

Drugs and Alcohol Needs Assessment for Walsall 2019

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Executive summary

This is the second drugs and alcohol needs assessment since the substance misuse service has been commissioned within the local authority. Following the 2012 transfer of public health, and with it the responsibility for commissioning drug and alcohol treatment services, into the local authority we successfully, in 2014, re-designed and re-tendered our drug and alcohol treatment programme. We achieved this by joining four separate services together to create a new integrated treatment system. Five years on, we are seeking to re-tender our integrated treatment system. This needs assessment has been completed written to support our re-tendering process using data from the Public Health Institute at Liverpool John Moores University, National Drug Treatment Monitoring System (NDTMS), Local Alcohol Prevalence Estimates (LAPE), and Walsall local data management system.

The Public Health Institute, John Moores University, 2019 annual drug prevalence estimates that Walsall has 1,915 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 reduced over the last 10 years from 2,052 in 2009/10. Despite the challenging prevalence rates, the local treatment system has a good penetration of the drug using population with 1,288.

The typical adult drug and alcohol service user in Walsall is male, White British with the next highest represented group being Asian/Asian British. 56% are parents with a fifth with dependent children living with them; the largest cohort fall within the 30-39 age range (40%). Opiates are the primary substances used by adults presenting into treatment (58%) followed by non-opiates (16%) and alcohol (26%). 29% of service users are injecting and 27% have previously injected; 71% are economically inactive; 84% have no accommodation issues with 10% have a housing problem and 6% have an urgent housing problem.

The Public Health England annual Local Alcohol Prevalence Estimates (LAPE), estimates that Walsall has 3,360 (1.6 per 100,000) 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 main Public Health Outcome for alcohol is to reduce the alcohol specific admissions to hospital (per 100,000 of the population). The most recent LAPE figures show that admissions for alcohol specific conditions in Walsall were 651 compared with 528 for the West Midlands, and 570 for England. This continues a trend where Walsall admissions have been higher over the last ten years.

There is a gender difference in the alcohol general admissions to hospital with a higher rate of males in the over 65 age categories; there is however an increasing trend in female admissions in the over 65 age category. Walsall performance in the over 65 category is worse than the regional and national average.

Alcohol related mortality in Walsall 57.1 per 100,000 compared to 46.2 (England), and 51.2 (West Midlands). Alcohol specific mortality for Walsall is 13.5 per 100,000 compared to 10.6 (England), and 13.1 (West Midlands); Walsall's rates are higher in both categories.

Young Adults and Young People

Typically, young people in specialist drug and alcohol services in Walsall are males (69%); they are mostly White British (76%); 76% fall within the 14-17 age group, however 20% are aged 14 years and under; cannabis (61%) and alcohol (25%) are the primary substances. 9% are looked after children; the highest volume of referrals come from Education (38%), Youth Justice Services (30%), and Children's Services (18%). 53% are in mainstream education, but 18% are not in any education, training or employment. The highest proportion (37%) remain in treatment between 13-26 weeks receiving psychosocial (41%) and harm reduction (39%) interventions; 87% left treatment in a planned way and 7% re-presented within six months of exit.

Drug policy

Successive drug strategies published by the UK government and devolved administrations have cited considerable social and economic costs associated with drugs and the need to design policies aimed at reducing these costs. There is a well-established link between certain drugs and acquisitive crimes committed by dependent users to fund their drug use like shoplifting and burglary. On the supply side, criminal gangs are often also involved with drug supply and human trafficking, child exploitation and violence. The harm to individuals is also recognised by policy-makers in the UK and a balanced approach is taken with the focus of policy being not just on enforcing drug laws but also on providing support to those who experience issues with dependence.¹

The UK government is responsible for setting the overall strategic approach to reducing drug-related harms. The 2017 Drug Strategy², as with the preceding strategy released in 2010, sets out its key aims of reducing drug use and increasing rates of recovery from dependence. Like the 2010 strategy, initiatives are arranged into themes of reducing demand, restricting supply and building recovery, with a new theme of global action introduced into the 2017 strategy.

The Misuse of Drugs Act 1971 (Her Majesty's Government, 1971) is the principal legislation in the UK for the control and supply of psychoactive substances that are considered dangerous or otherwise harmful when misused. The act divides such substances into three classes (A, B and C) and sets maximum criminal penalties for illicit production, possession and supply in relation to each class.

The Psychoactive Substances Act 2016, which came into force on 26 May 2016, prohibits the supply, production and trafficking of psychoactive substances (Her Majesty's Government, 2016). The act was brought in as a response to New Psychoactive Substances (NPS) and the speed at which new substances emerge. Keeping pace with the NPS market presented a challenge using the existing legislation, as substances need to be added to the Misuse of Drugs Act 1971 or included on a temporary class drug order (TCDO) in order to be controlled.

Demographics

Walsall population, trends, projected

Walsall is a metropolitan borough consisting of a mix of urban, suburban and semi-rural communities. Covering 40 square miles, it is located to the north-west of Birmingham, and is one of the four local authorities that make up the Black Country sub-region (with Dudley, Sandwell and Wolverhampton). Walsall town centre lies at the heart of the borough surrounded by Aldridge, Bloxwich, Brownhills, Darlaston and Willenhall district centres.³

¹ Focal point annual report 2017 (<https://www.gov.uk/government/publications/united-kingdom-drug-situation-focal-point-annual-report>)

² Her Majesty's Government, 2017

³ <https://www.walsallintelligence.org.uk/>

Walsall's overall population of 278,700 (ONS 2016) residents is predicted to increase by 5.9% over 10 years, from 274,200 in 2014 to 290,200 in 2024. Like many areas, the predicted growth of Walsall's older population (> 65) is higher than this at 12.4%. There has already been an 8.8% increase in births in Walsall between 2004 and 2014, and the number of reception pupils in Walsall schools has increased 11.34% between 2012 and 2017. Therefore, planning to meet the needs of a growing younger population as well as a growing number of older people is incorporated within the Local Authorities' key strategic priorities, while recognising that the proportion of residents likely to be economically active is projected to fall.

Walsall is a culturally diverse town where people of Indian, Pakistani and Bangladeshi background form the largest minority ethnic groups. The number of non-UK born residents in Walsall increased by 3.7% (or 9,900 people) between the 2001 and 2011 censuses and Walsall now has a small Eastern European population who make up about 1% of residents (2,700 people in total). In terms of children and young people aged 0-17, the proportion of pupils from minority ethnic groups has increased to 37.4% of all pupils living in the area from 36.7% in 2016 and 24% Primary pupils have English as an additional language⁴. As at 31st March 2017, there are eight Unaccompanied Asylum Seeking Children for whom the Local Authority are Corporate Parents, which is lower than other West Midland authorities.

Deprivation

The English Indices of Multiple Deprivation (IMD), produced by the Ministry of Housing, Communities and Local Government (MHCLG)⁵, identify small areas of England, which are experiencing multiple aspects of deprivation. They are an important tool for identifying and understanding deprived areas, and for targeting resources effectively. The most recent figures available are for 2015, superseding previous versions from 2010, 2007 and 2004. Figures are released at Lower Super Output Area (LSOA) level – a 'neighbourhood' level geography - allowing for a deep dive approach across the Borough.

The Indices are based on seven different aspects ('domains') of deprivation, all of which combine to produce an overall measure – the Index of Multiple Deprivation. The domains are:

1. Income
2. Employment
3. Health and disability
4. Education, skills and training
5. Crime
6. Barriers to housing and services
7. Living environment

Within Walsall, there is considerable variation in the levels of deprivation experienced in neighbourhoods across the Borough. MHCLG's IMD do not include measures of ward-level

⁴ School Census, January 2017

⁵ Formerly the Department for Communities and Local Government (DCLG)

deprivation. However, these have been calculated using their approved method. The average IMD score for each Walsall ward is shown in below.

Table 1 Average deprivation score by ward

Ward	2015 Rank	Average IMD Score	England Decile	2010 Rank	Map Key
Blakenall	1	52.9	1	1	E
Birchills Leamore	2	48.1	1	2	D
Pleck	3	44.0	2	3	N
Bloxwich East	4	41.4	2	4	F
Darlaston South	5	39.9	2	5	I
St Matthew's	6	38.9	2	8	Q
Bentley & Darlaston North	7	38.3	2	7	C
Palfrey	8	37.6	2	6	K
Willenhall South	9	37.4	2	9	T
Bloxwich West	10	35.0	2	10	G
Brownhills	11	26.7	4	11	H
Short Heath	12	24.5	4	13	P
Willenhall North	13	23.8	4	14	S
Rushall-Shelfield	14	23.5	4	12	O
Aldridge North & Walsall Wood	15	17.8	5	15	B
Pelsall	16	17.4	5	16	L
Aldridge Central & South	17	13.9	6	17	A
Paddock	18	13.8	7	18	J
Pheasey Park Farm	19	11.6	7	19	M
Streetly	20	5.5	10	20	R

Source: MHCLG Ward level deprivation in Walsall

The scores show Blakenall remains the most deprived ward overall, while Streetly is the least deprived. The ranking of the wards is largely unchanged since 2010. Table 1 also shows where the wards' average scored would lie if placed in the distribution of all LSOA scores national – Blakenall and Birchills, Leamore are in the 1st decile, so equivalent to the 10% most deprived small areas in England, whilst Streetly is among the 10% least deprived.

Figure 1 Deprivation by Walsall level quintile (IMD 2015)

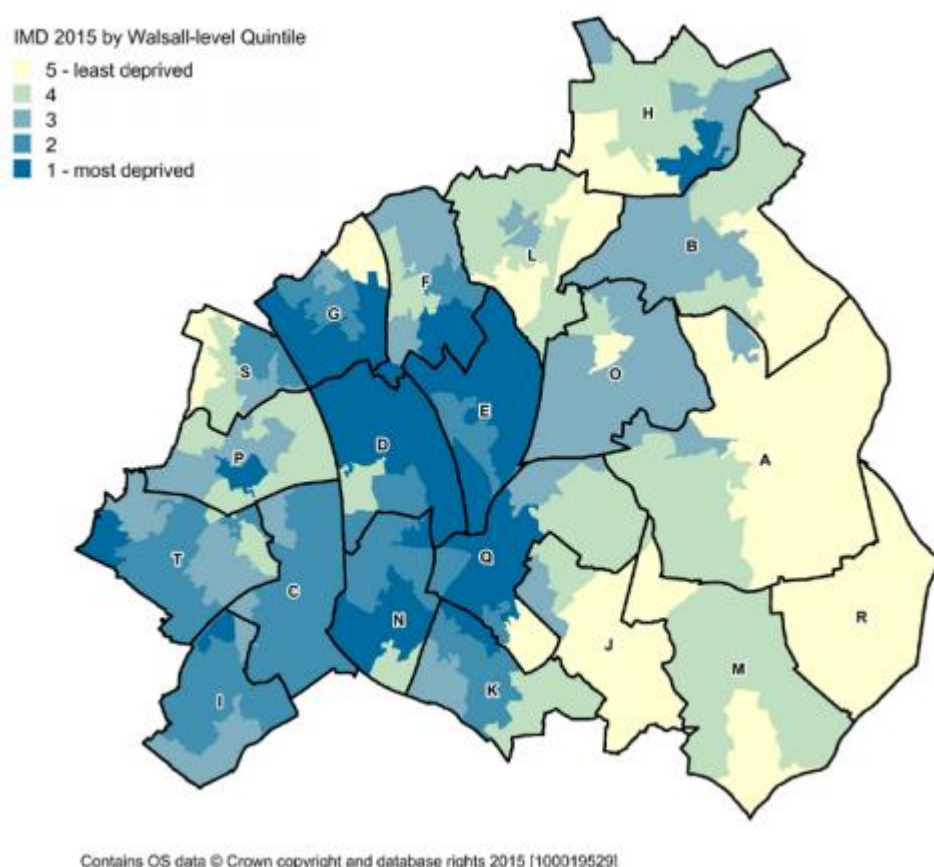


Figure 1 shows IMD relative to the rest of the Borough, split into quintiles. Within the Borough as a whole, the most deprived quintile (i.e. the most deprived 20% of LSOAs) is shown in darkest blue, and the least deprived quintile (i.e. the least deprived 20% of LSOAs) is pale yellow.

Deprivation 2015 key facts summarised include:

- 34 out of 167 neighbourhoods (LSOAs) are now amongst the most deprived 10% in England compared to 41 in 2010.
- The 2015 Index of Multiple Deprivation now ranks Walsall as the 33rd most deprived English local authority (out of 326), nudging Walsall just outside the most deprived 10% of districts in the country (30th in 2010 and 45th in 2007).
- There are extremes of deprivation, with central and western areas typically much more deprived than eastern areas, although pockets of deprivation exist even in the more affluent parts of the borough.
- Walsall fares particularly badly in terms of income (18th), employment (30th) and education, skills & training deprivation (12th), and many of the issues that challenge the borough match the geography of deprivation.
- The high and increasing levels of child poverty puts additional demands on services. Walsall ranks 18th of 152 upper tier local authorities for income deprivation affecting children index⁶ with the Borough's relative deprivation increasing over time.

⁶ IDACI 2015

- 1 in 3 (29.9%) aged under 16 years are living in low income families, higher than the national average of 20.1%⁷.

A revised version of the Index of Deprivation is due to be released by MHCLG in the autumn of 2019. This release will provide valuable insight in which to monitor and understand the impact of residents living within highly deprived areas.

Additional data, statistics and publications for Walsall can be found on the Walsall intelligence website: <https://www.walsallintelligence.org.uk/>

Client classification

Individuals presenting to adult alcohol and drug treatment services are categorised by the substances they cite as problematic at the start of treatment⁸. They are categorised by the following hierarchal criteria:

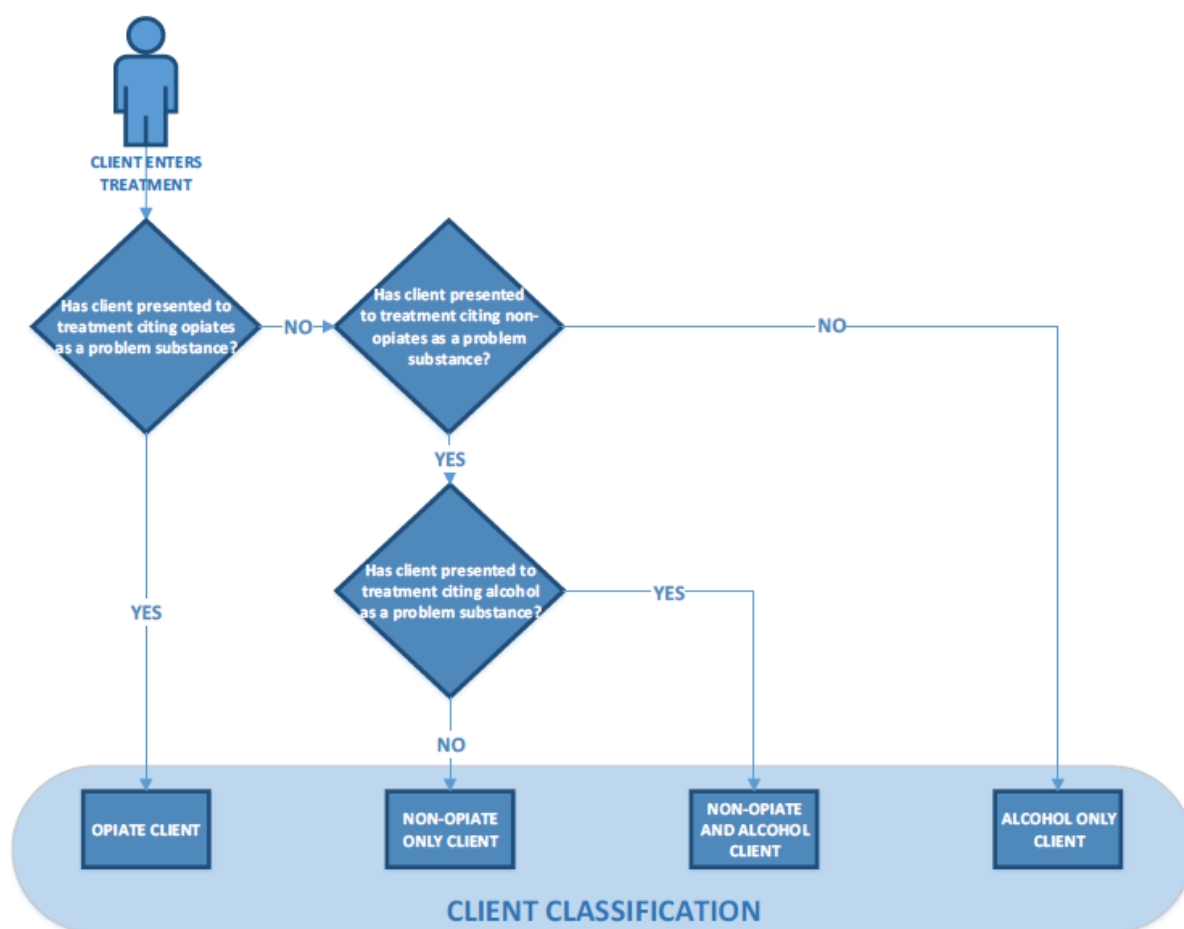
- any mention of opiate use in any episode would result in the client being categorised as an OPIATE client (irrespective of what other substances are cited)
- clients who present with non-opiate substances (and not opiates or alcohol) will be classified as NON-OPIATE ONLY
- clients who present with a non-opiate substance and alcohol (but not opiates) recorded in any drug in any episode in their treatment journeys will be classified as NON-OPIATE AND ALCOHOL
- clients who present with alcohol and no other substances will be categorised as ALCOHOL ONLY

The classification method is illustrated in the diagram below.

⁷ HMRC, 2016: The Children in Low-Income Families Local Measure shows the proportion of children living in families in receipt of out-of-work (means-tested) benefits or in receipt of tax credits where their reported income is less than 60% of UK median income.

⁸ Adult substance misuse statistics from NDTMS - Apr 2017 to Mar 2018 (PHE)

Figure 2 Client classification



Source: Public Health England

Prevalence estimates

These prevalence estimates for local areas were last updated in March 2019 for the period between 2016 and 2017⁹. They are published by Liverpool John Moores University (LJMU) and contain comparisons with prevalence estimates of previous periods between 2010/11 and 2014/15. There were no data for 2015/16.

‘OCU’ refers to use of opiates and/or crack cocaine. It does not include the use of cocaine in a powder form, amphetamine, ecstasy or cannabis. 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.

⁹ <https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates-for-local-populations>

It is advisable to look at the prevalence rate as well as the actual numbers, because any significant changes in the number of OCUs may simply reflect fluctuations in the general population for that area. The age range employed within the study is from 15 to 64 and where the estimates have been stratified by age group, these are from 15 to 24, from 25 to 34, and from 35 to 64.

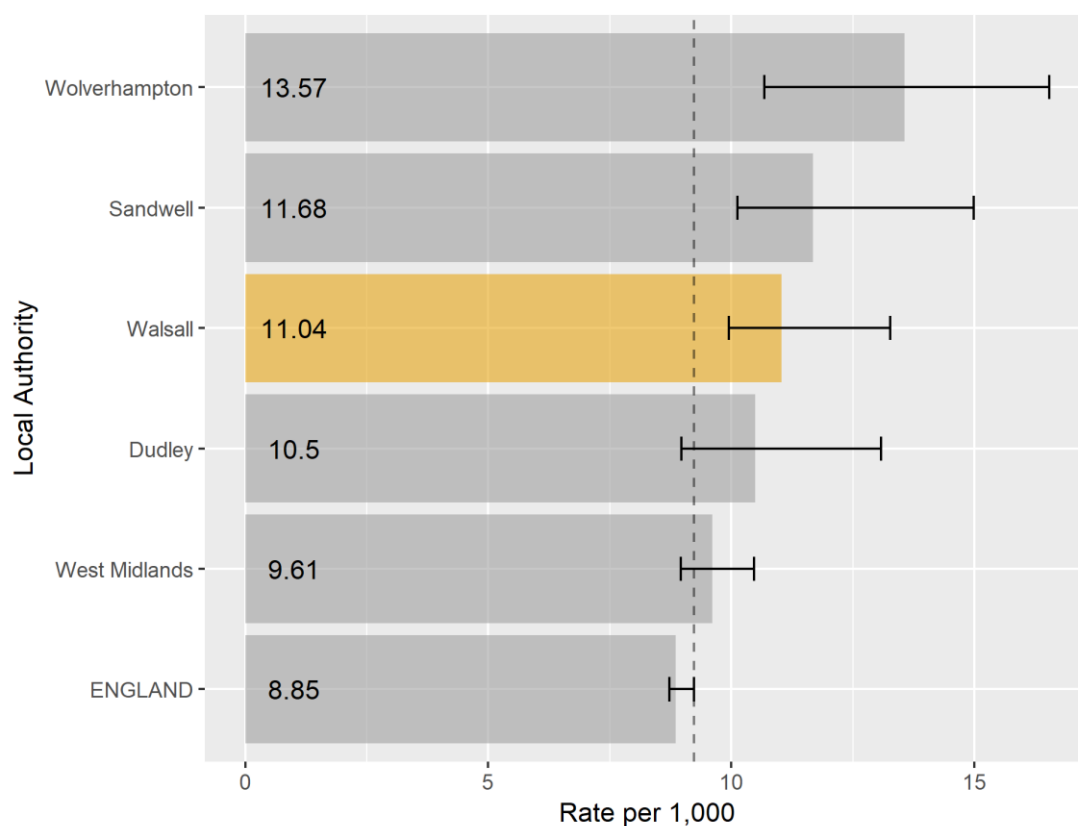
Opiate and/or crack cocaine use (OCU) in 2016/17

At a rate of 11.04 OCU per 1,000 population, Walsall is ranked 47th highest out of 151 English local authorities.

The chart below compares the OCU prevalence rate in Walsall with its Black Country neighbours and also the West Midlands and England. Although lower than Wolverhampton and Sandwell, Walsall's rate is statistically similar to the Black Country and West Midlands, but significantly higher than England. The vertical dotted line in the chart shows England's upper confidence interval, which aids comparison with other areas.

Walsall's OCU prevalence population of 1,915 people (rate of 11.04 per 1,000) in 2016/17 has increased by 9 people since 2014/15, but this is not statistically significant.

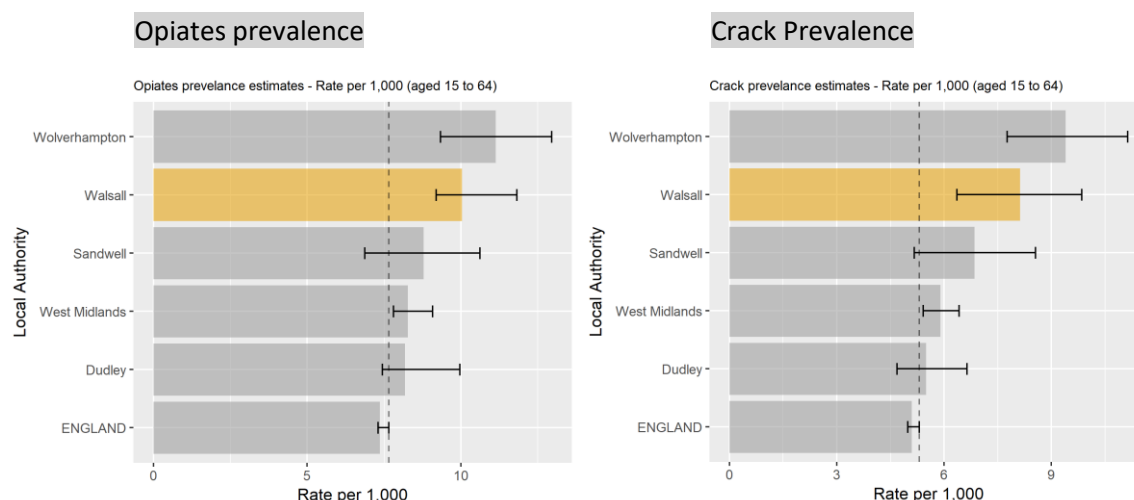
Figure 3 OCU prevalence estimates for those aged 15-64 in 2016/17 (with 95% confidence intervals)



Source: Liverpool John Moores University

The charts below show opiate and crack cocaine rates for Walsall compared to the comparators used above.

Figure 4 Prevalence estimates for opiate and crack users – rate per 1,000 (aged 15 to 64) with 95% CI



Source: Liverpool John Moores University

Below is a summary of Walsall's prevalence estimates in 2016/17, presented by number of users and rate per 1,000 of the population.

Table 2 Walsall OCU prevalence estimates 2016/17

Prevalence in 2016/17	OCU	Opiate	Crack
Estimated numbers of users	1,915	1,741	1,410
Estimated rate per 1,000	11.04	10.03	8.13

Note that the sum of opiate and crack users will not equal OCU users, as OCU indicates the use of one or both substance categories i.e. they are not mutually exclusive.

OCU age group analysis in 2016/17

The charts below show the estimated number and rate by age group. When looking at the number of users, there are significantly more over 35's compared to under 25's. Interestingly, when looking at the rate, the most prevalent group is those aged 24-34.

Figure 5 Prevalence estimates numbers by age group

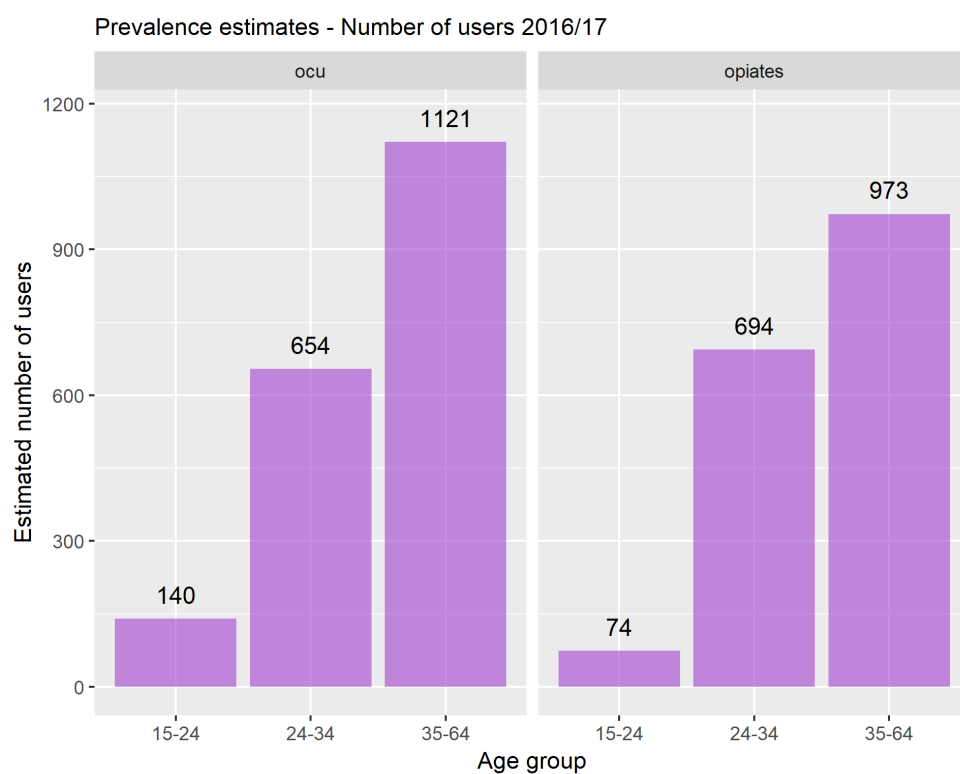
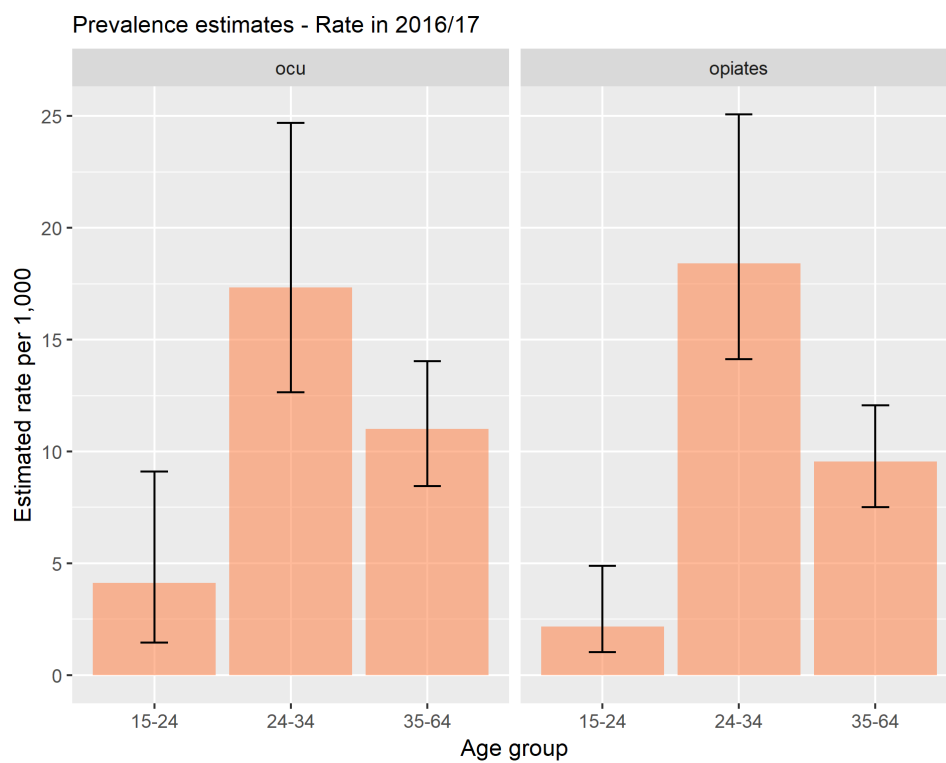


Figure 6 Prevalence estimate rate (per 1,000) by age group



Source: Liverpool John Moores University

OCU gender analysis in 2014/15

When analysing Opiate rates (per 1,000) by gender in 2014/15, it is estimated there are almost 4 times more males (15.15) than females (3.89). Gender analysis was not provided in the 2016/17 release of the prevalence estimates.

Alcohol prevalence estimates

The national estimates of alcohol dependence has been updated in November 2018 by the University of Sheffield, for the financial year 2016/17. It estimates the number of adults (aged 18+) within each local authority with an alcohol dependency, potentially in need of specialist treatment¹⁰.

The table and chart below compare the numbers and rate of estimated alcohol prevalence across the Black Country local authorities.

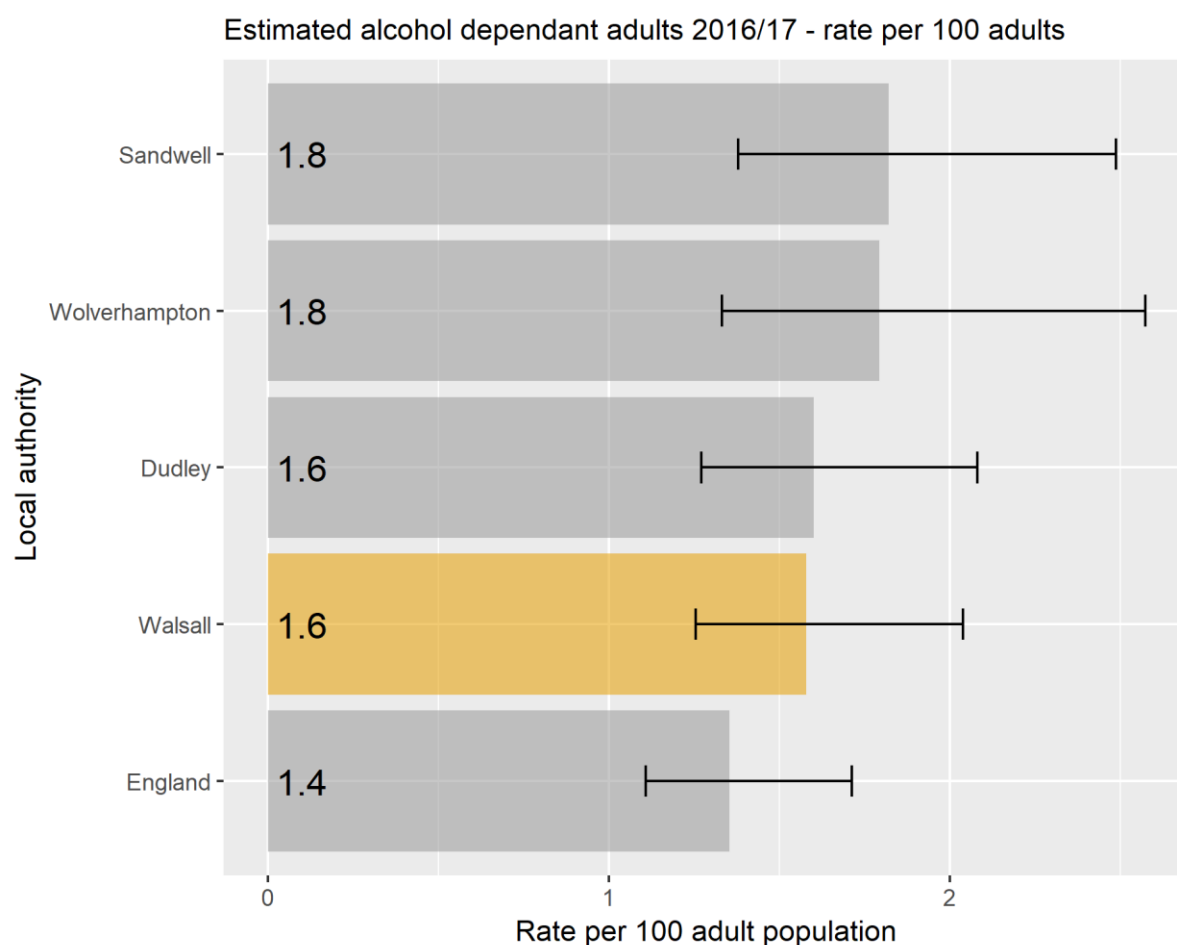
Table 3 Alcohol prevalence estimates

Local authority	Number of adults	Rate per 100 adults
Walsall	3,360	1.6
Wolverhampton	3,565	1.8
Dudley	3,996	1.6
Sandwell	4,421	1.8

Although Walsall has the lowest estimated number of alcohol dependant adults, when converted into a rate, there is no statistical significance between the Black Country local authorities and England.

¹⁰ <https://www.gov.uk/government/publications/alcohol-dependence-prevalence-in-england>

Figure 7 Estimated alcohol dependant adults in 2016/17 (rate per 100)



Source: University of Sheffield

In terms of trend, the estimated number of alcohol dependant adults has increased since 2010, but for the period between 2010 and 2014, confidence intervals were not calculated, therefore it is not possible to comment whether this increase is statistically significant.

However, between 2015/16 and 2016/17 the estimated numbers have fallen by 91 to 3,360 which is not significant. In fact, there is a wide confidence interval around this data, meaning there is the potential for considerable variation around the average.

Unmet need for alcohol treatment

PHE's commissioner support pack calculates Walsall's alcohol unmet need as 83% (95% CI: 79% to 87%), which is similar to England's 82% (95% CI: 79% to 86%). Walsall's unmet need is based on 567 clients in treatment (includes alcohol only and alcohol & non-opiate) as a proportion of the local estimate of 3,360 dependant drinkers. Specific rates of unmet need will however need to be determined locally.

Adults (combined drugs and alcohol)

Client characteristics

Numbers in treatment - 2017/18

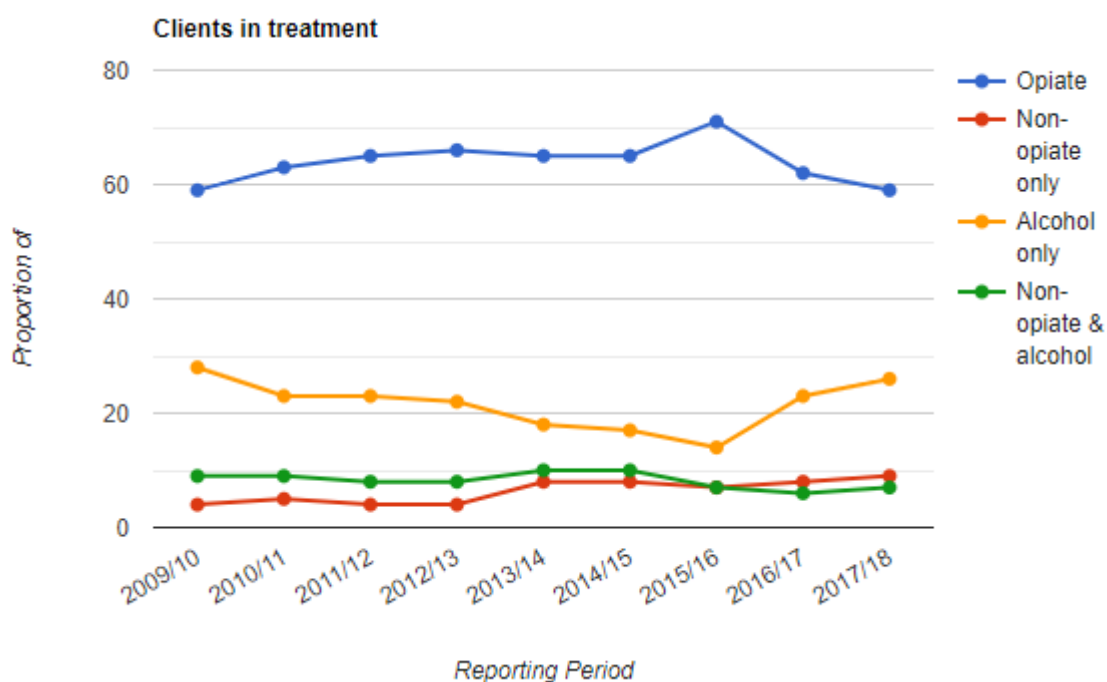
In 2017/18, NDTMS reported a total of 1,734 adults receiving structured treatment. Individuals can access treatment for either problematic drug use, alcohol or both. Throughout this report, the four main substance groups as outlined previously are used. The segmentation of individuals accessing treatment is presented below.

- Most clients in contact with treatment (59%), presented with a problematic use of opiates.
- Almost 16% of clients presented with problems with other drugs
- Just over a quarter (26%) presented with alcohol as the main problematic substance.

Numbers in treatment – trends

The chart below shows the proportion of clients receiving treatment by substance category, while the table shows the actual number of clients.

Figure 8 Proportion of adults in treatment (%)



Source: NDTMS View It

Table 4 Number of adults in treatment

Substance category	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Opiate	1138	1146	1082	1071	1067	1084	1086	1070	1019
Non-opiate only	81	89	67	69	129	138	114	146	148
Alcohol only	534	429	379	353	293	278	220	400	446
Non-opiate & alcohol	175	169	126	123	163	174	107	105	121
Total adults	1928	1833	1654	1616	1652	1674	1527	1721	1734

Source: NDTMS View It

Substance use profile (all in treatment)

Substance breakdown of all clients in treatment in 2017/18

The distribution of substances for all individuals in treatment in 2017/18 is shown in Table 5 below. This substance use profile defines clients by groups of substance use and relates to any use within a clients' journey. A client may therefore be categorised by one or more groups and as a result the totals in this table will be greater than the number of clients presented in the previous section. To prevent deductive disclosure, all numbers under 5 have been suppressed.

Table 5 Number and proportion of substances used in 2017/18

Substance	Opiate		Non-opiate		Non-opiate & Alcohol		Alcohol only		Total	
	n	%	n	%	n	%	n	%	n	%
Opiate and crack cocaine	498	35%		0%		0%	0	0%	498	22%
Opiate (not crack cocaine)	521	37%		0%		0%	0	0%	521	23%
Crack cocaine (not opiate)		0%	18	10%	16	6%	0	0%	34	1%
Cannabis	144	10%	82	47%	60	23%	0	0%	286	12%
Cocaine	49	3%	54	31%	61	23%	0	0%	164	7%
Benzodiazepine	17	1%		1%		0%	0	0%	18	1%
Amphetamine (not ecstasy)	11	1%	10	6%		2%	0	0%	25	1%
Ecstasy		0%		0%		0%	0	0%		0%
Mephedrone		0%		1%		0%	0	0%		0%
NPS	8	1%	7	4%		0%	0	0%	15	1%
Hallucinogen		0%		0%		0%	0	0%		0%
Alcohol	167	12%		0%	121	46%	446	100%	734	32%
Other		0%		1%		0%	0	0%	5	0%
Total	1422	100%	174	100%	263	100%	446	100%	2305	100%

Source: NDTMS View It

Table 6 below shows the proportion of substance use by those in treatment, as a trend between 2009/10 and 2017/18.

Table 6 Substance breakdown proportion of all clients in treatment, by financial year

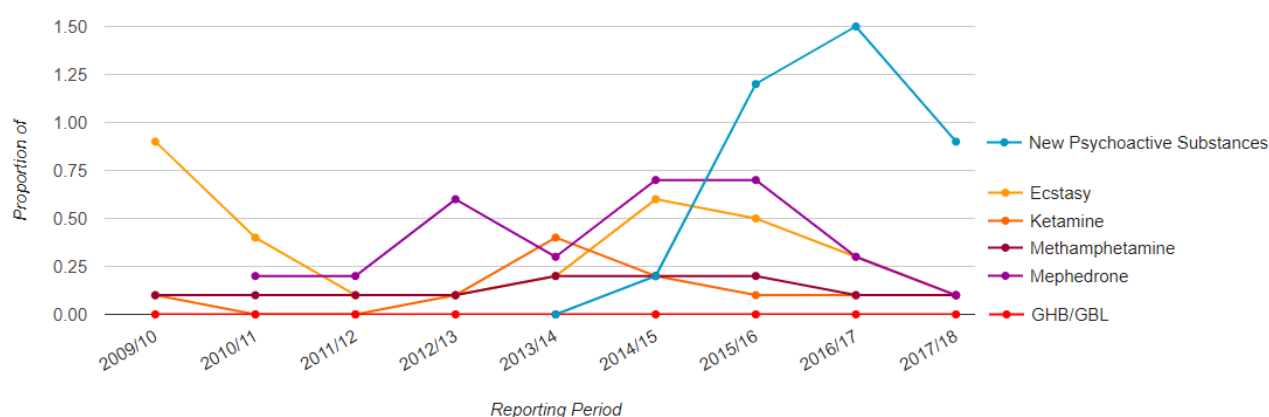
Substance	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Opiate and crack cocaine	20.9%	22.0%	22.6%	23.5%	22.7%	23.1%	24.8%	21.9%	21.6%
Opiate (not crack cocaine)	21.8%	22.7%	24.6%	23.3%	21.7%	20.6%	23.1%	23.0%	22.6%
Crack cocaine (not opiate)	1.4%	1.3%	0.9%	0.9%	1.3%	1.2%	0.7%	0.9%	1.5%
Cannabis	14.9%	15.1%	14.0%	13.2%	14.2%	14.5%	14.9%	13.1%	12.4%
Cocaine	6.1%	5.7%	5.1%	6.2%	9.4%	9.2%	7.2%	7.5%	7.1%
Benzodiazepine	1.3%	1.6%	1.6%	1.5%	1.5%	1.3%	1.2%	1.0%	0.8%
Amphetamine (not ecstasy)	1.0%	0.9%	0.7%	1.0%	0.8%	1.0%	1.3%	0.9%	1.1%
Ecstasy	0.7%	0.3%	0.1%	0.1%	0.1%	0.4%	0.4%	0.3%	0.1%
Mephedrone	0.0%	0.2%	0.1%	0.4%	0.2%	0.4%	0.5%	0.2%	0.1%
NPS	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.8%	1.0%	0.7%
Hallucinogen	0.1%	0.0%	0.1%	0.1%	0.3%	0.3%	0.2%	0.0%	0.0%
Alcohol	31.5%	29.9%	29.7%	29.2%	27.3%	27.2%	24.5%	29.9%	31.8%
Other	0.4%	0.5%	0.5%	0.5%	0.4%	0.5%	0.4%	0.3%	0.2%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%

Source: NDTMS View It

Club drugs and NPS – all in treatment

Club drugs and NPS (New Psychoactive Substances) bring together a number of different substances, typically used in bars and nightclubs, concerts and parties, before and after going out. The chart below shows a trend of the proportion of adults in treatment who are using these types of drugs. Although seeing an increase in recent years of NPS use, the peak in 2016/17 represents only 25 clients. When comparing the proportion of Walsall's NPS with the West Midlands and England, in 2017/18, they are very similar i.e. Walsall (0.9%), West Midlands (1.1%), England (0.8%).

Figure 9 Club drugs and new psychoactive substances



Source: NDTMS View It

Age of clients (all in treatment)

The age distribution of all individuals in treatment in 2017/18 is shown in Table 7 below. Age is calculated on April 1st for clients' already in treatment at that point or at the start of treatment for clients starting treatment in the year. The largest group overall is 35-39, but looking at substance categories, the following is observed:

- Opiate – the most prevalent age group is 35-39, but is prominent between 30 and 44.
- Non-opiate – is most prevalent in those in their 20's, slightly fewer in their 30's and tails off after 40 years.
- Non-opiate and alcohol – is most prevalent for those in their 20's and 30's.
- Alcohol – clients are spread throughout the various age groups and there are considerably more, older alcohol clients than any other substance category.

Table 7 Age distribution of all clients in treatment 2017/18 by substance type

Age Group	Opiate	Non-opiate	Non-opiate and alcohol	Alcohol	Total
18-24	2%	25%	13%	4%	5%
25-29	8%	26%	16%	9%	10%
30-34	24%	18%	21%	12%	20%
35-39	30%	19%	19%	14%	24%
40-44	20%	5%	16%	16%	17%
45-49	10%	5%	6%	15%	10%
50-54	5%	1%	3%	14%	7%
55-59	2%	0%	6%	9%	4%
60 or above	0%	1%	0%	7%	2%
Total	100%	100%	100%	100%	100%

Source: NDTMS View It

Age distribution trend

The table below shows the % of clients within each age group, by financial year, for all substance types combined. It can be clearly seen that clients are now generally older than they were 9 years ago, in 2009/10.

Table 8 Proportion of all clients in treatment by age group and year (all substance types)

Age Group	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)
18-24	16	14	10	7	9	8	7	6	5
25-29	24	24	21	19	18	15	12	11	10
30-34	20	22	25	26	27	26	26	21	20
35-39	15	15	16	17	18	20	21	23	24
40-44	10	10	12	13	12	13	16	16	17
45-49	7	7	7	8	8	9	10	11	10
50-54	4	4	5	5	5	5	5	6	7
55-59	2	2	2	3	3	3	3	3	4
60 or above	2	2	2	2	1	1	2	2	2

Source: NDTMS View It

Gender of clients (all in treatment)

Almost three quarters of all clients are receiving treatment for drug-related substances and the other quarter are alcohol only.

From a total of 1,734 client in 2017/18, there are 490 females (28%) and 1,244 males (72%). A breakdown by substance category can be seen in the table below.

Table 9 Substance category and gender

Substance category	Female		Male		Persons	
	n	% of gender	n	% of gender	n	% of substance
Opiates	254	25%	765	75%	1019	59%
Non-opiates only	33	22%	115	78%	148	9%
Alcohol & non-opiates	33	27%	88	73%	121	7%
Alcohol only	170	38%	276	62%	446	26%
Total	490	28%	1244	72%	1734	100%

Source: NDTMS View It

Ethnicity of clients

Ethnicity - new presentations

Drugs – from a total of 469 new presentations in 2017/18, the most common ethnic groups are summarised in the table below. Please note, that this is a subset of the data (showing largest categories) and totals will not equal the 469 total new presentations.

Table 10 Most common ethnic groups for new drug presentations in 2017/18

Most common ethnic groups in treatment for your local authority	Local	Proportion of new presentations	Proportion by gender	
	n		M	F
White British	363	77%	76%	81%
Indian	25	5%	7%	1%
Caribbean	13	3%	3%	2%
Pakistani	13	3%	4%	0%
White & Black Caribbean	13	3%	3%	4%
Missing / incomplete	5	1%	1%	2%

Source: Drugs commissioning support pack 2019-20 PHE

Alcohol – from a total of 283 new presentations in 2017/18, the most common ethnic groups are summarised in the table below. Again, as this is a subset of the data, totals will not equal 283.

Table 11 Most common ethnic groups for new alcohol presentations in 2017/18

Most common ethnic groups in treatment for your local authority	Local	Proportion of new presentations	Proportion by gender	
	n		M	F
		%	%	%
White British	235	83%	81%	87%
Indian	26	9%	13%	2%
Other White	9	3%	2%	5%

Source: Alcohol commissioning support pack 2019-20 PHE

Ethnicity – all in treatment

The tables below show the proportion of clients in treatment by ethnic group, self-reported by the client at the start of their journey. The first table includes all substance types and the second reports alcohol only clients. A separate table for drug clients has been omitted, as there is very little difference to the 'all substance' table.

Overall, for all clients, since 2009/10, there is very little difference in the proportions represented by the various ethnic groups. There has been a slight reduction in White clients (86% to 84%) and a corresponding increase in Asian clients. When looking at the alcohol only table below, we can see this shift is due to alcohol clients. Between 2009/10 and 2017/18, the proportion of White, alcohol only clients has reduced from 93% to 87%, with Asian clients increasing from 5% to 10%.

Table 12 Proportion of all clients in treatment by ethnic group (all substances)

Ethnicity	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)
White	86	87	87	86	85	85	85	86	84
Mixed/Multiple ethnic group	3	4	3	4	4	4	4	3	4
Asian/Asian British	8	8	8	9	9	9	9	9	10
Black/African/Caribbean/Black British	2	2	1	1	2	2	1	2	2
Other ethnic group	0	0	0	0	0	0	0	1	0

Table 13 Proportion of all clients in treatment by ethnic group (alcohol only clients)

Ethnicity	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)
White	93	93	92	91	92	89	89	88	87
Mixed/Multiple ethnic group	1	2	1	2	1	2	1	1	1
Asian/Asian British	5	4	6	7	7	9	8	9	10
Black/African/Caribbean/Black British	1	1	1	0	0	1	1	1	1
Other ethnic group	0	0	0	0	0	0	1	1	1

Source: NDTMS View It

Country of origin (new presentations)

Most new clients in 2017/18 (95%, n=711) reported the United Kingdom as their country of origin, with a very similar representation by substance type i.e. 95% (n=444) for drugs and 94% (n=267) for alcohol clients. To maintain confidentiality, it is not possible to analyse further¹¹.

Source: Drugs and alcohol commissioning support pack 2019-20

Religion

Religion - new presentations

All substances have been combined here to allow presentation of clients' religion. A considerable number of clients (n=120, 16%) didn't disclose their religion when entering the service during 2017/18. Of those who responded to this question:

- Almost half stated no religion (n=347, 46%)
- The majority citing a religion considered themselves Christian (n=199, 26%)
- 5% are Sikh (n=34)
- 3% are Muslim (n=22)

Source: Drugs and alcohol commissioning support pack 2019-20

Religion – using local data

The table below shows a summary of self-reported religion of all clients receiving structured treatment, between July 2015 and May 2019; this includes all substance types. In the 'unknown/other' category, 30% (n=285) declared no religion, but the majority (n=389, 41%) did not have religion recorded. Other categories include further categories for unknown and client refusing to disclose this information.

¹¹ Country of origin not available from local dataset, therefore analysis here limited to new presentations

Table 14 Religion of adults receiving structured treatment between Jul 2015 and May 2019

Religion	n	%
Christian	137	14%
Muslim	30	3%
Sikh	20	2%
Unknown/other	771	80%
Grand total	958	100%

Source: CGL

Sexuality

Sexuality – new presentations

Of the total 752 new presentations in 2017/18 for both drugs and alcohol,

- 84% (n=633) were heterosexual
- 1% (n=7) were gay/lesbian
- 1% (n=10) were bisexual

Data for remaining clients were categorised as other, missing/incomplete or not stated/not known.

Source: Drugs and alcohol commissioning support pack 2019-20

Sexuality – using local data

Of all those adults receiving structured treatment (n=958) between July 2015 and May 2019, 66% (n=632) were heterosexual and very few from other categories (gay/lesbian and bisexual totals similar to those newly presenting). A large number preferred not to say (n=190, 20%) and a 10% (n=94) didn't have their sexuality recorded.

Disability

Disability – new presentations

Drugs – from a total of 469 new presentations in 2017/18, almost three quarters of clients stated no disability, but 21% (n=100) report some kind of disability as seen in the table below. This equates to 23% of males and 14% females reporting a disability.

Table 15 Most common disabilities reported for new drug presentations in 2017/18

Most common disabilities reported by those in treatment for your local authority	Local	Proportion of new presentations	Proportion by gender	
	n		M	F
Behaviour and emotional	58	12%	13%	9%
Mobility and gross motor	25	5%	6%	3%
Learning disability	17	4%	4%	2%
No disability	348	74%	72%	80%
Not stated	19	4%	4%	5%

NB clients may cite disabilities from multiple categories

Source: Drugs and alcohol commissioning support pack 2019-20

Alcohol – from a total of 283 new presentations in 2017/18, 72% reported no disability, while 19% (n=45) stated some kind of disability as seen in the table below. This equates to 19% of males and 20% of females having a disability.

Table 16 Most common disabilities reported for new alcohol presentations in 2017/18

Most common disabilities reported by those in treatment for your local authority	Local	Proportion of new presentations	Proportion by gender	
	n		M	F
		%	%	%
Behaviour and emotional	25	9%	7%	13%
Mobility and gross motor	23	8%	9%	6%
Learning disability	7	2%	3%	1%
No disability	205	72%	71%	76%
Not stated	18	6%	7%	6%

NB clients may cite disabilities from multiple categories

Source: Drugs and alcohol commissioning support pack 2019-20

Disability – using local data

The table below shows self-reported disabilities for all those adults receiving structured treatment between July 2015 and May 2019. Clients are able to report zero or more disabilities, therefore the percentage has been omitted from this data. The majority of clients mention no disability, but out of those who recorded a disability, mental health difficulties and physical disabilities were prevalent.

Table 17 Most commonly cited disabilities for all adults receiving structured treatment

Disability	n
No disability	1583
Mental Health Difficulties	236
Physical Disability	49
Mobility Impairment	47
Literacy Impairment	18
Progressive conditions and physical health	18
Sight Impairment	15
Acquired brain injury	7
Attention deficit hyperactivity disorder (ADHD)	6
Learning Difficulty	6
Dyslexia	5
Hearing Impairment	5

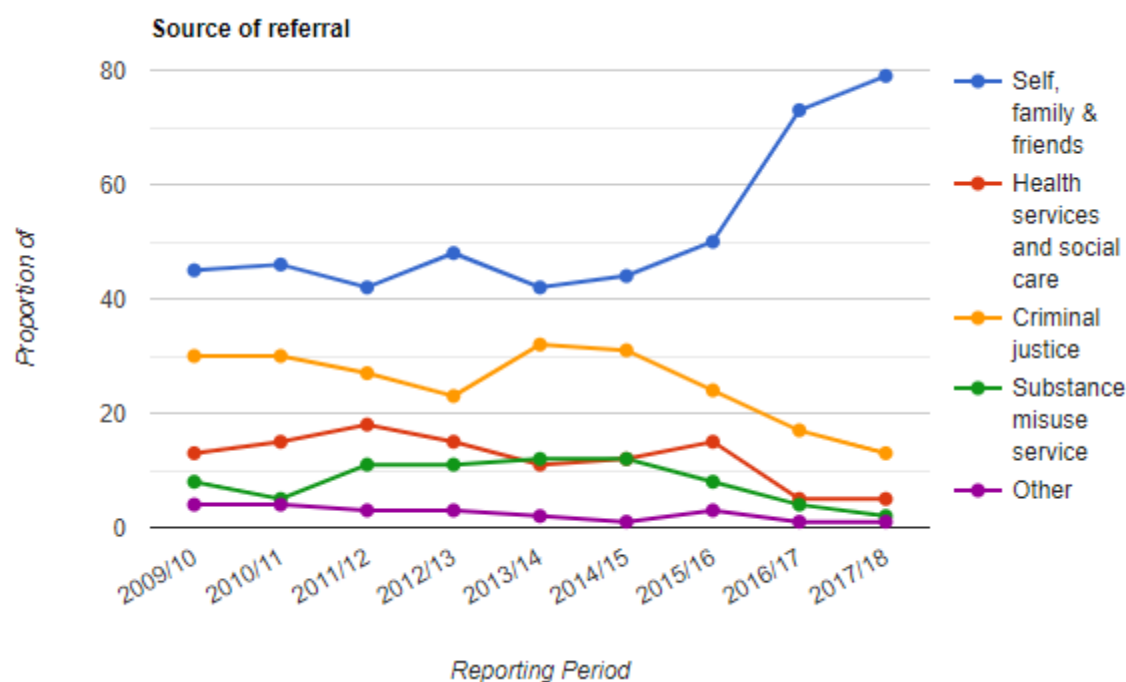
Source: CGL

NB clients may cite disabilities from multiple categories

Source of referral into treatment

The source of referral represents the nature of the service that referred the client into substance misuse treatment or the source which promoted their presentation. The graph below shows the proportion of clients referred by each category, by financial year. A considerable increase can be seen in the proportion of referrals from self, family & friends, while at the same time, there is a reduction in referrals from criminal justice and health and social care services.

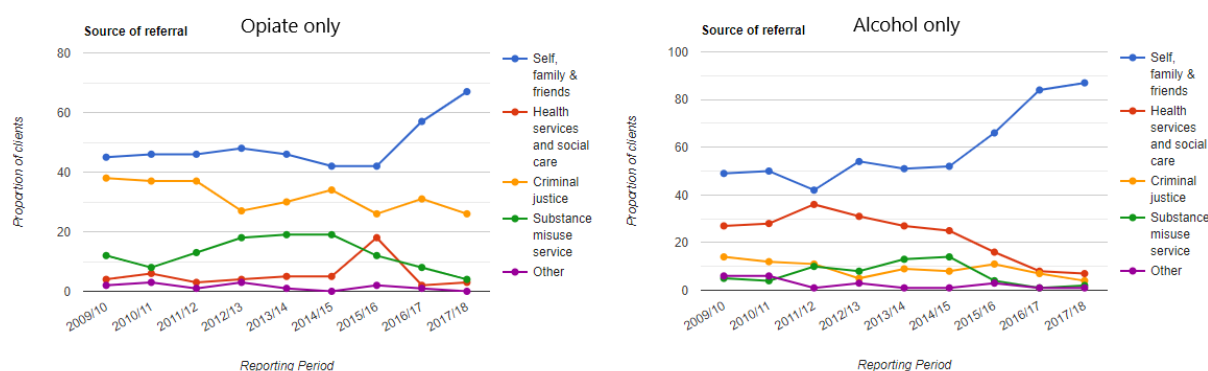
Figure 10 Source of referrals into treatment for new presentations (all substances)



Source: NDTMS View It

The two charts below show referral source trends for opiate and alcohol clients separately. Both opiate and alcohol clients are seeing an increasing trend in self-referrals, while alcohol clients are seeing a reduction in the proportion of referrals from health & social care services (from 36% in 2011/12 to 7% in 2017/18).

Figure 11 Source of referrals into treatment for new presentations (opiate and alcohol)



Source: NDTMS View It

Housing situation

Housing situation represents the (self-reported) housing status of the individuals at the time they presented to treatment. The table below (for all substance categories) shows a slight, gradual increase in those experiencing urgent housing problems; currently at 6% in 2017/18. However, for opiate clients with urgent housing issues, this has increased from 5% (n=17) in 2013/14 to 12% (n=34) in 2017/18.

Table 18 Housing situation for new presentations, as a proportion (all substances)

Housing Situation	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)
No problem	76	80	82	83	85	84	83	87	84
Housing Problem	16	13	13	13	11	11	12	8	10
Urgent Housing Problem	6	4	3	3	3	5	4	6	6
Other	2	3	2	1	1	0	0	0	0

Source: NDTMS View It

Walsall has the same proportion of urgent housing problem clients as the West Midlands (6%) and slightly lower than 8% in England.

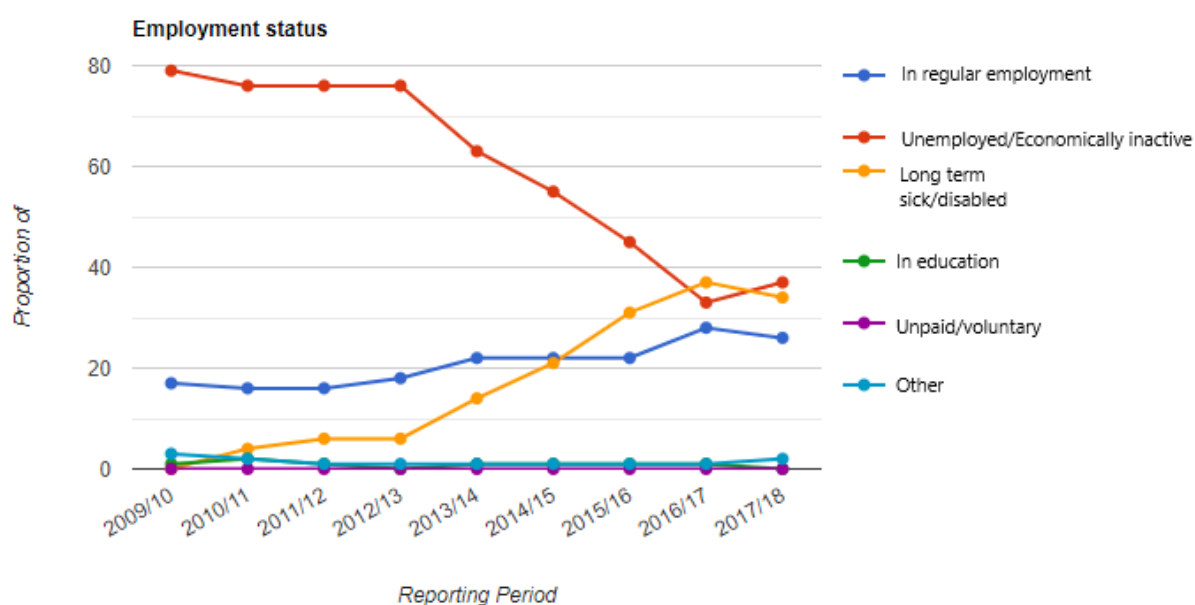
A safe, stable home environment enables people to sustain their recovery. Engaging with local housing and homelessness agencies can help ensure that the full spectrum of homelessness is understood and picked up: from statutorily homeless, single homeless people, rough sleepers to those at risk of homelessness.¹²

Employment status

The graph and table below shows the proportion of self-reported employment statuses as a trend since 2009/10, at the time they presented. While the proportion of unemployed clients has halved since 2012/13, the share of long-term sick/disabled have increased from 6% (n=36) to 34% (n=250) in the same period.

¹² Adult drugs commissioner support pack 2019-20

Figure 12 Employment status for new presentations, as a proportion (all substances)



Employment Status	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)
In regular employment	17	16	16	18	22	22	22	28	26
Unemployed/Economically inactive	79	76	76	76	63	55	45	33	37
Long term sick/disabled	0	4	6	6	14	21	31	37	34
In education	1	2	1	0	1	1	1	1	0
Unpaid/voluntary	0	0	0	0	0	0	0	0	0
Other	3	2	1	1	1	1	1	1	2

Source: NDTMS View It

Parental status and safeguarding

Drug clients

Table 19 below shows the number and proportion of drug users who entered treatment in 2017/18 and their parental status. From the 70 new clients living with children, this involved a total of 137 children living with them. Compared to the national average (34%), Walsall (43%, n=202) has a higher proportion of parents (entering treatment in 2017/18) who don't live with their children.

Table 19 Parental status of new drug clients in 2017/18

Parental status	Local n	Proportion of new presentations	Proportion by gender		National n	Proportion of new presentations	Proportion by gender	
			M	F			M	F
Living with children (own or other)	70	15%	13%	22%	13,626	18%	14%	27%
Parents not living with children	202	43%	43%	43%	25,946	34%	34%	34%
Not a parent/no child contact	197	42%	44%	35%	36,623	48%	51%	38%
Missing / incomplete	0	0%	0%	0%	456	1%	1%	1%
Living with children	Local		Proportion of children by client gender		National		Proportion of children by client gender	
	n		M	F	n		M	F
Number of children living with drug users entering treatment in 2017-18	137		61%	39%	25,205		61%	39%

Source: Drugs commissioning support pack 2019-20

Alcohol clients

Table 20 below shows the number and proportion of new alcohol clients in 2017/18 and it can be seen that Walsall's metrics are very similar to England's proportions. There are 148 children living with clients who entered treatment in 2017/18. Combining both drugs and alcohol clients entering treatment in the year, there are a total of 285 children living with these clients.

Table 20 Parental status of new alcohol clients in 2017/18

Parental status	Local		Proportion by gender		National	Proportion by gender		
	n	Proportion of new presentations	M	F		n	Proportion of new presentations	M
Living with children (own or other)	72	25%	24%	28%	11,967	24%	18%	32%
Parents not living with children	63	22%	25%	17%	12,906	25%	28%	22%
Not a parent/no child contact	148	52%	51%	54%	25,468	50%	53%	46%
Missing / incomplete	0	0%	0%	0%	315	1%	1%	1%

Living with children	Local		Proportion of children by client gender		National	Proportion of children by client gender	
	n		M	F		n	M
Number of children living with alcohol clients entering treatment in 2017-18	148		61%	39%	20,904	49%	51%

Source: Alcohol commissioning support pack 2019-20

Safeguarding status using local data

During the last 4 year (up to May 2019), a total of 958 individual adults are recorded as having received structured treatment (all substance). The safeguarding status of these clients can be seen in the table below, divided into 2 groups i.e. opiate and all other substances¹³. Overall, over a third of clients (n=340, 36%) either currently have safeguarding issues or have done previously. Over a quarter of all opiate clients (n=201, 27%) are identified as having safeguarding issues.

Table 21 Safeguarding status of all adults in treatment between Jul 2015 and May 2019

Safeguarding category	Opiate (n)	All other substance (n)	Total (n)	Opiate (%)	All other substance (%)	Total (%)
No Safeguarding Issues Identified	464	98	562	63%	45%	59%
Previously Safeguarding	66	8	74	9%	4%	8%
Safeguarding Issues Identified	201	65	266	27%	30%	28%
Under Review	8	48	56	1%	22%	6%
Grand Total	739	219	958	100%	100%	100%

Source: CGL

Mental health

Drugs clients

Data in the table below shows there were 199 (42%) drug clients who started treatment in 2017-18 who were identified as having a mental health treatment need. Of those, 140 (70%) were receiving

¹³ These substances include; alcohol only, non-opiate, non-opiate and alcohol

treatment from mental health services, which is comparable to 71% nationally. Comparing prevalence with treatment received can help assess whether need is being met.

Table 22 Mental health of drug clients entering treatment in 2017/18

Adults who entered treatment in 2017-18 and were identified as having a mental health treatment need								
	Local n	Proportion of new presentations	Proportion by gender		National n	Proportion of new presentations	Proportion by gender	
			M	F			M	F
Opiate	111	39%	35%	53%	15,976	39%	36%	47%
Non-opiate	49	46%	46%	44%	6,907	41%	38%	52%
Non-opiate and alcohol	39	49%	47%	52%	8,725	47%	43%	58%
All	199	42%	40%	51%	31,608	41%	38%	51%

Clients identified as having a mental health treatment need and receiving treatment for their mental health									
	Local n	Proportion of clients identified	Proportion by gender		National n	Proportion of clients identified	Proportion by gender		
			M	F			M	F	
Already engaged with the Community Mental Health Team/other mental health services	54	27%	33%	12%	7,273	23%	22%	26%	
Engaged with IAPT (Improving Access to Psychological Therapies)	0	0%	0%	0%	576	2%	2%	2%	
Receiving mental health treatment from GP	86	43%	42%	47%	13,728	43%	42%	45%	
Receiving any NICE-recommended psychosocial or pharmacological intervention provided for the treatment of a mental health problem	0	0%	0%	0%	760	2%	3%	2%	
Has an identified space in a health-based place of safety for mental health crises	0	0%	0%	0%	247	1%	1%	1%	
Total individuals receiving mental health treatment	140	70%	75%	60%	22,325	71%	69%	75%	

Source: Drugs commissioning support pack 2019-20

Alcohol clients

Table 23 below shows there were 138 (49%) alcohol clients who started treatment in 2017-18 who were identified as having a mental health treatment need and, of those, 111 (80%) were receiving treatment from mental health services, compared to 79% nationally. Comparing prevalence with treatment received can help assess whether need is being met.

Table 23 Mental health of alcohol clients entering treatment in 2017/18

Adults who entered treatment in 2017-18 and were identified as having a mental health treatment need								
	Local n	Proportion of new presentations	Proportion by gender		National n	Proportion of new presentations	Proportion by gender	
			M	F			M	F
Client identified a mental health treatment need	138	49%	46%	53%	20,789	41%	38%	46%

Client identified a mental health treatment need and receiving treatment for their mental health									
	Local n	Proportion of clients identified	Proportion by gender		National n	Proportion of clients identified	Proportion by gender		
			M	F			M	F	
Already engaged with the Community Mental Health Team/Other mental health services	34	25%	22%	29%	4,269	21%	20%	21%	
Engaged with IAPT	0	0%	0%	0%	534	3%	2%	3%	
Receiving mental health treatment from GP	78	57%	59%	53%	11,039	53%	52%	55%	
Receiving any NICE-recommended psychosocial or pharmacological intervention provided for the treatment of a mental health problem	0	0%	0%	0%	514	2%	2%	3%	
Has an identified space in a health-based place of safety for mental health crises	0	0%	0%	0%	147	1%	1%	1%	
Total individuals receiving mental health treatment	111	80%	81%	80%	16,321	79%	76%	81%	

Source: Alcohol commissioning support pack 2019-20

Geographic distribution of clients

Using local data from the current service provider, maps of Walsall have been plotted showing which wards have the highest density of service users. They include all adult clients (18+ years) who have received structured treatment in Walsall between July 2015 and 7th May 2019. Many of these clients would have been receiving treatment before July 2015, but this is the referral date recorded after the transition to the new service provider at the time. All clients in the maps are only counted once, even if they re-present. Some clients (n=85) were omitted from the maps as the postcode was either missing or invalid/incomplete.

The maps were created by calculating a crude rate per ward, per 10,000 population. The borough was divided into quartiles, so both maps could be quickly compared. By comparing quartiles 1 and 4 the lowest and highest wards can be identified. To aid identification, wards have been labelled with a letter, which corresponds to the equivalent on the deprivation map previously seen.

Two maps are presented, one showing clients in treatment for all substance types and another showing opiate only clients. As the majority of Walsall's clients are receiving structured treatment for opiate use, it is not possible to create separate maps for alcohol and non-opiate users, due to the relatively low numbers.

Figure 13 Clients residential ward density (all substances)

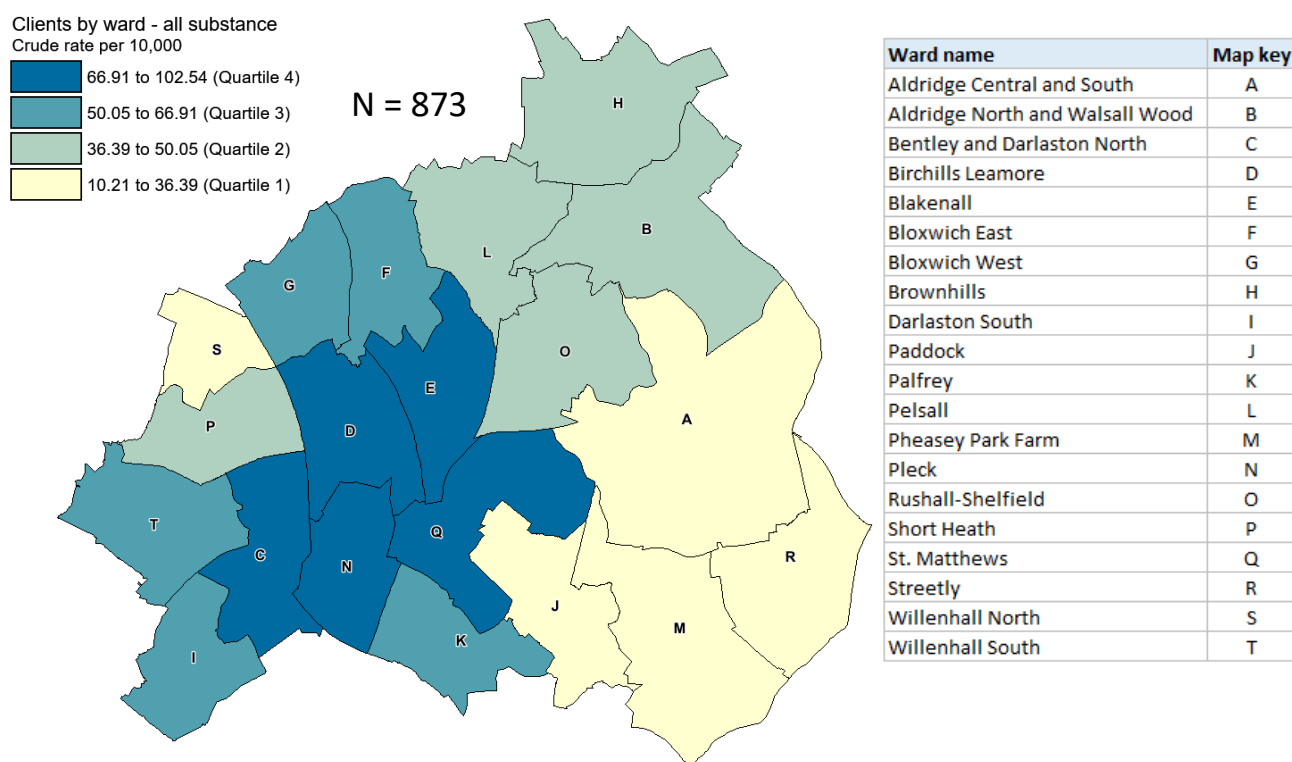
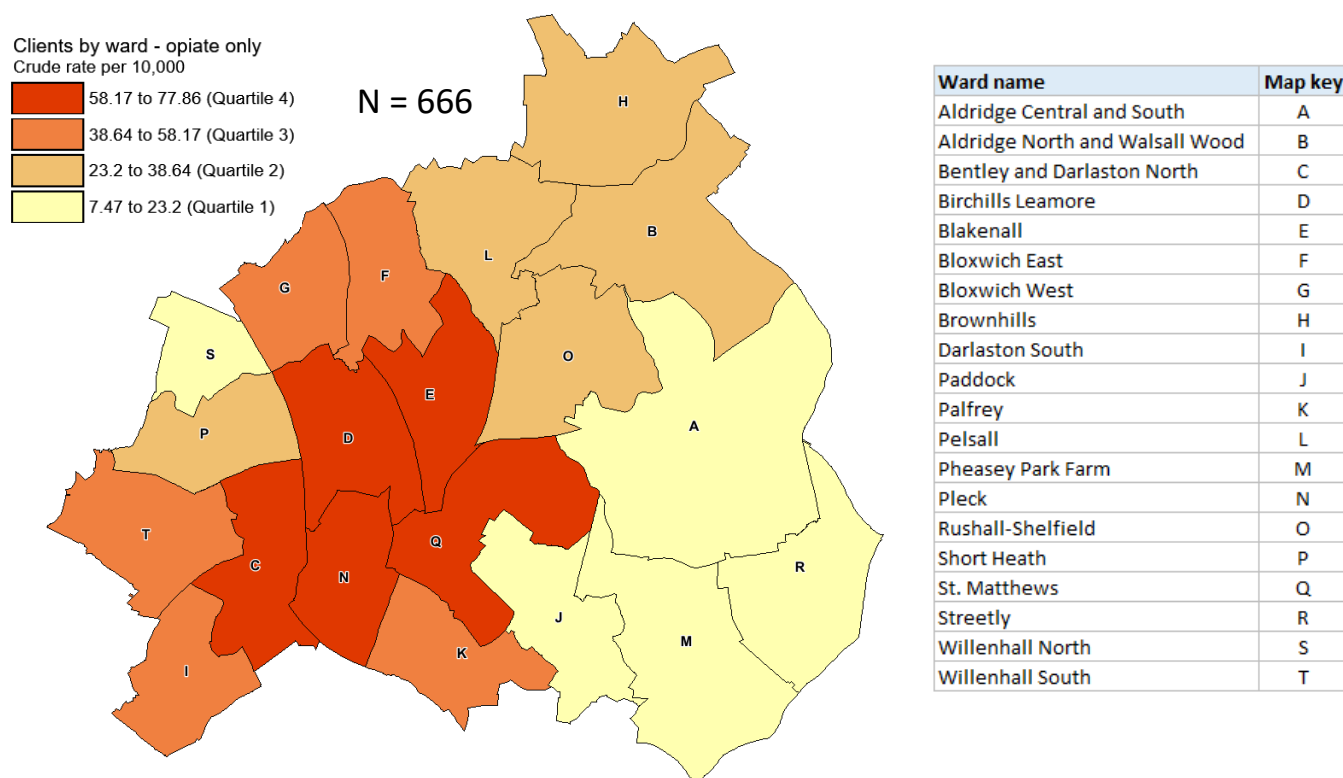


Figure 14 Clients residential ward density (opiate only)



Source: CGL

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Access to services - Waiting times

This represents the number of weeks from referral for an initial treatment intervention to the time when that intervention was available to start. For the last 2 years (2016/17 to 2017/18) Walsall has reached 100% of all clients being seen within a 3 week period. (Source: NDTMS View It). In the last 7 years (since 2011/12), not one client has waited over 6 weeks for the intervention to start.

Treatment and recovery outcomes

Treatment exits

The two tables below show the proportion and numbers of clients who exit treatment, as a trend since 2009/10. These exit reasons categories represent the reason for discharge, given at the point of final exit from a treatment journey (with no further treatment beginning within 3 weeks).

The data shows a considerable increase in the number and proportion of clients dropping out of treatment and this trend can be seen across all 4 substance categories in the tables below. This increase has an unfavourable influence on the successful completion proportion, although the number of clients successfully completing have almost doubled since the reduction in 2015/16. Client deaths will be discussed in a later section.

Table 24 Proportion of clients who exit treatment (all substances)

Treatment Exits	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)
Successful completion	43	63	60	63	62	55	34	42	35
Dropped out/left	33	14	15	18	17	26	38	41	49
Transferred - not in custody	7	10	10	7	9	7	13	6	5
Transferred - in custody	7	9	9	9	10	10	9	10	5
Treatment declined	2	2	3	1	1	1	3	0	3
Died	1	0	1	1	1	1	2	1	2

Table 25 Number of clients who exit treatment (all substance)

Treatment Exits	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Successful completion	310	445	398	419	405	390	159	267	304
Dropped out/left	233	96	98	120	110	185	179	263	418
Transferred - not in custody	53	73	67	44	58	50	61	39	40
Transferred - in custody	53	63	62	59	65	69	44	63	47
Treatment declined	17	13	19	9	7	5	12	*	26
Died	6	*	8	7	5	7	7	6	16

Table 26 Number and proportion of clients who exit treatment in 2017/18 by substance type

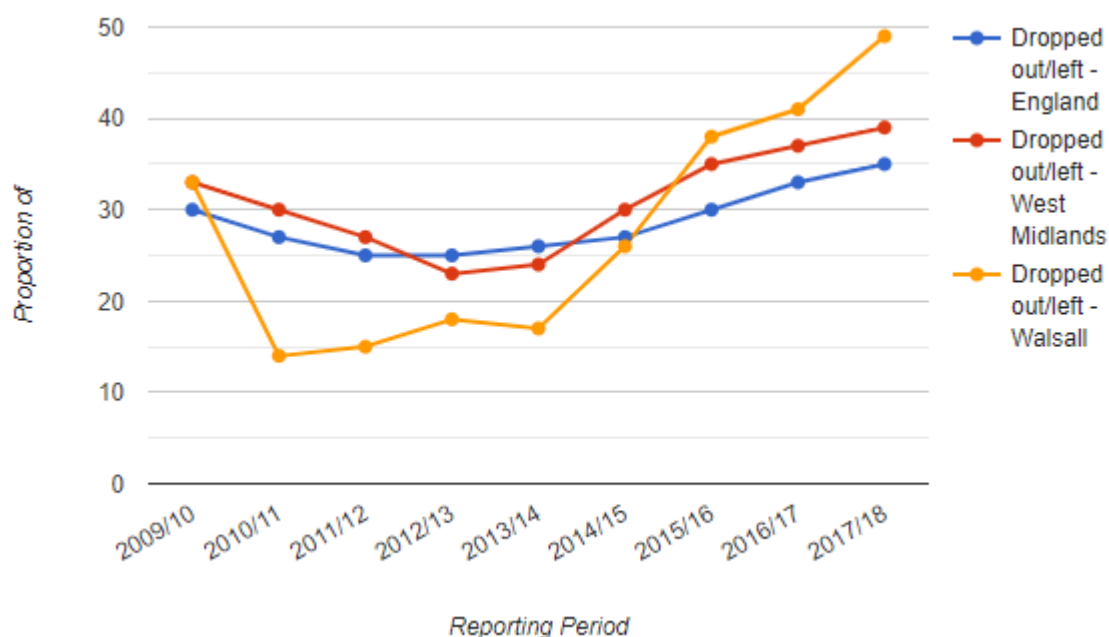
Treatment Exits in 2017/18	Opiate		Non-opiate		Non-opiate & Alcohol		Alcohol only		Total	
	n	%	n	%	n	%	n	%	n	%
Successful completion	62	19.6%	54	46.6%	35	35.7%	153	46.4%	304	35.3%
Dropped out/left	159	50.3%	53	45.7%	50	51.0%	156	47.3%	418	48.6%
Transferred - not in custody	28	8.9%		1.7%		4.1%	6	1.8%	40	4.7%
Transferred - in custody	39	12.3%		1.7%		2.0%		1.2%	47	5.5%
Treatment declined	8	2.5%	5	4.3%	5	5.1%	8	2.4%	26	3.0%
Died	12	3.8%		0.0%		1.0%		0.9%	16	1.9%
Prison	8	2.5%		0.0%		1.0%		0.0%	9	1.0%
Total	316	100.0%	116	100.0%	98	100.0%	330	100.0%	860	100.0%

Source: NDTMS View It

*Value suppressed due to low numbers

Although Walsall's dropout rates have increased in recent years, this does follow a similar trend in the West Midlands region and England, which can be seen below.

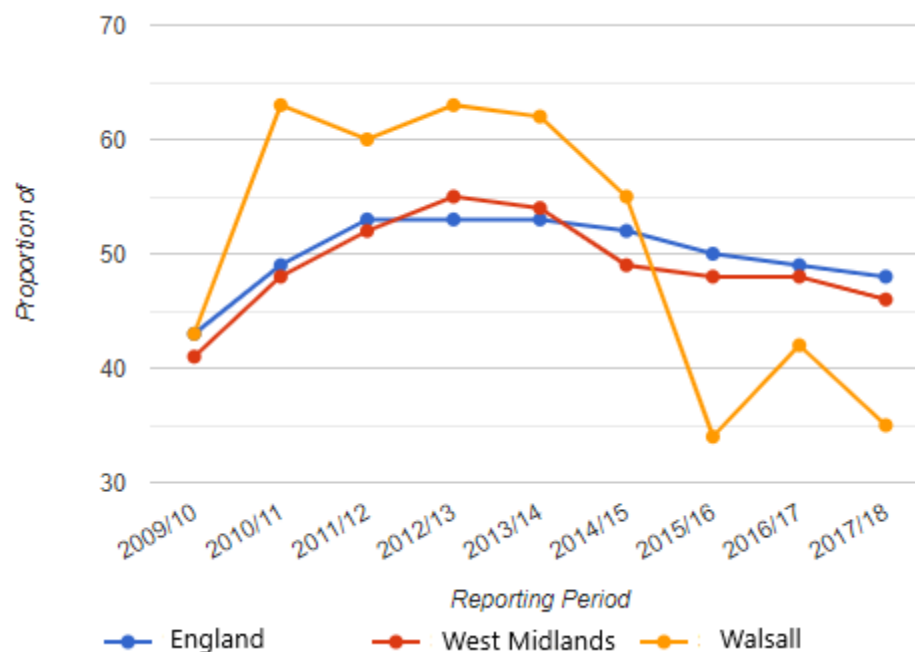
Figure 15 Proportion of clients who dropped out/left (all substance categories)



Source: NDTMS View It

In the six years up to 2014/15, Walsall's successful completions were consistently higher than the West Midlands and England proportions. Between 2014/15 and 2015/16, Walsall's proportion dropped from 55% to 34% and as of 2017/18 is still below the comparators mentioned previously.

Figure 16 Proportion of clients who successfully completed (all substance categories)



Source: NDTMS View It

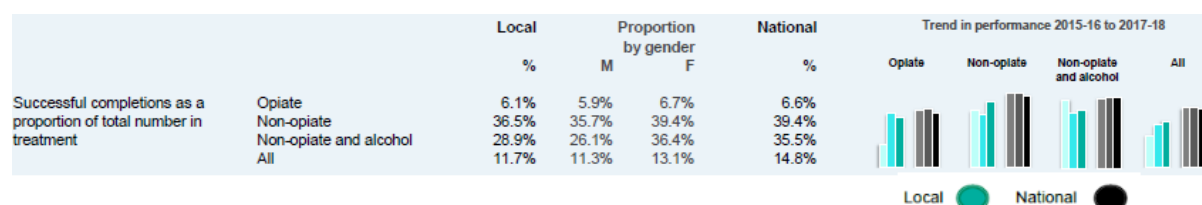
NB the y-axis on the above chart does not start at zero

Successful completions – as proportion of all in treatment

Drugs clients

The tables below show the proportion of drug users who successfully completed their treatment as a proportion of all those in treatment. This shows a positive improvement for all combined drug categories, with opiate completions just below the national average in 2017/18. Interesting to note the gender difference, with female successful completions rates higher than males across all drug categories.

Figure 17 Successful drug completions as a proportion of all in treatment



Source: Drugs commissioning support pack 2019-20 PHE

Alcohol clients

The tables below show the proportion of alcohol users who successfully completed their treatment as a proportion of all those in treatment.

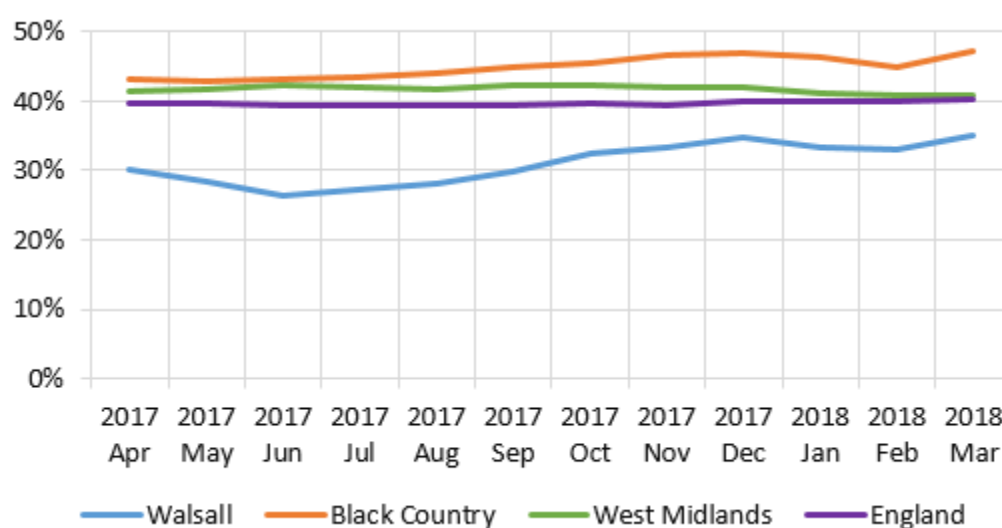
Table 27 Successful alcohol completions as a proportion of all in treatment 2017/18

	Local	Proportion of treatment population	Proportion by gender		National	Proportion of treatment population	Proportion by gender	
	n		M	F	n		M	F
Individuals leaving alcohol treatment successfully in 2017-18	153	34%	35%	34%	30,224	40%	39%	41%

Source: Alcohol commissioning support pack 2019-20 PHE

From the chart below, a clear improvement can be seen for Walsall's alcohol successful completions, increasing from a year low point of 26% in June 2017 to 34.9% in March 2018. While the England average is consistent at 40% throughout the year, the gap with Walsall is narrowing.

Figure 18 Successful alcohol completions as a proportion of all in treatment as a trend



Source: NDTMS adult successful completions and re-presentations reports

Each point on the chart is a rolling 12 months value, with July being an estimate (due to NDTMS data cleansing).

More recent NDTMS data, which are currently restricted, indicate that Walsall's successful completions are improving and are now on par with regional and national averages.

Successful completions and not re-presenting

This details the number of clients that successfully completed their treatment (free of dependence) who do not then re-present to treatment again within 6 months.

Individuals achieving this outcome demonstrate a significant improvement in health and well-being in terms of increased longevity, reduced blood-borne virus transmission, improved parenting skills and improved physical and psychological health.¹⁴

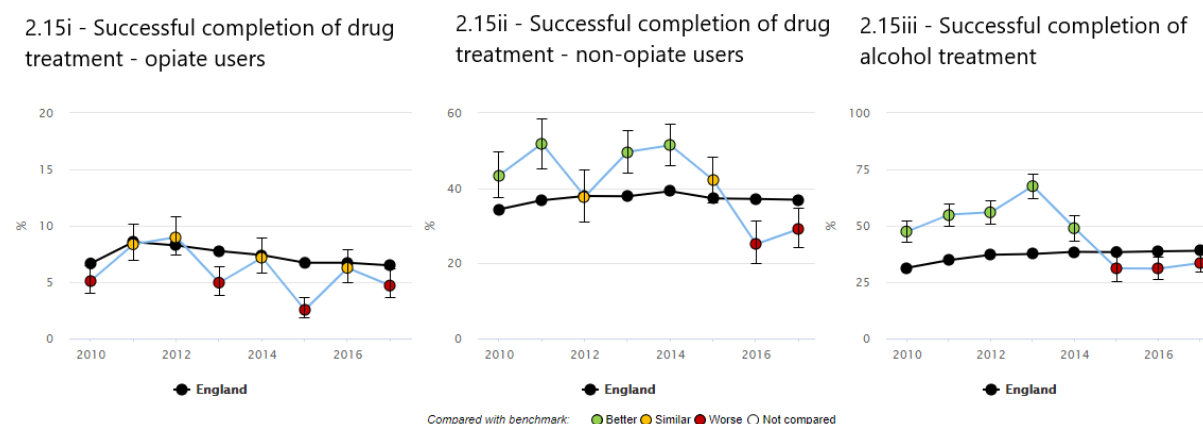
It aligns with the ambition of both public health and the Government's drug strategy of increasing the number of individuals recovering from addiction. It also aligns well with the reducing re-offending outcome [PHE Indicator 1.13] as offending behaviour is closely linked to substance use and it is well demonstrated that cessation of drug use reduces re-offending significantly. This in turn will have benefits to a range of wider services and will address those who cause the most harm in local communities.

The chart below shows that Walsall successful completions are statistically significantly lower than England. Recent trends show opiate successful completions are reducing, but non-opiate and alcohol are improving.

¹⁴ PHE's PHOF indicator rationale

More recent data, which is currently restricted, show that all 3 indicators are improving for Walsall, with opiate and alcohol clients on or near the national benchmark.

Figure 19 PHOF indicators for successful completions 2010 to 2017



Source: PHE Public Health Outcomes Framework¹⁵

Residential Rehabilitation and Detoxification

The treatment service in Walsall offers community based and ambulatory detoxification, where this is clinically possible. In situations where it is not possible, service users are placed in residential in-patient units for detoxification and rehabilitation. There were 49 alcohol detoxification placements in 2017/18, and 2 drug detoxifications. There were 5 placements where detoxification was followed up by an extended programme of rehabilitation.

The trend over the past 5 years has seen an increase in alcohol detoxification, while in-patient referrals for opiate use has remained at a low level. Rehabilitation stays have also declined.

There are local options for in-patient placements at present and this has reduced the number that have had to be placed further afield significantly, in recent years.

Drugs clients

Walsall had 18 adult drug users in 2017/18 who have been to residential rehabilitation during their latest period of treatment¹⁶. This is 1% of the whole treatment population compared to the equivalent 2% when compared nationally. Drug treatment mostly takes place in the community, near to users' families and support networks. Residential rehabilitation may be cost effective for someone who is ready for active change and a higher intensity treatment at any stage of their

¹⁵ <https://fingertips.phe.org.uk/profile/public-health-outcomes-framework>

¹⁶ Drugs commissioning support pack 2019-20 PHE

treatment, and local areas are encouraged to provide this option as part of an integrated recovery-orientated system.

Alcohol clients

There were 22 alcohol clients in 2017/18 who have been to residential rehabilitation during their latest period of treatment¹⁷. This is 5% of the local alcohol treatment population compared to 3% nationally. Structured alcohol treatment mostly takes place in the community, near to users' families and support networks. However, in line with NICE recommendations, a stay in residential rehabilitation is appropriate for the most serious cases, and local areas are encouraged to provide this option as part of an integrated recovery-orientated system.

Health protection & harm reduction

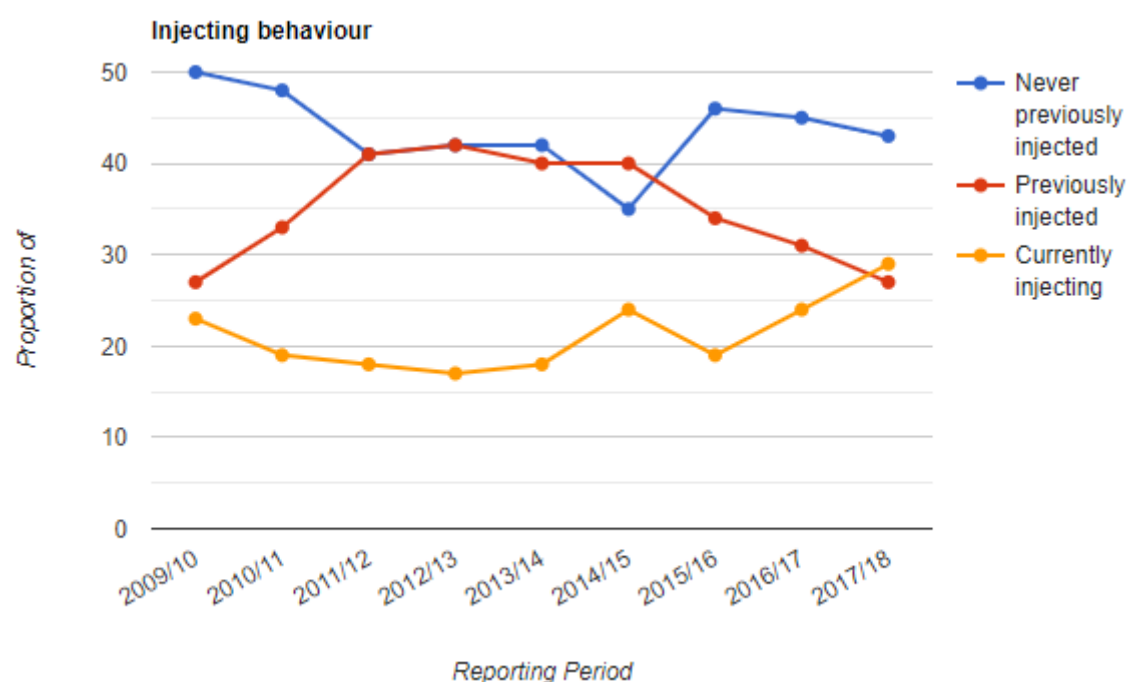
Injecting behaviour

The injecting behaviour at time of presentation, represents whether the client has injected in the last 30 days (categorised as current), previously or never. In 2017/18, three quarters (76%, n=567) of all new presentations (all substance) had never previously injected, 13% (n=95) had previously injected and 12% (n=87) were currently injecting.

The graph and table below shows injecting behaviour trends for opiate only clients in Walsall, as a proportion. There has been a recent increase in the proportion of current injectors, from 19% (n=59) in 2015/16 to 29% (n=83) in 2017/18. This is higher than the West Midlands and England's proportion, both at 26% (opiate current injectors at new presentation).

¹⁷ Alcohol commissioning support pack 2019-20 PHE

Figure 20 Injecting behaviour for new opiate presentations



Injecting Behaviour	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)
Never previously injected	50	48	41	42	42	35	46	45	43
Previously injected	27	33	41	42	40	40	34	31	27
Currently injecting	23	19	18	17	18	24	19	24	29

Source: NDTMS View It

Sharing of injecting equipment is the single biggest factor in blood-borne virus transmission among individuals who use and inject drugs, it also elevates the risk of premature mortality¹⁸.

Blood borne virus status

Sharing injecting equipment can spread blood-borne viruses. Providing opioid substitution treatment (OST), sterile injecting equipment and antiviral treatments protects people who use drugs and communities, and provides long-term health savings. Eliminating hepatitis C as a major public health threat requires the identification and treatment of many more infected people who use drugs. Hepatitis C testing and referral data will vary from area to area depending on local systems and pathways, the availability of test results to providers and where/how hep C treatment is provided, so it needs to be assessed and understood locally more than compared to national figures.

¹⁸ Adult substance misuse statistics from NDTMS 2017-18

Table 28 Blood-borne virus status for new presentations in 2017/18

Hepatitis B	Local	Proportion of eligible clients	Proportion by gender		National	Proportion of eligible clients	Proportion by gender	
	n	27%	M	F	n	37%	M	F
Adults new to treatment in 2017-18 eligible for a HBV vaccination who accepted one	117		27%	27%	18,928		36%	39%
Of those:								
the proportion who started a course of vaccination	15	13%	7%	33%	2,074	11%	11%	11%
the proportion who completed a course of vaccination	13	11%	14%	0%	2,609	14%	14%	12%
Hepatitis C								
Previous or current injectors new to treatment in 2017-18 eligible for a HCV test who received one	125	23%	21%	27%	18,123	20%	21%	20%
Clients who have a positive hep C antibody test	19	3%	3%	3%	3,288	4%	4%	0%
Clients who have a positive hep C PCR (RNA) test	11	2%	3%	0%	2,042	2%	2%	0%
Clients referred to hep C treatment	0	0%	0%	0%	337	0%	0%	0%

Source: Drugs commissioning support pack 2019-20 PHE

Drug related deaths

The definition of a drug misuse death is where either the underlying cause of death is drug abuse/drug dependence or the underlying cause is drug poisoning from any substance controlled under the Misuse of Drugs act 1971¹⁹.

In England and Wales, most drug-related deaths are certified by a coroner following an inquest and cannot be registered until the inquest is completed. This can take months or even years before the death is registered. In line with other mortality statistics, drug-related death figures are based on deaths **registered** in a particular year, rather than those occurring each year. This allows more timely publications, but can make trends difficult to interpret, especially for smaller geographical areas²⁰.

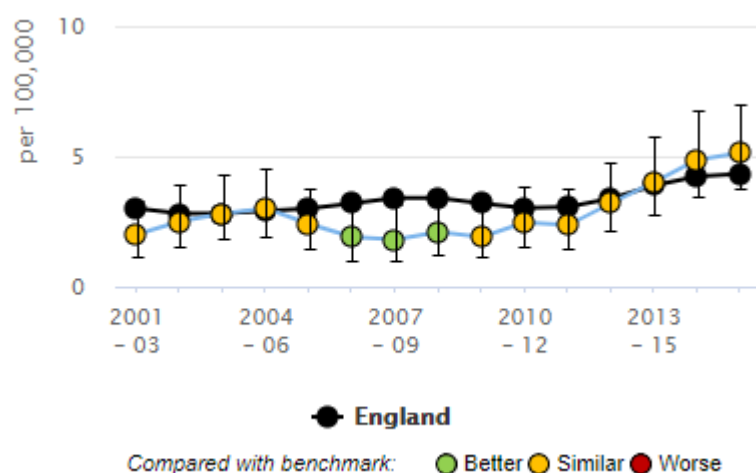
According to the latest ONS report ²⁰, the majority (80%) of drug-related deaths nationally are from accidental poisoning.

Drug-related deaths is included as an indicator within the Public Health Outcomes Framework (PHOF) and Figure 21 below shows how Walsall compared with England between 2001-03 and 2015-17. Walsall has seen an increasing trend since 2011-13 and currently has a rate of 5.1 deaths per 100,000 compared to England's 4.3. Although higher than both the West Midlands and England, Walsall's rate is not statistically significant.

¹⁹ <http://www.legislation.gov.uk/ukpga/1971/38/contents>

²⁰ ONS, Deaths related to drug poisoning in England and Wales: 2017 registrations

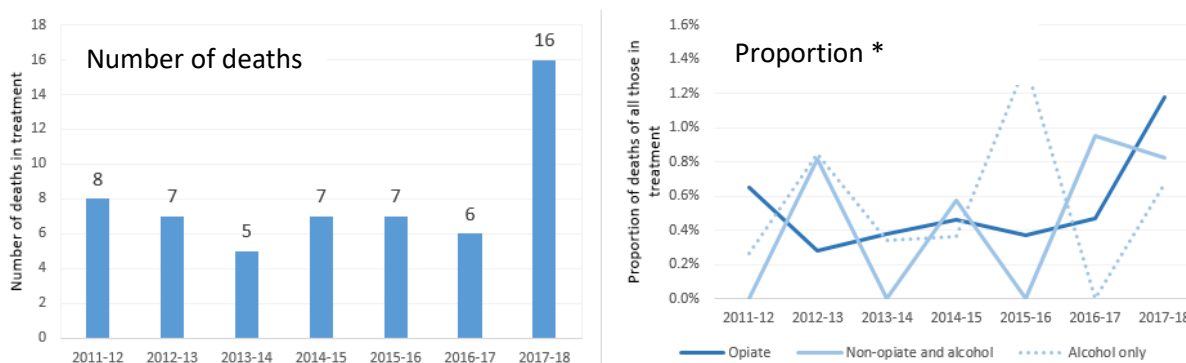
Figure 21 Deaths from drug misuse 2001-03 to 2015-17



Source: PHE PHOF 2.15iv

Figure 22 below shows the increased number of deaths in Walsall for those receiving structured treatment in 2017/18 and it can be seen that this is due to opiate clients. However, as noted previously, although these deaths were registered in the same year, from the data it is not possible to ascertain whether these clients actually died in that year.

Figure 22 Number and proportion of deaths in treatment



Source: NDTMS Local area trend report 2017-18 (showing Walsall's data)

* The non-opiate category has been omitted from 'proportion' figure, as there were no non-opiate deaths during the period.

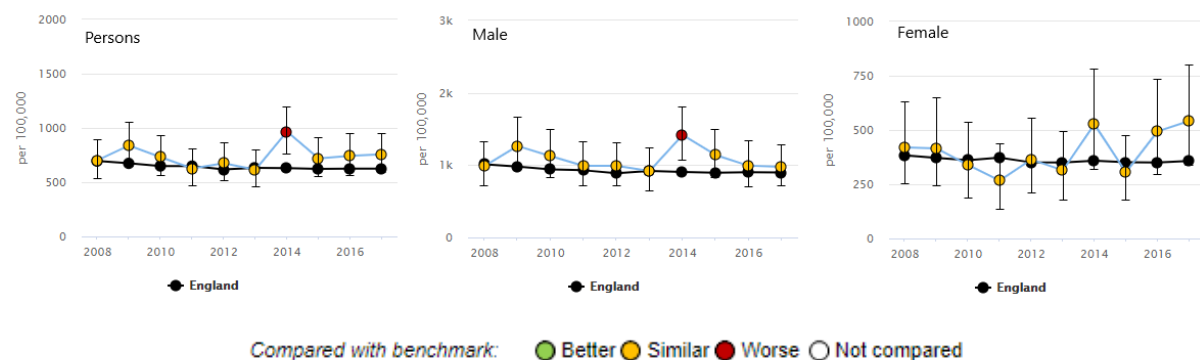
Alcohol-related deaths – years of life lost

In Feb 2017 a new PHE measure '1.02 Years of life lost due to alcohol-related conditions' replaced '1.01 Months of life lost due to alcohol'. The new indicator uses a method which is consistent with other Public Health England indicators based on premature mortality i.e. less than 75 years (such as those in the Public Health Outcomes Framework).²¹

²¹ http://fingertips.phe.org.uk/documents/LAPE_2017_User_Guide_231017.pdf

The charts below show Walsall's years of life lost, as a trend, compared to England. Although there's no significant difference between Walsall and England, there is an interesting gender difference, as there is a reducing trend for males and increasing trend for females. In 2017, the number of males (n=1,165) however is still almost double the number of females (n=641).

Figure 23 Years of life lost due to alcohol-related conditions (2008 to 2017)



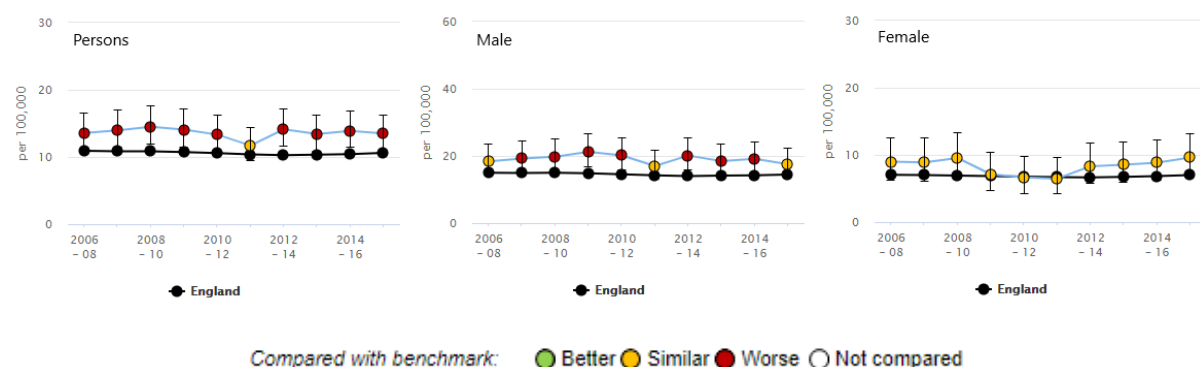
Source: PHE Fingertips – Local Alcohol Profiles for England (LAPE)

NB scale difference on the y-axis.

Alcohol-specific deaths

Alcohol misuse can be directly attributed to deaths from certain types of disease such as alcoholic liver disease, alcoholic gastritis, and excess alcohol blood levels. These are known as wholly-attributable conditions, where deaths are wholly caused by alcohol consumption. The graphs below show that Walsall as a whole have significantly more alcohol-specific deaths than England, but with reducing trend in the male population and increasing female trend (in count and rate).

Figure 24 Alcohol-specific mortality comparing Walsall with England (2006-08 to 2015-17)



Source: PHE Fingertips – Local Alcohol Profiles for England (LAPE)

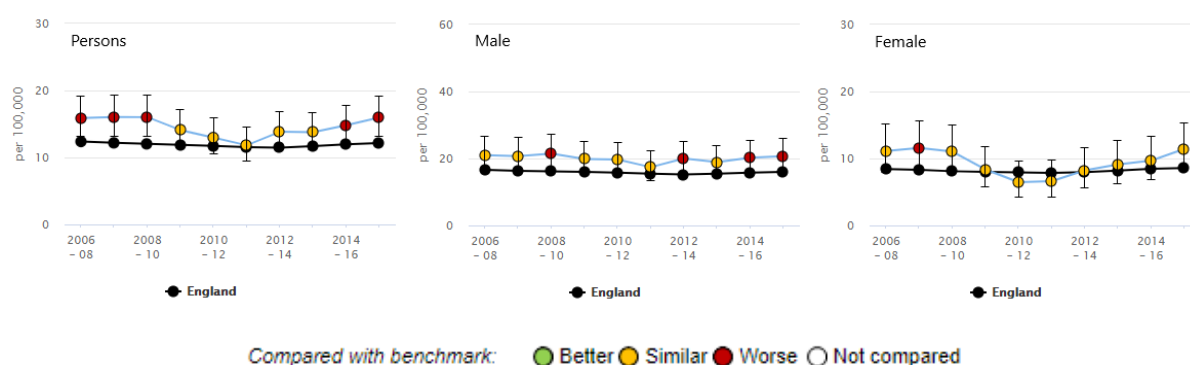
NB the scale difference on the y-axis.

Mortality from chronic liver disease

Liver disease is one of the top causes of death in England and people are dying from it at younger ages.²² Most liver disease is preventable and much is influenced by alcohol consumption and obesity prevalence, which are both amenable to public health interventions.

The graphs below show deaths from chronic liver disease, including cirrhosis, classified by underlying cause of death, registered in the calendar year for all ages. Three years of data are pooled. Walsall as a whole has significantly more deaths compared to England, and the trend is increasing with a widening gap between Walsall and England. As seen with previous indicators, there is a distinct difference between the genders – there is an increasing trend for both genders, but the increase is considerable for females. In the latest period (2015-17), there were 77 male deaths compared with 45 female.

Figure 25 Mortality from chronic liver disease (2006-08 to 2015-17)



Source: PHE Fingertips – Local Alcohol Profiles for England (LAPE)

NB the scale difference on the y-axis.

Alcohol screening – NHS Healthchecks

The NHS Health Check²³ offers advice to help prevent the onset of a vascular disease to eligible people, not currently on a vascular register, aged between 40 and 74. England faces an epidemic of largely preventable non-communicable diseases, such as heart disease, cancer, diabetes and liver disease.

The health check programme aims to promote and improve the early identification and management of individual behavioural and physiological risk factors for vascular disease and the other associated conditions. It also supports individuals to manage and reduce behavioural risks and associated conditions through information and evidence-based clinical interventions.²⁴

²² <https://fingertips.phe.org.uk/profile/local-alcohol-profiles>

²³ <https://www.healthcheck.nhs.uk/>

²⁴ <https://www.gov.uk/government/publications/nhs-health-checks-applying-all-our-health/nhs-health-checks-applying-all-our-health>

During the NHS Health Check, the patient will be asked some simple questions about family history and lifestyle, including alcohol consumption, where the Audit-C or FAST questionnaires are used for initial screening. Advice around alcohol consumption will be provided for those scoring low on the questionnaire, but those with a high score should be offered a referral to substance misuse services in Walsall.

Criminal Justice

The Drug Interventions Programme (DIP) has been in place for over a decade as the UK's main Criminal Justice initiative aimed at engaging substance misusing offenders in drug treatment. It did this through a variety of methods, some coercive, and some relying on voluntary engagement. Class A drug-misusing offenders are identified on their journey through the criminal justice system and steered towards treatment and wraparound support. Key points of intervention include following a positive drugs test in police custody, court appearance, as part of an alcohol or drug treatment condition of a community based sentence and following release from prison.

The landscape has changed with regard to the DIP more recently, with the funding being held by the office of the PCC and allocated at their discretion. In 2018/19 the PCC granted Walsall funding for arrest referral, court, probation and prison liaison services.

There is no guarantee that this funding will be in place after 2019/20, but if it is, our intention is that the service provider will maintain this element of the service.

Young people

Introduction

While the majority of young people do not use drugs, and most of those who do are not dependent, drug and alcohol misuse can have a major impact on young people's health, their education, their families and their long-term chances in life²⁵. It is for these reasons that local authorities are strongly encouraged to continue to invest in substance related service provision across the different levels of need from schools to treating young people's substance misuse.

This chapter provides key performance information about young people (under the age of 18 years) accessing specialist substance misuse interventions in Walsall alongside national data for comparison. The data is taken from the National Drug Treatment Monitoring System (NDTMS)²⁶ which, for young people, reflects specialist treatment activity reported for those with problems around both alcohol and drug misuse.

Evidence suggests that effective specialist substance misuse interventions contribute to improved health and wellbeing, better educational attainment, reductions in the numbers of young people not in education, employment or training (NEET) and reduced risk taking behaviour, such as offending

²⁵ PHE Young people – substance misuse commissioning support pack 2019-20: key data

²⁶ NDTMS Young people quarterly activity report

(Department for Education, 2010)²⁷. The data in this section provides a comprehensive overview of these specialist interventions.

When presenting this data, some categories are omitted due to the low numbers of young people involved. An example is referral sources, where only the top 4 categories are included.

NB Some totals presented here will differ to those in the commissioner support packs. The young people activity report was used as the main data source here (instead of the commissioner support packs), as there was more information available, in a format that allowed trends to be plotted.

Number in treatment

These figures reflect the number of young people in specialist substance misuse services in Walsall during 2015-16, 2016-17 and 2017-18 and also the number of new presentations within those years.

Table 29 Number of young people in treatment

	2015/16	2016/17	2017/18
Numbers in service (12 months)	101	115	123
Number of new presentations in the year	83	59	72

Source: NDTMS Young people quarterly activity report

In addition to young people engaged in structured care planned treatment. The young people's element of the specialist treatment service engage, on average an additional 60-80 young people offering brief, or extended brief interventions that don't meet the threshold for structure interventions but still require support.

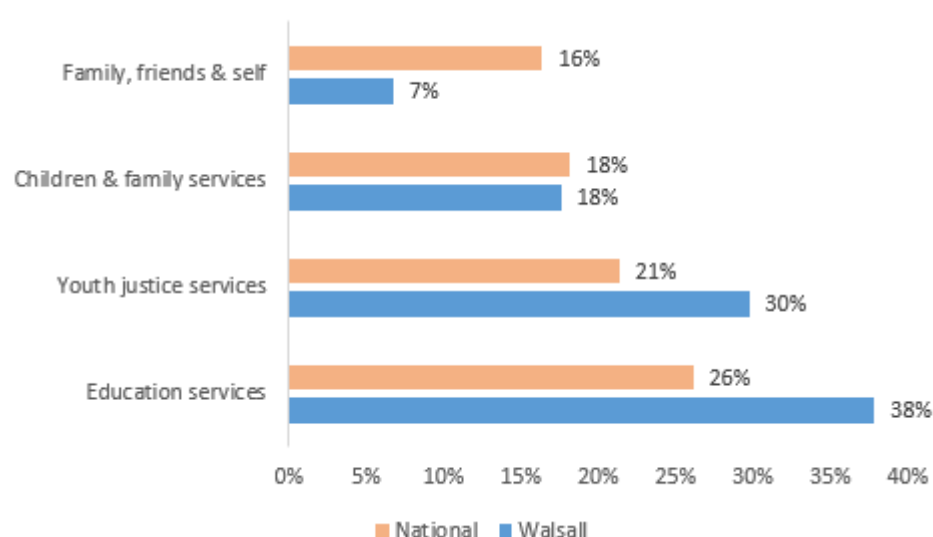
Referral sources (routes into treatment)

Young people come to specialist services from various routes but are typically referred by education, youth justice, children and family services and self, family and friends. Data in the chart and table below show the number and percentage of referrals in each year, for new presentations. As each individual episode is counted, there may be more episodes than new clients due to clients presenting more than once.

Figure 26 below compares the 4 main referral sources during 2017/18, comparing Walsall with England.

²⁷ Department for Education (2010) Specialist drug and alcohol services for young people: a Cost Benefit Analysis. Available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/182312/DFE-RR087.pdf

Figure 26 Young people referral sources in 2017/18



Source: NDTMS Young people quarterly activity report

In Table 30 below, referral source trends can be seen for a 3 year period, comparing Walsall with England. As a proportion, Walsall have more referrals from education services and youth justice service when compared to England.

Table 30 Young people referral sources trends

	Walsall						National		
	2015/16		2016/17		2017/18		2015/16	2016/17	2017/18
	n	%	n	%	n	%	%	%	%
Education services	32	39%	23	38%	28	38%	24%	25%	26%
Youth justice services	20	24%	13	22%	22	30%	26%	24%	21%
Children & family services	16	19%	13	22%	13	18%	18%	18%	18%
Family, friends & self	8	10%	6	10%	5	7%	14%	15%	16%
No referral source recorded	0	0%	0	0%	0	0%	0%	0%	1%

Source: NDTMS Young people quarterly activity report

Vulnerabilities of young people receiving specialist treatment

Many young people receiving specialist interventions for substance misuse have a range of vulnerabilities. Examples of the types of vulnerabilities / risks young people report having at the start of treatment include: not in education, employment or training (NEET), in contact with the youth justice system, experience of domestic abuse and sexual exploitation. Alcohol and drug use, for example, is associated with early sexual initiation and other risky sexual behaviours.

Universal and targeted services have a role to play in building resilience and providing substance misuse advice and support at the earliest opportunity. Specialist services should be provided to those whose use has escalated and/or is causing them harm. There should be effective pathways

between specialist services and children's social care for those young people who are vulnerable and age-appropriate care should be available for all young people in specialist services²⁸.

NB Clients may have more than one vulnerability and may therefore be recorded more than once in the data below.

Substance specific vulnerabilities

Several categories have been removed from the table below due to the low number of clients. Some of the categories which have been removed include injecting, opiate/crack use or being a high alcohol user. Walsall has a higher proportion than England of 'early onset' clients i.e. those who start using the problematic substance under the age of 15 years.

Table 31 Young people substance specific vulnerabilities

	Walsall						National		
	2015/16		2016/17		2017/18		2015/16	2016/17	2017/18
Substance misuse specific vulnerabilities	n	%	n	%	n	%	%	%	%
Early onset	82	64%	43	58%	53	65%	56%	54%	52%
Poly drug user	42	33%	29	39%	24	30%	38%	40%	41%

Source: NDTMS Young people quarterly activity report

Wider vulnerabilities

Several categories have been removed from the table below due to the low number of clients. The categories removed include sexual exploitation, housing problems, being pregnant, or being a child in need.

Table 32 Young people wider vulnerabilities

	Walsall						National		
	2015/16		2016/17		2017/18		2015/16	2016/17	2017/18
	n	%	n	%	n	%	%	%	%
Anti-social behaviour / criminal act	23	17%	21	21%	23	18%	18%	18%	17%
Affected by others' substance misuse	10	7%	13	13%	21	16%	13%	13%	13%
Mental health problem	24	18%	10	10%	17	13%	12%	12%	17%
NEET	14	10%	6	6%	16	12%	12%	12%	12%
Looked after child	9	7%	10	10%	12	9%	7%	6%	6%
Domestic abuse	16	12%	14	14%	12	9%	13%	13%	11%
Self harm	17	12%	8	8%	8	6%	10%	10%	9%
Child protection plan	11	8%	12	12%	6	5%	4%	4%	4%

Source: NDTMS Young people quarterly activity report

From the 17 identified as having a mental health need (in 2017/18), 88% (n=15) were receiving treatment; this compared with 69% nationally.

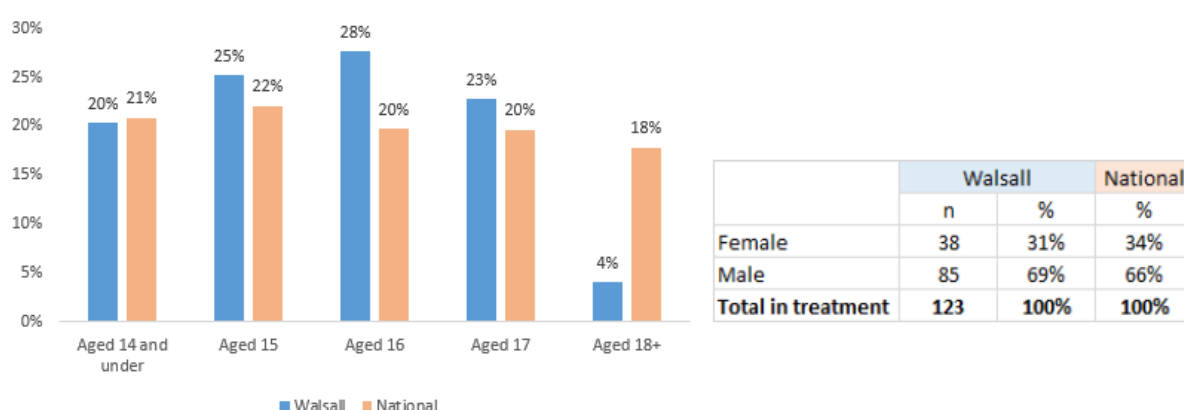
²⁸ PHE Young people – substance misuse commissioning support pack 2019-20: key data

Age of young people receiving specialist treatment

The chart and table below show the ages of those young people receiving specialist treatment in Walsall. Some categories have been grouped together where the numbers are less than 5.

In 2017/18, Walsall had 69% males receiving treatment, compared with 66% nationally.

Figure 27 Age and gender of young people receiving treatment in 2017/18



Source: NDTMS Young people quarterly activity report

Table 33 below shows the number and proportion of clients, by age, as a trend for both Walsall and England.

Table 33 Age of young people receiving treatment - 3 year trend

	Walsall						National		
	2015/16		2016/17		2017/18		2015/16	2016/17	2017/18
	n	%	n	%	n	%	%	%	%
Aged 14 and under	24	24%	26	23%	25	20%	18%	19%	21%
Aged 15	26	26%	22	19%	31	25%	22%	22%	22%
Aged 16	26	26%	34	30%	34	28%	22%	21%	20%
Aged 17	20	20%	28	24%	28	23%	22%	21%	20%
Aged 18+	5	5%	5	4%	5	4%	15%	17%	18%
Total in treatment	101	100%	115	100%	123	100%	100%	100%	100%

Source: NDTMS Young people quarterly activity report

Ethnicity of young people receiving specialist treatment

In 2015/16 and 2016/17 in Walsall, 86% of young people receiving specialist treatment were White British and by 2017/18, this had reduced to 76% (n=93), reflecting an increase in BAME clients.

Education, employment and training

Several categories have been removed from the table below due to low number of clients. The remaining data shows there is a reducing trend in the proportion of those engaged in mainstream or alternative education, an increase in those on an apprenticeship/training scheme, but also an increase in NEETs (Not in employment, education or training).

Table 34 Education, employment and training for young people receiving structured treatment

	Walsall						National		
	2015/16		2016/17		2017/18		2015/16	2016/17	2017/18
	n	%	n	%	n	%	%	%	%
Mainstream education	67	66%	86	75%	65	53%	48%	49%	49%
Not in employment, education or training (NEET)	15	15%	16	14%	22	18%	12%	14%	15%
Alternative education	6	6%	6	5%	21	17%	18%	17%	16%
Apprenticeship / training	6	6%	*	*	11	9%	5%	4%	4%

Source: NDTMS Young people quarterly activity report

*Value suppressed to prevent disclosure

Accommodation status of young people receiving specialist treatment

Many accommodation categories have been removed and values suppressed to prevent disclosure.

Table 35 below shows that Walsall, consistently has a higher proportion of young people living with their parents or other relatives.

Table 35 Accommodation status of young people

	Walsall						National		
	2015/16		2016/17		2017/18		2015/16	2016/17	2017/18
	n	%	n	%	n	%	%	%	%
YP living with parents or other relatives	83	82%	92	80%	101	82%	77%	77%	78%
YP living in care	*	*	11	10%	11	9%	5%	6%	6%
Looked After Child (LAC) living in care	5	5%	5	4%	0	0%	1%	1%	0%

Source: NDTMS Young people quarterly activity report

*Value suppressed to prevent disclosure

Substances cited

Table 36 below presents the substances cited by young people, for any episode in the year (any citation in drug 1, 2 and 3). Individuals may have cited more than one problematic substance, therefore the number of substances may be greater than the number clients in treatment.

The category 'Other substance' includes amphetamines, ecstasy, solvents, opiates, NPS, nicotine and other. These have been grouped together due to the small number of citations.

Table 36 Substances cited by young people receiving structured treatment

	Walsall						National		
	2015/16		2016/17		2017/18		2015/16	2016/17	2017/18
	n	%	n	%	n	%	%	%	%
Cannabis	89	57%	107	62%	109	61%	45%	45%	45%
Alcohol	44	28%	47	27%	44	25%	26%	26%	25%
Other substances	18	11%	13	8%	15	8%	24%	23%	23%
Cocaine	6	4%	5	3%	10	6%	5%	6%	7%
Crack	0	0%	0	0%	0	0%	1%	1%	1%

Source: NDTMS Young people quarterly activity report

Length of time in treatment and interventions

This shows the time young people in Walsall spent receiving specialist interventions (latest contact). Young people generally spend less time in specialist interventions than adults because their substance misuse is not as entrenched. However, those with complex care needs often require support for longer²⁹.

Young people have better outcomes when they receive a range of interventions as part of their package of care. If a pharmacological intervention is required, it should always be delivered alongside appropriate psychosocial support. Psychosocial interventions are a range of talking therapies designed to encourage behaviour change.

In Table 37 below, time in treatment data for Walsall in 2015/16 has been omitted due to small numbers and the possibility of disclosure.

Table 37 Length of time in treatment for young people

	Walsall				National		
	2016/17		2017/18		2015/16	2016/17	2017/18
Average treatment length (in weeks)	28		29		27	25	24
	n	%	n	%	%	%	%
0-12 weeks	20	17%	37	30%	38%	39%	39%
13-26 weeks	38	33%	45	37%	32%	31%	32%
27-52 weeks	44	38%	32	26%	20%	20%	20%
52 weeks+	13	11%	9	7%	10%	9%	9%
Total	115	100%	123	100%	100%	100%	100%

Source: NDTMS Young people quarterly activity report

In Table 38 below, the pharmacological interventions have been omitted, as there were zero for Walsall and very few nationally (less than 200 per year, which is a very low percentage). The psychosocial interventions include family interventions and harm reduction as well as other specific

²⁹ PHE Young people – substance misuse commissioning support pack 2019-20: key data

psychosocial intervention types.

Table 38 Interventions delivered to young people

	Walsall						National		
	2015/16		2016/17		2017/18		2015/16	2016/17	2017/18
	n	%	n	%	n	%	%	%	%
Psychosocial	86	59%	92	69%	90	41%	45%	44%	43%
YP harm reduction	35	24%	31	23%	84	39%	28%	28%	28%
YP multi agency working	24	17%	10	7%	43	20%	25%	27%	28%
Total	145	100%	133	100%	217	100%	100%	100%	100%

Source: NDTMS Young people quarterly activity report

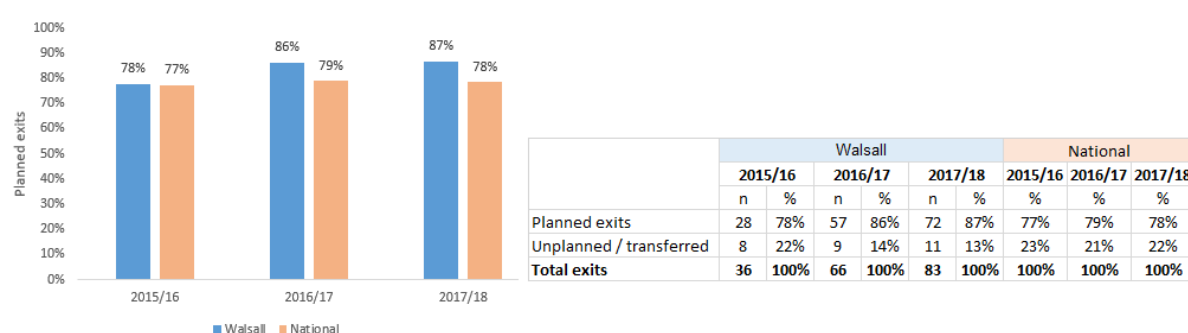
All structured interventions occur within the community setting.

Exiting services and re-presentations

This section shows the number of young people who have left specialist interventions successfully and the proportion that return to treatment, commonly referred to as re-presentations. Young people's circumstances can change, as does their ability to cope. If they re-present to treatment, this is not necessarily a failure and they should be rapidly re-assessed to inform a new care plan that addresses all their problems.

The data may help with monitoring the effectiveness of specialist interventions e.g. a high re-presentations rate may suggest room for improvement.

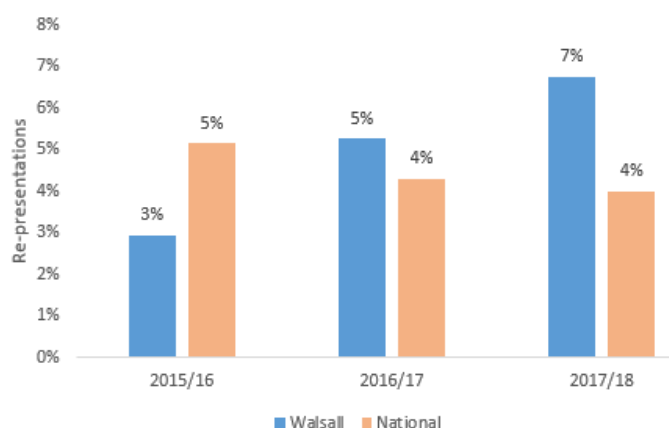
Figure 28 Young people planned exits



Source: NDTMS Young people quarterly activity report

Figure 29 below shows the percentage of young people leaving the substance misuse service in a planned way who re-present to a young people or adult specialist services within 6 months.

Figure 29 Planned exits with re-presentations for young people



NB Although Walsall's re-presentations in 2017/18 are 7%, compared with England's 4%, this constitutes only 5 young people.

Source: NDTMS Young people quarterly activity report

Young People data from local provider

As much of the data provided by NDTMS in their commissioner packs only includes those entering treatment in a particular year, data obtained from the local provider for over a 4 year period can provide additional insight. Between October 2014 and March 2019, the local service provider has identified 280 individuals who have accessed structured treatment for all substance types. A brief summary of the key data items can be seen below. Note that many of these data are self-reported by the young person themselves.

Young People care status

From the 280 young people over the 4 year period, 40 (14%) were looked after (LAC) and 20 (7%) were a child in need (CiN). These cohorts are mutually exclusive.

There are 34 (12%) young people subject to a Child Protection Plan (CPP). Those subject to a CPP may also be recorded as LAC or CiN.

Domestic abuse

Almost a fifth of young people (n=54, 19.3%) have been affected by domestic abuse at some point. There are currently 8 (3%) young people affected by domestic abuse.

Mental health

A total of 50 young people cited mental health problems, which is 18% of the cohort.

Sexual exploitation

Almost 6% (n=16) young people mentioned they were being sexually exploited at the start of their treatment journey, while 15 people stated this was currently happening. The young people in these two groups are not necessarily the same.

Self-harm and suicide

Over 15% (n=43) of young people admitted to previous episodes of self-harm, while 14% (n=39) stated that this was a current issue.

Ten young people (3.6%) have previously attempted suicide.

Sexual behaviour

Almost 15% (n=41) have admitted to have been engaged in unsafe sex.

STI screening

From a total of 280 young people, it was appropriate to offer STI screening to 226. Of these, almost a third accepted (n=65, 29%).

Hospital admissions – Alcohol

Introduction

Reducing harmful drinking is one of seven priority areas that Public Health England is focusing efforts on securing improvement. Alcohol misuse is the biggest risk factor for death, ill-health and disability among 15-49 year olds in the UK, and the fifth biggest risk factor across all ages. Alcohol is a causal factor in more than 60 medical conditions, including: mouth, throat, stomach, liver and breast cancers, high blood pressure, cirrhosis of the liver, and depression.³⁰

Definitions

Alcohol-related hospital admissions are used as a way of understanding the impact of alcohol on the health of a population.

Since 2014, PHE have reported alcohol-related hospital admissions using the two indicators of narrow and broad. These indicators provide a more comprehensive picture of the contribution of alcohol to ill-health. The technical details relating to these indicators can be found on the 'Public health matters' blog.³¹

In general, the Broad measure gives an indication of the full impact of alcohol on hospital admissions and the burden placed on the NHS. The Narrow measure estimates the number of hospital admissions which are primarily due to alcohol consumption and provides the best indication of trends in alcohol-related hospital admissions. This narrow measure is also part of the Public Health Outcomes Framework, indicator 2.18.

³⁰ PHE local alcohol profiles for England <https://fingertips.phe.org.uk/profile/local-alcohol-profiles>

³¹ <https://publichealthmatters.blog.gov.uk/2014/01/15/understanding-alcohol-related-hospital-admissions/>

PHE Fingertips present indicators in their Local Alcohol Profiles for England³² and definitions for these are shown below.³³

Wholly attributable / Alcohol specific: these are conditions known to be solely caused by alcohol consumption.

Partially attributable: these are conditions where it is known that a proportion of the cases are caused by alcohol consumption; examples are circulatory disease and certain cancers.

Alcohol specific: admissions to hospital where the primary diagnosis or any of the secondary diagnoses are an alcohol-specific (wholly attributable) condition code only.

Alcohol-related - Narrow definition: a measure of hospital admissions where the primary diagnosis (main reason for admission) is an alcohol-related condition; this represents a narrower measure; since every hospital admission must have a primary diagnosis it is less sensitive to coding practices but may also understate the part alcohol plays in the admission.

Alcohol-related - Broad definition: a measure of hospital admissions where either the primary diagnosis (main reason for admission) or one of the secondary (contributory) diagnoses is an alcohol-related condition; this represents a Broad measure of alcohol-related admissions but is sensitive to changes in coding practice over time.

NB In May 2017, alcohol admissions reporting methodology was amended. Previously, admissions had been expressed as the number of people being admitted, but now shows the number of admissions. This means that an individual may be counted more than once per year.³⁴

Key indicators

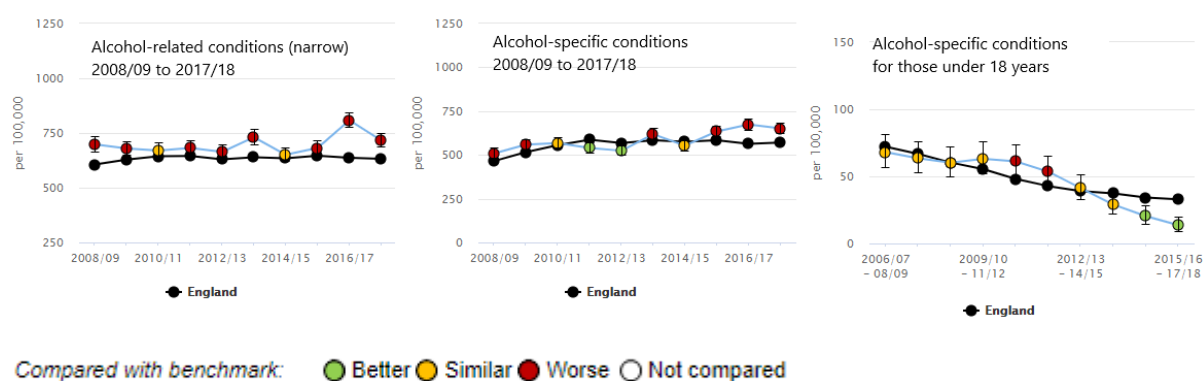
The following charts show Walsall hospital admission trends compared with England. Although nationally, both narrow and specific admissions are relatively stable, Walsall is showing a gradual increasing trend, which is statistically significantly higher than England. On the other hand, for those aged under 18, there is a reducing trend for alcohol specific conditions. Walsall's rate is significantly lower than England, with the gap widening considerably. In the latest 3 year period 2015/16 to 2017/18, only 27 under 18's were admitted to hospital with alcohol specific conditions. This is the lowest number in over a decade.

³² <https://fingertips.phe.org.uk/profile/local-alcohol-profiles>

³³ <https://www.gov.uk/government/publications/local-alcohol-profiles-for-england-february-2019-data-update/local-alcohol-profiles-for-england-short-statistical-commentary-february-2019>

³⁴ http://fingertips.phe.org.uk/documents/LAPE_2017_User_Guide_231017.pdf

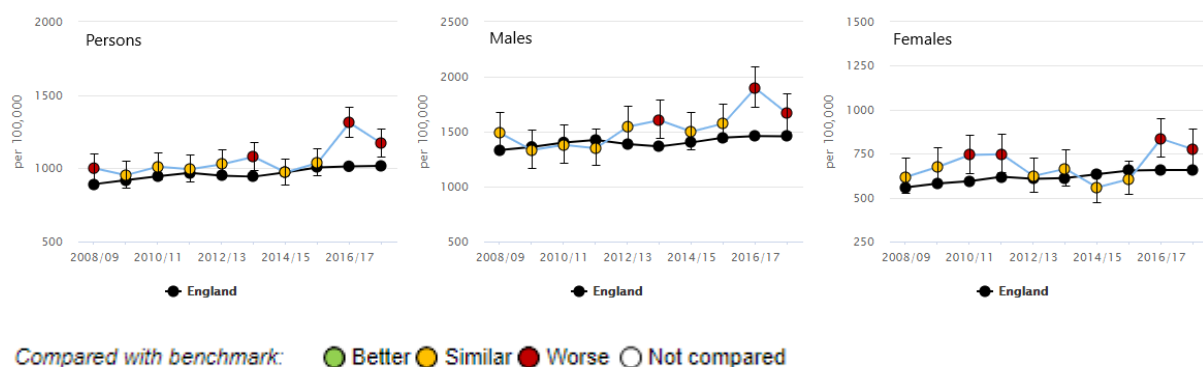
Figure 30 Alcohol hospital admissions - Walsall trend with England benchmark



Source: PHE Fingertips – Local Alcohol Profiles for England (LAPE)

PHE's data also provides further detail for alcohol-related (narrow) admissions, by categorising people by age-group, which are under 40s, 40-64 and over 65s. For all age-groups, Walsall has significantly higher admissions than England, with the most problematic group being the over 65's. Figure 31 below highlights that although the male rate is around double that of the females, there is an increasing trend in female admissions.

Figure 31 Admissions for alcohol-related conditions (narrow) for over 65's (2008/09 to 2017/18)



Source: PHE Fingertips – Local Alcohol Profiles for England (LAPE)

NB the y-axis starts at different numbers in the above.

Abbreviations and definitions

BAME	Black, Asian and Minority Ethnic
CGL	Change, Grow, Live
CiN	Child in Need
CJIT	Criminal Justice Intervention Team
CPP	Child Protection Plan
IBA	Identification and Brief Advice
IMD	Index of Multiple Deprivation
LAC	Looked After Child
LAPE	Local Alcohol Profiles for England
LJMU	Liverpool John Moores University
MHCLG	Ministry of Housing, Communities and Local Government
NB	Note well
NEET	Not in education, employment or training
NICE	National Institute for Health and Care Excellence
NPS	New Psychoactive Substances
OCU	Opiate and/or crack use
OST	Opioid Substitution Treatment
PHOF	Public Health Outcomes Framework
RX	Prescription
TCDO	Temporary Class Drug Order

Data sources, caveats and comments

Data sources

The main sources of data to support this needs assessment include:

- OCU prevalence estimates, from Liverpool John Moores University
- Alcohol prevalence estimates, from the University of Sheffield
- National Drug Treatment Monitoring System (NDTMS) – national statistics for substance misuse treatment.
- Public Health England (PHE) – reports and online data repository called Fingertips.
- Change, Grow, Live (CGL) – local treatment data from The Beacon recovery services.

Comments regarding NDTMS data

Many data items collected by the substance misuse service are self-reported e.g. employment, injecting status, housing status.

NB: the number of new presentations in 2017/18 differ slightly between two systems as follows.

Document or system	Drugs	Alcohol	Total
PHE Commissioner support packs	469	283	752
NDTMS View It	451	274	725

The latest data available which can be shared with the public is for those clients receiving structured drug or alcohol treatment in 2017/18. The restricted status of these data were lifted on the 1st November 2018.

Graphs and Charts

Many plots in the 'Prevalence estimates' section were created using the R programming language:

R Core Team (2019). R: A language and environment for statistical computing. R Foundation for Statistical Computing, Vienna, Austria. URL <https://www.R-project.org/>

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