JSNA For Substance Misuse (Adults) for Lewisham Council

The Centre for Public Innovation

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

Contents

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 references 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/ViewIt/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.

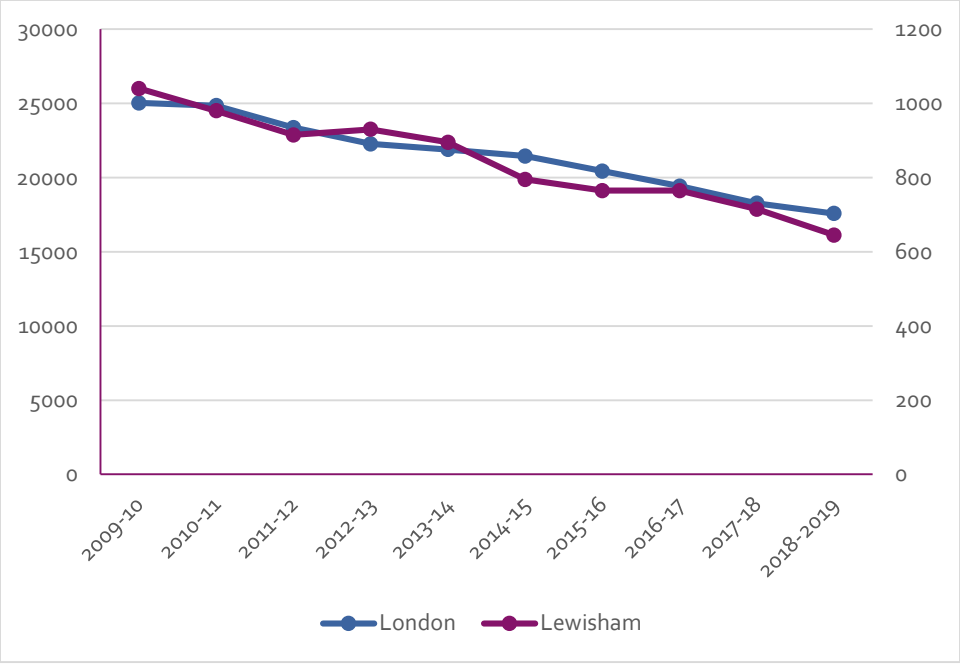
4.1.1 Drugs

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 1,0000 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 correlation[1] (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] R^1= 0.97

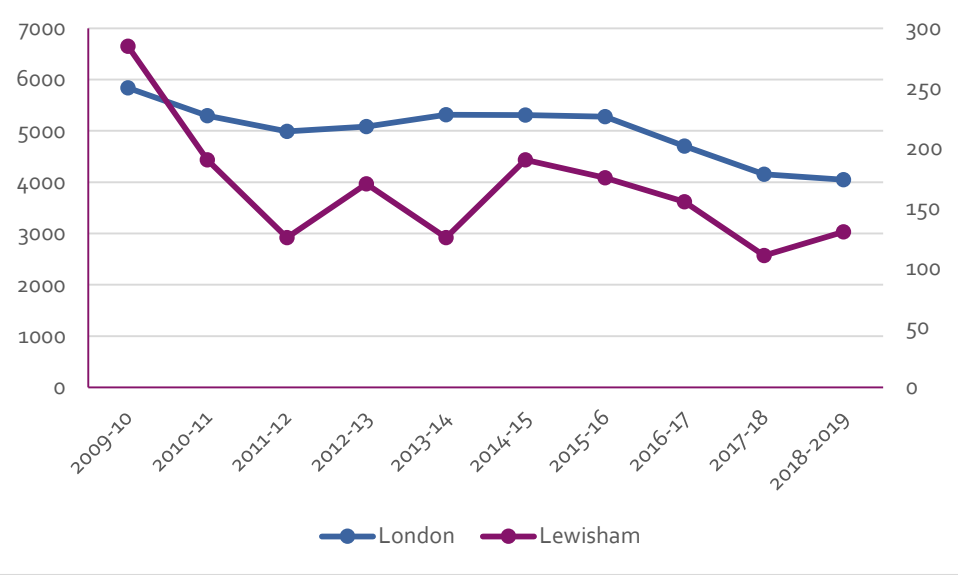
The data on what these trends are is not definitive but appears to be linked to an ageing opiate using cohort with very few younger people using opiates. As such, the numbers of heroin users are diminishing over time with very few "new" heroin users replacing them and requiring treatment.

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.

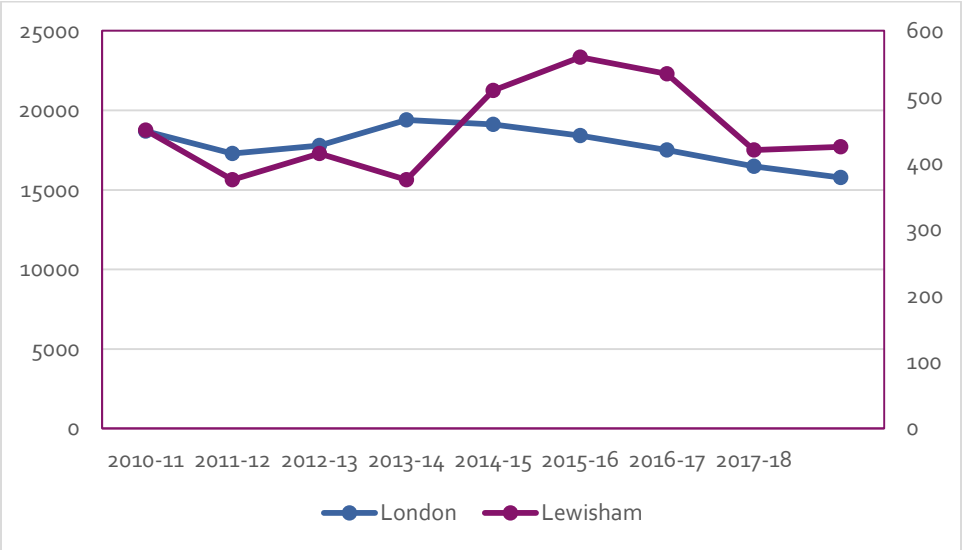
This analysis is set out graphically at Figure 2. While there is a degree of fluctuation between the two figures, as noted above, statistical analysis indicates a correlation between the trend in Lewisham and London.

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 as a whole 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 significant[2] 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)

	Year									
Length in treatment	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)

	Year									
Treatment Exits	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%)

	Year									
Treatment Exits	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%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	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%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Treatment withdrawn	0 (0%)	95 (12%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Moved away	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
No appropriate treatment	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Not known	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Other	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Referred on	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Inconsistent	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	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)

	Year									
Clients completing treatment and not re-presenting to treatment	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

	Abstinence			Significant reductions in use		
Six-month review outcomes	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 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

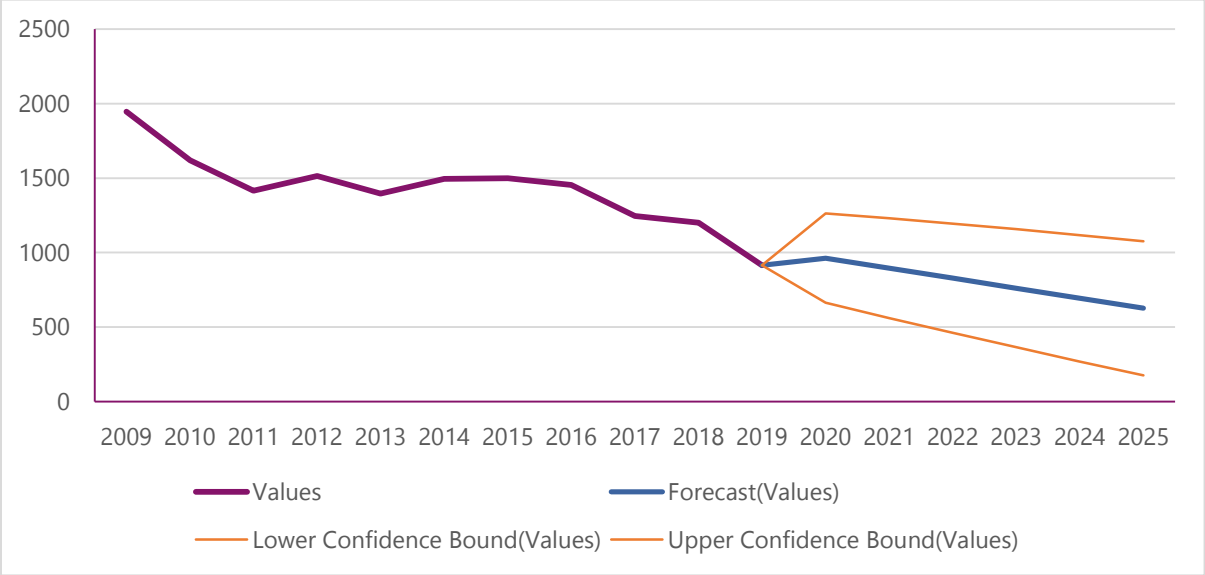
This section seeks to understand what the future demand for drug and alcohol services may be by extrapolating from the treatment trend data described above (Table 1).

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)

	Year										
Age Group	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: Viewlt 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.

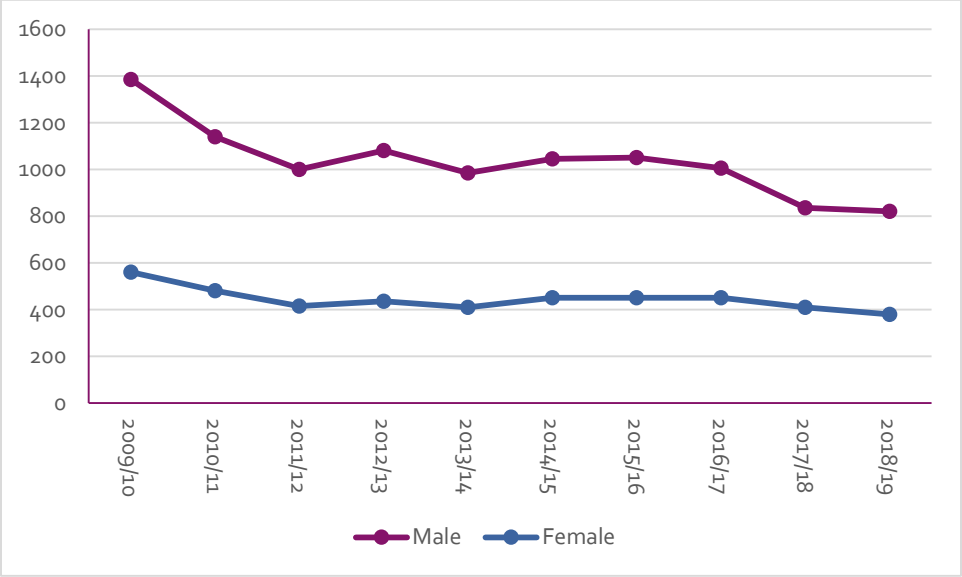
Table 22 Changes in gender, 2009-10 to 2019-20 (numbers and percentage)

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%

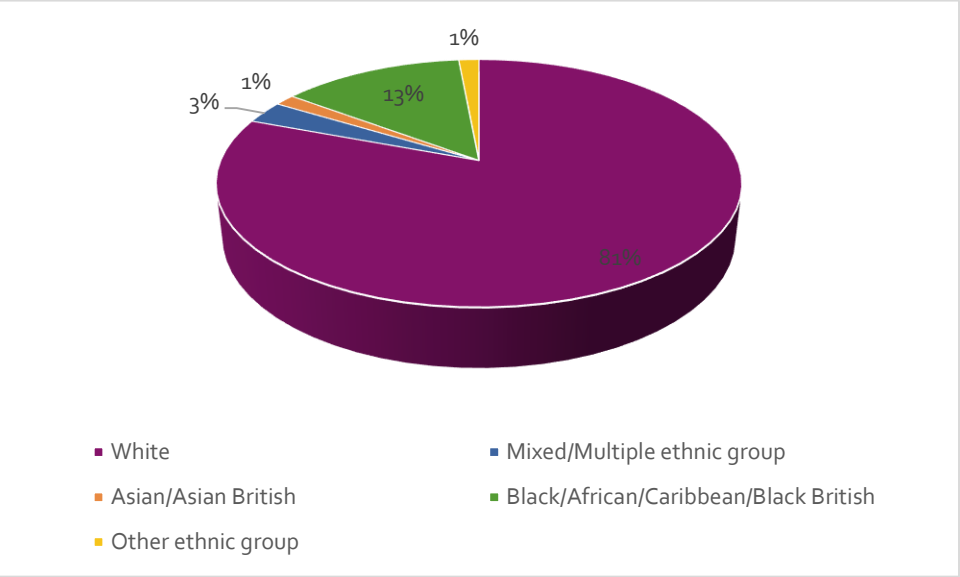
(Source: ViewIT. Note that the data derived from the JSNA adult packs use 'new to treatment' rather than the total or 'all' numbers in this table).

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)

	Year									
Housing Situation	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)

	Year									
Employment Status	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

Hepatitis B	Lewisham 2019-20 (number)	Proportion of new presentations (Lewisham)	Proportion of new presentations (National)
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 be 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:

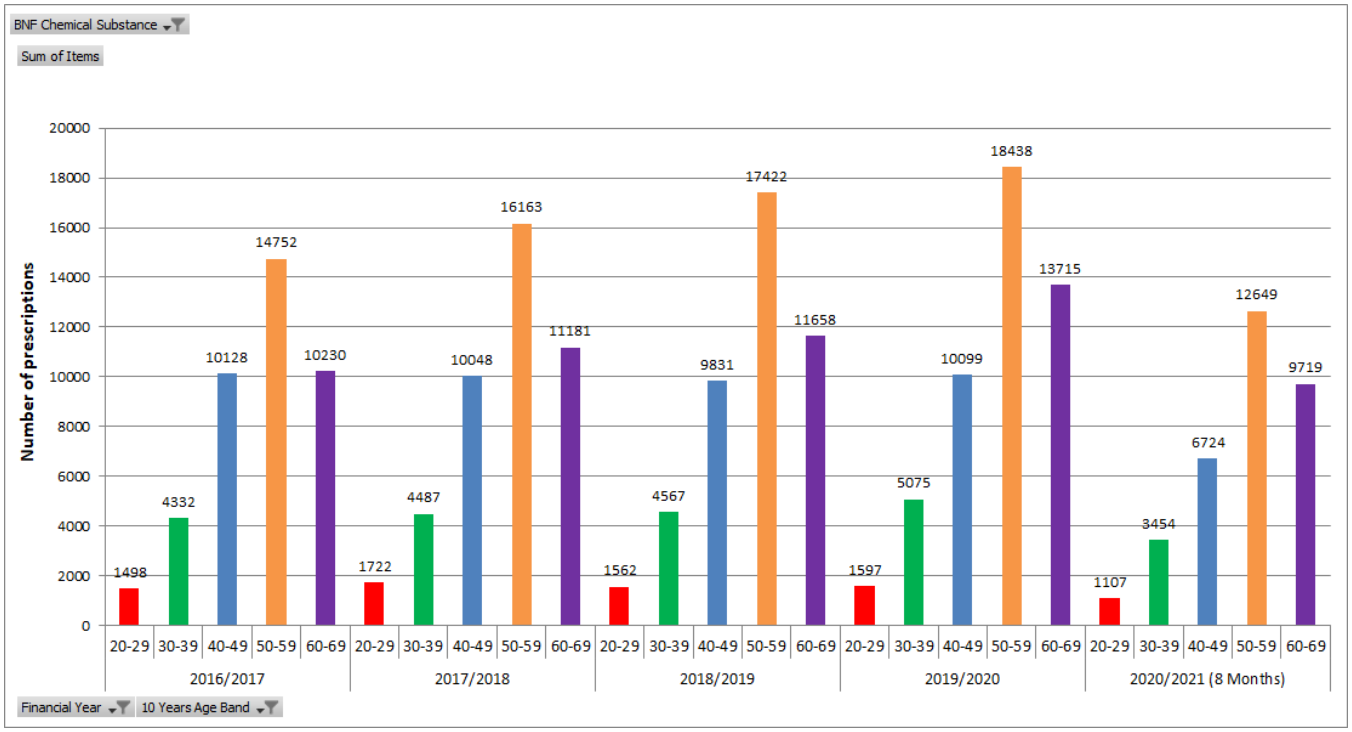
- tramadol,
- gabapentin and
- pregabalin

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%

(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 20202 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

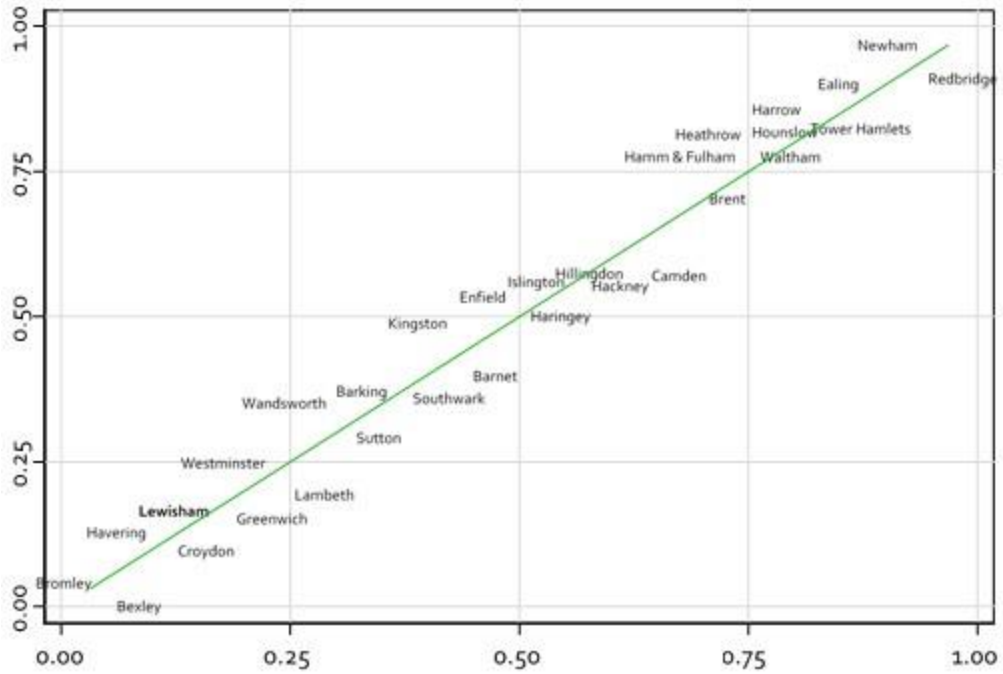


Figure 8 shows that Lewisham lies within a cluster of boroughs with a below average level of positive tests for opiates and cocaine. These show that Lewisham tends to cluster with other South London boroughs (Bexley, Bromley, Croydon, Greenwich, Lambeth) with regard to detainees in police custody that 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

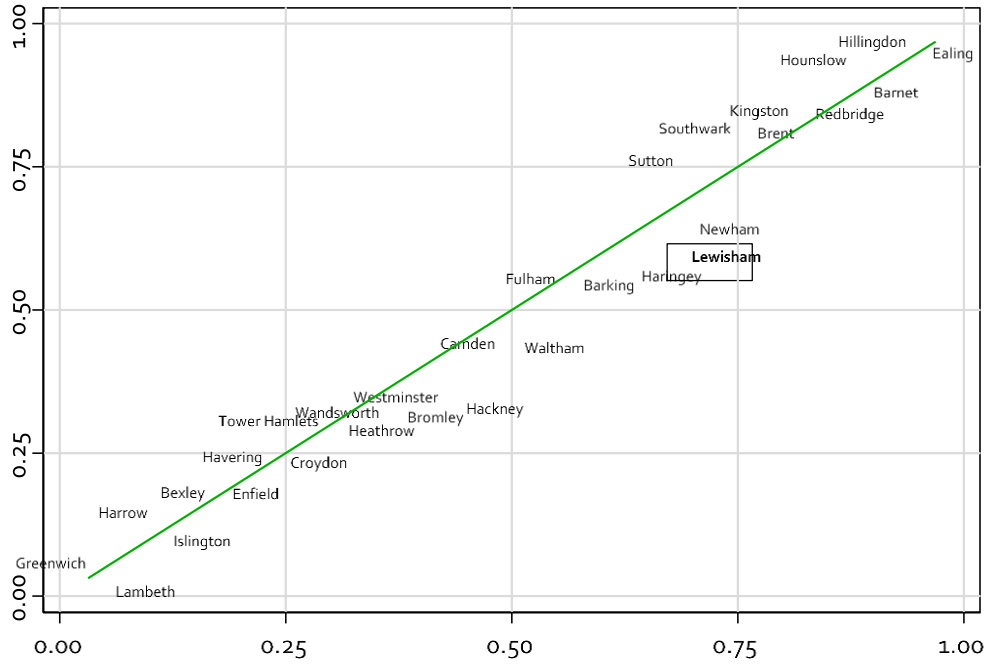


Figure 9 shows that Lewisham lies within a cluster of boroughs with a higher than average level of positive tests for opiates only. These show a cluster around North and East London (Haringey, Newham and Barking and Dagenham) and to a lesser extent Hammersmith and Fulham.

Cocaine

Figure 10 London-wide random effects for: positive test for use of cocaine

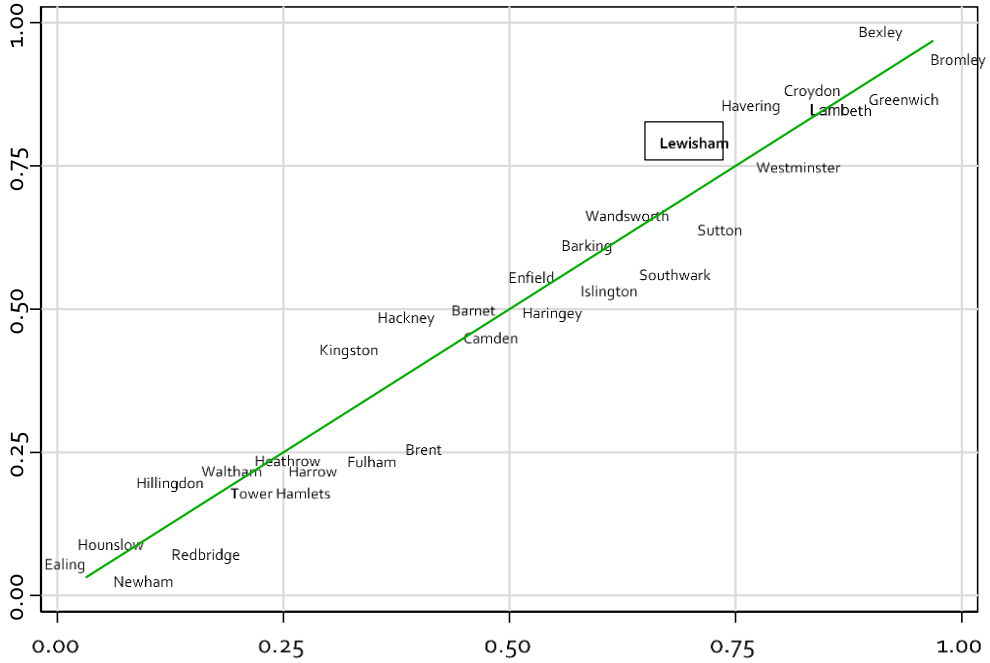


Figure 10 shows a cluster of boroughs in South East London emerge as those boroughs who were considerably more likely to test positive for cocaine-only (Bexley, Bromley, Croydon, Greenwich, Lewisham and Lambeth).

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 are 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 routed 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 than 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 recovery[5]. 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 instance[6].

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].

Gilman[11] 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 England[13]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 practice'[14]. It requires that a culturally sensitive attitude, principles of equal access and non-discrimination are translated into behaviours and action in service delivery[15].

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 training[16]. 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 competence[17].

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[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 activity[18].

[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 education[19].

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.

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[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 choice[30].

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[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 mosques[33].

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 facilities[36].

[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 Walpole[49] 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 Ditton[61] and Bentley and Hanton[62] 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'. Goode[63] 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 practice[64]. 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 important[65]

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 consultation[71].

An outreach project in Bradford employed outreach interventions to engage the wider Asian community[72]. 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 solutions[73].

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 communities[80].

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 working[82].

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 research [90] 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 on[96].

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 confidentiality[97].

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.

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[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 with 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 references 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 pharmacists. 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.