Drugs Use in Wirral: A Qualitative Study

Full Report

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Contents

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Introduction

This research was carried out by the Qualitative Insight Team in the Public Health Directorate at Wirral Council as requested by the Wirral Drugs Strategy Lead.

Wirral Council is currently undertaking a Joint Strategic Needs Assessment (JSNA) looking into the impact of drugs on our communities. Its purpose is to assess the current and future health, care and wellbeing needs of the local community to inform local decision making.

This information is informing a new Drugs Strategy for the Borough. The work carried out between February and April 2023 provides a snapshot of the qualitative data that we need in order to provide treatment services to those who need them, ensure that treatment services are working as best as they can, and that people who successfully leave treatment are supported to progress their lives and remain in recovery. One of the aims of the insight gathering is to understand how we can best support people to avoid developing dependency issues with drugs in the first place. The upcoming Wirral Drugs Strategy, produced in cooperation with the Combatting Drugs Partnership, will be enacted collaboratively with services and sets the direction for future work to reduce drug-related harms in Wirral.

The Qualitative Insight Team was asked to gather qualitative insight into people's personal experience of Drug and Alcohol use in Wirral. This work provides in-depth insights into people's current experiences around the culture and harms of drug use, engagement with treatment and recovery services, stigma and resilience, health inequalities, contact with the criminal justice system, and the experiences of children and families. The information included aims to ensure their voices and needs shape the design and delivery of the current local offer. It will also support the delivery of a new Health and Wellbeing Strategy, by ensuring that services are designed to strengthen the support for people with problem drug and alcohol use, prevent lasting impact, and address differences in health outcomes.

Between February and April 2023, the researchers from the qualitative insight team spoke to 21 participants using a variety of research methods. The table below provides a breakdown of the research methods that were used to engage with different participant groups and the number of engagement type.

Methods	Total	Participant Group
Focus groups	3	*1x* with 20 – 35-year-olds *2x* with 40–55-year-olds
In-depth interviews	2	20–35-year-olds
Informal conversations	1	20–35-year-old
Research grids	4	40–55-year-olds

The Researchers gathered detailed descriptions of people's current personal experiences and feelings using mixed methods. The focus was on **in-depth** interviews and focus groups, a research design based on in-person engagement, quality over quantity.

Note: For Executive Summary please see separate PowerPoint document **Drug and Alcohol use: Qualitative study -** *Executive Summary.*

Reference: Wirral Drugs Strategy Themes

Theme 1	• Building a positive culture to reduce drug-related harm.
Theme 2	• Preventing children, young people and families from being affected by drugs.
Theme 3	• Strengthening our excellent treatment and recovery system.
Theme 4	• Reducing health inequalities for people who use drugs and reducing drug-related deaths.
Theme 5	• Working together to reduce drug-related crime and harm in Wirral.

Key drivers for the project: gap for qualitative insights

The views and experiences of people in Wirral will be essential to providing a rich understanding of how we can reduce drug-related harms in the borough, producing a strategy that meets the needs of our communities.

The quantitative component of this work is currently underway.
The work of this project will provide qualitative output and outcomes in support of the new Public Health commissioning Drug Strategy for Wirral. The strategy aims to implement new ways of reducing illness and deaths from alcohol and drug use, aligning work and priorities between the Wirral Health and Wellbeing Board Strategy (in particular Priority 2) and the Safer Wirral Partnership Board (Safer Wirral).

Research Context

Objectives

The Qualitative Insight Team aimed to draw on the personal experiences of individuals with substance use problems to gain a more detailed understanding in the support of two main objectives:

1. To support the Wirral Drugs Strategy.

- In support of the effective commissioning of services, this work will prompt further discussion around qualitative insights surrounding problem drug use. It will also provide insight required to inform the provision of treatment services to those who need them, to help ensure that

treatment services are working as best as they can, and that people who successfully leave treatment are supported to progress their lives and remain in recovery. We also want to understand how people can be supported to avoid becoming addicted to drugs in the first place.

2. To support the Joint Strategic Needs assessment.

- To underpin the currently underway Joint Strategic Needs Assessment looking into the impact of drugs on our communities. The quantitative component of this work is currently underway, but the qualitative insight, views, and experiences of people in Wirral will be essential to providing a rich understanding of how we can reduce drug-related harms in Wirral.

Health and Wellbeing Strategy

The insights gathered from the project also contribute to the Health and Wellbeing strategy particularly *priority 2: Strengthen health and care action to address differences in health outcomes.* The priority has two major areas of focus:

1. Make sure that all local people have easy and timely access to health and care services shaped around them to screen, diagnose, treat, and prevent disease as early as possible through the Integrated Care Partnership and Wirral Place Plan.
2. Address differences in health outcomes by changing the way we deliver health and care services focusing on population health outcomes, with an understanding of needs within our communities and an emphasis on those who can benefit most.

Gap Analysis

At the outset of this project, the researchers undertook an exercise to understand the available qualitative and quantitative insights around problem substance use in Wirral. This exercise served to understand the previous insights gathered in Wirral around substance use and support researchers in their own understanding of current topic areas. This exercise reviewed select local, regional, and national insights with rationale context given by commissioners, these included the wider perception of drug use, its impact on communities and addiction services, barriers that prevent access to services, factors that help people in their treatment and recovery journeys and factors that draw people to and away from treatment and recovery.

Members of the Public Health Team supported by researchers, held early engagement sessions with people with substance use issues during November and December 2022. Sessions were held at YMCA; Spider Project; and Wirral Ways to Recovery. Over 20 individuals attended the sessions. These initial sessions were helpful in establishing further topics to be explored via in depth research.

Another supporting document was the Engaging Communities Solutions CIC (ECS) report (2022). This report was commissioned by Public Health to undertake a synthesis of existing evidence in relation to health and wellbeing in Wirral as part of the development of the Health and Wellbeing Strategy. Within this report contained select insights into substance use in Wirral, in the form of a literature review of existing evidence.

Identified Gaps

Based on engagement, and literature review and Commissioning briefs, identified gaps included:

- Age focused recovery/ length of time in treatment.

- 25-35 age bracket (Younger people who use services), Engagement/Disengagement with treatment/recovery services, and contemporary experience of drug use/uptake.
- Individuals engaging in problem drug use not currently presenting to services (People not in treatment and recovery)
- 45+ age bracket, (older people who use services), length of drug use journey/context, current health consequences of use, multiple entry/exit into and from treatment/recovery.

Supplementary focus:

- Increasing Benzo(diazepine) usage (pre/during/post-treatment/recovery)
- Gendered recovery, female/Maternity, pre/post-natal issues, family and relationships.
- Lack of post-Covid Engagement/Research

Project Methodology

Research Design

The Research design of this study held two key components, firstly, which questions were relevant to the current research context of drug use in Wirral from a qualitative standpoint, and secondly, which questions held the most value when considering the thematic nature of the upcoming Wirral Drugs Strategy.

Discussion was divided into five segments.

In the *first* segment, people were asked to consider and summarise their drug and/or alcohol use 'journey', including elements of:

- Which substances have they used and their reasons for uptake.
- Reasons for engaging with treatment and recovery services (what brought them here, what were their motivations)
- Reasons they may have left service (including barriers to entry and engagement)
- Their time out of treatment/recovery.
- The reasons they may have returned to service after time away.

With each individual age cohort, further considerations were given to how age affected their treatment and recovery journey, i.e. Early engagement, barriers to initial entry, uptake of substances, Early Intervention and Prevention (EIP), in the case of the younger cohort, and long-term health consequences, and periods of engagement/disengagement with services over time, for the older cohort. These topics were chosen for their current relevance to each age group at the current stage of their journey, with recognition to the fact that they may apply to individuals at past and future stages of their journey.

Secondly, participants were then asked to consider the strengths, weaknesses, opportunities, and threats (SWOT) of currently available drug and alcohol services in Wirral. This included questions on wider aspects of experience, such as:

- What works well.
- What do you get out of attending.
- What doesn't work so well.
- What is missing.
- How could services be improved.
- What are your challenges, concerns, or barriers to entry.

Consideration was also given to personal individual experiences of service quality, staff, treatment, and community and relationships made in treatment. In focus groups, the answers were arranged through a group exercise on a A3 chart with post-it notes under each main heading. In Interviews this activity was discussed less formally.

Thirdly, people were given the opportunity to tell us about a time they experienced stigma due to their substance use problem. Considering the circumstances of each case:

- How stigma affected them and their treatment and recovery journey,
- How they feel stigma can be challenged
- How the voice of people with personal experience can be prioritised throughout Wirral.

Fourthly, people were asked to describe how their problem drug use may have affected their family, friends, and relationships, and conversely, how this may have affected their treatment and recovery journey. This included discussion regarding child safeguarding, Early Intervention and Prevention, education, post-natal considerations, and childcare as well as interactions with services (police, social workers, family support services etc.). Consideration was also given to how wider system support and organisations could better work together to strengthen support for families.

Finally, each participant was asked to summarise their current short, medium, and long-term goals for life, treatment, and recovery.

Methods breakdown

Focus Groups

In total the researchers held 3 focus groups for the project. Two focus groups with people in the 40–55-year-old 'older' age bracket at 'Wirral Ways to Recovery' - Birkenhead Hub and one focus group with people in the 20-35 year 'younger' age bracket at Spider Project, Birkenhead.

The first focus groups with the 40-55 age group were split into 2 sessions, one with 5 people and another with 6 people with mixed personal experience of drug and alcohol use. Two researchers coordinated this group in tandem. The second focus group involved 3 people within the 20-35-year-old age group.

In-Depth Interviews

Two interviews with people in the 20-35-year-old age group followed the same structure as outlined in the research design that was used in the Focus Group sessions. With the amount of time spent (varying from 45-75 minutes) this allowed individuals to provide the researchers with a detailed summary of their substance use journey and how each element of the design related to their own personal experience.

Informal (semi-structured) conversations

In an appropriate 'less formal' environment at Nightingales Recovery café, researchers held informal and semi-structured conversations with participants. These participants had been sourced from a young people's football outreach group normally held at Tranmere Rovers Football Club, Prenton. Given the time consideration, individuals were given the opportunity prior to meeting to identify which elements of the research design were most relevant to their substance use journey and which questions they felt they could contribute to most effectively.

These conversations offered a more selective and nuanced view into people's personal experiences of substance use and gave people with varying levels of experience and availability, a more relaxed opportunity to talk with researchers.

Research grids

The researchers designed a research grid. This is a set of open-ended questions that are asked to glean opinions on topics without delving into the details. Usually, participants do not share their full names or identifiers other than basic demographic information such as age-range, sexual orientation, and location. A research grid is a great way to focus the discussion (not be derailed by details) and keeping the study design and ultimately the analysis focused on the original intent of the study.

The gathering of research grids took place after all Focus groups, In-depth interviews and semi-structured informal conversations had taken place. These were a great opportunity to 'mop up' any information for the research design that the Researchers felt could be captured in further detail at this time. *(The Research Grids used can be found in the Appendix section of this report.)*

Four people aged between 20-35 and 40-55 years of age completed the research grids in an informal setting at Spider Project, Birkenhead.

Data Analysis

The data gathered through the various methods was analysed using a thematic analysis process. The researchers collated the different insights gathered through the focus groups, interviews, conversations, and research grids, and pulled together the common themes, topics, ideas, and patterns. This was a systematic and reflexive process that enabled the researchers to find rich and useful insights and organise the data to see the broader context and achieve the objectives set for the project.

Names/Pseudonyms/quotes

All the names of people and organisations used in the report are pseudonyms. No real names are used to protect the identities of the participants and the organisations that took part in the research. Direct quotes extracted from engagement are written in blue italics throughout the report.

Findings

To produce the best mileage out of this report the findings are structured in a manner reflective of the Wirral Drug Strategy. This report also serves as a stand-alone qualitative study about drug use in Wirral, and so also contains further insights outside of the scope of the main themes of the strategy.

Theme 1

• Building a positive culture to reduce drug-related harm.

Stereotypes

Several people we spoke to held negative assumptions about treatment and recovery services in Wirral. Prior to engaging with services, they held negative assumptions around other people with dependency issues as well, we were told this was often due to a lack of engagement, or due to perceptions held by their family, friends, wider media and '*social constructs*' they were exposed to. These perceptions often proved to be a barrier to engaging with treatment until their dependency had progressed to be of serious concern. In many cases they felt their initial perceptions were proven to be incorrect when they did engage fully with services.

'I pass the cafe on the bus or in the car, I walked up and down Market Street by the shops, trying to go in, and it's always been 'the smackhead cafe.' (Female, aged 40-55)

'My family: 'Oh. what are you going there for? You don't smoke, inject. Why did you need to go there?' And I took a lot of prejudice from my own family over it.' (Female, aged 40-55)

'I'll get to Nightingales up there and I'll sit and have coffee, and people from groups will randomly walk in and you just have a coffee and a natter and people from the groups and just randomly walk and just sit there and have a coffee in another and it makes you feel a bit better, and the moment passes.'

People we spoke to felt there is a lack of wider understanding around drug use amongst residents in Wirral. We found a general pattern that people felt 'labelled' in their dependency, by families, friends, the wider public and people of authority, leading to trust and communication issues that would affect areas of their everyday life. Bolstering of negative behaviours were also present from others that weren't always appropriate for the individual, *'the shopkeeper would have a bottle of vodka ready for me', 'My partner got me back on cocaine'.* One individual told us that this often 'caused barriers and divides' and 'isolated' them. This proved increasingly damaging in their personal relationships when in response they would often 'push [them] away when they didn't understand' their journey with treatment and recovery. There was a general theme amongst those we spoke to that some Wirral residents needed to be more aware of the 'reality' and causes of substance use, perhaps through advertising or lessons in school, and that some service providers could improve empathy when working with people with substance use problems.

'I felt like I had a big label on my head, 'oh look her, she's off her head again'.

'It's supposed to be 'innocent until proven guilty', but with the social services, 'you're guilty' immediately.'

'If I have to go and be present with some kind of official authority, I don't trust them. I do not trust any of them.'

Stigma and shame

The people we spoke to told us they will often hide their substance use from public view, in many cases their substance use was often kept a secret from those closest to them, including their partners and children. This would at time affect their relationships building to circumstances where they were 'outed' by events beyond their control.

'I started smoking crack again secretly […] You just got you draw the curtains, you shut yourself off, you just go off your head.'

'I never used to be a sneaky liar... but i became one with addiction.'

'I was hiding it. And then it came out quite abruptly because I was in a raid and it was thrown across Facebook and she [my partner] booted me out' (Female, aged 40-55)'

Hiding substance use was often seen as a way to not accept that there is a problem. People told us they were not only hiding their use from others, but they would often feel a sense of false gratification when they were able to hide it successfully. However, this was paired with the realisation that they were only inflicting damage upon themselves and living in a state of 'denial' in many cases. There was a general theme that this attitude to substance use was caused by the stigma and shame they felt in their dependency which in turn hindered their ability to seek help and made some people feel only more alone in their dependency.

'You think you're getting one up on them, but you're not. You're getting one up on yourself' (Female, aged 40-55)

'Talking is a really crucial thing for me because we've […] got a lot of stigma attached to any kind of addiction […] It fuels addiction for me as well. And again, then that also feeds into mental health, which then feeds into chronic conditions as well. And this also goes around in a big messy cycle.' (Female, aged 20-35)

Acceptance

Acceptance of drug and alcohol use problems for the individuals we spoke to took time. People told us that they often compared their use to others. One person told us they *'knew they had a problem*, and *'they thought they could just stop'* - 'Denial' was found to be a common theme.

'I'm not as bad as the fella in the doorway... I weren't like him, but actually I am like him, I am him' (Female, aged 40-55)

However, when people came to accept that their use was a problem, they often felt that it wasn't 'bad enough' to enter recovery. This often delayed their access to treatment services, causing further harm, believing that they can do 'more' drugs and waiting for 'rock bottom' before quitting:

'I knew I was a drug addict. I knew it was going to get worse. But I didn't. I didn't have the will. I just. I knew that there was more yet to do' (Male, aged 20-35)

'You have to be at the point where you are on your knees begging.

Theme 2

• Preventing children, young people and families from being affected by drugs.

Experience and effects of familial Loss

Loss of a parent or guardian as a child was a common reason for the early uptake of drugs and/or alcohol between the people we spoke to, in many cases, *'going into the harder stuff'* or *'spiralling back into past behaviours*. This early event for several individuals in the study was seen as a defining moment in their journey and a shift in their mental attitude. The trauma caused by loss often led to *'self-destructive'* behaviours, *'[giving] up on everything'*, was a common thread. This was often defined by behaviours led by anger, regret or confusion surrounding the circumstances of loss, or the conditions in their life thereafter.

'I became very rebellious to society, to responsibility' … 'no one wanted to deal with it. No-one wanted the stress that came with saying this kid's got an issue.'

'Not having any intervention when I was younger has made it so much harder for me to know how to keep my son on the straight and narrow'?

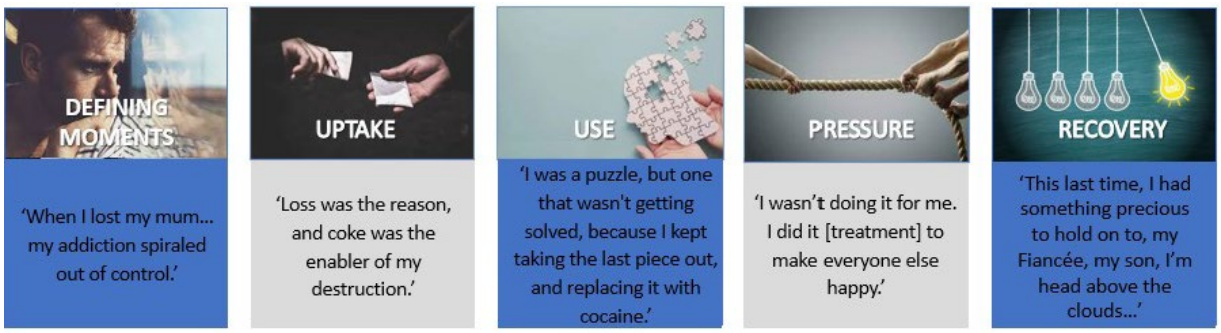
For some, however, loss was also a key reason for choosing to enter treatment and recovery later in life. One Mother we spoke to described the loss of a partner as *'their moment'* to enter treatment and recovery to protect her children from further trauma. Another reflected on familial loss and the negative experiences of their own substance use as a reason to protect their children from further harm and following in their footsteps.

'My two younger children, their dad died, so I was mad on the alcohol. So, if I died, they'd have nothing. I was their only family.'

'My dad was killed over drugs, my stepdad got sent back to Africa because of drugs, my mum's dead because of the drugs. My little brother's dead, because of drugs… I can't be the next one.'

'[I had to] be a mom to them, I didn't want that for them'.

Loss: Case Study



The Journey of loss, 'addiction' and treatment, from a 20–35-year-old Male in recovery.

Mental Health – Early onset causes and effects.

Conditions including ADHD, Autism and Bipolar Disorder, were often cited as a cause of poor mental health in the people we spoke to, or their friends and family who experienced substance use problems. There was a general connection found between these conditions and the causes for substance uptake in adolescence, exacerbating in adulthood. The experience of these conditions in adolescence often had negative effects on the school, university, and work lives of those we spoke to. Subsequent delays in diagnosis and treatment or ineffective treatments given was often cited as a contributing fact in substance uptake as a form of 'self-medication'.

'A lot of diagnosis of ADHD and things like that, they're just getting diagnosed. You get given medication and then you get - 'see you later'. That's not the solution.'

[With ADHD] I struggled in schools, work … So many adults like this have addiction issues their whole life, they begin self-medicating.'

Mental Health: Case Study

The Journey of 20–35-year-old female in recovery - Conditions as a trigger for poor mental health, uptake and maintaining dependency and challenges in a recovery journey.

Growing up around Drug Use – Influences and 'Influencers'

As well as mental health, people we spoke to cited external influences as a reason for their substance uptake in adolescence. This included parental influences and peer pressure from friends or social media.

'there's a lot of peer pressure [to use] when it comes to your mates' – 'it's Friday night, let's get a bag!'

YouTube, media that children [can] get hold of, is very much 'gangster', rap 'Influencers'. I wanted to be the biggest gangster in Eastham.'

Many became involved knowingly or unknowingly with their parents' substance use and followed in their footsteps later in life, repeating a cycle of behaviour with their own children. In some cases, this was explained to be more outright than others, from *'being in the pubs every day when I was growing up'* to '*my parents buying me crates of beer - it spiralled from there'*, participants explained patterns of association with their parents' or guardians' 'addiction' which led to enabling behaviours or introduction to substances in late adolescence.

'It was my uncle that first gave me heroin.'

'We had a little white box in the bathroom. You could go and get your pills, your heroin, your condoms, your weed... no questions asked. Just leave a little yellow sticky note on the top If you took something and my Mum would replace it.

'Don't bring other kids back into the house, I'm upstairs in my bedroom [tell them] Mum's not well.'

Relationships

People we spoke to told us those closest to them were often the reason they entered treatment and recovery. However, they explained that this notion was often - flawed, as the motivation to enter treatment and recovery was not coming from personal motivation, but from the external pressure from others, which often proved to be a fundamentally flawed reason to enter services. Problem substance use also had a marked effect on their behaviour within and outside of their closest relationships. Entering relationships with other people with substance use problems was common amongst those we spoke to, finding that 'drugs and relationships *'just sort of mix together'*. However, in some cases, leaving bad relationships behind was the correct choice for some in order to separate themselves and others from negative influences brought about by problem substance use.

'I've never come into a service for me, it's always been to get a relationship back, to please my family.' - *their main goal was to get me sober, and I wasn't interested, it [drugs] was like, my life.'*

'Yeah, get rid of my him [my dad]. Go. We need to, we need to go away. And we did, we did manage to, to get ourselves into a safe situation when he was gone.'

After leaving treatment and engaging in recovery, some found that their closest relationships were often a factor in their relapse. Returning to family units where another person was engaging actively in substance use meant some individuals found themselves *'drifting back in, a drink here, a drink there'*, *at times feeling unequipped to cope with their recovery alone, in a household where they didn't always have the full support and confidence of their family.*

'The trust that's there it's broken, and you hear 'they're going to do it again.'

Family Support Services

Throughout the research we spoke to several people engaging with services who reflected on their recovery journey as a parent, or on their time during childhood with parents who had substance use problems. A common theme in the research was the engaging with Social Services, the police and other authorities concerned with the protection and safeguarding of children. Many we spoke to had strong feelings about their experience with these services. The most prominent concern during conversations was notably expressed by one mother. *'If you've got an addiction, you're scared to get help in case your children get taken off you.'* This raised two key concerns prevalent in the research; a perception that the person's eligibility or ability to entering treatment and recovery to receive support could be impacted by being a parent, and that many feared entering services as their ability as a parent may be under scrutiny leading to family breakdown. Some people we spoke with felt that they *'were lucky to not have social services involved'* or that they would have '*no reassurance'* that their children would stay with them if they had. This oftenleft parents feeling that they were left *'between a rock and a hard place'*. When they engaged with family support or social services, they felt their views were not adequately taken into consideration, or that they engaged less formally, in an effort to protect the custody of their children.

'They wouldn't listen. I didn't need to be listened to. I was just this woman who drank and did cannabis, I was just a label.'

'Everything that I've done is kind of been like, under the radar, more social based. And it's like I can't go anywhere official.'

Others held the same perception after viewing the experiences of others, which continued to reinforce or fuel their fears about the risks of engaging with services in this way, often feeling that they had seen others consistently *'jump through hoops'* [with social services], only to lose custody of their children eventually. One individual told us that she had declined rehabilitation when offered, as having children meant *'it was the wrong time, my children were too young',* going on to raise questions about the level of financial and childcare support offered to parents engaging in services, as a barrier to entering treatment and recovery.

'[Social Workers] Once they're in your life, you can't get rid of them.'

'My daughter… she had a cocaine addiction, lost her five children, I had to foster them for her for 11 months.'

For children, the research sessions found that the diverting of custody from parents with substance use problems was not always seen to be in their best interests. The process of defining custody has worsened matters relating to substance use. One individual told us that drug testing had been requested by their partner because of a dispute in order to prove him 'unsuitable' to care for his children. Several others agreed that the home environment was the best place for their children and interventions often caused more harm than good.

'Me and my wife both used cocaine - but she got me tested as part of son's custody trial - I resented that.'

'Kids go into foster care then being passed around foster care at like four years old, it definitely harms them, just support that kid and their mother in their own environment to make them a unit and be a family.'

Conversely, others reflected on the negative effects of keeping children in the home and the more serious consequences of substance use under these conditions*: 'seeing the trauma the children went through'* [at the death of their father] had negative effects for one ladies' child, causing suicidal idealisations for her son in later life:

'My son, he came to me, I could see it in his eyes, he said, Mum, I'm suicidal. You've raised me and I'm broken, because of everything you've brought to my door.'

Another lady in service reflected on her experience during childhood:

> *'How did I slip through the cracks?... she kept custody on me, I mean... how did that happen? …I was left for three weeks in a flat on my own at three months [old] while my mom was out getting my script and use and my medication.'*

Schools

Research sessions found that the breakdown of families can have a knock-on effect in schools, at times people told us this led to issues with attainment for their children that had not occurred previously, including truancy or poor behaviour. Upon reflecting on childhood experiences, one younger participant questioned how they were allowed to continue their behaviour unnoticed for long periods, why they were *'allowed to go missing from school for months at a time'* and the inability of teachers and support staff to intervene effectively:

'My mother was a high-profile prostitute and drug user… she kept custody of me, how does that happen? Why did I go through the cracks? I'm still very angry about it.'

'Turn up to French and English lessons drunk as a fart, self-harming, off my face. I was selling pills in maths. How did that get through?'

'I caught my son trying to sell vapes to under-age kids, so I dragged him down the police station.'

'no one wanted to deal with it. No-one wanted the stress that came with saying this kid's got an issue.'

'Before my son was removed. He got C and D grades in school… Within three months of him being removed, he'd been kicked out of school. He took a knife into school, a big blade. There was just incident, after incident, after incident.'

Parents with substance use problems felt that some teachers showed a lack of understanding towards their dependency:

'I felt like I had a big label on my head, 'oh look her, she's off her head again'. I should be made up because the kids won their places there [grammar school], but people at school look down their nose at you.'

Early service engagement/disengagement

The research found that many younger people in the cohort engaging with treatment and recovery services had high rates of attrition from recovery and that multiple entry and exits were common for this group. For younger service users, they told us that considering entry to addiction services for the first time was a very uneasy experience, patterned by guilt and shame or a state of *'denial'* that they were in need of intervention. For one person the lack of a presence of people their own age was a turn off:

'100 percent! I was [in denial about my 'addiction'] … I never looked at myself rationally.'

'There was nobody my age there, most of them were easily older than me at the time.'

Deciding whether to enter services, younger people felt the pressure of expectations, on one side from their friends with whom they engaged in substance use behaviour, or their family attempting to intervene when they held serious concerns about their wellbeing. This accompanied with the feeling that their substance use wasn't quite *'bad enough'* or that they could *'manage on their own'.*

'There's a lot of peer pressure when it comes to your mates, but you've also got a lot of pressure coming from parents because parents say - you weren't brought up this way, you have morals, and values.'

Some told us that at an early age they simply weren't ready for abstinence…

'I didn't want to [stop], I was dead against it!'

'100% you're in denial about your addiction, I never looked at myself rationally.'

Early Intervention and Prevention Safeguarding (education and advertising)

People we spoke to told us that they felt there could be more knowledge and awareness of services that help with dependency, in their own experience or those of friends or family with substance use problems. In several cases they had been introduced to services at a time of serious concern in their substance use at an early age by friends or family directly. It was often explained that they had not known of specific addiction services in Wirral by name or location. The older cohort offered advice on their own experience, and how to dissuade the uptake of drugs in younger people.

*'[Kids need] better advertising, the **real** truth, what drugs really do to you.'*

'Show the real mess of a woman! instead of that gorgeous one with the body… the girl on the floor, the wreck, who doesn't wash for days, the one who sits on her bed in a dark room and gets off her head.'

Theme 3

• Strengthening our excellent treatment and recovery system

SWOT Analysis

Within each focus group session, we asked participants to identify what they felt were the current Strengths, Weaknesses, Opportunities and Threats within the network of treatment and Recovery services they had experienced within Wirral. This included GP and Hospital services, such as A&E. The results are displayed in the below (SWOT) analysis:

Strengths	Weaknesses	Opportunities	Threats
Treatment on Wirral is 'more laid back' and not 'as structured'.	Lack of communication between GPs and specialist addiction services when trying to acquire scripts/medication.	'Even if [young people] get involved [e.g., drugs and crime] they get help sooner, without slipping under the radar'.	People may turn away from using A&E if they see anti-social behaviour displayed by people with substance use issues (in crisis).
[Services are] 'doing a lot for the people in the community'.	Not receiving immediate help when calling GP and being offered delayed appointments, for example, up to 2 weeks.	Early Intervention: Support for schools to develop knowledge about drugs, alcohol, and service providers.	Delays in sharing patient notes between GPs and hospital can lead to late diagnosis and treatment.
Ability to drop-in to some services an socialise with other people who share similar experiences.	GP services and patients with ADHD: 'you get given a bag of stimulants and told to go away, no outside help'.	Smaller groups ideal for people who are attending a service for the first time.	If unable to get an appointment and treatment from GP can result in self-medicating and buying [drugs] on the street'.
A wide variety of available 12-step recovery/peer group sessions.	Complexity/co-morbidities of people with substance use issues means people need focused attention from their GP/Health professional.	Maintaining the momentum of recovery once a program is completed by providing tailored signposting to support.	Lack of trust with people in authority (e.g., police, social workers) due to past experiences and traumas.

Focus Group SWOT analysis of the network of Wirral Treatment and Recovery services.

Leaving recovery

Multiple entry to and exit from treatment and recovery was a common occurrence amongst the groups and people we spoke to. It was established that treatment and recovery is not always a linear process and individuals can enter stages of relapse, abstinence and recovery and multiple times during their journey. There were a wide range of causes reported for relapse after a period of more controlled substance use or abstinence from problem use. Crucially, there was no clear consensus on a 'set' time period for this to come about, whether it be hours, days, weeks months or in some cases, many years. The occurrence was often dependant on individual factors, people's resilience to stressors, and/or the severity of the unique events or conditions experienced by each person. Many we spoke to reported that moving away from these more stable conditions often shared similarities with the original uptake of their problem use. In some cases, this was an abrupt, potentially life-altering event, such as loss of a loved one, relationship separation or family breakdown that served as the *'impetus to start using again'*. One theme people reported in hindsight was the perceived propensity for relapse to occur. People reported feeling that the eventuality of relapse occurring was not an unexpected event, due to an absence of preparedness, proper support, or built resilience to the conditions they experienced.

'I had ten years free from class A addiction. Then my relationship broke down, and I started going to old mindsets'. (Male, aged 40-55)

'I Lost my 2 partners […] i found them dead, that kicked it off.'

Reaching the end of a more formal process of treatment such as leaving a treatment and recovery program or ending a custodial sentence without the correct level of necessary support, was also reported as being a critical stressor in relapse. It was felt by some that they had made the *decision* to be abstinent and to get *'back on track'*, however, in a stark change of circumstances and new reality people found themselves unequipped for their journey in the longer-term.

'After jail, I went from being a lost, broken kid, being addicted for many years, to living a normal life, having a car, going on holidays, having money, and going out for a drink with the lads, I thought 'Oh, you're normal like everyone else'.... But it turns out that I wasn't...'

'Our experience tells us that these things reoccur when things don't change. So, you can go through a program, I'm attached to this, it's going really well. Then it finishes and you're slowly back.'

In other cases, however, moving away from prior stability was less easily defined and a case of *'slowly' 'slipping'* back into previous harmful behaviours due to internal or external stressors, such as a declining state of mental or poor physical health. In these cases, people found that stress *'built up'*, key moments for intervention were missed and reuptake was seen as inevitable due to prior habits of use or 'self-medication'. For some, reacquainting themselves with people in their life who have their own issues with problem substance use, often out of necessity (home, work, social conditions), was also a common cause.

'It really came to a head after a period of illness, of chronic illness, and that I started using alcohol to cope with some of the effects of that illness as well. Because, you know, if I was too drunk to, to feel any symptoms, then the symptoms were gone.

'The difficulty I have, the principal difficulty is that is that the chronic condition I have, it still exists. And so, I still have that sort of temptation in my head whenever I've got symptoms flaring up (f).'

'Living with my partner again, got me back on it [cocaine].'

For some the structure of treatment and recovery programs available to them could be '*time consuming'* ***and*** *'require a lot of written work.'* This assertion often indicated that their particular treatment and recovery program wasn't well suited to their needs, explaining further that they would have preferred more flexible options for recovery that fit around work or childcare commitments. In some cases, they felt that their program wasn't addressing the more apparent roots of their problem substance use, such as financial or family/relationship considerations.

'i had a look at my recovery and how it was going, and I decided against going into it (WW2R after attending 8 sessions) […] because I think there's a lot of other stuff I could be doing around my recovery for my recovery, whereas if I was in rehab, I wouldn't be able to do that. It's just too, too time consuming.'

'they said they have to go to rehab, but I didn't really want to. My children were too young then.'

Life out of service

Strong feeling of *'loneliness'* ***and*** *'isolation'* were described by those not engaging in treatment and recovery. Their experiences of problem drug use were often defined by 'closing the curtains' or 'shutting themselves off' from the world around them. This was commonly a progressive experience, developing over time in response to the worsening of their dependency or the 'barriers' and *'divides'* that had been created between themselves and others. This experience correlated noticeably with people's experiences of stigma and shame around drug use and was often a contributing factor in developing more serious consequences through problem use.

[In these circumstances] you just go off your head - it doesn't start like that - but it certainly gets that way'.

'I lived alone. One day I woke up in the bath, didn't know where I was, my hands and feet were killing me, it was pitch black, I'd been there for hours, the water was so cold. I went to switch the lights on, the electric had gone. I went to the meter, and there was no emergency left. Throwing a towel on, I had no money, I had to ask my neighbour to go to the shop and get me some'. (Male, aged 40-55)

People in this group often described life out of service as 'chaotic'. Spending money on drugs and/or alcohol that would have otherwise been budgeted for food or bills was a contributing factor in the worsening of their circumstance and in some cases a driver for involvement in criminal behaviours.

'As a person, you're 'moulded' by it ['addiction'] You've done them for so long, when you stop, you find that you're not the same person. Then, you have to replace it with something else [which is very difficult]'

'It's making my life like hell, when I get paid, I'm spending all my money on it (yeah) I'm leaving myself without.'

'When you've been living a certain way for a certain amount of time, you acquire certain behaviours which don't really gel with normal society, abrasive, you're fearful, you're aggressive. These are your coping mechanisms out there.'

Returning to recovery

Amongst group members there was a considerable sentiment that recovery was defined and identified by ***any*** attempt to abstain from drug use of a problematic nature, that this should be understood more widely and supported appropriately. Having a routine and structure was important for the success of treatment and recovery efforts. Attendance at mandatory appointments or

treatment sessions was described as a useful tool in 'keeping busy' or creating 'distractions' from the urge to use substances. For some, collecting a daily prescription for drug treatment was at times described as a positive factor in this regard.

'Once we put the drugs down, we're not an addict anymore, we're in recovery' (Male, aged 40-55) … "But you still need the support" (Female, aged 40-55)

'Needing a script and say I have some kind of structure' (Female, aged 40-55)

Similarly, to leaving recovery or the initial uptake of drugs, pivotal moments in people's lives often determined (re-)entry into treatment and recovery. Incidences such as excessive consumption of drugs/alcohol, feeling lonely, 'rattling', and suicide attempts where a key driver to retuning to recovery and choosing to engage with services again:

'[rattling] I was like I can't do this, I'm gonna kill myself' (Female, aged 40-55)

'These seizures, I could have easily been dead off them […] This last one the things I have been told in hospital like my next seizure could be, you might not wake up of it. And I don't want that […] It's your life you're playing with'. (Male, aged 20-35)

'Completing' treatment and future goals.

Within two of the main focus groups, researchers asked each of the group members to share in turn their treatment and recovery goals and post sticky notes on A3 paper. They also asked people to reflect on what would help them to achieve their goals.

For those initially recovering from dependency, it's about focusing on getting better one day at a time:

'Like today it's just not picking that can up.' (Male, aged 20-35)

For others, they have bigger plans for the future when they have gotten 'clean':

'I'm hoping to detox this year and I've been homeless for a little while […] over the next 12 months I'm gonna move on to a canal boat sometime this summer. And that's the reason why I want to get clean and get off the methadone. I can do without being on the 'green handcuffs' [methadone script] when I'm travelling around the country" (Male, aged 40-55)

Goals: Focus Group A

Short Term	Medium Term	Long Term
Find more support options	*Finish the 12-step program*	*Have a nice home*
Start Volunteering with Wirral Ways	*Help support as many people as possible in addiction*	*Long-Term contented Sobriety*
Be in recovery	*Stay Clean*	*Travel on the canals system as a liveaboard*
Get Clean	*Stay in recovery*	*Remain Sober*
Start recovery	*Make myself healthy*	*Recover lost relationships*
Start my own Drugs support group	*Be well*	*Stay Well*

By attending Focus Group sessions about drug use, it encouraged some to attend other support services:

'I think after this talk, I will be looking into narcotics anonymous' (Female, aged 20-35)

Theme 4

- Reducing health inequalities for people who use drugs and reducing drug-related deaths.

Health Inequalities – Diagnosis and Treatment

Participants described the received quality of diagnosis and treatment of physical and mental health conditions as a key factor throughout their substance use journey – ranging from initial interactions with parents, schools, primary care services and secondary care. When the quality of received care was not what they expected this was often cited as a precursor to the uptake or worsening of an individual's problem substance use. In this event, dependency was often seen a *'symptom'* of their physical and/or mental health conditions.

In essence, 'Self-Medicating', and the use of drugs and alcohol to 'cope with the effects of illness' was identified as a way to alleviate more serious symptoms when chronic physical and mental health conditions 'came to a head' – participants described this in a number of ways:

'If I was too drunk to feel any symptoms, then the symptoms were gone' (Female, aged 20-35)

'When things go tits up … I'll just go onto the pipe or smoke, go on something, anything, to self-medicate, I suppose.'

'It changes your head space as well. If you're feeling rough you take a bit and then, you know you're like, right.'

'I know myself on Cannabis, it was like giving me Speed I'll be like, 'Whoooo!' but on Speed itself, I'm calm [ADHD, self-medicating]

Key reasons given for this behaviour included, the late or absent diagnosis of physical and mental health conditions at key early stages of life, including adolescence, or ineffective or unsuitable courses of treatment via prescribed medication.

'I realized that I was just self-medicating… the meds they were giving me weren't working […] and I'd gone through… 50 different medication combinations' (Male, aged 40-55)

'I started using benzos because they worked [as opposed to prescribed medication]'
'I never got a diagnosis or help until I came into recovery'.

'The waiting list for ADHD diagnosis is six years… yeah.'

Several people spoke about their frustrations when interacting with primary care services needing to communicate with or navigate treatment systems in a way that hadn't took co-morbidities into account or was not adequately tailored to their condition or abilities at that time.

'Before you even walk in the door [at the GP], there's a timer on you, you've got 10 minutes, that's it.'

[Message from the GP] – 'I'll send you the text messages and you can self-refer for counselling, physio' - You think, that won't work, it kind of needs to be more.

'[The current approach to the GP] Some people are okay, some people will need their hand-held.'

'I was diagnosed with it [ADHD] in 2015 and I was just constantly bounced everywhere, And I was given medication. I was still on drugs and taking the medication as well. I just went even more impulsive then.' (Male, aged 40-55)

Treatment for Problem Substance use

The perceived effectiveness of medicinal treatment for problem substance use varied amongst participants. Key treatments discussed included Methadone and Buvidal (Ref: Subutex). People discussed the manner in which these treatments were prescribed, their effectiveness in use to relieve symptoms, how they interacted with other drug use, and their personal preferences around treatment options.

People often described the treatments they were given in a comparative manner. For example, the differences they experienced in the use of such treatments. In a few cases, a key distinction was made between the use of Methadone and Buvidal (ref: Subutex). Methadone treatment's ability to prevent withdrawal symptoms craving, not offering the same 'high' made it possible and likely for some to 'double up' on their dependency and 'create another addiction', using opiates such as heroin at the same time. Some described that it was much harder to come off methadone than other treatments, such as Subutex.

'I feel that Methadone is misused, mis-prescribed and over-prescribed'.

'So, I drink my methadone in the morning and then I'm free to use heroin all day if I want to, just doubling up my addiction […] Not to mention the fact the methadone is a lot harder to come off than Subutex is […]'

'It [Methadone] was a really crap drug to substitute with because you could use on top of it. But now there are blockers in some other treatments to stop that [ref: Subutex]. I was using 6 'bags' on top of methadone.'

The practicalities and logistics of particular types of medicinal treatment were also discussed. Whilst some extolled the benefits of a more consistent structure given to recovery by the collection of prescriptions on a more regular basis, such as daily collection of Methadone, others found this to be an inconvenience or incompatible with other aspects of their life, 'making to difficult to spend time with … children and family' or 'getting in the way' of necessary work commitments. Methadone was perceived by some we spoke to as a 'cheaper' treatment and subsequently, they told us that had tried to 'fight against that' when prescribed. It was also commented on that the treatments use at times appeared to be more of an intermediary treatment for those not ready to be fully abstinent from use, in this respect, some people felt 'palmed off' by its prescription if they felt ready to commit to recovery.

The benefits of people able to lower substance use over time whilst taking Methadone were described, however, the inconsistent, and perhaps lengthy process of doing so, were described as 'being on the green handcuffs' by one individual. Reference was made on multiple occasions to the connection between Methadone, 'rattling' and symptoms of withdrawal. Several people described their intense discomfort experienced during this process 'wanting to die' or 'kill [their]self' and the importance of the effectiveness Methadone in reducing these symptoms.

Buvidal (ref: Subutex) treatments were generally more preferred by those we spoke to who had experienced them personally or heard about them from people they knew. The benefits of greater time intervals between injections 'up to a month' for one individual, were praised in practical terms and although receiving 'multiple' somewhat 'painful' injections, this was preferred due to ability to continue with their day-to-day schedule for longer. The 'blocking' effects of Buvidal were seen as more pragmatic than the benefits given by Methadone treatment as they removed the occurrence of 'doubling up' during use.

‘*I spent years and years on Subutex, which acts as a blocker for heroin so if you use heroin, it doesn't do anything to you and I was on that for years and years and years and it kept me off the heroin’ (Male, aged 20-35).*

Inequalities – Workplaces and Seeking Work

Work and education were presented as a common factor when dealing with most stages of problem substance use. In the early stages of use, it was described as both a contributing factor to the uptake of drugs and alcohol and an exacerbating factor in early recovery efforts. Worries about being dismissed from work due to problem substance use were common. The difficulties presented by sharing such issues with an employer were also expressed in respect of the lack of adjustments that could be made to accommodate this as a wider health condition or the process of recovery. This element was well connected with discussions around stigma and understanding from others around problem substance use. A few people explained that leaving work or education, whether voluntarily or involuntarily, removed barriers to accessing treatment.

‘I've always worked for years, I had to give my job up to recovery - if I told my bosses I've got this problem, I’d probably be sacked [fear] because of that you're 'untrustworthy'.

‘They tried to go around me and help me – but they could only do so much […] They let me go.’

‘I think 'recovery' should be put into policies as well [as a protected characteristic].’

In more progressed incidences of problem substance use the process of seeking work was often made problematic. People discussed the challenges inherent in seeking work when in or waiting to go into recovery, and the manner in which this could often negatively impact mental health. Comments were also made regarding the less than suitable methods and frequencies of work-related communications and appointments and their effects on the treatment and recovery journey. It was widely perceived by those discussing this topic that there was a lack of understanding received from back-to-work assessors, which was reflected in the decisions made regarding support payments.

‘5 months later, it’s causing me stress... We've got to have a PIP assessment now. We've got to get through back to work assessments. I've got mental illness I don’t need it; I just want to get in recovery’ (Female, aged 40-55)

‘The Jobcentre don't even allow you to have the time to go to your support meetings, and they're still signing you for jobs. I'm trying to get my life back on track. They don't accept it [addiction]. They keep panelling you, and they don't realize it's affecting your mental health. I'm going through it now and it's not fair.’

‘Every other day I'm getting text messages and emails to go back to work, I'm in recovery, it's all a joke, it adds to your mental health issues.’

‘Why don’t they talk to each other? [Back to work and PIP]’

‘[They] don't even allow you to have the time to go to your support meetings, and they're still signing you for jobs. I'm trying to get my life back on track. They don't accept it [addiction].’ (Female, aged 40-55)

‘A suicide attempt well, two of them […] I didn't want to be back [on drugs] […] it wasn't a cry for help. It was a definite attempt, and I was lucky enough to go to jail […] but it took me a number of months to get that out of my head’ (Male, aged 40-55)

Theme 5

- Working together to reduce drug-related crime and harm in Wirral

Becoming trapped in cycles of crime and drug use

Direct or indirect Involvement in crime as a means of supporting substance dependency was a common theme found throughout the research, though not experienced by all that we spoke to. A connection was found between the severity of an individual's substance use problem and their direct involvement with crime, in this respect cycles of crime and substance use were common. Select individuals had also received custodial sentences as well.

This type of behaviour was particularly present for those not engaging with services at the time they described. In addition, indirect involvement was common during childhood and adolescence and often linked to the substance use problems of a family member or close acquaintance, particularly defined by living situation, or peer pressures. As such, exposure to drug related crime and harm was often experienced early on in life.

'It's a progressive illness, my use became worse and worse and worse… and it was exactly the same for my criminal behaviour'.

'It all kind of intertwined into one the chaotic mess.'
"The likes of shoplifting, that kind of thing" – committing crime related activity to fund drug dependency. (m)

Exploitation and funding dependency

A number of individuals we spoke to experienced indirect involvement in drug related crime from an early age. Incidences of exploitation were described often, one case giving an account of a child inadvertently supporting drug dealing efforts by acting as a 'mule' to deliver drugs to a drop-off point at a school under the coercion of parents or close family members.

'My mum said to me: 'you're going to leave your book bag at school'. [Why?] 'Because someone else is going to pick it up, they just need to lend if for a bit, they need to lend a book…'

Concealment of drugs or drug use by children at the behest of parents within the family home was described on more than one occasion by the people that we spoke to, when recounting experiences from their childhood. Similar incidences were also described by parents, who actively engaged in or instructed the described behaviors personally, or in support of others, such as a spouse or other family member. In most cases this was done to prevent evidence of drugs, or related behaviors being found in police search efforts with children being aware of the effort. In all cases this behavior occurred in order to support dependency or involvement in drug dealing.

'She [my mother] made me and my stepbrother share a room and so we hid the drugs in our pillows.'

'a very close family friend of mine, I ended up realising that he was high up in the drug game […] 'I'm hanging around with these people. I can make some money. I knew where to get them [drugs], like a lot of my family.'

Generational connections in drug use dependency were also a common theme found within the research. In some cases, the criminal behaviours observed in parents, close family members or acquaintances during childhood were repeated by young people. Such incidences were either under direct coercion or found in commonality. One common connection was the support of dependency or recovery, for themselves or others, either knowingly or involuntarily. This was joined by an awareness or frustration that incidences of risk could have been prevented, given the wider knowledge and understanding of the circumstances held by police or support services. In most cases this was described as supporting the negative progression of an individual's substance dependency or detrimental to abstinence and recovery efforts.

*'My uncle was the first person to give me heroin to smoke [...] He taught me how to shoplift. And we used to do crime together to fund **our** addictions.'*

My brother and I used to fund a lot of mine by getting sugar daddies. Pay pigs. See it Paid for my mom to go to rehab four times. […] *'My mum was a high-profile prostitute' […] 'I idolised my Mum, but also at the same time, it [engaging in 'sex work'] was the only way I knew to help her and that's what I have to do.'*

'B*y doing that [sex work], to help her, it made me worse, and it made my mental health worse, which made my drug use worse.'*

'How was that not picked up? How was I left? I was left for three weeks in a flat on my own at three months [old] while my mom was out getting my script and using my medication'.

Approaches to enforcement

The research found that the approaches to policing, enforcement and crime prevention were not consistent across similar cases as they were described. People described incidences where they had easily avoided enforcement action, or appropriate action appeared to be out of the control of police or support services, as such prevention of further harm had been possible but not enacted. A number felt that they had received a *'slap on the wrist'* in respect of what they had considered a serious crime, where follow up action had not been taken. Incidences of multiple arrests were common for similar or connected offences, however, the nature of sentencing was often perceived to be inconsistent or disproportionate to the crime committed. Of those who had received custodial sentences for drug-related crimes, these were often repeated, in such instances treatment and recovery referrals were inconsistent or unsuccessful in preventing further drug-related crime or harm.

'They found the pouch of pills, and took them off me, I never heard anything more about it.'

'I've been convicted for selling drugs, criminal damage, assault, possession of offensive weapons... I've had suspended sentences, somehow, I've never gone to jail.'

'I've been in and out of jail for ten years.' 'No, it was no help.' [referral to drug services]

Diversionary Pathways - 'slipping through the net' and 'hitting rock bottom'…

People told us that they felt some disproportionate interventions were also seen as a missed opportunity to move away from problem drug use. Drug testing was not a common occurrence in those who had been arrested or engaged with the police or support services outside of treatment and in some cases, it had been easily circumnavigated by unwilling participants. Referral into treatment and recovery services had also not been recommended or mandated when it was felt that it could have been. In such instances people told us that felt they had slipped through the net, subsequently

missing an opportunity to prevent further progression of their problem substance use, and only engaging with recovery when they had hit what they described as *'rock bottom'*.

'After being arrested, they just capped me at a victim awareness course.'

'I've been arrested numerous times, probably over 30/40 times … [No referral].'

'[Drug testing] I'd just get someone else to do it for me.'

'You just don't stop until your money's gone' … 'I was waiting to hit rock bottom first'…

Moving from prison to the community.

The research found a small number of cases where custodial sentences had occurred as a result of drug-related crimes. In these instances, people described varying levels of treatment and recovery interventions in the community which had produced varying levels of success in supporting their recovery. Individuals explained that treatment intervention was not always available at prison but may have been mandated or offered as a condition of parole. In two cases people we spoke to described experiences of 'being left to withdraw', though extremely uncomfortable, this was generally favoured in hindsight, as it helped the progression of their recovery. One individual expressed a growing concern that this was not always the case, contemporarily, as drugs are now more available in prison, and you can *'come out of prison with your addiction'.* One individual who had received a suspended sentence described how they had been able to avoid drug testing as mandated by asking a friend to provide them with a sample instead. Continuity of care from prison to drug treatment was not always consistent however, and some of these individuals described how not receiving a more holistic approach to treatment had later left them feeling unequipped with the level of resilience required to maintain abstinence and recovery when faced with challenges circumstances in the longer term.

'I had to piss in a pot [as instructed by a Probation Officer], I'd just get someone else to do it for me.'

'When I came out of the cell, I wanted to kill myself, I was just in so much emotional pain and I, I didn't know what to do, from that point on I became addicted.'

'After jail, I went from being a lost, broken kid, being addicted for many years, to living a normal life, having a car, going on holidays, having money, and going out for a drink with the lads, I thought 'Oh, you're normal like everyone else'.... But it turns out that wasn't...'

'I had ten years free from class A addiction. Then my relationship broke down, and I started going to old mindsets.'

Other themes

Social media and the Internet

One person we spoke to described in detail the process they had used for drug dealing. This involved use of the 'Dark web' marketplaces such as Silk Road, the use of proxy browsers such as Opera VPN and Proxy servers. By these means they were able to *'ping their IP address around different servers at high speed'* creating a level of anonymity in their internet activity that made their dealing feel *'untraceable'.* Using these methods created an extra level of security for their activities by removing the more 'physical' or 'practical' elements of dealing that preceded the handover at point of sale. This included the sourcing of drugs *'that no one else could get'* within the geographic area, that were more 'pure' than other sources. They also described using conventional methods to have the drugs delivered when they were needed (to limit the time they were held in their house), this helped to avoid suspicion from the police who were unable to find the drugs during search, despite having knowledge of their dealing activities. They were also able to agree sales and places of sale over social media.

'My name was synonymous, because I used the internet to get drugs, I could get drugs [from abroad] that no one else could get.'

'The postman was my 'drug dealer'… He would come with a massive box; my parents were none the wiser.'

'I bought my drugs on the internet, completely untraceable'.

Covid-19 – Loneliness and Isolation

Given the timing of the research (April-March 2023) many of the insights gathered from participants covered time periods spanning the peak of Covid-19 Lockdowns. A key finding from the research was loneliness and isolation, both as a symptom and as a cause of problem substance use. It was clear from discussions with researchers that mandatory periods of lockdown often contributed to the worsening of people's dependency issues.

'It all went wrong during lockdown […] me cocaine levels came back through the roof. So did the alcohol.'

'When you're on your own, all the time, you just you go off your head even more, with loneliness, isolation, you just draw the curtains, you shut yourself off, you just go off your head.'

When engaging in recovery efforts during this time, people often found themselves isolating with others who had substance use problems, sometimes at a place that wasn't their usual residence. In these cases, they were largely unable to remove themselves from these environments as easily as they may have done previously.

'When covid hit the only place you can go is a car park where everybody else is. That's when the drinking and coke started.'

'It was purely because the social isolation combined with the social anxiety and being in a country that I hadn't lived in since I was five […] I was black out drunk every night. [Temporarily moving to Ireland to care for an elderly relative who could not be admitted to a care home due to the risks posed].

Post-covid, some people we spoke to were still feeling the effects that loneliness and isolation had brought to their mental health. However, from the recovery timelines described, it was clear that for others the 'break' in normal habits created by Covid lockdowns had given them space to consider their future recovery efforts more closely.

'That's when it [problem drug use], when covid lifted I was left, kind of isolated.'

I would move back in with them for a couple of months, get on my feet again, stable again, move out, and the same thing happens again. In my view, it's been different this time [post-covid]. It's the first time I've really engaged with government services.

Conclusion

The research conducted and presented here offers a current picture of qualitative insights providing a deeper understanding of people's experiences of problem substance use in Wirral. It gives fresh insights into the gaps identified within previous research and engagement and also explores new topics outside of this brief. The final insight includes perspectives on age focused recovery and the effects of varying lengths of time in treatment. This comes from younger service users and related issues with engagement/disengagement with treatment and recovery services, and contemporary experiences of drug uptake and use. There is also insight offered by older service users, including the experiences of extensive drug use journeys, multiple entry/exit into and from treatment and recovery, and the health consequences of prolonged drug use. The report has also presented insight beyond identified gaps and the themes of Wirral's upcoming Drug Strategy through the findings from discussions around current service provision, social media, and the impact of the COVID-19 pandemic on drug use journeys.

Overarching Themes

Below is a summary of the overarching themes that emerged from the research sessions with people with substance use problems and from review of the research presented above.

Trauma and Mental Health

When reviewing the research findings, it was apparent that most of the people we spoke to had experienced varying degrees of emotional distress throughout their life brought about by traumatic events, most poignantly during adolescence. These included, but were not limited to, the loss of a parent or close relative, domestic abuse, complex physical or mental health conditions, financial, work, or educational challenges, loss of child custody and divorce. The emotional trauma faced by most of the people we spoke to and the subsequent psychological damage it had brought to their mental health appeared to a connecting factor resulting in challenges in functioning or coping normally in everyday life. Their opinion that they had not received or approached the correct care focusing on their trauma during adolescence or at the time of distressing life events was given as a reason for the declining circumstances of their mental health and subsequent problem substance use. In this respect, the use of illicit substances and alcohol and subsequent dependency issues was often described as 'symptom' of the challenges present in their mental health. At times, problematic drug use and ability to engage in abstinence and recovery was often defined by each individual's level of resilience and the available practical and emotional resources they were able to draw on in the face of challenges.

Alcohol as a drug

Many people we spoke to felt that alcohol should be viewed in a similar way to illegal drugs. They described the potentially more dangerous characteristics of alcohol as a serious concern, being widely available, off the shelf, generally more dangerous when consumed in a 'binge-drinking' manner, particularly in terms of anti-social and violent behaviour. Participants told us that some shopkeepers recognise regular customers who have alcohol use problems and can encourage bad drinking practices. Conversely, drugs were seen by many we spoke to as inflicting more harm to the individual, at time of use, and people's capacity to cause harm to others in this respect was more minimalised than with alcohol. This added to the general argument, amongst those we spoke to, that conventional drugs were at times less dangerous than alcohol and respectively, the stereotypes held around drugs were not always correct.

'And it got to the point where the shopkeeper lives up the road […] before I got to the till, he would have a bottle of vodka waiting there for me.' (Female, aged 40-55)

*'[At home alone] getting like the downstairs [drunk], it was two hands on the rail. You start realizing that you're putting **yourself** in danger quite a lot.'*

*'[With alcohol] People fight every weekend, girls get raped, stab people, drink-drive, kill people – [but] when you do [drugs] - you're not gonna do f*ck all are ya? Just chilling, going to sleep – but which one's legalized?'*

Agency (decision making)

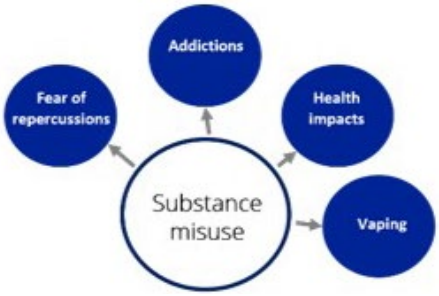
This research draws important distinctions about people's sense of personal agency when dealing with substance use dependency and recovery – the sense of control over actions and their consequences. From the research conducted, there were multiple impressions given on what this means to each individual at different stages of their journey.

The early stages of drug use were not always described as being problematic by the people we spoke to, but moreover a considered lifestyle choice at the time, *'To me, it was like Friday night, let's get a bag, party!' … 'Sounds like good night out'.* Drug use and related behaviours (rebelliousness, crime, creating barriers and divides between themselves and others) were also often considered a necessary, appropriate or practical response to the conditions in which they found themselves, including, *[self-medicating]-I used Benzos because they worked'* or overwhelming early influences, *'It doesn't surprise me where I am because of it [family drug addictions]'*.

Opinions given in hindsight often explained that personal agency over decision making was not always a *'rational'* choice or a well informed one *'it's not quite bad enough,' 'you think you can manage'* but instead professed to be made during a state of *'denial'.* In recovery decision making was often defined by a sense of urgency *'I was verge of going to prison, for something I know I wouldn't do when I was sober.' '[if I carry on] I'm gonna kill myself',* or heavily influenced by external pressures, or co-dependencies present from family, friends, and relationships.

Related Content

Risk Taking and resilience.



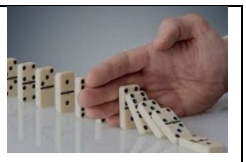
Main pressures and risks surrounding substance use for young people, summarised in the January 2023 report.

In January 2023, the Qualitative Insight Team in Public Health at Wirral Council reported on Young People's Risk-Taking Behaviours and Enablers/Barriers to Accessing Support and Services.

This report also offered insights on young people's substance use, including:

- 17–19-year-old's experiences around drug consumption and dealing.
- Young people's experiences of growing up around, dealing in and smoking substances such as cannabis and Class A drugs and their resilience towards them.
- Year 7 and Year 9's experiences and observations around vaping inside and outside of school.

Risk Taking: A Case Study

				
Uptake	**Use**	**Influences**	**Quitting**	**Resilience**
"They're my ways out, cos it has been since I was 14. If I get myself in a bad way, I'd take drugs to get out of it."	"I sat there and smoked 30 quid's worth [£30] a day. Every single day, without fail."	(When unemployed) "I'd be in the pub with all my mates, and then you get the influences, after you've had a drink."	2-3 years of support from a trusted professional, and a work/life routine helped them to quit: "It's a healthy repeat cycle".	Once you get out the habit its easy to say no' 'I'm not bringing myself down with you […] I don't want those type of people around me".

A brief look into a 17-19-year-old's substance use journey.

The 17-19-year-olds spoken to as part of the research were also engaged with a drugs and alcohol service. These young people described their experiences of consuming, quitting, and dealing cannabis, Class A drugs, tobacco, and alcohol:

Uptake of Drugs	**Impacts on health and relationships.**	**Differences in mentalities**

• Growing up around addictions
• Family breakdown or adverse experiences
• Exposure through friends
• Boredom
• Covid-19 pandemic
 	
"I had a group of mates in Birkenhead, so I always used to go up there, chill with them, and they'd be smoking weed"
	• Mood swings and anger
	• Paranoia and anxiety
	• Kidney disease and cancer within the family
	• Negative impact on parents and siblings
	  ◦ Arguments
	  ◦ Parent's energy and money goes to one child.
	
	"I was never the same".
		One young person felt they had *"no chance"* in life because they'd grown up around drug taking and dealing. They described smoking weed aged 12/13. Another young person was cautious of following the same path as their parents. They no longer smoke weed because they want a career, and it may cause harm to their body.

Drugs, alcohol, and the potential for developing dependency issues were risks identified by the Year 7 and 9s in the Risk-Taking report. Both groups also discussed their experiences and observations around vaping:

Prevalence Of vaping In school	**Impact on school experience**	**Managing peer pressure around vaping**
"It's more vaping, you won't catch someone with a cigarette in the toilets, it's just vapes…" *"We learn it [the dangers of vaping] in PSE, but people just think they're cool. It's like a trend now".*	• One pupil explained how they don't like the smell of vapes in the school toilet so try cover their mouth and rush out. • Concern about getting the smell on their clothes and being accused of vaping. • Checks for vapes before exams causing additional stress.	Abilities to say no depend on the young person's: • Personality • Confidence • Anxieties • Relationships with friends and family • Fear of being bullied. • Knowledge of what vapes contain.
Lack of knowledge There was uncertainty around what vapes contain, their possible dangers to health, and their addictiveness.	*"You go to the toilet just to go to the toilet, not to smoke".*	*"It depends on how people cope with certain situations".*

FULL REPORT LINK: '*Young people's risk-taking behaviours and enablers/barriers to accessing support and services: A qualitative study'* (Full report) January 2023: …

Sexual Health and Substance Use

In March 2023, the Qualitative Insight Team in Public Health at Wirral Council reported on data gathered around Wirral residents' sexual health outcomes and their experiences of using sexual health services. Professionals spoken to during this study identified that individuals engaging in sex work and substance use, were considered to be 'underserved or at risk of poorer sexual health outcomes.

Notable insights included:

- The biggest challenge for people who engage in sex work and drug use in accessing services, was engagement with service providers. They require consistency through seeing the same professionals and in most cases, this is not possible due to a shortage of professionals. This is further exacerbated by the complex daily routines, described by the professionals as 'chaotic', which can make engagement and outreach challenging.
- Organisations that provide support for people struggling with drug dependency also talked about how they provide support for blood born viruses associated with drug use. They have raised concerns on increasing rates of Hepatitis C (HEP C).
- Professionals felt that people often assume they aren't at risk of contracting HIV. Professionals working in the drugs and alcohol space described how they can often see this attitude among people who use steroids. According to the professionals, steroid users can feel like they're not vulnerable to HIV because they don't feel associated with the stereotypical 'drug addict' profile: *"They'll say, 'I'm not a 'smackhead' because they buy 'reputable steroids."* Despite professionals' efforts to educate around the risks of using other people's equipment or the wrong size needle, professionals find that some steroid users can be resistant to taking advice because of the perceived lack of risk: *"Even trying to tell a steroid user about the dangers of using other people's equipment, they'll say. 'Oh, no, no, no. I'm with John, he's spotless."*
- People engaging in drug use/sex workers are reluctant to go to the GP because they feel judged for their lifestyle, line of work and drug use.
- Professionals emphasised the importance of tailoring support to people's needs and bringing sexual health services to people in the spaces they feel comfortable. They felt this approach helps overcome people's reluctancies, however, they identified that limitations in staffing, funding and time prevent services from being able to offer sustainable and flexible support. For example, one professional explained how lack of staff prevents the outreach work that is necessary to build relationships with women who use ***drugs***: *"You're not going to just put a clinic on and they're going to go 'oh yeah, I must go for that smear'. It's not going to happen. It takes work. And at the moment we don't have somebody in that role."*
- Hesitancy to engage in health care services was also described by women who use drugs who said they can feel judged as *"second class citizens"* for their lifestyles. A professional that works with these women explained: *"People have bad experiences of health professionals. So, a lot of people, not just the female sex workers, people in general in treatment for drugs and alcohol,* ***they're used to getting treated a certain way, or being judged, so they're more reluctant to engage,*** *or they don't prioritise their health and they miss appointments, so then they've got a bad DNA [did not attend] rate, and that also goes against them."*
  The quote above shows the importance of not looking at sexual health in isolation when trying to understand people's reluctancy or lack of confidence to access sexual health services: *"Sometimes people don't know the bigger picture behind why people don't engage".*

FULL REPORT LINK: *'Sexual Reproductive Health: Qualitative Insights.'* (Full report) March 2023: …

Opportunities

The research findings in this report identify several opportunities for the treatment and recovery system in Wirral. These opportunities stem from our thematic analysis and subsequent reporting of the focus group and interview data, including discussions with participants that provide valuable qualitative insight around personal lived experiences of drugs use in Wirral:

- *Trauma informed care -* When reviewing the research findings, it was apparent that most of the people we spoke to had experienced varying degrees of emotional distress throughout their life brought about by traumatic life events, most poignantly during adolescence. Their opinion that they had not received or approached the correct care focusing on their trauma during adolescence or at the time of distressing events in adulthood was often given as a reason for the declining circumstances of their mental health and subsequent problem substance use. In this respect, the research reported here summarises that it is important to recognise the impact of trauma on people when delivering treatment and intervention for problem substance use and provide a holistic approach to treatment and recovery that goes beyond medicinal intervention.

- *Early intervention and prevention -* Within this report, there were several topics discussed regarding Early Intervention and Prevention:
  - Generational connections present, between parents and their children, in respect of substance use uptake, problem substance use and related behaviours.
  - Strong connections shown between physical and mental health conditions developed (particularly in adolescence) and uptake and exacerbation of drug use in adulthood.
  - Insights gathered in respect of young people's risk-taking behaviours when combined with the insight present in this report, strengthening the connections between issues created by growing up around addiction, family or relationship loss and breakdown, subsequent effects in schools and later life, and lack of knowledge surrounding drugs and alcohol in young people.
  - The risks present in problem substance use in relation to poor mental health and suicide attempts.

  In these respects, and others, there is an opportunity to increase focus on early intervention, and the availability of advice and information for people at higher risk of substance use intake and problem substance use.

- *Building capacity in diagnosis and treatment -* The research findings report that many of the people we spoke to held varying underlying health concerns alongside of their substance use problem. Delays in receiving treatment and diagnosis for both physical and mental health conditions were often discussed as a contributing factor for drug use uptake and the exacerbation of dependency issues over time. In this respect, building the capacity of diagnosis and treatment services, particularly for key conditions connected with problem substance use could, in turn, improve an individual's capacity for self-resilience at all stages of their drug use journey and identify higher risk for dependency issues at an earlier stage. This also has the potential to have a positive effect on efforts to reduce problem substance use uptake and improve the conditions under which people undertake treatment and recovery for addiction, providing improved chances for success. Over time, the effects of improved capacity in service and the built resilience this provides may also reduce

dependency on addiction services by ensuring that people seek continued access to support when needed and have the tools they need for the future.

- *Support for leaving custody and re-joining the community post sentence –* Individuals that had received a custodial sentence described how they could benefit from increased resilience through treatment and recovery after ending a custodial sentence. The qualitative insight in this report reflects how a more tailored approach to this stage of their journey would be preferred by individuals. This could be an important enabler in preventing relapse post-sentence and later in life, by equipping individuals with the connections, resources, and resilience to approach their recovery journey in the long-term. In this way, increasing the tailored nature of holistic support that individuals receive post-sentence could break the cycles of crime, drug use and imprisonment described by individuals in this study.

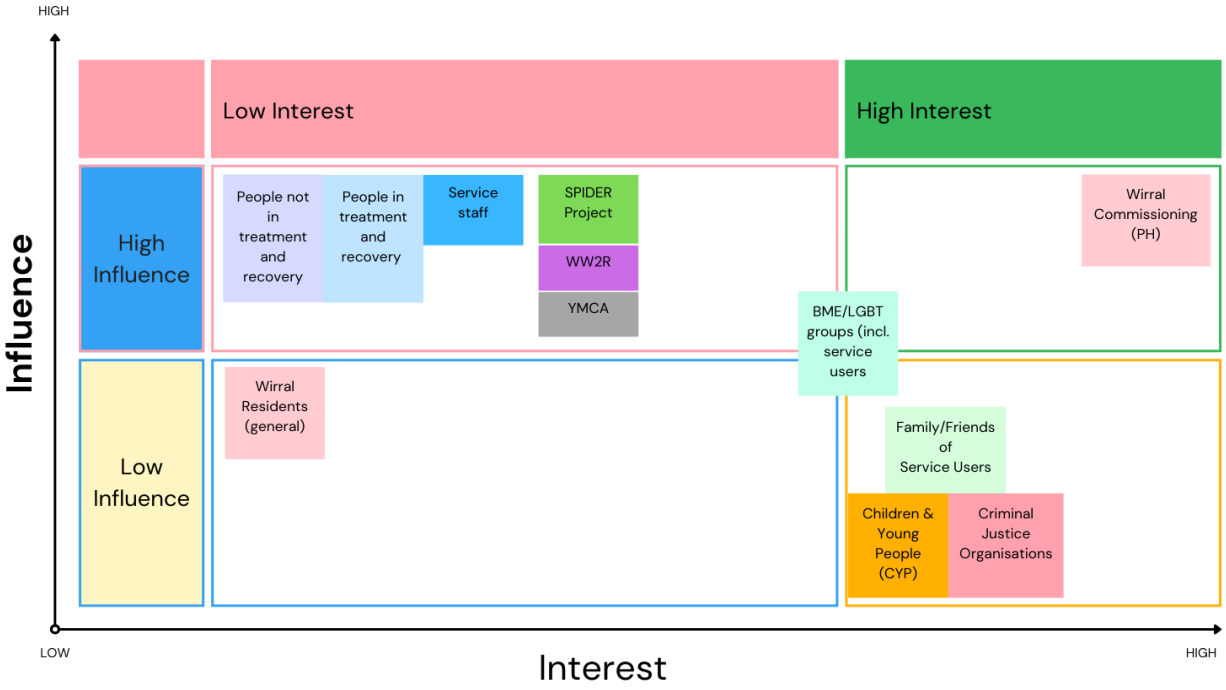
- *Continuity of care and increased partnership working –* Participants in the study described several missed opportunities when interacting with services throughout Wirral including primary care services, police, hospitals, and work support services, among others. Identifying those at higher risk of problem substance use at first contact with services and following through with necessary intervention appears to be crucial. For individuals engaging with treatment and recovery, the strengthening of partnership working and sharing of data and information could help to improve gaps in communication and provide more tailored, wrap around support for individuals. Additionally, increasing the number of referrals to treatment and recovery services, and providing consistently appropriate enforcement and support has the potential to divert individuals from drug use uptake and prevent harm through problem substance use.

- *Participant Voice (Stigma) –* The qualitative insight in this study illustrates that stigma was a key issue faced by people with personal lived experience of problem drug use. The individuals we spoke to described how stigma often acted as a barrier to treatment and recovery and to accessing addiction services. In many cases the effects of stigma caused many to hide their substance use from loved ones and fuelled dependency, poor mental health, and chronic illness. Acknowledging and addressing stigma could improve opportunities for people with problem substance use issues to seek the support and treatment they need. Any action plan of how to educate and challenge stigma should be informed by and prioritise the voice of people with personal lived experience when working to combat stigma.

Appendix

Stakeholder Matrix (Drugs use in Wirral – Qualitative Study)

Organisation/Network/or representatives of Specific Teams	Top Priority (High Interest / High Influence)	Manage with Care (Low Interest / High Influence)	Help Them (High Interest / Low Influence)	Low Priority (Low Interest / Low Influence)
Wirral Residents				X
People in treatment and recovery		X		
People not in treatment and recovery		X		
BME/LGBT Groups (inclusive of above categories) Positive Disc.		X	X	
Service provision staff		X		
Wirral Commissioning (PH)	X			
Children and Young People			X	
Friends and Family of people with substance use disorders			X	
Criminal justice organisations			X	
Wirral Ways to Recovery		X		
Spider Project		X		
Response Service		X		
YMCA		X		
Tomorrow's Women Wirral		X		
Wirral Change? /WMO		X		
Job Centre Plus?		X	X	
Housing Associations?		X		



Research Design

Focus group design: Group A/B

Duration: 1-1.5 hours per session

Core question/task	Activity/question prompts	Equipment required	Lead	Duration (mins)
Focus group brief	Researcher(s) to introduce themselves and run through information sheet with participants.	Information sheet	Jon	5
Icebreaker	Each participant states their name, age, where they come from, hobbies/work, Icebreaker: If they were an animal, what would they be and why?	n/a	Jon	5
Question 1: Drug use journey **How do you typically use/engage with Wirral drug use services?** a. What drugs taken and why? (Traumas etc.) b. Reasons to engage and stay with service	• Provide post-it notes to participants to provide answers for each of the questions A, B, C, and D • Have 4 pieces of flip-chart paper that provide space to stick their responses on. • Participants can reflect on their own experiences, or others.	Post-it notes Flip chart paper Pens	Jamie	15

(what brought them here, what was their motivation)? c. Reasons to not engage? (barriers to entry/engagement) d. Reasons to return				
Feedback and discussion on Question 1	Ask participants to share their treatment timelines from their responses and ask them to discuss: • First entry/to last (no. of occasions) In and out of treatment. • What was the key reason for leaving treatment? • What was your experience once you left treatment? • What or who made you return to treatment (what messages worked/would work)? **Follow up prompt questions:** **<u>What drugs did you take and why?</u>** **<u>(Cocaine and Benzo use and interactions with other drugs i.e., crack and opiate)</u>** o Why? (Trauma, Mental Health, Anxiety/Seizures/withdrawal/muscles spasms/restless leg syndrome) o Frequency? o Consequences? **<u>Age-related recovery (25-35/40-55yrs)</u>** • How does Age affect treatment/recovery (Barriers to entry, engagement level, outlook, considerations) • Early Intervention & Prevention (EIP) • How does Age affect your treatment outcomes? • Long term use and health concerns?	Dictaphone Researcher notebook	Jamie	15
BREAK	**BREAK**			5
Question 2: What do you think of drug	Give participants a SWOT analysis to fill out as a group.	Flip chart paper	Jamie	20

treatment/recovery services in Wirral? (SWOT analysis) **Participants to think about:** • Emergency hospital admission - Preventing hospital admissions - Continuity of care (referral into DT) • Primary care (GP) • The service they are attending now. • Service relationships with criminal and justice organisations. - Referral into DT	Strengths: • What works well? • What do you get out of it? Weaknesses: • What doesn't work well? • What is missing? Opportunities: • How could services be improved/what's missing? • What could be better? • What needs investment? Threats: • What are your challenges/concerns/barriers in accessing services. Also think about service approach, staff, treatment, and the community/relationships you make.	Pens		
Feedback and discussion on Question 2	Ask participants to share their thoughts and feelings against each element of the SWOT analysis.	Dictaphone Researcher notebook	Jamie	10
BREAK	**BREAK**			5
Question 3: Tell us about a time where you experienced stigma. • Role • Lived experience. • Limitations • What needs to change	- Where? - Why? - From Whom? (i.e., services/family/friends/workplace/volunteering) What is the effect of stigma on you? How can stigma be challenged? - In Wirral Drug Treatment services? - How do you challenge stigma? - How prioritize the voice of people with lived experience? (i.e., forums)	Dictaphone Researcher notebook	Jon	10

Question 4: How does drug use affect family, friends, and relationships (and vice versa)? • Age (younger/older) • Gendered recovery (Male/Female) • Families	• What's it like having a family (friends or others) while you're in drug treatment/recovery? • Protecting Children (safeguarding/ EIP/ Education/natal/post-natal journey/childcare/) • How can organisations work together to strengthen support for families? • Wider system support (Housing, education, employment, training)	Dictaphone Researcher notebook	Jon	10
Question 5: What is your goal and what do you need to achieve it? • Short Term • Medium Term • Long Term • Success	Ask participants to write down on a post-it note. Some things to think about: - What were you hoping for when you first approached treatment/recovery services? - Do your goals match up with those prescribed by your key worker? - Did your goals differ upon re-entry to treatment/recovery services? (i.e., post-relapse)	Dictaphone Researcher notebook Post-it notes. Pens	Jon	10
Wrap-up: Consent forms and incentives	• Participants to complete consent forms and incentive documentation	Consent forms Incentives Incentive documentation (acceptance slips) Pens	Jon	10

RESEARCH Exercise
Drug Use Project
Date:

Venue:
Pseudonym:

DEMOGRAPHIC INFORMATION
Wirral treatment/recovery services accessed:
Age:
Gender:
Home location:
Ethnic Group:
Occupation:

*The purpose of this questionnaire is to help the Public Health Research team to understand the lived experience of people in treatment and recovery**. All information is reported anonymously**. The insights gathered will help to inform the creation of a new Drugs Strategy for Wirral.*

1. **Please can you tell us about your journey with drug/alcohol use?**
   Use this space to show your timeline, for example:
   'I first entered treatment in 2016 at age 30 because …'
   'I left treatment in 2019 due to …'
   'I returned to treatment in 2023 because …'

2. **What barriers have you experienced to entering treatment and recovery?**

3. Have you had any experiences with the Criminal Justice system? *i.e., police, parole, courts etc* How did this effect your treatment and recovery journey?

4. Have drugs/alcohol had any impact on your personal relationships? *i.e., partner, family, children*

5. What are your goals for the future? (Short, medium, and long term…)
• • •

Additional Comments:

END

Notes