



HEALTH AND WELLBEING BOARD

Date: WEDNESDAY, 8 SEPTEMBER 2021 at 3.00 pm

Remote meeting – the public are welcome to observe via the Council's website at <https://lewisham.public-i.tv/core/portal/home>

Enquiries to: Mark Bursnell
Telephone: 020 8314 3352 (direct line)

MEMBERS

Mayor Damien Egan

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INVESTOR IN PEOPLE

Councillor Chris Best

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Tom Brown

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Donna Hayward-Sussex

South
London
and
Maudsley
NHS
Foundation
Trust

Michael Kerin

Health
Watch
Lewisham

Dr Faruk Majid

Lewisham
Clinical
Commissioning
Group

Dr Catherine Mbema

Public
Health,
London
Borough
of
Lewisham



Lewisham



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Dr Simon Parton

Lew
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Local
Medical
Committee

Members are summoned to attend this meeting

**Kim Wright
Chief Executive
Lewisham Town Hall
Catford
London SE6 4RU
Date: Tuesday, 31 August 2021**



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MINUTES OF THE HEALTH AND WELLBEING BOARD Thursday 4th March 2021 at 3.00pm

ATTENDANCE

PRESENT: Cllr Chris Best (Deputy Mayor of Lewisham and Cabinet Member for Health and Adult Social Care); Tom Brown (Executive Director for Community Services, LBL); Val Davison (Chair of Lewisham & Greenwich NHS Trust); Pinaki Ghoshal (Executive Director for Children and Young People, LBL); Philippe Granger (Chief Executive, Rushey Green Time Bank); Donna Hayward-Sussex (Service Director, South London and Maudsley NHS Foundation Trust); Michael Kerin (Healthwatch Lewisham); Faruk Majid (Lewisham Member of South East London CCG) and Dr Catherine Mbema (Director of Public Health, LBL).

APOLOGIES: Damien Egan (Mayor of Lewisham) and Dr Simon Parton (Chair of Lewisham Local Medical Committee).

IN ATTENDANCE: Paul Aladenika (Service Group Manager Policy Development, LBL); Lesley Allen (Community Champion, Diamond Club); Timothy Bradley (Community Champion, Lewisham Wellbeing Map); Miriam Bullock (Public Health Trainee, LBL); Mark Bursnell (Clerk to the Board, LBL); Dee Carlin (Director of Adult Integrated Commissioning); Alexandra Camies (Community Champion, South Lewisham Patient Participation Group Chair); Martin Crow (LSAB Business Manager); Laura Harper (Public Health Commissioning Manager, LBL); Cllr Coral Howard (Vice-Chair, Healthier Communities Select Committee); Sandra Iskander (Strategy Team, Lewisham and Greenwich NHS Trust); Amanda Lloyd (System Transformation and Change Lead, Lewisham Health and Care Partners); Edward Parker Humphreys (Cabinet Executive Officer, LBL); Michael Preston-Shoot (Independent Chair, Lewisham Safeguarding Adults Board); Vicky Scott (Programme Director, Lewisham and Greenwich NHS Trust); Sarah Wainer (Director of Systems Transformation, Lewisham Health and Care Partners); Chamu Mhomwa (Digital Scanning Officer, LBL); Cllr John Muldoon (Chair, Healthier Communities Select Committee); and Martin Wilkinson (Director of Integrated Care and Commissioning, LBL/South East London Clinical Commissioning Group).

Welcome and introductions

The Acting Chair opened the meeting. Apologies were received from Mayor Egan, and Dr Simon Parton.

1. Minutes of the last meeting

1.1 The minutes of the last meeting were agreed with no matters arising.

2. Declarations of interest

2.1 There were no declarations of interest.

3. Local COVID-19 Outbreak Engagement Board

- 3.1 Catherine Mbema presented the latest data on COVID-19 in Lewisham. As of 6th February there had been a total of 20,988 confirmed cases of Covid-19 in Lewisham. There was a surge in cases during late December to early January, closely associated with the identification of a new strain of Covid-19 first detected in England. Since the peak in January the rate of infection had slowed down and continues to do so. The Council has established four COVID-19 rapid testing sites across the borough to identify asymptomatic cases as part of a national initiative.
- 3.2 The Lewisham Covid-19 Community Champions initiative continues to be a key tool to ensure residents are provided with timely communications as part of the wider Covid-19 Communication and Engagement Plan. So far 172 Covid-19 Community Champions have been recruited. In December, Lewisham Council submitted a funding bid to the Ministry for Housing, Communities and Local Government's Community Champion Local Authority Fund for its Community Champion programme. As a result the Council has received £275,917 to deliver the objectives of the Fund. Several work streams are being implemented, including: the further recruitment of Community Champions across the demographic spectrum; campaigning to promote the Covid-19 vaccination programme; and increasing the capacity of the Community Champions to disseminate relevant knowledge within local communities.
- 3.3 John Jibogu, who has been a Community Champion for four months, spoke to the Board about his role and the outreach work he was undertaking in the community to counter anti-vaccine disinformation. John highlighted the webinars he had attended and the collaboration with the Clinical Commissioning Group (CCG) to provide a factual response to queries raised about the safety and efficacy of the vaccine. Partners thanked the Public Health team for all the work they've done behind the scenes to develop the Community Champions initiative and to the champions themselves for their valuable efforts in sharing reliable and accurate information within the community.
- 3.4 Val Davison updated the Board on the number of COVID-19 cases in local hospitals, there were now 38 in-patients in Lewisham and 71 across South-East London. This compares to nearly 500 with Covid-19 at the peak of the pandemic in early January. Around 75% of hospital staff have now received their first dose of the vaccine. Elective pathways for non-COVID-19 illnesses were now starting to slowly get back to normal.
- 3.5 Martin Wilkinson updated the Board on the roll-out of the vaccine across Lewisham and reported good progress was being made. The CCG are looking to identify appropriate pop-up based centres to administer the jab in community settings, to encourage greater take-up across the board. Ongoing conversations are being held with community leaders to identify barriers to the take-up of the vaccine and to stress the jab was still available to those people who had missed a previous appointment, or had not come forward.
- 3.6 Faruk Majid highlighted the experiences of local GP practices and that more surgeries are working together to offer a vaccine service to patients. There are logistical challenges associated with organising the second jab for vulnerable patients and the administration around booking appointments for the younger, more numerous cohorts.
- 3.7 Donna Hayward-Sussex updated the Board on developments around mental health services and the positive response from staff in dealing with a major re-configuration of services, as social distancing means current service delivery pathways are temporarily suspended.
- 3.8 Councillor Barnham referred to the positive spirit to the vaccination programme he had witnessed when he received his first jab and the positive impact the webinars had

achieved in encouraging greater local take-up and countering negative social media opinion. The work of partners in direct community engagement in public settings was also welcomed and more will continue to be done on this front.

3.9 Action:

The Board noted the content of the report

4. Annual Public Health Report

- 4.1 Catherine Mbema introduced the annual report, which is statutory requirement for all public health authorities. The report focused on Health for All policies and adopting a whole system approach which, in light of the pressures thrown up by COVID-19, was vital to address future health challenges and tackle health inequalities. A number of new case studies from both the Council (for example, setting up a locally enhanced COVID-19 contact tracking service and establishing COVID-19 rapid testing sites across the borough) and partners have been included in the report to demonstrate how this approach has helped Lewisham cope with the demands of the crisis.
- 4.2 The report also makes several recommendations around next steps such as formalising a Health for All approach and reinforcing the strategic links between improvements in the health of the population and achieving corporate priorities. The report will shortly be published and will have an accompanying communications plan, to embed the plan as part of the COVID-19 recovery approach.
- 4.3 Next year's report will focus on the differential impacts of Covid-19 on Lewisham's population, both in terms of health and their experiences of the wider determinants of health. The 2020/21 Report will include testimonials from Lewisham residents, combined with statistical analysis of data and the findings from relevant reports and inquiries.
- 4.4 Feedback from the Board was very positive with comments that the report was a compelling read with good examples of the practical improvements that have taken place. The suggestion of adopting the whole system approach as a fresh perspective to tackle the main public health challenges (for example differential health outcomes based on levels of deprivation in different wards, and tackling obesity) in Lewisham as part of the Health and Wellbeing strategy was strongly endorsed.
- 4.5 The mental health challenges facing local people, especially children and young people, as a result of the effects of the pandemic were also highlighted. The importance of promoting CAMHS and the offer from mental health teams in schools was supported in this regard. The Chair also mentioned the work of 'Lewisham Listens'.

4.6 Actions:

The Board endorsed the annual report and supported its recommendations

More details of the programmed work Public Health and health partners are undertaking in tackling obesity and mental health issues affecting both adults and children and young people, will be reported upon at the next meeting of the Board

5. Better Care Fund Plan 2020/21

5.1 Martin Wilkinson introduced the report which provided an update on the activity that is being funded through the Better Care Fund (BCF) in 2020/21 and the arrangements for the Council and the CCG for developing the BCF Plan for 2021/22. In December the Government advised that the Plan would not need to be submitted to NHS England and NHS Improvement for approval in 2020/21. Local areas were instead required to submit an end of year reconciliation to confirm compliance with national conditions and metrics. The BCF 2021/22 Plan will be jointly developed by the Council and CCG following publication of the policy framework and planning guidance. It was highlighted the draft BCF for 2021/22 will be presented to this Board for final approval before submission.

5.2 Some of the services that have been funded through the Better Care Fund over the last year included:

Enablement Service

5.3 The Service has worked closely with Discharge to Assess to increase the numbers of people able to return home from hospital with support, thus reducing the number of people delayed in an acute bed. The number of patient discharges supported by the service has increased from 20 per week at the start of 2020 to around 30-35 patients per week currently supported to leave hospital. The service is looking at ways to increase the number of complex discharges supported through enablement to reduce the need for long term care home placements.

Community Connections Lewisham (CCL)

5.4 From the beginning of the pandemic the service worked with voluntary and community sector partners on the COVID-19 support phone line, organising food deliveries, telephone befriending and volunteering across the borough. In September 2020 CCL was redesigned to be a public facing service for people aged 18+ looking for help with their health and wellbeing. A new phone line staffed Monday-Friday 9:30am-4pm provides callers with signposts to local services, referrals to key partners (Voluntary Services Lewisham, Lewisham Foodbank, Good Gym, the Dementia Hub, Lewisham Carers, etc.) or person-centred planning to empower people to achieve their health and wellbeing goals. CCL continues to support people during COVID-19, in particular providing help with shopping and accessing food and assisting people whose health prevents them from leaving their homes.

Health Navigator Pilot

5.5 Lewisham Health and Care Partnership (LHCP) have collaborated with healthcare company, Health Navigator and partner L2S2 Ltd to launch a home monitoring solution for patients with diabetes and respiratory disease which supports early, safe discharge by providing clinical coaching and virtual ward oversight. Developed specifically for LHCP and run by registered nurses, this home monitoring solution helps ease the pressure caused by COVID-19, as patients supported through the service have ongoing access to healthcare professionals who promote home self-care.

Lewisham Medication Optimisation Service (LIMOS)

5.6 Following a request from NHSE, the LIMOS Care Home team adapted its service model to deliver clinical pharmacy support to care homes as part of the pandemic response. LIMOS adapted its service model to continue to review patients with adherence issues using telephone/video consultations and carried out home visits to enable vulnerable patients to remain at home safely. The service reviewed patients and supported care home staff to implement the national free supply of vitamin D supplementation to appropriate residents. LIMOS is currently working with care

homes and associated GP practices to implement Proxy Ordering in care homes, a system which enables care home staff to order medicines electronically through the GP system directly.

Population Health

5.7 The COVID-19 vaccine dashboard is being used by PCNs and Public Health to track vaccine uptake and understand the trends around poor uptake. The dashboard is used to see if Local Super Output Area, ethnicity and Index of Multiple Deprivation are linked in any way to poor uptake and how partners can tailor the approach to how these cohorts are reached to encourage vaccine uptake. For diabetes, there are several tools available that track undiagnosed diabetics, for example women that had gestational diabetes but have missed follow up checks so could have undiagnosed type 2 diabetes, and catching blood pressure checks carried out in secondary care. The CCG are also working with partners to support getting Lewisham patients onto the National Diabetic Prevention Programme using the pre-diabetes case finding tool.

5.8 Action: The report was noted and its recommendations agreed

6. BAME Health Inequalities Update

6.1 Catherine Mbema provided an update to the Board on work undertaken to address BAME health inequalities in Lewisham during the COVID-19 pandemic, the work of the BAME working group - which had been set up to address health inequalities in Lewisham - and to note the updated action plan. In July 2018 the Board agreed the main focus of its work should be tackling health inequalities, with an initial focus on health inequalities for BAME communities in Lewisham. Three priority areas were identified, through which the Board will play a significant role: mental health; obesity and cancer.

6.2 A draft action plan covering all three areas was developed and at the 20th March 2020 Board meeting it was agreed that the action plan should be augmented with monitoring metrics to capture progress and the impact of completing actions within the plan. A Health Inequalities Working Group has met since March 2020 to oversee implementation of the plan and for 2021 the Group will review the actions within each section of the action plan each quarter. So for the first quarter (January-March 2021) the Working Group has focussed on the Covid-19 section, reviewing the communications/engagement and data sections of the plan.

6.3 Two actions for Covid-19 communications and engagement that are in progress are 1. To develop culturally appropriate communications around Covid-19; and 2. To engage with BAME communities and provide culturally appropriate mental health support. An external provider has been commissioned to provide mental wellbeing support and resilience sessions to the Black community and Lewisham staff. For data, the action is to analyse Covid-19 mortality rates by ethnicity/country of birth and to include ethnicity as a separate field in death certificates. The BAME Ethnic Health Inequalities Toolkit continues to be finalised, with support from Board partners to provide health related ethnicity data. Different frameworks are being looked at to use the Toolkit including 'Build Back Fairer'. The Toolkit will then be presented and discussed by the health leads at the Lewisham Black and Minority Ethnic Network.

6.4 Action:

The Board noted the contents of the report and the updated action plan and that progress in finalising the Toolkit will be reported to the next meeting of the Board before publication. The Board will also discuss priority areas in the action plan and consider how to best use the baseline school data which should be available

7. Joint Strategic Needs Assessment

7.1 The report set out the revised timescale for further work on the Joint Strategic Needs Assessment (JSNA). The Board was recommended to approve the revised timelines for developing the JSNA and review the most recently published topic assessments. It was proposed to undertake this work in September when resources should be available.

7.2 When work on the JSNA recommences it was proposed it includes a topic assessment examining the wider Covid-19 impacts to support recovery planning and commissioning, with a further topic assessment refresh on Air Quality. The 'Picture of Lewisham' element of the JSNA it was proposed, be updated in spring 2021 to help commissioners and other professionals in planning and decision-making.

7.3 The Board agreed that assessing the health need impact of 'long Covid-19' needed to be added to the JSNA work as well as the younger age cohorts, who may have had COVID-19 but were not hospitalised, especially where there is a link to deprivation.

7.4 Action:

The Board agreed to a pause in the work on the JSNA and including a topic assessment to explore the wider COVID-19 risks to support recovery planning

8. Lewisham Safeguarding Adult Partnership Annual Report 2019/20

8.1 The report sets out the work carried out by the Board over the year and is for the Board's information. Key outcomes delivered included organising the first of four Networking and Safeguarding Champions events to coincide with National Hate Crime Awareness Week, supported by the Council and Metropolitan Police and delivering two Hoarding Awareness workshops. The Board approved the creation of a local Modern Slavery Network supported by the Lewisham Safeguarding Adult Partnership business unit.

8.2 The Board commended the report, the excellent examples of partnership working contained within and the fact so much continues to be done despite the restrictions imposed by the pandemic. Lessons drawn from the lockdowns will be applied to future practice for example, around dealing with the impact of loneliness and isolation. The Board were informed that a poster promoting the service offer was now ready for distribution, once it was signed off by the Chair.

8.3 Action:

The Board noted the contents of the report

9. For Information items

9.1 Michael Kerin updated the Board on the recent public engagement activities of HealthWatch Lewisham and attention was drawn to the Patient Experience Quarter 2 feedback and the Snapshot Feedback Forums with BAME communities during the pandemic. The conclusions drawn from these consultations was set out in the reports included in the agenda for the meeting.

The meeting ended at 16:22 hours

Agenda Item 2



Health and Wellbeing Board

Declarations of Interest

Key decision: No

Class: Part 1

Ward(s) affected: All

Contributors: Chief Executive (Director of Law)

Outline and recommendations

Members are asked to declare any personal interest they have in any item on the agenda.

1. Summary

1.1. Members must declare any personal interest they have in any item on the agenda. There are three types of personal interest referred to in the Council's Member Code of Conduct:

- (1) Disclosable pecuniary interests
- (2) Other registerable interests
- (3) Non-registerable interests.

1.2. Further information on these is provided in the body of this report.

2. Recommendation

2.1. Members are asked to declare any personal interest they have in any item on the agenda.

3. Disclosable pecuniary interests

3.1 These are defined by regulation as:

- (a) Employment, trade, profession or vocation of a relevant person* for profit or gain
- (b) Sponsorship –payment or provision of any other financial benefit (other than by the Council) within the 12 months prior to giving notice for inclusion in the register in respect of expenses incurred by you in carrying out duties as a member or towards your election expenses (including payment or financial benefit from a Trade Union).
- (c) Undischarged contracts between a relevant person* (or a firm in which they are a partner or a body corporate in which they are a director, or in the securities of which they have a beneficial interest) and the Council for goods, services or works.
- (d) Beneficial interests in land in the borough.
- (e) Licence to occupy land in the borough for one month or more.
- (f) Corporate tenancies – any tenancy, where to the member’s knowledge, the Council is landlord and the tenant is a firm in which the relevant person* is a partner, a body corporate in which they are a director, or in the securities of which they have a beneficial interest.
- (g) Beneficial interest in securities of a body where:
 - (a) that body to the member’s knowledge has a place of business or land in the borough; and
 - (b) either:
 - (i) the total nominal value of the securities exceeds £25,000 or 1/100 of the total issued share capital of that body; or
 - (ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the relevant person* has a beneficial interest exceeds 1/100 of the total issued share capital of that class.

*A relevant person is the member, their spouse or civil partner, or a person with whom they live as spouse or civil partner.

4. Other registerable interests

4.1 The Lewisham Member Code of Conduct requires members also to register the following interests:

- (a) Membership or position of control or management in a body to which you were appointed or nominated by the Council
- (b) Any body exercising functions of a public nature or directed to charitable purposes, or whose principal purposes include the influence of public opinion or policy, including any political party
- (c) Any person from whom you have received a gift or hospitality with an estimated value of at least £25.

5. Non registerable interests

- 5.1. Occasions may arise when a matter under consideration would or would be likely to affect the wellbeing of a member, their family, friend or close associate more than it would affect the wellbeing of those in the local area generally, but which is not required to be registered in the Register of Members' Interests (for example a matter concerning the closure of a school at which a Member's child attends).

6. Declaration and impact of interest on members' participation

- 6.1. Where a member has any registerable interest in a matter and they are present at a meeting at which that matter is to be discussed, they must declare the nature of the interest at the earliest opportunity and in any event before the matter is considered. The declaration will be recorded in the minutes of the meeting. If the matter is a disclosable pecuniary interest the member must take not part in consideration of the matter and withdraw from the room before it is considered. They must not seek improperly to influence the decision in any way. **Failure to declare such an interest which has not already been entered in the Register of Members' Interests, or participation where such an interest exists, is liable to prosecution and on conviction carries a fine of up to £5000**
- 6.2. Where a member has a registerable interest which falls short of a disclosable pecuniary interest they must still declare the nature of the interest to the meeting at the earliest opportunity and in any event before the matter is considered, but they may stay in the room, participate in consideration of the matter and vote on it unless paragraph 6.3 below applies.
- 6.3. Where a member has a registerable interest which falls short of a disclosable pecuniary interest, the member must consider whether a reasonable member of the public in possession of the facts would think that their interest is so significant that it would be likely to impair the member's judgement of the public interest. If so, the member must withdraw and take no part in consideration of the matter nor seek to influence the outcome improperly.
- 6.4. If a non-registerable interest arises which affects the wellbeing of a member, their, family, friend or close associate more than it would affect those in the local area generally, then the provisions relating to the declarations of interest and withdrawal apply as if it were a registerable interest.
- 6.5. Decisions relating to declarations of interests are for the member's personal judgement, though in cases of doubt they may wish to seek the advice of the Monitoring Officer.

7. Sensitive information

- 7.1. There are special provisions relating to sensitive interests. These are interests the disclosure of which would be likely to expose the member to risk of violence or intimidation where the Monitoring Officer has agreed that such interest need not be registered. Members with such an interest are referred to the Code and advised to seek advice from the Monitoring Officer in advance.

8. Exempt categories

- 8.1. There are exemptions to these provisions allowing members to participate in decisions notwithstanding interests that would otherwise prevent them doing so. These include:-
- (a) Housing – holding a tenancy or lease with the Council unless the matter relates to your particular tenancy or lease; (subject to arrears exception)
 - (b) School meals, school transport and travelling expenses; if you are a parent or

guardian of a child in full time education, or a school governor unless the matter relates particularly to the school your child attends or of which you are a governor

- (c) Statutory sick pay; if you are in receipt
- (d) Allowances, payment or indemnity for members
- (e) Ceremonial honours for members
- (f) Setting Council Tax or precept (subject to arrears exception).

9. Report author and contact

9.1. Suki Binjal, Director of Law, Governance and HR, 0208 31 47648

Agenda Item 3



Health and Wellbeing Board

Report title: Local COVID-19 Outbreak Engagement Board update

Date: 8th September 2021

Key decision: No

Class: Part 1

Ward(s) affected: All

Contributors: Dr Catherine Mbema, Director of Public Health, London Borough of Lewisham

Outline and recommendations

The purpose of this report is to provide an update to the Lewisham Health and Wellbeing Board in its role as the Local Outbreak Engagement Board.

The Health and Wellbeing Board are recommended to:

- Note the contents of the report

Timeline of engagement and decision-making

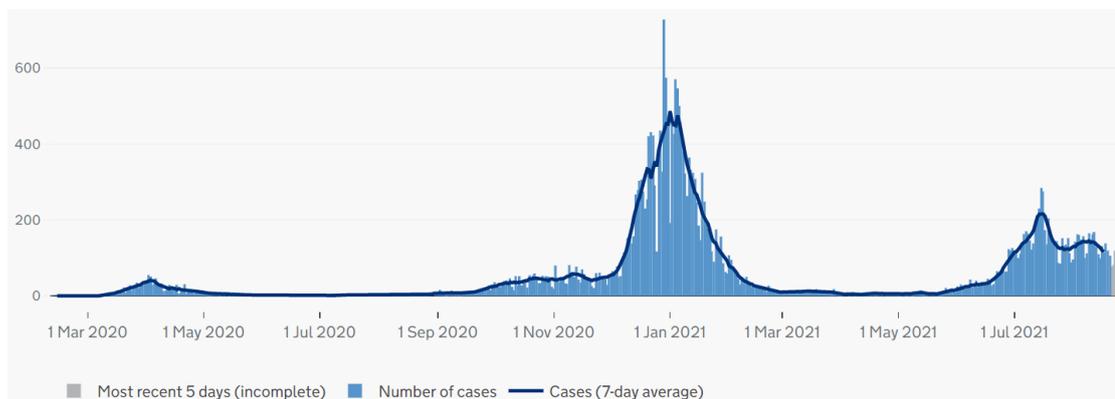
1. Recommendations

- 1.1. The purpose of this report is to provide an update to the Lewisham Health and Wellbeing Board in its role as the Local Outbreak Engagement Board.
- 1.2. The Health and Wellbeing Board are recommended to note the contents of the report.

2. Background

- 2.1. As of 20th August 2021, there have been a total of 31,010 confirmed cases of COVID-19 in Lewisham. Since July 2021 there has been a decrease and stabilisation in confirmed cases of COVID-19 in Lewisham. This is demonstrated in Figure 1.

Figure 1. Daily number of new lab confirmed cases in Lewisham until 20th August 2021



Source: <https://coronavirus.data.gov.uk/cases>

- 2.2. At the September 2020 meeting of the Lewisham Health and Wellbeing Board, it was agreed that the Board will act as the Local Outbreak Engagement Board as part of the governance of the COVID-19 Local Outbreak Management Plan. The most recent

version of our COVID-19 Local Outbreak Management Plan can be found at the following link: <https://lewisham.gov.uk/myservices/coronavirus-covid-19/health/the-lewisham-covid19-outbreak-prevention-and-control-plan>

3. Updated National COVID-19 Contain Framework

3.1. On 5th August 2021, the national COVID-19 contain framework was updated. The framework sets out 'how national, regional and local partners should continue to work with each other, the public, businesses, institutions (including schools, prisons, hospitals, care home and homelessness settings), and other local system partners in their communities, to prevent, manage and contain outbreaks of COVID-19'.

3.2. The framework outlines:

- the roles and responsibilities of local authorities and local system partners, and those of regional and national teams, as well as the decision-making and incident response structures
- the core components of the COVID-19 response across the spectrum of outbreak prevention and management, including to variants of concern (VOCs)
- the requirements of local authorities on the continued COVID-19 response, as well as how this should be factored into local outbreak management plans (LOMPs)
- the support local authorities can expect from regional and national teams

3.3 Since the end of national restrictions in July, the government has committed to:

1. Reinforce the country's vaccine wall of defence through booster jabs and driving take up.
2. Enable the public to make informed decisions through guidance, rather than laws
3. Retain proportionate test, trace and isolate plans in line with international comparators.
4. Manage risks at the border and support a global response to reduce the risk of variants emerging globally and entering the UK.
5. Retain contingency measures to respond to unexpected events, while accepting that further cases, hospitalisations and deaths will occur as the country learns to live with COVID-19.

3.4 In terms of local responsibilities:

- The DPH has a statutory duty for the COVID-19 Local Outbreak Management Plan; supported by wider local authority teams as necessary.
- The local authority chief executive is responsible for the local response, providing strategic leadership and direction, shaping local communications and engagement, and deploying local government resources.
- Local authorities, through their elected mayors and council leaders, are

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accountable to their local community for the local response, decisions and spending undertaken.

- Councillors, as local systems leaders, and local community leaders can facilitate systems relationships and community engagement.

- 3.5 The Lewisham Health and Wellbeing Board will therefore continue to have a role as the Local Outbreak Engagement Board going forward to oversee local efforts to manage COVID-19.
- 3.6 The Lewisham COVID-19 Local Outbreak Management Plan will be updated in line with the contents of the national contain framework this month and published on the Lewisham Council website.

(Source: <https://www.gov.uk/government/publications/containing-and-managing-local-coronavirus-covid-19-outbreaks/covid-19-contain-framework-a-guide-for-local-decision-makers>)

4. Financial implications

- 4.1. There are no significant financial implications of this report.

5. Legal implications

- 5.1. The legal context for managing outbreaks of communicable disease which present a risk to the health of the public requiring urgent investigation and management sits:
- With 'Public Health England' under the Health and Social Care Act 2012,
 - With Directors of Public Health under the Health and Social Care Act 2012
 - With Chief Environmental Health Officers under the Public Health (Control of Disease) Act 1984
 - With NHS Clinical Commissioning Groups to collaborate with Directors of Public Health and Public Health England to take local action (e.g. testing and treating) to assist the management of outbreaks under the Health and Social Care Act 2012
 - With other responders' specific responsibilities to respond to major incidents as part of the Civil Contingencies Act 2004
 - Specifically within the context of COVID-19 there is the Coronavirus Act 2020 which received royal assent on 25th March 2020.
- 5.2. The Equality Act 2010 (the Act) introduced a public sector equality duty (the equality duty or the duty). It covers the following protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
- 5.3. The Equality Act 2010 (the Act) introduced a public sector equality duty (the equality duty or the duty). It covers the following protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
- 5.4. In summary, the Council must, in the exercise of its functions, have due regard to the

need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- advance equality of opportunity between people who share a protected characteristic and those who do not.
- foster good relations between people who share a protected characteristic and those who do not.

5.5. It is not an absolute requirement to eliminate unlawful discrimination, harassment, victimisation or other prohibited conduct, or to promote equality of opportunity or foster good relations between persons who share a protected characteristic and those who do not. It is a duty to have due regard to the need to achieve the goals listed at above.

5.6. The weight to be attached to the duty will be dependent on the nature of the decision and the circumstances in which it is made. This is a matter for the Mayor, bearing in mind the issues of relevance and proportionality. The Mayor must understand the impact or likely impact of the decision on those with protected characteristics who are potentially affected by the decision. The extent of the duty will necessarily vary from case to case and due regard is such regard as is appropriate in all the circumstances.

The Equality and Human Rights Commission has issued Technical Guidance on the Public Sector Equality Duty and statutory guidance entitled “Equality Act 2010 Services, Public Functions & Associations Statutory Code of Practice”. The Council must have regard to the statutory code in so far as it relates to the duty and attention is drawn to Chapter 11 which deals particularly with the equality duty. The Technical Guidance also covers what public authorities should do to meet the duty. This includes steps that are legally required, as well as recommended actions. The guidance does not have statutory force but nonetheless regard should be had to it, as failure to do so without compelling reason would be of evidential value. The statutory code and the technical guidance can be found at: <https://www.equalityhumanrights.com/en/advice-and-guidance/equality-act-codes-practice>

<https://www.equalityhumanrights.com/en/advice-and-guidance/equality-act-technical-guidance>

5.7. The Equality and Human Rights Commission (EHRC) has previously issued five guides for public authorities in England giving advice on the equality duty:

- [The essential guide to the public sector equality duty](#)
- [Meeting the equality duty in policy and decision-making](#)
- [Engagement and the equality duty: A guide for public authorities](#)
- [Objectives and the equality duty. A guide for public authorities](#)
- [Equality Information and the Equality Duty: A Guide for Public Authorities](#)

The essential guide provides an overview of the equality duty requirements including the general equality duty, the specific duties and who they apply to. It covers what public authorities should do to meet the duty including steps that are legally required, as well as recommended actions. The other four documents provide more detailed guidance on key areas and advice on good practice. Further information and resources are available at:

<https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equality-duty-guidance#h1>

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- 5.8. The essential guide provides an overview of the equality duty requirements including the general equality duty, the specific duties and who they apply to. It covers what public authorities should do to meet the duty including steps that are legally required, as well as recommended actions. The other four documents provide more detailed guidance on key areas and advice on good practice. Further information and resources are available at:

<https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equality-duty-guidance#h1>

6. Equalities implications

- 6.1. COVID-19 has had a disproportionate impact on specific groups including older adults, and those from Black, Asian and Minority Ethnic groups. Health and Wellbeing Board Members' attention should be drawn to the following reports regarding these inequalities:

- Disparities in the risks and outcomes of COVID-19, PHE, 2020 (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf)
- Beyond the data: understanding the impact of COVID-19 on BAME groups, PHE, 2020 (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf)

7. Climate change and environmental implications

- 7.1. There are no significant climate change and environmental implications of this report.

8. Crime and disorder implications

- 8.1. There are no significant crime and disorder implications of this report.

9. Health and wellbeing implications

- 9.1. The health and wellbeing implications for this report are outlined in the main body of text.

10. Report author and contact

- 10.1. Dr Catherine Mbema

Catherine.mbema@lewisham.gov.uk

Agenda Item 4

HEALTH AND WELLBEING BOARD			
Report Title	Better Care Fund 2021/22		
Contributors	Executive Director for Community Services, Director of Integrated Care and Commissioning for SELCCG (Lewisham), Director of System Transformation	Item No.	
Class	Part 1	Date:	8 September 2021
Strategic Context	Please see body of report		

1.1 This report provides members of the Health and Wellbeing Board with an update on the development of the Lewisham Better Care Fund (BCF) plan for 2021/22 which includes activity funded by the Improved Better Care Fund (IBCF). Members are asked to note the current position and agree the recommendations set out below.

2. Recommendations

2.1 Members of the Health and Wellbeing Board (HWB) are asked to:

- Note the delay in publication of the formal policy framework and planning guidance by NHS England.
- Delegate development of the plan and agreement on the schemes to the S75 Agreement Management Group.
- Agree to receive the BCF 2021/22 plan for formal sign off by members of the HWB at the next appropriate Board.
- Delegate future approval of the BCF/IBCF quarterly returns to the S75 Agreement Management Group with members to receive the returns for information at the next available HWB following submission.

3. Strategic Context

3.1 The Health and Social Care Act 2012 requires Health and Wellbeing Boards to encourage persons who arrange for the provision of any health or social services in the area to work in an integrated manner, for the purpose of advancing the health and wellbeing of the area.

3.2 The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund. It allows for the mandate to NHS England to include specific requirements relating to the establishment and use of an integration fund.

3.3 The BCF is a joint health and social care integration fund managed by Lewisham Council and South East London Clinical Commissioning Group (Lewisham). The strategic framework is set out in the national BCF policy framework and planning guidance.

4. BCF Plan 2021/22

4.1 On 19 August 2021, the Department of Health and Social Care and Ministry of Housing, Communities and Local Government published the Better Care Fund Policy Framework for 2021/22. The document is intended for use by those

responsible for delivering the BCF at a local level and sets out the national conditions, metrics and funding arrangements for the BCF in 2021/22. These are set out in more detail in sections 5, 6 and 7 of this report.

- 4.2 All Health and Wellbeing Boards in England must agree a plan for the use of pooled funding to support integrated health and care services. Pooled funding includes the Disabled Facilities Grant which provides housing adaptations and related support. As in previous years, the Winter Pressures Grant will be added to the pooled funding to encourage more proactive, joint planning ahead of winter and minimise seasonal pressures.
- 4.3 The Policy Framework states that a full planning round will be undertaken in 2021/22 with areas required to formally agree BCF plans and fulfil national accountability requirements. When published, the detailed 2021/22 BCF planning requirements which accompany the policy framework will set out further details of the national planning and assurance processes.
- 4.4 The national conditions of the BCF continue to set a minimum contribution to support social care from the NHS, to support the health and wellbeing of people with care needs and to reduce the need for more acute care.
- 4.5 As in previous years, the BCF 2021/22 plan will be developed by SEL CCG (Lewisham) and the Council. Activity supported through the BCF will be developed jointly by commissioners and providers and agreed by the Director of Integrated Care and Commissioning for the CCG and the Executive Director for Community Services for the Council, and informed by the strategic review that is taking place this year. The plan will be produced and supported by CCG and LBL finance officers.
- 4.6 The BCF Plan 2021/22 covers one financial year. The 2021/22 plan will continue to fund activity in the following areas:
- Prevention and Early Action
 - Community based care and the development of Neighbourhood Care Networks
 - Enhanced Care and Support to reduce avoidable admissions to hospital and to facilitate timely discharge from hospital
 - Estates and IMT
- 4.7 Officers are in the process of finalising the schemes that will be supported by the BCF to ensure compliance with the national conditions and measures to support the achievement of the metrics.

5. Funding Contributions

- 5.1 In 2020/21 the financial contribution to the BCF from the CCG was £23.291m. The uplift for the first half of 2021/22 was confirmed as 5.3% but NHS planning guidance for the second half of the year is not anticipated until September. If the uplift for the second half of the year was also confirmed as 5.3%, then this would result in a CCG full year contribution of £24.525m. The IBCF grant to Lewisham Council is £14.502m. The Winter Pressures Grant and the Disabled Facilities Grant which are paid to the Council also form part of the pooled funding in line with grant conditions.

6. National Conditions

- 6.1 The BCF plan is required to demonstrate that the following national conditions

have been met:

- National condition 1: a jointly agreed plan between local health and social care commissioners and signed off by the HWB
- National condition 2: NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution
- National condition 3: invest in NHS commissioned out-of-hospital services.
- National condition 4: plan for improving outcomes for people being discharged from hospital.

6.2 National condition 4 has been introduced as part of the BCF planning process in 2021/22. This condition requires areas to agree a joint plan to deliver health and social care services that support improvement in outcomes for people being discharged from hospital, including the implementation of the hospital discharge policy, and continued implementation of the High Impact Change Model for Managing Transfers of Care.

6.3 Reporting of Delayed Transfers of Care was suspended in March 2020 and replaced with a situation report that reflects the revised hospital discharge policy. In 2021/22, performance on discharge on a HWB footprint will be monitored using data collected from hospital systems through the NHS Secondary Uses Service (SUS) and used to inform support offers to systems.

6.4 The BCF 2021/22 plan should focus on improvements in the key metrics below:

- Reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days;
- Improving the proportion of people discharged home using data on discharge to their usual place of residence.

6.5 Further details on measuring discharge will be set out in the BCF planning requirements.

6.6 In line with the Policy Framework the NHS contribution to adult social care has been maintained in line with inflation.

6.7 Through the BCF, investment will be made in the following NHS Commissioned out-of hospital services. These include:

- Primary Care
- Community Based Falls Team
- Community Mental Health Services including Home Treatment Team and Care Home Intervention Team
- Medicines Management
- Enablement Services

7. Planned Activity

7.1 The 2021/22 plan will outline targets and plans to deliver against the four national metrics:

- Discharge Indicator Set
- Avoidable admissions to hospital
- Admissions to residential and care homes

- Effectiveness of reablement

7.2 Information on specific metric targets for 2021/22 will be set out in the final BCF plan.

7.3 As in previous years, Lewisham Health and Care Partners aim to achieve a sustainable and accessible health and care system which supports people to maintain and improve their physical and mental wellbeing, to live independently and be able to access high quality care when they need it. The 2021/22 BCF plan will continue to contribute to the achievement of the LHCP aim.

7.4 Further information on planned activity in 2021/22 will be included in the narrative sections of the BCF plan.

8. Governance

8.1 The BCF arrangements are underpinned by pooled funding arrangements with a section 75 agreement. A section 75 agreement is an agreement made under section 75 of the National Health Services Act 2006 between a local authority and an NHS body in England. It can include arrangements for pooling resources and delegating certain NHS and local authority health related functions to the other partner.

8.2 The Section 75 Agreement Management Group (Adults) will oversee the 2021/22 BCF plan and expenditure. Further information on the governance arrangements will be included in the final 2021/22 BCF plan.

9. Financial Implications

9.1 There are no financial implications arising from this report. Monitoring of the activity supported by the Better Care Funding continues to be undertaken by the Section 75 Agreement Management Group (Adults).

10. Legal implications

10.1 As part of their statutory functions, members are required to encourage persons who arrange for the provision of any health or social services in the area to work in an integrated manner, for the purpose of advancing the health and wellbeing of the area, and to encourage persons who arrange for the provision of health-related services in its area to work closely with the Health and Wellbeing Board.

10.2 Where there is an integration of services and/or joint funding, then this is dealt with under an agreement under Section 75 of the NHS Act 2006 which sets out the governance arrangements for the delivery of services, and where relevant any delegation of functions from one party to another and the respective budget contributions of the local authority and the CCG in relation to the services.

11. Crime and Disorder Implications

11.1 There are no specific crime and disorder implications arising from this report or its recommendations.

12. Equalities Implications

12.1 Tackling inequalities in health is one of the overarching purposes of integration.

Each new or existing service funded by the BCF has regard to the need to reduce inequalities in access to care and outcomes of care. An equalities assessment/analysis is undertaken as part of the development of any new proposals to assess the impact of the new services on different communities and groups.

13. Environmental Implications

- 13.1 There are no specific environmental implications arising from this report or its recommendations.

14. Conclusion

- 14.1 This report provides an overview of the development of the Better Care Fund 2021/22 plan. Members are asked to note the contents and agree the recommendations set out in the report. Following submission, the BCF plan will be subject to a national assurance process. Confirmation of the timeframe for the SEL CCG (Lewisham) and the Council to be notified of the outcome of this process is awaited.
- 14.2 If you have problems opening or printing any embedded links in this document, please contact mark.burnnell@lewisham.gov.uk.
- 14.3 If there are any queries on this report please contact sarah.wainer@nhs.net.



Lewisham Health and Wellbeing Board

Report title: Lewisham Health Inequalities update

Date: 8th September 2021

Key decision: No

Class: Part 1

Ward(s) affected: All

Contributors: Dr Catherine Mbema, Director of Public Health, London Borough of Lewisham

Outline and recommendations

This report provides an update to the Board on local work to tackle Black, Asian and Minority Ethnic Health Inequalities in Lewisham.

Members of the Health and Wellbeing Board are recommended to:

- Note the contents of this report
- Note the updates to the Health Inequalities Toolkit
- Note the update approach to the proposed Health Inequalities Summit

Timeline of engagement and decision-making

1. Summary

- 1.1. This report provides an update to the Board on local work to tackle Black, Asian and Minority Ethnic Health Inequalities in Lewisham.

2. Recommendations

- 2.1. Members of the Health and Wellbeing Board are recommended to:
 - Note the contents of this report
 - Note the updates to the Health Inequalities Toolkit
 - Note the update approach to the proposed Health Inequalities Summit

3. Policy Context

- 3.1. The Health and Social Care Act 2012 required the creation of statutory Health and Wellbeing Boards in every upper tier local authority. By assembling key leaders from the local health and care system, the principle purpose of the Health and Wellbeing Boards is to improve health and wellbeing and reduce health inequalities for local residents.
- 3.2. The activity of the Health and Wellbeing Board (HWB) is focussed on delivering the strategic vision for Lewisham as established in Lewisham's Health and Wellbeing Strategy.
- 3.3. The work of the Board directly contributes to the Council's new Corporate Strategy. Specifically *Priority 5 – Delivering and Defending: Health, Social Care and Support – Ensuring everyone receives the health, mental health, social care and support services they need.*

4. Background

- 4.1. In July 2018 the HWB agreed that the main area of focus for the Board should be tackling health inequalities, with an initial focus on health inequalities for Black, Asian and Minority Ethnic communities in Lewisham.
- 4.2. Following analysis undertaken by a sub group of the Board, three priority areas were

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identified through which the Board could play a significant role in addressing the widest gaps in ethnic health inequalities. The areas identified were: mental health; obesity; and cancer.

- 4.3. A draft action plan covering all three priority areas (cancer, obesity and mental health) was developed in July 2019 in response to a referral made by the Healthier Communities Select Committee.
- 4.4. At the November 2019 Health and Wellbeing Board meeting, Board members agreed to further refine the draft action plan with the Lewisham Black and Minority Ethnic Network taking a co-production approach.
- 4.5. At the March 2020 Health and Wellbeing Board meeting, a further draft of the action plan was approved by Board members with an agreement to return to the next Board meeting with monitoring metrics to capture progress and impact of completing actions within the plan.
- 4.6. A Health Inequalities Toolkit and Health Inequalities Summit are being developed as part of this action plan.

5. Lewisham Health Inequalities and Health Equity Toolkit

- 5.1. A Health Inequalities Toolkit has been developed to provide a data overview of existing health inequalities Lewisham. The aim of this toolkit is to present data in a user-friendly format that can be used by community members and will also inform data insights for the joint work with Birmingham.
- 5.2. The development of the toolkit has taken a partnership approach to collate data from Health and Wellbeing Board partner organisations.
- 5.3. The toolkit aims to give all Lewisham stakeholders:
 - An introduction to health inequalities
 - An overview of the health inequalities in Lewisham
 - An overview of what is happening to address health inequalities in Lewisham
 - Suggestions for further collaborative action to tackle health inequalities in Lewisham
- 5.4. This toolkit will be refreshed every other year alongside the publication of the Annual Public Health Report and Picture of Lewisham documents.
- 5.5. The toolkit will be published on the Lewisham Observatory website:
<https://www.observatory.lewisham.gov.uk/>

6. Lewisham Health Inequalities Summit

- 6.1. A Lewisham Health Inequalities Summit has been proposed to take place in the autumn 2021 to take stock of what we have achieved to date in terms of addressing health inequalities in Lewisham and to plan for a system-wide approach going forward.
- 6.2. A planning group has been convened for the summit and developed a refined proposal for the objectives and approach required. The aim of the summit and associated events will be to support behaviour change in senior leadership and shift organisational decision making and investment to address health and wellbeing inequalities and equity in Lewisham.
- 6.3. COVID-19 exacerbated health inequalities which will continue to escalate through a

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disproportionate legacy (e.g. increased poor mental and physical health, unemployment, income/debt issues, housing issues, lack of care system capacity).

- 6.4. Health inequalities and inequity were unsustainable issues pre-COVID-19 and now require urgent radical change. Addressing health inequalities and improving equity at population level requires actions that are evidence-based, outcomes orientated, systematically applied, appropriately resourced and sustainable.
- 6.5. Developmental work at South East London CCG provides a basis to develop a system-wide approach across Lewisham leadership by developing individual and organisational understanding to deliver commitment, action and investment. There are also promising developments within Lewisham with the potential to achieve change if implemented (and invested in) at scale. This work will support statutory functions for health inequalities and population health management across the ICS in April 2022.
- 6.6. The main objectives of the summit and associated events will be to:
- Develop system leaders' understanding of the scale and implications of health inequalities and inequity in Lewisham and their individual and organisational role and responsibility in addressing them.
 - Support understanding across system leaders of evidence-based actions and investment to address health and wellbeing inequalities and inequity.
 - Identify specific, measurable actions and investments across anchor organisations and others to address health and wellbeing inequalities and inequity.
- 6.7. A developmental approach will support system leader and organisational change through supporting individual development (e.g. developing capability and motivation for action) and organisational development (e.g. improvement approach)
- 6.8. A three staged approach has been proposed:
- i) Developing individual and organisational understanding of health inequalities and inequities and their role and responsibility – October 2021
 - ii) Support collaborative evidence-based action planning and investment with a specific workshop/summit to facilitate this – November 2021
 - iii) Identification of actions – January-March 2021
- Organisations develop their own action plans for addressing health inequalities in health equity.
 - Develop a community event to present and discuss plans.

7. Financial implications

- 7.1. There are no significant financial implications of this report and resourcing of the toolkit

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and summit being developed will come from existing Public Health grants.

8. Legal implications

8.1. Members of the Board are reminded of their responsibilities to carry out statutory functions of the Health and Wellbeing Board under the Health and Social Care Act 2012. Activities of the Board include, but may not be limited to the following:

- To encourage persons who arrange for the provision of any health or social services in the area to work in an integrated manner, for the purpose of advancing the health and wellbeing of the area.
- To provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging the making of arrangements under Section 75 NHS Act 2006 in connection with the provision of such services.
- To encourage persons who arrange for the provision of health related services in its area to work closely with the Health and Wellbeing Board.
- To prepare Joint Strategic Needs Assessments (as set out in Section 116 Local Government Public Involvement in Health Act 2007).
- To give opinion to the Council on whether the Council is discharging its duty to have regard to any JSNA and any joint Health and Wellbeing Strategy prepared in the exercise of its functions.
- To exercise any Council function which the Council delegates to the Health and Wellbeing Board, save that it may not exercise the Council's functions under Section 244 NHS Act 2006.

9. Equalities implications

9.1. This report specifically aims to address health inequalities by outlining the development of a toolkit and plans for a health inequalities summit.

10. Climate change and environmental implications

10.1. There are no climate change or environmental implications of this report.

11. Crime and disorder implications

11.1. There are no crime and disorder implications of this report.

12. Health and wellbeing implications

12.1. Improving health outcomes and reducing health inequalities is central to the work of the Health and Wellbeing Board. This report directly aligns with these aims by outlining the development of a toolkit and plans for a health inequalities summit.

13. Report author and contact

13.1. Dr Catherine Mbema, Catherine.mbema@lewisham.gov.uk

Lewisham Health Inequalities Toolkit
June 2021

What's inside?

Purpose of this toolkit

Introduction to health inequalities

Lewisham and health inequalities

Overview of Lewisham health inequalities indicators

What is happening in Lewisham to address health inequalities?

Further resources

Purpose of this toolkit

This health inequalities toolkit has been developed for Lewisham residents, community groups and all other Lewisham stakeholders with an interest in health inequalities.

The toolkit aims to give all Lewisham stakeholders:

- An introduction to health inequalities
- An overview of the health inequalities in Lewisham
- An overview of what is happening to address health inequalities in Lewisham
- Suggestions for further collaborative action to tackle health inequalities in Lewisham

This toolkit will be refreshed every other year alongside the publication of the Annual Public Health Report and Picture of Lewisham documents.

Contributors

Robert Williams, Michael Brannan, Patricia Duffy, Brian Coutinho, Jacqueline Francis, Kerry Lonergan, Lisa Fannon, Daniel Johnson, Catherine Mbema

Introduction to Health Inequalities and Health Equity

Health inequalities are avoidable and unjustified differences in the health and wellbeing of groups and individuals, so are not inevitable or immutable.

Health equity means that everyone has a fair and just opportunity to be as healthy as possible.

In a borough guided by the principle “The welfare of the people is supreme”, we seek to address health inequalities, achieve health equity and create a just community.

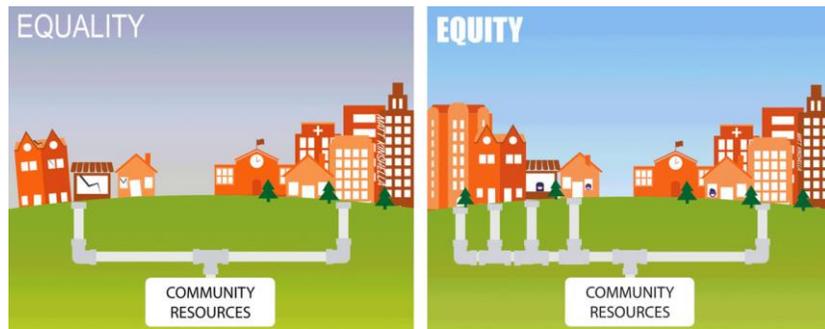
Health inequalities manifest across a number of areas and outcomes, including:

- Health status, e.g. obesity and life expectancy
- Access to care e.g. availability of NHS care
- Quality and experience of care, e.g. patient satisfaction
- Health behaviours, e.g. smoking and unhealthy diets
- Social determinants, e.g. housing and income

Despite the existence of the NHS in 1948 as a universal, free at the point of care health service, health inequalities persist and are increasing across England (e.g. a 2020 review by the Health Equity Institute and Prof Sir Michael Marmot demonstrated life expectancy has stopped increasing for the first time since 1900 and years spent in poor health is increasing, with inequalities in both increasing).

The greatest drivers of health (positive and negative) and health inequalities are not related to the health service and are driven by social and economic factors (the ‘social determinants of health’); See Figure 2 and 3.

Figure 1 Understanding equality and equity (Avarna Group, 2019, Matt Kinchella, 2016)



There are a number of aspects through which you can consider health inequalities:

- Socioeconomics and deprivation
- Geography
- Individual characteristics protected by law (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion, sex and sexual orientation)
- Socially excluded groups

Individuals and groups may span these characteristics, suffering multiple inequalities that multiply the negative impacts on health. 'Intersectionality' considers how these inequalities interact.

Figure 2 The Social determinants of health (Dahlgren and Whitehead, 1991)

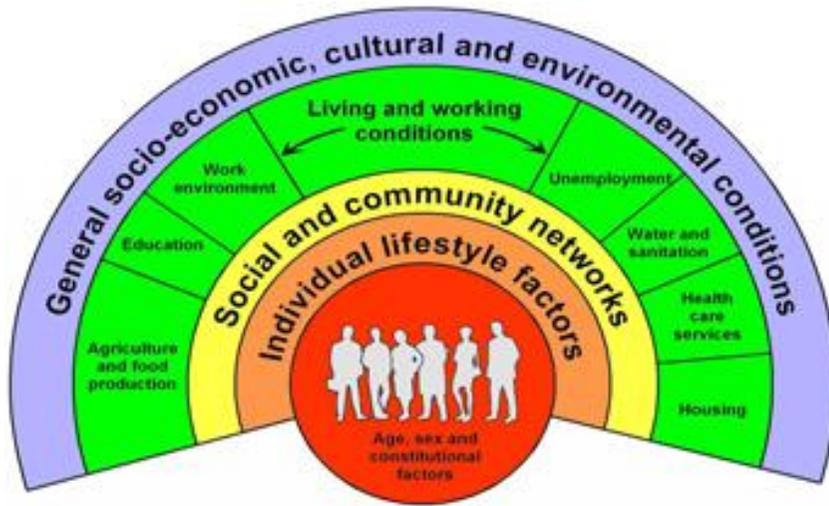
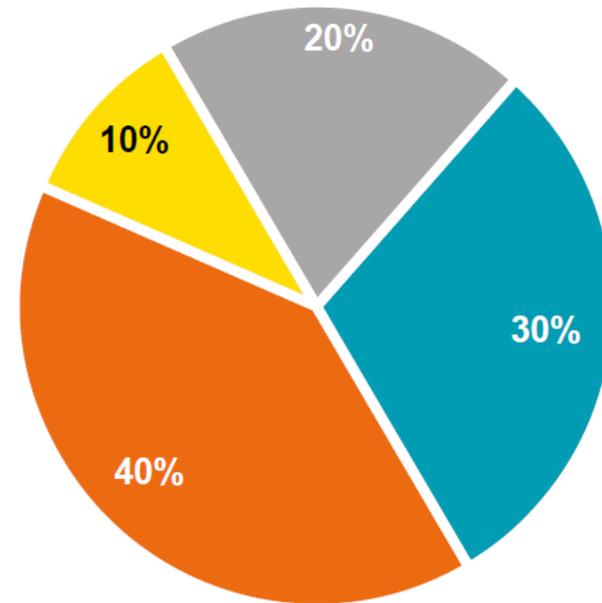


Figure 3

Figure 3: Factors that have the greatest influence on health (INSERT REF)



■ health behaviours ■ clinical care
■ socio-economic factors ■ built environment

- Health behaviours**
- Smoking
 - Diet/exercise
 - Alcohol
 - Poor sexual health

- Socio-economic factors**
- Education
 - Employment
 - Income
 - Family/social support
 - Community safety

For most health outcomes there is a 'social gradient' of health inequalities, whereby there is an inverse relationship between your socioeconomic status and your outcome; i.e. the less income you have the worse your outcome. This is particularly stark in life expectancy and disability-free life expectancy (i.e. years of life without disability); see Figure 4.

The nature of a gradient is that everyone is on it. Unless you are at the top, you are likely to live for shorter length of time and develop a disability earlier than those at the top.

Evidence also suggests that the more unequal a society, the worse the outcome for the whole population. Comparing health and social care outcomes between countries based on income inequality suggests a direct, inverse relationship between income inequality and health and social problem; Figure 3.

Figure 4 Life expectancy (LE) & disability-free LE by income (Marmot Review 2020)

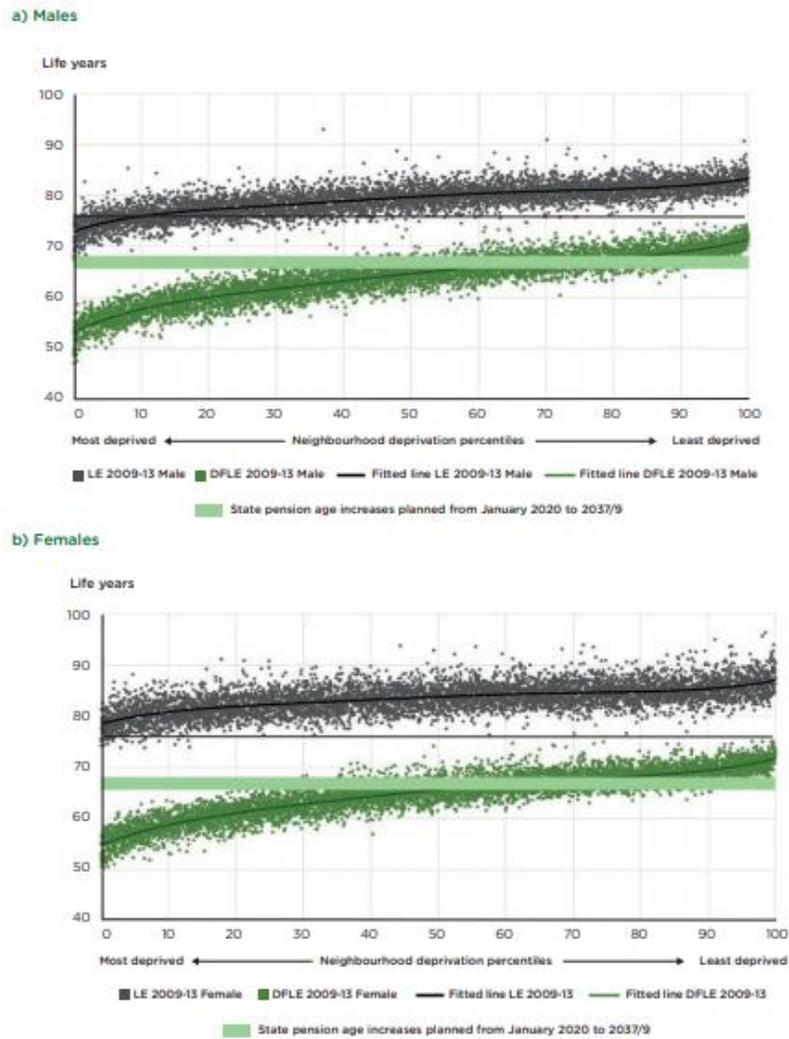
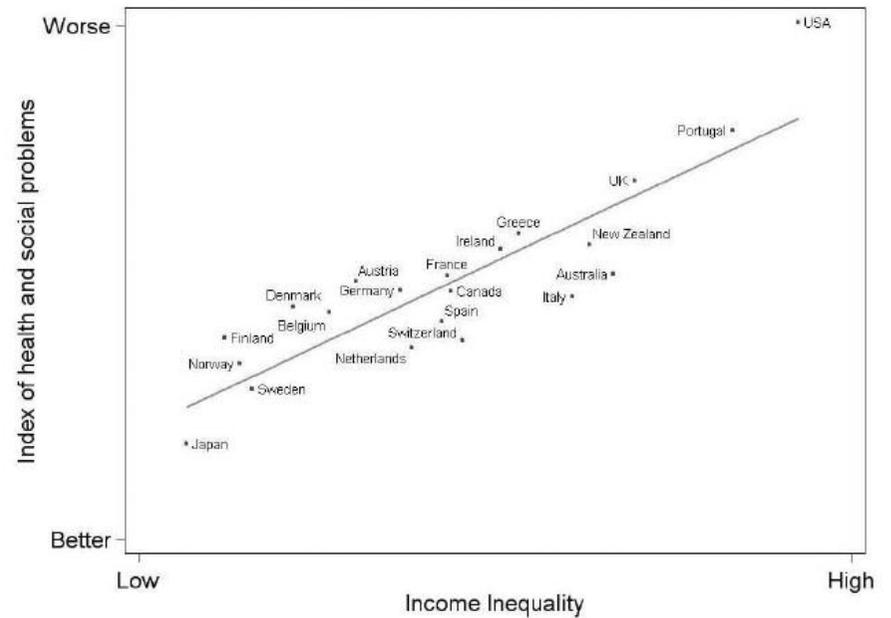


Figure 5 Association of health and social problems with income inequality



Index of health and social problems includes: life expectancy, maths and literacy, infant mortality, homicides, Imprisonment, teenage births, Trust, Obesity, social mobility, mental illness.

What works to reduce health inequalities?

The Strategic Review of Health Inequalities in England post-2010 (the Marmot Review) suggested that action to improve health and well-being for all and to reduce health inequalities should have two policy goals:

- To create an enabling society that maximises individual and community potential; and
- To ensure social justice, health and sustainability are at the heart of all policies

It demonstrated that health is accumulated through positive and negative experiences over a life-time, therefore there is a need to take a 'life course approach'. This approach focuses on six key areas:

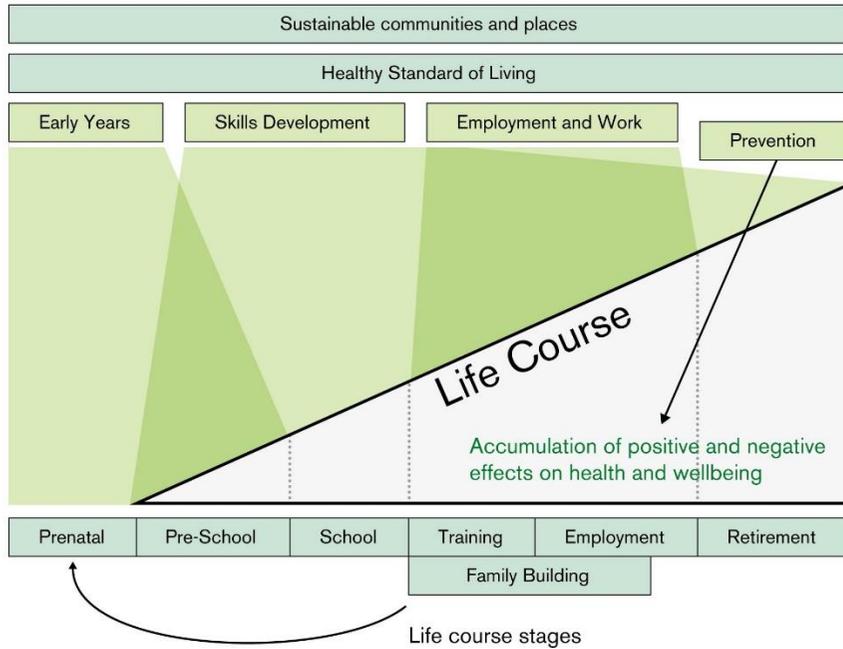
1. Give every child the best start in life.
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all.
4. Ensure healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill health prevention.

Whilst health inequalities impacts across a community, the social gradient of impacts dictates that not everyone is equally impacted. Therefore action should be based on 'proportionate universalism', with universal action delivered proportionately to need (i.e. those with the greatest need get proportionately more support).

Recognising that health inequalities are primarily driven by the physical, social and economic environment live in and that they impact communities as well as individuals, it is critical to focus on community centred approaches rather than individual behaviours. Successful action to address health inequalities must involve and actually led by communities through community-centred approach (Figure 7).

Figure 6 What works to address health inequalities? (Marmot Review, 2010)

i) Across the life course



ii) Evidence-based approaches to reduce health inequalities

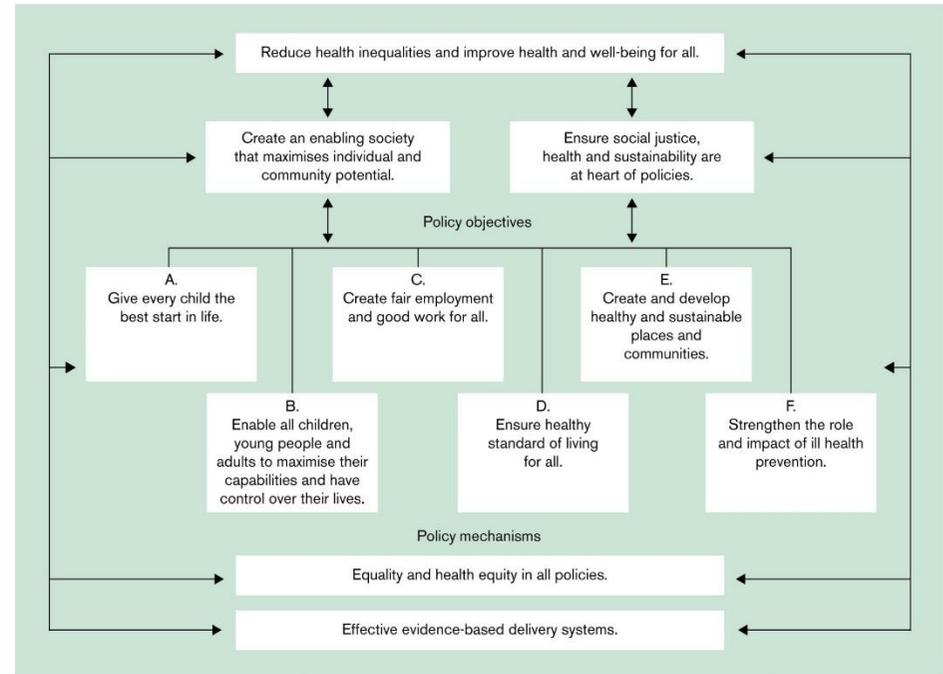
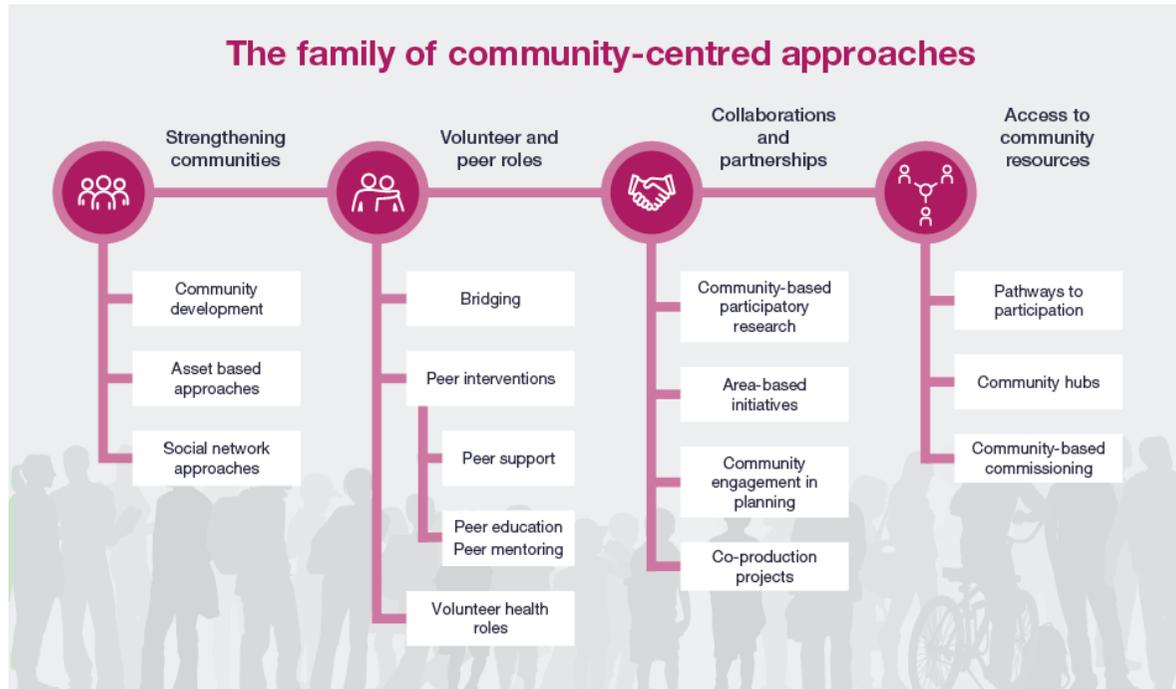


Figure 7 Community-centred approaches (PHE 2018)



Lewisham and Health Inequalities

Overview

In Lewisham, if you are a baby boy born in a household that falls within the least deprived areas within the borough you can expect to live just over 7 years longer than a fellow boy born in a household within the most deprived areas. This difference in health status (in this case life expectancy at birth) based on deprivation is a stark example of the health inequalities that are present in Lewisham.

Lewisham's greatest strength is the people who live and work here. We have a young, diverse and growing population, home to residents from more than 75 nationalities and with over 170 languages spoken.

Therefore there must be both targeted and universal action to reduce these inequalities i.e. the concept of proportionate universalism. Tackling these inequalities cannot be achieved by one organisation or group alone, it must be collaborative. In Lewisham, one of our key priorities is to reduce these health inequalities, particularly those from Black, Asian and Minority Ethnic backgrounds. We have been working with our local partners on this key priority through the local Health and Wellbeing Board (HWB) since July 2018.

Ethnic Health Inequalities

As well as focussing on socio-economic inequalities it is important to recognise health inequalities that exist between different ethnic groups. As shown later in this report, rates of disease and ill health vary widely between and within different ethnic groups. Additionally, these inequalities are not evenly spread between health conditions. Furthermore, there are often differences in health between genders, as well as between different generations of Black, Asian and Minority Ethnic groups.

The causes of these inequalities are complex. Rates of low-income households are higher in ethnic minority groups, services both health and non-health may not be culturally sensitive to users, and racial discrimination still persists. The challenges that Lewisham faces in reducing health inequalities are not unique and are seen across the country. However, data collection on these inequalities is poor. Another finding from the Marmot 10 Years On review was that there was limited data on health inequalities between ethnic groups. We echo the calls of the Marmot

Review which is for better data on ethnic health inequalities. This will help both national and local policy makers design services and policy interventions to reduce these inequalities.

Lewisham Population - Protected Characteristics and Geography

Age and Sex

Lewisham has a relatively young population with just under 25% of residents aged under 18 years.

	Male	Female	Total
0-17	35,095	33,363	68,458
18-64	102,157	104,440	206,597
65+	12,597	15,884	28,481
Total	149,849	153,687	303,536

Median age: 35.0 years

Source: [ONS 2018 Mid-Year Population Estimates](#)

Race (Ethnicity)

The latest estimated figures show that the largest ethnic group in Lewisham remains White with 51.8%, including those from White ethnic minority backgrounds, followed by Black African 11.6% and Black Caribbean backgrounds 9.8%. Black ethnic groups make up in total nearly a third of the borough's population.

The composition of the demographics for younger people is quite different to the population as a whole. While the white ethnicity group remains the single largest single group at 34%. The Black groups as a whole make up 45% of the under 18 population, with Black African and Black Caribbean population composing 24% of the population. While, Black Other population (including those of Mixed White and Black race) make up a further 21%.

Meanwhile, the over 65s population is 59% White British, with ethnic minority groups making up 30%. The Black Caribbean community is the second largest ethnic group making up 13% of the over 65 population.

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Religion or belief

	2011 Census	
	Number of residents	% of residents
<i>All residents (as of March 2011)</i>	275,885	100%
<i>Christian</i>	145,588	52.8%
<i>Buddhist</i>	3,664	1.3%
<i>Hindu</i>	6,562	2.4%
<i>Jewish</i>	643	0.2%
<i>Muslim</i>	17,759	6.4%
<i>Sikh</i>	531	0.2%
<i>Other religion</i>	1,478	0.5%
<i>No religion</i>	75,155	27.2%
<i>Religion not stated</i>	24,505	8.9%

[The 2011 Census remains](#) the most comprehensive source for data on religion/faith for residents.

Sexual orientation

Data on sexual orientation is not readily available at a local authority level. The best estimates are based upon the Office for National Statistics Annual Population Survey, which asks a question regarding sexual orientation. 2.7% of people over the age of 16 nationally identified as Lesbian, Gay or Bisexual. This rises to 6.6% of those aged 16-24% showing a changing demography that is being led by those of a younger age. 2.9% of males identified as LGB, while 2.5 of females identified as LGB. If the national figures were applied to Lewisham, this would equate to 16, 500 residents.

[Source: ONS Sexual Orientation, UK: 2019.](#)

Disability

14.5% of residents are living with a long term condition which limits their daily activities. This is slightly below the England average of 17.6%, however this is likely to be due to the younger population bias. For those of working age this reduces to 11.5%.

Pregnancy and maternity

There were 4,393 live births in Lewisham in 2019. ([ONS, 2020](#))

Marriage and Civil Partnership

The 2011 Census asked adult residents about that marital status. Almost half of the population stated they were single.

	Single	Married	Civil Partnership	Separated	Divorced	Widowed
% Martial status	49.7	32.7	0.5	4.3	8.1	4.6

Gender reassignment

We do not have any reliable local figures regarding gender reassignment. Currently data is not readily available on gender identity. The 2021 census included a voluntary gender identity question that was asked of those 16 years and over. When released, the data on gender identity may be useful in helping to identify areas for policy development and service planning.

Overview of Lewisham Health Inequalities Indicators

The public health outcomes framework (PHOF) from Public Health England (PHE) outlines key public health indicators in five key areas:

1. **Overarching indicators**
2. **Wider determinants of health**
3. **Health Improvement**
4. **Health Protection**
5. **Healthcare and Premature Mortality**

PHE have developed a Health Inequalities Dashboard to present evidence of health inequalities in England. The dashboard provides measures of inequality for key indicators being used by PHE to monitor progress on reducing health inequalities within England.

This toolkit presents the available data for Lewisham from the PHE Dashboard across the five areas outlined. Data has been taken from the most recently updated version of the PHE Dashboard (2nd March 2021). Where there is local data available with measures of inequality in any of these five areas by geography, deprivation or protected characteristic, it will be presented.

1. Overarching indicators

Life expectancy at birth

Life expectancy at birth data is available for Lewisham by area deprivation levels. This is also available split by gender (male and female).

Life expectancy at birth has increased for men between 2001-03 (74.5 years) and 2017-19 (79.1 years), however the rate of increase has slowed in recent reporting periods. This has also increased for women between 2001-03 (79.1 years) and 2017-19 (83.8 years) with the rate of increase slowing in the last 2 reporting periods (since 2013-15).

Slope index of inequality (SII) in life expectancy based on Index of Multiple Deprivation deciles

The Slope Index of Inequality (SII) in life expectancy for men in Lewisham was 7.4 years for the 2017-19 reporting period. This indicates the variation in life expectancy across most to least deprived areas in Lewisham for men is 7.4 years. The SII in life expectancy was lower for women at 5.8 years for the 2017-19 reporting period indicating a less steep gradient of inequality in life expectancy at birth.

2. Wider determinants of health

School readiness (% children not achieving a good level of development)

Education is an important determinant of health and school readiness i.e. children defined as having reached a good level of development at the end of the Early Years Foundation Stage (EYFS) is an indicator of early childhood learning and development. In Lewisham the proportion of children not reaching a good level of development at the end of EYFS was 23.6% for the 2018/19 reporting period.

In terms of inequality, this data is available for those who receive free school meals (FSM) and those that do not, which can be used as a proxy measure for deprivation. The absolute gap in those not achieving a good level of development between those receiving FSM and those who do not was 12.1% for the 2018/19 reporting period (34% for those receiving FSM and 21.9% for those who do not), which is an increase in absolute gap since 2013-14 (9.5%). The relative gap i.e. the proportional gap between those receiving FSM and those who do not was 1.6 for the 2018/19 reporting period. This indicates that children from deprived backgrounds in Lewisham are more at risk of poorer development and the evidence shows that differences by social background emerge early in life.

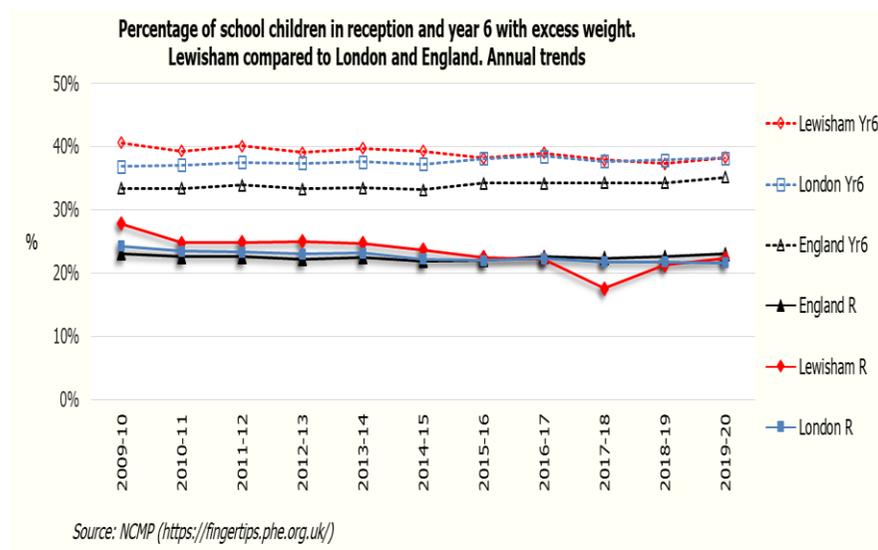
Employment rate

Employment and the availability of good work is another important determinant of physical and mental health and wellbeing. In terms of inequality the rate of employment in Lewisham is available for those that have a long-term health condition (that is expected to last for more than 1 year) and those who do not. In Lewisham the gap between employment rates in those aged 16-64 years with a long-term condition and the overall employment rate was 12.9% for the 2019-20 reporting period, with the rate being lower in those with a long-term condition. This gap has fluctuated in Lewisham since 2013 and 2020, being lowest in 2015-16 at 4.2% and highest in 2013-14 at 13.4%.

3. Health Improvement

Prevalence of overweight and obesity for reception and year 6 children (Local National Child Measurement Programme data)

Lewisham has high levels of childhood obesity with one in five children in Reception Year with excess weight (overweight or obese), similar to London and England levels. This rises to nearly two in five children in Year 6, similar to London but significantly higher than England. There has been a small reduction in prevalence but the challenges and inequalities persist. There are differences in childhood obesity levels depending on where children live in the borough with highest levels found in areas of highest deprivation, half of Year 6 children in New Cross are overweight or obese compared with just over a quarter in Crofton Park. There are differences depending on children’s ethnic background too, with 43% of Lewisham’s Black Year 6 children being overweight or obese compared with 26% of their White counterparts.



Children identifying as Black African, Black Caribbean and Black other have the highest BMI in both school years.

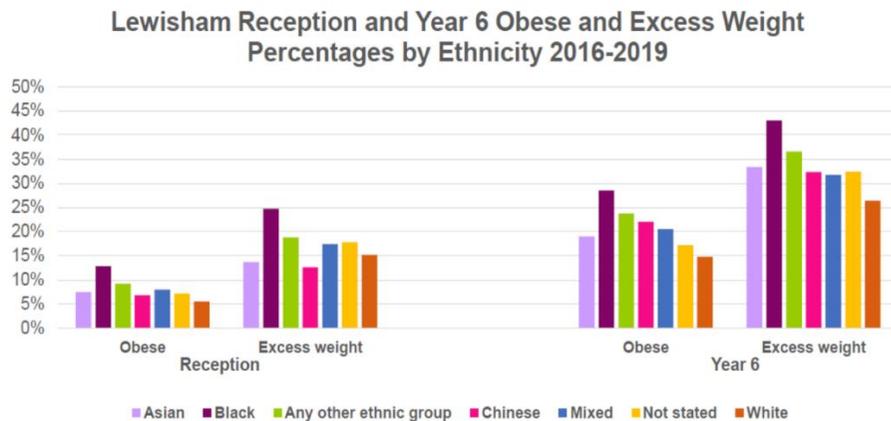


Figure 8 Excess weight in Lewisham (Annual Trends and by ethnicity)

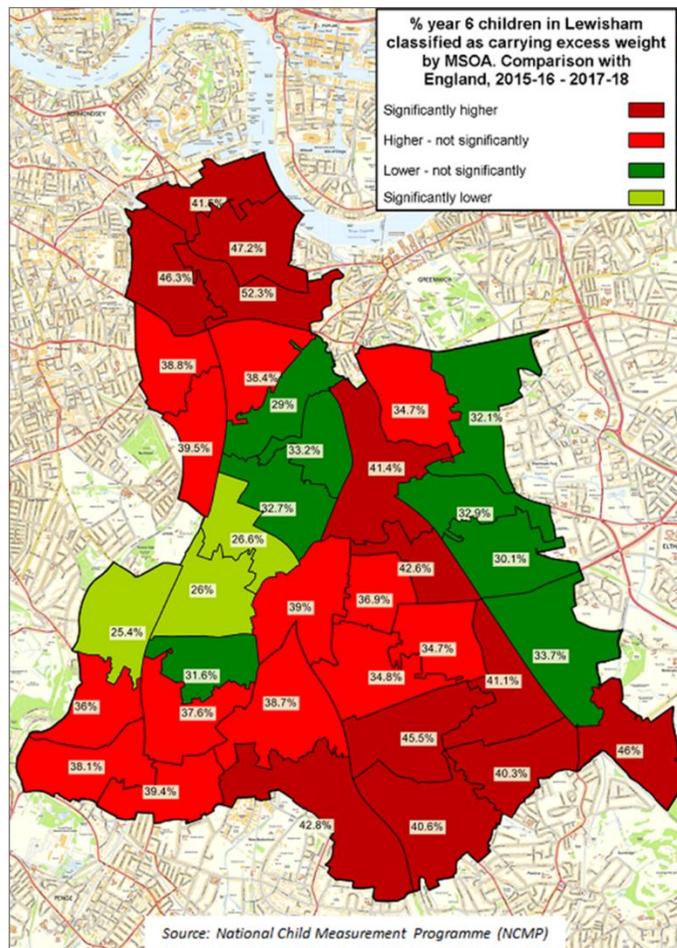
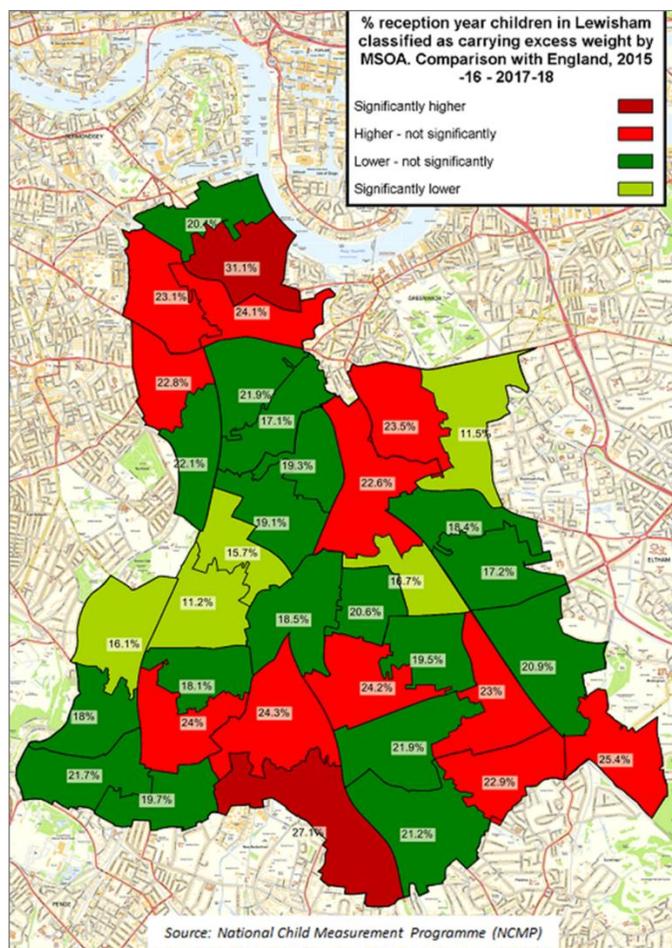


Figure 9 Excess weight in Lewisham by MSOA (reception and year 6)

Smoking Prevalence in adults (18+) - current smokers (APS)

Smoking is the one of the most important causes of preventable ill health and premature mortality in the UK. Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. It is also associated with cancers in other organs, including lip, mouth, throat, bladder, kidney, stomach, liver and cervix. Smoking rates in Lewisham are above the London and England average rates.

Smoking Prevalence in adults (18+) current smokers (%) 2018	
Lewisham	16.7
London	13.9
England	14.4

In terms of inequality there is significant divergence in smoking prevalence between social classes. Those in routine and manual occupations are most likely to smoke and in Lewisham have a smoking prevalence of 25.9%, while those in managerial and professional occupations are the least likely to smoke with a prevalence of 13.8% for the 2018 reporting period.

Lewisham is above the national and regional average for those who have quit smoking at 4 weeks, with 2,344 smokers quitting per 100,000 in Lewisham compared to 1960 in London and 1894 in England. This is a trend that has been in place since 2013, when Lewisham initiated and redesigned its Stop Smoking services. The target is to reduce smoking to 12%. In Lewisham we know that 30% of those who quit smoking are from minoritised groups: 8.5% black Caribbean, 5.3% black African, 1.5% other black groups, 5.2% all Asian groups, 5.4% mixed, 3.6% Chinese.

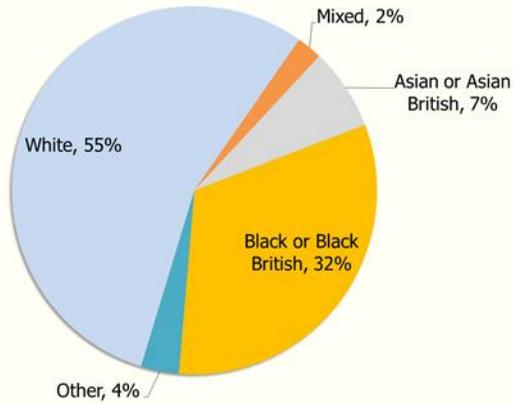
NHS Health Checks Programme

By promoting healthy ageing and tackling the top seven risk factors for early death and disability, the NHS Health Check provides a cornerstone for the prevention of cardiovascular disease, as well as kidney disease, type 2 diabetes and dementia. People are invited for a NHS health check every five years. Lewisham is now in its second five year cycle of invitations. Eligible people are defined as 40-74 year olds who are not already identified as having vascular disease or on a disease register and have not received a Health check in the past five years. Ensuring that a high percentage of the eligible population have a NHS Health Check is key to optimising the clinical and cost effectiveness of the programme.

The following key priority groups, who have an increased risk of cardiovascular disease are prioritised for invitation for a Health Check. They are: South Asians, males, people with a family history of cardiovascular disease, smokers and people residing in areas of higher deprivation by

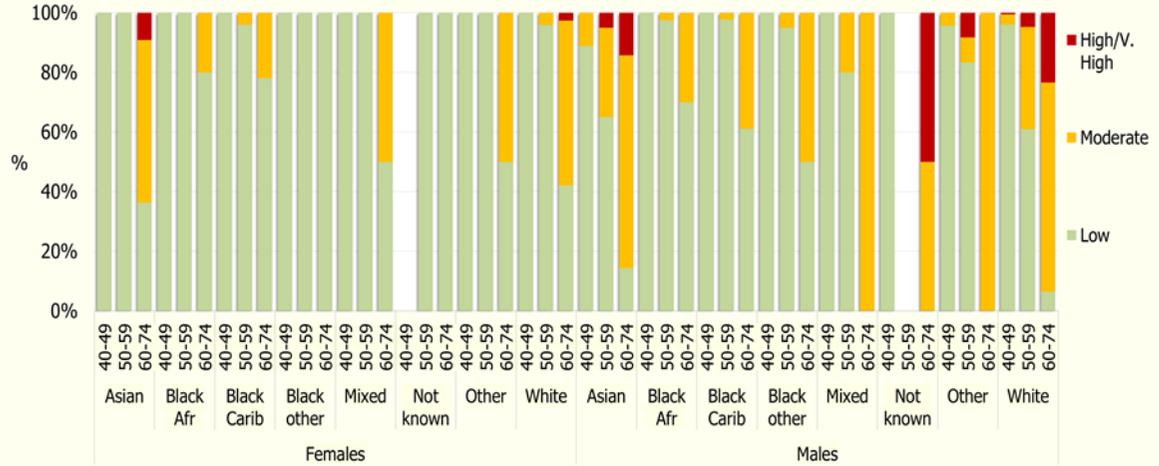
postcode. Whilst the White population received over 50% of NHS Health Checks in Lewisham in the financial year, due to the older average age profile of this population this was representative.

All NHS Health Checks delivered, by ethnicity, Lewisham, 2020-21



Source: QMS Health Check Focus

Percentage of the completed Health Checks by cardiovascular disease risk category, ethnicity and sex, 2020-21



Source: QMS Health Check Focus

4. Health Protection

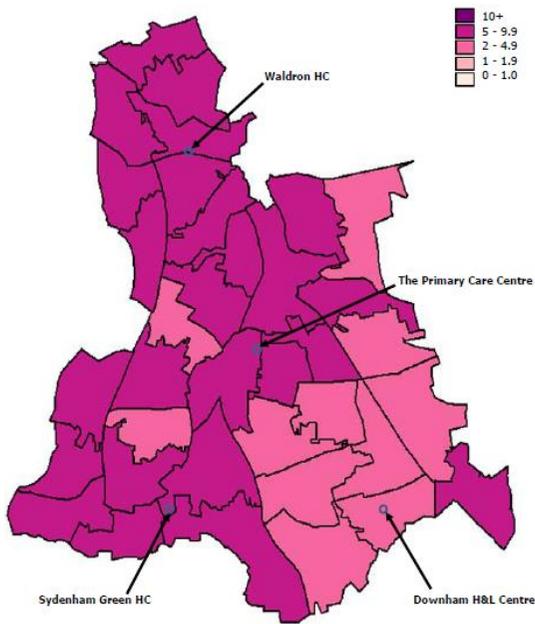
HIV Late Diagnosis

Lewisham has one of the highest rates of HIV prevalence in the country, with a new diagnosis rate at 20.1 per 100,000 aged 15+. HIV is now a treatable and liveable disease, however if diagnosed late there is a significantly higher risk of premature death. Therefore reducing the number of people who have a late diagnosis is vital. In Lewisham the late diagnosis rate from 2016-18 was 44.3%.

	Lewisham	London	England
New HIV diagnosis rate/ 100,000 aged 15+	20.1	20.9	8.8
HIV late diagnosis (%)	44.3	37.1	42.5

These figures paint a mixed picture with the new diagnosis rate lower than the London average, but the percentage of late diagnoses higher. The distribution of HIV prevalence is not even across the borough (Figure 10).

Figure 10 HIV prevalence/1000 population of all ages by Lewisham MSOA, 2017



Source: HIV and AIDS Reporting System (LASER report)

London wide the data shows that 48% of London residents diagnosed as living with HIV were White, while 31% were of Black African ethnicity. The rate of diagnosed HIV prevalence between ethnic groups varies significantly across London, from 26.0 per 1,000 residents aged 15-59 in the Black African population to 1.0 in the Indian/Pakistani/Bangladeshi population.

In Lewisham, heterosexual contact is the most common exposure type (54%) of those diagnosed with HIV. This differs from neighbouring boroughs where sex between men is the most common HIV exposure category. Late diagnosis is significantly higher in heterosexual men and women in comparison to men who have sex with men (MSM).

HIV late diagnosis (%), Lewisham 2018	
Heterosexual men	64.5
Heterosexual women	48.8
Men who have sex with men	34.8

In Lewisham free confidential home sampling kits are available for those in at risk groups, MSM, those from Black African communities, and injecting drug users.

Of those diagnosed with HIV, 99% of patients are on anti-retroviral therapy (ART). Successful ART ensures that someone who is HIV positive has an 'undetectable viral load' and are known as virally suppressed, which means that the levels of HIV in someone's blood are so low they cannot be passed on to another person. Of those on ART in Lewisham, 97% are virally suppressed (VS).

5. Healthcare and Premature Mortality

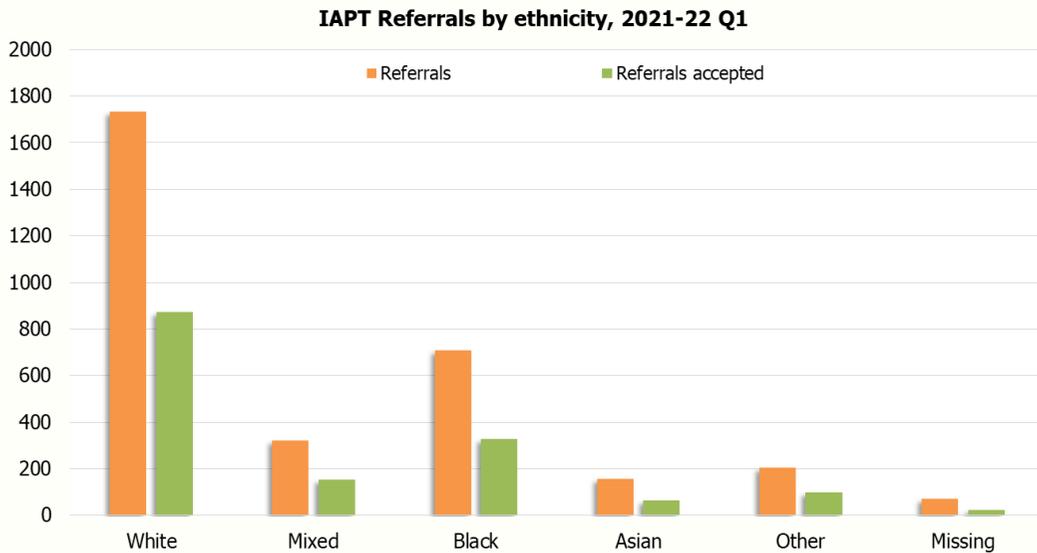
Mental Health in Lewisham

Lewisham has lower average wellbeing scores than London or England. Just over 8% of adults in Lewisham have a recorded diagnosis of depression. This is significantly higher than in London (7.1%). This is also likely to be an underestimate of actual prevalence, as not everyone who has depression will visit their GP. Just over 1% of people in Lewisham have a recorded diagnosis of severe mental illness (SMI). This is significantly higher than in London (1.1%) and in England (0.9%).

The prevalence of mental ill health is not spread evenly across the population, and there are some population groups that have higher rates of mental ill health in Lewisham, including:

- Black, Asian and Minority Ethnic populations have higher prevalence rates of some mental health conditions, e.g. psychotic disorder, Post-Traumatic Stress Disorder (PTSD), and also experience inequalities in access to services.
- The rate of admission to hospital for mental and behavioural disorders due to alcohol is significantly higher in Lewisham than in London. Approximately a fifth of adults receiving drug misuse treatment and alcohol misuse treatment were also in contact with MH services
- The gap between the employment rate for all people and just those in contact with secondary mental health services is higher in Lewisham than in London or England, and the gap has increased steadily in the last few years
- The proportion of adults in contact with secondary mental health services and known to be living independently (with or without support) is significantly lower in Lewisham than in England and London

There is a strong link between mental health and physical health: Adults in Lewisham who are in contact with secondary mental health services are more than three times as likely to die as people of the same age in the general Lewisham population. There are many causes of this, but the higher smoking prevalence amongst people with SMI is likely to be part of the explanation.



Source: IAPT Team, SLAM

IAPT (Improving Access to Psychological Therapies) services offer talking therapies, such as cognitive behavioural therapy (CBT), counselling, other therapies, and guided self-help. They aim to provide help for common mental health problems, like anxiety and depression.

In Lewisham in Quarter 1 of 2021/21 the greatest number of referrals to the IAPT service were for patients from a White ethnic group. Referrals appear to be more likely to be accepted for White patients than from any other ethnic group.

What is happening in Lewisham to address health inequalities?

Lewisham Health and Wellbeing Board and the Birmingham Lewisham African and Caribbean Health Inequalities Review (BLACHIR)

The Lewisham Health and Wellbeing Board is continuing to prioritise tackling health inequalities in Black, Asian and Minority Ethnic residents in Lewisham, particularly in light of the disproportionate impact that COVID-19 has had on Black and Asian communities. During the pandemic the Health Inequalities working group of the Health and Wellbeing Board has developed a specific work stream around COVID-19 to drive forward action in the following areas:

- COVID-19 communications and engagement with Black, Asian and Minority Ethnic residents through the development of the Lewisham COVID-19 Community Champion programme.
- Data collection around COVID-19 deaths where we now locally collect ethnicity data the time of death registrations.
- Overseeing the collaborative work that Lewisham is undertaking with Birmingham City Council to perform an in-depth review of health inequalities in Black African and Black Caribbean residents in Birmingham and Lewisham. This review has now started and is due to complete in 2022: <https://lewisham.gov.uk/myservices/socialcare/health/improving-public-health/birmingham-and-lewisham-african-and-caribbean-health-inequalities-review>

Health in All Policies Annual Public Health Report

This year's Annual Public Health Report for Lewisham focuses on Health in All Policies (HiAP). HiAP describes a whole-system approach to improving health and wellbeing, reducing inequalities and delivering better outcomes for individuals and communities.

The report makes the following recommendations for implementation over the coming year:

- Harness the learning from whole system working on COVID-19 and continue to work with stakeholders across the council and wider system to increase understanding and build capacity to further implement a health in all policies approach.
- Build on existing work to formalise a health in all policies approach at all stages of service development and strategy and policy-making.
- Continue to champion the health in all policies approach at a strategic level by highlighting the links between improvements in population health and the achievement of corporate and other strategic priorities.
- Develop a framework to enable the ongoing and robust assessment of the impact of policy decisions on health and health inequalities within the Lewisham population

Glossary

Health Inequalities: the avoidable and unjustified differences in the health status of groups and individuals that are not inevitable or immutable.

Healthy life expectancy: the average number of years that an individual is expected to live in a state of self-assessed good or very good health.

Intersectionality: the idea that when it comes to thinking about how inequalities persist, categories like gender, race, and class are best understood as overlapping and mutually constitutive rather than isolated and distinct.

Life expectancy at birth: the average number of years that a newborn could expect to live.

Lower/Middle Layer Super Output Area (LSOA/MSOA): a geographic area that has a minimum population of 1,000 people.

Premature Mortality: mortality rates for deaths under age 75 for all causes combined and leading causes of death.

Proportionate universalism: is the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need.

Protected Characteristics: Protected characteristics are specific aspects of a person's identity defined by the Equality Act 2010. The 'protection' relates to protection from discrimination. There are nine protected characteristics:

1. Age
2. Disability
3. Gender reassignment.
4. Marriage and civil partnership.
5. Pregnancy and maternity.
6. Race
7. Religion or belief.

8. Sex

9. Sexual orientation.

Slope index of inequality (SII): a measure of the social gradient in life expectancy, i.e. how much life expectancy varies with deprivation.

Social determinants of health: the broad social and economic factors that we grow up and live in that interact to influence the health of a population.

Further resources

Public Health England Health Inequalities Dashboard: <https://analytics.phe.gov.uk/apps/health-inequalities-dashboard/>

NICE guidance on Community engagement to reduce health inequalities: <https://www.nice.org.uk/guidance/ng44>

PHE guidance on local action to understand and reduce ethnic inequalities in health:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/730917/local_action_on_health_inequalities.pdf

PHE Reducing health inequalities: system, scale and sustainability:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/731682/Reducing_health_inequalities_system_scale_and_sustainability.pdf

PHE Place-based approaches for reducing health inequalities: <https://www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities>

Marmot review Health Equity in England: the Marmot review 10 years on: <https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on>

Marmot Review Fair Society, Healthy Lives: <https://www.instituteoftheequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review>

PEH Health Equity Assessment Tool: <https://www.gov.uk/government/publications/health-equity-assessment-tool-heat>

Agenda Item 7



Health & Wellbeing Board

Report title: Joint Strategic Needs Assessment Update

Date: 04 March 2021

Key decision: Yes/No.

Class: Either Part 1

Ward(s) affected: ALL

Contributors: Dr Catherine Mbema, Director of Public Health, London Borough of Lewisham

Outline and recommendations

This report provides details of the revised timescale for further work on the Joint Strategic Needs Assessment (JSNA).

The board is recommended to:

- Note the contents of the report
- Approve the revised timelines for the revision of the JSNA process and review of the most recently published JSNA Topic Assessments.

Timeline of engagement and decision-making

This paper is being submitted as part of the revised JSNA process originally agreed by the [Health and Wellbeing Board in 2017](#)

1. Summary

- 1.1. This update provides an overview that the JSNA process will resume from September 2021 for priority work to inform COVID-19 recovery.

2. Recommendations

- 2.1. The board is recommended to approve:
- 2.2. Resuming the JSNA process to start with a JSNA topic assessment examining the wider COVID-19 impacts to support recovery planning and commissioning, with a further topic assessment/refresh on Air Quality.

3. Policy Context

- 3.1. The production of a JSNA became a statutory duty of PCTs and upper tier local authorities in 2007. The Health and Social Care Act 2012 placed a new statutory obligation on Clinical Commissioning Groups, the Local Authority and NHS England to jointly produce and to commission with regard to the JSNA. The Act placed an additional duty on the Local Authority and CCGs to develop a joint Health and Wellbeing Strategy for meeting the needs identified in the local JSNA.
- 3.2. The objective of a JSNA is to provide access to a profile of Lewisham's population, including demographic, social and environmental information. It also provides access to in-depth needs assessments which address specific gaps in knowledge or identify issues associated with particular populations/services. These in-depth assessments vary in scope from a focus on a condition, geographical area, or a segment of the population, to a combination of these. The overall aim of each needs assessment is to translate robust qualitative and quantitative data analysis into key messages for commissioners, service providers and partners.
- 3.3. The most recent version of the JSNA can be found here:
<https://www.observatory.lewisham.gov.uk/jsna/>
- 3.4. The priorities of The Health and Wellbeing Strategy 2013-2023 were informed by the

JSNA.

4. Background

- 4.1. To undertake its responsibilities the Board needs to be periodically updated on the local population and its health needs. Individual JSNA topics provide in-depth analysis and recommendations for that specific service / population group.

5. JSNA Update

5.1. Resuming the JSNA process

From September 2021, the JSNA process will resume with two priority areas of JSNA work including:

- A JSNA topic assessment examining the wider COVID-19 impacts to support recovery planning and commissioning. This will be led by the Lewisham Public Health Team and will be supported by the 'What Works Centre for Wellbeing': <https://whatworkswellbeing.org/>.
- A JSNA topic assessment/refresh will also be performed on the topic of Air Quality

- 5.2. These priority JSNA topic assessments will be presented at the July 2022 meeting of the Health and Wellbeing Board.

- 5.3. Outstanding JSNA topic assessments, where completion was paused due to the pandemic, will also now be reviewed with appropriate timescales allocated for their completion. The updated timescales for completion will be presented at the December 2021 meeting of the Health and Wellbeing Board. The outstanding JSNA topic assessments include:

- LGBT health and wellbeing
- Self-harm in children and young people
- Transition between children to adult services

6. Financial implications

- 6.1. There are no specific financial implications. However the financial implications of any recommendations arising from the assessments subsequently produced will be considered either during or once the assessments are completed as appropriate.

7. Legal implications

- 7.1. The requirement to produce a JSNA is set out in the Policy Context section.
- 7.2. Members of the Board are reminded that under Section 195 Health and Social Care Act 2012, Health and Wellbeing Boards are under a duty to encourage integrated working between the persons who arrange for health and social care services in their area.

8. Equalities implications

JSNAs are a continuous process of strategic assessment and planning, with a core aim to develop local evidence based priorities for commissioning which will improve health and reduce inequalities. The Equality Act 2010 (the Act) introduced a public sector equality duty (the equality duty or the duty). It covers the following protected

Is this report easy to understand?

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characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

9. Climate change and environmental implications

9.1. There are no climate change or environmental implications from this report.

10. Crime and disorder implications

10.1. There are no crime and disorder implications from this report.

11. Health and wellbeing implications

11.1. There are no health and wellbeing implications from this report.

12. Report author and contact

12.1. Dr Catherine Mbema, Director of Public Health, catherine.mbema@lewisham.gov.uk

Agenda Item 8

HEALTH AND WELLBEING BOARD			
Report Title	Healthwatch Lewisham Annual Report 2020-21		
Contributors	Mathew Shaw, Operations Manager	Item No.	
Class		Date:	

1. Purpose

- 1.1 This report and accompanying copy of the Healthwatch Lewisham Annual Report for 2020-21 demonstrates the range of work that was carried out in order to capture people's experiences of health and care services during the COVID-19 pandemic.

2. Background

- 2.1 Your Voice in Health and Social Care was awarded the contract to deliver Healthwatch Lewisham from April 2020.
- 2.2 Healthwatch is a voice for children, young people and adults in health and social care living in Lewisham. Anyone, young or old can speak to us about their experiences of health or social care services and tell us what was good and what was not good. Healthwatch then ensures that service providers and commissioners hear this feedback to make changes to their services.
- 2.3 Healthwatch Lewisham is part of the regulatory and scrutiny function of health and social care and as such forms part of a national network of local Healthwatch. The network includes Healthwatch England which sits as a committee of the CQC. All Healthwatch Lewisham reports are shared with Healthwatch England and are used by the CQC to inform their work in hospitals, adult social care and primary care services.
- 2.4 Local Healthwatch are intended to hold both commissioners and providers of services to account by delivering the 6 statutory functions:
- Gathering the views and understanding the experiences of patients and the public.
 - Making people's views known.
 - Promoting and supporting the involvement of people in the commissioning and provision of local health and social services and how they are scrutinised.
 - Recommending investigation or special review of services via Healthwatch England or directly to the Care Quality Commission.
 - Providing information (signposting) about access to services and support for making informed choices.
 - Making the views and experiences of people known to Healthwatch England and the local Healthwatch network, and providing a steer to help it carry out its role as national champion.
- 2.5 The Healthwatch contract includes the delivery of NHS complaint advocacy

3. Policy Context

- 3.1 In 2012 the Health and Social Care Act received Royal Assent. From April 2013, local authorities were required to commission a local Healthwatch organisation.
- 3.2.1 The Lewisham Corporate Strategy 2018 – 2022 has as one of its commitments that ‘all health and social care services are robust, responsive & working collectively to support communities and individuals’. Healthwatch Lewisham supports the Council to deliver its commitment to local people.

4. Healthwatch Lewisham Annual Report 2020/21

4.1 Context

- From the beginning of April 2021, our staff team and volunteers had to adjust to a new provider and remote delivery model in response to Government guidelines relating to the COVID-19 pandemic.

4.2 Summary of work:

- We were able to adapt our engagement approach from a face-to-face model to a comprehensive digital model which saw us make direct telephone calls to residents and gather online reviews. We were also able to set up weekly Feedback Forums which gave people the platform to talk about the issues that mattered to them and ask questions about COVID-19.
- We heard from **4,231** people this year about their experiences of health and social care
- We provided advice and information to **292** people through our advocacy and signposting services
- We engaged with and supported **1,478** people to understand their experiences and share information during the COVID-19 pandemic this year.
- **2,803** people viewed our COVID-19 Information and Support webpage
- We published **9** reports about the improvements people would like to see to health and social care services
- **46** volunteers helped us to carry out our work. In total, they contributed **1,030** hours which is the equivalent of **147** additional working days

4.2. Highlights:

- Enabling the voices of **1,030** Lewisham residents about the impact of COVID-19 to be embedded within the borough’s COVID-19 recovery plan
- Supporting the local vaccination roll-out by regularly promoting information and sharing insight from the experiences of residents. We collected **273** reviews about vaccinations in February and March
- Delivering a weekly virtual Feedback Forum during April-July which gave **175** residents a platform to share their issues and ask questions about the virus and local response

- Creating a dedicated COVID-19 resource which provided national and local information about the vaccine, testing and other key messages
- We organised an 'Accessing Health Services' webinar in partnership with Public Health Lewisham after residents told us about the lack of clear information about GP arrangements within the borough
- Our Youth Board delivered a series of Instagram Live sessions called "Quaran-Teen" where they have discussions about topics that matter to them including the cancellation of exams and the mental health impact of the lockdown
- Through our representation at **61** operational and strategic meetings, we were able to voice the views of residents, encourage public involvement and share our intelligence
- Creation of SEL Healthwatch Director position provided a mechanism to enable our intelligence and the voice of Lewisham residents to be heard at a regional level within the Integrated Care System

5. Financial Implications

- 5.1 There are no specific financial implications arising from this summary.

6. Legal Implications

- 6.1 The Health and Social Care Act 2012 requires local authorities to have a local Healthwatch service

7. Crime and Disorder Implications

- 7.1. There are no direct crime and disorder implications from this summary

8. Equalities Implications

- 8.1 Through the work of Healthwatch and our targeted engagement with communities and groups that are often harder to reach or seldom heard we will support the reduction in inequalities in health and social care.

9. Environmental Implications

- 9.1. There are no direct climate change or environmental implications from this summary.

10. Report Author and Contact

- 10.1. If there are any queries on this report please contact Mathew Shaw, Operations Manager, Healthwatch Lewisham on 020 3886 0196 or email mathew@healthwatchlewisham.co.uk

Adapting to the pandemic

Healthwatch Lewisham Annual Report 2020-21



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Message from our Chair



Michael Kerin

Chair

**Healthwatch Lewisham
Committee**



Through our ongoing engagement with the Council and the local NHS, our data and intelligence have helped them better understand people's needs and concerns.

The impact of COVID-19 and subsequent changes to health and care services means that representing the voice of local people is more important than ever.

We have had to change our ways of engagement. Face-to-face discussions and visits have given way to telephone and internet contact and to virtual meetings with local providers.

Despite the difficulties, we managed to gather over **4,000** experiences about local services in the last year – both favourable and critical. We have continued to support people to make complaints. We have undertaken important surveys, notably on the impact of COVID-19 on different parts of our community and on services.

The rapid shift to telephone and online delivery of many services has caused real problems for people who do not have reliable, private access to smartphones and the internet, or who find using the technology difficult.

Our current research is seeking to identify their needs and to give them a voice. It is important that they are not overlooked or further disadvantaged as services are reconfigured.

Even without COVID-19, 2020-21 would have seen changes for Healthwatch Lewisham, with Your Voice In Health and Social Care (YVHSC) taking over the contract for providing the service. The pandemic has delayed our planned move to the Carers Centre at Waldram Place in Forest Hill, also run by YVHSC. We look forward to the opportunities provided by the move for engaging with carers.

We are grateful for the energy and commitment of our small staff team and our volunteers in rising to the challenges of the last year. We look forward to welcoming more volunteers – we have a range of roles to offer – so that we can continue to represent the voices of our diverse local population.

Statement from Your Voice in Health and Social Care

I am delighted to have the opportunity to introduce the inaugural annual report for Healthwatch Lewisham under Your Voice in Health and Social Care to reflect on what has been a hugely successful and ultimately challenging year.

A year that has seen health and social care services respond magnificently to extreme circumstances with the onset of COVID-19 and voluntary sector services work together to achieve the best possible outcome to support local efforts.

Healthwatch Lewisham have continued their statutory responsibility to:

- obtain the views of people about their needs and experience of local health and social care services
- make those views known to those involved in the commissioning and scrutiny of care services
- provide reports and make recommendations about how those services could or should be improved
- promote and support the involvement of people in the monitoring, commissioning and provision of local health and social care services.

Healthwatch Lewisham received **2,961** stories through our Patient Experience Programme from which services across the borough were commended for their overall quality of treatment and care, staff professionalism, attitude and professional advice.

This year Healthwatch Lewisham pioneered our approach to engagement during the COVID-19 pandemic which became standard practice across all of our Healthwatch service provision. Staff and volunteers continued to directly contact residents of Lewisham to understand the community's response to each lockdown.

Through this process we were able to identify not just people's experiences of a lockdown but also additional needs that required signposting and coordination. Staff and volunteers were able to liaise with local community organisations to support individual needs and were able to set up referral pathways to ensure the community received support from local community resources.

This year **46** volunteers helped us find out what people think is working, and what improvements people would like to make to services, contributing a combined **1,030** hours, the equivalent of **147** additional working days.

Throughout the year Healthwatch Lewisham published a total of **9** reports which focused on the impact of COVID-19 on our community, patient experience of local health services and the delivery of the COVID-19 vaccination programme.

As we look forward to recovery and the opportunity to meet and greet friends and family I would like to take this opportunity to thank all of the Healthwatch Lewisham staff and volunteers, who have continued to work with dedication to ensure a responsive and vital service continues to support the local community.

Tim Spilsbury,
CEO, Your Voice in Health and Social Care

About us

Here to make health and care better

We are the independent champion for people who use health and social care services in Lewisham. We're here to find out what matters to people and help make sure your views shape the support you need, by sharing these views with those who have the power to make change happen.

Helping you to find the information you need

We help people find the information they need about services in their area. This has been vital during the pandemic with the ever-changing environment and restrictions limiting people's access to health and social care services.

Our goals



1 Supporting you to have your say

We want more people to get the information they need to take control of their health and care, make informed decisions and shape the services that support them.



2 Providing a high quality service

We want everyone who shares can experience or seeks advice from us to get a high quality service and to understand the difference their views make.



3 Ensuring your views help improve health & care

We want more services to use your views to shape the health and care support you need today and in the future.



“Local Healthwatch have done fantastic work throughout the country during the COVID-19 pandemic, but there is more work ahead to ensure that everyone’s views are heard. COVID-19 has highlighted inequalities and to tackle these unfair health differences we will need those in power to listen, to hear the experiences of those facing inequality and understand the steps that could improve people’s lives.”

Sir Robert Francis, Chair of Healthwatch England

Our Values

By being part of the Your Voice in Health and Social Care family we embody five key principles:

Inclusive

Effective

Independent

Trustworthy

Reflective

Our Committee

The change in service provider of Healthwatch Lewisham has brought with it a new governance strategy and structure.

Under YVHSC, the role of our sub-committee is to be an advisory body made up of local community members who bring unique knowledge and skills, which supplement the experience of the YVHSC Board of Directors in order to more effectively guide the organisation.

We were pleased that **five** members of the previous Workplan Committee chose to remain involved with the organisation. They have played a vital role in supporting the new staff structure in responding to the significant challenges presented by the pandemic and a new model of delivery and expectations.

The local and regional response to COVID-19 has been the primary focus for the majority of strategic and operational meetings in 2020-21. Alongside this we are seeing the development of the Integrated Care System in south east London to align with the White Paper which sets out the legislative proposals for a Health and Care Bill.

Our members continue to play an important role in ensuring that the voices of patients are at the heart of the new structures and that a culture of meaningful co-production is embedded to enable services to meet the needs of local communities.

We have represented patients on a range of local committees and groups including the Health and Wellbeing Board, Healthier Communities Select Committee and Lewisham and Greenwich NHS Trust's (LGT) Patient Experience Committee.

Through our representation we have:

- **Ensured the findings from our COVID-19 research were heard at a borough-wide level and incorporated into the Lewisham Recovery Plan**
- **Shared insight and monitored the delivery of the new community Phlebotomy service provided by LGT**
- **Supported the development of the Childhood Obesity Trailblazer Programme by reviewing the submissions for the delivery of a co-produced healthy poster campaign**

We would like to thank each member of our Committee for their sustained commitment to offer guidance and advice to shape our plans and maximise impact for the benefit of local residents.

Our Workplan Committee

Agnes Agyepong, Nigel Bowness, Carolyn Denne, Catherine Jenkins, Michael Kerin and Geraldine Richards

Partnership and Representation

We are part of many strategic and operational meetings, groups and networks providing feedback on experiences of health and social care. Through our representation at **61** meetings, we were able to voice the views of Lewisham residents, encourage public involvement and share our intelligence

Partnership Groups and Meetings	
BAME Health Inequalities Working Group	Lewisham Council
Childhood Obesity Trailblazer Programme Steering Group	Lewisham Council
Digital Poverty Action Alliance	Lewisham Council
Healthier Communities Select Committee	Lewisham Council
Lewisham Adult Safeguarding Board	Lewisham Council
Lewisham Borough Based Board & Lewisham Health and Partners Executive Board	SEL CCG/Lewisham Health and Care Partners
LGT Inequalities Steering Group	LGT Trust
LGT NHS Trust Patient Experience Committee	LGT Trust
LGT NHS Trust Oversight Panel: Overseas Charging	LGT Trust
Lewisham Health and Wellbeing Board	Lewisham Council
Lewisham Health and Wellbeing Board Agenda Steering Group	Lewisham Council
Lewisham Health and Wellbeing Board Leaders Forum	Lewisham Council
Lewisham Obesity Alliance Meeting	Lewisham Council
Lewisham Primary Care Operational Group	SEL CCG
Lewisham Public Engagement Forum	SEL CCG
Local Healthwatch Leaders Group	SEL Healthwatch
SLaM and HW meeting	SEL Healthwatch

Our influence at a regional level



On 1 April 2020, the six Clinical Commissioning Groups (CCGs) in south east London all merged to form a new CCG at the regional level.

The joint CCG is responsible for planning and buying healthcare services and ensuring that good provision of care.

The merged CCG sits within the Integrated Care System (ICS).

Local Healthwatch and the CCG jointly created the post of South East London (SEL) Healthwatch Director to ensure visibility and voice for local people in the new regional governance and operational structures.

The SEL Director participated in over **192** governance, strategy or operational meetings during the year including representation at the CCG Governing Body. They are also a voting member on the Engagement Assurance Committee which monitors and assures that the CCG is engaging patients and the public in developing its plans and commissioning services.

Our organisation works closely with the SEL Director to ensure that the needs and experiences of Lewisham residents is heard at the regional level and contributes to service development.

Some of our achievements included:

- Our intelligence was included in a presentation on the experiences of Black communities during COVID-19 which highlighted the challenges faced by residents
- Sharing Healthwatch insights on myths and beliefs circulating among African and Caribbean communities to help the ICS counter inaccurate views on vaccination. Healthwatch pushed for urgent engagement with faith leaders to support informed faith communities
- We were able to shape the development of the 2-year action plan for the South London Mental Health Partnership through membership of the COVID-19 Mental Ill-Health Prevention Taskforce
- Our reports were used to inform the content of the ICS COVID-19 vaccination website as part of the SEL vaccine hesitancy campaign
- The HWL Accessible Information Standard report was shared with the Equality Committee to support understanding of the current picture across SEL
- Creating the South East London Healthwatch Patient Group to champion the diverse voices of patients, carers and the general public within the ICS

Highlights from our year

Find out about our resources and how we have engaged and supported people in 2020-21.

Reaching out



We heard from

4,231 people

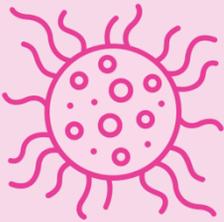
this year about their experiences of health and social care.

We provided advice and information to

292 people

this year.

Responding to the pandemic



We engaged with and supported

1,478

people during the COVID-19 pandemic this year.

2,803 people viewed our COVID-19 Information and Support webpage.

Making a difference to care



We published

9 reports

about the improvements people would like to see to health and social care services.

The findings and themes from our engagement about the impact of the pandemic on Lewisham residents were embedded within the borough's COVID-19 recovery plan

Health and care that works for you



46 volunteers

helped us to carry out our work. In total, they contributed **1,030** hours number of hours which is the equivalent of **147** additional working days..

We employ 6 staff

We received

£140,000 in funding

from our local authority in 2020-21.

Changes to Healthwatch Lewisham services

The change of service provider on the 1 April 2020 meant that the new contract and staff arrangements started in the middle of the first wave of COVID-19.

In order to abide with national guidelines our service had to quickly adapt the way we engaged with residents by transitioning from face-to-face community outreach to a flexible digital model.



Patient Experience Programme

At the heart of our work is the commitment to a comprehensive Patient Experience data collection programme.

During 2020/21 we heard the experiences of **2,961** residents through our programme.

We capture the issues and themes emerging from conversations with patients/residents in our quarterly reports which are shared with local providers.

Information & Signposting service

We continued to offer our signposting service to support residents get the information they needed during the pandemic.

Our website (www.healthwatchlewisham.co.uk) has a dedicated COVID-19 resource which is regularly updated to provide information about the vaccine, testing and other key messages.



Feedback Forums

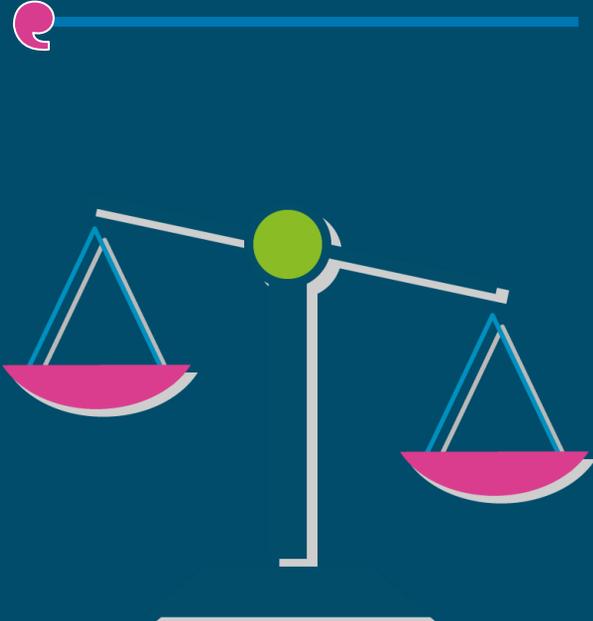
From April – July, we offered weekly Feedback Forums through Zoom where residents had the opportunity to share any experiences of local services or raise any health or care issues.

We provided signposting and offered guidance to support to residents worried about the outbreak of COVID-19.

Spotlight: Feedback Forums

Due to the popularity of the weekly sessions, we continue to hold a monthly Feedback Forum and have covered topics including COVID-19 vaccinations, mental health of unpaid carers and access to services.

A combined total of **175** people participated across 23 sessions. A few examples can be found below:



Ethnic Minorities Feedback Forums

We carried out targeted engagement with our African and Caribbean communities to understand their experiences of COVID-19 focusing on access to primary care, communication from services and impact on their mental health and emotional wellbeing.

Our intelligence helped to inform the BAME Health Inequalities Working Group's strategy and workplan.

The findings were also published in a local study which assessed and explored the impact of total triage and remote-by-default primary care on vulnerable patient groups.

Our report can be found at www.healthwatchlewisham.co.uk

South London Listens

In February, we worked with South London Citizens to deliver a session which explored the impact COVID-19 has had on the mental health of residents with a focus on the experiences of unpaid/informal carers.

18 people attended the session and the findings were included as part of the South London Listens campaign, an initiative looking to understand how mental health services can better support residents.



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Patient Experience: Then and now



A Digital Approach to Patient Experience

We use a variety of methods to understand people's needs and experience. Engagement through outreach activities is key to what we do and how we make sure voices are heard.

Prior to the pandemic, under the previous provider, Healthwatch Lewisham would carry out weekly engagement hubs at local hotspots within the community such as local festivals, libraries, GPs, hospitals and shopping centres.

From the beginning of April, our staff team and volunteers had to adjust to working from home and the delivery of a target driven Patient Experience Programme. We were able to adapt our engagement approach from a face-to-face model to a comprehensive digital model which saw us make direct telephone calls to residents and gather online reviews. As mentioned previously, we were also able to set up weekly Feedback Forums which gave people the platform to talk about the issues that mattered to them and ask questions about COVID-19.

Our Patient Experience team also took on the added responsibilities of providing information & signposting to people in need and conducting follow up case work to ensure that people's requests for access to services were being met.



A Digital Approach to Patient Experience

In addition to gathering feedback via direct telephone contact, our Patient Experience team developed a variety of different ways to capture the views of residents and service users during the last year:

- Worked with the Lewisham Homes Independent Living Scheme to distribute **482** patient experience forms to residents within their sheltered housing scheme
- Holding targeted engagement sessions at virtual community events
- Collecting online feedback via our Feedback Centre and other sources of online reviews
- Working with partners to deliver focus groups to their members
- Creating an online Patient Experience survey to provide an additional way for residents to share feedback
- Increasing our digital and social media presence to promote and encourage participation with our online surveys



“As Chair of my surgery PPG I have worked with Healthwatch for some time now. We liaise with them on visiting the surgery and have a space in our waiting area. There they can talk to people about their experiences of health services received and obtain information about health and social services.

Healthwatch Lewisham have been holding monthly online Zoom forums since the beginning of Covid, where residents can talk about their experiences of health services received, and as our PPG Chair I regularly take a part in these forums, which have proved to be an extremely useful way of learning about the various issues and problems of our different nationalities and abilities. This has proved to be an extremely useful learning platform, which I am able to take and utilise for our PPG, along with my work on patient and public reference groups.”

Alexandra Camies,

Chair of South Lewisham Group Practice Patient Participation Group



To share your experiences of health and care, visit our
Feedback Centre:

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<https://www.healthwatchlewisham.co.uk/services>



Lewisham Independent Health Complaints Advocacy Service

Our organisation continues to provide the Lewisham Independent Health Complaints Advocacy Service.

Between April- June, NHS England advised NHS Trusts to put their complaints processes on "pause" for three months. The Parliamentary and Health Service Ombudsman also were not accepting new health service complaints nor progressing existing ones that require contact with the NHS.

During this period, our advocates provided additional support for the Information & Signposting service.

We have supported **129** residents in making a complaint against a local NHS service this year.

A dedicated complaints resources page can be found on our website which explains the NHS Complaints process and how residents can be supported by us. We have created complaints letter templates and guidance to help empower residents in making a complaint.

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Our advocacy pages were visited **630** times during the year. More information can be found at <https://www.healthwatchlewisham.co.uk/complaints-advocacy/>

Analysis of our advocacy cases enables us to understand key issues which are causing people to register an official complaint.

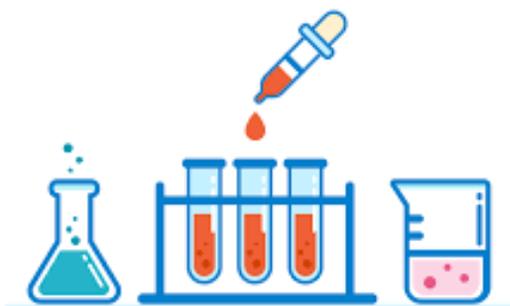
From speaking with clients, we recognised the following issues for Lewisham residents during the last year:



Early or poorly planned discharge from hospital



Access to GP appointments



Challenges with the community Phlebotomy service booking system



Reduction of benefits following information shared by mental health services

Feedback about our advocacy service

"Thanks for that update, and for your kind wishes. I am keeping the faith and hope that we get there with a good outcome. You guys have been my extra shoulder to lean on.

Can I say a huge thank you for all you have done..."

"Thanks for your email. I feel completely at unease and powerless regarding this situation.

And, it is heart-warming to know that you understand what I'm going through and will continue to do your utmost to ensure that my voice is heard and taken into consideration regarding decisions affecting my mental health care."

"I really can appreciate the letter draft - how you managed to capture the essence and true nature of the issues just in a few paragraphs!!!

This is absolutely admirable, and it sounds so cool and smart - but just the humble way as well!!!"

"I am really pleased with the way everything has gone and I thought I should tell you that, thank you."

"Thanks for taking the time to talk with us, it really helps to have someone "in our corner."

Ms A was very complimentary about our service and voiced her sincere appreciation.

She said we were the people that 'went the extra mile' and that the letters written were always very good.

Feature Case Study – Lack of informed consent

Problem

Mr X has a learning disability. He had undergone foot surgery at University Hospital Lewisham but had not understood the implications of the surgery when he was asked to consent to treatment.

Actions

The advocate worked closely with an advocate from Lewisham Speaking Up, who had an established relationship with Mr X. They had a number of collaborative telephone conversations with the client to gather information and understand what they wanted to gain from a complaint.

It became apparent that Mr X was alone and frightened when he attended the outpatient department at the hospital. The doctor had asked him if he understood the implications of the surgery and he had said yes because he was scared. He was not provided with support or given a follow up contact to assist with information.

The advocate drafted a letter in Easy Read to ensure Mr X's full understanding and approval before sending the complaint.

Outcome

The response from the hospital was incredibly positive. As a result of the complaint several initiatives have been put in place.

These include:

- The provision of staff training to support patients with a learning disability and/or autism
- All information on a patient passport to be uploaded onto the electronic system to provide continuity of care
- Creation of Learning Disability Champions within Lewisham and Greenwich NHS Trust
- Information has been sent to all GPs to ensure that referrals would reflect if a patient had a learning disability

The response from the Trust was not written in Easy Read so required the advocate to share the contents of the letter on the phone to Mr X. However, the client was delighted that the hospital had acknowledged his experience and said it was really important that those with a learning disability were listened to.





Responding to COVID-19

Healthwatch plays an important role in helping people get the information they need, especially through the pandemic. The insight we collect is shared with both Healthwatch England and local partners to ensure services are operating as best as possible during the pandemic.

This year we helped 4,281 people by:

- Adapting our own ways of working to ensure that we continued to represent the people's voice and notify health and social care partners about the issues people were facing
- Enabling the voices of **1,030** Lewisham residents about the impact of COVID-19 to be embedded within the borough's COVID-19 recovery plan
- Supporting the local vaccination roll-out by regularly promoting information and sharing insight from the experiences of residents. We collected **273** reviews about vaccinations in February and March
- Delivering a weekly virtual Feedback Forum during April-July which gave **175** residents a platform to share their issues and ask questions about the virus and local response
- Creating a dedicated COVID-19 resource which provided national and local information about the vaccine, testing and other key messages
- Directly providing people with the information that they needed to access services during this time

Top four areas that people have contacted us about:



24% on GP services



10% on Mental Health



20% on Hospital Care



16% on COVID-19

Case Study

Accessing Health Services Webinar
 Date: Thursday 10 December 2020
 Time: 6.00pm – 7.00pm (1 hour)
 Venue: Online (laptop or desktop computer)

Throughout the pandemic, we heard from residents about the lack of clear information about GP arrangements within the borough.

We organised an 'Accessing Health Services' webinar in partnership with Public Health Lewisham to address this issues.

The session saw over **30** residents learn more about the access arrangements for GP services, dentists, pharmacies and sexual health services allowing them to share it with their networks.



Contact us to get the information you need

If you have a query about a health and social care service, or need help with where you can go to access further support, get in touch. Don't struggle alone. Healthwatch is here for you.



www.healthwatchlewisham.co.uk

020 3886 0196

Info@healthwatchlewisham.co.uk

Signposting enquiries

Enquiry:

Local services informed us that refugees and asylum seekers were encountering barriers when trying to register with a GP practice.

GP practices were requiring them to provide identification such as a proof of address and/or photo ID.

The services wanted information they could share with residents about their GP access rights.

Response:

Our organisation provided LewCAS foodbank and Lewisham Refugee and Migrant Network with 100 'GP Access Cards' to support residents in accessing GP services within the borough.

Enquiry:

Ms A needed advocacy support to escalate a complaint to the Social Care Ombudsman.

The original complaint related to a care home where their mother previously lived and covered several issues including discrimination and how the service communicated with the family.

The resident explained that they to articulate their thoughts, an advocate would help them draw together the complaint.

Response:

Our service worked closely with a commissioner at Lewisham Council to identify a local organisation who could support the resident.

Due to the resident having a mental health diagnosis, they were eligible to receive help from the Lewisham Community Wellbeing service.

We supported the resident with a referral into the service.

Enquiry:

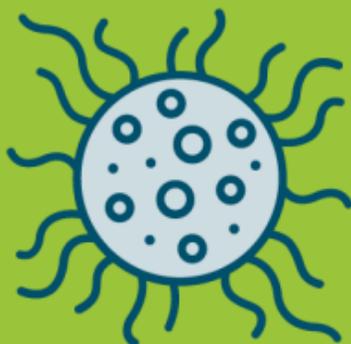
Three residents contacted our Information & Signposting service after being unable to register with local dental services.

They had varying levels of tooth pain, but all received the same response that dental practices were not currently accepting new NHS patients.

The residents sought advice on what options were available to access the treatment they needed.

Response:

We contacted the Lambeth, Southwark and Lewisham Local Dental Coalition who identified a dental practice that was accepting NHS patients and were able to register the residents.



Supporting the vaccination programme

SEL HW have helped support the vaccination programme across the region by hosting events, disseminating information and sharing feedback on residents' experiences of being vaccinated

We created the promotional materials for the first COVID-19 webinar organised by Public Health Lewisham and SEL CCG to provide residents with further information around the vaccination programme

Lewisham Pensioners' Fayre



We held an engagement session at the Lewisham Pensioners' Forum Health Fayre to facilitate a discussion about the COVID-19 vaccine programme, experiences and vaccine hesitancy

Whilst many attendees had received the vaccination and were satisfied with the process and efficiency, they highlighted that many people within Black communities particularly had mistrust towards the vaccine.

These findings were shared with SEL CCG and Public Health Lewisham who are overseeing the vaccination programme.



Vaccine Opinions



In partnership with Healthwatch England, we promoted a national research project which looked to understand the opinions of Black and Asian communities about the COVID-19 vaccine.

Page 84 Six Lewisham residents were selected to be involved with the project.



How we have made a difference

As well as providing people with the information they need, we conduct a minimum of two research projects each year to better understand issues which are of local interest.

Through our research we are able to provide local stakeholders and service providers with findings, key recommendations and potential next steps to ensure services are considering patient experience when developing services.

This year we published a total of **9** reports including:

- 4 Quarterly Patient Experience Reports
- Patient Experience Spotlight: Dental services July-December 2020
- Patient Experience Spotlight: Pharmacies October - December 2020
- The Impact of COVID-19 on Lewisham residents
- COVID-19 Vaccination Survey: February - March findings
- Snapshot Study: Experiences of Lewisham Black, Asian and Minority Ethnic Communities during COVID-19

Spotlight: Impact of COVID-19 on Lewisham residents

We carried out a research project during June and July to hear people's experiences during the first COVID-19 lockdown.



Our focus was on understanding issues including access to services, mental health impact and communication/ information provided by services.

A survey was co-produced with the Lewisham Primary Care Commissioning team and saw **1,030** people tell us their stories.

Findings:

- There remained a considerable reluctance by residents to access services because of the fear of catching COVID-19 or not wanting to be a burden on the NHS
- Residents were predominantly happy with their experience of using GP services and the availability of phone consultations
- However, respondents strongly feel there is a continued need for face-to-face appointments. It was felt that the main limitation of using a tablet, computer or smartphone is the digital exclusion for those who cannot use or afford to use the technology
- The COVID-19 outbreak and lockdown has had a substantial emotional impact on residents, with residents' experiencing issues such as bereavement, financial worries, isolation and anxiety

Recommendations

- Patients want written confirmation that services are safe and have adequate capacity. There is a need for a local communication campaign across the borough which covers the current primary care offer in view of the different access arrangements and informs patients about what services are available
- Wide provision of mental health support services must be included in services' recovery plans to help those with existing conditions but also for those who have never previously sought support
- While it is acknowledged that digital services are effective and resourceful, we feel there should always be an alternative. Services need to ensure that there is still equity of access for residents who cannot engage with the digital offer

Impact

We presented our findings at various operational and strategic meetings including the Health and Wellbeing Board and Borough Based Board. Our project has received significant local attention and appreciation from local stakeholders.

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Findings were included within the Lewisham COVID-19 Recovery Plan and have informed future engagement and communication activity around recovery planning.



Digital Exclusion

We are currently undertaking a research project to understand the impact of a “virtual by default” access model (with a focus on primary care) implemented by health and social care services in response to the COVID-19 pandemic.

The project will engage with the different communities and residents who would have no access or limited access to digital technology.

Our research will be in partnership with North Lewisham PCN who will enable us to gather the experiences of health professionals.

Through our recruitment we have identified **40** residents to participate in the project.

Interviews will be carried out between April and June 2021.



COVID-19 Vaccination survey

We developed a survey to understand residents’ experiences of being vaccinated to inform the delivery of the local vaccination programme.

The project will also look to identify the reasons which encouraged hesitant residents to book their appointments.

We received **273** responses to our survey during February and March. Our initial report can be found at www.healthwatchlewisham.co.uk

We found that the overwhelming majority of respondents had positive experiences of receiving their first COVID-19 vaccination across the different vaccination hubs in Lewisham

Responses will continue to be collected, analysed and shared as the COVID-19 vaccination programme roll-out widens across the borough.



What they said

“Healthwatch Lewisham have been great collaborators for the work we are doing on improving access to GP services within North Lewisham Primary Care Network. They helped us to understand some of the key issues following the introduction of increased remote consultation and triaging during the pandemic.

They worked with us to include questions in their community forums and report back to us in a timely and efficient manner. They worked closely with us on their project of digital exclusion, and we look forward to reviewing the results to help further inform our programme of improving access within our PCN.

Dr Aminah Verity
North Lewisham PCN Fellow for Health Inequalities



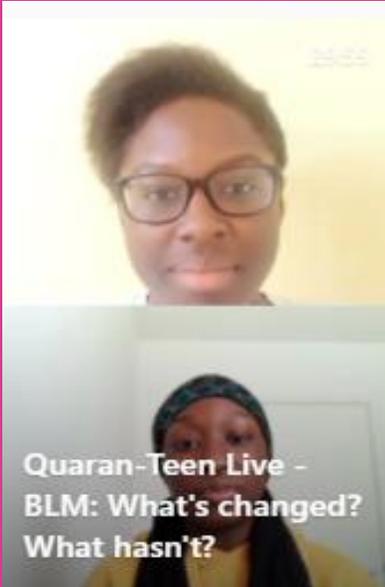
“As a carer and carer's rep I often look to Healthwatch Lewisham to engage my carer groups on updates regarding health and social care.

Healthwatch Lewisham are user friendly, respond as fast as possible and involving of the community.

Matthew Mckenzie
Carer Consultant

Youth Board

We continue to support the development of our Youth Board which represents the voices of young people in Lewisham in relation to health and social care services.



Quaran-Teen

Our Youth Board delivered a series of Instagram Live sessions called "Quaran-Teen" where they have 20-minute discussions about topics that matter to them.

In July and August, they produced six shows which focused on:

- Transitioning out of lockdown
- Black Lives Matter Movement
- School exam results and online studying

Over **150** residents have so far watched the "Quaran-Teen" series which can be found at:

www.instagram.com/hwl_youthboard

CYP Mental Health and Wellbeing

In January, Our Youth Board carried out a research project exploring what support young people in Lewisham would like to manage their emotional wellbeing needs.

The project was shaped to align with local priorities and the interests of our members. In total, **44** young people shared their experiences through a digital survey.

The report will be published in the next financial year.

Analysis of feedback from Black African and Black Caribbean respondents will be shared with the Birmingham and Lewisham African & Caribbean Health Inequalities Review



healthwatch Lewisham
YOUTH BOARD

Participants will be entered into a prize draw for a £50 voucher!

Logins to Kooth went up by 58% during lockdown	School/college worries are up 144% from 2019
Logins to Kooth from BAME young people went up by 44% during lockdown	Experiences of sadness have gone up by 128% from 2019

June 2020 Data, Kooth

Want wellbeing services to better support you? Fill out our survey to have your say
<https://www.surveymonkey.co.uk/r/YTWL7BL>

@hwl_youthboard | sophie@healthwatchlewisham.co.uk

Enter and View

The Health and Social Care Act 2012 gives us the statutory power to carry out Enter and View visits to publicly funded health and social care services to hear the views of service users, their families and carers.

During the COVID-19 pandemic local care home providers stopped allowing visitors into care homes as an infection prevention measure. In response, we introduced a new digital approach to delivering our Enter and View Programme.

As part of the new approach, services provide a virtual observation by streaming footage of the communal areas while answering the questions of our Authorised Representatives. The virtual tour would be supported by interviews with residents, staff, family members and online questionnaires for those who were unavailable on the day of the visit.

Swallows Care Home

We carried out a pilot virtual Enter and View visit to the Swallows Care Home in January 2021.

The purpose of our virtual visit was multifaceted; we wanted to better understand the experiences of residents and family members during lockdown. We also liaised with the local authority who suggested the care home as a potential location because of a recent refurbishment and change of management in September 2020.

Technological and communication difficulties impacted on the delivery of the Enter & View visit to the Swallows Care Home. However, we do recognise the additional pressures that local services have been under during the pandemic.

From talking to staff and residents' family members, our Authorised Representatives found that the service appeared to have a robust infection control procedure and has managed to support residents and family members to regularly communicate despite the lockdown.

Family members feel that their relatives are safe and staff felt protected from the virus. 'New Year's celebration' videos indicate that there is a good relationship between staff and residents.

Through observation and interview, Healthwatch staff feel improvements could be made around communication relating to visiting arrangements, safeguarding training and staff compliance to infection control measures.

Impact

We are waiting upon a response from the service provider to our report and recommendations



CQC Annual Regulatory Review

We shared feedback about **11** GP practices to inform the CQC’s new transitional regulatory approach to monitoring practices in the borough.

We highlighted experiences which have been shared through the Feedback Centre and from our advocacy service.

Healthwatch Involvement Panel

We are supporting an independent study carried out by King’s College London (KCL) to explore and enhance the local operation and impact of Healthwatch in England.

We are represented on the Healthwatch Involvement Panel which is composed of 16 representatives from the Healthwatch network.

The Panel contributes to the analysis of the data collected from five study sites and enables KCL to gain a broader perspective on their findings and how Healthwatch works.

The study has been extended to understand how the role of Healthwatch has changed during the pandemic. A report will be published next year.




Quality Accounts

We submitted our response to South London and Maudsley NHS Foundation Trust’s (SLaM) Annual Quality Accounts for 2019/20.

In our responses, we make sure to hold local Trusts to account in relation to their performance and quality.



Learning Disability Big Health Day

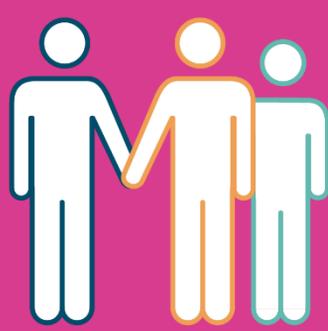
Following on from a successful event last year, we held an engagement session focusing on access to services for people with learning disabilities at the virtual South East London Learning Disability Big Health Day.

The event gave people with learning disabilities the chance to learn more about cancer and get involved in workshops and fun activities.

Patient Carer Race Equality Framework

We continue to work closely with South London and Maudsley NHS Foundation Trust.

We held an engagement session with residents from ethnic minorities in partnership with the Lewisham BME network, Bromley, Lewisham and Greenwich Mind and SLaM to inform the mental health trust's Patient Carer Race Equality Framework.



LGT Overseas Charging Panel

Lewisham and Greenwich NHS Trust (LGT) set up an overview panel in response to controversy about their implementation of statutory requirements that related to charging patients not eligible for NHS services.

Our organisation is represented on the Panel and worked with Healthwatch Greenwich and Lewisham Migrant and Refugee Network to recruit patients to share experiences of being charged by LGT to inform the review.

Have you had to pay for treatment at University Hospital Lewisham or Queen Elizabeth Hospital but couldn't afford it?

Lewisham and Greenwich NHS Trust has set up an independent panel to look at the Trust's charging policy.

Tell Healthwatch your experience and help to improve the care and treatment of patients not eligible for free NHS services.

Your name will not appear in any documents and you will not be identified.

Interviews take up to an hour and can be done remotely. We will give you £50 as a thank you for your time.



For more information call 020 3886 0196 or text 07309 736617
 Email info@healthwatchlewisham.co.uk or find us on social media.





Volunteers

We were supported by a fantastic team of 46 volunteers who helped us find out what people think is working, and what improvements people would like to make to services.

This year our volunteers:

- Contributed a combined **1,030 hours**, the equivalent of **147** additional working days
- Helped people to have their say, carrying out Patient Experience surveys over the telephone and online
- Provided up-to-date health and social care information via our social media channels.
- Co-produced a research project focusing on the mental health and emotional wellbeing needs of young people
- Represented us at a variety of different operational and stakeholder meetings across the borough
- Supported the delivery of focus groups by capturing the experiences of participants
- Carried out data analysis for our COVID-19 research project
- Took advantage of a bespoke training programme developed by YVHSC's Volunteer Hub which offers a variety of courses to help personal and professional development
- Were recognised at a joint 'Volunteer End of Year Celebration' in partnership with Healthwatch Bromley



Engaging residents- Karla

“I have always been passionate about supporting others’ health and wellbeing, so when the opportunity to volunteer as a Patient Experience volunteer with Healthwatch came about I jumped at the opportunity.

Being able to reach out to patients and have their voices be heard was important for me now more than ever with the COVID-19 pandemic. Some patients may struggle to engage with technology and others might not have the time to provide feedback on their experience, so being able to be that bridge between the user and service improvements, has made the work I am doing fulfilling.

Patients’ willingness to share feedback has really been eye-opening and has confirmed just how important this work is.

Rebuilding confidence - Hope

Wanting very much to be kept busy during the current crisis, volunteering was a great opportunity to work as part of a team of people supporting others.

Volunteering with Healthwatch has been empowering as I can contribute to making a difference in the lives of patients and service users.

I found it enjoyable to speak to patients over the phone gathering their experiences. Hearing similarities to my own experiences has helped me develop the empathy it takes to better understand and represent the views of patients and service users in the borough of Lewisham.

The role has helped build my confidence for re-entry into work and let me develop valuable skills.



Volunteer with us

Are you feeling inspired? We are always on the lookout for new volunteers. If you are interested in volunteering, please get in touch at:



www.healthwatchlewisham.co.uk

020 3886 0196

Info@healthwatchlewisham.co.uk

Finances

To help us carry out our work we receive funding from our local authority under the Health and Social Care Act 2012.

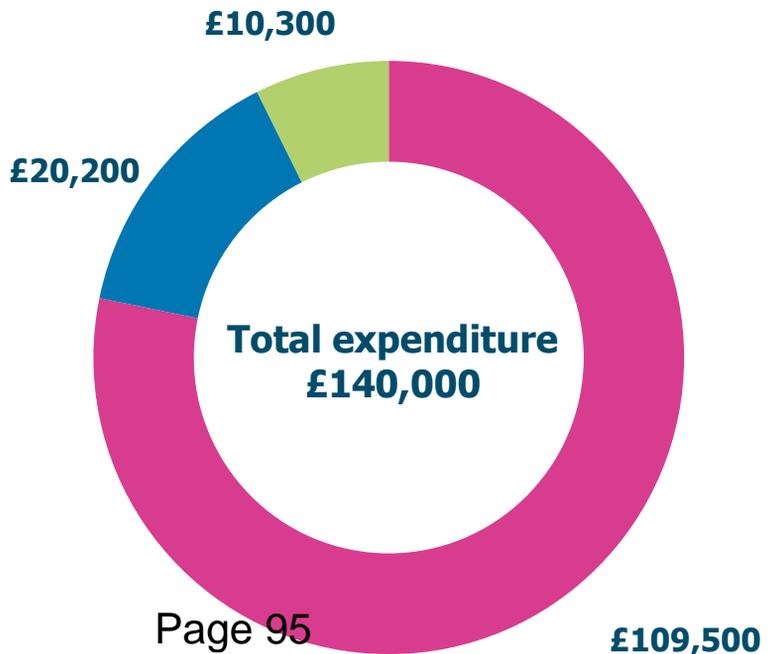
Income

- Funding received from local authority



Expenditure

- Staff costs
- Operational costs
- Support and administration



Next steps & thank you

Priorities for 2021-22

From the beginning of April 2021, we will be undergoing an organisational restructure and during the transitional period will continue to focus on priorities including:

- **Access to services for digitally excluded residents**
- **Experiences of the COVID-19 vaccination programme**

We will engage with residents upon the lifting of the lockdown to understand the issues that matter to them to help shape our long-term priorities and activities.

Next steps

- In line with guidelines and the recovery roadmap we will look to return to our office in Waldram Place and take a stepped approach to resuming face-to-face engagement in our community
- A hybrid approach of digital and non-digital engagement will be at the heart of our delivery to ensure our reach is as wide as possible
- Delivery of a Feedback Centre pilot which will see us work closely with Primary Care Networks and individual GP practices to increase patient feedback. Our pilot was included in the borough's GP Practice Resilience Programme 2021/22
- Carry out recruitment to widen the membership of our local committee
- Continue to identify opportunities to engage and understand the experiences of seldom heard groups
- Following up on the recommendations that we provided during the pandemic to understand their impact and support health and care partners in their implementation
- Work with SEL Healthwatch and other local partners to ensure that the patient voice is central to all new structures developed as part of the Integrated Care System



"2020-21 has been a year that has seen our community united and resilient in the face of extreme adversity. The voice of patients and residents has never been more important with the changes to services in response to the pandemic.

We are thankful to everyone who has shared their views and look forward to working with partners to ensure that local services understand and meet the differing needs of our population as we come out of lockdown. "

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Mathew Shaw, Operations Manager, Healthwatch Lewisham



Statutory statements

About us

Healthwatch Lewisham, Waldram Place, Forest Hill, London, SE23 2LB

Company holding local Healthwatch Contract

Your Voice Health and Social Care, 45 St. Mary's Road, Ealing, London W5 5RG

Healthwatch Lewisham uses the Healthwatch Trademark when undertaking our statutory activities as covered by the licence agreement.

The way we work

Involvement of volunteers and lay people in our governance and decision-making.

Our Healthwatch board consists of 6 members who work on a voluntary basis to provide direction and guidance around our work programme. Our committee ensures that decisions about priority areas of work reflect the concerns and interests of our diverse local community. Through 2020/21 the committee met 5 times and made decisions on matters such as strategies to maximise impact and reach of our COVID-19 report as well as the need to work in partnership with the community sector to engage with digitally excluded residents.

We ensure wider public involvement in deciding our work priorities. Our priorities are informed by a combination of local intelligence, system priorities and issues or gaps which are identified through the Patient Experience Programme, research projects and advocacy/signposting services.

Methods and systems used across the year’s work to obtain people’s views and experience.

We use a wide range of approaches to ensure that as many people as possible have the opportunity to provide us with insight about their experience of health and care services. During 2020/21 we have been available by phone, by email, provided a webform on our website, provided a feedback centre/rate and review system, attended virtual meetings of community groups and forums, provided our own virtual activities and engaged with the public through social media.

We are committed to taking additional steps to ensure we obtain the views of people from diverse backgrounds who are often not heard by health and care decision makers. This year we have done this by, for example, working with the Lewisham Homes Independent Living Scheme to distribute **482** patient experience forms to digitally excluded residents within their sheltered housing scheme. We also partnered with the Africa Advocacy Foundation to understand the experiences of residents with HIV accessing primary care services as part of our Feedback Forums aimed at Black African and Caribbean communities.

We ensure that this annual report is made available to as many members of the public and partner organisations as possible. We publish it on our website www.healthwatchlewisham.co.uk

2020-21 priorities

Project / activity area	Impact
Impact of COVID-19 on Lewisham residents report	<ul style="list-style-type: none"> Findings were included within the Lewisham COVID-19 Recovery Plan and have informed future engagement and communication activity around recovery planning. Experiences of residents from our Black and Asian communities informed the workplan of the BAME Health Inequalities Working Group

Responses to recommendations and requests

We recognise the pressures and challenges that local service providers and commissioners have faced in responding to the COVID-19 pandemic and ensuring the immediate and ongoing needs of our population are met.

During this year we received positive responses to our recommendations outlined in our **“Impact of COVID-19 on Lewisham residents”** report from Lewisham Health and Care Partners. We look forward to engaging with them and other local stakeholders in the coming year to understand the impact of our reports published in 2020-21 and explore how our recommendations and the voices of residents’ can influence service change.

We carried out one Enter & View visit to the Swallows Care Home and are waiting upon a response from the provider.

There were no issues or recommendations escalated by our Healthwatch to Healthwatch England Committee and so no resulting special reviews or investigations.

Health and Wellbeing Board

Healthwatch Lewisham is represented on the Health and Wellbeing Board by Michael Kerin, Healthwatch Lewisham Committee Chair. During 2020/21 our representative has effectively carried out this role by presenting our COVID-19 research and highlighting the importance of support for digitally excluded residents. He continues to ensure that the experiences of residents remain a priority in the discussions and decision-making processes.

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 www.linkedin.com/company/healthwatchlewisham

Agenda Item 11

HEALTH AND WELLBEING BOARD			
Report Title	Lewisham substance misuse Joint Strategic Needs Assessments		
Contributors	Director of integrated commissioning Director of Public Health	Item No.	
Class	Part 1	Date:	

1. Purpose

- 1.1 This report apprises the Lewisham Health and Wellbeing board of work undertaken to produce 2 joint strategic needs assessments (JSNAs) for substance misuse in Lewisham, and includes the Adults and Young Person's JSNAs and their findings for information.

2. Background

- 2.1 In using the Public health Grant, a local authority is required to improve the uptake of, and outcomes from, its drug and alcohol misuse treatment services.
- 2.2 A part of this is undertaking a JSNA every 4 years, to inform development of the local treatment system and the borough's strategic approach to substance misuse. The borough's last substance misuse JSNA was in 2016.

3. Policy Context

- 3.1 The Health and Social Care Act 2012 transferred operational and strategic responsibility for population based health improvement, including the reduction of health inequalities and improving the health and wellbeing of adults and young people misusing drugs and / or alcohol, to upper tier local authorities.
- 3.2 The local substance misuse treatment system supports Lewisham's corporate strategy 2018-22 in 3 main areas:
- Priority 3, Giving children and young people the best start in life; informing the borough's approach to treatment to young people, adults, parents and families
 - Priority 5, Delivering and defending: health care and support; supporting effective treatment outcomes in partnership with primary and secondary care, and through early intervention reducing pressure across health services

- Priority 7, Building safer communities; effective treatment reduces associated harms for communities including crime and antisocial behaviour

4. Report and process

- 4.1 The last substance misuse JSNA for Lewisham was published in 2016, so in line with guidance a further JSNA was required
- 4.2 The borough's core treatment contract for adults, and the young person's health and wellbeing service which delivers the treatment system for young people, were both due to expire and be reproced.
- 4.3 The COVID-19 pandemic impacted significantly on Lewisham's Public Health team's capacity to deliver the JSNA cycle as normal. Due to this the JSNA Steering Group is not currently meeting and JSNA Topic Assessment proposals are not submitted per the usual process. Given the importance of a proper substance misuse needs assessment informing the significant reprocurements, the decision was taken to seek an external partner to deliver this.
- 4.4 Officers sought an external partner through a competitive open process, and after receiving and assessing 2 bids, on September 7th 2020 the contract was awarded to Therapeutic Solutions.
- 4.5 Officers established a multidisciplinary project group to oversee the work and liaise with the provider, culminating in the 2 JSNAs attached to this report.

5. Financial Implications

- 5.1 There are no additional financial implications arising from this report.

6. Legal Implications

- 6.1 There are no additional legal implications arising from this report.

7. Crime and Disorder Implications

- 7.1 The attached needs assessments will inform the provision of specialist drug and alcohol treatment to Lewisham residents, which is a critical component of Lewisham's substance misuse Adult Treatment Plan and therefore make an important contribution to the work of the Safer Lewisham Partnership and links directly with the Safer, Stronger Communities outcome to 'minimise harm caused by illegal drugs'

8. Equalities Implications

- 8.1 The findings of the attached report identified particular communities under-represented in the treatment system, and drove work to consult directly with those communities, and to specify requirements around specific initiatives and approaches to reduce inequalities in access and outcomes.

9. Environmental Implications

- 9.1 There are no specific environmental implications arising from this report or its recommendations.

If there are any queries on this report please contact Iain McDiarmid, Assistant Director for adult integrated commissioning, on ain.mcdiarmid@lewisham.gov.uk

Background documents

JSNAs for adults and young people attached



JSNA FOR SUBSTANCE MISUSE (ADULTS) FOR LEWISHAM COUNCIL

The Centre for Public Innovation

April 2021

The Centre for Public Innovation is a Community Interest Company that provides research, training, support and advice in the fields of health, social care, criminal justice and community development.

Our mission is to improve the outcomes of services for their users, with a particular emphasis on the most disadvantaged.

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Glossary

DTR	Drug Test Recorder
HCV	Hepatitis C virus
IMD	Index of multiple deprivation
IRR	Incidence rate ratio
NDTMS	National Drug Treatment Monitoring System
OCU	Opiate and crack cocaine use
PHE	Public Health England
TOP	Treatment Outcomes Profile
POM/OTC	Prescription only medicine/over-the-counter medicine
NPS	Novel psychoactive substances
YTD	Year to date

1 Executive summary

Background

This Joint Strategic Needs Assessment explores adult substance misuse in Lewisham. A separate JSNA reports on substance misuse in relation to children and young people.

The JSNA seeks to:

- Give a better understanding of the needs of those who misuse substances and those who are at greater risk of misusing substances,
- Inform the development and re-commissioning of Lewisham's substance misuse services,
- Inform the development of a local strategic response to reducing the harm caused by substance misuse for 2022 and beyond.

The JSNA draws on range of qualitative and quantitative data.

Key findings

The data indicates clearly that the population in specialist drug and alcohol treatment in Lewisham is experiencing a steady decline from some 1,945 in 2009/10 to 1,200 in 2018/19. This is in line with both national and regional trends.

Data indicates that the alcohol treatment population, while fluctuating, has held steadier than the drug treatment population.

The data indicates that the current treatment system in Lewisham is working effectively and delivering positive outcomes. The majority of people in drug treatment experience a 'successful completion' of their treatment, reaching a peak of 63% in 2018-2019 at six months following treatment exist, rates of both abstinence and significant reduction were higher (i.e. better) in Lewisham across opiate, crack, cocaine and cannabis use compared to national rates meaning success in relation to both abstinence and harm reduction work.

Lewisham clients in alcohol treatment were shown to be more likely to report abstinence (61%) compared to nationally (51%) on exiting treatment. At six months existing from treatment over a fifth (21%) of alcohol clients in Lewisham reported significant reductions in use (compared to 17% nationally).

Other data indicates that there have been other notable successes, for instance 41% of clients in Lewisham in treatment received and completed a Hepatitis B course of treatment (a figure which is higher than the national average).

The treatment population appears to be ageing with those aged 50+ increasing from 13% (n=250) in 2009/2010 to over one-third (36%, n=425) in 2019/20. The age profile is likely to be linked to the ongoing presence of a group of users who have been engaged in treatment for 6 years and more and are therefore an ageing group of service users.

Members of the 'White' community are over-represented in both drug and alcohol treatment while members of all minority ethnic communities are under-represented.

The data (both qualitative and quantitative) would appear to suggest that a number of specific groups are under-represented in the current treatment system:

- Members of the LGBTQ+ community
- Sex workers
- Pregnant women
- Clients with a dual diagnosis

The biggest gap in current provision was believed to be among alcohol users not in treatment – particularly those who were treatment “naïve” (i.e. who had never engaged in any form of treatment).

Summary of recommendations:

1. Given the ongoing presence of a core group of ageing heroin users, future substance misuse provision in Lewisham will need to continue to support this significant, resource intensive group.
2. Future provision should seek to improve access and engagement with alcohol users to improve the penetration rate. Consideration should be given to increasing the presence of the online access to treatment for alcohol users provided by DrinkCoach.
3. Additional research is required looking at the substance misuse needs of black and minority ethnic communities. Research should be delivered in community languages and by culturally competent researchers to ensure access to the community.
4. While the exact nature of the drug and alcohol offer should await the findings of the research future provision should, at a minimum, include the following elements:

- a. Accurate recording of the ethnicity of all clients
 - b. Use of a culturally competent workforce
 - c. Providing information in a range of community languages
 - d. Publicising services through community channels and in culturally sensitive ways
 - e. Emphasising the confidentiality of service provision
5. Commissioners should hold discussions with key LGBTQ+ stakeholder organisations (such as Metro) to develop strategies to make substance misuse provision more LGBTQ+ friendly.
 6. Service providers should undertake diversity awareness training to understand issues in relation to the LGBTQ+ community and how to better promote their service to members of this community.
 7. Generic service provider promotional literature should explicitly reference that services welcome members of the LGBTQ+ community.
 8. Service providers should work with local LGBTQ+ charities to develop marketing material that are specific to this community.
 9. An awareness raising and training package should be commissioned to carry out targeted training for local professionals (particularly GPs) to promote awareness of LGBTQ+, chemsex and the treatment options (both sexual health and substance misuse) that can be offered to members of this community.
 10. Analysis should be carried out to understand the fifth of drug treatment clients who are referred through "Other" sources to understand whether significant new pathways exist that need to be better resourced or understood.
 11. GPs in Lewisham not engaged in shared care should receive training to make them aware of the range of treatment options available through substance misuse services in the borough.
 12. Future treatment provision should offer online and telephone access as a core element of service provision giving clients the option of virtual or physical engagement.
 13. Commissioners should consider increased investment in online early intervention support for non-dependent alcohol users.
 14. Consideration should be given to promoting a virtual offer among under-represented and vulnerable groups including black and minority ethnic and LGBTQ+ communities and pregnant women.
 15. Consideration should be given to providing more flexibility in the treatment service by offering a non-abstinence pathway.

16. Substance misuse and homelessness services should develop joint working/case management protocols to enable services to work collaboratively when managing homeless clients.
17. Treatment service providers should develop data sharing agreements with local homelessness services. This would enable homelessness services to be alerted if clients they have referred fail to attend an appointment.
18. Consideration should be given to commissioning outreach work targeted at the homeless population to promote engagement with treatment services.
19. Treatment services should pilot individualised care plans that would allow pregnant drug-using women to store a short supply of methadone at home rather than requiring them to consume at a pharmacists.
20. Consideration should be given to offering home visits to pregnant clients.
21. Discussions should take place between representatives from Lewisham Council and the Metropolitan Police South East Basic Command Unit (which covers the borough) to understand the significant drop in referrals from police custody, specifically exploring whether this: is related to an overall drop in drug-related offences, is related to a reduction in drug testing or is due to a drop in referrals being made.

2 Introduction

This Joint Strategic Needs Assessment explores adult substance misuse in Lewisham.

The JSNA seeks to:

- Give a better understanding of the needs of those who misuse substances and those who are at greater risk of misusing substances,
- Inform the development and re-commissioning of Lewisham's substance misuse services,
- Inform the development of a local strategic response to reducing the harm caused by substance misuse for 2022 and beyond.

The JSNA uses a range of qualitative and quantitative research approaches (as outlined in Section 3) to develop an in-depth understanding of substance misuse. Particular attention has been paid to the needs of specific groups with protected characteristics to understand substance misuse issues in relation to these communities. Finally the JSNA seeks to map out future trends.

3 Service review methodology

The JSNA adopted a mixture of both qualitative and quantitative research techniques. Details of each are set out below.

3.1 Quantitative data analysis

The review analysed data from a number of sources. For drug treatment statistics, two complementary sources based on the National Drug Treatment Monitoring System (NDTMS) were used. For the most recent data (2019-2020), a resource provided by Public Health England (PHE) was utilised 'Adults - alcohol commissioning support pack 2021-22: key data. Planning for alcohol harm prevention, treatment and recovery in adults'.

Tables that examined trends were downloaded from <https://www.ndtms.net/ViewIlt/Adult>. This captures trend information from 2009-2010 but at the time of writing (early December 2020), did not include the latest 2019-2020 data. Therefore, there will be some omissions in the years presented. Also, some of the data there are differences in how data from NDTMS are presented. For example, data presented online may differ slightly (e.g. variable categorizations) from that used in the data packs. The differences include using 'all' people in treatment or alternatively 'new' people in treatment. Differences in approach will be detailed in the text.

Other datasets include use of exogenous data (e.g. socio-demographic indices of the local population) were accessed from two sources: London Datastore (<https://data.london.gov.uk/>) and from PHE (<https://fingertips.phe.org.uk/>).

Additional datasets were also accessed separately including Drug Test Recorder (DTR) information for Lewisham residents only. Historic DTR data was accessed to compare the rate of positive tests across London. Additional analyses included access to bespoke datasets, and these are described in more detail in the text.

3.2 Professional stakeholder consultation

A range of professional stakeholders were consulted to explore their understanding and views in relation to substance misuse in Lewisham.

Professional stakeholders

The following professionals involved in the delivery of specialist treatment and associated services were interviewed:

- Service Manager - Humankind
- Services Manager – CGL, New Direction service
- GP with special interest
- Head of Looked After Children – Lewisham Council
- Public Health Training and Development Manager – Lewisham Council
- First Response, Referral & Assessment Team, Children’s Social Services – Lewisham Council
- Service Manager, Compass
- Inspector, SE Safer Neighbourhoods - Metropolitan Police Service
- Commissioning Officer (Addictions) Prevention, Inclusion & Public Health Commissioning Team – Lewisham Council
- Public Health Commissioning Manager – Lewisham Council
- Joint Commissioner 0 - 19 Health and Maternity - Lewisham Council

In addition a member of the research team attended Corporate Parenting Management Meeting managers meeting for round table discussion about Substance Misuse services and need.

Community representative and third sector stakeholders

In-depth telephone interviews were undertaken with seven community representatives between October and December 2020 representing:

- Thames Reach
- Equinox Care
- St Mungo’s
- Fulfilling Lives
- Metro
- Antenatal care and substance misuse services

- Mencap

3.3 Service user consultation

In-depth telephone interviews were undertaken with 24 service users between October 2020 and January 2021. Fourteen interviews were conducted by the CPI researcher, and ten by the peer researchers (including one interview the peer researcher 'conducted' with himself).

One online focus group was undertaken with six service users attending an aftercare service. Not all service users were online throughout the meeting, with people joining and leaving the meeting throughout. It was not possible therefore to capture the profile details of the respondents.

Service user contact details were obtained by the following:

- CGL
- Humankind
- Homeless charities
- Peers

Respondent profile of in-depth telephone interviews

Profile details were not recorded for one service user.

- 25-30 years - three service users
- 31-40 years - four service users
- 41-50 years - four service users
- 51-60 - seven service user
- 61+ - five service users

Ten service users were male and fourteen female.

- White British / Other - 19 service users
- Black British - two service users
- Mixed – two service users

Four of the service users interviewed were from the LGBTQ+ community.

Media review

A desk-based review of local media and social media sites was undertaken to understand the views expressed by residents in relation to substance misuse in the borough.

The comments made to any news articles and posts which referenced drug, alcohol or addiction related news in Lewisham between October 2017 and October 2020 were examined.

News outlets were chosen on the basis of the most popular outlets with a “local” focus and those with the most web traffic. The two most commonly used social media outlets were also selected.

The objective of the media review was to report on the topics and themes raised, and to highlight areas of concern, rather than to seek a representative sample of residents’ opinions. Please note therefore that the findings from the media review are not representative of all Lewisham residents. Those posting comments online to news articles or who respond to social media posts have been made by a small proportion of the population only.

The comments made to any news articles and posts which referenced drug, alcohol or addiction related news in Lewisham between October 2017 and October 2020 were examined.

Searches took place across the following online news and social media sites:

- News Shopper
- London Weekly News and Mercury
- News Now
- Evening Standard
- Facebook
- Twitter

4 Quantitative data findings

4.1 Demand for treatment

This sections sets out data regarding numbers of treatment for drug and alcohol misuse with analysis of key variables.

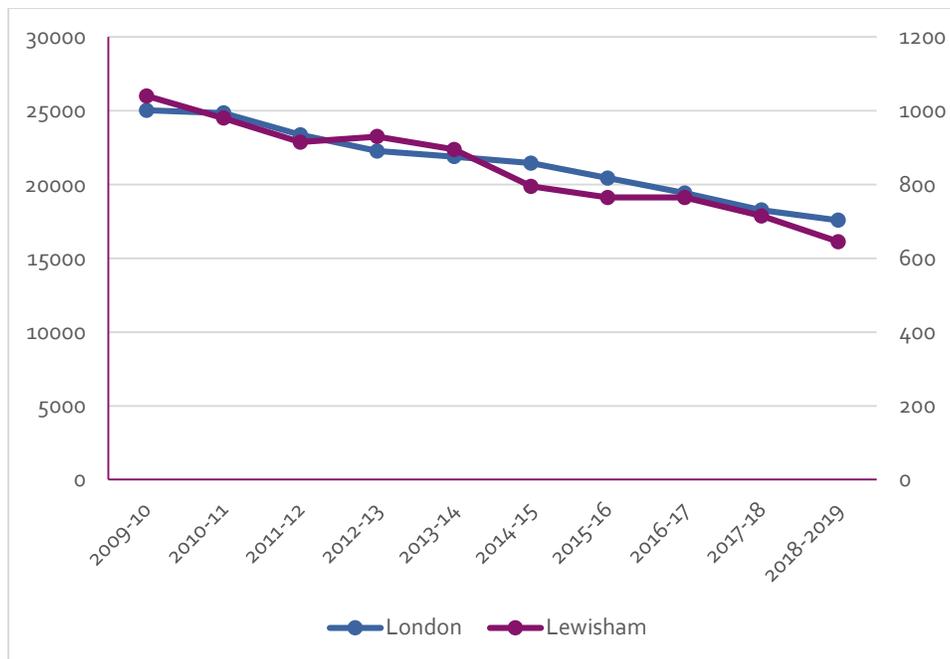
4.1.1 Drugs

Accessing treatment

This section examines changes the numbers of people accessing specialist treatment in Lewisham and how this has changed from the period 2009-10 to 2018-19. These data are derived from 'ViewIT' open source downloads (as of early December 2020) and have not been included in the JSNA Data Packs in the same level of detail.

Figure 1 below sets out in chart format the change in numbers accessing treatment over the 2009-10 to 2018-19 period.

Figure 1 Comparison between opiate use in London and Lewisham



As evidenced at Figure 1 there is a pronounced and steady decline in numbers accessing treatment. Significantly the trends in Lewisham corresponds very closely to the trend across London as a whole: that is, the pattern of drug treatment access in Lewisham is being replicated across London as a whole.

There are a range of factors that explain the consistent decline in treatment numbers. The two most significant factors are:

- As discussed through this report, the number of opiate and crack users across England is declining. This appears to be related to a situation whereby younger people are choosing not to use heroin and crack meaning that the numbers of OCUs requiring treatment is not being “replenished” by new users. As treatment systems focus on OCUs who are in turn a shrinking cohort, the net effect is to reduce numbers going into treatment.
- As significant as a reduction in numbers of potential clients are the cuts made to treatment services in Lewisham. The logical result of cuts to local treatment services is a reduction in capacity – i.e. fewer people are able to receive specialist treatment. This would also explain the consistent drop in numbers as shown at Figure 1.

The data used in Figure 1 is set out below in table form in Tables 1 and 2.

The data in Tables 1 and 2 indicate:

- A steady decline in the number of opiate clients in Lewisham from over 1,000 in 2009/10 to around 645 in 2018/19
- The rate per 1,000 population for opiate users in treatment in Lewisham fell from 4.9 per 1,000 in 2009/10 to 3.1 per 1,000 in 2018/19
- The rate per 1,000 population for opiate users in treatment in London fell from 4.2 to 2.9 per 1,000 over the same period,
- The rate per 1,000 population for opiate users in treatment in England fell from 4.8 to 4.0 per 1,000 over the same period.

There was also a fall in both the number and rate per 1,000 population of non-opiate clients albeit not as pronounced as for opiate clients. The number and rate of alcohol clients have fluctuated over the period but have remained much more stable than other treatment groups.

Tables 1 and 2 set out the data in detail.

Table 1 Access to Treatment, 2009-2010 to 2018-2019, Lewisham, London and England

	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
England										
Opiates	170032	169144	162435	157959	155852	152964	149807	146536	141189	139845
Non-opiates	24557	23613	22982	23975	25570	25025	25814	24561	23730	24253
Alcohol-only	88086	88020	86416	87544	91651	89107	85035	80454	75787	75555
Alcohol & Non-opiates	28992	28223	27732	27627	28871	28128	28128	28242	27684	28598
London										
Opiates	25030	24845	23370	22270	21890	21455	20440	19430	18275	17580
Non-opiates	5840	5295	4990	5080	5315	5305	5275	4705	4155	4050
Alcohol-only	11540	11420	10685	11190	12505	12715	12290	11440	10530	9985
Alcohol & Non-opiates	7410	7280	6600	6590	6895	6400	6115	6065	5955	5785
Lewisham										
Opiates	1040	980	915	930	895	795	765	765	715	645
Non-opiates	285	190	125	170	125	190	175	155	110	130
Alcohol-only	325	230	145	130	165	295	340	310	245	250
Alcohol & Non-opiates	295	220	230	285	210	215	220	225	175	175

(Source: ViewIT)

Table 2 Treatment Demand Rate per 1,000 population in Treatment, 2009-2010 to 2018-2019, Lewisham, London and England

	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
England										
Opiates	4.8	4.8	4.6	4.5	4.4	4.3	4.2	4.2	4.0	4.0
Non-opiates	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7
Alcohol-only	2.5	2.5	2.4	2.5	2.6	2.5	2.4	2.3	2.1	2.1
Alcohol & Non-opiates	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8
London										
Opiates	4.2	4.1	3.9	3.7	3.6	3.6	3.4	3.2	3.0	2.9
Non-opiates	1.0	0.9	0.8	0.8	0.9	0.9	0.9	0.8	0.7	0.7
Alcohol-only	1.9	1.9	1.8	1.9	2.1	2.1	2.0	1.9	1.8	1.7
Alcohol & Non-opiates	1.2	1.2	1.1	1.1	1.1	1.1	1.0	1.0	1.0	1.0
Lewisham										
Opiates	4.9	4.6	4.3	4.4	4.2	3.8	3.6	3.6	3.4	3.1
Non-opiates	1.3	0.9	0.6	0.8	0.6	0.9	0.8	0.7	0.5	0.6
Alcohol-only	1.5	1.1	0.7	0.6	0.8	1.4	1.6	1.5	1.2	1.2
Alcohol & Non-opiates	1.4	1.0	1.1	1.3	1.0	1.0	1.0	1.1	0.8	0.8

(Source: ViewIT and Population Estimates using ONS mid-year population estimate for 2015 as midpoint <http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-uk--england-and-wales--scotland-and-northern-ireland/index.html>)

When the data was analysed further it was found that there is a strong correlation¹ (i.e. a strong relationship between factors) between trends in presenting opiate use across Lewisham and in London. This relationship also holds when comparing trends in Lewisham with England (R=0.97).

This means that there are consistent national, population level factors that are likely to be affecting treatment numbers for opiate users: that is, factors that are driving down treatment demand in Lewisham are also driving down demand across London as a whole. Therefore, treatment trends in Lewisham are part of wider changes that are taking place across London and elsewhere.

¹ R²= 0.97

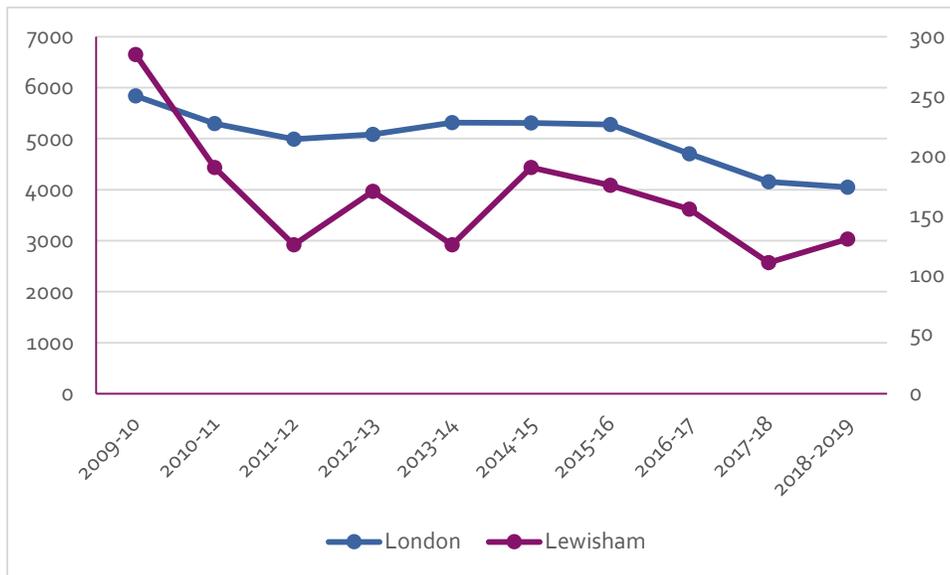
The data on what these trends are is not definitive but appears to be linked to an ageing opiate using cohort with very few younger people using opiates. As such, the numbers of heroin users are diminishing over time with very few “new” heroin users replacing them and requiring treatment.

The data for non-opiate users was also analysed. The results are set out at Figure 2 below.

The analysis indicates that there is a strong correlation between non-opiate use across Lewisham and London (R=0.75) but a much weaker association comparing Lewisham and England as a whole (R=0.19). This means that, as per opiate numbers, trends in Lewisham track those of London but not those seen in England as a whole. As noted above this is likely to be, in part, allied to cuts in the treatment budget which has limited the capacity of treatment services.

This analysis is set out graphically at Figure 2. While there is a degree of fluctuation between the two figures, as noted above, statistical analysis indicates a correlation between the trend in Lewisham and London.

Figure 2 Comparison between non-opiate use in London and Lewisham



Analysis was carried out in relation to alcohol use and whether it correlates to wider trends. This is set out at Figure 3 below.

Figure 3 Comparison between alcohol use (including alcohol combined with non-opiate use) in London and Lewisham



The relationship between alcohol use (including alcohol combined with non-opiate use) is weaker across London compared with Lewisham ($R=0.33$) and is negligible when comparing Lewisham and England ($R=0.09$). What this means is that factors influencing the numbers of alcohol clients in treatment are largely specific to Lewisham and are not really linked to trends across London and England that are driving the need for alcohol treatment. Simply put, the issues driving demand for alcohol treatment are largely specific to Lewisham.

NPS (novel psychoactive substances) and club drugs

In Lewisham, during 2019-20, there were two new treatment presentations of ‘any club drug use’ (defined as a proportion of all new treatment entrants) or 1% of the total.

Despite the small number, the proportions are equivalent to national figures for the same period (2% of all new treatment entrants).

For all adults new to treatment citing club drug use (no additional opiate use) in Lewisham for 2019-20 there were 15 reports (8%) of any club drug use (ecstasy, ketamine, GHB/GBL, methamphetamine,

mephedrone and NPS Other). (Note that people citing the use of multiple club drugs will be counted once under each drug they cite).

While numbers are low the data indicates that presentations levels are comparable proportionally to national figures (7%) – that is the numbers in treatment for NPS in Lewisham are broadly similar to figures elsewhere in England.

Data was not available for levels of club drug use in Lewisham. The United Kingdom Drug Summary (2019) estimates that 4.5% of those aged 16 to 19 years has used MDMA and that 2.9% of the adult population had used ketamine.

Prescription only medicine/over-the-counter medicine (POM/OTC)

Data for prescription medicines is set out at Table 3.

Table 3 Number of adults citing POM/OTC use, 2019-20

	Lewisham Number (2019-20)	Proportion of treatment population (Lewisham)	Proportion of treatment population (National)
Illicit use	70	8%	10%
No illicit use	16	2%	4%
TOTAL	86	9%	14%

(Source: Adults - drugs commissioning support pack 2021-22: key data. Planning for drug prevention, treatment and recovery in adults)

Using data for 2019-20, there was a slightly lower rate of engagement in treatment for adults stating a POM/OTC problem (9% in Lewisham compared to 14% nationally). This means that Lewisham has a smaller population in treatment for prescription drug use than tends to be seen elsewhere across England. Data set out later in this report at Figure 7 sets out prescription rates for a number of key prescription only medicines. The conclusion in relation to the prescription data is that trends are in line with the needs of the population. It would not therefore appear that there is a significant unmet need for treatment for POM/OTC clients.

Prevalence

Table 4 sets out estimates of the levels of need for drug treatment – that is, the estimated number of people across the entire population of Lewisham who have a substance misuse need, broken down by substance. This therefore enables an understanding to be reached of the size of the total population

versus the total level of potential demand for treatment. The difference between the two figures can be expressed as 'unmet need'. In Table 4 below this is expressed as a percentage (the extent to which people with a substance misuse need is in treatment).

The "estimated level" is a projection of the numbers that are thought should be in treated, with a confidence interval (i.e. a plus or minus to allow for variance) applied to this estimate of the size of the treatment population. This is then compared to actual numbers in treatment to arrive at an assessment of "unmet need".

Table 4 Prevalence estimates and rates of unmet need (2016/2017 data)

Age 15-64	Estimated level of Need in Lewisham (number)	Lower CI	Upper CI	Rate per 1,000	Lower CI	Upper CI	% Unmet Need (Lewisham)	% Unmet Need (National)
OCU	2285	1644	2900	10.77	7.75	13.67	71%	53%
Opiate	1751	1357	2133	8.25	6.40	10.05	64%	47%
Crack	1582	1215	1939	7.47	5.73	9.14	69%	58%

(Source: Adults - drugs commissioning support pack 2021-22: key data. Planning for drug prevention, treatment and recovery in adults)

Using this way of measuring levels of unmet need for OCU (opiate and crack use) are higher in Lewisham when compared to the national averages – that is, there is a larger group of drug users outside of treatment when Lewisham is compared to other areas. Note that this finding was challenged by local practitioners. The challenge and their counter-argument is set out in Section 5.1.

Epidemiological Modelling of Drug Related Needs

Analysis was undertaken to understand whether there was any correlation between levels of drug-related need (e.g. prevalence of OCU) with related socio-demographic and other indices. That is: do levels of drug need rise (or fall) in line with other measures (such as deprivation)?

These measures were based on the latest information available at the time of the study as derived from open source datasets and used to examine variations across all London boroughs, with the aim that any emerging finding would be applicable to Lewisham.

Three measures were chosen based on the available information at a London borough level:

- a. prevalence of opiate and/or crack cocaine use OCU,

- b. drug related deaths, and
- c. the number of drug offences.

The aim was to understand the full scope of drug-related need to examine the potential need for service provision. Details of the modelling methodology are set out at Appendix 1.

Table 5 below presents a matrix of the three variables selected (prevalence, deaths and offences) and how they related to the other factors.

Statistically significant² measures include an ‘*’ and are in bold.

Table 5 Effect sizes (incidence rate ratios) for a range of selected prognostics (with statistically significant values whose p-value =<0.05)

Prognostic	Drug-Related Death	Drug Offences	OCU Prevalence
Admissions for drug related mental and behavioural disorders 100,000 2018-19	0.974	1.01	1.006*
Poisoning by Drug Misuse 100,000 2018-19	1.03	1.02	0.99*
Drug-related Deaths 2016-2018		1.005	1.04*
Admissions where drug related mental and behavioural disorders were a factor 100,000 2018/19	1.0007	0.9996	1.0003*
Estimated prevalence of common mental disorders: % of population aged 16 & over	1.3	1.13	0.91*
Hospital stays for alcohol-related harm (Broad definition), standardised admission ratio Percent	2.1	0.86	2.4*
IMD Average (deprivation)	0.91	0.996	1.02*
Percentage who rent from private landlord	1.005	0.995	0.993 *
Percentage of the population who were born abroad (outwith the UK)	1.0002	1.02	0.99*
Percentage of the population who are aged between 15 and 24 years	0.995	0.96	1.05*
Net Natural Change Migration within a borough	0.9998	0.9997	1.0004*
Employment	0.9994	1.006	0.995*
Prevalence of Opiates and/or Crack Cocaine Use	1.00004	1.0002	
Drug Offences 2019-2020	0.995		1.06*
Acquisitive crime offences (separate to drug offences) 2019-2020	1.006	1.003	1.007*

Drug-related deaths

² A statistically significant association between two or more variables can occur showing that the relationship is caused by something other than chance

- No statistically significant factors were associated with drug-related deaths. This means that no socio-demographic, crime or health-related factors are associated with drug-related deaths in the borough. Simply put: if the various factors in the model change (such as a change in level of deprivation) this would have no effect on drug-related deaths.

Drug offences recorded by the Police

- No statistically significant factors were associated with drug offences. As per the data on deaths, this means that no socio-demographic or health-related factors are associated with the level of drug offences in the borough. As per the drug-related deaths this means that, were any of the factors set out in Table 5 to change, this would not affect drug offences in Lewisham.

Prevalence of opiate and cocaine use

- Increases in (a) admissions for drug related mental and behavioural disorders; (b) drug-related deaths; (c) Admissions where drug related mental and behavioural disorders were a factor; (d) hospital admissions for alcohol-related problems; (e) IMD deprivation indices; (f) % population aged 15-24 years; (g) % natural change of the internal population migration levels; (h) drug offences and (i) acquisitive crime are all associated with INCREASES in the prevalence rate of OCU
- Increases in (a) Poisoning by Drug Misuse; (b) Estimated prevalence of common mental disorders; (c) % of the population born abroad; (d) % renting from a private landlord and (e) employment rates are associated with DECREASED level of OCU

Unlike drug-related deaths and drug offences, the analysis suggests that there *are* a number of factors that are associated with levels of use of opiates and/or crack-cocaine in the borough.

In practice this means that OCU use correlate to changes in a range of socio-demographic and criminogenic factors. As these factors shift, it is likely that there will be a corresponding shift in OCU use as the trends continue to mirror one another.

Taken as a whole the analysis suggests that drug-related deaths and drug offending correlate to other factors other than those set out in Table 5 and may be being driven by specific local issues.

Referrals

Table 6 sets out referrals into substance misuse treatment in Lewisham from 2009/2010 to 2019/20.

Table 6 Referral Source, 2009-10 to 2019-20 (numbers and percentage)

Source of Referral	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Self, family & friends	390 (50%)	265 (54%)	345 (58%)	305 (56%)	275 (59%)	465 (69%)	350 (51%)	190 (35%)	145 (41%)	205 (49%)	211 (54%)
Health services and social care	90 (12%)	30 (6%)	110 (18%)	75 (14%)	50 (11%)	70 (10%)	115 (17%)	155 (28%)	95 (27%)	110 (26%)	50 (13%)
Criminal justice	185 (24%)	90 (18%)	85 (14%)	95 (17%)	70 (15%)	70 (10%)	70 (10%)	75 (14%)	30 (8%)	25 (6%)	45 (11%)
Substance misuse service	70 (9%)	65 (13%)	30 (5%)	35 (6%)	30 (6%)	20 (3%)	95 (14%)	105 (19%)	50 (14%)	55 (13%)	NA
Other	40 (5%)	45 (9%)	25 (4%)	35 (6%)	40 (9%)	45 (7%)	55 (8%)	25 (5%)	35 (10%)	25 (6%)	88 (22%)
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

(Source: ViewIT and Adults - drugs commissioning support pack 2021-22: key data. Planning for drug prevention, treatment and recovery in adults; * data for 2019-20 derived from 2021-22 data pack using different referral categories than those held on ViewIT).

The number of referrals via criminal justice has shifted dramatically – constituting nearly a quarter of referrals (24%) in 2009/10 to 11% in 2019/20. The reasons for this are likely to be manifold and complex. Reasons are likely to include some combination of the following:

- the Drug Intervention Programme (a Home Office directed initiative aimed at engaging Class A drug users in drug treatment) was defunded during the period with an associated move away from the focus on this client group;

- a number of police stations across London have closed (given that Lewisham residents would have been taken to custody suites across London as well as in the borough) meaning that there are fewer physical spaces for the criminal justice system to engage with clients;
- The Metropolitan Police have shifted to increasing use of diverting offenders from custody such as using on-street disposals. This means that offenders are not necessarily being taken into custody and tested for drug use.
- This period has seen significant changes to the operation of probation – notably the development (and subsequent ending) of Community Rehabilitation Companies.

The proportion in Other referrals may be due to a number of reasons including changing referral pathways and how data are recorded.

Table 7 compares Lewisham referral rates to national trends.

Table 7 Comparison of referral route, Lewisham and National

	Lewisham Average 2009/10 – 2019-20 NDTMS*	National Estimate as of 2019-20†
Self, family & friends	53%	62%
Criminal justice	14%	17%

† Derived from JSNA Support Packs on 2018-19 and 2019-20 data; * average of referrals 2009/10 to 2019/20; ** includes Other incl. Substance misuse service

Table 7 indicates that the level of referrals from self, family and friends (53% average compared to 62% nationally) and via the criminal justice system (14% on average compared to nationally 17%) are lower than would be expected. (Caution is advised in the interpretation of this table, as Lewisham figures have been averaged compared to a single national year snapshot (2019-20)).

Treatment metrics

Table 8 explores data in relation to the length of time clients spend in treatment services.

Table 8 Treatment length, 2009-10 to 2018-19 (numbers and percentage)

Length in treatment	Year									
	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Under 1 Year	1080 (57%)	845 (54%)	810 (58%)	780 (53%)	720 (53%)	890 (62%)	980 (64%)	835 (58%)	605 (50%)	610 (55%)
1 to 2 Years	380 (20%)	280 (18%)	175 (13%)	275 (19%)	220 (16%)	160 (11%)	170 (11%)	235 (16%)	230 (19%)	150 (13%)
2 to 4 Years	275 (14%)	245 (16%)	175 (13%)	165 (11%)	180 (13%)	135 (9%)	105 (7%)	125 (9%)	130 (11%)	130 (12%)
4 to 6 Years	90 (5%)	115 (7%)	110 (8%)	105 (7%)	85 (6%)	85 (6%)	90 (6%)	60 (4%)	65 (5%)	75 (7%)
Over 6 Years	75 (4%)	85 (5%)	115 (8%)	140 (10%)	165 (12%)	165 (11%)	185 (12%)	185 (13%)	185 (15%)	150 (13%)
TOTAL	1900	1570	1385	1465	1370	1435	1530	1440	1215	1115
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

The data indicates that the drug treatment system in Lewisham is operating effectively with the majority of people in treatment engaged for a period of under 1 year (from 64% n=980 in 2015-16 to 50% n=605 in 2017-18). This has been the case consistently across the ten year period for which data is presented.

The data indicates that there is a cohort of people who have been in treatment for over six years (at 13%, n=150 as at 2018-19) indicating a group of clients with ongoing needs who require long-term support or who are otherwise unable to exit treatment. The profile of this cohort was described in some detail by local practitioners and their views are set out in Section 5.1. Largely their views are that this is a group of male heroin users aged over 35 who do not feel confident enough to leave treatment and who are often on a low and stable dose of opiate substitution.

Table 9 shows data in relation to how clients exited treatment in Lewisham.

Table 9 Treatment exits, 2009-10 to 2018-19 (numbers and percentage)

Treatment Exits	Year									
	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Successful completion	235 (40%)	215 (28%)	205 (46%)	310 (55%)	310 (52%)	355 (52%)	320 (53%)	345 (57%)	265 (54%)	360 (63%)

Treatment Exits	Year									
	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Dropped out/left	225 (38%)	265 (35%)	125 (28%)	140 (25%)	145 (24%)	180 (26%)	180 (30%)	170 (28%)	155 (32%)	150 (26%)
Transferred - not in custody	75 (13%)	145 (19%)	70 (16%)	55 (10%)	100 (17%)	95 (14%)	60 (10%)	50 (8%)	40 (8%)	45 (8%)
Transferred - in custody	10 (2%)	20 (3%)	30 (7%)	55 (10%)	35 (6%)	35 (5%)	30 (5%)	30 (5%)	15 (3%)	5 (1%)
Treatment declined	20 (3%)	5 (1%)	0 (0%)							
Died	10 (2%)	5 (1%)	5 (1%)	0 (0%)	10 (2%)	15 (2%)	15 (2%)	10 (2%)	15 (3%)	10 (2%)
Prison	10 (2%)	15 (2%)	10 (2%)	0 (0%)						
Treatment withdrawn	0 (0%)	95 (12%)	0 (0%)							
Moved away	0 (0%)									
No appropriate treatment	0 (0%)									
Not known	0 (0%)									
Other	0 (0%)									
Referred on	0 (0%)									
Inconsistent	0 (0%)									
TOTAL	585	765	445	560	600	680	605	605	490	570
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

The data indicates that the drug treatment system in Lewisham is operating effectively with the majority of people in treatment experience a 'successful completion' of their treatment. This reached a peak of 63% in 2018-2019. This would therefore appear to represent an endorsement about how local treatment for drug users is currently configured and delivered.

While the overall picture is one of successful treatment, the data indicates a sizeable proportion of people in treatment who have 'dropped out or left' treatment. This varies from around one-third to one-quarter of the treated population (ranging from 24% in 2013-14 to 38% in 2009-10). The available data does not allow for analysis of why clients dropped out of treatment.

The most recent data for 2019-20 (not available at the time of writing on ViewIt) show that the proportion of 'successful completions' were down in total by 6% compared to 2018-19 for all categories of drug and alcohol misuse including opiate use (down 2%); non-opiate only use (down 3%); non-opiate and alcohol misuse (down 17%). The data may be a short-term anomaly and so no inference can be drawn from these recent changes.

Treatment Outcome

Completion of Treatment and Representation

Table 10 sets out data in relation to OCU clients completing treatment in Lewisham.

Table 10 Clients completing treatment and not re-presenting to treatment, 2009-10 to 2018-19 (numbers and percentage)

Clients completing treatment and not re-presenting to treatment	Year									
	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
All clients in treatment	1055	1005	920	935	915	840	785	780	760	660
Number of completions without re-presentation	70	70	65	60	110	60	50	50	70	50
% of all clients completing and not re-presenting	7	7	7	6	12	7	6	6	9	8

Using this performance measure, fewer than one in ten people in treatment complete and do not re-present to services (at an average of 8% of the period between 2009-10 and 2018-19 compared to an average for England as a whole of 5%). This would tend to indicate that clients are often successfully treated (see Table 9) but subsequently relapse – albeit at a better rate than for treatment services elsewhere in England. Again, this was described by local practitioners who discussed a group of heroin clients who are treated but who re-present to the treatment system. (See Section 5.1).

Abstinence and Significant Reductions in Drug Use

The data in Table 11 is drawn from the Treatment Outcomes Profile (TOP) dataset which tracks drug users' progress in treatment, including information on abstinence rates from drugs and statistically significant reductions in drug use and injecting.

Table 11 Treatment review

Six-month review outcomes	Abstinence			Significant reductions in use		
	Lewisham 2019-20 (number)	Lewisham 2019-20 (percent)	National Comparator	Lewisham 2019-20 (number)	Lewisham 2019-20 (percent)	National Comparator
Opiate	43	41%	40%	25	24%	25%
Crack	39	39%	37%	20	20%	19%
Cocaine	26	59%	65%	7	16%	11%
Cannabis	38	40%	44%	20	21%	12%
Alcohol*	27	27%	31%	22	22%	17%

(Source: Adults - drugs commissioning support pack 2021-22: key data. Planning for drug prevention, treatment and recovery in adults; data for amphetamines were not included due to the small numbers in treatment and completing TOP; * alcohol used as an adjunctive drug only)

Table 11 shows that the majority of users of all substances other than alcohol report either abstinence or a significant reduction in use.

41% of opiate users are abstinent and nearly a further quarter (24%) have significantly reduced. Rates are somewhat lower for crack, cocaine and cannabis.

Moreover there was broad comparability in abstinence and reports of significant reductions in use in Lewisham compared to national figures. Abstinence rates were lower for:

- cocaine (59% in Lewisham compared to 65% nationally),
- cannabis (40% v 44%), and
- alcohol when used in conjunction with other substances (27% v 31%).

This may be offset by Lewisham clients reporting higher rates of significant reductions in use for these three substances.

4.1.2 Alcohol

Accessing treatment

The size of the alcohol treatment population is set out above at Table 1 where they are set against the figures for the drug treatment population.

The data at Table 1 (see previously in the report) indicates a fluctuating alcohol treatment population but one which has proven to be more consistent than for drug users: 325 alcohol only clients in 2009/10 to 250 in 2018/19.

Table 12 explores drinking levels of clients in alcohol treatment.

Table 12 Drinking levels as measured by Severity of alcohol dependence questionnaire (SADQ), 2019-2020

SADQ	Lewisham 2019-20		National 2019-20	
	Male	Female	Male	Female
0-15: Mild dependence	35%	46%	30%	33%
16-30: Moderate dependence	31%	17%	18%	18%
31+: Severe dependence	25%	29%	19%	16%
Declined to answer	0%	0%	0%	0%
Not stated / Not known	5%	1%	18%	19%
Missing / incomplete	4%	7%	14%	15%

(Source: Adults - alcohol commissioning support pack 2021-22: key data. Planning for drug prevention, treatment and recovery in adults)

The data indicates that over a quarter of clients in alcohol treatment are severely dependent – note also that rates vary by gender with a greater proportion of women than men severely dependent.

Rates of severe dependency are higher in Lewisham than compared to the national average: for instance 16% of women in treatment nationally are severely dependent compared to 29% in Lewisham. Whilst this may indicate more complex and dependent clients in Lewisham than compared to the rest of the country, caution is advised in the interpretation of this table, as the national figures are skewed by high levels of missing or not known figures.

Prevalence

Alcohol-related harm is largely determined by the volume of alcohol consumed and the frequency of drinking occasions. As such, the risk of harm is directly-related to levels and patterns of consumption. However, there can be a considerable lag between alcohol consumption and alcohol-related harms, particularly for chronic conditions where the lag can be many years. In January 2016 the CMO issued revised guidance on alcohol consumption, which advises that in order to keep to a low level of risk of alcohol-related harm, adults should drink no more than 14 units of alcohol a week. In England, a quarter of the population are drinking at above low risk levels so may benefit from some level of intervention.

Drinking levels in Lewisham, compared to England, are set out in Table 13.

Table 13 2011-2014 Health Survey for England data

	Lewisham %	National %
Proportion of adults who abstain from drinking alcohol	16.8%	15.1%
Proportion of adults drinking less than 14 units a week	58.2	59.1
Proportion of adults drinking more than 14 units a week	25.1	25.7

(Source: Adults - alcohol commissioning support pack 2021-22: key data. Planning for alcohol harm prevention, treatment and recovery in adults)

The overall prevalence of alcohol consumption in Lewisham is broadly similar to national estimates. Lewisham has a higher proportion of people who state that they abstain from drinking alcohol which may be a function of the cultural, ethnic and religious profile of the area.

Prevalence estimates and rates of unmet need for alcohol treatment

Table 14 sets out the number of people in Lewisham with a potential alcohol treatment need, with data compared to national levels.

Table 14 Prevalence estimates and rates of unmet need for alcohol treatment

	Lewisham Estimate (2016-17)	Lewisham Rate per 100,000	Lewisham Number in Treatment	Lewisham Unmet Need %	National Estimate (2016-17)	National Rate per 100,000	National Number in Treatment	National Unmet Need %
Alcohol Only & Alcohol and Non-Opiates	3,314	14.2	417	87%	586,780	13.4	104,880	82%

(Source: Adults - alcohol commissioning support pack 2021-22: key data. Planning for alcohol harm prevention, treatment and recovery in adults)

As with data on drug treatment penetration (see Table 4) the data indicates a nationally developed estimate of the total number of people in the area who require treatment (3,314). This is then compared to the number in treatment to arrive at a figure for “unmet need”.

The penetration rate of alcohol misusers into treatment is estimated to be 13% compared to 18% nationally (for the period 2016-2017). The “unmet need” figure therefore indicates a high number of people who would benefit from alcohol treatment in the borough but who are not yet in treatment. Note that local practitioners were aware of the high volume of unmet need in the borough and the number of alcohol clients who could potentially be supported. For more on professional stakeholder views see Section 5.1.

Alcohol-Related Morbidities and Mortality

This section examines the extent and nature of presenting need for alcohol misusers attending treatment services in Lewisham.

Table 15 explores alcohol admission rates and alcohol-related mortality rates for Lewisham and in comparison to rates in London and England.

Table 15 Alcohol admission episodes and alcohol-related mortality, Lewisham, London and National Rate per 100,000 directly standardised rate

Indicator Name	Lewisham Rate per 100,000	London Rate per 100,000	National Rate per 100,000
Admission episodes for alcohol-related conditions (Narrow) 2018-19	547	556	664
Admission episodes for alcohol-related conditions (Broad) 2018-19	2561	2500	2367
Admission episodes for alcohol-specific conditions 2018/19	593	602	626
Admission episodes for alcohol-specific conditions - Under 18s 2016/17 to 2018/19	22	16.5	31.6
Alcohol-related mortality, 2018	48.4	39.4	46.5
Alcohol-specific mortality, 2016-18	11.1	7.9	10.8

(Source: <https://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/1/gid/1938132984/pat/6/par/E12000007/ati/102/are/E09000023/iid/91414/age/1/sex/4/cid/4>) Downloaded 17 October 2020. Lewisham and its CIPFA nearest neighbours (2018) was not available on the website).

Using a broad definition for hospital admission episodes for alcohol-related conditions, Lewisham has a higher rate per 100,000 (2,561) compared to London (2,500) and nationally (2,367).

Admission episodes for alcohol-specific conditions for people aged under 18s was higher between 2016-17 and 2018-19 in Lewisham (22 per 100,000) compared to the rest of London (16.5 per 100,000).

Alcohol-related mortality rates for 2018 and for 2016-2018 also show higher rates for Lewisham residents compared to London and national figures.

Table 16 gives a more granular analysis of alcohol-related admissions in Lewisham and in comparison to national rates.

Table 16 Alcohol admission episodes and alcohol-related morbidities, Lewisham and National Rate per 100,000 directly standardised rate

Indicator Name	Lewisham DSR per 100,000	Lower CI	Upper CI	National DSR per 100,000	Lower CI	Upper CI
Admission episodes for alcohol-related cardiovascular disease conditions 2018-19 (Broad) - Males	2,127	2,021	2,236	1,761	1,756	1,767
Admission episodes for alcohol-related cardiovascular disease conditions 2018-19 (Broad) - Females	1,079	1,018	1,142	776	772	779
Admission episodes for alcoholic liver disease condition (Broad) 2018-19 Males	239.3	208.7	272.9	182.1	180.5	183.8
Admission episodes for alcoholic liver disease condition (Broad) 2018-19 Females	49.7	37.2	64.8	83.3	82.2	84.4
Admission episodes for alcohol-related unintentional injuries conditions (Narrow) 2018-19 Males	190.7	164.0	220.1	228.8	227.0	230.7
Admission episodes for alcohol-related unintentional injuries conditions (Narrow) 2018-19 Females	190.7	164.0	220.1	228.8	227.0	230.7
Admission episodes for mental and behavioural disorders due to use of alcohol condition (Narrow) 2018-19 Males	79.3	63.7	97.3	106.1	104.9	107.3
Admission episodes for mental and behavioural disorders due to use of alcohol condition (Narrow) 2018-19 Females	33.7	24.2	45.4	46.1	45.3	46.9
Admission episodes for intentional self-poisoning by and exposure to alcohol condition (Narrow) 2018-19 Males	14.6	9.3	21.7	41.8	41.0	42.5
Admission episodes for intentional self-poisoning by and exposure to alcohol condition (Narrow) 2018-19 Females	32.2	23.5	42.8	56.6	55.7	57.5
Incidence rate of alcohol-related cancer 2015-17 Males	38.03	30.29	47.04	39.33	38.87	39.80
Incidence rate of alcohol-related cancer 2015-17 Females	33.43	27.18	40.63	36.80	36.38	37.22
Adults (18+) with alcohol-specific hospital admissions in 2019-20 and number of admissions in the preceding 24 months - No previous admission	181	164	198	260	259	262
1 previous admission	61	51	71	81	81	82
2 previous admissions	27	21	34	41	40	42
3 previous admissions	63	53	73	82	81	83
Mortality from chronic liver disease 2016-2018	48.8	39.2	59.9	46.5	46.0	47.1

(Source: Adults - alcohol commissioning support pack 2021-22: key data. Planning for alcohol harm prevention, treatment and recovery in adults)

The data at Table 16 shows that:

- There are higher rates of alcohol-related admissions for cardiovascular disease in Lewisham compared to nationally for males and females,
- Alcoholic liver disease rates are higher for males only,
- Lower rates were reported in Lewisham for alcoholic liver disease conditions for females,
- Lower rates were reported for alcohol-related unintentional injuries conditions for both males and females,
- Lower rates were reported for admissions due to mental and behavioural disorders for males and females,
- Lower rates were reported for intentional self-poisoning for males and females,
- There was a noted close similarity (slightly lower) in the incidence rates of alcohol-related cancer for both males in Lewisham relative to national estimates.

For those individuals who had an alcohol specific hospital admission in 2019-20, the number of previous alcohol specific admissions they had in the preceding 24 months suggests that Lewisham residents are less likely to be admitted having had previous admissions when compared to figures for England.

Finally, the rate per 100,000 recorded as dying from chronic liver disease during 2016-2018 was shown to be slightly higher in Lewisham (48.8) compared to national figures (46.5).

Referrals

Referral routes into alcohol treatment are set out at Table 17.

Table 17 Alcohol Treatment Routes for New Clients, 2019-20

Age Range	Lewisham Number 2019-2020	Lewisham Percentage	National Percentage
Self-referral	79	42%	67%
Criminal Justice Referral	6	3%	6%
GP	33	18%	10%
Hospital/A&E	4	2%	5%
Social Services	8	4%	2%
All Other Referrals	56	30%	10%

(Source: Adults - alcohol commissioning support pack 2021-22: key data. Planning for alcohol harm prevention, treatment and recovery in adults)

The data indicates that there are more referrals from people self-referring for alcohol treatment nationally (67%) compared Lewisham (43%). This may reflect how people choose to define and record their referral route rather than differences in pathways. Further work is also required in understanding the high rates of 'other' referrals in Lewisham (30%) compared to 10% nationally.

Treatment Metrics

Length of time in treatment

Table 18 shows data in relation to length of time for clients in alcohol treatment.

Table 18 Length of time in treatment, 2019-2020

Length of time in treatment	Lewisham Number (2019-20)	Proportion of new presentations (Lewisham)	Proportion of new presentations (National)
< 1 month	11	8%	9%
1 to <3 months	45	32%	27%
3 to <6 months	46	32%	32%
6 to <9 months	21	15%	15%
9 to <12 months	10	7%	7%
12 months and over	9	6%	11%
Average days in treatment		156 days	180 days

There is broad similarity in the extent to which Lewisham clients stay in alcohol treatment compared to national estimates. Lewisham clients were more likely to be in treatment for between one and three months (32% compared to 27% nationally) and less likely to stay for 12 months or more (6% compared to 11% national). Overall, Lewisham clients were slightly less likely to stay in treatment with a reported average of 156 days compared to 180 nationally. Further work is required to explore the optimal level of treatment engagement for alcohol clients.

Treatment outcomes

Table 19 looks at changes in drinking following treatment.

Table 19 Adults who entered alcohol treatment (new cases) in 2017-18, treatment outcome measures

	Lewisham Number (2017-18)	Proportion of new presentations (Lewisham)	Proportion of new presentations (National)
Abstinence rates at planned exit			
No. of individuals become abstinent	58	61%	51%
Days of drinking			
Change in drinking days between start and planned exit*	95	8.8	9.3
Total individuals leaving alcohol treatment in 2019-20	142	58%	64%
Individuals leaving alcohol treatment successfully in 2019-20	108	43%	38%
Individuals leaving alcohol treatment successfully in 2019-20, as a proportion of all exits		73%	59%
Proportion of all in treatment, who successfully completed treatment and did not re-present within 6 months (PHOF 2.15 iii)	109	43%	38%

(Source: Adults - alcohol commissioning support pack 2021-22: key data. Planning for drug prevention, treatment and recovery in adults; * calculated as the difference between the average number of says drinking at the start of treatment compared to the average number of days at treatment end)

The data on treatment outcomes, as per the data on drug treatment, indicates that the system is working effectively: nearly two thirds (61%) of clients in alcohol treatment were abstinent on exiting

treatment. Rates of abstinence in Lewisham were higher than national figures (51%) on exiting treatment.

By all other performance metrics, Lewisham residents do better (more likely to 'successfully' leave treatment; and to successfully complete treatment and not re-present to services within six months) than their peers elsewhere in England.

As such, the outcome data indicates a system that alcohol treatment in the borough is working effectively to achieve positive outcomes when compared to treatment provided elsewhere in England. It is additionally worth noting that there are a higher number of severely dependent alcohol users in treatment in Lewisham than is the case for other treatment services (see Table 12). This means that the service in the borough is achieving better results over a baseline of more dependent and complex clients than are found elsewhere.

4.2 Future trends

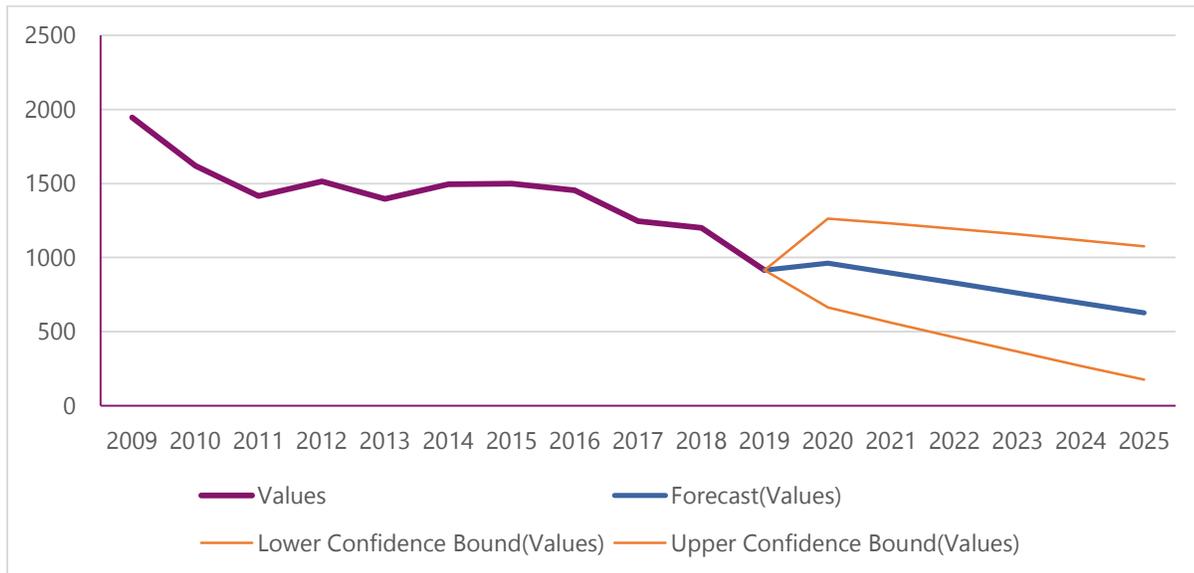
This section seeks to understand what the future demand for drug and alcohol services may be by extrapolating from the treatment trend data described above (Table 1).

The analysis in this section extrapolates historic and current figures and, from this, projects likely future levels of need. Note however that this modelling assumes that no changes are made to the current system – that it retains a focus on OCUs (which as noted elsewhere in this report make up a declining population) and that it does not seek to engage with “new” groups of under-represented drug and alcohol users (as described in this report). Moreover the downward trend in treatment numbers since 2009 is associated in part with cuts to treatment budgets. The modelling therefore has the effect of projecting the impact of these cuts going forward.

Given this, the modelling can be used as an indicative picture of what might occur should commissioners choose to retain the treatment system in its current guise.

Data presented are for financial years but presented in the graph as a single year (e.g. 2009) for convenience. Starting with the data for historic and the current treatment cohort, the estimated level of treatment demand for up to five years are presented below (that is, up to 2025).

Figure 4 Crude forecast extrapolating from existing treatment cohort for Lewisham of all drugs (numbers) 2019-2025 (extrapolated from NDTMS data)



What this model therefore tells us that, if the current model of provision is continued and works with the same core group of clients, then numbers in treatment will decline steadily over the next few years.

Clearly this pattern could be changed should the system be adapted and other groups of drug users and under-represented groups engaged.

The data from Figure 4 (above) is set out in table format below.

Table 20 Forecast of treatment population for Lewisham, 2009-10 to 2025-2026

Timeline	Values	Forecast (Values)	Lower Confidence Bound (Values)	Upper Confidence Bound (Values)
2009-10	1945			
2010-11	1620			
2011-12	1415			
2012-13	1515			
2013-14	1395			
2014-15	1495			
2015-16	1500			
2016-17	1455			
2017-18	1245			
2018-19	1200			
2019-20	915	915	915	915
2020-21		963	664	1262
2021-22		896	561	1230
2022-23		828	461	1195
2023-24		761	364	1157
2024-25		694	269	1118
2025-26		626	176	1077

Based on an OCU-oriented treatment system, and assuming that the system is not adapted to engage other groups, the forecasting model suggests a slow downward trend in the overall level of adult treatment numbers up to 2025-26. Further caution is advised in the interpretation of this finding due to the relatively wide confidence intervals (that is, by 2025/26 the range extends from 176 to 1077).

4.3 Profile of people in substance misuse treatment

This section give a picture of the profile of those people in drug and alcohol treatment in Lewisham.

4.3.1 Drug users

Age

The age profile of clients in drug treatment is explored below.

Table 21 Changes in age, 2009-10 to 2019-20 (numbers and percentage)

Age Group	Year										
	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
18-29	425	310	290	315	250	260	260	235	155	130	102
30-49	1270	1090	925	970	895	900	845	815	705	645	488
50+	250	220	200	230	250	335	395	405	385	425	325
TOTAL	1945	1620	1415	1515	1395	1495	1500	1455	1245	1200	915
18-29	22%	19%	20%	21%	18%	17%	17%	16%	12%	11%	11%
30-49	65%	67%	65%	64%	64%	60%	56%	56%	57%	54%	53%
50+	13%	14%	14%	15%	18%	22%	26%	28%	31%	35%	36%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

(Source: ViewIt and Adults - drugs commissioning support pack 2021-22: key data. Planning for drug prevention, treatment and recovery in adults)

There has been a decline in the number and proportion of people in treatment aged between 18 and 29 years from 2009/10 (22%, n=425) to 2019/2020 (11%, n=102). People in treatment aged 30-49 years also declined from around two-thirds of the treatment population in 2009/10 (65%, n=1270) to just over half (53%, n=488) in 2019/20. The level of people aged 30-49 has been consistently at this level since 2015-16. In comparison, people aged 50+ has increased from 13% (n=250) in 2009/2010 to over one-third (36%, n=425) in 2019/20.

Gender

Table 22 sets out the gender profile of the treatment population.

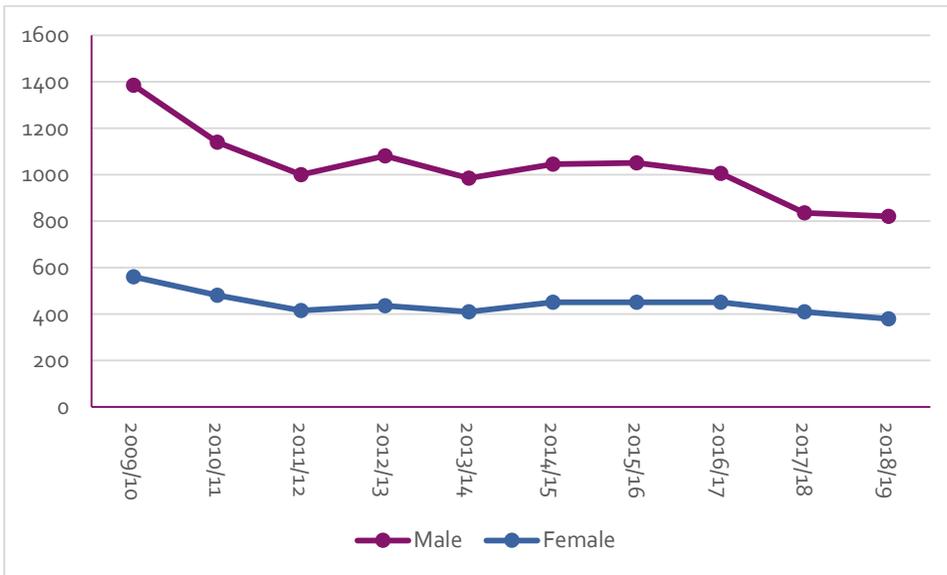
Table 22 Changes in gender, 2009-10 to 2019-20 (numbers and percentage)

Sex	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Male	1385	1140	1000	1080	985	1045	1050	1005	835	820	659*
Female	560	480	415	435	410	450	450	450	410	380	256*
TOTAL	1945	1620	1415	1515	1395	1495	1500	1455	1245	1200	915
Male	71%	70%	71%	71%	71%	70%	70%	69%	67%	68%	72%
Female	29%	30%	29%	29%	29%	30%	30%	31%	33%	32%	28%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

(Source: ViewIt and Adults - drugs commissioning support pack 2021-22: key data. Planning for drug prevention, treatment and recovery in adults; *numbers derived from percentages used in the JSNA support pack)

Proportionally, there is a consistent male-to-female ratio in treatment demand from 2009/2010 to 2019/2020 at around 70% (range 67-72% male). This is set out in chart form at Figure 5. Data from PHE indicates that, in the period 2017 to 2018, 73% of those in drug treatment in England were male. This indicates that the treatment population in Lewisham is wholly in line with the national picture regarding drug treatment.

Figure 5 Changes in gender (numbers), 2009-10 to 2019-20



Ethnicity

Table 23 sets out data in relation to the ethnicity of clients. The data is also set out in chart form at Figure 6.

Table 23 Changes in ethnicity – all in treatment, 2009-10 to 2018-19 (numbers and percentage)

Ethnicity	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
White	1270	1060	945	995	920	975	990	965	835	815
Mixed/Multiple ethnic group	125	100	80	90	60	50	50	50	35	30
Asian/Asian British	25	20	10	15	20	20	20	20	15	15
Black/African/Caribbean/Black British	185	145	140	180	150	220	175	190	160	135
'Other' ethnic group	25	15	10	10	15	25	25	30	5	15
TOTAL	1630	1340	1185	1290	1165	1290	1260	1255	1050	1010
White	78%	79%	80%	77%	79%	76%	79%	77%	80%	81%
Mixed/Multiple ethnic group	8%	7%	7%	7%	5%	4%	4%	4%	3%	3%
Asian/Asian British	2%	1%	1%	1%	2%	2%	2%	2%	1%	1%
Black/African/Caribbean/Black British	11%	11%	12%	14%	13%	17%	14%	15%	15%	13%
'Other' ethnic group	2%	1%	1%	1%	1%	2%	2%	2%	0%	1%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

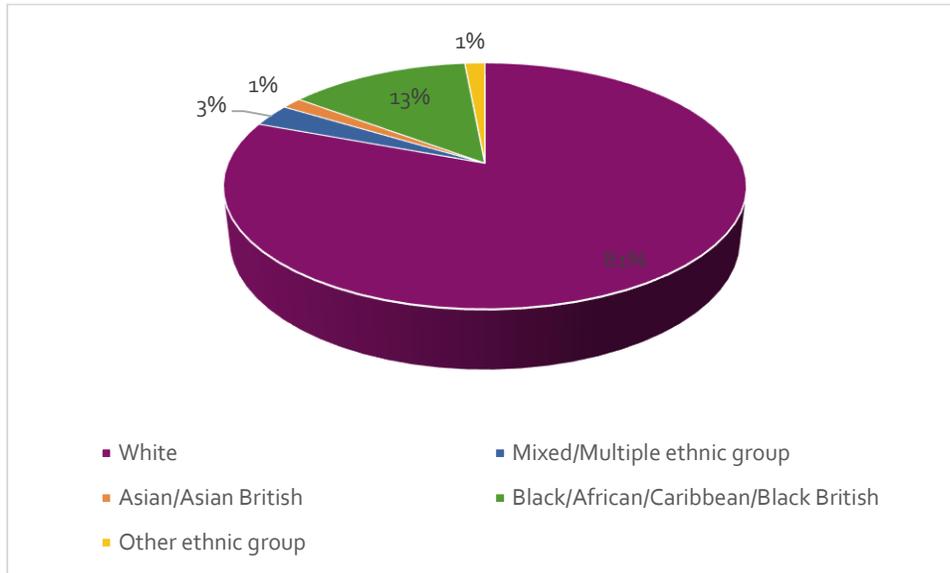
(Source: ViewIT. Note that the data derived from the JSNA adult packs use 'new to treatment' rather than the total or 'all' numbers in this table).

Trends in the proportion of people attending treatment by ethnicity have been broadly stable across most ethnic groups (although the 'mixed or multiple' ethnic groups have declined proportionally from 2009-10 to 2018-19).

Note that the way the data is presented does not enable further breakdown of each of the ethnic categories.

Data for ethnicity is set out in chart form at Figure 6.

Figure 6 Ethnic breakdown for Lewisham residents, 2018-19



The ethnicity of the treatment population is compared to the ethnic profile of the wider community in Lewisham at Table 24.

Table 24 Ethnic composition of the treated population compared to Lewisham

	Lewisham Average 2009/10 – 2018-19 NDTMS*	Lewisham Ethnic Composition†
White	78.3%	51.7
Mixed/Multiple ethnic group/Other	6.8%	14.3
Asian/Asian British	1.4%	7.9
Black/African/Caribbean/Black British	13.5%	26.0

*averaging the ethnic composition of the treated population between 2009-10 and 2018-19. † Data from Lewisham Observatory <https://www.observatory.lewisham.gov.uk/population/>

Comparison of the ethnic composition of the treated population, as measured by NDTMS, and the general population in Lewisham show that ‘White’ groups are over-represented in treatment.

By way of contrast, all other ethnic groups were under-represented.

The data indicates that Asian/Asian British comprise 7.9% of the Lewisham population but only 1.4% of the treated population thereby indicating a significant under-representation of this population. Further work is also recommended examining possible ethnic disparities not just at the point of entering treatment but at the point of discharge (e.g. difference in outcome status between ethnicities).

Housing and Employment Status

The housing and employment status of clients was explored.

This section includes trend data derived from ViewIT (which excludes 2019-20 data as at the time of writing).

Table 25 Housing Situation of the treated population, 2009-10 to 2018-19 (numbers and percentage)

Housing Situation	Year									
	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
No problem	595	400	475	375	370	505	555	440	355	385
Housing problem	150	75	95	90	60	115	85	75	60	70
Urgent housing problem	80	60	80	100	60	100	55	55	40	25
Other	10	35	25	35	25	40	95	50	0	10
TOTAL	835	570	675	600	515	760	790	620	455	490
No problem	71%	70%	70%	63%	72%	66%	70%	71%	78%	79%
Housing problem	18%	13%	14%	15%	12%	15%	11%	12%	13%	14%
Urgent housing problem	10%	11%	12%	17%	12%	13%	7%	9%	9%	5%
Other	1%	6%	4%	6%	5%	5%	12%	8%	0%	2%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

The majority of people presenting for treatment within Lewisham were reported to have no identified housing issue (reaching over three-quarters (78-79%) of the treated population from 2017-2018). The proportion with a housing problem has stayed broadly stable reaching 14% in 2018-19. The proportion with an urgent housing issue has fallen from a peak of 17% in 2012-13 to 5% in 2018-19.

Table 26 Adults who entered drug treatment (new cases) in 2019-20, employment and housing need

Employment and Housing needs	Lewisham Number (2019-20)	Proportion of new presentations (Lewisham)	Proportion of new presentations (National)
Employment status at the start of treatment			
Unemployed/economically inactive	150	38%	47%
Long term sick or disabled	89	23%	22%
Housing Needs			
Urgent problem (NFA)	29	7%	10%
Housing Problem	64	16%	13%
No longer reporting a housing need at planned exit			
Adults successfully completing treatment no longer reporting a housing need	20	83%	86%

(Source: Adults - drugs commissioning support pack 2021-22: key data. Planning for drug prevention, treatment and recovery in adults)

There were lower levels of unemployed/economically inactive rates in Lewisham (38%) reported in 2019-20 compared to nationally (47%). In contrast, there was a higher level of housing need in the borough (16% compared to 13% nationally).

The employment status of clients is explored at Table 27.

This section includes trend data derived from ViewIT which excludes 2019-20 data as at the time of writing. Additional but separate analyses on employment status are included based on 2020 data.

Table 27 Employment Status of the treated population, 2009-10 to 2018-19 (numbers and percentage)

Employment Status	Year									
	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
In regular employment	70	105	85	40	65	115	125	155	90	110
Unemployed/Economically inactive	355	325	325	355	315	365	445	280	195	170
Long term sick/disabled	0	60	220	145	110	215	150	165	130	135
In education	10	15	10	10	10	15	15	10	0	0
Unpaid/voluntary	0	0	0	0	0	0	0	0	0	0
Other	155	70	0	0	0	0	15	10	10	0
TOTAL	590	575	640	550	500	710	750	620	425	415
In regular employment	12%	18%	13%	7%	13%	16%	17%	25%	21%	27%
Unemployed/Economically inactive	60%	57%	51%	65%	63%	51%	59%	45%	46%	41%
Long term sick/disabled	0%	10%	34%	26%	22%	30%	20%	27%	31%	33%
In education	2%	3%	2%	2%	2%	2%	2%	2%	0%	0%
Unpaid/voluntary	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Other	26%	12%	0%	0%	0%	0%	2%	2%	2%	0%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Although there has been some fluctuation, there has been an increase in the number of proportion of the treated population that were recorded as in 'regular employment' (from 12%, n=70 in 2009-10; to 27%, n=110). No further data was available to explain this significant increase.

Those 'unemployed/economically inactive' fell from 60% (n=355) in 2009-10 to 41% (n=170).

Those defined as 'long-term sick/disabled' leapt to around one-third (33% in 2018-19) of the treated population from 0% in 2009-10. While no further data is available to help explain this pronounced shift it is possibly associated with changes to the benefit system and the introduction of Universal Credit.

Parental Status

The parental status of clients in specialist treatment is set out at Table 28.

Table 28 Parental Status, Lewisham compared to National Figures, 2019-2020

Parental status	Lewisham 2019-20 (number)	Proportion of new presentations (Lewisham)	Proportion of new presentations (National)
Living with children (own or other)	44	11%	18%
Parents not living with children	90	23%	34%
Not a parent/no child contact	259	66%	47%
Missing/incomplete	0	0%	<1%

(Source: Adults - drugs commissioning support pack 2021-22: key data. Planning for drug prevention, treatment and recovery in adults).

The data indicates fewer treatment users reported having children living with them in Lewisham compared to national trends (11% compared to 18% nationally).

The data also indicates fewer parents not living with children compared to the national rate (23% compared to 34% nationally).

Lewisham residents were more likely to state that they were not a parent or had no contact with a child (63% compared to 48% nationally).

There are no clear explanations as to the variation of parenting status compared to national trends. Whilst rates are lower the data clearly indicates however that there are numbers of adults in drug and alcohol treatment with dependant children. This issue is explored more fully in the parallel young people's substance misuse JSNA report.

Blood-borne virus and overdose death prevention

Data at Table 29 looks at blood-borne virus and overdose rates for Lewisham.

Table 29 Blood-borne virus and overdose death prevention

	Lewisham 2019-20 (number)	Proportion of new presentations (Lewisham)	Proportion of new presentations (National)
Hepatitis B			
Adults new to treatment in 2019-20 eligible for an HBV vaccination who accepted one	217	39%	40%
Of Those			
the proportion who started a course of vaccination	46	21%	16%
the proportion who completed a course of vaccination	90	41%	31%
Hepatitis C			
	Lewisham 2019-20 (number)	Proportion of new presentations (Lewisham)	Proportion of new presentations (National)
Previous or current injectors new to treatment in 2019-20 eligible for a HCV test who received one	607	80%	69%
Previous or current injectors in treatment in 2019-20 eligible for a HCV test who received one	289	91%	87%
Clients who have a positive hep C antibody test	118	28%	28%
Clients who have a positive hep C PCR (RNA) test	49	12%	15%
Clients referred to hep C treatment	85	14%	7%
Previous or current injectors in treatment in 2019-20 referred to Hep C treatment	74	26%	9%
Take home naloxone and overdose training			
	Rate per Opiate User (Lewisham)	Rate per Opiate User (National)	
Clients in treatment in 2019-20 issued with naloxone and overdose training	249	39%	27%

(Source: Adults - drugs commissioning support pack 2021-22: key data. Planning for drug prevention, treatment and recovery in adults)

The data indicates a number of successes for specialist treatment services in Lewisham.

Proportionally Lewisham residents were more likely to receive and complete a Hepatitis B course of treatment compared to national figures (41% Lewisham versus 31% national).

There were higher figures across Lewisham for Hepatitis C in terms of eligibility for HCV testing (80% in Lewisham compared to 69% nationally). There was an identical incidence rate of a positive HCV test (antibody and PCR) in Lewisham compared to national figures, although interestingly, the resulting higher level of referrals for HCV treatment in Lewisham (14%) was double compared to nationally (7%).

The rate of naloxone and overdose training was noticeably higher (39% of all opiate users) than national figures (27%). This suggests success in ensuring take-home naloxone training has been undertaken. Furthermore this means that, relative to drug users elsewhere in the country, users in Lewisham are more likely to be equipped with knowledge about how to avoid and respond to a drug overdose. This means that the drug using population of the borough is somewhat more “protected” than their peers elsewhere in England. This in turn is likely to have a bearing on local drug-related deaths.

Table 30 explores data in relation to drug-related deaths.

Table 30 Drug-related deaths and Drug Poisoning Admissions, 2017-2019 Lewisham compared to National estimates

Drug misuse deaths and drug-specific hospital admissions	Lewisham 2017-2019	National Estimate (Compared to nearest deprivation decile)
Drug misuse deaths 2017-2019, All persons, Directly age-standardised rate per 100,000	5.6	4.7
Hospital admissions for drug poisoning (primary or secondary diagnosis) All persons, crude rate per 100,000	27.8	53.8

(Source: Adults - drugs commissioning support pack 2021-22: key data. Planning for drug prevention, treatment and recovery in adults)

The data indicates that the rate of drug misuse deaths is higher in Lewisham compared to national trends (at 5.6 and 4.7 per 100,000 respectively). Caution is advised in the interpretation of these figures as the relatively small numbers of drug misuse deaths in the borough is likely to fluctuate over time and that the changes are in relation to very low numbers. (Note that the data for deaths includes drug use only and does not include alcohol deaths).

Mental Health Need

Table 31 sets out the mental health needs of clients.

Table 31 Adults who entered treatment in 2019-20 and were identified as having a mental health treatment need

Mental Health Need	Lewisham Number (2019-20)	Proportion of new presentations (Lewisham)	Proportion of new presentations (National)
Opiate	118	59%	54%
Non-Opiate	44	62%	60%
Non-Opiate and Alcohol	76	61%	65%
All	238	60%	58%

(Source: Adults - drugs commissioning support pack 2021-22: key data. Planning for drug prevention, treatment and recovery in adults)

There were slightly higher levels of mental health need comparing Lewisham residents with national estimates for:

- opiate (59% v 54%),
- non-opiate and alcohol users (62% v 60%), and
- overall (60% v 58%).

Non-opiate users were shown to report a mental health need at a slightly lower level of those nationally (61% in Lewisham compared to 65% nationally).

Use of Selected Prescription Drugs

This section looks at levels of prescribing for select drugs that have been shown to be associated with problematic use (e.g. high levels of potential addiction). These prescribed drugs include:

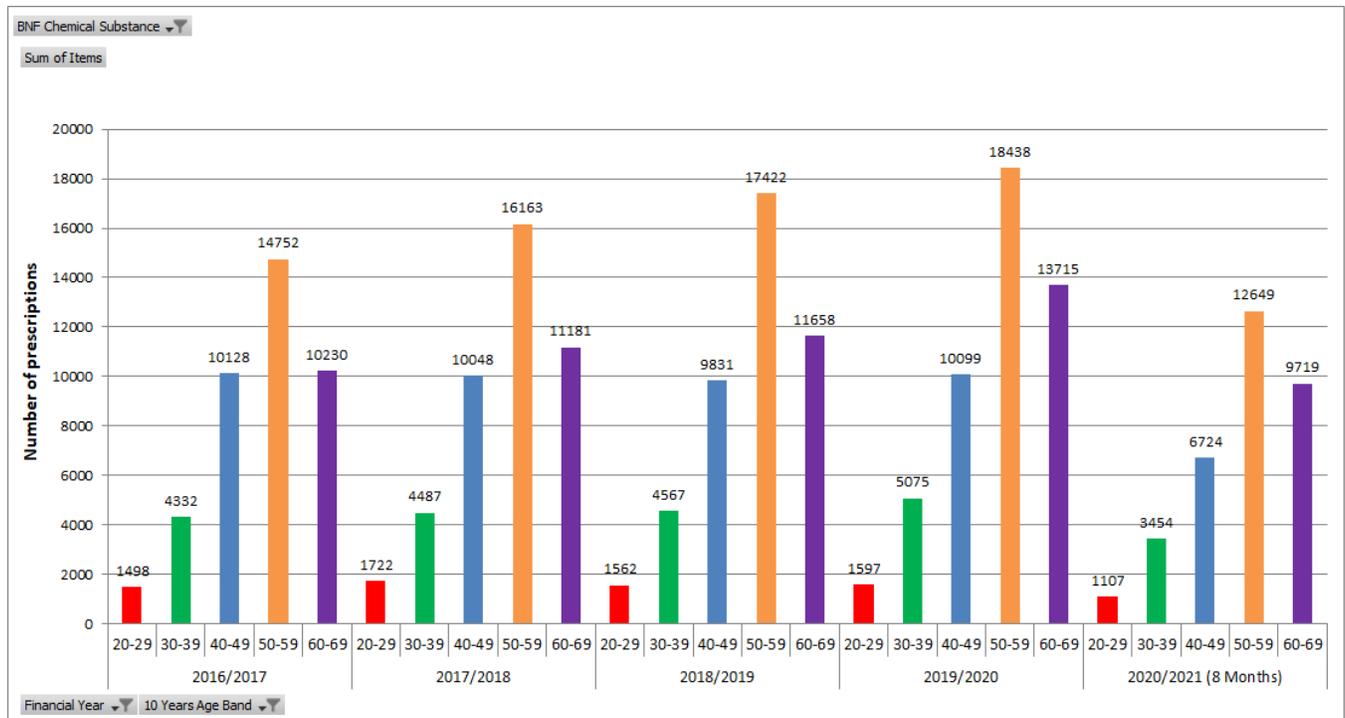
- tramadol,
- gabapentin and
- pregabalin

All of which are opiate-based analgesics used primarily for the treatment of pain.

Figure 7 shows overall prescription rates for the drugs listed above in which each bar represents total volume of prescription of the selected prescription drugs by age, where:

- Red: those aged 20 – 29 years
- Green: those aged 30 – 39
- Blue: those aged 40 – 49 years
- Amber: those aged 50 – 59 years
- Purple: those aged 60 – 69 years

Figure 7 The number of prescriptions issued for Gabapentin, Pregabalin and Tramadol between FY2016/17 and FY2020/21 (up to M8) for ages 20 years old to 69 years old



(Source: Figures kindly provided by Marina Maxwell from NHS South East London Clinical Commissioning Group, personal communication).

The figure shows an increase in the number of prescriptions for these three prescribed drugs from a total of 40,940 in 2016/2017 to 48,924 in 2019/2020 (the last year of full data).

As shown there is a clear increase in prescription rates by age cohort, peaking among those aged 50 – 59 years. It is likely therefore that this represents clinical need for an ageing population. It is unclear whether there are any substance misuse treatment implications of this analysis.

Note that prescription levels per annum are relatively stable with modest levels of increase indicating stable demand for prescription opioids.

4.3.2 Alcohol users

Age and Gender

Table 33 sets out the profile of clients in alcohol treatment.

Table 32 Socio-Demographic Characteristics of Alcohol Treatment Population, 2019-2020

Age Range and Gender	Lewisham Number 2019-2020	Lewisham Percentage	National Percentage
Age			
18-29 years	26	11%	9%
30-39 years	51	21%	23%
40-49 years	65	27%	29%
50-59 years	70	29%	27%
60-69 years	27	11%	10%
>70 years	4	1%	2%
Gender*			
Male	139	57%	60%
Female	104	43%	40%

(Source: Adults - alcohol commissioning support pack 2021-22: key data. Planning for alcohol harm prevention, treatment and recovery in adults; * numbers estimated from percentages)

There is broad similarity in the alcohol treatment population for Lewisham compared to national figures, with Lewisham residents in treatment slightly more likely to be aged in their between 18-29 and 30-40 years compared to nationally.

For the gender profile, Lewisham clients reported as having a 57-43 male/female split compared to 60-40 nationally.

Ethnicity

The ethnic profile of those in alcohol treatment is set out at Table 34.

Table 33 New alcohol presentations by ethnic group, 2019-20

Alcohol Presentations	Lewisham 2019/2020 NDTMS	Lewisham Ethnic Composition
White	75.5%	51.7
Mixed/Multiple ethnic group*	NA	14.3
Asian/Asian British	5.7%	7.9
Black/African/Caribbean/Black British	10.7%	26.0
Missing or not recorded	7%	NA

(Source: Adults - alcohol commissioning support pack 2021-22: key data. Planning for alcohol harm prevention, treatment and recovery in adults; * Mixed group not reported on with the JSNA pack p7)

Members of White groups are over-represented in treatment for alcohol related issues.

As per the data for drug treatment, all other ethnic groups are under-represented in treatment compared to Lewisham's ethnic population. Some caution however is advised in interpreting these figures as Lewisham's totals include 7% missing or not recorded.

As with the ethnic profile of those in drug treatment, it was not possible to break down the data into smaller ethnic cohorts.

Employment and housing

Table 35 sets out data with regard to the employment and housing needs of alcohol clients.

Table 34 Adults who entered alcohol treatment (new cases) in 2019-20, employment and housing need

Employment and Housing needs	Lewisham Number (2019-20)	Proportion of new presentations (Lewisham)	Proportion of new presentations (National)
Employment status at the start of treatment			
Unemployed/economically inactive	63	34%	38%
Long term sick or disabled	35	19%	19%
Housing Needs			
Urgent problem (NFA)	3	2%	2%
Housing Problem	16	9%	7%
No longer reporting a housing need at planned exit			

Adults successfully completing treatment no longer reporting a housing need	2	100%	84%
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(Source: Adults - alcohol commissioning support pack 2021-22: key data. Planning for drug prevention, treatment and recovery in adults)

The data above shows self-reported employment status at the start of treatment in 2019-20 along with review and exit status from TOP.

There was broad concordance in the levels of reported employment and housing need. There were lower levels of unemployed/economically inactive rates in Lewisham (34%) reported in 2019-20 compared to nationally (38%). In contrast, there was a slightly higher level of housing problems reported in the borough (9% compared to 7% nationally).

Mental health

Table 36 sets out data in relation to the mental health of clients.

Table 35 Adults who entered alcohol treatment (new cases) in 2019-20 and were identified as having a mental health treatment need

Mental Health Need	Lewisham Number (2019-20)	Proportion of new presentations (Lewisham)	Proportion of new presentations (National)
Client identified a mental health treatment need	118	63%	60%
Clients with a mental health need and receiving treatment			
Already engaged with the Community Mental Health Team/Other mental health services	13	11%	16%
Engaged with IAPT	9	8%	2%
Receiving mental health treatment from GP	72	61%	61%
Receiving any NICE-recommended psychosocial or pharmacological intervention provided for the treatment of a mental health problem	0	0%	2%
Has an identified space in a health-based place of safety for mental health crises	0	0%	<1%

(Source: Adults - alcohol commissioning support pack 2021-22: key data. Planning for alcohol harm prevention, treatment and recovery in adults)

There was broad comparability in the level of new presentations for alcohol treatment with a stated mental health need in Lewisham (63%) compared to national figures (60%).

Clients in Lewisham with an identifiable mental health need were less likely to be reported to have engaged their local Community Mental Health (11%) compared to nationally (16%) but more likely to have engaged IAPT services (8% to 2% nationally).

Parental status

The parenting status of clients is set out at Table 37.

Table 36 Clients who are parents/carers and their children, 2019-2020

Parental Status	Lewisham Number (2019-20)	Proportion of new presentations (Lewisham)	Proportion of new presentations (National)
Living with children (own or other)	38	20%	25%
Parent not living with children	31	17%	25%
Not a parent/no child contact	117	63%	49%
Missing / incomplete	0	0%	<1%

(Source: Adults - alcohol commissioning support pack 2021-22: key data. Planning for drug prevention, treatment and recovery in adults)

Lewisham clients accessing alcohol treatment were shown to be more likely to state that they are not a parent or have no child contact (63% to 49% nationally). In total some 186 adults in treatment who are also a parent/carer.

The data contrasts with the parenting status of drug users in treatment where a smaller proportion reported being a parent compared to national trends.

Co-use of drugs

Table 38 shows data in relation to alcohol clients who use other drugs.

Table 37 Alcohol dependent cohort who also use drugs, 2019-2020

All alcohol clients in your treatment system	Lewisham Number (2019-20)	Proportion of new presentations (Lewisham)	Proportion of new presentations (National)
Alcohol only clients	243	41%	58%
Alcohol and drug users in treatment			
Alcohol and opiate clients	29	5%	5%
Alcohol and non-opiate clients	174	29%	23%
Alcohol, opiates and non-opiate clients	152	25%	14%
- cited crack	144	24%	12%
- cited cocaine	65	11%	14%
- cited cannabis	155	26%	14%

41% of alcohol clients in Lewisham report only using alcohol. This is proportionally less than national figures (58%).

There were more reports for alcohol misused alongside non-opiates (29% in Lewisham compared to 23% nationally) and for alcohol to be combined with opiates and non-opiates (25% in Lewisham compared to 14%).

Higher levels of crack-cocaine and cannabis were noted by Lewisham residents in treatment than their national counterparts suggesting a possible intervention need.

4.4 Substance misuse and criminal justice pathways

This section examines the profile of Lewisham residents who have been tested for drugs in police custody as part of the Drug Intervention Programme between 2018 and 2020 (up to September 2020). Data is set out at Table 39. All analysis is from Drug Testing Recorder data.

Table 38 Drug Test at Police Custody for Lewisham residents, 2018-2020 (YTD)

Variable	2018		2019		2020 (YTD)	
	Number	Percent	Number	Percent	Number	Percent
Test Result						
Both (cocaine and opiate use)	165	23.4	152	22.0	88	23.8
Cocaine	205	29.1	203	29.4	84	22.8
Opiates	15	2.1	15	2.2	12	3.3
Negative	320	45.4	321	46.5	185	50.1
Total	705	100.0	691	100.0	369	100.0
Refused/Aborted/Not Recorded	112	13.7	101	12.8	67	15.4
Total Tests Attempted	817		792		436	

The number and proportion of positive-to-negative drug tests were shown to be stable between 2018-2019. It is not clear from the data that was available why there was a pronounced decline in total drug tests but appears to be part of a London-wide trends in a reduction in the total attempted tests. It is possible that this in part relates to changes to Metropolitan Police operating procedures as outlined in the section on referrals (see page 21).

Using YTD figures for 2020 (up to September 2020), there is a slight decrease in cocaine use (from 29% in 2019-20 to 22.8% in 2020 YTD). This was offset by an increase in negative tests (at around 45-46% between 2019-2020) to 50.1% in 2020 (YTD). (Caution is advised in the interpretation of these YTD figures, as there may be underlying factors that explain these changes (e.g. seasonality etc.)).

Data regarding the profile of those presenting in custody are set out at Table 40.

Table 39 Age-Range at Police Custody for Lewisham residents, 2018-2020 (YTD)

Variable	2018		2019		2020 (YTD)	
	Number	Percent	Number	Percent	Number	Percent
Age Group						
18-24	201	24.6	192	24.2	99	22.7
25-29	141	17.3	134	16.9	66	15.1
30-34	125	15.3	114	14.4	61	14.0
35-39	119	14.6	118	14.9	86	19.7
40-44	85	10.4	94	11.9	33	7.6
45-49	64	7.8	61	7.7	34	7.8
50-54	43	5.3	49	6.2	27	6.2
55-59	30	3.7	19	2.4	15	3.4
60+	8	1.0	11	1.4	14	3.2
Valid Total	816	99.9	792	100.0	435	99.8
Missing	1	0.1	0	0.0	1	0.2
Total Attempted Tests	817	100.0	792	100.0	436	100.0
Gender						
Female	124	15.2	93	11.7	79	18.1
Male	693	84.8	699	88.3	357	81.9
Total Attempted Tests	817	100.0	792	100.0	436	100.0
Ethnicity						
White	405	49.6	389	49.1	211	48.4
Black	356	43.6	339	42.8	203	46.6
Asian	25	3.1	32	4.0	13	3.0
Chinese, Japanese or SE Asian	10	1.2	7	.9	1	0.2
Middle Eastern	11	1.3	16	2.0	5	1.1
Unknown	10	1.2	9	1.1	3	0.7
Total Attempted Tests	817	100.0	792	100.0	436	100.0

For all Lewisham residents, there has been a broadly consistent picture in relation to age. Proportionally, there was a spike in tests for people aged 35-39 (19.7% in 2020 YTD from 14-15% in 2018

and 2019), with a commensurate drop in tests given to people aged 40-44 (7.6% in 2020 YTD from 10-12% in 2018 and 2019).

In terms of gender, there has been an increase in the proportion of females being tested in 2020 YTD (18.1%) from 11.7% in 2019.

In relation to ethnicity, there has been a consistent picture in the number and proportion of drug tests taken between 2018 and 2019 with a slight increase in the proportion of Black people reported to have been tested in 2020 (YTD) rising to 46.7% from 42.8% in 2019 (although this may reflect other factors associated with a snapshot of tests undertaken over 9 months rather than the full year).

The data suggests that Black ethnic groups are more likely to be in police custody and test positive for opiates and/or cocaine (between 43-47%) compared to their population in Lewisham (25%). This compares to: White (48-50% testing positive compared to 56% population in Lewisham) and Asian minority ethnic groups (3-4% testing positive compared to 9% population in Lewisham).

Table 41 sets out the offence type for those who presented in custody having tested positive for opiates and/or cocaine.

Table 40 Offence Type for Lewisham residents, 2018-2020 (YTD)

Variable	2018		2019		2020 (YTD)	
	Number	Percent	Number	Percent	Number	Percent
Offence Type						
Burglary	94	11.5	86	10.9	54	12.4
Drugs	208	25.5	254	32.1	133	30.5
Robbery	37	4.5	32	4.0	33	7.6
Theft	206	25.2	174	22.0	102	23.4
Non-Trigger Offence	187	22.9	162	20.5	62	14.2
Handling	36	4.4	33	4.2	23	5.3
Going Equipped	33	4.0	30	3.8	21	4.8
Other	16	2.0	21	2.7	8	1.8
Valid Total	817	100.0	792	100.0	436	100.0
Missing	0	0.0	0	0.0	0	0.0
Total Attempted Tests	817		792		436	

For offence type, there was a stable picture between 2018-2019 although a notable spike in drug offences was noted in 2019 (an increase in 46 tests, reaching 32.1%).

Although caution is advised in using the 2020 YTD figures, there has been a proportion increase in tests for people arrested for robbery as an offence who test positive for drug use (7.6% in 2020 YTD from around 4-5% in 2018 and 2019). Also data for 2020 is heavily skewed by the pandemic lockdown measures introduced that affected criminal activity in London.

Positive drug tests in Lewisham compared to other London boroughs

Analysis was undertaken looking at all positive tests across London (including Lewisham) between 2015 and 2017 (the data available for secondary analysis) looking at three test results:

- opiates and cocaine,
- cocaine-only, and
- opiates-only.

Details of the analytical method are set out at Appendix 2.

The following three charts rank the predictions by borough relative to the overall aggregated chance of testing positive for each binary outcome, averaged over by gender and years. The overall aggregated chance is located at 0.5. Therefore, the further above 0.5 a borough is, the higher than average its chance is of testing positive for that binary outcome.

Opiates and/or cocaine

Figure 8 London-wide random effects for: positive test for use of cocaine and opiate

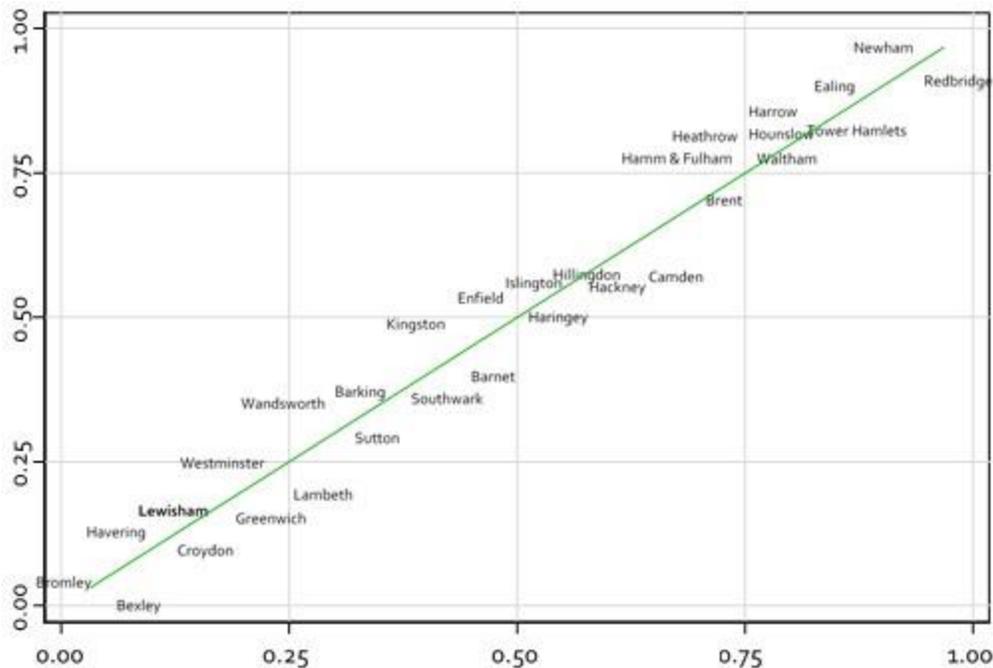


Figure 8 shows that Lewisham lies within a cluster of boroughs with a below average level of positive tests for opiates and cocaine. These show that Lewisham tends to cluster with other South London boroughs (Bexley, Bromley, Croydon, Greenwich, Lambeth) with regard to detainees in police custody that were less likely to test positive for both opiates and/or cocaine.

Opiates only

Figure 9 London-wide random effects for: positive test for use of opiates only

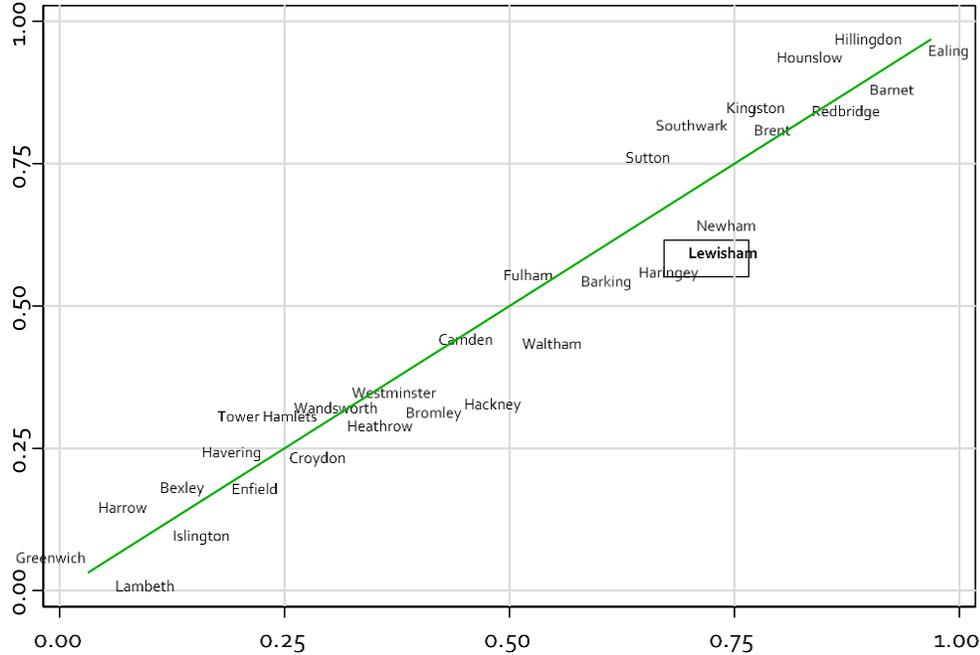


Figure 9 shows that Lewisham lies within a cluster of boroughs with a higher than average level of positive tests for opiates only. These show a cluster around North and East London (Haringey, Newham and Barking and Dagenham) and to a lesser extent Hammersmith and Fulham.

Cocaine

Figure 10 London-wide random effects for: positive test for use of cocaine

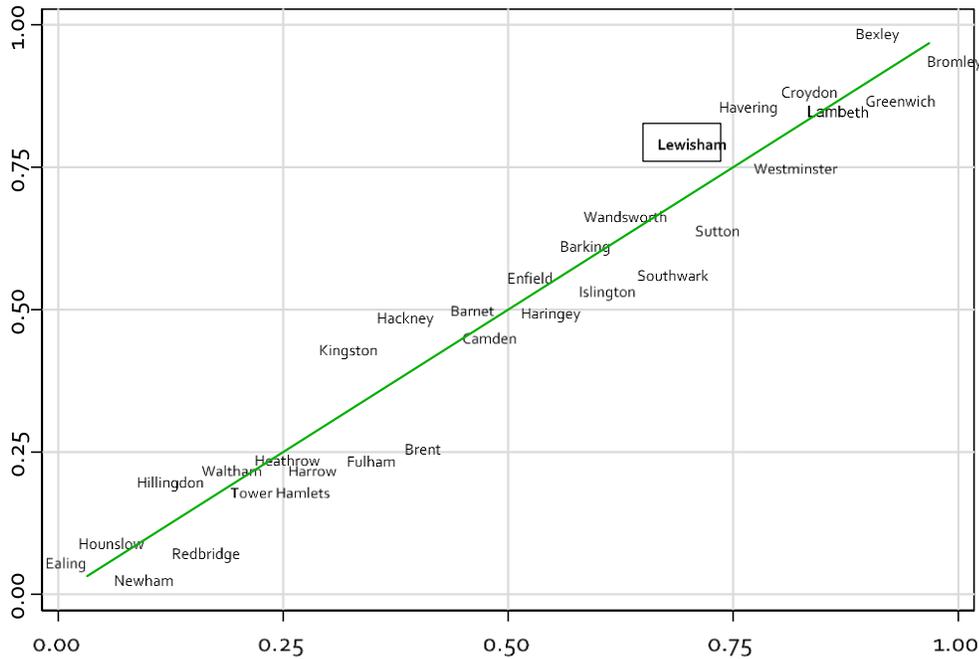


Figure 10 shows a cluster of boroughs in South East London emerge as those boroughs who were considerably more likely to test positive for cocaine-only (Bexley, Bromley, Croydon, Greenwich, Lewisham and Lambeth).

The analysis set out in Figures 8, 9 and 10 suggests that Lewisham has a higher than expected rate of positive tests for cocaine use only compared to other London boroughs. This tentatively suggests that cocaine may be a driver for levels of drug-related crime and that interventions are required at the point of arrest to address this need. Conversely it would appear that co-use of cocaine with opiates is not a driver, and that opiate only use has some effect on driving offending.

4.5 Summary of findings

There are a number of key findings from the quantitative data analysis set out above.

The data indicates clearly that the population in specialist drug and alcohol treatment in Lewisham is experiencing a steady decline from some 1,945 in 2009/10 to 1,200 in 2018/19.

For opiate users, the decline is attributable to a national trend whereby young people are not using heroin to any great scale and that the opiate population is largely male and aged 35 plus, with few new entrants. For non-opiate users the downward trend is part of wider changes that are taking place across London and elsewhere. Data however is not available to describe what is driving the changing nature of non-opiate use across London and so any suggestions would be largely speculative.

Data indicates that the alcohol treatment population, while fluctuating, has held steadier than the drug treatment population.

Note that the downward trajectory for numbers in treatment also coincides with cuts to specialist treatment budgets which is likely to have had an impact.

The treatment population appears to be ageing with those aged 50+ increasing from 13% (n=250) in 2009/2010 to over one-third (36%, n=425) in 2019/20. The age profile is likely to be linked to the ongoing presence of a group of users who have been engaged in treatment for 6 years and more and are therefore an ageing group of service users.

Data for the drug treatment population shows that members of 'White' groups are over-represented (78.3% of those in treatment compared to 51.7% of those in the population) while members of all minority ethnic groups are under-represented. Members of Asian communities appear to be particularly under-represented (1.4% of those in treatment compared to 7.9% of the population). Data for alcohol treatment indicates similar disparities with an over-representation of 'White' groups (75.5% of treatment population) and an under-representation of all minority communities. Members of Black communities are particularly under-represented (10.7% of treatment population versus 26% of the total population).

The majority of people in drug treatment experience a 'successful completion' of their treatment, reaching a peak of 63% in 2018-2019 at six months following treatment exist, rates of both abstinence and significant reduction were higher (i.e. better) in Lewisham across opiate, crack, cocaine and

cannabis use compared to national rates meaning success in relation to both abstinence and harm reduction work.

Lewisham clients in alcohol treatment were shown to be more likely to report abstinence (61%) compared to nationally (51%) on exiting treatment. At six months existing from treatment over a fifth (21%) of alcohol clients in Lewisham reported significant reductions in use compared to 17% nationally.

The data therefore indicates that the current system appears to be operating well and achieving positive outcomes for the majority of clients.

5. Qualitative data findings

5.1 Professional views

This sections sets out the views regarding substance misuse needs from professionals who are engaged in the treatment of services in Lewisham. The data is set out in relation to key themes identified below.

Heroin users

Interviewees who had the most knowledge of the adult treatment population in Lewisham pointed to adult opiate users as a key group. Although people referred to opiates they often meant specifically heroin.

This group of people was seen as key for a number of reasons.

- They were believed to make up the bulk of clients in the treatment system.
- They were believed to include the majority of the most difficult to manage clients who would frequently drop out of treatment for periods of time.
- They were seen as a group with the most individuals within it who were at risk of drug related death.
- They were seen as the group who had generally been in treatment the longest and who were likely to remain in treatment the longest.
- Overall they were resource heavy, both week to week and year after year, taking up the most clinical and drug worker time.
- Interviewees referred to the fact that almost everyone in this client group is aged over 35, with many in their late 40s and 50s. Most were seen as having poor physical and mental health.

The most resource heavy part of the work with this group was the reassessment of returning clients who had dropped out of treatment.

In particular stakeholders noted the time taken to reassess returning clients for opiate substitution prescriptions (commonly termed “script”) and how time consuming this could be. NICE guidelines state “Patients who miss three days or more of their regular prescribed dose of opioid maintenance therapy are at risk of overdose because of loss of tolerance” and therefore that practitioners should “Consider reducing the dose in these patients.”

Furthermore “if a patient misses five or more days of treatment, an assessment of illicit drug use is also recommended before restarting substitution therapy: this is particularly important for patients taking buprenorphine because of the risk of precipitated withdrawal.”³

Interviewees also referenced a relatively large number of people on a low dose “script” who did not feel confident enough to leave treatment. These stable low dose clients were on caseloads but potentially did not need the sort of specialist services provided by substance misuse providers. The reasons that they felt unable to move further with their recovery journey may be complex. Services were exploring how to work with these clients in a way that acknowledged individual needs.

Prevalence figures suggesting that there are large numbers of heroin users in Lewisham who are outside treatment were widely questioned by local practitioners. (These figures are set out in this report at Table 4). As such there is some gap between what national reported data sets from Public Health England report, and what practitioners on the ground report.

While it is difficult to reconcile the two apparently opposing pictures and arrive at a “correct” answer (whether there are actually large numbers of opiate users outside of treatment or not), practitioners did support their position by noting that people would expect to see heroin users appearing in custody suites or amongst the rough sleeper population or would at least be well known to other current service users. Regular use of heroin leads to increased tolerance and addiction. In the longer term this generally leads users to seek support from health professionals either privately or through publicly funded services. They pointed to the fact that none of these is the case locally and other agencies are *not* identifying heroin users outside of treatment.

It is clear therefore that local practitioners believe that national datasets do not accurately capture the picture of drug treatment need in Lewisham and, furthermore, have some evidence for their assertion. The views of local practitioners are corroborated by the needs assessment insofar as that other professionals in the borough also did not identify a group of heroin users outside of the treatment system.

Whilst providers were at pains to point out that workers maintain a therapeutic optimism for everyone in treatment there was also an acknowledgement that many people currently in treatment for heroin addiction are likely to remain attached to services for many years to come. (Note that this observation

³ <https://bnf.nice.org.uk/treatment-summary/substance-dependence.html>

is somewhat authenticated by reference to data on numbers of people in treatment for six years and more).

This was not just confined to clients who are moving on and off script but was also seen as a distinct possibility for those clients who are stable on a low dose of substitute medication. Those people may be reliant on services for different reasons but it will still be difficult to move them to a point where they are no longer being prescribed.

There were believed to be significant numbers of people on opiate substitution medicine who were “using on top” (that is using other drugs in conjunction with their prescription). There are a number of implications that flow from people in treatment using “on top”: commonly users will also be using opiates which increases the risk of overdose, it raises the question of whether the clients prescription has been properly assessed to stop them seeking additional drugs, it is likely to lead to further health complications and it is likely that users will continue to offend to feed their ongoing illicit drug habit.

Whilst the bulk of the clients were men there was a significant and difficult to manage female population of heroin users.

Practitioners were of the view that there are very few young heroin users with young people tending to use other drugs rather than heroin. As noted above, it was also widely agreed among local professionals that there are almost no new clients coming into treatment for heroin addiction and who are coming into treatment for the first time. That is, there is not a meaningful “treatment naïve” population.

Alcohol

The biggest gap between need and supply was seen as being amongst alcohol users not in treatment – particularly those who were treatment “naïve” (i.e. had never engaged in any form of treatment). Local practitioners felt that the numbers needing an intervention were ‘overwhelming’ and noted that, even if all the prevalence figures for alcohol hugely overstate the problem, the number of people in Lewisham who would require help with their alcohol use was seen as being far beyond the capacity of the current treatment system. The prevalence rates (see Table 14) substantiate these findings indicating that only around 14% of alcohol users who require treatment are engaged in treatment services. However, a significant caveat to this views is that the needs of alcohol users cover a spectrum. While there are a number of dependent drinkers, for whom structured treatment is required, there are also many drinkers using alcohol at a lower threshold who will not require a treatment plan. We note that the DrinkCoach

service is offered locally which is a set of early intervention tools aimed at those drinking at non-dependent levels and which can be accessed online

There was also a view that many alcohol users did not see treatment services as for them. They viewed themselves as entirely different from the heroin users that they associated with treatment services. This view of local practitioners was not substantiated in interviews with wider stakeholders and service users.

Other drug use and other groups

Crack

Crack use was seen as something that was possibly under-represented in treatment. There was a range of thoughts on why this may be the case. Respondents felt that possibly some of the crack users viewed their drug use as recreational and not 'problematic'. There was also a suggestion that perhaps the lack of a 'substitute' made treatment an unattractive prospect. There was a view that as with alcohol users crack users associated treatment services with heroin users.

Powder cocaine

Powder cocaine was viewed by respondents alongside crack as drug use that came to the attention of treatment services but perhaps not as often as might be expected. Respondents felt that this may be because powder cocaine users do not view their drug use as a problem and certainly not one requiring the support of a drug treatment service.

Prescription medicines

Some respondents felt that addiction to, and over reliance on, over-the-counter medication was something that was likely to be a problem but it was not showing up in treatment to any degree.

More was known about addictions to prescribed pain killers but some respondents felt that the problem was probably still going largely unchecked and more needed to be done. Others felt that there was an awareness of the issue but it was still a very difficult problem to address. The regime for managing the reduction of painkillers and other prescribed medications can be long and complex. It has often arisen because an initial prescription for pain relief has then gone on for a long time and the increased tolerance and addiction has arisen under the supervision of the GP. The cases that professionals in specialist treatment services are aware of are those that come to their attention through GP shared care arrangements.

Club drugs

Interviewees felt that ketamine, club drugs and other drugs were being used but only came to the attention of treatment services in relatively small numbers.

It was noted that people using club drugs do not necessarily develop any problems due to relatively infrequent and/or low-level use (for instance only using club drugs occasionally on some weekends). Professionals noted that such people are unlikely to see their drug use as problematic and are therefore unlikely to seek help.

Even where club drug use is having an impact it was the view of stakeholders that people will not always identify it as a problem or seek help from a specialist service.

Data was not available to indicate how widespread the use of club drugs are in Lewisham. A limited amount of data that sets out the national picture (see Section 4.1) and indicates that MDMA use is limited to around 4.5% among 16 to 19 year olds and that 2.9% of adults had reported using ketamine. Whilst very low numbers this is likely to create some demand for specialist treatment provision.

LGBTQ+ community

LGBTQ+ drug users and drug use came up hand-in-hand. The drug use was seen as predominantly linked to chemsex and clubbing. Providers felt that they needed to do more to understand the needs of LGBTQ+ service users and unmet need within the range of LGBTQ+ communities. CGL were undertaking research with the LGBTQ+ community. It was believed that some people would prefer to access services locally as they felt safer closer to home and because the location of central London services could be a trigger for use – for instance the services that operate in places such as Vauxhall (where there is a large LGBTQ+ clubbing scene) was viewed by some as problematic given the close proximity of treatment services to where drugs can be procured.

Aftercare

In terms of aftercare provision, a view was expressed that the current abstinence based service should expand to include a pathway for stable non abstinent clients. It was felt that this could be provided within the current funding envelope and could be developed relatively quickly and easily.

Hostel link work

The CGL Hostel Lead provides a link between the hostel providers and the specialist substance misuse treatment service. They hold a specific case load of clients who are residents at the hostels or involved in the housing pathway within Lewisham.

Pre-COVID, the Hostel Lead would attend the hostels (both Pagnell Street and Spring Gardens) to deliver interventions to clients. This would include harm reduction advice, recovery check-ups and re-engaging clients where appointments had been missed. The worker would also liaise directly with staff and complete joint reviews with clients. The hostel lead would also complete assessments on site where it was easier to access new residents.

During the pandemic contact has been maintained remotely including assessing new clients. There are multi-disciplinary teams meetings and CGL provides training to staff on the use of naloxone along with the kits that can be used in the event of a suspected opioid overdose.

5.2 Wider stakeholder views

Charities and organisations working with a number the priority groups of interest were invited to provide their views on the local substance misuse provision. These were stakeholders from organisations that did not provide substance misuse services, but whose clients may have a substance misuse need or may be in treatment. The purpose of the wider stakeholder consultation was to identify any areas of unmet demand, and to understand where efforts should be directed to meet the substance misuse needs of the groups they represent. As per the consultation with professional stakeholders, their views are set out thematically below.

Substance misuse in the community

Substance misuse commonly comprises a combination of alcohol and drugs. Representatives reported heroin and crack use by their service users, with occasional cocaine use amongst some. Cannabis is the drug predominantly used by service users in one homeless charity where the representative reports some spice use, "*but not bundles of it*", and an increase in skunk use.

Crystal methamphetamine, GBL and mephedrone usage was reported amongst Metro's client base, as well as some alcohol misuse.

There is very little substance misuse need amongst Mencap's service users. The main issues tend to be around social deprivation rather than any drug issues, although Mencap described the drug services as good and that they reach out to their community.

Representatives found it difficult to quantify the number of service users with substance misuse issues. Thames Reach estimated that 50%, and Equinox between 15% and 20% of their current service users have drug or alcohol issues, with Equinox saying that half of these are problematic drug users. St Mungo's estimated that they currently have four to five alcohol clients. Professionals working with rough sleepers were of the opinion that substance misuse tends to occur in those aged 25 years and over.

The pregnancy services see two or three women a year who use heroin or crack cocaine with cannabis users seen through a separate referral pathway.

The complexity of clients' needs

The community representatives described the substance misuse needs of the majority of their service users as complex. The substance misuse is often all-encompassing with ongoing recovery needs, all within the remit of a group of people who are notoriously difficult to engage.

Representatives explained that service users often have additional needs that should, in their opinion, be simultaneously addressed to achieve the best and longer-lasting outcomes. The additional needs comprise medical and mental health needs, homelessness, and domestic abuse, all of which impact on an individual's ability to seek help and fully engage with the treatment services.

Representatives described how service users, addressing the reality of addiction and illness, can be fearful about the extent of their illness and the road that lies ahead. Thus, a treatment package also tailored towards service users' anxiety and general poor health was thought to be required.

St Mungo's conduct some in-house substance misuse harm reduction activities comprising telephone counselling to understand the extent of the drugs and/or alcohol being consumed and the factors that impact on service users recovery.

Making referrals to specialist treatment services

Representatives were familiar with the specialist treatment services in Lewisham. They were informed of the addiction threshold each service specialises in and understand therefore which treatment service to refer service users to based on the nature of their substance misuse.

Community representatives did not report any problems with making referrals to the services; one felt that referring clients into the services had improved.

Some referrals are made through care co-ordinators, although one homeless charity often finds that service users have been referred to treatment services before they arrive at the charity.

Pregnant women are referred through the midwife service if drug use is disclosed during assessments.

Aspects of service provision that work well

Representatives were keen to point out that the treatment services are valued and do a good job, but, *"there is always room for improvement"*, with some elements that would benefit from redesign, particularly for certain service user groups.

The online/telephone offering

Some treatment services and appointments migrated online during the lockdown of March 2020 and this flexibility to the service offering was welcomed by representatives, enabling some to 'attend' appointments that may not otherwise be able to.

One representative said it is important to make clear that an online/telephone offering can itself be a barrier for those without a smart phone. One representative described how the service users that she represents are not capable of thinking beyond the moment and committing to appointments. *"If the appointment can come to them that makes it much easier. It is a 100,000 percent easier for virtual appointments. I can't say how helpful this is than having to get clients to go somewhere"*.

The rough sleeper pathway and, *"the new offer of two appointments a week is a great way to go forward"*, and has helped to reduce rough sleeping in Lewisham. The outreach nurse in the health inclusion team is considered a helpful resource in preparing clients for detox.

Gaps in the service provision – applicable to all service users

Dual diagnosis

Provision to meet the demands of dual diagnosis is inadequate according to some of the community representatives. With a high prevalence of dual diagnosis amongst clients, *"nine times out of ten there is a dual diagnosis"*. Respondents considered this to be *"a massive problem"*.

One representative said that substance misuse and mental health cannot, and should not be split up, *"there is mental health because of crack use, and substance misuse because of mental health issues"*, and

that addiction and mental health should be addressed concurrently. However this known association between the two is not addressed or provided for within the current treatment provision.

Charities see the impact of this gap and pick up on this outstanding demand themselves. One representative for instance described how, *"service users flop into St Mungo's because the services can't help"*.

Dual diagnosis is also a concern when treating pregnant women. The midwife reported how the perinatal team do not expect referrals due to drug use but the midwife said that it is difficult to untangle what came first – the mental health issues or the drug use. Some women therefore have to wait and are re-referred when the drug misuse is under control; this does not however provide the level of care that pregnant women need during the pregnancy. Similar dual diagnosis issues occur in instances of self-harm in pregnancy. The midwife said that there is a real need to improve joint working to provide better care and reduce harms for women *during* the pregnancy.

Metro felt that the current approach does not solve the root issues that are the catalyst to substance misuse amongst many of its client base. Counselling is not sufficient to resolve the deep rooted issues and further treatment options should be simultaneously provided.

Stakeholders flagged up issues in relation to those in violent relationships where domestic violence and drug use are rarely addressed at the same time. Given the interlinked nature of these, where substance misuse is used as a coping mechanism, the question within the current service provision is, *"which bit do you treat first?"* The representative said there is a need to treat both concurrently to fill the treatment gap for those with two consecutive problems.

Maintaining service user engagement

The community representatives appreciate that service users can be difficult to engage, and accept that there are challenges inherent in maintaining ongoing and sufficient levels of engagement. They are aware of the large number of missed appointments and frustration that this causes the providers.

The stakeholders interviewed felt therefore that maintaining service user engagement was crucial and that retaining users in treatment could best be accomplished by representatives from treatment working together with those in other sectors (such as homelessness). The suggestions, outlined below, could result in better service user engagement and limit the impact that premature case closure can have in the opinion of the representatives interviewed.

Faster access to treatment

Increasing the speed with which service users can see the doctor and be prescribed their script would improve outcomes for many. Representatives said that it is important that once service users have approached the services, getting them into treatment quickly is key. One respondent observed that whilst the providers are good at assessing clients and arranging the protocol for getting them into recovery, there is then often a delay in getting service users into treatment by which time blood tests are out of date.

This momentum delay extends to detox programmes with representatives stating that there has been a reduction in the number of detox programmes the providers can refer to, resulting in detox becoming harder to access with increased waiting times. Accepting that this is likely to be a casualty of funding cuts, the charities point to this as another example of a gap in the current provision, leaving service users with nowhere else to go. *"The number of detox beds has reduced. So we get the person ready to detox, wait for a bed, the client loses momentum and they drop out"*.

The one size fits all approach

Representatives interviewed felt that it is critical that a client's individual circumstances are taken into account when offering treatment. Some of those interviewed did not feel that the full range of a service user's needs are always understood and therefore met by currently treatment services. For instance one representative felt that the expectation from the providers was that all service users can, and should attend their appointments and respond to telephone messages etc. *"Substance misuse services can be a bit one size fits all way of thinking. That is, everyone can attend groups, answer their phone, and respond to messages"*.

However, the representative pointed out that service users who are in a state of high addiction are not necessarily able to do all these things. *"Their whole being is consumed by where they are going to get the money to score – that is all you are thinking of. The best that one might expect from a service user might be to speak once a month"*. Whilst the charities acknowledged that this means clients can be problematic, the provision should be tailored to the individual, and their individual circumstances. The journey to recovery is not the same for each person and not necessarily right for that person.

One stakeholder described how she felt there needs to be a fundamental change in the current 'punitive' approach adopted by the treatment services; it is too punitive or strict for the client group it is servicing.

"[Treatment services] can be quick to take you off the case load. You haven't done this so we'll take you off the case load".

If service users are re-housed, they may not necessarily be local and therefore may experience problems with picking up their script.

This is also true for women who may be experiencing domestic violence, where dropping on/off script is common and can lead them to being struck off the provider services. It can be difficult for women in this situation to stay on the script, purely because they cannot attend the appointments due to restrictions imposed on their movements. The representative felt that treatment services need to address this practical difficulty and offer a waiver in cases where women are in violent relationships.

Educating on the dangers of cannabis

One representative said that efforts should be directed towards educating people on the dangers of cannabis which may help to reduce future health problems that develop as a result of substance misuse.

With a noticeable increase in the use of skunk and spice amongst service users, the representative believes this is more important now than ever. The representative sees a large cohort of service users who don't believe that spice can contribute to future mental health issues, or be pivotal in the evolution to use of harder drugs. *"Things are different to how they were 15 to 20 years ago and people don't realise how dangerous it can be".*

Raising awareness and understanding on the dangers of skunk and spice use should be extended to both staff and service users.

Gaps in the service provision – service user group specific

Homeless community

The key message representatives in the homeless sector were keen to communicate is that they are there to help and would welcome taking a pivotal role in maintaining service user engagement in conjunction with the providers.

Currently, the charities are unaware if service users are not engaging, or do not attend their appointments. Improving the information flow between providers and charities could rectify this. *"We don't get any feedback from the providers if service users aren't engaging or haven't attended their appointments. Then the case is closed. We need to work together".*

Representatives suggested setting up liaison meetings where service user non-attendance, or those who have fallen off their script can be highlighted. Alternatively, if the charities were given the dates and times of appointments, they could ensure services users attend. The representatives acknowledge that improvements to communication are a two way thing and the charities must play their part.

The representatives were understanding of any data protection concerns that impact on information sharing but felt that both the charities and the providers are working together to achieve the same outcome. They must therefore work together to overcome any data protection barriers given that they do have informed consent to discuss service users.

The Thames Reach representative said that one of the difficulties within the homeless populations is the lack of a dedicated outreach worker. She believes that building better relationships with service users early on will provide the reassurance and support that service users are looking for. An outreach worker employed by the treatment provider who could create the initial relationships within the homeless community would be the catalyst to getting many more homeless services users to access the treatment services. The outreach element would benefit service users from first presentation, through the referral process, and ongoing. *"If we can start the journey this way, it will increase the number of cases helped"*.

Sex workers

A similar outreach approach would benefit those service users involved in street-based sex work, with the representative recommending the need for a dedicated outreach worker. However, any approach aimed at sex workers must be framed in the correct and sensitive manner, not specifically targeted at sex work *per se*. Outreach work, framed in a health-focused way, would offer support to those who may *not otherwise access the services*.

Pregnant women

It was felt by some practitioners that some pregnant women could be difficult to engage with in terms of their substance misuse needs. It was felt that the current pathway of home visits and GP letters does not necessarily for drug using pregnant women and that this is not always sufficient to link them into specialist treatment. It was however noted that some pregnant women do engage well.

There is also a gap in the current aftercare service for pregnant women, with aftercare often lacking altogether. If children are taken away this can enhance the vulnerability of an already vulnerable person, especially if drug use is still prevalent. The current service design is targeted towards women receiving

care during pregnancy, but no aftercare provision where women would benefit from support to reduce further harm.

Domestic abuse – a gender informed approach

Some stakeholders who were interviewed felt that there was a need for a gender informed approach to fill the gap in the services for those experiencing domestic abuse. (That is an approach that recognises the specific needs that relate to a person's gender and which reflect the lived-experience of women rather than assuming that service design inherently works for women if it works for men).

Stakeholders who worked in the field of domestic abuse thought that it is important that women can approach treatment providers to also seek support in relation to domestic abuse. It was noted however that it should be done in such a way that others are not aware of the domestic violence support need – that is that they remain “anonymous” in terms of their domestic abuse status. As such any provision should therefore not be labelled as ‘domestic violence support’ but could be offered within the women's group or a domestic violence worker based at the centre once a day for example.

Of note, no reference was made in relation to male victims of domestic abuse.

LGBTQ+ community

The representative from Metro said that some of their service users do not feel comfortable accessing substance misuse services. Unlike many other service user groups who can be difficult to initially engage, this does not appear to be replicated within the LGBTQ+ community; the sticking point tends to be getting service users to return after their first visit to, or interaction with, treatment providers. *“Clients often go once to the services but do not go back”.*

Service users have fed back to Metro that there does not appear to be anything to indicate that the services are gay friendly. It was pointed out that even basic strategies such as a rainbow sticker in public places within the treatment services were not being used. It was felt therefore that the lack of gay friendly messages or signs of gay awareness can lead to people finding the services intimidating and possibly not returning.

Furthermore, there appears to be a gap in awareness and understanding on homosexuality amongst some of the treatment staff. The representative said that if the services are presented as local services for everyone, service users should not have to be the educator on homosexuality and should not have to explain homosexuality to staff.

The LGBTQ+ representative explained that this perceived lack of gay awareness may present itself as an issue of trust for service users. Presented with the assumption that they are heterosexual, service users must then consider who they trust, what are the benefits of coming out, and do they feel safe? These questions are linked to clients' previous, often negative, experiences. The representative explained that if you do not feel safe, you will not feel safe in the treatment services and the lack of awareness amongst staff, is therefore enveloped wider issues of trust for some service users.

Chemsex

One representative said that treatment services need more specialist services to address the needs of those engaged in chemsex. She described chemsex as, "*Such a complex area, wrapped up in a lifestyle*".

The representative explained that chemsex is not simply limited to the LGBTQ+ community. There are occasions where men have sex with men as a means to obtain money to buy drugs but do not necessarily identify as LGBTQ+; for instance they can be sex working out of convenience.

Barriers to accessing treatment services

The community representatives also identified several barriers which may hinder service user recovery.

Co-morbidities

The presence of co-morbidities can impact on service users' ability to access treatment in its current form. Representatives said that those injecting drugs can develop issues at the injection site which may affect mobility and cause problems with appointment attendance. Memory problems are common in those with prolonged alcohol use which may impact on peoples' ability/accuracy at remembering to attend appointments, and liver pain caused by alcohol abuse can impact on the ability to focus. Representatives said that any one of these will be problematic for recovery and a combination, even more so.

One representative described how a service user had a serious leg problem which gave off a pungent odour. The service user was embarrassed to use public transport, and taxis were not comfortable with taking him, both of which resulted in him being unable to attend his appointment.

Intimidation and the presence of negative influences

Some representatives said that their service users find it extremely difficult to change their behaviours when they continue to be around 'negative influences'. Representatives stated that mixing with other

addicts, whom service users often know, can be a hindrance to recovery as it can on occasion lead some to start misusing substances again.

Respondents reported some reluctance amongst their service users to attend appointments where they feel intimidated by other service users. Service users may have worked hard on strategies to avoid drug users but bump into them at the treatment centres, with groups of people gathering outside the offices. However, service users have no other option if they want to continue accessing treatment. It was suggested that one possible solution to this would be to offer services from "satellite" locations around the borough and away from the main treatment centre.

Judgemental attitudes from professionals

Whilst an infrequent occurrence, two representatives said that service users had, on occasion, experienced judgmental attitudes from staff whether the staff were aware of it or not. This can be difficult for service users to deal with and impacts on their enthusiasm to attend further meetings or groups.

Language

One interviewee said that language could possibly be a barrier for some homeless populations although it was not considered to be a big concern at the present time. Language needs should be regularly reviewed as other client groups may need to be catered for in the future. Polish or Eastern European languages are thought to be language needs that may arise.

Mobile devices

On a practical level, service users who change their mobile phones frequently, as some in the homeless community do, can make it difficult to contact them.

Groups not accessing treatment services

Community representatives said that there are service users who are not engaged with and who are not accessing treatment services that they would benefit from. These are not necessarily specific groups of people, or unknown groups, but comprise people with substance misuse needs who would benefit from support.

There are some in the LGBTQ+ community who do not feel the treatment services are gay friendly and do not therefore continue with treatment.

Metro said that lesbian women tend not to be engaged in services. Reasons for non-engagement amongst this group can be that women do not feel their problems are serious enough and because the representative felt that there are, *"no places for lesbian women to go – there aren't support groups just for women"*.

The representative offered some further insight as to why lesbian women may not access substance misuse services but this may be difficult to address in any redesign of the services.

As the lesbian community in Lewisham is small, *"Word will get round too quick if you are accessing services, the rumour mill gets round"*. Furthermore, a consequence of such a small community is that there is the, *"Likelihood you'll bump into someone you have slept with"*, which they said is off-putting for some.

Metro said that there may also be some professional people in notifiable occupations who may not access treatment because they do not want drug use to appear on their job record, or attendance at a clinic or surgery to show up on their NHS record.

On a similar thread, there are some who do not want their drug use to be known by certain organisations such as housing associations and on benefit claims. Some housing associations have a no drug policy.

Some people will not access services simply because they are worried about letters being sent to the home address as they do not want others to know of their substance misuse.

5.3 Service user views

This section sets out the findings from the service user consultation exercise. As per the analysis of qualitative data for other stakeholder groups, the findings have been set out thematically.

The treatment services accessed

Service users had accessed a variety of local substance misuse providers:

- Humankind (Blenheim)
- CGL
- SLAM – including the IAPT service
- The Priory
- Kairos house
- Private doctors
- Counselling services

Referral routes and accessing services

Approximately half of the service users self-referred to the specialist treatment services CGL and Blenheim; some self-referred to these services after visiting the GP.

Two service users said that their GP referred them to the providers, two were referred through Children's Services and a further two through probation. Other referrals were made via a Community Psychiatric Nurse, a homeless charity, the police, and either the GP or midwife for a pregnant woman. One service user said that CGL visited him when he was arrested.

Others had been accessing services for a long time and were not sure how they were first referred.

One service user, initially referred by the GP to CGL, was subsequently referred by CGL to Blenheim as his alcohol consumption did not meet the threshold to qualify for CGL's services.

In the main, service users were happy with the referral process, describing it as quick and smooth. Some reported minor niggles, for instance having to chase the treatment provider and being referred to numerous departments. One service user said that it took eight weeks for the application to be processed but said this was fine as he knew that, "*Help was on the horizon*".

Just one service user was dissatisfied with the length of time the referral took and with the large number of questions he was asked. The delay was considered an inconvenience rather than having any long lasting impact.

Service users were however dissatisfied with their route into the mental health services. Service users experienced long waiting times and described mental health services as difficult to access.

Knowledge and awareness of treatment services

Almost all service users were unaware of the specialist treatment services before their referral. Several spoke about the despair they felt at that time with no idea of where to get help. *"I didn't know where to go. You just don't know where to go for help when in the middle of addiction"*.

Friends, associates, and other drug users sometimes acted as information sources for finding out about the treatment services, particularly for those misusing drugs.

Service users seeking alcohol support were familiar with AA but had very little awareness of other treatment options. *"I didn't really know any help existed outside of AA and the Priory"*. The GP was often the first point of contact for these service users, with many seeing the GP as a go-to point. However, one service user said that the GP did not make him aware of the services, *"But I had been to the GP several times in the past two years prior to my introduction to Humankind. On all occasions I was not made aware of any services available for alcohol or substance misuse"*.

Covid-19 pandemic - thoughts on service impact

In March 2020, as the nationwide lockdown was introduced, some traditional face-to-face services moved online, and some appointments were conducted by telephone. Service users often mentioned Covid and Zoom, and we therefore noted their feedback on this aspect of the service offering.

There was support for providing an element of services online. Online groups eased the logistical issues for those in employment offering more convenience, and less time 'out of the office' than face-to-face meetings entail. Flexibility and more convenient times were often discussed when talking about gaps in the current offering, and the online method goes some way to addressing this ongoing need.

Similarly, for older service users and those with mobility problems, online services and telephone appointments were welcomed, eliminating the need to travel to the centre, *"possibly online video calls is the way forward"*.

One service user who described the online groups as, "good, if not better [than face-to-face]", and felt that it was easier for her to engage online. She explained that she was nervous about, and felt intimidated attending meetings, but felt less conscious as a, *little head bobbing up on the screen*".

However, the importance of face-to-face meetings for some should not be ignored. Service users value face-to-face communication for the contact and interaction it provides with other people. For some, it was harder to remain engaged and focused in the online sessions finding it, *easier to drift off [online]*".

One felt that the zoom meetings were, *in my space*", and preferred the physical separation that going to the treatment centres provides.

Some service users spoke of technical problems when joining online groups, and others simply did not have the equipment to interact online. While this was raised as an issue, no-one was able to quantify the scale of the problem (i.e. how many service users lack access to the internet or internet enabled devices).

Support needs and perceived gaps in the current service provision

Whilst there were some common support needs, many aspects of the care requirements that service users discussed related to the group and the nature of the treatment they were seeking, that is, the needs of pregnant women were unlike those within the LGBTQ+ community and so forth.

The following section is therefore reported according to service user type. Please note, that on occasion, a single service user covered more than one priority group and their feedback covered in more than one group.

LGBTQ+ community – four service users

Service user profile and substance misuse

Four service users identified as LGBTQ+. One was female and three male and ages ranged between 25 and 50. All were White British.

One service user sought treatment for alcohol misuse, one a combination of drugs and alcohol, and two for drug misuse. The drugs they were using include crack cocaine, crystal meth, GBL and mephadrone.

Support needs and gaps in the service provision – gay men

LGBTQ+ service users who were interviewed said that the treatment services had not met their own support needs. They therefore questioned whether the services would meet the needs of the wider

LGBTQ+ community. (Necessarily this is however the perception of a small group of users). One said that the services helped him in the short term, but not with his long term needs relating to alcohol dependency.

Service users said that the LGBTQ+ community do not feel overly welcomed into the treatment services. Whilst putting up gay friendly flags in the offices would be a small touch, service users said that it would send an important message to those it is aimed at. According to one service user, welcome signs should also be displayed in chemists that offer needle exchange services as some within the LGBTQ+ community feel stigmatised going to the Chemist. A simple, *"you are welcome flag"* would help.

In the view of two service users, there is a culture of substance use engrained within the LGBTQ+ community. They explained that peer pressure is common and substance use entangled in the need to belong. *"I think in my circle of friends if you're not taking drugs or alcohol, you're not part of the family"*.

The service users interviewed for this report (and therefore not necessarily representative of wider views) suggested that abstinence was not an option. In their own case they had necessarily wanted abstinence and were of the opinion that many in the LGBTQ+ community would also not necessarily want an abstinence based service. While not wanting abstinence, one service user seeking help for alcohol use for instance, said that abstinence was the consistent and only option offered by the services he approached. The service users did however acknowledge that, *"Not all addicts are the same"*, with another service user noting that the services should offer an approach to drug reduction alongside abstinence.

A further support need currently missing within the LGBTQ+ community is the provision of education on how to use drugs safely. Given the culture of drug taking within the LGBTQ+ community, drug use can be the norm and there is a need therefore to teach people how to inject crystal meth safely without overdosing, and to increase awareness of the needle exchange facility.

Service users acknowledged that it is difficult to get safe drug messages to those that it would serve. One service user said that the key messages that should be disseminated to the LGBTQ+ community are:

- It is alright to talk about addiction,
- There is help available,

- Talking about chemsex is not taboo, and
- Treatment is not necessarily about total abstinence.

One service user would like to see focused substance misuse care combined with additional coping mechanisms such as relaxation classes.

Support needs and gaps in the service provision – lesbian women

The female service user offered some insight as to why she, and other lesbian women may not access the treatment services.

She said that she felt anxious accessing, and admitting she is gay within a mainstream group setting. Recognising that, *"things have improved massively in the last ten years in terms of LGBTQ+ acceptance"*, the service user explained that the perception is that groups will be, *"Full of 60 year old straight men in raincoats with an old fashioned view"*. The service user explained that these are the people she has experienced problems with in the past, although said that younger lesbian women may have different experiences given the change in LGBTQ+ acceptance.

The service user said that she now appreciates that what could be one of the biggest barriers to the lesbian community accessing treatments is incorrect - but felt that awareness of the variety of people accessing treatment services is missing within the lesbian community. Any advertising of the services should highlight that, *"all are welcomed and comprise a mixed bunch"*.

Chemsex

One service user explained how chemsex is linked to issues of cultural and religious issues fuelling embarrassment and/or shame.

One service user said there is a gap in the chemsex service provision. He described how the doctors were ill-informed regarding chemsex and he had had to explain chemsex to his doctor. The service user said that if doctors do not improve their knowledge on chemsex, they could easily and quickly lose those accessing the services for help.

Two service users were of the view that chemsex is on the increase as a result of the availability of drugs on the internet. One service user said that the ease of availability results in young straight and bisexual men dabbling in gay sex under the influence of drugs. Given the prevalence of dating apps, the increased exposure and acceptance of LGBTQ+, some felt that younger and younger men are engaging in chemsex.

Adverse childhood experiences – one service user

Service user profile and substance misuse

The service user was male, 45 and identified as White British. The service user was using crystal meth more and more frequently as a mood lifter throughout the day.

Support needs and gaps in the service provision

The treatment services did not meet the needs of this service user. The main reason for this he explained was the focus of the treatment approach on the drugs he used rather than the underlying cause of his drug use. A trauma led approach and finding out the reason for his out of control life would have better suited this service user.

The service user accessed other services but called for more joint working between the services saying that they do not work effectively together. The service user believes that to ensure that people do not repeatedly present to the services, it is imperative to treat the person as an individual human being, simultaneously treat the cause and effect of drug use, and to determine what has resulted in their life becoming out of control.

Pregnant women – two service users

Service user profile and substance misuse

One service user was White Other and the other Black British. Both were aged in their thirties.

The women reported using alcohol, cocaine, heroin and crack cocaine with one using drugs every day. Being told that, "*it was the drugs or the child*", was the catalyst to one woman seeking treatment.

Support needs and gaps in the service provision

Both women said that the services met their needs and helped them to stop misusing substances. The women were prescribed methadone and the services always ensured correct dosages were prescribed.

The requirement to physically present at the treatment centre was difficult for the pregnant women. One described the stigma and embarrassment she felt and said she disliked going to the centre where there were, "*loads of drugs people outside*". She was uncomfortable mixing with these people, but said that once inside she felt more comfortable. The service user expressed concern for her safety. A women's only service or a specific day for pregnant women where there are no other people to mix with would fill this gap.

Being 'forced' to attend the chemist to take the methadone prescription was extremely inconvenient for one. She described how with a young baby, and being pregnant, she had to attend the chemist and drink the methadone dose in front of the pharmacist. This contrasted to her experience when she was in GP care where she was provided with a week's supply of methadone to store at home. There is therefore a need to offer more flexibility on methadone provision to reduce the need for pregnant women to have to travel to centres and pharmacies.

Co-morbidities - four service users

Service user profile and substance misuse

Three service users were female, and one male. Three were White British/Other and one Mixed. Service users were between 26 and 63.

The drugs used amongst this group comprised cannabis, speed, LSD, barbiturates, with Class A intravenous drug use. One service users had fibromyalgia and anxiety, two COPD and mobility issues, and two with heart problems.

Two of the women described themselves as long-term addicts with drug use starting around aged 13 for one and 18 for the other. The male service user had been accessing services between three and five years.

Support needs and gaps in the service provision

In the main, the services met their needs, although one service user said he had not received much treatment in the previous six months due to lockdown. He had received around four telephone calls a month from the services which he considered was fine.

The requirement to shield for one service users meant that she felt that the service had only met her needs to some extent.

The older women said that the service providers should address, "*all the other issues which come as a result of old age*". They should be aware of the additional medical and mobility issues that come with aging. The mobility issues are of the main concern to the older women as they said it can be difficult for them to get to their appointments. The service user who was shielding said that she could not attend the clinic for her one-to-one sessions. Other illnesses such as COPD and heart troubles can impact on general health again meaning maintaining appointments and managing the addiction can be difficult.

One woman felt that the way people use drugs is changing and the providers must keep up with and adapt to the change.

Homeless population – one service user

Service user profile and substance misuse

The service user was male, 41 and was White British/Other. The service user said that he was using Class A drugs and injecting intravenously.

Support needs and gaps in the service provision

The service user said that he was keen to, "get back to a normal life", and needed help with his drug addiction and to understand how to stop taking drugs. He also needed help with ensuring that he didn't spend money on drugs and help to find his own housing. It was difficult for him to say whether the service had met his need needs as he had not received much treatment in the previous six months due to lockdown. During this time he had received around four telephone calls a month from the services which he felt was fine.

The service user could not identify any gaps in the service provision but said that one of the difficulties with the homeless population is that they do not have an address and contacting them can therefore be difficult.

Adults in treatment or recently completed treatment–12 one-to-one interviews with service users, plus input from the focus group with those in the aftercare service

Service user profile and substance misuse

Six service users were female and six male. Service users ranged between 26 and 65 and all but two were White British/Other; one was Black British and one of Mixed heritage.

Six respondents sought treatment for alcohol misuse, two for drugs, and four for a combination of drugs and alcohol.

Support needs and gaps in the service provision

In the main, service users described the drug and alcohol treatment services as meeting their needs; some described the services as a lifesaver, "in my honest opinion, I would not be alive today without the support I received from the key workers at Blenheim".

Service users were looking for strategies to help them stop misusing substances and sometimes needed help beyond the substance misuse such as with housing needs. Some service users said they needed an

incentive to stay sober, to be educated on addiction, to receive support from others in the same situation, and to find somewhere to feel safe.

Those interviewed felt that the ability for service users to access mental health treatment at the same time as substance misuse services was lacking. One service user had tried to access mental health services as she knew that her alcohol dependency was related to her mental health issues. The mental health services turned her away because of the alcohol dependency. Thus she considered not having services which were aligned as a gap in current provision.

Not offering age specific groups was considered to be a gap in the current service provision by one service user. She felt that the mixed ages was more of a problem for young people who may not be able to identify with older people. However, it should be noted that the mixed age group was considered a positive for one alcohol client finding it interesting to hear from people at different stages of their journey.

Around a third of service users who were interviewed said that advertising for the treatment services and support on offer was missing. Some felt that awareness of the treatment services was lacking amongst GP's who were often the first point of call for many. If the professionals do not know about the services, it is difficult for those needing support to find it. One service user was surprised that A&E did not refer him to any substance misuse services, after ending up in A&E after an episode. *"The vast majority of alcohol and drug misusers are not aware that there are services available offering support. Also, from my experience, there was no reference of support nor of the services available following frequent admission to A&E and hospitalisation"*.

One said that the services should be advertised in GP surgeries and in other places, *"if you are in a bad place, you might not have it in you to search for help"*.

For one service user there is an unmet need in the rehabilitation facilities on offer. She said that she was not looking for residential rehab but that a day facility would be more suited to her needs, but this was unavailable at the time.

The delay that one service user experienced between his first assessment and receiving his script could be costly for some. The service user said that the treatments should take place all on the same day. Any delay, even of a day, *"Is all it needs if you're not in a good place at the time"*.

There was a general consensus that ensuring more ex-addicts working in the treatment services would be advantageous to service user recovery, with one describing ex-addicts as a, “*valuable asset*”. Service users found it easier to talk to ex-addicts, who have first-hand experience and are more understanding of the issues addicts faced. This sentiment was echoed by those seeking treatment for both alcohol and drug substance misuse. Having ex-addicts on board on both a voluntary and/or paid basis would be welcomed.

The time that sessions are scheduled was said to be a barrier for some. Flexibility around the time of groups and appointments, especially for those who are working or with children would be welcomed. Having to queue up early in the morning does not coincide with the school drop off and others find it difficult explaining where they have to go if needing to leave the office. Evening sessions for those that cannot attend in the day would help prevent some of the current time barriers.

Family and carers – three service users

Service user profile

All services users were female, two were White British/Other and one Mixed. Two were aged 71 and one 39 years old.

One lady was seeking support for her husband, and two for their (adult) children.

Support needs and gaps in service provision

The family and carers service was considered a lifeline by those that use it. Service users needed support with a variety of issues relating to their family members substance misuse. One service user described how she was keen to understand how she could deal with her husband during a craving episode, and what her responsibility was in that situation. She found it helpful to learn about co-dependency, the skills she could implement to extract herself from that situation, and perhaps most importantly that it was ok to still laugh and have fun. The validation the support provided that they were not bad parents was invaluable to two service users.

Others found the strategies to deal with the addict useful, learning that addiction is an illness with one describing how she previously viewed her son as bad and not ill. Prior to accessing the support, some described how they had given up on their children and felt guilty at having done so, “*guilt can really stop us*”.

Having spent time researching the support available to family members, one service user said that the family and carers group would benefit from more advertising; the GP was unaware of the group and did not provide any information on substance misuse support. She felt it was an underutilised service and that there are many more people who would benefit from the friends and carers group.

Two service users felt that the support provided to family and carers would benefit from more structure. Whilst still a welcomed service, more support relevant topics should be included.

Another would like to see more holistic services offered such as acupuncture saying it was something that was offered in the past, and practical things such as knitting or cooking that could be done during any discussion.

Black and Minority Ethnic communities

Whilst information from Black and Minority Ethnic communities was limited, and support needs related to other aspects of service delivery such as support needs in pregnancy, one lady offered some insight as to the barriers and challenges she faced as a Muslim woman.

The service user said that she found it difficult to access the services due to the stigma that exists in her culture. She described embarrassment and feeling ashamed at having to attend the services.

The zoom offering made it much easier for the service user to access support and said that offering some outreach services where the services come to you, or certainly the offer of some services over the telephone would fill a gap for people experiencing similar cultural boundaries.

Groups not accessing treatment services

Service users were asked if they were aware of groups of people who are not accessing services but would benefit from doing so.

Amongst the service users attending the family and carers group, the consensus was that there are a lot of people not accessing the carers support. Lack of awareness of family and carer support was cited as one reason, but one service user said that some will be prevented from seeking help due to fear of being judged by other people. One described how, "*the years of being ground down by the addict*", and the co-dependency issues result in low self-esteem, which can prevent people accessing support.

There was some concern, although no real evidence to support this, that people with children may not access the services. Based on previous experience, the service users said that parents can be fearful of social services involvement and that children may be removed.

There is also thought to be a cohort of people with alcohol dependency who do not wish to involve themselves with the services. They do not want to admit that they have a problem with alcohol and are ignorant of the damage that they are doing to themselves and others.

One service user said that there is a group of professionals with alcohol needs that are not accessing services because they do not appreciate that, *"it is ok to seek treatment"*. They are fearful of the stigma attached as well as their substance misuse becoming known. This view was supported by another service user who felt that there is a group of, *"highly functioning professionals like myself who want to stop but cannot stop alone. They are also unaware of the risk to their health that their excess alcohol consumption is having on them"*. One service user said that these people do not access treatment because they cannot afford to take time off work or family commitments prevent them from following up with the alcohol misuse treatment services.

There are people in the LGBTQ+ community who are not accessing services due to the perception that the services are not gay friendly, but also outdated views that exist within the community, particularly by lesbian women (which were outlined earlier in this section of the report). There are possibly some men engaged in chemsex who do not continue to access services due to the perceived lack of knowledge of the specialist doctors. Stigma and cultural factors may also impact on some in the LGBTQ+ community from accessing services.

One service user felt that some homeless people are not accessing services as they do not have an address to enable contact, and do not know about the services and support available.

Local drug availability

Some respondents were unaware of the availability of drugs in the local area; many said that they had kept themselves out of the drug circles and others simply did not know.

Two service users said that crystal methamphetamine and GBL were easily accessible in the area and that drugs are generally more easily available on the internet more than ever before. One felt that drugs are especially easy for 17 and 18 year olds to obtain with many in this age group boasting about the drugs that they use.

5.4 Summary of findings

Professional stakeholders felt that there is a 'core' group of heroin users who are resource heavy and are likely to stay in treatment. They were identified as a group that use, and will continue to use, the bulk of the resources devoted to specialist substance misuse provision. This group were described as aged over 35 (with many in their late 40s and 50s). Most were seen as having poor physical and mental health.

Interviewees also referenced a relatively large number of people on a low dose "script" who did not feel confident enough to leave treatment. These stable low dose clients were on caseloads but potentially did not need the sort of specialist services provided by substance misuse providers

The biggest gap between need and supply was believed to be among alcohol users not in treatment – particularly those who were treatment "naïve" (i.e. who had never engaged in any form of treatment).

The qualitative data indicates that drug use is widespread in the LGBTQ+ community. LGBTQ+ service users who were consulted reported that that members of this community do not feel able or comfortable in accessing treatment services as currently configured. Additionally, it is likely that many LGBTQ+ drug users do not see their drug use as "problematic" (for instance only using occasionally/at weekends) and so would not necessarily wish to seek out treatment. While data are very hard to come by to understand the prevalence of chemsex, stakeholder consultation indicated that this was likely to be an issue.

In addition to members of the LGBTQ+ community a number of other groups were believed to be under-represented in treatment:

- Sex workers
- Pregnant women
- Clients with a dual diagnosis
- Black and minority ethnic communities

Homelessness services report working well with treatment services and that there were clear referral pathways in place, but expressed some concern that their clients often miss treatment appointments and disengage from the service.

Recognising that there is a GP with a Special Interest in the borough and that shared care is in operation, the qualitative findings appear to suggest that not all GPs in the borough are aware of how to refer drug and alcohol clients into treatment.

The online and telephone service offering, expedited by the Covid-19 pandemic, was welcomed and something representatives were keen to continue, noting that this offering is more suited to certain groups of service users, and the barrier that technical capabilities can present for some. It is important to note however that face-to-face human interaction was important for some and should be retained.

6. Local Media Review

6.1 Media review findings

This section sets out the findings of a review of local media which was undertaken to understand the views of the wider community in relation to substance misuse issues in Lewisham.

Drug and alcohol use are common in Lewisham

People expressed little surprise at news reports about drug related arrests and the increase in drink related deaths occurring in Lewisham. A few expressed the opinion that they had thought that the number of people being arrested for drug offences would be higher. One person was surprised the police still 'brag' about drug seizures in the area and felt that the war on drugs in the areas was lost a long time ago.

One post which commented on a County Lines arrest felt that County Lines is a huge problem and jailing one County Lines drug dealer is just 'a drop in the ocean'.

While therefore by no means a representative sample of the local population, there was a clear trend for users of social media and local news outlets to hold an opinion that problematic drink and drug use in Lewisham was relatively common.

Judicial sentences are too lenient

Many of the comments made to news articles on drug arrests centred on the criminal justice system being too soft when determining the punishments for those convicted of drug crimes. Many said that suspended sentences, and 'slaps on the wrist' are not sufficient and do not match the severity of the crime.

There was a consensus that harsher sentences should be given to those convicted of drug dealing. There were some who said that mandatory jail terms, and others that life sentences without early release for good behaviour, should be given to those convicted of drug crimes. There were a few comments that suggested drug dealers deserve the most brutal form of punishment.

Outdated drug laws

There was some discussion around the outdated, draconian, and radicalised drug laws with posts stating that the current drug laws discriminate against many of the residents in Lewisham and were causing a lot of social harm.

There was reasonable support for legalising cannabis as a means to reducing associated criminal gang activity. One supporter of this approach said that he would be happy to see Lewisham used to undertake a pilot scheme whereby a legalised cannabis zone is implemented, albeit supported by sufficient education and regulation.

A few news articles reported on the Mayor's statement that cannabis should be legalised to enable the police to focus on more serious crime and to reduce the exploitation of young people. The need to end the exploitation of vulnerable people by drug gangs was a commonly expressed view and there were several posts in support of the Mayor's stance, as well as to end cannabis stop and search.

Drug activity hotspots

Several comments suggested that there are certain areas in the borough which are known for both drug use and violence. Whilst not all comments referenced a specific location, there was one mention of the Harlow blocks and another to Lewisham Court where it was alleged that drugs are sold by an ice cream van and a local taxi service.

However, one post referring to a lot of drug activity happening in Lewisham alluded to off-licenses being drug activity hotspots whereby seemingly low stocked off licences in terms of alcohol wares, were somehow very busy both during the day and night.

Rough sleepers

Social media posts on homelessness and rough sleepers generated quite a lot of discussion. There were a number of comments identifying one or two 'well known' rough sleepers around Sainsbury's in Lower Sydenham and one outside Aldi in Bell Green. The general sentiment of the rough sleeper discussions were that they are pleasant people and should not be judged.

However comments then moved on to rough sleepers having drug problems and sometimes 'looking out of it'. There was some discussion on whether money should be given to rough sleepers when they ask for money to pay for a bed for the night. The majority of the subsequent posts centred on how

begging money is used to purchase drugs so offering money to rough sleepers only 'feeds the drug problem'.

People showed some empathy for rough sleepers, saying that homelessness and drug use go 'hand in hand'.

Concerns for personal safety

Unsurprisingly, people expressed concern for their safety and the safety of their children after reading articles on the drug and alcohol use in Lewisham. There was some understanding that 'these people have addictions' but the key point people made was their personal safety concerns.

Empathy for addicts

Whilst the tone of many comments was quite harsh towards addicts, there were alternative views expressed with some stating that addiction should be treated as a medical problem and not a criminal problem.

In relation to drink related misuse, there was some discussion on not always blaming individuals. Some people said that there is often a reason for out of control drinking and underlying causes of alcohol dependency such as self-medicating to provide relief from chronic pain.

One person said that instead, blame should lie with the medical professions who are 'inept' and 'abandoning' these people.

Youth groups

One post referred to the need to break the cycle of drugs in Lewisham, explaining that youth clubs in Lewisham and surrounding areas should adopt a zero policy to drug use. The author felt that the youth leaders were the closest thing youths had to responsible parenting and that if youth clubs close, this opens the door for drug gangs to recruit young people 'from the street'.

6.2 Summary of findings

Residents of Lewisham engaging in social media thought that problematic drink and drug use in Lewisham was relatively common and a number of local 'hotspots' for drug use were cited. Drug and alcohol misuse were a cause of some concern to some local residents who thought that it impacted on their safety and the safety of their children.

The misuse of alcohol was commonly associated by residents with local rough sleepers.

Strikingly there was much empathy for drug and alcohol users expressed by some residents on social media who noted that it should be seen as a medical rather than criminal justice issue.

7. Discussion and analysis of findings

7.1 Substance misuse and black and minority ethnic communities

One of the clear findings from this JSNA is the under-representation of members of Black and Minority Ethnic communities in both drug and alcohol treatment.

Engaging with Black and Minority Ethnic communities

Issues around engaging members of minority communities are not limited to Lewisham and there is a significant literature that describes the issue. As noted in one report:

'The underrepresentation of BME groups in drug and alcohol treatment services is complex, multifaceted, and varies considerably between communities and individuals, and change across generations. It demands a flexible and dynamic approach to service provision.'⁴

A number of attempts have been made to explore and respond to the issue including, in July 2015 a Recovery Partnership roundtable discussion in Birmingham attended by substance misuse commissioners, drug and alcohol service managers, frontline workers and volunteers from the West Midlands, as well as representatives from related sectors such as criminal justice, which considered how substance misuse treatment services could better address the needs of people from Black and Minority Ethnic communities ensuring that the values of equality and diversity were upheld and enacted in treatment and recovery⁵. Work from this roundtable as well as from the literature is set out below.

A whole system approach

It has generally been found that for minority communities to have access to culturally appropriate treatment and recovery services, engagement of the whole system is required. This will include:

- cultural competence running through the whole system, including commissioning.
- consultation with local community organisations and existing service users from minority ethnic communities about their needs and experiences.

⁴ Galvani S., Manders G., Wadd S. and Chaudhry S. (2013) Developing a Community Alcohol Support Package: An exploratory study with a Punjabi Sikh Community

⁵ ADFAM (2015) Treatment and Recovery: Black and Minority Ethnic Communities.

- where substance misuse need in communities is identified investment may be required – including for outreach activities, the training of staff and for interpreting and translation services, for instance⁶.

Multi-agency response

Researchers and commentators have argued that multi-agency partnerships - including community organisations and local health promotion initiatives aid the development of services by enabling resources to be shared and duplication minimised, whilst addressing a range of drug-related issues.

A multi-agency approach is understood to be the most effective way to access, consult, and assess the service needs of hard-to-reach groups^{7, 8, 9, 10}.

Gilman¹¹ discussed the issues raised by seven action research studies into Asian drug use in Bradford and stressed: 'Many of these issues will need to be tackled on a multi-agency basis. No one agency can deal with all the issues on their own. What is required is a commitment to formulate comprehensive strategies that outline the parts that different agencies can play in drugs prevention.'

It has been argued that a multi-agency approach also enables organisations to respond to drug-related problems in the context of broader health service provision. For example, Patel *et al*¹² pointed out that many female South Asian drug users would benefit from drug-related work conducted at general health, maternity and health promotion agencies. A conference in the North West of England¹³ added

⁶ Recovery Partnership (2015) State of the Sector 2014-15.

⁷ ADP (Asian Drugs Project) (1995): Substance use: an assessment of the young Asian community in Tower Hamlets and a summary of the development work of the Asian Drug Project. London: Asian Drug Project.

⁸ Chaudry MA, Sherlock K, Patel K (1997): Drugs and ethnic health project: Oldham and Tameside, 1997. A report to the West Pennine Drug Action Team. Manchester: Lifeline / Preston: University of Central Lancashire

⁹ Dhillon P (2001): Progress report: The Southall Community Drugs Education Project. Preston: Centre for Ethnicity and Health, Faculty of Health, University of Central Lancashire.

¹⁰ Patel K (2000b): 'Minority ethnic drug use: the missing minorities.' In Harbin F and Murphy-Russell J (eds): Substance Misuse Its Effects on Families and Child Protection. Lyme Regis: Russell House.

¹¹ Gilman M (1993): An overview of the main findings and implications of seven action studies into the nature of drug use in Bradford. Bradford: Home Office Drugs Prevention Team

¹² Patel K, Pearson G, Khan F (1995): Outreach work among Asian drug injectors in Bradford. A report to the Mental Health Foundation. Bradford: The Bridge Project / London: Goldsmith's College, University of London.

¹³ NWLHPU / GMLCA (North West Lancashire Health Promotion Unit / Greater Manchester and Lancashire Council on Alcohol) (1997): Alcohol and drugs: a transcultural perspective. Conference report

that mutual trust and understanding of all the partnership organisations is essential, and they and the community in question should be kept involved and informed of all developments to tackle drug misuse.

Developing culturally appropriate services

Cultural competence goes beyond cultural awareness as it refers to the capacity of effectively operating in different cultural contexts. Cultural competence is an ongoing process of self-reflection of one's own, or the organisation's, values, beliefs and professional practice¹⁴. It requires that a culturally sensitive attitude, principles of equal access and non-discrimination are translated into behaviours and action in service delivery¹⁵.

Cultural competence in the workforce

There is consensus that one of the most important elements in developing culturally appropriate services is a culturally competent workforce. However, a number of studies have suggested that many drug and alcohol service managers have tended to assume that all staff are confident supporting people from a range of cultural and linguistic backgrounds and this may not be the case. It has been recommended that as a priority drug and alcohol workers should be offered specific cultural competence training¹⁶. The key elements of cultural competence should include:

- Recognition of the influence of culture on people's beliefs and behaviours, including those surrounding illness, drug and alcohol use, and addiction.
- An understanding of cultural diversity and difference.
- Effective communication, to mitigate against the problems caused by linguistic and cultural misunderstandings.
- An awareness of the practitioner's own prejudices and biases.

It has also been argued that, for cultural competence training to be successful, organisations should embed training activities into a strategic model of cultural change, to promote organisational, rather than just individual, cultural competence¹⁷.

¹⁴ Luger, Lisa (2009) Enhancing cultural competence in staff dealing with people with drug and alcohol problems. Doctoral thesis, University of West London.

¹⁵ Banton P. M., Dhillon H., Johnson M. R. D. and Subhra G. (2006) Alcohol Issues and the South Asian and African Caribbean Communities – Improving education, research and service development. Commissioned by the Alcohol Education Research Council

¹⁶ Drug and Alcohol Findings (2003) Notes: Race and gender in the delivery of drug services

¹⁷ Luger L. (2009) Enhancing cultural competence in staff dealing with people with drug and alcohol problems. Doctoral thesis, University of West London

Example: Cultural competence in engaging Asian communities

Wolverhampton Service User Involvement Team (SUIT) works with volunteers who are currently receiving drug or alcohol treatment or who have received drug or alcohol treatment in the last six months. This group also makes up 75% of the SUIT workforce. Volunteers take part in a comprehensive training package and provide a wide range of activities and supports to people experiencing drug and alcohol issues in the Wolverhampton area. Activities include advocacy and peer support, advice and guidance and social activities. SUIT works with service users from all cultures and ethnic backgrounds, and, despite not operating as a specialist organisation for minority ethnic communities, has been successful in engaging a large number of service users from the Asian communities.

SUIT attributes its success to a number of factors, not least that a number of community specific languages are spoken by staff and volunteers. Staff and volunteers are perceived as recovery champions and members of Asian communities have approached the service because they feel that they will be able to identify with the experiences of SUIT's team. Other vulnerable individuals are also attracted to the service, not only those solely with substance use needs, but people with immigration, mental health, employment and domestic violence needs.

SUIT volunteers are encouraged to develop cross-sectoral competence, for instance in obtaining a basic knowledge of immigration laws and where to seek further advice when necessary. SUIT considers social integration to be an important part of the recovery journey, and it connects service users from minority ethnic communities who struggle with English to classes in English as a second language, and plans and tracks their journey towards financial independence and social wellbeing.

Working with faith communities and engaging the wider community

Much of the early research emphasised the key role that could be played by engaging faith groups such as local mosques and Imams as key community leaders. For example, one of the first things undertaken by a Drug Action Group in Blackburn was an event designed to engage representatives from the 12 mosques in the Brookhouse and Bastwell areas. They held six monthly meetings with representatives from the mosques to report on progress and plan future activity¹⁸.

¹⁸ Roy A with Buffin J and Bassa E. (2008) South Asian communities, drug supply and substance use in Blackburn: what is the potential role for the Drug Advisory Group? The International School for Communities Rights and Inclusion UCLAN

However, later research has suggested that while contacts within the mosque are important, there is also a need to move beyond the mosque to engage with those at the greatest risk who are often on the margins of community life and may not be engaged with the mosque. Work conducted in the North West found that Pakistani young men tended to be more critical of the mosque's role in health and social education than corresponding groups of Indian young men. Both groups stated that they often found Imams hard to approach on these subjects and suggested that mosques ought to employ people with a broader role around personal and social education¹⁹.

Issues around representation

Several researchers have raised questions as to how representative community leaders might be. It has also been recognised that in many areas where a number of different communities live, there can be a complicated make-up of different groups. Authors for instance specifically cite the need to recognise areas that have multiple Asian communities that each community will have its own characteristics. Much of the later research has described these differences and in some cases tensions, between different South Asian groups. It has been emphasised that it is important to highlight that these issues are complex and may appear contradictory in that different communities can appear cohesive on some issues whilst disparate and divergent on others. What is clear is that differences and distinctions within and between communities highlights the difficulties of 'representation'.

It is also the case that many services will need to creatively address the issues of gender in their user representation, as there is often an assumption that all drug users are male and are therefore deemed 'representative' in community development initiatives.^{20, 21, 22}. One drug service initiative in the North West supported a 'Parents as Educators' programme for Asian families and found that the South Asian women who attended had a strong level of interest in issues around drugs but had not been included in initiatives designed to address the issue.

¹⁹ Roy A with Buffin J and Bassa E. (2008) South Asian communities, drug supply and substance use in Blackburn: what is the potential role for the Drug Advisory Group? The International School for Communities Rights and Inclusion UCLAN

²⁰ Sheikh N, Fountain J, Bashford J, Patel K (2001): A review of current drug service provision for Black and minority ethnic communities in Bedfordshire. Final report to Bedfordshire Drug Action Team, August 2001. Preston: Centre for Ethnicity and Health, Faculty of Health, University of Central Lancashire

²¹ Bashford J, Patel K, Sheikh N, Winters M (2001): A review of current drug service provision for the South Asian community in Calderdale, with a particular focus on young people. Report to Healthy Living Team. February 2001. Preston: Centre for Ethnicity and Health, Faculty of Health, University of Central Lancashire.

²² Prinjha N, Sheikh N, Bashford J, Patel K (2001b): A review of current drug service provision for the South Asian community in Bolton. Report to Bolton Drug Action Team. June 2001. Preston: Centre for Ethnicity and Health, Faculty of Health, University of Central Lancashire.

Improving access to information about drugs, alcohol and substance misuse services

The need to improve the accessibility of information about drugs and alcohol and the local substance misuse services that are available has been emphasised in many studies. The challenge of providing this information in the range of languages spoken within a local area and delivering that information in a targeted and culturally appropriate way is a common thread in much of the literature.²³

The use of interpreters

The use of interpreters can be a helpful resource in drug services^{24, 25}. It has been pointed out that this is particularly important in areas where levels of illiteracy - in any language - are high^{26, 27, 28}. However, Sheikh *et al*²⁹ emphasised that interpreters should have the appropriate training in drug-using issues, especially during the assessment process.

It should be noted that the National Drug Helpline had provided a 24-hour service and advertised services in a range of community languages including Bengali, Urdu, Hindi, Punjabi and Cantonese. However, this service no longer appears to be available, although many local authorities and voluntary organisations have similar translation services.

Perera cautions that some second-generation individuals could feel patronised by having information delivered via an interpreter and suggested that information and publicity materials should always be prepared in both the language of the targeted group and in English, so that individuals have a choice³⁰.

²³ Banton P. M., Dhillon H., Johnson M. R. D. and Subhra G. (2006) Alcohol Issues and the South Asian and African Caribbean Communities – Improving education, research and service development.

²⁴ Mistry E (1996): Drug use and service uptake in the Asian community. Huddersfield: Unit 51.

²⁵ Patel K, Sherlock K (1997b): Preliminary assessment of services available for drug users from South East Asian communities. Preston: University of Central Lancashire.

²⁶ Arora R, Khatun A (1998): No to Nasha: drugs, alcohol and tobacco use in Bradford's Asian community. Bradford: Race Relations Research Unit.

²⁷ Patel K. (2000b) Minority ethnic drug use: the missing minorities.' In Harbin F and Murphy-Russell J (eds): Substance Misuse Its Effects on Families and Child Protection. Lyme Regis: Russell House.

²⁸ Patel K (2000b): 'Minority ethnic drug use: the missing minorities.' In Harbin F and Murphy-Russell J (eds): Substance Misuse Its Effects on Families and Child Protection. Lyme Regis: Russell House.

²⁹ Sheikh N, Fountain J, Bashford J, Patel K (2001): A review of current drug service provision for Black and minority ethnic communities in Bedfordshire. Final report to Bedfordshire Drug Action Team, August 2001. Preston: Centre for Ethnicity and Health, Faculty of Health, University of Central Lancashire

³⁰ Perera J (1998): Assessing the drugs information needs of Asian parents in North Hertfordshire: a brief report to inform the planning of a drugs education programme. London: Action Research Consultancies

Publicising services

The way in which services are presented and the means through which they are publicised is also important.

It has been found that the most common sources of information for drug users from minority communities includes friends and family, religious organisations and community groups.³¹ It has been acknowledged that communicating messages about drugs and alcohol to community leaders and religious leaders can be challenging but, if successful, getting them on board to provide advice and signposting can be extremely valuable. For instance research by Ram reported an initiative to publicise a local drugs service which had the approval of the local mosque's Imam which meant that individuals who had once 'buried their head in the sand' were forced to consider the possibility that members of their community might use drugs.³²

Confidentiality is a priority and discreetly branded literature about services should be made available in spaces used by the local community, such as schools, colleges, GPs surgeries, libraries and mosques³³.

Research on this issue has advocated promoting drug and alcohol services over community outlets such as South Asian TV and radio,^{34, 35} and has also suggested that the use of digital and social media can be used to provide information about substance misuse services in an easily accessible form to many people from their own home.

All service publicity should promote anti-discriminatory images of service staff and facilities³⁶.

³¹ Fountain, J. (2009) A series of reports on issues surrounding drug use and drug services among various Black and minority ethnic communities in England, *Drugs and Alcohol Today*, Vol. 9 Issue: 4,

³² Ram H (2000): Asian communities project report to National Lottery Charities Board. Dudley: The Warehouse (Dudley Drug Project)

³³ Fountain, J. (2009) A series of reports on issues surrounding drug use and drug services among various Black and minority ethnic communities in England, *Drugs and Alcohol Today*, Vol. 9 Issue: 4,

³⁴ Fountain J., Bashford J., Winters M. and Patel, K. (2003) Black and minority ethnic communities in England: a review of the literature on drug use and related service provision. National Treatment Agency for Substance Misuse and the Centre for Ethnicity and Health (University of Central Lancashire)

³⁵ Galvani S., Manders G., Wadd S. and Chaudhry S. (2013) Developing a Community Alcohol Support Package: An exploratory study with a Punjabi Sikh Community.

³⁶ Prinjha N, Bashford J, Patel K, Sheikh N (2001a): A review of current drug service provision for the South Asian community in Bury. March 2001. Preston: Centre for Ethnicity and Health, Faculty of Health, University of Central Lancashire.

Confidentiality

The fear that drug services will not maintain the confidentiality of their clients has been discussed by many commentators^{37, 38, 39, 40, 41, 42, 43, 44, 45}. It has been suggested that a distrust of 'officials' leads to an unwillingness of members of Black and Minority Ethnic groups to access drug and other health services^{46, 47}. Sheikh *et al*⁴⁸ pointed out that this distrust was a particular issue for refugees and asylum seekers who may be worried about their legal status or in hiding. Bola and Walpole⁴⁹ recommended that drug and alcohol services should include the provision of an anonymous telephone helpline.

³⁷ Dale-Perera A, Farrant F (1999): At home with diversity: race, rehab and drugs. Druglink, September/October:15-17.

³⁸ Hothi A, Belton E (1999): Use of drug services in Buckinghamshire by Asian Class A drug users aged 16-25. Aylesbury: Buckinghamshire Drug Action Team.

³⁹ Khan F, Ditton J (1999): Minority ethnic drug use in Glasgow. Part two: special problems experienced and possible gaps in service provision. Glasgow: Glasgow Drugs Prevention Team.

⁴⁰ Mistry E (1996): Drug use and service uptake in the Asian community. Huddersfield: Unit 51

⁴¹ Patel (2000b) 'Minority ethnic drug use: the missing minorities.' In Harbin F and Murphy-Russell J (eds): Substance Misuse Its Effects on Families and Child Protection. Lyme Regis: Russell House.

⁴² Patel K (1998): A preliminary enquiry into the nature, extent and responses to drug problems (if any) within the Asian population of Bradford. Social Work Education, vol. 8, no 1:39-41.

⁴³ Perera J, Khalifah A-R, Ahmed H (1997): Assessing the needs of Black and minority ethnic drug users: a preliminary report. Watford: Watford Drug Education Forum

⁴⁴ Ram H (2000): Asian communities project report to National Lottery Charities Board. Dudley: The Warehouse (Dudley Drug Project)

⁴⁵ Shahnaz I (1993): Drugs education and the Black community in Lothian. Report to Edinburgh and Lothian Drug Action Team. Edinburgh: Edinburgh and Lothian Drug Action Team

⁴⁶ ADP (Asian Drugs Project) (1995): Substance use: an assessment of the young Asian community in Tower Hamlets and a summary of the development work of the Asian Drug Project. London: Asian Drug Project.

⁴⁷ Patel K (1993): Minority ethnic access to services. In Harrison (ed): Race, culture and substance problems, chapter 4: 33-46. Hull: University of Hull.

⁴⁸ Sheikh N, Fountain J, Bashford J, Patel K (2001): A review of current drug service provision for Black and minority ethnic communities in Bedfordshire. Final report to Bedfordshire Drug Action Team, August 2001. Preston: Centre for Ethnicity and Health, Faculty of Health, University of Central Lancashire.

⁴⁹ Bola M, Walpole T (1997): Drugs information and communication needs amongst South Asian 11-14 year old boys. London: Home Office North West London Drugs Prevention Team.

The recruitment of community drug workers

The majority of early researchers were in agreement that the staffing of drug services should reflect their target communities^{50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60}. Khan and Ditton⁶¹ and Bentley and Hanton⁶² discussed the ethnic origin of workers with samples of drug users, non-users and drug workers. Respondents voiced concerns that, although a worker of the same cultural background as their client would understand the cultural factors surrounding their drug use, confidentiality could be compromised if they came from the same communities because of efficient 'gossip networks'. Goode⁶³ pointed out that this could be a particular problem in a small city or in rural areas.

Research has also found that while knowledge and/or experience of different cultures can have a positive impact on the capacity of workers to operate in a culturally competent way, it is also possible to be culturally competent without this and that knowledge/ experience alone is insufficient to guarantee culturally competent practice⁶⁴. Likewise, it has been pointed out that services cannot assume that matching a practitioner with a service user on the basis of ethnicity will automatically

⁵⁰ ADP (Asian Drugs Project) (1995): Substance use: an assessment of the young Asian community in Tower Hamlets and a summary of the development work of the Asian Drug Project. London: Asian Drug Project.

⁵¹ Awiah J, Butt S, Dorn N, Patel K, Pearson G (1992): Race, gender and drug services. ISDD Research Monographs, 6. London: ISDD.

⁵² Chantler K, Aslam H, Bashir C, Darrell J, Patel K, Steele C (1998): An analysis of present drug service delivery to black communities in Greater Manchester. Project report, March 1998. Manchester: Greater Manchester Drug Action Partnership (SRB and Black Drug Workers Forum (BDWF) North West.

⁵³ Chaudry MA, Sherlock K, Patel K (1997): Drugs and ethnic health project: Oldham and Tameside, 1997. A report to the West Pennine Drug Action Team. Manchester: Lifeline / Preston: University of Central Lancashire.

⁵⁴ Gilman M (1993): An overview of the main findings and implications of seven action studies into the nature of drug use in Bradford. Bradford: Home Office Drugs Prevention Team.

⁵⁵ Khan F, Ditton J (1999): Minority ethnic drug use in Glasgow. Part two: special problems experienced and possible gaps in service provision. Glasgow: Glasgow Drugs Prevention Team.

⁵⁶ Hothi A, Belton E (1999): Use of drug services in Buckinghamshire by Asian Class A drug users aged 16-25. Aylesbury: Buckinghamshire Drug Action Team.

⁵⁷ Patel K (2000b): 'Minority ethnic drug use: the missing minorities.' In Harbin F and Murphy-Russell J (eds): Substance Misuse Its Effects on Families and Child Protection. Lyme Regis: Russell House.

⁵⁸ Perera J, Khalifah A-R, Ahmed H (1997): Assessing the needs of Black and minority ethnic drug users: a preliminary report. Watford: Watford Drug Education Forum.

⁵⁹ Shahnaz I (1993): Drugs education and the Black community in Lothian. Report to Edinburgh and Lothian Drug Action Team. Edinburgh: Edinburgh and Lothian Drug Action Team

⁶⁰ Southwell M (1995): Shape up or pay up. Druglink 10(1): 13.

⁶¹ Khan F, Ditton J (1999): Minority ethnic drug use in Glasgow. Part two: special problems experienced and possible gaps in service provision. Glasgow: Glasgow Drugs Prevention Team.

⁶² Bentley C, Hanton A (1997): A study to investigate the extent to which there is a drug problem amongst young Asian people in Nottingham. How effective are drugs services in providing assistance for such minority ethnic groups? Report: ADAPT, Nottingham

⁶³ Gooden T (1999): Carers and parents of African Caribbean and Asian substance users in Nottingham: a needs analysis. Final report. Nottingham: ORCHID (Organisational Change Innovation Development) / NBI (Nottingham Black Initiative)

⁶⁴ O' Hagan K. (2001) Cultural Competence in the caring professions. Jessica Kingsley, London

create a strong therapeutic relationship, and in general the worker's sensitivity to the individual's concerns and their empathy towards the service user is far more important⁶⁵

Outreach and action research work in the community

Many early commentators stressed that outreach work is necessary to access minority ethnic drug users and those at risk of drug use^{66, 67, 68, 69, 70}. However, reduced funding has meant that many drug and alcohol services cannot support outreach projects. Patel *et al* have suggested that outreach work, can be broadly defined as combining needs assessment, awareness-raising and the development of services, with a focus on community consultation⁷¹.

An outreach project in Bradford employed outreach interventions to engage the wider Asian community⁷². The project dramatically increased the number of people from South Asian communities attending a drug service, from only a handful a year to several hundred. Patel attributed the success of the Bradford initiative to many factors, including that it was a two-year initiative, there had previously been outreach and community development work undertaken in the Asian community and there was a simultaneous development of a new drug service.

Ideally drug and alcohol services should proactively reach out to the target community ensuring that women's groups and youth groups, as well as religious leaders and faith-based organisations are informed of the substance misuse support available locally and are able to direct those experiencing drug or alcohol problems to relevant services. For example, working with religious leaders as part of its outreach work, KIKIT Pathways to Recovery has worked closely with mosques and Imams in

⁶⁵ Drug and Alcohol Findings (2000) Client-receptive treatment more important than treatment-receptive clients.

⁶⁶ Chantler K, Aslam H, Bashir C, Darrell J, Patel K, Steele C (1998): An analysis of present drug service delivery to black communities in Greater Manchester. Project report, March 1998. Manchester: Greater Manchester Drug Action Partnership (SRB and Black Drug Workers Forum (BDWF) North West.

⁶⁷ Hothi A, Belton E (1999): Use of drug services in Buckinghamshire by Asian Class A drug users aged 16-25. Aylesbury: Buckinghamshire Drug Action Team.

⁶⁸ NWLHPU / GMLCA (North West Lancashire Health Promotion Unit / Greater Manchester and Lancashire Council on Alcohol) (1997): Alcohol and drugs: a transcultural perspective. Conference report.

⁶⁹ Pearson G, Patel K (1998): Drugs, deprivation, and ethnicity: outreach among Asian drug users in a northern English city. *Journal of Drug Issues*, 28 (1):199-224.

⁷⁰ Prinjha N, Bashford J, Patel K, Sheikh N (2001a): A review of current drug service provision for the South Asian community in Bury. March 2001. Preston: Centre for Ethnicity and Health, Faculty of Health, University of Central Lancashire.

⁷¹ Patel K (2000b): 'Minority ethnic drug use: the missing minorities.' In Harbin F and Murphy-Russell J (eds): *Substance Misuse Its Effects on Families and Child Protection*. Lyme Regis: Russell House.

⁷² Patel K (2000a): 'Using qualitative research to examine the nature of drug use among minority ethnic communities in the UK.' In Fountain J (ed): *Understanding and responding to drug use: the role of qualitative research*. European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) Scientific Monograph series. Lisbon: EMCDDA.

Birmingham. They have trained Imams on safeguarding, harm reduction advice, and have established a referral pathway between the mosques and the mainstream service. Should a vulnerable individual or a family approach the mosque, the Imam is now able to contact KIKIT and arrange an appointment with a recovery coordinator.

Example - trained 'community interacters'

The Making Things Equal Project in Lancashire targets South Asian communities (particularly Pakistanis, Indians, Bangladeshi and Pathans) and is, in effect, a specialist service located within a generic drug project. The project utilises a network of trained community interacters who work within their own communities to raise the issues related to drug misuse and help those communities develop their own solutions⁷³.

Community engagement and community development approaches

A number of research studies have advocated Community Development approaches which promote community engagement and action to influence the development of drug services with a view to increasing the number of drug users from minority communities accessing them^{74, 75, 76}.

Sangster *et al*⁷⁷ suggested that a key feature of this approach is 'capacity building' which is likely to involve:

- the development of partnership services with community groups
- the establishment of satellite services
- community volunteer schemes
- training and mentoring schemes

⁷³ Sangster D, Shiner M, Sheikh N, Patel K (2002): Delivering drug services to Black and minority ethnic communities. DPAS/P16. London: Home Office Drug Prevention and Advisory Service (DPAS).

⁷⁴ Patel K, Sherlock K (1997a): Drug services and Asian drug users in England, Scotland and Wales: a report to the Lancashire Drug Action Team. Preston: University of Central Lancashire.

⁷⁵ Sheikh N, Fountain J, Bashford J, Patel K (2001): A review of current drug service provision for Black and minority ethnic communities in Bedfordshire. Final report to Bedfordshire Drug Action Team, August 2001. Preston: Centre for Ethnicity and Health, Faculty of Health, University of Central Lancashire. Influence service provision

⁷⁶ Patel K, Winters M, McDonald B (2002): Community engagement: a paper prepared for the Health Development Agency to support the development of a brief to be submitted to the Department of Health. Preston: Centre for Ethnicity and Health, Faculty of Health, University of Central Lancashire.

⁷⁷ Sangster D, Shiner M, Sheikh N, Patel K (2002): Delivering drug services to Black and minority ethnic communities. DPAS/P16. London: Home Office Drug Prevention and Advisory Service (DPAS).

- secondments from community organisations.

The need for 'collaboration' and 'partnership' have also featured in the more recent literature, suggesting a move away from initiatives in which communities are passive recipients, to those in which communities are taking an active and theoretically an equal role. The terms 'empowerment' and 'capacity building' are also recurrent terms in research recommendations, implying that communities may lack certain kinds of knowledge or skills at the outset of the initiative but can acquire more influence and power during the process.

However, it has been suggested that strategies purporting to promote 'community consultation' or 'community involvement' are likely to be perceived as useful by the community in question, but only if they form part of wider strategy to plan, develop and deliver appropriate services. Otherwise, they are likely to be perceived as tokenistic^{78, 79}.

Nonetheless, overall, the literature demonstrates the manner in which the process of capacity building in community engagement initiatives is a positive outcome for communities and can also directly benefit service providers and commissioners as they learn and gain experience working alongside community members.

Example: The implementation of an Asian in-reach programme

In South Yorkshire providers of drug services supported Asian students to volunteer on a twelve-month training programme. Individuals recruited to studentships had a dual responsibility: to undertake training and work experience with a provider organisation and to facilitate community in-reach to a target community. Their remit was to be:

- a change agent (by identifying gaps; developing innovative practice)
- a service developer (promoting joint working, education and training)
- a capacity builder in Black and Minority Ethnic communities
- an access facilitator to services; community resources; overcoming language and cultural barriers.

⁷⁸ Prinjha N, Sheikh N, Bashford J, Patel K (2001b): A review of current drug service provision for the South Asian community in Bolton. Report to Bolton Drug Action Team. June 2001. Preston: Centre for Ethnicity and Health, Faculty of Health, University of Central Lancashire

⁷⁹ Sangster D, Shiner M, Sheikh N, Patel K (2002): Delivering drug services to Black and minority ethnic communities. DPAS/P16. London: Home Office Drug Prevention and Advisory Service (DPAS).

Students were mentored by an appropriate person within the provider organisation and the community in-reach activity was coordinated and managed by a staff member who had the lead for equality and diversity in the service. This approach helped target action at the community, system and provider levels simultaneously. It built on established models developed by the Department of Health in Delivering Race Equality in Mental Health which had instituted Community Development Workers for Black and minority ethnic communities⁸⁰.

Culturally appropriate treatment and support

Research evidence suggests that certain elements of substance misuse treatment may also be more (or less) appropriate for some minority communities. For example, research in the Punjabi Sikh community in Birmingham indicated that middle aged and older men often found psychosocial talking therapies uncomfortable and the researchers proposed that existing approaches should be adapted or re-designed to meet the needs of this population. For example it has been suggested that clinical approaches and direct advice may be a more suitable way to engage with this group.⁸¹ Where talking therapies are going to be used, it has been proposed that time should be dedicated to introducing service users to this new way of working⁸².

It should be noted that a number of researchers^{83, 84, 85, 86} have found evidence that private, in-patient detoxification facilities are popular with South Asian families who pay for this because they feel that mainstream drug services either offer unacceptable treatments, cannot help or do not respond quickly enough.

⁸⁰ Wilson M (2009) Delivering Race Equality in Mental Health Care: a review. Department of Health.

⁸¹ Galvani S., Manders G., Wadd S. and Chaudhry S. (2013) Developing a Community Alcohol Support Package: An exploratory study with a Punjabi Sikh Community.

⁸² Galvani S., Manders G., Wadd S. and Chaudhry S. (2013) Developing a Community Alcohol Support Package: An exploratory study with a Punjabi Sikh Community.

⁸³ Bashford J, Patel K, Sheikh N, Winters M (2001): A review of current drug service provision for the South Asian community in Calderdale, with a particular focus on young people. Report to Healthy Living Team. February 2001. Preston: Centre for Ethnicity and Health, Faculty of Health, University of Central Lancashire.

⁸⁴ Prinjha N, Sheikh N, Bashford J, Patel K (2001b): A review of current drug service provision for the South Asian community in Bolton. Report to Bolton Drug Action Team. June 2001. Preston: Centre for Ethnicity and Health, Faculty of Health, University of Central Lancashire.

⁸⁵ Sangster D, Shiner M, Sheikh N, Patel K (2002): Delivering drug services to Black and minority ethnic communities. DPAS/P16. London: Home Office Drug Prevention and Advisory Service (DPAS). Also available on <http://www.drugs.gov.uk>

⁸⁶ Sheikh N, Fountain J, Bashford J, Patel K (2001): A review of current drug service provision for Black and minority ethnic communities in Bedfordshire. Final report to Bedfordshire Drug Action Team, August 2001. Preston: Centre for Ethnicity and Health, Faculty of Health, University of Central Lancashire

Mainstream or specialist Black and Minority Ethnic treatment services?

There has been considerable discussion as to whether specialist Black and Minority Ethnic services are better equipped to support service users from the minority communities than mainstream services.

Many researchers and practitioners have argued that specialist Black and Minority Ethnic drug services are unaffordable and also may be counter-productive for service development and service users.

It was, felt by many participants at the Recovery Partnership round table discussion in Birmingham that the two types of services work most productively alongside one another, as parts of a single larger system. For instance, a larger provider might have greater capacity and infrastructure to enhance the reach of smaller specialist services, while local, specialist services could offer an in-depth knowledge of and relationships with the community and cultural context. A key benefit of having specialist Black and Minority Ethnic services running alongside mainstream drug and alcohol services, was that both would have assets that the other can draw on to produce an overall system that is stronger as a result. In particular, it has been suggested that special services that secure initial engagement, were important and could provide a platform from which service users from minority ethnic communities could integrate more easily into the mainstream treatment system once trust has been established. An additional advantage of both types of services running alongside one another is that it enables service users to exercise choice over how they engage with treatment.

This has been the experience of mainstream services working together with a grassroots specialist Black and Minority Ethnic service in Birmingham.

[Example: Reach Out Recovery](#)

Reach Out Recovery provided by CRI is an integrated service commissioned by Birmingham City Council to offer support to anyone experiencing difficulties with drugs or alcohol in the city. CRI have sub-contracted KIKIT Pathways to Recovery to deliver a specialist, culturally sensitive service as part of the Reach Out Recovery model.

KIKIT Pathways to Recovery is a specialist Black and Minority Ethnic community-based health and social care enterprise that works with individuals, families and communities that are affected by drugs and alcohol. KIKIT projects and services are developed and designed to meet the needs of hard to reach and marginalised communities. KIKIT uses an integrated and culturally competent approach, which offers a diverse range of services designed to maximise transformative recovery and support individuals to take personal responsibility so that they may achieve freedom from addiction and become

productive individuals within their communities. As a community-based organisation KIKIT has established strong links with community groups, mosques, local charities and neighbourhood forums. It uses these local links to help service users reintegrate into their communities, which KIKIT considers an important part of recovery. KIKIT has also developed a minority ethnic recovery forum and the Muslim Recovery Network, adapting the 12 -step programme with the Islamic faith.

GP-based drug services

A number of researchers^{87, 88, 89} have reported that drug users from some communities would be more likely to approach their GP for advice, information or help than a drug service. One early piece of research⁹⁰ found that, their sample of young South Asians, reported that the main source of information about drugs was their GPs, although it was not ascertained whether this was via consultation or merely from a leaflet or poster in the surgery.

Some researchers and practitioners have advocated the development of GP-based drug services^{91, 92, 93} on the basis that GPs have the respect of some minority ethnic communities and there is no stigma attached to visiting them. GP-based drug services are suggested particularly as a method of attracting those women whose movements are restricted by their culture^{94, 95}.

⁸⁷ Chaudry MA, Sherlock K, Patel K (1997): Drugs and ethnic health project: Oldham and Tameside, 1997. A report to the West Pennine Drug Action Team. Manchester: Lifeline / Preston: University of Central Lancashire

⁸⁸ Khan F, Ditton J (1999): Minority ethnic drug use in Glasgow. Part two: special problems experienced and possible gaps in service provision. Glasgow: Glasgow Drugs Prevention Team.

⁸⁹ Patel K (2000b): 'Minority ethnic drug use: the missing minorities.' In Harbin F and Murphy-Russell J (eds): Substance Misuse Its Effects on Families and Child Protection. Lyme Regis: Russell House.

⁹⁰ Bentley C, Hanton A (1997): A study to investigate the extent to which there is a drug problem amongst young Asian people in Nottingham. How effective are drugs services in providing assistance for such minority ethnic groups? Report: ADAPT, Nottingham.

⁹¹ Chaudry MA, Sherlock K, Patel K (1997): Drugs and ethnic health project: Oldham and Tameside, 1997. A report to the West Pennine Drug Action Team. Manchester: Lifeline / Preston: University of Central Lancashire

⁹² NWLHPU / GMLCA (North West Lancashire Health Promotion Unit / Greater Manchester and Lancashire Council on Alcohol) (1997): Alcohol and drugs: a transcultural perspective. Conference report

⁹³ Patel K (2000b): 'Minority ethnic drug use: the missing minorities.' In Harbin F and Murphy-Russell J (eds): Substance Misuse Its Effects on Families and Child Protection. Lyme Regis: Russell House.

⁹⁴ Johnson MRD, Carroll M (1995): Dealing with diversity: good practice in drug prevention work with racially and culturally diverse communities. Paper 5, Drugs Prevention Initiative. London: Home Office

⁹⁵ Mistry E (1996): Drug use and service uptake in the Asian community. Huddersfield: Unit 51.

However, Sangster et al have expressed concerns about the capabilities of many GPs to deal with drug users or having the relevant information about services to signpost/ refer them on⁹⁶.

Support for the families of drug users

In a research project in Southall young people from minority communities suggested that families should be encouraged to become involved in the treatment of their members, although they recognised that this might have implications for confidentiality⁹⁷.

7.2 Discussion of findings

This section discusses some of the key findings as set out in this report.

Drug treatment population

The data indicates clearly that the population in specialist drug and alcohol treatment in Lewisham is experiencing a steady decline from some 1,945 in 2009/10 to 1,200 in 2018/19.

Analysis of the data indicates that there are consistent national, population-level factors that may affect treatment demand for opiate users. This would appear to relate to a national trend whereby young people are not using heroin to any great scale and that the opiate population is largely male and aged 35 plus, with few new entrants.

For non-opiate users the decline in the treatment population is related to wider trends across London. Therefore, treatment trends in Lewisham are part of wider changes that are taking place across London and elsewhere. Data is not available to describe what is driving the changing nature of non-opiate use across London and so any suggestions would be largely speculative.

In relation to alcohol users however more local factors seem to be more relevant with trends in the borough weakly linked to trends in London and England.

The analysis suggests that the treatment population, on current trends, will continue to decline. This would appear to be on par with national and regional trends.

⁹⁶ Sangster D, Shiner M, Sheikh N, Patel K (2002): Delivering drug services to Black and minority ethnic communities. DPAS/P16. London: Home Office Drug Prevention and Advisory Service (DPAS).

⁹⁷ Dhillon P (2001): Progress report: The Southall Community Drugs Education Project. Preston: Centre for Ethnicity and Health, Faculty of Health, University of Central Lancashire.

Profile of the treatment population

The treatment population appears to be ageing with those aged 50+ increasing from 13% (n=250) in 2009/2010 to over one-third (36%, n=425) in 2019/20. The age profile is likely to be linked to the ongoing presence of a group of users who have been engaged in treatment for 6 years and more and are therefore an ageing group of service users. This is likely to make up much of the 'core' group of users described in more detail below.

Alcohol users

Data indicates that the alcohol treatment population, while fluctuating, has held steadier than the drug treatment population.

Of those in drug treatment, the proportion of those who are severely dependent are higher than national rates (25% of men and 29% of women in Lewisham compared to 19% of men 16% of women nationally) indicating that the system works with more severe/complex clients than treatment services elsewhere in the country. As noted below, this does not appear to have impacted treatment outcomes.

The estimated penetration rate of alcohol misusers into treatment is estimated for 2016-2017 to be 13% compared to 18% nationally. Alcohol treatment rates are therefore some way off national levels. It is acknowledged however that not all of these clients will require specialist treatment and that the needs of a proportion of this population can be catered for via alternative mechanisms such as Motivational Interviews and Brief Interventions (for non-dependent drinkers).

Professional stakeholders were aware of the under-representation of alcohol users but also were aware that the treatment system would not be able to cope should significant numbers of non-engaged alcohol users seek treatment.

Treatment outcomes

The data indicates that the current treatment system in Lewisham is working effectively and delivering positive outcomes.

The majority of people in drug treatment experience a 'successful completion' of their treatment, reaching a peak of 63% in 2018-2019 at six months following treatment exist, rates of both abstinence and significant reduction were higher (i.e. better) in Lewisham across opiate, crack, cocaine and cannabis use compared to national rates meaning success in relation to both abstinence and harm reduction work.

Lewisham clients in alcohol treatment were shown to be more likely to report abstinence (61%) compared to nationally (51%) on exiting treatment. At six months existing from treatment over a fifth (21%) of alcohol clients in Lewisham reported significant reductions in use compared to 17% nationally. This is the case despite the fact that alcohol users in treatment in Lewisham appear to be more likely to be severely dependent when compared to clients in treatment elsewhere in the country.

The data therefore indicates that the current system appears to be operating well and achieving positive outcomes for the majority of clients.

Other data indicates that there have been other notable successes. 41% of clients in Lewisham in treatment received and completed a Hepatitis B course of treatment (higher than the national average).

Levels of referrals for HCV treatment in Lewisham were double to national rates.

39% of clients received naloxone and overdose training compared to 27% nationally.

Core group

While the majority of people in treatment are engaged for a period of under 1 year the data indicates a relatively large and stable cohort of people in drug treatment who have been in treatment for over six years (at 13%, n=150 as at 2018-19). This implies a cohort of people who are likely to be in treatment for an extended period of time and are likely to be in treatment for the foreseeable future.

Stakeholders, in consultation, talked about a 'core' group of heroin users who are resource heavy and are likely to stay in treatment. They were identified as a group that use, and will continue to use, the bulk of the resources devoted to specialist substance misuse provision.

Within the opiate using population it may be worth reconsidering the client pathways. If people are stable and able to function to their satisfaction on a low dose of substitute medication then should this be treated any differently to any other prescription? Indeed if recovery is a person-centred journey which allows clients to set their own goals, then for now and for the foreseeable future, these clients should perhaps be considered to have recovered on their own terms. There may then need to be different expectations and options placed in front of them that focus not on reducing their script or even leaving the service if that provokes too much anxiety, but on very gradually detaching to a different sort of service provision with minimal medical oversight but considerable aftercare support and peer activities.

For clients who are using on top of their script, services may need to be encouraged to look again at dosing. Alternatively it may be that this has to become a normal part of their pattern of treatment.

Overall the aim would need to be to reduce the workload with this group if there is to be any capacity to work with new clients or emerging trends.

Under-represented groups

The data would appear to suggest specific groups that are under-represented in the current treatment system:

Ethnicity

All minority ethnic groups are under-represented in the treatment population – both drug and alcohol treatment.

The situation appears to be most pronounced in relation to those of Asian/Asian British heritage who comprise 7.9% of the Lewisham population but only 1.4% of the drug treatment population and 5.7% of the alcohol treatment population. The qualitative data did not significantly pick up on members of the Asian community as an under-represented group but findings from the user engagement indicate that there is a need for treatment for this group and that cultural barriers exist to engagement.

LGBTQ+

The qualitative data strongly indicates that drug use is widespread in the LGBTQ+ community. LGBTQ+ service users who were consulted reported that that members of this community do not feel able or comfortable in accessing treatment services as currently configured. Additionally, it is likely that many LGBTQ+ drug users do not see their drug use as “problematic” (for instance only using occasionally/at weekends) and so would not necessarily wish to seek out treatment.

Users of other drugs

As noted above, the treatment system is largely focussed on addressing the needs of opiate users who make up over half of the current treatment population.

Prescription drugs

Rates of engagement for adults stating a POM/OTC problem were 9% in Lewisham compared to 14% nationally. Data regarding prescription drugs that have been shown to be associated with problematic use (specifically tramadol, gabapentin and pregablin) show an increase in the number of prescriptions

but it was felt that this reflected the clinical need for an ageing population. Given this, stakeholders felt that this group was likely to be under-represented.

Club drugs

The data indicates very small numbers users of any club drug who make up some 1% of the total treatment. When looked in relation to the qualitative research – particularly the engagement from representatives from the LGBTQ+ community, this is likely to be a significant under-representation of actual levels of demand.

Chemsex

While data are very hard to come by to understand the prevalence of chemsex, stakeholder consultation indicated that this was likely to be an issue. Moreover it appears to be one that not all stakeholders are familiar with – for instance one user having to explain chemsex to their GP.

Referral pathways

Self-referrals would appear to be an increasingly significant referral pathway, now making up over half of referrals. The referral data is however complicated by the fact that over a fifth (22%) of referrals are classified as 'Other'. Given this it is difficult to understand whether referral pathways are shifting to other key avenues and what they might be.

GPs

Recognising that there is a GP with a Special Interest in the borough and that shared care is in operation, the qualitative findings appear to suggest that not all GPs in the borough are aware of how to refer drug and alcohol clients into treatment.

Shift online

The online and telephone service offering, expedited by the Covid-19 pandemic, was welcomed and something representatives are keen continues, noting that this offering is more suited to certain groups of service users, and the barrier that technical capabilities can present for some.

It is important to note however that face-to-face human interaction is important for some and should be retained.

We note that DrinkCoach has been commissioned locally to address the needs of those drinking at non-dependent levels (increasing and higher risk drinkers). Service data indicates that, while there were over 400 "hits" in January. There would however appear to be scope to significantly increase use of this

service which would both help increase the online presence of services as well as tapping into the large population of people drinking alcohol at harmful levels but who do not require specialist treatment.

Homelessness and rough sleepers

The Hostel Pathway is deemed a success producing tangible benefits amongst the homeless population. It was noted however that not all the clients being supported are hostel residents and that it includes other homeless groups.

Homelessness services report working well with treatment services and that there were clear referral pathways in place, but expressed some concern that their clients often miss treatment appointments and disengage from the service. Providers of homelessness services however emphasised their willingness to collaborate closely with treatment providers in order to improve outcomes for their clients.

Service gaps

A number of service gaps appear to exist in relation to specific groups with protected characteristics:

Pregnant women

Pregnant women were highlighted as a group who could prove difficult to engage. This appears to be related in part to pregnant women not wishing to travel to treatment providers where they may be intimidated by other users. It also appears to relate to how methadone is dispensed, with women uncomfortable about consumption in pharmacies.

Sex workers

Sex workers were highlighted as a group that were difficult to engage and who required an outreach type response.

Dual diagnosis

Clients with co-morbid mental health and substance misuse issues appear to have difficulties in accessing specialist mental health provision with a number of stakeholders noting both the extent of dual diagnosis among service users as well as the inability for clients to be managed across both services.

8 Recommendations

Drawing on the data set out in this report, the following recommendations have been made:

1. Given the ongoing presence of a core group of ageing heroin users, future substance misuse provision in Lewisham will need to continue to support this significant, resource intensive group.
2. Future provision should seek to improve access and engagement with alcohol users to improve the penetration rate. Consideration should be given to increasing the presence of the online access to treatment for alcohol users provided by DrinkCoach.
3. Additional research is required looking at the substance misuse needs of black and minority ethnic communities exploring:
 - a. the prevalence of need
 - b. Differing needs in relation to drugs and alcohol
 - c. how need varies by different minority communities
 - d. how need varies by different groups within communities – for instance the differing needs of age groups, men and women and between first and second/third generation members of a community
 - e. Cultural factors that may act as a barrier to service engagement
 - f. Service models that may be appropriate – exploring the potential use of: Black and Minority Ethnic standalone provision, enhanced use of GPs, employing outreach workers, utilising community development approaches and offering a range of culturally appropriate options that recognise that some models of engagement do not meet the needs of some communities

Research should be delivered in community languages and by culturally competent researchers to ensure access to the community. Such research should seek to get beyond key community “gatekeepers” and into the community to understand the needs of all groups.

4. While the exact nature of the drug and alcohol offer should await the findings of the research (described above) future provision should, at a minimum, include the following elements:
 - a. Accurate recording of the ethnicity of all clients
 - b. Use of a culturally competent workforce
 - c. Providing information in a range of community languages

- d. Publicising services through community channels and in culturally sensitive ways
- e. Emphasising the confidentiality of service provision
5. Commissioners should hold discussions with key LGBTQ+ stakeholder organisations (such as Metro) to develop strategies to make substance misuse provision more LGBTQ+ friendly.
6. Service providers should undertake diversity awareness training to understand issues in relation to the LGBTQ+ community and how to better promote their service to members of this community.
7. Generic service provider promotional literature should explicitly reference that services welcome members of the LGBTQ+ community.
8. Service providers should work with local LGBTQ+ charities to develop marketing material that are specific to this community.
9. An awareness raising and training package should be commissioned to carry out targeted training for local professionals (particularly GPs) to promote awareness of LGBTQ+, chemsex and the treatment options (both sexual health and substance misuse) that can be offered to members of this community.
10. Analysis should be carried out to understand the fifth of drug treatment clients who are referred through "Other" sources to understand whether significant new pathways exist that need to be better resourced or understood.
11. GPs in Lewisham not engaged in shared care should receive training to make them aware of the range of treatment options available through substance misuse services in the borough.
12. Future treatment provision should offer online and telephone access as a core element of service provision giving clients the option of virtual or physical engagement.
13. Commissioners should consider increased investment in online early intervention support for non-dependent alcohol users. The additional investment should be for a time-limited period (for instance six months) after which time the impact of the additional investment should be reviewed (for instance comparing "hit" rates before and after). This should inform the level of funding for the service on an ongoing basis.
14. Consideration should be given to promoting a virtual offer among under-represented and vulnerable groups including black and minority ethnic and LGBTQ+ communities and pregnant women.
15. Consideration should be given to providing more flexibility in the treatment service by offering a non-abstinence pathway. This should then be targeted at groups most likely to engage, including the LGBTQ+ community.

16. Building on the work of the Hostel Pathway substance misuse and homelessness services should develop joint working/case management protocols to enable services to work collaboratively when managing homeless clients.
17. Building on the work of the Hostel Pathway Treatment service providers should develop data sharing agreements with local homelessness services. This would enable homelessness services to be alerted if clients they have referred fail to attend an appointment.
18. Consideration should be given to building on the work of the Hostel Pathway by commissioning outreach work targeted at the homeless population to promote engagement with treatment services.
19. Treatment services should pilot individualised care plans that would allow pregnant drug-using women to store a short supply of methadone at home rather than requiring them to consume at a pharmacist. The pilot should be monitored to determine whether this improves engagement with pregnant women as well as whether methadone is being used safely. The findings of the pilot should then inform the subsequent roll-out of this approach.
20. Consideration should be given to offering home visits to pregnant clients.
21. Discussions should take place between representatives from Lewisham Council and the Metropolitan Police South East Basic Command Unit (which covers the borough) to understand the significant drop in referrals from police custody (as evidenced at Table 38, Section 4.4), specifically exploring whether this: is related to an overall drop in drug-related offences, is related to a reduction in drug testing or is due to a drop in referrals being made.

Appendix 1: Poisson regression modelling

The relationship of these prognostics to the three primary outcomes was examined using a Poisson regression model that tested the relationship that each measure has (to each of the three outcomes) when weighted to all the other variables. All of these prognostics were used, therefore, as predictors of the drug-related outcome measurements, all expressed as percentages or rates. There were no missing values.

An initial exploratory stage was undertaken to examine the relationship across the variables. A number of results spanned a range so restricted that they that did not comprise one unit. As regression coefficients quantify the change in outcome for one or more units of the prognostics, this causes the respective estimates to cover a wide range, which would be unsuitable for a direct, practical interpretation. This initial exploratory phase also tested for multicollinearity (the extent to which a prognostic is related to the other variable). The prognostic 'socioeconomic deprivation overall IMD (index of multiple deprivation) score' is very strongly correlated (e.g. linearly related) to four other variables (socioeconomic deprivation of people living in the 20% most deprived areas, unemployment, child poverty and violent crime). This may be expected, as this deprivation score is an index that aggregates other indices into a single number.

If this measure were included in a regression exercise, its selection would make the interpretation of its effect difficult, as this index is directionless – that is, it has no measurement unit that would lend itself to immediate interpretation, whereas its individual components do (as a percentage or rate). Therefore, the only the overall measure of deprivation was included in the selection process. A Poisson regression model was fitted for each of the three outcomes. A prognostic was declared 'statistically significant' if its p-value ≤ 0.05 (e.g. working at 5% significance). A backward stepwise selection model was used for including prognostics. The output is presented as the 'incidence rate ratio' (IRR). An IRR of more than one quantifies an estimated relative increase in the rate outcome for an increase of one unit in the predictive prognostic and can be interpreted as follows: an IRR of 1.01 quantifies a relative increase of 1%; an IRR of 1.05 quantifies a relative increase of 5%; and an IRR of 1.1 quantifies a relative increase of 10%. Conversely, an IRR of less than one quantifies an estimated relative decrease in the rate outcome of one unit in the predictive prognostic. It is interpreted as follows: an IRR of 0.99 quantifies a relative decrease of 1%; an IRR of 0.95 quantifies a relative decrease of 5%; and an IRR of 0.9 quantifies a relative decrease of 10%.

Appendix 2: Positive drug tests multivariate modelling

To obtain a binary outcome, the test results were dichotomised (by opiates and cocaine v others, cocaine-only v others, opiates-only v others). The resulting binary outcomes relationship were modelled with gender, year, gender by year as fixed effects and borough as a random effect. In other words, a Generalised Linear Mixed Model (GLMM) was created accounting for the (unobserved) clustering effect of borough.

The GLMM model suggests that males are significantly more likely to test positive for both opiates and cocaine and for cocaine-only, but there is a non-significant gender difference for opiate-only positive testers. Positive cocaine tests in our GLMM increases significantly between 2015 and 2016, and between 2016 and 2017. In contrast, positive tests for opiates reduced significantly between 2015 and 2016, and between 2016 and 2017.



JSNA FOR SUBSTANCE MISUSE (YOUNG PEOPLE) FOR LEWISHAM COUNCIL

The Centre for Public Innovation

June 2021

The Centre for Public Innovation is a Community Interest Company that provides research, training, support and advice in the fields of health, social care, criminal justice and community development.

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Glossary

CAMHS	Child and Adolescent Mental Health Services
HRBQ	Health Related Behaviour Questionnaire
MASH	Multi Agency Safeguarding Hub
NDTMS	National Drug Treatment Monitoring System
NEET	Not in education, employment or training
PHE	Public Health England
SHEU	Schools Health Education Unit
YOS	Youth Offending Service

1 Executive summary

Background

This Joint Strategic Needs Assessment explores children and young people's substance misuse in Lewisham. A separate JSNA reports on substance misuse in relation to the adult population. For the purpose of this report, young people are designated as those aged up to 24 years of age.

The JSNA seeks to:

- Give a better understanding of the needs of those who misuse substances and those who are at greater risk of misusing substances,
- Inform the development and re-commissioning of Lewisham's substance misuse services,
- Inform the development of a local strategic response to reducing the harm caused by substance misuse for 2022 and beyond.

The JSNA draws on range of qualitative and quantitative data.

Key findings

The most significant finding in this needs assessment is the size of the treatment population compared to estimated levels of demand. Data for 2019-2020 indicates 82 young people under 18 in treatment and a further 25 aged 18 to 24 years giving a total of 107 in community treatment. While trying to build a picture of how many young people would benefit from drug or alcohol treatment is difficult, the prevalence rates set out in this report for alcohol and drug consumption indicates that the numbers of young people who would benefit from treatment are far in excess of the current figure of 107.

This report identifies that cannabis use is a significant issue among young people in Lewisham and this is reflected in the treatment population where 91% of the treatment population use cannabis. Class A drug use is negligible in the treatment population and levels of use are very low among young people in the community as a whole.

Looking at drug and alcohol consumption among young people more generally in Lewisham, data from an ONS survey indicate that over a third (38%) of young people had been offered drugs at some point,

which for Lewisham gives around 6,000 young people having been offered drugs. In relation to alcohol consumption, data from a separate survey indicates that 10% of young people (school years 7 to 11) report having had an alcohol drink in the last seven days. When applied to the population for Lewisham, this gives a total of over 6,000 young people. In the same survey, 6% of young people report drinking alcohol at least once a week, giving a number of just under 1,000 when applied to Lewisham.

While the majority of local young people do not use drugs and alcohol, the data makes clear that they often have a peer who does. Strikingly, by the age of 9, 11% of boys know someone who takes drugs. By the age of 15 exactly a third of young men and women know a person who takes drugs. This makes clear that drug use is a common part of many young people's lives.

The data makes clear that a number of cohorts of young people in Lewisham are particularly vulnerable to substance misuse. These vulnerable groups include young offenders and young people who have a parent/carer in treatment for drug or alcohol misuse.

There is some indication that young people are moving to drugs which are relatively novel in terms of the treatment population. Young people interviewed for the needs assessment referred to the use of "Lean" (meaning prescription cough medicine) and "forget-me-not" (which refers to Rohypnol). It is not possible to quantify the extent to which these drugs are being used and whether they are being used in combination with other drugs (particularly cannabis and alcohol). It however makes clear that drug use is constantly shifting and young people are migrating towards the use of novel substances. While there appears to be an evolution in drug use 91% of those in treatment are being supported for cannabis use (with 20% in treatment using two or more substances).

Summary of recommendations:

1. Given the very low numbers of young people currently receiving treatment, numbers of young people entering treatment should be enhanced to better align with the demand for treatment. Improvements should be made to referral pathways into the treatment service.
2. The data regarding substance misuse education gives some cause for concern insofar as it is not possible to state with any confidence how many young people (if any) have received drug awareness messages. Given this commissioners should ensure that a universal substance misuse education programme is available and offered to young people in the borough through schools and other young people's services.

3. The universal education programme (above) should develop strong links to the Improving Health and Wellbeing in Schools drug and alcohol offer to better support in-depth, specialist and targeted education work to be carried out which complements the universal offer.
4. Commissioners should incorporate family-based treatment into the young people's treatment offer, meaning that works young people are supported in the context of their family. The specialist treatment offer for young people should therefore be accompanied, as far as possible, by group work with the family to build skills and capacity in the wider family.
5. Commissioners should consider shifting how treatment services are currently delivered towards intensive multi-disciplinary work in which substance misuse workers are co-located alongside colleagues in Early Help, and social work teams rather than being based primarily in a drug and alcohol treatment specialist services and buildings.
6. Commissioners should consider investing in brief intervention and other low intensity interventions (such as motivational interviewing) to support young people who use drugs and alcohol but where usage does not warrant engagement with specialist treatment.
7. Commissioners should consider the feasibility of developing a peer-led awareness led by and delivered by young people – ideally including those with some lived experience of substance misuse.

2 Introduction

This Joint Strategic Needs Assessment explores young people's substance misuse in Lewisham. For the purpose of this report, young people are designated as those aged up to 24 years of age (an age which aligns with both the scope of the current young people's service and national reporting standards on drug and alcohol treatment).

The JSNA seeks to:

- Give a better understanding of the needs of those who misuse substances and those who are at greater risk of misusing substances,
- Inform the development and re-commissioning of Lewisham's substance misuse services,
- Inform the development of a local strategic response to reducing the harm caused by substance misuse for 2022 and beyond.

The JSNA uses a range of qualitative and quantitative research approaches (as outlined in Section 3) to develop an in-depth understanding of substance misuse. Particular attention has been paid to the needs of specific groups with protected characteristics to understand substance misuse issues in relation to these communities. Finally the JSNA seeks to map out future trends.

Note that this report addresses children and young people. The needs of the adult population are explored in a separate report, JSNA for Substance Misuse (Adults) for Lewisham Council (2021).

3 Service review methodology

The JSNA adopted a mixture of both qualitative and quantitative research techniques. Details of each are set out below.

3.1 Quantitative data analysis

The review analyzed data from a number of sources. For drug treatment statistics, two complementary sources were used: National Drug Treatment Monitoring System (NDTMS) and Public Health England “Commissioning Support Packs”. Some additional data was also obtained from the current service provider and from the London Borough of Lewisham.

In relation to some of the data used in this report, there are differences in how data from NDTMS are presented. For example, data presented online may differ slightly (e.g. variable categorizations) from that used in the data packs. The differences include using ‘all’ people in treatment or alternatively ‘new’ people in treatment. Differences in approach will be detailed in the text.

Other datasets include use of exogenous data (e.g. socio-demographic indices of the local population) were accessed from two sources: London Datastore (<https://data.london.gov.uk/>) and from PHE (<https://fingertips.phe.org.uk/>).

3.2 Professional stakeholder consultation

A range of professional stakeholders were consulted to explore their understanding and views in relation to young people and substance misuse in Lewisham.

Professional stakeholders

The following professionals involved in the delivery of specialist treatment and associated services were interviewed:

- Service Manager - Humankind
- Services Manager – CGL, New Direction service
- GP with special interest
- Head of Looked After Children – Lewisham Council

- Public Health Training and Development Manager – Lewisham Council
- First Response, Referral & Assessment Team, Children’s Social Services – Lewisham Council
- Service Manager, Compass
- Inspector, SE Safer Neighbourhoods - Metropolitan Police Service
- Commissioning Officer (Addictions) Prevention, Inclusion & Public Health Commissioning Team – Lewisham Council
- Public Health Commissioning Manager – Lewisham Council
- Joint Commissioner 0 - 19 Health and Maternity - Lewisham Council

Issues in relation to children and young people were explicitly explored with the stakeholders listed above.

In addition a member of the research team attended Corporate Parenting Management Meeting managers meeting for round table discussion about Substance Misuse services and need.

Community representatives and third sector stakeholders

In-depth telephone interviews were undertaken with representatives from organisations that deliver services to children and young people in Lewisham. Interviews took place between October and December 2020 representing:

- CAMHS
- Fulfilling Lives

3.3 Consultation with young people

Two online focus groups were undertaken with young people in groups that are known to be vulnerable in relation to substance misuse: Looked After Children and those Not in Education, Employment or Training. The focus groups aimed to explore attitudes, understanding and general views regarding drugs and alcohol among young people. The groups were arranged by relevant service providers and the consultation undertaken by a CPI researcher.

- Care leavers – two participants
 - Two males, aged 20 and 25
- NEET group – seven participants
 - Five male, two female. Two aged 17, two aged 18, two aged 19

In addition to the focus groups one telephone interview was undertaken with a male service user aged 22, who is Black British and one young male (aged 17) currently being supported by the YOS.

4 Quantitative findings

4.1 Treatment population

This sections sets out data regarding numbers of young people in treatment for drug and alcohol misuse with analysis of a range of key variables.

4.1.1. Accessing treatment

Table 1 below shows the size of the young people's treatment population over recent years and the proportion of young people in treatment:

- Under 18
- Between 18 and 24 years
- Under 18 within the secure estate

Data for Lewisham is set against national figures.

Table 1 Number and Rate per 100,000 population, treatment engagement levels Lewisham compared to National (England) estimates

	Indicator	2014-2015		2015-2016		2016-2017		2017-2018		2018-2019		2019-2020	
		No	Rate per 100,000										
Lewisham	Number of young people (aged under 18) in specialist services in the community	199	806.8	105	425.7	92	373.0	58	235.1	60	243.2	82	332.4
	Number of young adults (aged 18-24) in young people's specialist services in the community	71	273.4	107	412.0	123	473.6	39	150.2	15	57.8	25	96.3
	Number of young people (aged under 18) in specialist services within the secure estate	16	64.9	12	48.6	10	40.5	23	93.2	16	64.9	13	52.7
National	Number of young people (aged under 18) in specialist services in the community					16902	345.9	15952	326.5	14831	303.6	14291	292.5
	Number of young adults (aged 18-24) in young people's specialist services in the community					3334	67.8	3308	67.2	3391	68.9	3130	63.6
	Number of young people (aged under 18) in specialist services within the secure estate					1262	25.8	1289	26.4	1221	25.0	1186	24.3

(Estimated Resident Population Mid-Year by single year of age 2015 estimates)

<http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-uk--england-and-wales--scotland-and-northern-ireland/index.html>

Note the change in total number of young people being treated in Lewisham over the period of time set out in Table 1:

- 2015 – 16: 224 young people
- 2016 – 17: 225 young people

- 2017 – 18: 120 young people
- 2018 – 2019: 91 young people
- 2019 – 2020: 120 young people

The data does not indicate exactly why there was a decrease in numbers as of 2018 however we note that the timeframe aligns with both budget cuts to young people's services as well as the commencement of the delivery of services under the current provider (Compass).

Under 18s

The number (and rate per 100,000 population) for young people aged under 18 in treatment in Lewisham (as shown in Table 1) fell from a high of 199 (or 806.8 per 100,000 population) in 2014-2015. Numbers decreased in Lewisham until 2017-2018 from which the levels have steadily increased again. Note that, while there was also a decrease in numbers nationally, the rate of decline was more pronounced in Lewisham (a drop of 46% in Lewisham since 2015 compared to 15% nationally)

As shown at Table 1 the rate of young people's engagement in treatment per 100,000 of population in 2019-2020 is now slightly higher (332.4 per 100,000) than national levels (292.5). Additional analysis indicates that there is a moderate relationship between changes in the rate per 100,000 population in Lewisham with national rates ($r=0.30$) – that is, that trends that are driving young people's treatment rates across England are also playing a part in the size of the treatment population in the borough.

18 – 24 years

The number of young people aged 18-24 years in treatment (and the rate per 100,000 of population) decreased from a peak of 123 in 2016-17 (rate 473.6 per 100,000) to 25 in 2019-20 (96.3 per 100,000).

While the decline is pronounced, the rate in 2019-2020 is higher (96.3) compared to national figures (63.6) and increased from 2018-2019. As per the figures for the under 18 population, there is also a moderate correlation with national figures comparing changes over time ($r=0.21$).

The rate of young people from Lewisham residing within the secure estate is consistently higher than national estimates over the period 2016-2017 to 2019-2020.

Proportionally, there were fewer young people aged under 18 years accessing community services in Lewisham compared to national comparisons. For instance, in 2019-20 68.3% of the treatment population in Lewisham was under 18 compared to 76.8% nationally.

Proportionally, a higher proportion of younger people aged 18-24 access services in Lewisham (between 32.5-54.7%) compared to national figures for 2017-18 (16.4%). The data therefore suggests that the treatment population in young people is somewhat skewed towards “older” young people – i.e. those aged 18 to 24 years. It is not clear whether this “bias” reflects actual need in the community or how current services are configured – for instance whether the treatment system in the borough is more focused on or better able to engage those aged 18 and over.

The data at Table 1 indicates a marked jump of young people with a substance misuse need identified within the secure estate (that is Young Offender Institutions such as Feltham) provision reaching 19.2% in 2017-18. This compares to a figure of 6.4% nationally.

Statistics from NDTMS suggest that no young people (0%) were picked up from release from a secure estate to access treatment compared to 9% nationally (in 2017-18). This would tend to suggest issues in relation to pathways from secure facilities into specialist services in the community.

4.1.2 Length of time in services

Table 2 sets out the length of time young people spent in treatment.

Table 2 The length of time in services, interventions received and planned exits, Lewisham compared to England, 2016-2017 to 2019-2020

	2016-2017		2017-2018		2018-2019		2019-2020	
	Lewisham	National	Lewisham	National	Lewisham	National	Lewisham	National
Length of time in services								
0-12 weeks	33	42	43	43	52	44	45	42
13-26 weeks	27	31	33	32	30	32	38	32
27-52 weeks	25	19	19	18	15	18	11	19
>52 weeks	15	7	5	7	3	7	6	6
Interventions								
Pharmacological Only	0	0	0	0	0	0	0	0
Psychosocial (PSI) Only	100%	98%	100%	98%	100%	99%	100%	98%
Pharmacological + PSI	0	0	0	0	0	0	0	0

Other interventions	0	0	0	0	0	0	0	0
No named interventions	0	1%	0	1%	0	1%	0	0%
Planned Exits								
Leaving in a planned way	56	81	53	80	33	80	73	85
Leaving in a planned way who re-present within 6 months	3	5	4	5	6	5	0	4

For length in service, there have been some changes over the time period set out in Table 2.

Since 2018-2019, young people were more likely to be in treatment for less than 13 weeks compared to national figures: this trend is noticeable from 2017-2018 for young people retained for between 13-26 weeks.

Note that the offer to young people has almost entirely been psychosocial (100% in 2019-2020). This is to be expected given the near absence of heroin users who would require a pharmacological response (albeit that the qualitative data – see Section 5.3 indicates a possible issue regarding the use of cough medicines that contain codeine – a weak opioid).

In 2019-2020 no young person who was discharged from treatment re-presented within six months (compared to 4% in England).

4.1.3 Profile of people in substance misuse treatment

Substance misuse need

Table 3 sets out the treatment population for Lewisham by substance.

Table 3 The percentage of young people using selected substances, Lewisham compared to England, 2016-2017 to 2019-2020

25 years and under	2016-2017		2017-2018		2018-2019		2019-2020	
	Lewisham	Nat'l	Lewisham	Nat'l	Lewisham	Nat'l	Lewisham	Nat'l
Heroin and/or crack	8	2	4	3	3	3	0	2
Stimulants (cocaine, ecstasy, amphetamines, not crack)*	20	22	15	24	3	24	6	25
Cannabis	87	86	91	86	92	85	91	86
Alcohol	39	50	36	48	43	46	48	44
Novel psychoactive substances**	<1	4	0	2	0	1	-	-

Tobacco	10	16	9	16	35	16	23	14
'Other' drug	5	7	8	9	5	11	8	14

*Changes were made in reporting categories for stimulants in 2019-2020; **NPS was no longer reported in 2019-2020;

The majority of young people in Lewisham have been reported to treatment using cannabis and or alcohol as their main substance. Cannabis is reported at higher rates than England over the four-year period.

Data regarding the drugs used by those in treatment may be read in a number of ways: it is possible that cannabis use, almost ubiquitous among young people in treatment in Lewisham, is the main drug of choice among young people; it may however be the case that the current system is more focused on cannabis users or is better able to engage cannabis users than those who consume other drugs. The qualitative data (see Section 5) does indicate very widespread use of cannabis among young people but also suggests that this is not the sole drug being used. Consideration may therefore be required to determine whether the current system is configured in such a way as to have the unintended consequence of largely working with users of cannabis over those who use other drugs.

Note that nearly half of young people report alcohol use (48% in Lewisham compared to 44% in England).

The data at Table 3 indicates that young people in Lewisham report use of stimulants at a level that is more than four times lower than that of their counterparts in England (6% in 2019-2020 compared to 25% in England). This may be a function of actual levels of stimulant use among young people or the fact (discussed above) that the system has potentially been configured in such a way that it is better at engaging cannabis users rather than users of other drugs (including stimulants).

The levels of tobacco use amongst Lewisham young people has been reported as higher from 2018-2019 compared to national figures and currently stands at just under a quarter (23%).

Note the complete absence of young people using heroin and/or crack. This has some implications for future adult substance misuse treatment (explored in a separate report) which indicates a significant proportion of adults in treatment using these drugs. The data for young people would tend to indicate that, up until the age of 24 (i.e. for the age period for which young people's data is collected) there are no heroin or crack users who may go on to need support in the adult treatment system. As noted earlier the point is worth reiterating that this may be more a function of how the current system is configured rather than actual need. As also noted above, there is some evidence that young people are using other

opiates (codeine) which may require the kind of pharmacological response associated with heroin use and therefore that there is a level of unmet need among young people.

Data on the primary drug used by those in treatment was also provided by the current provider and is set out below at Table 4.

Table 4 Primary drug used, 2020-2021

Substance	Number	%
Alcohol	0	0.0
Cannabis	48	85.7
Cocaine	0	0.0
Ketamine	0	0.0
MDMA	0	0.0
Other	8	14.2
Prescription	0	0.0
None	0	0.0

Source: Compass

The data on primary drug indicates that nearly all (85.7%) young people used cannabis. NO further breakdown was available on the Other category who make up the remaining 14%.

Table 5 sets out a number of key substance specific vulnerabilities among young people in treatment.

Table 5 Substance specific vulnerabilities, Lewisham compared to England, 2016-2017 to 2019-2020

% of YP with each risk/vulnerability item	2016-2017		2017-2018		2018-2019		2019-2020	
	Lewisham	National	Lewisham	National	Lewisham	National	Lewisham	National
Substance-Specific vulnerabilities								
Opiate and/or crack user	2	2	2	2	2	3	1	1
High risk alcohol users	2	3	2	3	5	3	2	1
Using 2+ substances	25	60	24	58	52	57	20	21
Began using main problem substance under 15	61	84	58	77	59	77	29	28
Current or previous injector	0	1	0	1	0	1	0	0

The level of Lewisham young people who use opiates and/or crack and who are high-risk alcohol misusers are broadly similar with national estimates. Wide disparities in the percentage of Lewisham young people using two or more substances until 2018-2019 suggesting the possibility of data recording issues. A similar issue was noted with young people reported as starting their main problem substance under 15 which from 2019-2020 is similar to national totals (29% in Lewisham compared to 28% nationally).

Table 5 indicates that in 2019-20 a fifth (20%) of young people were using two or more substances (predominantly cannabis and another drug). Note also that, while this underpins the finding at Table 3 (above) about the centrality of cannabis use, it also indicates widespread use of other drugs in addition to cannabis (albeit that the data does not indicate what the other drugs used might be).

Demographic profile

Demographic data regarding the profile of young people is set out below.

AGE

The age of young people in specialist treatment is set out below at Table 6.

Table 6 Age of treatment population, 2020-2021

Age	Number	%
10	0	0.0
11	0	0.0

12	0	0.0
13	2	3.5
14	3	5.3
15	3	5.3
16	12	21.4
17	15	26.7
18	17	30.3
19	2	3.5
20	1	1.7
21	1	1.7
22	0	0.0
23	0	0.0
24	0	0.0
25	0	0.0

Source: Compass

Note that over half (57%) of young people in treatment are aged 17 or 18 years and over three quarters (78.4%) between 16 and 18 years. The numbers of young people aged 16 and under (43%) in treatment would tend to suggest the need for early intervention and preventative work to engage with young people upstream (i.e. before the need to engage with specialist services).

GENDER

Data regarding the gender profile of those in treatment is set out at Table 7.

Table 7 Gender of treatment population, 2020-2021

Gender	Number	%
Female	19	33.9
Indeterminate	0	0.0

Male	36	64.2
Not specified	1	1.7
Trans	0	0.0

Source: Compass

Data indicates a predominance of male clients (64.2%) compared to female clients (33.9).

Table 8 below explores key data in relation to the gender of those in treatment.

Table 8 The percentage of females and males by risk factor, Lewisham compared to England, 2016-2017 to 2019-2020

	2016-2017		2017-2018		2018-2019		2019-2020	
	Lewisham	Nat'l	Lewisham	Nat'l	Lewisham	Nat'l	Lewisham	Nat'l
Females								
Total in Treatment	26	34	38	34	32	34	44	33
Affected by domestic abuse	23	28	6	25	25	27	22	44
Mental health treatment need	23	24	0	37	0	42	40	44
Affected by sexual exploitation	15	14	0	13	17	11	100	80
Self-Harm	8	31	6	28	17	29	80	61
NEET	15	13	33	13	17	12	50	24
Offending/ASB	8	19	11	20	0	18	38	19
Alcohol as problem	46	64	41	62	74	59	57	43
Cannabis as problem	92	80	86	80	79	80	44	31
Aged <=15	21	55	32	57	32	58	70	36
Males								
Total in Treatment	74	66	62	66	68	66	56	67

Affected by domestic abuse	0	18	7	16	13	17	78	56
Mental health treatment need	0	15	0	22	0	28	60	56
Affected by sexual exploitation	0	2	0	1	0	1	0	20
Self-Harm	7	9	11	8	3	11	20	39
NEET	18	18	41	18	22	17	50	76
Offending/ASB	30	39	44	38	25	37	63	81
Alcohol as problem	19	43	14	40	32	38	43	57
Cannabis as problem	99	92	100	93	98	92	56	69
Aged <=15	34	48	31	50	34	51	30	64

For Lewisham, there has been an overall increase in the percentage of females in treatment from 26% in 2016-2017 to 44% in 2019-2020 (which is not mirrored in national figures which have remained relatively constant at about one-third (33%) of the overall treatment population). It is not clear whether this is related to increasing levels of need among females in Lewisham or whether the local treatment service has targeted or is otherwise better at engaging young women.

The data for female clients indicates that, across a number of domains, young women in Lewisham present with higher risk factors than their peers nationally: for instance all (100%) young women in treatment in Lewisham are flagged as at risk of sexual exploitation compared to 80% nationally, 80% in Lewisham report self-harm compared to 61% nationally, and half (50%) are NEET compared to 24% nationally.

There are notable fluctuations over the four-year period in the percentages reported across most other categories. This may be a function of relatively small numbers in each categories and enhanced data reporting issues. Caution is advised in further gender differences over time for this reason.

ETHNICITY

Data regarding the ethnicity of the treatment population is set out below at Table 9 and compared to the population of Lewisham as a whole and the school age population.

Table 9 Ethnicity of treatment population, 2020-2021

Ethnicity	Number in treatment	% of treatment population	Lewisham population %	Lewisham –
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				Ethnicity of primary and secondary school pupils
Black African	11	19.6	11.6	15.2
Bangladeshi	1	1.7	0.5	0.7
Black Caribbean	8	14.2	9.6	10.7
Other	3	5.3	5.9	4.9
Black Other	0	0.0	4.8	6.7
Mixed Other	1	1.7	2.2	6.3
White Other	2	3.5	12.9	11.4
White and Asian	2	3.5	1.3	2.1
White and Black African	4	7.1	1.6	2.7
White and Black Caribbean	4	7.1	3.3	5.5
White British	20	35.7	37.0	24.8
Pakistani	0	0	0.7	0.8
White Irish	0	0	1.8	0.4
Indian	0	0	1.8	1.1
Other Asian	0	0	4.9	3.7

Source: Compass; Population data from Lewisham Observatory <https://www.observatory.lewisham.gov.uk/population/>

The data at Table 9 indicates that the largest single cohort of clients were White British (making up 35.7% of those in treatment) followed by those of Black African heritage (19.6%).

Note that those of White British, Black African and Black Caribbean origin are over-represented compared to the school population.

Data from the Greater London Authority indicates that, as of 2015, 34.9% of the population were born outside the UK and that, as of 2016, 47.4% of the population were from Black or Minority Ethnic communities indicating that the profile of the population is likely to evolve significantly over time.

¹ <https://data.london.gov.uk/dataset/percentage-pupils-ethnic-group-borough>, Data for 2019, data does not include 3% of young people who are "unclassified".

Other vulnerabilities

Table 10 sets out a range of other vulnerability factors for young people in treatment.

Table 10 The percentage of young people with vulnerabilities, Lewisham compared to England, 2016-2017 to 2019-2020

% of YP with each risk/vulnerability item	2016-2017		2017-2018		2018-2019		2019-2020	
	Lewisham	National	Lewisham	National	Lewisham	National	Lewisham	National
Wider vulnerabilities								
LAC	4	12	0	11	5	10	1	4
Child in Need	0	7	2	9	2	10	6	4
Affected by domestic abuse	5	21	7	19	16	21	6	8
With a mental health treatment need	5	18	0	27	0	33	3	13
Sexual Exploitation	4	6	0	5	5	4	1	1
Self-Harm	7	16	9	14	7	17	7	6
NEET	18	16	38	16	20	15	7	6
NFA/unsettled housing	2	1	2	1	0	1	0	0
Offending/ASB	25	32	31	32	18	30	16	12
Pregnant/Parent	4	2	0	2	0	2	0	1
Child Protection Plan	0	8	2	8	5	8	2	3
Affected by others' substance misuse	2	23	0	22	11	23	7	8

Over the four-year period set out in Table 10, Lewisham reports lower levels across a number of vulnerability factors compared to national rates for:

- LAC,
- being a child in need (until 2019-2020),
- affected by domestic abuse (at least until 2019-2020 when the rates are broadly comparable [6% in Lewisham compared to 8% in England]),

- with a mental health treatment need,
- self-harm (at least until 2019-2020 when the rates are broadly comparable [7% in Lewisham compared to 6% in England]),
- with a child protection plan, and
- being affected by others' substance misuse (at least until 2019-2020 when the rates are broadly comparable [7% in Lewisham compared to 8% in England]).

By way of contrast, Lewisham residents were more likely to report being NEET and there was some variability in difference for offending/ASB; levels of pregnancy comparing Lewisham to England totals over this period.

Note that the data indicates much closer proximity between the rates in Lewisham and national rates for the most recent reporting period (2019-2020) indicating that the vulnerability of young people in the borough is now much closer to that as seen elsewhere in England.

Co-morbidities

Data on co-morbidities is set at Table 11.

Table 11 Co-occurring substance misuse and mental health issues

% of YP with each risk/vulnerability item	2016-2017		2017-2018		2018-2019		2019-2020	
	Lewisham	National	Lewisham	National	Lewisham	National	Lewisham	National
Co-occurring substance misuse and mental health issues								
Identified as having a mental health treatment need	-	-	0	27	0	33	6	37
Receiving treatment for their mental health need(s)	-	-	0	69	0	70	60	68

Comparing levels of dual diagnosis, where a young person has a reported co-occurring mental health and substance misuse need, there is a notable difference in reporting:

- 6% of Lewisham residents had been identified as having a mental health treatment need in 2019-2020 compared to 37% in England,
- 60% of young people in Lewisham were reported to be in receipt of treatment for their mental health needs compared to 68% nationally.

The sudden large increase in the last metric suggests the possibility of either improved data recording and/or changes in operational practices that may account for this discrepancy.

Multi-agency Safeguarding Hub

Data from the Multi Agency Safeguarding Hub (MASH) for 2018-19 show that 195 young people aged under 18 years were in contact with Lewisham multi-agency partnerships with 51% referred (n=99).

4.1.4 Referrals

Data regarding referrals into treatment are set out at Table 12.

Table 12 Continuity of care from secure estate release to community treatment

	2016-2017	2017-2018	2018-2019	2019-2020
Number of young people referred to treatment on release from secure estates	1	1	137	209
Number of young people picked up by a community service within 3 weeks of release	0	0	12	8
% of young people picked up within 3 weeks of release				
- Lewisham	0%	0%	9%	4%
- National	14%	9%	4%	4%

The number of young people referred to treatment on release from secure estates has risen from one person in 2016-2017 to 209 in 2019-2020. There has been an increase in the number of young people picked up (i.e. who engaged with adult or young people’s treatment services) within three weeks of release such that the proportion in 2019-2020 are comparable (4%) with national figures (4%).

Note that continuity of care (i.e. continuation of treatment from the secure estate into community services) is recognized nationally as an issue of concern – both in terms of how the data is collected and the actual numbers successfully transitioning into the community. The issue is being addressed in London by Public Health England who are developing protocols and pathways for the prisons serving the London population. This is likely to improve both the recording of data and the number of people who continue their treatment in the community post release.

Table 13 Source of referral into treatment, Lewisham compared to England, 2016-2017 to 2019-2020 (percentages)

	2016-2017		2017-2018		2018-2019		2019-2020	
	Lewisham	Nat'l	Lewisham	Nat'l	Lewisham	Nat'l	Lewisham	Nat'l
Education	13	14	10	31	11	32	20	33
Youth Justice	56	59	41	22	33	20	28	20
Children and Family Services	9	9	13	16	17	17	12	18
Self, Family and Friends	10	11	7	11	13	12	15	12
Health and mental health services (excl. A&E)	4	4	6	9	13	9	22	8
Other substance misuse services	3	3	19	7	8	8	2	5
Other services	0	0	3	2	5	2	1	2
Accident and Emergency	-	-	0	1	0	1	0	1

From 2017-2018, Lewisham reported lower rates of referrals from Education sources (20% in 2019 compared to 33% nationally in 2020) and from Children and Family services excepting 2018-2019 (12% across Lewisham in 2019-2020 compared to 18% nationally).

By way of contrast, a higher rate of referrals can be noticed from:

- youth justice services (28% in 2019-2020 compared to 20% nationally),
- health and mental health services from 2018-2019 (reaching 22% of all referrals in 2019-2020 compared to 8% nationally); and
- since (2018-2019) increased levels of referrals from self-family and friends (15% in Lewisham in 2019-2020 compared to 12% nationally).

The results therefore indicate that criminal justice routes are the most significant route into treatment.

4.1.5 Hospital admissions

Hospital admissions for alcohol specific conditions in under 18s in Lewisham

Hospital admission data² shows that the rate of people under the age of 18 in Lewisham admitted to hospital for alcohol specific conditions in the 2016/17 – 2018/19 period was 22 per 100,000. The breakdown by gender was:

- Male – 19.1 per 100,000
- Female – 25.1 per 100,000

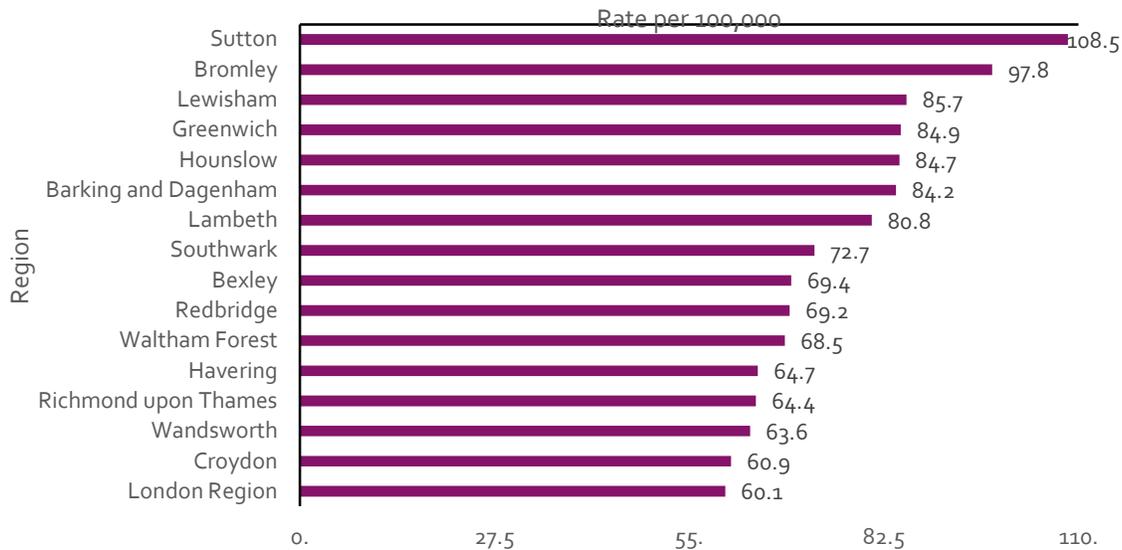
Hospital admissions due to substance misuse in 15 – 24 year olds in Lewisham

The hospital admission data for substance misuse³ shows that in the 2016/17 – 2018/19 period there were 85.7 per 100,000 admissions in Lewisham in those aged 15-24. The data for the 15 areas with the highest prevalence rates per 100,000 is shown in Figure 1, with the inclusion of the London region data for comparison.

² <https://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/1/gid/1938132982/pat/6/par/E12000007/ati/102/are/E09000023/cid/4/page-options/ovw-do-o> Accessed 25/01/2021

³ [://fingertips.phe.org.uk/search/substance#page/3/gid/1/pat/6/par/E12000007/ati/102/are/E09000023/iid/90808/age/156/sex/4/cid/4/page-options/ovw-do-o_car-do-o](https://fingertips.phe.org.uk/search/substance#page/3/gid/1/pat/6/par/E12000007/ati/102/are/E09000023/iid/90808/age/156/sex/4/cid/4/page-options/ovw-do-o_car-do-o) Accessed 25/01/2015

Figure 1 Hospital admissions due to substance misuse (15-24 years) – Top 15 areas (plus London Region)



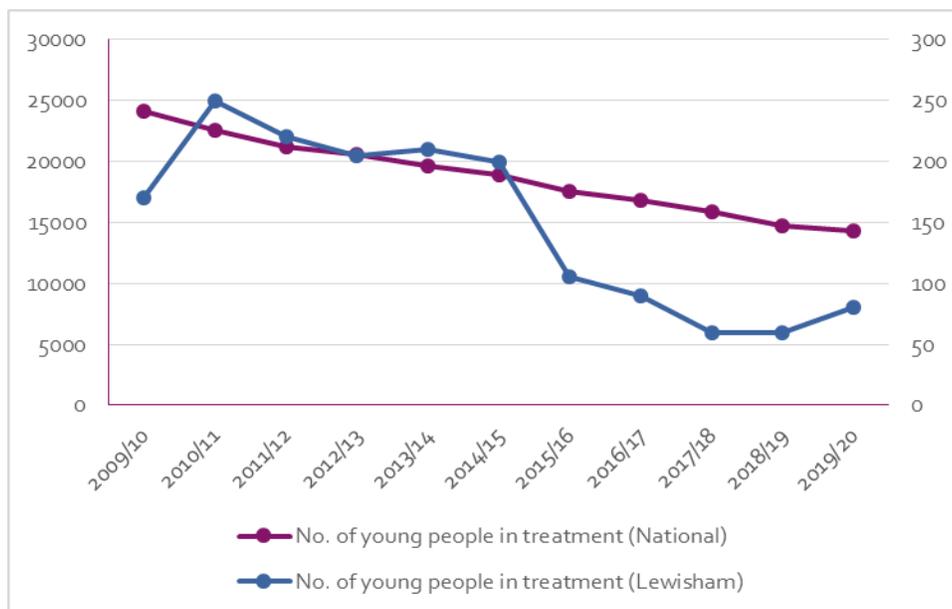
Note therefore that the rate of hospital admissions for young people in Lewisham is towards the top among a cluster of other London authorities with only Sutton and Bromley indicating higher rates. The rate of 85.7 for Lewisham is also significantly higher than the London regional average figure of 60.1 per 100,000. The data potentially indicates that those hospitals serving the Lewisham population (so primarily Lewisham and Queen Elizabeth) are better at flagging up young people who present for treatment. However it is more likely to be indicative of the fact that young people in Lewisham are more likely than their peers elsewhere in London to consume drugs to the extent that this requires a healthcare intervention.

4.2 Future trends

The parallel JSNA for adult substance misuse sets out a projection of possible future levels of treatment demand using modelling of current and historic numbers in treatment. A similar exercise is not possible for the young people’s population gives the small numbers which makes any forecasting extremely unreliable. Also the large drop in numbers from 2015/2016 onwards would lead to negative figures estimated in treatment.

Data on historic trends are however set out below at Figure 2.

Figure 2 Young people in substance misuse treatment – national rate compared to rate for Lewisham



Analysis of the data indicates that the drop in young people presenting to drug and alcohol services in Lewisham is correlated to changes at national level ($r=0.83$) although the drop within the borough is more severe. That means that the drop in the treatment population in Lewisham tracks wider trends across England. There is no data (nationally) to suggest that the drop in treatment numbers is due to reduced demand. Rather it would appear that the drop in numbers is related to the particularly steep reduction in young people’s treatment budgets that occurred across the country which had the effect of limiting service capacity. It would appear that local drops are a part of this relationship with a reduction in budgets. We also note that a new young people’s treatment provider commenced delivery within the period set out in Figure 2 which may also have been a contributory element in the drop in numbers. Whilst we cannot say with any certainty, one factor might therefore be the shift from a

standalone young people's substance misuse service to an integrated service that deals with other factors (emotional health and wellbeing and sexual health).

4.3 Drivers of need

This section explores a range of variables that may have some bearing on current and future demand for young people's treatment services. Issues are explored thematically below.

4.3.1 The Health Related Behaviour Questionnaire, 2016

The Health Related Behaviour Questionnaire (HRBQ) collected data on a range of health-related behaviours from children aged between eight and fifteen, including information on both legal and illegal drugs. This section reports the key findings from a survey that was conducted among 1,473 young people in Lewisham in 2016. Recognizing that this data is some five years old, it does however provide a snapshot of the views of young people in Lewisham (whereas data in 4.3.2 applies national opinion data to the population of Lewisham and is therefore represents more of a generalized view of young people across England).

Data for HRBQ is often set out by Year group (rather than age). As such Table 14 puts together the corresponding Year group with age of pupils in that group.

Table 14 Year group and corresponding age of child

HRBQ Year Group	Corresponding Age
Year 4	8-9
Year 6	10-11
Year 8/9	12-13
Year 10/11	14-16

Primary school pupils in Years 4 and 6 (aged 8 – 11)

In relation to children of primary school age, the 2016 Lewisham survey indicates that:

- 13% of primary aged children were fairly sure or certain that they knew someone who uses drugs.

- 43% of year 6 pupils said that their parents had talked to them about drugs and 47% that their teachers had.
- 27% of year 6 children said that they had talked to visitors in school lessons about drugs.
- 9% of year 6 pupils said that they had had at least one alcoholic drink, 1% said this was in the last seven days.
- Almost all, 99% of year 6 pupils said they had never tried smoking – 1% had tried smoking in the past.
- 28% of the year 4 and 6 pupils said that their parents / carers smoke. This compares to a smoking prevalence rate of 15.5% (which in turn is slightly higher than the London rate of 14.6%).⁴

Secondary school pupils in Years 8/9 and 10/11 (ages 12 – 16)

In relation to secondary school aged children, the 2016 survey indicated that:

- 9% of boys and 16% of girls in year 10/11 said they had used drugs.
- 6% of pupils overall said they had used drugs to get high.
- 6% of pupils in year 8 had been offered cannabis, increasing to 24% of year 10/11 boys and 29% of year 10/11 girls.
- 8% of pupils had had at least one alcoholic drink in the last seven days.
- 69% of pupils said that they never drink alcohol. Of those who do, 61% of pupils said their parents always know about it, 11% said their parents never know about it.
- 7% of pupils said that there was a special drug and alcohol service available for young people. 32% said there wasn't one and 61% didn't know.
- 92% of pupils said that they have never smoked.

⁴ <http://www.lewishamsna.org.uk/sites/default/files/Tobacco%20Control%20JSNA%20Refresh%20-%20Final.pdf>

- 1% of boys and 2% of girls reported that they smoke occasionally or regularly.
- 9% of pupils said that they have used an e-cigarette.

4.3.2 Prevalence of and attitudes towards alcohol, smoking and drugs

The following sections provides synthetic estimates of prevalence and attitudes towards drug use of children and young people based on analysis of the HRBQ 2019, and the Smoking, Drinking and Drug Use among Young People in England 2018 survey using population estimates for young people in Lewisham.

While this uses data from HRBQ (which was explored above) we note that this is a more recent version of the survey (and the most recent for which data are available) and so the results are somewhat more contemporaneous that for the 2016 Lewisham survey.

The HRBQ 2019⁵ commissioned by The Schools Health Education Unit (SHEU) collected data from children aged between eight and fifteen on a range of health-related behaviours.

The HRBQ 2019 data covers both legal and illegal drugs and collects data on drug use amongst young people, as well their perceived danger of using drugs.

The population estimates of young people in Lewisham used for the synthetic estimates were obtained from the Office for National Statistics population estimates for the UK, England and Wales, Scotland and Northern Ireland: mid-2019⁶.

Please note - HRBQ data is presented by school year group, i.e. Yr 4, Yr 6 etc. whereas the ONS population estimates are produced by age, i.e. nine years, eleven years etc. To calculate the estimated prevalence figures for Lewisham, we have transposed the year group data from the HRBQ to the corresponding ages as set out in Table 9 (above).

⁵ <http://sheu.org.uk/content/page/young-people-2019> (accessed 18/11/20)

⁶ <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2019estimates>

Consumption of any alcohol drink in the last seven days

Table 15 explores responses in relation to whether young people had consumed any alcohol in the last seven days.

The consumption of any alcoholic drink in the last seven days is highest amongst those aged fifteen years old at 21% amongst males and 23% amongst females – i.e. over a fifth of 15 year olds for both genders.

Table 15 Consumption of any alcoholic drink in the last seven days

Age and Gender	Lewisham Population	Percentage as identified in the HRBQ (%)	Expected Prevalence (count)
9 - Male	1,917	6%	115
9 - Female	1,872	3%	56
11 - Male	2,018	7%	141
11 – Female	1,748	3%	52
13 - Male	1,731	7%	121
13 – Female	1,761	6%	106
15 - Male	1,572	21%	330
15 - Female	1,462	23%	336

If we apply these same prevalence rates to the population of Lewisham, it is possible to estimate the amount of alcohol consumption amongst young people in the borough. That is, we would expect around 330 male and 336 female fifteen year olds to have consumed alcohol within the last seven days.

Smoke regularly and don't want to give up

The survey explores those who smoke but who do **not** wish to give up.

There are relatively low numbers of nine to fifteen year olds who regularly smoke, **and** who don't wish to give it up.

Below the age of fifteen it is only boys that say they smoke and do not want to give up at 1% of nine year olds and 1% 11 year old boys. There are no girls under fifteen who smoke and do not wish to stop. Rates of smoking with no desire to stop become more prevalent at fifteen years old with 3% of boys and 4% of girls.

Table 16 I smoke regularly and don't want to give it up

Age and Gender	Lewisham Population	Percentage as identified in the HRBQ (%)	Expected Prevalence (count)
9 - Male	1,917	1%	19
9 - Female	1,872	0%	0
11 - Male	2,018	0%	0
11 - Female	1,748	0%	0
13 - Male	1,731	1%	17
13 - Female	1,761	0%	0
15 - Male	1,572	3%	47
15 - Female	1,462	4%	59

If we apply these prevalence rates to the population of Lewisham, we would expect to see around 106 fifteen year olds who regularly smoke and not wish to stop (that is, applying the HRBQ prevalence rate to the number of 15 year olds who live in the borough).

Smoke regularly and want to give up

The survey explores data for young people who smoke and who **do** wish to give up.

The data shows that resources to help those who would like to give up smoking should be targeted at the older age groups; it is only fifteen year olds who smoke regularly and wish to stop – 1% of males, and 2% of females. Applying these same prevalence rates to Lewisham would suggest that there are a small number, circa 45 young, regular smokers who would like to give up and who would benefit from a referral to a stop smoking service. Equally the data suggests the need for ongoing prevention work to ensure that young people do not acquire smoking habits.

Table 17 I Smoke regularly but would like to give up

Age and Gender	Lewisham Population	Percentage as identified in the HRBQ (%)	Expected Prevalence (count)
9 - Male	1,917	0%	0
9 - Female	1,872	0%	0
11 - Male	2,018	0%	0
11 - Female	1,748	0%	0
13 - Male	1,731	0%	0
13 - Female	1,761	0%	0
15 - Male	1,572	1%	16
15 - Female	1,462	2%	29

Vaping at least weekly

The survey explores usage of e-cigarettes amongst young people.

There are some frequent e-cigarette users amongst those aged thirteen and fifteen, with usage slightly higher amongst boys than girls within each age category.

Table 18 Use Vaping now (at least weekly)

Age and Gender	Lewisham Population	Percentage as identified in the HRBQ (%)	Expected Prevalence (count)
13 - Male	1,731	3%	52
13 - Female	1,761	2%	35
15 - Male	1,572	4%	63
15 - Female	1,462	3%	44

Cannabis is always unsafe

The survey asks young people to respond to the comment that “cannabis is always unsafe”. Responses are set out below.

The perception that cannabis is *always* unsafe is lowest amongst those aged fifteen with only 22% of males and 17% of females perceiving cannabis as unsafe meaning 32% and 26% of thirteen year olds respectively. The results therefore indicate a significant number of young people who do not believe that cannabis has any health or other implications.

Table 19 Cannabis is ‘always unsafe’

Age and Gender	Lewisham Population	Percentage as identified in the HRBQ (%)	Expected Prevalence (count)
13 – Male	1,731	32%	554
13 – Female	1,761	26%	458
15 – Male	1,572	22%	346
15 - Female	1,462	17%	249

If these results are applied to the same age groups in Lewisham we can presume similar attitudinal prevalence in that there is more acceptance of cannabis, and less concern over its safety, amongst the older age groups.

Heroin is always unsafe

The survey asks young people to explore the comment that “heroin is always unsafe”.

While higher proportions of children consider heroin to be unsafe compared to cannabis the results are striking insofar as that they indicate a sizeable proportion of young people think that heroin can be safe – often the majority of young people. This would indicate that young people are not well informed

about the hazards associated with heroin use. (Note that, while the survey explicitly references heroin, it follows that young people are likely to be ill-informed about the dangers of opiates more widely).

Applying the figures in Table 20 to young people in Lewisham, and with the exception of thirteen year old girls, we estimate that around half of all thirteen and fifteen year olds in Lewisham would also consider heroin as always unsafe.

Table 20 Heroin is 'always unsafe'

Age and Gender	Lewisham Population	Percentage as identified in the HRBQ (%)	Expected Prevalence (count)
13 - Male	1,731	49%	848
13 - Female	1,761	39%	687
15 - Male	1,572	57%	896
15 - Female	1,462	50%	731

Certain I know someone who takes drugs

Given the known association between knowing someone who takes drugs and therefore being able to obtain drugs yourself, the HRBQ asks children if they know someone who uses at least one of a number of listed drugs.

Around one in ten nine year olds claim to know someone who uses one of the listed drugs, which increases to one third amongst fifteen year olds. For Lewisham, this means there could be over 250 children within each of the age groups identified in the table below who are certain they know someone using drugs; and over 500 fifteen year old boys.

Table 21 Certain I know someone who takes these drugs

Age and Gender	Lewisham Population	Percentage as identified in the HRBQ (%)	Expected Prevalence (count)
9 - Male	1,917	11%	211
9 - Female	1,872	9%	168
11 - Male	2,018	8%	161

11 - Female	1,748	6%	105
13 - Male	1,731	12%	208
13 - Female	1,761	11%	194
15 - Male	1,572	33%	519
15 - Female	1,462	33%	482

The results indicate that, by the age of 15, a third of young people will know a friend or peer who uses drugs, indicating widespread consumption among young people. Note also that around one in ten very young people (aged 9) are aware of someone who uses drugs.

Ever taken any drug

The survey explores whether a young person has taken any drug.

The percentages of those claiming to have taken any of the drugs listed increases with age from two percent of thirteen year olds to over one in ten of those aged fifteen. By applying the same prevalence rates to children in Lewisham, we estimate around 350 children aged fifteen who have tried any of the listed drugs, with usage slightly higher amongst males than females.

Table 22 Ever taken any drug

Age and Gender	Lewisham Population	Percentage as identified in the HRBQ (%)	Expected Prevalence (count)
13 – Male	1,731	2%	35
13 – Female	1,761	2%	35
15 – Male	1,572	12%	189
15 – Female	1,462	11%	161

The results indicate that, by the age of 15, around one in ten 15 year olds will have used a drug at some point in their life.

Ever taken cannabis

The survey explores young people's consumption of cannabis.

With 12% of fifteen year old boys and 10% of fifteen year old girls having tried cannabis, this would equate to circa 335 children aged fifteen having tried cannabis in Lewisham and 53 thirteen year olds.

Table 23 Ever taken any cannabis (any sort)

Age and Gender	Lewisham Population	Percentage as identified in the HRBQ (%)	Expected Prevalence (count)
13 – Male	1,731	2%	35
13 – Female	1,761	1%	18
15 – Male	1,572	12%	189
15 – Female	1,462	10%	146

Ever taken drugs and alcohol on the same occasion

The HRBQ includes a question on same occasion drug and alcohol use to identify behaviour that moves away from experimentation towards more risky behaviours.

Whilst the percentages of those in the HRBQ claiming to have taken drugs and alcohol on the same occasion are relatively low, if the same prevalence rates are applied to children in Lewisham, we could reasonably expect to see 63 fifteen year old boys, and 58 fifteen year old girls engaging in similar risky drug taking behaviour.

Table 24 Ever taken drugs and alcohol on the same occasion – Yes

Age and Gender	Lewisham Population	Percentage as identified in the HRBQ (%)	Expected Prevalence (count)
13 – Male	1,731	1%	17
13 – Female	1,761	0%	0
15 – Male	1,572	4%	63
15 – Female	1,462	4%	58

Taken drugs in the last month

The survey seeks to differentiate between the proportion of young people who have ever taken drugs, and those who have done so more recently.

Drug usage tends to be higher in the older age group, with three percent of fifteen year olds claiming to have taken drugs in the last month compared to one percent of thirteen year olds. This data indicates that the potential prevalence in Lewisham is around 35 children aged thirteen and 91 aged fifteen that have taken drugs in the last month.

Table 25 Taken drugs in the last month

Age and Gender	Lewisham Population	Percentage as identified in the HRBQ (%)	Expected Prevalence (count)
13 – Male	1,731	1%	17
13 – Female	1,761	1%	18
15 – Male	1,572	3%	47
15 – Female	1,462	3%	44

4.3.3 Smoking, Drinking and Drug Use among Young people in England 2018

This section reports and draws synthetic estimates from a survey conducted by the Office for National Statistics.

13,664 year 7 to 11 pupils responded to the 2018 survey, between September 2018 and February 2019⁷ therefore giving another relatively up-to-date picture of attitudes and behaviours among young people in England. While a snapshot of views of children and young people from across England (as opposed to just those from Lewisham) it gives a relatively contemporaneous assessment of the views of young people in relation to a number of key areas.

The survey includes core questions covering smoking, alcohol and drug attitudes and behaviours, as well some questions on wellbeing and family affluence. The relevant data have been used to create prevalence estimates of drug and alcohol use and associated behaviours to determine the estimated levels we could expect to see amongst young people in Lewisham.

Consumption of any alcohol drink in the last seven days

Ten percent of 11-15 year olds said they had consumed alcohol in the last seven days. If we apply these prevalence figures to Lewisham, we would expect to see approximately 6,134 year seven to eleven pupils who have drunk alcohol within the last week.

Table 26 Consumption of any alcoholic drink in the last seven days

Year Groups	Lewisham Population	Percentage as identified in the SDDU (%)	Expected Prevalence (count)
Yr 7-11	16,340	10%	6,134

Ever had an alcohol drink

Almost half (44%) of those in year groups 7 to 11 said that they had ever tried alcohol. We can therefore reasonably extrapolate from this to assume that around 7,190 of similar aged children in Lewisham have tried alcohol. The significant proportion of young people who stated that they have tried alcohol would

⁷ <https://digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england/2018> accessed 25/01/2021

therefore tend to indicate the need for ongoing education and awareness around alcohol consumption and its dangers.

Table 27 Ever had an alcoholic drink

Year Groups	Lewisham Population	Percentage as identified in the SDDU (%)	Expected Prevalence (count)
Yr 7-11	16,340	44%	7,190

Drink alcohol at least once a week

Frequent alcohol use is reasonably low amongst 11-15 year olds, with 6% claiming to drink alcohol at least once a week. This would equate to just under 1,000 frequent alcohol drinkers amongst 11-15 year aged children in Lewisham.

The hospital admissions data (see section 4.1.5) shows that in 2018/19, 45 people under the age of 18 were admitted to hospital for an alcoholic specific condition. There could therefore be a proportion of these 980 children who are drinking more frequently than once a week.

Table 28 Drink alcohol at least once a week

Year Groups	Lewisham Population	Percentage as identified in the SDDU (%)	Expected Prevalence (count)
Yr 7-11	16,340	6%	980

Ever smoked tobacco

16% of those answering the survey had tried smoking (tobacco) which would equate to 2,614 similar aged children ever smoked in Lewisham.

Table 29 Ever smoked tobacco

Year Groups	Lewisham Population	Percentage as identified in the SDDU (%)	Expected Prevalence (count)
Yr 7-11	16,340	16%	2,614

Current smokers

There are a small percentage of children who classify themselves as current smokers - 5%.

Although current smoking prevalence is generally low, this data indicates that there could be just over 800 children in Lewisham aged 11-15 who are smokers.

Table 30 Current smokers

Year Groups	Lewisham Population	Percentage as identified in the SDDU (%)	Expected Prevalence (count)
Yr 7-11	16,340	5%	817

Ever used E-Cigarette

A quarter of children in year groups 7 to 11 had used an e-cigarette. The data therefore indicates that just over 4,000 young people in Lewisham are likely to have used an e-cigarette.

Table 31 Ever used E-cigarette

Year Groups	Lewisham Population	Percentage as identified in the SDDU (%)	Expected Prevalence (count)
Yr 7-11	16,340	25%	4,085

Ever taken drugs

The national survey indicates willingness to experiment with substances with just under a quarter, 24%, reporting they have ever taken drugs. Applying this same prevalence rate to Lewisham would result in a little below 4,000 senior school aged children having ever taken drugs.

Table 32 Ever taken drugs

Year Groups	Lewisham Population	Percentage as identified in the SDDU (%)	Expected Prevalence (count)
Yr 7-11	16,340	24%	3,922

Note the results for the SDDU differ markedly from that of the HRBQ with the latter reporting 11% of 15 year olds stating that they had ever taken drugs (see Table 22).

Taken drugs in the last year

Nearly one on five, 17%, of children in year groups 7-11 said they had taken drugs within the last year. If we apply these prevalence rates to the population of Lewisham, we could expect to see approximately 2,778 children aged 11-15 who have taken drugs in the last year.

Table 33 Taken drugs in the last year

Year Groups	Lewisham Population	Percentage as identified in the SDDU (%)	Expected Prevalence (count)
Yr 7-11	16,340	17%	2,778

Taken drugs in the last month

Whilst we don't know the frequency of drug taking from these figures, Table 35 indicates that around one in ten young people have used drugs relatively contemporaneously – that is, within the last month. When applied to the population of Lewisham aged 11 to 15 this gives potentially 1,471 children who have possibly taken drugs in the last month.

Table 34 Taken drugs in the last month

Year Groups	Lewisham Population	Percentage as identified in the SDDU (%)	Expected Prevalence (count)
Yr 7-11	16,340	9%	1,471

The results of the SDDU contrast with that of the HRBQ that indicates that 3% of 15 year olds report having taken drugs in the last month (see Table 25).

Ever been offered drugs

The incidence of those who claim to have been offered drugs in the national survey is relatively high at 38%. This data indicates that the potential prevalence in Lewisham is around 6,209 senior school aged children who may have been offered drugs.

Table 35 Ever been offered drugs

Year Groups	Lewisham Population	Percentage as identified in the SDDU (%)	Expected Prevalence (count)
Yr 7-11	16,340	38%	6,209

4.4 Vulnerability factors

This section looks at possible drivers for drug and alcohol demand among children and young people, exploring local data in relation to a number of known vulnerability factors that correlate with substance misuse.

4.4.1 Vulnerability factors for young people

There is a well-established literature regarding young people and substance misuse that indicates a clear understanding of links between certain factors and issues in the lives of young people and the likelihood of drug and alcohol use. NICE identify key risk factors for young people as being:

- mental health problems
- being sexually exploited
- engaged in commercial sex work

- lesbian, gay, bisexual or transgender
- NEET
- excluded from school or who truant regularly
- families or carers use drugs
- looked after or who are care leavers
- in contact with youth offending services⁸

PHE notes that risk factors also include early sexual activity, antisocial behaviour and (as per NICE) exposure to parental substance misuse.

Furthermore the literature notes that, “The more risk factors young people have, the more likely they are to misuse substances”⁹. NICE note those that are particularly vulnerable include:

- in multiple groups of need (i.e. more than one of the factors set out above)
- whose personal circumstances put them at risk
- who use drugs on an occasional basis
- are already excessively using another substance such as alcohol¹⁰

The literature also notes that girls face a number of specific issues and are more likely to internalize problems in the form of depression and self-harm. It is therefore considered appropriate for provision to be differentiated by gender to allow the needs of girls to be met more effectively.

Lewisham Concern Hub

Lewisham Council has put in place a multi-agency risk management panel that specifically seeks to identify young people in the borough who are at risk of going missing, being exploited, being trafficked

⁸ Drug misuse prevention: targeted prevention. NICE Guideline NG64 (2014).

⁹ Young People – substance misuse JSNA support pack. p.5.

¹⁰ NICE Guideline, p.12.

or who may be the victim of violence. The Concern Hub brings together partners to determine an effective multi-agency response to these most vulnerable young people.

Since its inception in May 2019 the Hub has worked with 293 young people (of whom 85 are “live” cases). When working with the young people one factor explored is suspected drug or alcohol use. Giving a strong indication of the links between various manifestations of vulnerability and drug and alcohol use, of the 293 young people supported via the Hub 177 (60.4%) have a flag for drug and alcohol.¹¹

Protective factors

There is also an evidence base for those factors which have a protective effect. PHE note that “physical and mental wellbeing, and good social relationships and support are all protective factors”¹². PHE goes on to note that key predictors of wellbeing are:

- Positive family relationships
- A sense of belonging – at school and in communities
- Good relationships with adults outside the home
- Positive activities and hobbies¹³

PHE note that potentially the most significant protective factor is the age at which young people start using drugs and alcohol with severity of substance misuse problems strongly correlated to early onset.¹⁴

4.4.2 Mental Health

As evidenced at Table 11, while only 6% of those in treatment were flagged as having a mental health need, the national rate is 37% which tends to suggest that the rate in Lewisham is actually much higher (and that an issue of data recording is present).

¹¹ Note that the Concern Hub is a consent-based service, i.e. the Hub does not refer directly. Professionals sitting on the Hub make referrals that the young people have to consent to. As such not all flags for concern will lead to a referral onto a relevant service.

¹² Ibid, p.5

¹³ Ibid, p.6

¹⁴ Ibid., p.5

Data from the current provider Compass indicates that, out of a total of 157 clients in the year 2020-2021, 55 were receiving a substance misuse intervention and 93 support for emotional health over the course of the whole year indicating an overlap between clients.

Data from Lewisham's Concern Hub also gives an indication of links between mental health: 115 young people engaged by the Hub were flagged as having mental health and/or learning difficulties. Of these 72 (62.6%) also were flagged as having a possible drug or alcohol need.

4.4.3 Being sexually exploited

Data from Lewisham's Concern Hub gives an indication of links between sexual exploitation and drug and alcohol use.

51 young people were known to the Hub due to being the victim of sexual crime and/or abuse. Of the 51 young people 29 (56.8%) were flagged as having a drug or alcohol need. A further 78 young people were known to the Hub due to suspected Child Sexual Exploitation. Of these 41 (52.5%) were flagged as having a drug or alcohol need. (As noted at 4.4.1, given the nature of how the Hub operates it cannot be assumed that all drug and/or alcohol flags will translate into a referral).

4.4.4 LGBTQ+ community

Sexual identity is another known risk factor in terms of young people's substance misuse. While quantitative data is not available to set out patterns of drug and alcohol use among young people in the LGBTQ+ community, qualitative data was collected as part of the separate adult's substance misuse JSNA.

Key findings from the adult needs assessment consultation with members of the LGBTQ+ community indicated that:

- The use of drugs and alcohol is common within the LGBTQ+ community.
- Services are not necessarily seen as welcoming to members of the LGBTQ+ community with both gay men and lesbian women identifying perceived barriers to accessing services. In particular there was a sense that treatment services are not aware of the specific needs of members of this community.

- Chemsex is an issue among some gay men but they are unlikely to seek out support for their drug use.

4.4.5 Not in Employment, Education or Training

Table 37 shows the number of NEET young people aged 16 to 17 in Lewisham in 2019 and the number of these who were identified as having a substance misuse need.

Table 36 NEET YP and Substance Misuse – Monthly figures

Month	Number NEET aged 16-17	Recorded as having SMU need	% of NEETS
Apr-19	115	10	8.6
May-19	125	10	8.0
Jun-19	120	11	9.1
Jul-19	123	11	8.9
Aug-19	128	12	9.3
Sep-19	58	9	15.5
Oct-19	80	9	11.2
Nov-19	88	8	9.0
Dec-19	95	11	11.5
Jan-20	108	11	10.1
Feb-20	122	14	11.4
Mar-20	127	15	11.8

Please note that these are monthly figures and should not be added to produce a yearly total.

The data indicates that there is a consistent group of young people within the NEET cohort who have an identified substance misuse issue – ranging from 8% to 15.5%.

4.4.6 Parental substance misuse

Parental substance misuse is known to be a key contributing factor in relation to young people's consumption of drugs and alcohol. As noted at Table 10 7% young people in treatment were recorded as being affected by other's substance misuse.

Data presented in the adult substance misuse JSNA indicates that fewer treatment users reported having children living with them in Lewisham compared to national trends (11% compared to 18% nationally). The data also indicates fewer parents not living with children compared to the national rate (23% compared to 34% nationally). There are no clear explanations as to the variation of parenting status compared to national trends.

The data below indicates however that a number of adults in drug and alcohol treatment however report being a parent or a carer. This indicates that there are young people in the borough whose parents are affected by substance misuse which in turn puts them at heightened risk. The figure of 7% is therefore likely to under-report the full extent of the issue in Lewisham.

The parental status of adult *drug* using clients is set out at Table 37.

Table 37 Parental Status, Lewisham compared to National Figures, 2019-2020

Parental status	Lewisham 2019-20 (number)	Proportion of new presentations (Lewisham)	Proportion of new presentations (National)
Living with children (own or other)	44	11%	18%
Parents not living with children	90	23%	34%
Not a parent/no child contact	259	66%	47%
Missing/incomplete	0	0%	<1%

(Source: Adults - drugs commissioning support pack 2021-22: key data. Planning for drug prevention, treatment and recovery in adults).

Whilst lower than national figures the data indicates clearly however that there are 44 parents in drug treatment in the borough.

The parenting status of adult *alcohol* clients is set out at Table 38.

Table 38 Clients who are parents/carers and their children, 2019-2020

Parental Status	Lewisham Number (2019-20)	Proportion of new presentations (Lewisham)	Proportion of new presentations (National)
Living with children (own or other)	38	20%	25%
Parent not living with children	31	17%	25%
Not a parent/no child contact	117	63%	49%
Missing / incomplete	0	0%	<1%

(Source: Adults - alcohol commissioning support pack 2021-22: key data. Planning for drug prevention, treatment and recovery in adults)

Lewisham clients accessing alcohol treatment were shown to be more likely to state that they are not a parent or have no child contact (63% to 49% nationally). Again, while rates are lower than for national figures, the data indicates there are 38 parents receiving alcohol treatment who are living with children. These children are in turn at heightened risk of substance misuse themselves.

It should be noted that the data on parental substance misuse is an under-representation of the true picture given that the data uses the higher threshold of those in specialist treatment. The data does not take into account those parents/carers who misuse drugs and alcohol and are not accessing treatment. The scale of the issue is therefore greater than set out above.

Pregnancy status

Data from the adult treatment service regarding the pregnancy status of adults in treatment is set out at Table 39.

Table 39 Pregnancy status of female clients in drug and alcohol treatment

Pregnancy Status	Lewisham 2019-20 (number)	Proportion of new presentations (Lewisham)	Proportion of new presentations (National)
New female presentations who were pregnant	0	0%	4%

The data indicates a rate of zero. This however does not align with the findings of the adult JSNA (see separate report) in which a number of female clients were interviewed who had been pregnant during their treatment. This would therefore tend to indicate a gap in the data being collected.

Foetal alcohol syndrome (FASD)

A cohort study¹⁵ suggests that the screened prevalence of foetal alcohol spectrum disorder in a UK population-based sample was 6.0% using singly imputed data, 7.2% in complete case analysis, and 17.0% using multiply imputed data. Taking 4,504 live births in Lewisham for 2018 (latest data available) this suggests a range of 270-324 in Lewisham with a diagnosed FASD but using the imputed data this could rise as high as 766.

4.4.7 Looked after and care leavers

Children and young people who are looked after or who have otherwise had some contact with children's social care are known to be another group with a higher risk profile in relation to substance misuse.

The latest official figure identifying the number of looked after children in Lewisham is 481.

Table 40 gives a breakdown of young people in treatment who have been looked after or who have come into contact with children's services and compares this data to national trends.

Table 40 Clients' children receiving early help or in contact with children's social care; and pregnancy status of people in treatment

Receiving Early Help/Social Care	Lewisham 2019-20 (number)	Proportion of new presentations (Lewisham)	Proportion of new presentations (National)
Clients' children receiving early help or in contact with children's social care			
Early Help	5	4%	3%
Child in Need	5	4%	3%
Child Protection Plan in Place	9	7%	8%

¹⁵ McQuire, C., Mukherjee, R., Hurt, L., Higgins, A., Greene, G., Farewell, D., ... & Paranjothy, S. (2019). Screening prevalence of foetal alcohol spectrum disorders in a region of the United Kingdom: a population-based birth-cohort study. *Preventive medicine*, 118, 344-35

Looked After Child	4	3%	6%
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(Source: Adults - drugs commissioning support pack 2021-22: key data. Planning for drug prevention, treatment and recovery in adults).

For children receiving early help or who were in contact with children’s social care, there is broad concordance with the proportions seen in Lewisham for ‘early help’; ‘children in need’; and ‘children with a Protection Plan in Place’ compared to national averages.

There were lower numbers of looked after children seen in treatment in Lewisham (3%) compared to nationally (6%).

The Concern Hub has engaged 67 LACs since its inception, of whom 44 (65.6%) had a suspected drug or alcohol need. While not all of the LACs with a drug or alcohol need engaged in treatment, it should be not that the Hub adopts a consent based system – that is, young people must consent to an onward referral to another service. As such there is always likely to be a shortfall between those assessed as having a given vulnerability, and the numbers who are subsequently referred on (and note furthermore that this will be an issue for all vulnerabilities where a referral is required, not just substance misuse).

Missing children

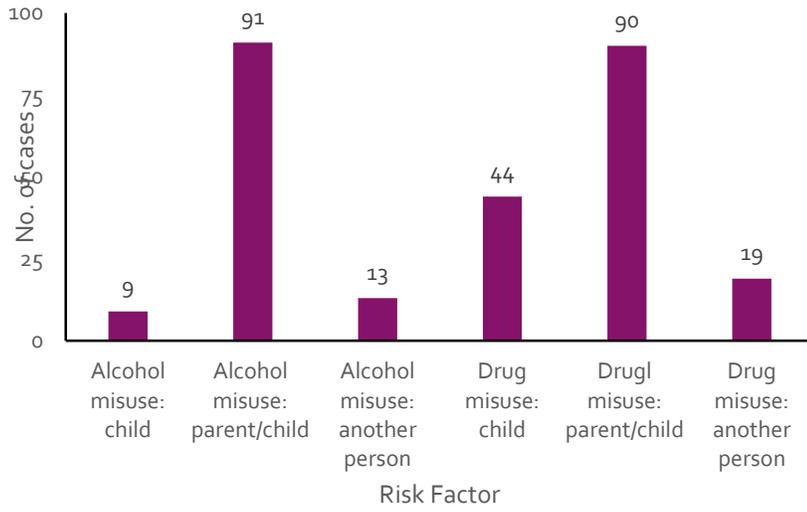
Another cohort of vulnerable children (not necessarily coterminous though with LACs) are those that go missing.

Data from the Concern Hub indicates that 34 children that came to the attention of the Hub had gone missing. Of these 18 (52.9%) had a suspected drug or alcohol need. As noted above, these would not all have automatically generated an onward referral to substance misuse treatment given the consent nature of the Hub.

Risk Factors

1,027 Children and Family Assessments were undertaken in Lewisham between June and September 2020. The number of these identified with risk factors is shown in Figure 2 below. Please note that multiple risk factors can be included for each assessment.

Figure 2 Number of identified risk factors during C&F Assessment between June 20 and Sep 20



4.4.8 Youth Offending

Young people known to youth offending services are known to be another cohort who are vulnerable to substance misuse.

Current caseload

Data for Lewisham YOS for the financial year 2019 -20, indicates the following:

- Young people receiving an intervention: 303
- Young people committing substance misuse related offence: 134
- Young people assessed as having a substance misuse issue: 176
- Young people receiving a substance misuse intervention: 124¹⁶

So, taking a baseline of 303 clients the data indicates that:

- Young people committing substance misuse related offence: 44.2%
- Young people assessed as having a substance misuse issue: 58%
- Young people receiving an substance misuse intervention: 40.9%

The data therefore very clearly highlights the extent to which substance misuse is an issue among young people engaged by the YOS, with over half of clients having this flagged as an issue.

¹⁶ Note that the data does not indicate what intervention these young people received.

Offending data

Further data was available looking at the numbers of young people who committed a primary or main drug-related offence. The data is set at Table 41.

Table 41 Young people receiving a substantive outcome for a primary/main drug-related offence

	2016	2017	2018	2019	2020
No. committing offence	58	63	61	89	66
Gender - M	94.8	95.2	91.8	87.6	87.8%
Gender - F	5.1	4.7	8.1	11.2	12.1%
Average age (years)	16	16	15	16	16

In 2020 66 young people were recorded as in receipt of a substantive outcome for a primary or main drug-related offence. The average age was 16 and a very significant majority were male.

Data was available for each young person on the offence. See Table 42

Table 42 Original offence

Offence type	2016	2017	2018	2019	2020
Possession – Cannabis	70.6	71.4	68.8	79.5	89.3
Possession – Cocaine	6.8	1.5	3.2	3.4	1.5
Possession - Crack Cocaine	1.7	0.0	1.6	2.2	1.5
Possession – Heroin	0.0	6.3	4.9	2.2	0.0
Possession – MDMA	0.0	0.0	0.0	1.1	0.0
Possess with intent to supply – Heroin	5.1	4.7	8.1	1.1	1.5
Possess with intent to supply – Cannabis	1.7	3.1	1.6	1.1	0.0
Possess with intent to supply – Cocaine	1.7	0.0	0.0	0.0	0.0
Possess with intent to supply – Crack	1.7	7.9	4.9	0.0	0.0
Supply – Cannabis	0.0	0.0	1.6	1.1	0.0
Supply – Cocaine	0.0	0.0	0.0	0.0	1.5
Supply - Heroin	6.8	0.0	0.0	0.0	0.0
Supply – Crack Cocaine	0.0	0.0	1.6	3.4	1.5
Obstruct an authorized person	0.0	1.5	3.2	1.1	3.0
Other	3.4	3.1	0.0	0.0	0.0

Note that in every year the overwhelming majority of offences was that of possession of cannabis, reaching 89% in 2020. Note also the very low levels of possession for other drugs.

The data therefore very clearly indicates that, where young people are coming into contact with the criminal justice system it is largely to do with possession of cannabis.

Data from the young people’s treatment provider indicates that, in relation to YOS clients:

- 120 were receiving brief interventions via targeted group work
- 57 were receiving one-to-one support

Additional data on youth offending was also provided by the Concern Hub. Hub data indicates that:

- Of 58 young people flagged as Possession with Intent to Supply (PWITs) 47 (81%) had a suspected drug or alcohol need,
- Of 63 young people flagged as involved in County Lines, 53 (84.1%) had a suspected drug or alcohol need.
- Of 57 young people who were a suspect of serious violence, 42 (73.6%) had a suspected drug or alcohol need.
- Of 98 young people who were suspect of possessing a weapon 62 (63.2%) had a suspected drug or alcohol need.

It is not possible to say how many of these young people ended up in treatment given, as noted above, the consent based approach of the Hub.

4.5 Summary of findings

There are a number of key findings from the quantitative data analysis set out above.

Data for 2019-2020 indicates 82 young people under 18 in treatment and a further 25 aged 18 to 24 years giving a total of 107 in community treatment. The data indicates a significant drop in numbers from 225 in 2016 – 17 to 91 in 2018 - 19 (with numbers increasing again as of 2019 – 2020). While there has also been a national decline in the numbers of young people in substance misuse treatment, the drop in Lewisham is more pronounced. While the data cannot conclusively set out why this drop occurred we note that it coincides with the shift to a new integrated youth provision at this point.

Proportionally, a higher proportion of younger people aged 18-24 access services in Lewisham (between 32.5-54.7%) compared to national figures for 2017-18 (16.4%). Slightly over half of clients were male (56.4%).

The treatment offer for young people is almost entirely psychosocial with very little (in some years no) clients requiring pharmacological support. This would tend to indicate a near absence of young people using opiates (albeit that the qualitative data indicates some use of codeine by young people). Nearly

all young people in treatment are receiving support for cannabis use (91%) followed by alcohol (48%). A fifth (20%) of young people in treatment are using two drugs (most likely cannabis and alcohol in combination). Levels of stimulant use are four times lower than the rate for England as a whole.

The data indicates that the largest single cohort of clients were White British (making up 40% of those in treatment) followed by those of Black African heritage (21.8%) who are both over-represented in the treatment population compared to the wider school population.

In relation to vulnerable groups of young people:

- YOS data indicates that 58% of their clients are assessed as having a substance misuse need and 40.9% were receiving an intervention. This breaks down as: 120 receiving brief interventions via targeted group work and 57 receiving one-to-one support.
- Data indicates that there is a consistent group of young people within the NEET cohort who have an identified substance misuse issue – ranging from 8% to 15.5%. Data does not indicate how many were receiving an intervention (albeit that data from the treatment provider indicates that 7% of its clients were NEETs).
- The Concern Hub has engaged 67 LACs since its inception, of whom 44 (65.6%) had a suspected drug or alcohol need. Data does not indicate how many of these were receiving an intervention (while data from the treatment provider indicates that 1% of its clients were LACs).
- Data from the Hub also indicates that, of the 51 young people flagged as the victim of a sexual crime or abuse, 29 (56.8%) were flagged as having a drug or alcohol need. Data does not indicate how many of these were receiving an intervention (while data from the treatment provider indicates that 1% of its clients were the victim of sexual exploitation).
- Data indicates that there are 44 parents in drug treatment in the borough indicating a population of young people in the borough who are exposed to drug use in the home. Data from the provider indicates that 7% of their clients were affected by other's substance misuse.
- Data from the Concern Hub indicates that 34 children that came to the attention of the Hub had gone missing; of these 18 (52.9%) had a suspected drug or alcohol need. Data does not indicate how many of these were receiving an intervention. The provider does not collect data on the whether its clients have ever been reported missing.

Looking at the wider population of young people (i.e. those outside of treatment) survey data applied to the local population indicates that a quarter of those in school years 7 to 11 report having ever taken drugs and 17% have used drugs in the last year. By the age of 15: 3% of young people reporting using drugs in the last month, a third of young people know a person who takes drugs and 12% of boys and 11% of girls have tried cannabis.

In relation to alcohol 21% of boys aged 15 and 23% of girls of this age report having consumed alcohol in the last seven days and (in a different survey) 44% of those in school years 7 to 11 report ever having tried alcohol.

5. Qualitative findings

5.1 Professional views

Professionals used the term young people to cover both under 18s and young adults up to the age of 24/25 (therefore in accordance with the age scope of the commissioned provider). However generally discussions were around young people from the age of about 12 through to the age of 18/19, occasionally up to 22 and very occasionally up to the age of 25. There was some confusion around the age limits for the Compass service. It was unclear in what circumstances they would work with people over the age of 21 and how many young adults accessed and benefitted from the service.

Drug use

Whilst cannabis and alcohol were both believed to be used across the age range, the number using the drug, (although not the impact) was felt to be much lower amongst the pre-teens.

All the respondents believed that there were large numbers of young people in Lewisham using cannabis. No-one felt able to put a figure or percentage on this but interviewees who would hazard a guess believed it was the majority. There was no sense of how much was being smoked or how often. There was a view that some young people would be using daily but there was no sense of how many young people used at this level. It was generally believed to be the 'older ones' by which people meant those 16 years of age and upwards.

Cannabis was viewed as a drug that had been largely 'normalized' and it was believed that young people were comfortable talking about cannabis use. Some respondents felt that professionals were also most comfortable asking about it. Because of this other drug use may be undetected.

Alcohol use was also felt to be commonplace. Some professionals felt that during the early period 'lockdown' it had been harder for young people to buy cannabis. They felt that this was a combination of supply and also opportunity. So few people were out that there was very little 'cover' for dealers to be on the street and there was also an expectation that young people would be staying at home. It was also felt that it was harder for young people to consume cannabis because they were at home and the smell would alert parents/carers. Because of this it was believed that some young people had turned to alcohol. One respondent pointed out that adult alcohol use is reported to have increased during lockdown and we shouldn't be surprised to see the same coping mechanisms in young people.

Some respondents felt that other drugs were being used by a smaller number of young people. The most widespread was believed to be nitrous oxide. Other drugs were largely seen as an 'unknown'. Interviewees felt that some young people must be using them but either had not seen that happening or had only seen it amongst very few young people. Among young adults (generally those aged 18 years and above) it was generally felt that there was a wider variety of drugs being used including some use of cocaine and other drugs.

Heroin use was believed to be confined to very, very small numbers of young adults.

The impact of drugs

Although cannabis use was considered to be very widespread it was also seen as having the potential to be harmful to young people.

It should be noted that some respondents differentiated between cannabis and 'skunk'. Young people in Lewisham they believed, were smoking skunk and this was felt to be having a markedly different impact than the marijuana that would have been commonly available twenty years ago. Skunk was seen as considerably stronger and had the potential to be more damaging.

The harm that people most often associated with the use of cannabis, in particular skunk, was its impact on young people's mental health. The view was either it could exacerbate existing problems or cause problems to arise. The impacts cited ranged from the relatively minor and temporary, such as young people feeling demotivated, through to paranoia and much more severe impacts such as schizophrenia. Professionals worried that cannabis use may do long term damage.

Interviewees also raised the harm done to young people due to the cost of cannabis. Professionals raised questions about where young people were getting the money from to pay for their cannabis use. There were also worries expressed about who they were then mixing with and whether they were getting into debt or getting involved in crime in order to earn money. Gangs and County Lines were seen as the main threat associated with young people seeking ways to raise money to pay for their drugs.

In most cases respondents did not see the illegality in itself as a problem unless it led to young people associating with criminals, or if it led to the young person being 'criminalized'. This 'criminalization' was seen as limiting young people's opportunities and was something that respondents generally felt needed to be avoided where at all possible. (We understand that a separate report is being prepared

looking at the impact of criminalizing young people for possession of drugs which will address this issue in detail).

The longer term physical health impacts of smoking cannabis were acknowledged but were not seen as something that was worrying the young people themselves. Some interviewees felt that this was because young people did not understand the harms.

Who is most at risk?

Whilst the use of cannabis was widespread it was clear that people felt that the impacts of cannabis use may be marginal for some and severe for others. The combination of emerging mental health issues and the frequent use of large amounts of cannabis was seen as particularly damaging. Much less was known about other drug use and less consideration had been given to who would be particularly impacted and how.

This marked difference that people believed cannabis would have across the population led some to conclude that efforts needed to concentrate on those young people who were already experiencing disadvantage and who were most at risk from the impacts of regularly smoking cannabis or indeed of taking other drugs.

What services are available?

Most respondents felt that services for young people who were using drugs were inadequate. Broadly this was because:

- There was not enough capacity overall to help the number of young people who had a problem with their drug use. The Compass service was believed to be limited in terms of the number of young people it would be able to work with and the Child and Adolescent Mental Health Services (CAMHS) had a long waiting list. The YOS service was part of a criminal justice pathway and therefore had very particular referral routes
- A number of professionals (but not all) interviewed felt that Compass was a service that lots of young people would not go to and which would not itself come out to meet young people. It was the view of some professionals that Compass was relatively reactive in relation to substance misuse and could do more to proactively engage with young people in the borough.

- CAMHS was seen as having very high thresholds which excluded many young people – that is, that they would only engage with young people with relatively high levels of mental health need and that many young people who use drugs or alcohol and who would benefit from an additional mental health intervention did not meet these thresholds and were therefore not able to access this support. Furthermore it was felt that the most disadvantaged young people needed intensive work that treated their substance misuse as one element in what was a very complex picture requiring multi-disciplinary input. Adult services were largely seen as unsuitable for the younger members of the young adult population and would only be accessed if there was an addiction that required a medical intervention
- There was a need for much earlier interventions that worked with young people at risk of using drugs or at risk of escalating their drug use. This could either be delivered across schools in the borough or with pupils where problems had emerged with behaviour or where there were older siblings who were known to be using drugs.
- The stakeholders interviewed were not aware of any young people had been referred to either of the Borough's adult services. It was thought that this may be because every young person who leaves Compass without the need for further interventions in an adult setting. However some thought that this lack of 'transition' may also point to a poorly developed referral pathway.

5.2 Community views

Representatives from two charities working with young people were invited to provide their views on the local substance misuse provision. The aim was to identify any areas of unmet demand, and to understand where efforts should be directed to meet the substance misuse needs of the young people they work with.

Substance misuse in the community

Interviewees said that they see cannabis use amongst their younger service users. One representative said that they see children as young as nine who smoke cigarettes, and the service often sees children drinking alcohol and smoking cigarettes by the age of ten. One described how there are people young aged between 18 and 25 who smoke cannabis but also have a diagnosed mental health medication.

Making referrals to the specialist treatment provider

Both make referrals to Compass for drug use. They were unable to quantify how many referrals they had made.

Gaps in the current service provision

Educating young people on cannabis use

Interviewees said there is a need to educate young people on cannabis as young people tend not to classify their cannabis use as drug use, and there is a lack of awareness about where it can lead.

The focus of any education programme must be on teaching young people about the impact cannabis can have on mental health. One representative said that the organisation sees mental health/anxiety issues and depression amongst its service users and felt that there is confusion amongst young people on cannabis use which needs addressing.

Preventing drug use

One representative said that there is a need to work on strategies amongst young people to prevent drug use. Indeed, addressing how young people get hold of cannabis should be a focus.

Some joint working could be implemented to develop the preventative strategies. One suggestion was for both the drug services and personal advisers to work together in cases where personal advisers are assigned to young people.

Service integration

A young person's reluctance to engage is important in determining their treatment outcome, however the current system is not designed to address the ongoing concern of service user engagement.

Within the existing set-up, the organisations and charities do not know what happens following the referral to the young person's treatment service. If a young person subsequently disengages, the referring organisation is not made aware and the young person can disengage and become lost from the system. Moreover there was a perception that the young persons 'service discharges people quite quickly. One representative said that the organisation does not know who the team at Compass is and simply knowing the team and names, would help.

The representative also felt that it would lead to better outcomes if the young people's service was more integrated into CAMHS to enable better monitoring of a young person's motivation to engage. The two

services could work closely together so that the work is less disjointed and more engagement work jointly undertaken. In-house teams would be more useful than separate services who are currently not working together.

It was suggested that where a service user has more complex needs, an integrated worker embedded in the CAMHS service could bridge the gap between CAMHS and the young person's substance misuse service.

Align the treatment services

Recognizing that capacity limitations at the heart of the issue, a gap identified by one representative is the fact that a child is currently not seen in a holistic way. This is especially important in cases of mental health and co-morbidities for example where a child may be seen by CAMHS, but is not treated for the co-morbidity issues at the same time. This, they believe, currently gives a child piecemeal interventions and seeing the child as a whole is therefore crucial. The sequence of the interventions must be tweaked so that drug addiction and mental health are treated concurrently.

This notion was supported by another interviewee who said there is a need to align the young persons' drug services and the mental health services. This approach should provide a young person wellbeing focus, rather than treating the individual aspects of service need.

Intervene earlier

One representative said that if a young person's needs could be addressed earlier on in their lives than they often are now, this would lead to better outcomes and put that young person on a different, more positive trajectory. Earlier interventions could involve bringing parents into the process and explaining the possible outcomes faced by their children unless they are helped onto another trajectory. A monthly, experience sharing parenting group, would help show parents how the services can address their children's needs.

5.3 Service user views

Two online focus groups were undertaken with young people:

- Looked after children – two respondents
 - Two males, aged 20 and 25
- NEET group – seven respondents
 - Five male, two female. Two aged 17, two aged 18, two aged 19

One telephone interview was undertaken with one male aged 17 who was being supported by the YOS.

Young people and substance misuse

Three participants said that they see quite a lot of recreational drug use amongst young people, particularly cannabis. They also see young people using lean/purple¹⁷, bencos (forget me not drug¹⁸), as well as some medical drugs.

They described how they see drug use at raves and parties and think that harder drug use is becoming the norm amongst young people at university where *"they have the money"*. There were a few respondents who said that drug use usually takes place outside of school, although there is some use inside school and colleges - in lunch breaks.

One said that there are some young people using marijuana who want to stop, and another that some young people use drugs every day, particularly those who use drugs to relieve stress.

One respondent said that all the people he knows who use drugs live with their parents and the parents do not punish their drug use.

Young people do not necessarily view drug use as bad, with one commenting, *"drugs are not bad if you know how to use them properly. They are illegal for financial purposes"*. However, one respondent said

¹⁷ "Lean", "Purple dank" and a number of other terms are used by young people to describe the misuse of prescription cough medicines that contain codeine (a weak opioid).

¹⁸ "Forget me not" is a slang term for Rohypnol, a benzodiazepine that is prescribed for short term relief of chronic insomnia.

that the impact of drug use can be huge for some young people, with some people unable to achieve anything else in the day as a result of their drug use.

There was some discussion amongst two respondents on the impact drugs have on the young people that use them. One felt that the message often conveyed about weed inducing laziness is a misconception. The conclusion of the discussion was that the extent of the impact depends on how individuals use the drugs, *"if you overuse drugs it will affect you"*.

How drug and/or alcohol use is established

There was a general consensus that many start using drugs from the age of 11 upwards, although this, *"depends on the type of people you are mixing with"*. Others said that drug use is common amongst those aged 14/15; another thought it was a little later around the age of 18 or 20.

There were many reasons put forward as to why young people start using drugs. The most frequently cited reason being, *"someone introduces it to you"*.

Others said that there can be some peer pressure to use drugs amongst the people that you mix with, particularly given the message that using drugs are, *"cool"*. One said that those suffering from anxiety will more easily give in to peer pressure. The, *"you only live once"* attitude can be popular in young people.

Depression was also considered a catalyst to drug use, with some seeking solace from drugs. This comfort seeing behaviour is then repeated, which can lead to problematic use.

Some said that previous bad experiences can instigate drug use; drugs are used to control anger management issues and to relax, and again, drug use becoming normalized. Similarly, one respondent described how alcohol can be used to, *"numb the body"*, and to block out pain which then becomes entangled in a vicious cycle and dependency.

Another said that whilst *"everyone has their own reason"* for starting to take drugs, and that drug use typically begins as a result of problems at home, or because your friends are using drugs. However, the respondent did not think that the social aspect associated with drug use should be overplayed, stating that social reasons are not always why people use drugs - it is the calming effect that drugs have which is the reason people use them.

One respondent described how drug use is normalized within certain cultures, explaining that drug use is normalized within certain sub-cultures. He said that there are two reasons people start using drugs -

no one would start using drugs in the absence of normalized cultural use, and someone introducing drugs to you.

One described a youth culture in London, *"if you do drugs, you do drugs"*, and another said that, in current urban culture, using "lean" is normalized. One respondent spoke about the sub-cultures inherent in drug use saying that, for instance, drug use is a sub-culture of the skateboarding scene.

Where there is acceptability of drug use by parents, young people felt that children will also take drugs and see drug use behaviour as acceptable. The normalization within some family set ups has an impact on drug use for those living in these environment, *"drug use is engrained in how you grow up and what you learn when growing up"*.

One respondent said that drug use can be popularized and described how drug use is not labelled substance misuse; drug use is called, *"a night out with my friends"*.

Some felt that the media heavily influences the acceptability of drug use amongst young people. One person explained that young people replicate what they see in the media where drug use is often glamorized by their favourite stars. The young people are therefore trying to be like these admired media stars.

The subject of boredom and its role in drug use came up frequently throughout the discussion with the looked after children. *"If you don't smoke or drink what do you do to make yourself happy?"*

One respondent felt that young people use drugs because they have nothing else to do. He said that these children have not been taught business, boxing or art for example, or anything else that they could do to usefully fill their time which would keep them away from drugs. He described it as the "Lil Wayne effect" where young people are idle and need something to do and their parents are often too busy with no time to help.

Obtaining drugs and alcohol

Four interviewees said that drugs are easy to obtain, with some saying that, *"they are everywhere"*. Another said that weed is easy to get hold of, *"someone will know someone,"* and this was supported by one interviewee who said that, *"you can get drugs in any area"*. The interviewee said that all you need to do is just ask two people in the local area and you will have access to drugs.

One young person felt that drugs have become cheaper which makes them more accessible, indeed, the affordability of drugs and alcohol was not considered to be a barrier to drug use amongst young people.

Respondents listed a variety of income sources used to fund drug purchases:

- Benefits
- Pocket money
- "Scams"
- Parents
- Legal and illegal work
- Selling drugs

One said that, *"people will get the money any way they can"*, and another that, *"certain privileges"*, makes drugs easier to get hold, *"posh do pills"*. Another interviewee commented that, *"everyone has their ways"* of obtaining money for drugs.

Seeking support or advice on substance misuse

Respondents listed a number of places they would go to for support or advice on alcohol and/or drugs.

- Friend
- Personal advisor
- Parents and family
- Youthbuild group
- Youth Offending Service (YOS)
- Specialist substance misuse service

Seeking support from a friend was mentioned most frequently by the young people. One respondent said that he would go to a friend and definitely would not look online for support. Others said though

that they would need to consider very carefully whether the person they went to could be trusted with the secret.

One respondent disagreed with seeking support from a friend and said that you cannot receive guidance from a peer and that you need someone with lived experience and knowledge. One said that he would rather receive guidance and support from an ex-addict who has turned their life around rather than, "*a professional*".

One respondent voiced over quite strongly that parents are not the right people to offer support on drugs or alcohol. He described parents as authority figures with little understanding of what is going on. He felt therefore that parents can sometimes be a barrier to young people seeking support. However, it should be noted that for one interviewee, his parents would be the first and only source for seeking advice on substance misuse.

There was little unprompted awareness of the specialist young people's drug and alcohol treatment services, although when prompted, some said they were aware of Compass.

One respondent said that the coping mechanisms Compass teaches are not sufficient to deal with drug and alcohol problems. He explained that these coping mechanisms are too theoretical and are not aligned to how the human body works. The respondent said that Compass should have a psychologist on the team, or the service should at least talk to psychologist.

Another interviewee said that although he is aware of Compass, he has little knowledge about how it operates. Believing that many young people have their drug use under control, there is therefore no need for them to seek support from others or from a specialist support service. Furthermore, there are certain individuals who would be uncomfortable in attending groups to discuss or seek support for substance misuse.

The impact of Covid-19

There was a consensus amongst the NEET (not in employment, education or training) group that Covid-19 had already impacted on substance misuse for some young people: some felt there had been an increase in drug use, '*it's already got much worse*'. The young people said that the combination of being locked in their homes and a lack of social contact, has led some to using drugs to help them deal with both these isolation issues.

Special considerations for young people

One respondent spoke with some passion about there being just one programme to stop young people using drugs without the offer of any alternative therapies. He said that physical activity programmes should be offered alongside traditional treatment therapies. The respondent said that getting young people into boxing for example would help. *"We can best support young people through fitness - boxing classes"*.

One felt that young people would benefit from the services including harm reduction learning rather than just total abstinence. Harm reduction sessions, alongside educating young people on the risks of and harmful impact of substance misuse would be helpful. There may also be a need to teach young people self-awareness and motivational techniques.

One person said that the services need to start building relationships with young people much earlier and that information and awareness workshops should take place before children enter secondary school. Workshops undertaken in schools from the age of five upwards was considered appropriate and would expose children to the dangers of substances and reduce the naivety.

In terms of the format of substance misuse sessions, both group and one-to-one sessions were considered suitable, although the consensus was that the delivery method depends on the specific individual; some voiced preference for one-to-one sessions.

One said there would be merit in teaching young people how to recognize substance misuse amongst their peers and help them to recognize the reasons/circumstance as to why they may be using drugs.

Telephone interview

One telephone interview was undertaken with a male service user aged 22, who is Black British.

The service user is currently engaged with the treatment services, seeking support for cannabis use. The service user was unaware of the treatment options available to him before he accessed CGL, but said this was because he had recently moved and was therefore new to the area.

He was referred into the treatment services by his keyworker at the supported housing service. The referral process was good and the service users did not have to wait very long before his first appointment at the service.

The service user said that the service had met his needs and helped him to address his cannabis use, as things were improving. He described the service he received as very good with an equal quality of provision in both the face-to-face and online sessions he received.

He described one gap in the service provision when his key worker went on leave for a month, followed by a period off work. The service user had not been contacted by a new key worker at the service.

Given his overall positive experience, he could not identify any other gaps in the service provision per se and could not comment on the availability of drugs in the area.

5.4 Summary of findings

In consultation with professionals who work with young people locally, all the respondents believed that there were large numbers of young people in Lewisham using cannabis. No-one felt able to put a figure or percentage on this but interviewees who would hazard a guess believed it was the majority. There was a view that some young people would be using daily but there was no sense of how many young people used at this level. Alcohol use was also felt to be commonplace. Some professionals felt that during the early period 'lockdown' it had been harder for young people to buy cannabis and so there had been a shift to greater levels of alcohol use.

While cannabis use was seen as being widespread, it was felt that its impact was more severe on certain groups of young people – particularly those with emerging mental health problems.

Young people who were consulted said that recreational drug use was common among their peers, particularly relating to cannabis use. It was felt that drug use starts from the age of 11 with some feeling that drug use is common by 14/15 (albeit some thought that it was common a little later by the age of 18 to 20).

Corroborating the findings from the professional consultation, young people felt that the Covid-10 lockdowns may have increased levels of drug and alcohol use as a way to manage boredom and isolation.

Young people often referred to being introduced to drugs by their peers and acknowledged a level of peer pressure to use. Others however noted that young people took drugs to "self-medicate" – for instance to deal with mental health issues or to control their anger. It was also noted that drugs are used by parents in some families which has the effect of normalizing their usage.

Young people were generally of the opinion that drugs were easily available in the borough and most young people also did not feel that affordability was a particularly significant barrier with a number of ways cited to obtain money to pay for drugs and alcohol.

When asked where they would seek advice around drugs, the most commonly cited response was friends.

Data from both professionals and young people indicates that some young people are shifting to new drugs such as Lean (prescription cough medicine). It is not possible to quantify the extent of the use of these newer drugs but, given that Lean contains codeine, this has implications for future treatment need (i.e. that a more pharmacological response may be required).

6 Discussion and analysis of findings

6.1 What works

This section explores the literature and evidence base for what works in relation to substance misuse and young people.

6.1.1 Young people focused services

The key message in addressing the needs of children and young people is that they are a distinct group of clients in themselves, that their needs are distinct and that they must be supported in ways that differ from the adult treatment population.

The literature stresses the importance of building provision around young people, stressing the importance of understanding young people as a distinct cohort: “Children are not small adults and the adult definitions of substance misuse are inadequate in capturing the developmental aspects of substance misuse in young people”¹⁹.

Given this PHE note the need for services to adopt an approach that recognize the strengths and assets of young people, which treat them with respect and as agents of change and which help to build:

- Resilience
- Life skills
- Ability to make better choices and to deal with difficulties²⁰

PHE therefore indicate that treatment services should be compliant with the Department of Health’s quality criteria for young people’s services, “You’re Welcome”²¹

¹⁹ Practice Standards for Young People with Substance Misuse Problems, Royal College of Psychiatrists (2012). p.5

²⁰ Specialist substance misuse services for young people: A rapid mixed methods evidence review of current provision and main principles for commissioning, Public Health England (2017), p.11.

²¹ Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216350/dh_127632.pdf

6.1.2 Education programmes

The evidence base

In terms of prevention work, evidence shows that information and education programmes alone do not reduce drug and alcohol-related harm²²; nevertheless, they have a role in

- Providing information
- Reframing drug and alcohol-related problems, and
- Increasing attention to alcohol on the political and public agendas.

School-based education can be important, but the literature indicates a number of important caveats to education programmes. A review of the literature by the Scottish Government noted that the evidence is not strong for school-based prevention work and that the effect sizes are small. The paper notes that data demonstrates the most effective interventions are those that combine social competence (that aim to improve personal and interpersonal skills) and social influences (reducing the influence of society by addressing norms for instance). The elements of effective education programmes were identified as:

- Interactive programmes with high levels of participation
- Multi-component programmes that include other elements, and
- Age appropriateness, with the optimal time being at the transition from primary to secondary education.

A number of named programmes that have been standardized and subjected to robust research were identified as being beneficial and cost-effective. These programmes were:

- The Good Behaviour Game
- PreVenture
- Strengthening Families

²² WHO (2009). *Evidence of the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm*. WHO Regional Office for Europe: Denmark

- Unplugged, and
- Life Skills Training.

The paper notes a number of educational programmes that have been demonstrated to have been *ineffective*. These include:

- Stand-alone school-based activities designed to increase knowledge of drugs
- Diversionary activities (such as theatre- and drama-based education)
- Fear arousal approaches
- Mentoring programmes, and
- Mass media campaigns.

The authors therefore conclude that the most effective responses are those that are linked to wider strategies that promote general health and wellbeing.

The evidence from the paper makes clear that, whilst education programmes can be valuable, their use must be carefully considered and the type of programme must be carefully selected and designed.

Further evidence indicates that peer-led/young people led awareness raising campaigns can prove to be effective, where young people are involved in developing messages and delivering content to other young people.²³ While the evidence-base shows that this has proved to be effective in relation to smoking reduction, organisations such as Young Addiction have applied the concept to the drug and alcohol sector where results also appear to be promising.

Education programmes in Lewisham

²³ See for instance "The effectiveness of prevention and early intervention to promote health outcomes for young people presented by Ann Hagell & Emma Rigby, Association of Young People's Health at Public Health England's Annual Conference, 16-17 September 2014."

Current drug education work in Lewisham is divided between the current young people's treatment provider and the Improving Health and Wellbeing in Schools offer provide by the council's Public Health Training team.

The young people's treatment service offers drop-in and group work sessions that explore three broad areas of risk-taking behaviour: sexual health, mental and emotional wellbeing and substance misuse. The substance misuse-specific training offer is made up of three sessions:

- "Peer pressure" - this includes gateway drugs, normative behaviour and parental drug use
- "Alcohol and the effects" – the effects of alcohol in both the short and long-term
- "Cannabis, Lean, Nitrous Oxide and the effects" – this looks at the effects of these three drugs over the short and long-term.

A combination session three strand package is also offered in which schools can choose which topic is covered and which includes drugs and alcohol as one of the strands.

In the year 2019/2020 52 training sessions were delivered. Note however that it is not possible to breakdown how many of these sessions covered substance misuse. It may therefore be the case that the majority (or all) of the training sessions addressed sexual health and emotional wellbeing.

In addition to the training offer outlined above, Lewisham Council's Health and Wellbeing in Schools offers additional support including drug and alcohol training. The service provides a bespoke drugs and alcohol education package to meet the needs of each school. The offer includes:

- Jointly planning and developing whole school approaches to drug and alcohol use
- Delivery of a school-based training programme
- Workshops for teachers, support staff and governors.

Schools are able to request training for their pupils and the service is offered free of charge.

6.1.3 Treatment

Evidence on the effectiveness of treatment interventions for young people is limited. There is both a relative scarcity of high quality published evidence and, where this evidence exists, much does not

relate to the UK context (with a tendency to report on treatment in the US). Given this, the conclusions that are reached must necessarily be somewhat tentative.

Whilst evidence is limited, what evidence does exist suggests that current recognized treatment approaches have some signs of effectiveness.

Standard pharmacological approaches which are normative practice in the treatment of adults were not identified in the literature as of significant relevance to young people. Partly it is noted that by far the majority of young people will not have a need that requires a pharmacological approach and additionally, due to the fact that research into pharmacological treatment of young people is sparse in terms of safety and effectiveness. Ahuja et al note that, "Pharmacotherapy should only be initiated with extreme caution after thorough assessment."²⁴ (We note that the data in this report that indicates possible use of codeine among young people in the borough may have implications for whether pharmacological inputs may be needed in the future).

The literature suggests that motivational interviewing and cognitive behavioural therapy (CBT) have a positive impact on young people. An Australian study of young people who received CBT alongside motivational interviewing noted significant improvements in depression and reductions in drug use compared to a group receiving standard treatment interventions²⁵.

There is a growing body of literature on family-based interventions which highlights the importance of engaging parents and carers in the treatment process and that family therapy (along with CBT) show the most consistent reductions in substance misuse²⁶. The review emphasizes the need for holistic assessments that explore wider issues in the life of the young person (i.e. looking beyond their substance misuse) and which then build support around the child dependent on the range of needs identified. Other studies endorse family-based approaches. A meta-review by Baldwin *et al* of family therapies notes that these approaches indicate better outcomes compared to non-family based approaches.²⁷ The study therefore suggests that family therapies are an important approach to treating young people's substance misuse. An evaluation of Family Intervention Projects found

²⁴ Engaging young people who misuse substances in treatment, Ahuja A., Crome I., Williams R., *Current Opinions in Psychiatry* 26, p.339.

²⁵ Does the addition of integrated cognitive behavioural therapy and motivational interviewing improve the outcomes of standard care for young people with comorbid depression and substance misuse, Hides et al, *Medical Journal of Australia*, (2011), 195

²⁶ *Ibid.*, 337.

²⁷ Baldwin S, Christian S, Berkeljon A, Shadish W. The effects of family therapy for adolescent delinquency and substance abuse: A meta-analysis. *Journal of Marital and Family Therapy*. 2012;38(1):281–304

reductions in drug and alcohol problems from 32% at the outset of engagement to 17% at treatment exit.

6.1.4 Integrated approach

Recognizing that substance misuse is often related to multiple vulnerabilities PHE recommend that, ideally, services understand and tackle multiple vulnerabilities as part of their approach.

Given this, PHE guidance indicates that treatment approaches offer “integrated services that deliver targeted interventions to young people at risk of developing problems with substance misuse alongside specialist services, particularly with identified vulnerable groups with specific risk factors”²⁸. As such, PHE stress the need for multi-agency responses with robust joint working arrangements. In particular it notes the need to engage with and provide seamless transition to services including:

- Child and Adolescent Mental Health Services (CAMHS)
- Child Sexual Exploitation and abuse support services
- Youth offending teams
- Sexual health services

6.2 Analysis of findings

This section analyses the key findings as set out in this report.

Treatment population

The most significant finding in this needs assessment is the size of the treatment population compared to estimated levels of demand. Data for 2019-2020 indicates 82 young people under 18 in treatment and a further 25 aged 18 to 24 years giving a total of 107 in community treatment. While numbers decreased in 2018 compared to previous years these have picked up somewhat in the period 2019-2020. The data does not indicate directly why such limited numbers of young people are in substance misuse

²⁸ Specialist substance misuse services for young people: A rapid mixed methods evidence review of current provision and main principles for commissioning, Public Health England (2017), p.18.

(given data indicating much higher levels of demand). It would appear the low numbers in treatment are a combination of significant cuts to the young people's treatment budget and the shift to a new provider who provides an integrated offer covering sexual health and emotional wellbeing as well as substance misuse.

While trying to build a picture of how many young people would benefit from drug or alcohol treatment is difficult, the prevalence rates set out indicates that the numbers are far in excess of 107. To take just a few metrics: over 6,000 young people in Lewisham have drunk alcohol in the last week and 980 drink at least once a week; 1,471 young people have taken drugs in the last month. While by no means all of these young people would benefit from specialist services, the numbers do however indicate a current levels of demand that is far in excess of numbers currently in treatment.

The data regarding drug use for those in treatment is consistent with the picture developed throughout this report. 91% of those in treatment in 2019-20 used cannabis. This compares to use of Class A drugs at extremely low levels (heroin and crack cocaine users making up zero per cent of the treatment population in 2019-2020 and 3% the year before). As is clear, cannabis use is a significant issue among young people in Lewisham and this is reflected in the treatment population.

Note also that 20% of young people in treatment (in 2019-2020) use two or more substances.

The report therefore shows that the current treatment system does not appear to be addressing need in the borough.

Drug use in the wider young people's population

Data from the national HRBQ survey makes clear that drug use is not limited to the very small minority of young people who end up in specialist treatment. By the age of 13 2% of young people had taken a drug. This figure rises steeply so that, by the age of 15, it reaches 12% of young men and 11% of young women. A separate national survey indicates that just under a quarter of those in school years 7 to 11 have ever taken drugs. This gives a figure for Lewisham of nearly 4,000 young people. The same survey indicates that 17% of young people have used drugs in the last year (giving a figure for Lewisham of around 2,700).

Moreover the data from the HRBQ survey makes clear that, by the age of 15, for some young people consumption of drugs is already relatively frequent with 3% in this age cohort reporting use in the last

month. The ONS survey reports 9% of young people having taken drugs in the last month (using a wider age cohort) thereby giving a figure of around 1,400 young people in Lewisham.

Of some concern, young people felt that the effect of lockdown has been to increase drug use among young people who were seeking ways to manage the isolation and boredom. (Note that this was also picked up with specific reference to alcohol use – see below).

Age

It is striking that, for those in treatment, over a quarter (29%) began using the main problem substance under the age of 15. While in line with the national rate of 28% this clearly indicates a need to address and engage young people at as an early stage as possible. It is clear that, by their mid-teens, many young people have already started to experiment with drugs and some will already be on a pathway which will require them needing specialist support.

Professionals working with young people corroborated early onset of substance misuse, talking about young people in primary school using tobacco and alcohol and that cannabis use is already common by early teens.

Young people themselves noted that drug use can start among their peers from the age of 11 upwards and felt that it was relatively common by 14 to 15 years (albeit some felt that common use was slightly older).

Vulnerable groups

The data makes clear that a number of cohorts of young people in Lewisham are particularly vulnerable to substance misuse. These groups are addressed below.

Offenders

The treatment data also indicates that 16% of those in treatment are involved in offending or ASB (the single most common vulnerability) while referral data backs up the point with 28% of referrals made from youth justice services (compared to a national picture of 20%). As such the data emphasizes the importance of pathways from youth offending and other criminal justice provision into treatment.

Data from the YOS indicates an even greater significance for criminal justice pathways: YOS data indicating that 58% of their clients are assessed as having a substance misuse issue and that 41% are receiving a substance misuse intervention (89% in 2020). Once again, the data are stark insofar as the

overwhelming majority of their clients have been charged in relation to possession of cannabis. Once again then there is a theme of the preponderance of usage of cannabis over other drugs.

Parental substance misuse

Data from adult treatment services indicates clearly that there are a cohort of parents/carers in treatment for drug and alcohol misuse who are both a parent and live with their child(ren). Data for 2019-20 indicates that there are 44 parents in drug treatment living with a child and 38 parents in alcohol treatment living with a child. While the proportion of adults in specialist treatment who are parents is lower than national rates, it nonetheless remains the case that there are at least 82 parents who have children who are exposed to the additional vulnerability of substance misuse in the home. As noted in the report, this is of course a significant under-representation of the true scale of the problem as only accounts for parents currently in treatment and therefore does not factor those people with a substance misuse need who are not engaged in any form of support.

While the data clearly shows a cohort of young people at significant vulnerability treatment data (see Table 10) indicates that only 7% of children in treatment were flagged as having been affected by another's substance misuse. This would appear to flag a gap in data collection or the failure of services to look at the wider factors in a young person's life. This point is emphasized by the young people. Where they have parents who take drugs, the consumption of these is normalized and so is likely to be transmitted to young people. Of considerable significance, some young people reported that their parents provided them with the funds to buy drugs.

Peer associations

While the majority of local young people do not use drugs and alcohol, the data makes clear that they often have a peer who does. Strikingly, by the age of 9, 11% of boys know someone who takes drugs. By the age of 15 exactly a third of young men and women know a person who takes drugs. This makes clear that drug use is a common part of many young people's lives.

The ONS survey indicate that over a third (38%) of young people had been offered drugs at some point, which for Lewisham gives around 6,000 young people having been offered drugs.

Young people themselves were aware of the effects of peer association. The most commonly cited reason for drug use was being introduced by a peer.

Again, this emphasizes the need for young people to understand drug use and its implications as many will clearly learn “lessons” about drugs from their peers.

The role of peers is further emphasized as, when asked who they would approach for support, young people commonly cited a friend. Therefore peers can also provide a route by which to offer support and advice.

Alcohol use

21% of boys aged 15 and 23% of women this age had consumed alcohol in the last seven days. In a separate national survey, 10% of young people (school years 7 to 11) report having had an alcohol drink in the last seven days. When applied to the population for Lewisham, this gives a total of over 6,000 young people. Moreover, in the same survey, 44% of young people (in the same school year cohorts) reporting ever having had an alcoholic drink which equates to some 7,000 young people in the borough. Finally, in the same survey, 6% of young people report drinking alcohol at least once a week, giving a number of just under 1,000 when applied to Lewisham.

It is clear therefore that alcohol is very commonly used by local young people and that many are consuming (and regularly consuming) alcohol at an early age. An interesting finding from the consultation with professional stakeholders is the possibility that alcohol use has increased amongst young people during lockdown. Lack of access to marijuana and the fear of being caught at home smoking cannabis has (it is said by some professionals) led to young people seeking out alcohol as an alternative. While there is no data to corroborate this shift there is a possibility that young people’s alcohol use will have increased as a consequence of the lockdowns.

Tobacco use

While not the focus of this report, levels of tobacco usage are worth noting. Data from a national survey indicates that 16% of those in school years 7 to 11 have smoked tobacco. Applied to Lewisham this gives a figure of around 2,600 young people. While level of current smoking are much lower the data indicates that 5% of those in these school year cohorts currently smoke, giving a figure for Lewisham of around 800 young people.

Note also figures for vaping with exactly a quarter of young people indicating that they have used an e-cigarette- giving a figure for Lewisham of just over 4,000 young people.

Cannabis

As noted above, the data for consumption of cannabis are striking with 91% in treatment using cannabis (although it is worth re-emphasizing that the national rate for young people in treatment who use cannabis is 86%). Essentially therefore this points to the fact that the treatment system is largely one that deals with problematic cannabis use.

Looking at the wider community of young people, by the age of 15 some 12% of boys and 10% of girls had used cannabis at some point. The data therefore highlights how widespread cannabis consumption is and how early use of it starts.

The data needs to be looked at in relation to young people's attitudes towards cannabis. In the HRBQ survey (albeit for the whole of England) 22% of young men aged 15 and 17% of young women thought cannabis was always unsafe - that is to say, a clear majority of young people think that cannabis *is* safe. The qualitative data from young people evidences this point. While some were able to describe risks associated with cannabis use, others did not see many (if any) negative effects associated with its use. Young people did however have a somewhat nuanced understanding and were able to point to a sliding scale of harm whereby the risk increased with the level of consumption.

Of some significance, young people note that some young people live with parents who are aware of their drug use but who do not attempt to manage their drug use.

The qualitative data bears out the findings from the survey data whereby professionals note the extensive use of cannabis among young people.

The use of other drugs

The evidence in this report makes it clear that the drugs most frequently used by young people are cannabis (and particularly skunk) and alcohol.

The data indicates no heroin or crack use in the period 2019-2020 and 3% the year before (compared to 2% nationally). (Note also that no young people in treatment in 2019-2020 were recorded as being or having injected drugs).

There is a striking difference in the rate of stimulant use between the Lewisham population (6% of young people in treatment) compared to nationally (25%).

It is important to note that there is some indication that young people are moving to drugs which are relatively novel in terms of the treatment population. The young people interviewed referred to use of "lean" (meaning prescription cough medicine) and "forget-me-not" (which refers to Rohypnol). It is evident therefore that young people are seeking new drugs to use. It is not possible to quantify the extent to which these drugs are being used and whether they are being used in combination with other drugs (particularly cannabis and alcohol). It however makes clear that drug use is constantly shifting and young people are migrating towards the use of novel substances.

7 Recommendations

Based on the evidence as set out in this report a number of recommendations have been made. We recognize that there are clear limits to the resources that are available to young people's substance misuse services. As such the recommendations have been prioritized and are set out in ranked order (i.e. the first recommendation has the highest priority, the last recommendation has the lowest priority).

Rationale

The rationale for the recommendations and the subsequent prioritization is that:

- Numbers of young people in specialist treatment in Lewisham are very low and do not appear to be close to matching actual levels of demand. Therefore the key priority should be to engage greater numbers of young people in structured treatment.
- While the main focus should be improving links to specialist treatment, the universal offer in place for young people to receive messages about drugs and alcohol does not appear to be well utilised. This means that there appears to be an acute lack of preventative work.
- The treatment system could benefit from the evidence base that incorporating families in the treatment process can help to improve outcomes. Moreover this will help respond to the evidence in this report about numbers of young people who live with a drug using parent or carer. Moreover the data from the report (showing high links between substance misuse and a range of vulnerabilities) indicates that young people could be better supported by adopting a multi-disciplinary approach that brings together a range of key professionals.
- Finally the current offer could, if possible, be extended by providing a range of low intensity interventions that can engage and respond to young people's needs before they require specialist interventions. This could be well complemented by peer led initiatives.

Recommendations

1. Given the very low numbers of young people currently receiving treatment, numbers of young people entering treatment should be enhanced to better align with the demand for treatment. Improvements should be made to referral pathways into the treatment service with particular emphasis on the following priority areas:
 - Youth Offending Service
 - The secure estate and custody
 - The Concern Hub
 - CAMHS
 - Children's Social Care
2. The data regarding substance misuse education gives some cause for concern insofar as it is not possible to state with any confidence how many young people (if any) have received drug awareness messages. Given this Lewisham Council should ensure that a universal substance misuse education programme is available and offered to young people in the borough through schools and other young people's services. The education programme should provide clear data on number of sessions delivered and the number of young people engaged.
3. The universal education programme (above) should develop strong links to the Improving Health and Wellbeing in Schools drug and alcohol offer to better support in-depth, specialist and targeted education work to be carried out which complements the universal offer.
4. Commissioners should incorporate family-based treatment into the young people's treatment offer, meaning that works young people are supported in the context of their family. The specialist treatment offer for young people should therefore be accompanied, as far as possible, by group work with the family to build skills and capacity in the wider family. The family-based approach should explicitly explore and address Hidden Harm (i.e. parental substance misuse) as required.

5. Commissioners should consider shifting how treatment services are currently delivered towards intensive multi-disciplinary work in which substance misuse workers are co-located alongside colleagues in Early Help, and social work teams rather than being based primarily in a drug and alcohol treatment specialist services and buildings. Strong links should be built between this team and other key groups working with vulnerable groups of young people including (but not limited to): LAC, NEETs, YOS and CAMHS.
6. Commissioners should consider investing in brief intervention and other low intensity interventions (such as motivational interviewing) to support young people who use drugs and alcohol but where usage does not warrant engagement with specialist treatment. The service should particularly focus on cannabis and alcohol consumption but should not be limited to users of these substances. The low intensity offer can be delivered through a range of channels including online/digital.
7. Commissioners should consider the feasibility of developing a peer-led awareness led by and delivered by young people – ideally including those with some lived experience of substance misuse. Young people should be supported to develop promotional information and deliver awareness raising activities for young people in the borough.

