Walsall Council

Public Health Walsall 2014 Substance Misuse Needs Assessment

This needs assessment is part of the Walsall Joint Strategic Needs Assessment process

Contents Page

Executive Summary

This needs assessment has been completed during a period of transition, as the Public Health responsibilities have been transferred from the NHS into Local Government. As a direct result of the transition opportunities have arisen to re-balance the investment in alcohol and drug services to create a more equitable service offer for alcohol and drug service users. Walsall drug and alcohol services will be re-procured during 2014/15 and this needs assessment has complemented the local consultation process (see appendix one), the learning from neighbouring authority procurements and Public Health England's advice to inform the specification of the new integrated services.

The main sources of data to support this needs assessment are; the Centre of Public Health annual drug prevalence study, the North West Observatory's annual Local Alcohol Prevalence Estimates (LAPE), the National Drug (and Alcohol) Treatment Monitoring System reporting on service users who have accessed structured treatment, in Walsall the local data management system (HALO) which includes service users engaged in open access services, data sets related to the former Drug Intervention Programme and Locally Commissioned Services primary care data.

Key Findings

Drugs

The Centre for Public Health, Liverpool University and Glasgow University (2014) annual drug prevalence estimates that Walsall has 2186 problematic drug users of opiate and crack cocaine. This is a higher rate in comparison to the West Midlands and National rates. Similarly Walsall has a higher rate of injecting drug users.

The estimated number of drug users has increased over last 4 years from 2052 in 2009/10, and this is contrary to the national trend, which has reduced at a rate of 4%. Despite the challenging prevalence rates the local treatment system has a good penetration of the drug using population with 1350 service users accessing structured treatment and 500 service users accessing open access services in 2013/14.

The typical adult drug service user in Walsall is male (79%); white British (77%) with the next highest represented groups being Indian (4%), Pakistani (4%) and white/black Caribbean mixed heritage (3%); 52 % are parents with a third with dependent children living with them; the largest cohort fall within the 25 – 34 age range (47%) followed by 35 – 44 range (27%). There has been an increase in the last 12 months of 18 – 24 year olds in treatment from 17% to 21%; the primary drug used is heroin (54%) followed by cocaine (16%) and cannabis (13%); 11% of service users are injecting and 22% have previously injected; 18% are in regular employment and 63% unemployed; 66% have no accommodation issues with 11% having housing issues of which 2 service users each month present with urgent housing needs.

Criminal justice agencies refer the most adult service users (36%) followed by self referral (35%). Service users referred from criminal justice agencies differ to the overall cohort in treatment in that there is a lower primary use of heroin (36%) and a higher rate of cocaine (31%) and cannabis (19%); lower numbers injecting (9%) and previously injected (16%); their age profile is younger with 26% being under 25 years. There are a number of

demographics where they are similar to the overall adult cohort; parental status, ethnicity, accommodation needs and employment status.

Alcohol

The North West Public Health Observatory, (now part of Public Health England) annual Local Alcohol Prevalence Estimates (LAPE), estimates that Walsall has 10,772 residents dependent on alcohol. The alcohol prevalence rate in Walsall is rising slower than both the regional and national rates resulting in Walsall's rate approaching the national and regional rate per 100,000 of the population.

The typical adult alcohol service user in Walsall is male (72%); 72% falling within the 25-54 age categories; white British (85%) and Indian (5%) being the second highest group. The highest volumes of referrals come from Health Services (37%) and self referrals (35%), followed by criminal justice services (11%). In addition to primary alcohol use secondary drug use includes cannabis (45%) and cocaine (25%).

In 2013/14 11,168 service users were screened for alcohol misuse in GP surgeries, of those screened 400 were identified as dependent drinkers and 96 accepted a referral into specialist alcohol services. Specialist alcohol services treated 937 service users in 2013/14 where 68% received an open access brief intervention services and 32% received a structured intervention service. Of those who received a structured intervention 96 individuals received a medically assisted detoxification service with 50% receiving the service in a residential setting.

The main Public Health Outcome for alcohol is to reduce the alcohol specific admissions to hospital (per 100,000 of the population). Although Walsall's rates are higher than the national and regional rates Walsall's rate has slowed over the last 5 years to 2170, meaning Walsall is now approaching the regional rate of 2090 and national rate of 2032. The age profile of service users entering hospital for alcohol specific conditions peaks between 40-49 with 79% of service users falling between 30-69 age ranges.

There is a gender difference in the alcohol specific admissions to hospital with a higher rate of females in the over 60 age categories accounting for 21% of admissions in comparison to 24% for males in the same age category.

There is also a gender difference in the alcohol mortality rates observed over the 6 year period between 2006-2012 where for females in Walsall there has been a 26% reduction against a national 3% reduction in the same period meaning Walsall's rate is now equal to the national rate and below the regional rate, whereas the rate for males has risen by 10% and is higher than the regional and national rates.

Alcohol related crime has been falling in Walsall since 2008/09 falling by 29% against a regional rate of 25% and national fall of 21%.

Young Adults and Young People

In the under 25 cohort (aged 19 – 25 years), in comparison to the total adult cohort, there are slightly higher rate of male (80%) to female (20%); referrals are low for 18 year olds, who may still be seen in the young people's service, with an upward trajectory of referrals from 19 years peaking at 23 years; fewer are unemployed (52%); fewer are parents (25%); there is higher rates of primary cannabis use(29%) and alcohol use(26%) followed by

cocaine (22%), lower rates of heroin (13%) with lower rate of injecting (3%) and never injected(68%). In comparison to the full adult cohort there is no significant difference in; ethnicity and accommodation needs. The highest referral source is criminal justice agencies (53%) in comparison to 36% in the full adult cohort.

The typical young people in under 18 years specialist drug and alcohol services in Walsall differs from the adult cohort with services having a higher ratio of females (39%) to males (61%); they are mostly white British (82%) with white/Black Caribbean (5%) being the second largest category; 79% fall within the 14-17 age group; cannabis (68%) and alcohol (25%) are the primary substances with increased use, but still small numbers, (n=8), presenting using mephadrone as a primary drug. The highest volume of referrals comes from Education (32%), Children's Services (20%), Youth Justice Services (16%) and the Hospital A&E Dept. (12%).

Priorities and Recommendations
The Needs Assessment has identified several aspects which will require action and these are listed below:

- Standardise local data sets for alcohol and drugs
- Develop local alcohol and drugs data sets independent of the specialist services and dependence upon NDTMS and LAPE
- Improve local data quality to minimise any missing data domains
- Monitor and evaluate the impact of primary care prevention services
- Systemise, as part of quarterly monitoring, service user feedback on service delivery and quality
- Develop data sets that demonstrate drug and alcohol services' contribution to corporate priorities eg. safeguarding children young people and vulnerable adults, reducing looked after children, reducing offending, the impact upon reducing domestic abuse and improving community safety by reducing the harm cause by drug and alcohol misuse
- Monitor and evaluate the outcomes for the criminal justice referrals into the treatment system
- Monitor and evaluate the service demand and engagement of alcohol service users as the integrated service model is implemented
- Strengthen the activity monitoring and the effectiveness of the Locally Commissioned Services (LCS) for substance misuse to include: harm reduction initiatives of BBV, needle exchange and supervised consumption
- Further develop the process for collating and interpreting data relating to safeguarding and parenting

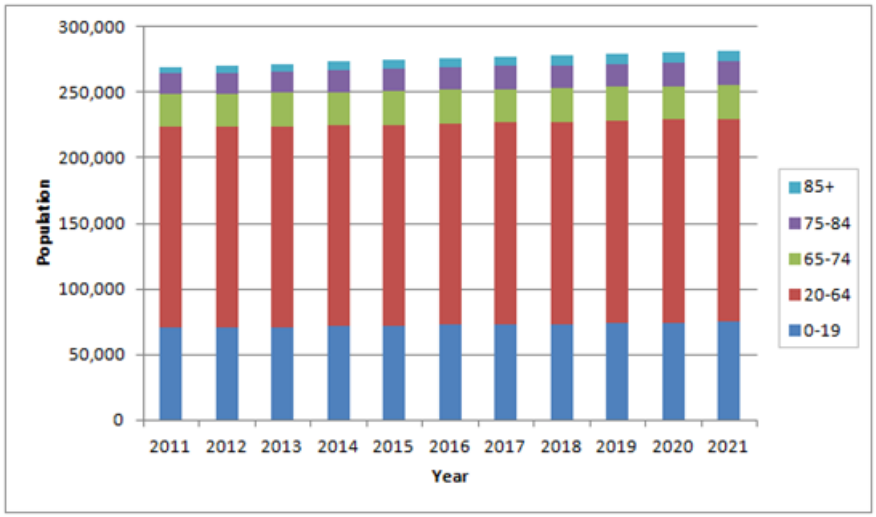
As the local infrastructure for drug and alcohol services changes, during a period of significant challenge, the active partnership between commissioners, stakeholders, provider agencies and service users, to achieve positive outcomes, has never been more important.

Demography

Background demography

Walsall's overall population is predicted to increase over the next 10 years by 4.5% from 269,500 in 2011 to 281,700 in 2021. In addition to this, Walsall's older population (those aged 65 and above) is also predicted to increase by 12.9%, with the number of people 85 years and older increasing from 5,467 in 2011 to 8,109 in 2021.

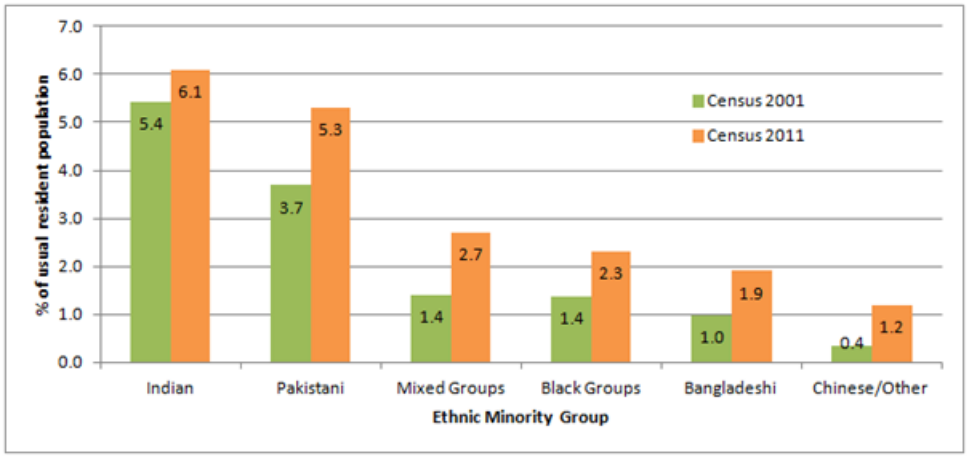
Table 1



Walsall population projections, by age 2011-2021 (Source: ONS)

Walsall also has a culturally-mixed population. People of Indian, Pakistani and Bangladeshi background form the largest minority ethnic groups in Walsall. The number of Non-UK Born residents in Walsall has increased by 3.7% (or 9,859 people) between the 2001 and 2011 censuses. Walsall now has a small Eastern European population who make up about 1% of the area residents (2,681 people in total). Access and the appropriate provision of services depend upon a well-informed understanding of the specific needs of these different communities.

Table 2



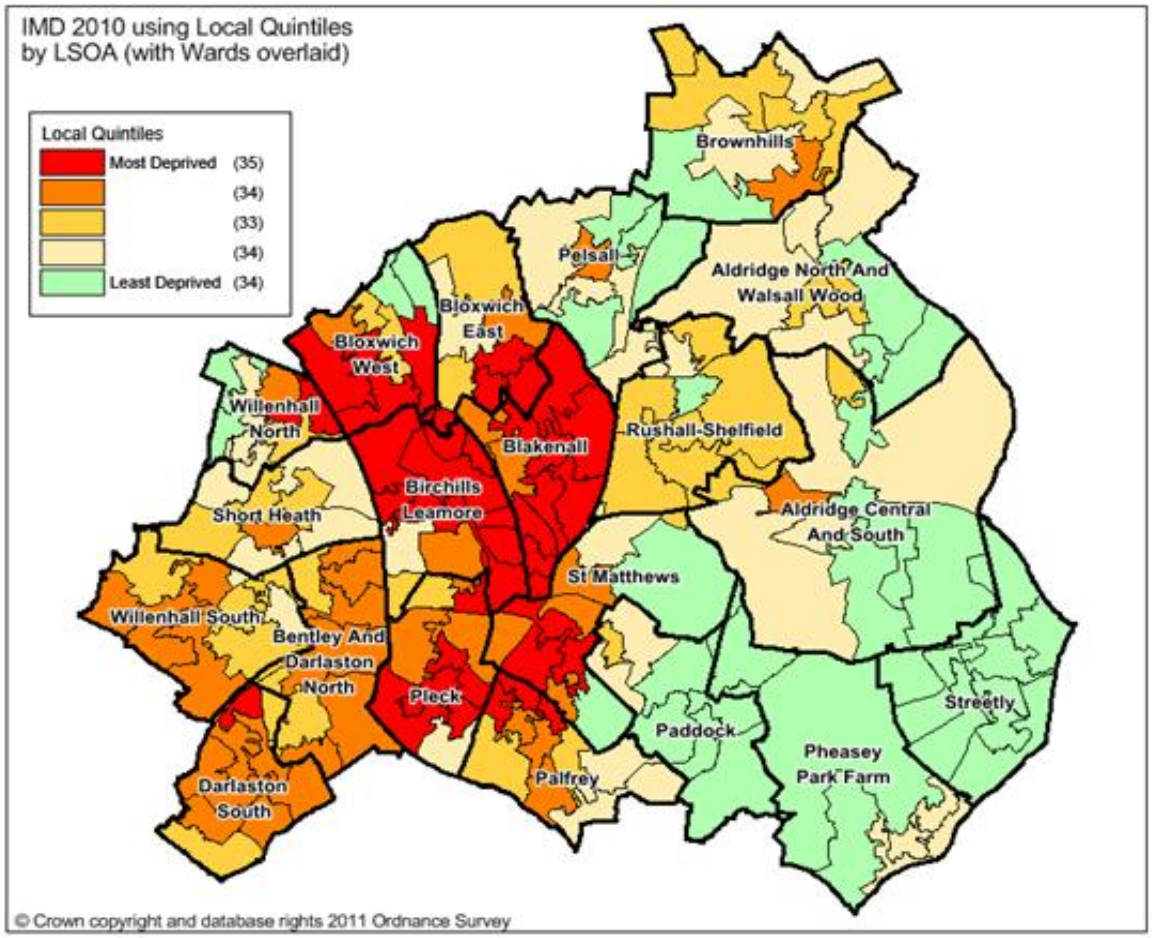
Minority ethnic group trends in Walsall 2001-2011 (Source: ONS)

Deprivation

The Indices of Multiple Deprivation 2010 (IMD) is a Lower Level Super Output Area (LSOA) measure of deprivation and is made up of seven domain indices: income, employment, health and disability, education skills and training, barriers to housing and services, living environment and crime. Developed by the Department for Communities and Local Government, it is a nationally-recognised measure across England and Wales. The indices are based on the concept that deprivation consists of more than just poverty; so while poverty is related to not having enough money to live on, deprivation refers to a much broader lack of resources and opportunities.

In 2010, Walsall was ranked as the 30th most deprived of the 326 Local Authorities in England. This position has worsened since the last data release in 2007, where Walsall ranked 45th out of 354. The borough fares particularly badly in terms of education, income and employment deprivation. Central and western parts of the borough are typically more deprived than the east.

The map below (page 9) also details that 114,800 (44.6%) of Walsall's total population (2010 mid-year estimates) live within the most deprived quintiles compared to 30,400 (11.8%) living in the least. Looking specifically by age, 28,100 (52.3%) of 0 to 15 year olds live within the most deprived quintiles in Walsall and 16,100 (35.5%) of over 65's. This compares to 5,000 (9.2%) of 0 to 15 year olds living within the least deprived quintiles in Walsall and 7,000 (15.6%) of over 65's.



Walsall LSOA deprivation using Local Quintiles (Source: Department for Communities and Local Government)

Demography and deprivation data sourced from Walsall JSNA 2013 refresh

Drugs Chapter

Drug misuse-inc. estimated prevalence, service users, context-sex, age ethnicity etc.

Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2009/10 - 2011/12

A report of national and local drug prevalence is produced annually for Public Health England by The Centre for Public Health, Liverpool John Moores University and Glasgow Prevalence Estimation Limited.

The report summarises the results of the fourth follow-up study to a three-year project to report the estimated prevalence of opiate and/or crack use (OCU) nationally (England only), regionally, and locally. Estimates are based on data comparison relating to the financial years 1 April 2009 to 31 March 2010 and 1 April 2011 to 31 March 2012.

Direct enumeration of those engaged in a largely covert activity such as the use of class A drugs is difficult and standard household survey techniques tend to underestimate the extent of such activity. Indirect techniques making use of various data sources offer a more reliable way of calculating prevalence estimates for the use of opiates and/or crack cocaine. The estimates presented in this report are derived using two indirect measurement techniques: the capture-recapture method (CRC); and the multiple indicator (MIM) method – these methods are described in detail in Hay *et al*., 2006 and Hay *et al*., 2007a. Methodological developments throughout the course of the previous three sweeps are discussed elsewhere (Hay *et al*., 2007b, Hay *et al*., 2008).

'OCU' refers to use of opiates and/or crack cocaine, including those who inject either of these drugs. It does not include the use of cocaine in a powder form, amphetamine, ecstasy or cannabis, or injecting by people who do not use opiates or crack cocaine. Although many opiate and/or crack users also use these drugs it is very difficult to identify exclusive users of these drugs from the available data sources.

All prevalence rates show the number of OCU's in the local authority per thousand people in the population. The report also indicates the estimated number and rate of Intravenous OCU's.[1]

[1] Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2011/12: Sweep 8 Summary Report: Centre for Public Health, Liverpool John Moores University & Glasgow Prevalence Estimation Limited

Table 3: Estimated OCU's by Number

	2009-2010	2011-2012	% Difference +/-
Walsall	2052	2186	**+6%**
Black Country	8167	8529	**+4%**
West Midlands	34368	34328	**similar**
National	306150	293879	**-4%**

Table 4: Estimated OCU's by Rate (2011/2012)

	Rate per thousand of the population									
	OCU	**Lower bound 95% CI**	**Upper bound 95% CI**	**Opiate users**	**Lower bound 95% CI**	**Upper bound 95% CI**	**Crack users**	**Lower bound 95% CI**	**Upper bound 95% CI**	**15-64 population**
Walsall	***12.80***	11.15	15.52	***11.87***	10.19	13.61	***7.66***	5.71	9.40	**170,800**
West Midlands	9.45	8.94	10.09	8.45	7.98	8.99	5.48	4.90	6.06	**3,632,400**
National	8.40	8.32	8.63	7.32	7.25	7.53	4.76	4.62	4.96	**34,991,400**

Table 5: Estimated Intravenous OCU's by Number

	2009-2010	2011-2012	% Difference +/-
Walsall	***604***	***606***	**similar**
Black Country	2416	2279	**-6%**
West Midlands	11244	9175	**-23%**
National (England only)	103185	87302	**-18%**

Table 6: Estimated Intravenous OCU's by Rate (2011/2012)

	Injecting	Lower Bound 95% CI	Upper Bound 95% CI
Walsall	***3.55***	2.68	4.45
West Midlands	2.53	2.28	2.78
National (England only)	2.49	2.44	2.58

Key Messages:

- Walsall's rate of OCU's is higher than the regional and National estimates (Table 4)
- Walsall number of OCU's has increased. National estimates indicate a downward trajectory (Table 3)
- Walsall's rate of intravenous OCU's is higher than regional and national estimates (Table 6)
- Walsall number of Intravenous OCU's remains constant. Regional and national estimates indicate a downward trajectory (Table 5)

Adult Drug Treatment Cohorts

Unless otherwise stated data for this needs assessment has been sourced from two sources: HALO and The National Drug Treatment Monitoring System (NDTMS)

HALO is the local web-based substance misuse case management system used by CRi/T3, Addaction and DWMH/Lantern House. Locally HALO provides data to commissioners for performance management purposes and nationally to NDTMS for analysis by Public Health England.

NDTMS is the Public Health England national database that collects, collates and analyses information from and for those involved in the substance misuse sector.

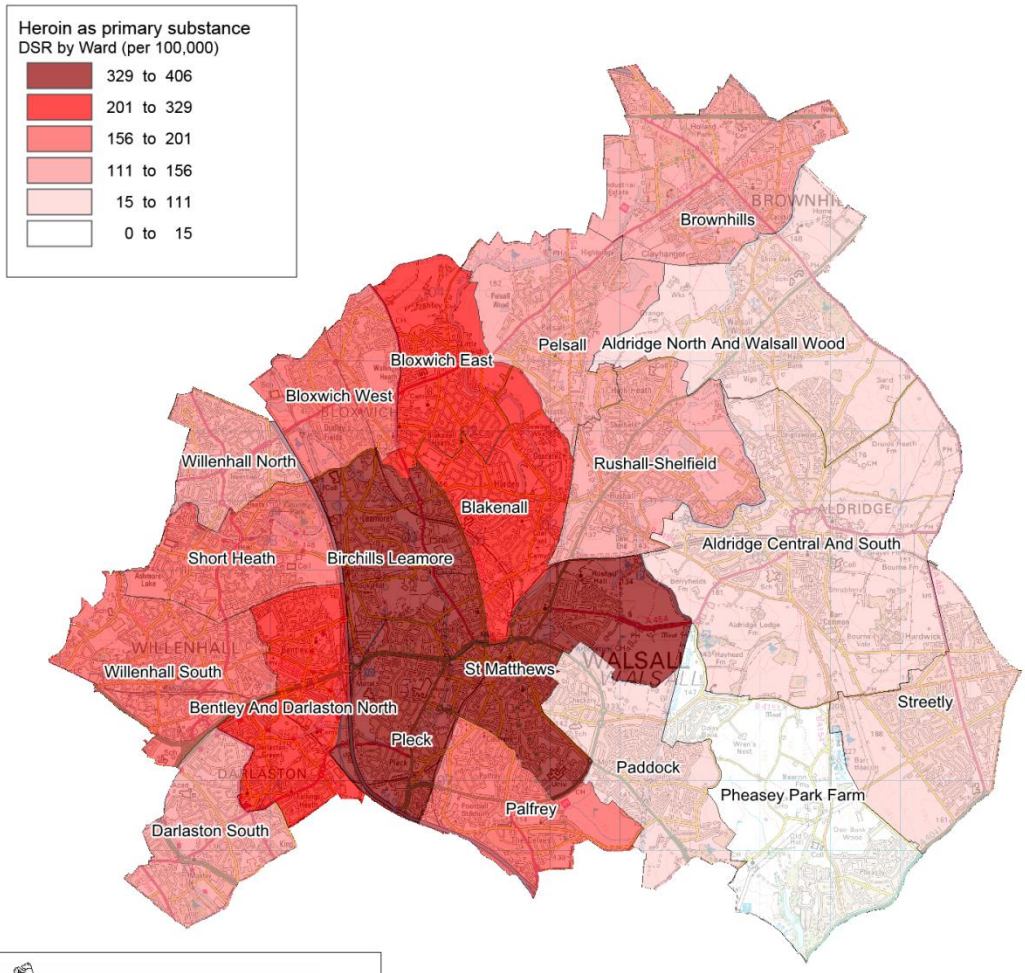
The date range for the adult section of the drug needs assessment is for the period January 2012 to March 2014 which lends itself to provide a wider timeframe to identify trends across Walsall's drug treatment system. Data for the period April 2013 – March 2014 has also been analysed to provide a one year snap-shot of activity within the overall timeframe.

For the purpose of this needs assessment adult drug data has been segmented to provide a comparison between the overall cohort of clients in treatment, those referred via the criminal justice system and 18-25 year olds in adult treatment services.

The maps on pages 13-15 demonstrate that clients in treatment for Heroin, Cocaine and Cannabis generally in live those areas that are most deprived.

Heroin Clients by Ward

Annual average of clients in treatment between Jan 2012 and Mar 2014 (persons)
Mapped by Ward represented by Direct Standardised Rate (DSR) per 100,000
These clients cited heroin as their primary substance
Reference population is European Standard 2013
Data Source: HALO
(it was not possible to map 211 clients due to invalid postcodes)

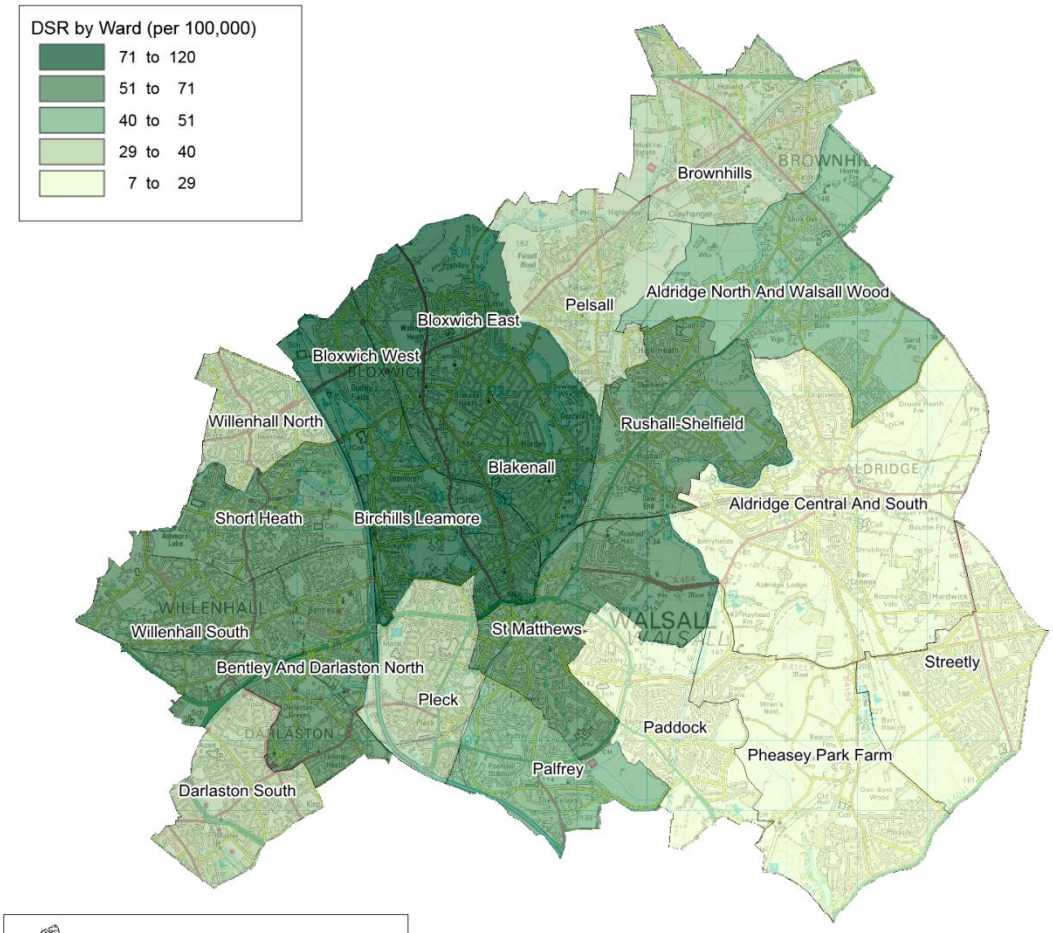


Walsall Council

Produced by Walsall Public Health Intelligence

Cocaine Clients by Ward
(Freebase crack, hydrochloride and unspecified)

Annual average of clients in treatment between Jan 2012 and Mar 2014 (persons)
Mapped by Ward represented by Direct Standardised Rate (DSR) per 100,000
These clients cited cocaine (freebase crack, hydrochloride or unspecified)
as their primary substance
Reference population is European Standard 2013
Data Source: HALO
(it was not possible to map 116 clients due to invalid postcodes)

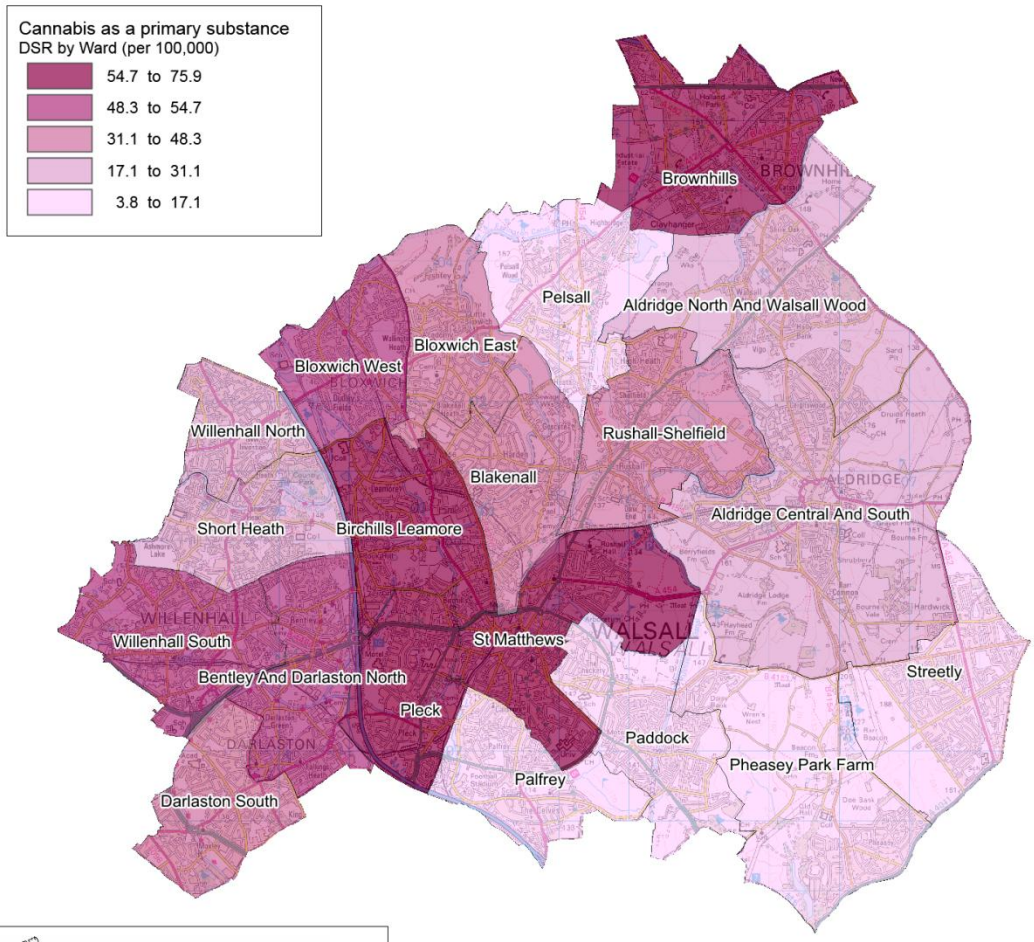


Walsall Council

Produced by Walsall Public Health Intelligence

Cannabis Clients by Ward

Annual average of clients in treatment between Jan 2012 and Mar 2014 (persons)
Mapped by Ward represented by Direct Standardised Rate (DSR) per 100,000
These clients cited cannabis as their primary substance
Reference population is European Standard 2013
Data Source: HALO
(it was not possible to map 54 clients due to invalid postcodes)



Walsall Council

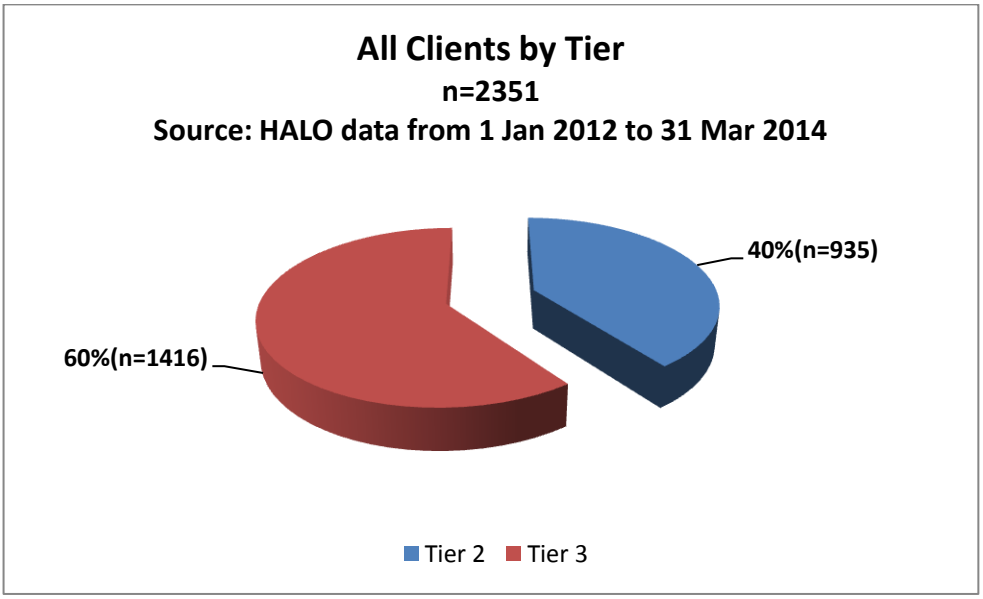
Produced by Walsall Public Health Intelligence

Adults – All Cohorts

Walsall Demographics

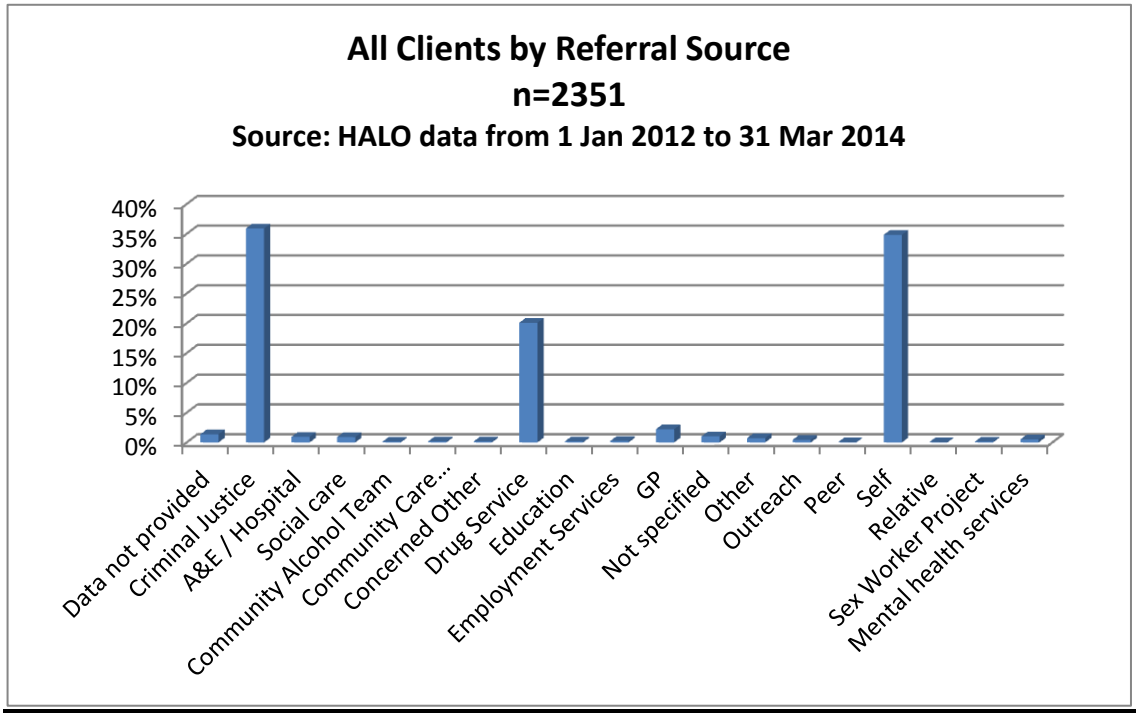
In Walsall 2351 individuals aged 18yrs-65yrs+ received adult drug treatment interventions in the period January 2012 – March 2014. In the latest twelve month period (April 2013-March 2014) the number in treatment was 1567.

Table 7 Treatment Tiers (Models of Care – See Appendix 2)



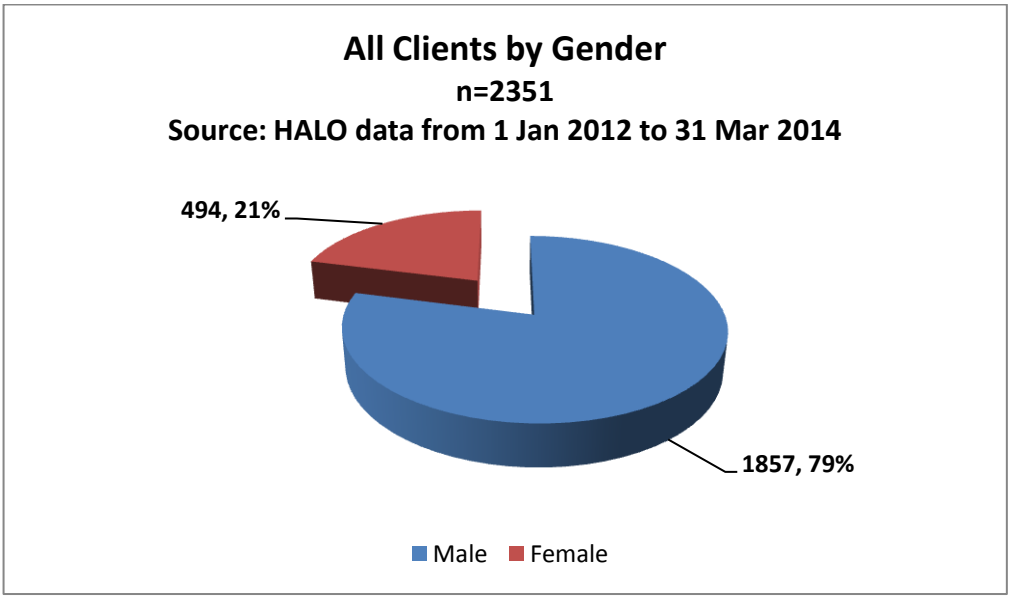
The majority of clients in adult treatment services (60% n=1416) received structured interventions at tier three. However in the latest twelve month period the proportion of those receiving tier three interventions increased to 72%.

Table 8 Referral Sources



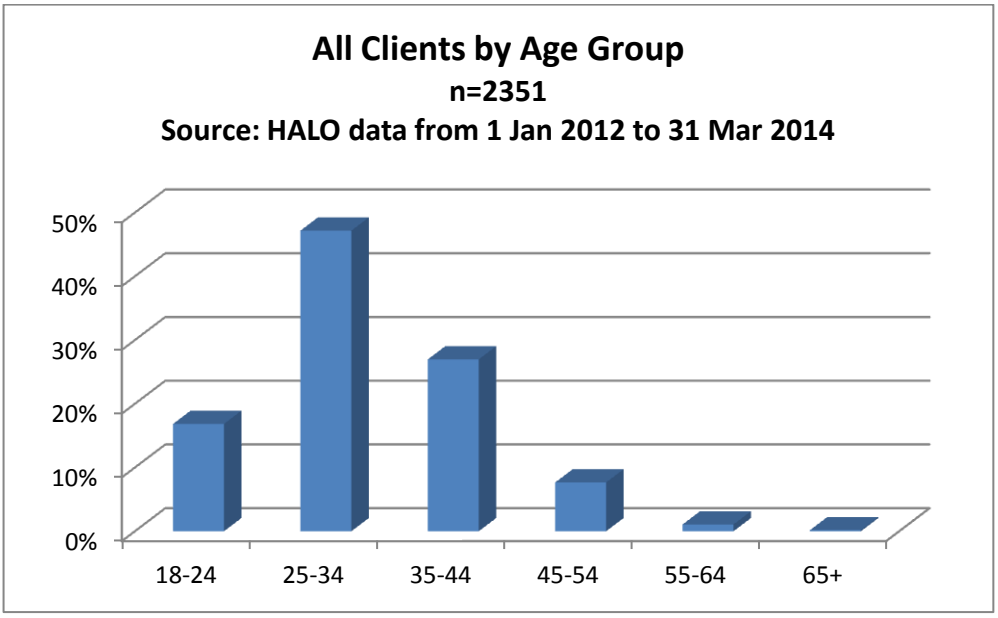
The majority of clients are referred into adult drug treatment services via established criminal justice pathways (36% n=844) while self-referrals is the second highest route (35% n=819). Criminal justice referrals are analysed further in the criminal justice segment of this needs assessment.

Table 9 Gender



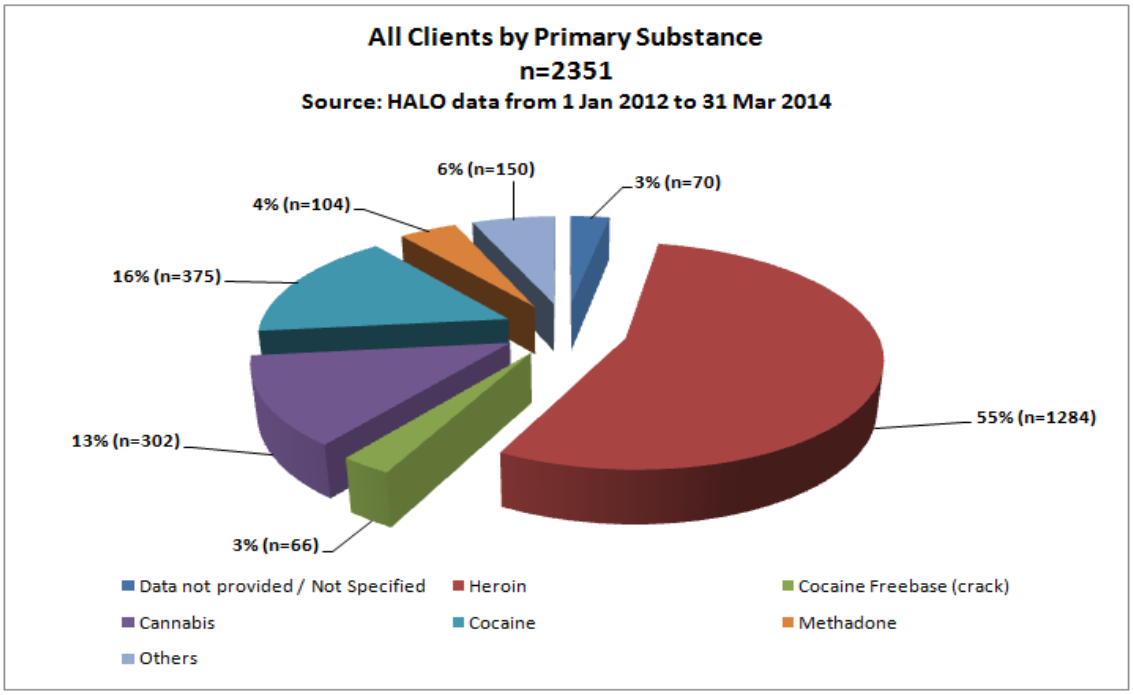
Three out of four individuals (79% n=1857) receiving interventions in adult treatment services were male which is also reflected within the latest twelve month period.

Table 10 Age Profile



At 47% (n=1109) those aged 25-34yrs formed the largest cohort of clients. Under a third (27% n=182) were aged 35-44yrs and those 18-24yrs represented 17% of those in adult treatment services. In the latest twelve month period there is a 4% increase in those aged 18-24yrs in adult treatment services and a 2%-3% decrease in 25-34yrs & 35-44yrs

Table 11 Substance



Clients in the adult treatment population presented with a wide range of primary substances. Over half (54% n= 1284) received treatment interventions for heroin use. Other significant primary presentations were for cocaine (16% n=375) and Cannabis (13% n=302). In the latest twelve month period 67% presented with heroin as primary substance, an increase of 13%, Cannabis presentations dropped by 3% to 9% and Cocaine dropped by 6% to 10%. Cocaine Freebase (crack) remained similar

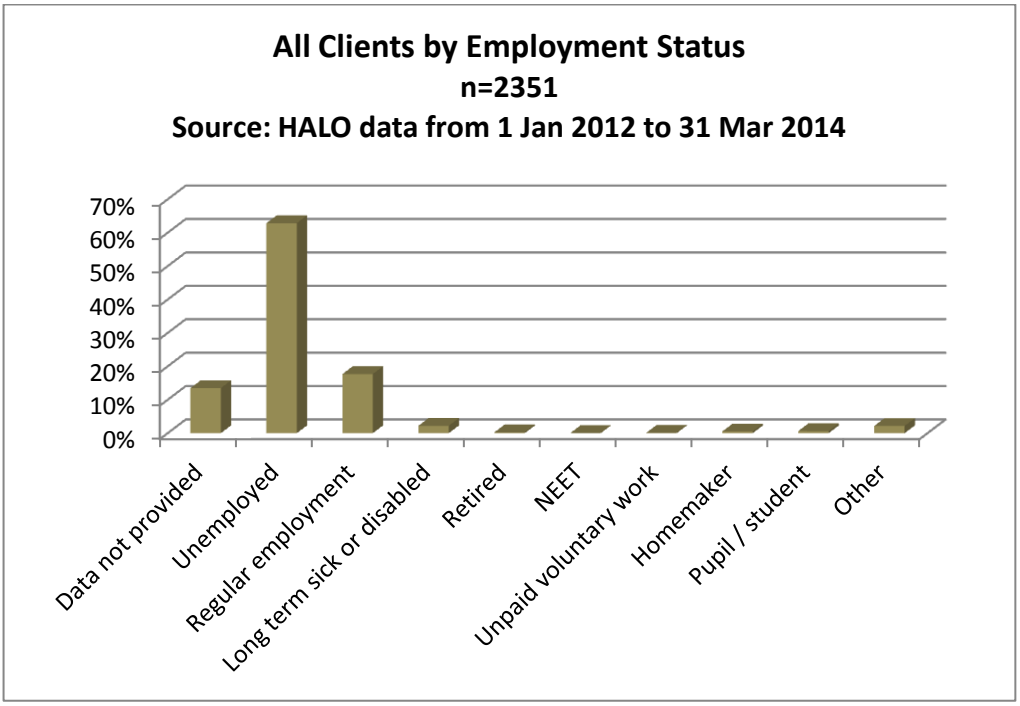
Table 12 Primary & Secondary Use

	Primary Substance	Secondary Substance															
		Heroin		Cocaine Freebase (Crack)		Cannabis		Alcohol		Amphetamine		Mephadrone		Methadone		Cocaine	
Primary Substance	Numbers	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
Heroin	1284			545	42%	82	6%	57	4%	*	0%	0	0%	81	6%	37	3%
Cocaine Freebase (crack)	66	23	35%			5	8%	7	11%	0	0%	0	0%	5	8%	*	3%
Cannabis	302	5	2%	11	4%			47	16%	*	0%	6	2%	0	0%	50	17%
Cocaine	375	*	0%	*	0%	75	20%	158	42%	0	0%	8	2%	*	1%		
Methadone	104	19	18%	11	11%	5	5%	5	5%	*	1%	0	0%			0	0%

Numbers less than 5 are represented by *

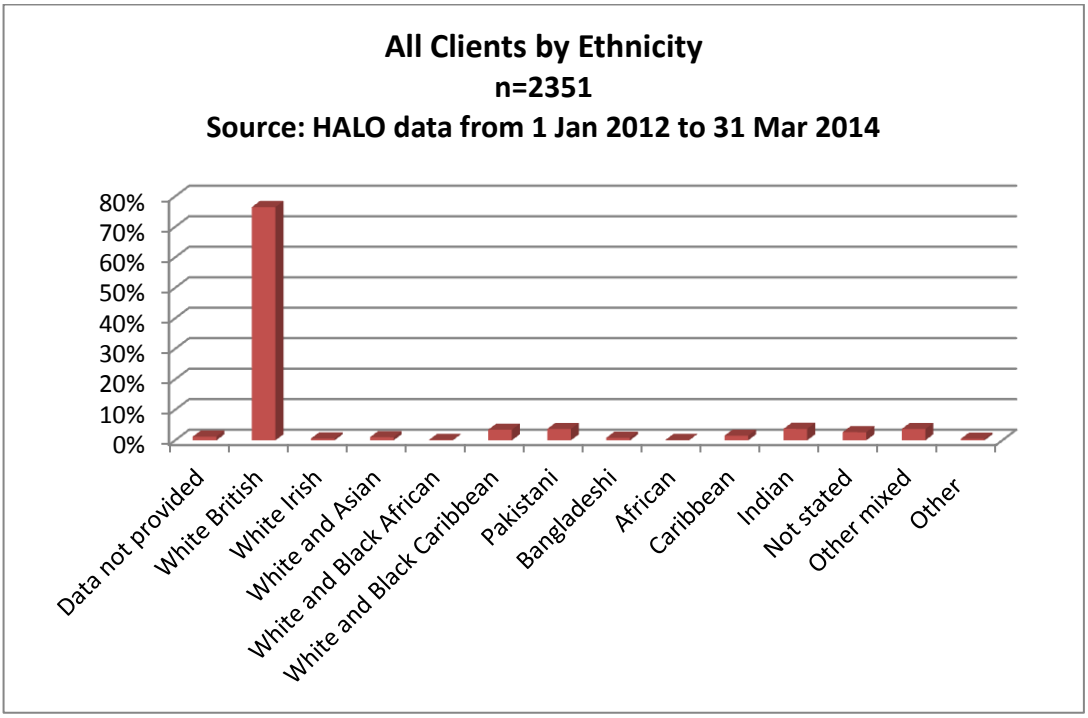
An examination of secondary drug usage reveals significant cocaine freebase (crack) use alongside heroin. The use of alcohol as secondary substance to cocaine is important to highlight.

Table 13 Employment Status



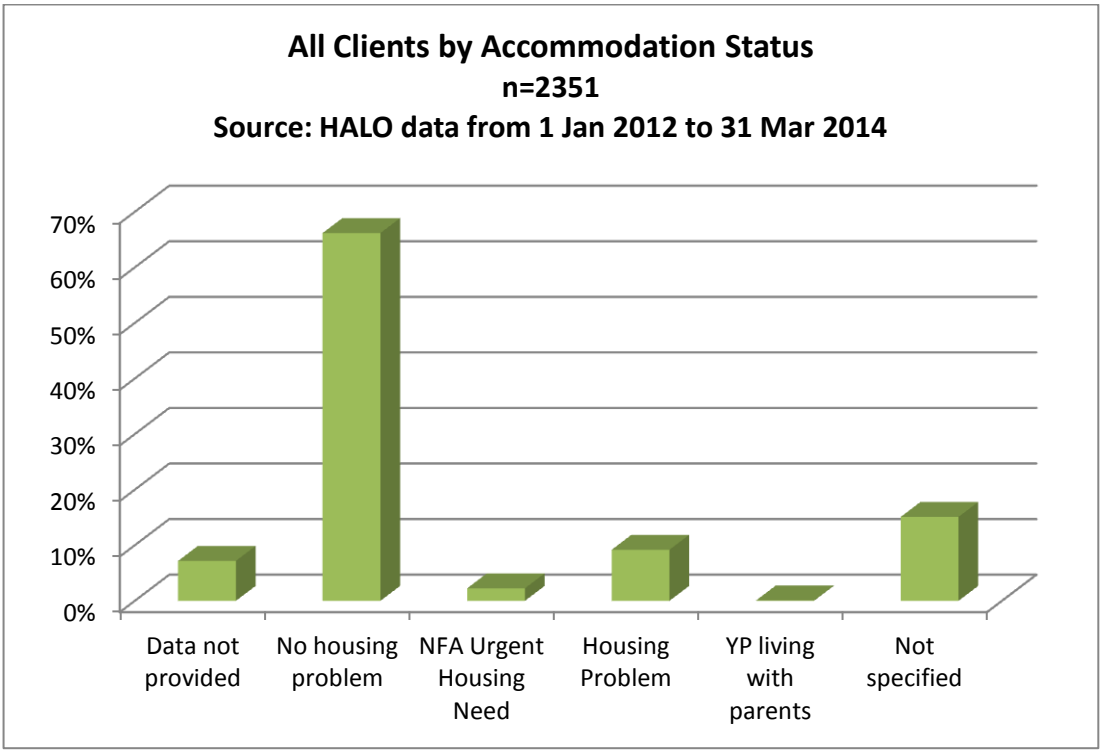
A significant amount (63% n=1478) of the adult treatment population is unemployed. Only 18% (n=416) indicated some form of regular employment. It is important to highlight that 13% (317) of records have no employment status recorded. In the latest twelve month period the cohort of those unemployed increased slightly to 67%. Those undertaking some form of regular employment showed a marginal decrease of 2% to 16%.

Table 14 Ethnicity



White British (77% n=1799) clients are the largest cohort in the adult treatment population. The largest BME groups are Indian (4% n=89), Pakistani (4% n=88) and White and Black Caribbean (3% n=82), which is also reflected within the latest twelve month period.

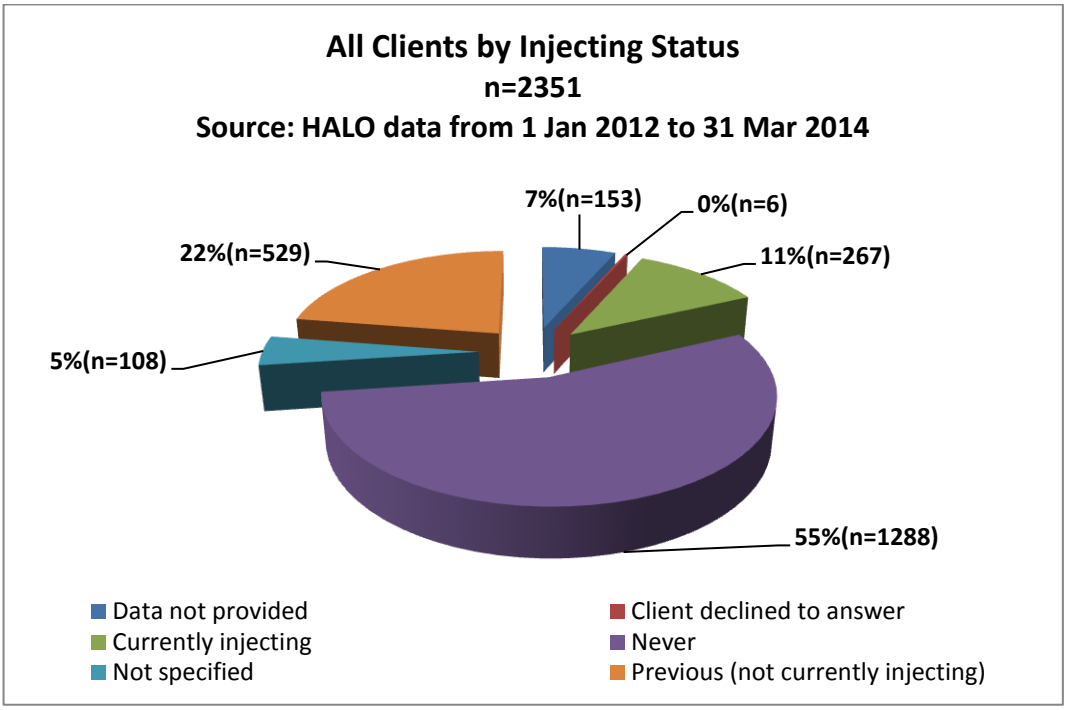
Table 15 Accommodation



66% (n=1556) identified no issues with their housing. 11% (n=269) were identified as having housing issues, and 53 service users had an urgent housing need.

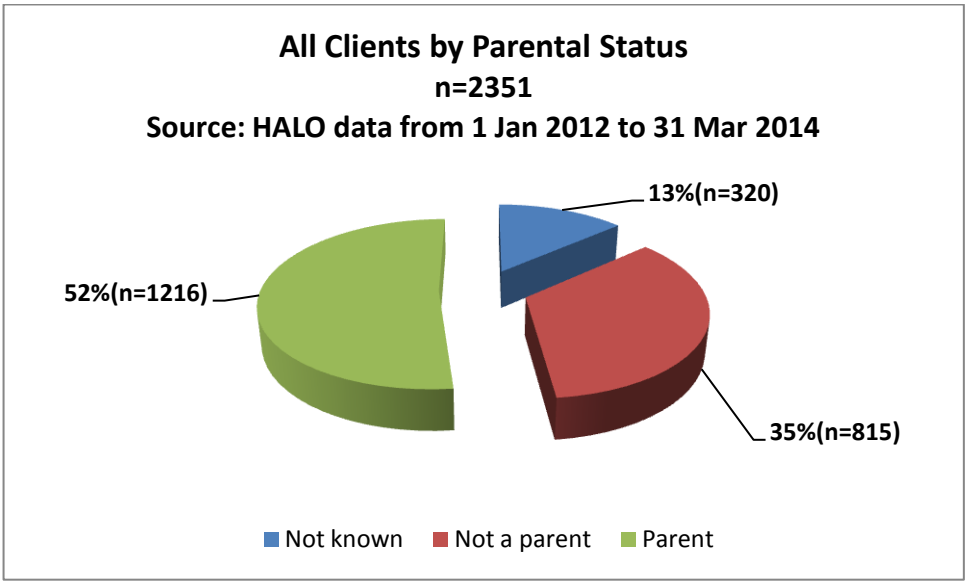
22% (n=524) of records have no specified status or the data was not recorded at assessment.

Table 16 Injecting Status



55% (n=1288) of clients in the adult treatment population have never injected drugs. Of those who have previously injected, or are currently injecting 39% (n=308) injected in the previous four weeks. In the latest twelve month period fewer clients (51%) had never injected but the proportion of those who had injected in the previous four week period remained the same. From the most recent Public health England Treatment Outcome Profile data (date range 2013-2014) 64% reported that they were no longer injecting at review.

Table 17 Parental Status



Over half (52% n=1216) of those in the adult treatment population are parents. Of those who are parents 36% (n=435) have at least one child who lives with them. It is important to highlight that 14% (n=320) of client records had no parental status specified or data had not been provided. In the latest twelve month period there were slightly more parents in treatment (55%), but slightly fewer of those parents (34%) had a least one child who lives with them

In the latest twelve month period Walsall treatment services delivered interventions to 51 pregnant women, of these 5 women miscarried, 2 women terminated the pregnancy, 25 babies were delivered and 19 women were still pregnant on 01/04/14. 6 of these women were under 25 years old.

Criminal Justice

The relationship between problem drug use and crime is complex. Even so, all the evidence indicates that problem drug users are responsible for a large percentage of acquisitive crime, such as shoplifting and burglary. As a direct consequence of the crime they commit, these problem drug users are highly likely to end up in the criminal justice system at some point. Some will serve community sentences, others will be sent to prison"[2]

Table 18 Court Mandated Drug Rehabilitation Requirement April 2013 – March 2014

Targets		Apr '13	May '13	Jun '13	Jul '13	Aug '13	Sept '13	Oct '13	Nov '13	Dec '13	Jan '13	Feb '14	Mar '14	YTD Total	% Against Annual Target
Target Commencements: 78	TOTAL COMMENCEMENTS FOR MONTH:	3	8	8	12	3	10	7	4	6	3	9	6	79	101%
	DRR High Intensity	0	0	0	0	0	0	0	0	0	0	0	0	0	
	DRR Medium Intensity	0	0	0	1	0	0	0	0	1	1	0	0	3	
	DRR Low Intensity	3	8	8	11	3	10	7	4	5	2	9	6	76	
Target Completions: 37	% COMPLETION RATE	78%	80%	40%	50%	57%	67%	29%	60%	-	73%	67%	70%		61% completion rate
	TOTAL COMPLETIONS FOR MONTH:	9	10	5	7	7	3	7	10	4	11	3	10	86	no. successful comps/ (successful comps & unsuccessful comps) *(using YTD total)*
	SUCCESSFUL COMPLETIONS	7	8	2	3	4	2	2	6	0	8	2	7	51	
	DRR High Intensity	0	0	0	0	0	0	0	0	0	0	0	0	0	
	DRR Medium Intensity	0	0	0	0	0	0	0	1	0	1	0	0	2	
	DRR Low Intensity	7	8	2	3	4	2	2	5	0	7	2	7	49	
	NEUTRAL COMPLETIONS	0	0	0	1	0	0	0	0	1	0	0	0	2	
	DRR High Intensity	0	0	0	0	0	0	0	0	0	0	0	0	0	
	DRR Medium Intensity	0	0	0	0	0	0	0	0	0	0	0	0	0	138% no. successful comps/ annual target *(using YTD total)*
	DRR Low Intensity	0	0	0	1	0	0	0	0	1	0	0	0	2	
	UNSUCCESSFUL COMPLETIONS	2	2	3	3	3	1	5	4	3	3	1	3	33	
	DRR High Intensity	0	0	0	0	0	0	0	0	0	0	0	0	0	
	DRR Medium Intensity	0	0	0	1	0	0	0	0	0	0	0	1	2	
	DRR Low Intensity	2	2	3	2	3	1	5	4	3	3	1	2	31	
	CASELOAD *(Form 20, as at end of month)*	27	25	28	33	29	36	37	31	33	25	31	29		

Walsall exceeded its commencements target by one in the latest full year period and over performed by 14% against the target for completions.

Drug Intervention Programme and West Midlands Police Drug Testing April 2013 – March 2014

The Drug Interventions Programme is an element of a national strategy for tackling drug abuse in those involved in the criminal justice system. Substance misuse arrest referral workers are based in Walsall's police custody suites to support the pathway into specialist drug treatment services. For a number of years police forces have legislative powers to mandatory drug test adults who are arrested for trigger offences such as burglary, robbery or shoplifting. Individuals may also be tested non-trigger offences if authority is granted by a police inspector. In 2012 West Midlands Police moved away from drug testing all adults that come into West Midlands Custody Blocks under arrest for Trigger Offences and Non Trigger Inspector Authority Testing to Targeted Testing. The table below shows that the Walsall has consistently exceeded all targets in regard to this initiative. Following the restructure undertaken by West Midland Police in 2013 Bloxwich Police Station became the sole custody block for the Walsall borough.

[2] http://www.nta.nhs.uk/criminal-justice.aspx

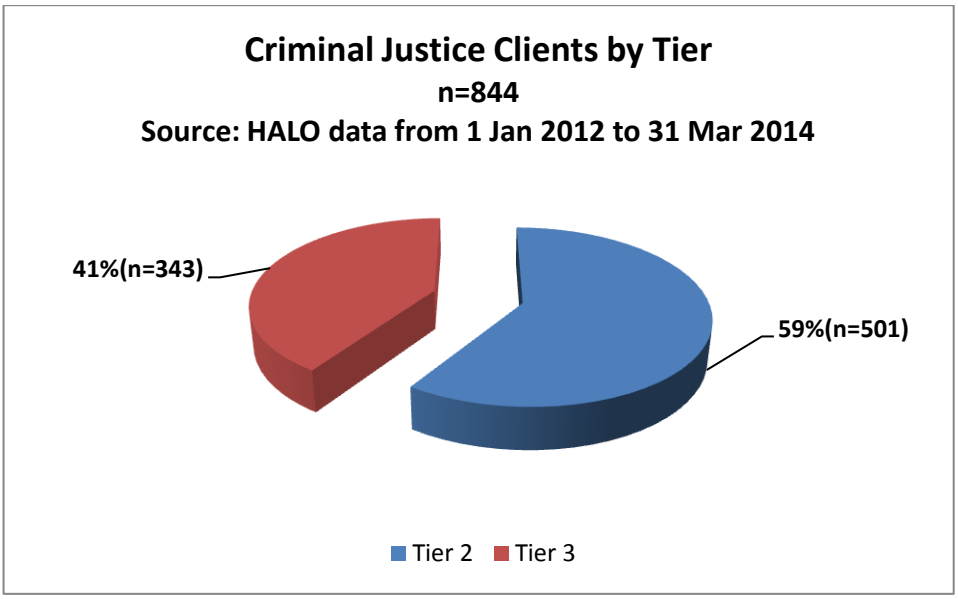
Table 19 West Midlands Police Walsall LPU Drug Testing Data

BLOXWICH [HE]										
MONTH	TESTS DONE			Missed Ops	TEST RESULTS				TARGETS	
	Total	Trigger Tests	IA Tests		Positive Tests	Positive Rate	Negative Tests	Negative Rate	Potential Positives	Potential Negatives
May-13	121	77	44	9	64	53%	57	47%		
Jun-13	106	78	28	6	63	59%	43	41%		
Jul-13	133	103	30	4	66	50%	67	50%		
Aug-13	95	78	17	4	51	54%	44	46%		
Sep-13	107	62	45	6	58	54%	49	46%		
Oct-13	134	104	30	6	68	51%	66	49%		
Nov-13	101	76	25	3	54	53%	47	47%		
Dec-13	98	77	21	5	50	51%	48	49%		
Jan-14	137	97	40	2	78	57%	59	43%		
Feb-14	104	75	29	5	58	56%	46	44%		
Mar-14	121	88	33	1	78	64%	43	36%		
Apr-14	102	77	25	3	70	69%	32	31%	44	51

Walsall Criminal Justice Cohort Demographics

In Walsall 36% (n=844) of all adult clients who received drug treatment interventions in the period between January 2012 – March 2014 were referred via the criminal justice system.

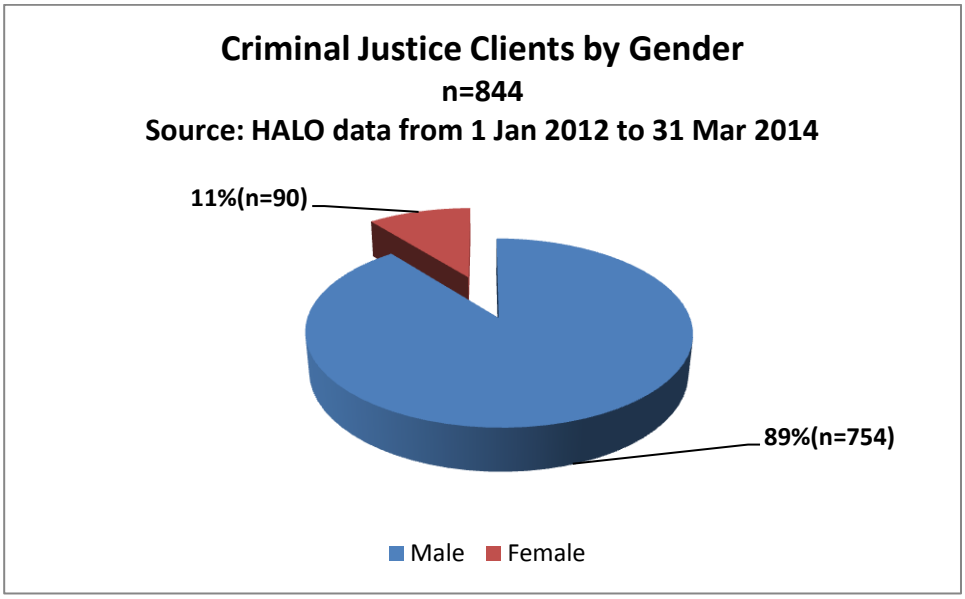
Table 20 Treatment Tiers



Just under two thirds of those in the adult criminal justice drug cohort have received treatment interventions at tier two which is just under 20% higher when compared to the

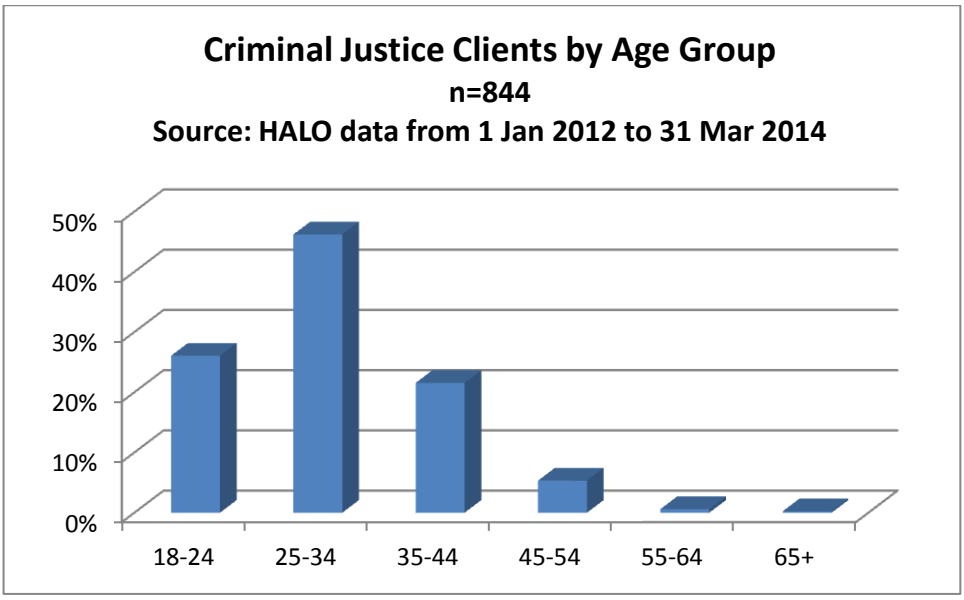
overall cohort of adults in drug Treatment. However, in the latest twelve month period 55% of criminal justice clients received interventions at tier 3

Table 21 Gender



Of all those in the criminal justice cohort nine out of ten clients receiving treatment interventions were male; which is 10% higher than the overall adult treatment cohort and this is also reflected within the latest twelve month period.

Table 22 Age Profile

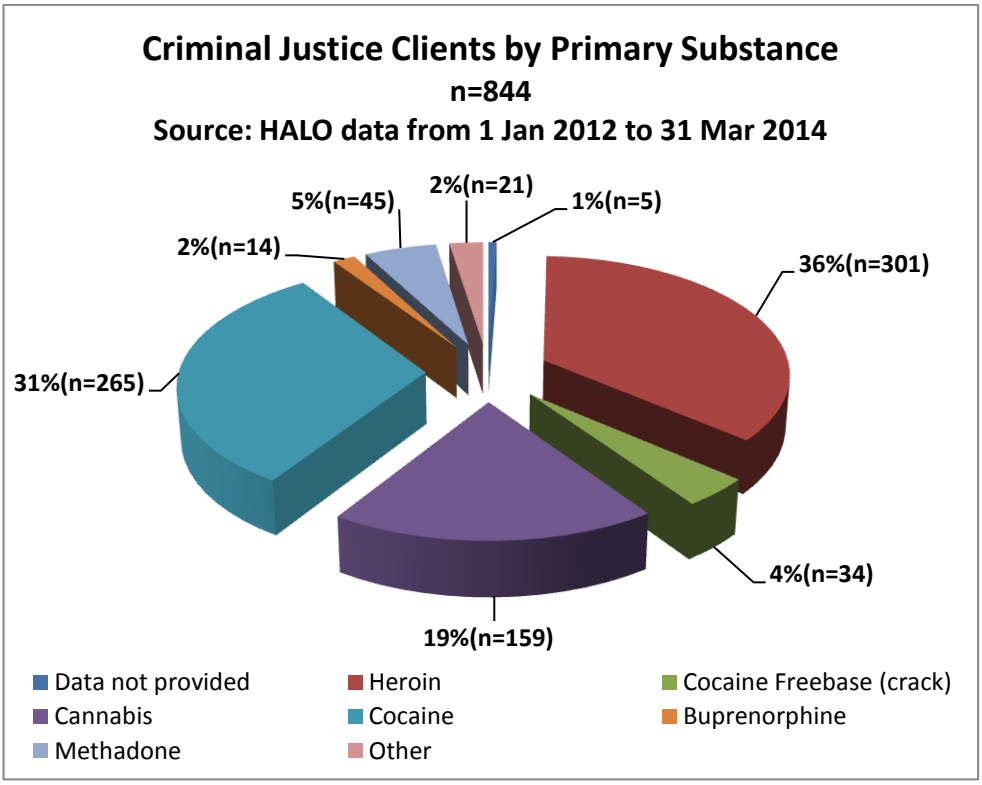


At 46% (n=390) those aged 25-34yrs formed the largest group of clients in the criminal justice cohort which corresponds with the overall client cohort of 47% (n=1109). Just over a quarter 26% (n=220) of criminal justice clients were aged 18-24yrs which was 9% higher

than the corresponding age group overall which is broadly consistent with the latest twelve month period

Substances

Table 23 Primary Use



36% (n=301) of the criminal justice cohort used heroin as primary substance which is considerably lower in proportion to the overall treatment cohort (55% n=1284). However the number of criminal justice clients using powder cocaine doubled compared to its use in the overall cohort. Although much lower in number, the use of cannabis 19% (n=159) was also higher in the criminal justice cohort compared to overall (13% n=302). In the latest twelve month period a higher proportion of criminal justice clients (48%) presented with heroin as primary substance, cocaine and cannabis presentations decreased to 20% and 16% respectively.

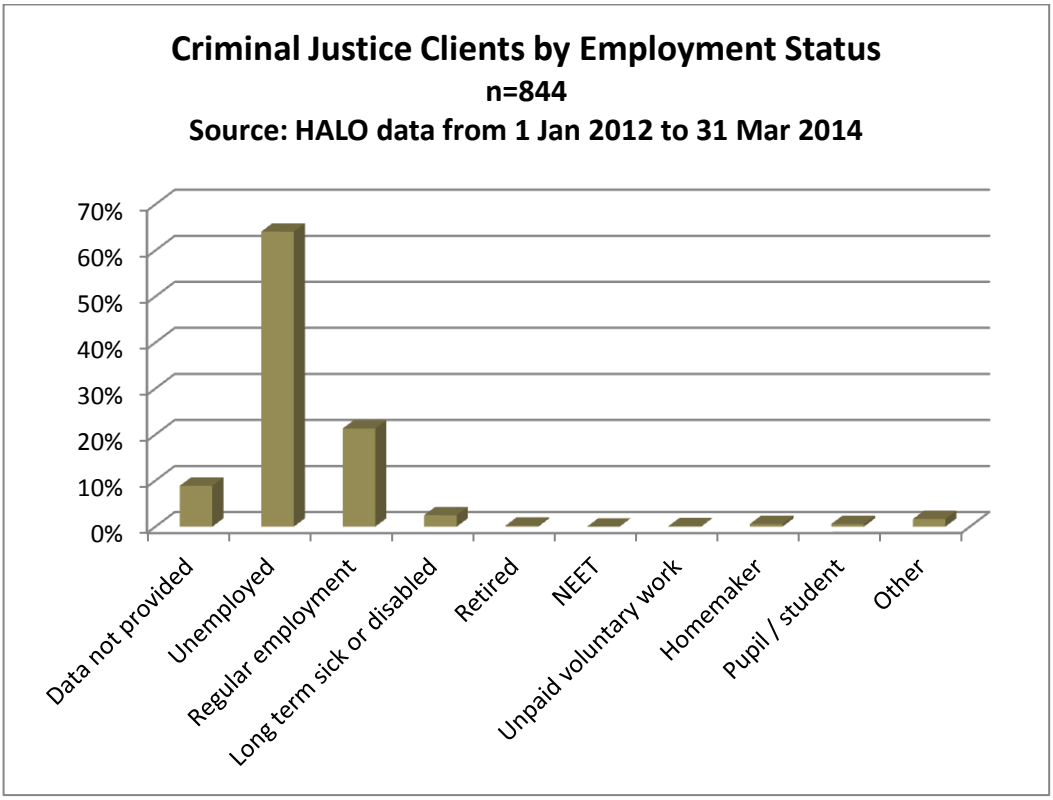
Table 24 Primary & Secondary Use

	Primary Substance	Secondary Substance															
		Heroin		Cocaine Freebase (Crack)		Cannabis		Alcohol		Amphetamine		Mephadrone		Methadone		Cocaine	
Primary Substance	Numbers	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
Heroin	301			164	54%	13	4%	20	7%	0	0%	0	0%	59	20%	10	3%
Cocaine Freebase (crack)	34	15	44%			*	9%	*	9%	0	0%	0	0%	*	12%	0	0%
Cannabis	159	*	2%	5	3%			29	18%	0	0%	*	1%	0	0%	35	22%
Cocaine	265	*	0%	0	0%	63	24%	127	48%	0	0%	0	0%	*	1%		
Methadone	45	9	20%	*	7%	*	2%	*	4%	*	2%	0	0%			0	0%

Numbers less than 5 are represented by *

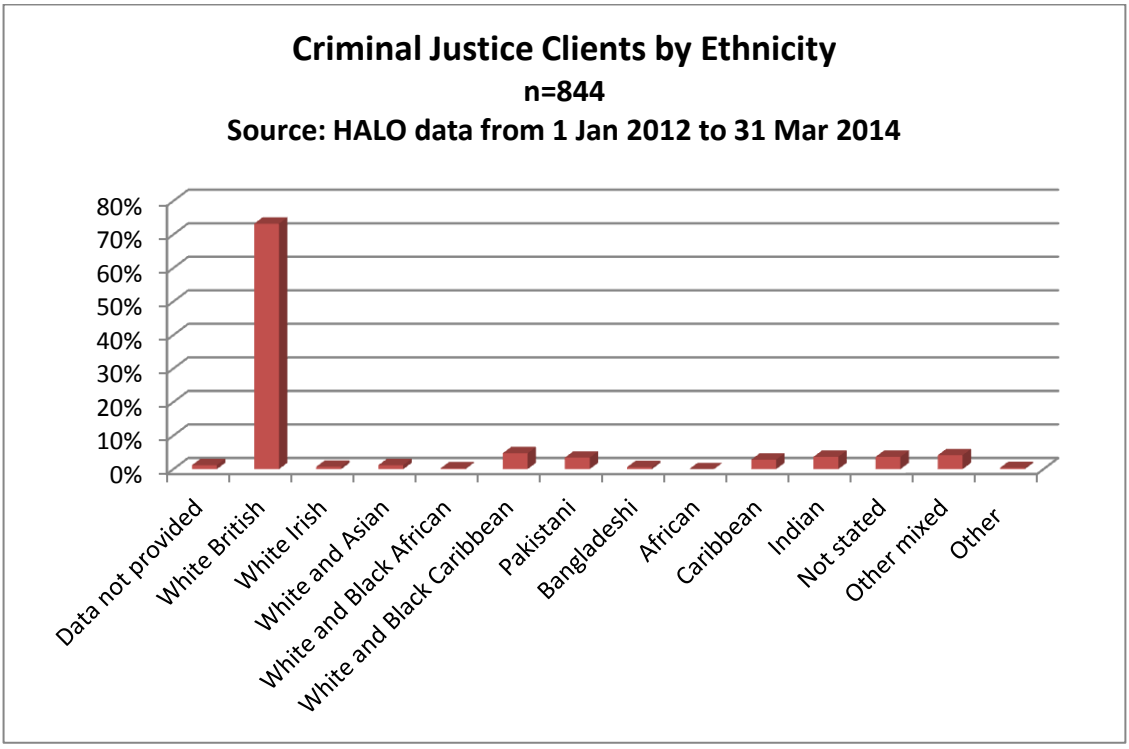
An examination of secondary drug usage reveals significant cocaine freebase (crack) use alongside heroin. The use of alcohol as secondary substance to cocaine and cannabis is important to highlight.

Table 25 Employment Status



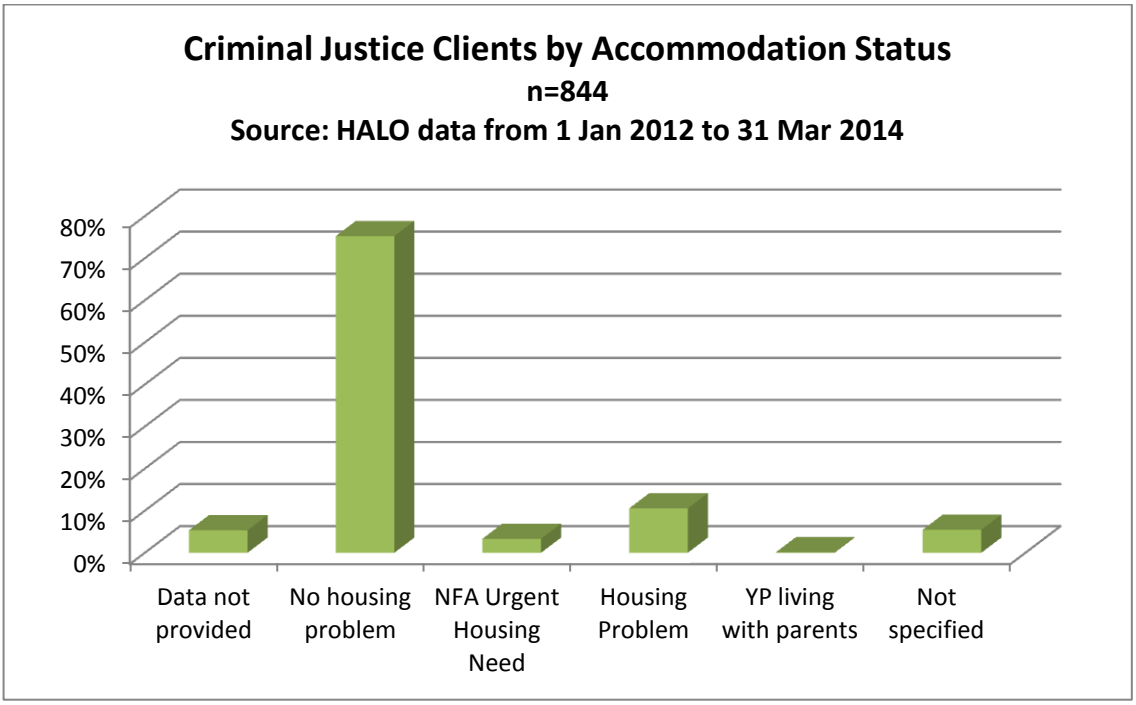
A significant amount (64% n=541) of the criminal justice cohort is unemployed which is very similar to the overall adult treatment population. In this cohort there is a slightly higher percentage (21% n=180) who indicate they have some form of regular employment when compared to the overall treatment population (18% n=416). In the latest twelve month period those unemployed increased to 69% whilst the proportion of those in regular employment decreased to 14%.

Table 26 Ethnicity



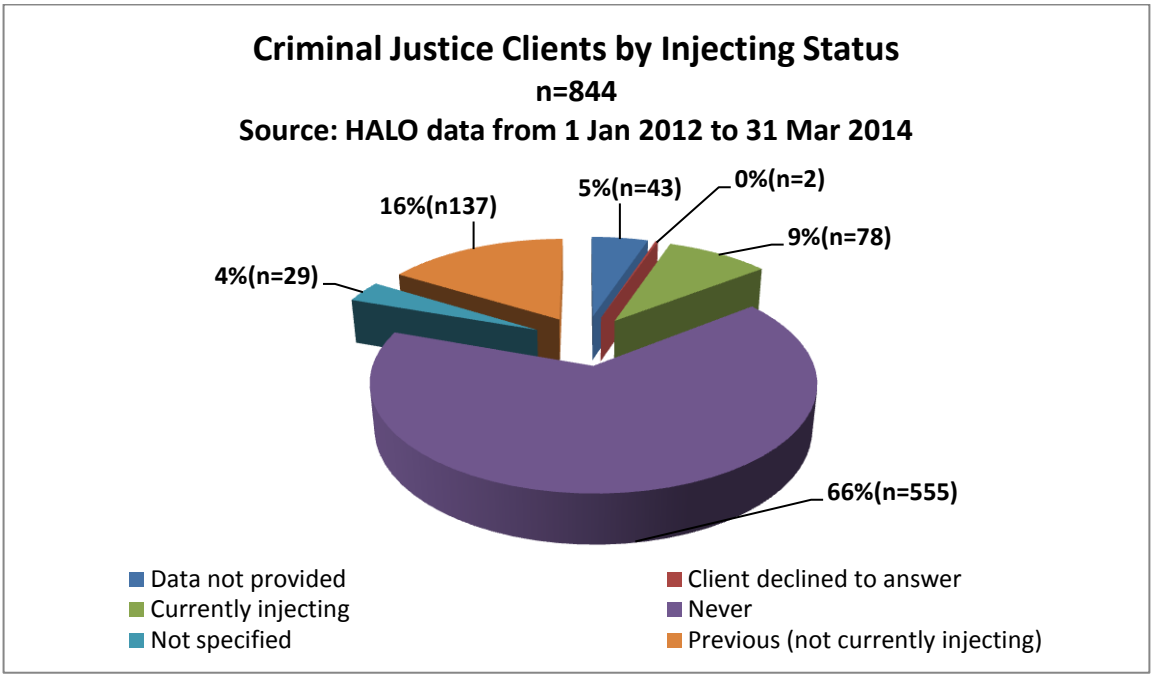
White British (73% n=618) clients are the largest ethnic grouping in the criminal justice cohort which is marginal less than the overall treatment population (77% n=1799). The most recent twelve month time-frame is in line with data in the table above

Table 27 Accommodation



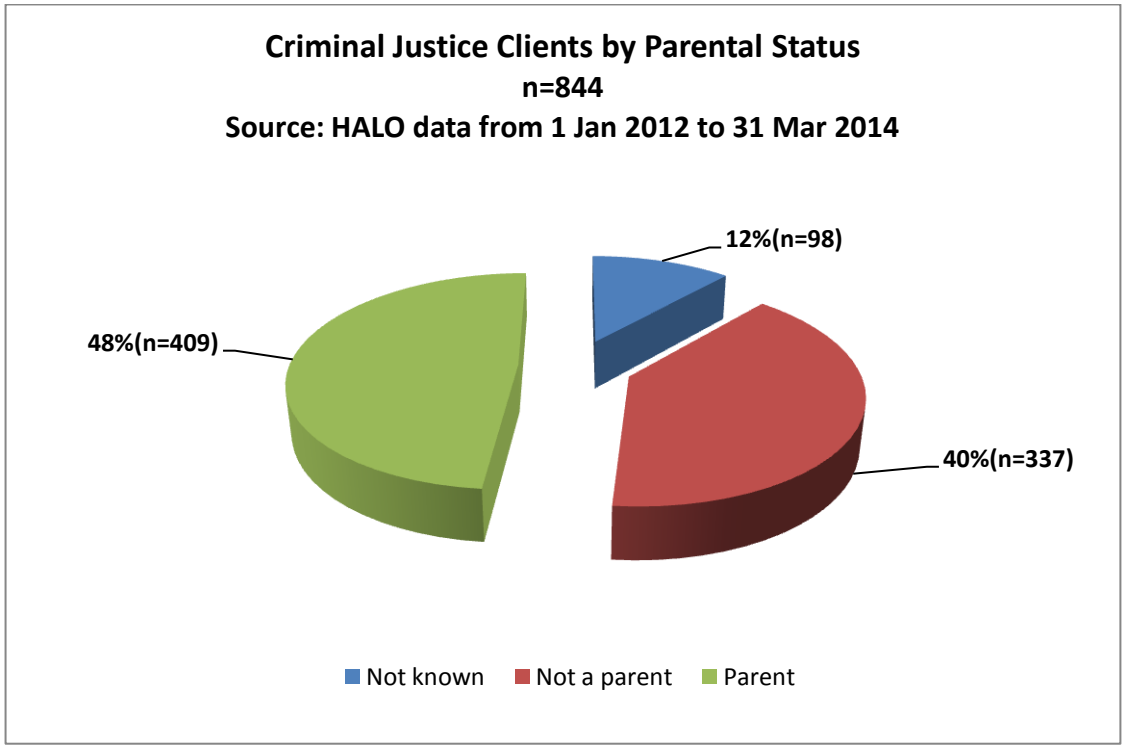
75% (n=635) of criminal justice clients declared no issues with their housing. This is higher than those in the overall treatment population (66% n=1556) which is also reflected within the latest twelve month period.

Table 28 Injecting Status



66% (n=555) of clients in the criminal justice system have never injected drugs compared to 55% of those in the overall treatment population. Of those who have previously injected, or are currently injecting 40% (n=87) injected in the previous four weeks. In the latest twelve month period only 54% of clients in the criminal justice have never injected.

Table 29 Parental Status

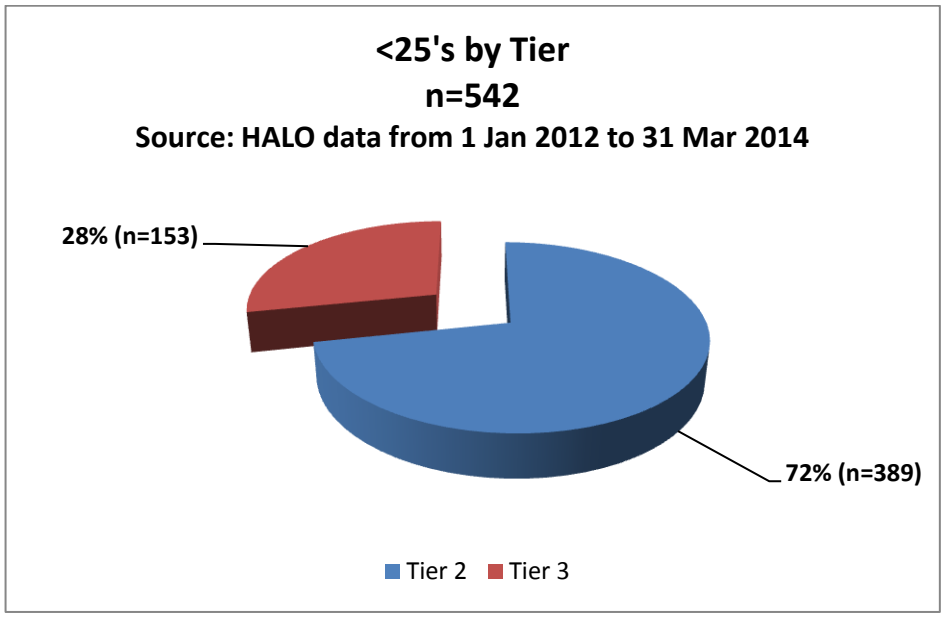


Nearly half (48% n=409) of those in the criminal justice cohort were parents. Of those who are parents 30% (n=123) have at least one child who lived with them. It is important to highlight that there was12% (n=98) of client records where parental status was not specified or data had not been provided. In the latest twelve month period there was slightly more parents in treatment (52%), but fewer of those parents (24%) had a least one child who lives with them.

<25's in Adult Treatment Services

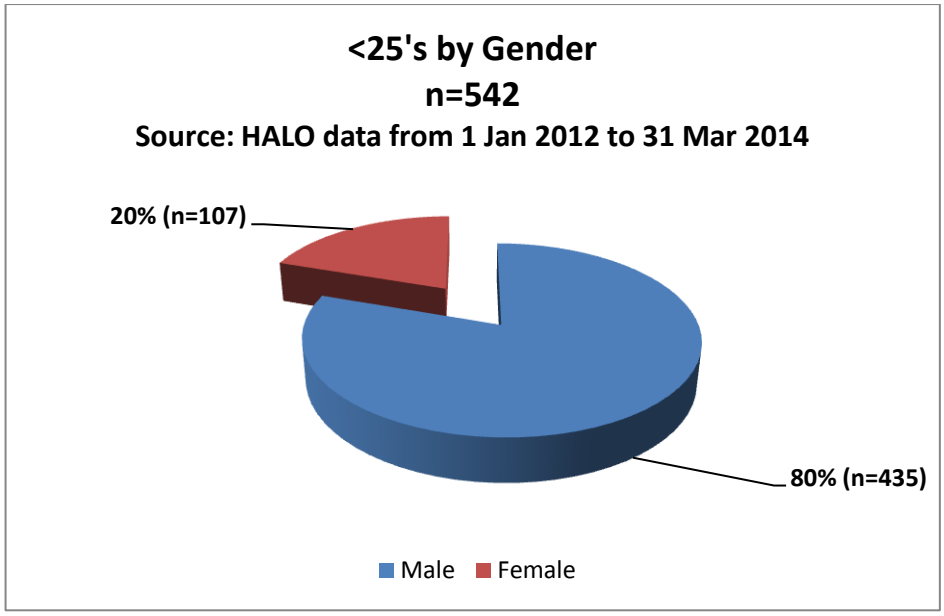
In Walsall 542 individuals aged <25 received adult drug treatment interventions in the period January 2012 – March 2104.

Table 30 Tiers



Just under three quarters of those in the <25's drug cohort have received treatment interventions at tier two which is 32% higher when compared to the overall cohort of adults and 13% higher than the criminal justice cohort. In the latest twelve month period 59% of <25's received interventions at tier 2.

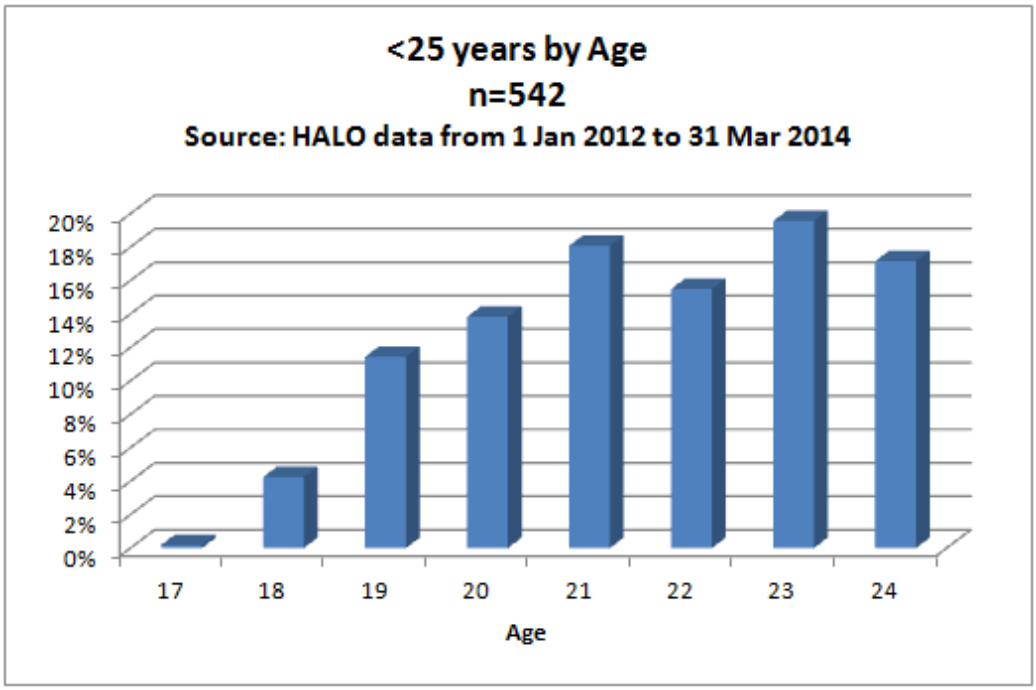
Table 31 Gender



Of all those in the <25's cohort eight out of ten clients receiving treatment interventions were male; which is comparable with the overall adult treatment cohort, but 9% fewer than

the criminal justice cohort. In the latest twelve month period 76% of clients in treatment were male.

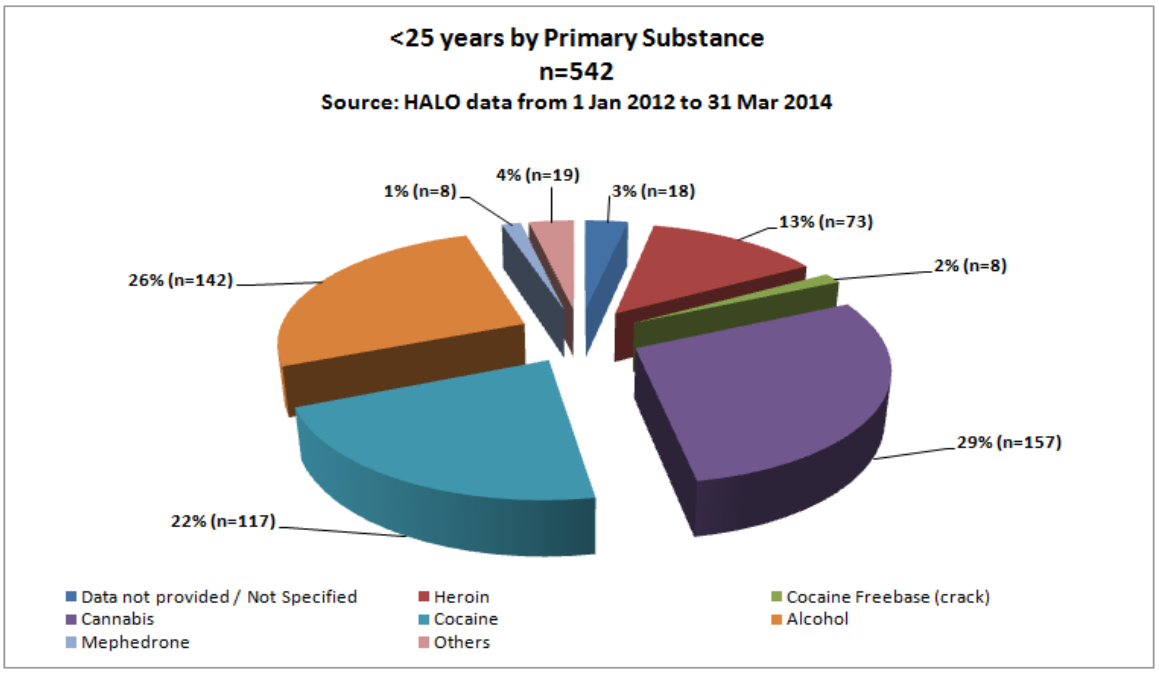
Table 32 Age



At 20% (n=106) those aged 23yrs formed the largest group of clients in the under 25 cohort. The second largest groups is the 21 year olds (18% n=98) which is broadly consistent with the latest twelve month period

Substances

Table 33 Primary Substance



Cannabis, alcohol and cocaine were the main substances used by <25's. Only 13% (n=78) of <25's used heroin as primary substance which is considerably lower in proportion to the overall treatment cohort (55% n=1284) and the criminal justice cohort (36% n=301) which is also reflected within the latest twelve month period.

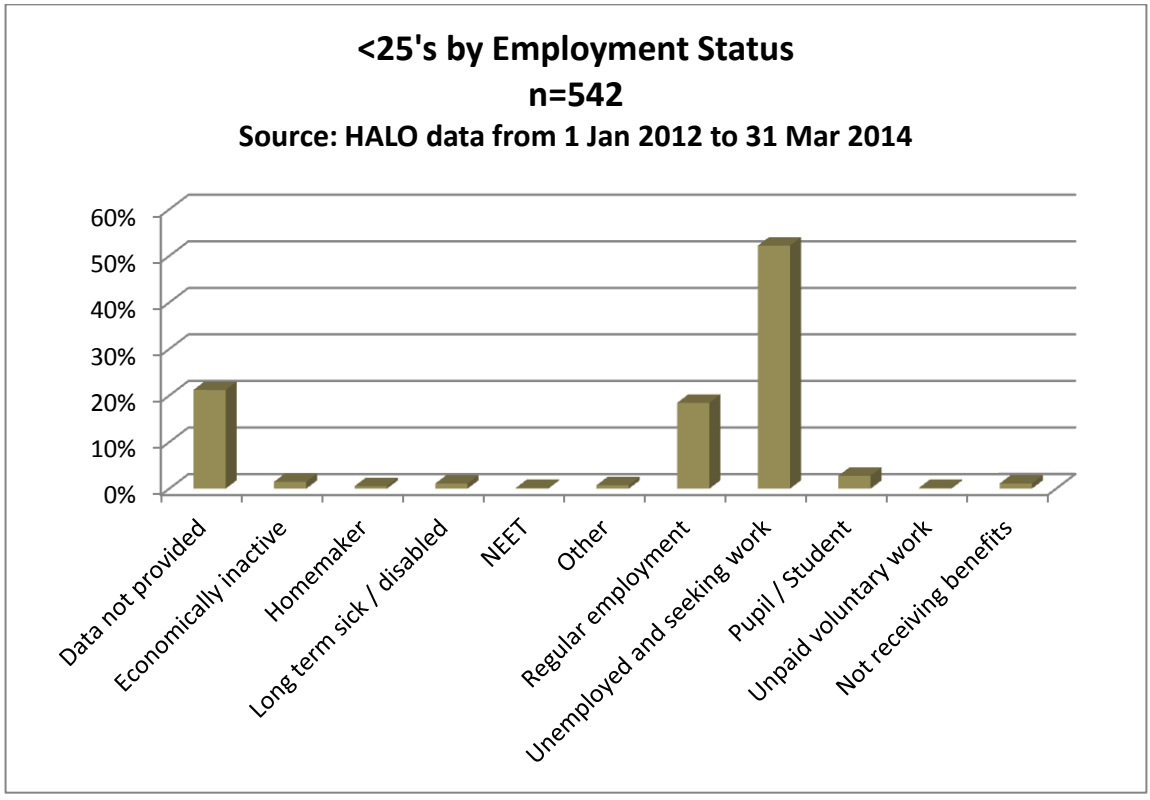
Table 34 Primary & Secondary

	Primary Substance	Secondary Substance															
		Heroin		Cocaine		Cannabis		Alcohol		Amphetamine		Mephadrone		Methadone		Cocaine	
Primary Substance	Numbers	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
Alcohol	142	0	0%	*	1%	28	20%			*	2%	0	0%	0	0%	12	8%
Heroin	73			31	42%	9	12%	*	3%	*	3%	0	0%	*	4%	*	3%
Cocaine Freebase (crack)	8	*	13%			0	0%	*	25%	0	0%	0	0%	0	0%	0	0%
Cannabis	157	*	1%	*	1%			29	18%	0	0%	*	3%	0	0%	31	20%
Cocaine	117	0	0%	0	0%	32	27%	46	39%	*	2%	*	3%	0	0%		
Methadone	9	*	11%	0	0%	*	11%	0	0%	0	0%	0	0%			0	0%

Numbers less than 5 are represented by *

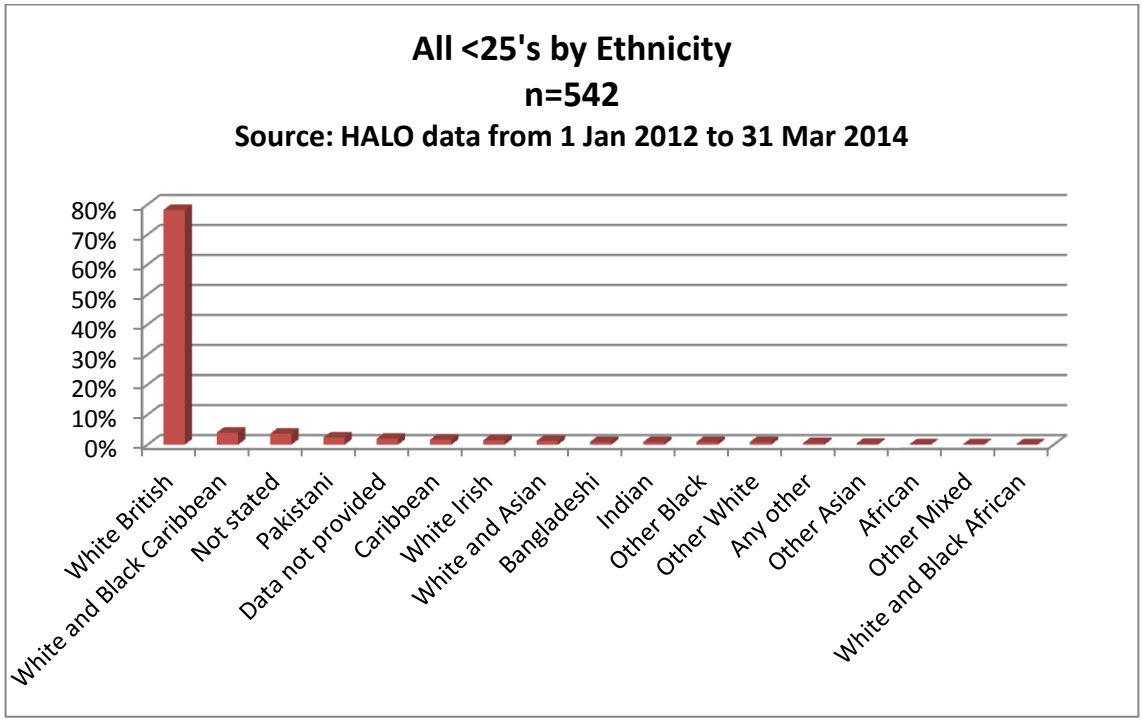
An examination of secondary drug usage reveals significant cocaine freebase (crack) use alongside heroin. The use of alcohol as secondary substance to cocaine and cannabis is important to highlight.

Table 35 Employment



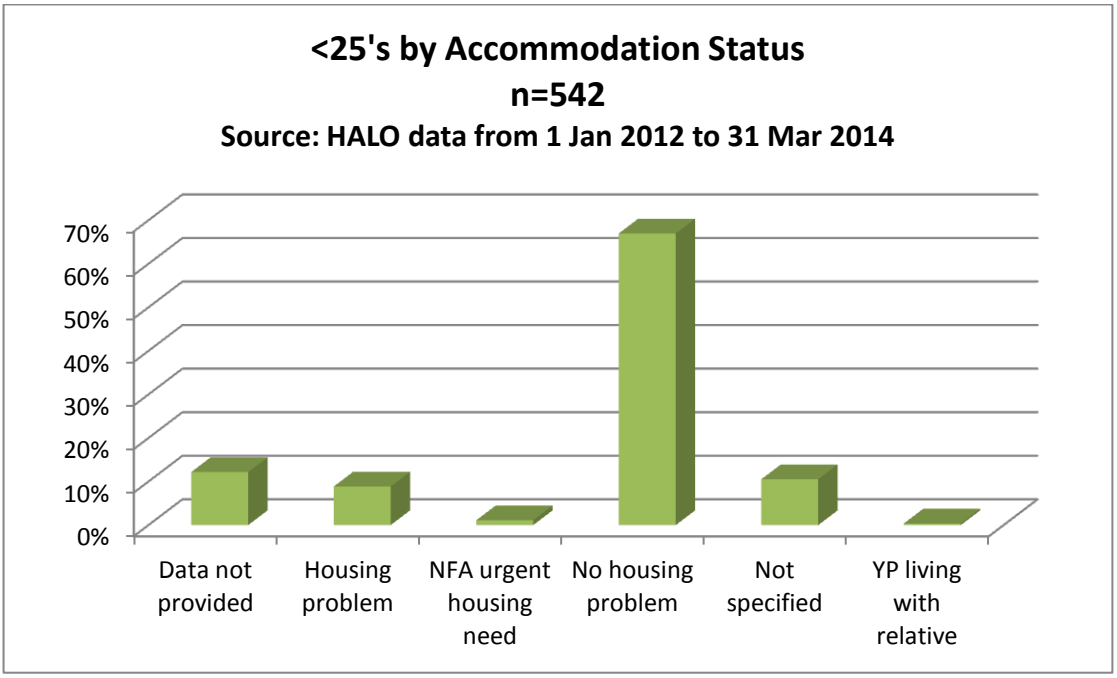
There were fewer unemployed <25's clients (52% n=115) compared to the criminal justice (64%) and overall cohorts (63%). In this cohort 18% (n=100) indicated they have some form of regular employment which is comparable with the other adult cohorts. In the latest twelve month period 58% of clients in this cohort declared some form of regular employment.

Table 36 Ethnicity



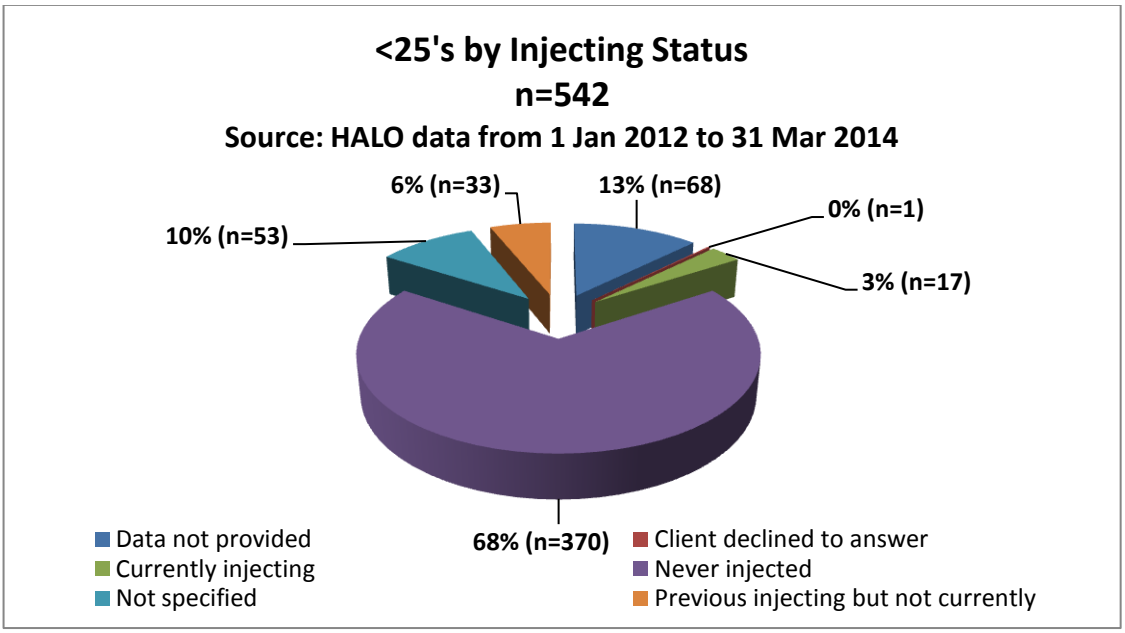
White British (78% n=424) clients were the largest cohort in the <25's cohort which is similar to the overall treatment population (77%) and was slightly higher (73%) than the criminal justice cohort. All other ethnic groups were similar in the corresponding cohort which is also reflected within the latest twelve month period.

Table 37 Accommodation



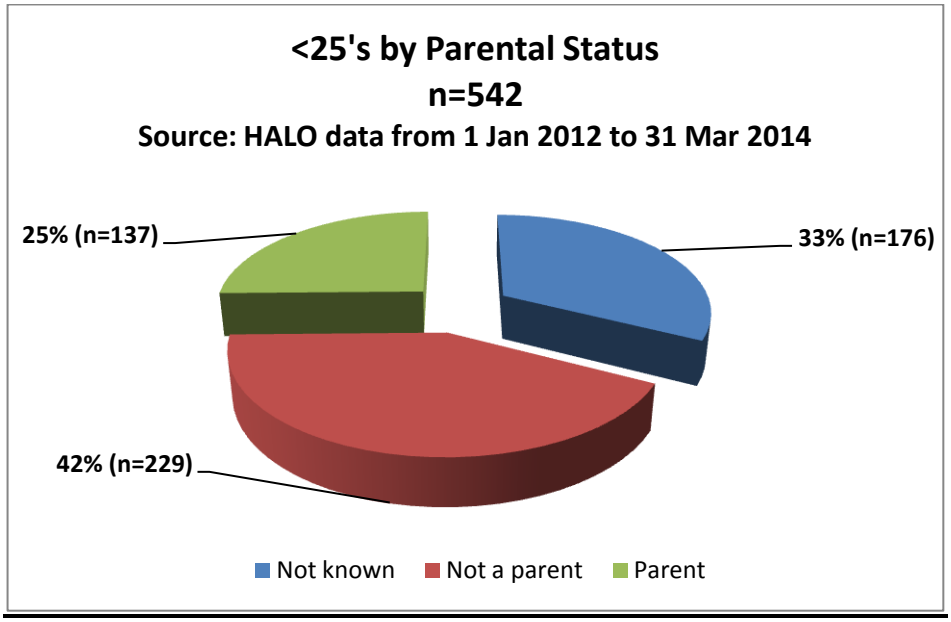
67% (n=363) of clients aged <25 declared no issues with their housing. This is Similar to those in the overall treatment population (66% n=1556) but lower than criminal justice clients 75% (n=635). In the latest twelve month period a slightly higher proportion (70%) of <25's had no accommodation issues.

Table 38 Injecting Status



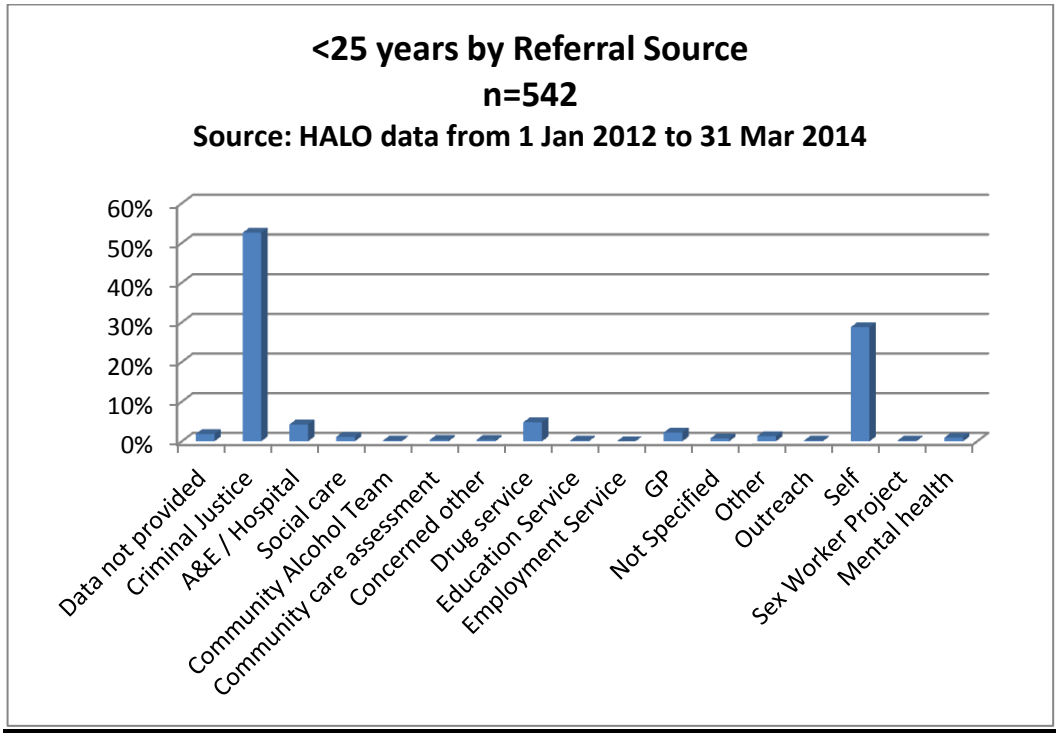
68% (n=370) of clients <25's have never injected drugs compared to 55% of those in the overall treatment population and 66% (n=555) of clients in the criminal justice cohort. Of those who have previously injected, or are currently injecting 36% (n=17) injected in the previous four weeks which is broadly similar to the latest twelve month period of 66% of all clients who had never injected.

Table 39 Parental Status



A quarter (25% n=137) of those in the <25's cohort are parents. Of those who are parents 23% (n=32) have at least one child who lives with them. It is important to highlight there were 32% (n=176) of client records where parental status was not specified or data had not been provided. The latest twelve month period reflected a similar pattern with 24% recorded as parents but only 10% had at least one child living with them.

Table 40 Referral Sources



53% (n=285) of <25's were referred through a criminal justice route. 57% (n=162) of all criminal justice referrals came through arrest referral. In the latest twelve month period only 45% were referred through a criminal justice route and only 43% were referred through arrest referral.

29% (n=156) of <25's self-referred which was the largest non-criminal justice referral route into treatment. In the latest twelve month period 33% self referred.

Benchmarking Performance against Local and National Indicators

Successful Completions – All Drugs

Walsall started the year in a much stronger position than the national, regional and Black Country averages. Performance thereafter was similar to the regional and national average. Towards the end of the year performance dipped below the regional and national averages but showed signs of improvement finishing the year better then the regional average and just below the national average. This was mainly due to non-opiate successful completions.

Table 41

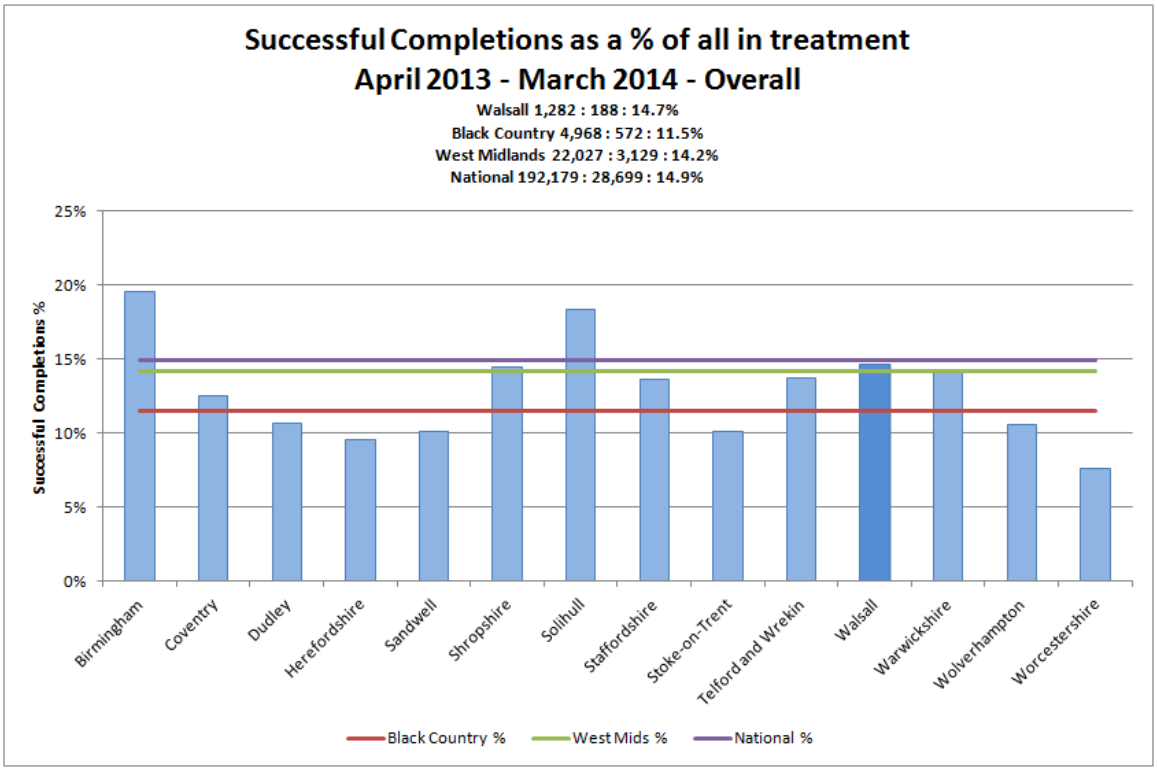
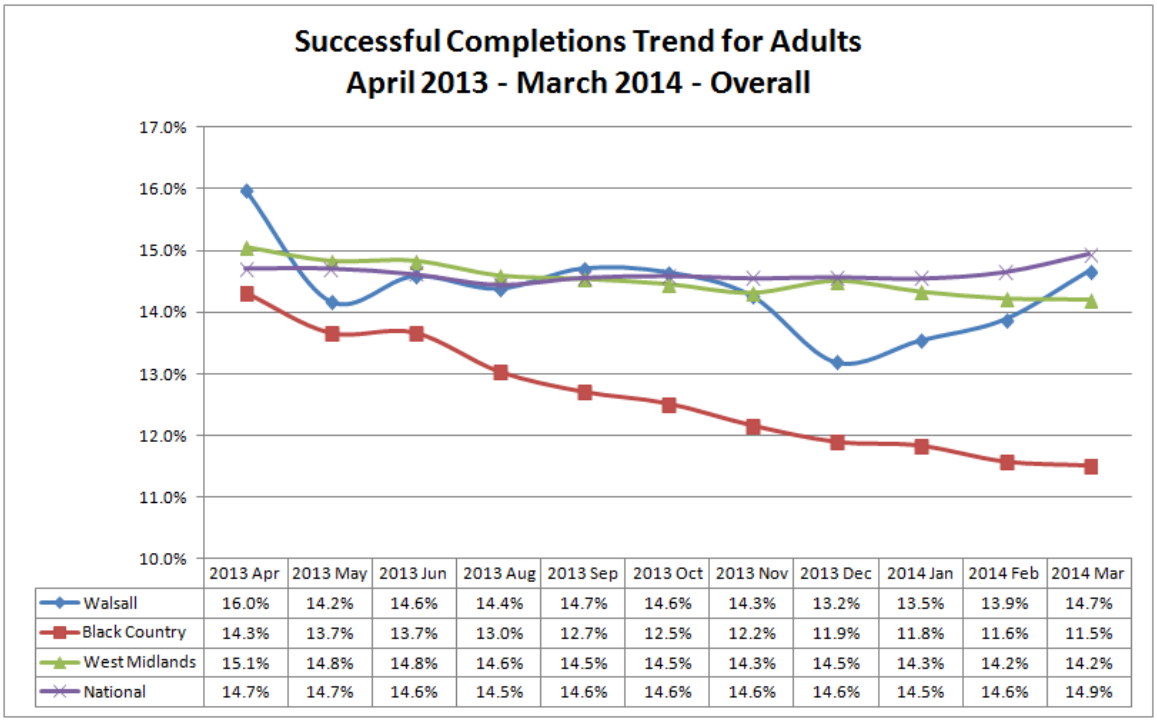


Table 42



	2013 Apr	2013 May	2013 Jun	2013 Aug	2013 Sep	2013 Oct	2013 Nov	2013 Dec	2014 Jan	2014 Feb	2014 Mar
Walsall	16.0%	14.2%	14.6%	14.4%	14.7%	14.6%	14.3%	13.2%	13.5%	13.9%	14.7%
Black Country	14.3%	13.7%	13.7%	13.0%	12.7%	12.5%	12.2%	11.9%	11.8%	11.6%	11.5%
West Midlands	15.1%	14.8%	14.8%	14.6%	14.5%	14.5%	14.3%	14.5%	14.3%	14.2%	14.2%
National	14.7%	14.7%	14.6%	14.5%	14.6%	14.6%	14.6%	14.6%	14.5%	14.6%	14.9%

Successful Completions – Opiate Only

The partnership's 2013-2014 performance on opiate successful completions has been extremely challenging. In year, Walsall has gone from one of the highest to one of the worst performing partnership areas in its statistical comparison group. This represents a drop in performance of 47% across the year compared to the cluster's dip of 7%. The average performance of the cluster has remained relatively stable. However, as a note of caution, a small decrease in numbers can result in a dramatic percentage change.

Table 43

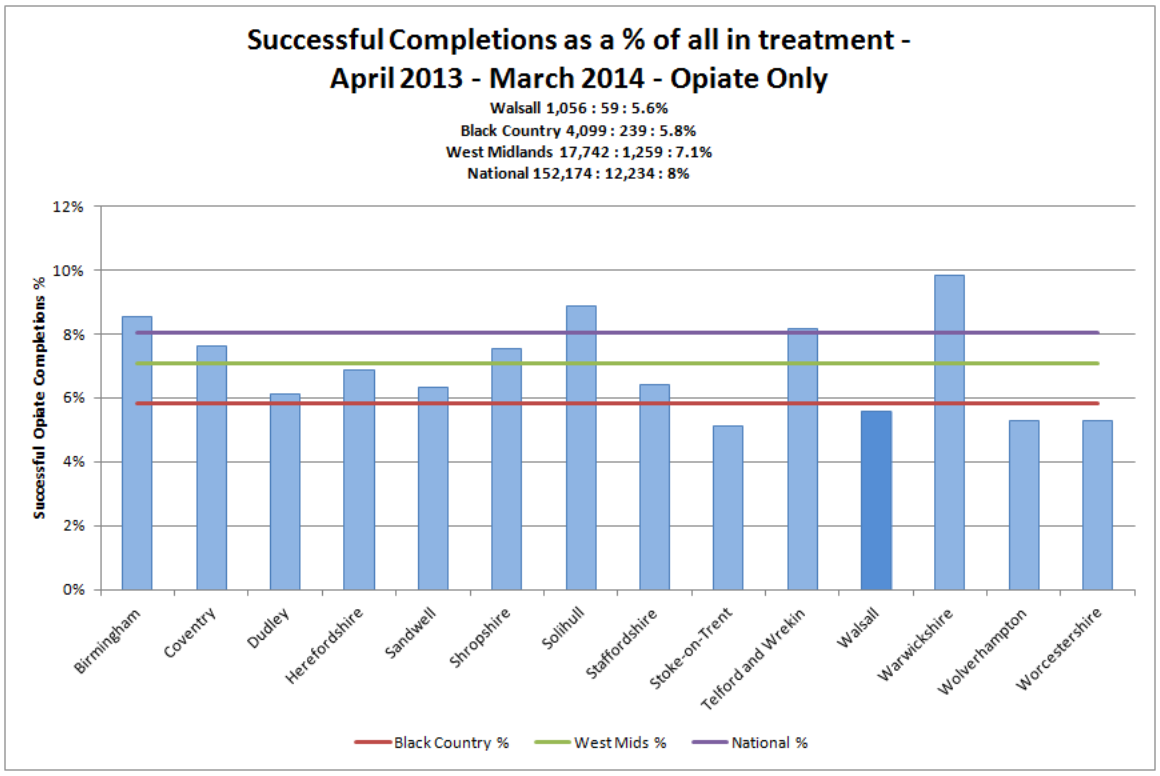
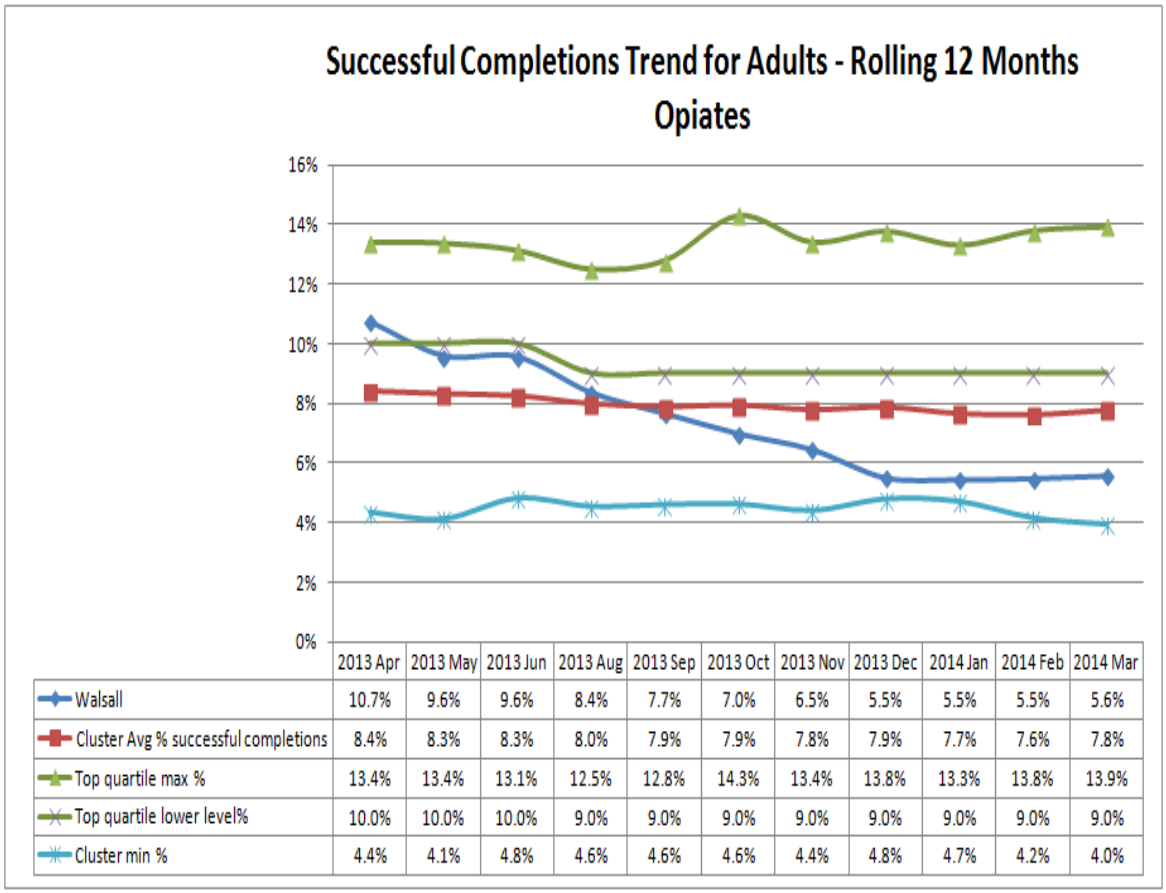


Table 44



	2013 Apr	2013 May	2013 Jun	2013 Aug	2013 Sep	2013 Oct	2013 Nov	2013 Dec	2014 Jan	2014 Feb	2014 Mar
Walsall	10.7%	9.6%	9.6%	8.4%	7.7%	7.0%	6.5%	5.5%	5.5%	5.5%	5.6%
Cluster Avg % successful completions	8.4%	8.3%	8.3%	8.0%	7.9%	7.9%	7.8%	7.9%	7.7%	7.6%	7.8%
Top quartile max %	13.4%	13.4%	13.1%	12.5%	12.8%	14.3%	13.4%	13.8%	13.3%	13.8%	13.9%
Top quartile lower level%	10.0%	10.0%	10.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%
Cluster min %	4.4%	4.1%	4.8%	4.6%	4.6%	4.6%	4.4%	4.8%	4.7%	4.2%	4.0%

Opiate Representations

In the last twelve month period 75 individuals have successfully completed their treatment. Of the 75, 17(23%) have represented during the six months following discharge which is a higher proportion of representations than the Black Country (18%) and the other local authority areas with whom Walsall is clustered (14%).

Caution must be used when interpreting this data because of the small cohort means small numerical changes can have a drastic impact on the indicator expressed as a percentage.

Table 45

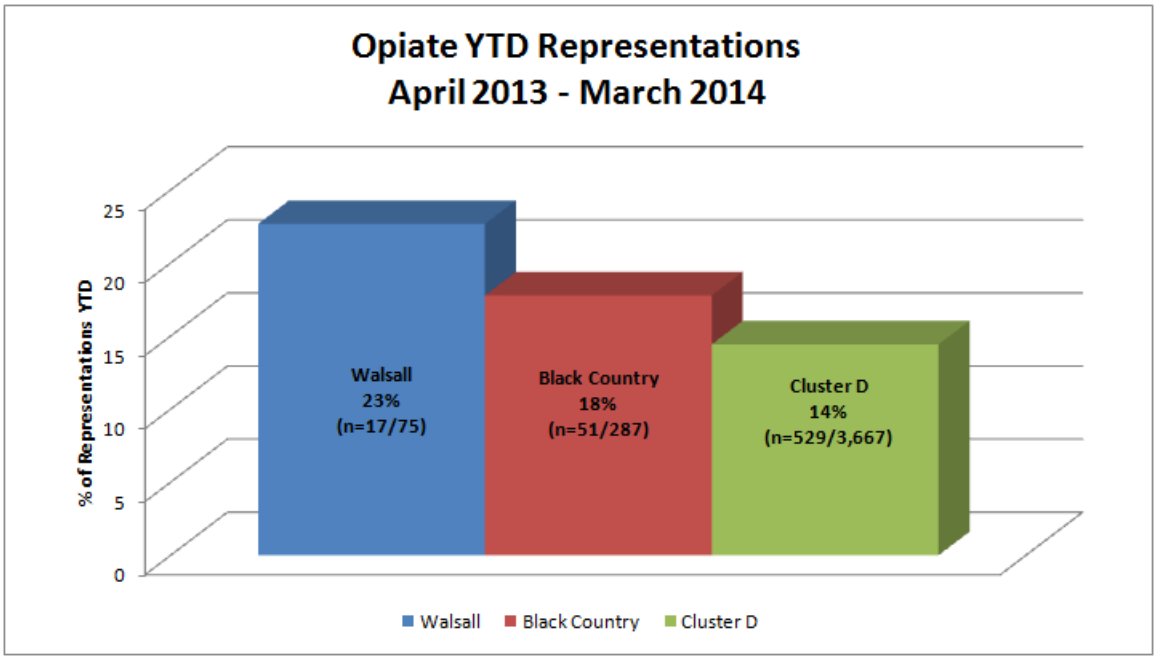


Table 46 Treatment Exits

Discharge Reason	*Number of exits*											
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Treatment completions (drug free and occasional user)	17	7	14	8	16	14	15	14	11	23	18	31
Transferred Out	5	6	8	6	8	6	6	8	6	9	11	12
Treatment Incomplete	5	*	5	7	12	11	14	7	5	8	7	13

Numbers less than 5 are represented by *

The table above illustrates detailed treatment exits on a month by month basis. Between April 2013 – March 2014 50% (n=188) successfully exited drug treatment. 23% (n=86) dropped out of treatment. 24% (n=91) of all exits were as a result of transfers out. 65% (n=59) of those that were transferred were transferred in to custody.

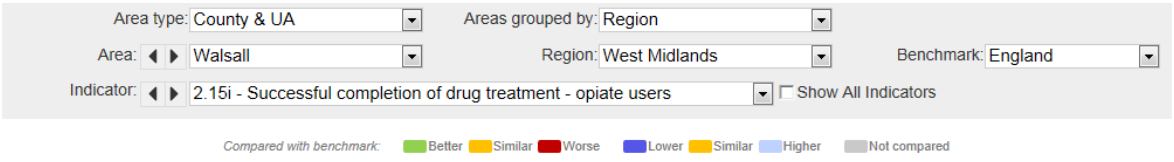
Waiting times

Data derived from the National Drug Treatment Monitoring System (NDTMS) shows that Walsall consistently meets the national target of the percentage of clients waiting over 3 weeks to start first intervention.

Public Health Outcomes Framework

The Public Health Outcomes Framework ,*(Healthy lives, healthy people: Improving outcomes and supporting transparency)* sets out a vision for public health, desired outcomes and the indicators that will help to us understand how well public health is being improved and protected. The use of illegal drugs in a factor in a range of public health outcomes. However there are two specific drugs indicators shown below. Walsall's performance against both indicators is similar to the national average.

2.15i - % of opiate drug users that left drug treatment successfully who do not re-present to treatment within 6 months

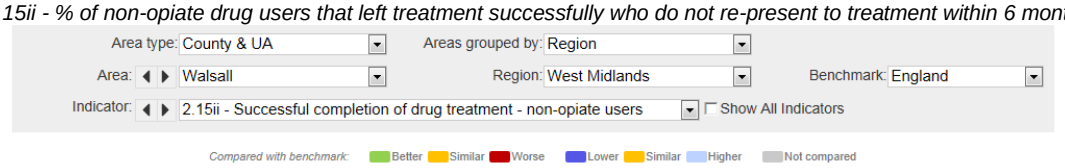


2.15i - Successful completion of drug treatment - opiate users 2012 Proportion - %

Area	Value	95% Lower CI	95%Upper CI
England	8.2	8.1	8.4
West Midlands	7.5	7.1	7.9
Birmingham	7.8	7.1	8.5
Coventry	6.7	5.3	8.5
Dudley	9.2	7.5	11.2
Herefordshire	4.0	2.6	6.0
Sandwell	4.8	3.7	6.3
Shropshire	7.4	5.6	9.7
Solihull	9.5	7.2	12.5
Staffordshire	8.4	7.2	9.8
Stoke-on-Trent	7.0	5.8	8.3
Telford and Wrekin	8.3	6.1	11.1
Walsall	8.8	7.2	10.6
Warwickshire	6.4	5.1	8.1
Wolverhampton	8.2	6.7	10.0
Worcestershire	6.7	5.5	8.2

Source: National Drug Treatment Monitoring System

2.15ii - % of non-opiate drug users that left treatment successfully who do not re-present to treatment within 6 months



2.15ii - Successful completion of drug treatment - non-opiate users 2012 Proportion - %

Area	Value	95% Lower CI	95%Upper CI
England	40.2	39.7	40.7
West Midlands	41.8	40.2	43.3
Birmingham	48.9	46.2	51.5
Coventry	34.9	28.5	42.0
Dudley	44.0	36.9	51.2
Herefordshire	18.6	12.3	27.3
Sandwell	29.6	22.3	38.1
Shropshire	39.8	32.9	47.1
Solihull	38.8	31.8	46.3
Staffordshire	41.9	36.8	47.0
Stoke-on-Trent	39.9	32.8	47.4
Telford and Wrekin	37.7	31.4	44.6
Walsall	38.8	30.0	48.5
Warwickshire	29.9	22.6	38.4
Wolverhampton	45.3	40.6	50.0
Worcestershire	23.6	17.3	31.2

Source: National Drug Treatment Monitoring System

Treatment Outcome Profile

The Treatment Outcomes Profile (TOP) measures change and progress in key areas of the lives of people being treated in drug and alcohol treatment services.

TOP consists of 20 simple questions focusing on the areas that can make a real difference to clients' lives - substance use, injecting risk behaviour, crime and health and quality of life. With the exception of cocaine abstinence Walsall has performed well against all TOP indicators.

REDUCED DRUG USE, HOUSING AND EMPLOYMENT OUTCOMES

	Abstinent	n	Expected	Reliably improved
Opiate abstinence and reliably improved: 6 month review in last 12 months	44%	64/144	34% to 51%	27%
Crack abstinence and reliably improved: 6 month review in last 12 months	52%	32/62	38% to 63%	8%
Cocaine abstinence and reliably improved: 6 month review in last 12 months	48%	16/33	53% to 85%	12%
Adjunctive alcohol abstinence and reliably improved: 6 month review in last 12 months	29%	10/35	18% to 49%	6%
No longer injecting: 6 month review in last 12 months	64%	21/33	44% to 77%	3%
Clients successfully completing treatment with no reported housing need (Exit TOP)	75%	12/16		
Clients successfully completing treatment working >= 10 days in last 28 at exit	37%	57/155		

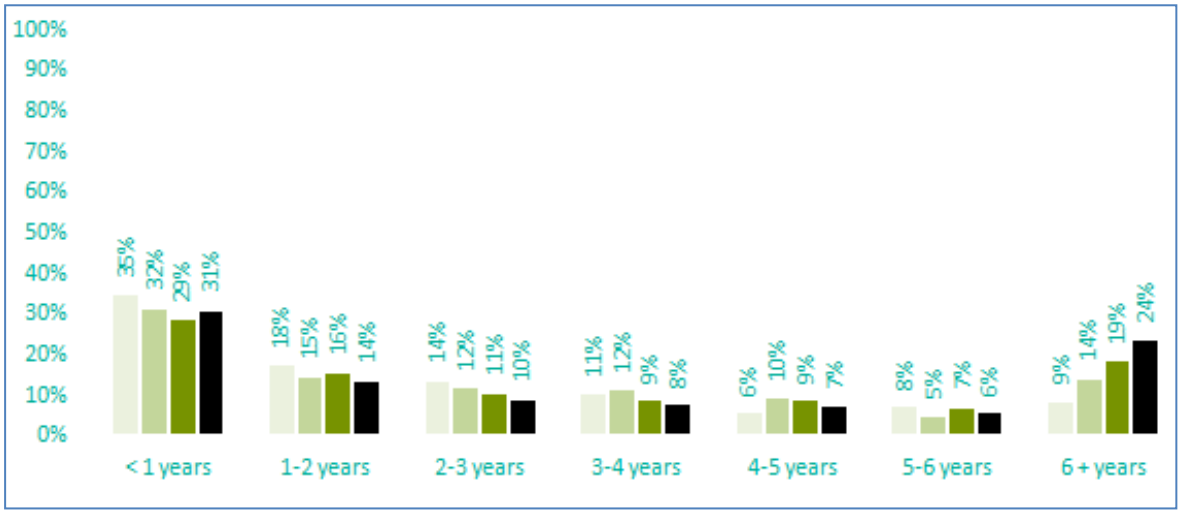
This section refers to all drug clients unless stated otherwise
Latest period: 1st April 2013 to 31st March 2014

With the exception of Cocaine abstinence at six and twelve month reviews the other outcomes are delivering positive outcomes and performing within the expected range based upon the complexity of the service users in Walsall's treatment system.

Length of Time in Treatment - Adults

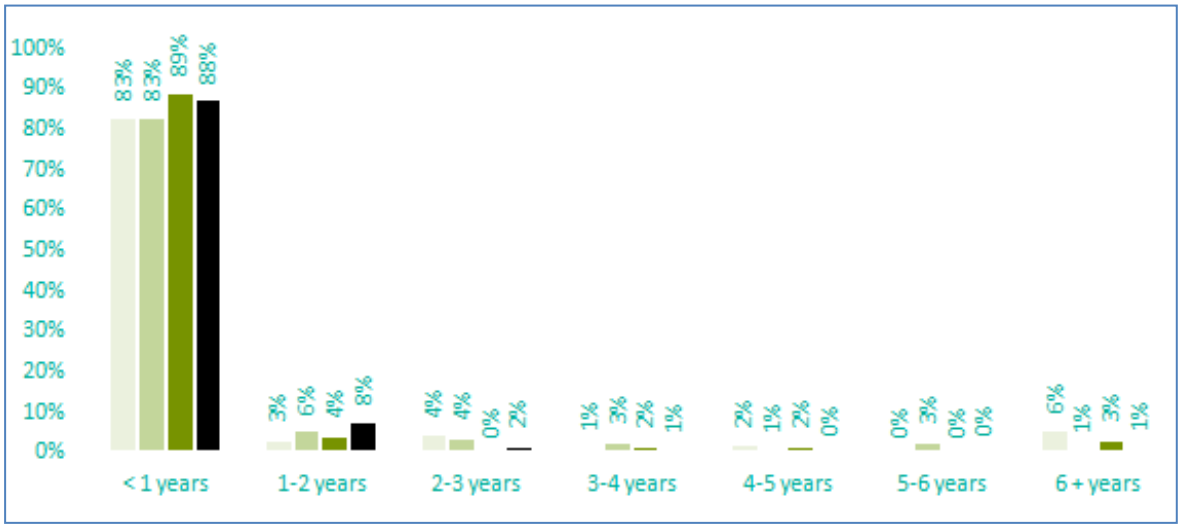
Key for both charts below:

Opiate Clients



Source: PHE; NDTMS Recovery Diagnostic Toolkit 2012-13

Non-Opiate Clients



Source: PHE; NDTMS Recovery Diagnostic Toolkit 2012-13

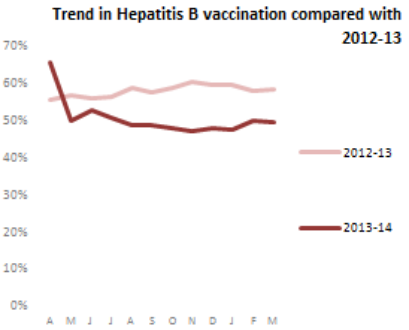
Opiate & non-opiate clients who have been in treatment less than one year form the largest cohort. Overall the length of time Walsall clients have been in treatment is similar to the national averages.

BBV – Screening Coverage/uptake, treatment

HARM REDUCTION

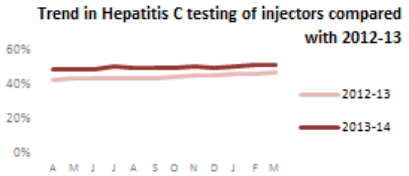
	Latest period	National average
Percentage of eligible new presentations YtD who accepted HBV vaccinations	49.3% (180/365)	43.1%
Of the 180 clients, the proportion who have started a course of vaccination (YtD)	16.1% (29/180)	20.1%
Of the 180 clients, the proportion who have completed a course of vaccination (YtD)	19.4% (35/180)	18.7%

Latest period: 1st April 2013 to 31st March 2014



Percentage eligible clients in treatment previously or currently injecting who received a HCV test (YtD)	51% (295/583)	73.9%

Latest period: 1st April 2013 to 31st March 2014



Walsall performance is better than the national average for clients accepting Hepatitis B vaccinations. However, once accepted, clients in Walsall are less likely to begin the course. For those that do start, Walsall is slightly better than the national average at getting clients to complete the course of vaccinations.

Local Outcome Comparators

For 2014/2015 Public Health England (PHE) has introduced a new reporting method to improve comparisons between local performance and that of other areas. In the new method, each local area will be compared to the 32 areas (called Local Outcome Comparators) that are most similar to them in terms of the complexity. Walsall is in different Local Comparator Groups for opiates and non-opiates.

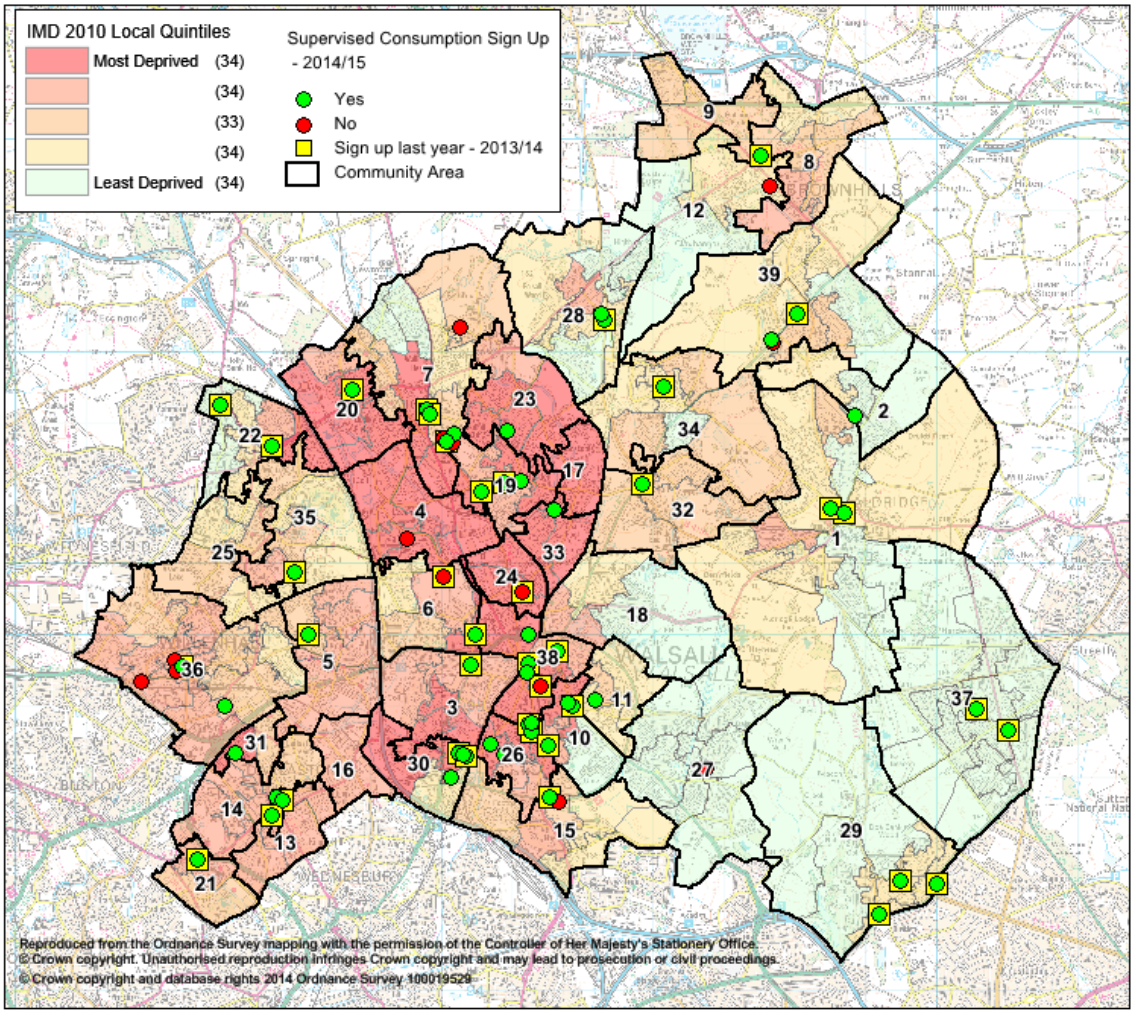
- A sample of Walsall's opiate Local Outcome Comparator Group partnerships includes Birmingham, Coventry, Manchester, Plymouth, Tameside and Wolverhampton.

- A sample of Walsall's non-opiate Local Outcome Comparator Group partnerships includes Birmingham, Herefordshire, Milton Keynes, Staffordshire, Southampton, and West Sussex.

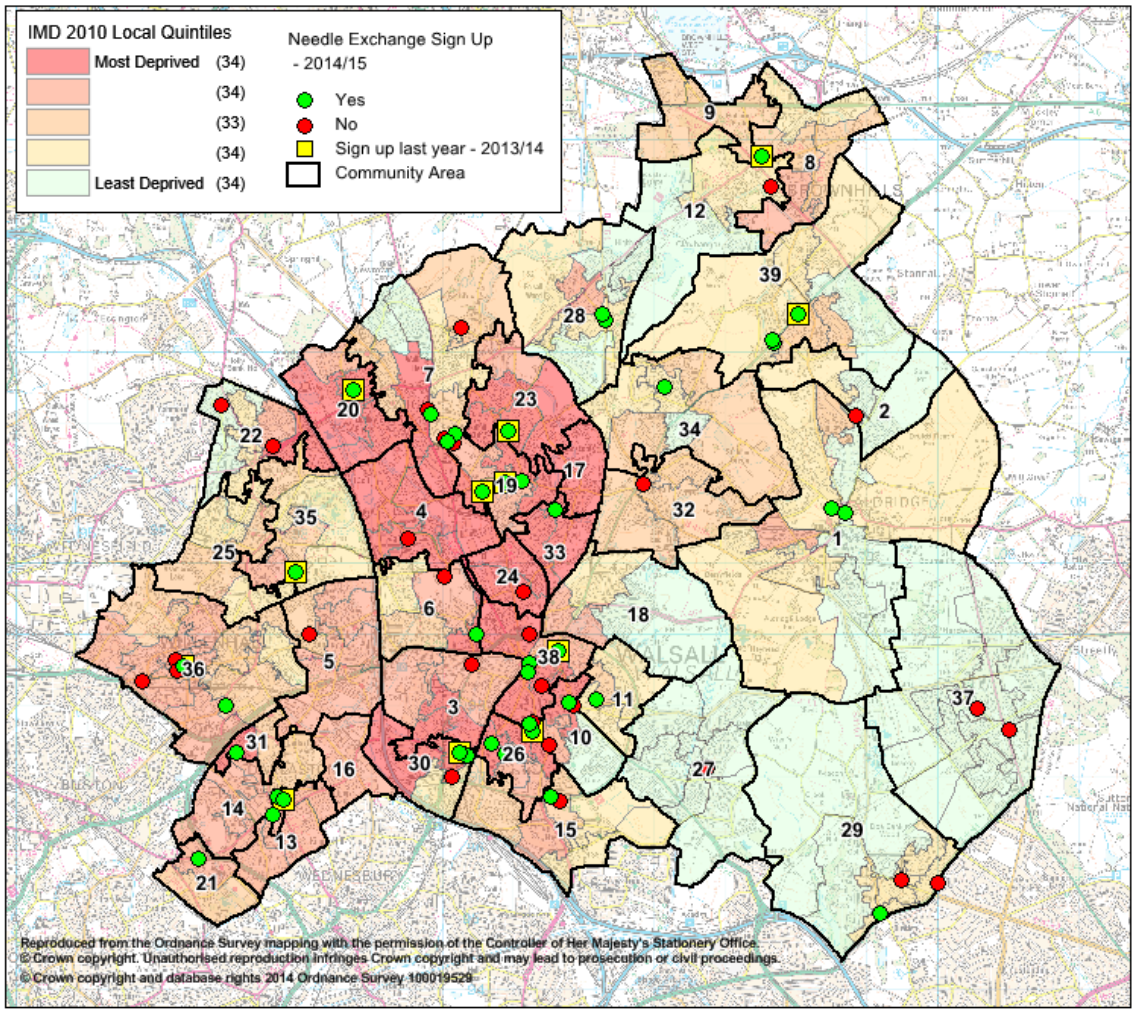
Pharmacy Services

Pharmacy Supervised Consumption

The maps below were sourced from the draft Walsall Pharmaceutical Needs Assessment 2015 they illustrate that pharmacy needle exchange and supervised consumption services are predominately located in areas of high deprivation and where clients in treatment services reside as illustrated in maps on pages 11-13 in this document.



Pharmacy Needle Exchange



Alcohol Chapter

Alcohol misuse-inc. estimated prevalence, service users, context-sex, age, ethnicity

An understanding of the way people drink in Walsall is important to gain insight into the types of alcohol related harm borough residents might experience, and the types of interventions that may be needed in order to reduce the harm. The Local Alcohol Profiles for England (LAPE, produced by the North West Public Health Observatory(now part of Public Health England)) provides definitions for increasing risk, higher risk and binge drinking (for definitions of categories of alcohol use see table 1). These estimates are based partly on self-reports (General Health Survey for England) and may be an under representation of the actual levels at which people in Walsall are drinking, as people might under-report the amount that they drink. For example, in 2005 Her Majesty's Revenue and Custom's data on clearances (alcohol sales) suggested that the average adult purchased the equivalent of 11.3 litres of pure alcohol over the year, whereas the GHS suggested that the average adult drank 5.6 litres of pure alcohol over the same time period[3].

There is evidence of higher than average rates of alcohol related harm in Walsall across a number of indicators. Information from the LAPE [4] measure alcohol misuse in each local authority area in England using 23 separate indicators, including, for example, months of life lost due to alcohol misuse, alcohol related violent crimes and rates of binge drinking (see table 1). The indicators are based on national data sources such as the Hospital Episode Statistics (HES) and mortality data produced by the Office for National Statistics (ONS), with an estimation factor for each local area applied where appropriate. The resulting profiles compare each authority's ratings to the national average and highlight indicators which are significantly better or significantly worse than average. The LAPE data shows that Walsall falls in the bottom half of ratings of local authorities (those who perform badly) for the majority of indicators, and is significantly worse than other areas for a number of indicators.

3 http://www.statistics.gov.uk/ssd/surveys/general_household_survey.asp

4 http://www.nwph.net/alcohol/lape/

Table 47 Categories of alcohol use (Definitions from LAPE[5], Safe, Sensible and Social[6]. and the Alcohol Needs Assessment Project[7]).

Categories of alcohol use

Sensible drinking is drinking within limits which do not pose any risk of harm to the person or others (no more than 3-4 units a day for men and 2-3 units a day for women)

Increasing risk (Hazardous drinking) is drinking above recognised sensible levels but not yet experiencing harm (consumption of between 22 and 50 units of alcohol per week for males, and between 15 and 35 units of alcohol per week for females)

Higher risk (Harmful drinking) is drinking that leads to significant harm to physical and mental health and that may be causing substantial harm to others (consumption of more than 50 units of alcohol per week for males, and more than 35 units of alcohol per week for females)

Binge drinking is drinking 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).

Dependent drinking is drinking above sensible limits and experiencing harm and symptoms of dependence

Estimates for Increasing risk, higher risk and binge drinkers in Walsall

LAPE estimates that there are 50,628 ***hazardous drinkers*** in Walsall (18.8% of the population). This is lower than the regional average (19.6%) and the national average (20.0%) and Walsall has one of the lowest rates of hazardous drinking in the UK (of 352 local authorities it has the 23rd lowest rate). It is therefore somewhat surprising that this aspect has not impacted upon the alcohol related hospital admissions figure.

LAPE estimates that there are 16,373 ***harmful drinkers*** in Walsall (6.08% of the population). This is slightly lower than the regional average (6.51%) and lower than the national average (6.75%).

LAPE estimates that there are 43,088 ***binge drinkers*** in Walsall (16.0% of the population). This is lower than the regional average (18.8%) and the national average (20.1%).

5 http://www.nwph.net/alcohol/lape/

6 Department of Health, Home Office, Department for Education and Skills, Department for Culture, Media and Sport (2007) Safe. Sensible. Social. The next steps in the National Alcohol Strategy

7Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP): The 2004 national alcohol needs assessment for England

The LAPE estimates that there are 52,944 (19.66%) citizens of Walsall who abstain from alcohol. This is higher than the regional (17.91%) and the national (16.53%) averages and may be partly explained by the 8.1% of the population who are Muslims and who would be expected to abstain as a tenet of the faith.

Walsall's estimated drinking patterns suggest lower than average hazardous and binge drinking rates and a slightly lower harmful drinking rate than the national average.

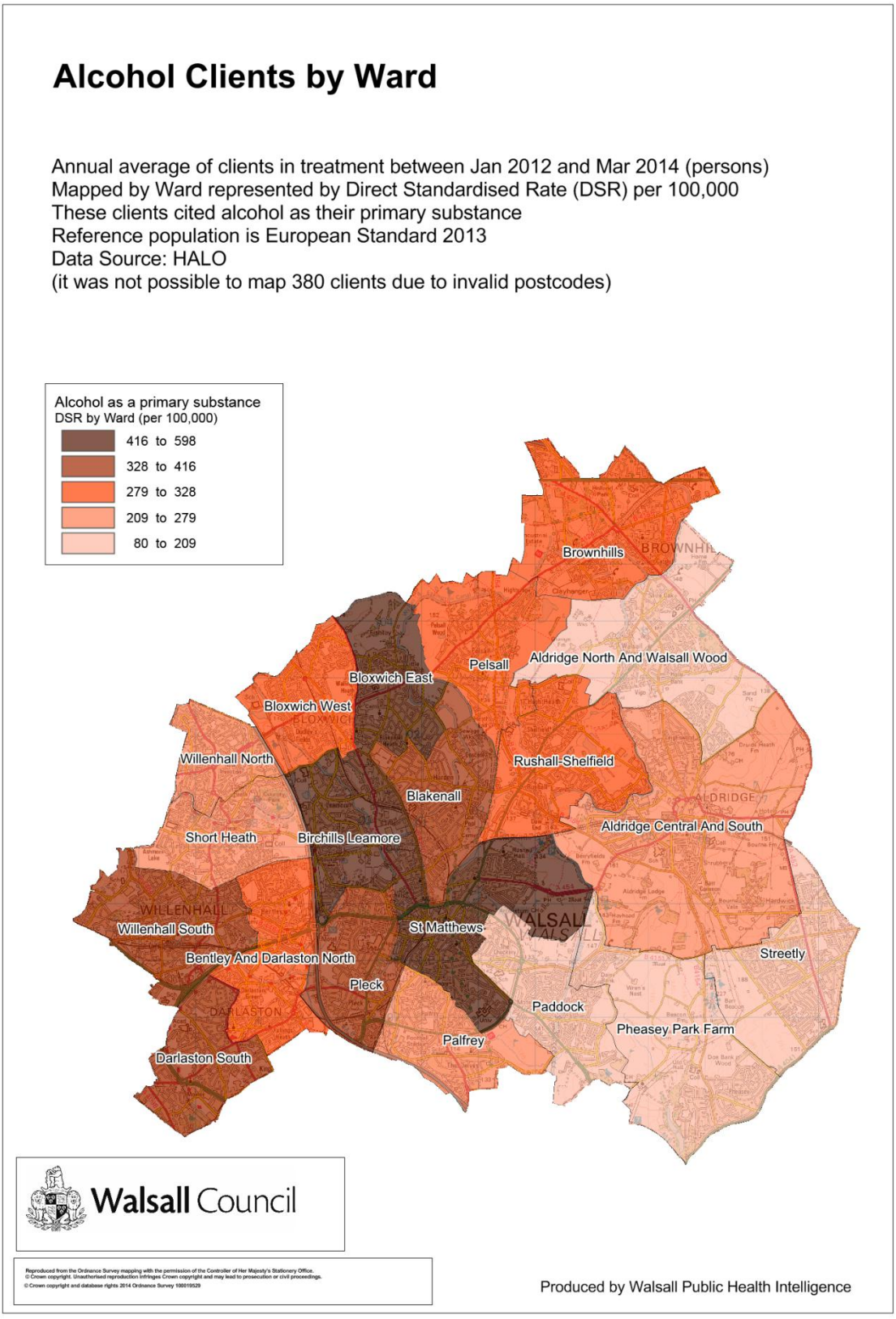
While the prevalence estimates for hazardous and binge drinking rates in Walsall were lower than the national average, the hard data is not so encouraging especially in light of the higher than average rates of alcohol related mortality and hospital admission rates. Based upon these estimates there would appear to be a discrepancy between the numbers of people accessing services and the numbers of problematic drinkers in the borough.

Only 1% of the estimated hazardous drinkers in Walsall are accessing structured alcohol treatment services. This suggests that there are significant numbers of people experiencing alcohol related harm who are not in contact with treatment services. There is also evidence that significant numbers of people are accessing the local hospital through planned and unplanned admissions. This suggests that individuals are not being identified at an early stage and they are entering the treatment system at an advanced stage of damage.

Alcohol dependency in Walsall

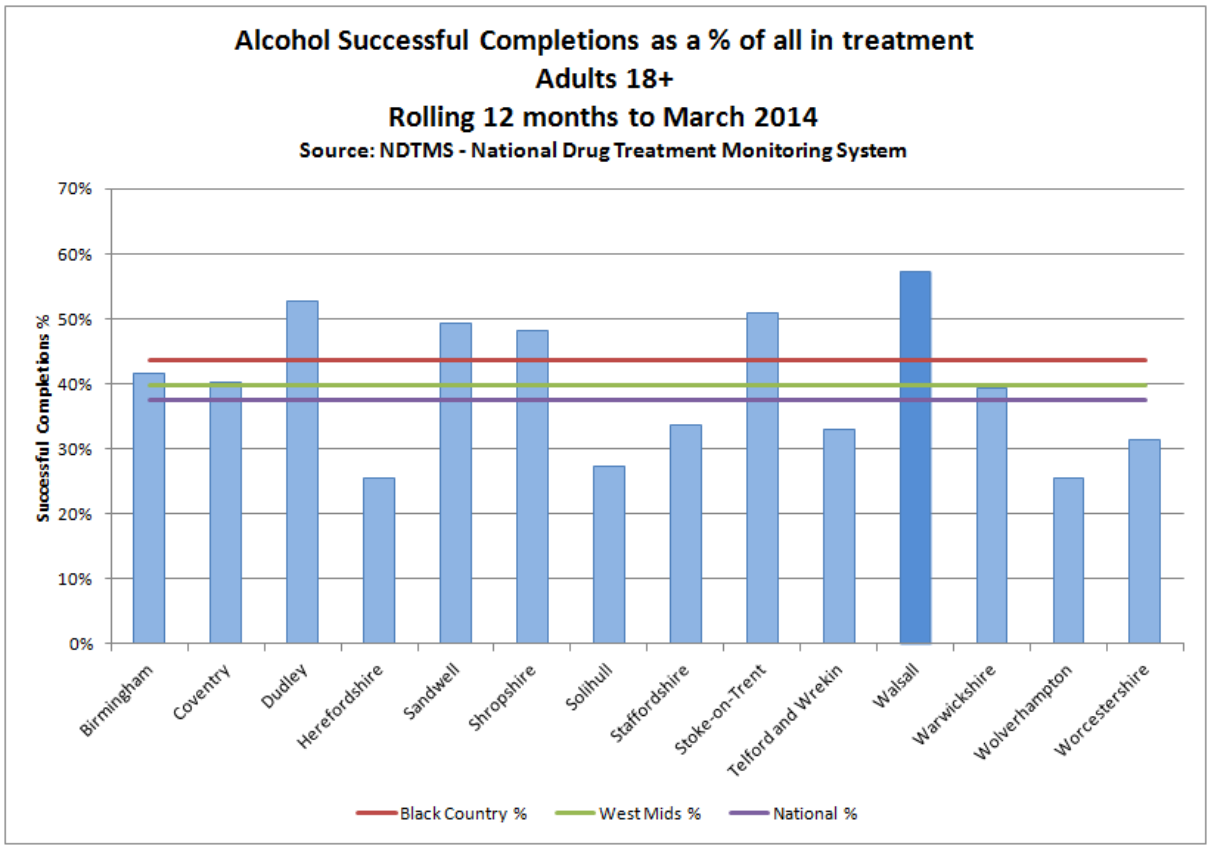
Those who are alcohol dependent may also be hazardous and/ or binge drinkers. The Alcohol Needs Assessment Research Project (ANARP) [8] found that 4% of adults in the West Midlands were dependant on alcohol. It is worth noting that the regions with the highest prevalence of hazardous/harmful drinking were different from those with the highest prevalence of alcohol dependence. This indicates the need for different levels/types of services in different regions. Based upon 2011 census data (that reports a population of 269,300 in the Borough) this would suggest that *10,772 adults in Walsall are alcohol dependent*.

8 Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP): The 2004 national alcohol needs assessment for England



Mapping of primary alcohol dependent clients in specialist treatment, (see above), shows a similar demographic distribution as those in specialist treatment for primary drug use illustrated in pages 11-13 of this needs assessment.

Table 48 Current Treatment Profiles



The chart above shows alcohol successful completions for adults over 18 years in Tier 3 structured treatment alcohol services. The Tier 3 service in Walsall has been structured to direct clients towards detoxification and ongoing abstinence and this defined criterion has resulted in smaller numbers in this tier of service than in other areas. In 2013/14, there were 408 clients who entered treatment and 234 (57.4%) of these are shown as a successful treatment completion. The comparable figure for the Black Country was 43.6% (1037 clients out of 3280), for the West Midlands 39.8% (5712 clients out of 14358) and nationally 37.5% (41,979 clients out of 111,799).

The chart below shows alcohol exits by quarter, in Walsall, for the last financial year. All exits relating to transfers have been grouped together and those relating to incomplete treatment have been grouped also.

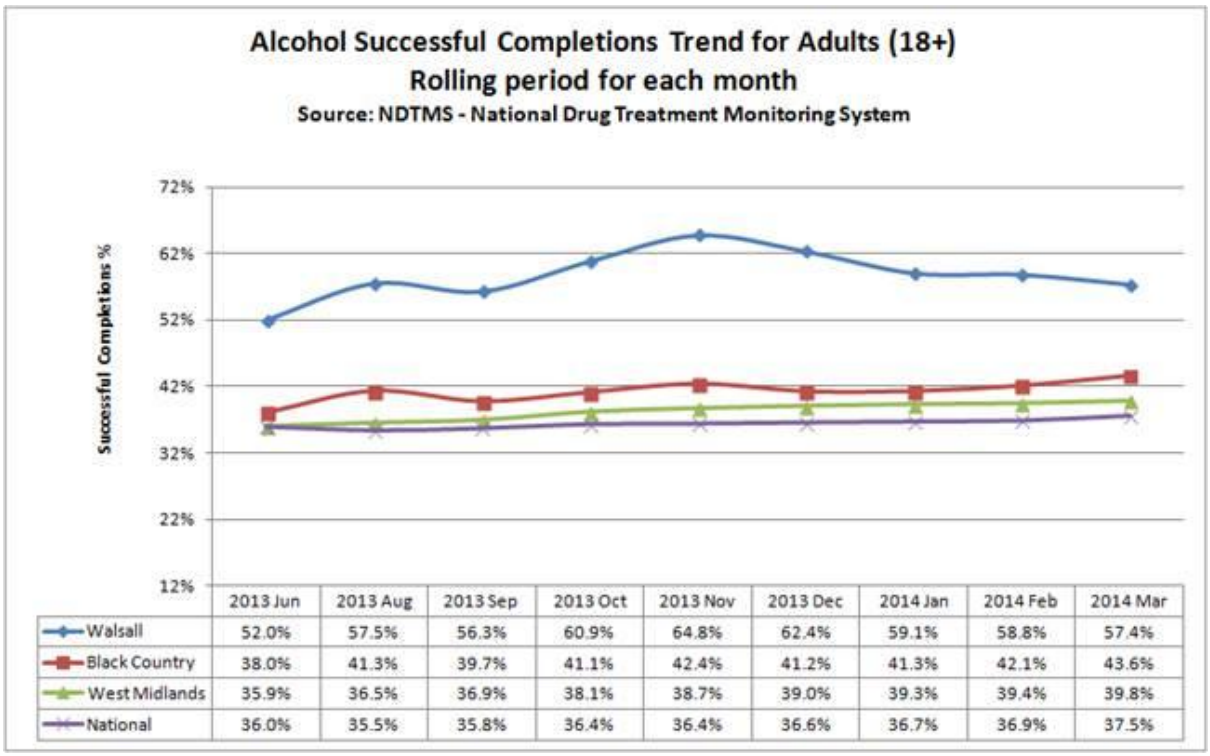
Table 49 Alcohol exits

Discharge Reason	*Number of exits in 2013-14*			
	Q1	Q2	Q3	Q4
Treatment completions (alcohol free and occasional user)	61	72	60	41
Transferred Out	9	4	11	11
Treatment Incomplete	8	7	7	13

Source: NDTMS successful completions

The following chart shows the alcohol successful completions data as a trend over several months i.e. each month in the chart below represents 12 months of rolling data.

Table 50



	2013 Jun	2013 Aug	2013 Sep	2013 Oct	2013 Nov	2013 Dec	2014 Jan	2014 Feb	2014 Mar
Walsall	52.0%	57.5%	56.3%	60.9%	64.8%	62.4%	59.1%	58.8%	57.4%
Black Country	38.0%	41.3%	39.7%	41.1%	42.4%	41.2%	41.3%	42.1%	43.6%
West Midlands	35.9%	36.5%	36.9%	38.1%	38.7%	39.0%	39.3%	39.4%	39.8%
National	36.0%	35.5%	35.8%	36.4%	36.4%	36.6%	36.7%	36.9%	37.5%

Table 51 below shows the same data, but cumulative:

Alcohol - Cumulative Exits	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Total Exits	19	60	78	119	136	161	192	221	239	258	287	304
Planned exits	16	47	61	98	115	133	160	181	193	206	225	234
% Planned exits	84%	78%	78%	82%	85%	83%	83%	82%	81%	80%	78%	77%

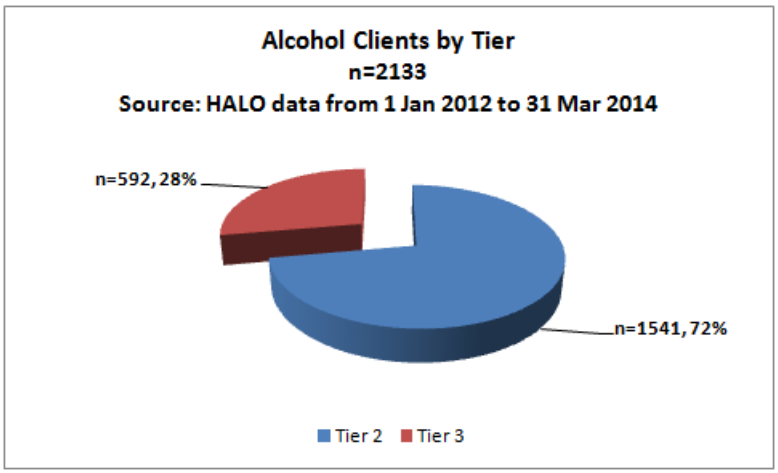
Source: NDTMS successful completions

Structured and Tier 2 treatment figures: (HALO data)

The data for numbers in treatment and outcomes from Tier 2 alcohol treatment services is not currently reported via the NDTMS outcomes data. This gap in the recognized source for comparison of performance means that we are reliant on locally derived data collated from HALO, which is the software currently used by existing providers in Walsall (see Table 6 below)

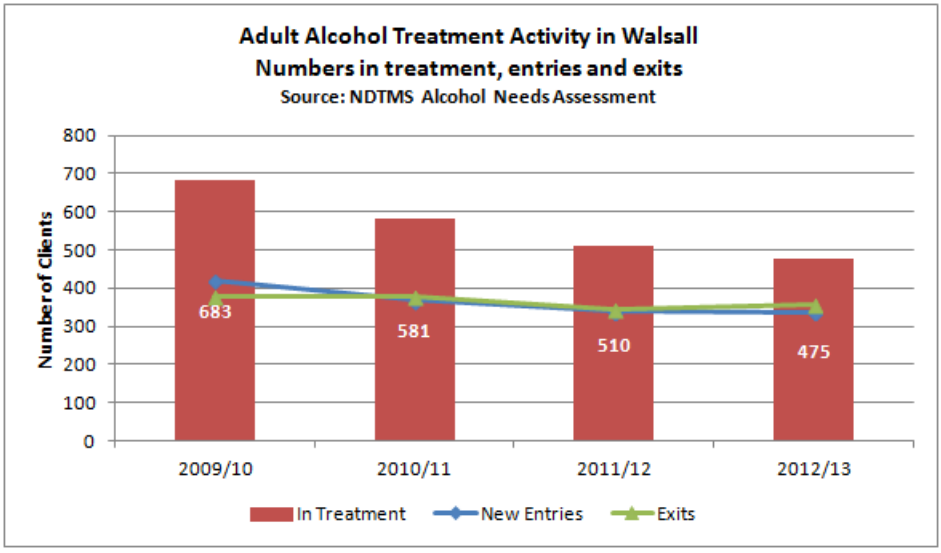
The total number of clients in alcohol treatment in Walsall between 01/04/2013 and 31/03/14 was 937. Of this number, 636 (68%) were treated in Tier 2 with the remaining 301 (32%) treated in Tier 3. If this is extended back over a longer period (the data is available for 27 months prior to the end of 2013/14), this split between the tiers is reinforced (see chart below).

Table 52



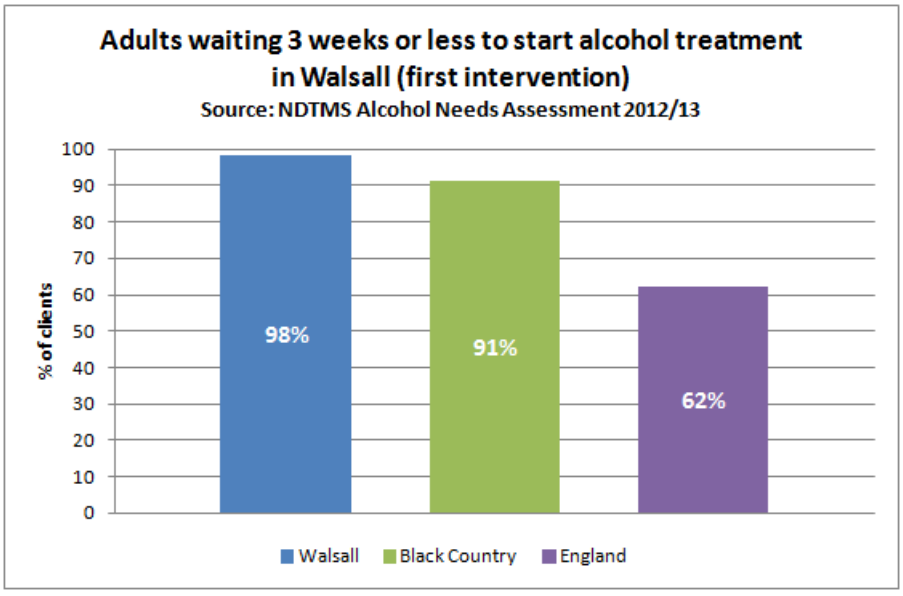
In the 27 months represented above, 72% of alcohol clients were receiving treatment at the Tier 2 level. Tier 2 interventions are open access, non-care planned, alcohol-specific interventions. Those clients receiving structured, care-planned treatment at Tier 3 level amounted to 28% (see chart below to trace this movement to lower numbers in Tier 3 further). The distribution between the tiers reflects the historically modest level of investment in Walsall (in comparison to some neighbouring areas with similar levels of need) in alcohol treatment services. The data shows that while PCTs were operating, they spent on average just over 0.1% of their budget on commissioning alcohol services and with the transition of the drug and alcohol budgets to local authority public health departments, the budgetary pressures on local government suggests that this is unlikely to change.

Table 53



There were 851 service users who were referred to the Community Alcohol Team (CAT) in 2013/14. The CAT delivers Tier 3 alcohol treatment in Walsall (for a definition of the tiers of treatment see pages 3 and 4). NDTMS data indicates that 98% receive a structured treatment intervention within 3 weeks of referral and assessment (see Table 8), and tier 2 services report no waiting times. Services are, therefore, appearing to meet demand.

Table 54

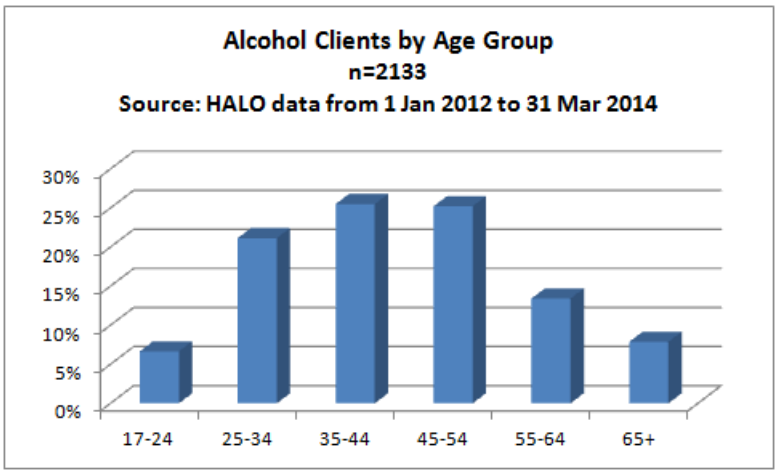


Whilst not all people drinking problematically or being admitted to hospital for alcohol attributable conditions will want or need an alcohol treatment service, these figures suggest that there may be large numbers of people experiencing alcohol related harm who are not in contact with treatment services in Walsall.

Prevalence by age.

Of the 937 clients in treatment in 2013/14, 57 (6%) were aged 18-24 with 208 (22%) between 25 and 34. There were 264 clients (28%) between the ages of 35 and 44 and a further 256 (27%) who were in the age group 45-54. The number of clients between 55 and 64 was 119 (13%) and there was 31 (3%) over the age of 65. This pattern is further evidenced in the longer time frame illustrated in the chart below.

Table 55

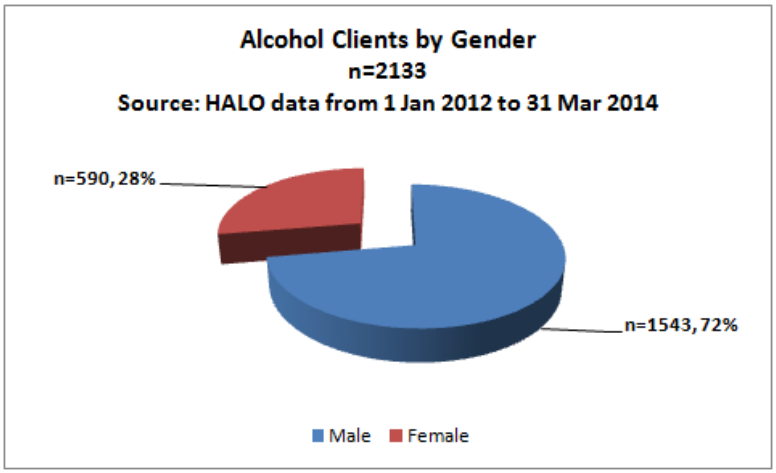


The largest number of people in treatment fall between the ages of 35 and 54 (51%). If the range is extended to cover the age range 25 – 54 it increases to 72% of those in treatment.

Alcohol Clients by Gender.

In 2013/14, of the 937 alcohol clients in treatment, 670 (72%) were male with 267 (28%) females. The figures are exactly reflected in the data for the longer period 01/12 to 03/14.

Table 56



28% of clients in treatment were female and this has also been reflected in the rise that has occurred in alcohol-attributable hospital admissions over the past decade.

Alcohol Related Hospital Admissions

Hospital admissions for alcohol related harm[9] (NI 39[10]) have been rising for some time in England. In 2008/9 there were 945,470 alcohol related admissions to hospital in England, an increase of 9% on the previous year. This was an increase of 46% since 2002/03 when there were 510,780 alcohol related admissions**.** The latest available data, for 2012/13, shows a total of 1,008,846 alcohol related admissions which is an increase of 6% on 08/09 admissions.

The rate of hospital admissions for alcohol related harm in Walsall has during this period been higher than the national and regional average. In 2008/9, Walsall ranked 52 highest of 326 local authorities for this indicator with 1996.0 admissions per 100,000 of the population compared to 1663.3 regionally, and 1582.4 nationally (see table 50). The figure for Walsall in 2012/13 was 2170 (per 100,000 of population), with 2089 for the region and 2032 nationally. The rate of increase has therefore slowed down in Walsall and is now just above the regional and national figure. Walsall's hospital admissions therefore remain higher in relation to regional and national levels across a range of alcohol related health indicators, but its relative position has improved.

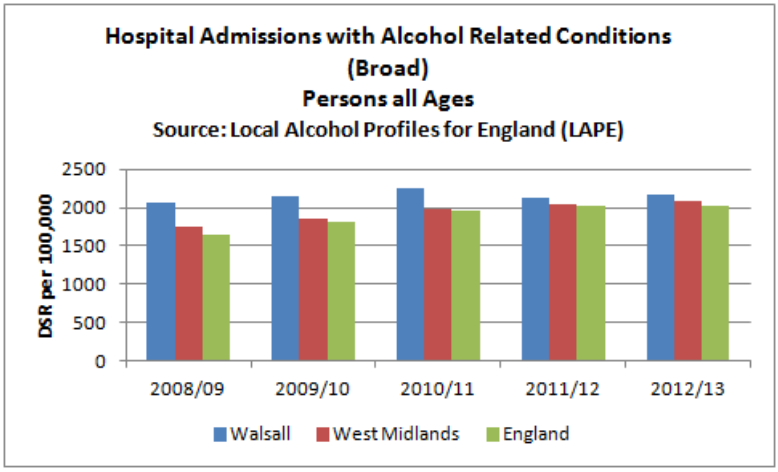
The level of hospital admissions for 2009/10 (Table 57) showed Walsall at a statistically significant higher level than the regional and national levels. The figures for the same category of admissions 2012/13 show that Walsall's rate has slowed (an increase of 49 over the 3 year period) while the regional and national figures have a higher level of increase.

Alcohol-specific outcomes include those conditions where alcohol is causally implicated in all cases of the condition; for example, alcohol-induced behavioural disorders and alcohol-related liver cirrhosis. The alcohol-attributable fraction is 1.0 because all cases (100%) are caused by alcohol.

Table 57

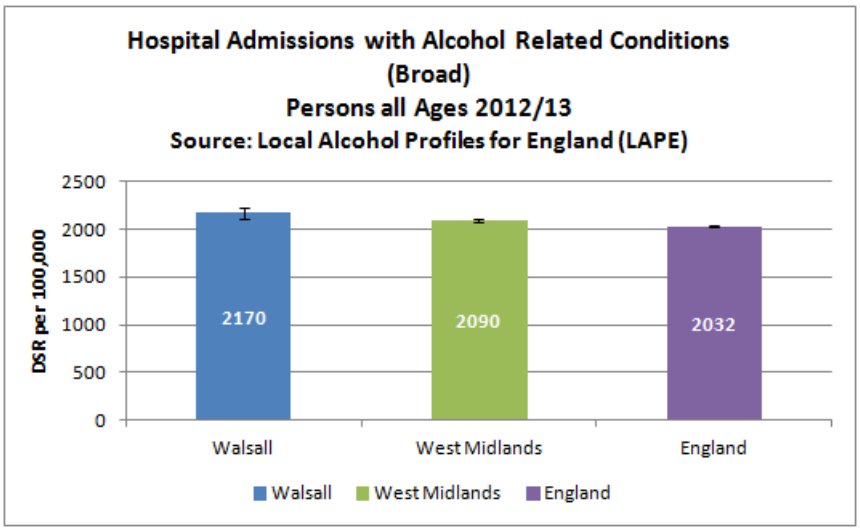
9 Directly age and sex standardised rate per 100,000 population, 2006/07. (Department of Health using Hospital Episode Statistics and Office for National Statistics mid-year population estimates).

10 http://www.communities.gov.uk/publications/localgovernment/nationalindicator



Taken from the North West Public Health Observatory annual Local Alcohol Profiles for England (LAPE) (2013) the rate of hospital admissions for alcohol **related** harm in the borough for men and women is higher than the regional and national averages. However, the rate of increase has slowed in recent years and Walsall is approaching the regional and national average.

Table 58



Walsall is ranked 237 highest out of 326 local authorities, which represents a steady improvement on 2009/10.

Hospital Admissions with alcohol related conditions (broad) - Females

The 2009/10 rate for Walsall, at 868, remained higher than the regional rate (812 per 100,000) and the national rate (790 per 100,000) and Walsall then was ranked 276 highest of 326 local authorities in this category. The figure for 2012/13 is 854 which put Walsall at 224 highest of 326 local authorities.

Alcohol related hospital admissions (Broad) for females had been rising in Walsall at a greater rate than the national rate but has now fallen to a level that is lower than the Black Country average and just above the national and West Midlands figure.(Table 59)

Table 59

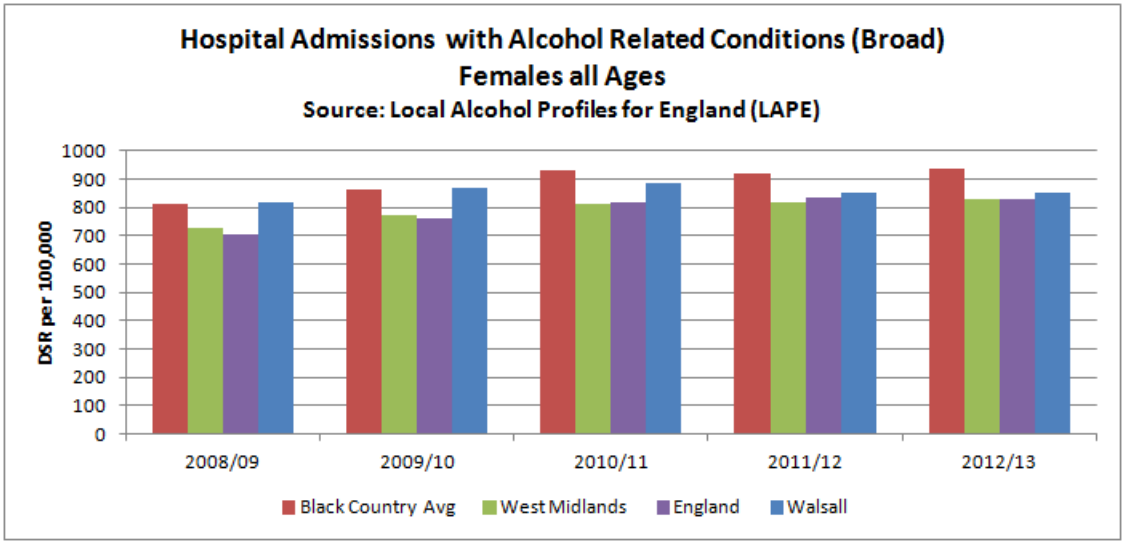
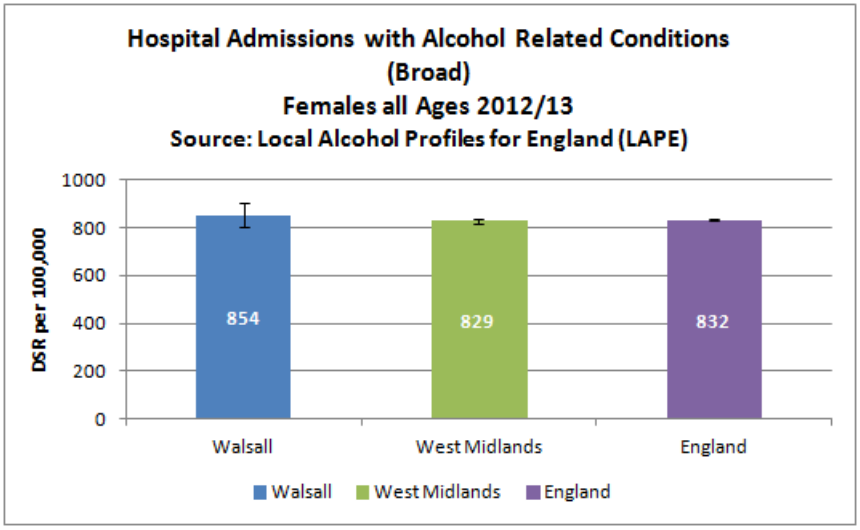


Table 60



The tables above (Tables 59 & 60) show that female hospital admissions measured on the broader criteria are in line with both the regional and national figures for 2012/13. This represents a significant improvement over the last 3 to 4 years. If we look at the narrower measure of alcohol specific hospital admissions the picture offers more encouragement of evidence that we are heading in the right direction.

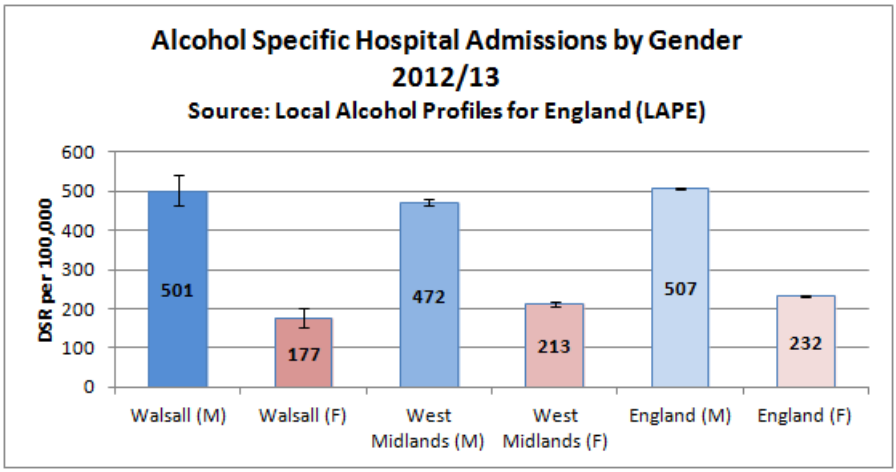
In addition to the wider measure of 28 conditions that make up the alcohol-attributable (Broad) categories, the position in Walsall in relation to alcohol specific hospital admissions is also showing signs of improvement.

Alcohol specific hospital admissions by Gender 2012/13

Nationally, regionally and locally, there are significantly more males than females being admitted to hospital with alcohol specific conditions (Table 61).

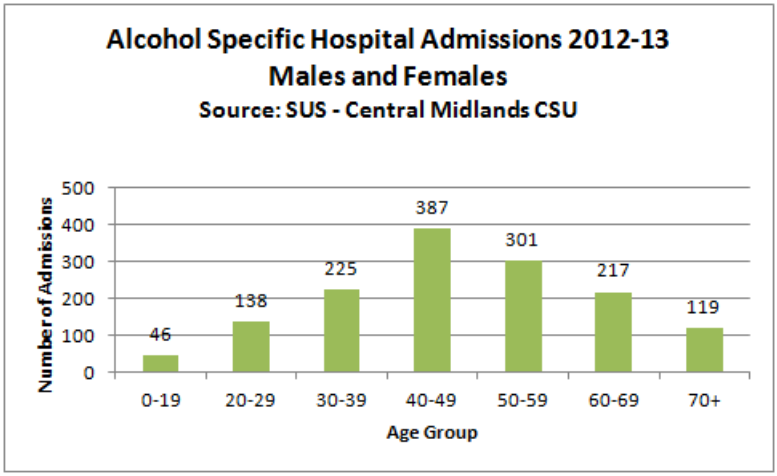
Alcohol-specific outcomes include those conditions where alcohol is causally implicated in all cases of the condition; for example, alcohol-induced behavioural disorders and alcohol-related liver cirrhosis. The alcohol-attributable fraction is 1.0 because all cases (100%) are caused by alcohol.

Table 61



Walsall is not hugely at variance on this measure with either the regional or national figures.

Table 62



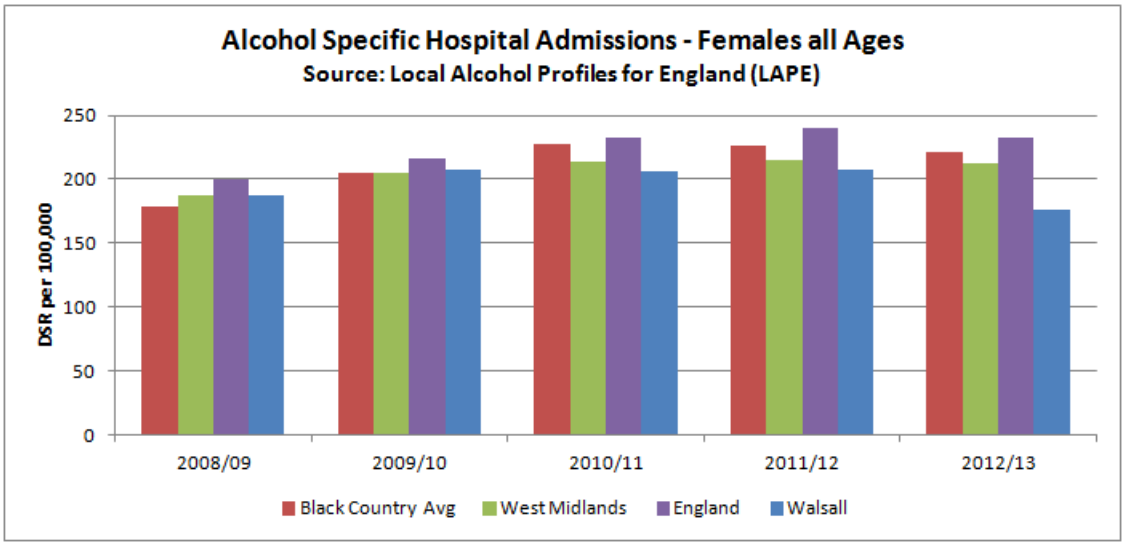
The highest age group for admissions is for those between 40 and 49 years who account for 387 or 27% of alcohol specific admissions. If the range is extended to cover the age group 30 to 60 the number equates to 913 or 64% (Table 62). This is in keeping with the wider treatment figures and results from the effects of sustained alcohol abuse often,

though not always, taking some years to manifest in the form of alcohol related illness and harm.

Hospital Admissions with alcohol specific conditions – Females

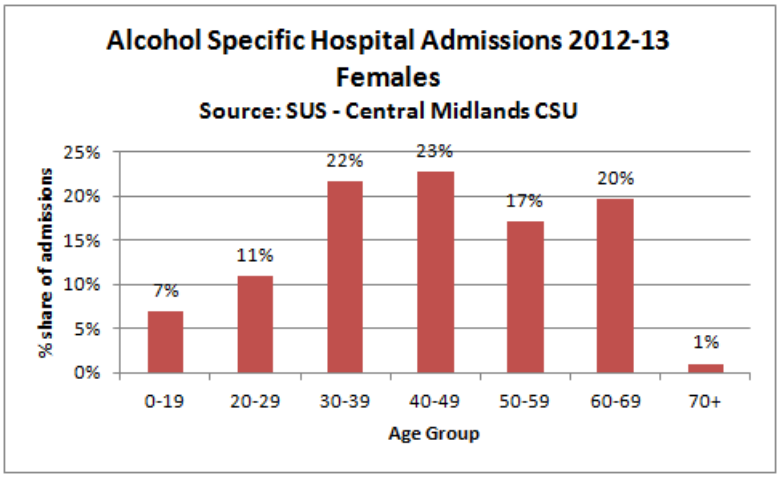
Walsall's alcohol specific hospital admissions for females reduced by 6% between 2008/09 and 2012/13, while all other areas in the graph increased (Table 63). The regional rate increased by 13% while the national increased by 16%.

Table 63



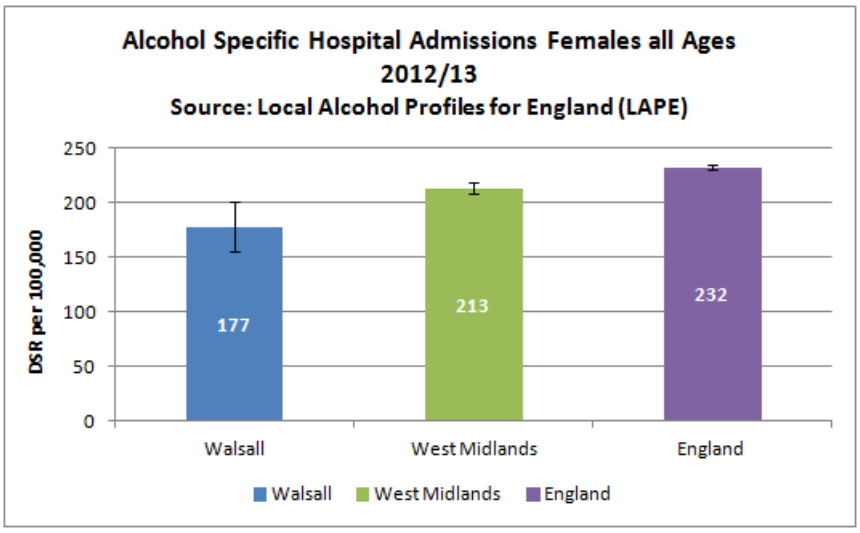
The charts below (Table 64), shows female admissions for 2012/13 by age group. 45% of alcohol specific female admissions involved women in the age range 30 – 50, which is in keeping with the wider picture. The number in the 60-70 age group makes up 20% of the total, which is higher than the male admissions in this age group (13%, see table 78).

Table 64



The chart below shows that Walsall has significantly fewer alcohol specific female admissions than the West Midlands and England.

Table 65

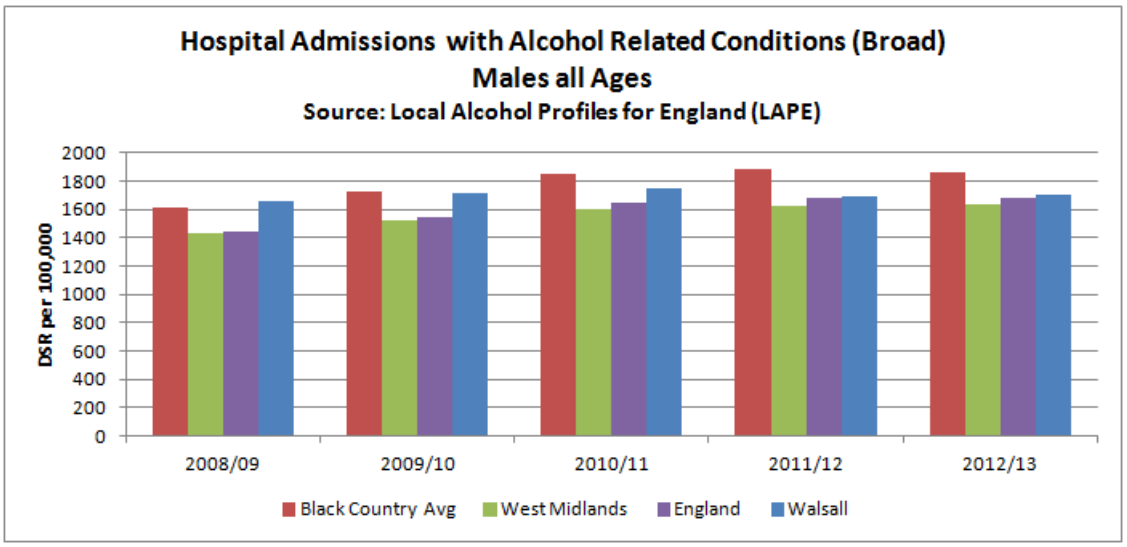


Hospital Admissions with alcohol related conditions (broad) – Males

The broad measure is alcohol as a primary diagnosis or any secondary diagnosis.

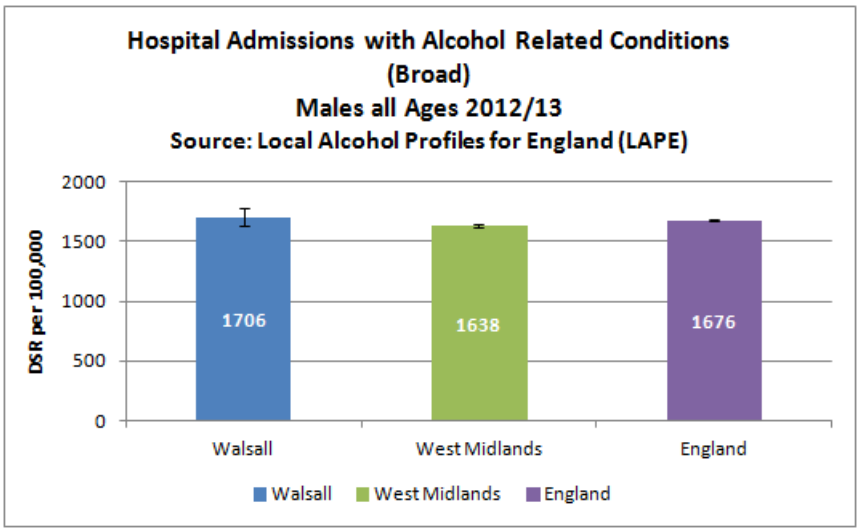
Alcohol- attributable (broad measure) hospital admissions for males[11] had been rising in England, from 836.4 per 100,000 in 2002/3 to 1216.7 per 100,000 in 2007/08. The rate of alcohol-attributable hospital admissions for males was rising year on year in Walsall at a greater rate than the national rate of increase during that period, and was significantly higher during that period than the national average. The position has improved since then as the chart below shows.

Table 66



The charts, above (Table 66) and below (Table 67), show that Walsall's rate of increase for broad admissions has slowed, at a time when the regional and national rates have escalated. The level of admissions for the Black Country overall, which was lower than Walsall in 2008/09 is now significantly higher.

Table 67

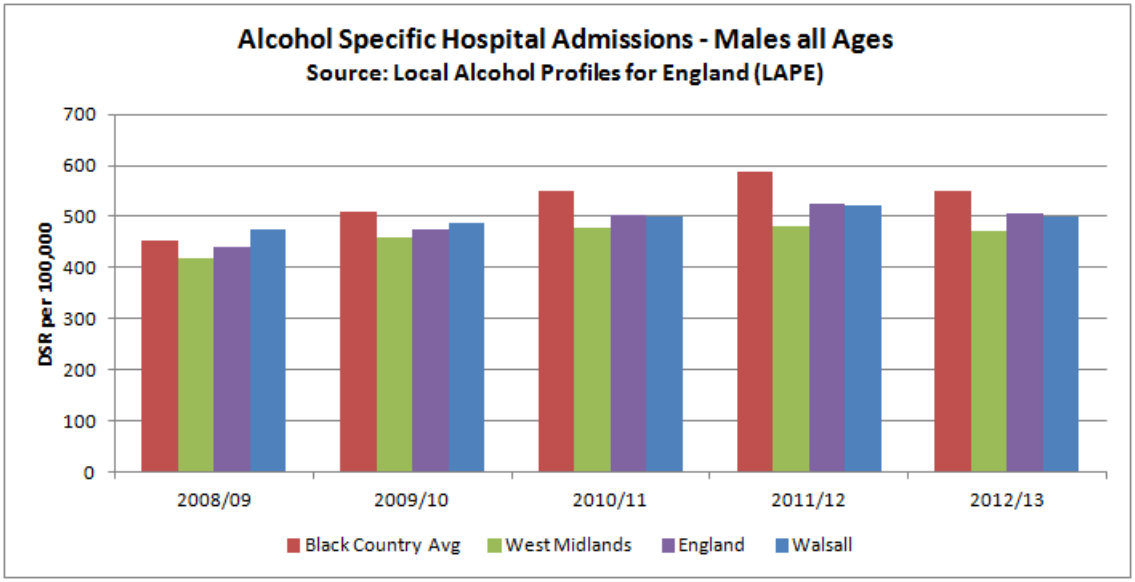


11 Does not include attendance at accident and emergency departments

Hospital Admissions with alcohol specific conditions – Males

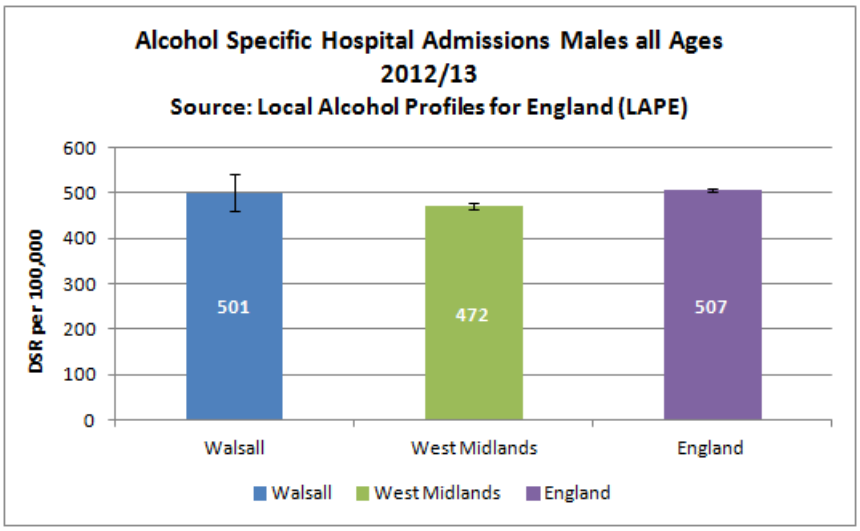
Male admissions with alcohol specific conditions have increased across all reported geographies since 2008/9 (Table 67). Walsall had the lowest increase over the period to 2012/13 at 6%, while the West Midlands have increased by 12% and England by 15%.

Table 68



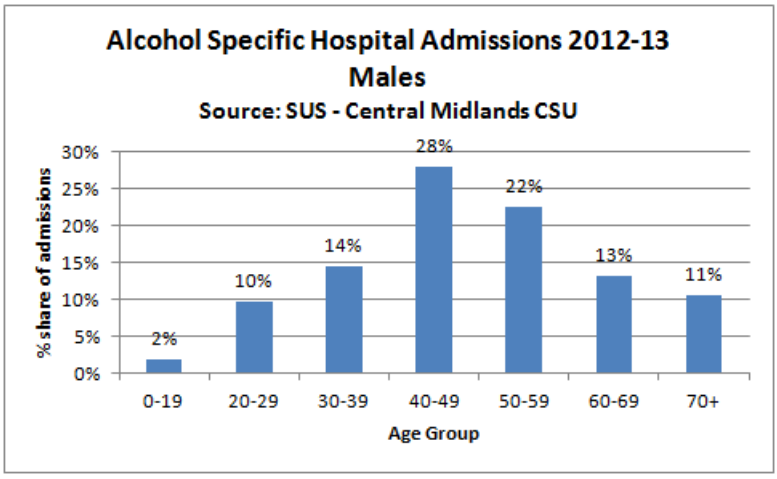
The chart above (Table 68) offers some encouragement, in as much that Walsall has reduced its comparative level of admissions in a period where they are rising in other areas. It is difficult to say exactly why this is so as there are multi-causal factors at play here. However, it seems highly likely that the introduction of an alcohol liaison service based in the acute hospital and working in conjunction with community based treatment services and primary care, has been a factor. The service employs two workers and in 2013/14 the nurse worked with 344 referrals, while the alcohol support worker offered psycho-social support to 425 clients.

Table 69



The overlap in the confidence intervals in the chart above shows there is no significant difference between Walsall, West Midlands and England.

Table 70

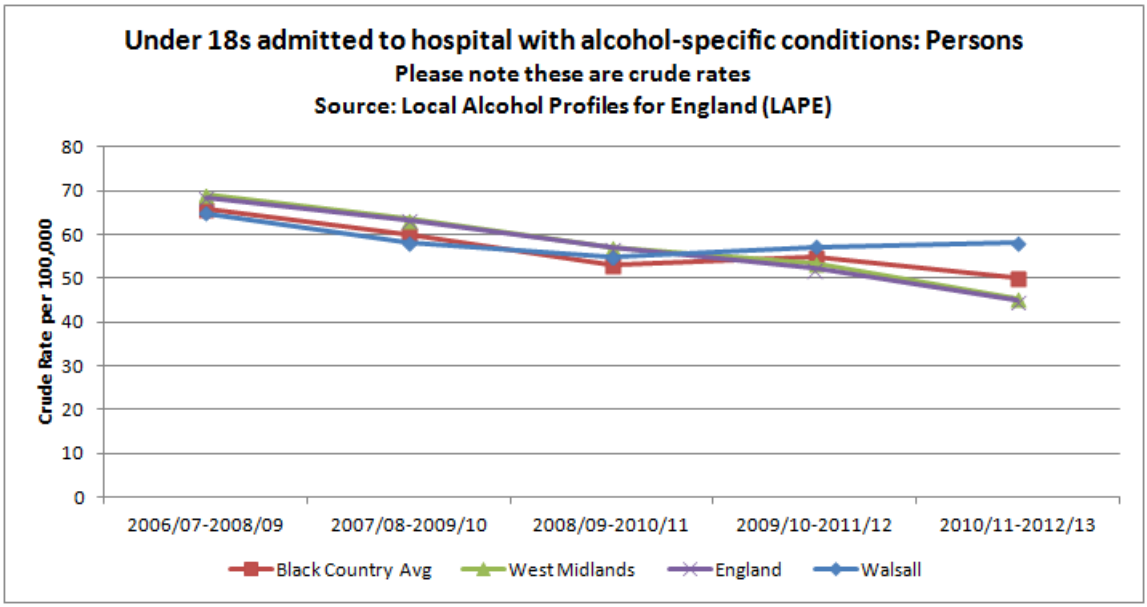


The 40-49 age- group, has the highest level of alcohol specific admissions for males (291 or 28%), while the 14% in the 30-39 group is significantly lower than the 22% for females of the same age group. The 'peak' years for male alcohol specific admissions are the two decades between 40 and 60. This fits with a fairly common feature of alcohol structured treatment, where hazardous drinking levels have evolved into harmful and/or dependent levels of alcohol use over a period of twenty, thirty or forty years. There would be substantial benefits to the individual, to the wider health economy and to society as a whole, if this pattern could be identified at an earlier stage and effective remedial action took place.

Under 18s Admissions Data

As the total number of admissions in any one year is quite low for general statistical comparison, two years data have been aggregated for reporting purposes by the LAPE. Although the West Midlands and England rates have fallen since 2008 (by 20% and 21% respectively), Walsall has increased from 48% to 54%, but is now levelling out. Walsall is generally following the Black Country trend, but the gap between the two has increased slightly in recent years.

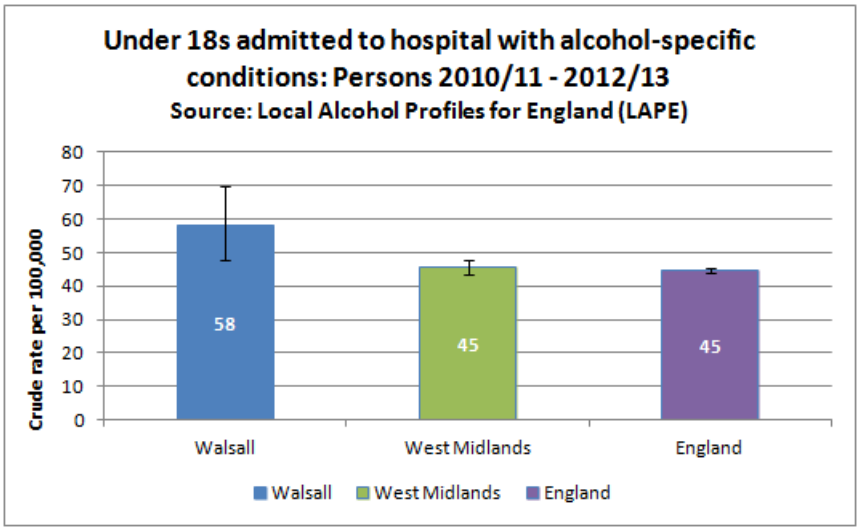
Table 71



The following chart (Table 72) shows Walsall and its comparators for the period 2010/11-2012/13.

Walsall's rate of 58 per 100,000 is higher than the 45 for both the West Midlands and England; however the confidence interval is very wide for Walsall as the numbers of admissions are generally low, so care must be exercised when drawing conclusions from these statistics.

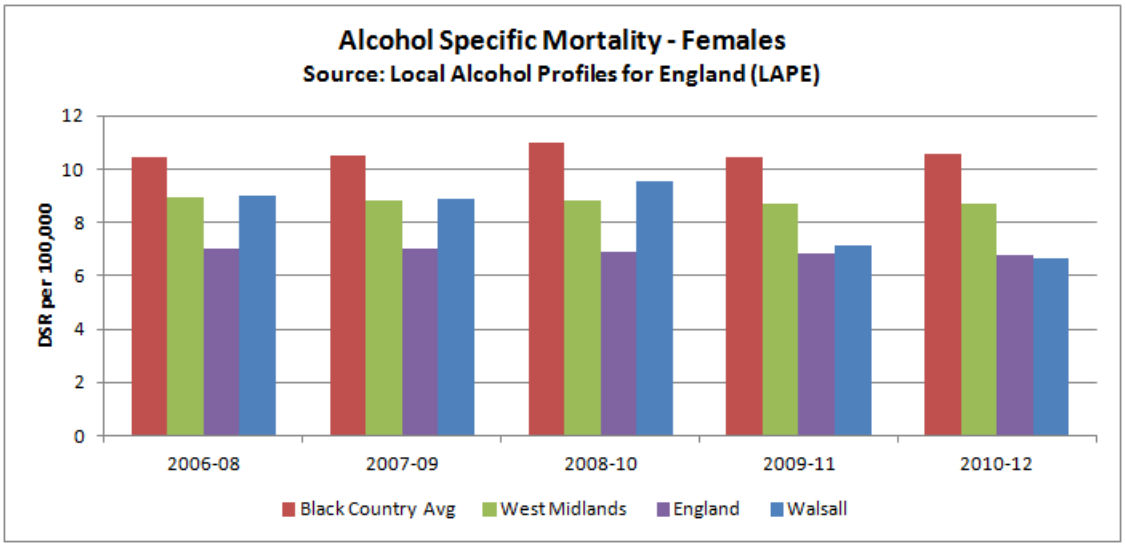
Table 72



Alcohol specific mortality for females

The national rate of alcohol specific female mortality has fallen considerably in recent years, from 9.53 (per 100,000) in 2008-10 to 6.66 (per 100,000) in 2010-12. Walsall's female mortality is on par with the national rate (both are 7 per 100,000) and lower than the regional rate of 9 per 100,000.Female mortality rates continue to be considerably lower than males across all areas.

Table 73

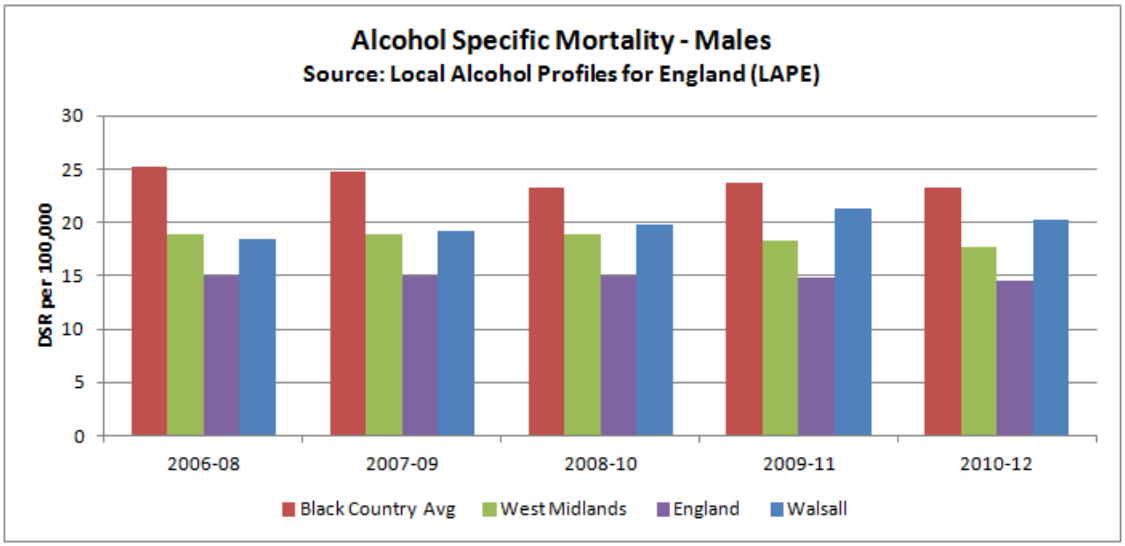


Walsall has shown a dramatic reduction of 26%, between 2006-08 and 2010-12, while the Black Country on average increased by 1%. During the same period, both the West Midlands and England rates reduced by 3%. Walsall now has a lower rate than the national level; with Walsall having a rate of 6.66 and England being 6.78 (see Table 73). Caution should however be exercised when interpreting trends with low annual incidence levels

Alcohol specific mortality for males

Alcohol-attributable mortality[12] for males had been on a slight downward curve in England, from 41.1 per 100,000 in 2003 to 35.86 per 100,000 in 2009. This reduction has also occurred regionally, from 47 per 100,000 in 2003 to 40.72 per 100,000 in 2009. The rates of alcohol-attributable mortality for males have risen in Walsall in previous years, whilst regional and national rates reduced.

Table 74



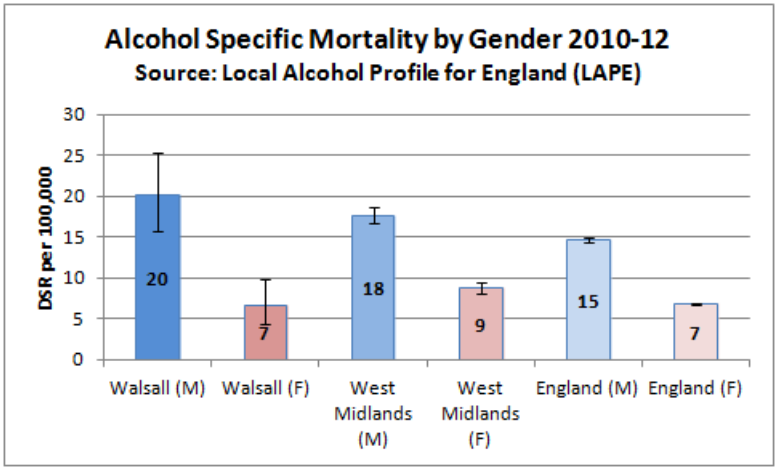
Walsall's male alcohol specific mortality has increased by 10% between 2006-08 and 2010-12 (see above), however the numbers involved are quite low, so again, care must be exercised during interpretation. The Black Country rate has fallen by 8% in the same period, while the West Midlands has fallen 6% and England has reduced by 3%. (Table 74).

12 To define alcohol attributable conditions The Strategy Unit report (Cabinet Office/Strategy Unit, 2003) presented alcohol attributable factions for 53 conditions, of which 11 were fully attributed to alcohol use and 42 where alcohol was believed to be a contributory factor

Alcohol specific mortality by gender for comparison

Alcohol specific mortality for males across all geographies reported is considerably higher than females. As in previous charts, the confidence intervals for Walsall are fairly wide, and therefore care must be taken with interpretation.

Table 75



Alcohol Related Recorded Crime

Total recorded crime, of all types, has been falling for the past 10 years in Walsall (see Safer Walsall Partnership strategic Assessment, 2014). Walsall's rate of alcohol recorded crime has been going down since 2008/09, falling by 29% (Table 76). In the same period the figure for the West Midlands fell by 25%, while that for England dropped by 21%.

Table 76

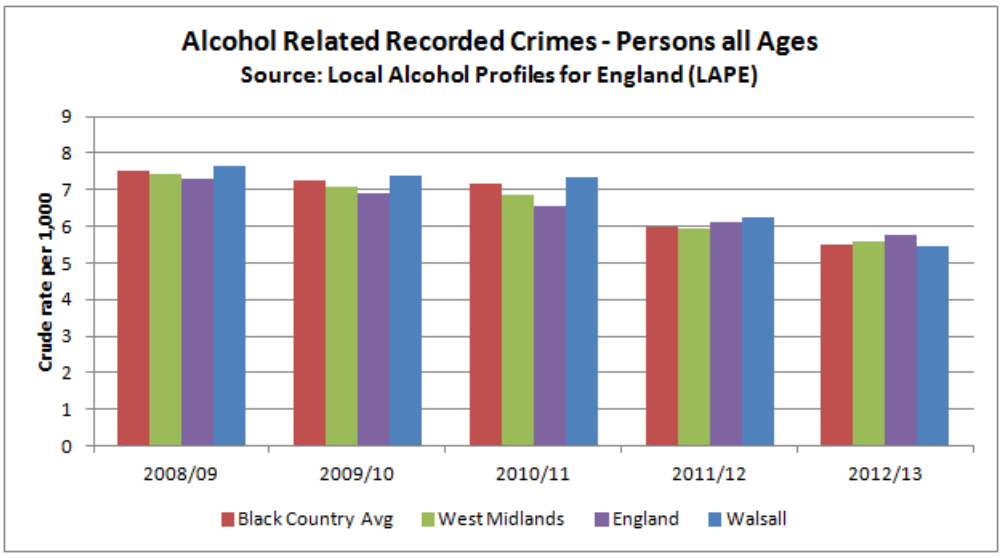
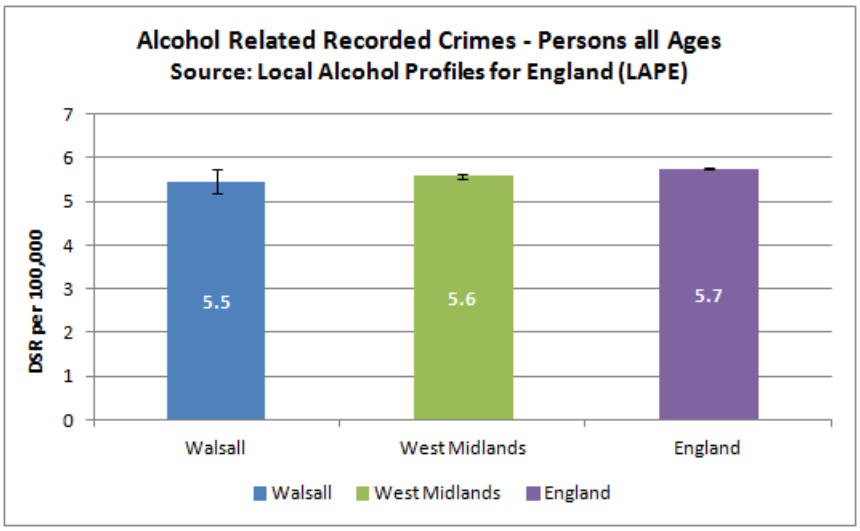


Table 77



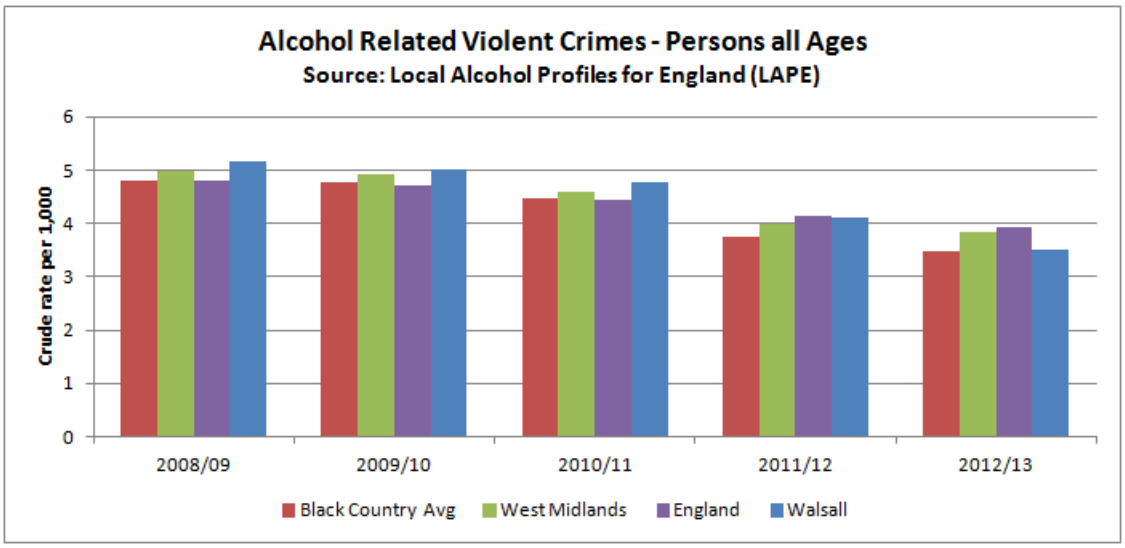
The police data shows however, an increase in 2012/13 for recorded crime involving violence with injury. The Strategic Assessment reports that town centre violence has increased with 50% of offences taking place around/during the night time economy. The Strategic Summary highlights the fact that it is likely that many of these offences are alcohol related (despite recording problems at arrest) although use of cocaine powder is a smaller but increasing issue[13]. It is interesting to note that of those referred to Walsall Alcohol Arrest Referral scheme, 22% gave an address with a WS3 postcode, and a further to this a further 24% gave an address with a WS1/WS2 postcode. This would suggest that the majority of town centre offenders are Walsall residents. The table 77 illustrates that in a period of albeit falling crime generally (see National Crime Survey, 2014), Walsall compares well in comparison to the regional and national positions.

13 Safer Walsall Partnership Strategic Assessment 2013/14

Alcohol Related Violent Recorded Crime

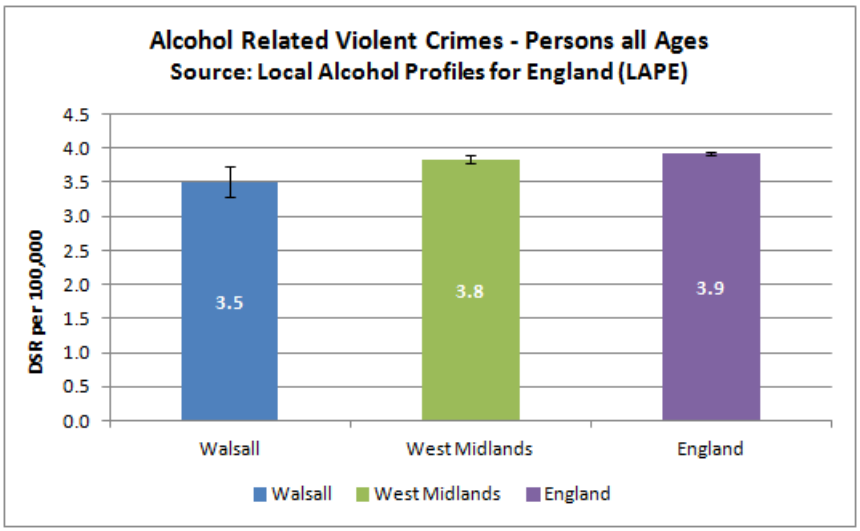
Walsall has shown the highest drop in alcohol related violent crime since 2008/09 (32%) compared with 23% drop for the region and 18% nationally.

Table 78



The chart below shows that Walsall's rate is now significantly lower than the West Midlands and England.

Table 79

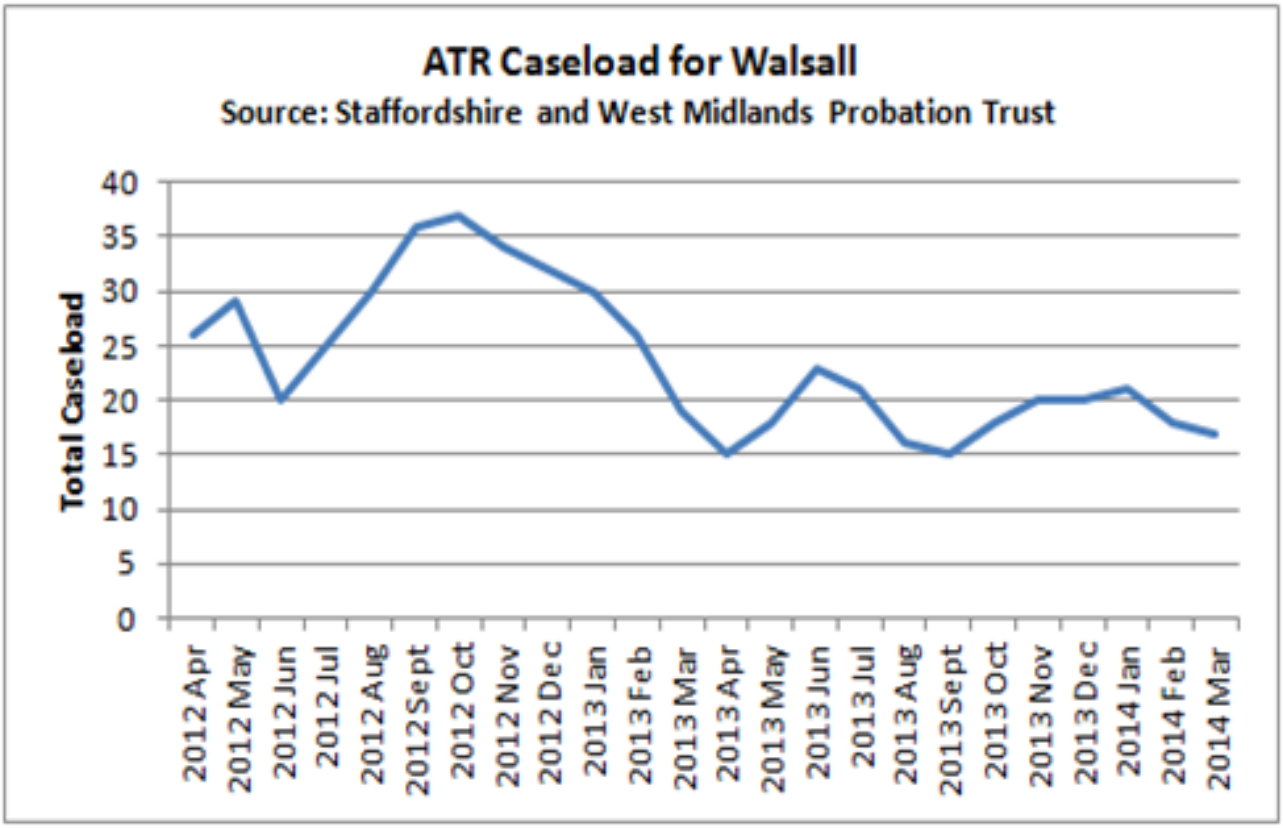


In May 2008 the National Offender Management Service (NOMS) commissioned Walsall to implement an Alcohol Treatment Requirement (ATR) pilot scheme, a court mandated condition of treatment as part of a community sentence supported by the probation service. The aim was to provide an opportunity for alcohol related offenders to access structured treatment to address their alcohol-related offending in order to reduce their use and subsequently their future risk of re-offending. The intervention has been successfully imbedded in Walsall with ATR workers (employed by the Tier 2 treatment provider) working

with the National Probation Service to provide these structured interventions to offenders over a six-month period.

The ATR was intended to be used with offenders who were alcohol dependent and it proved difficult to meet this criterion in all cases in the initial years of the scheme. The criteria are now strictly applied resulting in a drop in the number of orders as a result (see chart below). The often chaotic lifestyle of dependent drinkers has also impacted on the number of successfully completed ATRs, along with the ongoing changes to the Probation Service structures has also been a factor in this (Table 80).

Table 80



In the financial year 2013/14 there were 40 clients who started on an ATR and 23 who successfully completed

Table 81

Alcohol Treatment Requirements	*2013-14 Q1-Q2*	*2013-14 Q3-Q4*	*Total*
Actual commencements	24	16	40
Successful completions	15	8	23

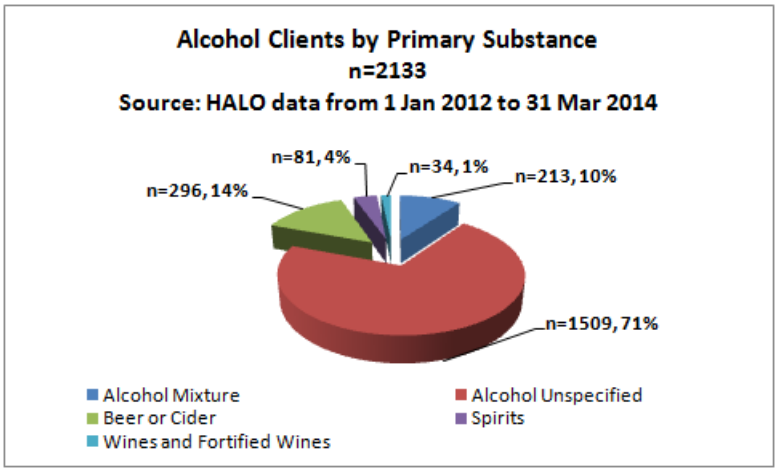
There is also a scheme in place to deal with lower level alcohol related offending. The Walsall Alcohol Arrest Referral Scheme (WAARs) was developed in January 2007 and was one of the first schemes of its kind. Workers based at the police custody suites and in the magistrate court see those who have been arrested for alcohol related offences, and offer harm reduction advice and support, including referral on for alcohol treatment.

The WAARs scheme is now getting an average of 27 referrals per month and all of those are offered a referral into alcohol treatment services at a level that is appropriate to their use.

What else do we know about alcohol clients in treatment?

The number of clients in treatment who do not specify a particular type of alcohol is high at 1509 or 71%, while those who specified wine (1%) or spirits (4%) is low. There is evidence of a data quality issue here, which may be explained by the fact that the focus in alcohol treatment is on the units consumed, rather than the alcohol type.

Table 82



Cannabis, followed by cocaine, is the most common secondary substance of choice for clients in alcohol treatment (Table 83)

Table 83

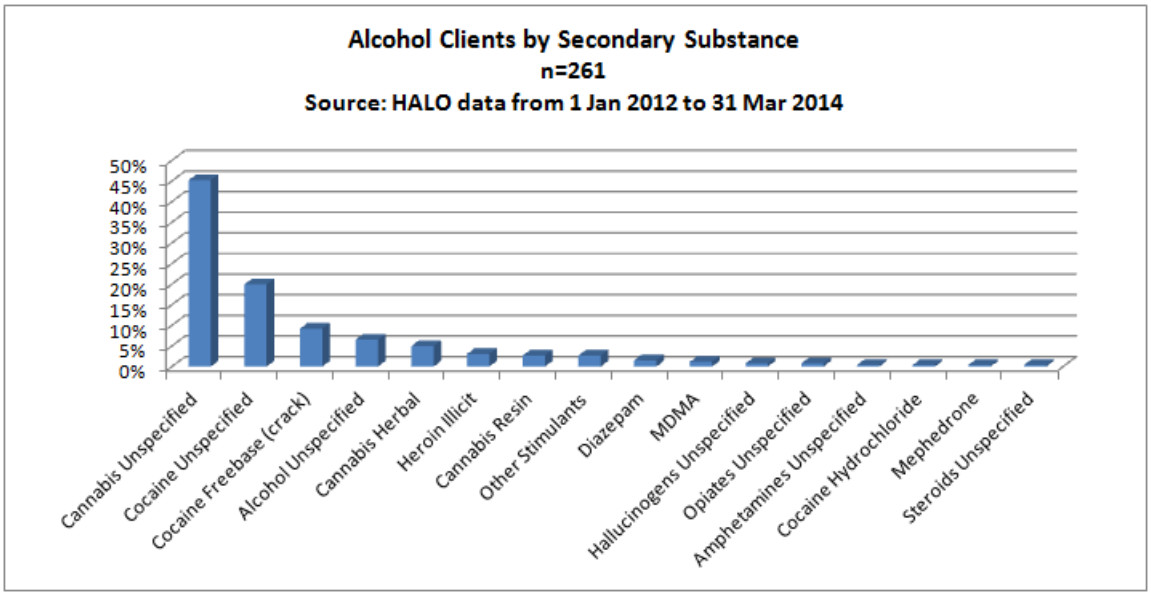
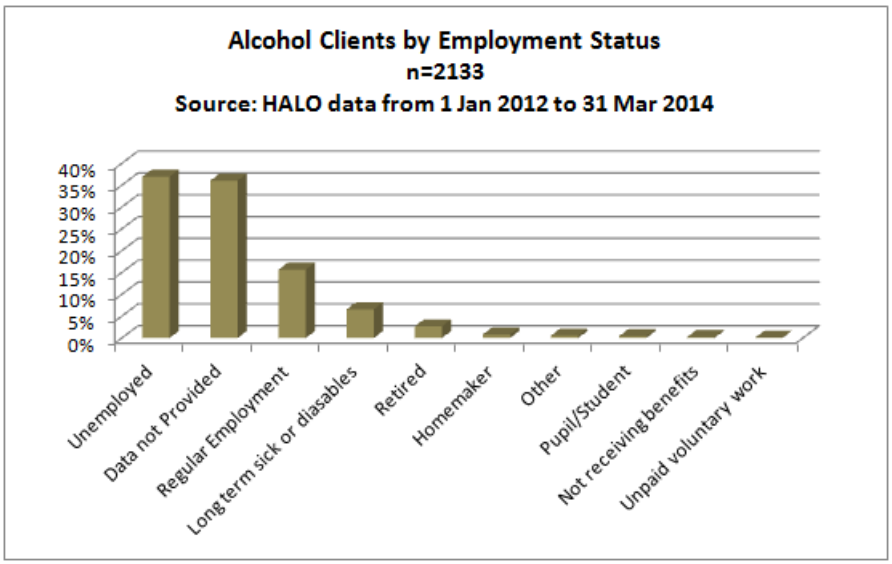
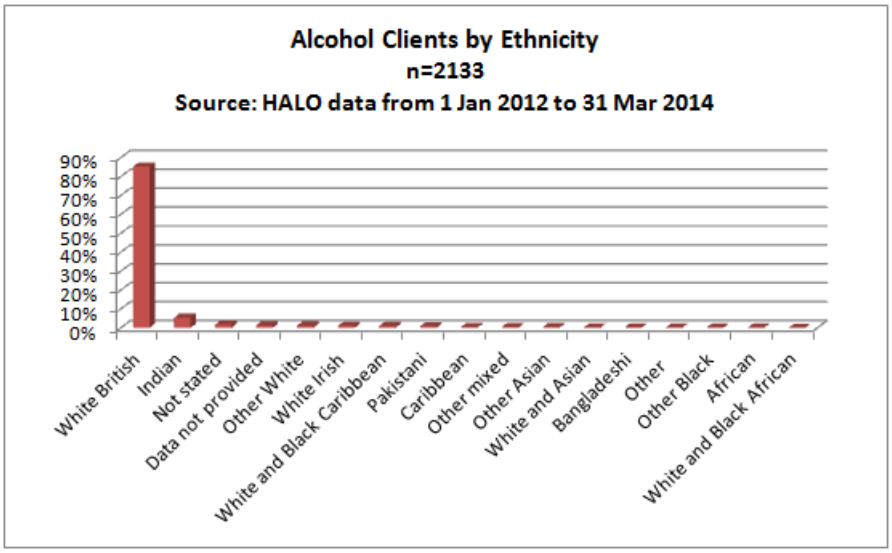


Table 84



Just over 1/3 of the alcohol clients in treatment (37%) are recorded as unemployed, with 16% listed as being in regular employment. There is however a further 36% where the data is not provided and this gap in the data will need to be addressed.

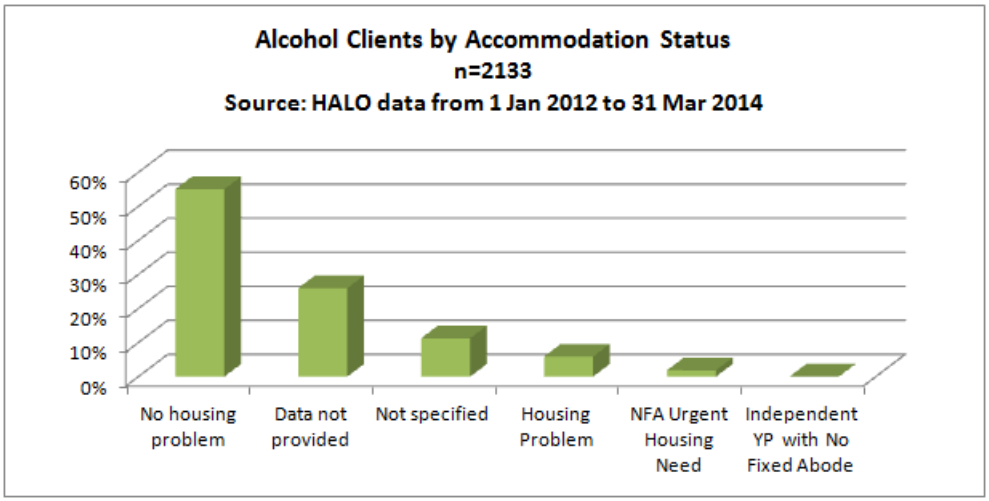
Table 85



85% of alcohol clients in treatment are White British with those who defined themselves as Indian making up 5% of the total. These figures, when compared with the Census data, might suggest an under representation of people from Black and Minority Ethnic (BME) communities in alcohol treatment services and there is some anecdotal evidence, partly supported by hospital data, that suggest there is an emerging problem amongst Indian/ Asian males. Likewise, the high figure for those who abstain from alcohol in Walsall is

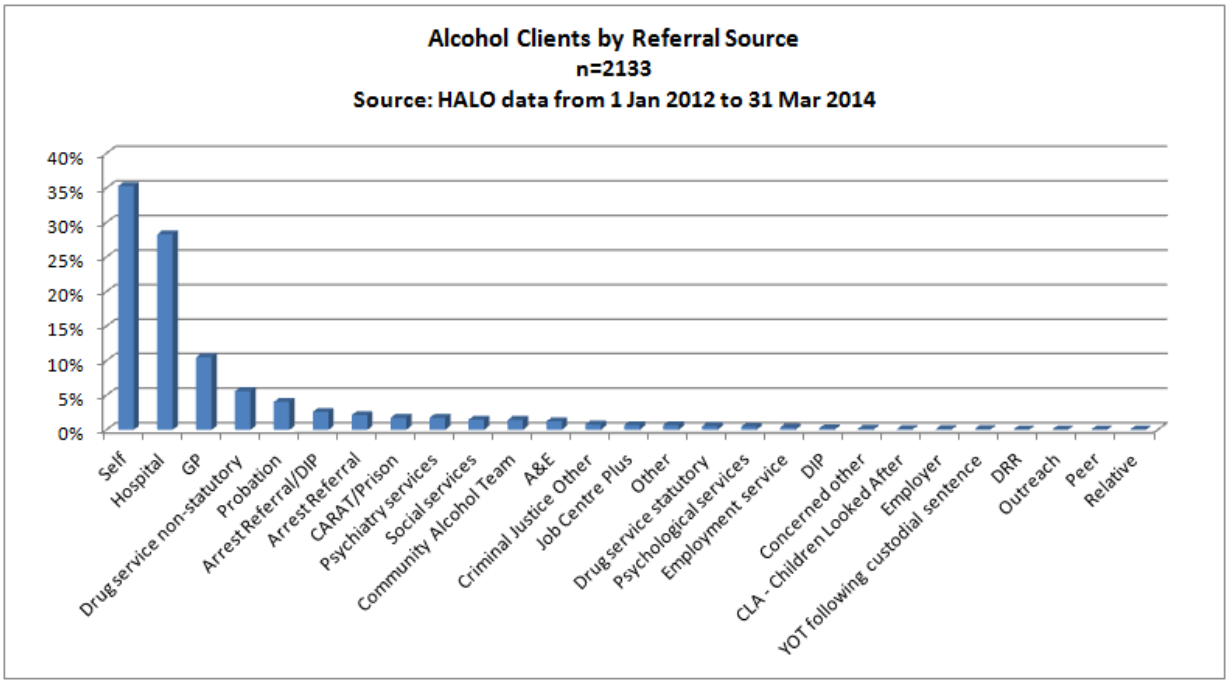
likely, in some part, to be a result of the relatively high percentage of the BME population recorded in the 2011 Census data.

Table 86



Just over half (55%) of clients reported no problem with housing, with 6% who identified an issue. There is again a gap in the data with a further 37% of clients where the information was not specified or recorded.

Table 87



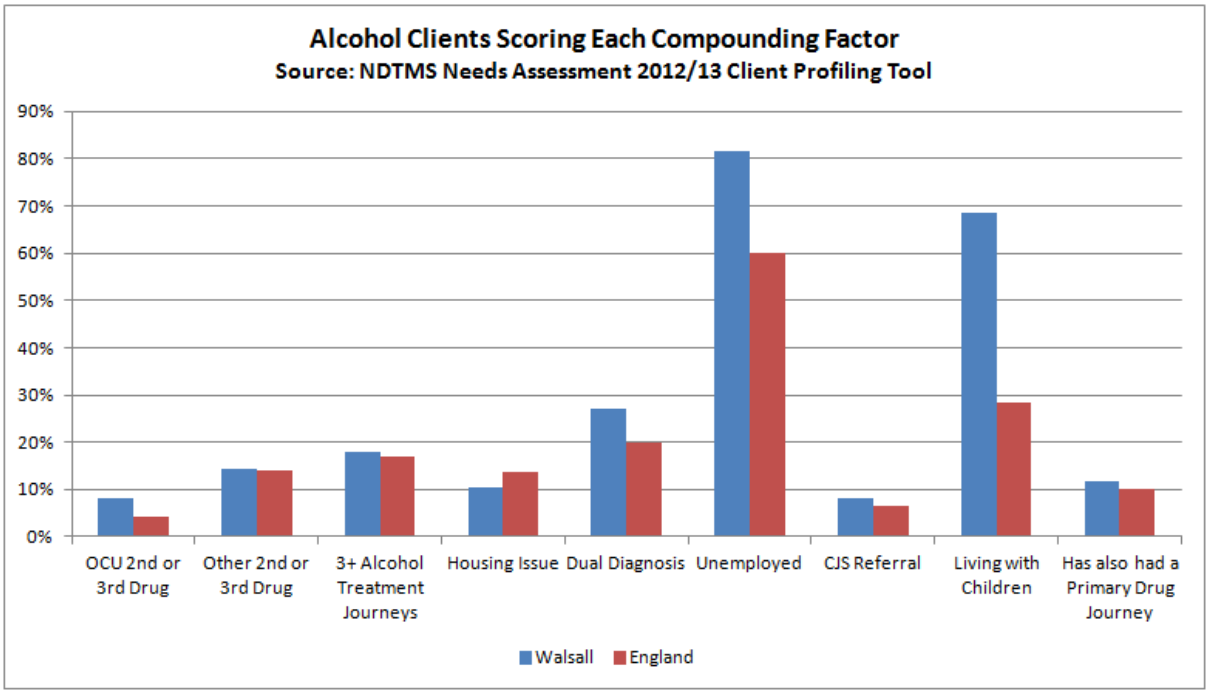
The largest number of referrals into alcohol treatment continues to come via self-referrals and from the hospital alcohol liaison service.

Compounding issues in the treatment population

Many adults in alcohol treatment experience complex and wide-ranging problems. The chart below shows an overview of these. This is intended to give an impression of the additional characteristics of these people treated locally and identify issues which may warrant further investigation (text from PHE: Walsall JSNA Support Pack 2013/14).

Clients may have more than one compounding factor, so combined % will be more than 100%.

Table 88



The level of dual diagnosis in Walsall at 27% is statistically significantly higher than the national average. Walsall also has higher numbers who are unemployed and/or living with children in their household.

The table below contains the data used to create Table 88:

Number of Clients Scoring Each Compounding Factor	Walsall	England
OCU 2nd or 3rd Drug	8%	4%
Other 2nd or 3rd Drug	14%	14%
3+ Alcohol Treatment Journeys	18%	17%
Housing Issue	10%	14%
Dual Diagnosis	27%	20%
Unemployed	82%	60%
CJS Referral	8%	6%
Living with Children	69%	28%
Has also had a Primary Drug Journey	12%	10%

In these charts, the abbreviations are:
CSU: Commissioning Support Unit
SUS: Secondary Users Services (Hospital NHS Data)

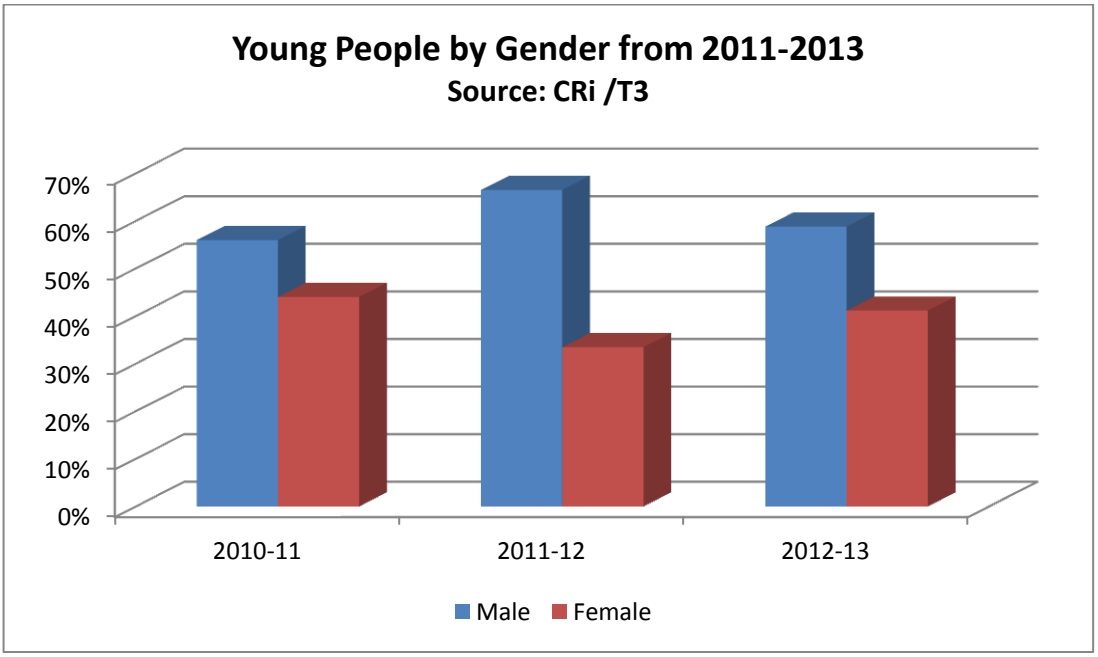
Young People's Chapter

Young People 10-19yrs

The data for the young people's element of the need assessment has been sourced from HALO and supplemented by the Public Health commissioned specialist young people's substance misuse treatment service for Walsall. The data range used is three full years from 2011-2013. For the purposes of comparison the data will look specifically at the latest full twelve month period.

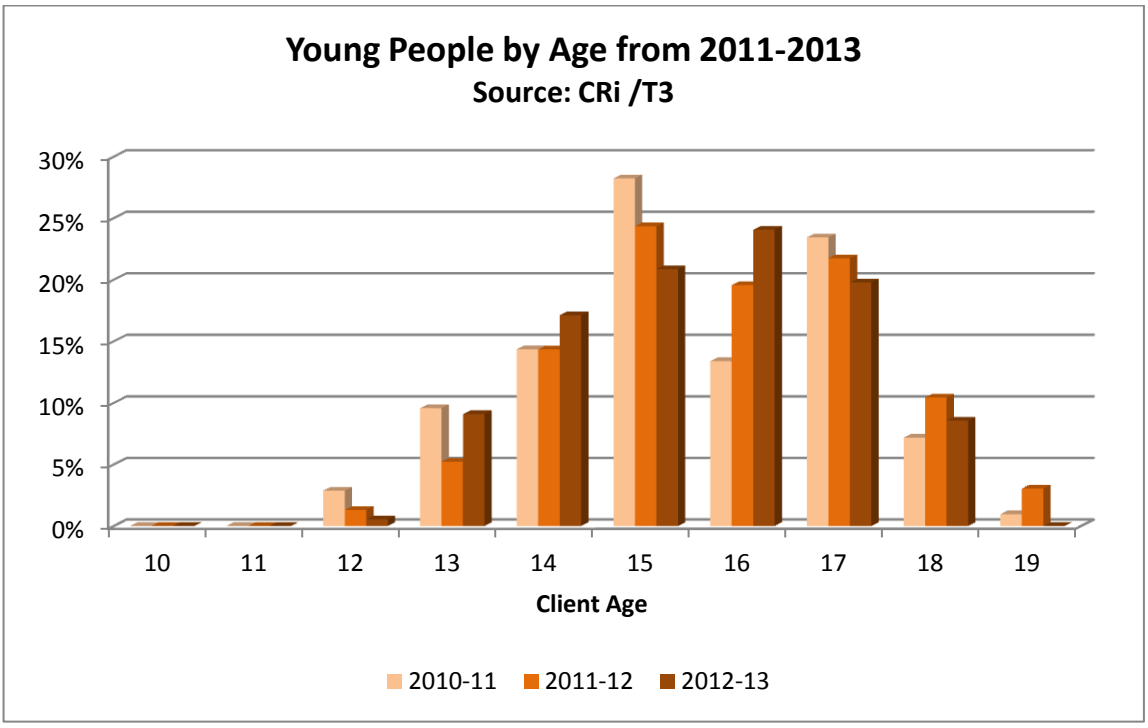
1220 referrals were made to 2011-2013. 51% (n=626) received structured treatment interventions, a further 30% (n=360) received brief interventions and 19% (n=234) were inappropriately referred, which is similar to the latest twelve month period.

Table 89 Gender



During the three year period 61% (n=380) of those in structured treatment have been males. In the latest twelve month period the balance has shifted downwards slightly to 59%.

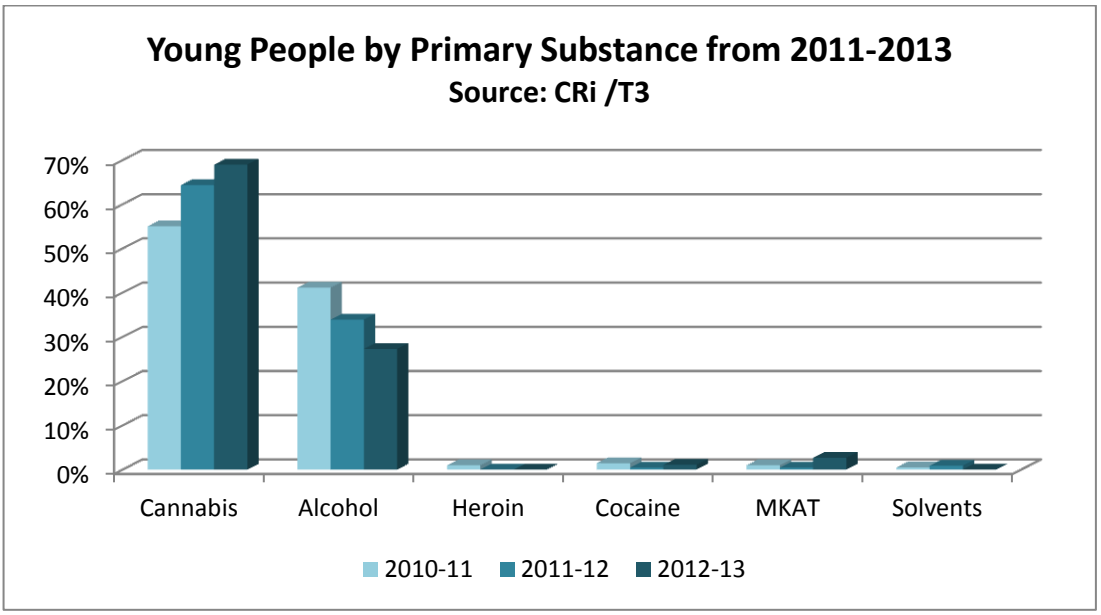
Table 90 Age



During the three year period 25% (n=154) of those in structured treatment were aged 15 years old. However In the latest twelve month period this has reduced to 21% whereas there has been an increase in those aged 13yrs (9%), 14yrs (17%), 16yrs (24%) and 18yrs (9%)

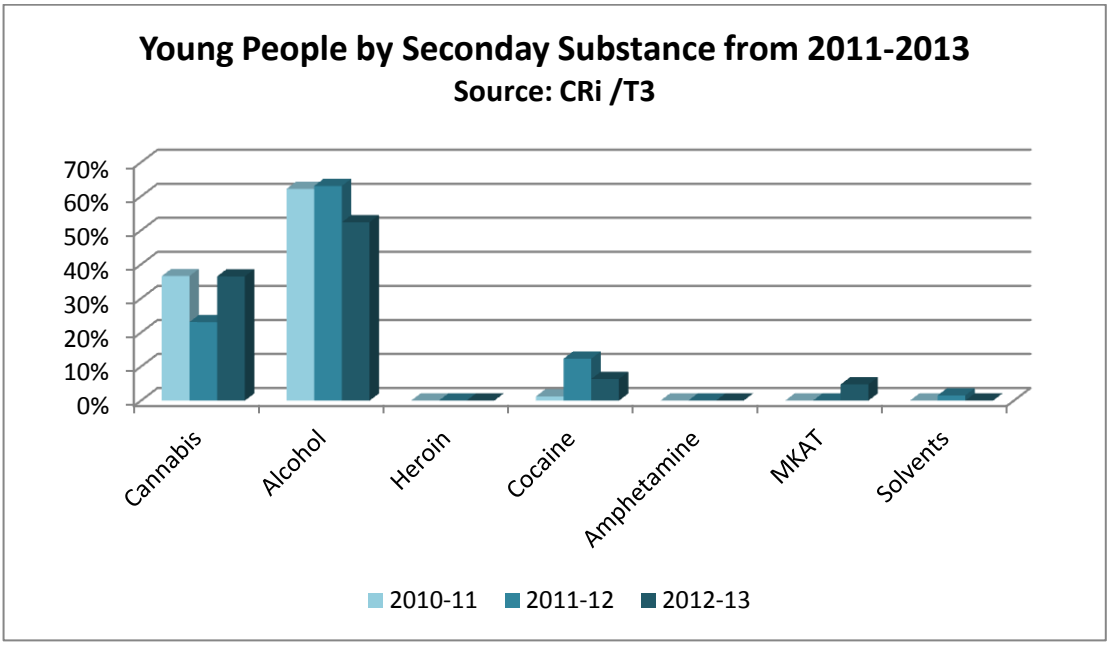
Substances

Table 91 Primary Substance Use



63% (n=392) of young people in the three year period presented with cannabis as the primary substance of use and this has continued to increase year on year to 69% in the latest twelve month period. 34% (n=215) disclosed alcohol use as primary substance, but this has reduced year on year to 27% in the latest twelve month period. Mephadrone accounted for 1% (n=8) of all substances used although in the latest one year period this increased 3%.

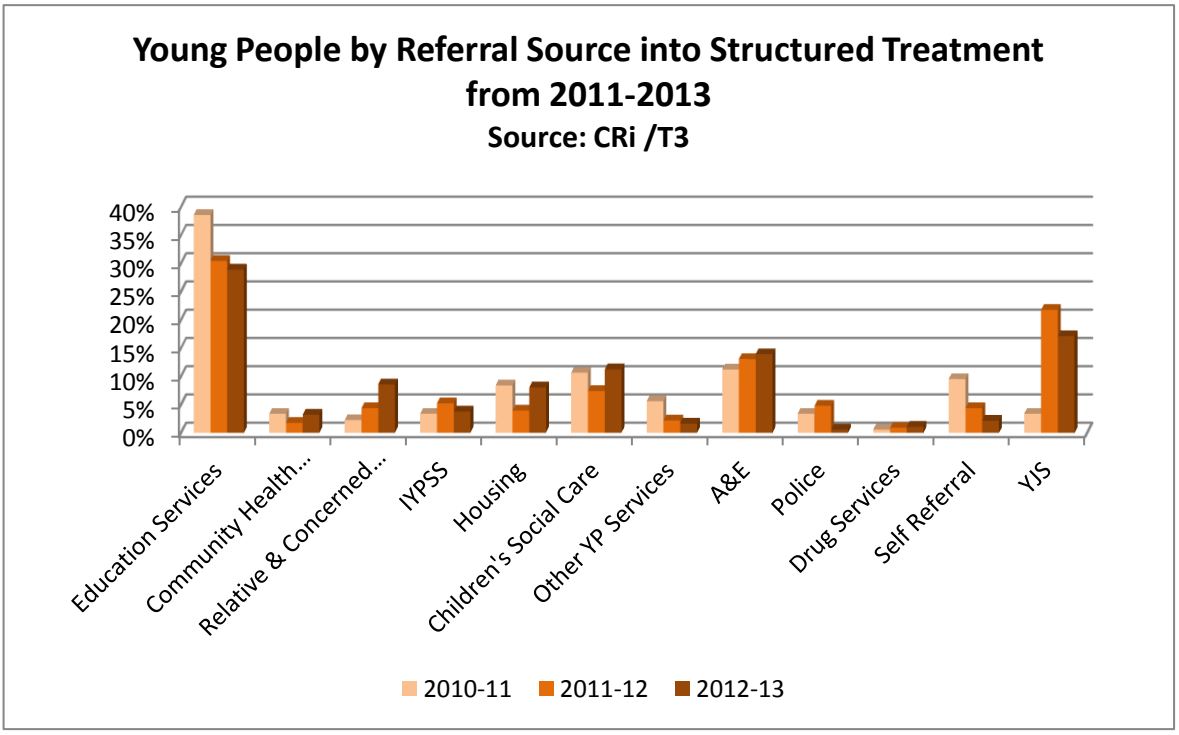
Table 92 Secondary Substance Use



In the three year period 210 young people disclosed the use of more than one substance. 60% (n=125) disclosed alcohol as their second substance and 32% (n=68) disclosed cannabis. However in the latest twelve month period secondary alcohol use has reduced to

52% whilst cannabis use has increased to 37%. There has been a slight increase in the use of cocaine and mephadrone.

Table 93 Referrals into structured Treatment

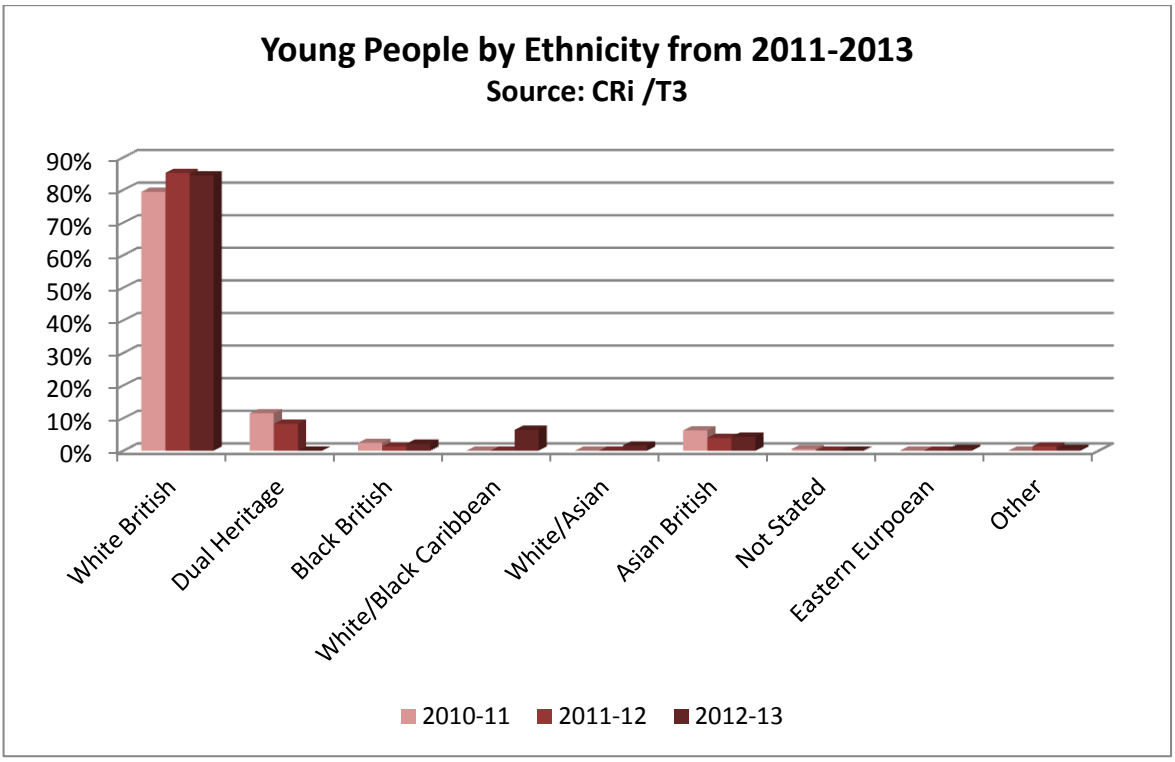


Although Education Services (schools, pupil referral units, further education, education welfare, etc) is the largest referral source (32% n=193) for those clients entering structured treatment services in the three year period there has been a steady reduction in the three year period. The second largest referral source is Walsall Youth Justice Service (WYJS) (15% n=88) which reflects the use of a dedicated resource, a substance misuse worker based, in the WYJS team.

Brief Intervention Referrals

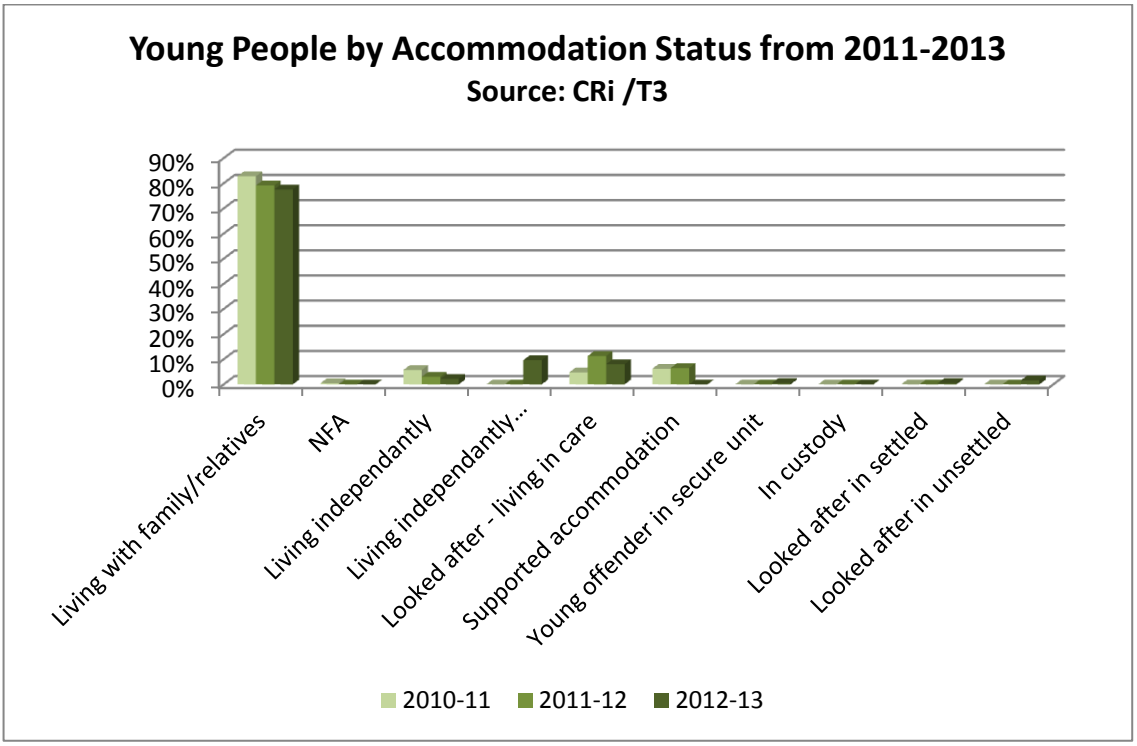
The young people's treatment services also operates as a preventative service delivering low level brief interventions to young people who would benefit from talking to a substance misuse use worker but don't require care planned interventions. The largest referral source in the three year period is again education services (31%n=108). The accident & Emergency Department at Walsall Hospital has been the second largest referrer for brief interventions (21% n=75).

Table 94 Ethnicity



White British young people form the largest group of clients in structured treatment. There appears to be an increase in White/Black Caribbean the latest twelve month period however this is likely to improvements in the quality of data capture when the young people's service went live on the HALO case management system.

Table 95 Accommodation status



In the three year period eight out of ten clients (80% n=500) referred into structured treatment lived with a family member or relative. Those living in some form of local authority care represented 9% (n=55) of the overall cohort.

Appendices

Appendix One

Substance Misuse Consultation - Service User & Stakeholder Reports

Walsall Council Public Health commissioners are undertaking an exercise to re-procure its drug & alcohol services. Commissioners have proposed changes to the local treatment system, based on knowledge of the changes in local service user's needs and reflecting national policy changes. The consultation involved a two stage process; firstly presenting to stakeholders, partner agencies and provider agencies for their feedback on the changes and secondly asking provider agency staff to facilitate service users' feedback on the proposed changes.

The changes are intended to improve positive outcomes for drug and alcohol service users. However, any change has the potential to create unintended consequences for partner agencies and concerns for services users. Therefore hearing the views of a range of stakeholders, provider agencies and service users has been critical in informing the eventual service model and service specification.

Drug and alcohol treatment providers, on behalf of public health commissioners, facilitated a service user consultation using a questionnaire consisting of five key questions relating to the proposed changes and an additional question where respondents were given the opportunity to tell commissioners any additional feedback not covered in the five questions. The detailed results of the service user consultation can be found attached.

Summary of the main findings:

- The majority of service users who responded stated that what they mostly valued from the service was the information, support and advice they received in both our adult and young people's services
- One in three adult service users said that their medication or prescription was the most valued element of the service they received
- Most service users responded that they were happy with the range of services on offer
- Of those who made suggestions about additional services the most popular was telephone support
- The majority of service users responded positively about the plans for developing services aimed at those young adults aged 25 years and under
- Nearly half of the service users who responded thought the proposal to integrate drug and alcohol treatment services would be advantageous, with only a small number disagreeing
- Most services users responded by telling us that they would be happy to contribute to continued planning of substance misuse treatment services by being involved in future decision making processes
- When invited to offer additional comments there were very few responses. Those that did responded told us that they wanted further support with employment skills.

DRUG AND ALCOHOL CONSULTATION EVENT 13TH FEBRUARY 2014

INTRODUCTION

An event was held on 13th February to commence the first stage of consultation in the tendering of Walsall's Drug and Alcohol services. Over 40 representatives were invited from the local drug and alcohol partner and stakeholder agencies; representatives of the Safer Walsall Partnership statutory agencies of Police, Local Authority and Probation Services; local provider agency managers and clinicians representing NHS and voluntary sector providers and clinical leaders from the drug and alcohol treatment services.

A comprehensive presentation, setting out the National Strategy, changes in the direction of government policy and the supportive evidence base, was presented to the group. The presentation concluded with the commissioner's proposed changes to the local treatment system with the objective of delivering better outcomes for service users, their families and local communities, whilst offering a efficient, effective and value for money investment from the available budget (Public Health Grant).

The four main changes were articulated as; introducing a Single Point of Contact and Assessment Service, An Integrated Treatment Service, a different balance to Clinical and Psychosocial Services and an Under 25s Service.

There followed facilitated table top sessions where all attendees had the opportunity to comment on the strengths, weaknesses and potential challenges/ barriers to the proposed changes. The feedback from each session was captured and fed back to the group for further discussion and clarifications. The feedback was then summarized in a written document and distributed to the attendees for any further comments.

The written summary of the feedback is captured below.

SINGLE POINT OF CONTACT

Strengths

- For non-specialists to refer
- Increased confidence of service user
- Reduce stigma for service users
- Continuity and joined up approach
- One-stop shop for everything
- Better communication between services

- Triaging of users
- Decreased confusion in who to contact

Weaknesses/ Challenges

- Change!
- Potential lack of choice for service user
- Depends on skill of contact point and pathway
- Only as good as information received at the time
- Cherry picking of referrals
- Bringing together of agencies with different systems
- Building new links
- Risk in service redesign
    - Need to prevent losing people in system
- Understanding of purpose of single point of contact
    - Is it meant to screen referrals?
    - Is it meant to assess referrals?
    - How are referrals then made to provider agencies?

Questions

- Who / which organization would be the single point of contact?
- Mechanism by which referrals made, e.g. email/phone call/face to face
- How would the system best be set up? Admin as front line staff, supporting duty person to refer to appropriate services.
- How would the single point of contact work with other services, e.g. hospital liaison worker?

Barriers

- Possible sophistication of system
- Mechanism of referral – phone/email
- Change management
    - Marketing
    - Logistics
    - Communications
    - Sign posting
- Complexity of phone system
- Needs to be free phone number, esp from mobile
- Should have a human answering immediately, not telephone ‘options’ system

Current unmet need

- Restrictions
    - Opening hours
    - Location
- Different systems for drugs and alcohol
- Different expectations of referrers
    - E.g. GPs/secondary care
- Difference access and referral routes
- Advertising/visibility of service currently not ideal.

How will unmet need be met?

- Single point of contact addresses some current unmet need, especially difference in access and referral routes
- Single point of access should be underpinned by appropriate:
    - Training
    - Skills
    - Marketing
- Ideally to include outreach based on clinical need

Decrease inequalities?

- Depends on skill of single point of contact staff
- Decreased risk of users being lost between services.

Integrated Treatment Service

Strengths

- Reduce duplication- dispel myths
- Holistic approach
- Strengthen detox delivery
- Highlight imbalance in resources
- Up-skill staff
- Increased worker job satisfaction
- Most logical approach-same social needs-addiction rather than drugs based
- Continuity-in line with current YP and Primary Care service approach

Weaknesses/Challenges

- Changing the culture of delivery
- Service user resistance
- Accommodation-one central venue?
- Changing age range for YP services

- Relapse prevention groups-separate or integrated groups?
- Tensions in area of finite resource availability
- Staff insecurity
- How to fund increase in detox demand/alcohol treatment upsurge?
- Up-skilling of workforce could present a challenge

Barriers

- Defining integration- how integrated is it possible to make the service
- NDTMS data-YP element
- Maintaining existing strengths while building integrated service
- Staff buy-in/strong leadership
- Limited funding
- Time available to manage transition
- Keeping an eye on current business-pilots-upcoming tender
- Potential for increase in case-loads

Medical –Psycho-Social Split

Strengths

- It was encouraging that no-one thought the proposed split was a bad idea and on balance most supported the split
- It was suggested that the alcohol services are already operating to a similar model across the Mental Health Trust and Addaction services
- The Glebe Centre services, albeit very early in their delivery, were cited as an example of co-located services
- The common caveat however was it could only be made possible with a co-located and integrated services, good care planning and excellent communication between the medical and psycho-social workers and correct attention to the associated workforce issues
- Appropriate matching of qualifications, and worker skills to patient complexity
- Matches the training and specialism of both medically trained and psycho-social trained workers to apply their knowledge and skills to the best affect
- Creates a clear distinction between the medical stabilization phase and next phase on the recovery journey
- Helps patients distinguish between the various factors that support successful recovery
- Removes the distraction of the medical prescription from the support services
- Assists sequencing in the phases of engagement, stabilization, interventions, support and exit preparation and post recovery support
- More concentration on recovery focused support

Weaknesses/ Challenges

- Too specialist in tasks
- Could lead to additional handover and an additional layer of bureaucracy?
- Problem of potential duplication of services if model is not strictly implemented
- Patients may only chose to take up the medical element leading to less successful completions and recovery
- Do we know what patients/clients want from psycho-social support services?
- How can we make psycho-social services as attractive as the medical services?
- How do we cater for the harm reduction needs of the estimated 20% patients who may chose not to take up the offer of anything other than specialist prescribing services?
- In having 3 recovery support teams(Generic, Criminal Justice and under 25s) could also lead to further handover as patients meet the various team criteria at different stage in their recovery
- Would it be appropriate to have the under 25s service co-located with the generic and criminal justice services?

Barriers

- Under which criteria will under 25 offenders be classified?
- The entry criteria will need to attend to any perceived inbuilt perverse incentives
- Accommodation
- The model would be difficult to implement unless the services are co-located
- No present accommodation lends itself to co-location
- Balance of present staff group may not match the medical –psychosocial split
- Medical staff may not find specialization an attractive prospect, which may have employment and retention implications

Questions

- Could the alcohol services configuration be applied in a pilot period to the new drug entrants?
- How will the present caseload be split and transformed into the new configuration?
- Will the new model reflect the alcohol recovery model by offering detoxification as a first treatment option?
- Will the workforce split allow for the intensive resource requirement to support community detoxification?
- Will drug users follow the alcohol cohort by requesting a detoxification as a first treatment option?

Under 25's Service

Strengths

- Bring focus on early intervention
- Enable building a clearer prevention message
- Continuity of service for clients and treatment teams
- Prevents people dropping out of the system
- Plugging the gap is positive and prevents future problems
- Reflects national developments
- Client centred
- Allows flexible service response to developmental maturity of young people/young adults
- More attractive culture for young people & young adults
- Opportunities for staff to work with a wider cohort of clients
- Bridge the 'shock' gap' for those transitioning into adult services
- Prevent exposure to more chaotic users
- One referral routes (SPOC crucial)
- Accessibility for those young adults who don't want to access services e.g.: LGBT & clubbers, etc

Weakness/Challenges

- Numbers…unknown population could lead to sudden increase in people requiring treatment – can the new model cope?
- Staff teams need to have the right skill mix
- Is the age cut-off point an arbitrary number? Should be based on the client profile instead
- Organisational culture
- Must have a clear definition of what an under 25's service means
- Communication of clear referral routes for partners and young people/young adults
- Clear packages support to enable treatment teams/services to work together
- Other agency thresholds (CAMHS)
- Safeguarding young people(under 18's) in an under 25's service
- How will an under 25's service fit with whole family interventions?
- Client segregation…which team works with an under 25 involved in the criminal justice system (including prison releases)?
- Young people/young adults drug taking changes with age, need to recognise this in service design
- Need to up skill partners/treatment teams/GP's in new drug taking behaviours
- Does it have be called an under 25's service or can it be an early intervention service?

- How has the current cohort of under 25's in treatment been profiled? Has analysis been undertaken to identify how many are involved in the criminal justice system, involved in the care system or what substances are being use?

Barriers

- More consideration on how prescribing will work in under 25's service
- If under 18's service is outreach based will this be the same for 18-25's?
- How will service dispel parental fears of their children mixing with adult drug taking cohort?
- Transition to adult services at 25 still requires careful management

Conclusion

The consultation event was well attended with wide representation from across the drug and alcohol sector. There was very active engagement from the representatives present and for the most, notwithstanding highlighting the challenges and potential barriers, the proposed changes received support. The consultation comments received have been fully incorporated into the service design and have been accurately reflected in the proposed tender service specifications. The main aspect, where the service design was altered as a result of the consultation, was to retain a discrete young people's service for the under 18s in an attempt to safeguard the younger service users from being exposed, whilst attending treatment, to more experienced adult service users.

Appendix Two

National Definitions of the Four Tiers of Treatment

Tier One

Definition
Tier 1 interventions include provision of: identification of substance misuse; information on substance misuse; simple brief interventions to reduce substance misuse related harm; and referral of those with substance misuse dependence or harm for more intensive interventions.

Interventions

- Substance misuse interventions
- Targeted screening and assessment for those using substances
- Brief interventions for those using substances
- Referral those that require more than a brief intervention

Settings

- Primary healthcare
- Social care services
- Criminal justice organisations
- Domestic Abuse services
- Schools
- Youth services
- Occupational Health services

Tier Two

Definition
Tier 2 interventions include provision of open access facilities and outreach that provide: substance misuse-specific advice, information and support; extended brief interventions to help those misusing substances reduce substance misuse-related harm; and assessment and referral of those with more serious substance misuse problems for care-planned treatment.

Interventions
Tier 2 interventions include open access facilities and outreach targeting substance misusers, which provide:

- Substance misuse-specific information, advice and support
- Extended brief interventions and brief treatment to reduce substance misuse-related harm
- Substance misuse-specific assessment and referral of those requiring more structured treatment
- Mutual aid groups, e.g. Alcoholics Anonymous
- Triage assessment, which may be provided as part of locally agreed arrangements.

Settings

As per tier one if staff have necessary competencies

Tier Three

Definition
Tier 3 interventions include provision of community-based specialised substance misuse assessment, and treatment that is care co-ordinated and care-planned

Interventions
Tier 3 interventions include:

- Comprehensive substance misuse assessment
- Care planning and review for all those in structured treatment, often with regular key working sessions as standard practice
- Community care assessment and case management of substance misusers
- A range of evidence-based prescribing interventions, in the context of a package of care, community detoxification and prescribing interventions to reduce risk of relapse
- A range of structured evidence-based psychosocial therapies and support within a care plan to address substance misuse and to address co-existing conditions, such as depression and anxiety, when appropriate
- Structured day programmes and care-planned day care (e.g. interventions targeting specific groups)
- Liaison services, e.g. for acute medical and psychiatric health services (such as pregnancy, mental health or hepatitis services) and social care services (such as child care and housing services and other generic services as appropriate).

Settings

- Specialised substance misuse treatment services with their own premises in the community
- Outreach (peripatetic work in generic services or other agencies, or domiciliary or home visits).
- Tier 3 interventions may be delivered alongside Tier 2 interventions.
- Primary care settings (shared care schemes and GP-led prescribing services)

Tier Four

Definition
Tier 4 interventions include provision of residential, specialised substance treatments which are care-planned and co-ordinated to ensure continuity of care and aftercare.

Interventions
Tier 4 interventions include:

- Comprehensive substance misuse assessment, including complex cases when appropriate
- Care planning and review for all inpatient and residential structured treatment
- A range of evidence-based prescribing interventions, in the context of a
- Package of care, including medically assisted withdrawal (detoxification) in inpatient or residential care and prescribing interventions to reduce risk of relapse
- a range of structured evidence-based psychosocial therapies and support to address substance misuse

Settings

- Specialised statutory, independent or voluntary sector inpatient facilities
- Residential rehabilitation units
- Dedicated specialised inpatient alcohol units

Adapted from the following guidance documents:

Models of care for alcohol misusers (MoCAM) (DH 2006)
Models of care for treatment of adult drug misusers: Update 2006 (NTA 2006)

Appendix Three

Walsall Drug and Alcohol Services based on Models of Care (2002, updated 2006) national service framework.

Walsall's public health commissioned substance misuse services are based upon a 4 tier model of care offering a screening and assessment service, care planned and coordinated structured interventions within connected integrated pathways. Although the tiers are presented as discrete entities there is significant flexibility and liaison between the services to enable smooth transition between the critical stages of residential and community services, young people's services into adult services and transfer between community agencies within the integrated system.

Tier	**Public Health Commissioned Provider Agencies**	**Walsall Services**
Tier 1 interventions include provision of: identification of hazardous, harmful and dependent drinkers; information on sensible drinking; simple brief interventions to reduce alcohol-related harm; and referral of those with	A schedule of training, advice and information is delivered to universal and targeted services to raise awareness of drug and alcohol issues and the ability to assess the extent of an individual's substance misuse by using the FAST, AUDIT C and DUST screening tools. Referral routes are promoted to enable access, where appropriate, into specialist substance misuse services for early intervention. **Walsall Health Care Trust, Darlaston Health Centre Pinfold St, Darlaston.**	**Universal Services delivering screening and referral** • Primary care GP practices and pharmacists • Adult and Children's social care and family services • Children Centres • Youth Justice Service • Integrated Young Peoples and Targeted Youth Support Services • Schools and Colleges • NHS community and acute health services • Probation Service • West Midlands Police • Walsall Magistrate and Youth Court • Domestic Abuse Services • Job Centre Plus, Training and Employment providers
2	**Open access drug and alcohol services.** The availability of drug and alcohol related information and advice,	**Specialist Services offered;** • Locally Enhanced Services in GP practices offering brief interventions • Locally Enhanced

	triage assessment and brief interventions. Services are available for self, family and agency referral. There is open access to the service without an appointment. **Addaction Stafford St.** **Black Country YMCA, His N lows and Comex, The Glebe Centre Wednesbury Rd.** **Pharmacists and GP Practices Across the borough**	pharmacy needle exchange services • Arrest referral services in police custody • Criminal Justice liaison services(court, probation, offender management and prisons) • Specialist needle exchange services • Specialist blood borne virus service • Homeless/temporary accommodation support service • Mutual aid groups • Family and carer support services • Targeted outreach and needle/drug paraphernalia pick up service
3	**Structured community based specialist substance misuse services.** Specialist drug and alcohol services offering a range of care planned interventions based upon the outcome of a comprehensive need assessment carried out by specialist workers. **Dudley and Walsall Mental Health Partnership Trust, Lichfield St.** **Addaction, Stafford St.** **Cri/T3 Young people's Service, Jervis Court**	**Specialist Services offered;** • Consultant-led drug and alcohol team • Assessment team • Specialist community stabilisation and maintenance prescribing • Community assisted detoxification • Shared care with GP practices • Supervised consumption with pharmacists • Structured counselling • Structured court mandated community orders (ATRs and DRRs) • Family, maternity and safeguarding service • Youth justice service • Domestic abuse support service • Hospital liaison service • Specialist sexual health

		service • Specialist young people's treatment services
4a	**Specialist residential substance misuse services.** In partnership with adult social care specialist drug and alcohol services assess and place individuals in out of borough residential service that matches the individual's needs. There are a range of providers where placements are sourced via spot purchase contracts. **Walsall Council Adults Social Care and Inclusion.** **Dudley and Walsall Mental Health Partnership Trust.** **Broadway Lodge.** **Burton Addiction Centre.** **Livingstone House.** **Western Counselling Services.**	**Specialist Services offered;** • Assessment and placement support team • Residential detoxification service • Residential rehabilitation service

Appendix Four

Drug Related Deaths

St Georges, London University, International Centre for Drug Policy produces an annual report to assist local areas to reduce and prevent drug-related deaths in the UK due to the misuse of drugs, both licit and illicit, by collecting, analysing, and disseminating information on the extent and nature of death.

Data is collated from the Coroners' database which was established in 1997.

To enable comparison with various national and international datasets all causes of death have been coded according to the International Classification of Diseases (ICD-10). This is an international standard for the classification of diseases and health-related problems published by the World Health Organisation (1992).

A case is defined as a relevant death where any of the following criteria are met at a completed inquest, fatal accident inquiry or similar investigation:

- One or more psychoactive substances directly implicated in death;
- History of dependence or abuse of psychoactive drugs;
- Presence of Controlled Drugs at post mortem; or
- Cases of deaths directly due to drugs but with no inquest.

Alcohol is included only when implicated in combination with other qualifying drugs, as are solvents.

A drug abuser/dependent case is defined as one with a history of substance abuse where one or more of the following criteria are met:

- Reported as a known illicit drug user by the Coroner, based on evidence obtained at inquest;
- Prescribed substitute medication for drug dependence;
- Presence of an illicit drug at post mortem, where not prescribed; or
- Presence of any additional information on the Coroner's report suggestive of a history of drug abuse, and where such a history fulfils ICD-10 criteria

Cause of death categories included in the headline indicator of 'drug misuse' deaths used to monitor progress against the Government's drug strategy are defined in terms of ICD-10 codes and Controlled Drug Status.

The definition comprises two types of deaths:

a) deaths where the underlying cause of death has been coded to categories of mental and behavioural disorders due to psychoactive substance use (excluding alcohol, tobacco and volatile solvents)
b) deaths coded where a drug controlled under the Misuse of Drugs Act 1971 was mentioned on the death record

Drug Related deaths in Walsall

	Walsall	Black Country*
2007	3	6
2008	4	12
2009	2	10
2010	No data submitted	No data submitted
2011	1	8
2012	2	4
2013(local estimate)	3	n/a

- includes Walsall, Dudley and Sandwell

Appendix 5

Acknowledgements

This needs assessment has been produced by the joint efforts of the following people, who either contributed to the writing, design or provided data and information.

Patrick Duffy
Public Health Programme Development & Commissioning Manager

Martin Ewin
Public Health Intelligence Manager

David Hughes
Public Health Intelligence Analyst

David Neale
Public Health Programme Development & Commissioning Manager

Adrian Roche
Public Health Head of Social Inclusion