TONIC

safe in... warwickshire

WARWICKSHIRE DRUGS NEEDS ASSESSMENT

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EXECUTIVE SUMMARY

Background and Context

Warwickshire County Council commissioned TONIC to undertake a Drugs Needs Assessment to inform future planning and commissioning decisions ahead of a re-commissioning process. 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 and 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. The strategy sets out three main objectives:

1. To Break 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.

2. To Deliver a World-Class Treatment and 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.

3. To Achieve 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

Who is at Risk and Why?

There are a number of groups where drug misuse levels are much higher than amongst the general public, and any local strategy should seek to focus on these:

- People with coexisting physical and/or mental health problems (often referred to as dual diagnosis)
- People experiencing homelessness
- People not in training, employment, and education
- People with learning disabilities
- People involved in Chemsex activities
- Sex workers
- Steroid users

- People involved in the Criminal Justice System
- Vulnerable young people – including people in or leaving care or excluded from school
- Children of drug and alcohol users

It is important to note that some people will be part of several of these groups. The Government Drug Strategy outlines that deprivation is linked to higher levels of drug use and that Government funding should be prioritised accordingly.

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.

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:

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

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 over recent years. This involves addressing the immediate health and social needs of problem drug users by offering opioid substitution treatment and needle and syringe exchange programmes to prevent overdose deaths and reduce the spread of infectious diseases. Additional approaches include outreach work, health promotion, and education.

2. Drug Treatment and Recovery for Adults

In recent years, there have been two key developments in best practice; the rise of recovery communities led by people with lived experience, and the expansion of support delivered online. Since the pandemic, many treatment agencies have offered their core services via virtual video services. This practice had been

adopted by some prior to the pandemic as a way both of cutting costs and providing services at times that were more convenient to their service users.

3. Drug Treatment and Recovery for Young People

Young people needing treatment have increasingly complex needs. Evidence highlights the importance of providing young people with a holistic, child-centred service, instead of a substance-centred one. There is a consensus that to meet the needs of young people, provision needs to be better co-ordinated across a range of young people's services. These include Children's Social Services, Youth Offending Services, Children and Adolescent Mental Health Services as well as specialist substance youth services.

4. Drug Prevention

The Government's Advisory Council on the Misuse of Drugs published a rapid review of Drug Misuse Prevention in May 2022 and highlighted the need for drug prevention work to be integrated using a whole systems approach. Their review came to three main conclusions:

- Prevention should focus less on specific vulnerable groups and be targeted at the risk factors and social determinants that make individuals vulnerable.
- The UK lacks a functioning drug prevention system as drug prevention work has been under-valued for many years with funding rarely available for specially trained staff.
- Improvements will require long-term public investment to rebuild prevention infrastructure as well as specific efforts to address inequalities, social capital, and social norms.

Warwickshire's Current Approach

Strategic Approach

A number of local strategies and agreements in Warwickshire contribute to the overall approach to substance misuse and associated impacts. The key objectives of these focus on:

- **Addressing causes of serious violence**, focusing on the underlying causal factors as well as preventing types of violence such as domestic violence, sexual offences, feuds, disrespect, territory-based violence that result in group or gang conflict and violence driven through social media.
- **Tackling inequalities**, developing safer, healthier, and empowered communities, through improved access to health-related and wellbeing support.
- **Preventing homelessness** by addressing the underlying issues.
- Utilising a **trauma-informed approach** and embedding a contextual safeguarding model to support.

Specialist Service Provision

Change Grow Live (CGL) is the current commissioned service provider for adult substance misuse treatment for Warwickshire. This is a free and confidential recovery-focused service with a full range of treatments and interventions designed to support people to take control of their recovery journey and achieve their recovery goals. CGL have three main hubs across Warwickshire, as well as conducting outreach work in the more rural parts of the county. Their services include harm reduction, opiate replacement prescribing, referrals to residential rehabs and community detoxes, counselling, emotional support, and supported access to mutual aid. Needle exchange and naloxone are available from their hubs. Support in accessing training, employment, and housing is also offered.

Warwickshire Children and Young People's Drug and Alcohol Service is delivered by Compass as a free, confidential substance misuse service for children and young people who need support around their own drug or alcohol use. The service works with anyone between 5 and 25 years of age in Warwickshire. They offer age-appropriate information, one-to-one support, group work, health promotion, early intervention, whole family support where appropriate, and safety planning, all within a multi-agency approach. As part of their service provision, Compass offers a Hidden Harm Service, supporting children and young people who have been affected by another person's drug and alcohol use. Compass also delivers up-to-date workforce training to a range of other professionals.

Warwickshire has succeeded in engaging constant numbers of people in drug and alcohol treatment over the last decade despite the impact of cuts in public funding. However, like the rest of the country, the county is only succeeding in engaging approximately one fifth of the people in need into alcohol treatment. It appears that Substance Misuse Services in Warwickshire are successful in publicising their services and making them accessible to the general public, as evidence by high self-referral rates, but are less effective in developing relationships and effective referral routes with colleagues in health and criminal justice. It also appears that Asian people are under-represented in the drug treatment population. Warwickshire works with a higher proportion of crack cocaine users than the national average, with police reporting high availability of/demand for crack locally. Warwickshire's treatment services are above average in successfully helping people using crack to reduce their usage, but below average in terms of re-presentation rates for the overall non-opiate group.

Warwickshire faces the same challenge as most of the country in terms of engaging 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. Although numbers are small, it appears that cocaine and ecstasy use may be high locally compared to the national treatment picture. The small number of boys and young men in treatment is of particular concern locally. The relatively high numbers of young people admitted to hospital for alcohol-specific conditions (mainly self-poisoning and accidents) provides an opportunity to develop referral pathways from hospital to the local young person's service.

Design, Methodology, and Sample Overview

To deliver this Drugs Needs Assessment, TONIC engaged **over 550 local people** through the following activities:

- **Literature review:** that summarised both local and 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 Warwickshire differs from the national picture.
- **Surveys:** reaching 402 people, including 35 individuals with direct lived experience and 29 respondents on behalf of someone with lived experience of substance use, as well as 303 professional stakeholders.
- **In-depth interviews and focus groups:** with 132 individuals with lived experience of substance use (including current service users, individuals not accessing support, and family and friends of those using substances) and 52 professional stakeholders.

Key Findings

Regarding trends in substance use across Warwickshire, largely those with lived experience and professionals agreed that the most prevalent substances of choice are alcohol, heroin, cocaine, crack, and cannabis – with the first four of these believed to be causing most harm to Warwickshire residents.

COVID-19 and related restrictions was thought to have increased consumption of substances, particularly as a form of coping due to social isolation, boredom, or deteriorating mental health at a time with reduced access to support.

Breaking Drug Supply Chains

There was little awareness amongst most participants in this exercise about local police action to restrict the supply of drugs across Warwickshire. However, we were continuously told during interviews and the survey that county lines are a prevalent issue in Warwickshire, as is 'cuckooing'. We were told by police that Warwickshire is currently believed to be predominantly an 'importer' of county lines, with lines from larger cities being run into Warwickshire. While Warwickshire Police have made noteworthy progress in tackling county lines in recent years, when considering areas for improvement, participants felt the police could do more to address drug dealers higher up the supply chain – highlighting the important role the Regional Organised Crime Unit (ROCU) for the West Midlands should have in breaking drug supply in Warwickshire and the wider surrounding region.

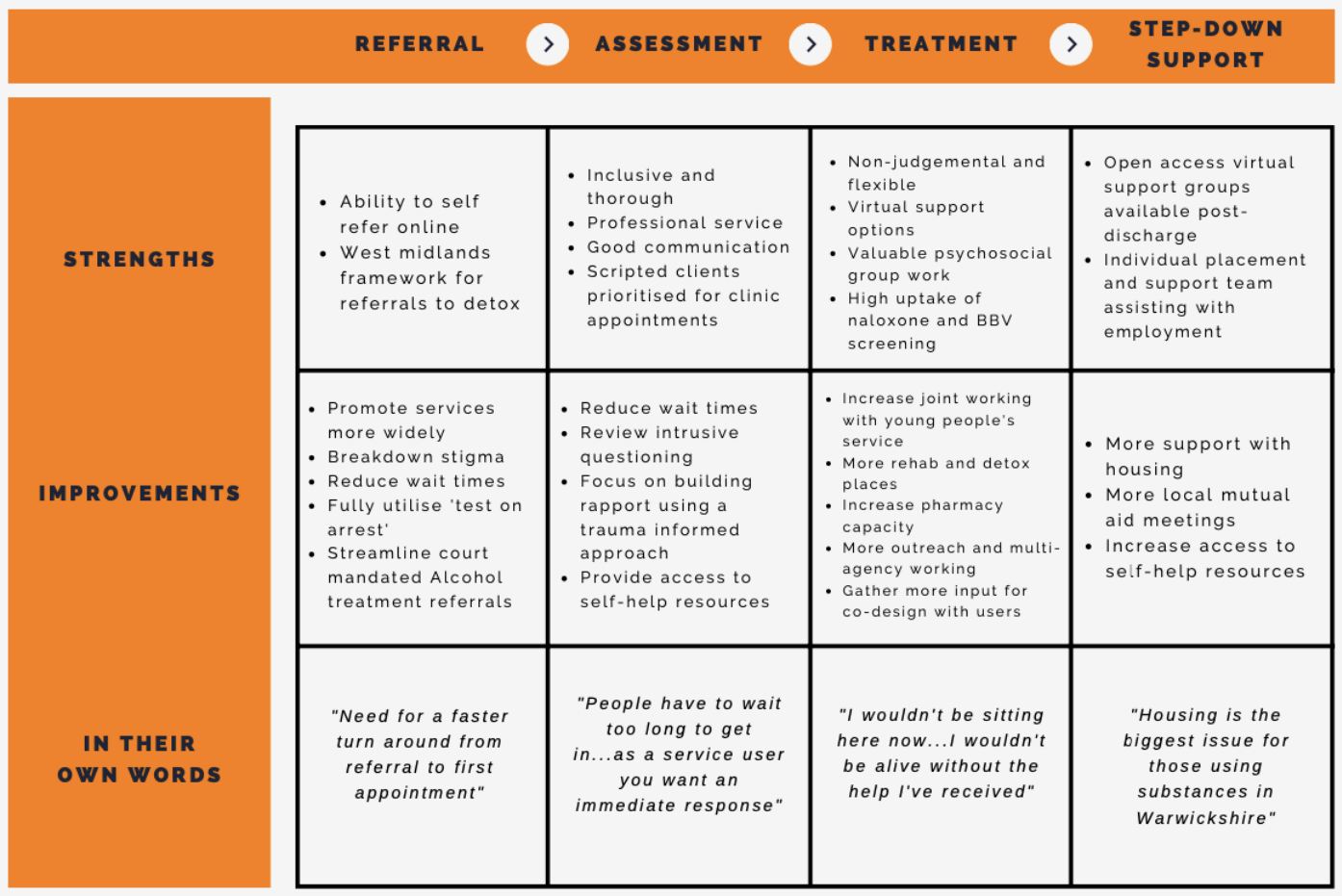
It is important to acknowledge that breaking drug supply chains is a wider issue than just policing and requires a full partnership approach to ensuring that vulnerable children, young people, and adults are not embroiled in criminal exploitation by key agencies working together to disrupt county lines and protect individuals at risk of exploitation.

Despite Warwickshire not having prisons within the local authority area, within the wider West Midlands region there are currently seven HMPPS run prisons. All have access to the regional resource, intelligence, and security hub, as well as a large dog unit which can be regionally deployed. Additionally, they all have the latest X-ray body scanners installed to confirm whether or not a suspected prisoner is hiding contraband inside their body and initiatives are in place to limit illicit substances entering the prisons through mail, 'throw overs' or 'drone drop offs'. Warwickshire Police were open to exploring more proactive ways they can work with prison security departments to monitor known organised crime group nominals, aiming to disrupt any drug dealing they continue to orchestrate from prison.

Delivering a World-Class Treatment and Recovery System

At a strategic level, Warwickshire was praised by stakeholders for having already established a local Drug and Alcohol Strategic Partnership. This was said to have helped foster good working relationships between key stakeholders within the County Council and other commissioning bodies, such as the Office for the Police and Crime Commissioner.

The following diagram has been used to summarise the experience's we were told about by service users on their journey through structured treatment, highlighting the positive aspects and areas for development.



	REFERRAL	ASSESSMENT	TREATMENT	STEP-DOWN SUPPORT
STRENGTHS	• Ability to self refer online • West midlands framework for referrals to detox	• Inclusive and thorough • Professional service • Good communication • Scripted clients prioritised for clinic appointments	• Non-judgemental and flexible • Virtual support options • Valuable psychosocial group work • High uptake of naloxone and BBV screening	• Open access virtual support groups available post-discharge • Individual placement and support team assisting with employment
IMPROVEMENTS	• Promote services more widely • Breakdown stigma • Reduce wait times • Fully utilise 'test on arrest' • Streamline court mandated Alcohol treatment referrals	• Reduce wait times • Review intrusive questioning • Focus on building rapport using a trauma informed approach • Provide access to self-help resources	• Increase joint working with young people's service • More rehab and detox places • Increase pharmacy capacity • More outreach and multi-agency working • Gather more input for co-design with users	• More support with housing • More local mutual aid meetings • Increase access to self-help resources
IN THEIR OWN WORDS	*"Need for a faster turn around from referral to first appointment"*	*"People have to wait too long to get in...as a service user you want an immediate response"*	*"I wouldn't be sitting here now...I wouldn't be alive without the help I've received"*	*"Housing is the biggest issue for those using substances in Warwickshire"*

The most commonly raised barriers to accessing or engaging with support included: lack of awareness of what help is available; restrictions due to capacity and waiting lists; the associated stigma; and lack of assertive outreach to promote inclusivity amongst individuals with protected characteristics.

There is a particular need to increase referrals for individuals from LGBTQ+ and minoritised ethnic communities.

We identified a number of gaps in terms of specific support for some key at risk groups. We were consistently told that dual diagnosis pathways are not working effectively, and commissioned services face significant challenges when a service user has a co-occurring mental health condition. Similarly, there is no specialist support on offer for those with learning disabilities or cognitive impairments and no specific training available to workers on how to tailor provision. Likewise, while there is a pathway in place, no specialist support exists for pregnant service users and there is no dedicated help for sex workers.

CGL and Compass both have Criminal Justice teams, which are working well but require expansion to enable workers to go into prisons more regularly to complete pre-release work so that prison leavers are better supported 'through the gate' and increase the continuity of care from prison to community.

We were consistently told there is a gap in the existing support offer in terms of the need to better support the partners, carers, children and loved ones of those misusing substances.

Achieving a Generational Shift in Demand for Drugs

There was an appetite for earlier intervention and prevention, and a desire for substance misuse treatment to become more innovative and proactive within a trauma-informed model. The majority of participants considered education to be the fundamentally most important aspect for preventing problematic substance misuse. Specifically, participants wanted to see education that teaches 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 the wider negative repercussions to friends, family, and society in general. Simultaneously, we were told this could usefully include the opportunity to raise awareness of harm reduction techniques to promote safer consumption if people do decide to use substances.

Linked to education, participants spoke about the need for local and national campaigns and media adverts to raise awareness to the public about substance use, the associated impacts and harm, and where to find support. This was seen as important as it was felt that some individuals may not realise their behaviour constitutes problematic use or may lack understanding of the repercussions their use is having on their health, lives, or society.

Additionally, participants wanted to see more support for children and young people of parents misusing substances. They wanted this to be delivered through a whole-family approach, as it was agreed that these individuals are at risk of going on to misuse substances themselves if they do not receive necessary support.

Recommendations

Based on our findings, as well as specific suggestions made by participants for us to consider, we set out a series of recommendations under each of the key ambitions from the national Drug Strategy, these are summarised at headline level below and presented in greater detail in the recommendations section of the full report.

1. Substance Misuse Services and police to track trends in substances of choice and those causing most harm in Warwickshire, to ensure the focus of support and interventions is able to respond to emerging needs.

Breaking Drug Supply Chains

2. To deliver the priorities set out within the Warwickshire Serious Violence Prevention Strategy related to county lines and drug supply markets.
3. Warwickshire Police to consider developing and running a series of communications campaigns around the positive and proactive work being undertaken to break drug supply chains and county lines, to raise awareness, and to build trust and confidence.
4. Warwickshire Police to consider ways to strengthen their work with the West Midlands Regional Organised Crime Unit, with a focus on pursuing drug dealers *higher up* the supply chain.
5. Warwickshire Police to explore ways to work more closely and proactively with prison security departments to monitor known organised crime group nominals, aiming to disrupt any drug dealing they continue to orchestrate from prison.
6. Training could be offered to frontline workers, including education providers, to encourage 'professional curiosity' around exploring the signs of child criminal exploitation and increase referrals to appropriate safeguarding teams. This work could be extended to parents and carers also.

Delivering a World-Class Treatment and Recovery System

7. Commissioned services require increased funding to drive the recruitment and retention of staff needed to build an experienced workforce, with reduced caseloads, and increased treatment places on offer, in order to increase the quality and quantity of support available. Consideration to be given to:
    - Varying methods of recruitment, that emphasise the importance of personal qualities required rather than desired qualifications
    - Making use of internships, apprenticeships, and pathways with colleges and universities
    - Developing a robust induction package for new starters
    - Enhanced provision for continuing professional development
    - Offering mandatory clinical supervision to all staff and developing a pathway to offer support to staff who may experience vicarious trauma through their work
    - Continuing to advertise opportunities for internal promotion, expanding this to national positions, and considering opportunities for secondments
    - Exploring opportunities to offer consistent salaries and enhanced terms and conditions across substance misuse services

Within the context of aiming to reduce caseloads and build capacity, the following recommendations are to be considered when additional funding becomes available:

8. The partnership to consider investing at a strategic commissioning level, to improve decision-making, enhance oversight, and ensure more meaningful performance monitoring and management occurs.
9. If commissioned services are to upscale their offer and build capacity, both in terms of staffing numbers and service users in treatment, they may require better equipped buildings that are accessible to all.
10. Relevant support services to work together to consider all barriers outlined within the report, affording consideration to corresponding proposed solutions, and aiming to develop an action plan to address these.
11. Commissioned services to increase promotion of their treatment options to clients, staff, and external stakeholders to ensure everyone is aware of them and can fully utilise the range of support available.
12. Commissioners and service providers to increase referrals by:
    - Increasing the use of Test on Arrest
    - Encouraging Warwickshire Police to continue supporting drug and alcohol users into treatment with seamless referral pathways and exploring more co-location with the police
    - Streamlining referrals from court-mandated Alcohol Treatment Requirements
    - Promoting awareness of services available to external partners to drive up direct referrals
    - Proactively challenge and collaborate with community and ‘by and for’ organisations to consider how they can reach out to more diverse communities and have a genuinely inclusive approach
13. Service providers to look to streamline the initial stages of access into treatment in order to reduce wait times, reduce the number of different practitioners and times people have to repeat their information to.
14. Commissioners and service providers to review assessment processes, with a shift to emphasising relationship building within a trauma-informed approach.
15. Commissioned services should offer a flexible approach to support (including location and timing), with options to continue working more flexibly built into future contracts through a hybrid model of support (including in person face-to-face contact, and virtual support).
16. Commissioned services to increase provision of alternative positive activities for service users, aiming to develop a sustainable recovery community and build individual recovery capital.
17. Nationally, there is a need for increased residential rehabilitation and in-patient detoxification places, with reduced waiting times. Locally, stakeholders believed that replicating the West Midlands detox framework for rehab applications could be beneficial.
18. Commissioners to explore what can be done to increase the capacity of pharmacies in the local area to meet the demand for dispensing.

19. Commissioned services to expand harm reduction provision (including training to administer naloxone), delivering training more widely to those not in treatment, their partners/family/carers and external professionals. This is to include highlighting and reminding service users of the importance of carrying naloxone kits.
20. Explore support available within primary care.
21. Needle exchange services to work to increase their reach to 'new clients'.
22. Commissioned services to proactively seek to engage individuals with 'additional needs' or protected characteristics by:
    - Establishing partnerships with 'by and for' organisations
    - Improving dual diagnosis pathways
    - Exploring the possibility of recruiting in-house psychologists
    - Raising staff awareness of learning disabilities and how to adapt support appropriately
    - Building better working relationships with LGBTQ+ organisations
    - Ensuring staff have appropriate cultural safety and awareness training with availability of appropriate interpreters/translators as needed for anybody whose first language is not English
    - Considering a specialist midwife role to co-ordinate support for pregnant service users
    - Developing a dedicated form of support or pathway for sex workers
    - Expanding 'prison in reach worker' roles
    - Introducing dedicated family support, and upscaling Family Drug and Alcohol Court (FDAC) provision.
23. Commissioned services to ensure a robust step-down support pathway is in place leading up to, and at the point of discharge from treatment, this could include:
    - Increasing prevalence of mutual aid meetings across Warwickshire, with representatives from the 12 Step fellowship coming into services to introduce themselves to clients and support visible recovery
    - Improving awareness and availability of self-help resources (such as Breaking Free Online), where possible these should be offered online and/or in apps
24. Commissioned services to increase opportunities for service users to provide feedback and engage service users in co-design, building on initiatives such as the Experts by Experience panel. This could be enhanced by considering and reviewing key performance indicators with commissioners.

Achieving a Generational Shift in Demand for Drugs

25. Warwickshire's Drug and Alcohol Strategic Partnership to explore ways to contribute to the development and monitoring of school curriculums to incorporate age-appropriate education, exploring the risks and dangers of substance use and raise awareness of harm reduction techniques.
26. Young people to be taught healthy coping strategies, building their resilience so they have sufficient lifeskills so as not to need to resort to substance use as a form of coping.
27. Consideration to be given to the role of the local Drug and Alcohol Strategic Partnership in establishing partnerships and pathways between those responsible for offering diversionary activities to children and young people.
28. There is a need for local and national campaigns and media adverts to raise awareness to the general public about substance use, the associated impacts and harm, and how they can find support.
29. The future Children and Young People's Drug and Alcohol Service provider to continue working with the Youth Justice Service on the 'universal referral pathway' as a preventative measure and to explore expanding this provision to children and young people not in touch with the criminal justice system.
30. Increase provision of support for children of parents misusing substances through a whole-family approach.
31. Family Drug and Alcohol Court provision must be evaluated and be rolled out long-term if successful.

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, Warwickshire County Council commissioned TONIC to undertake a Drugs Needs Assessment to inform future planning and commissioning decisions ahead of a re-commissioning process, 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 support services across Warwickshire in the future. The needs assessment sought to provide an overview of the needs of individuals, families, and communities affected by drug use in Warwickshire, and was conducted to complement the recently published Warwickshire Alcohol Joint Strategic Health Needs Assessment (2022)[1].

1 Please see: https://www.warwickshire.gov.uk/directory-record/7193/warwickshire-alcohol-health-needs-assessment-2022

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 consultation was led by Senior Researcher and Analyst Daisy Elvin, alongside Associate Researchers Maria Gallagher, Danielle Jones, Sanjidah Islam, Russell Webster, Senior Research Associate Dr Sarah Senker, and Director of TONIC Matthew Scott[2].

2.2. Literature Review

TONIC conducted a literature review to summarise local and national research, policies, and strategies, and to provide insight into who is at risk and why, and evidence of what works. Relevant local documents were identified and provided to us by commissioners within Warwickshire County Council.

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 Warwickshire County Council, partners, or providers. The data chapter focuses on overall prevalence, indicators of need, and details about treatment and outcomes in Warwickshire. It highlights trends, issues, and topics where Warwickshire differs from the national picture and is organised into three subsections – alcohol, drugs, and young people.

2.4. Fieldwork – Surveys, Interviews, and Focus Groups

In consultation with commissioners at Warwickshire County Council, two anonymous online surveys were developed: one for those with (direct or indirect) lived experience of substance use, and one for professionals (including frontline practitioners, service providers, key stakeholders, commissioners, and policy makers). The surveys were hosted by TONIC on SurveyMonkey and yielded both quantitative and qualitative data. The only pre-existing eligibility criteria was that respondents had to either live or work in Warwickshire. 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 at Warwickshire County Council. Interviews were semi-structured and designed to feel

2 TONIC were particularly well placed to carry out this Drugs Needs Assessment having recently completed a Violence Against Women and Girls Call for Evidence for Warwickshire's VAWG Board, as well as a Comprehensive Victim Needs Assessment for the Office for the Police and Crime Commissioner in Warwickshire, which included evaluating the Criminal Justice related support provided by the Substance Misuse Services in Warwickshire. Therefore, TONIC had a sound prior understanding and insight into the landscape of commissioning responsibilities and support services across the county. For the executive summary of the Victim Needs Assessment, please see: https://www.warwickshire-pcc.gov.uk/wp-content/uploads/2022/06/Warwickshire-VNA-Executive-Summary-redacted.pdf?x24877

like a 'conversation with a purpose' (Burgess, 1982). Interview schedules were used as a guideline for the focus groups that took place.

Managers from the commissioned Substance Misuse Services at the time of the needs assessment were also given the opportunity to provide feedback on draft materials to ensure they were relevant and accessible to their service users.

Warwickshire County Council 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 (direct or indirect) of substance use were recruited to take part in the survey through a combination of promotional materials that TONIC produced and had signed off by Warwickshire County Council's Communications Team. These were distributed by local and national charities, support services, and other relevant organisations, such as the police, 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).

The majority of fieldwork for this research was conducted between 29th June and 21st August 2022, including four researchers spending 3 days onsite in Warwickshire between 9th and 11th August 2022. The TONIC research team 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.

To analyse the qualitative data, TONIC researchers 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 at Warwickshire County Council via catch up meetings and/or email updates throughout the duration of the needs assessment.

2.5. Ethical Considerations

In terms of ethical considerations, TONIC researchers were extremely conscious of the sensitive nature of this research. 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 at Warwickshire County Council before being used.

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 retraumatising 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 Warwickshire. TONIC endeavoured to make the experience of contributing to this project as empowering as possible.

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, and only the TONIC team involved in this project had access to the raw data collected. 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).

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'[3], published in December 2021. The timing of the report (the previous strategy[4] 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[5] (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[6] (published in July 2021) focused on treatment, recovery, and prevention and its publication was delayed allowing the Government to start responding to Dame Carol's criticisms by launching a number of initiatives to tackle the issues she raised.

3.1.1. The Drug Strategy

The introduction to the strategy and the Prime Minister's foreword prioritises tackling drug-related crime, an ambition reflected in the paper's full title 'A 10-year drugs plan to cut crime and save lives'. The plan itself includes considerable investment in treatment, and initiatives relating to both early intervention and drug education. The plan is jointly presented by the Home Secretary, the Health Secretary, and the Combating Drugs Minister (currently Kit Malthouse as of May 2022, based within both the Home Office and the Ministry of Justice). The paper promises almost £900 million in additional funding over the 3 years starting in the 2022/23 financial year, which it claims will deliver 54,500 more treatment places, prevent nearly 1,000 deaths, and close over 2,000 more county lines[7].

The strategy sets out three primary objectives:

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

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

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

3 HM Government (2021) From harm to hope: A 10-year drugs plan to cut crime and save lives
4 HM Government (2017) 2017 Drug Strategy
5 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
6 Dame Carol Black (2021) Review of Drugs Part Two https://www.gov.uk/Government/publications/review-of-drugs-phase-two-report
7 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	 **Break drug supply chains**	 **Deliver a world-class treatment and recovery system**	 **Achieve a shift in the demand for recreational drugs**
Why?	Drug supply chains are violent and exploitative, degrading neighbourhoods across the country and internationally	Drug addiction harms individuals and society: deaths have risen to record levels and almost half of acquisitive crime is linked to addiction	Use of recreational drugs has grown over a decade, particularly among young people, risking individual harm and fuelling dangerous markets
How?	We will continue to roll up county lines and strengthen our response across the drug supply chain, making the UK a significantly harder place for organised crime groups to operate	We will invest a further £780 million to rebuild drug treatment and recovery services, including for young people and offenders, with new commissioning standards to drive transparency and consistency	We will strengthen the evidence for how best to deter use of recreational drugs, ensuring that adults change their behaviour or face tough con-sequences, and with universal and targeted activity to prevent young people from starting to take drugs
Who?	Home Office and MoJ, working with international and intelligence partners, NCA, Border Force, police, courts, prison and probation	DHSC, DLUHC, DWP and MoJ working with NHSE, local authorities, treatment providers and people with lived experience	DfE, DHSC, Home Office and MoJ, working with local authorities, police, education providers, secure facilities and youth services
What?	Within three years: close 2,000 more county lines, disrupt 6,400 OCG activities and deny more criminal assets	Within three years: prevent nearly 1,000 deaths, deliver 54,500 new high-quality treatment places and prevent a quarter of a million crimes	Reduce overall drug use to a new historic 30-year low over the next decade

The drug strategy starts by quoting a range of disturbing figures from Dame Carol's Review which lays bare the scale of drug-related crime, the lack of capacity in the treatment system, and the fact that deprivation is intimately linked with higher levels of dependency and other health inequalities. The plan is clear that the initial priorities will be to: *"combat the supply of heroin and crack cocaine, and… get those suffering from addiction the treatment and support they need."* [8]

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, summarised in the infographic reproduced below.

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

Figure 2 Drug Strategy 2021 – Break the Supply Chain Summary Plan

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

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

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"*.

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[9] 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. Warwickshire is not an area receiving enhanced funding for this[10].

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[11] 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

9 Full Government description of ADDER can be found here.
10https://www.gov.uk/government/publications/extra-funding-for-drug-and-alcohol-treatment-2022-to-2023/additional-drug-and-alcohol-treatment-funding-allocations-2022-to-2023
11 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

Requirements for those on community sentences[12]. 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.

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.

12 Via Community Sentence Treatment Requirements

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

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

Overarching best practice recommends the following critical success factors[14]:

- 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.

13 Via this website: https://www.gov.uk/Government/collections/alcohol-and-drug-misuse-prevention-and-treatment-guidance
14 These critical factors are derived from OHID commissioning advice and Dame Carol Black's work.

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[15] 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 starting drug treatment in 2020/21 said they had a mental health treatment need[16]. 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[17]. 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[18].

15 HM Government (2021) From harm to hope: A 10-year drugs plan to cut crime and save lives (page 10)
16 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
17 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
18 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

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[19]. 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[20]. OHID drug treatment data[21] 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.

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[22] which estimates that more than 1 in 3 people in prison are suffering from a *"serious drug addiction"*. The main Government initiatives in this area are: increasing the use of police diversion schemes and community sentences with treatment as an alternative to custody, investing more in prison drug treatment, and seeking to improve continuity of care on release from prison. The latest figures (for 2020/21) show that less than 4 out of 10 (38.1%) of people who access drug treatment in prison engage

19 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
20 Ministry of Housing, Communities and Local Government (2020) Rough sleeping questionnaire initial findings. https://www.gov.uk/government/publications/rough-sleeping-questionnaire-initial-findings
21 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
22 Dame Carol Black Review of Drugs: evidence pack https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/882953/Review_of_Drugs_Evidence_Pack.pdf p.102

with community treatment on release[23]. The figure for this in Warwickshire is above the national average at 43.8% which is positive; however, the Government target is 75%.

3.2.6. Domestic Abuse

We know that 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 perpetrator programmes have problems with alcohol and/or drugs[24]. 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[25]. Alcohol use by women in particular has been found to be a response to experience of abuse from partners[26]. For these reasons, there need to be good working relationships between treatment agencies and domestic abuse services.

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.[27]

3.2.8. Young People

Young people are generally always a priority group as a greater proportion of young people use drugs[28] and the proportion of young people using drugs has increased in recent years[29]. 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[30])
- Looked after children (18% referrals into treatment[31])
- 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[32])

23 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
24 Home Office (2020) Domestic Abuse Draft Statutory Guidance cites a range of research studies to this effect. (page 28)
25 Hester, M. (2009) Who Does What to Whom? Gender and Domestic Violence Perpetrators, Bristol: University of Bristol in association with the Northern Rock Foundation
26 Humphreys et al., Domestic Violence and Substance Use: Tackling Complexity, British Journal of Social Work, 2005
27 Public Health England (2019) Health inequalities: Substance Misuse
28 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
29 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.
30 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
31 Ibid.
32 Ibid.

- 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 groom 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'[33]). 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[34], 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[35].

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[36] in 2003 which concluded that parental problem drug use can and does cause serious harm to children at every age from conception to adulthood. The Government drug strategy recommends 'specific support' for families with parental substance misuse treatment needs, which should be *"co-ordinated at a local level"* [37].

3.2.10. Steroid Users

Recent research[38] 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[39].

3.2.11. Sex Workers

Drug using sex workers[40] may rely on sex work primarily to fund their drug use. The research literature[41] 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)

33 NSPCC (2021) Protecting children from county lines https://learning.nspcc.org.uk/child-abuse-and-neglect/county-lines
34 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
35 HM Government (2021) From harm to hope: A 10-year drugs plan to cut crime and save lives (page 36)
36 The Advisory Council on the Misuse of Drugs (2003) Hidden Harm – Responding to the needs of children of problem drug users
37 HM Government (2021) From harm to hope: A 10-year drugs plan to cut crime and save lives (page 36)
38 https://www.bournemouth.ac.uk/research/projects/male-users-anabolic-androgenic-steroids
39 https://www.nhs.uk/conditions/anabolic-steroid-misuse/ Latest Public Health England advice: https://www.gov.uk/government/publications/treating-substance-misuse-and-related-harm-turning-evidence-into-practice/services-for-image-and-performance-enhancing-drug-iped-users-turning-evidence-into-practice
40 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
41 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

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[42]. 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 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+[43] 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:

42 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

43 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.

- 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[44]. 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.

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[45] 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[46] 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

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[47].

44 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/deathsrelatedtodrugpoisoningin englandandwales/2020
45 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
46 EMCDDA (2016) Preventing opioid overdose deaths with take-home naloxone
https://www.emcdda.europa.eu/system/files/publications/2089/TDXD15020ENN.pdf
47 https://adf.org.au/drug-facts/buprenorphine-long-acting-injectable/

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[48], a Community Interest Company, which has evaluated the effectiveness of its work[49].

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'[50]. The UK Recovery Champion describes the key components of a Recovery Orientated Systems of Care:

> *"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."* [51]

48 https://wearetheloop.org/
49 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
50 Home Office and Department of Health and Social Care (2021) UK Government Recovery Champion Annual Report.
51 Ibid. Page 8

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[52] 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[53] 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[54] organisation which develops evidence-based digital behaviour change interventions that use proven behavioural science to empower people to overcome problem drinking, drug misuse, and smoking. The Breaking Free online resources are used by an increasing number of providers including CGL.

In the alcohol field, the treatment agency Humankind pioneered a range of online tools designed to help people track and change their drinking including both an online screening tool[55] and the DrinkCoach App[56].

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'. One of the leading drug and alcohol treatment providers 'We are with you'[57] also offers 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)[58] 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

52 Webster et al. (2021) Peers who volunteer https://peervols.russellwebster.com/wp-content/uploads/2021/11/Peers-who-volunteer-FINAL-November-2021.pdf
53 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
54 https://www.breakingfreegroup.com/
55 https://drinkcoach.org.uk/alcohol-test-intro
56 https://drinkcoach.org.uk/drinkcoach-app
57 https://www.wearewithyou.org.uk
58 https://www.cypnow.co.uk/analysis/article/drugs-review-highlights-five-ways-to-boost-support-for-young-people

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[59] 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.

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[60]. 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 that all approaches are

59 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
60 ACMD (2022) The prevention of drug misuse in vulnerable groups

evidence-based[61] and that all drug prevention work should be integrated in a whole system approach and delivered by staff with dedicated, accredited training (which needs to be developed).

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

3.4. Warwickshire's Existing Strategies and Services

The table below provides a brief summary of a range of Warwickshire-specific documents and strategies that were shared with us for the purpose of this literature review, all of which are important to consider as context for this drugs needs assessment.

Table 1 Summary of Key Local Documents, Policies, and Strategies that are of relevance to this Drugs Needs Assessment.

Document	Brief Summary
Warwickshire Community Safety Agreement 2022-2026 *(Responsible Owner: Safer Warwickshire Partnership Board)*	There have been significant changes since the previous Warwickshire Community Safety Agreement was produced in 2017, both to the community safety landscape and the wider societal context in which this work sits. This latest agreement takes into account: • The COVID-19 pandemic • The Police, Crime, Sentencing and Courts Bill • Serious Violence Reduction Fund launched in 2019 that led to the formation of Violence Reduction Units (VRUs) – Warwickshire does not have its own Violence Reduction Unit but close links are being established with interventions being developed in Coventry through the West Midlands VRU • The Domestic Abuse Act (2021) which led to the Warwickshire Safe Accommodation Strategy 2021-24 • Warwickshire Police and Crime Plan 2021-25 • The number of Police Officers increased to over 1,000 for the first time in Warwickshire since 2009 • The reunification of Probation bringing together the National Probation Service and Community Rehabilitation Companies • National refresh of the Integrated Offender Management (IOM) scheme, meaning Warwickshire IOM will shift its focus from high-harm offenders and refocus on those responsible for high volumes and reoffending rates (neighbourhood crimes). The vision is for the Safer Warwickshire Partnership Board to create safer communities through the reduction of crime and promotion of safety, with a focus on three key strategic ambitions: • Address the causes of violence • Tackle discrimination in all its forms • Safe, healthy, and empowered communities.

61 Ibid Page 2 provides details of quality standards.

	The ambitions will be delivered through the following subgroups: • Violence Against Women and Girls Board • Serious and Organised Crime Joint Action Group • Prevent Steering Group • Reducing Reoffending Board • Drug and Alcohol Partnership Board • Hate Crime Partnership Board • Prevent Steering Group. It is expected by addressing the causes of violence, Warwickshire will not only see a reduction in gang and knife crime, but over the life of this agreement, reductions in all forms of serious violence including domestic abuse, alcohol-related violence, and other forms of serious violence. Other key outcomes of success will include: • Implementation of preventative measures to reduce Adverse Childhood Experiences • Embedding Contextual safeguarding across all community safety partners • Public Health approach to addressing serious violence • Community cohesion • Responding to the changing nature of the economy and town centres • Improve accessibility to health-based support at the point of need • Development of an Equalities Charter self-assessment toolkit • Use of Section 17 as an auditing tool • Redefine the offer for those experiencing hate.
Warwickshire Joint Strategic Alcohol Health Needs Assessment (2022) *(Responsible Owner: Warwickshire County Council)*	The 2022 Warwickshire Joint Strategic Alcohol Health Needs Assessment establishes patterns in alcohol consumption across Warwickshire and the relation this may have with physical and mental health risks, hospital admissions, and crime. The report outlines that in 2018/19 it was estimated 4,018 alcohol dependent adults in Warwickshire were potentially in need of treatment. This equated to 79.9% of dependent drinkers in Warwickshire not being in alcohol treatment, which was slightly lower than the regional (83%) and national (82.4%) averages. There were around a third (33%) of clients in alcohol treatment that successfully completed treatment in Warwickshire in that period. This needs assessment further identifies risk factors that may contribute to alcohol dependency, barriers to accessing support, and an evaluation of existing support within Warwickshire, including for children and young people who live with someone they are concerned for or drink alcohol themselves. Recommendations arising from this needs assessment were grouped into five key areas, which include: 1. **Reducing alcohol consumption** – improve the quality and/or identification of alcohol-related data held across partners and departments including licensing, social care, police, health visiting, and primary and secondary healthcare and alcohol services. 2. **Promoting partnership working** – establish a system-wide partnership alcohol forum, with scope to encompass drug misuse as a topic of discussion.

	Stakeholders to be included; Warwickshire County Council commissioners, public health, adult drug and alcohol service providers, service users, armed forces representative, police representative, Primary Care, Secondary Care, Clinical Commissioning Group, maternity/health visitor services, community safety partners, district and boroughs, trading standards, and homelessness services representatives. 3. **Reducing higher risk and problem drinking** – raise awareness among key professionals to improve identification of, and support to, individuals, including children, and improve recording of alcohol-related concerns. 4. **Providing a healthier environment** – working with partners in a person-centred approach to establish an environment that supports the most vulnerable. 5. **Reducing health inequalities** – strengthen partnership working to focus on areas experiencing greatest alcohol-related harms, in particular Nuneaton and Bedworth, Warwick district, and areas of higher deprivation.
Warwickshire Health and Wellbeing Strategy 2021-2026 *(Responsible Owner: Warwickshire Health and Wellbeing Board)*	The Warwickshire Health and Wellbeing Strategy 2021-2026 aims to tackle inequalities in health within Warwickshire and overall improve health and wellbeing. Priorities identified include helping children and young people have the best start to life, helping people improve their mental health and wellbeing, with a particular focus on prevention and early intervention, and reducing inequalities in health. This will be achieved by aligning and coordinating prevention programmes across the system, with a particular focus on tackling barriers to healthy lifestyle choices, as well as working with communities to mobilise solutions informed by an understanding of local assets. In addition to this, health and social care commissioners will work with providers to commission and deliver services, and an emphasis will be placed on tackling health inequalities by addressing the wider determinants of health.
Preventing Homelessness in Warwickshire: A Multi-Agency Approach 2021-2023 *(Responsible Owner: Warwickshire County Council)*	The first ever Warwickshire-wide homelessness strategy seeks to prevent and tackle homelessness by addressing underlying issues that may contribute to homelessness and bringing together organisations working in these areas. The vision set out in the strategy for the next 2 years is of statutory, voluntary, and community organisations working together for the benefit of Warwickshire residents to promote and deliver the changes expected by the government in the Homelessness Reduction Act 2017 with particular reference to the prevention duty and the Duty to Refer. Five distinct priorities have been identified within this strategy, including: 1. Health 2. Financial inclusion 3. Young people 4. Domestic abuse 5. Offending The strategy explores and addresses each of these priorities in turn, with acknowledgement of the fact that drug and alcohol problems can be a cause or contributing factor to homelessness and rough sleeping. Indeed, the strategy highlights that data from 27 Health Needs Audits across England in 2019 showed that an estimated 44% of homeless people had a diagnosed mental health condition; 86% had reported a mental health difficulty (the most common issue being depression); 27% had

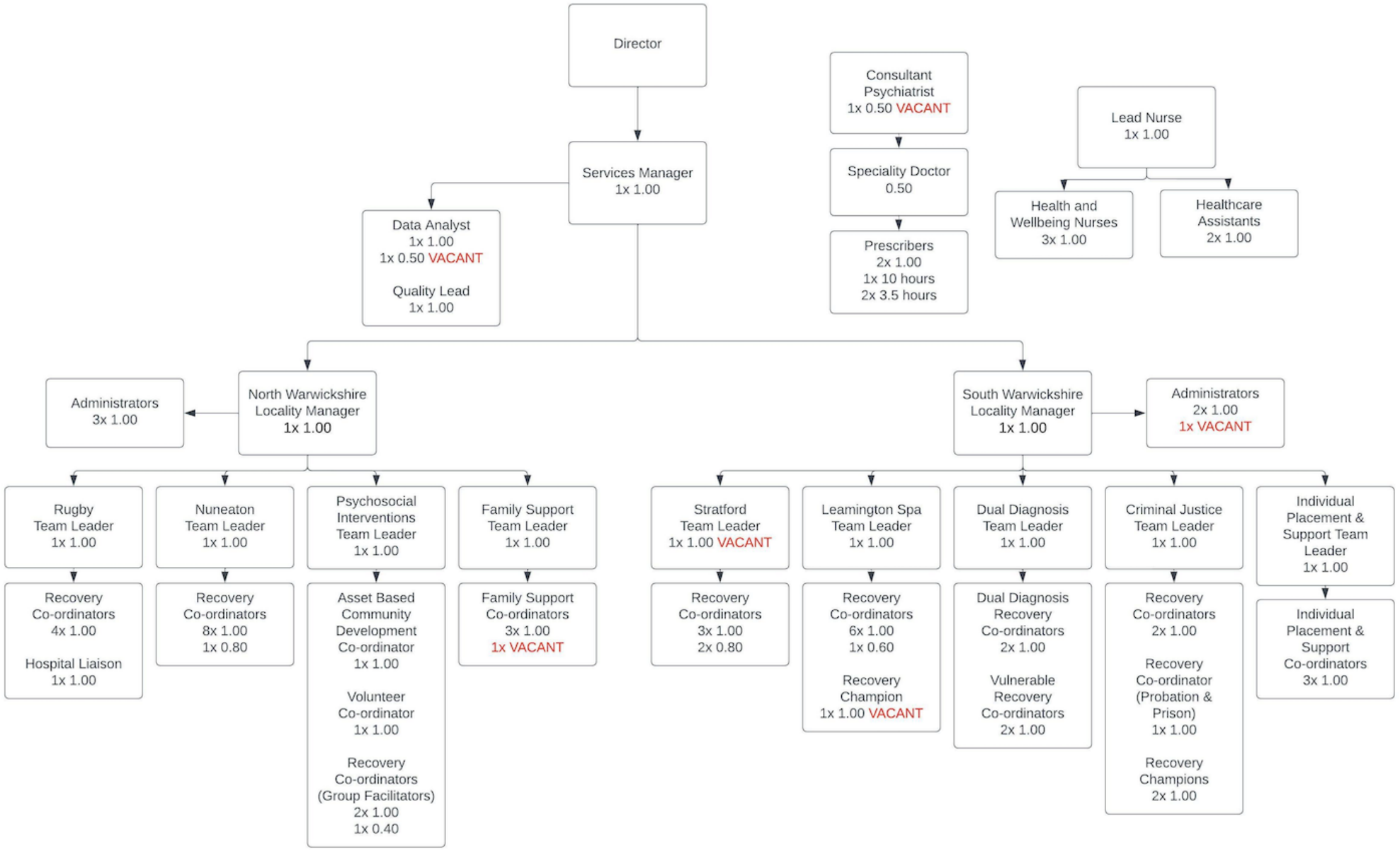
	an alcohol problem; 78% smoked; and 41% used drugs or were in recovery. While estimates of alcohol and drug use rates among homeless people vary, there is recognition that rates of substance misuse are much higher than they are within the general population. The strategy also points to the need for improvements to be made in terms of supporting the development and embedding of the Dual Diagnosis protocol and pathways into mental health and drugs and alcohol services.
Warwickshire Safeguarding Exploitation Strategy 2020-2023 *(Responsible Owner: Warwickshire Safeguarding Partnership)*	Warwickshire's Safeguarding Exploitation Strategy has been written to ensure that Warwickshire Safeguarding Partnership is working together to foster a greater understanding of exploitation, the impact it has on children, young people, adults with care and support needs, and the wider community, and to improve the lives of those who are at risk – this is the ambition. The scope of the strategy crosses the domains of sexual exploitation, missing children, gangs, criminal exploitation, organised crime, cuckooing, trafficking, hate crime and prevent/extremism. Within the document, it defines these various forms of exploitation, provides real examples occurring in Warwickshire, sets out the ambition, strategic objectives, approach, and outlines how success will be measured. Objectives include acting always in the best interest of the child; making safeguarding adults more personal by empowering, protecting, preventing, having a proportionate response, working in partnership to provide local solutions, and remaining accountable through transparent delivery; and taking the 4P approach of prepare, prevent, protect, and pursue. In order to provide a victim-centred approach, which values the importance of building trusted relationships with those who are experiencing or at risk of exploitation, Warwickshire aims to: • Take a trauma-informed approach • Utilise contextual safeguarding models • Adopt restorative practice to resolve problems with the least intrusive interventions. There is also a specific section on missing people, which outlines Warwickshire's commitment to deliver an effective response to missing people between services working with children and adults; supporting agencies in coordinating activity to reduce the number of people going missing and to limit the harm related to those who do. Information sharing is identified as crucial for this so that services are cohesive and adequately able to safeguard individuals who go missing or may be at risk of doing so. There is a pledge to develop shared datasets that build on the data that is already collated and plugs any perceived gaps in knowledge and understanding of the problem. partners of the Exploitation Subgroup, individually and collectively, have responsibility to ensure objectives and targets developed are being met and maintained and the 3-year plan will be reviewed annually.
Warwickshire Serious Violence	The Warwickshire Serious Violence Prevention Strategy (in draft form at time of summarising for this report) sets out a long-term partnership approach to address the

Prevention Strategy (Draft) *(Responsible Owner: Safer Warwickshire Partnership Board)*	causes of violence, highlighting the importance of adopting an approach whereby, "preventing serious violence is everyone's responsibility". While Warwickshire is one of the safest places to live in the country, with cases of serious violence involving a weapon (knife or gun) remaining low within the West Midlands region and compared nationally, the Safer Warwickshire Partnership Board has ambitions and priorities to reduce crime and the fear of crime. For the purpose of the strategy, the World Health Organisation's definition of violence has been adopted but expanded to include coercive and/or controlling behaviour and financial abuse. The strategy considers domestic abuse, sexual offences, county lines, knife crime, firearm offences, street gangs, serious violent acts driven through social media, and the underlying individual, family, peer, school, and community factors that directly impact on serious violence, and proposes a trauma-informed approach to prevention: • Realises the widespread impact of trauma for individuals, families, peer groups, schools and local communities affected by serious violence, and understands potential paths for recovery. • Recognises the signs and symptoms of trauma in clients, families, staff, and others affected by serious violence. • Responds by fully integrating knowledge about trauma into policies, procedures, and practices. • Resists Re-traumatisation of those we work with and our staff. The Warwickshire Serious Violence Model is based on well researched Public Health approaches to violence reduction, combined with current safeguarding principles: • The 5 C's approach • Trauma and adversity • Understanding risk and protective factors • Contextual safeguarding • Capricorn framework. Ultimately the model should be used to prevent serious violence before it happens, respond to emerging or immediate risks of serious violence, and provide long-term support. Within the strategy, it outlines that in Warwickshire, there are on average around 15-18 known county lines operating at any one time. The vast majority of these county lines come from Coventry, Birmingham, and the West Midlands region. There are also county lines from other areas, such as London and Manchester. Since 2020, a series of successful police operations has contained the number of lines.

3.4.1. Warwickshire Adult Drug and Alcohol Service – Change Grow Live (CGL)

Change Grow Live (CGL) is the current commissioned service provider for adult substance misuse treatment. CGL Warwickshire is a recovery-focused service with a full range of treatments and interventions designed to support people to take control of their recovery journey and achieve their recovery goals. CGL have three main hubs across Warwickshire: CGL Leamington Spa, CGL Nuneaton, and CGL Rugby, and are also co-located in the Fred Winter Centre in Stratford, as well as conducting outreach work in the more rural parts of the county. Their services include harm reduction, opiate replacement prescribing, referrals to residential rehabs and community detoxes, counselling, emotional support, and supported access to mutual aid. Needle exchange and naloxone are available from their hubs. Support in accessing training, employment, and housing is also offered. During the COVID-19 pandemic, appointments were conducted over the phone, with some groups running via Zoom, to ensure staff and client safety. The below depicts CGL Warwickshire's staffing structure as of the 14th July 2022, with red font indicating vacancies.

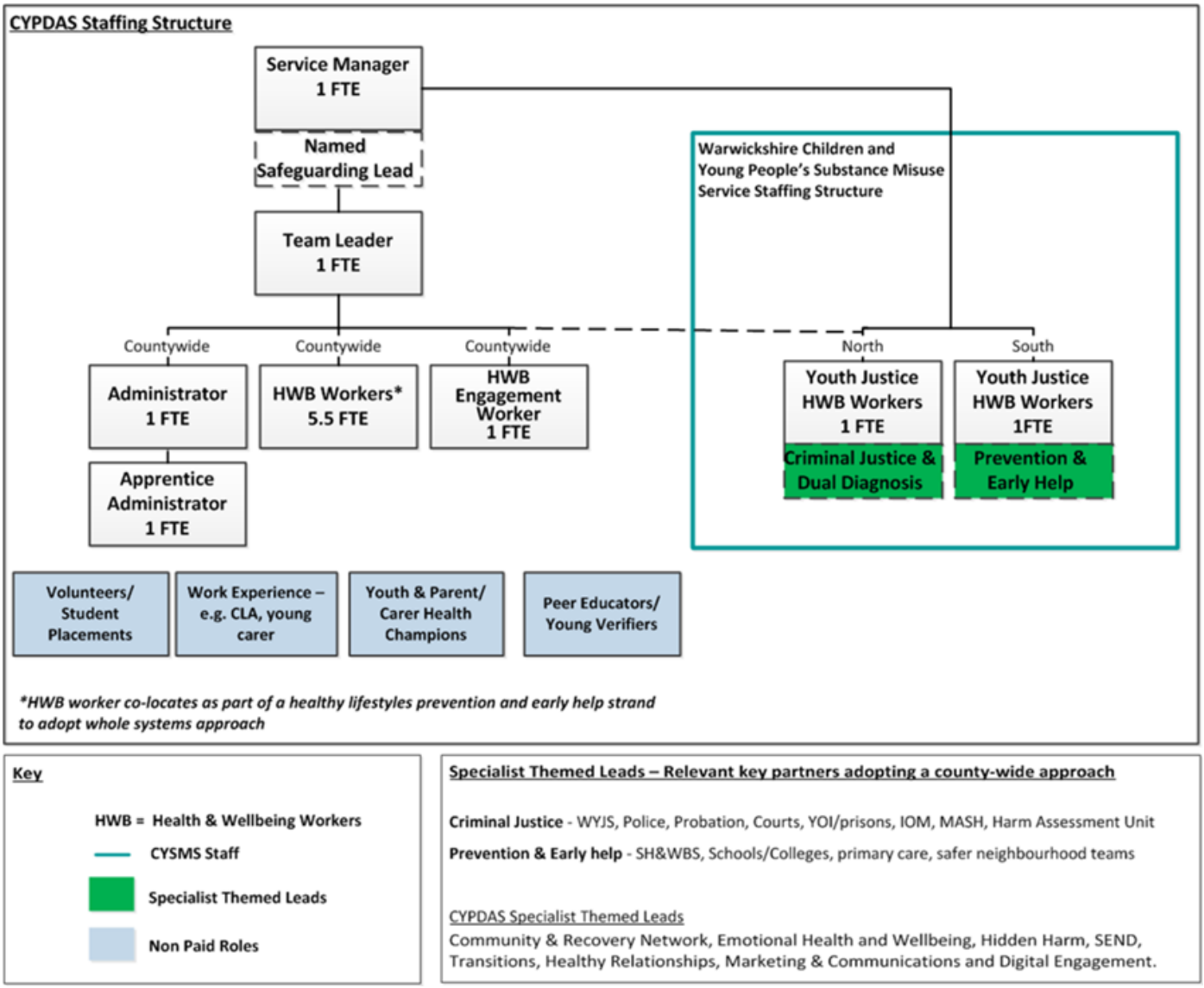
Figure 3 Warwickshire CGL Staffing Structure as of 14th July 2022



3.4.2. Children And Young People's Drug and Alcohol Service – Compass

Warwickshire Children and Young People's Drug and Alcohol Service (CYPDAS) is delivered by Compass as a free, confidential substance misuse service for children and young people who need support around their own drug or alcohol use. The service works with anyone between 5 and 25 years of age in Warwickshire. They offer age-appropriate information, one-to-one support, group work, health promotion, early intervention, whole family support where appropriate, and safety planning, all within a multi-agency approach. As part of their service provision, Compass offers a Hidden Harm Service, supporting children and young people who have been affected by another person's drug and alcohol use. Compass also delivers up-to-date workforce training to a range of other professionals. The below displays Compass' staffing structure as of the 29th June 2022; at that time, Compass had one Youth Justice Worker post and one Engagement Worker post vacant.

Figure 4 Warwickshire Compass Staffing Structure as of 29th June 2022



4. QUANTITATIVE DATA ANALYSIS

This chapter presents the data about drugs and alcohol in Warwickshire, focusing on overall prevalence, indicators of need and details about treatment and outcomes. We highlight trends, issues, and topics where Warwickshire differs from the national picture. The chapter is organised into three subsections – alcohol, drugs, and young people. Although this needs assessment focusses on drugs, we have taken the decision to include some information about alcohol in this report given the large amount of cross over in terms of treatment service provision between drugs and alcohol. All data charts/tables are from the Commissioning Support Packs unless specifically indicated to the contrary.

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[62], 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[63]. 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[64] 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. Alcohol Use Prevalence

Data from Local Alcohol Profiles for England included in the most recent (2022/23) Alcohol Commissioning Support Pack for Warwickshire estimates that a slightly greater proportion of adults in Warwickshire drink over 14 units of alcohol a week compared to the national average (24% vs 23%) but a smaller portion binge drink on their heaviest drinking day (13% vs 15%). The data estimates that a somewhat larger proportion of the local population abstain from drinking alcohol (18% vs an England average of 16%).

The Commissioning Support tool calculates that there are 5,260 adults in Warwickshire in need of alcohol treatment with a slightly greater proportion of these in treatment than the national average (19% vs 18%). It is important for Warwickshire to invest in alcohol treatment at a sufficient level to meet the needs of the 4,257 people (81%) of those in need who are not currently in treatment[65].

62 Department of Health (2016) How to keep health risks from drinking alcohol to a low-level Government response to the public consultation
63 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].
64 Public Health England (2018) Alcohol Commissioning Support: principles and indicators
65 This figure remains constant with the figure of 80.5% for the final quarter of 2021/22 cited in the data report prepared for the Warwickshire drug and alcohol partnership meeting in June 2022.

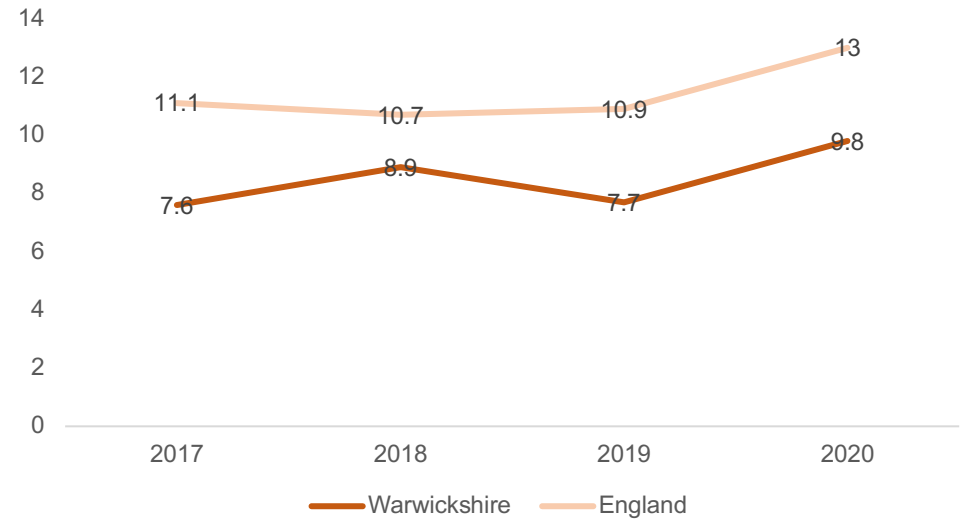
Indicators of Problematic Alcohol Use

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

Alcohol-Specific Mortality

Alcohol specific deaths are recorded as a standardised rate[66] per 100,000 people. The alcohol specific mortality rate for Warwickshire is consistently below the national (England) average as shown in the figure below.

Figure 5 Alcohol Specific Mortality Directly Standardised rate per 100,000 (LAPE)



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 substantially lower in Warwickshire than the national average (a directly standardised rate [DSR] of 517 per 100,000 people compared with 644). However, this overall figure masks the fact that there is a much higher rate of these admissions for under 18s locally (a

66 The adjusted or 'standardised' rate is obtained by dividing the total of expected cases by the standard population.

DSR of 47 per 100,000 vs 31 nationally). Both locally and nationally, these rates are higher for girls than for boys[67].

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[68]. The table below illustrates how Warwickshire compares with the national average for a range of admissions for men and women respectively. Warwickshire rates are slightly below national rates for every type of admission for both men and women with the exception that a slightly higher proportion of local men are admitted to hospital for alcohol-related cardiovascular disease.

Table 2 Alcohol-Related Hospital Admissions by Gender per 100,000 (DSR)

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	Warwickshire	1,516	172.2	87.3	100.7	29.5	38.7
	England	1,482	191.8	95.8	103.8	39.7	39.2
Women	Warwickshire	235	75.9	13.2	44.6	36.9	35.7
	England	239	89.3	13.7	45.3	52.8	36.8

4.1.2. Alcohol Treatment

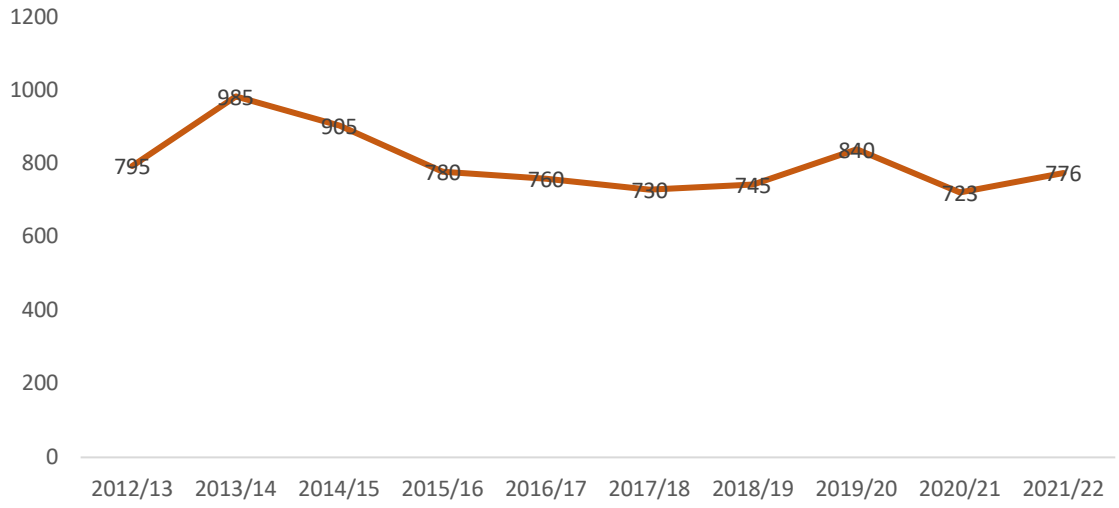
There were 776 adults in treatment solely for their alcohol use in Warwickshire in 2021/22[69], an increase of 53 on the previous year.

Data from the previous year (2020/21) on the demographic profile of this treatment population via the Adult Commissioning support pack shows that exactly three fifths of this treatment cohort (60%) were men with the other two fifths (40%) women; women appear to be slightly under-represented in treatment in Warwickshire compared with the national average of 42%. More than half (55%) of these individuals (52% men and 59% women) started treatment in that financial year, a considerably lower percentage than the national average (which was 68% overall and 68% for both men and women).

As the chart below shows, the figure of 776 is very similar to the number of people in Warwickshire in alcohol only treatment in 2012/13 (795). Despite an increase and fall in annual numbers throughout this time period, this trend closely mirrors the national one with no progress made at a national or local level in expanding the availability of alcohol treatment; this is attributed mainly to cuts in substance misuse treatment budgets over this period.

67 In Warwickshire, measured as a crude rate per 100,000 from LAPE data for the three year aggregated period of 2018/19-2020/21, there were 49.2 alcohol-specific admissions for girls (36.1 across England) and 36.1 for boys (vs 22.8).
68 Statistics on alcohol 2019, NHS Digital
69 Provisional monthly data from NDTMS.

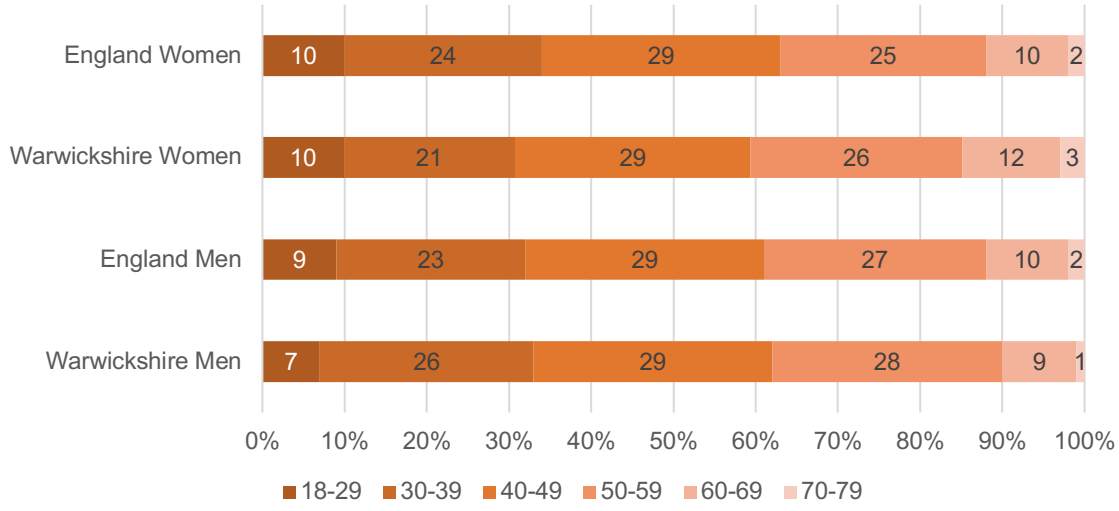
Figure 6 Warwickshire People in Alcohol only Treatment Trend Data (2012/13 – 2021/22) – NDTMS Data



Demographic Profile of People in Alcohol Treatment

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

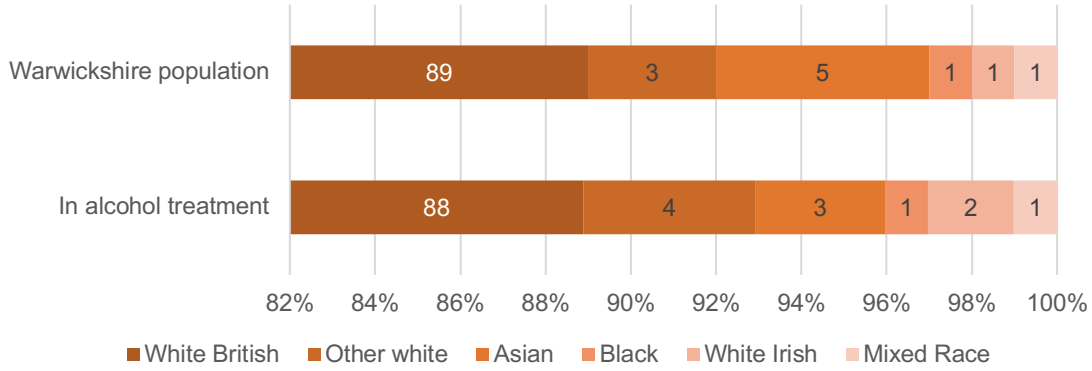
Figure 7 Age Profile of Warwickshire People in Alcohol only Treatment (%) 2020/21



The ethnic profile of people in Warwickshire starting alcohol treatment in 2020/21 is compared to the ethnic profile of the county[70] where it can be seen that Asian people appear[71] to be under-represented in alcohol treatment (3% of new presentations compared to 5% of the local population).

70 Using data from the Warwickshire County Council insights website.
71 We use the term "appear" because the numbers are very small (11).

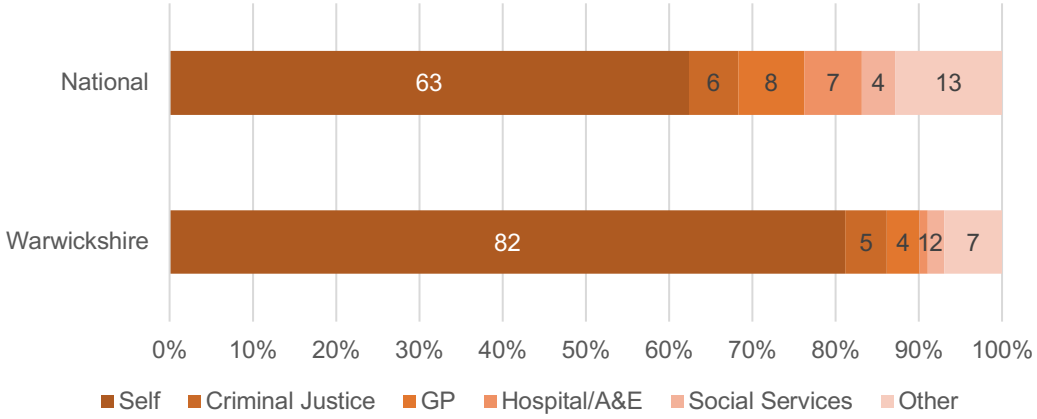
Figure 8 Ethnic Profile of Warwickshire People Starting Alcohol only Treatment (%) 2020/21



Referral Routes into Alcohol Treatment

One area in which Warwickshire differs significantly from the national picture is the routes into alcohol treatment. Locally, both men and women are much more likely to refer themselves into treatment and much less likely to be referred by criminal justice, health, or social services.

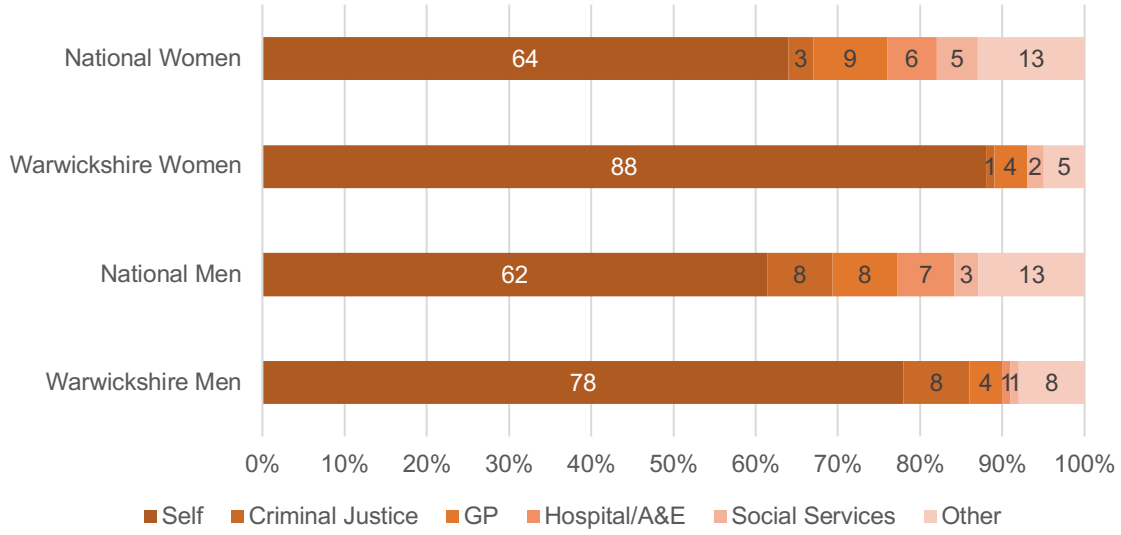
Figure 9 Referral Routes into Alcohol only Treatment (%) 2020/21



The reliance of self-referrals is much more pronounced for women as the chart below shows with 6% women across England referred into alcohol treatment via hospitals or A&E departments compared to 0%[72] in Warwickshire. Similarly, just 4% entered treatment via their GP locally (compared to 9% nationally) and only 2% via social services (5% nationally).

72 Just two women entered alcohol treatment via hospital or A&E referral in Warwickshire in 2020/21.

Figure 10 Referral Routes into Alcohol only Treatment (%) 2020/21



Additional Challenges

Although a greater proportion of local people entering alcohol treatment were identified as having a mental health need (68% compared to 64% nationally), these individuals were less likely to be already engaged with the community mental health team or other mental health services – just 10% compared to 16% nationally.

Local people entering alcohol treatment were recorded as being more likely to be unemployed or economically inactive (50% compared to 41% nationally) although this seems to be explained by the fact that just 9% of Warwickshire people were recorded as being long-term sick or disabled compared to 18% nationally.

The proportion of this cohort having a housing problem was similar to the national average, with 10% compared to 9% nationally, and 2% of people both locally and nationally having an urgent housing problem – being of no fixed abode.

Treatment Outcomes

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[73]. Warwickshire did not share data around brief assessments in primary care in its Alcohol Health Needs Assessment published this year, but the GP Extraction Service (GPES) can be used to monitor how many newly registered patients in a practice have been offered alcohol-related risk reduction screening and interventions or referral[74].

73 Cited in: Warwickshire Alcohol Health Needs Assessment 2022
74 The relevant codes are: FAST screen: 388u; AUDIT-C screen: .38D4; AUDIT score: .38D3; Brief advice: .9k1A; Extended brief advice: .9k1B & Referral to specialist services:.8HkG

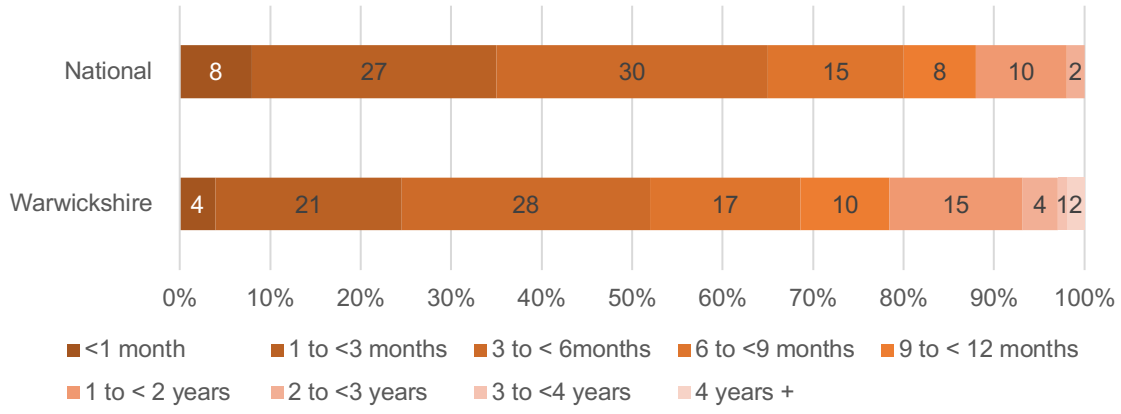
The number of young people, professionals and members of the public receiving brief advice on substance misuse has increased substantially over the last two years from 315 people in the last quarter of 2019/20 to 1,550 in Q3 2021/22[75].

Alcohol Treatment

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

The length of a typical treatment period is just over 6 months, although nationally 12% of adults remained in treatment for at least a year. Retaining adults for their full course of treatment is important in order to increase the chances of recovery and reduce rates of early treatment drop out. Conversely, having a high proportion of adults in treatment for more than a year may indicate that they are not moving effectively through and out of the treatment system. The chart below compares local time in alcohol treatment compared to the national average; there are two significant differences. Firstly, local people are more likely to be retained in treatment for 6 months or longer (47% compared to 35%). Secondly, people from Warwickshire are more likely to remain in treatment for over 1 year (22% compared to 12% nationally). Both these factors contribute to the statistic that people in Warwickshire stay in alcohol treatment for an average of 258 days compared to 192 days nationally.

Figure 11 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 Warwickshire people in treatment (33% vs 37% nationally) left treatment successfully and a slightly smaller proportion successfully completed treatment and did not re-present for 6 months (33% vs 35% nationally). On the other hand, 59% of people in Warwickshire who left treatment in a planned way were abstinent from alcohol compared to 53% nationally; making a bigger reduction in the number of average days they drank alcohol in a 4-week period. Locally people in alcohol treatment reduced the average number of days they drank by 12.3 days (from an average of 19.2 at the start of treatment to 6.9 at exit) compared to a national reduction of 8.8 days (from an average of 20.3 to 11.5).

75 Warwickshire Drug & Alcohol Strategic Partnership Report – March 2022.

4.1.3. Summary of Key Alcohol Trends

Warwickshire has succeeded in engaging constant numbers of people in alcohol treatment over the last decade despite the impact of cuts in public funding. However, like the rest of the country, the county is only succeeding in engaging approximately one fifth of the people in need into treatment. The most effective way of increasing the number of people in treatment is likely to be by improving professional referral routes. If the data regarding referral routes has been correctly recorded, it appears that alcohol services in Warwickshire are highly successful in publicising their services and making them accessible to the general public, but much less effective in developing relationships and effective referral routes with colleagues in health (including hospitals, A&E Departments and GPs) and criminal justice. Warwickshire would, of course, have to invest in extra treatment capacity to meet the needs of people coming from busier professional referral routes. This objective is even more important post-pandemic when a number of studies have reported increases in alcohol consumption[76]. It would also be valuable for Warwickshire 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.

4.2. Drugs

4.2.1. Drug Use Prevalence

There is limited 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[77], 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%).

76 Public Health England (2021) Monitoring alcohol consumption and harm during the COVID-19 pandemic: summary
77 Office for National Statistics (2022) Drug misuse in England and Wales: year ending March 20202

- 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 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 stable.
- 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.

Indicators of Problematic Drug Use

There were 72 drug-misuse deaths[78] in Warwickshire in the 3-year period 2018-20 with a DSR of 4.4 per 100,000[79] compared with a national average of 5 per 100,000. As well as being an important issue to be addressed itself, hospital admissions due to drug poisoning can be an indicator of future deaths. People who experience non-fatal overdoses are more likely to suffer a future fatal overdose. Data included in the Adult Drug Commissioning Pack shows that there were 279 admissions to Warwickshire hospitals for drug poisonings in 2021, a rate of 47.8 per 100,000, slightly below the national rate of 50.2 per 100,000.

The most recent official estimates of opiate and/or crack users in local authority areas are now somewhat out of date and relate to 2016/17. The estimates for Warwickshire were 1,245 crack users, 1,791 opiate users and 1,839 opiate and/or crack users. In every case, the prevalence rate is notably below the national average. Warwickshire was estimated to have 3.6 crack users per 100,000 people aged 15-64 years (compared with a national rate of 5.1), 4.4 per 100,000 opiate users (vs 7.3 nationally) and 5.3/100,000 opiate and crack users (8.9 nationally).

Warwickshire was calculated to be meeting the needs of a greater proportion of these Class A drug users than the national average with 49% crack users not in treatment in 2020/21 (compared to a national rate of 58%), 42% opiate users not in treatment (vs 47% nationally) and 42% opiate and/or crack users 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, trends in seizures of specific substances can helpful and will be considered later in this chapter.

4.2.2. Drug Related Deaths

Nationally[80]

The government has set a target to have *"prevented nearly 1,000 deaths, reversing the upward trend in drug deaths for the first time in a decade"* by the end of 2024-25.

In 2021, 4,859 deaths related to drug poisoning were registered in England and Wales – equivalent to a rate of 84.4 deaths per million people. This is 6% higher than the rate recorded in 2020 and the highest number since records began in 1993 – the rate has increased every year since 2012 after remaining relatively stable

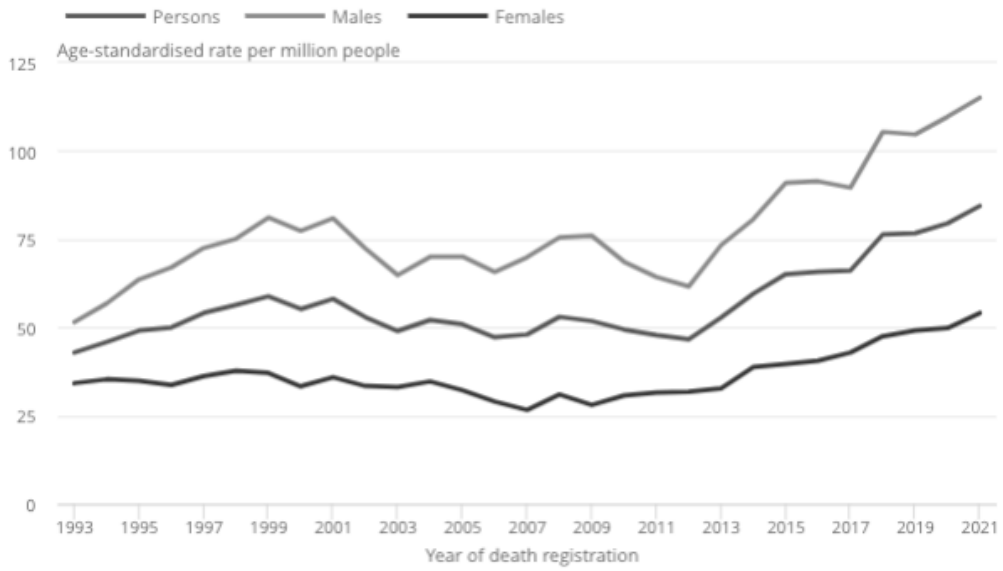
78 A drug misuse death is defined as a death where: the underlying cause is drug abuse or drug dependence and/or the underlying cause is drug poisoning and where any of the substances controlled under the Misuse of Drugs Act 1971 are involved

79 OHID (2022) Adult Drug Commissioning Support Pack (Warwickshire): 2022-23: Key Data

80 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2021registrations#:~:text=1.,(79.5%20deaths%20per%20million).

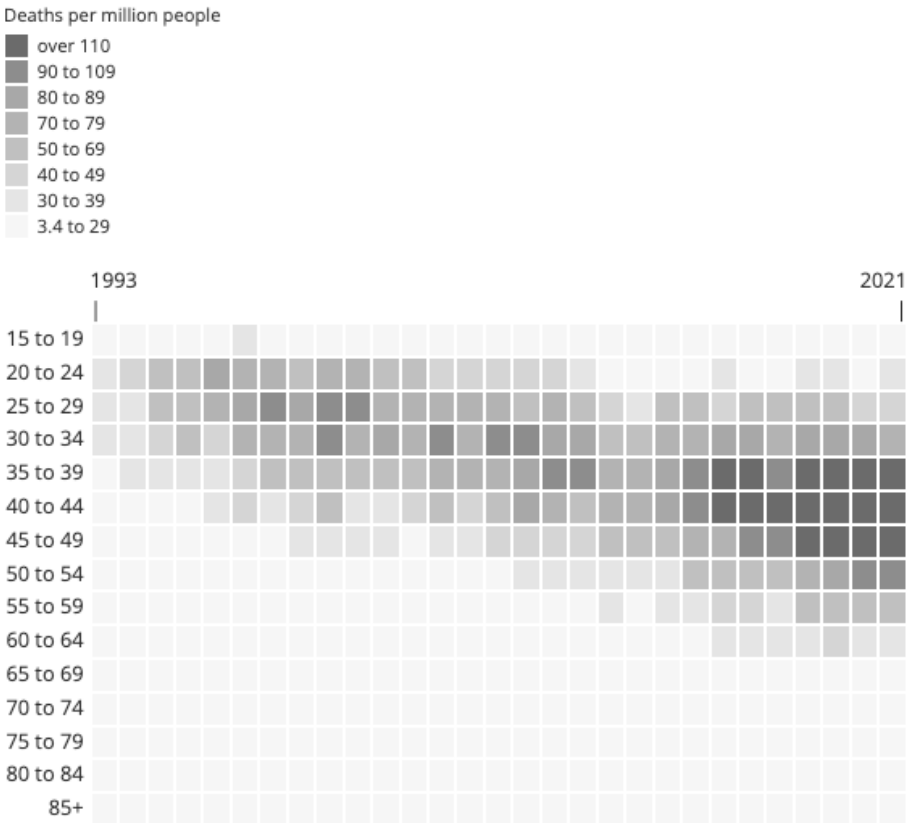
over the preceding two decades. Mortality rates from drug poisoning increased for both males and females in 2021 – see figure below.

Figure 12 Age-standardised mortality rates for deaths related to drug poisoning by sex, England and Wales, registered between 1993 and 2021



There were many more deaths amongst males (3,275) than females (1,584). Rates of drug misuse death were higher among those aged 45 to 49 years, closely followed by those aged 40 to 44 years.

Figure 13 Age-specific mortality rates for deaths related to drug misuse, by age group, England and Wales, registered between 1993 and 2021



The majority (67%) of these deaths were identified as being related to drug misuse. Just under half (46%) of all drug poisoning deaths involved an opiate, with 17% involving cocaine. Cocaine deaths rose for the tenth consecutive year. There has also been a significant increase in deaths involving methadone (663 deaths, 28.5% higher than the previous year). There were 258 deaths involving new psychoactive substances in 2021, 88.3% higher than the previous year. There have also been increases in deaths involving benzodiazepines (13% increase), pregabalin (19% increase), and gabapentin (13% increase).

Across Europe, rates of deaths involving heroin or morphine have been increasing, while the number of new heroin and morphine users has fallen[81]. This indicates higher rates of death among existing long-term drug users. Possible explanations include an ageing cohort of drug users[82] suffering from the effects of long-term drug use and becoming increasingly susceptible to a fatal overdose; new trends in specific drugs, including gabapentinoids[83] and benzodiazepines[84], alongside heroin or morphine, increasing the risk of overdose; and increased disengagement or non-compliance with opiate substitute therapy[85].

The rise in deaths involving cocaine is likely to be a direct consequence of the increasing prevalence in cocaine use in both the UK[86] and Europe[87].

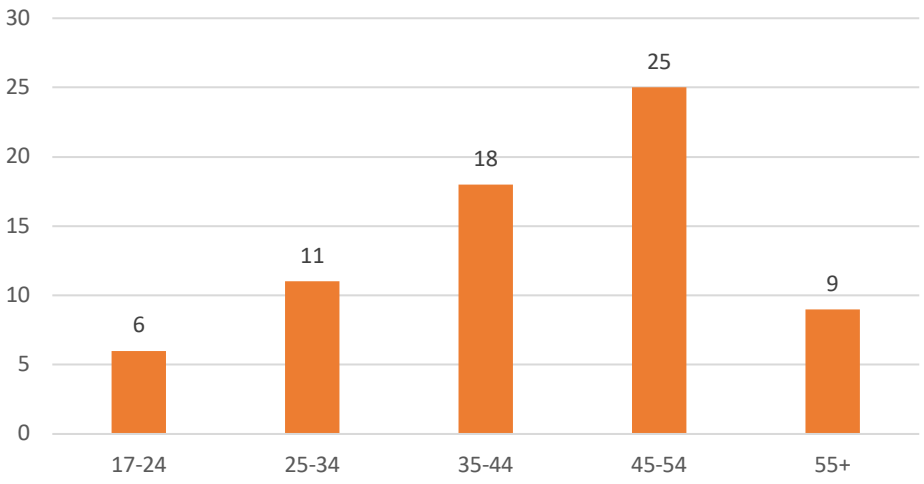
Both cocaine and heroin have been reported to have high availability in recent years, with low prices and high purity levels.[88]

Locally

In Warwickshire from January 2019 to February 2022, 69 drug related deaths were recorded, with 80% male and 20% female. Of these, 10 were drug and alcohol related.

Most drug related deaths (62%) were of people aged 35 to 54, with 25% aged under 35 and 13% aged over 55.

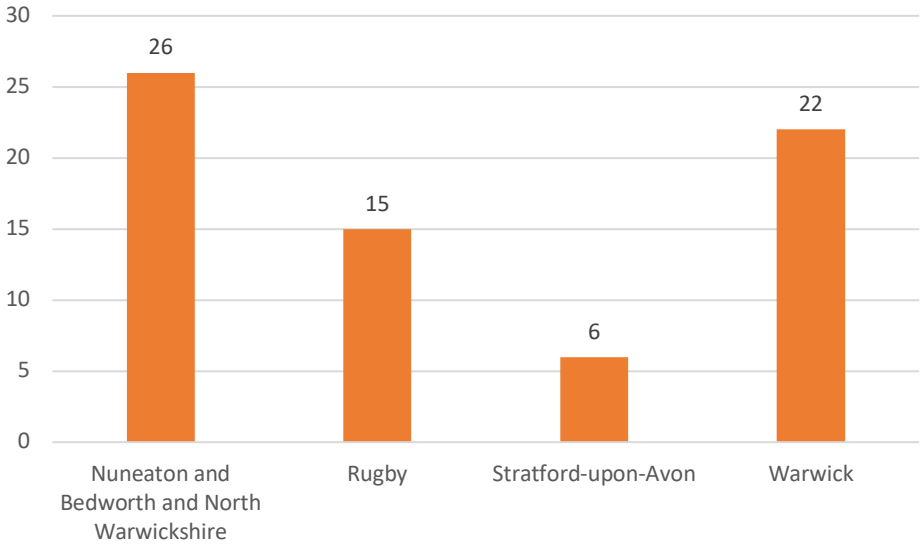
Figure 14 Drug Related Deaths in Warwickshire between January 2019 and February 2022, split by Age



81 https://www.emcdda.europa.eu/publications/edr/trends-developments/2022_en
82 https://www.gov.uk/government/publications/acmd-report-ageing-cohort-of-drug-users
83 https://pubmed.ncbi.nlm.nih.gov/28493329/
84 https://pubmed.ncbi.nlm.nih.gov/31228487/
85 https://www.emerald.com/insight/content/doi/10.1108/DAT-01-2014-0002/full/html
86 https://nationalcrimeagency.gov.uk/who-we-are/publications/533-national-strategic-assessment-of-serious-and-organised-crime-2021/file
87 https://www.emcdda.europa.eu/publications/edr/trends-developments/2022_en
88 https://www.gov.uk/government/publications/review-of-drugs-phase-one-report/review-of-drugs-summary#part-one---the-illicit-drugs-market

Around 1 in 3 drug related deaths were of people who lived in Nuneaton and Bedworth (33%) and in Warwick (32%). Over 1 in 5 (22%) were of people who lived in Rugby.

Figure 15 Drug Related Deaths in Warwickshire between January 2019 and February 2022, split by Area of Residence



- Half (52%) were living with family, friends, or in houses with other residents or support/care, with 36% living alone, and 12% unknown.
- Around 1 in 5 (19%) had been discharged from services in the 3 months before their death, with 23% being open to services at the time of their death.
  There was no information about whether 70% of people had been engaged with any services or not. Where there was information, 16% had been engaged with CGL and 11% had been engaged with mental health services.
- 12% were given naloxone.
- 9% were on their own at their time of death – but in most cases there were people in other rooms in the house.
- 1 in 4 (25%) had previous records of overdose.
- Most overdoses (80%) happened at the individual's home, with only 7% in a public place.
- In half (49%) of instances, opiates were identified on the toxicology report.
- Over half (57%) had a current or historic mental health diagnosis, with 42% not having a mental health diagnosis recorded.
- Over half (59%) had a current physical health diagnosis on record, with 41% having no physical health problem on record.
- The majority (68%) had a history of drug misuse recorded.

Please see Appendix B for data analysis relating to alcohol overdose deaths.

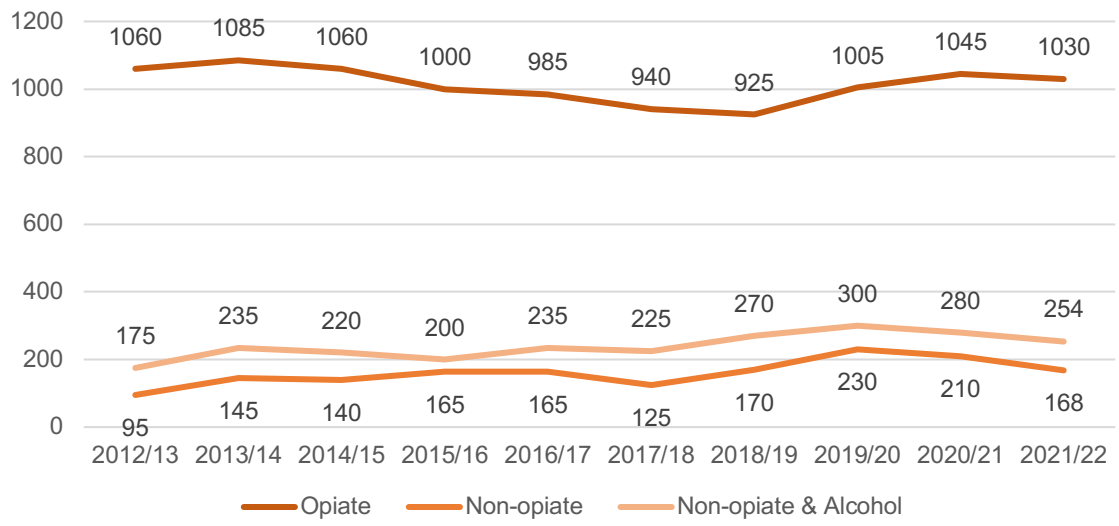
4.2.3. Drug Treatment

There were 1,533 adults in drug treatment in Warwickshire in 2020/21[89], a figure which fell by 5% to 1,452 in 2021/22[90]. Official data separates these into three treatment groups by substance of use: opiate users, non-

89 Data from Adult Commissioning Pack.
90 Provisional monthly data from NDTMS.

opiate users and alcohol and non-opiate users. The chart below shows the trends in Warwickshire over the last decade. The number of opiate users in treatment has remained fairly constant over this 10-year period. The number of non-opiate users more than doubled between 2012/13 and 2019/20 (from 95 to 230) before falling back to 168 in 2021/22. The number of alcohol and non-opiate users rose by 71% (from 175 to 300) between 2012/13 and 2019/20 before falling back to 254 in 2021/22.

Figure 16 Warwickshire People in Drug Treatment Trend Data (2012/13 – 2021/22)

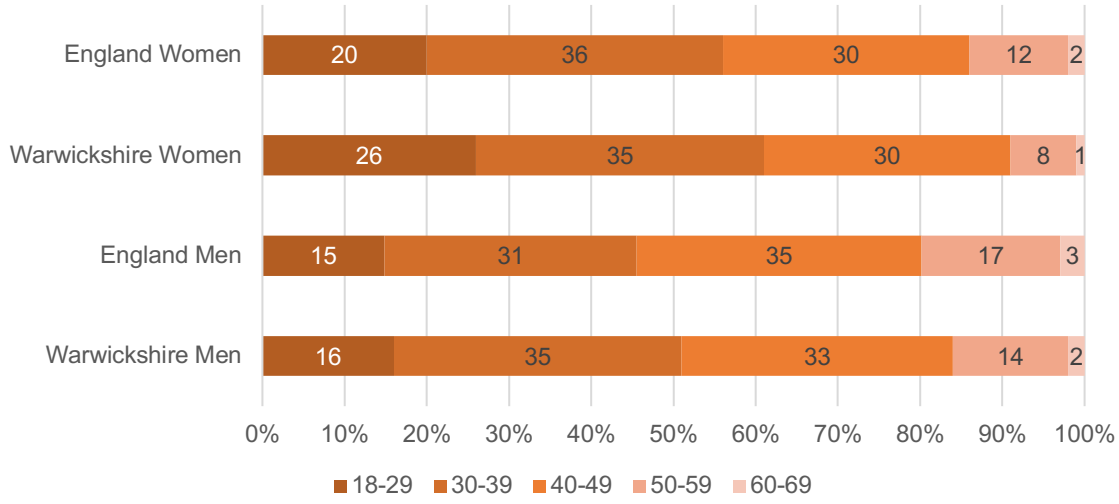


Almost three quarters of people in drug treatment in Warwickshire in 2021 (73%) were men with the other quarter (27%) women; as with alcohol treatment, women are slightly under-represented in treatment compared with the national average of 29%.

Demographic Profile of People in Drug Treatment

The age profile of people in drug treatment in Warwickshire mainly reflects the national picture as shown in the chart below, which provides separate data for men and women.

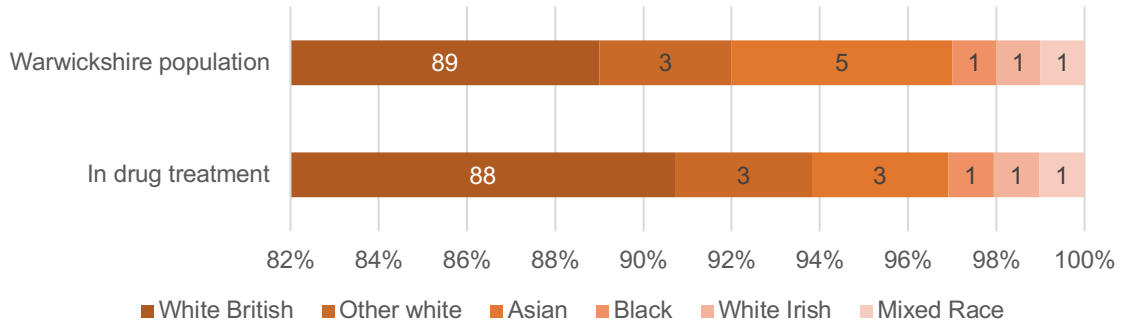
Figure 17 Age Profile of Warwickshire People in Drug Treatment (%) 2020/21



Men in drug treatment in Warwickshire are slightly more likely to be younger than the national average with 16% (compared to 15% nationally) aged 18 to 29 years and 35% (vs 31%) aged 30 to 39 years. Similarly,

there is a higher proportion of younger women in drug treatment in Warwickshire with more than a quarter (26%) aged 18 to 29 years compared to just one fifth (20%) on average across the country.
The ethnic profile of people in Warwickshire starting drug treatment in 2020/21 is compared to the ethnic profile of the county[91] where it can be seen that Asian people (as with alcohol treatment) appear[92] to be under-represented in drug treatment (3% of new presentations compared to 5% of the local population).

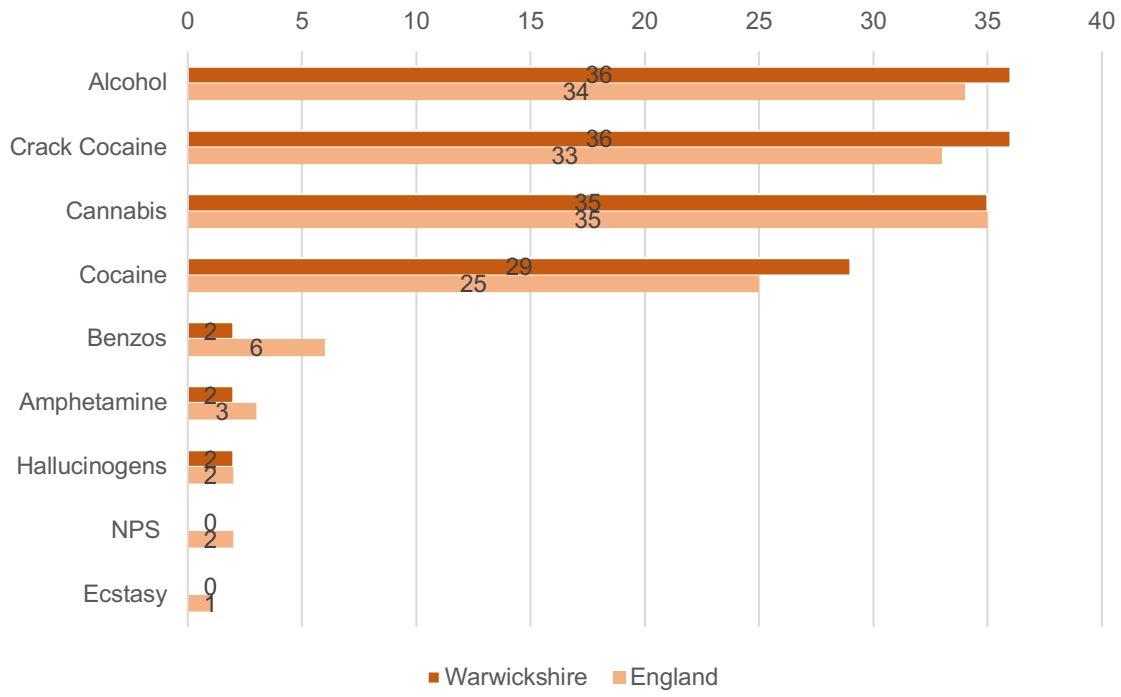
Figure 18 Ethnic Profile of Warwickshire People Starting Drug Treatment (%) 2020/21



Substances Used

The adult commissioning pack shows the most commonly cited substance(s) of all adults starting drug treatment in Warwickshire compared to the national picture in 2020-21. The chart below shows that a greater proportion of people in drug treatment in Warwickshire use cocaine (29% vs 25% nationally) and crack cocaine (36% vs 33%). The high level of crack use locally is corroborated by Warwickshire police[93] who have made more seizures of crack cocaine every year since 2015 within the context of an overall downward trend of total seizures in the county.

Figure 19 Most Common Substances of People Starting Drug Treatment (%) 2020/21

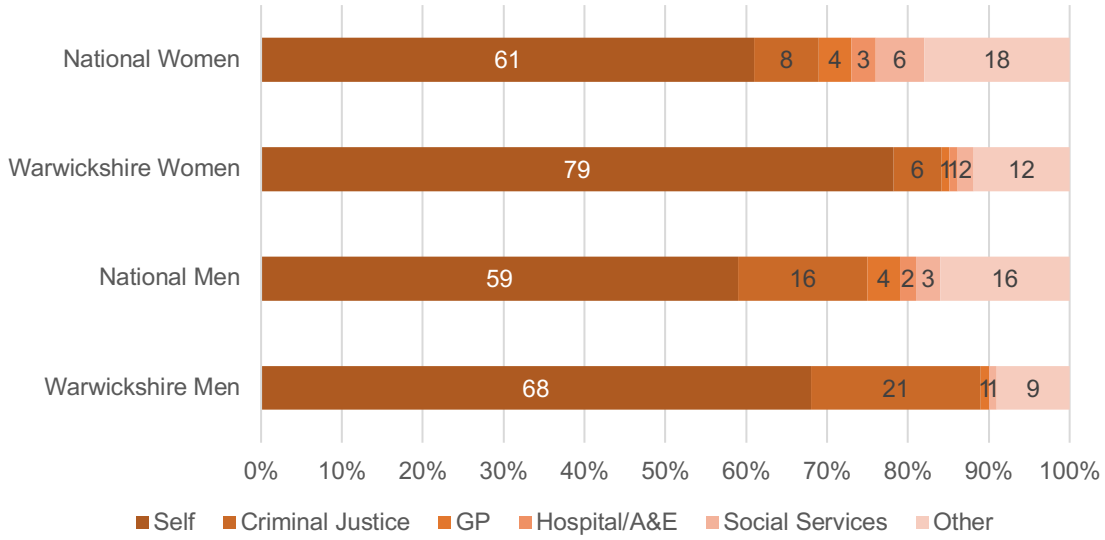


91 Using data from the Warwickshire County Council insights website.
92 We use the term "appear" again because the numbers are small (21).
93 Warwickshire Police (2022) Control Strategy Problem Profile Substance Abuse: Understanding Warwickshire's Drug Market

Referral Routes into Drug Treatment

One area in which Warwickshire differs significantly from the national picture is the routes into treatment. Locally, as with alcohol treatment, both men and women are much more likely to refer themselves into treatment and much less likely to be referred by health or social services. The reliance of self-referrals is much more pronounced for women as the chart below shows with just 1% entering treatment via their GP locally (compared to 4% nationally), and just 2% via social services (6% nationally). Only very small numbers of people enter drug treatment in Warwickshire via hospitals or A&E departments; 0% men[94] (vs 2% nationally) and 1% women (vs 3% nationally). Unlike for alcohol treatment, the criminal justice pathway (for men) is well developed with 21% referrals coming this route compared to 16% nationally.

Figure 20 Referral Routes into Drug Treatment (%) 2020/21



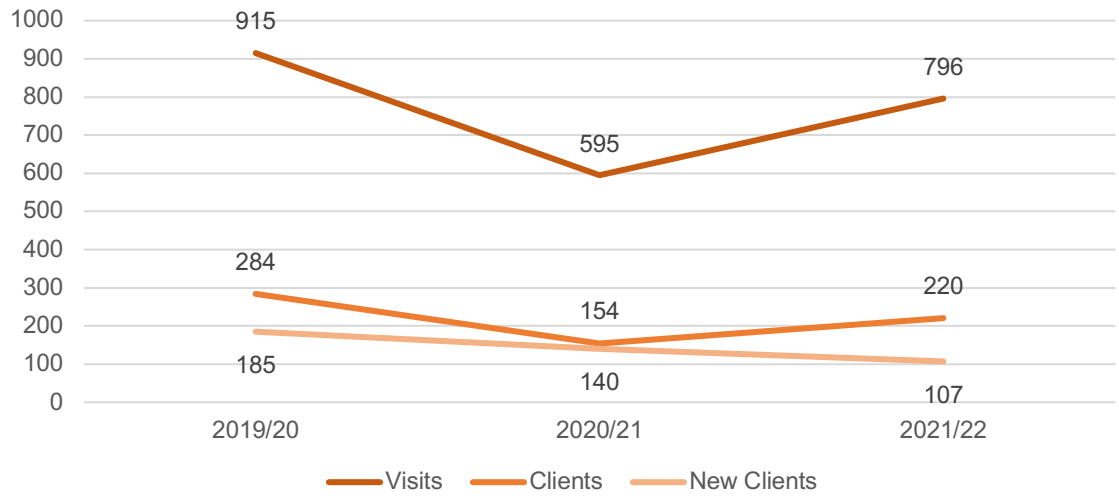
Treatment Interventions

The range of high-level interventions[95] and settings provided to local people in drug treatment reflect the national picture with the exception that much less support is available within primary care. Drug users in treatment locally are much less likely to receive pharmacological support (3% vs 13% nationally), psychosocial support (0% vs 5% nationally) and recovery support (0% vs 3%) in a primary care setting. Expanding provision in this setting would likely increase overall treatment capacity and increase the numbers of treatment referrals from health settings.

Needle exchange provision was affected by the pandemic. We have been able to source data from both the treatment provider and the pharmacy exchange scheme. Data from the provider shows the number of people using needle exchange services fell markedly in 2020/21 but recovered to an extent in 2021/22. The main area of concern shown in the chart below is the continued fall in the number of new clients.

94 Just three men entered alcohol treatment via hospital or A&E referral in Warwickshire in 2020/21.
95 NDTMS defines three high level interventions: Pharmacological interventions are defined as medication based and focused on clinical recovery outcome, psychosocial interventions as non-medication based and focused on clinical recovery outcomes, and recovery interventions as non-medication based and focused on personal recovery outcomes.

Figure 21 Warwickshire People using CGL Needle Exchange Services (2019/20 – 2021/22)



Data from the pharmacy exchange scheme shows a clear downwards trend. The number of pharmacies providing needles and syringes fell from 19 in 2019/20 to 15 in 2021/22 and client registration data for the same 3-year period shows that the number of provisions of equipment or personal interactions fell from a total of 696 in 2019/20 to 505 the following year before falling again to 358 in 2021/22 (just 51% of the total from 2 years earlier).

Additional Challenges

A slightly larger proportion of local people entering drug treatment were identified as having a mental health need (66% compared to 63% nationally), these individuals were less likely to be already engaged with the community mental health team or other mental health services – just 14% compared to 19% nationally.

Local people entering drug treatment were recorded as being more likely to be unemployed (63% compared to 50% nationally) with much of this discrepancy possibly explained by the fact that just 11% Warwickshire people were recorded as being long-term sick or disabled compared to 21% nationally.

The proportion of this cohort having a housing problem was similar to the national average, with 23% compared to 22% nationally, and 8% people both locally and nationally having an urgent housing problem – being of no fixed abode.

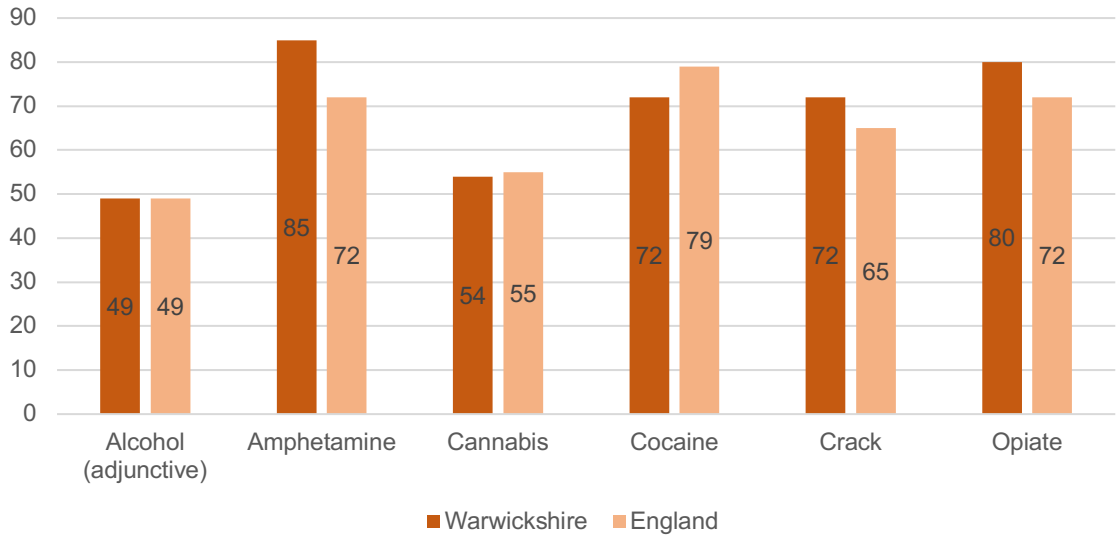
Treatment Outcomes

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 Warwickshire opiate users in treatment for this period of time (21%) is smaller than 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 use and injecting. Data from the National Drug Treatment Monitoring System (NDTMS) suggests that adults who stop using illicit opiates in the first 6 months of treatment are almost five times more likely to complete successfully than those who continue to use. The chart below shows the proportions of people who are either abstinent from specific substances or have significantly reduced their use at their 6-month review. Compared to the national cohort, more people in treatment in Warwickshire have abstained

from or significantly reduced their use of opiates (80% vs 72%), crack cocaine (72% vs 65%), and amphetamines (85% vs 72%). Conversely, fewer local people have reduced their cocaine use (72% vs 79%).

Figure 22 Abstinence / Significant Reductions by Substance of People Starting Drug Treatment (%) 2020/21



A slightly smaller percentage of local people in treatment had stopped injecting at their 6-month review (61% vs 63% national).

The proportions of people successfully completing treatment who did not re-present within 6 months for the 2021/22 year was identical to the national average for opiate users (5%) but lower for non-opiate users (which for this data includes those using non-opiates and alcohol; 31.2% vs 34.5%)[96].

Warwickshire has been slightly more successful than average in providing continuity of drug treatment for people released from prison, engaging 43.8% into structured treatment people compared to a national average of 38.1%.[97]

4.2.4. Summary of Key Drug Trends

Warwickshire has succeeded in engaging constant numbers of local people into drug treatment throughout the pandemic and in meeting the needs of a greater than average proportion of people in need.

There remains the same concern as for alcohol treatment (again, with the provision that the data regarding referral routes has been correctly recorded) with relatively unused referral pathways with colleagues in health (including hospitals, A&E departments and GPs) and social services. It also appears that Asian people are under-represented in treatment and the Drug and Alcohol Partnership should explore the reasons for this and how to improve treatment uptake amongst local Asian communities.

Warwickshire works with a higher proportion of crack cocaine users than the national average with police reporting high availability of/demand for crack cocaine locally. Warwickshire's treatment services are above average in successfully helping people using crack cocaine to reduce their usage but below average in terms of re-presentation rates for the non-opiate group (the data does not provide specific data for crack cocaine users within this group).

96 Data taken from report to the Drug and Alcohol Strategic Partnership June 2022.
97 Office for Health Improvement & Disparities (2020/21) Public Health Outcomes Framework Indicator C 20.

4.3. 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 OHID, 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.

4.3.1. Young People Substance Use Prevalence

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 in December of that year[98], 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 to19-year-olds had used any drug in the previous year, much lower than the 31.8% equivalent figure in 1995, but the highest rate since 2011 (23.3%). The literature review contains information on particular vulnerable groups of young people, known to be more prone to substance use. Around 1 in 12 (8.7%) young people aged 16-24 years old said they had used nitrous oxide in the year to 2019/20, an identical rate to the previous year.

Indicators of Young People's Problematic Substance Use

As previously stated, there is a substantially higher rate of hospital admissions for alcohol-specific conditions for under 18s locally (a DSR of 41.1 per 100,000 vs 29.3 per 100,000 nationally). Both locally and nationally, these rates are higher for girls than boys[99].

The proportion of children aged 10 to 17 years who enter the criminal justice system for the first time is markedly lower in Warwickshire (27%; a crude rate of 123 per 100,000 children of this age) than nationally (169 per 100,000)[100].

The proportion of looked after children identified as having a substance misuse problem in Warwickshire (2%) is lower than the national average (3%). However, the number of statutory social care assessments including the 'alcohol misuse – child' factor undertaken in 2020/21 was higher than the national average (2.9% vs 2.4%)[101].

Similarly, the proportion of school exclusions related to drugs and alcohol in Warwickshire (2%) is lower than the national average (3%).

The Warwickshire homelessness strategy[102] reports that young people (aged 16 and 17 years old) comprised 2% (a total of 49 cases) of the households officially designated as being owed a homelessness duty in 2019/20.

98 Office for National Statistics (2022) Drug misuse in England and Wales: year ending March 2020
99 In Warwickshire, measured as a crude rate per 100,000 from LAPE data for the three year aggregated period of 2018/19-2020/21, there were 49.2 alcohol-specific admissions for girls (36.1 across England) and 36.1 for boys (vs 22.8).
100 All data in this section comes from the (2022/23) Young People Substance Misuse Commissioning Support Pack for Warwickshire, unless otherwise indicated and refers to the financial year 2020/21.
101 Data included in the report prepared for the Warwickshire drug and alcohol partnership meeting in June 2022
102 Warwickshire CC (2020) Preventing Homelessness in Warwickshire: a multi-agency approach

4.3.2. Young People in Structured Treatment

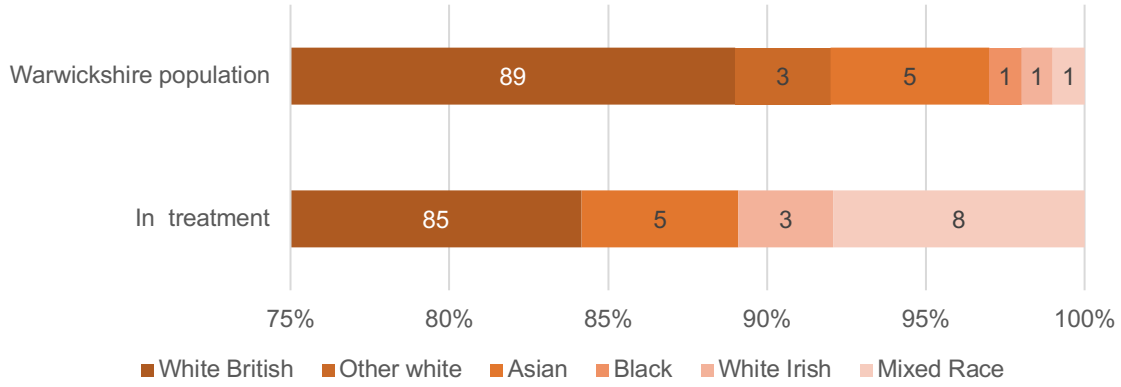
The numbers of local young people in community structured treatment (those under 18 and those aged 18-24 in young people's services but not counting those in adult drug and alcohol services) is low, a total of 70 in 2020/21 with 43 starting treatment in that financial year. For this reason, although national comparisons are still provided, readers should be aware that these are not as robust as those provided in our analysis of the adult treatment data. This low number (a reduction of 64% since 2009/10) is not atypical with a national drop of 41% young people in treatment over the same decade and equivalent falls of 83% in Worcestershire and 72% in Gloucestershire, two of Warwickshire's comparator counties[103].

Demographic Profile of Young People in Structured Treatment

Young people in treatment are much more likely to be female (53% vs 36%) than the national average, with this apparently being a consistent and growing trend with 56% of those starting treatment in 2020/21 girls or young women compared to a national figure of 35%.

The ethnic profile of Warwickshire young people in treatment in 2020/21 is compared to the ethnic profile of the county[104]. However, conclusions are hard to draw as the ethnic profile of young people in Warwickshire is likely to differ from the profile of the overall population.

Figure 23 Ethnic Profile of Young People in Treatment (%) 2020/21

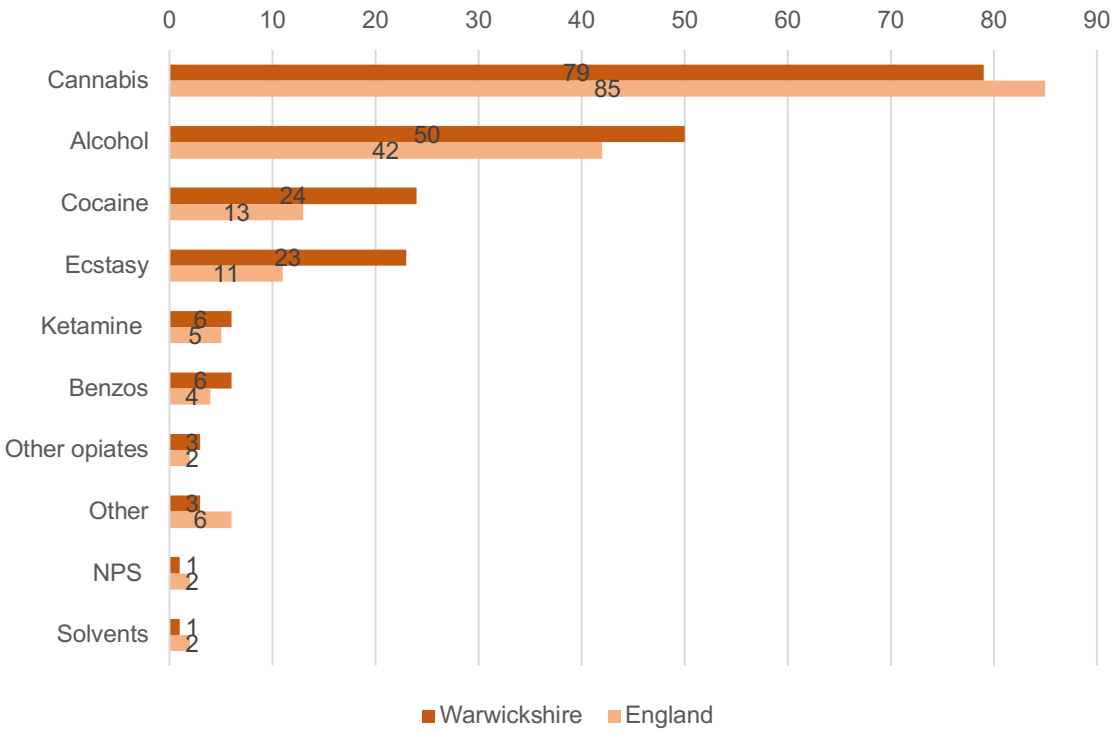


Substances Used

The commissioning pack shows the most commonly cited substance(s) of young people in treatment in Warwickshire compared to the national picture in 2020-21. The chart below shows that a greater proportion of young people in treatment in Warwickshire report using cocaine (24% vs 13% nationally), ecstasy (23% vs 11%), and alcohol (50% vs 42%). Conversely, fewer local young people reported usage of cannabis (79% vs 85 nationally), solvents (1% vs 2%), and new psychoactive substances (also 1% vs 2%).

103 Warwickshire County Council (2019) Adult Social Care Outcomes Framework - 2017/18 outturns Insight Service Briefing Note
104 Using data from the Warwickshire County Council insights website.

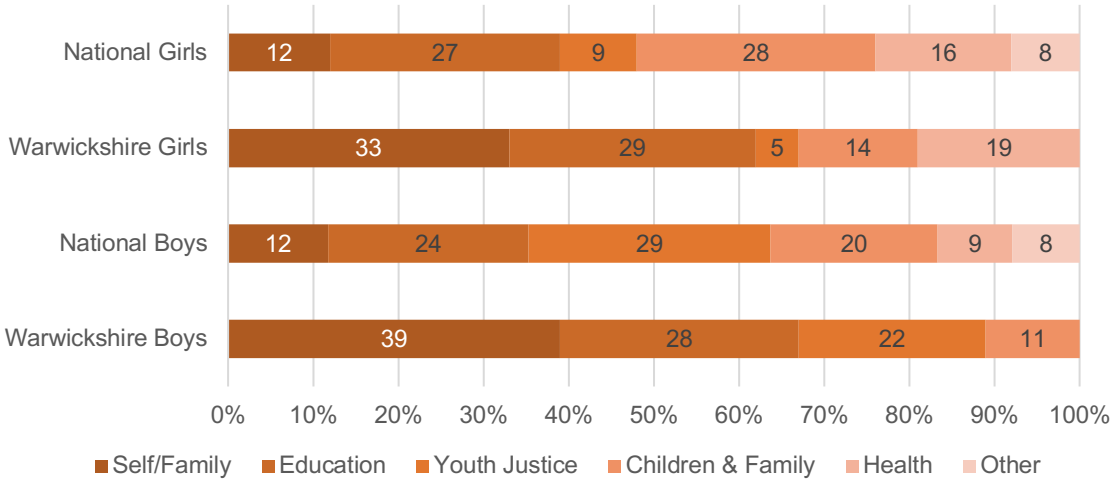
Figure 24 Most Common Substance of Young People in Treatment (%) 2020/21



Referral Routes into Structured Treatment

The smaller proportion of boys and young men in structured treatment may be partly explained by the lower proportion of referrals of boys (22% vs 29% nationally) from youth justice. The chart below provides a detailed breakdown which shows that the most common referral route locally is from the young person themselves or their family and friends. Referrals from youth justice, children and family services, and health (particularly for boys where there were no referrals in 2020/21) are much less frequent in Warwickshire than there are nationally.

Figure 25 Young People's Referral Routes into Treatment (%) 2020/21



Additional Challenges

There was a higher proportion of young men in treatment in Warwickshire with recorded mental health needs than nationally (44% vs 35%). Nevertheless, a mental health need was more common among young women, in line with the national picture (57% compared to 56% nationally). Half of these young people were already engaged in specialist treatment (compared to a national average of 55%).

Just over one fifth (21%) young people in treatment in Warwickshire 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 supported accommodation (8% compared to a national figure of 4%); although, none were living in care (compared to 7% nationally).

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. Warwickshire children in treatment are more likely to be involved in self-harm (21% vs 16% nationally) but less likely to be involved in anti-social behaviour (3% vs 21%), be affected by domestic abuse (5% vs 15%) or by others' substance misuse (5% vs 14%). They are also less likely to be a child in need (5% vs 9%) or be looked after (no-one locally but 8% nationally).

Treatment Outcomes

A total of 29 children under 18 successfully completed treatment in Warwickshire during 2020 with 93% not re-presenting to services within 6 months – this compares with a similar national non re-presentation rate of 96%.

4.3.3. Young People's Summary

Warwickshire faces the same challenge as most of the country in terms of engaging more young people in drug and alcohol treatment. Reported use of drugs among young people has been increasing over recent years while numbers in treatment continue to fall. The small number of boys and young men in treatment is a particular concern locally and, as with adult services, the first step appears to develop referral pathways with other professional groups with referrals from health service (particularly for boys), children and family services (particularly for girls) as well as criminal justice pathways (for both) priority areas. The relatively high numbers of local boys and girls admitted to hospital for alcohol-specific conditions (mainly self-poisoning and accidents) provides an opportunity to develop referral pathways.

Although numbers are small, it appears that cocaine and ecstasy use may be high locally and strategies to engage young people using these substances would, again, be a useful starting point to address unmet need.

5. KEY 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 Drugs Needs Assessment.

Quotes have been used throughout to illustrate that the findings are grounded in participants' voices – while we have restricted the number of quotes per point, for most areas, there were many more that could have been used to evidence the themes.

5.1. Sample Overview

For this Drugs Needs Assessment that TONIC conducted on behalf of Warwickshire County Council, a total of 402 people engaged with the online survey, of these, 367 were considered to be 'high quality' responses[105], gaining the views of:

- 35 individuals with direct lived experience of substance use
- 29 individuals responding on behalf of someone with lived experience of substance use
- 303 professionals that work directly or indirectly with people with substance use.

In addition, through a mixture of in person and virtual engagement, in-depth interviews, and focus groups, TONIC captured the opinions and experiences of:

- 132 individuals with lived experience of substance use (including current service users, individuals not accessing support, and family and friends of those using substances)
- 52 professionals that work directly or indirectly with people with substance use.

The majority of fieldwork for this needs assessment was conducted between 29th June and 21st August 2022, including researchers observing and engaging with various virtual sessions between 4th and 13th July and spending 3 days onsite in Warwickshire between 9th and 11th August 2022. The table below summarises some of the work TONIC undertook in person (the table excludes details of individual interviews conducted virtually or outside of the dates stated).

Table 3 Summary of TONIC Fieldwork – Observations and Engagement

	Virtual 04/07/2022 – 13/07/2022	In Person 09/08/2022 – 11/08/2022		
Site Visit Locations:	• Zoom	• Helping Hands • CGL Nuneaton • CGL Leamington Spa • CGL Stratford (Fred Winter Centre)	• CGL Nuneaton • CGL Rugby • CGL Leamington Spa • CGL Stratford (Fred Winter Centre including Spring Housing) • Compass Outreach Appointment	• CGL Nuneaton (+ St Nic's Church) • CGL Stratford (Fred Winter Centre + Bidford Health Centre)

105 While all responses were examined and considered in the analysis, 'high quality' survey responses were those in which the participant had answered most of the survey questions shown to them.

Observations:	CGL: • 5x attendees at Mindfulness Monday open group session • 3x attendees at Mindfulness Wednesday open group session • 4x attendees at Mindfulness Sunday open group session • 7x attendees at Peer Support open group session • 6x attendees at SMART Recovery open group session • 4x attendees at Foundations of Growth group session • 2x attendees at Alcohol Awareness open group session • 4x attendees at Family & Carers open group session	Helping Hands: • 11x attendees at breakfast session CGL: • 8x prescribing appointments during NMP Clinics • 1x personal assessment meeting	CGL: • 3x one-to-one appointments • 1x phone assessment • 1x joint appointment with P3 • 3x prescribing appointments during NMP Clinic • 2x prescribing appointments during GP Clinic • 1x CJ discharge appointment • 1x health check appointment • 6x attendees at Foundations of Change group session • Hep C staff training session	Fred Winter Centre: • breakfast club and housing CGL: • 4x prescribing appointments during NMP Clinics • 5x attendees at Peer Support group session • 6x attendees at Foundations of Growth group session • 2x attendees during Time to Talk Session
Lived Experience Engagement[106]:	35	21	23	23
Professional Engagement:	Not applicable	10	12	1

In addition, we have considered feedback received regarding the Substance Misuse Services and their Criminal Justice offer based on information gathered for the Comprehensive Victim Needs Assessment conducted by TONIC for the Warwickshire Office for Police and Crime Commissioner (OPCC). This took place between October 2021 and February 2022. Specifically, this included contributions from 18 CGL staff members and 7 Compass employees via the online survey, 3 CGL and 4 Compass staff interviews, 14 external stakeholders who provided feedback about CGL within their interview and 11 who commented on Compass.

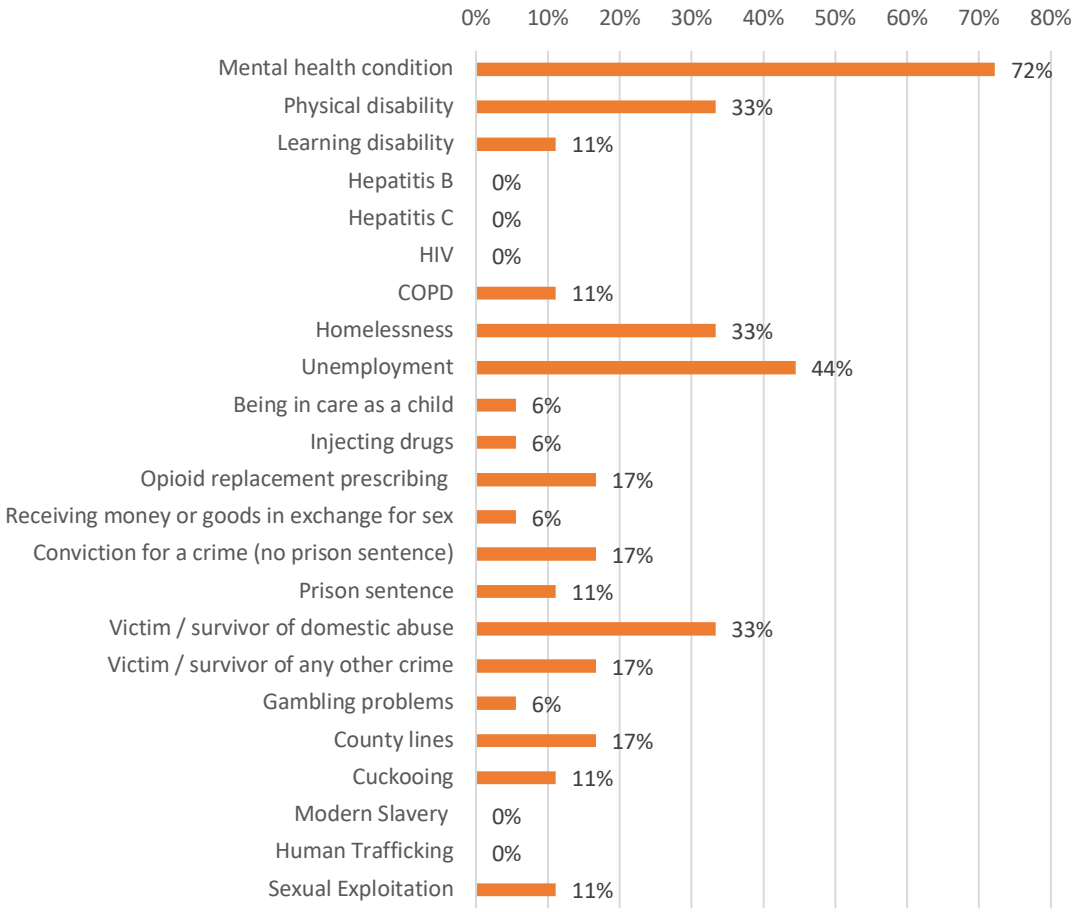
106 Number for lived experience engagement may not correspond to the numbers stated within our observations as some individual interviews took place when service users dropped into CGL hubs, or where they were happy to provide feedback but did not want a researcher to sit in on their appointment.

5.1.1. Lived Experience

Our sample consisted of individuals with lived experience of substance use from all districts and boroughs across the whole of Warwickshire. A higher proportion of our sample considered themselves to be in 'active addiction' as opposed to being 'in recovery' and most commonly described their use as 'multiple times per day'. In terms of substances of choice, the most common were heroin and crack cocaine, but the commonality of polysubstance use meant that the majority of the sample disclosed multiple substances of choice, which included a mixture of the following: alcohol, cocaine, cannabis, codeine, pregabalin, gabapentin, diazepam, tramadol, ketamine, amphetamines, ecstasy (MDMA), crystal meth, illicit methadone, buprenorphine or morphine, modafinil, and various psychedelics like magic mushrooms, psilocybin, and lysergic acid diethylamide.

Participants with lived experience ranged in age from 16 to 61 years, with a slightly higher proportion of males engaging with the needs assessment. Almost all identified as having a White ethnicity (although through in person interviews, we did speak to a small number of individuals who identified as Black, Asian, or Mixed ethnicity), and the vast majority who disclosed their sexual orientation said they were heterosexual. A significant proportion of our sample (especially those we engaged with in person) reported having 'additional needs', in particular difficulties with their mental health, issues surrounding housing and homelessness, and many had been in contact with the criminal justice system and received prison sentences. The graph below displays the range of issues the survey sample disclosed having experienced, demonstrating that TONIC engaged with a diverse range of individuals as part of this needs assessment.

Figure 26 Experiences and 'Additional Needs' of the Lived Experience Survey Sample (n = 18)



5.1.2. Professionals

The sample of professionals who engaged with this needs assessment also covered all districts and boroughs across the whole of Warwickshire – many having countywide roles, as well as some involvement of key stakeholders from the wider West Midlands region. It is important to note that some of those who responded to the survey or participated in interviews within a professional capacity, also themselves disclosed having lived experience of substance use. Indeed, Substance Misuse Services are known to often employ a high proportion of staff who are in recovery.

The types of stakeholders TONIC gained the views of as part of this needs assessment included, but was not limited to:

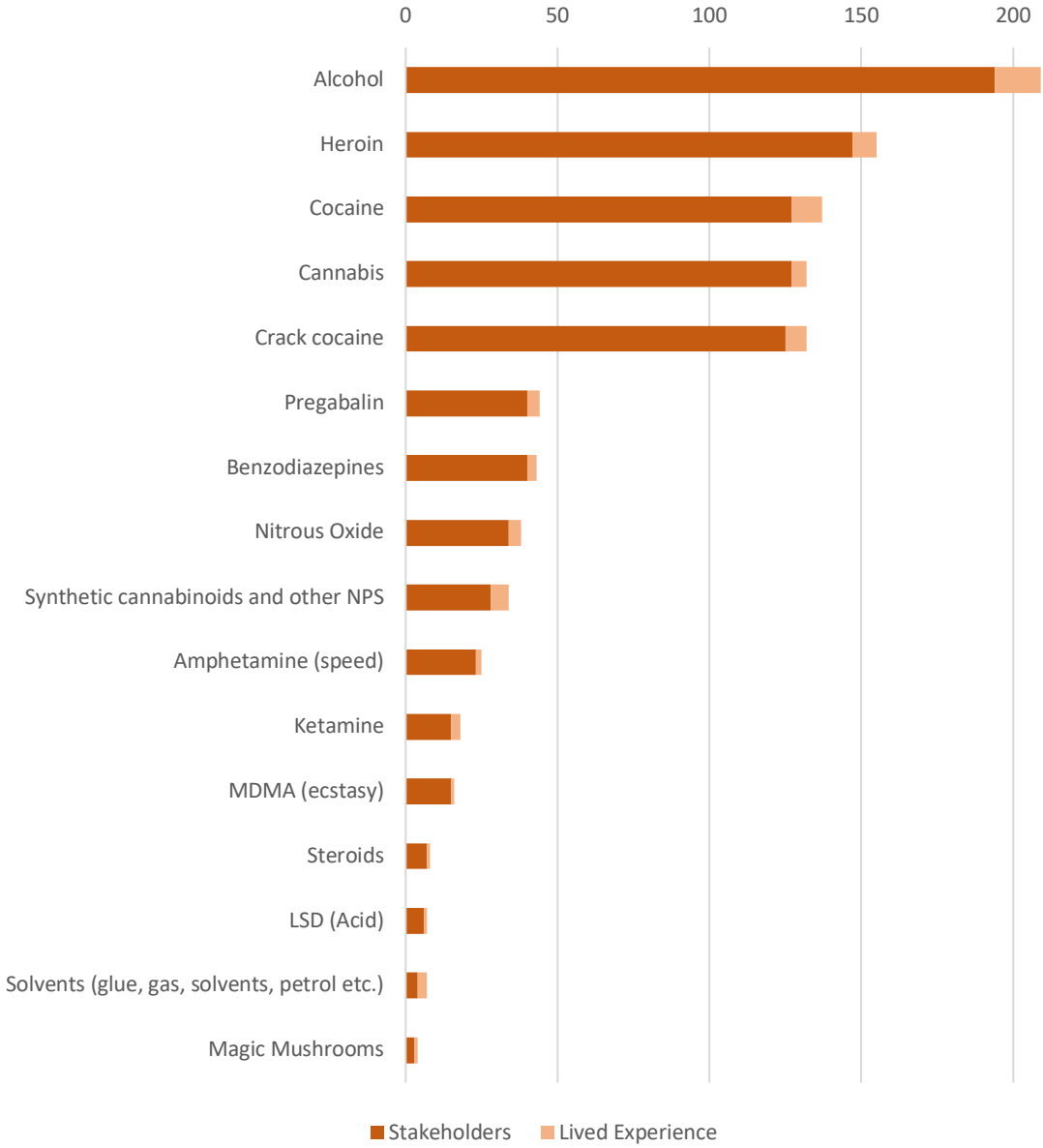
- Local Commissioners
- District / Borough Council and County Council representatives
- Office for the Police and Crime Commissioner (Warwickshire and West Midlands)
- Community Substance Misuse Services including Change Grow Live (CGL), Compass, and Street Scene Addiction Recovery Ltd
- Coventry and Warwickshire Family Drug and Alcohol Court
- Prison Substance Misuse Services including Inclusion within HMP Hewell, Phoenix Futures within HMP Onley and Rainsbrook Secure Training Centre
- Residential Rehab providers including Sefton Park Residential Treatment Centre, Tom Harrison House, and Willowdene Rehabilitation Ltd
- Police of varying ranks and roles
- Her Majesty's Prison and Probation Service including individuals working on implementing the new drug strategy within prisons across the West Midlands and Probation Officers
- The Coroner's Office
- Community Safety Teams
- Data Analysts
- Healthcare Professionals from all local NHS Trusts, The George Elliot Hospital, and Warwick Hospital
- GPs and Nurses from various Surgeries and South Warwickshire GP Federation
- Mental Health and Wellbeing Services including Improving Access to Psychological Therapies (IAPT), Flourish, and Together for Mental Wellbeing
- Counselling providers including Family Intervention Counselling Service, New Hope Counselling, and Western Counselling
- Accommodation, Housing, and Homelessness Support Services including Cyrenians, Helping Hands Community Project, Hope4 Rugby, LWS Night Shelter, P3 Charity, Spring Housing, St Basils, The Salvation Army, and Young People First
- Food Banks
- The Department for Work and Pensions
- Education Providers - headteachers, schoolteachers, college tutors, and representatives from the University of Warwick
- Children and Families Service
- Early Help
- Social Care
- Social Workers
- General Victim Recovery Services including Victim Support
- Domestic Abuse Services including Refuge
- The Sexual Assault Referral Centre (SARC)

- Rape or Sexual Assault Support (RoSA) – Independent Sexual Violence Advisors (ISVAs) and Children's Independent Sexual Violence Advisors (ChISVAs)
- Child Exploitation Support Services including Barnardo's
- By and for organisations including Equality and Inclusion Partnership (EQuiP).

5.2. Local Trends in Substance Use

Regarding trends in substance use across Warwickshire, largely those with lived experience and professionals agreed that the most prevalent substances of choice are alcohol, heroin, cocaine, crack cocaine, and cannabis and that the first four are those causing most harm to Warwickshire residents. Particularly within the survey, participants felt these substances are *"too readily available"*, *"easy to access"* and *"relatively cheap to buy"*. We heard reports that ketamine oscillates as a substance of choice, being a theme in 2021 and resurfacing again more recently.

Figure 27 Substances rated as Prevalent and Causing Most Harm in Warwickshire by Survey Respondents



"Over the last few years alcohol use has skyrocketed." (CGL Staff Interview)

For staff working within the criminal justice system, fentanyl was also mentioned on a few occasions, as was amphetamines. Within the prisons across the West Midlands, stakeholders said *"predominantly our main issue is synthetic cannabinoids… hooch periodically, and cannabis."*

Illicit pregabalin and benzodiazepines like Xanax and Diazepam also appear to commonly be misused across Warwickshire. Interestingly, amongst adult clients on scripts, CGL staff reported recently seeing an increase in people misusing prescribed antipsychotic medication like olanzapine and quetiapine, and people believed this may become more widespread as people start to sell their prescribed medication more regularly to help fund daily essentials during 'the cost-of-living crisis'.

Specifically, amongst young people, participants described alcohol, cannabis, ketamine, ecstasy (MDMA), and nitrous oxide[107] as the prominent trends, as well as observing an increase in vaping with cannabis oils.

> *"I'd say definitely trends are always cannabis and alcohol. I think we're seeing a lot more synthetic stuff like we're seeing the use of vaping has massively increased, but they're using synthetic oil, or cannabis oils within that… you'll always get a mix, you'll get an influx of ketamine sometimes, but cannabis and alcohol are always going to be the main ones for young people." (Stakeholder Interview)*

Some of the young people interviewed raised concerns around trends in drug use online and how social media portrays substance use, and the influence this is subsequently having on young people both within Warwickshire and nationally, with very little awareness around the associated dangers and risks.

> *"The issue is social media completely glorifies drug addiction, especially on Tik Tok. I've recently been on Tik Tok and they have this thing called Ping Tok where young people aged 13, 14, 15 years old are taking pills like ecstasy and then posting videos online… you see thousands and thousands of videos of children under the age of 18 using MDMA or using ketamine and posting it on Tik Tok and it glamorises it - they put flashing lights in the background to make it seem cool… it's really really bad and CGL and Compass need to start paying attention to what goes on social media and the influence that can have on young people's drug abuse. It's really really sad." (Young Person Lived Experience Interview)*

Spice does not appear to be a common substance of choice within Warwickshire and was described as a drug people only tend to misuse in prison rather than in the local community, which is different to what has been found in some of the surrounding areas in the West Midlands.

Generally, COVID-19 was thought to have increased consumption of substances, particularly as a form of coping due to social isolation, boredom, or deteriorating mental health at a time with reduced access to support. Although, local and national lockdowns were described as helping some individuals to focus on their recovery without the influence of external distractions.

> *"Nitrous oxide is a real problem for young people in Warwickshire and I think it rocketed again because of COVID because they were bored. It's not illegal to possess and it dissipates from the system very quickly, so it's not traceable. I think for a lot of young people, it's like, 'oh,*

107 In response to the increase in young people using nitrous oxide, Compass applied for and received £5,000 in grant funding in 2021-22 for a 'Feeling Gassed' project which sought to address the growing nitrous oxide use amongst young people in Rugby. It aimed to engage three schools most associated with the identified hotspots and delivered a range of activities including assemblies, awareness campaigns, and group work on the personal risks of nitrous oxide use, the impact on the community, and where help can be accessed. This is one example of Warwickshire's Children and Young People's Drug and Alcohol Service being responsive to local trends.

well, I won't get in trouble for this'… you see gas canisters littered everywhere, especially in the parks." (Stakeholder Interview)

"Alcohol use in young people has gone up significantly since the pandemic began. I think there's probably a number of reasons for that; we know that alcohol use went up across the board because of stress, boredom, unhappiness, etc. I think it has also probably been easier for young people to get hold of alcohol, particularly at the beginning of the pandemic." (Stakeholder Interview)

A concern that stakeholders were quick to highlight is that drug-related deaths in Warwickshire appear to be disproportionately high for the size of the county, with very little understanding of the reasons behind this.

5.3. Breaking Drug Supply Chains

This part of the national Drug Strategy sets out to make the UK a significantly harder place for organised crime groups to operate, by stepping up the response to the supply of the most harmful drugs, attacking all stages of the supply chain, reducing the associated violence and exploitation, and protecting prisons from being academies of crime, by:

1. **Restricting upstream flow** – preventing drugs from reaching the country
2. **Securing the border** – a ring steel to stop drugs entering the UK
3. **Targeting the 'middle market'** – breaking the ability of gangs to supply drugs wholesale to neighbourhood dealers
4. **Going after the money** – disrupting gang operations and seizing their cash
5. **Rolling up county lines** – bringing perpetrators to justice, safeguarding and supporting victims, and reducing violence and homicide
6. **Tackling the retail market** – so that the police are better able to target local drug gangs and street dealing
7. **Restricting the supply of drugs into prisons** – using technology and skills to improve security and detection.

When we explored current initiatives within Warwickshire to break drug supply chains into and across the county, participants often spoke to us about people being in denial of how bad drug use and supply is, and as such felt that Warwickshire has *"more of a reactive model currently".* Some participants felt that working to make improvements that restrict supply would be crucial to having a more proactive and preventive approach.

"People won't admit it, but we have got so many drug users in Warwickshire, a really high concentration." (Stakeholder Interview)

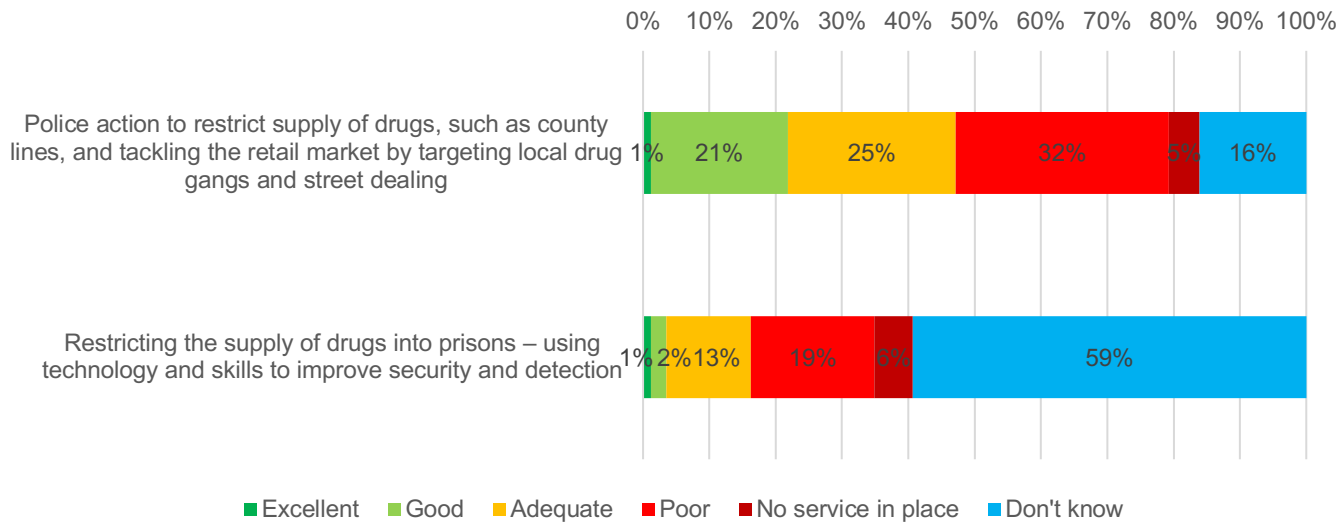
"In Nuneaton you can openly see people dealing on the streets." (Stakeholder Interview)

"Make it [substances] less available. I could honestly walk out my door and get drugs like that, they're so accessible. Especially with cannabis, and even cocaine it's just so readily available. It's just so easy to get, everybody knows someone who knows someone who sells it or who could give you a number for someone who sells it. I think tackling the selling of the drugs, making them less available, I think that's going to be the prevention, preventing people from getting their hands on them in the first place." (Lived Experience Interview)

Within the survey, 21.8% of professionals felt police action to restrict supply of drugs is 'good' or 'excellent' in Warwickshire, while 36.8% rated it as 'poor' or 'no service in place'. Only 3.5% of professionals felt initiatives to restrict supply of drugs into prisons is 'good' or 'excellent'; however, the majority (59.3%) responded 'don't know' to this.

"In terms of restricting drug dealers, I think we [Warwickshire police] are a million miles off." (Stakeholder Interview)

Figure 28 Professional Survey Respondents' ratings for Warwickshire's Approach to Breaking Drug Supply Chains



5.3.1. Police Action to Restrict Supply of Drugs

Generally, there was little awareness or negative perceptions amongst participants about local police action to restrict the supply of drugs.

"With regards to restricting the supply of drugs, I think the police know who the dealers are and know where they are. The police know who they are, where they are, know they're going to go to the pharmacies every day. There are warrants out for people's arrests, and they know exactly where they're going to go, but they don't do anything about it. If they do get caught, they get a slap on the wrist, and all they [the police] say is, 'oh, we're looking for the bigger picture', or 'as soon as this one's taken down, the next one will come up'. But that means there's no reason for anyone to stop. So, with restricting supply there's very, very little being done. I'm sure there's loads going on behind the scenes, but from an impact point of view, nothing gets done effectively." (Stakeholder Interview)

Within the survey we received many comments such as:

"Not enough officers on the ground to support with such a large area of concern." (Stakeholder Survey Response)

"I work with people who are dealing, the police know who are dealing and nothing ever gets done. It's a bit of a joke really." (Stakeholder Survey Response)

"As an ex-police officer I am embarrassed at the lack of initiatives to tackle drug supply in Warwickshire." (Stakeholder Survey Response)

Therefore, there were suggestions that some positive communication around police action being taken in this arena could be beneficial to enhancing trust and confidence in the police.

"There's a lot of negative press about the police and we don't really publicise the good work that we do." (Stakeholder Interview)

On the other hand, several participants were quick to suggest they did not feel police action should be the priority focus as *"we're never going to get rid of it, there's always going to be someone else dealing"*. Participants instead wanted the focus and investments to be concentrated on the treatment element of the drug strategy. Interestingly, representatives from the police described how as a force they have shifted to trying to *"help them [drug users], rehabilitate them, and support them, rather than prosecute them"*. Further collaborative working with commissioned services would enhance this – ensuring that when a supply chain is disrupted, the vulnerable individuals who may be left to seek unfamiliar dealers are supported to do so as safely as possible or are helped into treatment.

"I want there to be recognition that what treatment provides, especially in relation to OST [opioid substitution treatment], is benefits to enforcement activity. Actually keeping people on script has a massive impact in reducing the drug market." (Stakeholder Interview)

"Historically there hasn't been much in the way of activity around drug seizures at a local police level; but even if there was, it's not going to make much impact on the drugs market… it's treatment and opioid substitution therapy that has the biggest impact." (Stakeholder Interview)

A few stakeholders were able to articulate the important role that the Regional Organised Crime Unit (ROCU) for the West Midlands should have in breaking drug supply in Warwickshire and the wider surrounding region. The West Midlands ROCU is a collaboration between the police forces of Staffordshire, Warwickshire, West Mercia, and West Midlands to fight organised crime. The aim being to reduce the impact and increase the disruption of serious and organised crime within the region and beyond. The ROCU works to target areas of criminality believed to pose the greatest regional threats to the people and businesses of the area covered, working alongside other UK law enforcement agencies and many other partners from both private and public sectors. Within the ROCU, there is a specific County Line Task Force, which is a team of investigators who identify and target the region's highest threat drug dealing lines, developing investigations, and supporting other teams nationwide. They aim to build on community information to identify drug dealers that exploit children and other vulnerable people for their own financial gain, working closely with other partners to safeguard the vulnerable individuals whilst aiming to ensure that those responsible are brought to justice. However, currently, it was believed by stakeholders that Warwickshire police are not contributing to, or utilising, the ROCU enough as a vital resource. Despite this, Warwickshire police spoke to us about the regular regional meetings with ROCU and all relevant partners and said that due to the ROCU *"aiming to target those top-level suppliers of heroin and crack cocaine… they only get involved when you move up and try to cut the head off the snake"*.

"I think regional working with the ROCU is going to be key to that [breaking drug supply chains]. Warwickshire need to make more of ROCU. I don't think Warwickshire is actively contributing to or demanding things from ROCU. I think ROCU kind of occasionally looks at Warwickshire and will throw them a bone, but Warwickshire isn't going to ROCU and saying, 'do this', 'we need help with this', 'let's do X, Y and Z'." (Stakeholder Interview)

We were continuously told during interviews and the survey that county lines are a prevalent issue in Warwickshire, as is cuckooing. Warwickshire is not currently believed to be an 'exporter' of any county lines, but instead is an 'importer' only. Geographically, Warwickshire is a central location in England that is well connected by motorways and has *"a decent train network"*, meaning Warwickshire is consequently *"very vulnerable to county lines"*. The majority of county lines coming into Warwickshire are thought to originate from the West Midlands – i.e., Coventry and Birmingham. Additionally, we were informed about a recent influx into the North of Warwickshire from Nottingham – East Midlands, and Rugby commonly having county lines in from London. Police have observed a shift in drug dealers using social media platforms like Snapchat and Discord rather than more traditional forms of mobile phone communication.

"County lines are an issue every single day in Warwickshire." (Lived Experience Interview)

"Initiatives to break supply chains need to be high level activity around county lines… looking at the number of young people who are being exploited through county line gangs and looking at the number of adults who have either been exploited through things like cuckooing or forced dealing, or the end user who ends up being subject to exploitation, violence, and harm through toxic dealing environments… arresting these individuals ultimately doesn't restrict supply of drugs." (Stakeholder Interview)

As a key priority for UK law enforcement, Warwickshire police have made noteworthy progress in tackling county lines in recent years – for example, we were told that at the time of this needs assessment, North Warwickshire had approximately three county lines running into it; whereas, around 5 years ago there was estimated to be in the region of 20 different lines. Some of this success was attributed by stakeholders to the fact that Warwickshire previously had a dedicated county lines disruption team which was funded by the ROCU and was said to be *"really good while it lasted"*. This has since been disbanded and left Warwickshire police with one Detective Sergeant in post as the County Lines Co-ordinator. This role was described as a gateway to partners and regional crime teams.

Detectives within the police were able to explain the processes they have in place at present to help to tackle county lines – this primarily involves mapping any suspected lines on the police system Athena. Intelligence (including from strategy and safeguarding meetings) then gets added to this and is subsequently graded. The Force Intelligence Bureau has what is called a 'threat desk', and there are regular Serious Organised Crime Exploitation (SOCX) meetings that occur, as well as joint working with the West Midlands County Lines Task Force Team. The police in Warwickshire were praised as very knowledgeable on county lines.

"There are three proactive teams whose priority is tackling county lines and serious organised crime, over 20 Drug Experts, three Controlled Drug Liaison Officers (CDLOs), a County Lines Co-ordinator, threat desks and links into the ROCU for support." (Stakeholder Survey Response)

"I think we've got a really good county lines team in Warwickshire police who really know their stuff." (Stakeholder Interview)

"I have attended a police information session re county lines and this was very good. I'm not able to comment on how successful they are on actually dealing with this." (Stakeholder Survey Response)

When a young person is identified as involved in a county line, relevant referrals go into the local safeguarding teams to allow for a joined-up approach. If a young person is arrested in connection to county line drug dealing, the police provide them with a debrief at the point of them being released from police custody - where possible, they try to get the Child Abuse Trafficking and Exploitation (CATE) Team to deliver this.

With cuckooing, Warwickshire police do 'spot checks' on any addresses linked to, or suspected of, cuckooing based on intelligence received, and will work closely with the council to try to get vulnerable people moved away. However, it was described as very challenging to get such vulnerable people to accept the help on offer.

When considering areas for improvement, in line with limited levels of resourcing, participants felt that the police generally are only good at tackling 'low level' dealing, and some suggested that the police *"choose to turn a blind eye"* to much of the larger scale drug dealing across the county. The police also felt there was room for development in terms of them making *"better use of restrictions and civil orders".*

> *"I think Warwickshire Police have an excellent team who are very knowledgeable and conduct many successful operations with regards to county lines. Warwickshire is very good at mapping its county lines and serious organised crime groups. However, I think there is a gap when it comes to going after the people further up the chain; we are getting the low-level offenders and the exploited people but not the people pulling the strings." (Stakeholder Survey Response)*

> *"In Warwickshire we've [the police] probably got the capability to knock out your street runners, not a problem at all. We could probably go one level up but they're not going to be the main people - not even mid-market, just a little bit more muscle than the street runners. We then have a process where if we think that we need to go mid-market then we submit documentation through our Force Intelligence Bureau into the county lines task force team which sits in the West Midlands and they look at where the line sits and what action is to be taken." (Stakeholder Interview)*

Some stakeholders informed us that when arrests are made within Warwickshire, this simply leads to drug users going further afield as well as into Coventry to find alternative drug dealers.

> *"I don't think the police have restricted the supply of drugs, but they have certainly made it less visible and pushed dealers out of the town centres." (Stakeholder Interview)*

> *"As far as I am aware, the police do all that they can to prevent dealing but as soon as they get one drug dealer another two pop up." (Lived Experience Interview)*

> *"There's nothing that can be done, it's always going to be about somewhere." (Lived Experience Interview)*

It is important to acknowledge that breaking drug supply chains is a wider issue than just policing and requires a full partnership approach to ensuring that vulnerable children, young people, and adults are not embroiled in criminal exploitation by key agencies (such as education, social care, NHS, and support services as well as police) working together to disrupt county lines and protect individuals at risk of exploitation. In particular there needs to be a focus on child criminal exploitation, which Home Office guidance describes as being *"common in county lines and occurs where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18. The victim may have been criminally exploited even if the activity appears consensual."* This partnership work needs to focus on protecting children and the vulnerable as well as disrupting drug dealing activity, taking a contextual safeguarding approach[108].

108 For more information, please see: 9https://www.contextualsafeguarding.org.uk/media/rqybrewm/contextual-safeguarding-and-county-lines-briefing_-wroe-oct-2019-final.pdf

5.3.2. Restricting Supply of Drugs into Prisons

It was generally agreed that: *"drug supply and use is rife in prisons".* While *"Warwickshire doesn't have a prison within its local authority area"*[109], within the wider West Midlands region there are currently seven HMPPS run prisons – HMP Birmingham, HMYOI Brinsford, HMP Featherstone, HMP Hewell, HMP Stafford, HMYOI Stoke Heath, and HMP & YOI Swinfen Hall. Anecdotally we heard that the most commonly releasing prison to Warwickshire Substance Misuse Services is HMP Hewell followed by HMP Featherstone; however, prison leavers can be released to Warwickshire from prisons all over the UK. Issues surrounding continuity of care for prison leavers will be explored within the 'Delivering a World-Class Treatment and Recovery System' subsection of the report, and we focus here on security measures in place to restrict the supply of illicit substances into these most local prisons to Warwickshire.

The most common known ways contraband like illicit substances get smuggled into prisons are:

- During visits
- In letters
- By throwing over prison walls
- Using remote-controlled drones
- Hidden internally
- Corrupting staff (operational or non-directly employed prison staff or using outside contractors).

> *"I have concerns around how visits are conducted and monitored, always a concern that staff are bringing in the substances. Again, general staffing issues and the unsafe nature of the role lead inexperienced staff onto the landings who are expected to keep control, often leads to them being manipulated and targeted." (Stakeholder Survey Response)*

We were informed that all seven of the prisons outlined above have access to the regional resource, intelligence, and security hub, as well as a large dog unit which can be regionally deployed. In terms of tackling drugs being sent into prisons via mail, prisoners are being encouraged to use 'email a prisoner' wherever possible, friends and family are only permitted to send cards in via approved websites (i.e., moonpig), and to reduce the recent trend for fake rule 39[110] correspondence to be soaked in / sprayed with synthetic cannabinoids, legal letters are now having to be sent in with approved barcodes as proof of legitimate sender. Drones dropping drugs and 'throw overs' were described as rare for these prisons. In addition, four out of the seven prisons have 'enhanced gate security'.

All seven of the prisons have the latest X-ray body scanners installed. These have been rolled out across the closed male prison estate in recent years to confirm whether or not a suspected prisoner is hiding contraband (i.e., illicit substances) inside their body. If used as part of a searching strategy and with a trained, professional staff group, X-ray body scanning technology can provide an effective means of confirming the intelligence or reasonable suspicion that a prisoner is attempting to conceal contraband internally, which improves a prison's capability to detect contraband being brought in by way of internal concealment, contribute to the reduction of drugs being smuggled in or out of a prison, reduce the associated risks to the individual and wider establishment, and deter exploitation of vulnerable prisoners to convey items. The relevant security leads

109 Please note HMP Onley and HMP Rye Hill have Rugby postcodes and are on the boarder of Warwickshire.
110 Rule 39 of the Prison Rules 1999 states that any correspondence between a prisoner and his or her legal adviser or a court may not be opened, read or stopped unless the Governor has reasonable cause to believe that the correspondence contains an illicit enclosure, or that the Governor has reasonable cause to believe that its contents endanger prison security or the safety of others or are otherwise of a criminal nature. Even then it may only be opened for examination in the presence of the prisoner concerned (unless the prisoner waives the opportunity) and the prisoner must be informed if it (or any enclosure) is to be read or stopped.

locally are currently looking at developing an exploitation and vulnerability strategy to support any individuals caught via X-ray body scanners.

The importance of effective security measures to restrict supply of drugs into prisons was recognised and emphasised by participants, especially in relation to the benefits this can have for prompting somebody to pursue recovery.

"Improved security can't be a bad thing! Prison is often a chance to get clean." (Stakeholder Survey Response)

Warwickshire police were open to admitting that more proactive work could be done between prison security departments and the police in addition to what already occurs with *"monitoring what they [drug dealers] are up to in prison when mapped as OCG [organised crime group] nominal".*

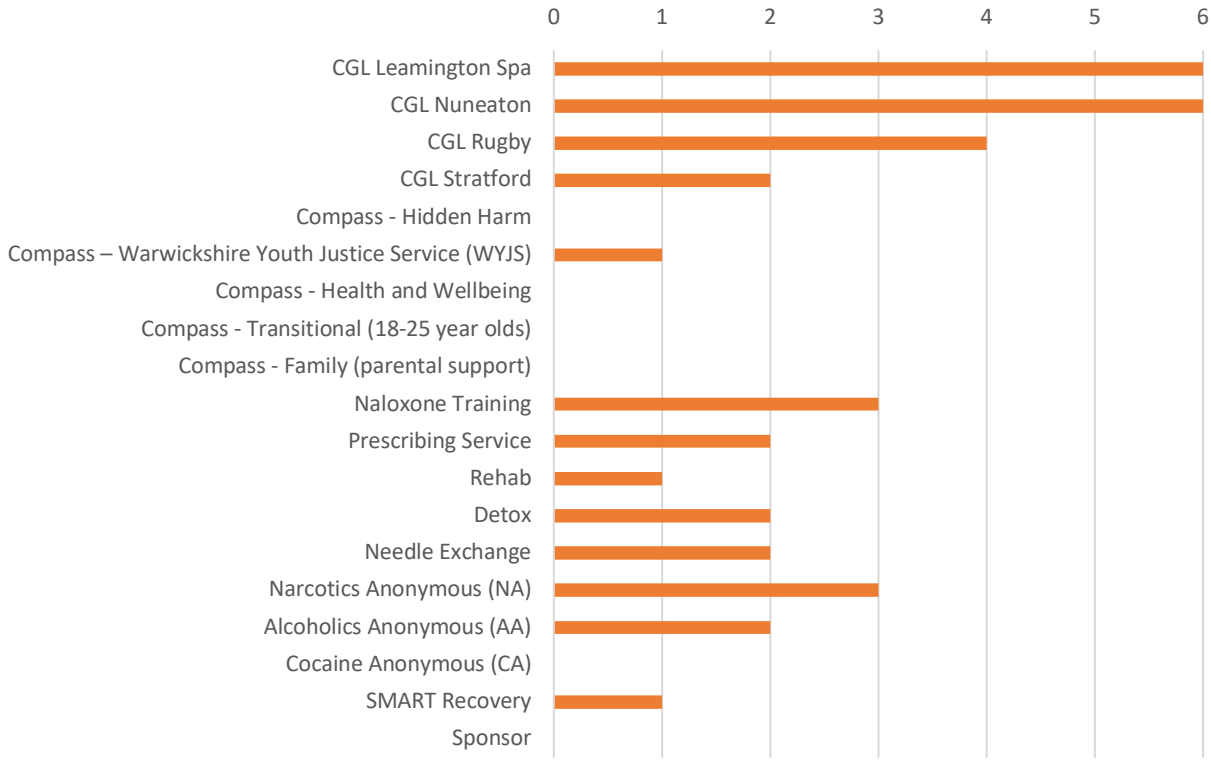
5.4. Delivering a World-Class Treatment and Recovery System

The national Drug Strategy states that within a decade, England will deliver a world-class treatment and recovery system. An additional £780 million investment is set out over 3 years to take this forward, implementing Dame Carol Black's key recommendations – treating addiction as a chronic health condition, breaking down stigma, saving lives, and substantially breaking the cycle of crime that addiction can drive by:

1. **Delivering world-class treatment and recovery services** – rebuilding local authority commissioned substance misuse services, improving quality, capacity, and outcomes
2. **Rebuilding the professional workforce** – developing and delivering a comprehensive substance misuse workforce strategy
3. **Ensuring better integration of services** – making sure that people's physical and mental health needs are addressed to reduce harm and support recovery, and ongoing delivery of Project ADDER to join up treatment, recovery, enforcement
4. **Improving access to accommodation alongside treatment** – providing access to quality treatment for everyone sleeping rough, and better support for accessing and maintaining secure and safe housing
5. **Improving employment opportunities** – employment support rolled-out across England and more peer support linked to Jobcentre Plus services
6. **Increasing referrals into treatment in the criminal justice system** – specialist drug workers to support treatment requirements as part of community sentences so offenders engage in drug treatment
7. **Keeping prisoners engaged in treatment after release** – improving engagement of people before they leave prison and better continuity of care into the community.

Within the survey, 58.1% of respondents were engaging with a support service at the time of participating, 30.2% said they had never engaged, and 9.3% had engaged with support but over 3 years ago. The graph below indicates which service(s) survey respondents had accessed. For those with lived experience who undertook an interview, the vast majority were being supported by CGL.

Figure 29 Services Accessed in Warwickshire by Survey Respondents with Lived Experience



5.4.1. Strategic Level / Commissioning Responsibilities

At a strategic level, Warwickshire was praised by stakeholders for being *"ahead of the curve compared to most other areas in setting up a local drug strategy partnership"*. This was said to have helped foster good working relationships between key stakeholders within the County Council and other commissioning bodies such as the OPCC. The desire for cohesive partnership working is evident by the fact that the OPCC have extended their Criminal Justice contracts with the existing Substance Misuse Service providers so that their re-commissioning cycle falls in line with those of the core services that the County Council are responsible for commissioning, meaning that resources can be pooled and co-commissioning can occur in the future if deemed appropriate. Furthermore, Warwickshire commissioners were described as working closely with the Regional Drug Strategy and Commissioning lead, who is part of the Regional Policy Team, which sits within West Midlands OPCC, and works to ensure best and emerging practice is shared between Staffordshire, Warwickshire, West Mercia, and West Midlands.

Some stakeholders believed that consideration could be given to expanding the commissioning capacity within Warwickshire. While stakeholders had nothing but praise for the existing commissioners and their genuine drive to improve the local response to substance misuse, it was felt that should investments be made at a strategic level, to increase commissioning capacity, there would be scope for better informed decision making, enhanced oversight, and more meaningful performance monitoring and management. As it stands, stakeholders believed that *"too much responsibility and decision making is delegated down to the providers because there is not the commissioning capacity"*.

"The commissioning capacity is not there to have good strategic oversight of what's going on."
(Stakeholder Interview)

5.4.2. Adult Drug and Alcohol Service – Change Grow Live (CGL)

As outlined within the literature review, Change Grow Live (CGL) is the current commissioned service provider for adult drug and alcohol treatment in Warwickshire. CGL have three main hubs across Warwickshire: CGL Leamington Spa, CGL Nuneaton, and CGL Rugby, and are also co-located in the Fred Winter Centre in Stratford, as well as conducting outreach work in the more rural parts of the county.

CGL Nuneaton

The hub in Nuneaton was located at the end of the high-street and had minimal signage making the location discrete. Service users commented on the site being easily accessible as it was in the centre of town and in close proximity to multiple pharmacies. There was a communal waiting area that felt welcoming and signposted lots of relevant services. The office space was a sizeable and each staff member appeared to have their own desk; although, staff can work from home, so if the whole team where onsite this may not have been the case. The hub layout meant the waiting room was at the front of the building and key work rooms, needle exchange, and clinic rooms were off the corridor that led to the staff office located at the back of the building. Staff said they would welcome a larger building as they felt the size was not relative to the number of clients they see nor the size of the staff team. The Nuneaton hub does not have a group meeting room, meaning CGL are not able to offer ambulatory detoxes here, but instead CGL use a space in St Nicolas' Parish Church or the CAVA Centre for their group work sessions. We saw the church, which was approximately a 10-minute walk from the main hub and the group space was signposted subtly and separate from any other space in the church.

CGL Rugby

The CGL Rugby site was located about a 5-minute walk away from the centre of town. The hub was upstairs and consisted of two floors with a large group meeting room on the second floor. There was a bright and welcoming waiting area that was attached to a corridor with numerous meeting rooms. There were dedicated rooms for prescribing clinics, needle exchanges, and criminal justice appointments. The office space was mid-size and there appeared to be room for every staff member to have their own desk space.

CGL Leamington Spa

The CGL Leamington Spa site itself is relatively far away from the centre of town and located at the back of an industrial estate. This made it difficult to locate initially but also meant it was very discrete and service users could attend without necessarily being seen by the general public. There was a large waiting area, a few key work rooms and a clinic space (next to the testing toilet) located on the ground floor which promoted accessibility, and a large group meeting room upstairs, as well as a second smaller meeting room, which was being used for an ambulatory detox during our site visit. Upstairs also hosted a staff only kitchen area, and large office space. The building was comfortable and clean however there was some feedback from service users who commented on it feeling rather clinical and impersonal.

CGL Stratford

The main CGL base in Stratford is located within the Fred Winter Centre. This centre is described as a multi-disciplinary community hub that tackles hardship by providing a range of services to help people improve their health and wellbeing, overcome financial problems, secure job opportunities, and sustain tenancies in local affordable homes. The 'all in one' building encourages partnership working as providers come together to offer help and advice. The CGL office is located at the back of the second floor which means that service users have to walk through the entire building, including the cafe and communal working spaces to get there. Service users commented on feeling 'out of place' in this environment that was newly renovated and

gentrified. They also reflected they could not afford to eat at the cafe there which made them feel uncomfortable;

"Us downtrodden have to walk past people eating expensive food, we see it sitting on the tables and I have to beg for a 99p burger." (Lived Experience Interview)

The CGL office was very compact, consisting of just two small rooms and a narrow corridor that served as a waiting area. This meant that confidentiality in appointments could be difficult to provide as noise travelled into the waiting area and staff were also using spaces for storage. There is a group meeting space shared by all the providers in the centre. The toilets were located directly opposite the office which allowed urine drug screens to occur; however, these toilets were shared with the rest of the building. There was no phone line in the room used for clinic appointments, meaning ECGs could not be conducted here.

We were informed that lone working should not occur at the Fred Winter Centre as there is no way to see or signal to other professionals located elsewhere in the building when in an appointment; however, on one of the days during our site visits, there was one lone female worker and limited other professionals onsite. Further, we witnessed heightened service users – sometimes either storming in or out unannounced, and on one occasion someone required 'ushering out' – which highlights the importance of adhering to the lone working policy.

Outreach clinics and appointments are also offered – for example, we attended the Bidford Health Centre, which was an aesthetically pleasing locality, with CGL signposted on the door to the clinic room and a thorough check-in process. However, availability of CGL staff here is very limited and the NMP prescriber is only based there once a month, with 17 prescribed clients currently accessing support from this base. This creates challenges with scheduling appointments and if someone misses their review (which commonly occurred during our site visit), then it can be hard to reschedule in a timely manner – for example, one individual who did not attend their appointment whilst we were there, has not been seen in person by the prescriber since February 2022.

5.4.3. Children and Young People's Drug and Alcohol Service – Compass

Compass is the current commissioned service provider for children and young people's drug and alcohol treatment in Warwickshire. Compass' Health and Wellbeing Practitioners are flexible and make themselves available at times that suit the individual client, at a place where they feel comfortable, including the undertaking of home visits. Generally, service users appeared to be happy with this approach; although, one young person reflected on the lack of confidentiality making them feel slightly uncomfortable during their appointments due to them occurring in a cafe. We observed a home visit, and one young person noted the importance of drug and alcohol support being delivered externally but an impartial, independent provider (outside of school). They reported that the advice and support was non-judgemental and balanced.

5.4.4. Barriers to Access

Much of the discussions about improving support to those misusing substances in Warwickshire centred around the barriers to accessing and engaging with services. In the table below we set out the barriers highlighted to us during the fieldwork, along with some suggestions derived from what participants said about how these can be overcome. All of the barriers discussed within this section should be considered by future commissioned providers to ensure their services are as accessible to all as possible.

Generally, barriers to accessing support exist on different levels. Firstly, there are 'personal' barriers which are based on an individual's own perceptions, often influenced by past experiences. Then there are 'structural' or 'organisational' barriers such as lack of staff awareness, training, resources, limited promotion of the support available, resource inadequacies, service fragmentation, poor interdisciplinary communication, etc. Finally, and perhaps the biggest issue to tackle, 'sociocultural' barriers based on society's values, beliefs, and attitudes.

Table 4 Summary of Barriers to Accessing Support Services and Proposed Solutions

Barrier	Proposed Solution
Some individuals misusing substances may be in denial, not recognise substance misuse, or not acknowledge it is problematic. *"It's the denial and the shame." (Lived Experience Interview)* *"I do think it's daunting to finally accept that there's a problem. I don't think a lot of people like to admit that that's where they're at some times, it is a daunting experience." (Lived Experience Interview)* Individuals may experience concern that the service may not be able to cater to their need (particularly if substance of choice is non-opiate, not alcohol, or use is not daily) – they may believe their use is not extreme enough to necessitate support. *"People get no support unless you are a full-blown heroin addict so what's the point?" (Lived Experience Survey Response)*	Education and awareness raising among the general public of what is a responsible or safe level of drinking for alcohol, and to demonstrate the associated risks and dangers of substance misuse, whilst encouraging people to reach out for support at the earliest opportunity. *"Alcohol wise, we've seen a lot of people when it's too late, that seems to be a big trend at the moment, we're not necessarily getting a lot of low-level drinkers. We're getting a lot of people that are coming in when they've got liver scoliosis or something serious like that. So, we end up sort of firefighting through that area, rather than preventing it seems to be kind of very reactive at the moment, because they're just coming in too late." (CGL Staff Member)* *"We're pretty good now with social media, but I think CGL as a whole should have a louder voice in the mainstream media." (CGL Staff Interview)*
Some individuals may simply not be ready to engage with support or have no desire to change. *"You can't help someone if they don't want to help themself." (Lived Experience Interview)* *"'I have thrown everything at him and he doesn't want to change." (CGL Staff Interview)*	Support should be offered at various time points and reassurance offered to individuals that when they are ready, they will be accepted into service, in the meantime they should be given as much harm reduction advice as possible to promote safe consumption. The onus should not always be on the individual struggling to present or refer themselves, as the initial step may be the hardest. Professionals should be completing referrals (with consent) as opposed to signposting with no follow up on whether the individual has self-referred.
There is an apparent lack of awareness and understanding of the existing support services in Warwickshire among both the general public and some professionals. While on the whole, it appeared that most people with substance use problems knew CGL were the current adult Substance Misuse Service across Warwickshire (usually through word of mouth from other	Commissioned providers should work to promote their services better to the general public, clearly outlining what they offer, setting out the eligibility criteria, and how to refer. *"I think there could be a lot more online, even if it's a Facebook forum, on Instagram, in the newspaper, they could go to events… because it might not just be that*

users) many did not have a clear idea of the service offer or treatment options. This was particularly made apparent by members of the homeless community in Warwickshire. *"I'd never even heard of them to be honest." (Lived Experience Interview)* *"They don't know where to go for the help." (CGL Staff Interview)* *"I don't actually see it promoted around anywhere." (Lived Experience Interview)* *"A lot of people still don't know who CGL are - they know we are the drug and alcohol service, but they don't actually know what we do." (CGL Staff Interview)* Lack of awareness of the existing provider seemed to be more of a prominent theme for the children and young people's service. *"Not sure of any support available [for children and young people]." (Stakeholder Survey Response)* *"Whilst it is commissioned, the provision of specialist treatment services for young people is limited." (Stakeholder Survey Response)*	*person that's got a problem and word of mouth is massive." (Lived Experience Interview)* *"I think definitely being out in the community and being visible. Whether that's through posters; although a lot of posters and promotion are in GP surgeries and people don't even go to GP surgeries anymore, they get a phone call from the doctor… Definitely improve visibility." (Lived Experience Interview)* *"TV adverts! Because people are sat at home watching TV and using… if that comes up, then they might think, 'Oh, maybe I should try it'." (Lived Experience Interview)* *"More of a street presence would help." (Lived Experience Interview)* Better awareness raising amongst all professionals should also be undertaken to encourage them to utilise referral pathways. *"One of the most important ones is to do some sort of presentation for example in the GP surgeries and places like that, so they know what we do and what we can and can't do… it would be great if we could have a volunteer in most GP practices at least once a week, being there giving information out, being a point of contact"" (CGL Staff Interview)*
There was a general consensus that existing services lack capacity, with funding cuts reducing the number of employees providers have, meaning services have typically seen a decrease in both quantity and quality of support on offer. Lengthy wait times for the adult service between point of referral and receiving support (particularly to get scripted) as well as for residential rehab can also be off putting for prospective clients. Those with lived experience told us how disheartening it can be if they reach out in a time of crisis when they want immediate support, to be put on a waiting list for a call back. *"Waiting times to respond when people make the decision to make a change is clearly a barrier" (Stakeholder Survey Response)* *"Accessibility is clearly an issue as waiting times can deter people from getting the help they need" (Stakeholder Survey Response)*	Wherever possible, commissioned services must be supported to utilise additional funding to build capacity and enhance quality of substance misuse treatment. Commissioned services should look to develop a wider and more robust self-serve offer – some people may benefit from self-help (i.e., signposting to resources online) and access to helplines. Alongside this, they should more readily promote use of open access groups, mutual aid meetings, recovery networks, and peer support. Services should also explore ways to streamline the process between referral, triage, assessment, allocation, and actually receiving support to make this as efficient as possible.
Substance misuse is a 'taboo' topic, individuals may be scared to open up, find it difficult to talk about, or not want to have to retell	Services must work to build trust and confidence through

their story multiple times. Additionally, individuals may fear judgement, judge themselves, feel embarrassed, and may try to hide their substance misuse and not want others to find out. *"Drug use is quite a taboo subject" (Lived Experience Interview)* *"There's quite a lot of stigma going to a treatment agency." (Stakeholder Interview)* *"It's embarrassment, shame, and feeling judged." (Lived Experience Interview)* *"Fear of the unknown. Not being taken seriously. Embarrassment." (Lived Experience Survey Response)* Some may fear the potential negative repercussions such as being in trouble with the law or social services involvement. *"If they do have problems with drug or alcohol use there, they're almost too afraid to admit it, because they feel like if they reach out and go and get help and support, they feel like that will be used against them in any child proceedings." (Lived Experience Interview)*	education and awareness raising among the general public, particularly focusing on use of non-stigmatising language and highlighting their confidentiality agreement and information sharing practices within promotional materials and again once an individual is within service. Maintaining anonymity of buildings may help people to feel able to present at services as it is discrete. Professionals should ensure they are making direct referrals rather than signposting, to assist individuals in making that first step.
Practical obstacles such as employment, travel, requiring childcare, and associated costs of attending a service. *"Travel in Warwickshire is an issue." (Stakeholder Interview)* *"They could have a service in Bedworth because it's a lot to travel when you've only got a little bit of money and I can't go out on my own, so it's hard to get to… everyone in Bedworth has to come over to Nuneaton… trains are a bit cheaper but only run every hour." (Lived Experience Interview)* Numerous participants commented on the lack of access to services in rural areas with poor, infrequent, and expensive transport connections, which prevents them from engaging in support.	Services must ensure their physical location is accessible and 'disabled friendly'. Continue and enhance the outreach offer - assertive outreach should be focused particularly in the most rural parts of Warwickshire. Provide flexible support wherever possible, with evening and weekend appointments and groups. *"It would be good to have more space available for drop ins." (Lived Experience Interview)* Explore hybrid model of working with options for virtual support where appropriate safeguarding procedures can be put in place.
Lack of: • mental health support to tackle the root cause of the problem • specialist support for the LGBTQ+ community • specialist support for minoritised	Establish partnerships with 'by and for' organisations, promote inclusivity through assertive outreach, and increase capacity for roles such as the 'Asset Based Community Development Coordinator' *"We need to be more proactively getting out. Rather than waiting for people to come to us." (CGL Staff Interview)* *"Posters in local religious locations, we don't see anything in local community centres. There's nothing up yet so many people access places that there's nothing there." (Lived Experience Interview)*

ethnic communities • support available in languages other than English.	Explore possibility of in-house mental health workers or psychologists and enhance joint working under the dual diagnosis pathway with statutory mental health providers. Ensure practitioners have cultural safety and awareness training and increase provision of interpreters/translators.

Respondents within the survey focused on the different innovative methods that would make the service more accessible. This involved initiatives that would tackle the barriers to accessing support and mould to service users' chaotic lifestyles. This included providing a 24/7 support service that operated on weekends and evenings which could be facilities using an online helpline. In addition, there was a dominant view that the service needs to be more visible in the community. Respondents suggested this could be provided through pop-up support hubs in the community as well the provision of workshops in 'harder-to-reach' settings and prevention workshops in schools.

"Be more visible in the community." (Stakeholder Survey Response)

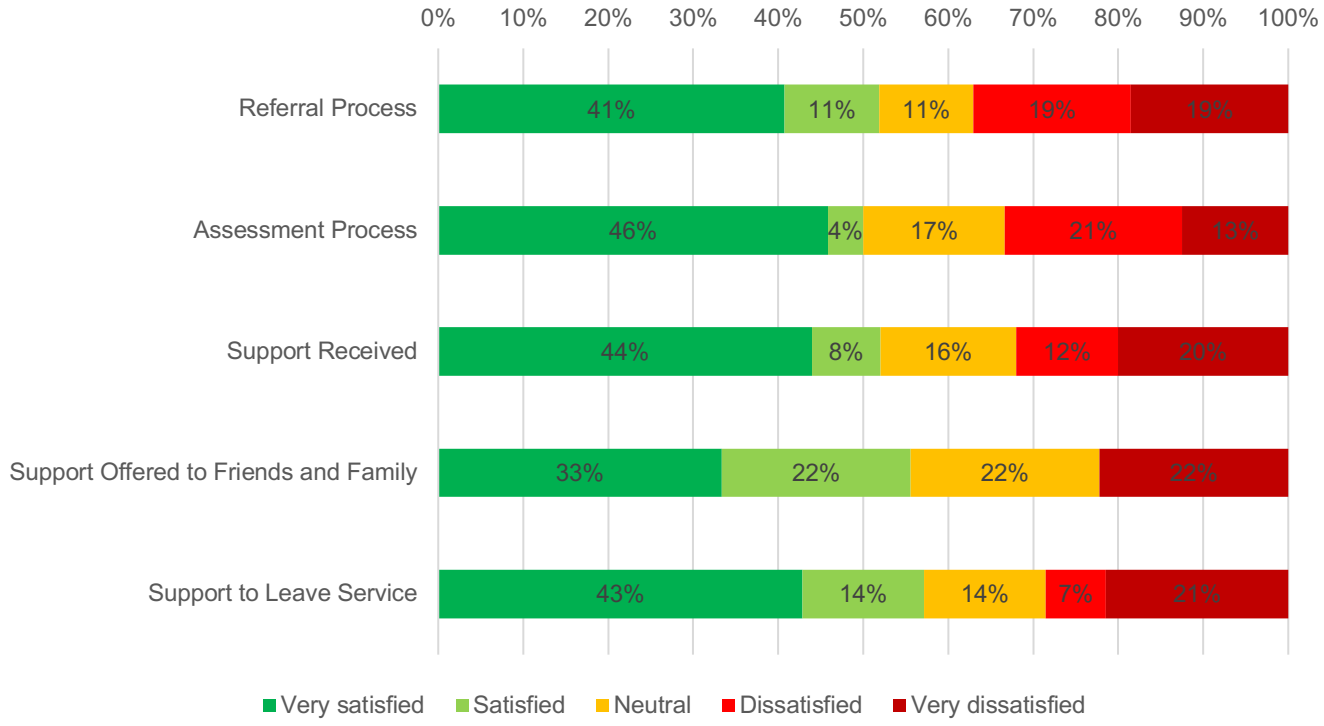
"More pop-up workshops in the area are needed where people can get the support they need, without having to call." (Stakeholder Survey Response)

5.4.5. Service User Journey

We will now explore different aspects of a service user's journey in chronological order. The following graph shows how satisfied survey respondents with lived experience said they are with each part in of this in Warwickshire – for each stage, 50% or more were 'satisfied' or 'very satisfied'. Typically, where participants identified issues within the existing system, they resulted from a lack of resources and funding.

"They need a lot more money and a lot more services." (Stakeholder Interview)

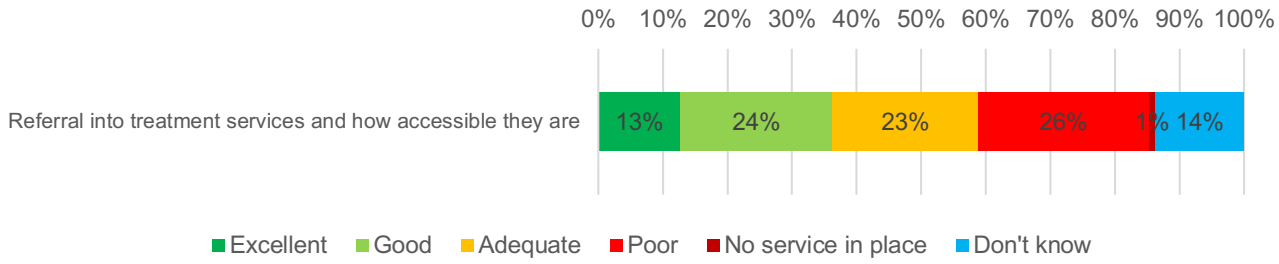
Figure 30 Service User Survey Respondents ratings for each stage of Treatment in Warwickshire



Referral Process

When stakeholders rated accessibility of referral pathways into treatment, the most commonly selected answer was 'poor' (26.5%).

Figure 31 Professional Survey Respondents' ratings for the Referral Process and Accessibility of Substance Misuse Services in Warwickshire



Despite this, the referral process into the core adult community drug and alcohol support service was generally described as straightforward and simple by both professionals and those with lived experience, with very little need for improvement as there are various referral routes, including an online form on the CGL Warwickshire website. Typically, service users said they had either been signposted to support by their GP or the police, or had found out about it for themself, often by word of mouth. The theme appeared to be that the former was most common for alcohol clients, and the latter for heroin and crack cocaine users. Within the survey, there was an appreciation from those with lived experience of the option to self-refer.

"The referral process was absolutely fine; I don't remember feeling overwhelmed or triggered from any of it." (Lived Experience Interview)

"Referral is accessible as referral forms are on the internet and can self-refer if preferred." (Stakeholder Survey Response)

Positively for adults, whilst waiting for their triage and assessment appointments, they are able to engage with the virtual open access group sessions like mindfulness and peer support so that they are not left unsupported during the wait period. We expect waiting times between the point of referral and assessment process commencing may have contributed to the negative ratings from professionals for this part of a service user journey, and we will explore this further in the next subsection.

"Need for a faster turnaround from referral to first appointment." (Stakeholder Survey Response)

Participants described the children and young person's community drug and alcohol support service being co-located with the Youth Justice Service as a real strength allowing for a seamless referral route. However, a few stakeholders felt that Compass has become overly reliant on the Youth Justice Team for their referrals at the expense of proactive outreach work.

"Compass have bedded in really well with the Youth Justice Service and I think the fact that they are co-located with the Youth Justice Service is really, really good, because they get that direct access and those kinds of open conversations with the Youth Justice Service so that they're not missing people." (Stakeholder Interview)

Some suggested that more co-location between the adult service and the police and Probation Service would replicate this and enhance referrals for the Criminal Justice part of the adult offer. Indeed, police reported a lack of awareness about the best way to make referrals.

"I think what the police struggle with is how we refer people into support agencies, especially CGL." (Stakeholder Interview)

Linked to this, it was brought to our attention that the 'Test on Arrest' scheme is not being utilised effectively by the police.

"Police are crap at doing drug tests on arrests." (Stakeholder Survey Response)

"Drug Test on Arrest is hardly ever happening. They have capacity for about 60 referrals a month, they're getting about six. We've been doing a heck of a lot of work over the last nearly two years to try and drive those referrals up. Unfortunately, at the end of the day, you're reliant on the custody sergeant to actually stick a swab in the detainees mouth and do the test. And they're just not doing it." (Stakeholder Interview)

Despite apparently having sufficient buy-in from senior stakeholders who have been advocating for increased use of Test on Arrest (with the majority of people, not just those arrested for 'trigger offences'), the issue was said to be due to the additional work this creates for Custody Sergeants, particularly when the individual does not then attend their appointment with the Substance Misuse Service.

"It all depends on 1) if the machine's working, which invariably it's not, 2) if there's somebody available to do it, and 3) and it shouldn't be this way, but it really depends on the Custody Sergeant… being completely honest, another reason why I think sometimes it doesn't get done is because of the work involved if someone does not attend their CGL appointment… Obviously, if someone tests positive they get an appointment with CGL, if they don't attend that appointment, the paperwork involved is a nightmare… it's probably a 2 hour piece of work putting it onto the system and then to go out and locate that person to then arrest them, interview them, and charge them, to then essentially put them before the Magistrates' Court where they will get a punishment or just sent back to CGL again… they don't want that additional work when their workload is already so high." (Stakeholder Interview)

A two-part solution to this issue was proposed:

1. 'Test on Arrest' should become mandated on Warwickshire's police system Athena for any 'trigger offences' – this would require approval from all other police force areas using this system for the change to be implemented (we were told this has already been escalated by the OPCC).
2. CGL to be funded to have a Criminal Justice Recovery Co-ordinator based within the police stations in order to conduct appointments immediately after a positive drug test result is returned.

"On the Athena police system when you've got somebody's custody record up if they have committed a trigger offence - so shoplifting, burglary, etc. - which should lead to a drug Test on Arrest, it is not mandatory on the system. It should be." (Stakeholder Interview)

"I guess in terms of how we can negate the whole people being given an appointment would be to have CGL or a CGL rep of some kind… permanently posted at the police station… we only have two custody blocks in Warwickshire - one in Nuneaton in the North and one in Leamington in the South… after office hours perhaps you could have someone on call… it

also means people who might need the help and support get it quick time rather than being put on a waiting list.“ (Stakeholder Interview)

We were also told that there is a need for referrals linked to court-mandated Alcohol Treatment Requirements to be simplified as they are sometimes being sent to / going through an out of area treatment provider.

“I think there's difficulties at the moment with the way the courts are operating, because some of them are in Coventry. So there's a bit of a difficulty between Cranston in Coventry and CGL and who's getting the referrals and how that's being recorded. It's all a bit messy.” (Stakeholder Interview)

There is always scope for a wider range of professionals (particularly health partners) to more actively refer to the Substance Misuse Services, and given their predominantly White-British client cohort, there is a need for providers to proactively explore ways to reach more diverse communities with their referral partners. In addition, some service users felt they would have benefitted from slightly more information at the point of referral to provide reassurance that they had come to the right place and would receive the support they needed.

In terms of referrals to residential rehab or inpatient detoxes, we were informed by CGL practitioners that the introduction of the West Midlands framework for detoxes has made it much easier to refer clients. The West Midlands framework is a relatively new, joined-up way of working that brings detox providers together and aims to prioritise the needs of the service users, allowing people to fully explore their detox options and have informed conversations about their journey and personal goals. Many thought it would be good to replicate this for rehab applications, as referrals to these were identified as a challenge.

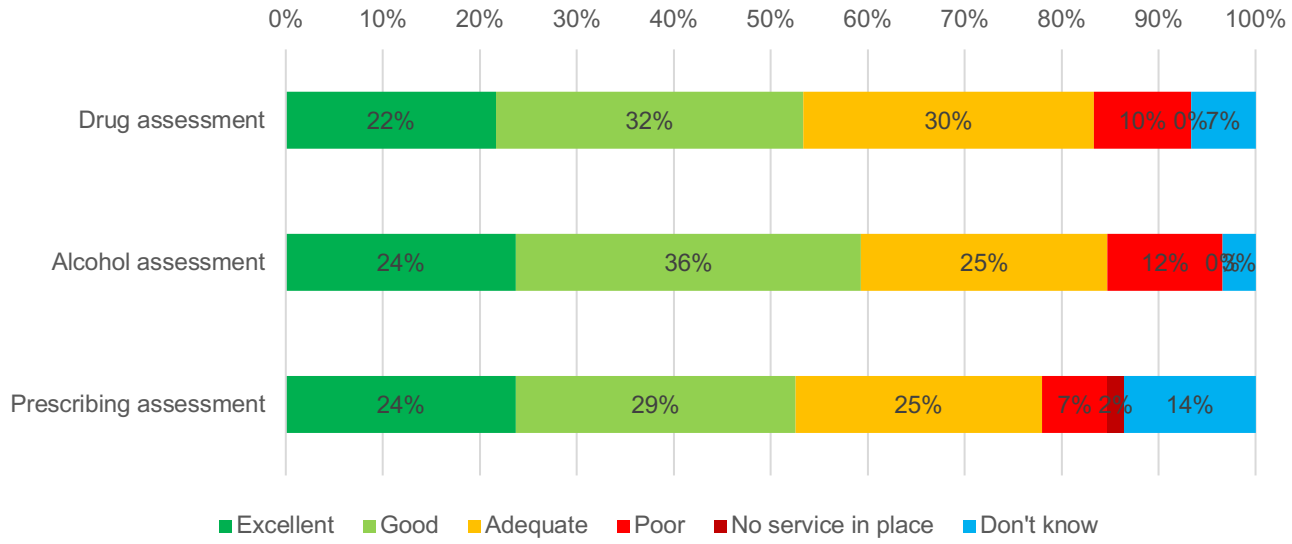
“Following the introduction of the West Midland framework I've found it to be incredibly beneficial for finding and securing placements for high-risk client detoxes. Before the West Midlands framework was in place it was a slog. Without a shadow of a doubt. I worked with a client for 6 months and had his applications to 4 separate placements ignored or rebuffed. Through the West Midlands framework, we then found a placement in Lancaster who could admit him within 6 days. He is now 7 weeks drug and alcohol free and going strong.” (CGL Staff Survey Response)

“To be honest, so far, I have sent no one to residential rehab placements in the past year. This is due to the complexity in applying for a rehab placement compared to a detox placement, and the restrictions and expectations following this.” (CGL Staff Survey Response)

Assessment

Over half of stakeholders rated the quality of drug, alcohol, and prescribing assessments positively – selecting ‘good’ or ‘excellent’. This was the most positive for alcohol assessments (59.3%).

Figure 32 Professional Survey Respondents' ratings for the Assessment Processes of Substance Misuse Services in Warwickshire



From the survey, of those with lived experience accessing support at the time of participating, 61.1% said their assessment was conducted in person and the remaining (38.9%) were done over the phone.

Within the existing adult service, with the exception of in the CGL Rugby hub, CGL has an 'Entry into Service' team, which is made up of experienced staff whose responsibility it is to process new clients. Largely CGL staff and clients felt this process works well and that the assessment is very inclusive; however, as the person who takes the referral, conducts the triage appointment, undertakes the assessment may all be different and usually not the allocated key worker, there is an issue with service users having to retell their story multiple times. Some clients said this led them to provide 'socially desirable' answers and not necessarily provide the full story or truth *"just to get the boxes ticked".*

"The first person you talk to won't be the person who does your triage and the person who does your triage won't be the person that does your assessment. So, it can feel like you're telling your story three times over. But then the fourth, when you get a key worker, that's a lot. That's a lot." (CGL Staff Interview)

There were two main issues raised around the assessment part of a service user journey, the first being the waiting time between referral to the adult service, being assessed, and then receiving treatment.

"There's a waiting time, that shouldn't really be there." (Stakeholder Interview)

"Able to refer to services ok but it is the slow reaction by the teams to allocate a worker to the client and so missing the opportunity to engage." (Stakeholder Survey Response)

"I think people have to wait too long to get in, we do this triage, and then assessment, and then they may or may not come in, it's too long… as a service user you want an immediate response." (CGL Staff Interview)

"Takes too long to get an assessment." (Stakeholder Survey Response)

"It usually takes quite a while and usually when someone's at the point of reaching out for help, or admitting that they need help, I feel like that's when it's most impactful. It's at that point, because they're already at their breaking point, and then to have to wait weeks or months after that to get some support. It can kind of feel like, 'well, I've finally told somebody,

and everyone says reach out if you've got a problem'. They finally identified a problem and if they've spoken about it, and then nothing happens, I feel like there needs to be almost like an immediate response." (Stakeholder Interview)

The second concern being the intrusive nature of some of the assessment questions, which professionals said feel more appropriate to be explored once a rapport has been established between client (adult or young person) and key worker rather than during the first contact with a service. Moreover, the assessment is usually conducted at pace, which some said made it feel impersonal despite the fact they are being asked very personal questions.

"Great service but let down by their gruelling assessment process." (Stakeholder Survey Response)

"I felt rushed during the assessment. I was only able to answer most of the questions as my Together worker had advised me of the sort of questions I may be asked. I struggle with thinking quickly and would have appreciated a slower pace and some preparation by CGL." (Lived Experience Survey Response)

"The assessment is getting more and more intrusive… the whole process is far too long, it's far too much about ticking boxes, very little is about building rapport with the client, and from my perspective unless you've done that the client is not going to come back or not going to engage properly." (CGL Staff Interview)

"It probably puts them off because of the questions that are asked and how long it takes. And actually, what do they actually get out of that? Absolutely nothing. What does the service get out of it? Not a great deal… and at least half the time, a lot of them say they lied at the start, because they weren't comfortable with sharing, then 6 months down the line, when they did get to know the practitioner, and there was a relationship, they would open up and felt in a position to talk about it and be a bit more honest. They [service users] said the assessment was worthless, because nothing in it was true." (CGL Staff Interview)

"I firmly believe that the assessment process of engaging young people into service is not trauma informed, and I think it's actually quite damaging in that it's really traumatising. It does re-traumatise and trigger young people. The assessment - and there's the expectation, you complete an assessment quite quickly - asks very invasive questions around sexual health, around mental health, around self-harm. If I was a young person, I wouldn't be feeling overly comfortable in baring my soul within the first or second session, and actually all that's doing is probably re-traumatising them. But the teams don't have a choice, they have to do that because that's what commissioners are expecting them to do. The process is not trauma informed in any way, shape, or form, it's actually really dangerous. I would say that needs to change, the whole assessment process." (Compass Staff / Stakeholder Interview)

"Not victim focused in any way. Assessments are a tool to benefit the service and not the service user. They use victim blaming language and are invasive and triggering. Pressure to complete comprehensive assessments within the first or second meeting which is not client led and can be very traumatising." (Stakeholder Survey Response)

Some wanted to see a complete overhaul of the assessment process and a shift to more trauma-informed practice. However, there was also an understanding that some of the details gained through the assessment are data required for reporting back to commissioners and funding bodies. As a compromise, practitioners working for the existing providers felt it would be more appropriate for them to have time to build up a

therapeutic relationship before asking service users to disclose personal information about themselves which they may not feel particularly comfortable discussing.

"I think they need to scrap the assessment process and start again and look at having just one assessment tool if need be." (CGL Staff Interview)

"I think a complete overhaul of the assessment process… need to go back to the drawing board and really look at what information is actually required. What does it or what is that achieving? What does it actually do? I know, it does absolutely nothing, nothing whatsoever because I've been there and done it, it doesn't really inform a lot of the treatment that that person truly needs. So, I think scrap it, simplify it, and focus on relationship and rapport building." (Stakeholder Interview)

"It's about relationship building. That's the key thing. It's about getting a relationship with your practitioner first and probably not talking about what you need to be talking about until you get to know each other. It shouldn't be time bound." (CGL Staff Interview)

When specifically considering the assessment for the prescribing service, the content was said to be good, with new starters being prioritised for clinic appointments.

"It's a very holistic assessment that we do. We will look at their physical health, their mental health, their social situation, including children, family, and we also look at their criminal background. Lots of things, it's about the whole person." (CGL Staff Interview)

However, waiting times were again flagged as a problem, and this seemed to be more of an issue in this context. Lengthy periods of time between referring and being scripted, and then subsequently titrated to optimum dose left opioid users to continue using to manage or avoid withdrawal symptoms, and further build tolerance.

"I've found the new-start clinics that I have been part of and participated in have all been well executed and thorough, with ample time given to focus on the needs of the individual rather than just as a scripting service. No concerns at this time." (Stakeholder Survey Response)

"Very long assessment process for OST [Opioid Substitution Treatment] initiation which is difficult for those who struggle with paperwork and concentration." (Stakeholder Survey Response)

"Self-referred and the 6 weeks wait to start an opiate replacement programme was difficult." (Lived Experience Survey Response)

Regardless of the wait, CGL was described as offering a professional service at this stage, having good communication about the process.

"It was a good process, and I was kept informed of what would happen next. It all went smoothly." (Lived Experience Survey Response)

"Assessment was thorough and professional." (Lived Experience Survey Response)

"Couldn't fault the process in my opinion and my situation." (Lived Experience Survey Response)

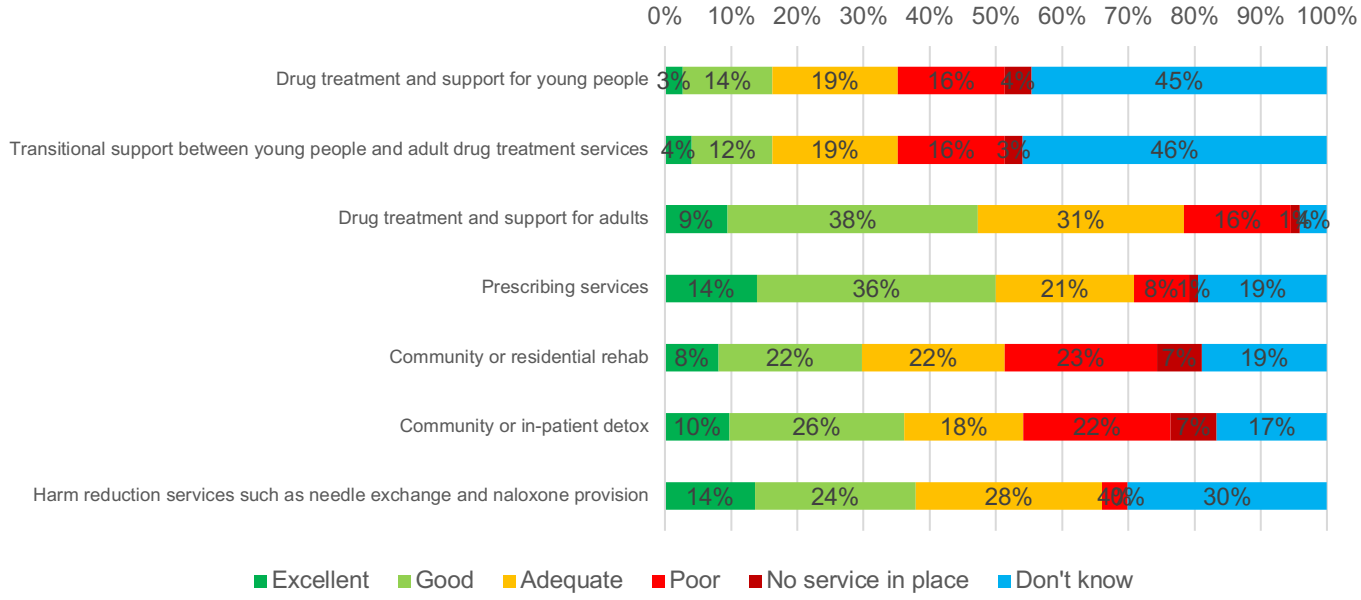
Treatment

Professionals rated prescribing services and drug treatment and support for adults most positively (50.0% and 47.3% respectively), while they appeared to be most uncertain about drug treatment and support for young people as well as the transitional offer (44.6% and 45.9% 'don't know' respectively).

"We have the clinical, which is the bio side of things, and then the psychosocial, so, the groups and the one-to-one work that people do, that works really well." (CGL Staff Interview)

"Good options are available if the service user wishes to engage." (Stakeholder Survey Response)

Figure 33 Professional Survey Respondents' ratings for the Treatment Options within Substance Misuse Services in Warwickshire



The next page provides some quotes and feedback on the existing providers from participants.

"My worker has been absolutely fantastic." (Lived Experience Interview)

"It's been an absolute lifesaver." (Lived Experience Focus Group)

"Good outcomes for those who access the service - customer feedback is positive." (Stakeholder Survey Response)

"You're so caught up in this world that is absolute chaos and it's nice to have somewhere to calm down" (Lived Experience Focus Group)

"With their help, I beat heroin addiction." (Lived Experience Survey Response)

"I have no complaints with CGL." (Lived Experience Interview)

"They're professional and they don't judge you." (Lived Experience Interview)

"I felt like it was traumatic, but I also felt like it was the best thing that I'd ever done." (Lived Experience Interview)

"I've had a few slips while I've been coming to CGL, I've been here for over a year now… because of what I've learned from CGL I've managed to pull myself out of it. I had a slip about 3 weeks ago now and it came from nowhere, it just hit me, I was so ill, I was verging on hospital, but somehow I managed to pull it around within a matter of days and stop… that was all because of everything I have learned from CGL. CGL has saved me really." (Lived Experience Interview)

"My one-to-ones have been amazing, when I was going through a really bad time, I probably could have asked for a phone call every day and they would have done that for me… when I was going through a really bad time she was always there for me." (Lived Experience Focus Group)

"I am very grateful, it has kept me sane." (Lived Experience Focus Group)

"You can fly or you can sink and there is no judgement." (Lived Experience Focus Group)

"I'd be lost without CGL." (Lived Experience Focus Group)

"I wouldn't be sitting here now; I wouldn't be alive without the help I've had and that's a fact." (Lived Experience Interview)

"I've got no doubt that I wouldn't be where I am today if it wasn't for the help of these groups… the staff are absolutely invaluable, they will go out of their way for any of us, they are always willing to help, they spend hours in the evening looking after us on the phone when they should be with their own families, it's that above and beyond that makes the support as successful as it is." (Lived Experience Focus Group)

"I walk away from appointments feeling so much better." (Lived Experience Interview)

"Staff genuinely want to help." (Lived Experience Interview)

"I think Compass are fantastic." (Lived Experience Interview)

"The best thing about CGL is they provide a support system." (Lived Experience Interview)

"I just can't sing their praises enough" (Lived Experience Focus Group)

"If I needed her [key worker name removed], she was there." (Lived Experience Focus Group)

"CGL served me so well." (Lived Experience Interview)

"The practitioners themselves are the best thing about CGL, I know within the team are really good practitioners. I think the quality of work they're delivering is really good. I think it has impact. They see change from that. I think it's the whole system that isn't working well." (Lived Experience Interview)

"For me, it's having someone to hold you accountable. It's having that person to report back to once a week or once every few weeks, it makes you think about what you're doing more because you have someone checking on you and making sure you're ok. They can't force you to be sober or stop doing drugs or whatever but what they do do is support you while you're going through it and make sure you're not being unsafe… having that person there is really important." (Lived Experience Interview)

"Compass have always been great." (Lived Experience Interview)

"The right person can get you to the place you want to be." (Lived Experience Focus Group)

"My key worker was very understanding and non-judgemental, they were interested in teaching me the motivational skills to move forward. Therefore, I was receptive in response." (Lived Experience Survey Response)

"It's just that consistency of a regular time, it's a structure every single week with people you know, and trust, you just work together." (Lived Experience Interview)

"They just never give up on you. That's one good thing, even when you've sort of given up on yourself, they haven't." (Lived Experience Interview)

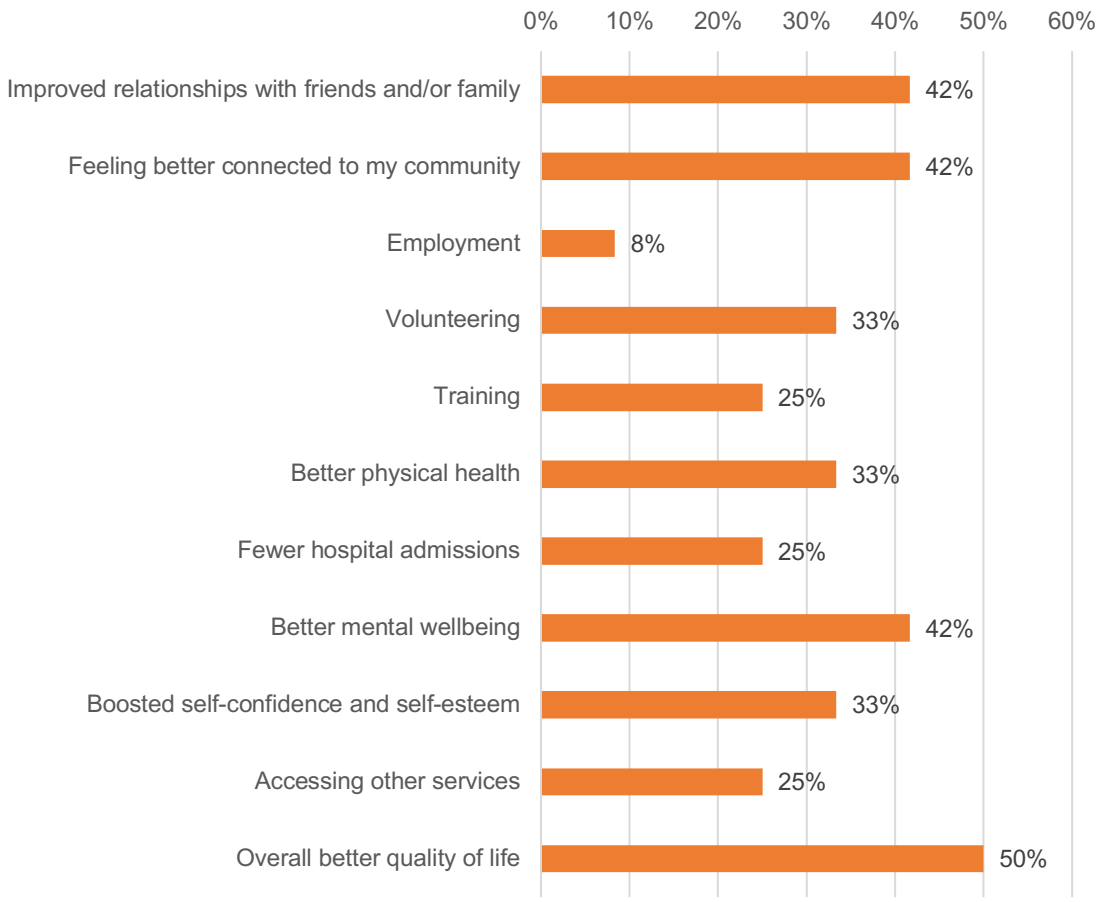
"If it wasn't for CGL I wouldn't be stable… it's a great service." (Lived Experience Interview)

"I feel I am very supported and looked after in my recovery and I have been a part of the decisions made in my recovery." (Lived Experience Survey Response)

"I don't have a bad word to say about Compass." (Lived Experience Interview)

Generally, those with lived experience provided positive feedback about current service providers when they felt they had experienced a non-judgemental, flexible approach to support, based on their individual needs. People appreciated being able to text or phone their key worker when they needed between appointments, typically describing their workers as *"very easy to talk to"*, often saying the best thing about the current services is feeling listened to and supported. Many service users liked when their Recovery Co-ordinator had a 'straight talking' approach with them, and Compass in particular was praised for having persistence with those initially reluctant to engage. The below graph shows what impact those in the survey with lived experience believed accessing support has had on their life.

Figure 34 Service User Survey Respondent's Self-Reported Impacts / Outcomes of Treatment in Warwickshire



During interviews, stakeholders described there being lots of treatment options on offer, and providers being service user led.

Transitional Support

On paper, the current model in Warwickshire, whereby young people can access support via Compass up until the age of 25 to help reduce the stress of transitioning to the adult service, appears to be a robust one. This is supported by research within the mental health field that proposes this type of model as best practice, given that for young people, approaching the age of 18 can be a time of significant change and uncertainty characterised with them starting to make key life-long decisions as they move towards an age of greater independence and responsibility including decisions about further and higher education, jobs and careers, leaving home, and starting relationships. Therefore, reducing pressure to transition to the adult service at this already challenging time should be beneficial.

"Young people at 18 are not automatically ready to jump into an adult service." (Stakeholder Survey Response)

However, it is unclear how well this is working in reality. Compass service users spoke extremely highly of the individual transitional worker, as did external stakeholders who said this is a valuable role – despite saying there is a need for an additional worker as they are always at capacity. Nevertheless, joint working between Compass and CGL appeared to be lacking, and CGL stated they receive minimal referrals from Compass, which is a clear gap in the current system, leading some stakeholders to suggest one provider for all would be better.

"I can't remember the last time Compass referred anyone to us." (CGL Staff Survey Response)

"I don't think I've ever seen a referral for an individual from a young person's recovery service to our own. I've taken referrals which we've had to signpost back as they are too young to access our service, but besides that…" (CGL Staff Survey Response)

"There's not really much communication between ourselves [CGL] and the young person service." (CGL Staff Interview)

"Again, not enough staff in place to make this run smoothly. More linked up working needs to take place as well between the different departments." (Stakeholder Survey Response)

"Why do they need to transition, why can't we have one service that is for all ages?" (Stakeholder Survey Response)

On the other hand, we heard anecdotal evidence that CGL sometimes turns young people away until they are over the 25 years threshold and that this can be damaging to the individual's confidence for then reaching out for support in the future.

"CGL wouldn't see me when I was 19, even though you have to be 18 to start there, but I think it's just because they're overwhelmed with all the adults and Compass will do up to 24-year-olds or something, so they were like 'just go to Compass'." (Lived Experience Interview)

For young people requiring some form of prescribing, whether that is an opioid substitution treatment or for acamprosate or other equivalent medication (to help prevent cravings and urges to drink alcohol), they have to engage with a key worker and prescriber from CGL for this, alongside their support worker with Compass, who leads the psychosocial element of their support. This was described as an unnecessary duplication of resources and service users were not very satisfied with this set up as it did not seem to be working efficiently.

Psychosocial

Both the Children and Young People and Adult Substance Misuse Services offer psychosocial support in the form of one-to-ones and group work. While it is important to retain a mixed approach, as some individuals are not comfortable or confident in group settings, which can also be triggering if some individuals are not doing very well, generally staff and service users spoke most positively about group sessions.

"I definitely think that the groups are one of the better things that we offer." (CGL Staff Interview)

"This group kicks me back into touch and I always think I am so glad I went." (Lived Experience Focus Group)

"It's the support network and friends that you make from groups… it's a little community, you're not judged, you can say exactly what you want, where it can be hard to say that to your family." (Lived Experience Focus Group)

"The groups are fantastic, I've never had anything like that in my life before, a real eye opener." (Lived Experience Focus Group)

"The relationships you build with the other people in groups is what makes you want to come back to make sure everyone is alright and it makes you want to do well and not let them all down really or yourself, they are forgiving… they are the only people you can tell you have messed up and they don't tell you that you've failed." (Lived Experience Focus Group)

"Group work is really, really dynamic, it's really exciting, you can see some massive movement for people. You get to see people on a weekly basis for a solid 2 hours, rather than once every 4 to 6 weeks, for a quick 30-minute check in. It's structured so that we have psychoeducation, as well as the psychosocial stuff." (CGL Staff Interview)

"Group work and having that face-to-face contact really helps people because they become more responsible and accountable for their own recovery. I do think that helps - the psychosocial part of it." (CGL Staff Interview)

Constructive criticism received about the psychosocial elements was that Compass has been *"very slow"* to get group sessions back up and running post-COVID, and for CGL, attendance was described as variable across the sites based on staff buy-in, with groups being most well attended at the CGL Rugby site. Encouragingly CGL offers a range of online groups facilitated over zoom to increase accessibility to those in full-time employment, living in the most rural parts of the county, or who struggle with travel.

In addition to what is already on offer, service users requested that commissioned providers explore the possibility of running more creative activities, day outs, or trips, that help to build their confidence and take them away from talking solely about their addictive behaviours. A small number of service users also asked for alternatives like acupuncture to be offered. Those further along in their recovery now typically wanted the opportunity to create a new identity for themselves in which they are not defined by their substance use, as well as expanding their support network to incorporate more prosocial people. Disassociating from known or ex-users was said to be particularly challenging and some people opted not to attend mutual aid meetings for this reason. CGL informed us that they have some OHID funding which they are looking to use to trial 'diversionary activities' and want to be guided by what service users about what activities they would like most. CGL have previously run art classes and had facilitated 'walking groups' during the pandemic, which they said clients found to be *"very therapeutic"*.

"They could try to organise a trip for users, a group trip… being a user you don't get to go out like that so it would be something positive to look forward to." (Lived Experience Interview)

"I don't think there's not enough free clubs, groups, activities… someone might be an amazing rock climber and that might be their outlet. They may never touch drink or drugs, again, if they go rock climbing, but if it's not there for them to try in the first place, then they're never going to have the opportunity to know any different." (Stakeholder Interview)

"Just to keep their mind occupied, and not just related problems, but take their mind away from using, so they're not thinking about it. If you go into a meeting, and you're talking about it all the time, it puts it in your head. Whereas if you go to a group session where you can all relate, because you've all been through the same thing, you can all talk to each other and get advice from each other. But then there's an activity to take the mind off afterwards." (Lived Experience Interview)

"I do think that we need to think about social prescribing more… plugging young people back into communities, because I think that's what we hear a lot of the time, especially with COVID is actually they're feeling quite disconnected or not part of something." (Stakeholder Interview)

"I think we don't ask enough strength based questions…. Tell us what you want to do? What are you interested in? Do you like horse riding? Do you like doing art? What are your interests? Let's start there. Let's talk about you know, what's going on there for you. So I think there's that type of stuff." (Compass Staff Interview)

CGL offer virtual mindfulness group sessions three times per week, as well as having recently secured some funding for equine therapy in Stratford, but service users wanted to see a wider variety of options.

"Perhaps gardening or something like that? I think that's really good for mental health people who want to plant things. It's giving them something at the end of it, giving them a reward, because they've actually grown it from scratch. I've actually done that myself, off my own back, I have managed to get an allotment. I just go there, and I just feel at peace and relaxed. So, it's good, it's good for people, I think that would be ideal." (Lived Experience Interview)

"Rather than just having set groups. I think maybe having more social stuff going on." (Lived Experience Interview)

Within the survey, respondents with lived experience were asked to think back to the last time they had a lapse or relapse and tell us what would have helped them to do things differently. Most respondents stated different personal and family circumstances as the reason for their relapse. However, many spoke about the need for improved access to positive, drug free social communities that would have prevented their relapse. They spoke about how these could be provided through more social activities run by support services, emphasising the importance of this.

Clinical (Prescribing)

The current adult treatment provider CGL offers methadone and buprenorphine prescribing as opioid substitution treatment for clients requiring this, and feedback on this part of the service was very positive. TONIC observed numerous clinical appointments, which were generally attended by the key worker or stand-in Recovery Co-ordinator, which was good. There were some inconsistencies in how thoroughly prescribing agreements were covered and understanding checked for new starters, but on the whole service users reported no issues with their prescribing appointments and reviews once scripted. Non-Medical Prescribers (NMPs) in particular appeared to be very holistic in their approach to checking in on all aspects of the individual's lives and making sure the appropriate support was in place, as well as constantly refreshing harm reduction advice.

"The adult treatment provider co-ordinate a good service here - evidenced by the number of people using the service." (Stakeholder Survey Response)

"We have excellent doctors and prescribers who prioritise needs and high-risk clients - good liaising with local pharmacies." (Stakeholder Survey Response)

There is a particular challenge around individuals who 'fall off' their prescription regularly and CGL Warwickshire demonstrated a policy of 'suspending' people's prescriptions if they had not been seen for some time. There is a fine balance between risk management and working with individual nuances. One individual was distressed she could not be prescribed due to a low blood pressure, which she reported meant she 'had to use'. Those who present without opiates in their system, after falling off their prescription but not using, are unable to be prescribed which presents the individual user with a conundrum of continuing to abstain or using illicitly to be re-prescribed. We observed appointments where people who had 'come off script' but had used over the weekend were prioritised by way of harm reduction.

CGL hosts evening clinics for those who require a prescription but are working.

In terms of CGL's clinical offer, professionals felt the only way to improve the service would be to increase the number of qualified prescribers employed and potentially review the prescribing staffing structure, as currently each prescriber is expected to oversee a very large number of clients – a mixture of whom want to restart, titrate, maintain, and reduce their doses. At the time of writing this report, the prescribing team consisted of:

- Two full-time non-medical prescribers (who are both qualified nurses) – one based in the North and one in the South
- One part-time (0.50 FTE) speciality doctor – who covers the whole of Warwickshire
- One prescribing doctor who works 10 hours per week – based in the North
- Two prescribing doctors who work 3.5 hours each – one based in the North and one in the South.

It was highlighted to us that CGL Warwickshire have had real difficulty with recruiting and retaining a Consultant Psychiatrist (since around May 2021), meaning any concerns have to be escalated to the regional consultant.

"I think what is working well is the prescribing, but we need more doctors basically." (CGL Staff Interview)

"From my NHS experience, 100 was the absolute max for one NMP. Whereas in Warwickshire, there are hundreds under each person, but then they're expected to do maintenance, reduction, and all of that with the key workers." (CGL Staff Interview)

While CGL were described as having an excellent relationship with most of the local pharmacies across the county, and individual pharmacists were praised as really good at their job, CGL staff identified issues surrounding capacity. We were told that many of the pharmacies do not have the spaces to take on new clients and others are closing down unexpectedly. This problem was described as most prominent in the Leamington Spa area, but is an issue on a national scale that needs looking into.

"We're really struggling with pharmacies at the moment because they're not able to take on a lot of clients. We have certain pharmacies that can't take on any more clients. We've lost some availability with some of the pharmacies where they're shutting and not informing us." (CGL Staff Interview)

"It's the Leamington pharmacies we're struggling with closures, and not having the pharmacists." (CGL Staff Interview)

The result of this is requiring scripted clients to have to attend less local pharmacies, which was already something service users were not happy about, with those living in the most rural locations having to travel long distances to access their nearest available pharmacy. Service users told us this commonly leads them to miss collections and instead use illicitly.

"There's not that many pharmacies for clients that live further afield. So, they're quite limited on choices." (CGL Staff Interview)

In late August / early September 2022, CGL Warwickshire are set to start a pilot of the long-lasting opioid replacement treatment option – Buvidal, which supports service users to stabilise and maintain their recovery, offering a new and promising opportunity for those more 'serious' about recovery and who do not want daily or weekly pick up. However, OHID funding will only initially allow for seven clients to access this across the whole of Warwickshire – this is likely to be four within the North of the county and three within the South. CGL staff were set to attend Buvidal training the week after our site visit. Staff expressed concerns about how individuals will be prioritised and selected for this, saying: *"how do we offer an equitable service with patients all having the same access to treatment?"* It will be important to closely monitor this pilot and explore upscaling if proved to be as successful as early findings in other areas suggest it is likely to be.

Positively we were informed that six out of the seven locally HMPPS run prisons in the West Midlands have procedures in place to continue a Buvidal script if someone was transferred into the establishment already on one.

Rehabilitation and Detoxification

CGL was described as having good links with relevant stakeholders for rehab and detox.

"There is a wide range of ambulatory and residential detox provision, a new framework of providers and some good outcomes." (CGL Staff Survey Response)

The main feedback we received about residential rehabs and detoxes was that service users and staff would like to see significantly more places with reduced waiting times. There is also a national issue around rehab placements not accepting clients who have a history of sexual offending or arson.

"Can be very difficult to get a funded placement, and people have to jump through hoops to get this." (CGL Staff Survey Response)

"Demand always seems to outstrip supply." (Stakeholder Survey Response)

"Feedback from service users that have completed rehab has been positive - however, lack of funding and placements." (CGL Staff Survey Response)

"Paperwork heavy process, a need to go to a funding panel monthly delays ease of access to rehab for holistic recovery. Should be prescriber and key worker decision and funding already accessible with quicker direct detox/rehab bed admissions." (CGL Staff Survey Response)

Harm Reduction

Generally, participants felt harm reduction provision within Warwickshire is a strength of the current system, with some room to improve promotion of this amongst substance users not in service and for people not

working directly with those using substances (i.e., frontline practitioners for other commissioned support services).

"The adult treatment provider performs well in providing harm reduction services." (Stakeholder Survey Response)

"I think there is plenty of opportunity at the moment for users to access needle exchange services, both at their local pharmacy or through a community provider like CGL. The harm reduction advice and measures are there." (Stakeholder Survey Response)

"I wouldn't even be able to name a needle exchange base in Warwickshire - so if there is, this needs to be publicised and shared better." (Stakeholder Survey Response)

Needle Exchange

Many of the service users we interviewed during our site visits had a history of accessing needle exchanges and none raised any concerns – we typically heard that hospital or chemist needle exchanges were physically easier to access than CGL, but that CGL's needle exchange was *"more complete with nothing missing from the packs"*. CGL staff are provided with relevant training to deliver this service and the range of places offering needle exchanges across Warwickshire can be seen as a strength promoting safer consumption, but there is always room for expanding this further. Survey responses implied there is very limited access to needle exchange for residents in Bedworth specifically.

"Many of the pharmacies do needle exchange which I think is good." (Stakeholder Interview)

"In terms of needle exchange, I think the provision that we have in CGL is really good." (CGL Staff Interview)

"Nationally all drug services could be doing more to get safe injection equipment to a lot more people." (Stakeholder Interview)

Naloxone

During our site visits, in almost all of the appointments TONIC shadowed with service users who had an opioid as a substance of choice, the individual was asked about whether they had a naloxone kit, and staff checked on the system that it was still in date. Where service users either did not have a naloxone kit already, or it was from an out of date batch, a new kit was issued, lock boxes were offered, and uptake was extremely high. Similarly, every prison leaver we spoke to said they had received naloxone training before their release, which was very positive, and the prisons across the West Midlands region were described as *"very much focused on take home naloxone"* with many operational staff (including Custodial Managers and Heads of Function) receiving relevant training on naloxone. To improve this further, staff could work on highlighting and reminding their service users of the importance of actually carrying their naloxone kits – particularly for those still in active addiction – as most stated their kit was at home, and not on their person when using.

"Warwickshire are really, really good at getting the naloxone out, and understanding the risks around it, having those conversations with service users. So as much as the formal training is not there, whatever's been done, is working because the figures are still really really strong despite the turnover of staff." (Stakeholder Interview)

CGL staff felt that if funding allowed, their uptake of take-home naloxone would be even higher if they could offer nasal naloxone.

"Nasal sprays would make it far easier for people - I know, it's quite expensive and I believe that's why it's not used as much, and I think it goes out of date quicker - but actually, if it saves somebody's life, it's quite helpful, isn't it? And it's an easy thing to use. If I was walking down the street, and I saw somebody unconscious that I suspected had overdosed on a substance, it would be very easy to use." (CGL Staff Interview)

There appeared to be inconsistencies in the level of naloxone training staff had received and some staff said it was a shame that they were not able to carry a naloxone kit themselves and were unsure why this was the case. However, management said there were no issues with this and that staff are able to carry their own kit. Naloxone training could be incorporated into new starters induction package and refresher training should be offered to staff to ensure their knowledge remains up-to-date. This is important as some stakeholders spoke about how *"lots of myths about naloxone still remain"*, particularly around naloxone only being for people who inject heroin.

The CGL Asset Based Community Development Co-ordinator was described as regularly delivering naloxone training (as well as using these sessions as an opportunity to raise awareness of the adult Substance Misuse Service) to other organisations and expressed a desire to expand this provision to local taxi drivers, McDonalds staff, and others who are most likely to come across individuals who may have taken an opioid overdose. Within the survey there was a suggestion that it would be beneficial for Substance Misuse Services to deliver more training to people housed in accommodation where known users and dealers are often housed.

The police in Warwickshire do not currently carry naloxone, with it only being available to them within their custody blocks. We heard that there are ongoing talks in which consideration is being given to piloting officers carrying this, but it should be explored who is most appropriately positioned to do this.

Blood Borne Viruses

Whilst onsite at CGL Nuneaton, TONIC observed a staff training session delivered by the Hepatitis C Regional Lead (this had also taken place at CGL Rugby the day prior). Staff appeared to be confident in offering and encouraging uptake of BBV testing and Hepatitis B immunisations – indeed, we witnessed several service users have refresher tests during their NMP reviews – the uptake of this appeared to be good and within some of the hubs adverts were clearly visible promoting regular testing and incentivising Hepatitis B vaccination. We were told that as a service, CGL is *"testing more now than ever before"*, that *"Warwickshire are very committed to eliminating to Hep C"* with sound relationships, that must be retained, with relevant agencies for Hepatitis C – treatment can be sought via the George Elliot Hospital.

For less confident or newer staff members, it is important that they are encouraged to take up the training on offer and ensure they explore the reasons behind a refusal to be tested.

"It is about offering it in the right way and making it accessible, and reoffering it multiple times. You need to unpick what people are scared of if they refuse a test." (Stakeholder Interview)

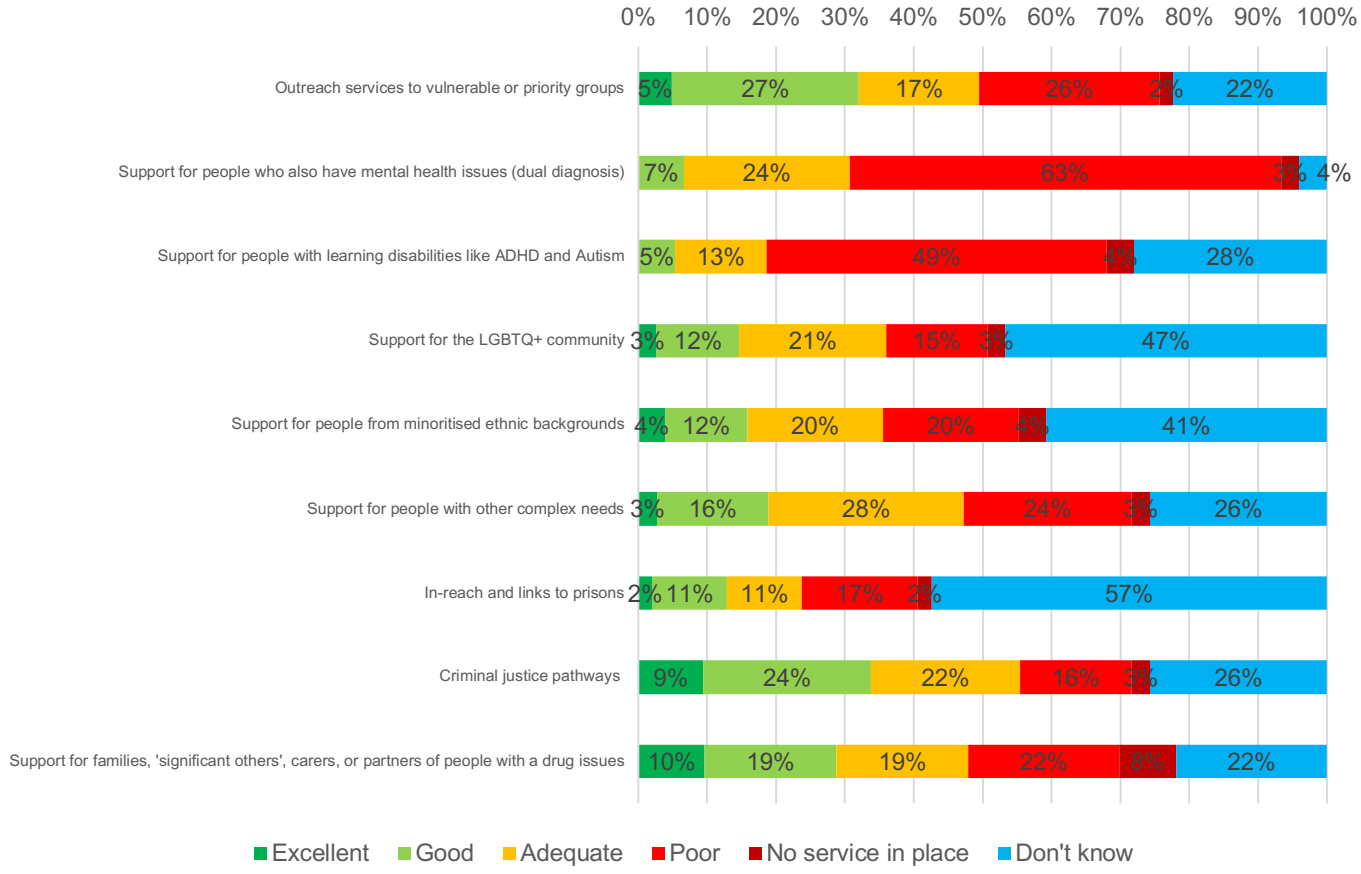
"If you make it something you do for everyone, then it feels less stigmatised." (Stakeholder Interview)

In-reach, Outreach, and Promoting Inclusivity

The next graph displays professional survey respondents' rating for in-reach and outreach with various types of 'vulnerable at risk' cohorts. The most negatively rated aspects were support for people who also have a

mental health concern and support for people with learning disabilities (66% and 53% 'poor' or 'no service in place' respectively).

Figure 35 Professional Survey Respondents' ratings for the In-Reach, Outreach, and Inclusivity of Substance Misuse Services in Warwickshire



Physical Disabilities

All of the CGL sites we visited had considered disabled access, and staff said they have a good relationship with local disability services. Most buildings had meeting rooms located on the ground floor or had lift access so that individuals with mobility issues could use the service comfortably. The main barrier here is in terms of the distance some service users are required to travel to get to the CGL hubs. In instances where a service user has a particular disability or experiences other barriers preventing them from attending a hub, the CGL team can conduct home visits.

Compass workers conduct their appointments within the community and can do home visits to ensure physical disabilities do not hinder an individual's ability to access their service.

Mental Health (Dual Diagnosis)

We were consistently told the *"biggest problem is mental health provision"* and that *"the community mental health teams are often very reluctant to work with clients who have alcohol or substance misuse issues. It is a massive barrier to clients coming off alcohol and coming off drugs, because they're self medicating the mental health issues, in my opinion, through these substances".*

"People are often fobbed off until alcohol or drug use is addressed but it's impossible to address without mental health input." (CGL Staff Survey Response)

"Mental health services are a constant battle. They're very quick to point the finger and say 'they're intoxicated, you deal with it first'. It's the whole chicken and the egg thing. You know, with a dual diagnosis, it's so hard to put it forward to say, this person's out of their face, because they're depressed or anxious." (CGL Staff Interview)

"Mental health is a huge, huge gap I'm struggling with at the minute in regards to when they've got dual diagnosis. There is a big gap in that mental health services won't work with them when there's an addiction. However, CGL hasn't got a psychologist or people on the team that can address mental health. So, there is a real gap." (CGL Staff Interview)

Although there should be a dual diagnosis pathway in place, there is evidently a need for better partnership working from mental health services to ensure support is joined up.

"Things need to be treated simultaneously, so I think working together with mental health, having a proper liaison with or connection with mental health or recovery workers in the mental health team or vice versa, will be essential to get any sort of help at all." (CGL Staff Interview)

CGL have a small designated Dual Diagnosis team, which was said to have enabled good partnership working with inpatient facilities. However, some colleagues raised concerns that these workers are not specifically trained in mental health and it would instead be better to have an in-house psychologist. There is also a need for this within the Children and Young People's service.

"They need a dual connection with mental health services, that is a massive, massive one for me. That applies to both CGL and Compass – there is no ongoing dual care for people with addiction issues, and people with mental health issues… people forget most of the time people who are using have had mental health issues in the first place which have caused them to start using… mental health services need to understand that or it would be good if the drug team had a psychologist or psychiatrist on the team." (Stakeholder Interview)

"Any drug programme should include mental health support. You can not deal with issues like addiction by just reducing the script. You need to address traumas and the catalyst behind addiction, or else the whole process is pointless." (Stakeholder Survey Response)

"I think it'd be good to see more in-house counselling, I think that's missing, possibly CBT also." (Lived Experience Interview)

Those with lived experience also emphasised the need for better support of service users' mental health. Specifically, over half of the survey respondents commented on the value of counselling and support groups that would help service users identify the root causes of their addiction and aid recovery.

"Personal counselling with key workers, therapists and mental health professionals can help resolve root causes of addictions" (Lived Experience Survey Response)

"The reason it doesn't work is because people don't have mental health support and that's what is important to keep your sobriety once you've managed to get off drink and drugs, you need ongoing mental health support after you're sober." (Lived Experience Interview)

In addition to CGL's Dual Diagnosis team, they offer voluntary student counsellor placements (supervision is provided via the associated educational establishments), which were highly rated amongst staff. However, there is very limited capacity to this, and individuals who express an interest must go on waiting lists.

"We have the most amazing volunteer counsellors who are doing their hours with us as part of their degree. They add what is missing. So, where there is a complex client to be able to refer them to those counsellors is amazing." (CGL Staff Interview)

"Every single one of our service users could really do with a stint in counselling but there isn't that support available." (CGL Staff Member)

Learning Disabilities

Despite a documented link between learning disabilities and substance use, there is no specialist support on offer and no specific training available to workers within the Substance Misuse Services. This was identified as a clear gap in the current system.

"Never witnessed any CGL clinician acknowledge neurodiversity and how to change ways of working accordingly." (Stakeholder Survey Response)

"I'm not sure how confident Compass practitioners would be in adapting their treatment or interventions to neurodiverse young people." (Stakeholder Interview)

"As well as lived experience in addiction and alcoholism I also have a diagnosis for ADHD. Getting the diagnosis was impossible in Warwickshire due there being no adult ADHD referral service available - this was in 2016/17 - I had to go via my parents address in Leicestershire to enable the process to even begin let alone receive treatment. The link between ADHD and addiction is huge and quite obvious. To me it is baffling as to why this isn't addressed more readily." (Lived Experience Survey Response)

"I work with a client who has severe ADHD, because of this, they started self-medicating with alcohol and illicit amphetamine use at a young age. This spiralled out of control, to the point where they recognised they needed help to stop the amphetamine and alcohol use. Following a detox, mental health services have refused to engage with them, not because they are currently dependent drinking or using amphetamines - both of which stopped, the amphetamine use prior to the detox, and the alcohol use from the detox - but because ADHD does not come under their specific remit. As a client, they face a very real risk of lapsing back into alcohol or amphetamine use because they cannot receive professional help to manage their severe ADHD. To make matters worse, there is on average a 4 year wait for someone with ADHD to be diagnosed and start treatment, following a referral from their GP. 4 years. For someone who has only just managed to become clean of all drug and alcohol use. Now you tell me, what are the chances that over the course of that time this individual, who up until now has never received support for their ADHD or addiction issues, and will have other very real social and psychological issues tied to this, will relapse into dependent use? And then tell me this is 'accessible'." (CGL Staff Survey Response)

"Lack of understanding by professionals in this area - more training and awareness needed." (Stakeholder Survey Response)

LGBTQ+ Community

Participants did not raise any concerns regarding inclusivity for service users identifying as LGBTQ+. The Asset Based Community Development Co-ordinator had recently attended a Pride event in Leamington Spa.

"All those working for all agencies have proven accepting and supportive to the LGBTQ+ community." (Stakeholder Survey Response)

"CGL support both staff and clients in this category." (Stakeholder Survey Response)

"No concerns at this time. CGL treat everyone equally and fairly, with no bias regarding their gender identity or preference. This has had a beneficial effect on client's time in treatment." (Stakeholder Survey Response)

However, there was an acknowledgement of additional barriers individuals identifying as LGBTQ+ may face, particularly for transgender individuals, necessitating more assertive outreach and engagement with these communities.

"I've worked with a lot of trans women in my lifetime and it's very difficult for them to access mainstream services." (Stakeholder Interview)

"The LGBTQ+ community need to be specifically targeted, in reach work needs to be done to gain their trust." (Stakeholder Survey Response)

During the fieldwork for this needs assessment, nobody mentioned chemsex as a concern within Warwickshire, it is unclear whether this is representative of the true picture, or the fact that it is likely a hidden issue.

Minoritised Ethnic Communities

For 2021-22, the OPCC granted funded (value of £5,045) Equality and Inclusion Partnership (EQuIP), who worked in partnership with Compass to deliver a 'Drugs and County Lines Awareness' project. The project aimed to engage minoritised ethnic communities, particularly women, on drug and substance misuse awareness. EQuIP targeted women so that they are better able to recognise the different types of drugs and know what to look out for. The project also worked to educate minoritised ethnic communities about young people and county lines, about which anecdotally there is poor awareness. EQuIP reported that initially it was quite difficult to engage with some diverse community groups due to the taboo nature of this type of conversation but said once they had established the necessary relationships and delivered their sessions, they felt this project had been successful and said they received very positive feedback.

EQuIP stressed the need for persistence in outreach work to minoritised ethnic communities to build trust and confidence and that this needs to be continuous work, not run as ad hoc projects. Additionally, the need for culturally appropriate messaging was highlighted in any promotional materials.

"Services are available but poor engagement due to trust and confidence issues." (Stakeholder Survey Response)

"Unless you reach out to them, they don't actively try to reach out to you." (Stakeholder Interview)

"Recent focus on increasing accessibility for minority groups has been a knee jerk reaction to high profile media events rather than a genuine active approach to inclusion and accessibility." (Stakeholder Survey Response)

Furthermore, participants believed that frontline practitioners should be provided with more culturally informed training that helps them to understand the nuances of drug and alcohol use within different cultures,

so that they do not just have a UK perspective on this matter. For example, EQuIP spoke to us about different pockets of communities having different substances of choice and varying cultural norms that should be better appreciated by workers.

"There is a lot of work to be done with agencies to improve cultural awareness and cultural competence." (Stakeholder Survey Response)

There was evidence of services trying to adapt their provision, but scope for further improvement and more connections to be made with faith-based groups, particularly considering what can be done to make sure support is accessible to those who don't speak English as their first language.

"We've made sure that all our leaflets and things are all indifferent languages because we're getting quite a high influx of Polish and Romanian service users, so we are trying to be more inclusive to make sure that we can cater for them." (CGL Staff Interview)

"I feel like what would be really good is if groups were spoken in different languages. So for example, I know that in Rugby there is a lot of Polish speaking people who are really suffering with alcoholism - I'm talking about people who are drinking a litre of vodka a day - these individuals can't access our groups because yes they'll understand bits of it, but if you don't understand all of it, how can it make sense?" (CGL Staff Interview)

"It's hard to access Punjabi speaking Detox and Rehab services in the West Midlands." (Stakeholder Survey Response)

Pregnancy

There is an apparent need to combine maternity services and drug and alcohol services to improve partnership working. Numerous barriers for pregnant women accessing substance misuse support were identified, such as the waiting room environment being daunting and uncomfortable. In addition, pregnant women can face extra judgement and shame when walking into a Substance Misuse Service site from the public. In an attempt to address these barriers, the Substance Misuse Service in Birmingham has benefitted from having a dedicated midwife whose role is to liaise with CGL and pregnant substance users. Training sessions for hospital staff and midwives have also been provided to ensure staff are better educated and to remove the prejudice directed at pregnant women in addiction. Staff within the adult Substance Misuse Service said they would like to see this replicated in Warwickshire and felt having a specialist midwife would be hugely beneficial on top of the pregnancy pathways they currently have in place in most areas.

"I think it's [a specialist midwife] still important to have, especially if they cover a region, because it helps for liaison with the maternity wards and deliveries, then where people are going in for delivery and then being advised on what's safe, what's not safe." (CGL Staff Interview)

Sex Workers

There is no specialist work or support in place for sex workers with substance misuse problems despite them being a key group identified as at high risk of drug use and dependence, and this being a group targeted in other areas.

"If people are sexually active [as a sex worker] they're more likely to be using substances as well, so why don't we join those two together and have a look about how they can be creative together." (Stakeholder Interview)

"Wherever you've got people using heroin and crack, you will have sex sold. It's the easiest way to get money if your life is chaotic." (Stakeholder Interview)

The existing model in Birmingham aims to bring together support for sex workers, sexual health services, and drug and alcohol support services. In addition, the model aims to overcome barriers to accessing support faced by sex workers. This involves strategically placing outreach Recovery Co-ordinators within sexual health clinics and hospitals to offer preventative and emotional support. In addition, this worker can offer rapid drug testing and prescriptions which combat the long waiting times in hospitals that often result in people dropping out of the service. The model relies on the fact that once a connection is built with the sex worker they can be more easily signposted to mainstream drug services, such as CGL.

It is important to acknowledge that it can be very difficult to ascertain levels of sex work generally, and specifically in Warwickshire cases are said to be very low, reportedly with no 'on-street sex workers' in the county – all being 'in property', so more difficult to engage with.

Criminal Justice Pathways and Continuity of Care for Prison Leavers

Alongside CGL's 'core service', the OPCC currently commissions CGL as the provider for the Adults Criminal Justice Drug and Alcohol Abuse Service. For this, CGL works with a number of partners across Warwickshire, including the police, prison, and probation services. CGL works on the 'Test on Arrest' (ToA) programme in Warwickshire, which is led by the police, and provide assessments and ongoing support throughout particular orders alongside probation, such as Drug Rehabilitation Requirements (DRR) and Alcohol Treatment Requirements (ATR). Additionally, CGL works closely with the Integrated Offender Management (IOM) teams for those people who are using substances and are causing the most harm in the communities, trying to break the cycle of crime, reoffending, and substance use. Clients accessing CGL's Criminal Justice response, receive support from dedicated workers but have access to all of CGL's core service provision.

"Small criminal justice team but due to funding and unable to cover all areas across Warwickshire and prisons. They do an amazing job for what they are but massive gap in funding." (Stakeholder Survey Response)

Like with CGL, the OPCC currently commissions Compass as the provider for the Children Criminal Justice Drug and Alcohol Abuse Service. For this, Compass works alongside the Youth Justice Service, who they are embedded with in Leamington and Nuneaton, to work with children and young people who are 'at risk' of, or engaged in, criminal activity. Again, as with CGL, clients accessing Compass' Criminal Justice response, receive support from dedicated workers but have access to all of Compass' core service provision.

"Criminal Justice workers work closely with Prisons and Probation services." (Stakeholder Survey Response)

As outlined earlier within this report, HMP Hewell, followed by HMP Featherstone are the most common prisons to release and refer individuals to Warwickshire Substance Misuse Services. Prisons generally, were described by stakeholders and the community providers as *"a bit difficult to work with"*, meaning that some viewed current continuity of care for prison leavers as *"abysmal"*, and generally the Criminal Justice offer within the adult community service was considered to be underutilised. While issues with housing were described as the biggest problem for this client cohort, participants were able to propose various ideas of how Substance Misuse Services could work to make significant improvements. These suggestions centred around the concept of having more dedicated 'prison in reach workers' (sometimes also known as prison link workers) who sit within the Criminal Justice part of the community Substance Misuse Service but are vetted, security cleared, and trained in order to be able to draw keys and go into local prisons to conduct pre-release work with prisoners who will be returning to Warwickshire. These workers can then support the individual

'through the gate' and potentially even continue as their key worker within the community to provide consistency and ongoing support.

"There's all sorts of issues around housing offenders and that is simply the biggest problem." (Stakeholder Interview)

"I think there's more work to be done actually in the prison… be there earlier in someone's sentence, not just the end." (CGL Staff Interview)

"There's a lot of work that can be done with a prisoner in the weeks leading up to their release to get everything into place for them." (Stakeholder Interview)

"A lot of our issues with people [prison leavers] relapsing or not getting into treatment is because there's a break in professional engagement when somebody leaves prison, even if it's just for a couple of days." (Stakeholder Interview)

"Be better if and when we can access the prisons to link in with people prior to leaving." (Stakeholder Survey Response)

HMP Hewell was described as the prison within the West Midlands region that is furthest forward in terms of having community drug and alcohol teams vetted, security cleared, and trained to draw keys to come into prisons and conduct pre-release work. Within this, the prison is also looking to expand the offer to involve key workers from Approved Premises where applicable so that joint working occurs between Approved Premises and community Substance Misuse Service staff from the earliest opportunity. Unfortunately, this does not seem to have reached CGL Warwickshire as yet but will hopefully be explored in the future. Work with prisoners 'through the gate' has been consistently demonstrated by research to produce the best outcomes, particularly with regards to continued community engagement, as this provides an opportunity for the individual to start to develop a trusting relationship with their community key worker prior to release, meaning that they are far more likely to turn up their appointments in the community and continue to access support from the service post-release.

"There is no in-reach to prison but there is a Criminal Justice team who have links with prisons for treatment in the community after release." (Stakeholder Survey Response)

Where the above is not possible, prison Substance Misuse Services must try to give as much notice to the community teams as possible, particularly where a continuation in script is required. We heard that this is a real challenge at present. Stakeholders hoped that the Government's new proposed plans to end Friday prison releases for those vulnerable to addiction, mental health issues, or homelessness would help.

"Communications from prisons is very poor." (Stakeholder Survey Response)

"Prisons do not always send the alerts advising of release or send this late on Friday afternoon leaving no time to organise continued care." (Stakeholder Survey Response)

"Appointments are not always made in time for prison release to match up with suitable clinic appointments for prescribing, adequate notes are not normally sent through from the prison." (Stakeholder Survey Response)

Although it was described as not having been very successful to date, prison Substance Misuse Services across the West Midlands region have also been conducting an exercise in an attempt to track when and

why prison leavers do not engage with community teams, so that solutions can be explored to overcome any barriers that are discovered. This should be continued to encourage learning of best practice.

"I think where we could have the most impact is around them, reduction of demand. And that's probably the area that we most need to develop. So, when we're looking very much at kind of enhancing our environments, enhancing the offer that we've got within the prisons, kind of promoting successes, achievements, that kind of stuff, building that" (Stakeholder Interview)

Within the survey, a small number of stakeholders mentioned the positive work that is being conducted by Futures Unlocked to support the continuity of care for prison leavers and helping them to link into Substance Misuse Services where this is required. Futures Unlocked support ex-prisoners on release in Warwickshire and Coventry to increase community safety, reduce re-offending, and strengthen communities. They are described as an inclusive organisation, which encourages volunteer involvement and works with clients from all backgrounds. They offer one-to-one mentoring support which typically lasts between 6-12 months, provided by trained volunteers or staff, to men and women with desistance from crime, who are already in the community or are returning from prisons across the country. They have been OPCC grant funded, allowing them to work with clients returning to Warwickshire from out of area prisons. Once a referral is received before the client is released, one of their team will contact the client by Email a Prisoner, try to organise video link calls with the client to carry out our initial assessment, and then offer a gate pick up for the client on day of release prior to the mentoring support commencing in the community.

Other Complex Needs

In terms of 'other complex needs' or a combination of those outlined above, stakeholders described a need to utilise the most experienced workers for these clients in order to see successful outcomes. It was raised that some Recovery Co-ordinators have little understanding, appreciation, or training around what constitutes 'complex needs' or how to support with them despite acknowledgement that *"the majority of service users have experienced trauma".* This again highlighted a need for improved training to frontline practitioners, alongside increased resourcing to allow for intensive support for these clients.

"I don't think we have a clear understanding of what complex needs is. I think that all services are starved of the funding that makes it impossible to do that work." (CGL Staff Interview)

"We need more time to offer intensive support that they might need." (CGL Staff Interview)

"More funding is needed for more specialised workers to support these people, rather than adding them to already too large caseloads." (Stakeholder Survey Response)

"Some really promising commissioning around more intensive support. The most chaotic people really need focused work." (Stakeholder Survey Response)

During our site visit and observations of appointments, domestic abuse was a highly prevalent and current issue for female service users. In some appointments this was openly discussed and well-documented but there was a perceived lack of routine policy and procedure about safeguarding on this. For example, it was unclear how much training staff have around domestic abuse, the different ways it can present and who women could access for specific support on this. Further, where there were live concerns, this did not seem to trigger an immediate referral to other agencies. In one appointment for example, when this was queried, the key worker noted 'the police are aware'. This potentially highlights a need for closer joint working with Substance Misuse Services and domestic abuse organisations; although, we were informed that CGL staff sit on MARAC meetings.

Family Drug and Alcohol Court (FDAC)

In terms of Family Drug and Alcohol Court (FDAC) provision, the Department for Education initially funded a pilot in Coventry for work with families going through care proceedings where there was a high risk of substance misuse and concerns around capacity to parent, as well as other associated issues like domestic abuse, mental health difficulties. Following the success of this, in October 2021, an equivalent pilot went live to families in Warwickshire. The Warwickshire pilot has capacity for 15 families in Warwickshire over an 18-month period. As a relatively new project, there appeared to be limited awareness of this provision for Warwickshire (referrals all come from the courts when diverted to FDAC); nevertheless, FDAC informed us that they will easily be able to fill the available spaces and are *"hoping to attract more funding to sustain the provision"* in the future.

The FDAC team is made up of a range of specialists including, a clinical lead psychologist whose role is to do the trauma informed work, social workers, children and family workers, a parenting officer, and substance misuse workers. Should funding allow for an expansion in provision, FDAC will require more staff, and said in an ideal world they would like to *"have extra specialists embedded within the team".* For example, at present, *"there is no funding for peer mentor roles with parent graduates, which has been shown to be really valuable in other areas".*

The FDAC team works specifically with the parents related to the child(ren) that are subject to care proceedings. As a self-directed programme, the parent is expected to be motivated towards making positive changes. FDAC usually meet the parent for the first time at the removal hearing – some of the individuals they work with will be open to treatment services already, while others won't be. FDAC then undertake an initial assessment, conduct a prognosis of change – exploring their understanding of the risks to their children, understanding their adverse childhood experiences, their relationships, emotional health, and substance misuse. FDAC then offers an intervention plan in four areas – trauma, lifestyle, abstinence, and relationships. If the parent signs up, they commit to a 12-week intensive intervention in the community called 'Trial for Change'. FDAC support is designed to be an 'add on' to what an individual would receive in treatment, rather than be a replacement. The FDAC workers try to work closely with the treatment service to 'layer up support' and described themselves as having a *"really good relationship with Warwickshire CGL".* The ultimate aim is to create a portfolio of evidence of change, which is used when they report back to the courts every 2 weeks.

Family Support

A gap in the existing support offer that was consistently raised to us during interviews with staff, stakeholders, service users, and family members was the need to support the loved ones of those misusing substances. Currently, this provision is limited to those involved with social services (via a small CGL pilot[111] team of Family Support Workers within the North of the county who are embedded within children's teams), care proceedings (see FDAC above), or via an open access virtual evening group run by the CGL Asset Based Community Development Co-ordinator once a week. Participants wanted to see the introduction and investment in Family Support Worker roles, whereby support – equivalent to that offered to the individual with substance misuse issues – is offered to interested family and friends.

"It would be nice if there was a dedicated worker for families." (Stakeholder Interview)

"In an ideal world family support would mirror what is offered to clients." (CGL Staff Interview)

"The biggest thing for me is there is very little for families." (Lived Experience Focus Group)

111 This pilot is due to end in March 2023, and staff reported it has been going well so far, so should funding allow, CGL would like to roll it out countywide.

"We need to put more resources into family work, not just families who are open to social services." (CGL Staff Interview)

The existing group CGL run was highly rated.

"It's a wonderful escape and distraction." (Lived Experience Focus Group)

"The group itself has been amazing, it has given us strength." (Lived Experience Focus Group)

"We are very grateful, it's kept us sane and we have made friends for life" (Lived Experience Focus Group)

"We have learnt a lot – we previously were struggling alone." (Lived Experience Focus Group)

However, there is a need to expand Family Support, this could consist of a range of different types of interventions including (but not limited to):

"Currently we have one evening family group which is well attended but does not reflect the need which is far greater." (CGL Staff Survey Response)

1. Psychoeducation to increase understanding around substance misuse and develop an ability to spot the signs of a lapse or relapse.

"Support for families would be really helpful… we have a group but it needs expansion and needs more advertising, particularly for family members who don't really understand the drug or alcohol use." (CGL Staff Member)

"I feel like if my family knew, like if I was to relapse, know what to look out for… well, instead of it getting really bad, because I'm like hiding, they could support me." (Lived Experience Interview)

2. Tools to effectively help support the loved one misusing substances, rather than isolating, punishing, or enabling the use.

"For me, a big aspect of it was obviously, the people around me knowing and understanding what was going through my head, because that was really difficult to explain, which just then added more pressure. So I think, as well as me having my meetings, making sure that someone who is obviously there to look after somebody, or whoever's around them also knows what they're going through." (Lived Experience Interview)

"What we find is that family members feel left out. So often they feel very ignored and then they impact on people's ability to sustain recovery." (Stakeholder Interview)

3. Coping strategies to manage the 'ripple effect' of substance misuse and support with boundary setting – knowing when to walk away.

"It is important for them to get information, to know how to deal with things I'm going through - they need the same kind of support to what I do." (Lived Experience Interview)

4. Joint meetings between client and their loved ones, facilitated by a practitioner to explore the effects of substance use and support moving forward.

"My vision has always been to have the family support, and the client journey, but then bring them together once they're in a safe, stable place. So it will create a safe space in which things can be discussed, because if they're not discussed, they'll only come out later. I would love to facilitate that level of healing." (CGL Staff Interview)

5. Peer support networks – expanding on the current virtual support group so that more loved ones can connect and learn from one another in their shared experience.

"Group for families so they can connect and support each other." (Lived Experience Interview)

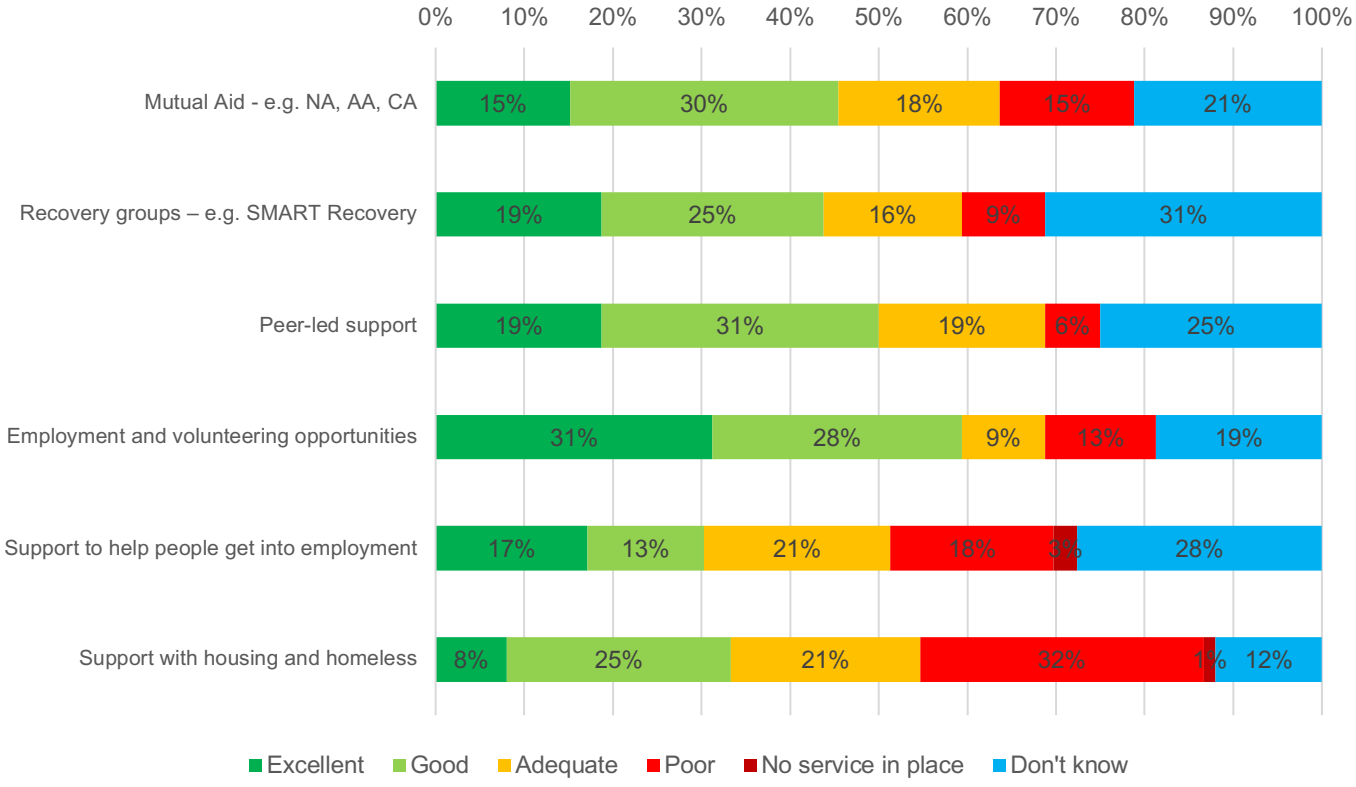
6. Progress updates (from the individual's practitioner with consent) on engagement with services and interventions undertaken – this is offered by some practitioners within CGL already and individuals whose families were given progress updates were really pleased that this had been on offer.

Step Down Support

The graph below displays professionals' views on how well various forms of potential 'step-down' support are operating in Warwickshire. This shows that while professionals rated 'employment and volunteering opportunities for people with a history of drug use' most positively (59.4%), they rated 'support to help people get into employment' the least positively (30.3%), suggesting that opportunities are there but people are not supported to access these.

"On the DOMES outcome report, Warwickshire fairs well in terms of employment outcomes. There is also the IPS initiative in place that is working to improve outcomes here." (Stakeholder Survey Response)

Figure 36 Professional Survey Respondents' ratings for Step-Down Support in Warwickshire



Practitioners generally agreed that there is not enough step-down support in place prior to or after discharge from treatment, particularly for when somebody leaves after a period of time in a residential rehab.

"I have been in rehab 4 times… I went into rehab just for short spells – I did the week detox on medication and then I got out of there as quick as I could because I felt fine, thinking I'm fixed, I'm cured, but not understanding how serious the aftercare is." (Lived Experience Interview)

"I've worked with people who got clean and then killed themselves, because it was so difficult to live without drugs." (Stakeholder Interview)

We were told that when someone is coming towards the end of their treatment at CGL, they go into a phase of *"light touch brief check in appointments"* which gradually tapers off, until reaching the final discharge appointment. CGL then offers virtual open access evening groups that people can attend via zoom even when closed to the service, these include the mindfulness, peer support, and SMART Recovery group sessions. There is also the option to re-refer at any point and if this occurs within the 6-month window after being discharged, it is a very quick process to reopen someone's file.

"When you've finished, you get access to all these groups, and what they told me when I was signed off with them a year ago, they told me that your case stays open for 6 months and you can be fully reactivated at a push of a single button, and you can go back to where you were… there was definitely support in place, it wasn't a case that they signed you off and just threw you out the door to fail… I believe my key worker phoned me at 3 months and 6 months after to see how you are getting on." (Lived Experience Focus Group)

In some instances, when an individual has been engaging with support for a prolonged period of time – sometimes for many years – there is a risk of fostering dependence on the service. We heard of a few examples whereby individuals had 'self-sabotaged' to remain in service – this appears to be most common when a service user has a very limited pro-social support network in place, highlighting a potential need to connect individuals with others ahead of discharge, whether that be through mutual aid (i.e. SMART Recovery groups facilitated by CGL or 12 Step meetings) or other means.

"I feel we create a dependency sometimes; it's easily done. If somebody has been very isolated, they come to us and feel accepted. They want to stay, and we have to be careful with that." (CGL Staff Interview)

A couple of service users we interviewed who had very recently detoxed off their methadone scripts, said they felt the most valuable work to help prepare them for leaving the service would be robust relapse prevention sessions, reflecting on their progress and how far they have come, as well as reassurance that there will always be someone available to help if they were ever to lapse or relapse in the future. Young people especially emphasised a need to have self-help resources available online or via apps which can be accessed as a refresher when not accessing formal support.

Overall, it is important to take a holistic view when closing someone's treatment episode, exploring all aspects of their life that may contribute to future triggers, potentially signposting on to other relevant agencies.

"Post-treatment, things like jobs or housing, getting their life back together… ideally you follow a pathway… so, you have this problem, you've got this addiction, you come here [to CGL], we will get you scripted, or will help you get on to some sort of medication that prevents you from drinking, come to the psychosocial groups, you stop using or you stop drinking, then the next

step would be like the ongoing support, maybe even looking at things like nutrition, that sort of thing that would really help and then how to get your life back together." (CGL Staff Interview)

"If people have purpose, they're more likely to want to turn away from addiction. So I guess it's kind of getting out there and not just offering help, but maybe finding out what they can do, finding out what skills they've got. Then connecting them… you want to empower people and enable them rather than just kind of standing there, like, 'this is who we are, come and talk to us if you need help'." (CGL Staff Interview)

Mutual Aid

As part of step-down support, but also as a form of support in its own right, mutual aid meetings can be pivotal to some people's recovery. Mutual aid was often described as a source of hope – by seeing people further along in their recovery journey and empowering due to being able to share similar experiences to others, which helps to reduce isolation or feeling like they are the only person going through it.

"It's good listening to other people's stories." (Lived Experience Interview)

However, we did not receive much feedback about mutual aid meetings within interviews, other than that there is a need for more local mutual aid meetings.

"They need more NA groups in Warwickshire, they seem to be more regular in Coventry… it doesn't seem very easy to get to them." (Lived Experience Interview)

While some individuals with lived experience said that a 12 Step programme or group meetings in general were not for them, others said they had never attended AA or NA meetings despite wanting to, due to feeling scared or intimidated about going to their first meeting alone. In response to this, CGL staff felt it could be beneficial to get people into CGL hubs from the 12 Step fellowship to introduce themselves so people feel more comfortable to go along to meetings.

"While the fellowships operate across the county efficiently and with open arms, there just isn't any involvement in the work we [CGL] do. We could have a liaison, or a member of the AA / NA community that could come and speak to our clients and engage with them, to explain what they offer and drum up support. But no one does this." (CGL Staff Survey Response)

We were told that post-COVID, mutual aid meetings are now back up and running in all seven of the locally HMPPS run prisons across the West Midlands, where these had been paused for a prolonged period of time due to restricted regimes within prisons nationally.

CGL is a licensed facilitator of SMART Recovery Meetings (Self-Management and Recovery Training). SMART Recovery is a science-based approach to self-empowered recovery. Through a range of motivational, behavioural, and cognitive methods, meetings aim to teach individuals tools and skills that will help them to manage and recover from addictive behaviour. It focuses on building and maintaining motivation; coping with urges; managing thoughts, feelings, and behaviours; and living a balanced life. CGL runs a weekly in person SMART Recovery group in CGL Leamington Spa, as well as an online open session one evening per week (facilitated on zoom). We observed the latter, which attempted to follow a standard SMART Recovery Meeting format, but due to being well attended, did not get through the whole structure in the allotted time, as check-ins were lengthy. This showcased how comfortable attendees felt in sharing within the space, with positive feedback during the focus group conducted, but highlighted a need for more regular meetings that are potentially longer in duration. There was also quite limited knowledge of SMART Recovery

amongst service users as well as those not accessing support within the Leamington Spa area that we engaged with during in person fieldwork. Additionally, the above graph indicates that almost a third (31.3%) of professionals responding to the question did not know what SMART Recovery was on offer in Warwickshire, suggesting CGL could do more to advertise this.

"Feedback from patients is that SMART works well." (CGL Staff Survey Response)

CGL provides weekly in person peer support group sessions at each of their main sites – CGL Nuneaton, CGL Rugby, and CGL Leamington Spa, as well as an online open session one evening per week (facilitated on zoom). These operate on an informal 'drop in' basis. We observed an in-person session at CGL Nuneaton that was held in the meeting room at St Nicholas' Church, as well as a virtual session. These were structured around a weekly 'check in' that encouraged service users to discuss their substance use and their journey to recovery. Service users discussed the value of this group in allowing them to form positive connections and be inspired by other people's stories. Participants commented on wanting more of these sessions on different days of the week and in more rural locations. Service users spoke about the value of the online evening group which promotes accessibility.

Employment / Volunteering Opportunities

CGL has a new Individual Placement and Support (IPS) service across Warwickshire and Coventry, which started taking referrals in January 2022. They work directly with existing CGL clients, who get assigned a dedicated IPS worker. The service is focused on giving clients a routine and keeping them busy in order to sustain their recovery and prevent relapse. The service is led by the individual client and shaped around their employment preferences. This service received very positive feedback from CGL staff and stakeholders but requires wider promotion.

"We have recently been provided with a team, IPS that offers support to clients to get back into work. They are excellent." (CGL Staff Survey Response)

"We've got the IPS team within CGL, who are sort of recruitment advisors helping people to find work... I think that is a really good intervention. Having stability of work, having routine, is great for our service users." (CGL Staff Interview)

"IPS Recruitment – Strive into Work – have been a valuable asset in helping people in recovery get back into work and upskill through training." (Stakeholder Survey Response)

"IPS service do a great job in supporting people getting into employment." (Stakeholder Survey Response)

"It is difficult when the cycle of addiction has a grip. We offer our expertise and unlimited support to those who want it. We cannot force anybody to do anything and employment is massively daunting to some and others who are desperate to work find themselves in an extremely competitive marketplace where there are lots of opportunities but many people vying for them." (CGL Staff Survey Response)

Once a referral is received by the IPS they have to make contact with the individual within 28 days but said at present the turnaround is usually within a week. After an initial consultation, IPS reach out to potential employers. They have a variety of contacts and networks from Jobcentres, the Department of Work and Pension, and job fairs. There is a focus on supporting the client through the entire employment process, not just at the point of recruitment, and they also offer support to the employer themselves.

"We are very much focused around what people want to do, we don't just get jobs for them, it has to be what they want… it's all about the long-term" (CGL Staff Interview)

"We provide training to employers to support understanding about the impact of substances in the workplace and how we can work together to enable people to maintain employment and for people with a history of substance misuse to regain employment." (CGL Staff Survey Response)

Staff commended plans to start offering training to potential employers so they are more knowledgeable on substance misuse and can better support employees who may be struggling (regardless of whether they are a CGL service user or not).

In terms of room for improvement, staff within the IPS team described a need for greater focus on employment from the point of entry into the service as the majority of their referrals tend to be at the end of the client's recovery journey. In addition, there is a gap related to the Criminal Justice service, which could benefit from a specific IPS worker to liaise directly with prisons and encourage referrals from prison releases. Generally, this was another area where staff felt there is a need for increased capacity.

"In IPS we have a team of four people covering Coventry and Warwickshire. Is it all about funding again? DWP are involved in efforts to engage with vulnerable members of our society and our clients are making some progress but we need more." (CGL Staff Survey Response)

"More employment workers are needed to support people who are in recovery and to target employers so that they are not stigmatised." (Stakeholder Survey Response)

CGL were also described as a genuine recruiter of people in recovery – several CGL Warwickshire staff members we interviewed had lived experience. The training offered to volunteers was reported to be robust and there are opportunities for progression into paid posts, although there was some debate about whether this should be possible whilst someone was on a low-level prescription and what this means for their recovery and options for employment. Overall, volunteering provides people with a way to 'give back' to the service and wider system.

"There are various volunteering opportunities; we have many staff that have lived experience in different roles." (CGL Staff Survey Response)

"A lot of people are interested in volunteering and are well supported in how to get on to this. Employment team also can be referred to if required." (CGL Staff Survey Response)

"We actively promote volunteering opportunities within CGL and link with CAVA to support external volunteering. We have a full-time volunteer coordinator in Warwickshire." (CGL Staff Survey Response)

"The volunteer workstream is going really well, going from strength to strength actually, volunteers bring a lot to the service in terms of support to our teams as well as to those in recovery." (CGL Staff Interview)

Housing / Homelessness

Housing and homelessness were described as some of the biggest issues contributing to continued substance use. While good joint working was reported with CGL by those working for housing providers within the survey, it was generally felt that *"the council is failing our clients big time"*.

"It's so hard to find accommodation as normally they've been evicted due to arrears or anti-social behaviour and they're not given a second chance." (Stakeholder Survey Response)

"I know there is support, but wait lists for housing are long - lack of suitable housing - staff trying their best but limited resource." (Stakeholder Survey Response)

"Homeless charities are good; however, there is much room for improvement from the council." (Stakeholder Survey Response)

"If it wasn't for organisations such as P3, the housing crisis would be horrendous in this borough. Due to the shortage of affordable, social and council housing, people are not being allowed onto the register unless they are homeless or about to become homeless. Homeless people are refused temp housing if they do not have a medical condition or 'priority need'. The Government as a whole needs to regulate and level up the private rental sector. Temporary and supported housing is way too expensive so if you have a job but have become homeless, you cannot afford temp. All of your wages will go on the rent for this." (Stakeholder Survey Response)

"Often as a result of alcohol and/or drug misuse, individuals will prioritise funds on the substance(s) therefore resulting in rent arrears, non payment of bills, anti-social behaviour when under the influence, etc resulting in council evicting and advising no duty to house so pass to Social Care. This is inappropriate as Social Care do not have a duty to accommodate unless meets criteria for residential care, which is very infrequently the case and not appropriate." (Stakeholder Survey Response)

Services users and staff told us that individuals in recovery who are looking to *"escape their old lifestyle"* are often being housed in blocks of apartments/flats with known drug users and dealers, which was described as *"setting them up to fail"*. One individual, who had been abstinent for 3 months, said he found it hard to leave his house for fear of bumping into old associates and had drug users knocking on his door regularly to ask for 'dealers' numbers'. Some service users also reported that their housing, provided by local housing agencies, was inadequate and in poor repair but they struggled to have their concerns heard or taken seriously. The accommodation provided above the Fred Winters Centre received very favourable review (one service user described them as 'beautiful') and was used by some of CGL's clients.

"There is some good interaction between substance misuse workers and homelessness services." (Stakeholder Survey Response)

"With the cases that I have been involved with, CGL have been very proactive in working with us to ensure that the applicant is given support and help to go forward with sustaining a tenancy." (Stakeholder Survey Response)

"I think I will be fighting this for the rest of my life, it's always in my face where I live." (Lived Experience Interview)

"Putting drug users in drug user areas of housing is exacerbating usage. Those wanting to get clean need to live in drug free areas." (Stakeholder Survey Response)

Service users described a need for more assertive outreach with the homeless communities from Substance Misuse Services, particularly to raise awareness of harm reduction techniques and promote safer consumption. We were told that a representative from CGL's Complex Case team usually goes to the Helping

Hands Breakfast Club in Leamington Spa on a Tuesday morning; however, this was not the case when we attended during our site visit (possibly due to annual leave).

"Workers from CGL should go out to homeless shelters." (Lived Experience Interview)

"There's no dedicated team, there's no dedicated street outreach, immediate harm reduction, that kind of thing. I think that would be really useful." (Lived Experience Interview)

Joint Working

"If all appropriate agencies worked together, at the same time, with someone with substance misuse to offer full support, then the person might actually benefit and be able to engage more in working to obtain support for their substance misuse." (Stakeholder Survey Response)

This 'step-down support' section has highlighted the importance of sound joint working policies and procedures and a need for enhanced multi-agency working. Whilst the current providers have a strong reputation with other partners and there was evidence of joint working with numerous organisations, this is an area that can always be improved further to ensure individuals using substances are supported in a holistic manner. It is possible that the necessary pathways are in place, but providers need support from a strategic level to pull all commissioned services together.

"I've never had any issues engaging with them [CGL], they're always really helpful. They're always up for kind of trying to innovate and do new things. They've got a pretty good reputation with other partners." (Stakeholder Interview)

"Joint working has definitely improved over the last 10 years, they're [CGL] really keen to get involved." (Stakeholder Interview)

"Compass are very good at engaging with partners." (Stakeholder Interview)

For CGL, due to the nature of the Fred Winter Centre, joint working was described as working best in Stratford, meaning there is potential for learning from this hub to be replicated in other areas too. During our visit the Fred Winter Centre was namely dominated by professionals, rather than being buoyant with service users. It could also be beneficial to have both a statutory and third sector mental health representative located there.

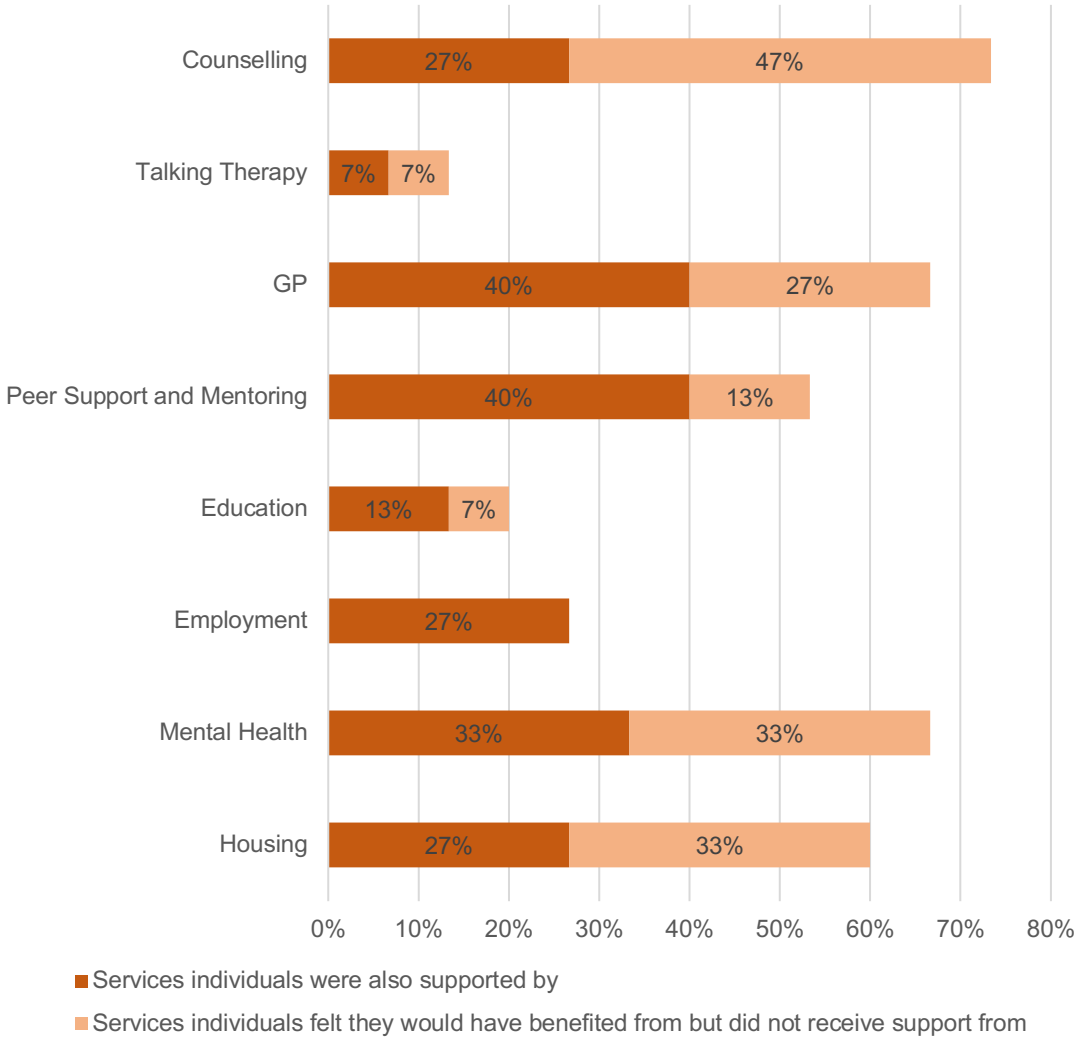
"The Fred Winter Centre is a good example of how to position a drug and alcohol service. Accessible and amongst other key partners." (Stakeholder Survey Response)

"Fred Winter Centre works well, a joint hub in Leamington would be fantastic." (CGL Staff Survey Response)

"I think co-location sites would be beneficial and would allow better integration between services." (Stakeholder Survey Response)

The graph below shows which services those with lived experience completing the survey felt also supported in their recovery journey, and which services they feel they would have benefitted from but were not present in their support network. Unsurprisingly, this highlights mental health support as key.

Figure 37 Services that also Supported with Service User Survey Respondents' Recovery and those that did not help but Service Users believed would have been Beneficial



Key Performance Indicators

Substance Misuse Service staff called for commissioners to review the data they require collecting, their targets, and key performance indicators (KPIs). Staff felt that they are under a lot of pressure, often dictated by numerical targets rather than based on the service users' needs.

"I think that's definitely changed the way that treatment is. I think it's much more data-led than it is person-led, which I think is completely wrong." (CGL Staff Interview)

"There is a lot of pressure via KPIs, like a certain number of assessments being completed. The spotlight is very much on that rather than, what do our young people actually want? What do they need from this service?" (Compass Staff Interview)

Frontline practitioners talked about the large amount of admin and data entry that is required of them, which essentially takes up time they could otherwise be spending delivering interventions.

"There's all kinds of data entry and recording that goes with it, so they [staff] have to be really organised and have good time management skills." (CGL Staff Interview)

Commissioners seemed to be open to reviewing this and working with providers to establish a balance – they will still require some level of quantitative monitoring to show that what is being funded is being delivered against but are otherwise open to shift towards more qualitative feedback, as long as this is meaningful and not a series of case studies.

"I think they need to look at their KPIs or what they're measuring. I don't know what they actually mean. Some of the KPIs are like the number of assessments completed, how many kids attended a group session. What does that actually achieve? How is that helpful? How does that provide a good service to young people? I just don't think it does. I think what they need to look at is rather than numbers, it's about impact, so is there a way to better evaluate the impact that the interventions they're receiving are having? I think they need to look at their KPIs and ask themselves, why are they asking these questions? Can we not measure quality instead of quantity?" (Stakeholder Interview)

Service User Input

Generally both service users and staff within the Substance Misuse Services felt that at present there is limited opportunity for service users to have their say in service delivery, or provide any form of feedback. During interviews the vast majority of service users said they would feel comfortable raising any concerns, offering constructive criticism, or providing positive feedback to their key worker if they wanted or needed to; however, none felt they were actively encouraged to comment on service provision or suggest where there is room for improvement.

"No, never been asked this question." (Lived Experience Survey Response)

"No one has ever asked me before I saw this survey." (Lived Experience Survey Response)

"No, they don't ask. People need to listen to the addict for what they need." (Lived Experience Survey Response)

Some service users mentioned that CGL used to have feedback forms in the waiting areas and thought that bringing this back would be a good idea, as well as responsibility being put onto key workers to periodically check in and ask for any feedback at the end of one-to-one appointments. CGL staff spoke about Service User Forums which were run pre-pandemic, but said *"it's not been a priority"* to get these back up and running post-COVID. There was an acknowledgement amongst some of the *"need to be led by service users"* and the Psychosocial Interventions Team Leader and Asset Based Community Development Co-ordinator have plans to re-establish these in September 2022, rebranding them as 'Expert by Experience' sessions in the hope of driving more engagement.

COVID-19

The COVID-19 pandemic had, and continues to have, a significant impact on trends in substance use - appearing to be most pronounced for increased alcohol consumption, mental health, access to support, and barriers to engagement.

"I got furloughed and ended up with a massive drug problem." (Lived Experience Survey Response)

"A large increase in use initially, so maybe those that had hidden their issues found they needed to address these; some positives, whereby it gave service users time to reflect and make positive changes. It has also enabled the services to provide more choice - remote

appointments and groups for example. The number of alcohol service users accessing is still high!" (CGL Staff Survey Response)

Many participants felt there had been both positives and negatives resulting from the pandemic as well as many opportunities to learn and adapt delivery models. In particular, external service providers commented on the way the pandemic had limited opportunities to further partnership working – this was often described as something services had a desire to achieve, but that due to other commitments, the influence of national lockdowns, and subsequent new working from home arrangements, it had *"slipped down the priority list"*. Practitioners reflected that it is crucial that providers work to improve this to enhance the support service users receive, ensuring holistic 'wrap around' care wherever possible. Likewise, service providers reported that the pandemic had restricted their ability to network, raise awareness, and promote their services. Some felt frustrated that COVID-19 is still being used as *"an excuse"* for services not being fully operational and that commissioners should be putting more pressure on providers to get back to the 'pre-pandemic normal'.

"I just think COVID issues are a bit of an excuse sometimes. Actually, nothing's really changed... young people were using drugs before, young people were still using drugs throughout the pandemic, and they still are. I'm not sure that the spotlight needs to be on the substances used. It should be around the mental health fallout that I think we're starting to see. Drugs do come hand-in-hand as a coping mechanism, so I understand... But really, I think we just need to stop talking about it, stop using blame, forget about it, and actually look at where we're at now. What are the needs of young people now?" (Stakeholder Interview)

On the other hand, service providers highlighted that the pandemic had created opportunities to adapt provision, explore more flexible ways of working. CGL in particular were reported to have been very fast in switching over and mobilising to provide virtual support options. Largely, participants felt this had been useful, particularly for service users who may have otherwise faced barriers relating to travel or living in more rural areas and therefore not have accessed support through the service pre-pandemic.

"The zoom meetings are brilliant for me, as I do live a bit out of the way… I was sceptical at the start, but it's been a lifeline, and it's been a turning point for me." (Lived Experience Focus Group)

Both staff and service users expressed wanting to see options to continue working more flexibly built into future contracts, through a hybrid model of support. The importance of virtual support not replacing face-to-face work was also emphasised.

"COVID-19 has changed the way we work and some of this has improved the things we do and made it easier for clients to access the service. However, telephone support and Zoom meetings are not for all and we need a mixture of both with a choice for clients who would prefer face-to face-support." (CGL Staff Survey Response)

"I think some of them really benefited from the telephone system because travel is a massive thing, because of the expense, it's just ridiculous… So they found it easy to have sessions on the phone and should be retained. Working remotely was really good for some clients… I think it would be good to have some sort of hybrid model moving forward." (CGL Staff Interview)

"I think COVID pushed them into a different way of working, but I think it opened up doors in terms of engaging young people. So there's different ways of doing that, rather than it being a rigid model of just offering one to one. People were quite set in their ways. It's pushed us a bit outside of that. So I think that works." (Stakeholder Interview)

"It's important to have that balance between having it anonymised and being able to chat online or on a phone call, but then some people relate more to people face-to-face as well. It's just kind of having that balance." (Lived Experience Interview)

"When people are in active recovery they need accountability… it's more valuable when it's person-to-person." (CGL Staff Member)

We spoke to a small number of individuals who had been accessing support but were discharged from services during lockdowns (most remained open to treatment at the time of their interviews). They described this as a really challenging time for them as they felt *"abandoned"* with very little step-down support available or in place at an already very isolating time – this led some to re-present at services very quickly.

The biggest challenge CGL staff described facing during the pandemic was continuing to prescribe clients whilst ensuring appropriate safeguards were in place. Almost all prescribed clients were switched to fortnightly collection, this was even the case for some of the 'riskiest' clients who were continuing to inject daily.

"It's hard to assess the risk, make sure things are going okay, from a health perspective, you can't tell if someone is withdrawing over the phone." (CGL Staff Interview)

Despite the difficult decisions and risks taken, staff said that this had been useful in reminding them to *"treat people as individuals and not as a blanket rule"*. Additionally, for some service users, this was extremely beneficial as daily pick ups from pharmacies affects their ability to attend work, and therefore, many of these clients have since expressed frustrations that they have returned to more regular collections. As have those who had not accessed services pre-pandemic so do not have a concept of how COVID-19 changed things. Staff felt there could have been a better 'exit strategy' to support them and their service users with coming out of COVID-19 restrictions.

"Here's a can of worms that no one opens… What was the plan following COVID-19? I can have hour-long conversations and read hundred page reports of the effects of COVID-19 on the service back in 2020, and the immediate changes that needed to be made, and the prescribing reviews and agreements, and the stuff that came from the pandemic. But there is no information regarding the short- and long-term exit plan coming away from this. By winter 2021 the pressure was there to have clients return to face-to-face contact for their key work and clinic reviews, but there was no actual structure or road-map to ease people back into this. Let me explain with an example: you have a client who in 2020 decided that now was the time to get their heroin use under control. Fantastic, so they are signposted to our service [CGL], go through the initial triage and assessment processes, and before you know it they are speaking to a prescriber about opioid substitution treatment, and then they are given 7 days worth of medication. Maybe at first they have 7 days supervised at the pharmacy, but after this initial period they are put on weekly collection, which before COVID would never have happened, not at such a rapid rate, and post-COVID doesn't happen with the clients I work with. But for that individual in 2020 the opportunity they had was to suddenly be trusted with a week's worth of medication at a time, which is all understandable. The virus wasn't well known at the time, and the risks had to be managed - as I said, hours of conversations, hundreds of pages of documents. But the psychological effect on the client is immeasurable. All of a sudden as the service starts to re-open, they have this flexibility removed, which if they hadn't started treatment in 2020, they wouldn't have experienced, and post-2020 they wouldn't have experienced. That person could have been given this flexibility, with no face-to-face contact or reviews, for the better part of a year and then they are told that this has to

stop, because we are seeing people again and the doors are open. Then the complaints start. Why was the exit plan for COVID-19 not constructed? Why is it not being examined now? Because ultimately while I appreciate there wasn't time at the start of the outbreak, well 3 years on we are living with the consequences of this." (CGL Staff Survey Response)

Staff – Recruitment and Retention

Individual staff within the Substance Misuse Services were often praised or pointed to as the best thing about the service, with clients being very grateful for the support they provide.

"Very dedicated and professional staff who care about their clients' welfare and manage risks well. Also prioritise treatment needs first." (Stakeholder Survey Response)

"The worst thing is that there isn't enough funding. The best thing is, I think we genuinely want to do right by clients." (CGL Staff Interview)

"We are very committed and passionate, we never give up on a person. Even if a person is relapsing for the 50th time." (CGL Staff Interview)

"We are definitely a good team." (CGL Staff Interview)

Large Caseloads, Increased Workload Pressure, High Staff Turnover

Staffing teams appeared to be motivated with a highly evident desire and appetite to care for service users, but this was against a backdrop of limited time to undertake in-depth one-to-one work as a result of large caseloads and competing demands (i.e., admin, answering ad hoc phone calls, organising prescriptions, making referrals etc.).

"If you have one person in crisis it will take up hours." (CGL Staff Interview)

"There's always something going on, there's always a crisis or a clinic that you need to cover or a personalised assessment, or a lovely interview like this that you have to do. It's the kind of line of work - you do wish there was more time in the day." (CGL Staff Interview)

"Caseloads are really high. I know that's everywhere, but it's quite simple… if there's more money, the more people you've got in a team, the better it is, the more practitioners, the better. We definitely need reduced caseloads, and then that gives you the chance to do more meaningful work." (CGL Staff Interview)

"I think they are just overstretched, the amount of people that go to CGL." (Lived Experience Interview)

"Caseloads are too high. I would definitely say caseloads are too high to do any really good, productive and constructive psychosocial work with clients." (CGL Staff Interview)

Staff agreed that caseload maximums should be around 40 clients, but within CGL they currently sit at around 60 per Recovery Co-ordinator (this is lower for those working within the specialist teams). Although there was widespread recognition of the need to reduce caseloads and workload, the associated issue of recruitment and retention in the sector were discussed. We were told that staff often use Substance Misuse Services *"as a steppingstone just to gain some experience"* but that ultimately staff leaving only puts more pressure on other members of the team, which can in turn lead them to burn out, or leave themselves as a result of the pressure.

"We just don't have the resources and by resources, I mean manpower." (CGL Staff Interview)

"If you've got fewer staff, they're unable to deliver services, the scale that's needed both in terms of capacity and quality." (Stakeholder Interview)

"In terms of retaining staff, because it's so short staffed, a lot of them leave because it's just so stressful. It's like… they don't earn very much per hour when you actually work out how many hours they're doing, and then their colleagues leave and then they end up with more work, so then they leave as well. So I think primarily, it's about trying to get more people into that profession and supporting people at the very beginning of their career." (Stakeholder Interview)

"More funding to hire more staff!" (CGL Staff Survey Response)

One issue that arose was around inconsistencies between staff both in terms of their approach to support and their level of knowledge and experience. This was picked up by staff, external stakeholders, and service users, and is potentially in part due to high levels of staff turnover within the sector. Several individuals told us they had worked with multiple Recovery Co-ordinators, often in short spaces of time, which they found to be counterproductive and challenging when it came to *"having to go over the same story over and over again"*.

"I have seen clients receiving very good service but I have also seen clients not receiving the support they should be." (Stakeholder Survey Response)

"It's very worker dependent. Some workers are brilliant, others not so good. But I suppose that's no matter where you go, no matter what service you access." (Stakeholder Survey Response)

"I had literally about seven workers in like, 2 months. They didn't get to know me, and they swap and swap and swapped, and then [key worker name removed] came. She's the only one that I feel like isn't just here for a pay check." (Lived Experience Interview)

"I've had lots of swapping and changing of the worker… I reckon I have had at least five workers in the last 18 months." (Lived Experience Interview)

Benefits of Lived Experience

Many Recovery Co-ordinators have lived experience and are in recovery themselves. Both service users and stakeholders emphasised the positives of Substance Misuse Services employing staff with personal lived experience of substance use. While service users described how inspirational this can be, providing them with a sense of hope, as well as meaning staff were considered to be more relatable and understanding, it was not considered to be essential, and it was also highlighted that *"if you want to talk to someone with lived experience you can go to AA or NA meetings"*.

"You know that it's not just you, you know that it's someone that's been through it, and they've not just learned it through a textbook or a course. They've lived it, they've had to go through it themselves, it's something that they've done, and they can talk to you from personal experience. It's not somebody that's judging you or looking down on you, or doesn't actually get it when you're saying, 'oh, I'm having withdrawals' or 'it feels like this', or, 'uh, I can't help it'. They know how that feels." (Lived Experience Interview)

"It's about meeting other people who are in the same situation as them. So they get that motivation from them, they get inspired by them, they get challenged by them in a way that I don't think, if you have no history of substance misuse, I think it's more difficult to challenge." (Stakeholder Interview)

"I think the volunteering side of things is important. If we can get people moving from recovery champion positions into a recovery coordinator position obviously it makes things work a little bit more seamlessly." (CGL Staff Interview)

"There is something really important about shared experience." (Lived Experience Focus Group)

Recruitment

"We need more recovery workers and we need more prescribers." (CGL Staff Interview)

"One of the biggest challenges we've had is recruitment." (CGL Staff Interview)

To improve recruitment, participants suggested use of better advertisement, national campaigns, and varying the job descriptions – highlighting necessary skills and development opportunities rather than requesting desired qualifications – to catch people's attention through selling the story of what Substance Misuse Services deliver. Other suggestions included expand advertising, considering pathways with colleges and universities, and exploring increased use of apprenticeships. It was also recommended to utilise scenario-based questions more within interviews.

"In terms of recruitment, I think the process needs to change for sure… raising greater awareness around these sorts of roles." (CGL Staff Interview)

"Expand your advertising and sell CGL…tell the CGL story a little bit more." (Stakeholder Interview)

"It's about having that compassion and the right amount of empathy… I think it's more about the kind of person than the experience." (Stakeholder Interview)

"Maybe they should be looking at whether there's a substance misuse pathway for people who want to study. There needs to be more avenues for the training as well, because I sometimes feel like when I see these jobs advertised, it's like, oh, £20k, but you need to have years of experience... So, I think opportunities to train with internships, things like that… it's that front loaded investment, isn't it in order to generate the workers, who will then come and do the work." (Stakeholder Interview)

"We know that lots of people think, 'oh, I'd love to be a nurse or something like that'... actually kind of saying to them, 'okay, so you're interested in caregiving or kind of supporting vulnerable people, have you considered this instead?' Also removing the stigma around drug and alcohol use because I think it can be a bit scary for a 17/18 year old to go and work with crack addicts, you know, actually humanising people who have addiction problems and saying, 'yeah, okay, this person acts a little bit scarily, maybe when they're under the influence, but actually, this is their life, and these are the problems that they've come from, these are the traumas they've experienced, and here's some examples of people who have turned it around and what impact it can have'." (Stakeholder Interview)

Many staff spoke positively of opportunities for internal promotion and progression within CGL (this is not so readily available within Compass as a much smaller service). However, when the service recruits internally, they then have another post to backfill, creating more work in terms of recruitment and prolonging the time gap with less staff. Staff felt there was room for more promotion of roles within CGL that are in other regions, and that potentially offering secondments would be a way to vary the role to avoid people becoming complacent or bored in their role.

"Always encourage internal promotions." (CGL Staff Interview)

"I think it's easy to get bored isn't it…people that have been here a long time, that have been through over services, maybe it gets a bit stale." (CGL Staff Interview)

Staff Training

Participants felt that a more official induction package for new starters (including a checklist of things that must be shadowed) as well as access to better continuous professional development (CPD) would help to remedy some of the problems with staff inconsistencies. It was acknowledged that there is no longer a requirement for job applicants to have any particular qualifications and that it could be beneficial for staff to have to work towards one whilst working for a service. Current induction processes, despite being said to have improved, were still described as too fast and not in-depth enough, with new staff being expected to take on substantial caseloads very rapidly.

"A robust and effective training regime of, say, 8-12 weeks. With measures in place to stop people being dropped in at the deep end and burning out. I should know, I am a new member of staff, I started literally last year, after that 4-week training period I had a caseload which within 2 months doubled. I was drowning in clients which needed specialised support that I was not equipped to deal with. There are the needs of the business, and then there is doing the right thing. And to reference every army drill sergeant 'the fastest way through basic training, is to complete basic training.' You rush someone, drop them in the deep end, apply pressure and wonder why they burn out. Invest in people with time, experience and security - of not being dropped in the deep end and told to swim - and you won't have to keep training new staff on a constant basis." (CGL Staff Survey Response)

"Better inductions to ensure they are ready for the high-pressure roles." (Stakeholder Survey Response)

"New staff should have some sort of qualification to work towards in the substance misuse field like they used to have." (Lived Experience Interview)

Once in post, staff at CGL have access to a variety of e-learning modules, and we were told *"if you see some training that you think will be useful for you, you can do it so that's pretty good"*, but these options did not seem to be taken up much. It was instead suggested that training may be more beneficial if delivered in person by external organisations – for example, Refuge coming in to teach Recovery Co-ordinators about domestic abuse, the signs to look out for, how to tailor support, and how to make onward referrals. Upskilling practitioners to be more trauma-informed in their approach was also considered to be vital.

"A lot of the workers are inexperienced." (Stakeholder Interview)

"Proper training definitely needs to be in place." (CGL Staff Interview)

"Fund them better and have a focus on CPD with accredited courses and career development." (Stakeholder Survey Response)

Staff Support and Clinical Supervision

Management within CGL were described as approachable and *"really really supportive"* – although, frontline practitioners felt little was done to action any feedback they had and that *"we need a bit more connection with head office as they're a little bit out of touch with the reality of day-to-day service running"*. Similarly, we were told *"Compass as an employer has always been really supportive… good line management, good supervision"*.

CGL management have 'open door' policies, and have implemented daily 'flash meetings' in which staff can bounce ideas off one another, and more experienced staff can spot signs that less experienced staff may not have picked up on such as safeguarding concerns. There are other regular team meetings and every member of staff is encouraged to take a 'wellbeing hour' per week. CGL staff appreciated these measures that have been brought in in recognition that they have a difficult job role that has a risk of vicarious trauma for staff.

"Staff have appraisals throughout the year where we try to concentrate on their own development. They have the choice to have one-to-one supervision every month. CGL supports team leaders with that, and the team leaders offer the one-to-ones to the staff members. They'll touch on all areas, staff wellbeing, how they're feeling at work, if there's any issues at home, any cases we need to look at etc. So staff members have lots of opportunities to discuss cases. We have morning flash meetings… the chance to be able to share that information with the teams and gain any support. We have monthly team meetings where we can bring cases, we have weekly MDTs where they can bring cases to the clinical and medical team. CGL offers case management supervision where we look at the quality of the work." (CGL Staff Interview)

"I think if you've got a team of people that are burnt out, have compassion fatigue, suffering from their own vicarious trauma, how are they expecting them to be able to deliver a good, safe, thorough service to people?" (Stakeholder Interview)

This necessitates robust supervision, which should be separate to case management reviews, so staff have a safe space to discuss their wellbeing and any concerns. Currently it was felt these can become blurred.

"They really genuinely want to help. I think sometimes too much. I think we have to take into account that there is a lot of vicarious trauma, after hearing some of the stories that the young people tell us because ultimately, most of the time, most of our young people come with trauma of some description. There's things I'll never forget that I'll take to my grave with me that some of the young people have shared and I think, you know, the team go over and above for their young people." (Compass Staff Interview)

"I think there's definitely got to be a bit more thought around vicarious trauma for the team, they carry a lot of trauma that they've absorbed over the years from their young people." (Compass Staff Interview)

"I think there needs to be more thought around the type of supervision that they access. So, because there is a difference between management, clinical, and safeguarding and sometimes it is all amalgamated into one." (Stakeholder Interview)

Staff Contracts

Many participants simply said that if Recovery Co-ordinator roles paid better then recruitment and retention of experienced staff would be easier. Staff wanted salaries to reflect experience and for there to be consideration to unanimous and consistent terms and conditions within and across contracts. In the current adult service, some staff remain on contracts from previous providers, arguably with *"better terms and conditions, benefits and perks"* – many of these members of staff have been working for the Substance Misuse Service (under various providers) for numerous years, which evidences that when staff feel their employment package is reflective of the work they put in, they are more likely to be retained. Although not palpable, it was discussed on several occasions that having staff within the service being on varying contracts, has created tension between team members due to differences in pay and benefits despite workers being in the same job role. This has also led some workers to feel *"financially trapped"* in their current role and *"stuck"* due to not feeling able to progress or seek alternative employment with comparable benefits.

"They need better wages, it's stressful and it's quite a lot of responsibility. Abysmal wages." (CGL Staff Interview)

"Salary to reflect experience." (CGL Staff Interview)

"Need better T's and C's." (CGL Staff Survey Response)

"Rewards could be better." (CGL Staff Interview)

"Paying a decent wage to employees will help retain staff." (Stakeholder Survey Response)

"Pay needs to improve as does the benefits of doing the job, which is always challenging but is also very rewarding on a personal level as supporting others always helps your own self-esteem. More staff is always needed as demands for the service are very high." (CGL Staff Survey Response)

Overall, it was believed that retention 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, all of which relies on increased funding.

"Higher salary to attract more experienced workers, continue with wellbeing hours, this helps, flexible working, wellbeing support for staff clinical supervisions monthly one-to-one to explore upsetting cases that has an impact, promote visible good mental health. 35 days annual leave plus bank holidays, to encourage regular breaks from such intense work." (CGL Staff Survey Response)

"It all relies on funding and support from the management team. Employ more staff, train them to the level required and provide them with a caseload which is manageable and monitored. Should the caseloads rise then additional staff should be employed. Funding will prevent this, and I can't see any other options to retain staff and manage caseloads effectively." (Stakeholder Interview)

Smoking

During our surveys and interviews, we asked participants about whether or not commissioned Substance Misuse Services should offer support to quit smoking as part of their provision in the future. Responses to this were mixed. Within the lived experience survey, of those who answered the respective question, 55.1% identified as smokers and almost all said that if they wanted to quit smoking, they would go to their GP for

advice and assistance (a small number said they would be able to do it for themselves without professional help). All but one of these individuals said they did not think Substance Misuse Service should offer support to quit smoking. This perhaps implies that it would therefore be better for Substance Misuse Services to simply have a more robust referral pathway and joint working with smoking cessation providers. On the other hand, during interviews the majority of those with lived experience did think it would be beneficial for Substance Misuse Services to offer support to quit smoking, as this would mean they are more of a 'one-stop shop', and individuals believed this was relevant as another form of addiction, that often worsens during the process of becoming drug-free.

Meanwhile, professional feedback on this also varied. Some said things along the lines of:

"I have noticed that once people have stopped using they say 'I'm gonna stop smoking as well now'. So, yeah, I think that would be really good to kind of go along with it." (CGL Staff Interview)

Conversely, other staff, particularly those with personal lived experience, expressed concerns that having this offer sit within the Substance Misuse Service may add to the pressure an individual feels to stop all harmful addictive behaviour, even if that is not what they want, or that it may make them feel overwhelmed, or like a failure if this is not something they take up, and consequently be more harmful than beneficial. Either way, there was a general consensus that Substance Misuse Services must not be the only provider of smoking cessation, as it would create barriers for individuals who smoke and want to stop, but do not have problematic substance use and accordingly do not want (or do not feel eligible) to refer to a Substance Misuse Service for this.

5.5. Achieving a Generational Shift in Demand for Drugs

The national Drug Strategy sets out to take bold steps to change attitudes in society around the perceived acceptability of illegal drug use, by:

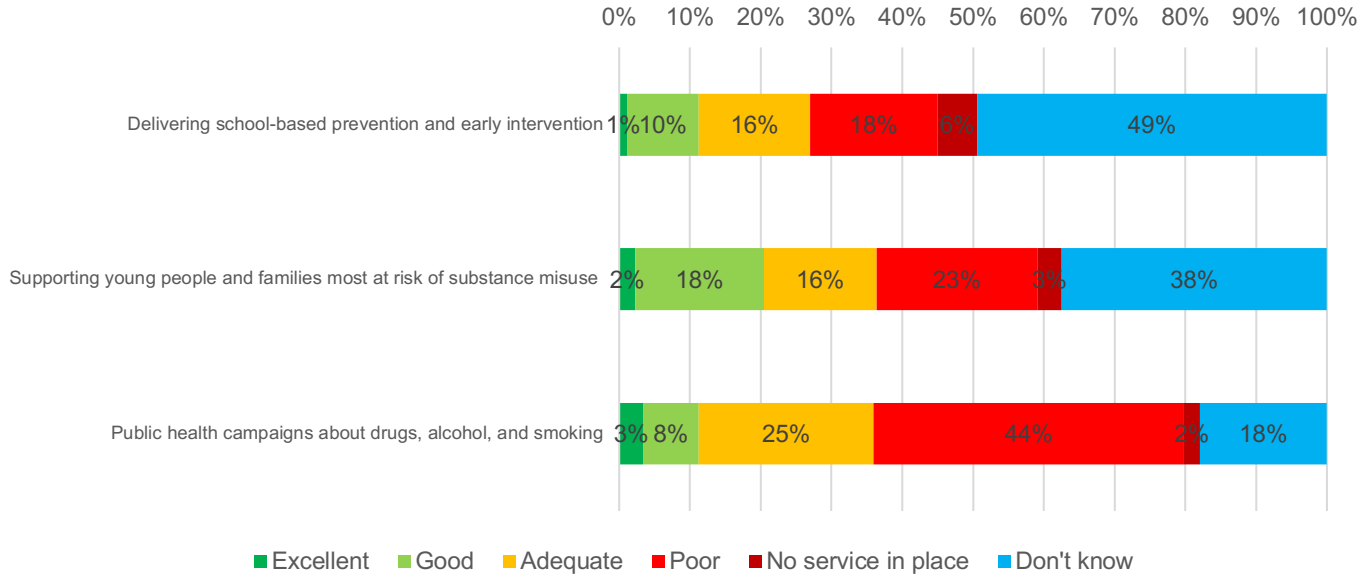
1. **Building a world-leading evidence base** – of ambitious new research backed by a cross-government innovation fund to test and learn and drive real-world change
2. **Applying tougher and more meaningful consequences** – taking decisive action to do more than ever to target more people in possession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

Almost half (49.4%) of professionals who responded to this section of the survey, said they did not know how good Warwickshire's delivery of school-based prevention and early intervention for children and young people is. Similarly, just under half (46.0%) rated Warwickshire's public health campaigns about drugs, alcohol, and smoking as 'poor' or 'no service in place', suggesting this as a definite area that needs addressing. The most positively rated area in this section was Warwickshire's support to young people and families most at risk of substance misuse through programmes providing early, targeted support – however, even for this, only around 1 in 5 professionals (20.5%) said this was 'good' or 'excellent'. Overall, these

ratings emphasise that Warwickshire has significant room for improvement when it comes to preventative work and achieving a generational shift in demand for drugs.

"Getting educational information out at an early stage may help with reducing the number of people who use drugs and alcohol in later years." (Stakeholder Survey Response)

Figure 38 Professional Survey Respondents' ratings for Warwickshire's Approach to Achieving a Generational Shift in Demand for Drugs



There was an appetite for earlier intervention and prevention, and a desire for substance misuse treatment to become more innovative and proactive within a trauma-informed model, but at the same time an apparent nervousness around this due to *"drugs policy being really political".* Many participants called for consideration to be given to the decriminalisation and then regulation of substances in the UK, or to take learning from other countries such as Portugal.

"More innovation, prevention, and diversion is critical." (Stakeholder Interview)

"There aren't enough people championing early prevention." (Stakeholder Interview)

"Prevention is certainly more cost effective and it's going to save the country £1,000s and £1,000s ultimately in treatment." (Stakeholder Interview)

"Be more trauma informed…the current system is re-traumatising." (Stakeholder Survey Response)

"Warwickshire is a very conservative county and because of that, some of the more innovative policies are not attractive." (Stakeholder Interview)

Within earlier sections of the needs assessment we have outlined the work being undertaken by CGL and Compass as well as the Family Drug and Alcohol Court with regards to families. All of these components of the service offer contribute to this part of the drug strategy. However, there was a consensus that the commissioned services need to do more prevention and early intervention work in the future to help promote a generational shift in the demand for drugs.

"Needs to start much earlier, there needs to be much more presence in schools, I think we need to be doing a lot better joint work with Compass, which seems to have disappeared over

the last few years. I think they've got a new manager. So, it's an opportunity for us to kind of get back in there and rebuild that partnership. The early intervention, again, I think having a really strong presence in the media will make a difference because it's about so much, it's about what people don't know, we could be doing a lot more than we are, we could be also working with the night time economy better than we are in kind of promoting things earlier. It's thinking outside the box at festivals, etc., etc." (CGL Staff Interview)

5.5.1. Education – Prevention and Early Intervention

The majority of participants considered education to be the fundamentally most important aspect for preventing problematic substance misuse, with most mentioning it at some stage during their engagement with the needs assessment. 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. Simultaneously, this should provide the opportunity to raise awareness of harm reduction techniques to promote safer consumption if people do decide to use substances.

"Educate more." (Lived Experience Survey Response)

"Better education in schools." (Stakeholder Survey Response)

"There needs to be more education in schools as there is a huge issue in local secondary schools with cannabis, vaping, pills, etc. and youngsters getting involved in county lines." (Stakeholder Survey Response)

"I am passionate about a harm reduction approach; we have to tell children and young people the truth about drugs." (Stakeholder Interview)

"Prevention is better than cure, educating young people in the right way will help significantly, schools have a role to play in identifying children and their families… education is a huge things." (CGL Staff Interview)

It was generally believed that education around drugs and alcohol is lacking, if occurring at all within schools, colleges, and at university.

"I don't believe enough is done to raise awareness with young people about recreational drugs and alcohol they come into service completely uneducated about the harms." (CGL Staff Survey Response)

"As far as I know, having a family member who is a primary school teacher, a daughter going into year 6 at a [location removed] school, police officer friends, and two other friends who are head teachers, I am unaware of any specific drug and alcohol educational programmes. I am creating something to present for this purpose and having been through 25 years of alcohol and drug addiction I feel qualified to help and bring some key messages to our children." (Stakeholder Survey Response)

Participants, particularly those with histories of substance use, believed that there would be value in young people being educated on drugs and alcohol by a person who is 'more relatable' to them (e.g., not a teacher) and that perhaps this could consist of a combination of police officers, Recovery Co-ordinators, and people with lived experience delivering sessions. It was also highlighted by Compass service users that any education should be 'balanced' rather than fear inducing or 'lecturing' in nature.

"I think lived experience speaks louder than a presentation as well. I think we need to give kids access to people who've been through that." (Stakeholder Interview)

"I think for me, as a young kid, it would have been really interesting to have an experience of someone who has abused drugs for years. So you can literally see this person or have an account of someone who has abused this drug and see how it has affected and ruined their life as such. It needs to be more talked about the physical effects of this drug, it needs to be spoken about by workers to users… these conversations need to happen and young people need to understand the severity of the drugs they are using." (Lived Experience Interview)

Participants considered it particularly important to start education at the youngest age possible to increase awareness and understanding, but alongside this, teach young people healthy coping strategies, building their resilience so that when they are older, they have the skills so as not to need to resort to substance use as a form of coping. For this, some suggested that commissioned Substance Misuse Services could have regular slots in schools to conduct creative sessions like arts and crafts, or drama, so that they have a presence in schools, but through these lessons can promote hobbies, distraction techniques, and simultaneously educate and raise awareness.

"I think we need to shine a light in primary schools years 5 and 6. I think there needs to be some work there particularly with a focus on the transition from year 6 into year 7." (Stakeholder Interview)

"CGL teach you very very basic day-to-day relatable techniques and procedures to put into place, whether you've got a drink or drug problem - I actually think everyone should learn this kind of thing." (Lived Experience Interview)

There was recognition amongst our sample that it will be impossible to prevent all substance use, and to believe this is achievable would be unrealistic as it would require a much more significant national, societal, and generational shift, affording consideration of the root causes of substance misuse such as trauma and austerity.

"It is not realistic to aim for a drug free society." (Stakeholder Interview)

Nevertheless, through early interventions, there should be the capability to prevent escalation to problematic substance misuse. This highlights the need for more attention to be given to low level drug use. Similarly, for more targeted work to be done with children and young people at an age when they start to experiment with illicit substances.

"I don't think we're very innovative and I think that's because low level support is missing to stop escalation." (CGL Staff Survey Response)

"Drugs education in schools needs to primarily seek to improve the resilience of young people to not to need to seek out drugs to cope with life. That's the group we really need to focus on - those young people who are going to be the dependent users of the future because of trauma, adverse childhood experiences etc etc. trying to convince ourselves we can stop young people using drugs is naive, there is always going to be a level of experimentation with young people." (Stakeholder Interview)

The current Children and Young Person's Drug and Alcohol Service provider Compass have a relatively new working agreement with the Youth Justice Service which sees young people 'universally referred' (no

substance use at assessment or discharge), if consenting, for support as a preventative measure. This is one specific example of Compass working to provide early intervention in an attempt to divert children and young people away from substance use. Practitioners reflected that this diversionary work is a real strength of the current service and alongside this, they reported regularly working closely alongside the Youth Justice Service team to educate individuals around the law and legalities. This is potentially a provision that could be expanded more widely to reach children and young people who are not in touch with the criminal justice system too.

"There is a universal pathway in place for all young people who enter the Youth Justice Service regardless of whether they have been flagged for drug or alcohol misuse. This is a really good way to prevent and divert people at an early stage who may not yet be presenting. I'm not sure there is much in place for families though." (Stakeholder Survey Response)

It was also highlighted to us that there can be very little for young people to do to occupy their free time in Warwickshire, meaning participants wanted to see more youth clubs, and activities on offer as diversionary options for young people. Additionally, it was suggested that Recovery Co-ordinators could be strategically placed in areas where young people do often attend, or that training should be offered to those running such places like nightclubs to promote correct information about the realities of drugs going out to young people.

"So hooking up with all the alternative education providers, youth clubs, and actually doing more work together with what youth workers are left, doing more work in conjunction with them, I think, to really embed it. It's hard to do everything everywhere though." (CGL Staff Interview)

"As I work in mental health, often cannabis use in young people leads to further problems… a deterioration in their mental health, causing serious symptoms leading to a diagnosis of psychosis. It seems that drug use in schools and colleges needs to be tackled more firmly and education needs to be given. However, as we live in a high poverty area, I feel that all children in schools should be offered the opportunity to have at least two counselling sessions individually so that they can discuss any issues at home and support can be given if needed. Also, great collaboration with parents and pupils on this subject might help. This is a subject that is ongoing and until the money is put into these troubled families allowing them support, the isolated and vulnerable children who are targeted by friends and groups and dealers to use drugs won't be reduced. If investments are made will not feel the need to engage in these groups to fit in, to feel part of something. All activities outside school are expensive which leads to young people hanging around the streets together in groups, if money was put into travel and outside activities so they didn't cost so much this would help young people to find more healthy and productive activities that don't mean hanging around in groups causing trouble." (Stakeholder Survey Response)

Alongside all of the above for children and young people, it was considered critical to also work to educate parents and carers, as the key people in a young person's life.

"In terms of the kind of educational awareness etc. I think we should be doing stuff with the parents, and not just the kids. Parents have are the best people in a child's life, hopefully, most of the time, to kind of pick up when a child is behaving oddly, or maybe hanging out the wrong people, starting to be take risks, exhibiting risky behaviours, like every child does when they become a teenager, and actually sit down with them and say, 'this is why you shouldn't do that…' Not just kind of have somebody at the front of the classroom saying 'drugs are bad'." (Stakeholder Interview)

5.5.2. Public Health Campaigns

Linked to education, participants spoke about the need for local and national campaigns and media adverts to raise awareness to the general public about substance use, the associated impacts and harm, and where they can turn to seek support. This was considered to be important as some individuals may not realise their behaviour constitutes problematic use or may lack understanding of the repercussions their use is having on their health, lives, or society.

"Alcohol dangers should be more widely advertised as generally most people are not aware of long-term harm associated with heavy drinking patterns over many years." (Stakeholder Survey Response)

"Far more awareness around substance use issues is needed for the general public." (Lived Experience Survey Response)

There was acknowledgement that public health campaigns do exist, but that they either do not have powerful enough messaging, or they are not placed very strategically.

"I am aware that these campaigns run but as I can't recall any straight away, I can only assume that these haven't resonated with me and, therefore, this could be the case with others." (Stakeholder Survey Response)

"I feel that these health campaigns exist mainly in places where someone would go if they were already struggling e.g. the GP, the pharmacy, specialist services. They need to be in the open more to prevent use." (Stakeholder Survey Response)

"I haven't seen much material around harm reduction or risks of using substances. If it exists I don't think it reaches people." (Stakeholder Survey Response)

"The people who would listen to these campaigns already have in terms of reducing alcohol/smoking. A different tact would likely be needed for those who ignore the health warnings etc." (Stakeholder Survey Response)

Participants suggested that public health campaigns should appear on the television during advertisement breaks, be displayed in public toilets and pubs, on notice boards in supermarkets and off licences, and pop up on social media, etc.

"It would probably be good to have like alcohol and drug posters with the information on in men and women's toilets, for them to be able to gain access to telephone numbers or online websites and stuff." (Lived Experience *Interview)*

In terms of alcohol consumption, education and public awareness campaigns were considered to be more complex due to alcohol being a legal substance. A couple of stakeholders said that there is a need for further conversations and exploration about this.

"I mean, I think alcohol, particularly just because of the prevalent in society and the impact it has, in regards to the health of people who use alcohol problematically, and things like liver disease, but also the impact it has on, you know, night time economy, domestic violence, genuinely by violence. Now… How do you support the population to reduce alcohol intake? This is a really complex issue where the night time economy is driven by alcohol consumption, we know that everyone drinks over the recommended units on a regular basis,

and if they didn't, the night time economy wouldn't be able to sustain itself. There has to be an honest conversation about recognising that… it's reliant on people misusing alcohol, or drinking to levels that are potentially harmful. Do we as a society accept that and then put things in place to support people who get into trouble? Or do we want to drive down alcohol. Does public health know how many premises have been fined or cautioned for serving intoxicated people? Does Trading Standards go in? Do the licencing inspectors actually make sure that people keep their licencing conditions? If they did, people wouldn't be able to serve people who are drunk..." (Stakeholder Interview)

5.5.3. Support for the Children of Parents with Substance Misuse Issues

The current Children and Young Person's Drug and Alcohol Service provider Compass has a 'Hidden Harms' service called 'Compass Stars', which supports children and young people who have been affected by another person's drug and alcohol use. As part of this service, Compass reports offering age-appropriate information, one-to-one support, workforce training, group work, health promotion, early intervention, whole family support where appropriate, and safety planning, all through a multi-agency approach. Amongst stakeholders generally, there was very little awareness of the Compass Stars service, what it looks like in practice, or how successful it is.

"I know organisations such as Compass exist, but I couldn't tell you how well they operate." (Stakeholder Survey Response)

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

"More consideration to intergenerational support. It's all well and good engaging a young person in treatment, and then to close them when nothing has changed regarding their home environment. More whole family support, measuring outcomes post closure." (Stakeholder Survey Response)

"The Children and Families Team and Warwickshire County Council provide a helpful multi-disciplinary team role however I think there is a role for commissioned services to prioritise an input into addressing Hidden Harm caused by parent/carer substance misuse." (Stakeholder Survey Response)

6. RECOMMENDATIONS

In this section, based on all of the findings from the Drugs Needs Assessment, as well as specific suggestions made by participants for us to consider, we set out recommendations under each of the key ambitions from the national Drug Strategy. In recognition that some of the recommendations require a national response, Warwickshire's Drug and Alcohol Strategic Partnership should explore escalation for certain points.

1. In light of the national aspiration to reduce drug and alcohol related deaths, Substance Misuse Services and the police should be mindful of the trends in substances of choice and those causing most harm in Warwickshire identified within this needs assessment (i.e., alcohol, heroin, cocaine, crack cocaine, as well as illicit use of prescription medication like pregabalin and benzodiazepines) to ensure the focus of support and interventions is able to respond to emerging needs. In light of finite resources, it is important to concentrate efforts on high harm and high frequency issues to yield the biggest impact.

6.1. Breaking Drug Supply Chains

2. To deliver the priorities set out within the Warwickshire Serious Violence Prevention Strategy related to county lines and drug supply markets.
3. Warwickshire police could consider developing and running a series of communications campaigns around the positive and proactive work being undertaken to break drug supply chains. This may help to raise awareness and build trust and confidence amongst the general public, as well as simultaneously providing an opportunity to signpost individuals to support.
4. Warwickshire police should consider ways to strengthen their work with the West Midlands Regional Organised Crime Unit wherever possible, while there is evidence that this is taking place, it is crucial to fully utilise the support available, with a focus on pursuing drug dealers *higher up* the supply chain. This may assist Warwickshire police in achieving targets set out within the national drug strategy.
5. Warwickshire Police could explore ways to work more closely and proactively with prison security departments to monitor known organised crime group nominals, aiming to disrupt any drug dealing they continue to orchestrate from prison. Attention could initially be given to actioning this within HMP Hewell and HMP Featherstone as the prisons most commonly releasing individuals to Warwickshire.
6. Training could be offered to frontline workers, including education providers, to encourage 'professional curiosity' around exploring the signs of exploitation and increase referrals to appropriate safeguarding teams. Training could potentially be delivered by the police or commissioned exploitation services. Additionally, this work could be conducted with parents and carers, as the key people in a young person's life.

6.2. Delivering a World-Class Treatment and Recovery System

7. Commissioned services require increased funding to drive recruitment and retention of staff (within all parts of the service including specialist teams, prescribers, admin etc.) to build an experienced workforce, with reduced caseloads, in order to increase quality and quantity of support offered. Consideration should be given to:
    - Varying methods of recruitment, with eye-catching adverts that emphasise the importance of personal qualities required rather than desired qualifications.
    - Use of internships, apprenticeships, and pathways with colleges and universities.

- Developing a robust induction package for new starters, that is not to be rushed, incorporating checklists of shadowing opportunities and training to be completed.
- Enhanced provision for continuing professional development (CPD) to ensure practitioners maintain up-to-date knowledge and skills to deliver a professional service to their clients. This will help to guarantee practitioners are aware of changing trends and directions within their specialist area. Additionally, external service providers in the local area could be brought in to offer training to staff.
- Offering mandatory clinical supervision to all staff and developing a pathway to offer support to staff who may experience vicarious trauma through their work. Practitioners should also meet regularly (ideally every 4-8 weeks) with their supervisor/line manager to discuss and evaluate their casework in a structured way.
- Continuing to advertise opportunities for internal promotion, expanding this to national positions, and considering opportunities for secondments. At the same time, ensuring time to backfill posts is minimised to avoid disruption to service delivery.
- Exploring opportunities to offer consistent salaries and terms and conditions to staff, which mirrors previous contracts and could improve further with time in service and experience.

Within the context of aiming to reduce caseloads and build capacity, the following recommendations should be considered when additional funding is available.

8. The partnership could consider investing at a strategic commissioning level, as participants felt that this would help to improve decision making, enhance oversight, and ensure that more meaningful performance monitoring and management can occur. This could also be beneficial in encouraging more joined up working between commissioned services to ensure holistic support is provided to those who need it.
9. If commissioned services are to upscale their offer and build capacity both in terms of staffing numbers and service users in treatment, their premises must allow for this, and new more well-equipped buildings may be required that are accessible to all, including those with disabilities or who face other barriers (such as travel) to engaging with support.
10. Relevant support services should work together to consider all barriers outlined within the report (see summary table), affording consideration to the corresponding proposed solutions, and aiming to develop an action plan to address as many of these as possible. Prioritisation could be given to the most commonly raised barriers, which included lack of awareness of what help is available, issues around capacity and waiting lists, breaking down associated stigma, and promoting inclusivity to reach individuals from all backgrounds.
11. It was apparent through our fieldwork that both professionals and service users were not always fully aware of all the available support on offer to individuals with substance use issues. As such, commissioned services could consistently increase promotion of their treatment options to clients, staff, and external stakeholders to ensure that everyone is aware of them and can fully utilise all of the support applicable to their situation. Within this, it will be particularly important to raise awareness amongst groups that are not typically accessing treatment.
12. Commissioners and service providers could increase referrals by:
    - Increasing use of Test on Arrest – if possible, by mandating this on Warwickshire's Police system Athena for any 'trigger offences'.
    - Encouraging Warwickshire police to continue supporting drug and alcohol users into treatment with seamless referral pathways. We received suggestions that this could be achieved by exploring more co-location with the police (as well as probation), potentially with funding to have a Criminal Justice Recovery Co-ordinator based within the police stations in order to conduct appointments immediately after a positive drug test result is returned.

- Streamlining referrals from court-mandated Alcohol Treatment Requirements, as we were informed there can be confusion with the current set up resulting in referrals being sent to an out of area provider.
- Promoting awareness amongst external partners to drive direct referrals, to respond to areas where limited referrals have been identified, particularly focussing on health services such as GPs.
- Proactively challenging and collaborating with referrers to consider how they can reach more diverse communities, as the data suggests under-representation within treatment for certain cohorts, like those identifying as LGBTQ+ or from minoritised ethnic backgrounds.

13. Service providers should look to streamline the stages (initial contact, triage, assessment), and reduce wait time, a new service user has to go through before receiving support, limiting the number of different practitioners and times they have to repeat their personal information to. People should not need to 'tell their story' multiple times, and there should be good communication, data sharing, and co-ordination between different support services. Where there are multiple needs for a person or in a family, services should work together to assess their needs, develop a shared care plan, and consider the role of the 'lead practitioner' – someone who acts as a single, consistent, and trusted point of contact for different organisations and services.
14. As stakeholders raised concerns about the intrusive nature of the current assessment process and questions, commissioners and service providers could look to review the assessment processes. Specifically, shifting to have a greater emphasis on relationship building, and exploring the most appropriate timing for this to be conducted within a trauma-informed approach.
15. Commissioned services should continue to offer a flexible approach to support (including location and timing), with options to continue working more flexibly built into future contracts through a hybrid model of support (including in person face-to-face contact, virtual support facilitated via Microsoft Teams, Zoom, or an equivalent, and phone calls).
16. Commissioned services to provide more alternative activities for clients, aiming to build a recovery community and individual recovery capital through exploring the possibility of running more creative workshops, day outs, or trips, that help to build confidence and take people away from talking about their addictive behaviours. This was requested by service users numerous times during our fieldwork and was considered to be especially important when someone is coming towards the end of their treatment.
17. Nationally, there is a need for increased residential rehabs and detox places, with reduced waiting times. Locally, stakeholders believed that replicating the West Midlands framework that has been introduced for detoxes to rehab applications could be beneficial.
18. Given the context of reducing pharmacy availability and a national shortage of pharmacists, commissioners should explore what can be done to increase capacity of pharmacies in the local area to ensure dispensing provision can meet the demand for those requiring opioid substitution treatment.
19. Commissioned services should expand harm reduction provision, delivering training more widely to those not in treatment and external professionals. While we were impressed at the number of CGL service users who had been given (or already had) a naloxone kit during our in person fieldwork, staff within commissioned services could work on highlighting and reminding their service users of the importance of carrying their naloxone kits. This is vital for those still in active addiction and in light of the high proportion of drug related deaths in Warwickshire involving an overdose when somebody did not have a naloxone kit on their person. Family and friends should be able to access training to administer naloxone. Funding could also be explored to allow for CGL staff and Warwickshire police to carry naloxone, with consideration to expanding this to local taxi drivers and others who may come into contact with people who have taken an opioid overdose.

20. There is a need to explore support available within primary care as this is currently much lower in Warwickshire compared to nationally. Expanding provision in this setting would likely increase overall treatment capacity and increase the numbers of treatment referrals from health settings.
21. As the numbers of 'new clients' accessing needle exchange services decreased during the pandemic, and have not increased since, needle exchange services should work to increase their reach to promote harm reduction techniques and encourage safer consumption.
22. Commissioned services to proactively seek to engage with individuals who have 'additional needs' or protected characteristics by:
    - Establishing partnerships with 'by and for' organisations that assist with the promotion of commissioned support services, to ensure individuals with protected characteristics are reached and aware of the support available to them.
    - Improving dual diagnosis pathways – clearer joint working agreements, protocols, and procedures need to be established between commissioned services and key mental health support providers.
    - Exploring the possibility of recruiting in-house psychologists.
    - Raising staff awareness of learning disabilities and how to adapt support appropriately.
    - Building better working relationships with LGBTQ+ organisations within the area. A mapping exercise should be undertaken to identify potential services to joint-work with.
    - Ensuring staff have appropriate cultural safety and awareness training with availability of appropriate interpreters/translators as needed for anybody whose first language is not English to allow service users to express themselves freely.
    - Considering appointing a specialist midwife to co-ordinate support for pregnant service users.
    - Developing a dedicated form of support for sex workers.
    - Expanding 'prison in reach worker' roles who can support individuals 'through the gate' by being involved during their time in prison and conducting pre-release work.
    - Introducing dedicated family support, and upscaling the Family Drug and Alcohol Court provision.
23. Commissioned services to ensure a robust step-down support pathway is in place leading up to, and at the point of discharge from treatment, this could include:
    - Increasing prevalence of mutual aid meetings across Warwickshire, with representatives from the 12 Step fellowship coming into services to introduce themselves to clients.
    - Improving awareness and availability of self-help resources (such as Breaking Free Online), where possible, these should be offered online and/or in apps.
24. Commissioned services should increase opportunities for service users to provide feedback and enhance this through considering and reviewing key performance indicators with commissioners. Feedback should be regularly sought from service users in order to be responsive to their needs, as well as driving improvement. There should be options to provide feedback via a range of modes, including in person, online, through surveys, and with the choice to remain anonymous. At present, low rates of service users appear to be asked about their satisfaction. This should then be expanded to incorporate more co-production and co-design into service delivery, whereby people who access treatment and recovery services and those who have been personally affected by drug harm have input and involvement across all levels of the organisation and decision making, with a commitment to the principles of diversity and inclusion.

6.3. Achieving a Generational Shift in Demand for Drugs

25. Warwickshire's Drug and Alcohol Strategic Partnership could explore 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 education, which should

be delivered from primary school through to higher 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. Recent statutory guidance sets out requirements in relation to Relationship, Health, and Sex Education (RSHE) curriculum – teaching about tobacco, alcohol, prescription medicines, and illicit drugs (implementation to be monitored by Ofsted inspections). Teachers will require high-quality training programmes to deliver the new drug prevention curriculum effectively and this new prevention effort should be subject to scientific evaluation to promote continuous improvement. This simultaneously provides an opportunity to raise awareness of harm reduction techniques to promote safer consumption if people do decide to use substances. Education providers could consider the potential value in young people being educated on drugs and alcohol by a person who is 'more relatable' to them (e.g., not a teacher) – this could consist of a combination of police officers, Recovery Co-ordinators, and people with lived experience delivering sessions.

26. Alongside substance awareness lessons, young people should be taught healthy coping strategies, building their resilience so that they have the skills so as not to need to resort to substance use as a form of coping. Both stakeholders and those with lived experience believed there would be benefit in this. Commissioned Substance Misuse Services could have regular slots in schools to conduct creative sessions like arts and crafts, or drama, so that they have a presence in schools, but through these lessons can promote hobbies, and distraction techniques. Evidence shows that prevention programmes which target core risk factors in schools, in the community and in the family, can reduce drug use as well as many other problems for young people. In line with this, Dame Carol Black's report recommends investment in age-appropriate evidence-based services and support all young people to build resilience and to avoid substance misuse, with local authorities identifying, and providing additional support to those young people most at risk of being drawn into using illicit substances or involvement in supply.
27. Consideration could be given to the role of the local Drug and Alcohol Strategic Partnership Board in establishing partnerships with those responsible for offering diversionary activities to children and young people. Appropriate pathways need to be in place, and providers should be encouraged to expand their provision to ensure larger scale diversionary activities for child criminal exploitation and substance use are delivered within a contextual safeguarding model. Resources should specifically target cohorts most at risk[112] with the aim of reducing the risk of children and young people being exploited by county line drug dealers and providing support to those who are involved.
28. There is a need for local and national campaigns and media adverts to raise awareness to the general public about substance use, the associated impacts and harm, and where they can turn to seek support. Participants in this needs assessment emphasised the importance of these being strategically placed for all to see. Additionally, young people with lived experience who participated in the needs assessment felt that there should be more awareness amongst professionals of social media trends relating to substance use, and support services could utilise platforms like TikTok to educate people about harm reduction techniques, raise awareness of associated risks and dangers, and promote their provision.
29. The future Children and Young People's Drug and Alcohol Service provider should continue working with the Youth Justice Service on the 'universal referral pathway' as a preventative measure and could explore expanding this provision to children and young people who are not in touch with the criminal justice system.
30. Supporting young people and families most at risk of substance misuse or criminal exploitation is key – co-ordinating early, targeted support to reduce harm within families that is sensitive to all the needs

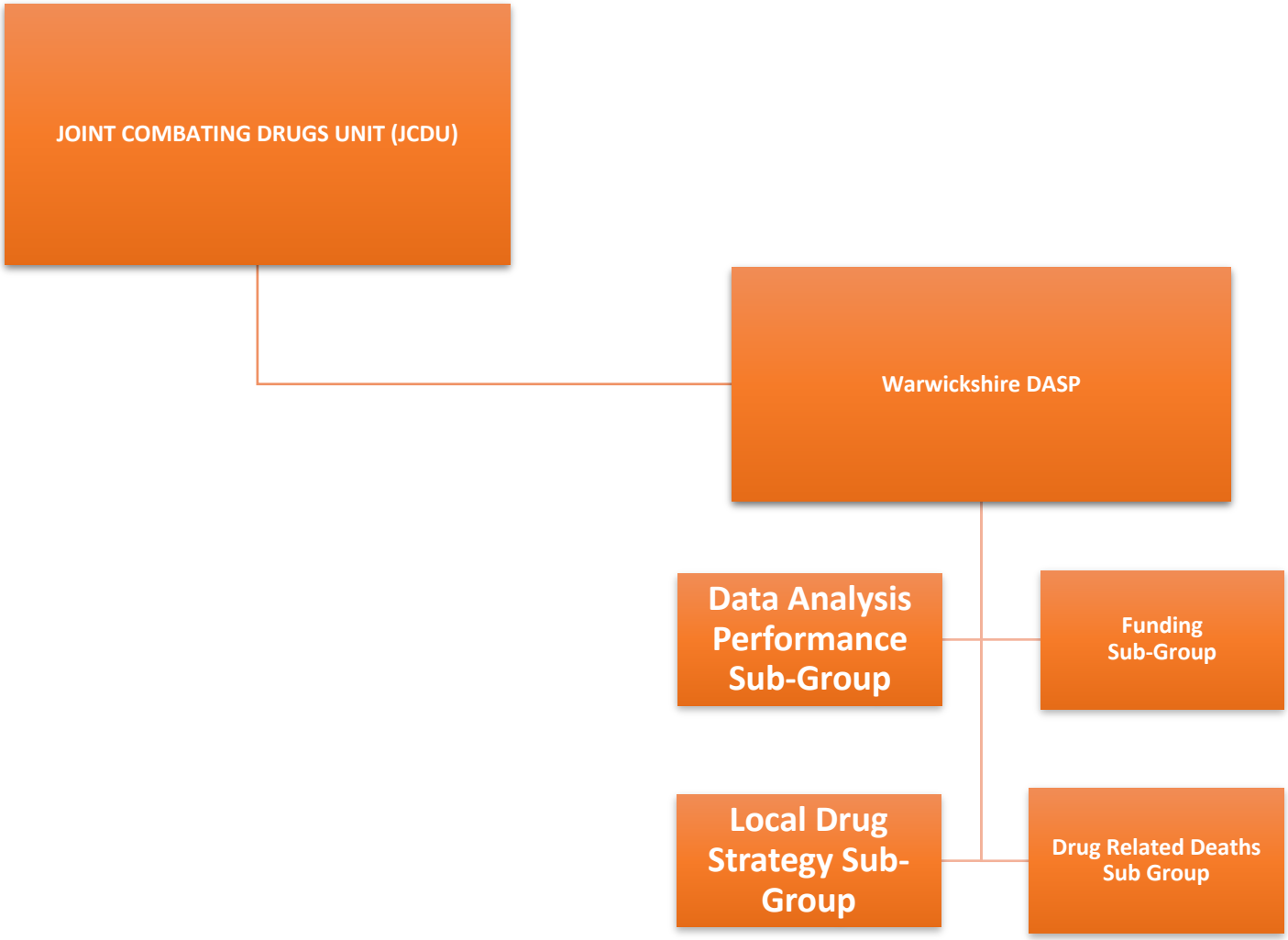
112 For more information, please see: https://www.preventingexploitationtoolkit.org.uk/home/what-is-exploitation/what-is-vulnerability/

of the person or family and seeks to address the root causes of risk is needed. Provision for supporting the children and young people of parents misusing substances through a whole-family approach should be increased and made more readily available, which effective promotion of the support offered.

31. The current Family Drug and Alcohol Court provision must be evaluated, and learning taken from the pilot. If found to be successful, this should be rolled out long-term and expanded to reach an increased number of families.

APPENDICES

Appendix A – Warwickshire Drug and Alcohol Strategic Partnership (DASP) Governance Structure 2022



Appendix B – Warwickshire Alcohol Related Death Data

In Warwickshire between December 2020 to February 2022, 14 alcohol related overdose deaths were recorded:

- 2 in 3 (64%) were male and 1 in 3 (36%) female.
- 2 in 3 (64%) were aged 45 to 64, with no deaths recorded for under 35s.
- 3 were shown as having been discharged from services in the 3 months before their death, and 3 were shown to be open to services at the time of their death – 1 person was recorded as being open to CGL, 1 engaged with hospital services and 1 with IAPT.
- Most (86%) were at home and alone when they overdosed.
- Most (86%) had a mental health diagnosis – mostly anxiety, depression, and alcohol dependency.
- Only 1 person had a history of drug misuse.

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