PUBLIC HEALTH BIRMINGHAM

Drugs & Alcohol

NEEDS ASSESSMENT

2013 / 2014

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"We exist to help reduce the harm caused by drugs & alcohol in order to improve well-being. To achieve this we use co-ordination, collaboration and pooled resources to invest in proven and effective services, activities, education and support. Our activities will improve health and well-being, economic standing, community safety and criminal justice for individuals, families and communities across Birmingham".

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1.0 Executive Summary

1.1 Synopsis

Drug Action Teams were established by the Government in 1995 to ensure the strategic co-ordination of local action on drug misuse. In 2012, the Birmingham Drug & Alcohol Action Team (BDAAT) was incorporated into Public Health England with a view to transfer to the management of Birmingham City Council in April 2013. This Needs Assessment is a report that presents an evaluation to substance misuse stakeholders across Birmingham and forms an important component in the service commissioning process. It provides an indication of current performance levels against benchmarks and offers recommendations for improvements or alternative strategies.

The document follows the guidance of the Drug Strategy 2010 [1] which "sets out the Government's approach to tackling drugs and addressing alcohol dependence, both of which are key causes of societal harm, including crime, family breakdown and poverty". There are three main themes to this strategy: reducing demand, restricting supply and building recovery in communities. The Government's Alcohol Strategy [2] is also reflected with the requirements for alcohol-related issues to be tackled locally and individuals are challenged to "change their behaviour" by receiving information and support. The Birmingham Health and Wellbeing Strategy [3] is also considered. This sets out key priorities that will deliver better health and wellbeing for residents of Birmingham, especially children and vulnerable adults, to live long lives.

The Needs Assessment is informed by various data sources including the National Drug Treatment Monitoring System (NDTMS) and the Birmingham Drug Interventions Programme (DIP) PALBASE database. The Needs Assessment has been designed to reflect proposals to restructure the current adult treatment model – to streamline pathways into a more client-centric treatment and support provision across specific geographical areas throughout Birmingham. It focuses on the diverse needs of Birmingham communities and considers the changing trends and market forces related to substance misuse.

1.2 Key Findings

Drug Treatment

- For Birmingham, in the 15 to 64 age group it is estimated that there are 10,263 opiate/crack users (OCUs), of which 9,128 are opiate users and 6,926 are crack users. This represents an increase of 570 OCUs (6%) since the prevalence estimation of 2009-10. Opiate users have increased by 476 (5%) and crack users by 333 (5%). 1,735 users are estimated to be injecting – a fall of 158 (8%).
- Non-OCU drug is also continuing to rise. It is estimated that there are in Birmingham 48,495 Cannabis users, 15,462 Powder Cocaine users, 9,840 Ecstasy Users, 5,623 Amyl nitrate users, 5,623 amphetamine users, 7,731 Methedrone users and 4,217 ketamine users.
- The number of clients in drug treatment during 2011-12 was 6,257. 5,171 (83%) were opiates – which was a fall of 7% from the previous year – This is despite an increase in the opiate prevalence. 1,086 were non-opiates (17%) – which was an increase of 1% from 2010-11.
- A typical drug treatment client is a white British male, aged between 26 and 35 who uses opiates. He lives near the city centre of Birmingham and is unemployed. He has been in treatment between 1 and two years.
- The number of mandatory drug tests conducted by West Midlands Police has fallen considerably due to cost-saving measures introduced in July 2012. In 2011, 9,033 tests were conducted in custody with 2,613 tests (29%) positive. In 2012, 6,367 tests were conducted with 2,071 (36%) positive. It was thought that these changes may affect the numbers entering drug treatment. However, Drug Interventions Programme data analysis shows that virtually the same amount of assessments was conducted each year (1,961 in 2011, 1,986 in 2012).

- Crime has fallen over the last 12 months. March 2011 – April 2012 saw over 19,000 fewer victims of crime across the West Midlands area. However, 26% of Birmingham offenders re-offend and this figure rises to 70% for Priority and Prolific Offenders (PPO) upon prison release.
- Drug treatment has prevented an estimated 79,000 offences from being committed last year in Birmingham. This has provided an estimated £38.9m benefit to the city.
- Treatment services across Birmingham are commissioned to support mainly heroin and crack addicts yet non-OCU clients are increasing – particularly alcohol clients. Whether this is a data recording issue needs to be investigated.
- Service pathways are complicated and confusing, resulting in high attrition rates which infers the need to integrate treatment services and provide a more seamless service.
- Most treatment agencies have clients from more than 20 different wards in Birmingham, implying that large numbers of clients are travelling outside not only their ward but also their constituency area in order to obtain drug treatment.
- Over the last two years, 10,435 clients have entered drug treatment in Birmingham. As of January 2013, there were 4,723 individuals in drug treatment in Birmingham.
- The wards with the most clients currently in drug treatment are Ladywood (224), Shard End (224), Lozells (193), Soho (189) and Sparkbrook (168). These 5 wards account for over 20% of the total 'in treatment' population. 7 of the Birmingham wards with the highest numbers in treatment are in the top 12 deprived ward areas.
- Although the numbers of drugs users from BME communities continues to increase, treatment services still have proportionally higher numbers of white drug users in treatment. When comparing the Birmingham population ethnicity statistics, there is a +9% white cohort compared to -14% Asian cohort and -5% Black cohort.
- 49% (2,321) of the current numbers in structured treatment are unemployed. 38% (1,788) have not stated their employment status.
- The Needle Exchange Programme database, NEO, has indicated that there are over 6,500 registered individuals across Birmingham who are injecting. Although the prevalence estimates suggest that there are 1,735 OCU injectors in Birmingham, there have been 946 client episodes in treatment over the last two years which stated they were currently injecting. Also in the last 2 years, 2,410 client episodes stated that they had previously injected.
- Although NEO indicates that the majority of subscribers to the Needle Exchange Programme may be steroid users, anecdotal evidence from drugs workers suggest that 1/10 needles are used for steroids while the remainder are used for drugs.
- The population of Birmingham is projected to increase by 150,000 over the next fifteen years. Future strategies need to take this into consideration.
- On average 8% of opiates clients and 43% of non-opiates clients complete their treatment.
- 20% of opiates clients and 6% of non-opiates re-present to treatment services within 12 months
- The median length of time in treatment for an opiate user is between two and three years and under 1 year for a non-opiate client
- An opiate user in treatment has been using the drugs for an average 12-15 years.
- A third of the opiates cohort has never engaged in treatment previously.
- A fifth of all clients in treatment are considered to have a 'very high' complexity banding.
- Within the last two years, 38 clients died whilst receiving drug treatment and 35 adults died whilst receiving alcohol treatment
- The Institution of Public Care consultation has highlighted that "drug use is changing into a more complex and frequently shifting pattern with new drugs including 'legal highs', cannabis as a much more significant issue, and use of alcohol problematically within wider drug use".

Alcohol Treatment

- NICE guidelines inform that the most effective way of reducing alcohol related harm is by making alcohol less affordable as well as making it less available in terms of the number of outlets selling alcohol in a given area and the days and hours when it can be sold. Although the Government had proposed a minimum cost per unit of alcohol, this has been sidelined.

- In 2012, Birmingham launched a 4-year alcohol strategy to tackle the health and social problems caused by alcohol misuse. Research shows that 25% of men and 17% of women in the city are drinking above safe limits.
- It is estimated that there 117,000 hazardous/increasing risk drinkers; 39,000 harmful / high risk drinkers and 22,000 dependent drinkers in Birmingham.
- At peak times, up to 70 per cent of all admissions to accident and emergency departments in Birmingham are related to alcohol. During 2010/11, an estimated 14,385 people in Birmingham had 22,887 alcohol-attributable admissions. Of these, 4,205 people had admissions specifically due to alcohol.
- When comparing 2011 national hospital admissions figures, the rates per 100,000 population are significantly higher for Birmingham. Alcohol-attributable admissions for males in Birmingham are 1,833/100k compared to 1,485/100k nationally (+23%). Alcohol-attributable admissions for females in Birmingham are 950/100k compared to 846/100k nationally (+12%). Alcohol-specific admissions for males in Birmingham are 647/100k compared to 451/100k nationally (+43%). Alcohol-specific admissions for females in Birmingham fared slightly better with 223/100k compared to 225/100k nationally (-0.9%).
- 3,600 incidents of domestic violence (around a third) are linked to alcohol misuse;
- Up to 170,000 working days are lost through alcohol-related absence, costing the city's economy about £30 million each year.
- In 2012, 2,742 adults were engaged in alcohol treatment in Birmingham (2.5% of the National total). As of December 2012, 1,258 were still in treatment.
- A typical alcohol services client is a white British male, aged between 36 and 55. He lives outside the inner city areas of Birmingham city centre and is seeking work. He has been in treatment for less than 1 year.
- There are high concentrations of alcohol clients in the Weoley, Shard End, Northfield and Moseley wards of Birmingham. Each ward has an average of 36 alcohol services clients in treatment.
- 36% of clients in alcohol treatment services in Birmingham have no fixed abode or have not stated an address.

1.3 Priorities & Recommendations

In 2008, Birmingham City Council published its vision of the future. Entitled "Birmingham 2026", Cllr Mike Whitby outlined the City's plan to "make Birmingham the best place to live, learn, work and visit – a global city". BCC have adopted four key principles to govern the delivery of this strategy:

1) Prevention – redirecting energies and resources into working with communities to stop problems developing and to reduce dependency
2) Targeting – protecting and nurturing vulnerable people and tackling disadvantaged communities in the city.
3) Personalisation – ensuring services are tailored to people's needs
4) Sustainable Development – improving quality of life and sustainable economy within environmental limits.

Over the last few years, the commissioning of services by Birmingham Drug & Alcohol Action Team needed to adhere to the principles of the Birmingham Local Area Agreement "Working Together for a Better Birmingham", which contained key priorities to be addressed in order to achieve the ambitions and vision that are set out in "Birmingham 2026": and specifically the following objectives:

- Reduce inequalities in health and mortality across Birmingham and support more people to choose healthy lifestyles and improve their wellbeing
- Increase employment and reduce poverty across all communities through targeted interventions to support people from welfare into work
- Improve Birmingham's neighbourhoods, particularly the least affluent ones, in terms of deprivation, service delivery and overall quality of life for residents
- Tackle serious acquisitive crime, and increase public and investor confidence in neighbourhoods by dealing with local crime, disorder and antisocial behaviour and securing cleaner, greener and safer neighbourhoods and public spaces
- Reduce re-offending through the improved management of offenders and effective treatment of drug and alcohol using offenders

- Improve opportunities for service users going through and sustaining recovery through the delivery of better value services, cost efficiencies and the development of knowledge about how more effective cross working delivers better services.

The Birmingham Health and Wellbeing Board launched their strategy in January 2013. The priorities of this strategy fall into the following domains:

- Improve the health and wellbeing of our most vulnerable adults and children in need
- Improve the resilience of our health and care system
- Improve the health and wellbeing of our children

The BHWB has indicated that transformation policies will be adopted to manage resources and communications with all partner organisations regarding the consequences of disinvestment will be of paramount importance. The Board's focus on safeguarding reflects national issues raised through recent Ofsted reports. All of the domains will reflect the following themes:

- The strategy needs to target the most vulnerable individuals and communities.
- Prevention needs to be stressed as does early intervention
- Early identification and optimal treatment of disease is important
- Independence and personal responsibility needs to be encouraged in all communities
- People need to be able to choose healthy lifestyles and in environments that support these choices
- Services need to be joining up resources to deliver tangible results

With these considerations, the following recommendations have been forwarded:

1) A comprehensive Drug and Alcohol Strategy needs to be completed for Birmingham
2) The prevalence of alcohol misuse and the prison population is an area which requires further integration.
3) Drug and Alcohol service providers are still utilising different assessment forms despite the introduction of the Birmingham Assessment Form (BAF). This causes unnecessary duplication and may deter clients from accessing treatment. This also prohibits data sharing, research and risk assessments.
4) Harm reduction and maintenance has been the focus within treatment services for many years. Since the publication of the Government's 2010 drug strategy, the focus on recovery still needs to be adopted throughout the Birmingham treatment system. This could be achieved by using existing NDTMS tools.
5) Park House opened in July 2010 and demand has outstripped capacity. There are a number of non commissioned religious organisations across the City that can increase bed space capacity for in-patient services.
6) Data collection / quality needs to improve – particularly information relating to recovery, outcome monitoring and non-treatment interventions.
7) A single case management system that is used by all service providers across Birmingham would maximise staff efficiencies, reduce bureaucracy and enhance client engagement.
8) Outreach programmes should be co-ordinated between service providers to maximise contact with hard-to-reach communities
9) Care co-ordination could be improved by having a single organisation managing client pathways into treatment and recovery.
10) A classification system should be introduced to measure the complex needs of the client and offer personal choice of service. This segmentation process would also identify specific groups (e.g. dependent drinkers, injectors, etc.). This would also assist in any payment by results initiatives.
11) Treatment services should focus on clients with the most complex needs.
12) Specialist services should engage with mainstream treatment providers to encourage engagements and successful completions in treatment.
13) Targets should be introduced that are shared between providers rather than being directed to individual agencies. This would encourage referrals between agencies and provide a better service to clients.
14) Safeguarding policies need to be uniformly adopted across all providers.

2.0 Birmingham Profile

2.1 Demographics

The city of Birmingham has a diverse population of 1,029,000 individuals, of whom approximately 504,000 are male and 525,000 are female. This equates to 49% and 51% respectively. Birmingham has a relatively youthful population. Nearly 46% of residents are younger than 30, compared with the England average of 38%.The city has a large BME population with one in three residents being from an ethnic minority. The largest ethnic group in the city are Pakistani accounting for 10% of the city's population.

The number of migrants moving to Birmingham has been particularly high over the last decade, largely due to the expansion of the European Union which has resulted in large numbers of economic migrants coming to the city for work. Numbers have been declining in recent years however, since the peak in 2006/07.

Population projections suggest that Birmingham's population is expected to grow by more than 150,000 between 2008 and 2028. Over this time Birmingham's young age profile will see the working age population grow at nearly twice the national rate, whereas the number of older people in Birmingham will grow by less than half the national average. This means that Birmingham will have an advantage in people of prime working age that will persist for some time. In 2029 the proportion of people in England who will be aged 50 or more will be 40%. However, in Birmingham this proportion will have only risen to 29%.

Source: Local Economic Assessment for Birmingham 2011 (BCC)

Projected population change in Birmingham to 2028

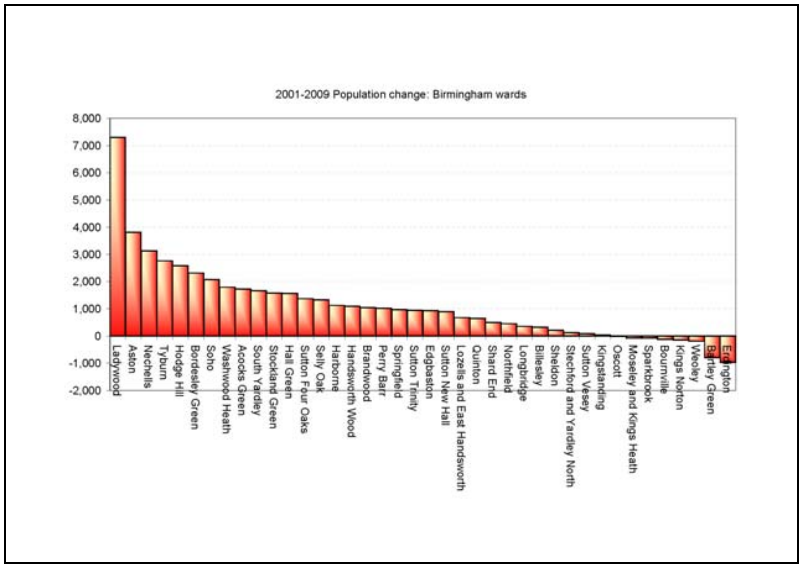
Birmingham				England
2028 population	**Change 2008-2028**	**Change 2008-2028 (%)**		**Change 2008-2028 (%)**
All ages	1,169,500	+150,300	+14.7%	+14.7%
Children (Age 0-15)	270,500	+ 47,500	+21.3%	+12.1%
Working Age*	710,000	+ 71,800	+11.3%	+6.3%
Older Ages*	188,900	+ 30,800	+19.5%	+44.8%
**based on the 2008 pension ages of 60 for females and 65 for males*				

Source: ONS 2008

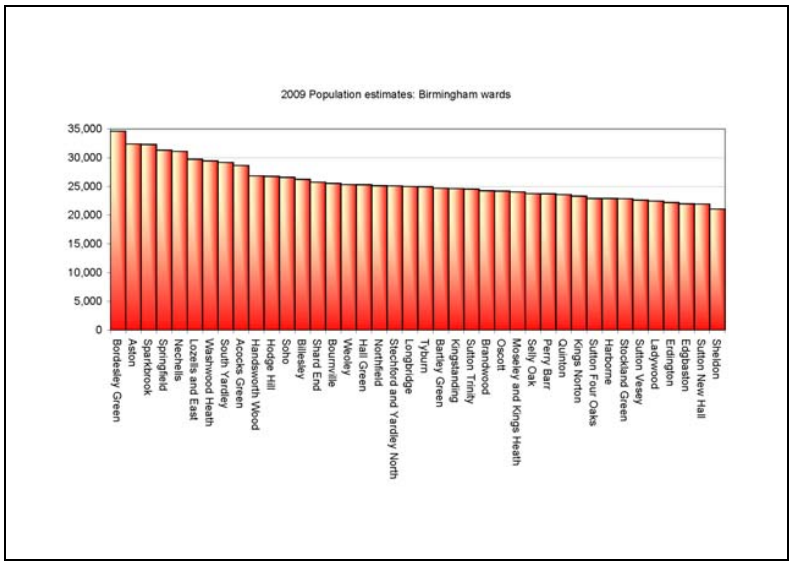
While this growth in Birmingham's population is at the same rate as projected nationally, there are considerable differences when broken down by age group. In particular, the working age population will grow at nearly twice the national rate, whereas the number of older people in Birmingham will grow by less than half the national average.

Area	Population	Working Age Population (16-64)	Economic Output GVA £bn 2008	Total Jobs 2008	Employment Rate Working Age	VAT Registrations per 10,000 Population 2007
Birmingham	1,073,039	666,500	£20.2bn	528,000	59.4	24.2

Source: Office of National Statistics

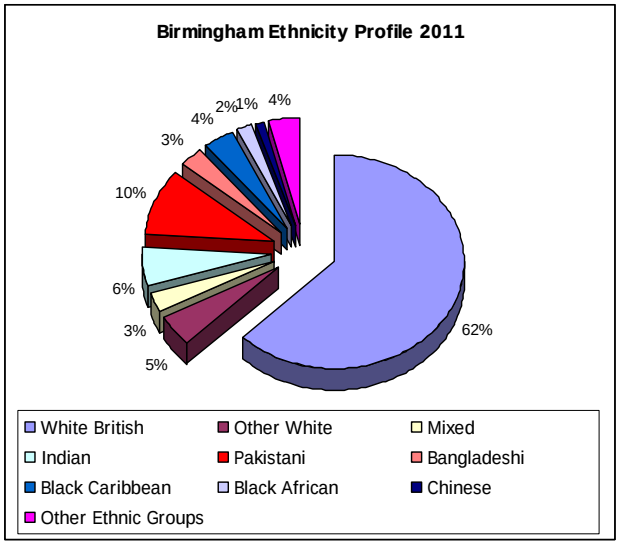


Source: www.birmingham.gov.uk



Source: www.birmingham.gov.uk

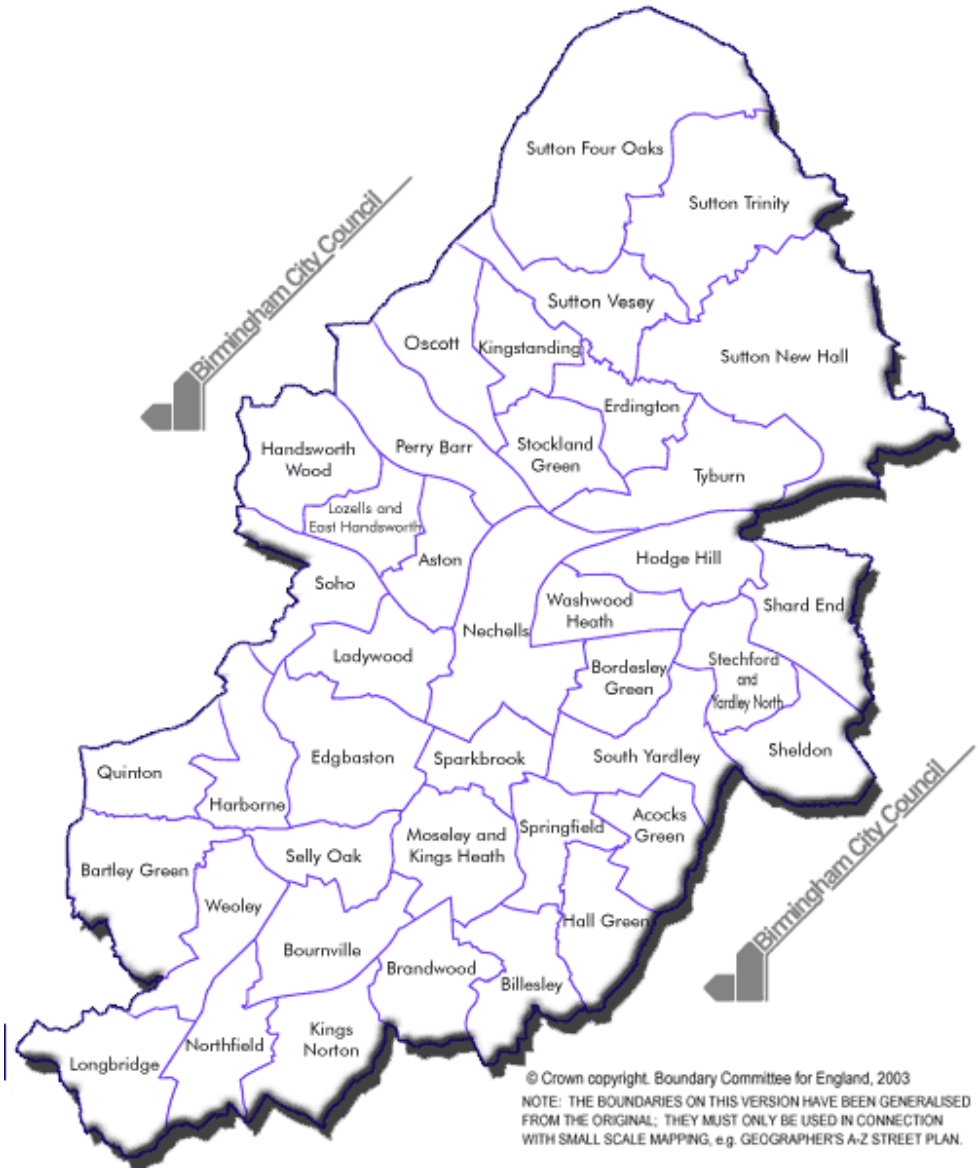
Birmingham	Birmingham		England
Ethnic Group	No (000s)	%	%
All Groups	1,073,039	100%	100%
White British	650.8	63%	83%
Other White	48.9	5%	5%
Mixed	33.4	3%	2%
Indian	59.4	6%	3%
Pakistani	99.8	10%	2%
Bangladeshi	25.5	3%	1%
Black Caribbean	41.0	4%	1%
Black African	20.7	2%	2%
Chinese	11.4	1%	1%
Other Ethnic Groups	37.8	4%	2%



Source: Experimental Estimates, 2011 Census ONS

Research from Manchester University breaks down the population projections for Birmingham by ethnic group. Findings show that population growth will be most apparent for the Pakistani, Bangladeshi and Black African groups, while there will be a decrease in the White and Caribbean groups.

Some groups expected to see the strongest growth currently have low economic activity and employment rates as well as comparatively poor skills levels. While this presents challenges for the city, if skill levels can be increased, it also presents an opportunity. Official population projections suggest that Birmingham will have an advantage in people of prime working age that will persist for some time. In 2029 the proportion of people in England who will be aged 50 or more will be 40%. However, in Birmingham this proportion will have only risen from 27.7% in 2009 to 29.3% in 2029.



Source: Birmingham City Council

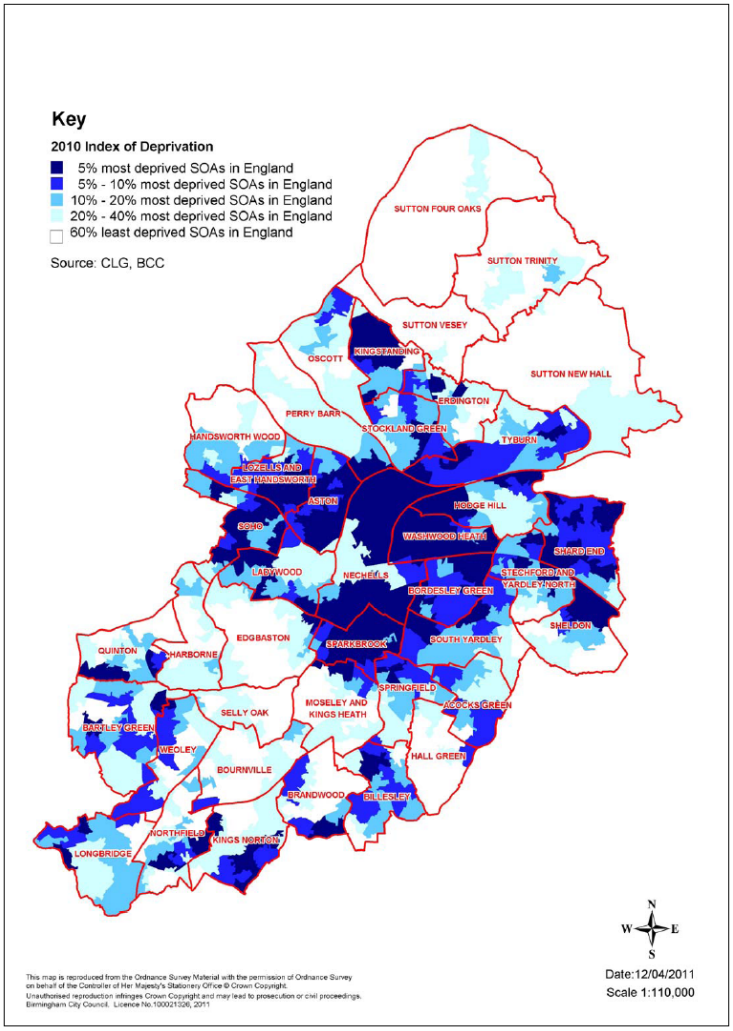
Birmingham is divided into 40 electoral wards which are used to elect local councillors. It has 10 constituencies, with four wards within each constituency.

Deprivation

Birmingham suffers from high levels of deprivation; it is the ninth most deprived local authority out of 354 authorities across England. Birmingham is the most deprived local authority in the West Midlands and the third most deprived core city after Liverpool and Manchester. Birmingham has a high proportion of residents living in deprived areas – with 40% of Birmingham's population living in SOAs (Super Output Areas – used by the Office of National Statistics) that are amongst the 10% most deprived in the country. Out of the 32,482 SOAs in England, Birmingham has 3 SOAs in the 100 most deprived in England - including an SOA in Sparkbrook that is the 25th most deprived in the country. Ladywood is the most deprived constituency in Birmingham.

Inner city areas and some outer city estates that have been previously identified as having low levels of skills and qualifications, high levels of worklessness and low household income levels which generally experience the highest levels of deprivation. For example, 94% of Washwood Heath's residents live in SOAs that are amongst the 10% most deprived in England. In contrast to this, the more suburban areas away from the city centre experience significantly less deprivation - for example, the Sutton wards to the north of the city have no SOAs considered amongst the 10% most deprived in England.

Measures of child poverty also show Birmingham performing poorly compared to the region and country. The proportion of dependent children who live in households whose equivalised income is below 60% of the contemporary national median in Birmingham (31.8%) is significantly higher than the West Midlands (21.6%) and England (19.2%).



Source: Local Economic Assessment for Birmingham 2011 (BCC)

Birmingham's economy is set to be driven by demands to create a skilled workforce, resulting in problems for those with low or no skills. Evidence suggests that a significant skills gap already exists amongst Birmingham's adult population. Birmingham has the highest proportion of working age adults holding no qualifications out of all the core cities. Retaining those with the highest level of skills also remains a problem for the city.

The backdrop of rising youth unemployment and a growing young population in Birmingham has emphasised the need for young people to gain appropriate skills to ensure they can be resilient to changing business needs in the future. Whilst recent evidence suggests that GCSE attainment has been improving, at a rate above the national average, foundation stage attainment amongst many of Birmingham's primary school pupils has remained lower than the national average.
Significant health inequalities are also evident within Birmingham. The city suffers from a high infant mortality rate. Male and female life expectancy levels are not only significantly lower than the national average but there are also dramatic differences in life expectancy across the forty wards of the city. Birmingham's residents are also more likely to die as a result of smoking, heart disease, strokes and cancer when compared with national mortality rates.

Table 4: Proportion of the ward population that lives in the 5%, 10%, 20% and 40% most deprived SOAs in England (IMD 2010)

Ward	5%	10%	20%	40%	Remainder
Acocks Green	0%	44%	65%	94%	6%
Aston	53%	85%	100%	100%	0%
Bartley Green	10%	35%	57%	84%	16%
Billesley	6%	38%	68%	83%	17%
Bordesley Green	30%	88%	100%	100%	0%
Bournville	0%	6%	14%	47%	53%
Brandwood	13%	32%	38%	54%	46%
Edgbaston	6%	6%	14%	57%	43%
Erdington	11%	20%	42%	80%	20%
Hall Green	0%	7%	8%	27%	73%
Handsworth Wood	0%	9%	49%	69%	31%
Harborne	0%	0%	15%	62%	38%
Hodge Hill	28%	41%	61%	100%	0%
King's Norton	26%	45%	45%	88%	12%
Kingstanding	66%	74%	91%	94%	6%
Ladywood	28%	36%	70%	100%	0%
Longbridge	12%	23%	53%	85%	15%
Lozells & East Handsworth	53%	90%	97%	100%	0%
Moseley & Kings Heath	10%	24%	31%	63%	37%
Nechells	76%	82%	82%	100%	0%
Northfield	13%	19%	40%	63%	35%
Oscott	0%	13%	26%	74%	26%
Perry Barr	7%	7%	13%	62%	38%
Quinton	13%	20%	40%	66%	34%
Selly Oak	0%	0%	2%	32%	68%
Shard End	54%	85%	94%	100%	0%
Sheldon	15%	22%	37%	67%	33%
Soho	50%	62%	90%	100%	0%
South Yardley	24%	50%	76%	90%	11%
Sparkbrook	74%	93%	100%	100%	0%
Springfield	13%	40%	81%	99%	1%
Stechford & Yardley North	25%	38%	78%	84%	16%
Stockland Green	13%	41%	86%	94%	6%
Sutton Four Oaks	0%	0%	0%	7%	93%
Sutton New Hall	0%	0%	0%	9%	91%
Sutton Trinity	0%	0%	7%	28%	72%
Sutton Vesey	0%	0%	0%	3%	97%
Tyburn	23%	59%	74%	100%	0%
Washwood Heath	90%	94%	100%	100%	0%
Weoley	1%	50%	67%	79%	27%
Birmingham	23%	40%	56%	75%	25%

Source: CLG/BEIC

Crime

Crime across the region is at its lowest level in a decade. Since 2003 recorded crime has fallen by 44.7%, which means 156,335 fewer victims. Last year (March 2011 – April 2012) saw over 19,000 fewer victims of crime across the West Midlands, compared to the previous year. As well as a dramatic fall in total recorded crime, reductions have also been achieved in most serious violence, burglary, vehicle crime and business crime. Main findings are:

- There were 3,800 fewer victims of vehicle crime and 3,000 fewer victims of house burglary.
- Victims of serious violence fell by 250 and 2,900 fewer businesses were affected by crime.
- The force's crackdown on robbery resulted in almost 1,400 fewer victims compared to the same period last year.
- 26.09% of all Birmingham's offenders are known to re-offend. This is below the national average of 26.30% and the lowest of all similar areas.
- For adult offenders Birmingham has the lowest re-offending rate compared with those Probation Trusts of similar size.
- The key factors behind re-offending are Class A drug misuse, followed by alcohol misuse. Unemployment and unsuitable accommodation are significant contributing factors
- In Birmingham 70.3% of prolific offenders re-offended within 12 months of being released from custody or commencing a community order, compared with the national average of 75.1%.
- In Birmingham there were 5,409 domestic violence calls to the police, who made 1,567 arrests.
- Birmingham had the lowest estimated rate of hazardous drinking across the eight core cities and is also lower than the regional average.
- Over the last four years alcohol-related crime has reduced. However, Birmingham had the second highest rate in the West Midlands and the fourth highest alcohol related violent crime rate of the core cities.
- 60% of Accident & Emergency hospital admissions due to violence were alcohol-related.
- The city centre is a hotspot for recorded crime and ASB, due largely to its role as a night time entertainment zone particularly around Broad Street and Southside.
- In the Ladywood and Perry Barr areas there is a large number of high profile gangs plus 'feeder' gangs with younger members. These are mainly African-Caribbean young men involved in drug dealing and street robberies. In the Hodge Hill, Hall Green and Yardley areas there is a number of highly organised gangs involved in drugs, some in very specific crime types such as car ringing. There are also lower level groups involved in ASB, criminal damage and violence.
- To the north in the Erdington area there is a number of groups connected through social and family networks. Gang members are generally males aged between 19-51 and of Asian or white European ethnicity. Gangs in Northfield, Selly Oak and Edgbaston most often supply drugs and are known to use violence and intimidation. The higher level gangs have access to or are known to use firearms.
- While most gang members are male, one gang has a prominent female leader and young women fulfil a variety of roles including storing or hiding weapons and drugs, smuggling weapons and drugs into nightclubs and acting as 'look outs'. Some women have willingly participated in these activities while others have only done so under duress, including though sexual violence.
- Birmingham continues to face the greatest threat from international terrorism when compared to the West Midlands region as a whole and is still assessed to have the highest risk in the UK, outside of London.

Source: West Midlands Police Annual Review 2011/12 / Community Safety Partnership 2012

2.2 Drugs Misuse

Trends

Drug misuse among adults (16 - 59 years) In England and Wales:

- In 2011/12 an estimated one in three adults (36.5%) had ever taken an illicit drug in their lifetime (around 12 million people), 8.9% of adults had used an illicit drug in the last year (nearly three million people) and 5.2% of adults had used an illicit drug in the last month (an estimated 1.7 million people).
- Between 1996 and 2011/12 last year use of any illicit drug fell from 11.1% to 8.9%.
- Cannabis was the most commonly used type of drug in 2011/12. 6.9% of 16-59 years had used cannabis in the last year followed by powder cocaine (2.2%) and ecstasy (1.4%).
- In 2009/10 it was estimated that there were 306,150 opiate and/or crack users in England. This corresponds to 8.93 per thousand of the population aged 15-64.

Drug misuse among young adults (16 – 24 years) In England and Wales:

- In 2011/12 an estimated 37.7% young adults have ever taken an illicit drug (around 2.5 million people), 19.3% had done so in the last year (nearly 1.3 million) and 11.1% in the last month (an estimated 0.7 million).
- Illicit drug fell from 29.7% to 19.3% between 1996 and 2011/12. This was due in large part to notable declines in cannabis (26.0% to 15.7%) and amphetamine use (from 11.8% to 2.0%).
- Class A drug use among 16 to 24 year olds has fallen in the long term from 9.2% in 1996 to 6.3% in 2011/12.

Drug misuse among children (11 - 15 years) In England:

- There has been an overall decrease in drug use reported by 11- 15 year olds since 2001. There were also decreases in the proportion of pupils who reported taking drugs; from 20% in 2001 to 12% in 2011.
- In 2011 3% of pupils reported taking drugs at least once a month, a decline from 7% in 2003.
- Reported drug use was more common among older pupils; for example, 3% of 11 year olds said they had used drugs in the last year, compared with 23% of 15 year olds in 2011.
- Cannabis was the most widely used drug in 2011; 7.6% of pupils reported taking it in the last year, a long term decrease from 13.4% in 2001.
- The number of young people (aged 18 and under) accessing help for drug and alcohol misuse during 2010/11 was 21,955. The equivalent figure in 2009/10 was 23,528
- The number of young people accessing services for primary use of Class A drugs has decreased year on year. Those receiving help primarily for heroin fell from 480 in 2009/10 to 320 in 2010/11 and those receiving help for cocaine use fell from 457 to 350.
- The proportion of young people dropping out before completing a course of therapy has continued to fall, from 29% in 2005-06 to 16% last year and 13% in this year.

Health outcomes In England (unless otherwise stated):

- In 2011/12, there were 6,173 admissions to hospital with a primary diagnosis of a drug-related mental health and behavioural disorder. This is 7% (467) less than 2010/11 when there were 6,640 such admissions.
- In 2011/12 almost three times as many males were admitted to hospital with a primary diagnosis of drug-related mental health and behavioural disorders than females (4,558 and 1,615 respectively).
- In 2011/12 more people aged 25-34 were admitted with a primary diagnosis of drug related mental health and behaviour disorders than any other age group, accounting for 33.8% (2,084 out of 6,173) admissions.
- Where primary or secondary diagnosis was recorded there were 57,733 admissions in 2011/12, this is a 12.4% (6,380) increase from 2010/11 when there were 51,353 such admissions. Figures from this type of admission have continued to increase
- The 16-24 age group reported the highest number of admissions (3,202) with a primary diagnosis of poisoning by drugs in 2010/11 with those in the 65-74 age group reporting the lowest (353).
- During 2010/11, there were 204,473 adults (those aged 18 and over) in contact with structured drug treatment services. This is a 1.2% decrease from 2009/10, where the number was 206,889. Most individuals in treatment are aged 30-34 (22%) and male (73.2%)

- Those taking opiates only (which includes heroin) was the main type of drug for which people received treatment (49% of all treatments), with a further 32% of treatments for those who have taken both opiates and crack in 2010/11.
- There were 64,994 discharged episodes of treatment for drug dependency during 2010/11, 27,969 (43%) of these were for those no longer dependent on the substances that brought them into treatment; a further 16,530 (25%) were referred on for further interventions outside of community-structured treatment.
- The total number of deaths related to drug misuse in England and Wales was 1,784 in 2010, of those 77% were male. The most common underlying cause of death was from accidental poisoning for both males and females (694 out of 1,382 and 193 out of 402 respectively).

Source: NHS Information Centre: Statistics on Drug Misuse 2012

Deaths Related to Drug Poisoning in England and Wales, 2011

There were 1,772 male and 880 female drug poisoning deaths (involving both legal and illegal drugs) registered in 2011, a 6 per cent decrease since 2010 for males and a 3 per cent increase for females.

- In 2011 the drug poisoning mortality rate was 63.8 deaths per million population for males and 29.9 deaths per million population for females, both were unchanged compared with 2010.

- The number of male drug misuse deaths decreased by 14 per cent from 1,382 in 2010 to 1,192 in 2011; female deaths increased by 3 per cent from 402 in 2010 to 413 in 2011.

- The male mortality rate from drug misuse decreased significantly between 2010 and 2011 (from 50.8 to 43.4 deaths per million population), but remained stable for females (14.4 deaths per million population in 2011).

- Deaths involving heroin/morphine decreased by 25 per cent compared with 2010, but they were still the substances most commonly involved in drug poisoning deaths (596 deaths in 2011).

- The highest mortality rate from drug misuse was in 30 to 39-year-olds (110.0 and 30.2 deaths per million population for males and females respectively).

- Evidence suggests that from October 2010 there has been a 'heroin drought' in the UK, with shortages in the availability of heroin continuing in some areas in 2011/12. This heroin drought has resulted in typical street heroin purity falling from 46 per cent in September 2009 to around 32 per cent in September 2010, and down again to 19 per cent in July to September 2011 (SOCA, 2011 and 2012 and Simonson and Daly, 2011).

- Drugs workers were concerned that the heroin drought may result in more drug-related deaths, as users who had developed a reduced tolerance could overdose if they used a high quality batch of heroin (Simonson and Daly, 2011). However, ONS data show the opposite trend with deaths involving heroin falling in recent years.

- In 2011 there were 486 deaths involving methadone (an opiate substance used to treat heroin addiction, which is sometimes abused). The male mortality rate for deaths involving methadone increased significantly from 9.9 deaths per million population in 2010 to 13.5 in 2011. This is a 36 per cent increase and is the highest rate since 1997. The equivalent rate for females increased slightly in 2011 to 4.3 deaths per million population.

- There were 112 deaths involving cocaine in 2011. The male mortality rate was 3.2 deaths per million population in 2011, which continues a significant downward trend since the peak in 2008. The equivalent rates for females were lower than for males, rising slightly from 0.7 deaths per million population in 2010 to 0.9 in 2011

Source: Deaths Related to Drug Poisoning in England and Wales, 2011 – www.ons.org.uk

Prevalence

Research into the prevalence of opiate and crack use in England is conducted each year by Glasgow Prevalence Estimation, University of Manchester and Liverpool John Moores University. The report for 2010/11 estimates that there are 298,752 opiate and/or crack users in England. This converts to 8.67 per thousand population aged 15 to 64.

For Birmingham, in the 15 to 64 age group it is estimated that there are 10,263 opiate/crack users, of which 9,128 are opiate users and 6,926 are crack users. 1,735 users are estimated to be injecting. This converts to 14.97 per thousand of the 15 to 64 population are OCUs.

	Number of users			
	OCU	Opiate users	Crack users	Injecting
Birmingham	10,263	9,128	6,926	1,735
West Midlands	34,498	31,046	20,754	9,844
England	298,752	261,792	170,627	93,401

	Rate per thousand of the population				15-64 population
	OCU	Opiate users	Crack users	Injecting	
Birmingham	14.97	13.32	10.10	2.53	685,500
West Midlands	9.77	8.80	5.88	2.79	3,529,500
England	8.67	7.59	4.95	2.71	34,476,900

There have been marked increases in the estimation since last year. OCUs have increased by 570 (+5.6%), Opiate users by 475 (+5.2%) and Crack users by 334 (+4.8%).

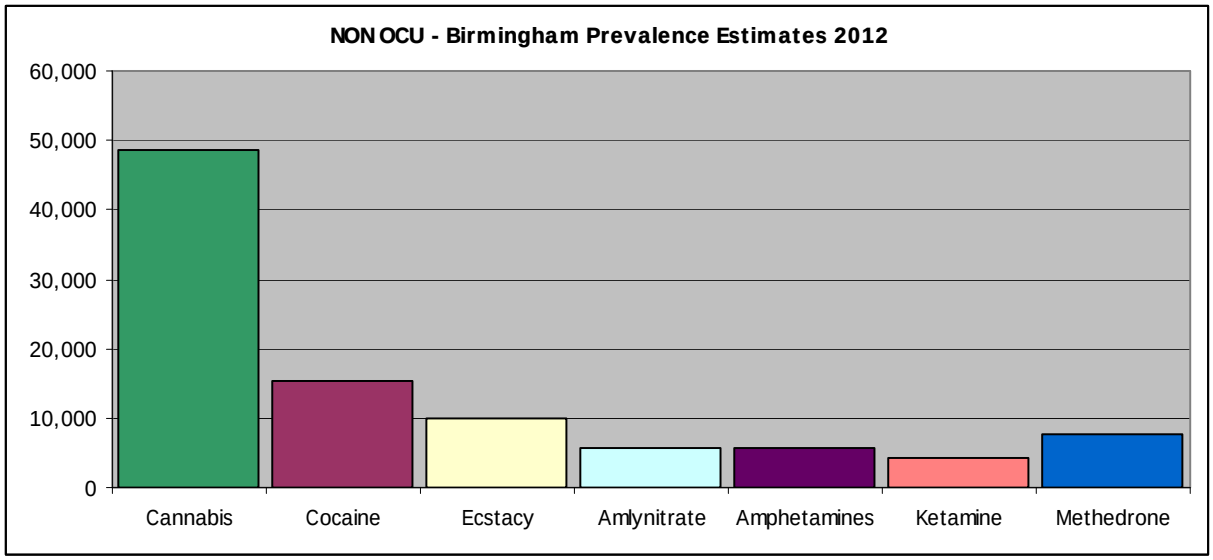
However, the number of injectors has been estimated to have fallen by -158 (-8.3%). The data suggests that 17% of Birmingham OCUs are injecting, as opposed to a National average of 31%.

	Difference between 2010/11 and 2009/10 prevalence estimates			
	OCU Difference	Opiate Difference	Crack Difference	Injecting Difference
Birmingham	570	475	334	-158
West Midlands	130	480	-379	-1,400
England	-7,398	-2,280	-13,620	-9,784

Source: Estimates of the Prevalence of Opiate use and/or crack cocaine use (2010/11)

In January 2013, there were 3,670 OCU clients in treatment. There were an additional 3,212 OCU clients that had been in treatment during the last year. This means that there were an estimated 3,381 OCU users who had not engaged in treatment in Birmingham since 2011.

Based on the 2011/12 Crime Survey for England and Wales (CSEW) it is estimated that there are in Birmingham 48,495 Cannabis users, 15,462 Powder Cocaine users, 9,840 Ecstasy Users, 5,623 Amyl nitrate users, 5,623 amphetamine users and 4,217 ketamine users. Although, data on novel psychoactive substances (NPS), or 'legal highs', is limited, the CSEW does suggest that there are 7,731 Methedrone users in Birmingham.



Source: Drug Misuse Declared: Findings from the 2011/12 Crime Survey for England and Wales/2011 Census

Birmingham Drug Strategy

There is currently no comprehensive drug strategy for Birmingham but Public Health Birmingham are expected to produce one this year.

Average UK Street Drug Prices

Drug	Average Quantity	Average Price
Herbal cannabis (standard)	per qtr oz	£37
Herbal cannabis (high strength)	per qtr oz	£55
Resin cannabis	per qtr oz	£27
Heroin	per 0.21g bag	£11
Cocaine	per gram	£46
Crack	per 0.25g rock	£16
Ecstasy	per pill	£6.30
MDMA powder/crystal	per gram	£39
Amphetamine	per gram	£13
Ketamine	per gram	£21
Mephedrone	per gram	£19
Diazepam	per pill	£0.67

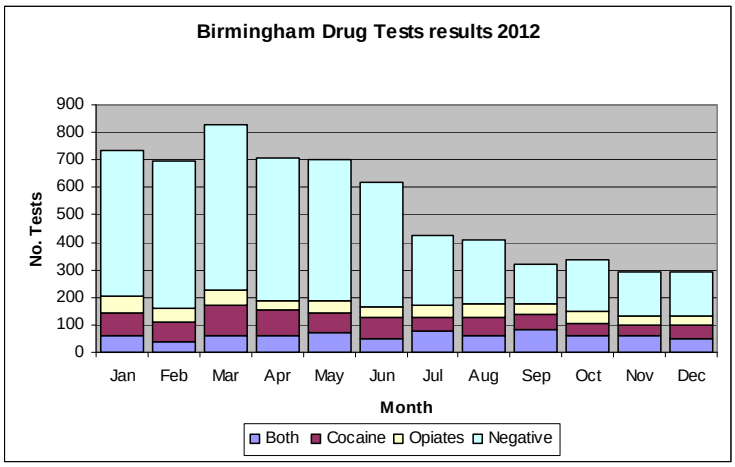
Source: Druglink Street Drugs Survey 2012

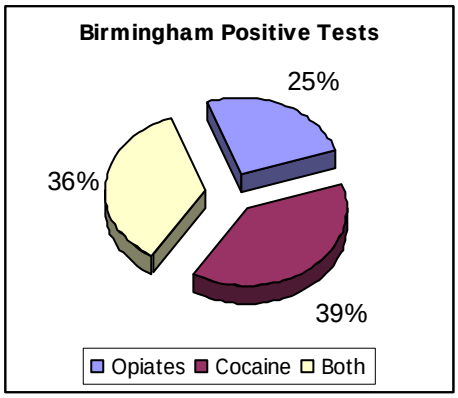
Birmingham Mandatory Custody Drug Tests

As the current economic climate and 'austerity cuts' continue, it has become necessary to review the expenditure on mandatory drug testing. Each drug test costs £9 and when a test is disputed the cost for forensic analysis is £27 per test. With the introduction of the Police Crime Commissioners in 2012, this cost became part of financial arrangements between the Home Office and the Commissioners. The cost of servicing the negative kits and the forensic element of DIP in 2011 was in excess of £150,000. In addition, the time taken by a Detention Escort Officer (DEO) to perform a drug test which results in a negative finding last year was calculated at 7,706 hours or the equivalent to 963 eight hour shifts.

During 2011, a discretionary testing pilot was run to determine how costs could be saved whilst maximising positive testing. The pilot was not looking to reduce the number of positive tests but to increase them by bringing about a culture shift in custody. By utilising existing warning markers, Inspectors Authority, intelligence, staff experience and offender trigger offence and demeanour, all decisions not to test were justified and recorded via a 'Targeted Drug Testing' checklist. By adopting these techniques and reviewing missed opportunities to engage with offenders, the pilot proved that targeting which offenders to drug test produced similar (if not greater) volumes of positive tests while reducing the number of negative tests.

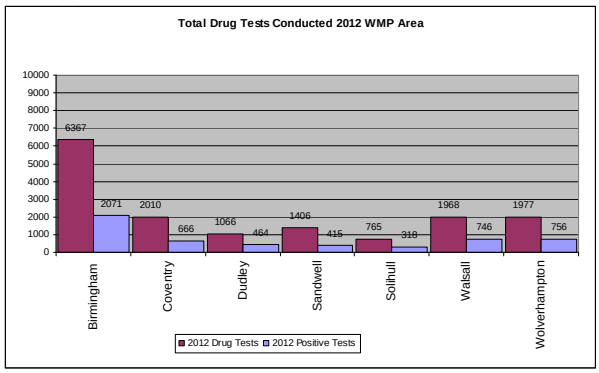
This procedure was rolled out across Birmingham custody blocks in July 2012 – with instantaneous results. Before July, the average positive rate was 26% with an average of 187 tests completed per month. After July the positive rate increased to 46% with an average of 179 tests completed each month. In 2011, there were a total of 9,033 tests completed. 6,420 were negative (71%) and 2,613 were positive (29%). Of the positive total, 584 (22%) were opiates, 1,137 (46%) were cocaine and 892 (34%) were both. In 2012, there were a total of 6,367 tests completed. 4,296 were negative (64%) and 2,071 were positive (36%). Of the positive total, 522 (25%) were opiates, 811 (39%) were cocaine and 738 (36%) were both.

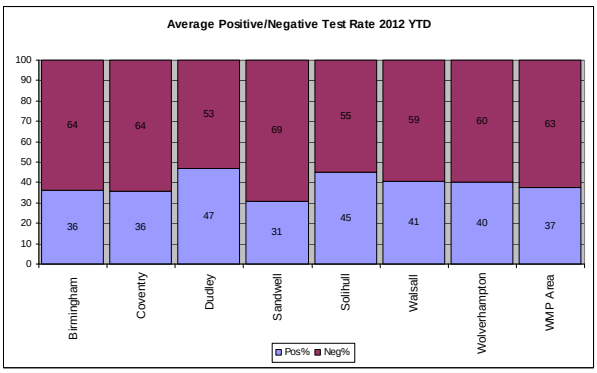




Source: WMP DIP Data Team

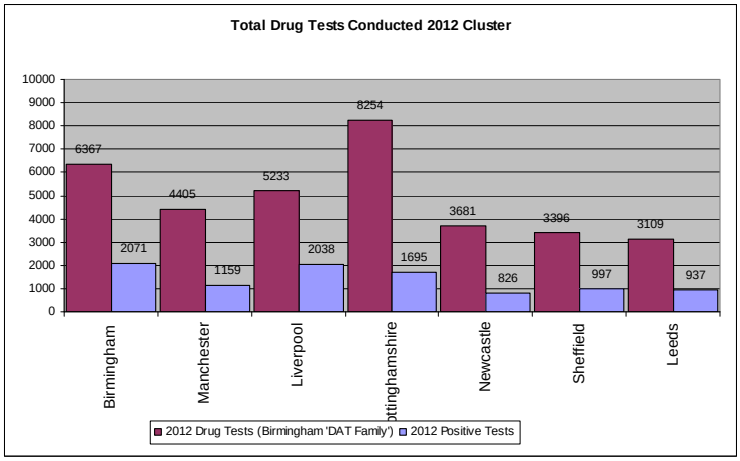
When compared with other DAT areas across the West Midlands Police Force area, Birmingham conducts the most drug tests and achieves the largest volume of positive drug tests results. Statistically, Dudley has the highest percentage of positive tests (47%) followed by Solihull (45%). The highest percentage test rate for cocaine only is in Sandwell (48%).



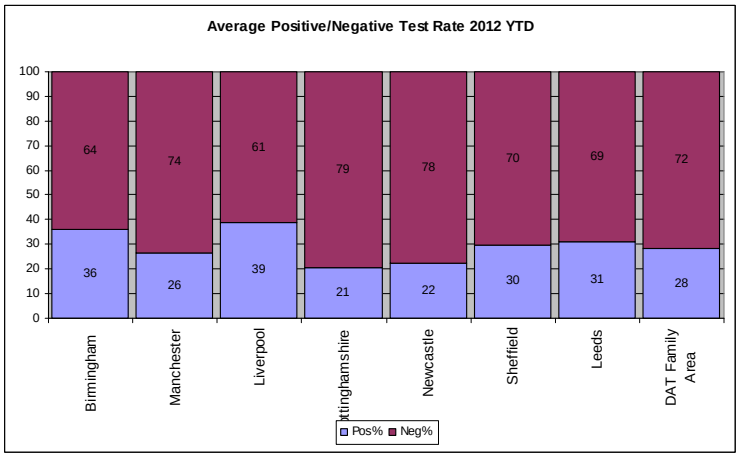


Other Force areas have reduced the number of drug tests over the last 12 months. Based on the relative size of DAT areas, Nottinghamshire completes the largest amount of drug tests yet has the poorest positive tests rate (21%).

Liverpool drug tests volumes are perhaps the most similar to Birmingham but the positive cocaine only test rate is much higher at 65%.



Nationally, the positive test breakdown is Both (26%), Cocaine Only (50%) and Opiates (25%).



Opiate / Crack Users by Birmingham Ward

A new study by the DIP Data Team utilised the prevalence statistics 2010/11 to determine the average number of Opiate / Crack Users (OCU) per Birmingham ward. This was achieved by proportioning the 15-64 year old cohort of each ward area to the total prevalence estimates. The numbers of clients in drug treatment (as of December 2012) were then matched to their respective ward of residence (where an address was available).

- The population of Birmingham, according to the 2011 Census is 1,073,039 people.
- The main propensity to misuse crack and opiates within this population is within the 15 to 64 year olds cohort. This equates to 704,908 people in Birmingham. 49% of this cohort is male.
- Based on the Glasgow Prevalence Estimation of OCUs, it is estimated that 10,263 (1.46%) of 15 to 64 year olds who reside in Birmingham are OCUs.
- According to the latest figures from the National Treatment Agency Birmingham had within a 12 month period 5,218 OCUs in effective treatment (50.8% of the estimated total).
- As of December 2012, there were 4,465 (43.5%) still actively receiving treatment.

Ethnicity

There are 40 ward areas across Birmingham. It is estimated there are an average 256 OCUs for each ward. 228 are using opiates and 173 are using crack. 43 are injecting. Based on population estimates, and if propensities to misuse opiates and crack are equal across ethnicities, the Black and Asian populations of Birmingham are not engaging in structured treatment as much as the other ethnic populations. The Black treatment cohort was under-represented by -3% whereas the Asian treatment cohort was under-represented by -12%. The White treatment cohort exceeded the expected representation by +11%. These findings indicate that Black and Asian communities within Birmingham may be facing additional barriers to accessing treatment for opiates / crack misuse.

Ethnicity	Birmingham %	OCU In Treatment %	Difference
White	58%	69%	+11%
Mixed	4%	6%	+2%
Asian	27%	15%	-12%
Black	9%	6%	-3%
Other	2%	4%	+2%

By analysing the ward data by ethnicity further, it can be inferred that an average of only 41% of the OCU population by ward is currently in treatment. It is estimated that there are on average 106 OCUs in treatment per Birmingham Ward.

Ethnicity / Ward average	OCU	Opiate	Crack	Injecting	In treatment
White	**149**	**132**	**100**	**25**	**77**
Mixed	**11**	**12**	**9**	**2**	**6**
Asian	**68**	**64**	**48**	**12**	**17**
Black	**23**	**22**	**17**	**4**	**4**
Other	**5**	**5**	**4**	**1**	**2**
TOTAL	**256**	**228**	**173**	**43**	**106**

OCUs By Ward

- The ward with the largest cohort of 15-64 year olds is Ladywood, with an estimated 370 OCUs. This ward also has the most clients who are actively engaged in treatment (270). Ladywood has a higher than average black population (17%) but only 25% of estimated cohort of black OCUs are currently in treatment.

- The ward with the most residents is Nechells (34,242) with an estimated 335 OCUs, of which 150 are in treatment. Nechells ethnicity is white 27%, Mixed 6%, Asian 38%, Black 24% and Other 5%. This ward has the largest black population of 15 to 64 year olds (5,503).

- The ward with the largest Asian population is Washwood Heath with 14,968 people (74% of the total 15 to 64 population). 48% of the OCU cohort in treatment for this ward is Asian.

- The ward with the largest White population is Selly Oak with 15,247 people (71% of the 15 to 64 year old population). 76% of the OCU cohort in treatment for this ward are white.

- The ward with the largest number of OCU clients in treatment is Shard End with 199 clients. The ethnicity of this ward is White 82%, Mixed 6.3%, Asian 5.6%, Black 5.4% and Other 0.6%.

- The ward with the least number of OCU clients in treatment is Sutton New Hall with 27 clients. The ethnicity of this ward is White 89%, Mixed 2%, Asian 6%, Black 2% and Other 1%.

OCU by Ward by Deprivation / Ethnicity

The following tables list the Birmingham Wards by order of the most deprived. These areas are also some of the most populous and so have a higher number of estimated OCUs. When compared to the active number of OCUs in treatment, it appears that there is a correlation between propensities to engage in treatment with higher levels of deprivation as 7 of the wards with the highest numbers in treatment are in the top 12 deprived ward areas. This also infers that OCUs in less deprived wards are less inclined to engage into treatment because funding drug misuse is less of a consideration. Other findings are:

- 58% of the estimated OCU population are not in treatment

- Shard End has the highest proportion of estimated OCU population in treatment

- The highest estimated number of injectors is in Nechells, followed by Selly Oak.

- On average, there are 43 OCU injectors per ward.

Table 1: OCU by Birmingham Ward –
15-64 Census population by OCU, Opiates, Crack and Injecting estimates / In Treatment population

OCU By Ward 1	Index of Deprivation Rank	2011 Census	2011 Census 15 - 64 estimate	2011 15 - 64 %	OCU	Opiate	Crack	Injecting	In Treatment OCU 201212	Not In Treatment	NOT in Treat-ment %
Washwood Heath	1	33,268	20,118	60%	293	261	198	50	73	201	68.7%
Sparkbrook	2	32,166	20,218	63%	294	262	199	50	149	131	44.4%
Nechells	3	34,242	23,026	67%	335	298	226	57	150	161	48.1%
Aston	4	32,003	21,150	66%	308	274	208	52	142	174	56.4%
Lozells & East Handsworth	5	31,511	20,360	65%	296	264	200	50	177	122	41.3%
Bordesley Green	6	34,108	20,388	60%	297	264	200	50	114	169	56.9%
Shard End	7	26,686	16,773	63%	244	217	165	41	199	28	11.5%
Kingstanding	8	25,480	16,111	63%	235	209	158	40	87	149	63.3%
Soho	9	30,211	20,099	67%	293	260	197	49	171	112	38.1%
Ladywood	10	30,196	25,398	84%	370	329	250	63	216	153	41.3%
Tyburn	11	25,002	15,853	63%	231	205	156	39	136	93	40.2%
Stockland Green	12	24,495	16,799	69%	245	218	165	41	135	98	40.2%
Hodge Hill	13	27,652	16,726	60%	244	217	164	41	133	87	35.5%
South Yardley	14	29,912	19,020	64%	277	246	187	47	101	174	62.7%
Acocks Green	15	29,056	16,702	57%	243	216	164	41	83	193	79.3%
Springfield	16	31,283	19,791	63%	288	256	194	49	90	184	64.0%
Stechford & Yardley North	17	26,119	16,415	63%	239	213	161	40	40	196	82.0%
Bartley Green	18	25,046	16,307	65%	237	211	160	40	80	160	67.6%
Kings Norton	19	24,226	15,362	63%	224	199	151	38	95	122	54.5%
Erdington	20	22,894	14,942	65%	218	193	147	37	112	91	41.6%
Weoley	21	25,573	16,223	63%	236	210	159	40	122	101	42.7%
Billesley	22	26,429	16,969	64%	247	220	167	42	107	144	58.3%
Longbridge	23	25,128	16,644	66%	242	216	164	41	137	77	31.9%
Handsworth Wood	24	27,642	18,959	69%	276	246	186	47	87	185	67.0%
Moseley & Kings Heath	25	25,916	18,469	71%	269	239	181	45	136	115	42.7%
Brandwood	26	25,802	16,583	64%	241	215	163	41	122	93	38.7%
Oscott	27	24,833	15,897	64%	231	206	156	39	52	175	75.8%
Sheldon	28	21,530	13,528	63%	197	175	133	33	48	143	72.6%
Northfield	29	26,025	16,918	65%	246	219	166	42	144	74	30.2%
Quinton	30	24,079	15,345	64%	223	199	151	38	76	150	67.0%
Perry Barr	31	23,750	15,562	66%	227	202	153	38	29	194	85.5%
Bournville	32	26,053	17,289	66%	252	224	170	43	52	204	80.9%
Harborne	33	23,216	16,317	70%	238	211	160	40	61	177	74.3%
Edgbaston	34	24,510	18,764	77%	273	243	184	46	73	191	70.0%
Selly Oak	35	25,999	21,384	82%	311	277	210	53	50	261	83.7%
Hall Green	36	26,106	16,702	64%	243	216	164	41	50	183	75.4%
Sutton Vesey	37	23,349	14,961	64%	218	194	147	37	20	202	92.7%
Sutton Trinity	38	25,561	16,222	63%	236	210	159	40	47	185	78.5%
Sutton New Hall	39	22,011	14,193	64%	207	184	139	35	27	182	87.9%
Sutton Four Oaks	40	23,970	14,333	60%	209	186	141	35	34	173	82.7%
TOTAL		1,073,039	702,822	65%	10,233	9,101	6,906	1,730	3,957	6,005	58.5%
NFA / Unassigned			-2,086		30	27	20	5	508	-176	
Average / TOTAL					256	228	173	43	4,465	5,829	10,294

Table 2: OCU by Ward: White Ethnicity – 15-64 Census population by OCU numbers in treatment and estimated OCU numbers NOT in treatment

OCU per Ward 2: White	Index of Deprivation Rank	2011 Census 15 - 64 estimate	White 2011	White 2011 %	White OCU Est	White ONCase	White Diff
Washwood Heath	1	20,118	2,495	12.4	36	26	10
Sparkbrook	2	20,218	2,527	12.5	37	68	-31
Nechells	3	23,026	6,125	26.6	89	115	-26
Aston	4	21,150	2,898	13.7	42	58	-16
Lozells & East Handsworth	5	20,360	2,240	11.0	33	70	-37
Bordesley Green	6	20,388	2,936	14.4	43	52	-9
Shard End	7	16,773	13,754	82.0	200	192	8
Kingstanding	8	16,111	12,776	79.3	186	83	103
Soho	9	20,099	4,120	20.5	60	95	-35
Ladywood	10	25,398	12,521	49.3	182	168	14
Tyburn	11	15,853	11,937	75.3	174	120	54
Stockland Green	12	16,799	10,046	59.8	146	115	31
Hodge Hill	13	16,726	7,493	44.8	109	112	-3
South Yardley	14	19,020	10,024	52.7	146	80	66
Acocks Green	15	16,702	10,556	63.2	185	68	117
Springfield	16	19,791	4,176	21.1	61	26	35
Stechford & Yardley North	17	16,415	11,162	68.0	163	36	127
Bartley Green	18	16,307	13,192	80.9	192	70	122
Kings Norton	19	15,362	13,119	85.4	191	95	96
Erdington	20	14,942	11,655	78.0	170	109	61
Weoley	21	16,223	12,994	80.1	189	118	71
Billesley	22	16,969	13,168	77.6	192	90	102
Longbridge	23	16,644	14,846	89.2	216	152	64
Handsworth Wood	24	18,959	4,304	22.7	63	36	27
Moseley & Kings Heath	25	18,469	11,359	61.5	165	110	55
Brandwood	26	16,583	12,835	77.4	187	132	55
Oscott	27	15,897	13,020	81.9	190	49	141
Sheldon	28	13,528	11,526	85.2	168	44	124
Northfield	29	16,918	15,024	88.8	219	154	65
Quinton	30	15,345	10,726	69.9	156	69	87
Perry Barr	31	15,562	8,264	53.1	120	18	102
Bournville	32	17,289	14,523	84.0	211	37	174
Harborne	33	16,317	10,736	65.8	156	46	110
Edgbaston	34	18,764	10,752	57.3	157	56	101
Selly Oak	35	21,384	15,247	71.3	222	41	181
Hall Green	36	16,702	9,336	55.9	136	43	93
Sutton Vesey	37	14,961	12,941	86.5	188	14	174
Sutton Trinity	38	16,222	14,535	89.6	212	50	162
Sutton New Hall	39	14,193	12,674	89.3	185	24	161
Sutton Four Oaks	40	14,333	12,799	89.3	186	34	152
TOTAL		702,822	407,361	60.7	5,962	3,075	2,887
NFA / Unassigned		-2,086	0		266		
Average per ward			0		149	77	72

Table 3: OCU by Ward: Asian Ethnicity – 15-64 Census population by OCU numbers in treatment and estimated OCU numbers NOT in treatment

OCU Per Ward 3: Asian	Index of Deprivation Rank	2011 Census 15 - 64 estimate	Asian 2011	Asian 2011 %	Asian OCU	Asian ONCase	Asian Diff
Washwood Heath	1	20,118	14,968	74.4	218	52	166
Sparkbrook	2	20,218	12,434	61.5	181	69	112
Nechells	3	23,026	8,727	37.9	127	29	98
Aston	4	21,150	11,548	54.6	168	58	110
Lozells & East Handsworth	5	20,360	12,277	60.3	179	71	108
Bordesley Green	6	20,388	13,905	68.2	202	65	137
Shard End	7	16,773	939	5.6	14	9	5
Kingstanding	8	16,111	999	6.2	15	1	14
Soho	9	20,099	9,105	45.3	133	48	85
Ladywood	10	25,398	6,019	23.7	88	19	69
Tyburn	11	15,853	1,522	9.6	22	5	17
Stockland Green	12	16,799	3,024	18.0	44	8	36
Hodge Hill	13	16,726	6,824	40.8	99	28	71
South Yardley	14	19,020	6,657	35.0	97	17	80
Acocks Green	15	16,702	4,343	26.0	63	10	53
Springfield	16	19,791	13,419	67.8	195	76	119
Stechford & Yardley North	17	16,415	3,316	20.2	48	5	43
Bartley Green	18	16,307	864	5.3	13	2	11
Kings Norton	19	15,362	507	3.3	7	0	7
Erdington	20	14,942	1,151	7.7	17	1	16
Weoley	21	16,223	1,346	8.3	20	2	18
Billesley	22	16,969	2,240	13.2	33	4	29
Longbridge	23	16,644	350	2.1	5	7	-2
Handsworth Wood	24	18,959	9,802	51.7	143	32	111
Moseley & Kings Heath	25	18,469	4,673	25.3	68	16	52
Brandwood	26	16,583	1,774	10.7	26	6	20
Oscott	27	15,897	1,192	7.5	17	6	11
Sheldon	28	13,528	1,096	8.1	16	7	9
Northfield	29	16,918	491	2.9	7	4	3
Quinton	30	15,345	2,148	14.0	31	0	31
Perry Barr	31	15,562	4,404	28.3	64	9	55
Bournville	32	17,289	1,245	7.2	18	2	16
Harborne	33	16,317	3,475	21.3	51	5	46
Edgbaston	34	18,764	4,766	25.4	69	5	64
Selly Oak	35	21,384	3,956	18.5	58	5	53
Hall Green	36	16,702	6,163	36.9	90	11	79
Sutton Vesey	37	14,961	1,197	8.0	17	0	17
Sutton Trinity	38	16,222	892	5.5	13	1	12
Sutton New Hall	39	14,193	880	6.2	13	1	12
Sutton Four Oaks	40	14,333	1,003	7.0	15	0	15
TOTAL		702,822	172,104	24.5	2,703	696	2,007
NFA / Unassigned		-2,086			-190		
Average per ward					68	17	50

Table 4: OCU by Ward: Mixed Ethnicity – 15-64 Census population by OCU numbers in treatment and estimated OCU numbers NOT in treatment

OCU Per Ward 4: Mixed	Index of Deprivation Rank	2011 Census 15 - 64 estimate	Mixed 2011	Mixed 2011 %	Mixed OCU Est	Mixed ONCase	Mixed Diff
Washwood Heath	1	20,118	563	2.8	8	7	1
Sparkbrook	2	20,218	788	3.9	11	14	-3
Nechells	3	23,026	1,497	6.5	22	15	7
Aston	4	21,150	867	4.1	13	6	7
Lozells & East Handsworth	5	20,360	896	4.4	13	14	-1
Bordesley Green	6	20,388	734	3.6	11	3	8
Shard End	7	16,773	1,057	6.3	15	9	6
Kingstanding	8	16,111	789	4.9	11	0	11
Soho	9	20,099	1,306	6.5	19	13	6
Ladywood	10	25,398	1,651	6.5	24	6	18
Tyburn	11	15,853	919	5.8	13	7	6
Stockland Green	12	16,799	1,075	6.4	16	10	6
Hodge Hill	13	16,726	719	4.3	10	13	-3
South Yardley	14	19,020	799	4.2	12	3	9
Acocks Green	15	16,702	785	4.7	11	1	10
Springfield	16	19,791	653	3.3	10	1	9
Stechford & Yardley North	17	16,415	706	4.3	10	2	8
Bartley Green	18	16,307	897	5.5	13	5	8
Kings Norton	19	15,362	814	5.3	12	2	10
Erdington	20	14,942	777	5.2	11	7	4
Weoley	21	16,223	795	4.9	12	11	1
Billesley	22	16,969	747	4.4	11	6	5
Longbridge	23	16,644	732	4.4	11	0	11
Handsworth Wood	24	18,959	834	4.4	12	11	1
Moseley & Kings Heath	25	18,469	960	5.2	14	19	-5
Brandwood	26	16,583	829	5.0	12	7	5
Oscott	27	15,897	525	3.3	8	0	8
Sheldon	28	13,528	406	3.0	6	3	3
Northfield	29	16,918	694	4.1	10	11	-1
Quinton	30	15,345	890	5.8	13	4	9
Perry Barr	31	15,562	654	4.2	10	3	7
Bournville	32	17,289	692	4.0	10	5	5
Harborne	33	16,317	702	4.3	10	4	6
Edgbaston	34	18,764	957	5.1	14	11	3
Selly Oak	35	21,384	898	4.2	13	2	11
Hall Green	36	16,702	518	3.1	8	3	5
Sutton Vesey	37	14,961	344	2.3	5	2	3
Sutton Trinity	38	16,222	422	2.6	6	0	6
Sutton New Hall	39	14,193	284	2.0	4	0	4
Sutton Four Oaks	40	14,333	258	1.8	4	1	3
TOTAL		702,822	31,030	4.4	458	241	217
NFA / Unassigned		-2,086	0		-5		
Average per ward			0		11	6	5

Table 5: OCU by Ward: Black Ethnicity – 15-64 Census population by OCU numbers in treatment and estimated OCU numbers NOT in treatment

OCU Per Ward 5: Black	Index of Deprivation Rank	2011 Census 15 - 64 estimate	Black 2011	Black 2011 %	Black OCU	Black ONCase	Black Diff
Washwood Heath	1	20,118	1,750	8.7	25	7	18
Sparkbrook	2	20,218	2,163	10.7	31	8	23
Nechells	3	23,026	5,503	23.9	80	12	68
Aston	4	21,150	5,351	25.3	78	6	72
Lozells & East Handsworth	5	20,360	4,479	22.0	65	13	52
Bordesley Green	6	20,388	2,039	10.0	30	7	23
Shard End	7	16,773	906	5.4	13	6	7
Kingstanding	8	16,111	1,450	9.0	21	2	19
Soho	9	20,099	4,864	24.2	71	17	54
Ladywood	10	25,398	4,241	16.7	62	15	47
Tyburn	11	15,853	1,363	8.6	20	5	15
Stockland Green	12	16,799	2,453	14.6	36	8	28
Hodge Hill	13	16,726	1,472	8.8	21	2	19
South Yardley	14	19,020	1,103	5.8	16	0	16
Acocks Green	15	16,702	818	4.9	12	3	9
Springfield	16	19,791	970	4.9	14	0	14
Stechford & Yardley North	17	16,415	1,116	6.8	16	0	16
Bartley Green	18	16,307	1,207	7.4	18	0	18
Kings Norton	19	15,362	799	5.2	12	5	7
Erdington	20	14,942	1,270	8.5	18	8	10
Weoley	21	16,223	827	5.1	12	3	9
Billesley	22	16,969	662	3.9	10	3	7
Longbridge	23	16,644	649	3.9	9	5	4
Handsworth Wood	24	18,959	3,166	16.7	46	9	37
Moseley & Kings Heath	25	18,469	1,016	5.5	15	5	10
Brandwood	26	16,583	945	5.7	14	3	11
Oscott	27	15,897	1,113	7.0	16	1	15
Sheldon	28	13,528	419	3.1	6	0	6
Northfield	29	16,918	609	3.6	9	1	8
Quinton	30	15,345	1,274	8.3	19	1	18
Perry Barr	31	15,562	2,085	13.4	30	3	27
Bournville	32	17,289	692	4.0	10	3	7
Harborne	33	16,317	995	6.1	14	3	11
Edgbaston	34	18,764	1,708	9.1	25	7	18
Selly Oak	35	21,384	920	4.3	13	2	11
Hall Green	36	16,702	384	2.3	6	3	3
Sutton Vesey	37	14,961	389	2.6	6	0	6
Sutton Trinity	38	16,222	341	2.1	5	0	5
Sutton New Hall	39	14,193	284	2.0	4	0	4
Sutton Four Oaks	40	14,333	186	1.3	3	1	2
TOTAL		702,822	59,986	8.5	932	177	755
NFA / Unassigned		-2,086	0		-56		
Average per ward			0		23	22	17

Table 6: OCU by Ward: Other Ethnicity – 15-64 Census population by OCU numbers in treatment and estimated OCU numbers NOT in treatment

OCU Per Ward 6: Other	Index of Deprivation Rank	2011 Census 15 - 64 estimate	Other 2011	Other 2011 %	Other OCU	Other ONCase	Other Diff
Washwood Heath	1	20,118	362	1.8	5	0	5
Sparkbrook	2	20,218	2,325	11.5	34	5	29
Nechells	3	23,026	1,174	5.1	17	3	14
Aston	4	21,150	465	2.2	7	6	1
Lozells & East Handsworth	5	20,360	468	2.3	7	6	1
Bordesley Green	6	20,388	775	3.8	11	1	10
Shard End	7	16,773	101	0.6	1	0	1
Kingstanding	8	16,111	97	0.6	1	0	1
Soho	9	20,099	703	3.5	10	8	2
Ladywood	10	25,398	965	3.8	14	9	5
Tyburn	11	15,853	111	0.7	2	1	1
Stockland Green	12	16,799	185	1.1	3	5	-2
Hodge Hill	13	16,726	217	1.3	3	2	1
South Yardley	14	19,020	418	2.2	6	3	3
Acocks Green	15	16,702	217	1.3	3	0	3
Springfield	16	19,791	594	3.0	9	1	8
Stechford & Yardley North	17	16,415	115	0.7	2	0	2
Bartley Green	18	16,307	147	0.9	2	0	2
Kings Norton	19	15,362	138	0.9	2	0	2
Erdington	20	14,942	90	0.6	1	2	-1
Weoley	21	16,223	243	1.5	4	1	3
Billesley	22	16,969	153	0.9	2	0	2
Longbridge	23	16,644	67	0.4	1	1	0
Handsworth Wood	24	18,959	853	4.5	12	3	9
Moseley & Kings Heath	25	18,469	462	2.5	7	4	3
Brandwood	26	16,583	199	1.2	3	0	3
Oscott	27	15,897	48	0.3	1	0	1
Sheldon	28	13,528	81	0.6	1	0	1
Northfield	29	16,918	102	0.6	1	2	-1
Quinton	30	15,345	322	2.1	5	0	5
Perry Barr	31	15,562	171	1.1	2	0	2
Bournville	32	17,289	138	0.8	2	1	1
Harborne	33	16,317	408	2.5	6	3	3
Edgbaston	34	18,764	582	3.1	8	3	5
Selly Oak	35	21,384	385	1.8	6	1	5
Hall Green	36	16,702	317	1.9	5	0	5
Sutton Vesey	37	14,961	90	0.6	1	0	1
Sutton Trinity	38	16,222	49	0.3	1	0	1
Sutton New Hall	39	14,193	71	0.5	1	0	1
Sutton Four Oaks	40	14,333	86	0.6	1	0	1
TOTAL		702,822	13,301	1.9	211	71	140
NFA / Unassigned		-2,086	0		-17		
Average			0		5	2	4

2.3 Alcohol Misuse

While most people drink responsibly, alcohol misuse ruins thousands of lives in Birmingham and costs the city around £200 million last year.

In 2012, Birmingham launched a 4-year alcohol strategy to tackle the health and social problems caused by alcohol misuse. Research shows that 25% of men and 17% of women in the city are drinking above safe limits.

The damage caused by alcohol misuse includes:

- At peak times, up to 70 per cent of all admissions to accident and emergency departments in Birmingham are related to alcohol;
- 3,600 incidents of domestic violence (around a third) are linked to alcohol misuse;
- Up to 170,000 working days are lost through alcohol-related absence, costing the city's economy about £30 million each year;
- About 20,000 children in Birmingham are affected by parental alcohol problems;
- Marriages where there are alcohol problems are twice as likely to end in divorce;
- In 2009, half of all 11 to 15-year-olds in the city had already had an alcoholic drink;
- Parental alcohol misuse has been identified as a factor in more than 500 child protection cases.

The size of the problem in Birmingham is significant. Figures derived using the Alcohol Learning Centre's ready reckoner in the table below show an estimate of the number of problem drinkers in the City.

Hazardous / Increasing Risk Drinkers	117,000
Harmful / High Risk Drinkers	39,000
Dependent Drinkers	22,000

The strategy's three key objectives are:

Promoting a safe and sensible approach to alcohol consumption –

- Maintain a range of alcohol services in hospitals, GP surgeries, pharmacies, community settings, police stations and courts;
- Continue to focus on underage drinking in pubs and bars and underage sales of alcohol in off-licences and supermarkets, to ensure young people do not obtain alcohol illegally;
- Lobby for the implementation of a minimum unit price for alcohol.

Protecting families and the wider community from the adverse impact of alcohol –

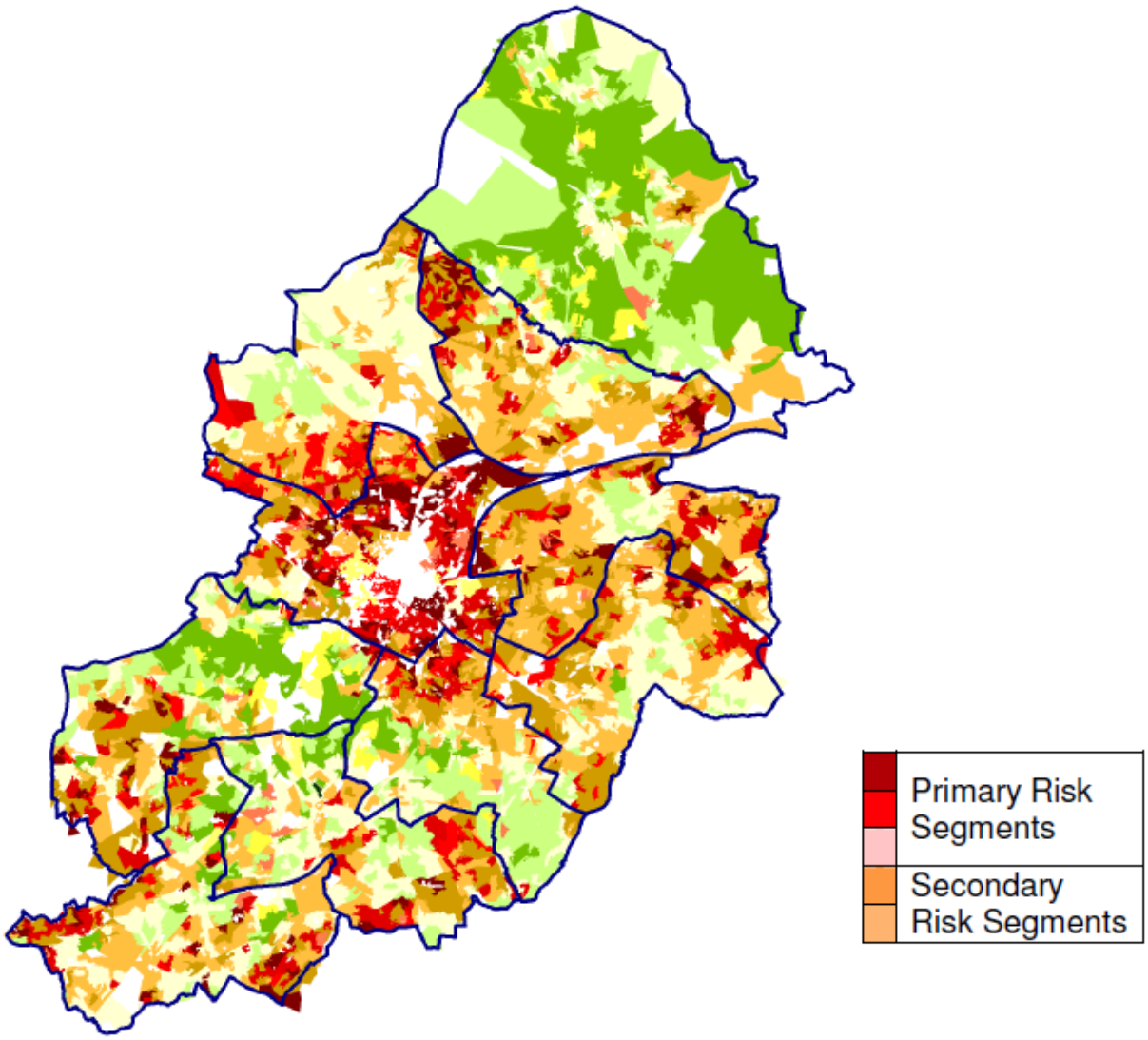
- Continue to increase the effectiveness and availability of the alcohol treatment system for offenders;
- Establish a healthy workforce pilot programme for Birmingham's main employers in order to reduce alcohol-related absenteeism;
- Continue to develop services which protect young people from alcohol-related incidents and illnesses.

Reducing the impact of alcohol-related damage to people's health –

- Further develop services which assist high risk groups including those from a hostel, homeless and student population;
- Develop specialist treatment provision for the relative, parents and carers of problem drinkers;
- Ensure alcohol services deliver family focused alcohol interventions.

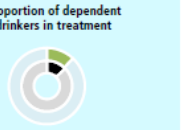
The new strategy builds on work already undertaken by the partners, which has reduced anti-social behaviour incidents across the city by nearly half from 8,000 to 5,000 a month since November 2009. Alcohol-related crime has dropped by 24.5% in four years, while the number of alcohol-related deaths in Birmingham has reduced by 12% from six years ago to 473 last year.

New initiatives include a system currently being introduced by Birmingham's Drug and Alcohol Action Team to increase the number of alcohol referrals by systematically sending out lists of patients admitted to hospital for alcohol-specific conditions to their GP, asking them to review and refer the individual to treatment services if necessary. From the time when the patient starts treatment, the subsequent rate of future hospital admissions will be tracked to monitor effectiveness of the programme.
Source: Birmingham Alcohol Strategy 2012- 2016 – Birmingham City Council



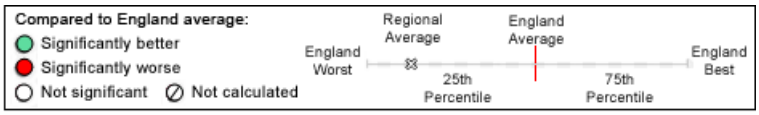
The National Treatment Agency estimates that there are 775,000 dependent drinkers nationally with 100,000 of this number in treatment.

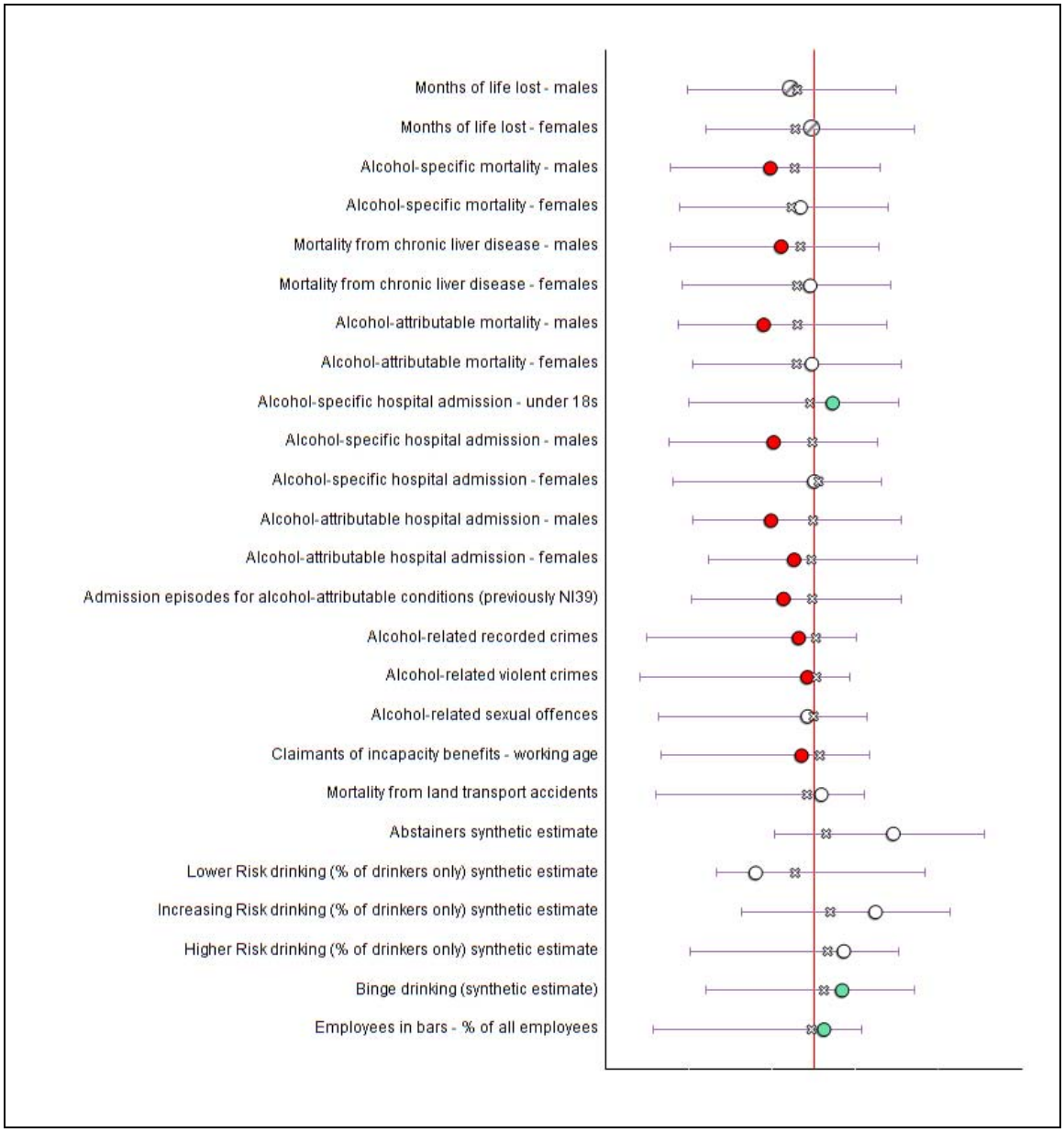
Prevalence estimates (aged 18-75)	Local	National
Number of dependent drinkers	21608	774029
Proportion of dependent drinkers in treatment	12%	13%



Source: National Treatment Agency

The chart shows Birmingham's measure for each LAPE indicator, as well as the regional and England averages and range of all local authority values for comparison purposes.

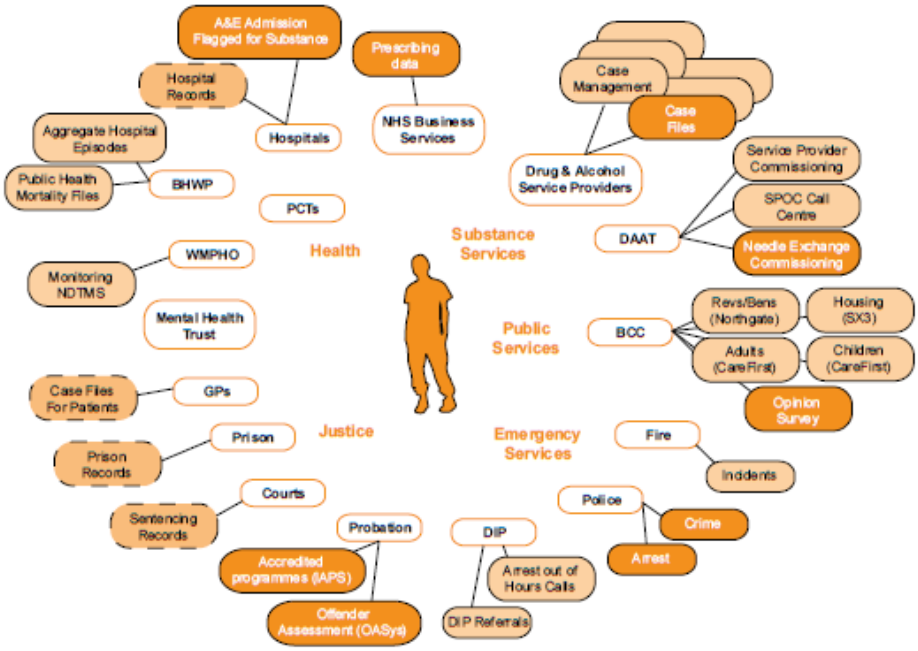




Alcohol Treatment- Prevalence per 1,000 population - currently only available at primary care organisation level
Source: Birmingham LAPE (Local Alcohol Profiles for England) – North West Public Health Observatory

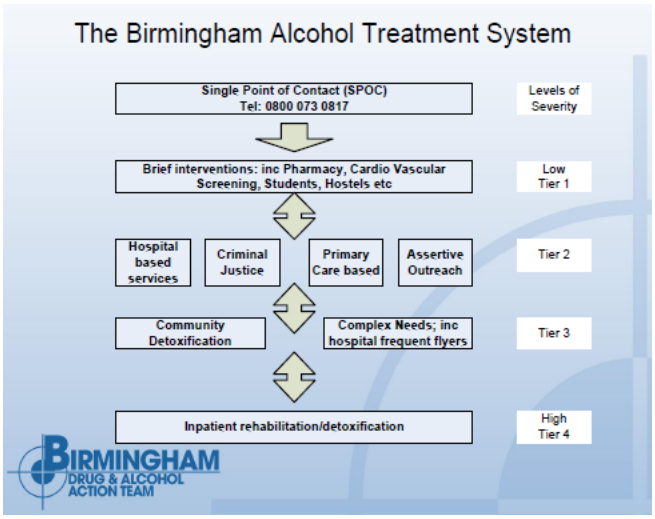
3.0 Birmingham Treatment System

In 2011, a study was conducted that highlighted the potential agencies across Birmingham that could engage with drug and / or alcohol misusers. The graphic below demonstrates how complex an individual's engagement could become.



Source: Local Government Improvement & Development: Birmingham Drugs & Alcohol 2011

Models of care for alcohol misusers (MoCAM) provides best practice guidance for commissioning and provider organisations to deliver a planned and integrated local treatment system for adult alcohol misusers. The map of Birmingham's Alcohol Treatment system below shows a less complex picture than that of the drug treatment. However, research shows that Birmingham's Alcohol Treatment System has around 30 agencies providing 54 different services, and that a client can go through 24 assessment processes on his or her treatment journey.



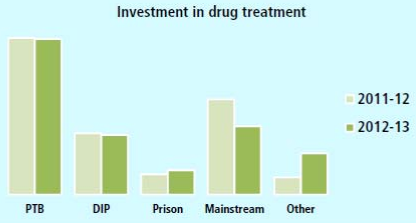
Source: Birmingham Needs Assessment 2011/12

3.1 Investment

The total Investment in drug treatment for Birmingham for 2012-13 is £29,036 667. This includes allocations for a Pooled Treatment Budget (PTB, the central government contribution to funding for adult treatment - £12,937755); DIP funding (which engages drug-using offenders in treatment - £4,948,695); prison drug treatment (for HMP Birmingham - £2,026,100); and mainstream PCT contributions to drug treatment (£5,690,020); plus other local funding sources (£3,434,097).

PTB allocations are based on drug treatment system performance. Essentially, if local areas attract more drug treatment funding by effectively engaging more people in treatment and helping them recover. 20% of funding for 2012-13 was based on the number successfully completing treatment and not returning. The Advisory Committee for Resource Allocation has advised that this broad methodology (praised as effective by the National Audit Office) should continue to be a component of the public health grant which will flow to Local Authorities in 2013-14.

	2012-13	2011-12	Change from 2011-12
PTB	£12,937,755	£13,015,202	-0.6%
DoH DIP	£3,229,154	£5,098,220	-2.9%
HO DIP	£1,719,541		
Prison	£2,026,100	£1,689,905	19.9%
Mainstream	£5,690,020	£7,920,625	-28.2%
Other	£3,434,097	£1,434,547	139.4%
Total	£29,036,667	£29,158,499	-0.4%



Source: National Treatment Agency

3.2 Value For Money

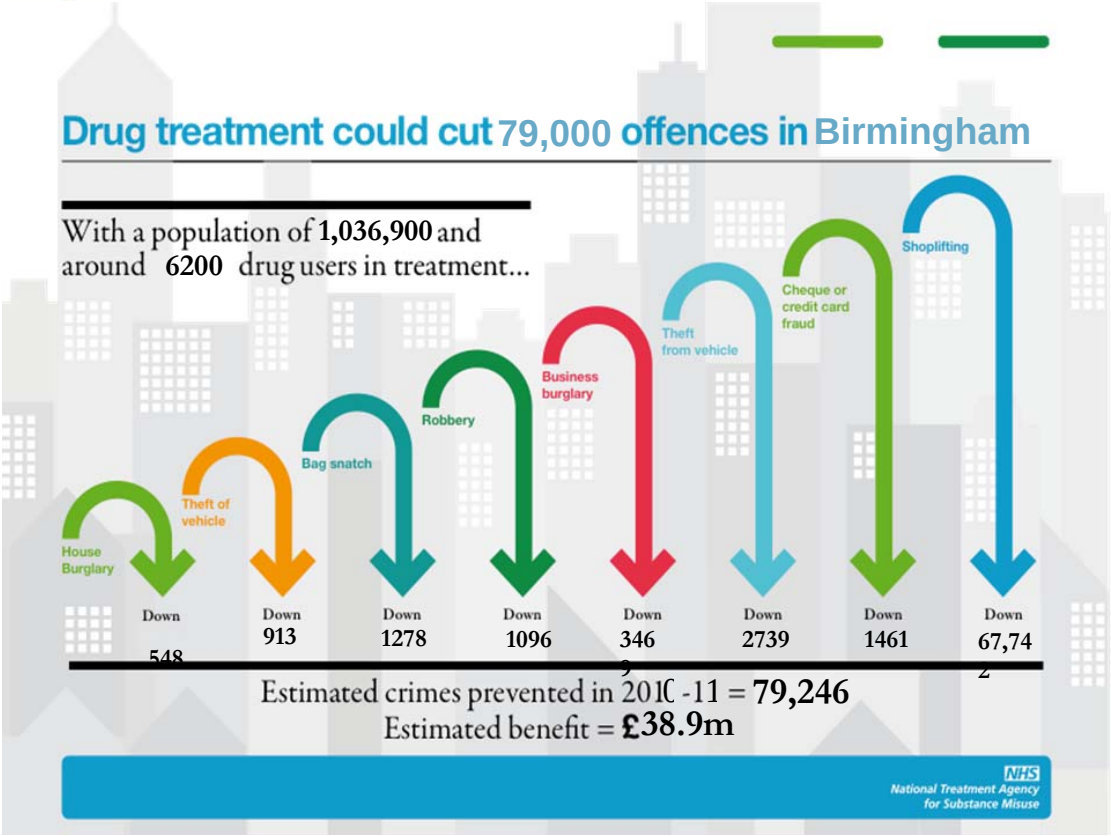
Expenditure Profile	Expenditure	Partnership %	National %	Local Cost per Day	National Cost per Day
Community Prescribing	£10,155,758.43	38.2%	30.6%	£7.35	£6.19
Structured Day Programmes	£704,295.00	2.6%	4.8%	£58.70	£30.09
Structured Psychosocial Interventions	£652,049.00	2.4%	7.6%	£0.88	£14.57
Other Structured Drug Treatment	£1,048,963.00	3.9%	8.6%	£9.60	£19.45
Inpatient Treatment	£768,814.00	2.9%	3.7%	£334.77	£430.30
Residential Rehabilitation	£877,828.00	3.3%	4.1%	£90.95	£175.26
Lower threshold	£3,153,708.00	11.8%	10.4%		
Drug Interventions Programme (DIP)	£5,264,095.00	19.8%	12.1%		
Prison Based Drug Treatment	£2,423,100.00	9.1%	9.2%		
Commissioning System / Overheads	£1,570,342.00	5.9%	6.9%		
Contingency / Below the line	£0.00	0.0%	2.0%		
TOTAL	**£26,618,952.43**	**100.0%**	**100.0%**		

Source: NTA Cost Effective Tool for Birmingham 2011-12

When comparing local expenditure percentages with Nationals, it is important to consider that Birmingham is the largest DAT area in the country with the largest caseload in treatment. Referral pathways and maintenance scripting incur the highest costs as the population volumes are higher than anywhere else in the country. The high cost of community prescribing, however, is potentially reducing spend which could be afforded to delivering treatment or recovery programmes across the city.

The cost per day is based on expenditure divided by NDTMS client numbers. When comparing local cost per clients with Nationals, it appears that spends on structured interventions and treatments are considerably lower. This infers that Birmingham is achieving significant value for money in these areas.

The indirect benefits of providing drug treatment in Birmingham are substantial. The National Treatment Agency has deduced that for 2010/11, 79,246 crimes were prevented due to offenders engaging in treatment. The estimated savings to the Birmingham economy is £38.9m.



Source: National Treatment Agency

3.3 Waiting Times

Since the introduction of the Birmingham Drug Interventions Programme in 2004, waiting times for Class A drug clients has improved considerably. 98% of clients wait under three weeks from their assessment to commence treatment in Birmingham.

	Local	Proportion of all initial waits	National	Proportion of all initial waits
Adults waiting under three weeks to start treatment	2260	98%	66,358	97%
Adults waiting over six weeks to start treatment	5	0%	478	1%

Source: National Treatment Agency

Waiting times for Alcohol clients in Birmingham is also better than the National average. 24% of alcohol clients engage in community interventions within 3 weeks in Birmingham, compared to 14% nationally. The average waiting time is 17 days.

Waiting over 3 weeks to commence the first treatment intervention		Local	National
Community Interventions	*n*	351	9875
	%	24%	14%
Inpatient Intervention/Residential Rehabilitation	*n*	11	835
	%	22%	22%
Any Intervention	*n*	362	10710
	%	24%	15%

Average waiting time *(in days)* to commence the first treatment intervention		
Community Interventions	17.1	10.1
Inpatient Intervention/Residential Rehabilitation	23.3	16.2
Any Intervention	17.3	10.4

Source: National Treatment Agency

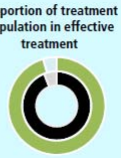
3.4 Treatment Engagement

Drugs

According to NDTMS figures for 2011-12, there were 6,257 adults effectively engaged in drug treatment agencies in Birmingham (i.e. people who have been in treatment for three months or more). 5,171 (83%) were Opiates clients while 1,086 (17%) were non-opiate clients. These figures represented an average fall of -5% of adults engaged in treatment from the previous year. The opiate cohort fell by -7% while the non-opiate cohort increased by +1% year on year.

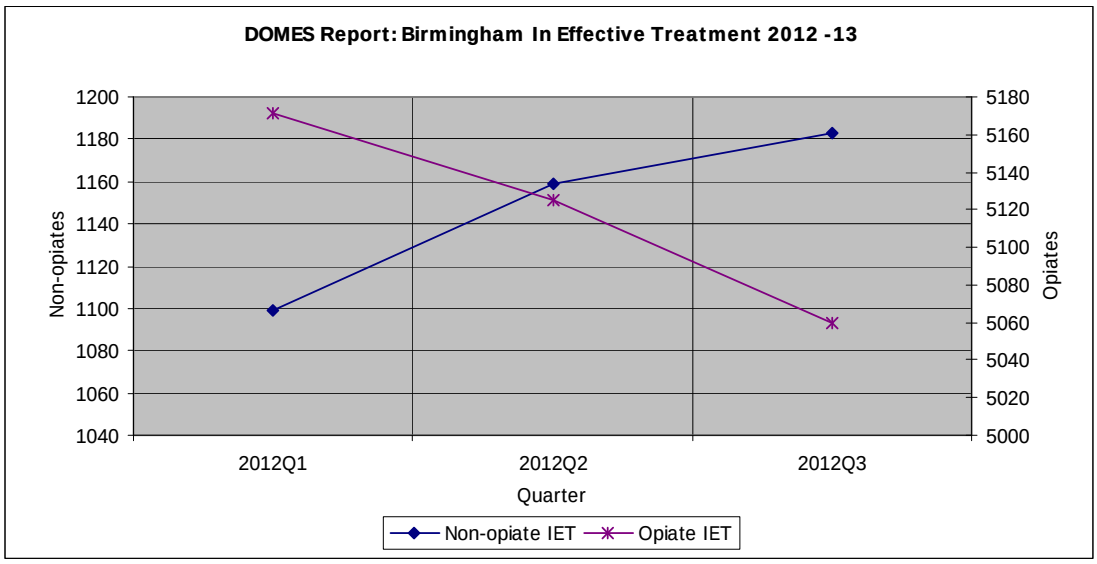
Adults effectively engaged in treatment 2011-12

	Local	Growth from 10-11	Proportion of treatment population	National	Growth from 10-11	Proportion of treatment population
Opiate	5171	-7%	83%	152,722	-3%	82%
Non opiate	1086	1%	17%	32,706	-1%	18%
All	6257	-5%	96%	185,428	-3%	94%



Source: National Treatment Agency

The most recent DOMES (Diagnostic Outcomes Monitoring Executive Summary) reports for Birmingham issued by the National Treatment Agency indicate that the falls in opiate clients engaging in treatment and increase in non-opiates clients will continue. This echoes the National trend that the number of adults using non-opiates and entering treatment is increasing. However, with the increases of substances to the UK market it could be conceivable that opiates are not being classed as the primary substance during assessment, which may be influencing these figures.

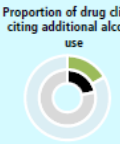


Source: Diagnostic Outcomes Monitoring Executive Summary Reports

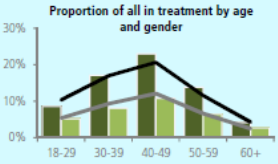
Alcohol

During 2011/12, 12, 2,742 adults were engaged in alcohol treatment in Birmingham (2.5% of the National total). 1,670 (61%) started treatment during this period. The average age of an adult accessing alcohol treatment in Birmingham is 42.

		Local	National
Number of adults in alcohol treatment in 2011-12		2742	108936
Number of adults starting new alcohol treatment in 2011-12	n	1670	74319
	% *	61%	68%
*% is the proportion of adults **starting** new treatment in the year out of all clients in treatment during the year*			
Number and proportion of adults in drug treatment in 2011-12 who cite additional problematic alcohol use	n	1106	43036
	%	17%	22%



		Local	National
Mean age and gender of all adults in alcohol treatment in 2011-12	*Male*	42.6	41.7
	Female	42.6	42.0
	All	42.6	41.8



Source: National Treatment Agency

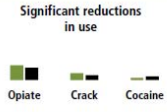
3.5 Progress In Treatment

Clients who receive drug treatment complete a Treatment Outcomes Profile (TOP), which tracks the progress drug users make in treatment. This includes information on rates of abstinence from drugs and statistically significant reductions in drug use and injecting, and those successfully leaving treatment with secure housing and in work. A TOP is filled in at the start of treatment, at regular review periods during treatment, when the client completes treatment, and possibly at a review after the treatment completion. In all instances, a review of the client's progress over the preceding 28 days takes place. For the most part, the Birmingham performances in these measures reflect the National averages. Abstinence was achieved for 43% of Opiate users, 53% for Crack users and 60% for Cocaine users. Complimenting these figures, significant reductions in use were also achieved – 27% for opiate users, 14% for crack users and 7% for cocaine users. In effect, significant progress is achieved in Birmingham for over two thirds of adults who remain in treatment to complete a TOP review.

Other testaments to the calibre of the treatment and support received in Birmingham are:

- 68% of 91 clients who were injecting at the start of treatment were no longer doing so at the time of their review.
- 83% of 133 adults who successfully completed treatment no longer had a housing need
- 27% of 203 clients were working ten or more days in the month before successfully completing treatment.

	Local		National
Abstinence			
Opiate abstinence	351	43%	46%
Crack abstinence	287	53%	53%
Cocaine abstinence	93	60%	63%
Significant reductions in use			
Opiate significant reductions in use	221	27%	23%
Crack significant reductions in use	78	14%	11%
Cocaine significant reductions in use	11	7%	9%
Injecting use, housing need and employment			
Adults no longer injecting at review	91	68%	62%
Adults successfully completing treatment no longer reporting a housing need	133	83%	85%
Adults working ten or more days in the month before successfully completing treatment	203	27%	25%



Source: National Treatment Agency

Currently, it is not mandatory for Alcohol services to use the TOP. However, staff use other tools, such as the Alcohol Star to monitor aims and progress. Higher risk levels of drinking alcohol are monitored at the start of treatment. In Birmingham, 22% of alcohol clients were drinking over 1,000 units a month before commencing treatment.

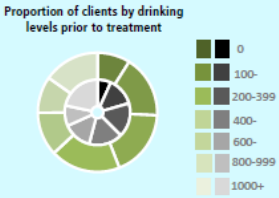
		Local	National
Drinking at higher risk levels in the 28 days prior to entering treatment	*n*	2101	80195
	%	81%	77%

*note: proportions here are calculated out of total clients with completed data rather than all clients in treatment

Units consumed in the 28 days prior to entering treatment

		0	100-199	200-399	400-599	600-799	800-999	1000+	Missing
Local	*n*	173	359	437	431	365	262	559	156
	% *	7%	14%	17%	17%	14%	10%	22%	6%
National	% *	9%	17%	18%	19%	12%	10%	15%	4%

*note: proportions here are calculated out of total clients with completed data rather than all clients in treatment



Source: National Treatment Agency

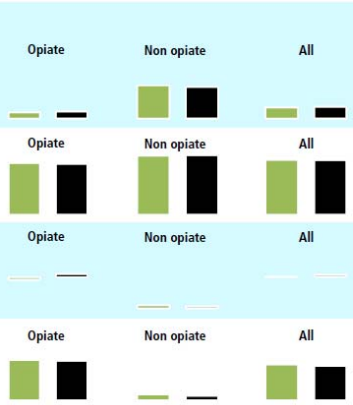
3.6 Successful Completions

Drugs

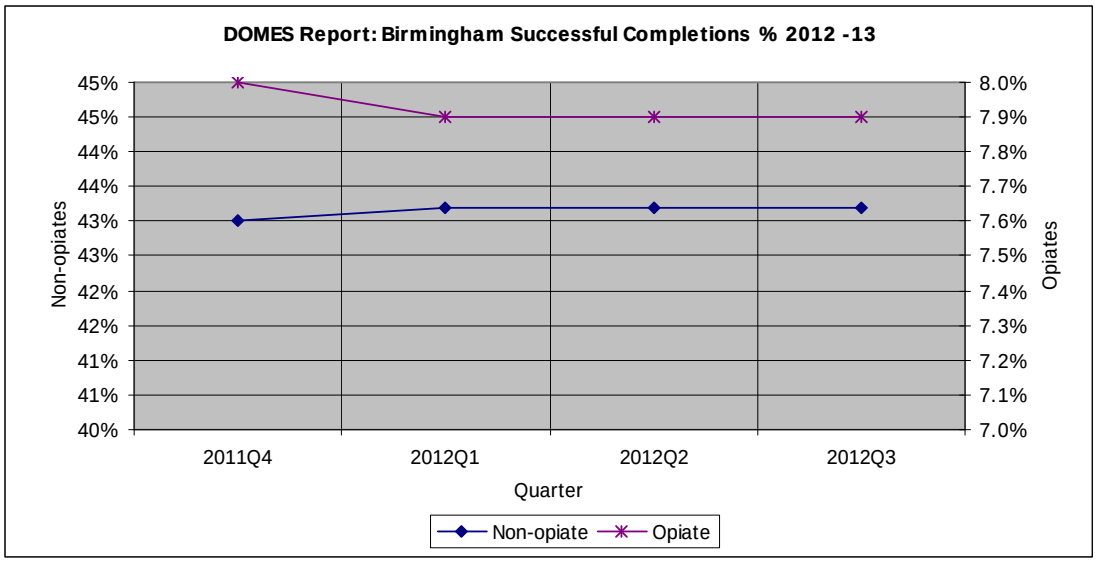
Generally, Birmingham drug treatment services have a good record with client treatment successful completions:

- 14% of drug clients successfully complete treatment in Birmingham (compared to a national average of 15%). This equates to 8% of the opiate cohort and 43% of the non-opiate cohort. Based on the NTA DOMES report these figures are expected to continue.
- 81% of the opiate cohort that successfully completed did not return to treatment within 6 months. This increased to 93% for the non-opiate cohort.
- Despite a 10% growth in successful completions nationally, Birmingham opiate successful completions saw a -8% decrease last year. This trend could be reversed with a greater focus on recovery going forward. Non-opiate successful completions increased by 5% last year.
- 54% of the opiate cohort has been in treatment for over 2 years – this compares with the national average of 53%. Only 8% of the non-opiate cohort has been in treatment for this length of time.
- 45% of adults in drug treatment in Birmingham have been on the caseload for more than two years.

		Local	National
Successful completions as a proportion of total number in treatment	Opiate	8%	9%
	Non opiate	43%	41%
	All	14%	15%
Proportion who successfully completed treatment and did not return within 6 months	Opiate	81%	80%
	Non opiate	93%	94%
	All	87%	86%
Growth in successful completions since 2010-11	Opiate	-8%	10%
	Non opiate	5%	4%
	All	-1%	7%
Proportion of adults in treatment for more than two years	Opiate	54%	53%
	Non opiate	8%	6%
	All	45%	44%



Source: National Treatment Agency



Source: DOMES Reports - National Treatment Agency

- Based on annual figures from NDTMS, Birmingham performance in significantly over the last 5 years.
- Successful completions have increased by a factor of 4.
- Numbers in Effective Treatment (NiETs) have increased by half.
- Numbers in treatment have increased tenfold.
- Waiting times under 3 weeks has improved tenfold.

	05/06	06/07	07/08	08/09	09/10	10/11
Successful Completions	208	207	327	589	755	940
Numbers In Effective Treatment	4643	5257	6016	6480	6443	6613
Numbers In Treatment	5330	5832	6439	6894	6833	6992
Waiting Times < 3 Weeks	206	2252	2320	2405	2310	2350
Percent of Waits < 3 Weeks	90	94	95	94	95	96

Source: NDTMS.net

Alcohol

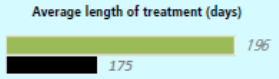
- During 2010-11, 763 clients successfully completed alcohol treatment in Birmingham. This equates to 46% of all discharges for this period and 28% of the 'in treatment' cohort. However, the National average for successful discharges is 57% and 35% of the 'in treatment' cohort.
- An alcohol client is in treatment in Birmingham for an average 196 days compared to the National average of 175 days.
- 647 clients were in alcohol treatment for more than a year. This is 24% of the Birmingham cohort, compared to the National average of 15%.
- 1,655 adults left alcohol treatment during this year. This churn rate equates to 60% - the National average is 61%.
- Although the rate of successful completions is lower than the National average, the proportion of clients NOT returning to treatment within six months is better. 26% of clients completing treatment successfully did not return to treatment within 6 months, compared to 34% nationally. For the dependent drinkers' cohort, the Birmingham figure is 4% whereas the national is 5%.

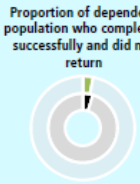
		Local	National
The average length of a course of treatment *(in days)* for clients leaving treatment in the year		196	175
Clients in treatment for more than a year	*n*	647	16320
	*%**	24%	15%
The number of adults leaving alcohol treatment in 2011-12	*n*	1655	66911
	*%**	60%	61%
Clients completing treatment successfully in 2011-12	*n*	763	38139
	% of all exits	46%	57%
	% of all in treatment	28%	35%
Clients completing treatment successfully *(between 01,01,11 and 31,12,11)* and not returning within 6 months	*n*	704	36779
	%	26%	34%
The proportion of the dependent population completing treatment successfully *(between 01,01,11 and 31,12,11)* and not returning within 6 months		4%	5%

*note: % is the number in treatment for more than a year out of all clients in treatment in the year

*note: % is the number who left in the year out of all clients in treatment in the year

*note that in order to allow for a representation period, the treatment population time period refers to the calendar year rather than the financial year used in the rest of this report. Therefore the number of completions will differ from that in the above item which refers to the financial year.





Source: National Treatment Agency

3.7 Residential Rehab

Residential rehabilitation for Birmingham residents is conducted at Park House. NDTMS figures reveal that 275 clients (4% of the 'in treatment' cohort) received this service during 2011-12. This compares to 2% nationally.

	Local	Proportion of treatment population	National	Proportion of treatment population
Number of adults who attended residential rehab	275	4%	4,026	2%

Source: National Treatment Agency

3.8 Prescription Only Medicine / Over The Counter Medicine (POM/OTC)

Almost 50 million antidepressants were prescribed in 2011. Antidepressants such as Prozac and Seroxat account for the largest annual rise in prescriptions from 2010 to 2011. Just under 46.7 million prescriptions for antidepressants were dispensed in 2011, a rise of 3.9 million on 2010. While prescription numbers overall are rising the total cost to the NHS is falling. This is probably because more drugs are now 'out of patent' and are being prescribed in cheaper generic forms.

Source: Health and Social Care Information Centre (HSCIC), "Prescriptions Dispensed in the Community: England - 2001 to 2011"

- During 2011-12, 770 adults in drug treatment (12%) recorded admitted using POM/OTC drugs – 724 (11%) illicitly. This compares with 17% of adults in treatment nationally with 15% using illicitly.

		Local	Proportion of treatment population	National	Proportion of treatment population
Number of adults citing POM/OTC use	Illicit use	724	11%	28,618	15%
	No illicit use	46	1%	4,048	2%
	Total	770	12%	32,666	17%

Source: National Treatment Agency

3.9 Blood-borne Viruses and Drug-Related Deaths

Adults in drug treatment who are or have been injecting should be routinely asked about their Hepatitis B, Hepatitis C and HIV status.

- 1,025 clients, or 52% of the eligible cohort, accepted a hepatitis B vaccination. This compares to the national average of 48%.
- 1,441 adults, 62% of the eligible cohort, received a hepatitis C test. This percentage is slightly below the 70% national average.
- No specific drug-related deaths have been published for Birmingham in 2012 due to reporting issues. However, local data suggests that within the last two years 38 clients died whilst receiving drug treatment and 35 adults died whilst receiving alcohol treatment.

	Local	Proportion of eligible clients	National	Proportion of eligible clients
Adults new to treatment eligible for a HBV vaccination who accepted one	1,025	52%	23,436	48%
Previous or current injectors eligible for a HCV test who received one	1,441	62%	73,556	70%

Source: National Treatment Agency

3.10 Parents and Families

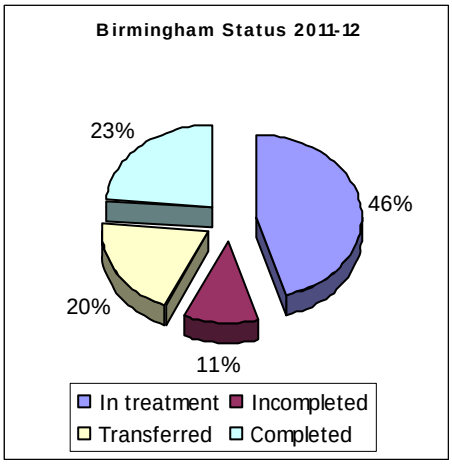
37% (2,428) of adults in drug treatment in Birmingham have children who live with them. This is potentially a huge safeguarding issue. 21% (1,348) of the drug treatment population are adults who are parents but do not live with any children.

	Local	Proportion of treatment population	National	Proportion of treatment population
Adults who live with children	2428	37%	66,193	34%
Adults who are parents but do not live with any children	1348	21%	39,587	20%
Adults with incomplete data	176	3%	6,287	3%

Source: National Treatment Agency

3.11 Drug Treatment Overview

Status	Clients	%
In Treatment	4,723	45%
Incomplete - client died	38	0%
Incomplete - dropped out	847	8%
Incomplete - retained in custody	134	1%
Incomplete - treatment commencement declined by client	64	1%
Incomplete - treatment withdrawn by provider	106	1%
Transferred - in custody	589	6%
Transferred - not in custody	1,484	14%
Treatment completed - alcohol free	315	3%
Treatment completed - drug free	1,302	12%
Treatment completed - occasional user (not opiates or crack)	833	8%
	10,435	



Source: BDAAT Service Provider Report December 2012

- In the last two years, Birmingham drug treatment agencies have recorded 10,435 treatment episodes on NDTMS. As of December 2012, 4,723 (46%) were still in treatment. 2,450 (23%) episodes were successfully completed. 2,073 (20%) client episodes were transferred to other agencies while 1,189 (11%) episodes were incomplete.
- Full NDTMS consent / personal details were not granted for 102 (1%) episodes. 253 (2%) client episodes had no address details available.
- The majority of clients (5,730) had been on the caseload for less than 1 year (55%). However, 4,603 clients (45%) had been in treatment for over 1 year. 12% (1,227) have been in treatment for over 5 years.
- The most common age banding of clients was '26-35' (45%) followed by '36-45' (32%). 115 clients (1%) were aged '18-20'.

AgeBand	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
Under 18											**0**
18 -20	21	23	15	32	19	5					**115**
21 - 25	149	155	95	189	155	74	31	16	7	11	**882**
26 - 35	333	392	354	737	756	763	407	295	174	456	**4667**
36 - 45	145	229	216	524	545	473	296	225	183	462	**3298**
46 - 55	50	88	73	158	150	119	101	74	67	217	**1097**
56 +	13	35	16	37	26	21	18	11	16	81	**274**
Unknown											**0**
TOTAL	**711**	**922**	**769**	**1677**	**1651**	**1455**	**853**	**621**	**447**	**1227**	**10333**
	7%	**9%**	**7%**	**16%**	**16%**	**14%**	**8%**	**6%**	**4%**	**12%**	

- 6,272 client episodes (61%) cited Heroin as the primary drug, followed by Cannabis with 874 (8%), Cocaine with 835 (8%), Crack with 610 (6%) and surprisingly for drug treatment agencies, alcohol with 639 client episodes (6%). 1,005 (10%) client episodes cited 'other drugs' as the primary drug. This is a significant proportion which may need further investigation.
- 1,875 client episodes (18%) that cited heroin as the primary drug had been on the caseload for over three years.
- Only 4 client episode recorded ecstasy as the primary drug.

Drug 1	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
Alcohol	101	188	101	150	69	22	6	2			**639**
Amphetamines	3	7	7	15	13	12	6	2	9	20	**94**
Cannabis	160	153	108	205	163	51	16	9	4	5	**874**
Cocaine	237	210	87	141	111	30	6	5	2	6	**835**
Crack	20	45	41	135	155	96	38	31	12	37	**610**
Ecstacy	1	1	1	1							**4**
Heroin	133	210	350	884	999	1122	699	496	366	1013	**6272**
Other Drugs	56	108	74	146	141	122	82	76	54	146	**1005**
TOTAL	**711**	**922**	**769**	**1677**	**1651**	**1455**	**853**	**621**	**447**	**1227**	**10333**
	7%	**9%**	**7%**	**16%**	**16%**	**14%**	**8%**	**6%**	**4%**	**12%**	

- 65% of client episodes were of White British ethnicity followed by 6% Pakistani, 4% White Irish, 4% White/Caribbean and 4% Caribbean.

Ethnicity	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
African	30	35	8	10	5	9	4	2	2	1	**106**
Bangladeshi	42	25	12	13	22	21	19	14	12	20	**200**
Caribbean	26	41	29	81	91	61	30	18	8	29	**414**
Indian	7	17	15	51	53	42	24	18	16	30	**273**
Not Stated	17	32	27	60	70	36	9	3	5	8	**267**
Other	12	19	4	23	15	23	16	10	8	22	**152**
Other Asian	10	9	17	34	42	26	22	9	15	15	**199**
Other Black	4	10	7	16	13	13	5	1	2	2	**73**
Other mixed	6	4	8	17	12	19	5	7	3	9	**90**
Other White	10	12	12	31	31	28	14	12	2	26	**178**
Pakistani	17	35	32	92	129	110	67	64	31	90	**667**
White and Asian	9	20	6	16	9	13	11	6	9	17	**116**
White/Black African	1	5	4	7	6	3	4	3	1		**34**
White/Black Caribbean	32	37	43	84	101	58	34	24	18	27	**458**
White British	470	589	527	1091	1009	934	558	410	300	851	**6739**
White Irish	18	32	18	51	43	59	31	20	15	80	**367**
TOTAL	**711**	**922**	**769**	**1677**	**1651**	**1455**	**853**	**621**	**447**	**1227**	**10333**
	7%	**9%**	**7%**	**16%**	**16%**	**14%**	**8%**	**6%**	**4%**	**12%**	

- The Birmingham caseload has a greater proportion of clients of white ethnicity than the Birmingham average (+11%) yet the clients of Black and Asian ethnicity have a significantly lower proportion (-4% and -16%). 3% were not stated.

Birmingham Ethnicity	Birmingham %	PHE Drug Treatment	PHE Drug treatment %	Diff %
White	58%	7106	69%	11%
Mixed	4%	608	6%	2%
Asian	27%	1140	11%	-16%
Black	9%	520	5%	-4%
Other	2%	692	7%	5%
Not Stated		267	3%	3%
		10333		

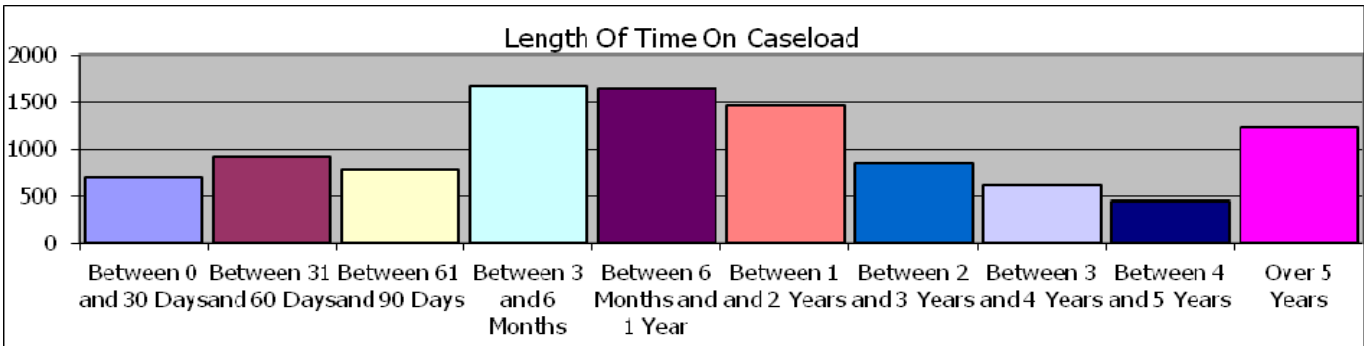
- Of the Birmingham client episodes active over the last 2 years, 76% have been male and 24% female.

Sex	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	**TOTAL**
female	136	190	195	394	384	399	198	161	98	317	**2472**
Male	575	732	574	1283	1267	1056	655	460	349	910	**7861**
TOTAL	**711**	**922**	**769**	**1677**	**1651**	**1455**	**853**	**621**	**447**	**1227**	**10333**
	7%	**9%**	**7%**	**16%**	**16%**	**14%**	**8%**	**6%**	**4%**	**12%**	

- On average, Birmingham Drug Treatment Agencies took on to the caseload 289 clients each month during 2012 – 177 (61%) were OCU and 112 (39%) were Non-OCU.
- 52% of new presentations are retained in treatment for more than 3 months in 2012. This compares to 62% in 2011.
- There were an average 117 client episodes per month (43%) that successfully completed in 2012, 95 (35%) were transferred and 58 (21%) were incomplete. The average discharge total per month was 271.
- With an average 289 episodes commencing and 271 episodes ending each month, the overall caseload is expected to increase slightly.

Injecting Status	<>	Client declined to answer	Currently injecting	Never injected	Previously injected (but not currently)
In Treatment	242	16	469	2803	1193
Incomplete - client died			6	17	15
Incomplete - dropped out	17	6	77	582	165
Incomplete - retained in custody	2	2	16	81	33
Incomplete - treatment commencement declined by client	1	1	3	48	11
Incomplete - treatment withdrawn by provider	2		13	60	31
Transferred - in custody	17	5	56	346	165
Transferred - not in custody	16	8	232	759	469
Treatment completed - alcohol free	94	4	5	183	29
Treatment completed - drug free	49	13	56	929	255
Treatment completed - occasional user (not opiates or crack)	233	2	13	541	44
	673	**57**	**946**	**6349**	**2410**

- 86.2% of the client episodes had a care co-ordinator. The re-presentations rate for the period 2011-12 was 14.6%.
- Birmingham drug treatment agencies complete on average (based on the last 5 months of 2012) 191 start TOPS, 831 review TOPS and 116 End TOPS each month. In the last two years, 36 Post Discharge TOPS were completed.



Data Quality

Data quality is generally quite good across the Birmingham treatment partnership but there are some NDTMS data fields that need improving. Nationality has been captured for only 66% of client episodes. Although accommodation status has been collected for 95% of cases, the specific type of accommodation or postcode area needs to be reviewed. In the 'employment' data, 34% of its total is 'not stated' or 'other'. There are several case management systems in use by Birmingham treatment agencies – none of which are able to communicate with each other (see Appendix 6.9).

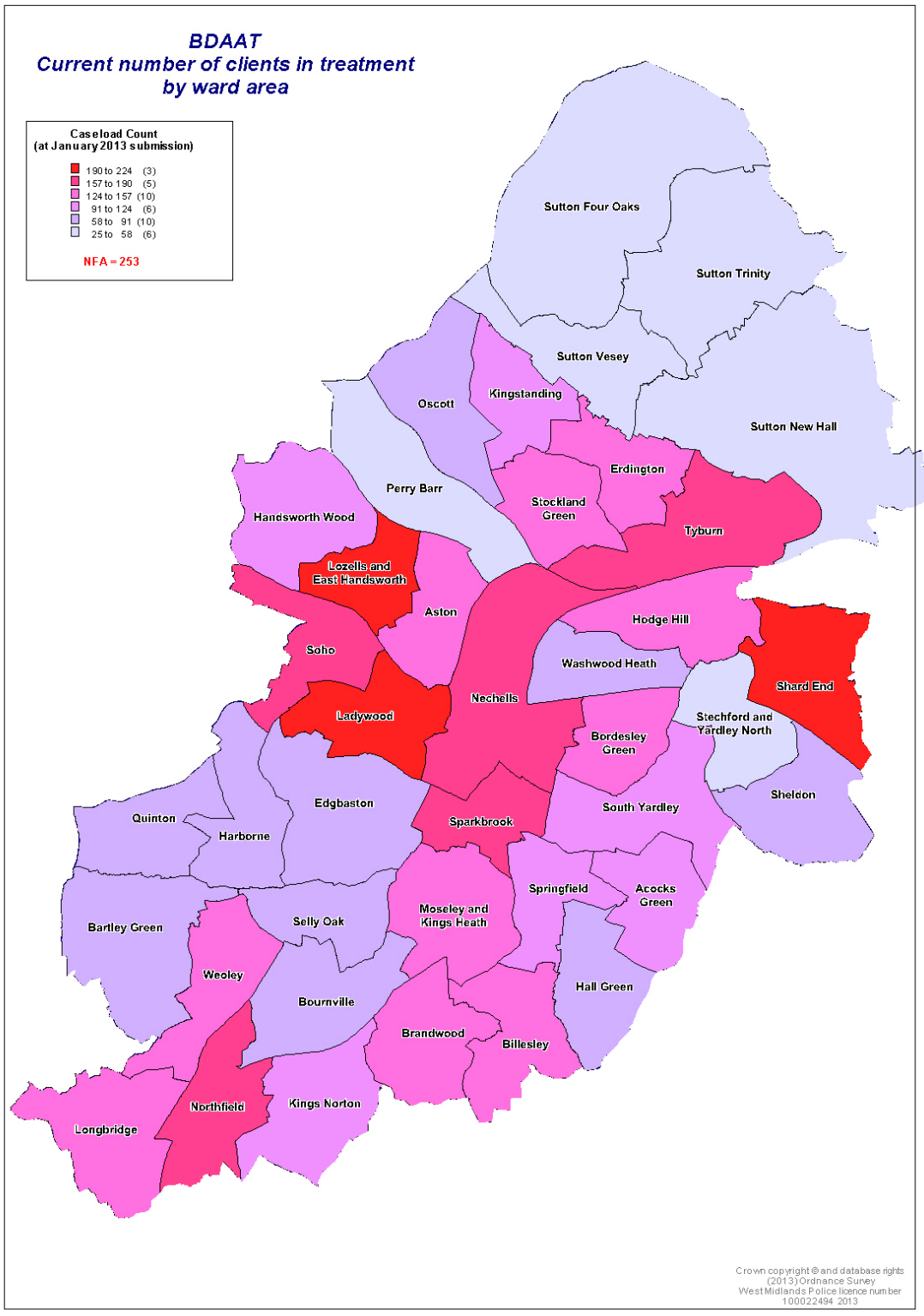
DIP Caseload

In December 2012, 1,955 active clients were recorded on PALBASE as being referred to Birmingham treatment agencies for specialist drug treatment as part of the Drug Interventions Programme. 1,908 clients of this cohort have been recorded as engaging in treatment. Therefore, Criminal Justice clients represent 39% of the total number in treatment in Birmingham drug treatment. The latest DOMES report for Birmingham agrees that 39% of all clients in treatment are DIP. On average, 145 DIP referrals are made to Birmingham treatment agencies each month.

Geography

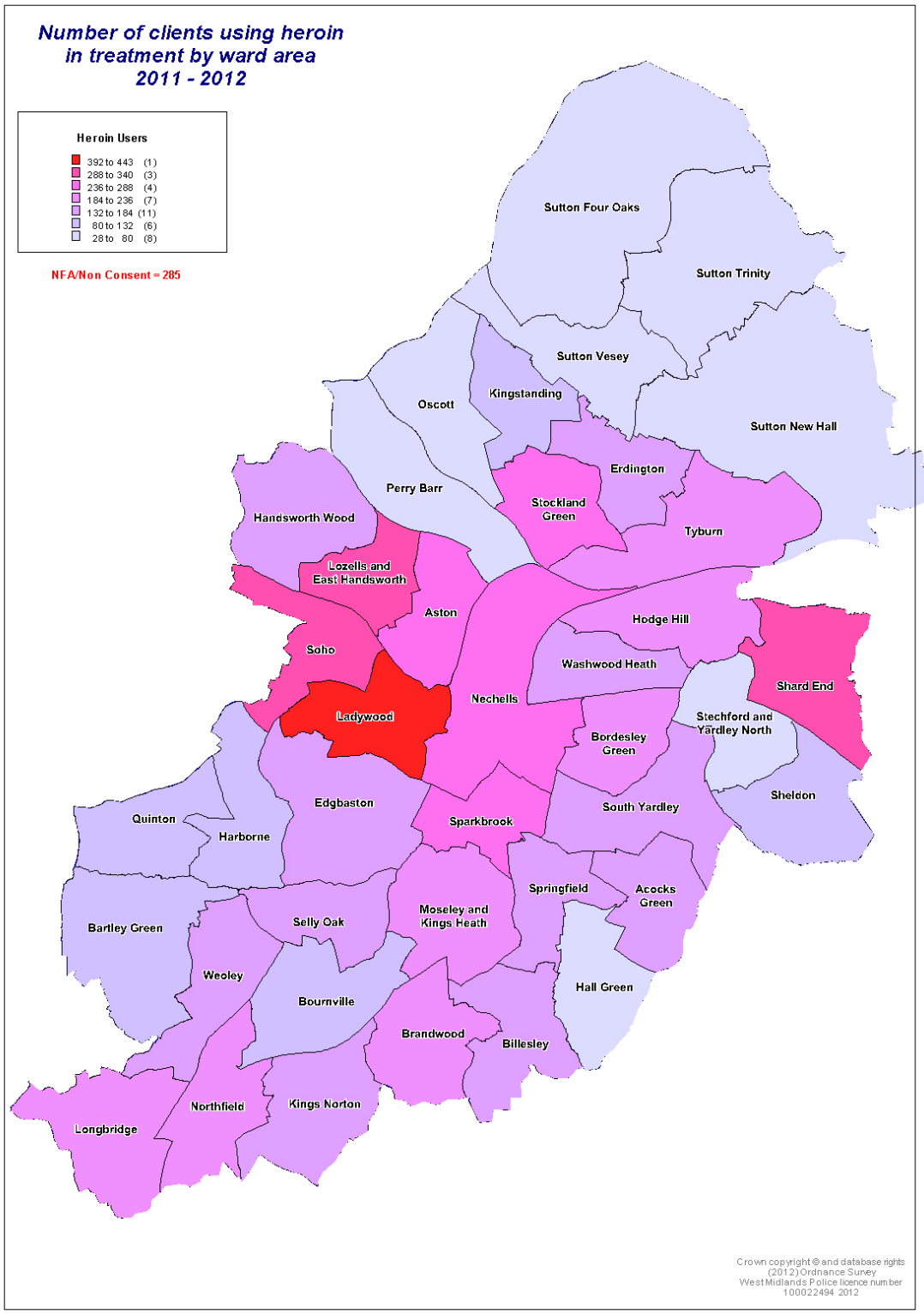
Drug treatment agencies in Birmingham have clients in all 40 wards. From December 2012 data, the ward with the highest number of clients is Ladywood (224 / 4.7%), followed by Shard End (224 / 4.7%), Lozells and East Handsworth (193 / 4.1%) and Soho (189 / 4.0%). 22 wards have over 100 clients residing. The average number in drug treatment per ward is 118. 253 client episodes did not have the postcode sector of the client recorded.

The greatest concentration of Birmingham adults in drug treatment is across the centre of the city from west to east and also at the very south of the city. There are less clients in treatment in the Sutton, Oscott and Perry Barr wards in the north and in the Stechford and Yardley North ward to the east of Birmingham.



Source: Service Provider data

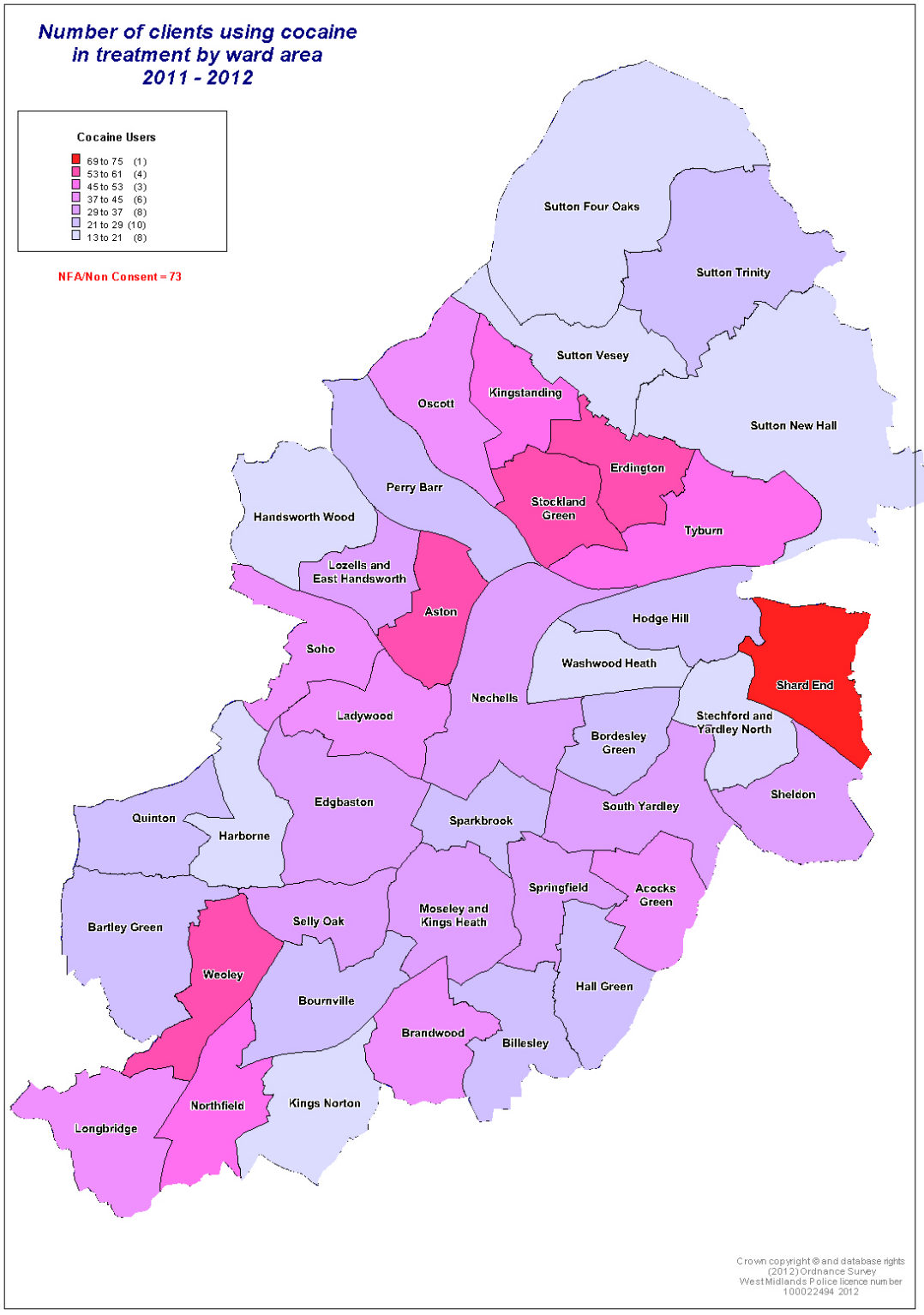
Number of clients between 2011 and 2012 who stated they used Heroin



Source: Service Provider data

- There are clients in treatment for Heroin misuse from all 40 Birmingham wards. The largest numbers of clients reside in the inner city areas around Birmingham city centre and in Shard End.

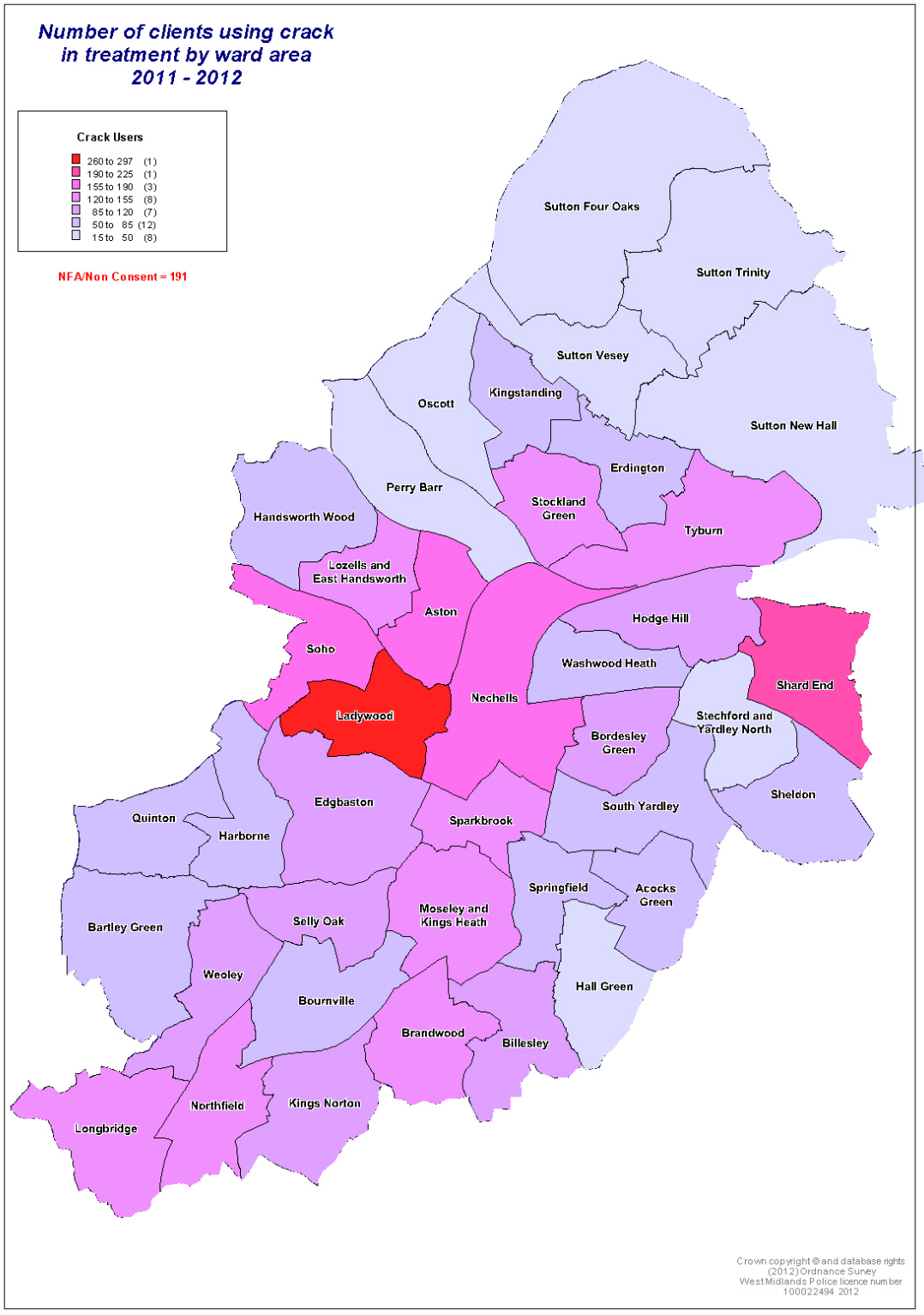
Number of clients between 2011 and 2012 who stated they used Cocaine



Source: Service Provider data

- There are clients in treatment for Cocaine misuse from all 40 Birmingham wards. The largest numbers of clients reside in Shard End and Weoley. There are also concentrations of clients that live in wards that lie between the city centre and Sutton Coldfield (i.e. Aston, Stockland Green and Erdington).

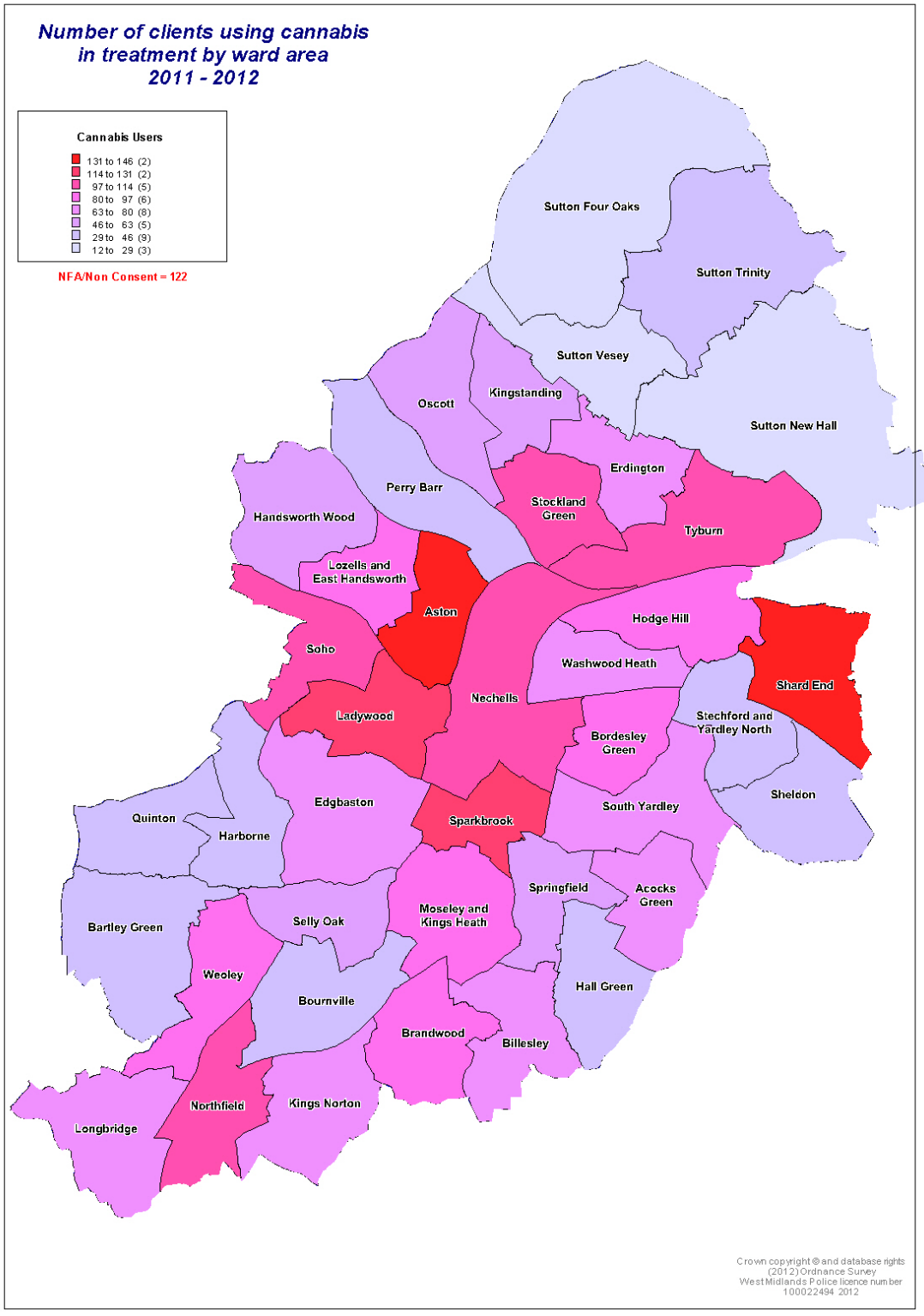
Number of clients between 2011 and 2012 who stated they used Crack



Source: Service Provider data

- There are clients in treatment for crack misuse from all 40 Birmingham wards. The largest numbers of clients reside in the inner city areas around the city centre and in Shard End to the east of the city. There are also concentrations of clients that live in wards along the Alcester Road (i.e. Sparkbrook, Moseley and kings Heath and Brandwood).

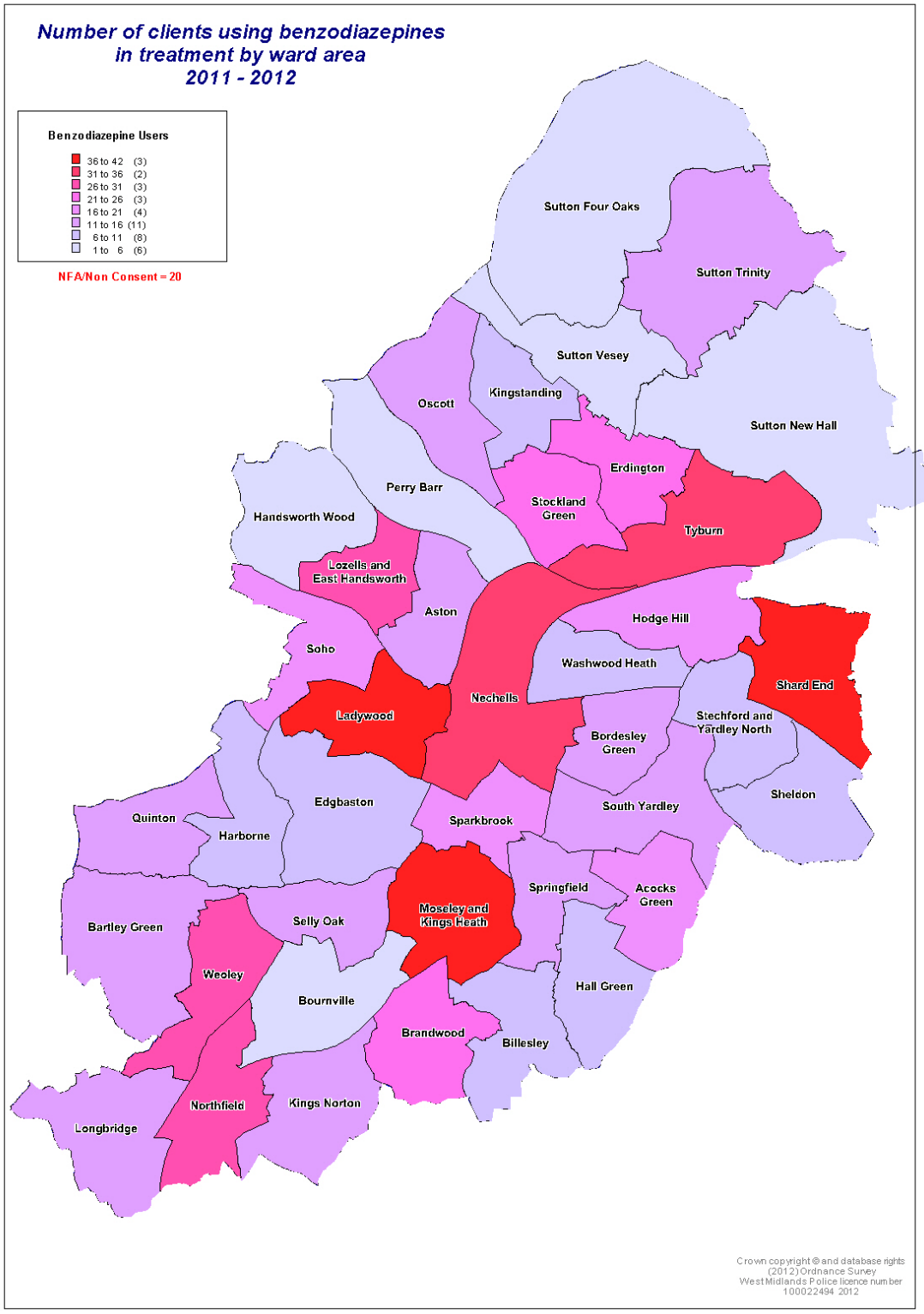
Number of clients between 2011 and 2012 who stated they used Cannabis



Source: Service Provider data

- There are clients in treatment for cannabis misuse from all 40 Birmingham wards. The largest numbers of clients reside in the inner city areas around the city centre (in particular Aston, Ladywood and Sparkbrook) and in Shard End to the east of the city.

Number of clients between 2011 and 2012 who stated they used Benzodiazepines

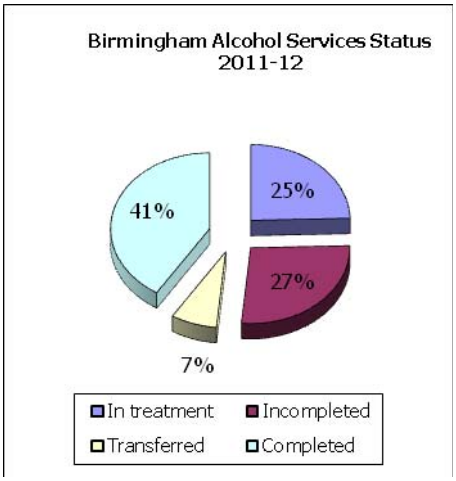


Source: Service Provider data

- There are clients in treatment for benzodiazepines misuse from all 40 Birmingham wards. The largest numbers of clients reside in Ladywood, Moseley and Kings Heath and Shard End.

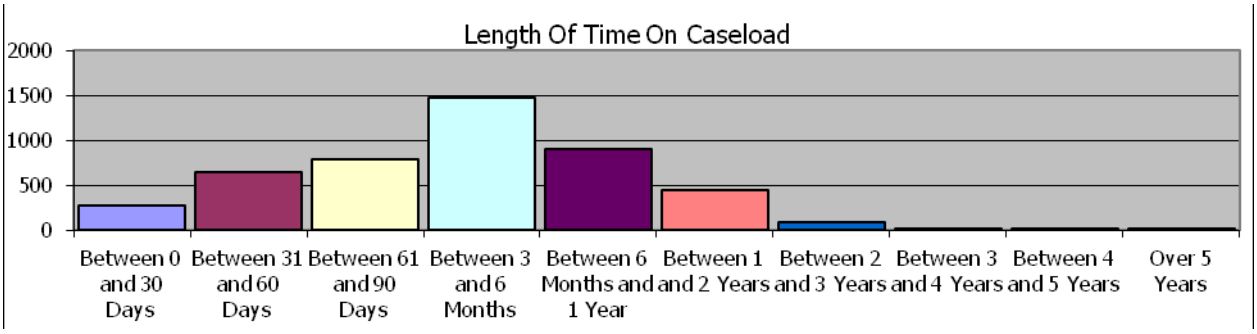
3.12 Alcohol Treatment Overview

Status	Clients	%
In Treatment	1258	25%
Incomplete - client died	35	1%
Incomplete - dropped out	1107	22%
Incomplete - retained in custody	47	1%
Incomplete - treatment commencement declined by client	167	3%
Incomplete - treatment withdrawn by provider	23	0%
Transferred - in custody	46	1%
Transferred - not in custody	338	7%
Treatment completed - alcohol free	513	10%
Treatment completed - drug free	2	0%
Treatment completed - occasional user (not opiates or crack)	1586	31%
	5122	



- In the last two years, Birmingham alcohol services have recorded 5,122 treatment episodes on NDTMS. As of December 2012, 1258 (25%) were still in treatment. 2,101 (41%) episodes were successfully completed. 384 (7%) client episodes were transferred to other agencies while 1,379 (27%) episodes were incomplete.
- Full NDTMS consent / personal details were not granted for 456 (9%) episodes. 469 (9%) client episodes had no address details available.
- The majority of clients (4,098) had been on the caseload for less than 1 year (88%).
- The most common age banding of clients was '36 - 45' (30%) followed by '46-55' (29%). 24 clients (1%) were aged '18-20'.

AgeBand	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
Under 18		1	1	2							**4**
18 -20	3	5	5	10	1						**24**
21 - 25	26	26	29	41	28	13					**163**
26 - 35	56	119	157	290	211	79	17	4			**933**
36 - 45	80	197	236	435	267	140	28	3	1		**1387**
46 - 55	71	161	247	425	287	136	32	8		3	**1370**
56 +	41	132	119	273	116	84	17	2		1	**785**
Unknown											**0**
TOTAL	**277**	**641**	**794**	**1476**	**910**	**452**	**94**	**17**	**1**	**4**	**4666**
	6%	**14%**	**17%**	**32%**	**20%**	**10%**	**2%**	**0%**	**0%**	**0%**	



- 4645 client episodes (99%) cited Alcohol as their primary substance. There were 21 instances of other drugs recorded, which are presumed erroneous.
- 75% of client episodes were of White British ethnicity followed by 4% White Irish, 3% Indian and 2% Caribbean. 8% did not state their ethnicity.

Ethnicity	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
African	3	2	2	3	6	1					**17**
Bangladeshi	1			1	3	1					**6**
Caribbean	3	14	20	19	14	6	3	1			**80**
Indian	11	24	30	34	27	15	3				**144**
Not Stated	20	21	49	117	110	41	3			1	**362**
Other	3	5	6	7	5	2	1				**29**
Other Asian	6	8	6	20	15	9	2				**66**
Other Black	1	3	2	9	5	5					**25**
Other mixed	1	2	8	8	4	5			1		**29**
Other White	4	5	10	15	7	3	1				**45**
Pakistani	4	4	12	19	9	7	1				**56**
White and Asian	1	6	6	13	6	1					**33**
White/Black African	2	2			2	1					**7**
White/Black Caribbean	4	10	11	26	16	9	1				**77**
White British	200	512	605	1136	636	330	69	14		3	**3505**
White Irish	13	23	27	49	45	16	10	2			**185**
TOTAL	**277**	**641**	**794**	**1476**	**910**	**452**	**94**	**17**	**1**	**4**	**4666**
	6%	**14%**	**17%**	**32%**	**20%**	**10%**	**2%**	**0%**	**0%**	**0%**	

- The Birmingham Alcohol Services caseload has a greater proportion of clients of white ethnicity than the Birmingham average (+21%) yet the clients of Black and Asian ethnicity have a significantly lower proportion (-7% and -23%). 8% were not stated.

Birmingham Ethnicity	Birmingham %	Alcohol Services	Alcohol Services %	Diff %
White	58%	3690	79%	21%
Mixed	4%	117	3%	-1%
Asian	27%	206	4%	-23%
Black	9%	97	2%	-7%
Other	2%	194	4%	2%
Not Stated		362	8%	8%
		4666		

- Of the Birmingham Alcohol Services client episodes active over the last 2 years, 67% have been male and 33% female.

Sex	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
female	59	196	256	499	324	147	36	8	1	2	**1528**
Male	218	445	538	977	586	305	58	9		2	**3138**
TOTAL	**277**	**641**	**794**	**1476**	**910**	**452**	**94**	**17**	**1**	**4**	**4666**
	6%	**14%**	**17%**	**32%**	**20%**	**10%**	**2%**	**0%**	**0%**	**0%**	

- On average, Birmingham Alcohol Services took on to the caseload 128 clients each month during 2012. The monthly average for 2011 was 83.
- 44% of new presentations are retained in treatment for more than 3 months in 2012. This compares to 75% in 2011.
- There were an average 90 client episodes per month (57%) that successfully completed in 2012, 17 (11%) were transferred and 51 (32%) were incomplete. The average discharge total per month was 158.
- With an average 128 episodes commencing and 158 episodes ending each month, the overall caseload is expected to continue to reduce.
- The re-presentations rate for the period 2011-12 was 12%.
- Birmingham Alcohol Services generally do not complete TOPS forms.

Data Quality

9% of clients in treatment with Birmingham Alcohol Services have not granted consent for their data to be recorded on NDTMS. This prohibits a full analysis. Consequently, the data quality has an average score of 75%. Data on ethnicity, nationality, ward and accommodation average between 80% and 88%. Employment status, pregnancy status and modality data average between 71% and 79%. Aquarius use Illy's Links Careplan system to process data on Birmingham Alcohol services clients. (see Appendix 6.9).

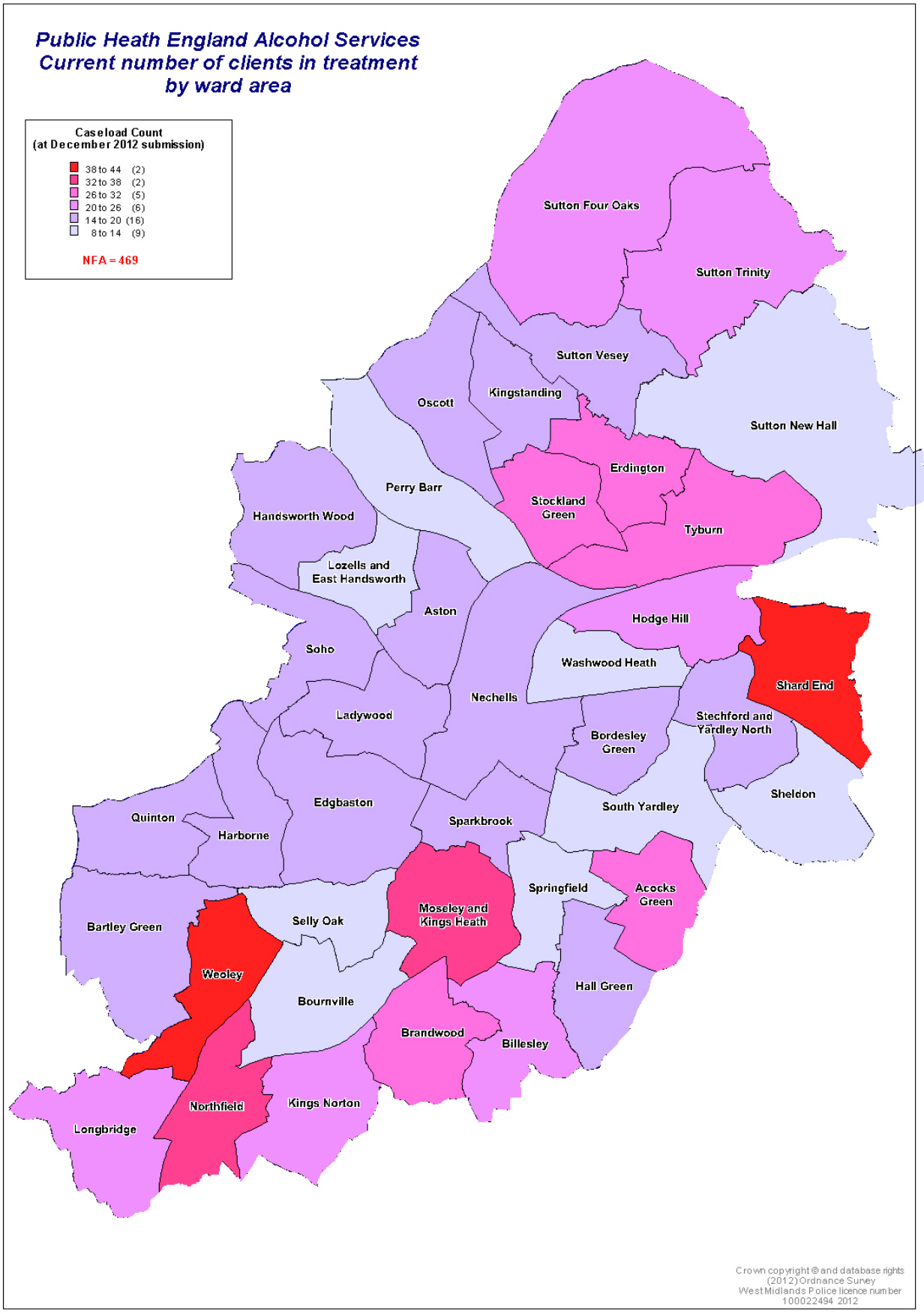
DIP Caseload

Only criminal justice clients accessing drug treatment services are recorded on PALBASE.

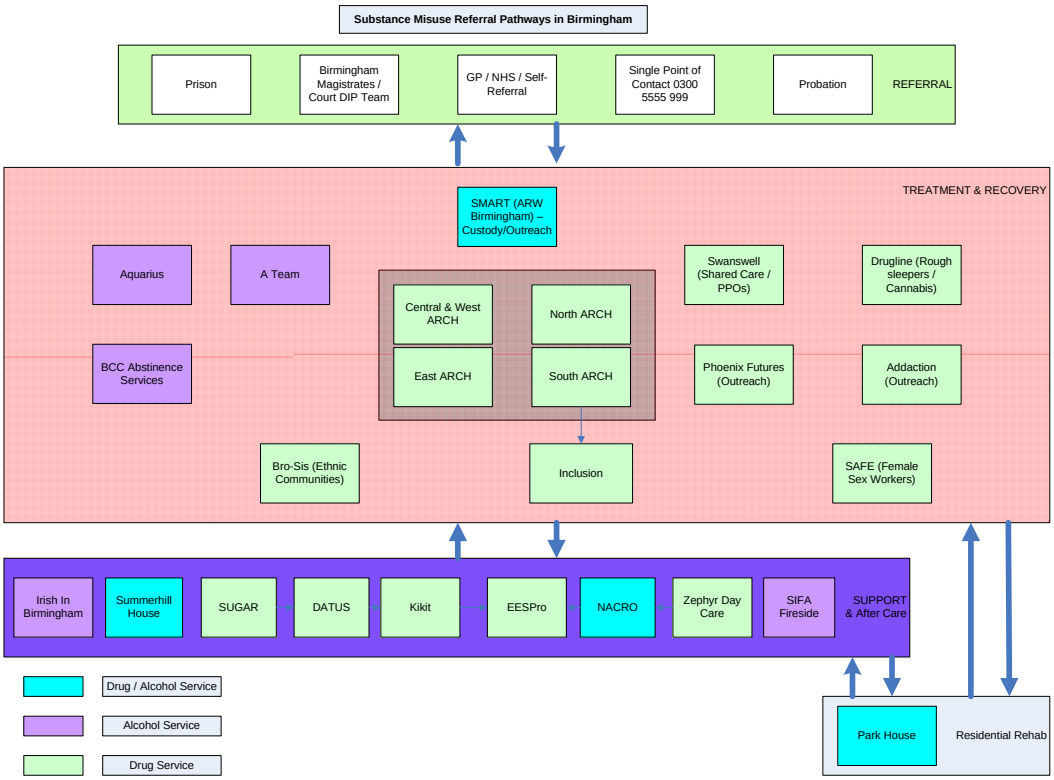
Geography

Birmingham alcohol services have clients in all 40 wards across Birmingham. From December 2012 data, the wards with the highest number of clients are Shard End (44/3.5%) and Weoley (44/3.5%). 15 wards have over 20 clients residing.

The greatest concentration of Alcohol clients are in the north, east and south of the city. There is a lower client presence from the central and western parts of Birmingham.


Public Heath England Alcohol Services
Current number of clients in treatment
by ward area
Caseload Count
(at December 2012 submission)
38 to 44 (2)
32 to 38 (2)
26 to 32 (5)
20 to 26 (6)
14 to 20 (16)
8 to 14 (9)
NFA = 469
Sutton Four Oaks
Sutton Trinity
Sutton Vesey
Kingstanding
Oscott
Sutton New Hall
Erdington
Perry Barr
Stockland Green
Handsworth Wood
Tyburn
Lozells and East Handsworth
Aston
Hodge Hill
Soho
Washwood Heath
Shard End
Nechells
Ladywood
Stechford and Yardley North
Bordesley Green
Sheldon
Edgbaston
South Yardley
Quinton
Sparkbrook
Harborne
Springfield
Acocks Green
Moseley and Kings Heath
Bartley Green
Selly Oak
Weoley
Hall Green
Bournville
Brandwood
Billesley
Northfield
Kings Norton
Longbridge
Crown copyright © and database rights (2012) Ordnance Survey West Midlands Police licence number 100022494 2012

4.0 Treatment & Support Agencies



4.1 Drug Interventions Programme

The Drug Interventions Programme is a key part of the United Kingdom's strategy for tackling drug abuse. It engages drug-misusing offenders involved in the Criminal Justice system (CJS) in formal addiction treatment and other support, thereby reducing drug-related harm and reducing offending behaviour. Introduced in 2003, it formed a part of both of New Labour's '10 year' drug strategies. In their 2010 Drug Strategy, the Conservative / Liberal Democrat coalition state their continued intention to support DIP. DIP engages offenders through a variety of methods, some coercive, such as the Tough Choices program, and some relying on voluntary engagement. Class A drug-misusing offenders are identified on their journey through the CJS and steered towards treatment and wraparound support. Key points of intervention include following a positive drugs test in police custody, and following release from prison.

DIP's key partners in Birmingham include West Midlands Police, the National Probation service, HMP Birmingham prison, Birmingham Magistrates Court and other criminal justice agencies, as well as the National Treatment Agency and Birmingham City Council / Public Health England.

Under the Police and Criminal Evidence Act 1984(PACE), it had been possible for police to drug test Detained Prisoners since 1984. The Drugs Act 2005 introduced a mandatory drug test for every individual who had been arrested for a specified list of "trigger offences." Trigger offences were first set out in the Criminal Justice and Court Services Act 2000, and constitute a list of offences known have a clear link to substance misuse (such as Theft). Arrestees may also be tested for 'non-trigger' offences (including, for example, those related to prostitution) with the authority of a police inspector. Individuals who refused to take this test, a "non-intimate saliva sample", could face up to three months in custody and a £2,500 fine. Individuals who tested positive were then compelled to undergo a two-part "Required Assessment" with a drug worker from their local DIP.

Individuals who test positive under the "Test on Arrest" scheme are required to see a drug worker for a single appointment. Although the Drugs Act 2005 had introduced a contingency for a "Follow-up Required Assessment" process, this measure was not implemented until March 2007. Individuals who fail to attend either of these appointments could face up to three months in prison or a £2,500 fine.

Restrictions on Bail had been introduced under the Criminal Justice Act 2003. This piece of legislation amended the Bail Act 1976 by reversing the presumption of bail to anyone who had tested positive to a class A drug, unless they agreed to undergo assessment and treatment with their local DIP for the duration of their court bail. This effectively obliged courts to implement a bail condition compelling such persons to attend their local DIP. The stated aim of this was to "prevent offending on bail". Failure to abide by this condition could result in the denial of further court bail.

In 2004, the Prolific and Other Priority Offenders (PPO) Scheme was set up. A crime reduction initiative, it aims to identify a hard-core of individuals (a significant proportion of whom have drug dependency issues) considered responsible for large amounts of crime, and manage them through either rehabilitation or conviction.

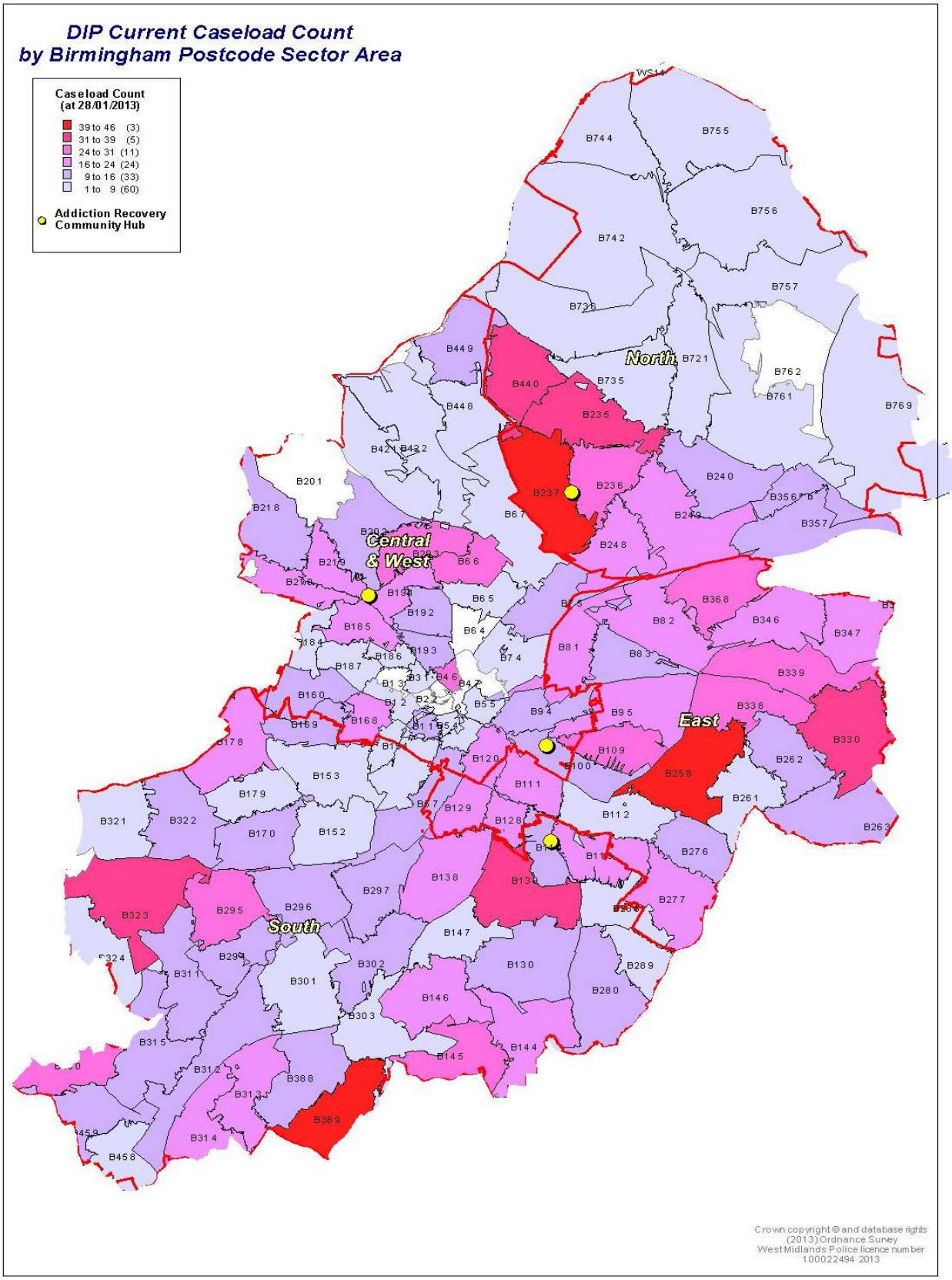
Source: Wikipedia – Drug Interventions Programme

There is a wealth of research available which looks at the links between drug use, and treatment, and the impact on crime. Back in 2008, the Home Office conducted a rapid round-up of impact information. In 2012, the National Treatment Agency (NTA) published a document called “Estimating the Crime Reduction Benefits of Drug Treatment and Recovery”. Their document “Why invest?” also provides some key facts and figures on the reasons for investment in drug treatment, including the impact on crime.

DIP was set up to provide a pathway into treatment and recovery for drug using offenders at the earliest stages of their entry into the criminal justice system and to link with other agencies in the criminal justice system to ensure continuation of treatment and recovery.
From the latest stats available (11/12):

- 6,000 individuals each month were drug tested in custody for the first time to identify those who drug using was linked to their offending
- 400 DIP Conditional Cautions diverted users away from court and into treatment and recovery
- 6,000 individuals were given Restriction on Bail, ensuring drug users have contact with a drugs worker and access to treatment and recovery services before a court disposal
- 17,000 individuals engaged voluntarily with drug workers for support and treatment for drug use
- 45,000 new clients in the community agreed they needed help for their drug misuse and offending problems
- 14,000 prisoners were picked up on release and managed into recovery and rehabilitation
- 29% of new presentations into treatment were directly referred from the criminal justice system with 13% of all referrals directly through DIP.

In 2013-14 Police and Crime Commissioners (PCCs) will receive money from a Community Safety Fund (CSF). PCCs can use this funding to invest in crime, drugs and community safety activities and programmes. All local authorities are expected to have a Health and Wellbeing Board (HWB) fully operational by April. In designing these new arrangements, local authorities have also been thinking through how existing partnership bodies such as DAATs, adult and children's safeguarding boards and community safety partnerships will be positioned in relation to the HWB. It will be a matter for local determination how planning and commissioning structures for health and public health services will be structured.
Source: Home Office


DIP Current Caseload Count
by Birmingham Postcode Sector Area
Caseload Count
(at 28/01/2013)
39 to 46 (3)
31 to 39 (5)
24 to 31 (11)
16 to 24 (24)
9 to 16 (33)
1 to 9 (60)
Addiction Recovery
Community Hub
North
Central
& West
East
South
Crown copyright © and database rights
(2013) Ordnance Survey
West Midlands Police licence number
100022494 2013

4.2 Birmingham & Solihull Mental Health Foundation Trust (BSMHFT) ARCHs

BSMHFT's aim, through their ARCHs (Addiction Recovery Community Hubs) is to support service users in recovering from their drug and/or alcohol problem within their own community. ARCH provides a range of services, some of which are delivered in partnership with partner agencies. Services include:

- Specialist addiction assessment
- Access to the ASPIRE Peer Mentoring and Recovery Coaching scheme - an opportunity to meet and gain support from those who are currently in recovery
- Service user development opportunities
- Physical health clinics- advice on how physical health which may be affected due to addiction problems, i.e. basic health checks, blood borne virus testing and vaccination and referral to primary care and/or allied health professionals
- One to one sessions using psychological therapies with a member of the ARCH team to address specific issues
- ARCH meetings - meeting subjects such as what treatment involves, how to avoid relapse, how to move towards recovery, healthy lifestyle choices and preparation for detoxification
- Referral to 'community rehabilitation'-engaging with ARCH and other service providers within Birmingham to improve your housing situation, employment/training/education prospects and develop new interests and hobbies away from old friends and routines
- Support for your family, partner of carer in conjunction with other service providers
- Specific support for those service users who have children or have access to children, i.e. assessment and referral for family support services or social services liaison

ARCH accept referrals from a range of professional sources such as GPs, social care and health and other drug and alcohol treatment providers, including those via approved referral routes within the criminal justice system. ARCH also accept direct self referrals. ARCH Services in Birmingham are located within the South, North, East and Central/West areas of the city at the following locations:

ARCH North: *411 Slade Road, Erdington, Birmingham. B23 7JA Tel: 0121 301 5470*

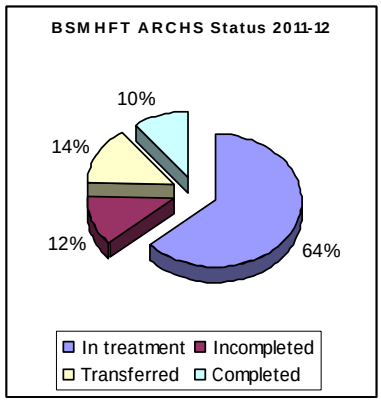
ARCH East: *42 Chapman Rd, Small Heath, Birmingham, B10 0PG Tel: 0121 301 6744*

ARCH South: *570 – 576 Stratford Road, Sparkhill, Birmingham, B11 4AN Tel: 0121 301 3900*

ARCH Central and West: *55 Terrace Road, Handsworth, Birmingham, B19 1BP Tel: 0121 301 1660*

Source: www.bsmhft.nhs.uk

Status	Clients	%
In Treatment	2093	64%
Incomplete - client died	6	0%
Incomplete - dropped out	323	10%
Incomplete - retained in custody	43	1%
Incomplete - treatment commencement declined by client	11	0%
Incomplete - treatment withdrawn by provider	11	0%
Transferred - in custody	180	5%
Transferred - not in custody	288	9%
Treatment completed - alcohol free	144	4%
Treatment completed - drug free	139	4%
Treatment completed - occasional user (not opiates or crack)	53	2%
	3291	




BSMHFT
Addiction Recovery
Community Hub
areas
North
North ARCH
Central
& West
Central &
West ARCH
East
East ARCH
South ARCH
South

BSMHFT ARCH Analysis

- In the last two years, the ARCHs have recorded 3,291 treatment episodes on NDTMS. As of December 2012, 2,093 (64%) were still in treatment. 336 (10%) episodes were successfully completed. 468 (14%) client episodes were transferred to other agencies while 394 (12%) episodes were incomplete.
- Full NDTMS consent / personal details were not granted for 64 (2%) episodes. 143 (4%) client episodes had no address details available.
- The majority of clients had been on the caseload between 3 months and 2 years (1504 episodes (59%)). 593 clients (18%) had been in treatment for more than three years.
- The most common age banding of clients was '26-35' (45%) followed by '36-45' (31%). 42 clients (1%) were aged '18-20'.

AgeBand	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
Under 18											**0**
18 -20	1	2	7	15	12	5					**42**
21 - 25	2	7	27	74	88	36	8	6	2	2	**252**
26 - 35	30	66	85	287	344	323	142	86	42	92	**1497**
36 - 45	18	44	60	154	201	201	103	74	39	115	**1009**
46 - 55	11	26	20	42	50	49	44	25	19	63	**349**
56 +	8	12	3	5	6	8	8	2	3	23	**78**
TOTAL	**70**	**157**	**202**	**577**	**701**	**622**	**305**	**193**	**105**	**295**	**3227**
	2%	**5%**	**6%**	**18%**	**22%**	**19%**	**9%**	**6%**	**3%**	**9%**	

- 2,192 client episodes (67%) cited Heroin as the primary drug, followed by Alcohol with 243 (7%) and Cannabis with 220 (7%). As the emphasis within the ARCHs is on Class A treatment, it is unexpected to see Alcohol so prominent as a primary drug. Whether this is due to data recording or is a policy decision is unknown.
- 492 client episodes (15%) that cited heroin as the primary drug had been on the caseload for over three years.
- Only 1 client episode recorded ecstasy as the primary drug.

Drug 1	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
Alcohol	42	76	34	37	25	21	6	2			**243**
Amphetamines			1	4	3	4	3	1	2	6	**24**
Cannabis	2	8	24	77	76	22	6	3		2	**220**
Cocaine	6	4	7	52	55	16	1	1	1	2	**145**
Crack	1	9	11	33	62	41	6	6	1	9	**179**
Ecstacy			1								**1**
Heroin	17	57	116	344	442	475	249	156	92	244	**2192**
Other Drugs	2	3	8	30	38	43	34	24	9	32	**223**
TOTAL	**70**	**157**	**202**	**577**	**701**	**622**	**305**	**193**	**105**	**295**	**3227**
	2%	**5%**	**6%**	**18%**	**22%**	**19%**	**9%**	**6%**	**3%**	**9%**	

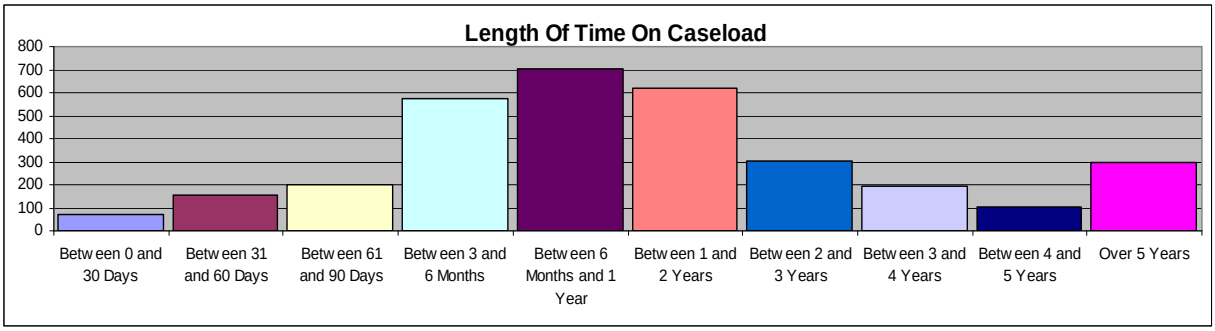
- 60% of client episodes were of White British ethnicity followed by 9% Pakistani, 4% Indian, 4% Caribbean and 4% White/Caribbean.

- 130 client episodes (4%) did not have an ethnicity stated. 55 of these cases had been in treatment for over 6 months.

Ethnicity	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
African			2	4	2	4	3	1	1		**17**
Bangladeshi	1	1	3	8	16	13	11	9	4	4	**70**
Caribbean	3	6	5	36	38	27	11	6	2	14	**148**
Indian		5	3	26	29	29	14	7	7	7	**127**
Not Stated	9	13	17	33	49	6			2	1	**130**
Other		3	2	13	7	10	10	4	2	1	**52**
Other Asian		2	4	13	18	12	9	4	6	5	**73**
Other Black	2	2	1	5	5	3			2		**20**
Other mixed				2	5	4	1	1	2	3	**18**
Other White	1	1	4	13	21	15	4	5		9	**73**
Pakistani	2	7	10	38	67	63	33	31	9	24	**284**
White and Asian	2	1	1	2	2	2	2	1	1	3	**17**
White/Black African				2	3	2	1		1		**9**
White/Black Caribbean		3	8	29	31	28	13	11	6	2	**131**
White British	46	105	140	340	393	385	180	111	59	210	**1969**
White Irish	4	8	2	13	15	19	13	2	1	12	**89**
TOTAL	**70**	**157**	**202**	**577**	**701**	**622**	**305**	**193**	**105**	**295**	**3227**

- The ARCH caseload has a greater proportion of clients of white ethnicity than the Birmingham average (+5%) yet the clients of Black and Asian ethnicity have a significantly lower proportion (-5% and -12%). 6% were not stated.

Birmingham Ethnicity	Birmingham %	ARCH Ethnicity	ARCH %	Diff %
White	58%	2058	63%	5%
Mixed	4%	157	5%	1%
Asian	27%	481	15%	-12%
Black	9%	165	5%	-4%
Other	2%	236	7%	5%
Not Stated		194	6%	6%



- Of the ARCH client episodes over the last 2 years, 76% have been male and 23% female. However, for client episodes active for over 5 years, 28% are female and 72% are male.

Sex	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
female	20	41	47	99	148	170	72	39	23	82	**741**
Male	50	116	155	478	553	452	233	154	82	213	**2486**
TOTAL	**70**	**157**	**202**	**577**	**701**	**622**	**305**	**193**	**105**	**295**	**3227**
	2%	**5%**	**6%**	**18%**	**22%**	**19%**	**9%**	**6%**	**3%**	**9%**	

- On average, the ARCHs took on to the caseload 131 clients each month during 2012 – 90 (69%) were OCU and 41 (31%) were Non-OCU. The monthly average for 2011 was 127.
- 74% of new presentations are retained in treatment for more than 3 months in 2012.
- There were an average 37 client episodes per month (30%) that successfully completed in 2012, 42 (34%) were transferred and 44 (36%) were incomplete. The average discharge total per month was 132.
- With an average 131 episodes commencing and 132 episodes ending each month, the overall caseload has remained stable.
- 97% of the client episodes had BSMHFT as the care co-ordinator. The re-presentations rate for the period 2011-12 was 7.8%.
- The ARCHs complete on average (based on the last 5 months of 2012) 102 start TOPS, 248 review TOPS and 41 End TOPS each month. In the last two years, only 8 Post Discharge TOPS were completed.

Data Quality

Data quality is generally very good with Ethnicity, address /accommodation, drug and injecting status fields all achieving over 90% compliance. Pregnancy and Hepatitis B/C data all achieve over 85% compliance. Although the 'employment' data has been collected, 60% of its total is 'not stated' or 'other'. This could have serious consequences if employment status is used as a performance measure in the future. No 'Nationality' data is collected by the ARCHs. The RIO system is used to collect and report on ARCH data (see Appendix 6.9).

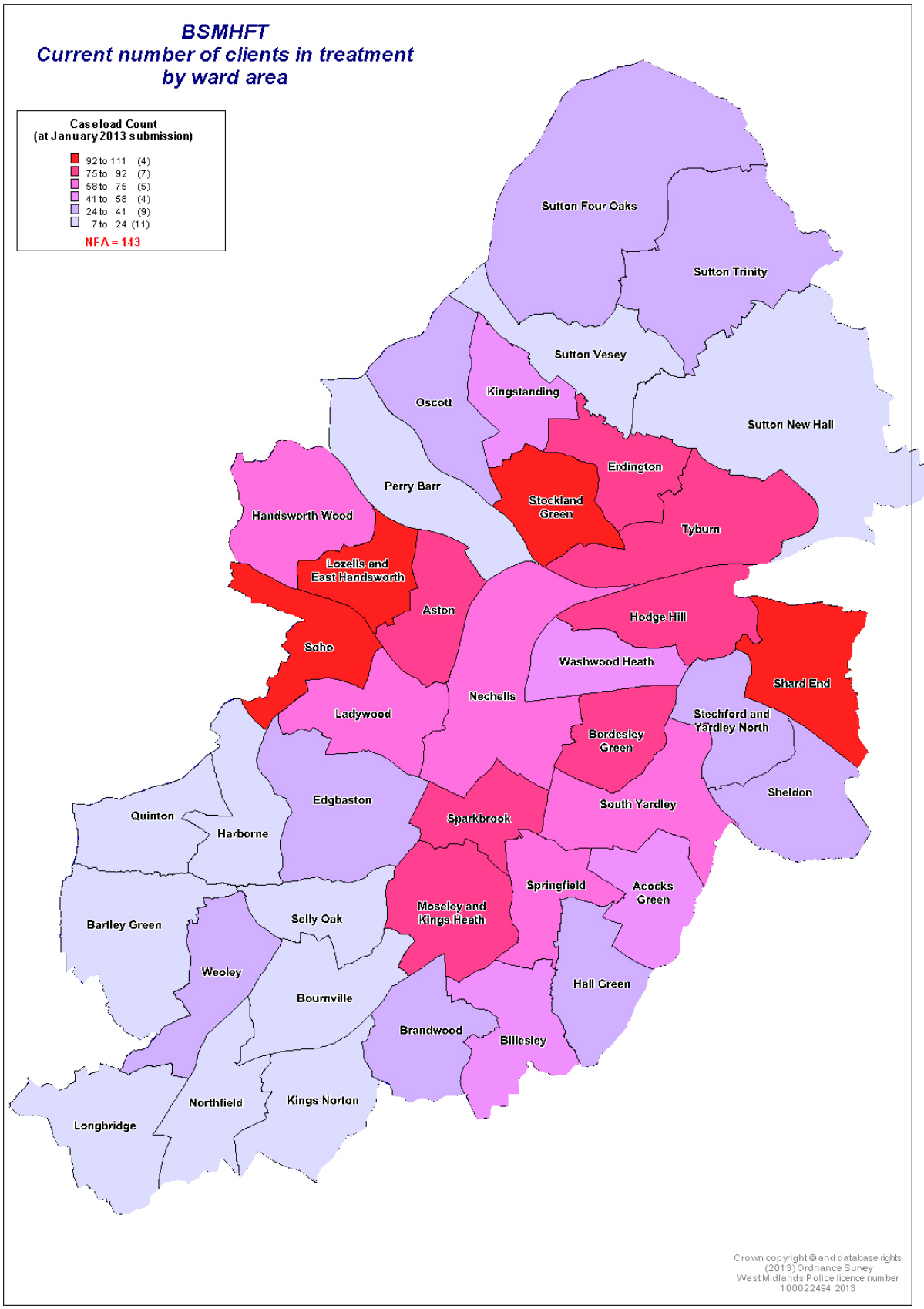
DIP Caseload

In December 2012, 853 active clients were recorded on PALBASE as being referred to the ARCHs for specialist drug treatment as part of the Drug Interventions Programme. 640 clients of this cohort have been recorded as engaging in treatment. Therefore, Criminal Justice clients represent 40% of the total number in treatment in the four ARCHs. The latest DOMES report for Birmingham estimates that 39% of all clients in treatment are DIP. On average, 64 DIP referrals are made to the ARCHs each month.

Geography

The four ARCHs have clients in all 40 wards across Birmingham. From December 2012 data, the ward with the highest number of clients is Shard End (114 (5.3%) East ARCH), followed by Lozells (113 (5.3%) Central ARCH) and Soho (104 (4.9%) Central ARCH). 6 wards have between 75 and 100 clients while 10 wards have between 50 and 75 clients.

The greatest concentration is across the central part of the City. There are less ARCH clients in treatment in the wards at the northern and southern parts of Birmingham. In the Southern wards this may be because of client referrals to the Inclusion treatment agency.


BSMHFT
Current number of clients in treatment by ward area
Caseload Count (at January 2013 submission)
92 to 111 (4)
75 to 92 (7)
58 to 75 (5)
41 to 58 (4)
24 to 41 (9)
7 to 24 (11)
NFA = 143
Sutton Four Oaks
Sutton Trinity
Sutton Vesey
Sutton New Hall
Oscott
Kingstanding
Erdington
Perry Barr
Stockland Green
Handsworth Wood
Tyburn
Lozells and East Handsworth
Aston
Hodge Hill
Soho
Washwood Heath
Shard End
Nechells
Ladywood
Stechford and Yardley North
Bordesley Green
Sheldon
Edgbaston
Quinton
Sparkbrook
South Yardley
Harborne
Springfield
Acocks Green
Moseley and Kings Heath
Bartley Green
Selly Oak
Weoley
Hall Green
Bournville
Brandwood
Billesley
Northfield
Kings Norton
Longbridge
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4.3 Swanswell

In 1968, Lord Leigh formed a group with like-minded individuals to help people in Coventry and Warwickshire overcome alcohol and drugs. The group achieved charity status a year later, under the name Alcohol and Drugs Community Service Coventry and Warwickshire. In 1994, the charity became known as Swanswell Charitable Trust when they moved from Priory Row to the new Swanswell Pool in Coventry. A new drug misuse support service in Birmingham commenced in 2002. Swanswell have grown from a Midlands-based service provider to a national organisation, winning new contracts for a carers' support service in Barnsley, substance misuse services in Sandwell, Leicestershire and Rutland, and providing online support for the popular national parenting website Netmums. Today, Swanswell helps more than 9,000 people overcome problem alcohol and drug use through face-to-face and telephone interventions as well as over 100,000 people online – with a turnover of more than £10.3million.

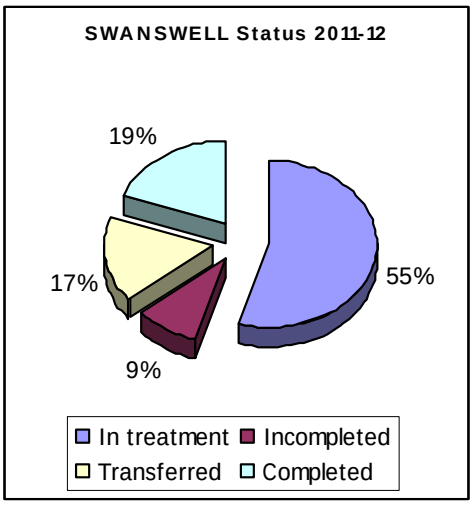
Swanswell, Ruskin Chambers, 191 Corporation Street, Birmingham, B4 6RP
Tel: 0121 233 7400
Source: www.Swanswell.org

Swanswell is commissioned by the DAAT to provide primary care or 'shared care' drug services throughout Birmingham for service users who are engaged in drug treatment with their GPs. Swanswell employs primary care drug workers linked directly to GP surgeries across the city. Generally individuals involved in 'shared care' are more stable and many are not offenders. Swanswell is the onward pathway for the majority of service users from the DIP teams, those who are sufficiently stable enter into primary care services with their GP, others who do not have a GP willing to offer shared care or who need more intensive support are managed via Swanswell DIP clinics.

Swanswell provides drug treatment services to all Prolific and other Priority Offenders (PPOs) in Birmingham, and also a similar service for those offenders who are under the supervision of the Probation Service, either as part of a Community Order or while on licence following release from custody.
Source: www.bdaat.co.uk

Swanswell Analysis

Status	Clients	%
In Treatment	1880	54%
Incomplete - client died	23	1%
Incomplete - dropped out	233	7%
Incomplete - retained in custody	53	2%
Incomplete - treatment commencement declined by client	9	0%
Incomplete - treatment withdrawn by provider	9	0%
Transferred - in custody	280	8%
Transferred - not in custody	300	9%
Treatment completed - alcohol free		0%
Treatment completed - drug free	556	16%
Treatment completed - occasional user (not opiates or crack)	117	3%
	3460	



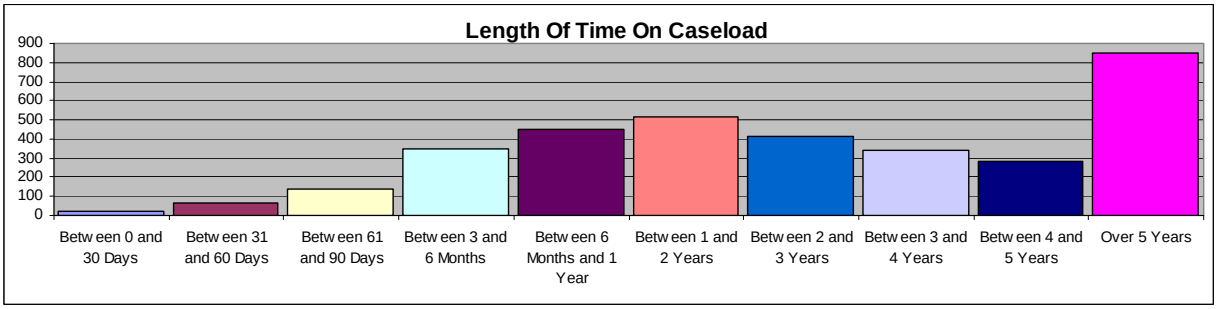
- In the last two years, Swanswell have recorded 3,460 treatment episodes on NDTMS. As of December 2012, 1,880 (54%) were still in treatment. 673 (19%) episodes were successfully completed. 580 (17%) client episodes were transferred to other agencies while 327 (9%) episodes were incomplete.

- Full NDTMS consent / personal details were not granted for 36 (1%) episodes. 98 (3%) client episodes had no address details available.
- The majority of clients had been on the caseload for over 3 years (1,479 episodes (43%)). 927 clients (27%) had been in treatment between 1 and three years.
- The most common age banding of clients was '26-35' (45%) followed by '36-45' (35%). 15 clients (<1%) were aged '18-20'.

Age Band	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	**TOTAL**
Under 18											**0**
18 -20	1	2	1	8	3						**15**
21 - 25	2	12	17	44	28	22	17	9	3	9	**163**
26 - 35	9	28	63	167	215	268	207	164	113	328	**1562**
36 - 45	4	20	43	103	155	171	140	125	119	314	**1194**
46 - 55	3	4	13	23	42	44	44	38	42	147	**400**
56 +				2	6	7	7	7	8	53	**90**
TOTAL	**19**	**66**	**137**	**347**	**449**	**512**	**415**	**343**	**285**	**851**	**3424**

- 2,653 client episodes (77%) cited Heroin as the primary drug, followed by Crack with 225 (7%) and Cocaine with 92 (3%). 341 (10%) client episodes cited 'other drugs' as the primary drug. This is a significant proportion which may need further investigation.
- 1,217 client episodes (36%) that cited heroin as the primary drug had been on the caseload for over three years.
- No client episode recorded ecstasy as the primary drug.

Drug 1	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	**TOTAL**
Alcohol		1		2							**3**
Amphetamines	1		1	1	1	2	1		5	10	**22**
Cannabis	2	12	11	30	20	6	3	1	2	1	**88**
Cocaine	3	5	10	25	30	8	2	4	1	4	**92**
Crack		8	8	41	52	34	24	22	9	27	**225**
Ecstacy											**0**
Heroin	13	33	98	231	303	410	348	273	233	711	**2653**
Other Drugs	0	7	9	17	43	52	37	43	35	98	**341**
TOTAL	**19**	**66**	**137**	**347**	**449**	**512**	**415**	**343**	**285**	**851**	**3424**



- 65% of client episodes were of White British ethnicity followed by 8% Pakistani, 5% White Irish, 4% White/Caribbean and 3% Caribbean.

Ethnicity	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
African	1			1	1	1				1	**5**
Bangladeshi		1	2	2		7	7	5	8	15	**47**
Caribbean		4	7	17	21	15	12	5	5	12	**98**
Indian		1	4	8	11	8	7	11	9	22	**81**
Not Stated		3	4	13	14	27	9	1	3	6	**80**
Other	1			2	3	11	5	4	7	20	**53**
Other Asian			5	7	16	8	12	4	7	9	**68**
Other Black		1	1	6	5	5	5	1		1	**25**
Other mixed		1	2	4	5	8	4	6	1	4	**35**
Other White		1	2	4	7	6	10	5	2	17	**54**
Pakistani		3	9	28	48	36	32	31	21	66	**274**
White and Asian		2		7	3	5	7	4	8	13	**49**
White/Black African		1	1		2	1		2			**7**
White/Black Caribbean		1	16	21	37	16	15	10	11	23	**150**
White British	16	47	82	215	261	333	273	239	190	577	**2233**
White Irish	1		2	12	15	25	17	15	13	65	**165**
TOTAL	**19**	**66**	**137**	**347**	**449**	**512**	**415**	**343**	**285**	**851**	**3424**

- The Swanswell caseload has a greater proportion of clients of white ethnicity than the Birmingham average (+11%) yet the clients of Black and Asian ethnicity have a significantly lower proportion (-6% and -15%). 3% were not stated.

Birmingham Ethnicity	Birmingham %	Swanswell Ethnicity	Swanswell %	Diff %
White	58%	2398	69%	11%
Mixed	4%	206	6%	2%
Asian	27%	402	12%	-15%
Black	9%	103	3%	-6%
Other	2%	235	7%	5%
Not Stated		116	3%	3%
		3460		

- Of the Swanswell client episodes active over the last 2 years, 79% have been male and 21% female. However, for client episodes active for over 3 years, 24% are female but below three years the average percentage falls to 18%. In other words, Swanswell are not proportionally engaging female clients as successfully as three years ago.

Sex	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
female	2	12	32	52	70	118	80	87	62	208	**723**
Male	17	54	105	295	379	394	335	256	223	643	**2701**
TOTAL	**19**	**66**	**137**	**347**	**449**	**512**	**415**	**343**	**285**	**851**	**3424**
	1%	**2%**	**4%**	**10%**	**13%**	**15%**	**12%**	**10%**	**8%**	**25%**	

- On average, Swanswell took on to the caseload 49 clients each month during 2012 – 43 (87%) were OCU and 6 (13%) were Non-OCU. The monthly average for 2011 was 59.
- 58% of new presentations are retained in treatment for more than 3 months in 2012. This compares to 78% in 2011.
- There were an average 31 client episodes per month (47%) that successfully completed in 2012, 23 (35%) were transferred and 12 (18%) were incomplete. The average discharge total per month was 66.
- With an average 49 episodes commencing and 66 episodes ending each month, the overall caseload is expected to continue to reduce.
- 98.5% of the client episodes had Swanswell as the care co-ordinator. The re-presentations rate for the period 2011-12 was 15.7%.
- Swanswell complete on average (based on the last 5 months of 2012) 28 start TOPS, 429 review TOPS and 26 End TOPS each month. In the last two years, only 6 Post Discharge TOPS were completed.

Data Quality

Data quality is excellent with all major NDTMS fields achieving over 95% compliance. In the 'employment' data, 17% of its total is 'not stated' or 'other'. The HALO system is used to collect and report on Swanswell data (see Appendix 6.9).

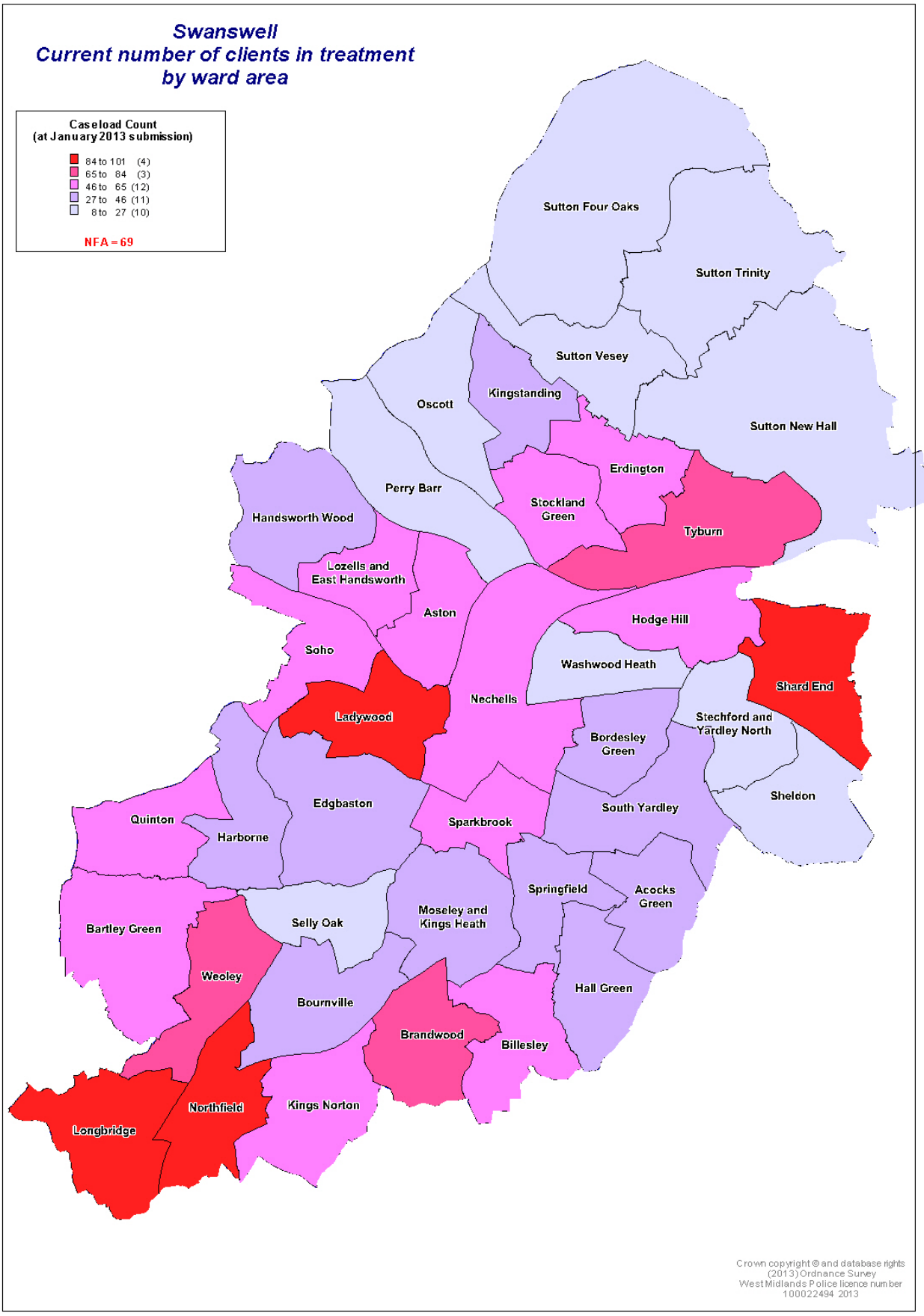
DIP Caseload

In December 2012, 805 active clients were recorded on PALBASE as being referred to Swanswell for specialist drug treatment as part of the Drug Interventions Programme. 738 clients of this cohort have been recorded as engaging in treatment. Therefore, Criminal Justice clients represent 39% of the total number in treatment in Swanswell. The latest DOMES report for Birmingham estimates that 39% of all clients in treatment are DIP. On average, 27 DIP referrals are made to Swanswell each month.

Geography

Swanswell have clients in all 40 wards across Birmingham. From December 2012 data, the ward with the highest number of clients is Northfield (101 /5.4%), followed by Longbridge (96 / 5.1%), Shard End (96 / 5.1%) and Ladywood (92 /4.9%). 17 wards have over 50 clients residing.

The greatest concentration of Swanswell's clients is in the city centre and to the south of the region. There are less clients in treatment in the Sutton, Oscott and Perry Barr wards in the north and in the Washwood Heath, Stechford and Sheldon wards to the east of Birmingham. Selly Oak is also under represented.


Swanswell
Current number of clients in treatment
by ward area
Caseload Count
(at January 2013 submission)
84 to 101 (4)
65 to 84 (3)
46 to 65 (12)
27 to 46 (11)
8 to 27 (10)
NFA = 69
Sutton Four Oaks
Sutton Trinity
Sutton Vesey
Kingstanding
Oscott
Sutton New Hall
Erdington
Perry Barr
Stockland Green
Handsworth Wood
Tyburn
Lozells and East Handsworth
Aston
Hodge Hill
Soho
Washwood Heath
Shard End
Nechells
Ladywood
Stechford and Yardley North
Bordesley Green
Edgbaston
Sheldon
Quinton
Sparkbrook
South Yardley
Harborne
Springfield
Acocks Green
Moseley and Kings Heath
Bartley Green
Selly Oak
Weoley
Hall Green
Bournville
Brandwood
Billesley
Kings Norton
Northfield
Longbridge
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4.4 Turning Point

Turning Point is a social enterprise, focused on improving lives and communities. For almost 50 years, Turning Point has offered multiple services for people with the most complex needs - whether this is for drug or alcohol problems, mental health issues, learning disabilities or access to employment. In Birmingham, Turning Point offers Drugline core services including a dedicated Rough Sleepers Vulnerable Person (RSVP) team, the Zephyr Structured Day Programme and EESPro, an education and employment project.

Drugline offers Information and advice on drug use, treatment options and general emotional support for people who are using drugs, or affected by someone else's drug use. They provide complementary therapies, counselling, drop-in service, needle exchange and prescribing clinics. Their Street outreach team work with people who are sleeping rough and male sex workers. Drugline also offer support with housing, benefits, health and employment.

Drugline: Dale House, New Meeting St, Birmingham, West Midlands B4 7UG
Tel: 0121 632 6363

Zephyr is a Community Rehabilitation Service that provides a range of courses, groups and activities to help people experiencing drug and alcohol issues achieve sustained recovery.
Their services include a range of personal development and substance misuse courses including:

- Building Confidence
- Health & Wellbeing
- Understanding Loss
- Stress Control
- Cannabis Recovery and Recovery from Stimulant Use
- Employment and skills development support
- Access to online recovery resources
- Service user involvement activities and mutual aid
- Peer mentoring opportunities

Turning Point Zephyr, 3 Barker Street, Lozells, Birmingham B19 1EL
Tel: 0121 523 5109

The Education Employment Support Project (EESPro) supports people who are recovering from a drug or alcohol problem & Prolific and Priority Offenders (PPO) to access employment, education and training opportunities to enhance rehabilitation and reduce social exclusion. EESPro offer support, information, advice and guidance to clients to enhance their employment prospects through education and skills. They also enable people to contribute to society by working with them to improve their health, safety and quality of life.
Services include:

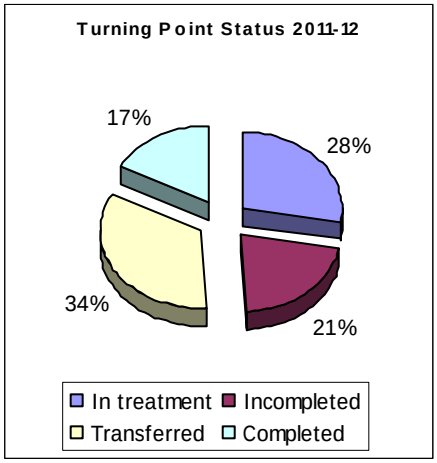
- One-to-one education and employment support
- Help with letter writing, CV's and application forms
- Support with phone calls and interview techniques
- Support with reading, writing, maths and I.T.
- Support with English for speakers of other languages

EESPRO, Room 306, The Custard Factory, Gibb Street, Birmingham, West Midlands B9 4AA
Tel: 0121 771 0544

Source: www.turning-point.co.uk

Turning Point Summary

Status	Clients	%
In Treatment	266	28%
Incomplete - client died	5	1%
Incomplete - dropped out	177	18%
Incomplete - retained in custody	19	2%
Incomplete - treatment commencement declined by client	0	0%
Incomplete - treatment withdrawn by provider	2	0%
Transferred - in custody	22	2%
Transferred - not in custody	304	32%
Treatment completed - alcohol free	0	0%
Treatment completed - drug free	127	13%
Treatment completed - occasional user (not opiates or crack)	39	4%
	961	



- In the last two years, Turning Point has recorded 961 treatment episodes on NDTMS. As of December 2012, 266 (28%) were still in treatment. 166 (17%) episodes were successfully completed. 326 (34%) client episodes were transferred to other agencies while 203 (21%) episodes were incomplete.
- The three treatment services of Turning Point have varying degrees of treatment success. *Drugline Core Services* had 611 treatment episodes with 198 (32%) episodes in treatment, 146 (24%) successfully completed, 120 (20%) transferred and 147 (24%) incomplete.
- *Drugline Rough Sleepers Vulnerable Sleepers Team* had 150 treatment episodes with 47 (31%) episodes in treatment, 9 (6%) successfully completed, 69 (46%) transferred and 25 (17%) incomplete.
- *Zephyr* had 200 treatment episodes with 21 (11%) episodes in treatment, 11 (6%) successfully completed, 137 (69%) transferred and 31 (16%) incomplete.
- Full NDTMS consent / personal details were obtained for all episodes. 12 (1%) client episodes had no address details available.
- The majority of clients (66%) had been on the caseload for under 1 year (639 episodes). 927 clients (27%) had been in treatment between 1 and three years.
- The most common age banding of clients was '26-35' (44%) followed by '36-45' (31%). 11 clients (1%) were aged '18-20' – the majority of which were engaged with Zephyr.

AgeBand	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
Under 18	0	0	0	0	0	0	0	0	0	0	**0**
18 -20	0	3	0	5	3	0	0	0	0	0	**11**
21 - 25	21	20	15	44	31	10	2	4	0	0	**147**
26 - 35	23	26	40	86	87	94	25	13	12	13	**419**
36 - 45	14	15	17	67	67	51	38	9	9	11	**298**
46 - 55	2	5	3	15	20	14	6	5	0	0	**70**
56 +	0	2	3	3	2	3	1	1	0	1	**16**
Unknown	0	0	0	0	0	0	0	0	0	0	**0**
TOTAL	**60**	**71**	**78**	**220**	**210**	**172**	**72**	**32**	**21**	**25**	**961**
	6%	**7%**	**8%**	**23%**	**22%**	**18%**	**7%**	**3%**	**2%**	**3%**	

- 635 client episodes (66%) cited Heroin as the primary drug, followed by Cannabis with 164 (17%), Crack with 43 (4%) and Cocaine with 40 (4%). 55 (6%) client episodes cited 'other drugs' as the primary drug.
- 68 client episodes (7%) that cited heroin as the primary drug had been on the caseload for over three years.
- 1 client episode recorded ecstasy as the primary drug.

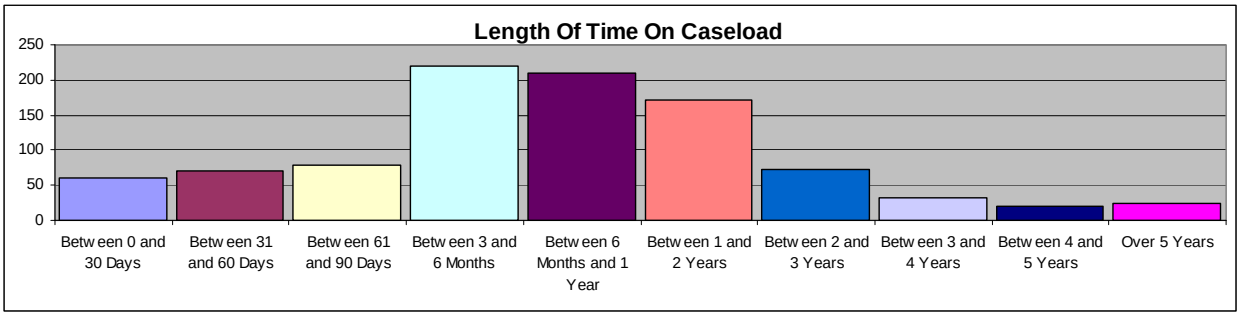
Drug 1	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
Alcohol	0	2	2	6	2	0	0	0	0	0	**12**
Amphetamines	0	2	0	5	2	1	1	0	0	0	**11**
Cannabis	15	16	19	49	42	16	5	1	1	0	**164**
Cocaine	5	7	2	11	9	5	1	0	0	0	**40**
Crack	6	4	4	14	12	3	0	0	0	0	**43**
Ecstacy	0	0	0	1	0	0	0	0	0	0	**1**
Heroin	31	39	48	122	129	137	61	27	18	23	**635**
Other Drugs	3	1	3	12	14	10	4	4	2	2	**55**
TOTAL	**60**	**71**	**78**	**220**	**210**	**172**	**72**	**32**	**21**	**25**	**961**
	6%	**7%**	**8%**	**23%**	**22%**	**18%**	**7%**	**3%**	**2%**	**3%**	

- 72% of client episodes were of White British ethnicity followed by 4% White Irish, 4% Caribbean, 4% Pakistani and 3% White/Black Caribbean.

Ethnicity	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
African	1	1	1	0	1	2	0	0	1	0	**7**
Bangladeshi	1	2	0	0	5	2	0	0	1	0	**11**
Caribbean	2	2	5	9	11	5	3	1	1	0	**39**
Indian	0	1	2	9	4	4	2	1	0	0	**23**
Not Stated	0	1	0	0	0	0	0	1	0	0	**2**
Other	1	2	0	3	2	2	0	0	0	0	**10**
Other Asian	0	0	0	6	2	4	0	0	2	1	**15**
Other Black	0	0	0	1	1	0	0	0	0	0	**2**
Other mixed	0	0	2	4	1	5	0	0	0	0	**12**
Other White	1	2	0	6	1	5	1	1	0	0	**17**
Pakistani	3	4	3	7	8	10	2	0	1	0	**38**
White and Asian	1	5	1	3	3	4	1	0	0	0	**18**
White/Black African	0	1	0	3	0	0	2	0	0	0	**6**
White/Black Caribbean	0	4	3	6	8	4	2	1	0	1	**29**
White British	48	43	58	151	156	116	57	27	15	22	**693**
White Irish	2	3	3	12	7	9	2	0	0	1	**39**
TOTAL	**60**	**71**	**78**	**220**	**210**	**172**	**72**	**32**	**21**	**25**	**961**

- The Turning Point caseload has a greater proportion of clients of white ethnicity than the Birmingham average (+18%) yet the clients of Black and Asian ethnicity have a significantly lower proportion (-4% and -20%).

Birmingham Ethnicity	Birmingham %	Turning Point Ethnicity	Turning Point %	Diff %
White	58%	732	76%	18%
Mixed	4%	53	6%	2%
Asian	27%	72	7%	-20%
Black	9%	46	5%	-4%
Other	2%	56	6%	4%
Not Stated		2	0%	0%
		961		



- Of the Turning Point client episodes active over the last 2 years, 74% have been male and 26% female. However, for client episodes active for over 3 years, 17% are female but below three years the average percentage increases to 28%. This infers that male clients engage in Turning Point services longer than female clients.

Sex	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	**TOTAL**
female	24	19	24	58	59	36	19	4	5	4	**252**
Male	36	52	54	162	151	136	53	28	16	21	**709**
TOTAL	**60**	**71**	**78**	**220**	**210**	**172**	**72**	**32**	**21**	**25**	**961**
	6%	**7%**	**8%**	**23%**	**22%**	**18%**	**7%**	**3%**	**2%**	**3%**	

- On average, Turning Point took on to the caseload 20 clients each month during 2012 – 13 (65%) were OCU and 7 (35%) were Non-OCU. The monthly average for 2011 was 23.
- 58% of new presentations are retained in treatment for more than 3 months in 2012. This compares to 58% in 2011.
- There were an average 4 client episodes per month (21%) that successfully completed in 2012, 11 (58%) were transferred and 4 (21%) were incomplete. The average discharge total per month was 19 (10 from core services, 6 from Zephyr and 3 from RSVP).
- With an average 20 episodes commencing and 19 episodes ending each month, the overall caseload is stable.
- 74% of the client episodes had Turning Point as the care co-ordinator. The re-presentations rate for the period 2011-12 was 8%.

- Turning Point complete on average (based on the last 5 months of 2012) 12 start TOPS, 37 review TOPS and 5 End TOPS each month. In the last two years, only 11 Post Discharge TOPS were completed.
- Zephyr does not produce any TOPS forms.
- Drugline Core services produce on average 8 start TOPS, 32 review TOPS and 4 End TOPS each month.
- Drugline RSVP services produce on average 4 start TOPS, 5 review TOPS and 1 End TOPS each month.

Data Quality

Data quality is very good although 'pregnancy status' needs reviewing. The address data for clients in the rough sleepers' cohort is incomplete but this is probably to be expected. Generally, all major NDTMS fields achieved over 90% compliance. Turning Point use a bespoke version of ILLY's Links Careplan system called KIM to collect and report on their data (see Appendix 6.9).

DIP Caseload

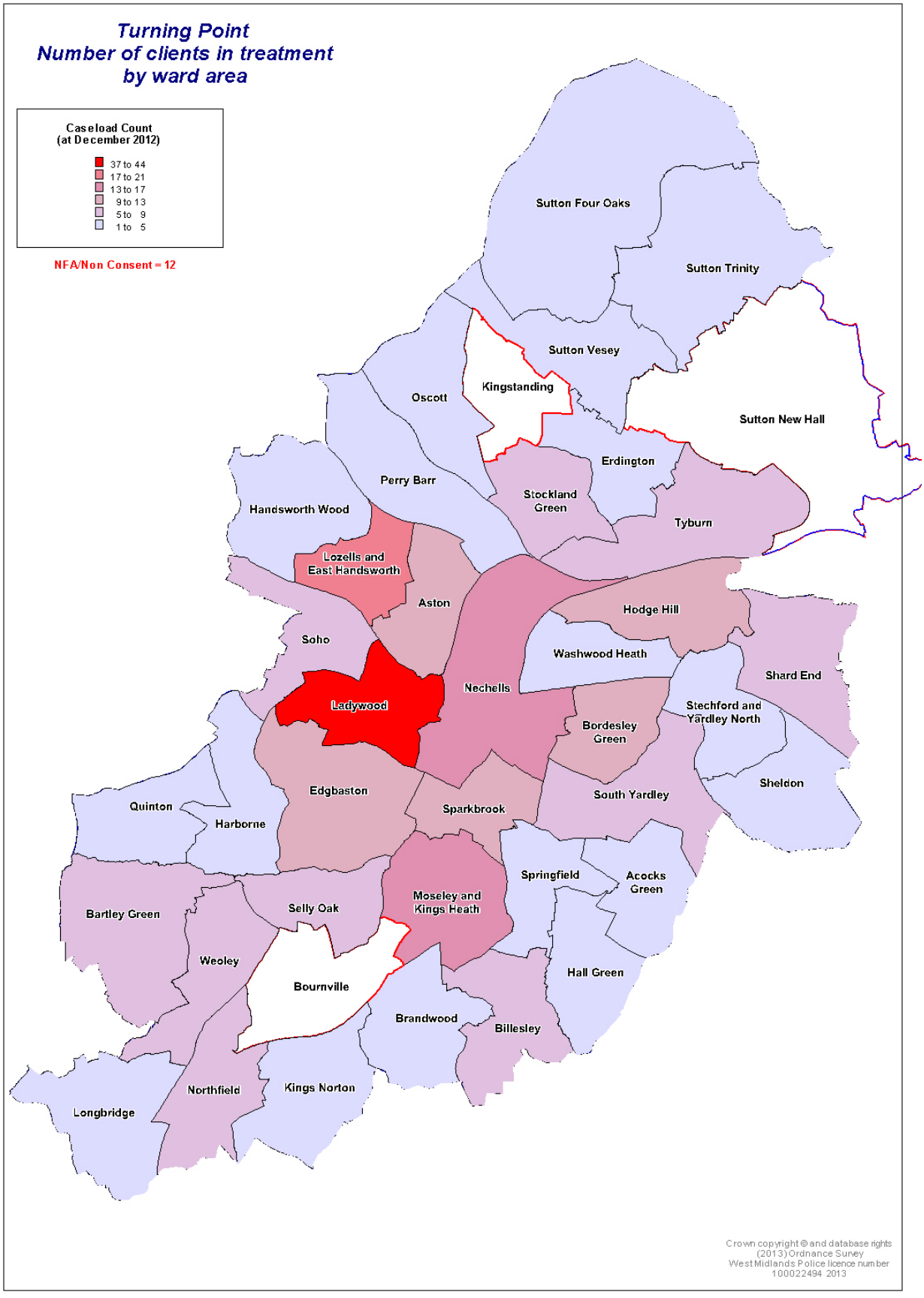
In December 2012, 86 active clients were recorded on PALBASE as being referred to Drugline (Core and RSVP) for specialist drug treatment as part of the Drug Interventions Programme. 77 clients of this cohort have been recorded as engaging in treatment. Therefore, Criminal Justice clients represent 29% of the total number in treatment in Turning Point. The latest DOMES report for Birmingham estimates that 39% of all clients in treatment are DIP. On average, 6 DIP referrals are made to Turning Point each month.

Although EEsPRO do not record any NDTMS data, on average 9 DIP referrals are made each month. In December 2012, 31 DIP referrals were active to EEsPRO with 18 confirmations of engagement.

Geography

Turning Point Drugline and Zephyr services have clients in 37 of the 40 wards across Birmingham. From December 2012 data, the ward with the highest number of clients is Ladywood (44 / 17%), followed by Lozells (17 / 6%), Moseley & Kings Heath (16 / 6%) and Nechells (15 / 6%). As Turning Point operations regarding the drop in centre and homelessness are focused on the city centre these findings are to be expected.

Although the greatest concentration of Turning Point clients is in the city centre, inner city wards are also serviced by the treatment agency. They have no clients in active treatment from Kingstanding, Sutton New Hall or Bournville.


Turning Point
Number of clients in treatment
by ward area
Caseload Count
(at December 2012)
37 to 44
17 to 21
13 to 17
9 to 13
5 to 9
1 to 5
NFA/Non Consent = 12
Sutton Four Oaks
Sutton Trinity
Sutton Vesey
Kingstanding
Oscott
Sutton New Hall
Erdington
Perry Barr
Stockland Green
Handsworth Wood
Tyburn
Lozells and East Handsworth
Aston
Hodge Hill
Soho
Washwood Heath
Shard End
Nechells
Ladywood
Stechford and Yardley North
Bordesley Green
Sheldon
Edgbaston
South Yardley
Quinton
Sparkbrook
Harborne
Springfield
Acocks Green
Moseley and Kings Heath
Bartley Green
Selly Oak
Weoley
Hall Green
Bournville
Brandwood
Billesley
Northfield
Kings Norton
Longbridge
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4.5 Phoenix Futures

Phoenix Futures provides services for people with drug and alcohol problems within community, prison and residential settings in England and Scotland. Their services include:

- engagement on the streets and in communities
- harm reduction at drop in centres
- structured day programmes
- residential rehabilitation
- supported resettlement
- services within prisons

The UK's first 'Phoenix House' opened its doors in London in 1969, offering Therapeutic Community (TC) based residential rehabilitation. Throughout the 1970s the Phoenix House TC programme adapted and modernised, becoming less rigid and adding Cognitive Behavioural Therapy (CBT) based group work to the programme. Phoenix's services were abstinence based, for clients who wanted to be 'clean' and had stopped taking illegal drugs before they walked through the door. The first shift in approach came with the opening of the Fountain Project in 1994, an HIV/AIDS palliative care unit in South London. This service took clients on methadone prescriptions for the duration of their stay.

From this point on the organisation began to embrace services for people who were trying to abstain, but were not quite at the point of actually achieving it. As these abstinence-oriented services expanded, Phoenix won prison contracts where the goal of treatment was abstinence but the clients themselves were more ambivalent. Phoenix then expanded into delivering harm reduction. The last four decades has seen Phoenix grow from a single pioneering residential service to a national organisation with nearly 90 services across community, prison and residential settings.

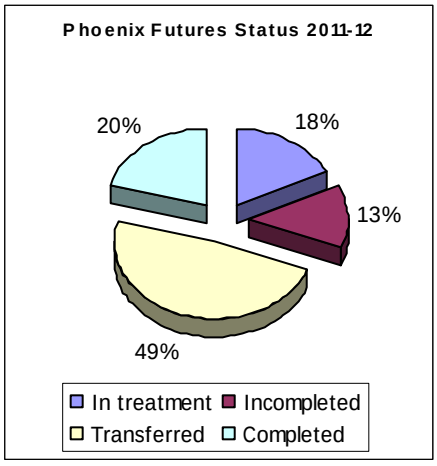
In Birmingham, Phoenix Futures offer a structured day care service and a community engagement outreach service. Phoenix Futures also provided an offenders users rehabilitation service but National Probation Service funding was withdrawn in January 2013.

Phoenix Futures, 2nd Floor, Ruskin Chambers, 191 Corporation Street, Birmingham,B4 6RP
Tel: 0121 212 1122

Source: www.phoenix-futures.org.uk

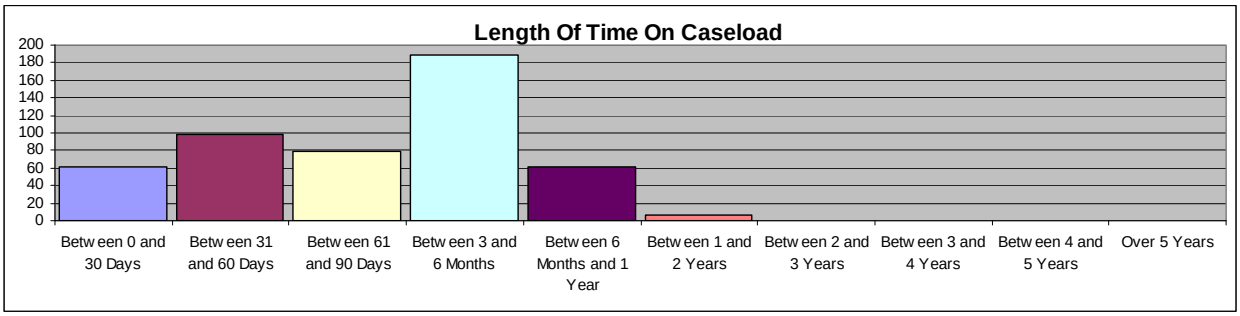
Phoenix Futures Summary

Status	Clients	%
In Treatment	88	18%
Incomplete - client died	15	3%
Incomplete - dropped out	33	7%
Incomplete - retained in custody	15	3%
Incomplete - treatment commencement declined by client	1	0%
Incomplete - treatment withdrawn by provider	0	0%
Transferred - in custody	64	13%
Transferred - not in custody	177	36%
Treatment completed - alcohol free	4	1%
Treatment completed - drug free	79	16%
Treatment completed - occasional user (not opiates or crack)	18	4%
	494	



- In the last two years, Phoenix Futures has recorded 464 treatment episodes on NDTMS. As of December 2012, 88 (18%) were still in treatment. 101 (20%) episodes were successfully completed. 241 (49%) client episodes were transferred to other agencies while 64 (13%) episodes were incomplete.
- The three treatment services of Phoenix Futures have different treatment focuses:
- *Phoenix Futures Community Outreach* had 65 treatment episodes with 13 (20%) episodes in treatment, 23 (35%) successfully completed, 14 (22%) transferred and 15 (24%) incomplete.
- *Phoenix Futures Offending Users Rehabilitation Service,* based at probation approved premises, had 264 treatment episodes with 30 (11%) episodes in treatment, 77 (30%) successfully completed, 109 (41%) transferred and 48 (19%) incomplete.
- *Phoenix Futures Community Rehabilitation* had 165 treatment episodes with 45 (27%) episodes in treatment, 1 (1%) successfully completed, 118 (71%) transferred and 1 (1%) incomplete.
- Full NDTMS consent / personal details were obtained for all episodes. 35 (7%) client episodes had no address details available.
- The majority of clients (99%) had been on the caseload for under 1 year (488 episodes).
- The most common age banding of clients was '26-35' (47%) followed by '36-45' (32%). 1 client (<1%) was aged '18-20'.

AgeBand	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
Under 18	0	0	0	0	0	0	0	0	0	0	**0**
18 -20	0	0	0	1	0	0	0	0	0	0	**1**
21 - 25	7	12	8	13	2	0	0	0	0	0	**42**
26 - 35	33	46	49	74	25	4	0	0	0	0	**231**
36 - 45	16	26	12	77	26	2	0	0	0	0	**159**
46 - 55	4	13	8	18	7	0	0	0	0	0	**50**
56 +	1	1	2	6	1	0	0	0	0	0	**11**
Unknown	0	0	0	0	0	0	0	0	0	0	**0**
TOTAL	**61**	**98**	**79**	**189**	**61**	**6**	**0**	**0**	**0**	**0**	**494**
	12%	**20%**	**16%**	**38%**	**12%**	**1%**	**0%**	**0%**	**0%**	**0%**	



- 257 client episodes (52%) cited Heroin as the primary drug, followed by Cannabis with 69 (14%), Crack with 67 (14%) and Cocaine with 49 (10%). 15 (3%) client episodes cited 'other drugs' as the primary drug while 27 (5%) said it was alcohol.
- Probably due to the short term nature of approved premises but the majority of OURS clients were on the caseload between 31 and 60 days whereas the Community Rehabilitation clients were on the caseload between 3 and 6 months.
- No client episode recorded ecstasy as the primary drug.

Drug 1	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
Alcohol	11	3	7	5	1	0	0	0	0	0	**27**
Amphetamines	0	3	1	4	1	1	0	0	0	0	**10**
Cannabis	5	16	11	30	6	1	0	0	0	0	**69**
Cocaine	7	12	10	15	5	0	0	0	0	0	**49**
Crack	6	17	9	26	9	0	0	0	0	0	**67**
Ecstacy	0	0	0	0	0	0	0	0	0	0	**0**
Heroin	29	40	40	106	38	4	0	0	0	0	**257**
Other Drugs	3	7	1	3	1	0	0	0	0	0	**15**
TOTAL	**61**	**98**	**79**	**189**	**61**	**6**	**0**	**0**	**0**	**0**	**494**
	12%	**20%**	**16%**	**38%**	**12%**	**1%**	**0%**	**0%**	**0%**	**0%**	

- 69% of client episodes were of White British ethnicity followed by 7% White / Black Caribbean, 7% Caribbean, 5% Pakistani and 2% White Irish.

Ethnicity	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
African	0	0	0	0	0	0	0	0	0	0	**0**
Bangladeshi	1	1	0	0	0	0	0	0	0	0	**2**
Caribbean	1	9	4	13	7	0	0	0	0	0	**34**
Indian	1	2	0	3	2	0	0	0	0	0	**8**
Not Stated	0	2	1	2	0	0	0	0	0	0	**5**
Other	1	1	0	1	0	0	0	0	0	0	**3**
Other Asian	0	2	0	1	0	0	0	0	0	0	**3**
Other Black	1	3	0	1	0	0	0	0	0	0	**5**
Other mixed	3	0	0	3	0	0	0	0	0	0	**6**
Other White	0	0	3	3	0	0	0	0	0	0	**6**
Pakistani	5	6	6	6	3	1	0	0	0	0	**27**
White and Asian	0	1	1	1	0	0	0	0	0	0	**3**
White/Black African	0	2	1	1	0	0	0	0	0	0	**4**
White/Black Caribbean	2	10	5	11	8	1	0	0	0	0	**37**
White British	42	57	57	140	40	4	0	0	0	0	**340**
White Irish	4	2	1	3	1	0	0	0	0	0	**11**
TOTAL	**61**	**98**	**79**	**189**	**61**	**6**	**0**	**0**	**0**	**0**	**494**
	12%	**20%**	**16%**	**38%**	**12%**	**1%**	**0%**	**0%**	**0%**	**0%**	

- The Phoenix Futures caseload has a greater proportion of clients of white ethnicity than the Birmingham average (+13%) yet the clients of Black and Asian ethnicity have a significantly lower proportion (-2% and -20%).

Birmingham Ethnicity	Birmingham %	Phoenix futures Ethnicity	Phoenix Futures %	Diff %
White	58%	351	71%	13%
Mixed	4%	44	9%	5%
Asian	27%	37	7%	-20%
Black	9%	34	7%	-2%
Other	2%	23	5%	3%
Not Stated		5	1%	1%
		494		

- Of the Phoenix Futures client episodes active over the last 2 years, 69% have been male and 31% female.

Sex	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
female	20	26	20	65	19	1	0	0	0	0	**151**
Male	41	72	59	124	42	5	0	0	0	0	**343**
TOTAL	**61**	**98**	**79**	**189**	**61**	**6**	**0**	**0**	**0**	**0**	**494**
	12%	**20%**	**16%**	**38%**	**12%**	**1%**	**0%**	**0%**	**0%**	**0%**	

- On average, Phoenix Futures took on to the caseload 12 clients each month during 2012 – 7 (61%) were OCU and 5 (39%) were Non-OCU.
- The Community Rehabilitation team had no successful completions as the clients are transferred into other services. At the end of the OURS contract, all clients were transferred to other services.
- The Community Outreach team averaged 3 discharges with 2 successful completions each month in 2012.
- With an average 3 episodes commencing and 3 episodes ending each month, the overall Community Outreach caseload is stable.
- 94% of the Community Outreach client episodes had Phoenix Futures as the care co-ordinator.
- Phoenix Futures Community Rehabilitation team and Community Outreach team do not produce any TOPS forms.

Data Quality

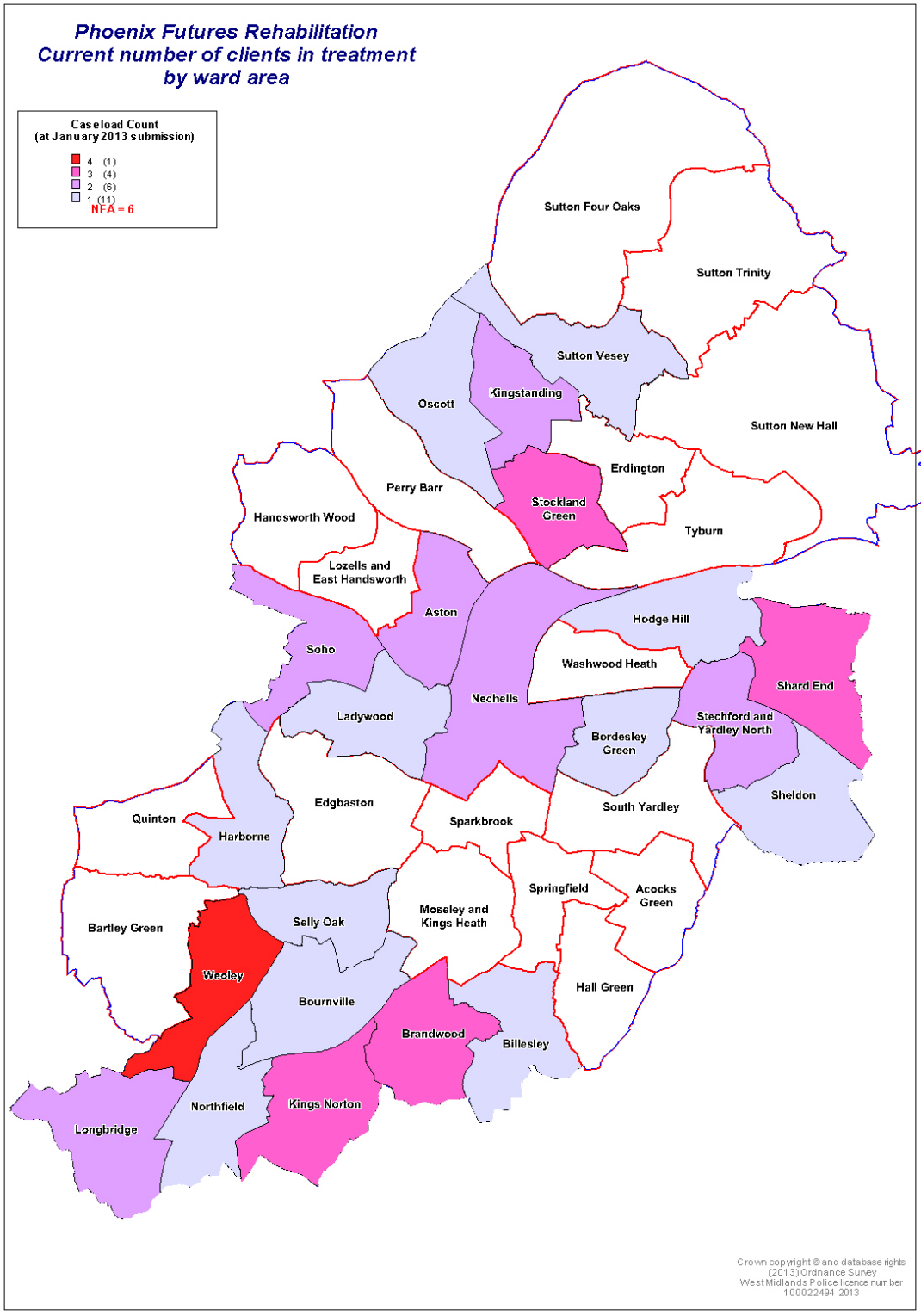
Data quality is very good. Generally, all major NDTMS fields achieved over 90% compliance. Phoenix Futures use the JANUS system to collect and report on their data (see Appendix 6.9).

DIP Caseload

In December 2012, 3 active clients were recorded on PALBASE as being referred to Phoenix Futures for specialist drug treatment as part of the Drug Interventions Programme. 3 clients of this cohort have been recorded as engaging in treatment. On average, 2 DIP referrals are made to Phoenix Futures each month.

Geography

As Phoenix Futures no longer have the approved premises contract, the majority of the current caseload is in community rehabilitation. The Community Rehabilitation team have 45 clients in 22 wards (see map below) while the community outreach team have 13 clients across 10 wards including Aston, Lozells and Washwood Heath.



4.6 NACRO / A Team

Nacro is the largest crime reduction charity in the UK. Its team of 1,400 staff and volunteers work in over 200 communities across England and Wales. Nacro works with young people to stop them becoming involved, or further involved, in crime. They work with people who have either been arrested, are in prison or are serving community sentences, by challenging their behaviour and addressing the factors that led them to crime and helping offenders with resettlement issues. As well as tackling negative attitudes and substance misuse problems, they provide education and training that leads to employment. Nacro also works towards ensuring people with mental health problems are diverted from the criminal justice system.

In the year from March 2011 to April 2012:

- 40,500 people accessed NACRO's Resettlement Advice Service, which includes the public helpline.
- 27,000 individuals and employers received advice on the disclosure of criminal convictions from Nacro's Resettlement Advice Service.
- NACRO housed 1,200 people.
- 5,900 housing support referrals were received by Nacro.
- 4,800 prisoners were helped by Nacro through their employability contract in prisons.
- 1,600 prisoners were helped into education, employment or training upon release from prison.

Birmingham Alcohol Services (A-team) is an alcohol service aimed at reducing individuals' alcohol consumption and providing alcohol awareness throughout Birmingham. Working in over 20 surgeries around the city they meet with any clients that are referred by their GP at their surgery, working through alcohol issues in up to six confidential sessions. Through partnership working they also refer to other agencies that may benefit the person's individual situation.

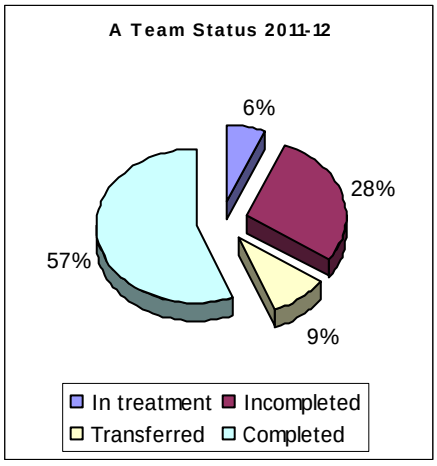
A-Team, Lee House, Highfield Road, Edgbaston, Birmingham, B15 3ED
Tel: 0121 455 8175

Housing Services Birmingham helps offenders to resettle into the community by providing support with housing-related issues such as managing their tenancies. Housing Services Birmingham aims to equip ex-offenders with housing needs with the practical skills to live safe, independent, crime-free lives.

NACRO, 1st Floor Alma House, Newtown Shopping Centre, Aston, Birmingham, B19 2SS
Tel 0121 333 6795.
Source: www.nacro.org.uk
Nacro do not have any clients in structured drug treatment and do not forward any NDTMS data.

A Team Analysis

Status	Clients	%
In Treatment	145	6%
Incomplete - client died	1	0%
Incomplete - dropped out	617	27%
Incomplete - retained in custody	1	0%
Incomplete - treatment commencement declined by client	28	1%
Incomplete - treatment withdrawn by provider	6	0%
Transferred - in custody	9	0%
Transferred - not in custody	206	9%
Treatment completed - alcohol free	161	7%
Treatment completed - drug free		0%
Treatment completed - occasional user (not opiates or crack)	1134	49%
	2308	

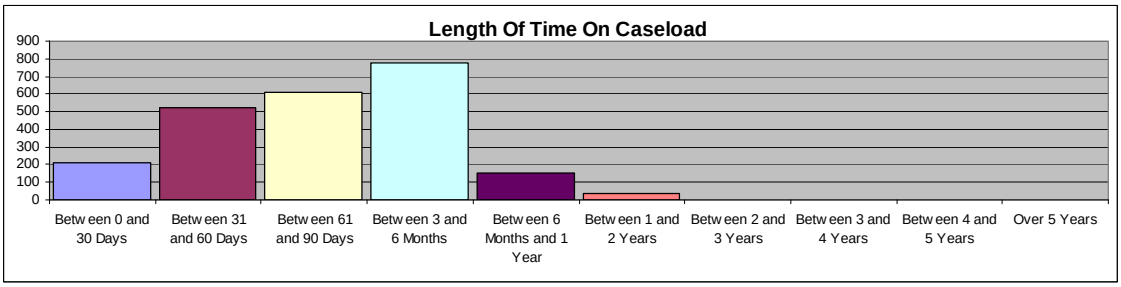


- In the last two years, the A Team has recorded 2,308 treatment episodes on NDTMS. As of December 2012, 145 (6%) were still in treatment. 1,295 (57%) episodes were successfully completed. 215 (9%) client episodes were transferred to other agencies while 653 (28%) episodes were incomplete.
- Full NDTMS consent / personal details was granted by all clients. 91 (4%) client episodes had no address details available.
- The majority of clients had been on the caseload for less than 6 months (2,116 episodes / 92%).
- The most common age banding of clients was '46-55' (30%) followed by '36-45' (28%). 8 clients (<1%) were aged '18-20'.

AgeBand	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
Under 18											**0**
18 -20	2	2	2	2							**8**
21 - 25	22	19	15	17	3	3					**79**
26 - 35	42	94	119	129	26	8					**418**
36 - 45	55	161	176	210	33	12					**647**
46 - 55	54	135	191	247	57	10	1				**695**
56 +	35	111	108	168	33	6					**461**
Unknown											**0**
TOTAL	**210**	**522**	**611**	**773**	**152**	**39**	**1**	**0**	**0**	**0**	**2308**
	9%	**23%**	**26%**	**33%**	**7%**	**2%**	**0%**	**0%**	**0%**	**0%**	

- 2,296 client episodes (99.5%) cited Alcohol as the primary drug.
- 2,116 client episodes (92%) had been on the caseload for less than 6 months.

Drug 1	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
Alcohol	208	520	611	769	149	38	1				**2296**
Amphetamines				1	1						**2**
Cannabis											**0**
Cocaine											**0**
Crack											**0**
Ecstacy											**0**
Heroin											**0**
Other Drugs	2	2		3	2	1					**10**
TOTAL	**210**	**522**	**611**	**773**	**152**	**39**	**1**	**0**	**0**	**0**	**2308**
	9%	**23%**	**26%**	**33%**	**7%**	**2%**	**0%**	**0%**	**0%**	**0%**	



- 80% of client episodes were of White British ethnicity followed by 3% Indian, 3% White Irish, 2% White/Caribbean and 2% Caribbean.

Ethnicity	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
African	3	2	1								**6**
Bangladeshi				1							**1**
Caribbean	3	13	14	15	1	1					**47**
Indian	10	22	22	19	5	1					**79**
Not Stated	10	11	25	36	5	1					**88**
Other	1	4	3	2							**10**
Other Asian	4	6	6	9	2	1					**28**
Other Black	1	1	2	1							**5**
Other mixed	1	2	5	3							**11**
Other White	3	5	9	5	2	1					**25**
Pakistani	1	3	9	6		1					**20**
White and Asian	1	5	4	4	2						**16**
White/Black African	1	2									**3**
White/Black Caribbean	3	9	9	17	1	2					**41**
White British	158	418	484	631	129	30	1				**1851**
White Irish	10	19	18	24	5	1					**77**
TOTAL	**210**	**522**	**611**	**773**	**152**	**39**	**1**	**0**	**0**	**0**	**2308**
	9%	**23%**	**26%**	**33%**	**7%**	**2%**	**0%**	**0%**	**0%**	**0%**	

- The A Team caseload has a greater proportion of clients of white ethnicity than the Birmingham average (+11%) yet the clients of Black and Asian ethnicity have a significantly lower proportion (-7% and -23%). 4% were not stated.

Birmingham Ethnicity	Birmingham %	A Team Ethnicity	A Team%	Diff %
White	58%	1928	84%	26%
Mixed	4%	60	3%	-1%
Asian	27%	100	4%	-23%
Black	9%	53	2%	-7%
Other	2%	79	3%	1%
Not Stated		88	4%	4%
		2308		

- Of the A Team client episodes active over the last 2 years, 66% have been male and 34% female.

Sex	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
female	44	155	201	298	67	15					**780**
Male	166	367	410	475	85	24	1				**1528**
TOTAL	**210**	**522**	**611**	**773**	**152**	**39**	**1**	**0**	**0**	**0**	**2308**
	9%	**23%**	**26%**	**33%**	**7%**	**2%**	**0%**	**0%**	**0%**	**0%**	

- On average, The A Team took on to the caseload 55 clients each month during 2012. The monthly average for 2011 was 48.
- 35% of new presentations are retained in treatment for more than 3 months in 2012. This compares to 40% in 2011.
- There were an average 39 client episodes per month (63%) that successfully completed in 2012, 7 (11%) were transferred and 16 (26%) were incomplete. The average discharge total per month was 62.
- With an average 55 episodes commencing and 62 episodes ending each month, the overall caseload is expected to continue to reduce.
- No client episodes had the A Team as the care co-ordinator. The re-presentations rate for the period 2011-12 was 11.5%.
- The A Team no longer complete any TOPS forms.

Data Quality

Data quality is quite good but attention needs to be paid to accommodation, employment and pregnancy status. The database system used by the A Team is unknown (see Appendix 6.9).

DIP Caseload

No DIP referrals are made to the A Team.

Geography

The A Team have between 1 and 8 clients in 39 wards across Birmingham – Bournville is the only exception.

4.7 Inclusion

Inclusion was established in 2002 as part of the specialist directorate of South Staffordshire and Shropshire Healthcare NHS Foundation Trust. It has since produced a network of community, residential and prison based services which link health and social care responses to service user and criminal justice needs.

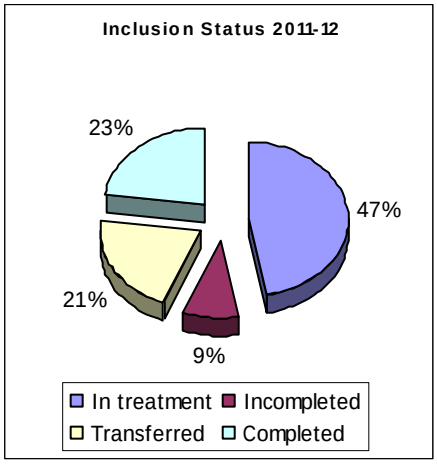
Although Inclusion's headquarters are in Staffordshire, they provide services for drug users from the Isle of Wight, Wiltshire, through the Home Counties, Middlesex and on to the West Midlands. With this broad geographical base, Inclusion is viewed as a local provider of services both in the South and the Midlands. Inclusion also provides psychological therapy services (IAPT) to the people of Liverpool, Sefton and the Wirral.

Inclusion has extensive experience of working in partnership with the Prison Service, Drug Action Teams, Crime Reduction Partnerships, Primary Healthcare Trusts, the Probation Service, Drug Intervention Programmes, housing and employment organisations and third sector services.

In Birmingham, Inclusion offers CARAT services to HMP Birmingham, a community drug service to South Birmingham and (in partnership) residential rehabilitation services at Park House.

Inclusion Community Drug Team, 40 Imperial Court, Pershore Road South, Kings Norton Business Centre, Birmingham B30 3ES Tel: 0121 465 4033
Source: www.inclusionuk.org

Status	Clients	%
In Treatment	214	47%
Incomplete - client died	4	1%
Incomplete - dropped out	21	5%
Incomplete - retained in custody	2	0%
Incomplete - treatment commencement declined by client	12	3%
Incomplete - treatment withdrawn by provider	3	1%
Transferred - in custody	14	3%
Transferred - not in custody	82	18%
Treatment completed - alcohol free		0%
Treatment completed - drug free	95	21%
Treatment completed - occasional user (not opiates or crack)	9	2%
	456	



- In the last two years, Inclusion has recorded 456 treatment episodes on NDTMS. As of December 2012, 214 (47%) were still in treatment. 104 (23%) episodes were successfully completed. 96 (21%) client episodes were transferred to other agencies while 42 (9%) episodes were incomplete.
- Full NDTMS consent / personal details was achieved for all episodes. 3 client episodes had no address details available.
- 50% of the caseload (229) has been engaged in treatment for longer than 12 months.
- The most common age banding of clients was '26-35' (41%) followed by '36-45' (36%). 6 clients (<1%) were aged '18-20'.

AgeBand	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	**TOTAL**
Under 18											**0**
18 -20	1			4	1						**6**
21 - 25	1	2	4	9	4	5	2	1	1		**29**
26 - 35		7	18	34	35	40	20	18	8	9	**189**
36 - 45	3	9	9	30	28	26	15	14	12	18	**164**
46 - 55		2	4	9	8	7	5	4	6	5	**50**
56 +		1	3		1	3	1	1	5	3	**18**
Unknown											**0**
TOTAL	**5**	**21**	**38**	**86**	**77**	**81**	**43**	**38**	**32**	**35**	**456**
	1%	**5%**	**8%**	**19%**	**17%**	**18%**	**9%**	**8%**	**7%**	**8%**	

- 266 client episodes (58%) cited Heroin as the primary drug, followed by Cannabis with 29 (6%). 103 (23%) client episodes cited 'other drugs' as the primary drug. This is a significant proportion which may need further investigation.
- 163 client episodes (36%) that cited heroin as the primary drug had been on the caseload for over one year.
- No client episode recorded ecstasy as the primary drug.

Drug 1	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
Alcohol				1							**1**
Amphetamines		1	3	2	3	3	1	1	2	4	**20**
Cannabis		6	6	10	6	1					**29**
Cocaine		1	2	13	3						**19**
Crack			1	6	4	1	4		2		**18**
Ecstacy											**0**
Heroin	1	10	16	29	47	63	31	30	20	19	**266**
Other Drugs	4	3	10	25	14	13	7	7	8	12	**103**
TOTAL	**5**	**21**	**38**	**86**	**77**	**81**	**43**	**38**	**32**	**35**	**456**
	1%	**5%**	**8%**	**19%**	**17%**	**18%**	**9%**	**8%**	**7%**	**8%**	

- 79% of client episodes were of White British ethnicity followed by 5% White/Caribbean and 4% White Irish.

Ethnicity	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
African			1								**1**
Bangladeshi											**0**
Caribbean		1		3	1		1				**6**
Indian				1	3	1					**5**
Not Stated			2	3	2	2		1		1	**11**
Other		2			2			1			**5**
Other Asian					1	2	1	1			**5**
Other Black		1	1	1		2				1	**6**
Other mixed				1	1			1			**3**
Other White			1	1		1					**3**
Pakistani				1	2		1				**4**
White and Asian				1							**1**
White/Black African		1		1	1		1	1			**5**
White/Black Caribbean		1	2	7	8	1	2	2	1		**24**
White British	4	15	29	65	54	67	37	29	29	32	**361**
White Irish	1		2	1	2	5		2	2	1	**16**
TOTAL	**5**	**21**	**38**	**86**	**77**	**81**	**43**	**38**	**32**	**35**	**456**

- The Inclusion caseload has a greater proportion of clients of white ethnicity than the Birmingham average (+25%) yet the clients of Black and Asian ethnicity have a significantly lower proportion (-7% and -25%). 2% were not stated.

Birmingham Ethnicity	Birmingham %	Inclusion Ethnicity	Inclusion %	Diff %
White	58%	377	83%	25%
Mixed	4%	30	7%	3%
Asian	27%	9	2%	-25%
Black	9%	7	2%	-7%
Other	2%	22	5%	3%
Not Stated		11	2%	2%
		456		

- Of the Inclusion client episodes active over the last 2 years, 60% have been male and 40% female. Proportionally, this is the highest percentage of females of any of the Birmingham treatment agencies.

Sex	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	**TOTAL**
female	3	7	18	32	32	36	16	18	6	13	**181**
Male	2	14	20	54	45	45	27	20	26	22	**275**
TOTAL	**5**	**21**	**38**	**86**	**77**	**81**	**43**	**38**	**32**	**35**	**456**
	1%	**5%**	**8%**	**19%**	**17%**	**18%**	**9%**	**8%**	**7%**	**8%**	

- On average, Inclusion took on to the caseload 12 clients each month during 2012 – 8 (69%) were OCU and 4 (31%) were Non-OCU. The monthly average for 2011 was 8.
- 44% of new presentations are retained in treatment for more than 3 months in 2012. This compares to 72% in 2011.
- There were an average 4 client episodes per month (38%) that successfully completed in 2012, 4 (38%) were transferred and 2 (24%) were incomplete. The average discharge total per month was 10.
- With an average 12 episodes commencing and 10 episodes ending each month, the overall caseload is expected to rise.
- 87% of the client episodes had Inclusion as the care co-ordinator. The re-presentations rate for the period 2011-12 was 7%.
- Inclusion complete on average (based on the last 5 months of 2012) 14 start TOPS, 25 review TOPS and 8 End TOPS each month. In the last two years, no Post Discharge TOPS were completed.

Data Quality

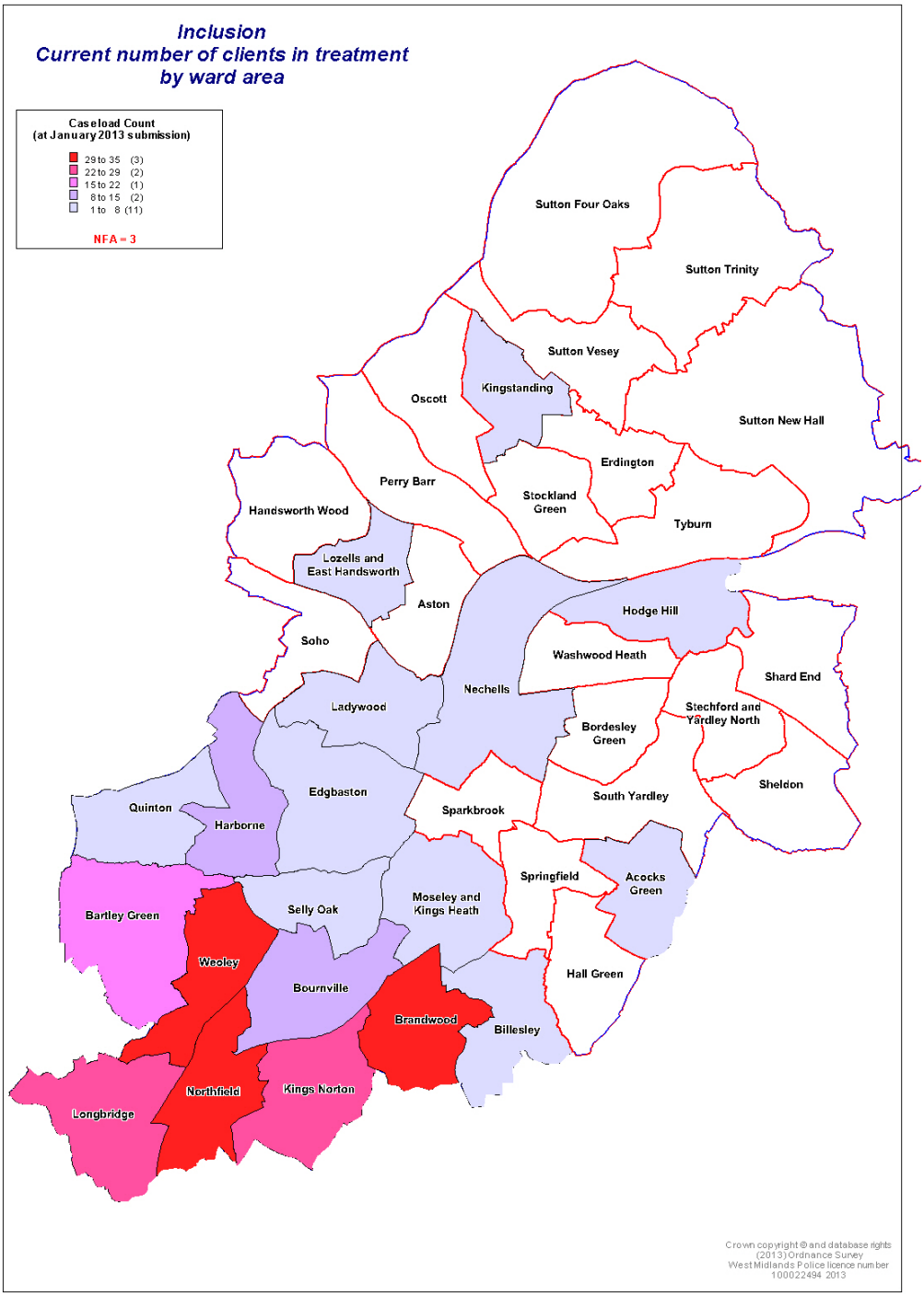
Data quality is very good with all major NDTMS fields achieving over 95% compliance, except accommodation status. The HALO system is used to collect and report on Inclusion data (see Appendix 6.9).

DIP Caseload

In December 2012, 4 active clients were recorded on PALBASE as being referred to Inclusion for specialist drug treatment as part of the Drug Interventions Programme. 1 client of this cohort have been recorded as engaging in treatment.

Geography

Swanswell have clients in 19 wards across Birmingham – mainly in the South. From December 2012 data, the ward with the highest number of clients is Brandwood (35 / 16%), followed by Northfield (32 / 15%), Weoley (31 / 14%) and Longbridge / Kings Norton (24 / 11% each).



4.8 The SAFE Project

The SAFE Project seeks to promote the health and well-being of women who have worked, are working or are at risk of becoming involved in the commercial sex industry. To reduce the harm associated with sex work and to empower women to make positive choices. The SAFE Project does not strive to control, reduce or promote commercial sex work. It believes that by offering a wide range of services and resources they will reflect the differing needs of the individuals and groups they aim to work with.

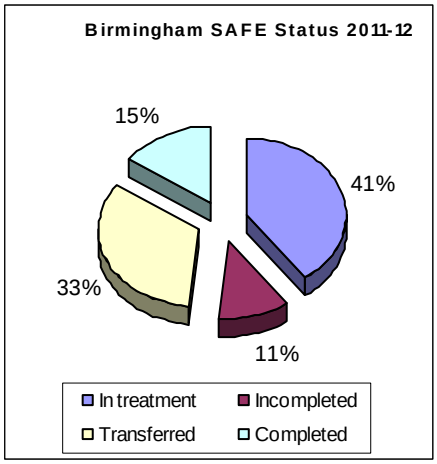
The SAFE Project aims to promote the health and well-being of female sex workers in Birmingham, Sandwell and Walsall, aged 18 or over. Services include:

- Monday sexual health clinic
- Outreach to indoor sex workers
- Evening outreach to outdoor sex workers
- SAFE Specialist Drug Treatment Service
- Support and advice
- Counselling

SAFE, Centre for Community Health, Highgate St, Birmingham B12 0YA Tel: 0121 440 6655

Source: www.safe.wmids.nhs.uk

Status	Clients	%
In Treatment	63	40%
Incomplete - client died		0%
Incomplete - dropped out	13	8%
Incomplete - retained in custody		0%
Incomplete - treatment commencement declined by client	2	1%
Incomplete - treatment withdrawn by provider	3	2%
Transferred - in custody	11	7%
Transferred - not in custody	41	26%
Treatment completed - alcohol free		0%
Treatment completed - drug free	24	15%
Treatment completed - occasional user (not opiates or crack)		0%
	157	

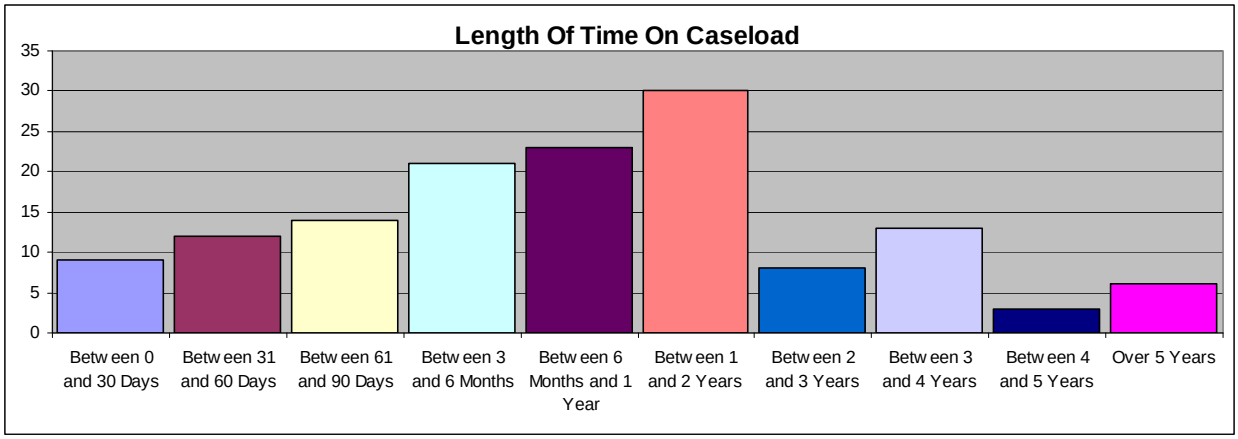


- In the last two years, SAFE has recorded 157 treatment episodes on NDTMS. As of December 2012, 63 (41%) were still in treatment. 24 (15%) episodes were successfully completed. 52 (33%) client episodes were transferred to other agencies while 18 (11%) episodes were incomplete.
- Full NDTMS consent / personal details were obtained for all client episodes. 2 (1%) client episodes had no address details available.
- The largest number of clients (32/20%) had been on the caseload for between 1 and 2 years. The majority of clients (56%) were on the caseload between 3 months and 2 years. 15% of SAFE clients had been on the caseload for over three years.
- The most common age banding of clients was '26-35' (58%) followed by '36-45' (22%). No clients were aged '18-20'.

AgeBand	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
Under 18											**0**
18 -20											**0**
21 - 25	1	3	3	5	3	3	1				**19**
26 - 35	8	7	7	11	14	19	7	10	1	7	**91**
36 - 45	1	2	2	9	8	8	1	2	1		**34**
46 - 55			1	5	2	2		2			**12**
56 +										1	**1**
Unknown											**0**
TOTAL	**10**	**12**	**13**	**30**	**27**	**32**	**9**	**14**	**2**	**8**	**157**
	6%	**8%**	**8%**	**19%**	**17%**	**20%**	**6%**	**9%**	**1%**	**5%**	

- 112 client episodes (71%) cited Heroin as the primary drug, followed by Crack with 42 (27%).
- No client episode recorded ecstasy as the primary drug.

Drug 1	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
											0
Alcohol											**0**
Amphetamines											**0**
Cannabis											**0**
Cocaine											**0**
Crack	3	4	6	9	9	8	1	1		1	**42**
Ecstacy											**0**
Heroin	6	7	7	20	18	24	8	13	2	7	**112**
Other Drugs	1	1		1							**3**
TOTAL	**10**	**12**	**13**	**30**	**27**	**32**	**9**	**14**	**2**	**8**	**157**
	6%	**8%**	**8%**	**19%**	**17%**	**20%**	**6%**	**9%**	**1%**	**5%**	



- 74% of client episodes were of White British ethnicity followed by 10% White/Caribbean and 5% White/Asian.

Ethnicity	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
African								1			**1**
Bangladeshi											**0**
Caribbean					1	1	1				**3**
Indian											**0**
Not Stated											**0**
Other	1	1						1			**3**
Other Asian			1		1						**2**
Other Black			1								**1**
Other mixed	2	1				1				1	**5**
Other White					1						**1**
Pakistani			1								**1**
White and Asian		1	1	2	1	1	1			1	**8**
White/Black African											**0**
White/Black Caribbean	1			7	2	4				1	**15**
White British	6	9	9	20	21	25	7	12	2	5	**116**
White Irish				1							**1**
TOTAL	**10**	**12**	**13**	**30**	**27**	**32**	**9**	**14**	**2**	**8**	**157**
	6%	**8%**	**8%**	**19%**	**17%**	**20%**	**6%**	**9%**	**1%**	**5%**	

- The SAFE caseload has a greater proportion of clients of white ethnicity than the Birmingham average (+17%) yet the clients of Black and Asian ethnicity have a significantly lower proportion (-6% and -26%).

Birmingham Ethnicity	Birmingham %	SAFE	SAFE %	Diff %
White	58%	117	75%	17%
Mixed	4%	23	15%	11%
Asian	27%	1	1%	-26%
Black	9%	4	3%	-6%
Other	2%	12	8%	6%
Not Stated		0	0%	0%
		157		

- All of the SAFE clients are female.

Sex	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
female	10	12	13	30	27	32	9	14	2	8	**157**
Male											**0**
TOTAL	**10**	**12**	**13**	**30**	**27**	**32**	**9**	**14**	**2**	**8**	**157**
	6%	**8%**	**8%**	**19%**	**17%**	**20%**	**6%**	**9%**	**1%**	**5%**	

- On average, SAFE took on to the caseload 5 clients each month during 2012 – 100% were OCU. The monthly average for 2011 was 4 clients.
- 67% of new presentations are retained in treatment for more than 3 months in 2012. This compares to 67% in 2011.
- There were an average 2 client episodes per month (40%) that successfully completed in 2012, 2 (40%) were transferred and 1 (20%) were incomplete. The average discharge total per month was 5.
- With an average 5 episodes commencing and 5 episodes ending each month, the overall caseload is expected to remain stable.
- 98.7% of the client episodes had SAFE as the care co-ordinator. The re-presentations rate for the period 2011-12 was 21.7%.
- SAFE do not complete any TOPS forms.

Data Quality

Data quality is excellent with all major NDTMS fields achieving over 95% compliance. A bespoke excel spreadsheet is used to collect and report on SAFE data although there are plans to use Illy's LINKS CarePath software in the future (see Appendix 6.9).

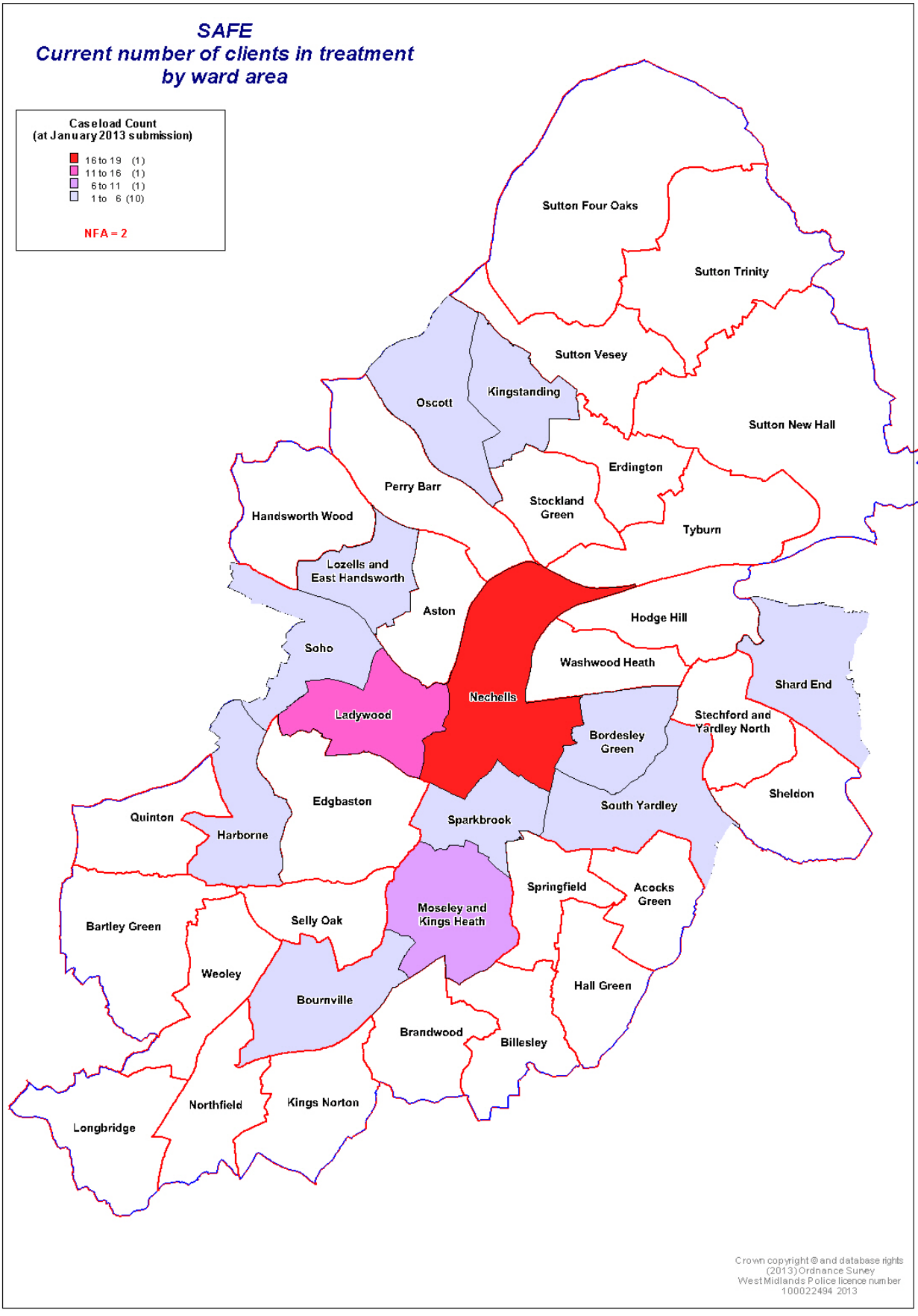
DIP Caseload

In December 2012, 29 active clients were recorded on PALBASE as being referred to SAFE for specialist drug treatment as part of the Drug Interventions Programme.

Geography

SAFE have clients in 13 wards across Birmingham. From December 2012 data, the ward with the highest number of clients is Nechells (19 / 30%), followed by Ladywood (15 / 24%), and Moseley and Kings Heath (9 / 14%).

The greatest concentration of the SAFE Project's clients is in the city centre. There are less clients in treatment from the north and south of the city.


SAFE
Current number of clients in treatment by ward area
Caseload Count (at January 2013 submission)
16 to 19 (1)
11 to 16 (1)
6 to 11 (1)
1 to 6 (10)
NFA = 2
Sutton Four Oaks
Sutton Trinity
Sutton Vesey
Sutton New Hall
Kingstanding
Oscott
Erdington
Perry Barr
Stockland Green
Handsworth Wood
Tyburn
Lozells and East Handsworth
Aston
Hodge Hill
Soho
Washwood Heath
Shard End
Nechells
Ladywood
Bordesley Green
Stechford and Yardley North
Sheldon
Edgbaston
South Yardley
Quinton
Sparkbrook
Harborne
Springfield
Acocks Green
Moseley and Kings Heath
Bartley Green
Selly Oak
Weoley
Hall Green
Bournville
Brandwood
Billesley
Northfield
Kings Norton
Longbridge
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4.9 Aquarius

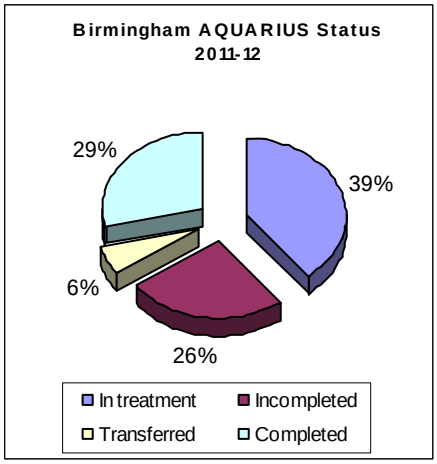
Aquarius is an agency that started working in the alcohol field in the 1970's. Since then the work has spread into other areas including gambling and drugs. Their purpose is to help individuals and communities with problems arising from addictive behaviours to reduce the harm either to themselves or others. The way that Aquarius works has developed through involvement with research and an awareness of the evidence for good practice. For Aquarius this means having a clear focus on enabling people to change through motivational approaches, skill training and the maintenance of change. Services include:

- Individual alcohol and drug counselling
- Motivational Interviewing
- Cognitive Behavioural Therapy
- Groupwork, Women's groups, User groups and networks
- Family work / Home detoxification – in partnership with Primary Care Trusts
- Addictions awareness training for non-specialist staff
- Drink-drive rehabilitation courses
- partnership work with the National Probation Service

In Birmingham, Aquarius also operates an alcohol outreach team (Birmingham Outreach Alcohol Team – BOAT) in partnership with SIFA Fireside and Irish In Birmingham.

Aquarius Birmingham, 236 Bristol Road, Birmingham, B5 7SL
Tel: 0300 5555 999
Source: www.aquarius.org.uk

Status	Aquarius	Hospital Team	Early Inter ventions	TOTAL	%
In Treatment	846	88	179	**1113**	**40%**
Incomplete - client died	31	2	1	**34**	**1%**
Incomplete - dropped out	447	14	29	**490**	**17%**
Incomplete - retained in custody	45		1	**46**	**2%**
Incomplete - treatment commencement declined by client	119	2	18	**139**	**5%**
Incomplete - treatment withdrawn by provider	16		1	**17**	**1%**
Transferred - in custody	34	2	1	**37**	**1%**
Transferred - not in custody	100	13	19	**132**	**5%**
Treatment completed - alcohol free	329	10	13	**352**	**13%**
Treatment completed - drug free	2			**2**	**0%**
Treatment completed - occasional user (not opiates or crack)	425	3	24	**452**	**16%**
TOTAL	**2394**	**134**	**286**	**2814**	



- In the last two years, Aquarius has recorded 2,814 treatment episodes on NDTMS. As of December 2012, 1,113 (40%) were still in treatment. 806 (29%) episodes were successfully completed. 169 (6%) client episodes were transferred to other agencies while 726 (26%) episodes were incomplete.
- NDTMS data is submitted for three operations – Aquarius (core services), the hospital team and the outreach (early interventions) team. The subsequent analysis is on the core services.
- Full NDTMS consent / personal details were not granted for 339 (14%) episodes. 349 (15%) client episodes had no address details available.

- The majority of clients (75%) had been on the caseload for 1 year (1,538 client episodes).
- The most common age banding of clients was '36-45' (32%) followed by '46-55' (29%). 6 clients (<1%) were aged under 20.

AgeBand	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
Under 18				1							**1**
18 -20			1	4							**5**
21 - 25	3	6	8	22	21	10					**70**
26 - 35	10	23	34	126	173	68	17	4			**455**
36 - 45	18	29	45	188	212	127	28	2	1		**650**
46 - 55	10	29	56	132	203	121	32	7		3	**593**
56 +	3	13	14	78	76	77	17	2		1	**281**
Unknown											**0**
TOTAL	**44**	**100**	**158**	**551**	**685**	**403**	**94**	**15**	**1**	**4**	**2055**
	2%	**5%**	**8%**	**27%**	**33%**	**20%**	**5%**	**1%**	**0%**	**0%**	

- Although alcohol is the primary substance for alcohol services, 6 clients cited other substances as their primary drug.

Ethnicity	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
African			1	1	5	1					**8**
Bangladeshi	1			1	2	1					**5**
Caribbean		2	3	5	12	5	3	1			**31**
Indian	1	2	4	12	20	13	3				**55**
Not Stated	10	12	23	77	99	38	3			1	**263**
Other	2	1	3	3	4	2	1				**16**
Other Asian	2	1	3	8	12	8	2				**36**
Other Black		1	1	4	5	4					**15**
Other mixed			1	6	2	5			1		**15**
Other White	1		2	7	5	2	1				**18**
Pakistani	2		1	12	7	6	1				**29**
White and Asian		1	1	8	3	1					**14**
White/Black African	1			1	1	1					**4**
White/Black Caribbean		1	2	8	13	7	1				**32**
White British	23	75	107	377	458	295	68	13		3	**1419**
White Irish	1	4	6	21	37	14	11	1			**95**
TOTAL	**44**	**100**	**158**	**551**	**685**	**403**	**94**	**15**	**1**	**4**	**2055**
	2%	**5%**	**8%**	**27%**	**33%**	**20%**	**5%**	**1%**	**0%**	**0%**	

- 69% of client episodes were of White British ethnicity followed by 5% White Irish and 3% Indian. 13% did not state their ethnicity.

- The Aquarius caseload has a greater proportion of clients of white ethnicity than the Birmingham average (+16%) yet the clients of Black and Asian ethnicity have a significantly lower proportion (-7% and -23%).

Birmingham Ethnicity	Birmingham %	AQUARIUS	AQUARIUS %	Diff %
White	58%	1514	74%	16%
Mixed	4%	50	2%	-2%
Asian	27%	89	4%	-23%
Black	9%	39	2%	-7%
Other	2%	100	5%	3%
Not Stated		263	13%	13%
		2055		

- Of the Aquarius client episodes active over the last 2 years, 68% have been male and 32% female.

Sex	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
female	8	37	46	164	229	128	37	7	1	2	**659**
Male	36	63	112	387	456	275	57	8		2	**1396**
TOTAL	**44**	**100**	**158**	**551**	**685**	**403**	**94**	**15**	**1**	**4**	**2055**
	2%	**5%**	**8%**	**27%**	**33%**	**20%**	**5%**	**1%**	**0%**	**0%**	

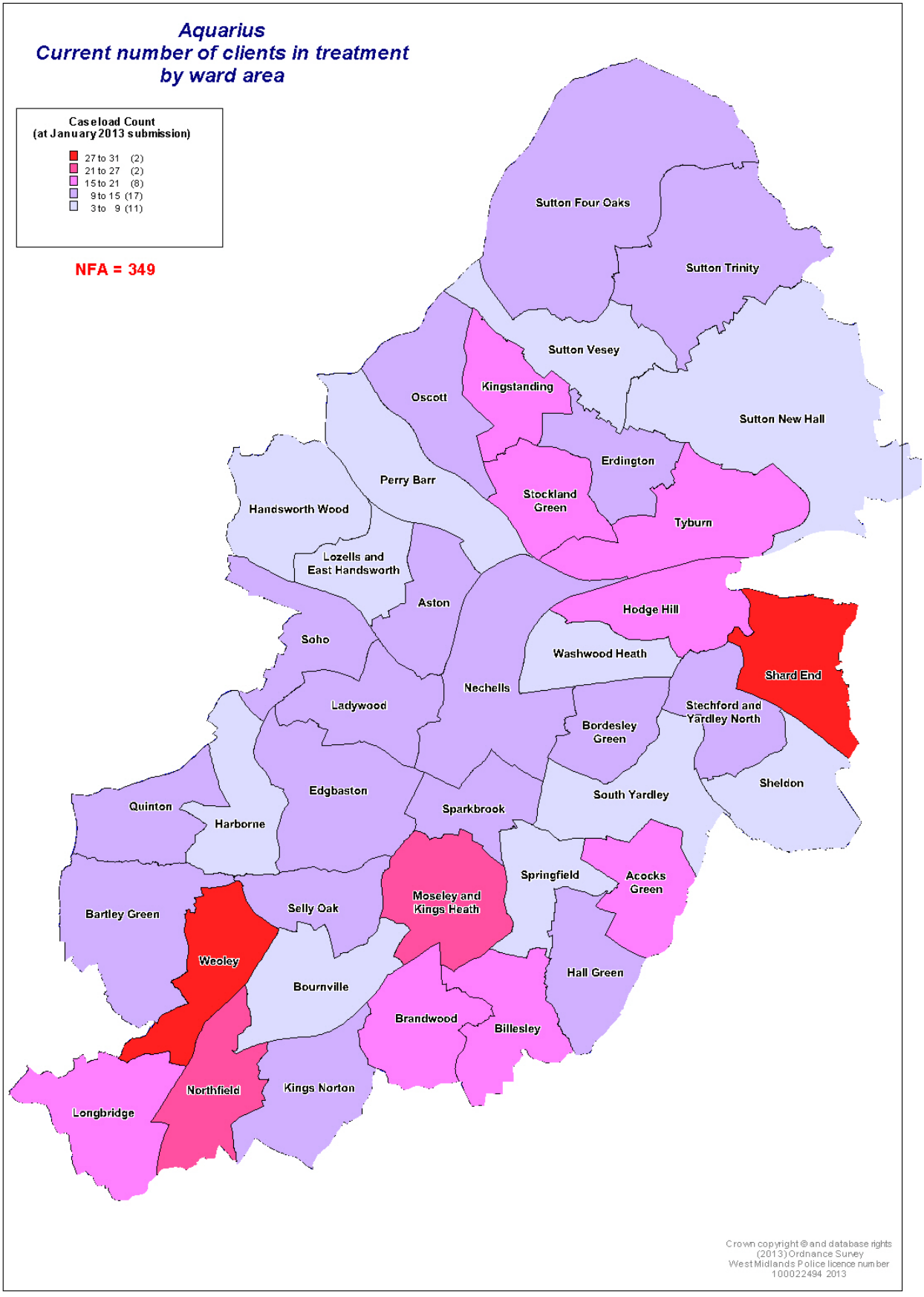
- On average, Aquarius took on to the caseload 56 clients each month during 2012. The monthly average for 2011 was 35.
- 60% of new presentations were retained in treatment for more than 3 months in 2012.
- There were an average 48 client episodes per month (56%) that successfully completed in 2012, 8 (9%) were transferred and 30 (35%) were incomplete. The average discharge total per month was 85.
- With an average 56 episodes commencing and 85 episodes ending each month, the overall caseload is expected to decline.
- 30% of the client episodes had Aquarius as the care co-ordinator. The re-presentations rate for the period 2011-12 was 7.9%.
- Aquarius does not complete TOPS forms.

Data Quality

The high number of clients who have no consented to forward data to NDTMS has affected data quality. Most major NDTMS fields achieved between 80 and 90% compliance. The Illy LINKS CarePlan system is used to collect and report on Aquarius data (see Appendix 6.9). No Aquarius data is recorded on PALBASE.

Geography

Aquarius has clients in all 40 wards across Birmingham. From December 2012 data, the ward with the highest number of clients is Weoley (31 / 3.7%), followed by Shard End (30 / 3.5%) and Moseley & Kings Heath (24 / 2.8%). The largest concentrations of clients are towards the east and south of Birmingham.


Aquarius
Current number of clients in treatment
by ward area
Caseload Count
(at January 2013 submission)
27 to 31 (2)
21 to 27 (2)
15 to 21 (8)
9 to 15 (17)
3 to 9 (11)
NFA = 349
Sutton Four Oaks
Sutton Trinity
Sutton Vesey
Kingstanding
Oscott
Sutton New Hall
Erdington
Perry Barr
Stockland Green
Handsworth Wood
Tyburn
Lozells and East Handsworth
Aston
Hodge Hill
Soho
Washwood Heath
Shard End
Nechells
Ladywood
Stechford and Yardley North
Bordesley Green
Sheldon
Edgbaston
South Yardley
Quinton
Sparkbrook
Harborne
Springfield
Acocks Green
Moseley and Kings Heath
Bartley Green
Selly Oak
Weoley
Hall Green
Bournville
Brandwood
Billesley
Kings Norton
Northfield
Longbridge
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4.10 Park House

Park House, in Hockley, offers the city a unique 'all under one roof' approach to drug and alcohol detoxification, stabilisation and rehabilitation treatment for residential and community patients. Service users benefit from 24-hour nursing and health care, with the centre containing its own dispensary and GP-style treatment rooms. It even houses its own blood testing facilities. Birmingham residents have had access to detoxification and stabilisation programmes in the city in the past, but had to travel further afield to receive rehabilitation treatment.

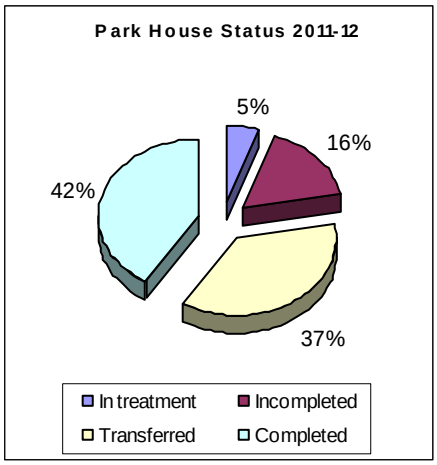
The 18-bed unit has a maximum capacity of 24 service users (18 residential and 6 day care). Park House was made possible through a unique collaboration between Birmingham Drug and Alcohol Action Team (BDAAT), Birmingham City Council (BCC), Inclusion Drug Alcohol Services, Phoenix Futures and Midland Heart.

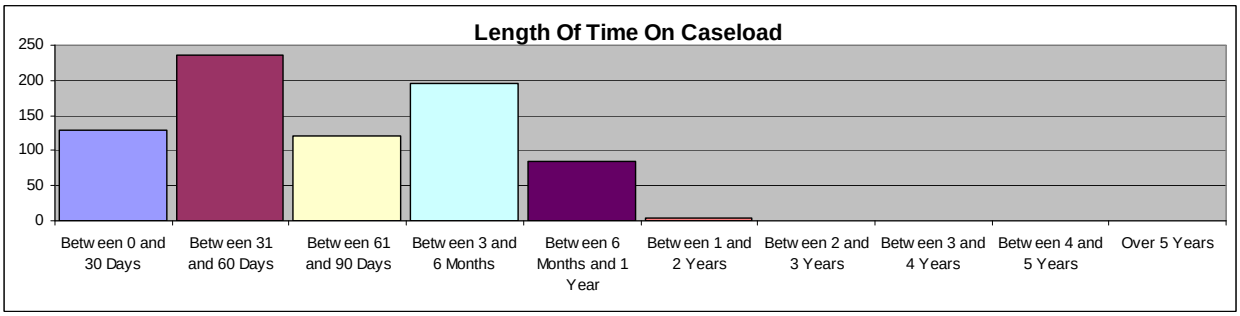
BDAAT and BCC secured capital funding for the project from the National Treatment Agency. Inclusion delivers a range of drug alcohol services that aim to minimise drug and alcohol related harm for users, their families and the wider community. Phoenix Futures is the leading provider of care and rehabilitation services for adults with drug and alcohol needs in the UK. And Midland Heart, one of the top 10 regeneration groups in the country, provided the premises for the project.

Park House, 15 Park Road South, Birmingham, B18 5QL Tel: 0121 523 5940

Source: Park House News – www.bdaat.co.uk

Status	Clients	%
In Treatment	41	5%
Incomplete - client died		0%
Incomplete - dropped out	25	3%
Incomplete - retained in custody		0%
Incomplete - treatment commencement declined by client	26	3%
Incomplete - treatment withdrawn by provider	76	10%
Transferred - in custody	1	0%
Transferred - not in custody	285	37%
Treatment completed - alcohol free	164	21%
Treatment completed - drug free	151	20%
Treatment completed - occasional user (not opiates or crack)	1	0%
	770	





- In the last two years, Park House has recorded 770 treatment episodes on NDTMS. As of December 2012, 41 (5%) were still in treatment. 316 (42%) episodes were successfully completed. 286 (37%) client episodes were transferred to other agencies while 127 (16%) episodes were incomplete.

- Full NDTMS consent / personal details was granted for all client episodes. 4 (0.5%) client episodes had no address details available.
- The majority of clients had been on the caseload for less than 6 months (680 episodes (88%)).
- The most common age banding of clients was '26-35' (39%) followed by '36-45' (38%).

AgeBand	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
Under 18											**0**
18 -20		1									**1**
21 - 25	8	10		6	2						**26**
26 - 35	50	96	50	71	34	1					**302**
36 - 45	52	89	43	73	33	4					**294**
46 - 55	17	27	20	30	12						**106**
56 +	2	13	7	15	4						**41**
Unknown											**0**
TOTAL	**129**	**236**	**120**	**195**	**85**	**5**	**0**	**0**	**0**	**0**	**770**
	17%	**31%**	**16%**	**25%**	**11%**	**1%**	**0%**	**0%**	**0%**	**0%**	

- 340 client episodes (44%) cited Alcohol as the primary drug, followed by Heroin with 152 (20%). 254 (33%) client episodes cited 'other drugs' as the primary drug. This is a significant proportion which may need further investigation.

Drug 1	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
Alcohol	46	103	52	99	39	1					**340**
Amphetamines	1		1	1	2						**5**
Cannabis			1	1							**2**
Cocaine		1									**1**
Crack	3	3		5	4						**15**
Ecstacy		1									**1**
Heroin	34	41	23	36	15	3					**152**
Other Drugs	45	87	43	53	25	1					**254**
TOTAL	**129**	**236**	**120**	**195**	**85**	**5**	**0**	**0**	**0**	**0**	**770**
	17%	**31%**	**16%**	**25%**	**11%**	**1%**	**0%**	**0%**	**0%**	**0%**	

- The Park House caseload has a greater proportion of clients of white ethnicity than the Birmingham average (+19%) yet the clients of Black and Asian ethnicity have a significantly lower proportion (-7% and -20%). 3% were not stated.

Birmingham Ethnicity	Birmingham %	Park House	Park House %	Diff %
White	58%	594	77%	19%
Mixed	4%	39	5%	1%
Asian	27%	55	7%	-20%
Black	9%	15	2%	-7%
Other	2%	41	5%	3%
Not Stated		26	3%	3%
		770		

- 72% of client episodes were of White British ethnicity followed by 5% White Irish, 5% Pakistani, and 4% White/Caribbean.

Ethnicity	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
African			1								**1**
Bangladeshi	1		1	2							**4**
Caribbean		5	4	3	2						**14**
Indian	2	5	2	5	2						**16**
Not Stated	2	9	4	7	3	1					**26**
Other		3	2	2	1						**8**
Other Asian	3	3	4	5	2						**17**
Other Black			1	2	1						**4**
Other mixed			2	2	1						**5**
Other White	2	2		2	1						**7**
Pakistani	9	16	1	9							**35**
White and Asian	1	4									**5**
White/Black African											**0**
White/Black Caribbean	5	8	8	7	5	1					**34**
White British	101	163	85	140	64	2					**555**
White Irish	3	18	5	9	3	1					**39**
TOTAL	**129**	**236**	**120**	**195**	**85**	**5**	**0**	**0**	**0**	**0**	**770**
	17%	**31%**	**16%**	**25%**	**11%**	**1%**	**0%**	**0%**	**0%**	**0%**	

- Of the Park House client episodes active over the last 2 years, 74% have been male and 26% female.

Sex	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
female	38	56	29	49	22	3					**197**
Male	91	180	91	146	63	2					**573**
TOTAL	**129**	**236**	**120**	**195**	**85**	**5**	**0**	**0**	**0**	**0**	**770**
	17%	**31%**	**16%**	**25%**	**11%**	**1%**	**0%**	**0%**	**0%**	**0%**	

- On average, Park House took on to the caseload 23 clients each month during 2012 – 11 (47%) were OCU and 12 (53%) were Non-OCU. The monthly average for 2011 was 22.
- There were an average 9 client episodes per month (40%) that successfully completed in 2012, 9 (40%) were transferred and 5 (20%) were incomplete. The average discharge total per month was 24. With an average 23 episodes commencing and 24 episodes ending each month, the overall caseload is expected to remain stable in the short to medium term.
- No client episodes had Park House as the care co-ordinator. The re-presentations rate for the period 2011-12 was 17%. Park House does not complete TOPS forms.

Data Quality

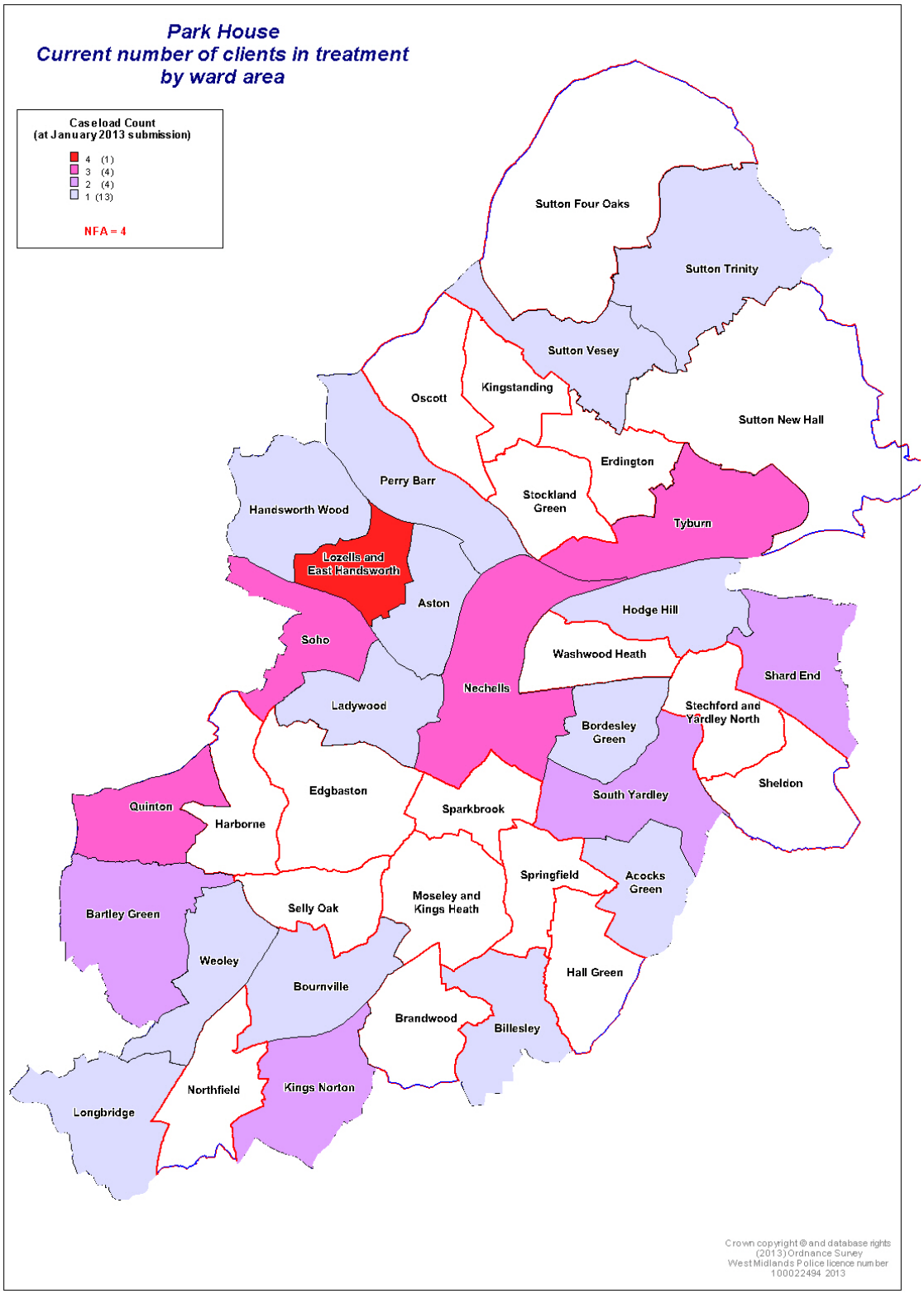
Data quality is generally good with all major NDTMS fields achieving over 95% compliance apart from the modality start date field which had 85% compliance. The HALO system is used to collect and report on Park House data (see Appendix 6.9).

DIP Caseload

No DIP referrals are currently made to Park House.

Geography

Park House has clients in 22 wards across Birmingham.



4.11 Freshwinds : Bro-Sis

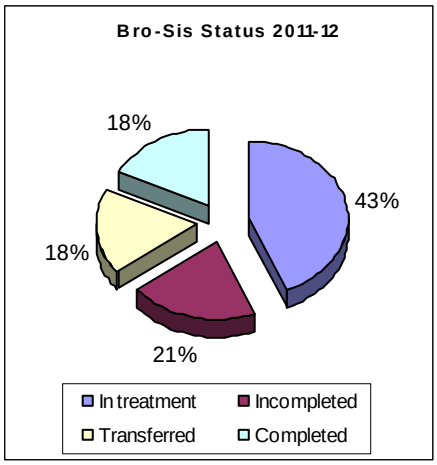
Since 1992 Freshwinds has been offering care and support, without charge, to adults and children living with life threatening and life-limiting illness as well as individuals from socially excluded backgrounds. They deliver a range of services including the provision of integrated complementary therapy, advocacy, employment advice, debt counselling and community based initiatives on HIV, substance misuse and crime.

In the last year, Freshwinds have seen over 8,500 people access their services and a further 60,000 (est) receiving one off and community level advice. Approximately 50% of the people they work with are from ethnic minority backgrounds. They receive 8,500 telephone calls per month and currently have over 270 volunteers.

The substance misuse service at Freshwinds is called BRO-SIS. The project is accessible to all individuals (18 years+) from Black and Minority Ethnic communities with a focus on those with an African Caribbean background who experience issues with drugs. It aims to support adults to both access and maintain drug recovery services. They do not provide a prescribing service but do provide accurate and unbiased information on substances and all their effects; support individual goals and personal recovery choices; encourage and support access to effective treatment and recovery services; and promote healthier lifestyles and alternatives to drug misuse within the African Caribbean Community.

Freshwinds Bro-Sis, Prospect Hall, 12 College Walk, Birmingham, West Midlands B29 6LE
Tel:0121 415 6670
Source: www.freshwinds.org.uk

Status	Clients	%
In Treatment	27	44%
Incomplete - client died	11	18%
Incomplete - dropped out		0%
Incomplete - retained in custody	2	3%
Incomplete - treatment commencement declined by client		0%
Incomplete - treatment withdrawn by provider		0%
Transferred - in custody	2	3%
Transferred - not in custody	9	15%
Treatment completed - alcohol free		0%
Treatment completed - drug free	5	8%
Treatment completed - occasional user (not opiates or crack)	6	10%
	62	



- In the last two years, BRO-SIS has recorded 62 treatment episodes on NDTMS. As of December 2012, 27 (44%) were still in treatment. 11 (18%) episodes were successfully completed. 11 (18%) client episodes were transferred to other agencies while 13 (21%) episodes were incomplete.
- The majority of clients had been on the caseload for over 6 months (50 episodes / 81%). The most common age banding of clients was '26-35' (44%) followed by '36-45' (24%).
- 27 client episodes (44%) cited Cannabis as the primary drug, followed by Crack with 20 (32%) and Heroin with 11 (18%).
- 63% of client episodes were of Caribbean ethnicity followed by 8% Other Black, 8% White British, 6% African and 6% White/Caribbean.
- Of the Bro-Sis client episodes active over the last 2 years, 92% have been male and 8% female.

- The Bro-Sis caseload has a greater proportion of clients of black ethnicity than the Birmingham average (+60%) yet the clients of white and Asian ethnicity have a significantly lower proportion (-50% and -24%).

Birmingham Ethnicity	Birmingham %	Bro-Sis	Bro-Sis %	Diff %
White	58%	5	8%	-50%
Mixed	4%	6	10%	6%
Asian	27%	2	3%	-24%
Black	9%	43	69%	60%
Other	2%	6	10%	8%
Not Stated			0%	0%
		62		

- On average, Bro-Sis took on to the caseload 1 client each month during 2012. The monthly average for 2011 was 2.
- There was an average 1 client episode per month that successfully completed in 2012.
- 69% of the client episodes had Bro-Sis as the care co-ordinator. The re-presentations rate for the period 2011-12 was 4.8%.
- Bro-Sis does not complete TOPS forms.

Data Quality

Data quality is very good with most major NDTMS fields achieving over 95% compliance. Postcode data achieved 87%.

DIP Caseload

There are no DIP referrals made to Bro-Sis.

Geography

Bro-Sis has clients in 12 wards across central Birmingham and to the south of the city.

4.12 Addaction

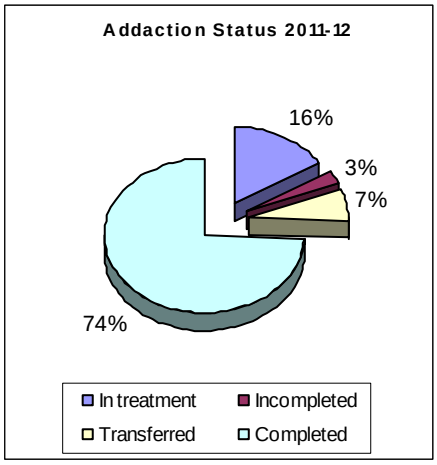
Addaction was formed in 1967, when Mollie Craven wrote to the Guardian newspaper about her experiences as the mother of a registered heroin addict. Acutely aware of the hopelessness many parents in her position felt, Mollie suggested forming a supporting association which, from these small roots, grew to become Addaction. Addaction now have more than 120 services in 80 locations across England and Scotland. They support over 28,000 people with a drug or alcohol problem every year.

Their work takes in community support services, education and prevention initiatives, help for those in the criminal justice system, residential rehabilitation, family support, aftercare, support around employment. Addaction support adults, teenagers, young adults and older people who have a problem with drink or drugs – also their children, their parents, their partners and their communities. Although they receive money from Government, they rely on donations from companies, trusts and individuals to fund the development of new projects and to address emerging problems.

Addaction Birmingham: 279 Gooch St, Birmingham, West Midlands B5 7JE
Tel:0121 465 4030

Source: www.addaction.org.uk

Status	Clients	%
In Treatment	17	16%
Incomplete - client died		0%
Incomplete - dropped out		0%
Incomplete - retained in custody		0%
Incomplete - treatment commencement declined by client	3	3%
Incomplete - treatment withdrawn by provider		0%
Transferred - in custody	1	1%
Transferred - not in custody	6	6%
Treatment completed - alcohol free	1	1%
Treatment completed - drug free	33	31%
Treatment completed - occasional user (not opiates or crack)	45	42%
	106	



- In the last two years, Addaction has recorded 106 treatment episodes on NDTMS. As of December 2012, 17 (16%) were still in treatment. 79 (74%) episodes were successfully completed. 7 (7%) client episodes were transferred while 3 (3%) episodes were incomplete.
- The majority of clients (98%) had been on the caseload for less than 12 months.
- The most common age banding of clients was '26-35' (36%) followed by '36-45' (20%).
- 63 client episodes (59%) cited cannabis as the primary drug, followed by cocaine with 24.
- 65% of client episodes were of White British ethnicity followed by 8% Pakistani and 7% White/Caribbean.
- The Addaction caseload has a greater proportion of clients of white ethnicity than the Birmingham average (+9%) yet the clients of Black and Asian ethnicity have a significantly lower proportion (-6% and -17%).

Birmingham Ethnicity	Birmingham %	Addaction	Addaction %	Diff %
White	58%	71	67%	9%
Mixed	4%	7	7%	3%
Asian	27%	11	10%	-17%
Black	9%	3	3%	-6%
Other	2%	12	11%	9%
Not Stated		2	2%	2%
		106		

- Of the Addaction client episodes active over the last 2 years, 70% have been male and 30% female.
- On average, Addaction took on to the caseload 5 clients each month during 2012. The monthly average for 2011 was 3.
- There were an average 5 client episodes per month. The average discharge total per month was 2. With an average 5 episodes commencing and 5 episodes ending each month, the overall caseload is expected to remain stable.
- 94% of the client episodes had Addaction as the care co-ordinator. The re-presentations rate for the period 2011-12 was 1.1%.
- Addaction complete on average (based on the last 5 months of 2012) 2 start TOPS, 2 review TOPS and 2 End TOPS each month.
- Data quality is excellent with all major NDTMS fields achieving over 95% compliance except 'employment status' (92%). No DIP referrals are made to Addaction.
- Addaction has clients in 8 wards across Birmingham.

4.13 Birmingham Substance Misuse Recovery Service (Summerhill House)

Adults and Communities is part of Birmingham City Council (which used to be called Social Care and Health and, before that, Social Services). It provides social care services that help adults in Birmingham to live as independently as they can and to be part of their local community. They support people to live the life they choose. This approach to adult social care is called 'personalisation'. From 1 April 2011, Adults and Communities performance is relative to four quality statements (domains) in the new Adult Social Care Outcomes Framework. The four domains are:

- Enhancing quality of life for people with care and support needs
- Delaying and reducing the need for care and support
- Ensuring that people have a positive experience of care and support
- Safeguarding adults whose circumstances make them vulnerable and protecting them from harm.

Birmingham City Council supports adults to stop misusing alcohol or drugs through a residential rehabilitation (at Park House – see 4.8) and after care programme at Summerhill House. The After Care programme offers support once clients leave a residential rehabilitation programme by offering social work support, community group sessions, attendance at Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) (or any other 12-step work), acupuncture, social events and help with accommodation. Summerhill House is a two-storey supported housing centre built to house 25 state-of-the-art flats alongside specialised mental health, HIV and café-hub services on the ground floor. It helps the most vulnerable service users integrate back into society once they leave Park House.

Summerhill House, 18-21 Summer Hill Terrace, Birmingham B1 3RA
Tel: 0121 248 1228

Source: www.Birmingham.gov.uk

4.14 DATUS

Established in 2006, a group of volunteers came together to develop a directory of available services for people with substance misuse support needs in the Birmingham area. The idea behind the project was to empower service users to gain control over their treatment journey through having an available directory that charted the treatment options available to the city's drug using community. The directory was completed in July 2007 and was circulated widely in the Birmingham area.

Upon completion of the directory the group stayed together and formed DATUS, a peer based group promoting service user rights, involvement and activity. As the range and amount of work undertaken increased the newly formed DATUS in partnership with Birmingham Drug & Alcohol Action Team agreed to support the local treatment system by providing service user involvement and peer based support through the provision of a commissioned service and as such became a registered charity and incorporated company in 2008. DATUS has extended its work to cover several areas and multiple contracts, including: advocacy, peer support groups, text network, volunteer opportunities, mystery customer programme and an allotment project.

Tel: 0121 523 4855

Source: www.datus.org.uk

4.15 KIKIT

KIKIT Community project is the first Drug Support Service in Sparkbrook to specialise in the needs of the Black and Minority Ethnic groups. Mohammed Ashfaq helped set up the KIKIT project in 2006 with the help of a small team of volunteers. The community project offers a full range of services for drug addicts

and substance mis-users in the local area helping them on the road to recovery. The small outreach team of drug workers based at the Ashiana community project run a drop in service, one to one support, a fast track referral service for treatment and a user group support network. The project also sign posts clients to other beneficial services across Birmingham.

KIKIT was set up to support individuals, families and carers of substance misusers living in Sparkbrook and the surrounding areas. Because of the culturally diverse communities in the area being culturally sensitive and multi – lingual is a very important part of the support KIKIT offer. The Asian community make up 70-80% of KIKIT's clients. However there's a strong culture of denial in the community that there is actually a drugs problem. Places of worship and the families are very reluctant to admit the problems in the area. Asian women in the community are especially harder to reach. Many users of KIKIT have especially benefited from the user support group service. Having the support from the volunteers and other members of the group has helped other drug users stay on the road of recovery and get their lives back.

KIKIT, 23 Grantham Road, Sparkbrook, Birmingham B11 1LU
Tel no: 0121 687 6767

Source: www.bbc.co.uk / www.ashianacp.org.uk

4.16 SUGAR

In September 2010 the Birmingham Drug and Alcohol Action Team (BDAAT) decided to enhance the service user and carer provision by bringing together a group of service users who were known to be enthusiastic and passionate about the development of involvement.

From a group of four service users who first met in November 2010, a steering group was created with the purpose of developing a forum for service users and carers. The steering group had support from BDAAT throughout the entire development and implementation process, and the steering group quickly grew into a team of fifteen service users and carers whose membership represents the diverse service user groups within drugs, alcohol and carers across the whole of Birmingham.

The first 'Birmingham Recovery Forum' (BRF) was attended by about 35 service users who took ownership and led on its future direction. Once the steering group was not needed, it was dissolved with a view to creating a Pan-Birmingham user and carer involvement team. This team, now called 'SUGAR' (Service User Group About Recovery) now has an average attendance of 60 members. SUGAR have set up multiple events for national days including Carers Day, International Remembrance Day, World Drugs Day; and created a new Birmingham service user magazine. All of this is only part of the ever growing 'Recovery Movement' happening in Birmingham.

Source: www.bdaat.co.uk

4.17 SIFA Fireside

SIFA Fireside is the result of the merger of two charities; Supporting Independence from Alcohol and the Fireside Charity. They are based in the Digbeth area of Birmingham and have around 50 staff and a similar number of volunteers. SIFA Fireside works with those who are homeless, those affected by alcohol or otherwise socially excluded to improve their physical, social and mental wellbeing. They empower people to meet their short and long term goals through practical support, including daily drop-ins, a resettlement service, a specialist alcohol support service, well being and activity groups and an employment and training programme.

SIFA are funded by Birmingham City Council Adults & Communities Dept to provide Alcohol Recovery Day Services, working particularly with those who are marginalised and homeless or vulnerably housed. SIFA Fireside offers immediate practical support, a Recovery assessment, and individual or group support to help people towards reduction or abstention from alcohol. SIFA Fireside's specialist alcohol service includes the option to have Acupuncture and Electric Stimulation Therapy (EST) sessions, a dedicated mental health worker and Hospital liaison. SIFA Fireside is also part of Birmingham Outreach Alcohol

Team (BOAT) in partnership with Aquarius and Irish in Birmingham, providing community advice and support in relation to alcohol within the Heart of Birmingham area. In addition SIFA Fireside provides an Alcohol Support Worker to Aquarius teams within the four District General Hospitals.

SIFA Fireside, 48-52 Allcock Street, Birmingham B9 4DY
Tel: 0121 766 1700

Source: www.sifafireside.co.uk

4.18 IDTS / CARATS

HMP Birmingham is enabling prisoners to overcome their substance misuse while in custody, in line with Prison Service National Drug and Alcohol Strategies. Full-time CARAT workers (Counselling, Assessment, Referral, Advice and Throughcare) offer support to prisoners both during custody and after release. The provision of the CARAT service from South Staffordshire and Shropshire Healthcare also includes group work interventions, ranging from individual drugs to complete relapse prevention programmes. The team run a number of psychosocial courses including:-

- Relaxation techniques
- Harm reduction issues
- Drug awareness
- Clinical interventions to support recovery
- Alcohol awareness
- Healthy living and healthy balanced diet

HMP Birmingham's Integrated Drug Treatment System [IDTS] aims to increase the volume and quality of treatment available to prisoners who are assessed as requiring treatment for drug misuse, with particular emphasis on early custody. Birmingham and Solihull Mental Health NHS Foundation Trust are contracted to provide clinical health services for HMP Birmingham. IDTS work closely with the CARAT Team and outside services to deliver care and support to prisoners. The prison is also delivering the National Drug Strategy Recovery Model, and this aims to support prisoners by reducing demand, restricting supply, building recovery: supporting people to live a drug-free life.

The management of continuity of treatment is therefore vital, and the Integrated Drug Treatment System for prisons is designed to facilitate continuity at both points of a period of custody: reception of individuals who are in current receipt of treatment, and release of IDTS clients with continuity of treatment needs. IDTS services include:

- Mental health care services
- Severe and enduring mental illness
- Screening for mental illness at reception through primary care and drug, substance and alcohol misuse assessments
- Provide a dual diagnosis service with substance misuse services
- Clinical and nursing services to a specific number of dedicated beds
- Discharge co-ordination for individuals being released from prison and on a care plan approach (CPA) or enhanced CPA
- Discharge co-ordination for individuals on a CPA or enhanced CPA being transferred from HMP Birmingham to another prison or a forensic mental health service
- Wing based mental health services for those prisoners on CPA in need of crisis resolution or assertive services
- Other psychotherapeutic interventions.
- Low level psychiatric mental health maintenance, care or case management

There is a Short Duration Programme also available for suitably assessed prisoners who are either on remand, waiting a sentence, or with sentences of 12 months or less. This is predominately for prisoners who have a history of substance dependence, and the aim of the programme is reduce their risks associated with substance use. The team work in liaison with the CARAT team and Compact Based Drug

Testing (CBDT). The aim of the programme is to Reduce Reoffending, and Reduce Substance Misuse and Related Deaths.

Compact Based Drug Testing (CBDT) is a voluntary drug testing programme that involves a prisoner making a commitment to remain drug free and signing a compact to that effect. It is important to build on every prisoner's commitment to remain drug free as the greater the number of drug free prisoners, the closer the prison moves to becoming a drug free environment and of benefit to all prisoners. In turn this should reduce the demand for drugs in the prison.

Access to Alcoholics Anonymous is planned and the prison regularly hosts Family Days for prisoners attempting to overcome substance misuse. Inclusion provides a Substance Misuse Prison Inreach Team to the area of Birmingham. This team provides a link for service users leaving prisons being reintegrated back into the Birmingham area and promotes and ensures continuity of care for prisoners being released

HMP Birmingham, Winson Green Road, Birmingham, B18 4AS
Tel: 0121 598 8000

Source: www.hmpbirmingham.co.uk / www.bsmhft.nhs.uk / www.southstaffsandshropshealthcareft.nhs.uk

4.19 National Probation Service

Probation services are provided by 35 Probation Trusts across England and Wales. Trusts receive funding from the National Offender Management Service (NOMS) to which they are accountable for their performance and delivery. Probation trusts are responsible for overseeing offenders released from prison on licence and those on community sentences made by judges and magistrates in the courts. Probation prepares pre-sentence reports for judges and magistrates in the courts to enable them to choose the most appropriate sentence. Probation also works with victims of crimes where the offender has committed a sexual or violent offence and has been given a prison sentence of 12 months or longer. Probation trusts manage approved premises (hostels) for offenders with a residence requirement on their sentences or licences. Probation staff also work in prisons, assessing offenders, preparing them for release and running offending behaviour programmes.
Source: www.justice.gov.uk

Proven re-offending is defined as any offence committed in a one year follow-up period and receiving a court conviction, caution, reprimand or warning in the one year follow-up. Following this one year period, a further six month waiting period is allowed for cases to progress through the courts.

In England & Wales between April 2010 and March 2011, around 640,000 offenders were cautioned, convicted (excluding immediate custodial sentences) or released from custody. Around 170,000 of these offenders committed a proven re-offence within a year. This gives a one year proven re-offending rate of 26.8 per cent, which represents a rise of 0.5 percentage points compared to the previous 12 months and a fall of 1.1 percentage points since 2000. These re-offenders committed an average of 2.88 re-offences each. In total, this represents around 500,000 re-offences of which 82 per cent were committed by adults and 18 per cent were committed by juveniles.

- 55.9 per cent (around 280,000) were committed by re-offenders with 11 or more previous offences.
- 0.7 per cent (around 3,300) were serious violent/sexual proven re-offences
- 5.1 per cent (around 25,000) were committed by re-offenders on the Prolific and other Priority

Offenders with a large number of previous offences have a higher rate of proven re-offending and this is true for both adults and juveniles. The proven re-offending rates range from 11.4 per cent for offenders with no previous offences to 48.2 per cent for offenders with 11 or more previous offences.

	2000	12 months ending March 2010	12 months ending March 2011	Percentage change 2000 to 12 months ending March 2011[1]	Percentage change 12 months ending March 2010 to 12 months ending March 2011[1]
All offenders					
Proportion of offenders who re-offend (%)	**27.9**	**26.3**	**26.8**	*-1.1pp* ↓	*0.5pp* ↑
Average number of re-offences per re-offender	3.37	2.80	2.88	*-14.6%* ↓	*3.0%* ↑
Proportion of offenders who re-offend - Adjusted to baseline[2] (%)	25.5	27.0	27.1	-	-
Average number of re-offences per offender	0.94	0.73	0.77	*-17.9%* ↓	*5.0%* ↑
Number of re-offences	579,770	500,656	495,162	*-14.6%* ↓	*-1.1%* ↓
Number of re-offenders	171,935	179,040	171,949	*0.0%* ↑	*-4.0%* ↓
Number of offenders in cohort	617,024	681,555	641,742	*4.0%* ↑	*-5.8%* ↓
Adult offenders					
Proportion of offenders who re-offend (%)	**26.2**	**24.9**	**25.4**	*-0.8pp* ↓	*0.5pp* ↑
Average number of re-offences per re-offender	3.39	2.80	2.88	*-15.1%* ↓	*2.9%* ↑
Proportion of offenders who re-offend - Adjusted to baseline[2] (%)	23.6	25.6	25.9	-	-
Average number of re-offences per offender	0.89	0.70	0.73	*-17.7%* ↓	*4.9%* ↑
Number of re-offences	423,989	395,386	404,228	*-4.7%* ↓	*2.2%* ↑
Number of re-offenders	125,023	141,254	140,314	*12.2%* ↑	*-0.7%* ↓
Number of offenders in cohort	477,698	567,971	553,385	*15.8%* ↑	*-2.6%* ↓
Juvenile offenders					
Proportion of offenders who re-offend (%)	**33.7**	**33.3**	**35.8**	*2.1pp* ↑	*2.5pp* ↑
Average number of re-offences per re-offender	3.32	2.79	2.87	*-13.4%* ↓	*3.2%* ↑
Proportion of offenders who re-offend - Adjusted to baseline[2] (%)	32.0	33.9	35.2	-	-
Average number of re-offences per offender	1.12	0.93	1.03	*-8.0%* ↓	*11.0%* ↑
Number of re-offences	155,781	105,270	90,934	*-41.6%* ↓	*-13.6%* ↓
Number of re-offenders	46,912	37,786	31,635	*-32.6%* ↓	*-16.3%* ↓
Number of offenders in cohort	139,326	113,584	88,357	*-36.6%* ↓	*-22.2%* ↓

Source: Proven Re-offending Statistics Quarterly Bulletin – Ministry of Justice

Birmingham

In the Birmingham Probation service in 2012, there were 21 Senior Probation Officers, 122 Probation Officers, 100 Probation Service Officers, 62 Case administrators and 58 ancillary staff who managed 5116 offenders in the community and 2688 offenders in custody.
Source: www.swmprobation.gov.uk

The DIP Court Team is located at Birmingham Magistrates' Court. The DIP Court Team aims to track those who have tested positive through the court system, providing screening and assessment of drug misusing offenders at court, where this has not already been undertaken by an Arrest Referral Worker. The team makes referrals to drug treatment agencies and ensures that DIP treatment agencies are kept informed of the results of court cases.

All positive drug test results are notified to the court by the Crown Prosecution Service and the court takes this into consideration when deciding on suitability for bail. The DIP Court team ensures that the court has information about the offender's suitability for 'Restriction on Bail' and tracks all of those made subject to restriction on bail, ensuring that the court is updated on progress.

The Drug Rehabilitation Requirement (DRR) is the most appropriate community sentence for offenders with a history of Class A drug-related offending. This is a rigorous and demanding Community Order that can require attendance up to five times per week with mandatory drug testing twice a week. The Drug Rehabilitation Requirement can include more or less contact, supervision and testing, depending on the needs of the offender and seriousness of their offending.

DRRs are delivered in partnership, the Probation Service provides the offender management and Birmingham and Solihull Mental Health Foundation Trust provide the drug treatment. Both the Probation Service and the Safer Birmingham Partnership/Drug and Alcohol Action Team (DAAT) have significant targets to achieve in terms of the number of commencements of DRRs annually and also numbers of successful completions.
Source: www.bdaat.co.uk

The table below shows the one-year proven re-offending rates for offenders released from prison on licence in 2008 and 2009 across Staffordshire and West Midlands. This proportion of re-offences is significantly higher than the National average.

Staffordshire and West Midlands	2008	2009
Proportion of offenders who re-offend	39.3	34.1
Average number of offences per re-offender	3.22	3.01
Average number of re-offences per offender	1.26	1.03
Number of re-offences	3,538	2,887
Number of offenders	2,800	2,808
Proportion of offenders who re-offend - Adjusted to baseline (%) (predicted rate)	39.3	38.5

Source: 2012 Compendium of re-offending statistics and analysis – Ministry Of Justice

Birmingham Crown Court, 1 Newton Street, Birmingham B4 7NA
Tel: 0121 248 0099

Birmingham Magistrates' Court, PO Box 4081, Corporation Street, Birmingham, B4 6QU
Tel: 0121 248 6080

Probation administrative offices:
Head Office, 5 St Philips Place, Birmingham B3 2PW
Tel: 0121 634 1300
5th floor, King Edward House, 135a New Street, Birmingham B2 4QJ
Tel 0121 329 7900

4.20 Public Health England

Public Health England has been established to protect and improve the nation's health and wellbeing, and to reduce inequalities. It will take up its full powers on 1 April 2013.
Public Health England will work collaboratively with the devolved administrations at the highest level of the agency to provide a range of health protection services across the UK.
The devolved administrations will continue to have similar access and representation on expert committees as they do now. An executive board will complement the senior team and ensure Public Health England's decision-making draws on significant senior scientific and professional expertise.

Public Health England's leadership team will lead eight directorates:

- health protection
- health improvement and population
- knowledge and intelligence
- operations
- strategy
- programmes
- finance and corporate services
- human resources

Directors will provide the leadership to secure integrated working between all directorates and across all areas of public health. Each of the directorates' priorities and structure is introduced in this document.
The health protection directorate will be responsible for health protection services, establishing and maintaining internationally benchmarked best practice.

Source: www.gov.uk/government/organisations/public-health-england

4.21 West Midlands Police / SMART – Substance Misuse Arrest Referral Workers

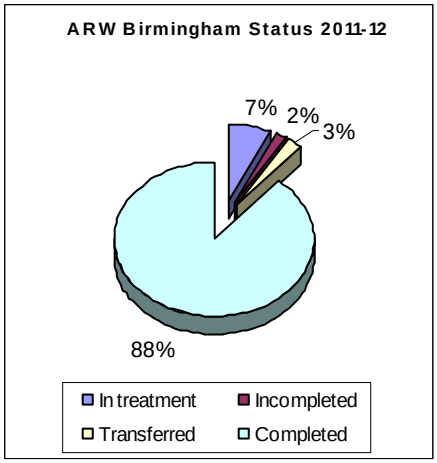
West Midlands Police employs specially trained Arrest Referral Workers (ARWs), who are based in police custody suites. ARWs are essential to the success of drugs programme because they form the vital link between drug-misusing offenders who are in police custody and the drug treatment services. They will provide rapid access to services and will assist in dealing with the needs of the individual. Arrest referral uses the point of arrest as a vital opportunity for drug workers to make that contact with drug users, independent of the police.
Source: www.west-midlands.police.uk

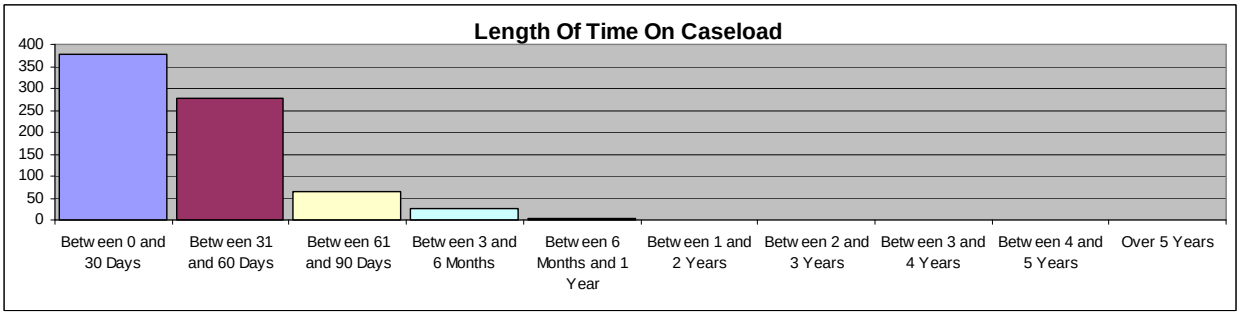
The West Midlands Police Service is commissioned by Birmingham DAAT to provide the Arrest Referral Service across Birmingham. Arrest Referral Workers are based in each Police custody suite and are a vital link between the Police, service users, the court based DIP team and treatment providers. The focus of the service is two fold:

(i) To undertake initial screening and 'Required Assessment' in relation to drug misuse following a positive drug test and to identify offenders within the custody suite who may have tested negative but who have a drug problem. Having conducted an assessment, the Arrest Referral Workers make referrals into drug treatment and other appropriate pathways dependent upon the needs of the individual.

(ii) To offer a range of interventions in the custody suite including giving harm reduction information, motivational interviewing and support to encourage the individual to engage into treatment. Arrest Referral Workers also deliver brief structured treatment interventions for cannabis and stimulant users.
Source: www.bdaat.co.uk

Status	Clients	%
In Treatment	51	7%
Incomplete - client died		0%
Incomplete - dropped out	10	1%
Incomplete - retained in custody		0%
Incomplete - treatment commencement declined by client	1	0%
Incomplete - treatment withdrawn by provider	2	0%
Transferred - in custody	15	2%
Transferred - not in custody	5	1%
Treatment completed - alcohol free	2	0%
Treatment completed - drug free	112	15%
Treatment completed - occasional user (not opiates or crack)	551	74%
	749	





- In the last two years, SMART has recorded 749 treatment episodes on NDTMS. As of December 2012, 51 (7%) were still in treatment. 665 (88%) episodes were successfully completed. 20 (3%) client episodes were transferred to other agencies while 13 (2%) episodes were incomplete.

- Full NDTMS consent / personal details were not granted for 2 (<1%) episodes. 10 (1%) client episodes had no address details available.
- The majority of clients (87%) had been on the caseload for less than 60 days.
- The most common age banding of clients was '26-35' (45%) followed by '36-45' (35%). 36 clients (5%) were aged '18-20'.

AgeBand	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
Under 18											**0**
18 -20	18	12	4	2							**36**
21 - 25	125	107	23	9							**264**
26 - 35	182	112	27	10	2	1					**334**
36 - 45	40	31	10	4							**85**
46 - 55	10	10	2								**22**
56 +	2	4									**6**
Unknown											**0**
TOTAL	**377**	**276**	**66**	**25**	**2**	**1**	**0**	**0**	**0**	**0**	**747**
	50%	**37%**	**9%**	**3%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	

- 472 client episodes (63%) cited cocaine as the primary drug, followed by cannabis with 250 (33%).

Drug 1	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
Alcohol	4	4	2		1						**11**
Amphetamines	1	1									**2**
Cannabis	137	89	16	8							**250**
Cocaine	227	178	48	17	1	1					**472**
Crack	2	1									**3**
Ecstacy	1										**1**
Heroin	5	3									**8**
Other Drugs											**0**
TOTAL	**377**	**276**	**66**	**25**	**2**	**1**	**0**	**0**	**0**	**0**	**747**
	50%	**37%**	**9%**	**3%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	

- The ethnicities of the SMART caseload almost match the Birmingham averages apart from the Asian cohort which is under-represented by -16%.

Birmingham Ethnicity	Birmingham %	SMART	SMART %	Diff %
White	58%	447	60%	2%
Mixed	4%	51	7%	3%
Asian	27%	79	11%	-16%
Black	9%	106	14%	5%
Other	2%	53	7%	5%
Not Stated		11	1%	1%
		747		

- 59% of client episodes were of White British ethnicity followed by 9% African and 9% Bangladeshi, 5% Caribbean and 5% White/Caribbean.

Ethnicity	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
African	30	32	3	5							**70**
Bangladeshi	39	19	6	2							**66**
Caribbean	22	10	2	1	1						**36**
Indian	6	5	2								**13**
Not Stated	7	3		1							**11**
Other	9	7		1							**17**
Other Asian	7	3	2								**12**
Other Black	1	2	1								**4**
Other mixed	2	3	2								**7**
Other White	6	6	1								**13**
Pakistani											**0**
White and Asian	5	8									**13**
White/Black African	1	1	1								**3**
White/Black Caribbean	23	9	2	1							**35**
White British	216	166	44	14	1	1					**442**
White Irish	3	2									**5**
TOTAL	**377**	**276**	**66**	**25**	**2**	**1**	**0**	**0**	**0**	**0**	**747**
	50%	**37%**	**9%**	**3%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	

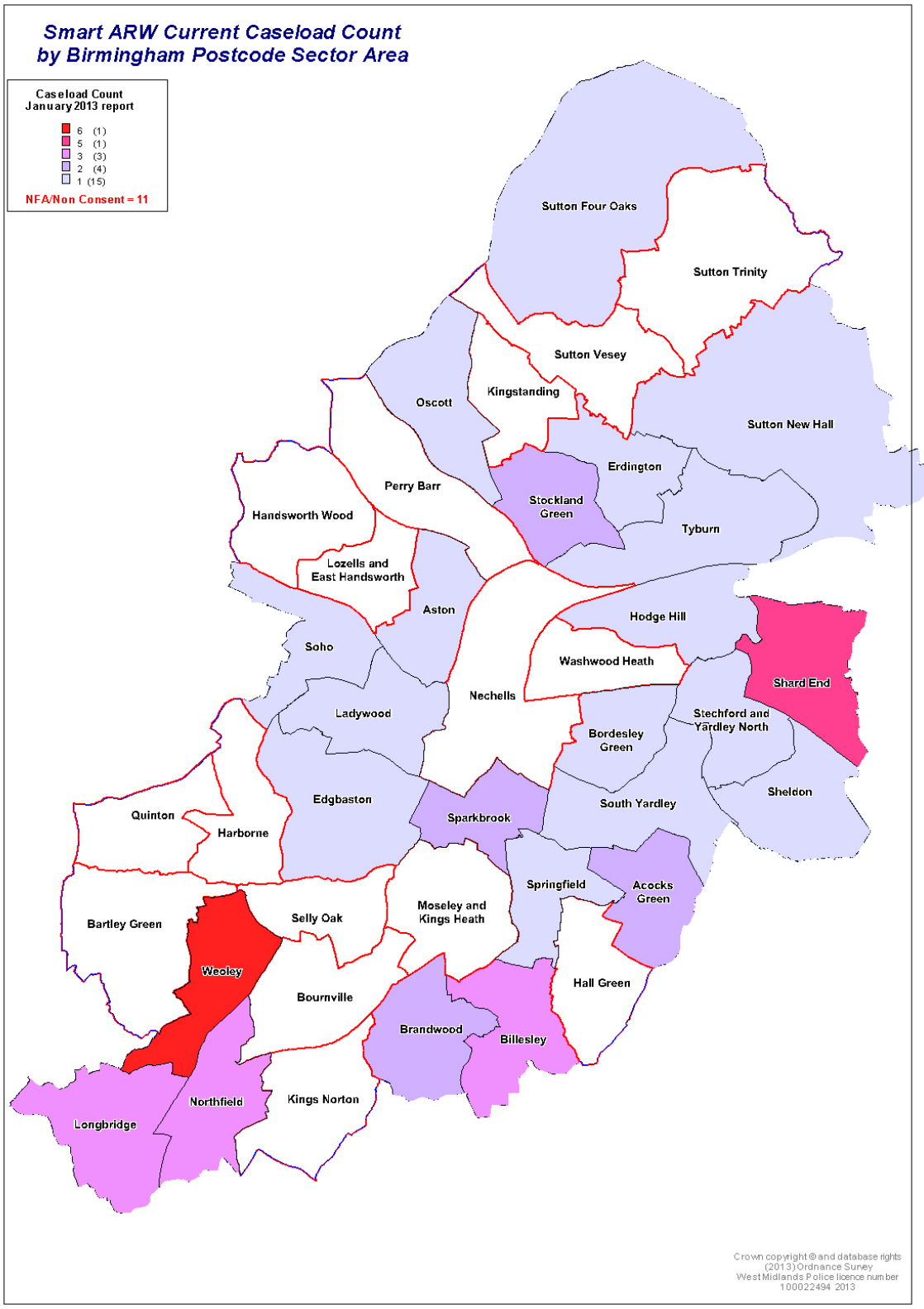
- Of the SMART client episodes active over the last 2 years, 94% have been male and 6% female.

Sex	Between 0 and 30 Days	Between 31 and 60 Days	Between 61 and 90 Days	Between 3 and 6 Months	Between 6 Months and 1 Year	Between 1 and 2 Years	Between 2 and 3 Years	Between 3 and 4 Years	Between 4 and 5 Years	Over 5 Years	TOTAL
female	21	23	3	1							**48**
Male	356	253	63	24	2	1					**699**
TOTAL	**377**	**276**	**66**	**25**	**2**	**1**	**0**	**0**	**0**	**0**	**747**
	50%	**37%**	**9%**	**3%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	

- On average, SMART took on to the caseload 34 clients each month during 2012 – 1 (3%) were OCU and 33 (97%) were Non-OCU. The monthly average for 2011 was 25.
- 2% of new presentations are retained in treatment for more than 3 months in 2012. There were an average 33 client episodes per month (97%) that successfully completed in 2012. The average discharge total per month was 34.
- With an average 34 episodes commencing and 34 episodes ending each month, the overall caseload is expected to remain stable.
- 99% of the client episodes had SMART as the care co-ordinator. The re-presentations rate for the period 2011-12 was 2.7%.
- SMART complete on average (based on the last 5 months of 2012) 33 start TOPS, 0 review TOPS and 35 End TOPS each month.
- Data quality is generally quite good with most major NDTMS fields achieving over 90% compliance. However, Nationality (78%) and Accommodation (72%) data need improving.

NDTMS Employment data is missing and needs to be gathered for potential performance analysis. PALBASE is used to collect and report on SMART data (see Appendix 6.9).

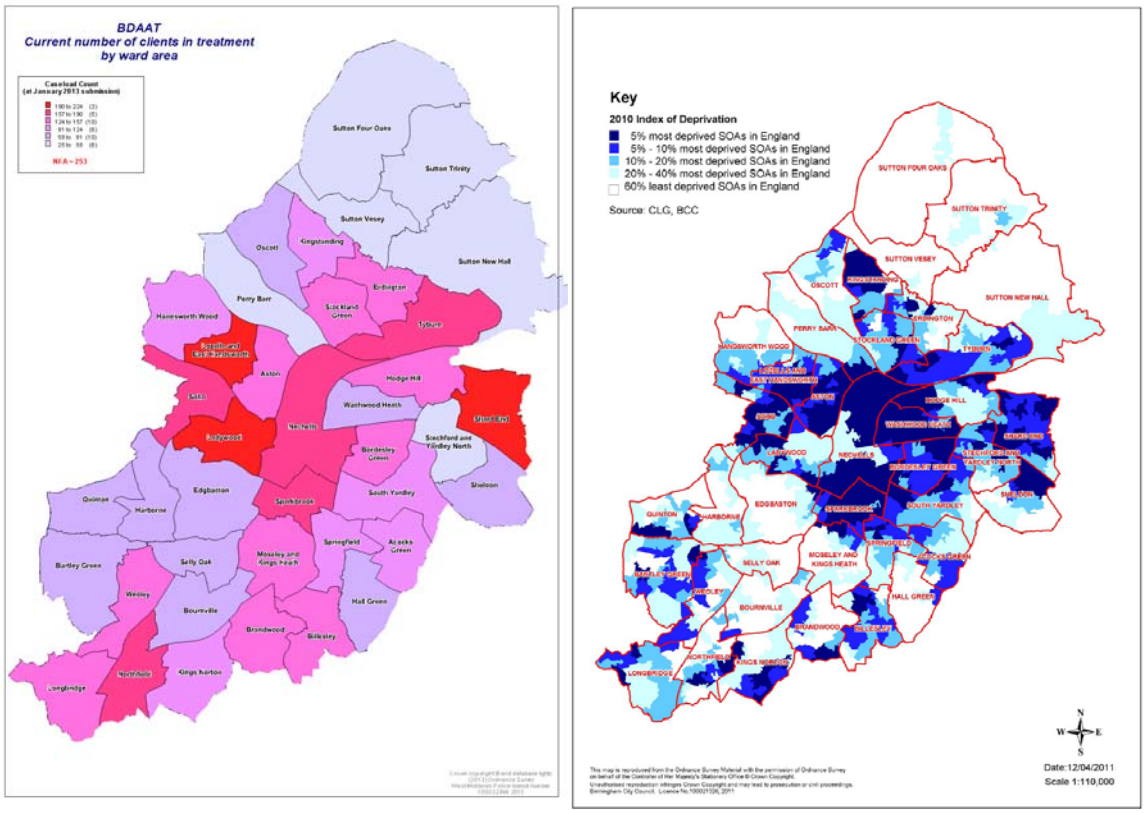
- In December 2012, 63 active clients were recorded on PALBASE as being referred to SMART for specialist drug treatment as part of the Drug Interventions Programme. On average, 36 DIP referrals are made to SMART each month.
- SMART has clients in 24 wards across Birmingham.



5.0 Analysis

5.1 Treatment Service Review

5.1.1 Correlation with drugs misuse and deprivation



When the current penetration map of clients in drug treatment is compared with the map of the index of deprivation for Birmingham it becomes clear that there is a significant link between substance misuse and poverty. For the main, the ward areas where there are more adults in drug treatment are similar to the wards with the higher levels of deprivation. 7 of the wards with the largest numbers in drug treatment are in the top 12 of the list of deprived areas.

Evidently, Birmingham service providers are attracting substance mis-users in to treatment from these locations. What this also suggests is that services should focus engagement strategies in these less affluent areas, or discern different approaches to individuals depending on their wealth or social standing. Analysis of opiate and crack prevalence in the city indicates that perhaps only 40% of this cohort is accessing treatment so there is still a large potential need for drug treatment services.

There does not appear to be the same correlation between deprivation and alcohol abuse in Birmingham, presumably because of cheaper costs, social acceptance and widespread availability.

5.1.2 The Recovery Agenda

The Government's Drug Strategy of 2010 includes an overarching aim to "increase the numbers recovering from their dependence". By analysing the NDTMS data detailing the last 2 years provided by service providers, it was found that 74% of non-active clients were discharged on the same day as their treatment modality ended. This infers that recovery initiatives are not being exercised in the Birmingham

drug treatment service. Re-presentations were at 14%. Further evidence is provided by the lack of post treatment reviews recorded on NDTMS.

This perhaps paints a false picture as recovery is certainly high on the agenda for service providers, especially DATUS and SUGAR. Residential rehabilitation at Park House and the support programmes at Summerhill House have also proven successful with the recovery of clients.

With the advent of NDTMS core dataset J, the opportunity to record specific recovery modalities within a treatment episode became more apparent. For service providers to evidence how successful client recovery is in Birmingham then recovery will have to be adopted as part of the treatment episode and this information will need to be recorded on NDTMS.

5.1.3 Pathways into Treatment

The formation of the Drug Interventions Programme in Birmingham in 2004 provided the city with an injection of funding and a direct route for drug misusing offenders to access drug treatment. Adults in courts, prisons and custody blocks were fast-tracked, sometimes coarsely, to drug service providers. Alcohol services also partnered with the criminal justice system to provide brief interventions and specific treatments for drink drivers. Commissioners from various services joined forces in partnership to introduce policies and systems that would facilitate engagement. In addition to traditional referrals from professionals and doctors and self-referrals from individuals, the Birmingham treatment system appears to have provided ample opportunity for adults to access drug and alcohol treatment. Volunteer groups and support agencies have also increased in numbers.

Consequently, the routes into treatment have become numerous and confusing to individuals. For instance, DIP clients are forwarded to the ARCHs, unless they are Prolific and Priority Offenders (PPO) when they are then referred to Swanswell. Self-referrals can access practically any service. GP practices have a 'shared-care' arrangement with Swanswell. Aquarius receives alcohol referrals from the south of the city while RAPT-NACRO / A-Team attract clients from the north. Services with specific client populations, such as Bro-Sis, Kikit or SAFE, can sometimes focus their activities in isolation from mainstream agencies. Indeed, a by-product of performance measures has been to maintain a client caseload level which may have prohibited agency-to-agency referrals.

This is not to say that the pathways have been unsuccessful. Birmingham has the largest individual DAT caseload in the country and thousand of clients have entered and received treatment successfully. However, to make the pathways less confusing to clients would require a more cohesive approach between service providers with shared targets and a tailored, personalised plan for each individual in treatment that utilised specialised services from various providers.

5.1.4 Care Co-ordination

When a client makes contact with an agency of the Birmingham drug treatment system, the existing process means that the initial agency becomes the initial care co-ordinator. When the client is transferred to another agency that delivers structured treatment the mantle of care co-ordinator is passed. If the client engages in residential rehab in Birmingham then the care co-ordination remains with the referring agency. As there is not a case-management system used by all service providers across Birmingham, it is sometimes difficult to determine who the care co-ordinator of the client is. For alcohol services this is not quite an issue as there are less service providers.

External organisations, DATs and prisons that wish to refer clients to services in Birmingham call the Single Point of Contact (SPoC) service provided by First Response (0300 5555 999). First Response identifies the relevant ARCH or Addaction service depending on the client's postcode.

Analysis of NDTMS shows that 86% of drug client episodes had a care co-ordinator. The remaining 14% suggests that there is no care co-ordinator or that the case co-ordinator is not the current agency administering treatment. To avoid confusion, reduce assessments and administration, and to streamline

referral processes it would be prudent to have a single database system (or a single care co-ordinator) that tracks the client entirely through treatment and recovery.

A count of individual agencies per client infers that Birmingham clients engage with an average 1.2 treatment agencies. This also supports evidence that clients predominantly engage in treatment with a single agency in Birmingham, and referrals between agencies seldom occur once treatment commences. This may be exactly what the client desires but it does reduce the capacity of choice across the Birmingham treatment system.

5.1.5 Non-treatment Interventions

Much of this Needs Assessment document has focused on clients in treatment but it should not be forgotten that a huge amount of work is conducted by staff delivering harm reduction advice and support that does not lead to an episode of treatment. All service providers, and Alcohol services especially, engage with a large amount of people each month.

Service Provider	Average Monthly Contacts	Average Monthly DIP Contacts *	Average Monthly On Caseload	Average Monthly Discharge
ARCHs	131	64	131	132
Swanswell	75	27	49	66
Turning Point	41	6	23	19
Kikit	20	0	4	3
DATUS	180			
Addaction	125	0	10	5
NACRO	32			
A Team	64	0	55	62
SAFE	30	2	5	5
Inclusion	25	1	12	10
Phoenix	50	2	12	6
Aquarius	1,672	0	55	85
SMART (ARWs)	275	65	34	34
Park House			23	24
Bro-Sis	24	0	1	1
TOTAL	**2,744**	**167**	**414**	**452**

* Does not include court / prison referrals

The benefits of these “tier 2” engagements are often overlooked as DIP evidence suggests that a third of offenders that receive this initial intervention do not come into contact with the criminal justice system again. From a health perspective, if sufficient information is collected, these initial contacts could be followed up to determine if substance misuse and associated problems are progressive. Further research could also assist strategic decisions.

5.1.6 “Hard to Reach” Communities

The analysis of the 2011 census data reveals that adults from the black and Asian ethnicities in Birmingham are under represented in the substance misuse agencies. Whether this is a particular predilection for these communities to not misuse drugs or alcohol can not be determined but anecdotal evidence would suggest that services are more tailored to the white British ethnicity. A review of marketing techniques may highlight where messages are not reaching these particular individuals.

The approaches manifested by agencies such as Kikit and Bro-Sis could be adopted throughout mainstream agencies to encourage take up of BME communities. Perhaps individual sessions could be increased across treatment hubs that utilised the skills from these specialist agencies. The same could be true to promote engagement with more female adults by accessing staff from agencies such as SAFE and Anawim in a more co-ordinated manner. Outreach activities already target ethnic groups, gay and lesbian communities and criminal justice offenders. A co-ordinated marketing plan and resource allocation could improve efficiencies and maximise client engagement from these hard to reach communities.

5.17 Focus

Previous funding from the Home Office resulted in a focus on Class A drugs. However, the Drug strategy of 2010 recognises that the drugs market is changing and this focus needs to be widened:
"Previous drug strategies have focused on the harms caused by heroin and crack cocaine. Tackling these harms remains vitally important; however patterns of drug use and the illicit drugs market have not stood still. The world is increasingly globalised. While the increase in global trade has brought undoubted benefits, it has also brought new threats, including the trafficking of new psychoactive substances (so-called 'legal highs'), precursor chemicals (frequently used in or for the illicit production of drugs) and cutting agents (substances used to adulterate controlled drugs). Although there has been some progress in tackling drug dependence, an integrated approach to support people to overcome their drug or alcohol dependence has not been the priority. Insufficient continuity of case management and support resulted in repeated assessment, particularly for individuals moving into and out of the criminal justice system (CJS), with disrupted treatment and expenditure focused on delivering process targets not outcomes. Treatment success has been eroded by the failure to gain stable accommodation or employment".
Birmingham agencies have previously been set performance targets that seek to maximise OCU client engagement. Although OCU clients should remain a priority, a classification system adopted by Birmingham agencies would identify the complexities and needs of all individuals during assessment and provide a manageable framework for future support. This would also assist with costs and resource planning.

5.18 Personalisation

The Government is committed to introducing payment by results initiatives across services. PbR pilots across England have indicated that these will be based on the reductions of the levels of complexity of clients and their recovery and employment statuses. To achieve these initiatives, Birmingham substance misuse agencies would need to introduce a classification system that would allocate an individual to a cluster type. This cluster would then be monitored for improvements. However, a by product of this would be a personalisation of treatment for clients which could lead to a greater choice of service and support. Once the client has been identified as certain type of cluster than a menu of treatment and support options can be offered. This could also enhance resource and costs planning. Pareto's principle dictates that 20% of a collective needs 80% of effort. This classification would also reveal where staffs' efforts should be concentrated.

5.19 Assessments

Birmingham City Council promotes that the health and wellbeing of Birmingham citizens should improve, especially for vulnerable adults and children. In order to evidence how substance misuse agencies are completing with this direction that the appropriate information needs to collected. Birmingham Drug & Alcohol Team (BDAAT) initiated a consultation exercise in 2011 to compile a comprehensive Birmingham Assessment Form (BAF) which would encapsulate all of the necessary information to assess an individual for drug or alcohol treatment and also take into consideration the wider safeguarding issues. A working document was produced and distributed (see Appendix 6.10) but participation in completing this assessment form for each adult meaningful contact by all treatment agencies has not been achieved. This has resulted in clients having multiple assessments and information not being shared across treatment agencies. A case management system used by all agencies where the information on the BAF (or its successor) can be input, amended or retrieved would provide an adequate solution and hasten client engagement in treatment. An electronic version of the form linked to the database on portable devices would also expedite client processing.

5.2 Implementing Recovery Orientated Opioid Substitution Treatment

Professor John Strang's 2011 interim report "Medications In Recovery" described 12 immediate steps to improve the recovery-orientation of treatments such as prescribing, and to ensure people in treatment get appropriate support to achieve the best gains. The steps are detailed below and how they could possibly be adopted in Birmingham

1. Audit the balance in your service between overcoming dependence and reducing harm to ensure both objectives properly coexist; and that individual clinicians understand and apply a personalised assessment for each patient, regularly repeat it, and, based on its findings, re-examine and adjust the treatment plan with the patient.

This would entail the adoption of a new classification dependent on the stage of the client's treatment/recovery journey. The complexity of treatment and support required would also need to be factored in. Greater analysis of available data would need to be completed in order to process this audit and targets would have to be revised to encourage compliance.

2. Review all your patients to ensure they have achieved abstinence from their identified problem drug(s) or are working to achieve abstinence. Patients should be offered the opportunity to come off medication after appropriate careful planning, when they are ready.

Service providers could complete a post-treatment TOP review before the client is finally discharged from caseload. This would determine whether further treatment is required. Appropriate treatment 'milestones' should be recorded.

3. Consider whether to change the current balance between promoting overcoming of dependence and promoting reduction of harms, with the aim of actively encouraging more patients to take opportunities to recover. Although no clinician should take unwarranted risk, neither should they protect patients to the extent that they are not encouraged and enabled to get better. This must always be undertaken in a way that supports each patient to make an informed choice that is relevant to their personal situation and is based on an accurate description of the available options.

It would be prudent to introduce a measure that service providers need to justify why a client has been in continual treatment after 12 months and whether a recovery plan has been adopted.

4. Ensure exits from treatment are visible to patients from the minute they walk through the door of your service. This means giving them enough information to understand what might comprise a treatment journey, even if their eventual exit appears some way off. And make visible those people who have successfully exited by explicitly linking your service to a recovery community, or employing former service users or using them as a volunteer recovery mentors and coaches.

Each treatment agency in Birmingham markets themselves. Perhaps a co-ordinated approach would make the treatment journey less confusing to the client with clear objectives and definitions.

5. If agonist or antagonist medications are being prescribed, then review, jointly with each patient and with input, as appropriate, from relevant third parties, the extent of benefit still being obtained.

Review processes would have to be streamlined and information shared across providers.

6. For patients who have achieved stability while on medication and who choose to reduce and/or stop the medication, ensure that support mechanisms are in place to support this transition, and also ensure that rapid re-capture avenues are in place and are understood and acceptable to the patient, in the event of failure of the transition.

This would mean that more information is shared with non-clinical organisations.

7. Check that all treatment is optimised so patients are receiving the range and intensity of interventions that will give them the best chance of recovery. This may include optimised doses of appropriate medications; the reintroduction, reduction or dropping of supervised consumption as appropriate; active keyworking, including case management and psychosocial interventions that keyworkers are competent to provide; access to other psychosocial interventions requiring additional competences; etc. As a first step, audit the availability of key NICE-recommended psychosocial interventions, using the audit tool in the NTA/BPS Toolkit.

In Birmingham, there is no one single agency that co-ordinates the care of every client. Key workers are in place at Birmingham's specialist drug services.

8. Strengthen or develop patients' social networks, involving families where appropriate and facilitating access to mutual aid by, for example, providing information, transport, or premises for meetings, and by bringing local recovery champions into the service to meet patients.

Birmingham agencies offer support where appropriate. Social networks and self evaluation media such as "mylife4me" has been introduced. Evidence on families interactions has not been collated. Recovery champions have been promoted through DATUS and Aquarius.

9. Establish opportunities to accrue 'social capital' via work experience placements or employment, training opportunities, volunteer work, etc.

No Birmingham research exists to support this initiative.

10. Ensure all keyworkers are trained and supervised to deliver psychosocial interventions of a type and intensity appropriate to their competence. Effective keyworking entails recovery care planning, case management, advocacy and risk management, and collaborative interventions that raise the insight and awareness of patients and help them plan and build a new life. This will often involve attention to employment and housing.

BDAAT and individual treatment agencies have delivered numerous training packages to increase the skill sets of Birmingham staff.

11. Review the quality of your service's recovery care planning and take steps to improve it, where possible. Recovery care plans should be personally meaningful documents, developed over a period of comprehensive assessment, and reviewed and adapted regularly, so that they are important to and owned by the patient.

Post treatment review TOPS which would record recovery modalities are not routinely conducted in Birmingham. The recovery plan is generally included in the main care plan.

12. Ensure your service works with local housing and employment services, and with commissioners, to ensure there is supported and integrated access to relevant provision.

Birmingham treatment services engage with housing providers, Job Centre Plus and specialist agencies across Birmingham although demand normally outstrips supply.

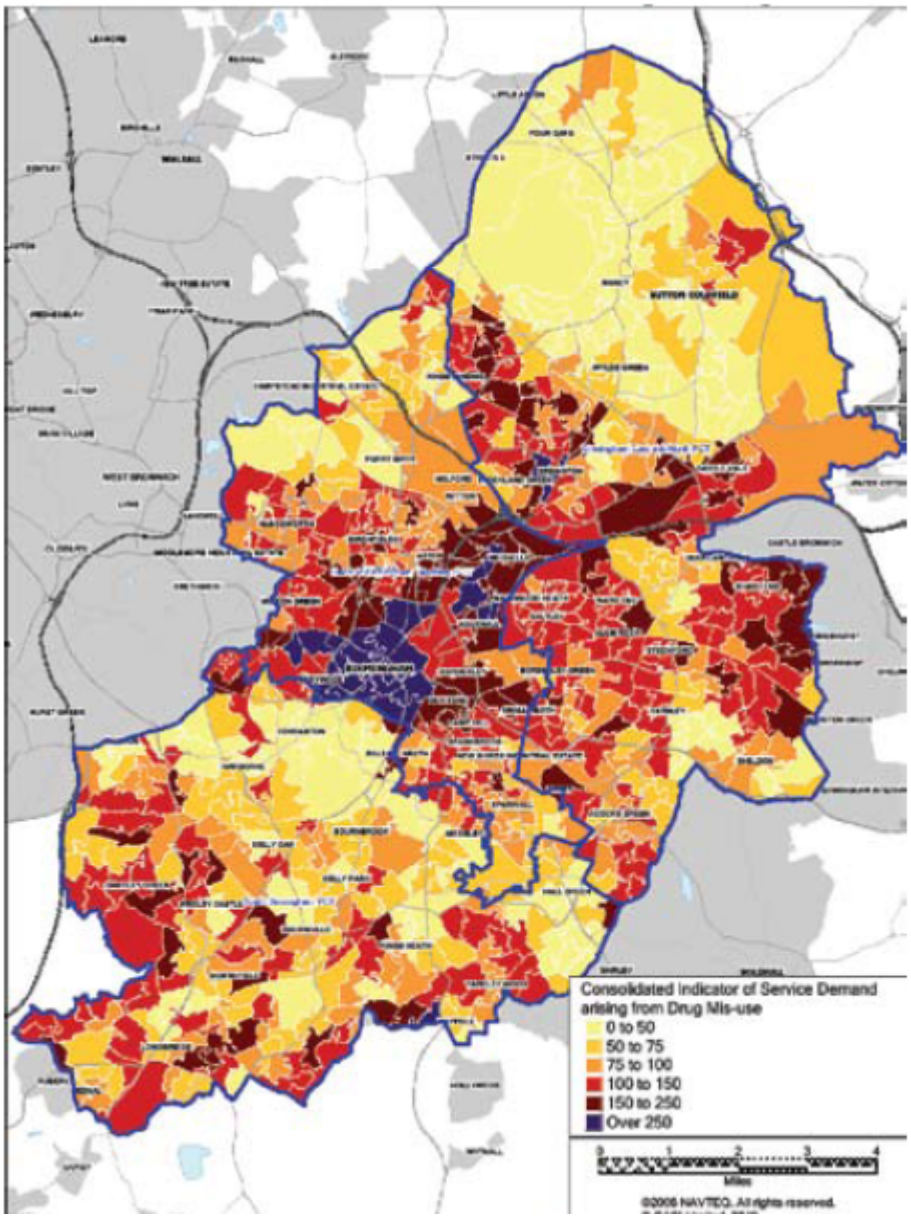
Source: Medications in Recovery (Strang – 2012)

5.3 Local Government Study 2011

A Local Government Improvement and Development study was published in January 2011. The research was conducted to review service provision from the perspective of service users and their needs. The findings from this project are realised in the following 2 charts which represent service demand and costs arising from drugs misuse across Birmingham. This particular study found that demand and costs are focused across the central region.

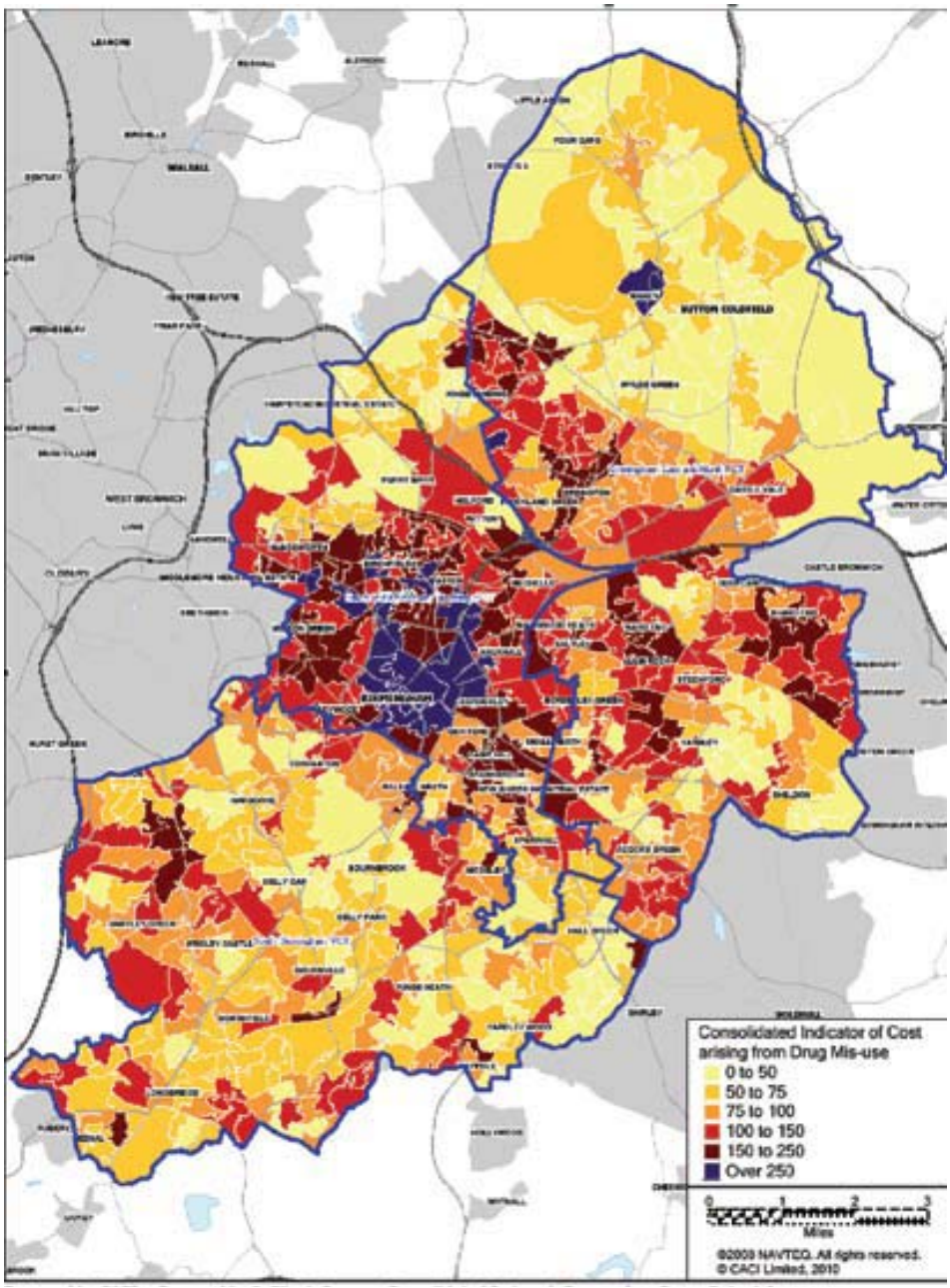
The data sources that contributed to this consolidated index included DAAT needle exchange volumes, NHS Business Authority spend (associated with opiate dependency), Police data referring to drug-misusing offenders, Probation OaSys system, ACORN demographic information, Birmingham Opinion Survey and HES Inpatient Admissions data.

Consolidated indicator of **service demand** arising from drugs misuse



Source: www.local.gov.uk

Consolidated indicator of **cost** arising from drugs misuse



Source: www.local.gov.uk

Findings from this study indicated:

- There is limited systematic evidence and insight into what treatment, harm reduction or prevention strategies really work and for which types of people.
- There is no shared ongoing visibility across the system of the total population of substance abusers, how many people are receiving support, their referral routes into these services and the cost and impact of substance abuse on other service areas.
- The system is structured and managed based upon stand-alone services and contracts commissioned and managed to spend these individual budgets, rather than being driven by a coordinated programme of tailored pathways and treatment plans that are informed by shared insight, to deliver better outcomes for service users and better value for money.

- The system relies upon a one-size fits all approach. There is no differentiated approach within the system that allows for the fact that different people may respond to different treatment or support in different ways.
- Service users expressed frustration with the current choice and flexibility for both harm reduction and treatment. In particular, the view was broadly shared that the current role and approach to methadone did not match what they felt were their needs and did not match the approach they would like to take to managing their recovery.
- The funding is primarily a health contribution, which drives the focus on treatment, where the total place analysis indicates that the impacts of drug and alcohol abuse are also significantly felt by other agencies.
- It would seem that the contribution by other agencies to identifying, targeting, supporting and referring problem users would seem to be very low. From a need perspective, it is clear that housing and social care, for example, are responsible for supporting many of the issues that may be influencers in a journey towards substance abuse, yet there seemed to be no evidence of proactive referral from these agencies.
- There is no shared reporting about outcomes, percentage of drinkers in treatment, numbers of people in treatment (and per cent of substance abusers that this represents), or referral routes. Furthermore, there is no shared ongoing assessment of the impact of substance abuse (on domestic violence, employability, housing churn, crime etc) that might allow a better understanding of the impact of the problem and provide the tracking of how well the system is working. This shared insight, with a focus on outcomes (as well as current service consumption and referral processes), could also usefully be broken down geographically to allow ongoing understanding of the size of the problem and where is happening.
- On a more positive note, the research identified many strengths of the current system, but it is worthy of note that perhaps one of the greatest strengths is the commitment of the people interviewed who work within the system. This is reflected in one of the key findings reported that almost all of the service users referred to their key contacts and key-workers in glowing terms and place great significance in the role that those individuals are playing and have played in their current or previous recoveries.

The recommendations of this study were:

- To establish outcome tracking and service demand – including a clear reporting process that identifies the numbers of substance abusers (at differing levels – hazardous, harmful and dependent for example), the numbers getting support and the type of support, and, the cost and impact on other service areas. This will help provide the necessary data for analysis and reporting by demography and geography.
- Undertaking a review and tightening of all contracts and the DAAT operation.
- Drive transformation through a number of pilot projects such as creating Social Media Support Networks (for alcohol service users); Life Event Triggered Interventions around Customer Need; Using advocates to Join Up Services toward Desired Outcomes; Self Directed Personalised Support for drug service users and Local Commissioning to Drive Service Efficiencies.

The project also recommends moving towards a system that is owned by all stakeholders will demand better ongoing sharing of performance information. This reporting should identify the total estimated numbers of substance abusers across the city, the numbers receiving treatment, the impact and cost of substance abuse on issues such as health, domestic violence, crime and other social disruption that drives cost in other budgets. This ongoing view will help drive shared ownership of the issue.

5.4 DIP Performance

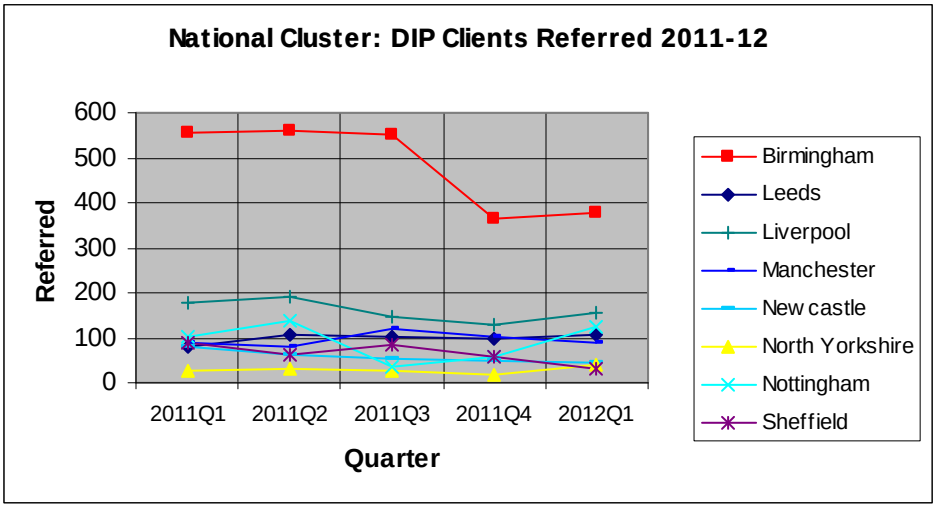
The Drug Interventions Programme (DIP) in Birmingham has been very successful in encouraging offenders out of crime and into treatment. Indeed, when compared Nationally, Birmingham DIP accounts for 7% of the total DIP cohort.

Total Clients Referred (NATIONAL Cluster)

	2011Q1	2011Q2	2011Q3	2011Q4	2012Q1	**Average**
National	7653	7809	7855	6267	6760	**7269**
Birmingham	**557**	**562**	**549**	**366**	**378**	**482**
Leeds	80	108	103	100	107	**100**
Liverpool	177	191	145	127	154	**159**
Manchester	89	79	118	104	90	**96**
Newcastle	80	61	52	47	45	**57**
North Yorkshire	27	30	28	19	39	**29**
Nottingham	103	139	36	59	125	**92**
Sheffield	87	61	84	59	30	**64**
B'ham To National %	7.3%	7.2%	7.0%	5.8%	5.6%	**6.6%**

Source: DIRWeb: NTA / DIP Quarterly Summary Reports

Birmingham DIP has more clients referred in treatment than Liverpool, Manchester, Leeds and Newcastle combined.



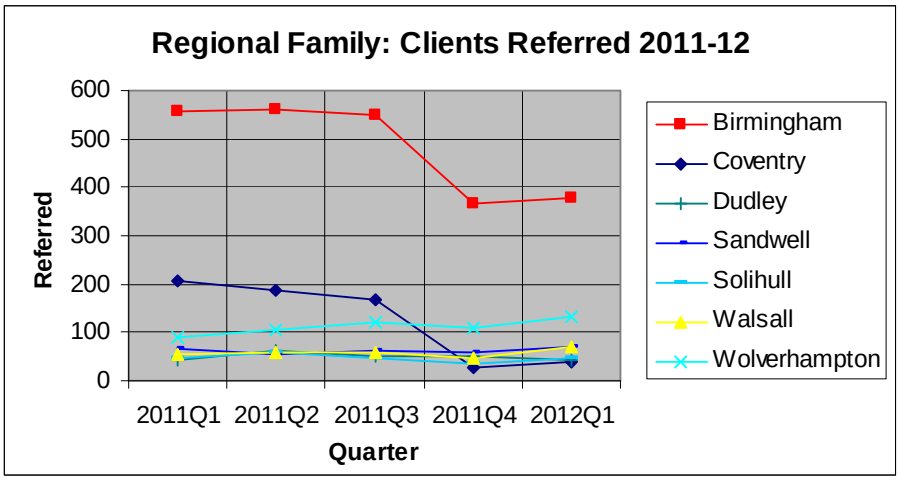
Source: DIRWeb: NTA / DIP Quarterly Summary Reports

Total Clients Referred (Regional Cluster)

	2011Q1	2011Q2	2011Q3	2011Q4	2012Q1	**Average**
National	7653	7809	7855	6267	6760	**7269**
Birmingham	**557**	**562**	**549**	**366**	**378**	**482**
Coventry	206	186	167	28	39	**125**
Dudley	42	63	51	49	43	**50**
Sandwell	68	56	62	58	72	**63**
Solihull	46	58	47	35	46	**46**
Walsall	53	57	58	45	70	**57**
Wolverhampton	88	107	121	108	132	**111**

Source: DIRWeb: NTA / DIP Quarterly Summary Reports

Across the West Midlands area, Birmingham has more DIP clients than all of the other Drug Action Teams (DATs) combined.



Source: DIRWeb: NTA / DIP Quarterly Summary Reports

Until recently, the performance of the Drug Interventions Programme was evaluated through four dashboard indicators. Apart from DI2, Birmingham generally outperforms the National average:

Dashboard Indicator 1: 95% of adults arrested for a trigger offence to be drug tested

- Birmingham has consistently achieved this target with an average of 99%.
- The National achievement for 2012 was 97%.

Dashboard Indicator 2: 95% of adults who test positive and have an initial Required Assessment imposed to attend and remain at the RA

- Due to the size of the cohort and the complexity of the pathways in Birmingham, this target has never been achieved. A large number of clients who transfer to services outside of Birmingham also affect this figure.
- This target is problematic for most other DIP programmes across the country.
- The Birmingham average for 2012 was 78% whereas the National figure achieved was 80%.

Dashboard Indicator 3: 85% of adults assessed as needing a further intervention to have a care plan drawn up and agreed

- Birmingham has improved this target over the last 12 months with an average of 90%. The average for 2011 was 86%
- The National achievement for 2012 was 92%.

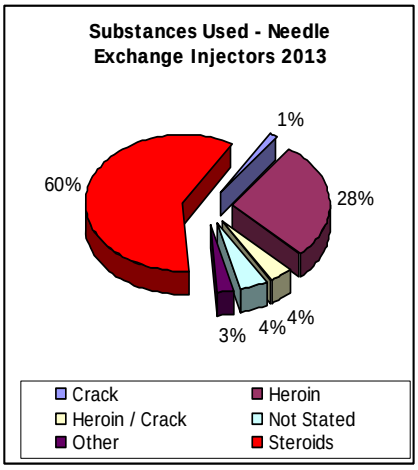
Dashboard Indicator 4: 95% of adults taken onto the caseload to engage in treatment

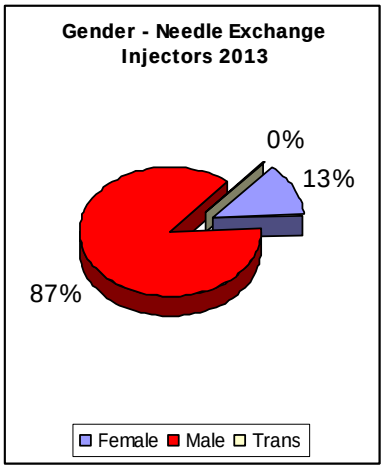
- Birmingham has improved this target over the last 12 months with an average of 99%. The average for 2011 was 98%
- The National achievement for 2012 was 96%.

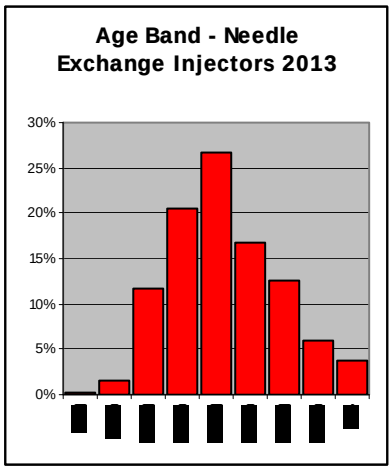
5.5 Needle Exchange / Supervised Consumption

NICE recommends that local strategic partnerships (LSPs) and NHS organisations should offer a range of services for people over 18. All programmes should, as a minimum: encourage people who inject drugs to use the services on offer; provide as many needles and syringes and other injecting equipment as someone needs; provide sharps bins and advice on how to dispose of equipment safely; and provide advice on safer injecting and ways to get help to stop using drugs or switch to non-injecting methods.

- As of March 2013, there are 6,984 injectors that have registered with the Birmingham Needle Exchange programme.
- There are over 100 pharmacies / specialist drug treatment services where needles can be exchanged and consumption can supervised across Birmingham. Drug paraphernalia is also provided.
- Injectors have to register to access these services and the data is collected on a bespoke database system know as NEO.
- 87% of the injectors are male. The largest age-band is 30-34 years (27%), followed by 25-29 years (21%) and 35-39 years (17%).
- 4,794 (69%) injectors have stated that they have been in structured treatment
- Of the 6,984 injectors, 656 (9%) stated which substance they were injecting. 60% said they were injecting steroids, 28% Heroin, 4% Heroin/Crack, 3% Other substances and 1% Crack. 4% were not valid. This data was probably collected from service providers rather than pharmacies.

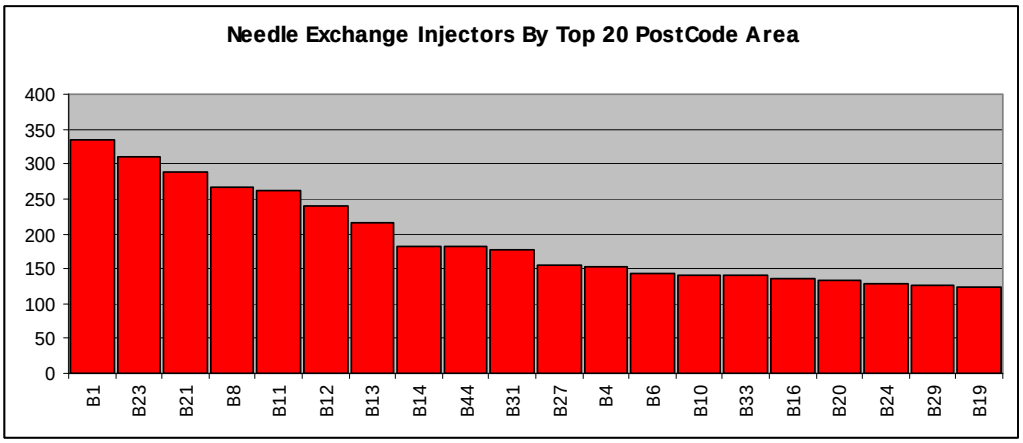






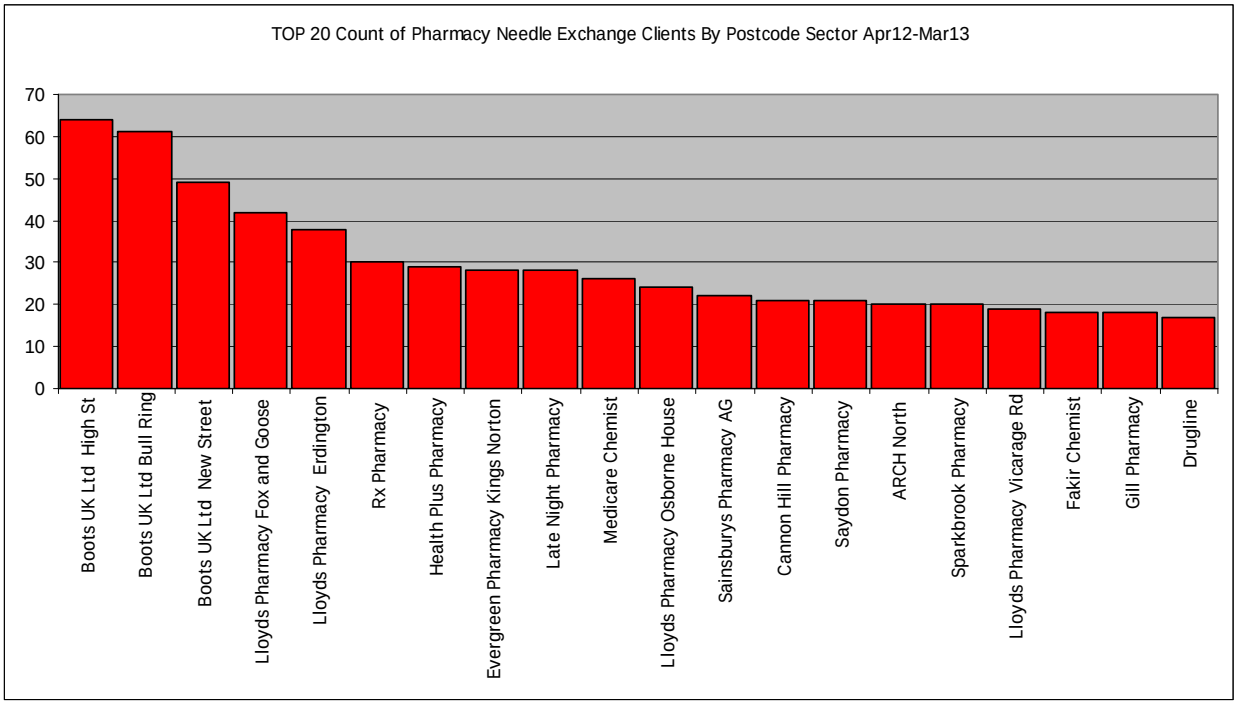
Source: NEO

- The residence of injectors is determined by postcode area. There are on average 69 registered injectors for each postcode area in Birmingham. The postcode area with the most registered injectors is B1 (Ladywood), followed by B23 (Stockland Green/Erdington) and B21 (Handsworth).



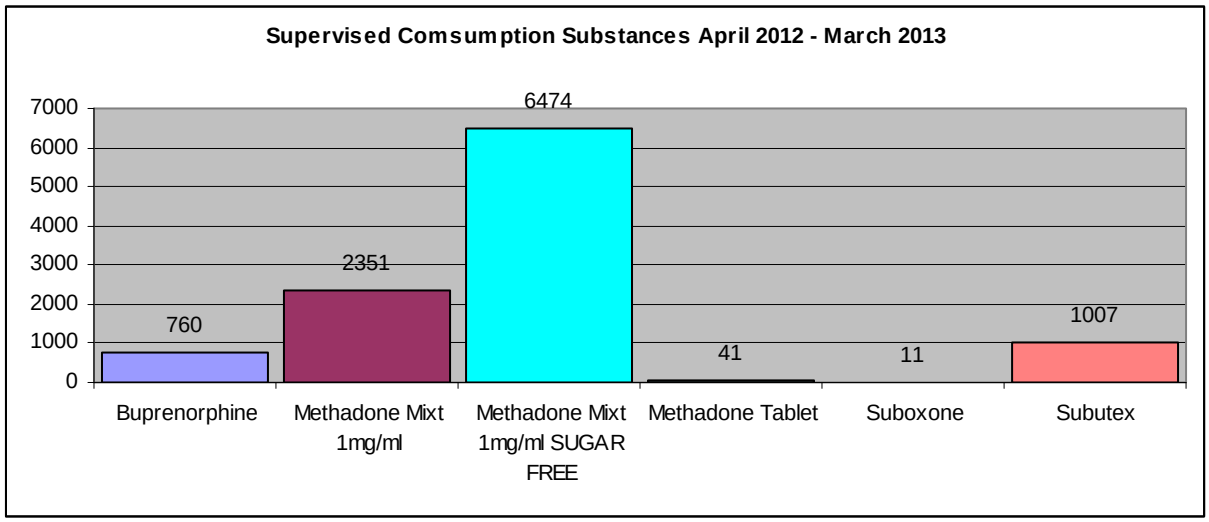
Source: NEO

- The Pharmacy with the most clients is Boots, High Street Birmingham, followed by Boots in the Bull Ring Shopping centre and Boots, New Street Birmingham. The City Centre is a convenient place to exchange needles or to obtain paraphernalia.



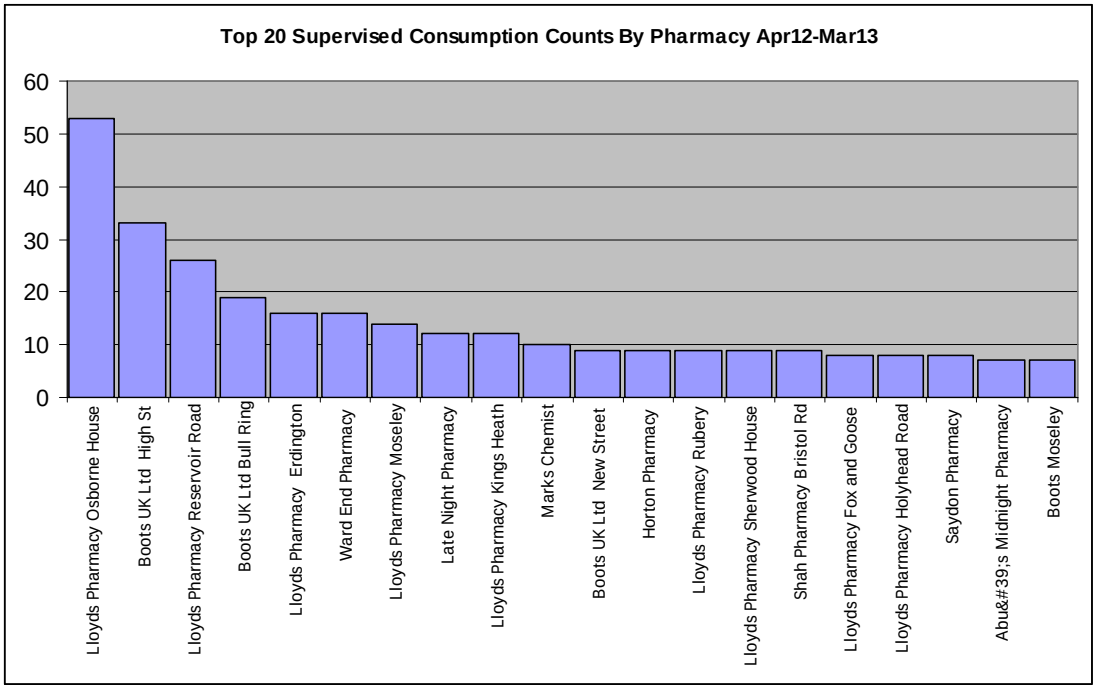
Source: NEO

- Prescribed supervised consumption is another aspect of Birmingham's Needle exchange Programme. Over the last 12 months, 8,825 doses of methadone and 1,760 doses of subutex have been supervised due to this programme.



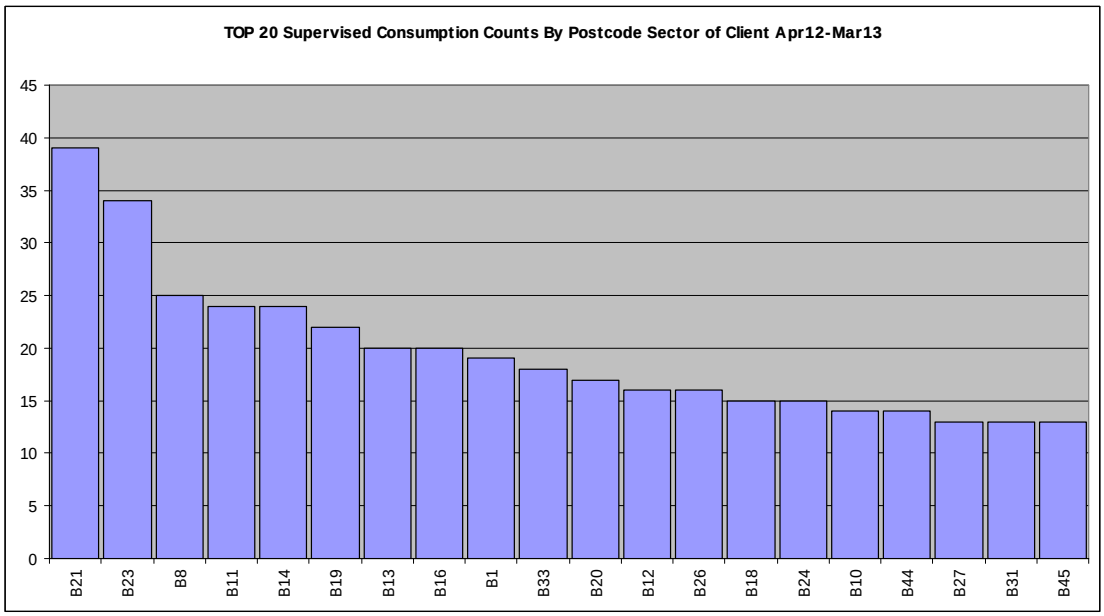
Source: NEO

- Lloyds Pharmacy at Osborn House saw the most supervised consumptions during the last year with 1,049 doses observed. It also had the most amount of unique clients of any other site.



Source: NEO

- The most supervised consumptions were by clients from B21 (Handsworth), B23 (Stockland Green / Erdington), B8 (Washwood Heath), B14 (Brandwood) and B11 (Sparkbrook / Yardley).



Source: NEO

- There are three types of needle packs that are provided at the needle exchange sites – 1ml, 2ml and steroids. Each pack contains 10 barrels, 10 needles, 10 swabs, 10 citric acid satchets, 10 filters and 10 cookers.
- Although data indicates two thirds of the injectors have been in structured treatment (and mainly use steroids), this is possibly because steroid packs are in greater demand as they contain needles that pierce deeper veins and pharmacies, under NICE (National Institute for Health and Care Excellence) guidelines, do not press injectors for further personal details or what substances the needles will be used for.
- A needle is provided for a single injection only.
- An average heroin user could be injecting 2 – 6 times a day so a pack could last 2 days. An injector speedballing (using heroin and crack combined) could use a pack in a single day.

Birmingham City Council

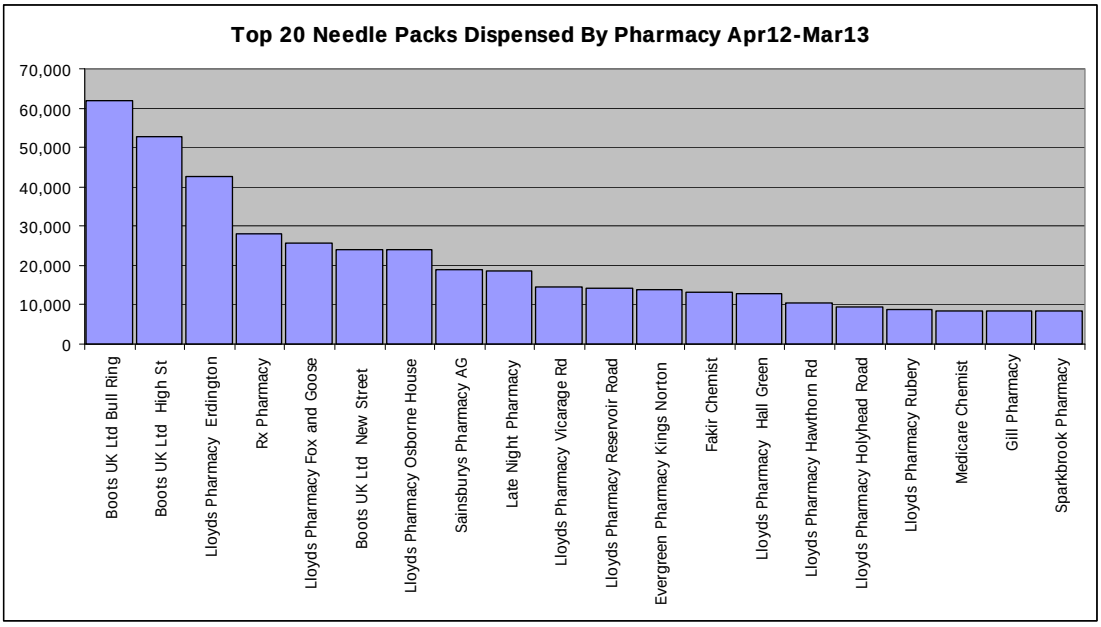
Items Dispensed to Services / Pharmacies April 2012 – March 2013

	Barrels	Dropin Services	Needles	Pack	Paraphernalia	Sexual Health	Sharpsbins	Grand Total
Addaction	105		152		303		2	562
ARCH East	979	24	1,614		676	126	20	3,439
ARCH North	1,867	24	4,301	25	2,476	60	71	8,824
ARCH South	2,177		4,396		813	21	24	7,431
Asif's Pharmacy	1,740		3,990	386	15,436		386	21,938
B S B Pharmacy	890		2,170	149	4,069		149	7,427
Bartley Green Pharmacy	1,170		3,560	342	13,602		342	19,016
Boots Harborne	140		370	33	1,233		33	1,809
Boots Kings Heath	880		2,080	202	8,102		202	11,466
Boots Northfield	860		2,010	159	5,259		159	8,447
Boots UK Ltd High St	20,280		52,660	4,890	189,210		4,890	271,930
Boots UK Ltd Kingstanding	1,380		5,760	567	22,977		567	31,251
Boots UK Ltd New Oscott	180		710	58	1,988		58	2,994
Boots UK Ltd New Street	10,600		23,970	2,185	83,225		2,185	122,165
Boots UK Ltd Bull Ring	28,020		61,920	5,844	229,164		5,844	330,792
Boots UK Ltd Tile Cross	60		540	54	2,214		54	2,922
Brutons Pharmacy	20		160	16	656		16	868
Buckingham Chemist	160		400	27	717		27	1,331
Calstar Pharmacy	160		3,680	368	15,088		368	19,664
Cannon Hill Pharmacy	1,720		4,390	402	15,372		402	22,286
Care Pharmacy	1,180		3,070	297	11,877		297	16,721
Chemipharm Pharmacy	400		710	71	2,911		71	4,163
Co-op Chemist Great Barr	2,460		5,480	404	12,244		404	20,992
Co-op Chemist Shard End	480		2,910	291	11,931		291	15,903
Co-op Pharmacy Handsworth Wood	200		400	34	1,214		34	1,882
Co-op Pharmacy Yardley	1,220		4,660	448	17,828		448	24,604
Dispharma LTD Alum Rock	470		2,870	286	11,696		286	15,608
Dispharma LTD Small Heath	1,240		3,270	272	9,502		272	14,556
Drugline	4,013		6,194		4,629		67	14,903
Druids Heath Pharmacy	640		1,060	106	4,346		106	6,258
Evergreen Pharmacy Bordesley	1,130		4,220	411	16,521		411	22,693
Evergreen Pharmacy Erdington	1,080		2,470	196	6,506		196	10,448
Evergreen Pharmacy Kings Heath	310		3,650	350	13,900		350	18,560
Evergreen Pharmacy Kings Norton	6,610		13,860	1,128	38,508		1,128	61,234
Fakir Chemist	2,790		13,330	1,270	50,180		1,270	68,840
Gill Pharmacy	1,770		8,510	767	28,927		767	40,741
Health Plus Pharmacy	2,390		8,040	662	22,882		662	34,636
Health Stop Pharmacy	840		1,810	181	7,421		181	10,433
Hingley Chemist	30		440	44	1,804		44	2,362
Horton Pharmacy	1,980		5,770	548	21,598		548	30,444
Hurcomb Chemist	820		2,300	228	9,288		228	12,864
Hustans Pharmacy	1,930		5,020	445	16,535		445	24,375
Jhoots Pharmacy Acocks Green	1,260		2,520	228	8,628		228	12,864
Jiggins Lane Pharmacy	1,070		2,800	270	10,770		270	15,180
Knights Pharmacy Longbridge	650		2,320	208	7,808		208	11,194
	Barrels	Dropin	Needles	Pack	Paraphernalia	Sexual	Sharpsbins	Grand Total

		Services				Health		
Ladywood Pharmacy	1,930		3,860	356	13,696		356	20,198
Laser Pharmacy	250		1,400	140	5,740		140	7,670
Late Night Pharmacy	5,960		18,680	1,856	75,736		1,856	104,088
Lloyds Pharmacy Castle Vale	820		2,560	253	10,283		253	14,169
Lloyds Pharmacy Erdington	15,800		42,440	3,714	136,374		3,714	202,042
Lloyds Pharmacy Hall Green	3,980		12,880	1,088	38,608		1,088	57,644
Lloyds Pharmacy Hodge Hill	240		2,460	235	9,305		235	12,475
Lloyds Pharmacy Kitts Green	1,350		4,910	392	13,102		392	20,146
Lloyds Pharmacy Northfield	3,450		7,130	544	17,234		544	28,902
Lloyds Pharmacy Sheldon	340		4,450	422	16,612		422	22,246
Lloyds Pharmacy Walmley	170		430	28	698		28	1,354
Lloyds Pharmacy Wylde Green	590		1,800	159	5,889		159	8,597
Lloyds Pharmacy Bromford			40	4	164		4	212
Lloyds Pharmacy Fox and Goose	9,770		25,790	2,163	76,203		2,163	116,089
Lloyds Pharmacy Hawthorn Rd	1,880		10,470	936	35,046		936	49,268
Lloyds Pharmacy Holyhead Road	2,540		9,500	938	38,098		938	52,014
Lloyds Pharmacy Kingstanding Rd	1,050		3,810	302	10,012		302	15,476
Lloyds Pharmacy Moseley	2,830		6,240	602	24,022		602	34,296
Lloyds Pharmacy Osborne House	8,570		23,850	2,277	90,117		2,277	127,091
Lloyds Pharmacy Reservoir Road	5,540		14,060	1,287	49,197		1,287	71,371
Lloyds Pharmacy Rubery	5,800		8,960	811	30,701		811	47,083
Lloyds Pharmacy South Yardley	360		1,770	171	6,831		171	9,303
Lloyds Pharmacy Vicarage Rd	5,880		14,640	1,347	51,717		1,347	74,931
Lloyds Pharmacy Weoley Castle	1,150		4,380	407	15,757		407	22,101
Lodge Pharmacy	740		1,460	144	5,844		144	8,332
M. W. Phillips Ltd New Oscott	200		1,210	110	4,180		110	5,810
M. W. Phillips Ltd Twickenham Rd	980		7,250	718	29,228		718	38,894
Marks Chemist	1,630		3,830	383	15,703		383	21,929
Masters Pharmacy	570		3,260	310	12,230		310	16,680
Medicare Chemist	2,390		8,530	734	26,524		734	38,912
Medichem	850		1,550	111	3,231		111	5,853
Merali Pharmacy	4,150		7,680	734	29,074		734	42,372
Mirage Pharmacy	120		280	28	1,148		28	1,604
MY Local Chemist	1,650		4,130	362	13,312		362	19,816
Nechells Pharmacy	1,050		4,560	445	17,915		445	24,415
Noor Pharmacy	3,100		6,540	653	26,743		653	37,689
Pan Pharmacy	2,150		6,660	614	23,614		614	33,652
Poolway Pharmacy	440		3,740	372	15,192		372	20,116
Royston Hall	1,480		4,390	384	14,094		384	20,732
Rx Pharmacy	6,370		28,020	2,541	96,351		2,541	135,823
Sainsburys Pharmacy AG	9,990		18,790	1,486	49,136		1,486	80,888
Saydon Pharmacy	2,380		8,210	669	22,869		669	34,797
Selcroft Pharmacy	1,270		2,860	225	7,395		225	11,975
Shah Pharmacy Bristol Rd	600		2,100	187	6,977		187	10,051
	Barrels	Dropin	Needles	Pack	Paraphernalia	Sexual	Sharpsbins	Grand Total

		Services				Health		
Shah Pharmacy Ltd.	540		2,430	214	7,904		214	11,302
Shire Pharmacy	260		800	71	2,641		71	3,843
Sparkbrook Pharmacy	2,090		8,360	809	32,359		809	44,427
Twighlight Pharmacy	930		2,220	188	6,688		188	10,214
W. M. Brown Chemist Hawkesley	980		1,760	161	6,151		161	9,213
W. M. Brown Chemist YW	1,540		4,900	448	17,108		448	24,444
W.M. Brown Chemist Kings Norton	820		1,720	134	4,354		134	7,162
White's Pharmacy Ltd	580		2,000	200	8,200		200	11,180
Yardley Pharmacy	130		640	62	2,482		62	3,376
Grand Total	240,581	48	662,907	58,781	2,241,823	207	58,940	3,263,287

Source: NEO



Source: NEO

- In the last year, 662,907 needle packs have been dispensed from pharmacies across Birmingham.
- The largest single dispenser of syringes/needles, indeed all products in Birmingham, is Boots in the Bull Ring.
- A recent survey suggested that 60% of injectors' point of entry is an arm, 20% is in the groin and 20% in other parts of the body.
- Anecdotal evidence from Birmingham drugs workers suggest that only 1/10 needles provided at needle exchanges are used for steroids while the remainder are used for drugs.

5.6 Recovery Diagnostic Toolkit

The National Treatment agency has produced a Recovery Diagnostic Toolkit (RDT) which presents an analysis of several different groups and factors in the Birmingham area. This analysis shows that:

- Opiate and non-opiate clients in treatment have a different profile and experience significantly different treatment outcomes.
- Treatment naïve clients (those new to the treatment system) and those abstinent from their main problem drug during treatment are more likely to complete treatment successfully.
- While the more complex, and those with previous experience of treatment, are often in treatment for much longer periods.
- Clients that have been in treatment long term (over four years), or those with long drug using and treatment careers, are most likely to remain there.

As well as an overview of successful completions and non re-presentations, it breaks down local treatment data into themed sections about factors linked to outcomes, such as:

- length of time in treatment and drug using career
- starting treatment for the first time or having previous experience
- client complexity
- extent of their recovery capital

When comparing results with other DAT areas, NDTMS place Birmingham in specific clusters of DATS relating to the size and level of services provided (see Appendix 6.5). For Birmingham, Opiate Clients are relative to NDTMS Cluster E, while Non-Opiate Clients are relative to Cluster D.

5.61 Completion Rates

- On average, 8% of opiates clients in treatment complete their treatment.

Opiates Completion Rates	2010-11	2011-12	Oct-12
Number in treatment	5777	5350	5187
Completions	457	414	455
% completions of all in treatment (cluster average)	7%	8%	8%

Source: National Treatment Agency

- On average, 43% of non-opiates clients in treatment complete their treatment.

Non-Opiates Completion Rates	2010-11	2011-12	Oct-12
Number in treatment	1215	1201	1270
Completions	483	515	641
% completions of all in treatment (cluster average)	40%	43%	43%

Source: National Treatment Agency

5.62 Re-Presentation Rates

- One in five of opiates clients (20%) in treatment re-present in the 12 months following treatment.

Opiates Re-Presentation Rates	2010	2011	Oct-12
Number of completions (calendar year)	470	582	533
Of which, re-presented	116	112	100
% re-presented following completion (cluster average)	22%	20%	20%

Source: National Treatment Agency

- Only 6% of non-opiates clients in treatment re-present in the 12 months following treatment.

Non-Opiates Re-Presentation Rates	2010	2011	Oct-12
Number of completions (calendar year)	473	536	604
Of which, re-presented	30	37	39
% re-presented following completion (cluster average)	6%	6%	6%

Source: National Treatment Agency

5.63 Length of time in treatment

Opiates

- The median length of time in treatment for an opiate user is between two and three years
- 43% of opiate users have been in treatment for over three years.
- 32% of the opiates cohort has been in treatment for less than 1 year.

2011-12 Opiates	< 1 years	1-2 years	2-3 years	3-4 years	4-5 years	5-6 years	6 + years
Number in treatment	1706	773	569	530	401	359	1012
% in treatment	**32%**	**14%**	**11%**	**10%**	**7%**	**7%**	**19%**
% in treatment (cluster)	32%	15%	11%	10%	7%	6%	19%
Number of completions	153	71	53	43	25	24	45
% completions of all in treatment (cluster average)	11%	10%	8%	6%	6%	6%	4%

Source: National Treatment Agency

Non-Opiates

- The median length of time in treatment for a non-opiate user is under 1 year
- 7% of non-opiate users have been in treatment for over three years.
- 87% of the non-opiates cohort has been in treatment for less than 1 year.

2011-12 Non-Opiates	< 1 years	1-2 years	2-3 years	3-4 years	4-5 years	5-6 years	6 + years
Number in treatment	1039	71	15	9	8	12	47
% in treatment	**87%**	**6%**	**1%**	**1%**	**1%**	**1%**	**4%**
% in treatment (cluster)	88%	7%	2%	1%	1%	0%	1%
Number of completions	485	22	2	1	0	2	3
% completions of all in treatment (cluster average)	44%	44%	38%	20%	11%	10%	7%

Source: National Treatment Agency

5.64 Completion by Length of time in treatment

Opiates

- The median length of time a client in treatment has been using opiates is between 12 and 15 years.
- 38% of the opiate cohort in treatment has been using for over 15 years.
- Just over a fifth of the opiate cohort had been using for under 10 years.
- The longer the client has been using opiates the less successful completions are achieved. 13% successful completions were achieved for those who had been using for under three years compared to 5% for those who had been using for over 21 years.

2011-12 Opiates	0-3 years	3-6 years	6-9 years	9-12 years	12-15 years	15-18 years	18-21 years	21 + years
Number in treatment	157	388	539	896	1222	918	425	594
% in treatment	**3%**	**8%**	**10%**	**17%**	**24%**	**18%**	**8%**	**12%**
% in treatment (cluster)	3%	7%	9%	13%	17%	17%	12%	22%
Number of completions	21	46	58	68	92	60	29	30
% completions of all in treatment	**13%**	**12%**	**11%**	**8%**	**8%**	**7%**	**7%**	**5%**
% completions of all in treatment (cluster average)	16%	12%	10%	9%	8%	7%	7%	7%

Source: National Treatment Agency

Non-Opiates

- The median length of time a client in treatment has been using non-opiates is between 9 and 12 years.
- 25% of the non-opiate cohort in treatment has been using for over 15 years.
- 44% of the non-opiate cohort had been using for under 10 years.

2011-12 Non - Opiates	0-3 years	3-6 years	6-9 years	9-12 years	12-15 years	15-18 years	18-21 years	21 + years
Number in treatment	124	153	178	191	136	80	51	129
% in treatment	**12%**	**15%**	**17%**	**18%**	**13%**	**8%**	**5%**	**12%**
% in treatment (cluster)	9%	15%	18%	16%	12%	9%	7%	14%
Number of completions	74	77	79	73	54	23	15	42
% completions of all in treatment	**60%**	**50%**	**44%**	**38%**	**40%**	**29%**	**29%**	**33%**
% completions of all in treatment (cluster average)	48%	48%	44%	42%	41%	41%	40%	41%

Source: National Treatment Agency

5.65 Treatment population by previous treatment journeys

Opiates

- A third of the opiates cohort had never engaged in treatment previously.
- The successful completions rate was slightly better for those who had not entered treatment previously (9%).
- 15% of the opiates cohort has engaged 4 or more times in treatment services.

2011-12 Opiates Previous Treatment Journeys	None	1	2	3	4 or more
Number in treatment	1771	1257	884	638	800
% in treatment	**33%**	**23%**	**17%**	**12%**	**15%**
% in treatment (cluster)	36%	23%	16%	10%	16%
Number of completions	156	102	68	48	40
% completions of all in treatment	**9%**	**8%**	**8%**	**8%**	**5%**
% completions of all in treatment (cluster average)	9%	8%	8%	7%	6%

Source: National Treatment Agency

Non-Opiates

- Almost two-thirds (63%) of the non-opiates cohort had never engaged in treatment previously.
- The successful completions rate was slightly better for those who had not entered treatment previously (46%).
- Only 4% of the non-opiates cohort has engaged 4 or more times in treatment services.

2011-12 Non-Opiates Previous Treatment Journeys	None	1	2	3	4 or more
Number in treatment	756	252	103	41	49
% in treatment	**63%**	**21%**	**9%**	**3%**	**4%**
% in treatment (cluster)	62%	21%	9%	4%	4%
Number of completions	351	102	36	9	17
% completions of all in treatment	**46%**	**40%**	**35%**	**22%**	**35%**
% completions of all in treatment (cluster average)	45%	41%	39%	36%	26%

Source: National Treatment Agency

5.66 Treatment Population by Complexity Group (All Clients)

2011-12	Very Low	Low	Medium	High	Very High
Number in treatment	922	1212	1611	1597	1209
Number of completions	405	204	144	112	64
% completions of all in treatment	**44%**	**17%**	**9%**	**7%**	**5%**
% completions of all in treatment (national average)	**43%**	**15%**	**10%**	**8%**	**6%**
Distribution of treatment population	14%	19%	25%	24%	18%
Distribution of treatment population (national avg)	15%	25%	26%	20%	14%
Distribution of completions	44%	22%	16%	12%	7%
Distribution of completions (national avg)	43%	25%	16%	10%	5%

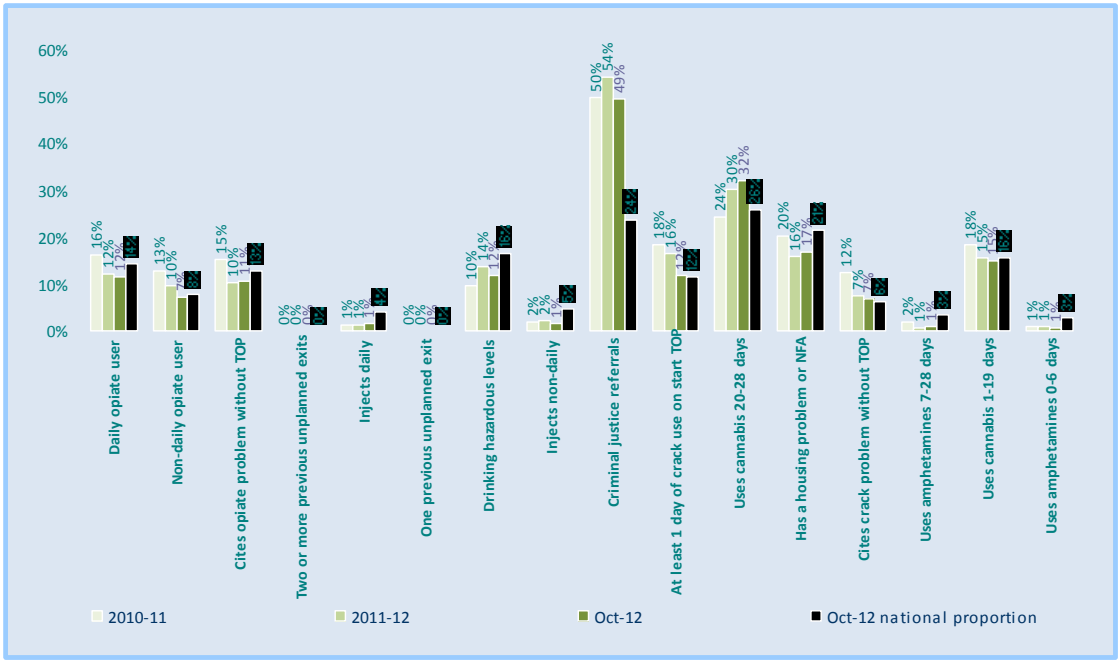
Source: National Treatment Agency

Analysis of NDTMS data has revealed that the rate of successful completions increases when the complexity level of the individual is lower. These levels of complexity are determined by NDTMS references and the presenting characteristics of the client. This gauge of complexity could possibly be used as a simple model to base future payment by results initiatives.

- 44% of all completions of the treatment cohort fall within the 'very low' complexity banding as opposed to 5% completions in the 'very high' banding.
- A quarter of the treatment population fall in the 'medium' complexity banding.
- Almost a fifth (18%) falls into the 'very high' complexity banding. It is this cohort where the most efforts should be made by substance misuse agencies.

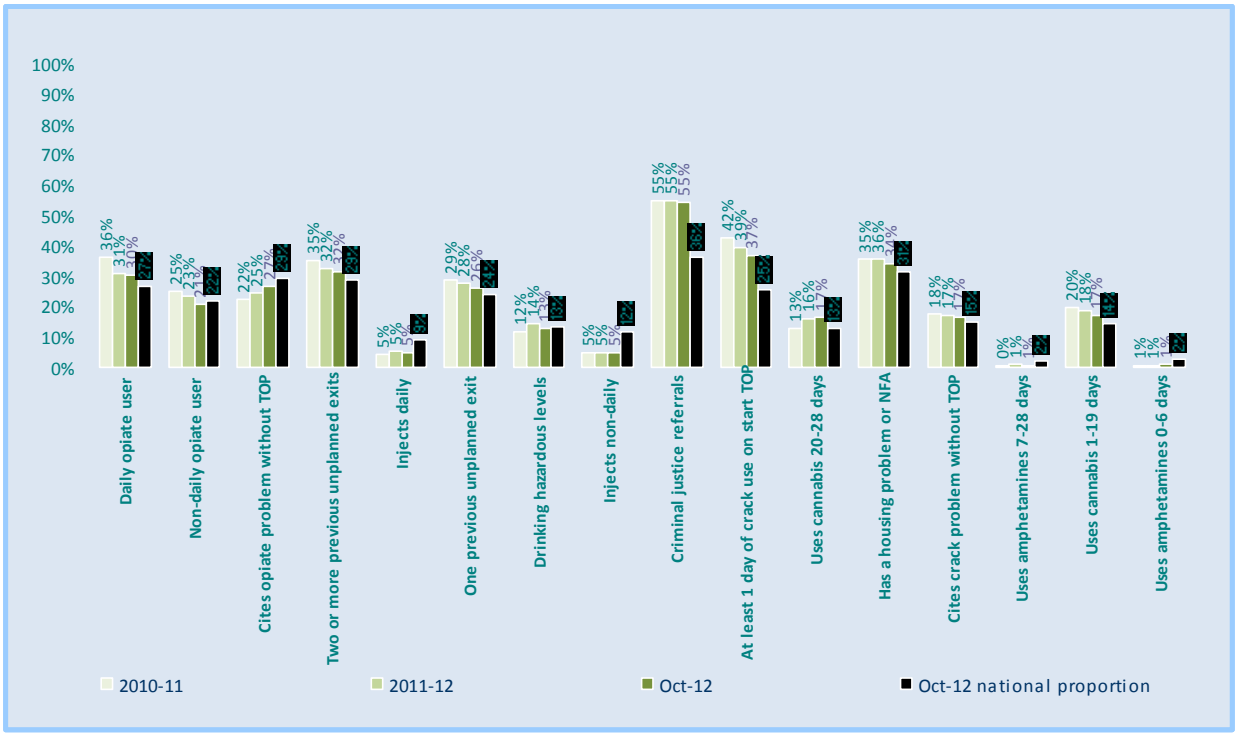
Treatment naive presentations citing each complexity indicator

		2010-11		2011-12		Oct-12		National Oct 12
Indicator	Score	N	%	N	%	N	%	%
Daily opiate user	15	136	16%	96	12%	90	12%	14%
Non-daily opiate user	14	108	13%	76	10%	55	7%	8%
Cites opiate problem without TOP	13	129	15%	82	10%	82	11%	13%
Two or more previous unplanned exits	10	0	0%	0	0%	0	0%	0%
Injects daily	5	11	1%	9	1%	11	1%	4%
One previous unplanned exit	5	0	0%	0	0%	0	0%	0%
Drinking hazardous levels	4	81	10%	107	14%	91	12%	16%
Injects non-daily	4	16	2%	18	2%	11	1%	5%
Criminal justice referrals	3	423	50%	427	54%	384	49%	24%
At least 1 day of crack use on start TOP	3	157	18%	130	16%	91	12%	12%
Uses cannabis 20-28 days	3	207	24%	238	30%	248	32%	26%
Has a housing problem or NFA	3	172	20%	125	16%	130	17%	21%
Cites crack problem without TOP	2	106	12%	58	7%	54	7%	6%
Uses amphetamines 7-28 days	2	15	2%	4	1%	8	1%	3%
Uses cannabis 1-19 days	1	155	18%	122	15%	117	15%	16%
Uses amphetamines 0-6 days	1	7	1%	8	1%	5	1%	3%



Non-Treatment naive presentations citing each complexity indicator

		2010-11		2011-12		Oct-12		National Oct 12
Indicator	Score	N	%	N	%	N	%	%
Daily opiate user	15	590	36%	476	31%	438	30%	27%
Non-daily opiate user	14	402	25%	361	23%	298	21%	22%
Cites opiate problem without TOP	13	362	22%	380	25%	385	27%	29%
Two or more previous unplanned exits	10	571	35%	500	32%	458	32%	29%
Injects daily	5	73	5%	80	5%	67	5%	9%
One previous unplanned exit	5	462	29%	425	28%	377	26%	24%
Drinking hazardous levels	4	193	12%	220	14%	187	13%	13%
Injects non-daily	4	78	5%	72	5%	68	5%	12%
Criminal justice referrals	3	888	55%	844	55%	791	55%	36%
At least 1 day of crack use on start TOP	3	688	42%	604	39%	536	37%	25%
Uses cannabis 20-28 days	3	209	13%	243	16%	241	17%	13%
Has a housing problem or NFA	3	574	35%	550	36%	491	34%	31%
Cites crack problem without TOP	2	287	18%	262	17%	243	17%	15%
Uses amphetamines 7-28 days	2	8	0%	14	1%	8	1%	2%
Uses cannabis 1-19 days	1	322	20%	284	18%	247	17%	14%
Uses amphetamines 0-6 days	1	12	1%	12	1%	14	1%	2%



5.67 Outcomes Analysis

Opiates

- After 6 months in treatment, 43% of the opiates cohort has stopped using the drug. This rises to 50% after 1 year in treatment.
- Opiate users at the start of treatment averaged using 21 days out of 28 days. After 6 months treatment this falls to an average of 7 days.

	6 months			12 months		
	Local		National	Local		National
Opiate outcomes	1003	-	32774	721	-	23613
Using at start to treatment	**703**		**69.9%**	**527**		**70.8%**
Stopped	299	42.5%	46.1%	263	49.9%	51.6%
Improved	164	23.3%	23.6%	137	26.0%	23.5%
Unchanged	215	30.6%	27.1%	116	22.0%	22.3%
Deteriorated	25	3.6%	3.2%	11	2.1%	2.7%
Mean days use start	20.5	-	20.5	21.0	-	20.9
Mean days use at review	6.8	-	6.4	5.9	-	5.4
Not using at start of treatment	**300**		**30.1%**	**194**		**29.2%**
Initiated use	77	7.7%	6.4%	51	7.1%	6.6%

Source: National Treatment Agency

Crack

- After 6 months in treatment, 49% of the crack cohort has stopped using the drug. This rises to 58% after 1 year in treatment.
- Crack users at the start of treatment averaged using 15 days out of 28 days. After 6 months treatment this falls to an average of 6 days.

	6 months			12 months		
	Local		National	Local		National
Crack outcomes	601	-	13386	431	-	9484
Using at start of treatment	**420**		**66.2%**	**298**		**65.3%**
Stopped	206	49.0%	51.5%	172	57.7%	56.6%
Improved	66	15.7%	11.7%	39	13.1%	12.1%
Unchanged	132	31.4%	32.4%	78	26.2%	27.3%
Deteriorated	16	3.8%	4.5%	9	3.0%	4.0%
Mean days use start	14.7	-	12.3	13.4	-	12.2
Mean days use at review	5.7	-	4.9	4.4	-	4.0
Not using at start of treatment	**181**		**33.8%**	**133**		**34.7%**
Initiated use	51	8.5%	7.7%	34	7.9%	8.6%

Source: National Treatment Agency

5.68 Improvements in health and quality of life

The TOPS forms monitor the clients personal perception of how their physical, psychological and quality of health has improved during their time I treatment. Based on a 20 point scale from poor to good, clients record their perceptions at the start of treatment and at the end of treatment or review. Below are the average point changes for Birmingham opiates clients.

Changes in physical health as a function of change in opiate users

	Physical		Psychological		Quality of Life	
	Local	National	Local	National	Local	National
Stopped	1.8	2.1	1.9	3.0	2.7	3.4
Improved	2.0	1.5	1.6	1.8	2.4	2.3
Unchanged	-0.2	0.2	-0.6	0.3	0.2	0.7
Deteriorated	-0.4	-1.4	0.2	-1.1	0.0	-1.5

Source: National Treatment Agency

Birmingham Physical Health

- For Opiate users who have stopped usage their physical health has improved by 1.8 points.
- For Opiate users who have reduced usage their physical health has improved by 2.0 points.
- For Opiate users who have continued using their physical health has fallen by -0.2 points.
- For Opiate users who have increased using their physical health has fallen by -0.4 points.

Birmingham Psychological Health

- For Opiate users who stopped usage their Psychological Health has improved by 1.9 points.
- For Opiate users who reduced usage their Psychological Health has improved by 1.6 points.
- For Opiate users who continued using Psychological Health has fallen by -0.6 points.
- For Opiate users who increased using their Psychological Health has improved by 0.2 points.

Birmingham Quality of Life

- For Opiate users who have stopped usage the quality of life has improved by 2.7 points.
- For Opiate users who have reduced usage the quality of life has improved by 2.4 points.
- For Opiate users who have continued using the quality of life has improved by 0.2 points.
- For Opiate users who have increased using the quality of life has remained unchanged.

5.7 Consultation

Birmingham Public Health - Birmingham Drug and Alcohol Stakeholder Consultation

Initial summary of the main results

Introduction

The Institute of Public Care (IPC), a centre of Oxford Brookes University, was commissioned by the then Birmingham Drug and Alcohol Action Team, now Public Health Birmingham, to conduct a stakeholder consultation across the substance treatment system. The consultation has been conducted during March and April 2013 using a range of methods, as follows:

- An on-line survey, open to any relevant stakeholder to contribute.
- Focus Groups separately conducted for service users and workers and held in the premises of the three main providers, Aquarius, the Birmingham and Solihull Mental Health Community Trust, and Swanswell.
- Meetings with substance misuse service managers.
- Visits to a number of alcohol and drugs projects.
- Attendance at meetings, notably at a regular meeting of the Recovery Forum.
- Meetings with key statutory agencies, including DIP Mangers, Prison managers and Probation managers.
- One to one interviews and phone interviews.
- Written submissions by e-mail and letter.

This report is a summary covering only the most frequently mentioned and central issues. The full report will develop these findings and a number of additional issues.

IPC's brief was to consult across 4 main areas of concern or domains:

- Prevention,
- Engagement,
- Treatment and
- Recovery.

This summary follows those headings but also includes an emerging final section on structure issues.

1 Prevention

Contributions covered both primary and secondary prevention issues. The main ideas and concerns in primary prevention were as follows:

- Work in schools continued generally to be seen as important, but many felt that former service users with suitable training should be at the centre of this activity, and that messages generally needed to be franker and more explicit.
- Many staff, managers and service users felt that the focus should be much more on those who were at higher risk among young people- notably those in care or leaving care; those with behavioural problems and children from families with substance misusing carers.
- It was felt that much better use could be made of social media and a better and more co-ordinated public awareness approach. It was also felt that a more common approach across agencies with shared badging and materials would be helpful.
- Some agencies had experience of a more informal outreach approach to prevention- in supermarkets to address alcohol issue, for example, and within nightclubs. It was felt that this work tended to be short term and piece meal, but was effective and merited further support. The pharmacists consulted all felt that pharmacies could contribute more fully within a co-ordinated approach.

- A theme throughout the 4 domains was that drug use was changing into a more complex and frequently shifting pattern with new drugs including 'legal highs', cannabis as a much more significant issue, and use of alcohol problematically within wider drug use. Many felt that prevention work now needed to adapt to this new context.
- A significant concern was the need for primary prevention to be carried forward by people in mainstream services, but that this would demand good quality materials and training. A number of mentions were specifically made about social work staff within Social Services, where many clients were said to be reluctant to engage with treatment because of their concern about what would happen to children once safeguarding issues were shared with Social Services. This is also an issue for engagement and this anxiety doses seem to delay access to treatment for many substance misusing parents.

Concerns at a secondary level centred particularly on two key areas, as follows:

- Among most professionals and service users there was a shared recognition of the importance of maintaining harm reduction approaches by way of sustained needle exchange, work on Blood Borne Viruses (BBV) and access to prescribing for those people at risk from ongoing substance misuse. There was an anxiety that funding reductions and a greater emphasis on recovery issues might threaten provision.
- It was generally felt that access to information for family members coping with problematic drug or alcohol use was more difficult than it should be and a number of people suggested the development of a help line specifically for family members. The issue of a more family friendly treatment system was raised in other domain areas as well.

2 Engagement

Many people made the point that a more developed approach to prevention would itself have a positive impact on engagement. Otherwise the main issues raised were as follows:

- Most people, whether workers, volunteers or service users felt that the system in Birmingham was too complex, hard to understand and as a result more difficult to access than it needed to be. They felt that a smaller number of agencies more effectively co-located within the community would be better.
- It was mentioned many times that Birmingham services needed to be marketed much more heavily with better and wider publicity and a common approach across agencies targeting demographic groups most in need and the whole population.
- A number of people with experience of living in large hostels said that they received little information about service while they were there and few had experienced efforts to encourage them to seek help. The Salvation Army was seen as an exception to this.
- Service users and former service users involved in volunteering felt that they could play a much fuller part in the attracting of people to service and in supporting individuals from the beginning.
- Some services had been working hard to develop a more welcoming approach, both in terms of the welcome environment and their initial processes. It was felt by some though that this could be taken further- drop in provision to encourage confidence, an informal café atmosphere and so on.
- There was much concern about the need to attract more women into service generally and this was even more marked in some of the BME communities. It was generally felt that marketing, the agency environment and access to women's groups and a female staff and volunteer option all had a part to play.
- Birmingham has a number of outreach activities including a service which successfully carries out harm reduction and service access for female street sex workers. There is a need for a more co-ordinated approach to outreach. If the treatment system is to be streamlined and more 'co-located' the design needs to incorporate a place for outreach work.
- Birmingham has a number of BME specific providers and organisations which play a valuable part in reaching into communities, contacting hard to reach groups and ensuring that the needs of those communities are understood and responded to. Those involved saw their value as being located within their community and with a local identity. While they saw the case for a more

streamlined system with fewer providers they argued strongly that they could provide trust, access and confidence in a way which the larger 'mainstream' agencies could not, and that any new service system needed to retain their involvement.

- There was real concern around the system about the waste and disincentive to clients in a failure to follow common assessment processes, so that difficult issues for clients were raised again and again in separate assessments. There was a general view that this needed to be streamlined and designed out of the new system to maintain strong engagement.
- In both the engagement and treatment domains there was a general consensus on the importance of clients having fewer doors to knock on, with services more co-located into hubs, relatively locally on 3 or 4 sites. An integral part of this idea was the notion that external services- probation, employment, social services etc could have a base or contact point in these hubs as well. There was a good deal of discussion about the need to achieve reasonably local access. At present there is a co-terminosity issue about the present ARCH hubs covering 'patches', which are not the same as Birmingham City Council's 3 areas. Given the establishment, now, of substance misuse services within the local authority it was felt that this anomaly needed to be addressed. There was a concern about the size of South Birmingham, which at present has both an ARCH and the Inclusions Centre, and which may need to continue with this level of coverage.

4 Treatment

The main issues in this domain again centre on the need for streamlining and a more intelligible pattern of service. There were inevitably different ideas about the priorities, which should be adopted within the treatment system. Most people stressed that the large number of treatment providers in Birmingham did not so much offer choice as confusion, and indeed during some focus groups both staff and service users, many of whom had been involved for some time, expressed surprise at hearing information on other services about which they had known nothing previously. This was illustrated in the survey where around one third of participants, that's service users and alcohol and drugs workers equally, thought the current treatment system was not being delivered effectively. Overall the main issues were as follows:

- There was general consensus that pathways and referral processes needed to be redesigned and wherever possible simplified.
- Many people from all stakeholder perspectives spoke of the 'unhelpful competition' between agencies. Some service users felt that they had been 'held on to' to keep numbers up and could have been transferred earlier. Some felt that their worker had a limited sense of the available options in any event. Many said that much depended on the qualities of your individual worker, and that there were too many transfers of worker.
- There was a general feeling that 'navigation' was difficult and that a more obvious case manager 'navigator' role was needed to follow people through. Similarly the large and developing groups of former service users volunteering within agencies felt that they could assist individuals as they went through the treatment system, helping to maintain a sense of continuity.
- There was a general sense among service users and the professionals involved that shared care was working well and should be developed further if possible- may argued strongly that the 'normalising' of treatment in this way also enabled it to stay local. People going through shared care, though, did need to be helped to an involvement in the social networks which are developing so strongly in Birmingham through the Recovery movement and the organisations involved in it, including the traditional fellowships.
- It was generally felt that access to prescribing had been improved and that the more co-ordinated approach of the Hubs had made a significant impact. There is some Criminal justice concern though about the consequences of not having specific Criminal justice workers within the Hubs, and a feeling that this has made liaison and a shared approach more difficult.
- DIP Managers, Prison based services and probation all express concern about the potential within any new structures for the work with offenders to be less clearly focused. They point out that successful operation over many years has brought many people into treatment and that the 'fast tracking' involved has been justifiable on the grounds of public concern, as well as the needs of offenders.

- There was a general concern among service users that treatment might become too 'speeded up' and that some people needed much more time than others. There is clearly value in shorter term interventions, such as those within current alcohol provision, but to work well this calls for effective assessment and 'streaming'.
- On the whole there was a consensus for integration of drug and alcohol services. It is acknowledged that there is generally more coherence of provision on the alcohol side, but overall it was felt as wasteful and unhelpful to continue with two 'streams'. It was felt that this was especially difficult for those with both drug and alcohol problems. It is accepted that there are some alcohol specific interventions but that these could be accommodated within well-designed integrated services. While some people spoke of the reluctance of alcohol clients to be associated in treatment with drug users, others spoke of the benefits they had gained from shared insights about addiction overall. Interestingly this perception of the value of an overall addiction approach was stronger among those furthest along their treatment journey.
- High care residential services in Birmingham now focus on Park House, which provides both detox and residential treatment. While formerly Birmingham made significant numbers of external residential rehabilitation placements financial constraint now means that all placements go through the Park House facility. Inevitably there were mixed views about this, but a general acceptance of the situation. There was a strong feeling that more places for both detox and treatment were need within the Birmingham provision and that this was an urgent priority.
- A number of service users spoke strongly about their sense that they had been 'parked on methadone' and overall a view that people should be given the chance to reduce or seek abstinence more consistently.
- There were, however, some people with long stabilised maintenance use who were anxious about the prospect of being 'forced along' within the new Recovery focused world. It may be, in any event, that future planning will need to take account of the longer term needs of an ageing population of these clients.
- As indicated earlier there were many references to the need for more family friendly services generally, and indeed some family specific provision, especially for parents and carers. Some agencies, such as Aquarius have established such interventions and the Hubs and community agencies generally have also begun to tackle these needs. Most people felt that these issues should be a key priority in the designing of a new pattern of services.
- Some contributors felt that the treatment system overall was very 'medicalised' and that it was time to look for a broader based approach with more emphasis on psycho-social approaches, peer support and a generally more holistic approach to people's lives. Pharmacists also felt that they could play a bigger role, including contributing to some prescribing, given recently established pharmacist qualifications for this work.
- On other areas of public care the importance of advocacy has been identified as key to the implementation of personalisation. Advocacy, currently provided in Birmingham by DATUS will need to be further developed assuming that choice and personalisation will in due course be implemented in drug and alcohol treatment.
- Prison based staff expressed real concerns about the quality of handover into the community. They felt that a more streamlined service could help, and there was also a clear role for peer support in meeting people on release. They also felt, though that an over arching aim should be the harmonisation of information exchange, and standardised assessment.
- Transition from young people's services is not seen as particularly effective and could be improved by a newly developed pathway and better shared understanding between young people's and adult services about transition issues and the needs of younger service users.

5 Recovery

Throughout the consultation a running theme was the level of energy and enthusiasm within Birmingham's Recovery community. On a number of occasions people spoke of Birmingham being 'on fire' in this respect. This owes a great deal to the commitment and determination of the leaders involved, and a result the main representative group, the Recovery Forum has a very high level of attendance and participation. Against this backdrop the main issues which emerged were as follows:

- There is a need for a locally 'owned' and inclusive definition of recovery, which incorporates all those who are making changes in their lives and seek further change.
- Many agencies are now using peer mentors, or Recovery champions. As indicated earlier many feel that they could do more as volunteers within the system. The role, regardless of title, seems to be similar across agencies and some felt that again there would be advantage in having a more common designation. Some also felt that efforts on training and support could be pooled across agencies. It was also felt that more could be done to tackle restrictions and delays within the system on accreditation, CRB checking and so on.
- A number of people felt that some further resourcing should be committed to those running the Forum to enable work to develop including its role as the main representative group. This should not, though, compromise its independence.
- Many service users and former service users expressed a strong view about the vital importance of people having access to constructive activity as part of their new lifestyle, particularly at a time when finding employment may be difficult. It was felt that a coherent approach by the Council to extending volunteer opportunities would be really helpful. While many people wish to volunteer with drug and alcohol services, as indicated above, there are others who wish to work as volunteers outside it.
- Access to support communities and networks is also seen as crucial and many NA and AA members contributed to the consultation. Some made the point that while support for NA and AA is embedded in a number of agencies there are others where staff may be less well informed about the Fellowships, or do not perceive their value. They felt that this was a significant training issue, which could only be addressed by direct contact and attendance at a meeting. Birmingham also has a developing provision of SMART Choices, a more recent network, and a facilitator was interviewed within the consultation. The establishment of another option is attractive to many service users and is seen as very helpful in extending the choice of networks.
- There was much discussion about the issue of training and employment and some contacts were made with providers and users of those services. They were generally positively regarded, but it was acknowledged generally that the constraints of the current employment situation and benefit changes were serious pressures which would affect some people's recovery.
- Similarly many people were concerned about the lack of available accommodation. The Birmingham City council based after care service for those who have been in Park House provides a well integrated after care provision, which makes much use of volunteers.
- The Changes agency in effect provides an alternative Recovery based model for treatment and after care using follow up houses leased on the private market. This sense of a wider role for Recovery based agencies suggests an effective model, which may have scope for further development.
- There was an overriding concern that shorter treatment periods might mean people being forced to independent living earlier than was sustainable for them. This is a significant message for the new treatment system and flexibility will be need. It is clear that access to and involvement in a Recovery network should be an aim of all case planning.

6 Structure issues

During the period of consultation the NTA became part of Public Health England, and the Birmingham DAAT was subsumed into the Public Health Department of Birmingham City Council. It was clear that these changes had major implications for future planning and management of services and several views were expressed which are summarised as follows:

- The establishment of a new joint Commissioning structure seemed to many people to be a top priority, and that this would also offer the opportunity to ensure service user representation at all levels.
- The interface at strategic and commissioning level between Public Health and Criminal Justice is seen as a key concern particularly by Criminal justice and DIP managers who feel that dialogue has been more limited in recent times, and that there needs to be a regular agreed forum to address commissioning and planning issues.

6.0 Appendices

6.1 Acknowledgements

1 HM Government Drug Strategy 2010: Reducing Demand, Restricting Supply, Building Recovery.
2 The Government's Alcohol Strategy – March 2012
3 Birmingham Joint Health and Wellbeing Strategy 2013
4 Birmingham Alcohol Strategy 2012- 2016
5 Drug Treatment 2012: Progress Made, Challenges Ahead – National Treatment Agency
6 Alcohol Treatment in England 2011-12 – National Treatment Agency
7 Alcohol Concern
8 NICE National Institute for Health and Care Excellence 2011 Census
9 2012 Compendium of re-offending statistics and analysis – Ministry Of Justice
10 BDAAT Service Provider Report December 2012
11 Birmingham City Council
12 Birmingham LAPE (Local Alcohol Profiles for England) – North West Public Health Observatory
13 Birmingham Needs Assessment 2011/12
14 Community Safety Partnership 2012
15 Darren Radburn – West Midlands Police
16 Dawn Hannigan – Public Health Birmingham
17 Deaths Related to Drug Poisoning in England and Wales, 2011 – www.ons.org.uk
18 Debbie Bowen– Public Health Birmingham
19 Diagnostic Outcomes Monitoring Executive Summary Reports
20 Drug Misuse Declared: Findings from the 2011/12 Crime Survey for England and Wales
21 Druglink Street Drugs Survey 2012
22 Estimates of the Prevalence of Opiate use and/or crack cocaine use (2010/11)
23 Government Improvement & Development: Birmingham Drugs & Alcohol 2011
24 Health and Social Care Information Centre (HSCIC), "Prescriptions Dispensed in the Community: England - 2001 to 2011"
25 Home Office
26 Institute of Public Care (IPC)
27 Julie Bach– Public Health Birmingham
28 Local Economic Assessment for Birmingham 2011 (BCC)
29 Mark Sheldon - BDAAT
30 Max Vaughan– Public Health Birmingham
31 Medications in Recovery (Strang – 2012)
32 National Treatment Agency
33 NDTMS
34 NEO
35 NHS Information Centre: Statistics on Drug Misuse 2012
36 NTA Cost Effective Tool for Birmingham 2011-12
37 Office of National Statistics
38 PALBASE
39 Proven Re-offending Statistics Quarterly Bulletin – Ministry of Justice
40 Ricky Bhandal– Public Health Birmingham
41 Sarah Feeley– Public Health Birmingham
42 West Midlands Police Annual Review 2011/12
43 WMP DIP Data Team
44 www.aquarius.org.uk
45 www.ashianacp.org.uk
46 www.bbc.co.uk
47 www.bdaat.co.uk

6.1 Acknowledgements (continued)

48 www.birmingham.gov.uk
49 www.bsmhft.nhs.uk
50 www.datus.org.uk
51 www.dirweb.co.uk
52 www.freshwinds.org.uk
53 www.gov.uk/government/organisations/public-health-england
54 www.hmpbirmingham.co.uk
55 www.inclusionuk.org
56 www.justice.gov.uk
57 www.local.gov.uk
58 www.nacro.org.uk
59 www.phoenix-futures.org.uk
60 www.safe.wmids.nhs.uk
61 www.sifafireside.co.uk
62 www.southstaffsandshropshealthcareft.nhs.uk
63 www.Swanswell.org
64 www.swmprobation.gov.uk
65 www.turning-point.co.uk
66 www.west-midlands.police.uk
67 www.wikipedia.co.uk

6.2 SWOT Analysis

Strengths

The real strength of Birmingham substance misuse partnership was that it enabled all agencies to work more effectively within a shared, strategic framework. Birmingham Treatment Agencies have developed and adapted to meet the diverse needs of the city's population and communities through geographical location and cohort targeting.

BDAAT ensured that a large pool of resources and expertise was made available to partnership agencies enabling them to efficiently provide treatment and interventions to their clients. The successful outcomes of the NTA and Home Office performance indicators reflect the hard work of the Birmingham treatment agencies and the way they have changed the lives of thousands of adults who have succumbed to addictions.

Weaknesses

The coalition government launched its criminal justice policy with a commitment to only fund what could be proven to work. There is an on-going debate about what outcomes should count. Should it be reducing re-convictions or helping someone to desist from crime by reducing their likelihood to be reconvicted? There is a subtle but important difference. The Government are heavily leaning towards the easier to measure reduction in reconviction rates and this is something that will undoubtedly affect many VCSE organisations.
Source: Safer Future Communities Newsletter

Opportunities

Road-side Drug Screening

The Government is taking through Parliament a new offence of driving with specified controlled drugs (above specified limits) in the body. This would involve an amendment to the Road Traffic Act 1988 and follows an independent review of drink and drug driving law (the North Review) in 2010 which recommended that a new specified limit offence should be developed.

The new offence will make it easier for the police to take action against drug drivers, by removing the need for the police to prove impairment. It is expected that the new offence will come into effect in 2014. The identification by the police of drug drivers will be aided by the availability of new oral fluid screening devices, to be 'type-approved' by the Home Office. These devices will assist the police in applying the existing offence of driving whilst impaired with drink or drugs, although a positive result alone will not prove impairment.

Police forces conducting testing on arrest as part of the Drug Interventions Programme may also wish to screen suspected drug drivers in police custody (under the current Road Traffic Act impairment offence). Beyond April 2013, when local areas will be deciding whether to continue drug testing on arrest in custody, they will also be considering whether to procure roadside screening devices to test individuals under the new offence (when those devices become available).

These two approaches have different aims; testing suspected drug drivers is aimed at improving road safety while testing misusing offenders helps identify individuals who would benefit from referral to treatment and recovery services. There may also be potential for the police to engage drug drivers who have been identified by a positive test (for heroin and/or cocaine/crack) in drug treatment, through existing mechanisms, with a view to reducing their likelihood of re-offending.

Source: Home Office

Payment by Results

Eight DAT areas across England (Bracknell Forest, Enfield, West Kent, Lincolnshire, Oxfordshire, Stockport, Wakefield and Wigan) are taking forward innovative Payment by Results (PBR) models for drug and alcohol recovery, with support from central Government (including reports on their outcome metrics from centrally matched data systems). A number of other local partnerships are now also adopting or looking to adopt PbR approaches for drug and alcohol recovery, and many may wish to adopt an offending outcome.

The aim of PbR, based on the 2010 Drug Strategy, is to test whether such an approach can help more people to break the cycle of dependence and achieve long-term recovery, with recovery having an impact not only for the individual, but also for their families and communities too.

Source: Home Office / Department of Health: www.recoverypbr.dh.gov.uk

Supply Chains

Due to the large geographical scale of national probation contracts and the financial risk of Payments by Results, it is likely that large contracts will be won by a few larger organisations. Prime providers will need to form partnerships with more local providers to show that they have expertise and local knowledge.
Source: Safer Future Communities Newsletter

Threats

Public Health Funding – 2013/14

With the Department of Health's funding for the DIP coming to an end after 31 March 2013, the department has been considering how best to distribute resources between local authorities for their new public health responsibilities from April 2013. Healthy Lives, Healthy People: Update on Public Health Funding was published on 14 June, and sets out the interim recommendations of the Advisory Committee on Resource Allocation (ACRA) on the formula for the preferred distribution of resources between local authorities for their new public health responsibilities from April 2013; this will include drug treatment services. Although local authorities will receive a single grant that they must prioritise, the formula for the preferred distribution is built up from three components.

ACRA recommends that the component for drug services (currently commissioned by Drug Action Teams through the Pooled Treatment Budget (PTB)) should continue to follow the approach currently used for the PTB, which has been praised as effective by the National Audit Office. The current PTB is based on both a need and activity component, and this will continue in the public health ring-fence model. The formula used for the 2012/13 allocation of the PTB also included an element that was dependent on the number of people successfully completing treatment. Data on the number of people successfully completing treatment were not available in time for ACRA's interim recommendations, but will be included in a further iteration of the public health ring-fence model from 2013. This means that if fewer people are treated or there is a reduction in positive outcomes, the formula for subsequent years will be reduced.
In effect, this means that from April 2013, when DIP funding ceases, the formula for the ring-fenced grant to local authorities will include a clear element of support for drug treatment.
Source: Home Office Bulletin 10/2012

The Probation Service reforms propose 16 large contracts that will cover the delivery of the contracted-out offender services. These will be commissioned and procured nationally. In contrast, PCCs and local health commissioners will commission services locally. This has resulted in a mix of policy for the Voluntary, Community and Social Enterprise (VCSE) sector to respond to. There will be a need to try and join up commissioning and for VCSE organisations to think more about collaboration in order to be sustainable. Payments by results (PbR) is proposed in the probation reforms as the vehicle by which the Government hopes to realise its focus on only funding services that make an impact on reducing re-

offending, paying service providers once they have achieved a specified measurable result. It is unclear whether local commissioners will chose to use similar models and is likely to vary to across localities.
Source: Safer Future Communities Newsletter

Public services are more and more subject to competition and grants that might have previously been earmarked, or funds that were previously ring-fenced, are now done so to a lesser degree and competitive tendering exercises are being put in its place. VCSE organisations may need to think about how they can compete in this environment.
Source: Safer Future Communities Newsletter

6.3 PEST Analysis

Political

Sir Albert Bore, Leader of the Labour Group in Birmingham believes that Drug and alcohol abuse is a key driver of much of the crime, domestic abuse and anti social behaviour which occurs in Birmingham. He wants to better integrate drug treatment and probation services in a new drug and alcohol abuse reduction strategy

He believes that alcohol treatment should address binge drinking as well as chronic alcoholism. He wants Council Trading Standards officers to be used, in conjunction with the police, to enforce the law on the sale of alcohol and age restrictions.

Source: Labour's Vision For Birmingham - May 2012

In March 2013, Birmingham City Council's Social Cohesion and Community Safety Overview & Scrutiny Committee held an Inquiry into Reducing Re-offending. The following excerpt displays some of the findings that were published:

- **Recognising Good Practice:** Members recognised and commended the fact that there is so much excellent work already happening. There were numerous examples of good practice and initiatives that are already being implemented and proving effective including: the co-location of police, drug and alcohol treatment and support, probation, education, employment, officers who catch and convict, all under 'one roof' in Integrated Offender Management Teams such as the team based in Sutton Coldfield Police station.
- Having the right pathway available so that offenders can be referred to the appropriate support as necessary i.e. housing, education, skills, drug and alcohol treatment are all covered and the appropriate support and motivation to change behaviours can be provided.
- **Partnership Working**: There is some impressive partnership working being demonstrated across the city across a range of agencies and organisations in relation to criminal justice and in particular examples of the public sector aligning together to address issues jointly. We were particularly impressed with the 'Aspire' project that employs the experience of ex-drug users as 'coaches' to support those in recovery from substance misuse and recognised that this work allowed the Aspire workers to build their personal capacity enabling them to move forward to further employment opportunities.
- **Third Sector:** We heard about the 'Aspire' project where former drug users are working with current users in a mentoring capacity and were encouraged to hear that similar good work was happening in voluntary organisations such as the 'Back on Track' apprenticeship programme offered to vulnerable young people at risk of involvement in crime by the housing and care organisation Midland Heart. Recently Midland Heart had employed 20 such apprentices within their organisation. We therefore feel that the City Council through its Health and Wellbeing remit can work in partnership facilitating and developing this work further through its networks with other agencies in particular looking at how the third sector can support the work of the Youth Offending Service that has already made and will be making further efficiency savings.

- **Payment by Results:** The Government's proposal concerned Members especially with the fact that low and medium risk offenders (70% of the Probation Service's current workload) would be managed by private contractors meaning that there will be a lack of local accountability as contracts will be let nationally. Members heard that the Probation Service recognises the good work of Third sector organisations in working with offenders and would welcome the opportunity to commission voluntary organisations. However there was concern that support mechanisms would need to be in place for the third sector providers to ensure continuity of supervision of offenders. It was also noted that if third sector agencies were to undertake such roles then there would need to be the necessary accountability structure in place.

- **Links to/sharing information with prisons:** The visit to the Integrated Offender Management Team highlighted the importance of effective links and sharing of information with prisons. It is crucial to have a corporate policy and system that works to facilitate sharing information with police and other agencies for selected prisoners especially Prolific and Priority Offenders. Most of the other agencies such as probation, police, drugs agencies work fairly similarly across the country. By contrast, prisons are more autonomous in the way they work and record data and this can make it more difficult to maintain links and share information. They will be even more autonomous in the future. Currently there are two West Midlands prison liaison officers but it can still be a struggle to get information from prisons.

Source: Social Cohesion & Community Safety Overview & Scrutiny Committee April 2013: Reducing Reoffending Inquiry

Birmingham City Council has already made several recommendations to reduce the impact of Drug and Alcohol misuse in Birmingham. In the Local Services and Community Safety Overview and Scrutiny Committee of 2010, the following recommendations were made:

- Birmingham Drug and Alcohol Action Team (BDAAT) to determine how data can be shared with Constituency community safety teams to enable it to form part of Constituencies' needs analysis.
- Collect better data through according cases a special interest marker (as the West Midlands Police and accident and emergency departments do) to inform needs analysis and improve interventions.
- To consult on and give further consideration as to how (BDAAT) best ensures access to and delivers treatment to a wide range of potential service users including parents, women, new and established black and minority ethnic groups, young people in their 20s, and people with dual diagnosis and how it provides support and information to existing organisations working with such groups.
- Regulatory Services to work proactively with Safer Birmingham Partnership, BDAAT, West Midlands Police and (hospitals) to engage with bodies such as sports clubs and student organisations around harm reduction of alcohol and drugs.
- That Constituencies work with relevant Directorates and partner agencies (including BDAAT, the Police, Safer Birmingham Partnership and service providers) to provide feedback to residents on how issues relating to drugs and alcohol are being tackled locally and to provide information about sources of support for example through use of existing newsletters.
- Promote messages about the harmful effects of the use and impact of drug and alcohol to children, young people and also their families.
- Investigate the implications for Birmingham in following the lead of some other cities and becoming a recovery city.
- Following the service design, there is enough in place to support families, including children of substance misusers.
- BDAAT have in place quality control and robust contract management to demonstrate understanding of services provided, impact and value for money.

Source: Reducing the Impact of Drug and Alcohol Misuse in Birmingham - BCC

Economic

The prospects for a strong recovery in 2013 remain subdued with the UK economy still facing constraints on domestic demand as a result of falling government expenditure coupled with consumers and business taking a cautious approach to spending. The latest local Quarterly Economic Survey (for October to

December 2012) undertaken by the Birmingham Chamber of Commerce Group for the Greater Birmingham area shows that despite the subdued economic climate local business on balance are still reporting some growth and remaining generally positive about the future. However, there has been a recent downward trend in the local business community's perception of business conditions. Business confidence over the coming 12-month period in terms of turnover and profitability remains positive for both manufacturing and service sectors. Manufacturers and service sector firms on balance continue to report increased domestic sales and orders.

Source: Birmingham Economic Update

Social

Sections of Birmingham are becoming no-go areas where drugs gangs are effectively in control, a United Nations drugs chief has said. Professor Hamid Ghodse, president of the UN's International Narcotics Control Board (INCB), said there was "a vicious cycle of social exclusion and drugs problems and fractured communities" in some UK cities, and cited Birmingham, as well as Liverpool and Manchester. The development of "no-go areas" was being fuelled by threats such as social inequality, migration and celebrities normalising drug abuse, he warned.

Source: Birmingham Post February 28th 2012

Technological

North East firm Draeger Safety UK has been given approval from the Home Office for police to use their drug testing kit on people suspected of using cannabis. The machine, worth around three thousand pounds, can only be used in police stations. It works in conjunction with a saliva test and it is hoped it can be used for roadside testing by the summer of 2014. The machine, Dräger DrugTest 5000, can test up to six drugs but can only be used for cannabis testing within the UK. A suspect would also have to undergo a blood test before a conviction could be carried out.

Source: http://tyneandwear.sky.com/news/article/53796/approval-for-cannabis-testing-kit-to-target-drug-drivers

6.4 National Drug & Alcohol Summary

Drugs

Of the three million or so people who use drugs in England, only around 300,000 use the most problematic drugs (heroin and crack) and over half of those are in treatment. Many of the people in treatment today started using drugs during the recessions of the 1980s and 1990s. Those addicted to heroin and crack are concentrated in the poorest communities of the country. They also tend to lack social resources – they have not succeeded in education, have little work experience, lack supportive relationships and often suffer with mental illness. They place an increasing burden on the NHS and pose a significant crime problem.

Many addicts are now starting to recover. The original pool of heroin and crack addicts is shrinking and because fewer young people are using heroin or crack (the pool) is not being topped up. (Treatment) demand is generally declining but services are helping more people to make a full recovery.

Services face challenges to maintain investment and safeguard the gains drug treatment has made in recent years. There is also the problem of new drugs, prescription drugs and alcohol.

National Drug Trends 2012

The Drug Strategy 2010 marked a fundamental shift in the Government's approach and placed recovery from drugs at the centre of the Government's commitment to tackling drug use and its associated problems. It also emphasised the local response that is required to ensure that full recovery can be achieved. In its review of the Strategy in 2012, the Government committed to supporting local partners in the continued provision of services for drug misusing offenders in the transition period before Police and Crime Commissioners (PCCs) take office.

Latest drug treatment figures from the National Treatment Agency (NTA) indicate that record numbers of individuals in England are overcoming addiction. Nearly 30,000 (29,855) successfully completed their treatment in 2011-12, up from 27,969 the previous year and almost three times the level seven years ago (11,208). The data also reveals that nearly one third of users in the last seven years successfully completed their treatment and did not return, which compares favourably to international recovery rates.

The number of young adults needing treatment for heroin or crack has plummeted to the lowest recorded level, and the existing heroin using population is ageing, making the over-40s the only group to increase their numbers in treatment. The number of new heroin addicts has sharply reduced: 9,249 started treatment for heroin addiction in 2011-12 for the first time, compared to 47,709 in 2005-06.

The latest drug trends have been analysed in a report 'Drug treatment 2012: progress made, challenges ahead' reflecting long-term drug use and addiction trends amongst adults in England, as well as presenting the annual figures. The report says that: Of the 366,217 individuals who have received treatment in the last seven years, 29% (104,879) have completed treatment successfully and not returned. The prospects for people starting treatment today are better: between 2008 and 2011, 41% successfully completed and did not return, compared to 27% in 2005-08. Heroin remains the biggest problem for those in treatment: out of the total 197,110 adults in treatment, 96,343 were receiving help for heroin dependency and a further 63,199 for heroin and crack, accounting for 81% (159,542) of those in treatment. Cannabis accounts for 8% (15,194) and powder cocaine for 5% (9,640).

- Fewer people aged 16-59 in England are using drugs (3.3m in 2005, 2.9m in 2011)
- There are fewer heroin and crack users in England (332,000 in 2005/6, 306,000 in 2009/10)
- Fewer people are injecting (130,000 in 2005/6, 103,000 in 2009/10)
- Fewer people are in treatment for drug use (210,815 in 2008/9, 197,110 in 2011/12)
- Average waiting time is down (9 weeks in 2001, 5 days in 2011/12)

- More drug users are recovering – successful completions rose from 11,208 in 2005/6 to 29,855 in 2011/12
- Fewer people are dropping out of treatment – 37,156 in 2005/6 compared with 17,517 in 2011/12.
- 29% of people who have successfully completed treatment have not returned.
- Fewer under-30s are dying from drug misuse (677 in 2001, 299 in 2011)
- The over-40s are the only age group whose treatment numbers are going up (31% of all adults in treatment)
- Drug-related crime is falling. Drug treatment prevents an estimated 4.9m crimes each year, saving an estimated £960m cost to the public, businesses, criminal justice and NHS.
- For every £1 taxpayers spend on drug treatment, they save £2.50 in reduced crime and lower costs to the NHS.

Source: Drug Treatment 2012: Progress Made, Challenges Ahead – National Treatment Agency [ ]

The involvement of organised crime in drug trafficking

The UK illegal drugs market remains extremely attractive to organised criminals. The prices charged at street level are some of the highest in Europe, and are sufficient to repay the costs of smuggling the drugs into the UK. The traditional distinction between international importers and the UK-based wholesalers is becoming more blurred, with some regional wholesalers travelling to the continent to arrange their own imports.

British organised criminals are active at all levels of the UK drugs trade, from importing to street-level distribution. A large number of foreign nationals are also heavily involved in the illegal drugs trade in the UK. Some have cultural and familial ties to the countries the drugs come from or travel through – this makes it easier for them to take major roles in the trade.

Heroin - The amount of heroin estimated to be imported annually into the UK is between 18-23 tonnes. The vast majority of this is derived from Afghan opium. Pakistan is a major transit country for Afghan opiates with well established ethnic and familial links to the UK. Heroin trafficked via Pakistan to the UK is likely to have either been sent directly by parcel, air courier or maritime container; or been trafficked by sea onto eastern or southern Africa for onward movement. Iran is another important gateway for Afghan opiates, which are trafficked west from Afghanistan, often en route to Turkey and western Europe.

Opiates also leave Afghanistan and enter Central Asia, however this routing primarily supplies the Russian heroin market and little is thought to be directed at the UK from this 'northern route'. In Europe, the Balkans is an important transport nexus with crime groups utilising long-established trafficking routes, while the Netherlands plays a strategically important role for organising the importation of heroin into the UK market.

Cocaine - The amount of cocaine estimated to be imported annually into the UK is between 25-30 tonnes. A significant proportion of the UK's identified cocaine supply is produced in Colombia, or from the border areas of neighbouring Venezuela and Ecuador. Peru and Bolivia account for the remainder and, unlike Colombia, have seen production levels rise, increasing their potential threat to the UK.

Various routes and methods are used to get the cocaine to the UK, one of Europe's largest and most profitable markets. Traditionally, most of the cocaine destined for Europe, including the UK, has crossed the Atlantic by ship and entered via Spain. The most significant method currently used to smuggle bulk amounts is in maritime container ships arriving in European hub ports, such as Antwerp and Rotterdam, before being moved into the UK. The use of other maritime methods, such as yachts, general cargo vessels, air couriers and cargo are also significant. Traffickers use varied routings with many shipments passing through South American countries, such as Ecuador, Brazil and Venezuela, as well as the Caribbean and West Africa while en route to Europe. Crime groups based in key European countries, such as Spain and the Netherlands, help facilitate this trade.

New Psychoactive Substances - Synthetic drugs are defined as artificial substances produced for the illicit market, almost entirely manufactured from chemical compounds in illicit laboratories. Those most commonly seen in the EU and trafficked to the UK are known as amphetamine type stimulants (ATS): amphetamine, methylamphetamine and 3, 4 methylenedioxymethamphetamine (MDMA) commonly referred to as 'ecstasy'. The UK continues to be considered as the major market for amphetamine and MDMA in the EU. The UK drugs market has seen diversification through the emergence of a variety of new psychoactive substances (NPS), commonly referred to as 'legal highs'. However, this name is in itself misleading as frequently these substances contain controlled drugs. This has led to associated health problems among users. The marketing and sale continues to take place on the internet presenting challenges for law enforcement to control their sale and distribution.

Cannabis - Cannabis is still the most widely used illegal drug in the UK and the UK wholesale cannabis market is worth almost GBP 1 billion a year. SOCA estimates that 270 tonnes of cannabis is needed to satisfy annual UK user demand. Most of this is herbal skunk cannabis. Despite increasing domestic cultivation most cannabis in the UK is still imported via all modes of transport. Afghanistan and Morocco are source countries for cannabis resin. Herbal cannabis is also smuggled into the UK from south African countries, the Caribbean and the Netherlands. There is no evidence to suggest the UK exports commercial quantities of cannabis.

UK distribution - Once the drugs have been successfully brought into the UK, they have traditionally been transported to major cities such as London, Liverpool and Birmingham before being distributed. Many other cities and large towns act as secondary distribution points, with drugs moved in bulk before being sold on to local dealers. Drugs destined for Wales, Scotland and Northern Ireland are mostly routed via England, reflecting the extensive use of the Channel ports. Most drugs are 'cut' by adding adulterants to increase their volume. Generally, adulterants used are chosen because they match the appearance of the drug being cut, mimic its effects or alter it in a sought-after way. Cutting can happen at any point in the chain and often takes place several times before the drugs reach the end user. Cutting agents now integrally feature within the UK drugs trade and suppliers have developed stronger links with organised drugs traffickers. Cutting agents are bought from businesses outside the UK, primarily in China and India. Criminals have adapted their importation methodology to avoid detection at UK and other European borders by mis-describing loads.

There has been an increase in the importation of cutting agents for heroin. Levels of heroin adulteration were higher in 2011 than during 2010 and the most common type of cutting agents were caffeine and paracetamol. The increased use of active pharmaceutical ingredients such as benzocaine, lidocaine and phenacetin for bulking cocaine maximises profit margins for drug traffickers and distributors, but has led to low purity at street level, ranging between 8 and 20% in 2011/12.
Source: Serious Organised Crime Agency

There were 1,757 notifications of drug-related deaths occurring in 2011. This represents a decrease of 126 (6.7%) over the same reporting period in 2010. The highest rates of drug-related deaths per 100,000 population aged 16 and over in 2011 were in City of Manchester (14.86); Blackburn, Hyndburn & Ribble Valley (13.35); Liverpool (11.37); and Blackpool & the Fylde (11.10). The majority of cases were males (72%), under the age of 45 years (66%), and White (97%). Most deaths (78%) occurred at a private residential address.

The main underlying cause(s) of death were: accidental poisoning (70%); intentional self-poisoning (13%); and poisoning of undetermined intent (9%). Heroin/morphine continues to be the principal substance implicated. The proportion of cases involving methadone rose by 4%, and that for other opiates/opioid analgesics rose by 6%. As in 2010, there was a substantial number of deaths reported involving novel psychoactive substances such as mephedrone and other methcathinones, and the benzodiazepine phenazepam.
Source: Drugs-related deaths in the UK Annual Report 2012 – St. Georges University London

Alcohol

Around 9m adults in England drink at levels that pose some risk to their health. An estimated 1.6m people have some degree of alcohol dependence. 250,000 are believed to be moderately or severely dependent and require intensive treatment. There were around 1.2m alcohol-related hospital admissions in England in 2010-11 while close to 15,500 people died from alcohol-related causes in 2010. Alcohol-related harm overall costs the NHS in England an estimated £3.5bn a year.

The NTA has been collecting alcohol treatment data for the last 4 years. While more people came into treatment for alcohol problems (last year), even more got better over the same time, meaning the total number in treatment fell. An aim for the coming years is that GP surgeries and A&E departments will become more active in identifying and referring people who need treatment for harmful drinking and alcohol dependency.

National Alcohol Trends 2012

- 108,906 people received alcohol treatment in 2011-12, down from 111,025 the year before
- 74,353 people started treatment during the year, up from 73,705 in 2010-11.
- 18,819 people dropped out of treatment, down from 19,777 in the previous year.
- 38,174 people successfully completed their treatment, up from 35,913 in 2010-11.
- 70% of all people in alcohol treatment were concentrated in the 30 – 54 age range.
- The average age of a person in treatment was 42
- Men accounted for nearly two-thirds of the treatment population (64%)
- The biggest ethnic group was white British (88%).
- 38% were self-referred while 19% were referred from GP surgeries. Referrals from hospital A&E departments accounted for 1%. Drug services referred 11%.
- 35% of all A&E attendances are alcohol related.

Source: Alcohol Treatment in England 2011-12 – National Treatment Agency [ ]

Consumption and Costs

- Alcohol consumption has nearly doubled since the 1950s
- In 2009 UK consumption of alcohol was 8.4 litres per head
- In 2010 under half of 11-15 year olds had ever had an alcohol drink (45%) continuing a decline from a high of 61% in 2003. But those that do drink are consuming more than ever, twice as much as in 1990 (Smoking, Drinking and Drug Use 2010)
- Children are starting to drink earlier and are drinking more. In 2010 children aged 11-13 years old that had drunk consumed 50% more than in 2007 (ibid)
- UK teenagers also have the most positive expectations of being drunk (ibid)
- The total cost of alcohol harm is estimated to be between £17.7 billion and £25.1 billion a year
- Of this, the cost to the NHS is £2.7 billion per year
- Alcohol-related crime and disorder is thought to cost the taxpayer between £8bn-£13bn every year
- The number of alcohol-related deaths in the UK has consistently increased since the early 1990s, rising from the lowest figure of 4,023 in 1992 to the highest of 9,031 in 2008. There were 6,584 deaths directly related to alcohol in 2009.
- Parental alcohol misuse has been identified as a factor in over 50% of child protection cases

Source: Alcohol Concern Key Statistics [ ]

6.5 NDTMS – DAT Partnerships Clusters Relating to Birmingham

CLUSTER E - Opiates
Birmingham
Bolton
Bradford
Brighton and Hove
Bristol
Camden
Doncaster
Gloucestershire
Hackney
Islington
Kingston Upon Hull
Lambeth
Lancashire
Leeds
Leicester
Liverpool
Manchester
Middlesbrough
Newham
Nottingham
Nottinghamshire
Sefton
Sheffield
Southwark
Staffordshire
Stoke-on-Trent
Tower Hamlets
Wakefield
Westminster
Worcestershire

CLUSTER D - Non Opiates
Barking and Dagenham
Birmingham
Bolton
Bournemouth
Bradford
Brighton and Hove
Bristol
County Durham
Coventry
Croydon
Enfield
Essex
Greenwich
Hertfordshire
Kent
Knowsley
Lancashire
Leeds
Liverpool
Manchester
Middlesbrough
Newcastle upon Tyne
Norfolk
Nottinghamshire
Redbridge
Rochdale
Sheffield
Staffordshire
Stockport
Sunderland
Thurrock
Tower Hamlets
Wakefield
Wirral
Wolverhampton

6.6 NDTMS References

Below are the definitions for NDTMS field references.

Sheet	Description
Completion and re-presentation	Successful completion rates for all in treatment in the relevant period showing the proportion who successfully completed from their latest treatment journey. Re-presentations are those who re-present to treatment within 6 months of their latest successful completion in the period. Cluster comparisons are included on both indicators. Please note that due to the six month lag required to establish if a person has re-presented the periods used to calculate re-presentation rates are different to those used elsewhere in the report.
Length of time in treatment	The length of time in treatment that the person has spent continuously in treatment in their latest treatment journey. This is calculated in whole years from the earliest triage in that treatment journey to the latest discharge, or to the end of the period if the person was still in treatment at that date. Time spent in treatment in prior journeys is not considered.
Career Length	The length of time that the person has been using up to their latest point of contact with the treatment system. This is calculated in whole years from their reported first use to their latest discharge, or to the end of the relevant financial year if the person was still in treatment at that date.
Previous journeys / previous unplanned journeys	The number of previous treatment journeys the person has had in total. This includes all prior journeys anywhere in England. For previous unplanned journeys, this has been limited to journeys where the outcome reported for the journey was not a successful completion. Journeys that end with a transfer to custody or a transfer that is not picked up are considered to have ended in an unplanned way.
Treatment naïve clients	Clients are identified as treatment naïve in a given year if their latest journey in that year was their first treatment journey anywhere in England. Note that this is not limited to those who started a new journey in the year - for example a client who started their first ever journey in 2008/09 and was still in treatment as part of the same journey in 2011/12 would be considered to be treatment naive as at 2011/12 by the definition used in this report.
Complexity	Complexity is assigned to clients individually using a scoring system initially developed for use in the Payment by Results pilots. A score is assigned based on presenting characteristics on TOP and NDTMS if the person started treatment in the year, or if the person was already in treatment at the start of the year the most recent available TOP data (providing there is a TOP within the 12 months) for the person as a proxy for their status at the start of the year. The resulting scores are then grouped into the five complexity groups shown, from very low through to very high. Opiate use is a factor in this calculation and for this reason data is only provided for all clients and not broken down by opiate/non-opiate.
Using Behaviour	The data is based on the information reported on the latest review TOP completed between November 2011 and October 2012. All clients must have had a start TOP that was completed within +/- 14 days of the earliest modality start dateA housing issue includes either an acute housing problem or housing risk, as reported on the TOP

Below are treatment pathways used by Public Health England to determine treatment cost effectiveness. These are existing parameters that could be used to determine payment by results (PbR).

Treatment pathway / Presenting characteristics
Inpatient treatment only
Inpatient treatment, Prescribing
Inpatient treatment, Prescribing, Other
Inpatient treatment, Prescribing, Psychosocial, Residential rehabilitation, Other
Inpatient treatment, Prescribing, Residential rehabilitation
Other structured treatment only
Prescribing only
Prescribing, Other
Prescribing, Psychosocial
Prescribing, Psychosocial, Other
Prescribing, Psychosocial, Residential rehabilitation
Prescribing, Psychosocial, Structured day programmes
Prescribing, Psychosocial, Structured day programmes, Other
Prescribing, Residential rehabilitation
Prescribing, Residential rehabilitation, Other
Prescribing, Structured day programmes
Prescribing, Structured day programmes, Other
Psychosocial only
Psychosocial, Other
Psychosocial, Structured day programmes
Psychosocial, Structured day programmes, Other
Residential rehabilitation only
Structured day programmes only
Structured day programmes, Other

6.7 Common Drugs – Health and The Law

Heroin

Common terminology / 'street names'
Anti-freeze, black tar, boy, brown, brown sugar, China White, crank, dope, dragon, elephant, gear, 'H', Harry, Harry Morphine, hell dust, horse, lady, junk, morph, mud, poison, skag, smack, train, thunder

Short term effects on user
Sedation / drowsiness. Feeling or warmth and euphoria. Reduced anxiety. No feeling of pain (analgesia). Dry mouth. Heavy extremities. Clouded mental function (due to depression of central nervous system.

Long term effects on user
Collapsed veins. Infection of the heart lining and valve. Skin infections and abscesses. Cellulitis. Liver disease. Risk of HIV / AIDS / Pneumonia. Blocked blood vessels. Poisoning. Rotten teeth. Weight loss / depressed appetite.

Possess class 'A' drug heroin (personal)
Summary = 6 months prison &/or fine not exceeding the statutory maximum.
Indictment = 7 years prison &/or fine

Supply (Inc' PWITS) class 'A' drug heroin
Summary = 6 months prison &/or fine not exceeding the statutory maximum
Indictment = Life imprisonment &/or fine.

Cocaine

Common terminology / 'street names'
Coke, Charlie, flake, snow, powder, blow, happy dust, gold dust, sherbert, cecil, C, toot, white girl, ice, nose candy, white girl, jelly, icing, Percy, choo choo, snort, sniff.

Short term effects on user
Energy rush. Increased endurance. Mental alertness. Increased confidence and more talkative. Sense of greater physical strength. Decreased appetite and weight loss. Increased blood pressure / heart rate. Increase in work productivity and creativity.

Long term effects on user
Addiction / Tolerance build up. Irritability. Restlessness. Paranoia. Auditory hallucinations. Digestive disorders and dehydration. Loss of sexual appetite. Heart problems. Damage to membranes lining the nostrils / Nose bleeds.

Possess Class 'A' Drug Cocaine (Personal)
Summary = 6 months prison &/or fine not exceeding the statutory maximum.
Indictment = 7 years prison &/or fine.

Supply class 'A' drug cocaine
Summary = 6 months prison &/or fine not exceeding the statutory maximum.
Indictment = Life imprisonment &/or fine.

Crack cocaine

Common terminology / 'street names'
Crack, Rocks, Stones, Crystals, Wash, Micro, Pebbles, Freebase, Scud.

Short term effects on user

Almost instantaneous rush of euphoria. Extremely short effects lasting only 5-10 minutes. Extreme 'come down' / physical crash (like depression). Increased confidence. Sense of greater physical strength and endurance. Decreased appetite and weight loss. Increased blood pressure / heart rate. Indifference to pain.

Long term effects on user
Addiction. Heart irregularities. High blood pressure. Possible brain seizure. Convulsions. Paranoia and violent behaviour. Headaches, dizziness and insomnia. Lack of interest in usual activities.

Possess class 'A' drug crack cocaine (personal)
Summary = 6 months prison &/or fine not exceeding the statutory maximum
Indictment = 7 years prison &/or fine.

Supply class 'A' drug crack cocaine
Summary = 6 months prison &/or fine not exceeding the statutory maximum.
Indictment = Life imprisonment &/or fine.

Ecstacy

Common terminology / 'street names'
Brownies, burgers, disco biscuits, doves, Damons (Damon Hill/Pill) E's, Ecstasy, Eckies, M&M's, Mitsi's, Mitsubishis, Pills, sweeties, X, XTC.

Short term effects on user
Intense euphoria. Sense of mental clarity. Increased heart rate and blood pressure. Loss of appetite. Pupil dilation. Enhances photosensitivity and colour perception. Restlessness.

Long term effects on user
Addiction. Paranoia / Depression / Aggression. Acne like rash. Liver damage. Blurred vision. Chills and sweating. Confusion / anxiety. Liver / Brain damage. Sever sleep problems.

Possess class 'A' drug crack cocaine
Summary = 6 months prison &/or fine not exceeding the statutory maximum.
Indictment = 7 years prison &/or fine.

Supply class 'A' drug crack cocaine
Summary = 6 months prison &/or fine not exceeding the statutory maximum.
Indictment = Life imprisonment &/or fine.

Cannabis

Common terminology / 'street names'
Bhang, black, blast, blow, blunts, Bob Hope, bud, bush, dope, draw, ganja, grass, hash, hashish, hemp, herb, marijuana, pot, puff, Northern Lights, resin, sensi, sensemella, skunk, smoke, solid, spliff, wacky backy, weed, zero

Short term effects on user
More relaxed / talkative / giggles. 'Red-eye'. Poor balance/coordination. Loss of concentration, focus and awareness. Faster heart rate. Loss of inhibitions, more prone to sexual activity/situations. Hunger / 'The munchies'.

Long term effects on user
Cannabis contains chemicals that cause lung disease and cancer with long term use. It can worsen asthma and increase blood pressure. Links have been made to schizophrenia and other mental health problems. Paranoia and anxiety. Frequent use can reduce a male's sperm count and suppress ovulation in women. Whilst 10% of users become psychologically dependant, users are more likely to become addicted to the nicotine rolled with the 'spliffs'

Possess class 'B' controlled drug cannabis
Up to 5 years imprisonment and / or unlimited fine

Supply class 'B' controlled drug cannabis
Up to 14 years imprisonment and / or unlimited fine

Amphetamines

Common terminology / 'street names'
Amph, Billy, Whizz, base, chalky, flour, footballs, phet, speed, sulph, sulphate, wakers.

Short term effects on user
Increased energy and alertness (lasting 4-6 hours). Increase in heart and pulse rate. Increase in blood pressure. Loss of appetite. Pupil dilation. Dizziness. Anxiety / Restlessness. Insomnia.

Long term effects on user
Potential Psychological dependence. Depression, anxiety and paranoia. Excessive snorting can lead to damage to the mucus membranes in the nose. Users may develop Amphetamine Psychosis that is characterised by excessive mood swings, irritability, agitation, confusion and bouts of uncontrollable violence.

Possess class 'B' drug amphetamine
Summary = 3 months prison &/or fine not exceeding £2500
Indictment = 5 years prison &/or fine.

Supply class 'B' drug amphetamine
Summary = 6 months prison &/or fine not exceeding the statutory maximum.
Indictment = 14 years imprisonment &/or fine.

6.8 ACP-KIKIT Research

A third of Birmingham's population is non-white. However, ethnic groups remain difficult to encourage into treatment and indeed, in some cases, difficult to access to discuss the issue in any depth. The purpose of this Research was to identify the needs of the local BME groups with Birmingham and highlight barriers into treatment. ACP-KIKIT is based within Sparkbrook in Central Birmingham and is an Asian focused substance misuse support service (although KIKIT will and do treat all ethnicities). Funded by the BDAAT, ACP-KIKIT carried out this research over six months, via questionnaires to community groups, service users and local projects; assistance was also provided by West Midlands Police, Probation Service, the Primary Care Trusts, Sure Start and Ashiana Community Project

Birmingham is one of the most ethnically diverse cities in England. Of the 34% non-white, Pakistani is the largest minority group, followed by Indian, Black Caribbean and, since 2008, Bangladeshis. The remaining minority groups collectively account for a further 12% of the Birmingham population. A clear pattern is shown, with minority groups clustered close to the city centre, and a higher proportion of white groups towards the edges of the city.

According to NDTMS (figures from 2012), 29% of clients in treatment are non-white (BME). The ethnic makeup of those in treatment differs from Ward to Ward. For example, in Sparkbrook the population is 65% Asian but in drug treatment, only 33% are Asian. In alcohol treatment, from the whole of the Asian population in Birmingham only 5% are engaged in treatment. In addition, there is a shortfall in the figures where no ethnicity data has been collated – this differs from Ward to Ward, with Aston having 42% of clients in treatment without an ethnicity and Washwood Heath missing data for 12%. This will have an impact on the percentage ratios. However, despite this, it is clear that where there is large concentration of non-white, the numbers in treatment are under-represented.

With its well-respected Universities and Colleges, its history in industrious trade, and its close commute links to other key cities, Birmingham will always be an attractive prospect for those seeking opportunity. Central Birmingham in particular has a high ethnically diverse population and as such, services need to tailor themselves to meet the unique problems this diversity raises. With the obvious language and culture barriers aside, awareness of drug and alcohol abuse is poor and needs be addressed immediately. The promotion of needle exchange clinics, harm reduction training, and steps to reduce drug related crime, must all be tackled across all the community groups regardless of ethnicity.

In an initial survey of 73 respondents:

- 82% believe there is a drug and alcohol problem within their community
- 85% believe young BME people being affected by drugs are increasing and there is not enough support for them.
- 90% link the increase in drug misuse to an increase in crime rates.
- 52% admitted there was a Khat problem in their community
- 51% cited language and culture as a barrier into seeking help for Khat addiction
- 48% feel there is not adequate provision for BME service users
- 70% feel the needs of BME communities are not being met in Birmingham
- 58% stated women from BME communities affected by drugs, do not know where to access help and 59% felt culture was a barrier for them.
- 80% were not aware of needle exchange or vaccination services
- 82% admitted to having no knowledge of blood borne viruses

A further survey of 50 respondents revealed:

- 90% think there is a drug and alcohol problem within their community and 61% have been directly or indirectly affected by substance misuse.
- 86% feel the number of young BME people affected by Drugs and Alcohol is increasing.
- Of BME women groups, 74% felt drugs/alcohol use was increasing within this group and 59% felt culture was a barrier to them accessing

As well as drugs, alcohol abuse is also an issue within the BME community, with 37% drinking alcohol. Khat is particular to the BME groups and is rarely found within the White community. As it is particular to this group's traditions and culture, it is, in many ways, accepted as part of their heritage. When dealing with Khat addiction, you are not just dealing with the drug misuse, but also with the cultural identity it carries. When asked if the use of Khat is a problem within the BME community, a considerable 86% said yes. 45% were not aware of the harms associated with Khat use. The rise of the Bollywood film culture has added pressure on young people to obtain the "Bollywood Body", increasing the use of steroids to bulk muscle quickly. The questionnaire highlighted 30% knew someone who has or is using steroids. Worryingly, 18% thought sharing needles was common and 92% felt steroid users were not aware of the harm reduction measures.

The report concluded that in order to provide treatment services that can help the different cultures and traditions, and being able to access local community groups (both religious and social), requires a service that understands the differences between different cultures and would be readily accepted by those groups. It is therefore apparent a specialised BME treatment service is required to promote awareness, build links with local communities and facilitate users in engaging in treatment. The local community questioned in this exercise, 87% of which belong to the BME hard to reach groups, have indicated they need the following services:

- Open access drop in centre
- Drug and Alcohol testing
- One to one support / counselling
- Confidential service with peer support
- Information and advice in BME languages

ACP-KIKIT is well placed to continue providing its specialised service to the community. However, the amount of work involved will require the assistance of all treatment services in Birmingham working together, seeking the support and advice from KIKIT when dealing with any cultural challenges.

Source: ACP-KIKIT Research September 2012

6.9 Case Management Systems

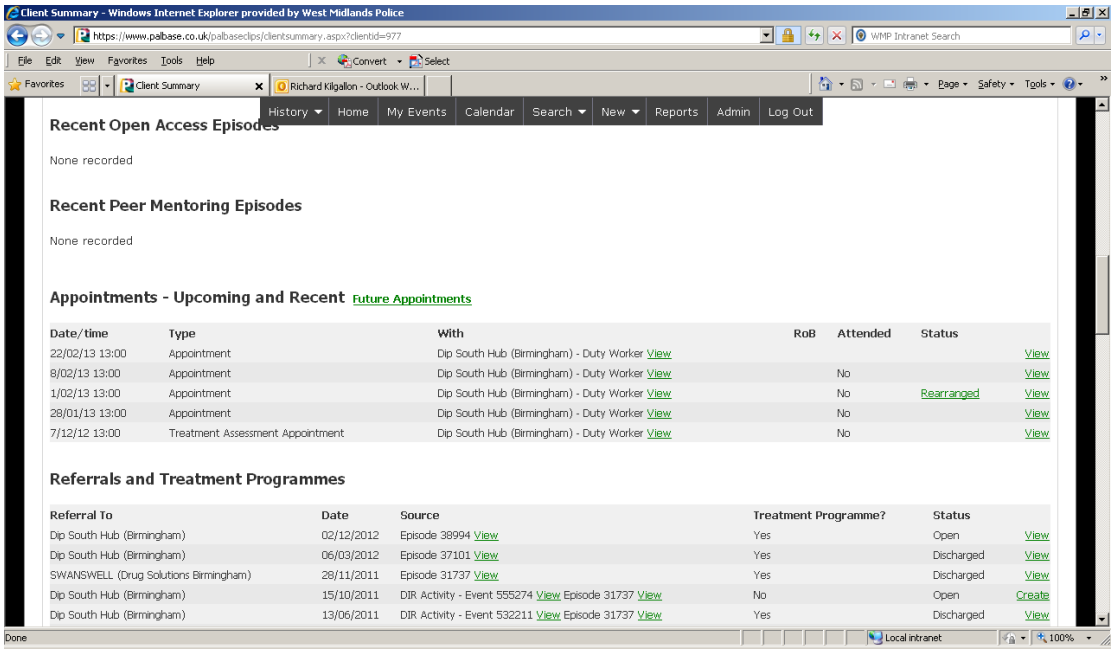
Partners across Birmingham use different case management systems for various reasons. Listed below are several of these different systems:

PalBase

PalBase is a multi agency system developed for use by Drug Intervention Programme agencies in England and Wales, and is a comprehensive and easy to use web-based Drug Arrest and Treatment monitoring tool. PalBase ensures that people referred for treatment and care can access it in the shortest possible time by eliminating the need for extensive manual records.

Key features:

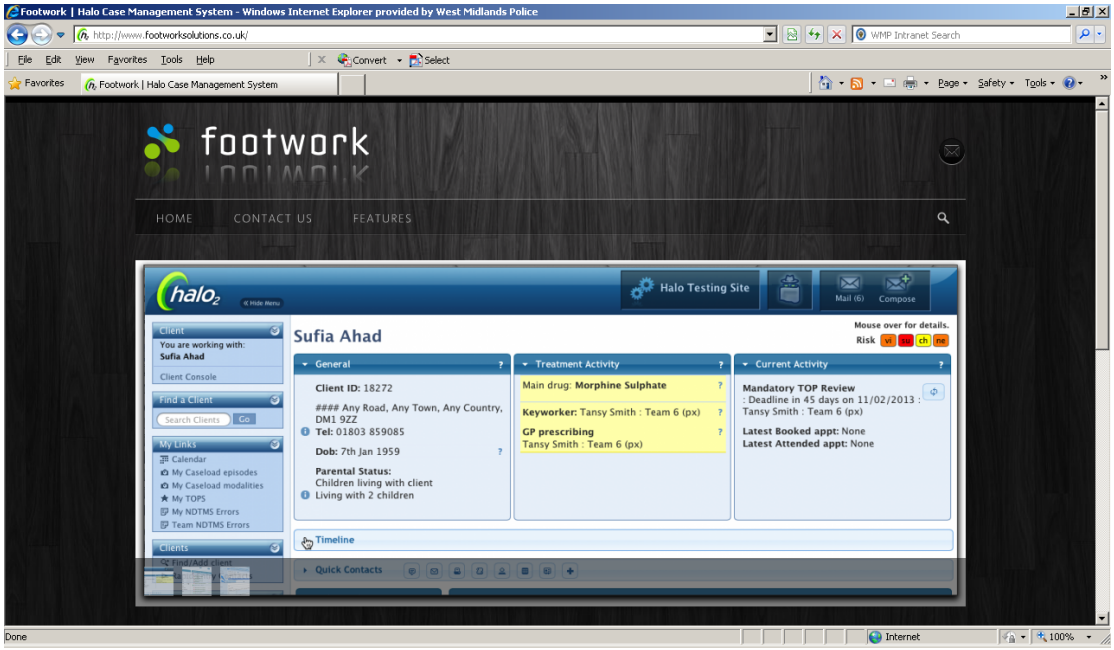
- Tracking clients through all treatment including structured follow up processes on failure to attend individual sessions or drop out
- Identify and record risks like injecting behaviour, mental/physical health, pregnancy, suicidal ideation and potential danger to the general public or professionals
- Production of comprehensive statistical information on substance misuse and offending behaviour
- Tracking and sharing live appointment information
- Maintaining social profiles of clients, including review dates, third party information, rejection information and personal information such as GP and housing
- Tracking and monitoring offence outcomes / waiting times for treatment
- Tracking discharge information
- Identifying care coordinators and key workers and ensuring consistency of treatment by creating accessible audit trails and strategic and tactical information
- Standardising information
- Monitoring drug screening information, substance and criminality profiles
- Monitoring court dates, non attendance triggers, remand and bail management as well as prison release dates
- Quick Data Entry screen minimises data entry
- Security access protocol is provided



HALO

Halo is a Seamless Care Management web based application for teams to manage drug treatment casefiles Halo manages the paper form cycle by designing screens based on existing forms. Footwork Solutions is now entirely focused on the development and support of the Halo application. The Halo Care Coordination system has been selected by over 12 Drug Action Team in the UK as a complete solution for multi agency working.

www.footworksolutions.com



LINKS CarePath

Illy's LINKS CarePath is a comprehensive case management and reporting system for substance misuse services. The system has been developed through considerable feedback from Commissioners, Service Managers and Practitioners. Features include:

- A fully web-based case management tool
- NDTMS compliant
- A flexible, fully scalable solution
- Integrated functionality for all services:
- Young Peoples
- Prescribing
- Harm Reduction
- DIP teams
- Prison (CARAT and Healthcare)
- Future-proofed for Payment by Results
- Benefits
- An intuitive interface
- Makes data entry quick and easy
- Advanced reporting tools to make analysing data simple
- Stores all client information in one place:
- Assessments
- Care plans
- TOPs and any other outcomes
- Case notes
- Drug tests
- Integrated modules and advanced consents for multi-agency working

BOMIC

Bomic has been designed to meet the needs of a wide range of services involved with the treatment and care of people with addictive disorders, including drugs and alcohol. A highly modifiable software application Bomic has been developed in line with Microsoft's best practices. Bomic is provided on a modular basis – customers who purchase the core system can then add the following modules if required:

- Prescribing Module
- Drug Intervention Programme (DIP) Module
- Needle Exchange Module

Using a tabular layout, Bomic displays client information in a logical and clear manner, making data entry quick and easy. Features of the Bomic software application include:

- Full Client Record
- NDTMS Compliant
- Flexible Report Generation and Microsoft Excel extract function
- Fully scaleable system
- Advanced Security Control
- Stand alone or Networkable
- Mail Merge facility for bulk mailing
- No limit on number of users

RIO

Designed around the person and their carers RiO has become a favourite with mental health and community services organisations within the NHS National Programme in England. Through either direct support from CSE Healthcare or via its partner BT Global Services, RiO is able to meet current and future requirements of the Government's strategy for the NHS.
Predominately operational in mental health, learning difficulty and community services, RiO can also be deployed to support joint social services requirements and interoperability with general practice. Its technical architecture is web-based favouring mobile operation, which is becoming an increasing requirement in the NHS as its estate reduces and care becomes more focused in the home. Hence CSE Healthcare is providing solutions for disconnected use through its RiO Mobile range.

RiO configuration utilities support, time management, scheduling, note taking, assessment, care planning, ordering, reporting of diagnostic results; prescribing and the administration of medication. RiO Public Health functionality supports children's services for 0 to 19 and configurable public health screening and surveillance features to meet local authorities' disease management programmes. CSE Healthcare Systems has recently extended RiO's Reporting Services through the introduction of its

Business Intelligence system Acumen. As an extension to RiO's Report Writer and statutory return reporting, Acumen extracts from RiO and other information databases, combines and presents information in graphical and dashboard formats

JANUS

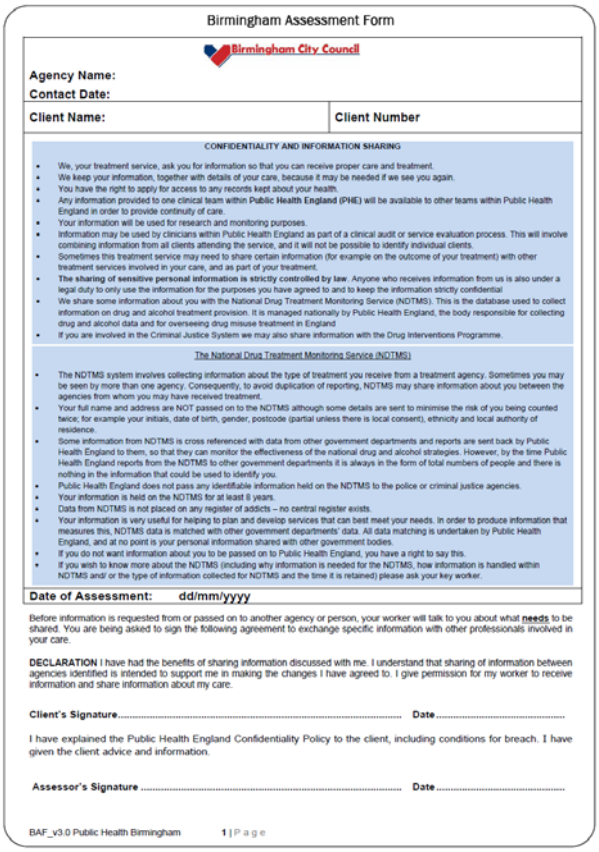
Phoenix Futures' Sheffield Community service originally commissioned MJ Software to build a small database several years ago. The organisation was so impressed with this that they brought MJ Software in to design a new database named Janus to cover the whole charity. This database operates at over 30 services and has over 300 users nationwide. Features provided to Phoenix Futures, via the Janus Database include: -

- A database application that enabled the efficient storage and retrieval of information.
- Each service/office to be given the appropriate rights to their own cases, restricting them from accessing clients outside of their area.
- Output data and validation of information for submission to NDTMS (National Drug Treatment Monitoring Service).
- User friendly data filtering, querying facilities.
- Document linking - PDFs, Word Documents, Letters, etc. can all be linked to the client's records.
- Actions can be recorded against groups, or individual clients.
- Complex data validation, ensuring information is keyed in accurately.
- When creating new clients, an "advanced pattern match" query is used to identify whether or not the client already exists, minimising duplicate data.

The following software suppliers have all registered an interest in working with NDTMS, DATs and treatment providers to provide software solutions, and currently produce NDTMS Core Data Set H (Version 8) compliant extracts.

Software Title	Supplier	Web	Email
Advantage	Blithe Computer System	www.blithesystems.com	sales@blithesystems.com
Aspire	Aspire Business Solutions	www.aspire-uk.com	office@aspire-uk.com
Bomic	Blithe Computer Systems	www.blithesystems.com	sales@blithesytems.com
CareNotes	Strand Technology	www.strandtechnology.co.uk	sales@strandtechnology.co.uk
LINKSCarePath	ILLY Computer Systems	www.illycorp.com	info@illycorp.com
CarePlus	McKesson UK	www.mckesson.co.uk	ukinfo@mckesson.co.uk
Creative Computer Solutions	Creative Computer Solutions	www.crecomsol.co.uk	admin@crecomsol.co.uk
CTK	Community TechKnowledge	www.communitytech.net	sales@communitytech.net
Draftspace Form	HighQ Solutions	www.highqsolutions.com	info@draftspace.com
Halo	Footwork Solutions	www.footworksolutions.co.uk	info@footworksolutions.co.uk
Janus	Phoenix Futures/ M J Software Solutions	www.mjsoftware.co.uk/janus	martyn@mjsoftware.co.uk
MARACIS	MARACIS Solutions Ltd	www.maracis.co.uk	sales@maracis.co.uk
Mi-Case	Business & Decision	www.mi-case.com	info@mi-case.com
Nebula	Orion Practice Management Systems Ltd	www.orionpms.org.uk	orion@orionpms.org.uk
NECA Achieve	NECA	www.neca.co.uk	info@neca.co.uk
Online Data Manager	The Gallery Partnership Ltd	www.gallerypartnership.co.uk	odm@gallerypartnership.co.uk
ORION	Orion Practice Management Systems Ltd	www.orionpms.org.uk	orion@orionpms.org.uk
Palbase	Paloma Systems	www.paloma.co.uk	sales@paloma.co.uk
POPPIE	Blithe Computer System	www.blithesystems.com	sales@blithesystems.com
Rio	CSE Healthcare Systems	www.cse-healthcare.com	sales@cse-healthcare.com
SystmOne	The Phoenix Partnership	http://www.tpp-uk.com/	enquiries@tpp-uk.com
Theseus	Cyber Media Solutions Ltd	www.theseus.org.uk	info@theseus.org.uk
DHARMA	4MATT	01275 373059	matt@mattstephenson.co.uk
Form Advantage	BluWare Ltd	http://www.formadvantage.com	sales@bluware.co.uk

6.10 Birmingham Assessment Form (BAF)



Birmingham Assessment Form

Birmingham City Council

Agency Name:

Contact Date:

Client Name:	Client Number

CONFIDENTIALITY AND INFORMATION SHARING

- We, your treatment service, ask you for information so that you can receive proper care and treatment.
- We keep your information, together with details of your care, because it may be needed if we see you again.
- You have the right to apply for access to any records kept about your health.
- Any information provided to one clinical team within **Public Health England (PHE)** will be available to other teams within Public Health England in order to provide continuity of care.
- Your information will be used for research and monitoring purposes.
- Information may be used by clinicians within Public Health England as part of a clinical audit or service evaluation process. This will involve combining information from all clients attending the service, and it will not be possible to identify individual clients.
- Sometimes this treatment service may need to share certain information (for example on the outcome of your treatment) with other treatment services involved in your care, and as part of your treatment.
- **The sharing of sensitive personal information is strictly controlled by law**. Anyone who receives information from us is also under a legal duty to only use the information for the purposes you have agreed to and to keep the information strictly confidential
- We share some information about you with the National Drug Treatment Monitoring Service (NDTMS). This is the database used to collect information on drug and alcohol treatment provision. It is managed nationally by Public Health England, the body responsible for collecting drug and alcohol data and for overseeing drug misuse treatment in England
- If you are involved in the Criminal Justice System we may also share information with the Drug Interventions Programme.

The National Drug Treatment Monitoring Service (NDTMS)

- The NDTMS system involves collecting information about the type of treatment you receive from a treatment agency. Sometimes you may be seen by more than one agency. Consequently, to avoid duplication of reporting, NDTMS may share information about you between the agencies from whom you may have received treatment.
- Your full name and address are NOT passed on to the NDTMS although some details are sent to minimise the risk of you being counted twice; for example your initials, date of birth, gender, postcode (partial unless there is local consent), ethnicity and local authority of residence.
- Some information from NDTMS is cross referenced with data from other government departments and reports are sent back by Public Health England to them, so that they can monitor the effectiveness of the national drug and alcohol strategies. However, by the time Public Health England reports from the NDTMS to other government departments it is always in the form of total numbers of people and there is nothing in the information that could be used to identify you.
- Public Health England does not pass any identifiable information held on the NDTMS to the police or criminal justice agencies.
- Your information is held on the NDTMS for at least 6 years.
- Data from NDTMS is not placed on any register of addicts – no central register exists.
- Your information is very useful for helping to plan and develop services that can best meet your needs. In order to produce information that measures this, NDTMS data is matched with other government departments' data. All data matching is undertaken by Public Health England, and at no point is your personal information shared with other government bodies.
- If you do not want information about you to be passed on to Public Health England, you have a right to say this.
- If you wish to know more about the NDTMS (including why information is needed for the NDTMS, how information is handled within NDTMS and/ or the type of information collected for NDTMS and the time it is retained) please ask your key worker.

Date of Assessment: dd/mm/yyyy

Before information is requested from or passed on to another agency or person, your worker will talk to you about what **needs** to be shared. You are being asked to sign the following agreement to exchange specific information with other professionals involved in your care.

DECLARATION I have had the benefits of sharing information discussed with me. I understand that sharing of information between agencies identified is intended to support me in making the changes I have agreed to. I give permission for my worker to receive information and share information about my care.

Client's Signature..... **Date**.....

I have explained the Public Health England Confidentiality Policy to the client, including conditions for breach. I have given the client advice and information.

Assessor's Signature ..... **Date**.....

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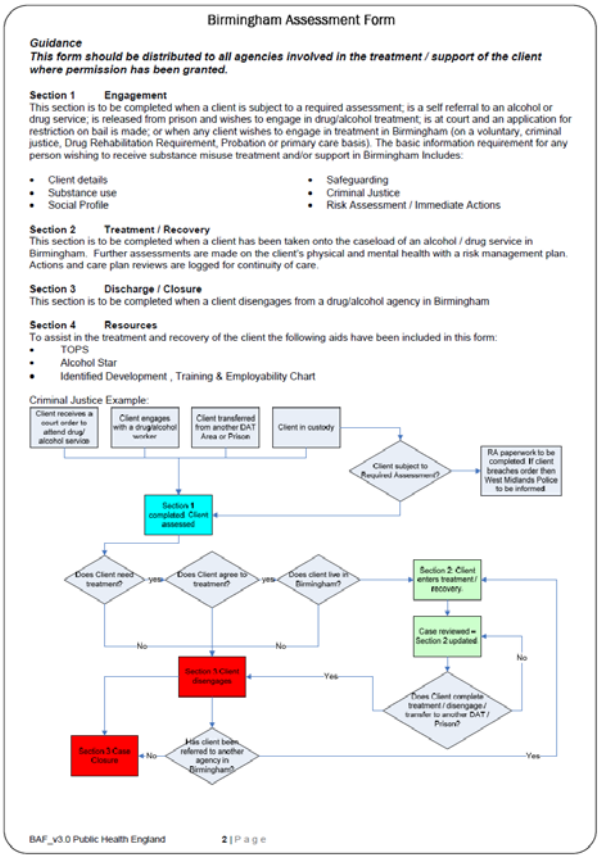

Birmingham Assessment Form

Guidance

This form should be distributed to all agencies involved in the treatment / support of the client where permission has been granted.

Section 1 Engagement

This section is to be completed when a client is subject to a required assessment; is a self referral to an alcohol or drug service, is released from prison and wishes to engage in drug/alcohol treatment; is at court and an application for restriction on bail is made; or when any client wishes to engage in treatment in Birmingham (on a voluntary, criminal justice, Drug Rehabilitation Requirement, Probation or primary care basis). The basic information requirement for any person wishing to receive substance misuse treatment and/or support in Birmingham Includes:

- Client details
- Substance use
- Social Profile
- Safeguarding
- Criminal Justice
- Risk Assessment / Immediate Actions

Section 2 Treatment / Recovery

This section is to be completed when a client has been taken onto the caseload of an alcohol / drug service in Birmingham. Further assessments are made on the client's physical and mental health with a risk management plan. Actions and care plan reviews are logged for continuity of care.

Section 3 Discharge / Closure

This section is to be completed when a client disengages from a drug/alcohol agency in Birmingham

Section 4 Resources

To assist in the treatment and recovery of the client the following aids have been included in this form:

- TOPS
- Alcohol Star
- Identified Development , Training & Employability Chart

Criminal Justice Example:

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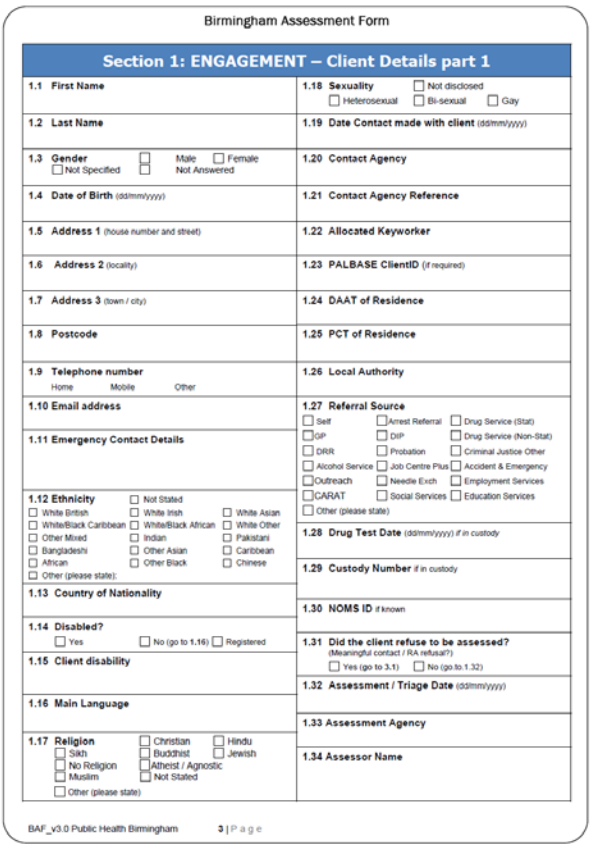

Birmingham Assessment Form

Section 1: ENGAGEMENT – Client Details part 1

1.1 First Name	**1.18 Sexuality** ☐ Not disclosed ☐ Heterosexual ☐ Bi-sexual ☐ Gay
1.2 Last Name	**1.19 Date Contact made with client** (dd/mm/yyyy)
1.3 Gender ☐ Male ☐ Female ☐ Not Specified ☐ Not Answered	**1.20 Contact Agency**
1.4 Date of Birth (dd/mm/yyyy)	**1.21 Contact Agency Reference**
1.5 Address 1 (house number and street)	**1.22 Allocated Keyworker**
1.6 Address 2 (locality)	**1.23 PALBASE ClientID** (if required)
1.7 Address 3 (town / city)	**1.24 DAAT of Residence**
1.8 Postcode	**1.25 PCT of Residence**
1.9 Telephone number Home Mobile Other	**1.26 Local Authority**
1.10 Email address	**1.27 Referral Source** ☐ Self ☐ Arrest Referral ☐ Drug Service (Stat) ☐ GP ☐ DIP ☐ Drug Service (Non-Stat) ☐ DRR ☐ Probation ☐ Criminal Justice Other ☐ Alcohol Service ☐ Job Centre Plus ☐ Accident & Emergency ☐ Outreach ☐ Needle Exch ☐ Employment Services ☐ CARAT ☐ Social Services ☐ Education Services ☐ Other (please state)
1.11 Emergency Contact Details	**1.28 Drug Test Date** (dd/mm/yyyy) *if in custody*
1.12 Ethnicity ☐ Not Stated ☐ White British ☐ White Irish ☐ White Asian ☐ White/Black Caribbean ☐ White/Black African ☐ White Other ☐ Other Mixed ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Other Asian ☐ Caribbean ☐ African ☐ Other Black ☐ Chinese ☐ Other (please state):	**1.29 Custody Number** if in custody
1.13 Country of Nationality	**1.30 NOMS ID** if known
1.14 Disabled? ☐ Yes ☐ No (go to 1.16) ☐ Registered	**1.31 Did the client refuse to be assessed?** (Meaningful contact / RA refusal?) ☐ Yes (go to 3.1) ☐ No (go to 1.32)
1.15 Client disability	**1.32 Assessment / Triage Date** (dd/mm/yyyy)
1.16 Main Language	**1.33 Assessment Agency**
1.17 Religion ☐ Christian ☐ Hindu ☐ Sikh ☐ Buddhist ☐ Jewish ☐ No Religion ☐ Atheist / Agnostic ☐ Muslim ☐ Not Stated ☐ Other (please state)	**1.34 Assessor Name**

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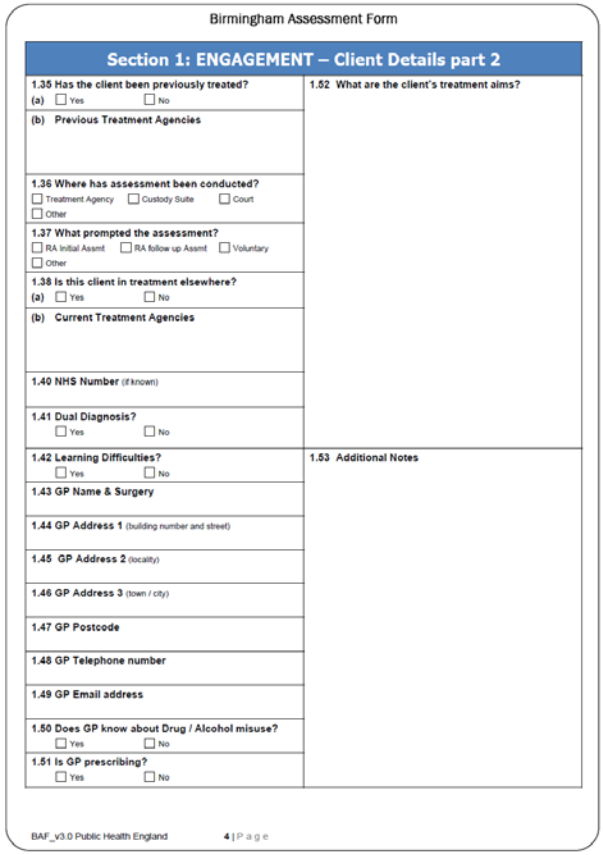

Birmingham Assessment Form

Section 1: ENGAGEMENT – Client Details part 2

1.35 Has the client been previously treated? (a) ☐ Yes ☐ No	**1.52 What are the client's treatment aims?**
(b) Previous Treatment Agencies	
1.36 Where has assessment been conducted? ☐ Treatment Agency ☐ Custody Suite ☐ Court ☐ Other	
1.37 What prompted the assessment? ☐ RA Initial Assmt ☐ RA follow up Assmt ☐ Voluntary ☐ Other	
1.38 Is this client in treatment elsewhere? (a) ☐ Yes ☐ No	
(b) Current Treatment Agencies	
1.40 NHS Number (if known)	
1.41 Dual Diagnosis? ☐ Yes ☐ No	
1.42 Learning Difficulties? ☐ Yes ☐ No	**1.53 Additional Notes**
1.43 GP Name & Surgery	
1.44 GP Address 1 (building number and street)	
1.45 GP Address 2 (locality)	
1.46 GP Address 3 (town / city)	
1.47 GP Postcode	
1.48 GP Telephone number	
1.49 GP Email address	
1.50 Does GP know about Drug / Alcohol misuse? ☐ Yes ☐ No	
1.51 Is GP prescribing? ☐ Yes ☐ No	

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Birmingham Assessment Form

Section 1: ENGAGEMENT – Substance Use

1.54 Which drugs have been misused most often in the last month and how often? Please update the frequency, age first used, weekly spend and method of administration for each drug. Identify the main drugs (1,2 or 3) in order of problematic drug misuse.

Substance	Tick one drug 1, one drug 2 and one drug 3			'IN'=inject, 'SF'=sniff, 'OL'=oral, 'SM'=smoke or 'OT'=Other	Frequency of misuse (tick one)			Age first Used	Weekly Cost £
	Drug 1	Drug 2	Drug 3	Method Of Administration	Daily (2-7x per week)	Week (2-5x per month)	Month (1-2x per month)		
Alcohol	☐	☐	☐	☐ IN ☐ SF ☐ OL ☐ SM ☐ OT	☐	☐	☐		
Cocaine	☐	☐	☐	☐ IN ☐ SF ☐ OL ☐ SM ☐ OT	☐	☐	☐		
Crack	☐	☐	☐	☐ IN ☐ SF ☐ OL ☐ SM ☐ OT	☐	☐	☐		
Heroin	☐	☐	☐	☐ IN ☐ SF ☐ OL ☐ SM ☐ OT	☐	☐	☐		
Methadone	☐	☐	☐	☐ IN ☐ SF ☐ OL ☐ SM ☐ OT	☐	☐	☐		
Cannabis	☐	☐	☐	☐ IN ☐ SF ☐ OL ☐ SM ☐ OT	☐	☐	☐		
Amphetamines	☐	☐	☐	☐ IN ☐ SF ☐ OL ☐ SM ☐ OT	☐	☐	☐		
Benzodiazepines	☐	☐	☐	☐ IN ☐ SF ☐ OL ☐ SM ☐ OT	☐	☐	☐		
Ecstasy	☐	☐	☐	☐ IN ☐ SF ☐ OL ☐ SM ☐ OT	☐	☐	☐		
Subutex	☐	☐	☐	☐ IN ☐ SF ☐ OL ☐ SM ☐ OT	☐	☐	☐		
Methamphetamines	☐	☐	☐	☐ IN ☐ SF ☐ OL ☐ SM ☐ OT	☐	☐	☐		
Other 1	☐	☐	☐	☐ IN ☐ SF ☐ OL ☐ SM ☐ OT	☐	☐	☐		
Other 2	☐	☐	☐	☐ IN ☐ SF ☐ OL ☐ SM ☐ OT	☐	☐	☐		

Birmingham Assessment Form

1.55 Has the client used "legal high" (NPAs)? ☐ Yes ☐ No (go to Q1.57)

1.56 State what legal highs have been used:

1.57 Is client misusing the following prescription drugs? (If so, record dosage)
☐ Heroin Dosage
☐ Methadone Dosage
☐ Benzodiazepines Dosage
☐ Subutex Dosage
☐ Other Dosage
☐ Other Dosage

1.58 Injecting Status ☐ Declined to answer ☐ Currently ☐ Previously ☐ Never injected

1.59 Ever shared injecting equipment? ☐ Yes ☐ No (go to Q1.61)

1.60 Shared in the last month? ☐ Yes ☐ No

1.61 Ever shared drug paraphernalia? ☐ Yes ☐ No (go to 1.63)

1.62 Shared in the last month? ☐ Yes ☐ No

1.63 Where does client source substances from? ☐ Family / Friends ☐ Over the counter ☐ Prescription ☐ Street

1.64 Does the client smoke? ☐ Yes ☐ No (go to Q1.66)

1.65 How many cigarettes are smoked per day? ☐ 0-10 ☐ 11-20 ☐ 21-30 ☐ 30+

1.66 How often have you had an alcoholic drink in the last 28 days?
☐ Abstinent (go to Q1.72) ☐ Once ☐ 2-4 a month
☐ 2-3 a week ☐ 4+ a week ☐ Daily

1.67 How many units of alcohol do you drink on a typical day?
☐ 1-5 units ☐ 6-10 units ☐ 11-15 units
☐ 16-24 units ☐ 25 or more units

1.68 How often does the client have the following units of alcohol on one occasion? (Females:6 or more units/Males:8 or more units)
☐ Every day ☐ 2-6 days ☐ Every week
☐ Every 2-3 wks ☐ Every month ☐ Never

1.69 How long has the client drunk at these levels?

1.70 What age did client start drinking alcohol?

1.71 How many units has client drunk in last week?

Birmingham Assessment Form

Section 1: ENGAGEMENT – Social Profile

1.72 Employment Status? (tick one)
☐ Regular Employment ☐ Casual/temp Employment
☐ Unemployed ☐ Pupil/student ☐ Economically Inactive
☐ Not Known ☐ Other

1.73 How long have you been unemployed?
☐ 0-5 months ☐ 5 – 12 months ☐ 1 – 2 years
☐ 2 – 4 years ☐ Over 4 years ☐ Never worked

1.74 Are you currently receiving benefits?
☐ No
☐ Yes (Job Centre benefits from:)

1.75 What benefits are you receiving?

1.76 Do you have any deductions taken from your benefits? ☐ Yes ☐ No

1.77 Do you have any debts?
(a) ☐ Yes ☐ No
(b) **How are they being addressed?**

1.78 Do you have any qualifications? Tick ALL that apply:
☐ Yes ☐ No ☐ CSE ☐ O Level
☐ GCSE ☐ A Level ☐ Degree or higher
☐ NVQ ☐ City & Guilds ☐ Other

1.79 Do you have the right to live in the UK? ☐ Yes ☐ No

1.80 Do you have the right to work in the UK? ☐ Yes ☐ No

1.81 Current valid driver's licence? ☐ Yes ☐ No

1.82 What is your accommodation status?
☐ No fixed abode (go to Q1.83)
☐ Housing problem (go to Q1.84)
☐ No housing problem (go to Q1.85)

1.83 No Fixed Abode status…
☐ Sleep on streets ☐ Use night shelter (night by night)
☐ Sleep on different friends floor each night
☐ Risk of eviction ☐ Other

1.84 Housing Problem status
☐ Short term B&B or other hostel ☐ Squatting
☐ Nigt winter shelter ☐ Direct access short stay hostel
☐ Friends/family short term guest ☐ Other

1.85 No Problem Housing status
☐ LA/RSL rented ☐ Private rented ☐ Approved premises
☐ Traveller ☐ Own property ☐ Supported Housing
☐ Settled with friends ☐ Other

1.86 If the client is homeless / lives in a hostel what is the reason for this? (tick all that apply)
☐ Lost tenancy / rent appears ☐ Unable to afford bond / deposit
☐ No housing payments accommodation ☐ Prefer to live on street
☐ Unable to live independently ☐ Hostel on condition of court order
Evicted by ☐ Parents ☐ Partner ☐ Landlord
History of ☐ Violence ☐ Arson

1.87 What effects are drugs/alcohol having on your current accommodation?
☐ Drug users/dealers/drinkers visit the home
☐ Drug/alcohol use impacting neighbours
☐ Unable to pay rent/mortgage/bills
☐ Lack of décor/furniture depressing

1.88 What would you like to achieve over the next 3-6 months in relation to accommodation? (tick ALL that apply)
☐ Not to be homeless ☐ Move out of hostel to own accommodation
☐ Improve relations with neighbours ☐ Reduce debts / pay bill
☐ Be able to live independently ☐ Avoid eviction
☐ Decorate / furnish accommodation
☐ Move away from drugs/alcohol users

Additional notes:

Birmingham Assessment Form

Section 1: ENGAGEMENT – Safeguarding Part 1

SAFEGUARDING VISION

"To promote and protect individual human rights, independence and well-being and secure assurance that vulnerable adults stay safe, are effectively safeguarded against abuse, neglect, discrimination, embarrassment or poor treatment, are treated with dignity and respect and enjoy a high quality of life. All agencies to work together in partnership with those thought to be at risk, their carers and communities to:

- protect and empower those at risk from being exploited/abused
- respond sensitively and consistently to reported incidents of self neglect and abuse
- ensure that action is taken as quickly as possible
- put in place plans to protect and assist the vulnerable person in the best way for them
- support carers who may themselves be vulnerable
- ensure regular monitoring is in place when concerns have been raised
- to actively work together within an inter agency framework based on "No Secrets" guidance and relevant best practice guidance
- to actively promote through the services they provide the empowerment and well being of those who are thought to be at risk
- to act in a way that supports the rights of the individual to lead an independent life based on self-determination and personal choice
- to recognise people who are unable to take their own decisions and/or protect themselves, their assets and bodily integrity
- to ensure that when the right to an independent lifestyle and choice is at risk, the individual concerned receives appropriate help, including advice, protection and support from relevant agencies

In applying these principles, agencies will balance the requirements of confidentiality with the consideration that, to protect persons thought to be at risk of abuse, it may be necessary to share information consistent with the Caldicott principles on confidentiality and information sharing."

Birmingham Safeguarding Adults Board state the definition of a Vulnerable Adult is:

"any person who is aged 18 years and over who is or may be in need of community care services because of frailty, learning or physical or sensory disabilities or mental health issues and who is or may be unable to protect him or herself from significant harm or exploitation"

1.89 Have you ever been identified as a vulnerable adult? ☐ Yes ☐ No

1.90 Abuse can be experienced at any point in child and adult life. This can include physical, sexual, emotional, psychological, neglect, financial and discriminatory abuse. Have you experienced ANY abuse at ANY time in your life? ☐ Yes ☐ No ☐ Declined to answer.

1.91 If yes, give brief details.

1.92 Do you have Carer responsibility for another adult?
(a) ☐ Yes ☐ No
(b) **If Yes, give details (including name, DOB, address of vulnerable adult and care provided)**

1.93 Do you have a Carer?
(a) ☐ Yes ☐ No
(b) **If yes, give details (name, DOB, Carer address)**

1.94 Do you have anyone else (family or friends) who provide you with support?:
(a) ☐ Yes ☐ No
(b) **If yes please state details**

1.95 Do you feel you need any additional support?
(a) ☐ Yes ☐ No
(b) **If yes what support (e.g. budget, tenancy, OT)**

1.96 How satisfied are you with the decisions made regarding your finances? Score
Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good

1.97 How safe do you feel in your home and wider local community? Score
Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good

1.98 Client's overall quality of life (e.g. able to enjoy life, gets on well with family and partner? Score
Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good

Notes:

Birmingham Assessment Form

Section 1: ENGAGEMENT – Safeguarding Part 2

1.99 Professionals involved with Client

Name of professionals involved	Position (e.g. SCH worker, CPN, floating support)	Agency address and telephone number

Abuse and Violence

1.100 Have you ever been in an abusive relationship? ☐ Yes (go to 1.101) ☐ No (go to 1.104)

1.101 Were you the victim of domestic abuse? ☐ Yes ☐ No

1.102 Are you currently in a relationship you would consider controlling, violent or in any other way abusive? (a) ☐ Yes ☐ No

(b) **If yes, give brief details:**

1.103 Is there any current or previous police involvement regarding domestic abuse? ☐ Yes ☐ No

1.104 Is there any family member, friend or carer who would like to be involved in your treatment? (a) ☐ Yes ☐ No

(b) **If yes, give brief details:**

1.105 History of substance abuse or psychiatric illness within close family i.e. mother, father, brother, sister? (a) ☐ Yes ☐ No

(b) **If yes give brief details:**

1.106 Are you ever expected to do anything you are not comfortable with? (a) ☐ Yes ☐ No

(b) **If yes give details:**

1.107 Description of a typical day/week:

Children

1.108 Children (If no children go to 1.115)
"CHILD" = child under the age of 17 – THIS QUESTION RELATES TO YOUR OWN CHILDREN (I.E. THOSE YOU ARE A PARENT OF)
"LIVING WITH" = stay in the same house for at least 1 night a week on a regular basis

Name of child (First Name AND Surname	Date of Birth	Age	Where does the child live (e.g. with client/ partner/ other family member/in care/other – specify)? What contact arrangements does the client have with child (e.g. supervised/ via family /none /other – specify)?	On "Child Protection Plan", "CAF" or other (specify)?

Birmingham Assessment Form

Section 1: ENGAGEMENT – Safeguarding Part 3

1.109 Professionals involved with children

Name of professionals involved	Position (e.g. SCH worker, CAF lead, Midwife, Health visitor, GP etc.)	Agency address and telephone number	Name of child involved with.

1.110 Is the client currently pregnant? ☐ Yes (go to 1.111) ☐ No (go to 1.113)

1.111 Expected Due Date (if known): DD/MM/YYYY

1.112 What hospital is client booked with:

1.113 Details of parental experience/outcome (i.e. child remains in care of client/moved into care)

1.114 Does anyone else help you with childcare or have contact with these children? ☐ Yes ☐ No

1.115 Children living with client summary:
"CHILD" = any child under the age of 17 (whether they are your children, partner's children, siblings or un-related); "LIVING WITH" = stay in the same house for at least 1 night a week on a regular basis

☐ All children live with client ☐ Not a parent/no children
☐ Some children live with client ☐ Client declined to answer
☐ None of the children live with the client

1.116 Do you feel you would benefit from a parenting / budgeting / money management course? (a) ☐ Yes ☐ No

(b) **If yes give details**

1.117 Has safe storage of BOTH illicit drugs and prescribed medications (controlled and non-controlled) been discussed with the client? ☐ Yes ☐ No

1.118 What contact do you have with other children?

1.119 Does current partner use drugs/alcohol problematically? ☐ Yes ☐ No

1.120 Where are the children when you are funding or using drugs and/or alcohol?

DO YOU NEED TO COMPLETE A CAF?

Does the family appear to be:	YES	NO	NOT SURE
Healthy?	☐	☐	☐
Safe from Harm?	☐	☐	☐
Learning and developing?	☐	☐	☐
Free from crime or antisocial behaviour?	☐	☐	☐
Free from the Impact of Poverty or worklessness?	☐	☐	☐
Free School Meals			
Benefit type			

If you answered "no", what additional services are needed for the family including child, young person, their parent(s) or carer(s)?

☐ Education ☐ FIP ☐ Health ☐ CAMHS ☐ Housing
☐ Criminal Justice ☐ School Support ☐ IFST ☐ Job Support
☐ Mental Health ☐ Citizen's Advice ☐ Early Support Service
☐ Other ☐ Other

By recognising the need to complete this section demonstrates a Family CAF is recommended. Obtain client's permission, sign information sharing consent form, complete Family CAF pre-assessment form and implement CAF process document available on www.birmingham.gov.uk/CAF

Additional notes:

Birmingham Assessment Form

Section 1: ENGAGEMENT – Criminal Justice

1.121 Has the client committed crime to fund drug/alcohol use? ☐ Yes (go to 1.122) ☐ No (go to 1.131)

1.122 What crimes are committed to fund drug/alcohol habit? Tick ALL that apply
☐ Shoplifting ☐ Domestic burglary ☐ Commercial burglary
☐ Dealing ☐ Robbery ☐ Sexwork ☐ Car theft
☐ Fraud ☐ Other

1.123 How often do you commit crime to fund your habit? Tick ONE
☐ Daily ☐ 2-6 times a week ☐ Weekly ☐ Fortnightly
☐ Monthly ☐ Occasionally ☐ Never

1.124 Have you ever been caught or charged for an offence? ☐ Yes (go to 1.125) ☐ No (go to 1.130)

1.125 When did you last commit an offence? Tick ONE
☐ Last week ☐ Last month ☐ 2–6 months ago
☐ 6–12 months ago ☐ Over 12 months ago

1.126 How many times have you been in trouble with the police? Tick ONE
☐ Once ☐ 2–4 times ☐ 5 –9 times
☐ 10 times or more

1.127 Have all your crimes been alcohol and/or drug related? ☐ Yes ☐ No

1.128 Are you currently on an order / licence? ☐ Yes ☐ No

1.129 Have you ever been arrested/charged with any of the following? Tick ALL that apply

Theft	☐ Shoplifting	☐ of a vehicle	☐ from a vehicle
Burglary	☐ Domestic	☐ Other	☐ Other Robbery
Attempted	☐ Theft	☐ burglary	☐ robbery
	☐ fraud	☐ handling	
Other	☐ TWOC	☐ Fraud	☐ Handling
	☐ Going equipped	☐ Possession	☐ Supply
	☐ Begging	☐ Domestic violence	
	☐ Soliciting	☐ Wounding or assault	
	☐ Other		

1.130 How do alcohol and/or drugs impact on your offending? Tick ALL that apply
☐ Have to commit crime every day ☐ Can't pay fines
☐ Turn to other crime to fund habit ☐ Stealing from family
☐ Missed court appearance ☐ Possibility of prison

1.131 How do you fund your drug/alcohol use? Tick ALL that apply
☐ Partner's/child's benefits ☐ Sell family belongings
☐ Client's benefits ☐ Family give money ☐ Work
☐ Begging

1.132 Do you currently have any involvement with a Criminal Justice Agency? (a) ☐ Yes ☐ No

(b) **If yes give brief details:**

Notes:

Birmingham Assessment Form

Section 1: ENGAGEMENT – Initial Risk Assessment & Actions

ASSESSMENT

1.133 Has the client thought of suicide? ☐ Yes ☐ No

1.134 Has client ever made a suicide attempt? ☐ Yes ☐ No

1.135 Has the client had thoughts of self harm? ☐ Yes ☐ No

1.136 Has client made any self harm attempts? ☐ Yes ☐ No

1.137 Is the client expressing thoughts of violence / aggression? ☐ Yes ☐ No

1.138 Has the client ever engaged in episodes of violence / aggression? ☐ Yes ☐ No

1.139 Are there any fire setting issues? ☐ Yes ☐ No

1.140 Is there concern about harm or exploitation from others (physical, financial,etc)? ☐ Yes ☐ No

1.141 Are there any child protection issues? ☐ Yes ☐ No

1.142 Is the client at risk of self-neglect? ☐ Yes ☐ No

1.143 Does the client have a history of adverse life events (e.g. abuse, illness, bereavement)? ☐ Yes ☐ No

1.144 Is there concern regarding the client's mental health treatment? ☐ Yes ☐ No

1.145 Is there concern about the client's general behaviour (risk taking, daily activities)? ☐ Yes ☐ No

1.146 Is there a history of misusing alcohol? ☐ Yes ☐ No

1.147 Is there a history of depression or serious mental illness, inc. any current episode? ☐ Yes ☐ No

1.148 Is there a history of falls? ☐ Yes ☐ No

ACTIONS

1.149 Further Intervention Needed ☐ Yes ☐ No (go to 3.2)

1.150 Further Interventions Accepted ☐ Yes ☐ No (go to 3.3)

1.151 Client agreed to a careplan ☐ Yes ☐ No (go to 3.4)

1.152 Careplan Date DD/MM/YYYY

1.153 Refer to Alcohol Agency? ☐ Yes ☐ No

Agency	Date
	DD/MM/YYYY
	DD/MM/YYYY
	DD/MM/YYYY

1.154 Refer to Drug Agency? ☐ Yes ☐ No

Agency	Date
	DD/MM/YYYY
	DD/MM/YYYY
	DD/MM/YYYY

1.155 Housing Action Tick ALL that apply
Refer to: ☐ Hostel accommodation ☐ Homeless ☐ CAB
☐ SP Provider ☐ Housing

1.156 Other agencies contacted (e.g. family support, probation, housing, etc.)? ☐ Yes ☐ No

Agency	Date
	DD/MM/YYYY
	DD/MM/YYYY
	DD/MM/YYYY

1.157 Assessment completed by: Enter Name

1.158 Assessment completed: DD/MM/YYYY

1.159 Assessor Agency: Enter Name

Notes:

Birmingham Assessment Form

Section 1: ENGAGEMENT – Additional Notes

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Birmingham Assessment Form

Section 2 : TREATMENT - Care Plan Reviews / Referrals

This document records every structured care plan review conducted by the client's keyworker and the type of intervention(s) made as a result of the care plan review. Additional pages should be attached if required	Client Name: Keyworker: Keyworker Agency:

Care Plan Reviews

	INTERVENTIONS			ACCESS TO						COMMUNITY			SESSIONS		OTHER		
Care Plan Review Date	Harm reduction	Stimulant	Alcohol brief	Prescribing	Primary Healthcare	Finance & Benefit Advice	Mental Health Interventions	Educ / Training Support	Employment Support	Leisure activities	Peer support	Work with families / carers	Group work	1:1 Work	Housing advice / Info referral	Overdose Management	Other
e.g. 01/01/2012	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☒	☐	☐	☐
DD/MM/YYYY	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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DD/MM/YYYY	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Referrals made

Referred to	Referral Date	Referral Type	Referred By	Date Engaged	Treatment / Support Start Date	Discharge Date
e.g. East ARCH	01/01/2012	Drug treatment	A Manager	10/01/2012	15/01/2012	20/02/2012
	DD/MM/YYYY			DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
	DD/MM/YYYY			DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
	DD/MM/YYYY			DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
	DD/MM/YYYY			DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
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	DD/MM/YYYY			DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
	DD/MM/YYYY			DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY

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Birmingham Assessment Form

Section 2 : TREATMENT - Risk Management Plan

Actions to reduce risk / promote safety

In these sections provide a summary of the risk identified, a formulation of the situation in which the identified risk may occur and actions to be taken by practitioners and the service user in response to crisis.

2.1 Suicide

2.2 Self-harm

2.3 Violence / harm to others

2.4 Risk to Children (Including caring capacity)

2.5 Risk to others (Including exploitation)

2.6 Neglect

2.7 Vulnerability

2.8 Substance misuse

2.9 Any other (Please specify. Include risk of absconding from inpatients and disengagement from community services)

Name / Keyworker:		Designation:	
Signature:		Date:	DD/MM/YYYY

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Birmingham Assessment Form

Section 2 : TREATMENT - Health

2.10 Does the client suffer from any of the following? Tick ALL that apply

Condition	Now	Ever	Condition	Now	Ever
Asthma	☐	☐	DVT	☐	☐
Diabetes	☐	☐	HCV	☐	☐
Liver Disease	☐	☐	HBV	☐	☐
Heart Problems	☐	☐	HIV	☐	☐
Respiratory Disease	☐	☐	STIs	☐	☐
Dental Problems	☐	☐	Stomach Ulcers	☐	☐
Abscesses/Ulcers	☐	☐	Epilepsy	☐	☐
Other (Please state) :				☐	☐

2.11 If ticked 2.10, are you currently receiving any form of medical care?
(a) ☐ Yes ☐ No
(b) **If yes give details**

2.12 Does client suffer from any allergies?
(a) ☐ Yes ☐ No
(b) **If yes give details**

Hepatitis B Screening

2.13 Test Received? ☐ Yes ☐ No

2.14 Hepatitis B Date Last Tested? DD/MM/YYYY

2.15 Previously Hepatitis B infected? ☐ Yes ☐ No

2.16 Hepatitis B Intervention Status?
☐ Offered & Accepted ☐ Offered & refused
☐ Immunised already ☐ Not offered
☐ Acquired immunity ☐ Not appropriate to offer

2.17 Hepatitis B vaccination count?
☐ One ☐ Two ☐ Three
☐ Course complete ☐ Booster

Notes:

Hepatitis C Screening

2.18 Test Requested? ☐ Yes ☐ No

2.19 Test Received? ☐ Yes ☐ No

2.20 Hepatitis C Date Last Tested? DD/MM/YYYY

2.21 Hepatitis C positive? ☐ Yes ☐ No

2.22 Referral to Hepatology? ☐ Yes ☐ No

2.23 Hepatitis C Intervention Status?
☐ Offered & Accepted ☐ Offered & refused
☐ Not offered ☐ Not appropriate to offer

2.24 Ever tested for HIV? ☐ Yes ☐ No

2.25 Date of last HIV test? DD/MM/YYYY

2.26 Result of last HIV test?

2.27 Health Updates

2.28 Assessment completed by:

2.29 Assessment completed date: DD/MM/YYYY

2.30 Assessor Agency:

Notes:

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Birmingham City Council

Birmingham Assessment Form

Section 2 : TREATMENT – Mental Health

2.31 How many times has the client been treated for any psychological or emotional problems as an inpatient?

2.32 How many times has the client been treated for any psychological or emotional problems as an outpatient?

2.33 How long ago was the last time?

2.34 Is the client currently receiving treatment from mental health services?
☐ Yes ☐ No

2.35 Do you have any persistent psychological or emotional problems that continue to interfere with your life?
(a) ☐ Yes ☐ No
(b) If yes, please specify.

2.36 Do you receive any benefits for a psychiatric disability?
(a) ☐ Yes ☐ No
(b) If yes, please specify.

2.36 Do you receive any benefits for a psychiatric disability?
(a) ☐ Yes ☐ No
(b) If yes, please specify.

2.37 How many days out of the last 30 have you experienced psychological or emotional problems?

2.38 Client's rating of psychological health status (anxiety, depression and problem emotions and feelings)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good | Score

2.39 Have you experienced the following:

Disorder / Event	Ever In your Life	In the Past 30 days				
		Never	Rarely	Sometime	Often	Always
Serious depression	☐	☐	☐	☐	☐	☐
Serious anxiety	☐	☐	☐	☐	☐	☐
Trouble understanding or remembering	☐	☐	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐	☐	☐
Trouble controlling violent behaviour	☐	☐	☐	☐	☐	☐
Serious thoughts of suicide	☐	☐	☐	☐	☐	☐
Attempted suicide	☐	☐	☐	☐	☐	☐
Eating disorder	☐	☐	☐	☐	☐	☐
Prescribed medication for psychological or emotional problem	☐	☐	☐	☐	☐	☐

If yes to any, consider completing the **PSYCHIATRIC ASSESSMENT**

2.40 Past Psychiatric History
List all episodes of treatment, contact with psychiatric services, admissions to hospital, etc:

2.41 Current Psychiatric Treatment – Is client on enhanced CPA? ☐ Yes ☐ No
If YES MH Care Co-ordinator if known

2.42 Has the client ever been in A & E following an overdose?
☐ Yes ☐ No

2.43 Client's description of current physical and psychological health:

2.44 Has a Mental Capacity Assessment been completed?
☐ Yes ☐ No

2.45 MH Assessment completed: [name]

2.46 MH Assessment completed date DD/MM/YYYY

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Birmingham Assessment Form

Section 2 : TREATMENT – Modalities

2.47 Keyworker:

2.48 Agency:

2.49 Comprehensive assessment date DD/MM/YYYY

2.50 Care plan commenced date DD/MM/YYYY

All (Top Level) Treatment Modalities

2.51 Modality	Setting	Date Referred	First Appointment Offered	Modality Start Date	Modality End Date	Modality Exit Status
Adult Drug Treatment Provider Services						
Needle Exchange	C	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	
Outreach	C	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	
Advice & Information	C	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	
Pharmacological Intervention	C	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	
Psychosocial Intervention	C	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	
Recovery Support	C	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	

Structured Sub-Interventions

Sub-Interventions	PHARMACOLOGICAL: Assessment & Stabilisation	Maintenance	Withdrawal	Relapse Prevention	PYSCHOLOGICAL: Motivational	Contingency Management	Family & Social Network	Cognitive & Behaviour	Evidence based PI for co-existing mental health problems	Psychodynamic therapy	Counselling - BACP	Other	RECOVERY: Peer Support	Access to Mutual Aid	Family Support	Parenting Support	Housing Support	Employment Support	Education & Training Support	Recovery Check Ups	Evidence based PI to support relapse prevention	Complementary Therapies	Mental Health Intervention
e.g. 01/01/2012	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Birmingham Assessment Form

2.52 Have all TOPS forms for this treatment programme been completed?
☐ Yes ☐ No

2.53 Has this treatment programme been completed?
☐ Yes (go to 3.19)

Treatment / Additional Notes

DD/MM/YYYY / KEYWORKER :

DD/MM/YYYY / KEYWORKER :

DD/MM/YYYY / KEYWORKER :

DD/MM/YYYY / KEYWORKER :

DD/MM/YYYY / KEYWORKER :

DD/MM/YYYY / KEYWORKER :

DD/MM/YYYY / KEYWORKER :

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Birmingham Assessment Form

Section 3 : DISCHARGE / CLOSURE

Disengagement Before Care Plan

3.1 EXIT before Assessment reason (tick one)
☐ Already in treatment and does not want to engage
☐ Assessed and waiting care plan ☐ Assessment not offered
☐ Client on Drug Rehabilitation Requirement (DRR)
☐ Concerned about impact on criminal case ☐ No drug use
☐ Refused to engage ☐ Other

3.2 EXIT as further intervention denied reason
☐ No Problem drug use ☐ Assessment is sufficient intervention
☐ Other

3.3 EXIT - further intervention refused reason
☐ Not ready to engage
☐ Client does not think intervention needed
☐ Assessment not offered
☐ Client states no suitable treatment available
☐ Already in treatment and does not want to engage
☐ Other

3.4 Has the client been transferred to another DAAT of residence or a prison?
☐ Yes - DAAT (go to 3.5) ☐ Yes - Prison (go to 3.7)
☐ No (go to 3.10)

3.5 EXIT as client transferred to DAT of residence
[Name of DAAT]

3.6 Date referred to DAT of residence
DD/MM/YYYY

3.7 EXIT as client sent to Prison
[Name of Prison]

3.8 Date sent to prison
DD/MM/YYYY

3.9 Prison informed?
☐ Yes ☐ No

After Care Plan Agreed / Treatment

3.10 DISCHARGE Treatment Agency
[Agency]

3.11 DISCHARGE Date
DD/MM/YYYY

3.12 DISCHARGED by Keyworker:
[Keyworker]

3.13 DISCHARGE destination:
[Transferred to for After Care]

Discharge / Closure

3.14 Discharge Reason (tick one)
Completed ☐ Drug free ☐ Alcohol free
☐ Occasional user - Not opiates / crack
Transferred ☐ Not in custody ☐ In custody
Incomplete ☐ Dropped Out ☐ Retained in custody
☐ Treatment withdrawn by provider
☐ Treatment declined by client
☐ Client died

CLOSURE after ALL treatment / support in Birmingham has ended

3.15 CLOSURE Treatment Agency
[Agency]

3.16 Closure Date
DD/MM/YYYY

3.17 Closure by Keyworker:
[Keyworker]

3.18 Closure destination:

3.19 Closure Reason (tick one)
☐ Client still a Class A drug user but no longer offending
☐ Client no longer a Class A drug user but still offending
☐ Client is no longer a Class A drug user and no longer offending
☐ Client has begun a community sentence (e.g. DRR)
☐ Client died
☐ Client transferred to another DAT
☐ Client transferred to Prison (Please state)
☐ Client has begun specialist treatment
☐ Other (please state)

3.20 Closure Checklist (tick if applicable)
☐ Has there been a peer review of the client's case to ensure that discharge from treatment is the most appropriate course of action?
☐ Have you checked that the correct 'discharge code' has been applied/entered onto local data systems/ NDTMS
☐ If the client is leaving treatment 'unsuccessfully' have alternative treatment options been discussed/explored?
☐ If the client has 'dropped out' of treatment have all methods to re-engage the client been exhausted (letters / texts / phone calls / home visits)?
☐ If the client is being 'transferred' have you had discussions with the receiving agency to ensure that a continuity of care is in place?

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