Unmet Treatment Need Among Heroin and Crack Users and Dependent Drinkers

FINAL REPORT (2025)

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SUPPORTED BY
NIHR | National Institute for Health and Care Research

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Acknowledgements

Research of this sort is not possible without the kind of generosity and willingness that was shown to us by the people who took part in this study. We are very grateful for this. We are also very grateful to the National Institute for Health and Care Research and the Department of Health and Social Care for their responsive research management and their engagement with our findings. Finally, we want to thank Marie O'Neil Queenan, for her input in the early stages of the research.

This study was funded by the NIHR Policy Research Programme (NIHR203449). The views expressed are those of the authors and not necessarily those of the National Institute for Health and Care Research or the Department of Health and Social Care.

Summary

The majority of people in England who use opiates and/or crack cocaine, or who are dependent drinkers, are not in structured treatment[1], together accounting for what has been described as 'unmet treatment need.' All three substances are associated with high levels of harm, but the evidence suggests that getting problematic users into treatment may be associated with significant reductions in harms and associated costs. This study was undertaken to explore the nature of dependent alcohol use and drug use among out-of-treatment users (OOTUs), their previous experiences of treatment, and obstacles to future engagement. Adults who had been out of treatment for at least a year were interviewed in Exborough, an urban area of a large city in the South of England and Northton, a town in the North of England (both pseudonyms). We also undertook interviews with professionals in both sites, conducted an analysis of local and national drug treatment data and undertook a short national survey of treatment services.

Previous research

- Research shows that stigma is an obstacle to treatment access for all groups, whereas major life events such as bereavement, births, relationship breakdown and loss of employment can be a spur to seeking help.
- While heroin users in the UK are an ageing population, there is growing evidence of new cohorts of younger crack cocaine users. By comparison with heroin and crack users, dependent drinkers are less likely to be socially excluded, and more likely to have secure housing and employment.
- Opioid substitution treatment (OST) is an effective treatment for dependent opiate users, many of whom are highly marginalised. OST prescribing should be flexible.
- Crack users are also highly marginalised, making abstinence an ambitious goal. There is no 'gold standard' for treatment and no accepted form of substitution therapy. Rapid response and dedicated services may be most effective.
- Harmful and hazardous drinking is widely normalised, raising the bar to self-recognising dependent use. Shame and embarrassment are additional barriers to accessing treatment, along with limited awareness of treatment options and inadequate referral pathways.

Study findings

Comparison with National Drug Treatment Monitoring System (NDTMS) data

We interviewed 73 people who met our OOTU inclusion criteria: 19 in Exborough and 54 in Northton. Using NDTMS definitions, 25 were dependent drinkers with no crack or opiate use, 33 were crack-only users, and 16 were opiate users (with or without crack and alcohol). Information about these (small) groups were compared with local in-treatment populations using data from the National Drug Treatment Monitoring System (NDTMS):

- In seeking to identify OOTUs in the two sites, we found much lower proportions of opiate users and much higher proportions of crack users compared with those engaged in treatment. In Northton, 49% of our OOTU sample were crack-only, which compares with only 4% of people in Northton's structured treatment services being crack users;

[1] 'Structured treatment' is defined as: '… a comprehensive package of concurrent or sequential specialist drug- and alcohol-focused interventions. It addresses multiple or more severe needs that would not be expected to respond, or have already not responded, to less intensive or non-specialist interventions alone' (PHE, 2019: 42).

- Northton OOT (out-of-treatment) opiate users and crack-only users were much more likely to have poor mental and physical health and urgent housing problems than the Northton treatment cohorts. Among the Northton OOT crack users, 85% had disabling mental ill health and 74% were in urgent need of housing, compared with 18% and 8% respectively, of those in treatment;
- Northton crack-only users (whether in or out of treatment) were much younger than the Exborough crack-only users;
- Reflecting the areas they were drawn from, Exborough's OOTUs were much more ethnically diverse;
- OOT dependent drinkers in both sites were much more likely to have high levels of disability arising from mental and physical ill health.

Professionals' views from interviews

33 interviews with charity staff, drug workers, treatment managers and commissioners were undertaken:

- Professionals recognised the complex and multi-faceted needs (beyond substance use) OOTUs faced and thought there were a lot of people in their area using crack, opiates or drinking dependently who weren't in structured treatment;
- Crack use was thought to be a major issue in both sites because there was a limited treatment offer, and use of the drug had become much more widespread. By contrast, opiate use was thought to have declined;
- The large majority of OOT dependent drinkers were thought to be using only alcohol;
- Many OOTUs were thought to be cycling through brief treatment episodes, particularly when referred by other agencies. Others did not want to be in treatment, especially if they were part of a peer group that normalised problematic use and/or if employment could be maintained while using;
- Women, Asian groups and people from Eastern Europe were thought to be overrepresented among OOTUs;
- Stigma lay at the heart of perceived barriers to structured treatment, but other barriers included disaggregated services in different locations, previous bad experiences of treatment, administrative barriers, and poor continuity of care due to high staff turnover.
- These barriers were seen to result in treatment services being misaligned with the lives of OOTUs;
- Interviewees believed the number of OOTUs could be reduced if there was: i) longer term commissioning of individual services, ii) greater flexibility in assessment and treatment, iii) one-stop-shops or hubs where support could be provided to clients while still on waiting lists, and iv) greater involvement of people with lived experiences in services.

Service provider survey findings

140 complete responses were received:

- Overall, professionals thought there were a lot of opioid users (62% of respondents), a lot of crack users (72% of respondents), and a lot of dependent drinkers (94% of respondents) who were not engaged by structured treatment in their area;

- Qualitative responses indicated that some were bemused by the gap between national prevalence estimates and the local situation; for example, many were “unable to locate” the local OOT opioid users that the national data suggested were present in their region;
- Mental health and housing were seen as the two most important barriers to treatment access for all three types of OOTU. Previous bad experiences was the next most important for opiates and alcohol, but a limited treatment offer was felt to be the next most important barrier for crack users.

Interviews with out-of-treatment (OOT) crack and opioid users

Forty-eight OOT crack and/or opioid users were interviewed, 39 from Northton and ten from Exborough. Substance use was complex, but among the 48 OOT crack and/or opioid users, 23 were crack-only users, 11 were primarily crack and opioid, and seven were primarily crack and alcohol:

- Only four of the sample reported the kind of reinforcing, complementary use of crack and opioids widely documented in the research literature;
- Most of the crack users described compulsive use, limited only by having the money to buy the drug;
- Daily expenditure of £100-500 on crack was reported, with benefits, begging and shoplifting the main sources of income;
- Participants reported using the drugs for temporary relief from psychological and physical pain;
- The ubiquity of crack in Northton made some feel their use was unavoidable and had been a key feature in their initiation and inability to stop;
- Nonetheless, a group of crack users did feel that they could give up their drug up quite easily, given the right circumstances;
- Long histories of substance use were often described. Bereavement and loss were often central in beginning to use and moving on to dependent use;
- Use of cocaine, including injecting, was a frequent precursor to starting crack use;
- Violence was endemic in the lives of OOT crack and opioid users, and many had extensive experiences of imprisonment;
- Physical health was generally very poor, with conditions/injuries relating to their drug use and violent attacks. Poor mental health and suicidal ideation were also common;
- Relationships with children tended to be limited or non-existent and romantic relationships tended to revolve around drug use;
- Most had previous experiences of drug treatment, mainly for heroin use, and there were many instances of people giving up heroin and/or crack for periods of time;
- Familiar frustrations with OST were reported by OOT heroin users about the rigidity of prescribing and access to substitute drugs;
- While for opioid users, treatment was synonymous with OST, OOT crack users were unclear about what treatment could offer them, with a lack of any prescribed substitute;
- Despite the ongoing trauma and structural disadvantage they faced, participants had a strong sense of their own agency in talking about giving up their drug use;
- For many, their drug use was part of their complex and extreme marginalisation. Drug treatment could not, therefore, be a meaningful response to their situation. Safety and warmth came first.

Interviews with OOT dependent drinkers

- Pathways into dependent alcohol use were varied, including accidents, bereavement, problematic relationships, and a steady progression from social to dependent use;
- For many, dependent drinking was associated with significant harm, including lost or troubled relationships with children, physical violence, serious health conditions, poor mental health and suicidal ideation;
- Some participants, particularly women, described periods of abstinence following residential rehabilitation or inpatient treatment;
- While some recognised their own treatment need, others lacked motivation or did not see their drinking as a problem. For homeless drinkers, getting a roof over their heads was the first priority;
- Concerns about treatment included potential stigmatisation, not wanting to be in groups of people and thinking that they would not be able to get into residential rehabilitation.

Introduction

The majority of people in England who are using opiates and/or crack, or who are dependent drinkers, are not in structured treatment[2]. The latest data (2019-2020) suggest that 52% of the estimated 293,863 people using opiates, 56% of the estimated 176,752 people using crack, and 82% of the estimated 602,391 dependent drinkers are not in structured treatment. Dame Carol Black's Independent Review of Drugs has placed this treatment gap against a backdrop of funding cuts for drug treatment services (some of which also provide alcohol treatment), a shrinking workforce, and a fall in the quality of service provision (Black, 2021).

Significant harms are associated with these three substances, with Nutt et al. (2010) ranking alcohol as the most harmful drug to society, and heroin and crack cocaine as the most harmful drugs to individual users. Evidence compiled for Dame Carol Black's Review identifies 86% of the £19 billion cost of illicit drug use to be associated with opiates and crack (Black, 2020), with these drugs being associated with high levels of mortality and morbidity (including mental illness), crime, homelessness and associated economic costs (Black, 2020). Moreover, evidence shows that there are particularly high levels of harm among out-of-treatment users (OOTUs). The estimated cost of alcohol harms to society is £25 billion (DHSC, 2023). Dependent drinking places a great burden on health and social care and is the leading risk factor for early death, ill-health and disability among 15- to 49-year-olds (PHE, 2016).

Moving disengaged, dependent users of these substances into treatment yields substantial reductions in mortality, morbidity, and social costs. There is, therefore, a strong motivation to find ways to engage OOTUs into structured treatment, with the associated reduction in harms to individuals and society. Despite the importance of these issues, little previous research has been undertaken on OOTUs. This study was funded to find out more about the nature of substance use among OOTUs, their previous experiences of treatment and the barriers that prevent them from accessing structured treatment.

The particular focus of this study, which sets it apart from the limited previous research in this field, is on OOTUs who have been out of structured treatment for a year or more. This was an ambitiously high bar to set, but one that meant we would access a very different group from the many studies of drug and alcohol treatment and relapse, and the few studies of recreational/controlled users of Class A drugs.

The study used multiple methods, including interviewing OOTUs and professionals, analysis of treatment data, and a survey of treatment professionals. Two case-study sites in England were chosen to situate the data we collected within specific contexts. The sites were chosen to support comparisons between them—whilst they both had similarly high rates of substance use, they had many historical, cultural, economic and demographic differences. One case-study site (named Exborough here) is an urban area of a large city in the South of England, whereas the other case-study site (named Northton here) is a town in the north of England.

[2] Defined as 'a comprehensive package of concurrent or sequential specialist drug- and alcohol-focused interventions' (PHE, 2019: 42). Structured treatment includes intensive psychosocial support, all types of Opiate Substitution Treatment (OST), inpatient detoxification and residential treatment.

Review of the literature

This chapter summarises the findings from a scoping, non-systematic literature review (Bhardwa et al., *Forthcoming [A]*) that was conducted as part of the study. This chapter presents a summary of the reviewed literature and its key messages.

Searches were conducted of relevant electronic databases and academic journals, policy documents and other grey literature. Initial searches focused on the UK context and were limited to a ten-year period (2013-2023). They were later expanded to include key international studies and some earlier literature. Searches were further augmented with backwards and forwards citation searching using Google Scholar.

Understanding 'unmet need for treatment'

In English policy, 'unmet need for treatment' is taken to be the gap between estimates of problematic usage in the community and the number of people in structured treatment (Nelson and Park, 2006; Borges et al., 2009; Kenneth Wells et al., 2001; Edlund et al., 2012; Fountain et al., 2003; Lu et al., 2022). This view is grounded in evidence that treatment can be effective, particularly for people who actively seek it, but also offers a limited understanding of 'unmet need' (Bhardwa et al. *Forthcoming [B]*). Research consistently shows that small proportions (as low as 2.5%) of people diagnosed with substance use disorders want or need treatment (SAMHSA, 2021). Additionally, some individuals who are neither problematic nor dependent users may benefit from support, whilst many dependent or problematic[3] users may find the treatment options offered by statutory services poorly suited to their specific needs (Ritter et al., 2019, Druss et al., 2007). Indeed, people engaged in structured treatment may still feel that they have a (subjectively defined) unmet treatment need; such as an unmet mental health need, which they have not sought a formal assessment or diagnosis for. (Ritter et al., 2019, Druss et al., 2007). The literature highlights the need for a cautious approach to needs, built on an understanding of people's stated beliefs, needs and preferences (Peterson *et al* 2010).

Demographics of heroin, crack cocaine and alcohol-dependent users

UK studies indicate that dependent heroin users are an ageing population (ACMD, 2019), with a high prevalence of serious health conditions. In contrast, UK research on crack cocaine suggests that, alongside increases in production and purity, there has also been an increase in its use and the appearance of new 'hidden cohorts' of younger users, professionals, students, and clubbers, none of whom are in contact with treatment services (PHE and Home Office, 2019). Alcohol is legal and readily available, leading to more socially-conforming cohorts of dependent drinkers—older, with better recovery capital, and greater access to secure housing and employment (e.g. ACMD 2013; Cloud and Granfield 2008).

Barriers and facilitators to accessing structured treatment

This section focuses on the barriers and facilitators for each of the substances (opiates, crack and alcohol) individually, but is it important to note that the feeling of stigma or shame associated with

[3] According to the United Nations Office on Drugs and Crime (UNODC) 'problem drug users' are: "people who engage in the high-risk consumption of drugs. (United Nations, 2023). 'Dependent use' can be defined as: "a cluster of physiological, behavioural and cognitive phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state" (United Nations, 2023).

addiction — which is grounded in, for example, social expectations around gender and parenting, family obligations, and the stigma of visible dependence (Radcliffe and Stevens, 2008; Lloyd, 2013; Room, 2005; Global Commission on Drug Policy, 2017) — impact all three cohorts.

Opiate, crack and alcohol users do, however, experience stigma and shame in ways that are substance specific. For example, Sumnall et al. (2021) has reported on how heroin users report experience greater stigmatisation and dehumanisation in both blatant and subtle ways. Research has also identified how crack users suffer from having no specific or substitute prescribing options (Briggs, 2010; Harwick and Kershaw, 2003). With respect to alcohol, research has identified that the most commonly-cited barriers to accessing treatment were attitudinal, rooted in individuals wanting to handle the problem on their own, or not believing their drinking was a serious problem (Houghton and Kaufman et al. 2014); and has also flagged embarrassment about problematic alcohol use as a key barrier. (Taylor, 2021)

Opiate users

Opioid substitution treatment (OST) remains the most robustly evidenced and effective treatment for dependent opiate use (e.g. Godfrey, Stewart and Gossop 2003). Evidence suggests that maintenance prescribing should be flexible and supported by psychosocial pathways for those who wish to detoxify. Having supportive relationships is a facilitator for heroin users to access and engage with treatment. Life events such as a new relationship, becoming a parent or experiencing bereavement can prompt users to seek help (Neale et al., 2007).

Crack users

Highly marginalised crack users share many of the same characteristics as heroin users. However, while opiate dependence can be treated with substitute opioids, which act on opioid receptors in the brain (Noble and Marie 2019), and are proven to be safe and effective for very long-term use (Hser et al., 2001), cocaine lacks an obvious pharmacokinetic target (Strang 1989). Attempts to find alternative substances that might reduce use remain nascent and are primarily focused on mitigating highs rather than preventing physiological withdrawals (Allain et al., 2021). National studies (e.g., Gossop et al., 2022) indicate that no effective long-term 'gold standard' for crack treatment exists. Research suggests a need for rapid response, dedicated services for crack cocaine users, capitalising on windows of opportunity or 'flashpoints of crisis' (e.g., at A&E) to engage in treatment which circumvent protracted, bureaucratic referral systems, and avoid waiting lists which can deter crack users with complex problems (Harwick and Kershaw, 2003: 127).

Dependent drinkers

Alcohol consumption is almost ubiquitous in the UK, and patterns of harmful or hazardous drinking are widely normalised (Alcohol Change, 2023). Within this context, research identifies that the most cited barriers to receiving alcohol treatment are attitudinal, with individuals not recognising problematic consumption or wanting to manage problems without assistance (Kaufman *et al* 2014). Embarrassment is another key barrier, with drinkers concealing concerning behaviours from health professionals during screening (Houghton and Taylor, 2021). Limited awareness of treatment options and modalities may also hinder access, with particular concerns that treatment only consists of medication or residential treatment, and/or that treatment is exclusively abstinence focused (Livingston, 2012; Finn and Andreasson, 2014).

For individuals seeking access to services, the literature highlights several barriers for problem drinkers. Some non-specialist primary care services may not provide people with appropriate support (Dhital et al., 2022, McGarva and Machin, 2017), and a move away from dedicated alcohol services towards generic substance misuse services has been highlighted as a specific barrier in England (PHE 2018). Equally, inadequate multi-agency work and poorly developed links between primary care and specialist providers can discourage treatment entry (PHE 2018). Long waiting lists, restrictive assessment criteria and transportation difficulties also limit access (Resnick and Griffiths 2012; Andréasson et al 2013).

Contrastingly, specific events – such as a loss of employment, or a relationship breakdown – can trigger individuals to seek change and/or treatment (McGarva and Machin, 2017, Dorey et al., 2021). Through one such event or an accumulation of crises, dependent drinkers may reach a 'tipping point', wherein the personal and social consequences of drinking outweigh any attitudinal barriers, spurring engagement in treatment (McGarva and Machin, 2017; Dorey et al., 2021; Andréasson et al, 2013). At a commissioning level, strong local leadership, the prioritisation of alcohol-specific services, and supporting access to provision through flexible working (e.g., home visits and satellite clinics) can support greater engagement (PHE 2018).

Policy responses

In addition to understanding the barriers faced by OOTUs, the literature also assesses several policy recommendations. Some literature recommends tailored or person-centred services, able to reflect the nuanced cultural and demographic backgrounds of OOTUs. Another recommendation is for a broader menu of treatment options, including less structured options for OOTUs in need of flexibility (Perri, et al. 2022). Finally, in reviewing who is missed or under-represented in treatment populations, our review calls for further qualitative research into better understanding the needs of OOTUs through an intersectional lens.

Methods

This study used primary qualitative data and secondary quantitative data in a case study-focused, multi-method design. The individual methods used are detailed below.

National Drug Treatment Monitoring System (NDTMS) analysis

The National Drug Treatment Monitoring System (NDTMS) contains details on the demographic and social characteristics of people accessing treatment services and the treatment pathways they take, along with information on the nature and level of any drug or alcohol use. Following a review of NDTMS data fields, we requested data on a total of 72 variables. To minimise data loss, we discussed with the Department for Health and Social Care (DHSC) ways that we might collapse variables to ensure data remained meaningful, without potentially revealing the identity of individuals[4]. A 'location' variable was divided into three categories – Exborough, Northton and Other – to allow for comparison between our sites and the rest of England. Data was received in Excel format, and transferred to SPSS. As K3 anonymisation[5] meant that some cases had been lost – and that this would disproportionately affect those groups who were less represented in the data (e.g., women, religious and global majority populations) analyses remained descriptive.

Interviews with professionals

We interviewed professionals working with OOTUs in Exborough and Northton, including those from non-government organisations (NGOs), local councils, drug and alcohol services, and NHS workers. Purposive sampling was used to target a wide range of professionals in different roles. An invitation to participate was sent out to individuals along with a Participant Information Sheet (PIS). Written or verbal consent to participate was recorded. All interviews were audio recorded with the recordings then professionally transcribed and imported into NVivo for analysis. Initially, the research team inductively coded 19 transcripts before collaboratively agreeing on a coding framework that could then be applied to all the remaining transcripts. This led to the development of three themes based on different stages of engagement (see Chapter 5), with these themes being further developed and refined through additional discussions amongst the research team during the writing-up stage.

Interviews with OOTUs

Potential participants were eligible if they were aged 18 years and over, had been disengaged from structured treatment for at least a year and were currently using opiates, crack or alcohol. If a participant disclosed something during an interview about their treatment history or current drug use that might make them ineligible in some way, the interview continued, and the research team then met later to decide on their potential inclusion.

Other than the few who were recruited through snowball sampling, all of the OOTUs were recruited from 11 locations in the study sites (five in Exborough; six in Northton): two drop-in services; three

[4] Age was gathered in 5-year age bands. Sexuality was collapsed into 'heterosexual' and 'other,' with 'missing' and 'not stated' collapsed into one category. Ethnicity was collapsed into 'white,' 'mixed / multiple ethnic groups,' 'Asian / Asian British, 'Black / African / Caribbean / black British' and 'other.' Religion was collapsed into 'Christian,' 'Muslim,' 'Other / none' and 'missing /not stated.' Nationality was collapsed into 'British' and 'Not British.'

[5] 'K3' anonymisation means that all data for groups with three or fewer individuals within them was suppressed. K3 anonymisation for this reason also shaped the categories of NDTMS data we requested, as fewer variables and less granular levels of each variable (e.g. five-year age bands) would lead to significantly less data loss than precise ages. The same applies to other categories - so, for example, we reduced religion to Christian, Muslim, other/none as we expected these two religions to have some potential impact on site demographics; but seeking more granular data on other religions (with very low numbers in each site) would lead to much more lost / suppressed data.

locations providing hot food; a non-structured drug service; two housing providers; two large NHS hospitals (one in each site); and one NHS outpatients service (in Exborough). As the research team did not have direct access to case file information, the team relied on help from frontline workers in order to identify and recruit people in the target group. Frontline workers were able to briefly outline the study to eligible people, including its aims and what participation would entail, before introducing those who were interested in taking part to the research team. In some locations, frontline workers requested edits to the recruitment flyer to better suit their clients, and the research team was permitted to disseminate or pin these fliers to their noticeboards. Some field sites required two researchers to be present when conducting interviews to adhere to service/organisational safety protocols.

Each participant was given a Patient Information Sheet (PIS) and informed consent was taken in writing or verbally recorded. A £20 supermarket voucher compensated participants for their time. Eight interviewees were recruited via referrals from other participants ('snowball sampling'), with participants who referred other eligible participants being given a £5 supermarket voucher as an incentive.

The majority of the OOTU interviews took place in rooms and spaces separate from the main shared space of a service. However, this level of confidentiality was not always practically possible and so some interviews took place in locations chosen to mitigate the risk of being overheard, such as in the corner of a noisy cafe, or on a bench outside the service. For interviews that had to be conducted in hospital wards – where patients were unable to physically move – or in busy hospital departments, voices were kept low and the researcher regularly checked that the interviewee was happy to continue. Interviews in all settings were often interrupted, for example, by other service users, or by hospital staff conducting routine clinical tasks. Finally, some interviews were conducted remotely, over the phone. Most of the interviews were audio recorded, with contemporaneous notes taken when participants did not consent to being recorded. All audio recordings were fully transcribed.

In addition, 36 days of observations were undertaken in the study sites, which provided greater contextual information to support the data collected through the interviews. Research team members had multiple informal conversations with OOTUs and professionals who worked closely with them; shadowed street homeless outreach workers on their shifts; and were present in 'back-of-house' office spaces where services and clients were discussed. During observations, detailed, contemporaneous notes were taken. All qualitative data (including observational notes) were imported into NVivo for coding and analysis. A coding framework was developed collaboratively by the research team—coding was adaptive (Layder 1998), with an initial set of deductive codes providing a framework within which additional inductive codes could emerge. Full interview transcripts and notes were entered into NVivo, and divided between the team for coding.

Nationwide survey of drug and alcohol treatment professionals

The national survey of treatment providers was informed by our analysis of professionals and OOTUs. To support engagement, the survey was brief and mostly comprised closed questions with some text boxes to allow expanded answers. It was administered through Qualtrics[6]; the PIS and consent process were embedded in the survey. The survey link was disseminated through articles in the DrugsWise

[6] Qualtrics (2020) Provo, UTAH; Available at: https://www.qualtrics.com

daily newsletter[7], and emailed to commissioners and service leads across England by an OHID representative. The survey remained live for a period of four weeks (March to April 2024).

Patient and public involvement and engagement

Our involvement and engagement activities comprised working with current and former opiate and crack users, and dependent drinkers, who we engaged through three different approaches, designed to reflect different stages along the use-recovery continuum. Firstly, we held meetings and had informal conversations with Lived Experience workers who were currently working for structured treatment organisations. These meetings helped shape our recruitment strategy and contributed towards the development of interview topic guides. Secondly, we attended three meetings organised by an NGO where everyone present had lived and living experience of substance misuse (opiate, crack and alcohol); some attendees were using substances and were out of treatment. The attendees of these meetings shared their views on our recruitment strategy, data analysis and preliminary findings, and we made adjustments following their feedback. A total of 13 contributors attended these meetings. Finally, we held one meeting with seven OOTUs where we sought feedback on our preliminary findings and again made adjustments following their feedback. Two of these contributors had already taken part in an interview. All contributors were compensated for their time with a supermarket voucher.

Ethical approvals

The study was approved by the SPSW Ethics Committee in the School for Business and Society, University of York (Ref: SPSW/S/22/12) and Birkbeck, University of London, Research Ethics Committee. The study received NHS REC and HRA approval (22/WA/0331) on 5th December 2022.

[7] Available at: https://www.dsdaily.org.uk/

National Drug Treatment Monitoring System (NDTMS) Data

In this chapter, we compare our recruited OOTUs (all individuals who had been out of structured treatment for at least one year) with NDTMS records for those in structured treatment. For the purposes of this section, we use the categories presented in NDTMS reports, focusing on: alcohol only; opiate (no crack); crack (no opiate) and both opiate and crack. We did not seek to interview people who were not using any of these drugs and so, to support comparability, we filtered out individuals not using these substances from the NDTMS analyses. Table 1 compares our sample (19 Exborough and 55 Northton OOTUs) with NDTMS records (2,027 Exborough, 2,076 Northton and 285,112 Other Local Authority) for individuals in treatment. Treatment populations differed between sites. At 47%, Northton has a much greater proportion of in-treatment opiate (without crack) users than Exborough or the national picture, and strikingly fewer alcohol-only service users. Exborough is more aligned with national treatment profiles, but has more crack users (with or without opiates).

Table 1. Drug use x cohort	Opiates, no crack	Opiates and crack	Crack, no opiates	Alcohol only
Exborough NDTMS	18%	35%	6%	41%
Exborough OOTU	5%	16%	32%	47%
Northton NDTMS	47%	22%	4%	26%
Northton OOTU	5%	16%	49%	29%
National NDTMS	27%	27%	3%	44%

In both sites, the most striking disparity in populations is between in-treatment and OOT cohorts. Among Northton OOTUs, we found almost no opiate users; but twelve times the percentage of OOT crack users than were engaged in local treatment (49% vs 4%). Some other differences were apparent. Northton's OOT cohort were considerably more male (82% vs 63-69% in other LAs); and more of Exborough's OOTUs interviewees were older—79% were over 45, compared with 24-45% in other cohorts. Given we only secured OOT cohorts from Exborough and Northton, it is possible that these differences are more representative of national in-treatment/OOTU cohorts rather than our focal sites being unusual.

Opiates (with or without crack and alcohol)

We recruited four opiate users in Exborough, and 12 in Northton. Data presented here is only drawn from Northton, as the small numbers in Exborough made comparison impossible. In terms of demographics, Northton's OOT opiate users showed some similarities with those in treatment. They were of comparable age, with approximately three-quarters of each sample being male and a similar proportion being between 30-49 years old. All of our Northton opiate users were also white, British and heterosexual (again, marking no great change from the 92% white and 94% British in-treatment cohort).

However, we also saw some notable indicators of additional needs. We asked interviewees about their physical and mental health (see Table 2); 92% identified that they were significantly impaired by poor mental health, contrasting with just 7% of those in treatment. Similarly, 42% of OOTUs described seriously debilitating physical conditions, contrasting with 7% of those in treatment. It is likely that some of this discrepancy is due to differences in assessing need (we adopted a low-

threshold definition of disability, only asking our interviewees if they were disabled; NDTMS records are likely to reflect higher thresholds); however, the OOTU figures alone highlight very substantial problems for this cohort.

Table 2: Opiate cohort x disability	Disability		
	Learning	Mental health	Physical
Northton NDTMS	2%	7%	7%
Northton OOTU	0%	92%	42%

We also saw differences in other indicators of marginality, with much greater proportions of OOT opiate users having either a housing problem (see Table 3; e.g. facing eviction) or an urgent housing problem (e.g. being street homeless). Small proportions of either cohort were in regular employment (8% of each) or living with children (30% of in-treatment opiate users and 17% of OOTUs).

Table 3: Opiate cohort x housing	No problem	Housing problem	Urgent housing problem
Northton NDTMS	77%	12%	6%
Northton OOTU	25%	25%	50%

Crack use (no opiates; with or without alcohol)

We recruited 6 crack users in Exborough, and 27 in Northton. The small numbers in Exborough again make a comparison between in-treatment and OOTU cohorts challenging, though we have presented them here with a clear view that the very low base rate means all figures should be interpreted with caution. Northton's crack users (both NDTMS and OOT) were strikingly younger, as shown in table 4. Approximately three-quarters of each sample was male, and nearly all Northton crack users (90-96%) were white British. Exborough's in-treatment crack users were much more diverse, with 42% white and 36% black. Exborough's OOT sample included one black British interviewee.

Table 4: Crack cohort x age	Age band		
	18-29	30-39	40-65
Exborough NDTMS	7%	28%	60%
Exborough OOTU	0%	34%	66%
Northton NDTMS	26%	50%	21%
Northton OOTU	22%	41%	37%

We again saw striking indications of marginality in our OOTU cohorts, with the vast majority of OOT crack users in each site indicating disability related to mental health (see Table 5), and between a third and a half describing physical disability. A very small number identified that they had diagnosed learning disabilities, though without describing specific diagnoses. These levels were much higher than those identified in in-treatment crack users. As before, it is likely that some of this is due to differences between our interview process (asking people if they were disabled) and the more stringent assessment criteria used by treatment services, but this nonetheless indicates very real levels of need.

Table 5: Crack cohort x disability	Disability		
	Learning	Mental health	Physical
Exborough NDTMS	4%	12%	11%
Exborough OOTU	33%	100%	33%
Northton NDTMS	4%	18%	9%
Northton OOTU	4%	85%	48%

Levels of housing need (Table 6) indicated particular problems in Northton's OOT crack using cohort, with three quarters identifying an urgent housing problem (e.g., being street homeless). Housing problems were less apparent in in-treatment crack users, and in Exborough's small sample of OOTUs (we had some missing data, hence rows not summing to 100%). Small proportions of each cohort were in regular employment (7-18%), and very few were living with children (0-11%).

Table 6: Crack cohort x housing	No problem	Housing problem	Urgent housing problem
Exborough NDTMS	68%	24%	8%
Exborough OOTU	67%	0%	0%
Northton NDTMS	63%	26%	8%
Northton OOTU	7%	19%	74%

Alcohol only

We recruited nine non-crack or -heroin using dependent drinkers in Exborough and 16 in Northton. Just over half of all NDTMS and OOT cohorts (56-62%) were male, except for Northton's OOT drinkers – who were 88% male. Over a fifth (2 of 9) of Exborough's OOT drinkers identified as gay or lesbian, twice the rate of Exborough's in-treatment drinkers and 4-5 times the rate of Northton's cohorts. Drinkers in Exborough were also more ethnically diverse. Just 44% of OOTUs were white (N=4), compared with 61% in treatment), with 22% black and 33% other (N=2 and N=3 respectively). Northton was 94-95% white, with the same proportion British; juxtaposed with two-thirds of Exborough's cohorts. In both sites, in-treatment drinkers were spread fairly evenly across age bands

(Table 7), though two-thirds of Exborough's OOTUs were over 50 whilst three-quarters of Northton's were younger.

Table 7: Alcohol cohort x age	Age band			
	18-29	30-39	40-49	50-65
Exborough NDTMS	14%	28%	25%	22%
Exborough OOTU	0%	0%	22%	66%
Northton NDTMS	16%	33%	26%	17%
Northton OOTU	13%	37%	38%	6%

We again found indications of greater marginality in OOT cohorts. OOT drinkers in each site described very high levels of mental ill health and physical disability (Table 8) – between 5 and 10 times the levels of their in-treatment comparators. These levels were much higher than those identified in in-treatment alcohol-only cohorts – again, it is likely that some of this is due to differences in assessment criteria, but this nonetheless indicates very real levels of need.

Table 8: Alcohol cohort x disability	Disability		
	Learning	Mental health	Physical
Exborough NDTMS	4%	9%	11%
Exborough OOTU	22%	89%	56%
Northton NDTMS	4%	11%	11%
Northton OOTU	0%	75%	50%

OOTUs were experiencing particularly pronounced difficulties with housing, too (see Table 9). In Exborough, a third of interviewees (3 of 9) described an urgent housing problem (Table 9); whilst nearly two-thirds of Northton's OOTU drinkers faced urgent housing problems (e.g. street homelessness), with not even one in five securely housed.

Alcohol-only cohorts were the most likely to be in regular employment (28-33% of each cohort, except Northton's OOT cohort at 19%). Those in treatment appeared to be slightly more likely to have parental responsibility, with an 8% difference in Exborough (19% vs 11%) and a 17% difference in Northton (23% vs 6%).

Table 9:	No problem	Housing problem	Urgent housing problem

Alcohol cohort x housing			
Exborough NDTMS	81%	17%	2%
Exborough OOTU	56%	11%	33%
Northton NDTMS	81%	11%	3%
Northton OOTU	19%	19%	63%

Professionals' Views of Unmet Treatment Needs

Thirty-four professionals (18 in Exborough and 16 in Northton) were interviewed, with data collection taking place between November 2022 and April 2024. Interviewees included harm reduction and housing outreach workers, charity employees, local council workers, clinicians employed by the NHS, complex case workers, and treatment service managers and commissioners. The majority (n=21) were women and almost half had management responsibilities (n=16); more than a third of the sample (n=14) did not work for substance use services. Except for four interviews, which were conducted in person, interviews took place online, using Microsoft Teams or Zoom. The three themes developed during the data analysis are summarised in the first three parts of this chapter. Indicative quotes from Exborough professionals are denoted by "E#" and quotes from Northton professionals are denoted by "N#".

We received 140 complete responses to the survey of treatment providers in England. The final part of this chapter summarises these data. The findings from these responses are summarised in the final part of this chapter.

Theme 1: Who is out of treatment?

Most professionals interviewed said there were a lot of people in their area using crack, opiates or alcohol who weren't in structured treatment. They talked about how crack users and dependent drinkers were more likely to be out of treatment than opiate users; and crack use, in particular, was seen as a major issue in both sites, partly because of its increasingly widespread use:

> *"The problem is that the number of people using crack and cocaine are massive [here]. That's ranging from your well-off middle-class working professionals to your construction scaffolders to the homeless clients." E13*

And partly because of the limited treatment offered for crack users:

> *"A big barrier for our crack cocaine users is managing their expectations around what treatment will look like with no clinical intervention" N1*

In contrast, heroin or other opiate use was thought to have declined, which was ascribed by two professionals as being due to the decline in its purity since 2021.

In Northton, diverted medication (and imported imitations of medication containing unknown drugs of unknown purity) was very prominent. Whilst this was not a direct focus of the study, it was having an impact on service capacity to deal with crack and opiate users, and dependent drinkers.

> *"The biggest thing popping into mind really is tablets. We see a lot of illicit tablet use, [including] diazepam, zopiclone, gabapentin, pre-gab[alin]s." T8*

Most dependent drinkers were thought to be using only alcohol, with very small numbers also using cocaine or cannabis (T14).

There was a widespread view that most OOTUs, regardless of substance used, were involved in brief, cyclical treatment episodes.

"We don't get a lot of new presentations, so treatment naïve. Our dropouts tend to re-present." T11

This happened particularly amongst those people referred to treatment from other agencies, such as the criminal justice system or social care, rather than self-referrals. A professional providing unstructured groups noted that such referrals were generally much less engaged:

"We get some that come through and purely don't want to be there. They've been sent from [criminal justice, for example, and] they're quite hard to engage because they don't want to be there." T7

Professionals also said they thought some OOTUs did not feel they wanted or needed treatment, or did not know what treatment involved.

"There are one or two of our clients that … say point-blank, I enjoy using drugs, it's part of my life, and I'm really not thinking about stopping for now" E3

The professionals said some OOTUS – particularly highlighting dependent drinkers and crack users – used in ways that were normalised within their peer group; perhaps holding down a job, and avoiding (at least for now) the worst consequences of dependent substance use:

"…quite a lot [clients who do not use opiates] are employed and don't really see it as an issue. [They] have never come into treatment because they do the same as their friends do." T12

Most professionals also named people from certain groups, backgrounds or communities as being more likely to be out of treatment, regardless of substance, with these categories often intersecting. Taking all these comments together, global majority populations and those with Eastern European heritage were felt to be notably under-represented.

"There's a lot of the Asian lads that are on heroin, but I think through the culture, through shame, through stigma, it's behind closed doors ... In [our] service, we don't see [them]." T5

Professionals in both sites felt less able to talk about the representation of LGBTQ+ groups within services, with one noting they have little information on trans people.

Theme 2: Barriers to treatment

This theme outlines the barriers to structured treatment that professionals identified. These include barriers that exist when OOTUs first encounter services and issues that lead to clients dropping out of structured treatment and becoming out-of-treatment users again.

The treatment landscape

Many professionals said they thought OOTUs are less likely to access treatment when the service buildings or general environment are not very welcoming, or if they fear seeing someone that they don't want to see there.

"It can be intimidating: if you … come into the reception and it's kicking off. [They might not] think, 'Oh, that's the place for me.' Then … where would they go, really?" E13

As with many of the barriers highlighted, professionals felt this could be a particular difficulty for women.

> *"If you've had maybe a … relationship with a partner and he might be accessing the service, or somebody knows somebody, it puts women off from actually going into the centre." E5*

Comments about this barrier often included some recognition of the stigma surrounding substance misuse and its treatment.

> *"We're not allowed to do a needle exchange [at our centre] so when people do go there, we have to ask them to go round the corner [and] we'll do it in a back alley, which is just so stigmatising" T10*

Stigma as an overarching concept ran through all the barriers that professionals named and was seen to be more pronounced for those who came from certain global majority communities.

> *"I mean, how is a young kid [from an ethnic minority community] who's using drugs going to tell [us], let alone his family?" E13*

Some professionals also said that navigating different services could be a barrier for access.

> *"So, I come here for this, and I go over there for that, but also you want to talk to me … I can understand why that'd be confusing for service users rather than like a one-stop-shop." T10*

Failed by treatment services

Professionals said that even though recent new investment had allowed them to improve structured treatment offers, OOTUs could be deterred by previous bad experiences

> *"[They'll say], 'I'm done with services,' and [it] may be because one [service has] failed. You find that quite a bit." T7*

A particular feature here was a lack of continuity of care, with high staff turnover leading to demands for repeated disclosure—a poor therapeutic experience and the antithesis of 'trauma-informed' care.

> *"His [reason for] not engaging with services is [the] continuous change of workers. So, he would establish a rapport, or he would start to divulge his traumatic events that have led to his substance misuse." T9*

The problem here was structural, with poor pay and conditions meaning few workers stayed:

> *"The pay's not that great … so, they go to look somewhere else [because they have] high caseloads and high demands." E3*

The importance of continuous care was very clear in professional accounts, with several noting that several contacts with one person were necessary to initiate trust and engagement.

> *"We had a lot of referrals or assessments that we've done by speaking to the women that are coming into those drop-ins and building those relationships over time." E15*

Shortages in inpatient detoxification for dependent drinkers were also seen as a particular problem in Northton, preventing progression to available beds in residential rehabilitation.

> *"The greatest unmet need is, it's got to be … detox places. In this game, I've never put one person in there, I've never done it." T5*

Access requirements

Many professionals said that administrative barriers like form filling, appointment scheduling and long waiting times could also mean services missed opportunities to engage OOTUs.

> *"Sometimes, people just give up … They might ring in a crisis [but if they're] sitting on a phone for too long, sometimes that opportunity is gone." E13*

OOTUs who had a dual diagnosis of substance misuse and mental health problems were particularly affected by administrative or policy hurdles.

> *"[The] mental health team might say, 'We can't work with them until they stop using.' Then we might say, 'They're too unwell to come and work with us.'" E13*

All professionals expressed frustration at such barriers, whilst recognising the need for frameworks.

> *"There's reasons [as to what] we have to do, and we have to work towards NICE guidelines and all the clinical guidelines and the governance and stuff." T14*

Northton's same-day Opiate Substitute Treatment (OST) prescribing service made engaging opiate users much easier.

> *"The great thing is that people can access treatment very quickly, so there's no waiting time." T14*

Inflexibility in relation the lives of OOTUs

Some professionals expressed the view that treatment services, generally, were not well aligned with the lives of OOTUs, particularly those using opiates and/or crack, and that missed appointments were inevitable.

> *"[You've] woken up with the absolute best intention to get there, and then in your journey … it takes you 40 minutes to get to where you need to be … or you've bumped into somebody. All of those things happen, and we need to accept that." E9*

One of the key misalignment issues emphasised by interviewees was the housing needs of OOTUs.

> *"Someone's housing situation will determine them accessing treatment. It's paramount ... Without somewhere to lay your head … how can you even contemplate trying to change?" T9*

Theme 3: What can we do?

Professionals said that offering tailored support to as many potential clients as possible could improve service reach and get OOTUs into structured treatment.

"[We have to] understand what their values are, what's important to them at that moment in time and [see] if we've got a way of being able to help provide that." T15

To improve engagement, some professionals were keen to stress the importance of lived experience—people with experience of dependent use were felt to be those best suited to guiding out-of-treatment users into and through structured treatment.

"I think lived experience needs to be right the way through the model [whereas now] I think lived experience has always been lumped at the end of a model." T8

Although professionals welcomed new funding that had arrived following the Black Review, they felt that more was needed to overcome barriers to engagement. More long-term investment in services would, among other things, have an important impact on staffing and service continuity.

"If we could also have more funding to look after the wellbeing of the staff, I think then we wouldn't have as much turnover." E14

This, in turn, needed to be backed by the assurance provided by long-term commissioning cycles:

"Services really should be funded for ten years, so there's massive amounts of continuity there, and [OOTUs] don't have to start again [each time]." T14

Some professionals felt that services could do more to reduce entry requirements and/or make it easier for potential clients to stay engaged. Examples included shortening initial assessments for structured treatment and being more flexible when clients have stopped engaging.

"I think [potential clients] should be able to … come here and [in] a 15-minute meeting … I could extract a lot of information that I need. [We could] simplify the process, shorten the wait times." E13

"Perseverance is needed. [We need to] keep looking at the bigger picture of, 'Okay, this guy has attended today,' [and reach] out to that person and [not just close them]." T9

Finally, professionals said the creation of pragmatic one-stop shops for all users could provide support while clients were on waiting lists, help reduce treatment dropouts, and support clients after they had finished treatment.

"There should be somewhere where someone can walk into and get all the help they need in one combined place… there should be a door somewhere where they can walk through and access everything." T4

"Having places where there's a friendly space, like the old drop-ins … that we don't really have anymore, where there's a cup of tea and there's food, and you're not judged. You can come in and … you can talk to somebody about things if you want, and there's a bit of help there." E8

Findings from the survey of treatment services

Of the 140 complete responses we received, 128 of these were from services directly engaging crack, heroin, and/or dependent alcohol users, 121 of whom provided structured or unstructured treatment for all three[8]. The remaining 12 responses were from commissioners, triage services, and adjacent services (e.g. a club drug service, homelessness outreach). Most respondents worked daily alongside 20 or more colleagues (75%, N=102) with the remaining 25% split almost evenly between teams of under 10 (13%) and between 10 and 20 (12%) people. Most respondents worked within services delivering structured treatment—with 95% delivering structured psychosocial treatment, and 89% providing prescribing (including OST). Slightly lower – but still high – percentages provided drop-in facilities (83%) or talking therapies (85%).

Table 10: Services provided by survey respondents	Count
Prescribing (inc. OST)	114
Harm reduction services (inc. needle exchanges)	119
Outreach work	119
Drop-in services	106
Talking therapies (inc. groups)	109
Non-prescribing structured (psychosocial, rehab etc.)	122

In line with the views of professional interviewees, there was a strong sense of there being a significant "unmet need" for treatment for users of each of our focal drugs[9]. However, this was notably tiered: whilst 62% of respondents thought there were a lot of local opioid users who were not in treatment, this increased to 72% for crack users, and 94% for dependent drinkers. Estimates of unmet need did not vary meaningfully between respondents who worked with users of particular drugs and (the often very small number of) those who did not. Respondents' estimates of OOT opioid users fell into two broad camps: some were clear that their understandings of local need came entirely from national estimates; others stated that national estimates did not reflect local experience, noting that their services had made extensive attempts to engage OOT opiate users with very little success.

[8] Three responses were from alcohol-only services. No responses were from crack-only services. A very small number of the 125 opioid services did not engage crack (N=1) users or dependent drinkers (N=4).

[9] Our questions were deliberately vague, asking if respondents thought there were 'a lot' of local drug users disengaged from structured treatment. This is because we did not think survey respondents could realistically assess percentages or absolute numbers.

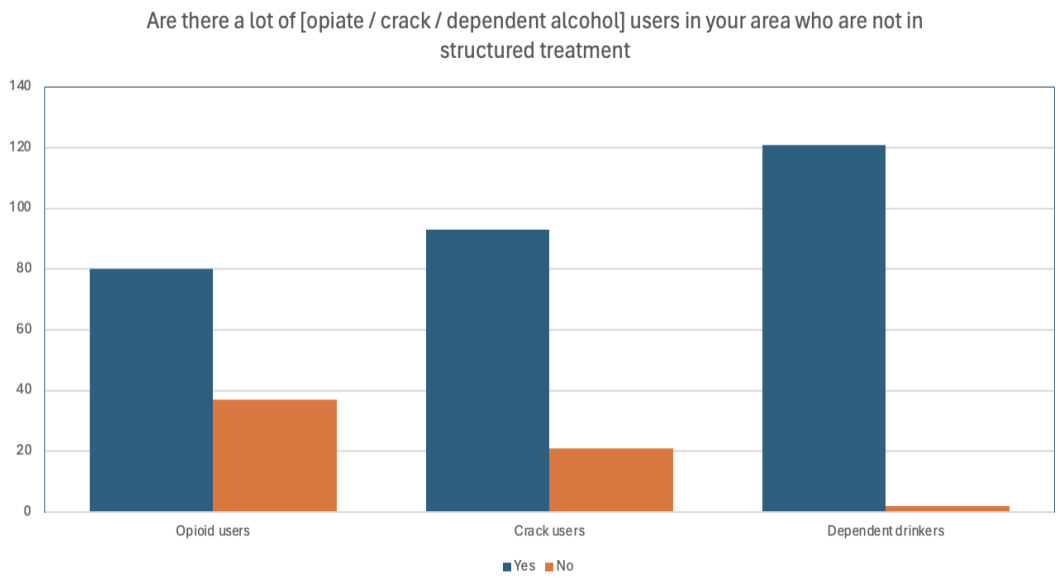

Chart 1. Perceptions of local levels of unmet need x drug of dependence

"Prevalence rates for Opiate and Crack cocaine users published nationally indicate a significant level of unmet need; however, within the borough, there is little evidence of this."

Within such comments, a sense of large OOT cohorts of dependent drinkers (and smaller populations of highly problematic OOT crack users) was more widespread.

Drawing on the findings from the professional interviews, we also asked respondents to rank ten potential barriers to accessing structured treatment for OOT opioid, crack and dependent alcohol users. We then calculated the mean ranking of each factor for each drug and placed these in rank order, where 1 is the most important barrier to treatment, 2 is the second most important barrier, etc. As the table below sets out, there was a strong sense that structural factors presented the leading barrier to engagement, with a strong desire for improved housing and mental health support. Bad previous experiences of services and difficulties in securing access to provision were also a significant concern. Rankings were fairly consistent between drugs, with a couple of notable exceptions - most notably, respondents felt that a limited treatment offer for crack was a serious problem for crack users. This was not a concern for alcohol or heroin. The lack of a treatment offer for crack users came through strongly – ranked as the third most important factor for this drug (but 9th and 6th for opioids and alcohol). In contrast to the findings of the interviews, a lack of lived experience was not widely seen as a significant problem; we cannot tell if this is because services already had robust lived experience, or because they saw it as inconsequential.

Table 11: Potential barriers to treatment access	Mean ranked order of importance		
	Opioids	Crack	Alcohol
Inadequate mental health support	1	1	1
Inadequate local housing provision	2	2	2
Bad previous experiences of treatment	3	4	3
Access difficulties (e.g. waiting lists, location)	4	5	4
Rigid treatment requirements (e.g. attendance, prescribing etc.)	5	10	8
Specific treatment gaps (e.g. LGBTQ, women)	6	6	7
Limited interagency coordination (e.g. police, NHS, prisons)	7	9	9
Drug and alcohol users unaware of local services	8	7	5
Limited treatment offer for opioid/crack/dependent alcohol users	9	3	6
Few professionals with lived experience	10	8	10

Some of this was apparent in qualitative comments in the survey, where respondents consistently expressed a desire to move away from an emphasis on structured treatment to providing more unstructured treatment options (particularly including assertive outreach and drop-in services), and improved housing and mental health support, in particular:

> *"There is little or no outreach for alcohol harms, and no focus on affected others. Without secure housing people in treatment have no chance of successful completion."*

Crack and opioid users

Forty-eight participants (10 in Exborough; 39 in Northton) who used crack, opiates or both were interviewed with data collection taking place between April 2023 and April 2024. All interviews took place face to face in the case study locations.

This section begins with a description of participants' current drug use, before moving on to cover early drug use, pathways into problematic use, treatment history and current needs. Indicative quotes from Exborough crack and opioid users are denoted by "E#" and quotes from Northton crack and opioid users are denoted by "N#".

Current use

Twenty-three reported crack as their only current problematic drug; 11 reported crack use alongside heroin or diverted opioid medication; seven crack and alcohol; three opioids and alcohol; 1 heroin crack and alcohol and two crack and zopiclone/pregabalins. Only one (additional) person reported using opioids alone as their main drug. This is clearly not a simple picture with one of the interviewees summarising the situation well:

> ***"Do you think of alcohol or crack as your main problem?"***
> *"Fuck knows, mate. I don't know. It might be both!"*

Patterns of use differed greatly across these substances. Opiate users tended to report the familiar pattern of withdrawal symptoms (or the fear of them), pushing them to obtain money to buy their drugs. Alcohol also sometimes formed part of this picture:

> *"…the gear [heroin] … just takes the rattle off the day, so… It's about the same, I'll be on like, I'll have gear on Monday, drink Tuesday, gear on Wednesday…" (N10, male 40s).*

Only four people in their forties – three men (N47, N68 and E76) and a woman (N3) – reported the profile of complementary crack and opioid use so widely documented in the research literature: for example, taking buprenorphine to mitigate the comedown from crack. The scarcity of combined crack and heroin users is likely to reflect our one-year out-of-treatment criterion, with opioid users accessing OST and therefore being excluded, but may also reflect the particular profile of substance use in Northton (where the majority of these interviews were conducted), with particularly high levels of crack use and drug users who have arrived at their crack use without experimenting with opioid drugs.

Reflecting both previous research and popular imagination, most of the crack users in the sample described compulsive and largely continuous use (when money allowed). When asked how often they used, most responded that it simply depended on how much money they had to spend on the drug. Many 'binged' on the drug whenever they could, spending days taking the drug repeatedly.

> *"Give me one. I won't stop. I won't stop." (N15, male 30s).*

Others reported spending between £100 and £500 on the drug per day. Benefits, begging, and shoplifting were the main sources of income. Among the sample, there were four interviewees who seemed to describe more regulated or occasional use of crack, one of whom was in employment and two others were street drinkers using the drug as an additional dimension to familiar patterns of street drinking.

Given the precarious situations faced by these people, crack and heroin use could clearly provide a temporary release:

> *"…honestly, you've never known a feeling like it. It's like, all your adrenaline and your endorphins and all that. It makes you so happy and feel so good and confident. That's what crack gives you, but it's an expensive buzz for two minutes." (N13, male 40s).*

While this release was usually from the psychological pain associated with their lives, escape from physical pain was another function of their drug use, especially heroin and alcohol users.

> *"I broke my back in the car crash, that's really bad when it's cold… but once I started getting into the day, it started easing off a bit, once I've had drugs, the heroin." (N18, male 30s).*

Others had had industrial or work-related accidents or had been beaten up.

Some people's circumstances led to them feeling that their drug use – particularly crack use – was unavoidable, especially for those in hostels and supported accommodation:

> *"…when you're chilled in your room, it's hard because the people who are in there will knock on your door and go, 'Do you want a pipe?' You want to say no so badly, but your brain starts ticking and you're like, 'Yes, I'll have one.' (N5, female 20s)*

Or with a substance-using partner:

> *"Obviously, he [partner] wants it, so I have it because it's there." (N9, female in 30s).*

Nevertheless, there was something of a disjunction between narratives describing compulsive, exhaustive crack use and a substantial minority suggesting that crack was something they had given up in the past and could give up quite easily again, given the right circumstances.

> *"…but then I go to jail, and I couldn't give a shit about it. I think I've sat in jail for a drug I don't even fucking want now." (N40, female in 40s).*

Early drug use

Most people had long histories of substance use, with initiation into cannabis, drinking and other drug use in their late childhood/early teens. Families and people visiting the home while the participants grew up were often key in terms of access to drugs. As an example, one participant described, as an eight-year-old, picking up and smoking a joint left by a friend of his mother's.

As with so many aspects of users' narratives, bereavement was often central in terms of making sense of events in their lives, including starting to use psychoactive substances and starting to use them to gain temporary relief from internal pain and loss.

> *"My dad died when I was ten. Nobody explained to me what was going on, and I started glue sniffing, just to escape." (N11, male 50s).*

Later onsets could also result from loss. One 26-year-old man had started using drugs at age 21 (N20) after finding the body of his father, who had hanged himself.

Starting crack and heroin use

Crack

While the pathways our sample had taken through licit and illicit substances were varied, a frequent precursor to starting crack use first (rather than heroin) was the use of cocaine, including injecting.

> *"First, it used to be on nights out, you know, having a line of coke, but then I started injecting… 'pure'[10] […] Then I stopped that, because… I was just, like, seeing things that weren't there… So I just thought… stick to smoking… crack cocaine." (N17 male 40s)*

Other reasons for progressing from cocaine to crack included the former ceasing to have the desired socially disinhibiting effects (N14) and being sectioned for mental health problems (N27).

Partner's use and loss

As previous research has shown, crack- and/or heroin-using women were often introduced to these drugs through their male partners. A woman in her 40s (N8) described having had a 'normal life' with her partner: "*I used to come home, and I used to clean my little flat and then watch telly and go to bed…the odd line of coke and stuff like that… but it was never a problem."* Her partner started using crack and when he subsequently died, she received some money and had "*cracked it all up"* with her partner's friend. She had used crack ever since.

Another woman (N16, female 30s) described having started using crack four months before the time of the interview when she moved to Northton and after she had had a miscarriage. Loss also featured in the account given by a man in his 30s (N21) who had not used drugs before the age of 23. Then two years prior to the interview, things had gone wrong in his life:

> *"I split up with my lass… and my grandma died, and I gave up… I was in a party once and someone put it [a crack pipe] in my mouth without me realising because I was mashed, and… I took it." (N21, male 30s)*

The link between loss and substance use was also graphically depicted by a man who had started using crack at his brother's funeral (N13, male 40s):

> *"Thirty-two, I was… my brother died and… someone offered me a pipe after the funeral, and I was like, "What are you doing, and what's that?" They went, "Here, just try it…" and I did. That's the first time I got on it, at my brother's funeral. I wish they'd never offered me it." (N13, male 40s)*

Friends and family

As with initiation into early drug use, family and friends were often key. One young woman had had a daughter adopted when she was a very young mother. She had returned to the parental home to find that all her family were using crack. While she had resisted at first, she was tempted to try it, and went on to spend her £10,000 savings on the drug in three weeks.

Another relatively young crack user – a man in his 20s (N6) – described his friend's involvement in his first exposure to crack:

[10] Three participants referred to a recent historical period when injectable cocaine was being sold in Northton as 'pure'. Two had bad experiences after injecting the drug, including this overdose.

"I took my mate to [nearby town] one time… and he pulled out 20 stone [rocks of crack]…. I loved the coke [but] despised the crack then [but] I got curious about it, said, "Do us a little pipe, mate," and then it just went from there. Started selling everything from my flat… Madness, mate, what that crack does to you." (N6, male 20s)

Drug availability

In Northton, most OOTUs said that crack was readily available in the town, whereas obtaining heroin was much more difficult. Some OOTUs said the relatively easy access to crack was one explanatory factor for why they started using Class A drugs.

"…when I'd moved down to [town near Northton], then it went from doing coke to crack because it was easier to get hold of (N73, male teens)."

Other interviewees similarly described starting to use crack because they had come to Northton, which appeared to be awash with the drug. Another interviewee (N1, male 20s) described how he had been thrown out of his flat and the area he was in was 'notorious for crack usage'.

"...I ended up in a hostel… It's fair to say there's more than likely a crack pipe in each room, for the best part. It wasn't ideal."

Prison

One interviewee described how he was initiated into crack use in prison when a fellow prisoner pulled out a joint when he came round to visit his cell:

"He did a little [sucks], "Listen, you take two, pass it back to me." "Yes, nice one," thinking I'm getting stoned. I take two off, pass it back, and I can feel the lumps [of crack] in it… "This is a bit of dodgy Ganja, this, man." On my sixth drag, I'm like… chatting my fucking arse off. I'm fucking smoking… rock, crack... "Jesus Christ, is that coke? Is that crack?"" (N32, man 50s).

Two participants had started their crack use following buprenorphine habits that had started in prison – one directly and one through a partner. The partner of a 31-year-old participant (N9) had started a buprenorphine 'habit' in prison and the couple had used diverted buprenorphine on release. They had gone on to use crack together (N9). She had never used heroin. A man in his 40s (N12) had also begun using diverted buprenorphine in prison and continued using it on release, but had never used heroin. He was later introduced to crack by his brother.

Drug-related harms

Violence and imprisonment

The harms described by crack and heroin users presented a picture of complex marginalisation. Few were entirely attributable to drug use, though many were exacerbated by it. Violence was systemic—the result of Class A drug markets, of the volatility of crack use, and of the desperation of dependent crack and heroin users.

"There's a little alley, and I was going to score drugs, and a bloke… had a knuckle duster on… and he banged me, knocked me down." (N27 male 50s).

Violence also arose over sexual jealousy:

"[He] started going on a bit of a bad one because the lass who I was with rejected him… As I've tried to push him back and fight back, he's pulled out a knife, stabbed me seven times." (N45, 28-year-old male).

Despite patterns of shared using, volatility often lay just below the surface, with violence breaking out among groups of users. Dealers were also widely feared.

Many of our crack- and opioid-using interviewees had extensive experience of prison, often from an early age and often for offences relating to their substance use, such as drug dealing or shoplifting, but others for more serious violent offences. Across all such accounts was a sense of the irrelevance of the law: police would not help crack-using victims of violence; policing would not deter potential offending; and prison was not a concern if it offered better material conditions than homelessness in the community.

Physical and psychological harms

Our interviewees also described a plethora of physical health harms, some directly attributable to their drug use, some to accidents (see the Current Use section above). Four reported overdoses, usually involving opiates and/or zopiclone, one remaining in a coma for two months. Others described breathing problems arising from smoking crack, one a heart attack, and another a stroke. Violence was also associated with lasting physical harm.

"[My] health… is not like it used to be because I got baseball batted." (N11, male 50s).

Others had injuries from being stabbed, and bruises and broken teeth from physical beatings. There were, of course, also lasting psychological impacts associated with this violence.

Anxiety and depression were another major feature of our cohort. Suicidal thoughts were widespread:

"It's one of those things you wake up every day thinking: 'Tomorrow, I hope I don't wake up.' There's nowt worth living for. Life's shit. It sucks." (N58, male 50s)

Several had friends who had taken their own lives. Panic attacks and anxiety were sometimes compounding depression and trauma, and drugs could be taken to temporarily alleviate such symptoms. Others described using heroin or cannabis to ease brittle mental health following a crack high. This pattern of drug use was very hard to escape.

The complex vulnerability of interviewees' situations made any path out of crack and opiate use much harder to envision. Those who had children often had limited or no contact with them.

"I lost my daughter to adoption through drugs." (N40, woman 40s).

Romantic relationships tended to be centred on drugs, and concomitantly labile, and, like so many other Class A drug users, interviewees also felt stigma profoundly:

"[People] just look at you like a piece of shit, really." (N14, man 30s).

Previous experiences with drug treatment

Most of the sample had previous experiences of structured treatment and/or other support for their substance use, many for past or current heroin use, with many instances of people giving heroin

and/or crack up for periods of time. For example, one heroin and crack user in his 40s had stopped injecting heroin and crack in his 20s for a two-year period (E76). Experience of residential rehabilitation was quite common, with three interviewees having been in residential rehabilitation for their crack use.

Another notable feature of this sample was the sizeable group of people who had given up dependent heroin use in the past (and remained abstinent at the time of interview). In the majority of these cases, abstinence was achieved during periods of imprisonment.

A sizable proportion of the sample had been on OST. There was a very mixed set of experiences here. Familiar frustrations were expressed about the rigidity of local prescribing services and very different views were expressed about the quality of additional support:

> *"[You] go to the counter, get your methadone, that's it, you're gone." (N10, male 30s).*

But another person talked about a responsive, supportive worker within a local prescribing centre who had helped her:

> *"My worker… she was actually, you could tell she was genuinely concerned and interested in how I was doing. That's what you need, isn't it really?" (N25, male 30s).*

A strong theme in this research was the agency that participants expressed, despite the trauma and structural disadvantage they faced. Many emphasised that it is either up to people to take up available help or give up crack or heroin on their own. A number talked about giving up heroin either in prison or the community, without any medical support.

> *"When I go to jail, I do it bareback." (N32, male 50s).*

Another man spoke, in similarly macho terms, about his desire to *man up and do it* [detoxify] *himself* (N68), rather than go on OST. As noted above, there was also a widespread view that crack was something that could simply be given up. An interviewee talked about stopping crack use recently for two weeks because she was simply sick of the lifestyle. The lack of "rattle" (physical withdrawal) meant for many that it was a matter of personal decision and determination. This sense of agency could also extend to controlling crack use, alongside some fundamental self-doubt:

> *"I'm making sure I've bought my shopping, my clothes, my rent's paid. That's enabled me to think it's alright… but it's crack at the end of the day, whether I've got food or not...I've built that illusion for myself a little bit: "I smoke crack, but I'm not a crackhead." Really, it's the same thing... but for years I tried to get away with it, excusing it." (N72, male 30s).*

Some other themes that are very familiar from the addiction literature came out in relation to previous experiences of treatment. Some people spoke about not wanting to be involved in treatment groups:

> *"Would you want to sit there and talk to someone in a group of people? I wouldn't. I know some do, but I don't " (N10, male 30s).*

Others referred to the importance of having workers who had personal experience of addiction:

"Unless you've been through it yourself, realistically you probably won't be able to help no one" (N45, male 20s).

A number also spoke about the difficulty of escaping social groups whose lives revolved around drug use:

"That's because I couldn't break that cycle, that circle of people who I was associating with. Because I wasn't really thinking, hang on a minute, if I wanted to get off drugs, I have to stay away from this circle. That wasn't connecting in my head, and I just thought if I came off drugs I could carry on with the same circle. That was my biggest mistake" (N11, male 50s).

As referred to above, prison was often a way for people to become (re)exposed to heroin and/or buprenorphine, leading to continuing drug use after release. However, prison was also a means of stopping crack use and getting treatment for heroin use, which could lead to abstinence on release, at least for a limited period. One person described how he had got a place on an intensive rehabilitation course through the probation service and had remained drug-free for two years.

"When I got out of jail, I didn't want to go back down that road… In my bail hostel… there was lads… that was on the [crack] pipe… I was like… I just need a little bit of support. So they put me on a drug counsel rehabilitation course [for 2 years]… I smashed it… I was clean all the way through…" (N6, male 20s).

He had later begun using crack again but there was clearly the potential for transformative change in people's lives if intensive support could be provided on release.

Current treatment needs and barriers to accessing treatment

For those with current/past heroin dependencies, 'treatment' was seen as synonymous with OST. However, defining treatment was more problematic for crack users. As one interviewee surmised:

"What treatment can they give me for crack? There's nothing, is there…? I don't take heroin, so what's the point in getting any treatment? When you go for crack, all they do is, like, "How much are you using? Okay, do you think you could cut down a bit?"" (N13, male 40s)

There was a widespread sense that talking therapies were not an adequate response to the potency of crack use or the layered problems associated with it; and that a meaningful treatment response would involve a substitute therapy or blocker akin to methadone or naltrexone for opiates:

"Something to block my cravings… there must be something to block them receptors for the crack. If they can do it for heroin… they must be able to do it for crack." (N40, female 40s)

For several of our interviewees, this meant they had no desire to access structured treatment. Another sizeable subset of interviewees had no interest in treatment, because they felt that it was not well suited to their needs. As already noted, a few felt reasonably in control of their crack use, even when they appeared to be incurring significant harms. Others associated problematic use only with physiological dependence and so felt their use literally could not benefit from professional help.

"I don't think I need [treatment]. With crack, you can't get addicted to crack, can you? It's all in your mind." (N25, male 30s)

This group reflected quite a common view amongst our interviewees, discussed in the last section, that crack use was not physically addictive and therefore a choice, and that the only path to reduced use was an individual, voluntary decision.

However, some interviewees did want help. Some thought that adjustments to existing services would be enough. Crack-specific support groups, for example, might provide more relevant support:

> *"They haven't got a group for crack, but they need it; they do, they do." (N9, female 30s).*

Others wanted alternatives to groups, being either wary of other local crack users or struggling more generally with other people. Finally, two interviewees wanted access to residential treatment:

> *"I've been… asking probation to… get me into a rehab out of the [region]." (N18, male 30s)*

He saw rehab as a means of getting out of the area, away from troublesome people, and (importantly) into warm and secure accommodation before the worst of winter arrived.

It is also essential to note that, for many interviewees, crack and heroin use were part of complex marginalisation, and these problems could not be disentangled so cleanly as to see drug treatment as a meaningful response to their situation. For this group, including many street homeless people, responses to basic survival needs (starting with housing) were a prerequisite for any kind of wider change.

> *"When you wake up in the morning on the street and it's… five o'clock and it's freezing, and you've got an appointment, but your mate gets paid that day… You're thinking about going round your mate's house, get warm and have some drugs." (N72, male 30s).*

A number were living in tents on the street, and this presented a serious barrier to beginning OST or detoxification.

> *"I don't think I'd be able to stay in treatment… if I had somewhere [to live]… I think I'd be all right then. I'm just anxious and worried about being ill on the street… You're constantly walking all day… When you're rattling, you just want to be relaxed." (N18, male 30s).*

Change was no more plausible for those in hostels, which were described as violent, chaotic, and suffused with crack.

> *"There's more than likely a crack pipe in each room." (N1, male 20s).*

For most interviewees, safe and secure housing consequently provided more of a pathway to change than any drug treatment.

Interviewees described numerous other barriers to accessing treatment. One obstacle that came through repeatedly in the interviews with crack users was the ubiquity of the drug – and users of the drug – which made it exceptionally hard to detach from the scene.

> *"Go out there and whistle! [Laughs] That's how easy it is. It's on every corner… Sold by every little kid with a pushbike. It's harder to get brown (heroin) and weed round here than it is crack." (N21, male 30s).*

As we have seen earlier in this chapter, the onset of crack and heroin use often arose in response to loss and bereavement—traumas that continued to overwhelm them and underpin their current use.

> *"I haven't let myself grieve. I've always been wrecked… As soon as me mam died, I just turned to drink… I couldn't stop. I tried to kill myself… I've OD'd… 20 times." (N15, female 30).*

Addressing their drug use needed to be secondary to addressing their trauma. And, finally, two women were wary of engaging with treatment because of fears that doing so could stop them from ever regaining custody of their children: *'if you fail a blood test, it goes straight to social services'* (N9).

Dependent drinkers

This chapter is based on interviews with 36 dependent drinkers, 25 of whom were exclusively alcohol users and 11 of whom were also using crack or opioids. Indicative quotes from Exborough dependent drinkers are denoted by "E#" and quotes from Northton dependent drinkers are denoted by "N#".

Current alcohol use

Interviewees struggled to precisely quantify their average daily/weekly drinking. For some, there was no limit; they drank irrespective of notional constraints, until they were either unconscious or unable to secure more alcohol. A small number of interviewees, did, however, monitor their use and tried their best to stick to their own personal agreed daily amount.

> *"I'll drink about 6-7 12% bottles of wine a day… that was every day. I was pinching every single day to do that. I have a drink now, miss a day, miss a day, have a drink, miss a day… I've cut down a bit now because I want to see my daughter again, man." (N10, male 30s)*

Routes into dependent alcohol use

Routes into dependent alcohol use were varied. Some interviewees described their use becoming problematic as it increasingly numbed acute emotional or physical pain. Others used alcohol to come down off Class A drugs, or steadily progressed from social to dependent use. Several of those who had progressed from social drinking identified triggers that tipped them into problematic use.

> *"I worked… I was on about £650 a day, but… I fell through a load of floors and trapped me pelvis. So that put me on the sick... I went from working to having a couple of drinks and then… I couldn't walk and stuff, oh that's when the drink habit kicked in, for pain and all." (N11, male 50s)*

> *"[I had] a very stressful job…. plus, my wife was suffering postnatal depression…. So, I started drinking more and more…" (N70, male 40s)*

For some interviewees, close relationships played an important role in their early use. Bereavement played a significant role in the trajectories of quite a few drinkers:

> *"I was 15; I watched my best friend die in front of me. Me mum, she was my soul mate, and I watched her take her last breath in front of me. It fucking killed me. So, I turned to drink…" (N15, female 30s)*

And women, in particular, described problematic use arising from abusive intimate relationships:

> *"Well, it started because I got into a relationship with my then-partner, and he was abusive. I was stuck, I couldn't get out of it. So, [alcohol] was my coping mechanism." (N52, female 30s)*

Alcohol-related harms

Our interviewees experienced significant harms associated with their drinking. At one end of the spectrum were predictable harms – the relational damage that arose from heavy, constant drinking:

"I haven't seen my daughter for about a year now because I don't want to see her while I'm like this… I haven't seen my mum and dad for about two years… [The relationship with] my ex-missus, it's atrocious. She hates my guts. She said to me she wants me to die." (N10, male 30s)

Other harms were even more extreme. Women were particularly at risk of violence from intimate partners:

"This bloke I was staying with, we both drink a lot, a lot, and then get into fights. I mean, we'd both wake up bruised and not even know how we got there." (E56, Female, 50s)

Whilst homeless, dependent drinkers could encounter extreme and unexpected violence.

"My ribs have only just started to heal now. Because [passersby] see you on the floor, and they're like a pack of hyenas. It's fun and games for them to kick seven shades out of somebody who's at their lowest because they know you can't do anything." (N35, Male, 40s)

Heavy drinking also impacted the physical and mental well-being of interviewees. The physical health consequences of dependent drinking were particularly apparent in hospitalised interviewees.

"I've developed [dilated blood vessels] in my oesophagus. I threw up loads of blood. I've had to have two blood transplants... I've got cirrhosis of the liver and DTs [Delirium Tremens]." (N52, Female, 30s)

Mental health harms were also apparent, with anxiety and depression highly prevalent.

"The last six months have just been locked in a room with the blinds shut… That exacerbates the drinking, the drinking exacerbates the mental health. A vicious circle." (N66, Male, 40s)

A deep sense of hopelessness was commonplace, sometimes associated with suicidal ideation.

"You wake up every day thinking, "Fuck it. There's nowt worth living for. Life's shit." (N58, Male, 50s)

Previous experiences of treatment

Whilst many OOT drinkers were currently engaged with an array of unstructured treatment and support services, some described significant histories of structured treatment in the past. Several drinkers described periods of abstinence following residential treatment. Other residential or inpatient breaks seemed to offer similar windows of opportunity. One woman routinely sustained periods of abstinence from alcohol consumption following health scares:

"When I come out of the hospital, I would have stints of abstinence." (N52, Female, 30s)

A third had maintained a long period of abstinence whilst in specialist-supported housing:

"Until 2015, I was calm, clean, and sober… in [a] dry house." (E56, Female, 50s)

Gender may be important here. It is noteworthy that these past accounts of self-described residential success came from three of our six alcohol-dependent women; none arose from the 19 men in our sample.

At the other end of the spectrum, some interviewees described brief, low-impact interventions. One man found himself cycling repeatedly through hospital, unable to initiate or sustain change:

> *"I can't count. Maybe 30 medical detoxes since 2015… In hospital, yes. If I'm not exaggerating, an average of four, five, six, seven times a year." (E53, Male, 40s)*

A couple had also sought treatment through the criminal justice system, again with limited results:

> *"Probation tried to help me a couple of year ago. I don't think they've sent me a [treatment] appointment…" (N37, Male, 30s*)

Some had accessed mutual aid, though accounts of AA attendance were not generally positive. Overall, there was a sense that this was a cohort of drinkers who had accessed some services, but who had experienced relatively little in the way of positive outcomes or change.

Current treatment need

Dependent drinkers had mixed views on whether or not they had a 'treatment need.' Some did:

> *"Yes, I do [have a treatment need]. I do need help to get off it." (N57, Male, 30s)*

Others were more ambivalent, often because they either lacked the motivation to change or because they did not believe change was necessary:

> *"I refused all treatment because I didn't see it as a problem…" (E34, Male, 60s)*

Perhaps inevitably, asking people about their treatment needs also highlighted other serious and significant problems. Some felt they could not make change without work, and similarly to the crack and opioid users, secure housing:

> *"When I've got a roof over my head… I shouldn't need to drink... I wake up every morning in a panic… I just want to drink so I can stop thinking about it." (E35, Male, 40s)*

Dual diagnosis was, relatedly, a prominent concern. Some interviewees felt their mental health needs were discounted, and therefore unmet, because – in the words of one – *"I've been … written off as just an alcoholic." (E69, Male, 40s)*

Barriers to treatment

Barriers to treatment fell into several categories. Some were personal or interpersonal, often rooted in a lack of motivation or ongoing relationships that made abstinence hard or practically impossible:

> *"I'll go back to my mum's, and she goes, "You need to change," and I go, "I know." I never do… I go, "All right, fuck off, who are you?" You know?" (N63, Male, 30s)*

Other barriers were rooted in concerns about treatment. Some felt that appropriate treatment options were not available – for example, because they struggled with group programmes:

> *"I don't like having to go into groups. Or even speaking to other people." (N16, female 30s)*

Or because they wanted resource-intensive interventions:

> *"I want to do the clinical [rehab], where you get the drugs and you get the counselling, and not just, "Jesus loves you."" (N35, Male, 40s)*

Accompanying this was a sense that some interviewees were unclear about local treatment offers. Several believed that only group treatment was available or that all services were abstinence focused. A handful found structured treatment unmanageable because expectations were incompatible with full-time work.

Finally, we encountered a broader sense that interviewees were deterred from seeking support by prior bad experiences. One female interviewee had felt pressured into traumatic disclosures:

> *"You don't need to know any more details. I had an uncle who abused me. Do you want to know exactly what he done, in detail? You don't need to know that." (E51, Female, 40s)*

Across all of these barriers was a broader sense that treatment may both unhelpful and stigmatising:

> *"You don't want to get judged… You don't want to get a label put on you. You don't want to go to an alcohol service because you're an alcoholic." (N26, male 20s)*

Conclusions

A changing landscape of drug use

One of the most important findings from our research is the ubiquity of crack cocaine in Northton and Exborough. In 2021, the Black Review noted that crack cocaine was increasing in popularity amongst new groups of younger drug users and this has been borne out by other research (PHE and Home Office, 2019). Our study supports this picture: without exception, PPI participants, OOTUs and professionals interviewed in Northton, in particular, reported the very widespread availability and relative reliability of crack cocaine in comparison to heroin. Another, related finding is the substantial number of crack-only users, many of whom had arrived at their crack habits through less stigmatised patterns of 'party' drug use very different from historical associations between crack and heroin.

The implications of this increase in crack use are profound. The surge of additional funding for treatment services that followed the Black Review has led to greatly improved reach for services seeking to engage the most marginalised drug users. Whilst prevalence estimates continue to suggest that many opiate users are out of treatment, we found it very hard to locate such individuals, and service providers described similar difficulties. Contrastingly, there is nothing comparable to OST for crack users and little in the way of an available, appealing and effective psychosocial treatment offer for them (Gossop et al, 2002; Fischer *et al.,* 2015). Structured treatment offered little to crack users, and we had no difficulty in finding dozens of OOT crack users. Crack has the potential to become an increasingly costly problem if current trends in its use continue, particularly if new cohorts of crack users begin to accrue serious or significant social problems.

Alcohol presents a very different set of issues. Over 90% of surveyed professionals felt that there was a great deal of unmet need for alcohol treatment in their area. Public Health England (2019) estimated there are over 600,000 dependent drinkers in England, and many more will be drinking hazardously and harmfully. The OOT drinkers we encountered had more social resources than OOT users of other drugs but needed very different engagement strategies. Some normalised their use; others struggled to recognise that they had a problem, despite experiencing significant alcohol-related harms. Dependent drinkers had clearer routes into abstinence, and some had historically achieved it.

Barriers to treatment

Both OOTU and professional interviews suggested that most OOTUs, particularly those with some history of opiate use and/or dependent drinkers had been engaged in treatment in the past. However, negative experiences of provision had led many to disengage and this experience had discouraged them from seeking treatment again. Those dependent drinkers with more robust social capital told us that their experiences of statutory provision were very poor. Re-traumatisation was also a real issue, with several interviewees across OOTU cohorts being asked explicit details of horrendous events in their pasts, sometimes in group contexts (and sometimes because of a repeating cycle of requested disclosure as key workers moved on, and new workers asked for the same life histories). Relatedly, bad experiences relating to dual diagnosis ran across our OOTU cohorts, with exceptional levels of severe need, but very little in the way of a joined-up response between treatment agencies and mental health support.

Lack of information also hindered access. Many OOTUs, particularly crack users, did not know what structured treatment existed for crack, and there was a widespread tendency for interviewees in all cohorts to equivalate 'treatment' with OST. Calls from crack users for a crack substitution therapy

seemed to reflect a fundamental desire to find some kind of stability through treatment. Few crack users felt they had the resources needed to aim for abstinence (see, for example, ACMD 2013), but nor could they see any aspect of treatment that offered them the apparent stability and maintenance of OST.

Finally, some barriers were rooted in social or structural contexts. In terms of social contexts, for street homeless and highly precarious OOTUs access to treatment was confounded by systemic violence. Northton had a culture of ubiquitous crack availability, suffused by very high levels of unpredictable violence. Domestic abuse played a strong part in the initiation and sustenance of women's drug and alcohol use, in particular, and complex networks of acquaintances made it very hard for some to envision significant progress or change. The onset of people's drinking and drug use also made it clear how embedded difficulties were. Narratives often began with significant childhood trauma, and the role of bereavement alongside violence and abuse was evident. In terms of structures, short-term staffing models appeared poorly suited to the needs of long-term OOTUs. The interviews with professionals reinforced what was noted in the Black Review about the lack of a robust skills framework and a lack of recognition, development and career progression options within the sector meaning that many drug workers move on swiftly. Without changes to this, services will rotate, recruitment will remain difficult, caseloads high, skills limited, and continuity of care will be immensely difficult. All these factors very significantly deter engagement.

Considering treatment

There is a paradox at the heart of offering structured drug treatment to the most marginalised drug users: being street homeless, cold, unemployed, seriously mentally ill and/or highly stigmatised, *and also* drug free was not at all appealing for our sample. We found extensive, layered, complex needs rather than drug use *per se,* to be the leading problem experienced by marginalised OOTUs. They identified unmet needs for housing, for dignity, for warmth, for physical and mental health care; but few of the most marginalised felt that they had an unmet need for drug treatment. For many, support needed to be multidimensional and start with a warm, safe place to live.

We also saw this play out in fieldwork visits. The services that were effectively engaging street homeless, begging, shoplifting drug users were not structured (or unstructured) treatment services. They were locations that offered warmth, food, dignity, and unconditional respect. Indeed, outreach workers – from drug services, health projects (e.g. hepatitis C screening), and housing – were coming to these venues in order to find the OOTUs who were not coming to them. Within these contexts, workers began the complex work of building fragile relationships—of talking to people, over tea and food, about their mental health, relationships and/or housing situation; and about small steps that could meaningfully support change.

There is something of Maslow's (1948) hierarchy of needs here: people were going to places that met basic survival needs – warmth, sustenance and shelter – before they could consider any form of psychological or personal change. However, this view may suggest that each need should be addressed sequentially, but there is a risk with this approach that too much focus on doing so might lead to structured interventions being delayed. A more integrated approach offering a response to all of an individual's needs might have the greatest impact. The services in the two case-study sites gave some indications as to how to design services that might effectively engage the most marginalised users in this way: one-stop-shops and/or support hubs offering flexible engagement in low-threshold contexts, offering the provision of the things that OOTUs want and need, such as food, housing, dignity and relationships, as well as links through to more structured interventions. It is important to note,

however, that sharing a hub building does not necessarily mean that services are integrated (Changing Futures, 2021)

However, there may also be benefit in looking towards windows of opportunity, and models of recovery capital (e.g. Best and Laudet 2010). There will be moments when opportunities for radical change arise. Measures that meaningfully boost individuals' recovery capital and services that are flexible, responsive, and able to capitalise on windows of opportunity as soon as they arise are likely to be those best positioned to support OOTUs into change. It seems very likely that structured treatment is not the best initial response to substance use needs, for many OOT drug and alcohol users. A full reconsideration of individuals and their stated needs, backed by meaningful resourcing, may yield much greater reductions in apparently drug-related harms.

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