Walsall Drug and Alcohol Needs Assessment

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Executive Summary

The Task

Following the renewed interest in drug and alcohol provision, after the Dame Carol Black Review and additional funding from the Office for Health Improvement and Disparities (OHID) for local authorities, Walsall Council commissioned TONIC to conduct a Drug and Alcohol Needs Assessment to review all aspects of the local drug and alcohol treatment service delivery. The overall aims of this Needs Assessment were to provide clear, high-quality evidence regarding the needs and inequalities relating to substance use to improve support services across Walsall in the future. The Needs Assessment sought to provide an overview of the needs of individuals, families, and communities affected by drug use in Walsall. TONIC afforded consideration as to whether needs are being met (e.g., reviewing the impact of criminal justice team and making recommendations to continue or change; review the impact of a hospital alcohol detoxification pathway); to consider whether the service is offering best value; explore and understand the experience of service users; accessibility and how to improve services to ensure that residents want to access them. The Needs Assessment ran from April to August 2022.

Method

To undertake this project, a mixed methods approach was adopted. TONIC worked with the commissioner to identify key contacts for data and interview purposes. A survey was created and promoted to relevant individuals, cascaded throughout services and promoted by the local authority. In total, **187 local people engaged with this exercise** and their views have contributed to this needs assessment. To produce this report, TONIC drew on the following sources:

- 101 responses to a survey
- 86 semi-structured interview and focus group participants: with 3 key groups[1]:
    - 52 people with lived experience of substance misuse[2]
    - 16 staff from the commissioned substance misuse service - run by CGL
    - 18 relevant external key-stakeholders - from a range of services involved in prevention, treatment and recovery, or disruption of supply chains
- Quantitative data analysis: of key data sets

1 In our findings section, where quotes are used, we refer to 'CGL Staff Member' 'External Stakeholder' and 'Lived Experience Interview' to distinguish between these three groups.

2 Although some professionals also had lived experience, we counted these as 'professional' interviews rather than 'lived experience'.

Findings

Breaking Drug Supply Chains

There are a number of services in Walsall to support those who have been exploited by drug dealers and criminal gangs. However there was a prevailing sense throughout the interviews conducted for the needs assessment that there is less provision to restrict supply by way of mapping and disrupting criminal gangs. This was said to be necessary to tackle the root cause of drug supply. Overall, the offer for prevention and disruption around exploitation was noted as an area for improvement and, external stakeholders, felt it was not a Force priority, postulated to be because of the difficulties in securing convictions and the competition for resources across the force. For example, police outlined the challenges in securing finite resources for Walsall when compared to more 'buoyant' areas such as Birmingham, Coventry and Wolverhampton.

However, there was an appetite from police to form a multi-agency approach which considers not just risk but also vulnerability and identifies a specific cohort to work with to achieve sustainable behaviour change. This part of the needs assessment also identified a need for more training for frontline staff to be better placed to identify exploitation and vulnerability. There was also a recommendation for a cohesive 'voice' from the education sector to better tackle this issue and involve community leaders to penetrate certain 'closed communities' where drug supply and violence was said to be prevalent.

Deliver a World-Class Treatment and Recovery System

CGL's overall offer is positive and received favourable review by those who contributed to the needs assessment by both survey and interview. In terms of *who* is in treatment, the age profile of people in drug treatment in Walsall differs from the national picture. Men in drug treatment in Walsall are more likely to be younger than the national average with more than half 53% (compared to 36% nationally) aged under 40 years old. Just 11% of men in drug treatment in Walsall are aged 50 years or older compared to a national average of 20%. The same picture is found for women. Women in drug treatment in Walsall are more likely to be younger than the national average with more than two thirds 67% (compared to 56% nationally) aged under 40 years old. Just 7% of women in drug treatment in Walsall are aged 50 years or older, just half the national average of 14%.

There were 1,268 adults in drug treatment in Walsall in 2020/2021, a figure which increased by 7% to 1,363 in 2021/22. Official data separates these into three treatment groups by substance of use: opiate users, non-opiate users and alcohol and non-opiate users. The number of opiate users in treatment has fallen (by 12%) over this 10-year period. The number of non-opiate users more than doubled between 2012/13 and 2021/22 (from 70 to 170). The number of alcohol and non-opiate users fell substantially between 2015 and 2019 before climbing to 220 in 2021/22, an increase of 76% compared to 2012/13. The ethnic profile of people in Walsall starting drug treatment in 2020/21 is compared to the ethnic profile of the local authority[3] where it can be seen

3 Using data from the Walsall Council insights website

that Asian people (as with alcohol treatment) are under-represented in the drug treatment population (10% of new presentations compared to 15% of the local).

Both men and women are much more likely to refer themselves into drug treatment and much less likely to be referred by health or social services. The reliance on self-referrals is similar for both men and women. Not a single person of the 503 individuals starting drug treatment in 2020/21 was recorded as being referred into treatment by their GP, just two were referred by hospitals and Accident and Emergency Departments and four from social services.

However, the criminal justice pathway (for men) is reasonably well developed with 13% referrals coming via this route compared to 16% nationally. Almost one in six (16%) of people in drug treatment in Walsall are in contact with a criminal justice agency (compared to a national average of 11%), this figure rises to one in five (20%) for opiate users (vs 14% nationally). Continuity of care figures for the criminal justice team are above average in Walsall. The criminal justice team received favourable review from probation, prison and police colleagues, including treatment providers working in these settings. Having someone who can do prison in-reach is critical to this provision. The onset of West Midlands Mentoring service offer can continue to improve engagement and outcomes for CJ clients.

Walsall has succeeded in engaging constant numbers of local people into drug treatment throughout the pandemic and in meeting the needs of a greater than average proportion of people in need. The proportion of non-opiate users and alcohol and non-opiate users have both grown substantially over the last decade although opiate users remain by far the largest group in treatment (71%). Walsall works with a higher proportion of crack users than the national average.

There remains the same concern as for alcohol treatment (again, with the provision that the data regarding referral routes has been correctly recorded) with relatively unused referral pathways from colleagues in health (including hospitals, Accident & Emergency Departments and GPs) and social services.

Compared to national figures, people in treatment in Walsall are less likely to be offered in-patient treatment and less likely to be successfully engaged in Hepatitis B vaccination programmes.
Treatment services in Walsall are above average in helping people using both crack and opiates to reduce their usage. However they are below average in terms of successful treatment without re-presentation for all treatment groups.

For alcohol, Walsall has also succeeded in increasing the number of people in alcohol treatment over the last decade despite the impact of cuts in public funding. However, like the rest of the country, the area is only succeeding in engaging approximately one fifth of the people in need into treatment. Compared to the national picture, locally, those in alcohol only treatment are more likely to self-refer than be referred by another agency. Therefore, the most effective way of increasing the number of people in treatment appears to be improving professional referral routes. If the data regarding referral routes has been correctly recorded, it appears that CGL Walsall are highly successful in publicising their services and making them accessible to the public, but less

effective in developing relationships and effective referral routes with colleagues in health (including hospitals, Accident & Emergency Departments and GPs) and criminal justice. Walsall would, of course, have to invest in extra treatment capacity to meet the needs of people coming from busier professional referral routes. This objective is even more important post-pandemic when a number of studies have reported increases in alcohol consumption[4].

With regards to young people, Walsall faces the same challenge as most of the country in terms of engaging more young people in drug and alcohol treatment. Reported use of drugs among young people has been increasing over recent years while numbers in treatment continue to fall. The small number of girls and young women in treatment is a particular concern locally. It appears that the young people's services works predominantly with young people who use alcohol and cannabis with young people using other substances less likely to access services. Referral routes from the education system and criminal justice are working well with fewer than expected referrals from family and children's and health services. Most noticeably, self-referrals and referrals from family and friends are extremely low.

The fact there are only two sites (in close proximity) for service users to attend does limit the reach of the treatment service. There were recommendations for increased outreach and the suggestion of satellite hubs to better support those 'hard to reach' clients such as sex workers, those in more rural areas or those with physical disabilities that makes travel a challenge. However, there was unanimous feedback that staff caseloads were too high, accompanied by a difficulty in recruiting new members of staff. This has implications for recommendations such as increased outreach or increasing referrals because the current team wouldn't have capacity for this. Overall staff reported feeling overwhelmed with the work they have to do e.g. paperwork, liaising with other services (mental health, housing, GPs, social care) with an overarching sense that they, more than other professionals, are a 'jack of all trades'. The impact of this was that it distracts from the time they can spend on substance misuse work. The high caseloads were also said to prevent in-depth 1-1 motivational or therapeutic work.

There is a recognition of the need to expand the workforce in the grant submission from Walsall Council to OHID which includes:

- Offering accredited professional development to non-clinical treatment workforce
- Increase workforce to expand treatment delivery to cover less sociable working times
- Expand our volunteer recruitment and apprenticeship scheme
- Working with partners to identify secondment opportunities
- Completing a workforce audit

However, we would suggest including additional and specific recruitment of a psychologist to the treatment and recovery team, to be able to offer therapeutic support.

Throughout the needs assessment it was observed that there is an array of group-work sessions available, for adults only, and the way the team is structured with specialist focus (e.g., the criminal

4 Public Health England (2021) Monitoring alcohol consumption and harm during the COVID-19 pandemic: summary

justice team, complex cases, alcohol users) was said to be a strength of the service. The family safeguarding approach was also said to be very effective, with lower caseloads. However, the Family Drug and Alcohol Court has struggled to achieve the number of referrals they have been funded for, but for those families who attend, the service received favourable reviews on the whole. There is scope to strengthen the offer for families of those in addiction beyond Families Anonymous.

The fact 'The Beacon' can provide in-house prescribing and detox is advantageous but there were gaps identified in partnership working with the hospital and mental health. As it stands, 'The Beacon' are reliant on GPs undertaking bloodwork for detox assessments and although they have an in-house addiction psychiatrist, which is commendable, however they currently cannot prescribe mental health medication.

Achieve a Generational Shift in Demand for Drugs

Although the current model includes work with schools this is not consistent across Walsall and the small young people's team, which includes one hidden harm worker does little to 'dent' the scale of prevention and early intervention that is required to enable a 'generational shift'. Many workers at CGL remarked on an intergenerational pattern they have observed, where they are now working with adult service users whose parents they historically supported. Again, the family safeguarding model and hidden harm work is excellent but would benefit from being expanded and there being a dedicated role to promote CGL's service for young people and promote awareness in schools.

Recommendations

As a result of triangulating our findings across primary and secondary data sets for the needs assessment, we make the following recommendations to be discussed with commissioners and providers in order to support the creation of a strategy and action plan.

Breaking Drug Supply Chains:

1) **Cohesive School Representation:** In terms of prevention and disruption, all agencies should work to convene a more cohesive voice and representation from schools to prevent exploitation and provide intelligence on county lines. This would support a more unanimous focus on this part of the agenda and give schools a more active role in disruption.

2) **Involve Community Leaders:** There should be concerted efforts to involve community leaders in prevention and disruption, working collaboratively with West Midlands Police. Agencies should work together to identify key individuals to invite to be part of multi-agency efforts to tackle drug supply. The aim of this is not for community leaders to simply share intelligence with police, but to identify shared goals and objectives for reducing harm in specific 'hot spots' that police identify as key in drug supply and violence. Working in collaboration with trusted individuals within these communities, agencies and police should empower communities to be part of the solution.

3) **Multi-Agency Working with Police:** A multi-agency approach should be considered to support vulnerability and risk/harm, amongst those who are involved in both supply and the consumption of drug. This would involve agencies working with police to identify organisations who can support those who are involved in this market as well as deciding on criteria for this cohort.

4) **Training Front-line professionals:** Police provided a recommendation to better train front-line professionals to be 'professionally curious' about exploitation by way of increasing referrals. This could be undertaken by exploitation services within the local authority or street teams.

Delivering a world class treatment and recovery system:

5) **Improving access to treatment:** Women and Asian people are both currently under-represented in the treatment population in Walsall. The Drug and Alcohol Partnership should explore the reasons for this and identify with treatment providers and partners a set of actions that will improve treatment uptake amongst both groups.

6) **LGBTQ+ Engagement**: CGL should work to build up better working relationships with LGBTQ+ organisations within the area. A mapping exercise should be undertaken to identify potential services to joint-work with.

7) **Primary care interventions:** It would be valuable to know the extent of alcohol screening and brief interventions in primary care in order to assess whether this proven harm reduction approach is under-utilised locally.

8) **Partner Relations:** The provider should continue to develop relationships and effective referral routes with colleagues in health - including hospitals, Accident & Emergency Departments and GPs.

9) **Assessment Process:** There should be more homogeneity in the assessment process, across criminal justice providers (e.g., in custody, prison and community) to reduce duplication on release. This will involve liaison with all providers in the area to achieve a commonality in approach, perhaps through revised information sharing agreements.

10) **DIVERT after-care:** Cranstoun and CGL would benefit from working together to establish a comprehensive onward referral pathway after DIVERT is completed as this is an opportunity for entry into treatment on a more long-term basis and could work as a method of early intervention

11) **Integrating clinical and psychosocial approaches:** With the opportunity of a new building, the concept of integrating clinical and psychosocial approaches more closely should be explored. Further, the suggestion of having more of a multi-agency hub where, once a week, professionals from DWP or housing are on site to support service users should be considered

12) **Increased Outreach for vulnerable groups:** There is a need for the onset of greater staff numbers to pursue greater outreach. The focus of this should be on 'hard to engage' populations including sex workers but also those in unstable accommodation and from non-English speaking communities (especially Eastern European).

13) **Community Hubs:** Satellite hubs, 'getting out into the community' should be discussed and explored. This could take a similar approach to the 'no wrong door' bus or CGL could see if any joint working could be undertaken to be present on these facilities. There is an associated opportunity to 'get out in the community more' and be more visible, capitalising on events which aim to increase awareness of blood borne viruses.

14) **Structured Activities:** Recommendations around the need for more structured activities away from solely drugs or alcohol recovery should be implemented and could be supported by the volunteers in place at CGL.

15) **Greater groupwork portfolio:** Young people should also be offered group work opportunities, so too should there be dedicated family groups (aside from Families Anonymous) and more specific groups for non-opiate or non-alcohol users.

16) **In-house Psychology Offer:** It is accepted that caseloads are too high, and staff are feeling the weight of this, especially as they feel unable to undertake therapeutic or motivational work with service users. Therefore there is a critical

need to build up the offer of a therapeutic component to the service and this should begin with recruitment of an in-house psychologist to hold their own caseload.

17) **Prescribing medication:** The offer from the in-house consultant psychiatrist could be strengthened by being able to prescribe 'mental health' medication as per the model in CGL in Dudley.

18) **Blood tests in-house:** CGL should seek investment and permission to undertake blood work in house to speed up the assessment process for detox.

19) **Restarts:** Due to the high numbers of restarts, CGL should consider whether there should be a dedicated team for this. This would also support in some of the discussions where known individuals repeatedly present for restarts and begin to tackle some of the underlying issues and motivations with this.

Achieving a generational shift in the demand for drugs:

20) **Hidden Harm**: The hidden harm function should be expanded to include a dedicated worker to promote the service across schools and safeguarding leads as well as deliver training. By having two workers, instead of one, this would facilitate supporting more young people affected by familial substance misuse.

21) **Primary Care Response**: In accordance with recommendation 7, once it has been ascertained the extent brief interventions are being used by GPs, a body of work should be undertaken to upskill pharmacies and GPs to enable them to be able support lower-level substance misuse.

1. The Task

Drug and alcohol use is a significant risk factor for a number of chronic health morbidities, reduced life expectancy, lower quality of life, and a range of social and economic issues such as unemployment, homelessness, exposure to criminal activity, violence and modern slavery. Substance use is associated with cyclical exploitation, i.e. exploited individuals recruiting and targeting other vulnerable people. The impact of drug and alcohol use is far reaching, affecting the life outcomes of wider family members and communities. There are strong linkages between substance use and health inequalities and poverty. Drug and alcohol use requires interventions based on national guidance and policies and community-level treatment, prevention and recovery programmes that address the needs of substance users holistically.

Following the renewed interest in drug and alcohol provision, after the Dame Carol Black Review and additional funding from the Office for Health Improvement and Disparities (OHID) for local authorities, Walsall Council commissioned TONIC to conduct a Drug and Alcohol Needs Assessment to review all aspects of the local drug and alcohol treatment service delivery. Needs Assessments are required to provide contextual information about drug and alcohol use, prevention, and treatment needs.

Findings from any needs analysis should support commissioning planning and decision making, and also contribute to the general monitoring, evaluation, development, and learning for organisations delivering services. The overall aims of this Needs Assessment were to provide clear, high-quality evidence in regard to the needs and inequalities relating to substance use to improve support services across Walsall in the future.

The Needs Assessment sought to provide an overview of the needs of individuals, families, and communities affected by drug use in Walsall. TONIC afforded consideration as to whether needs are being met (e.g., reviewing the impact of criminal justice team and making recommendations to continue or change; review the impact of a hospital alcohol detoxification pathway); to consider whether the service is offering best value; explore and understand the experience of service users; accessibility and how to improve services to ensure that residents want to access them.

This Needs Assessment exercise ran from April to August 2022.

2. Methods

To undertake the project, a mixed methods approach was adopted. TONIC worked with the commissioner to identify key contacts for data and interview purposes. A survey was also created and promoted to relevant individuals, cascaded throughout services and promoted by the local authority. Accordingly, to produce this report, TONIC drew on the following sources:

- Quantitative data analysis: the main data sources include data from the provider, the Drugs, Alcohol and Young People Commissioning Support Packs for Walsall 2022/23, NDTMS (including provisional monthly figures), Walsall Council Insights website, Public Health Outcomes Framework Indicators & the Walsall Homelessness Strategy 2018-2022).
- 101 responses to a survey distributed for stakeholders and people with lived experience:
    - 71 answering as a professional
    - 22 answering as someone with lived experience
    - 2 answering on behalf of someone with lived experience
    - 6 people answering as a member of the general public

Within the survey, 59% of those with lived experience reported being in 'current addiction', and 41% said their substance use was 'historic' and that they were in recovery at the time of completing the survey. As displayed in the table below, just over half (53%) identified alcohol as a substance of choice for them, with the next most common substance of choice being cocaine (29%), followed by heroin (18%). Over half (56%) of survey respondents disclosed that their use is/had been as frequent as 'multiple times daily' - see table below. Just over three quarters (78%) were currently accessing support for their substance use (17% engaged in support over 3 years ago, 6% had not accessed any support).

Substance(s) of Choice	Number	Percentage
Alcohol	9	52.9%
Cocaine	5	29.4%
Heroin	3	17.6%
Crack	2	11.8%
Cannabis	2	11.8%
Pregabalin	1	5.9%
Tramadol	1	5.9%
Methadone	1	5.9%

Figure 1: Main substance used by survey participants

Frequency of use	Number	Percentage
Multiple times daily	9	56.3%
4 or more times per week	3	18.8%
2-3 times per week	2	12.5%
2-4 times per month	1	6.3%
Less than twice per month	1	6.3%
Total	16	100%

Figure 2: Frequency of substance use by survey participants

For the survey, 59% of respondents with lived experience were male, and 41% female. The most common age bracket for survey respondents was 55-64 and 88% stated they were White-British, with 6% Asian / Asian British - Indian and 6% prefer not to say. Almost all (94%) identified as heterosexual, with 6% selecting gay or lesbian. 82% reported they have experienced a mental health condition, 59% have been unemployed, and 35% have received a conviction for a crime. Within the survey, professionals from the following organisations responded: Walsall Council, West Midlands Police, HMPPS, National Probation, Change Grow Live (CGL), The Glebe Centre, and Rethink Mental Health Illness. It is important to note that over half (56%) of professional survey respondents identified as working for CGL in Walsall.

We engaged 86 people through semi-structured interviews and focus groups with 3 key groups[5]:

- 52 people with lived experience of substance misuse - either through their own use or a family members[6]
- 16 staff from the commissioned service, run by CGL and known locally as 'The Beacon'
- 18 relevant external key-stakeholders from a range of services that are involved in either prevention, treatment and recovery and disruption of supply chain

For the people with lived experience:

- 53.8% were women (including one transgender service user), 1 preferred not to say
- 5 people were not accessing treatment from 'The Beacon' at the time of the interview
- 5 people were volunteering for 'The Beacon'
- 22 were accessing support from Station Street including 3 Family Drug and Alcohol Clients (FDAC) and 2 young people
- 25 were accessing support from Bradford Street
- 1 person was visited at home alongside his complex case worker
- 1 person was with Families Anonymous

5 In our findings section, where quotes are used, we refer to 'CGL Staff Member' 'External Stakeholder' and 'Lived Experience Interview' to distinguish between these three groups.

6 Although some professionals also had lived experience, we counted these as 'professional' interviews rather than 'lived experience'.

Interviewees were asked what their substance of choice, at present, was:

Substance of choice	Number of interviewees
Alcohol Only	25 (4 said they were currently abstaining)
Opiate only	9
Crack only	1
Opiate and crack cocaine	4
Prescription medication cited (in isolation or with other substances)	6
Alcohol and cocaine	2
Heroin, crack, and cannabis	1
Heroin, crack, and alcohol	1
Cocaine and Cannabis	1
Cannabis only	2

Figure 3: Main substance used by interview participants with lived experience

3. Literature Review

3.1 Current Drug Policy and Strategy

The main policy context for all work aimed at tackling drugs is the Government's new 10-year drug strategy "From harm to hope[1]", published in December 2021. The timing of the report (the previous strategy[2] was published in July 2017) was driven by the need for the Government to respond to Dame Carol Black's Review of Drugs, itself commissioned by the Government. This review was extremely critical of Government drug policy, in particular the deterioration in drug treatment services. Dame Carol's review was published in two parts. The first part[3] (published in February 2020) provided a detailed analysis of the challenges posed by drug supply and demand, including the ways in which drugs fuel serious violence. The second part[4] (published in July 2021) focused on treatment, recovery, and prevention and its publication was delayed allowing the Government to start responding to Dame Carol's criticisms by launching a number of initiatives to tackle the issues she raised.

3.1.1 The Drug Strategy

The introduction to the strategy and the Prime Minister's foreword prioritises tackling drug-related crime, an ambition reflected in the paper's full title "A 10-year drugs plan to cut crime and save lives". The plan itself includes considerable investment in treatment, and initiatives relating to both early intervention and drug education. The plan is jointly presented by the Home Secretary, the Health Secretary, and the Combating Drugs Minister (currently Kit Malthouse as of May 2022, based within both the Home Office and the Ministry of Justice). The paper promises almost £900 million in additional funding over the 3 years starting in the 2022/23 financial year, which it claims will deliver 54,500 more treatment places, prevent nearly 1,000 deaths, and close over 2,000 more county lines.

The strategy sets out three primary objectives:

1) To break drug supply chains
2) To deliver a world-class treatment and recovery system and
3) Achieve a generational shift in demand for drugs.

In addition to chapters dedicated to each of these three areas, the 10-year plan has a chapter focused on a new system of national and local outcomes and a commitment to publish annual reports on the progress made by the strategy against its key targets.

The key strategic priorities are summarised in an infographic "our plan on a page" which is reproduced on the following page.

Priority	 **Break drug supply chains**	 **Deliver a world-class treatment and recovery system**	 **Achieve a shift in the demand for recreational drugs**
Why?	Drug supply chains are violent and exploitative, degrading neighbourhoods across the country and internationally	Drug addiction harms individuals and society: deaths have risen to record levels and almost half of acquisitive crime is linked to addiction	Use of recreational drugs has grown over a decade, particularly among young people, risking individual harm and fuelling dangerous markets
How?	We will continue to roll up county lines and strengthen our response across the drug supply chain, making the UK a significantly harder place for organised crime groups to operate	We will invest a further £780 million to rebuild drug treatment and recovery services, including for young people and offenders, with new commissioning standards to drive transparency and consistency	We will strengthen the evidence for how best to deter use of recreational drugs, ensuring that adults change their behaviour or face tough con-sequences, and with universal and targeted activity to prevent young people from starting to take drugs
Who?	Home Office and MoJ, working with international and intelligence partners, NCA, Border Force, police, courts, prison and probation	DHSC, DLUHC, DWP and MoJ working with NHSE, local authorities, treatment providers and people with lived experience	DfE, DHSC, Home Office and MoJ, working with local authorities, police, education providers, secure facilities and youth services
What?	Within three years: close 2,000 more county lines, disrupt 6,400 OCG activities and deny more criminal assets	Within three years: prevent nearly 1,000 deaths, deliver 54,500 new high-quality treatment places and prevent a quarter of a million crimes	Reduce overall drug use to a new historic 30-year low over the next decade

The drug strategy starts by quoting a range of disturbing figures from Dame Carol's Review which lays bare the scale of drug-related crime, the lack of capacity in the treatment system, and the fact that deprivation is intimately linked with higher levels of dependency and other health inequalities. The plan is clear that the initial priorities will be to "*combat the supply of heroin and crack cocaine, and… get those suffering from addiction the treatment and support they need.*[5]"

The strategy promises to meet the needs of people using a variety of drugs including new psychoactive substances. It also commits the Government to do more to reduce non-dependent *"so-called recreational drug use"*.

In the rest of this chapter, we summarise briefly the main areas of activity within each of the three primary objectives.

3.2 Breaking Drug Supply Chains

The plan sets out a vision to "level up our neighbourhoods by ridding them of drugs, making them safe and secure places and enabling all areas to prosper and grow" and says that its priority is to cut off the drug supply that is causing most harm with a particular focus on "rolling up" county lines. There are seven key elements to the Government's plan to break the supply chain, summarised in the infographic reproduced below.

Restricting upstream flow		• extending the NCA's Near Europe Taskforce which focuses on the response upstream • supporting the NCA's International Liaison Officer network and Border Force international work to stop drugs from coming to the UK in the first place • responding to the changed situation in Afghanistan by pivoting operational capabilities along this drug supply route and continuing to disrupt key actors
Securing the border		• trialling innovative approaches, led by the NCA and Border Force, to secure the border and tackle drug supply
Targeting the 'middle market'		• making sure our dedicated organised crime partnerships continue to receive support and investment, targeting the disruptive 'middle market' • leveraging the recruitment of 20,000 more police officers to grow Regional Organised Crime Units and London equivalents, allowing them to bear down on the enablers of drug supply, including illicit firearms and money laundering
Rolling up county lines		• strengthening our flagship County Lines Programme to tackle the most violent and exploitative distribution model yet seen
Tackling the retail market		• continuing Project ADDER for a further two years up until March 2025, trailblazing a whole system approach
Going after the money		• recruiting more financial investigators, strengthening the NCA's National Economic Crime Centre and bolstering our engagement with international partners
Prison security		• utilising technology and skills to improve security and detection and rid our prisons of drugs

The most relevant for local areas to address are the two objectives relating to closing county lines drug dealing operations and tackling local retail markets.

3.2.1 Rolling up County Lines

The plan makes tackling county lines a high priority, saying that the Government *"will move county lines from a low-risk, high-reward to a high-risk, high-consequence criminal activity"*. The plan promises to invest an extra £145 million into its county lines programme over the next 3 years. In addition to the existing three dedicated County Lines Taskforces in London, Merseyside, and the West Midland, the Government intends to extend its British Transport Police County Lines taskforce. The plan also promises funding for *"specialist support for criminally exploited and trafficked young people and their families to help them exit from county lines activity and break their association with criminal gangs"*.

3.2.2 Tackling the Retail Market

The main approach here is Project ADDER (Addiction, Diversion, Disruption, Enforcement and Recovery). Project ADDER primarily aims to divert people dependent on drugs who are funding this dependency via daily criminal activity into treatment. It is important to note that ADDER is not an updated version of the Drugs Intervention Programme to be rolled out to every area of the country. Rather it is a 10-site pilot with an evaluation intended to inform local practice. It is not clear how long ADDER will run for, the current official information on the Government's dedicated ADDER webpage[6] states until March 2023 but the graphic reproduced above says this will be extended for a further 2 years. The Government is prioritising the allocation of resources under its drug strategy to the geographical areas in greatest need, particularly some northern cities and seaside towns. Walsall is not an area receiving enhanced funding for this[7].

3.3 Delivering a World-Class Treatment and Recovery System

The Government promised to invest an additional £780 million in drug treatment over the next 3 years and the strategy also commits to adhere to Dame Carol Black's other primary recommendations; to adopt a whole system approach which will expand treatment capacity, rebuild the drug treatment workforce, give local leaders more power and accountability, and put in place strong partnerships with education providers, local authorities, the NHS, and criminal justice agencies.

The strategy promises a new national commissioning quality standard which will set out the full range of treatment and recovery interventions that local areas should provide for their population based on an assessment of need. It also acknowledges that the field has lost many expert staff over the last decade and pledges to rebuild the sector's health professional workforce (including psychiatrists, doctors, nurses, and psychologists) and improve the level of skill and training among drug workers and peer recovery workers.

The paper commits to improve housing and employment opportunities for people in recovery and includes a commitment to invest in a peer mentoring programme where mentors will work in partnership with Jobcentre Plus and treatment staff.

The Government appears to agree with the Probation Inspectorate's recent assessment[8] that most of the services whose role was to identify and engage into treatment drug using offenders have *"withered on the vine"* and pledges an additional £120 million to engage offenders with *"recovery-focused treatment services"*. This money will fund mandatory and voluntary testing regimes in prison, support for prisoners to engage with community treatment ahead of their release and increasing the use of intensive drug rehabilitation requirements for those on community sentences[9]. The strategy also makes a commitment to put funding back into drug testing on arrest with the positive results notified to Liaison and Diversion schemes.

There is also the promise of a renewed focus on continuity of treatment on release from prison, utilising RECONNECT and the chance for people to have pre-release video appointments with community-based treatment providers.

3.4 Achieve a Generational Shift in Demand for Drugs

Drugs prevention (also known as demand reduction) is typically the most difficult objective to attain in any drug strategy and many commentators argue that it is not possible for Government to control their citizens' demand for drugs – particularly within a global economy with drugs easily available for purchase in a wide variety of ways. Nevertheless, the strategy breaks demand reduction down into three separate objectives:

1) Building a world-leading evidence base.
2) Reducing the demand for drugs among adults.
3) Preventing the onset of drug use among children and young people.

The work on a local level will most likely be focused at this third objective and will make the involvement of the education and youth services within local implementing structures important. The strategy gives details about evaluating current drug education in schools before going on to talk about the "Start for Life" and "Supporting Families" programmes designed to support vulnerable families. There is also welcome news about £560 million funding in the Youth Investment Fund to try to redress the substantial disinvestment in youth services over the last decade.

3.5 Implementation of the Strategy

The new recommendations for local partnerships to drive activity around drugs are reminiscent of the multi-agency Drug Action Teams which operated under previous strategies. The Government says that partnerships may be on a local authority or larger area but should have membership from across the health, local authority, education, and criminal justice sectors and should base their activities on a joint needs assessment whose findings form the core of this report.

3.6 Guidance and Standards

The last time the Government launched a major change in the way it delivered drug and alcohol treatment was in 2001 when it launched the National Treatment Agency for Substance Misuse (NTA) with a remit to improve the availability, capacity, and effectiveness of drug treatment. The NTA was subsumed into Public Health England in 2013 with local accountability for drug and alcohol treatment moving from multi-agency Drug Action Teams to local authority led Health and Wellbeing Boards (HWBs).

Public Health England was itself replaced in October 2021 by the Office for Health Improvement and Disparities (OHID), previously known as the Office for Health Promotion, which will coordinate central and local Government, the NHS and wider society to promote improvements in the public's health, including taking over the central Government remit for drugs and alcohol (and tobacco). The role of HWBs in relations to drug and alcohol will be taken over by the new local partnerships stipulated in the drug strategy.

Following Dame Carol's recommendations, the Government intends to publish a national outcomes framework to track the effectiveness of the strategy. There will also be new local outcomes aligned with these. These outcomes will be the primary drivers of local work tackling drugs and the Government has made it clear that performance will be compared between areas and that future funding may be dependent on local areas demonstrating progress against these outcomes. Initial indications suggest that OHID will be quite prescriptive in its recommendations and that it will closely monitor local areas' performance.

OHID publishes and regularly updates[10] a wide range of information and other resources to support commissioners, service providers and others providing alcohol and drug interventions. Current guidance covers these key topics:

- Alcohol and drug treatment guidance
- Guidance for commissioners
- Drug and alcohol screening and treatment tools
- Guidance for health and care professionals
- Substance misuse and mental health
- Alcohol and tobacco use in hospital patients
- Professional roles in alcohol and drug misuse treatment
- Parental substance misuse
- Preventing drug and alcohol problems
- Service quality improvement
- Opioid substitution treatment: good practice resources.

Overarching best practice recommends the following critical success factors[11]:

- Robust local plans based on up-to-date needs assessments
- Effective local systems are those that provide welcoming, easy to access, flexible services that cater for the needs of a broad range of people and their different drug problems.
- Services should raise recovery-orientated ambitions and facilitate the progress of service users toward their recovery goals, while continuing to protect them from the risks of drug misuse. They should promote recovery while acknowledging that not everyone is ready for recovery and those who are not should receive interventions that minimise the harms to themselves and others of their drug use.
- Each area should have a full range of interventions.
- Local treatment services should proactively target vulnerable groups including people who are in contact with the criminal justice system and social services, and people who are experiencing homelessness.
- Local treatment systems should seek to improve pathways to treatment for people who may not access specialist drug services, for example working with sexual health, mental health, domestic violence support including refuges, and lesbian, gay, bisexual, and transgender (LGBT) charities.

In Walsall, a Supplemental Substance Misuse Treatment and Recovery Grant submission was prepared for OHID and received favourable approval and sign off in June 2022. The funding is intended to be used to address the aims of the treatment and recovery section of the drug strategy and includes the creation of a new Substance Misuse dedicated board. The uplift in funding should increase the numbers of people in treatment between 2022-2025 as per the figures below.

Numbers in treatment by substance	**2022**	**2023**	**2024**	**2025**
All adults “in structured treatment”	1852	1888	2111	2222
Opiates	963	982	1059	1155
Non opiates (combined non-opiate only and non-opiates and alcohol)	368	375	405	442
Alcohol	521	531	573	625
Young people "in treatment"	76	78	83	91

There are also specific aims to increase the number of individuals in residential rehabilitation and decrease the number of drug related deaths. In Walsall the number of alcohol related deaths have not been increasing in line with the national trend. The age trend is mainly mid-40s to mid-50s

and male. Mental Health and Physical Health (liver, high blood pressure) tend to be the dominant cohort. It is noted that the increase is 1.4%. The number of drug related deaths have also not been increasing in line with the national trend. The age trend is mid 40s - mid 50s and male. Co-morbidity and physical health complications tend to be the dominant cohort.

CGL in Walsall are working on a joint pathway with the Rough Sleepers Team and the Black Country Mental Health Trust with regards to discharge, and are establishing a joint hospital Alcohol pathway between both New Cross Hospital and the Manor Hospital. Risk is identified and reported at Clinical Operational meetings. Data is reported weekly to Operational and Service managers and a Consultant. Deaths and non-fatal overdoses are reviewed by operational managers and reported to SMT at Integrated Governance team meetings, which lessons learned are then filtered to service meetings. The project manager will oversee and lead on the implementation of the joint pathway mentioned above. The newly created Substance Misuse Board will also be part of reviewing data and lessons learned. One avenue that is being pursued by the local provider to reduce drug related deaths are safe consumption rooms. These will also act as a point of entry for those that are not in treatment and give access to clinical care as it would be staffed with nurses and health care assistants.

National	**2016**	**%**	**2017**	**%**	**2018**	**%**	**2019**	**%**	**2020**	**%**
Drug related deaths	2,386	100%	2,310	100%	2,670	100%	2,685	100%	2,830	100%
Alcohol specific deaths	1,671	100%	1,758	100%	1,685	100%	1,710	100%	2,074	100%
Deaths in treatment	**2016-17**	**%**	**2017-18**	**%**	**2018-19**	**%**	**2019-20**	**%**	**2020-21**	**%**
Death in treatment - opiate users	1,741	100%	1,712	100%	1,897	100%	2,010	100%	2,418	100%
Death in treatment - non-opiate users	172	100%	174	100%	193	100%	178	100%	244	100%
Death in treatment - alcohol only	767	100%	774	100%	799	100%	741	100%	1064	100%
Walsall number of deaths	**2016**	**%**	**2017**	**%**	**2018**	**%**	**2019**	**%**	**2020**	**%**
Drug specific deaths	13	1%	12	1%	11	0%	12	0%	14	0%
Alcohol specific deaths	12	1%	17	1%	19	1%	11	1%	14	1%
Deaths in treatment*	**2016-17**	**%**	**2017-18**	**%**	**2018-19**	**%**	**2019-20**	**%**	**2020-21**	**%**
Death in treatment - opiate users	5	0%	12	1%	12	1%	0	0%	12	0%
Death in treatment - non-opiate users	0	0%	0	0%	0	0%	0	0%	0	0%
Death in treatment - alcohol only	0	0%	0	0%	0	0%	0	0%	0	0%

Walsall's overall plan, following the funding being granted is included in Annex A.

The next section offers an overview of the main priority groups explaining who is at risk and why, and provides a summary of innovative and effective drug treatment and recovery work to implement the guide summarised above.

4. Who is at Risk and Why

People from every part of society use, misuse, and become dependent on drugs. Nonetheless, it is clear that there are a number of groups where usage and harm levels are much higher, and any local drug strategy should seek to target these. The Government Drug Strategy[12] makes it clear that deprivation is linked to higher levels of drug use and that Government funding will prioritise areas with high levels of deprivation.

Other groups likely to have higher levels of problematic drug use who will require proactive interventions to encourage access to services are set out below. Of course, many individuals will be part of several of these groups, having multiple or complex needs.

4.1 People in Contact with the Criminal Justice System

Both the Government Drug Strategy and Dame Carol Black's Review of Drugs highlight the importance of targeting groups of people who are in contact with the criminal justice system. Dame Carol says that *"too many people with addictions are cycling in and out of prison, without achieving rehabilitation or recovery"* citing evidence collected for her review[13] which estimates that more than 1 in 3 people in prison are suffering from a "serious drug addiction". The main Government initiatives in this area are: increasing the use of police diversion schemes and community sentences with treatment as an alternative to custody, investing more in prison drug treatment and seeking to improve continuity of care on release from prison. The latest figures (for 2020/21) show that less than 4 out of 10 (38.1%) of people who access drug treatment in prison engage with community treatment on release[14]. Walsall has been significantly more successful than average in providing continuity of drug treatment for people released from prison, engaging 52.5% into structured treatment.

4.2 People with Co-existing Physical and Mental Health Problems

This is another group of people highlighted by Dame Carol. In respect of mental health, she says: "mental health problems and trauma lie at the heart of their drug and alcohol dependence. However, they are too often excluded from mental health services until they resolve their drug problem and excluded from drug services until their mental health problems have been addressed". One of the consequences of the budget cuts experienced by all statutory agencies through the "austerity years" was that organisations focused primarily on their own statutory duties and ceased multiagency work. Many of the initiatives put in place in the first decade of this century to provide a holistic, co-ordinated service for people with coexisting substance use and mental health problems (then termed "dual diagnosis") were disbanded, and practice has regressed. Nearly two-thirds (63%) of adults starting drug treatment in 2020/21 said they had a mental health treatment need[15]. This is part of a trend of rising numbers over the previous 2 years (from 53% in 2018/19). Over half of new starters in all substance groups needed mental health treatment.

This need ranged from 57% in the opiate group to nearly three-quarters (71%) of people using drugs other than opiates and alcohol. The focus of work here is on improving pathways between mental health and drug and alcohol services to provide a co-ordinated, holistic approach.

4.3 People with Blood Borne Viruses

It is estimated that over one quarter (29%) people aged 15 to 64 who use opiate and/or crack cocaine in England inject drugs. People who inject drugs (PWID) are vulnerable to a wide range of health harms which can result in high levels of morbidity and mortality, including blood borne viral infections, bacterial infections, and overdose. HIV, HBV (Hepatitis B) and HCV (Hepatitis C) are effectively transmitted through the sharing of needles, syringes, and other injecting equipment. Over 90% people with HCV in England are thought to have acquired the infection through injecting drug use. One fifth (20%) of people who injected drugs in the last year had chronic HCV, a substantial fall from 33% in 2016, when the level of chronic infection was at its highest, during the past decade, and from 28% in 2019[16]. This fall is due to significant Government investment in attempts to eradicate HCV through the use of new effective medications. The use of peer supporters has been found to be key to encourage PWID to engage in HCV testing and treatment[17].

4.4 People Experiencing Homelessness

Drug dependence can be both a cause and consequence of homelessness and rough sleeping. The Ministry of Housing, Communities and Local Government has estimated that almost two-thirds of people who sleep rough have a current drug or alcohol problem[18]. OHID drug treatment data[19] shows that almost 1 in 5 (18%) adults starting treatment in 2020/21 reported a housing problem, increasing to over one quarter (28.4%) of people in treatment for opiates. Providing drug and alcohol outreach services to homeless shelters and hostels is the most common way of increasing access to treatment for this group.

4.5 People not in Training, Employment, and Education

Dame Carol highlights the high levels of unemployment among individuals using heroin and crack cocaine and highlights that employment is an essential part of recovery, both for financial stability and to offer something meaningful to do. She highlights that recent intensive, employer-focused employment support inside treatment centres has shown promising results, based on a recent trial of Individual Placement and Support (IPS) in seven local authorities. She also recommends the introduction of peer mentors in each Jobcentre Plus to help people with drug dependence to receive more tailored and sympathetic support.

4.6 People with Learning Disabilities

Overall, the evidence indicates that people with learning disabilities are less likely to misuse substances than the general population. However, the official guidance suggests that when people with learning disabilities do drink alcohol, there is an increased risk that they will develop a problem with it[20].People with learning disabilities and other vulnerable people who live independently can be at risk of having their home taken over by drug gangs as bases for selling drugs and places for people to use drugs, a practice commonly called “cuckooing”.

4.7 Sex Workers

Drug using sex workers[21] may rely on sex work primarily to fund their drug use. The research literature[22] concludes that sex work is very complex and that tackling problematic drug and alcohol use is likely to be one of many issues for sex workers that need to be addressed simultaneously. The research suggests that a harm reduction approach (as opposed to a full recovery approach) has the potential to support sex workers but that there is no clear evidence on what treatment works for this target group. Dedicated outreach work (often by specialist teams who work across sexual health, women specific services, and drugs and alcohol) seek to provide holistic support to help sex workers overcome addiction, be protected against sexual violence, find safe and stable homes, and ultimately exit sex working altogether. The provision of clean injecting equipment, condoms, and sexual health support can often be a first step to engage people into services.

4.8 Families

The effects of a family member’s use of drugs and or alcohol often has a range of different impacts on a family including on their emotional wellbeing and finances[29], while the help of families is often enlisted to try to support an individual with a drug and/or alcohol problem, it is also generally accepted that family members themselves need a dedicated service[30].

The children of drug and alcohol users have been identified as a priority group. However, their needs have often been overlooked since the publication of the first Hidden Harm report[31] in 2003 which concluded that parental problem drug use can and does cause serious harm to children at every age from conception to adulthood. The government drug strategy recommends *“specific support”* for families with parental substance misuse treatment needs, which should be *“co-ordinated at a local level”*[32].

4.9 Steroid Users

Recent research[33] has found that anabolic androgenic steroids (AAS) are increasingly used by the general population, particularly male gym users, for their muscle-building and aesthetic effect, and that they can have a detrimental impact on physical and emotional wellbeing. Many needle exchange schemes seek to engage with steroid users by visiting gyms and ensuring that they have clean injecting equipment, outreach workers offer harm reduction advice and seek to engage people with concerns about their use into treatment[34]. However, unpublished research conducted by Senker et al. (2020) on a specific support service for steroid users in Essex, found there was a huge level of denial within this community and a overwhelming rejection of the need for help, outside of needle exchange.

4.10 Chemsex

Chemsex is now a mainstream term commonly used by gay or bisexual men to describe sex that occurs under the influence of drugs, which are taken immediately preceding and/or during the sexual session. The drugs most commonly associated with Chemsex are crystal methamphetamine, GHB/GBL, mephedrone and, to a lesser extent, cocaine, and ketamine[35]. All, except ketamine, are stimulant drugs in that they typically increase heart rate and blood pressure and trigger feelings of euphoria. Crystal methamphetamine, GHB/GBL, and mephedrone also have a common effect of facilitating feelings of sexual arousal. Ketamine is an anaesthetic and is typically used alongside practices such as “fisting” since it allows the brain to dissociate from any pain.

These drugs are widely known to facilitate pleasure or euphoria but are also associated with a range of harms. Particular concern has been raised regarding the role of crystal methamphetamine, GHB/GBL, and mephedrone in the transmission of sexually transmitted infections (STI). The link between drug use and risk-taking behaviour is complex, but there is a clear association between the two. These drugs can facilitate long sexual sessions with multiple partners and the likelihood of STI transmission may be increased due to rectal trauma or penile abrasions. The extreme sexual disinhibition associated with using these drugs in a Chemsex context means that people often indulge in unsafe sexual practices which they would not usually do. There are also harms associated with drug overdose, especially in relation to GHB/GBL, which is typically administered in small, carefully timed doses.

There are also concerns that levels of injecting behaviour (traditionally low amongst this population) have been increasing with reports of “slamming” both methamphetamine and mephedrone in particular.

For all these reasons, drug treatment services should consider partnering with local LGBTQ+ services to ensure both that harm reduction information is easily available to people involved in Chemsex and that people are aware of how to access local treatment services if they have concerns about their drug use.

5. Evidence of What Works

From the above, it is clear that local treatment systems need to establish a balance by providing both a universally easy-to-access service (with low waiting times and access outside office hours) with a range of interventions targeted at vulnerable groups, often in partnership with the key agencies working with these different groups within local communities. This section briefly summarises what the evidence base tells us about effective practice and highlights recent developments and innovations. We specifically consider the following four different practice areas:

1) Harm reduction
2) Drug treatment and recovery for adults
3) Drug treatment and recovery for young people
4) Drug prevention

Before examining these areas, it is important to emphasise that both harm reduction and recovery-oriented approaches are important, and that effective harm reduction work provides repeated opportunities to offer people using drugs the option to engage in treatment and recovery work.

5.1 Harm Reduction

One of the key objectives of the National Drugs Strategy is to reduce the number of drug-related deaths which have been rising continuously over recent years[36]. The strategy specifically mentions the importance of expanding the provision of naloxone, the opioid overdose reversal drug and exploring the potential of Buvidal, the new long-lasting form of the opioid substitute medication buprenorphine.

A core principle of harm reduction is the development of pragmatic responses to dealing with drug use through a hierarchy of intervention goals that place primary emphasis on reducing the health-related harms of continued drug use. It addresses the immediate health and social needs of problem drug users, especially the socially excluded, by offering opioid substitution treatment and needle and syringe programmes to prevent overdose deaths and reduce the spread of infectious diseases.

5.1.1 Naloxone

Naloxone is considered a key component in the drive to reduce opioid-related deaths. However, a recent systematic review and meta-analysis of studies relating to the ownership and use of Take-Home Naloxone (THN)[37] found good levels of ownership of THN – an average of 57% of at risk people who inject drugs – but a much lower level of carriage: 20%. Carriage simply means whether people regularly have their naloxone with them – clearly if someone has a naloxone kit at home, it is of little use if they overdose anywhere else.

It is therefore considered good practice that naloxone is not just distributed widely but that training[38] is given alongside the medication to encourage effective use and its regular carriage. Training is typically given both to opioid users and their family members.

5.1.2 Long Lasting Buprenorphine

Early research on long-lasting (by depot injection) buprenorphine suggests that use on its own is unlikely to result in an overdose and that buprenorphine maintenance keeps the person stable while they make positive changes in their lives. Weekly or monthly injections take away the need for daily pick-up of other substitute medications and make it easier for people to engage in work or study[39].

5.1.3 Other Harm Reduction Work

Additional approaches include outreach work, health promotion, and education. More recently, new opportunities for improving the reach and effectiveness of harm reduction interventions have opened up, especially through developments in the field of information technology and mobile applications. New approaches include, for example, the use of e-health applications to deliver brief interventions and recovery support more widely, and the use of behavioural insights to develop more effective programmes.

The advent of Drug Checking is a recent example of this innovative practice, particularly at festivals where members of the public can bring any substances of concern for testing and receive results as part of an individually tailored brief intervention by healthcare staff. The primary benefits of this approach are:

- To link harm reduction advice directly with chemical analysis of substances of concern currently in circulation in local drug markets, which research shows to be more effective.
- To reach hidden and hard-to-reach populations who otherwise do not engage with existing substance misuse services.
- To provide information that can be distributed via media, social media, early warning systems and other channels relating to concerns about particular substances.

The leading provider of this service in the UK is the Loop[40], a Community Interest Company, which has evaluated the effectiveness of its work[41].

5.2 Adult Drug Treatment and Recovery

We have already briefly summarised the critical success factors of an effective local treatment system. To recap, these are: a flexible, easy to access system with a full range of interventions which provides both recovery-oriented and harm reduction services, and one that proactively targets those in most need. This sub-section focuses on two recent developments in best practice; the rise of recovery communities led by people with lived experience and the development of support delivered online.

5.2.1 Peer-led Recovery Communities

The Government has formally endorsed "Recovery Orientated Systems of Care" (ROSC) which involve an equal partnership between 'professionals by training' and 'professionals by experience'[42]. The UK Recovery Champion describes the key components of a ROSC:

> "Person-centred services offer choice, honour each person's potential for growth, focus on a person's strengths, and attend to the overall health and wellness of a person with addiction. There is an increasing understanding that recovery-oriented services should be provided in communities, in specific environments of need, and be provided by professionals, family members, and peers. A ROSC arranges services to address the long-term and complex needs of people living with addiction. It should be built on the core values of individual choice and person-centred services and support multiple non-linear pathways to recovery[43]."

In Dame Carol Black's influential Review of Drugs, she made a strong recommendation that treatment services should include people with lived experience of drug dependence working as recovery champions and recovery coaches. However, she also warned that peer supporters should not be left to do the work of professionals without appropriate training, pay or support – an approach she described as exploitative. A new (2021) co-produced guide[44] sets out best practice in supporting peer volunteers derived from and informed by the lived experience of more than 250 peer volunteers. The guide covers a range of topics including training, support and helping people convert their volunteering experience into paid employment.

5.2.2 Online Support

Online support for people with drug and alcohol problems has been developing steadily over the last decade, but was, unsurprisingly, accelerated by the coronavirus pandemic. In late 2018, the European Monitoring Centre for Drugs and Drug Addiction published a scoping survey[45] of mobile health applications aimed in the substance misuse sector and identified three main groups of drug-related applications:

1) Apps that aim to disseminate drug-related information and advice.
2) Apps that provide interventions and support for drug users.
3) Apps for capacity building among health professionals.

Most apps address risk behaviours associated with drugs in general or drug use in specific settings (e.g., nightlife settings). Some drug-specific apps are available for more commonly used drugs such as cannabis and cocaine. One of the best-known digital interventions used in the UK comes from the Breaking Free[46] organisation which develops evidence-based digital behaviour change interventions that use proven behavioural science to empower people to overcome problem drinking, drug misuse and smoking.

In the alcohol field, the treatment agency Humankind provides a range of online tools designed to help people track and change their drinking including both an online screening tool[7] and the DrinkCoach App[8].

Since the pandemic, a number of treatment agencies have offered their core individual (and group) services via online video services such as Zoom and Microsoft Teams. Again, this practice had been adopted by some agencies prior to the pandemic as a way both of cutting costs and providing services at times that were convenient to their service users, particularly those who are either working during normal office hours, are based in rural location, or who think treatment services are only for "addicts". The leading drug and alcohol treatment provider 'We are with you' also provides an online drug and alcohol advice service[9].

5.3 Young People's Treatment System

Young people needing treatment have increasingly complex needs. Nationally, of the 3,000 young people in treatment with Change Grow Live (CGL)[47], 42% have a diagnosed mental health need, 36% have previously self-harmed, 28% are engaging in offending, and 15% are at risk of criminal or sexual exploitation. There is a consensus that in order to meet the needs of these young people, provision needs to be better coordinated across young people's services (Children's Social Services, Youth Offending Services, Children and Adolescent Mental Health Services) as well as specialist substance youth services. It is recommended that young people should be able to more easily access the right support, at the right time and that this support should include, as a minimum, integrating support for emotional wellbeing, unhealthy relationships and sexual health.

The evidence base that young people need a holistic, child-centred service (rather than a substance-centred one) is well established, going back to the Health Advisory Service reports in 1996 and 2001. The most recent guidance from Public Health England[48] establishes four core commissioning principles of specialist substance misuse services for young people:

- Young people and their needs are at the centre of services
- Quality governance is in place
- Multiple vulnerabilities and complex needs are properly addressed
- Young people becoming young adults are supported as they move into adult services through appropriate transitional arrangements.

Dame Carol Black highlights that there is work to be done on defining and promoting effective drug and alcohol practice for young people and the Office for Health Promotion is charged with this task. It is clear that involving young people with lived experience in the design of local services will be an important way of developing effective treatment systems.

7 https://drinkcoach.org.uk/alcohol-test-intro

8 https://drinkcoach.org.uk/drinkcoach-app

9 https://www.wearewithyou.org.uk/

5.4 Drug Prevention

Dame Carol highlighted the need for a much better evidence base for drug prevention work. The first step in developing this evidence base was provided by the Government's (independent) Advisory Council on the Misuse of Drugs who published a rapid review of Drug Misuse Prevention in May this year[49]. This review came to three main conclusions:

- Sole focus on vulnerable 'groups' will limit the reach of prevention activities; rather, prevention should be targeted also at the risk factors, contexts, and behaviours that make individuals vulnerable. Strategies to reduce vulnerability must also target structural and social determinants of health, well-being and drug use.
- Despite reasonably good evidence of 'what works', the UK lacks a functioning drug prevention system, with workforce competency a key failing in current provision.
- There is no 'silver bullet' that will address the problems of vulnerability to drug use. Improving resilience will require significant, long-term public investment to rebuild prevention infrastructure and coordination of the whole range of services that can be harnessed proactively to increase the likelihood of healthy development of children and young people across a range of domains, including efforts to address inequalities, social capital, and social norms.

The second point is perhaps the most important at a local level, drug prevention work has been under-valued for many years with funding rarely available for specially trained staff. There has been widespread criticism that many drug education and prevention approaches have not been based on the evidence base (and in some examples, such as "Just Say No" and DARE, have been proved to be ineffective or even counter-productive). The Advisory Council on the Misuse of Drugs' review recommends that all approaches are evidence-based[50] and that all drug prevention work should be integrated in a whole system approach and delivered by staff with dedicated, accredited training (which needs to be developed).

This section has pinpointed some of the key components of effective treatment and prevention approaches and highlights some of the key trends and innovations in the sector which are looking to improve and/or modernise service delivery.

The findings sections of this report is broken down into three strands to mirror the national drug strategy.

We first look at the work in Walsall to disrupt supply chains, this affords consideration to exploitation, mapping and disruption of organised crime groups, tackling street dealing and efforts to reduce violence.

Secondly, we focus on the treatment system in place in Walsall. This largely centres around the work of CGL and their service 'The Beacon' and we attend to the various parts of the service user journey for this segment.

Finally, we explore how to prevent future generations becoming embroiled in substance misuse, considering early intervention and prevention work.

We use data from all sources to address these sections, weaving in the data about drugs and alcohol in Walsall, focusing on overall prevalence, indicators of need and details about treatment and outcomes. Where possible we have included trends and highlight issues and topics where Walsall differs from the national picture.

6. Findings: Breaking Drug Supply Chains

For this part of the Drug Strategy, the stated aims are:

Within a decade the UK will be a significantly harder place for organised crime groups (OCGs) to operate. We will step up our response to the supply of the most harmful drugs, attacking all stages of the supply chain, reducing the associated violence and exploitation, and protecting prisons from being academies of crime. We will achieve this by:
1. Restricting upstream flow – preventing drugs from reaching the country
2. Securing the border – a ring of steel to stop drugs entering the UK
3. Targeting the 'middle market' – breaking the ability of gangs to supply drugs wholesale to neighbourhood dealers
4. Going after the money – disrupting drug gang operations and seizing their cash
5. Rolling up county lines – bringing perpetrators to justice, safeguarding and supporting victims, and reducing violence and homicide
6. Tackling the retail market – so that the police are better able to target local drug gangs and street dealing
7. Restricting the supply of drugs into prisons – technology and skills to improve security and detection

In line with what's noted above, the areas we sought to explore for the needs assessment were vulnerability, county lines, exploitation and cuckooing, disruption of supply chains and pathways including organised crime gangs, criminal gangs and street gangs. In order to understand this we interviewed a range of external stakeholders including police, local authorities and third sector partners with a view to better understand the link between exploitation, substance misuse and supply chains. Overall it was felt that once a victim of exploitation was identified there were mechanisms and support systems in place for them, but less was being done to tackle the root cause of exploitation through the disruption of organised crime groups.

6.1 Vulnerability, Exploitation and County Lines

The data analysis conducted for this needs assessment highlights that particular groups of vulnerable young people are known to be more likely to take drugs and more likely to develop problems associated with their use including:

- Young people in contact with Youth Offending Services (22% referrals of young people in drug/alcohol treatment were via the criminal justice system10)
- Looked after children (18% referrals into treatment)11
- Young people excluded from school and those not in formal education, employment or training (cited as a vulnerability for more than one in nine young people in treatment)[12]

Young people are involved in county lines drug dealing where drug dealers often use drugs and alcohol to entice young people into the gang lifestyle. In some cases, gangs trick young people into incurring drug debts that they then have to pay off through county lines activity. This is often referred to as 'debt bondage'. Indeed, county lines were said to be an issue in Walsall, with a historical line running through the Black Country, affecting young people in Walsall, Sandwell, Dudley and Wolverhampton.

Walsall has benefitted from recent investment and dedicated resources for the vulnerability and exploitation hub. As part of the needs assessment TONIC interviewed key stakeholders with responsibility for preventing exploitation, as well as those who support people who have been exploited. The vulnerability service in Walsall is an 'all age' exploitation service and this was said to be a real benefit in having oversight in patterns.

> 'We do have a good presence within the exploitation pathway within the Walsall safeguarding partnership. So, also Walsall have an all-age exploitation strategy. So we're part of the adult exploitation delivery group and subgroup and when we have cases of someone's been cuckooed or some victim of modern slavery, that we've worked together in some cases quite well actually.' (CGL staff member)

> 'I think there's some really good services for young people. And I think especially in Walsall, there's good kind of links around like exploitation, the police do a lot of good work. Around exploitation, we've got the exploitation team, we've got street teams as well. So there's good pathways in place that are very robust, and there's regular multi agency partner meetings, and everyone will kind of share intelligence and information. So I think that part of it's really good.' (CGL staff member)

A recent shift was noted where young adults had been being groomed and were now replacing children to run lines. There were also discussions about OCGs deliberately supplying females with drugs so they would become addicted. Some concern was expressed across a range of stakeholders about the police's ability to keep on top of county lines activity and map changes.

10 Public Health England (2021) Young people's substance misuse treatment statistics 2019 to 2020: report https://www.gov.uk/government/statistics/substance-misuse-treatment-for-young-people-statistics-2019-to-2020/young-peoples-substance-misuse-treatment-statistics-2019-to-2020-report#referral-routes-into-treatment

11 Ibid

12 ibid

Cars and road networks were said to now be a more popular method of transport for drug supply and county lines than they had been previously.

Overall, whilst there was said to be support for people once exploited, the offer for prevention and disruption around exploitation was noted as an area for improvement.

External stakeholders felt it was not a Police priority, this was thought to be because of the difficulties in securing convictions and the competition for resources across the force. Although there are a number of agencies involved in the multi-disciplinary anti exploitation work, there were said to be fewer referrals for vulnerable young people and adults than would be expected by agencies such as health or CGL who encounter front line victims.

Police suggested a recommendation to better train front-line professionals to be 'professionally curious' about exploitation by way of increasing referrals.

However, prevention work from the police side of things was also said to require improvement and there were discussions around a potential reluctance to 'overturn the stone' as there were not enough dedicated resources to deal with the scale of exploitation (related to substance misuse supply and OCGs). This contributes to a reluctance for people to refer to specialist services when exploitation is suspected. Certain schools in the area were said to be more attuned to gangs and exploitation within their cohorts of young people, but there is a lack of consistency across Walsall. However, we were told there has just been a significant investment from the Department of Education to implement a project in Walsall schools which uses a positive engagement method, using one to one youth work mentors. Street teams are in place to support victims of exploitation and do some work in schools. There are also two St Giles Trust workers providing targeted prevention work and support for young people in Walsall. One stakeholder indicated what needs to be done to better tackle exploitation and prevention, including the sharing of data and intelligence across agencies to identify trends.

> 'It is more of a holistic approach. I think we cannot rely on the police to do it all. Some of this stuff is really deeply entrenched in community, and police can't, and probably won't ever be able to link in like that. So it's about awareness. But everybody safeguarding needs and, like I said, that analytical oversight. It's about pulling all the data together, it be great if you could share data that the beacon were having on a daily basis, data from children's social care' (External Stakeholder)

A further stakeholder specifically made reference to the need for more early intervention work:

> 'I think resources needs to be put into early intervention, I think police need to focus on early intervention and support in those kids, not just waiting for them to kind of commit an offence

> before they even look at county lines or whatever. I think we need to change our mindset as professionals around early intervention' (External Stakeholder)

One senior police officer noted that whilst there are representatives for health and justice at exploitation hub meetings, it's often very challenging to get one 'voice' from the education sector. This was reported to be gap in the current model, with this sector feeling disparate and unconnected with an array of academies, colleges and Madrasas across Walsall acting independently rather than cohesively on this topic.

There was therefore a recommendation and drive for a more strategic approach to involve schools across the area.

6.2 Organised Crime Gangs, Criminal Gangs, Supply Chains

West Midlands Police reported:

> 'We don't really have a drugs lead or role in drug reduction, any more than any other police, it could potentially come under the vulnerability. But in reality, it doesn't. A lot of people that we get referred to will have drug issues and we will make referrals on but they're inevitably normally known to services.' (External Stakeholder)

Further police noted the challenges associated with competing for resources and funding with large neighbouring areas such as Birmingham, Wolverhampton, and Coventry which means local Walsall police often have less resources to map and consider OCGs within the area. With this in mind, there was a unanimous consensus that there was less local resource and specific interventions and disruption methods discussed which tackle the 'root cause' and 'source' of the issue in terms of officially mapped organised crime groups. More serious crime groups will go to the regional organised crime units (ROCUs) but lower-level groups and gangs including those who do not meet the specific threshold and definition for an OCG will be managed locally at a neighbourhood policing level. In terms of criminal gangs, one non-police stakeholder said there were five or six criminal gangs running out of Walsall and tended to be concentrated in specific ethnic communities that were 'closed' and difficult to get intelligence about. Police stated there were two mapped, official OCGs and only one was involved in drug supply. A number of stakeholders made reference to the challenges in penetrating certain closed communities and neighbourhoods within Walsall where drug dealing, supply, and violence was prevalent.

For these neighbourhoods there was also discussion around the importance of community leaders and 'elders' being involved in tackling these issues, not just police or local authority agencies.

Police highlighted the correlation of violence and drug supply:

> 'I will say off the top of my head probably, you know, if you look at the sort of levels of exploitation and organised crime, we see the violence, probably 88% of it is around drug supply. Next 20% is around acquisitive sort of stuff really. And often the violence comes with that as well. There's also a lot of drug use in those aren't involved in drug supply' (External Stakeholder)

In terms of the night time economy, Operation Argonite has been implemented locally to tackle this. The idea of a 'bus' to support people while on a night out was noted as a valuable harm reduction effort but there were some concerns that this was not acting early enough and was already dealing with the outcome of intoxication, being reactive rather than proactive in reducing supply.

6.3 A multi-agency approach

Police commented on the cross section of people who are harming the public, for example, through theft or stealing cars, but are actually relatively low risk (on an offender management scale) but high vulnerability and required support rather than being *'put into the system'*. It was therefore advocated that a model should be adopted, like the integrated offender management model, but which focuses more on vulnerability of individuals rather than the risk attached to their offending.

> 'With our criminal exploitation, we've got groups of young people who are nicking cars or selling drugs, and many other people are making money out of it. And we want to do something about that. But they're very vulnerable, they come from broken homes who have been looked after children, they've got the issues, mental health issues, but the only thing we can do to focus on an individual is to say we're going through Offender Management, let's say more than that, it's more vulnerability support, or it's a bit of both.' (External Stakeholder)

It was suggested, therefore, that this would require a multi-agency approach, with mental health, substance misuse, police, and other partners coming together to agree and identify which cohort they'd like to tackle and support.

> 'We've done this a little bit with a Bowbrush's work, actually, which is about youth violence. Actually from that they're looking at what we've got people on the risk profile, but then also measure, what do you think is the sort of the agency here for change? What's the opportunity? You might have some quite high risk individuals, but everyone's throwing everything at them already and you might have some low risk individuals, actually, it doesn't take much probably for these guys; a bit of a mentor, bit of support from that. And actually, you prevent stuff in the future. If you've got very valuable resources even though you've always got to justify why you're not doing more to reduce the high risk, I've got to also make the biggest bang for our buck as well. We've got to, we've got to sort of work more with the people who are, who we think we can change, not typically want to work with us because we can coerce them maybe. But if the coercion works, and the threat of you do this, or you'll be prosecuted, or you'll get fined, if that works, and that gets into it, and that's fine. You know, the outcomes the same, isn't it? And so long as it's a sustainable change.' (External Stakeholder)

Police stated they would signpost and refer people with substance misuse issues to CGL at 'The Beacon' but would value intelligence and more information from local authorities or other services about what they're seeing in terms of what routes are being used for supply, dangerous batches, emerging trends and what drugs are causing the most harm. The police also indicated a gap for *'individuals that are causing harm to their communities, but are not accepting help'.* Although there is the option of court mandated orders to attend treatment, this was said to only tackle people *using* substances rather than those dealing them. Out of court disposals were said not to be suitable for this cohort.

7. Deliver a world class treatment and recovery system

The national Drug Strategy states:

Within a decade, we will deliver a world-class treatment and recovery system in England. An additional £780 million over three years will be committed to begin to take this forward, implementing Dame Carol Black's key recommendations. We will treat addiction as a chronic health condition, breaking down stigma, saving lives, and substantially breaking the cycle of crime that addiction can drive by:
1. Delivering world-class treatment and recovery services – rebuild local authority commissioned substance misuse services, improving quality, capacity and outcomes
2. Rebuilding the professional workforce – develop and deliver a comprehensive substance misuse workforce strategy
3. Ensuring better integration of services – making sure that people's physical and mental health needs are addressed to reduce harm and support recovery, and ongoing delivery of Project ADDER to join up treatment, recovery and enforcement
4. improving access to accommodation alongside treatment – access to quality treatment for everyone sleeping rough, and better support for accessing and maintaining secure and safe housing
5. Improving employment opportunities – employment support rolled-out across England and more peer support linked to Jobcentre Plus services
6. Increasing referrals into treatment in the criminal justice system – specialist drug workers to support treatment requirements as part of community sentences so offenders engage in drug treatment
7. Keeping prisoners engaged in treatment after release – improved engagement of people before they leave prison and better continuity of care into the community

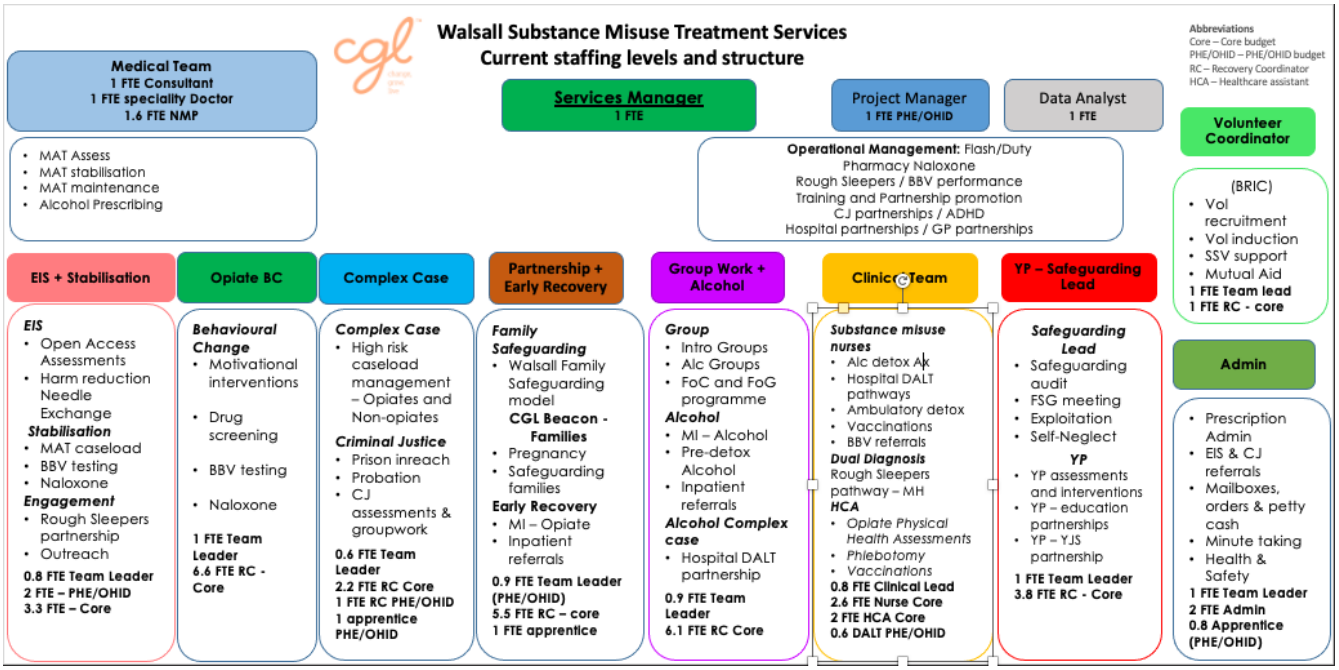
7.1 The local treatment system

By way of context, the current Walsall service, 'The Beacon', is a fully integrated adult and young persons' service for alcohol and drugs. The service offers a multi-disciplinary approach to care and consists of a team of around 60 staff members form a variety of disciplines: leadership, adult and Young People recovery workers, specialist roles, a clinical team being led by a Consultant Psychiatrist, with prescribing staff and nurses. It is a CQC registered service, achieving 'Good' across all domains and rated overall 'good' within the latest CQC Inspection. The service offers a range of interventions which include:

- Safe, effective prescribing/optimised doses aligned Medication-Assisted-Treatment (MAT), keeping Service Users safe. Includes a pilot of a long-lasting opioid Buvidal, which supports service users to stabilise and maintain their recovery

- A recovery hub which delivers a full range of group interventions for service users to build recovery capital and sustain their recovery. For example, Arts and Crafts, Relapse Prevention, Anxiety and coping Strategies, Mindfulness and relaxation, SMART recovery and Mutual Aid groups, Breaking free Online courses
- Access to harm reduction, psycho-social interventions, particularly BBV testing/vaccination targeted at high-risk cohorts and Needle Exchange Provision, keeping vulnerable Service Users safe, reducing impact on wider health services
- Availability of effective Nurse led community alcohol detox, maximising resources by reducing inpatient numbers
- Consultant led care to vulnerable groups: Complex/Safeguarding Needs including homelessness/mental health/pregnancy and ensuring pathways/partnerships are in place, maximising shared resources
- Nurse led alcohol interventions including physical health assessments, Drink Down diaries to reduce prescribing and continuity of care in primary care, Full range of Nurse led Detoxification services and psychosocial interventions including group delivery
- Family safeguarding through Family Drug and Alcohol Courts, CGL staff seconded into children's social care and Pregnancy lead with specialist pregnancy clinics
- Criminal justice team with responsibility of delivering DRR and ATRs
- Young people's, transition and hidden harm workers

The following diagram shows an overview of the staffing structure for the Walsall substance misuse treatment service run by CGL.



The service comprises two physical locations; one at Station Street which tends to be where psychosocial groups are delivered and once a week is open only for young people. The second site, Bradford Street, is a short walk away and delivers the clinical side of the service such as

needle exchange and clinical prescribing. For the rest of the week, the young person's service is based in the community, for example at early help hubs, schools, CAMHS, and youth justice sites. Staff reported being happy with the Station Street locality, however CGL have applied for a new building to replace the Bradford Street one which is more enclosed and has a less therapeutic feel, especially within the waiting area which can quickly become filled. One external stakeholder, responding to the survey, commented on the lack of privacy Bradford Street affords.

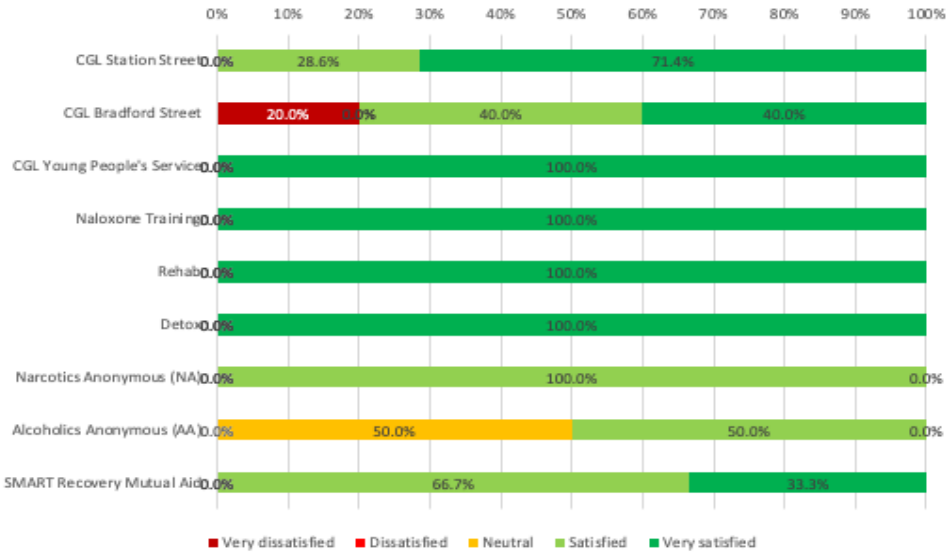
> 'The waiting room and reception need to be separate for the privacy of the individual… sensitive information is passed to the receptionist for all other parties to hear' (External Stakeholder, Survey)

Both buildings have a lot of stairs which can be limiting for service users with physical disabilities or issues with mobility.

> 'We've definitely created a space that feels safe for service users coming in [to station street] even our service-users struggling being in a space, when they come into this space they automatically feel like, Oh, this is welcoming, this is safe, this is somewhere I can be. And even if I'm aggy, I don't have to be aggy here. Now they'll come in aggy, and within minutes, that's dissipating, because the building we've created and the space we've created is such that it doesn't, there's no energy, there's no oxygen to fuel, something as some of those behaviours that more enclosed, more chaotic environment, they tend to breed. they tend to escalate pretty quickly.' (CGL staff member)

It was noted, during fieldwork that both sites have a service user feedback box, but it is unclear how this is used and reported back to service users. Drug alerts were seen to be displayed at Station Street but not at Bradford Street which is where this information is probably most useful.

We asked survey respondents to rate their overall experience of treatment.



The feedback regarding service users' satisfaction with the support they received was generally positive. There were 11 responses to this question in reference to CGL Bradford Street and Station Street and only 2 stated that they were very dissatisfied with the support received. The reasons given for this dissatisfaction centred around disorganisation and 'confusion as to where appointments were to take place' and appointments being cancelled 'without informing the client'. However, this negative feedback can be viewed as anomalous when considered in juxtaposition with the 9 other responses in which the respondents were either satisfied or very satisfied. The other responses to this question were answered in reference to Rehab, Detox, NA, AA or SMART Recovery. There was a generally positive feeling of satisfaction around the support offered by these services with the responses being either very satisfied, satisfied or neutral.

'I have always felt constantly supported. CGL staff are polite, non-judgemental, and very encouraging' (Service User, Survey)

The high volume of staff caseloads was raised unanimously as an important issue impacting on the quality of services across all CGL interviews.

This was against a backdrop of a motivated staff team with a highly evident desire and appetite to care for service users but having limited time to undertake in-depth one to one work as a result of large caseloads. Although there was widespread recognition of the need to reduce this, the associated issue of recruitment into the sector was also discussed.

'Nationally, there is just a shortage of substance misuse workers, and that will be as a direct impact of the disinvestment, really. If you're not consistent in recruiting, people aren't interested in the sector, and that falls off. They don't see it as an option for a career progression or pathway or whatever that might be. So I think funding is an issue, we haven't

> got enough staff to meet the needs of our current service-user population. And we've got people carrying caseloads of seventy. So I think that's a really important issue' (CGL Staff Member)

We use the following section to walk through the different parts of the service offer from referral and entry to aftercare.

7.1.1 Referrals, assessment and entry into the treatment service

CGL staff and stakeholders that were interviewed for the needs assessment reported that overall they had good relationships with partner agencies, such as GPs, pharmacies and social care. Indeed, some service users indicated they had been referred or signposted to 'The Beacon' by their GP.

> 'GPs all know our services, because we also do shared care. So we do get lots of referrals from the GPs. Again, through attending our partnership meetings, I think other services are quite well known. We've got a partnership working with Rethink, and again, they can direct people towards us. We are open access. Our phone number is everywhere' (CGL staff member)

'The Beacon' seems to have a well-known reputation amongst the 'using community' although some service users said there could be more promotion in 'hot spots' such as pubs or newsagents that sell alcohol. Of interest, and differing from the national picture, locally, both men and women are much more likely to refer themselves to alcohol treatment. 16 (4%) of 370 people who started alcohol only treatment in 2020/21 were referred by other agencies. This would also suggest people, who identify they need support, are able to find 'The Beacon' readily.

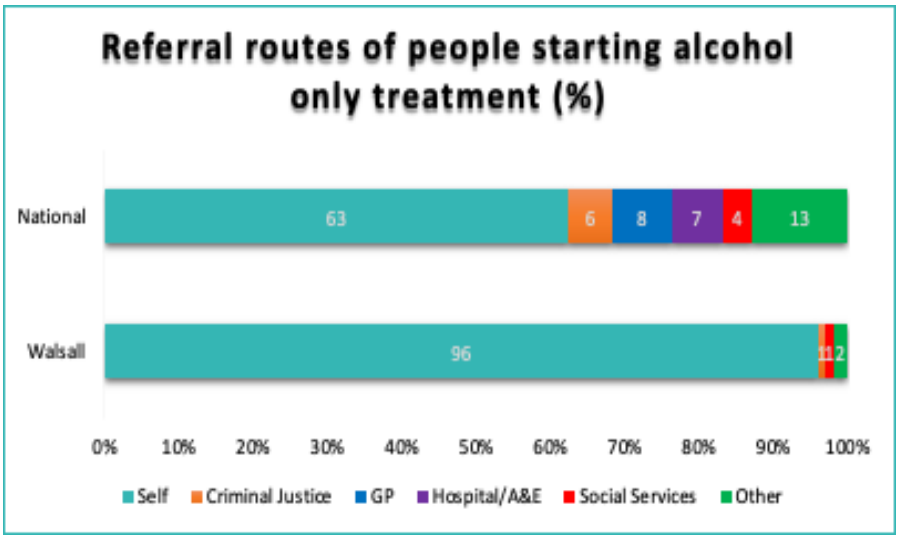


Figure 4: Referral routes of people starting alcohol only treatment (%)

Locally, as with alcohol treatment, both men and women are much more likely to refer themselves into drug treatment and much less likely to be referred by health or social services. The reliance on self-referrals is similar for both men and women. Not a single person of the 503 individuals starting drug treatment in 2020/21 was recorded as being referred into treatment by their GP, just two were referred by hospitals and Accident and Emergency Departments and four from social services. However, looking at the needs assessment survey data intervention (rather than direct referral) from an external party appeared to be a common reason for service users seeking out support; 5 survey responses out of 11 noted the involvement of someone else in their decision to access a support service. Family members, police and social services were the highlighted external parties that prompted a service user to first engage with support suggesting that service users needed prompting from others before they considered seeking out help.

The criminal justice pathway (for men) is reasonably well developed with 13% referrals coming via this route compared to 16% nationally. Almost one in six (16%) of people in drug treatment in Walsall are in contact with a criminal justice agency (compared to a national average of 11%), this figure rises to one in five (20%) for opiate users (vs 14% nationally).

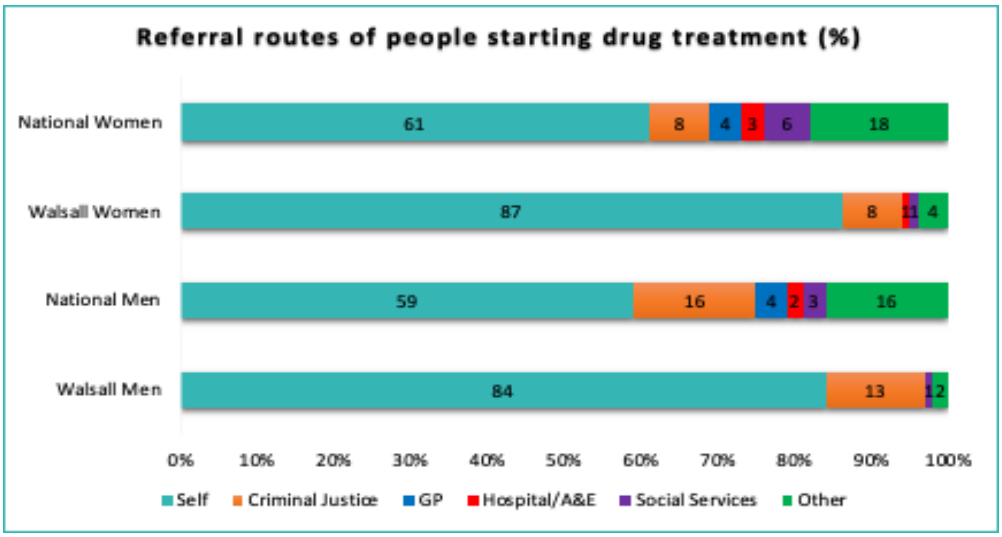


Figure 5: Referral routes into drug treatment 2020/21

For the young person's service, although CGL has a good relationship with a number of schools in the area, this is only a small percentage of the total schools and there is an ambition to increase referrals from education providers.

> 'I feel like we're only kind of getting a tiny, tiny part of Walsall. So I think we have some schools that refer to us, and it's only a few schools. And then on the back of that we were picking up a lot of structured work. So if they're going into structured work it means that there's quite, you know, that they could be using quite regularly or they want to stop their use. And it's more than maybe just a one off use where we do like a brief intervention. It's kind of more serious. So the referrals that we get are from like a small, small percentage of

> schools. And I think if more of the schools were referring to us we would have like a huge amount of referrals' (CGL staff member)

The service was praised for having a dedicated 'entry into service' team. Further, every day there is a dedicated worker for walk-ins. However, there was a recommendation that the 'open access' part of the service should be expanded and include duty workers who do not also have their own caseload to manage. One CGL staff member, responding to the survey mentioned how waiting times and open access services *'have created a barrier for our clients who suffer from anxiety…it has created issues with wait times as well and caused our reception area to get quite full'.*

Within the survey, the shift to open access and 'walk in' treatment services was contentious, and a further respondent stated:

> 'people prefer booked appointments. Service users do not want to drop in and have to wait sometimes over an hour to be seen'. One other member of staff reported 'if assessments could be booked rather than operated as a drop-in service, we could assess more people'. (Survey respondent)

However, service users completing the survey gave overall positive feedback for the assessment processes. There were 10 responses from service users rating CGL Bradford Street and Station Street, 8 of which were either satisfied or very satisfied. The most common theme that emerged as the reason for such positive feedback was regarding the staff. Survey respondents highlighted how the staff at both locations were helpful, friendly and respectful; service users did not feel judged during the assessment process and were grateful for the way they were treated. The interactions with staff during the assessment process are therefore shown to be of high importance to service users.

The fact there are two physical sites to cover the whole of Walsall means there is limited geographical coverage. Although 'The Beacon' does provide some bus passes, this disadvantages service users with mobility issues as well as those who may have anxiety and are unable to travel. CGL provided us with the number of outreach sessions recorded from the PHE universal fund between 2021-2022. The figures are listed below. It is interesting to note, therefore, that although these do occur, a number of staff and stakeholders still felt the service is too centre based.

It was suggested that having some satellite hubs would increase the breadth of CGL's reach. This would help reach missed demographics including sex workers, those living in more rural and remote parts of the area, those with disability issues and those who don't want to come to Station street or Bradford street.

Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 5
Not sent	90	65	65	73

The assessment process was said to be effective and comprehensive, especially around safeguarding information. One staff member felt that the amount of information required during assessment may be off putting for some service users and, once the risk information is collated, could potentially be done in shorter assessments over time. There was some feedback on duplication of assessments (especially from the Criminal Justice team) and for rehab purposes, despite the intention that the West Midlands framework is meant to reduce this. The data we received from CGL indicated that 100% of people are seen within three weeks of being referred. Regarding the referral process at CGL Station Street, 6 out of 7 survey respondents said they were either satisfied or very satisfied with their experience. CGL Bradford Street received more varied comments. Of the 11 respondents, 8 said that they were either satisfied or very satisfied with the referral process while 3 stated that they were very dissatisfied or had a neutral view of this referral process.

7.1.2 The Treatment System

Overall, the way 'The Beacon' is structured means that there are lots of specialist, dedicated teams covering a multiplicity of needs. It was impressive, during interviews, that even if someone was not working within a specific team, they had knowledge of what was going on within that part of the service, which contributed to a real sense of cohesion and integration across the provision. We explore each part of the service below but begin with a discussion about the level of indicators of drug use in the area.

There is no official data on levels of drug use on a local level. However, national trends are available with the most recent information taken from an overview of the extent and trends of illicit drug use for the year ending March 2020 published by the Office of National Statistics in December of that year[13], utilising data from the Crime Survey for England and Wales. This data is valuable since it is not distorted by the changes in use reported during the pandemic so can be reasonably regarded as a reliable indicator of trends in illegal drug use. The research showed a relatively stable picture with no change in overall drug use or Class A drug use in the year under investigation. The main findings were:

- An estimated 1 in 11 adults aged 16 to 59 years had taken a drug in the last year (9.4%; approximately 3.2 million people); this is the same as the year ending March 2019 but an increase from 8.6% in the year ending March 2010.
- 3.4% of adults aged 16 to 59 years had taken a Class A drug in the last year (approximately 1.1 million people); this was similar to the previous year (3.7%).
- 2.1% of adults aged 16 to 59 years and 4.3% of adults aged 16 to 24 years were classed as "frequent" drug users (had taken a drug more than once a month in the last year); these are similar to the previous year's estimates.

13 Office for National Statistics (2022) Drug misuse in England and Wales: year ending March 2020

Similarly, there were no changes in last-year's drug use for the majority of individual drug types including cannabis, ecstasy, powder cocaine, new psychoactive substances, and nitrous oxide. However, there were falls in the use of two low volume drug types and the proportion of frequent powder cocaine users:

- **Cannabis** continues to be the most common drug used in the last year among adults aged 16 to 59 years and 16 to 24 years, 7.8% and 18.7% respectively; this is much larger than the second most prevalent drugs used in the last year, powder cocaine use for 16 to 59-year-olds (2.6%) and nitrous oxide use among 16 to 24-year-olds (8.7%).
- **Amphetamine** use in the last year in adults aged 16 to 59 years fell by 42% compared with the previous year (to 109,000 people), continuing the long-term decline since the year ending December 1995.
- **Anabolic steroid** use among 16 to 59-year-olds in the last year also fell compared with the previous year from approximately 62,000 to 31,000 people, following a period over the last decade where reported use was relatively flat.
- **Cocaine**: Although there was no change in last-year powder cocaine use among adults aged 16 to 59 years compared with the year ending March 2019, the proportion of frequent users fell from 14.4% in year ending March 2019 to 8.7% in year ending March 2020.

7.1.3 Indicators of drug use

There were 37 drug-misuse deaths in Walsall in the 3-year period of 2018-20, with a directly standardised rate of 4.7 per 100,000[14] compared with a national average of 5 per 100,000. As well as being an important issue to be addressed itself, hospital admissions due to drug poisoning can be an indicator of future deaths. People who experience non-fatal overdoses are more likely to suffer a future fatal overdose. Data included in the Adult Drug Commissioning Pack shows that there were 136 admissions to Walsall hospitals for drug poisonings in 2020/21, a rate of 47.4 per 100,000, slightly below the national rate of 50.2 per 100,000. Nationally, the latest figures, which relate to 2021, show that the number of drug related deaths which involve cocaine (usually in combination) has risen consistently over the last decade and rose again in this week's figures (August 2022).

The most recent official estimates of opiate and/or crack users (OCUs) in local authority areas are now somewhat out of date and relate to 2016/17. The estimates for Walsall were 1,410 crack users, 1,741 opiate users and 1,915 opiate and crack users (OCUs). In every case, the prevalence rate is notably above the national average. Walsall was estimated to have 8.1 crack users per 100,000 people aged 15-64 years (compared with a national rate of 5.1), 9.2 per 100,000 opiate users (vs 7.3 nationally) and 11/100,000 opiate and crack users (8.9 nationally).

Walsall was calculated to be meeting the needs of a greater proportion of these Class A drug users than the national average with 49% crack users not in treatment in 2020/21 (compared to

14 OHID (2022) Adult Drug Commissioning Support Pack (Walsall): 2022-23: Key Data

a national rate of 58%), 42% opiate users not in treatment (vs 47% nationally) and 42% OCUs not having their needs met (compared with 53% nationally).

The needs assessment survey asked respondents to rate the most common and problematic substance in Walsall. Based on this, those with lived experience and stakeholders believe that alcohol is the most common and problematic substance in Walsall with almost all who responded to this question selecting it as one of their answers (93% of those with lived experience and 95% of professionals). Those with lived experience then most commonly selected crack cocaine (86%) and heroin (79%), while stakeholders selected these the other way round - heroin (80%) and then crack cocaine (59%). Regardless of the exact order, this shows that those with lived experience and stakeholders agree that alcohol, heroin, and crack cocaine are the most common and harmful substances in Walsall. For all those who selected 'other', they identified Black Mamba as a current substance of choice and concern in Walsall. Nobody believed speed, LSD, or magic mushrooms are common or causing significant harm in Walsall.

7.1.4 The drug treatment population

There were 1,268 adults in drug treatment in Walsall in 2020/2021[15], a figure which increased by 7% to 1,363 in 2021/22[16]. Official data separates these into three treatment groups by substance of use: opiate users, non-opiate users and alcohol and non-opiate users. The chart below shows the trends in Walsall over the last decade. The number of opiate users in treatment has fallen (by 12%) over this 10-year period. The number of non-opiate users more than doubled between 2012/13 and 2021/22 (from 70 to 170). The number of alcohol and non-opiate users fell substantially between 2015 and 2019 before climbing to 220 in 2021/22, an increase of 76% compared to 2012/13.

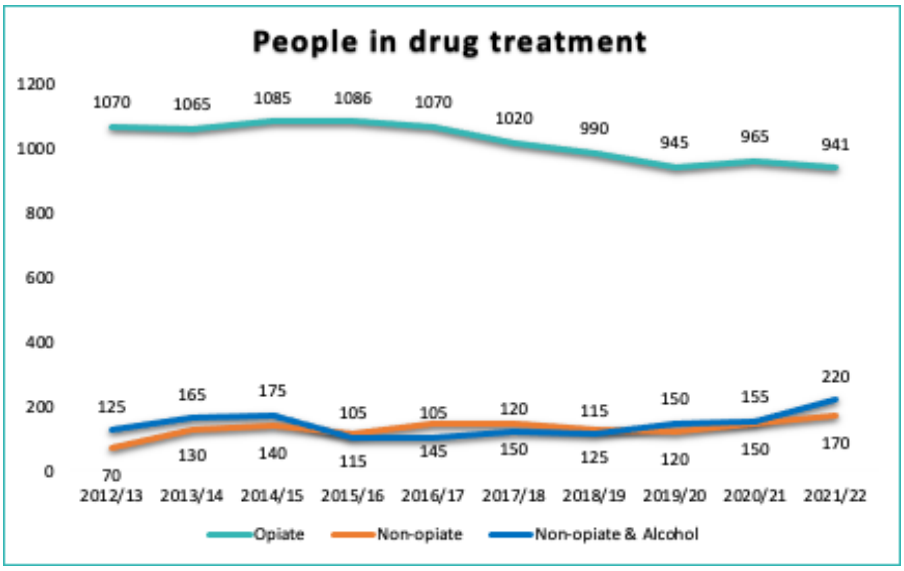


Figure 6: Walsall People in drug treatment trend data (2012/13 – 2021/22)

15 Data from Adult Commissioning Pack.

16 Provisional monthly data from NDTMS

Exactly three quarters of people in drug treatment in Walsall in 2021 (75%) were men with the other quarter (25%) women; as with alcohol treatment, women are slightly under-represented in treatment compared with the national average of 29%.

7.1.5 Demographic profile of people in drug treatment

The age profile of people in drug treatment in Walsall differs from the national picture as shown below in the chart below, which provides separate data for men and women. Men in drug treatment in Walsall are more likely to be younger than the national average with more than half 53% (compared to 36% nationally) aged under 40 years old. Just 11% men in drug treatment in Walsall are aged 50 years or older compared to a national average of 20%.

The same picture is found for women. Women in drug treatment in Walsall are more likely to be younger than the national average with more than two thirds 67% (compared to 56% nationally) aged under 40 years old. Just 7% women in drug treatment in Walsall are aged 50 years or older, just half the national average of 14%.

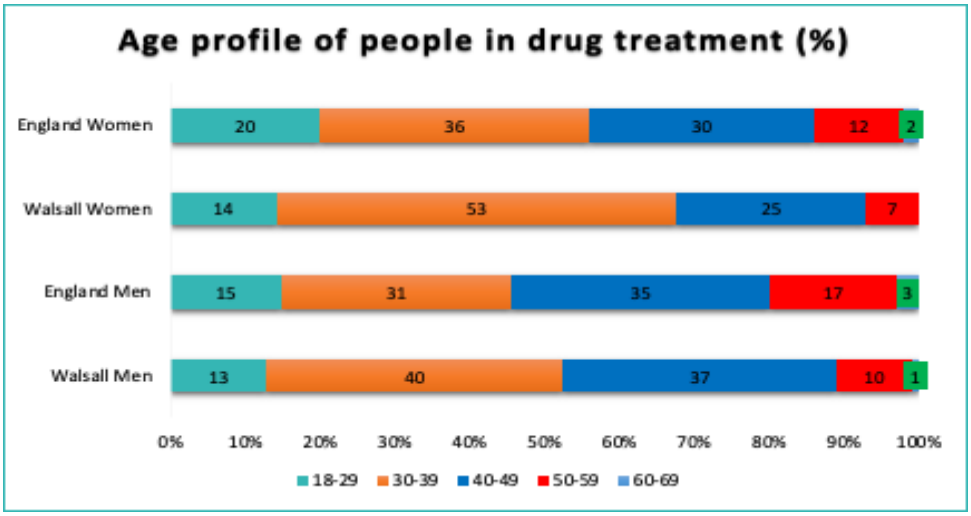


Figure 7: Age profile of Walsall people in drug treatment 2020/21

The ethnic profile of people in Walsall starting drug treatment in 2020/21 is compared to the ethnic profile of the local authority[17] where it can be seen that Asian people (as with alcohol treatment) are under-represented in drug treatment (10% of new presentations compared to 15% of the local population). This would suggest this is a group that is being missed by the current service offer.

17 Using data from the Walsall Council insights website

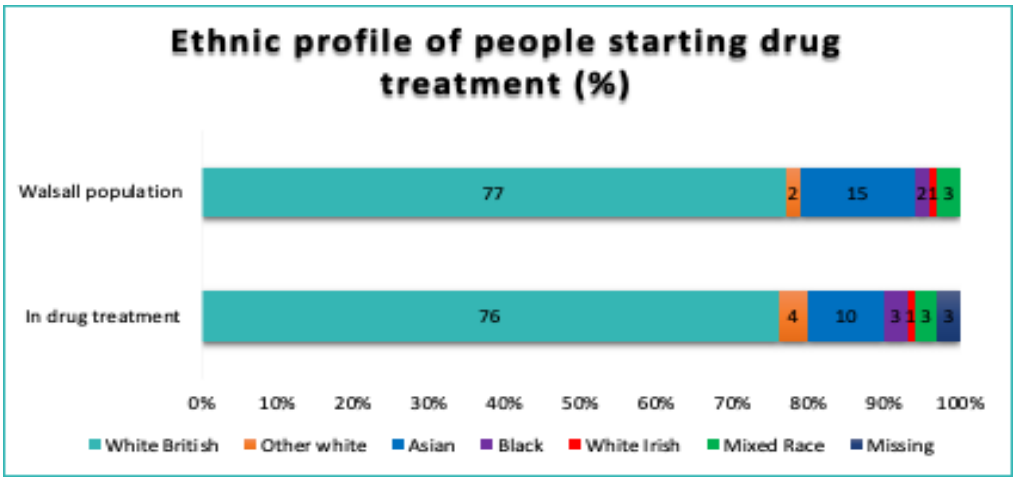


Figure 8: Ethnic profile of Walsall people starting drug treatment 2020/21

7.1.6 Substances used

The Adult Commissioning Pack shows the most commonly cited substance(s) of all adults in drug treatment in Walsall compared to the national picture in 2020-21. The chart below shows one significant difference with a considerably larger proportion of people in drug treatment in Walsall using crack cocaine (49% vs 39%). This trend is continuing as the Commissioning Pack also records the most commonly cited substances of people starting drug treatment in 2020/21; this data set shows that 44% of people entering drug treatment in Walsall said they used crack cocaine compared with 33% nationally. People in treatment in Walsall are also less likely to use benzodiazepines (2% vs 8% nationally).

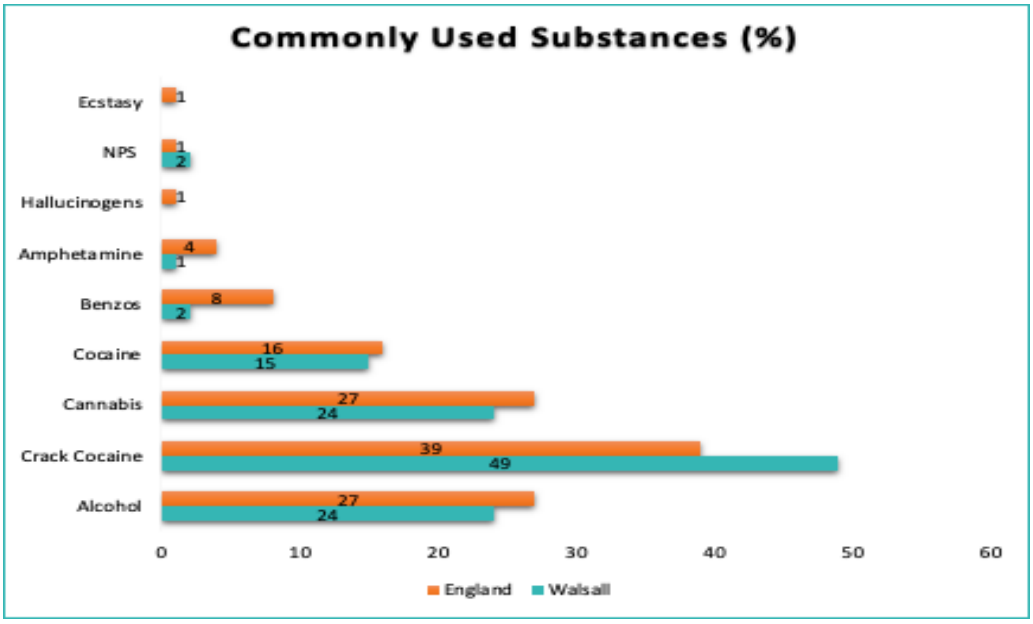


Figure 9: Figure 10 Most common substance of people in drug treatment 2020/21

People entering treatment in Walsall were less likely to have a problem with prescription only/over-the-counter medicines than the national average with just 2% (vs 4%) using legally acquired medicines and 3% (vs10%) using illicit ones.

7.1.7 Drug treatment outcomes

Adults with opiate problems who have been in treatment for over 6 years will usually find it harder to successfully complete treatment. The proportion of Walsall opiate users in treatment for this period of time (27%) is identical to the national average.

The data below is drawn from the Treatment Outcomes Profile (TOP), which tracks the progress drug users make in treatment. This includes information on rates of abstinence from drugs and statistically significant reductions in drug use and injecting. Data from NDTMS suggests that adults who stop using illicit opiates in the first 6 months of treatment are almost five times more likely to complete successfully than those who continue to use.

The chart below shows the proportions of people who are either abstinent from specific substances or have significantly reduced their use at their 6-month review. Compared to the national cohort, more people in treatment in Walsall have abstained from or significantly reduced their use of both opiates (86% vs 72%) and crack (78% vs 65%). Conversely, fewer local people have reduced their cocaine use (73% vs 79%). Although only 25% people in treatment in Walsall had stopped using or significantly reduced their amphetamine use, the numbers are very small with just four amphetamine users in treatment locally.

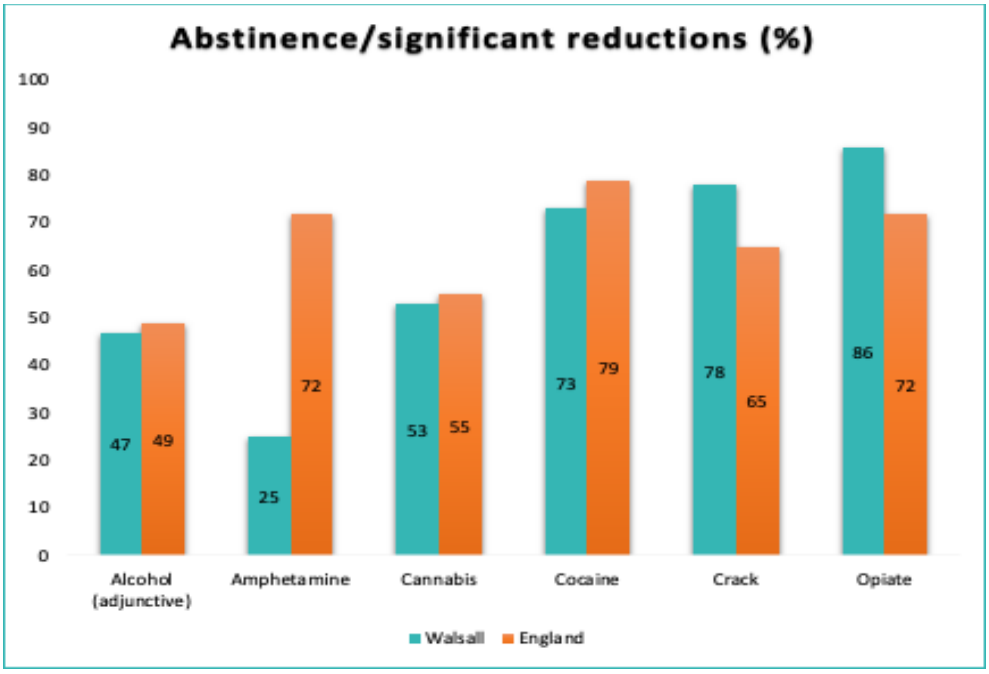


Figure 10: Figure 12 Abstinence/significant reductions by substance of people starting drug treatment 2020/21

A smaller percentage of local people in treatment had stopped injecting at their 6-month review (58% vs 63% national).

The proportions of people successfully completing treatment who did not re-present within 6 months for the 2021/22 year was below the national average for both opiate users (3.7% vs 4.7%) and for non-opiate users (which for this dataset includes those using non-opiates and alcohol - 25.3% vs 33%).

The way the CGL Walsall service is currently structured, with resourcing issues, means that they may only be dealing with the riskiest clients and the 'tip of the iceberg'. There was some discussion, across a number of staff members, as to whether the resource could be proportioned differently, rather than targeting entrenched opiate and alcohol users, staff debated whether more could be being done for non-opiate users who may have more scope to change.

'There's a handful of service users who are really chaotic, and really high risk that we provide the support, but then it takes up a lot of resources to do the same kind of thing with that person over and over again, whereas we could be potentially seeing someone new into service might not be as high risk, but really wants to make the changes in the life. So maybe looking at in terms of how many times a person cannot attend an appointment, or a person can fall off a prescription and expect to restart because I think it is looking at resources. You'd rather have, obviously people coming into service knew we're going to make the changes. And then it helps us with our targets as well.' (CGL staff member)

'…in our service, if you're Coke or cannabis, or any sort of anything else apart from alcohol, heroin crack, you are just put into that category of you're going into groups and that's it. That's, that's the help you're going to get. I feel like, I understand, it's more because of funding, and because there are people who are alcoholics and crack and heroin users can be more high risk. But I feel like if ultimately, our goal is to help people with drug addictions, we're not helping the full umbrella of people. And the lower risk, people, in my opinion, have more chance of getting back to full health and into society and becoming a functioning member of society. Who can do more? I feel that's an issue is that we're not we're focused more on the people that are just more trouble, instead of the people that we think could actually make it and are going to be more potentially, what's the word I'm trying to think of, successful in recovery' (CGL staff member)

'…my frustration is, is helping the people that want the help, we tend to be focusing on people who just want a script, which is keeping them going until they get their next bit of money. And then they drop off scripts. And then we've got to chase around and getting them back on scripts. And it's like, we've got other people here who are screaming to get help, and that they're so close to success. And they just need a little bit of support, a little bit of a push, but we can't help them. Because we are too focused on the people that are just an issue, trouble. They don't really want it, they're just, they're just, it's frustrating. I feel like we need to put those kinds of people into a category and keep them with certain workers who

understand they're going to be chaotic, and they're not going to really change. And we need to get other people into groups where these people want change' (CGL staff member)

One staff member reflected that she would like to see:

Services doing more for the 'middle tier' clients as well as having provision to upskill pharmacies and GPs to support lower-level substance misuse.

'How I tend to explain it is that it's almost like a triangle really. And you've got your specialist service at the top that is with most complex, and that's what we're dealing with. Some of the middle sector that, where it's starting to become problematic, but that bottom tier where people are drinking in the home address might be coming a bit too problematic. People smoking cannabis, that we can't, we do do some of it, but we haven't got capacity to do the wide-reaching stuff that perhaps commissioners are looking for. We're dealing with those really complex needs service users.' (CGL staff member)

7.1.8 Alcohol team and complex cases

Previously the complex case workers had both non-alcohol and alcohol clients on their caseload. Now, the two are separated which was reported to be preferential because the alcohol complex workers are based at Station Street with the other alcohol specialist team whereas the other complex case workers are at Bradford Street where prescribing takes place. At present, within the Alcohol team there are 2 Alcohol Complex case workers – they have service users with Alcohol and Alcohol and Non-opiates. Then within the Complex case team, there are 2 Complex case workers who have all other substances. TONIC accompanied one complex case worker on a home visit during the needs assessment and it was abundantly clear that without this outreach option, this client would not engage in any drug support as he rarely left his house and demonstrated little desire to change his behaviour.

At present the criteria for the complex casework team *and* complex alcohol is as follows:

- High risk injecting behaviours (IV groin, neck)
- Toxic trio (Alcohol, benzos and heroin)
- Suicide attempt within the last 12 weeks
- Overdose within the last 12 weeks
- Unmanaged physical health concerns – not engaging with GP or hospital appointments
- Unmanaged mental health concerns - not engaging with GP or Community mental health team
- Complex physical/mental health concerns that requires significant partnership working
- Homelessness and sex working and high-risk substance use

- Chronic physical health concerns linked to long-term alcohol misuse
- Service users that are difficult to engage and need outreach appointments
- Service users with a disability for example needing an interpreter for BSL

The Entry into Service team have a decision matrix and the CGL management team will discuss every week cases of concern and review case management reports with different themes:

- Week 1 – no medical review within 12 months
- Week 2 – service users with suicide attempts and not seen for 8 weeks
- Week 3 – service users with Toxic trio, high doses – not seen for 8 weeks
- Week 4 – service users with physical health concerns, not seen for 8 weeks

7.1.9 Prevalence of alcohol use in Walsall

Data from Local Alcohol Profiles for England included in the most recent (2022/23) Alcohol Commissioning Support Pack for Walsall estimates that a slightly smaller proportion of adults in Walsall drink over 14 units of alcohol a week compared to the national average (20.8% vs 22.8%) and a considerably larger proportion of the local population abstain from drinking alcohol (26.7% vs an England average of 16.2%).

The Commissioning Support tool records 640 people in alcohol treatment[18] in 2020/21 and calculates that there are 3,305 adults in Walsall in need of alcohol treatment with a slightly greater proportion of these in treatment than the national average (19% vs 18%). It is clearly important for Walsall to invest as heavily as possible in alcohol treatment in order to meet the needs of the 2,665 people (81%) of those in need who are not currently in treatment. It is pleasing to report that the number of people in alcohol treatment on 31 March 2022 was 732, an increase of 92 on the previous year[19].

7.1.10 Indicators of problematic alcohol use

The Local Alcohol Profiles for England record a number of key health-based indicators of harmful alcohol use including alcohol-specific deaths and hospitalisations.

7.1.11 Alcohol-specific mortality

Alcohol specific deaths are recorded as a standardised rate per 100,000 people. The alcohol specific mortality rates for both men and women in Walsall for the three-year period 2017-19 were higher than the national average. These were 21.4 per 100,000 for men (vs 14.9 national average) and 10.4 per 100,000 for women (vs 7.1).

18 This figure comprises people in treatment in the alcohol only and alcohol/non-opiate treatment categories.

19 Data from NDTMS provisional monthly figures Community adult treatment performance report, again comprising people in treatment in the alcohol only and alcohol/non-opiate treatment categories.

7.1.12 Alcohol-related hospital admissions

Alcohol-related hospital admissions can be due to regular alcohol use that is above recommended levels and are most likely to involve increasing risk drinkers, higher risk drinkers, dependent drinkers, and binge drinkers. Alcohol has been identified as a factor in more than 60 medical conditions, many leading to hospital admission. Men account for the majority (65%) of alcohol-related admissions, which reflects a higher level of harmful drinking among men compared to women overall.[20]

Health conditions in which alcohol plays a causative role can be classified as either *'alcohol-specific'* or *'alcohol-related'*. *'Alcohol-specific'* conditions are those where alcohol is causally implicated in all cases, including alcohol poisoning or alcoholic liver disease. *'Alcohol-related conditions'* include all alcohol-specific conditions, plus those where alcohol is causally implicated in some but not all cases, for example high blood pressure, various cancers, and falls.

Alcohol-related conditions are further sub-divided into *'narrow'* where the main reason for admission to hospital is an alcohol-related condition and *'broad'* where either the primary reason for hospital admission or a secondary diagnosis was linked to alcohol. The two measures provide information for different reasons: the *broad* measure gives an indication of the full impact of alcohol on hospital admissions and the burden placed on the NHS. The *narrow* measure estimates the number of hospital admissions which are primarily due to alcohol consumption and provides the best indication of trends in alcohol-related hospital admissions.

The figure below illustrates how Walsall compares with the national average for a range of differently defined hospital admissions separated out for men and women. The rate of admissions for men for alcohol-related conditions under both *Narrow* and *Broad* definitions are substantially higher than the national average. This is not the case for women where admission rates are very similar to the national picture and the proportion of admissions for alcohol specific conditions is substantially lower.

Measure		**Admission episodes for alcohol-specific conditions**	**Admission episodes for alcohol-related conditions (Narrow)**	**Admission episodes for alcohol-related conditions (Broad)**
Men	Walsall	807	721	2,525
	England	806	603	2,290
Women	Walsall	294	327	813
	England	380	322	805

Figure 11: Alcohol-related hospital admissions by gender DSR per 100,000

20 Statistics on alcohol 2019, NHS Digital

7.1.13 The alcohol treatment population

There were 524 adults in treatment solely for their alcohol use in Walsall in 2021/22[21], an increase of 37 on the previous year.

Data from the previous (2020/21) year on the demographic profile of this treatment population via the Adult Commissioning support pack shows that almost two thirds of this treatment cohort (65%) were men; women (35%) appear to be slightly under-represented in treatment in Walsall compared with the national average of 42%. More than three quarters (76%) of these individuals started treatment in that financial year, a higher proportion than the national average of 68%
As the chart below shows, the figure of 524 people in alcohol only treatment at March 2022 shows a steady and significant increase (+68%) over the last decade. This compares with the overall number of people in alcohol only treatment in the West Midlands area falling (from 10,525 in 2012/13 to 9,235 in March 2022) by 12%.

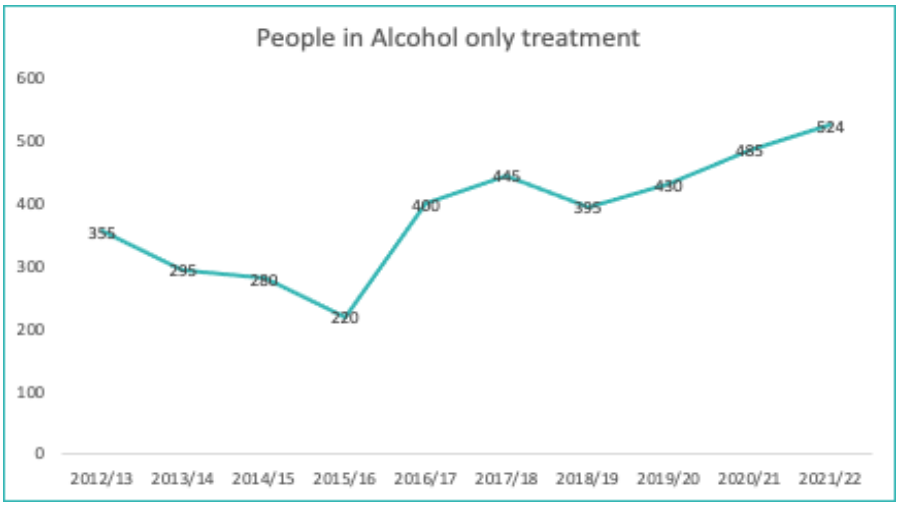


Figure 12: Walsall People in alcohol only treatment trend data (2012/13 – 2021/22)

7.1.14 Demographic profile of people in alcohol treatment

The age profile of people in alcohol only treatment in Walsall mainly reflects the national picture as shown below in the chart below, which provides separate data for men and women. Both women (37% vs national average of 34%) and men (35% vs 32%) in alcohol only treatment in Walsall are more likely to be aged under 40 years old. They are also less likely to be aged over 60 years old – this older age group comprises 10% of Walsall women in alcohol only treatment (vs 12% national average) and 8% of local men (vs 12% nationally).

21 Provisional monthly data from NDTMS.

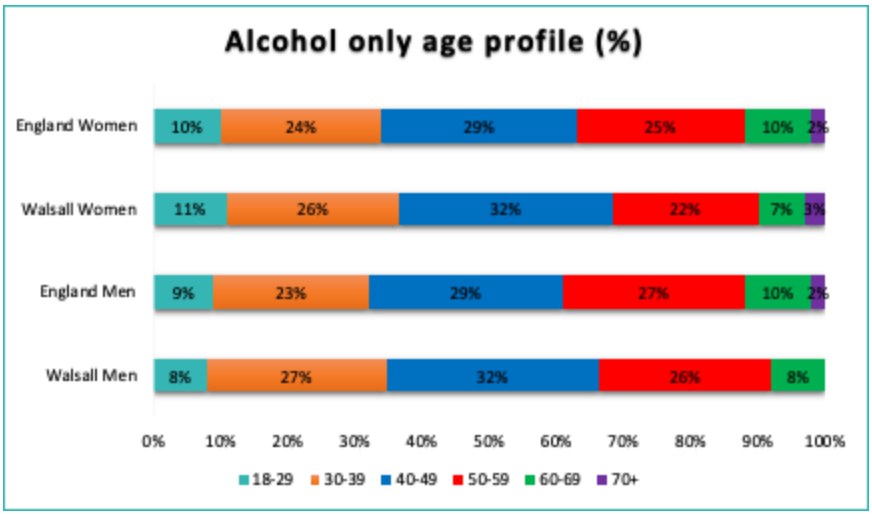


Figure 13: Age profile of Walsall people in alcohol only treatment 2020/21

The ethnic profile of people in Walsall starting alcohol treatment in 2020/21 is compared to the ethnic profile of the area[22] where it can be seen that Asian people are under-represented in alcohol treatment (11% of new presentations compared to 15% of the local population).

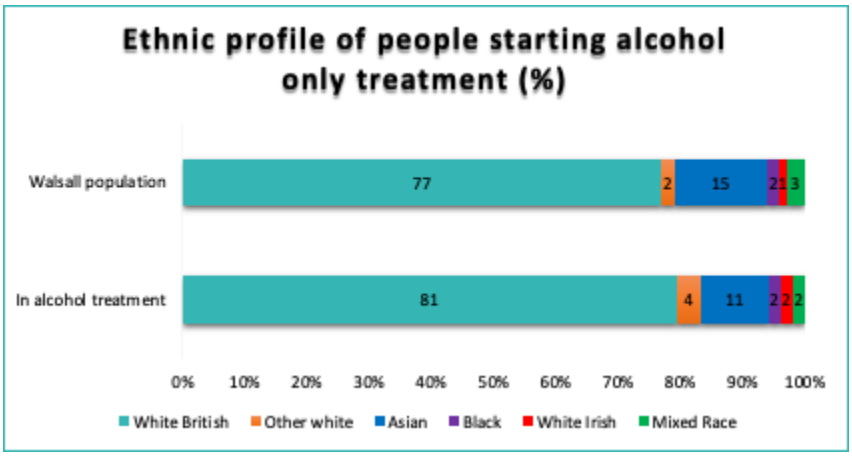


Figure 14: Ethnic profile of Walsall people starting alcohol only treatment 2020/21

Local people entering alcohol treatment were recorded as being less likely to be unemployed or economically inactive (38% compared to 41% nationally) although a greater proportion of local people (24%) were recorded as being long-term sick or disabled compared to 18% nationally. The proportion of this cohort having a housing problem was lower than the national average (7% compared to 9% nationally, with 2% of people both locally and nationally having an urgent housing problem – being of no fixed abode).

22 Using data from the Walsall Council insights website.

7.1.15 Treatment outcomes

The official alcohol commissioning support guidance[23] recommends a range of different interventions for those using alcohol:

- Effective population-level actions to control supply and marketing
- Large scale delivery of targeted brief advice
- Specialist alcohol care services for people in hospital
- Quick access to effective, evidence-based alcohol treatment

7.1.16 Alcohol-related risk reduction

There is a robust evidence base about the positive impact of brief advice interventions on people with alcohol issues. Identification and brief advice in primary care reduce weekly drinking by 12%, reducing the risk of alcohol-related illness by 14% and absolute lifetime alcohol-related death by 20%. It can also save the NHS £27 per patient per year.[24] Walsall was not able to provide data concerning brief assessments in primary care within the time frame for this needs assessment. However, the GP Extraction Service (GPES) can be used to monitor how many newly registered patients in a practice have been offered alcohol-related risk reduction screening and interventions or referral and this is important data for commissioners to access.

7.1.17 Alcohol treatment

NICE Clinical Guideline (CG115) recommends that mildly dependent and some higher risk drinkers receive a treatment intervention lasting 3 months, those with moderate and severe dependence should usually receive treatment for a minimum of 6 months while those with higher or complex needs may need longer in specialist treatment. The optimum time in treatment is, of course, based on individual assessment of adult need.

The length of a typical treatment period is just over 6 months, although nationally 12% of adults remained in treatment for at least a year. Retaining adults for their full course of treatment is important in order to increase the chances of recovery and reduce rates of early treatment drop out. Conversely, having a high proportion of adults in treatment for more than a year may indicate that they are not moving effectively through and out of the treatment system. The chart below shows that local time in alcohol treatment is similar to the national average. Although a smaller proportion of people locally exit treatment in the first month (5% vs 8%), the proportion of people remaining in treatment for at least six months is also lower locally (33% vs 35%). A slightly larger proportion of people in alcohol only treatment in Walsall remain in treatment for longer than one year (14% vs 12%).

23 Public Health England (2018) Alcohol Commissioning Support: principles and indicators

24 Cited in: Warwickshire Alcohol Health Needs Assessment 2022

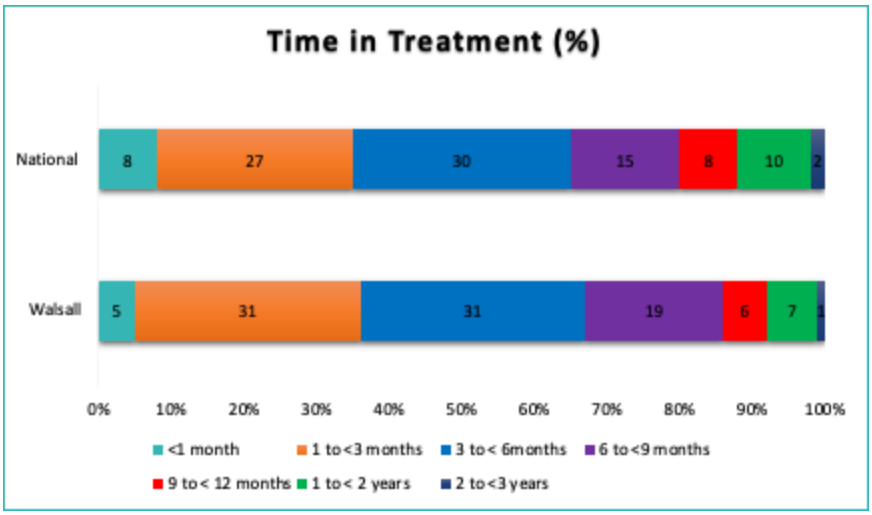


Figure 15: Length of time in alcohol treatment based on treatment exits in 2020/21

Alcohol treatment outcomes are positive when benchmarked against national performance. A larger proportion of Walsall people in alcohol treatment (41% vs 37% nationally) left treatment successfully and a slightly larger proportion successfully completed treatment and did not re-present for 6 months (36% vs 35% nationally). Again, 64% of people in Walsall who left treatment in a planned way were abstinent from alcohol compared to 53% nationally; making a bigger reduction in the number of average days they drank alcohol in a 4-week period. Locally people in alcohol treatment reduced the average number of days they drank by 10.9 days (from an average of 21.6 at the start of treatment to 10.7 at exit) compared to a national reduction of 8.8 days (from an average of 20.3 to 11.5).

As part of the needs assessment, TONIC attended alcohol group support at Station Street, interviewed 25 alcohol (only) users and 52.9% of survey respondents had alcohol as their main substance of choice. Overall, those using the alcohol support and treatment service within CGL Walsall were very satisfied with what was on offer, which included one to one support, ambulatory detox and groups.

7.2 Young People's Provision

The majority of young people do not use drugs, and most of those who do, are not dependent. Substance misuse can have a major impact on young people's health, education, families and their long-term chances in life. It is for these reasons that the government, via its 10 Year Drug Strategy and specific advice from the Office for Health Improvement and Disparities, strongly encourages local authorities to invest in substance-related service provision across the different levels of need from schools to treating young people's substance misuse.

There are no official data about levels of drug use on a local level. However, national trends are available with the most recent information taken from an overview of the extent and trends of illicit

drug use for the year ending March 2020 published by the Office of National Statistics (ONS) in December of that year[25], utilising data from the Crime Survey for England and Wales which does provide separate information on different age groups. Although most young people do not use drugs, young people are more likely to use drugs than other age groups. The ONS data found that 21.1% of 16–19-year-olds had used any drug in the previous year, much lower than the 31.8% equivalent figure in 1995, but the highest rate since 2011 (23.3%).

'The Beacon' has an integrated young people's service which covers children 5-25 years old, through the 'Hidden Harm' and transition service. The service is mainly an outreach based provision, except on a Wednesday Station Street is open specifically for young people. The young people's service is a relatively small team comprised of two young people's workers, 1 transition worker and 1 hidden harm worker. It was reported that the young person's team is cohesive and has a robust approach to safeguarding as well as strong partnership working with other professionals such as housing.

> 'There's a definite positive to outreach. Because not all young people will want to come into a service. So it just gives us that flexibility. And it just means that we're kind of catering towards, you know, different young people and what they would want out of the service. But I think we would definitely benefit from having our own style. I think that's been a bit of a challenge, because it's having one day a week, where you can see people in the buildings, not everybody's in education, not everybody can be seen at home and only being able to offer a Wednesday has been quite limiting' (CGL staff member)

There is currently no group work for young people which is something that was identified as an avenue worth pursuing. Caseloads within the young person's team are currently operating at about 20-25 people.

7.2.1 Indicators of young people's use of drugs and alcohol

There is a substantially lower rate of hospital admissions due to substance misuse for young people aged 15-24 years in Walsall than the national average (a DSR of 68 per 100,000 vs 85/ 100,000 nationally[26]). Similarly admission episodes for alcohol-specific conditions for under 18s is much lower locally (a DSR of 15 per 100,000 vs 31 per 100,000 nationally[27]).

The proportion of children aged 10-17 years who enter the criminal justice system for the first time is higher in Walsall (a crude rate of 192 per 100,000 children of this age) than nationally (169 per 100,000)[28]

25 Office for National Statistics (2022) Drug misuse in England and Wales: year ending March 20202

26 Data from Office for Health Improvement & Disparities (2022) Young people substance misuse commissioning support pack 2022-23: Key data. This data is trend date from 2017/18 to 2019/20.

27 All data in this section comes from the (2022/23) Young People Substance Misuse Commissioning Support Pack for Walsall, unless otherwise indicated and refers to the financial year 2020/21.

28 Data for 2010-2020.

The proportion of looked after children identified as having a substance misuse problem in Walsall (5%) is higher than the national average (3%)[29]. However, the proportion of school exclusions related to drugs and alcohol in Walsall (2%) is lower than the national average (3%) and the proportion of permanent exclusions related to drugs and alcohol half the national average (5% vs 10%)[30].

The Walsall homelessness strategy[31] does not provide data on the number of young people homeless locally but the housing department was able to confirm that there are no local rough sleepers under the age of 25 years.

7.2.2 Young people in structured treatment

The numbers of local young people in community structured treatment (those under 18 and those aged 18-24 in young people's services but not counting those in adult drug and alcohol services) is low, a total of 74 in 2020/21 with 47 starting treatment in that financial year and 51 starting treatment in 2021/22[32]. For this reason, although national comparisons are still provided, readers should be aware that these are not as robust as those provided in our analysis of the adult treatment data. This low number (a reduction of 69% since 2009/10) is not atypical with a national drop of 41% young people in treatment over the same decade and an equivalent fall of 64% in nearby Warwickshire.

Young people in treatment locally are much less likely to be female (22% vs 36%) than the national average, with this apparently being an established trend with just 21% of those starting treatment in 2020/21 girls or young women compared to a national figure of 35%.

The ethnic profile of Walsall young people in treatment in 2020/21 is compared to the ethnic profile of the area[33]. Conclusions may be unreliable, since the ethnic profile of young people in Walsall is likely to differ from the profile of the overall population. Nevertheless, it appears that Asian young people are under-represented in treatment while local Black young people are over-represented compared to the local population.

29 Data for 2017/18 to 2020/21.

30 Data for 2014/15 to 2019/20

31 Walsall Council (2018) Walsall Homelessness Strategy 2018-2022

32 NDTMS provisional monthly figures.

33 Using data from the Walsall Council insights website.

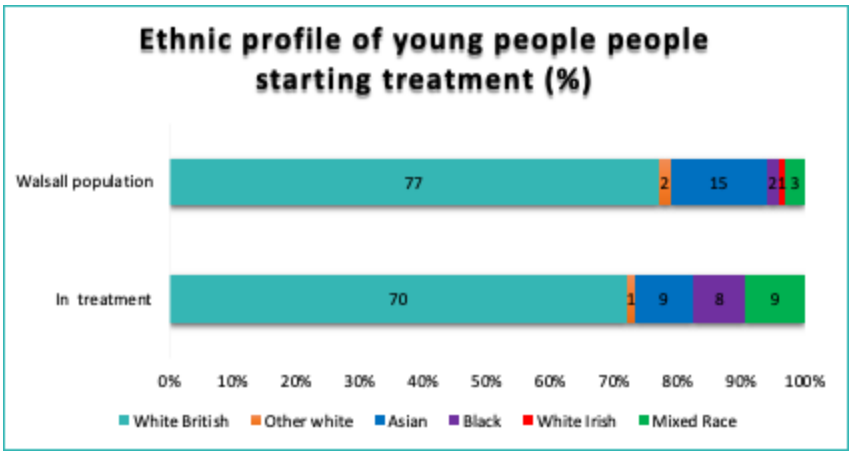


Figure 16: Ethnic profile of Young people in treatment 2020/21

7.2.3 Substances used

The commissioning pack shows the most commonly cited substance(s) of young people in treatment in Walsall compared to the national picture in 2020-21. The chart below shows that a considerably smaller proportion of young people in treatment in Walsall are recorded as using almost every substance other than cannabis (92% locally vs national average of 85%). This finding may reflect that local services work almost solely with cannabis and alcohol users, although we did interview one young person who was prescribed an opiate substitute after using morphine illicitly.

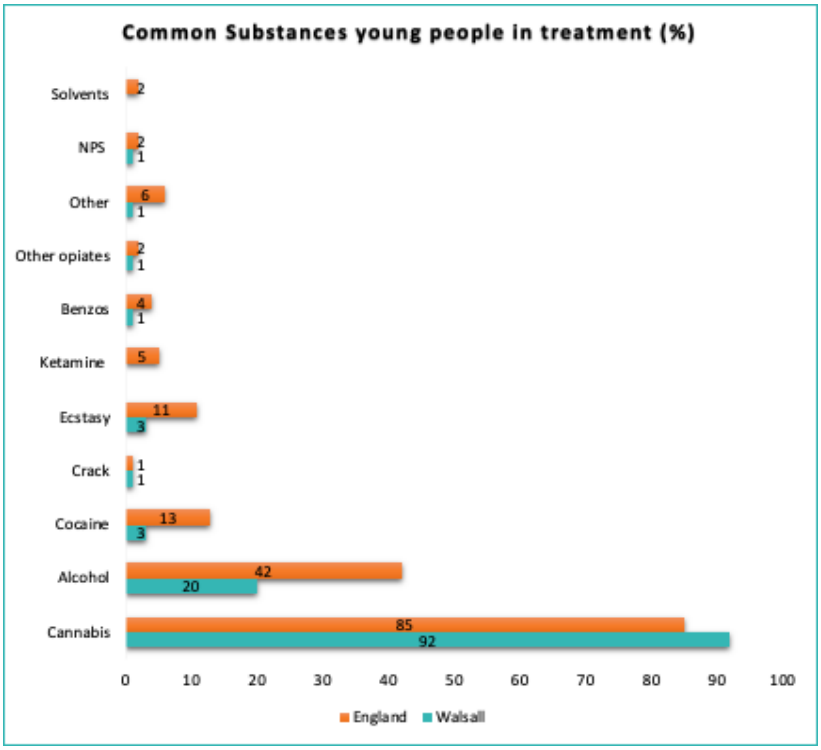


Figure 17: Most common substance of young people in treatment 2020/21

One survey respondent commented on the use of 'mamba' in the young person's service and a lack of specific detox or provision for this.

> 'A large majority of young people use mamba and there is no treatment offered other than support groups. As mentioned previously this does not address the withdrawal symptoms from mamba, detox should be offered to these individuals.' (CGL staff member, Survey)

7.2.4 Routes into treatment for young people

Unlike adult services, very few young people (under 18) refer themselves (or are referred by family and friends) into treatment in Walsall. Again, caution must be urged because of the small numbers involved but local referral routes are significantly different from the national picture. More than two out of five young people locally (44%) including a majority of young women (53%) are referred from education services (compared with 25% nationally). Local young people are much less likely to be referred by children and family services (13% vs 28% nationally for girls and 13% vs 20% for boys).

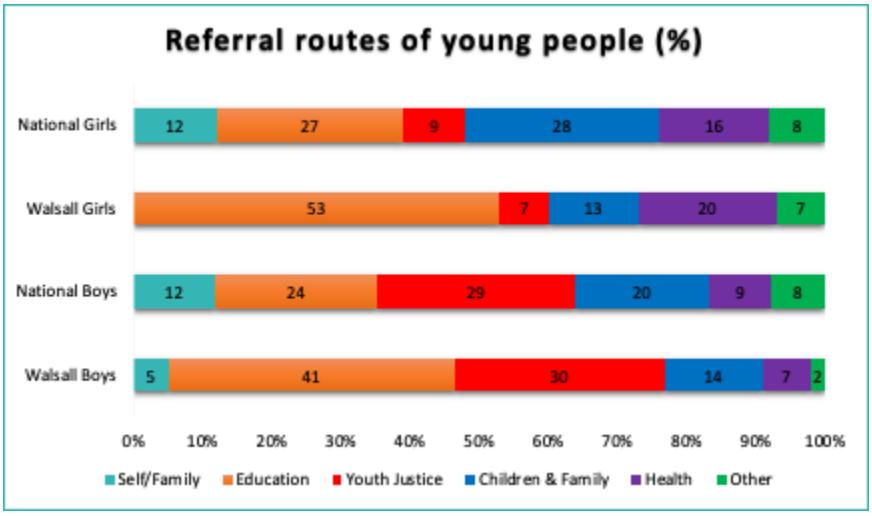


Figure 18: Young people's referral routes into treatment 2020/21

7.2.5 Additional challenges

There was a smaller proportion of young people in treatment in Walsall with mental health needs than nationally (39% vs 42%). A substantial majority (71%) of these young people were already engaged in specialist treatment (compared to a national average of 55%).

Just one in seven (15%) young people in treatment in Walsall were recorded as not being in education, employment or training compared to a national average of 16%.

Local young people in treatment were more likely to be living with their parents (89% compared to a national figure of 82%) and slightly less likely to be living in care (6% vs 7%) or in supported housing (3% vs 4%).

The Commissioning Support Pack provides data on a range of wider vulnerabilities for children aged under 18 in treatment. Again, numbers are small, so readers are urged to exercise caution in using the data for service planning reasons. Walsall children in treatment are more likely to be involved in self-harm (24% vs 16% nationally), be affected by domestic abuse (21% vs 15%) or by others' substance misuse (17% vs 14%) but less likely to be a child in need (6% vs 9%).

7.2.5 Young people's treatment outcomes

A total of 63 children under 18 successfully completed treatment in Walsall during 2020 with no-one re-presenting to services within 6 months – this compares with a similar national non re-presentation rate of 96%.

7.2.6 Transitions to adult service

The transitions service supports older young people between 17.5 to 25 years old. This is important as it's a particularly vulnerable age group and other services such as social care, youth justice and mental health may change quite radically once someone turns 18. The transitions worker noted a caseload of between 25-35 individuals with the main substances being cannabis, cocaine and alcohol. A particular spike in cocaine use, for this age group, was noted as well as the prevalence of county lines, grooming and exploitation in the area. We interviewed one particularly vulnerable young person, working with the transition service who reported that his worker calls him every single day and she is instrumental in his well-being and managing his vulnerability. For example, she ensures he has got home safely each day as he has experience of being cuckooed in the past.

7.2.7 Hidden Harm service

The hidden harm worker can work with children as young as 5 up to 18. This is for children whose parents are using substances and may or may not be in treatment. This is important given that people entering treatment in Walsall were more likely (21% vs 18%)[34] than the national average to be parents living with children[35]. However there is currently only one hidden harm worker which does not leave any scope for absence due to sickness or otherwise. Her caseload was said to be manageable between 20-25 but the demand for her services is greater and there is often a waiting list. A group work intervention has been piloted as a way of seeing multiple children at once, in one school and was said to be positive. The hidden harm worker also trains professionals across education settings across Walsall.

34 Please note: this data refers to 2019/20. Public Health England Parents with problem alcohol and drug use: Data for England and Walsall, 2019 to 2020

35 NB this service is not just for children with parents in treatment.

There was a recommendation, therefore, to expand the hidden harm function to include a dedicated worker to promote the service across schools and safeguarding leads as well as deliver training. This would free up time for the other team member to concentrate on casework and attending child in need meetings. The hidden harm service received favourable review from schools, safeguarding leads and young people.

'I like the activities that we do. The time lapses between appointments. Work is reviewed every 2-3 months. I feel listened to, I feel like my feelings matter. I feel that I can talk about anything, and I think being able to talk about anything with a trained person that my thoughts and feelings are in the right hands. I feel that the Beacon should be promoting the service more as some children are ashamed to talk about their parents. But when my worker was off sick there was no one else from beacon that could support me' (Hidden Harm Client, age 16[36])

'She made sure I was alright, and everything was alright at home for me' (Hidden Harm Client, age 6[37])

One professional reflected on the benefits of this service being provided by an external organisation. She commented that the children have directed and dedicated time with the hidden harm worker unlike school staff support where they may get disturbed because of being on call or a parent arriving. She stated the children feel understood by the hidden harm worker, she is able to provide knowledge, facts and challenge myths. In addition, the children come to understand they are not the only family in the school with a parent that has or is involved with drug or alcohol misuse, begin to have a better understanding of why the parent may behave the way they are helping build relationships at home.

There was a recommendation to have a specific space for families and young people, rather than using the Station Street venue. This would be a dedicated therapeutic space and would also be able to offer groupwork activities. At present, families or parents who need to be prescribed take their children to Bradford Street and reception staff reported they sometimes have to 'entertain' client's children with colouring activities. Although Station Street is more therapeutic and recovery focused, no clinical activities take place there.

It was also noted that there is scope to improve knowledge of what CGL's young person service can offer. There was some concern noted by CGL staff that there is a misconception that they only offer support to young people using at a high level, but they can also offer prevention and early intervention work.

36 NB. this feedback was collated by the hidden harm worker for the needs assessment

37 ibid

> 'We do work with people, and young people where they've got quite serious substance issues, but then I'd say like, quite a large percentage of the work we do is around like education and doing like more brief interventions as well and offering kind of, you know, that more preventative work, to, to stop it from becoming more of an issue. And I think a lot of people don't realise that I think maybe there's a bit of a misunderstanding of what we offer. We're starting to put on regular training for professionals. And part of that is going to be like giving an overview of what the service is' (CGL staff member)

There was previously a peer mentoring scheme running, offering young people support from other young people which was said to be resumed shortly.

7.3 Family Support Offer

The mainstream service across Station Street and Bradford Street includes specialist, dedicated workers for pregnant clients as well as 'family workers'. There is a specific family safeguarding service, where CGL staff have been seconded into children's social care. In addition there is the Family Drug and Alcohol Court (FDAC) model in place in Walsall, with FDAC staff currently based in Station Street. Overall it was felt that families who are experiencing substance misuse are well catered for, but families of those who are using have less support available.

7.3.1 Family Drug and Alcohol Court

FDAC launched in April 2020 and has been affected by challenges in high staff turnover within the local authority and the limitations placed on the team by the pandemic. The service reported they are currently receiving a lower level of referrals than anticipated. The team has been doing work around this, but one potential barrier has been the focus on domestic abuse and neglect, by children's social care, without further enquiry into whether substance misuse is fuelling this. The FDAC service is a collaboration with three local authorities, with Walsall leading the programme. Families are referred to the programme by children's services usually once proceedings have commenced. However, CGL put in an addendum to their contract which now allows them to work with families pre-proceedings before '*the clock starts ticking'*. This was in recognition of the level of complexities families will present with.

> 'What our thought process was, is if we could capture the pre proceedings, we could have that relationship building times as an additional potential 12 weeks, we could do the assessment, we could do the plan, we can start help try and stabilise them around the substance misuse to be in a place if care proceedings are issued, that they're then able to have more capacity for that reflective learning and space for change' (FDAC staff member)

For those families that sign up for FDAC, after assessment, a 'trial for change' period commences, which lasts approximately 18 weeks. This period is described as *'the parents' best opportunity to demonstrate that they can make the changes in the timeframe'.* During this period the parents will be offered multiple weekly appointments, both bespoke FDAC group work and one to one sessions. They also have fortnightly reviews where they can speak directly with the Judge, without lawyers present, creating a consistent, on-going relationship instead of the Judge '*reading about the case off a bit of paper'.*

> 'I think the fact that it is the parents' best opportunity to demonstrate change, because we're able to actually evidence, how they've dealt with situations in the community. What is it that we've actually done? So we're not doing a parenting assessment, making recommendations and that's it…they're getting the support package alongside it, because even though the focus is always on the child, the well being of the child, FDAC is about how can we help the parent overcome their issues in order to provide them' (FDAC staff member)

The service did report some challenges in accessing information from hospitals and mental health treatment providers as well as the multiple housing providers that operate in Walsall. However, the 'no wrong door' pathway was said to have helped refer and signpost parents into a range of other services. The fact FDAC is also part of CGL's wider service and is positioned at Station Street, is positive. If the child is taken into proceedings, there are 'family workers' who can continue to support the high-risk parent if needed. There was also an example during fieldwork where a psychiatrist appointment for an FDAC client was observed. Having access to an 'in-house' consultant addiction psychiatrist was said to be highly beneficial.

Parents have fed back to FDAC that they would like a group for people going through care proceedings. This would centre around the thoughts, feelings, and experiences of going through this process and cover content such as how to safely end contact with children.

7.3.2 Family safeguarding model

The family safeguarding model operates across the four areas of Walsall's children's services. Within each area, there are four adult workers:

- Mental health
- Substance misuse
- Domestic violence – victims
- Domestic abuse - perpetrators

Each of these professionals are seconded into social care from specialist agencies. The team can get referrals from the first point of assessment by social care (compared to FDAC which is when proceedings have or are likely to be issued). In the current model, the service is for anyone with a child under 13. Families can access the prescribing provision and groups offered by 'The

Beacon', but their keyworker will be from the family safeguarding team and will provide them with 1-1 sessions. Families on this caseload benefit from the worker having a much lower number of clients (e.g. 12 active), relative to the main CGL service. For example, the family safeguarding team maintained the provision of home visits throughout the pandemic. This was rewarding not only for the client but also the staff.

> 'When this job role was advertised, it was advertised as being person centred, having a restorative approach. You know, the fact that I can see people weekly because I carry a smaller caseload. Which means you can do some work, you can have some impact. When somebody's coming into a service once a month and they probably don't want to be there anyway, and you know, they've already they're already saying, you'll have to be quick, I gotta go. And then you've got to do all the data collection…with that you're never going to engage them in any meaningful support, because they're going to, they're going to already be thinking, why am I going there just to be nagged at.' (Family Safeguarding team member)

The makeup of the multidisciplinary team also means that the drug and alcohol workers, within the family safeguarding model can really focus on substance misuse, rather than having to also do other tasks. This was also noted by many staff in the main team, who reflected that they often have to deal with mental health, social care or housing, which distracts from the core substance misuse work.

> 'Sometimes it's a bit too much for us, as workers, we try to do housing, we try and do mental health or try and sort GP appointments. And sometimes we don't get to deal with the stuff that we should be dealing with. Because we try to do everything else, because those supports aren't there' (CGL staff member)

The family safeguarding team however has not only a mental health professional but also a psychologist and assistant psychologist. The secondment model has allowed social care to gain a better understanding of substance misuse. A number of workers in the main CGL service noted cases of 'repeat removals' and a gap in care and support for families affected by this.

> 'We have a lot of pregnancies in Walsall, where mums have kind of repeat, you know, they have repeat pregnancies, repeat workers, repeat removals for children, you know, maybe up to six or seven pregnancies. And this, there's definitely a missing link there. Because once they become pregnant, they'll come in access treatment. And then it will often be the case that baby's then removed. And then they go back to sex working and then a year down the line they present again, and they're pregnant again. And I think there's a bit of a missing link there. And I've always thought in terms of sexual health as well, and the kind of health

interventions for them. Because it's quite difficult, really, because then when you speak to them, they'll often say that they want to have contraception, but then they don't always engage past the point of having babies. So it's really, really difficult. Yeah, I think more or less, we need more, we need to do more with that group, to try and engage them' (CGL staff member)

There was some debate about the importance of the family support offer being linked to, but independent from, the local authority because of issues about people being honest about their substance misuse for fear of their children being removed. This seems like a critical component in the continuation of this offer but also has a bearing on creating a space, within the main provision, where people can speak openly and honestly about their issues, before social service intervention.

'Parents are often concerned that a referral to drug and alcohol services results in social services involvement, this could be managed better so more people could seek help without feeling judged.' (CGL staff member, Survey)

'I know that The Beacon have to report things to social services. So it was very difficult. I was in a catch 22. Because if I was completely honest about how much I was drinking, I know they would have took the kids off me sooner. So I wasn't, I wasn't often honest, I downplayed a lot of things to my key worker, which obviously, then they couldn't help me, or give as much support maybe as what I needed. Because I knew I had to lower the amount because they'd take the children off me sooner.' (FDAC Service User)

7.4 Criminal Justice Team

The criminal justice team focuses on supporting clients who have been mandated to attend substance misuse support by the court or recommended to attend by probation. They are responsible for delivering specific groups such as the alcohol treatment requirement (ATR) and drug rehabilitation requirements (DRR) as well as undertaking one to one work. Cranstoun is the provider in four custody blocks across the West Midlands.

Last year they voluntarily assessed 210 Walsall residents which is approximately 6% of their overall assessment figure. From this, Cranstoun reported they made 88 referrals to 'The Beacon' in the period April 2021- March 2022. In this same period, of the 210 people assessed, 10 'offenders' were already in treatment and 78 did not want an onward referral to treatment. They noted Walsall made up a total of 8.5% ATR suitability assessments and 5.6% of DRR suitability assessments.

However, Cranstoun noted they miss a number of people despite being in custody and a new pilot where workers are based in Wolverhampton magistrates court, has been effective in enhancing the use of ATRs and DRRs. The criminal justice team received very favourable review from criminal justice partners, such as Cranstoun, who stated the relationship with CGL was robust and enabled client centred work to be undertaken effectively with a high level of continuity of care.

> 'I have to say The Beacon is one of the best treatment teams in the West Midlands. They do have a super specific criminal justice team, which I think has been, you can definitely see the difference rather than it being just in the generic pool. So in terms of the DRRS and ATRs they can offer one to one appointments, and they've also got groups available. The provision I think, is a lot better than what it was a couple of years ago. I have to say in terms of feedback and discussing clients, they are really good. Since they have got the criminal justice team, they're very responsive. And we can pick up the phone and say, look, we're really concerned about this person, is there any way you can prioritise them? And they do. I'd like to replicate the process for The Beacon into other areas, I think it would work a lot better.' (External Stakeholder)

> 'If somebody is tested in custody, and we're not there, so let's say they are tested at 10 o'clock at night, then released from custody at seven in the morning. So we have kind of missed that timeframe. The police will book them an out of hours appointment so we have a day in each treatment team across the West Midlands where we will then see the client in their residence, in the treatment team wherever they live. So The Beacon have been really good in terms of coordinating that. So if we see somebody for an out of hours, and they do want treatment, we can get an appointment off them for the next appointment, so they can leave with it. While some treatment teams won't provide that, it's just right, we'll send you a 14 day letter when you make contact, which is just very disjointed. And it's not the best service' (External Stakeholder)

There are also different treatment providers in the prisons that have Walsall residents in them. Despite this and, as noted previously, Walsall has been significantly more successful than average in providing continuity of drug treatment for people released from prison, engaging 52.5% into structured treatment people compared to a national average of 38.1%.[38]

The number of clients being released with 'no fixed abode' from prison and police custody was raised as a challenge despite the existence of the 'rapid rehousing navigators' within the local authority provision.

38 Office for Health Improvement & Disparities (2020/21) Public Health Outcomes Framework Indicator C 20.

'I think across the board, housing is an ongoing issue for every area. But I do have to say in my experience of working within these roles and treatment teams. I think the Black Country are very poor. In terms of rough sleeping, homelessness, emergency accommodation. It's usually just a case of signposting, the person is usually signposted to Birmingham, because there isn't anything locally. it just feels very unmanaged, just to signpost, somebody, rather than either trying and get an appointment before that person leaves custody, or at least you've made a specific referral and you can tell somebody what the process is and what to expect. Whereas at the moment, it's just, attend on the day and potluck, that's how it feels. So I know from our point of view, we find that very frustrating. And especially with the vulnerabilities on top of drug and alcohol that comes with homelessness and rough sleeping, and then people get lost very quickly as well' (External Stakeholder)

'Good relationship with the housing team and link up with the housing support workers. Needs improvement though - service users being housed into hostels outside of their local areas. Not all hostels are regulated and leave vulnerable people open to abuse and exploitation.' (CGL staff member, Survey)

Overall the feedback from the justice team, about the links with relevant partner agencies was positive.

However, one recommendation centred around the need for more homogeneity in the assessment processes to reduce duplication. Another way around this would be to establish information sharing agreements that would allow CGL to take data straight from other provider's assessments, or use a shared system. This was hypothesised to offer benefits to staff as well as service users.

'If we could legally just take the information they've got from Cranston and then input the data on them up and be like, can I just offer and cross reference double check this and this and that and ask you about this? Yes. And that's perfect. And if they're happy to continue with that being the assessment, and then we could save a lot of time, save them a headache, because I mean, we work with clients that are chaotic at best, and their heads are all muddled, and they're struggling, especially if they've come out of prison, and they've got like 1000 and one interviews and things to go to, and we've got sort of Universal Credit, they've got to go to probation to go do this. How do we lessen the work that they have to put in because these people tend to not be in work, and they don't like work and this is like work for them. Hence why sometimes people just don't show up. Yeah, maybe they want the help, but they don't want the hassle of just sitting down again, and going through the assessment' (CGL staff member)

As part of the needs assessment, TONIC qualitatively explored prison releases and continuity of care. There is a dedicated staff member responsible for prison liaison, ensuring people's treatment and recovery journey continues on release from prison, back into Walsall. This is said to be most effective when she is able to do inreach to prisons prior to someone being released. This was affected by the pandemic but has now been reinstated.

> 'Quite a few of the girls that had previously when they come out, they'd be like, you know, you're the only person that came to visit me. And it sort of helps build that relationship as well, when they come out. And they sort of learn to trust you a bit more' (CGL staff member)

This is dependent on the prison getting in touch with CGL with notification about a release, to enable adequate planning. A number of service users will go to HMP Birmingham on short, revolving sentences which is often challenging but the service reported this was dealt with effectively, with the team in HMP Birmingham calling CGL to check what prescription someone has been on in the community. There have been some recent progressions in prisons prescribing Buvidal, if someone has started this in the community. A representative from the Office of the Police and Crime Commissioner (OPCC) also commented on the value of being able to start someone on Buvidal pre-release to reduce the need for an urgent prescribing appointment on release. Issues around funding were raised as a barrier to this.

> 'If someone was in their last week or last two weeks of prison, they were initiated onto Buvidal, it gives them that bit more time when they come into the community. So there's not that urgent need for the first day they come out to get on a script and it gives them a bit more breathing room. So the issue that people wanting treatment often find is that when they come out of prison, they obviously need to get a script straightaway. Or else you've lost them. And they go back to the illegal supplier, so there's generally issues getting that script, and if they miss an appointment, they don't get it. If they have used drugs, there might be issues so that's a real crucial point. So if you could provide someone with Buvidal help before they leave prison, and give them a bit of breathing room in that first two weeks to not have to get a script immediately. Then it gives them time to sort everything else out' (External Stakeholder)

There was feedback from the CGL criminal justice team, that for people being released from prison after serving a long sentence, more could be done to support this person prior to release, as it can be overwhelming with a lot of appointments to attend. Where possible the stabilisation worker within the criminal justice team at CGL will see someone jointly with probation to minimise appointments and enhance joint working. To facilitate this, she is based at Bloxwich Police station once a week. Probation stated they do no 'in house' substance misuse work and refer this to CGL. A further recommendation was to have a service that could offer gate pickups to take prison

leavers to their appointments. This may be able to be fulfilled by West Midlands Mentoring service which works with people across the region's prisons, whilst people are in custody, through the gate and between 6-9 months on release. The intention of this provision is to bridge the gap between people referred for drug treatment while in custody and the numbers that continue to engage on release. The mentors can also support people around accessing other services and offer aftercare and step-down support once treatment has ended.

It is also relevant to note that Cranstoun hold the contract to deliver 'DIVERT' which is for individuals (young people and adults) found in possession of any illicit substance, however, it is not available to those suspected of intending to supply an illicit substance. It allows drug users to receive a non-criminal sanction (Community Resolution), rather than a more traditional outcome such as a cannabis warning or arrest and subsequent prosecution. This is a non-statutory, out of court disposal for officers to utilise and does not lead to a criminal record. Repeated engagement with a programme is sometimes required to change behaviour and therefore multiple Community Resolutions will be possible for 'simple possession of drugs' offences, provided the individual engages with the programme after each referral. It is not a deferred prosecution model – the individual does not need to abide by the conditions that have been set by the police in order to avoid prosecution for the offence. However, if they choose not to engage in the programme at all after their first offence, they will not be offered the opportunity to attend DIVERT again.

The OPCC are clear that, wherever possible, Cranstoun and CGL should work together for onward referrals after DIVERT is completed.

7.5 Prescribing and clinical provision

We interviewed a number of individuals who were receiving clinical support from Bradford Street. Overall the service received positive review.

'I don't think you could do any more to help people to be honest. I often never have any problems or issues coming in, ever' (Service User, Bradford Street).

'I'm just glad that the services is here because we'd be a mess if they weren't' (Service User, Bradford Street)

A number of service users described it was sometimes challenging, however, to see people in active addiction, when collecting a prescription.

> 'You see active users coming in for the needle exchange. And they are rude, and they are aggressive. And yeah, we all get it. But it also, as an addict, it makes your tastebuds tingle, you know, you start salivating' (CGL Service User, Bradford Street)

Staff reported that the policy at CGL is to offer Buprenorphine, as an Esprinor prescription, as a first port of call and is advocated over and above methadone, unless the pain clinic and GP confirms that Buprenorphine would not be appropriate. Despite this, the majority of service users (approximately 75%) are prescribed methadone. This was said to present a difficulty for the service as they may be more likely to 'fall off script' because of the association with 'using on top' and service users were open about this during interviews. There were discussions as to whether this should be challenged more, but this also presents a conundrum if the service user is at risk of disengaging as a result.

> 'Only if we think that someone should not or cannot have buprenorphine, then methadone should come in. Because we're always dealing with this high risk of overdose on methadone. Every time someone falls off script, we have to go through the whole process of re-titrating them very slowly. And during those six to seven days, when they are titrating from 30, back to 60. They're always using on top as well, because I know that the 30 is not going to hold them' (CGL staff member)

A further, albeit infrequent challenge, is when someone has been in police custody and been off their prescription and illicit opiates for a number of days. Service users cannot be prescribed on release and presentation to CGL if there are no opiates in their system. For a small number of service users this means they go and use illicitly, only to present back at service for their prescription to restart.

> 'It's all about continuity of care. Because somebody has been arrested, you're actually putting them in more of a vulnerable situation, potentially, potentially, to overdose. And to get the money to buy illicit substances. And so just because somebody is in custody, doesn't mean they use illicitly, they could be very stable on their medication, and then it just completely interrupts everything they've done. And that is that is a massive frustration from the people that we've seen custody' (External Stakeholder)

We did not receive quantitative data on the time it takes to start someone on a prescription. When asked about the speed of starts and restarts, CGL staff reported they were satisfied with this and the joint working between the clinical and administration team but this was also largely dependent on the speed information came back from GPs. A number of service users we spoke to at Bradford Street cited wait times of approximately 2 weeks.

> 'We can request direct to the GP a copy of the summary care record, which would tell us what is being prescribed. But again, depending on the GP surgery will depend on how quickly that information comes back. We try and get somebody prescribed, or at least initiated, because obviously, then that reduces their risk to have to go and use illegal substances. So it's quite time precious for us and I don't think again GPs necessarily understand that it's those time pressures that are quite important. Some do very good and get back to us, sometimes we get it and sometimes you have to chase.' (CGL Staff Member)

Restarts were said to be generally quite quick although it was recommended there could be a dedicated individual or team just for restarts because of the frequent nature of them and the urgency they present with. One survey respondent commented on the need for more non-medical prescribers (NMPs).

> 'Prescribing Services are generally quite good. We could do with more NMPs support, as it can be quite difficult to get time with a medic [...] further, these med reviews are booked up for three months nearly, meaning if you need an urgent med review rebooking, this is quite difficult. This leads to medics rushing through docs, making more mistakes and missing px change emails, etc.' (CGL staff member, Survey)

A further service user, at Bradford Street, put forward the idea of an 'emergency' prescribing team for those at high risk. However, across professionals there was some debate about this group who regularly fall off script. CGL staff discussed the challenge in finding the balance between restarting someone promptly and the risk of them becoming over reliant on this service and regularly using over the weekend.

> 'I think we do restart people too quickly. Because obviously, if it was the first time they've fallen off script you have that discussion and we work with them around that. But if you've got somebody that is constantly falling off script, I think as a service, we're pressured to get people back on script. So it's like, we want it more than they do. And I think that's a bit of a thing. It's like, you've got to get them back on script, you've got to keep them safe. But actually, are we keeping them safe? You know, it's like, we're forcing them to come in and not forcing them. But it's like, you've got to come in, you've got to do we do lots of chasing, whereas the client isn't showing motivation. And I think that's where the balance isn't there is sometimes to say we want it more than they do' (CGL staff member)

One staff member reflected on changes to practice that took place during COVID where prescriptions were taken to pharmacies for service users to collect and an assessment was done

over the phone. This was said to reduce the attrition and non-attendance rates for appointments and enabled pharmacists to have regular, sometimes daily contact with service users. Pharmacists offer a good opportunity for safety and well-being checks and therefore should be upskilled and encouraged to monitor for changes in presentations.

> 'A lot of our clients, the pharmacists know them, because they've been going there for a long time. So quite often it's a pharmacist will phone me and say, I'm quite concerned how they're presenting. They know that they're looking unkempt, they're not very well, and that sort of thing. So it's, it's the fact that somebody's having eyes on rather than nobody at all. Obviously, you get pharmacists that don't really do anything, just give them meds and whatever. But a lot of them that are doing it do feedback' (CGL staff member)

However, now the pandemic and associated restrictions have eased, the 'old' system has returned.

> 'I was disappointed that we went back to the old way. I mean, it was, we've got to offer appointments, the day after release, now from prison. Some are coming, some aren't. Or they won't come for the time of their appointment. They'll just come and collect the script. So you only get to do the really basic stuff with them because they're turned up last minute. It's just scripts, doing harm min and stuff, making sure they've got Naloxone, whereas I personally feel a pharmacy seeing somebody every day and they're taking their meds. It is better than them just not coming at all' (CGL staff member)

Although rare, young people who are prescribed still have to go to Bradford Street, but they will be accompanied by their worker from Station Street to mitigate risk around this.

Buvidal offers a new and promising opportunity for those more 'serious' about recovery and who do not want daily or weekly pick up. TONIC sat in on a Buvidal appointment and talked to service users about their experiences of this, which was reviewed favourably.

> 'We have the injection for over a year now people have had a fantastic experience with it, lives have changed, and you know we can shift you on to the injection and that's it, you're done' (CGL staff member)

However, at present this is operating as a trial with 20 service users, prioritising the most complex should they be suitable.

The number of people using the needle exchange service has fallen by 55% (from 499 to 226) between 2019/20 and 2021/22, with the number of new clients falling even more (by 68% from 185 to 60). The service described this was due to the use of postal needle exchange. However, while the reduction in the number of visits (down by 68%) might be partially explained by the pandemic, this cannot account for the huge drop in the number of needles supplied which has fallen by 73% (from 84,996 to 23,088).

There was some qualitative feedback about the reputation of Bradford Street and the fact that needle exchange is being accessed elsewhere at pharmacies where service users are not being encouraged to access treatment alongside harm minimisation. This also related to feedback from staff *and* service users that the Bradford Street building is not 'fit for purpose' and may deter people from accessing the clinical offer there. There is a currently an application for a new building. However, one professional respondent on the needs assessment survey also commented on the over reliance on pharmacies to deliver needle exchanges as they are busy and understaffed.

It was suggested that it may be beneficial to introduce more outreach roles such as a harm reduction officer within pharmacies to support them. Naloxone provision was said to have good coverage across pharmacies, and this was especially important as they operate outside of core service hours.

Year	Clients	New Clients	Visits	Needles provided
2019/20	499	185	1749	84,996
2020/21	215	58	556	34,787
2021/22	226	60	561	23,088

Figure 19: Needle Exchange Data from 2019/20 to 2021/22

7.6 Psychosocial Interventions

The psychosocial offer from CGL takes place at Station Street. As part of the needs assessment a number of groups were attended and observed, conducting focus groups at the end of the session. Service users discussed how important it was to be with like-minded people and hear other people's stories. They reported it helped them feel less isolated and provided a source of hope as well as reassurance that others have problems too.

> 'I feel positive after I leave here'
>
> 'I look forward to coming on a Monday, I get all excited'
>
> 'I really enjoy coming here'
>
> 'It's so nice to watch individuals' progress'
>
> 'I am always learning something new' (Service users focus group)

From the outside the building is uninviting and appears somewhat derelict although inside is welcoming and open.

There are a good array of psychosocial groups available although, it was reported that some 'non opiate' users may benefit from something more specific as well as the offer of 1-1 sessions.

This was especially noted in the case of cannabis users who will be offered non-specific groupwork support but may be experiencing high levels of anxiety and paranoia as a result of their drug use. However there was recognition that attending groups may support people entering mutual aid and fellowship work to continue recovery, should this be appropriate.

> 'I feel like the groups are paramount to this service. And they do a lot more than what you can do in one to one. So I think the only issue is, obviously there's people with anxiety don't want to go to groups, trying to motivate them to get into it. And I think, from what I do in my groups, from what I've seen other people do in group, some of the feedback I get from people in groups, it's that they get more information, they get shared experiences. It's something we're definitely doing right, in my opinion' (CGL staff member)

It was noted that there is a lack of groupwork provision for those who do not speak English as a first language.

The data from CGL on ethnicity suggests those who are non-White British are within a very small percentage accessing the service, and this may be because there is not a service specific offer for them. Anecdotally staff and stakeholders indicated the Eastern European community have a high rate of drug and alcohol use.

> 'I think we could do more to engage people that don't speak English as a first language. I really do. Because such a massive part of the service, we offer here is through groups. And it can be really difficult for people to access those groups if they don't speak English as a first language. So we've got big polish speaking community here in Walsall. So we've got a lot of Polish service users. So I think there's, I think we could do more.' (CGL staff member)

There was a desire, from service users for more structured activities that do not centre solely around recovery e.g. art, music, walks, book club, day trips.

This was discussed, too, by CGL staff who stated that this would be much more feasible if groupwork facilitators did not have to also carry their own caseload. As the volunteer provision is expanded this may offer an opportunity to explore this further. Some of this can also be provided by other agencies such as The Glebe, who have a dedicated activities coordinator. However this service is for rough sleepers, homeless, insecurely housed drug users, or alcohol users and therefore may not necessarily be appropriate for those who are securely housed and further along in their recovery journey.

One staff member recommended a peer-led veterans group. Further, there was some discussion about the possibility, with the new building, to offer more integration between the clinical and psychosocial offers from the service.

At present, those accessing the clinical component, rarely access group-work and whilst there is certainly merit in separating people who are at different parts of their recovery journey, having more integration also makes recovery more 'visible' for those only accessing clinical support. This was articulated by one service user who is an entrenched alcohol, opiate and crack user. When asked if there was anything that could be done to help her stop using she said *'there's nothing for me. I've lost everything by becoming an addict so if I stop being an addict, I'm going to have no one'.* This highlighted the lack of connection she felt outside of the 'using' community and the need to offer alternatives for people like her who want to make changes but risk being even more isolated if they do. A further service user, who identified himself as a crack user, also alluded to the need to have something beyond his one-to-one appointments at Bradford Street, by way of social prescribing, to fill his time better.

> 'I have a fantastic worker, I've had her for a long time now. We've got a really, really good friendship. And she is brilliant but the thing is, with crack they're hard to get off and I just

> wish there was an outlet to go to the gym or something like that, keep my mind occupied. You know, rather than sitting in there and twiddling my thumbs. I want to do a bit more than see a worker and go home.' (CGL Service User, Bradford Street)

A small number of staff offered suggestions about whether Station Street be more of a 'hub'. For example, building on The Glebe model who have someone there once a week from DWP. This was also relevant in light of feedback from one service user who mentioned the need for support around debt and the unanimous feedback from staff and service users about the challenges associated with housing. This would also fit with feedback from staff who struggle to contact or access professionals from these agencies. Having them 'on site' regularly could support this.

There was also a strong desire, from staff and service users, for more 'in-depth' 1-1 sessions as part of the psychosocial offer. This would only be achievable if caseloads are reduced, allowing caseworkers to undertake more motivational interviewing and psychosocial work or a specific role for this was created (e.g. a counselling or psychology offer).

> 'I think the gap is around the psychology element. So for those a) it's about reducing caseload. So actually, our staff have more quality time, one to one time with service users that they can, you know, use their you know, they are trained in kind of brief solution focused therapy, motivational interviewing all of those recognised psychosocial interventions, do they get time to use it? Probably not. Because they're in crisis management quite a lot of the time.' (CGL staff member)

As has been noted earlier in the report, caseloads were said to be chronically high and there was a perceived overemphasis and focus on data collection, to the detriment of client facing work. Alongside this the service, especially Bradford Street, are also highly risk averse and have to chase clients who are not engaging but are known to be high risk. This affects the time and nature of the care given to each client. This was discussed by staff and service users alike, reflecting on a perceived reduction in giving a person-centred approach, despite a desire and willingness from staff. A number of staff described feeling like they just 'collect data' and tick boxes, which detracts from therapeutic work.

> 'I think the speed at which people can get support is great in Walsall. People come, they asked for support, they ask us about scripting and things like that. And as long as it's safe, it's got really quickly, which, for me, is positive, it actually captures people's recovery. I think where there is an energy to get people through treatments in Walsall, which is a positive thing. But I think it gets stalled in lots of ways by the energy, the emphasis on paperwork, and all that sort of stuff. And I think that's what I find, for me as a worker, and as a manager is that it's that sort of stuff that people that workers and staff get bogged down by, and the

bit they struggle to do rather than can't, is the therapeutic stuff… the pressure of all this stuff is kind of debilitating.' (CGL staff member)

This approach was also reported to put lots of people off staying in the job, who wanted more time to work therapeutically with people on a 1-1 basis. This creates a staff churn and a lack of continuity of care for service users.

'It's not just about sitting down and answering questions. It's about enjoying life, or having someone to look up to like a big brother or a dad. I mean, and I feel like that's what people need is someone who's, who's there. And that's another issue that falls back on is that is the turnover of people. Some people like have had seven workers in the past six months. So how can they build a rapport or have someone showing that and if for some people that might be traumatic, because they might have had their dad walk out in their life, they might have had people walking out on them all the time? And then need someone who's stable, one person who's going to show that stability and say, Look, I'm always going to be here for you when you need me. Yeah, and I feel that we have the opportunity to provide that, or we can help' (CGL staff member)

'I think also swapping and changing, swapping and changing, I don't think that's any good. I think once you sit down with one person and start talking, you should stay with that same person. Because it's just a waste of time' (Service User, Bradford Street)

A number of staff discussed a specific desire and perceived need for dedicated therapy service for those who do not require secondary mental health care but do need something to address their trauma history. It was reported that the NHS talking therapies wait list is around 6 months at present.

'If we had a Psychologist on site that would be perfect. I know we did have one but yeah, another one would be good. But I know that we would need more than one, because there's so many people that need to be having counsellors. We need that one-to-one support. They need that one-to-one support. They need them extra counselling sessions. It'd be really fantastic service, if we could offer all of that and see, like, people probably in recovery and getting over things a lot quicker than keep relapsing, relapse and relapse because of old triggers.' (CGL staff member)

This fits with the finding from the data that a slightly larger proportion of local people entering drug treatment were identified as having a mental health need (66% compared to 63% nationally), these individuals were less likely to be already engaged with the community mental health team

or other mental health services – just 14% compared to 19% nationally. For people entering alcohol treatment who were identified as having a mental health need (68% compared to 64% nationally), these individuals were slightly less likely to be already engaged with the community mental health team or other mental health services – 14% compared to 16% nationally.

7.7 Detoxification and rehabilitation options

The West Midlands Framework (WMF) gives access to detoxification units across 14 local authorities across the country. Feedback from staff and stakeholders on this was mixed and there were discussions around the benefit of someone travelling far from home for this. It was reported that applications for detoxification (outside of CGL) were '*few and far between'* and where possible, detox was tried to be managed and supported in the community through ambulatory detoxes. Ambulatory detox received favourable review by those service users who had experienced it. However, one nurse did state that there were sometimes delays as blood work was done externally and if they were done in house it could expedite the assessment process. The exception to prioritising 'in-house detox' was if someone was at high risk of seizure. The limited budget on detox and rehabs was said to make it hard to know who and when to use the funding for.

> '…traditionally, we used to have a fair number of rehab applications, because then the budget used to be with the commissioners, every two weeks, our detox nurse would take the appropriate referrals or funding application. Now it's with us. So we have an alcohol MDT every week, and we have ambulatory detoxes, we try to detox as many people as possible ambulatory, in house. Because the moment you send someone to inpatient…we only have a little pot of money. So sometimes I will try to say okay, let's keep a little bit just in case a more seriously ill patient comes in, but it's very difficult to do that, because that means we are unknowingly stalling someone else.' (CGL staff member)

The WMF was said to support decision making around detox, education and upskilling practitioners about who may be suitable. However one detox inpatient provider said the framework diluted direct relationships between providers such as CGL and the detox units.

> 'Historically, we would focus on the highest risk, most dependence, generally alcohol service users that needed a detox that couldn't be detoxed in the community. And outside of that, the majority of service users wouldn't have known that detox was an option for them. And for me, that's part of the purpose of the framework is to support practitioners to educate and also promote that detox and stabilisation is an option for those service users. I think what's lacking, and that's been identified through the framework is that historically, because there wasn't a lot of funding, there's a lack of knowledge around who is suitable for detox

> and who is suitable for stabilisation and what aftercare look good aftercare looks like and that's part of what we're doing as a framework.' (External Stakeholder)

A number of staff responding to the survey also felt it added to the time and bureaucracy required to apply for detox.

> 'I made my first alcohol referral detox and it took 6 months from start to finish to be processed. Due to a number of reasons and hold ups. The place was a cancellation, so I was given 45 mins to confirm with the patient that they could go into rehab the next day. The WMF process was very repetitive, had to resend the same information a lot, and then when going in for detox they asked me for information I had already sent over a few times.' (CGL staff member, Survey)

> 'WMF paperwork is too long and repetitive, we need to have a seamless pathway not tons of paperwork. We need quick access.' (CGL staff member, Survey)

Those alcohol users who had had detox and were now attending groups at Station Street described the importance of this.

> 'It's marvellous they haven't just took us out of detox and then let us carry on, on our own coming here and talking, is making you feel much better than just being let out after detox and get on with it' (CGL Service User, Station Street)

It was reported there was a demand for residential rehab but, again, the money that is allocated for this was said to be used quite quickly and therefore community and residential rehab is not offered widely. Provider figures show that a total of just 16 people attended residential rehabilitation in the three-year period between 2019/20 and 2021/22. One service user, who was with the FDAC provision highlighted the need for rehab opportunities for people with children. She stated this should either be somewhere children could also go or be put in temporary foster care while she went.

> 'There should be some form of rehab or some sort of option for rehab for people with children. Because that's what really stopped me from accessing, I needed rehab a long time ago. I was never able to access it because I couldn't leave the children. But things had to get so bad that the children had to be removed before I managed to get the help I needed, which seems a bit of a backwards way of working' (FDAC Service User)

There was a specific section on the survey about rehabilitation. Responses touched on rehab being a lengthy process and also being extremely costly, thus not always being a viable option, although a desirable one in other aspects. It was also often noted on the survey that rehab is only available for higher risk clients and not for a long enough amount of time which could potentially lead to relapses, whereas rehab is not used for lower risk clients who it is more likely to be beneficial for as they are less likely to relapse following rehab/detox.

> 'Costs are too high and beds are limited to higher risk clients, when they are the most likely to relapse. Whereas lower risk clients who want rehab to help start the ball rolling for their recovery, will be more likely to succeed, but they are not eligible.' (CGL Staff Member, Survey)

> 'Residential rehab tends to only be offered to individuals with alcohol or heroin addiction, it needs to be more widely offered to addicts of other drugs. It can be a lengthy process as funding is required. When an individual attends detox it tends to be for 7 days which is not enough as this just addresses the withdrawal symptoms, it does not address the person's behaviour or thought processes towards their addiction, so it is highly likely they will return to using again following the end of a 7-day detox.' (CGL staff member, Survey)

> 'In my opinion, there should be much greater emphasis on rehab not only detox for people. I feel very sad when people ask for rehab but are declined for different reasons, commonly funding. Particularly if they have been in treatment for 10+ years and fall into revolving door client category.' (CGL staff member, Survey)

Further, discussions with staff and stakeholders centred around the need to improve the preparation for someone entering rehab (e.g. they should not, ideally go straight from chaotic use to rehab), thorough assessment of someone's position on the cycle of change, as well as ensuring there were significant aftercare services for people coming out of both rehab and detox, to ensure they continue to be supported in the community. As one detox provider noted *'our detoxes are only as good as the follow up*'. The best practice process was outlined by one staff member below.

> 'Before they get to the panel, they would do like an assessment and a piece of work with a key worker, where they'd really look at their set, why they want to go, how it will benefit them, how things will be different when they come out, make enough to care for them. And then yeah, it will go to a panel and the panel might advise that they do maybe more group work to prepare or get more of a robust aftercare plan, that kind of thing. And then the funding will be agreed' (CGL staff member)

One detox provider noted a need for greater consistency across detoxes for non-alcohol clients and the role of addiction psychiatrists in this.

> 'I think there does need to be a proper discussion about how detox beds are used for non-alcohol. Alcohol is fairly clear, there are NICE guidelines which talk about assessment tools which kind of steer people. There isn't that same consistency when you talk about readiness to change someone who's on 90mls of methadone and using every day, actually, I think that's a bit easier to work out about their readiness compared to someone who's drinking alcohol and they've had two detoxes before. I would raise the question of where addiction psychiatrists fit in …unfortunately, the numbers of addiction psychiatrists have dropped so significantly, that often they're not involved in things at all' (External Stakeholder)

At present, the hospital can offer a brief alcohol intervention with their own internally commissioned service and onward referrals would be made to 'The Beacon'. The hospital described they would ideally like new referrals to be triaged within 48 hours of the referral being made, but at present it could be 10-14 days before someone is assessed. However, CGL noted that they were not always aware of people being discharged from hospital following an alcohol detox. The hospital noted they would prefer people to be detoxed through CGL, and the hospital would largely only detox someone if they came in for a physical concern and also had an issue with alcohol, rather than someone coming into hospital *just* for a detox.

> 'So somebody might come out, we might find out, we might not find out. But then obviously, that that kind of detox is obviously wasted in hospital, because if we don't either continue that detox in the community and we've got the aftercare packaging, and then somebody will just started drinking again, and you've just got a group of people where that's that continual cycle really is in hospital' (CGL staff member)

Both CGL and the hospital noted this was actively something they were working on, improving the relationship and pathway between patients who had received a hospital detox and 'The Beacon'. The hospital nurses praised CGL keyworkers for knowing so much about their clients when they are in the hospital.

> 'We are working with the hospital quite closely, trying to get a pathway in place where we can continue alcohol detoxes, when the hospital's discharged patients, when their physical health is stable, but they're still undergoing an alcohol detox. And very often what happens is that the hospital might let us know someone who's been discharged. But the service user never attends our service. So it's for us to look at how can we continue at the top of the

medical, the clinical detox, for those patients in the community at the same time as engaging them in to psychosocial support' (CGL staff member)

'The key worker seems to know everything about their patients, or if they're in the hospital, the key workers normally tell us before our own hospital tells us that they're in' (External Stakeholder)

'We have [something] nurses in the hospital that we liaise with quite well. So what we're looking at, at the moment, is establishing a pathway with the clinical teams in the hospital, and our consultants hear and see if, depending on the criteria of the services that we could continue the detoxes in the community, do the assessment process alongside it, and then get services. Yeah, get patients in rather than not going back to drinking. So that we meet the physical needs first, and then we'll do the assessments and the psychosocial while they're undergoing that detox. That's the idea' (CGL staff member)

One staff member within the hospital noted they were trying to establish a pathway with 'The Beacon' whereby the detox can start in hospital but continue in the community, if suitable. However, it was felt that the criteria for this was quite restrictive as those with a mental health condition cannot be detoxed in the community and, instead, have to go to rehab. The hospital also noted a reluctance from some people to attend Bradford Street for their alcohol detox because of the number of drug users that are also at the building. Some patients from the hospital had fed back that they do not always want groupwork at Station Street and would value more one-to-one work as an alcohol client.

'Their criteria list is horrendous, it's pages and pages and pages long, yeah, it's quite some of it I find quite unrealistic so it says like no mental health issues. Isn't that over 40% of service users that have an addiction problem? So over 40% have mental health issues, don't they? So they're saying then 40% can't be detoxed in the community. They have to go to rehab. It seems their criteria is you've got to be a young healthy person with no comorbidities, which is unrealistic. If somebody's having a detox, they're going to come with some comorbidities or maybe they've done some damage to themselves physically or mentally along the way.' (External Stakeholder)

7.8 Aftercare, mutual-aid and step-down support

This part of the needs assessment considered what exists for people later in their recovery journey by way of after-care, step-down offers following structured treatment and mutual aid. It was noted that there are 12 step fellowship meetings in Walsall, but this is more catered for in larger cities such as Birmingham. There was said to be limited support for families, despite Families Anonymous running monthly in Walsall. It was also discussed, by staff and service users, that there is scope for more visible recovery such as a recovery community away from 'The Beacon'. This related to an earlier point on structured activities that are *not* based on triggers, urges, cravings but centre more on art, music, reading or physical exercise.

> 'Something that's a bit more like some community, community groups. Book community activities, for people in new recovery. Like, you know, just even like maybe like meeting something like going for coffee once a month, or going to for a walk around the park just meeting, like an organised walk or something like, so when you do like stop using and that you've suddenly got all this time and it's a bit lonely. It'd be nice' (CGL Service User, Station Street)

> 'It's almost like you become institutionalised, where you speak at group all the time and the group rules. And then in the real world, you're getting away from all of those people that you used to drink with or smoke while you were away from those people. And you've kind of socially got, so most about, like socially getting a bit of a network. But not in like a structured where oh this is your turn to talk. Actually just talking in a natural environment' (CGL Service User, Station Street)

CGL has a dedicated volunteer coordinator. At the time of the needs assessment, four volunteers were in post with 11 more going through DBS checks. CGL states they have created local, sustainable employment opportunities for Service Users with the Recovery Motivator role, supporting unemployed Walsall residents into paid employment. This has progressed into a more formal apprenticeship scheme with investment from OHID. Volunteers benefit from Level 2/3-accredited Peer Mentor training and offer a chance to tackle stigma around substance misuse.

Volunteers are able to support paid staff across a range of groups and activities and this was welcomed by the team and service users alike. Staff members reflected on the importance of having volunteers in service, to support them with tasks especially in relation to the increased paperwork paid employees need to complete.

Volunteers can offer 'recovery support' when people are further along in their recovery journey and support therapeutic activities such as 'coffee and connect'. Once someone has completed their treatment and leaves the service, they are offered fortnightly check in calls to see how they are progressing. Service users reported that they like having volunteers, and staff members, with

lived experience as it makes them more relatable and provides a source of hope, in the form of visible recovery.

> 'I just think that, sometimes you can go to these appointments, and you can talk to people, but they've never been an alcoholic. They've never been a drug addict. So when I first started one of my key workers, I was talking to them, and I just used to get really angry, because you don't know what it's like you've just learned about it? Like through qualifications, but you don't actually know what it feels like' (Service User, Station Street)

The training offered to volunteers was reported to be robust and there are opportunities for progression into paid posts, although there was some debate about whether this should be possible whilst someone was on a low-level prescription and what this means for their recovery and options for employment. Overall volunteering provides people with a way to 'give back' to the service and wider system. Two volunteers remarked on how the opportunity to have support from and then work for CGL had been 'life-changing'.

> 'As for the service I have received, it's been on point, it's been exceptional. And like I say it's been life changing' (CGL Volunteer)

> 'There is, obviously mutual aid. That continues. It's once a week, SMART recovery, NA, and AA. You can stay with us in something called recovery support, where you don't have to attend anything, but a whole timetable is open to yourself to attend. And you have a checking call once a month. Okay, so all the groups are still there. There's also foundations of growth, that's for people that have completed foundations of change. And abstinent and kind of really unstructured treatment, they do foundations of growth, if they would like to, and then yeah, do mutual aid, and then all the other Coffee and Connect. Yeah, just to peer mentoring, as well, if you're interested in supporting others, so you can still be kind of in treatment, or in your last little bits of treatment and support others to get out there that are coming through the door' (CGL staff member)

There was a specific question on the needs assessment survey which asked service users how *satisfied they were with the support they received to help prepare for leaving the service* - 5 survey respondents, answered in reference to CGL Bradford Street and Station Street, 3 survey users said they were very satisfied with the support they received in preparation for them leaving the service. There was 1 respondent who was very dissatisfied, and it should be noted that this was consistent feedback given by this particular service user over all areas of the survey. There were 2 responses to this question regarding leaving Detox, both of which were very satisfied. Overall, the support offered to service users as they prepare to leave the service appears to be good and service users appear to be happy with the level of support that they received.

7.9 Overarching findings regarding the treatment system

7.9.1 Partnership working

Overall, partnership working was found to be strong in Walsall. 'The Beacon' was well known as the 'go to' provider for drug and alcohol support locally and the external stakeholders we spoke to were very positive about the service. The relationship with GPs and joint care planning was said to be good in Walsall but the care that service users received from their GP was dependent on how understanding they were of addiction and recovery, creating a lack of consistency.

> 'Mental health is a key one, and we never seem to get anywhere. We never get engagement. It's a national issue, but it is a big issue. There are a number of really complex service-users at Walsall, that originally, if we identify mental health needs is to refer back to the GP. But we know our service-users are never going to present to a GP practice. Engagement with GPs is sporadic as well. So we have some that are very good, some that aren't so great. And it generally depends on their personal preference of whether they understand the needs of our service users' (CGL staff member)

Despite positive partnership working, the number of self-referrals to the service far outweighs referrals from other agencies. There was feedback around the need to work better with third sector organisations in the local area (rather than statutory agencies). CGL do have a 'bringing recovery into the community role' (BRIC) but this individual had been on long term sick leave. Unanimously mental health was said to be the one service difficult to permeate and joint work with. This was especially important because of the high prevalence of dual diagnosis clients. Staff consistently cited mental health as a particular need for the Walsall service, relative to other CGL services nearby. When asked why this was, the suggestion was that the Dudley service has a CPN located within their team and there are a number of bail hostels in the Walsall area, alongside entrenched deprivation.

> 'The big blockage in Walsall right now is the mental health behind if they're taking the drugs, if they're taking the alcohol, they always see that as well. If they're doing that they've got to get off of that before they actually get the mental health treatment. But why I keep banging my head against the wall is they don't realise that maybe they're taking the drugs, they're taking the alcohol because of the mental health to start off with. There is something there' (External Stakeholder)

> 'GPs and secondary mental health are very reluctant to help clients in our service, whether they are still using drugs or abstinent for many years. They are stigmatised. Clients are told that their mental health is purely down to their drug use, and can not receive help until they

have stopped using. This completely neglects the fact that mostly people are using drugs to mask some kind of mental health issue. Mental health are extremely difficult to get in contact with, no clear line of communication, can spend half a day trying to get through and then they are very reluctant to share information.' (CGL staff member, Survey)

The service was trying to recruit for a CPN at the time of the needs assessment to make an attempt to remedy this. Another option would be to second a member of CGL staff into the mental health team. Although there is a specialist addiction psychiatrist within CGL's provision, he currently cannot prescribe medication for general mental health diagnoses (e.g. antipsychotic or antidepressant medication). This is unlike the Dudley service, which was said to be a 'better model' as it doesn't have to go through the GP or local mental health service to start or adjust people's medications.

'It's very frustrating seeing a consultant psychiatrist and then going away without medication and saying, actually sitting in this chair, I can't give you this medication. They don't understand all that nitty gritty and payment, you know, as a patient is frustrating for them. And then if I refer them on to the Early Access service interval comparison, that's not even a psychiatrist role, let alone a consultant, who's going to go through everything again, and then decide whether a psychiatrist sees them or not. And then maybe prescribe or let the GP know that okay, they're not for us, give them this' (CGL staff member)

'If somebody presents to us, we shouldn't have to refer them back to the GP to access mental health care, you know, we should be able to do a direct referral in and that person to access whatever mental health provision they need, you know, we've got a clinical consultant within our service, we've got full nursing team, we've got clinicians, we've got prescribers. So we should be able to have that direct access for somebody to go and so we can then also support them to present it to mental health, whether that's crisis intervention, or kind of more therapy side or, you know, whichever element it might be. Then it would be a joint coordinated care really, between us and the mental health, so they will do our assessment, we've got our assessment and actually we'll work together' (CGL staff member)

The aforementioned model that is in place in Dudley, where the consultant psychiatrist can prescribe medication for mental health needs would also support this cohort more effectively.

However, there was an acknowledgement that what was needed, for a large number of service users was access to talking therapy, over and above any secondary mental health pathways. CGL also acknowledge that there is room for improvement with regards to adult and young people's mental health and hospital pathways after detoxification.

Of note, the survey asked respondents, who had lived experience of treatment to answer which services they had also relied on for support and which services they *needed* but did not get support from. Unsurprisingly mental health was rated as a much-needed support offer, although 62.5% felt they *had* support from this service. Notably 50% said they'd have liked counselling.

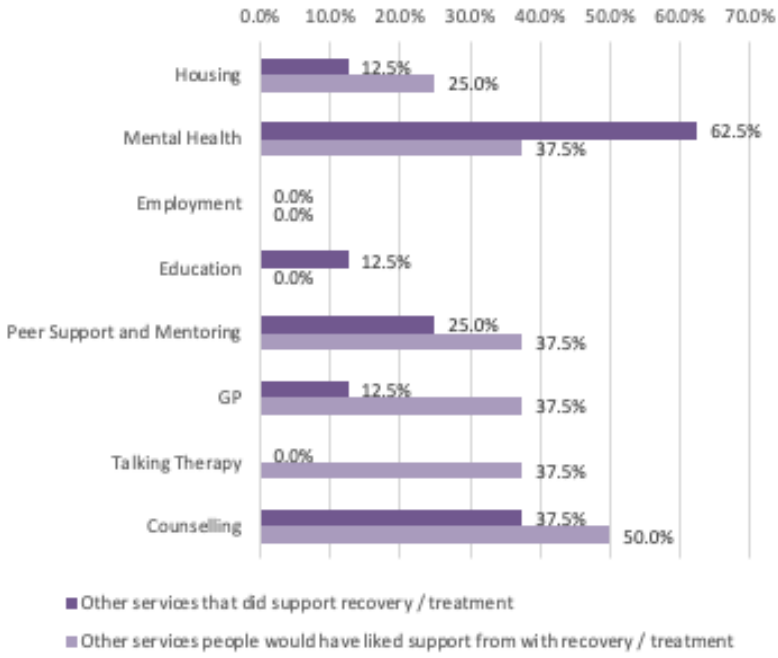


Figure 20: Feedback on support from other services

We also asked respondents to rate what other support exists for people in treatment, on the following needs. A number of people discussed the challenges and pressures of getting people into employment, especially those on universal credit and suggested a need for better ties with employment support agencies.

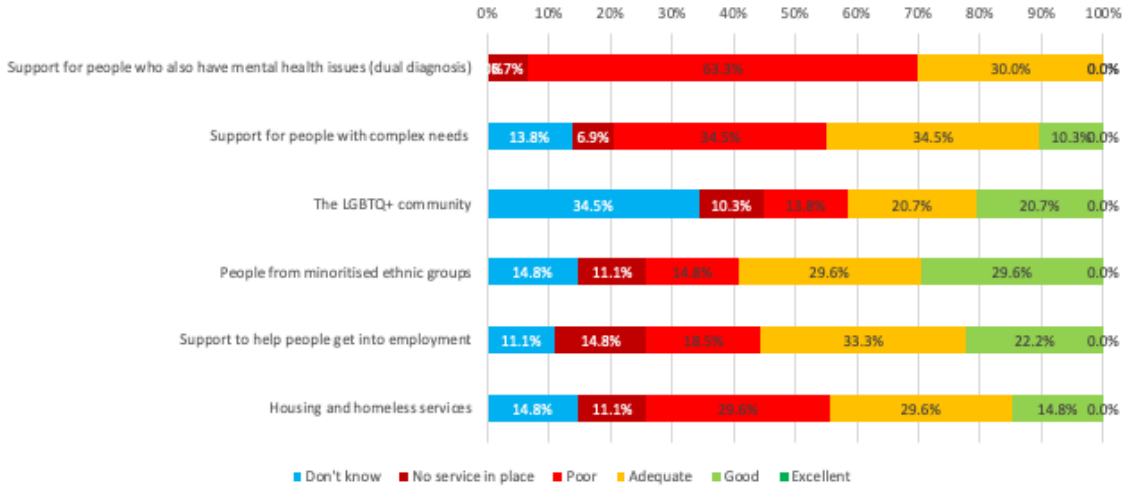


Figure 21: Ratings for support for different parts of the community

7.9.2 Unmet needs and missed groups

There was a consistent theme around the need for a dedicated drug and alcohol provision for sex workers.

Not least because Bradford Street is a 'hot spot' for this type of activity. There are relevant skill sets within CGL's service, with one complex case worker having experience of setting up and running an outreach provision for sex workers in Birmingham. Although there is a dedicated 'exploitation team' within the local authority, this was still noted as an avenue that could be explored by way of a specialised arm of the drug and alcohol service. Another red light area, Caldmore, was noted as having a lack of outreach or engagement despite it being an area associated with alcohol use. It was also said to be populated with an Eastern European community which also created barriers for support. Those on the survey also noted Travellers and the Asian community as being missed groups.

'Anyway, that's a well-known area, it sees the red light area of Walsall or one of the red light areas of Walsall, but there's an absolutely massive [number of] Eastern Europeans living in motor houses and multiple occupancy. So they come out into the streets late at night, and they're grouped into certain areas, and it's quite difficult. They're up there, they're drinking, using drugs and what have you. It's a very entrenched community. And I don't think that gets a lot of support or engagement' (CGL staff member)

'We could do with satellite services for Asian community, we are struggling to reach the Traveller community.' (CGL staff member, Survey)

'It would be good to have a Polish worker. We have quite a high level of polish speaking referrals.' (CGL staff member, Survey)

A further member of staff remarked on a model of good practice in London, which consists of an assertive outreach approach for any 'hard to engage clients'. This was said to be especially important, in Walsall, where there was reportedly a high rate of 'DNA's to certain appointments[39] which has an impact on staff time and resources alongside financial implications.

39 We received data from CGL on the highest rates of DNA per type of contact for the last 12 calendar months. Groups received the highest DNA's, followed by service user plan reviews, full risk review and NMP assessment.

One survey respondent, a staff member at CGL, expressed frustration and stated:

> 'There is barely any outreach service. The only outreach is knocking doors to check people are alive when they have fallen off script or delivering scripts to pharmacies. There is no actual meaningful work currently being done with this group of people.' (CGL staff member)

This was echoed by an external stakeholder:

> 'There needs to be more outreach available to work with individuals in their own home or for some people on the streets if necessary. individuals who require support live chaotic lives and they need support on a regular basis. some individuals require intense daily support that is not provided by the beacon as they simply do not have the capacity to do this.' (External Stakeholder Survey)

The proportion of those in drug treatment who identified as having a housing problem was smaller than the national average (17% compared to 22% nationally, although the same proportion (8% both locally and nationally) were recorded as having an urgent housing problem – being of no fixed abode). For those in alcohol treatment, the proportion of this cohort having a housing problem was lower than the national average (7% compared to 9% nationally, with 2% of people both locally and nationally having an urgent housing problem – being of no fixed abode).

CGL has good working relationships with the rough sleepers' team within the local authority as well as The Glebe, where recovery workers can visit people who are homeless. This was said to be a well-executed two-way relationship where 'The Beacon' also contact the rough sleepers team too.

> 'How it used to work was we used to contact The Beacon, they used to be aware of myself and my team and they used to give us an appointment, whether that be the same week, the following week. But as you well know, rough sleepers with addictions have got other priorities. And if they're saying they want help now, with the drug or alcohol misuse, they want help now, not in two weeks' time. So within The Beacon, the service has evolved and now they've got a team that deal with specifically rough sleepers, and no fixed abode. My team worked closely with that team and basically say, we come across a rough sleeper in town today, or any part of the Borough. And they say, look, I've got a drug addiction, I need to get on script, I need help, we then contact The Beacon, that team specifically, and nine times out of 10, they'll get them in the same day. Or if the rough sleeper and that individual wants to go there, we'll get them there the same day, if not, they operate an outreach service to come to a safe place for that individual to get them obviously, up and running on the

systems, get them scripted, and so on. And it's working phenomenally. To be fair, it's brilliant.' (External Stakeholder)

However one CGL staff member advocated more work needed to be done for the 'less obvious homeless population', those in inappropriate and unstable housing, rather than just those who are street homeless.

'The homelessness that's hidden, you know, like sofa surfing, or living in inappropriate housing, you know, what's been done there in that respect, you know, what could we do in that respect and servicing that group in inappropriate homes is what gets people back in addiction, isn't it?' (CGL staff member)

There was also feedback about the need to develop a greater resource to support families of those in addiction and recovery. This was said to be crucial in ensuring that the individual's efforts were being supported in the best way and that family members' behaviour was not creating any further risk of lapse or relapse.

There was recognition of the need to support family members in their own right; not just for the benefit of the service users.

'The family involvement, involving the families in their own recovery rather than the addict's recovery. That for me is where we are missing something in Walsall' (CGL staff member)

Although Families Anonymous exists in Walsall, it doesn't run as frequently as AA or NA and the attendance is less. This was said to be because there wasn't a project to support families pre and post Families Anonymous. When asked what this would consist of it was felt that a group that featured psychoeducation about addiction, or a therapeutic space would be beneficial.

'If we had like a family project, that could then feed into, like families anonymous, that would help families anonymous and help us as well. And actually, it will ultimately help the service users who are, you know, the main reason why people end up in that position where they are a family of addiction. I've kind of been involved in services where the family, the engagement in the family is about keeping the addict in the family. Sometimes that's the absolute worst thing for the family. But they're made to feel guilty, so a space for them to work through that.' (CGL staff member)

Finally, support for the LGBTQ+ community was said to be lacking and one professional survey respondent indicated a lack of provision for service users engaging in chemsex.

The young people's service reported that they had a number of individuals who identified as LGBTQ+ but in the adult service, this was far less common and one staff member felt this community remained hidden. Interviews with staff indicated the best approach would be for CGL to work alongside an existing 'by' and 'for' organisation that supports this cohort, however, as part of the needs assessment TONIC asked if there were any specific LGBTQ support services to liaise with but none were identified aside from an LGBTQ mental health meeting in Bloxwich on a Wednesday night (which clashed with a fellowship meeting). It was suggested that CGL could promote the service through this forum. One volunteer within the service identified as transgender and said she felt very safe and welcomed within the service.

7.9.3 Opportunities for development

Throughout the needs assessment there was an acknowledgement of the need for greater staffing resources to be able to implement the desired changes and vision that CGL sees for the service. The OHID funding includes money to expand the workforce and is outlined, for the first year, below. However, it is unclear *how* these individuals will be recruited as there are national shortages and staff reflected on high turnover and churn within substance misuse posts. The following table gives further detail:

Workforce category	Notes	Baseline 2021-22[40]	Year 1 2022-23 planned recruitment[41]
Social workers	Social workers registered to practice on the Social Work England register https://www.socialworkengland.org.uk/umbraco/surface/searchregister/results	0	0
Pharmacists	Pharmacists registered to practice on the General Pharmaceutical Council (GPC) register https://www.pharmacyregulation.org/registers/pharmacist	0	0
Nurses	Nurses registered to practice on the Nursing and Midwifery Council register https://www.nmc.org.uk/registration/search-the-register/	3.4	2.1
Addiction psychiatrists	Doctors registered on the General Medical Council (GMC) specialist register to practice 'substance misuse psychiatry' https://www.gmc-uk.org/registration-and-licensing/the-medical-register	1	0
Other doctors	Doctors registered on the GMC register to practice https://www.gmc-uk.org/registration-and-licensing/the-medical-register	1	0
Consultant psychologists	Consultant psychologists registered on the Health and Care Professions Council (HCPC) register https://www.hcpc-uk.org/check-the-register/	0	0
Practitioner psychologists	Practitioner psychologists registered on the HCPC register https://www.hcpc-uk.org/check-the-register/	0	0
Assistant psychologists	Assistant psychologists should only be employed where there is a qualified HCPC-registered psychologist to supervise them.	0	0
Drug and alcohol workers	A paid employee of a local council-commissioned drug and/or alcohol treatment provider who does in-person and digital clinical work, and usually holds a caseload of people in structured treatment including keywork, harm reduction, outreach and psychosocial interventions, with individuals who have, or have had, drug and/or alcohol problems. This includes specialist roles targeting specific need, populations or working in specific settings including: women; the BAME community; LGBT community; mental or physical comorbidities; people involved with the criminal justice system; families; housing and employment support; and GP shared care. Also counted here should be outreach workers who may not carry a caseload or work with people currently in structured treatment but do provide harm reduction and other interventions to people who could, and arguably should, be in treatment.	34.5	0
Criminal justice drug and alcohol workers (subset of total in drug and alcohol workers row)	A 'drug and alcohol worker' (see previous definition) who works with individuals involved in the criminal justice system in order to facilitate their engagement and retention in treatment, including supporting individuals through a range of criminal justice pathways including out of court disposals, court mandated community sentence treatment requirements and during/after custody/imprisonment.	0.8	2
Young peoples' drug and alcohol workers (subset of total in drug and alcohol workers row)	A paid employee of a local council-commissioned young peoples' specialist substance misuse service who does face-to-face and digital clinical work, including keywork, harm reduction, outreach and psychosocial interventions, with young people who have, or have had, drug and/or alcohol problems or are at risk of developing problems.	3.8	0.5
Other drug and alcohol workers (subset of total in drug and alcohol workers row)	Definition as in drug and alcohol worker row above, but excluding young people's drug and alcohol workers and criminal justice drug and alcohol workers	4	3
Service managers	Drug and alcohol treatment service managers, who do not carry a clinical caseload. Team leaders who do carry a clinical caseload should be included in the row relevant to their training/role, e.g. drug and alcohol worker, nurse.	6.3	2
Local council commissioners/coordinators/ analysts	Local council-employed adult and young peoples' drug and alcohol treatment commissioners, coordinators and analysts, leading on or supporting any of, but not limited to, the following: commissioning; needs assessments; performance management; partnership coordination; drug and alcohol related death investigations; supporting collaboration, information sharing and joint working arrangements; regional or sub-regional commissioning.	0	0.83

40 Number of full time equivalent posts to nearest 0.25FTE, excluding those funded by 2021-22 universal drug treatment grant

41 Number of full time equivalent posts to nearest 0.25FTE - this should include ongoing posts originally funded by 2021-22 universal drug treatment grant

There was an appetite, amongst staff, for more training, around harm reduction and being trauma informed, a dedicated outreach team, an expansion of the hidden harm team to enable more preventative work to be carried out, and a dedicated therapeutic offer for clients. At the time of the needs assessment CGL reported they were recruiting for a dual diagnosis nurse to go out with the rough sleepers' team (in recognition of the prevalence of mental health needs in their client group) but recruitment had been a challenge. This raises an important point, which is that funding a post is one part of the picture, but services across health and justice are struggling to find suitable candidates and are reporting a general lack of applicants.

> 'We have a vacancy of the dual diagnosis nurse. But then it's a question about recruiting it because they've extended it now be up for six weeks and haven't had one application.' (CGL staff member)

There was a specific question on the needs assessment survey which invited feedback as to how recruitment to the sector could be improved. Some people cited the need for better pay and financial incentives. One person noted the high cost of parking per year as a specific Walsall issue. Others felt there was a need for remuneration by way of training, progression and mental well-being support.

> 'More attractive pay - the pay does not reflect the complexity of the work.' (CGL staff member, Survey)

> 'We could look at making the positions available more attractive by providing added incentives or benefits from working in the industry. For example, having access to other services like free counselling or therapy. Better pathways and pay structures. More structured induction programmes which include physical first hand training instead of online classrooms.' (CGL staff member, Survey)

> 'Offer incentives including extra holiday for service, more wellbeing days.' (CGL staff member, Survey)

> 'Better training when people join, it is really not very good or organised, and generally falls to the other members of the team to help and shadow. Which they do not have time for due to their high caseload, therefore it is not done well.' (CGL staff member, Survey)

As the OHID table above illustrates, there is no plan to recruit any further psychologists to the team, which the needs assessments suggests is a key gap in the service and the treatment and recovery offer would be considerably strengthened by having an 'in-house' therapeutic offer for those who do not need secondary mental health support.

Although well known by other services and agencies, there is an opportunity to 'get out in the community more' and be more visible, capitalising on events which aim to increase awareness of blood borne viruses. At present the Hep C nurse comes into CGL once a week to discuss positive cases but it was reported that there are a lot of 'DNAs' for Hep C treatment. This was said to be because of a misunderstanding of what treatment involves indicating a need for some education around this within the community.

> 'Having an increased budget for training, really, for training the workforce will be great. And maybe a budget to have like different events, as well. So there's the hepatitis World Day coming in now, you could have events in the town centre. I was thinking of for a year or two, thinking about like an outreach bus or a harm reduction van, how reduction leads as a worker, and taking BBV testing, Naloxone out into the community, even just like, you know, open access, initial contact, taking that out into the community, rather than waiting for service-users to come to the Beacon, I mean, training, we could offer training to GP surgeries. You know, about what we offer. Pharmacies as well, you know, because they obviously are really important partners' (CGL staff member)

Further, the data provided indicates Walsall is not as successful as the average area in England in engaging people in Hepatitis B vaccinations – just 4% completed a course of vaccination against a national average of 9% of eligible adults.

8. Achieve a generational shift in demand for drugs

The national Drug Strategy sets out the following ambitions regarding this:

We will take bold steps to change attitudes in society around the perceived acceptability of illegal drug use. We will achieve this by:
1. Building a world-leading evidence base – ambitious new research backed by a cross-government innovation fund to test and learn and drive real-world change
2. Applying tougher and more meaningful consequences – decisive action to do more than ever to target more people in possession of illegal drugs, and a White Paper next year with proposals to go further
3. Delivering school-based prevention and early intervention – delivering and evaluating mandatory relationships, sex and health education to improve quality and consistency, including a clear expectation that all pupils will learn about the dangers of drugs and alcohol during their time at school
4. Supporting young people and families most at risk of substance misuse – investing in a range of programmes that provide early, targeted support, including the Supporting Families Programme

Earlier in the needs assessment we outlined the work being undertaken by CGL with regards to families (the family safeguarding model, the family drug and alcohol court) alongside the work with young people using substances and those whose parents are using. All of these components of the service offer contribute to this part of the drug strategy. However, across CGL's service there was a consensus to do more prevention and early intervention work. Police reflected on the inconsistencies across the schools, colleges and academies in Walsall, with different establishments having different approaches to substance misuse; early intervention and prevention. The Hidden Harm worker had a good relationship with the schools she was working in, but this was a relatively small percentage of the overall schools in the area.

'If I had a pot of money, and I could decide on it, I'd say we need a prevention worker to go out and do that kind of work within the schools and offering training to professionals to get more, to promote the service and get referrals into the service as well. Because I do feel we just have working with such a small percentage of the population in Walsall and then the ones that we ARE working with, even if it's a referral from a school, they can then they'll present with really complex needs' (CGL staff member)

'I just think it's really important that we've got the capacity to go out and do that prevention work. I think it's something that's kind of missing in Walsall at the moment. It's helping to educate young people, and maybe stopping it from becoming an issue further down the line, because we found as well, where one thing that our YP workers have always said, it's actually

> sometimes when you sat down with a young person, one to one, it can be a little bit nerve wracking for them. And a little bit daunting. But then when they're with their peers, they open up a little bit more and they become more engaged. And, you know, that they've asked more questions. So I think there's always that to keep in mind when working with young people and actually being able to actually go out into schools and do that kind of work with them. And to the point where it doesn't become an issue that they're then coming into adult services in a few years' time with a worse problem' (CGL staff member)

There was recognition of the importance of prevention and a desire and appetite to build it in as a core part of the service delivery model. This therefore created a recommendation to expand this part of the service and have dedicated workers for this role. Staff also felt that this could support a reduction in future service demand, by preventing young people's behaviour escalating as well as reducing the complexity of people's presentation when they first come to service. A number of staff reflected that they had worked with current service users parents and noted the intergenerational cycle they were witnessing. A number of staff members also commented on the need to do more promotional work, so people can access the service sooner or in a proactive rather than reactive way.

> 'With the funding reduction, a lot of that outward facing work had to be reduced. So a lot of the preventative work, a lot of the just being able to go out to partners and engage partners and have conversations, promotional work, really, you know that that all had to go.' (CGL staff member)

This was echoed by one survey respondent who stated that 'desperation' was their trigger. This further suggests that service users are not engaging with support until the situation they are in is as bad as it can get, highlighting the need for prevention and early intervention once more so that service users are not in dire circumstances before they recognise and reach out for support. One young person felt police could also play a role in promotion.

> 'With the police and stuff walking around the town, what the police should do is carry like a little beacon card with like bullet points of information. So then if the police come across someone who needs help with like, drug use or whatever, they can give them that card.' (Service User, Station Street, YP service)

We contacted a number of schools for their feedback on this part of the needs assessment. One college stated they make referrals to 'The Beacon' and moving forwards there will be regular support on campus from CGL. The college stated they run their own drugs awareness programme

when found with cannabis but felt there was a gap in educating young people on the lasting effects of cannabis and the contributory factors it has on their pre-existing anxiety levels.

> 'There seems to be a theme this year where young people are telling me they are using cannabis in order to reduce their anxiety, they are unaware of any of the long term affects it has on their brain. It would be great to have some education awareness specifically for cannabis.' (External Stakeholder)

9. Conclusions and Recommendations

9.1 Conclusions

The importance of a needs assessment being conducted independently means that we are able to enter a space without any preconceived hypotheses, ideas or influence of previous conversations and historical relationships. It is reassuring that, as a result of conducting 86 interviews, receiving 101 survey responses, looking at quantitative data sources and national literature, as well as spending time on site, that there are overarching similarities between the conclusions we draw and those included in the OHID bid and CGL's own priority areas. For example, in May 2022, CGL Walsall identified the following areas of focus moving forwards:

- Consider increased complexity of presenting need within the service user group
- Improve outreach within vulnerable groups.
- Improve partnership working
- Reduce caseloads
- Psychology offer

It is clear from our visits and fieldwork that CGL Walsall has a robust reputation within the area and is, overall, meeting the needs of those to attend the provision. TONIC have rarely been made to feel so welcome within a service, there was an unequivocal openness and transparency, with "no task too big an ask" and being granted access to any area or dataset we require.

The staff were also clearly an extremely motivated team, with a passion for supporting those with substance misuse needs. There is also an array of groups on offer and the way the team is structured seems to work well. The ability to offer ambulatory detoxes, have a dedicated criminal justice team, specific family support and young people's care is particularly positive. However, caseloads were extremely high, and staff felt this was detracting from their ability to do meaningful work with their clients.

There were discussions about the 'type' of people the service was able to reach and there was an, understandable, focus on high-risk clients including those with opiate, crack and alcohol issues, but perhaps to the detriment of other individuals who do not fit in this 'high risk' category yet still require support. Staff had an appetite to do 'less chasing' and 'more therapeutic work' with clients who identify they are ready to change.

There were other 'missed groups' mentioned such as 'sex workers', those who are not obviously homeless, those with disabilities, those within LGBTQ+ and minoritised ethnic communities. The fact there are two sites, with some, limited outreach work, means people are limited in terms of access. The need for a dedicated psychologist or counselling offer was unanimously discussed, alongside better pathways for those requiring secondary mental health care. One option is to adopt the model from CGL in Dudley where the in-house addiction psychiatrist can prescribe mental health medication.

The service has also noted the need to strengthen pathways between themselves and the local hospitals when service users are undergoing detoxes. More people should have the ability to access rehab, but there needs to be adequate support before and after to maximise this opportunity and ensure long-term recovery. In addition, the group-work offer can be improved by offering 'non treatment' focused groups, by way of structured activities such as walking groups, arts and crafts or book clubs, giving people an opportunity to move away from their identity as someone with a substance misuse issue and build a new identity within recovery.

In terms of early intervention and prevention, this is a notable gap and there is a need for investment in a dedicated resource to cover more schools, colleges and academies in the local area *before* issues are identified. Further, the hidden harm worker has too high a case load for one individual, on top of managing training and promotion of the service, so this, too should be expanded. Both these recommendations would serve to hopefully decrease the complexity and risk of young people who may end up entering the adult service in the future.

For disruption of supply chains, there is good coverage of support *once* people have become vulnerable and are exploited but more can be done to prevent this, not least by increasing efforts to disrupt those who are ultimately responsible. Police should work with other stakeholders, and community leaders to build up intelligence about those involved in drug dealing and criminal gangs and offer opportunities for desistance. The idea, put forward by neighbourhood police teams, about a multiagency offer for those offenders who are both risky *and* vulnerable, similar to schemes such as integrated offender management, could be worth pursuing.

We outline a full list of our recommendations, for invited discussion, below:

9.2 Recommendations

As a result of triangulating our findings across primary and secondary data sets for the needs assessment, we make the following recommendations to be discussed with commissioners and providers in order to support the creation of a strategy and action plan.

Breaking Drug Supply Chains:

1) **Cohesive School Representation:** In terms of prevention and disruption, all agencies should work to convene a more cohesive voice and representation from schools to prevent exploitation and provide intelligence on county lines. This would support a more unanimous focus on this part of the agenda and give schools a more active role in disruption.

2) **Involve Community Leaders:** There should be concerted efforts to involve community leaders in prevention and disruption, working collaboratively with West Midlands Police. Agencies should work together to identify key individuals to invite to be part of multi-agency efforts to tackle drug supply. The aim of this is not for community leaders to simply share intelligence with police, but to identify shared goals and objectives for reducing harm in specific 'hot spots' that police identify as key in drug supply and violence. Working in collaboration with trusted individuals within these communities, agencies and police should empower communities to be part of the solution.

3) **Multi-Agency Working with Police:** A multi-agency approach should be considered to support vulnerability and risk/harm, amongst those who are involved in both supply and the consumption of drug. This would involve agencies working with police to identify organisations who can support those who are involved in this market as well as deciding on criteria for this cohort.

4) **Training Front-line professionals:** Police provided a recommendation to better train front-line professionals to be 'professionally curious' about exploitation by way of increasing referrals. This could be undertaken by exploitation services within the local authority or street teams.

Delivering a world class treatment and recovery system:

5) **Improving access to treatment:** Women and Asian people are both currently under-represented in the treatment population in Walsall. The Drug and Alcohol Partnership should explore the reasons for this and identify with treatment providers and partners a set of actions that will improve treatment uptake amongst both groups.

6) **LGBTQ+ Engagement**: CGL should work to build up better working relationships with LGBTQ+ organisations within the area. A mapping exercise should be undertaken to identify potential services to joint-work with.

7) **Primary care interventions:** It would be valuable to know the extent of alcohol screening and brief interventions in primary care in order to assess whether this proven harm reduction approach is under-utilised locally.

8) Partner Relations: The provider should continue to develop relationships and effective referral routes with colleagues in health - including hospitals, Accident & Emergency Departments and GPs.

9) **Assessment Process:** There should be more homogeneity in the assessment process, across criminal justice providers (e.g., in custody, prison and community) to reduce duplication on release. This will involve liaison with all providers in the area to achieve a commonality in approach, perhaps through revised information sharing agreements.

10) **DIVERT after-care:** Cranstoun and CGL would benefit from working together to establish a comprehensive onward referral pathway after DIVERT is completed as this is an opportunity for entry into treatment on a more long-term basis and could work as a method of early intervention

11) **Integrating clinical and psychosocial approaches:** With the opportunity of a new building, the concept of integrating clinical and psychosocial approaches more closely should be explored. Further, the suggestion of having more of a multi-agency hub where, once a week, professionals from DWP or housing are on site to support service users should be considered

12) **Increased Outreach for vulnerable groups:** There is a need for the onset of greater staff numbers to pursue greater outreach. The focus of this should be on 'hard to engage' populations including sex workers but also those in unstable accommodation and from non-English speaking communities (especially Eastern European).

13) **Community Hubs:** Satellite hubs, 'getting out into the community' should be discussed and explored. This could take a similar approach to the 'no wrong door' bus or CGL could see if any joint working could be undertaken to be present on these facilities. There is an associated opportunity to 'get out in the community more' and be more visible, capitalising on events which aim to increase awareness of blood borne viruses.

14) **Structured Activities:** Recommendations around the need for more structured activities away from solely drugs or alcohol recovery should be implemented and could be supported by the volunteers in place at CGL.

15) **Greater groupwork portfolio:** Young people should also be offered group work opportunities, so too should there be dedicated family groups (aside from Families Anonymous) and more specific groups for non-opiate or non-alcohol users.

16) **In-house Psychology Offer:** It is accepted that caseloads are too high, and staff are feeling the weight of this, especially as they feel unable to undertake therapeutic or motivational work with service users. Therefore there is a critical

need to build up the offer of a therapeutic component to the service and this should begin with recruitment of an in-house psychologist to hold their own caseload.

17) **Prescribing medication:** The offer from the in-house consultant psychiatrist could be strengthened by being able to prescribe 'mental health' medication as per the model in CGL in Dudley.

18) **Blood tests in-house:** CGL should seek investment and permission to undertake blood work in house to speed up the assessment process for detox.

19) **Restarts:** Due to the high numbers of restarts, CGL should consider whether there should be a dedicated team for this. This would also support in some of the discussions where known individuals repeatedly present for restarts and begin to tackle some of the underlying issues and motivations with this.

Achieving a generational shift in the demand for drugs:

20) **Hidden Harm**: The hidden harm function should be expanded to include a dedicated worker to promote the service across schools and safeguarding leads as well as deliver training. By having two workers, instead of one, this would facilitate supporting more young people affected by familial substance misuse.

21) **Primary Care Response**: In accordance with recommendation 7, once it has been ascertained the extent brief interventions are being used by GPs, a body of work should be undertaken to upskill pharmacies and GPs to enable them to be able support lower-level substance misuse.

Annex A: Walsall OHID plan

Main area of development	Cohort	Outline plan for 2022-23	Outline plan for 2023-24	Outline plan for 2024-25
Needs Assessment	Young people (under 18) & Adults	Walsall Council has commissioned a needs assessment to review all aspects of the local drug and alcohol treatment service delivery and whether needs are being met (e.g. reviewing impact of criminal justice team and make recommendations to continue or change; review the impact of a hospital alcohol detoxification pathway); if the service is offering best value; the experience of the service users; accessibility and how to improve services to ensure that residents want to access them. Therefore, the findings, data and recommendations from this Needs Assessment may change the plan below.	N/A	N/A
Increased treatment and harm reduction capacity, including inpatient detoxification and residential rehabilitation	Young people (under 18)	The focus will be on: 1) Strengthening communication and pathways from and to other young people's services school nursing, CAMHS, Children Services, Education, Sexual Health); 2) Expanding evidence-based approaches (harm reduction and groupwork; Hidden Harm interventions); 3) Building capacity to engage with Children's Social Care to enhance existing support provided	The focus will be on: 1) Increasing numbers in treatment via the implementation of new pathways and better communication between organisations and the Adult Service (Hidden Harm); 2) Reviewing the appropriateness of referrals; 3) Embedding the pathways and processes; 4) Establish an Aftercare and Peer Mentoring Programme.	The focus will be on: 1) Continue to enhance pathways between other young people's services 2) Continue to increase Early Intervention and new treatment places for young people
	Adults	Focus will be on: 1) Ensure capacity funded from the UG is maintained; 2) Enhance the existing Tier 4 budget to provide additional capacity;	We will focus on: 1) Continue building our capacity to introduce more specialist residential rehabilitation provision;	Focus will be on: 1) Analysing data to identify best practices for admittance, referrals, preparation, matching individuals to facilities and

		3) Review with partnerships the impact of specialist roles to meet the needs of our treatment population; 4) Increasing capacity into our Entry Into Service to increase our number of New Starts (Social Media, GP pathways, Hospital pathways, Family Services, local charities)	2) Delivering an enhanced hospital pathway into a specialist alcohol clinic; 3) Continue to invest in our criminal justice team (established from the 2021/22 grant); 4) Improve our harm reduction offer to adults with complex vulnerabilities via Outreach and in partnership with other adult community providers.	completions / discharges; 2) Developing an action plan to improve Tier 4 outcomes; 3) Depending on last year's criminal justice review, develop response / delivery to offenders; 4) Review our harm reduction pathways and hospital alcohol pathway.
Enhanced treatment quality	Young people (under 18)	To build capacity, reduce caseloads and focus on outcomes, we will focus on: 1) Offering accredited professional development to non-clinical treatment workforce; 2) increase workforce to expand treatment delivery to cover less sociable working times; 3) expand our volunteer recruitment and apprenticeship scheme; 4) working with partners to identify secondment opportunities; 5) completing a workforce audit.	Focus will be on 1) Continuing to developing strong working relationships with local colleges, further education and higher education, universities etc to offer placements, recruitment days, fast-track schemes to employment; 2) Reviewing secondments to identify learning and value for all organisations; 3) Developing plans aligned to our workforce audit and Needs Assessment.	We would explore plans to 1) Consider whether specific drugs and alcohol modules for local courses can be developed and supported which link to local treatment provision / employment; 2) Review secondments and consider value, including extensions, renewals or long-term postings supporting to multi-agency teams; and 3) Continue building on the recommendations from the Needs Assessment.
	Adults	To build capacity, reduce caseloads and support focus on outcomes, we will focus on: 1) Ensure capacity funded from the UG is maintained and recruit staff; 2) Expanding our Buvidal pilot; 3) Improve our Whole Family approach (Adult service and Hidden Harm); 4) Expand our groupwork programme and Ambulatory Detox Programme and Aftercare package in accordance to the findings of the Needs Assessment.	Focus will be on: 1) reviewing impact of reduction in caseload size to inform further planning; 2) maintaining regular clinical supervision for all frontline staff; 3) amending or expanding Buvidal provision based on review; 4) building on ACEs training to implement a trauma-informed treatment service with whole family focus in accordance to the findings of the Needs Assessment.	Focus will be on: 1) producing a detailed full proposal identifying consolidation / development of enhanced treatment quality measures; 2) reviewing trauma-informed approach for effectiveness.
Expanding and developing the workforce	Young people (under 18)	The core service provider will carry out a workforce audit and focus on: 1) Offering accredited professional development to non-clinical treatment workforce;	Focus will be on: 1) Continuing to develop strong working relationships with local colleges, further education	We would explore plans to: 1) Consider whether specific drugs and alcohol modules for local courses can be developed and

		2) Increase workforce to expand treatment delivery to cover less sociable working times; 3) Expand their volunteer recruitment and apprenticeship scheme; 4) Working with partners to identify secondment opportunities.	and higher education, universities etc to offer placements, recruitment days, fast-track schemes to employment; 2) Reviewing secondments to identify learning and value for all organisations; 3) Developing plans aligned to our workforce audit.	supported which link to local treatment provision / employment; 2) Review secondments and consider value, including extensions, renewals or long-term postings supporting to multi-agency teams.
	Adults	As above and a CIS has been commissioned to lead on 1-to-1 mentoring / Prisoner Inreach programme, who will also lead on the multi-disciplinary night-time economy project	Focus on: 1) Accredited professional development being offering to non-clinical treatment workforce; 2) Increase to expand treatment delivery to cover outreach; 3) Expand our volunteer recruitment and apprenticeship scheme; 4) Working with partners to identify secondment opportunities	As above
Reducing drug related deaths and improving access to mental and physical health care	Young people (under 18)	We will focus on: 1) Reviewing local children and young people's serious case reviews where drugs and alcohol featured: 2) Introducing in-house specialist mental health support for young people identified as requiring support; 3) Developing a therapeutic offer to children affected by parental substance misuse.	Focus will be on: 1) producing a detailed full proposal identifying local themes, places and events to target in order to reduce harms to children and young people; 2) implementing the proposal; 3) Developing a relationship-based, personalised mentoring service provision for young people - that is aimed at meeting 1-to-1 engagements focusing on harm and risk reduction	Developing work from previous year/s
	Adults	We will focus on: 1) Carry out mortality reviews and near-miss audits in relation to drugs and alcohol, including wider complex needs; 2) Establish a DRD Partnership Review Group (which will report to the Drug & Alcohol Board) to aid identification of learning and gaps;	Focus will be on: 1) Based on review, improve hospital admission discharge arrangements for drug and alcohol users. 2) Based on Needs Assessment and reviews in Yr 1 - identifying priorities re physical and mental	Developing work from previous year/s and delivering a joined-up response to physical and mental health care needs for substance misuse treatment cohort.

		3) Via the Partnership Group: develop a partnership approach to reduce alcohol and drug-related deaths; 4) Commence implementation within the 1st year, directing existing resource and re-profiling if required 5) Review hospital admission discharge arrangements for drug and alcohol users; 6) Deliver a full proposal to reduce alcohol and drug-related deaths in funding proposal for year 2 of SSMTRG.	health unmet needs within service and developing a response with ICS colleagues. 3) Working with local hospitals on processes and case management systems to ensure that all those with identified drug and alcohol needs are, with consent, effectively linked with treatment services at discharge.	
Recovery orientated system of care, including peer-based recovery support services	Adults	We will focus on: 1) Ensuring active engagement across the breadth of local lived experience individuals and organisations; 2) Increase integration between core service and identified stakeholders / partners, ensuring a multi-disciplinary partnership; 3) Reviewing pathways between treatment and recovery services;	Focus will be on: 1) Producing a detailed full proposal for improving recovery support in funding proposal for year 2 of SSMTRG; 2) Explore opportunities to build additional capacity within existing provision, ensuring Substance Misuse has stronger links with Mental Wellbeing and Healthcare; 3) proposing and commence implementation of pathways between treatment and recovery services across the Borough	Focus will be on: 1) delivering high quality, co-produced recovery services; 2) developing peer support to specific cohorts; 3) managing the pathways between treatment and recovery services.

Footnotes

[1] HM Government (2021) From harm to hope: A 10-year drugs plan to cut crime and save lives

[2] HM Government (2017) 2017 Drug Strategy

[3] Dame Carol Black (2020) Review of Drugs Part One https://www.gov.uk/Government/publications/review-of-drugs-phase-one-report/review-of-drugs-summary

[4] Dame Carol Black (2021) Review of Drugs Part One https://www.gov.uk/Government/publications/review-of-drugs-phase-two-report

[5] HM Government (2021) From harm to hope: A 10-year drugs plan to cut crime and save lives (page 12)

[6] Full Government description of ADDER can be found here.

[7]https://www.gov.uk/government/publications/extra-funding-for-drug-and-alcohol-treatment-2022-to-2023/additional-drug-and-alcohol-treatment-funding-allocations-2022-to-2023

[8] Her Majesty's Inspectorate of Probation & the Care Quality Commission (2021) A joint thematic inspection of community-based drug treatment and recovery work with people on probation

[9] Via Community Sentence Treatment Requirements

[10] Via this website: https://www.gov.uk/Government/collections/alcohol-and-drug-misuse-prevention-and-treatment-guidance

[11] These critical factors are derived from OHID commissioning advice and Dame Carol Black's work.

[12] HM Government (2021) From harm to hope: A 10-year drugs plan to cut crime and save lives (page 10)

[13] Dame Carol Black Review of Drugs: evidence pack
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/882953/Review_of_Drugs_Evidence_Pack.pdf p.102

[14] Public Health Outcomes Framework CO 20 https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/0/gid/1000042/pat/6/par/E12000007/ati/102/are/E09000002

[15] Office for Health Improvement and Disparities (2021) Adult substance misuse treatment statistics 2020 to 2021: report https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2020-to-2021/adult-substance-misuse-treatment-statistics-2020-to-2021-report#housing

[16] All BBV data from UK Health Security Agency (2021) Shooting Up: infections and other injecting-related harms among people who inject drugs in the UK, 2020
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1053202/Shooting_Up_2021_report_final.pdf

[17] European Monitoring Centre for Drugs & Drug Abuse (2019) Hepatitis C: new models of care for drugs services https://www.emcdda.europa.eu/drugs-library/hepatitis-c-new-models-care-drugs-services_en

[18] Ministry of Housing, Communities and Local Government (2020) Rough sleeping questionnaire initial findings. https://www.gov.uk/government/publications/rough-sleeping-questionnaire-initial-findings

[19] Office for Health Improvement and Disparities (2021) Adult substance misuse treatment statistics 2020 to 2021: report https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2020-to-2021/adult-substance-misuse-treatment-statistics-2020-to-2021-report#housing

[20] Public Health England (2016) Substance misuse in people with learning disabilities: reasonable adjustments guidance https://www.gov.uk/government/publications/substance-misuse-and-people-with-learning-disabilities/substance-misuse-in-people-with-learning-disabilities-reasonable-adjustments-guidance

[21] Distinguished by Melrose from sex-working drug users, who may be sex workers who are also recreational drug users. Melrose, M. (2009) 'Out on the Streets and Out of Control? Drug Using Sex Workers and the Prostitution Strategy'. In J. Phoenix (ed) 'Regulating Sex for Sale: Prostitution Policy Reform in the UK'. Bristol: Policy Press

[22] Helpfully summarised in: Sagar, Jones & Symons (2015) Sex Work, Drug and Alcohol Use: Bringing the Voices of Sex Workers into the Policy and Service Development Framework in Wales

[23] The most recent (2020) Crime Survey for England and Wales showed that around 1 in 11 adults aged 16 to 59 years had taken a drug in the last year (9.4%); the comparable figure for young adults (16 to 24 years) was more than double at 21%.
https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/drugmisuseinenglandandwales/yearendingmarch2020#overall-trends-in-drug-misuse

[24] Office of National Statistics (2019) Smoking, Drinking and Drug Use among Young People in England 2018. In 2018, 24% secondary school pupils reported that they had ever taken drugs, compared to 15% in 2014.

[25] Public Health England (2021) Young people's substance misuse treatment statistics 2019 to 2020: report https://www.gov.uk/government/statistics/substance-misuse-treatment-for-young-people-statistics-2019-to-2020/young-peoples-substance-misuse-treatment-statistics-2019-to-2020-report#referral-routes-into-treatment

[26] Ibid.

[27] Ibid.

[28] NSPCC (2021) Protecting children from county lines https://learning.nspcc.org.uk/child-abuse-and-neglect/county-lines

[29] Adfam, the national charity for the families and friends of people using alcohol and drugs cites some of the main impacts: "Family members are sometimes the victim of criminal behaviour by their loved ones such as theft of property to sell for money to buy drugs or alcohol. Others pay off substantial drug debts. If a substance user is unable to work or remains financially dependent this can also put additional strain on finances. Some family members find themselves needing to reduce working hours to cope with the situation or may even be unable to work due to the stress it causes them." https://adfam.org.uk/help-for-families/understanding-the-issues/the-effects

[30] HM Government (2021) From harm to hope: A 10-year drugs plan to cut crime and save lives (page 36)

[31] The Advisory Council on the Misuse of Drugs (2003) Hidden Harm – Responding to the needs of children of problem drug users

[32] HM Government (2021) From harm to hope: A 10-year drugs plan to cut crime and save lives (page 36)

[33] https://www.bournemouth.ac.uk/research/projects/male-users-anabolic-androgenic-steroids

[34] https://www.nhs.uk/conditions/anabolic-steroid-misuse/ Latest Public Health England advice: https://www.gov.uk/government/publications/treating-substance-misuse-and-related-harm-turning-evidence-into-practice/services-for-image-and-performance-enhancing-drug-iped-users-turning-evidence-into-practice

[35] Much of the information in this section is taken from: Bourne et al. (2014) The Chemsex Study: drug use in sexual settings among gay and bisexual men in Lambeth, Southwark & Lewisham. Sigma: http://sigmaresearch.org.uk/projects/item/project59

[36] Latest official data found that 4,561 deaths related to drug poisoning were registered in 2020, the worst number since records began in 1993. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2020

[37] Gillian Burton, Andrew McAuley, Joe Schofield, Alan Yeung, Catriona Matheson, Tessa Parkes, (2021)
A systematic review and meta-analysis of the prevalence of take-home naloxone (THN) ownership and carriage, International Journal of Drug Policy, Volume 96

[38] EMCDDA (2016) Preventing opioid overdose deaths with take-home naloxone https://www.emcdda.europa.eu/system/files/publications/2089/TDXD15020ENN.pdf

[39] https://adf.org.au/drug-facts/buprenorphine-long-acting-injectable/

[40] https://wearetheloop.org/

[41] Fiona Measham & Gavin Turnbull (2021) Intentions, actions and outcomes: A follow up survey on harm reduction practices after using an English festival drug checking service, International Journal of Drug Policy, Volume 95

[42] Home Office and Department of Health and Social Care (2021) UK Government Recovery Champion Annual Report.

[43] Ibid. Page 8

[44] Webster et al. (2021) Peers who volunteer https://peervols.russellwebster.com/wp-content/uploads/2021/11/Peers-who-volunteer-FINAL-November-2021.pdf

[45] EMCDDA (2018) m-Health applications for responding to drug use and associated harms https://www.emcdda.europa.eu/system/files/publications/10244/EMCDDA%20Papers_m-Health%20applications_Final.pdf

[46] https://www.breakingfreegroup.com/

[47] https://www.cypnow.co.uk/analysis/article/drugs-review-highlights-five-ways-to-boost-support-for-young-people

[48] Public Health England & The Children's Society (2017) Specialist substance misuse services for young people: A rapid mixed methods evidence review of current provision and main principles for commissioning

[49] ACMD (2022) The prevention of drug misuse in vulnerable groups

[50] Ibid Page 2 provides details of quality standards.