



Mayor of London Consultation Draft London Health Inequalities Strategy 2009

London Drug and Alcohol Network (LDAN) Response

The London Drug and Alcohol Network (LDAN) was established in January 2001 following the merger of the Greater London Association of Alcohol Services (GLAAS) and the London Drug Services Consortium (LDSC). In March 2009, LDAN merged with the national information and membership organisation for the drug sector, DrugScope.

LDAN is a pan-London second tier organisation with a wide membership base covering over 200 drug and alcohol treatment service providers, from London's voluntary and statutory sectors. There are also associate and corporate members providing links with services outside of the capital. LDAN is funded to provide secretariat support to the Greater London Alcohol and Drug Alliance (GLADA) and the Joint Action Group for Alcohol in London (JAG) to deliver London's Regional Statement of Priorities for Alcohol.

LDAN supports its members through information sharing, capacity building and representation to develop high-quality drug and alcohol services for Londoners.

LDAN aims to:

- Provide independent and expert advice to member agencies, commissioners and other stakeholders
- Support member agencies in providing cost-effective high quality services that are user-focused
- Actively engage policy and decision makers, seeking influence and investment in services
- Represent the views of member agencies at a strategic and policy level.

Introduction

Support for wider physical, mental and emotional health needs is essential to enable those with substance misuse problems to engage with treatment and work towards recovery. Yet drug or alcohol users can face many barriers when attempting to access health and social care provision, including prejudice and a lack of coordination between relevant support agencies.

Our response is based on the views expressed by LDAN members through email submissions, telephone interviews and consultation with the LDAN Senior Managers Group, which is a forum for senior drug and alcohol managers across London.

The key message that came out of our consultation process is that *the health inequalities strategy for London should recognise and provide for the particular health and social care needs of people with drug or alcohol problems.*

Our response focuses on the first consultation question 'Are these the right actions and proposals?' with particular reference to Objective Two which aims to 'Improve access to London's health and social care services, particularly for Londoners who have poorer health outcomes.'

Individuals with drug or alcohol problems are clearly one of the major groups in London who have poorer physical and mental health outcomes. The Drug Treatment Outcomes Research Study (DTORS) found that 24 per cent of those aged 35 and over reported poor health, as did 14 per cent of those aged 25 to 34 and 13 per cent of those aged 16 to 24.¹ Research conducted for the National Treatment Agency suggests that 75 per cent of people accessing drug services have some form of mental health problem, with the majority experiencing depression and/or anxiety.² The specific barriers that drug and alcohol users face in accessing health and social care services therefore need to be addressed in the London Health Inequalities Strategy.

Are these the right actions and proposals?

Objective One Empower individual Londoners and their communities to improve health and wellbeing.

The drug and alcohol sector in London has significant experience in community engagement and health and well being communication and promotion. We particularly support action A3 in the strategy: 'To create more opportunities for Londoners to adopt healthier behaviours including those related to alcohol and drugs'. Many of our member organisations already contribute to this action point.

One example is the Westminster Drugs Project (WDP) community outreach team, which runs a community peer education course on drug and alcohol awareness that is Open College Network (OCN) accredited. The team also enable local community groups to hold healthy living and drug awareness events by assisting with planning, facilitation and funding. Events have included a Muslim Woman's Day and Hindu Navratri Event with a focus on substance misuse. WDP provide opportunities for graduate learners to volunteer at events,

¹ Jones *et al.* 2007, *The drug treatment outcomes research study (DTORS): baseline report*, Research Report 3, Home Office, London

² Weaver *et al.* 2002, *Co-morbidity of substance misuse and mental illness collaborative study*, NTA, London

in order to gain experience of event organisation, with a view to them being able to hold further drug awareness events in their own communities.

LDAN supports the GLADA Women's Voices project, which brings together women who have experienced substance misuse to influence national policy, and we are happy that this is highlighted in the strategy. LDAN helped to facilitate the Women's Voices consultation event that fed into the health inequalities strategy at an earlier stage. We are also supporting a programme of work being delivered through GLADA to promote responsible drinking and providing secretariat support to GLADA's 'Joint Action Group for Alcohol in London'. As part of this work, we are currently helping to co-ordinate a project to produce guidelines to support more consistent practice across London in working with children and young people around alcohol-related harm.

The benefit to the broader health and well being of communities from drug and alcohol services needs to be explicitly acknowledged within the strategy. Equally, commissioning processes in London need to allow for more innovative substance misuse services that have a broader focus on the health and well being of service users to be developed, and their integration into – and contribution to – their neighbourhoods and communities. As one LDAN member suggests: 'the driver behind the funding of treatment programmes is often reduction in offending/crime or financial savings. As with other areas of health delivery, the improvements in an individuals wellbeing, family links and social functioning within the community need to be a key consideration.'

Objective Two Improve access to London's health and social care services, particularly for Londoners who have poorer health outcomes.

In our response we will be examining both the barriers to accessing drug and alcohol services and wider health and social care services in London for people with drug or alcohol issues.

1. Barriers to accessing drug and alcohol services in London

Awareness

A number of LDAN members reported that people with drug or alcohol issues can be prevented from accessing treatment because of a lack of awareness amongst other professionals, for example: 'More drug / alcohol awareness training for the police, GP's and other healthcare providers along with how to access services would help overcome access barriers.'

A lack of awareness of available services combined with preconceptions about substance misuse and treatment services can prevent people accessing support. One LDAN member suggests that this is a particular issue amongst young people: 'drug awareness education within schools and colleges and effective links to Tier 2 Open Access services would help improve access routes for young people...However, it is fundamentally important that the information given out in campaigns is accurate and chimes with young people's experience, in order for it to impact positively.'

Availability

We heard that drug and alcohol service provision across London is uneven. Because of the local connection criteria that exists for most services, individuals from some London Boroughs may be disadvantaged when they seek to access help for drug or alcohol problems. This is a particular issue for itinerant populations such as homeless people – a

group that regularly moves between boroughs and also has a particularly high incidence of substance misuse problems.³ For this reason we support action A10 in the strategy: 'To improve the commissioning of health and social care for the most disadvantaged or excluded Londoners, including pan-London and sub-regional commissioning.'

The particularly chaotic lifestyles of homeless people and rough sleepers can make it difficult to access drug and alcohol treatment and to complete treatment programmes. To this end, LDAN has commenced a new partnership project with Homeless link and Shelter to help improve the links between homelessness and drug and alcohol services in London, which is being funded over four years by London Councils. We welcome the focus in the strategy on the particular health needs of homeless people, including those relating to substance misuse, and the suggestion that more high quality, accessible services for this group need to be developed.

LDAN members expressed particular concern about the availability of alcohol treatment services across London. One alcohol service suggested that they are inundated with referrals and do not advertise more widely because they cannot meet the need. They do not want to have a long waiting list and would rather more alcohol services were developed to meet this need. Although they were pleased with the government drive around 'prevention' and problematic alcohol use - such as brief interventions in GP surgeries - they were concerned that this agenda should not divert funding away from the already overstretched day or residential alcohol treatment services. The service felt that alcohol needs assessments in London do not always consult enough local stakeholders and therefore may not adequately reflect this need for more services.

Other members suggested that there is a lack of longer-term residential rehabilitation in London: 'Service users who have had long drug/alcohol using careers often have complex needs, and this combined with learning to negotiate the world without substances, means that they need more than 12 weeks at the residential rehabilitation stage, in order to sustain the changes.'

Equally 'aftercare services' for those who have completed treatment are rare in London, but important for people to move on to independent living: 'Comprehensive aftercare in dedicated services enables ex-service users to continue to access any support needed, without entering back into drug/alcohol treatment. Conversely drop-in services can lead to contact with previous associates and the reminder of previous behaviour can lead to relapse.'

A particular focus is also needed on the availability of appropriate drug and alcohol services for those in custody or on release from prison. Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system ('The Bradley Report') highlighted that there are particular issues about the standards of health care for people with drug and alcohol problems in the prison system.⁴ One of our respondents also suggested that: 'service users being released from prison establishments can often wait for prescribing appointments due to waiting lists or short notice of release date. Prescribing services need to provide evening and Saturday services – this will enable those released on Fridays to access services more readily.'

³ A recent research report suggests that 42% of clients in an average homelessness project have drug problems, and 39% have alcohol support needs, Homeless Link (2009) 'Survey of Needs and Provision', Homeless Link, London

⁴ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098694

Diversity

Another key access barrier to drug and alcohol services in London is that they are not always sensitive or accessible to different demographics or equality groups. One member suggests that: 'treatment services are orientated to 'white men' and little attention paid to other groups, for example Black and minority ethnic groups and female drug and alcohol users'. The Department of Health and National treatment Agency (NTA) have published a number of reports to show that diversity is a key issue that needs to be addressed in the substance misuse field.⁵

Treatment premises are seen as generally not child friendly and another respondent expanded on this to suggest that the lack of access to childcare is a key barrier to treatment. They also suggest that flexible opening hours that fit with childcare responsibilities would be very beneficial. Also, despite the fact that there are higher rates of disability among the drug-using population, many drug or alcohol services have no or insufficient disabled access.⁶

A Department of Health report on barriers to drug service access for Black and minority ethnic groups⁷ suggests that some of the key barriers to treatment include a lack of awareness of drug services, stigma from community/families, concerns about confidentiality, language barriers and drug services' need to develop cultural competence. Nationally, just over half (54%) of the local drug partnerships have now undertaken a race equality impact assessment (REIA) specifically relating to substance misuse services.⁸ The most common REIA findings included the need to improve diversity training among the local workforce, produce drug treatment literature in community languages and to commission a translation service.

One member highlighted that drug/alcohol misuse is a serious issue amongst the Lesbian, Gay, Bisexual or Transgender (LGBT) community, however they are less likely to access services. They suggested that more specific services and outreach work is needed. An example of a relevant specialist service in London is the new Comic Relief-backed alcohol counselling service to support young Londoners who identify as LGBT. Juice, based at Greenwich's Metro Youth Service, offers alcohol-related advice, counselling and one-to-one and group support to 11-21 year olds.⁹ GBL misuse is a particular drug trend amongst certain LGBT groups in London. South London and Maudsley NHS Trust has recognised this problem and set up a specific treatment service.¹⁰

Another member suggested that there is a lack of appropriate treatment services for older adults with substance misuse problems. An example of a specialist service is the Hammersmith and Fulham Older Persons Alcohol Project, which was created in response to both the high level of alcohol related hospital admissions for those aged 45+ and the low number of these individuals accessing community treatment services. The service works in partnership with professionals from generic health care services, mental health services and local adult social care services in order to improve the health of the individual, reduce their

⁵ For example, Diversity: learning from good practice in the field, NTA, 2009 and Black and minority ethnic drug misuse needs assessment project, Department of Health, 2000-2006.

⁶ Physical inaccessibility negatively impacts the treatment participation of persons with disabilities. West, S. L., Luck, R. S., & Capps, C. F. Addictive Behaviors 2007 32, 1494-1497.

⁷ Black and minority ethnic drug misuse needs assessment project, Department of Health, 2000-2006.

⁸ Diversity: learning from good practice in the field NTA 2009

⁹ <http://www.nta.nhs.uk/publications/documents/diversitypractice0709.pdf>

¹⁰ <http://www.metrocentreonline.org/>

<http://www.slam.nhs.uk>

isolation and promote better integration into wider community networks for individuals when they have stabilised their alcohol use.¹¹

2. Barriers to accessing Wider Health and Social Care Services in London

Our respondents supported the statement in the strategy that people with substance misuse problems can be 'excluded from services because of limited opening hours and rigid appointment procedures'. One member commented on the incompatibility of the 'inflexible engagement rules' of health and social care services, with the 'unstructured lives of problematic drug and alcohol users'.

Stigma/Discrimination

We received significant support for the statement in the strategy which suggests that 'some Londoners feel excluded by the initial responses from front-line staff when trying to access primary health care. Fears about confidentiality can be a barrier to disclosing personal information, such as addiction'.

As part of our consultation process we interviewed a GP who has significant experience of working with drug and alcohol issues. She felt that prejudice is one of the main barriers that prevent people with drug and alcohol problems accessing mainstream health care services. In her experience, health care staff make assumptions about clients with drug or alcohol problems and 'because the client feels they are being treated badly, they may behave badly'. She suggests that because of a lack of knowledge, staff in GP surgeries can feel intimidated and there is a need for training on drug and alcohol issues and how to develop 'compassionate competence' in their working practice.

One member noted that parents with substance misuse issues can encounter particular negative reactions from health and social care professionals, and said that this applied to both men and women. As one respondent suggested: 'The negative reaction presented to drug and alcohol misusers when entering mainstream services limits their future engagement and ability to make steps to resolve their problem.'

An example of a service working to combat this issue in London is Health E1 for the homeless in Tower Hamlets, who provide substance misuse training to try to improve awareness among generic general practitioners.¹²

Dual Diagnosis

A key argument that we received from LDAN Members is that the Mayor's Health Inequalities Strategy needs to acknowledge the significant problem in London of people with drug and alcohol *and* mental health problems being excluded from services. As mentioned earlier, research suggests that 75 per cent of people accessing drug services have some form of mental health problem, with the majority experiencing depression and/or anxiety.¹³ One treatment provider reported to us, for example, that their clients suffered from 'anxiety, phobia, depression, personality disorders, self harm, long term trauma including childhood abuse, as well as psychoses in a few'. However counselling and other mental health support is often limited or inaccessible. As another suggests: 'The complex needs of some drug and alcohol users need to be addressed in a cohesive multi-agency manner, with a stronger focus on dual diagnosis issues'.

¹¹ http://www.lbhf.gov.uk/AZofServices/D/27861_Drug_and_alcohol_support.asp

¹² <http://www.healthe1practice.nhs.uk/register/>

¹³ Weaver et al 2002, *Co-morbidity of substance misuse and mental illness collaborative study*, NTA, London

We interviewed a specialist dual diagnosis nurse to inform our response who suggested that workers in both substance misuse and mental health services often don't feel skilled enough and lack confidence in working with people who have dual diagnosis issues. She suggested that assessment tools within drug and alcohol services do not always adequately examine mental health and vice versa. If assessment tools were designed to examine these issues then services would be able to use this data to lobby for more dual diagnosis training and specialist staff. She felt that capacity needs to be built into services so that adequate time can be taken to work with clients on these complex issues. In particular, she felt pharmacist support is essential within mental health and substance misuse services to advise on the contraindications of the wide range of medication that may be prescribed to someone with mental health, physical health and substance misuse issues. Another member suggested that they needed support to understand when a client's symptoms are a product of withdrawal or side effects from drug or alcohol use or whether they are due to independent mental health issues.

LDAN/Drugscope have been working with the Improving Access to Psychological Therapies Programme (IAPT) to highlight the importance of access to support for low level mental health problems such as anxiety and depression for people with drug or alcohol problems. Currently IAPT services may not be accessible to this client group in London and this should be addressed in the strategy. One LDAN member said that having drug and alcohol issues is being used as a blanket exclusion criteria for IAPT services in her local area, and, to compound the problem, there is a lack of any alternative provision for drug and alcohol service users with depression and anxiety to access therapy. Our understanding from IAPT's national policy leads is that substance misuse should not be used as an exclusion criteria in this way, but this is not always being reflected in the local development of the IAPT initiative.

Dual diagnosis is a particular issue within the criminal justice system. The issue of dual diagnosis was strongly highlighted in the Bradley Report.¹⁴ A report on London's prisons published by the Sainsbury Centre for Mental Health in 2006 concluded that, despite very high levels of 'co-morbidity' among prisoners, provision for 'dual diagnosis' remained a 'big gap' in London's prisons – partly because substance misuse services had historically been viewed as outside the remit of 'health care' within the prison system. Noting some innovative work at HMP Wormwood Scrubs, the Sainsbury Centre argued that 'given the number of prisoners who suffer from both mental health and substance misuse problems, addressing the needs of these prisoners should be part of the core business of mental health services in prisons'.¹⁵ This is also an issue for policy seeking to divert more offenders from prison and/or the criminal justice system into more constructive and effective programmes. For example, research by Nacro published in 2005 would suggest that many court diversion schemes in London are not equipped to work with offenders who have both mental health and substance misuse problems – it found that only 3 out of over 60 mental health diversion schemes across the country had drug and alcohol workers.¹⁶

An example of a multi-agency dual diagnosis project is Brighton and Hove's Dual Diagnosis Steering Group. When a service user is discharged from one service, the agencies on the steering group can have a conference meeting and work together to find appropriate alternative support.¹⁷

¹⁴ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098694

¹⁵ http://www.scmh.org.uk/pdfs/policy5_prison_mental_health_services.pdf

¹⁶ <http://www.nacro.org.uk/data/files/nacro-2005042200-394.doc>

¹⁷ <http://www.sussexpartnership.nhs.uk>

Social network/Family support services

A key message to come from consultation with our LDAN Senior Managers Group was that the strategy does not highlight or examine social isolation as a cause of health inequalities. Many people with drug or alcohol problems will have been cut off from family and friends due to their addiction. The stress of isolation and loneliness coupled with problems such as substance misuse can lead to rapidly decreasing overall health and well being and this should be reflected in the Health Inequalities Strategy. One member stressed that 'isolation from supportive networks (families, friends) increases the rate of depression amongst our clients.'

GP and medical services

The UK Guidelines on Clinical Management state that as a general principle people seeking drug treatment should have a general health assessment and be referred for appropriate treatment.¹⁸ However, some responses from members suggested that the broader health care needs of drug and alcohol users often get sidelined because their addiction problems take precedence. Examples of health needs that are often under recognised and under treated included cardiovascular and gastro-intestinal problems, diabetes, high blood pressure, acute asthma, long term respiratory problems - including Chronic obstructive pulmonary disease (COPD) and 'crack lung' and even lung cancer - TB, and pneumonia. The health needs that are more commonly recognised include blood borne viruses (BBV) and bacterial infection risk, Hepatitis C and sexually transmitted infections, particularly amongst injecting drug users. But these are not always addressed. There are also health risks associated with the use of substitute treatments, such as methadone, including digestive problems, dental decay and depression.

Although there are still large gaps in provision in London, many drug and alcohol services have developed broader health services or have nurses or GPs on site. For example, practitioners at The Westminster Drug Project are trained to offer 'dry blood spot testing' so that service users can have a BBV test at any point including as part of an initial assessment.

Due to capacity constraints GP and A&E services are often unable to give sufficient time to the complex health problems that drug and alcohol service users can have. LDAN members particularly highlighted the need for more thorough and efficient assessments for drug and alcohol use and wider associated problems in both GP and A&E services. One provider supported brief assessment and sign posting for *all* registered GP patients rather than just new ones, allowing linkage of 'illness', accidents, mental health issues, with associated substance misuse problems. Another suggested that 'drug and alcohol screening in Accident and Emergency departments would ensure referral into the appropriate service earlier'.

Provider opinion varied (dependent on circumstance of clients and stage in treatment process) as to whether it is better to have internal nurse or GP practitioners within drug and alcohol services, or for clients to be referred out to access this support. However all agreed that it is essential that these links are in place so that people with drug and alcohol support needs can access broader health care support.

¹⁸ Department of Health and devolved health departments 2007, Drug misuse and dependence – UK guidelines on clinical management, NTA, London

A GP we interviewed in our consultation process suggested that drug services are not set up to manage broader health conditions, so drug users should be treated in general practices, or at least remain as a 'patient' of their doctor (In 2007-08, over a third (37%) of GP practices were involved in drug treatment¹⁹). She felt that when patients are referred to drug or alcohol services, this link is often cut and the service will re-do the GP's assessment and start from scratch. She suggested that the 'Edinburgh shared care model' works particularly well, in which patients remain with their GP through treatment and after its completion.

An example of integrated working between substance misuse and broader health care is Brent DAAT shared clinical governance meetings, which are attended by housing, user groups and GPs to look at Common Assessment Forms and develop effective working relationships.²⁰

'Healthy Living' services

Drug and alcohol service users can have particular difficulty accessing 'health living' services despite the fact that they often have nutritional problems and many are smokers.

One LDAN member suggested that 'drug and alcohol misusers may have limited knowledge, access or desire regarding healthy eating and may suffer additional health issues as a result of this. Training in healthy living - i.e., cooking / nutrition and life skills - is essential in all drug and alcohol services' Related to this issue is the high incidences of dental problems amongst drug and alcohol services users. They suggested that all clients should have free access to dental treatment.

Financial constraints mean that access to gym and fitness education can be difficult. One respondent felt that all local councils in London should look into funding free gym placements for drug and alcohol service users.

Smoking cessation support was also highlighted as lacking in London for drug and alcohol service users. One LDAN member felt that this problem is often compounded by drug and alcohol workers who do not prioritise this issue and choose not to signpost their clients to such services. DrugScope responded to a Department of Health tobacco control consultation to highlight this issue at a national level.²¹ An example of an organisation working to combat this problem in London is Islington NHS Stop smoking service, which has provided training to the staff and service users of drug and alcohol agencies in Islington in 'Level 1 Stop smoking'. The course includes basic evidenced information and details of local services so staff can sign post, where appropriate.²²

Domestic violence services

There are clear links between domestic violence and substance misuse, however victims of domestic violence with substance misuse problems can have difficulty accessing refuge spaces and support. The Stella Project is highlighted in the strategy for its work across London to address gaps in service provision for both survivors and perpetrators of domestic violence with substance misuse problems.

LDAN has received funding from London Councils to deliver a pan-London 4 year domestic violence project. This initiative is supporting organisations to work across the drug, alcohol and domestic violence field with victims and perpetrators. We are creating a network to bring together domestic violence and drug and alcohol misuse agencies across London.

¹⁹ <http://www.pulsetoday.co.uk/story.asp?storycode=4120114>

²⁰ http://www.gldvp.org.uk/module_images/BRENT%20DAAT%20Substance%20Misuse%20Plan%20Final%202008-09.pdf

²¹ <http://www.drugscope.org.uk/ourwork/Policy-and-public-affairs/topics-and-campaigns/special-topics/tobacco-control.htm>

²² <http://www.smokefreeislington.nhs.uk/pages/go.asp?PageID=477&Path=5&Parent=1.01&instance=504>

Network meetings are focusing on improving approaches to joint working, improving cross sectoral knowledge and understanding and highlighting good practice. We would be happy to share our findings from this project with the strategy implementation team.

Objective Three Reduce income inequalities and minimise the negative health consequences of relative poverty.

Studies have shown that up to 80% of problem drug users (PDUs) are unemployed, yet work has been shown to be an important component of rehabilitation and reintegration into society, reducing the likelihood of relapse. People with drug or alcohol problems face significant barriers to employment, not least of which is stigma and prejudice from employers. Two thirds of the employers surveyed in a UKDPC research project suggested that they would not employ someone with a history of problematic drug use.²³

We fully support the actions in the strategy to tackle unemployment and financial insecurity as a way to help reduce health inequalities. LDAN members agreed with the suggestion in the strategy that low income can contribute to the adoption of 'coping' behaviours such as smoking and excessive alcohol consumption. One member suggested that: 'If the use of drugs and alcohol is coupled with poor housing, stress and low income the negative health effects will be increased'

One LDAN member felt that drug and alcohol service users are 'grossly underrepresented when tackling areas of unemployment and financial security.' Despite this, a number of drug and alcohol services in London are working to create pathways to employment for their service users. To date this work has not been significantly highlighted or promoted within London.

LDAN has been funded by the City Parochial Foundation to identify and collate good practice, to start building an evidence base on what works in employment support for people with drug and alcohol problems, to disseminate this to LDAN members and to influence pan-London and national policy and strategy in this area. We would be happy to share our findings from this project with the strategy implementation team and provide links to good practice in employment support for this client group within London.

An example of an employment support model used in London is the Individual Placement Support Model (IPS) which involves having employment specialists within substance misuse teams.²⁴ This model includes assessing and including 'vocational needs' in care plans, alongside other treatment needs, in order to create a holistic recovery plan owned by the service user. The specialist provides both job search and in-work job retention support. One respondent felt that 'having an employment specialist within a clinical team can provide a different perspective within the team, and ensures there is a focus on client's strengths and abilities'.

We particularly welcome action A14 to 'support the development of programmes to increase financial security for people at points of transition in their lives', and the recognition that 'leaving prison or moving to employment after a period in treatment - can mark a defining point when a person becomes financially insecure'. The strategy should further emphasise the need for employment support provision for those accessing or leaving drug or alcohol treatment.

²³ http://www.ukdpc.org.uk/publications.shtml#Employment_report.com

²⁴ Agencies such as the Central and North West London NHS Foundation Trust have implemented the IPS model: <http://66.102.9.132/search?q=cache:Op-bPgRYFSkJ:cnwl.org/uploads/CNWL%2520Employment%2520Services%2520Update.doc+IPS+Model+substance+misuse&cd=4&hl=en&ct=clnk&gl=uk>

Objective Four Increase opportunities for people to access the potential benefits of work and other forms of meaningful activity.

We support the suggestion that ‘feeling undervalued and unsupported can cause stress, which often leads to unhealthy behaviours such as...drinking too much alcohol’, however we were disappointed that this was not reflected in any recommendations about employment and in-work support for people with drug or alcohol problems.

As part of LDAN’s City Parochial funded employment project, we will be looking at effective ways of working with employers in London to promote increased understanding on drug and alcohol problems and will be holding an event specifically on this issue. Again we would be happy to share our findings with the strategy implementation team.

The ‘Drugs and alcohol in the workplace toolkit’ produced by the London Drug Policy Forum suggests that the provision of general drug and alcohol awareness training for all staff, as well as more specialised training for front-line supervisors on how to manage staff who experience these issues, should form a key part of any employer drug and alcohol policy.²⁵

LDAN is keen to ensure that we work together in London to maximise the positive impact of Government policy to improve the employment, education and training prospects of people in drug and alcohol treatment. Recent initiatives with important implications across London include the creation of the new role of ‘drug co-ordinators’ in 2009 – backed by £9 million in Government investment - to work in JobCentres to improve the links between employment, education and training (EET) and substance misuse services, and the plans to pilot a new regime for problem drug users contained in the Welfare Reform Act 2009 in Central London (along with four other sites across England) from October 2010.

Objective Five Develop and promote London as a healthy place for all – from homes to neighbourhoods and the city as a whole.

LDAN is committed to providing continuing support towards the delivery of the Regional Statement of Priorities for Alcohol, which will contribute to some of the key actions included in the strategy, such as promoting best practice management of the night time economy and promoting effective interventions to tackle the sale of alcohol to underage young people.

Conclusion

The focus of the strategy on physical *and* mental health, as well as healthcare for socially excluded groups, such as homeless people, is particularly welcome and relevant to the drug and alcohol sector. We are pleased that the strategy acknowledges ‘the use, or level of use, of tobacco, alcohol or other substances’ as a key health determinant in London, and recognises that five per cent of Londoners are estimated to be dependent drinkers (compared to 3.6 per cent across England) and that London has the highest number of problematic drug users for any region (approximately 74,000).

Overall however, the strategy has a much stronger focus on alcohol rather than drug misuse. The emphasis on alcohol is very welcome, but it is important not to lose sight of the impact of illicit drug use too. It is concerning, therefore, that the strategy’s ‘health inequalities indicators’ include ‘alcohol consumption’, but not drug use. Equally, although the Greater London Association on Drugs and Alcohol (GLADA) is identified as a key partner, neither the

²⁵ http://www.cityoflondon.gov.uk/Corporation/LGNL_Services/Health_and_social_care/Substance_misuse/dat_workplace.htm

regional National Treatment Agency (NTA) nor the local Drug and Alcohol Action Teams (DAATs) are identified as delivery agents for the strategy.

Lack of public awareness and availability of drug and alcohol treatment, as well a limited provision suitable for different equality groups were identified by our members as some of the main barriers to accessing drug and alcohol services in London. These issues should be addressed within the strategy to promote equality of access to drug and alcohol support for all Londoners.

Stigma and discrimination towards drug and alcohol service users should be highlighted in the strategy as a barrier to equality of access to generic and mainstream health and social care services. A key area that the strategy should give greater prominence to is 'dual diagnosis' and the difficulties in accessing services for people with mental health *and* substance misuse problems. Also the particular barriers that drug and alcohol service users face when attempting to access social network/family support, GP and medical services, 'Healthy Living' support, and domestic violence projects should be acknowledged.

The strategy has a positive focus on tackling unemployment and providing 'in-work support'. We would however like to see employment support for people with drug and alcohol problems or histories included in this section.

LDAN represents a wide range of drug and alcohol services across London. We would be pleased to link the strategy implementation team up with local drug and alcohol organisations, groups or forums.

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