DRAFT FOR CONSULTATION

Triple Zero City Strategy

Birmingham

2020-2030

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1. Our shared ambition

We want Birmingham to be a city where drugs and alcohol addiction do not cause preventable deaths and damage lives through overdose and crime.

We want Birmingham to be a city where young people grow up without addiction and where adults who are living with addiction to substances can access treatment and support and regain control of their lives.

2. Outcomes

We have three key ambitious outcomes we want to achieve through working in partnership across the city:

- Zero deaths due to drug or alcohol addiction
- Zero overdoses due to drug or alcohol addiction
- Zero people living with addiction to drugs or alcohol not receiving support to manage and overcome their addiction

These are deliberately ambitious as we need to keep pace and focus to drive change at scale and truly impact on the challenge of drug and alcohol addiction in the city.

3. Key objectives

These three outcomes are underpinned by a series of objectives which allow us to monitor progress towards these three longer-term goals:

- Reduce access to, and the affordability of, illegal drugs in Birmingham
- Reduce the proportion of young people trying illegal drugs
- Reduce the number of harmful and hazardous drinkers
- Increase the proportion of people with drug and alcohol addiction in treatment
- Explore new models of treatment, care and support to minimise the risk of overdose and death
- Improve access to Naloxone and other interventions that can improve outcomes of overdose
- Improve access to employment support for people accessing treatment and support for drug and alcohol addiction
- Improve access to healthcare services for people accessing treatment support for drug and alcohol addiction
- Work in partnership with citizens, businesses, and organisations across the city to achieve our shared ambition to achieve the triple zero targets

4. Context

Birmingham is a diverse, global, vibrant city with over a million citizens, however, too many of our citizen's lives are being damaged by addiction to alcohol or drugs.

Addiction to drugs comes in many forms and the landscape of drugs has evolved significantly over the last twenty years. The Triple City Zero Strategy will address a broad definition of drug addiction including novel psychoactive substances, steroid abuse, club drugs and prescription drug addiction as well as the more traditional opioid-based drug addiction models.

Alcohol addiction is often described in the context of harmful and hazardous drinking. The National Institute for Health and Care Excellence (NICE) defines harmful drinking as a pattern of alcohol consumption that causes health problems, including psychological problems such as depression, alcohol-related accidents or physical illness such as acute pancreatitis. Harmful drinkers can become alcohol dependent, which NICE defines as characterised by craving, tolerance, a preoccupation with alcohol and continued drinking despite harmful consequences.

Tackling alcohol and drug addiction and the harm that it causes needs us to work in partnership across the city. Preventing addiction requires action across the life-course to improve mental wellbeing, reduce access, reduce demand and give people other pathways to managing life challenges. Supporting those living with addiction to reduce the risk of death and overdose requires early identification, brief interventions as well as, for some, longer-term treatment and support. Enabling those living with addiction to manage and overcome their addiction and regain balance means working with educators and employers, as well as health and social care providers, to provide opportunities for individuals to achieve a healthy and productive life.

Led by Birmingham City Council in partnership with the West Midlands Police and Crime Commissioner, the Triple Zero City Strategy sets out a refreshed approach to creating a healthier and safer city for all the residents of Birmingham.

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5. Definitions

5.1 Drugs

In the UK illegal drugs are classified into three main categories, A, B and C, with class A drugs attracting the most serious punishments and crimes (Table 1). The drugs are classified as controlled by the Misuse of Drugs Act (1971) and the class is allocated based on the level of harm the drug is thought to cause. Under the Act, it is illegal for individuals to possess the drug, supply it or sell it, or allow it to be used in premises they own.

Table 1: Drug Classifications

Class	Drug
A	Crack cocaine, cocaine, ecstasy (MDMA), heroin, LSD, magic mushrooms, methadone, methamphetamine (crystal meth)
B	Amphetamines, barbiturates, cannabis, codeine, ketamine, methylphenidate (Ritalin), synthetic cannabinoids, synthetic cathinones (for example mephedrone, methoxetamine)
C	Anabolic steroids, benzodiazepines (diazepam), gamma hydroxybutyrate (GHB), gamma-butyrolactone (GBL), piperazines (BZP), khat
Temporary class drugs (The government can ban new drugs for 1 year under a 'temporary banning order' while they decide how the drugs should be classified.)	Some methylphenidate substances (ethylphenidate, 3,4-dichloromethylphenidate (3,4-DCMP), methylnaphthidate (HDMP-28), isopropylphenidate (IPP or IPPD), 4-methylmethylphenidate, ethylnaphthidate, propylphenidate) and their simple derivatives

There is a range of other words used in relation to drugs and alcohol which we have included definitions of here:

Opioids is a term used to describe a group of psychoactive substances derived from the poppy plant, including opium, morphine and codeine, as well as their semi-synthetic counterparts, including heroin (World Health Organisation, 2004).

Novel psychoactive substances (NPS) describes a group of new drugs that have been designed to replicate some of the effects of other drugs like cannabis, cocaine and ecstasy while remaining legal which is why they are sometimes called 'legal highs'. The effects of NPS vary significantly from drug to drug and, compared to more traditional drugs, we have relatively little information on them. However, there is a growing body of evidence to

demonstrate the potential short and long-term harms associated with their use.

Club drugs is a term used to describe a group of drugs that are associated with use in parties and club nights. This includes drugs like MDMA (Ecstasy), GHB, Rohypnol, Ketamine, Methamphetamine, and LSD. Club drugs carry significant health risks and can cause serious harm and death with the risk often increased through contamination with other substances.

ChemSex drugs describes drugs that are predominantly used in association with sexual activity, the most common drug in this group is Methamphetamine, more commonly known as Crystal Meth, Tina, Glass or Yaba. Chemsex drugs carry health risks as drugs but also associated with higher sexual risk-taking.

Steroids, in the context of steroid abuse, describes anabolic steroids which are often used illegally to increase muscle mass, decrease fat and enhance athletic performance. Steroids have significant health risks in both the shorter and longer-term.

Prescription and over-the-counter drug abuse is the use of a prescription or over-the-counter medication in a way not intended by the prescribing doctor or dispensing pharmacist, this can be as a result of addiction or criminal activity. The most commonly abused drugs include opioids like codeine, antidepressants, ADHD medication and anti-anxiety medication.

5.2 Alcohol

Unlike most drugs in this policy alcohol is legal for adults to drink. The Chief Medical Officer recommends that adults drink no more than 14 units of alcohol a week. A unit of alcohol is about half a pint of normal strength beer or cider or a single shot, a small glass of wine is about 1.5 units.

There are two main terms used in the context of alcohol misuse:

Harmful drinking

The definition of harmful alcohol use in this guideline is that of the World Health Organisation's International Classification of Diseases, 10th Revision [The ICD-10 Classification of Mental and Behavioural Disorders] (ICD-10; WHO, 1992):

"A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (e.g. hepatitis) or mental (e.g. depressive episodes secondary to heavy alcohol intake). Harmful use commonly, but not invariably, has adverse social consequences; social consequences in themselves, however, are not sufficient to justify a diagnosis of harmful use"

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Hazardous drinking

The term ‘hazardous use’ appeared in the draft version of ICD-10 to indicate a pattern of substance use that increases the risk of harmful consequences for the user. This is not a current diagnostic term within ICD-10. Nevertheless, it continues to be used by WHO in its public health programme (WHO, 2010a; 2010b).

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6. Policy context

There is significant variation in policy on drug and alcohol misuse across the world. As a global city, we have developed the strategy for Birmingham drawing on policy and practice from both UK and international policy.

As a city, our citizens experience the impact of drugs and alcohol misuse at an individual, family, community and city-wide level. Cities often face additional challenges in relation to organized crime and being a hub for transport and migration. Cities also face tensions between the desire for economic growth linked to the night-time economy and the interconnection between this economy and drug and alcohol misuse. There is some evidence that cities are often at the forefront of tackling the challenges of drugs and alcohol because they have the immediate responsibilities for responding to the impact of these challenges such as violence, disorder, crime and inequality.

6.1 National & international drug policy overview

The Home Office Drug Strategy 2017 sets out an approach based largely on reducing demand and supply, with a mention of rehabilitation and co-operation in action to reduce the overall global supply of Class A drugs.

National policy places the responsibility for the commissioning of drug treatment services as part of the recommended services commissioned through the local authority public health grant. However, it is not a statutory service. Local authorities have responsibilities with regards to the NHS Constitution under the 2012 legislation to deliver drug and alcohol recovery services and are required to fund appropriate interventions as recommended by the National Institute of Clinical Excellence (NICE).

NICE have published guidelines on drug treatment and also made recommendations about interventions at a system level that can influence drug misuse but these are not government policy.

The World Health Organisation (WHO) identifies the world drug problem as both a public health issue and a safety and security issue, with different countries responding with their own balance between these two domains. The WHO recommends that drug use disorders are managed within the public health system, as the evidence shows this is what works best. In certain countries, the idea of including treatment of drug use disorders still meets resistance – *"partly owing to a delay in transferring science to policy and ultimately to the implementation of evidence-based clinical practices".* The WHO advocates for a life course approach to prevention on the basis that intervention in the early years has the most impact.

In international terms, the UK has taken a less liberal approach to drug criminalisation[i] than some other countries although in general this is restricted to liberalisation relating to Cannabis. There are some areas where there has been

significant innovation internationally, especially in relation to heroin-assisted treatment such as “safer injecting facilities”. In some countries, drug consumption rooms, where illicit drugs can be used under the supervision of trained staff, have been operating for the last three decades and are now found in 10 countries. The benefits of providing supervised drug consumption facilities may include improvements in safe, hygienic drug use, especially among regular clients, increased access to health and social services, and reduced public drug use and associated nuisance. There is no evidence to suggest that the availability of safer injecting facilities increases drug use or frequency of injecting. These services facilitate rather than delay treatment entry and do not result in higher rates of local drug-related crime.

6.2 National and international alcohol policy overview

The WHO provides a Global Status Report on Alcohol Policy. The mechanism by which this works is through the Global Alcohol Policy Alliance. A report was produced for the World Health Assembly in 2019 to report on the implementation of the WHO’s global strategy to reduce the harmful use of alcohol during the first decade of its endorsement. A conference will be held in Dublin in March 2020.

National policy on Alcohol was produced by PHE in 2018: “Alcohol: applying All Our Health”. This focuses on work to reduce alcohol harm in professional practice and action that can be taken by front-line health and care professionals. It also outlines actions that can be taken by both management and strategic leaders. The primary measures of the impact of alcohol harm are found in the Public Health Outcomes Framework Indicators (alcohol-related admissions to hospital and successful completion of alcohol treatment). There is an Everday Interactions measuring impact toolkit that can be used by health care professionals and an alcohol impact pathway. NICE PH24 provides guidance on the prevention of alcohol use disorders.

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7. The context of drugs in Birmingham

7.1 The drug market in Birmingham

The majority of organised crime groups (OCGs) in the West Midlands are heavily involved in the drugs trade. In 2017, there were 84 OCGs being tracked by West Midlands Police, of these 31 were primarily involved in drug-related criminality. OCGs involved in the drugs trade are likely to have an international client base; The National Crime Agency (NCA) has reported Birmingham as one of the three main exporting areas of drugs in the UK, alongside London and Liverpool. Of the 84 OCGs tracked, 27 were known to have an international footprint. Organised criminals in the West Midlands are profiting from a drug market worth approximately £188m.

One of the eight drug policy recommendations from the West Midlands Police and Crime Commissioner is to seize the money from organised criminals including across the drug market and put this towards improving drug services. Those who have previously been benefiting from the drug market will instead be paying for drug services to help those suffering from drug addiction and to reduce the number of drug-related deaths. Between 2012 and 2017, West Midlands Police seized more than £17 million from offenders under the Proceeds of Crime Act (POCA).

7.2 Drug misuse in Birmingham

The estimated prevalence of opiate and/or crack cocaine use in Birmingham residents (5-64 years old) has been nearly twice the national rate in recent years. In 2011/12 the rate was 15.2 per 1000 population (England 8.4). In 2016/17 Birmingham's rate decreased to 14.2 and the national rate has increased to 8.9 per 1,000 population.

The city's recorded number of drug users (opiate and/or crack cocaine use measured by various organizations, including drug treatment, probation, police and prison data) fluctuates over time: with cases at a peak of 10,743 (2011/12), then decreasing to 9,705 (2014/15) and rising again to 10,525 (2016/17).

We have limited local data on patterns of drug and alcohol misuse but there are national prevalence estimates from the Crime Survey for England and Wales from which we can estimate the potential burden of misuse in Birmingham (Table 2). This modelling estimates that in the last month over 8,900 adults in Birmingham have used a class A drug (this is an underestimation as this will not include hostels, students and anyone else with temporary addresses. Over the last year, over 1,370 have used anabolic steroids and 43,870 used non-prescribed prescription-only painkillers. However, it is important to note that there is significant variation in use frequency e.g. only 5.9% of adults using powder cocaine in the last month were using daily compared to 25.4% of cannabis users using daily.

Table 2: Estimated number of adults using drugs based on national and regional prevalence data from the Crime Survey for England and Wales 2018/19[ii] (based on est. pop of 16-59yr of 685,603)

Data from Crime Survey for England and Wales 2018/19	Adults 16-59yrs who used drug ever in their lifetime		Adults 16-59yrs who used drug ever in the last year			Adults 16-59yrs who used drug in the last month	
	% National	**Est. pop. In B'ham**	**% National**	**% West Midlands**	**Est. pop. In B'ham**	**% National**	**Est. Pop in B'ham**
Class A							
Any cocaine	10.80%	74,045	2.90%	N/A	19,882	1.10%	7,542
Powder cocaine	10.70%	73,360	2.90%	2.10%	14,398	1.10%	7,542
Crack Cocaine	0.80%	5,485	0.10%	N/A	686	0.00%	0
Ecstasy	9.90%	67,875	1.60%	0.70%	4,799	0.30%	2,057
Hallucinogens	8.50%	58,276	0.70%	0.50%	3,428	0.10%	686
LSD	5.00%	34,280	0.40%	N/A	2,742	0.00%	0
Magic mushrooms	6.90%	47,307	0.50%	N/A	3,428	0.10%	686
Opiates	0.70%	4,799	0.10%	N/A	686	0.10%	686
Heroin	0.50%	3,428	0.10%	N/A	686	0.00%	0
Methadone	0.40%	2,742	0.10%	N/A	686	0.00%	0
Class A/B							
Any amphetamine	8.90%	61,019	0.60%	N/A	4,114	0.10%	686
Amphetamines	8.80%	60,333	0.60%	0.40%	2,742	0.10%	686
Methamphetamine	0.50%	3,428	0.00%	N/A	0	0.00%	0
Class B							
Cannabis	30.20%	207,052	7.60%	6.30%	43,193	4.00%	27,424
Ketamine	3.10%	21,254	0.80%	N/A	5,485	0.30%	2,057
Mephedrone	1.70%	11,655	0.00%	N/A	0	0.00%	0
Class B/C							
Tranquillisers	2.80%	19,197	0.40%	N/A	2,742	0.20%	1,371
Class C							
Anabolic steroids	1.10%	7,542	0.20%	N/A	1,371	0.10%	686
New psychoactive substances	2.50%	17,140	0.50%	N/A	3,428	N/A	N/A
Nitrous Oxide	N/A	N/A	2.30%	N/A	15,769	N/A	N/A
Non-prescribed prescription only painkillers	N/A	N/A	6.40%	N/A	43,879	N/A	N/A
Any Class A drug	16.00%	109,696	3.70%	2.50%	17,140	1.30%	8,913
Any drug	34.20%	234,476	9.40%	7.90%	54,163	5.00%	34,280

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There is some variation in patterns of use between different age cohorts for example younger adults are more likely to be using nitrous oxide than the overall adult population (8.7% compared to 2.3%) and this may mean the true picture for Birmingham is slightly different given our larger proportion of young adults.

There is also variation in drug use patterns in different ethnic groups (Table 3). In general, drug use is highest in mixed ethnicity groups and white ethnicity groups within the population. Given Birmingham's significant diversity this reinforces the need for local approaches to consider cultural identity in the provision of services and support.

Table 3: Proportion of 16 to 59-year olds reporting use of illicit drugs by ethnic group in 2018/19[iii]

	Class A Drugs			**Class B Drugs**		**Any Drug**
	Any Class A	**Powder Cocaine**	**Ecstasy**	**Amphetamines**	**Cannabis**	
ALL ADULTS AGED 16 to 59	**3.7**	**2.9**	**1.6**	**0.6**	**7.6**	**9.4**
Ethnic group						
White	4.1	3.3	1.7	0.7	8.0	9.9
Non-White	1.9	1.1	1.0	0.1	5.9	6.7
Mixed	10.5	6.2	4.7	0.6	18.5	23.4
Asian or Asian British	0.5	0.3	0.3	0.1	2.8	3.0
Black or Black British	1.1	0.6	0.6	0.0	6.7	6.8
Chinese or other	1.7	0.6	1.2	0.0	7.5	8.4

The lesbian, gay, bisexual and transgender (LGBT) community has a higher than average reported use of recreational drugs and different patterns of drug misuse. A 2011 survey highlighted that 50% of respondents had used drugs for recreational purposes.

At a national level, communities that are most deprived have nearly three times the prevalence rate than the least deprived areas for opiate and/or crack cocaine use.

Steroid abuse is most commonly associated with male bodybuilders; however, the use has spread to female bodybuilders as well as into the recreational gym scene[iv]. One study in South Wales found over 70% of recreational gym users reported using anabolic steroids[v]. There is also reported use alongside the street drug scene where steroids can be used to counteract some of the anorexic effects of other drug addictions.

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7.3 Treatment and support

The main national focus of treatment and support commissioning guidance is on opioid drug addiction and harmful alcohol addiction. There is limited national emphasis on the treatment of club drugs, steroid abuse or NPS. This trend might be the result of individuals who tend to access treatment tend to be opiate users rather than anyone using any other type of substance, therefore the data available is likely to be opiate heavy. Provision of treatment and support services is not a statutory requirement but is a recommended service for commissioning through the local authority public health grant.

In 2020 it is estimated that 43% of opiate users in the City are engaged in treatment services. Those opiate users in treatment and new to treatment tend to have a relatively high level of multiple complexities compared to similar areas nationally and are an ageing cohort that is generating new areas of health and social care need.

In 2020 Birmingham City Council invested £14.8m in drug and alcohol treatment and support for all ages funded by the public health grant. A single system with a matrix of partnership providers has been commissioned to deliver these services. GP and pharmacy primary care, as well as the third sector, are part of the provider matrix led in 2020 by Change, Grow, Live (CGL). There is a range of service responses provided through this partnership including specific service elements focused on mental health, prison release, employment, criminal justice, blood-borne viruses, domestic abuse, acute sector, child protection and homelessness.

In 2018/19 5,399 people accessed treatment, 76% of these were male and 24% female, the largest age group was aged 30-39yrs but it is important to note that 13% of clients were over 50yrs old. Over 90% of people were in treatment for opioid drug addiction, with a much smaller number being treated for alcohol addiction or alcohol and non-opioid addiction. 1,757 people were new presentations to treatment, over 60% of these were White British, 7% were Pakistani and 5% Caribbean and just under 90% were UK nationals. Although most new presentations reported no religion, 18% were of a Christian faith and 8% were Muslim. At the time of presentation, 2% reported a lesbian, gay or bisexual sexual orientation and 27% of clients had at least one disability recorded.

At presentation, 8% of clients reported use of prescription-only medicines or over-the-counter medicines and 8% of clients reported use of club drugs.

99% of clients had an initial wait of less than three weeks to start treatment which is in line with the national average and unplanned exit from treatment was slightly lower than the national average (17% compared to 18%).

The local service compares well to the national picture in terms of opiate treatment with 47% completing treatment in under two years, 38% of users achieving abstinence at six-month review and 24% reporting a significant reduction in use.

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Treatment outcomes are tracked nationally through the Treatment Outcomes Profile which reviews outcomes for different drug types at six months in terms of abstinence, significantly reduced use and injecting use. Across most drug types the profile for Birmingham on abstinence at six months is not as strong as nationally, however, it is more positive for a significant reduction in use. A similar proportion of clients are no longer injecting at 6 months.

Successful completion of treatment by clients who do not re-present to treatment in Birmingham is slightly lower for Opiates than nationally (5.4% compared to 5.8%) but higher for Non-Opiates (37.9% compared to 34.4%).

In line with the national policy focus, the current service provision has primarily an opiate user focus although there is some service provision for alcohol addiction and other forms of drug addiction.

The commissioned system has a primary focus on treatment although the nationally funded individual placement support pilot has strengthened the approach to employment support for people in treatment. The focus on prevention, early intervention and longer-term recovery is an area that needs further development in the future.

Alongside the commissioned drug and alcohol treatment services there is a range of voluntary and community sector providers including peer-to-peer support groups and organisations like Alcoholics Anonymous, Cocaine Anonymous and Narcotics Anonymous, as well as charitable provision of residential rehabilitation support.

7.4 Drug overdose

Drug overdose is monitored at a national level as hospital admissions related to drug poisoning. As well as being a key issue to be addressed in themselves, poisoning admissions can be an indicator of future deaths. People who experience non-fatal overdoses are more likely to suffer a future fatal overdose.

Drug overdose is reported as a crude rate per 100,000 people. The most recent published data for 2018-19 suggests the rate in Birmingham is higher than the national average (Table 3).

Table 4: Crude rate of hospital admissions for drug poisoning (2018/19)

Indicator	Birmingham	England
Hospital admissions for drug poisoning (primary or secondary diagnosis) All persons, crude rate per 100,000	65.2	56.2

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7.5 Deaths related to drug misuse

Drug-related deaths in the UK are at a record high and have been increasing for the last four years. More specifically within the West Midlands, every three days someone dies from a drug poisoning; nationally over 54% of deaths involved opiates. There has been an increase in the number of overdose deaths due to the impact of fentanyl mixed with heroin in the UK drugs market. This highlights the importance of focusing on preventing these deaths and educating the public on the effects of drugs. The latest available data (2016-18)[vi] shows that the rate of deaths from drug use in Birmingham is 6.3 (per 100,000 population) and this is significantly higher than the England and West Midlands rates that are both 4.5. Birmingham has the second highest rate in the region behind Stoke-on-Trent and is the 6th lowest of the 8 Core Cities.

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8. The context of alcohol in Birmingham

There is in general more limited data on the scale of alcohol misuse and the impact in terms of crime and health services when compared to drug misuse.

8.1 The alcohol economy in Birmingham

In our city alcohol is often part of socialising and celebration and the hospitality and recreation sector is an important and valued part of Birmingham's economy, especially the vibrant night-time economy. Across the city there are over 170 supermarkets selling alcohol, with many more shops, bars and pubs with an alcohol licence.

In England we spend on average £16.30 per week on alcoholic drinks, of this about £8.10 per week is spent on alcoholic drinks away from home[vii]. The average spend per household in the West Midlands is slightly lower at £14.60 per week, however, the proportion of this spend for at-home consumption is higher than the national average (53% compared to 51%). Nationally the average household spend on alcohol has fallen over the last decade, especially in relation to the spend on alcoholic drinks away from home. This has been reflected in over 11,000 pubs closing over the last decade in the UK, although in the same period employment in pubs and bars has increased by 6%[viii].

In Birmingham, there are about 2.8 pubs per 10,000 people which is lower than the UK average of 5.8 pubs per 10,000. There are now about 220 fewer pubs in Birmingham than in 2001, a fall from 545 pubs in 2001 to 325 pubs in 2018. Approximately 5,000 people have jobs in Birmingham's pubs and bars, although this has fallen by 28.6% since 2001[ix]. Birmingham is also home to several breweries and distilleries which are important parts of our local economy.

In 2010, £42.1 billion was spent on alcohol in England and Wales alone. Alcohol is often heavily discounted so that it is now possible to buy a can of lager for as little as 20p or a two-litre bottle of cider for £1.69[x]. The pricing of alcohol is a national issue, but it is also a local issue in terms of business responsibility as well.

Much like healthy food the approach has to balance the practicalities of business, the importance of jobs and economic growth alongside the potential health impacts and risks of harm from alcohol misuse and addiction. We have to work constructively with businesses and communities to support responsible drinking across the city.

8.2 Alcohol misuse in Birmingham

Alcohol-related harm is largely determined by the volume of alcohol consumed and the frequency of drinking occasions.

In January 2016 the Chief Medical Officer (CMO) issued revised guidance on alcohol consumption, which advises that in order to keep to a low level of risk of alcohol-related harm, adults should drink no more than 14 units of alcohol a week. The 2011-2014 Health Survey for England found that almost double the proportion of adults in

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Birmingham abstain from alcohol compared to the national average (30.9% compared to 15.5%), and although the proportion of adults drinking more than 14 units of alcohol a week is lower in Birmingham than the national average it is still significant (18.9% compared to 25.7%).

Based on national prevalence rates it was estimated that there are approximately 12,667 adults in Birmingham with alcohol dependence in need of specialist treatment.

National data has highlighted there are variations in rates of harmful drinking in different ethnic groups, rates are highest in White British ethnic communities (Table 5).

Table 5: The percentage of adults nationally, by ethnic group, who drink at harmful or dependent levels (2014)

Ethnicity	% of adults drinking at harmful or dependent levels
White British	5.2%
White other	1.9%
Asian	1.0%
Mixed	3.9%
Black	3.5%

There is also variation depending on deprivation; 2.1% of adults in the most deprived decile were dependant drinkers, compared to 0.9% in the least deprived.

8.3 Treatment and support for alcohol misuse

In 2017/18, Birmingham had 1,617 dependent drinkers in alcohol treatment of which males were estimated to be 13% of those estimated to be in need, compared to 18% nationally. Treatment for alcohol misuse is part of the CGL commissioned service.

Analysis by Public Health England of clients in alcohol treatment in 2018-19 reported that 64% were male and 36% female which is comparable to the national gender balance. The largest proportion of clients in treatment were aged 40-49yrs and 50-59yrs, and it is important to note that 11% of clients in treatment were aged over 60yrs.

Analysis of clients presenting new to treatment in 2018-19 in Birmingham highlights that most clients are White British (66%) followed by Indian (5%) and Pakistani (4%) ethnicities. 89% of those presenting for treatment have a UK nationality and after no religion (45%), Christianity (23%) and Islam (4%) and Sikh (3%) are the most common faiths.

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3% of clients presenting new to treatment had a gay, lesbian or bisexual sexual orientation and 35% of clients had at least one disability.

100% of clients waited less than three weeks to start the first intervention for alcohol treatment. The service had a lower proportion of unplanned exits from treatment (11%) than the national average (14%).

It is important to highlight that the caseload of clients in Birmingham appears to have a higher proportion of severely dependent drinkers (32% of male and 26% of female clients) compared to the national profile (18% male and 15% female), however, there are a higher proportion of clients nationally where this profile is unknown.

The NICE Clinical Guidelines on treatment recommend that harmful and mildly dependent drinkers receive a three-month treatment intervention and for those with moderate and severe dependence this should be for a minimum of six months. In Birmingham the average time in treatment is 180 days compared to 186 days nationally, however, only 27% of clients leave treatment before 3 months compared to 35% nationally.

There are two key measures of in-treatment success, abstinence rates at planned exit and days of drinking change between start and planned exit. Birmingham had a lower proportion of individuals achieving abstinence at exit (49%) than nationally (51%). However, the service achieved a great change in the number of drinking days dropping from 22.2 at entry to 9.6 at exit, compared to 20.7 and 11.5 days nationally.

Successful treatment is measured in the context of the completion of treatment and the client not returning to alcohol within 6 months. Birmingham is achieving a slightly higher level of successful treatment against this indicator in 2018 (40%) than the national average (38%).

8.4 Alcohol overdose

Alcohol overdose is described in the context of admission episodes for intentional self-poisoning by and exposure to alcohol condition, it is reported as a directly standardised rate by gender of clients (Table 6). The rate of alcohol overdose is lower in Birmingham than nationally, especially for women.

Table 6: Directly standardised alcohol overdose rates for Birmingham and England (2017/18)

2017/18	Birmingham Per 100,000 adults	National rate Per 100,000 adults
Male	38.8	39.5
Female	47.7	53.0

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8.5 Impact of alcohol misuse

Alcohol consumption is a contributing factor to hospital admissions and deaths from a wide range of conditions which costs the NHS about £3.5 billion per year and society £21 billion annually.

Whilst the overall drinking rates in England have decreased from 2011 to 2016 (from 34% to 31% for males and 18% to 16% for women), Birmingham's (2017/18) hospital admissions for alcohol-related conditions are significantly higher than in England. For male admissions it was 3,553 per 100,000 (England 3,051) and for females 1,762 (England 1,513) (Table 7).

The Birmingham rate for alcohol-specific and alcohol-related mortality is significantly higher than the England average and has been over recent years. The latest period 2015/17, has the alcohol-specific mortality rate for Birmingham at 14.4 deaths per 100,000 population (England, 10.6 deaths). Similarly, the 2015/17 alcohol-related mortality rate for Birmingham is 53.3 deaths compared to the England rate of 46.2 deaths per 100,000 population.

Table 7: Hospital admissions counts and rates for alcohol-related conditions for Birmingham, West Midlands and England

Indicator	**Period**	**Birmingham**		**West Midlands**	**England**
		Count	**Rate/100,000**	**Rate/100,000**	**Rate/100,000**
Admission episodes for alcohol-specific conditions - <18yrs	2016/17-18/19	140	16.2	26.1	31.6
Admission episodes for alcohol-related conditions (narrow)	2018/19	6,748	706	739	664

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9. Drug and alcohol misuse amongst young people and their parents in Birmingham

Birmingham has a larger proportion of children and young people than the UK average and if we are going to address drug and alcohol misuse fully we have to explicitly consider how to work with them to change the city.

Drug and alcohol misuse impacts children and young people in many ways, either because they are themselves using alcohol or drugs, or their parents or other family members are, or because they are pawns in organised crime or victims of crime.

Although the number of young people who are using drugs and alcohol is much smaller than adults this is a highly vulnerable group. A Substance Misuse Needs Assessment for Children and Young People, was carried out in August 2018, shows:

Table 8: What About Youth (WAY) Survey 2014/15 (age 15): Birmingham results

Getting drunk in the last 4 weeks	Rates were lower in Birmingham than in England (5.9% vs 14.3%) Within Birmingham, rates were higher for girls than boys; highest for white ethnicity amongst girls and mixed ethnicity amongst boys
Ever trying cannabis	A lower proportion of Birmingham children reported ever trying cannabis (6.5%) than in England (10.5%) Within Birmingham, mixed ethnicity had the highest rates.
Taking cannabis in the last month	A lower proportion of Birmingham children reported taking cannabis in the last month (2.0%) than in England (4.55) Within Birmingham, rates were highest for black boys and mixed ethnicity girls.
Ever trying drugs other than cannabis	A lower proportion of Birmingham children reported ever trying drugs other than cannabis (1.4%) than in England (2.4%) Within Birmingham, rates were higher for girls; highest for white girls and black boys
Taking drugs other than cannabis in the last month	A very low proportion of Birmingham children reported taking drugs other than cannabis in the last month (0.2% vs 0.8% in England)

Young people receiving interventions for substance misuse have a range of vulnerabilities that require specialist support and intervention. Those in treatment often say they:

- are/were victims of domestic violence
- have contracted a sexually transmitted infection
- have experienced sexual exploitation

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And are more likely to:

- not be in education, employment or training and
- be in contact with the youth justice systems

Table 9: Numbers affected in Birmingham: 11-15 year olds

	National Prevalence %	**Estimated B'ham Prevalence (ethnicity adjusted) %**	**Est. number in B'ham population aged 11-15yrs N=73,252 (2016)**
Ever taken drugs	23.9	26.0	19,000
Taken drugs in the last month	17.4	18.2	13,300
Taken drugs in the last month	9.7	9.8	7,200
Ever drunk alcohol	45.3	30.4	22,300
Drunk alcohol in the last week	10.3	5.7	4,200
Ever smoked	19.0	16.3	12,000
Current smokers	6.3	5.0	3,600
Regular smokers	2.7	2.0	1,500

Table 10: Number affected in Birmingham: 16-24 year olds

	National Prevalence %	**Estimated numbers in Birmingham population aged 16-24 N=169,046 (2016)**
Infrequent drug users (once or twice a year)	46	77,800
Frequent drug users (>once a month)	4.1	7,000
Taken NPS in the last year	1.2	2,000
Number drinking >8/6 units on heaviest drinking day	20.4	34,500

Source: Smoking, drinking and drug use among young people, 2016

9.1 Young people in treatment 2019/20

Young People's substance misuse treatment services in Birmingham offer support to anyone under 18 years who has a substance misuse problem, or who is affected by parental (or guardian) substance misuse.

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This support is delivered by means of a service offering brief interventions and advice, comprehensive assessment and care planning and 1:1 structured interventions. The current contract for the service was awarded to Aquarius Action Projects in October 2019 for a period of 2 years with an option to extend for a further two years (e.g. 2 + 1 + 1) subject to available funding and satisfactory performance.

On 31st December 2019 there were:

- 350 under 18s in treatment (up 5% compared to previous rolling year)
- 56 in a secure estate
- 0 over 18s in YP services
- 93% wait less than 3 weeks
- 80% had planned exits (England 82%)
- 30% drug-free (England 33%)
- Main substances: cannabis (95%), alcohol (44%), nicotine (3%), cocaine (3%) and Solvent (4%)

9.2 Parental substance misuse

Dependent parental alcohol and drug use has an adverse impact on children, particularly regarding their physical health, psychosocial wellbeing and personal alcohol and drug use.

There is increasing evidence that adverse childhood experiences (ACEs) such as living in a household with problem alcohol use can contribute to long-term harms. If a child experiences four or more risk factors during childhood they have a substantially higher risk of developing health-harming behaviours, such as smoking, heavy drinking and cannabis use.

A report by the Children's Commissioner produced in July 2018 showed:

- 30,000 children and young people aged under 18 in Birmingham are living with an adult who has reported substance misuse
- Of these, over 11,000 are living with an adult who is dependent on drugs or alcohol
- Of these, 2,500 are living with an adult who also has severe mental health problems and has experienced DV

The Quarter 2 Diagnostic Outcomes Monitoring Executive Summary 2019/20 shows:

- There are 1,564 adults currently accessing treatment who live with children (this represents 22.6% of all adults accessing treatment)
- 19.3% of all adults starting treatment in quarter 2 were adults living with children
- 8.9% of children were on Child Protection Plans (higher than the national average of 7%)
- 2.9% of children were looked after (national average of 2.9%)

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Although a small number of pregnant women present each year for treatment for drug or alcohol misuse these are an important group and our local maternity providers have specialist midwives who are trained to work with these women and support them through pregnancy and work with treatment providers to achieve positive outcomes for bother mother and baby.

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10. Our framework for action

The framework for action is focused on delivery through six themed workstreams that will work together to create a safer, healthier city.

The six themed workstreams are:

1. Prevention
2. Early intervention
3. Treatment, support and recovery
4. Children and young people
5. Additional challenges
6. Data and evidence

Through the six workstreams there a five 'golden threads' which weave across all of the Forum frameworks for action:

Citizen first
We will put the citizen at the heart of our approach, working with citizens across the city to help co-produce a healthy, sustainable, economically viable environment that is accessible to everyone.

Regulation and enforcement
We want to support businesses to be financially and environmentally sustainable and make the most of the everyday contact between regulation and enforcement authorities in the city and the region to support businesses to work towards our shared ambition of a city in which people enjoy alcohol responsibly and without it causing harm.

Diversity and inclusion
We know that there are significantly different relationships with drugs and alcohol in different cultures and communities across the city and as we progress this work we want to work with these communities to find solutions and approaches that work in the context of celebrating this diversity.

Scale and pace
Birmingham is a large city with a diverse community and it is important that we keep a focus on moving at pace and scaling to reach every part of Birmingham with our work, building on success and finding ways to scale across the whole city to ensure every citizen benefits.

Learning and listening
We also know we need to listen and be humble in our approach, learning in true partnership with cities, in the UK and across the world, as well as learning from research, practice-based evidence and our citizens. We will be open and honest in our conversations about the challenges as well as the opportunities and successes.

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10.1 Workstreams of action

Through the development of the action plan that will deliver this strategy, we will review the evidence and take an action-learning approach to the action plan to move at pace to address the drivers of addiction as well as support those whose lives are blighted by the impact.

The six workstreams of action will create a framework for delivering the vision and ambition of the strategy.

(1) Prevention

Prevention requires action on multiple levels across the city to reduce the supply of drugs and saturation of alcohol as well as reducing demand. Action on prevention may include:

- Disrupt and close-down organised crime that underpins the drug trade
- Challenge the saturation of low-cost alcohol sales
- Education and awareness-raising, especially with communities most at risk
- Exploring opportunities to tackle sales of steroids and nitrous oxide in the city
- Targeted social marketing and awareness work with communities at the highest risk
- Medicine monitoring and support in healthcare settings to tackle prescription and over the counter medicine misuse
- Work with key settings such as workplaces, schools and universities to support organisational approaches to reducing drug and alcohol misuse

(2) Early intervention

Early intervention is about providing support to prevent addiction from forming and providing alternative ways of managing the stress and pressures that are pushing people towards misuse. Action on early intervention may include:

- Promoting access to peer support and self-care early interventions
- Increasing training and awareness among professionals working with communities most at risk
- Work with community and performance gyms to raise awareness of steroid abuse risks and impacts
- Continue to strengthen the collaboration between homelessness, mental health and substance misuse services
- Explore how to better support family and friends to enable peer early intervention and support

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(3) Treatment, support and recovery

Treatment aims to help people to manage their addiction, ideally with the ambition to achieve a life free of drug or alcohol misuse, or where this is not possible to achieve a level of maintenance which enables them to actively participate in society. Action on treatment, support and recovery may include:

- Continue to support drug and alcohol treatment services in line with national commissioning guidelines and national provided funding resources
- Continue to review the models of care provided against the emerging pattern of usage
- Employment support for people accessing drug or alcohol treatment services and work with employers to encourage the provision of job opportunities
- Increase connectivity between commissioned professional treatment services and community-based mutual aid groups such as Alcoholics Anonymous, Cocaine Anonymous and Narcotics Anonymous
- Explore innovative models of risk minimisation in treatment such as heroin-assisted treatment and safer injecting facilities

(4) Children and young people

The impact of drugs and alcohol on children and young people can last a lifetime and it is important that we have a specific focus on their needs and issues as well as engage them in active solutions for the city. Action on children and young people may include:

- Address youth gang violence and crime and particularly tackle organised crime's use of children and young people in drug trafficking
- Integrate drug and alcohol prevention and early intervention into other services concerned with reducing risky behaviours in children and young people such as sexual health or truancy
- Support schools to deliver high-quality evidence-based education on personal resilience in all educational settings including schools, and universities
- Promote access for young people to accurate information about drugs to allow them to make informed choices
- Increased screening and referral of young people at risk of substance misuse through mainstream services working with higher risk groups
- Ensure that drug and alcohol treatment services have strong relationships with social care and safeguarding support to ensure children and young people in families where there is substance misuse are safe and protected
- Ensure that support for children and young people is closely joined up to support for adults so that young people get the support they need as they get older and transition between services.

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(5) Additional challenges

Many individuals who are struggling with addiction face additional challenges. These include homelessness/insecure housing, living with mental health issues, experiencing violence, coercion or abuse or involvement in the criminal justice system.

In 2018/19 the drug treatment service identified 35% of new presentation clients had a mental health condition. In alcohol treatment, this was higher at 40%. Of these, 72% of those in drug treatment and 80% of those in alcohol treatment were receiving active mental health treatment from their GP or the Community Mental Health team. In the same cohort 17% of those with drug issues and 10% of those with alcohol issues presented with a housing problem or no fixed abode at the start of treatment.

14% of newly presenting clients for drug treatment and 18% of those presenting for alcohol treatment in 2018-19 were living with children and a further 35% in drug treatment and 25% in alcohol treatment are parents but not living with children. It is important that through our approach we consider the additional challenges of drugs and alcohol not just on individuals but also on their families, especially their children. We will make sure that children living in families and households where adults use drugs and alcohol are safe and supported.

In the same year 3% of women presenting for drug treatment, and 2% presenting for alcohol treatment, were pregnant, although this is a small number, these are a particularly high-risk group to consider.

It is important that we specifically consider the needs of these individuals in developing our approach generally and also consider where explicit intervention is needed. Action on people with additional challenges may include:

- Additional targeted training and awareness to support engagement and referral for people accessing mental health or housing services
- Specific work with the Birmingham Children's Trust to strengthen links and support for families where a parent or family member is misusing alcohol or drugs
- Specific work with Birmingham United Maternity Partnership (BUMP) to ensure interconnected pathways of care and support for mothers with addiction issues
- Specific work with the criminal justice health system to address drug and alcohol issues within custody and through probation and youth justice services

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(6) Data and evidence

Through the work to deliver this strategy, we aim to increase the understanding of the picture of drug and alcohol misuse and addiction in the city and strengthen the evidence base for what works. Action on data and evidence may include:

- Developing a more detailed local data set of indicators to track progress and impact
- Explore the potential for economic indicators and metrics to look at the impact of low-cost alcohol
- Research into steroid, nitrous oxide, club drug and NPS to better understand patterns of use and supply chains
- Research to better understand the cultural context of alcohol and substance misuse and the inequalities within the city

10.2 Measuring success

The Triple Zero City Strategy has three headline objectives:

- Zero deaths due to drug or alcohol addiction
- Zero overdoses due to drug or alcohol addiction
- Zero people living with addiction to drugs or alcohol not receiving support to manage their addiction

The baseline data for these three objectives are:

10.2.1 Deaths attributable to alcohol misuse

Deaths from alcohol misuse are measured through two nationally reported indicators (Table 11):

Alcohol-Specific Mortality - Deaths from alcohol-specific conditions, all ages, directly age-standardised rate per 100,000 population. Reported annually by Public Health England.

Alcohol-Related Mortality - Deaths from alcohol-related conditions, all ages, directly age-standardised rate per 100,000 population. This includes deaths of children where parental alcohol use was a significant contributing factor such as foetal alcohol syndrome causing infant mortality. Reported as a 3yr average rate.

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Table 11: Birmingham deaths attributable to alcohol

		2016-18	2015-17	2014-16	2013-15	2012-14
Alcohol-Specific Mortality	*Persons*	15.0	14.4	14.3	14.2	13.9
	Males	22.3	21.7	21.9	21.6	21.2
	Females	8.1	7.7	7.3	7.2	6.9
		2018	**2017**	**2016**	**2015**	**2014**
Alcohol-Related Mortality	*Persons*	57.4	53.2	53.0	51.9	59.2
	Males	83.1	79.2	79.8	77.5	92.0
	Females	35.2	31.4	30.1	30.4	30.9

10.2.2 Deaths attributable to drug misuse

Deaths from drug misuse are measured through one nationally reported indicator (Table 12):

Deaths in drug treatment, mortality ratio - The indicator is calculated as a three-year rolling average expressed per 100,000 population and is published by the Office of National Statistics (ONS). ONS data is based on the current National Statistics definition of deaths related to drug poisoning by both legal and illegal drugs and includes accidents, suicides and assaults involving drug poisoning, as well as deaths from drug misuse and drug dependence. From these, a smaller number of cases are selected that satisfy a definition of drug misuse deaths (a) deaths where the underlying cause is drug abuse or drug dependence or (b) deaths where the underlying cause is drug poisoning and where any of the substances controlled under the Misuse of Drugs Act (1971) are involved.

Table 12: Birmingham deaths attributable to drugs

		2014/15 - 16/17	2013/14 - 15/16
Deaths in drug treatment	*Count*	122	102
	Mortality Ratio/100,000	0.77	0.70

10.2.3 Overdose

For alcohol we are using the following indicator as a metric to measure impact:

Admission episodes for intentional self-poisoning by and exposure to alcohol
Admissions to hospital where the secondary diagnosis is an alcohol-attributable intentional self-poisoning by and exposure to alcohol code on the hospital record system. It is reported each financial year as sex-specific annual average rates calculated per 100,000 population (Table 13).

Table 13: Admission episodes for alcohol poisoning and exposure in Birmingham

		2017-18	2016-17	2015-16	2015-14	2014-13
Admission episodes for intentional self-poisoning by and exposure to alcohol	*Persons*	43.2	49.0	53.7	50.9	49.8
	Males	38.8	47.5	46.7	46.9	47.7
	Females	47.7	50.7	60.7	54.8	51.8

For drugs we are using the following indicator as a metric to measure impact:

Admission episodes with a primary diagnosis of poisoning by drug misuse **-** Admissions to hospital where the primary diagnosis is poisoning by drug misuse as coded on the hospital record system. It is reported each financial year as annual average sex-specific rates calculated per 100,000 population (Table 14).

Table 14: Admission episodes with a primary diagnosis of drug misuse poisoning in Birmingham

		2017-18	2016-17	2015-16	2015-14	2014-13
Admission episodes with primary diagnosis of poisoning by drug misuse	*Persons*	37	26	28	27	23
	Males	40	31	32	33	26
	Females	34	21	24	22	21

10.2.4 People not receiving treatment/support

For alcohol we are using the following indicators as metrics to measure the proportion of people not accessing treatment and support for alcohol (Table 15):

Number in treatment at specialist alcohol misuse services - The total number of individuals who received treatment at a specialist alcohol misuse service. Reported annually in financial years.

Proportion of people waiting more than 3 weeks for alcohol treatment - Proportion of first alcohol treatment interventions where the person waited over 3 weeks to commence treatment. Reported annually in financial years.

Proportion of dependent drinkers not in treatment - The estimated proportion of alcohol-dependent adults in the given year who were not in contact with alcohol treatment services in that year. Reported annually in financial years.

Table 15: Number in alcohol treatment indicators for Birmingham

	2017/18	**2016/17**	**2015/16**	**2014/15**
Number in treatment at specialist misuse services (persons)	1413	1,895	1,824	2,105
Proportion waiting more than 3 wks for alcohol treatment (persons)	1.0%	1.4%	5.8%	10.5%
Proportion of dependent drinkers not in treatment (%)	N/A	81.1%	82.3%	79.3%

For drugs we are using the following indicators as metrics to measure the proportion of people not accessing treatment and support for opioid drugs (Table 16):

Proportion of opioid users not in treatment – The estimated proportion of the local opiate users in the given year who were not in contact with drug treatment services for an opiate problem in that year. Reported for adults aged 15-64yrs, annually in financial years.

Proportion of people waiting more than 3 weeks for opioid drug treatment - Proportion of first opioid drug treatment interventions where the person waited over 3 weeks to commence treatment. Reported annually in financial years and this measure has evolved in the way this is reported due to providers recording this incorrectly in the past.

Table 16: Number in drug treatment indicators for Birmingham

		2016/17	**2015/16**	**2014/15**
Proportion of opioid users not in treatment (persons)	Count	3,159	3,325	3,228
	%	38.4%	40.4%	39.2%
Proportion waiting more than 3 wks for opioid drug treatment (persons)	Count	13	52	112
	%	0.4%	1.7%	3.7%

We will develop a further matrix of proxy metrics based on local service data which will enable us to monitor the implementation and impact of the strategy.

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11. Governance

The Triple Zero City Strategy will be overseen by the Health and Wellbeing Board, as a statutory committee of Cabinet.

The Framework for Action workstreams will be delivered through the Creating a City Without Inequality Forum, which reports to the Health and Wellbeing Board, under the leadership of the Cabinet Member for Inequalities and Community Cohesion.

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