

ESSEX  
Drug and Alcohol  
Health Needs Assessment



ESSEX  
RECOVERY  
FOUNDATION

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## EXECUTIVE SUMMARY

### Background & Context

The Essex Recovery Foundation (ERF) has undertaken a comprehensive needs assessment to look at all aspects of the local drug and alcohol treatment system and how best to meet the needs of the individual. Focusing on what the experience is for individuals who access those services and to better understand the reasons why individuals do not wish to access them. Future plans and focus may flex or change dependent on the findings of the needs assessment. ERF commissioned TONIC to work with them to undertake a drug and alcohol needs assessment for Essex, to inform future planning and commissioning decisions. The evidence provided in this needs assessment is designed to inform strategic investment decisions, providing contextual information about substance use, treatment, and current need.

### Current Policy & Strategy

The main policy context for efforts aimed at tackling drugs is the Government's 10-year drug strategy 'From Harm to Hope', published in December 2021 (as the Government's alcohol strategy has not been updated since 2012). This latest strategy sets out three main objectives:

#### Breaking Drug Supply Chains

The plan sets out a vision to "level up our neighbourhoods by ridding them of drugs, making them safe and secure places and enabling all areas to prosper and grow" and states that its priority is to cut off the drug supply that is causing most harm. This involves a particular focus on 'rolling up' County Lines, targeting funding towards the three dedicated County Lines Taskforces and specialist support for criminally exploited young people and their families.

#### Delivering a World-Class Treatment & Recovery System

The strategy promised to invest an additional £780 million in drug treatment over the next 3 years. This would be used to adopt a whole system approach which will expand treatment capacity, rebuild the drug treatment workforce, and give local leaders more power and accountability. In addition, the funding will help build stronger partnerships with education providers, local authorities, the NHS, and criminal justice agencies.

#### Achieving a Generational Shift in Demand for Drugs

The strategy aims to reduce the demand for drugs, breaking this down into three objectives:

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

### Evidence of What Works

There is a variety of evidence that tells us about effective practices and highlights recent developments that can be used to improve outcomes and modernise service delivery. This can be split into four key practice areas:

- Harm reduction – inc. opioid substitution treatment, BBV prevention and treatment, needle exchanges, outreach work & health promotion
- Substance misuse treatment & recovery for adults – a comprehensive offer in line with NICE clinical practice guidelines, with peer-led recovery communities
- Substance misuse support for young people - holistic and child-centred instead of substance-centred
- Targeted prevention – focussing on the risk factors and social determinants that make individuals vulnerable, using evidence-based approaches such as advice and brief intervention (IBA)

## Design, Methodology & Sample Overview

To deliver this drug and alcohol needs assessment, **TONIC engaged 538 local people** through the following activities:

- **Literature review:** that summarised national key documents, policies, and strategies to provide insight into the current understanding, knowledge, and approach, focusing on who is at risk and why, and evidence of what works.
- **Quantitative data analysis:** of a range of local quantitative data about alcohol, drugs, and young people, focusing on overall prevalence, indicators of need, and details about treatment and outcomes, highlighting trends, issues, and topics where Essex differs from the national picture.
- **Qualitative fieldwork:** surveys, In-depth interviews and focus groups reaching:
  - **282 people with Lived Experience**
    - 165 paper survey responses
    - 60 long survey responses (45 with lived experience and 15 on behalf of someone with lived experience)
    - 37 short survey responses
    - 10 in-depth Interviews
    - 9 focus groups
  - **231 Stakeholders**
    - 194 survey responses (50 of whom self-reported also having lived experience)
    - 37 in-depth interviews
  - **25 people preferred not to say** what respondent type they were (survey responses)

## What the Data Tells Us

The following table sets out the key findings from our analysis of data in Essex:

*Table 1 Summary of Quantitative Data Analysis Findings*

Quantitative Data Analysis Key Findings	
<b>ALCOHOL</b>	<ul style="list-style-type: none"> <li>• Essex has succeeded in engaging constant numbers of people in alcohol treatment over the last decade despite the impact of cuts in public funding. However, Essex only engages 1 in every 8 of those in need into treatment.</li> <li>• The number of people entering alcohol treatment last year (2021/22) fell by 10%</li> <li>• Essex will need to significantly increase investment in additional treatment capacity to meet the needs of the estimated 87% of the in-need population not currently in treatment.</li> <li>• This is important given:                     <ul style="list-style-type: none"> <li>○ The higher-than-average levels of unsafe alcohol use locally</li> <li>○ A number of studies have reported increases in alcohol consumption during the pandemic</li> </ul> </li> <li>• Where people do enter treatment, Essex engages a substantially higher proportion than the national average</li> <li>• It would be valuable for Essex to know the extent of screening and brief interventions taking place in primary care, in order to assess whether this proven harm reduction approach is under-utilised locally</li> </ul>

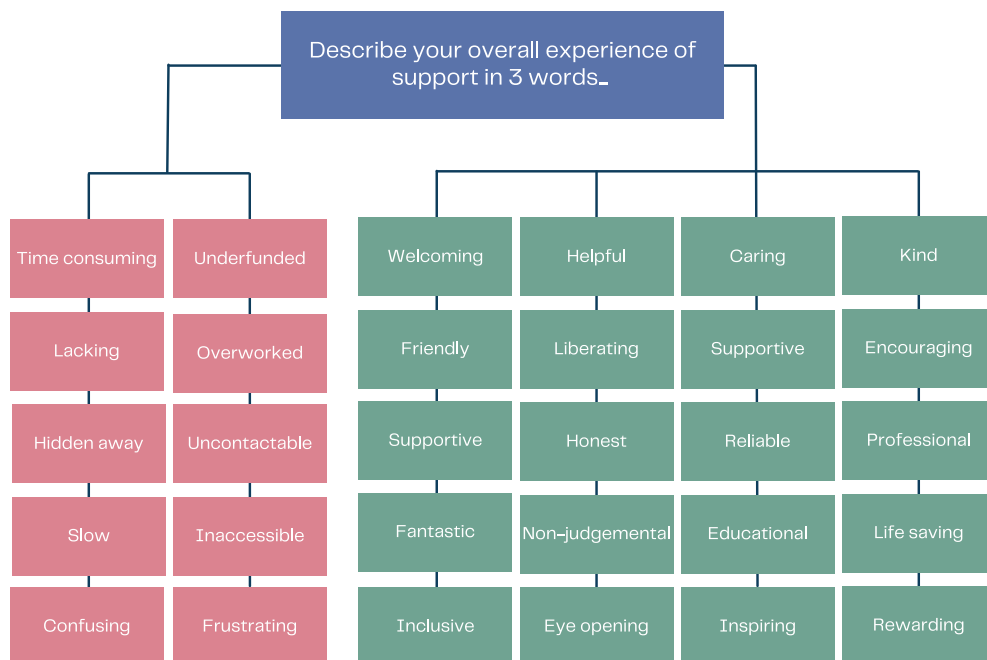
<b>DRUGS</b>	<ul style="list-style-type: none"> <li>• Essex has successfully engaged constant numbers of people in drug treatment over the last 10 years</li> <li>• The profile of this population has changed in this time, with fewer opiate users and more users of other drug types. Nevertheless, opiate users remain by far the largest group in treatment (66%)</li> <li>• The rate of drug-related deaths is well below the national average</li> <li>• People in Essex are more likely to refer themselves into treatment than average and much less likely to be referred via the criminal justice system</li> <li>• Help with drug problems is less likely to be delivered within primary care in Essex</li> <li>• People are only half as likely to attend residential rehabilitation compared to the national average</li> <li>• Essex treatment services are successful in helping high numbers of people become abstinent or substantially reduce their use of a wide range of substances</li> <li>• Providers are successful at tackling injecting behaviour, with services particularly successful at engaging people to participate in both Hepatitis B and C vaccination programmes</li> </ul>
<b>CHILDREN &amp; YOUNG PEOPLE</b>	<ul style="list-style-type: none"> <li>• Essex faces the same challenge as most of the country in terms of engaging more young people in drug and alcohol treatment – with reported drug use by young people increasing over recent years while numbers in treatment continue to fall</li> <li>• Treatment referral routes from education services work particularly well, but more attention needs to be paid to referral routes from criminal justice (particularly for young men) and from Children and Families Services</li> </ul>

## The Voice of Lived and Living Experience

Over 240 people who are using or have recently used treatment services in Essex rated the current system in our survey and interviews. The average rating for each step of the journey as “good” (over 4 out of 5), with the exception of recovery, which was rated as a high “adequate” (3.7 out of 5). These are shown in the following diagram:



We asked service users to describe their experience of treatment in 3 words. Overall, there were mostly positive experiences of treatment by service users, but some key areas for improvement were highlighted:



Many said that having multiple commissioned services in the area can be problematic and confusing. This included the number of different referral pathways used for each service – people felt this should be streamlined. There was a call for a single treatment service provider across Essex - building on all the local good practice. Some felt a need for improved joint working, communication and training from the different services, so that all referring professionals are aware of *specific* support each service offers, to avoid mis-referrals or unmet need.

There was appetite for a greater suite of psychosocial groups and diversionary activities - particularly in person.

Some felt the pathway into recovery was clearer for those using alcohol, and less so for opiate users. It was reported that it is harder to see opiate users in visible recovery.

High staff turnover means keyworkers were reported to change often, which was said to decrease service users’ motivation, engagement and progress. The solution was thought to lie in improving staff retention through robust training programmes, competitive salaries and smaller caseloads that permit in-depth working with clients and allow for greater job satisfaction.

It was felt there was a lack of clear and consistent “aftercare” pathways to support people through and out of treatment, and still very little visible recovery community to inspire people and motivate change.

Many raised issues with COVID-19 restrictions limiting access to buildings, waiting rooms and some group activities run before the pandemic.

## The Views of Stakeholders

Over 230 stakeholders took part in depth interviews or surveys to share their views on prevention, tackling supply and treatment. Their average ratings (out of 5) for the following areas shows that they largely saw treatment as “adequate” (with some aspects as “good”), highlighting some areas for attention. On average stakeholders rated prevention and tackling supply as below adequate:

PREVENTION	TACKLING SUPPLY	HARM REDUCTION & OUTREACH	ASSESSMENT	TREATMENT	OTHER SUPPORT ALONGSIDE TREATMENT	RECOVERY
Avg Rating <b>2.6</b>	Avg Rating <b>2.8</b>	Avg Rating <b>3.0</b>	Avg Rating <b>3.3</b>	Avg Rating <b>3.1</b>	Avg Rating <b>2.9</b>	Avg Rating <b>3.2</b>

They identified the following strengths and areas for improvement:

STRENGTHS	AREAS FOR DEVELOPMENT
Drug assessment	Restricting supply of drugs and alcohol into prisons
Prescribing assessment	Support for people with learning disabilities like ADHD and Autism
Drug and alcohol treatment for adults	Delivering school-based prevention & early intervention with CYP
Drug and alcohol treatment for young people	Supporting young people & families most at risk of substance misuse through programmes providing early, targeted support
Prescribing services	Public health campaigns on drugs, alcohol & tobacco
Support to help people get into employment	In-reach and links to prisons
Mutual Aid - e.g. NA, AA, CA	Support for families, carers or partners of people with drug / alcohol issues
Recovery groups – e.g. SMART Recovery	Community or residential rehabilitation
Peer-led support	Community or in-patient detoxification
	Support for people who also have mental health issues (dual diagnosis)
	Support for people BAME groups

## Prevention

**Strengths:** Stakeholders identified the following as strengths of the local approach:

- EYPDAS service for under 18s
- Risk in the Community (RIC) and Missing & Child Exploitation (MACE) meetings for young people vulnerable to exploitation
- The specialist response at EYPDAS to 18-24s
- Project NOVICE in Basildon
- Risk Avert programme in schools

**Area for Development:** There was a call to develop an Essex-wide drug and alcohol prevention or wellbeing strategy for schools.

## Tackling Supply

**Strength:** The response to County Lines and wider drug supply was reported as a strength in Essex, but this was felt to need constant review due to the ever-changing nature of organised crime groups and street gangs.

**Area for Development:** HMP Chelmsford was reported to have, issues with prisoners diverting their medication, which needs to be addressed. The issues with illicit drug supply in the prison (recognised by HMIP inspectors) was said to be being addressed by a joint action plan between HMPPS and Essex Police.

## Treatment System

### Strengths

- Overall, the treatment provision in Essex was felt to be of good quality
- The partnership model of treatment delivery is seen as largely positive, allowing each service to focus on what they do best
- Co-location, following teething problems and a re-think during COVID-19, is now considered to be working well
- The establishment of the Essex Recovery Foundation (ERF) was widely seen as a strength, with lots of potential to bring about positive change through a genuine co-production approach with services users and people with lived experience
- We were told that a number of staff across the treatment services have lived experience was a strength of local provision
- Long-term funded contracts were seen as positive, allowing for services to develop and invest in their workforce and infrastructure
- Offering evening clinics, satellite clinics in rural locations, and having a 'no wrong door' approach were viewed positively
- The Buvidal pilot is working well, with significant benefits for service users
- The role of dedicated dual diagnosis workers was felt to be a positive step but needed to be expended to meet high levels of demand
- Most aspects of the criminal justice response were reported to be working well, with extra funding due for more dedicated workers
- Essex has a comprehensive offer for Blood Borne Viruses (BBV) prevention and treatment (Hep B/C & HIV)



## Areas for Development

- The current system, with multiple providers, service types and pathways were felt by some to be confusing and seen as overly complex to some service users and partner agencies. It was said that there was not always good communication between services meaning they do not always know about the full range of services available
- There are low penetration rates for engaging opiate and crack users (OCUs) in treatment in Essex
- People living in rural and coastal areas, smaller towns, and villages with poor transport systems have greater difficulty accessing services
- There was felt to be little promotion of treatment services to the community as these services are already at capacity and would not be able to cope with increases in demand (capacity is already below potential demand)
- Caseloads were felt to be far too high and to impact negatively on both the quality and frequency of support that can be offered
- Limited opportunities for people in treatment to gain employment or work experience was raised as a gap
- A lack of affordable, accessible and suitable housing provision and meaningful supported accommodation has been seen for substance misuse clients, as they can be seen as too high risk and too high need for general housing
- People from minoritised ethnic groups, women, and people from LGBTQ+ communities were felt to be underrepresented in the treatment population
- Services have seen limited numbers of people accessing treatment as a result of chemsex activities, which they understand is a growing issue in Essex
- It was felt the coming years will see a worsening of the cost-of-living crisis, driven by high inflation, that will impact disproportionately on treatment clients, and there is currently a lack of practical help with this that services offer
- The national shortage of pharmacists is leading to closing of some Essex pharmacies, which has a big impact on clients picking up their medication, resulting in them having to get new prescriptions and find new pharmacies - dealing with this costs services both time and money
- Support for families was described as somewhat patchy, without a consistent offer to all ages, all substances, all stages of the treatment journey, across all areas of Essex.
- In spite of additional detox provision, there are waiting lists for inpatient detoxification
- There are now reduced numbers of placements for residential rehab - limiting the choice, variety and quality of specialist provision available

## Recommendations

Arising from the analysis of data and the views of people with lived experience and stakeholders, a number of recommendations are made for consideration. They are summarised here and set out in full in the recommendations chapter (Chapter 6) of this report:

### Prevention

- In order to develop the most effective Children and Young People's substance misuse service for Essex, effort should be made to ensure a holistic child-centred approach that does not just focus on substance misuse. This could involve expanding the offer to include trauma-informed early interventions, take learning from and potentially expand the Novice Pilot and optimise supportive prevention structures, such as increasing the use of digital interventions.
- To achieve a generational shift in the demand for drugs, there is demand for an overarching drug and alcohol strategy for schools in Essex. With a clear policy and pathway on drug and alcohol exclusions to

reduce their use/duration. Supported by best practice guidance for universal education. This could involve exploration into the ways to contribute to the development and monitoring of school curriculums to encourage schools, colleges, and other education providers to ensure their curriculums incorporate age-appropriate drugs and alcohol education exploring the risks and dangers of substance use and misuse, teaching people about the realities of drug dependence and addiction, focusing on the short-and long-term mental and physical health implications, the impacts on all other aspects of an individual's life, and wider negative repercussions to friends, family, and society in general, harm reduction techniques, as well as teaching healthy coping strategies to build resilience. One way this could be done, is by taking learning from the Risk Avert programme and expanding the programme to more schools across Essex.

### Tackling Supply

- Engage people with lived/living experience in providing intelligence related to local drug markets to Essex Police when conducting more regular (twice yearly) drug market profiles.
- Continue to enhance security measures to restrict the supply of drugs into HMP Chelmsford, reviewing progress on the joint action plan between Essex Police and HMPPS, restricting diversion of medication by supervising meds-queues, and promoting support with recovery amongst the prison population.

### Treatment

- Commissioners and service providers to develop a treatment system map that details and explains the current system: (i) for professionals and (ii) for service users, to help people navigate this. This should also be the starting point for a review of the current system map and pathways in light of requests for a simplified model to be used across Essex.
- Promote awareness and provide training amongst external partners to drive up direct referrals - to respond to underrepresented groups, including the criminal justice system (for adults and young people), children and families' services, BAME communities, women and LGBTQ+.
- Streamline the stages of access to treatment services (i.e., initial contact, triage, and assessment), to reduce the overall time between referral and support starting, and to limit the number of times/different staff an individual has to repeat their 'story' to.
- Have greater emphasis on relationship building within a trauma-informed approach.
- Increase harm reduction capacity and provision across Essex by: boosting pharmacy needle exchange provision; more strategic support of pharmacists; and enabling Open Road and peers to give out Naloxone (as they do in their Medway contract).
- Increase investment in inpatient and community detoxification and residential and community rehabilitation – with efforts to develop a more varied local rehab supplier market offer.

### Recovery

- Increase and expand the recovery offer - through expanding wider community, businesses, 3<sup>rd</sup> sector and voluntary group involvement & making recovery more visible to reduce stigma, inspire and motivate.

### Dual Diagnosis

- Create more meaningful and holistic dual diagnosis support based around the needs of the individual. Jointly developed by substance misuse and mental health commissioners and services.

## Outreach

- Focus treatment service outreach to reach more rough sleepers, people from minoritised ethnic communities and individuals misusing prescribed medication. Establishing partnerships with 'by and for' organisations will help engage more people from underrepresented groups (BAME, women, LGBTQ+).

## Criminal Justice

- Improve joint working and communication with agencies in the criminal justice system by developing a strategy between Probation and treatment system to make best use of the full range of relevant orders (ATR, DRR etc.)
- Streamline the criminal justice pathway by linking up with IOM (Integrated Offender Management), utilising the community offer for Naloxone, and improving continuity of care from prisons outside Essex where people return to Essex

## Workforce, Capacity and Quality

- Increase investment and support commissioned services to improve recruitment and retention of staff to grow capacity, build an experienced workforce, reduce caseloads, and improve quality of treatment.

# 1. AIMS AND OBJECTIVES

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

A 'needs assessment' is the systematic process of identifying and determining how to bridge the gap between an organisation's current and desired state; specifically, the findings from a needs assessment should outline and make corresponding recommendations about which areas a team should prioritise, improve, or provide additional resources to meet its goals. The results should assist commissioning, planning, and decision making, and contribute to the general monitoring, evaluation, development, and learning for organisations delivering services. There has been a recent renewed interest in drug and alcohol provision, following the Dame Carol Black Review, as well as additional funding from the Office for Health Improvement and Disparities (OHID) for local authorities.

Accordingly, TONIC was commissioned to undertake a drug and alcohol needs assessment for Essex to inform future planning and to help make strategic investment decisions based on contextual information about local substance use, treatment, and the current need.

The overall aims of this needs assessment were to provide clear, high-quality evidence regarding the needs and inequalities relating to substance use, to improve the response to substance misuse in Essex in the future. The needs assessment sought to provide an overview of the needs of individuals, families, and communities affected by drug and alcohol misuse, by:

- Identifying the demographics and specific vulnerabilities of drug and alcohol users across both local authorities
- Assessing the extent to which current treatment services and prevention initiatives meet the needs identified, describing key gaps and making corresponding recommendations to improve services
- Evaluating the extent to which agencies work cooperatively, including criminal justice partners, housing, social care, and employment services and identifying areas for improvement in linkages and pathways
- Assessing the effectiveness of integrated responses to physical and mental health issues for those misusing substances
- Determining the coverage and effectiveness of recovery services and the extent to which peer-based recovery support services sufficiently address the needs of those affected by substance misuse
- Evaluating and describing the presenting needs and profile of drug and alcohol using young people and highlighting any changing trends or complexities
- Determining the extent to which the local system is meeting family needs (parental substance misuse and children)
- Establishing the effectiveness of integration and care pathways between the criminal justice settings and drug treatment, analysing any barriers
- Describing the way in which COVID-19 affected drug and alcohol misuse, changes in presentations to services and all aspects treatment. Drawing comparisons on behaviours, access and utilisation of services pre- and post-pandemic
- Collating and interpreting existing data from multiple stakeholders and organisations to build a detailed situation analysis of the impact of substance misuse across Essex

TONIC was asked to produce a comprehensive, detailed needs analysis with clear recommendations that can be utilised for strategic planning and future commissioning decisions.

## 2. DESIGN AND METHODOLOGY

### 2.1 About TONIC

TONIC are specialists in social research and public consultation with a focus on criminal justice and public health. With a team of highly experienced and skilled researchers, academics, practitioners, and analysts, TONIC aims to help organisations make the best use of public funds and to assist them in improving outcomes for the public, especially vulnerable and under-represented groups. TONIC values the voice of service users, as well as stakeholders, partners, providers, and commissioners, to inform real-world change based on the evidence.

This work was conducted by Matthew Scott, Dr Sarah Senker, Russell Webster, and Maria Gallagher from TONIC, in partnership with Laurence Hickmott, Sally Muylers, and Jo Horgan from the Essex Recovery Foundation (ERF), and ably supported by ERF's peer researchers Anne, Dan, Ruth, Kellie, Claire, Lisa, and Toni.

### 2.2 Literature Review

To set this needs assessment in context, TONIC have provided a short review of current drug policy and strategy, followed by an overview of the groups considered to be particularly vulnerable to developing drug and/or alcohol problems and a brief overview of what the evidence base tells us about effective practice which highlights recent developments and innovations.

### 2.3 Quantitative Data Analysis

TONIC analysed and summarised a range of local quantitative data that was either publicly available or shared with us by commissioners, partners, or providers. A list of data sources is provided at the very end of the appendices. The data chapter focuses on overall prevalence, indicators of need, and details about treatment and outcomes in Essex. It highlights trends, issues, and topics where Essex differs from the national picture and is organised into three subsections – alcohol, drugs, and young people.

There are two main limitations to the data. This first is that, in order to benchmark statistics against national trends, the report relies predominantly on the OHID commissioning support pacts for 2022/23 which provide data for 2020/21 rather than the more recent 2021/22. The second is that although we know that the pandemic impacted on people's drug and alcohol use, their help-seeking behaviour, and the ways in which services were delivered, this impact varied by geographical area and while we can sometimes assume that a dip in the number of people receiving a specific service in 2020/21 may be attributable to COVID-19, we cannot assess whether this is the sole cause.

### 2.4 Fieldwork – Surveys, Interviews, Focus Groups, and Site Visits

In consultation with commissioners, three anonymous online surveys were developed: two for those with lived experience of substance use (short and long versions covering the same key questions), and one for stakeholders (including frontline practitioners, service providers, key stakeholders, commissioners, and policy makers). A paper version of the short survey was also produced and sent to all service providers to distribute with their service users.

The surveys were hosted by TONIC and yielded both quantitative and qualitative data. The only pre-existing eligibility criteria was that respondents had to either live or work in Essex. Individuals who did not meet inclusion criteria were automatically transferred to a disqualification page that provided signposting to relevant support services if required.

Interview schedules for those with lived experience, and professionals were also developed in consultation with commissioners. Interviews were semi-structured and designed to feel like a 'conversation with a purpose' (Burgess, 1982). Interview schedules were used as a guideline for the focus groups that took place.

ERF and the Peer Researchers provided feedback on draft materials to ensure they were relevant and accessible to service users.

Commissioners provided contact details for relevant professionals so that TONIC could invite them to engage with the project, this created a snowball sampling effect. Individuals with lived experience of substance use were recruited to take part in the survey through a combination of promotional materials that TONIC produced. These were distributed by local and national charities, support services, and other relevant organisations via their communication channels and social media accounts. The online survey then asked respondents whether they would be willing to 'tell us more' in a confidential interview, and frontline practitioners also signposted clients to the research team in order to contribute. Depending on the individual's preference, interviews took place via a recorded phone or video call (to allow for transcription).

We aimed to hear from a wide range of people during the process, to compare and contrast the similarities and differences in opinions to provide the most detailed picture possible.

The majority of fieldwork for this needs assessment was conducted between September and November 2022<sup>1</sup>, including site visits by ERF and Peer Researchers to nine service provider sites across Essex, spending a total of 27 hours meeting with service users. A further planned visit was cancelled due to low projected numbers in attendance.

*Table 2 – Summary of Fieldwork Site Visits*

Date	Location	Time / Hours
Monday 31 <sup>st</sup> Oct	SHARP Braintree	1 hour
Tuesday 1 <sup>st</sup> Nov	Phoenix Futures Billericay	5 ½ hours
Thursday 3 <sup>rd</sup> Nov	Open Road Mid Essex Centre	4 hours
Monday 7 <sup>th</sup> Nov	Open Road South Essex	4 hours
Tuesday 8 <sup>th</sup> Nov	Open Road West Essex	4 hours
Wednesday 9 <sup>th</sup> Nov	Open Road North Essex	4 hours
Wednesday 9 <sup>th</sup> Nov	ARC Harlow	2 hours
Thursday 10 <sup>th</sup> Nov	STaRs clinic Clacton	3 hours [Cancelled]
Thursday 10 <sup>th</sup> Nov	FIM peer mentor course Chelmsford	1 ½ hours
Thursday 10 <sup>th</sup> Nov	STaRs clinic Harlow	3 hours

<sup>1</sup> Fieldwork was extended until November 2022 for services supporting children and young people only, to try to drive an increase in responses regarding this cohort.

The Peer Researchers and ERF staff underwent training on how to conduct peer research with Dr Sarah Senker, and met weekly to discuss emerging findings, before holding a final session to share what had been learned during these discussions. Completed surveys have also been factored into our analysis in this report.

To analyse the qualitative data, we used Braun and Clarke's (2006) six-step method of Thematic Analysis:

- Step 1: Become familiar with the data
- Step 2: Generate initial codes
- Step 3: Search for themes
- Step 4: Review themes
- Step 5: Define themes
- Step 6: Write-up

Thematic analysis was chosen due to its flexible nature and compatibility with a social constructionist approach. Thematic analysis was used to explore the dataset as a whole and consider themes that emerged across survey responses and interviews, applying a constant comparison approach (Butler-Kisber, 2010), considering similarities as well as differences between individual narratives and sources of feedback. Within this framework, TONIC used an inductive method, whereby themes were derived and grounded in participant responses, rather than being imposed on the data from a pre-existing theory or hypothesis.

The TONIC Project Lead remained in regular contact with commissioners via catch up meetings and/or email updates throughout the duration of the needs assessment.

## 2.5 Ethical Considerations

TONIC researchers were extremely conscious of the sensitive nature of this research. Surveys and interview schedules were designed in a way that meant participants were asked to only share information they felt comfortable talking about. To avoid inflicting psychological harm and reduce risk of re-traumatising participants, those with lived experience were not asked to describe reasons behind their substance use, but instead were asked to focus on and discuss their experience of accessing support services, what they found beneficial, what gaps they feel exist, any barriers to engagement, and suggestions for future improvements in support across Essex. TONIC endeavoured to make the experience of contributing to this project as empowering as possible. Please refer to Appendix A for full ethical considerations taken for this needs assessment.

## 3. LITERATURE REVIEW

### 3.1 Current Drug Policy and Strategy

The main policy context for all work aimed at tackling drugs is the Government's new 10-year drug strategy 'From Harm to Hope'<sup>2</sup>, published in December 2021. The timing of the report (the previous strategy<sup>3</sup> was published in July 2017) was driven by the need for the Government to respond to Dame Carol Black's Review of Drugs, itself commissioned by the Government. This review was extremely critical of Government drug policy, in particular the deterioration in drug treatment services. Dame Carol's review was published in two parts. The first part<sup>4</sup> (published in February 2020) provided a detailed analysis of the challenges posed by drug supply and demand, including the ways in which drugs fuel serious violence. The second part<sup>5</sup> (published in July 2021) focused on treatment, recovery, and prevention and its publication was delayed allowing the Government to start responding to Dame Carol's criticisms by launching a number of initiatives to tackle the issues she raised.

#### 3.1.1 The Drug Strategy

The introduction to the strategy and the Prime Minister's foreword prioritises tackling drug-related crime, an ambition reflected in the paper's full title 'A 10-year drugs plan to cut crime and save lives'. The plan itself includes considerable investment in treatment, and initiatives relating to both early intervention and drug education. The plan is jointly presented by the Home Secretary, the Health Secretary, and the Combating Drugs Minister. The paper promises almost £900 million in additional funding over the 3 years starting in the 2022/23 financial year, which it claims will deliver 54,500 more treatment places, prevent nearly 1,000 deaths, and close over 2,000 more county lines<sup>6</sup>.

The strategy sets out three primary objectives:

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

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

The key strategic priorities are summarised in an infographic 'our plan on a page' which is reproduced below.

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

3 HM Government (2017) 2017 Drug Strategy




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

5 Dame Carol Black (2021) Review of Drugs Part Two <https://www.gov.uk/Government/publications/review-of-drugs-phase-two-report>

6 County Lines is where illegal drugs are transported from one area to another, often across police and local authority boundaries (although not exclusively), usually by children or vulnerable people who are coerced into it by gangs. The 'County Line' is the mobile phone line used to take the orders of drugs. Importing areas (areas where the drugs are taken to) are reporting increased levels of violence and weapons-related crimes as a result of this trend.



Figure 1 Drug Strategy 2021 – Plan on a Page

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

The drug strategy starts by quoting a range of disturbing figures from Dame Carol's Review which lays bare the scale of drug-related crime, the lack of capacity in the treatment system, and the fact that deprivation is intimately linked with higher levels of dependency and other health inequalities. The plan is clear that the initial priorities will be to: *"combat the supply of heroin and crack cocaine, and... get those suffering from addiction the treatment and support they need."*<sup>7</sup>

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

In the next section, we summarise briefly the main areas of activity within each of the three primary objectives.

### 3.1.2 Breaking Drug Supply Chains

The plan sets out a vision to *"level up our neighbourhoods by ridding them of drugs, making them safe and secure places and enabling all areas to prosper and grow"* and says that its priority is to cut off the drug supply that is causing most harm with a particular focus on 'rolling up' county lines. There are seven key elements to the Government's plan to break the supply chain. The most relevant for local areas to address are the two objectives relating to closing county lines drug dealing operations and tackling local retail markets.

#### Rolling up County Lines

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

County line gangs are known to target vulnerable children and adults; some of the factors that heighten a person's vulnerability include:

- Having prior experience of neglect, physical and/or sexual abuse
- Lack of a safe/stable home environment, now or in the past (for example through domestic violence or parental substance misuse, mental health issues or criminality)
- Social isolation or social difficulties
- Economic vulnerability
- Homelessness or insecure accommodation status
- Connections with other people involved in gangs
- Having a physical or learning disability
- Having mental health or substance misuse issues
- Being in care (particularly those in residential care and those with interrupted care histories)
- Being excluded from mainstream education, in particular attending a Pupil Referral Unit

Although, it is also known that some gangs target so called 'clean skins', i.e., young people with no criminal record or obvious links to the groups above so that they are less likely to be stopped by police.

<sup>7</sup> HM Government (2021) From harm to hope: A 10-year drugs plan to cut crime and save lives (page 12)

### Tackling the Retail Market

The main approach here is Project ADDER (Addiction, Diversion, Disruption, Enforcement and Recovery). Project ADDER primarily aims to divert people dependent on drugs who are funding this dependency via daily criminal activity into treatment. It is important to note that ADDER is not an updated version of the Drugs Intervention Programme to be rolled out to every area of the country. Rather it is a 10-site pilot with an evaluation intended to inform local practice. It is not clear how long ADDER will run for, the current official information on the Government's dedicated ADDER page<sup>8</sup> states until March 2023 but the graphic reproduced above says this will be extended for a further 2 years. The Government is prioritising the allocation of resources under its drug strategy to the geographical areas in greatest need, particularly some northern cities and seaside towns.

### 3.1.3 Delivering a World-Class Treatment and Recovery System

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

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

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

The Government appears to agree with the Probation Inspectorate's recent assessment<sup>9</sup> that most of the services whose role was to identify and engage into treatment drug using offenders have "*withered on the vine*" and pledges an additional £120 million to engage offenders with 'recovery-focused treatment services'. This money will fund mandatory and voluntary testing regimes in prison, support for prisoners to engage with community treatment ahead of their release and increase the use of intensive Drug Rehabilitation Requirements for those on community sentences<sup>10</sup>. The strategy makes a commitment to put funding back into Drug Testing on Arrest with the positive results notified to Liaison and Diversion schemes.

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

<sup>8</sup> Full Government description of ADDER can be found here.

<sup>9</sup> Her Majesty's Inspectorate of Probation & the Care Quality Commission (2021) A joint thematic inspection of community-based drug treatment and recovery work with people on probation

<sup>10</sup> Via Community Sentence Treatment Requirements

### 3.1.4 Achieve a Generational Shift in Demand for Drugs

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

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

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

### 3.1.5 Implementation of the Strategy

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

### 3.1.6 Guidance and Standards

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

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

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

OHID publishes and regularly updates<sup>11</sup> a wide range of information and other resources to support commissioners, service providers and others providing alcohol and drug interventions.

Overarching best practice recommends the following critical success factors<sup>12</sup>:

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

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

## 3.2 Who is at Risk and Why

People from every part of society use, misuse, and become dependent on drugs. Nonetheless, it is clear that there are a number of groups where usage levels are much higher, and any local drug strategy should seek to target these. The Government Drug Strategy<sup>13</sup> makes it clear that deprivation is linked to higher levels of drug use and that Government funding will prioritise areas with high levels of deprivation.

Other groups likely to have higher levels of problematic drug use who will require proactive interventions to encourage access to services are set out below. It is important to acknowledge that many individuals will be part of several of these groups.

### 3.2.1 People with Coexisting Physical and Mental Health Problems

People with coexisting physical and mental health problems is a group highlighted by Dame Carol. In respect of mental health, she says: *“mental health problems and trauma lie at the heart of their drug and alcohol dependence. However, they are too often excluded from mental health services until they resolve their drug problem and excluded from drug services until their mental health problems have been addressed”*. One of the consequences of the budget cuts experienced by all statutory agencies through the ‘austerity years’ was that organisations focused primarily on their own statutory duties and ceased multiagency work. Many of the initiatives put in place in the first decade of this century to provide a holistic, co-ordinated service for people with coexisting substance use and mental health problems (then termed ‘dual diagnosis’) were disbanded, and practice has regressed. Nearly two-thirds (63%) of adults

11 Via this website: <https://www.gov.uk/Government/collections/alcohol-and-drug-misuse-prevention-and-treatment-guidance>

12 These critical factors are derived from OHID commissioning advice and Dame Carol Black’s work.

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



starting drug treatment in 2020/21 said they had a mental health treatment need<sup>14</sup>. This is part of a trend of rising numbers over the previous 2 years (from 53% in 2018/19). Over half of new starters in all substance groups needed mental health treatment. This need ranged from 57% in the opiate group to nearly three-quarters (71%) of people using drugs other than opiates and alcohol. The focus of work here is on improving pathways between mental health and drug and alcohol services to provide a co-ordinated, holistic approach.

### **People with Blood Borne Viruses**

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

## **3.2.2 People with Learning Disabilities**

Overall, the evidence indicates that people with learning disabilities are less likely to misuse substances than the general population. However, the official guidance suggests that when people with learning disabilities do drink alcohol, there is an increased risk that they will develop a problem with it<sup>17</sup>. People with learning disabilities and other vulnerable people who live independently can be at risk of having their home taken over by drug gangs as bases for selling drugs and places for people to use drugs, a practice commonly called ‘cuckooing’.

## **3.2.3 People Experiencing Homelessness**

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

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

15 All BBV data from UK Health Security Agency (2021) Shooting Up: infections and other injecting-related harms among people who inject drugs in the UK, 2020 [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1053202/Shooting\\_Up\\_2021\\_report\\_final.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1053202/Shooting_Up_2021_report_final.pdf)

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

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

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

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

### 3.2.4 People Not in Training, Employment, and Education

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

### 3.2.5 People in Contact with the Criminal Justice System

Both the Government Drug Strategy and Dame Carol Black's Review of Drugs highlight the importance of targeting groups of people who are in contact with the criminal justice system. Dame Carol says that *"too many people with addictions are cycling in and out of prison, without achieving rehabilitation or recovery"* citing evidence collected for her review<sup>20</sup> which estimates that more than 1 in 3 people in prison are suffering from a *"serious drug addiction"*. The main Government initiatives in this area are:

- Increasing the use of police diversion schemes and community sentences with treatment as an alternative to custody
- Investing more in prison drug treatment
- Seeking to improve continuity of care on release from prison

The latest figures (for 2020/21) show that less than 4 out of 10 (38.1%) of people who access drug treatment in prison engage with community treatment on release<sup>21</sup>, the Government target is 75%.

### 3.2.6 Domestic Abuse

We know there is not a simple causal relationship between substance misuse and domestic abuse; however, we do know that both perpetrators and victims/survivors of domestic abuse are more likely to have issues relating to drugs and/or alcohol. Up to 60% of men in domestic abuse perpetrator programmes have problems with alcohol and/or drugs<sup>22</sup>. Some victims may also use drugs or alcohol to help cope with abuse. Perpetrators can exploit and sustain addictions to keep a victim controlled and dependent on them, as well as manipulate the threat of exposing this to professionals (given the possible subsequent impacts should the victim have children). Research has shown that first responders can find it difficult to correctly identify perpetrators of abuse due to a tendency to see the perpetrator as the individual who is abusing alcohol or drugs<sup>23</sup>. Alcohol use, by women in particular, has been found to be a response to experience of abuse from partners<sup>24</sup>. For these reasons, there need to be good working relationships between treatment agencies and domestic abuse services.

20 Dame Carol Black Review of Drugs: evidence pack

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/882953/Review\\_of\\_Drugs\\_Evidence\\_Pack.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/882953/Review_of_Drugs_Evidence_Pack.pdf) p.102

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

22 Home Office (2020) Domestic Abuse Draft Statutory Guidance cites a range of research studies to this effect. (Page 28)

23 Hester, M. (2009) Who Does What to Whom? Gender and Domestic Violence Perpetrators, Bristol: University of Bristol in association with the Northern Rock Foundation

24 Humphreys et al., Domestic Violence and Substance Use: Tackling Complexity, British Journal of Social Work, 2005

### 3.2.7 People Living in more Deprived Areas

There is a strong association between socioeconomic position, social exclusion, and substance-related harm in relation to both alcohol and other drugs in the general population. People living in more deprived areas and with lower individual resources and socioeconomic capital are at greater risk of harm.<sup>25</sup>

### 3.2.8 Young People

Young people are generally always a priority group as a greater proportion of young people use drugs<sup>26</sup> and the proportion of young people using drugs has increased in recent years<sup>27</sup>. However, particular groups of vulnerable young people are known to be more likely to take drugs and more likely to develop problems associated with their use including:

- Young people in contact with Youth Offending Services (22% referrals of young people in drug/alcohol treatment nationally were via the criminal justice system<sup>28</sup>)
- Looked after children (18% referrals into treatment<sup>29</sup>)
- Young people excluded from school and those not in formal education, employment, or training (cited as a vulnerability for more than 1 in 9 young people in treatment<sup>30</sup>)
- Young people involved in County Lines drug dealing (drug dealers often use drugs and alcohol to entice young people into the gang lifestyle. In some cases, gangs trick young people into incurring drug debts that they then have to pay off through county lines activity. This is often referred to as 'debt bondage'<sup>31</sup>). As we have already seen, the Drug Strategy makes tackling county lines a major priority.

### 3.2.9 Families

The effects of a family member's use of drugs and/or alcohol often has a range of different impacts on a family including on their emotional wellbeing and finances<sup>32</sup>, while the help of families is often enlisted to try to support an individual with a drug and/or alcohol problem, it is also generally accepted that family members themselves need a dedicated service<sup>33</sup>.

The children of drug and alcohol users have been identified as a priority group. However, their needs have often been overlooked since the publication of the first Hidden Harm report<sup>34</sup> in 2003 which concluded that parental problem drug use can and does cause serious harm to children at every age from conception to adulthood. The Government

25 Public Health England (2019) Health inequalities: Substance Misuse

26 The most recent (2020) Crime Survey for England and Wales showed that around 1 in 11 adults aged 16 to 59 years had taken a drug in the last year (9.4%); the comparable figure for young adults (16 to 24 years) was more than double at 21%.

<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/drugmisuseinenglandandwales/yearendingmarch2020#overall-trends-in-drug-misuse>

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

28 Public Health England (2021) Young people's substance misuse treatment statistics 2019 to 2020: report

<https://www.gov.uk/government/statistics/substance-misuse-treatment-for-young-people-statistics-2019-to-2020/young-peoples-substance-misuse-treatment-statistics-2019-to-2020-report#referral-routes-into-treatment>

29 Ibid.

30 Ibid.

31 NSPCC (2021) Protecting children from county lines <https://learning.nspcc.org.uk/child-abuse-and-neglect/county-lines>

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

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

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



drug strategy recommends ‘specific support’ for families with parental substance misuse treatment needs, which should be “*co-ordinated at a local level*”<sup>35</sup>.

### 3.2.10 Steroid Users

Recent research<sup>36</sup> has found that anabolic androgenic steroids are increasingly used by the general population, particularly male gym users, for their muscle-building and aesthetic effects. They can have a detrimental impact on physical and emotional wellbeing. Many needle exchange schemes seek to engage with steroid users by visiting gyms and ensuring that they have clean injecting equipment, outreach workers offer harm reduction advice and aim to promote treatment amongst people with concerns about their use<sup>37</sup>.

### 3.2.11 Sex Workers

Drug using sex workers<sup>38</sup> may rely on sex work primarily to fund their drug use. The research literature<sup>39</sup> concludes that sex work is very complex and that tackling problematic drug and alcohol use is likely to be one of many issues for sex workers that need to be addressed simultaneously. The research suggests that a harm reduction approach (as opposed to a full recovery approach) has the potential to support sex workers but that there is no clear evidence on what treatment works for this target group. Dedicated outreach work (often by specialist teams who work across sexual health, women specific services, and drugs and alcohol) seek to provide holistic support to help sex workers overcome addiction, be protected against sexual violence, find safe and stable homes, and ultimately exit sex working altogether. The provision of clean injecting equipment, condoms, and sexual health support can often be a first step to engage people into services.

### 3.2.12 Chemsex

Chemsex is now a mainstream term commonly used by gay or bisexual men to describe sex that occurs under the influence of drugs, which are taken immediately preceding and/or during the sexual session. The drugs most commonly associated with Chemsex are crystal methamphetamine, GHB/GBL, mephedrone, and, to a lesser extent, cocaine, and ketamine<sup>40</sup>. All, except ketamine, are stimulant drugs in that they typically increase heart rate and blood pressure and trigger feelings of euphoria. Crystal methamphetamine, GHB/GBL, and mephedrone also have a common effect of facilitating feelings of sexual arousal. Ketamine is an anaesthetic and is typically used alongside practices such as ‘fisting’ since it allows the brain to dissociate from any pain.

These drugs are widely known to facilitate pleasure or euphoria but are associated with a range of harms. Particular concern has been raised regarding the role of crystal methamphetamine, GHB/GBL, and mephedrone in the transmission of sexually transmitted infections. The link between drug use and risk-taking behaviour is complex, but there is a clear association between the two. These drugs can facilitate long sexual sessions with multiple partners and the likelihood of sexually transmitted infections may be increased due to rectal trauma or penile abrasions. The

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

36 <https://www.bournemouth.ac.uk/research/projects/male-users-anabolic-androgenic-steroids>

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

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

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

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

extreme sexual disinhibition associated with using these drugs in a Chemsex context means that people often indulge in unsafe sexual practices which they would not usually do. There are also harms associated with drug overdose, especially in relation to GHB/GBL, which is typically administered in small, carefully timed doses.

There are concerns that levels of injecting behaviour (traditionally low amongst this population) have been increasing with reports of ‘slamming’ both methamphetamine and mephedrone.

For all these reasons, drug treatment services should consider partnering with local LGBTQ+<sup>41</sup> services to ensure that both harm reduction information is easily available to people involved in Chemsex and people are aware of how to access local treatment services if they have concerns about their drug use.

### 3.3 What Works Evidence

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

- Harm reduction
- Drug treatment and recovery for adults
- Drug treatment and recovery for young people
- Drug prevention.

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

#### 3.3.1 Harm Reduction

One of the key objectives of the National Drugs Strategy is to reduce the number of drug-related deaths which have been rising continuously over recent years<sup>42</sup>. The strategy specifically mentions the importance of expanding the provision of naloxone, the opioid overdose reversal drug and exploring the potential of buvidal, the new long-lasting form of the opioid substitute medication buprenorphine.

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

<sup>41</sup> It is important to recognise the diversity of sexuality and gender identities that exist, and to acknowledge that not all transgender individuals identify as being LGB. Where possible, consideration should be afforded to the distinctions between issues of sexual orientation and gender identity in recognition of the fact that those identifying as part of the LGBTQ+ community are not a homogeneous group and should not be treated as such. We have used the umbrella term LGBTQ+ believing this to be the most inclusive; however, we recognise that this acronym does not necessarily reflect the nuances and individual journeys and is, as such, arguably becoming increasingly less inclusive. The + is intended to extend to other non-normative sexualities such as queer or pansexual.

<sup>42</sup> Latest official data found that 4,561 deaths related to drug poisoning were registered in 2020, the worst number since records began in 1993.

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoningenglandandwales/2020>

## **Naloxone**

Naloxone is considered a key component in the drive to reduce opioid-related deaths. However, a recent systematic review and meta-analysis of studies relating to the ownership and use of take-home naloxone<sup>43</sup> found good levels of ownership of take-home naloxone – an average of 57% of at-risk people who inject drugs – but a much lower level of carriage: 20%. Carriage simply means whether people regularly have their naloxone with them – clearly if someone has a naloxone kit at home, it is of little use if they overdose anywhere else. It is therefore considered good practice that naloxone is not just distributed widely but that training<sup>44</sup> is given alongside the medication to encourage effective use and its regular carriage. Training should typically be given both to opioid users and their family members.

## **Long Lasting Buprenorphine (Buvidal)**

Early research on long-lasting (by depot injection) buprenorphine suggests that use on its own is unlikely to result in an overdose and that buprenorphine maintenance keeps the person stable while they make positive changes in their lives. Weekly or monthly injections take away the need for daily pick-up of other substitute medications and make it easier for people to engage in work or study<sup>45</sup>.

## **Other Harm Reduction Work**

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

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

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

The leading provider of this service in the UK is the Loop<sup>46</sup>, a Community Interest Company, which has evaluated the effectiveness of its work<sup>47</sup>.

43 Gillian Burton, Andrew McAuley, Joe Schofield, Alan Yeung, Catriona Matheson, Tessa Parkes, (2021)

A systematic review and meta-analysis of the prevalence of take-home naloxone (THN) ownership and carriage, International Journal of Drug Policy, Volume 96

44 EMCDDA (2016) Preventing opioid overdose deaths with take-home naloxone

<https://www.emcdda.europa.eu/system/files/publications/2089/TDXD15020ENN.pdf>

45 <https://adf.org.au/drug-facts/buprenorphine-long-acting-injectable/>

46 <https://wearetheloop.org/>

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

### 3.3.2 Adult Drug Treatment and Recovery

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

#### Peer-Led Recovery Communities

The Government has formally endorsed ‘Recovery Orientated Systems of Care’, which involve an equal partnership between ‘professionals by training’ and ‘professionals by experience’<sup>48</sup>. The UK Recovery Champion describes the key components of a Recovery Orientated Systems of Care:

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*“Person-centred services offer choice, honour each person’s potential for growth, focus on a person’s strengths, and attend to the overall health and wellness of a person with addiction. There is an increasing understanding that recovery-oriented services should be provided in communities, in specific environments of need, and be provided by professionals, family members, and peers. A Recovery Orientated Systems of Care arranges services to address the long-term and complex needs of people living with addiction. It should be built on the core values of individual choice and person-centred services and support multiple non-linear pathways to recovery.”<sup>49</sup>*

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In Dame Carol Black’s influential Review of Drugs, she made a strong recommendation that treatment services should include people with lived experience of drug dependence working as recovery champions and recovery coaches. However, she warned that peer supporters should not be left to do the work of professionals without appropriate training, pay, or support – an approach she described as exploitative. A new (2021) co-produced guide<sup>50</sup> sets out best practice in supporting peer volunteers derived from and informed by the lived experience of more than 250 peer volunteers. The guide covers a range of topics including training, support and helping people convert their volunteering experience into paid employment.

#### Online Support

Online support for people with drug and alcohol problems has been developing steadily over the last decade, but was, unsurprisingly, accelerated by the coronavirus pandemic. In late 2018, the European Monitoring Centre for Drugs and Drug Addiction published a scoping survey<sup>51</sup> of mobile health applications aimed in the substance misuse sector and identified three main groups of drug-related applications:

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

Most apps address risk behaviours associated with drugs in general or drug use in specific settings (e.g., nightlife settings). Some drug-specific apps are available for more commonly used drugs such as cannabis and cocaine. One of the best-known digital interventions used in the UK comes from the Breaking Free<sup>52</sup> organisation which develops

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

49 Ibid. Page 8

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

51 EMCDDA (2018) m-Health applications for responding to drug use and associated harms

[https://www.emcdda.europa.eu/system/files/publications/10244/EMCDDA%20Papers\\_m-Health%20applications\\_Final.pdf](https://www.emcdda.europa.eu/system/files/publications/10244/EMCDDA%20Papers_m-Health%20applications_Final.pdf)

52 <https://www.breakingfreegroup.com/>

evidence-based digital behaviour change interventions that use proven behavioural science to empower people to overcome problem drinking, drug misuse, and smoking.

In the alcohol field, the treatment agency Humankind provides a range of online tools designed to help people track and change their drinking including both an online screening tool<sup>53</sup> and the DrinkCoach App<sup>54</sup>.

Since the pandemic, a number of treatment agencies have offered their core individual (and group) services via online video services such as Zoom and Microsoft Teams. Again, this practice had been adopted by some agencies prior to the pandemic as a way both of cutting costs and providing services at times that were convenient to their service users, particularly those who are either working during normal office hours, are based in rural location, or who think treatment services are only for ‘addicts’. The leading drug and alcohol treatment provider ‘We are with you’<sup>55</sup> also provides an online drug and alcohol advice service.

### 3.3.3 Young People’s Treatment System

Young people needing treatment have increasingly complex needs. Of the 3,000 young people in treatment with Change Grow Live (CGL)<sup>56</sup> nationally, 42% have a diagnosed mental health need, 36% have previously self-harmed, 28% are engaging in offending, and 15% are at risk of criminal or sexual exploitation. There is a consensus that in order to meet the needs of these young people, provision needs to be better co-ordinated across young people’s services (Children’s Social Services, Youth Offending Services, Children and Adolescent Mental Health Services) as well as specialist substance youth services. It is recommended that young people should be able to more easily access the right support, at the right time and that this support should include, as a minimum, integrating support for emotional wellbeing, unhealthy relationships, and sexual health.

The evidence base that young people need a holistic, child-centred service (rather than a substance-centred one) is well established, going back to the Health Advisory Service reports in 1996 and 2001. The most recent guidance from Public Health England<sup>57</sup> establishes four core commissioning principles of specialist substance misuse services for young people:

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

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

53 <https://drinkcoach.org.uk/alcohol-test-intro>

54 <https://drinkcoach.org.uk/drinkcoach-app>

55 <https://www.wearewithyou.org.uk>

56 <https://www.cypnow.co.uk/analysis/article/drugs-review-highlights-five-ways-to-boost-support-for-young-people>

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

### 3.3.4 Drug Prevention

Dame Carol stressed the need for a much better evidence base for drug prevention work. The first step in developing this evidence base was provided by the Government's (independent) Advisory Council on the Misuse of Drugs who published a rapid review of Drug Misuse Prevention in May 2022<sup>58</sup>. This review came to three main conclusions:

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

The second point is perhaps the most important at a local level, drug prevention work has been under-valued for many years with funding rarely available for specially trained staff. There has been widespread criticism that many drug education and prevention approaches have not been based on the evidence base (and in some examples, such as 'Just Say No' and DARE, have been proved to be ineffective or even counter-productive). The Advisory Council on the Misuse of Drugs' review recommends all approaches are evidence-based<sup>59</sup> and all drug prevention work should be integrated in a whole system approach and delivered by staff with dedicated, accredited training (which needs to be developed).

## 3.4 The Impact of COVID-19 on Substance Use and Treatment

The total number of people who died in England while in contact with substance use treatment services in 2020 to 2021 was 3,726, representing a 27% increase of deaths in treatment compared to the previous year<sup>60</sup>. It is likely that a number of factors contributed to this rise in the number of service users who died while in treatment during COVID-19. These include changes to lifestyle and social circumstances during lockdowns as well as reduced access to drug and alcohol support services<sup>61</sup>.

### 3.4.1 Impact of COVID-19 on Drug Use

The COVID-19 pandemic impacted the drug market, causing local fluctuations in the availability and price of drugs in England between 2020-2021<sup>62</sup>. Despite this, the overall supply of drugs was maintained. However, patterns of drug use shifted during the COVID-19 pandemic. For example, in the UK generally, drug users reported an increase in their substance use compared to 2019, with 17% injecting drugs more frequently and 27% reporting a change in their normal daily drug use<sup>63</sup>.

58 ACMD (2022) The prevention of drug misuse in vulnerable groups

59 Ibid Page 2 provides details of quality standards.

60 Office for Health Improvement and Disparities (2021) Adult substance misuse treatment statistics 2020 to 2021: report. Available at: <https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2020-to-2021/adult-substance-misuse-treatment-statistics-2020-to-2021-report>, (Accessed 24 October, 2022)

61 Ibid.

62 UK Health Security Agency (2021) Shooting Up: infections and other injecting-related harms among people who inject drugs in the UK. Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1053202/Shooting\\_Up\\_2021\\_report\\_final.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1053202/Shooting_Up_2021_report_final.pdf), (Accessed 24 October, 2022)

63 Ibid.



### 3.4.2 Impact of COVID-19 on Alcohol Consumption

The increase in substance related deaths was the largest among ‘alcohol only’ clients, with a 44% increase in deaths during 2020-2021<sup>64</sup>. It is evident that in addition to the direct effects of COVID-19, the pandemic had numerous other indirect effects on health and wellbeing, including affecting people’s alcohol consumption. Interventions to control coronavirus involved restrictions on social contact as well as the closure of support services and non-essential businesses<sup>65</sup>. This resulted in the purchasing and consumption of alcohol being displaced towards off-trade settings such as supermarkets and off-licences making it more readily available in large quantities<sup>66</sup>. As a result, there was a rise<sup>67</sup>.

### 3.4.3 Impact of COVID-19 on Substance Treatment and Support Services

COVID-19 meant that treatment services had to restrict face-to-face contact, which limited the interventions that service users could access. There were numerous impacts that resulted from this, such as fewer service users being able to access inpatient detoxification for drugs or alcohol due to increased pressure on the NHS at the time of the pandemic. In addition, there was a reduced supply and interrupted access to medicines due to pharmacies being closed<sup>68</sup>. In response to this, more clients were given take-home doses of opioid substitution treatment (OST), which increased the risk of the illegal selling of prescriptions such as methadone<sup>69</sup>. In response to lockdown restrictions and to mitigate the difficulties in providing face-to-face support, services began to increasingly use remote technology via mobile phones or online platforms. Despite its positive contributions, this raised numerous challenges such as excluding clients who do not have access to the internet or a mobile phone, further marginalising specific groups from the service<sup>70</sup>. During COVID-19, many harm reduction interventions including needle exchanges were reduced or suspended. Over 25% of drug users reported greater difficulties accessing equipment for the safer consumption of drugs in 2020 compared to 2019<sup>71</sup>. Testing for blood-borne viruses (BBV) was also significantly reduced as a result of COVID-19, with a 60% decrease in antibody and ribonucleic acid testing<sup>72</sup>. In response to these challenges, services formulated innovative approaches to the provision of harm reduction interventions including home delivery of needles and self-testing kits for BBV. Overall, while the COVID-19 pandemic may be driving innovative models of service provision, it is important that face-to-face services are adequately reinstated to mitigate increased adverse health outcomes and disparities<sup>73</sup>.

64 Office for Health Improvement and Disparities (2021) Adult substance misuse treatment statistics 2020 to 2021: report. Available at: <https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2020-to-2021/adult-substance-misuse-treatment-statistics-2020-to-2021-report>, (Accessed 24 October, 2022)

65 Institute of Alcohol Studies (2021) The COVID hangover: Addressing long term health impacts of changes in alcohol consumption during the pandemic. Available at: <https://www.ias.org.uk/wp-content/uploads/2022/07/The-COVID-Hangover-report-July-2022.pdf>, (Accessed 24 October 2022)

66 Hardie, I. Stevely, A. K, Sasso, A, Meier, P. S, and Holmes, J. (2022) The impact of changes in COVID-19 lockdown restrictions on alcohol consumption and drinking occasion characteristics in Scotland and England in 2020: an interrupted time-series analysis. *Addiction*, 117(6), 1622-1639.

67 Institute of Alcohol Studies (2020) Alcohol consumption during the COVID-19 lockdown: summary of emerging evidence from the UK. Available at: <https://www.ias.org.uk/wp-content/uploads/2020/06/sb28062020.pdf>, (Accessed 24 October 2022)

68 Public Health England (2021) COVID-19: guidance for commissioners and providers of services for people who use drugs or alcohol. Available at: <https://www.gov.uk/government/publications/COVID-19-guidance-for-commissioners-and-providers-of-services-for-people-who-use-drugs-or-alcohol/COVID-19-guidance-for-commissioners-and-providers-of-services-for-people-who-use-drugs-or-alcohol>, (Accessed 24 October, 2022)

69 Office for Health Improvement and Disparities (2021) Adult substance misuse treatment statistics 2020 to 2021: report. Available at: <https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2020-to-2021/adult-substance-misuse-treatment-statistics-2020-to-2021-report>, (Accessed 24 October, 2022)

70 Pirona, A. (2020) EMCDDA trendspotter briefing-May 2020-Impact of COVID-19 on drug services. Available at: [https://www.emcdda.europa.eu/publications/ad-hoc/impact-of-COVID-19-on-drug-services-and-help-seeking-in-europe\\_en](https://www.emcdda.europa.eu/publications/ad-hoc/impact-of-COVID-19-on-drug-services-and-help-seeking-in-europe_en), (Accessed 24 October, 2022)

71 UK Health Security Agency (2021) Shooting Up: infections and other injecting-related harms among people who inject drugs in the UK. Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1053202/Shooting\\_Up\\_2021\\_report\\_final.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1053202/Shooting_Up_2021_report_final.pdf), (Accessed 24 October, 2022)

72 Ibid.

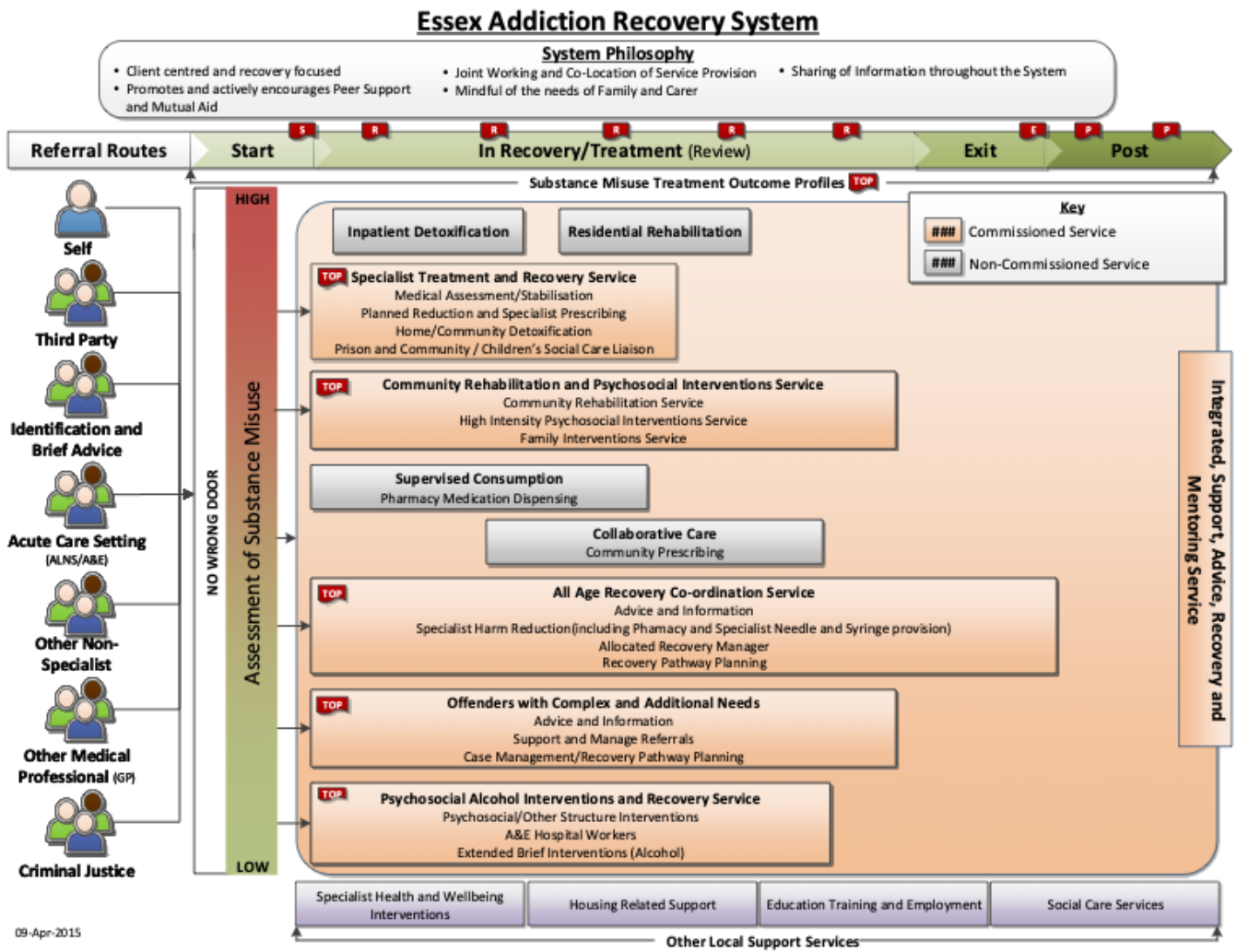
73 Ibid.

This section has pinpointed some of the key components of effective treatment and prevention approaches, highlights some of the key trends and innovations in the sector which are looking to improve and/or modernise service delivery and explores the impact the COVID-19 pandemic had on both substance use and the corresponding treatment.

### 3.5.2 System Map

The following substance misuse system map was provided by ECC commissioners:

Figure 2 Essex Substance Misuse System Map





## 4. QUANTITATIVE DATA ANALYSIS

This chapter presents the available data about drugs and alcohol in Essex, concentrating on overall prevalence, indicators of need and details about treatment and outcomes. We focus, in particular, on trends and highlight issues and topics where Essex differs from the national picture. The chapter is organised into three subsections – alcohol, drugs, and young people.

### 4.1 Alcohol

Alcohol-related harm is largely determined by the volume of alcohol consumed and the frequency of drinking occasions. The risk of harm is directly related to levels and patterns of consumption. There can be a considerable lag between alcohol consumption and alcohol-related harms, particularly for chronic conditions where the delay can be many years. In January 2016, the Chief Medical Officer issued revised guidance on alcohol consumption<sup>74</sup>, which advises that, 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, it is estimated that just under a quarter of the population (23%) are drinking above the 14 units per week level and so may benefit from some level of intervention<sup>75</sup>. However, harm can be short-term and instantaneous, due to intoxication, or long-term, from continued exposure to the toxic effect of alcohol or from developing dependence. The official alcohol commissioning support guidance<sup>76</sup> recommends a range of different interventions:

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

#### 4.1.1 Prevalence

Data from Local Alcohol Profiles for England included in the most recent (2022/23) Alcohol Commissioning Support Pack for Essex estimates that a smaller proportion of adults in Essex drink over 14 units of alcohol a week compared to the national average (20.6% vs 22.8%) although a slightly larger proportion report binge drinking on their heaviest drinking day (16.8% vs 15.4%). The data also estimates that a considerably smaller proportion of the local population abstain from drinking alcohol (12.4% vs an England average of 16.2%).

The Commissioning Support tool calculates that there are 12,756 adults in Essex in need of alcohol treatment with a smaller proportion of these in treatment than the national average (13% vs 18%). It is clearly important for Essex to invest as heavily as possible in alcohol treatment in order to meet the needs of the 11,055 people (87%) of those who are not currently in treatment.

#### 4.1.2 Indicators of Problematic Alcohol Use

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

<sup>74</sup> Department of Health (2016) How to keep health risks from drinking alcohol to a low level Government response to the public consultation

<sup>75</sup> National estimate of 22% of people in England drinking 14 units or more per week [cited in Adults - Alcohol Commissioning Support Pack 202-23: key data. Planning for alcohol harm prevention, treatment and recovery in adults].

<sup>76</sup> Public Health England (2018) Alcohol Commissioning Support: principles and indicators

### 4.1.3 Hospital Admissions

Alcohol-related hospital admissions can be due to regular alcohol use that is above recommended levels and are most likely to involve increasing risk drinkers, higher risk drinkers, dependent drinkers, and binge drinkers. Health conditions in which alcohol plays a causative role can be classified as either ‘*alcohol-specific*’ or ‘*alcohol-related*’. ‘*Alcohol-specific*’ conditions are those where alcohol is causally implicated in all cases, including alcohol poisoning or alcoholic liver disease. ‘*Alcohol-related conditions*’ include all alcohol-specific conditions, plus those where alcohol is causally implicated in some but not all cases, for example high blood pressure, various cancers, and falls.

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

#### *Alcohol-Specific*

Hospital admissions for alcohol-specific conditions are very substantially lower in Essex than the national average (a directly standardised rate [DSR] of 377 per 100,000 people compared with 644 nationally<sup>77</sup>). The equivalent figure for these admissions for under 18s locally is also substantially lower than the national average (crude rate of 20/100,000 vs 31 nationally).

#### *Alcohol-Related*

Alcohol has been identified as a factor in more than 60 medical conditions, many leading to hospital admission. Men account for the majority (65%) of alcohol-related admissions, which reflects a higher level of harmful drinking among men compared to women overall<sup>78</sup>.

The following table illustrates how Essex compares with the national average for a range of admissions for men and women respectively.

Essex men are less likely than the national average to be admitted to hospital for any alcohol-related reason and have extremely low rates of admission for alcoholic liver disease and alcohol-related mental and behavioural disorders. Essex women are less likely than the national average to be admitted to hospital for any alcohol-related reason with the exception of alcohol-related cancer where the admission rate is almost identical to the national average. Again, they are substantially much less likely to be admitted for alcoholic liver disease.

<sup>77</sup> The data from the Commissioning Support pack relates to 2019/20

<sup>78</sup> Statistics on alcohol 2019, NHS Digital

Figure 3 Alcohol-related hospital admissions by gender DSR per 100,000

Measure		Alcohol-related cardiovascular disease (Broad)	Alcoholic liver disease (Broad)	Alcohol-related unintentional injuries (Narrow)	Mental & behavioural disorders due to use of alcohol (Narrow)	Intentional self-poisoning by and exposure to alcohol (Narrow)	Incidence rate of alcohol-related cancer
Men	Essex	1,352	85.5	86.8	64.4	39.1	36.5
	England	1,482	191.8	95.8	103.8	39.7	39.2
Women	Essex	195	55.6	12.3	37.1	49.9	36.9
	England	239	89.3	13.7	45.3	52.8	36.8

#### 4.1.4 Probation Caseload

Essex Probation helpfully provided a snapshot of the drug and alcohol needs of all people supervised by the Probation service on 1 October 2022. 1,154 men on Probation (18% of the overall caseload) and 163 women (21% caseload) were recorded as having alcohol needs. Seventy-six men and 19 women had been required by Essex courts to abide by Alcohol Treatment Requirements as a condition of their community sentence in the first nine months of 2022. In the same time period, 78 men and 24 women were required to wear an alcohol monitoring tag as part of an Alcohol Abstinence Monitoring Requirement.

#### 4.1.5 The Alcohol Treatment Population

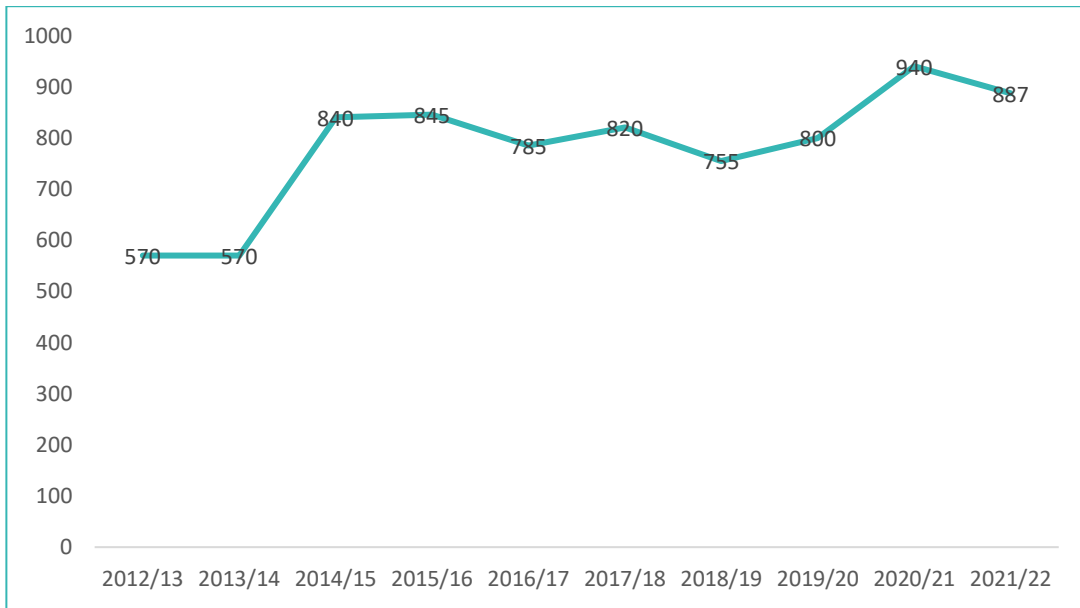
There were 1193 adults in treatment solely for their alcohol use in Essex in 2021/22<sup>79</sup>, a fall of 67 (-5.6%) on the previous year. Data kindly shared by the provider, CGL, shows that 518 adults presented to treatment in 2021/22 compared to 576 the previous year (a fall of 10.1%).

Data from the previous (2020/21) year on the demographic profile of this treatment population via the Adult Commissioning support pack shows that 55% of this treatment cohort were men with the other 45% women; women appear to be slightly over-represented in treatment in Essex compared with the national average of 42%. More than half (61%) of these individuals (61% men and 62% women) started treatment in that financial year, a lower percentage than the national average (which was 68% overall and 68% for both men and women).

As the following chart shows, the figure of 887 people in alcohol only treatment is substantially higher than the comparative figure of 570 in 2012/13.

<sup>79</sup> Provisional monthly data from NDTMS. Data from the Theseus system does not completely align with NDTMS data, reporting 1165 people in alcohol only treatment on 31 March 2022, an acceptable discrepancy of 2.3%.

Figure 4 Essex People in alcohol only treatment trend data (2012/13 – 2021/22)

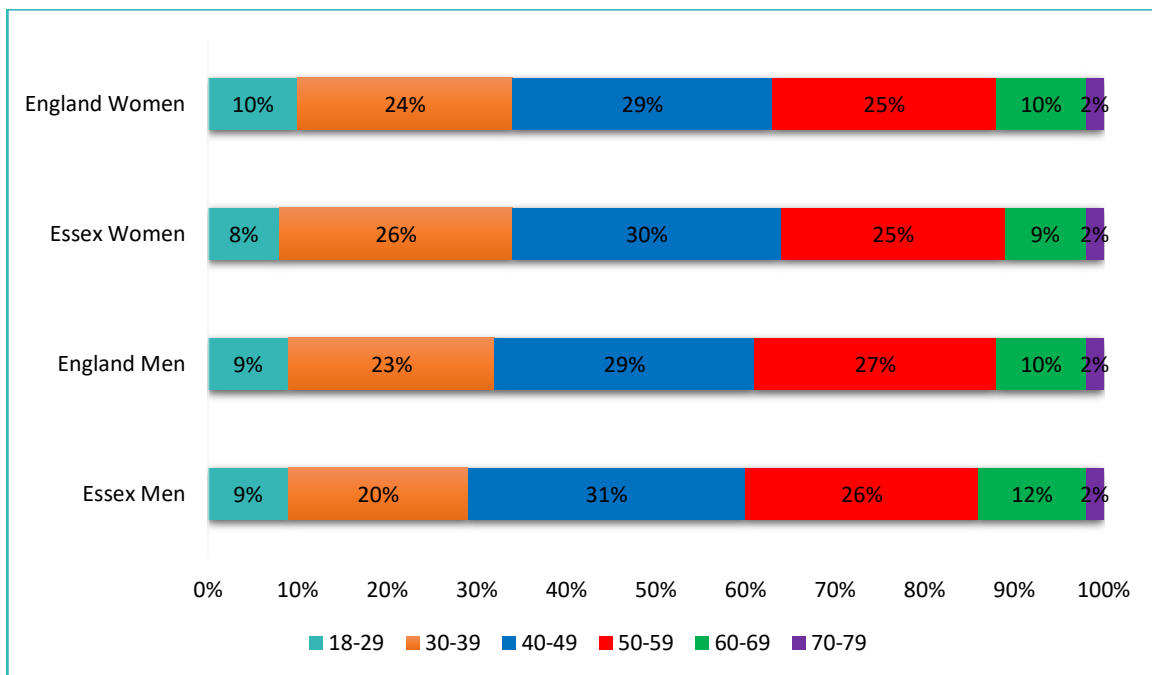


624 of the 636 (98.1%)<sup>80</sup> individuals starting an alcohol intervention in 2021/22 received support in the community with 14 people (2.2%) receiving help in an inpatient unit and 11 (1.7%) in a residential setting.

### 4.1.6 Demographic Profile of People in Alcohol Treatment

The age profile of people in alcohol only treatment in Essex closely reflects the national picture as shown below in the following chart, which provides separate data for men and women.

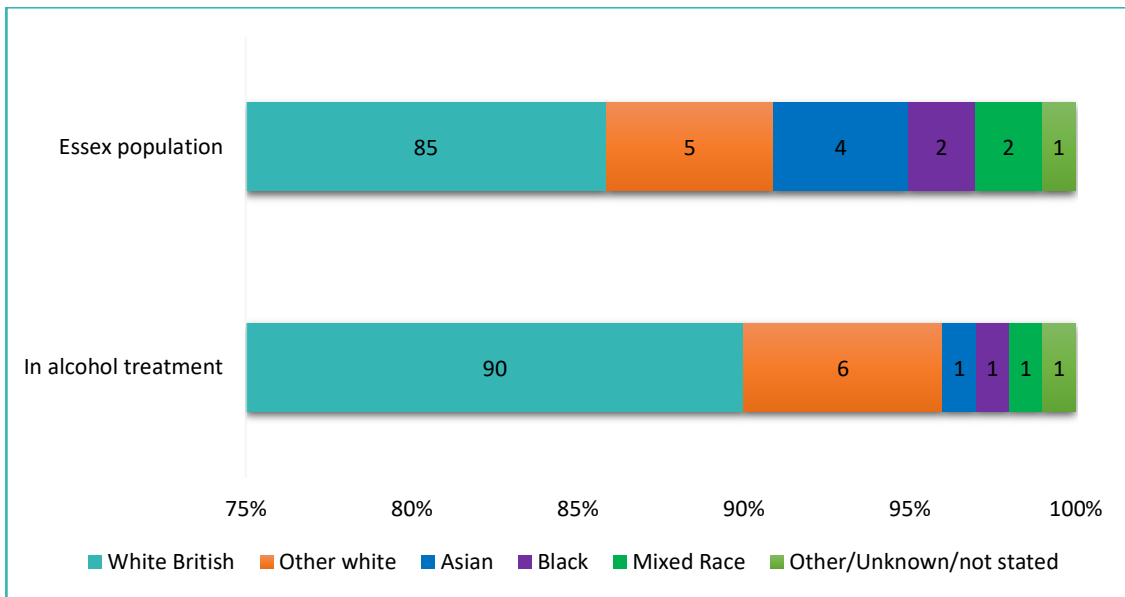
Figure 5 Age profile of Essex people in alcohol only treatment 2020/21



<sup>80</sup> Data in this section is taken from Theseus.

The ethnic profile of people in Essex starting alcohol treatment in 2020/21 is compared to the ethnic profile of the county<sup>81</sup> where it can be seen that Asian people are under-represented in alcohol treatment (1% of new presentations compared to 4% of the local population).

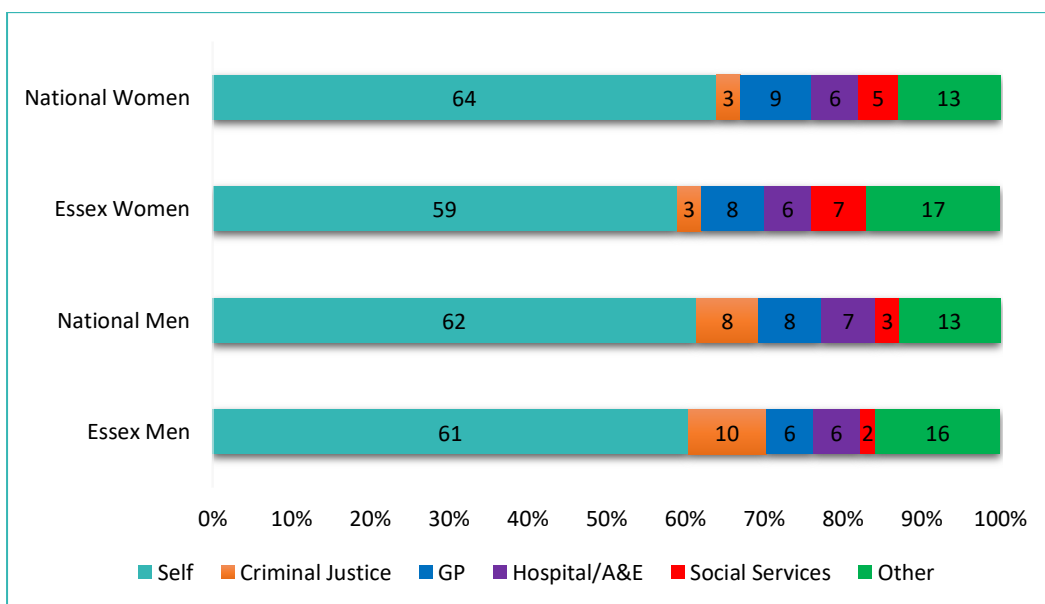
Figure 6 Ethnic profile of Essex people starting alcohol only treatment (%) 2020/21



### 4.1.7 Referral Routes

In terms of referral routes into alcohol treatment<sup>82</sup>, Essex closely resembles the national picture with a small number of exceptions. Essex women (59% vs 64%) are less likely to refer themselves into treatment. Essex men are slightly more likely to be referred via the criminal justice system (10% vs 8%), a trend borne out by the fact that 23% of the Essex alcohol treatment population had a criminal conviction in the two years preceding admission to treatment compared to 21% nationally. Finally, Essex men are slightly less likely to be referred via their GP (6% vs 8%) than is the case nationally.

Figure 7 Referral routes into alcohol only treatment (%) 2020/21



<sup>81</sup> Data from 2021 Census published 29 November 2022.

<sup>82</sup> Commissioning Support Pack data used rather than Theseus as Theseus data in the form provided to TONIC was not split by gender.

### 4.1.8 Additional Challenges

A smaller proportion of local people entering alcohol treatment were identified as having a mental health need (57% compared to 64% nationally). This was true for both men (51% locally vs 59% nationally) and women (63% vs 71%). It was pleasing to find that those who were identified as having a mental health need were more likely to be already engaged with the community mental health team or other mental health services – 25% compared to 16% nationally. Local people entering alcohol treatment were recorded as having an identical rate of being in regular employment as the national picture (36%). They were, however, more likely to be unemployed/economically inactive (47% vs 41%) although this is mainly explained by the fact that Essex people in alcohol treatment were less likely to be recorded as being long-term sick or disabled (14% compared to 18% nationally).

The proportion of this cohort having a housing problem was identical to the national average (9% compared to 9% nationally).

## 4.2 Alcohol Treatment Outcomes

### 4.2.1 Alcohol-Related Risk Reduction

There is a robust evidence base about the positive impact of brief advice interventions on people with alcohol issues. Identification and brief advice in primary care reduce weekly drinking by 12%, reducing the risk of alcohol-related illness by 14% and absolute lifetime alcohol-related death by 20%. It can also save the NHS £27 per patient per year.<sup>83</sup> Although data about the number of brief interventions delivered by the health service should be recorded, it was not possible to access this information.

### 4.2.2 Alcohol Treatment

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

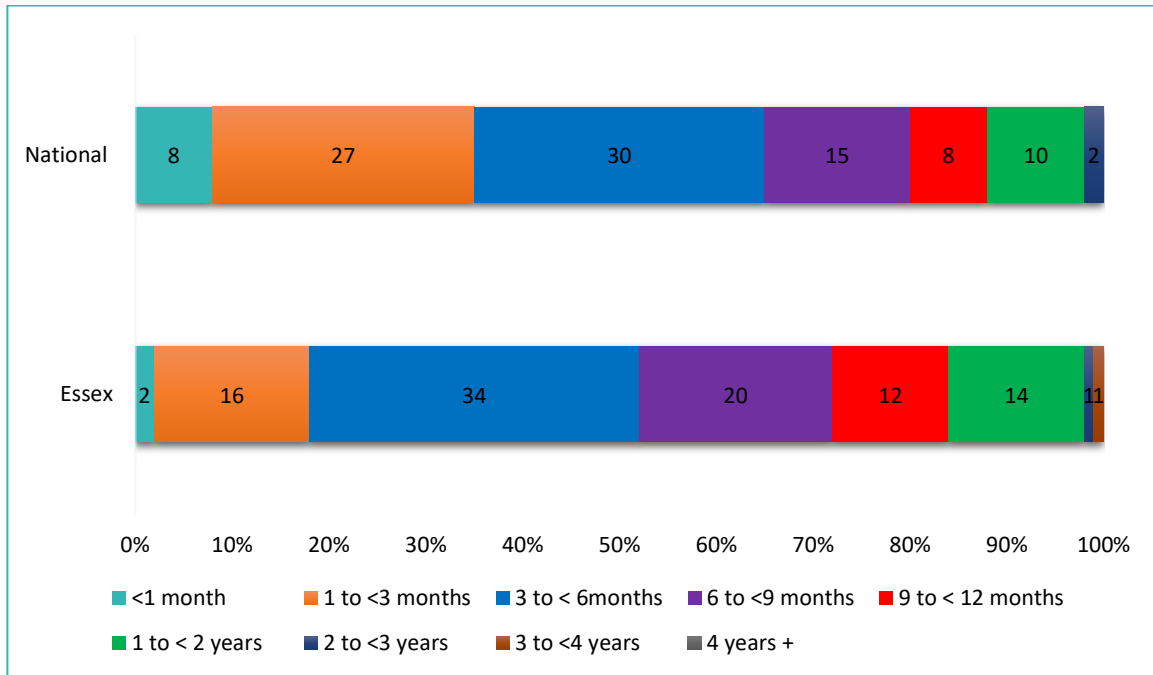
The length of a typical treatment period is just over 6 months, although nationally 12% of adults remained in treatment for at least a year. Retaining adults for their full course of treatment is important in order to increase the chances of recovery and reduce rates of early treatment drop out. Conversely, having a high proportion of adults in treatment for more than a year may indicate that they are not moving effectively through and out of the treatment system.

The following chart compares local time in alcohol treatment compared to the national average; there are two significant differences. Firstly, local people are much more likely to be retained in treatment for 6 months or longer (48% compared to 35%). Secondly, people from Essex are more likely to remain in treatment for over 1 year (16% compared to 12% nationally). Both these factors contribute to the statistic that people in Essex stay in alcohol treatment for an average of 227 days compared to 192 days nationally.

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<sup>83</sup> Cited in: Warwickshire Alcohol Health Needs Assessment 2022

Figure 8 Length of time in treatment based on treatment exits in 2020/21 (%)



Treatment outcomes are mixed when benchmarked against national performance. A smaller proportion of Essex people in treatment (28% vs 37% nationally) left treatment successfully and a smaller proportion successfully completed treatment and did not re-present for 6 months (24% vs 35% nationally). Conversely, 65% of people in Essex who left treatment in a planned way were abstinent from alcohol compared to 53% nationally. Locally people in alcohol treatment reduced the average number of days they drank in the most recent 4-week period by 6.7 days (from an average of 18.7 days at the start of treatment to 12 at exit, a reduction of 35.8%); this is less than the national reduction average reduction of 8.8 days (from an average of 20.3 to 11.5 days, a reduction of 43.3%).

### 4.3 Summary of Key Alcohol Trends

Essex has succeeded in engaging constant numbers of people in alcohol treatment over the last decade despite the impact of cuts in public funding. However, the county is only succeeding in engaging one in eight of the people in need into treatment. There is also a concern that the number of people coming into alcohol treatment last year (2021/22) fell by 10%.

Essex would, of course, have to invest in extra treatment capacity to meet the needs of the estimated 87% of the in-need population not currently in treatment. This objective is important given the higher-than-average levels of unsafe alcohol use locally and even more essential post-pandemic when a number of studies have reported increases in alcohol consumption<sup>84</sup>.

Where people do enter in treatment, Essex is succeeding in engaging a substantially higher proportion than the national average.

It would also be valuable for Essex to know the extent of screening and brief interventions in primary care in order to assess whether this proven harm reduction approach is under-utilised locally.

<sup>84</sup> Public Health England (2021) Monitoring alcohol consumption and harm during the COVID-19 pandemic: summary

## 4.4 Drugs

There are no official data on levels of drug use on a local level. However, national trends are available with the most recent information taken from an overview of the extent and trends of illicit drug use for the year ending March 2020 published by the Office of National Statistics in December of that year<sup>85</sup>, utilising data from the Crime Survey for England and Wales. This data is valuable since it is not distorted by the changes in use reported during the pandemic so can be reasonably regarded as a reliable indicator of trends in illegal drug use. The research showed a relatively stable picture with no change in overall drug use or Class A drug use in the year under investigation. The main findings were:

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

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

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

### 4.4.1 Indicators of Drug Use

There were 124 drug-misuse deaths in Essex in the 3-year period 2019-21 with a DSR of 2.9 per 100,000,<sup>86</sup> slightly lower than the East of England rate of 3.3 and substantially lower than the national rate of 5.1 per 100,000. The Essex figure represents a welcome downward trend since the 2014-16 three-year period (when there were 162 deaths). Two areas within the County had a death rate higher than the East of England average – Tendring (7.3/100,00) and Colchester (4.7). Eighty of the 124 people who died from drug-misuse in Essex over this most recent three-year period were men, a rate of 3.9/100,000 which compares favourably to the East of England (4.8) and national (7.4) rates. The

<sup>85</sup> Office for National Statistics (2022) Drug misuse in England and Wales: year ending March 2020

<sup>86</sup> ONS (2022) Drug Misuse Deaths by Local Authority



DSR of the 44 women who died in Essex over the same period was 1.9/100,00 compared to 1.8 for the East of England and 2.8 nationally. Although complacency is obviously to be avoided with every person who dies from drug-misuse a tragedy for the individual, their family and friends, our key conclusion is that the rate of deaths is declining in Essex while it is increasing across England.

As well as being an important issue to be addressed in itself, hospital admissions due to drug poisoning can be an indicator of future deaths. People who experience non-fatal overdoses are more likely to suffer a future fatal overdose. Data included in the Adult Drug Commissioning Pack shows that there were 505 admissions to Essex hospitals for drug poisonings in 2021, a rate of 33.7 per 100,000, appreciably below the national rate of 50.2 per 100,000.

The most recent official estimates of opiate and/or crack users (OCUs) in local authority areas are now somewhat out of date and relate to 2016/17. The estimates for Essex were 4,091 crack users, 4,374 opiate users and 5,398 OCUs. In every case, the prevalence rate is below the national average. Essex was estimated to have 4.5 crack users per 100,000 people aged 15-64 years (compared with a national rate of 5.1), 2.9 per 100,000 opiate users (vs 7.3 nationally) and 6.0/100,000 opiate and crack users (8.9 nationally).

However, Essex was calculated to be meeting the needs of a lower proportion of these Class A drug users compared to the national average with 67% crack users not in treatment in 2020/21 (compared to a national rate of 58%), 59% opiate users not in treatment (compared to a national rate of 47%) and 65% OCUs not having their needs met (compared with 53% nationally).

Data about local drug seizures by police is generally regarded as an unreliable indicator about levels of use. However, an informative survey undertaken by Essex Police for their 2020 Drug Market Profile<sup>87</sup> asked both drug practitioners and drug users for their perceptions on the availability of a range of commonly used illegal drugs. Figure 7 reproduces a table from that market profile, drug practitioner views are in black, drug user responses are in blue with yellow background. It is clear that most types of drugs are readily available to most people most of the time. Cannabis, crack, cocaine and heroin are more easily accessible than illicit pharmaceuticals and new psychoactive substances.

Table 3 *Perceived level of availability of drugs in Essex*

	Always available		Highly available		Available		Sometimes available		Rarely available		Never available	
Cocaine	46	57	23	26	5	15	2	0	1	2	1	0
Crack cocaine	21	53	19	23	8	16	1	3	2	0	6	0
Heroin	18	43	19	30	8	16	2	2	2	0	8	0
Cannabis	37	69	22	24	7	6	0	0	0	0	0	0
Psychoactive substances	16	23	11	20	2	26	5	7	2	3	9	0
Illicit pharmaceuticals	14	27	15	22	4	27	4	2	4	2	9	0
Other	8	11	2	3	1	15	5	0	3	1	8	1

<sup>87</sup> C. Sykes & G. Harford (2020) Essex Drug Market Profile. Essex Police.

### 4.4.2 Probation Caseload

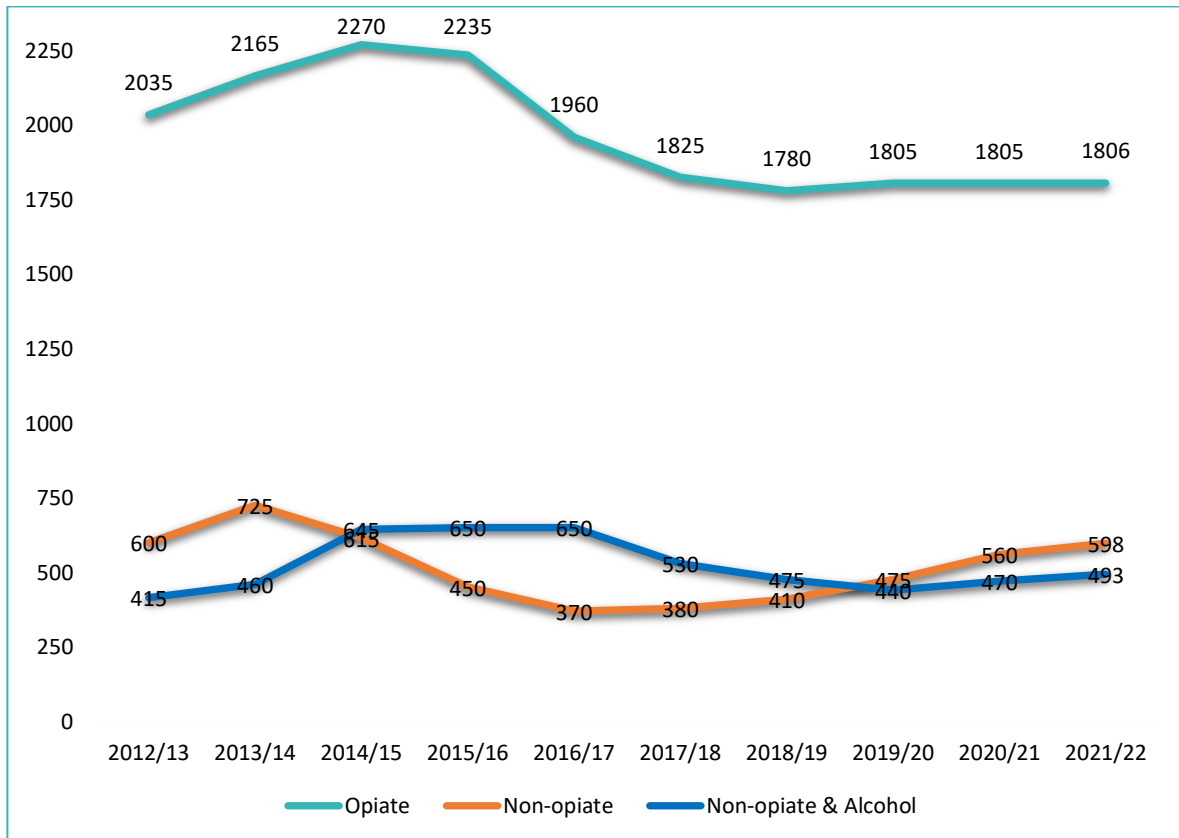
Essex Probation helpfully provided a snapshot of the drug and alcohol needs of all people supervised by the Probation service on 1 October 2022. 1,328 men on Probation (21% of the overall caseload) and 145 women on Probation (19% of caseload) were recorded as having drug needs. Fifty-nine men and 23 women were required to abide by Drug Rehabilitation Requirements as a condition of their community sentence in the first nine months of 2022.

### 4.4.3 The Drug Treatment Population

There were 2,831 adults in drug treatment in Essex in 2020/21<sup>88</sup>, a figure which increased slightly (by 2.3%) to 2,897 in 2021/22<sup>89</sup>. Official data separates these into three treatment groups by substance of use: opiate users, non-opiate users and alcohol and non-opiate users. The following chart shows the trends in Essex over the last decade. The number of opiate users in treatment has reduced steadily over this 10-year period (by a total of 11%).

The number of non-opiate users (598) in treatment is almost identical to the figure ten years ago (600), but this fact hides considerable fluctuation with the number of non-opiate users in any one year varying between 370 and 725. The number of alcohol and non-opiate users in treatment (493) has increased by nearly a fifth (19%) from 415 a decade ago. However, these book-end figures hide another series of fluctuations with the number of alcohol and non-opiate users in any one intervening year varying between 440 and 6,505.

Figure 9 Essex People in drug treatment trend data (2012/13 – 2021/22)



<sup>88</sup> Data from Adult Commissioning Pack.

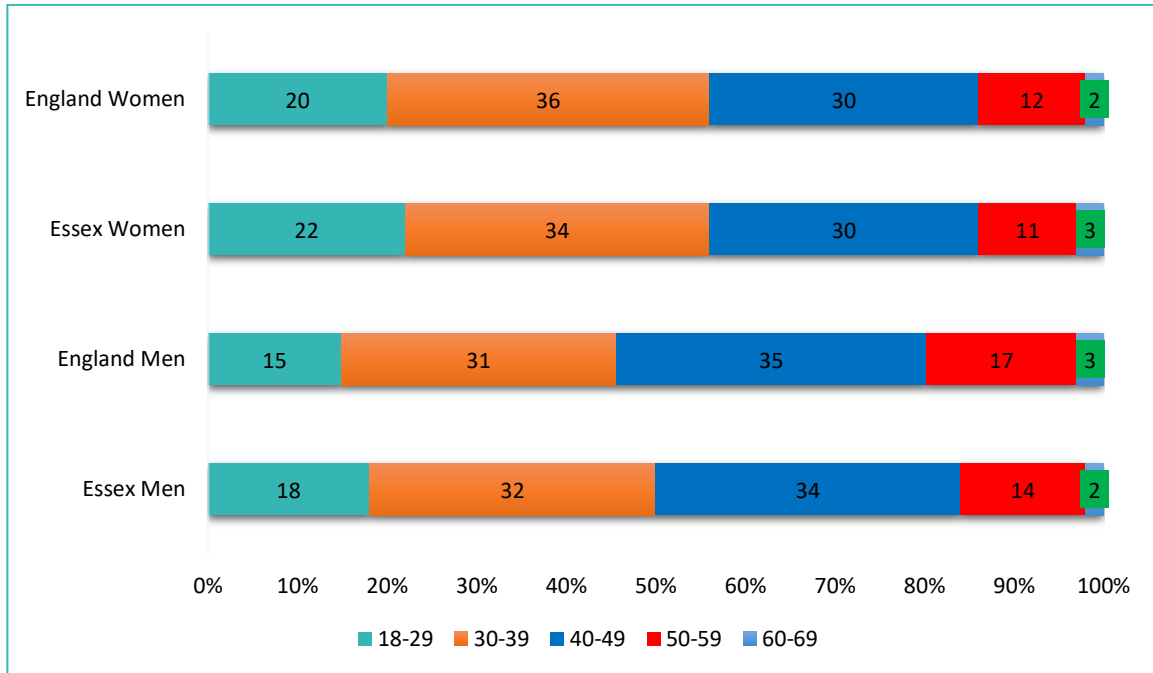
<sup>89</sup> Provisional monthly data from NDTMS. Identical figure on Theseus.

### 4.5 Demographic Profile of People in Treatment

In total, 68% of people in drug treatment in Essex in 2021 were men with the other 32% women; women are slightly over-represented in treatment compared with the national average of 29%.

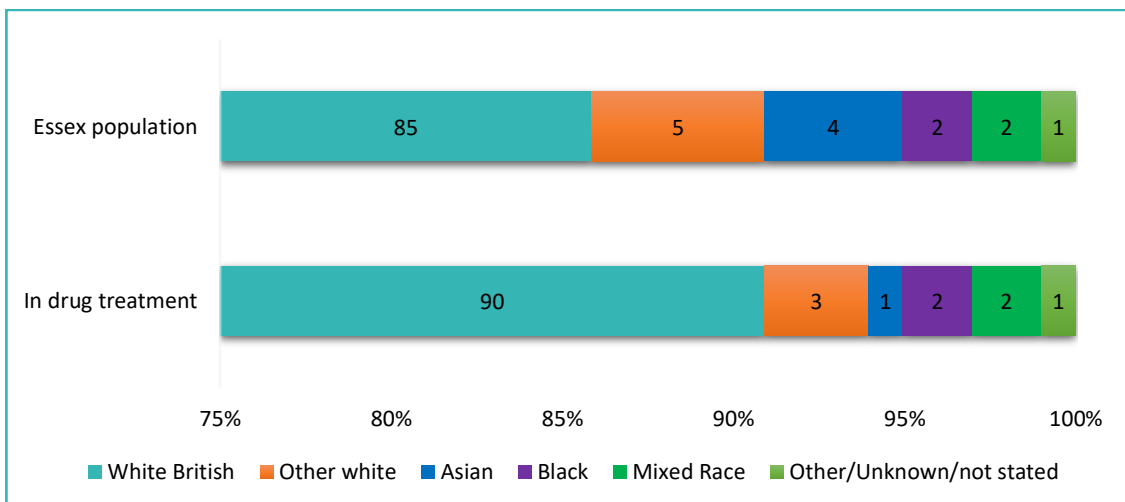
The age profile of people in drug treatment in Essex mainly reflects the national picture as shown below in the following chart, which provides separate data for men and women. The principal difference is that there are a greater proportion of people aged under 30 years old in treatment in Essex than nationally; this applies to both men (18% vs 15% nationally) and women (22% vs 20%).

Figure 10 Age profile of Essex people in drug treatment (%) 2020/21



The ethnic profile of people in Essex starting drug treatment in 2020/21 is compared to the ethnic profile of the county<sup>90</sup> where it can be seen that Asian people (as with alcohol treatment) are under-represented in drug treatment (1% of new presentations compared to 3% of the local population).

Figure 11 Ethnic profile of Essex people starting drug treatment (%) 2020/21

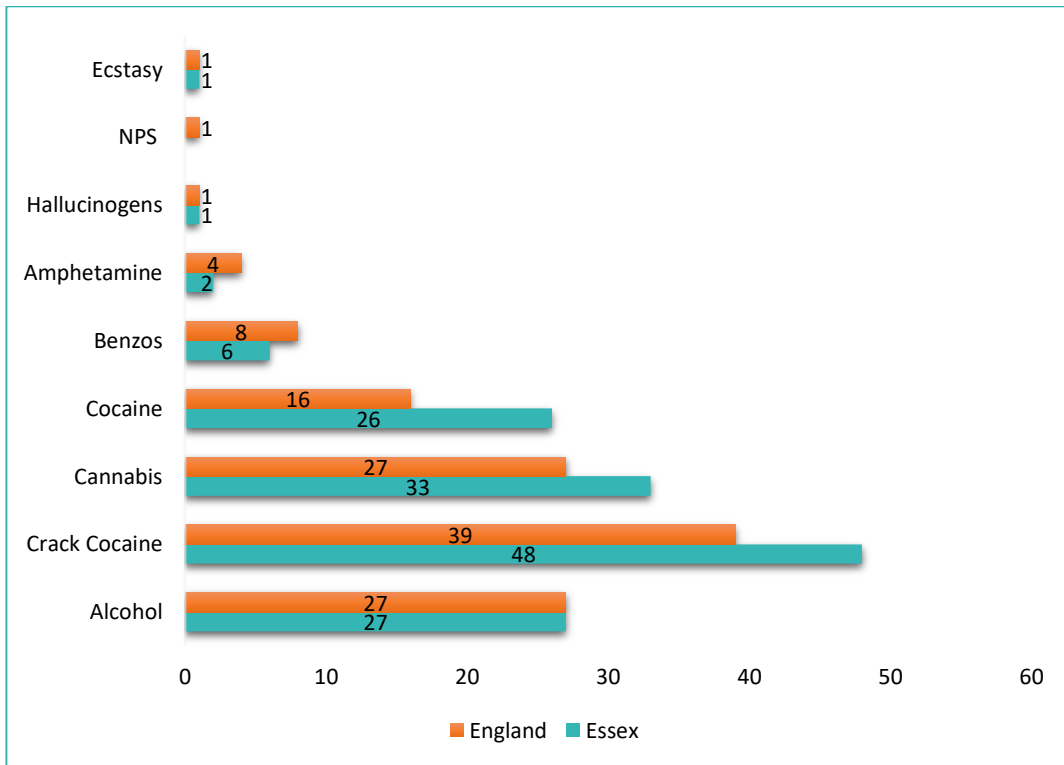


<sup>90</sup> Data from 2021 Census published 29 November 2022.

### 4.5.1 Substances Used

The adult commissioning pack shows the most commonly cited substance(s) of all adults in drug treatment in Essex compared to the national picture in 2020-21. The following chart shows that a greater proportion of people in drug treatment in Essex use both crack cocaine (48% vs 39% nationally) and cocaine (26% vs 16%). They are also more likely to use cannabis (33% vs 27%) but less likely to use benzodiazepines (6% vs 8%) and amphetamines (2% vs 4%).

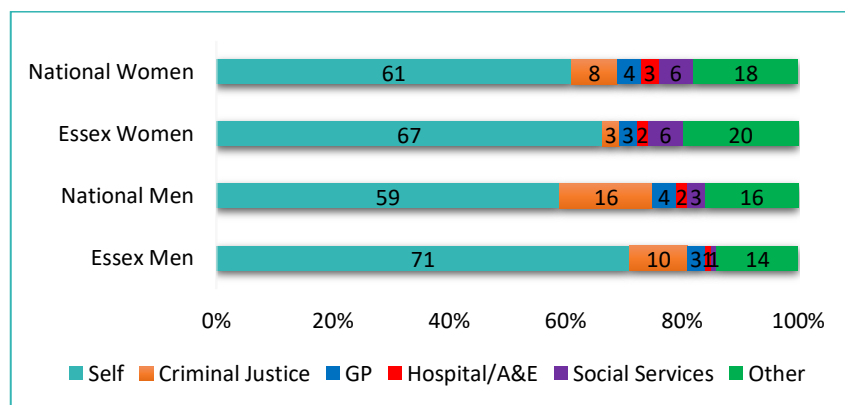
Figure 12 Most common substance of people in drug treatment (%) 2020/21



### 5.4.2 Referral Routes

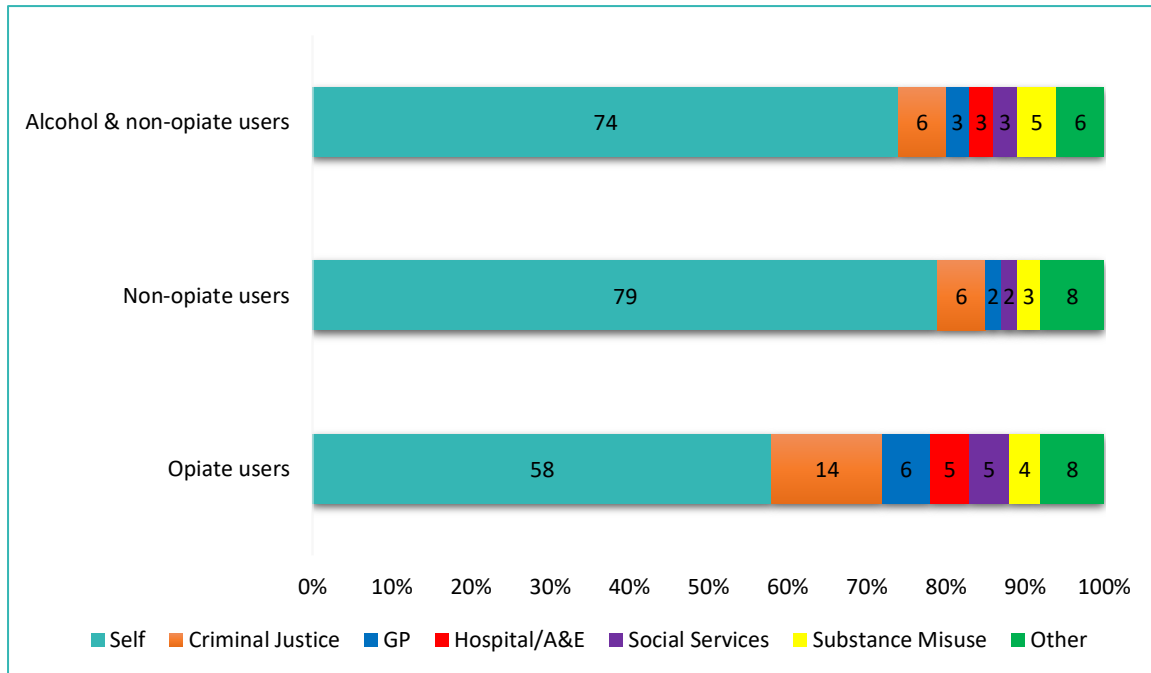
One area in which Essex differs significantly from the national picture is the routes into treatment. Locally both men (71% vs national average of 59%) and women (67% vs 61%) are much more likely to refer themselves into treatment. Local criminal justice pathways are less likely to refer both men (10% vs 16% nationally) and women (3% vs 8%) into treatment.

Figure 13 Referral routes into drug treatment (%) 2020/21



Information from the Theseus system reveals the different referral routes according to category of drug use as shown in the following chart.

Figure 14 Referral routes into drug treatment (%) 2021/22 by category of drug use



It is clear that opiate users are much less likely to self-refer (58% compared to 79% non-opiate users and 74% of alcohol and non-opiate users) and more than twice as likely to be referred by the criminal justice system (14% vs 6% of both non-opiate users and alcohol and non-opiate users). Opiate users are also much more likely to be referred via their GP (6% compared to 2% non-opiate users and 3% of alcohol and non-opiate users).

### 4.5.3 Treatment Interventions

The range of high-level interventions and settings provided to local people in drug treatment generally reflect the national picture with two main exceptions. Firstly, a considerably smaller proportion of people received support within primary care (just 4% of people in drug treatment in Essex compared with a national average of 10%). Expanding provision in this setting would likely increase overall treatment capacity and increase the numbers of treatment referrals from health settings. Secondly, just 1% of people in treatment receive treatment within an in-patient setting compared to 3% nationally.

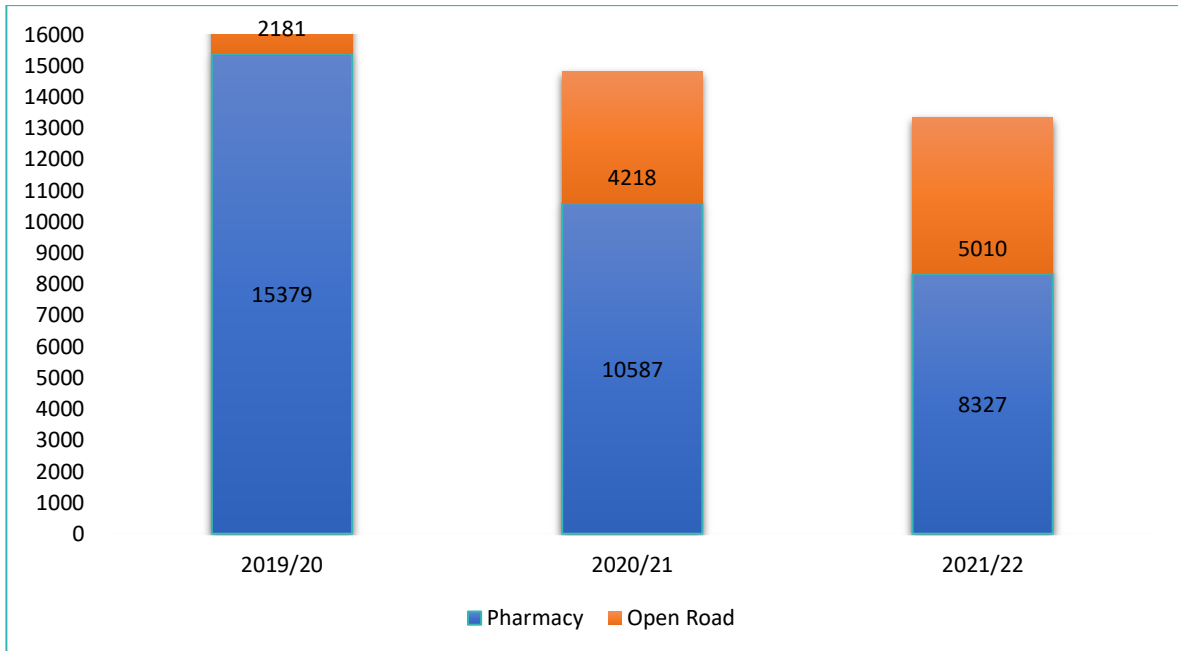
However, it should be highlighted that over the last three years Essex has substantially increased its spending on both inpatient detoxification (£157,550 in 2021/22 compared to £86,537 two years earlier) and residential rehabilitation (£298,812 in 2021/22 compared to £91,517 two years earlier).

Local services were successful in getting 29% eligible people to complete a course of vaccination against Hepatitis B compared to 9% nationally.

Services were also successful in tackling Hepatitis C, getting 61% eligible adults to accept an HCV test (vs 41% nationally) and referring 5% eligible adults into treatment (vs 2.1% nationally).

The number of needle exchange items/packs distributed in Essex has dropped by 24% over the last three years (in part affected by the pandemic)<sup>91</sup>. A total of 17,560 exchanges were made by Open Road and pharmacies in 2019/20, dropping to 13,337 in 2021/22. The following chart also shows the change in distribution points with pharmacy exchanges dropping by 46% over this three-year period while the number of exchanges made by Open Road increased by 130%.

Figure 15 Needle Exchanges (2019/20 – 2021/22)



#### 4.5.4 Additional Challenges

A larger proportion of men entering drug treatment were identified as having a mental health need (62% compared to 58% nationally), these individuals were also more likely to be receiving mental health treatment (74% compared to 68% nationally). The picture was the same for women with a higher proportion entering drug treatment identified as having a mental health need (84% compared to 73% nationally), like their male counterparts, these women were more likely to be receiving mental health treatment (84% compared to 77% nationally).

Local people entering drug treatment were recorded as being more likely to be in regular employment (28% vs 21% nationally) but equally likely to be unemployed (50%). People entering drug treatment in Essex were less likely to be recorded as being long term sick or disabled (18% compared to 21% nationally).

The proportion of this cohort having a housing problem was identical to the national average (22%), with the same proportion of people as the national average (8%) having an urgent housing problem – being of no fixed abode).

#### 4.6 Drug Treatment Outcomes

Adults with opiate problems who have been in treatment for over 6 years will usually find it harder to successfully complete treatment. The proportion of Essex opiate users in treatment for this period of time (23%) is below the national average (27%).

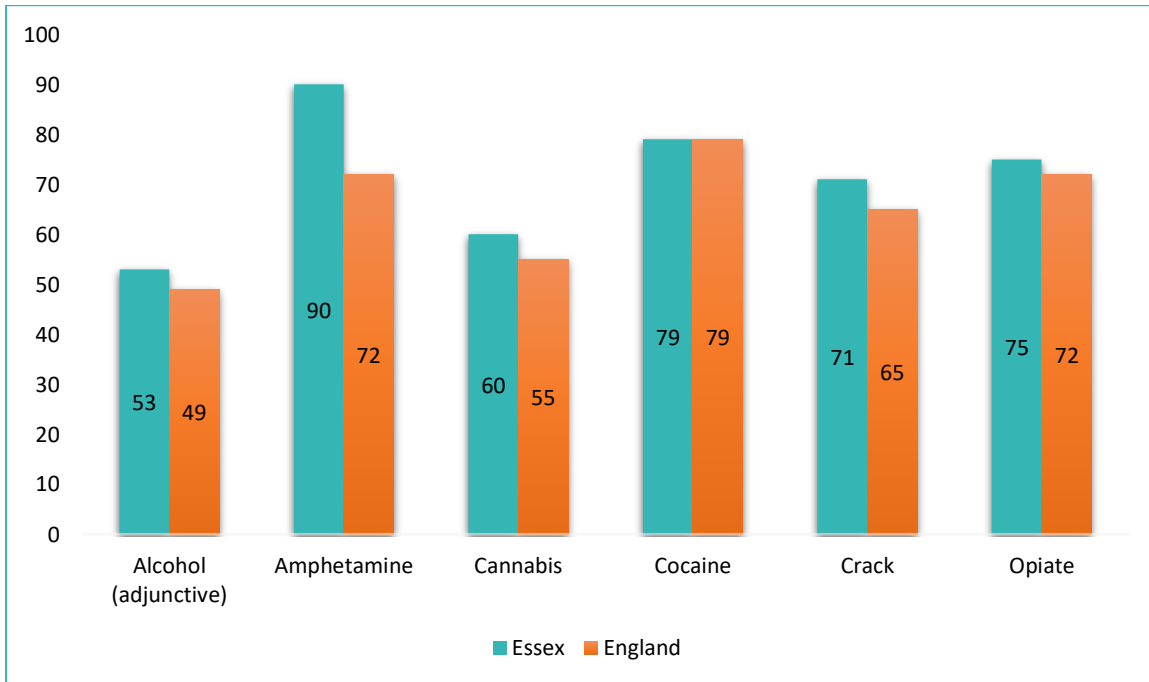
The data below is drawn from the Treatment Outcomes Profile (TOP), which tracks the progress drug users make in treatment. This includes information on rates of abstinence from drugs and statistically significant reductions in drug

<sup>91</sup> Data supplied by Essex Wellbeing & Public Health Manager

use and injecting. Data from NDTMS suggests that adults who stop using illicit opiates in the first 6 months of treatment are almost five times more likely to complete successfully than those who continue to use.

The following chart shows the proportions of people who are either abstinent from specific substances or have significantly reduced their use at their 6-month review. Compared to the national cohort, more people in treatment in Essex have abstained from or significantly reduced their use of all drugs with the exception of cocaine where the performance is identical.

Figure 16 *Abstinence/significant reductions by substance of people starting drug treatment (%) 2020/21*



Another positive finding is that a much larger percentage of local people in treatment had stopped injecting at their 6-month review (85% vs 63% national).

The proportions of people successfully completing treatment who did not re-present within 6 months for the 2021/22 year were lower than the national average for opiate users (4% vs 5% nationally) but much higher for non-opiate users (which for this data includes those using non-opiates and alcohol; 48% vs 33%).

Essex has been more successful than average in providing continuity of drug treatment for people released from prison, engaging 45% into structured treatment people compared to a national average of 38.1% and an East of England average of 41.7%<sup>92</sup>.

<sup>92</sup> Office for Health Improvement & Disparities (2020/21) Public Health Outcomes Framework Indicator C 20.



## 4.7 Summary of Key Drug Trends

Essex has succeeded in engaging constant numbers of local people into drug treatment over the last ten years although the profile of this population has changed with a reduction in the number of opiate users and increase in other groups. Nevertheless, opiate users remain by far the largest group in treatment (66%).

The rate of drug-related deaths is substantially below the national average.

People in Essex are more likely to refer themselves into treatment than average and considerably less likely to be referred via the criminal justice system.

Help with drug problems is less likely to be delivered within primary care locally. Local people are also only half as likely to attend residential rehabilitation compared to the national average.

Essex services are successful in helping high numbers of people become abstinent from or substantially reduce their use of a wide range of substances.

Providers are successful at tackling injecting behaviour, with services particularly successful at engaging people to participate in both Hepatitis B and C vaccination programmes.

## 4.8 Young People

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

There are no official data about levels of drug use on a local level. However, national trends are available with the most recent information taken from an overview of the extent and trends of illicit drug use for the year ending March 2020 published by the Office of National Statistics (ONS) in December of that year<sup>93</sup>, utilising data from the Crime Survey for England and Wales which does provide separate information on different age groups. Although most young people do not use drugs, young people are more likely to use drugs than other age groups. The ONS data found that 21.1% of 16-19 year olds had used any drug in the previous year, much lower than the 31.8% equivalent figure in 1995, but the highest rate since 2011 (23.3%).

However, particular groups of vulnerable young people are known to be more likely to take drugs and more likely to develop problems associated with their use including:

- Young people in contact with Youth Offending Services (22% referrals of young people in drug/alcohol treatment were via the criminal justice system<sup>94</sup>)
- Looked after children (18% referrals into treatment<sup>95</sup>)

<sup>93</sup> Office for National Statistics (2022) Drug misuse in England and Wales: year ending March 2020

<sup>94</sup> Public Health England (2021) Young people's substance misuse treatment statistics 2019 to 2020: report <https://www.gov.uk/government/statistics/substance-misuse-treatment-for-young-people-statistics-2019-to-2020/young-peoples-substance-misuse-treatment-statistics-2019-to-2020-report#referral-routes-into-treatment>

<sup>95</sup> Ibid.

- Young people excluded from school and those not in formal education, employment or training (cited as a vulnerability for more than one in nine young people in treatment<sup>96</sup>)
- Young people involved in County Lines drug dealing (drug dealers often use drugs and alcohol to entice young people into the gang lifestyle. In some cases, gangs trick young people into incurring drug debts that they then have to pay off through county lines activity. This is often referred to as ‘debt bondage’<sup>97</sup>).

### 4.8.1 Indicators of Young People’s Use of Drugs and Alcohol

Young people (15–24-year-olds) are less likely to be admitted to hospital due to substance misuse in Essex than nationally<sup>98</sup> (DSR of 70/100,000 compared to 85/100,000).<sup>99</sup> Essex children (aged under 18 years) are also less likely to be admitted to hospital for alcohol specific conditions (a crude rate of 20/100,000 compared to 31/100,000 for the 2017/18 – 2019/20 period).

The proportion of children aged 10-17 years who enter the criminal justice system for the first time is also lower in Essex (a crude rate of 120 per 100,000 children of this age) than nationally (169 per 100,000)<sup>100</sup>.

However, Essex Police<sup>101</sup> highlight concerns about young people being recruited across different parts of the county to be involved in County Lines (including Epping and Harlow in particular).

No looked after children in Essex are formally identified as having a substance misuse problem compared to the national average of 3%.

The proportion of suspensions from school related to drugs and alcohol in Essex in 2019/20 is identical to the national average (3%). However, the number of permanent exclusions related to drugs and alcohol is almost twice that of the national average (19% compared to a national average of 10%). However, this relates to just 13 people in the academic year 2019/20, falling to ten the following year and five in the first two terms of 2021/22<sup>102</sup>.

National data for the last quarter of 2021 showed that 21 people aged 16-17 years old and 256 people aged 18-24 years old were assessed as needing help with housing by Essex local authorities<sup>103</sup>.

### 4.8.2 Young People in Structured Treatment

The numbers of local young people in community structured treatment (those under 18 and those aged 18-24 in young people’s services but not counting those in adult drug and alcohol services) has mainly recovered following the impact of the pandemic. There were 345 young people in treatment in 2019/20<sup>104</sup>, but only 170 in 2020/21<sup>105</sup>. At 31 March 2022, the number of young people in treatment had jumped to 305<sup>106</sup>. The figures have stabilised in the current

<sup>96</sup> Ibid.

<sup>97</sup> NSPCC (2021) Protecting children from county lines <https://learning.nspcc.org.uk/child-abuse-and-neglect/county-lines>

<sup>98</sup> Data for three year period 2017/18 – 2019/20.

<sup>99</sup> All data in this section comes from the (2022/23) Young People Substance Misuse Commissioning Support Pack for Essex, unless otherwise indicated and refers to the financial year 2020/21.

<sup>100</sup> All data in this section comes from the (2022/23) Young People Substance Misuse Commissioning Support Pack for Essex, unless otherwise indicated and refers to the financial year 2020/21.

<sup>101</sup> C. Sykes & G. Harford (2020) Essex Drug Market Profile. Essex Police.

<sup>102</sup> Data provided direct by Essex County Council.

<sup>103</sup> Department for Levelling Up, Housing and Communities (2022) Statutory homelessness: Detailed local authority-level tables October to December 2021 England. Technical definition is: “applicant assessed as owed a prevention or relief duty by local authority”,

<sup>104</sup> NDTMS Young people in treatment profiles.

<sup>105</sup> Young People Substance Misuse Commissioning Support Pack for Essex

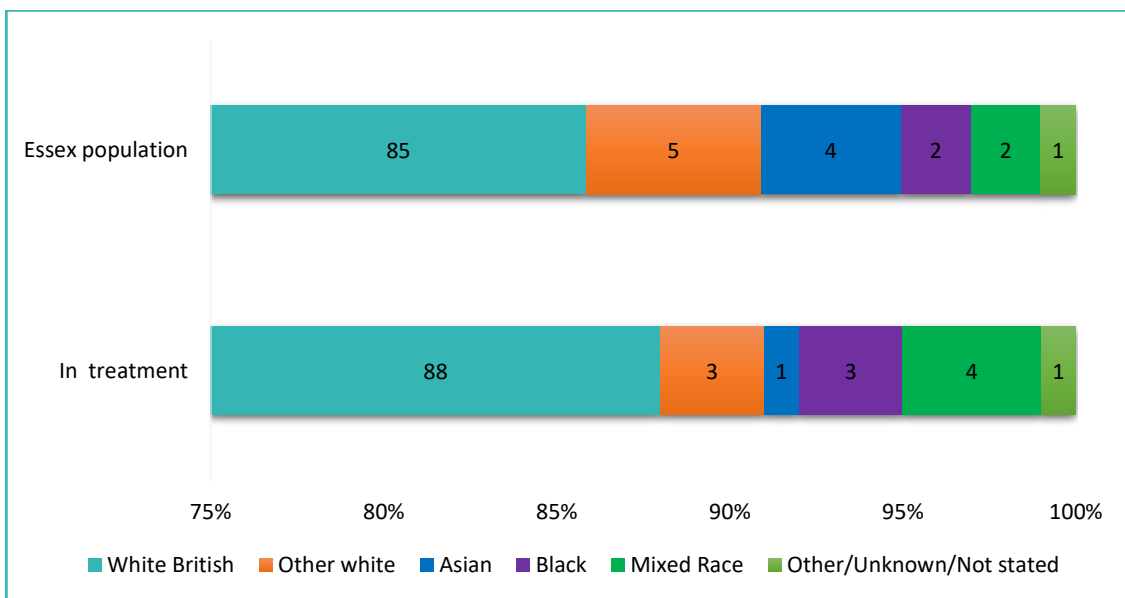
<sup>106</sup> NDTMS Community young people treatment performance report – Essex.

financial year with the latest available (provisional) figure for 31 August 2022 standing at 292<sup>107</sup>. There are far fewer young people in drug and alcohol treatment, although national comparisons are still provided, readers should be aware that these are not so robust as those provided in our analysis of the adult treatment data. The number of young people in treatment in Essex has fluctuated over the last decade reaching a peak of 530 in 2014/15 but falling steadily since then before apparently levelling off in the last five years (with the exception of 2020/21 where numbers were adversely affected by the pandemic).

A larger proportion of Essex young people in treatment were men (69% vs 64% nationally), meaning, of course, that women are relatively under-represented (31% vs 36% nationally). However, a greater proportion (34%) of young people starting treatment in 2020/21 were girls and young women.

The ethnic profile of young people in Essex starting treatment in 2020/21 is compared to the ethnic profile of the county<sup>108</sup> (where it can be seen that Asian people) are under-represented in treatment (1% of new presentations compared to 4% of the local population).

Figure 17 Ethnic profile of Essex young people starting treatment (%) 2020/21



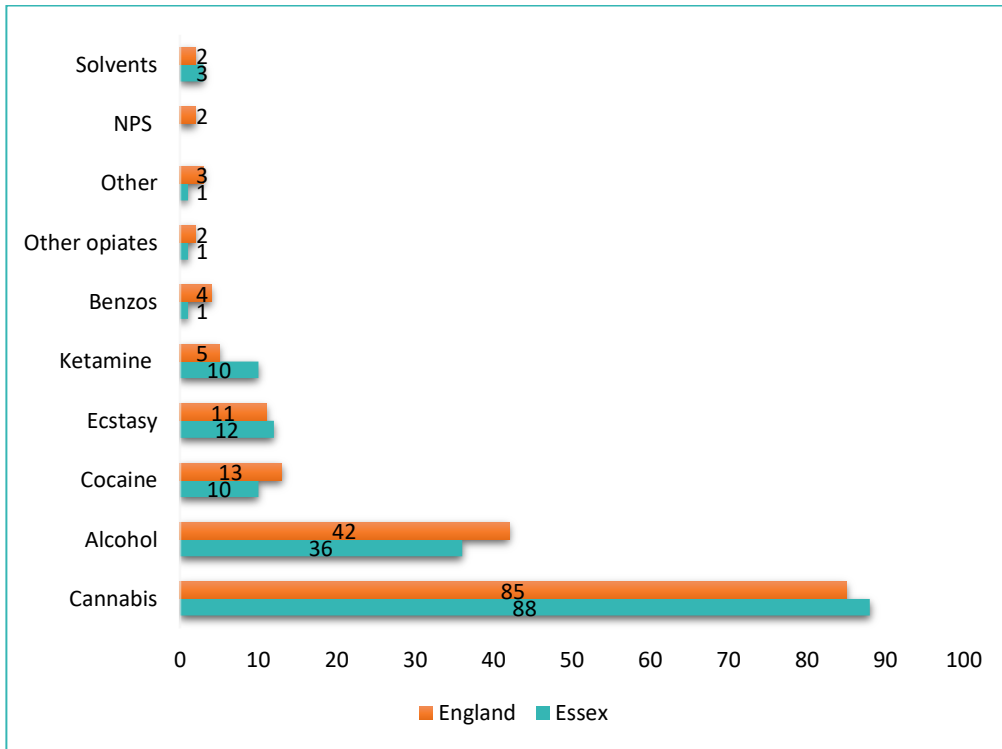
### 4.8.3 Substances Used

The commissioning pack shows the most commonly cited substance(s) of young people in treatment in Essex compared to the national picture in 2020-21. The following chart shows that young people in treatment in Essex are twice as likely to use Ketamine as the national average (10% vs 5% nationally) but much less likely to use benzodiazepines (1% vs 4%).

<sup>107</sup> Ibid.

<sup>108</sup> Data from 2021 Census published 29 November 2022.

Figure 18 *Most common substance of young people in treatment (%) 2020/21*

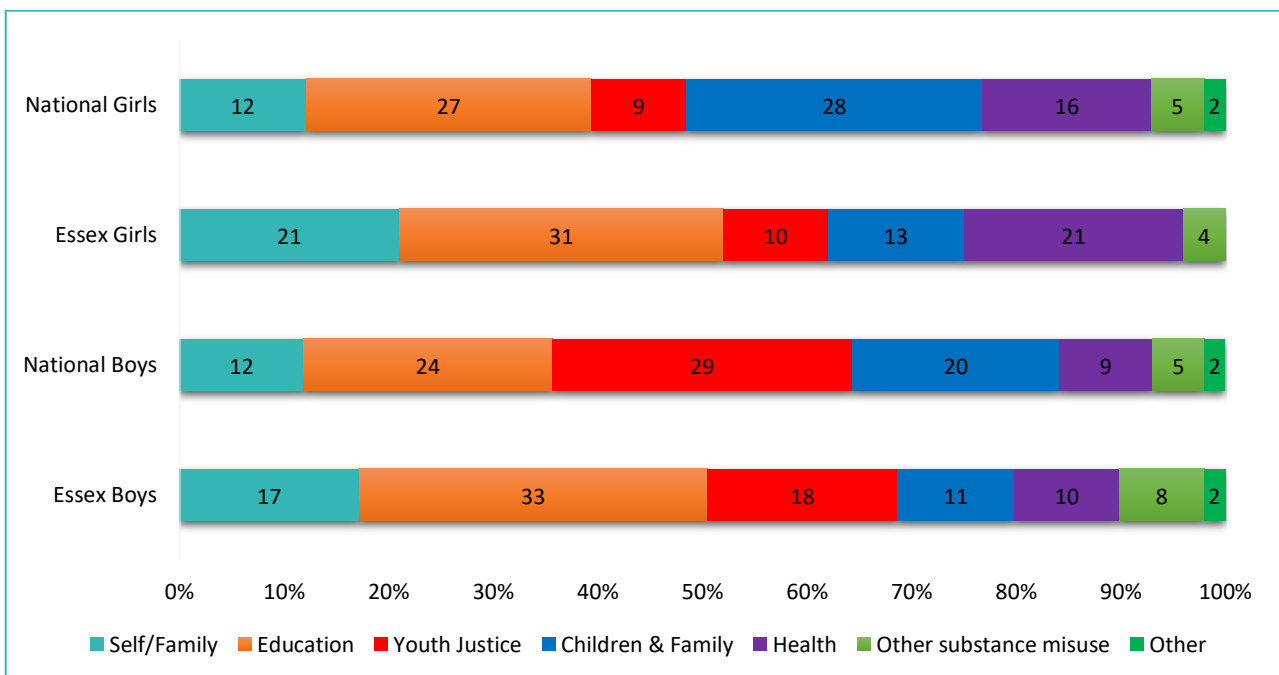


#### 4.8.4 Routes into Treatment

Referral routes into treatment for young people in Essex are somewhat different from the national picture. Boys (17% vs 12% nationally) and girls (21% vs 12%) are more likely to refer themselves or be referred by family or friends into treatment. Boys are much more likely to be referred from education services (33% vs 24% nationally) but much less likely to be referred via youth justice (18% vs 29%) or children and family services (11% vs 20%).

Local girls are also more likely to be referred by education services (31% vs 27% nationally) and by health services (21% vs 16% nationally). They are much less likely to be referred by children and family services (13% vs 28%).

Figure 19 *Young people’s referral routes into treatment (%) 2020/21*



#### 4.8.5 Additional Challenges

There was a substantially higher proportion of both young men (50% vs 35%) and young women (69% vs 56%) in treatment in Essex with mental health needs than nationally. Local young people of both sexes were also more likely to be already engaged in specialist treatment (boys 65% vs 53%, girls 69% vs 56%).

Only one in nine (11%) young people in treatment in Essex were recorded as not being in education, employment or training compared to a national average of 16%.

Local young people in treatment were more likely to be living in care (11% vs 7% nationally), despite the low levels or recorded referrals from children and family services.

The Commissioning Support Pack provides data on a range of wider vulnerabilities for children aged under 18 in treatment. Again, numbers are small, so readers are urged to exercise caution in using the data for service planning reasons. Essex young people in treatment are more likely to be likely to be involved in anti-social behaviour (25% vs 21%<sup>109</sup>) and less likely to be affected by domestic abuse (8% vs 15%) than the national picture.

#### 4.8.6 Treatment Outcomes

A total of 130 children under 18 successfully completed treatment in Essex during 2020 with just 6 (5%) re-presenting to services within 6 months compared to a national re-presentation rate of 4%.

### 4.9 Young People's Summary

Essex faces the same challenge as most of the country in terms of engaging more young people in drug and alcohol treatment. Reported use of drugs among young people has been increasing over recent years while numbers in treatment continue to fall.

Treatment referral routes from education services work particularly, but more attention needs to be paid to referral routes from criminal justice (particularly for boys) and from Children and Families Services (for both boys and girls).

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<sup>109</sup> Again, this may be related to the fact that the Youth Offending Service offers substance misuse treatment.

## 5. FINDINGS FROM FIELDWORK

In this section, we start by providing an overview of the sample, and then outline the findings from the surveys and interviews with all participants in this drug and alcohol needs assessment. Quotes have been used throughout to illustrate that the findings are grounded in participants' voices.

For this drug and alcohol needs assessment, **a total of 538 local people engaged and participated**. Through a mixture of in person and virtual engagement, in-depth interviews, and focus groups, TONIC captured the opinions and experiences of:

- **282 people with Lived Experience**
  - 165 paper survey responses
  - 60 long survey responses (45 with lived experience + 15 on behalf of someone with lived experience)
  - 37 short survey responses
  - 10 in-depth Interviews
  - 9 focus groups
- **231 Stakeholders**
  - 194 survey responses (50 of whom self-reported also having lived experience)
  - 37 in-depth interviews
- **25 people preferred not to say** what respondent type they were (survey responses)

The majority of fieldwork for this needs assessment was conducted between September and November 2022, including ERF and a team of Peer Researchers conducting nine site visits, where many of the paper surveys were completed. We explore the key themes that emerged across this data set below, grounding evidence in quotes where possible.

### 5.1 The Voice of Lived Experience

As part of the needs assessment, individuals with lived experience of substance misuse and recovery could share their views in a number of ways. Firstly, there were two online surveys created, one long version and one shorter version. In addition, a 'one pager' was produced and sent to drug and alcohol services across the area. Individuals could complete this on their own however, there was also the opportunity to complete this, on consultation, with a number of peer researchers who visited sites throughout the needs assessment. Individuals could also text or email to sign up for an online or phone interview to share their views in more depth and detail. Those engaging in phone interviews received a £20 voucher for their time.

Peer researchers were recruited through Essex Recovery Foundation and were all individuals with experience of substance misuse and recovery, having previously engaged with support services in Essex. A training event was held for peer researchers in October, ahead of them conducting fieldwork. This covered the specific objectives of the needs assessments, how to record findings and how to ensure participant and peer researcher well-being. One-page surveys were sent back to TONIC to analyse, as well as notes taken by peer researchers. Peer researchers also came together with TONIC at the end of fieldwork to debrief and share key themes.

We asked people with lived experience to give ratings and key points for each stage of the journey. These are summarised in following diagram and then in detail in the rest of this section.



### Essex Lived Experience Journey

240 people with lived experience gave their views on current services. Their ratings are summarised below with differences between certain groups highlighted. **FINDINGS:** Most people rated services highly (avg. over 4 out of 5) & would strongly recommend the service to others. However, recovery was clearly rated notably lower than all other service elements.

**Ratings Scale:**  
 1 = Very poor 2 = Poor  
 3 = Adequate  
 4 = Good 5 = Very good

	Finding Support		Referral		Assessment		Inclusive & Accessible		Treatment		Recommending Treatment to Others		Recovery	
Avg. Higher Ratings	BAME Alcohol	18-45 year olds	Female	BAME Alcohol	BAME	Alcohol	BAME	18-45 year olds	18-45 year olds	BAME	Alcohol	BAME	OCU	18-45 year olds
Avg. Lower Ratings	LGB+	OCU	LGB+	OCU	Straight	OCU	LGB+	OCU	45 years +	LGB+	LGB+	OCU	LGB+ Alcohol	White British
Rating (max. 5)	4.2		4.2		4.2		4.2		4.1		4.5		3.7	
Positive Comments	"They were recommend as well as prior knowledge of existence" "Through probation and sharps" "GP Word of Mouth" "Walking by Open Road or heard from others in AA about Open Road maybe 10 years ago " "Previous knowledge and Doctor's advice" "Numerous previous attempts with home detox failed & community rehab was offered which felt more "me" "Had a mental health crisis and was given details to contact Open Road but as they only deal with drug issues in Basildon they gave me Phoenix Futures number."		"My therapist didn't force this help but let me know how and gave me a number to call if I felt brave enough" "An immediate and 121 personal contact. I was then supported to attend a group. Really good" "It was a huge leap of faith but once I began to trust others I began to feel hope and I was so depressed I had no other route except suicide"		"After contacting the service I was promptly allocated with a recovery worker and a plan" "I went to Open Road groups & other activities while I waited to start Sharp then it was easy progress to Futures in Mind and it started straight from sharp which for me was important" "Assessment by people who haven't lived with addiction can be patronising" "It was brilliant, the person really understood me and what I was saying and shared that they too had a drug problem in the past" "In depth and monitored" "They listened and cared"		"Athena CGL and fulfilling lives were amazing when I eventually surrendered. Sadly this is not everyone's experience" "Safe places and helpful people" "Key workers came and went. I had no one through lockdown" "Phoenix experience was better when another key worker (female) got involved who was very enthusiastic about recovery"		"Fortunate to be supported by a very knowledgeable ARC practitioner" "I was supported to attend a group. Really good" "I was made to feel comfortable discussing my story openly and honestly. I was made aware of the services offered" "I have had a great experience" "Mostly always got help or reply eventually"		"They did what I needed to get myself in a place to stay sober" "Finally a good, confident relationship with key worker and a rehab programme that didn't take me away from home and family, all 'clicked', I learnt about myself and to understand me"		"CA has helped my obsession of cocaine leave me and taught me a new way of life" "I get all I can from AA" "Cocaine Anon gave peer support which I found useful" "I think where substance Fellowships are concerned, the support in Essex is really good including daily programmes, Fellowships and Rehabs"	
Areas for Improvement & Suggestions	<b>SUGGESTIONS ON SERVICES SHOULD BE PROMOTED</b> "Advertise on facebook, promote on community noticeboards such as supermarkets. Promote by sharing stories of who accesses them & what happens when you engage with them" "Have more people with lived experience willing to share non judgmentally" "Ensure health professionals have up to date information and provide it to patients more readily" "Posters around town" "Promotion of positive difference made as a result of accessing service - case studies, video blogs etc."		"My GP referred me to CHANGES where I was initially helped quite quickly, but a particular key worker caused a lot of distress and was detrimental so things deteriorated for me (I've since heard this person didn't continue there!) Thankfully after some time a new community based rehab was started and I was extremely fortunate to be forwarded for, but prior to that I felt quite isolated and unsupported."		"I got minimal help from drug services" "Waited too long for script & support" "I'm not good on technology would prefer phone call or face to face" "3 weeks waiting for an appointment" "Important to engage with the right practitioner" "The chap at Phoenix could have been more enthusiastic about promoting services they offer, advantages & good news stories, not a lot of effort put in" "System was slow" <b>SUGGESTIONS</b> "Telephone consultation/clinic so people can call in and discuss their needs before walking in"		"Waited too long for script and support" "Open Road kept having people leaving so did not really help. STARS were more supportive but no where near early enough" "Lots of people can't get to places due to travel expenses" "Harwich has hardly no help, ALWAYS HAVE TO TRAVEL" "Members of staff were rude in rehab" "Felt judged by open road" "felt judged and not confident to tell anyone I had an addiction"		"I feel when the alcohol service was given to Phoenix's Futures this has not been very good, hardly any groups, no follow up, no walk in and not very welcoming. Most alcoholics are cross addicted & feel the same way. The big space is underused - not a good investment of money" "Stars and open road keep you well on a script but nothing more with addressing the issues that led you to addiction" "Open road offered a 10 min call every two weeks. I had no support while waiting" "I have never known services for Mental health or addiction to be as bad"		"Synergy - not bad but I didn't like the group environment and felt I was not connected to the others" "Support needs to be quicker" "The support I did receive in Harlow I felt were of little use and provided by people who had zero experience of addiction and little of life" <b>SUGGESTIONS</b> "There needs to be more done to address the problems more peer support and mentoring" "24 hour and weekend support" "Be more visible!"		"The only time I rang the AA helpline in a crisis they never returned my call as promised" "I know many people who went to Phoenix Futures their stay was short and the aftercare nonexistent" <b>SUGGESTIONS</b> "A centralised system with levels of access where an individual's basic details and needs can be logged and be made available to all organisations involved in his/her journey to recovery i.e substance misuse agencies, police, homelessness, debt, mental health etc" "I was very isolated within my addiction so probably a peer support network may have helped"	

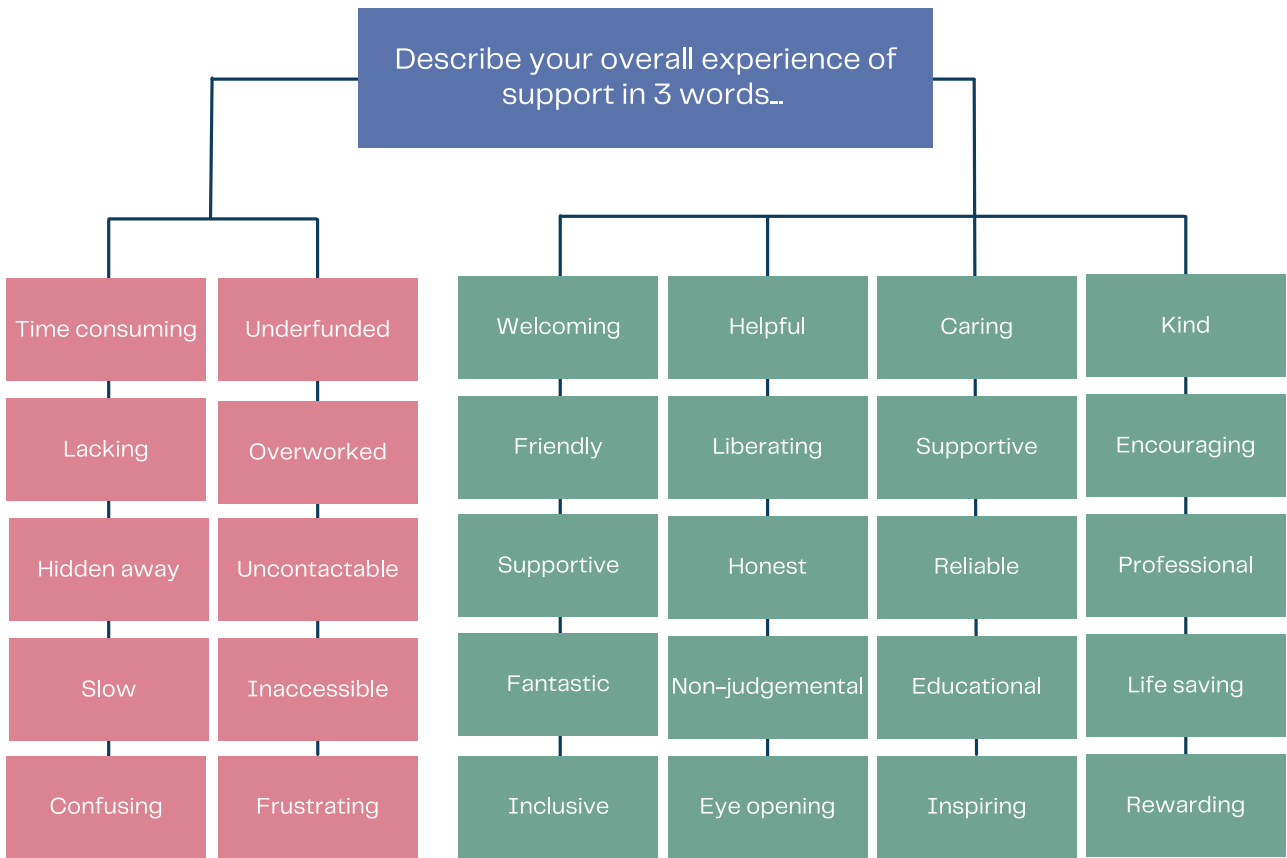
#### Differences between groups:

- Generally women rated services elements higher than men, with the exception of inclusivity
- Services appear inclusive for BAME groups but less so for LGB+
- No significant differences for those aged under 45 and those aged over 45
- People who stated their sexuality as LGB+ rated all service elements lower than those who were heterosexual
- OCUs rated all service elements much lower than those in alcohol treatment (with the exception of recovery)



We also asked people with lived experience to summarise their experiences of treatment support in 3 words, and have summarised this below, separating out positive and negative comments:

Figure 20 Service users experience of support in 3 words



### 5.1.2 A Busy and Confusing System

Respondents discussed how having multiple commissioned services in the area is problematic and confusing. One of the most prominent issues was the fact that there are multiple different referral pathways used for each service and participants felt this needs to be streamlined urgently. There was a call for one holistic substance misuse service provider across the whole of Essex that takes into account all of the good practice in the area. This ‘umbrella service’ was felt to enable efficient information sharing with other agencies, communication, and joint working.

Service users praised components of the Essex substance misuse system. Notably, the Self-Help Addiction Recovery Programme (SHARP) was said to be a hugely valuable local asset because of the ability to stay ‘at home’ rather than attend residential rehabilitation far from friends and family. In addition, Essex Young Person’s Drug & Alcohol Service (EYPDAS) provision for young people *and* families (regardless of if the young person was engaging) was also said to be extremely positive. However, overall, there was a clear message from service users (and stakeholders) that the system is confusing and there are ‘*too many parts of the chain*’. The resulting impact of this was that for people newly entering the system and accessing help for the first time, the trajectory of support offer was unclear. Similarly, this was raised by family members.

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“I'll be honest, I'm a social worker, and I was lost in all this. If I couldn't get him help, what about people who don't have anybody?” (Lived Experience Family Interview)

“...these people, you know, they're not in any fit state to even feed themselves sometimes. How can we expect them to pick up the phone and know what to do, there needs to be somewhere he can go and there will be someone who can look at him, listen to him and say this is where you're at with the whole thing, if you're up for it, this is where you can go, and these are your options. A one stop place and understand what's on offer...but it's all acronyms. I just wanted, as a mother, a flow chart. Here's a flow chart of services. And this is what you do at this stage.” (Lived Experience Family Interview)

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People reported that they struggled to see how they would get from the initial help seeking stage to recovery and long-term abstinence. As a result, there was a request for a service or systems map that clearly depicted the range of services and support available, where this could be accessed, and what part of the recovery journey they supported with. Service users reported a lack of physical material to visualise the journey ahead. They were not provided with any leaflets or paperwork, nor any statistics about the numbers of those recovering or successfully completing treatment, which they said would be motivating. Further, survey respondents discussed how having a large number of commissioned services in the area can be problematic. One of the most prominent issues raised was about the multiple different referral pathways used for each individual service and how this was felt to need streamlining.

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“...my personal feeling, and from my experience, it would be better if there was a central number, a central desk, a central office that took all the referrals. And oriented it better if it was just one organisation, certainly a central desk that took every referral, and said, thanks for all your details I'm going to go to the service provider. Now, whether it's Open Road, Phoenix or whoever, because you know, they can offer you the best service and for it to work that way” (Lived Experience Interview)

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### 5.1.3 A System for Opiate and Alcohol Users

There was a sentiment that the pathway to recovery was clearer for those using alcohol, especially what was required in order to get to SHARP. However, for opiate users, there was not parity, and it was reported that it is harder to see opiate users in visible recovery, to access recovery opportunities (psychosocial interventions), and the focus is mainly on prescribing. However, in Southend, it was reported there is a day programme for opiate users which was praised. In the survey, a lack of support for non-opiate service users was highlighted by respondents (cocaine, cannabis, spice etc). This was due to the fact that non-opiate treatment is not commissioned for a specific substance misuse service, resulting in clients having to receive support through their primary care provider. This was highlighted as a significant gap and limitation to the current system that provides treatment for drugs and alcohol separately. In one case example, during a phone interview, a mother shared her experiences about her son who was a cocaine user. She felt that because he was housed and employed, services did not take his risk seriously despite his numerous attempts to ask for support. He went on to take his own life.

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“He had a house, rented accommodation, which we found to be a bit of a barrier really, because the number of times people said well, actually you're working, you're living somewhere, you're well dressed and clean... I think people get complacent and it becomes just a tick box exercise. But that's not the whole story. If I didn't pay for him to get to work, he wouldn't have got to work. If often I didn't pay for his rent. He wouldn't have anywhere to live. There were dealers hounding him for money.” (Lived Experience Interview)

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This case also highlighted significant failing in joined up working between substance misuse and mental health services – despite being seen by a dual diagnosis worker. The interviewee was clear that her son was disadvantaged by the factors identified above and that risk should be determined on an individual basis rather than prioritising opiate or homeless service users. She also described how services sent letters to her son, but because of his mental state he was not able to open them, which she suggested would have been circumvented by home visits and outreach. Young people also highlighted the disjointed nature of substance misuse and mental health services.

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“As soon as they hear that you have addiction problems. They almost shut you out. They instantly go, okay, so you're getting help with the addiction service. So that's it. You don't need any mental health service. You just need addiction help, like all of your mental issues are being caused by this one thing. So, you get help with that first, and then talk to us. And I think maybe if they work in conjunction with one another, it might be better because I originally tried to get help for mental health before this, and then they sent me here. So, I'm still looking for mental health services and I'm currently going backwards and forwards. It's been a crazy past few months. I've literally just had one referral after another and they keep sending me in circles? If they just kind of worked together, it might be a bit more helpful. Especially because there are so many people who struggle with mental health alongside addiction problems like it's, it's not, it's not a strange thing most people do. So, it would be a lot more helpful if they understood that, you know, maybe having the two together is a good idea.” (Young People’s Focus Group)

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### Entry into Services

A number of individuals we spoke to as part of the needs assessment highlighted that it was hard to find and identify the right service that could support them or their family. Although a small number of individuals had been signposted by police or other charities, others reported finding it easier to turn to national helplines rather than identifying local support. During the focus group with young people, they specifically indicated a need for schools and education providers to be able to provide students with a leaflet about where to access help and reassure them that it will be a confidential, non-judgemental offer. Parents who were interviewed, also asserted they struggled to identify whether their children’s behaviour was problematic or ‘normal’ and at what stage to seek help and from where.

Referrals into treatment were said to be a key issue across the area. As well as streamlining the referral pathways, participants emphasised a need to encourage GPs, hospitals, and other healthcare agencies to make direct referrals into the substance misuse service. Overall, support services were recommended to be more visible.

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“Have face to face referral points in public places like job centres, libraries.” (Lived Experience Survey Response)

“Ensure health professionals have up to date information and provide it to patients more readily.” (Lived Experience Survey Response)

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It was felt that this should be accompanied by improved joint working, communication, and training so that healthcare professionals are aware of the *specific* support the substance misuse services offers to avoid mis-referral (as there are currently separate organisations for alcohol and drugs). Should the system be streamlined, as suggested above, this would facilitate referrals from a range of providers as it would be easier to identify who to refer into. A ‘no wrong door’ policy should be adopted so that, regardless, of substance of choice, people are supported rather than being signposted to a different service.

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“There should be more publicity around what is available, because you have to hunt for stuff, there's nothing that's off the top of your head, you can think of I mean, I was lost, where do I go? You know, who can help?” (Lived Experience Interview)

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Despite some of these challenges, once referred and the correct support has been identified, survey respondents were positive about the process. Where staff had lived experience, this was said to specifically promote empathy and beneficial for the service users.

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“After contacting the service, I was promptly allocated with a recovery worker and a plan.” (Lived Experience Survey Response)

“It was a huge leap of faith but once I began to trust others, I began to feel hope.” (Lived Experience Survey Response)

“It was brilliant. The person really understood me and what I was saying and shared that they too had a drug problem in the past.” (Lived Experience Survey Response)

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### *Centres can be hard to access for some*

During our fieldwork, there were numerous reports that some centres are ‘closed’ and there is no community spirit or ‘drop in’ facility that existed and was valued before the pandemic. Service users were witnessed having to wait outside for appointments rather than being let into the building. They described the fact that doors were locked as particularly demoralising and ‘unacceptable’. Although COVID-19 has meant that many services are now delivered online, young people especially noted a desire to attend groups in-person. Overall, across the provision for adults and young people, there was an appetite for a greater suite of psychosocial groups.

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“...the fact that you have to get dressed and you have to go out, it's like you almost feel productive. It's like you definitely take something off for yourself. You say, hey, look, I've done this. I mean, I know it's the same, even if you have an online thing, you can still say, hey, look, I've done this. But it's also nice to go out and to see people as well to be able to connect properly.” (Young People's Focus Group)

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Some individuals completing the survey also highlighted that there was little support available to people who were not willing or able to engage in groups, nor access centres in person. Trauma-informed principles were noted by some respondents, which advocates for ‘choice’. A greater range of ways that people could engage in recovery should be implemented. For those who found travel to centres challenging, building a network of peer mentors could support this.

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“To be more understanding and accommodating of my circumstances, to offer more choice/opinions. I feel unsafe in groups and going into places after leaving an abusive relationship.” (Lived Experience Survey Response)

“I have to travel quite a way and I have no money, need this closer to home.” (Lived Experience Survey Response)

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### **Staff Churn, Wait-times, and Gaps in parts of the Process**

A number of individuals noted that their keyworker had changed a number of times and there is a lack of consistent staff in the system. The impact of this is said to be on motivation to continue to engage, and the need, often to repeat their story to someone new. In addition, a small number of service users reported that they had missed the opportunity to engage in SHARP because their detoxification was not able to be accessed in time. One individual described how he had to wait 4-5 months for a detoxification and was advised to *'keep drinking, but cut it down'* whilst waiting. In addition, there was reported to occasionally be a gap between detoxification and SHARP, which required more support.

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*"Definitely needs to be more support. Yeah. 100% in the future, trying to give up something or having a gap between services, it's so easy just to think, you know, like I did before, nope, no one cares, really, and just go back to our ways."*  
(Lived Experience Interview)

*"I see people go in (to groups) and then never come back again or they'll do three weeks and never come back again. Because they're just waiting for a place, and you know it seems that they've got to tick all the boxes or jump through these hoops to get into SHARPS and it is a fantastic programme. But it doesn't seem I don't know enough places or enough of them."* (Lived Experience Interview)

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### **Lack of Clear After-Care Pathways**

A number of those contributing to the lived experience feedback had progressed through SHARP and been maintaining abstinence for a number of months or years. This cohort highlighted a lack of clear and consistent after-care pathways for individuals who were further along in their recovery. SHARP provides individuals with structure and consistency for a period of 8 weeks (9 including induction), but it was felt that a step-down programme would be beneficial after this ends, especially one that capitalises on the peer support built throughout. This was considered to be particularly important as loneliness was flagged as a key risk for relapse. It was also highlighted, by survey respondents, that education around other risk markers for relapse such as addiction to sex or gambling should be included in aftercare plans.

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*"My recovery feels fragile. I spend most of my days alone. It would be nice if there was somewhere to go."* (Lived Experience Survey Response)

*"...they do they do have sit down with their care managers and have a care plan, but it's a one-time session. And although SHARP has a good success rate, I think one of the biggest problems is people go out and they don't always stick with their peers. And they kind of get lost in the system again, so more preparation for that."* (Lived Experience Interview)

*"...you build such relationships with your peers here. I feel that should carry on as long as everyone's okay, when they leave here, but have a firm plan. Because there's no real plan, right? It's like something on a piece of paper that says, right, I'm going to do this. I'm going to do that. I'm going to do this. But then nothing. There's, there's no follow up."*  
(Lived Experience Interview)

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One individual described how he had been given details about the Peer Mentoring service offered by Phoenix Futures but had struggled to gain any traction with this and there was very little information available. It was reported that if this was up and running it would provide people a great opportunity to support others earlier on in their recovery, after coming out from SHARP or otherwise. It was recommended that aftercare, for those further along in recovery, should consist of activities, away from centres, based around nature, hobbies, and days out. Individuals were unclear

if they could access groups that they had used before SHARP, such as relapse prevention; however, it was felt this may not be relevant any longer and it was noted that this was only once a week, and they were looking to replicate some more structure.

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“I think there should be a centralised system...for people that are newly recovered, where they can go to, and then like literally they'd be asked what, what did you enjoy? What do you want to do? And then be able to fill them in that direction. Because sometimes people are lost, they don't know where to look, when they're out. It's almost like being a baby relearning how to live. And I think if there was somewhere central you could go to when you do recover, to help follow and find out what you're interested in.” (Lived Experience Interview)

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Individuals highlighted the importance of continuing to be around those with lived experience and feeling connected to the recovery community.

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“I've got my family and that but unless you're like, an addict, you don't really kind of get it. Whereas fellow addicts do. And that would be that'd be so much better. Or even, like, I know, they've got like this SOS bus that goes down...because it seems to, well, my point of view is if you're in you're in, if you're out, you're out sort of thing. It needs to be a bit more, a bit more structured, or even when you leave SHARPs, even break it down to like, two days a week or three days or whatever. Gradually break it down to people that ease into normal life again. Rather than having that five, six days a week process and then it's just suddenly stopped” (Lived Experience Interview)

‘Some form of community hub that people can freely access Monday to Friday 9-5, ran my volunteers in recovery’  
(Lived Experience Survey Response)

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A further recommendation about aftercare was that once someone has been detoxed and is coming to an end at SHARP, that mental health support could be organised as part of the step-down process. This was especially relevant in light of consistent feedback that mental health services will *not* engage with people while they were still using substances. Therefore, the period of abstinence achieved through SHARP could be capitalised on.

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“I suffered with my mental health as well. As soon as I got out of SHARP, I've been trying to get to see a psychiatrist. And I've only just managed to get an appointment. So it's been about three months. I was contacting my doctor, they said they'd contacted the psychiatry, the mental health team. The mental health team said that the doctor never contacted them, and it just went back and forth for ages. So maybe there's a psychiatrist in place that people who need support with mental health could be put on a fast track whilst they're at SHARP or talks to have it lined up when they come out again.” (Lived Experience Interview)

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Young people noted that having a community of peers could be particularly supportive over weekends when services were closed.

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“...over the weekends and stuff where I've not really been sure who to turn to. And that's sort of like the situations where it is good to have other young people that are also in recovery, because you've got somewhere to turn to...”  
(Young People's Focus Group)

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### *Suggestions from people with lived experience*

As a result of the lived experience engagement there seem to be a number of key areas for consideration:

- Creating a clear and simple summary, perhaps a one pager or leaflet, which provides an overview of services available to people. A visual representation of the journey ahead to motivate people and provide them clarity on the pathway to recovery.
- Encouraging staff retention within substance misuse support services through a robust training programme, competitive salaries and caseloads that permit in-depth working with clients for increased job satisfaction
- Making centres accessible to service users to create an inclusive 'drop in' centre culture that was previously valued by people with lived experience
- Building a robust after care programme for people leaving SHARP or in later stages of recovery to maintain contact with peers and creating a visible recovery community

## 5.2 Stakeholder Views

### Stakeholder Interviews

We conducted 37 depth interviews with strategic and frontline stakeholders across all key agencies. The main points from the Thematic Analysis of the interview transcripts and notes are set out here, broken down by prevention, supply and treatment strands, with each showing strengths highlighted; gaps, issues and areas for development raised in discussions; and recommendations and suggestions that were made.

#### 5.2.1 Prevention

##### **PREVENTION: STRENGTHS**

These strengths and areas of good practice were highlighted by stakeholders during our interviews:

- **The EYPDAS service** was well regarded and said to be "*approachable, reliable and easy to access – always giving a quick response*" – this was mentioned specifically in terms of their links with education, social care, and the Youth Offending Service.
- The **Risk in the Community (RIC)** and **Missing and Child Exploitation (MACE)** meetings for young people vulnerable to exploitation approach were well regarded. This included their pathways, multi-agency meeting, and dedicated practitioners. The approach was said to be working well in protecting vulnerable children and young people at risk, including effective links into EYPDAS for substance misuse related issues.
- **The specialist response to 18-24s** has engaged more people in treatment than previously seen for this age group, often at an earlier stage of drug use than seen previously, and successfully retained them in support.
- **Project NOVICE in Basildon**, where an under 18 in possession of cannabis is diverted away from a criminal justice response through engagement with EYPDAS, was considered to be working well.
- The **Risk Avert** programme in schools was well regarded, with evaluation evidence of a positive impact.

##### **PREVENTION: GAPS, ISSUES AND AREAS FOR DEVELOPMENT**

In this section we present the gaps, issues and areas for development that were raised by stakeholders we interviewed.

The overarching move of treatment provision to a more **recovery-based model** was said to not reflect the needs of under 18s and may need a rethink for children and young people's support around drugs and alcohol going forward and how this service is delivered.



A **static level of funding** (with no increases) for the children and young people's service has meant it is now stretched in delivering the same level of service as all costs are rising sharply.

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“We are struggling to deliver the service on the same budget as 6 years ago – with a decreasing budget that was required by the tender process.” (Stakeholder Interview)

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There is **no Essex-wide drug and alcohol prevention or wellbeing strategy for schools**. Therefore, this is left to individual schools to determine as part of delivering their Personal, Health, Social & Economic (PHSE) and Sex & Relationships Education (SRE) statutory requirements. As part of this, it was felt that there was **no clear and consistent drug or alcohol related suspension and exclusion pathway** that ensured engagement with specialist services. It was also suggested that drugs and alcohol was a gap in the current Essex **Children and Young People Plan (CYPP) and the Levelling Up Strategy**.

## 5.2.2 Tackling Supply

### TACKLING SUPPLY: STRENGTHS

These strengths and areas of good practice were highlighted by stakeholders during our interviews:

**The response to County Lines and wider drug supply** was reported as a strength in Essex, in particular through the following activities: the Police County Lines team; increased levels of Police activity; cash seizures under POCA (Proceedings of Crime Act); the Tackling Drug Supply group led by intelligence team in serious crime directorate; raising the average sentence from 18 months to 4.5 years for drug supply; and ensuring the response when a minor is being criminally exploited is seen as victim. We understand the County Lines processes are being reviewed currently but are generally considered to be working well.

### TACKLING SUPPLY: GAPS, ISSUES AND AREAS FOR DEVELOPMENT

In this section we present the gaps, issues and areas for development that were raised by stakeholders we interviewed:

Methods used by organised crime groups and street gangs are constantly evolving (e.g. "The Deliveroo-isation of Drug Supply"). This means **responses to tackling supply need to be constantly under review** and adapted to meet changing supply approaches being seen by partners and people with living experience. Also, it was felt to be important to acknowledge that Essex has its own **county lines gangs** and is not just an 'importer' of lines run from other areas.

HMP Chelmsford have had an issue with prisoners diverting their medications due to medicines queues being unsupervised (unlike in most other prisons) – this was picked up by HMIP Inspectors, as well as issues with the availability of Spice and Class A drugs. These issues are of concern given the links to drug deaths, victimisation, and drug debt bondage. However, we understand that efforts to address this are being led through a new joint approach by HMPPS and Essex Police delivering an agreed action plan, which has been recognised by HMIP Inspectors in their most recent visit.

## 5.2.3 The Treatment System

### TREATMENT: STRENGTHS

These strengths and areas of good practice were highlighted by stakeholders during our interviews:

#### Strategy and Governance

The establishment of the **Essex Recovery Foundation (ERF)** was widely seen as a strength, with lots of potential to bring about positive change through a genuine co-production approach with services users and people with lived experience.

Having the **Director of Public Health for Essex as the Senior Responsible Officer (SRO)** for the Essex Drug and Alcohol Partnership (EDAP) Board will ensure a high profile for the issue of reducing harm from substance misuse.

We were told that a number of **staff across the treatment services have lived experience** was a strength of local provision.

#### The Delivery Model and Treatment System

The **partnership model of treatment delivery** is seen as largely positive, allowing each service to focus on what they do best. Co-location, following teething problems and a re-think during COVID-19 – is now considered to be working well in general.

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"The Essex Treatment System works well – with lots of co-operation between partners, co-location and co-contracting. We reap the benefits of a partnership that individual entities could not achieve alone. It is better than the sum of its parts. For example, the NHS are good at accessing NHS services and managing complexity, whilst the 3rd sector can be more agile, bringing in additional resources etc. We challenge each other and hold each other to account. This all means we can provide a range of options that are not available in all areas." (Stakeholder Interview)

"We have fortnightly clinical meetings with EPUT and meet with the manager on a regular basis to troubleshoot any issues. Our relationship has really progressed – especially since COVID-19 where we needed to review how we work together in those different circumstances." (Stakeholder Interview)

"We are all trying to be more flexible – joint working with Open Road or running joint appointments with them. We have been doing more outreach, looking to address the barriers of travel limiting access." (Stakeholder Interview)

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**Long-term funded contracts** were seen as positive, allowing for services to develop and invest in their workforce and infrastructure.

It was said there were **positive partnerships between treatment services and a range of other key agencies**, including (but not exclusively): alcohol services with NHS Liver Clinics; sexual health with the Terrence Higgins Trust; Police; and Mind.

#### Access to Services

The **"no wrong door" approach** operated by Open Road and The Children's Society, enabling an all-age provision was seen as very positive.

**Evening clinics** are being run from the main centres and some **satellite clinics** are being run in more rural areas.

Some felt that offering **digital access to services has improved attendance** at group and individual sessions run online. This includes the 18–24-year-olds and their groupwork sessions held online. Some services are moving towards a hybrid model of working, offering flexibility and choice around accessing services digitally or in person. This was also felt to have the potential to help manage rising costs by reducing travel expenses and venue/office costs, increasing "up time" for practitioners as a result of reduced travel time and improved attendance.

The **COVID-19 vaccination programme** led by EPUT ensured both treatment staff and service users were vaccinated, achieving a very high rate of service users being vaccinated. They also managed to keep the main treatment centres open throughout the pandemic restrictions and did not have any COVID-19 breakouts. They kept the 'R rate' lower for the treatment population than the Essex average at all times, due to the vaccination programme, safety procedures put in place at centres, and revised systems for prescription pick-ups.

There was positive feedback about the **Violence and Vulnerability Partnership outreach** that sought to help people into treatment earlier.

### Treatment Quality & Capacity

Overall, the **treatment provision in Essex was felt to be of good quality.**

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*"Our treatment provision is regarded as good by service users and colleagues, and the partnership model is seen as positive, allowing services to focus on what they do best." (Stakeholder Interview)*

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Open Road has some **new funding for an additional Criminal Justice System (CJS) worker in each area**, which is expected to help reduce caseloads (estimated to reduce from circa 70 to around 60).

The **new clinical governance lead** coming into the Essex County Council (ECC) Public Health Team presents an opportunity to continue to improve treatment quality and engagement from wider health and social care provision.

Essex is a **Changing Futures area**. This was seen as a positive opportunity that will help by identifying high impact individuals experiencing three or more issues, with the top 10 in each District care managed by a co-ordinator.

The **Essex Buvidal pilot** (using depot injections weekly/monthly as opposed to much more regular collection of prescriptions for other forms of opiate substitute prescribing) is going very well, changing the cycle of addiction and helping people get back to work, education, caring responsibilities once they are stable.

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*"This is the best thing ever – it's like a light switch – it changes the way people think. They become far more stable." (Stakeholder Interview)*

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The **HMP Chelmsford Buvidal pilot**, although experiencing some teething problems whilst first being established, now also has very good feedback.

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*Patient feedback is overwhelmingly positive – this has allowed people more opportunity/encouragement to make changes and reducing offending." (Stakeholder Interview)*

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## Mental Health

The **ECC Mental Health and Wellbeing Team (Social Care)** is being expanded to meet the mental health needs of low-level drug and alcohol users.

The **dedicated Dual Diagnosis workers** for each quadrant (EPUT) were said to be starting to work well but had limited capacity to meet the high levels of demand.

## Criminal Justice

The **process for Drug Rehabilitation Requirements (DRRs)** was said to have been improving recently, based on better joint working between Probation and treatment services.

We were told that **CJS workers from substance misuse teams will be working from Probation sites** in future.

**Probation will commence drug testing** from January 2023.

It was felt that **the treatment system is well joined up with Police custody** through healthcare practitioners working in custody settings. In addition to this, **Essex Police are aiming to establish a drug testing on arrest scheme** from April 2023, to target Domestic Abuse and violent offenders from the night time economy, linking to tackling serious violence and Violence Against Women and Girls (VAWG), and aiming to encourage more people into treatment for a variety of different drugs (not just opiates) e.g. ketamine, cocaine. These efforts are expected to increase referrals into treatment.

Performance for the **“Continuity of Care” for those leaving prison** into Essex, i.e., being able to quickly and seamlessly accessing treatment and continue prescribed medication programmes, has been above the national average rate for a number of years. We also heard positive feedback about **the Phoenix Futures CJS service** working well.

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“This has improved continuity of care coming out of prison from HMP Chelmsford because of Forward Trust involvement with Phoenix Futures.” (Stakeholder Interview)

“This works because of the community treatment service has picked this up well historically – this has survived even when the provider of the community and prison treatment changed (it was the same provider for both in the past). There is a high level of integration and a can-do attitude rather than sticking to the wording of what they are commissioned to do. This makes the pathways work.” (Stakeholder Interview)

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## Harm Reduction, Blood-Borne Viruses and Drug Deaths

There was felt to be a **comprehensive offer on Blood Borne Viruses (BBV) prevention and treatment**. This included a high success rate seen with Hep C treatment in the community being delivered from a range of hospitals and by EPUT from their centres. HIV rates were said to be under control, supported by a good testing offer by treatment services. There are vaccinations offered for service users for Hep A, Hep B, Flu, and COVID-19.

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“We are clearing the Hep C virus from Essex.” (Stakeholder Interview)

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There has been a **reduction in drug deaths** in Essex despite the rise seen nationally. This was felt to have been contributed to by a range of measures put in place by services, such as: safety measures around prescriptions;

providing safe home storage facilities; **increasing the use of Naloxone** (including by training pharmacists to give this out); and their approach to **learning from the Mortality Review Process** (a multi-agency group chaired by EPUT, with a commissioner from ECC), which also shares learning from Domestic Homicide Reviews (DHRs) and Safeguarding Adult Reviews, in a learning and non-blaming way that helps to drive improvements in practice.

### Workforce

There is a **new ERF Training and Development Manager** in place to build workforce quality, support recruitment and retention, and link to the workforce strategy for the East of England. We also understand that there is a **new Open Road Training and Development Manager** that has recently started to help with improving staff quality, recruitment, and retention.

As shown above, we were told about general difficulties with recruitment and retention; however, we were told that **EPUT have only one vacancy across the county and have good staff retention levels**. They put this down to the longer contracts that were given by ECC allowing them to invest in developing and training staff and offering career progression, along with being an NHS provider with the additional benefits that brings (e.g., pensions).

Phoenix Futures have employed **trainees in a partnership with the University of Essex**.

### Rehabilitation and Detoxification

Additional rehabilitation funding from the Office for Health Improvement and Disparities (OHID) is time limited but we understand that Essex is keen to explore the potential of this funding to **kick start the development of rehabilitation capacity within the county**.

The Eastern Region provider consortium has pooled OHID funding to create an **inpatient medically managed detoxification unit of 4 beds at the Topaz Ward** in Broomfield Hospital and run by EPUT. This provision is for people too complex for conventional detoxification (e.g., homelessness, history of fitting, complicating conditions). This service started in 2022 and has reduced waiting lists and improved the detoxification offer for those who otherwise would not have receive it.

The **community rehabilitation service, SHARP**, was felt to be a good provision, offering a viable alternative to residential rehabilitation and enabling people to attend who would not otherwise consider the residential option.

### Recovery

The **Aspire Programme** run in Wickford, focussing on life skills and running a catering company, received positive feedback.

**Futures in Mind** was said to be a good model for those that accessed it.

## **TREATMENT: GAPS, ISSUES AND AREAS FOR DEVELOPMENT**

In this section we present the gaps, issues and areas for development that were raised by stakeholders we interviewed:

### The Treatment System and Governance

Partners felt they did not know enough about what is working well and where there are gaps across Essex, with some requesting **better sharing and use of data**.

The **current system, with multiple providers, service types and pathways were felt to be confusing and seen as overly complex** to some service users and partner agencies. There is not always good communication between services meaning they do not always know about the full range of services available.

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"There is an issue with the complexity of the treatment system – who holds the ring and co-ordinates care when multiple services are engaged? People are having to retell their story multiple times." (Stakeholder Interview)

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Some felt there was very **limited opiate or crack user representation in ERF along with a gap in volunteers** from this group across services.

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"The opiate users voice is missing in the co-design approach at present." (Stakeholder Interview)

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### Access

There are **low penetration rates for engaging opiate and crack users (OCUs) in treatment** in Essex, but there is some doubt about the accuracy of the OHID synthetic OCU estimates.

People living in **rural and coastal areas, smaller towns, and villages with poor transport systems** have greater difficulty accessing services. Although some outreach or satellite clinics are run, coverage is patchy and sometimes delivery can be inconsistent. This means some cannot access the full range of services because of where they live. Services do not currently repay transport fees to enable people to access their service centres.

**Stigma is a barrier** to accessing treatment support – especially amongst opiate users.

Some clients stopped attending services during COVID-19 restrictions but are now beginning to return. However, the **continuation of some of the restrictions and measures in premises**, although in place to ensure the safety of both staff and service users, are said to be having a detrimental impact on access and the experience of using some treatment services. This can result in waiting rooms not being fully utilised, meaning that some people are left waiting outside in all weathers and feel unwelcome and disenfranchised by this situation. We understand that EPUT are reviewing whether to continue or adapt current procedures from 23<sup>rd</sup> January 2023.

The COVID-19 restrictions saw the introduction of some services being provided online. The issue of **digital poverty** was raised, with many opiate users not having access to the required devices or data to allow them to access these online services.

### Caseloads, Capacity, and Workforce

There was felt to be **little promotion of treatment services to the community** as these services are already at capacity and would not be able to cope with large increases in demand.

The **capacity of the treatment system is lower than the current level of demand**, resulting in caseloads being very high. Typical caseloads for Open Road are around 70, with higher numbers at the alcohol service run by Phoenix Futures. EYPDAS also experience high caseload numbers, and are seeing increasingly complex cases requiring more intensive responses. Overall, **caseloads were felt to be far too high and to impact negatively on both the quality and frequency of support** that can be offered. Services feel that caseloads should be capped, with some saying that 40 would be a desired maximum.

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“You can’t do meaningful work with people when you are just a sausage factory churning out paperwork all the time. Services are very under resourced.” (Stakeholder interview)

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There have been **difficulties with staff retention and recruitment**, with gaps in available skilled, qualified and experienced people in the job market. Essex has struggled to recruit and retain staff due to higher wages being offered in neighbouring London attracting many people away from existing jobs or limiting numbers applying for vacancies. We were told about particular issues with high staff turnover at Open Road, which impacted negatively on service users, who had to experience regular changes of key worker.

### Criminal Justice

COVID-19 and the **reunification of Probation** have impacted negatively on provision of a consistent offer for people in the criminal justice system that require substance misuse treatment. Although we were told things are improving, it was felt that treatment provision for offenders could be better, along with more consistent support for pre-sentence assessments. This will be needed to ensure all Probation clients who need treatment can access this quickly.

The **use of drug and alcohol specific requirements and orders, such as Alcohol Treatment Requirements (ATRs) and Drug Rehabilitation Requirements (DRRs) was said to have reduced over recent years**, with some people being unnecessarily rejected for this type of support. A data snapshot in late 2022 showed that 7% of men and 12% of women on the Probation caseload with an identified alcohol need had an ATR. This data also showed that 4% of men and 16% of women on the Probation caseload with an identified drug need had a DRR.

Although the DRR process was said to have improved recently, overall, it was felt by some stakeholders that these requirements are not currently robust enough to offer a real alternative to custody (e.g. appts less frequently, less testing, less intensive). We also received feedback that Judges would like to see a stronger offer (e.g. monthly reviews for Crown Court cases). In addition, joint reviews between Probation and treatment providers were said to not always be happening regularly enough.

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“Separation and reunification of Probation has had a big impact on capacity over the past few years – recruitment is a real struggle.” (Stakeholder interview)

“The number of these requirements have decreased over time – there are some misunderstandings about criteria for eligibility for ATRs, with the provider sometimes resist treating people coming out of prison who are not currently drinking but still need support on release. Sometimes providers assess clients as not being ready – but Probation suggest people need to go through this system a number of times (chronic relapsing condition/cycle of change) – this means some opportunities to intervene are missed and people are refused inappropriately.” (Stakeholder interview)

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RECONNECT is a care after custody service that seeks to improve the continuity of care of vulnerable people leaving prison. This involves working with people before they leave to support their transition to community-based services, aiming to improve their wellbeing reduce inequalities and address health-related drivers of offending behaviours. We were told that **RECONNECT is not currently available in Essex**, and this was felt to be an important gap to address to improve the criminal justice pathway for people misusing substances.

Linking up with prisons outside Essex for people being released to Essex was said to be harder to ensure **continuity of care** into community treatment and prescriptions than it is with HMP Chelmsford (where relationships and systems are working well). Continuity of care works less well for people on shorter sentences; however, we understand that Probation are working to improve this with a specific team.



## Gaps

We were told that approximately 1 in 3 **domestic abuse reports** made to Essex Police involve drugs or alcohol. It was felt that the process is currently unclear for ensuring that responding Police officers ask about substance misuse and have the knowledge and the confidence to make referrals into drug or alcohol treatment. Ideally, it needs to be made easier for the Police to refer or signpost to treatment, and to identify high frequency domestic abuse victims or perpetrators in need of treatment support.

There was felt to be a gap in the **local response for people with low motivation to change** – particularly change-resistant drinkers and non-OCU drug users.

Some felt there was a gap in **diversionary activities** being provided to support those in treatment to move towards building recovery capital and improve wellbeing.

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"There is nothing that comes alongside structured treatment to help with diversionary activities, so it is hard to move people on from treatment" (Stakeholder Interview)

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It was felt that gaps exist across the system for those with both substance misuse dependency and mental health problems (also known as **Dual Diagnosis**). Some suggested that the language used was too medicalised and agencies do not have a shared understanding of the issue, with no agreed definitions or thresholds, which limits a joined-up approach to people with both substance misuse and mental health issues.

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"Although this has been improving over recent years, there are still big gaps. There is a lack of understanding of mental health and of dual diagnosis and what this means. Everyone in substance misuse treatment has some form of mental health condition but only a small percentage will meet the Secondary Care criteria for specialist mental health provision. Most will have a primary care mental health issue (Tier 1), meaning that IAPT, GPs, and wellbeing services should deal with this but there are gaps as primary care services do not feel well set up for those with substance misuse issues, fearing they are too chaotic, cannot access digital services etc." (Stakeholder interview)

"The dual diagnosis pathways are difficult – people are pushed between different services and often end up with no support." (Stakeholder interview)

"Addiction is a mental health issue! But very few services allow for this. IAPT can't cope with substance misuse and substance misuse services are not equipped to cope with even low-level mental health needs. They are not getting their needs met – they just get ping ponged." (Stakeholder interview)

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Limited opportunities for people in treatment to gain **employment** or work experience was raised as a gap.

Outreach from treatment services to organisations working with people who are **homeless** was felt to be a gap currently, with previous support stopping during COVID-19 and is now not available. Access to housing for some of those in treatment was regularly raised as a gap in the current system.

A **lack of affordable, accessible and suitable housing provision and meaningful supported accommodation** has been seen for substance misuse clients, as they can be seen as too high risk and too high need for general housing. Housing legislation means people are deemed intentionally homeless when they go into custody – this then becomes hard to turn around as they cannot get a tenancy with this status and so cannot shake off this label.

It was felt there was not a clear support offer for **those using substances other than opiates or crack/cocaine** - meaning an opportunity for prevention of escalation is being missed.

People from **minoritised ethnic groups, women and people from LGBTQ+ communities were felt to be underrepresented** in the treatment population. A lack of women only provision, and services linked to 'by and for' organisations were said to limit uptake of treatment.

Currently there is no pathway for people **misusing prescribed and over the counter medicines**. This is considered to be a substantial gap leaving large numbers of people at risk with little or no support to address their dependency. Learning can be taken from the MSK Team in West Essex who are supporting GPs to "*deprescribe*".

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"It would be good to have gender-based services for women coming out of the criminal justice system as many of them will have had more trauma and vulnerabilities – including exploitation, prostitution and Class A dealing." (Stakeholder Interview)

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### Current Issues

Services have seen limited numbers of people accessing treatment as a result of **chemsex** activities (either self-reporting or being referred by sexual health services). This is felt to be a gap as it is understood that there are people going to London regularly to participate in chemsex activities but not seeking support for their drug use or sexual risk-taking behaviours.

It was felt that the coming years will see a worsening of the **cost-of-living crisis**, driven by high inflation, which will impact disproportionately on the client group of treatment services, and that there is a lack of practical help with this that treatment services can offer.

Some felt that many of the **harms that young people experience are hidden** from adults – including online content and interactions, buying illicit substances and alcohol online (inc. through the dark web), child criminal exploitation, and child sexual exploitation.

The national **shortage of pharmacists** is leading to closing of some Essex pharmacies, which has a big impact on clients picking up their medication, resulting in them having to get new prescriptions and find new pharmacies. Dealing with this costs services both time and money. Some pharmacies are no longer opening at evenings or weekend, limiting their accessibility for those who work. Many pharmacies are now reliant on locums, which means there is no consistency of care offered there. This also has an impact in that pharmacies cannot deliver much added value around harm reduction, brief interventions or and information and advice. Where EPUT have offered training not many pharmacy staff attend, and they often move on.

Treatment services have been contracted to provide **drug and alcohol training for other agencies** (including pharmacists and GPs), but this has largely not been happening in recent years. This, along with other pressures on GPs, has resulted in **Shared Care prescribing "dying"** in the last few years and meaning **pharmacies are not as well prepared** to support treatment as they should be.

Most of the people in treatment will have experienced some form of trauma that will impact their substance misuse. We were told that some of the processes used by treatment services could be re-traumatising, and it was felt that the

pathways, the workforce and the interventions could usefully be reviewed for how **trauma-informed** the system is and how it could be improved.

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“Most service users have trauma in their lives, often from early age and these are the triggers for addiction.”  
(Stakeholder Interview)

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It was felt that the **ageing opiate client group** were now seeing more co-morbidities that are likely to contribute to drug deaths in future.

**Support for families** in the current treatment system was described as somewhat patchy, without a consistent offer to all ages, all substances, all stages of the treatment journey, and across all areas of Essex. It was also felt that the current offer of treatment support was insufficiently targeted for mothers who had multiple children taken into care due to their substance misuse. We were also told that treatment services often cannot provide reports or attend Child Protection meetings.

### Recovery

There was felt to be **limited additional support for building recovery capital provided during and after treatment**, with the recovery provision that is there sometimes being hard to access for some (e.g. eligibility for opiate users and being able to travel for those living in remote areas).

It was felt there is a **gap in provision of psychosocial support** alongside opiate substitute prescribing to help move people on, with only two high intensity psychosocial workers in place across the county at Open Road.

There were said to be **no volunteers or peer mentors** in Open Road currently.

### Rehabilitation and Detoxification

In spite of the additional detoxification provision, there are still **waiting lists for inpatient detoxification** (e.g. 1 client recently waited 7 months) – often for lower-level need patients, with the gap being for “medically supervised” detoxification rather than “medically managed” detoxification offered at Topaz. Sometimes the application process for alcohol detoxification was said to be overly lengthy and complex, with too many agencies involved.

Funding shortages over recent years, along with the impact of COVID-19, has meant many residential rehabilitation providers have closed. There are now **reduced numbers of placements for residential rehabilitation - limiting the variety and quality of specialist provision available**. This limits the options, variety and choice available for individuals in need, and has led to **longer wait times**.

We were told about some **difficulties in gaining access for opiate users into SHARP community rehabilitation**, where they were still receiving some prescribed medication. However, the providers of SHARP were keen to say that there were not barriers for opiate users accessing this service.

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“We cannot get opiate clients into SHARP if they are taking any medication, and we have found this restrictive. We can get alcohol drug users into SHARP, so it feels like a lack of equity for recovery for opiate clients.” (Stakeholder Interview)

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We were told about some **difficulties in gaining access for opiate using clients to the Futures in Mind (FiM) programme**, as FiM and their peer mentors do not currently work from Open Road centres.

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"The focus of FiM seems more focused on mental health than drug misuse - possibly due to where the majority of funding comes from." (Stakeholder Interview)

"Community Recovery provision is just not there for opiate users." (Stakeholder Interview)

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### 5.3 STAKEHOLDER SURVEY FINDINGS

We ran a survey that received 194 responses from stakeholders from a wide range of agencies across Essex. The key points from the Thematic Analysis of the survey responses are set out here, broken down by prevention, supply, and treatment strands, focussing on gaps, issues, and areas for development, with suggestions that were made to address these.

#### Overview of Results

The survey findings showed that overall stakeholders in Essex rated the treatment system to be adequate to good, highlighting some areas of concern. The headlines from this are set out in the following diagram:

Figure 21 Summary of Stakeholder Survey Findings

PREVENTION		TACKLING SUPPLY		HARM REDUCTION & OUTREACH		ASSESSMENT		TREATMENT		OTHER SUPPORT ALONGSIDE TREATMENT		RECOVERY	
Avg Rating	<b>2.6</b>	Avg Rating	<b>2.8</b>	Avg Rating	<b>3.0</b>	Avg Rating	<b>3.3</b>	Avg Rating	<b>3.1</b>	Avg Rating	<b>2.9</b>	Avg Rating	<b>3.2</b>
Delivering school-based prevention and early intervention with children & young people	<b>Adequate (low)</b>	Police action to restrict supply of drugs, e.g. county lines & tackling the retail market, targeting local drug gangs & street dealing	<b>Adequate</b>	Ham reduction services - needle exchange, Naloxone & advice	<b>Adequate</b>	Drug assessment	<b>Adequate to Good</b>	Drug and alcohol treatment for adults	<b>Adequate to Good</b>	Support for people who also have mental health issues (dual diagnosis)	<b>Adequate (low)</b>	Mutual Aid - e.g. NA, AA, CA	<b>Good</b>
Supporting young people & families most at risk of substance misuse through programmes providing early, targeted	<b>Adequate (low)</b>	Restricting supply of drugs and alcohol into prisons	<b>Poor</b>	Outreach services to vulnerable or priority groups	<b>Adequate</b>	Alcohol assessment	<b>Adequate</b>	Drug and alcohol treatment for young people	<b>Adequate to Good</b>	Support for people with learning disabilities like ADHD and Autism	<b>Poor</b>	Recovery groups – e.g. SMART Recovery	<b>Adequate to Good</b>
Public health campaigns on drugs, alcohol & tobacco	<b>Adequate (low)</b>			In-reach and links to prisons	<b>Adequate (low)</b>	Prescribing assessment	<b>Good</b>	Transitional support between young people & adult	<b>Adequate</b>	Support for the LGBTQ+ community	<b>Adequate</b>	Peer-led support	<b>Adequate to Good</b>
				Referral into treatment services	<b>Adequate</b>			Prescribing services	<b>Good</b>	Support for people BAME groups	<b>Adequate (low)</b>	Employment & volunteering opportunities	<b>Adequate</b>
								Criminal justice pathways - from prison, probation & courts	<b>Adequate</b>	Support to help people get into employment	<b>Adequate to Good</b>		
								Support for families, carers or partners of people with drug / alcohol issues	<b>Adequate (low)</b>	Support with housing & homeless	<b>Adequate</b>		
								Community or residential rehab	<b>Adequate (low)</b>	Support for people with other complex needs	<b>Adequate</b>		
								Community or in-patient detox	<b>Adequate (low)</b>				

From this, we can see that the key strengths and areas for development according to stakeholders are:

Table 4 Key Strengths and Areas for Development According to Stakeholder Respondents

STRENGTHS	AREAS FOR DEVELOPMENT
Drug assessment	Restricting supply of drugs and alcohol into prisons
Prescribing assessment	Support for people with learning disabilities like ADHD and Autism
Drug and alcohol treatment for adults	Delivering school-based prevention and early intervention with children & young people
Drug and alcohol treatment for young people	Supporting young people & families most at risk of substance misuse through programmes providing early, targeted support
Prescribing services	Public health campaigns on drugs, alcohol & tobacco
Support to help people get into employment	In-reach and links to prisons
Mutual Aid - e.g. NA, AA, CA	Support for families, carers or partners of people with drug / alcohol issues
Recovery groups – e.g. SMART Recovery	Community or residential rehabilitation
Peer-led support	Community or in-patient detoxification
	Support for people who also have mental health issues (dual diagnosis)
	Support for people BAME groups

### 5.3.1 Prevention

#### Education

Stakeholders survey respondents gave an average rating for current school-based prevention and early interventions of 2.6 out of 5. In addition, the average rating for public health campaigns related to substance use was 2.6 out of 5. This was consistent with the average rating for prevention from the stakeholder survey, which was 2.6.

Respondents highlighted education as a key element to the prevention of substance misuse. Specifically, participants wanted to see education that teaches people about the realities of drug dependence and addiction, focuses on the short- and long-term mental and physical health implications, the impacts on all other aspects of an individual's life, and wider negative repercussions to friends, family, and society in general. Respondents considered it particularly important to start education at the youngest age possible as a form of early intervention, to increase awareness and understanding around substance use. This would involve schools collaborating with local substance misuse services so they could have a presence in schools and deliver workshops and lectures that would educate young people about the consequences of substance use and raise awareness.

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*"More information in schools, having people with lived experiences going in to give talks." (Stakeholder Survey Response)*

*"Improved education for children in schools but on-going education of adults around honest harms of drugs. More family sessions available for drug using parents with children to help break the cycle of use." (Stakeholder Survey Response)*

*"I think we are missing better early support around mental health, emotional health and trauma informed practice for young people." (Stakeholder Survey Response)*

*"Secondary schools need to be more educated in drug and alcohol effects. bring back the local police officer going into schools and educating the young people, and also get people with lived experience to speak to the young people in the schools to try and deter them from taking the pathways the people with lived experience took." (Stakeholder Survey Response)*

*"This may already happen but service users with lived experience educating young people on the harms of drugs. Honest education of the pro's and con's of using drugs and drinking and smoking so that young adults can make informed choices not just based upon peer knowledge." (Stakeholder Survey Response)*

*"Education and awareness of the damage alcohol causes and how easy it is to become physically dependent." (Stakeholder Survey Response)*

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#### Whole Family Approach

Stakeholders survey respondents rated existing support for young people and families at risk of substance use 2.7 out of 5. This was consistent with the average rating for prevention from the stakeholder survey, which was 2.6.

Participants wanted to see more in the way of support for children and young people of parents misusing substances through a whole-family approach. It was agreed that these individuals are at risk of going on to use substances themselves if they do not receive the necessary support.

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“Children are at risk from birth in family environments and pregnant women must be educated of the harm. We need a presentation to the public daily informing them of the risk of alcohol to people and their families and life and well-being.” (Stakeholder Survey Response)

“Prevention resources should be aimed at education and family interventions for adult drug users with children.” (Stakeholder Survey Response)

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### **Referral Process**

Stakeholders survey respondents rated the existing referral process into treatment 3.2 out of 5. This was slightly higher compared to the average rating for harm reduction and outreach from the stakeholder survey, which was 3.0.

### **Long Wait Times**

Professional survey respondents claimed that a significant problem with the current route into treatment is the long wait times to access support.

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“Referral process and immediate assessment. No long waiting lists or difficult criteria to even qualify for the support.” (Stakeholder Survey Response)

“Faster response from treatment services.” (Stakeholder Survey Response)

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### **Streamline Routes into Treatment**

Professional respondents expressed a need to streamline the route into treatment to assess new service users more promptly and tackle issues with long wait times. They described how this could be achieved by encouraging self-referrals and providing more opportunities for clients to drop into the service.

In addition, participants referenced a lack of knowledge about the substance misuse support service from other healthcare providers. There was a recognition that GPs are often the first point of contact for an individual reaching out for support and a need to ensure GPs are better equipped to signpost to specialist substance misuse support. Stakeholders identified a need to raise awareness about the service in other healthcare settings to encourage healthcare professionals to make direct referrals to the substance misuse service provider. This could also be encouraged by providing training to ensure all stakeholders to develop understanding on substance misuse and addiction and what support the service offers as well as having dedicated liaison workers to assist with the referral process.

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“One point of access, one referral form and some publicity on how the systems work” (Stakeholder Survey Response)

“Routes into treatment when someone attends the A&E department or is admitted onto the general wards in the acute trust. It would be helpful for the hospital liaison team to have a drug and alcohol worker embedded in the team” (Stakeholder Survey Response)

“More partnership working to improve how referrals are made between different agencies” (Stakeholder Survey Response)



“GP surgeries and hospitals need direct access to Open Road and refer clients directly to us themselves they need to be informed and updated about what treatment is available and to refer for mental health and substance use together”  
(Stakeholder Survey Response)

“GP's are not always fully aware of how the treatment system works” (Stakeholder Survey Response)

“Better information for GPs would be good so they fully understand the way Alcohol Clients are dealt with, what they can prescribe, how long a detox through our services will take etc.” (Stakeholder Survey Response)

“There is some confusion between who offers support for drug use and who offers alcohol support. Also unclear about the interventions being offered” (Stakeholder Survey Response)

“All services should be widely known without clients having to search extensively on the internet - often GP's are unaware of services available” (Stakeholder Survey Response)

“Direct referrals from GP and Hospitals is missing as well as schools and colleges” (Stakeholder Survey Response)

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### One Service

Professional respondents described how the multiple different service providers across Essex negatively impacts the routes into treatment as it can be confusing and incoherent. There was a consensus that one main service provider of substance misuse support with one clear referral mechanism would assist with streamlining the route into treatment.

“It would be good to have all drug and alcohol services under one service (one umbrella) and one clear referral mechanism in. Currently there are at least 4 different referral forms for drug and alcohol services (one for FIM, one for Open Road and EYPDAS, one for Full Circle and one for Phoenix Futures ARC. Having lots of separate services causes confusion.” (Stakeholder Survey Response)

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### Outreach

Stakeholders survey respondents rated current outreach interventions to vulnerable groups 3.0 out of 5. This was consistent with the average rating for prevention from the stakeholder survey, which was 3.0.

Outreach was described as key to improving the route into treatment. This would involve raising awareness and promoting the service in the community to encourage hard to reach individuals to access treatment. In addition, respondents described how this could involve more proactive outreach from the service provider including targeted outreach to underrepresented groups and home visits to disabled service users.

“Truer outreach. Not to wait for service users to approach the providers. More home visits for those that can't travel. More outreach to marginal groups” (Stakeholder Survey Response)

“Outreach work. A lot of the work is still virtual or over the telephone. It is difficult at times to get drug and alcohol services doing outreach work and home appointments. Some clients can not make it into the centres and need to be seen at home. Also more face to face work in general is needed to build therapeutic relationships. A lot of staff told me they left roles in drug and alcohol services due to feeling that it was all paperwork and very little client work”  
(Stakeholder Survey Response)

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## Assessment

Stakeholders survey respondents rated the existing alcohol assessment process 3.1 out of 5. The drug treatment assessment was rated slightly higher as 3.5 out of 5, and the prescribing assessment was rated even higher as 3.7 out of 5.

### Streamline the Assessment Process

Professional respondents described a need to streamline the assessment process in order to address the long wait times between the initial assessment and access to treatment. They described how this could be achieved by making the assessment more engaging by reducing the amount of paperwork and number of questions.

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*“Get into treatment faster” (Stakeholder Survey Response)*

*“The paperwork in general for services such as Open Road and ARC is too long. It prevents them from being able to effectively work with clients. This needs to be condensed and make it easier to record, to enable a better therapeutic relationship with clients” (Stakeholder Survey Response)*

*“Reduce the amount of paperwork and frequency that this has to be completed. Would allow more time to work with the client” (Stakeholder Survey Response)*

*“Service users are constantly being asked the same questions and sometimes can be quite lengthy” (Stakeholder Survey Response)*

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## Training

Stakeholder respondents also commented on how there should be more training offered to staff who are conducting the assessment. This should focus on giving professionals the tools to build a therapeutic relationship with the service user whilst remaining attentive and gathering all the necessary information.

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*“Training for staff who are not experienced in detailed substance misuse assessment” (Stakeholder Survey Response)*

*“The processes in place are good but sometimes with the staff turnover or agency workers they might miss something. Training needs to be key and emphasis with staff on the importance of capturing information at this stage of someone's journey” (Stakeholder Survey Response)*

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## 5.3.2 Treatment

Overall, stakeholders survey respondents rated current treatment provision an average of 3.1 out of 5.

### Wait Times

Professional respondents described how the treatment pathway could be improved through addressing the long wait times for service users who are at risk of relapse. This would include enabling quicker access into detoxification and fast-tracking service users who have fallen off script for clinic appointments.

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*“I think quicker access into detox and for script restart appointments would prevent relapse. Currently in the North West of England people can get restarted the next day, in Essex it can be weeks. It should be supportive rather than*

punitive. Also harm prevention support being available out of GPs and CMHTs would be good” (Stakeholder Survey Response)

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### **Recovery Community**

Professional respondents described how the treatment pathway could be improved through better provision of step-down support and aftercare for service users. This could involve increased provision of psychosocial support and creative activities as well as facilitating access to a recovery community with peer mentors.

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“Aftercare for drug clients, especially opiates. Visible recovery peer mentors in drug services. Activities that are wider than walking and boxing” (Stakeholder Survey Response)

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### **Transparency**

Respondents stated there was a need to manage boundaries and expectations about the treatment pathway and maintain coherence about what is expected of the service user. This would help to avoid confusion, miscommunication, or disappointment for new service users.

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“More transparency about what each area of treatment covers and what is expected of the clients” (Stakeholder Survey Response)

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### **Rehabilitation/Detoxification**

Stakeholders survey respondents rated existing community or residential rehabilitation provision as 2.9 out of 5. In addition, community or in-patient detoxification was rated as 2.7 out of 5. This was lower than the average rating for treatment provision from the stakeholder survey, which was 3.1.

The main feedback from professional respondents related to residential rehabilitation and detoxification was that staff would like to see clearer pathways, significantly more places, with reduced waiting times.

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“Not enough places for in-patient detox in Essex. The waiting times are up to 9 months and the process is not clear cut” (Stakeholder Survey Response)

“Less paperwork to complete for people that need a Detox, simple criteria and actual communication on a face to face basis” (Stakeholder Survey Response)

“More access to Detox and rehab would enable a smoother transition for clients, having more choice and say in where they can receive this treatment. Giving clients a voice on where they can go. Having access to these facilities in their local community would make this type of treatment more of an option” (Stakeholder Survey Response)

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### **Accessibility**

Stakeholder survey respondents identified a need to improve the accessibility of the support service. This could involve specific interventions that target marginalised groups within a community, such as those who identify as LGBTQ+, from minoritised ethnic backgrounds or with disabilities, in order to design a service that caters for everyone’s needs and differences. Respondents also highlighted a need enhance outreach interventions towards communities who live

outside of large cities and in more rural areas of Essex as well as enhancing outreach and tailoring support for young people.

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“I think more needs to be done to support LGBTQ and BAME clients accessing these services. This could be helped by outreach work with local community groups and people with lived experience going and telling their life stories with these groups.” (Stakeholder Survey Response)

“Regular clinical prescribing, assessment, and initiation of treatment to be available in all towns across Essex. Currently this is limited to the City of Chelmsford and City of Colchester and creates a large barrier for those who want to address their difficulty. Currently no towns in Essex have the relevant services in place for service users to initiate their treatment. This is significant, as the drug use / county lines issues become more prominent in cities, this spills over into the local towns and the population is at great risk of having high levels of deprivation without available services to tackle the prevalence and effects of drug and alcohol misuse.” (Stakeholder Survey Response)

“There are areas of Essex that aren't as well supported as others, e.g. Saffron Walden is far from Harlow where most of the support for the West of Essex operates. More hubs would help with equity for all.” (Stakeholder Survey Response)

“Need services that reach out to the community. Basildon is not a place people can walk from one end to the next. Services need to come to them.” (Stakeholder Survey Response)

“More minority specific services.” (Stakeholder Survey Response)

“It needs to be more mobile and visible to marginalised groups.” (Stakeholder Survey Response)

“More community-based interventions such as youth services and centres, street work and open access services for young people to access support and information when they need it.” (Stakeholder Survey Response)

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### **Non-Opiate Support**

Professional respondents discussed how there is a current gap in provision for support targeted at non-opiate service users.

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“Stars are no longer commissioned for Codeine or Diazepam, there is a big gap in service provision”. (Stakeholder Survey Response)

“Pathway/treatment/support for clients using prescription drugs/illicit use of opiates and benzodiazepines. Currently, illicit opiate use (non-heroin) is commissioned to be managed by primary care services, however they feel unable to provide this service due to lack of training/education. Should this not be provided by substance misuse services as it is in other localities to provide the specialist knowledge/expertise. Physical health management of clients receiving alcohol treatment. Currently there are no medical professionals working in these services and the only advice they can seek is through Essex STARS/GP. They should have specialist medical/nursing staff working within the services to manage the physical health needs.” (Stakeholder Survey Response)

“Cannabis users have hardly any routes for recovery and this is sometimes a gateway drug. I would like to see this addressed and some sort of treatment put into place for those wishing to stop using cannabis. Maybe drop in where they can get instant support be this medical or talking therapies.” (Stakeholder Survey Response)

“Pharmacological interventions for service users that are not using heroin or alcohol as their main substance of misuse.” (Stakeholder Survey Response)

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## **Additional Support**

### **Mental Health**

Stakeholders survey respondents rated existing support with mental health as 2.8 out of 5. This was slightly lower compared to the average rating for additional support alongside treatment from the stakeholder survey, which was 2.9.

Mental health support was identified by professional respondents as a huge problem in this sector. Although there should be dual diagnosis pathways in place, there is evidently a need for better partnership working between mental health and substance misuse services to ensure support is joined up.

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“Improved education between CMHTs and drug and alcohol services as to what CMHTs are able to support with drugs and alcohol. Obviously better funding and investment in training MH and substance misuse staff, as there simply are not enough of them.” (Stakeholder Survey Response)

“There needs to be a more joined approach between the mental health – adult social care and support agencies – there seems to be too much ‘passing the buck’ and hoping someone else will provide the support.” (Stakeholder Survey Response)

“Having a DD [dual diagnosis] worker embedded in all drug and alcohol services would be extremely beneficial to clients.” (Stakeholder Survey Response)

“The gap between substance misuse, mental health and housing has always been an issue. Whilst there has been some great improvements in the last few years, there is still a gap for our clients in the substance misuse treatments and being able to access mental health support. This is the same with housing and lack of provision.” (Stakeholder Survey Response)

“Mental health worker based directly in the centres to support those who are in crisis.” (Stakeholder Survey Response)

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### **Recovery Community**

Stakeholders survey respondents rated existing recovery support as adequate with an average score of 3.2 out of 5. More specifically, mutual aid provision was rated slightly higher with 3.6 out of 5, recovery groups were rated as 3.4 out of 5, peer support was rated as 3.5 out of 5 and employment and volunteering opportunities were rated as 3.3 out of 5.

Professional respondents commented on numerous examples of good practice related to ‘step-down support’ and emphasised how this needs to be expanded and made consistent across the county. In particular, this would involve establishing a strong recovery community, consistent with a network of peer support, that service users could access as they prepare the leave treatment.

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“There is good support for people in Essex there just needs to be more of it.” (Stakeholder Survey Response)

“Recovery needs to be seen and celebrated. Really good Essex Alcohol Recovery but not so much with other substances.” (Stakeholder Survey Response)

“More visible recovery community.” (Stakeholder Survey Response)

“Sense of a community of recovery.” (Stakeholder Survey Response)

“Need more community and peer-led support commissioned.” (Stakeholder Survey Response)

### **Joint Working**

Participants described a lack of joint working as being a significant issue with the current system in Essex, mainly due to the multiple different service providers in the area using a variety of systems. They identified a need to improve information sharing and communication between agencies through multi-disciplinary meetings and dedicated liaison workers. There was a significant proportion of professional participants who called for a single service provider to be commissioned in the future to address these issues.

“There are too many separate agencies involved in service user care which does not work.” (Stakeholder Survey Response)

“One online portal for all services in Essex so that clients can self-refer and get to the right place.” (Stakeholder Survey Response)

“Overall an improvement in partnership working to allow all treatment to function better.” (Stakeholder Survey Response)

“Central point of accessing services would be great.” (Stakeholder Survey Response)

“Merge alcohol and drug dependency offer to people. Let Open Road run it all as they have consistently hit excellent outcomes on national and local benchmarks and work really well with primary care.” (Stakeholder Survey Response)

“No idea how well Phoenix Futures performs in this area. They should emulate Open Road.” (Stakeholder Survey Response)

Maintaining contact via multidisciplinary team meetings to discuss progress and treatment plans.” (Stakeholder Survey Response)

“Working on the same clinical systems (currently each service has different systems). One service providing all areas of treatment.” (Stakeholder Survey Response)

“Services are disjointed at present.” (Stakeholder Survey Response)

“Better communication [using a] centralised referral system.” (Stakeholder Survey Response)

“Have a linked client database.” (Stakeholder Survey Response)

“Communicating with each other more regularly and working together as a single team against addiction.” (Stakeholder Survey Response)

“Work directly with primary care networks to target known areas of concern. I would let Open Road run the whole set up, with a merge with Phoenix Futures. There is no sense in treating alcohol separate to substance misuse...it’s rare to get in isolation and people bounce between services.” (Stakeholder Survey Response)

“Having a designated member of staff to link with each service, so all staff know who to get in contact with.”  
(Stakeholder Survey Response)

### **Workforce Recruitment and Retention**

Overall, professional participants believed that both recruitment and retention into the sector would be improved by training staff to an accredited level, paying more money, making sure they are not burnt out by employing more staff, reducing caseloads, and offering supportive supervisions. In addition, stakeholder respondents discussed a need to advertise careers in the substance misuse sector within the community, particularly targeted towards young people, to attract people to the sector and compete with job opportunities in London.

“Actual funding and training is needed for the workforces. The agencies are fragmented due to commissioning. There should be retention incentives.” (Stakeholder Survey Response)

“I think all areas could be improved but staffing levels need to increase as well as staff pay. Retention of staff can be a difficulty and affects the service provided if key workers change regularly and groups etc are limited.” (Stakeholder Survey Response)

“Higher staff levels to better support clients and provide a higher quality of treatment. Also better pay for staff to help with retention and in turn help with the quality of the treatment system.” (Stakeholder Survey Response)

“Increased funding to enable more frontline staff to be recruited on fair wages.” (Stakeholder Survey Response)

“More staff, better pay.” (Stakeholder Survey Response)

“Being staffed to capacity/ appropriately would increase services capacity and create a better working environment for staff. Pay is fairly low within the sector, pay increases may help retain staff. Advertise additional benefits such as training opportunities in job descriptions which may appeal to new recruits.” (Stakeholder Survey Response)

“It simply comes down to pay, organisations offer a wage lower than Aldi for high risk and responsibility. In a cost-of-living crisis you will struggle to employ with these wages. There is also a lack of training, opportunities and high expectation to hit the ground running due to lack of staff.” (Stakeholder Survey Response)

“More career information for school leavers to study further with support at college and university graduates given the information and opportunity when they start at Freshers week.” (Stakeholder Survey Response)

“Maybe incentives into Essex, as we have to compete with London wages. Advertising from a multi-agency perspective on working within Essex.” (Stakeholder Survey Response)

“They should not be looking at reducing capacity/caseloads. They need appreciate this area of care is growing and will need more resources to fund it.” (Stakeholder Survey Response)

“More publicity/marketing about the benefits and rewards of working in this area - with stats showing the numbers of lives touched by these issues (including the wider family effects).” (Stakeholder Survey Response)



“Increase pay. Most staff can't afford to live on the current salaries with the cost of living being so close to that of London whilst pay is much less. Staff will regularly leave and commute to London services as it gives them a better quality of life. Increasing pay would also allow more staff to commute from London.” (Stakeholder Survey Response)

“Better pay, the stress and workload that people have to manage is too high. The cost of living now has increased at such a high rate yet the wages for this work have stayed the same. We are losing exceptional workers due to the level of pay not being enough to run a family home.” (Stakeholder Survey Response)

## Impact of COVID-19

### Prescribing

One of the most prominent challenges as a result of COVID-19, identified by professionals, was continuing to prescribe clients whilst ensuring appropriate safeguards were in place. Respondents discussed how the pandemic caused significant delays in scripts due to staff shortages and closures.

“Staff shortages causing delays in scripts.” (Stakeholder Survey Response)

“Prescribers are prescribing up to 3 months worth on a regular basis and often do not meet with their clients. These clients have not had their dose reduced in years.” (Stakeholder Survey Response)

### Lack of In-Person/Online Support

Stakeholder participants described a shift towards virtual forms of support as a result of the pandemic that some staff and service users struggled to engage with. This was due to certain barriers, such as removing opportunities for informal conversations or allowing staff to pick up on non-verbal cues or behaviours. On the other hand, some respondents described how this hybrid form of working was a positive contribution from COVID-19 and should be retained, giving clients the option to engage with face-to-face or virtual support.

“Services mainly moved to telephone and it is now taking clients a while to understand that we need them to come into the service moving forward.” (Stakeholder Survey Response)

“Telephone contact has not been as effective.” (Stakeholder Survey Response)

“Too much virtual stuff...not really checking in on a person's wellbeing.” (Stakeholder Survey Response)

“Sadly, a lot of face-to-face work/ groups have ceased. This is no good, online recovery courses are in no way good for the addict. Very isolating.” (Stakeholder Survey Response)

“COVID-19 meant a new way had to be found to deliver the service to Essex, with more remote/telephone support. Whilst we have returned mainly to face to face support, we have learnt from the pandemic and online meetings can be very beneficial, especially for working clients.” (Stakeholder Survey Response)

“Has made services more adaptable to suit individual needs. More utilising phone and online appointments, whereas face to face would be the norm which can put time and financial pressures on people.” (Stakeholder Survey Response)

“Most services went to minimal face to face work during the height of the pandemic. The issue is that most services continue to work this way and have not returned to regular face to face appointments to the detriment of service users.” (Stakeholder Survey Response)

“Although this was a testing time for the services, it highlighted how well we could all adapt and the importance of access to IT etc. ECC were supportive and updated us regularly on changes within guidelines and rules and the system pulled together to support the community.” (Stakeholder Survey Response)

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## Commissioning Priorities

### Education

Majority of professional survey respondents identified the importance of education. In particular, they identified a need for interventions targeted at young people as a form of early intervention and prevention, also public awareness campaigns in everyday spaces and healthcare settings.

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“Education of the public of drugs and alcohol misuse starting from the school.” (Stakeholder Survey Response)

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### Recovery

Another priority for stakeholder participants was related to addressing the gap in provision related to recovery support. This would involve facilitating a *“a visible recovery community”* (Stakeholder Survey Response) that would allow service users to manage their recovery more independently.

### Increase Capacity

Majority of professionals identified a need for commissioners to focus on recruitment and retention of the workforce. This would involve more incentives and competitive job offers for staff and enable enhanced recruitment to reduce caseloads and allow for more focused one-to-one support.

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“More resources, funding, practitioners to provide more intensive support.” (Stakeholder Survey Response)

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### Commission a Single Service Provider

There was a consensus among professional respondents that there is a need to commission a single substance misuse service provider in the future. This would enable good communication and joint working as well as preventing any confusion or incoherence related to the provision of support.

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“A single Essex Drug and Alcohol service with a single provider.” (Stakeholder Survey Response)

“A return to a single service provider for drug and alcohol services with all workers being under one roof.” (Stakeholder Survey Response)

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## 6. RECOMMENDATIONS

This section sets out initial recommendations and areas to consider put forward by people with lived experience and stakeholders.

### 6.1 PREVENTION

**P1.** It would be useful to review the delivery model for the children and young people service in order to **protect the capacity and “difference” for under 18s treatment services**. Consideration of **increased investment** should be given, as this may be needed to continue the current level of provision. It was suggested that this increased investment may be achieved by closer integration with other/wider children and young people services providing targeted youth support, education and social care.

**P2.** Some felt there should be an element of the offer which provides **trauma-informed early interventions** with those experiencing multiple adverse childhood experiences, taking the pathway forward from Risk Avert, and where this is not operating.

**P3.** Following the findings from the **NOVICE pilot in Basildon**, consideration should be given to expanding this to all areas in Essex if it is successful.

**P4.** Some requested that **drug and alcohol training was needed for the range of agencies** working with young people, in both universal and targeted settings, including foster carers and social care staff.

**P5.** Some requested an **overarching drug and alcohol strategy for schools in Essex**, to provide clear advice on drug education (based on evidence of what works and best practice), referral pathways, and drug and alcohol-related suspensions and exclusions pathway to ensure the offer of referral to EYPDAS and limits the use of exclusions and reduces the duration of time away from mainstream education. This should be linked to work on preventing exploitation and contextual safeguarding – including RIC, MACE, and the Violence and Vulnerability Unit. In future, we understand that ECC and all schools will have to report on permanent and temporary exclusions showing the reasons (which would include drugs/alcohol) - this data can be used by the EDAPB to monitor progress.

**P6.** Drugs and alcohol needs and responses could usefully be **written into relevant existing strategies** for children and young people to ensure integration with the wider children and young people system, rather than trying to deal with everything under a substance misuse strategy – including the CYPP and Levelling Up Strategy.

**P7.** Some suggested a drive to **increase uptake of the Risk Avert** programme by more schools across Essex.

**P8.** It was felt there is a need to **optimise supportive prevention structures** such as increasing the use of digital interventions, Making Every Contact Count (MECC), promotion of Interventions and Brief Advice (IBA) through a digital strategy, and support for pharmacies to ensure they can deliver prevention in the current difficult climate.

## 6.2 TACKLING SUPPLY

**S1.** Intelligence is vital to tackling drug supply markets. Future drug market profile exercises could usefully engage **people with living experience to feed in intelligence** to this process and build a better and more up to date understanding of local drugs markets. This should include online drug supply and use of social media in drug supply.

**S2.** It was said to be useful for HMPPS and NHSE Crime and Justice Team to explore ways to **supervise the medication queues in HMP Chelmsford** to limit opportunities for diversion of medication (as is done in other prisons).

## 6.3 TREATMENT

### The Treatment System: Commissioning, Strategy and Governance

**T1.** The future of commissioning drug and alcohol treatment will be led by the Essex Recovery Foundation. **Embedding the voice of service users and people with lived experience** will be a vital role of ERF, which they could usefully continue to develop emerging activities such as growing, training and supporting their Peer Researchers team.

**T2.** Commissioners and service providers to develop a treatment system map that details and explains the current system: (i) for professionals and (ii) for service users, to help people navigate this. This should also be the starting point for a review of the current system map and pathways in light of requests for a simplified model to be used across Essex. As part of this, they should seek to also explore ways to **reduce the period of time spent in treatment and speed up access to community recovery** services, which would also require increased access to recovery for all groups.

**T3.** Locate drug and alcohol services as a subgroup within a larger focus on complex needs, such as with the Changing Futures Model, to **ensure more link up with the Integrated Care System (ICS)** of mental health and Adult Social Care.

**T4.** An **audit of current and potential funding sources** could be conducted to help increase and improve the treatment workforce, capacity and quality. This could include:

- The Primary Care Network Directed Enhanced Service (PCN DES) – where additional funding is going into the primary care system for drugs of addiction, health coaches, social prescribers (e.g. recovery colleges)
- Locally Enhanced Services (LES)
- Impact in Investment Funding
- Stewardship Groups run by Integrated Commissioning Boards (ICBs) – e.g. Looking into the feasibility of establishing a Stewardship Group for Substance Misuse
- Ensuring links to the wider work of the ICS

**T5.** We understand that the Essex County Council (**ECC**) **Public Health team will act as a Commissioning Support Unit (CSU)** for ERF in undertaking the specialist substance misuse commissioning, financial and legal functions required. This will enable ERF to set the direction of travel. Appropriate checks and balances to ERF's decisions will need to happen at the joint commissioning group (ECC, NHS, PCC, Police etc.) and the Essex Drug & Alcohol Partnership Board (DAPB), with ERF as key partners on this Board. Part of this CSU role could usefully be to develop a **dashboard of the most useful and meaningful data measures** across each of the three priorities of the drug strategy, combining key performance indicators (KPIs) for the service providers around performance with partner data around prevention, tackling supply and treatment. This should seek to be in plain English and to tell the story of the data so that it engages all partner agencies and gives a clear direction of travel. It would be of benefit for this to include qualitative measures and feedback from regular surveys of treatment service users and/or service visits by peer researchers.

## Access

**T6.** Consider introducing a **single online portal for agencies to make referrals** to treatment and for self-referrals, which would then be allocated to the most relevant service to follow up on.

**T7.** Ensure a **consistent training programme is available for frontline staff in key agencies** on identification and support pathways. This could include substance misuse and complex needs training for Police Officers.

**T8.** Analysis of treatment data has shown a need for **targeted service promotion to reach the following groups:**

- Given the higher-than-average levels of unsafe alcohol use locally, there should be attempts to increase treatment engagement with people misusing alcohol.
- Acknowledging the fact there has been a reduction in the number of opiate users engaging with treatment, there should be promotion targeted at engaging people misusing opiates in treatment.
- Promote awareness amongst external partners to drive direct referrals, to respond to areas where limited referrals have been identified, particularly focusing on the criminal justice system (for adults and young people) and from children and families services.

## Harm Reduction and Drug-Related Deaths

**T9.** **Boost pharmacy needle exchange provision** and resolve contractual difficulties with the collection of sharps from pharmacies.

**T10.** **Enable Open Road to hand out Naloxone.** They do this in their contract in Medway, so this can be learned from and adapted to work in Essex. The Medway approach also allows people with lived and living experience to give out Naloxone.

**T11.** Ensure wide engagement with health and social care providers to **ensure older clients have health checks and can access mainstream healthcare.**

## Recovery

**T12.** **Increase and expand the recovery offer**, making it more accessible and more varied. This could include allowing different levels of time required, from intensive provision such as SHARP (5-6 days a week) through to ad-hoc support available as and when this is wanted. The offer could also include programmes that are not abstinence-based and that enable opiate users and those on support medication to benefit from the range of provision in place. The offer could include support with the key issues and gaps highlighted in this report that build recovery capital, such as housing, life skills, wellbeing, employment, healthcare, social isolation, social prescribing, links with Fellowships (e.g., NA, AA and CA) and SMART recovery. Consideration could be given to setting up venues to run services from, or development of community cafes and other social enterprises to create employment opportunities. This approach could see service users able to build their own personalised programmes with support and ensure that recovery is made more visible. Good practice examples that could be learned from include the Liverpool Recovery Village, Glasgow, and Red Rose Recovery.

**T13.** Consider using **community rehabilitation (SHARP) as a licence condition** for people leaving prison.

**T14.** Plan to **engage the wider community much more in recovery**, to address employment, housing and social capital needs. ERF and the EDAP Board should lead this, but it is worth noting that this may need additional investment in staff to take forward directions given from strategic groups. The aim would be to create a much larger and broader recovery community across mental health, substance misuse, offending, homeless, and floating support etc, ensuring

recovery fits in with wider work on social inclusion, physical health, and wellbeing driven by the NHS and Public Health. The aims would be to tackle loneliness, build community and resilience, build life skills, peer to peer support groups, benefit from social prescribing, healthy weight etc. It was felt that co-ordination of this was needed at senior strategic level (e.g., ICS). Examples were put forward regarding employment included engaging Anchor employment work, looking at the Reverse Job Fair model, and building on Open Road's IPS provision.

**T15.** Help to **make recovery more visible and reduce stigma** by creating a more empowered recovery community to take forward their own activities, deliver co-production with providers, start their own projects or begin social enterprises. An aim within this could be to **increase capacity of the communities, peers, and volunteers** to support recovery – this could be supported by FiM, SHARP, and ERF to ensure appropriate training and support are given to ensure this provision is of the best quality.

**T16. Review all the individual "family" provision** from across all services and decide if this is the right approach to use, considering how to fill gaps and whether it would be better to join all family provision together.

### Dual Diagnosis

**T17.** We understand that commissioners are keen to move away from the artificial barriers that have created gaps in the current pathway for those with co-occurring mental health and substance misuse issues and **create more meaningful dual diagnosis support based around the individual and their needs NOT the needs of services**. Therefore, this will need to involve people with lived experience and commissioners and service providers from substance misuse and mental health and NHSE regional commissioning. This could involve the following elements:

- Increased levels of in-house mental health support built into the model
- Clear pathways, training and tools (inc. self-help tools) should be adopted or developed if gaps exist
- A detailed approach should be agreed with measurable minimum standards to enable commissioners to determine whether it is effective
- This could be further facilitated by Mental Health commissioning building drugs and alcohol into each Tier of their system, including IAPT and Secondary Care
- Take learning from the Changing Futures and Futures in Mind models.

### Prescribing and Pharmacies

**T18.** If findings from the Buvidal pilot are as positive as we understand they will be, **access to Buvidal prescribing for opiate users should be expanded and rolled out across the county**. We understand that EPUT will need to put this onto their formulary. To inform and enable this expansion, it may be necessary to undertake a business case analysis to explore an invest to save model to help fund increased access. Additional funding is likely to be needed to support roll out of Depot facilities (e.g. capital costs for clinic rooms needed) and nursing capacity.

**T19.** Pharmacies could be used more strategically for supporting substance misuse treatment. Open Road and Stars should **use the recent Pharmacy Needs Assessment to help strategically plan Needle Exchange, prescribing and other support needed from pharmacies**. In addition, **consideration could be given to whether EPUT could provide dispensing** – especially if this is set up to all for providing Buvidal.

**T20.** Explore the potential to **reinvigorate GP shared care prescribing** to build additional capacity into the system for opiate users. We understand there is a shared care locally enhanced service (LES) available in Essex which does have some additional funding available for it.

## Rehabilitation and Detoxification

**T21. Increased investment in inpatient and community detoxification and residential and community rehabilitation** will be needed to meet the Government drug strategy ambition of 2% of the treatment population having access to detoxification and/or rehabilitation. This could be done in a combination of ways, including:

- Expanding Community Detoxification capacity – e.g., by increasing the capacity of nurses to do home visits in conjunction with STaRS.
- Exploring long-term rehabilitation options – including establishing provision within Essex to serve the Eastern Region. Work would need to be done to develop the local supplier market.

## Addressing Gaps and Unmet Needs

**T22. Bring all homeless and housing providers together to agree clear pathways and commitments** with the substance misuse treatment system to ensure the Government target of a 33% increase in the number of people rough sleeping or at risk of this accessing treatment by March 2025 is met. Approaches could include co-location of substance misuse workers alongside homeless provision, which we understand used to take place and was seen to be effective.

**T23. More engagement is needed with 'by and for' organisations** by the treatment and recovery system (including ERF) to enable improved pathways into support and **a more tailored offer to key underrepresented groups**, including women, minoritised ethnic groups, LGBTQ+ communities, and the homeless.

**T24.** There is a pilot for people dependent on **prescribed or over the counter medication** in North East Essex (with the findings due in the coming months) run by Open Road, EPUT, IAPT, and the local NHS Pain Team and Consultant as a multi-disciplinary group. If the pilot is successful, this could be replicated in other parts of the county. However, it is worth noting that not all CCGs have a Pain Team.

**T25.** Ensure full **representation of opiate and other drug users on ERF**. This should be in line with the percentage of the Essex treatment population that are opiate users.

## Criminal Justice

**T26. Review the current arrangements between Probation and the treatment system to ensure they make best use of the full range of relevant orders**, including: Community Sentence Treatment Requirements (CSTRs), Alcohol Treatment Requirements (ATRs), Drug Rehabilitation Requirements (DRRs), Mental Health Requirements (MHRs), Alcohol Abstinence and Monitoring Requirements (AAMRs), and Community Rehabilitation Requirements (CRR). This should ensure all partners fully understand what the offer is across Essex, detailing exact requirements and expectations from each partner agency to ensure the criminal justice system has confidence in the use of these requirements. This review should seek to learn from the recent co-commissioning multi-agency refresh of Mental Health Treatment Requirements (MHTR). This process should also seek to clarify where the funding for drug testing is and who holds this. To monitor progress on this, clear outcomes data should regularly be shared with the partnership board.

**T27.** The **revised approach to Integrated Offender Management (IOM)** presents an opportunity to further improve the CJS pathway for priority offenders.

**T28.** We understand there is an expectation that NHS England will commission RECONNECT for Essex, but that they want to **ensure RECONNECT links well into the Essex system to avoid duplication and complimenting the existing system**.



**T29.** We understand there is additional funding available for everyone accessing drug treatment in the secure estate to be given **Naloxone on release from prison. The community offer for Naloxone will need to continue this.**

**T30.** NHSE Crime and Justice Teams, local commissioners, Probation and peer mentors from Essex services could look to work together to **improve continuity of care from prisons outside of Essex where people are returning to Essex** (e.g., HMP Highpoint, HMP Wayland, HMP & YOI Hollesley Bay, and women from HMP Peterborough). This may include clear through the gate support and ensure the link up with the Essex Buvidal pilot where similar pilots in the prisons are taking place. This will be important in delivering the Government Drug Strategy commitment to *“keep prisoners engaged in treatment after release – improve engagement before leaving prison and better continuity of care into the community”*.

### **Workforce, Capacity and Quality**

**T31.** Take a **trauma-informed approach to the design and delivery of services and procedures**, accompanied by training for staff.

**T32.** The **workforce training, retention and recruitment strategy needs to be long term with sufficient funding to enable sustainable solutions** to the challenges currently being seen in this area. This could include more CPD accredited training, longer term posts, better support for staff (including perks), and recognition from commissioners and ERF (e.g. celebrating success).

**T33.** The **capacity of treatment and recovery provision need to be increased**, to help reduce caseloads, facilitate greater access, and meet the Government drug strategy ambition to *“deliver a phased expansion of treatment capacity with at least a 20% increase in new high-quality treatment places”* by March 2025.

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*“We want to make the substance misuse sector in Essex somewhere, both in terms of location and the sector, that is attractive for the best people to work in. We should continue to invest in developing the workforce, using new posts in Essex and linking to both regional and national efforts, to ensure they feel valued to help with treatment quality and capacity through improved recruitment and retention.” (Stakeholder interview)*

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## 7. APPENDICES

### Appendix A – Ethical Considerations

In line with TONIC's safeguarding policy, the team all had enhanced DBS (Disclosure and Barring Service) certification and worked in accordance with the British Psychological Society's Code of Ethics and Conduct. TONIC's research proposal and materials were all signed off by the relevant commissioners before being used.

During both surveys and interviews, participants were able to skip any questions they did not want to answer, were able to pause, and come back to points, or stop completely without needing to provide a reason. Participants were all provided with information ahead of participation so that they could carefully consider whether they wished to proceed, and do so, providing informed consent. Participants under the age of 18 had to also confirm they had consent from a parent or carer. Participants were made aware of their withdrawal rights and were able to request their data was removed at any time, up until the end of data collection (the date all surveys closed, and interviews finish).

All participants with lived experience were provided information about local and national support services, and on completion of the survey and interviews, participants were offered the opportunity for the research team to signpost them to relevant support if they felt they needed or wanted this. The TONIC team all have experience in motivational interviewing and are able to establish and build a rapport with service users, skills which were utilised in an attempt to make participants feel as comfortable as possible.

Throughout, individuals were able to remain completely anonymous (even from the researchers) if they wanted to. Responses to the questions have been used for the purpose of this project only, and any identifiable information collected during this consultation has been removed if included within this report, so that participants' data can remain strictly confidential, in line with the EU General Data Protection Regulation (GDPR, 2018).

## Appendix B – Quantitative Data Sources

- Department of Health (2016) How to keep health risks from drinking alcohol to a low level Government response to the public consultation
- Adults - Alcohol Commissioning Support Pack 2022-23: key data. Planning for alcohol harm prevention, treatment and recovery in adults
- Adults - Drug Commissioning Support Pack 2022-23: key data. Planning for alcohol harm prevention, treatment and recovery in adults
- Young people substance misuse Commissioning Support Pack 2022-23: key data. Planning for alcohol harm prevention, treatment and recovery in adults
- Public Health England (2018) Alcohol Commissioning Support: principles and indicators
- Statistics on alcohol 2019, NHS Digital
- Public Health England Recovery Diagnostic Toolkit
- Office for National Statistics (2022) Drug misuse in England and Wales: year ending March 20202
- ONS (2022) Deaths related to drug poisoning by local authority, England and Wales.
- Essex Police (2022) Essex Drugs Market Profile
- Office for Health Improvement & Disparities (2020/21) Public Health Outcomes Framework Indicator C 20.
- Office for National Statistics (2022) Drug misuse in England and Wales: year ending March 20202
- Public Health England (2021) Young people's substance misuse treatment statistics 2019 to 2020: report <https://www.gov.uk/government/statistics/substance-misuse-treatment-for-young-people-statistics-2019-to-2020/young-peoples-substance-misuse-treatment-statistics-2019-to-2020-report#referral-routes-into-treatment>
- NSPCC (2021) Protecting children from county lines <https://learning.nspcc.org.uk/child-abuse-and-neglect/county-lines>
- Department for Levelling Up, Housing and Communities (2022) Statutory homelessness: Detailed local authority-level tables October to December 2021 England

## Appendix C – Action Plan Template

Based on the areas for consideration at the end of each subsection of the report, it will be useful to develop an ‘action plan’ of the agreed recommendations and actions resulting from this. This will enable ERF, commissioners and relevant partners to allocate actions to the most suitable people or organisations to take forward, record current progress, and outline plans for the future.

Ref.	Drug Strategy Objective	Recommendation	Responsible Owner	Action in Progress	Actions Planned
1	To deliver a world-class treatment and recovery system				
2	To break drug supply chains				
3	To deliver a world-class treatment and recovery system				

## Appendix D – Commissioning Information

# Current Funding Levels

Source	Baseline		Year 1	Year 2	Year 3
	2020-21 (actual)	2021-22 (projected)	2022-23	2023-24	2024-25
Adult substance misuse spend categories <sup>1</sup>	£9,716,000	£9,716,000	9,716,000	9,716,000	9,716,000
Specialist drug and alcohol misuse services for children and young people <sup>2</sup>	£763,000	£763,000	763,000	763,000	763,000
Additional local investment that contributes substantially to substance misuse treatment and recovery outcomes <sup>3</sup>	£399,785	£399,785	399,785	399,785	399,785
Supplemental substance misuse treatment and recovery grant		£596,000	915,409	1,758,412	2,886,357
Inpatient detoxification grant		£135,058	135,058	135,058	135,058
<b>Total</b>		<b>£11,609,843</b>	<b>11,929,252</b>	<b>12,772,255</b>	<b>13,900,200</b>

£11.9m of funding is available for addressing substance misuse in Essex for 2022-23:

- £9.7m adults
- £0.76m young people
- £0.4m additional local investment
- £0.9m supplemental grant
- £0.135m Inpatient detox grant

Overall investment is set to grow to £13.9m by 2024-25 – an increase of nearly 17%.

## Current Commissioning

- Specialist Treatment and Recovery Service - Essex Partnership University NHS Foundation Trust
- Psychosocial Alcohol Interventions and Recovery Service - Phoenix Futures
- Community Rehabilitation and Psychosocial Interventions Service - Forward Trust
- All Age Recovery Co-ordination Service - The Children's Society & Open Road Visions
- Offenders with Complex and Additional Needs Service - Phoenix Futures
- Integrated Support, Advice, Recovery and Mentoring Service\* - Phoenix Futures, Mind Mid, [North East](#) and West Essex

\* Jointly commissioned

Contract/Grant Title	Provider	Services known as	2022-23	2023-24
Specialist Treatment and Recovery Service (STARS)	Essex Partnership University NHS Foundation Trust (EPUT)	STARS	4,333,964	4,323,269
Psychosocial Alcohol Interventions and Recovery Service (PAIRS)	Phoenix Futures	ARC	923,023	928,795
Community Rehabilitation and Psychosocial Interventions Service (CRAPIS)	Forward Trust		889,018	887,697
All Age Recovery Co-ordination Service (AARCS)	The Children's Society & Open Road Visions	EYPDAS Open Road	1,966,250	1,957,548
Offenders with Complex and Additional Needs Service (OCAN)	Phoenix Futures	Full Circle	1,025,523	-
Integrated Support, Advice, Recovery and Mentoring Service* (ISARMS)	Phoenix Futures, Mind Mid, North East and West Essex	Futures in Mind	605,252	606,000

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