

Drug treatment in the South East 2006/07

**Analysis from the National Drug Treatment Monitoring System (NDTMS)
including an update of Choosing Health in the South East: Problem Drug Use**



Photographs: Left, opium poppy head. Above right, powder cocaine and snorting equipment. Below right, injecting paraphernalia.
Source: Home Office www.drugs.gov.uk

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Key Points

This report provides a summary of data from the National Drug Treatment Monitoring System (NDTMS) for the financial year 2006/07. Analysis of data from the Drug Interventions Records (DIR) for 2003-2007 is also included alongside an update of analysis from the 2006 SEPHO Choosing Health in the South East: Problem Drug Use report.

- During 2006/07 there were approximately 19,000 people in contact with the treatment system in the South East, of which 3,000 were young people, aged under 17 years.
- The number of clients in treatment in the South East has increased by 130% from quarter four of 2004/05 to quarter four of 2006/07.
- Males aged between 25 and 34 years form the largest demographic of clients in treatment in 2006/07.
- The average age of clients in treatment in the South East during 2006/07 was 30.6 years.
- Over half of clients in treatment in 2006/07 in the South East reported heroin as their primary drug.
- Over 85% of young people in treatment in the South East during 2006/07 reported either alcohol or cannabis as their primary drug.
- Youth Offending Teams (YOT) were the principle source of referrals of young people into treatment in the South East during 2006/07.
- The majority of clients in tier 3 and 4 treatment in the South East in 2006/07 used specialist prescribing within their structured treatment programme.
- Between quarter one 2004/05 and quarter four 2006/07 there was an increase in percentage of planned discharges of 13.5 percentage points.
- Between April 2005 and March 2007 non-intensive DAT areas in the South East processed information on over 3,500 clients in the community and just under 8,000 individuals in prisons.
- There is considerable variation in drug related hospital admissions between DAT areas in the South East in 2005/06.
- The average rate of drug-related deaths in the South East between 2003 and 2005 was 2.3 per 100,000 population.

Glossary

BME – Black and Minority Ethnic

CDRP - Crime and Disorder Reduction Partnership

CJS – Criminal Justice System

DAAT – Drug and Alcohol Action Team

DAT - Drug Action Team

DIP – Drug Interventions Programme

DIR – Drug Intervention Record

DTMU – Drug Treatment Monitoring Unit

GP – General Practitioner

ICD-10 – International Classification of Disease 10th edition

MoC – Models of Care

NDTMS – National Drug Treatment Monitoring System

NHS – National Health Service

NTA – National Treatment Agency for substance misuse

PCT – Primary Care Trust

YOT – Youth Offending Team

Drugs glossary

(from www.talktofrank.com)

Cannabis

The most widely used illegal drug in Britain. It's a naturally occurring drug made from parts of the cannabis plant. It's a mild hallucinogen and often gives sedative like effects that make some people feel 'chilled out' and others feel sick. It's not very expensive and widely available.

ID: Bhang, black, blast, blow, blunts. Bob Hope, bush, dope, draw, ganja, grass, hash, hashish, hemp, herb, marijuana, pot, puff, Northern Lights, resin, sensi, sinsemilla, shit, skunk, smoke, soap, spliff, wacky backy, weed, zero. Some names are based on where it comes from – Afghan, homegrown, Moroccan etc.

Appearance and use

Cannabis comes in different forms. Hash is a blacky-brown lump made from the resin of the plant. It's quite often squidgey. Grass or weed is the dried leaf of the plant. It looks like tightly packed dried garden herbs.

Less common is sinsemilla. This is bud grown in the absence of male plants and has no seeds. And cannabis oil that is dark and sticky and comes in a small jar.

Most people mix cannabis up with tobacco and smoke it as a spliff or a joint. Some people put it in a pipe. Others make tea with it or put it in food like cakes.

Cost

Varies widely around the country. Grass is usually more expensive than resin (hash).

Cocaine

Cocaine and crack are both stimulants with powerful, but short-lived effects. The main difference is that crack is much stronger and more addictive than cocaine.

ID: Cocaine is also known as coke, charlie, C, white, Percy, snow, toot.

Appearance and use

Coke is a white powder that's usually divided into lines on a smooth surface and snorted up the nose with a rolled up bank note or a straw. It can be smoked and is sometimes made into a solution and injected.

Cost

A gram of coke generally costs between £40 and £60.

Crystal meth

Methylamphetamine (commonly referred to as methamphetamine) is one of a group of a psychostimulant drugs called amphetamines that act on the brain and nervous system.

ID: Methamphetamine, Methylamphetamine, Ice, Glass, Tina, Christine, Yaba, Crazy medicine.

Appearance and use

Illicit methylamphetamine is produced in tablet, powder, or crystalline forms. These products are taken orally, snorted or can be prepared for injection, but unlike amphetamine, methylamphetamine can also be smoked.

The powder is sometimes referred to as 'crystal meth', but this term is more often used for the purer crystalline form, also known as 'ice', 'glass', 'tina' and 'christine'.

The tablet form is sometimes referred to as 'yaba'.

Crack

Crack is a smokeable form of Cocaine that's made into small lumps or rocks. It's called crack because it makes a crackling sound when it's being burnt. It's a stimulant with short-lived effects and it's very addictive.

ID: Crack is also known as rocks, wash, stones, pebbles, base, freebase.

Appearance and use

A rock of crack is about the size of a raisin. It's usually smoked in a pipe, glass tube, plastic bottle or in foil. Most people take it this way and it's known as freebasing. Although it can be injected.

Cost

A rock costs between £12 and £20 although it's sometimes sold cheaper by the slice or as a 'clubbing rock' for about £10.

Ecstasy

The original designer drug, Ecstasy shot to fame in the early 90s as the rave culture took off and clubbers took it to stay awake and dance for hours. An estimated 500,000* people take it every weekend. There's a lot of controversy about the long-term side effects of E. Some evidence suggests it can damage the brain causing long-term problems. *Source: www.drugscope.org.uk

ID: Adam, E, pills, brownies, burgers, disco biscuits, hug drug, 'Mitsubishis', 'Rolexes', 'Dolphins', XTC

Appearance and use

Pure Ecstasy is a white crystalline powder known to chemists as MDMA. Ecstasy sold on the street is usually in tablet form although it's getting more common to see it sold as powder. Es come in all sorts of colours and some of them have pictures or logos stamped into them. They are usually swallowed although some people do smoke or snort them.

The effects take about half an hour to 'kick in' and tend to last between three and six hours, followed by a gradual comedown. It's the drug of choice for many clubbers and 4% of 16–25 year olds have taken some in the last three months.

Cost

Between £3 and £8 depending on the type of pill and where it was obtained.

GHB

Not to be mistaken with GBH the crime, although there are reasons why people might confuse the two. GHB is a dangerous drug which can cause grievous bodily harm. That's because it's hard to tell the difference between a dose that gives a pleasant buzz and an overdose that could kill you.

ID: GHB, GBH, Liquid Ecstasy, gammahydroxybutrate.

Appearance and use

GHB is usually sold as an odourless liquid in small bottles or capsules. It's rarer but it does come in powder form. It tastes slightly salty. A teaspoon or a capful is a normal dose although strength of GHB varies so it can be very difficult for people to know how much they are taking. The effects start between ten minutes and one hour after taking it and can last up to a whole day.

Cost

A 30ml plastic container is about £15.

Gases, glues and aerosols

Solvents cover a huge number of substances:

Gas lighter refills, aerosols containing hairspray, deodorants and air fresheners, tins or tubes of glue, some paints, thinners and correcting fluids, cleaning fluids, surgical spirit, dry-cleaning fluids and petroleum products

When inhaled, solvents have a similar effect to alcohol. They make people feel uninhibited, euphoric and dizzy.

ID: Gases, Aerosols, Glue, Thinners, Volatile Substances

Appearance and use

All sorts of famous household names. Each contain different substances with different effects. Solvents are sniffed from a cloth, a sleeve or a plastic bag. Some users put a plastic bag over their heads and inhale that way. Gas products can be squirted directly into the back of the throat which makes it difficult to control the dose.

Most users are between 11 and 16.

Cost

Solvents are cheap and can be bought for as little as £2.

Heroin

Heroin is a natural opiate. It's made from the morphine which comes from the opium poppy. Like many drugs made from opium, including the synthetic opioids like methadone, heroin is a very strong painkiller.

Heroin sold as 'brown' is sometimes used by clubbers as a 'chill out'. Brown is still heroin, some people mistakenly think it's not as addictive.

ID: Brown, skag, H, horse, gear, smack.

Appearance and use

Heroin comes as a white powder when it's pure. But because of the range of substances it's 'cut with', street heroin can be anything from brownish white to brown.

It can be smoked, snorted or dissolved in water and injected.

Cost

A heroin habit can cost up to £100 a day.

Ketamine

Ketamine is a short-acting but powerful general anaesthetic which has been used for operating on humans and animals. It has powerful hallucinogenic qualities. Ketamine first appeared on the streets in the US in the 70s.

ID: Green, K, special K, super K, vitamin k

Appearance and use

Legally produced ketamine comes in liquid form which is injected. The illegally produced version usually comes as a grainy white powder which is snorted or bought as a tablet.

Khat

Khat is a stimulant with similar effects to amphetamine. It comes from a leafy green plant of the same name. Used mostly in Africa, Khat is getting more common in Europe particularly in immigrant communities.

ID: Khat, quat, qat, qaadka, chat, Catha edulis

Appearance and use

Khat is a leaf which is chewed over a number of hours.

Cost

A 'hit' which is a small bunch of leaves costs around £4.

Magic mushrooms

Magic Mushrooms are mushrooms which grow in the wild that produce similar effects to LSD when you eat them. There are two main types and they are both very different. The most common form is a species called psilocybe, the other more potent variety is amanita muscaria. There are deadly poisonous species of amanitas.

ID: Liberties, magics, mushies, liberty cap, psilcybe semilanceata, psilcybin, shrooms, Amani agaric, Fly Agaric.

Appearance and use

Psilcybin mushrooms are small and tan coloured and bruise blue when they're touched. Amanita Muscaria are more like the red and white spotted toadstools in fairytale books. After picking, they're both either eaten raw or dried out and stored. Most people take between 1–5 grams.

Cost

Free if you know where to find them or up to £5 for a handful.

Methadone

Opiates are derived from the opium poppy. Opium is the dried milk of the opium poppy. It contains morphine and codeine, both effective painkillers. Methadone is one of a number of synthetic opiates (also called opioids) that are manufactured for medical use and have similar effects to heroin. These include dihydrocodeine (DF118s), pethidine (often used in childbirth), diconal, palfium and temgesic.

Methadone and subutex (buprenorphine) are used as substitutes for heroin in the treatment of heroin addiction.

ID: methadone, methadone mixture, meth, linctus, physeptone.

Other synthetic opiates include: DF118 (dihydrocodeine), pethidine, diconal (containing dipipanone), palfium (dextromoramide) and temgesic or subutex (buprenorphine).

Appearance and use

The methadone that's prescribed to people trying to 'come off' heroin is usually a syrup which is swallowed. Pethidine, dihydrocodeine (DF118s), diconal, palfium, temgesic and also some types of methadone come in tablet or injectable form.

Effects can start quickly and can last several hours but this varies with how much is taken and how much the drug is taken.

Cost

The street cost of methadone is £1 per 10ml.

PMA

PMA looks like and is being sold as Ecstasy. The effects are very similar to E but PMA is much stronger and can cause a fatal rise in body temperature. The effects of PMA take longer to happen. Some users have taken a fatal overdose by mistakenly taking pill after pill waiting for PMA to take effect.

ID: Chicken yellow, chicken fever, double stacked, mitsubishi turbo, red mitsubishi, killer, para-methoxyamphetamine, paramethoxymethamphetamine

Appearance and use

PMA is usually a white pressed tablet. They're often underscored, 7mm in diameter and 6mm thick. They weigh about 230mg. Unusually thick compared to ecstasy, they've been nicknamed 'double stacked'.

Like Ecstasy, PMA is swallowed.

Cost

Between £3 and £8.

Poppers

Poppers are small bottles filled with liquid chemicals called Amyl Nitrates. They were used at the turn of the century for people suffering from chest pains. Nitrites like Amyl Nitrite dilate the blood vessels and allow more blood to get to the heart. They're usually sniffed straight from the bottle and deliver a short, sharp high. Poppers are sold in sex shops, clubs and gay bars.

ID: Amyl nitrite, butyl nitrite, isobutyl nitrite, Ram, Thrust, Rock Hard, Kix, TNT, Liquid Gold

Appearance and use

Nitrites originally came as small glass capsules that were popped open, hence the name. Nowadays they're available in small bottles with brand names like Ram, Thrust and Rock Hard. The effects fade after a couple of minutes.

Cost

£2–£5 per bottle

Speed

Speed is the street name for Amphetamine. Like coke it is a stimulant that people take to keep them awake and alert. It's Britain's least pure illegal drug. It's often taken along with E.

Appearance and use

Amphetamines like speed are usually sold in 'wraps' like cocaine. The powder is off-white or pinkish and can sometimes look like small crystals. Base speed is purer and is a pinkish-grey colour and feels like putty.

Crystal Meth (Methamphetamine or Methylamphetamine) is processed speed that looks like off-white rocks or crystals. Both Speed and Crystal Meth are amphetamines although Crystal Meth is able to be smoked, it is much stronger and more likely to lead to dependence.

Prescription amphetamines like dexamphetamine are usually small white pills.

Speed's either dabbed onto the gums or sniffed in lines like cocaine using a rolled up bank note. Sometimes it's rolled up in cigarette paper and swallowed. This is called a speedbomb. It can be mixed in drinks, or injected and methamphetamine can be smoked in its 'crystal' form.

The effects 'kick in' after about half an hour if ingested but much quicker if injected or smoked (methamphetamine) and can last for up to six hours. It depends on the quality of the speed. The 'high' is followed by a long slow comedown.

ID: Amphetamine Sulphate, Phet, Billy, Whizz, Sulph, Base, Amphetamine, Paste, Dexamphetamine, Dexies, Dexedrine

Cost

£8–£12 per wrap

Tranquillisers

Tranquillisers are manmade drugs produced to treat anxiety, depression and insomnia. Manufactured to be prescribed by a doctor, they're designed to reduce anxiety and promote calmness, relaxation and sleep.

There are hundreds of different tranquillisers around but most common are the Benzodiazepines. Benzos, as they're sometimes called, come in over 50 different forms. Some people extract the liquid from temazepam capsules and inject it as a substitute for heroin. This is extremely dangerous as the thick liquid easily blocks veins and can lead to limb amputations.

ID: Jellies, benzos, eggs, norries, rugby balls, vallies, moggies, mazzies, roofies, downers.

Appearance and use

Tranquillisers come as tablets, capsules, injections or suppositories (tablets you put up your bum). They're often used as 'chill out' drugs on the club scene. Some people use them to 'come down' from acid, speed or ecstasy.

Cost

Around £1 for four 5mg capsules

Statistical methods

Standardised rates

Standardisation allows like to be compared with like, by making sure that differences in the number of events (e.g. numbers of people in treatment or drug-related deaths) observed in two or more populations are not due to differences in the age and sex profile between the different populations. (For example, suppose population A has a higher death rate than population B. However, if population A also has a higher proportion of older people, then we would expect there to be more deaths and it would be misleading to infer that people are dying at a faster rate in population A than population B). Directly standardised rates adjust for differences age and sex distribution by applying observed rates (e.g. numbers of people in treatment or drug-related deaths) for each age band in the study population to a standard population structure to obtain a weighted average rate. The standard population used in this report is the European Standard Population.

Crude rates

A crude rate is the number of observations divided by the appropriate population multiplied by 100,000 (or other appropriate multiplier).

Confidence intervals

Confidence intervals (CIs) are a way of expressing how certain we are about an estimate, such as an estimated prevalence based on the results for a small sample of the population. CIs define a range of values which we are 95% certain contains the true value. They are often shown on charts as a shape like a capital I. When the CIs for two values do not overlap we can say that the difference between the two values is statistically significant.

Treatment interventions

Within a treatment episode a client can have one or more treatment modalities. NDTMS records treatment modalities from agencies providing tier 2, 3 and 4 services, however the treatment system is monitored by Central Government on structured treatment within tiers 3 and 4. Treatments in tier 3 include prescribing, psychosocial interventions and structured day programmes, tier 4 includes inpatient treatment and residential rehabilitation. Tier 2 services include advice and information and aftercare.

Community and specialist prescribing

The National Treatment Agency (NTA) define specialist prescribing as normally including comprehensive assessments of drug treatment need and the provision of a full range of prescribing treatments in the context of care planned drug treatment.

Specialist prescribing is typically provided in a secondary care setting whereas GP prescribing, another method of community prescribing, is provided in a primary care setting, such as a GP practice which is commissioned by the Primary Care Trust (PCT). GP prescribing should be provided within a care plan with regular keyworking, and provision of appropriate psychosocial or other interventions as required.

(NTA, Models of Care update 2006)

Psychosocial interventions

The NTA Models of Care 2006 provides this definition of psychosocial interventions.

The term 'structured psychosocial interventions' replaces the old term 'structured counselling' and has been used for NDTMS monitoring since April 2006. Structured psychosocial interventions are clearly defined, evidence-based psychosocial interventions, delivered as part of a client's care plan. These interventions are normally time limited and should be delivered by competent practitioners.

Evidence-based psychosocial interventions include:

- Cognitive behaviour therapy (CBT)
- Coping skills training
- Relapse prevention therapy
- Motivational interventions
- Contingency management
- Community reinforcement approaches
- Some family approaches

Tiers of treatment (Models of Care 2006, NTA)

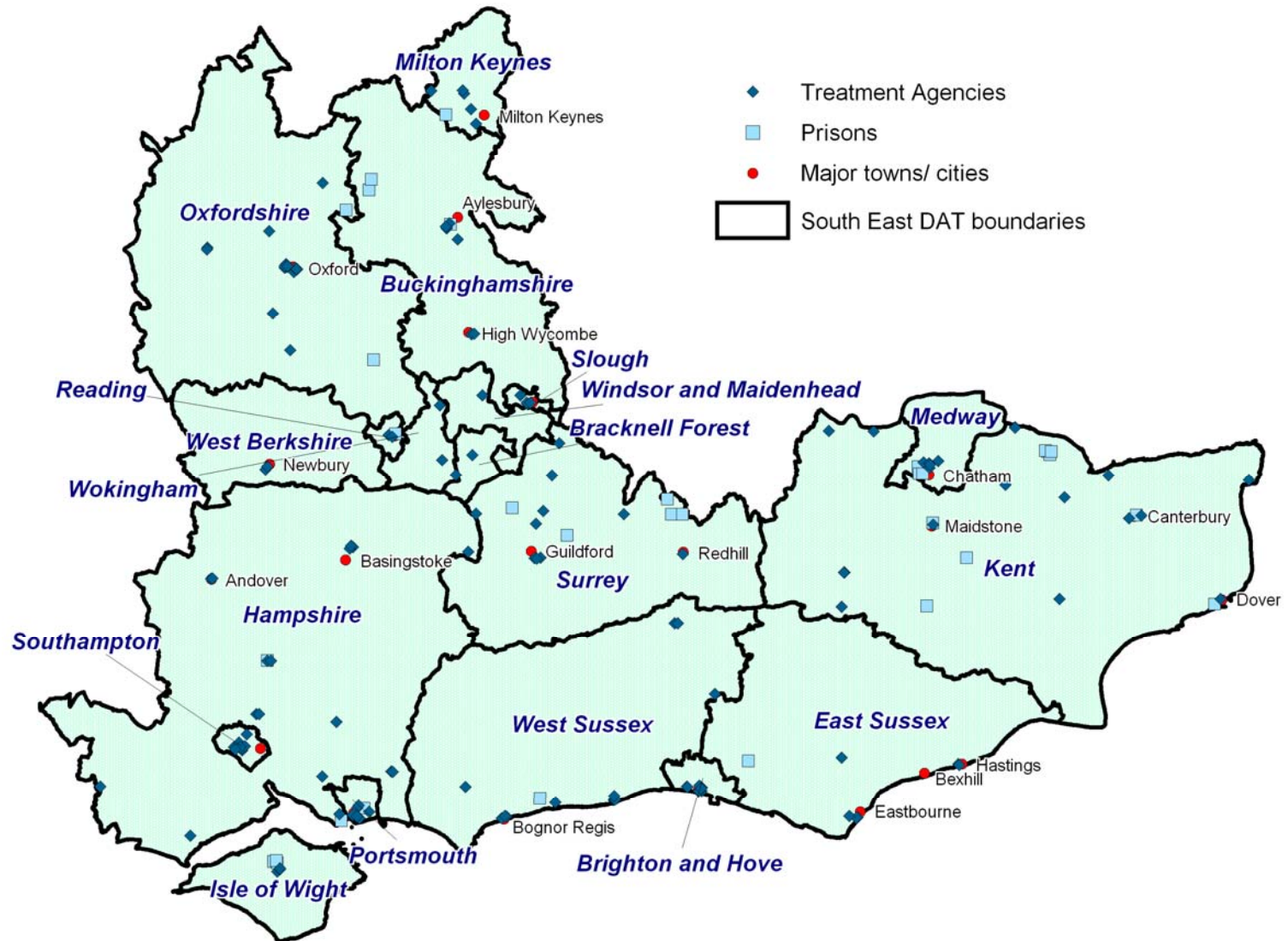
Tier 1 interventions include provision of drug-related information and advice, screening and referral to specialist drug treatment.

Tier 2 interventions include provision of drug-related information and advice, triage assessment, referral to structured drug treatment, brief psychosocial intervention, harm reduction interventions (including needle exchange) and aftercare.

Tier 3 interventions include provision of community-based specialist drug assessment and co-ordinated care-planned treatment and drug specialist liaison.

Tier 4 interventions include provision of residential specialised drug treatment, which is care planned and care co-ordinated to ensure continuity of care and aftercare.

Map of the South East region



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Introduction

This report summaries data from the National Drug Treatment Monitoring System (NDTMS) for April 2006 to March 2007, the Drug Interventions Programme (DIP) aggregated data for 2005/06 and 2006/07, Hospital Episode Statistics (HES) and data on drug related deaths for the South East region. The NDTMS collects data on all clients in contact with structured drug treatment services, including young people in treatment for alcohol misuse. All NDTMS data for all clients, all ages and for adults only, in drug treatment in this report excludes clients whose primary drug is recorded as alcohol. This is because prior to April 2008 NDTMS did not collect data on adults with alcohol as a primary drug. Within the section on young people in treatment, clients with alcohol as their primary drug have been included.

The DIP is part of a Central Government strategy introduced in 2003 aiming to tackle crime and drug use. Data on clients in the criminal justice system is collected using Drug Intervention Records (DIR) by Criminal Justice Integrated Team (CJIT) workers in the community and Community, Assessment, Referral, Advice and Throughcare Services (CARATS) and healthcare services in prisons.

This report includes data on drug-related admissions to hospital from HES, trends in drug-related deaths and data on hepatitis B and C as an update to the Choosing Health in the South East: Problem Drug Use report, published in 2006 by the South East Public Health Observatory (SEPHO).

Further information and definitions can be found in the National Treatment Agency (NTA) publication Models of Care.

The South East is one of nine Government Office regions in England. The South East is split into 19 Drug Action Team (DAT) areas; these areas are coterminous with County Councils and Unitary Authority areas. Throughout this report all the Drug Action Team areas will be referred to as DAT areas; however a number of the areas are known by other titles such as Drug and Alcohol Action Teams (DAAT) or Crime and Disorder Reduction Partnerships (CDRPs).

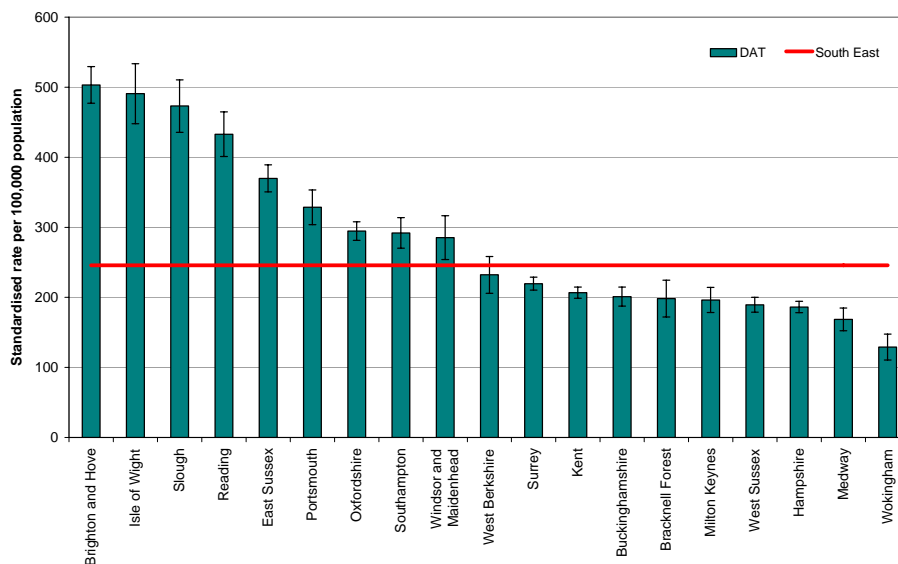
During 2006/07 there were 182 treatment agencies in the South East submitting data to NDTMS.

The Drug Treatment Monitoring Unit (DTMU), based within SEPHO, manages and analysis the South East NDTMS data. The South East NDTMS dataset holds data on clients in treatment in the South East who are resident in the region and clients who are resident in other regions using treatment services in the South East. This report only includes data on clients resident in the South East region who use treatment services within the region. Further information and data from NDTMS can be found at www.ndtms.net.

Section one - Number in Treatment

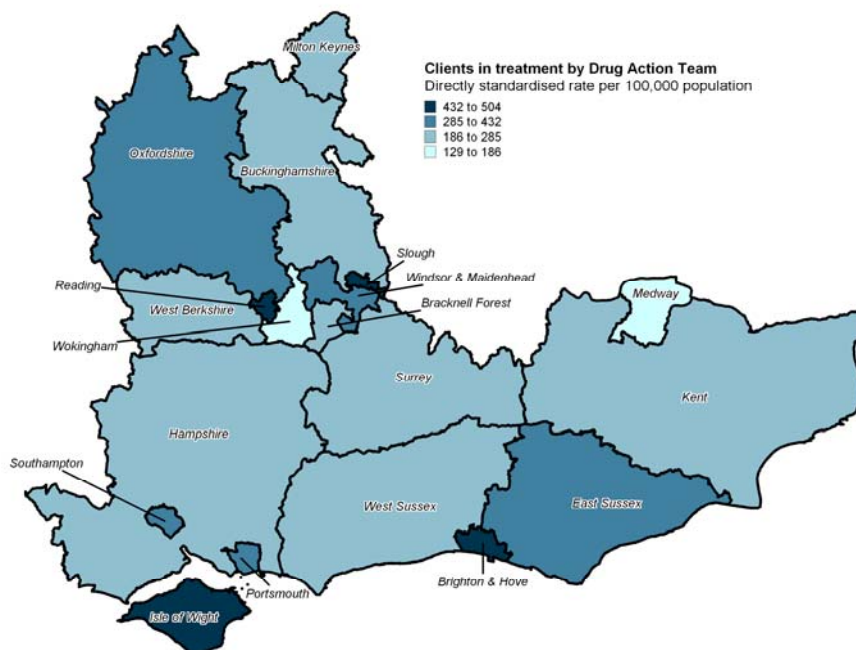
During 2006/07 there were approximately 19,000 people in contact with the treatment system in the South East recorded on NDTMS. Seventy-two percent of people in treatment were male. Eighty-nine percent of the South East treatment population were aged between 15 and 44 years.

Figure 1.
Directly standardised rate all persons in treatment by DAT of residence. 2006/07
Source: NDTMS



Brighton and Hove DAT had the highest rate of people in treatment with 503 persons in treatment per 100,000 population. The Isle of Wight and Slough also had high rates, 490 and 473 per 100,000 respectively. Wokingham DAT had the lowest rate of 129 people in treatment per 100,000 population.

Figure 2.
Directly standardised rate all persons in treatment by DAT of residence, rate per 100,000 2006/07
Source: NDTMS



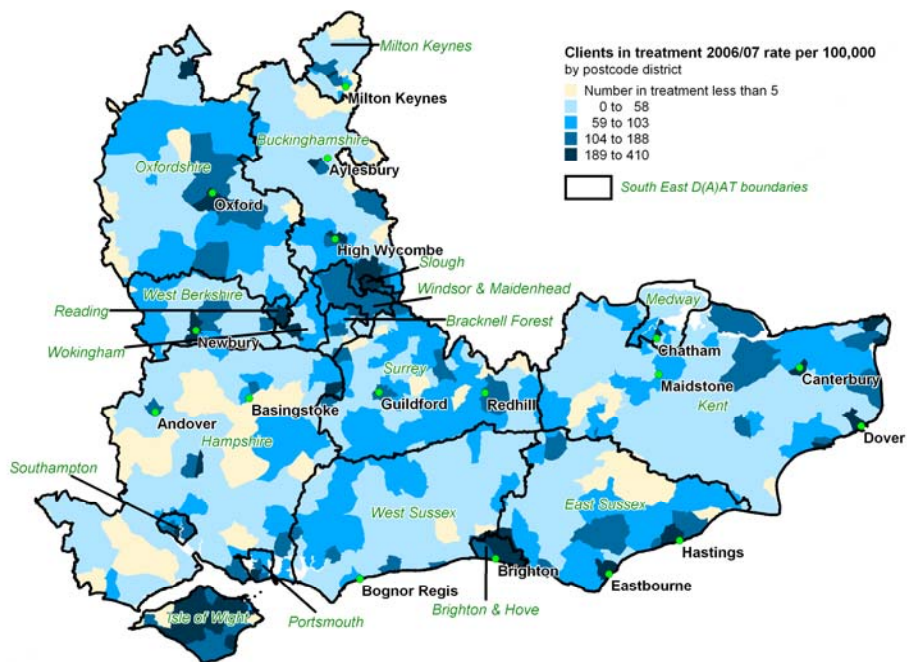
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Within each DAT area there are areas with higher numbers of clients in treatment. NDTMS collects postcode district and postcode sector for each client which can be mapped to show where there are concentrations of clients resident.

Figure 3.

All clients in treatment by postcode district of residence 2006/07. Crude rate per 100,000

Source: NDTMS



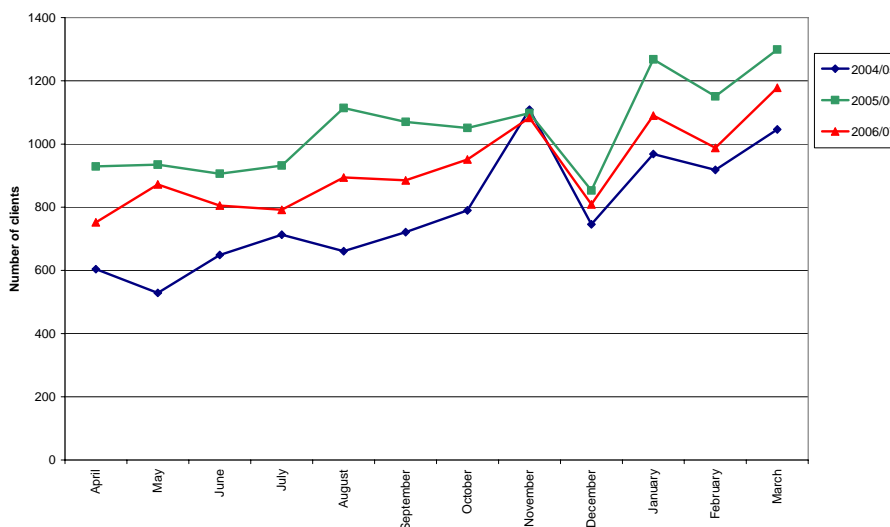
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Figure 3 is a geographic illustration of the crude rate per 1,000 in treatment by client postcode district (e.g. OX1). Of the 19,000 people in treatment 8% are not included on the map due to blank or invalid postcode district. There are high concentrations of clients in treatment resident in the large towns and cities across the South East, including Brighton, Hastings, Dover, Slough, Reading, Newbury, Oxford, Banbury and Milton Keynes.

Figure 4.

Monthly trend in number of new clients into treatment in the South East 2004/05, 2005/07 & 2006/07

Source: NDTMS



The number of clients new to treatment per month in the South East is shown in figure 4, each client is counted only once in each financial year. The trends in numbers of new clients per month are very similar for each year between 2004/05 and 2006/07. Numbers increase steadily from April to November then fall during December. At the beginning of each calendar year the numbers new in treatment increases by between 200 and 400 people.

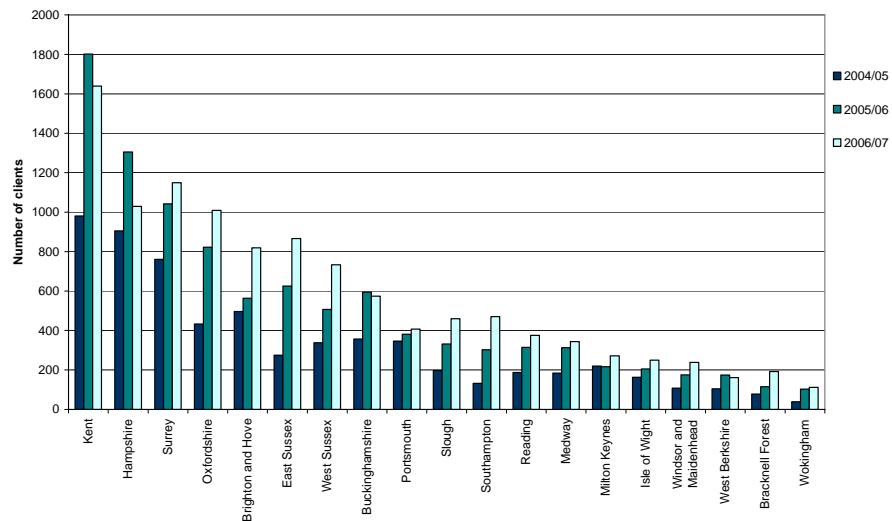
Between March and April 2006 the numbers new to treatment in the South East fell by over 500 people. There were more new clients in treatment month by month for 2005/06 compared to both 2004/05 and 2006/07.

Figure 5 shows a breakdown of numbers new to treatment per year by DAT. The higher numbers of new clients in 2005/06 shown in figure 4 are due to the new clients in Kent and Hampshire where the numbers increased by 820 and 400 respectively.

Figure 5.

Number of new clients into treatment by DAT of residence 2004/05, 2005/07 & 2006/07

Source: NDTMS

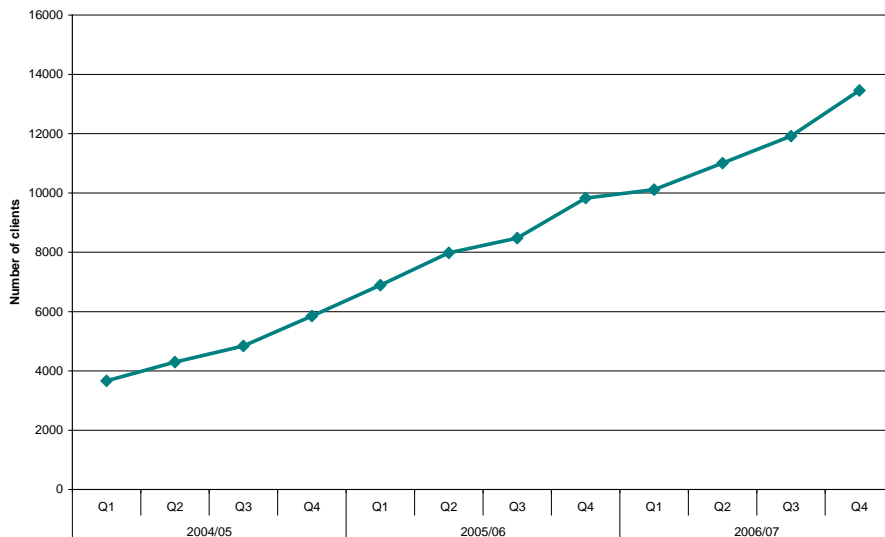


Between 2004/05 and 2006/07 most DAT areas saw a steady increase in the numbers new to treatment per year. Kent, West Berkshire, Buckinghamshire and Hampshire DATs had a decrease in the number of new clients between 2005/06 and 2006/07.

Figure 6.

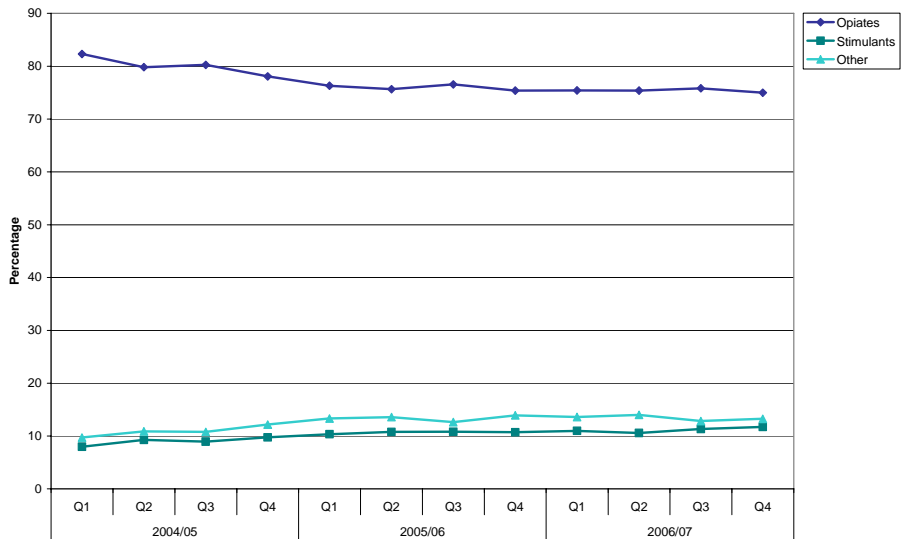
Trend in total number of clients in treatment in the South East by financial quarter 2004/05 to 2006/07

Source: NDTMS



Data in figure 6 is a count of clients in treatment per quarter, clients are counted only once per new triage in each quarter. From quarter 4 2004/05 to quarter 4 2006/07 the numbers in treatment in the South East increased by 130%. There were less than 4,000 clients in treatment in Q1 2004/05, this increased gradually each quarter and peaked at 10,000 clients in Q1 2006/07.

Figure 7.
 Percentage of clients in treatment in the South East by primary drug group, quarter one 2004/05 to quarter four 2006/07
 Source: NDTMS



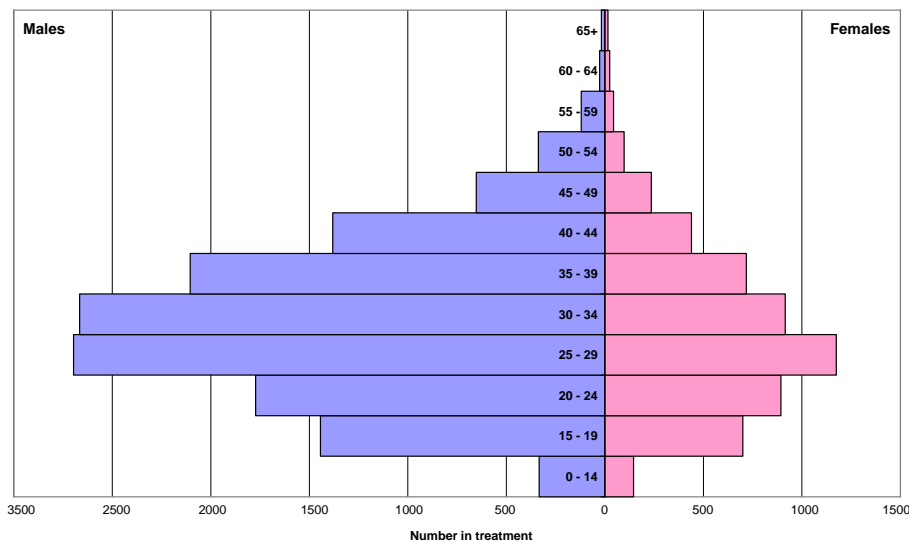
Opiates, particularly heroin, were the principal primary drug of clients in treatment resident in the South East. From April 2004 to March 2007 the proportion of clients in treatment with opiates as their primary drug has decreased from 82% in quarter one of 2004/05 to 75% in quarter four of 2006/07. In quarter one of 2004/05 8% of clients reported their primary drug as a stimulant, this increased to 12% of clients in quarter four of 2006/07.

Section two - Demographics

Figure 8.

Number in treatment in South East, population pyramid 2006/07

Source: NDTMS



Males aged between 25 and 34 years form the largest demographic of clients in treatment. In 2006/07 there were over 5,300 male clients aged 25-34 years, there were over 3,200 male clients aged 15-24 years. The largest 5 year age group for females in treatment was 25-29 years, with over 1,100 clients, there were over 2,000 females in treatment aged 25-34 years.

Figure 9.

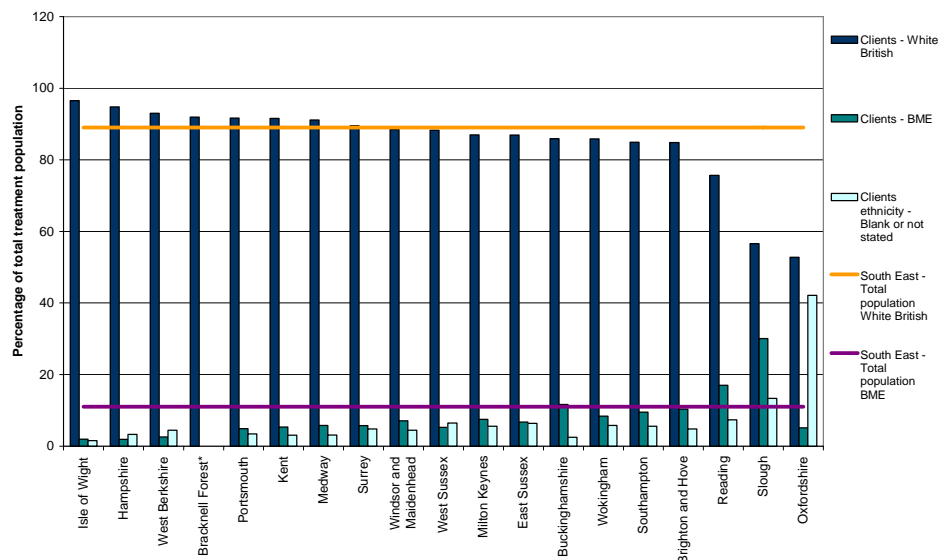
Percentage of total number in treatment by ethnic group and DAT of residence 2006/07

With comparison to South East total population by ethnicity

Source: NDTMS

Ethnicity data for 2005 from Office for National Statistics

* Data suppressed as number of clients in less than 5



Eighty-four percent of clients in treatment in 2006/07 resident in the South East were White British, 7% were from Black and Minority Ethnic (BME) groups. Nine percent of clients' ethnicity was either not stated by the client or not collected.

Figure 9 shows the 2005 population estimates for the South East region states the population as 89% White British and 11% BME. Slough, Reading and Buckinghamshire DATs have a higher proportion of clients from BME groups compared to the over all population of the South East region, 30%, 17% and 12% respectively. Bracknell Forest, Hampshire, Isle of Wight, Kent, Medway, Portsmouth, Surrey and West Berkshire DATs have a higher proportion of clients that are White British compared to the overall population of the South East.

The average age of clients in treatment during 2006/07, resident in the South East was 30.6 years. The average for males is 30.9 years, slightly higher than for females, 29.7 years.

Figure 10.
Average age at triage of clients in treatment by DAT of residence
Source: NDTMS

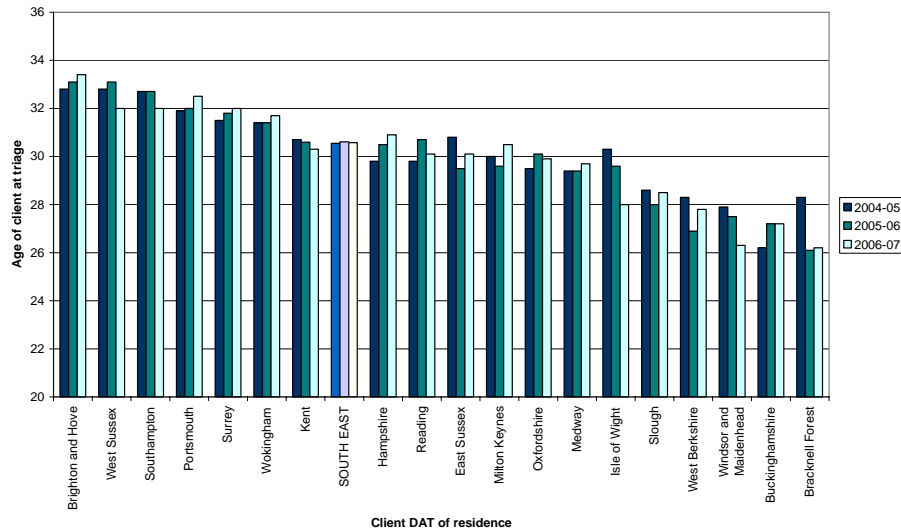


Figure 10 shows the trend in average age of clients from 2004/05 through to 2006/07, the South East region has not seen a change in the average age of clients in this time, remaining at 31 years, however there are variations across the DAT areas.

Isle of Wight DAT has seen the largest change in average age of clients with a decrease of 2.3 years from 30.3 years in 2004/05 to 28.0 years in 2006/07. Hampshire has seen the largest increase in average age of clients from 29.8 years in 2004/05 to 30.9 in 2006/07.

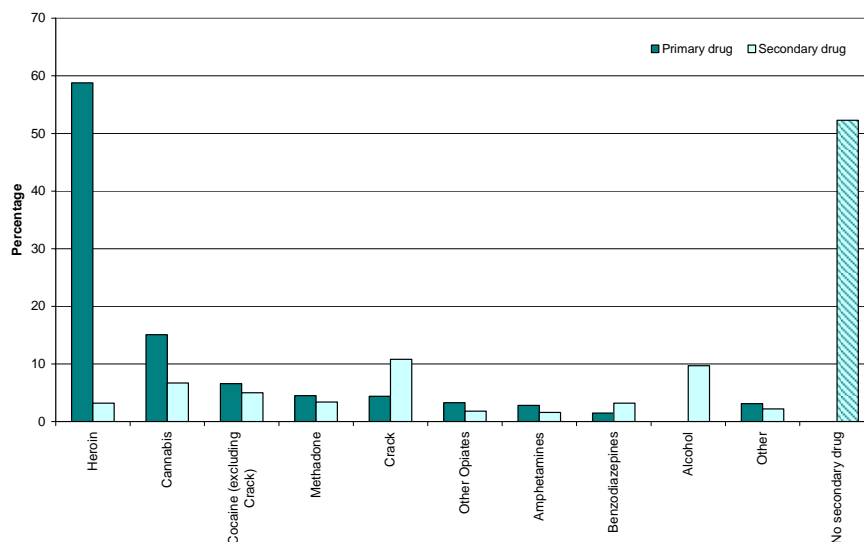
Section three - Drug Use

NDTMS data for 2006/07 does not report alcohol as a primary drug for adults in treatment, alcohol is reported for clients aged 17 and under. However, data presented for all clients, which includes young people and adults, does not include alcohol as a primary drug for any client.

Figure 11.

Primary and secondary drug of all clients in treatment in the South East, percentage 2006/07

Source: NDTMS

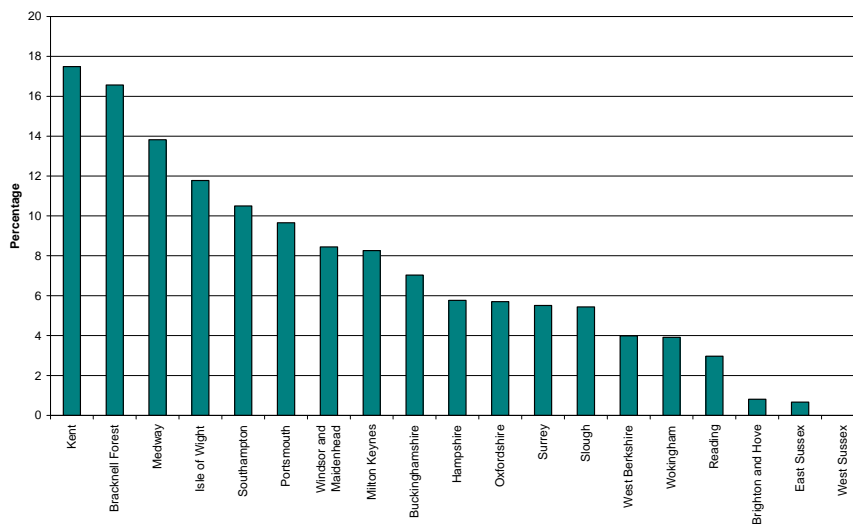


Over half (59%) of clients in treatment in 2006/07 reported heroin as their primary drug, cannabis was the second most common primary drug with 15% of clients. Fifty-two percent of clients did not have a secondary drug reported to NDTMS. Crack was the most common secondary drug, reported by 11% of clients, 10% of clients reported alcohol as their secondary drug.

Figure 12.

Percentage of adult clients stating alcohol as their primary drug by DAT of residence 2006/07

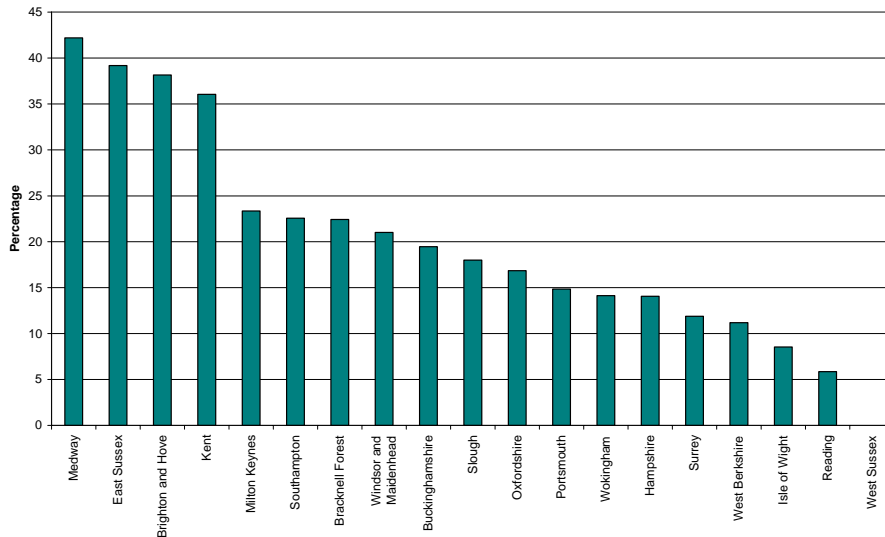
Source: NDTMS



Alcohol was not recorded as a primary drug for adults on NDTMS for 2006/07, however it can be reported as a secondary drug. Kent DAT has the highest proportion of adult clients reporting alcohol as their secondary drug, 18% of clients in 2006/07, 17% of adult clients resident in Bracknell Forest stated alcohol as their secondary drug. Brighton and Hove and East Sussex DATs had the lowest proportions with less than 1% of adult clients reporting alcohol as their secondary drug.

West Sussex did not report client secondary drug in 2006/07.

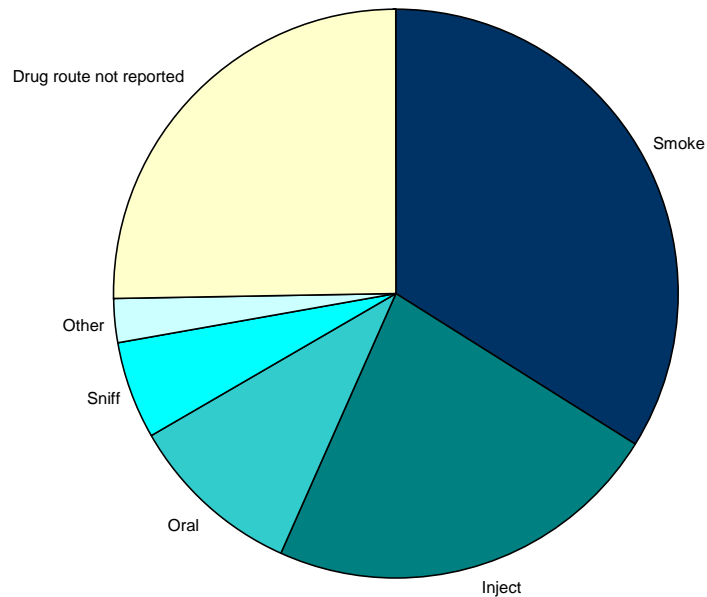
Figure 13.
 Percentage of clients reporting a third problem substance by DAT of residence 2006/07
 Source: NDTMS



Twenty-one percent of South East clients in treatment were recorded as having a third problem drug. Medway, East Sussex and Brighton and Hove DATs had the highest proportion of clients in 2006/07 reporting a third drug, 42%, 39% and 38% respectively. Isle of Wight and Reading DATs had less than 10% of clients reporting a third problem substance.

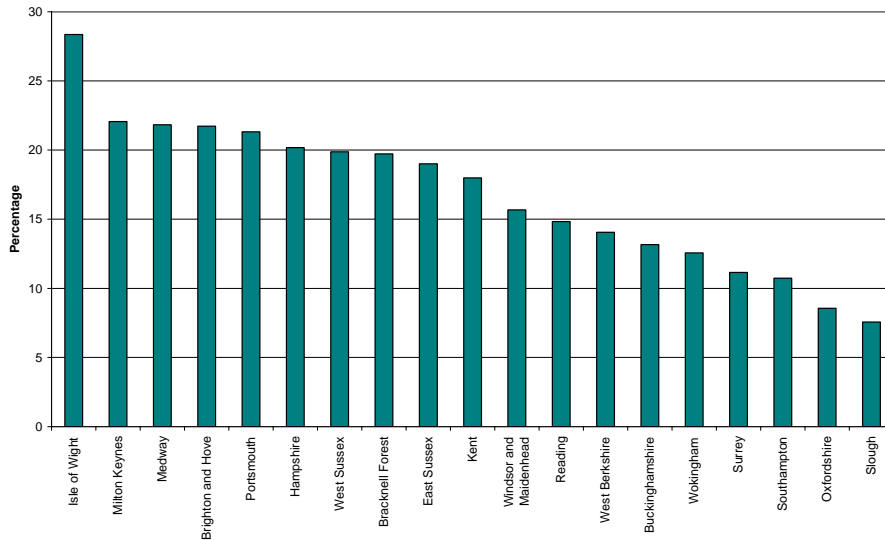
West Sussex did not collect the third problem substance of clients in 2006/07.

Figure 14.
 Route of administration for primary drug for clients in the South East 2006/07
 Source: NDTMS



NDTMS records the route of administration of the clients' primary drug. For all clients in the South East 34% reported their drug route as smoking and 23% reported injecting their primary drug. Data on drug route was not recorded for 25% of clients.

Figure 15.
 Percentage of clients currently injecting by DAT of residence 2006/07
 Source: NDTMS



Data on clients injecting status is recorded by NDTMS. Figure 15 shows the proportion of clients who state that they are currently injecting by DAT of residence as a percentage of all clients in treatment. Injecting status was not reported by agencies in the South East for 40% of clients in treatment in 2006/07.

Isle of Wight DAT has the highest proportion of clients reporting to be currently injecting (28%). Twenty-two percent of clients resident in Milton Keynes, Medway and Brighton and Hove DATs reported they were currently injecting.

Figure 16.
 Percentage of clients in the South East referred by the criminal justice system by primary drug 2006/07
 Source: NDTMS

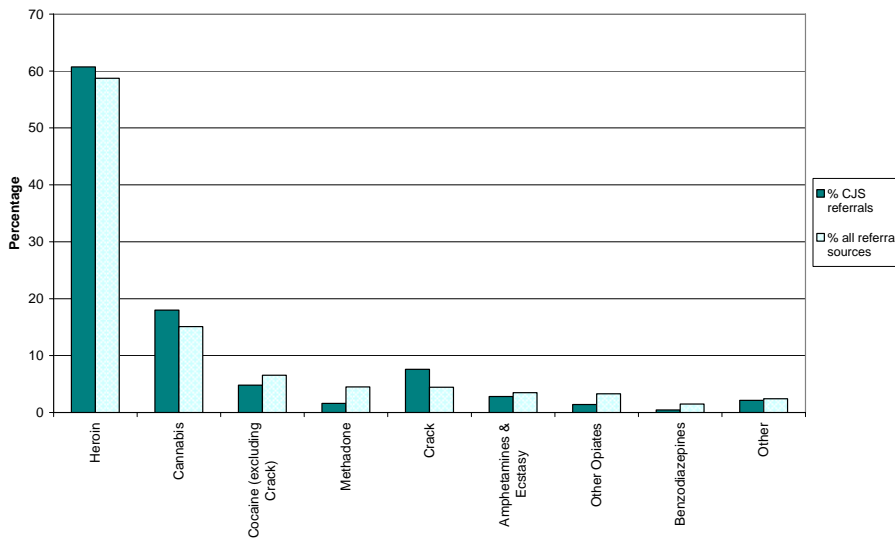


Figure 16 shows the proportion of referrals into treatment from the Criminal Justice System (CJS) and the proportion of all referrals, by the client's primary drug. Sixty-one percent of all referrals from the CJS are from clients stating heroin as their primary drug. Of all referral sources 59% were from clients with heroin as their primary drug.

A higher proportion of clients were referred from the CJS with heroin, cannabis and crack as a primary drug, than the proportion from all referral sources.

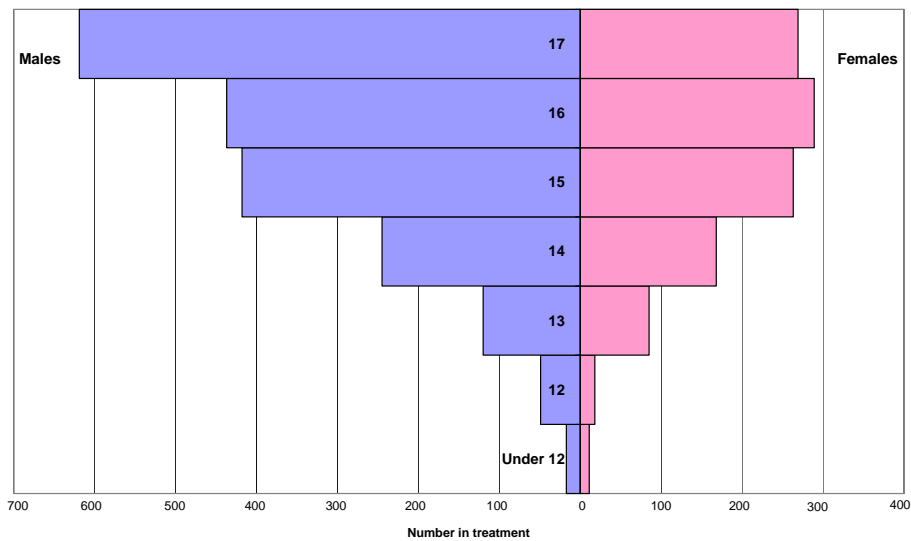
Section four – Young People in Treatment

During 2006/07 there were approximately 3,000 people aged 17 and under in treatment for drug and alcohol misuse in the South East. Sixty-three percent of young people in treatment were male, 37% were female.

Figure 17.

Number of young people in treatment in the South East. Population pyramid 2006/07

Source: NDTMS



Males aged 17 made up over one-fifth of young people in treatment in the South East, this accounts for over 600 out of the 3,000 in treatment in 2006/07. There were approximately 270 females aged 17 in treatment.

Figure 18.

Rate of young people in treatment in the South East by DAT of residence. Crude rate per 1,000 2006/07

Source: NDTMS

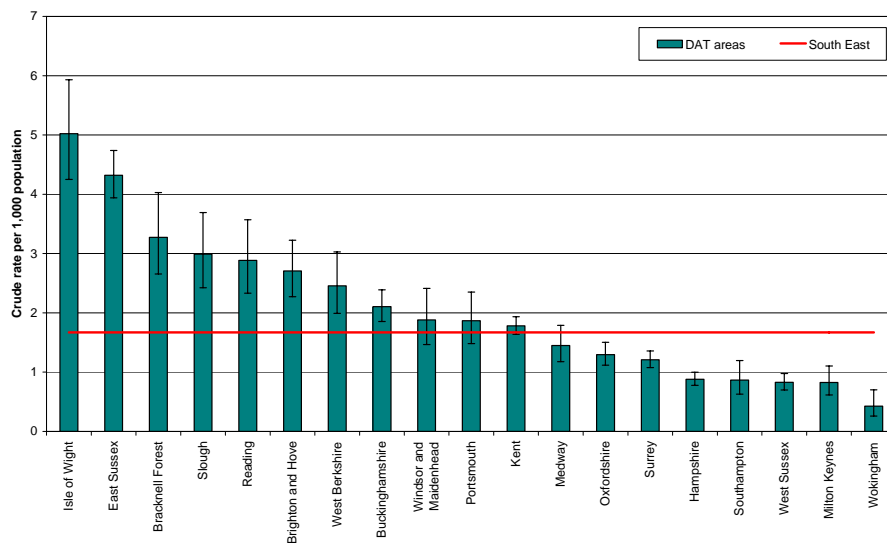
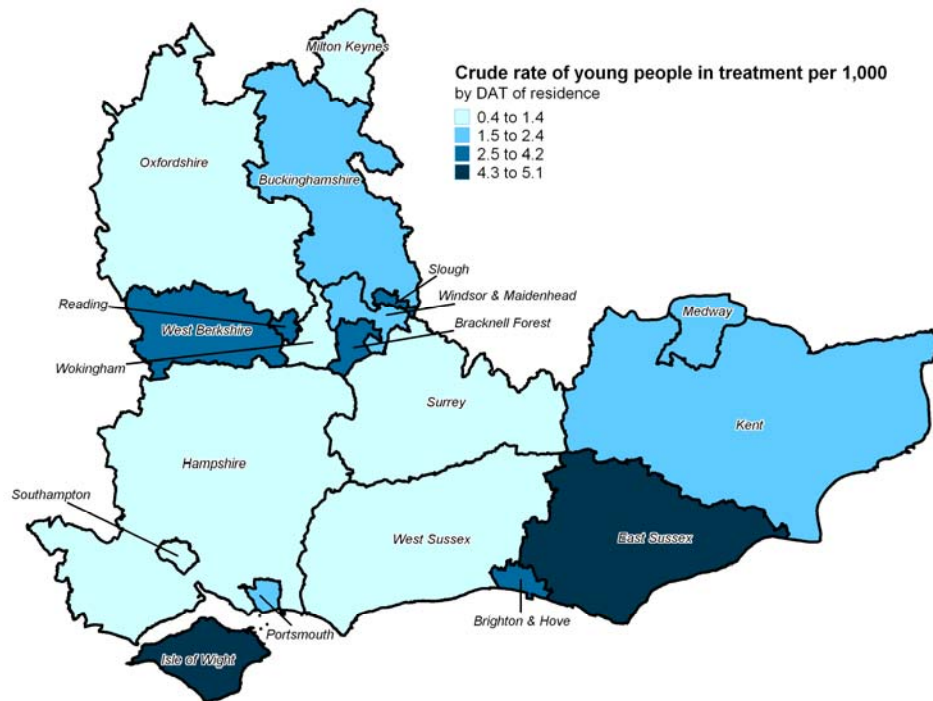


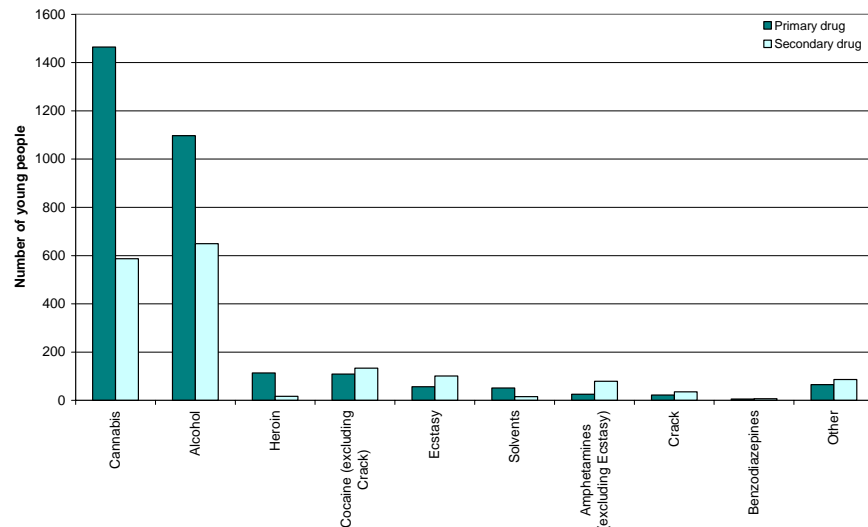
Figure 19.
Rate of young people in treatment in the South East by DAT of residence. Crude rate per 1,000 2006/07
Source: NDTMS



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Figures 18 and 19 show the crude rate of young people in treatment per 1,000 by DAT of residence. Isle of Wight and East Sussex DAT areas have the highest rates of young people in treatment in the South East, 5 and 4.3 per 1,000 respectively. Hampshire, Southampton, West Sussex, Milton Keynes and Wokingham have a rate of less than 1 per 1,000 young people in treatment.

Figure 20.
Number of young people in treatment in the South East by primary and secondary drug 2006/07
Source: NDTMS



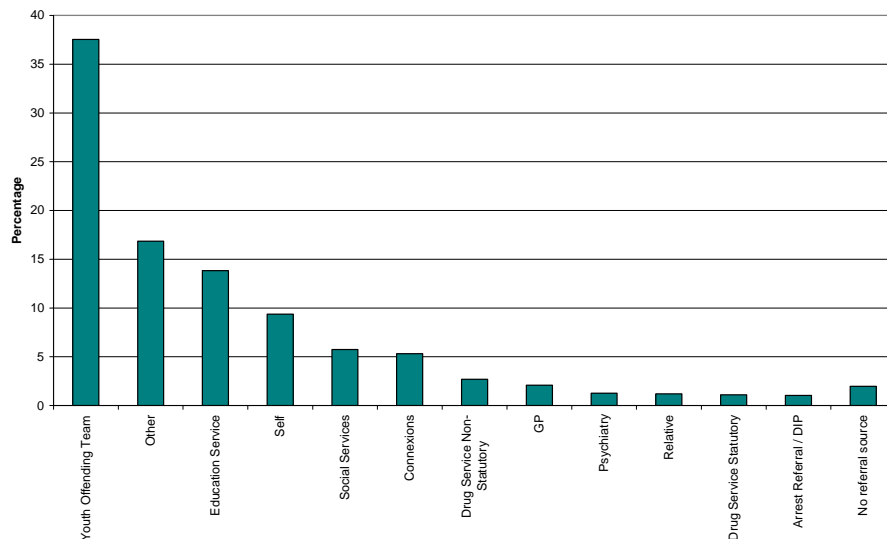
Over 85% of young people in treatment reported either alcohol or cannabis as their primary drug, this equates to approximately 1,500 young people presenting with cannabis and 1,100 with alcohol as their primary drug. Approximately 110 young people in treatment in the South East reported heroin as their primary drug, similarly over 100 clients reported cocaine as their primary drug.

More young people reported cocaine, amphetamines and ecstasy as a secondary drug than as their primary drug. Of all clients reporting a secondary drug nearly three-quarters stated

either alcohol or cannabis. Approximately 1,100 young people in treatment did not report a secondary drug.

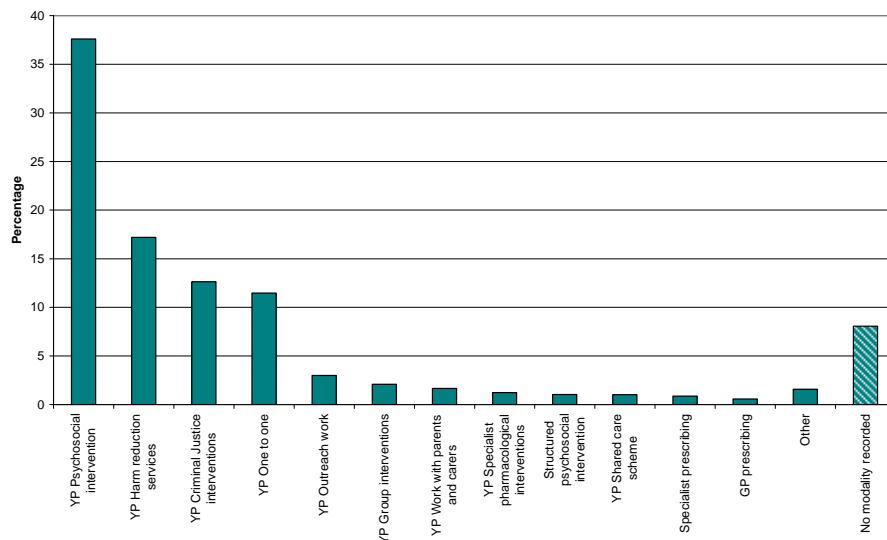
Forty-six percent of young people reported smoking as the route of administration of their primary drug, 40% reported oral consumption.

Figure 21.
Referral source for young people in treatment in the South East, percentage 2006/07
Source: NDTMS



Youth Offending Teams (YOT) were the principle source for referrals of young people into treatment. In 2006/07 38% of young people were referred by a YOT. The education service was the next single largest referral source, referring 14% of young people into treatment. Approximately 280 (9%) young people self referred.

Figure 22.
Treatment interventions for young people in treatment in the South East, percentage 2006/07
Source: NDTMS



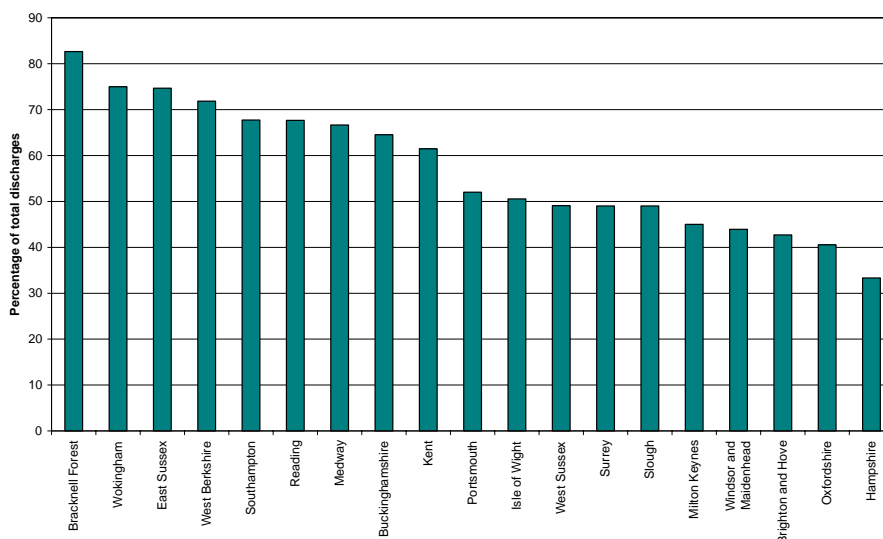
In 2006/07 38% of all treatment modalities for young people were young persons psychosocial interventions. Young persons harm reduction services and criminal justice interventions also had a high proportion of clients, 17% and 13% respectively.

Young persons one to one services, outreach work and group interventions were discontinued from April 2007.

Figure 23.

Percentage of total discharges that are planned for young people in treatment in the South East by DAT of residence 2006/07

Source: NDTMS



Planned discharges from a treatment agency include clients who have completed treatment, completed treatment drug free and clients who have been referred on to another treatment service. Bracknell Forest DAT had the highest proportion of all discharges that were planned, 83%. Seventy-five percent of all discharges were planned for young people resident in Wokingham and East Sussex DAT areas. One-third of discharges for young people resident in Hampshire were planned. Milton Keynes, Windsor and Maidenhead, Brighton and Hove and Oxfordshire DAT areas all had 45% or less planned discharges.

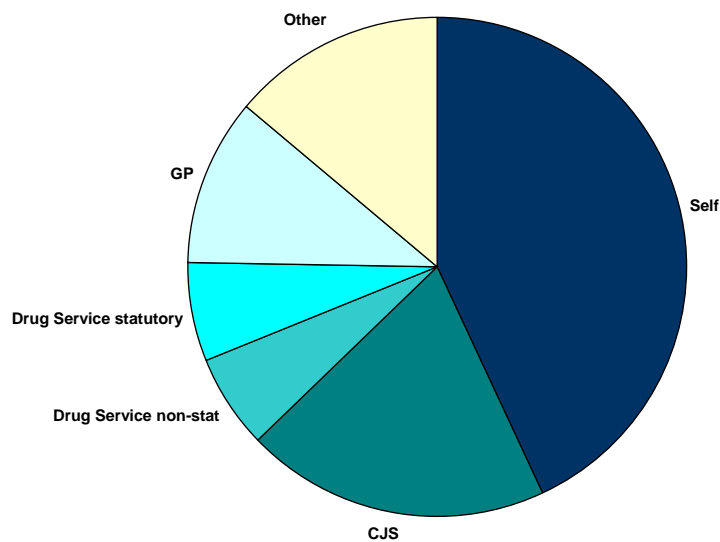
Section five – Treatment Journey

Figure 24. Referral source

Figure 24.

Referral source for clients in treatment in the South East 2006/07

Source: NDTMS

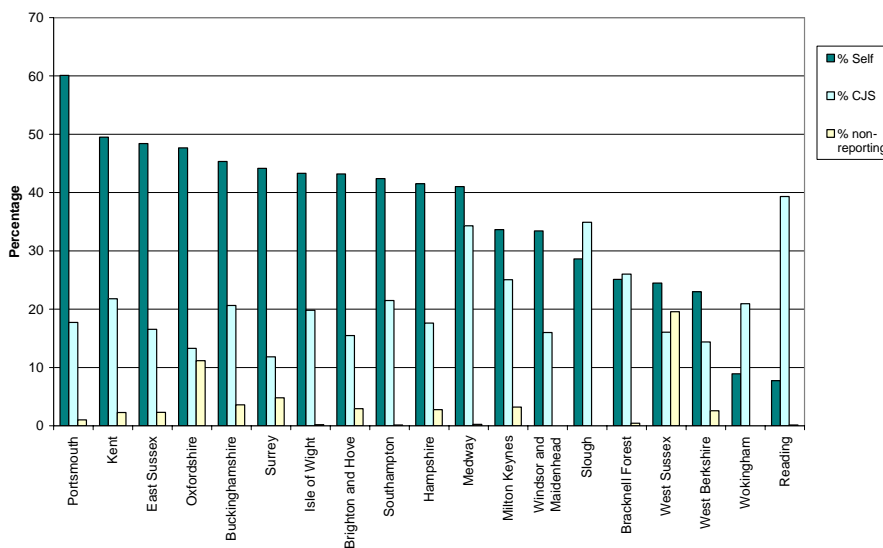


In 2006/07 42% of all referrals into drug treatment were individual clients self referring. The criminal justice system referred 20% of all clients in 2006/07. Other referral sources include referrals from hospitals, education, employment, mental health, local authority and community services. Thirteen percent of referrals to agencies were from other drug services, 7% from statutory services and 6% from non-statutory services. Statutory services are agencies funded and run by the NHS through PCTs and mental health trusts, non-statutory services are agencies run by the voluntary sector or charities. Over 4% of clients did not have a referral source recorded on NDTMS.

Figure 25.

Referral source for clients in treatment in the South East, percentage 2006/07

Source: NDTMS



Residents of Portsmouth DAT have the highest percentage of self referring clients, 60%. Wokingham and Reading have less than 10% of clients self referring. Reading and Slough would be expected to have higher proportion of referrals from the criminal justice system as along with Oxfordshire, they are intensive areas within the Drug Interventions Programme (DIP).

Oxfordshire has a high proportion, 48%, of clients self referring and just 13% of clients being referred into treatment from the criminal justice system (CJS), however 11% of clients' referral

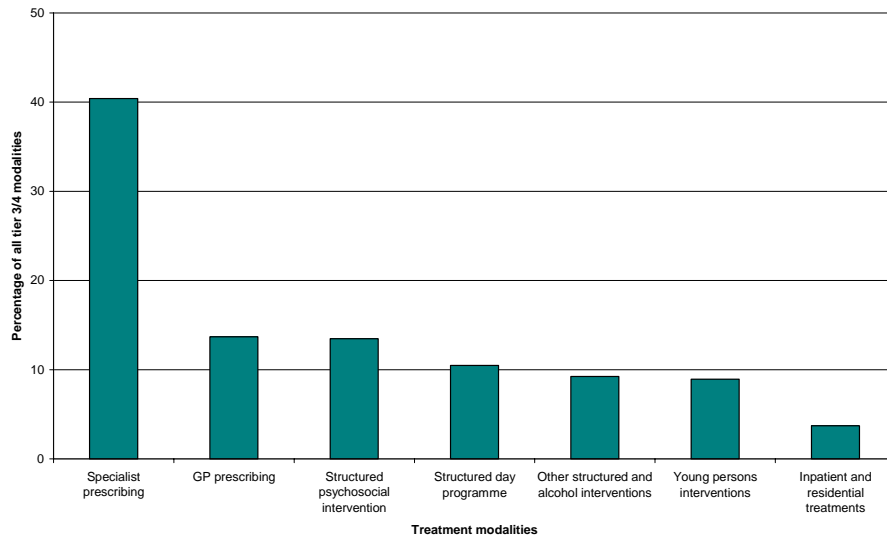
source was not reported to NDTMS. Reading had 39% of clients referred through the CJS, the highest in the South East. Slough had the second highest proportion of CJS referrals, 35%. Medway had 34% of resident clients referred into treatment from the CJS.

Where an area has a high proportion of non-reporting of data is it not possible to present valid analysis of the data. In 2006/07 20% of clients resident in West Sussex did not have their referral source reported to NDTMS.

Figure 26.

Percentage of tier 3 and 4 modalities by treatment intervention 2006/07

Source: NDTMS

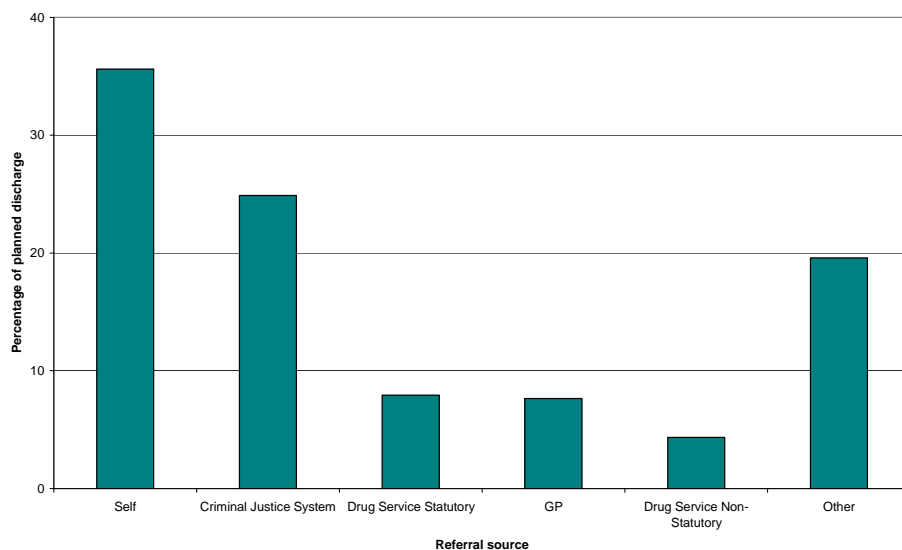


The majority of clients in tier 3 and 4 treatment in the South East in 2006/07 (40%) used specialist prescribing within their structured treatment programme, 14% of treatment modalities were GP prescribing. In 2006/07 4% of treatment modalities were tier 4 inpatient treatment and residential rehabilitation.

Figure 27.

Percentage of all planned discharges by referral source 2006/07

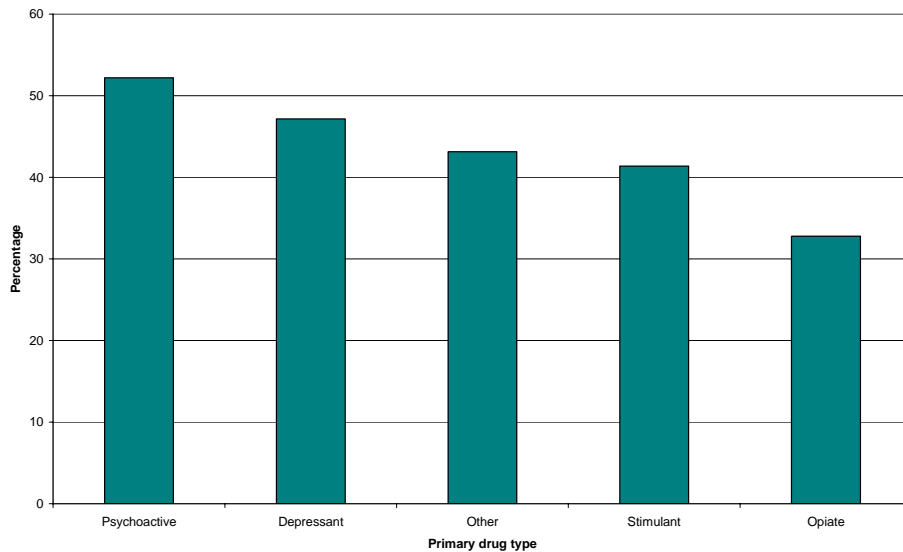
Source: NDTMS



Planned discharges from a treatment agency include clients who have completed treatment, completed treatment drug free and clients who have been referred on to another treatment service. Figure 27 shows of all planned discharges the proportions which enter treatment from each referral source. Thirty-six percent of planned discharges are from clients who have self referred; therefore clients had more success in the treatment system if they made a personal choice to enter drug treatment, compared to other referral sources. Of all planned discharges,

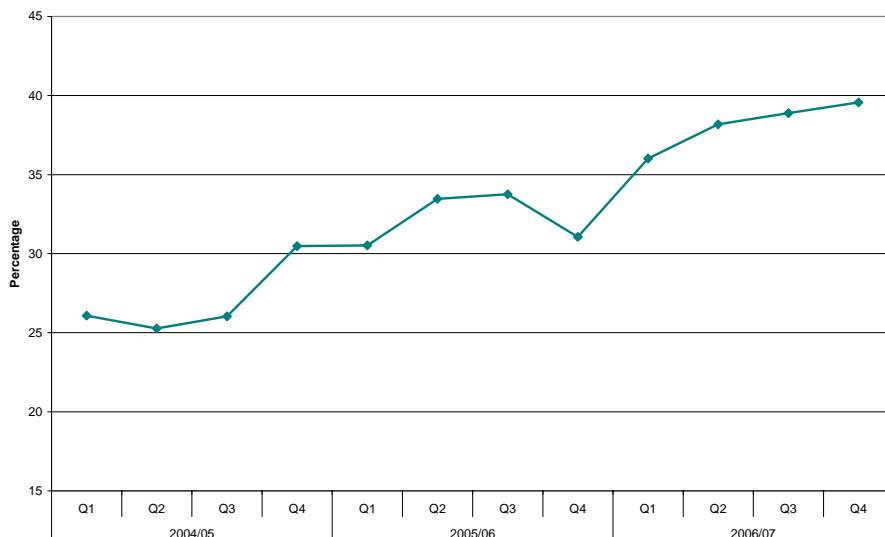
one-quarter of clients were referred through the criminal justice system. Other referral sources include hospitals, education, employment, mental health, local authority and community services.

Figure 28.
Percentage of planned discharges by primary drug type 2006/07
Source: NDTMS



Out of all discharges for clients stating either psychoactive drugs or depressant drugs as their primary substance 52% were planned. Forty-one percent of discharges for clients stating a stimulant as their primary drug were planned discharges. Clients with opiates as their primary drug had the lowest proportion of discharges that were planned, just one-third of discharges in 2006/07 for primary opiate users were planned.

Figure 29.
Trend in successful discharges, percentage of all discharges 2004-2007
Source: NDTMS



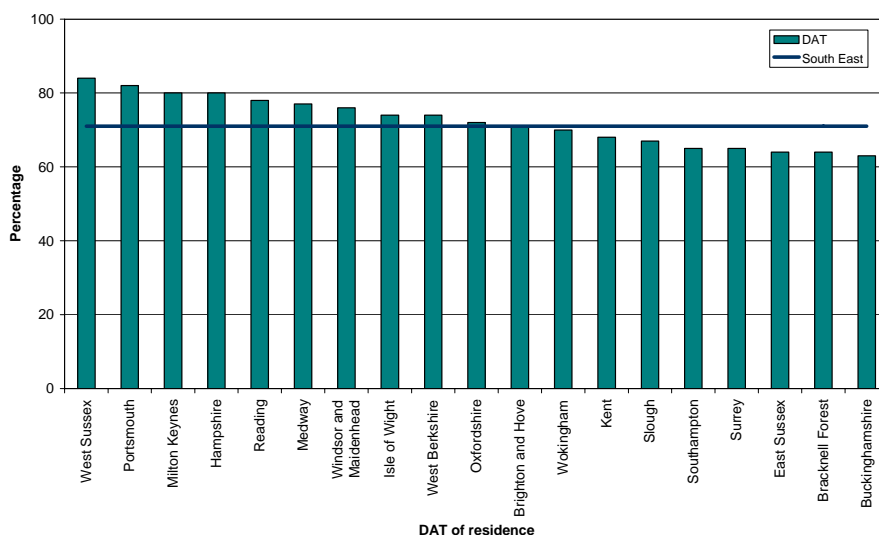
Between quarter one 2004/05 and quarter four of 2006/07 there was an increase in percentage of planned discharges of 13.5 percentage points.

In quarter one of 2004/05 26% of all discharges for clients resident in South East DAT areas were planned, this increased to 31% in the final quarter of 2004/05. 2006/07 saw an increase quarter by quarter of the proportion of planned discharges, in the final quarter of 2006/07 just under 40% of all discharges were planned.

Figure 30.

Percentage of adult clients retained in treatment by DAT of residence 2006/07

Source: NDTMS



Drug treatment is more likely to be effective if clients are retained in treatment for 12 weeks or more, with marked improvements in reducing drug use, reducing morbidity and mortality associated with misuse, reducing crime, and improving health and social functioning. (Retaining clients in drug treatment, a guide for providers and commissioners, NTA 2005)

Of all new presentations in 2006/07 84% of clients resident in West Sussex DAT were retained for 12 weeks or more. Additionally at least 80% of clients resident in Portsmouth, Milton Keynes and Hampshire DAT were retained within the drug treatment system 12 weeks after first presentation. In 2006/07 less than 65% of clients resident in East Sussex, Bracknell Forest and Buckinghamshire were retained in treatment for 12 weeks.

In 2006/07 the South East region saw a rate of 713 resident clients per 1,000 in treatment retained for 12 weeks or more.

Section six – Drug Interventions Programme

The Drug Interventions Programme (DIP) was introduced in 2003 and is a key part of the Government’s strategy for tackling drugs and reducing crime. There are 19 DIP areas in the South East, coterminous with the DAT areas. Three DIP areas in the South East are intensive areas; the data for these areas are not included in these analyses as the DTMU does not have ownership of the data. The DIP intensive areas have high rates of crime and deprivation, within these areas individuals committing trigger offences are drug tested on arrest. Drug Intervention Record (DIR) forms were introduced in 2005 to gather information on the needs of clients in the community and in prisons.

Within the non-intensive DIP areas, individuals committing offences who test positive for Class A drugs are given rapid access to treatment services. The analysis below presents the data from Drug Intervention Record (DIR) monitoring forms which are completed with offenders on arrest or on entry to prison for prisoners seeking drug treatment.

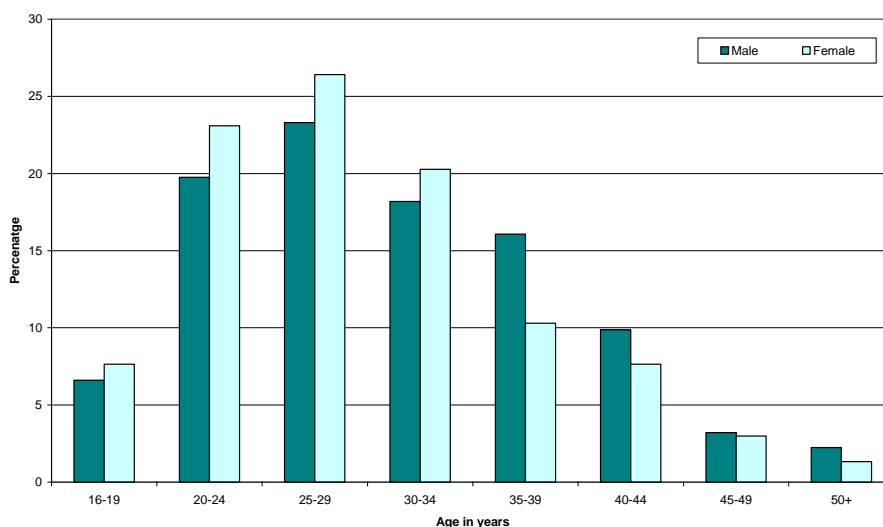
Drug Intervention Records 2005-2007 – DAT records

Between April 2005 and March 2007 non-intensive DAT areas in the South East processed information on over 3,500 clients.

Figure 31.

Percentage of DAT clients by age and sex Apr 2005 to Mar 2007

Source: Home Office



Eighty-three percent of clients in the non-intensive drug interventions programme were male, 17% were female. Overall female clients were younger than males, over 25% of female clients were aged 25-29 and less than 15% of females were aged over 40. Fifty percent of male clients were aged under 30, 84% of male clients were under 40.

Figure 32.

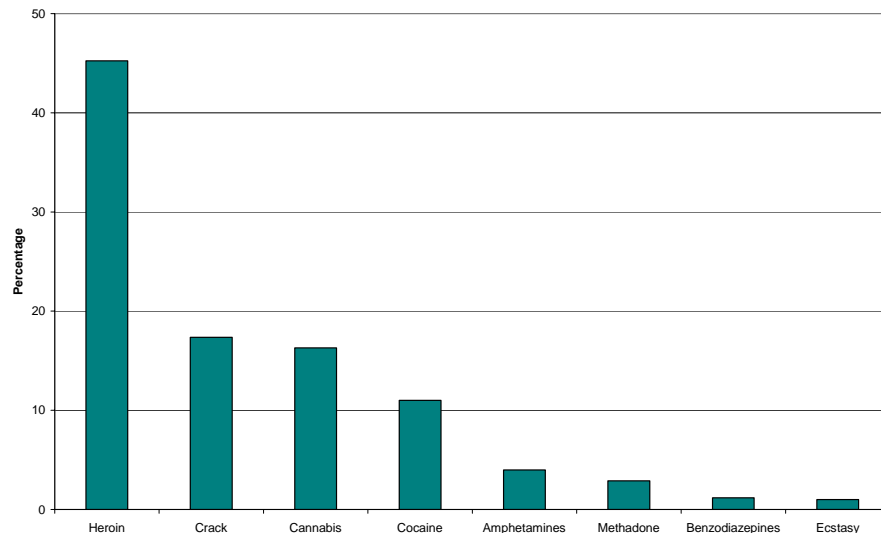
Percentage of DAT clients by ethnic group Apr 2005 to Mar 2007

Source: Home Office South East population by ethnic group for 2005, Office for National Statistics

Ethnic group	Number	Percentage	Percentage of total South East population
White British	3021	84.5	88.5
White Other	96	2.7	4.5
Mixed	100	2.8	1.4
Asian	81	2.3	3.1
Black	113	3.2	1.3

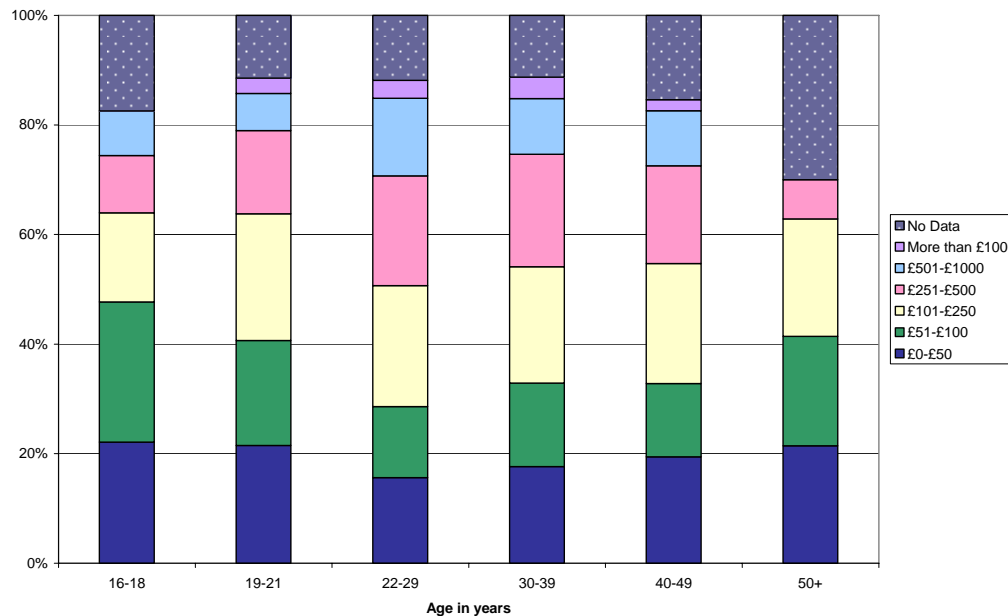
Of the clients whose ethnicity was collected 85% were White British. Around 3% of clients reported their ethnicity as Black and 3% reported Mixed ethnic groups. There is variation in the proportions of clients in each ethnic group across each DAT area.

Figure 33.
 Percentage of DAT clients by main drug
 Apr 2005 to Mar 2007
 Source: Home Office



Heroin was reported as a main drug by 45% of clients, 17% of clients reported crack and 16% reported cannabis as their main drug. Over 10% of clients reported cocaine as their main drug.

Figure 34.
 Reported spend on drugs per week by age, DAT clients Apr 2005 to Mar 2007
 Source: Home Office



The DIR form asks clients: *How much would drugs cost you each week if you (had to) pay for them?* Clients are asked about their drug using behaviour in the previous 28 days.

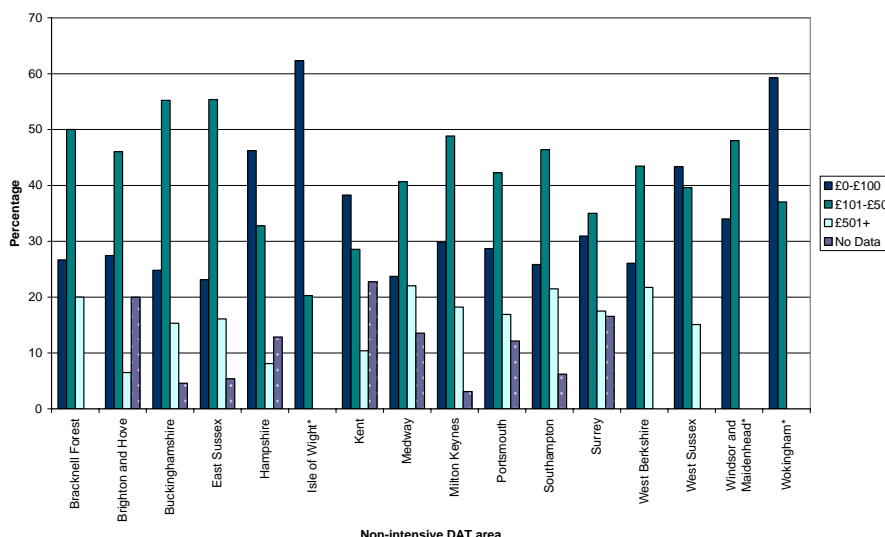
Clients aged between 22 and 39 years reported the highest level of spending per week on drugs. Of clients aged 16 to 18 years, 47% reported spending up to £100 per week, 23% of clients aged 19-21 years reported spending between £101 and £250 per week on drugs. Fourteen percent of clients aged 22-29 years reported spending £501 to £1000 and 4% of clients aged 30-39 years reported spending over £1000 on drugs each week.

Figure 35.

Reported spend on drugs per week by age, DAT clients by DAT of residence Apr 2005 to Mar 2007

Source: Home Office

* Data for clients spending £501+ is suppressed as number of clients is less than 5

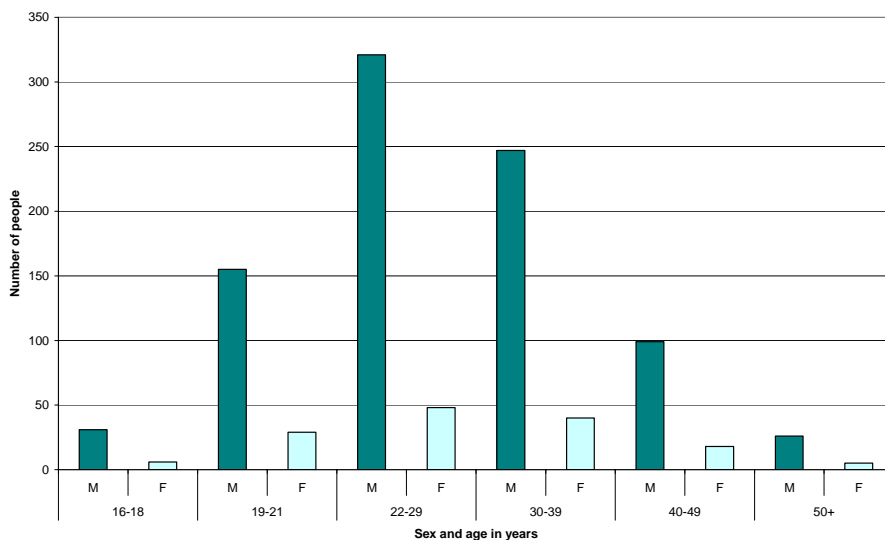


The amount clients reported spending on drugs per week varies between DAT areas. Of the clients resident in Isle of Wight DAT 62% reported spending up to £100 per week on drugs. Within Buckinghamshire and East Sussex DAT areas, 55% of clients reported spending between £101 and £500. Within Medway, Milton Keynes and West Berkshire DAT areas 22% of clients resident in each DAT reported spending over £501 per week on drugs.

Figure 36.

Number of DAT clients who have not been in treatment in the last two years by age and sex Apr 2005 to Mar 2007

Source: Home Office



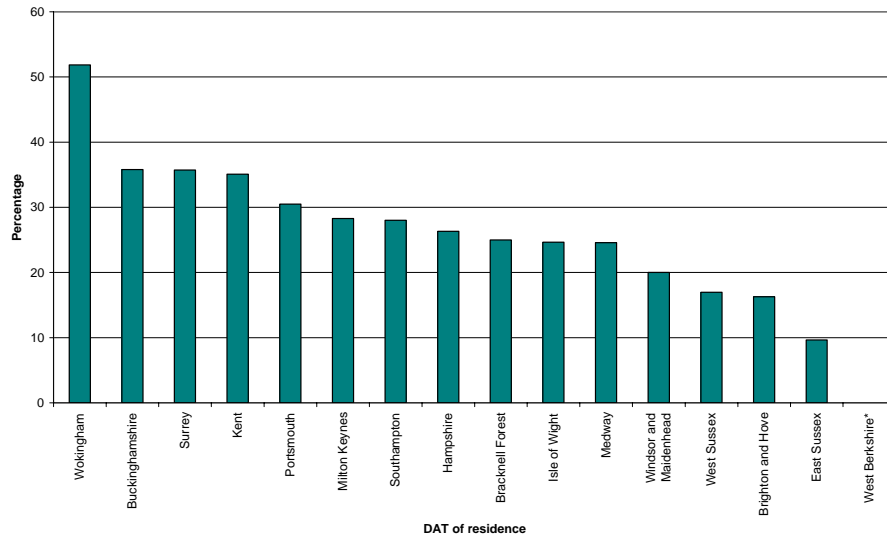
Over 1,000 clients (29%) resident in the South East non-intensive DAT areas reported through the Drug Intervention Records stated they had not been in contact with the treatment system in the last 2 years, 86% of these clients were male and 14% were female.

Figure 37.

Percentage of DAT clients who have not been in treatment in the last two years by DAT of residence
Apr 2005 to Mar 2007

Source: Home Office

* Data suppressed as number of clients is less than 5

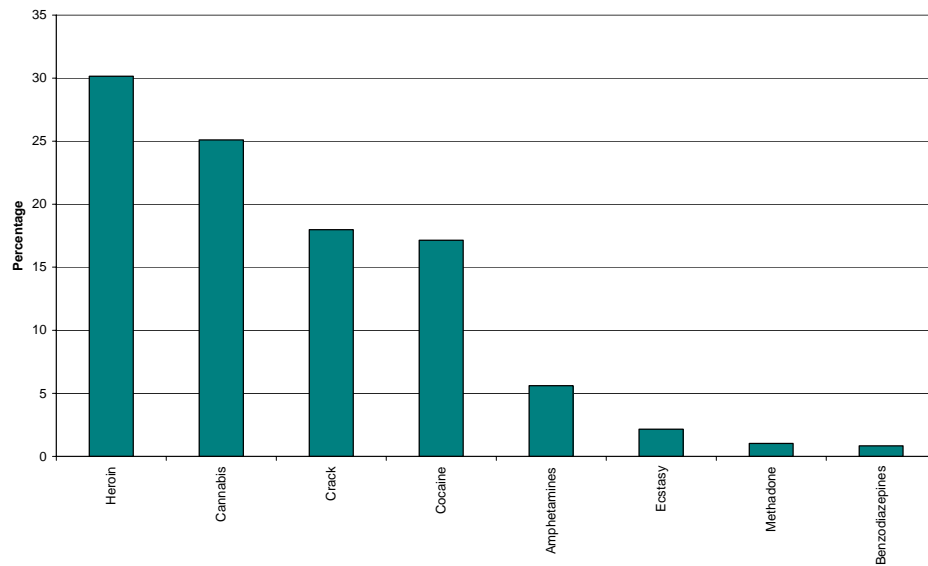


Over 50% of the clients resident in Wokingham had not received treatment in the last 2 years. Additionally, of clients resident in Buckinghamshire, Surrey and Kent over one-third had not received treatment in the last 2 years.

Figure 38.

Main drug of DAT clients who have not been in treatment in the last two years by DAT of residence, percentage
Apr 2005 to Mar 2007

Source: Home Office



Heroin was the main drug of 30% of the clients who reported not receiving treatment in the last 2 years, 25% of clients stated cannabis. Crack and cocaine were reported as the main drug for 17% and 18% of clients respectively.

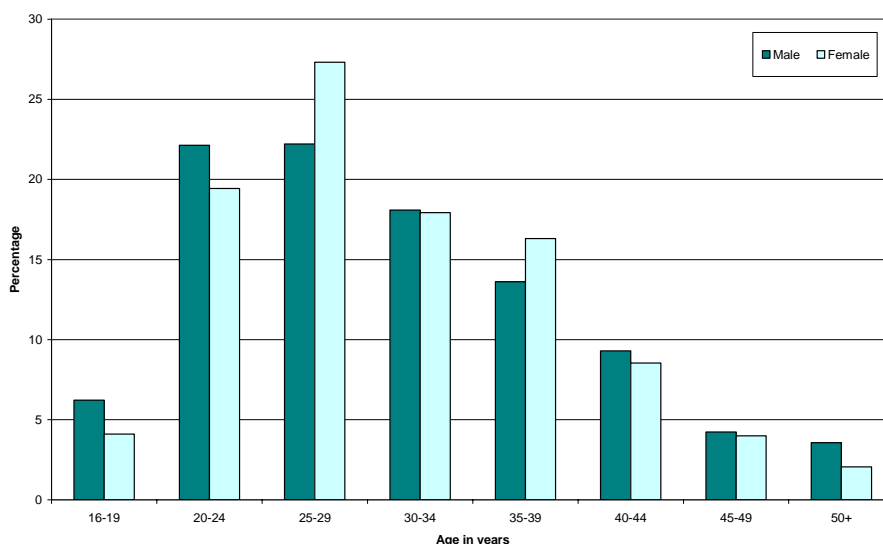
Drug Intervention Records 2005-2007 – Prison records

There are 27 prisons in the South East region, 2 of which are women's prisons. Between April 2005 and March 2007 prisons in the South East returned drug intervention records for just under 8,000 individuals.

Figure 39.

Percentage of prison clients by age and sex Apr 2005 to Mar 2007

Source: Home Office



Eighty-eight percent of clients in prisons in the South East were male, 12% were female. Over 50% of both male and female clients were aged under 30, 27% of female clients were aged 25-29. Seventeen percent of male clients were aged over 40.

Figure 39.

Percentage of prison clients by ethnic group Apr 2005 to Mar 2007

Source: Home Office South East population by ethnic group for 2005, Office for National Statistics

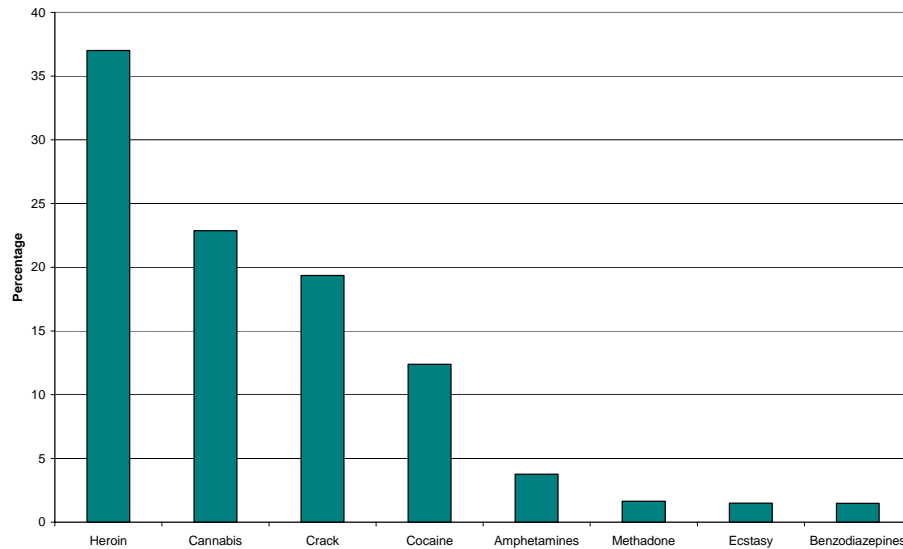
Ethnic group	Number	Percentage	Percentage of total South East population
White British	6617	83.6	88.5
White Other	319	4.0	4.5
Mixed	224	2.8	1.4
Asian	188	2.4	3.1
Black	450	5.7	1.3

The majority of clients stated their ethnicity as White British, 6% of clients were Black and 4 % were from other White ethnic groups.

Figure 41.

Percentage of prison clients by main drug
Apr 2005 to Mar 2007

Source: Home Office

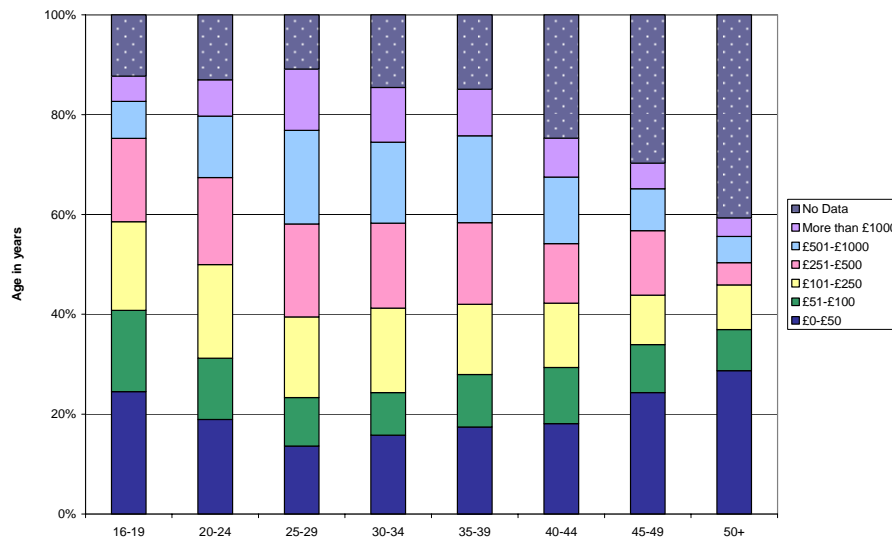


Heroin was the main drug for 37% of clients, 23% of clients reported cannabis as their main drug. Crack was reported by 19% of clients and cocaine by 12% of clients as their main drug. Less than 5% of clients stated amphetamines, benzodiazepines, ecstasy or methadone as their main drug.

Figure 42.

Reported spend on drugs per week by age, prison clients Apr 2005 to Mar 2007

Source: Home Office



The DIR form asks clients: *How much would drugs cost you each week if you (had to) pay for them?* Clients are asked about their drug using behaviour in the previous 28 days before entry into prison.

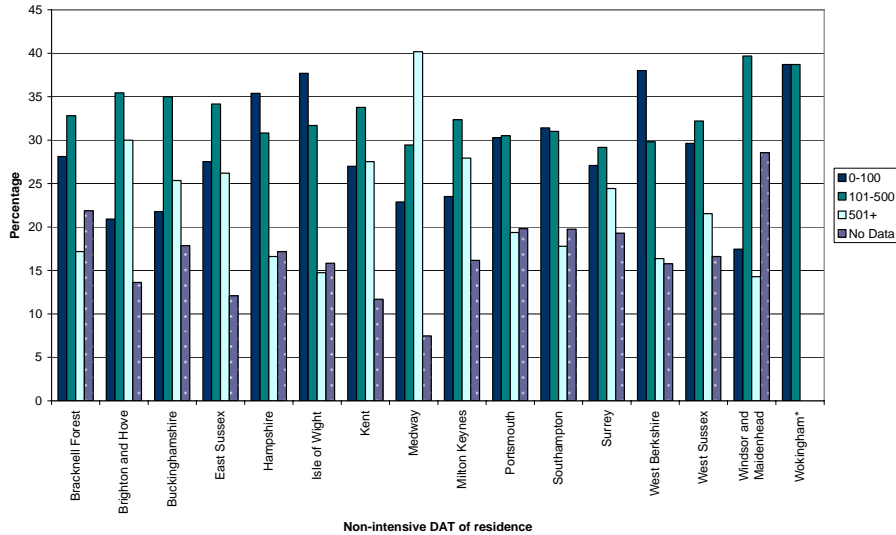
Clients aged 25-29 years reported spending more per week on drugs compared to other age groups, 50% of 25-29 year olds spent more than £250 per week, 12% of clients from this age group reported spending over £1,000 per week. Forty percent of clients aged 16-19 reported spending up to £100 per week on drugs, 17% of clients aged 35-39 years reported spending between £501 and £1,000 per week.

Figure 43.

Reported spend on drugs per week by age, prison clients by DAT of residence Apr 2005 to Mar 2007

Source: Home Office

* Data suppressed as number of clients is less than 5

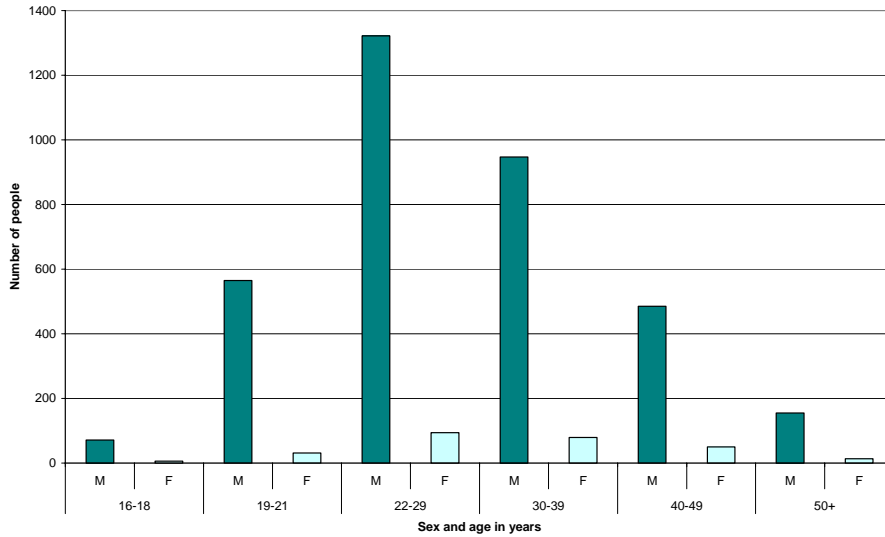


Spend on drugs per week varies between clients' DAT area of residence, 40% of clients resident in Medway spent over £501 per week on drugs. Thirty five percent or more clients with Buckinghamshire, Brighton and Hove, and Windsor and Maidenhead as their DAT of residence reported spending between £101 and £500 on drugs per week.

Figure 44.

Number of prison clients who have not been in treatment in the last two years by age and sex Apr 2005 to Mar 2007

Source: Home Office

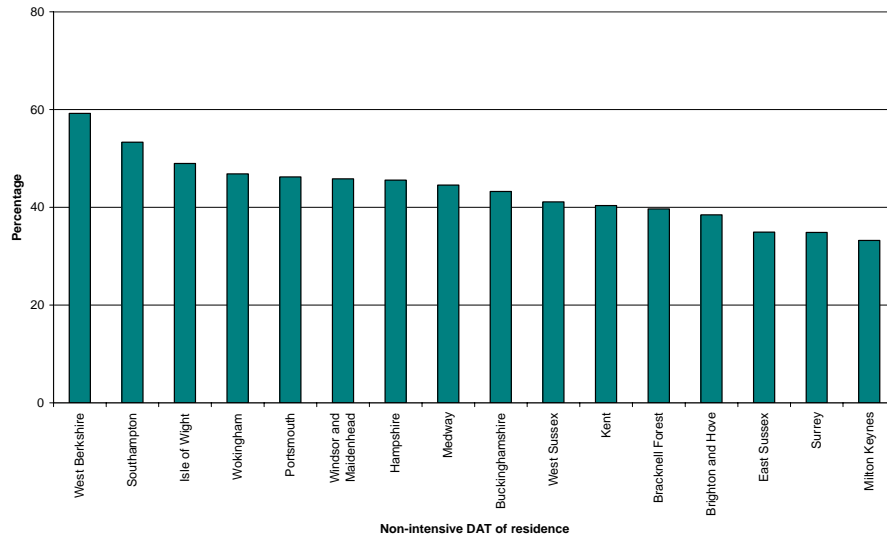


Over 3,800 (41%) clients interviewed in prisons in the South East had not been in treatment in the previous 2 years, 93% were males. Over 1,300 were male aged between 22 and 29 years.

Figure 45.

Percentage of prison clients who have not been in treatment in the last two years by DAT of residence Apr 2005 to Mar 2007

Source: Home Office

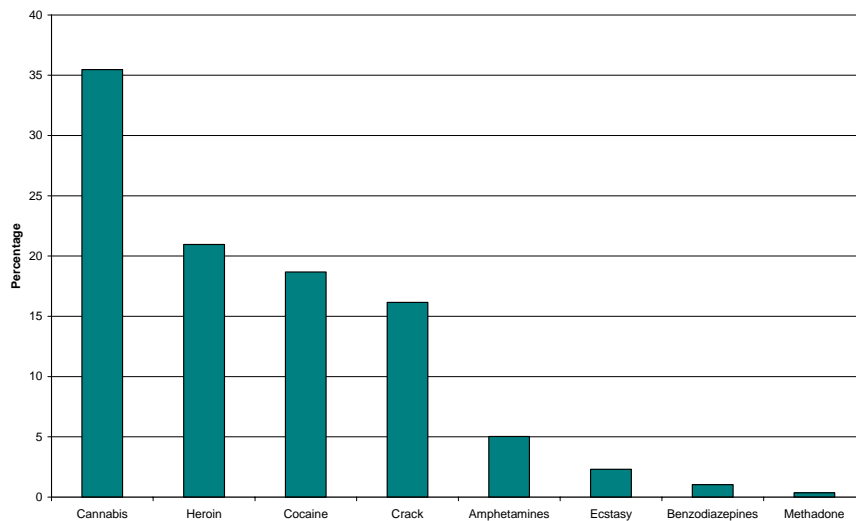


Over 50% of clients in prisons resident in West Berkshire and Southampton DAT areas had received treatment in the previous 2 years. Less than 40% of clients resident in Bracknell Forest, Brighton and Hove, East Sussex, Surrey and Milton Keynes had received treatment in the previous 2 years.

Figure 46.

Main drug of DAT clients who have not been in treatment in the last two years by DAT of residence, percentage Apr 2005 to Mar 2007

Source: Home Office



Cannabis was the main drug for 36% of clients who had not received treatment in the previous 2 years, 21% of clients stated heroin and 19% stated cocaine as their main drug. Five percent or less clients stated amphetamines, ecstasy, benzodiazepines or methadone as their main drug.

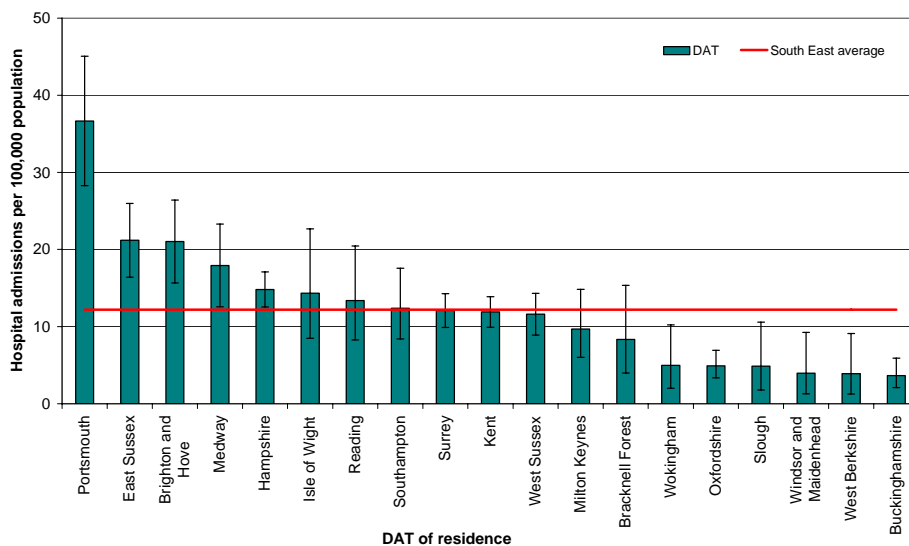
Section seven – Hospital admissions and drug related deaths

The definition of drug related hospital admissions and deaths used in this report are admissions and deaths recorded under the following ICD10 codes F11-F16, F18-F19.

Figure 47.

Hospital admissions for drug-related poisonings by DAT of residence 2005/06 Standardised rate per 100,000

Source: Hospital Episode Statistics
Department of Health

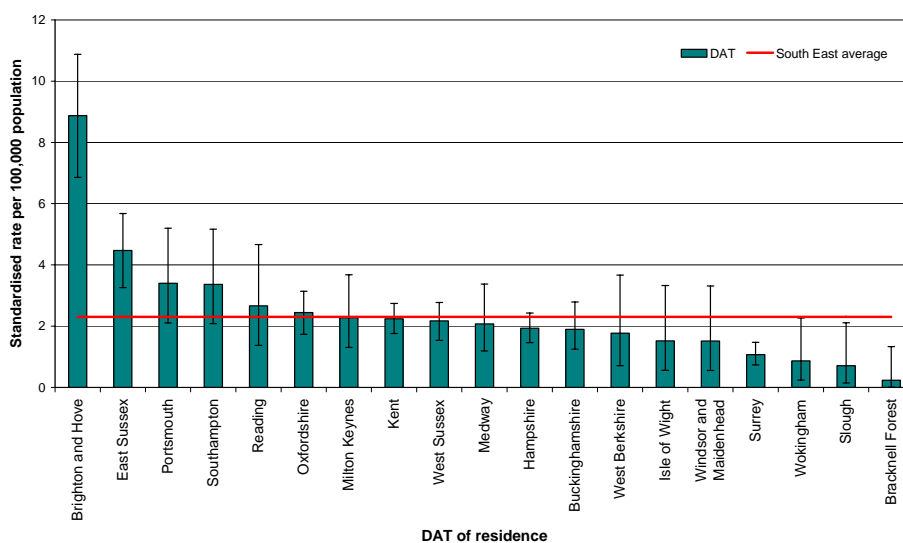


There is considerable variation in drug related hospital admissions between different DAT areas in the South East. During 2005/06 Portsmouth had the highest rate at 37 admissions per 100,000 population, East Sussex and Brighton and Hove both had a rate of 21 admissions per 100,000. Windsor and Maidenhead, West Berkshire and Buckinghamshire had the lowest rate of drug related hospital admissions with 4 admissions per 100,000 population.

Figure 48.

Drug-related deaths in the South East by DAT of residence 2003-2005

Source: Office for National Statistics

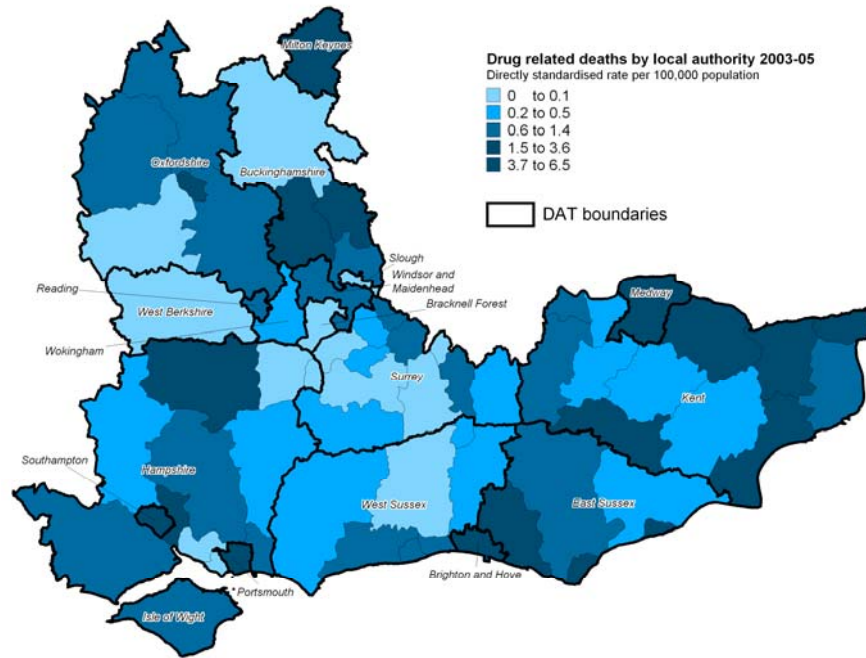


The average rate of drug related deaths in the South East between 2003 and 2005 was 2.3 per 100,000 population. The death rates vary between DAT areas in the South East from less than 1 per 100,000 population in Wokingham, Slough and Bracknell Forest to 8.9 per 100,000 in Brighton and Hove and 4.5 per 100,000 population in East Sussex.

Figure 49.

Drug-related deaths in the South East by local authority of residence 2003-2005

Source: Office for National Statistics



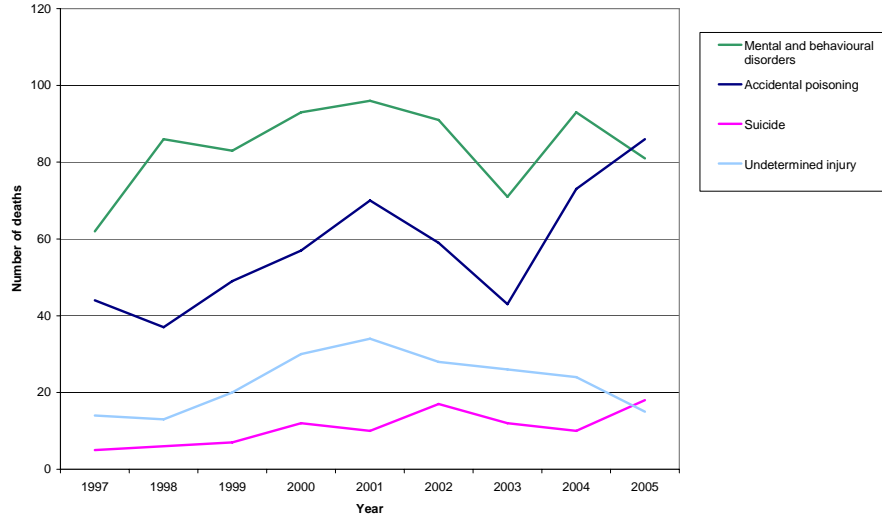
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The rates of drug related deaths in the South East in 2003/05 are illustrated geographically in the map. Higher rates of drug related deaths can be seen in the larger cities such as Oxford, Southampton, Portsmouth and Brighton and Hove, however Medway and the coastal local authorities in Kent also have relatively high rates of drug related deaths.

Figure 50.

Drug-related deaths by cause in the South East 1997-2005

Source: Office for National Statistics

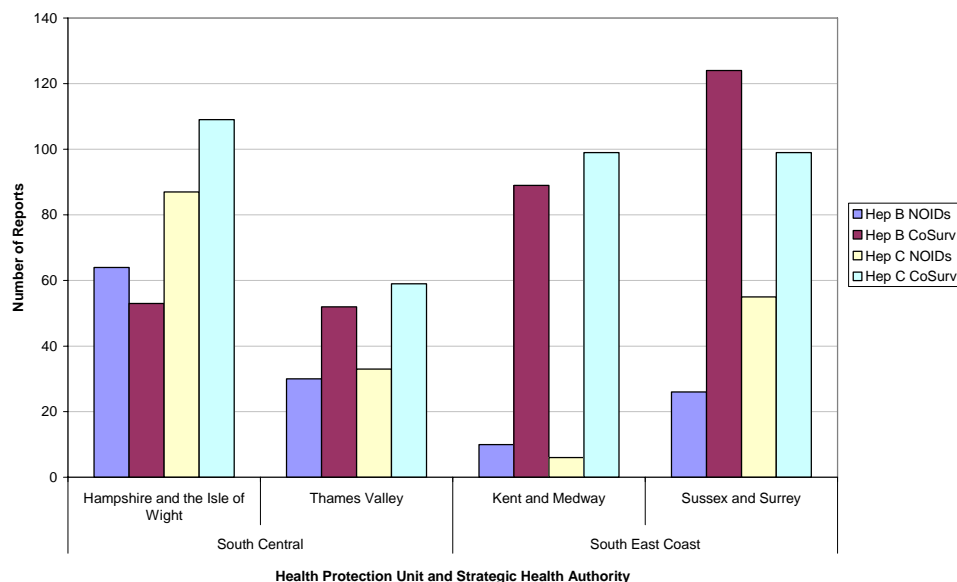


Mental and behavioural disorders were the most common cause of drug related death from 1997 to 2005, followed by accidental poisoning. People with mental health disorders who are also problem drug users are therefore at higher risk of drug related death.

Figure 51.

Hepatitis B and C in the South East by Strategic Health Authority, 2006

Source: Health Protection Agency



There are currently two routine sources of data on hepatitis, both sources have limitations.

1. Acute hepatitis is a notifiable disease and doctors who diagnose a case should report it to the statutory Notifications of Infectious Disease Surveillance System (NOIDS). However, it is generally agreed that this system under-estimates new cases, as they are not always reported.
2. Laboratory data is used to report clinically confirmed cases of viral hepatitis through the CoSurv system. This is notorious for over-reporting though double counting of cases from different settings (such as hospital and community) and at different stages (new (acute) or ongoing (chronic) cases).

Across the South East in 2006, 130 new cases of hepatitis B were reported through NOIDS and 318 laboratory reports were received through CoSurv. There were 181 hepatitis C notifications via NOIDS and 366 laboratory reports of hepatitis C in the same year. Figure 51 shows this data broken down by Strategic Health Authority.

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