Safer West Sussex Partnership Understanding and Reducing Drug Demand

Bognor Regis Analysis

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Authors:
Robert Whitehead & Catherine Wells

Public Health and Social Research Unit
West Sussex County Council
jsna.westsussex.gov.uk

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Foreword

"*Understanding & Reducing Drug Demand: Bognor Regis Analysis 2021"* is a new analytical report conducted by our Safer West Sussex partners. It is a report that the Safer Arun Partnership (SAP) is pleased to fully endorse.

This report will serve to inform SAP's strategic priorities and partnership plan going forward. We see it as invaluable to influencing our own operational responses, but also providing a key reference for partnership decision makers at a commissioning and programme funding level.

This is the first report of its kind to be conducted in West Sussex. Its findings will help our partnership work to understand the drivers and implications of drug demand on the locale of Bognor Regis. Recognising the impact on resources and communities is also important learning.

Recommendations made in the 2018 Bognor Regis Home Office Locality Review, sponsored by the National Violence and Vulnerability Unit, provides the rationale for conducting this analysis. Bognor Regis was identified for this review as a result of the impact of County Lines on the town and surrounding area. It was suggested that partners consider producing an informed problem profile looking at the status of the drug market. Public health was also identified as having a major role in understanding the nature of local drug demand.

Findings from the Locality Review are addressed by this report. Importantly, its analysis corroborates Dame Carol Black's recent independent report: *Review of drugs part two: prevention, treatment, and recovery*. Scrutiny of the partnership data will allow greater collective understanding of the demand for drugs in Bognor Regis, enabling the creation of multi-agency and sustainable public health interventions. These must meet the needs of local residents as championed by Dame Black's report.

My sincere gratitude is extended to the authors of this report, Robert Whitehead and Catherine Wells from the West Sussex Public Health and Social Research Unit. Thank you also to Guy Pace, West Sussex County Council Prevention and Intervention Lead Officer, for his drive and determination to bring all the elements of this report together. Covid-19 presented many challenges to the compilation of this report, and I am grateful for the perseverance of key partners namely West Sussex County Council, Arun District Council, Sussex Police, and Change Grow Live.

Councillor Mrs Alison Cooper

Chair of the Safer Arun Partnership

Executive summary

Synopsis

The illicit drugs market in the UK is worth almost £10 billion a year, with 3 million users and a supply chain that has become increasingly violent and exploitative. Drug deaths are at an all-time high and drug addiction fuels many costly social problems, including homelessness and rising demands on children's social care. The drugs market is driving most of the nation's crimes: half of all homicides and half of acquisitive crimes are linked to drugs. People with serious drug addiction occupy one in 3 prison places.

> - *Dame Carol Black: Independent report Review of drugs part two: prevention, treatment, and recovery*

"Government has long recognised that effective drug treatment makes a significant contribution to limiting drug supply by reducing demand. However, political views have shifted over time on where accountability should lie and on what constitutes good treatment… The demand for opiates and crack/cocaine, and deaths from misuse of these substances, is closely associated with poverty and deprivation"[1]

In January 2018, Bognor Regis was identified for a Home Office Locality Review as a result of the impact of county lines on the town and locale, which was sponsored by the national Violence and Vulnerability Unit. The findings of this report suggested that partners consider producing an informed problem profile charting the current status of the drug market and identified public health as having a major role in terms of understanding the nature of the drug demand locally. This would help to identify the implications on resources for partners going forward.

The local review found "a thriving market for class A drugs" and strong indications of violence linked to county lines activity. The authors concluded that framing these as 'serious organised crime' issues was likely to lead to a lack of engagement from partner agencies in public health and safeguarding, who are vital to incorporating whole systems approaches to reducing drug-related violence and exploitation in the community.

The Pan-Sussex Outcomes Framework (2021)[2] references three core priorities which will define the work of the Sussex Violence Reduction Partnership in the coming period:

- Priority 1: Individuals, organisations and communities to work together to address the **underlying drivers of serious violence across Sussex**.
- Priority 2: Individuals, organisations and communities to work together to **identify young people and vulnerable groups** at risk from serious violence and **address the underlying risk factors**.
- Priority 3: **Raise awareness of the impact and harm** caused by serious violence and ensure all communities are given a voice, by listening, engaging and responding to their concerns.

[1] *Dame Carol Black:* Review of Drugs, Executive Summary *(2020)*
[2] *Sussex Violence Reduction Partnership: Response Strategy (2021)*

National drug policy and strategy aim to work at the levels of (1) Reducing demand, (2) Restricting supply, (3) Building recovery and (4) Global Action.[3] Law enforcement agencies can be traditionally seen as occupying the second of these levels, and treatment and community services as occupying the third. The rationale of a preventative public health approach is that we work locally to address the first of these levels, to reduce the demand for drugs.

The working premise for this report is that:

1. **Demand is driven by a continuing cycle,** whereby drug use affects individual health and the community in a myriad of ways (e.g., mental and physical health problems, violence and exploitation, diminished life opportunities etc.). From a public health standpoint, these then increase risk factors and reduce resilience, making individuals more vulnerable to harm and exploitation.
2. **Understanding the drivers of this continuing cycle** and reducing these at a community level should reduce demand and therefore meet national policy.

Adopting a 'place-based approach', this report aims to explore the prevalence and impacts of drug demand in the Bognor Regis area, using partnership data and learning from the views and experiences of professionals in the community. As in our working model for reducing drug demand, the impacts explored are conceptually divided into health impacts – these being direct to the individual, be they psychological or physical – and community impacts, these being impacts to the civil space, including housing, safety and social outcomes (e.g., education, employment and crime).

The report will:

1. Analyse of the size and scale of the illegal drugs market in Bognor Regis, allowing for a deeper and richer understanding of supply and demand in the town.
2. Consider the associated impacts of drug demand on vulnerability, criminal exploitation of children and adults, and on gangs and violence.
3. Assess the efficacy of this work. As a pilot approach, we cannot be sure that such analyses will bring relevant and timely information to policy leads. Where possible and practical, this method could then be expanded into other areas of the county.

Bringing together this partnership data will allow us greater collective understanding of the demand for drugs in the Bognor Regis area and enable us to create multi-agency and sustainable public health interventions to meet the needs of local residents. This may also provide additional child and adult safeguarding opportunities and present alternative options to tackle the drugs supply in the area for the long term.

[3] Global actions may include international aid and development to discourage employment in drug trafficking industries, increasing international surveillance and partnerships to reduce cross-border trafficking.

The report will be used to:

1. Influence strategic, operational and tactical responses, to influence commissioners and programme funding.
2. Understand the drivers and implications of drug demand.
3. Establish a baseline, using community-level analysis, of current issues and service provision, and the minimum drug demand; collate indices like drug litter and antisocial behaviour; and tie the work into wider contexts, such as public health.

The report will also complement a substance misuse health needs assessment, published in early 2021 by the WSCC Public Health Department, which has acted as the primary evidence base for the recommissioning of drug and alcohol intervention services in the next commissioning cycle.[4]

Structure of the report

The layout of this document will follow the call for a public health approach to reducing drug demand, examining:

1. Prevalence, in terms of drug use, drug type and criminal activity.
2. Impacts in the community, which will include exploitation and violence; criminal activity, arrests, and criminal justice; social care, for adults and for children/families; housing; and education and employment.
3. Impacts on the individual's health and wellbeing, which will include physical health, mental health, addiction, and related service use.

These three themes will be considered first quantitatively in Section 2 and then qualitatively, from the community-level insight, in Section 3. The demographics and characteristics of the individuals within the above are detailed where known.

A full methodological review will summarise the strengths and limitations of this analysis, in Section 4, along with the successes and failure, so as to improve the approach for future iterations.

Results from the quantitative and qualitative data sections will then be synthesized into a final findings and recommendations, in Section 5.

[4] *PHSRU:* West Sussex Substance Misuse Needs Assessment *(2021)*

Key findings – Partnership data

Prevalence:

- Over 300 pieces of drug litter were identified in public spaces by council cleansing teams between 2018 and 2020 and, whilst recording is incomplete, were largely found in or outside of public toilets and located in three streets (Bedford Street, Belmont Street and Waterloo Square) in the centre of the town. A lesser used, but common, location was the Fitzleet multi-storey car park.

- The majority of drug-related offences took place in the centre of Bognor Regis and were for possession of drugs (87%), although drug trafficking offences increased substantially over the period. Offences for possession of cannabis (the most common drug involved), heroin and cocaine also increased over the period.

- The proportion of all stop and searches specifically looking for drugs rose over the three years (69% in 2020) and were mostly conducted in the Hotham, Marine, Orchard and Bersted wards.

- There were 128 recorded drug seizures in the Bognor area between 2018 and 2020; the number of recorded drug seizures in the Bognor area rose each year, although data may be incomplete and the circumstances of seizures unknown.

- Over the three-year period, 38% of seizures were of crack cocaine, 32% of heroin and 20% of cocaine.

- The range of purities of seized crack cocaine and heroin increased each year, with more lower purity drugs being seized for both in 2020 than previous years. The average purity of heroin was 29% in 2020 compared to around 50% in previous years. Purities of crack cocaine ranged from 32% to 95% in 2020, with a third of all seizures being the latter. Excluding outliers, the average purity of cocaine seized in 2020 was 80%.

- Over half of all cocaine, crack cocaine and heroin seizures were of weights of less than a gram and 85% or more of the latter two under 5g.

Impacts in the community:

- Children's social care assessments mentioning parental and/or child drug use increased between 2018 and 2020, rising to 20% of all CSC assessments in the Bognor area in 2020. By age, assessments mainly involve the parent's drug use in the early years, then shift towards the child's drug use in adolescence.

- The need for focused maternity service provision on this topic is clear in that 12% of assessments mentioning drugs were recorded for unborn children and, of all CSC assessments in the Bognor area, over a third of those conducted for pregnant women mentioned drug use.

- Between August 2020 and July 2021, Sussex Police recorded 17 custody arrests for possession with intent or possession of controlled drugs for county lines substances (heroin and crack cocaine) in the Bognor area.

- Three-quarters of people arrested were male and 25-34 year olds accounted for half of all arrests. Around a quarter of people arrested were recorded as having/at risk of a drug dependency and a further quarter as having/at risk of both a drug dependency and mental health issue.

- During the same period, 64 individuals in the Bognor area were linked to and/or flagged as vulnerable to cuckooing, although it was not clear from the data provided whether these people were victims alone or victims and offenders.

- Three referrals of potential victims of modern slavery relating to drugs supply in the Bognor area were made to Sussex Police via the National Referral Mechanism between August 2020 and July 2021, two of whom were under 18 years of age.

- 16% of all offences committed by children living in Bognor Regis during 2018-2020 were drug-related, and nine in ten of these related to possession of cannabis, with one instance of possession with intent to supply cannabis. Most offences resulted in a community resolution and three in a youth caution. Of the 28 offenders, most were male and older adolescents (16-17 year olds), although the age of offenders ranged from 13 years to 17 years.

- Of YJS assessments for children living in Bognor Regis who received a court disposal, 19 had a drug-related issue identified. Most of these started using drugs under the age of 16 (the youngest starting at age 9) and as having a history of cannabis use. Thirteen children had a history of multiple drug use, so were classed as regular drug users. Whilst most of these children were assessed as having low/medium risk likelihoods of reoffending and serious harm to others, the risk likelihood for their safety and wellbeing was largely medium/high.

- A quarter of all referrals to the YJS of children living in Bognor Regis were for substance misuse intervention, with most of these citing an initial action relating to cannabis use.

- Of all offenders known to the Kent Surrey Sussex Community Rehabilitation Company and living in the Bognor Regis area between April 2019 and Jan 2021, 21% were assessed to have a drug need linked to their offending behaviour; of the one in ten of these who had committed a drug-related offence, this proportion rose to a third. Over half of service users with a drug need were reported to be undertaking activities which promote the continual use of drugs.

- There were 374 individuals with a Bognor Regis postcode in structured treatment for drugs misuse with West Sussex DAWN between 2018 and 2020, including 52 individuals who received treatment in two or more separate episodes within the timeframe. 5% of the individuals receiving treatment were recorded as having no fixed abode.

- 73% of individuals were male and 27% female, and the majority aged 25-54 years; proportionally, female service users tended to be more in the younger part of this cohort whilst a greater proportion of male service users were in the older part of this cohort and above.

- Heroin and other opioids/opiates were recorded as the main drug type for over half of all treatment episodes (56%), cocaine a quarter (24%) and cannabis 13%. Over the three years, the proportion of all treatment episodes rose for heroin (37% to 47%) and cannabis (15% to 22%), whilst the proportion of treatments for cocaine fell (31% to 21%).

- Of the treatment episodes where the service user was discharged, three-quarters of episodes lasted for a year or less, with episodes of 5-8 weeks and 9-12 weeks the most frequently recorded; however, in those yet to be discharged, over three-quarters had been in treatment for more than a year.

- Data for needle syringe programmes at the Bognor geography were not available, although data for Arun showed an average of 500 transactions per month during 2020/21.

Impacts on health:

- There were 78 attendances by people living in the Bognor Regis geography to St. Richard's A&E where illicit drug use was recorded between 2018 and 2020, although the number of attendances decreased year-on-year.

- Attendances by males were consistently higher than females, although decreased year-on-year, whilst the small number of female attendees remained stable. Most attendances were made by people aged 16-24 years, followed by 25-34 year olds; half of female attendees were in the 16-24 years age bracket whilst males were more spread out across the ages.
- More male attendees went on to be admitted to the inpatient ward than females, as did those in the older cohorts, although the overall number of those admitted decreased year-on-year.

- Over the three years, most attendances were made by people living in the Bersted, Hotham and Marine wards. By IMD ranking, 87% of attendees lived in deciles 1-6 (1 being the most deprived); nearly a third of attendees lived in the two most deprived deciles.

Key findings – Qualitative engagement

Impacts in the community:

- A significant portion of all local crime was believed to be driven by funding drug use. Drug dealing and theft were seen as common methods to acquire funds for personal drug use, whilst street begging was believed to have become more common and had been normalised.

- Young people's drug use was suggested to be funded by stealing from family members; alternative routes to acquire substances were also suggested, such as swapping prescription medications for street methadone and offering money to vulnerable addicts to shoplift alcohol for them.

- Vulnerable females were believed to be engaged in sex work to fund their drug use; there was said to be too little support and protection for these individuals.

- Exposure to violence for individuals in the drug-related community was believed to be commonplace, with unpaid drug debts cited as main driver. A pattern of getting young people trapped in 'debt bondage' was also mentioned.

- Sexual, physical and financial abuse when under the influence of drugs was thought to be common, as was cuckooing by drug suppliers. Those who were homeless or rough sleeping were said to be extremely vulnerable, as were those in co-dependent relationships.

- Those attempting to end their drug use were said to lose access to community support, meaning less peer support should they be a victim of violence or intimidation.

- Drug debts were believed to be a primary driver of fear for one's safety, causing people to want to flee into hiding or relocate. However, being unable to flee an adequate distance – due to a shortage of emergency housing, for instance – and not having the full support of housing providers to do so were also mentioned, as was the lack of community/peer support in new areas for those able to move.
- Those living with dealers or drug users were said to be at risk from domestic abuse and violence related to drug debts, and to fear unpredictable behaviour from partners' using drugs.

- Some young people in residential care were believed to be afraid to return home, due to violence and exploitation in the local area.

- Fear of violence was said to be a cause of under-reporting issues to the police.

- Drug use was said to affect every aspect of a person's life and wellbeing; impacts relating to many of the wider determinants of health, such as poverty, unemployment, homelessness and more, were discussed.

- Reinforcing cycles entrenching people into drug use were frequently described, such as loss of family support resulting in other drug users becoming the only people individuals would interact with; loss of accommodation leading to homelessness, begging and antisocial behaviour; and greater drug use to cope with the negative mental health impacts of addiction leading to increasingly chaotic lives.

- Mental health issues were related to barriers to treatment; individuals with mental health problems may find drug treatment difficult whilst mental health treatment is rarely accessible for those still using drugs.

- A negative cycle in younger people using cannabis was described, with a lack of motivation leading to lack of engagement with education, training and employment and a resulting lack of funds, leading to stealing from their family and retail theft, and the risk of a spiral of exploitation.

Impacts on health:

- Mental health problems were reported to increase the likelihood of substance misuse whilst substance misuse was observed to lead to a variety of mental health issues and disorders, including psychosis, eating disorders, depression, poor sleep patterns, alcohol abuse, self-harm and suicidal ideation. Suicide attempts were known to result in A&E attendances from serious self-harm.

- Accessing mental health support was seen as difficult, with drug users finding it difficult to accept help due to professional stigma and some providers requiring drug cessation to begin treatment.
- Self-medication for mental health problems with further drug use was said to be commonplace.

- Complications from injecting (e.g., infections, amputations, sepsis) were commonly mentioned as physical health impacts, as were deaths from overdoses, whilst needle sharing was known to result in communicable disease, such as hepatitis and HIV.

- Most individuals were said to have been in hospital at least once as a result of the above, in addition to drug-associated violence or mental health problems. However, those with mental health problems were reported to be released from hospital after only minimal treatment, due to the complexity of their needs.

- Individuals being found unconscious in public with heavy withdrawal symptoms, overdoses or adverse reactions from tainted drug batches were also mentioned.

- Other physical health impacts, ranging from liver failure to dental problems to dementia, were seen as commonplace, yet drug use was believed to reduce regular engagement with health services.

Commissioning and community responses:

- Adverse Childhood Experiences (ACEs) and school exclusions were believed to make young people more vulnerable to habitual drug use, whilst experiences of trauma, domestic abuse and exploitation were said to affect people of all ages.

- Poverty, homelessness, unemployment and lifestyle were frequently mentioned as major risk factors for drug use, whilst the ongoing austerity in public services was felt to have had a negative impact.

- Risks in the wider social environment included return to a negative environment after detox and availability of drugs in the community; negative peer influences or lack of positive social peer-support; relationship breakdown or removal of children; and isolation resulting from housing and relocation.

- Mental health problems were also seen as a vulnerability for drug use, yet drug use was described as creating barriers to mental health support, due to weaker support for 'dual-diagnosis' issues.
- Interventions and opportunities for younger ages were regarded as important to reduce vulnerabilities to drug use (e.g., youth clubs, volunteering and counselling), as were increased employment opportunities and better education and retraining for adults.

- The need for networks between services providing support and reform was discussed, with a move away from criminal justice alone to a prevention-based approach to risk factors.

- Better education and training opportunities for frontline workers were seen as a service priority for more effective working and insight-sharing, as were trauma-informed approaches in multiagency settings and utilising more outreach workers.

- Integrated care and dual diagnosis support becoming the norm were outlined as needed by respondents, in addition to a wider understanding of the complexities surrounding addiction.

- Regarding safeguarding, improved mechanisms to allow individuals to 'flee' to safe accommodation in a different local authority or to move families away from areas of high drug use were also raised.

- Barriers to accessing support ranged from a personal level to service/system level. Of the former, low resilience, a dependency on drugs to 'feel normal' and not admitting that they have a drug problem were cited as barriers, as were shame, perceived professional stigma and mistrust following previous negative experiences with services.

- Fear of involvement from children's social services and losing custody of their children was a major obstacle for some in accessing support, and fear of arrest.

- Underfunded and inflexible services with long waiting lists were further obstacles, as were travel costs to reach in-person services and lack of foreign language translators.

- Mental health services were believed to often screen people 'out' of the service, rather than screening them 'in', and there was said to be a shortage of mental health provision after a period of detox.

- Feelings of helplessness were said to arise from lack of information on available services and self-referral, or inability to access these.

- Lack of service provision more widely – believed to be affected by short-term funding cycles – and joined-up working were further issues, with lack of walk-in support, temporary accommodation, outreach workers and drug-support workforce mentioned.

Recommendations and methodological review

The following outline priority areas of work which span across partnerships, and so require an embedded partnership response. These are framed within the theoretical models outlined in Section 1, of public health approaches to risk and resilience factors, the wider determinants of health, and place-based solutions.

Referring to the public health approach to reducing drug demand in the community, defined in Section 1, it is possible to minimise negative individual and community-level impacts across the partnership, by addressing vulnerabilities and improving resilience in the community.

- Reducing community level impacts

Start of life:

Adverse Childhood Experiences (ACEs) and school exclusions were believed to make young people more vulnerable to habitual drug use, whilst experiences of trauma, domestic abuse and exploitation were said to affect people of all ages.

Clear vulnerabilities exist in childhood, as explained in the number of Children Social Care assessments including reference to substance misuse. This includes pre-natal periods of development. Fear of involvement from children's social services and losing custody of their children was a major obstacle for some in accessing support, and fear of arrest.

Children and young people:

Young people's involvement with the police and youth justice often concerned possession of cannabis. Of these, most were young men and boys. Many of these started using drugs under the age of 16 and were regular drug users.

Interventions and opportunities for younger ages were regarded as important to reduce vulnerabilities to drug use (e.g., youth clubs, volunteering, and counselling), as were increased employment opportunities and better education and retraining for adults.

Police and criminal justice involvement with drugs in the community is largely concentrated in those under the age of 35; for those with mental health issues; and for those with drug dependency issues.

Exploitation and safeguarding:

Modern slavery and exploitation are known to occur in Bognor Regis, with a link to drug markets. Fear of violence was said to be a cause of under-reporting issues to the police.

Being under the influence of drugs was said to present a significant safeguarding risk to the individual, who is more vulnerable to sexual and financial exploitation. It was suggested that not enough is being done to support vulnerable persons engaged in sex work, as a method to fund their drug dependence.

Crime and support:

A significant portion of all local crime was believed to be driven by funding drug use. Drug dealing and theft were seen as common methods to acquire funds for personal drug use, even amongst children and young people.

The need for networks between services providing support and reform was discussed, with a move away from criminal justice alone to a prevention-based approach to risk factors.

Unpaid depts and financial pressures were believed to be primary mechanisms through which people were exploited or coerced into drug dealing and habitual use.

Housing, relocation and community networks:

People who attempt to end their drug dependence can often find themselves removed from previous peer support networks, leaving them isolated. This also manifests for those who attempt to flee or relocate from unsafe environments, domestic violence, and exploitation. A shortage of secure social housing can also make relocation inflexible, placing vulnerable individuals either too close or too far from their hometowns.

Risks in the wider social environment included return to a negative environment after detox and availability of drugs in the community; negative peer influences or lack of positive social peer-support; relationship breakdown or removal of children; and isolation resulting from housing and relocation.

Regarding safeguarding, improved mechanisms to allow individuals to 'flee' to safe accommodation in a different local authority or to move families away from areas of high drug use were also raised.

Community responses and commissioning:

Drug use was said to affect every aspect of a person's life and wellbeing, creating a cyclical relationship which impacts many of the wider determinants of health, such as poverty, unemployment, homelessness and more. The ongoing austerity in public services was felt to have had a negative impact on service outreach and delivery.

Lack of service provision more widely – believed to be affected by short-term funding cycles – and joined-up working were further issues, with lack of walk-in support, temporary accommodation, outreach workers and drug-support workforce mentioned.

Better education and training opportunities for frontline workers were seen as a service priority for more effective working and insight-sharing, as were trauma-informed approaches in multiagency settings and utilising more outreach workers.

- Improving health and treatment

Drug treatment services:

Those who enter drug treatment do not always complete successfully and may represent at a later date. Heroin addiction is the largest primary reason for drug treatment.

Coexisting mental health and substance misuse:

Mental health issues were known to create barriers to accessing and completing drug treatment programmes, whilst substance addiction was itself a barrier to accessing mental health treatment.

Mental health services were believed to often screen people 'out' of the service, rather than screening them 'in', and there was said to be a shortage of mental health provision after a period of detox.

Integrated care and dual diagnosis support becoming the norm were outlined as needed by respondents, in addition to a wider understanding of the complexities surrounding addiction.

Accessibility of treatment and support services:

Barriers to accessing support ranged from a personal level to service/system level. Of the former, low resilience, a dependency on drugs to 'feel normal' and not admitting that they have a drug problem were cited as barriers, as were shame, perceived professional stigma and mistrust following previous negative experiences with services.

Underfunded and inflexible services with long waiting lists were further obstacles, as were travel costs to reach in-person services and lack of foreign language translators.

Feelings of helplessness were said to arise from lack of information on available services and self-referral, or inability to access these.

Secondary care services:

Drug use and dependence is a driver of demand of Accident and Emergency departments, as well as hospital inpatient wards. This is particularly driven by young people and males. The majority of attendances can be mapped to areas of higher deprivation.

- Methodological approach

Partnership working:

The group generally felt that the quantitative data were useful but were limited by aforementioned complications in their extraction from the data-holding organisations. The insights gained from future iterations of the project would likely improve with a more streamlined and cooperative partnership. Overall, the group felt that the project has been successful and, with some of the complications and limitations ironed out, future iterations should be considered, both with the quantitative and qualitative components intact.

It was recommended that, in the future, participation from senior managers for each area/organisation be agreed by SWSP executive board, so that data collection can be better facilitated, and regular feedback and accountability can be maintained at senior levels.

The group felt that future efforts should ensure that the most senior people available in the organisations should be approached for their buy-in, to increase the timeliness of responses.

Data collection:

One common barrier to timely responses was that many organisations require standardised data requests, using template forms, requesting exact fields. In future it is recommended that each analyst or representative first be approached one-to-one, to discuss the data they carry, to ensure that requests are realistic, manageable, and collect the most effective fields.

Whilst these are largely in Bognor Regis, they do include some satellite villages. Consideration of the geographies of data collection should be made in future iterations, as should development of clear data-sharing agreements where individual-level postcodes are stored.

In terms of sharing, it is possible that there is a degree of over-caution about data protection, which can inhibit expediency in sharing; a clear information sharing agreement may aid future iterations. Any recommendations for data storage and sharing can be incorporated into the Sussex Police-led 'Drug related harm reduction strategy for West Sussex'.

Qualitative engagements:

The quality of data from the community engagement was praised, but the gaps in data from the low response were sorely missed by the group. Whilst the professionals did contribute rich data, it was not possible to contrast their views with those of the service users and vulnerable younger people. It is hoped that future iterations of this work will be able to balance the professional view with those of residents.

The insights from the qualitative component were seen to be useful where these were realised from the professionals. However, some in the group felt that the questions were too general to provide sufficient richness of data for their working area/profession. It was recommended that, where possible, future engagements should revolve around live conversations, rather than template surveys, either as one-to-one interviews (easily conducted over the phone) or focus groups for multiple participants of the same cohort.

Defining terms:

One limitation of the feedback from professionals was that we did not ask explicitly enough what, if anything, makes Bognor Regis distinct to other areas. This oversight was because we were unable to sufficiently pilot the questions with a range of stakeholders before the wider roll-out. Following this, it was felt that much of the insight could be similar to those of any local geography. However, whilst this possibility remains, it may be that findings from other geographies in the future will contain different issues, and therefore validate the salience of the Bognor Regis-level data.

Project management:

More practically, over the course of the project it became apparent that a single project manager to bring in data, negotiate returns, increase engagement, and maintain deadlines would have been beneficial. Similarly, whilst efforts were made to obtain an experienced analyst to dedicate full time to the collation, interpretation, and write-up of the data, this was ultimately performed by a member of the working group, with other responsibilities. Increased meeting frequency for the working group may also have expedited some elements of the project. Future efforts should not negate the necessity of dedicated resources to facilitate the project, from conception to publication.

Future geographies:

The group proposed two candidate geographies for future iterations in West Sussex: Littlehampton and Crawley. It is entirely possible that these two separate geographies could be conducted simultaneously, should sufficient project-management and support resources be applied to maintaining a balanced and consistent approach. An alternative presented was to conduct this work in an area that was not believed to have a heavy county lines presence, as a comparison.

1. Background and introduction

The illicit drugs market in the UK is worth almost £10 billion a year, with 3 million users and a supply chain that has become increasingly violent and exploitative. Drug deaths are at an all-time high and drug addiction fuels many costly social problems, including homelessness and rising demands on children's social care. The drugs market is driving most of the nation's crimes: half of all homicides and half of acquisitive crimes are linked to drugs. People with serious drug addiction occupy one in 3 prison places.

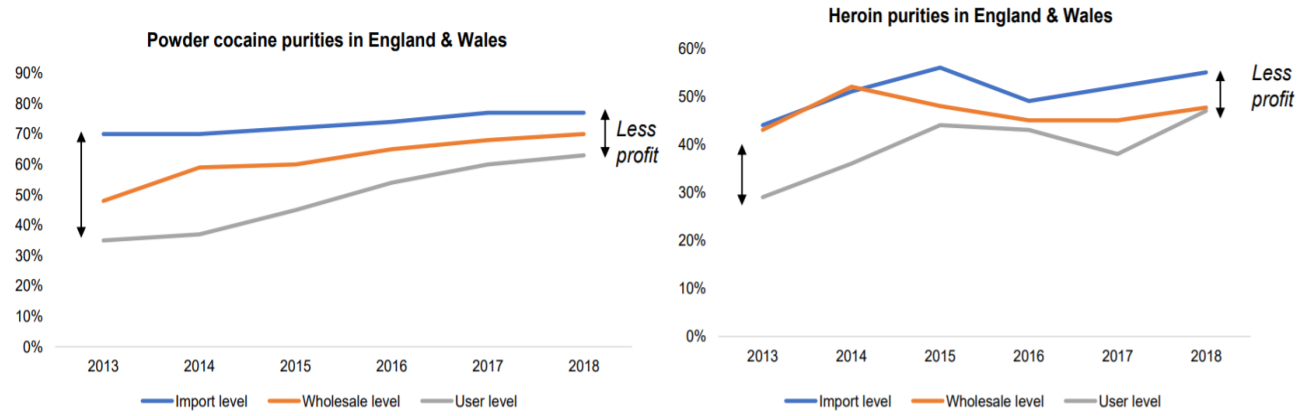
> - *Dame Carol Black: Independent report Review of drugs part two: prevention, treatment, and recovery*

National policy

"Government has long recognised that effective drug treatment makes a significant contribution to limiting drug supply by reducing demand. However, political views have shifted over time on where accountability should lie and on what constitutes good treatment… The demand for opiates and crack/cocaine, and deaths from misuse of these substances, is closely associated with poverty and deprivation."[5]

"Data on drug purity provides an indication of the ease of supply into the UK, the levels of profit made at different levels of the market, and the level of competition in the market. Data on the surge in cocaine production suggests an increasingly competitive UK market, with increased purities evidencing that supply is outstripping demand. With street prices for powder and crack cocaine remaining constant, this has eroded profits per gram of cocaine sold at the retail stage. However, increase in usage balances this out to a certain extent".[6]

Figure 1.1, Example of national trends in drug purities



Source: Dame Carol Black: Review of Drugs - evidence relating to drug use, supply and effects, including current trends and future risks (2020), p.47

5 Dame Carol Black: Review of Drugs, Executive Summary (2020)
[6]Dame Carol Black: Review of Drugs - evidence relating to drug use, supply and effects, including current trends and future risks (2020)

"Data could include hospital data on knife injuries, the number of exclusions and truancies in local areas, police recorded crime, missing data and other measures of vulnerability, volume of ACEs, Police Systems data (local crime information), CAD data (emergency call requests), areas of high social services interventions, and information on threats such as county lines including the activity of serious organised crime gangs and on drugs markets, data on reoffending and retaliation, etc."[7]

"Without involvement from the Department for Health and Social Care and the Department for Education, it will not be possible to embed early intervention and prevention measures across all key agencies and implement the right interventions to divert individuals away from violent crime."[8]

Local policy

In January 2018, Bognor Regis was identified for a Home Office Locality Review as a result of the impact of county lines on the town and locale, which was sponsored by the national Violence and Vulnerability Unit. The findings of this report suggested that partners consider producing an informed problem profile charting the current status of the drug market and identified public health as having a major role in terms of understanding the nature of the drug demand locally. This would help to identify the implications on resources for partners going forward.

The local review found "a thriving market for class A drugs" and strong indications of violence linked to county lines activity. The authors concluded that framing these as 'serious organised crime' issues was likely to lead to a lack of engagement from partner agencies in public health and safeguarding, who are vital to incorporating whole systems approaches to reducing drug-related violence and exploitation in the community.

A central finding of the review was that there was: "Not much understanding amongst those interviewed of how the local drug market works and what drives it – this is how public health should be involved, in order to verify and assess the medium and short terms implications of increased drug use." From these, several recommendations were included on the topic of partnership intelligence gathering and identifying local risks.

In May 2018, the Violence and Vulnerability Unit also produced the report 'County Lines – a national summary & emerging best practice'[9]. The work of Bedfordshire and Essex in successfully drawing in public health professionals was noted as emerging best practice but it was concluded that no one can really explain/understand the local drugs market and how they are driving violence.

The Pan-Sussex Outcomes Framework (2021)[10] references three core priorities which will define the work of the Sussex Violence Reduction Partnership in the coming period:

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[7] *UK Home Office: Violence Reduction Unit Interim Guidance (2020)*
[8] *Local Government Association: Police, Crime, Sentencing and Courts Bill: Second Reading, House of Lords (2021)*
[9] *The Violence and Vulnerability Unit: County lines - a national summary & emerging best practice (2018)*
[10] *Sussex Violence Reduction Partnership: Response Strategy (2021)*

- Priority 1: Individuals, organisations and communities to work together to address the **underlying drivers of serious violence across Sussex**.
- Priority 2: Individuals, organisations and communities to work together to **identify young people and vulnerable groups** at risk from serious violence and **address the underlying risk factors**.
- Priority 3: **Raise awareness of the impact and harm** caused by serious violence and ensure all communities are given a voice, by listening, engaging and responding to their concerns.

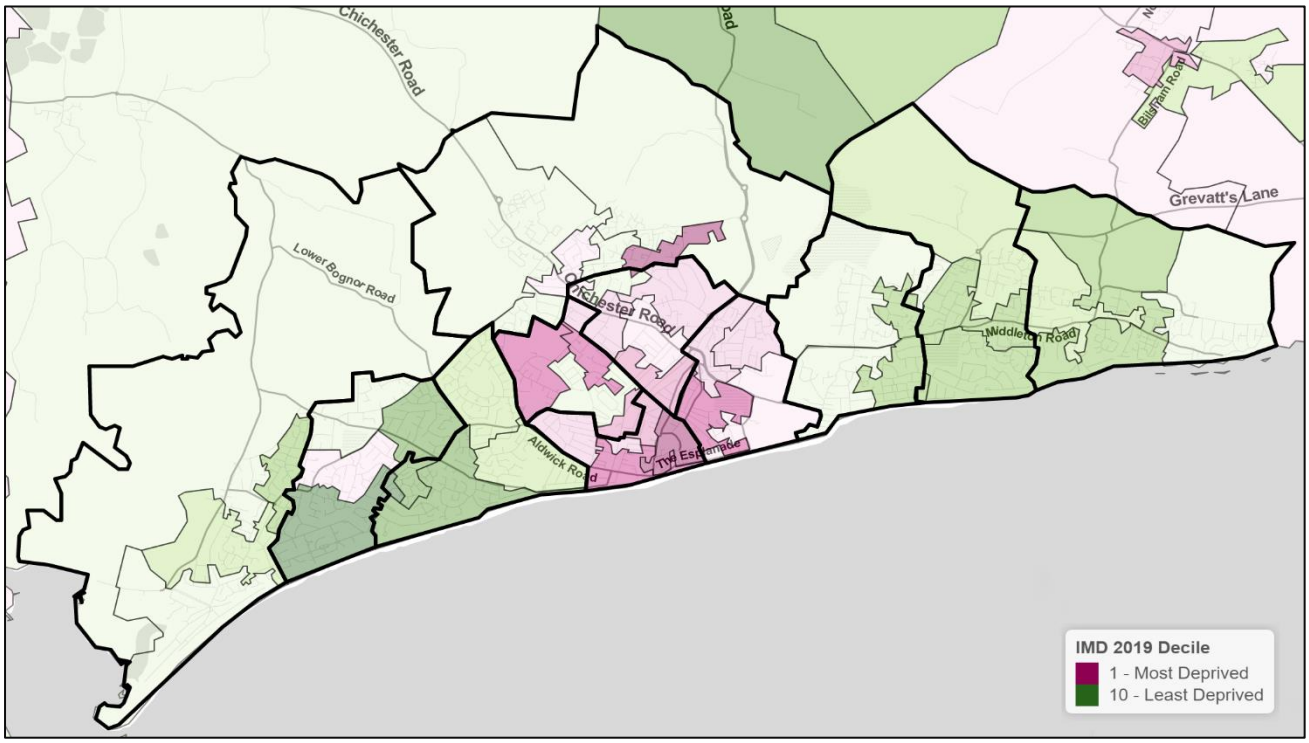
Setting the context of Bognor Regis

Bognor Regis is a coastal seaside town, in the county of West Sussex on the South coast of England and is within the unitary authority of Arun District. The population of the Bognor Regis area, including Felpham, Middleton, Flansham and Elmer to the East, and Aldwick, Rose Green and Pagham to the West, was 64,000 at the 2011 census, and the building of several new estates since then implies some thousands more by 2021.

There are direct rail links with London and the town sits between the nearby cities of Portsmouth to the West and Brighton and Hove to the East.

Within Bognor Regis are areas of deprivation, comprising the majority of the four central wards, Hotham, Marine, Orchard and Pevensy, and also to the north of the town in Bersted. Figure 1.2 shows deprivation relative to England averages, based around Barriers to housing services, Crime, Employment, Education skills and training, Health and disability, Income, and Living environment.

Figure 1.2, Bognor Regis wards, by national deciles of Index of Multiple Deprivations-2019



Source: PHSRU, using ONS, IMD (2019) figures

'Taking a Public Health approach'

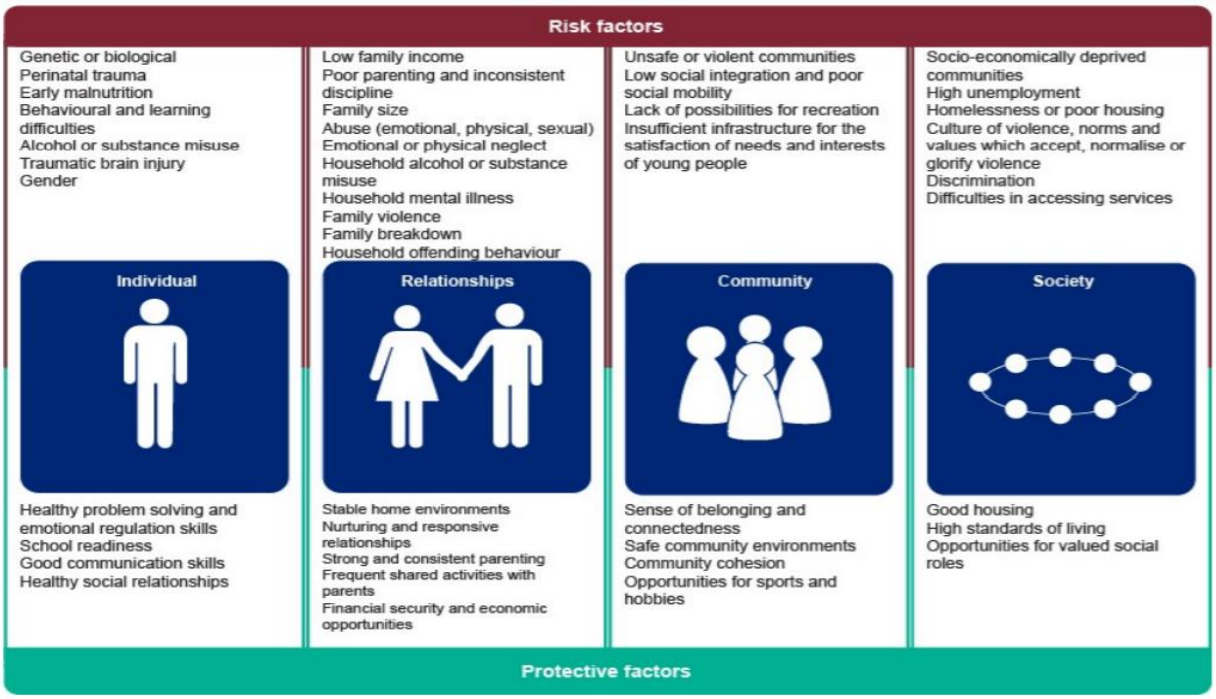
Public health has been defined as the science and art of (1) preventing disease, (2) prolonging life, and (3) promoting health and efficiency through organised community efforts.[11]

The focus of public health is on the health, safety and wellbeing of entire populations; it aims to provide the maximum benefit for the largest number of people.

Public health relies on knowledge from a broad range of disciplines including medicine, epidemiology, sociology, psychology, criminology, education and economics, as well as input from a range of public and private sectors working in health, social care, education, justice and policy. For these reasons, public health is often referred to as a multi-agency approach; however, there are six guiding principles of public health which incorporate a broader set of skills than partnership working alone. The underlying principles of a public health approach define it as being:

- focused on a defined population, often with a health risk in common
- with and for communities
- not constrained by organisational or professional boundaries
- focused on generating long term as well as short term solutions
- based on data and intelligence to identify the burden on the population, including any inequalities
- rooted in evidence of effectiveness to tackle the problem

Figure 1.3, Risk factors which increase the likelihood of violence and protective factors which mitigate against perpetration or victimisation of violence (11-16)

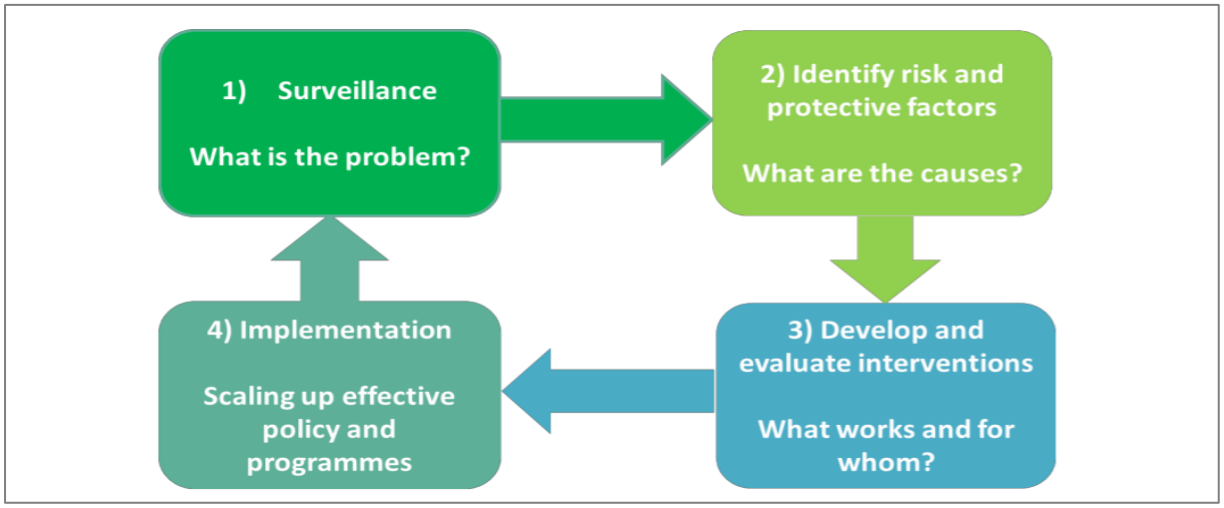


Source: PHE, A whole-system multi-agency approach to serious violence prevention A resource for local system leaders in England (2019)

[11] PHE: *A whole-system multi-agency approach to serious violence prevention A resource for local system leaders in England* (2019)

The cycle of a public health approach, shown in Figure 1.3, can be described as 1) identifying the problem; 2) identifying risk/protective factors; 3) developing and evaluating interventions; and 4) scaling up the implementation of effective interventions.[12]

Figure 1.4, WHO model of public health processes for violence prevention (2014)



Source: WHO, Global status report on violence prevention (2014)

The wider determinants of health:

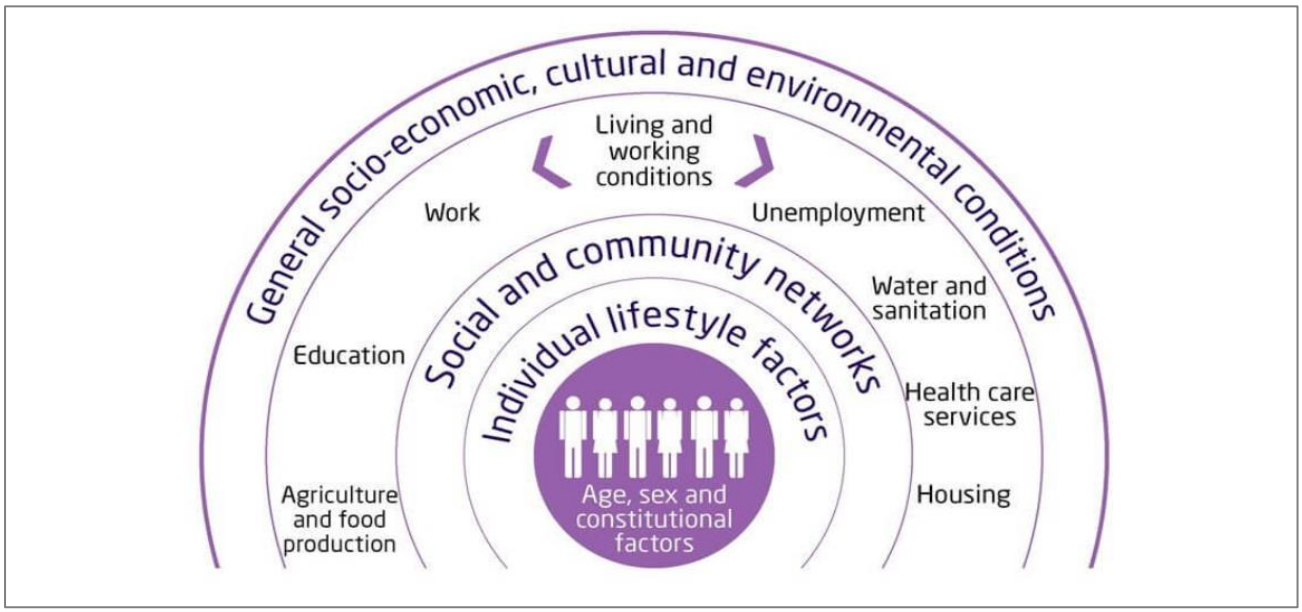
The wider determinants of health are a conceptual framework for understanding how persistent health inequalities interact with persistent social inequalities for individuals and communities. It is important to note that the relationship is bi-directional, and that poor health can diminish social outcomes. Therefore, addressing social inequalities can improve population health, and improving population health can improve social outcomes elsewhere.[13]

"**Wider determinants**, also known as **social determinants**, are a diverse range of social, economic and environmental factors which **impact on people's health**. Such factors are influenced by the local, national, and international distribution of power and resources which shape the conditions of daily life. They determine the extent to which different individuals have the **physical, social and personal resources** to identify and achieve goals, meet their needs and deal with changes to their circumstances. The Marmot review, published in 2010, raised the profile of wider determinants of health by emphasising the strong and persistent **link between social inequalities and disparities in health outcomes**. Variation in the experience of wider determinants (i.e., social inequalities) is considered the fundamental cause (the 'causes of the causes') of health outcomes, and as such health inequalities are likely to persist through changes in disease patterns and behavioural risks so long as social inequalities persist. Addressing the wider determinants of health has a **key role to play in reducing health inequalities**, one of PHE's core functions."

Source: Public Health England: Wider Determinants of Health - https://fingertips.phe.org.uk/profile/wider-determinants

[12] *WHO: Global status report on violence prevention (2014)*
[13] *For a complete examination of these issues, see WHO Europe: European strategies for tackling social inequities in health: Levelling up Part 2 (2007)*

Figure 1.5, The wider determinants of health



Source: The King's Fund, referencing Dahlgren, G. and Whitehead, M. (1993) Tackling inequalities in health: what can we learn from what has been tried?

A place-based approach:

Place is both a physical setting and social context. It means different things to different people but always relates to somewhere meaningful to the individual. A place-based approach crosses organisational boundaries and is intended to reduce 'siloed working' by bringing partners together to focus on improving long term outcomes of the 'whole place' and not just individuals. To be effective, the place must be meaningful to, and therefore defined by, local partners, including members of the community.

Each place has its own histories and dynamics and these will influence how a partnership is formed, who participates in it and how it relates to the wider community. It is important to know these previous histories as these are part of the local knowledge, expertise and context which a partnership can build upon.[14]

Other examples of drug demand analyses:

Two examples of drug market profiles were reviewed to aid the scoping of this project: The Bedfordshire Police 'Drug Market Profile: Summary Document' (2019)[15]; and the North Wales Safer Communities Board 'Multi-Agency County Lines Needs Assessment' (2019)[16]. These both followed qualitatively different approaches, with the former focusing on the market and criminal

[14] *LGA: Place-based partnership working (2021)*
[15] *Bedfordshire Police: Drug Market Profile: Summary Document (2019)*
[16] *North Wales Safer Communities Board: Multi-Agency County Lines Needs Assessment (2019)*

business analyses of drug use in the community, and the latter focusing on the links to serious violence, exploitation and vulnerability.

The North Wales document provided an example framework of an applied 'public health approach'; thus, the structure and tone of this report was favoured by the working group. However, whilst the North Wales report mainly focused on serious safeguarding concerns, such as domestic violence and exploitation, this analysis will take a broader view including community, health and wellbeing issues.

Conceptual framework and methodological approach

National drug policy and strategy aim to work at the levels of (1) Reducing demand, (2) Restricting supply, (3) Building recovery and (4) Global Action.[17] Law enforcement agencies can be traditionally seen as occupying the second of these levels, and treatment and community services as occupying the third. The rationale of a preventative public health approach is that we work locally to address the first of these levels, to reduce the demand for drugs.

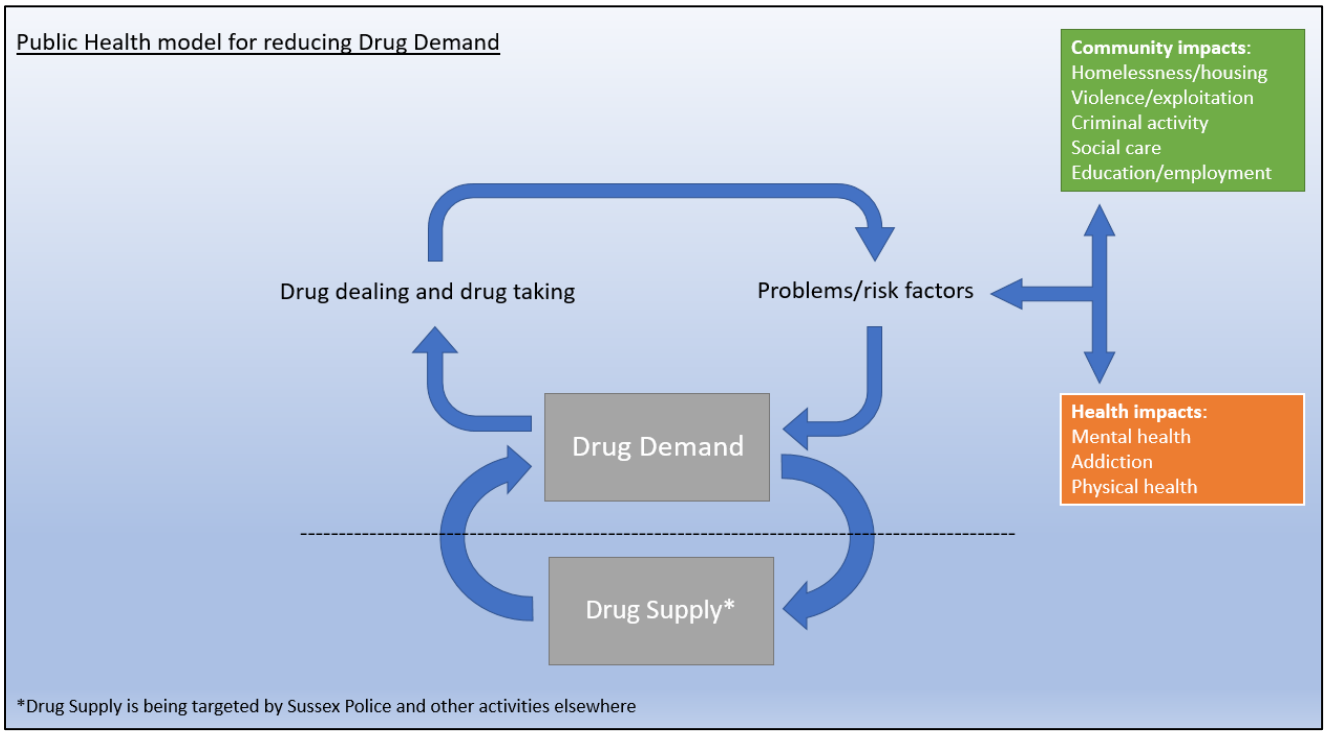
The working hypothesis for this report is that:

1. **Demand is driven by a continuing cycle,** whereby drug use affects individual health and the community in a myriad of ways (e.g., mental and physical health problems, violence and exploitation, diminished life opportunities etc.). From a public health standpoint, these then increase risk factors and reduce resilience, making individuals more vulnerable to harm and exploitation.
2. **Understanding the drivers of this continuing cycle** and reducing these at a community level should reduce demand and therefore meet national policy.

Adopting a 'place-based approach', this report aims to explore the prevalence and impacts of drug demand in the Bognor Regis area, using partnership data and learning from the views and experiences of professionals in the community. As in our working model for reducing drug demand, the impacts explored are conceptually divided into health impacts – these being direct to the individual, be they psychological or physical – and community impacts, these being impacts to the civil space, including housing, safety and social outcomes (e.g., education, employment and crime).

[17] Global actions may include international aid and development to discourage employment in drug trafficking industries, increasing international surveillance and partnerships to reduce cross-border trafficking.

Figure 1.6, Working model for reducing drug demand in West Sussex (2021)



The report will:

1. Analyse of the size and scale of the illegal drugs market in Bognor Regis, allowing for a deeper and richer understanding of supply and demand in the town.
2. Consider the associated impacts of drug demand on vulnerability, criminal exploitation of children and adults, and on gangs and violence.
3. Assess the efficacy of this work. As a pilot approach, we cannot be sure that such analyses will bring relevant and timely information to policy leads. Where possible and practical, this method could then be expanded into other areas of the county.

Bringing together this partnership data will allow us greater collective understanding of the demand for drugs in the Bognor Regis area and enable us to create multi-agency and sustainable public health interventions to meet the needs of local residents. This may also provide additional child and adult safeguarding opportunities and present alternative options to tackle the drugs supply in the area for the long term.

The document will be used to:

1. Influence strategic, operational and tactical responses, to influence commissioners and programme funding.
2. Understand the drivers and implications of drug demand.
3. Establish a baseline, using community-level analysis, of current issues and service provision, and the minimum drug demand; collate indices like drug litter and antisocial behaviour; and tie the work into wider contexts, such as public health.

The report will also complement a substance misuse health needs assessment, published in early 2021 by the WSCC Public Health Department, which has acted as the primary evidence base for the recommissioning of drug and alcohol intervention services in the next commissioning cycle.[18]

Structure of the report

The layout of this document will follow the call for a public health approach to reducing drug demand, examining:

1. Prevalence, in terms of drug use, drug type and criminal activity.
2. Impacts in the community, which will include exploitation and violence; criminal activity, arrests, and criminal justice; social care, for adults and for children/families; housing; and education and employment.
3. Impacts on the individual's health and wellbeing, which will include physical health, mental health, addiction, and related service use.

These three themes will be considered first quantitatively in Section 2 and then qualitatively, from the community-level insight in Section 3. The demographics and characteristics of the individuals within the above are detailed where known.

A full methodological review will summarise the strengths and limitations of this analysis, in Section 4, along with the successes and failure, so as to improve the approach for future iterations.

Results from the quantitative and qualitative data sections will then be synthesized into a final findings and recommendations, in Section 5.

[18] *PHSRU:* West Sussex Substance Misuse Needs Assessment *(2021)*

2. Data analysis

2.1 Approach

Data collection from various partners began in the autumn of 2020, with approaches to partners first ascertaining whether these internal departments or external organisations held any data relevant to drug use in the Bognor Regis area, followed by requests for these data, if held. Many of the third sector organisations approached were unable to provide quantitative data relating to drugs, as this is not routinely collected, but were keen to provide views and experience via a qualitative engagement approach (see section 3).

Data were requested for the three-year period 2018-2020 (inclusive), covering the Bognor Regis postcodes PO21 and PO22 (with the caveat that these also cover small areas of countryside and satellite villages).

All submissions were analysed by the authors of this report and are summarised over the following pages.

Table 2.1, Partners approached and corresponding data avenues explored

Department/organisation approached	**Data avenues explored**
Prevalence	
Arun District Council	• Drug litter found by the Cleansing team
Sussex Police	• Drug-related offences • Stop and searches for drugs • Drug purities and seizures • *Integrated Offender Management* • *Controlled Drug Liaison Officers (i.e., pharmacy links)* • *Licensing Officers*
Impacts in the community	
WSCC Adult Social Care	• *Drug misuse is not routinely recorded; data are only recorded where the Drug and Alcohol Action Team put funded services in place for adults, but support for drugs and alcohol is not disaggregated.*
WSCC Children's Social Care (CSC)	• CSC assessments where drug use is mentioned for either the parent/carer, child or both
Individual schools	• Several schools in the Bognor Regis area were approached for permanent exclusion data; over the three-year period, there were no permanent exclusions relating to drug or alcohol use.
Sussex Police	• County lines and exploitation data, including referrals to the National Referral Mechanism for modern slavery relating to drugs
British Transport Police	• Drug-related offences at the end-of-the-line Bognor Regis train station – nil return • *Any other drug-related incidents*
WSCC Youth Justice Service (YJS)	• YJS assessments with drug-related issues identified and/or referrals for substance misuse interventions
Probation Services (Kent Surrey Sussex Community Rehabilitation Centre)	• Service users who have committed a drug-related offence and/or have drug need linked to their offending behaviour
Change Grow Live – local drug treatment service	• NDMTS data for service users in structured treatment • Needle and syringe programme
Homelessness charities	• *Quantitative data relating to drug misuse are not routinely collected*
Voluntary and community organisations	• *Quantitative data relating to drug misuse are not routinely collected*
Arun District Council	• *Housing* • *Antisocial behaviour* • *Revenue and benefits*
West Sussex Fire and Rescue Service	• *Data relating to illicit drug use are not specifically recorded*
Impacts on health	
St Richard's Hospital	• A&E attendances where illicit drug use was recorded
Bognor Medical Centre (GPs)	• *Patients recorded with drug misuse*
The Bedale Centre – Community Mental Health	• *Patients recorded with drug misuse*
South East Coast Ambulance (SECAmb)	• *Drug-related incidents attended*

Note: Some organisations were approached for multiple themes of data so are shown multiple times. Data avenues in grey italics were explored but not available for a variety of reasons.

2.2 Prevalence

The following concerns data describes the scale of drug activity in the Bognor Regis area.

Drug litter:

Arun District Council contracts a cleansing team to maintain clean public spaces, with town centres and busy areas cleaned daily whilst other roads in the district are cleaned on a rota basis. The number of pieces of drug litter collected from these public spaces is recorded, although recording is inconsistent and the recorded data incomplete. Moreover, other organisations, such as Bognor Regis Town Council, also collect litter but do not record the volume of drug litter found. Thus, the following data provides an illustration of the drug activity in public spaces in the Bognor area, but does not represent all public drug use or observed litter.

In the three-year period 2018-2020, there were 321 pieces of drug litter recorded by Arun District Council. Due to the significantly lower numbers recorded in 2019, this year is assumed to have had data collection issues. There were a further 86 pieces of litter recorded in the first nine months of 2021. In one instance this was burnt foil, but in all other cases these were needles and syringes.

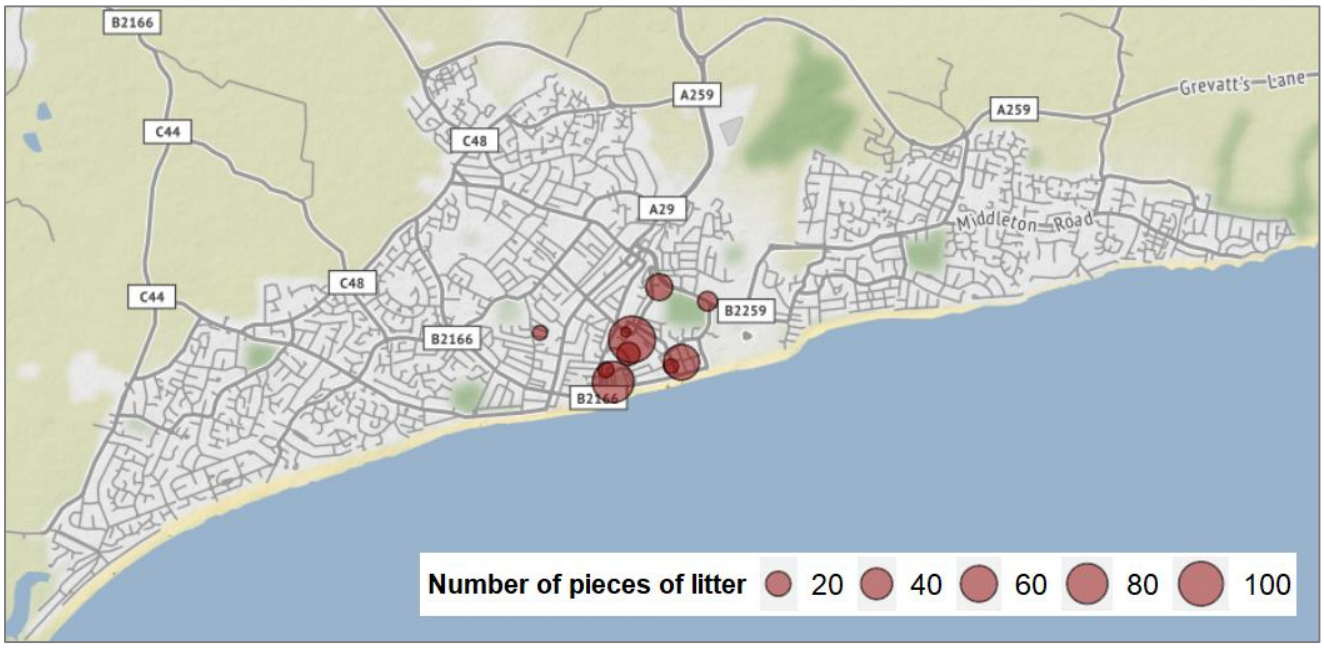
The majority of finds were in three streets: Bedford Street (which runs past the Morrisons supermarket), Belmont Street (to the rear of the Regis Centre), and Waterloo Square (opposite to the pier). In all three locations there are public toilets, where most of the findings were recorded. A lesser used, but common, location was the Fitzleet multi-storey car park, and the public toilets on London Road (passing the public library and police station).

Table 2.2, Items of drug litter recorded by Arun District Council, by year

Street address	2018	2019	2020	2021 (Jan-Sep)
Albert Road	-	-	1	-
Bedford Street	43	7	64	39
Belmont Street	36	1	20	26
Chapel Street	4	-	-	-
Clarence Road	3	-	-	-
East promenade	2	-	-	-
High Street	1	-	-	-
Hawthorn Road	-	-	-	1
Hotham Park	5	0	4	3
London Road	13	2	10	4
Queensway	9	6	1	3
Steyne Gardens	1	-	-	-
The Avenue	0	0	3	0
Victoria Road	-	-	-	1
Waterloo Square	52	6	25	9
(blank)	-	2	-	-
Grand Total	169	24	128	86

Source: Arun District Council, Cleansing Team

Figure 2.1, Drug litter items recorded in Bognor Regis by Arun District Council, 2018-2020



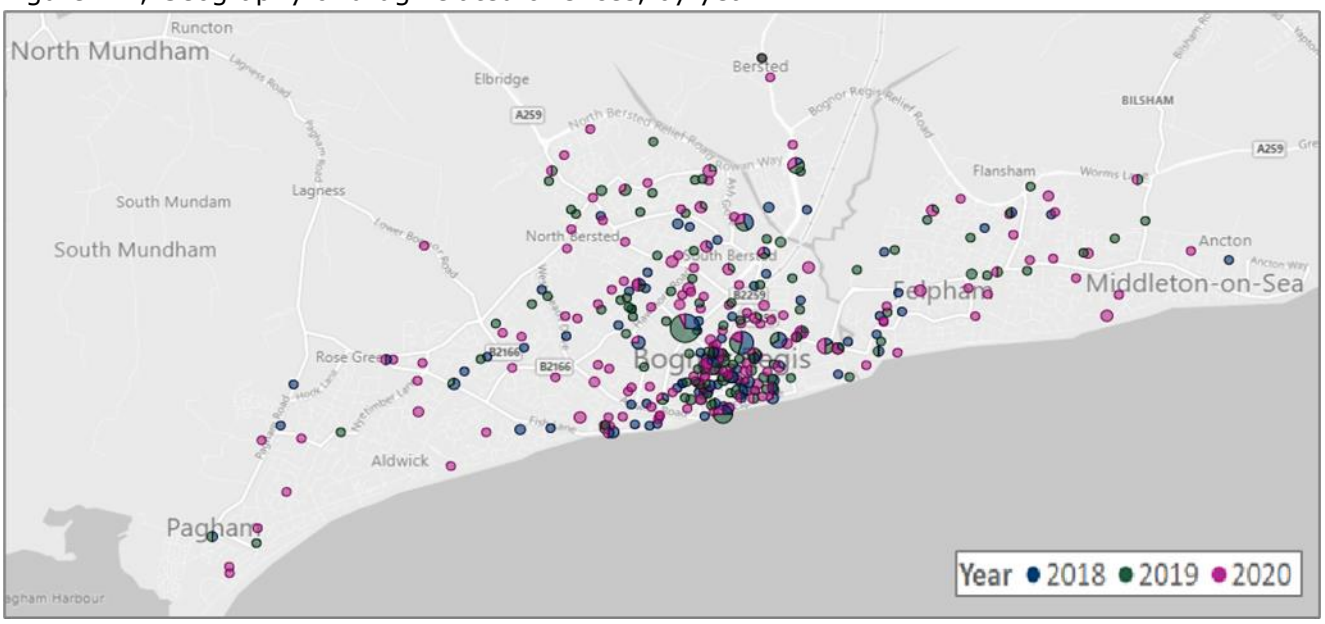
Source: ADC Cleansing Team

Drug offences:

The below analysis of data relating to drug-related offences in the Bognor Regis area in 2018-2020 was compiled by colleagues in Sussex Police.

The majority of drug-related offences took place in the centre of Bognor Regis, though there was a sizeable amount of activity in the suburban east and west of the town.

Figure 2.2, Geography of drug-related offences, by year



Source: Sussex Police performance data

Types of drug offences:

Possession of drugs accounted for most of the drug offences in Bognor (448 out of 517; 87%), with the majority of these being possession of cannabis (67%). Offences for possession of cannabis, heroin and cocaine increased in recent years, whilst offences for drug trafficking increased substantially, rising from 19 to 32 in the three-year period. (See table 2.3).

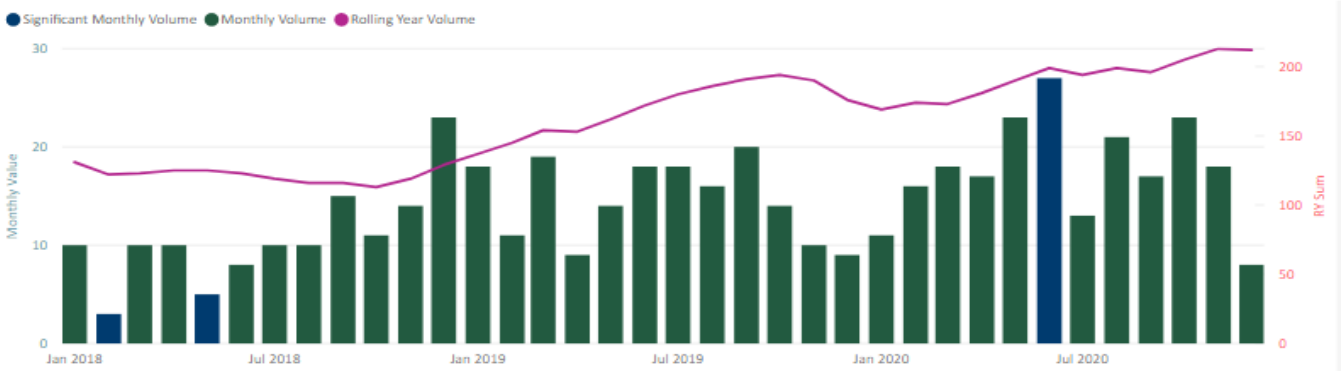
Table 2.3, Drug offences in Bognor Regis, by classification code

HO Classification and Code	2018	2019	2020	Total
Trafficking of Drugs	**19**	**16**	**32**	**67**
92/1 Offence in relation to the unlawful IMPORTATION of a drug controlled under Misuse of Drugs Act 1971 - Other Class			1	1
92/3 Offences in relation to the unlawful IMPORTATION of a drug controlled under the Misuse of Drugs Act 1971: -Class A			7	7
92/21 Production of or being concerned in the production of a controlled drug Class B Cannabis			8	8
92/4 Offences in relation to the unlawful IMPORTATION of a drug controlled under the Misuse of Drugs Act 1971: -Class B	1	1	8	10
92/10 Production of or being concerned in the production of a controlled drug Class A Cocaine		1		1
92/21 Production of or being concerned in the production of a controlled drug Class B Cannabis	1	7		8
92/23 Production of a controlled drug - Class B. Cathinone Derivatives Including Mephedrone		1		1
92/30 Supplying or offering to supply (or being concerned in supplying or offering to supply) a controlled drug Class A Cocaine	2			2
92/31 Supplying or offering to supply (or being concerned in supplying or offering to supply) a controlled drug Class A Heroin	1			1
92/33 Supplying or offering to supply (or being concerned in supplying or offering to supply) a controlled drug Class A MDMA			1	1
92/34 Supplying or offering to supply (or being concerned in supplying or offering to supply) a controlled drug Class A Crack			1	1
92/39 Supplying or offering to supply (or being concerned in supplying or offering to supply) a controlled drug Other Class A			1	1
92/41 Supplying or offering to supply (or being concerned in supplying or offering to supply) a controlled drug Class B Cannabis		1	1	2
92/48 Supplying or offering to supply (or being concerned in supplying or offering to supply) a controlled drug (Other Class C)				0
92/70 Having possession of a controlled drug with intent to supply Class A Cocaine	5	2	3	10
92/71 Having possession of a controlled drug with intent to supply Class A Heroin	7	2		9
92/73 Having possession of a controlled drug with intent to supply Class A MDMA		1		1
92/79 Having possession of a controlled drug with intent to supply Other Class A	1			1
92/81 Having possession of a controlled drug with intent to supply Class B Cannabis	1			1
92/89 Having possession of a controlled drug with intent to supply Class Unspecified			1	1
Possession of Drugs	**110**	**158**	**180**	**448**
92/50 Having possession of a controlled drug Class A Cocaine	16	28	22	66
92/51 Having possession of a controlled drug Class A Heroin	7	9	13	29
92/52 Having possession of a controlled drug Class A LSD			1	1
92/53 Having possession of a controlled drug Class A MDMA	1	2	2	5
92/54 Having possession of a controlled drug Class A Crack	4	3	2	9
92/59 Having possession of a controlled drug Other Class A	3	5	2	10
92/60 Having possession of a controlled drug Class B Amphetamine	10	9	7	26
92/61 Having possession of a controlled drug Cannabis	68	100	130	298
92/65 Having possession of a controlled drug Other Class B		1		1
92/68 Having possession of a controlled drug Other Class C	1	1	1	3
Other drug offences	**0**	**2**	**0**	**2**
93/14 Permitting premises to be used for unlawful purposes Class A Crack		1		1
93/30 Obstructing exercise of powers of search etc. or concealing drugs etc.		1		1
Total	**129**	**176**	**212**	**517**

Source: Sussex Police performance data

The gradual increase in drug offences over the three-year period can be seen in Figure 2.3. Of note, there were three months with an unusual volume of offences; February and May 2018 were significantly low, and June 2020 was significantly high.

Figure 2.3, Monthly volume of Drugs offences



Source: Sussex Police performance data

Stop and search:

Searches for drugs account for most of all stop and searches within Bognor, with the percentage of these increasing during the three-year period. It is also worth noting that the find rate for drugs only was slightly but consistently higher than the overall find rate each year.

Table 2.4, Stop and search, looking for drugs and finding drugs, as a percentage of total searches

	Searches – Total	Searches – Drugs	Searches – Drugs (% of total)	Find rate – Total searches	Find rate – Drugs (% of total)
2018	258	142	55%	12%	15%
2019	527	356	68%	25%	27%
2020	519	357	69%	25%	30%
Total	1,304	855	66%	23%	26%

Source: Sussex Police performance data

Local geographies were not as well recorded in 2018, leading to less certainty around trends. However, the majority of searches occurred in the Hotham, Marine, Orchard and Bersted wards over the three years.

Table 2.5a, Stop and search, by local geography, 2018

2018	Searches – Total	Searches – Drugs	Searches – Drugs (% of total)	Find rate – Total searches	Find rate – Drugs (% of total)
Bersted	18	9	50%	22%	44%
Felpham West	3	1	33%	33%	100%
Hotham	53	18	34%	23%	22%
Marine	16	10	63%	6%	10%
Middleton	1	1	100%	-	-
No Parish (Beat Zero)	147	95	65%	9%	12%
Orchard	7	3	43%	-	-
Pagham	1	-	-	-	-
Pevensey	12	5	42%	-	-
Total	**258**	**142**	**55%**	**12%**	**15%**

Source: Sussex Police performance data

Table 2.5b, Stop and search, by local geography, 2019

2019	Searches – Total	Searches – Drugs	Searches – Drugs (% of total)	Find rate – Total searches	Find rate – Drugs (% of total)
Aldwick East	5	3	60%	-	-
Aldwick West	2	2	100%	50%	50%
Bersted	31	26	84%	26%	31%
Felpham East	10	8	80%	-	-
Felpham West	17	14	82%	35%	43%
Hoe Lane	5	3	60%	20%	33%
Hotham	288	185	64%	30%	35%
Marine	81	51	63%	15%	14%
Middleton	4	3	75%	25%	33%
No Parish (Beat Zero)	2	1	50%	-	-
Orchard	38	27	71%	29%	22%
Pagham	3	-	-	33%	-
Pevensey	41	33	80%	15%	9%
Total	**527**	**356**	**68%**	**25%**	**27%**

Source: Sussex Police performance data

Table 2.5c, Stop and search, by local geography, 2020

2020	Searches – Total	Searches – Drugs	Searches – Drugs (% of total)	Find rate – Total searches	Find rate – Drugs (% of total)
Aldwick East	18	13	72%	28%	31%
Aldwick West	2	-	-	-	-
Bersted	37	16	43%	19%	25%
Felpham East	13	11	85%	15%	18%
Felpham West	15	11	73%	53%	64%
Hoe Lane	4	4	100%	25%	25%
Hotham	254	180	71%	26%	31%
Marine	75	52	70%	13%	13%
Middleton	12	11	92%	50%	55%
Orchard	55	38	69%	33%	47%
Pagham	6	3	50%	17%	33%
Pevensey	28	18	64%	14%	11
Total	**519**	**357**	**69%**	**25%**	**30%**

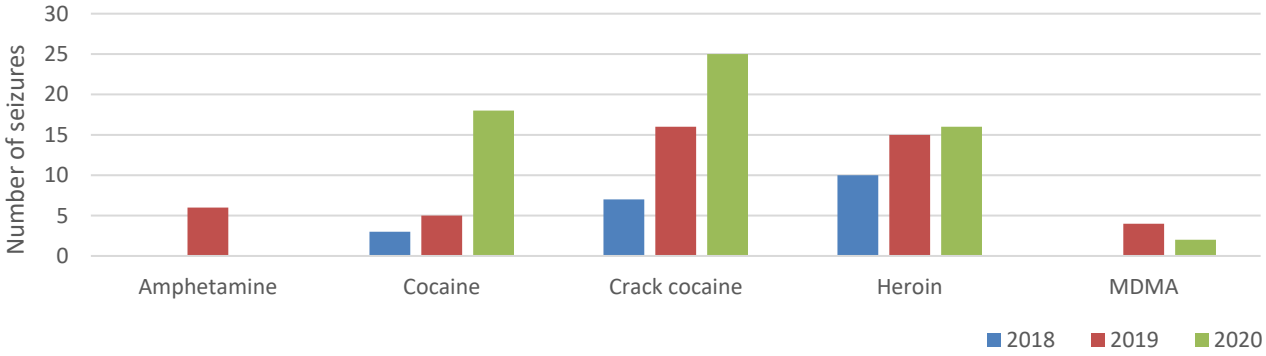
Source: Sussex Police performance data

Drug seizures and purity:

Data on drugs seized in the Bognor area during 2018-2020 was provided by Sussex Police; however, due to uncertain recording practices, data provided for 2018 may be incomplete. Whilst the type of drug seized, its weight and purity, and the date of seizure were provided, data on the circumstances of the seizures (e.g., seized via stop and search; premise searches; non-drug related arrests etc.) were not available, nor were data on whether/how many of these seizures were made on the same occasion or from the same person/premises. Data on impurities, adulterants or dilutants were also not available.

There were 128 recorded drug seizures in the Bognor area between 2018 and 2020. The number of recorded seizures rose each year, with nearly half of all seizures made in 2020. Over the three-year period, 38% of seizures were of crack cocaine and a further 20% of cocaine. 32% of seizures were of heroin whilst amphetamine and MDMA each accounted for 5% of seizures.

Figure 2.4, Number of recorded drug seizures in the Bognor area, 2018-2020

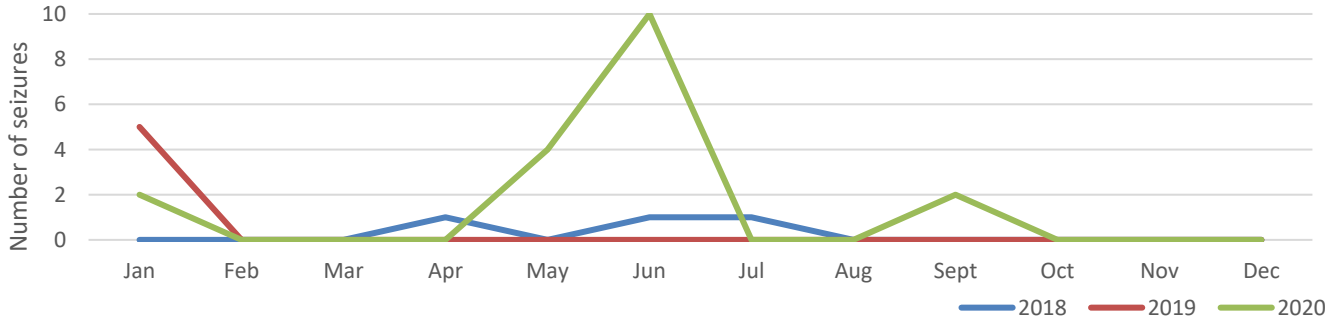


Source: Sussex Police

The number of seizures of cocaine, crack cocaine and heroin were generally low throughout each year, with a variably sized rise in seizures in the summer/autumn period. Compared to 2018 and 2020, a larger number of seizures of cocaine, crack cocaine and heroin were made in January/February in 2019.

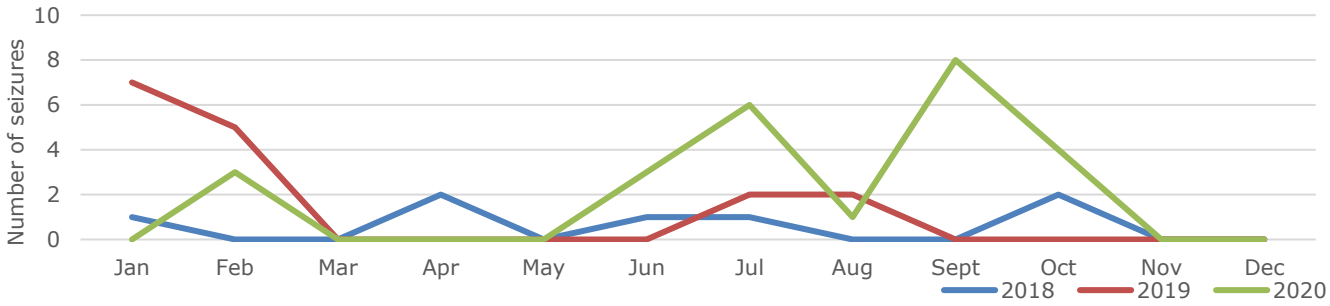
Due to the above-described uncertainties in the circumstances of these seizures and the small numbers recorded, it is difficult to ascribe meaning to this variation throughout the year.

Figure 2.5a. Seizures of cocaine, in the Bognor area, 2018-2020



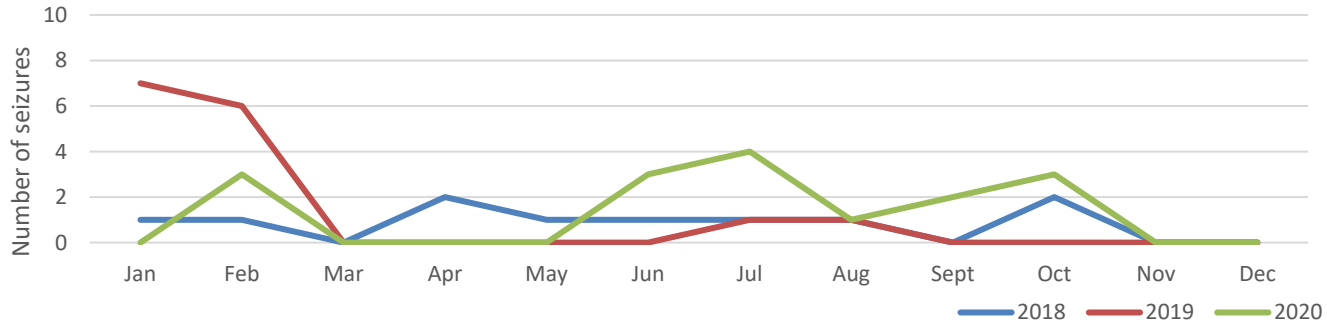
Source: Sussex Police

Figure 2.5b, Seizures of crack cocaine in the Bognor area, 2018-2020



Source: Sussex Police

Figure 2.5c, Seizures of heroin in the Bognor area, 2018-2020



Source: Sussex Police

Purity data was available for 84% of the recorded drug seizures. With fewer drug seizures in 2018 and 2019 than 2020, the smaller sample size of these earlier years must be borne in mind; this is particularly apparent in the spread of purities for cocaine in 2018 and 2019, which is based on three and four data points, respectively.

Excluding two outliers of 46% and 50%, the average purity of cocaine seized in 2020 was 80%, higher than the average purities of the small number of seizures in previous years.

The range of purities of seized crack cocaine increased each year, with a third of all seizures in 2020 being of 95% purity; purities were otherwise fairly evenly distributed between 32% and 95% in 2020.

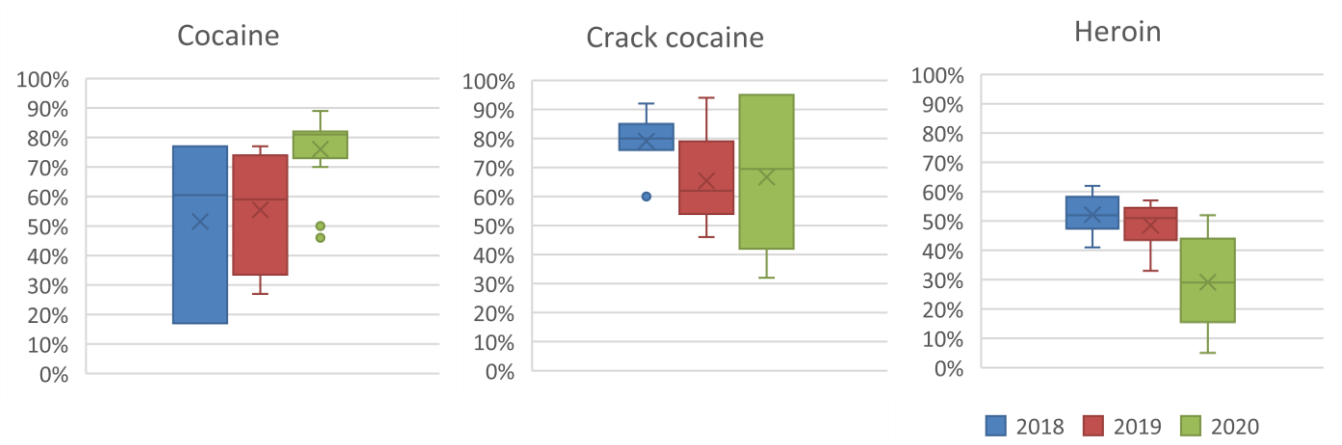
The range of purities of seized heroin increased each year, with significantly more lower purity drugs seized in 2020 compared to the previous two years (seen in the average 29% purity in 2020 compared to 52% in 2018 and 49% in 2019).

The national average purities of cocaine (63%), crack cocaine (77%) and heroin (46%) at user-level seized in 2018 are broadly reflected in the purities of seizures in the Bognor area in 2018, although information was not provided on the origin of Bognor seizures, so it is not known if drugs seized in Bognor are of user-level purity or higher in the supply chain.[19]

Of the small number of amphetamine seizures, the average purity was 7%. Percentage purity data for seizures of MDMA was not available.

[19] *PHE: United Kingdom drug situation 2019: Focal Point annual report (2021)*

Figure 2.6, Percentage purity of cocaine, crack cocaine & heroin seized in the Bognor Regis area, 2018-2020.



Note: The mean is indicated by crosses and outliers are indicated by dots coloured by year
Source: Sussex Police

Weight was provided for 99% of the recorded seizures, bar MDMA, which was recorded as number of tablets seized. Over half of all cocaine, crack cocaine and heroin seizures were of weights of less than a gram. A further 15-27% weighed less than 5g. Larger seizures of 5g or more were more infrequent for crack cocaine and heroin, although accounted for 28% of cocaine seizures.

The small number of seizures of MDMA were largely recorded as tablets. Most seizures were of 9 tablets or fewer and there was one seizure of 90 tablets.

Table 2.6, Proportion of the drugs seized in the Bognor Regis area by weight in 2018-2020.

Weight	Cocaine (n=26)	Crack cocaine (n=49)	Heroin (n=41)	Amphetamine (n=6)
<1g	58%	58%	68%	33%
1g ≤ n < 5g	15%	27%	22%	17%
5g ≤ n < 10g	8%	4%	5%	0%
10g ≤ n < 20g	12%	4%	0%	17%
≥20g	8%	6%	5%	33%
Total	100%	100%	100%	100%

Source: Sussex Police

2.2 Prevalence – Key Points:

- Over 300 pieces of drug litter were identified in public spaces by council cleansing teams between 2018 and 2020 and, whilst recording is incomplete, were largely found in or outside of public toilets and located in three streets (Bedford Street, Belmont Street and Waterloo Square) in the centre of the town. A lesser used, but common, location was the Fitzleet multi-storey car park.

- The majority of drug-related offences took place in the centre of Bognor Regis and were for possession of drugs (87%), although drug trafficking offences increased substantially over the period. Offences for possession of cannabis (the most common drug involved), heroin and cocaine also increased over the period.

- The proportion of all stop and searches specifically looking for drugs rose over the three years (69% in 2020) and were mostly conducted in the Hotham, Marine, Orchard and Bersted wards.

- There were 128 recorded drug seizures in the Bognor area between 2018 and 2020; the number of recorded drug seizures in the Bognor area rose each year, although data may be incomplete and the circumstances of seizures unknown.

- Over the three-year period, 38% of seizures were of crack cocaine, 32% of heroin and 20% of cocaine.

- The range of purities of seized crack cocaine and heroin increased each year, with more lower purity drugs being seized for both in 2020 than previous years. The average purity of heroin was 29% in 2020 compared to around 50% in previous years. Purities of crack cocaine ranged from 32% to 95% in 2020, with a third of all seizures being the latter. Excluding outliers, the average purity of cocaine seized in 2020 was 80%.

- Over half of all cocaine, crack cocaine and heroin seizures were of weights of less than a gram and 85% or more of the latter two under 5g.

2.3 Impacts in the community

Children's Social Care:

Children's Social Care (CSC) data available to this review showed a number of valuable fields: the age of the child; the year of assessment; if there were mention of a parent using drugs; if there were mention of a child using drugs; and the postcode (allowing for ward level analysis). There is believed to be some inconsistencies in how these fields are completed, particularly around drug use recorded for unborn and very young children.

For Bognor Regis, the three-year period showed 339 instances of parental drug use mentioned in CSC assessments and 165 instances of child drug use. When examining these together, there were 454 instances where parent and/or child drug use were mentioned; 50 of these instances had both parent and child drug use mentioned. Importantly, the number of assessments mentioning drug use has been increasing over the three-year period, both in terms of incidence and percentage of all assessments completed.

Table 2.7(a), Drug use mentioned on CSC assessment form, by year and geography, shown as total count and as a percentage of all CSC assessments in the area

		Parent drug use mentioned		Child drug use mentioned		All CSC assessments
2018	WSx (Excl. Bognor)	928	9.5%	480	4.9%	9,778
	Bognor	96	10.9%	50	5.7%	880
2019	WSx (Excl. Bognor)	1,114	11.1%	586	5.8%	10,061
	Bognor	115	12.5%	51	5.5%	920
2020	WSx (Excl. Bognor)	1,028	11.4%	420	4.7%	9,005
	Bognor	128	14.7%	64	7.3%	872
All	Total (Average)	3,409	10.8%	1,651	5.2%	31,516

Source: West Sussex CC, internal performance data

Table 2.7(b), Drug use mentioned on CSC assessment form, by year and geography, shown as total count and as a percentage of all CSC assessments in the area

		Parent AND/OR Child drug use mentioned		Parent AND Child drug use mentioned		All CSC assessments
2018	WSx (Excl. Bognor)	1,282	13.1%	126	1.3%	9,778
	Bognor	134	15.2%	12	1.4%	880
2019	WSx (Excl. Bognor)	1,536	15.3%	164	1.6%	10,061
	Bognor	149	16.2%	17	1.8%	920
2020	WSx (Excl. Bognor)	1,363	15.1%	85	0.9%	9,005
	Bognor	171	19.6%	21	2.4%	872
All	Total (Average)	4,635	14.7%	425	1.3%	31,516

Source: West Sussex CC, internal performance data
Note: The Parent AND child figures are a subset of the total Parent AND/OR child category

Drug use (by a parent, child or both) was identified in 17% of the 2,672 CSC assessments mapped to a Bognor Regis geography. This compares to 14% of the 28,844 assessments carried out elsewhere in the county in this period.

In terms of raw count, the five central wards (Marine, Pevensey, Hotham, Orchard and Bersted) contained most mentions of drug use in CSC assessments, followed by Felpham West (adjacent to Hotham), which had the same number of incidents as Bersted. Marine ward carried the greatest

number of drug mentions (89 incidents), but, with a greater volume of CSC activity in this ward, it was not the highest in terms of percentage of all assessments.

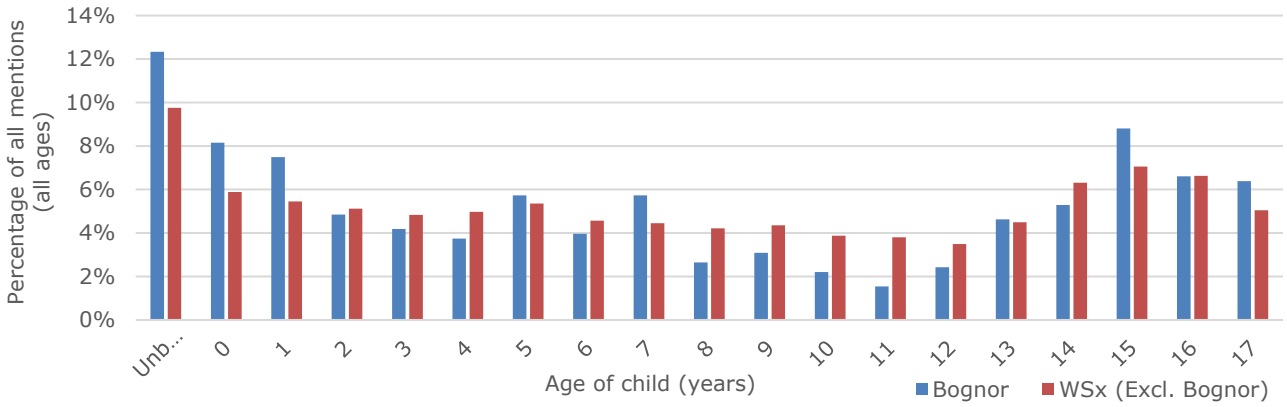
Table 2.8, Parent and/or child drug use mentioned in CSC assessment, Bognor Wards, 2018-2020

Bognor Wards	Count of parent and/or child mentioned	Percentage of all assessments	All CSC assessments
Marine	89	14%	649
Pevensey	78	21%	375
Hotham	70	26%	270
Orchard	61	19%	323
Bersted	45	13%	338
Felpham West	45	21%	219
Aldwick West	29	21%	136
Pagham	19	27%	70
Middleton-on-Sea	8	10%	78
Aldwick East	5	8%	59
Felpham East	5	3%	155
All Bognor Regis	**454**	**17%**	**2,672**

Source: West Sussex CC, internal performance data

Figure 2.7 shows the ages of the children where drug use by a parent, child or both was mentioned. With 12% of all incidents occurring in the 'unborn' age group, this highlights the need for focused maternity service provision on this topic.

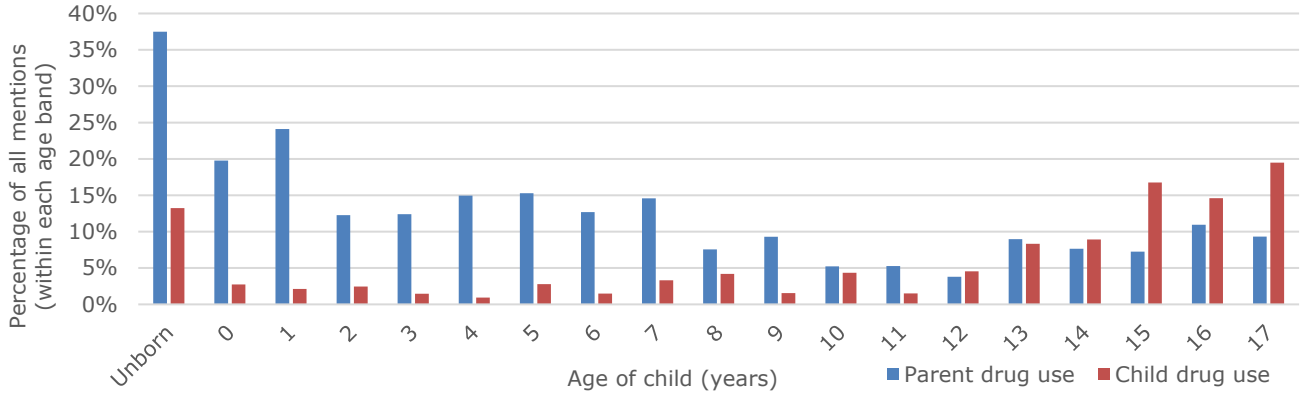
Figure 2.7, Age distribution of children, for CSC assessments mentioning parent and/or child drug use, 2018-2020



Source: West Sussex CC, internal performance data

When looking at CSC activity by age group, this mainly involves the parent's drug use in early years, but this shifts towards the child's drug use in adolescence. Of all CSC assessments in Bognor Regis, over a third of those conducted for pregnant women mentioned drug use on the assessment. Patterns here are similar for the rest of West Sussex.

Figure 2.8, Age distribution of children, for assessments in Bognor Regis mentioning parent and/or child drug use (percentage for each year of age of children)



Source: West Sussex CC, internal performance data
Note: Incidents mentioning both parent and child drug use may be duplicated here

County lines and exploitation:

The following data provided by Sussex Police were for the period August 1st, 2020 to July 31st, 2021 and are limited to data relating to heroin and crack cocaine (as the substances dealt in by county lines) in the Bognor area.

Data on custody arrests for possession with intent (PWI) and possession of controlled drugs (PCD) in the Bognor area were provided for arrests where heroin and crack cocaine were reported.

Variables provided include the age, sex and ethnicity of people arrested, the date and circumstances of arrest, and several fields relating to risks to health of those arrested, including illness/injury, mental health, self-harm and signs of harm, drug/alcohol dependency and healthcare.

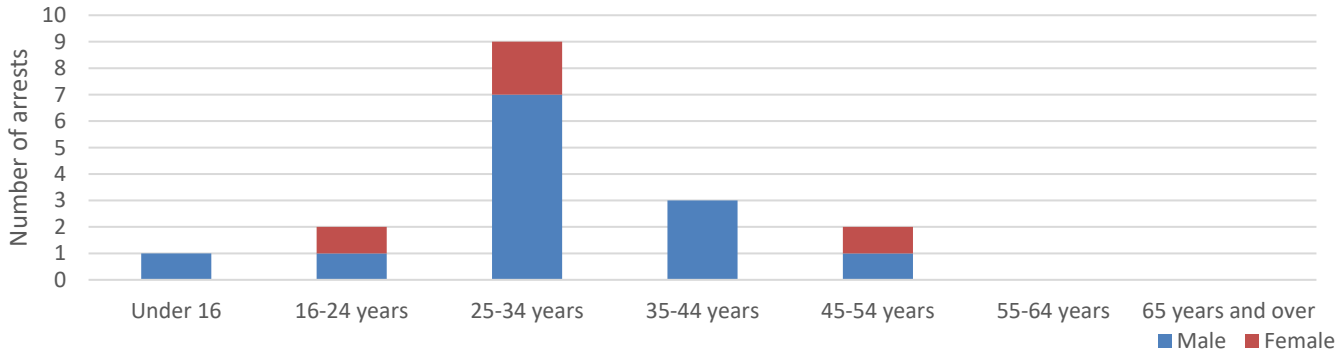
In the one-year period from Aug 2020 to July 2021, 17 custody arrests were recorded as PWI or PCD for heroin or crack cocaine in the Bognor area. Due to lack of uniformity in recording details of the arrests, differentiation between the number of arrests for PWI and PCD, and of the drug type(s) found was not possible.

Free-text information on the circumstances of arrest was provided and subsequently grouped into the following themes. A quarter of arrests were the result of a Section 23 Misuse of Drugs Act (MDA) premises search warrant where class A drugs were found; a further quarter were the result of a Section 23 MDA stop and search, of either person or vehicle, where class A drugs were found. The remaining arrests found drugs in relation to other incidents, such as violent offences, vehicles evading police and Section 1 Police and Criminal Evidence Act (PACE) stop and searches, although inconsistency in recording practice meant that it was unclear if some of these arrests were also performed under Section 23 MDA.

The date of arrest was provided, although the effect of the COVID-19 restrictions and lockdowns over the period is evident; the majority of arrests were made in Aug/Sept 2020 and in Mar/Apr 2021 following eased lockdown restrictions.

Three-quarters of people arrested were male. All arrests were made in people under 55 years of age; 25-34 year olds accounted for half of the arrests. 60% of people arrested were of White British ethnicity and 30% of Black or Mixed ethnicities.

Figure 2.9, Number of custody arrests by sex and age band, Aug 2020–Jul 2021



Source: Sussex Police

Recorded health risks were grouped into four categories: drug dependency only; mental health only; drug dependency and mental health; and no risk recorded.

Around a quarter of people arrested were recorded as having/at risk of a drug dependency only and a further quarter as having/at risk of both a drug dependency and mental health issue (mostly depression and anxiety were recorded). A third of arrests had no health risks recorded.

The British Transport Police were also contacted for information on any arrests that may have occurred in the station or on trains near Bognor Regis, which is an end-of-line stop, but they reported that no drug-related arrests had been recorded for the three-year period.

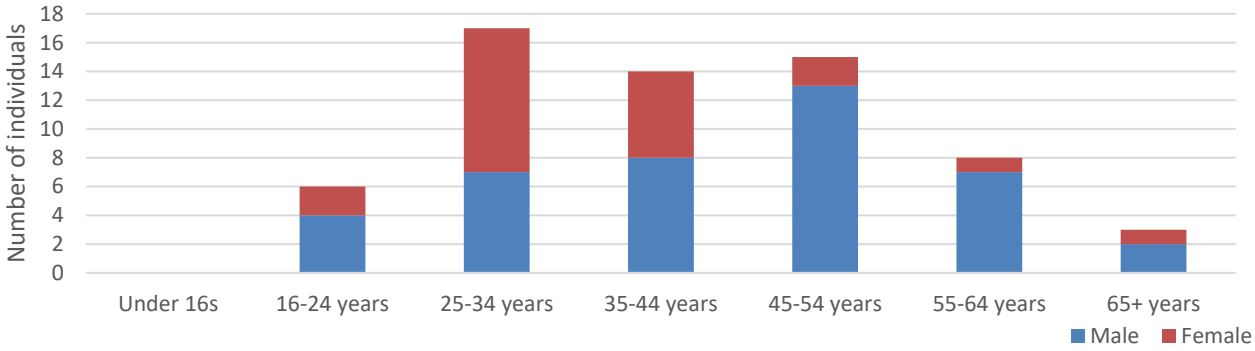
Operation Cuckoo:

Data from the NICHE Operation Cuckoo database of individuals living in the Bognor area linked to and/or flagged as vulnerable to cuckooing were provided by Sussex Police. It was not clear from the data provided whether those linked to cuckooing were victims alone or victims and offenders.

Between August 2020 and July 2021, 64 individuals in the Bognor area were linked to and/or flagged as vulnerable to cuckooing.

Two-thirds of these individuals were male and a third female. Nearly three-quarters of individuals were aged 25 to 54 years but the proportions of individuals in each age band differed significantly by sex. Of females, nearly three-quarters were in the 25-34 years and 35-44 years age brackets; this proportion was lower in males, at around two-fifths. Half of males were in the older age brackets (45 years and above) compared to less than a fifth of females.

Figure 2.10, Number of individuals linked to and/or vulnerable to cuckooing by sex and age band, Aug 2020–Jul 2021



Source: Sussex Police

National Referral Mechanism referrals:

Between Aug 2020 and July 2021, there were three referrals of potential victims of modern slavery in the Bognor area, relating to drugs supply, made to Sussex Police via the National Referral Mechanism.[20] All three were male and of British/English nationality, and two were under 18 years of age. All three were exploited through criminal services for drug dealing and/or cuckooing.

Youth Justice Service:

The analysis below is based on data from the local Child View Youth Justice (CVYJ) case management system for 2018-2020, extracted on the 12th April 2021, and was compiled by colleagues in the Youth Justice system. The figures in this section largely refer to the number of offences and not the number of children.

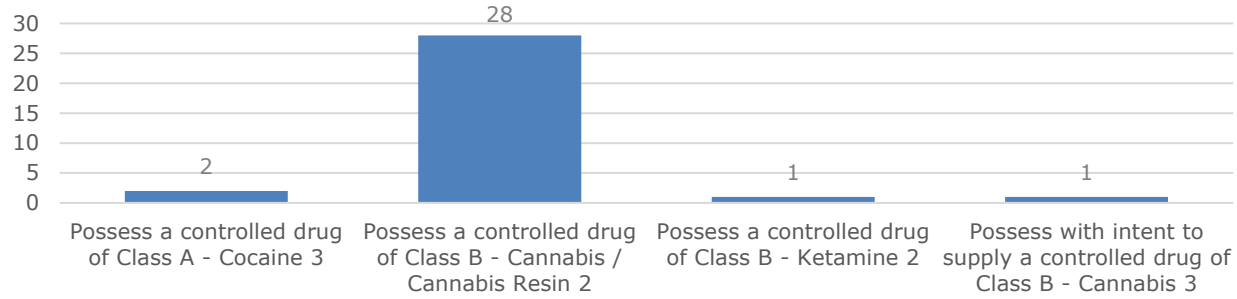
Recorded Offences:

Thirty-two (16%) of the 202 offences committed by children living in Bognor Regis during 2018-2020 were drug related and were committed by 28 children. This compares to 351 (14%) of the 2,512 offences committed by children living in West Sussex, and 462 (14%) of the 3,276 offences recorded on CVYJ during this period.

Of the 32 drug-related offences committed by children in Bognor Regis, most related to cannabis; 28 were 'Possess a controlled drug of Class B - Cannabis / Cannabis Resin 2' whilst there was a single offence for 'Possess with intent to supply a controlled drug of Class B – Cannabis 3'.

[20] *https://www.gov.uk/government/publications/human-trafficking-victims-referral-and-assessment-forms/guidance-on-the-national-referral-mechanism-for-potential-adult-victims-of-modern-slavery-england-and-wales*

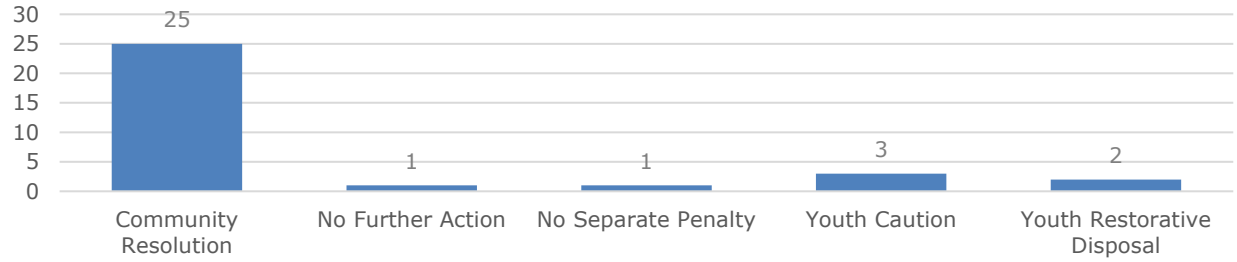
Figure 2.11, Drug-related offences committed in Bognor by offence type, 2018-2020



Source: WSCC Youth Justice Service performance data

Twenty-seven (84%) of the 32 drug-related offences resulted in a Community Resolution[21] or Youth Restorative Disposal. Three drug-related offences resulted in a Youth Caution, a substantive outcome[22] (representing 6% of the 51 offences committed by children in Bognor Regis resulting in a substantive outcome, similar to the 10% of all offences committed by children living in West Sussex).

Figure 2.12, Drug-related offences committed in Bognor by outcome type, 2018-2020



Source: WSCC Youth Justice Service performance data

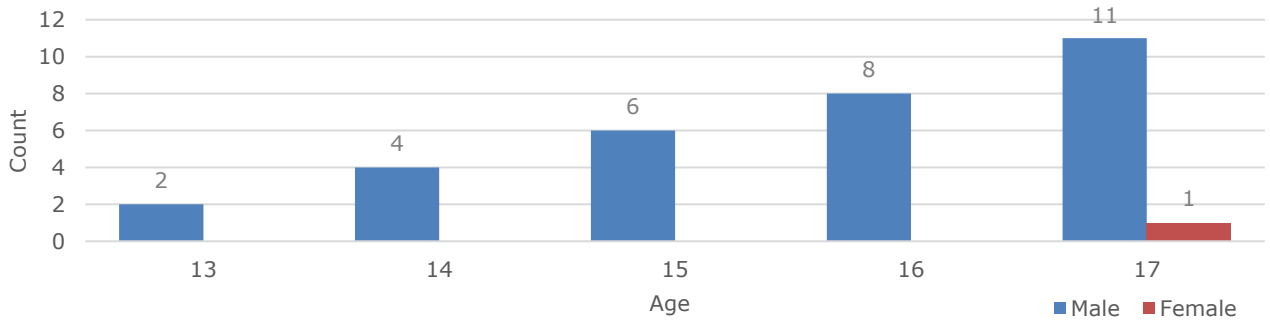
Males committed 31 of the 32 drug-related offences. The number of offences increased with age, although the age of offenders ranged from 13 years to 17 years. 60% of offences were committed by 16 and 17 year olds.

[21] A Community Resolution is the term for the resolution of a minor offence or anti-social behaviour incident through informal agreement between the parties involved, as opposed to progression through the traditional criminal justice process.

[22] A substantive outcome is defined as one of the following:

- *An Out of Court Disposal (Youth Caution or Youth Conditional Caution)*
- *A First-Tier Penalty (Sentence Deferred, Absolute Discharge, Conditional Discharge, Bind Over, Fine, Compensation Order, Referral Order, or Reparation Order)*
- *A Community Penalty (Youth Rehabilitation Order)*
- *A Custodial Sentence (Detention and Training Order, Section 90-91, Section 226, or Section 226B).*

Figure 2.13, Drug-related offences committed in Bognor by gender and age at the time of the offence



Source: WSCC Youth Justice Service performance data

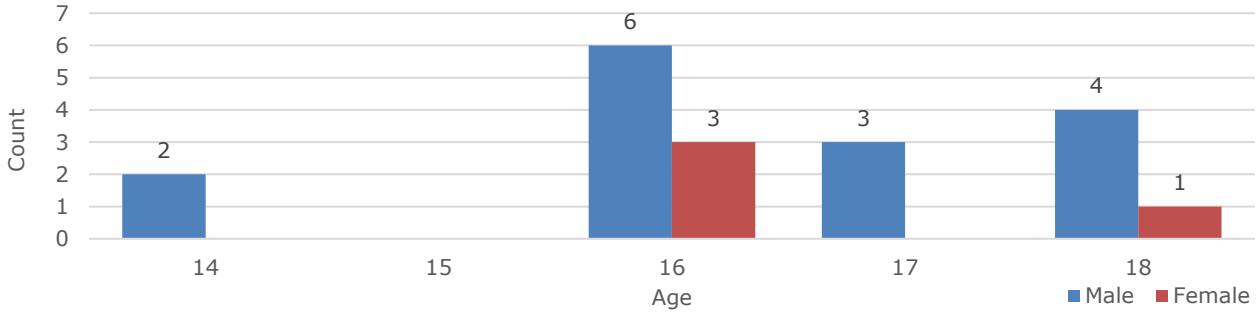
Youth Justice Service assessments and substance use:

This section relates to assessments conducted with AssetPlus (an assessment and planning interventions framework) on CVYJ. In West Sussex, AssetPlus assessments are only used for court disposals as there is a locally developed assessment tool for out-of-court disposals, from which it has not been possible to extract data.

During 2018-2020, there were 19 children with a drug-related issue identified in their AssetPlus assessment that were living in Bognor Regis at the time of their assessment (representing 8% of the total 241 children with a drug-related issue identified in their AssetPlus assessment).

Fifteen of these 19 were male and four were female. Most children were aged 16-18, although the five who were 18 years old when their most recent assessment started were 17 years old at the beginning of their court disposal.

Figure 2.14, AssetPlus assessments for children from Bognor Regis which mention drug issues, by age at assessment and gender

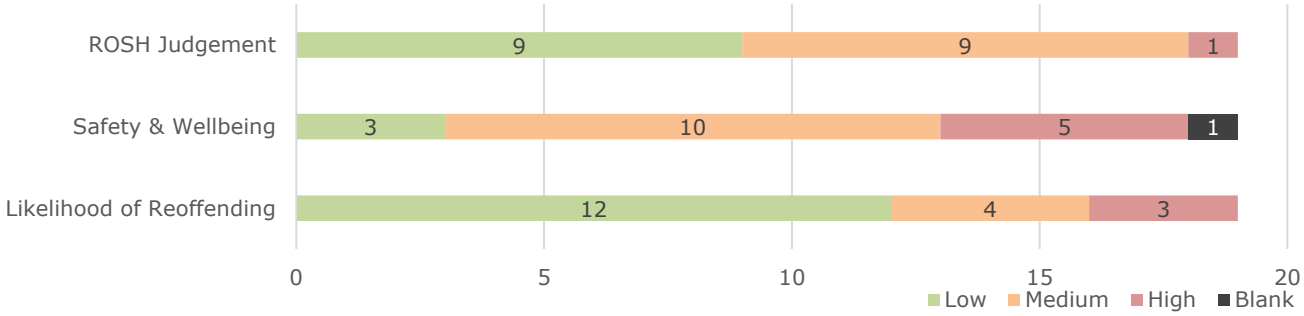


Source: WSCC Youth Justice Service performance data

The majority of children in Bognor Regis with drug-related issues identified in their AssetPlus assessment during 2018-2020 were assessed as low risk for their likelihood of reoffending. For the risk of serious harm to others (ROSH), all but one child was assessed as either low or medium risk. Children with drug-related issues were generally assessed as being at a higher risk level for their Safety and wellbeing, compared to the other two risk categories, Risk of serious harm (ROSH) judgement, and Likelihood of reoffending (Figure 2.15). However, it is not possible to analyse the reason for this or establish if this increased risk was linked to their use or associations

with substances. One child was classified as 'high' in all the domains of risk used within the youth justice assessment framework.

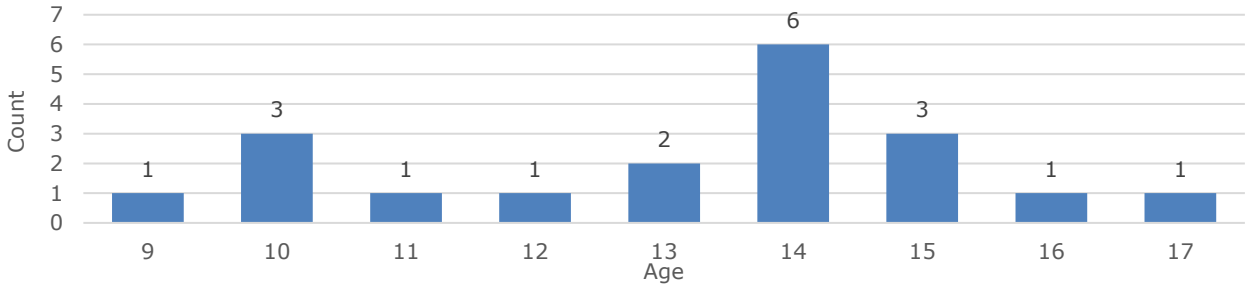
Figure 2.15, AssetPlus assessments for children from Bognor Regis, which mention drug issues, by risk category and level



Source: WSCC Youth Justice Service performance data

The age of first drug use of the 19 children with an identified drug-related issue in the Bognor area ranged from 9 years to 17 years; half of these children started using drugs between ages 14 and 16.

Figure 2.16, AssetPlus assessments for children from Bognor Regis which mention drug issues, by age of first drug use

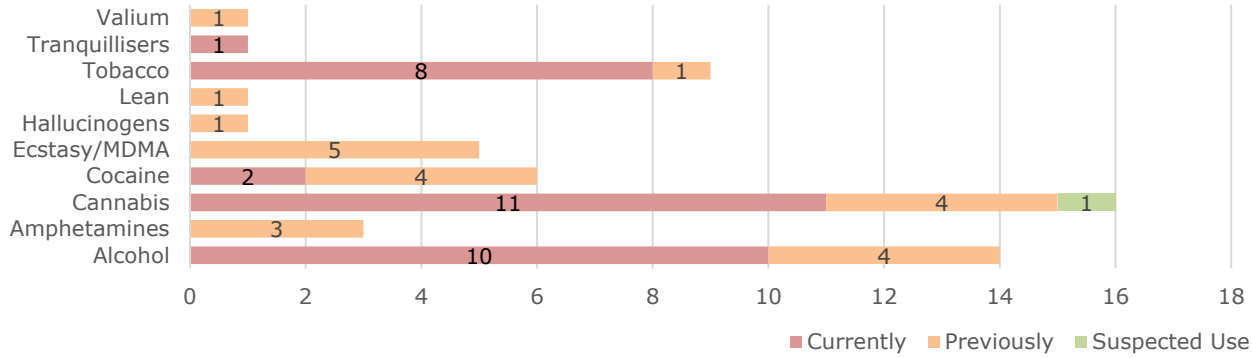


Source: WSCC Youth Justice Service performance data

Sixteen of the 19 children had a (suspected) history of cannabis use, 11 of whom were reported as still using cannabis. Thirteen children had a history of multiple drug use, so were classed as regular drug users.

Ten of the 19 children were also recorded as currently using alcohol and a further four recorded as drinking alcohol previously.

Figure 2.17, AssetPlus assessments for children from Bognor Regis, which mention drug issues, by type of drug use and status



Note: Lean is liquid codeine mixed with fizzy drink.
Source: WSCC Youth Justice Service performance data

Referrals for substance misuse intervention:

Ten of the 38 referrals for children living in the Bognor Regis area during 2018-2020 recorded on CVYJ were drug-related. This proportion of all referrals is similar to West Sussex overall, of which 29% were drug-related (112 referrals of 387 total).

By year, 2018 and 2019 each had five drug-related referrals for children living in Bognor whilst there were no drug-related referrals in 2020.

Most of the 10 drug-related referrals for children living in Bognor have an initial action relating to cannabis use.

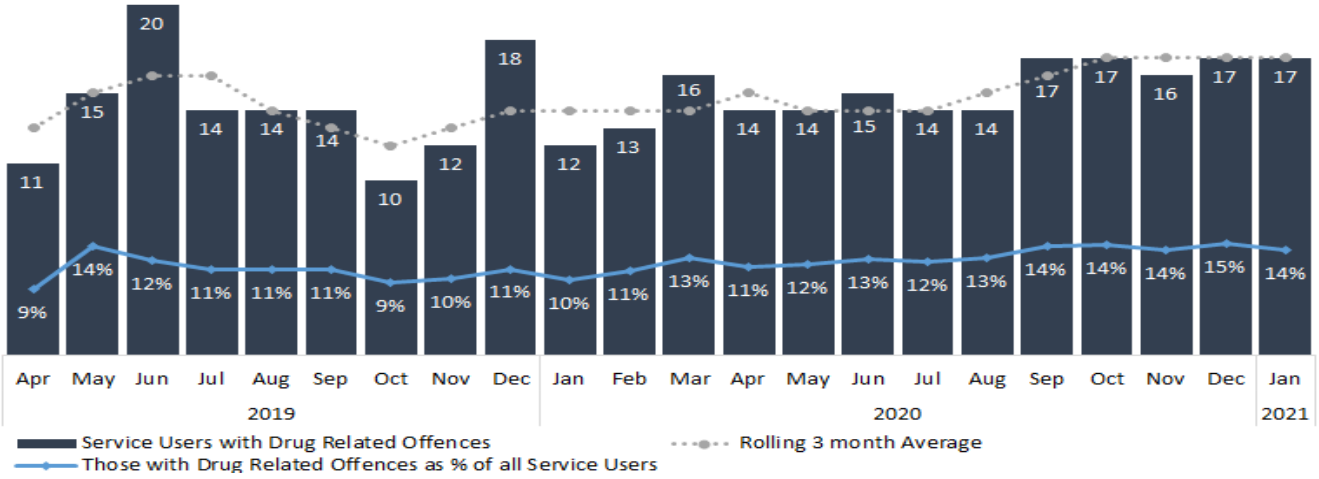
Probation:

This analysis, compiled by Kent, Surrey and Sussex Community Rehabilitation Company (KSS CRC) colleagues, is based on a collective of service users managed by KSS CRC between April 2019 and January 2021, who were serving community orders, on post release licence or in custody. Details were derived from a series of month end caseload samples of those having a recorded main address postcode in the Bognor Regis area.

Caseload details were sourced from the HMPPS National Delius system and combined with offending risk assessments. Responses to questions within the "Habit" section of service user assessments (using the MSAT assessment system) have provided the details of substance use and links to offending behaviour.

Whilst there has been some fluctuation in the number of actively known service users to KSS CRC with drug-related offences, the volume has overall had slight but negligible increase. The range in the number of service users indicate that recent figures in the volumes have become more stable with less variance than seen in previous years.

Figure 2.18, Volumes of service users with a drug-related offence by caseload month



Source: Kent, Surrey and Sussex Community Rehabilitation Company

Drug misuse linked to offending behaviour:

Of the 321 unique service users residing in the Bognor Regis area and known to KSS CRC within the period, 34 (11%) had committed a drug-related offence.

Sixty-eight (21%) of the unique service users were assessed to have a drug need linked to their offending behaviour. This proportion was higher in the 34 who had committed a drug-related offence, with around one in three of these having a known drug-related need. Drug need was also tied to 28% of those with a burglary offence and 20% of those with a violent offence.

Table 2.9, Drug needs by offence type

	All service users	With drug need	% with drug need
Violence	119	24	20%
Driving	78	10	13%
Burglary/theft	53	15	28%
Drugs	34	12	35%
Fraud	20	5	25%
Public order	17	4	24%
Other	11	0	0%
Criminal damage	9	1	11%

Source: Kent, Surrey and Sussex Community Rehabilitation Company

At the time of reporting, over half of the 68 service users with a drug need were undertaking activities which promote the continual use of drugs; 26 continued to undertake some activities that promote the continual use of drugs and 13 continued to undertake significant activities that promote the continual use of drugs.

Sixty-two of the 321 unique service users (19%) were identified as having used or currently using one or more class A drugs; this equates to 91% of the 68 service users with a drug need having previously used or currently using class A drugs. The most prevalent class A drugs being used are cocaine and heroin.

Table 2.10, Drug usage by drug type

Drug usage	Cocaine	Cocaine hydrochloride	Heroin	Methadone	Ecstasy	Hallucinogen	Psychoactive substance
Occasionally	13	7	3	0	0	0	0
Weekly	10	3	5	0	0	0	0
Daily	9	4	7	1	0	0	0
Total	32	14	15	1	0	0	0
	52%	23%	24%	2%	0%	0%	0%

Source: Kent, Surrey and Sussex Community Rehabilitation Company

Of the 321 unique service users, 83% were male. The proportion of male service users with a drug need was equal to the proportion of female service users (21%).

Table 2.11, Number and proportion of service users by gender and drug need

	Male	Female
All service users	265	56
	83%	17%
With drug need	56	12
	21%	21%

Source: Kent, Surrey and Sussex Community Rehabilitation Company

Table 2.12, Number of service users with a drug-related offence by age at earliest conviction date

	Service Users
18-20	2
21-29	12
30-39	12
40-49	6
50-60	1
60+	1

Source: Kent, Surrey and Sussex Community Rehabilitation Company

Drug treatment services:

National Drug Monitoring Treatment System (NDMTS) data were provided by partners in Change, Grow, Live. Records of people in structured treatment with the West Sussex Drug and Alcohol Wellbeing Network (DAWN), with a PO21/PO22 postcode either at time of presentation or during treatment, were provided for the period January 1st, 2018 and December 31st, 2020.

The data provided included several useful variables for each service user: age, sex at birth, ethnicity, sexual orientation, short postcode at assessment and current short postcode, whether they had no fixed abode, triage date (defined as the date the service user entered structured treatment) and discharge date (defined as the date the service user left structured treatment, planned or unplanned), and the main drug type and group.

There are other fields recorded by NDMTS which were not provided for this analysis which may lend further insight to future analyses. For example, the age of first use of the main problem substance, source of referral (e.g., self, GP, hospitals, arrest, community rehabilitation and other services), employment status, housing status, parental responsibility, mental health treatment

need, physical health status and so on, would help to build a picture of the circumstances of drug users and the effects of drug misuse on health, quality of life and the community.[23]

Similarly, records of additional substances that brought the client to treatment would provide a more in-depth picture of the drug market and the extent to which service users use several different drugs.

Due to some individuals entering treatment multiple times over the timeframe of interest, including several separate episodes in a single year, and some individuals being in the same treatment episode across a year boundary (e.g., 2018-2019) or across multiple years, the data is framed in two ways, as:

- Unique individuals. Used for scale, demographics and where the service user lives.
- Treatment episodes – individuals may be counted two, three or four times in this, depending on the number of times they entered structured treatment. Used for time in treatment and drug type.

Structured drug treatment definition:

Structured drug and alcohol treatment consists of a comprehensive package of concurrent or sequential specialist drug- and alcohol-focused interventions. It addresses multiple or more severe needs that would not be expected to respond, or have already not responded, to less intensive or non-specialist interventions alone.

Structured treatment requires a comprehensive assessment of need, and is delivered according to a recovery care plan, which is regularly reviewed with the client. The plan sets out clear goals which include change to substance use, and how other client needs will be addressed in one or more of the following domains: physical health; psychological health; social well-being; and, when appropriate, criminal involvement and offending.

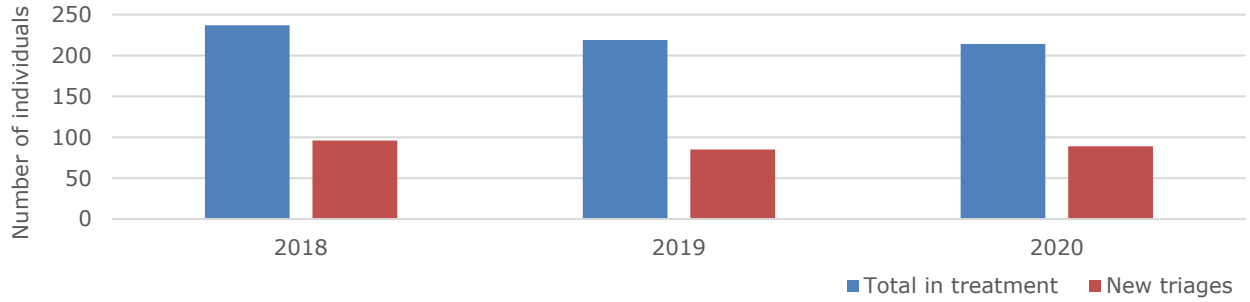
Structured drug and alcohol treatment provides access to specialist medical assessment and intervention and works jointly with mental and physical health services and safeguarding and family support services according to need. Pharmacological and psychosocial interventions are provided alongside, or integrated within, the key working or case management function of structured treatment, as well as further advice and guidance.

Between January 1st, 2018 and December 31st, 2020, 374 individuals received treatment for drugs misuse with West Sussex DAWN, including 141 individuals who began treatment in 2016 or 2017. Of these, 52 individuals were in treatment for two or more separate episodes within the timeframe; over the three years, there were 440 distinct treatment episodes across the 374 individuals.

The number of individuals in treatment and new triages each year decreased slightly from 2018 to 2019 then remained at a similar number in 2020. Around 40% of all individuals in treatment each year were new triages, similar to the average for a similar period in West Sussex and the South East (38% and 40% respectively).

[23] *Source: PHE, NDTMS Adult drug and alcohol treatment business definitions (2020)*

Figure 2.19, Those new to treatment and totals currently in treatment



Note: Individuals are counted once per year, regardless of the number of times they entered treatment that year; individuals whose treatment episode lasted over one or more years are included once for each calendar year they were in treatment.
Source: NDMTS

Repeat service users:

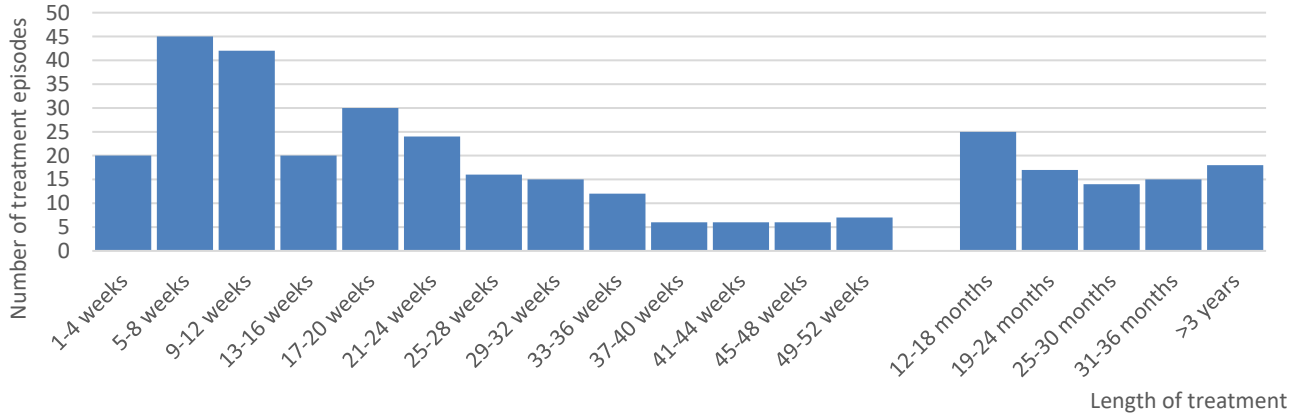
Around three in four of the 52 individuals who were in treatment multiple times between 2018 and 2020 were in treatment for two separate episodes; the remainder were in treatment three or four times over the timeframe. However, the data provided does not include additional treatment episodes that may have occurred prior to or following the timeframe of interest; the number of service users who received treatment multiple times may therefore be higher.

Time spent in treatment:

Of the treatment episodes where the service user was discharged, episodes of 5-8 weeks and 9-12 weeks were the most frequently recorded, whilst the median treatment episode length was 23 weeks. A quarter of treatment episodes were more than a year in duration, mirroring the West Sussex and South East average for a similar period.

If giving an artificial cut-off point of January 1st, 2021 (i.e., the end of the period of interest) to the treatment episodes with no recorded discharge date (23% of the total), 56% of these have lasted over three years, and a further 22% have lasted 13 months or more.

Figure 2.20, Time spent in treatment for service users discharged between 2018-2020



Source: NDMTS

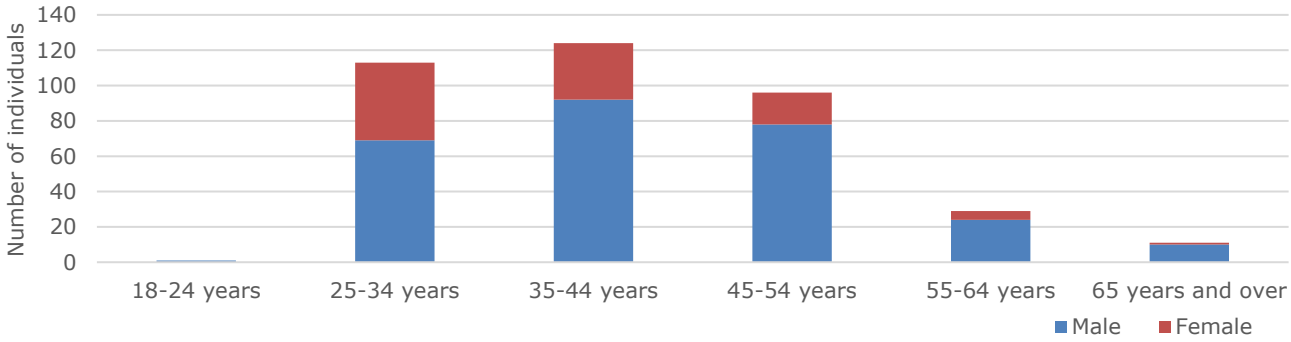
Demographics:

Of the 374 individuals who received treatment between 2018 to 2020, 73% were males and 27% were females. This aligns with the averages in West Sussex and the South East over a similar period, both at 72% males and 28% females.

35-44 year olds accounted for a third of individuals in treatment and 25-34 year olds slightly less than a third, whilst 45-54 year olds made up a further quarter of those in treatment.

Of female service users, around three-quarters were in the 25-34 years and 35-44 years age brackets; in male service users, this proportion was lower, at around three-fifths of male service users. A greater proportion of male service users were of the 45-54 years age bracket compared to female service users (28% vs. 18%).

Figure 2.21. Number of individuals in treatment between 2018 and 2020, by age and sex



Source: NDMTS

Eighty-nine percent of individuals in treatment were of White British or White Irish ethnicities, whilst individuals of Other White ethnicity accounted for 7% of those in treatment. A small number of individuals in treatment were of Asian, Black or Other ethnicities or did not state their ethnicity.

Seventy-six percent of individuals in treatment identified as heterosexual and 20% as unstated or unknown. A small number of individuals identified as gay/lesbian, bisexual or other.

Drug type:

"Any opiate" was recorded as the drug group in 60% of all treatment episodes; 40% of all treatment episodes were recorded as "Non-opiates". NB: any mention of opiate use would result in the person being categorised as "Any opiate", irrespective of other substances are cited; this is evident in the 17 treatment episodes where a person with a non-opiate main drug type was categorised as "Any opiate" (most of which were cocaine freebase (crack)).

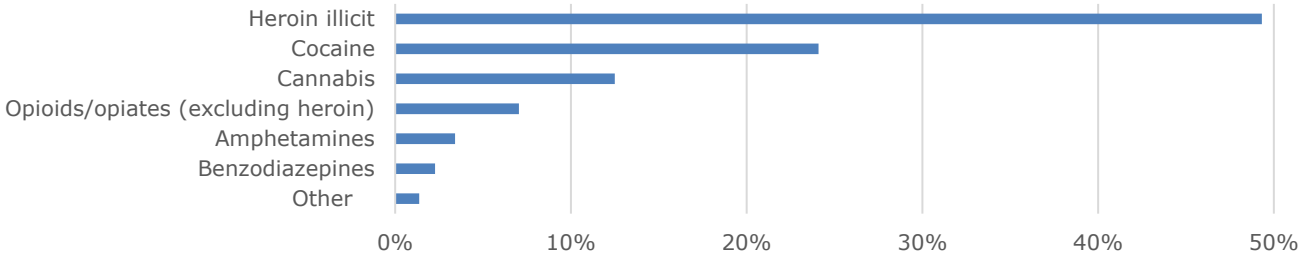
The main drug type recorded for each treatment episode was classified according to its broad pharmacological grouping, in line with the groupings used in the 2019 West Sussex Drug-related Death Audit. Other methods of grouping the drug types, such as mode of action/effect, class, prescription/legality and prescribing intent, were considered; however, these were ruled out due to uncertainties within them, such as how a prescription drug was obtained.

The drug types recorded and their associated pharmacological grouping are listed below:

- **Amphetamines** – amphetamine sulphate, amphetamines unspecified;
- **Antiepileptics** – gabapentin, pregabalin;
- **Benzodiazepines** – diazepam, benzodiazepines unspecified;
- **Cannabis** – cannabis herbal, cannabis herbal (skunk), cannabis unspecified;
- **Cocaine** – cocaine unspecified, cocaine hydrochloride, cocaine freebase (crack);
- **Ketamine**;
- **Other stimulants** – MDMA, stimulants – other;
- **Heroin illicit**; and
- **Opioids/opiates (excluding heroin)** – morphine sulphate, buprenorphine, dextromethorphan (Actifed Dry Coughs etc.), fentanyl, methadone mixture, methadone unspecified, opiate containing mixture, opiates unspecified, codeine prescription, codeine tablets, codeine unspecified, dihydrocodeine.

Heroin was the most common main drug type recorded, at 49% of all treatment episodes, whilst other opioids/opiates accounted for a further 7%. Cocaine accounted for 24% of treatment episodes and cannabis accounted for 13%. Less prominent were amphetamines and benzodiazepines, which accounted for 3% and 2%, respectively.

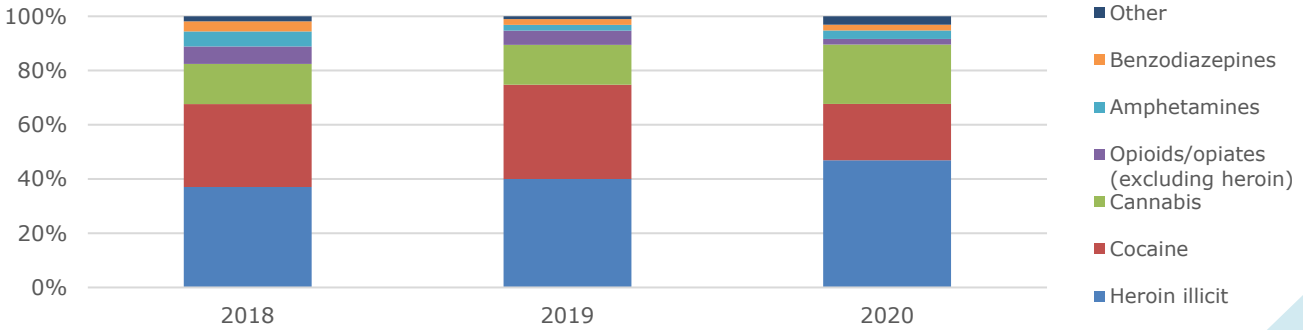
Figure 2.22. Proportion of treatment episodes by the main drug type recorded between 2018-2020



Note: Drug groupings included in "Other" are those which individually account for fewer than 2% of treatment episodes
Source: NDMTS

From 2018 to 2019, small increases were seen in the proportion of new treatment episodes each year for the top two reported main drug types (heroin and cocaine) and no change in the third (cannabis). The proportion of treatment episodes with heroin as the main drug type increased more from 2019 to 2020, from 40% to 47%, whilst the proportion of new treatment episodes with cannabis as the main drug type rose from 15% to 22%. Cocaine, however, accounted for a lower proportion from 2019 and 2020, decreasing from 35% of new presentations to 21%.

Figure 2.23, Proportion of new treatment episodes by the main drug recorded per year



Note: Drug groupings included in "Other" are those which individually account for fewer than 3% of treatment episodes
Source: NDMTS

Of the service users who were in treatment multiple times over the period, around three-quarters had the same main drug type recorded for each treatment episode. Heroin was the main drug type for over half of these individuals and cocaine for around a third. A small number of individuals had cannabis or amphetamines recorded as the main drug type in each of their treatment episodes.

Of the repeat service users who had a different drug recorded for one or more of their treatment episodes, all had at least one of heroin, other opiates/opioids or cocaine recorded for at least one treatment episode. With only small numbers of people in treatment multiple times for different main drug types, examination of whether there is a pattern of a certain drug type leading to another (e.g., treatment for heroin following treatment for cocaine) was not possible.

Geography of those in treatment:

Of the 374 individuals who had a PO21/PO22 postcode recorded, 72% lived in the Bognor area at assessment and remained in the area. Similar proportions moved into and out of the Bognor area from elsewhere during treatment, at 15% and 13%, respectively. 5% of the individuals receiving treatment were recorded as having no fixed abode and had similar proportions of those remaining in and moving in/out of Bognor during treatment.

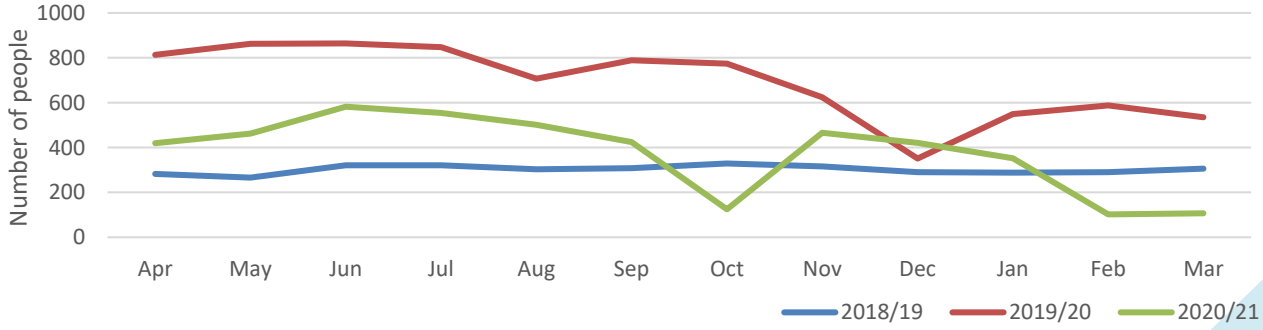
For service users in treatment multiple times during the period, the above figures reflect their postcode during their first treatment episode in this timeframe. Around half of these individuals lived in the Bognor area at assessment and remained in the area for all treatment episodes, and around two-fifths had at least one treatment episode where they moved into the Bognor area during treatment. Less than a tenth moved out of the Bognor area during treatment. Full postcode was not provided so ward-level analysis was not possible.

Needle and syringe programme:

Data for CGL's needle and syringe programme (NSP) at the Bognor geography were not available. Data for West Sussex for 2018/19 to 2020/21 are presented for illustration.

The number of people utilising needle syringe exchange services in West Sussex varied year-on-year, rising from a steady 300 people per month on average in 2018/19 to more than double this for the first eight months of the following year. Numbers were variable throughout the remainder of 2019/20 and 2020/21.

Figure 2.24. Number of people using the needle syringe programme in West Sussex, 2018/19 - 2020/21.



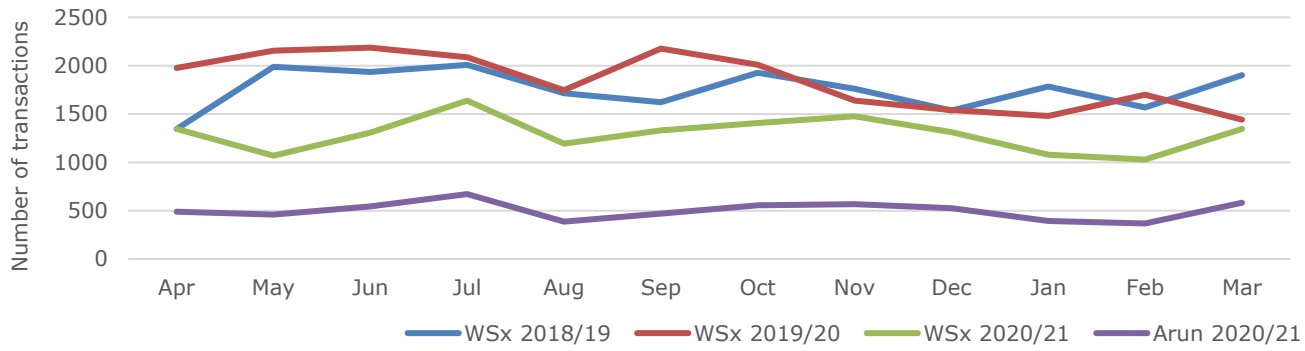
Source: Change, Grow, Live

Data for the number of transactions in Arun district were provided for 2020/2021. Transactions in Arun represented an average of 39% of all West Sussex transactions in 2020/21 and largely mirrored the monthly fluctuations in West Sussex overall. On average, there were 500 transactions per month in Arun.

In West Sussex, the number of transactions varied by year and month, with fewer transactions recorded in 2020/21 than the previous two years.

It is not known if some individuals account for many transactions or if transactions are roughly equal per person.

Figure 2.25, Number of transactions recorded by the needle syringe programme in West Sussex in 2018/19 – 2020/21 and Arun in 2020/21.



Source: Change, Grow, Live

2.3 Impacts in the community – Key Points:

- Children's social care assessments mentioning parental and/or child drug use increased between 2018 and 2020, rising to 20% of all CSC assessments in the Bognor area in 2020. By age, assessments mainly involve the parent's drug use in the early years, then shift towards the child's drug use in adolescence.

- The need for focused maternity service provision on this topic is clear in that 12% of assessments mentioning drugs were recorded for unborn children and, of all CSC assessments in the Bognor area, over a third of those conducted for pregnant women mentioned drug use.

- Between August 2020 and July 2021, Sussex Police recorded 17 custody arrests for possession with intent or possession of controlled drugs for county lines substances (heroin and crack cocaine) in the Bognor area.

- Three-quarters of people arrested were male and 25-34 year olds accounted for half of all arrests. Around a quarter of people arrested were recorded as having/at risk of a drug dependency and a further quarter as having/at risk of both a drug dependency and mental health issue.

- During the same period, 64 individuals in the Bognor area were linked to and/or flagged as vulnerable to cuckooing, although it was not clear from the data provided whether these people were victims alone or victims and offenders.

- Three referrals of potential victims of modern slavery relating to drugs supply in the Bognor area were made to Sussex Police via the National Referral Mechanism between August 2020 and July 2021, two of whom were under 18 years of age.

- 16% of all offences committed by children living in Bognor Regis during 2018-2020 were drug-related, and nine in ten of these related to possession of cannabis, with one instance of possession with intent to supply cannabis. Most offences resulted in a community resolution and three in a youth caution. Of the 28 offenders, most were male and older adolescents (16-17 year olds), although the age of offenders ranged from 13 years to 17 years.

- Of YJS assessments for children living in Bognor Regis who received a court disposal, 19 had a drug-related issue identified. Most of these started using drugs under the age of 16 (the youngest starting at age 9) and as having a history of cannabis use. Thirteen children had a history of multiple drug use, so were classed as regular drug users. Whilst most of these children were assessed as having low/medium risk likelihoods of reoffending and serious harm to others, the risk likelihood for their safety and wellbeing was largely medium/high.

- A quarter of all referrals to the YJS of children living in Bognor Regis were for substance misuse intervention, with most of these citing an initial action relating to cannabis use.

2.3 Impacts in the community – Key Points continued:

- Of all offenders known to the Kent Surrey Sussex Community Rehabilitation Company and living in the Bognor Regis area between April 2019 and Jan 2021, 21% were assessed to have a drug need linked to their offending behaviour; of the one in ten of these who had committed a drug-related offence, this proportion rose to a third. Over half of service users with a drug need were reported to be undertaking activities which promote the continual use of drugs.

- There were 374 individuals with a Bognor Regis postcode in structured treatment for drugs misuse with West Sussex DAWN between 2018 and 2020, including 52 individuals who received treatment in two or more separate episodes within the timeframe. 5% of the individuals receiving treatment were recorded as having no fixed abode.

- 73% of individuals were male and 27% female, and the majority aged 25-54 years; proportionally, female service users tended to be more in the younger part of this cohort whilst a greater proportion of male service users were in the older part of this cohort and above.

- Heroin and other opioids/opiates were recorded as the main drug type for over half of all treatment episodes (56%), cocaine a quarter (24%) and cannabis 13%. Over the three years, the proportion of all treatment episodes rose for heroin (37% to 47%) and cannabis (15% to 22%), whilst the proportion of treatments for cocaine fell (31% to 21%).

- Of the treatment episodes where the service user was discharged, three-quarters of episodes lasted for a year or less, with episodes of 5-8 weeks and 9-12 weeks the most frequently recorded; however, in those yet to be discharged, over three-quarters had been in treatment for more than a year.

- Data for needle syringe programmes at the Bognor geography were not available, although data for Arun showed an average of 500 transactions per month during 2020/21.

2.4 Impacts on health

Hospital services:

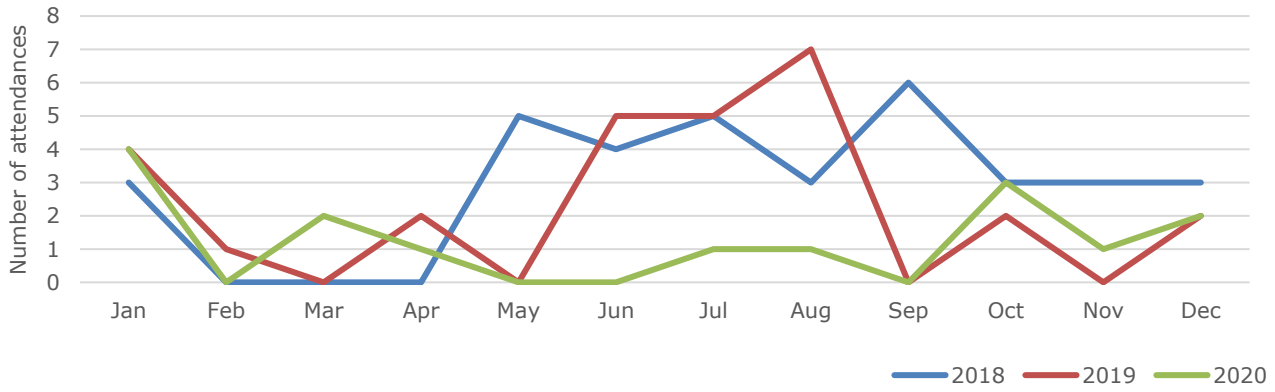
As Bognor Regis' closest primary Accident and Emergency ward, data for St Richard's Hospital were requested from University Hospitals Sussex NHS Foundation Trust. Attendances to A&E where illicit drug use was recorded, by individuals with a PO21 or PO22 postcode at time of attendance, were provided for the period January 1st, 2018 to December 31st, 2020.

The data provided included several variables for each A&E attendee: age, sex, ethnicity, postcode (allowing for ward level analysis), A&E arrival date and date of admission to the ward (if relevant), and drug type.

Accident and Emergency:

For the three-year period, 78 A&E attendances where illicit drug use was recorded were made by people living in the Bognor Regis geography. The total number of attendances decreased year-on-year, by 20% from 2018 to 2019, and by 46% from 2019 to 2020. The number of attendances varied by month each year, although more attendances were made in the summer months than winter in 2018 and 2019, and a greater number of attendances were made in January each year than the three months either side. In 2020, attendances were lower in the spring/summer than autumn months, which may be explained by the COVID-19 restrictions.

Figure 2.26, A&E attendances for people living in the Bognor Regis geography, where illicit drug use was recorded

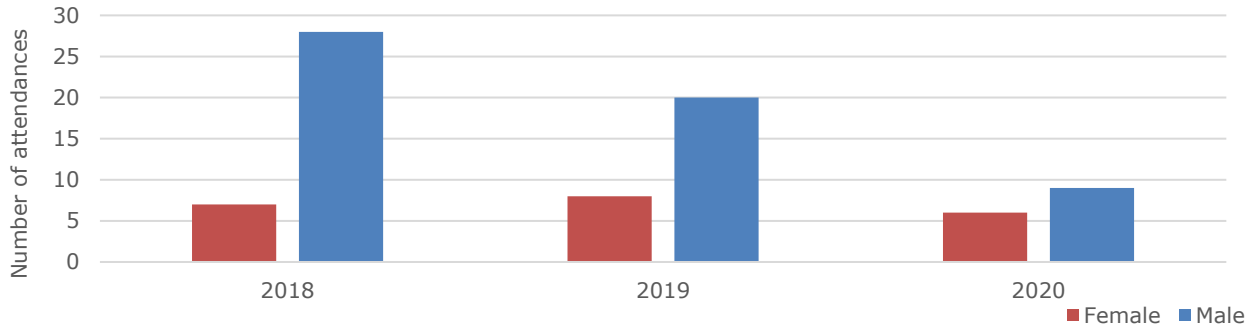


Source: University Hospitals Sussex NHS Foundation Trust

Demographics:

Attendances by males were consistently higher than females, although decreased year-on-year, by 29% from 2018 to 2019 and by 55% the following year. In contrast, female attendances remained stable over the three years.

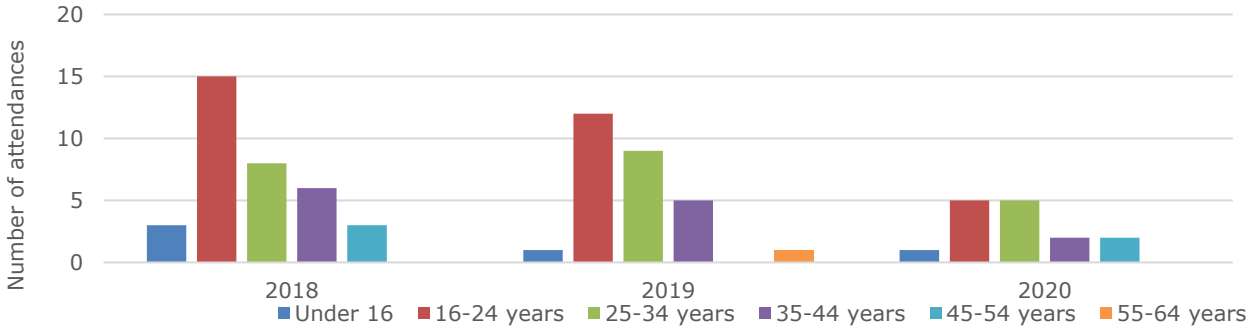
Figure 2.27, Number of A&E attendances by sex



Source: University Hospitals Sussex NHS Foundation Trust

Most attendances were made by people aged 16-24 years (43% in 2018 and 2019, and 33% in 2020). The proportion of attendances decreased with age, with few attendances made by those aged over 45 years each year. Under-16s similarly accounted for fewer than one in ten attendances each year.

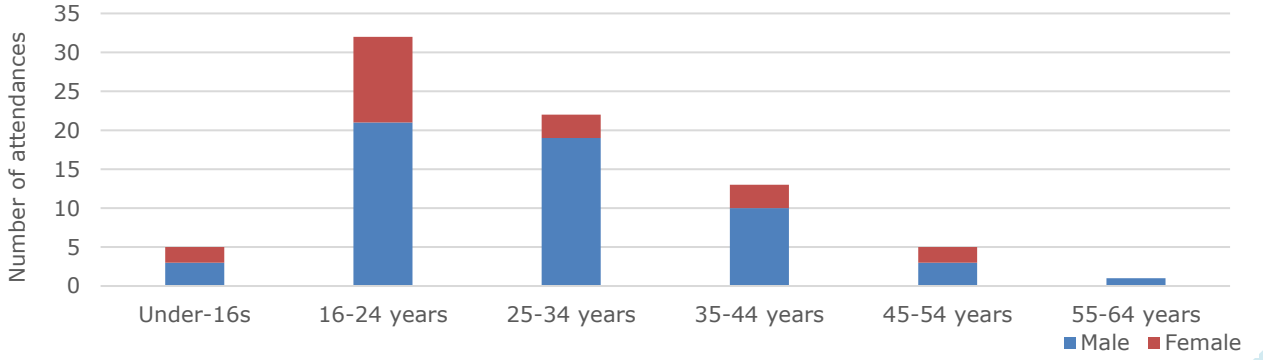
Figure 2.28, Number of A&E attendances by age-band



Source: University Hospitals Sussex NHS Foundation Trust

Of females attending A&E, half were in the 16-24 years age bracket. Male attendees were spread more across the age bands, although had similarly few attendees aged 45 years and older. 16-24 year olds and 25-34 year olds together accounted for around 70% of male attendees, and 35-44 years around 18%. Males accounted for a greater proportion of attendances than females in each age group; this was most pronounced in 25-34 year olds, with nearly 9 in 10 attendances by males.

Figure 2.29, Number of A&E attendees by sex and age band



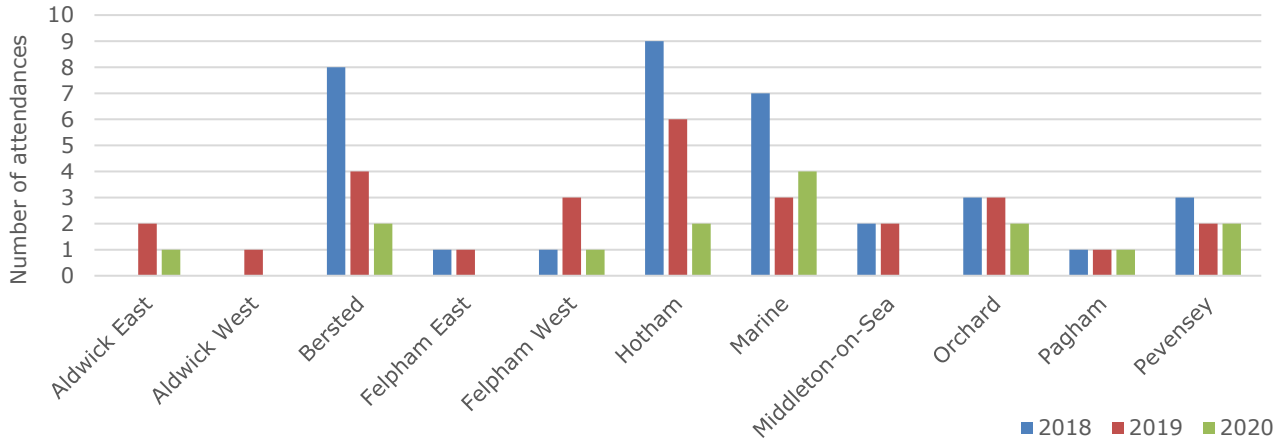
Source: University Hospitals Sussex NHS Foundation Trust

Mapping geographies:

In 2018, around two-thirds of A&E attendances were made by people living in the Bersted, Hotham and Marine wards. People attending A&E the following year were more spread out across the Bognor wards, although the Hotham and Bersted wards still accounted for the greatest proportion of attendances. Only 15 attendances were made in 2020, a quarter of which were from people living in the Marine ward.

Due to the small number of attendances at this geography, analysis of attendances by demographic characteristics at ward-level would not be meaningful.

Figure 2.30. Number of A&E attendances by ward



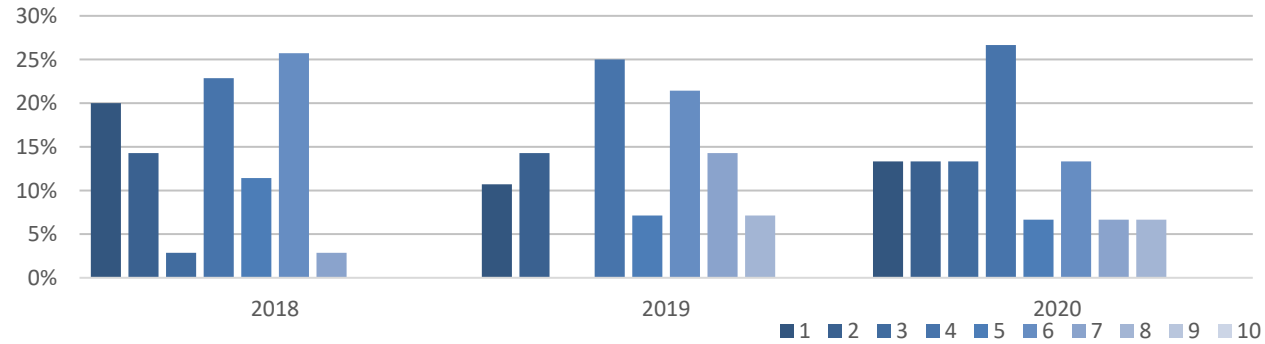
Source: University Hospitals Sussex NHS Foundation Trust

Deprivation:

Each ward in Bognor Regis can be split into several statistical neighbourhoods, named lower super output areas (LSOAs). This allows us to examine several overlapping factors of deprivation, calculated into the Index for multiple deprivations (IMD).

By the recorded postcode of the 78 A&E attendances made over the three years, an average of one-third lived in the three most deprived areas (deciles 1-3), around half in the middling deciles 4-6, and around 13% in the four least deprived areas (deciles 7-10); in this latter figure, none of the attendees lived in deciles 9 or 10.

Figure 2.31. Proportion of A&E attendances by LSOA IMD decile



Note, 1 = most deprived, 10 = least deprived
Source: University Hospitals Sussex NHS Foundation Trust

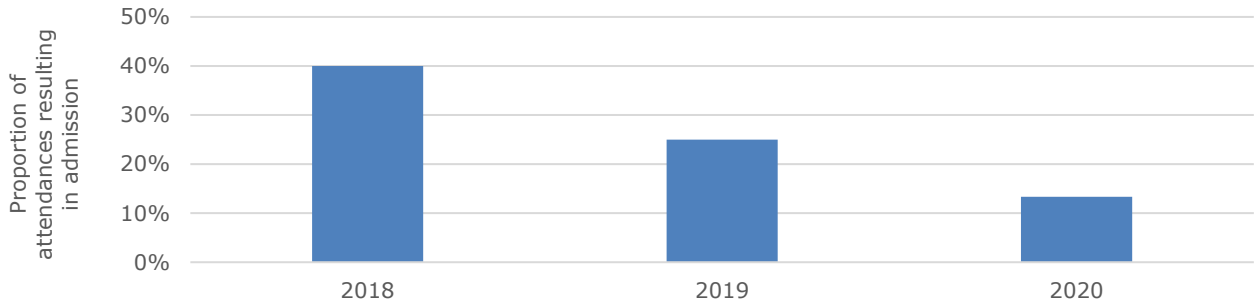
Types of drugs:

The type of drug was recorded as unknown for nearly 90% of attendances. Of known drugs, cocaine accounted for six attendances, whilst amphetamines, MDMA, speed and steroids each accounted for one attendance over the three-year period. Further analysis of the drug types used by different demographic groups is not possible with these small numbers. Opiates were not recorded where drug type was known, but likely account for many of the unknown attendances.

Admission to hospital inpatient ward:

The proportion of people attending A&E that went on to be admitted to the hospital ward decreased year-on-year, from 40% of attendances in 2018 to 13% in 2020. A higher proportion of males attending A&E went on to be admitted to the ward compared to females, at one-third of male attendances to one-fifth of female attendances. A greater proportion of people were admitted to the ward with increasing age.

Figure 2.32, Proportion of A&E attendances relating to drug use by Bognor residents resulting in a ward admission



Source: University Hospitals Sussex NHS Foundation Trust

2.4 Impacts on health – Key Points:

- There were 78 attendances by people living in the Bognor Regis geography to St. Richard's A&E where illicit drug use was recorded between 2018 and 2020, although the number of attendances decreased year-on-year.
- Attendances by males were consistently higher than females, although decreased year-on-year, whilst the small number of female attendees remained stable. Most attendances were made by people aged 16-24 years, followed by 25-34 year olds; half of female attendees were in the 16-24 years age bracket whilst males were more spread out across the ages.
- More male attendees went on to be admitted to the inpatient ward than females, as did those in the older cohorts, although the overall number of those admitted decreased year-on-year.
- Over the three years, most attendances were made by people living in the Bersted, Hotham and Marine wards. By IMD ranking, 87% of attendees lived in deciles 1-6 (1 being the most deprived); nearly a third of attendees lived in the two most deprived deciles.

3. Community engagement work

3.1 Approach

Four qualitative surveys were developed by the working group to gain first-hand insights into drug demand issues, tailored into two over-arching groups of interest: people who misuse drugs or have been exposed to/affected by drugs, and professionals who support those misusing drugs or who are exposed to/affected by drugs.

Service users of Change, Grow, Live (CGL), the local drug treatment service, and school children with known drug issues were targeted as the former groups of interest, whilst professionals who support those with drug issues and the professionals who support young people in the school settings were targeted as the latter group.

The relevant surveys were initially piloted with a number of professionals and volunteers from CGL and reviewed by the relevant partners in school safeguarding. Following feedback from these groups and completion of research governance, the surveys were hosted online, with the aim of developing an engaging and user-friendly engagement platform, where only those with the web-link could access the surveys, learn about the project, and ask questions. In addition to the surveys, an asset mapping tool was developed to gain insight into positive spaces in the community.

The surveys aimed at drug treatment service users and supporting professionals were open to those with the link from May through to November 2021. Members of the working group shared the link with partners previously identified as willing to participate, which mirrored the organisations approached with the initial request for quantitative data (see Section 2), including several third sector organisations that had been unable to provide quantitative data but were willing to discuss their "on the ground" experience. The survey was also promoted via the adults' safeguarding board and children's safeguarding partnership, with guidance that the survey was not for onward dissemination; the working group was keen to limit the survey to relevant professionals – i.e., those working in the Bognor Regis area with relevant experience. Feedback from the pilot surveys indicated that users of drug treatment services may not have access to the online survey, so partners in CGL recommended the use of paper surveys for clients willing to participate, including those supported by their youth-specific service.

The surveys aimed at young people and their safeguarding leads were similarly planned to be completed during the summer term of 2021 but the disruption from the ongoing COVID-19 pandemic stalled progress. Whilst partners in the schools of interest restated their support for future survey attempts in the autumn term, pressure from the pandemic response continued to disrupt efforts.

Twenty-four responses were received for the professionals' survey, including respondents from local housing associations and homelessness charities, third sector providers of drug treatment services, a community youth service, a GP practice, Sussex Police and local authority teams, such as adult social care, youth justice, anti-social behaviour, housing. Unfortunately, no responses were received for the surveys aimed at drug treatment service users.

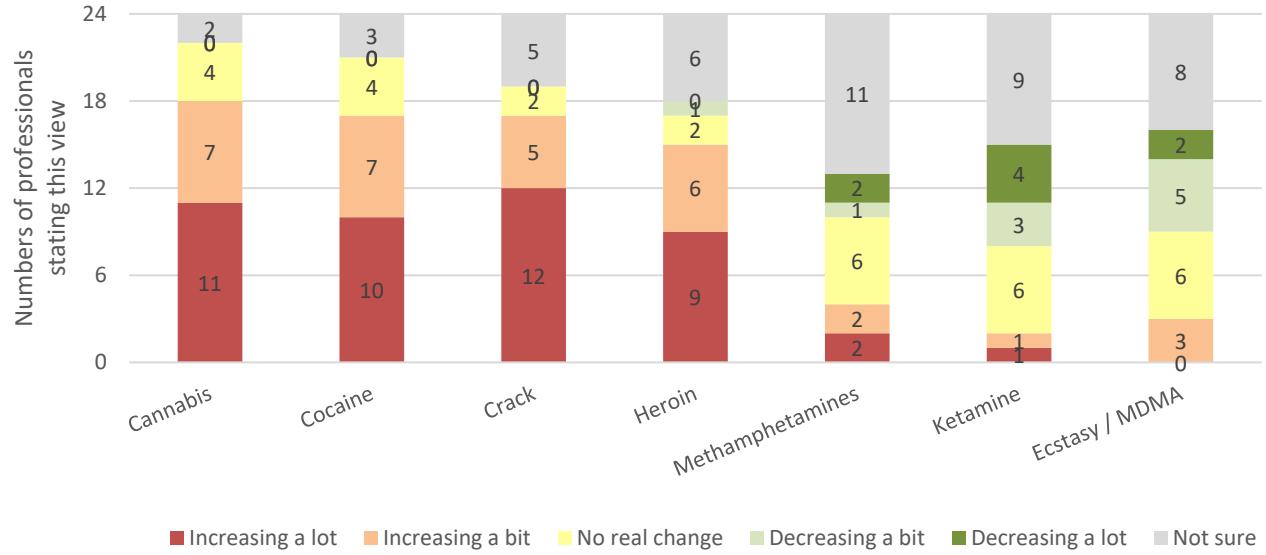
All responses from the professionals' survey were analysed by the authors of this report and are summarised over the following pages, following the structure of previous sections: perceived prevalence, followed by perceived impacts in the community and impacts on health.

3.2 Prevalence

The professional respondents were asked what they thought about the current levels of drug use in the community and if use of each major drug type was increasing or decreasing in recent years.

Cannabis, cocaine, crack and heroin were all seen as increasing 'a lot' or 'a bit' by the majority of respondents. Views were more varied for use of methamphetamines, ketamine and ecstasy/MDMA, with a small minority thinking these drugs were increasing in the community.

Figure 3.1, Professionals' perceptions of whether drugs are increasing or decreasing drugs in the community



Source: Bognor Regis professionals and community organisations survey, 2021

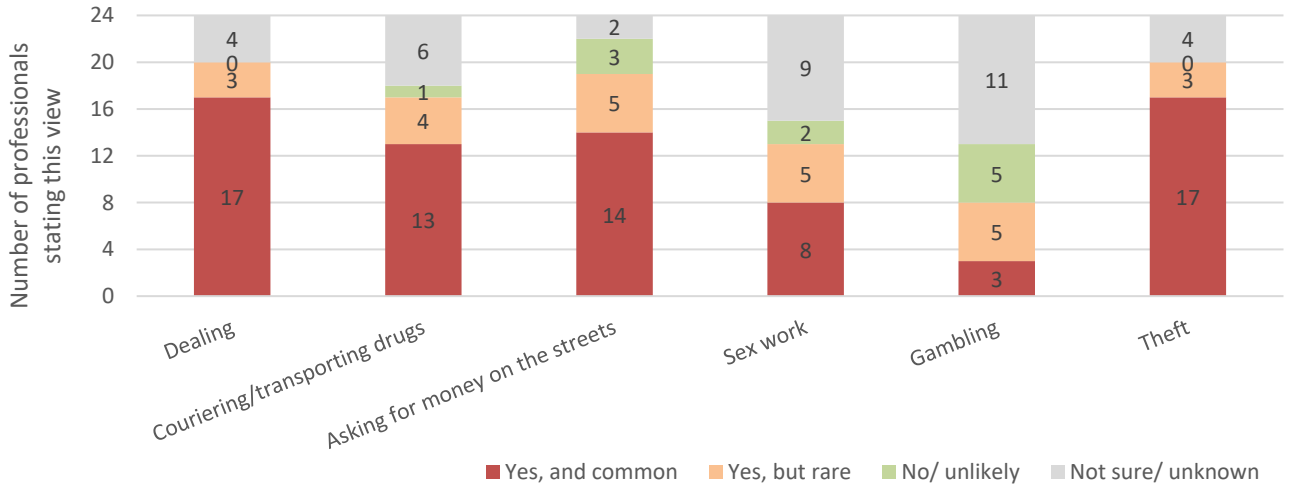
3.3 Impacts in the community

Funding drug use:

The professionals were asked how they thought people funded their drug use beyond any regular employment that they might have. Responses were pre-supplied, and respondents rated their answers as 'Yes, common'; 'Yes, rare'; or 'No, unlikely'.

Of the 24 respondents, 20 believed that dealing was a source of additional revenue for drug use, with 17 believing it was common. The other answers to this question (see Figure 3.2) suggest that by reducing the demand for drugs in the local community, a lot of crime and potentially dangerous activities could also be reduced.

Figure 3.2, Additional ways that professionals believed drug users fund their drug use



Source: Bognor Regis professionals and community organisations survey, 2021

Professional feedback regarding drug users needing additional funds covered the following themes:

Drug dealing was seen by many to be the most common method of acquiring more funds for personal drug use. It was suggested that attempts by the police to address this at a street level simply move dealing from one area of town to another.

Anecdotal feedback suggested that young people were swapping prescription medications for street methadone and would also steal from family members. One professional suggested young people were offering money to vulnerable addicts in order to shoplift alcohol for them.

Street begging was believed to have become more common in recent years and had been normalised. Enforcement orders were said to have been used in an attempt to inhibit this.

Vulnerable females were believed to be engaged in sex work locally to fund their drug use, and it was suggested that there was too little support and protection for these individuals.

One professional said that installations of CCTV cameras had increased at shelters and temporary accommodation, due to anxiety around local crime, and theft from motor vehicles was also referenced as being motivated by drugs. Indeed, a significant portion of all local crime was believed to be driven by funding drug use.

Exposure to violence:

Respondents were asked if the people they supported had ever been exposed to violence, as a result of their involvement with drugs.

Exposure to violence for individuals in the drug-related community was believed to be commonplace.

Unpaid drug debts were commonly cited as a driver of violence in the community, including threats, intimidation and exploitation. This included violence around enforcement of even minor debts, and a pattern of getting young people trapped in 'debt bondage', as a form of intimidation and exploitation. County line activity was said to result in the use of violence to enforce debt and supply; however, it was said that victims may not approach the police for help, leading to fewer reports of this issue than may exist.

Sexual, physical and financial abuse when under the influence of drugs were believed to be common, as were cuckooing and physical abuse/violence from drug suppliers. Those who were homeless or rough sleeping were said to be extremely vulnerable, as were those in co-dependent relationships.

It was also suggested that individuals would lose access to peer-support within their social community if they attempted to end their drug use, meaning that, should they be a victim of violence or intimidation, they would have fewer or no options for support in their community.

Fear for one's safety:

Respondents were also asked if the people they supported were concerned for their safety, as a result of their involvement with drugs.

The issue of drug debts was repeatedly mentioned as a primary driver of fear, causing people to want to flee into hiding or to relocate to other housing and accommodation; however, it was mentioned that housing providers may fail to fully support those who needed to escape threats of violence in the local area. The professionals said that people cannot always flee far enough from the local area, even if they are ex-users. The risk of exploitation, from cuckooing in particular, were repeatedly mentioned in the context of personal safety. One professional felt that few individuals would admit it, but that personal safety is a serious concern to many in the community.

Beyond this, non-drug users were said to be scared of the behaviour change of their partners, who could become unpredictable with some types of drugs.

Respondents were further asked about people being able to go home to somewhere safe, i.e., if the people they support felt safe in their home or where they live.

Children were said to be often signposted to local support services, including the multiagency safeguarding hub (MASH) for safeguarding concerns, but it was said that some young people in residential care are still afraid to return home, due to violence and exploitation in the local area.

Those who live with other dealers or drug users were said to be particularly at risk; domestic abuse was a factor, as was violence related to drug debts. Whilst some adults can be referred for emergency housing, housing shortages were referenced as a cause of people being unable to

move far enough away from exploitation, whilst those able to move may experience a lack of community/peer support in their new location. This was referenced specifically for victims of cuckooing exploitation and violence.

Despite the fact that some shelters had installed CCTV security as a necessity for people to feel safer, some shelters were said to try and find people temporary respite in camping sites, to escape violence in the local area.

Overall, the fear of violence was said to be a cause of under-reporting issues to the police.

Life and wellbeing in the community:

The respondents were asked to think about the individuals' lives and wellbeing more generally: in which ways had an involvement with drugs impacted their life or quality of life?

Many of the wider determinants of health, referenced in Section 1, were mentioned, including poverty, deprivation, unemployment, homelessness, antisocial behaviour, health problems and disability, involvement with criminal justice, and the breakdown of relationships and isolation from supportive communities and peer networks. Drug use was believed by some to affect every aspect of a person's life.

Most frequently mentioned was the loss of family support, however, with other drug users becoming the only people that individuals would interact with, in a reinforcing cycle. This was coupled with losing access to one's children.

Mental health impacts were also mentioned, with a reduced ability to interact with others and socialise, and an increase in depression. These could also lead to barriers to accessing support for treatment, whereby individuals with mental health problems find drug treatment difficult and mental health treatment is rarely accessible whilst still using drugs. A cycle develops, of using more drugs to cope with the negative mental impacts of addiction. A decline in self-care occurs, with a loss of interest in personal appearance and hygiene, and lives become more chaotic, and drug use – and funding their drug use – eventually consumes their everyday lives. In the words of one professional, this can make life not worth living.

The loss of accommodation and cycles of homelessness were said to lead to begging, hording, public drug use and antisocial behaviour.

For younger people, cannabis as an initial drug was said to affect motivation, resulting in a lack of engagement with education, training and employment, leading to financial implications, stealing from their family and potentially retail theft. The risk of a spiral of exploitation also begins here.

3.3 Impacts in the community – Key Points:

- A significant portion of all local crime was believed to be driven by funding drug use. Drug dealing and theft were seen as common methods to acquire funds for personal drug use, whilst street begging was believed to have become more common and had been normalised.

- Young people's drug use was suggested to be funded by stealing from family members; alternative routes to acquire substances were also suggested, such as swapping prescription medications for street methadone and offering money to vulnerable addicts to shoplift alcohol for them.

- Vulnerable females were believed to be engaged in sex work to fund their drug use; there was said to be too little support and protection for these individuals.

- Exposure to violence for individuals in the drug-related community was believed to be commonplace, with unpaid drug debts cited as main driver. A pattern of getting young people trapped in 'debt bondage' was also mentioned.

- Sexual, physical and financial abuse when under the influence of drugs was thought to be common, as was cuckooing by drug suppliers. Those who were homeless or rough sleeping were said to be extremely vulnerable, as were those in co-dependent relationships.

- Those attempting to end their drug use were said to lose access to community support, meaning less peer support should they be a victim of violence or intimidation.

- Drug debts were believed to be a primary driver of fear for one's safety, causing people to want to flee into hiding or relocate. However, being unable to flee an adequate distance – due to a shortage of emergency housing, for instance – and not having the full support of housing providers to do so were also mentioned, as was the lack of community/peer support in new areas for those able to move.

- Those living with dealers or drug users were said to be at risk from domestic abuse and violence related to drug debts, and to fear unpredictable behaviour from partners' using drugs.

- Some young people in residential care were believed to be afraid to return home, due to violence and exploitation in the local area.

- Fear of violence was said to be a cause of under-reporting issues to the police.

- Drug use was said to affect every aspect of a person's life and wellbeing; impacts relating to many of the wider determinants of health, such as poverty, unemployment, homelessness and more, were discussed.

3.3 Impacts in the community – Key Points continued:

- Reinforcing cycles entrenching people into drug use were frequently described, such as loss of family support resulting in other drug users becoming the only people individuals would interact with; loss of accommodation leading to homelessness, begging and antisocial behaviour; and greater drug use to cope with the negative mental health impacts of addiction leading to increasingly chaotic lives.

- Mental health issues were related to barriers to treatment; individuals with mental health problems may find drug treatment difficult whilst mental health treatment is rarely accessible for those still using drugs.

- A negative cycle in younger people using cannabis was described, with a lack of motivation leading to lack of engagement with education, training and employment and a resulting lack of funds, leading to stealing from their family and retail theft, and the risk of a spiral of exploitation.

3.4 Impacts on health

Mental health impacts:

Respondents were asked if any of the people they support have experienced mental health issues as a result of their involvement with drugs.

Drug users were felt to be less able to regulate their emotions, leading to periods of distress. Suicide attempts were known to result in A&E attendances from serious self-harm. Mental health problems were also reported to increase the likelihood of substance misuse.

Some observed consequences of drug use included psychosis, paranoia and hallucinations, personality disorders, eating disorders, memory problems, depression, anxiety, poor sleep patterns, alcohol abuse, self-harm and suicidal ideation. It was thought that many drug users find it difficult to accept help, due to other professionals believing their problems are self-inflicted as a result of their drug use; this was framed as an issue of stigma.

A GP surgery reported that one in three of their consultations were for mental health problems and that drug use makes this more acute.

Referrals to community groups and engaging with volunteering had been seen to help, by giving the individual a sense of purpose; as such, these interventions were seen as highly valuable.

Some professionals referenced the links between young people using cannabis and consequently developing mental health problems.

Accessing support for mental health problems was explained as difficult, as providers may require drug cessation to begin treatment and if an individual uses drugs whilst waiting for mental health treatment, it can void their application. Self-medication for mental health problems with further drug use was seen as commonplace.

Physical health impacts:

Respondents were asked if any of the people that they support have experienced physical health issues, as a result of their involvement with drugs.

Infections, amputations and mobility issues, due to intravenous injections causing arteries to fail, were referenced frequently, as were deaths from overdoses. Some individuals were known to continue to inject into amputation sites, commonly resulting in sepsis, whilst needle sharing had resulted in transmitted illnesses, such as hepatitis and HIV.

Falls leading to head injuries, liver failure, chest infections, poor diet, dental problems, stomach problems, dementia, fatigue, chronic pain and food poverty were all referenced as commonplace.

Drug use was believed to cause people to have problems taking health-related medications at the prescribed intervals, as well as lowering regular engagement with health services.

Some drug users have needed to go into residential care homes, as there was insufficient care in the community.

Hospital services:

Respondents were further asked if any of the people that they support had ever been in hospital because of their involvement with drugs. Responses mirrored those of the above.

Most individuals have been in hospital, as a result of overdoses, injection wounds and infections, organ damage, drug-associated violence or mental health problems (including sectioning), and many have had multiple hospital admissions. Suicide attempts were also said to have often resulted in hospital admissions.

Those with mental health problems are reported to be released after only minimal treatment, due to the complexity of their needs.

People were said to be often found unconscious in public, including those with heavy withdrawal symptoms, overdoses and adverse reactions from tainted drug batches. One professional described an individual who was admitted to hospital after their drink was spiked with LSD, when they were already high from cocaine and cannabis. Other overdoses occur from mixing prescription medications with alcohol or other drugs.

3.4 Impacts on health – Key Points:

- Mental health problems were reported to increase the likelihood of substance misuse whilst substance misuse was observed to lead to a variety of mental health issues and disorders, including psychosis, eating disorders, depression, poor sleep patterns, alcohol abuse, self-harm and suicidal ideation. Suicide attempts were known to result in A&E attendances from serious self-harm.

- Accessing mental health support was seen as difficult, with drug users finding it difficult to accept help due to professional stigma and some providers requiring drug cessation to begin treatment.

- Self-medication for mental health problems with further drug use was said to be commonplace.

- Complications from injecting (e.g., infections, amputations, sepsis) were commonly mentioned as physical health impacts, as were deaths from overdoses, whilst needle sharing was known to result in communicable disease, such as hepatitis and HIV.

- Most individuals were said to have been in hospital at least once as a result of the above, in addition to drug-associated violence or mental health problems. However, those with mental health problems were reported to be released from hospital after only minimal treatment, due to the complexity of their needs.

- Individuals being found unconscious in public with heavy withdrawal symptoms, overdoses or adverse reactions from tainted drug batches were also mentioned.

- Other physical health impacts, ranging from liver failure to dental problems to dementia, were seen as commonplace, yet drug use was believed to reduce regular engagement with health services.

3.5 Commissioning and community responses

Vulnerabilities to habitual drug use:

The respondents were asked what they thought made people in the community more vulnerable to habitual drug use. Predictably, many of these responses were aligned with wider determinants of health and validated the other vulnerabilities set out in Section 1.

When thinking about growing up in Bognor Regis, school exclusions were cited as a contributing factor, as were 'Adverse Childhood Experiences' (ACEs)[24], with particular reference to problems at home, neglect or a lack of consistent parental care. These were believed to add to issues that can affect people of all ages, including experiences of trauma, domestic abuse and exploitation.

Poverty, homelessness, unemployment and lifestyle were frequently mentioned as major risk factors, whilst the ongoing austerity in public services was felt to have had a negative impact, with a perception of fewer community activities to engage in.

Regarding the wider social environment, some professionals felt that having to move back to a negative environment after detox presented problems, as did negative peer influences or a lack of positive social peer-support. Relationship breakdowns or having one's children removed also significantly lowered resilience.

Other contributing factors to people maintaining drugs use were said to be direct pressure from drug dealers and the related fear of violence and exploitation, and the availability of drugs in the community.

When considering housing and relocation, isolation and being away from supportive networks was explained as creating vulnerabilities.

Mental health problems were seen as common in this context, yet drug use was described as also creating barriers to mental health support, due to the historically weaker support for 'dual-diagnosis' issues.

Regarding service provision more widely, some respondents felt there were barriers to accessing support, including a lack of walk-in support; lack of temporary accommodation; too few outreach workers to engage with the community; and a smaller than ideal drug-support workforce. The political and logistical nature of short-term funding cycles was felt to contribute to a shifting sands level of provision, with a lack of joined-up working in some areas. Frontline workers were described by some as lacking the training and support they needed to address issues in-house, and judgement-free, requiring a referral system which overburdened acute drug-treatment services.

[24] "*Adverse childhood experiences (ACEs) are stressful or traumatic experiences including abuse, growing up in the care of someone who has addictions or mental illness, parental discord or incarceration, bereavement or poverty.*"
Source: Safe in Sussex, Our work with professionals *(2021)*

What partnerships can do to reduce vulnerabilities:

The respondents were asked what more they thought community partnerships could be doing, to reduce the vulnerabilities that they had previously outlined.

Interventions at younger ages were regarded as important by many of the professionals, such as greater provision of youth clubs and spaces, affordable activities or volunteering opportunities in the community, and better access to counselling. Increasing employment opportunities was also important, as well as better education and retraining for adults.

Regarding safeguarding, some described the need to better allow for people to 'flee' the area to safe accommodation in a different local authority, or to move families away from areas of high drug use.

Regarding service priorities, it was felt that better education and training opportunities for frontline workers elsewhere in the system would allow more effective and joined-up working and insight sharing. Trauma-informed approaches in multiagency settings were cited as a desirable priority, as were utilising more outreach workers and more policing.

Respondents felt that services should act more quickly on the information they receive and rely on a network of services to provide support or reform, rather than on criminal justice alone. Some believed that there should be fewer convictions for drug offences all together, and that prevention should focus on the core drivers surrounding drug use (i.e., poverty or trauma), rather than the 'dangers'.

Respondents felt that wider systems change should integrate care, with more mental health nurses and outreach teams in the community, and potentially needle stations for safe drug use. Respondents felt that dual diagnosis support should become the norm, as well as a wider understanding of the complexities surrounding addiction. More specifically, some felt that services should focus more on face-to-face connections, social prescribing and resilience building, with outreach workers to work with those whose complexities made engagement less likely.

Barriers that can prevent people from accessing help or support:

The respondents were asked what barriers existed that might prevent people from seeking support, whether from authorities, health/treatment services or charities.

On a personal level, low resilience and shame were seen to be major issues, as well as the dependency on drugs to 'feel normal'. Negative experiences with service providers in the past were thought to create a feeling of mistrust and scepticism, preventing future engagement. Perceived professional stigma was said to be common enough to act as a further barrier, particularly in A&E and other healthcare settings.

Some professionals felt that charities were underfunded and services too inflexible, with long waiting lists for treatment and 9-5 working hours.

Some people were said to feel helpless, in that they didn't know what services were available or couldn't access them, and, as GPs were seen to be too busy for their referral role, people did not know to which services they could self-refer. Where services require face-to-face meetings, funding for travel was noted as an inhibitor and a lack of interpreters for foreign languages commonly mentioned.

Mental health services were believed to often screen people 'out' of the service, rather than screening them 'in', and that a shortage of mental health provision after a period of detox led to frequent issues and relapses.

Respondents noted that some people simply did not want to decrease their drug use, or that they perhaps would not admit that they had a drug problem. Having negative peer relationships or a lack of positive peer relationships was noted as a possible contributor to this, creating a homogenous community identity of drug use. This can be exacerbated by homelessness, exploitation or pressure from drug dealers; it was suggested that peer mentoring may be able to alleviate part of this.

Respondents said that a fear of Children's Social Care involvement was the biggest barrier for some, as they may lose custody of their children. Similarly, fear of arrest was seen as a common barrier.

3.5 Commissioning and community responses – Key Points:

- Adverse Childhood Experiences (ACEs) and school exclusions were believed to make young people more vulnerable to habitual drug use, whilst experiences of trauma, domestic abuse and exploitation were said to affect people of all ages.
- Poverty, homelessness, unemployment and lifestyle were frequently mentioned as major risk factors for drug use, whilst the ongoing austerity in public services was felt to have had a negative impact.
- Risks in the wider social environment included return to a negative environment after detox and availability of drugs in the community; negative peer influences or lack of positive social peer-support; relationship breakdown or removal of children; and isolation resulting from housing and relocation.
- Mental health problems were also seen as a vulnerability for drug use, yet drug use was described as creating barriers to mental health support, due to weaker support for 'dual-diagnosis' issues.
- Interventions and opportunities for younger ages were regarded as important to reduce vulnerabilities to drug use (e.g., youth clubs, volunteering and counselling), as were increased employment opportunities and better education and retraining for adults.
- The need for networks between services providing support and reform was discussed, with a move away from criminal justice alone to a prevention-based approach to risk factors.
- Better education and training opportunities for frontline workers were seen as a service priority for more effective working and insight-sharing, as were trauma-informed approaches in multiagency settings and utilising more outreach workers.

3.5 Community responses – Key Points continued:

- Integrated care and dual diagnosis support becoming the norm were outlined as needed by respondents, in addition to a wider understanding of the complexities surrounding addiction.

- Regarding safeguarding, improved mechanisms to allow individuals to 'flee' to safe accommodation in a different local authority or to move families away from areas of high drug use were also raised.

- Barriers to accessing support ranged from a personal level to service/system level. Of the former, low resilience, a dependency on drugs to 'feel normal' and not admitting that they have a drug problem were cited as barriers, as were shame, perceived professional stigma and mistrust following previous negative experiences with services.

- Fear of involvement from children's social services and losing custody of their children was a major obstacle for some in accessing support, and fear of arrest.

- Underfunded and inflexible services with long waiting lists were further obstacles, as were travel costs to reach in-person services and lack of foreign language translators.

- Mental health services were believed to often screen people 'out' of the service, rather than screening them 'in', and there was said to be a shortage of mental health provision after a period of detox.

- Feelings of helplessness were said to arise from lack of information on available services and self-referral, or inability to access these.

- Lack of service provision more widely – believed to be affected by short-term funding cycles – and joined-up working were further issues, with lack of walk-in support, temporary accommodation, outreach workers and drug-support workforce mentioned.

4. Methodological efficacy of the approach

The working group for this project conducted a process of self-reflection on completion of the data analysis phase of the project. Questions regarded the appropriateness and effectiveness of the scope and design, the partnership collaboration, the data collection, the interpretation and usefulness of the findings, and the options for continuing the work in other geographies.

4.1 Data capture and analysis

Do you feel that we approached the right organisations for data, and were there any that should have been approached, but were not?

The working group felt that the correct organisations were approached, citing that we followed the practice of the North Wales and the Bedfordshire examples. Some organisations were immediately forthcoming with their data, whilst others took six or even nine months to reply to requests. Some organisations expressed an immediate interest in supporting the work but then failed to cascade this into action, and so did not inform the analysis of this project.

There were significant delays to obtaining data from some organisations we approached. Do you have any views on what contributed to these delays and was there anything that could have been done to get data sooner?

The group felt that it was likely that some of the organisations, under high workload demands, put their contribution to this project as a lower priority. This may have been exacerbated by the continuing strains on healthcare services from the pandemic response, or to pre-existing staffing pressures. The group felt that future efforts should ensure that the most senior people available in the organisations should be approached for their buy-in, to increase the timeliness of responses.

One member of the group explained that: *"If this work was to be commissioned to other local areas by the Safer West Sussex Partnership Executive or Violence & Exploitation Board, I would advocate the need to consider developing a coordinated information network, whose primary focus would be on working to establish linkage and information sharing, a reporting mechanism among the different professionals and institutions involved in monitoring drug demand/treatment, and also work to address the issue of training for selected key personnel in drug misuse epidemiology, especially with regard to guidelines on developing key indicators, data management and analysis across invested services (e.g. Adult Social Care don't have a marker for drug misuse), as well as data capture at the clinical level, as GPs appear not to be able to provide data on patient drug misuse specifically."*

One common barrier to timely responses was that many organisations require standardised data requests, using template forms, requesting exact fields. This presented a problem, because the working group did not know what data were carried by such organisations and dialogue between individuals was cumbersome. In future it is recommended that each analyst or representative first be approached one-to-one, to discuss the data they carry, to ensure that requests are realistic, manageable, and collect the most effective fields.

If you were responsible for obtaining data, did the data received meet your expectations, or was it lacking in some way?

Data quality and quantity were seen to be lacking from some sources, including good data practices (e.g., metadata), a lack of context of how data is collected and recorded, and unclear data filtering methods, all of which inhibited the analysis. Limitations in data quality and quantity were generally believed to be due to how data is recorded by the parent organisation, making timely access more difficult.

It is noteworthy that some organisations received the request, analysed the data themselves and wrote summary documents with core tables and narratives included. This was helpful in reducing analytical load on the working group, but also in that the local data expert had a working knowledge of the datasets available and their caveats, and was thus better placed to interpret the data in real time. A second follow-up conversation for each data summary was sometimes required to discuss the findings, before exporting them into this document. It is accepted that such conversations were not always possible due to time constraints, but with senior management buy-in (described above) and a three to six month window, it is entirely feasible to collate such summaries from each organisation.

The geography of Bognor Regis was originally believed to have clear boundaries, as it is surrounded by sparsely populated farmlands; however, this belief was an oversight that unfortunately made data collection more difficult, as few organisations could map precisely to the Bognor urban area. This was due to two issues: firstly, where organisations operated on a wider area, they did not record town-specific data, instead recording data by district or an internal administrative area; secondly, where individual postcodes were stored by the organisation, the tendency to resolve to 'data security/privacy issues' meant that only partial post-codes could be shared, which had to be mapped to the PO21 and PO22 areas. Whilst these are largely in Bognor Regis, they do include some satellite villages. Consideration of the geographies of data collection should be made in future iterations, as should development of clear data-sharing agreements where individual-level postcodes are stored.

4.2 Community engagement

Do you feel we approached the right people and groups for qualitative responses? Were there any groups we should have approached, but didn't?

The group felt that the right organisations were approached for qualitative engagement feedback, although it is possible that senior executive buy-in was lacking, which resulted in lower motivation for participation from the organisations approached. The professionals from a range of support services in the area that we approached did eventually respond with detailed feedback, but whilst some responded inside a month, others took as long as five or six months, with multiple requests.

It was also originally hoped that service users from drug treatment support services, young people identified as having a safeguarding concern related to drug use, and school safeguarding leads would be available to contribute their experiences. Ultimately, none of these groups were able to source participants within the six-month window that was available to them.

There were significant delays to obtaining qualitative responses from some organisations we approached. Do you have any views on what contributed to these delays and was there anything that could have been done to get data sooner?

The group felt that work-pressures on staff within the approached organisations created a sense that this was low priority work which was put to the bottom of the pile. Pressures from the ongoing pandemic were a particular issue, slowing and eventually preventing timely engagement for the young people and designated safeguarding leads. Similar calls for senior leadership buy-in (as mentioned for quantitative data) were made in the hope that this could increase participation from actors within the partnership.

Did the level of engagement we received meet your expectations?

The quality of data from the community engagement was praised, but the gaps in data from the low response were sorely missed by the group. Whilst the professionals did contribute rich data, it was not possible to contrast their views with those of the service users and vulnerable younger people. It is hoped that future iterations of this work will be able to balance the professional view with those of residents.

One limitation of the feedback from professionals was that we did not ask explicitly enough what, if anything, makes Bognor Regis distinct to other areas. This oversight was because we were unable to sufficiently pilot the questions with a range of stakeholders before the wider roll-out. Following this, it was felt that much of the insight could be similar to those of any local geography. However, whilst this possibility remains, it may be that findings from other geographies in the future will contain different issues, and therefore validate the salience of the Bognor Regis-level data.

4.3 Generating meaningful insights

The largest test of the efficacy of this approach was whether we were able to generate meaningful insights that would not have been available to us otherwise.

The group generally felt that the quantitative data were useful but were limited by aforementioned complications in their extraction from the data-holding organisations. The insights gained from future iterations of the project would likely improve with a more streamlined and cooperative partnership.

The insights from the qualitative component were seen to be useful where these were realised from the professionals. However, some in the group felt that the questions were too general to provide sufficient richness of data for their working area/profession. It was recommended that, where possible, future engagements should revolve around live conversations, rather than template surveys, either as one-to-one interviews (easily conducted over the phone) or focus groups for multiple participants of the same cohort.

Overall, the group felt that the project has been successful and, with some of the complications and limitations ironed out, future iterations should be considered, both with the quantitative and qualitative components intact.

4.4 Future iterations

Do you feel we had all the relevant stakeholders on the project working group? If repeated, who else should be approached to be in a working group?

The working group felt that additional representation from primary care, mental health and joint commissioning would have improved the work, so as to speak for those who will be responsible for driving forward the recommendations. However, this was coupled with an awareness that there needs to be a willingness to participate and help shape the scoping of the local issues, the data collection and its interpretation.

It was recommended that, in the future, participation from senior managers for each area/organisation be agreed by SWSP executive board, so that data collection can be better facilitated, and regular feedback and accountability can be maintained at senior levels.

Do you have any recommendations as to how data concerning drug demand should be recorded by organisations, or shared within the partnerships?

The group felt there was a need to consider developing a coordinated information network (as outlined above), whose primary focus would be to establish linkage and information sharing and a reporting mechanism among the different professionals and institutions involved in monitoring drug demand/treatment. This network would also work to address the issue of training for selected key personnel in drug misuse epidemiology – with particular regard to guidelines on developing key indicators, data management and analysis across invested services (e.g., Adult Social Care don't have a marker for drug misuse) – as well as data capture at the clinical level, as GPs appear to not be able to provide data on patient drug misuse specifically.

From the Sussex Police perspective, the data that is recorded on their systems is set out for receipt by the Home Office and therefore isn't open to local change. In terms of sharing, it is possible that there is a degree of over-caution about data protection, which can inhibit expediency in sharing; a clear information sharing agreement may aid future iterations. Any recommendations for data storage and sharing can be incorporated into the Sussex Police-led 'Drug related harm reduction strategy for West Sussex'.

Do you have any recommendations as to how to better engage with the public/with professionals?

Beyond the traditional methods for engagement (transparency, trust, and ease of access etc.), the working group felt that senior leads should be approached to gain buy-in and increased levels of engagement via a top-down approach.

Do you have any recommendations regarding how the Working Group functioned, to improve its effectiveness next time around?

The working group felt that they, as a whole, functioned well, but a lack of engagement from other sectors of the partnership may have diminished its overall effectiveness to plan data collection and to engage with relevant stakeholders and members of the public.

More practically, over the course of the project it became apparent that a single project manager to bring in data, negotiate returns, increase engagement, and maintain deadlines would have been beneficial. Similarly, whilst efforts were made to obtain an experienced analyst to dedicate full time to the collation, interpretation, and write-up of the data, this was ultimately performed by a member of the working group, with other responsibilities. Increased meeting frequency for the working group may also have expedited some elements of the project. Future efforts should not negate the necessity of dedicated resources to facilitate the project, from conception to publication.

If this work is to be repeated – which geographic area(s) do you think should be next, and will you be able to support such work, or do you have an appropriate colleague for that geography?

The group proposed two candidate geographies for future iterations in West Sussex: Littlehampton and Crawley. It is entirely possible that these two separate geographies could be conducted simultaneously, should sufficient project-management and support resources be applied to maintaining a balanced and consistent approach. An alternative presented was to conduct this work in an area that was not believed to have a heavy county lines presence, as a comparison.

5. Recommendations

The following outline priority areas of work which span across partnerships and so require an embedded partnership response. These are framed within the theoretical models outlined in Section 1, of public health approaches to risk and resilience factors, the wider determinants of health, and place-based solutions.

Referring to the public health approach to reducing drug demand in the community, defined in Section 1, it is possible to minimise negative individual and community-level impacts across the partnership, by addressing vulnerabilities and improving resilience in the community.

5.1 Reducing community-level impacts

Start of life:

Adverse Childhood Experiences (ACEs) and school exclusions were believed to make young people more vulnerable to habitual drug use, whilst experiences of trauma, domestic abuse and exploitation were said to affect people of all ages.

Clear vulnerabilities exist in childhood, as explained in the number of Children Social Care assessments including reference to substance misuse. This includes pre-natal periods of development. Fear of involvement from children's social services and losing custody of their children was a major obstacle for some in accessing support, and fear of arrest.

Children and young people:

Young people's involvement with the police and youth justice often concerned possession of cannabis. Of these, most were young men and boys. Many of these started using drugs under the age of 16 and were regular drug users.

Interventions and opportunities for younger ages were regarded as important to reduce vulnerabilities to drug use (e.g., youth clubs, volunteering, and counselling), as were increased employment opportunities and better education and retraining for adults.

Police and criminal justice involvement with drugs in the community is largely concentrated in those under the age of 35; for those with mental health issues; and for those with drug dependency issues.

Exploitation and safeguarding:

Modern slavery and exploitation are known to occur in Bognor Regis, with a link to drug markets. Fear of violence was said to be a cause of under-reporting issues to the police.

Being under the influence of drugs was said to present a significant safeguarding risk to the individual, who is more vulnerable to sexual and financial exploitation. It was suggested that not enough is being done to support vulnerable persons engaged in sex work, as a method to fund their drug dependence.

Crime and support:

A significant portion of all local crime was believed to be driven by funding drug use. Drug dealing and theft were seen as common methods to acquire funds for personal drug use, even amongst children and young people.

The need for networks between services providing support and reform was discussed, with a move away from criminal justice alone to a prevention-based approach to risk factors.

Unpaid depts and financial pressures were believed to be primary mechanisms through which people were exploited or coerced into drug dealing and habitual use.

Housing, relocation and community networks:

People who attempt to end their drug dependence can often find themselves removed from previous peer support networks, leaving them isolated. This also manifests for those who attempt to flee or relocate from unsafe environments, domestic violence, and exploitation. A shortage of secure social housing can also make relocation inflexible, placing vulnerable individuals either too close or too far from their hometowns.

Risks in the wider social environment included return to a negative environment after detox and availability of drugs in the community; negative peer influences or lack of positive social peer-support; relationship breakdown or removal of children; and isolation resulting from housing and relocation.

Regarding safeguarding, improved mechanisms to allow individuals to 'flee' to safe accommodation in a different local authority or to move families away from areas of high drug use were also raised.

Community responses and commissioning:

Drug use was said to affect every aspect of a person's life and wellbeing, creating a cyclical relationship which impacts many of the wider determinants of health, such as poverty, unemployment, homelessness and more. The ongoing austerity in public services was felt to have had a negative impact on service outreach and delivery.

Lack of service provision more widely – believed to be affected by short-term funding cycles – and joined-up working were further issues, with lack of walk-in support, temporary accommodation, outreach workers and drug-support workforce mentioned.

Better education and training opportunities for frontline workers were seen as a service priority for more effective working and insight-sharing, as were trauma-informed approaches in multiagency settings and utilising more outreach workers.

5.2 Improving health and treatment

Drug treatment services:

Those who enter drug treatment do not always complete successfully and may represent at a later date. Heroin addiction is the largest primary reason for drug treatment.

Coexisting mental health and substance misuse:

Mental health issues were known to create barriers to accessing and completing drug treatment programmes, whilst substance addiction was itself a barrier to accessing mental health treatment.

Mental health services were believed to often screen people 'out' of the service, rather than screening them 'in', and there was said to be a shortage of mental health provision after a period of detox.

Integrated care and dual diagnosis support becoming the norm were outlined as needed by respondents, in addition to a wider understanding of the complexities surrounding addiction.

Accessibility of treatment and support services:

Barriers to accessing support ranged from a personal level to service/system level. Of the former, low resilience, a dependency on drugs to 'feel normal' and not admitting that they have a drug problem were cited as barriers, as were shame, perceived professional stigma and mistrust following previous negative experiences with services.

Underfunded and inflexible services with long waiting lists were further obstacles, as were travel costs to reach in-person services and lack of foreign language translators.

Feelings of helplessness were said to arise from lack of information on available services and self-referral, or inability to access these.

Secondary care services:

Drug use and dependence is a driver of demand of Accident and Emergency departments, as well as hospital inpatient wards. This is particularly driven by young people and males. The majority of attendances can be mapped to areas of higher deprivation.

5.3 Methodological approach

Following from Section 4, there are a range of recommendations which can be made to improve and refine this approach for future iterations.

Partnership working:

The group generally felt that the quantitative data were useful but were limited by aforementioned complications in their extraction from the data-holding organisations. The insights gained from future iterations of the project would likely improve with a more streamlined and cooperative partnership. Overall, the group felt that the project has been successful and, with some of the complications and limitations ironed out, future iterations should be considered, both with the quantitative and qualitative components intact.

It was recommended that, in the future, participation from senior managers for each area/organisation be agreed by SWSP executive board, so that data collection can be better facilitated, and regular feedback and accountability can be maintained at senior levels.

The group felt that future efforts should ensure that the most senior people available in the organisations should be approached for their buy-in, to increase the timeliness of responses.

Data collection:

One common barrier to timely responses was that many organisations require standardised data requests, using template forms, requesting exact fields. In future it is recommended that each analyst or representative first be approached one-to-one, to discuss the data they carry, to ensure that requests are realistic, manageable, and collect the most effective fields.

Whilst these are largely in Bognor Regis, they do include some satellite villages. Consideration of the geographies of data collection should be made in future iterations, as should development of clear data-sharing agreements where individual-level postcodes are stored.

In terms of sharing, it is possible that there is a degree of over-caution about data protection, which can inhibit expediency in sharing; a clear information sharing agreement may aid future iterations. Any recommendations for data storage and sharing can be incorporated into the Sussex Police-led 'Drug related harm reduction strategy for West Sussex'.

Qualitative engagements:

The quality of data from the community engagement was praised, but the gaps in data from the low response were sorely missed by the group. Whilst the professionals did contribute rich data, it was not possible to contrast their views with those of the service users and vulnerable younger people. It is hoped that future iterations of this work will be able to balance the professional view with those of residents.

The insights from the qualitative component were seen to be useful where these were realised from the professionals. However, some in the group felt that the questions were too general to provide sufficient richness of data for their working area/profession. It was recommended that,

where possible, future engagements should revolve around live conversations, rather than template surveys, either as one-to-one interviews (easily conducted over the phone) or focus groups for multiple participants of the same cohort.

Defining terms:

One limitation of the feedback from professionals was that we did not ask explicitly enough what, if anything, makes Bognor Regis distinct to other areas. This oversight was because we were unable to sufficiently pilot the questions with a range of stakeholders before the wider roll-out. Following this, it was felt that much of the insight could be similar to those of any local geography. However, whilst this possibility remains, it may be that findings from other geographies in the future will contain different issues, and therefore validate the salience of the Bognor Regis-level data.

Project management:

More practically, over the course of the project it became apparent that a single project manager to bring in data, negotiate returns, increase engagement, and maintain deadlines would have been beneficial. Similarly, whilst efforts were made to obtain an experienced analyst to dedicate full time to the collation, interpretation, and write-up of the data, this was ultimately performed by a member of the working group, with other responsibilities. Increased meeting frequency for the working group may also have expedited some elements of the project. Future efforts should not negate the necessity of dedicated resources to facilitate the project, from conception to publication.

Future geographies:

The group proposed two candidate geographies for future iterations in West Sussex: Littlehampton and Crawley. It is entirely possible that these two separate geographies could be conducted simultaneously, should sufficient project-management and support resources be applied to maintaining a balanced and consistent approach. An alternative presented was to conduct this work in an area that was not believed to have a heavy county lines presence, as a comparison.