Public Health England

Protecting and improving the nation's health

Health Equity Assessment Tool (HEAT):

Full version

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Public Health England
Wellington House
133-155 Waterloo Road
London SE1 8UG
Tel: 020 7654 8000
www.gov.uk/phe
Twitter: @PHE_uk
Facebook: www.facebook.com/PublicHealthEngland

Prepared by: Lina Toleikyte, Public Health Manager, National Health Inequalities Team
For queries relating to this document, please contact: Lina.Toleikyte@phe.gov.uk or health.equity@phe.gov.uk

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About HEAT

What is HEAT?

HEAT is a tool consisting of a series of questions and prompts, which are designed to help you systematically assess health inequalities related to your work programme and identify what you can do to help reduce inequalities. It will also help you to consider the requirements of the Equality Act 2010.

When and why should I use it?

HEAT has similarities to other health equity assessment tools, but is unique in providing a lightweight yet still systematic framework for assessing and driving action on health inequalities.

It provides an easy-to-follow template which can be applied flexibly to suit your work programme. Its specific prompts ensure consideration of multiple dimensions of health inequalities.

How is it structured?

The tool has 4 stages:

1. Prepare
2. Assess
3. Refine and Apply
4. Review.

It is designed to be completed at the start of a work plan to help you consider its potential effects, but it can be used retrospectively. In practice, your assessment is likely to be iterative and will help you continuously improve the contribution of your work to reducing health inequalities.

Because tackling health inequalities at scale is likely to require ‘buy-in’ from senior leaders in your organisation or the system you work in, we recommend that the use of the HEAT process is sponsored by a senior leader.

What should be considered when completing it?

There are a number of different dimensions or characteristics to consider when completing HEAT.

1. The protected characteristics outlined in the Equality Act 2010 are as follows:
   - age
   - sex
   - race
   - religion or belief
   - disability
   - sexual orientation
   - gender reassignment
   - pregnancy and maternity
   - marriage and civil partnership

2. Socio-economic differences by individual socio-economic position. For example, National Statistics Socio-economic Classification, employment status, income, area deprivation.
3. Area variations by deprivation level (Index of Multiple Deprivation), service provision, urban/rural or in general.
4. Vulnerable and Inclusion Health groups, for example people experiencing homelessness, people in prison, or young people leaving care.

What should be considered when completing it?

Health inequalities are unjust differences in health and wellbeing between different groups of people (communities) which are systematic and avoidable. Health inequalities in England exist across a range of dimensions or characteristics, including the nine protected characteristics of the Equality Act 2010, socio-economic status, geographic deprivation, or being part of a vulnerable or Inclusion Health group.

Health inequalities may be driven by:

1 Different experiences and distribution of the wider determinants of health or structural factors. For example, the environment, community life, income or housing. In other words, the social economic and environmental conditions in which people live, work and play.

2 Different exposure to social, economic and environmental stressors and adversities. These affect states of mind from an early age and throughout life. Stress and psychological wellbeing directly affect resilience, health conditions and health behaviours.

3 Differences in health behaviours or other risk factors between groups, for example smoking, diet, and physical activity levels have different social distributions. Health behaviours may be influenced by wider determinants of health, like income.

4 Unequal access to or experience of health and other services between social groups.

People who share protected characteristics, as defined in the Equality Act 2010, may experience poorer health outcomes as a direct result of discrimination or due to different experiences of the factors described above.

The tool

Programme or project being assessed	Drug and Alcohol Services – Commissioned Service Review
Date completed	September 2024
Contact person (name, Directorate, email, phone)	Laura Pain (Drug and Alcohol Commissioner)
Name of strategic leader	Rachel Jackson (Strategy and Commissioning Manager)

Steps to take	Your response – remember to consider multiple dimensions of inequalities, including protected characteristics and socio-economic differences
A. Prepare – agree the scope of work and assemble the information you need	
1. Your programme of work What are the main aims of your work? How do you expect your work to reduce health inequalities?	Warwickshire County Council (WCC) has a statutory duty to improve the health and wellbeing of the population it serves. The D&A services are required to support local ambitions to reduce health inequalities and supports people to make positive choices to improve their health and wellbeing outcomes, improve family functioning targeting the priority needs of adults, children and young people and their families. WCC currently commissions Drug and Alcohol service contracts since 1st May 2018. The system contains three core system components that include an overarching generic vision and outcome focussed framework. The system is commissioned in three separate Lots, which are as follows: • Children and Young People's (CYP) Drug and Alcohol Service (Targeted and Specialist Support, Treatment & Interventions) delivered by Compass. • Adult Drug and Alcohol Service (Community & Inpatient Support, Treatment and Interventions delivered by • Change Grow Live (CGL) • All Age Drug and Alcohol Recovery Network delivered by CGL There are also other service elements: The Coventry and Warwickshire Detox and Rehab Framework and Panel (for Residential Rehabilitation and Inpatient Detoxification), Supervised Consumption and Needle Exchange. These form an integral core component to the wider drug and alcohol service and are offered as part of the adult treatment service.

	The service offer seeks to support residents of Warwickshire with drug and alcohol problems and their families to achieve quality of life outcomes, motivate and support people to achieve both short- and longer-term goals of recovery through evidence based and innovative approaches. The current service contracts end on 30th April 2024, and a service review is being undertaken. All three contracts have been in scope for this review. WCC has the potential for making a real difference to prevent, treat and promote recovery from drug and alcohol misuse. There is an opportunity to better embed a focus on health inequalities in the new service that will begin 1st May 2024 and contribute to WCC's work towards Levelling Up objectives and priorities for the county, which will be prioritised by groups of people and place. HEAT analysis will inform the re-commissioning of the D&A services by identifying areas where greatest inequalities exist and ensure consideration of multiple dimensions of health inequalities and inequity are considered in this re-design. It will: • systematically address health inequalities and equity-related issues in the context of D&A services • identify what action can be taken to reduce health inequalities and promote equality and inclusion HEAT analysis will allow WCC to ask providers to consider the needs of people with protected characteristics, specify how people in lower socio-economic groups will access the service and how wider determinants of health can be mitigated within their tender responses. The HEAT analysis will allow us to: • Inform the service specification • Inform specific tender questions for prospective providers • Help identify eligibility criteria for the service • Help identify referral routes and criteria • Identify sources of data we need to collect from future services which demonstrate more fully the impact on inequalities and help monitor equity to service The findings of the service reviews and needs assessments, this HEAT and the Equality Impact Assessment will be used to develop a refreshed service specification and performance indicators which will seek to improve the monitoring of data against health inequality indicators.

2. Data and evidence What are the key sources of data, indicators, and evidence that allow you to identify HI in your topic? • Consider nationally available data such as health profiles and RightCare • Consider local data such as that available in JSNA, contract performance data, and qualitative data from local research	• Commissioning data/service monitoring data • Joint Strategic Needs Assessment data • National Treatment Drug Monitoring System (NDTMS) • Warwickshire Drugs Needs Assessment 2022 (DNA) • Warwickshire Alcohol Needs Assessment 2022 (ANA) • Coventry and Warwickshire Pharmaceutical Needs Assessment 2022 (PNA) • Fingertips Profiles • Draft Coventry and Warwickshire Integrated Care Strategy 2022 • Warwickshire Health and Wellbeing Strategy 2021-2026 • Warwickshire Equality and Diversity Profile Dashboard • State of Warwickshire 2022 • Director of Public Health Annual Report 2022 • Warwickshire County Council Preventing Homelessness in Warwickshire: A multi-agency approach 2020-2023 • Homelessness Kills 2012 report • Institute for Alcohol Studies 2018 report • NHS Long Term Plan • Internal commissioned service reviews
B. Assess - examine the evidence and intelligence	
3. Distribution of health Which populations face the biggest health inequalities for your topic, according to the data and evidence above?	**Local Picture:** The estimated population of Warwickshire in 2021 was 596,773 and it is projected to grow to 684,307 by 2043[1]. This is broken down into District/Borough level as: North Warwickshire - 65,035 Nuneaton and Bedworth – 134,197 Rugby – 114,363 Stratford-on-Avon – 134,725 Warwick – 148,452

[1] Figures from 2021 Census

People with addiction often have one or more associated health issues, which could include lung or heart disease, stroke, cancer, or mental health conditions. Alcohol has been identified as a factor in more than 60 medical conditions, many leading to hospital admission. Alcohol contributes to conditions including cardiovascular disease, cancer and liver disease, harm from accidents, violence and self-harm, and puts substantial pressure on the NHS. Alcohol is a focus in Chapter 2 on Prevention/Health Inequalities of the NHS Long Term Plan [2].

Short-Term Health Risks
Excessive alcohol use has immediate effects that increase the risk of many harmful health conditions. These are most often the result of binge drinking and include the following:

- Injuries, such as motor vehicle crashes, falls, drownings, and burns.
- Violence, including homicide, suicide, sexual assault, and intimate partner violence.
- Alcohol poisoning, a medical emergency that results from high blood alcohol levels.
- Risky sexual behaviours, including unprotected sex or sex with multiple partners. These behaviours can result in unintended pregnancy or sexually transmitted diseases, including HIV.
- Miscarriage and stillbirth or fetal alcohol spectrum disorders (FASDs) among pregnant individuals.

Long-Term Health Risks
Over time, excessive alcohol use can lead to the development of chronic diseases and other serious problems including:

- High blood pressure, heart disease, stroke, liver disease, and digestive problems.
- Cancer of the breast, mouth, throat, oesophagus, voice box, liver, colon, and rectum.
- Weakening of the immune system, increasing the chances of getting sick.
- Learning and memory problems, including dementia and poor school performance.
- Mental health problems, including depression and anxiety.
- Social problems, including family problems, job-related problems, and unemployment.
- Alcohol use disorders, or alcohol dependence.

Admission episodes for alcohol-related conditions in Warwickshire is 505 per 100,000 population (2020/21). Of the Districts/Boroughs, North Warwickshire has the lowest rate.

Table 1 below suggests that rates for those in treatment for opiates and non-opiates are at a slightly lower level than the England rate when looked at on a population basis. It would appear that numbers in treatment for alcohol are above the national rate which corresponds with admission episodes for alcohol-specific conditions amongst those aged under 18 in the county which are the second highest across the West Midlands region[3].

[2] https://www.longtermplan.nhs.uk/online-version/chapter-2-more-nhs-action-on-prevention-and-health-inequalities/alcohol/#ref
[3] Interpretation of numbers in treatment activity could be misleading due to the influence of COVID in the last few years.

Table 1 Numbers in Treatment by Quarter Q2 2020/21 – Q1 2022/23

Numbers of all in treatment - year to date (NDTMS, Adult Quarterly Activity Partnership Report)	2020/21 Q2	2020/21 Q3	2020/21 Q4	2021/22 Q1	2021/22 Q2	2021/22 Q3	2021/22 Q4	2022/23 Q1
Warwickshire: opiates	925	987	1,040	882	935	989	1,031	870
Warwickshire: non-opiates	145	187	210	84	109	133	168	110
Warwickshire: alcohol	548	644	714	430	518	638	776	490
Warwickshire: non-opiates and alcohol	203	246	277	148	176	207	254	176
Warwickshire: Total	1,821	2,064	2,241	1,544	1,738	1,967	2,229	1,646
England: opiates	126,127	133,661	140,127	120,898	127,611	134,147	140,006	117,407
England: non-opiates	17,071	21,990	27,025	15,676	20,194	24,580	29,921	14,397
England: alcohol	50,443	63,525	75,547	45,086	58,808	71,165	83,582	44,826
England: non-opiates and alcohol	20,149	25,224	30,025	17,816	23,421	28,585	33,716	18,102
England: Total	213,790	244,400	272,724	199,476	230,034	258,477	286,595	194,732

Table 2 below shows that Opiate service users have the lowest rate of successful completions, but the most in treatment. The highest rate of successful completions is for non-opiate service users, but this group have the lowest of the 4 groups in treatment.

Table 2 Successful completions as a proportion of all in treatment (DOMES 1.2) 01/10/2021 to 30/09/2022

	Successful completions %	No. Successful Completions / all in treatment
Opiate	6.0%	62 / 1030
Non-opiate	32.2%	66 / 205
Alcohol	28.4%	233 / 820
Alcohol and non-opiate	23.4%	67 / 286

The two tables below (Table 3 and 4) show the estimated proportion of people in Warwickshire who are dependent on opiates and/or crack cocaine or alcohol not in the treatment system. As above, it suggests that Warwickshire is doing slightly better with meeting the need than the national picture. It also suggests that there is greater unmet need for alcohol misuse than there is for drug misuse.

Table 3 Estimated Unmet Need (DOMES 2.3) – 01/10/2021-30/09/222[4]

	Local	National
Opiates and/or crack cocaine	41.9%	54.3%
Opiates	42.9%	47.9%
Crack	51.3%	57.9%
Alcohol	79.0%	80.5%

Table 4 Estimated Unmet Need (DOMES 2.3) – July 2020-June 2023

The estimated proportion (%) of people in your area who are dependent on opiates and/or crack cocaine or alcohol not in the treatment system (DOMES 2.3)	2020/21 Q2	2020/21 Q3	2020/21 Q4	2021/22 Q1	2021/22 Q2	2021/22 Q3	2021/22 Q4	2022/23 Q1
Warwickshire: opiate and/or crack cocaine	41.7	41.0	40.9	40.8	41.8	41.9	42.5	42.0
Warwickshire: opiate	43.2	42.6	42.2	42.3	42.8	42.5	42.9	43.2
Warwickshire: crack	50.8	49.9	49.2	49.6	51.2	51.4	53.0	51.7
Warwickshire: alcohol	78.4	78.7	80.2	79.4	79.8	81.3	80.4	79.5
England: opiate and/or crack cocaine	53.6	53.7	53.7	53.3	53.6	53.7	53.7	54.0
England: opiate	46.8	46.9	47.0	46.6	46.9	47.0	47.1	47.5
England: crack	57.9	57.8	57.9	57.4	57.7	57.7	57.6	57.7
England: alcohol	82.7	82.4	82.1	80.8	80.4	80.7	80.5	80.5

Table 5 below suggests that since quarter 3 of 2020/21, Warwickshire have been doing better with naloxone administration to counteract the effects of drug overdose than the national rates.

Table 5 Naloxone Administrations (DOMES 2.16) – July 2020- March 2022

Has the client ever been administered with naloxone to reverse the effects of an overdose/has the client (%) been administered with naloxone to reverse the effects of an overdose in the last 6 months? (DOMES 2.16)	2020/21 Q2	2020/21 Q3	2020/21 Q4	2021/22 Q1	2021/22 Q2	2021/22 Q3	2021/22 Q4
Warwickshire	0.0	4.2	5.8	7.4	8.7	8.8	9.6
England	4.1	3.6	3.9	4.5	5.1	5.6	6.0

Socio-economic status

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. [5]

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.

One main barrier to receiving treatment was found by the DNA to be practical obstacles such as employment, travel, requiring childcare, and associated costs of attending a service – all factors that are influenced by socio-economic status.

Geographic deprivation:
The Warwickshire Alcohol Needs Assessment included data from Warwickshire Clinical Commissioning Group (CCG) from 2017-2021 showing that the highest alcohol-related rates of hospital admissions were associated with those from the most deprived areas.

People living in more deprived areas with lower individual resources and socioeconomic capital are at greater risk of harm – highest levels of alcohol and drug-related deaths in the UK occur in those areas of greatest neighbourhood deprivation.

While Warwickshire is not generally a deprived county, high levels of deprivation do exist in parts of the county - 11.9% (11,425) of children live in low-income families, the highest level of this can be seen in Nuneaton and Bedworth Borough.

[4] Alcohol unmet need rate calculated using alcohol only and alcohol and non-opiate substance groups

[5] Advisory Council on the Misuse of Drugs (2018) What are the risk factors that make people susceptible to substance use problems and harm?

People not in training, employment and education
Children in absolute low income families (under 16s) (2020/21) – 10.5% (lower than England value of 15.1%).
Children in relative low income families (under 16s) (2020/21) – 13.2% (lower than England value of 24.6% but is increasing and getting worse)

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%.

Geographic area
Warwickshire is a large and very diverse county, with large differences seen between all 5 Districts and Boroughs. There are also many rural areas with limited transport networks.

In 2021 the crime rate per 1000 population in Nuneaton and Bedworth Borough was 50% greater than South Warwickshire[6]. However, drug offences were one of the top 5 crimes in South Warwickshire reported from July 2020-June 2021.

Between January 2019 and February 2022 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.

Nuneaton and Bedworth was the only area above the regional average at 55.4 per 100,000 population alcohol related deaths.

6 Out of the top 15 LSOA alcohol related admission rates in Warwickshire were from Nuneaton and Bedworth.

The current Adult D&A provider CGL has 4 hub sites in Warwickshire. As seen in Table 6, on average Nuneaton seems to have the most referrals, followed by Leamington. Stratford has the lowest number of referrals. Nuneaton and Stratford have a similar sized population estimate, however there is no hub in North Warwickshire so service users from this area may use Nuneaton as their closest hub. Nuneaton has the greatest need and this will stretch the service resources further.

Stratford has a larger population than Rugby but lower average referrals, suggesting either a lesser need in Stratford/poorer accessibility/both. Stratford has by far the largest geographical area of all 5 Districts and Boroughs, meaning that location may be a bigger issue for those living in more rural locations.

Table 6 Adult Service Referrals by Service Location May 2018 – November 2022

	May 2018 – March 2019	April 2019 - March 2020	April 2020 – March 2021	April 2021- March 2022	April 2022 – Nov 2022	

[6] Spreading opportunity, embedding aspiration and tackling disparities: A countywide approach to Levelling Up in Warwickshire (2022) found at https://api.warwickshire.gov.uk/documents/WCCC-970487194-271

Leamington	465	315	246	297	241	
Nuneaton	583	328	252	302	267	
Rugby	234	186	157	205	162	
Stratford	219	87	120	109	98	

Practical issues around service locations can cause a barrier, especially to those who are less financially well-off. Numerous participants engaged with for the DNA 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.

Differences across Districts and Boroughs in Warwickshire can be identified in how treatment is offered. As one example, the table below shows individual ambulance call outs resulting in administration of Naloxone to counteract the effects of drug overdose, with comparisons to drug poisonings and deaths, broken down by District/Borough. Numbers of deaths in Nuneaton and Bedworth and Rugby were highest (in that order), and comparable. However there was lower Naloxone usage in Rugby. North Warwickshire and Stratford had lowest deaths (in that order), and they both had quite high proportions of Naloxone usage per death.

Table 7 Prevalence of Naloxone Use in 2022 [7]

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	WMAS naloxone usage	Drug Poisonings	Drug misuse deaths	Naloxone administrations per drug misuse death
North Warwickshire					1				1	2		1	5	3	1	5.0
Nuneaton & Bedworth	3	1	4	1	4	1	4	3	3	4	2	1	31	14	9	3.4
Rugby	1	2	5	2	3	3	3	2	1	1	1	1	25	10	8	3.1
Stratford-on-Avon	1	1	1	2			1	4	3		3		16	5	4	4.0
Warwick	5	2	4	1	4		2	7	3	1		1	30	8	7	4.3

[7] West Midlands Ambulance Service (WMAS) figures

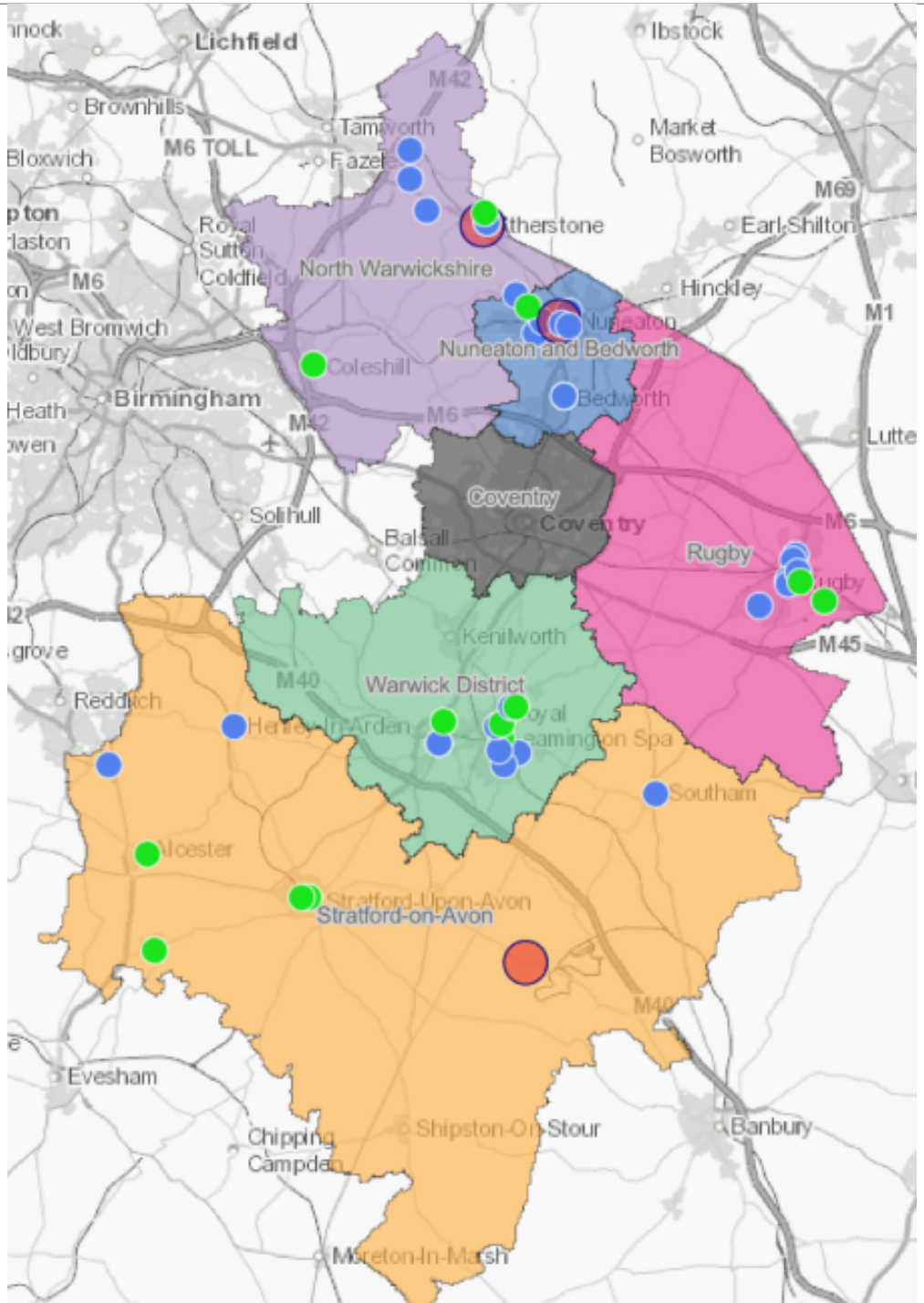
Provision of supervised consumption and needle exchange can be used as another example. In Warwickshire there has been a reduction of the number of active pharmacies providing needle exchange and supervised consumption service and a reduction in the number of interactions since 2018 to 2022. National data is not available to compare for needle exchange, but supervised consumption shows an opposite trend to the national picture, which shows a slight increase in the service.

Table 8 shows the provision of pharmacies who provide needle exchange, supervised consumption, or both services in Warwickshire. This is then mapped in figure 1, with the colours in the table corresponding to the coloured circles on the map.

Table 8 Pharmacies who provide Needle Exchange, Supervised Consumption, or Both in Warwickshire

Source: Pharmoutcomes

	Both	Needle Exchange	Supervised Consumption	Total
North Warwickshire	3	1	4	8
Nuneaton and Bedworth	2	1	8	11
Rugby	2		6	8
Stratford-on-Avon	4	1	3	8
Warwick	4		7	11
Total	15	3	28	46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Ibstock
M42
Brownhills
Tamworth
Market Bosworth
M6 TOLL
Bloxwich
Fazeley
M69
Atherstone
Earl Shilton
Royal Sutton Coldfield
North Warwickshire
Hinckley
M6
M1
West Bromwich
Nuneaton
Nuneaton and Bedworth
Coleshill
Bedworth
Birmingham
M42
M6
Solihull
Coventry
Rugby
Balsall Common
M6
Kenilworth
M45
M40
Warwick District
Redditch
Southam
Stratford-upon-Avon
Stratford-on-Avon
Evesham
Shipston-On-Stour
Banbury
Chipping Campden
Moreton-In-Marsh

Figure 1 Pharmacies who provide Needle Exchange, Supervised Consumption, or Both in Warwickshire[8]

Figure 1 highlights geographical areas with limited access to needle exchange/supervised consumption services e.g. south Stratford-on-Avon, and outskirts of Warwick and Rugby where services seem to be concentrated. It is worth noting however that the D&A service providers include needle exchange in their offer.

To achieve the national ambition outlined in the National Drug Strategy 2021, expanding the number of providers delivering supervised consumption and needle exchange programmes in Warwickshire is needed to ensure there is fair and equitable provision countywide. Adequate provision will need to be sought in the more deprived areas and those with higher drug and alcohol prevalence. Individuals within these areas are more likely to have a range of health inequalities and poorer health outcomes.

Inclusion health and vulnerable groups (for example, people experiencing homelessness, prison leavers, young people leaving care):

Those with a drug and/or alcohol dependence fall into an Inclusion Health Group.

Blood Borne Viruses (BBV)
Drug use can also increase the risk of contracting infections. HIV and Hepatitis C (a serious liver disease) can occur from sharing injection equipment or from unsafe practices such as condom-less sex. Infection of the heart and its valves (endocarditis) and skin infection (cellulitis) can occur after exposure to bacteria by injection drug use. This is why needle exchange services are so important.

The DNA found that staff appeared to be confident in offering and encouraging uptake of BBV testing and Hepatitis B immunisations and the uptake of this appeared to be good. Adverts were clearly visible in some hub locations, promoting regular testing and incentivising Hepatitis B vaccination. It was suggested that CGL are “testing more now than ever before”, that “Warwickshire are very committed to eliminating Hep C” with sound relationships, that must be retained, with relevant agencies for Hepatitis C.

However, work needs to be done to increase uptake; as can be seen in the below 2 tables (Table 9 and 10), Warwickshire figures are not as positive as the England figures.

Table 9 Hepatitis C Test Uptake (DOMES 2.8) July 2020-March 2022

Clients offered and accepted a hepatitis C test as a proportion (%) of eligible clients in treatment at the end of the reporting period(DOMES 2.8)	2020/21 Q2	2020/21 Q3	2020/21 Q4	2021/22 Q1	2021/22 Q2	2020/21 Q3	2021/22 Q4
Warwickshire	47.2	30.9	30.0	33.1	38.8	40.8	43.8

[8] Source: Pharmoutcomes

England	48.5	45.8	44.9	45.7	46.0	47.0	48.0

Table 10 Hepatitis B Vaccination Uptake (DOMES 2.12) July 2020-March 2022

Clients (%) offered and accepted a hepatitis B vaccination as a proportion of eligible clients in treatment at the end of the reporting period (DOMES 2.12)	2020/21 Q2	2020/21 Q3	2020/21 Q4	2021/22 Q1	2021/22 Q2	2021/22 Q3	2021/22 Q4
Warwickshire	34.6	17.4	16.6	17.5	18.2	20.6	21.4
England	38.4	34.4	32.5	32.1	31.2	30.8	30.1

Homelessness

Drug and alcohol problems can be a cause or contributing factor to homelessness and rough sleeping. The Preventing Homelessness in Warwickshire Strategy 2021-2023 highlights that data from 27 Health Needs Audits across England in 2019 showed that an estimated 27% had an alcohol problem 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 supporting the development and embedding of the Dual Diagnosis protocol and pathways into mental health and drugs and alcohol services.

The 'Homelessness Kills' report, published in 2012, investigated the mortality of homeless people in England for the period 2001-2009. The report identified that homeless people have seven to nine times the chance of dying from alcohol-related diseases and 20 times the chance of dying from drugs (CRISIS, 2012)[9].

Table 11 Number of people sleeping rough in Warwickshire on a single night in autumn 2020

Local Authority	Approach	Single night estimate
North Warwickshire	Estimate including spotlight	0
Warwick District	Estimate including spotlight	4
Stratford-on-Avon	Estimate including spotlight	4

[9] CRISIS, 2012. Homelessness Kills, An analysis of the mortality of homeless people in early twenty-first century England. [Online] Available at: https://www.crisis.org.uk/media/236799/crisis_homelessness_kills_es2012.pdf

Rugby	Estimate including spotlight	5
Nuneaton and Bedworth	Estimate including spotlight	6

The DNA found that most people with substance use problems appeared to know CGL were the current adult Substance Misuse Service across Warwickshire (usually through word of mouth from other users) but 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. 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.

The Institute for Alcohol Studies and Centre for Mental Health in 2018 surveyed mental health and alcohol services. The survey found that most staff in both settings thought that support for people with co-occurring conditions was poor, with support for homeless people being consistently the biggest area of concern.[10]

One of the critical success factors of best practice identified by OHID commissioning advice and Dame Carol Black's review is that local treatment services should proactively target vulnerable groups including people who are experiencing homelessness.

Contact with the Criminal Justice System
Dame Carol Black's Review of Drugs estimated that 1 in 3 people in prison have a "serious drug addiction"[11].
43.8% of people who access drug treatment in prison engage with community treatment on release in Warwickshire, which is higher than the national average (38.1%), but the Government target is 75%.
There is a national issue around rehab not accepting clients who have a history of sexual offending or arson.

Domestic Abuse
The engagement with service users in development of the DNA demonstrated that domestic abuse was a highly prevalent and current issue for female service users, but that there are gaps in when service users are referred to specialist services. The ANA highlighted that Multi Agency Risk Assessment Conference (MARAC) data shows a significant increase in cases where alcohol, drugs or mental health were involved during lockdown periods.
79% of Domestic Abuse cases referred into the MARAC during the first quarter of 2021/22 had an alcohol flag, and 73% of cases had a drug flag. This is an increase from the previous year, where the average for the year was 64% for alcohol and 59% for drugs.

Children and Young People including:
Looked After Children
Young people in contact with Youth Offending Services

[10] Institute for Alcohol Studies, 2018. Alcohol and Mental Health: Policy and Practice in England. [Online] Available at: http://www.ias.org.uk/uploads/pdf/IAS%20reports/rp31042018.pdf
[11] 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

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)
- Looked after children (18% referrals into treatment)
- 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)
- 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'). The Drug Strategy makes tackling county lines a major priority. [12]

The DNA noted that county lines and cuckooing are a prevalent issue in Warwickshire, and that Warwickshire is an "importer" of county lines. County lines has become the highest ranked threat for the UK, from a Serious and Organised Crime perspective. The West Midlands Force area remains the second largest exporter of County Lines in the UK, with Warwickshire directly affected by this. Vulnerable children, young people and adults can become victims of criminal exploitation including cuckooing. County lines are usually conducted by children or vulnerable people who are coerced into it by gangs. and the DNA suggests that a partnership approach to tackle this is needed to disrupt county lines and to safeguard vulnerable individuals. 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 in the DNA as very challenging to get such vulnerable people to accept the help on offer.

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 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%)[13]. Nationally, 44% of children looked after with an identified substance misuse problem received an intervention. Nationally, 8% of young people in community structured substance misuse treatment are children looked after.

Sex Workers
Sex workers have been identified as a key group at high risk of drug use and dependence. There is limited support or specialist work in place currently.

Steroid Users

12 Figures from 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

13 Data included in the report prepared for the Warwickshire drug and alcohol partnership meeting in June 2022

	Anabolic androgenic steroids are increasingly used by the general population, particularly male gym users, for their muscle-building and aesthetic effects[14] but these can negatively affect physical and emotional wellbeing and increases the risk of BBVs. **Those who have experienced adverse childhood experiences (ACEs)** Substance use levels are disproportionately high in those who have experienced ACEs. Inequalities and ACEs increase the risk of substance use significantly, and in those who use substances, of dependent/high risk use into adulthood.
	Experience related to protected characteristics: **Age** The population of Warwickshire can be broken down as: 0 – 15 years 106,704 (18.3%) 16-64 years 355,847 (61%) 65+ years 121,235 (20.8% - higher than the West Midlands and national averages of older people) As people age, their needs for NHS and Social Care increase. PHE datasets for drugs 2019/20 show that the largest age profile in drug treatment services is between 30-39. People aged 35-64 years old are most likely admitted into hospital for an alcohol-related condition. Most drug related deaths (62%) were of people aged 35 to 54, with 25% aged under 35 and 13% aged over 55.

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

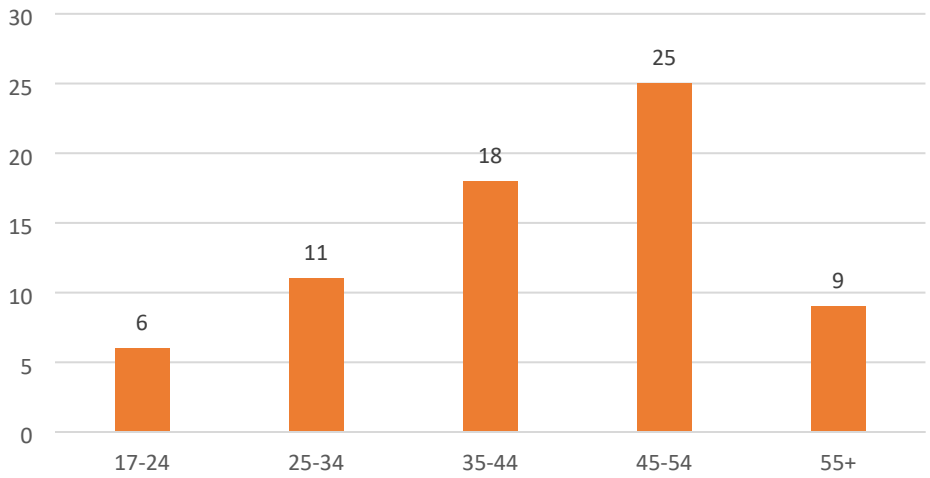

Figure 2 Drug Related Deaths in Warwickshire between January 2019 and February 2022, split by Age

Hospital admissions have also increased locally for alcohol specific conditions in under 18s[15] and the rates are higher for girls than boys[16]. Rates are higher in all Districts and Boroughs compared to the regional and national average.

The DNA highlighted that reported drug use among young people has increased over recent years, but numbers in treatment are falling, which is concerning. The number of young people in treatment Is low, and there has been a reduction of 64% in since 2009/10 (which is a similar trend to the national drop of 41% and drops in 83% and 72% in Worcestershire and Gloucestershire respectively)[17]. A reduction of 8% was recorded in quarter one of 2021/22 compared to the previous year.

PHE Children and Young People Substance Misuse Interventions Executive Summary 2021-2022 demonstrated that 92% of those within the CYP Service required support with cannabis misuse and 38% ecstasy. This is higher than the national levels of 88% (cannabis) and 11% (ecstasy). 53% of those within the CYP Service required support with their alcohol misuse. This is higher than the national level of 45%.

Substance misuse can have a major impact on young people's health, education, families, and their long-term chances in life. There are no official data about local levels of CYP drug use. However, national trends are available from ONS 2020[18]. 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%). Nationally, between April 2021-March 2022 the most common vulnerability reported by young people starting treatment was early onset of substance use (80%) meaning the young person started using substances before the age of 15[19].

The Government drug strategy recommends specific support for families with parental substance misuse. The current model provides support through the Hidden Harm service.

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. Currently, young people can access support via Compass up until the age of 25 to help reduce the stress of transitioning to the adult service. However, the Warwickshire Drugs Needs Assessment identified that joint working between Compass and CGL appeared to be lacking, and CGL stated they receive minimal referrals from Compass.

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 in the Warwickshire Drugs Needs Assessment 2022 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.

Disability - Learning Disabilities (LD)
There is a documented link between LD and substance use but there is no specialist support on offer and no specific training available to workers within the Substance Misuse Services.

Disability - Mental Health Problems
The DNA found that many respondents felt there is a large gap in mental health provision alongside substance misuse services, and there is a lack of mental health support to tackle the root cause of the problem. Drugs and alcohol are often used as a coping mechanism following mental health problems or adverse events.

Table 12 shows that local rates for the number of clients entering treatment who have been identified as having mental health treatment needs (for opiates, non-opiates, alcohol and alcohol & non-opiates) are all above the national rates [20]. The proportion of clients entering treatment who have been identified as having mental health issues increased from 2020/21 to 2021/22 but show some reductions in Q1 of 2022/23. However, local rates are still above those nationally.

[15] https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/ data#page/4/gid/1000042/pat/6/par/E12000005/ati/302/are/E10000031/iid/90284/age/26/sex/4/cid/4/page-options/ovw-do-0

[16] 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).

[17] Warwickshire County Council (2019) Adult Social Care Outcomes Framework - 2017/18 outturns Insight Service Briefing Note

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

[19] National Statistics - Young people's substance misuse treatment statistics 2021 to 2022: report published 2 February 2023

[20] DOMES 2.22 (2021/22-2022/23 data)

Table 12 Clients entering treatment (cumulative % year to date) identified as having a mental health treatment need (DOMES 2.22)

Clients entering treatment (*cumulative % year to date*) identified as having a mental health treatment need (DOMES 2.22)	2020/21 Q2	2020/21 Q3	2020/21 Q4	2021/22 Q1	2021/22 Q2	2021/22 Q3	2021/22 Q4	2022/23 Q1
Warwickshire: opiate	65.6	67.5	70.3	65.2	64.2	65.9	71.4	67.3
Warwickshire: non-opiate	73.6	69.3	69.8	64.5	67.9	73.8	76.1	74.4
Warwickshire: alcohol	72.3	74.8	75.6	70.3	71.7	72.6	74.8	73.6
Warwickshire: alcohol and non-opiate	68.5	78.1	80.5	80.0	81.3	82.6	83.6	92.5
England: opiate	56.4	58.2	60.2	59.8	61.7	62.7	63.5	61.5
England: non-opiate	64.4	65.9	66.3	66.0	67.7	68.6	68.5	69.2
England: alcohol	64.6	66.2	66.9	66.5	67.2	68.2	68.3	67.4
England: alcohol and non-opiate	70.6	72.2	73.2	72.2	72.9	74.0	74.3	74.7

Nationally, nearly half (46%) of young people starting treatment between April 2021-March 2022 said they had a mental health treatment need, which continues the rising trend of the last 3 years (43% in 2020 to 2021, 37% in 2019 to 2020 and 32% in 2018 to 2019). A higher proportion of girls reported a mental health treatment need than boys (60% compared to 38%). Most young people (69%) who had a mental health treatment need received some form of treatment, usually from a community mental health team[21].

Pregnancy and Maternity
The DNA identified Numerous barriers for pregnant women accessing substance misuse support, including the waiting room environment being daunting and uncomfortable, and judgement and shame when walking into a Substance Misuse Service site from the public. Additional to those identified, childcare issues e.g. timings, cost, can limit access to services.

The DNA cited an apparent need to combine maternity services and D&A services to improve partnership working. Additionally, a recommendation of the ANA was to “Improve maternity services, data recording systems. Developing a standardised approach to assess alcohol misuse and strengthen referral pathways from maternity services to treatment”. This shows that referral pathways are not working as well as they should be at present.

Race
North Warwickshire – 97.9% White British, followed by 1.1% White Other
Nuneaton and Bedworth – 88.9% White British, followed by 4.6% Asian or Asian British: Indian and then 1.8% White Other
Rugby – 84.1 White British, followed by 5.2% White Other, then 3.1% Asian or Asian British: Indian
Stratford-on-Avon – 93.6% White British, followed by 2.9% White Other

Warwick – 83.4% White British, followed by 4.9 Asian or Asian British: Indian, then 4.2% White Other

11.5% of the county population are from an ethnic minority background (62,857), with approximately twenty-one languages spoken. The most commonly spoken "main language" in Warwickshire is English, followed by Panjabi (2.3%), Polish (2%), Gujarati (0.83%), Urdu (0.82%) and Arabic (0.6%). The DNA highlighted a lack of specialist support for minoritised ethnic communities, and support available in languages other than English. This includes providers of detox/rehab on the Coventry and Warwickshire Detox and Rehab Framework.

Table 13 demonstrates that the current service is not being accessed by diverse populations that are reflective of Warwickshire. In all areas the proportion of White British service users are above 83%. There are very low proportions of Black/Black British service users accessing in all areas. The cells highlighted in blue are any proportions over 2%. In terms of proportions across all categories, Rugby has the most diverse service user group of the areas, however the numbers are still very low.

The data in Table13 also backs up the DNA finding that Asian people are under-represented in drug treatment:
Leamington hub had 3.4% Asian or Asian British: Indian service users, compared to the 4.9% population in Warwick.
Nuneaton hub had 1.5% Asian or Asian British: Indian service users, compared to the 4.6% population in Nuneaton and Bedworth.
Rugby hub had 1.2% Asian or Asian British: Indian service users, compared to the 3.1% population in Rugby.

Table 13 Adult Service - Breakdown of ethnicity by service area, on average between May 2018 – November 2022.

Ethnicity (CGL Adult Service Users)	Average Number (SUs)	Percentage
Leamington	**313**	
Asian/ Asian British - Indian	11	3.4%
Asian/ Asian British - Other Asian	2	0.7%
Asian/ Asian British - Pakistani	1	0.4%
Black/ Black British - African	2	0.6%
Black/ Black British - Caribbean	2	0.7%
Black/ Black British - Other Black	1	0.4%
Mixed - Other Mixed	2	0.5%
Mixed - White and Asian	2	0.6%
Mixed - White and Black African	2	0.5%
Mixed - White and Black Caribbean	5	1.5%

[21] National Statistics - Young people's substance misuse treatment statistics 2021 to 2022: report published 2 February 2023

Not Stated	2	0.5%
Other	2	0.7%
White - Other White	14	4.5%
White - White British	264	84.5%
White - White Irish	5	1.5%
(blank)	2	0.8%
Nuneaton	**346**	
Asian/ Asian British - Indian	5	1.5%
Asian/ Asian British - Other Asian	3	0.7%
Asian/ Asian British - Pakistani	1	0.3%
Black/ Black British - African	1	0.4%
Black/ Black British - Caribbean	2	0.6%
Black/ Black British - Other Black	2	0.4%
Mixed - Other Mixed	2	0.6%
Mixed - White and Black African	1	0.3%
Mixed - White and Black Caribbean	3	0.7%
Not Stated	2	0.6%
Other	3	0.9%
White - Other White	8	2.4%
White - White British	312	90.0%
White - White Irish	4	1.3%
(blank)	4	1.1%
Rugby	**189**	
Asian/ Asian British - Bangladeshi	1	0.5%
Asian/ Asian British - Indian	2	1.2%
Asian/ Asian British - Other Asian	2	1.1%
Asian/ Asian British - Pakistani	2	0.8%
Black/ Black British - African	2	0.8%
Black/ Black British - Caribbean	2	1.1%

Black/ Black British - Other Black	2	1.1%
Mixed - Other Mixed	2	0.9%
Mixed - White and Asian	3	1.3%
Mixed - White and Black African	2	1.1%
Mixed - White and Black Caribbean	4	1.9%
Not stated	3	1.8%
Other	3	1.5%
White - Other White	10	5.2%
White - White British	157	83.2%
White - White Irish	2	1.0%
(blank)	2	1.2%
Stratford	**127**	
Asian/ Asian British - Indian	2	1.2%
Asian/ Asian British - Other Asian	2	1.2%
Black/ Black British - African	1	0.8%
Black/ Black British - Caribbean	1	0.8%
Black/ Black British - Other Black	2	1.2%
Mixed - Other Mixed	1	0.8%
Mixed - White and Asian	1	1.1%
Mixed - White and Black Caribbean	1	0.8%
not stated	2	1.6%
Other	4	3.2%
White - Other White	3	2.5%
White - White British	117	92.4%
White - White Irish	2	1.2%
(blank)	2	1.2%

Sex

Out of the Warwickshire population, 288,334 (49.4%) are males and 295,452 (50.6) are females.

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.

There are differences between men and women in terms of alcohol consumption. For example, there is a strong association between levels of consumption and severity of dependence, but women are likely to become dependent at lower levels of consumption than men. Men are more likely to be admitted into hospital due to alcohol consumption compared to women.

Males are referred more than females for rehab and detox, as shown below.

Table 14 Referrals to Rehab broken down by Gender, between April 2019-January 2023

Rehab Referrals (by Gender)	2018-19	2019-20	2020-21	2021-22	April 2022 - Jan 2023
Female	16	12	5	8	20
Male	15	20	25	18	29

Table 15 Referrals to Detox broken down by Gender, between April 2019-January 2023

Detox Referrals (by Gender)	2018-19	2019-20	2020-21	2021-22	April 2022 - Jan 2023
Female	14	15	4	4	10
Male	24	24	17	15	17

There is a concerningly small number of boys and young men in treatment in Warwickshire.

With CYP, there are a number of specific issues facing girls, including increased citation of alcohol as a problematic substance, involvement in self-harm, being affected by domestic abuse, and affected by sexual abuse including exploitation as can be seen in the table below. These trends can also be seen across England. Boys also experience domestic abuse, sexual exploitation and self-harm, and this should be explored by services[22]. Nationally, more boys than girls had a mental health treatment need identified but either did not receive treatment or refused treatment between April 2021-March 2022[23].

[22] OHID – Young people substance misuse commissioning support pack 2022-23: Key data

[23] National Statistics - Young people's substance misuse treatment statistics 2021 to 2022: report. Published 2 February 2023

Table 16 **Young people (under 18) in treatment with wider and substance specific vulnerabilities for Warwickshire, 2020-21**

Wider vulnerabilities	Total young people	Proportion of all in treatment	Male (%)	Female (%)
Anti-social behaviour	1	3%	6%	0%
Involved in self-harm	8	21%	6%	33%
Affect by domestic abuse	2	5%	0%	10%
Affected by others' substance misuse	2	5%	0%	10%
Child in need	2	5%	0%	10%
Looked after child	0	0%	0%	0%
Subject to a child protection plan	2	5%	6%	5%
Affected by sexual exploitation	1	3%	0%	5%
Pregnant and/or parent	1	3%	0%	5%
NFA/unsettled housing	0	0%	0%	0%
Early onset (starting before 15)	9	23%	28%	19%
Using two or more substances (incl. alcohol)	20	51%	44%	57%
High risk alcohol users	2	5%	0%	10%
Opiate and/or crack	1	3%	0%	5%
Injecting	0	0%	0%	0%

Sexual Orientation and Gender Reassignment

	The proportion of the national population identifying as lesbian, gay or bisexual (LGB) increased from 1.6% in 2014 to 2.2% in 2018. This is comprised of 1.4% identifying as gay or lesbian and 0.9% as bisexual. Locally applied, this translates to a population of approximately 12,714 in Warwickshire. The DNA found a lack of specialist support for the LGBTQ+ community. CGL does not report on LGBTQ+ demographics. Compass reports on gender (including reassignment), but not sexual orientation; this could be inapplicable for some young people so it is not appropriate to ask on service forms. At the moment there is a lack of research regarding trans and non-binary communities specifically and substance misuse. Transgender people drink more alcohol than cisgender people[24]. On a global level, trans and non-binary people report needing greater help for reducing substance use including alcohol harm than cisgender respondents.[25] Chemsex - There is an association between drug use and risk-taking behaviour, and concern has been raised around the transmission of sexually transmitted infections, drug overdoses and increasing injecting behaviour. It is suggested that drug services should partner with LGBTQ+ services to promote harm reduction information and ensure awareness of how to access treatment for drug use.
4. Causes of inequalities What does the data and evidence tell you are the potential drivers for these inequalities? • Which wider determinants are influential? E.g. income, education, employment, housing, community life, racism and discrimination.	In 2019 there was 4.6% of the Warwickshire population (15,300) having no qualifications at all, with 20.8% (28,700) having 5 GCSE grades A* to C or equivalent. Of the school population 16.2% are eligible for free school meals. Persistent absence in secondary school is 12.6%, lower than the region and England rates. In Warwickshire 4.4% (12,200 (6,700 males and 5,600 females)) of working age adults are unemployed, this is higher in the north of the county than the south. WCC's Health and Wellbeing Board's Covid-19 residents survey respondents with a prior mental health condition were more likely to report engaging in less healthy behaviours as coping mechanisms, such as drinking more alcohol[26]. Many young people receiving specialist interventions for substance misuse have a range of vulnerabilities. Examples of the types of vulnerabilities / risks young people report having at the start of treatment include: not in education, employment or training (NEET), in contact with the youth justice system, experience of domestic abuse and sexual exploitation. Substance misuse, for example, is associated with early sexual initiation and other risky sexual behaviours[27]. People who experience inequalities in relation to substance misuse may not be aware of the D&A services and/or how to access them for various reasons that affect each group e.g. people who are socially isolated due to their location or those who are not computer literate due to socioeconomic status. The service gets the majority of referrals via self-referral as can be seen in Table 17,

[24] Prevalence and correlates of substance use among transgender adults: A systematic review. December 2020. Available at: www.sciencedirect.com/science/article/abs/pii/S0306460320306742?via%3Dihub

[25] Comparing intentions to reduce substance use and willingness to seek help among transgender and cisgender participants from the Global Drug Survey May 2020. Available at: www.sciencedirect.com/science/article/abs/pii/S0740547219306993

[26] Health and Wellbeing Strategy 2021-2026 https://api.warwickshire.gov.uk/documents/WCCC-1350011118-2972

[27] OHID - Young people substance misuse commissioning support pack 2022-23: Key data

- What aspects of mental wellbeing are affected? Consider risk and protective factors.
- Which health behaviours play a role?
- Does service quality, access and take up increase the chance of health inequalities in your work area?

Which of these can you directly control?
Which can you influence?
Which are out of your control?

however if people are not aware of the service or how to self-refer they could miss out on the D&A support they need. Table X shows that some agencies who have contact with people facing health inequalities in relation to D&A, have low referral rates, for example Job Centre Plus (people not in employment) and domestic abuse services. An improvement on the range of referral sources and is something that can be influenced as part of the re-commissioning process, via the service specification, ITT questions, and through performance management of the new contract (as well as the current contract).

Table 17 Adult Service Referral Sources May 2018 – November 2022

Referral Sources	May 2018 -March 2019	April 2019 - March 2020	April 2020 -March 2021	April 2021 -March 2022	April 2022 - Nov 2022
Adult mental health services			5	21	20
Adult social care services	10	12	11	24	6
Adult treatment provider			5	20	16
Arrest referral	12	27	4	7	7
ATR	6	19	3	16	6
Children and Family Services					14
Children's Social Services	5	3	1		
Community Alcohol Team			1		
Community Rehabilitation Company (CRC)	3		1	2	
Criminal Justice - other	14	21	15		
Domestic abuse services			1	2	5
DRR	8	4	1		
Drug Service Non-Statutory	26	9	7		
Drug Service Statutory	19	2	1		
Employer		1		1	
Employment Service	2			1	1
GP	57	33	16	29	23
Hospital (inc. A&E)	26	9	3	10	10
Hospital alcohol care team/liaison nurse			1	8	9
Housing/homelessness service			8	10	12

Job Centre Plus		1	1		
Liaison and Diversion		1		6	3
Other	11	3	12	16	17
Outreach	3		2	1	1
Peer (i.e. other service user) – Alcohol projects only		1			
Prison	67	32	33	47	50
Probation Services	32	9	32	39	30
Psychiatry services	4	5	1		
Psychological Services	14	2	6		
Relative	2	1	3		
Relative/peer/ concerned other	3		3		1
Self	1163	709	592	642	528
Self-referred via health professional	14	12	4	11	8
Sex worker project			1		
Young people structured treatment provider			1		1
Grand Total	1501	916	775	913	768

The DNA found that there is an apparent lack of awareness and understanding of the existing support services in Warwickshire among both the general public and some professionals. 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 users) but many did not have a clear idea of the service offer or treatment options.

The Adult service data detailed in Table 13 (in section 3) demonstrates that the service is currently being accessed predominantly by White – British service users, and other ethnic minorities are underrepresented in the service. This suggests that there are barriers to access for ethnic minority groups that will be contributing to health inequalities, and these barriers (some of which have been identified in the DNA) need to be addressed and mitigated against in future delivery.

In current contract performance monitoring frameworks, limited demographic data is reported on, which is shown in the table below:

Table 18 Demographics reported on by providers

	CYP Service	Adult Service & Recovery Network

Age	Yes	Yes
Disability		Yes
Gender Reassignment	Yes	
Marriage/Civil partnership		
Pregnancy/Maternity		
Race/Ethnicity	Yes	Yes
Religion/Belief		
Sex	Yes	Yes
Sexual Orientation		Yes
Location	Yes	
Additional Vulnerabilities	Yes	

In the Adult and Recovery Network reporting these demographics are not broken down into treatment group (combining opiate, alcohol, non-opiate, and non-opiate/alcohol). This makes it difficult to understand the extent to which the service is reaching vulnerable groups and those who are particularly affected by health inequalities and makes it challenging to understand which aspects of the service need more focus to reduce health inequalities.

In the CYP service, support is offered across the county in various locations – including education settings, family centres, in outdoor spaces, cafes/coffee shops and community centres to suit individual need. 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.

The following are identified barriers with the current service model:

- Lack of rural locations of services
- Employment
- Travel and limited transport networks
- Childcare issues
- Timings of service
- Costs of attending a service
- Living in Warwickshire's rural locations

	• Financial status • Reduction of pharmacies offering supervised consumption/needle exchange services • Dual diagnosis pathways are not strong enough • Lack of awareness of the service offer/treatment options • Transitional pathway between CYP and Adult service not working efectively • Young people who have prescribing needs need a key worker from the adult service • Waiting room environment can be daunting for pregnant service users • Fear of judgement from public when walking into a service building • Language, reading and translation issues • Physical settings of support e.g. cafe could cause concerns about confidentiality • Computer literacy • Service capacity and waiting lists • Stigma
C. Refine and apply – make changes to your work plans that will have the greatest impact	
5. Potential effects In light of the above, how is your work likely to affect health inequalities? (positively or negatively) Could your work widen inequalities by: • requiring self-directed action which is more likely to be done by affluent groups? • not tackling the wider and full spectrum of causes?	Potential to widen inequalities: • Social issues that can particularly be caused by D&A use e.g. family problems, job related problems and unemployment. • Locations of service and pharmacies e.g. there is no hub in North Warwickshire • Differences in staff training across different areas in Warwickshire • Dual diagnosis pathways are not strong enough • Assertive outreach not working as effectively e.g. with the homeless population • Rehab often does not accept those with a history of arson/sexual offending • No specialist support for those with learning disabilities and no specific training • Lack of mental health support

• not being designed with communities themselves? • relying on professional-led interventions? • not tackling the root causes of health inequalities?	• Pregnancy/maternity referral pathways not working effectively • Lack of specialist support for minority ethnic groups • Lack of specialist LGBTQ+ support • Adult service does not report on LGBTQ+ demographics • Referral routes for professions working with those experiencing health inequalities are not strong enough e.g. Job Centres. • The service currently mostly relies on self-referral
6. Action plan What specific actions can your work programme or project take to maximise the potential for positive impacts and/or to mitigate the negative impacts on health inequalities? • How can you act on the specific causes of inequalities identified above? • Could you consider targeting action on populations who face the biggest inequalities? • Could you design the work with communities who face the biggest health inequalities to maximise the chance of it working for them?	**Healthy Lifestyles** Ensure the new service specification includes a requirement for Provider to possess appropriate skill and knowledge of MECC activity to support service users to adopt healthier lifestyles and signpost to lifestyle-risk management services. **Protected Characteristics** Ensure practitioners have cultural safety and awareness 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 (e.g. different pockets of communities having different substances of choice and varying cultural norms that should be better appreciated by workers). Additionally, training for hospital staff and midwives around pregnant women in addiction to help remove prejudice. There is a need for culturally appropriate messaging in any promotional materials. Establish partnerships with 'by and for' organisations, ask that they assist with promotion of D&A Services, and develop an asset-based approach. Recommendation from DNA: Raise staff awareness of learning disabilities and how to adapt support appropriately. Recommendation from DNA: Building better working relationships with LGBTQ+ organisations within the area. A mapping exercise should be undertaken to identify potential services to joint-work with. Recommendation from DNA: 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. **Accessibility**

• Could you seek to increase people's control over their health and lives (if appropriate)? • Could you use civic, service and community-centred interventions to tackle the problem – to maximise the chance of reaching large populations at scale? • Who else can help?	Deliver a hybrid model of working with options for virtual support with appropriate safeguarding procedures. This should include phone, text, email and video calling options and home visits if necessary. Providers should work with agencies to promote computer literacy. Increase provision of interpreters/translators. Provide flexible support with evening and weekend appointments and groups. Services must ensure their physical location is accessible and 'disabled friendly'. Services should be well-promoted to the general public, clearly outlining what they offer, setting out the eligibility criteria, and how to refer. The language used in promotional materials is important and needs to be inclusive. Better awareness raising amongst all professionals should also be undertaken to encourage them to utilise referral pathways. Recommendation from DNA: 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. Recommendation from DNA: 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. **Outreach** Continue and enhance the outreach offer - assertive outreach should be focused particularly in the most rural parts of Warwickshire. Promote inclusivity through assertive outreach. This should be targeted to areas with higher number of minority ethnic communities, and communities with higher population with protected characteristics. Pop-up support hubs in the community as well the provision of workshops in 'harder-to-reach' settings and prevention workshops in schools. There is a need for persistence in outreach work to minoritised ethnic communities, and other groups of vulnerable individuals and those with protected characteristics, to build trust and confidence and that this needs to be continuous work, not run as ad hoc projects. For example, the Birmingham model involves an outreach worker placed within sexual health clinics and hospitals with an aim to engage with sex workers and once the connection is built, they can be more easily signposted to mainstream services. Another example is that many needle exchange schemes visit gyms to ensure steroid users have clean injecting equipment and outreach workers offer harm reduction advice[28].

[28] 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

	There is a need for closer joint working with Substance Misuse Services and domestic abuse organisations. **Age** 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. The transitional offer needs to be clear in the specification and tender responses. The Hidden Harm element of the service which provides support to families with parental substance misuse is important to continue. Specialist services should be provided to those whose use has escalated and/or is causing them harm. There should be effective pathways between specialist services and children's social care for those young people who are vulnerable and age-appropriate care should be available for all young people in specialist services. Substance misuse services for young people may need to consider sex differences in the treatment population. Services available need to be tailored to the specific needs of girls and boys within these services and ensure that young people with multiple vulnerabilities or a high risk of substance misuse-related harm get extra support with clear referral pathways and joint working protocols. **BBVs** Promotion of BBV testing and incentivisation of Hepititis B immunisations should be maximised. Relationships with relevant Hepatitis C agencies across the county should be formed/maintained. For less confident or newer staff members, they need to be encouraged to take up the training on offer and ensure they explore the reasons behind a refusal to be tested. Providers are required by the current service specification to offer measures to prevent drug related deaths, particularly for those leaving prison, rough sleepers/the homeless, vulnerable groups or those returning from inpatient/residential rehab. Harm reduction should underpin all elements of the service, to include vaccinations for Hepatitis A & B, TB, HIV and Hepatitis B & C testing, and syringe programmes. The current model offers and encourages uptake of BBV testing and Hepatitis B immunisations. **Dual Diagnosis (Mental Health)** One of the opportunities to improve outcomes for homeless people will be by supporting the development and embedding of the Dual Diagnosis protocol and pathways into mental health/drugs and alcohol services. There is a need for a stronger partnership working from mental health services to ensure support is joined up. Currently the drug and alcohol workers that work in the dual diagnosis pathway are not specifically trained in mental health so there is need for mental health professionals dedicated to the pathway. Explore possibility of in-house mental health workers or psychologists and enhance joint working under the dual diagnosis pathway with statutory mental health providers. Additionally, the DNA found there is a strong value placed on counselling and support groups to help service users identify the root causes of their addiction and aid recovery. Recommendation from DNA: Improving dual diagnosis pathways – clearer joint working agreements, protocols, and procedures need to be established between commissioned services and key mental health support providers

	Employment CGL has an Individual Placement and Support (IPS) service across Warwickshire and Coventry, which started taking referrals in January 2022. This is funded by OHID and commissioned by Coventry City Council. The IPS service works 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. 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. **Health Care Settings** Clearly defined referral pathways should be established with acute trusts, hospitals and ambulance services. **Family support** Families in communities at risk will be supported by this service and Hidden Harms element will be a part of CYP service. Addressing parental substance use early and quickly will prevent the occurrence of the ACE of parental substance misuse for children currently growing up in the county and increase the chance of successful parenting and family life. Recommendation from DNA: Introducing dedicated family support, and upscaling the Family Drug and Alcohol Court provision. **Pregnancy and Maternity** Barriers that pregnant woman in addiction face need to be addressed. In an attempt to address these barriers, the Substance Misuse Service in Birmingham has a dedicated midwife to liaise with CGL and pregnant substance users. Training sessions for hospital staff and midwives have also been provided to help remove prejudice. A replication of this would be beneficial in Warwickshire. Recommendation from DNA: Considering appointing a specialist midwife to co-ordinate support for pregnant service users. **Prison Leavers** Recommendation from DNA: 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. **Service User Feedback, Co-Design and Co-Production** Expand opportunities for service users to provide feedback, through a variety of mechanisms, so that those affected by D&A use can have input and involvement throughout all levels of the service provider organisations and recommissioning activity.

7. Evaluation and monitoring How will you quantitatively or qualitatively monitor and evaluate the effect of your work on different population groups at risk of health inequalities? What output or process measures could you consider?	**Reporting on service usage and demographics** Ensure the new service specification includes mandatory reporting on protected characteristics and other vulnerabilities identified in this HEAT, and others that are identified by the service e.g. smoking status, self-harm, suicidal ideation and broken down into service area. This will be monitored on a quarterly basis through contract monitoring. The Drug and Alcohol Strategic Partnership will have overview of the Performance Management Framework which will track both national and local outcome measures. The data will feed into the NDTMS. Market engagement TBC. Continuous further engagement.
Set a health equity assessment review date, recommended for between 6 and 12 months from initial completion. Review date: April 2025	

D. Review – identify lessons learned and drive continuous improvement	
Date completed (should be 6-12 months after initial completion):	
Contact person (name, directorate, email, phone)	
1. Lessons learned Have you achieved the actions you set? How has your work: a) supported reductions in health inequalities associated with physical and mental health? b) promoted equality, diversity and inclusion across communities and groups that share protected characteristics? What will you do differently to drive improvements in your programme? What actions and changes can you identify?	