

## **Sandwell Adult Drug Treatment Needs Assessment Summary 2008/9**

### **Prevalence estimates:**

- According to the latest 2006/7 estimates there are 2,147 problematic drug users in Sandwell (heroin and/or crack)– a small decrease from the initial estimate sweep – accounting for 1.2% of the population aged 15-64.
- The local rate of PDUs per 1,000 population at 11.55 is higher than regional or national rates meaning more of our population are affected by opiate/crack use.
- Estimates suggest significant opiate use and as such a relatively smaller proportion of sole crack users (often used alongside opiates as evidenced from increasing proportion of those entering treatment with a secondary drug of crack).
- Sandwell has a higher rate of younger PDUs (aged 15-24) than regionally or nationally and as such a need to further engage such a population into treatment services alongside strengthened ties and robust transitional pathways from children to adult services.
- Treatment statistics show an under-representation of non-White clients in treatment – in particular those Indian, Pakistani and Black Caribbean. Mid year estimates also suggest an underrepresentation of ‘White Other’ accessing treatment.

### **Treatment Penetration:**

- There are still approximately 1,000 PDUs locally who are not accessing treatment services/ treatment naïve.
- In order to understand those client groups not accessing treatment, bullseye data is useful to determine key target groups in need of more active engagement – namely males, 15-24 year olds and BME clients.
- Sandwell has the lowest penetration levels of PDUs receiving effective treatment regionally (40% compared to regional average of 47%). Effective treatment = clients receiving treatment 12 weeks+ / or who have completed treatment.
- In terms of effective treatment (12 weeks+/treatment complete), younger clients and those never injectors show lower levels of effective retention than other groups – indicates a need to expand modalities offered for those non-injecting users through Tier 2 services.
- Effective treatment penetration levels of crack users are higher than regional or national levels seen – however this is most likely accounted for by the high proportion of secondary crack users (often alongside heroin use) seen in treatment. Previous crack needs analysis suggests a higher proportion of primary crack users locally than is seen from treatment statistics who may only access services if they see services as being relevant for crack cocaine dependency. This suggests a need to place psycho-social interventions at the heart of our treatment service in order to address the perception of treatment services as a methadone only service.

### **Treatment Map Summary:**

- Treatment map data shows the flow of client groups into, through and out of the treatment system. ‘Self’ and criminal justice services are the main referral sources for clients into structured Tier 3 services showing a need for Tier 2 services to ‘widen’ out referral routes through increased partner wide pathways, outreach and community based work.
- 87% of those in structured treatment 2007/8 were at Anchor – showing an overreliance on one provider with very few onward referrals to other structured treatment providers - again, an area where Tier 2 service will impact and where ‘widening out’ of the treatment system via shared care will help such flows.

- A decrease in the proportion of younger clients entering the treatment system from 43% in 2006/7 to 30% in 2007/8 as well as a loss in the proportion of 18-24s through every stage in the treatment map. Linked to this may be the increase seen in younger users showing up at hospital with a drug related admission but who are not accessing structured treatment – a key area for referrals to increase penetration levels for this under-represented group.
- Main drug of opiates still account for nearly 9/10ths of all new presentation into treatment – this is at odds with ‘front end’ criminal justice data which shows an increasing proportion of crack, cocaine and cannabis users along with a corresponding decrease in heroin users – again a need to address the range of treatment modalities available and the accessibility of treatment in light of increasing stimulant use seen.
- A higher proportion of males and BME clients are leaving the treatment system with an unplanned exit – need to focus on client satisfaction with service received and user involvement in care planning for increased ‘ownership’ of the treatment journey in order to address increasing levels of ‘drop out’ discharges seen.

#### **‘In Treatment’ Analysis:**

- Specialist prescribing accounted for over two-thirds of modalities received during 2007/8. National user satisfaction survey found that those receiving substitute methadone were significantly less likely to be satisfied with treatment than those who received no substitute medication. This may reflect the desire for abstinence based modalities to be made available especially considering that 4 in 5 heroin users wanted to stop using completely as did 3/4s of crack and cocaine users.
- 75% of treatment journeys that commenced during 2007/8 lasted for 12 weeks or more (lower than regional or national levels) – the most numerous discharge reasons for those not retained were ‘prison’ and ‘drop out’. The lack of joined up data systems at a national level means an inability to capture continuous care received from CARATs– something only the NTA can address. Local user consultation suggested non-drug help in areas such as housing, employment, benefits, finance and parenting as something which could help improve retention – a holistic approach the ‘one stop shop’ concept Metro Court aims to deliver.
- The increasing proportion of clients who are ‘dropping out’ of treatment may reflect the current lack of a Tier 2 service to deliver motivational and preparatory work for users who may not be ‘ready’ for structured treatment and therefore more likely to drop out.
- NI40 has a challenging target set of a 13% increase in the number of PDUs effectively retained – repeat presentations towards the end of the financial year could slow growth in progress against this seen already. Also the ‘bedding in’ period of the newly commissioned open access service and reconfiguration of/ integration into the existing treatment system combined with a move of all treatment provision to the new Metro Court premises could well impact adversely on projected numbers of new presentations to treatment and could exacerbate retention issues.
- Inclusion of ‘treatment complete’ whether before or after 12 weeks as a successful outcome for NI40 increases local scope to offer shorter term interventions and so opens up recognition of work with stimulant users – a currently under-represented group accessing treatment.
- Where retention /effective engagement is often used as the yardstick of effective treatment this tends to overlook the issue of relapse and rate of return i.e. that we are seeing the same clients presenting to treatment again and again. Approximately half of those clients who left treatment during 2006/7 returned to receive another episode of treatment the following year. Provision of support for clients leaving care and relapse prevention are therefore necessary to deliver long lasting outcomes for clients.

**Treatment Outcome Profiles:**

- Overall TOP data is showing good progress in terms of increasing completion levels however the biggest challenge which remains is around review TOPs (also a challenge seen across most DAATs nationally).

**Hospital Episode Statistics:**

- Overall number of drug related hospital admissions has increased year on year since 2003/4.
- In terms of benchmarking, Sandwell does not have an above national or regional rate of primary or secondary drug related mental health & behavioural disorders per 100,000 population but does have a higher than regional rate of primary diagnosis of poisonings by drugs per 100,000 population.
- Trends in the type of drug related admissions locally show a greater increase in mental and behavioural disorders due to the use of opioids and due to the use of cannabinoids and a greater increase in poisonings by narcotics/ psychodysleptics (excludes inebriation).
- Only 25% of those with a drug related hospital admission were accessing structured treatment. In particular, those NOT accessing treatment tend to be younger which questions treatment accessibility for those younger users as well as targeted harm reduction for an age group more likely to be using drugs in an experimental manner as evidenced by the younger age profile for those 'T' codes (poisoning by narcotics/psychodysleptics) and therefore indicative of more acute episodes as opposed to those F11 codes (mental and behavioural disorders due to use of opioids) indicative of longer term/ dual diagnosis needs and characterised by an older age group (predominantly 25-34 age range).
- Caution must be given to ethnicity data fields associated with hospital episode statistics (50% of all records were either 'null' or 'not stated') however of those hospital episode records with an ethnicity status recorded, 0% of Black, Mixed or Other ethnic groups were also accessing structured treatment – in comparison to 21% of White clients and 19% of Asian clients. Again this compounds earlier treatment and bullseye data findings in raising questions about the accessibility of treatment services for BME clients.

**Criminal Justice:**

- An increasing proportion of crack, cocaine and cannabis use evidenced from criminal justice data.
- Extending the range of treatment modalities available would not only help to increase treatment penetration of those stimulant users seen but would also help to increase the proportion of probation clients who could be recommended for a DRR. DRRs are currently only recommended on the basis that an appropriate treatment is available (currently 25-30% of those probation clients scoring above the threshold for drug use are recommended for a DRR) – whilst also increasing the volume of DRR starts.
- Drug test data shows that in 2007/8, for the first time, the number of positive tests for crack/cocaine has overtaken the number of positive tests for opiates.
- 18–24 year olds were more likely to test positive for crack/cocaine than for opiates which may indicate younger people are moving towards stimulants as drug of choice.
- Asian and Black Caribbean cohort were less likely to test positive than dual heritage and white cohorts. The proportion of the Black Caribbean cohort testing positive for crack/cocaine was higher than any other ethnic group.
- 72% of those assessed by DIP workers were classed as PDUs (30% of whom were not daily users) – highlighting a need for interventions to prevent use from escalating

further for such clients. Alcohol use was more prevalent amongst non-PDUs which has implications for targeted harm reduction messages.

- Average age of first use for PDUs was 21 years and 18 for non-PDUs. This may highlight a need for drugs education/awareness campaigns to be continued at local colleges beyond primary and secondary school ages.

#### **Employment/Training/Education:**

- Of those clients in treatment during 2007/8 with an employment status recorded, 83% were unemployed and a further 1% economically inactive. TOPs data also shows lower levels of clients in employment than regionally or nationally. Locally 2.3% of IB/SDA claimants cited a drug and alcohol condition compared to 3% regionally and 3.5% nationally – suggesting more accessible welfare/benefits advice for those accessing treatment – something the one stop shop Metro concept aims to deliver.
- Parental status and accommodation status has an impact on employment status of clients in treatment – clients with no dependent children and clients in stable housing were more likely to be in regular employment than those clients with a housing problem. This suggests support for non-drug issues in order to increase successful outcomes for clients.
- Strengthened links with JobCentre+ are necessary in order to increase treatment penetration and to engage those treatment naïve clients.
- Non-PDUs were more likely to be in employment than those PDUs – therefore need to ensure appropriate accessibility of treatment services (e.g. out of office hours opening) in light of increasing stimulant use seen.

#### **Needle Exchange/Harm Reduction:**

- An increase in the proportion of current and previous injectors into treatment since last year suggests an increasing need for prompt and effective harm reduction services. PDU estimates suggest only half of those currently injecting drug users with immediate harm reduction needs are accessing structured treatment. The current lack of a specialist needle exchange service is a key delivery gap at present to be addressed through the newly commissioned Tier 2 service.
- Local estimates of Hepatitis C prevalence for 2005/6 place Sandwell into a 'High' prevalence band – i.e. that HCV prevalence is higher than 50%. Over two-thirds of those new presentations into treatment year to date 2008/9 were offered a Hep C test – work to understand why clients are not offered/fail to have an intervention status recorded is to be addressed through the local Harm Reduction Working Group. Applying national infection prevalence rates to the estimated currently injecting PDU population suggests half of those potentially infected currently injecting PDUs have received a Hepatitis C test.
- Nationally 2/3rds of IDUs accessing structured treatment received a Hepatitis B vaccination – similar to the 63% take up rate seen locally. However in terms of overall PDU estimates this would mean approximately 3/4s of currently injecting PDUs are yet to be vaccinated (PDU estimate of IDUs against the total numbers vaccinated via structured treatment).
- Local drug related deaths data shows a high incidence of alcohol in combination with drugs cited in cause of death – local overdose awareness training to address the use of alcohol together with drugs (e.g. cocaethylene) as well as safer practices is essential to this end.