The overall number of adults addicted to both heroin and crack has fallen for the first time... figures also show, for the first time, a substantial reduction in the numbers of people seeking treatment for problems with cocaine, in both crack and powder form

DRUG TREATMENT IN 2009-10

EFFECTIVE TREATMENT CHANGING LIVES
www.nta.nhs.uk

NHS
National Treatment Agency
for Substance Misuse

The findings of this independent study indicate... there are now almost 11,000 fewer heroin addicts in England

Overview

Illegal drugs are harmful. Although illicit drug use is common in this country, most people who dabble with drugs stop using them when they realise the risks are not worth taking. However, a minority of people find they cannot stop without help, and need treatment to overcome their addiction.

Drug misuse by these individuals has repercussions for society as a whole. While the number of people with a serious problem is relatively small, their misuse affects their families, friends and communities. Effective treatment not only offers the individuals the opportunity to get on the road to recovery, but also gives communities a break from drug-related crime and anti-social behaviour.

The British Crime Survey (BCS) records that overall drug use in England has been steadily falling in recent years, particularly among young people. It also tells us that less than 1% of the population recently used the most harmful drugs – that is, heroin and crack cocaine. This is gratifying, but not a cause for complacency, since it is recognised that standard household surveys tend to underestimate the extent of such illegal and covert activity. In the mid-2000s the Home Office commissioned a detailed estimate of the numbers of problematic drug users, and the National Treatment Agency (NTA) asked Glasgow University to conduct a follow-up exercise for 2008-09.

The findings of this independent study indicate the first signs of an important shift among this hard-to-reach population. For example, they report a real decrease in the number of opiate users: put simply, there are now almost 11,000 fewer heroin addicts in England. Other headline changes are deemed to be within the usual margins of error. So where the previous Home Office research suggested the number of problem drug users was stable at around 330,000, the fall to about 321,000 in the latest estimates is not statistically significant.

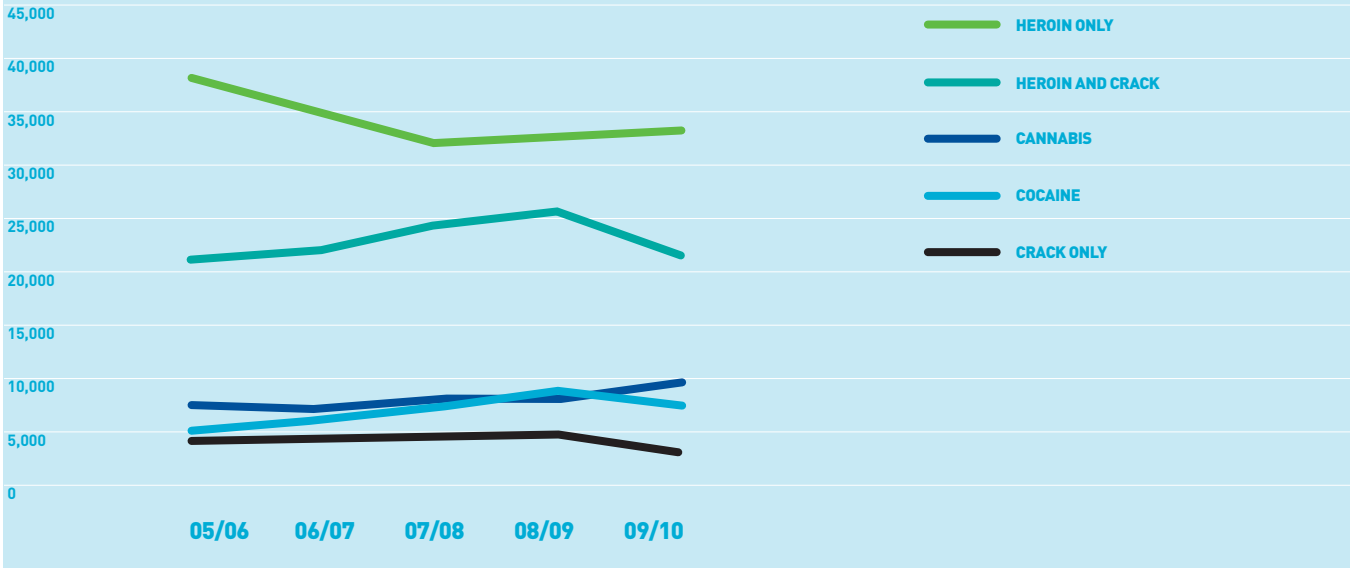
Nevertheless the researchers explored the data in more detail and found significant decreases in the numbers in younger age groups, particularly the 15-24s but also the 25-34s. The data therefore suggests an existing population of problem drug users is getting older. It also recorded significant reductions in heroin use in London and the North West - those areas of the country where the heroin epidemic first took off in the 1980s.

The real decrease in the number of heroin addicts was anticipated by the annual statistics collected by the National Drug Treatment Monitoring System (NDTMS). A year ago the NTA charted a dramatic fall in heroin use among young adults in treatment, heralding a generational shift in patterns of drug dependence. We wondered then whether we had passed the high-water-mark for heroin addiction as the 'trainspotting' generation got older, fewer young people became addicted, and treatment began to show an impact.

We can now go further, taking Glasgow University's study as a sign NDTMS is an early predictor of prevalence. The 2009-10 figures demonstrate a continuing fall in treatment demand by heroin addicts. Although more over 40s are being treated, the

Effective treatment using talking therapies is available for cocaine addicts, and people who need help are responding well

FIGURE 1: **NUMBER OF NEW PRESENTATIONS BY DRUG**



overall number of adults addicted to both heroin and crack has fallen for the first time, confirming our hypothesis that the heroin epidemic is beginning to come to an end. However, the figures also show, for the first time, a substantial reduction in the number of people seeking treatment for problems with cocaine, in both crack and powder form. Some of this is offset by a modest increase in cannabis use, particularly among young adults, but overall the 18-24 age group show the most dramatic fall in presentations to treatment for heroin, powder cocaine and crack.

Changing patterns in use of cocaine and crack

The number of people coming into treatment for problems with powder cocaine during 2009-10 fell substantially, from the previous year's figure of 8,522 to 7,304 (figure 1). This fall comes after a steady increase in numbers being treated for cocaine over the four years from 2005 to 2009 – and it's a trend that has been consistent across all age groups.

The picture is similar for people being treated for crack cocaine, either on its own or in combination with heroin. The numbers for crack alone have risen steadily since 2005, hitting 5,045 in 2008-09, but dropping off to 3,686 in 2009-10. Likewise, those treated for crack and heroin together fell substantially from 25,460 in 2008-09 to 21,341 in 2009-10.

The figures also reveal large regional variations in treatment for crack use. Generally, the south has a higher prevalence of crack users among those entering treatment, although areas of the urban North West show similar levels. In Bristol and some London boroughs, as many as 45-60% of all new presentations are crack users.

The good news is that effective treatment using talking therapies is available for cocaine and crack addicts, and people who need help are responding well to treatment. Emerging data from the Treatment Outcomes Profile (TOP) for people coming into treatment in 2009-10 shows 74% of powder cocaine users and 60% of crack users either stopped or reduced their use within the first six months.

There is also growing evidence that treatment has lasting effects. A recent NTA analysis showed that 64% of powder cocaine and 49% of crack cocaine users who finished treatment in 2005-06 did not come back within four years of leaving the system, suggesting they had sustained their recovery.

Cocaine – the bigger picture

The dramatic fall in cocaine use among treatment seekers should come as no surprise, since it fits with a number of other recent

Dr Jenny Maslin, clinical psychologist, Lambeth Addictions, South London and Maudsley NHS Foundation Trust

Over the last few years there has certainly been a shift in focus towards a more consistent recovery-oriented treatment model. We have started to adopt a more holistic approach towards treatment, as people with substance use problems often have a range of other difficulties in their lives, for example, with their relationships, living environments, finances, social networks, opportunities and physical and psychological well-being. So we take an overview. We think about their treatment and substance use problems in a broader way, making sure that each person has an individual personalised support plan. From a psychologist's point of view it is important that service users are able to access support to address additional psychological problems (such as anxiety, depression and trauma), which substance use may have become a key way of managing. Therefore, we

developments in the drugs field.

The United Nations Office on Drugs and Crime (UNODC) believes that the world's supply of cocaine is declining. The World Drug Report 2010 found the global area under coca cultivation has shrunk by 28% in the past decade, and production fallen.

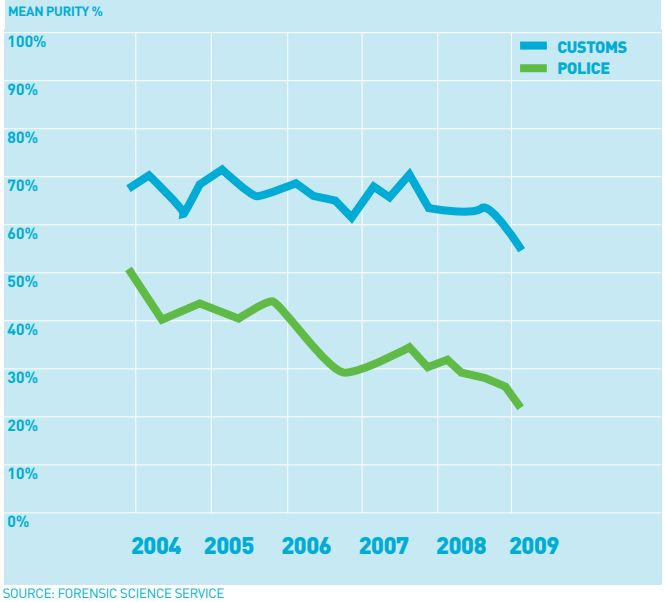
In this country the latest British Crime Survey (BCS) 2009-10 recorded a 0.6% fall in those recently using cocaine – the biggest annual drop since 1996, when this data was first collected. That represents 200,000 fewer adults reporting using the drug, effectively reversing a sharp increase in use recorded in the previous year.

Although the long-term trend in England and Wales remains on a slow upward trajectory, it's fair to assume a sudden fall in general use would also mean a fall in the numbers needing treatment.

There are a number of reasons why cocaine may be less attractive in the drugs market. One is increasing evidence that as efforts to disrupt supply bear fruit, the wholesale cost of cocaine has been rising steadily, encouraging dealers to boost their profits by bulking it up before selling it on the streets.

According to the Serious Organised Crime Agency (SOCA), the purity of both powder cocaine and crack cocaine has declined markedly in recent years (figure 2). It would come as little surprise if users turned their backs on a low-quality product.

FIGURE 2: **PURITY OF COCAINE SEIZED IN THE UK 2003-2009**



SOURCE: FORENSIC SCIENCE SERVICE

Another is evidence that 'legal highs' have emerged as an alternative to low-quality cocaine. Mephedrone became widely popular (until it was classified under the Misuse of Drugs Acts earlier this year). The nature of the legal highs market means that new substances are continually emerging, bringing with them renewed concerns about their actual chemical composition and

work collaboratively to help service users build their strengths and find more useful ways of managing psychological distress.

Psychological symptoms are not always easy to fit within a diagnosis and often become a barrier to someone making changes to their substance use. So as psychologists we talk with service users to formulate their difficulties and try to establish what that barrier might be. This helps us decide on the most appropriate interventions to help them move on with their recovery journey and build their non substance using identity.

It's important to recognise that each person's recovery is a unique and individual journey; it's not one size fits all.

the potential harmful effects.

Drugs services report instances of users reporting serious problems with mephedrone and other synthetic stimulants, and it is important for drugs workers to respond appropriately when users seek help. However, the overall number of people seeking treatment for addiction to these substances remains extremely low.

Similar caveats apply when we are talking about cocaine. The BCS shows cocaine is consistently more popular than other Class A drugs, with an estimated 800,000 adults reporting using it last year. Cocaine is harmful, particularly in conjunction with alcohol, and its adverse effects well documented with increases in emergency hospital admissions and suspected heart attacks.

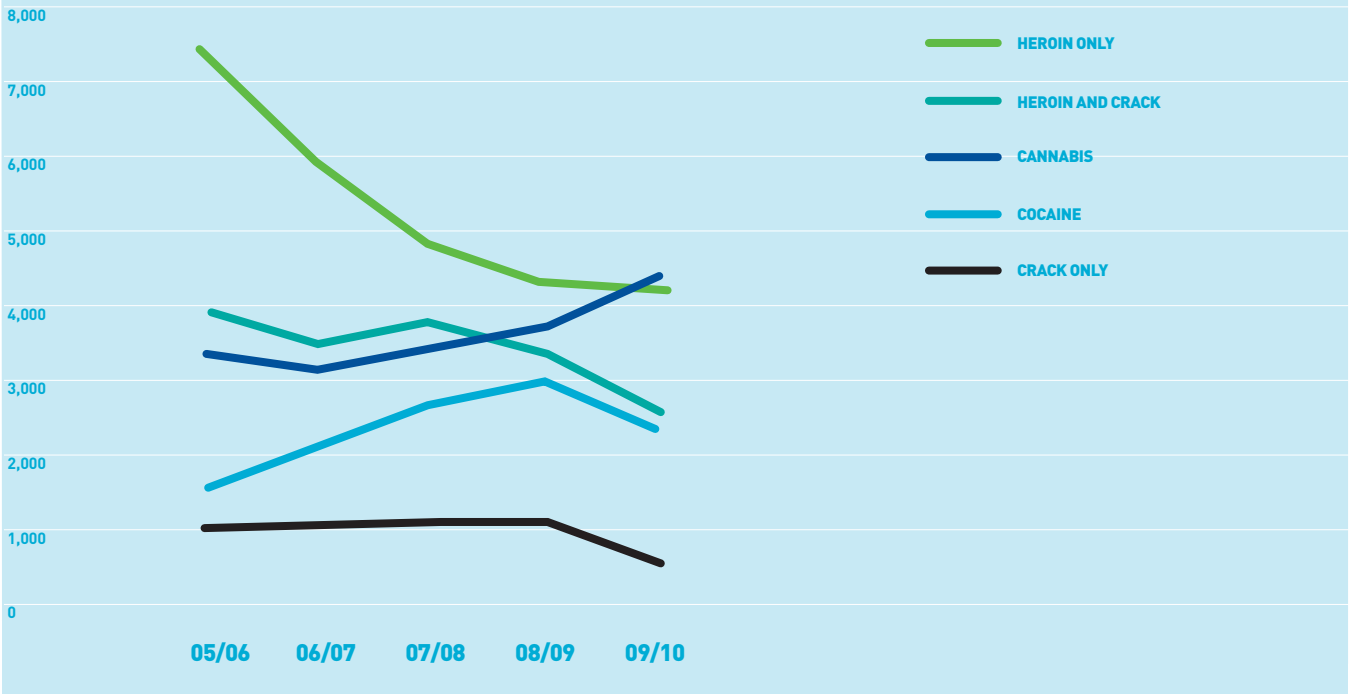
Nevertheless addiction to powder cocaine or to crack alone accounts for less than one tenth of total treatment demand. Three times as many clients report crack use in conjunction with heroin – when both drugs are equally problematic. In all these cases, the expansion of the treatment system in recent years means that anyone who needs treatment can now get it quickly, and it works.

Changing trends among young adults

The number of young adults aged 18 to 24 coming into treatment during 2009-10 fell sharply for every drug except cannabis (figure 3). This suggests young adults are turning away from Class A drugs.

Just over 4,400 under-25s had cannabis as their main drug, accounting for 29% of all new treatment cases among this age group in 2009-10, compared to 18% (or nearly 3,300) four years previously. Many were referred to treatment either by their

FIGURE 3: **THE NUMBER OF PRESENTATIONS TO DRUG TREATMENT IN UNDER 25s, BY MAIN DRUG**



Peter Kelsey, Team leader, Lifeline Redcar and Cleveland

People hear the word legal and they think safe. Yet it's anything but. We're seeing a big rise in people coming to us because of 'legal highs', which we think may be down to the poor quality and price of coke and the legal aspect. Cocaine has been around for literally thousands of years. We know what it does and how to treat people. But with legal highs there have been lots of reports of different side effects like people committing suicide or becoming paranoid because of mephedrone binges. It's new so we are still trying to establish the best way to deal with it.

A factor seems to be price. Which would you choose if you were looking at £10 for a gram of mephedrone or £30 for coke? Also, we find that cocaine users take it up because, like coke, it's a 'social drug'.

People come to us because we are a stimulant service. Many of them never thought they had a problem before but their

families or psychiatric services.

A range of talking therapies (known in the trade as psychosocial interventions) is used in treating under-25s for cannabis. Many of these young adults are aged 18 and 19, and so won't have been using long or intensively enough to warrant treatment for dependency. In these cases, treatment will focus more on the impact their drug use is having on their family and other relationships, and on education or employment.

Most of the cannabis users in this age group do well in treatment. According to TOP data, on average they reduce their use of the drug by almost half, with nearly 40% of this group becoming abstinent within six months of starting treatment.

Nevertheless, heroin – on its own or in combination with crack – is still the biggest problem for this age group, even though the long-term fall in heroin cases that we highlighted last year is matched this year by a further drop in heroin and/or crack cases.

The number of young adults coming into treatment for the two most problematic drugs (heroin and/or crack) was 7,427, down significantly from 12,320 in 2005-06. That represents a significant fall from 67% to 49% of all new cases for this age group over four years.

Despite this apparent step away from the most harmful street drugs, there is some evidence of a corresponding move towards new synthetic compounds (sometimes known as 'legal highs') such as mephedrone. According to DrugScope's annual street survey, this diversification goes hand-in-hand with a longer-term trend of poly-drug use, taking a variety of substances in combination or at different times.

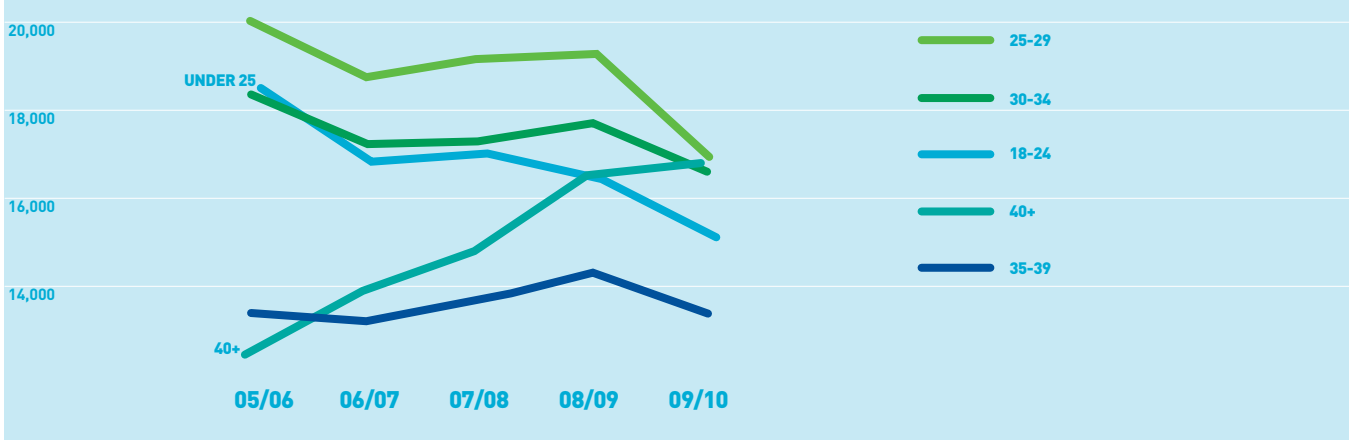
Treatment data suggests few people so far have needed help for these new drugs. It could take some time for those using 'legal highs' to develop problems that would call for formal treatment. So it's too early to tell if there is an emerging treatment need, although reports from A&E units suggest these new drugs do cause significant harm.

Similar trends are apparent for the 25-29 age group (figure 4), although they are less marked than for the younger generation. New presentations for heroin fell from about 10,000 in 2005-06 to just over 7,000 last year, down from 50% of entrants aged 25-29 to 42%.

Changing trends among older users

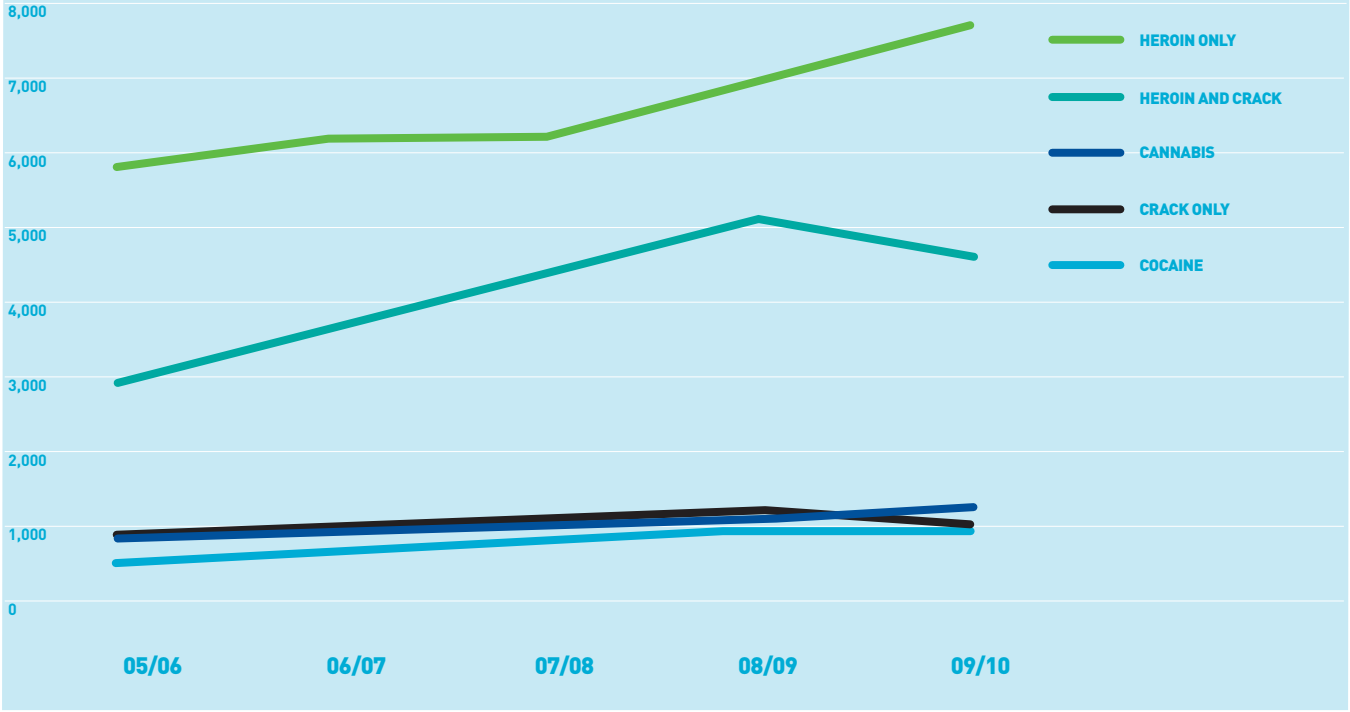
While the number of people coming into treatment has fallen across all other age groups, it has actually gone up among the over-40s.

FIGURE 4: **TOTAL NUMBER OF PRESENTATIONS BY AGE**



experiences with legal highs have scared them. As a response to this and to the number of young people coming into our service, we've set up a drop-in at the local college on Tuesday lunchtimes so people can access support and advice from a member of Lifeline. We've had quite a few referrals from this - sometimes it's just enquiries from people who have dabbled and want more information. Our mephedrone leaftets fly out the door.
We're seeing more cannabis use too, particularly in younger people coming to us for help. Cannabis use can have a knock on effect on a person's life causing difficulties later in terms of getting a job and having a stable future. Often it can be down to something really simple like boredom. They are leaving school and thinking where's my first job going to come from, never mind my second, or even a career. If we can prevent the younger generation from dabbling with cannabis, it may stop the transition into harder drugs.

FIGURE 5: **NUMBER OF PRESENTATIONS BY SUBSTANCE OVER 40s**



The main problem drug for this age group is heroin, either used alone or in combination with crack cocaine. These drugs accounted for 12,335 new cases in 2009-10, representing 73% of all new treatment presentations for the over-40s (figure 5). Indeed, this figure has been rising year-on-year since 2005-06, when it was 8,787.

This sustained increase in cases for heroin-only problems may be explained in part by a drop off in people needing treatment for heroin and crack combined. Users may also be abandoning crack as its purity worsens, yet continue to use heroin at dependency levels.

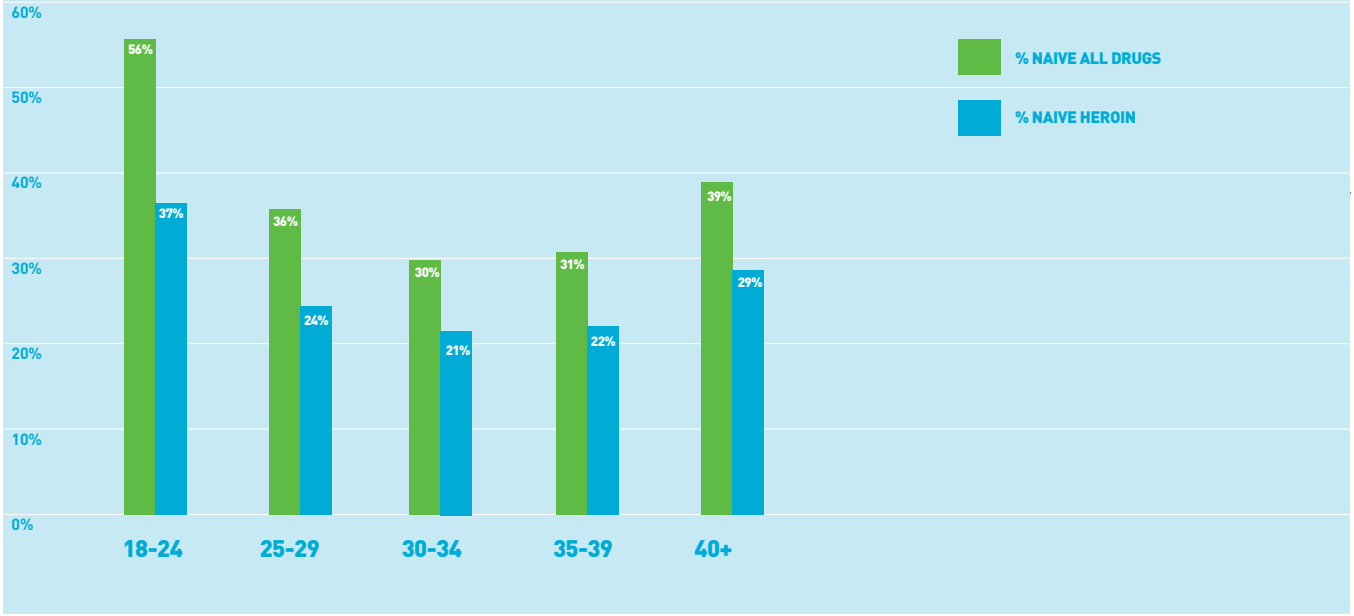
Interestingly, many over-40s are coming into the treatment system for the first time in their lives. Almost a third of all admittances for heroin use in 2009-10 among that age group were 'treatment naive' (figure 6 on next page). This proportion was higher than for any age-group apart from the 18-24s (and it stands to reason that people who need treatment this early in their lives are unlikely to have been in the system before).

Among these over-40s who accessed treatment for the first time, about a quarter only started using heroin in the last five years.

What is particularly striking, however, is the proportion of new entrants with long addiction careers. More than a quarter, 27%, appear to have been using drugs for 25 years or more. In other words, they belong to the ageing heroin-using population who got caught up in the epidemic of the1980s.

They have apparently managed to maintain a long history of heroin dependency without resorting to crime (or at least, not being caught in drug-related activity which would result in treatment); and without seeking medical help either (because

FIGURE 6: **NEW PRESENTATIONS BY AGE**



when they do eventually access treatment, they are more likely than other age-groups to be referred through GP and psychiatric routes).

Prolonged heroin use causes chronic physical and psychological problems. It is not surprising, therefore, that as entrenched users get older they become more susceptible to infectious diseases such as HIV and hepatitis, collapsed veins and abscesses, liver or kidney disease, and pulmonary complications including the various types of pneumonia that result from depressing effects of heroin on the respiratory system.

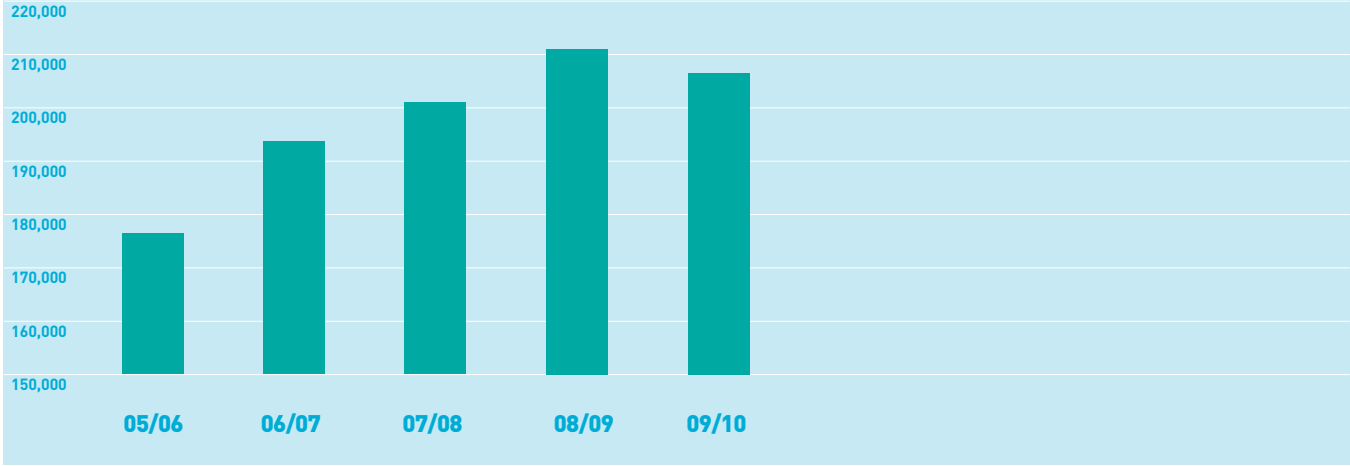
The treatment system is already adapting to the needs of this particularly vulnerable group and in the short-term we may well see more over-40s presenting to treatment for the first time.

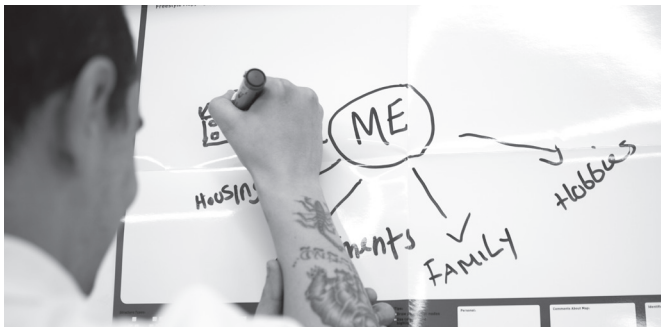
However, this is not a new phenomenon, simply the consequence of the heroin epidemic working its way through the system. In the long-term, we expect a fall in the numbers of heroin addicts, as indicated by the Glasgow research and the shrinking number of young adults presenting to treatment.

Other treatment statistics

This commentary has concentrated so far on significant changes thrown up by the latest statistics. The figures also highlight how the treatment system as a whole has stabilised in 2009-10 following the rapid expansion of previous years. The annual NDTMS figures for the numbers in treatment provide a snapshot of a complex system subject to a steady ebb and flow of clients over several years. However, we now have five years of increasingly robust data from which to identify firm trends and

FIGURE 7: **NUMBER OF ADULTS IN CONTACT WITH DRUG TREATMENT**





The number completing treatment represents an increasing proportion of people who leave, meaning that fewer drop out

establish a benchmark going forwards.

The 2009-10 figures are the most accurate so far, reflecting a number of changes to coding and strengthened definitions which are explained in the relevant sections below. This has affected some of the year-on-year variations, reducing some totals and boosting others. However, the lasting impact is that NDTMS is not only a reliable indicator of trends but also a solid tool for measuring developments.

A total of 206,889 adults were in treatment during the year (figure 7), 93% of whom were effectively engaged. This means they either successfully completed a treatment programme or remained in treatment for at least 12 weeks, which is considered the minimum needed to achieve a lasting benefit.

The small fall in headline numbers reflects a data audit undertaken to ensure local records were up to date. This removed from the books a number of clients who should have been recorded by providers as discharged in previous years. This does not affect the overall trend, of a system which is stabilising after a period of expansion. In fact the proportion effectively engaged in treatment rose 1%.

As in previous years the vast majority of those in treatment (almost 175,000 or 84%) were problem drug users, i.e. dependent on heroin and other opiates and/or crack cocaine. About four in ten of all those in treatment were new cases coming in during the year. Of these 79,255 individuals, about three-quarters (58,016) were problem drug users.

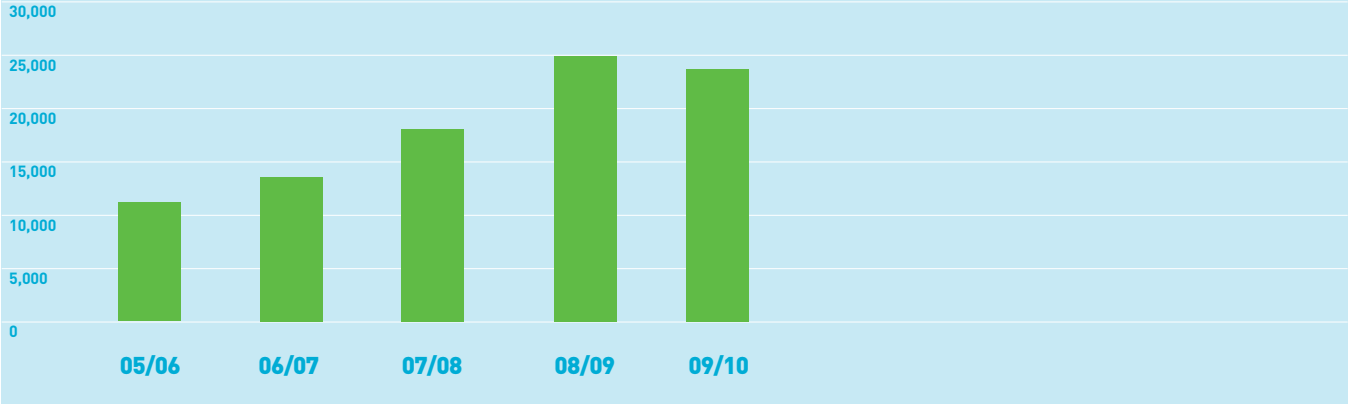
The average waiting time to start treatment in 2009-10 remained low, at around one week, compared with nine weeks in 2001. The vast majority of users (94%) were in treatment within three weeks – the accepted clinical benchmark, after which there is a real risk of drop-out.

The number of adults who successfully completed treatment during the year and left free of their dependency was 23,680 (figure 8). This represents a small drop from the previous year's 24,970, reflecting tighter coding definitions introduced in April 2009 to ensure that local reporting accurately reflected the results of treatment.

Nevertheless the trend remains upward. Of the new total, 15,568 were not only free from dependency but also not using any other illicit drugs; although the remaining 8,112 were still free from dependency on the drug for which they sought treatment.

The numbers successfully completing treatment represent a steadily increasing proportion of the three in ten people who leave the system each year, meaning that fewer are dropping out.

FIGURE 8: **NUMBER OF CLIENTS SUCCESSFULLY COMPLETING TREATMENT FREE OF DEPENDENCY**



Dave, ex user
Until last year, I never thought I had a problem actually and I've been using drugs for 35 years.

It was the emotional side that wasn't right. I couldn't control my crying, the fits, the depression. I couldn't get out of that and it really scared me. When I was working I could stop for three days knowing that at the end of it I could go on a massive bender again.

I didn't see myself as a junkie. I had clean clothes and looked smart. I'd go on a sunbed so my mother would think I looked well.

But the psychosis got worse, the suicidal tendencies were getting worse too. I'd been to hospital with pneumonia and numerous overdoses. I had Hep C.

Once I was in treatment,I started to sit in on classes at the service and I realised I was like the others there. I started letting feelings back in and opening up. I heard stories like my own. Being depressed and not knowing why. Getting into debt. I just thought it was part of my life. If I got up in the morning and felt rough, I'd just take some drugs.

The number of users recorded as 'treatment incomplete' fell from 27,210 last year to 23,275 this year.

The new codes and definitions mean that not all 2009-10 data is directly comparable with previous years. The figures now give greater clarity about clients referred on to other settings. For the first time, we know 5,266 were transferred to prison treatment and 9,352 to other treatment providers. In the past, some of these clients might have been inadvertently recorded as completions because they had finished with a particular treatment provider.

The revisions mean we can confidently use the 2009-10 data as a benchmark for measuring success in future.

A balanced treatment system

Alongside the changing pattern of cocaine and crack use highlighted earlier are other shifts in treatment trends among new presentations.

The 1,262 fall in the number of new cases where powder cocaine was the problem drug was offset by a rise in new cases of cannabis (from 8,187 to 9,413), although the two are not necessarily connected. Similarly the drop in the number of people newly presenting for crack problems, either on its own or in combination with heroin, coincided with an increase of a few hundred in the number newly presenting with heroin alone (to 32,989).

Significant as these movements are, the trends are less evident when considering the entire adult treatment population. The medical consensus is that the majority of those seeking help for drug dependency, the heroin and crack addicts, are going to take several years to overcome addiction and spend repeated efforts in treatment before they do. Four out of every five clients in treatment (167,200) are heroin addicts (figure 9).

Consequently the predominant treatment provided in 2009-10 was substitute prescribing, either methadone or buprenorphine as recommended by the National Institute for Health and Clinical Excellence (NICE). According to NICE guidelines, prescribing should always be accompanied by talking therapies. In addition, during any year, individual clients may experience a variety of interventions or combinations in their treatment pathway.

The chart opposite (figure 10) illustrates the breakdown of different treatment types experienced by individual clients during the year. The numbers add up to more than 206,889 because a considerable number of clients received more than one intervention during their time in treatment. For example, over one-third of the 153,632 clients who received prescribing interventions also received at least one other form of treatment, including psychosocial interventions, structured day programmes, inpatient detoxification or residential rehabilitation.

Establishing the precise number of clients who went into

FIGURE 9:
PRESENTING SUBSTANCES OF ALL CLIENTS

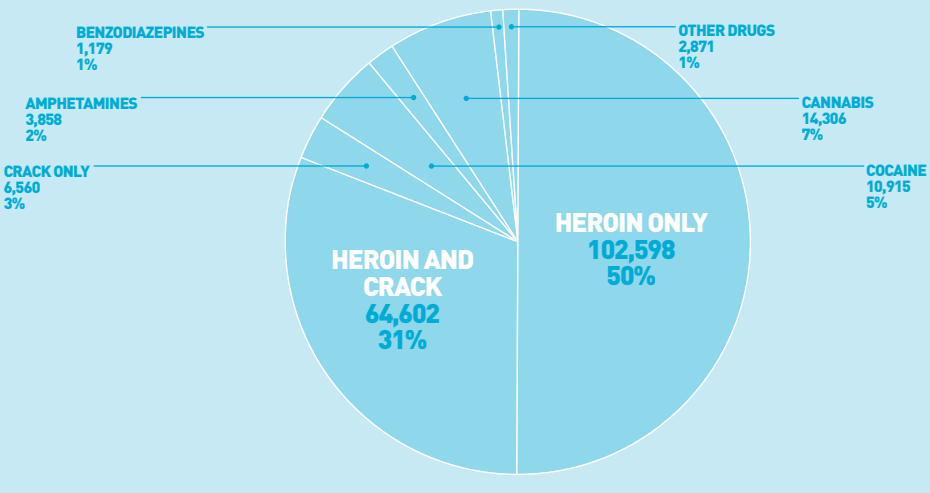
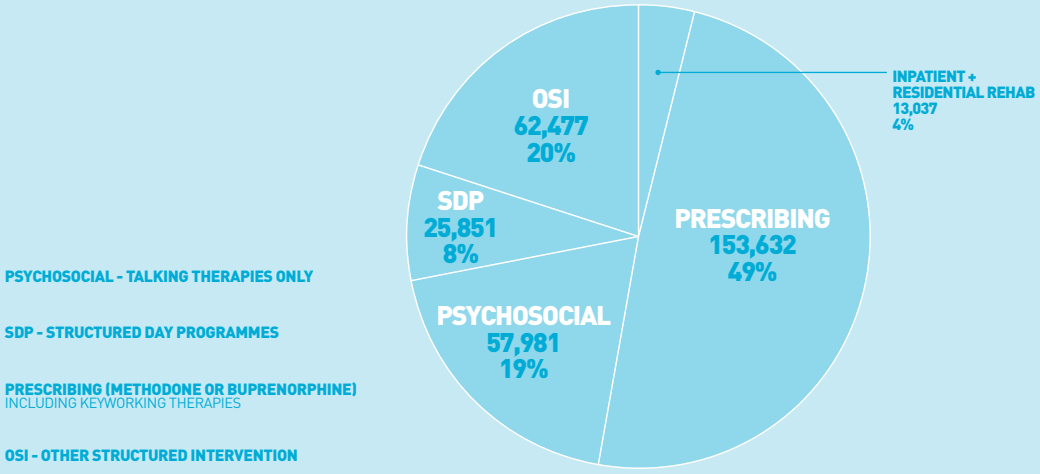


FIGURE 10:
CLIENTS RECEIVING TREATMENT TYPES



residential rehabilitation is particularly problematic. NDTMS recorded 3,914 individuals in this category during the year but we know this is an under-estimate since only two-thirds of registered rehab providers submit returns to the database.

Independent treatment providers are under no obligation to provide figures to NDTMS, so the NTA surveyed the 149 drug partnerships which commission treatment based on a needs assessment of their local areas. This audit confirmed the extent of under-reporting and suggested that a more comprehensive assessment would show at least 6,400 individuals took up residential rehabilitation places during the year.

Measuring outcomes

The Treatment Outcomes Profile (TOP) is a clinically-validated monitoring tool that tracks the progress of individuals through their treatment journey. It measures drug use, injecting risk behaviour, health, social functioning and self-reported criminal activity.

In practice the TOP consists of a short questionnaire which the drugs worker completes with the client at the start of treatment, at regular points throughout, and at the end. The TOP is being rolled out by treatment services, and the results incorporated within NDTMS to provide the most accurate assessment we have of the effectiveness of treatment.

Full-year data will not be available until 2010-11, but the NTA is publishing (Annexe A on next page) an overview of information collected in 2009-10 from over 40,000 treatment journeys where clients had a TOP start and a six-month review during the year.

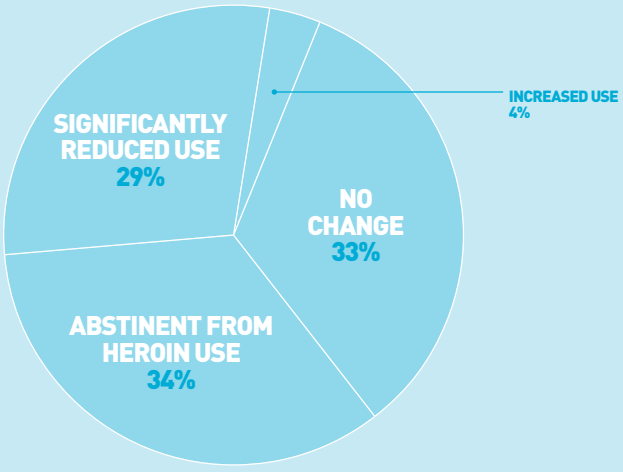
Drug use

Reference has already been made to TOP data for cocaine, crack and cannabis clients.

Among the heroin users coming into treatment during 2009-10, 24,605 had outcomes information, meaning they completed a treatment start TOP and treatment review TOP within the year.

Within the first six months of starting treatment, more than a third had stopped using heroin altogether, and almost as many had significantly reduced their drug use (figure 11).

FIGURE 11:
HEROIN CLIENTS THAT HAD A SIX MONTH REVIEW 2009-10



THE RELIABLE CHANGE INDEX METHODOLOGY HAS BEEN USED TO DETERMINE STATISTICALLY SIGNIFICANT CHANGE (LANCET, 2009 DOI: 1016/S0140-6736(09)61420-3)

"Now I'm clean, all the money and drugs in the world wouldn't make me feel any happier."
Dave, ex-user

According to the strict methodology employed, any change in drug use by the remaining third was not statistically significant, although further analysis suggested some of them were improving.

Overall, this shows that, among the largest group in treatment, people can make dramatic progress within a relatively short space of time, and even become abstinent. However, they may also require more time in treatment to consolidate those gains.

Evidence for recovery

Changes in drug use are relatively easy to monitor but the TOP is also being developed in other areas. In due course it should be able to show how those who stop using make gains in physical and psychological health and their quality of life; but meanwhile it does give early indications of what progress clients are making in overcoming housing problems and being in work or education.

Housing

Drug treatment has positive results for most of the users who report a housing problem at the start of the TOP process. By the time of their review, 64% say they have resolved the issue. However, many drug users remain vulnerable and for some housing problems arise while they are in treatment. Overall, TOP data shows that the numbers reporting housing problems decreased from 8,902 at treatment start to 7,029 at review.

Employment

Treatment can have a positive effect on a user's employment status. Of those who said they were in paid work at treatment start, almost 70% held on to their jobs. TOP data also reveals that a significant number (4,193) who were not in work at the start of treatment had found employment during their treatment.

Education

TOP data also shows treatment can help users with their education. The number who reported they were in full-time education almost doubled between treatment start and review; around 46% of those in education at the start were still engaged at the review; and a further 1,519 who were not in education at the start were by the time of the review. This is an increase of 857 individuals which is nearly a 70% increase in the number of people attending education.

We would like to say thanks to everyone at HMP Chelmsford for their help with the photographs

The National Treatment Agency for Substance Misuse
6th Floor
Skipton House
80 London Road
London SE1 6LH
T 020 7972 1999
F 020 7972 1997
E nta.enquiries@nta-nhs.org.uk

ANNEXE A

TOP ITEM	N	MEAN (SD)	REVIEW (SD)	MEAN CHANGE 95%(CI)	ABSTINENT	IMPROVED	UNCHANGED	DETERIORATED
OPIATES	24,605	21.9 (9.7)	8.8 (10.5)	13.0 (12.9, 13.2)	34.0%	28.9%	33.4%	3.7%
CRACK	9,510	12.2 (10.4)	5.3 (8.3)	6.9 (6.7, 7.2)	49.0%	11.7%	35.0%	4.3%
COCAINE	4,066	8.8 (8.1)	2.2 (4.9)	6.6 (6.4, 6.9)	64.8%	9.3%	24.5%	1.5%
AMPHETAMINE	1,602	13.3 (10.4)	5.7 (9.2)	7.6 (7.1, 8.2)	54.2%	8.5%	34.6%	2.7%
CANNABIS	9,851	19.3 (10.3)	11.2 (11.9)	8.0 (7.8, 8.3)	38.5%	12.9%	43.1%	5.4%

* WORKING AT START 7,368 (16.7%)	* WORKING AT REVIEW 9,325 (18.5%)	
* EDUCATION AT START 1,235 (2.8%)	* EDUCATION AT REVIEW 2,092 (4.2%)	
* * HOUSING AT START 8.902 (17.4%)	* HOUSING AT REVIEW 7.029 (13.8%)	