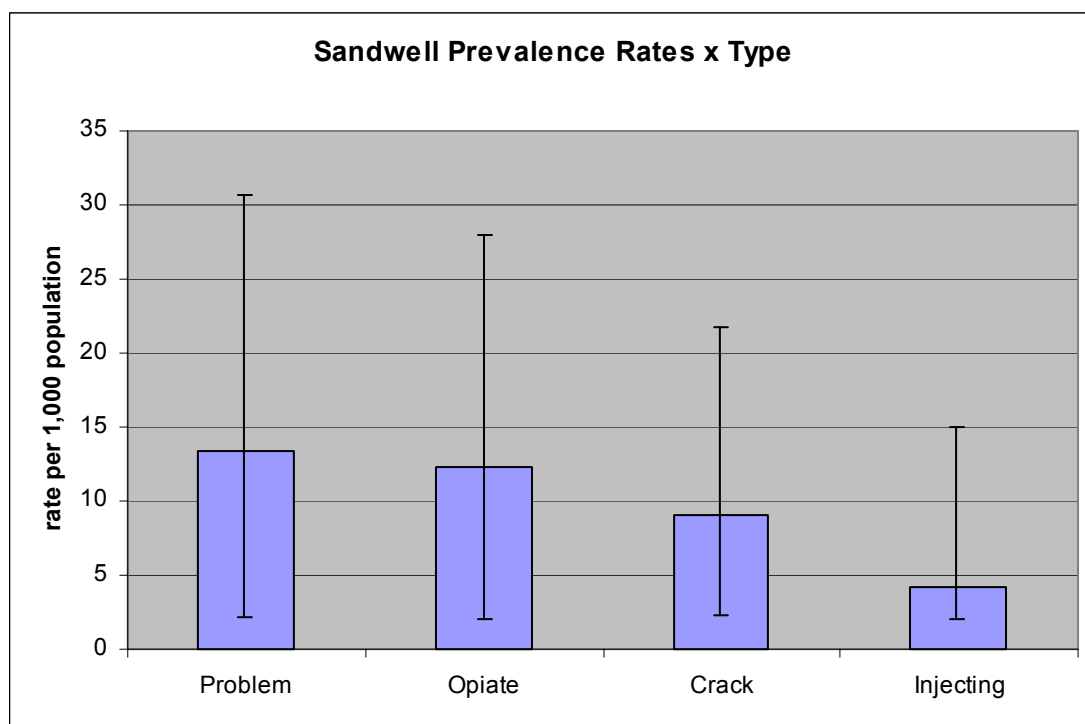


Sandwell Adult Drug Treatment Needs Assessment 2007/8

Home Office Estimates: Prevalence of opiate use and/or crack cocaine use 2004/5

In Sandwell there are an estimated 2,441 problematic drug users. In relation to the 2006 mid year estimates of the local population this accounts for 0.84% of the total local population.

Sandwell features within the top 6 areas with the highest number of problem drug users in the West Midlands region, yet in proportion to the overall population (rate) this rises to 4th highest in the West Midlands region. This is also true of the opiate estimates.



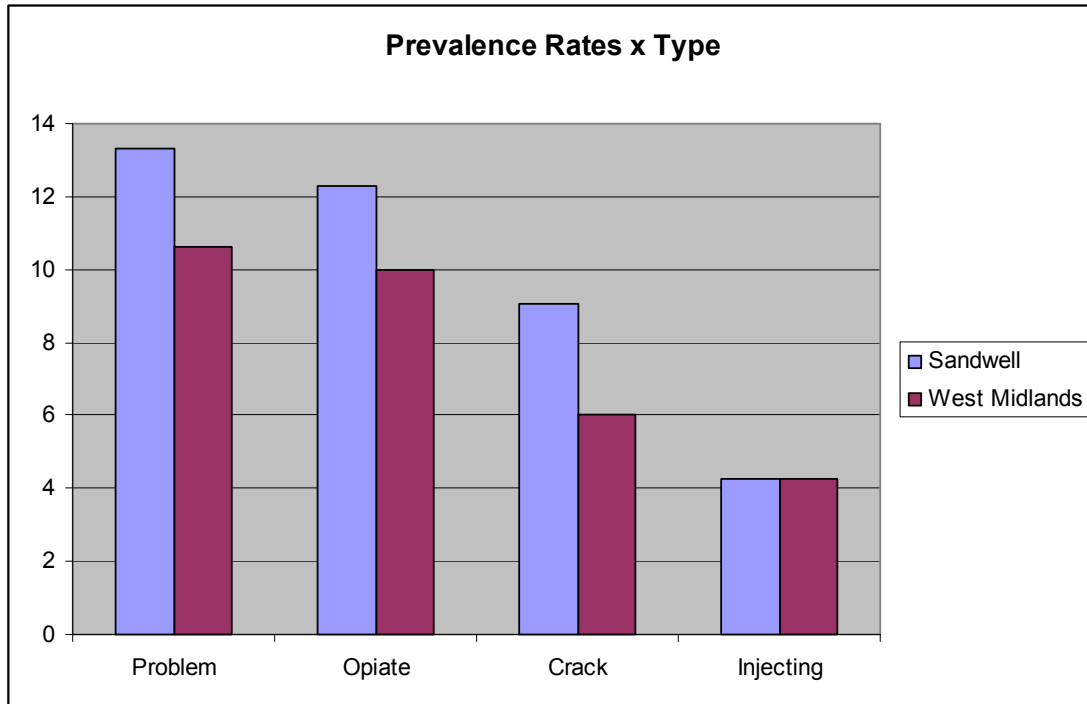
92% of the estimated PDU population are opiate users – this is in line with the high proportion of opiate users seen in the treatment stats (96% of those in treatment during 2006/7 at Anchor and 78% at Addaction).

68% of the estimated PDU population are crack users – this use could be alongside that of opiate use.

Under a third of the estimated PDU population (32%) are injecting drug users. Locally this is above the proportion of current injectors seen in treatment during 2006/7 (24%) but below the current/previous drug using proportions seen in treatment during 2006/7 (41%). (Quarter 4 green report).

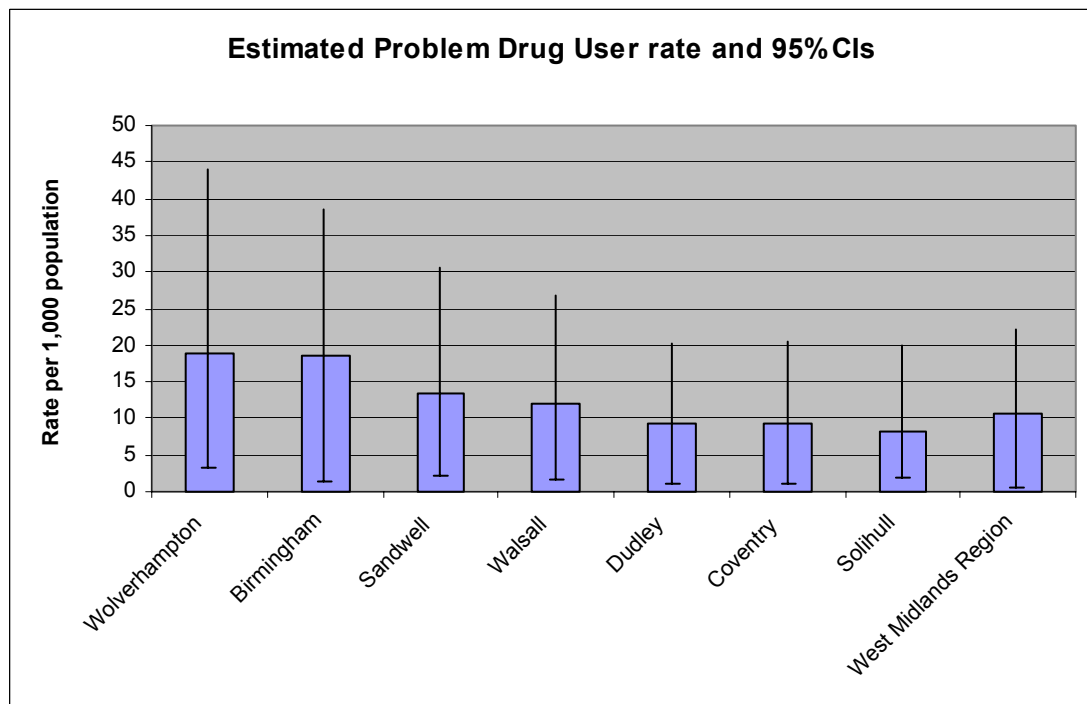
Bullseye data shows an increasing proportion of ‘never injected’ users as we move away from the inner circle and illustrates a need to engage those who have never injected into treatment. (For bullseye diagram see Appendix 2).

We can see from the chart below that Sandwell has a higher rate of problem, opiate and crack users than the regional rate, yet a similar rate of injecting drug users. Within Sandwell there is a comparatively larger number of opiate than crack users.



The following chart displays the associated confidence intervals – the range of values within which we can be 95% sure that the true estimate lies of problem drug users in the West Midlands County.

There is a large degree of overlap between DAT areas within the West Midlands County, which suggests a large degree of similarity between areas.



Since the 2004/5 estimates the second sweep of prevalence estimates has recently been completed. The estimated number of problematic drug (opiate and/or crack cocaine) from the 2005/6 estimates for users aged 15-64 is 1,918 (1,724 – 2,215 at

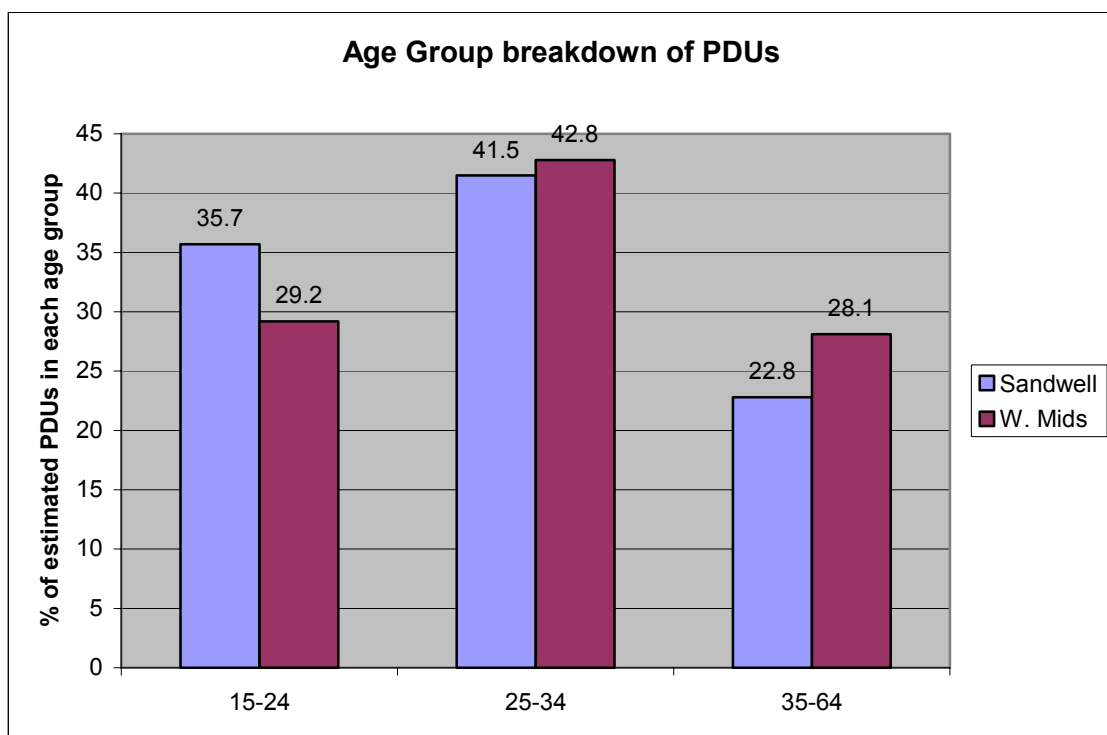
95% confidence interval). In order to detect any real change we must consider the confidence intervals surrounding the difference between the two estimates (as confidence intervals for capture-recapture estimates are asymmetric). As the difference in both sets of confidence intervals straddles 0, then we can infer that no statistically significant change has occurred. Any real changes within our local PDU population will probably take a number of years to become apparent (as with any other population).

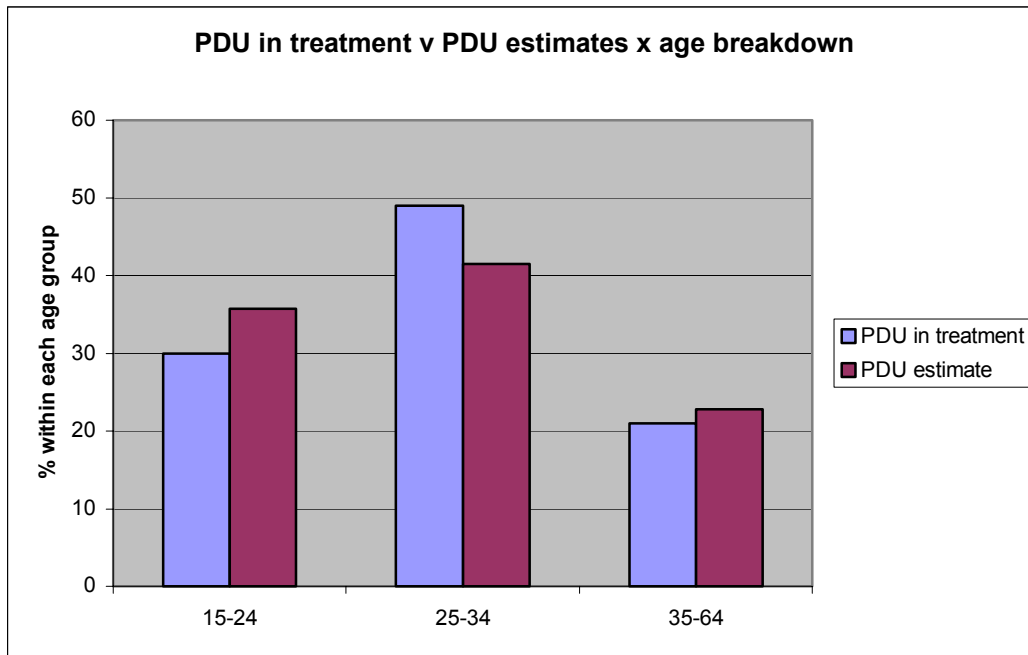
Age

The following chart displays the higher proportion of younger problematic drug users in Sandwell compared to the regional average, along with a lower proportion of older problematic drug users.

This suggests young people are continuing to enter the PDU population and that more focus may be needed on young people's services, drug education programmes and intervention/prevention policies. (The need for more active engagement of those aged 15-24 is also illustrated in the subsequent chart, which compares age profile of those PDUs in treatment during 2006/7 against the estimated PDU age populations).

The relatively low proportion of older drug users may suggest a much smaller established drug population with long-term problematic drug use.





The bullseye data (Appendix 2) also illustrates the higher proportion of 15-24 year olds in contact with DIP but not known to treatment compared to the proportion of 15-24 year olds in treatment (39% v 30% respectively).

The treatment system map by age (Appendix 1) shows 43% of clients at referral to Anchor are aged 18-24, but of those in treatment just 29% are aged 18-24. Are we losing some of the younger clients on entry into structured treatment?

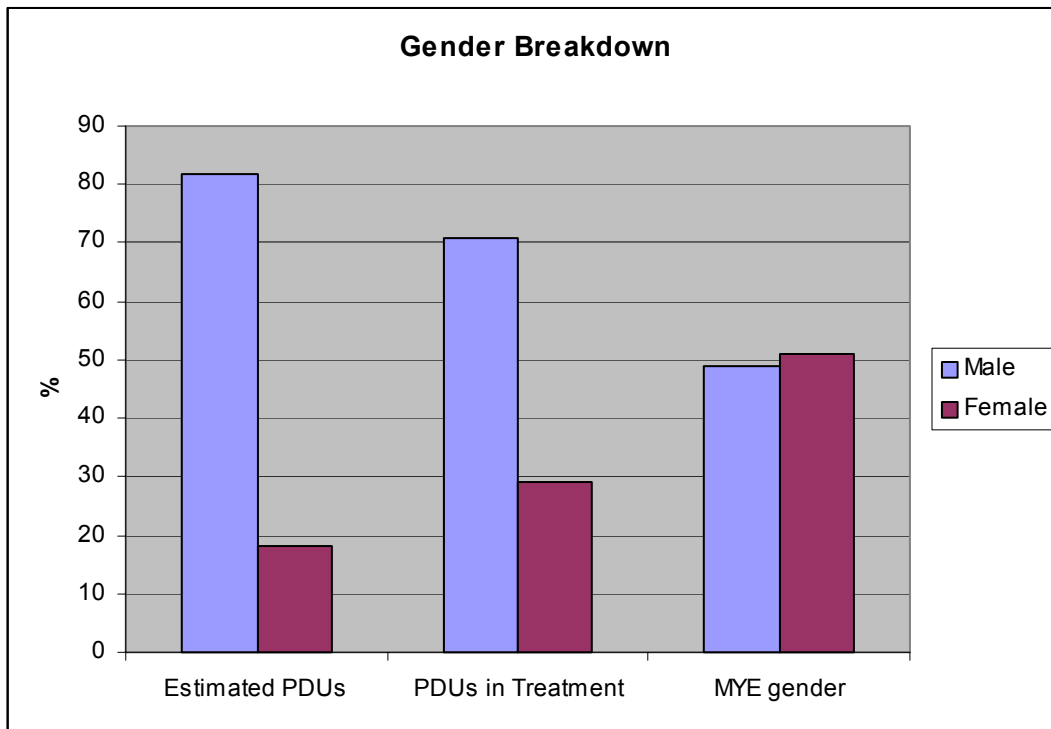
Gender

The gender breakdown of estimated PDUs shows a higher proportion of males than females in comparison to the regional average (81.7% males locally compared with 78.2% regionally).

If we compare this to the gender breakdown of those opiate and/or crack users in treatment during 2006/7, and also to the overall gender split as evidenced by the latest 2006 mid year estimates we can see that the PDUs in treatment gender split is a medium between the overall population split and that of the estimated PDU gender split (see following chart). There is still however a need to engage more males into treatment according to the estimates.

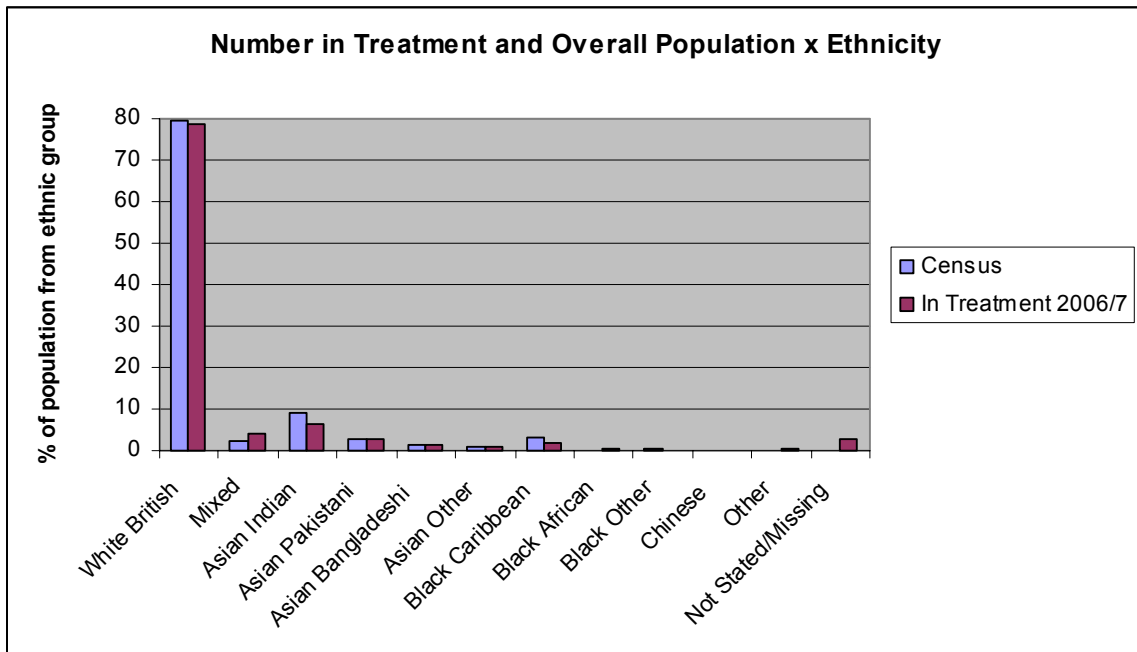
This is also evident in the bullseye data chart, which displays an increasing proportion of males as we move further away from the centre of the bullseye.

Anecdotal evidence obtained from a workshop session conducted with local practitioners stated that our main Tier 3 provider, Anchor, was seen as being particularly good at engaging women – hence the apparently lower proportion of males seen in treatment. We need to bear this in mind when comparing such treatment figures to the gender split of estimated PDUs.



Ethnicity: Numbers in Treatment & Overall Population

In comparison to the overall population there is a slightly higher proportion of non-white clients in treatment than in the overall population (21.4% v 20.3% respectively). This is accounted for in the higher proportion of Mixed clients seen in treatment compared to the overall population (4.25% v 2.1% respectively). The comparatively lower levels of Asian and Black clients in treatment may be due to the way in which clients classify their ethnicity as ‘mixed’ rather than Asian or Black. However we must bear in mind the Census is increasingly out of date, and changes in the diversity of the overall population may account for the larger proportion of non-white clients seen in treatment during 2006/7. 2.8% of clients in treatment had not stated their ethnicity or had a missing ethnicity value.

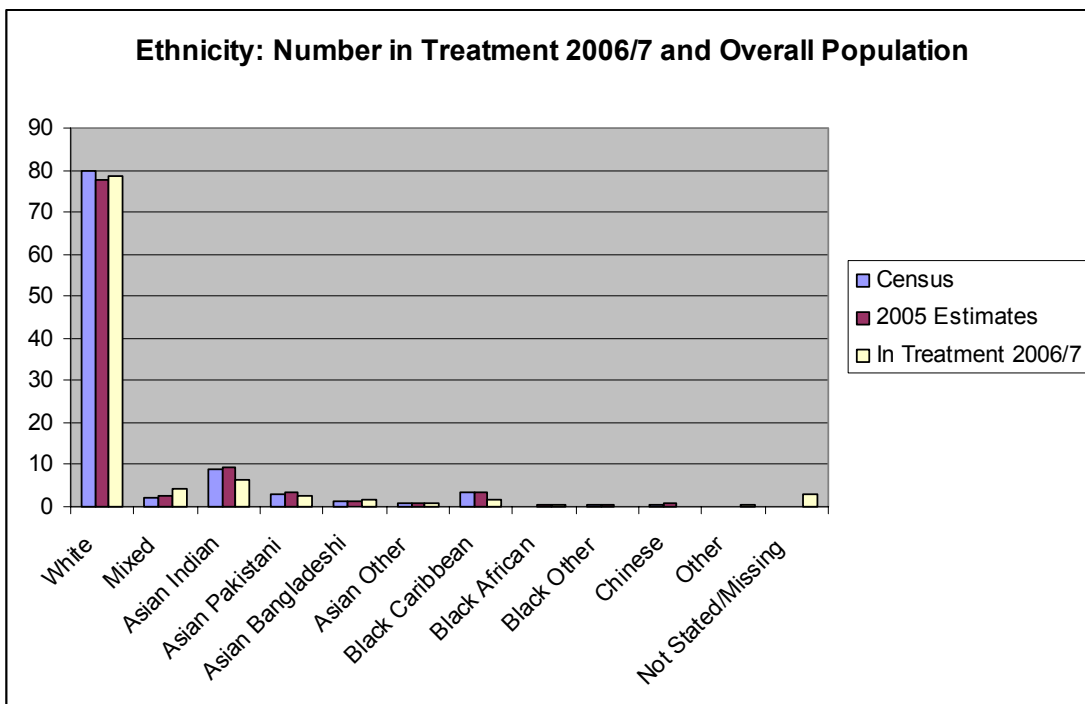


Data from the bullseye chart shows an increasing proportion of non-white clients as we move further away from the centre of the chart i.e. those in treatment. We must therefore ensure that services are accessible to all ethnic groups – in particular those of Asian and Black ethnicity.

Further analysis using 2005 ethnicity population estimates (produced by ONS) show that there is now a lower proportion of non-white clients in treatment compared with the overall population (21.4 v 22.3%).

The updated ethnicity estimates reflect some overall growth in the Mixed population which suggest that this group is not as 'over represented' in treatment as initially thought on comparison with the 2001 Census.

More notably Asian Indian & Asian Pakistani seem to be further under-represented in light of the updated ethnicity estimates.



Conclusions:

Following on from the evidence so far which shows 18-24s, males and BME groups in treatment are not as prevalent as proportions from the estimates suggest, please see the following treatment system maps for our main Tier 3 provider by these variables (Appendix 1).

Main points to consider from these:

- Decrease in the proportion of young males between referral stage and in treatment stage (43% v 29%)
- Lower proportion of males, 18-24s and BME clients in treatment for over 2 years than in treatment stage
- Although very small numbers, no BME referrals from GP
- No planned discharges for BME clients compared to 14% for white clients

Numbers in treatment and the prevalence estimates

The following table compares the number in treatment to the estimated PDU population – treatment penetration levels.

	PDU Estimate	In Treatment 2006/7	Treatment Penetration	PDU's in Treatment	PDU penetration
Birmingham	11865	6265	52.8	3913	33.0
Coventry	1871	1288	68.8	585	31.3
Dudley	1845	1154	62.5	621	33.7
Sandwell	2441	1037	42.5	578	23.7
Solihull	1062	580	54.6	376	35.4
Walsall	1922	1165	60.6	770	40.1
Wolverhampton	2920	1534	52.5	995	34.1
W. Mids Region	36384	20748	57.0	12395	34.1

Sandwell has the lowest overall penetration rate of West Midland county DATs and the lowest PDU penetration rate (opiate and/or crack users in treatment).

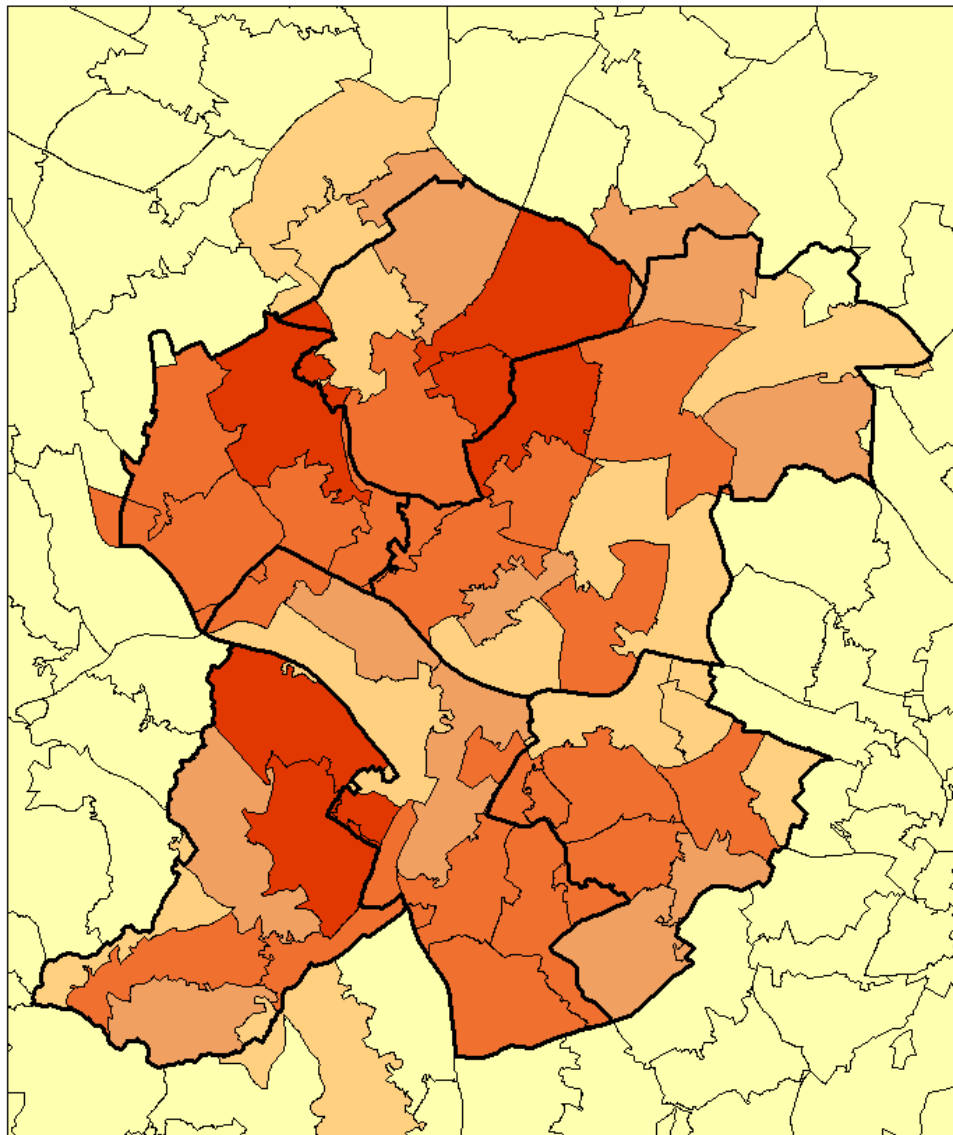
In 2005/6 there were 800 drug users in treatment at year end (32.7% of the estimated PDU population) – 506 of which were problematic drug users in treatment (20.7% of the estimated PDU population).

In relation to numbers in treatment for this current financial year, we can project forward the trend of numbers in treatment seen so far. A simple linear forecast estimates a total of 1104 clients in treatment predicted for year end – against a year end target of 1105. This would mean a treatment penetration of 45.3% of all those in treatment - an increase of 3% since last year.

The geographical distribution of clients (using either heroin and/or crack) accessing structured Tier 3 treatment is illustrated in the map below (including both Addaction Tier 3 and Anchor Tier 3 clients).

Due to restrictions in the nominal details that are recorded it is only possible to identify the home address of individuals accessing treatment to postcode sector level. Areas with the highest concentration of individuals accessing treatment are consistent with those areas identified as having a high concentration of individuals on the DIP project however the town of Rowley Regis seems to have a cluster of above average PDU's in treatment in comparison to the mapped DIP rates. (DIP nominal map can be found later in the document under the 'DIP data' section).

**Problematic Drug Users (Heroin and/or Crack)
in Treatment during 2006/7**



No of Problematic Drug Users	
35 to 51	(5)
17 to 35	(16)
8 to 17	(10)
1 to 8	(10)
0 to 1	(236)

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In terms of client distribution and service location it was suggested (during a service managers workshop) that a transient service provision may be useful in targeting hot-spots (alongside an established service base). This was also cited in relation to a perceived lack of out-reach in the borough.

From December 2008 the Metro Court complex in West Bromwich centre will act as a ‘one stop shop’ for drug services which was felt by practitioners as increasing options and accessibility between agencies for clients.

Retention

Sandwell's most recent (Q2 2006/7) retention performance at 56% is one of the poorest for all partnerships nationally. However the overall partnership figure masks a great difference between the two main providers as can be seen from the below tables (ranging from an average of 17% at one provider and 75% at the other). The tables highlight in red and green the highest and lowest monthly retention values for each agency.

	No 12+ wks	New presentations	Anchor Retention %
Apr 06	12	16	75
May 06	17	22	77
Jun 06	17	26	65
Jul 06	21	28	75
Aug 06	20	30	67
Sep 06	16	22	73
Oct 06	19	25	76
Nov 06	25	32	78
Dec 06	24	30	80
Jan 07	11	13	85
Feb 07	15	24	63
Mar 07	24	28	86
Avg	221	296	75

	No 12 wks+	New Presentations	Addaction Retention %
Apr 06	8	29	28
May 06	<5	29	10
Jun 06	<5	30	13
Jul 06	5	27	19
Aug 06	6	31	19
Sep 06	6	30	20
Oct 06	7	42	17
Nov 06	<5	40	10
Dec 06	6	30	20
Jan 07	7	39	18
Feb 07	6	38	16
Mar 07	8	52	15
Avg	70	417	17

In terms of those in treatment, Sandwell has a significantly younger user profile than regionally or nationally. The under 25 cohort (37%) is 10% higher than the regional profile and 16% higher than the national profile; the middle age cohort of 25-34 is similar to the regional and national profile; and the older cohort (35+) 9% lower than the regional profile and 17% lower than the national profile.

National research suggests that age and gender are linked to and have an effect on retention. In considering age as a factor on retention results for our main Tier 3

structured treatment provider, Anchor, results for males aged below 25 seem to reflect this – with greater retention success as the male client populations gets

Chart removed due to low figures

The local proportion of criminal justice new presentations (43%) is higher than the regional average (40%) and significantly higher than the national average (29%). Non-CJS referred cases tend to have a larger proportion of positively retained clients than CJS clients as illustrated in the following chart. Overall, 56% of non-CJS clients were retained for the 12 weeks or more compared with 46% of CJS clients.

Chart removed due to low figures

The presenting substance profile of opiate users (85%) is higher than the regional average (80%) and significantly higher than the national average (70%). Conversely, stimulant use of cocaine, crack and amphetamines account for 7% of those in treatment, which is lower than the regional average (11%) and national average (18%).

Interestingly, 69% of those DIP clients on caseload during 2006 had a main drug of heroin, 11% cocaine, 7% crack cocaine, 9% cannabis and 1% amphetamines – this is in contrast to the predominantly opiate users (85%) seen in structured treatment. This suggests that engagement of stimulant users are under represented in the treatment system. This could be as a result of client characteristics who may be more difficult to engage or it could point to a lack of appropriate service provision – or very possibly – a combination of both.

Looking at retention by ethnicity we can see that a higher proportion of white clients are retained for 12 or more weeks in comparison to non-white ethnic clients in treatment. 47% of those Mixed or Asian clients and 48% of Black clients were successfully retained in comparison to 53% of white clients.

The greatest proportion of negatively retained clients are those with an unplanned discharge reason of ‘prison’ as can be seen from the following chart.

Chart removed due to low figures

The Service Users Perception of Drug Services questionnaire November 2007 conducted by SAVE (Sandwell’s Addicts Views Expressed) asked why service users dropped out of treatment.

The most frequently cited reason for dropping out of treatment was prison. This correlates with the above chart ‘Retention x Discharge Reason’ and also the fact that Sandwell has an above rate of CJS clients then regionally or nationally.

The next most commonly cited reasons given for dropping out of treatment were missing appointments and not being ready for change.

6 respondents (nearly 10% of the sample) gave work as the reason for missed appointments – whereas other commonly cited reasons included bus fare, rattling, illness and forgetfulness. There may therefore be some need for more varied opening hours of service evidenced from such responses and SAVE members have recommended text messaging as a way of appointment reminders backed up with

phone calls and an appointment card given the commonly cited forgotten appointments of respondents (The SAVE questionnaire had a total of 63 responses).

The SAVE questionnaire also uncovered a significant interest in rehab amongst respondents – bearing in mind that Sandwell has no local rehab facilities. When asked what drug services should be offered rehab scored almost as highly as prescriptions and counselling did. This may also have some bearing on retention levels. SAVE members have subsequently recommended that we consider funding detox programmes as a short term measure offering immediate relief and respite where necessary, but still advocate that drug treatment clients should have the option of accessing rehab.

Tier 2 and Tier 3

Drug service provision in Sandwell is provided via Addaction (open access Tier 2 service which also provides some Tier 3 modalities) and Anchor (structured Tier 3 service).

Many referrals are made between the two services however due to the nature of the open access Tier 2 service many PDUs not in structured treatment may be known here, or at least had some fleeting contact here.

Client details from the Tier 2 service (including Tier 2 clients, referrals where no further contact was made and prison releases where the client did not access the service during 2006/7) has therefore been cross matched against those PDU client details in structured treatment to see the extent of overlap and to identify PDUs ‘known’ to treatment but not in structured treatment.

A total of 1027 Tier 2 service user details (including Tier 2 clients, referrals where no further contact was made and prison releases where the client did not access the service) were matched to those known PDU clients receiving structured treatment 2006/7 (tier 3 modality from either Tier 2 or Tier 3 service).

A total of 464 PDU details (those using heroin and/or crack) could not be matched against details of those clients already in structured treatment in 2006/7. Some of these 464 may therefore be classed as ‘known to treatment but not in treatment’ and may not, therefore, form part of the estimated 1385 treatment naïve population (bullseye data).

However some of these 464 may be completely treatment naïve as they include details of those where no contact was made with the service and could form some part of the 1385 treatment naïve population. Unfortunately however it is not possible to distinguish between those who have or have not had any contact with the service from the data provided. Further integration of partner-wide data sources would therefore help to distinguish such clients and their characteristics.

Further analysis of all 464 PDUs ‘known’ to but not in treatment in the last year by age, gender and ethnicity is now considered to aid understanding of clients ‘known’ to but not engaging in treatment.

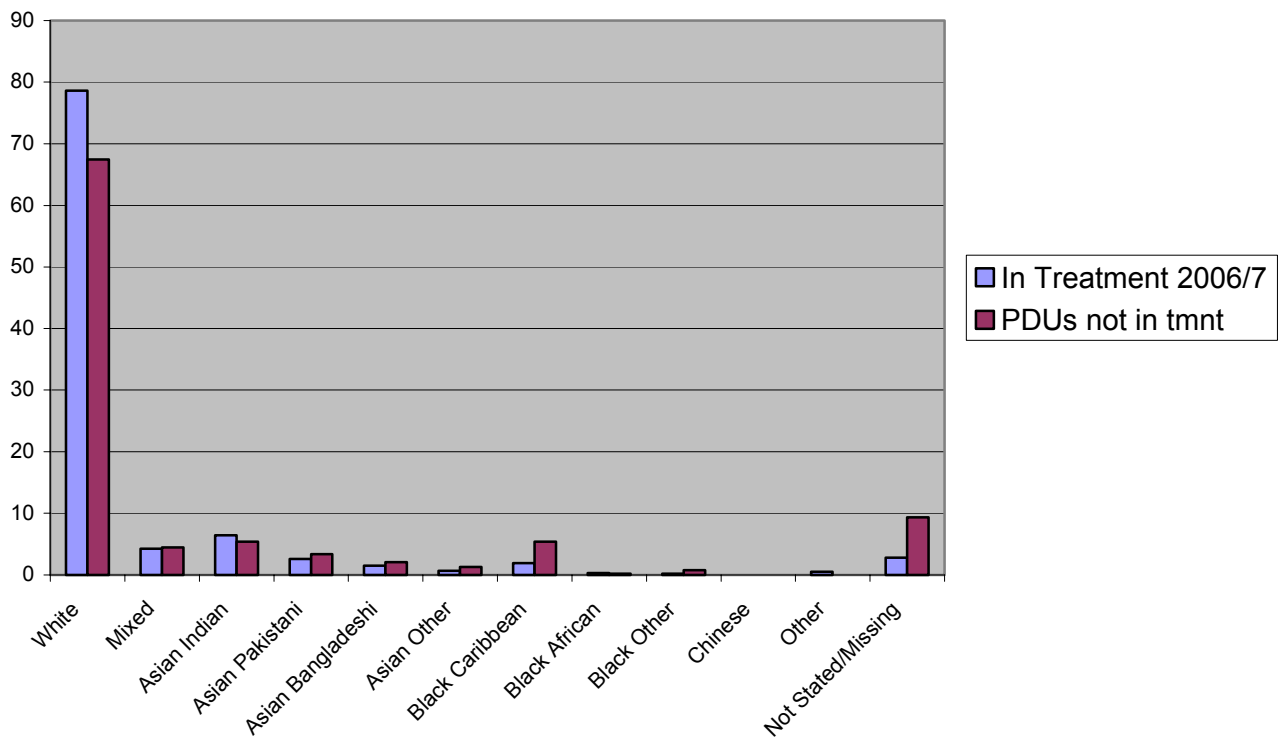
The following chart illustrates that male heroin users aged 25-34 account for the single largest group ‘known’ to but not in treatment.

Chart removed due to low figures

The overall PDU estimates show that within Sandwell there is a comparatively larger number of opiate than crack users suggesting a significant proportion of the PDU population are not solely crack users. This is also reflected in the cross match results where 50% of crack users (primary drug) also use heroin (secondary drug). Overall 87% were primary heroin users and 13% primary crack users.

The following chart looks at the ethnicity of those PDUs known to but not in treatment compared with those PDUs in structured treatment. There is a higher proportion of ‘non-white’ PDUs known to but not in treatment compared to those in treatment, however there is a much higher proportion of missing/not stated ethnicity of those not in treatment which we need to consider also. Bullseye data suggests an increasing amount of non-white PDUs as we move further away from the centre of the circle i.e. those in treatment – which is reflected in the below chart – in particular, those who are Pakistani, Bangladeshi and Black Caribbean seem to be over-represented when compared to those already in treatment. We need to consider the higher proportion of these particular groups who know of but are not actively accessing treatment.

Ethnicity of those PDUs in/ not in treatment 2006/7



MOSAIC lifestyle data

The MOSAIC lifestyle data classifies the population into 61 groups - aggregated into 11 broad types - in terms of their socio-demographics, lifestyles, culture & behaviour using a wide variety of data sources such as the Census, electoral register, land registry, council tax data etc.

In relation to the national average, Sandwell has an over-representation of the following groups shown in the below table.

	MOSAIC Group	MOSAIC Type	Index Value*
C20	Suburban Comfort	Asian Enterprise	732
D26	Ties of Community	South Asian Industry	636
H44	Blue Collar Enterprise	Rustbelt Resilience	582
G43	Municipal Dependency	Ex-industrial Legacy	402
H45	Blue Collar Enterprise	Older Right to Buy	300
F38	Welfare Borderline	Tower Block Living	255
F37	Welfare Borderline	Upper Floor Families	267
I50	Twilight Subsistence	Cared for Pensioners	230
G42	Municipal Dependency	Low Horizons	225
D22	Ties of Community	Affluent Blue Collar	221
H47	Blue Collar Enterprise	New Town Materialism	215
F39	Welfare Borderline	Dignified Dependency	214
G41	Municipal Dependency	Families on Benefits	212

*Where an index of 100 would equal that of the national average, those groups listed are at least twice the prevalence of the national average as indicated by an index value of 200+.

HES (Hospital Episode Statistics) are one of the indexed variables within each profile. Those with the highest HES for alcohol and drug misuse nationally are within the following groups:

	MOSAIC Group	MOSAIC Type	Index Value*
F39	Welfare Borderline	Dignified Dependency	479
F35	Welfare Borderline	Bedsit Beneficiaries	409
F37	Welfare Borderline	Upper Floor Families	372
D25	Ties of Community	Town Centre Refuge	371
I48	Twilight Subsistence	Old People in Flats	226
G42	Municipal Dependency	Low Horizons	220
D24	Ties of Community	Coronation Street	219
G41	Municipal Dependency	Families on Benefits	218
G43	Municipal Dependency	Ex-industrial Legacy	200

*The national average = 100.

Those groups with an indexed drug and alcohol HES of twice the national average have been highlighted yellow in the initial table.

This enables us to see local groups/populations at an increased risk of alcohol and drug misuse.

The following table illustrates at a postal sector level, the quartile rate of PDUs in treatment per 1,000 against the proportion of each lifestyle group within those postal sectors. This allows us to identify those postal sector areas where there may be a mismatch between users in treatment compared with those populations at most risk. That is, if the proportion of above average HES drug/alcohol indexed lifestyle groups (G41,G42,G43, F37,F39) within an area could be used as an indicator of problem drug use, the postcode sectors highlighted in the following table would be expected to show a higher rate of clients in treatment than are currently known.

POSTAL SECTOR	F37 % of all RDPs in Postal sector	F39 % of all RDPs in Postal Sector	G41 % of all RDPs in Postal Sector	G42 % of all RDPs in Postal Sector	G43 % of all RDPs in Postal Sector	PDU in Treatment Quartile*
B42 1						1
B43 5	4.9	0.0	4.4	0.5	0.5	1
B43 6	0.0	0.0	0.0	0.0	0.0	1
B43 7	0.0	0.0	0.0	0.0	0.0	1
B62 8	0.0	0.0	0.0	0.0	0.0	1
B64 5	8.7	0.0	0.0	0.0	15.4	2
B64 6	14.0	0.0	3.3	6.0	20.0	4
B64 7	0.8	0.0	0.0	14.3	5.3	2
B65 0	0.8	5.0	0.0	0.0	3.3	4
B65 8	0.0	0.6	0.6	4.8	3.6	2
B65 9	3.6	0.6	0.0	4.2	17.3	4
B66 1	14.3	0.0	32.7	2.0	0.0	2
B66 2	10.3	0.0	25.9	1.7	1.7	4
B66 3	16.2	8.1	19.9	4.4	5.9	4
B66 4	1.9	0.0	2.9	0.0	0.0	2
B67 5	0.0	1.2	0.0	0.0	0.6	2
B67 6	3.1	0.5	0.0	2.0	5.6	3
B67 7	11.9	4.4	0.0	0.0	8.1	3
B68 0	1.2	0.6	0.0	0.6	4.3	2
B68 8	1.2	1.2	0.0	0.0	3.0	2
B68 9	0.0	0.0	0.0	0.4	6.2	3
B69 1	4.2	1.1	1.9	6.1	15.5	4
B69 2	0.0	3.3	0.0	1.1	0.0	2
B69 3	0.0	0.0	6.3	0.0	4.8	4
B69 4	0.8	17.4	1.5	5.3	3.8	3
B70 0	5.3	4.0	0.0	10.7	18.0	3
B70 6	12.3	6.9	0.8	0.8	3.8	4
B70 7	2.3	4.7	0.0	0.0	25.6	3
B70 8	0.9	2.8	0.0	0.9	8.4	2
B70 9	6.7	2.0	2.0	8.7	26.7	4
B71 1	1.1	0.0	0.0	14.4	14.9	4
B71 2	2.5	0.0	0.0	7.5	18.9	4
B71 3	3.6	4.8	0.0	0.0	1.2	3
B71 4	0.0	1.2	0.0	10.5	0.0	1
DY4 0	3.0	4.1	2.6	11.2	14.2	4
DY4 7	2.8	12.4	0.0	0.0	10.1	3
DY4 8	6.8	5.3	0.0	4.2	12.6	2
DY4 9	2.7	0.0	4.7	23.6	21.6	3
WS10 0	0.0	0.0	2.0	16.8	13.8	3
WS10 7	8.0	13.3	0.0	12.0	10.7	1
WS10 9	1.7	0.0	0.6	0.6	2.3	1
WS5 4	6.7	0.0	0.0	0.8	18.3	1
WV14 8	0.0	0.0	0.0	0.0	0.0	1

*Quartile value of 1 = lowest PDU rate in treatment per 1,000 population

*Quartile value of 4 = highest PDU rate in treatment per 1,000 population

Drug Test Data

A total of 2763 offenders who committed offences in Sandwell borough between January – December 2006 were tested for Class A drugs. 1030 (37%) of these tested positive.

In total there were 2604 arrests for trigger offences (both positive and negative results) and 159 people were arrested and tested for non-trigger offences.

Males are more likely to be trigger offence defendants than females (79% male to 21% female). This is higher than the proportion of males to females seen in treatment (71% male to 29% female).

50% of those who commit trigger offences (regardless of test results) in Sandwell and who are resident within the borough are aged 18-24. This is slightly higher than the proportion of all trigger offences committed within the Sandwell areas (regardless of DAAT residence) where 47% are aged 18-24. This illustrates a higher proportion of resident trigger offenders aged 18-24.

Chart removed due to low figures

Comparing the proportion of those who test positive (cocaine, opiate or both) for a trigger offence by age group (following chart) to the overall proportion committing a trigger offence -positive or otherwise by age group (previous chart), those males aged 18-24 year olds who test positive are less prominent as an age group in comparison to those males aged 25-34 who test positive than is seen in overall trigger offence defendants.

This suggests that those 18-24 year olds who test positive for a trigger offence may be less regular drug users or may be using drugs other than opiates or cocaine?

Chart removed due to low figures

The most common trigger offence for individuals testing positive was theft including attempted theft, which accounts for nearly two thirds (64%) of all positive records.

Offence	Total no. of offences	Total testing positive	% of that offence testing positive	% of all +ve records
Theft (incl. Attempted)	1534	623	40.6	64.0
Burglary (incl. Attempted & aggravated)	352	113	32.1	11.6
Possession / Supply of Drugs	203	113	55.7	11.6
Robbery (incl. Attempted)	179	47	26.3	4.8
Deception (inc. attempted)	137	31	22.6	3.2
TWOC / Aggregated Vehicle Taking	120	23	19.2	2.4
Going Equipped	40	12	31.6	1.2
Handling stolen goods (incl. Attempted)	38	11	27.5	1.1

In terms of ethnicity, police records use different and less specific categories than those used in treatment or Census statistics. It is therefore difficult to compare such data against our 'in treatment' ethnicity statistics.

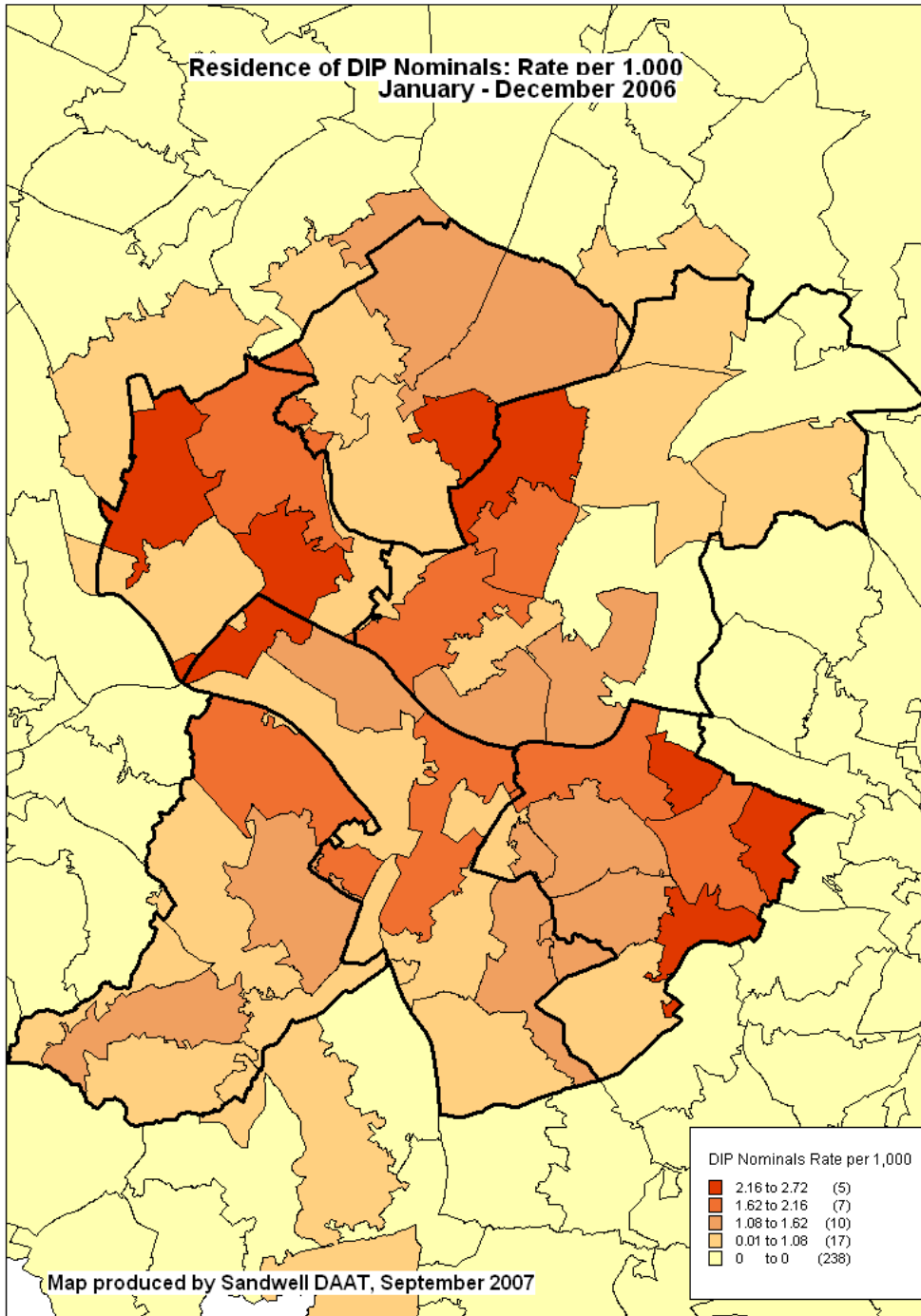
DIP data:

Data covering the drug using offender population between January and December 2006 seen by the Sandwell DIP team is also analysed here to understand the drug using offender population (please note that numbers relate to an individuals' latest offence.)

A total of 621 individuals on the DIP caseload were assessed – 68% (423) Sandwell residents, 32% (198) out of area. Of those 423 Sandwell residents assessed:

- Male 81%; Female 19%
- 18-24 (43%); 24-34 (41%); 35-44 (14%); 45+ (1.7%)
- 82% White; 10% Asian; 5% Black; 2.6% Mixed
- 97% of those assessed used illicit drugs in the past month – the main drug of choice breakdown is as follows: -
 - 69% Heroin
 - 11% Cocaine
 - 9% Cannabis
 - 7% Crack Cocaine
 - 1% Amphetamine
- Of those 69% (284) using heroin, nearly 3/4s (205) also used crack-cocaine
- Of those 9% (38) stating cannabis was their main drug, none used Class A drugs on a daily basis: these are therefore likely to be recreational users only. A distinction between casual and problematic use is therefore necessary as casual use is more likely to be inexpensive and financed to a lesser extent by acquisitive crime. We need to ask whether DIP is the correct vehicle to deal with such recreational drug users.
- Residence of DIP nominals are mapped to postal sector in the following map

Overall the gender and age traits of these clients on the DIP caseload seem to reflect the estimated PDU age and gender proportions evidenced by the Home Office estimates.

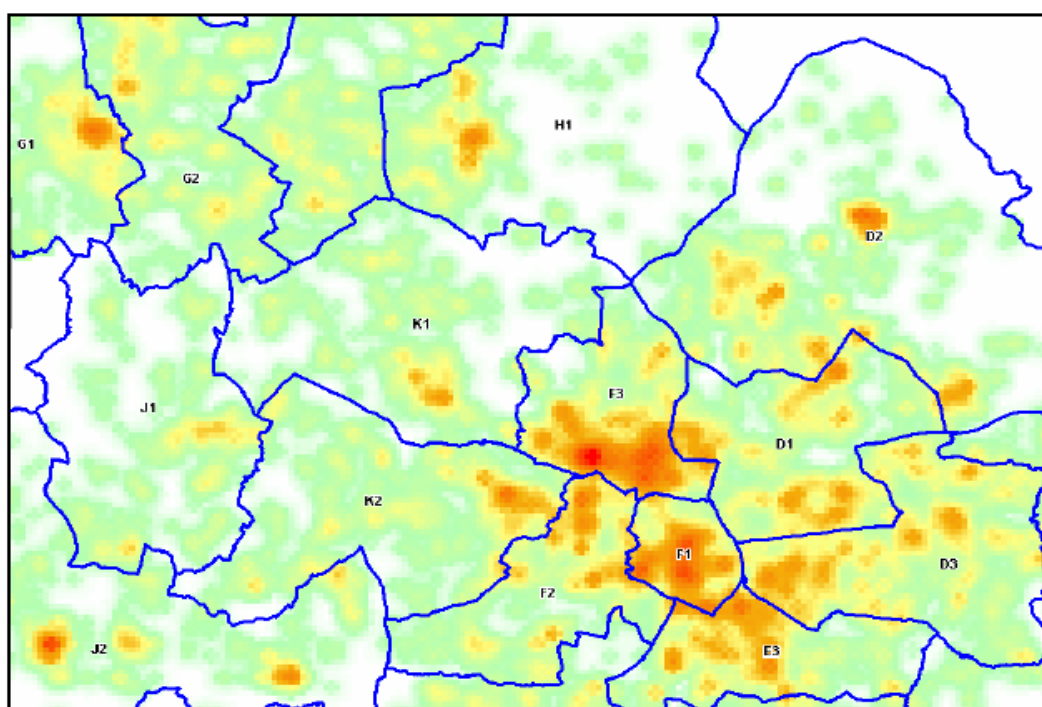


Drug Offences:

The following map shows all drug offences across the West Midlands police area from January – December 2006 based on date first committed. In order not to skew the hot spot locations, all drug offences that have been recorded within a Police station have been removed from the data. The hot spot clearly shows there is a small dense area of offences within the West Bromwich Town centre and Smethwick, however the majority of drug offences occur outside of the Sandwell police areas.

Please note that the below map is likely to be more indicative of police activity targeted at drug offences rather than where actual offences may occur (crime recording as opposed to reported crime). The detected drug offence locations show no significant change from last year – again this is due to being centred around the two PACE detention centres where police would routinely search persons in custody.

Overview of all drug offences in West Midlands Police Force area



The following table gives a breakdown of drug offences occurring during the 2006/7 financial year by offence type. Possession of Class C Cannabis continues to be the main problem in the borough accounting for over two-thirds (69.5%) of all crime offences within the borough (73% for the previous financial year). This is in line with national research, which shows that cannabis is the most widely used illegal drug in Britain. The peak age for people arrested with Class C drugs is 19-21 with over nine-tenths (94%) of offenders male. These are more likely to be recreational users than ‘problematic drug users’ who are defined as Class A drug users estimated to be responsible for 90% of drug related crime (National Drug Strategy findings).

The type of cannabis that is being used is becoming stronger. Skunk (a type of cannabis) contains far higher quantities of chemical tetrahydrocannabinols (THC) than herbal or resin based cannabis (four to seven more times), which is linked to psychosis, depression and anxiety. In the mid 1980s only 10% of cannabis in the UK was in the form of skunk but over the last 10 years this has risen to approximately 60% according to an article in the Independent newspaper (<http://news.independent.co.uk/uk/crime/article1751723.ece>).

Service managers have flagged up the increasing use of cannabis as an emerging issue and although conventional definitions of ‘problematic’ drug use relate to opiate and/or

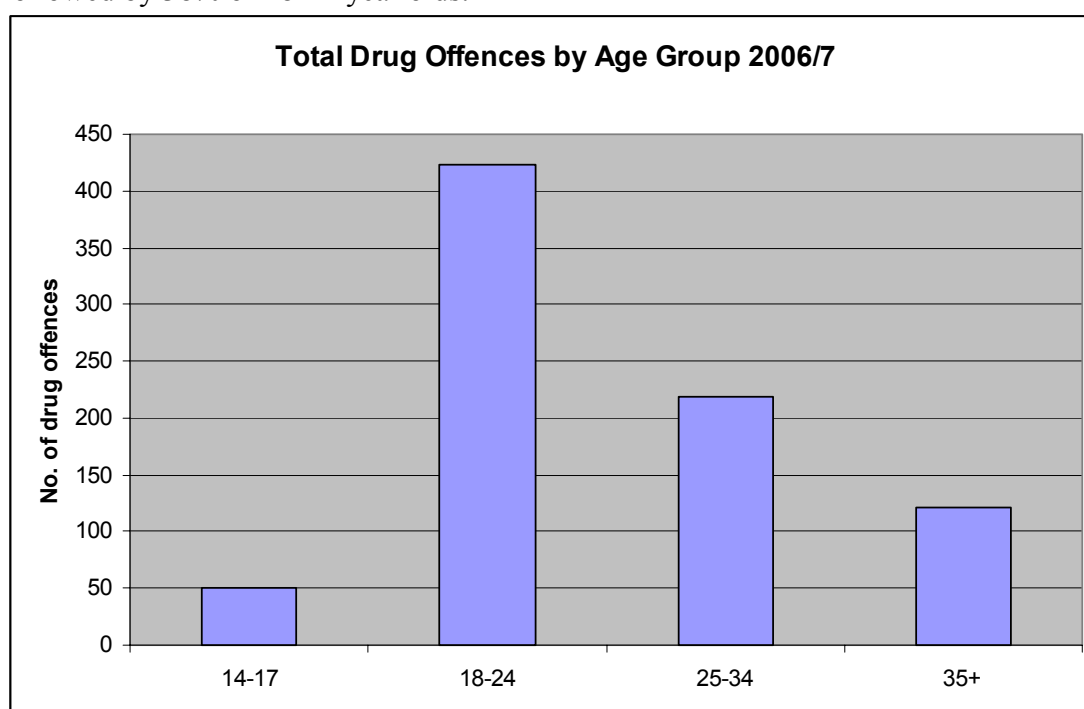
crack use, feel that the high quantity and frequency of cannabis use locally is in itself problematic for those users.

Indeed, the link between cannabis use and schizophrenia in terms of dual diagnosis is seen as an area of partnership working needing further investigation.

Table removed due to low figures

Overall drug offences in the borough have decreased from 916 offences in 2005/6 to 788 in 2006/7. Proportionately, the type of offences committed has not changed since last year.

Those aged 18-24 account for 52% of all drug crime defendants. In terms of drug offence type 18-24s account for 57.9% of all 'possession of class C drug: cannabis'. Those aged 25-34 account for the largest proportion (40%) of defendants for the second most numerous drug offence type 'possession of class A drug: heroin' followed by 38% of 18-24 year olds.



In terms of gender, males account for 90% of all drug related offences and females 10%. The gender difference is even more pronounced for possession of cannabis (males 95%, females 5%), yet similar to the gender split seen in the 'in treatment' population for heroin offences (males 77%, females 23%).

Police drug offence data is collected by ethnicity however categories are not comparable with those used for treatment statistics. However the statistics do show a higher than normal prevalence of non-white ethnicity when compared with treatment statistics (44%* v 21.4% respectively).

*44% accounts for all ethnic categories other than white skinned European and not known/ blank (African Caribbean, Asian, Arab, Chinese, Dark European and Oriental).

Perceptions of drug related issues:

The following table shows that overall there has been a decrease in the proportion of residents who feel that drug use, drug dealing, discarded needles and syringes, and people being rowdy or drunk in public places is a very or fairly big problem in their local neighbourhood.

Thinking about your local neighbourhood, do you think the following drug and alcohol related issues are a problem? Do you think this is a problem that has increased or decreased?

	Sep. 2006		Mar. 2007		Change Very/Fairly big problem %
	Very/Fairly big problem %	Not a big/Not at all a problem %	Very/Fairly big problem %	Not a big/Not at all a problem %	
People using drugs	10.2	82.9	6.2	85.9	-39.2
People dealing drugs	10.3	82.4	5.8	86.1	-43.7
Discarded needles and syringes	4.0	87.7	2.1	89.6	-47.5
People being drunk or rowdy in public places	11.4	84.7	4.2	88.5	-63.2

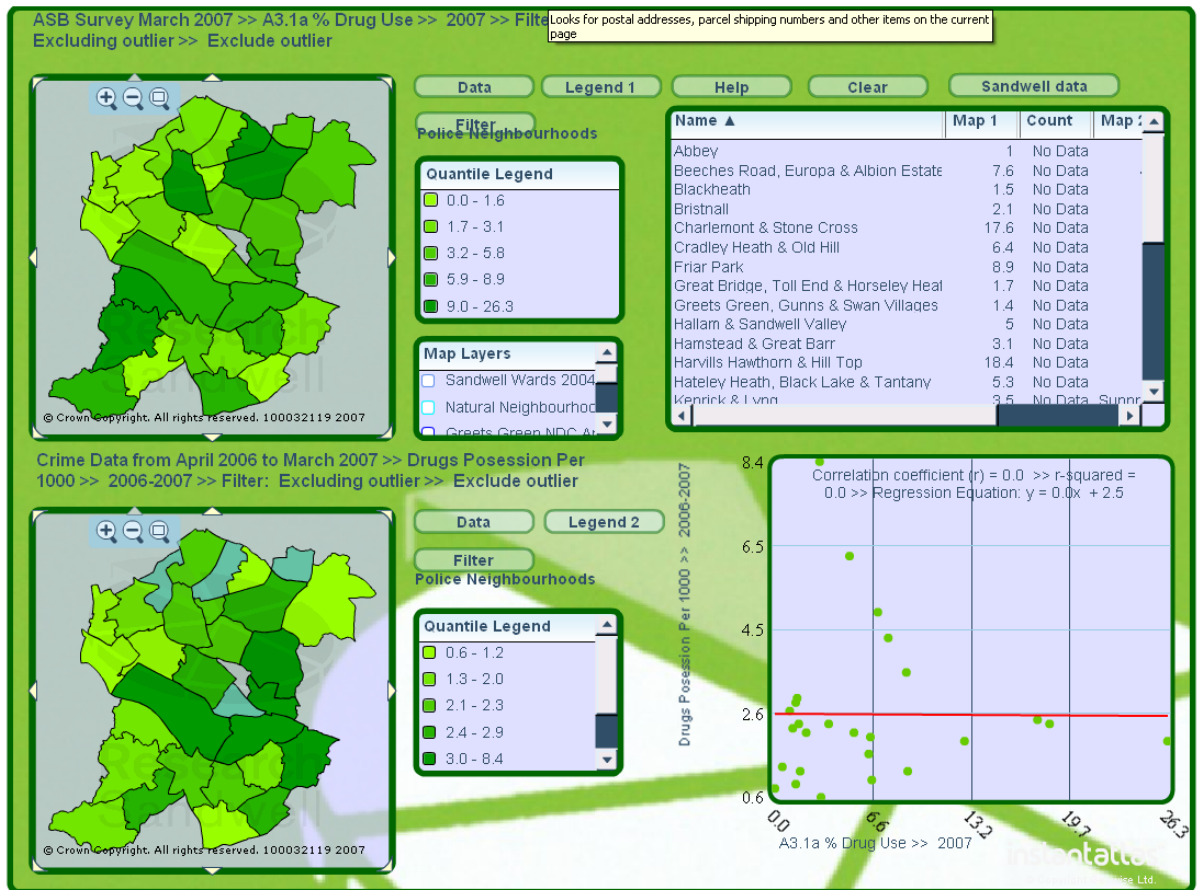
Concern about drink and drug issues in the local neighbourhood appear to decline with age. Those aged 16-24 were more likely than any other age group to report that people either using or dealing drugs and people being drunk or rowdy in public places were a problem in the local neighbourhood. This may reveal younger residents concerns (social pressures in terms of experimentation with drugs and alcohol are far greater at this age) or may indicate that they are more exposed to such happenings than older residents who are less likely to go out after dark.

This is highly significant in light of the Home Office PDU estimates which suggest a high proportion of 18-24s – young people who are continuing to enter the drug using population.

The below screen shot compares the level of concern by neighbourhood of drug using as a problem (top map) against the actual number of offences for possession of all classes of drugs (bottom map).

(Some of the values for possession of drugs have been suppressed due to the small figures for such a geography).

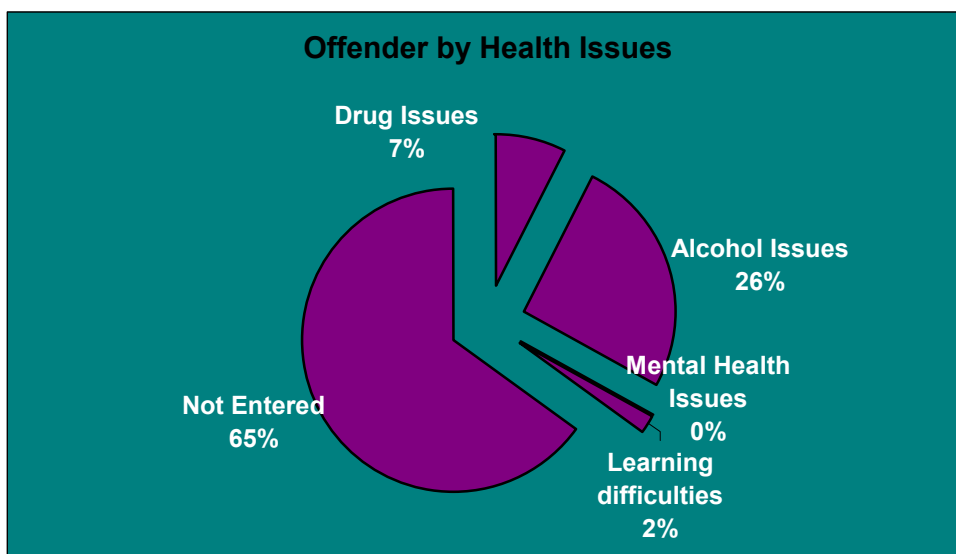
Overall we can see very little correlation between levels of actual offences and level of concern (bottom right scatter graph). This may be due to differing tolerance levels between communities or may be due to less ‘visible’ drug taking in some communities.



Domestic Violence:

Victims and offenders of domestic violence who have been seen by SOADA also feature clients with drug health needs.

Of those 3,435 domestic violence offenders who were assessed by SOADA during the 2006/7 financial year, 7% (n=253) were identified as having drug health needs.



Of those 4,129 domestic violence victims seen by SOADA during the 2006/7 financial year, 14 were assessed as having a drug health need.

It was not possible to obtain any further detailed statistics on those victims and offenders with a drug health need in order to understand their age, gender or to see whether they were receiving any formal treatment for their needs. It is anticipated that such information will be available for next year's analysis.

Social Services:

A query of the SWIFT database system used by social services showed that during 2006/7 a total of 5 clients who were receiving some kind of social services support were classed as having substance misuse health needs. On further analysis, <5 of those 5 people had a main substance issue problem of alcohol and the other <5 were from outside of the local borough area. Neither were accessing structured drug treatment.

Harm Reduction:

According to the Home Office prevalence estimates 32% (n=778) of the local problematic drug using population are injecting drug users.

The 2006 Shooting up report sites a recent national survey of the estimation of IDUs using heroin or crack cocaine in England at 140,000 –this would account for 42.8% of national PDU estimate – a slightly higher prevalence than is seen locally.

In Sandwell, of those in treatment during 2006/7, 41% stated they were either current or previous injectors: 121 clients (24%) were currently injecting and 88 (17%) had previously injected of those 510 clients with an injecting status. The lower level (32%) of estimated injecting drug users in comparison to the proportion of injecting drug users in treatment is in line with the bullseye data which shows an increasing proportion of 'never injected' users as we move away from the inner circle.

According to the 2007 'Shooting Up' Health Protection Agency report:

“Injecting drug users (IDUs) are vulnerable to a wide range of infections, including those caused by viruses such as HIV and hepatitis C and bacteria such as *Clostridium botulinum* and group A streptococci.”

By applying the national prevalence of such infections to local estimate figures we can estimate approximate numbers affected:

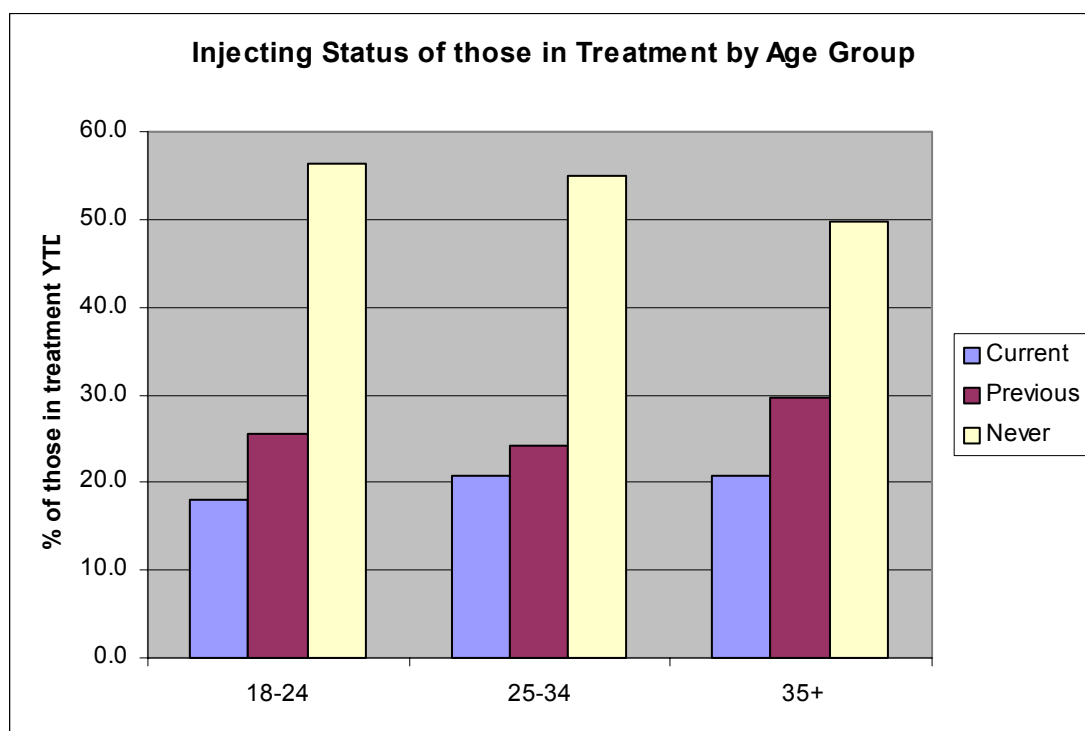
Hepatitis C: Almost half of IDUs in the UK have been infected with hepatitis C. This would translate to 389 IDUs infected with Hepatitis C locally. During 2006/7, 65 clients were tested for Hepatitis C (16% of those previously or currently injecting).

The below chart illustrates a snapshot of injecting status by broad age group of those in treatment year to date (Q2 2007/8). Clients from the 35+ age group are least likely to have never injected. Considering this and the recommendation from the Royal College Conference on Hepatitis C – this is a group that should be given high priority for treatment. (At the Royal College of Physicians of Edinburgh's Consensus Conference on Hepatitis C, during April 2004, it was recommended that “*a high priority for case finding should be given to former injecting drug users, especially those over 40, who are likely to have a stage of disease which would benefit from treatment*”).

HIV: Nationally around one in 75 IDUs now have HIV infection. This would translate to approximately 10 IDUs infected with HIV infection locally.

Vaccination: Around two-thirds of IDUs now reporting accepting at least one hepatitis B vaccine dose. This would translate to 513 IDUs locally. During 2006/7, 147 clients with an injecting status had been offered and accepted a Hepatitis B intervention locally.

Bacterial infections: Around one-third of IDUs report having had an abscess, sore or opened wound at an injecting site in the last year, indicating that injecting site infections are common. This would translate to 259 IDUs with some kind of injecting site infection locally.



Both the 2006 and 2007 Shooting Up reports highlight and re-iterate the increasingly widespread use of injecting crack cocaine and the impact this has on risk – in particular the possible shift towards use of higher risk injecting sites such as groin (femoral vein) & the fact that those injecting crack-cocaine report more equipment sharing.

The Home Office estimates suggest that there are 1,663 crack cocaine users locally (between 1,250 and 2,313 at a 95% confidence interval). The overall PDU estimates show that within Sandwell there is a comparatively larger number of opiate than crack users suggesting a significant proportion of the PDU population are not solely crack users. This is also evident from treatment data where crack accounts for 1.9% of main drug type, yet 70% of second drug type.

Of those crack cocaine users in treatment we know that they are more likely to be male, white, aged 25-34 and where crack cocaine is main drug of choice, smoked; and where crack is the second drug of choice, used alongside heroin. (Smoking or chasing of crack in itself could be considered as a harm reduction strategy to injecting as there is already evidence of such a route of administration from treatment statistics).

We have yet to see if injecting of crack cocaine is an evolving drug behaviour pattern.

The crack cocaine bullseye data suggests an increasing proportion of never injected users as we move further away from the bullseye centre, an increasing proportion of males and those aged 15-24 of those 'not known to treatment'. (See appendix for bullseye diagram).

Crack & Cocaine Needs Analysis 2005

A local needs analysis was commissioned during 2005 to give a snapshot of crack and cocaine use in Sandwell. In total 47 respondents took part with particular emphasis on people using crack cocaine (62% of respondents) and of these nearly 50% were not currently accessing services. Other respondents included workers from within commissioning, police and drugs services as well as representatives from community groups and families and carer's groups.

Results illustrate and re-iterate treatment figure findings that the primary route for taking crack in Sandwell is smoking (chasing and intravenous were indicated as the most popular secondary routes after this).

Of all users interviewed (29) 62% said that they had always or often shared equipment in the last 3 months. The high proportion of users sharing equipment is of great concern - need to raise awareness of the dangers associated with sharing as a matter of urgency.

23 of 29 users interviewed used other drugs in the past 3 months. However 5 people (17% of users interviewed) were not using any other drug other than crack cocaine). This should be taken into consideration in relation to treatment statistics cited earlier, which would not suggest such a proportion of primary crack users accessing services in Sandwell. There may well be more primary crack users in Sandwell than are currently recorded who will only access services if they see services as being relevant for crack cocaine.

Anecdotal evidence from practitioners working with PPOs stated there was a small group of primary crack users particularly from the Tipton area who were involved in car-jacking activity (as opposed to the majority of PPOs in the borough who mainly use heroin and/or crack).

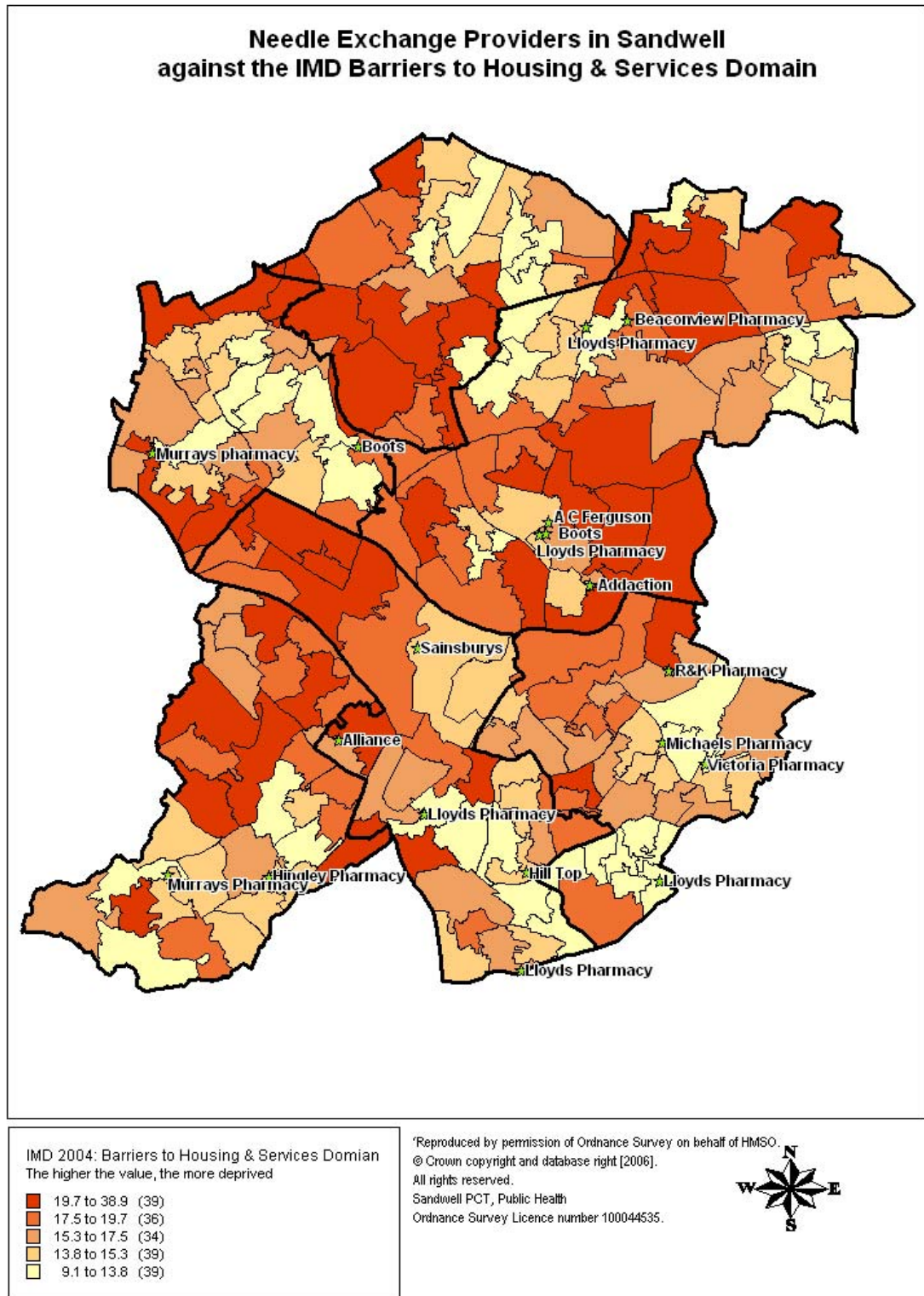
“Treatment statistics also tend to emphasise the use of opiates, since treatment is mostly directed towards problematic heroin use. While cocaine, amphetamine, benzodiazepine tranquillisers (such as diazepam and temazepam) and cannabis are not often identified as the main drug of misuse, they are frequently reported as subsidiary drugs, reinforcing the picture of increasing poly-drug use.”

United Kingdom Threat Assessment of Serious & Organised Crime. NCIS 2003.

Further to this, anecdotal evidence obtained from a workshop session conducted with service managers stated that people using non-dependency forming substances were an emerging group with needs not currently met by the existing treatment system. Examples were cited of very high quantities and frequencies of amphetamines, cocaine, cannabis and alcohol being used but users not feeling that appropriate treatment was available for such needs. It was felt that this is an issue that needs to be addressed at a national level in order to help the situation locally.

Needle Exchange:

Local needle exchange services are provided from 18 pharmacists along with a Needle Exchange and information service provided by our Tier 2 provider – Addaction. The location of these pharmacy outlets are mapped below against the Index of Multiple Deprivation 2004 Barriers to Housing & Services domain:

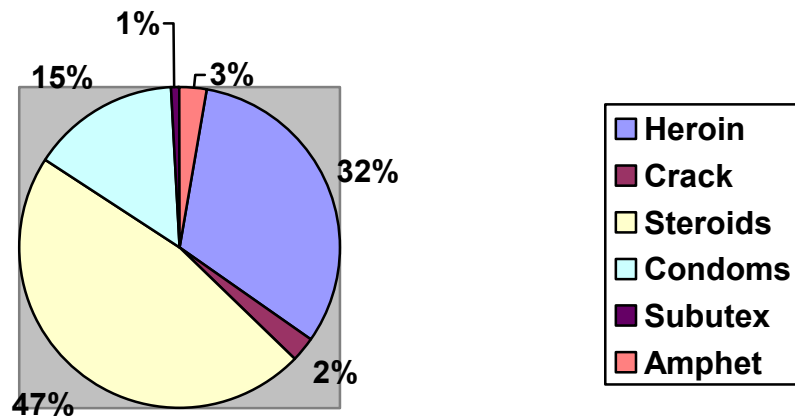


As part of a data collection exercise to inform a regional Harm Reduction report there were an estimated 260 individuals involved with the local pharmacy NX scheme. This is 33% of the estimated IDU population engaged in HR services – however we must bear in mind that locally we have a large proportion of steroid users and the proportion of IDUs (in terms of PDUs as heroin and/or crack users) may actually be lower.

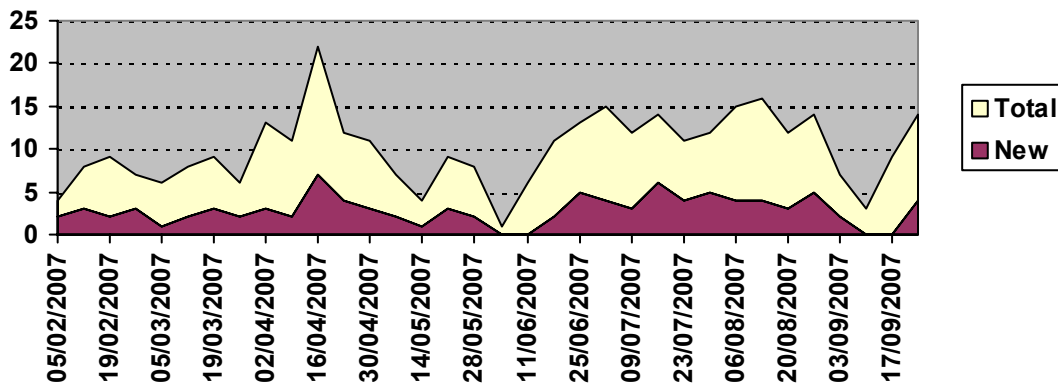
Sandwell – in a similar vein to many other regional DAATs – does not collect client details on those accessing pharmacy NX services. Such data would be of use in determining our target audience and to also tailor additional information/ advice around health related issues such as BBVs and to focus on safer injecting practice

Data from the needle exchange and information/advice service provided by our open access Tier 2 service, Addaction is available.

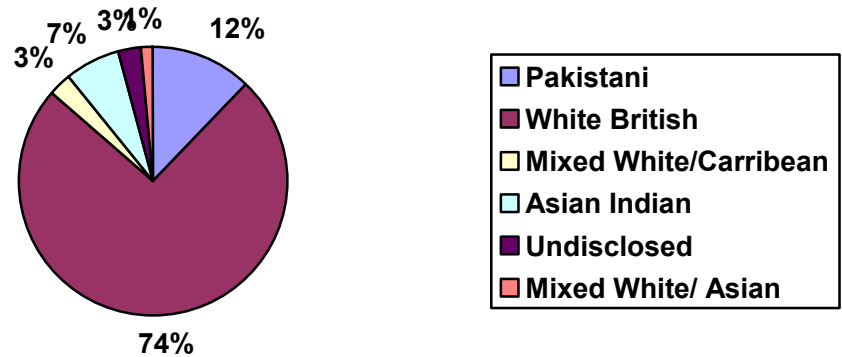
Since Addaction Sandwell started offering needle exchange facilities in October 2006 there have been 310 visits. In contrast to treatment statistics the single largest substance type of clients presenting to the service are steroid users accounting for nearly half of all visits (47%).



The below chart shows the proportion of new and existing clients accessing the service since February 2007.



Ethnicity of those accessing the Needle Exchange service is shown in the following pie chart. Pakistani clients appear to be over represented in relation to the overall population (12% v 3% respectively).



90% of those accessing the needle exchange service are male, and those aged between 25-34 account for over half of all visits to the service:

	% Accessing NX service
18-24	18.4
25-34	52.0
35+	28.9

In addition to local needle exchange services, SAVE members (Sandwell Addicts Views Expressed) offer an overdose workshop which plans to extend areas covered to include injecting advice and Blood Borne Virus workshops. Such relatively inexpensive workshops are invaluable in harm reduction and help to form credible links with drug using populations.

Homelessness: From the 2006 Shooting Up report around three-quarters of IDUs have ever been homeless, and around half of those who had been homeless reported a period of homelessness during the last 12 months. This would mean approximately 583 IDUs have been homeless at some point locally – 291 of which have been homeless in the past year.

This figure is extremely significant in light of the ‘Shooting Up’ report findings where the impact of unstable housing or homelessness on health risk among IDUs shows higher levels of injecting risk and associated infections. For example, 1 in 4 homeless people reported sharing equipment in the past month compared with 1 in 6 of those not homeless.

Of those in treatment during 2006/7, 59% were in rented accommodation and 28% in owned property. A total of 47 clients in treatment do not have stable housing status and a further 18 are in supported housing.

Table removed due to low figures

P1E data on homeless applications made to the local authority are classified according to priority need category. This includes 'drug dependency' and can be used to give us an idea of those drug users with urgent housing needs.

Priority groups listed within the local Homelessness Strategy are: victims of domestic violence; young people; asylum seekers & refugees; BME and older people.

People who may have several priority needs (including drug health needs) may be recorded under one of their other priority needs instead.

Rectification to enable a full count of all homeless applications with drug health needs (in addition to other priority needs) is an area of work flagged up for further development between the DAAT and the Housing Strategy division.

Both practitioners and service managers cited lack of stable housing as a gap affecting attendance at treatment.

The below table shows those local homeless applications for the past 3 financial years by priority need category – less than 10 people are stated as having drug dependency needs over the 3 years.

Research from the 2006/7 National Supporting People client record group report shows that of the primary client group with drug problems, less than a fifth of clients had been accepted as statutory homeless and owed a main homelessness duty. This may mean that locally approximately 20 people in 2006/7 with drug problems may have submitted a homeless application to the local authority.

Table removed due to low figures

Another source of data on those with housing problems by type of need can be obtained from Supporting People client records.

Findings from the 2006/7 National Supporting People client record group report shows that of the primary client group 3.9% (n=7,225) had drug problems.

Overall, 61% of this client group were between the ages of 25 and 38 years and almost three-quarters of all people with drug problems were male (74%). Just over one-fifth of clients were subject to Probation or Youth Offending Team supervision. The prior living arrangements of people with drug problems varied generally:- clients were more likely to have been sleeping rough (16%), have been local authority tenants (12%) or were living with family members (10%) or in supported housing (10%).

While people with drug problems were most likely to self-refer (23%), 17% were referred by voluntary agencies, 16% were referred by other agencies and 13% were referred by the Probation or Prison service.

Supporting People client records for Sandwell show that for 2006/7, 0.28% (n=<5) of the primary client group had drug problems. This is a much lower proportion than seen nationally, and may indicate a need for better referral links and awareness raising between agencies. A further 31 clients of the secondary client group had drug problems during 2006/7. It is not possible to cross-reference these clients against those already in treatment owing to data sharing issues.

If we take into consideration the characteristics of those Supporting People clients with drug problems seen in national figures, referral links from probation or prison services may need to be strengthened in light of the fact that over a fifth were subject

to Probation or YOT supervision, and in line with PDU estimates of those treatment naïve, younger males.

Anecdotal evidence obtained from a workshop session conducted with local practitioners flagged up the need for other services and organisations to recognise drug users as a priority group. Raising awareness of drug use issues onto others' agendas was seen as a way to progress partnership working and extend support for drug users in line with a holistic approach.

Indeed, with the reconfiguration of Tier 2 services currently underway this was seen as an opportune time to discuss the new model of treatment with external partners and how they fit into this.

It is not just injecting drug users who need HR interventions - Drug users are at increased risk of developing a variety of problems related to their alcohol use (NTA 2004 Promoting safer drinking - A briefing paper for drug workers).

The role of alcohol in drug use in particular in relation to overdose and the dangers of using alcohol, benzodiazepines and opiates means there is a real opportunity to raise awareness and to contribute to reducing the risk of overdose through key harm reduction messages.

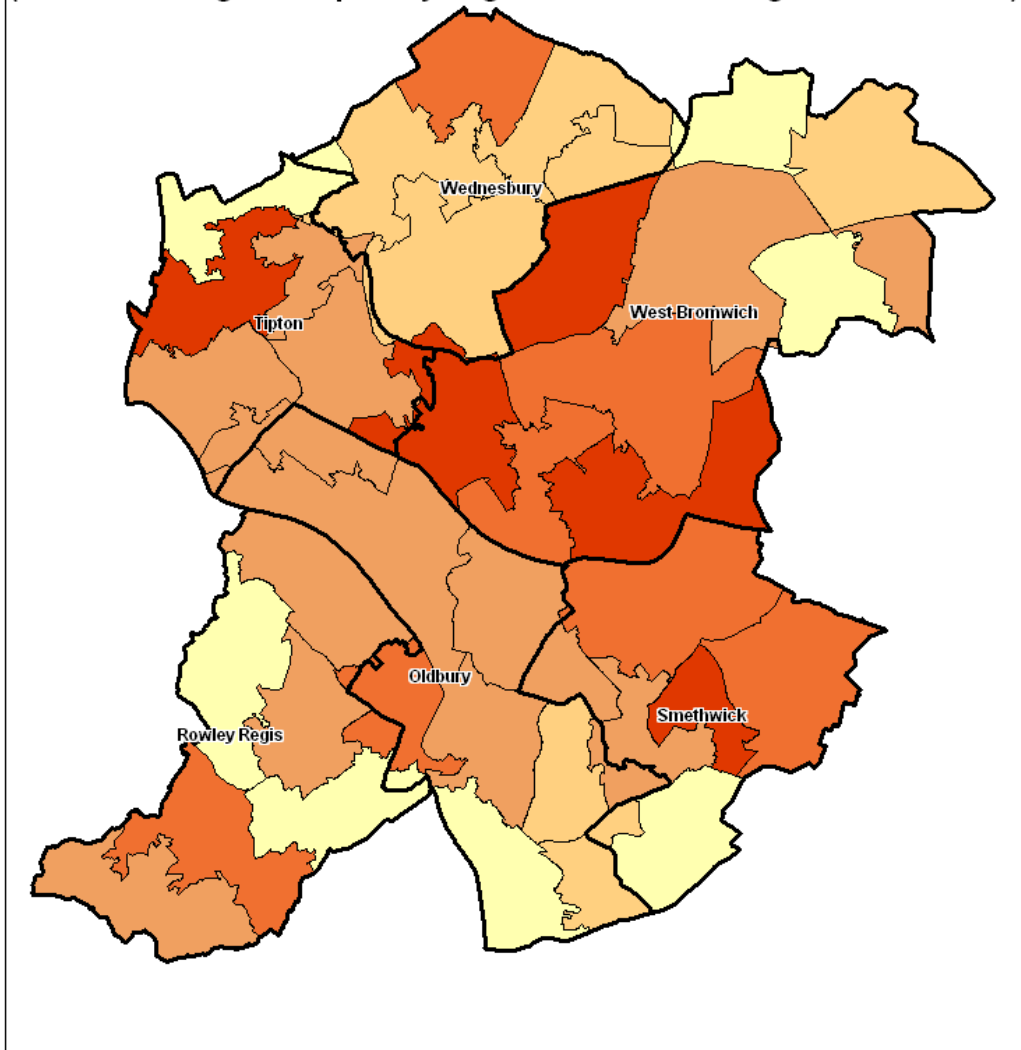
Hospital Episode Statistics:

The following map illustrates the geographical distribution of drug and alcohol related hospital admissions for the 2006/7 financial year. (Note that alcohol episodes will account for the majority of incidents but is useful as an indication of substance misuse across the borough).

In particular the hotspot in Tipton seems to be a recurring area of high substance related activity as indicated by corresponding hotspots seen in the PDU in treatment map as well as the DIP nominal map.

The hospital episode hotspot areas seen in West Bromwich and Smethwick town are also notable hotspots in the DIP nominal map but to a lesser extent the PDU in treatment map – this may therefore show areas of potential drug users who are not currently accessing treatment. This also re-iterates the bullseye data which shows a higher proportion of 15-24s who are in contact with DIP but not known to treatment (note also that those aged 18-29 account for the largest proportion of illicit drug related hospital episodes).

**Hospital Episode Statistics 2006/7:
Directly Standardised Ratio per 100,000 population Under 75s
(Includes all drug related primary diagnosis codes including alcohol F10 code)**



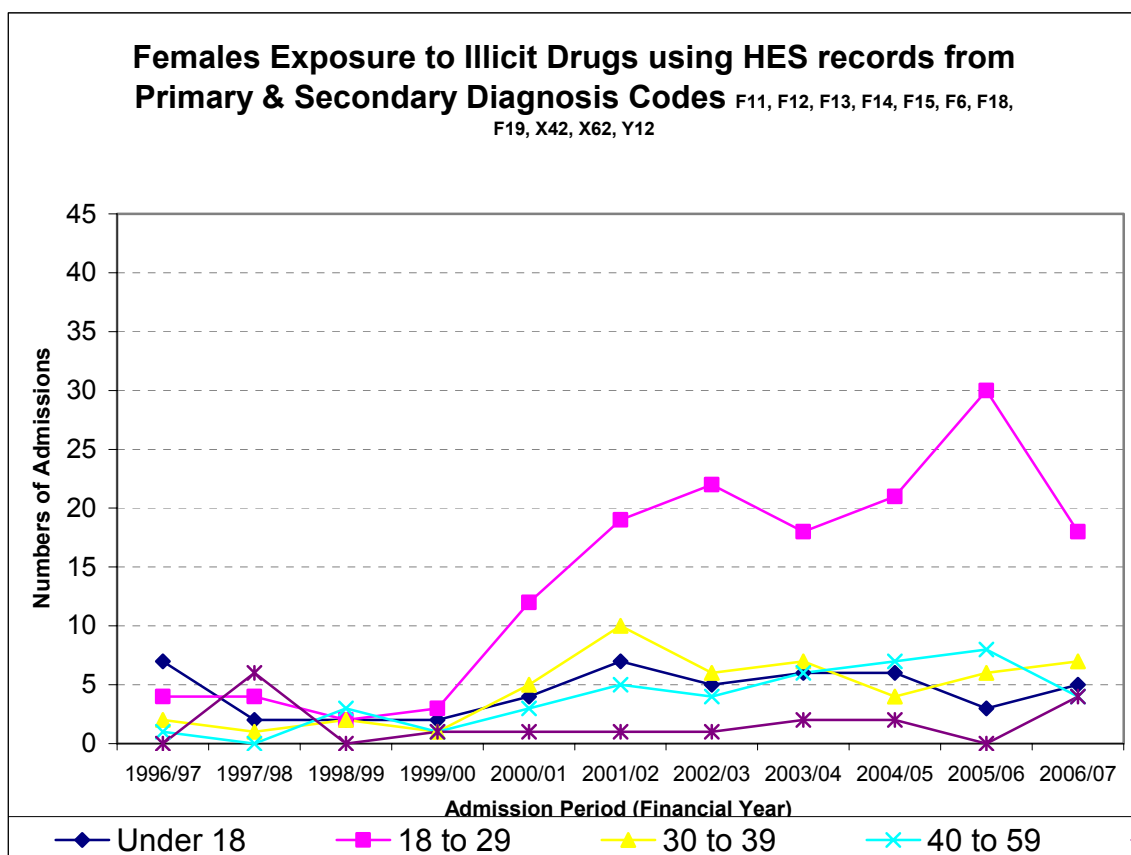
DSR per 100,000 Under 75s	
■	170 to 187 (5)
■	126 to 170 (7)
■	99 to 126 (12)
■	76 to 99 (7)
■	40 to 76 (7)

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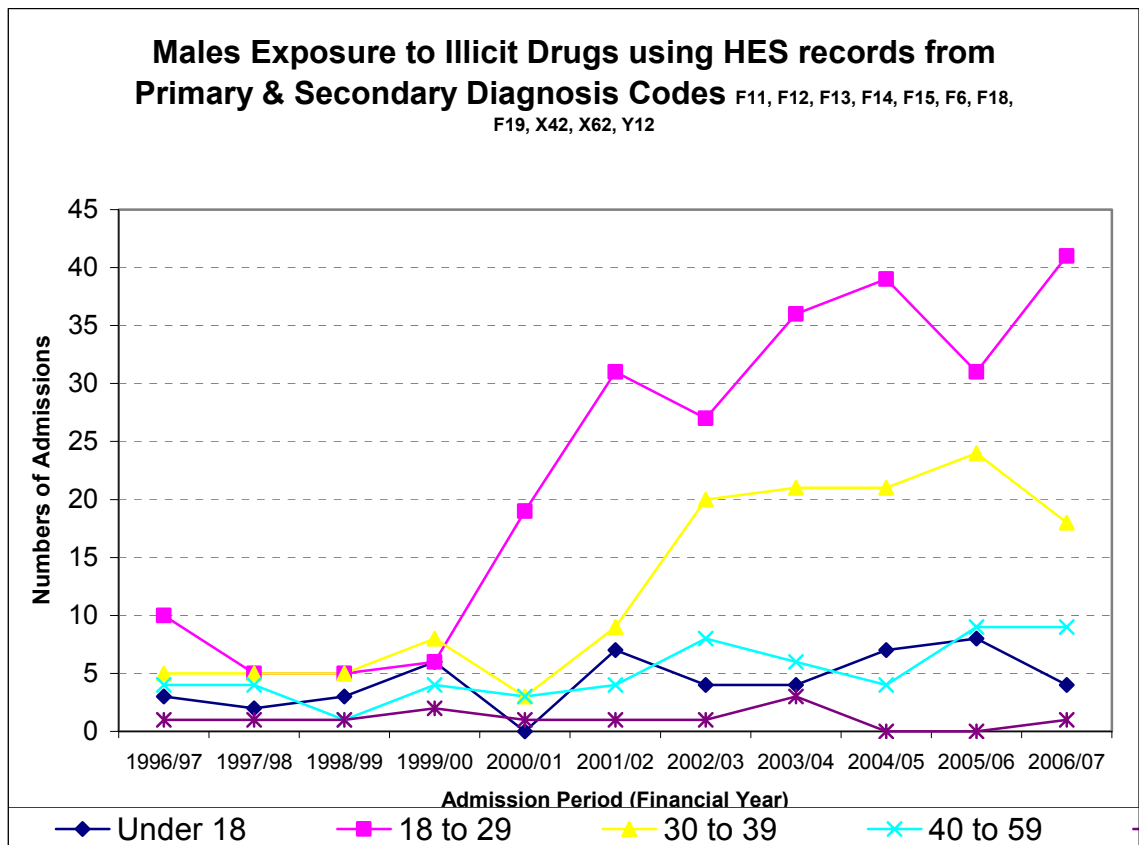
The following charts look at primary and secondary drug related hospital episodes by gender and over the past ten years. Males and females aged 18-29 account for the largest increase in numbers of such admissions over the ten-year period, and to a lesser extent, males aged 30-39. This is in line with the Home Office PDU estimates which suggest a higher proportion of younger PDUs locally than regionally or nationally – young people who are continuing to enter the PDU population.

This also has implications for targeted harm reduction messages to such a population who by fact they have ended up in hospital may be practicing some very dangerous drug taking habits or experimentation at this early age.



National drug related deaths data (covered further on in this document) has shown that that drug related deaths have been increasing and that the increase is attributable to males aged 20-29 and 30-39 using heroin (younger males – of which the bullseye data highlights as a treatment naïve population locally in need of engagement in treatment services) - we need to ensure far-reaching harm reduction at all tiers of service, and an increased focus on such an at risk population into treatment given that this population is showing up in hospital episode data featured here.

The Service Users Perception of Drug Services questionnaire November 2007 conducted by SAVE (Sandwell’s Addicts Views Expressed) commented on the very small numbers reporting overdose. However also noted “it is disturbing to realise that our respondents did not tell their key workers.... our guess is that service users are reluctant to admit overdosing for fear of loosing their script or other medication or, for example, being supervised”. (The SAVE questionnaire had a total of 63 responses).



Males accounted for 17 of 25 primary drug diagnosis codes during 2006/7 and females 8 of 25.

Males accounted for 51 of 85 secondary drug diagnosis codes during 2006/7 and females 34 of 85.

Overall males accounted for 62% of both primary and secondary drug related hospital admissions and females 38%.

Of those 110 primary and secondary diagnosis codes of hospital admissions for mental and behavioural disorders due to psychoactive substances (excluding F10 alcohol) during 2006/7, a total of 19 were also accessing structured drug treatment in 2006/7 (17%).

5 of 25 primary drug diagnosis codes were receiving structured treatment, and 14 of 85 secondary drug diagnosis codes were receiving structured treatment in 2006/7.

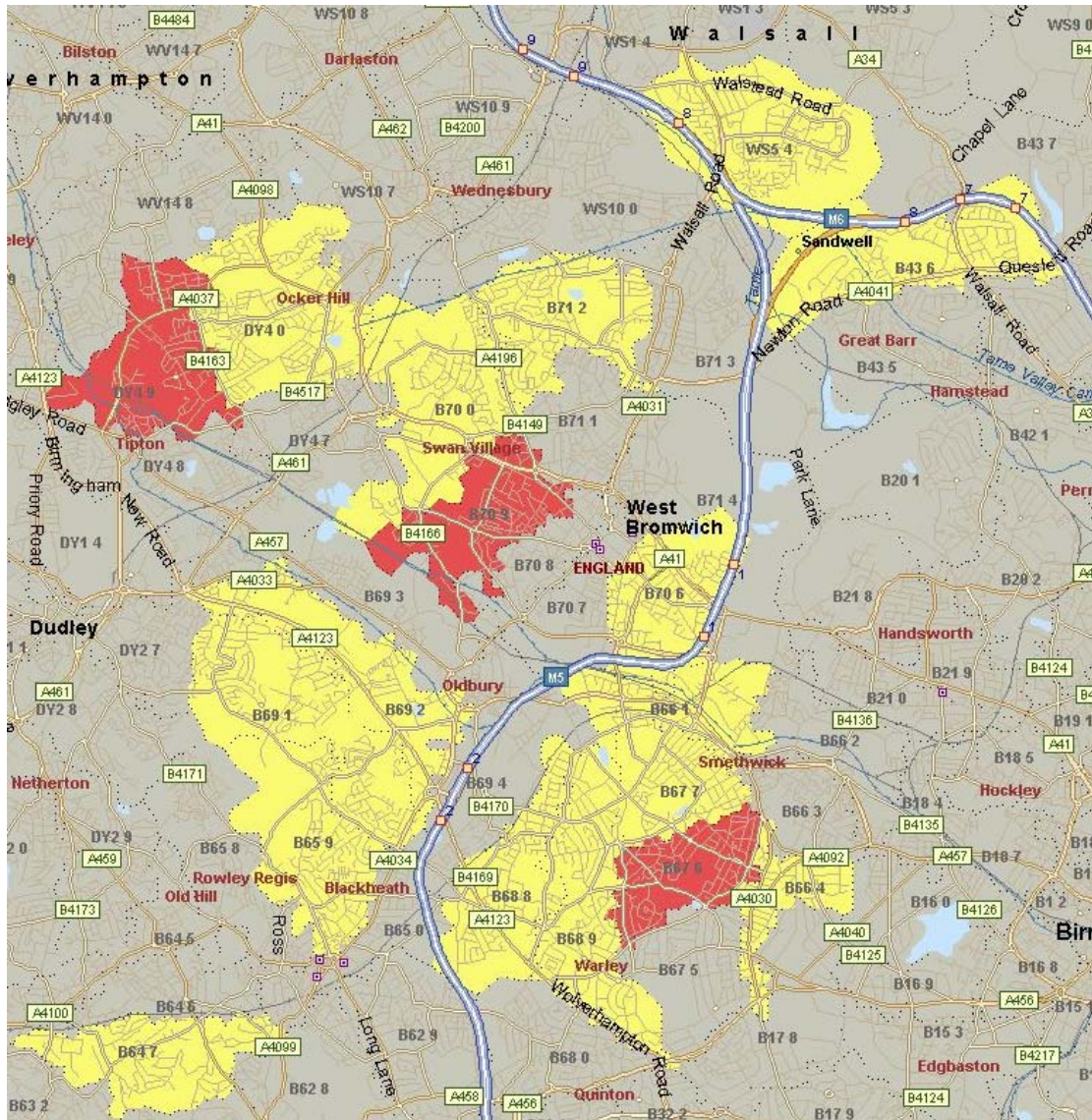
In comparing those drug related hospital episode clients who were accessing treatment and those not accessing treatment, there is a slightly higher proportion of males admitted to hospital who were not accessing structured drug treatment (65%) compared to those hospital episode clients who were receiving structured treatment (63%).

Ambulance Data

The below map shows the volume density of ambulance call outs for the quarter 1 period (April-June) 2007 for all 'narcotics suspected' call outs.

Yellow indicates one call out and red indicates two or more call outs. Owing to the short time period of data collection (the 'narcotics suspected' is a new tick box on the

forms for ambulance crew since the start of the financial year) it is difficult to make any real conclusions. However the postal sectors of highest call out volumes are also recognised as postal sectors with an above average rate of users in treatment. The borough has a rate of 2.0 PDUs per 1,000 population – those postal sectors with the highest call outs as evidenced by the red areas in the map (B67 9, B70 9 and DY4,0) have a PDU rate per 1,000 of 2.9, 3.1 and 2.7 respectively.



Drug Related Deaths:

Data on drug related deaths at a local level would be highly disclosive given the small numbers involved. However national data is available for drug misuse related deaths (deaths where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances controlled under the Misuse of Drugs Act 1971 are involved).

The percentage of all deaths related to drug poisoning that are due to drug misuse has increased from 54% in 2004 to 58% in 2005.

There has been a rise in the last 3 years (2003-2005) mainly due to a rise among males, and the highest number of deaths occurred in the 30-39 and 20-29 age group for men (for women there was an even distribution across age groups).

Among males, death rates for heroin/morphine were substantially higher than for any other substance from 1998 onwards. Among females, the highest rates were for paracetamol and compounds and anti-depressants, the most commonly used substances in suicides (which make up the majority of drug related poisonings deaths among women). Source: Health Statistics Quarterly 33, Spring 2007.

In light of these findings – particularly the fact that drug related deaths have been increasing and that the increase is attributable to males aged 20-29 and 30-39 using heroin (younger males – of which the bullseye data highlights as a treatment naïve population locally in need of engagement in treatment services) - we need to ensure far-reaching harm reduction at all tiers of service, and an increased focus on such an at risk population into treatment.

In one D[A]AT area, there has been a reported increase in drug related deaths and it is recognised that a high risk situation exists for prison releases and service users leaving rehabilitation programmes. Work is being undertaken to review housing stock, providing support for people in accommodation and hostels. Additionally work was being planned to examine the pathway more closely in order to improve partnership working across the treatment system. (Harm Reduction Regional report).

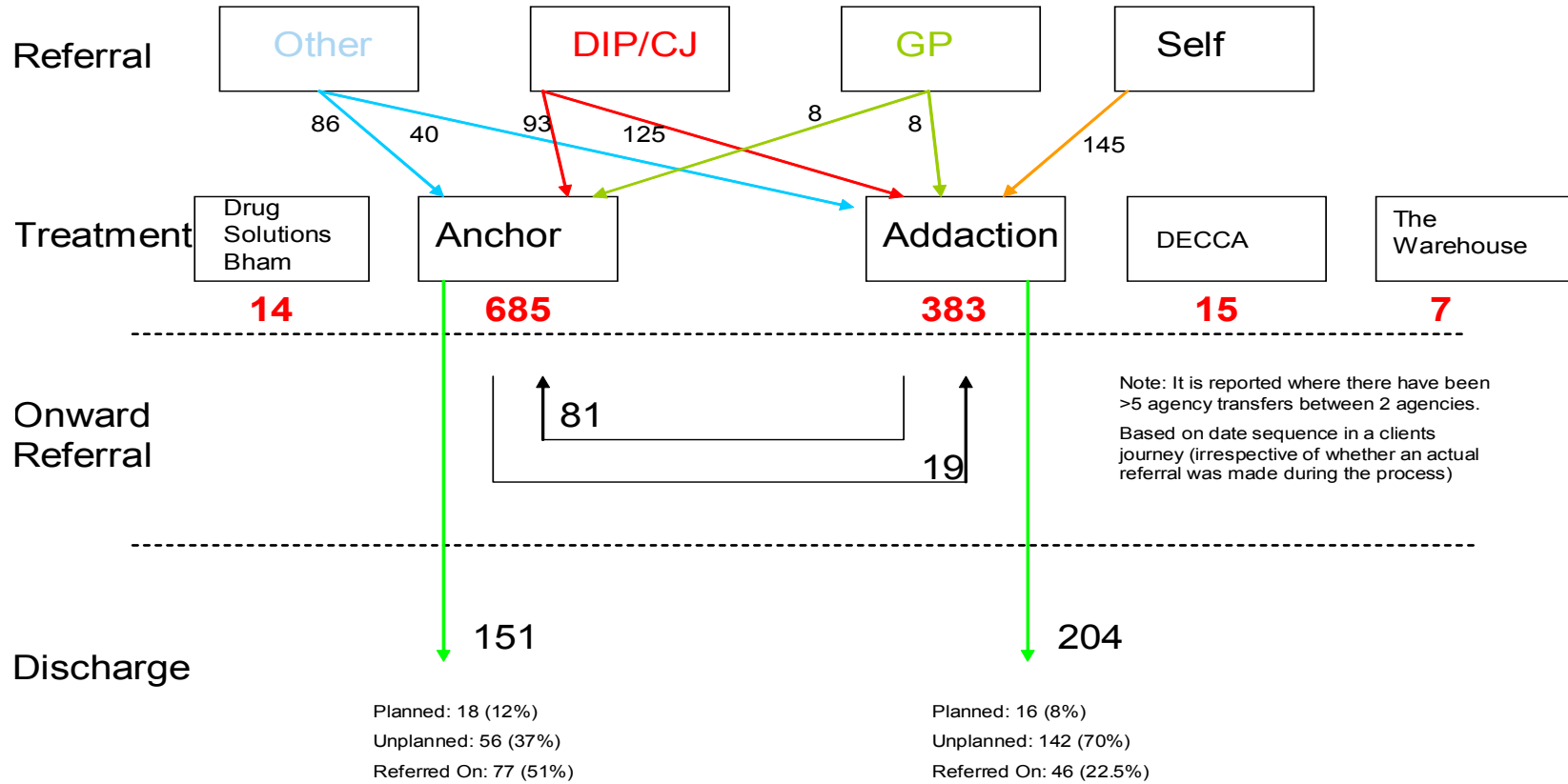
Other considerations:

SAVE members recommend that the role of wrap around services i.e. employment, training, education, financial advice is imperative to help people rebuild their lives – a possible role that could be delivered in partnership/through Tier 2. This report has not really covered such considerations due to the little data available for such areas – however these should be borne in mind for producing and delivering the drug treatment plan.

Appendix 1

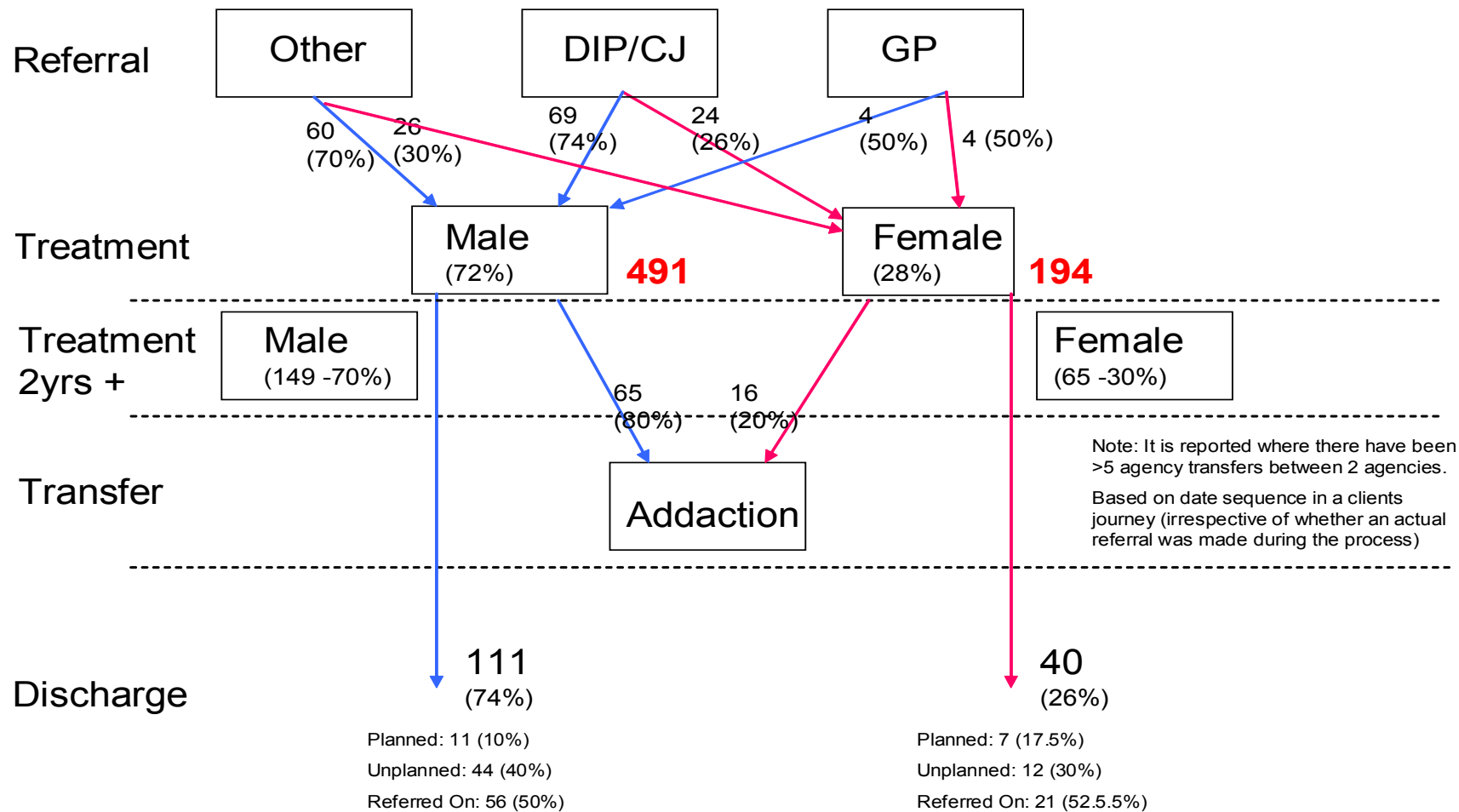
Treatment Map Summary 2006/7

Tier 3



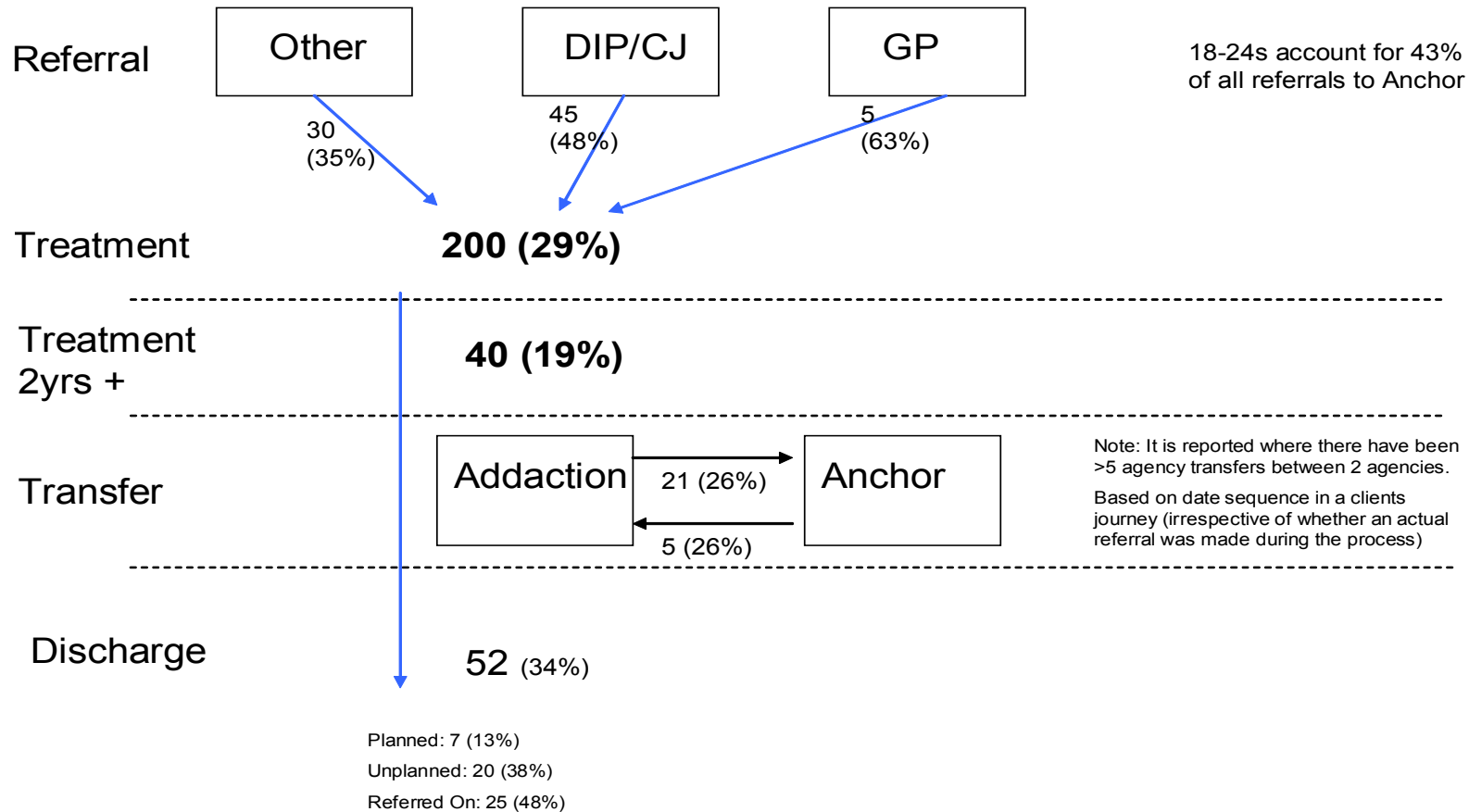
Treatment Map Summary 2006/7

Anchor: Sex



Treatment Map Summary 2006/7

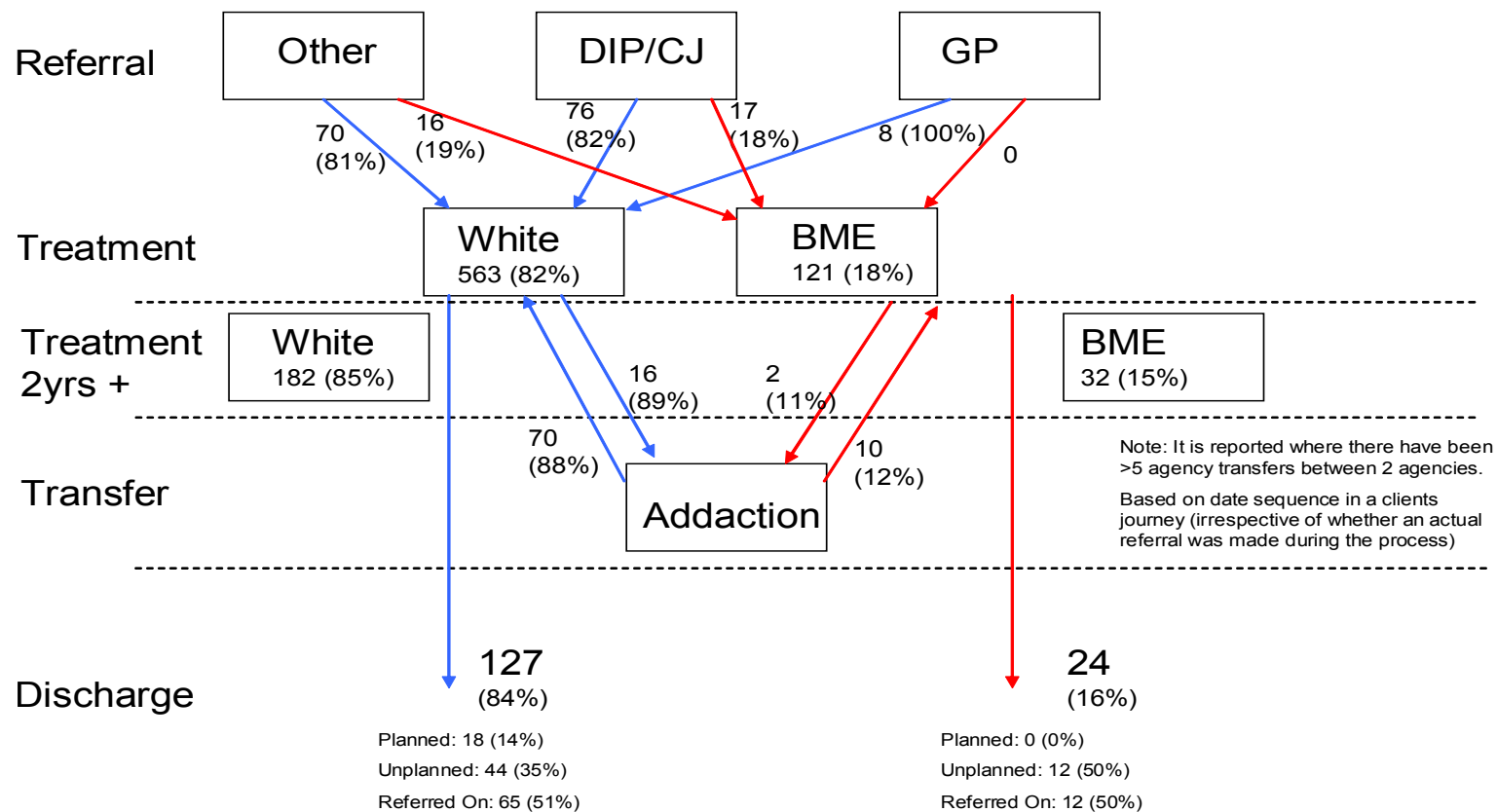
Anchor: 18-24s (% of all ages)



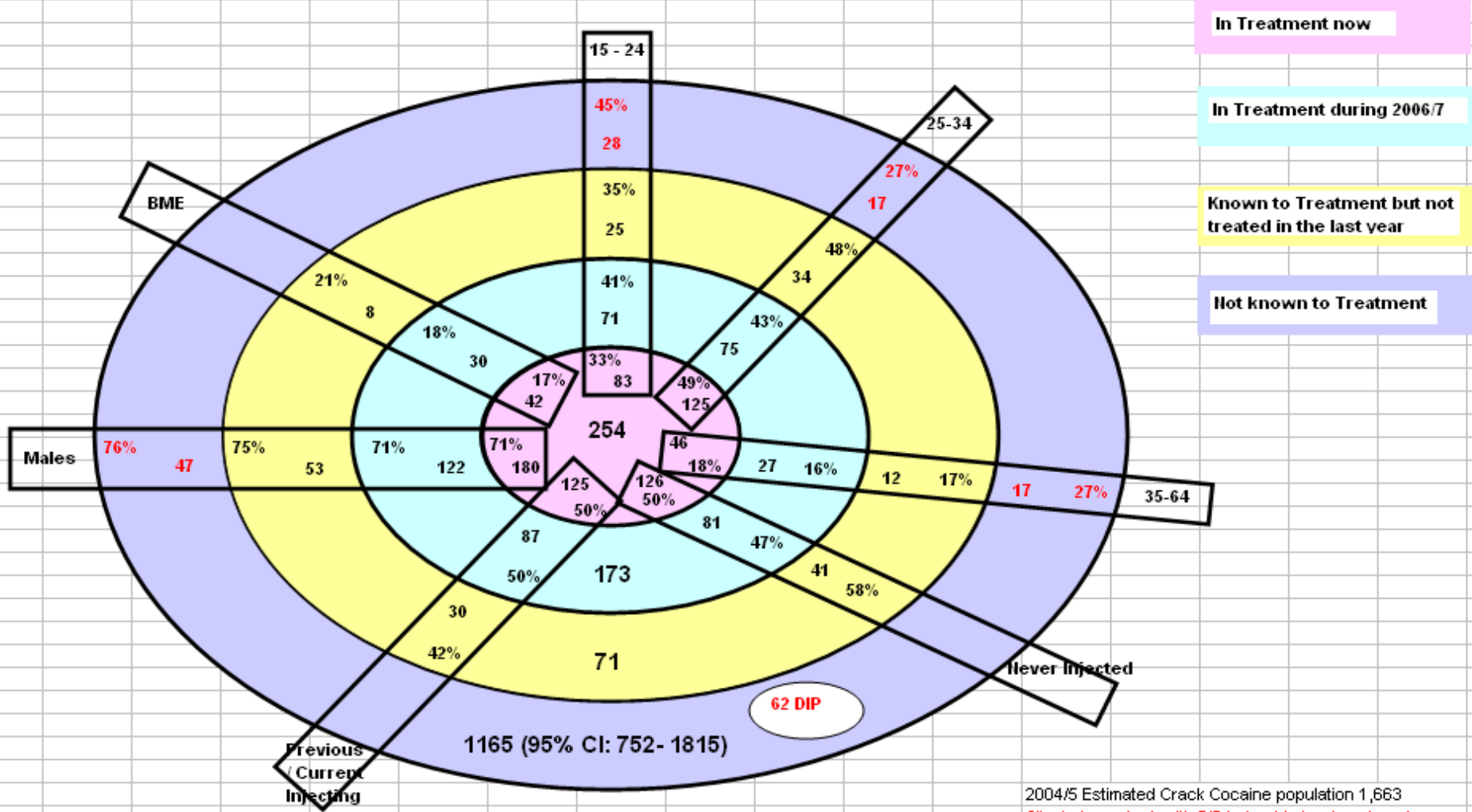
18-24s account for 43% of all referrals to Anchor

Treatment Map Summary 2006/7

Anchor: BME



Bullseye Data 2006/7: Crack Cocaine



2004/5 Estimated Crack Cocaine population 1,663
 Clients in contact with DIP but not in treatment system

