

# Health and Wellbeing Board Agenda



**Date:** Wednesday, 28 June 2017

**Time:** 2.30 pm

**Venue:** The Writing Room, Floor 1, City Hall, BS1 5TR

## Distribution:

Mayor Marvin Rees, Dr Martin Jones, Alison Comley, John Readman, Cllr Asher Craig,  
Cllr Helen Godwin, Cllr Helen Holland, Linda Prosser, Becky Pollard, Vicki Morris, Elaine Flint,  
Keith Sinclair, Steve Davies, Justine Mansfield and Pippa Stables

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**Date:** Tuesday, 20 June 2017



# Agenda

## 1. Welcome, apologies and introductions

## 2. Public forum - must be about items on the agenda

### Written questions (must be about items on the agenda):

Written questions may be submitted in advance of the meeting by a member of the public or a member of Council. These must be about items on the agenda for this meeting. A maximum of 2 written questions per individual can be submitted. The deadline for receipt of questions for the 28 June Health and Wellbeing Board is **5.00 pm on Thursday 22 June**. These should be emailed to [democratic.services@bristol.gov.uk](mailto:democratic.services@bristol.gov.uk)

Please note: wherever possible (bearing in mind the limited time available in advance of the meeting for the preparation of replies), a written reply will be provided to a question at the meeting, and the questioner will then receive an opportunity to ask one supplementary oral question per question submitted.

### Petitions and written statements (must be about items on the agenda):

Members of the public and members of the Council may submit a petition or submit a written statement to the Health and Wellbeing Board. These must be about items on the agenda for this meeting.

The deadline for receipt of petitions and statements for the 28 June Health and Wellbeing Board is **12.00 noon on Tuesday 27 June**.

These should be e-mailed to [democratic.services@bristol.gov.uk](mailto:democratic.services@bristol.gov.uk)

Please note: details of all petitions / statements submitted by the deadline will be sent to Board members in advance of the meeting. Subject to time, anyone who has submitted a petition / statement will be given an opportunity to briefly present their petition / statement at the meeting.

Maximum time allocation for public forum – 30 minutes

## 3. Declarations of interest

## 4. Minutes of previous meeting - 12 April 2017 - to be confirmed as a correct record (Pages 4 - 10)

## 5. Key decision - Adult substance misuse treatment services recommissioning 2.40 pm

To be presented by Peter Anderson, Safer Bristol Manager

(Pages 11 - 92)



<b>6. Better Care Fund - planning and governance update</b>	<b>2.55 pm</b>
To be presented by Becky Pollard, Director of Public Health	<b>(Pages 93 - 104)</b>
<b>7. Joint Strategic Needs Assessment - update</b>	<b>3.10 pm</b>
To be presented by Joanna Copping, Consultant in Public Health and Nick Smith, Strategic Intelligence and Performance Manager	<b>(Pages 105 - 113)</b>
<b>8. Health and wellbeing - roundtable discussions</b>	<b>3.30 pm</b>
To be presented by Becky Pollard, Director of Public Health	<b>(Pages 114 - 119)</b>
<b>9. Thrive Bristol - delivering a citywide approach to mental health and wellbeing</b>	<b>3.50 pm</b>
To be presented by Victoria Bleazard, Mental Health and Social Inclusion Programme Manager, Leonie Roberts, Consultant in Public Health, and Jo Copping, Consultant in Public Health.	<b>(Pages 120 - 126)</b>
<b>10. Progress update - Bristol alcohol strategy</b>	<b>4.10 pm</b>
To be presented by Blanka Robertson, Public Health Principal.	<b>(Pages 127 - 414)</b>



## Bristol City Council Minutes of the Health and Wellbeing Board

12 April 2017 at 2.30 pm



### **Present:**

Dr Martin Jones, Alison Comley, John Readman, Becky Pollard, Jill Shepherd, Cllr Asher Craig, Cllr Helen Godwin, Cllr Helen Holland, Cllr Claire Hiscott, Elaine Flint, Steve Davies, Justine Mansfield, Pippa Stables, Morgan Daly

### **1. Welcome, apologies and introductions**

Attendees were welcomed to the meeting. Apologies were received from Mayor Rees, Linda Prosser and Vicki Morris.

### **2. Public forum - must be about items on the agenda**

The following public forum items were received and noted:

- Public forum statement from Mike Campbell on CCG/Sustainability and Transformation Plan update.
- Public forum statement from Karin Smith on CCG/Sustainability and Transformation Plan update.

### **3. Declarations of interest**

None.

### **4. Minutes of previous meeting**

**Resolved:**

**That the minutes of the meeting held on 15 February 2017 be confirmed as a correct record and signed by the Chair.**

## **5. Bristol Safeguarding Adults Board - Annual Report 2015-16**

The Board considered the annual report and presentation from Bristol Safeguarding Adults Board. The Independent Chair, Louise Lawton had extended her apologies and Richard Kelvey presented the report on her behalf.

The Board were asked to note the following from the report:

- This is the second report from the BSAB since the establishment of the Board as directed by the Care Act 2014.
- All of the last five SCRs/SARs involved adults with mental health needs living in the community (3 published in 2016, 2 underway).
- The question - 'is the current service provision sufficient for meeting the needs of adults with complex needs, including mental health, in the community?'
- The question of who leads on the issue.
- Some professionals have limited skills to support the needs of those with poor mental health. The police have powers of arrest but this is not the solution when addressing issues arising from the behaviour of a person with poor mental health. Many police officers working in the field now have access to a specialist advisor to give guidance. This problem is one encountered by other professions, for instance care workers and housing officers working in the community.
- The other theme is one of vulnerable adults causing harm to one another, giving rise to the question of how best to assess the complex needs of a vulnerable adult living and sharing accommodation with others.
- Emerging theme – is the oversight of risk management arrangements for adults with mental health needs placed in supported accommodation in Bristol by other local authorities sufficient?
- The challenge for all partners is to consider this question: 'are we practiced in considering these issues and questioning the requirements of service users?'
- Also acknowledged is the difficulty in keeping track of vulnerable adults. Unlike the obligation to know the whereabouts of children in care, adults are able to move from region to region at will.
- The challenge amongst health professionals is who takes the lead to support the complex needs in this area. Working professionals who come into contact with vulnerable adults with poor mental health require training / knowledge to support the needs of this group in society.
- The learning from the SCRs will be shared between regional authorities and partners.

The following was noted from the discussion:

- a. The reporting of safeguarding concerns arising from care provided in hospitals and care homes appeared to have grown. It was explained that the mechanism for reporting and recording has improved, therefore allowing for more informed data. In turn, the data can be used to properly inform learning and training for the workforce.

- b. There continues to be a strong link between the incidents relating to vulnerable adults and poor mental health reflected in the SCRs. The issue of vulnerable people obtaining access to the right care and receiving advice from professionals working in the community remains a challenge. The CCG is strategically reviewing the issue of overall integration of services.
- c. Housing officers, when faced with the actions of tenants, for example who hoard items, would be looking to make the home decent and a fit environment for them to continue to live in. Actions would be taken to move the tenant to alternative accommodation to allow cleaning of the property; they are not skilled in identifying and diagnosing whether such behaviour is 'eccentric' or resulting from poor mental health.
- d. Concern that the wider issue of financial constraints being faced by all partners impacts on the provision of the mental health triage service.
- e. The challenge of accessing support for those vulnerable adults identified as needing support from the mental health services but who fail to engage or who suffer relapses and then refuse to re-engage.
- f. Acknowledged the need for support to those professionals in housing who place vulnerable clients in places that may cause challenge. A form of capability assessment is required to aid the process.
- g. BSAB is seeking support and endorsement from partners to release staff to participate in audit work assessment.
- h. It was suggested that training of professionals should be locality based rather than via a citywide event.

Action agreed:

- Letter from the Chair of the H&W Board to the BSAB to confirm support.
- Becky Pollard to lead on the issue of delayed transfer of care from hospitals to community and integrated work.
- Contact and sharing with local neighbourhood partnership groups to share issues of poor mental health.

## **6. CCG / Sustainability and Transformation Plan (STP) - update for information**

The Board were asked to note the key developments of Bristol Clinical Commissioning Group (BCCG) and the Sustainability & Transformation Plan (STP) for Bristol, North Somerset and South Gloucestershire (BNSSG).

Dr Martin Jones, Bristol CCG Chair asked the Board to note:

- The interrelated themes:-
  - Prevention, early intervention and self-care.
  - Integrated primary and community care.
  - Acute care collaboration.
- The 'checkpoint' review by NHS England - the BNSSG STP has started the development of a number of specific proposals. The programme of work includes:
  - Diabetes
  - MSK

- Respiratory
- Making Every Contact Count
- Appointment of Julia Ross as the BNSSG Accountable Officer in role from the 2<sup>nd</sup> May.

The following was noted / arose from the discussion:

- a. With the implementation of the BNSSG STP, the health landscape would change and the question was one of the future role of the Board. The Board would need to be informed as things progress in order to determine the impact on the population of Bristol.
- b. Clear lines of governance – concerns were raised that the Board should ensure that this happens to avoid duplicating the work of BNSSG STP. The Board should be engaged in supporting the right conversations taking place in the correct setting to avoid duplication in the regions and different boards.
- c. The Health Committees across the regions have met and intend to continue to work together.
- d. The STP Plan aspires to make better use of available resource; support the seamless sharing of services across partners; doing things better; the Board must continue to support the voice of Bristol.

## **7. Integrated healthy lifestyles service procurement: Bristol Behaviour Change for Healthier Lifestyles Programme**

The Board were presented with a report on the Bristol Behaviour Change to Healthier Lifestyles Programme.

Becky Pollard, DPH introduced the report outlining the intention of the draft commissioning strategy.

The Board was asked to note the tight timescale running from May 2017 to completion in April 2018, and to agree the commencement of the 12 week formal consultation on the draft strategy.

### **Resolved:**

- To agree the consultation on the draft strategy.

## **8. Health in all policies**

The Board received a report updating them on the work underway to embed consideration of health and wellbeing in all relevant strategies and policies by targeting the factors that affect health.

Katie Porter presented the report and highlighted:

- The 10 year life expectancy gap between residents living in certain wards in Bristol, i.e. depending on where people live.
- The 16 year healthy life expectancy gap between the least and most deprived areas of Bristol.
- People in these deprived areas not only die early, but before their death live with poor health for longer than people in the least deprived areas.
- There are approximately 60 strategies and policies across Bristol that affect people's health.

- The strategy to embed HiAP would require:
  - Supporting the use of health impact assessments in new strategies and policies.
  - Working with teams drafting policies and strategies to determine health impacts and optimise the impacts to benefit health outcomes.
  - Set up a template to undertake health equity assessments during a commissioning process.
- The Public Health team have the skills to carry out health impact assessments and support, train and encourage others to do so.
- Consult with other DPHs in the West of England region to consider their joint input into devolved authority around HiAP to ensure that the strategic plans for economic development, transport and the spatial plan achieve the best health outcomes possible.

The following points were raised:

- a. It was confirmed that the intention was to share this practice with partners but first to start with Bristol City Council. The learning from the strategy development would then be shared.
- b. HiAP is established practice in Wales and is a consideration for all Welsh legislation. This is managed with the use of cross-department key performance indicators.
- c. The strategy would sit well in a task & finish work group to establish an agreed approach amongst partners.
- d. It was agreed that work be undertaken to map out the central theme for the strategy and feed it into a workshop for final outcome.

## **9. Healthy weight strategic plan - progress report**

The Board received a report and presentation from Beth Bennett-Britton, Public Health Registrar and Sally Hogg, Consultant in Public Health, updating members on the progress in developing a Healthy Weight Strategic Plan for Bristol.

The following was noted from the discussion:

- a. The question of how the success of the strategy would be measured and its impact on communities in areas of deprivation. Measuring outcomes falls within the remit of the terms of reference of the Healthy Weight Group. The group will oversee the implementation of an action plan that has SMART objectives.
- b. A number of outcomes would be realised over a 3 – 5 year period such as a reduction in childhood obesity and a move to increase individuals' activity.
- c. The programme requires the endorsement of the Board to allow for this to be reflected in all areas of the strategy. The strategy objectives support a number of the Health & Wellbeing Board priority areas.

**Resolved:**

- 1. To note the update.**
- 2. To endorse the strategy.**

## **10. Pharmaceutical needs assessment**

Becky Pollard, DPH addressed the Board on the report outlining the Pharmaceutical Needs Assessment.

Main points raised/noted:

- a. The production of the PNA is a statutory requirement transferred to the local authority under the Health and Social Care Act 2012. There is a statutory requirement for the PNA to be updated every 3 years and it is next due for refresh in March 2018. The duty includes a requirement to engage in a minimum 60 day consultation period.
- b. The report outlined the uses of the PNA by NHS England and the way it is used as a point of reference.
- c. The PNA must be completed in collaboration with the other regional authorities.
- d. There was general concern about NHS England using the plan to determine the needs of the Bristol region for pharmacists. Pharmacists are engaged with supporting the strategies of Public Health and lesser provision would impact on many programmes.

The Board agreed to note the work to be undertaken.

## **11. Information item - SEND reforms**

Carole Watson, Bristol City Council presented the information report and spoke to the presentation.

The report:

- Provided an overview of the statutory duties of the local area with regard to children, young people with Special Educational Needs and Disability (SEND) and their families as required through the Children and Families Act, known as the SEND reforms.
- Update on the self-evaluation and progress of the SEND reforms.
- Sought to raise awareness of the local area inspection framework.

The Board agreed to note the report.

## **12. Information item - European City of Sport**

This report informed the Board on the position with the award of the European City of Sport 2017 and the impact on Bristol.

The Board agreed to note the report.

Meeting ended at 4.30 pm

**CHAIR** \_\_\_\_\_

<b>Heading:</b> Adult Substance Misuse Treatment Services Recommissioning	
<b>Ward:</b> Citywide	<b>Cabinet lead:</b> Cllr. Asher Craig
<b>Author:</b> Peter Anderson	<b>Job title:</b> Safer Bristol Manager
<p><b>City Outcome overview:</b> The re-commissioning of treatment services will support vulnerable citizens to access health interventions that support their health and well-being needs. This proposal contributes to the Corporate Plan in helping to tackle health and inequality and contributes towards a safer city. The Local Authority is responsible for commissioning drug and alcohol treatment services and is measured by Public Health England on the achievement of the following national Public Health Outcomes Framework indicators:</p> <ul style="list-style-type: none"> <li>• 2.15i,ii - Successful completion of drug treatment (opiate users and non-opiate users)</li> <li>• 2.15iii - Successful completion of alcohol treatment</li> <li>• 2.15iv - Deaths from drug misuse</li> </ul>	
<p><b>Equalities Outcome overview:</b> During the consultation period the potential for the proposed model to adversely impact on people with protected characteristics has been considered. The newly commissioned treatment system will work with BCC to demonstrate how equalities groups are supported both as service users and within the workforce. A full EQIA will be published alongside the final commissioning strategy on 6<sup>th</sup> July.</p>	
<p><b>Impact / Involvement of Partners overview:</b> Colleagues from primary care, health and social care, housing, criminal justice, education, mental health, neighbouring authorities, VOSCUR and Public Health England are actively involved in the commissioning process.</p>	

<b>Approx. Cost:</b> £ 8.7 million per annum is proposed to be made available for the new commissioned services	<b>Revenue</b> BCC General Fund revenue contribution £1.411m and Public Health contribution of £9.377m in 2017/18	<b>Saving / Income generation</b> Achieves the published budget reduction RS23 (£81k) and contributes toward FP01.
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**Proposed budget:** Commissioned services would be paid out of cost centre 10339

#### Finance narrative:

Safer Bristol is intending to commission a new service with a total annual value of £8.7m. The new service is anticipated to be in place by December 2017 therefore the annual value of the new service will be prorated for 2017/18, which is a transitional year for the service.

The new service is to be funded out of a pooled budget administered by the Substance Misuse Joint Commissioning Group. Cabinet is due to consider approval of the Substance Misuse Accommodation Pathway 16 May 2017, which is also funded from this pooled budget. Table 1 below sets out a profile of the planned expenditure from this pooled budget for existing services (including those in and out of the scope of either the new Substance Misuse Accommodation Pathway or Substance Misuse Treatment Service) and the new commissioned services over the financial years of the proposed contractual period.

**Table 1: profile of pooled budget expenditure**

	2016/17 £000s	2017/18 £000s	2018/19 £000s	2019/20 £000s	2020/21 £000s	2021/22 £000s	2022/23 £000s
Services in scope	11,209	7,254	-	-	-	-	-
Out of scope services	473	535	606	556	556	556	556
Implementation costs	-	1,478	-	-	-	-	-
Substance Misuse Accomm. Pathway	-	313	750	750	750	750	750
Substance Misuse Treatment Service	-	2,900	8,700	8,700	8,700	8,700	8,700
<b>Total</b>	<b>11,682</b>	<b>12,480</b>	<b>10,056</b>	<b>10,006</b>	<b>10,006</b>	<b>10,006</b>	<b>10,006</b>

In 2018/19 the annual contract value of the Substance Misuse Treatment Service is £8.7m and in 2017/18

it is £2.9m, reflecting four months of the new service.

Implementation costs estimated at £1.478m in 2017/18 are based upon a one and half month overlap of services at £1.178m and £300k provision for a new case management system.

The pooled budget is funded by contributions from the General Fund, Public Health, CRC Partnership Funding and neighbouring local authorities. Appendix H sets out details of the actual funding profile for 2016/17 and the budgeted profile for 2017/18, confirming that the £20k budget reduction for 2017/18 (RS23) has been achieved.

Appendix H also sets out that the total funding required in 2018/19 is £9.936, which is a reduction of £961k (9%) from the funding required in 2017/18 of £10.897m.

If this reduction was apportioned between the funding sources on the basis of their current proportional contributions then the funding required from the General Fund would reduce by £125k in 2018/19, exceeding the £61k required in 2018/19 as per the published budget reduction RS23 by £64k to contribute toward published budget reduction FP01 (Reduce third party payments).

Appendix H sets out the full apportionment of this reduction including that for Public Health contributions.

Finally, should the estimate for implementation costs of £1.478m be more than required in practice this will further reduce the future funding required and generate greater savings.

**Finance Officer:** Robin Poole, Finance Business Partner, Neighbourhoods

#### **Summary of issue / proposal:**

In October 2016 the Health & Wellbeing Board approved the re-commissioning of adult substance misuse services. Following the formal 12-week consultation period (ending on 07/04/17) this report seeks the Boards approval on the model of service delivery, procurement approach and funding as defined in the attached Commissioning Strategy (Appendix A)

The following points are of particular relevance to the Health and Well-Being Board:

- Given the specific nature and setting of their work we believe that the substance misuse hospital provision (which includes the current NBT and UBT alcohol and drug liaison roles) and the ACER inpatient facility (AWP provided) to be relevant for a direct award. We are currently working with Legal to take this approach.
- The Commissioning Strategy has factored in an implementation period to enable the safe transfer of clients and for staff organisation. This will allow commissioners and providers to manage the complex transition of staff and clients.
- Primary Care is an integral part of the treatment system in delivering opiate substitute prescribing, alcohol detox prescribing and supervised consumption services. We are currently exploring procurement options and are not in a position to ask the H&WBB to take a key decision on this element of the ROADS model. This also has an impact on the procurement of sexual health services and we will update the H&WBB on a combined approach.

#### **Key background points:**

- Bristol has an estimated 5,400 opiate and/or crack users, which equates to around 18 in every 1,000 adults. This is higher than other core cities in England.
- There are nearly 3,000 opiate and 1,000 alcohol clients in our services each year.
- Approximately 20% of clients in treatment live in a household with children under 18yrs.
- Bristol has a higher proportion of clients with very complex needs than the national picture.

**Recommendation(s) / steer sought:**

- That the Commissioning Strategy (Appendix A) be approved, which enables the Council (as lead commissioners) to progress to invitation to tender and contract award.

**Legal Issues:** The Substance Misuse Team and BCC Procurement Support will need to ensure that they are working in line with all commissioning and procurement regulations during this process to minimise the risk of any legal challenges. Continuity of care is crucial throughout.

**Legal Officer:** Kalvinder Saib, Legal Services, Corporate Legal Team

<b>DLT sign-off</b>	<b>SLT sign-off</b>	<b>Cabinet Member sign-off</b>
[Alison Comley] 27.04.17	16.05.17	[Cllr. Asher Craig] 04.05.17

Appendix A – Further essential background / detail on the proposal (Commissioning Strategy)	<b>YES</b>
Appendix B – Details of consultation carried out - internal and external – please note this is contained within the Commissioning Strategy.	<b>YES</b>
Appendix C – Summary of any engagement with scrutiny	<b>NO</b>
Appendix D – Risk assessment	<b>YES</b>
Appendix E – Equalities screening / impact assessment of proposal	<b>YES</b>
Appendix F – Eco-impact screening/ impact assessment of proposal	<b>NO</b>
Appendix G – Exempt Information	<b>NO</b>
Appendix H – Financial Appendix	<b>YES</b>

# Bristol City Council Substance Misuse Commissioning Strategy 2017



July 2017

Author

Kath Williams

## Version Control

Document Review		
Section	Amendment	Pg
1.1	Added sentence to Introduction section highlighting this is now the final commissioning strategy following the consultation period	9
1.1	Removed paragraph relating to consultation approach and replaced with paragraph directing to formal consultation section	9
1.1	Updated dates to reflect the final timeline	9
1.1	Removed paragraph relating to the publication of new national drug strategy due to its delay	9
1.3	Updated paragraph to reflect that the projects key milestones have been signed off at the relevant points	12
2.3	Updated paragraph to reflect that the annual budget has now been confirmed and implementation contingency budget has been added	14
5	Added new section 'Formal Consultation' to outline the results of the consultation period and removed previous section that detailed the consultation approach.	21
6.1	Revised in and out of scope contracts and intentions for direct award.	27
6.2	Updated paragraph to reflect that the model has been shaped by information that is outlined in the 'Formal Consultation' section	30
6.2	Service descriptions updated to reflect changes to the services following the formal consultation	30 - 40

6.3	Allocation of resources table updated to reflect changes following the formal consultation	41
6.4	Financial evaluation section updated and appendix 6 added.	42
7	Timeline section updated to reflect changes	47

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# **1 Introduction**

## **1.1 Background**

Substance misuse services in Bristol currently provide a wide range of treatment and support under the Recovery Orientated Alcohol and Drugs Service (ROADS) brand. This treatment system is commissioned by the Substance Misuse Team (SMT) in line with the current National Drug Strategy (2010) and other key guidance from Public Health England (e.g. Medications In Recovery, NICE Guidelines etc.). These contracts were commissioned in November 2013 until March 2016 with the option of a further two years. Contract extensions have subsequently been agreed and expire in November 2017.

Following the commissioning of the community contracts, a tender process took place for Bristol clients to access residential rehabilitation provision across the country. A framework agreement was implemented in 2014 to deliver this provision and this is also due for renewal in 2017.

In 2010 the Substance Misuse Team commissioned an integrated, multi-agency, caseload system for the management of substance misuse clients across the city. There are approximately 20 teams who use the system and around 200 active Theseus users. The contract for the system (Theseus) expires in 2018 and having explored procurement options a competitive tendering process will be run. The expectation is that commissioned treatment providers will be required to use this system. Whilst this strategy makes reference to the commissioning of the case management system this will be run as a separate/interrelated procurement process.

This document outlines the development of a new model for substance misuse provision to meet the needs of those who misuse substances in the city and replaces the current substance misuse contracts, rehab framework agreement and case management system.

These will be commissioned and procured by the Substance Misuse Team by following BCC's Enabling Commissioning Framework (Fig.1). This is the agreed four stage commissioning cycle that has been adopted from the IPC joint commissioning model for public care. This approach will enable Bristol City Council to comply with European Union (EU) procurement law, and provide assurance that it is commissioning substance misuse services in line with best practice.

Fig.1. BCC Enabling Commissioning Framework



This document seeks to provide additional information in relation to this specific commissioning activity and is intended for use by a range of stakeholders in order to develop a cooperative approach to the commissioning model that will go out to tender in 2017. In particular, this document is intended for:

- Existing and potential providers who will be able to use the information presented to identify the role they can play. We hope that this document will enable providers to respond to the identified service model, identify potential opportunities for collaborative working, as well as bring forward new and innovative ways of working in the future.
- Voluntary and community sector (VCS) organisations and mutual aid groups who make a key contribution to building and maintaining resilience, recovery and reintegration. We hope these stakeholders, who may or may not deliver currently commissioned services, will be able to use this document to understand the proposed changes to the commissioned service provision and to develop links between commissioned and non-commissioned support.
- Members of the public, including but not limited to people who need support relating to substance misuse, who wish to contribute to the development of a treatment system for Bristol.

The period of formal consultation took place between 16th January 2017 until the 16th April 2017. Please see Chapter 5 – Formal Consultation for a collation of the feedback that we received during this period and how it shaped the final commissioning model and approach.

We will be commencing a competitive procurement exercise (where relevant) during July and August 2017 with the aim of awarding contracts to deliver the new services from the 1<sup>st</sup> December 2017. We recognise the challenges of moving to a newly commissioned treatment system for our stakeholders. Details of key milestones can be found in the final timeline in Section 7.

A glossary and definition of the key terms used in this strategy can be found in Appendix 1 and 2.

A number of legal acts and national strategies influence the provision of substance misuse services. This commissioning process will work within these parameters; further detail on the legal and national policy context is included in Appendix 3.

*Update: This document is the final version of the Commissioning Strategy following a twelve-week consultation period. This consultation period has helped to inform and develop the final treatment system model outlined in this strategy that will be commissioned this year.*

## 1.2 Local Context

Bristol has an estimated 5,400 opiate and/or crack users. This equates to approximately 18 of every 1000 adults in Bristol using opiates and/or crack. Bristol has the highest estimated rate of opiate and crack users of all English core cities and the largest proportion of very high complexity clients which makes them more likely to be in treatment for longer and need specific support. Accordingly, substance misuse is one of Bristol Public Health's top 10 priority work areas to improve and protect the health and wellbeing of people in Bristol, and to reduce health inequalities within the population.

The current substance misuse contracts were commissioned in November 2013 under the Recovery Orientated Alcohol and Drugs Service (ROADS) brand. These contracts were initially commissioned until 31<sup>st</sup> March 2016. Subsequently, contract extensions have been agreed with the current contract holders to continue to deliver ROADS until 30<sup>th</sup> November 2017.

Although procurement regulations stipulate that public services should be regularly put out to competitive tender, the Substance Misuse Team did consider alternative options (e.g. re-negotiating with current contract holders). A number of factors were taken in to account before deciding on the process of re-tendering these contracts. These included, but were not limited to:

- Expected reductions in levels of funding. The Council has consulted on a proposed Corporate Strategy for 2017-2025 which aims to make £92m savings. This is required due to changes in Government funding and increasing demands for services. The Council will have to look at all areas of spend, including commissioned services, to determine what areas have priority and where to make savings. Furthermore the removal of the ring fence for the Public Health Grant from 2017/18 has meant there is currently less certainty around funding for substance misuse provision in Bristol. Given the level of uncertainties it was considered that a newly commissioned treatment system to reflect any new funding levels would be required. Please see Section 2.3 for expected funding levels for the new system.
- The changing needs of clients accessing substance misuse treatment. Current ROADS providers have adapted well to the shifts in the profiles of those accessing treatment, particularly around the increase in primary alcohol users. However there is a recognition that system wide changes brought about by re-designing services through re-commissioning is now required to fully meet these emerging demands.
- The transfer of Public Health contracts. Due to internal restructures within the Council, the Substance Misuse Team will be managing a number of additional substance misuse related contracts (e.g. GP and Pharmacy Substance Misuse Public Health Service contracts, formally known as Local Enhanced Services) that have historically been contract monitored by the Public Health team.
- The publication of a new National Drug Strategy. It was anticipated that a new national drug strategy would be published at the start of 2017. In order for services to align with national policy it was considered that services should be re-commissioned to reflect any developments included in this.

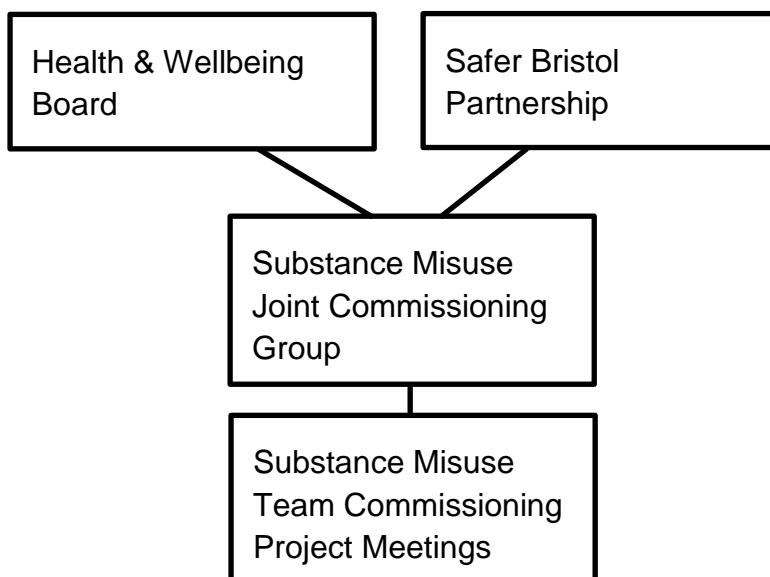
Our focus is on providing the best possible services for the people that need them and throughout the commissioning process we will be working with service users to help ensure services are accessible, appropriate and acceptable.

In line with the approach developed by Bristol City Council's Adult Social Care it is the Substance Misuse Team's intention to develop and commission a system that focuses on helping people in the most appropriate way dependent on an individuals need.

## 1.3 Governance and Decision Making

The Substance Misuse Joint Commissioning Group is a multi-agency governance group that oversees the work of the Substance Misuse Team. It has been agreed that this group will oversee the delivery of this commissioning process, whilst also reporting back through the Council's Health and Wellbeing Board and the Safer Bristol Partnership for sign off at key milestones of the project.

Fig.2 Governance Pathway



The Substance Misuse Team has also complied with the Council's decision making pathway process. Key milestones of the project have been presented to Bristol City Council's Senior Leadership Team, People and Neighbourhoods Directorate Leadership Teams, CCG (Clinical Commissioning Group) and Public Health's Management Team. Positive feedback has been received from these sessions and input has helped to shape the commissioning intentions included in this document.

Overall these Boards support the proposals outlined in this strategy and support the need to strategically align with some of the wider agendas in Bristol City Council through joint working and co-commissioning. It is recognised that this project has a number of interdependencies with other commissioning projects currently taking place in the Council, namely the Preventing Homelessness Strategy. More detail on the drug and alcohol accommodation as part of the Preventing Homelessness recommissioning can be found in the Commissioning Model section. We are working closely with colleagues in the Council to ensure that there is a strategic alignment in our project plans.

These commissioning intentions have also been brought to Bristol City Council's CPG (Commissioning and Procurement Group). This group has responsibility for the implementation of the corporate strategy that relates to commissioning and procurement which requires a saving of £30m to be achieved over the next five years.

## 2 Financial Analysis

### 2.1 Funding Streams

The Substance Misuse Joint Commissioning Group is accountable for the substance misuse budget. The 2016/17 funding streams that are relevant for this commissioning strategy includes:

Funding	2016/17	2017/18
<b>Bristol City Council Contribution</b>	1,623,590	1,461,231
<b>Substance Misuse Public Health</b>	7,709,220	6,938,298
<b>Public Health GP, Pharmacy and Wet Clinic Contracts</b>	1,702,505	1,532,254
<b>Community Rehabilitation Company</b>	87,000	30,000
<b>South Gloucester Partnership Funding</b>	40,000	40,000

As detailed above we have built in a reduction in the BCC contribution and the Public Health income as part of the ongoing BCC corporate budget consultation. A 10% reduction has been factored into the funding available for BCC and Public Health funding for recommissioning.

### 2.2 Current ROADS annual contract values 2016/17

Contracts	2016/17 (£ annual)
<b>Engagement Cluster</b>	1,701,751
<b>Change Cluster</b>	4,023,960
<b>Completion Cluster</b>	1,371,350
<b>Support Cluster</b>	433,030
<b>Housing Support</b>	882,190
<b>Residential Rehabilitation</b>	800,000
<b>Primary Care Costs<sup>1</sup></b>	1,650,000
<b>Hosted Case Management System<sup>2</sup></b>	27,546

<sup>1</sup> This includes GP drug and alcohol public health services, pharmacy public health service and prescribing costs

<sup>2</sup> Based on current hosting and admin costs and excluding perpetual software license, migration and set up costs

Please note that there are a number of other commitments, contracts and infrastructure costs that are considered out of scope for the recommissioning that make up the value of the total income streams listed above.

## **2.3 Funding Envelope for the new treatment system**

An annual budget of £8.7 million has been allocated to the newly commissioned treatment system.

An additional £750,000 has been allocated to redefine the substance misuse accommodation pathway as part of the commissioned adult homelessness prevention services.

A budget of £27,500 is allocated to the hosting and maintenance of our case management system. We anticipate that if recommissioning a new provider there may be additional set up costs to include licenses, migration of data etc and a budget has been allocated accordingly.

At the JCGs recommendation an implementation contingency budget has been set aside to cover the potential cost of a short overlap between incoming/outgoing provider following contract start. This also includes an amount if a new case management system licence fee is incurred.

See Section 6.3 for the proposed allocation of resources across the new treatment system.

## **3 Needs Assessment and Stakeholder Engagement**

### **3.1 Needs Assessment Approach**

The Substance Misuse Team adopted Bristol City Council's Public Health template when producing the substance misuse needs assessment. This approach considers a number of factors including who is at risk and why, what is the level of need, what services/assets we have to meet and prevent this need, what do staff/users/carers think and what is the evidence base.

Given that substance misuse impacts on a wide range of areas in an individual's life, the Substance Misuse Team applied this template to the sections below to inform the commissioning of services and improve partnership working across the city:

- Physical Health
- Mental Health
- Housing
- Relationships
- Training, Education, Employment and Volunteering
- Criminal Justice

The draft substance misuse needs assessment was published in July 2016 and feedback was sought by all stakeholders on this document throughout this month. After consideration of the feedback the final needs assessment was published by the Substance Misuse Team in October 2016. This document can be found here:  
<https://www.bristol.gov.uk/social-care-health/substance-misuse-treatment-services-tender>

### **3.2 Needs Assessment Key Recommendations and Predictive Analytics**

Recommendations were drawn from the evidence presented within each section of the needs assessment and can be found in Appendix 4. It should be noted that not all of the recommendations outlined are within the remit of the newly commissioned treatment system but have been included to inform and shape the wider commissioning and partnership working of services that work with people who use drugs and/or alcohol in Bristol.

Two overarching recommendations were developed to address the need to commission an effective treatment system:

1. Bristol needs a structured treatment system that provides a range of evidence based interventions to maximise recovery opportunities. Commissioners need to ensure the system can manage a broad range of conditions and client complexities. Treatment options should include access to a range of psychosocial and pharmacological interventions, including relapse prevention.
2. Within structured treatment there needs to be an enhanced focus on the delivery of health protection and harm reduction interventions.

Further to the Substance Misuse Needs Assessment, (which took a retrospective look back at various sources of data) the Substance Misuse Performance Team also developed a ‘predictive analytics’ approach (that took a prospective view of the ROADS substance misuse treatment data). This ‘predictive analytics’ approach considered what stage a service user was currently in their treatment journey and depending on the various stages they would go through what the likelihood of their future outcomes would be.

This data overwhelmingly demonstrated the importance of receiving effective aftercare support following structured treatment interventions to support them in maintaining their recovery. These findings were also considered as part of the proposed treatment model development work.

### **3.3 Stakeholder Engagement**

A series of stakeholder events took place during September and October 2016 across the city. These events were designed to both inform stakeholders on the recommendations from the needs assessment and the prioritised commissioned functions as a result of these recommendations. These events helped to shape the proposed treatment model development work. Details of these events can be found below:

<b>Location</b>	<b>Venue</b>	<b>Number of confirmed attendees</b>
<b>South</b>	Gatehouse Centre	52
<b>Central*</b>	Unitarian Chapel	24
<b>North</b>	Greenway Centre	12
<b>East</b>	Barton Hill Settlement	22

\*A drop in session was also held here to encourage additional input from members of the public and service users.

In addition to this a number of thematic events took place during this period that followed a similar approach which gained feedback from stakeholders and further informed the commissioning intentions. These included:

- Dual Diagnosis Workshop
- GP Best Practice Event
- Complex Needs Network

Following these events, we invited all attendees to consider the proposed functions discussed in these sessions in more detail and reply with any further feedback to assist in developing our commissioning intentions.

A wealth of useful feedback was given and has informed the development of the proposed model. A summary of the key messages from the Stakeholder Engagement sessions is included in Appendix 4.

## 4 Models of Delivery and Lessons Learned

### 4.1. Models of Delivery

Following the completion of the needs assessment, the Substance Misuse Team contacted substance misuse commissioners in both the core cities and Local Outcome Comparators (LOCs: areas defined by PHE with similar opiate and non-opiate caseload complexity to Bristol) to gain an understanding of the range of treatment systems commissioned across the country. See the table below for the areas contacted for information requests:

LOC opiate/non-opiate	Core Cities
Barnsley	Birmingham
Calderdale	Leeds
Cambridgeshire	Liverpool
Derbyshire	Manchester
Leicestershire	Newcastle
Lincolnshire	Nottingham
North Yorkshire	Sheffield
Nottinghamshire	
Wigan	
York	

Not all of these areas responded to this information request however Bristol Public Health Team did complete an additional information gathering exercise with the core cities to address some of these gaps. Some of the main findings from this exercise included:

- A strong trend for areas to deliver a more integrated approach to address both drugs and alcohol related harm.
- A strong trend for areas to offer services from GP surgeries and/or locality hubs to ensure that services are more accessible across a region for service users rather than being centrally based.
- A strong trend for areas to commission multi-agency treatment systems
- Some trends of areas commissioning a ‘single point of access’ for entry in to substance misuse treatment.

- Some trends for areas to commission specialist nurse prescribers to address needs around dual diagnosis.
- No trends of commissioning specific drug and alcohol housing provision. Instead mainstream housing is expected to meet the needs of drug and alcohol users.

## **4.2 Market Analysis**

The market is well developed and there are a number of national providers who are currently delivering similar services to neighbouring local authorities and core cities across England; as well as small and medium sized local organisations who are providing specialist services with well-developed community links.

In the last round of substance misuse commissioning, 16 bids were received for the five ROADS lots from eight different organisations (with multiple subcontracting organisations). Following discussions with other commissioners, Public Health England and provider networks we are confident that there is the market to deliver substance misuse services for Bristol. It is important to be mindful of the potential for 'market failure' i.e. setting commissioning expectations too high and at too low a cost for any provider to feasibly deliver and this has been considered throughout the consultation period.

## **4.3 Lessons Learned**

As part of the re-commissioning process, the Substance Misuse Team conducted a lessons learned exercise. The aim of this exercise was to improve the current commissioning project by having a retrospective look back over the previous commissioning process and subsequent contract monitoring to understand what steps could be built in to improve the current project. Some of the main issues identified here are outlined below:

- More detail to be included in the Commissioning Strategy document, including details of the key components and funding. This information was only available at the invitation to tender stage and stakeholders have fed back that this made it difficult to meaningfully comment on the commissioning strategy and the viability of the model. See Sections 5.2 and 5.3.
- We have received consistent feedback from stakeholders that contracts should be commissioned for a longer duration during this commissioning cycle to give services the opportunity to develop their new models of delivery and improve partnership working with wider stakeholders. The Substance Misuse Team also recognise that short commissioning cycles can be unsettling for both service users and employees of currently commissioned services and wish to address this by commissioning longer contracts in the new system. See Section 5.5.

- The SMT would like to support collaborative working and encourage innovative practice. Where appropriate, specifications will not be overly prescriptive about service delivery to allow for innovation. BCC is committed to full-cost recovery (a principle of the Bristol Compact) and as such recognises that, in some cases, overhead costs may be different in collaborations. As we are keen to encourage collaboration between providers, we will take into account different costs of effective collaborative and managing multiple relationships and will ask bidders to provide details.

-The Substance Misuse Team received feedback from colleagues in Primary Care that they were not effectively consulted during the last round of commissioning. Given the particular pressures currently being experienced in primary care and the need to have effective working relationships to address the needs of substance misusers in this setting, the Substance Misuse Team have looked to address this need by being more targeted in the pre-consultation period whilst building in plans to target this cohort in the formal consultation period.

## 5 Formal Consultation Stage

A formal consultation period was held with stakeholders between January and April 2017. A number of events were held as well as an online survey.

We asked Stakeholders attending events and completing an online survey to tell us about themselves to ensure our consultation was fair and accessible. 77% said they worked or had worked in substance misuse services and 19% said they worked for another type of service. 24% had used substance misuse services themselves and 22% were carers of someone who had experienced drug/alcohol problems. 14% of participants told us they had experienced problems with drugs/alcohol but not accessed ROADS services.

Participant demographics: Gender was split evenly between male and female. 90% were aged 18-64 with no responses from children. 13% were BME. 32% told us they held a religion or belief. 7% were disabled. 14% said they were lesbian, gay or bisexual. No participants told us they were transgendered.

Stakeholders	Method	Number of participants
All stakeholders	Online survey	82
All stakeholders	4x locality consultation events	96
Service users including peer supporters and family/carers	11 x focus groups and interviews	109
Staff / workforce of commissioned services	3 x Staff Meetings	113
GPs and primary care liaison workers	Events and meetings	35
Residential rehab providers	Event	19
Written responses from agencies and individuals	Email	18
Relevant professionals	Equalities Impact Assessment Workshop	12
Relevant professionals	VOSCUR hosted Event	7

Stakeholder feedback	Our response
<p>System wide</p> <ul style="list-style-type: none"><li>The proposed model for service delivery is generally positive</li><li>Ensure that transition between services is as smooth as possible</li><li>Mixed views about where to hold assessment coordination function</li><li>Need a ROADS website and main contact phone number, with increased digital offer to maximise accessibility</li></ul>	<p>We will</p> <ul style="list-style-type: none"><li>Clarify the proposed assessment process and referral pathways in the final commissioning strategy and tender documents</li><li>Ensure commissioned providers work with BCC to demonstrate how equalities groups are supported both as service users and within the workforce.</li></ul>

Stakeholder feedback	Our response
<ul style="list-style-type: none"> <li>Include provision for NPS / other drugs</li> </ul>	<ul style="list-style-type: none"> <li>Make sure there are ROADS services suitable for people using NPS / other drugs</li> </ul>
Commissioning approach and allocation of resources	<p>We will</p> <ul style="list-style-type: none"> <li>Consider tenders using a revised financial evaluation to make it fairer for smaller organisations</li> <li>Ensure contracts have variation and termination clauses which allow for changes over time.</li> <li>Have an annual review process to manage funding fluctuations.</li> <li>Where possible allow extra time for commissioning and implementation</li> <li>Review our financial evaluation process</li> </ul>
Specialist Nursing Provision	<p>We will</p> <ul style="list-style-type: none"> <li>Include that midwives are able to engage with clients at the most appropriate location</li> <li>Increase information sharing and liaison with the ROADS system</li> <li>Ensure close collaboration in the development for the service specifications for specialist nursing provision and the Complex Needs service</li> </ul>
In-Patient (Detox & Stabilisation) and Residential Rehab	<p>We will</p> <ul style="list-style-type: none"> <li>Work with the current inpatient facility to support the viability of this service remaining.</li> <li>Ensure that rehabs can demonstrate that they are effective in delivering detoxes and ensure that services are enabled to assess clients for this level of detox.</li> </ul>
Complex Needs Service	<p>We will</p> <ul style="list-style-type: none"> <li>Remodel the service to case-hold the top 10% of complex clients in the system. In addition to this an enhanced liaison role will be</li> </ul>

Stakeholder feedback	Our response
<ul style="list-style-type: none"> <li>Risks that the service would be too clinical in its delivery</li> <li>Concerns raised that the service would not work with risks in a proactive way which could lead to barriers in accessing the service.</li> <li>Risk of the service becoming 'clogged up' that would prevent new clients entering this service.</li> </ul>	<p>expected of the service, which will work with more clients across the system to reduce complexity.</p> <ul style="list-style-type: none"> <li>Ensure that the service has a multi-disciplinary team to meet the multiple needs of clients.</li> <li>Specified that the service will need to demonstrate how they will proactively work with risks and overcome any barriers for clients who are not engaging in treatment.</li> <li>Ensure that integrated pathways are developed with other ROADS elements and develop agreed threshold guidance.</li> </ul>
<b>Community Recovery Service</b> <ul style="list-style-type: none"> <li>Agreement for increasing local delivery</li> <li>Mixed views about the best locations to deliver locality services from</li> <li>Providers should share premises flexibly with other local community services rather than committing to separate premises.</li> <li>Good idea to offer relapse prevention following all detox but need to ensure there is capacity and a smooth transition between services</li> <li>Risk that treatment will be too short with not enough aftercare</li> <li>Increased peer support service very positive but need to ensure peers have suitable resources, a central hub, and host agencies must provide meaningful roles and workplace support</li> <li>Lack of TEVE service may reduce positive outcomes so link with outside services that support training, work and volunteering.</li> <li>Workforce development function will help make links with outside organisations and overcome stigma/discrimination</li> <li>The working title of CRC is confusing</li> </ul>	<p>We will</p> <ul style="list-style-type: none"> <li>Make sure there is a flexible local offer that works in partnership with existing community resources.</li> <li>Provide anonymised maps showing where current service users are located to help providers make realistic proposals</li> <li>Liaise with VOSCUR and BCC Employment, Skills and Learning Team to identify links with training education and employment opportunities</li> <li>Ask CRCs to include open-access and low-threshold aftercare interventions</li> <li>Rename to a working title of the Community Recovery Service</li> </ul>

Stakeholder feedback	Our response
Substance Misuse (Alcohol & Drugs) Liaison	
<ul style="list-style-type: none"> <li>• 4-6 weeks is a tight timeframe to prepare someone for alcohol detox and deliver post detox care</li> <li>• Specialist support will be needed to support primary care delivery</li> <li>• Limited amount of psychosocial interventions will be possible in alcohol detox shared care model</li> <li>• Can peer supporters boost capacity in GP surgeries and help support transition to aftercare etc?</li> <li>• Most opiate clients are poly drug users – how will this be addressed?</li> </ul>	<p>We will</p> <ul style="list-style-type: none"> <li>• Make sure timeframes are linked with need and ensure clients with increased complexities are seen by the appropriate service. Post-detox support pathway to Community Recovery Service will be established at the pre-detox stage to ensure continuity of care.</li> <li>• Ensure the Complex Needs service will be able to offer liaison and advice to primary care</li> <li>• All clients will have a package of care agreed prior to detox to ensure appropriate access to psychosocial interventions from ROADS services</li> <li>• Make sure Peer support workers are an essential part of supporting clients through detox and into the Community Recovery Service</li> <li>• Set an expectation that Opiate Substitution Therapy includes the provision of interventions that reduce the harm, and increase cessation, of all substances being used (including crack, alcohol and NPS)</li> </ul>
GP Public Health Service (Alcohol & Drugs)	
<ul style="list-style-type: none"> <li>• Payment needs to properly cover the cost of an alcohol detox</li> <li>• Room Space is an issue within practices and additional clients may put strain on the system</li> </ul>	<p>We will</p> <ul style="list-style-type: none"> <li>• Introduce a two tier approach to alcohol detox. Initially starting with mild to moderate dependencies in primary care followed by an enhanced approach with interested practices – including enhanced payments once primary care detoxes established</li> <li>• The service will operate within the capacity of the participating practices.</li> </ul>
Pharmacy Public Health Service	
<ul style="list-style-type: none"> <li>• Concern about large cohort on OST being maintained for years – impact on their health and future wellbeing. Model assumes</li> </ul>	<p>We will</p> <ul style="list-style-type: none"> <li>• Ensure that all maintenance prescribing is reviewed (at least 3 monthly in line with guidance) and</li> </ul>

Stakeholder feedback	Our response
capacity for primary care based on maintenance clients being seen infrequently – but they still need thorough regular reviews	ensure the offer of a detox is regularly reviewed.
<b>Early engagement and intervention</b>	
<ul style="list-style-type: none"> <li>Need to make it explicit that this is for people at all levels of need who are not already engaged in services</li> <li>Little money available for staffing the service. Large non-staff costs (NSP stock, BBV tests, naloxone, clinical waste, etc.)</li> <li>Very opiate focussed. Missing explicit reference to provision for people using NPS and where it fits in the model</li> <li>Needs a specific focus on engaging equalities communities</li> </ul>	<p>We will</p> <ul style="list-style-type: none"> <li>Ensure the service is targeted to work with people actively using drugs and alcohol in order to increase contact with ROADS services</li> <li>Increase the funding for the service to ensure it can be staffed appropriately</li> <li>Include NPS, non-opiates and alcohol in service specifications</li> <li>Make explicit reference to the need to address the needs of people with protected characteristics</li> </ul>
<b>Families and Carers Support</b>	
<ul style="list-style-type: none"> <li>Most people agree joint commissioning with South Glos. and B&amp;NES is good idea but if this is not possible the service will be underfunded.</li> </ul>	<p>We will</p> <ul style="list-style-type: none"> <li>Commission a new service with South Glos and B&amp;NES.</li> <li>If we are not able to jointly commission this service with other local authorities we will include the functions as part of Community Recovery Service to maximise efficiency.</li> </ul>
<b>Substance Misuse Accommodation Pathway</b>	
<ul style="list-style-type: none"> <li>Agreement for increasing amount of prep housing</li> <li>Complex clients may not have their needs met if substance misuse floating support is decommissioned</li> <li>If abstinent housing is decommissioned there may not be enough suitable accommodation for people in early recovery</li> <li>Agreement for commissioning homelessness prevention peer support together with ROADS</li> </ul>	<p>We will</p> <ul style="list-style-type: none"> <li>Review the needs of all long-term floating support clients and potentially refer some to the Complex Needs service</li> <li>Allocate some appropriate low support accommodation for newly abstinent tenants.</li> <li>Nb These proposals are part of a separate commissioning process: <a href="#">Preventing Homelessness Accommodation Pathways – families and adults (22+)</a></li> </ul>
<b>Hosted Case Management System</b>	
<ul style="list-style-type: none"> <li>Avoiding disruption to ROADS services is a priority</li> </ul>	<p>We will</p> <ul style="list-style-type: none"> <li>Award new contract separately</li> </ul>

Stakeholder feedback	Our response
<ul style="list-style-type: none"> <li>• Need to have a system that will work across multiple sites.</li> </ul>	<p>from other ROADS contracts to avoid disruption</p> <ul style="list-style-type: none"> <li>• Ensure that successful the provider has a comprehensive training and implementation plan</li> </ul>

## 6 Commissioning Model

### 6.1 In and Out of Scope

#### In Scope – Competitive

The funding from the following contracts will contribute to the re-commissioning budget. The activity that each of these contracts provides has been considered and has informed the development of the future model that is being put out to the market for competitive tender.

Contract	Provider
Engage Cluster	St Mungos
Change Cluster	AWP
Completion Cluster	BDP
Support Cluster	DHI
Residential Rehabilitation	Various spot providers through a framework
Homeless Health Prescribing Service (SMART services)	Brisdoc
Child minding/support to access services	BCC
Probation – Drug Rehabilitation Requirements	CRC
Eden House dual diagnosis service	Eden House
Maternity Drug Service – Social Worker Element	BCC
Hosed Case Management System	Cybermedia Solutions Ltd
Wet Clinic	Brisdoc

### **In Scope – Not Competitive**

The funding from the following contracts contributes to the re-commissioning budget but will not be put out for competitive tendering. The \* denotes that the activity that each of these services has been considered and deemed most appropriate to re-negotiate with current contract holders given the settings. Whilst it is our intention to take this approach and re-model the services in line with the newly commissioned system this is subject to the approval of the Health and Wellbeing Board and BCC's Commissioning and Procurement Group.

<b>Contract</b>	<b>Provider</b>
<b>Maternity Drug Service- Midwife Element*</b>	UBHT and NBT
<b>Hospital Based Alcohol Nurses*</b>	UBHT and NBT
<b>Hospital Based Drug Liaison Nurses*</b>	UBHT and NBT
<b>Inpatient Stabilisation and Detox Unit*</b>	AWP

### **In Scope – Procurement Approach To Be Confirmed**

Primary Care is an integral part of the treatment system in delivering opiate substitute prescribing, alcohol detox prescribing and supervised consumption services. We are currently exploring procurement options and are not in a position to ask the H&WBB to take a key decision on this element of the ROADS model. We will return at a later date and will update the commissioning strategy accordingly.

<b>Contract</b>	<b>Provider</b>
<b>Pharmacy contracts</b>	Participating pharmacies across Bristol
<b>GP contracts</b>	Participating GP surgeries across Bristol

### **In Scope – Preventing Homelessness**

Funding from the following contracts is contributing to the commissioned adult homelessness prevention services.

<b>Contract</b>	<b>Provider</b>
<b>ROADS Housing Support</b>	ARA
<b>Housing Solutions</b>	BCC

### **Out of scope**

Within the Substance Misuse budget there are a number of elements that are not directly related to service delivery and as such these are out of scope.

#### **Contract**

**Contribution to Integrated Healthy Lifestyle Service**

**GP with special interest**

**West of England High Risk Offenders Floating Support**

**Contribution to Violence Against Womens and Girls specialist Refuge**

**Contribution to Drugs & Young People Project (DYPP).**

**Contribution to CAMHS YP service**

**Substance Misuse Team**

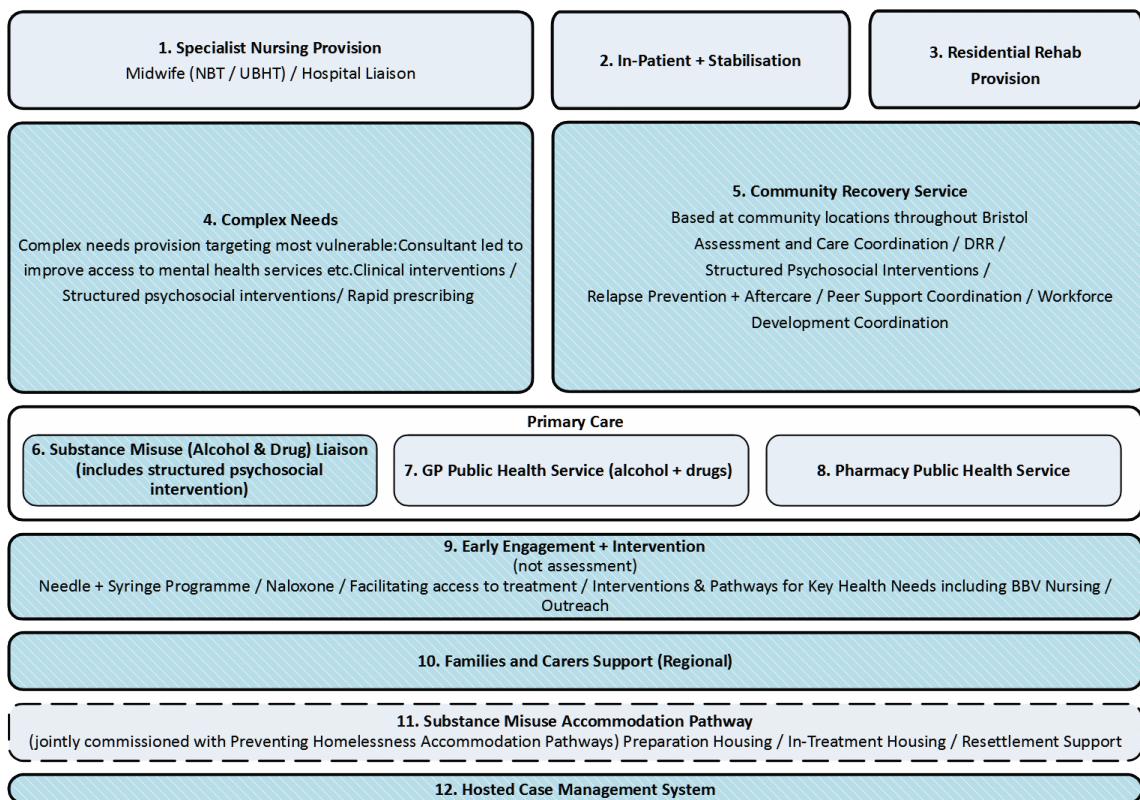
**RCGP training - alcohol and drugs**

**Drug Testing Court Orders (CRC delivered)**

## 6.2 Proposed treatment model - ROADS

The intention is to keep the ROADS brand for the newly commissioned treatment system. Stakeholder feedback has highlighted that this brand is now well known across the city to both service users and referrers.

The model has been designed based on the findings outlined in Sections 3,4 and 5 alongside national guidance, local policy and best practice for substance misuse treatment and support.



The new ROADS model will consist of 11 integrated elements:

### 1) Specialist Nursing Provision

#### Substance Misuse Midwife

Substance misuse specialist midwives will operate from the city's maternity units to co-ordinate the midwifery care for women who misuse substances in pregnancy or pregnant women who are in substance misuse treatment. The midwives will liaise closely with the consultant obstetricians, neonatologists and Complex Needs service when planning care for these women and their families.

## **Hospital Substance Misuse Liaison Nurses**

A team of substance misuse specialist nurses will operate from Bristol Royal Infirmary and Southmead Hospital. The team will improve health outcomes for people admitted to hospital who use drugs and/or alcohol; reduce repeat attendance and admissions to hospital; and ensure continuity of care with community substance misuse services (including ROADS for Bristol residents) upon discharge from hospital.

## **2) Inpatient Detox & Stabilisation**

This element will need to provide a clinically safe inpatient detoxification or stabilisation regime to the most complex individuals whose needs cannot be met in the community or through a residential rehab detox.

This provision will be required to provide a planned regime of 24-hour medically directed evaluation, care and treatment of substance related disorders in an acute care inpatient unit. This will be staffed by designated addiction accredited physicians, as well as clinicians and recovery workers.

This service will provide medically supervised prescribing, assessment, care and treatment to individuals requiring detoxification from either drugs or alcohol or stabilisation on opiate substitution therapy (OST) where abstinence is not the goal.

## **3) Residential Rehab(Detox, Primary and Secondary)**

Residential rehabilitation is a specialised service offering accommodation, support and rehabilitation to people with complex drug and/or alcohol and other health needs. This will be provided according to a recovery plan and will include intensive and structured programmes delivered in a residential environment.

The Substance Misuse Team intend to commission a range of residential rehab across the country in order to meet individuals needs for this type of intervention. The following placements will be commissioned from residential rehab providers:

- Detox placements which will usually be provided for up to 2 weeks.
- Primary stage one placements which will usually be for 12 weeks, with a minimum of 6 weeks and a maximum of 16 weeks.
- Secondary stage two placements which will usually be for 12 weeks, with a minimum of 6 weeks and a maximum of 16 weeks.

Residential rehab providers who are placed on the dynamic purchasing system will be required to form close working relationships with the Complex Needs provider of the ROADS system to ensure prompt access in to rehab, joint care coordination during the placement and effective aftercare planning at the end of the placement.

A dynamic purchasing system (open framework) is being proposed as a way of commissioning these elements to ensure value for money and to provide a greater degree of competition and transparency in the market place. It is envisaged that a formal tender process will be carried out to establish a Res Rehab and Detox Framework of approved support providers through this process. The Substance Misuse Team will be considering both block and spot purchases on this framework to ensure we get the best value for money for this provision and propose to continue to manage the placing of clients in rehab.

#### **4) Complex Needs**

In order to reflect the increasing levels of complexity for substance misusers at both a local and national perspective, this complex needs provision will be required to identify and case hold the most vulnerable and chaotic clients across the city who are affected by substance misuse (we predict this cohort to be in the region of 10% of the overall treatment population).

This service will need to demonstrate how it can provide an enhanced offer to those most severely affected by physical and mental health needs that are unable to engage in mainstream substance misuse provision and have multiple barriers to working towards recovery. Key to this success will be how the service proactively links in with local physical and mental health services to collaborate and optimise the treatment offer for complex clients. This service will need to demonstrate how it intends to meet the needs of 'dual diagnosis' clients, particularly around trauma and post traumatic stress disorder in relation to their substance misuse.

It will need to deliver high level consultant led treatment for these clients whilst also providing clinical leadership and advice through a liaison style approach to support partners in the substance misuse system as well as primary and secondary care support across Bristol. We envisage this service to have a skills mix of professions to most effectively engage with these complex clients. This will include but not be restricted to non-medical prescribers, social workers and psychiatrists. It will also need to work closely with the 'Specialist Nursing' provision element of ROADS to care coordinate pregnant women alongside specialist midwives and hospital discharges with drug liaison nurses.

This service will be required to offer a range of specialist drug related interventions to including rapid and relapse prevention prescribing, community detoxification, BBV services and drug testing in order to engage these complex clients. This service will also need to demonstrate how it will work with homeless health services to meet the prescribing needs of this population. Furthermore intensive psychosocial interventions will be delivered in either a one to one or group setting for both service users who are receiving medically prescribed and non medically prescribed treatment as part of their recovery care plan.

## **Facilitating Access to Res Rehab**

This element of the Complex Needs service will lead on facilitating access to residential rehab placements for clients in need of this higher intensity by utilising the newly commissioned Res Rehab and Detox Framework. They will need to demonstrate how they will deliver this element to both clients open in the Complex Needs service and those in other parts of ROADS where community relapse prevention has been unsuccessful and they require additional support in their recovery.

## **Transitions**

The Complex Needs service will include a named worker who will work closely with young people's substance misuse services. This person will support the most vulnerable young people (from age 17) to make the transition from young people to adult services and provide for ongoing structured treatment support as required. The transitions service will be required to engage with the Bristol Young People Friendly quality standard process and to have achieved this within a year of the contract being awarded. Close working links with young people's substance misuse treatment services and other services engaging with the most vulnerable young people will be required and clear information sharing agreements will be put in place to support the transition between providers.

## **5) Community Recovery Service**

The Community Recovery Service will deliver a range of one-to-one and group-work psychosocial interventions in line with best practice to support individuals in their recovery. Interventions will include those suitable for service users referred from criminal justice e.g. Drug Rehabilitation Requirements (DRR). The use of digital interventions should also be utilised where appropriate at all stages of an individual's recovery journey.

The Community Recovery Service will play an essential role in ensuring there is enough capacity to deliver relapse prevention support for all individuals who undertake detoxes (both opiates and alcohol) within ROADS. Facilitating access to mutual aid and linking in with wider recovery support across the local community will also be key in delivering this element successfully.

We recognise the importance of individuals accessing support around their substance misuse at locations that are easily accessible to them. We will commission a flexible service that works in partnership with existing community resources to provide a locality based Service situated across various sites in Bristol.

The Community Recovery Service will be required to comprehensively assess an individual's needs to support them in their recovery. This will include all assessments that will take place in a primary care setting. An individually tailored package of treatment and support will need to be offered to reflect their levels of need and stage of recovery. Recovery care plans will need to be collaboratively developed with individuals and reviewed periodically to ensure that they are continuing to benefit from treatment and support.

### **Peer Support**

We recognise that peer support plays a pivotal role in supporting recovery and contributes to a wide range of positive outcomes including tackling discrimination and stigma; advocacy; providing opportunities for education training and employment etc.

We will commission a Peer Support Coordination function as part of the Community Recovery Service to support peers and facilitate a high quality training programme. The service will have strong links with all other ROADS functions to ensure that peer support is available throughout the entire recovery journey. Adult homelessness prevention services will contribute additional funding to increase the capacity of the peer support element to recruit, train and supervise people with experience of homelessness, and match them to support people in homelessness services.

To facilitate the peer support element of the Community Recovery Service we will require all ROADS providers to be accountable for facilitating placements and overcoming barriers with appropriate targets in place to ensure this happens.

### **Workforce Development**

We are committed to ensuring that ROADS has a skilled workforce and that other organisations in Bristol have a good understanding of substance misuse and are able to work with people who use drugs and alcohol or who are in recovery. Whilst all ROADS providers will be expected to contribute to delivering internal and external workforce development to support this we plan to commission a new workforce development role. Based in the Community Recovery Service this role will co-ordinate activity and work with partners to maximise the training, development and equality good practice that is embedded within all ROADS services.

This role will facilitate collaborative working, skill-sharing and emerging good practice between ROADS agencies; coordinate substance misuse awareness training for other professionals; promote equality of opportunity and anti-discriminatory practice by establishing strong links with statutory and non-statutory organisations, local business, communities and faith based groups.

## **6) Substance Misuse (Alcohol and Drugs) Liaison**

The substance misuse liaison service (SML) will operate out of GP practices participating in the Alcohol Detox and/or OST primary care local enhanced contracts. The SML will care coordinate primary alcohol and opiate clients attending their GP practice for pharmacological interventions, deliver appropriate psychosocial interventions commensurate to need and facilitate pathways with the Community Recovery Service.

It is intended that this will be an integrated service with practitioners' caseloads comprising primary alcohol and primary opiate clients to maximise capacity and ensure the greatest geographical coverage.

### **Community Alcohol Detox**

The SML will be expected to enable capacity for 1,488 primary alcohol clients to undertake community alcohol detoxes per year. It is expected that the SML will prepare clients for detox, support them through the withdrawal process and offer brief post-detox support to facilitate access to the Community Recovery Service for ongoing psychosocial interventions, relapse prevention and aftercare. It is envisaged that the SML will work with clients for 4-6 weeks (although this may be longer dependent on the needs of the client).

Effective working relationships with GP practices participating in the Community Alcohol Detox GP Public Health Service will be vital for the success of this function.

### **Opiate Substitution Therapy**

The SML will be expected to enable capacity to case manage approximately 1,600 opiate clients accessing opiate substitution therapy at any given time. Care coordination, strategic reviews and packages of psychosocial interventions will be delivered by the SML to all clients accessing primary care for OST.

Effective working with colleagues in Primary Care and the Early Engagement and Intervention service will be vital to ensure there is access to priority interventions including hepatitis B vaccinations and testing for hepatitis B, hepatitis C and HIV. Supporting clients to access healthcare to ensure early identification and treatment of conditions, such COPD and other respiratory illness, to minimise the impact of ill-health will be a key deliverable of the SML.

After undertaking a period of assessment and stabilisation commensurate with their level of need clients receiving OST will have access to maintenance and detox pathways.

### **Opiate detox pathway**

The detox pathway will require the SML to deliver a 12 week reduction programme for clients identified as motivated and clinically appropriate to undertake withdrawal from their opiate substitute medication. This will include the delivery of higher intensity treatment and will be expected to facilitate access with the Community Recovery Service for relapse prevention and aftercare as a prerequisite of undergoing detox.

### **Community Maintenance Pathway**

The community maintenance pathway will be available to those clients not yet appropriate for detox but who meet the agreed definition of being in medically assisted recovery. Due to clients' adherence to treatment a lower intensity and frequency of treatment would be expected to be delivered within this pathway. The SML will be expected to continuously assess the suitability for detox alongside clients' strategic care plan reviews.

## **7) GP Public Health Service (Alcohol and Drugs)**

### **Primary Care Alcohol Detox – GP Public Health Service**

A 'shared care' service is the preferred model to be commissioned for the delivery of community alcohol detoxes. A GP Public Health Service is being negotiated to increase the availability of prescribing for alcohol withdrawal within Primary Care. The Substance Misuse Liaison service will support the delivery of this service by delivering care coordination, psychosocial interventions and facilitating the onward pathway to other services to support the success of the detox.

### **Primary Care Opiate – GP Public Health Service**

A GP Public Health Service is being negotiated to provide the prescribing for opiate substitution therapy in Primary Care settings for people who are opiate dependent. Access to the wider services on offer in health centres, e.g. vaccinations for HBV, will be enabled through the service. The Substance Misuse Liaison service will support the delivery of this service by delivering care coordination, psychosocial interventions and facilitating the onward pathway to other services.

## **8) Pharmacy Public Health Service**

A Pharmacy Public Health Service is being negotiated for the supervision of opiate substitution therapy in pharmacies. It is not envisaged that this will be significantly different to the supervised consumption arrangements that are currently in place.

## **9) Early Engagement and Intervention**

The Early Engagement and Intervention service will operate across Bristol in order to engage with active substance users, including those who are not in contact with ROADS services. As well as alcohol, opiates and crack cocaine, this will include engaging with people who use non-opiates, Novel Psychoactive Substances, and performance and image enhancing drugs.

Interventions to improve health and reduce the harms associated with drug and alcohol use will be delivered as well as supporting those furthest away from services to access treatment in a timely manner.

### **Outreach/early engagement and intervention**

Contact with non-treatment seeking drug and alcohol users will be established to ensure early interventions can be delivered to reduce health complexities and support people to access services to improve the wellbeing of individuals not currently accessing ROADS services. This will need to include in-reach to hostels and non-commissioned dry-houses as well as effective partnership working with allied services (e.g. homelessness, mental health, etc.) and facilitate access to help meet individuals' needs.

### **Facilitating access to treatment**

Opportunistic interventions will be delivered to increase motivation to change and, where need necessitates, assess clients to ensure speedy access to structured treatment. Early reengagement pathways for clients dropping out of opiate substitution therapy and alcohol detox treatment will be developed to ensure clients can be rapidly reengaged

### **Needle and Syringe Provision (NSP)**

NSP will be delivered across Bristol to ensure availability of injecting paraphernalia to reduce blood borne viruses and infections in people who inject opiates/crack, non-opiate drugs (including emerging/novel psychoactive substances) and image and performance enhancing drugs (IPED). NSP will be supplied through a range of sites, including pharmacy, agency based and mobile (including outreach), all of which will be coordinated by the contract holder.

Over one million needles were supplied to people who inject drugs in Bristol in 2015/16, with an approximate 50:50 split between pharmacy and agency/outreach provision. The coverage rate of needles supplied per estimated injection stood at 66% for 2015/16 and increasing the coverage rate of needle supply will be a key deliverable of this contract.

The NSP will be expected to identify clients not accessing any form of structured treatment and ensure motivational interventions and referral pathways are effective in engaging people into ROADS. Additionally, early re-engagement pathways with providers of opiate substitution therapy for clients dropping out of treatment will need to be in place to ensure clients no longer benefitting from the protective factors of treatment can be rapidly reengaged.

### **Naloxone supply to individuals at risk of overdose**

The supply of naloxone to opiate users and those likely to be in contact with people at risk of overdose will be coordinated through this contract. This will include, but not limited to, targeting people who inject drugs; families and carers of people using opiates; hostel/supported housing workers; and supporting providers of OST and community & inpatient detox to ensure their clients receive naloxone. Opiate clients dropping out of treatment will be a priority group.

### **Interventions and pathways for key health needs**

Interventions to support the identification and prevention of blood borne viruses will be coordinated through the Engagement contract. Dry blood spot testing and venous blood specimens will be available for the detection and diagnosis of hepatitis B, hepatitis C and HIV for those clients identified as being at risk. Care pathways will be established for clients receiving positive results and supporting clients to engage in services. A clinical lead will be responsible for ensuring the quality and effectiveness of interventions and ensure pathways with NHS services are accessible for the client group.

Clinical support will be available for clients experiencing harms associated with drug and alcohol use. This will include wound care and injecting related infections as well as coordinating ROADS responses to emerging health needs and working with health protection colleagues in the event of an outbreak scenario.

Utilisation of peers will be critical to increase the reach of health protection and harm reduction messages to hard to engage clients.

## **10) Families and Carers Support (Regional)**

We are keen to jointly commission a sub-regional Families and Carers service alongside neighbouring local authorities South Gloucestershire and Bath & North East Somerset. This service will work with adults<sup>3</sup> who are affected by someone else's substance use, including significant others and close friends as well as families and carers.

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<sup>3</sup> Children in Bristol who are affected by someone else's substance misuse are currently supported by Hidden Harm services provided by Bristol Youth Links and Drugs and Young People Service.

The Family and Carers service will help affected others learn more about substance misuse and treatment, and give them new skills to better cope with problems as they arise. The service will also offer opportunities for peer support, and promote affected others' involvement in treatment services where appropriate.

A joint regional service will need to have a strong local offer with good links to community organisations and area based support. To increase accessibility we expect that the Families and Carers service will offer a wide range of support e.g. information and training, advice and signposting, support groups, one to one support, online and telephone support.

## **11) Substance Misuse Accommodation Pathway**

Providing housing support for drug and alcohol users working towards recovery continues to be a priority and we have allocated £750,000 to redefine the substance misuse accommodation pathway as part of the commissioned adult homelessness prevention services.

Because there are already established providers of these accommodation based services, and a very limited supply of accommodation that can be used for the purpose, we plan to negotiate new contracts with the current providers. This has been approved by Cabinet.

Our proposal is to maintain the current overall number of accommodation units, increase the units of preparation accommodation to meet increased demand, and keep in-treatment accommodation. To do this we will no longer provide abstinence housing, or have a substance misuse specific floating support service.

The risks posed by stopping providing a substance misuse specific floating support service can be partly mitigated by better equipping people during the preparation and in-treatment services to maintain independent living as well as ROADS providing support in their recovery planning. There are also generic floating support services in Bristol that may be able to provide support to ROADS service users, and the Council is currently reviewing all commissioned floating support services to address a potential gap in provision for complex clients.

ROADS providers and other nominated referrers, including the Rough Sleepers Team and prisons, will be able to make a direct referral into substance misuse housing (where assessment has already taken place and been approved). Links between ROADS and other preventing homelessness provision will be improved through workforce development and integrated peer support coordination.

Full details about the proposals for new accommodation pathways can be found in a separate draft commissioning plan “Preventing Homelessness Accommodation Pathways (families and adults 22+)”

[https://www.bristol.gov.uk/housing/commissioning-homelessness-prevention-services.](https://www.bristol.gov.uk/housing/commissioning-homelessness-prevention-services)

## **12) Hosted Case Management System**

In 2010 we commissioned Cybermedia Solutions Ltd to provide an integrated, multi-agency, caseload system ('Theseus') for the management of substance misuse clients across the city. There are over 20 agencies / teams registered on the system including non-ROADS and housing providers, and around 200 active Theseus users.

Our case management system allows practitioners to record details of their work with substance misuse clients and share this information securely with other providers and commissioners. The software also collates provider performance information for commissioners, and facilitates the reporting of all required data to Public Health England etc.

We feel it is important to maintain these functions and for BCC to remain the Data Owner. As our contract expires in 2017 we plan to recommission our hosted case management system and this interrelated procurement process will take place to ensure that the contract starts prior to the ROADS go live date.

## 6.3 Proposed Tendering Approach and Allocation of Resources

<b>Contract</b>	<b>Proposed Contract Value</b>	<b>Proposed Purchasing Option</b>
<b>Specialist Nurse Provision (hospital based)</b>	£260,000	Direct Award
<b>Inpatient</b>	£550,000	Direct Award
<b>Residential Rehab</b>	£680,000	Open Framework (Dynamic Purchasing System)
<b>Early Engagement &amp; Intervention</b>	£1,000,000	Competitive Tender
<b>Substance Misuse Liaison</b>	£1,400,000	Competitive Tender
<b>Primary Care Costs<sup>4</sup></b>	£2,100,000	Direct Award
<b>Community Recovery Service</b>	£1,450,000 (Preventing Homelessness to contribute additional £50,000 for peer support)	Competitive Tender
<b>Complex Needs</b>	£1,120,000	Competitive Tender
<b>Families &amp; Carers Support</b>	£80,000 (South Glos & B&NES to make additional contributions)	Competitive Tender (regional)
<b>Hosted Case Management System</b>	£30,000 <sup>5</sup>	Competitive

<sup>4</sup> This includes drug and alcohol public health services, pharmacy public health service and prescribing costs

		Tender
<b>Substance Misuse Accommodation Pathway</b>	£750,000	Co-Commission with Homelessness Team. Negotiate with current providers

For planning purposes the proposed competitive tender contract values have been calculated by considering the posts required to deliver the proposed functions and 40% on costs/management fees have been applied.

## 6.4 Evaluation Approach

The proposed evaluation criteria are 80% quality and 20% price. A panel will be formed to include a range of stakeholders and perspectives and the views of service users will form part of the evaluation. Details of the panel will be released in the tender documents.

Bids will be invited up to the contract ceiling, this amount is the maximum available for the contracts and bids must not exceed this figure unless the bidder brings in significant other resources.

There will be no inflationary uplift for the duration of the five year contract. Bidders are expected to factor in any increased costs into their proposals. Annual contract reviews will take place throughout the life of the contract and the financial position and changes will be considered as part of this.

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<sup>5</sup> Based on current hosting and admin costs and excluding perpetual software license, migration and set up costs

In line with BCCs Social Value policy<sup>6</sup> providers must also consider how they can provide additional social value to Bristol. This could include, for example, tackling stigma of people who misuse substances, creating apprenticeships, using local contractors including those with social objectives. As a minimum 10% of the quality score will be related to adding social value. Bidders may wish to refer to the Social Value Toolkit<sup>7</sup> to consider how they could incorporate social value into their proposals.

Furthermore BCC aims to spend at least 25% of the Council's total procurement budget with micro, small and medium size businesses, social enterprises and voluntary / community organisations (less than 250 employees). Within this commissioning process we intend to encourage that at least 25% of the funding available in the competitively tendered contracts goes to micro, small and medium size businesses, social enterprises and voluntary / community organisations. This could be achieved through collaborative bids from providers working together in, for example, lead partner collaborations or sub-contracting arrangements.

Sub-contracting arrangements are welcomed with the expectation that the majority of the activity will be carried out by the main provider as opposed to being sub contracted out which makes the contract management convoluted. Where collaborative bids or sub-contracting arrangements are proposed details will need to be provided at the Invitation to Tender stage where the role(s) of the subcontractors/collaborators will need to be provided with the approximate percentage of contractual obligations assigned to the subcontractor/collaborators.

Part of BCC's procurement process requires an assessment of the financial risk of individual providers. Further detail is included in Appendix 6. As part of this assessment to be designated low risk it is advised that a provider's annual turnover should be one and a half times the contract value. It is also recommended that this financial assessment is based on the total of all the contracts the provider is bidding for i.e. if an organisation applies for several contracts their risk should be assessed on the combined contract values. The Joint Commissioning Group will decide what level of risk would be acceptable prior to contract award.

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<sup>6</sup> <https://www.bristol.gov.uk/documents/20182/239382/Social+Value+Policy+-+approved+March+2016-1.pdf/391b817b-55fc-40c3-8ea2-d3dfb07cc2a0>

<sup>7</sup> <https://www.bristol.gov.uk/documents/20182/239382/Creating+Social+Value+-+Social+Value+Toolkit+-+approved+March+2016-1.pdf/a596f490-ab73-4827-9274-5025ca5a4f1b>

## **6.5 Contract Duration**

In line with evidence presented by the Advisory Council on the Misuse of Drugs<sup>8</sup> in relation to reducing drug related deaths the intention is to provide more stability by entering into five year contracts with the option to extend for a further two periods of two years each i.e. potentially nine years in total. This has been strongly supported by professionals and service users throughout the consultation, particularly with reduced funding. Strong ‘no fault’ break clauses will be included and an annual review process will be established to manage funding fluctuations and changes in service users’ needs during the contract period.

## **6.6 Performance Monitoring**

The Local Authority is responsible for ensuring that appropriate quality governance is in place for commissioned services and it is measured by Public Health England on the achievement of the following national Public Health Outcomes Framework (PHOF) indicators:

- 2.15i - Successful completion of drug treatment - opiate users
- 2.15ii - Successful completion of drug treatment - non-opiate users
- 2.15iii - Successful completion of alcohol treatment
- 2.15iv - Deaths from drug misuse
- 2.16 - Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison

The newly commissioned treatment system will contribute towards meeting these outcomes, in conjunction with other partners (e.g. prisons), by providing high quality services. Key to this will be the treatment system’s ability to deliver on the eight best practice outcomes outlined in the Government’s current Drug Strategy (any changes to these in the upcoming Drug Strategy will be updated accordingly):

- Freedom from dependence on drugs or alcohol;
- Prevention of drug related deaths and blood borne viruses;
- A reduction in crime and re-offending;
- Sustained employment;
- The ability to access and sustain suitable accommodation;
- Improvement in mental and physical health and wellbeing;
- Improved relationships with family members, partners and friends; and

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<sup>8</sup> Advisory Council on the Misuse of Drugs, Reducing Opioid-Related Deaths in the UK: December 2016

- The capacity to be an effective and caring parent.

In order to ensure ROADS services are delivered to the highest standards and achieve the best outcomes the Substance Misuse Team intends to implement a performance management framework based on the domains of Safety, Accessibility & Effectiveness, and Quality. All audits, performance measures and service user feedback will focus on these three strands.

1. Safety: Assurance mechanisms to monitor the safety of service delivery will include:
  - Safe prescribing of medication
  - Appropriate prescribing and dispensing
  - Safeguarding for children, young people and vulnerable adults
  - Adverse Incidents including drug related deaths
2. Accessibility and Effectiveness: Services will be monitored to demonstrate their ability to meet the needs of the population. Measures will include:
  - Waiting times
  - Service user retention rates
  - Successful completion rates
  - Representation rates
3. Quality: A programme of quality improvement activities will include:
  - Evidence based practice
  - Clinical audit
  - Continuing professional development
  - Research and development

In times of reducing resources, we recognise the need for outcomes of the treatment system to be both achievable and realistic. Therefore we propose:

- 1) To increase the use of standardised PHE outcome reports and tools (e.g. DOMES, NDTMS Reports) to measure the health of the treatment system. Bespoke local reports will be utilised to enable an immediate local focus on areas of interest to mitigate the time delay in PHE reporting processes.
- 2) That outcomes and key performance indicators will be developed and refined with the successful providers, as both part of the implementation period and formal contract review periods, to demonstrate the effectiveness of the contract.

## **6.7 Case Management System**

Commissioned providers will be required to use BCC's commissioned substance misuse case management system and for client records to be accessible, where appropriate, across the treatment system. Please see Section 6.2 for more information about recommissioning of this case management system.

## **6.8 TUPE**

Current and potential providers will need to be aware of the implications of both the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) as well as the updated "Collective Redundancies and Transfer of Undertakings (Protection of Employment) (Amendment) Regulations 2014.

When a service activity transfers from one provider to another, the relevant employees delivering that service may transfer from the old to the new provider on the same contractual terms and conditions of employment. In these cases, the new provider/employer takes on all the liabilities arising from the original employment contracts.

Bidding providers will need to consider the cost and other implications of TUPE. The council will obtain from current providers basic information about the employees who will potentially be affected by this commissioning process. It is our intention to provide such information in advance of the 28 days (prior to contract start) required by current regulations so that bidders can develop accurate proposals and budgets. Providers must seek their own legal and employment advice on TUPE. It is the responsibility of bidders/ providers to satisfy themselves regarding TUPE requirements.

In future contracts, we intend to include requirements of the contract holder to provide workforce information at earlier stages.

## 7 Timeline

This is the timeline we intend to follow. Please note that dates below are subject to change through the life of the project.

- Sign off final commissioning strategy at Health & Wellbeing Board: 28th June 2017
- Publish final commissioning strategy: 6th July 2017
- Provider tender events: 14th July 2017
- Invitation to tender: 18th July 2017 – 25th August 2017
- Award decision: Week commencing 9th October 2017
- Contract award: Week commencing 23rd October 2017
- Contract start: Week commencing 1st December 2017
- Implementation period: 1st December 2017 – 1st March 2018

After contract award time is needed for implementation to enable the safe transfer of clients and for staff organisation. An implementation budget has been established to factor in an overlap between incoming and outgoing provider.

As previously stated an implementation period has also been budgeted for.

## **Appendix 1: Glossary**

ACMD – Advisory Council on the Misuse of Drugs

ARA – Addiction Recovery Agency

B&NES – Bath and North East Somerset

BCC – Bristol City Council

BDP – Bristol Drugs Project

BSDAS – Bristol Specialist Drug and Alcohol Service

CCG – Clinical Commissioning Group

DHI – Developing Health and Independence

DOMES – Diagnostic Outcome Measurement Executive Summary

IPED – Image and Performance Enhancing Drug

NDTMS – National Drug Treatment Monitoring System

NHS – National Health Service

NICE – The National Institute for Health and Care Excellence

NSP - Needle and Syringe Provision

OST – Opiate Substitution Therapy

PHE – Public Health England

PHOF - Public Health Outcomes Framework

ROADS – Recovery Orientated Alcohol and Drug Service

SML – Substance Misuse Liaison

SMT – Substance Misuse Team

UKPDC - UK Drug Policy Commission

VCS – Voluntary and Community Sector

## **Appendix 2: Definitions**

### **Substance Misuse Definition**

Substance misuse is defined by the World Health Organisation as: "...the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs ... [which] can lead to dependence syndrome." Throughout this strategy where the term 'substance' is used, it is referring to both drugs and alcohol.

### **Recovery Definition**

The Substance Misuse Team have adopted the UK Drug Policy Commission (UKDPC) definition of recovery which explains "the process of recovery from problematic substance use as characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society" (UKDPC, 2008).

### **Commissioning Definition**

The Institute of Public Care (IPC) defines commissioning as the "process of identifying needs within the population and of developing policy directions, service models and the market, to meet those needs in the most appropriate and cost effective way". Each year Bristol City Council commissions or procures approximately £360 million (14/15) worth of goods, services and works. Commissioning and procurement are a vital area of the Council's operations.

### **Procurement Definition**

The National Procurement Strategy for Local Government defines procurement as "the process of acquiring, goods, works and services, covering both acquisition from third parties and inhouse providers. The process spans the whole cycle from identification of needs through to the end of a services contract or the end of the useful life of an asset. It involves options appraisal and the critical 'make or buy' decision which may result in the provision of services in-house in appropriate circumstances".

## Appendix 3: Legal Context and National Policy

**Health and Social Care Act (2012)** describes the local authorities' statutory responsibilities for public health services which conferred new duties on local authorities to improve public health. It abolished primary care trusts and transferred much of their responsibility for public health to local authorities from 1 April 2013. From this date local authorities have had a duty to take such steps as they consider appropriate to plan for improving the health of the people in their areas, including services to address drug or alcohol misuse.

**The Care Act (2014)** aims to improve people's quality of life, delay and reduce the need for care, ensure positive care experiences and safeguard adults from harm.

Local authorities are required to consider the physical, mental and emotional wellbeing of the individual needing care, and assess the needs of carers. They must ensure the provision of preventative services and carry out their care and support functions with the aim of integrating services with those provided by the NHS or other health-related services.

**The EU Public Contracts Directive (2014)** sets out the legal framework for public procurement. This directive includes the procedures which must be followed before awarding a contract to suppliers, where the contract value exceeds the thresholds set, except where specific exclusions apply. The fundamental principles of the EU Treaty are: free movement; non-discrimination; fairness; transparency and proportionality.

**Public Services (Social Value) Act 2012** requires all public bodies in England and Wales to consider how the services they commission and procure might improve the economic, social and environmental wellbeing of the area. To comply with the Act commissioners must think about how what they are going to buy, or how they are going to buy it could address these benefits, and must also consider whether they should consult on these issues.

**The Local Government Act (2000)** provides a general duty of best value to make arrangements to secure continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness.

**Equality Act (2010)** requires that when carrying out commissioning/procurement activity public bodies have regard to the: elimination of discrimination, harassment, victimisation and other analogous conduct; advancement of equality of opportunity between those who share protected characteristics and those who do not; and fostering of good relationships between those who share protected characteristics and those who do not.

**National Drug Strategy (TBC)** It is anticipated that a new National Drug Strategy will be published around the end of the calendar year of 2016 by the Home Office. Early indications suggest that it will build on and strengthen the approaches taken in the National Drug Strategy 2012 to reduce demand, restrict supply and build recovery. Any guidance and recommendations included in this document will be considered alongside local need in the development of the final Commissioning Intentions document:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/98026/drug-strategy-2010.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98026/drug-strategy-2010.pdf)

**National Alcohol Strategy (2012)** intended to change attitudes towards alcohol and reshape the approach towards tackling alcohol related harm. In terms of dependant drinkers, it aimed to increase the number accessing effective treatment in order to reduce the number alcohol related admissions and to reduce NHS costs.

**Modern Crime Prevention Strategy (2016)** sets out how to reduce drug-related crime prevention by focusing on three areas: treatment; diversion; and enforcement. It recognises that getting users into treatment is key, as being in treatment itself reduces levels of offending. It advocates for full recovery from dependence being the aim of treatment and that this is more likely to be achieved and sustained if users are given support to improve their 'recovery capital' – particularly around housing and meaningful employment. For a small cohort of entrenched, long-term opiate users who have not achieved recovery through optimised oral substitution treatment, there is evidence that heroin assisted treatment (supervised injectable heroin) reduces crime.

**The National Compact (2010)** is an agreement between the government and the voluntary and community sector (VCS) which sets out a way of working that improves their relationship for mutual advantage. It considers areas such as involvement in policy design, service design and delivery, funding arrangements, promoting equality and strengthening independence. Bristol City Council is fully committed to the Compact and elements of the Bristol Compact are integrated into this commissioning process.

## **Appendix 4: Recommendations from Substance Misuse Needs Assessment 2016**

### **Physical Health**

1. Continue to support the provision of naloxone.
2. Continue to support the police/coroner coordination to ensure that timely analysis of deaths and changes in trends inform treatment delivery.
3. Increase strategic priority for delivery of health protection and harm reduction interventions (including optimised doses and maintenance prescribing in line with PHE/ACMD advice) within structured treatment and opiate substitution therapy (OST).
4. Clear governance structures are needed to ensure auditability of key interventions (naloxone supply, optimised prescribing, etc.).
5. Request a full, public health led, health needs assessment, including matching of health/hospital records, of the opiate and crack using cohort
6. Consider the retention of primary care based provision of OST to ensure easy access to healthcare and to reduce burden on secondary health care, particularly Emergency Departments.
7. Continue to support homeless health services.
8. Retain a hospital based service to provide support to drug and alcohol users who are admitted to wards.
9. Continue to support a maternity service for pregnant substance misusing women and their partners. Investigate effectiveness and efficiency of various delivery options to maximise outcomes for both drug and alcohol users.
10. Continue to support needle and syringe provision to be delivered within NICE guidance. Investigate effectiveness and efficiency of various delivery options to maximise outcomes.
11. Ensure chemsex/slamsex participants and IPED are included in priority groups for targeting interventions.
12. Continue to support hepatitis specialist clinical leadership within treatment services.
13. Continue to support dry bloodspot testing– including HCV, HBV and HIV.

14. Explore ways of increasing opportunistic availability of HBV vaccinations throughout the treatment system.
15. Ensure HBV vaccinations are included in GP contract as a priority intervention and that data is recorded and shared appropriately.
16. Continue to work with PH colleagues to improve access to HCV treatment for clients.
17. Explore opportunity with sexual health commissioners of co-commissioning accessible services for MSM/LGBT clients with focus around chemsex/slamsex.
18. Continue to support hospital based alcohol liaison work.
19. Continue to support homeless alcohol services.
20. Ensure investment enables the provision and uptake of evidence-based specialist treatment for at least 15% of estimated dependent drinkers in line with DH guidance.
21. Ensure capacity allows comprehensive assessments for all individuals scoring 16 and over on Alcohol Use Disorders and Identification Test (AUDIT).

### **Mental Health**

22. Explore opportunities for increased joint working with the CCG (BMH Commissioners) to develop more effective service provision for dual diagnosis clients going forward. There is a need here to focus on how to work with substance misusers with less severe MH needs.
23. Improved data monitoring is required to understand the needs of dual diagnosis in Bristol. Further work is required as to how we can demonstrate good outcomes for this cohort in order to build these into future service specifications.
24. There needs to be further consideration regarding the offer of services for dual diagnosis clients when presenting in primary care to ensure that their needs are being best met.
25. Explore opportunities for co-location of staff to improve joint working and improve outcomes for dual diagnosis clients.
26. Explore opportunities for joint referral meetings between SM and MH services to improve joint recovery care planning.
27. Explore how feasible it is for social prescribing services to work with substance misuse clients with low level mental health needs and link with commissioners.

28. There is a need for improved workforce development for both substance misuse and mental health professionals around dual diagnosis issues. This needs to encourage confidence of when to refer between services and how to manage levels of risk appropriately.

29. Increase the strategic priority of dual diagnosis across SM and MH by holding 6 monthly dual diagnosis workshops with key stakeholders.

## **Housing**

30. Consider the possibility of having an outreach team for engaging substance misusing people into community treatment.

31. Co-locate SM professionals in Level 1 hostels to engage potential clients

32. Deliver a training package to preventing homelessness staff/staff in frontline services receiving prison leavers, such as hostels and homeless health services, in Spice use, its effects and treatment options.

33. Explore the potential for co-commissioning substance misuse housing with Preventing Homelessness services to benefit from economies of scale, fewer contracts and better pathways.

34. Further work with the Preventing Homelessness is required to explore the increases in homelessness in Bristol.

35. Work with BCC colleagues to understand whether substance misuse is a factor in evictions as well as whether substance misuse is a refusal reason for housing providers in the Preventing Homelessness pathway.

36. Consider increasing Preparation housing units to respond to levels of demand.

## **Relationships**

37. Safeguarding children is paramount and remains a key priority within substance misuse services.

38. Review what happens when children who have been exposed to parental substance misuse are taken into care.

39. Continue to link with the commissioners of young people's substance misuse services and the Drugs and Young People project to meet the needs of children effected by parental substance misuse.

40. Maintain close working with young people's treatment services to ensure a smooth transition for young people moving from young peoples into adult treatment.

41. Work closely with young people's services to identify young adults coming into treatment who are unknown to young people's services. This will identify gaps and strengthen prevention and harm reduction
42. There is a continued need to support clients to be good parents and to address the stigma that parents face as this could continue to prevent vulnerable clients accessing appropriate services.
43. The Think family/Early Help overlap with substance misuse services should be reviewed. All practitioners need a clearer view of the support clients are receiving to ensure services can work together effectively.
44. Work with colleagues in Children and Family Services to ascertain whether the following challenges that have been identified in research are in issue in Bristol. For professionals working with families where substance misuse is a factor the barriers presented were: engagement, conflicting agency focus, inter-agency communication, conflicting assessment needs, children having significant needs but remaining largely invisible.
45. Review the substance misuse knowledge/skills of those practitioners who are the main contact with families to meet the parents and children's needs. This needs to consider drug and alcohol awareness.
  
46. Further work is needed to map out how information sharing does/does not take place when working with families who have substance misuse issues.
47. Treatment services have a relationship with over 100 suspected domestic violence perpetrators and could be well placed to address the issues that contribute to the cycle of abuse.
48. Victims of domestic violence and abuse may also benefit from targeted support.
49. The combined impact of domestic violence, substance misuse and mental health is recognized. The services offered to these vulnerable individuals need to be sufficiently resourced. Learning from the Golden Key initiative will be critical in informing the approach.
50. Peer support offers considerable benefits to both the peers and those receiving their support. This should be considered as a fundamental part of a treatment system.
51. The availability of peer supporters does need consideration to ensure plans are realistic.

52. Explore the possibility of co-commissioning peer support with other commissioners in recognition of the fact that people using drugs and alcohol are likely to experience a number of issues.
53. It is important to continue to support those who are caring for friends/family members with substance misuse issues. Commissioners could consider whether on line support would be viable for carers services and the role that peer support could play within carers and family services.
54. Explore the opportunity for joint commissioning carers and family services with substance misuse commissioners from neighbouring authorities.

### **Training, Education, Volunteering and Employment**

55. Opportunities for training, education, volunteering and employment are a critical part of recovery and the specific challenges that substance misuse presents need to be catered for either in specific TEVE services or within wider TEVE provision.
56. Communication between all relevant agencies including commissioners, JCP and WP should be written into protocols which are acted upon and included in performance management of agencies.
57. Consider a one stop shop so that clients who are more chaotic and have more difficulty accessing training can be engaged in TEVE services and other training opportunities across the city.
58. Continue close working relationships with VOSCURs Sustain Programme.
59. Explore joint working opportunities to address the stigma faced by former drug users from potential employers, relating to previous drug use and criminal history.

### **Criminal Justice**

60. As a result of the new licensing arrangements as directed by the Transforming Rehabilitation Act, there is a need for clear working protocols and information sharing agreements between treatment providers and the National Probation Service and the Bristol Gloucestershire Wiltshire and Somerset Community Rehabilitation Company in order to ensure that the needs of service users' substance misuse needs are met.
61. Commissioners of SM treatment within HMP Bristol to ensure that referrals to existing psychosocial services as well as substitution therapies are offered to clients. Pathways to OST are good, whereas fewer people attend psychosocial services.

62. Commissioners of AIRS and ROADS to develop a joint working protocol to better meet the needs of clients leaving the custody suites. Consider an in-reach services by ROADS or a peer led meet and greet service in custody.

63. Targeted work by ROADS for AIRS clients already in treatment.

64. There should be guaranteed and immediate ongoing substitute prescribing for people returning to Bristol from custody, including locally, regionally and nationally.

65. Further explore how Substance Misuse services and Streetwise teams can work better together.

## Appendix 5: Stakeholder Engagement - Main Themes/Findings

Below is a summary of key messages from the Stakeholder Engagement feedback:

**Advocacy:** People need access to advocacy to help them understand and assert their rights regarding treatment and challenge referral criteria – both within ROADS and for other services e.g. mental health. Tackling stigma and discrimination should be the responsibility of all ROADS services.

**Assessment:** Have a single integrated assessment process which is shared with relevant professionals across the treatment system and with relevant partners to avoid duplication. Assessment should lead to clear referral pathways. Medical assessment should allow GPs to refer people to ROADS depending on their level of complexity.

**Commissioning and procurement:** A small number of contracts are appropriate, rather than one big contract, or many small contracts. Several ROADS functions are cross-cutting and need to be shared across more than one Lot / Provider. As the commissioning cycle will be longer, allocate funding for small grants in response to emerging trends and challenges.

**Communication:** We need clearer information about what ROADS services are and how to access them, including treatment pathways and referral criteria.

**Community Alcohol Detox Pathway:** The Local Enhanced Service has to be reworked and we need to ensure that capacity can meet demand. Community detox should only be offered with aftercare in place. We need to consider provision for people who have physical health complexities.

**Community Opiate Detox Pathway:** Detox needs to be supported by relapse prevention – consider a group work element alongside this service. Co-deliver with pain management service where required.

**Community Opiate Maintenance Pathway:** Recognise the value of medication in recovery where clinically appropriate. GPs may not have the capacity to hold maintenance clients who have increased risk. Improve the identification of potential maintenance clients to free up capacity. Proactively offer other interventions as appropriate.

**Families and carer support (regional):** A joint regional service will need to have a strong local offer with good links to community organisations and area based support. Having a digital component would increase accessibility.

**GP Local Enhanced Contract (drug and alcohol):** Use the same model for alcohol as for OST<sup>9</sup> shared care and integrate where possible, but consider the feasibility and capacity of GP practices. Be aware of other key elements that may impact e.g. Rapid Prescribing. There will need to be extra support for people with complex needs. We should examine need at a locality level if not offering the alcohol service in every surgery.

**Harm reduction and healthcare:** Have pathways for key health needs including BBV<sup>10</sup>, pain management and liver disease. Promote the use of Naloxone. Needle and syringe provision should be accessible out of hours and in a range of ways including static, detached and via pharmacies. Make sure needle exchange service is appropriate for people who inject image and performance enhancing drugs.

**Homeless substance misuse provision:** GP led drop in sessions, supervised methadone and resettlement and wet clinic are highly valued. Homeless people often have complex needs and a history of trauma so the service needs to be person centred as well as addressing physical needs.

**Hospital Liaison:** Need to work across hospital and community. Consider if this could be done with a rapid prescribing model rather than in all hospitals. Some clients avoid hospital admission for fear of being abruptly detoxed.

**Hosted Case Management System** In November 2016 we asked current Theseus users in Bristol to give us their views on the existing case management software via an online survey. We had 86 responses – mostly from practitioner / client facing staff, and also from managers and administrators who use the system. 96% of respondents told us that it was ‘absolutely essential’ or ‘very important’ for all ROADS services to share the same case management system. They also told us that ‘avoiding disruption’ and ‘performance’ should be our most important priorities when recommissioning a case management system.

**Maternity substance misuse provision – midwife:** This should always be a high priority as the service is effective at reducing risk and keeping service users engaged and on script. It might be better to have a Bristol wide service with a midwife based at St Michael’s Hospital as a centre of excellence.

**Non community detox pathway – residential and inpatient:** Provides a higher level of safety for people with complex needs and can address physical health problems. Inpatient admission is needed for some people with high risk in order to access residential rehab e.g. sex workers and pregnant women. Both local and single sex provision are required.

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<sup>9</sup> Opiate substitute prescribing

<sup>10</sup> Blood borne viruses e.g. Hepatitis and H.I.V.

**Peer support:** Peer support plays a pivotal role in supporting recovery. All providers should be accountable for facilitating peer placements and overcoming barriers. Having peer support as a separate service from treatment providers can lead to a greater emphasis on peer supporter's needs.

**Pharmacy local enhanced contract:** Pharmacies are the main point of contact for some people on scripts, so increase liaison with shared care workers as appropriate. Ensure supervised OST is available during all pharmacy opening hours for people with daytime commitments.

**Preparation and In-Treatment Housing:** More prep housing is urgently needed. If housing comes out of the ROADS contract we need to ensure good communication across agencies including training and information sharing. Can non-ROADS floating support services support tenants using drugs and alcohol to maintain their tenancy?

**Psychiatric led complex needs provision:** This would deliver improvements to joint working with mental health services. A consultant led service is important for diagnosis and mental health reviews to support treatment and referrals. Requires a community presence and links into outreach and street based working. There may be a gap in provision for people with 'medium level' mental health needs because of rising thresholds to accessing mental health services.

**Rapid access to prescribing for vulnerable groups:** The service is working well, but needs to be very accessible and flexible as many people with complex needs struggle with appointments. There should be a service for street sex workers with links to One25.

**Recovery planning:** We need more joined-up care planning with an aftercare plan that includes relevant services outside ROADS.

**Relapse Prevention / Aftercare:** There needs to be capacity to offer relapse prevention support for every detox. Providers can promote training, education, volunteering and employment opportunities by having strong links with community organisations. All services are responsible for facilitating access to mutual aid e.g. SMART Recovery/12 step fellowships.

**Residential Rehab:** We should have a quick and straightforward process for accessing residential rehab for those that need it. Preparation sessions are beneficial when they focus on increasing motivation and commitment. People leaving residential rehab require a clear aftercare plan including appropriate housing.

**Social value:** Providers can demonstrate added value through having strong links with local community organisations. Providers are likely to have a preventative role reducing the citywide need for social care, policing etc. Social value can be direct and indirect - influencing emotional wellbeing, reducing social isolation etc.

**Structured psychosocial interventions (including clinically led interventions):**

One-to-one support is needed because not everyone is group-ready. Interventions should be linked to level of need and there should be a wide range of evidence based interventions offered e.g. CBT, Contingency Management, Behavioural Couples Therapy, DBT and Motivational Interviewing. Appoint clinical leads to deliver / supervise interventions. Encourage the use of technology e.g. web-chat to deliver interventions.

**Substance Misuse (Alcohol and Drug) Liaison:** Workers need to have realistic caseloads, with client complexity and levels of need linked to intensity and duration of treatment. This includes structured psychosocial interventions.

**Workforce development:** Have a workforce development and training function within ROADS to share skills and increase understanding of substance misuse for outside organisations including generic ETE<sup>11</sup>, volunteering and Floating Support services.

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<sup>11</sup> Education, Training and Employment

## **Appendix 6: FINANCIAL STANDING APPRAISAL**

The Financial Information provided will be used by the Authority to assess whether the bidders possess the necessary economic and financial capacity to perform the contract.

When undertaking the assessment the Authority looks at the bidders most recent financial statements along with those of any ultimate parent company (if appropriate). These would be checked for general audit issues and then analysed to give an indication of profitability, net worth, liquidity, capacity and general stability.

The Authority reserves the right to use a variety of indicators as it considers appropriate including those from credit agencies. The Authority will also consider any additional information submitted by the applicant should the applicant consider this necessary for the Authority to have a fuller understanding of its financial position. This may be appropriate, for example, to obtain a fuller understanding of an applicant's financial structure or funding arrangements. The Authority would expect any such information to be verified by an independent source, for example, the applicant's auditors. Furthermore the Authority may (but is under no obligation) request further information or explanation from a bidder

Initially basic checks are made on a bidder's name and any relevant registration details (e.g. registered number at Companies House). The Authority would check whether the bidder is trading or dormant and whether it has a parent company. The status of the financial statements is also determined to check whether information submitted is for the last accounting period.

When considering profitability the Authority looks at whether the organisation has made a profit or a loss in the year, which indicates the efficiency of the organisation. A loss in the year would be looked at in conjunction with the balance sheet resources available to cover this loss.

The Authority would look at the bidder's balance sheet and determine the net worth of the organisation and that element that can be mobilised in a financial crisis. To do this the Authority looks at net assets and also at the net tangible worth (excluding intangible assets) of the organisation.

When looking at liquidity the Authority uses the current ratio and the acid test ratio. The current ratio is a measure of financial strength and addresses the question of whether the bidder has enough current assets to meet the payment schedule of its current debts with a margin of safety for possible losses in current assets. The Acid Test ratio measures liquidity and excludes stock to just really include liquid assets. Generally the Authority would expect a bidder to have a current ratio of at least 1:1.

Contract limit is the size of contract that is considered ‘safe’ to award to a bidder, based on a simple comparison of the estimated annual contract value to the annual turnover of the organisation. This gives an idea of financial strength to ensure that the bidder can cope financially with this size of contract. The Authority assesses the capacity issue of whether the bidder has the resources to carry out the work and also considers whether the bidder will become over-dependant on the contract in question. Generally the Authority would expect a bidder to have a turnover of 1.5 times the annual contract value.

The Authority would consider all of the above in relation to the bidder and that of any ultimate parent company and then a judgement would be made as to the risk that the organisation would represent to the Authority. If the Authority decides that the financial and economic standing of the bidder represents an unacceptable risk to the Authority then the bidder will be excluded from further consideration in this process.

<b>PROJ NAME:</b>	Re-commissioning of Substance Misuse Services							<b>PROJECT ID:</b>								
<b>PROJ MGR:</b>	Kath Williams							<b>DATE LAST AMENDED:</b>	11/05/16							
Category: 'E/F' Economic/Financial; 'E' Environmental; 'L' Legal/Regulatory; 'O/M' Organisational/management; 'P' Political; 'S/C' Strategic/Commercial; 'T/O' Technical/Operational																
Probability/Impact: 4 = Very high; 3 = High; 2 = Medium; 1 = Low																
ID	Category	Type	Description (inc. consequence & impact on project)			Likelihood	Impact	Priority	Countermeasure / Risk response (inc. contingency)							
	O/M	R	the commissioning remit of the substance misuse team e.g. welfare reforms, jobs and training, mental health services. If service users are unable to meet their needs in these areas then they may continue to			3	3	9	Contact local commissioners to explore co-commissioning opportunities							
	E/F	R	Overall funding envelope for the substance misuse contracts still be confirmed due to reductions in PHE Grant and BCC funding			4	4	16	Confirmation of funding to be sought as soon as possible to allow model design work.							
	T/O	R	Capacity of treatment system to deal with ongoing drug trends (e.g. aging cohort of heroin users, capacity to deal with increased alcohol numbers)			3	3	9	Need to design a model that addresses these changes and builds flexibility in to the system to respond to any future changes.							
	T/O	R	Risk of changes to the current case management system (Theseus) impacting on the implementation of new contracts			1	3	3	Likelihood is that current case management system will be retained during this period.							
	O/M	R	Risk of delays to the process following the H&WB discussions in relation to the overall governance of the project			1	4	4	Need to respond promptly to any feedback from the H&WB regarding governance. May need to consider delaying contract start date if H&WB want to retain overall governance of the project due to the frequency of their meetings.							
	E/F	R	Risk to overall funding levels reducing to commission the system due to transferring the management of some contracts to the SMT without the corresponding funding attached to these contracts moving over.			3	4	12	Implications of this approach and associated risk to be made clear. Consider this funding shortfall in the overall design of the new model.							
Aug 16	O/M	R	Delay in completion of the needs assessment has meant that the original timeline has been revised with only 1 month of implementation now in place. This time may be insufficient			4	4	16	Aim to identify any other slack in the timeline to allow for more implementation time. May need to consider delaying contract start date of the project if 1 month is deemed too short.							
	T/O	R	Initial model design that is being consulted with stakeholders is proposing the possibility of inpatient detoxes being on a framework. This funding approach could lead to the current inpatient unit becoming unsustainable leading to Bristol not having a local inpatient detox unit available to residents.			2	4	8	Consider alternative approaches to a framework. Consult stakeholders on this approach and the likely impact on having a framework.							
	P	R	Risk that local VCS providers will be excluded from the bidding process due to the financial implications imposed by BCC procurement. Particularly where the encumbant providers are concerned due to their funding streams being reliant on BCC already.			2	4	8	Ensure clarification from Finance on the financial regulations and share with stakeholders. Consider these implications in the overall design of the treatment system model to consult on.							
	L	R	Risk of challenge from providers as a result of procurement processes			3	4	12	Ensure all procurement and commissioning tasks are signed off by the appropriate governance boards and documents are loaded up at each commissioning stage on to ProContract for procurement sign off.							
	L	R	Implications of TUPE - risk to finances of service providers			3	3	9	Build in sufficient time for incumbant providers to share TUPE information with commissioners.							
	T/O	R	Risk of the intention to procure longer term contracts impacting on the sustainability of unsuccessful local providers			2	3	6	Work with Voscur to minimise this impact.							
	O/M	R	Risk that CPG do not extend current contracts required to complete re-commissioning project due to H&WB lead in time			1	4	4	Need to clearly outline why an extension is required to CPG else it will risk the overall feasibility of the project.							
	T/O		Risk of challenge from providers wishing to provide the direct award elements of the procurement process.			1	4	4	Consider alternative approaches to commissioning (e.g. discuss with CCG taking on contracts of hospital based ones). Consider releasing a pin notice to gain market feedback on direct award approach.							

## APPENDIX E

### Bristol City Council Equality Impact Assessment Form

(Please refer to the Equality Impact Assessment guidance when completing this form)



Name of proposal	ROADS Recommissioning
Directorate and Service Area	Strategic Commissioning
Name of Lead Officer	Jody Clark

### Step 1: What is the proposal?

*Please explain your proposal in Plain English, avoiding acronyms and jargon. This section should explain how the proposal will impact service users, staff and/or the wider community.*

#### 1.1 What is the proposal?

The substance misuse team is currently developing the commissioning strategy for the tendering opportunity for adult substance misuse services (ROADS).

The indicative budget for ROADS contracts is £8.5million. This is a 10% reduction on the 2016/17 budget, which itself contained a 10% reduction from the 2014/15 allocation received from Public Health. A further £750k has been allocated to the Preventing Homelessness commissioning exercise, for which a separate EqIA is being conducted.

Following a series of stakeholder engagement events, a proposed model for the new treatment system has been developed to enable BCC to procure the necessary services. 10 contracts are proposed to be awarded to respond to the recommendations from the Substance Misuse Needs Assessment [BCC, 2016]:

- Specialist Nursing Provision
- Inpatient & residential rehab provision
- Complex Needs
- Community Recovery Centres
- Substance Misuse Liaison (shared care)
- GP Public Health Service contract for opiate substitution therapy
- GP Public Health Service contract for community alcohol detox
- GP Public Health Service contract for supervised consumption
- Early Engagement & Intervention
- Regional Families and Carers Support (co-commissioned with B&NES and South Glos Councils)

The newly configured ROADS system will be aimed at engaging people with support needs around the use of alcohol, opiates and non-opiate drug groups. The current government Drug Strategy sets out 8 best practice outcomes which all substance misuse treatment services should work towards achieving:

- Freedom from dependence on drugs or alcohol;
- Prevention of drug related deaths and blood borne viruses;
- A reduction in crime and re-offending;
- Sustained employment;
- The ability to access and sustain suitable accommodation;
- Improvement in mental and physical health and wellbeing;
- Improved relationships with family members, partners and friends; and
- The capacity to be an effective and caring parent

The government are due to publish a new drug strategy in early 2017 and we await to see if there is a change in the outcomes which are expected to be met, although information received thus far points towards the new strategy being broadly in line with that currently in place.

## **Step 2: What information do we have?**

*Decisions must be evidence-based, and involve people with protected characteristics that could be affected. Please use this section to demonstrate understanding of who could be affected by the proposal.*

### **2.1 What data or evidence is there which tells us who is, or could be affected?**

According to the Public Health England Value for Money calculation every £1 spent on substance misuse in Bristol will derive £2.50 of benefit in terms of crime reduction and increased health and wellbeing. This benefit is above the national average of £2.

The reduction in funds available to procure substance misuse services has potential to lead to additional costs for criminal justice and the health system as there is the potential for less effective mitigation of offending behaviours and harms associated with drug and alcohol use.

The “Bristol ROADS Workforce Diversity –Training Needs Analysis 2015-16” [Diversity Trust, May 2016] identified that ROADS providers have approximately 200 members of staff working as part of individual contracts or across lots (excluding volunteers).

As the largest proportion of spend within ROADS contracts is staffing costs, the reduction in budget is likely to result in either decreased pay rates to sustain current employee levels or a smaller workforce.

The needs analysis identified the following demographics of the workforce:

#### Gender

- 72% (n=99) Female
- 25.5% (n=35) Male

#### Sexual orientation:

- 6.5% (n=9) staff were Lesbian, Gay or Bisexual (LGB).
- 84.7% (n=116) staff identified as Heterosexual.
- 8.8% (n=12) answered 'prefer not to say'.

#### Ethnicity

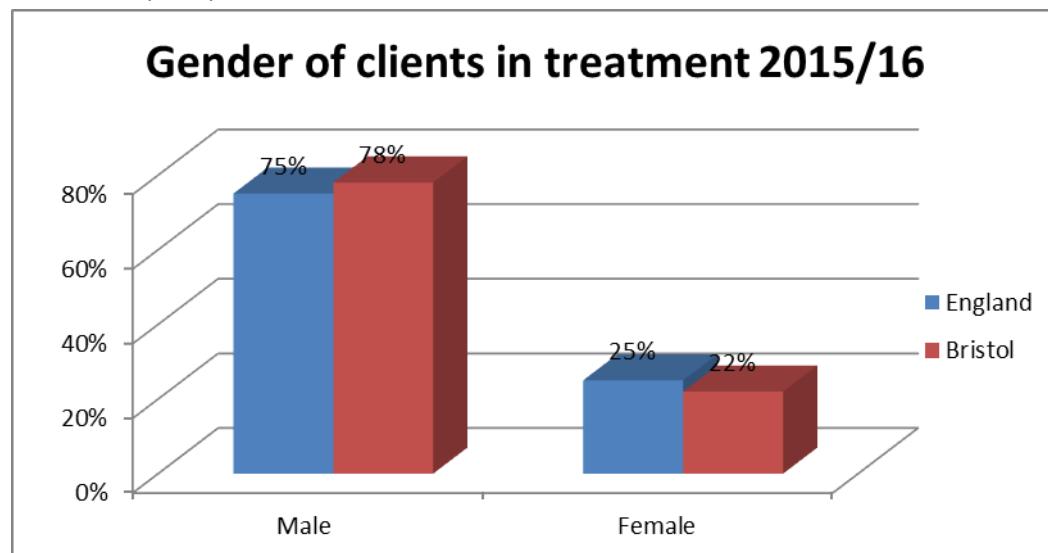
- 18% BME
- 78% White British
- 4% Prefer not to say

#### Disability

- 76% (n=108) individuals do not identify as being a disabled person
- 22% (n=32) individuals identified as disabled people
- 2% (n=3) of individuals prefer not to say

The recently published National Drug Treatment Monitoring System (NDTMS) Treatment Bulls Eye Data for England reports on demographics and key characteristics (such as proportion of people injecting) of people accessing treatment in 2015/16.

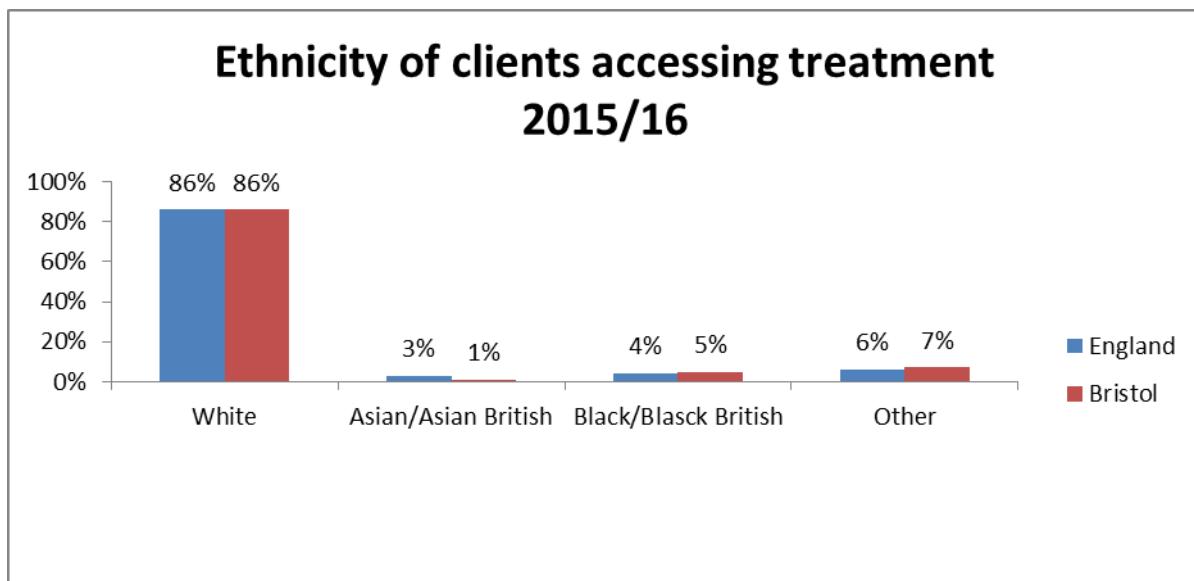
The gender split for people accessing treatment in England is reported as being 75% Male and 25% female. Bulls Eye data for Bristol shows a greater proportion of male clients (78%) to female (22%).



Bristol's gender proportions may indicate that currently treatment is not perceived as accessible for females in Bristol.

86% of clients in treatment in England in 2015/16 identified as White; 3% Asian or Asian British; 4% Black or Black British; and 6% Other.

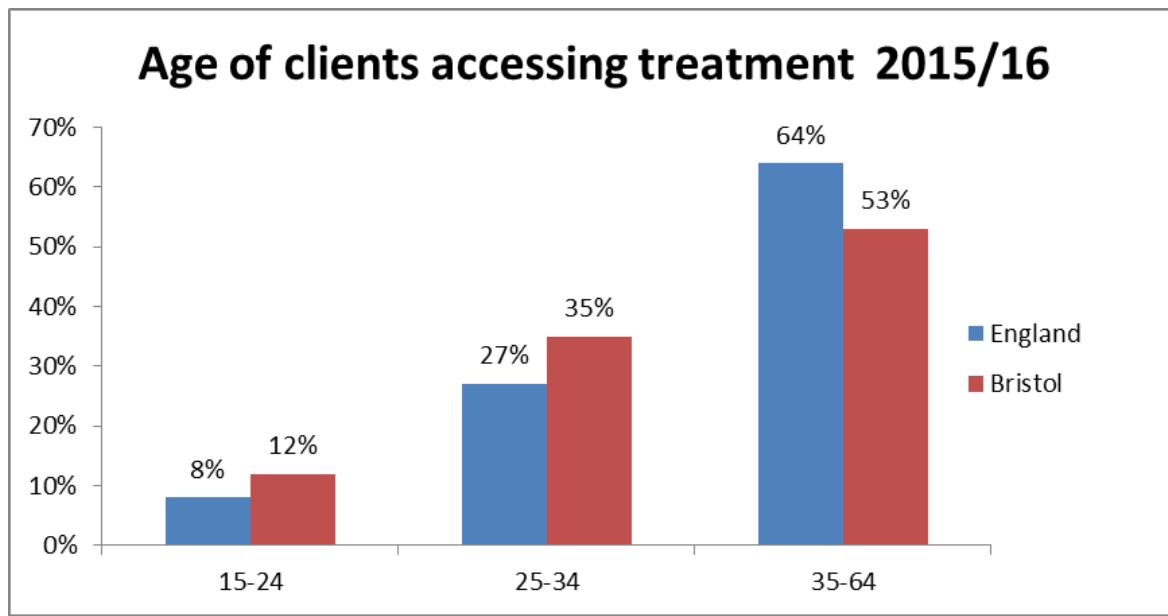
In Bristol 86% identified as White; 1% as Asian or Asian British; 5% as Black or Black British; and 7% as Other. Whilst this is broadly in line with the England representation this is significantly below the BME proportion of Bristol's population of 16% (2011 census data).



Substance misuse levels are not estimated as equal within differing ethnic groups, with White British and people of dual heritage (reported within "Other" above) suffering the highest levels. The "Prevalence of Drug Use Among BME Communities in Bristol" report [Safer Bristol, 2012] identified the following real and perceived barriers to treatment:

- Lack of trust in the cultural competence of drug services
- Low level of confidence in drug service from the BME communities
- Stigma surrounding drug use if the users from these groups attempt to access drug services
- Taboo on discussing drug use
- Fear that disclosing drug use would negatively affect immigration status. (It was a commonly held belief that drug services work with law enforcement and immigration agencies, and that contact with drug services would lead to deportation, suggesting a high level of discomfort at the thought of using statutory services.)
- Waiting time is often reported as a key barrier to accessing services.

In England 8% of people in treatment were aged 15-24; 27% 25-34 and 64% 35-64. Bristol's proportions were 12% were aged 15-24; 35% were 24-34; and 53% 35+. The smaller representation of younger clients in Bristol is primarily due to the focus on engaging opiate and alcohol users in treatment. These groups have an older profile compared to non-opiate drug users who tend to be younger.



Due to the historic collection of the data we are able to produce performance reports on the successful completion of treatment by gender and ethnicity to identify whether there is equality of outcomes for the relevant groups.

Male opiate clients have significantly better outcomes, measured against 2.15i of the PHOF Outcome Framework, than their female counterparts (7.1% and 5.8% respectively).

**2.15i** Number of users of opiates that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number of opiate users in treatment.

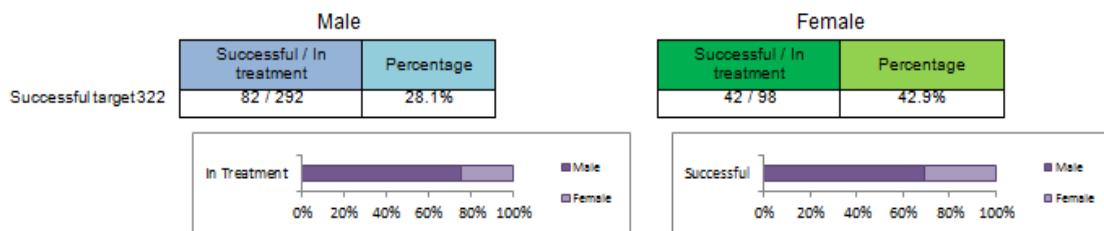
Completion period: 01-Apr-2015 to 31-Mar-2016

Representations up to: 30-Sep-2016



Female non-opiate clients have significantly better outcomes, measured against 2.15ii of the PHOF Outcome Framework, than their male counterparts (42.9% and 28.1% respectively).

- 2.15ii** Number of users of non-opiates that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number of non-opiate users in treatment.



Female and male alcohol clients have similar outcomes (27% and 27.9% respectively) for the proportion of clients in treatment who successfully complete alcohol treatment.

#### Successful Completions as a proportion of all in treatment (rolling 12 months)

Latest completion period: 01-Apr-2015 to 31-Mar-2016

Male		Female	
	Completions/In treatment		Completions/In treatment
2.9 Alcohol: Target 368	201 / 720	Percentage	92 / 342
	27.9%		27%

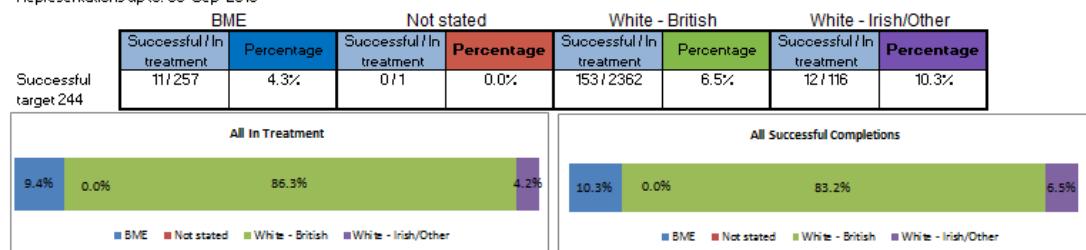
BME clients have significantly poorer outcomes across all drug groups compared to their White British and White Irish counterparts. BME opiate clients are 2.2% and 6% below the outcomes for White British and White Irish/Other respectively; 15.7% and 22% poorer for non-opiate clients; and 5.6% and 9.6% poorer for alcohol.

#### Public Health Outcome Framework

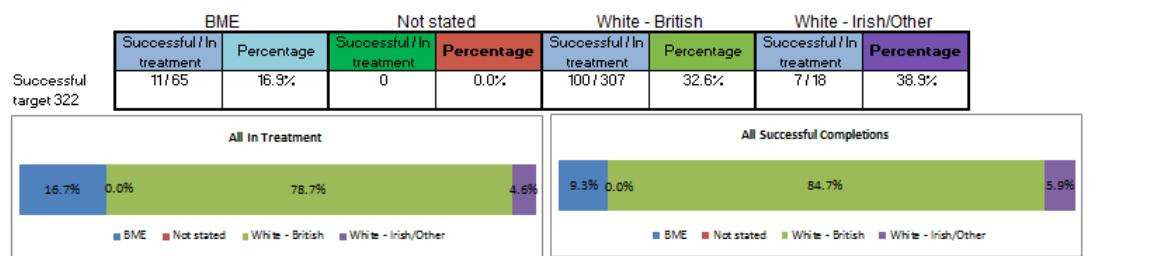
- 2.15ii** Number of users of opiates that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number of opiate users in treatment.

Completion period: 01-Apr-2015 to 31-Mar-2016

Representations up to: 30-Sep-2016



2.15ii Number of users of non-opiates that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number of non-opiate users in treatment.



Alcohol: Target 368	Completions/ In treatment							
	Completions/ In treatment	Percentage						
	19 / 85	22.4%	1 / 3	33%	245 / 886	28%	28 / 88	32%

## 2.2 Who is missing? Are there any gaps in the data?

ROADS providers are mandated to complete monthly returns to NDTMS which collects, collates and analyses information from and for those involved in the drug treatment sector. Public Health England and Local Authorities use this data to monitor the performance of the treatment systems against local and national targets.

Much of the data collected around client demographics/protected characteristics by treatment services are part of the dataset and so is collected in the fields stipulated by NDTMS.

Data on gender, age and ethnicity have been a consistent part of the dataset for many years but reliable information for sexuality, gender reassignment, disability and religion have only been collected since changes to the dataset were introduced in April 2016. This significantly impacts on our ability to understand the treatment profile and successful completion rate for these groups, either due to the data not containing enough entries due to clients preferring not to answer given the nomenclature of options (e.g. sexuality recorded as being homosexual rather than lesbian, gay or bisexual) or the data not being collected at all (e.g. religion).

Recognising the absence of reliable data the Diversity Trust was commissioned by ROADS providers in 2015 to publish the “Lesbian, Gay, Bisexual and Trans Research Report”. The report included the following key findings:

- Higher levels of health risk behaviours, such as alcohol misuse, substance misuse and smoking.
- LGB and Trans people are less likely to engage with generic interventions and services.
- LGB and Trans communities have higher levels of need for interventions and targeted support.

- LGB and Trans communities are more likely to experience health inequalities in relation to public health areas and preventing premature mortality.
- LGB people demonstrate a higher likelihood of being substance dependent, dependence is highest amongst gay men and bisexual men and women.
- 24% of Trans people have used drugs within the last 12 months.
- 10% of trans people indicated signs of severe drug abuse using the Drug Abuse Screening Test.
- LGB and Trans people may have different patterns of substance use.
- LGB and Trans substance users may use a wider range of illicit drugs not recorded in the British Crime Survey.

The report states that a lack of cultural competence of support agencies means LGB and Trans people believe generic services aren't appropriate for them and concludes:

- Many LGB and / or Trans people report feeling 'invisible', therefore access to services is often framed by a general lack of awareness or understanding either about gender identity and / or sexual orientation.
- Depending on issues such as attachment to LGB and Trans communities, being "out" in the environment, being resilient when accessing services will all depend on how LGB and / or Trans people feel when accessing support.
- *"The most disadvantaged sections of the LGBT community will always need LGBT-specific services that link them to the LGBT community. The more affluent, self-assured, LGBT people may not require LGBT services at all."*
- (Joe Lavelle, Projects Coordinator, OUTreach Liverpool / North Liverpool CAB)

The report goes on to make following recommendations for commissioners:

- The Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing Strategy should include the specific health needs of gay, bisexual and other men having sex with men (MSM); lesbian and bisexual women; Trans women and Trans men; including the specific substance misuse needs of these populations;
- Collection of sensitive gender identity and sexual orientation monitoring data should be consistent;
- Further research is required with Trans communities and substance misuse to better understand the prevalence amongst Trans communities;
- Service specifications should address LGB and Trans specific needs and outcomes;
- Carry out an LGB and Trans audit of providers.

For clients entering a treatment system from April 2016 we have a thorough view of equalities groups within the treatment system. Prior to this time we are limited to age, gender and ethnicity. In April 2017 a full equalities performance report will be produced for the Substance Misuse Team to monitor the outcomes for all equalities groups. This report will be included in the finalised EqIA in April 2017 to inform the Commissioning Strategy (due for publication May 2017).

### **2.3 How have we involved, or will we involve, communities and groups that could be affected?**

A 12-week consultation period starting from the 16th January 2017 will seek feedback on the planned commissioning strategy for the recommissioning of ROADS services. Events are planned across Bristol with interested and affected communities and groups as well as an online questionnaire in order to garner feedback to ensure the proposed commissioning strategy is right for Bristol.

The impact on equalities groups will form part of this consultation and specific events targeting representatives of equalities group will be held in order to better understand the necessary responses for those communities.

#### Response from the public to the budget proposals

##### Black South West Network

Major concerns were expressed regarding the inter-related nature of the issues that individuals and families experiencing crisis have:

The stress caused by prolonged crisis can cause mental health issues, if undiagnosed, individuals won't get the necessary support under the Mental Health Act. Drug dependency can result for people experiencing crisis and mental health issues, which often leads to criminality and custodial sentences.

Whilst in prison, people either continue to use drugs, or begin to due to high levels of stress and the ease of availability. There is little support for people leaving prison with drug addictions, and no 'half-way house' type accommodation available. This means that ex-offenders tend to be housed in hostels where many of the other residents are drug users. This often leads to ex-offenders continuing to use, or relapsing into use, and subsequently leading them back into criminality.

Young homeless people, and young people leaving care at 18 with nowhere to live are also often housed in hostels where drug and alcohol use is prevalent. This creates a significantly increased risk of these young people using, particularly if experiencing stress and crisis about the homelessness.

There needs to be an integrated prevention and early intervention service that combines housing support with mental health service, drug dependency services, ex-offender

resettlement and support services, and care leavers services to seek to break these multiple cycles of crisis.

### **Step 3: Who might the proposal impact?**

*Analysis of impacts on people with protected characteristics must be rigorous. Please demonstrate your analysis of any impacts in this section, referring to all of the equalities groups as defined in the Equality Act 2010.*

#### **3.1 Does the proposal have any potentially adverse impacts on people with protected characteristics and can these impacts be mitigated or justified?**

***This section is currently in draft due to the consultation period not yet starting***

##### ***Age***

- 1) No impact has been currently identified.

Mitigation – events are planned between Jan 16<sup>th</sup> and April 15<sup>th</sup> 2017 to gather qualitative feedback from equalities groups to further understand any potential impact on groups arising from the proposed commissioning strategy

##### ***Disability;***

- 1) The lack of reliable data up to Apr 1<sup>st</sup> 2017 makes it difficult to quantitatively analyse current experience of ROADS clients identifying as disabled.

Mitigation – an equalities performance report is to be produced in April 2017 to include all protected characteristics reported to NDTMS since 1<sup>st</sup> April 2016. Events are planned between Jan 16<sup>th</sup> and April 15<sup>th</sup> to gather qualitative feedback from equalities groups to further understand any potential impact on groups arising from the proposed commissioning strategy

##### ***Gender reassignment;***

- 1) The lack of reliable data up to Apr 1<sup>st</sup> 2017 makes it difficult to quantitatively analyse current experience of ROADS clients identifying as having had gender reassignment.

Mitigation – an equalities performance report is to be produced in April 2017 to include all protected characteristics reported to NDTMS since 1<sup>st</sup> April 2016. Events are planned between Jan 16<sup>th</sup> and April 15<sup>th</sup> to gather qualitative feedback from equalities groups to

further understand any potential impact on groups arising from the proposed commissioning strategy

2) Diversity Trust report states Trans community feel there is a general lack of awareness or understanding either about gender identity

Mitigation – consider including the recommendations from the Diversity Trust “Lesbian, Gay, Bisexual and Trans Research Report” in the final commissioning strategy

***Pregnancy and maternity;***

1) No impact has been identified currently.

Mitigation – events are planned between Jan 16<sup>th</sup> and April 15<sup>th</sup> to gather qualitative feedback from equalities groups to further understand any potential impact on groups arising from the proposed commissioning strategy

***Race;***

1) Due to high level of representation within the workforce, changes to the staffing levels or pay structure will have a negative effect on BME employees.

Mitigation – equalities data can be captured as part of the TUPE process to ensure the impact on equalities groups is monitored and raised with employers if disproportionate.

2) BME service user’s experience of poorer outcomes than white peers continues within new services

Mitigation – consider including the cultural competency of providers being assessed as part of the evaluation process. Ensure equalities performance reports include the breakdown of outcomes for race.

***Religion or belief;***

1) The lack of reliable data up to Apr 1<sup>st</sup> 2017 makes it difficult to quantitatively analyse current experience of ROADS clients identifying as any particular religion.

Mitigation – an equalities performance report is to be produced in April 2017 to include all protected characteristics reported under to NDTMS since 1<sup>st</sup> April 2016. Events are planned between Jan 16<sup>th</sup> and April 15<sup>th</sup> to gather qualitative feedback from equalities groups to further understand any potential impact on groups arising from the proposed commissioning strategy

***Sex;***

1) Due to high level of representation within the workforce, changes to the staffing levels or pay structure will have a negative effect on female employees.

Mitigation – equalities data can be captured as part of the TUPE process to ensure the impact on equalities groups is monitored and raised with employers if disproportionate.

1) Under representation of females continues in the new ROADS system

Mitigation –locating alcohol detox and OST in primary care may make ROADS more accessible to females. Consider the provision of women only services. An equalities performance report is to be produced in April 2017 to include all protected characteristics reported under to NDTMS since 1<sup>st</sup> April 2016. Events are planned between Jan 16<sup>th</sup> and April 15<sup>th</sup> to gather qualitative feedback from equalities groups to further understand any potential impact on groups arising from the proposed commissioning strategy

***Sexual orientation.***

- 1) The lack of reliable data up to Apr 1<sup>st</sup> 2017 makes it difficult to quantitatively analyse current experience of ROADS clients identifying as any particular religion.

Mitigation – an equalities performance report is to be produced in April 2017 to include all protected characteristics reported under to NDTMS since 1<sup>st</sup> April 2016. Events are planned between Jan 16<sup>th</sup> and April 15<sup>th</sup> to gather qualitative feedback from equalities groups to further understand any potential impact on groups arising from the proposed commissioning strategy.

- 2) Diversity Trust report states LGB community feel there is a general lack of awareness or understanding about sexual orientation

Mitigation –consider including the recommendations from the Diversity Trust “Lesbian, Gay, Bisexual and Trans Research Report” in the final commissioning strategy

***3.2 Does the proposal create any benefits for people with protected characteristics?***

- 1) Ensuring ongoing compliance with the new NDTMS dataset will ensure that robust and relevant information is collected and collated to monitor the engagement, retention and successful completion of equalities groups in contact with ROADS.
- 2) By situating alcohol detox and opiate substitution therapy in primary care we envisage making the entry point into ROADS services more accessible for clients in need of services for whom the stigma associated with substance misuse is a continuing barrier to access support. This is particularly relevant for increasing the proportion of females and BME clients accessing ROADS.
- 3) Developing locality Community Recovery Centres in North, Central/East and South has the potential to make the recovery community in each locality more representative of the ethnic diversity of each area and increase BME representation with ROADS
- 4) Following the Social Value policy of ensuring 25% of procured services are awarded to SME organisations allows the opportunity for community organisations, including equalities groups, to be involved in the commissioning process in a consortia or sub-contractual basis.

### **3.3 Can they be maximised? If so, how?**

Building an equalities performance monitoring framework will aid the focus on ensuring equality of outcome across equalities groups and enable us to highlight areas of inequality early to ensure improvement measure can be implemented to improve the situation.

### **Step 4: So what?**

*The Equality Impact Assessment must be able to influence the proposal and decision. This section asks how your understanding of impacts on people with protected characteristics has influenced your proposal, and how the findings of your Equality Impact Assessment can be measured going forward.*

#### **4.1 How has the equality impact assessment informed or changed the proposal?**

Anecdotal reports received by the Substance Misuse Team suggest that some equalities groups are reluctant to access mainstream substance misuse services due to the perception that services are not culturally competent or due to the stigma associated with substance misuse. Situating alcohol detox alongside OST in primary care and the development of locality community recovery centres are a response to calls to develop more accessible services.

The feedback from the Black South West Network reinforces the identified need to improve the pathway between substance misuse services and the mental health system to ensure people experiencing crisis are able to have their needs met.

Issues raised by the Black South West Network relating to combining housing support with mental health service, drug dependency services, ex-offender resettlement and support services, and care leavers services to seek to break these multiple cycles of crisis will be considered alongside the Preventing Homelessness Accommodation Pathways Families and Adults commissioning process.

Care leavers will be included as a priority group in the risk assessment process for clients accessing ROADS as they are already identified as a population with elevated prevalence of substance misuse.

The commissioning strategy is to be published week commencing 16<sup>th</sup> January 2017. Further feedback and responses from representatives from equalities groups will be sought to inform the final commissioning strategy

#### **4.2 What actions have been identified going forward?**

Obtain further feedback to the proposed commissioning strategy during the upcoemeing 12 week consultation period (Jan 16<sup>th</sup> – April 9<sup>th</sup> 2017) to inform the final commissioning strategy

#### **4.3 How will the impact of your proposal and actions be measured moving forward?**

Monitoring of the levels of engagement ROADS has with equalities groups through NDTMS published reports

Development of equalities focussed performance reports to mirror the headline performance reporting mechanisms.

Engagement with service user groups to gain qualitative feedback from equalities groups' representatives

Service Director Sign-Off:  Patsy Mellor	Equalities Officer Sign Off: Anne James – Equality and Community Cohesion Team
Date:	Date: 5/1/2017

# Adult Substance Misuse Treatment Services Recommissioning

## Appendix H: Financial Appendix

The new service is to be funded out of a pooled budget administered by the Substance Misuse Joint Commissioning Group. Cabinet is due to consider approval of the Substance Misuse Accommodation Pathway 16 May 2017, which is also funded from this pooled budget. Table 1 below sets out a profile of the planned expenditure from this pooled budget for existing services (including those in and out of the scope of either the new Substance Misuse Accommodation Pathway or Substance Misuse Treatment Service) and the new commissioned services over the financial years of the proposed contractual period.

**Table 1: profile of pooled budget expenditure**

	2016/17 £000s	2017/18 £000s	2018/19 £000s	2019/20 £000s	2020/21 £000s	2021/22 £000s	2022/23 £000s
Existing services in scope	11,209	7,254	-	-	-	-	-
Out of scope services	473	535	606	556	556	556	556
Implementation costs	-	1,478	-	-	-	-	-
Substance Misuse accomm. pathway	-	313	750	750	750	750	750
Substance Misuse Treatment Service	-	2,900	8,700	8,700	8,700	8,700	8,700
<b>Total</b>	<b>11,682</b>	<b>12,480</b>	<b>10,056</b>	<b>10,006</b>	<b>10,006</b>	<b>10,006</b>	<b>10,006</b>

In 2018/19 the annual contract value of the Substance Misuse Treatment Service is £8.7m and in 2017/18 it is £2.9m, reflecting four months of the new service.

Implementation costs estimated at £1.478m in 2017/18 are based upon a one and half month overlap of services at £1.178m and £300k provision for a new case management system.

The pooled budget is funded by contributions from the General Fund, Public Health, CRC Partnership Funding and neighbouring local authorities. The actual funding profile for 2016/17 and the budgeted profile for 2017/18 set out in table 2.

**Table 2: profile of pooled budget funding**

	2016/17 £000s	2017/18 £000s
CRC Partnership	-30	-27
Neighbouring LAs	-82	-82
BCC General Fund	-1,430	-1,411
BCC Public Health	-9,590	-9,377
<b>Total</b>	<b>-11,132</b>	<b>-10,897</b>
Expenditure (from table 1)	11,682	12,480
Deficit (Surplus)	550	1,583

The reduction in the BCC General Fund contribution between 2016/17 and 2017/18 is the £20k budget reduction RS23 (Recommission alcohol and other drugs misuse services for adults) with a rounding difference. The actual deficit in 2016/17 and the projected deficit in 2017/18 are funded by balances brought forward on cost centre 10863 and table 3 below shows this.

**Table 3: deficits funded by balances brought forward**

	2016/17 £000s	2017/18 £000s
Balance brought forward	-2,535	-1,985
Deficit(from table 2)	550	1,583
Closing balance	-1,985	-402

The remaining balance of £402k could be utilised over the financial years of the proposed contractual

period to create a flat remaining funding requirement of £9.936m per annum as per table 4.

**Table 4: Funding Requirement over the financial years of the proposed contractual period**

	2018/19 £000s	2019/20 £000s	2020/21 £000s	2021/22 £000s	2022/23 £000s
Planned Expenditure (from table 1)	10,056	10,006	10,006	10,006	10,006
Use of balance brought forward	-120	-70	-70	-70	-70
Funding Requirement	9,936	9,936	9,936	9,936	9,936

Funding required of £9.936m in 2018/19 is a reduction of £961k (9%) from 2017/18 funding of £10.897m (from table 2).

If this reduction was apportioned between the funding sources on the basis of their current proportional contributions then the funding for 2018/19 would be as follows:

**Table 5: 2018/19 Funding Requirement apportioned**

	2017/18 £000s	2018/19 £000s
CRC Partnership	-27	-25
Neighbouring LAs	-82	-75
BCC General Fund	-1,411	-1,286
BCC Public Health	-9,377	-8,550
<b>Total</b>	<b>-10,897</b>	<b>-9,936</b>

For the General Fund this would be a reduction of £125k, exceeding the £61k required in 2018/19 as per the published budget reduction RS23 by £64k to contribute toward published budget reduction FP01 (Reduce third party payments).

Finally, should the estimate for implementation costs of £1.478m be more than required in practice this will further reduce the future funding required and generate greater savings.

**Finance Officer:** Robin Poole, Finance Business Partner, Neighbourhoods



## Bristol Health & Wellbeing Board

<b>Better Care Fund planning and Governance update</b>	
Author, including organisation	Daniel Knight – Joint appointment between Bristol CCG and Bristol City Council  Amy Carr – Joint appointment between Bristol CCG and Bristol City Council
Date of meeting	28th June 2017
Report for Information and Decision	

### 1. Purpose of this Paper

This paper is to inform the Health and Wellbeing Board of the key changes within the Better Care Fund Planning Framework for 2017/19 and to detail the amended governance for monitoring the Better Care Programme in Bristol.

The purpose of this paper is to ensure that the HWB notes and considers:

#### Policy Framework

- **For information** - the changes to the Better Care Fund Policy Framework
- **For information** - the additional grant to be included in the BCF
- **For Approval** - the principle of a BNSSG narrative plan.

#### Revised Governance

- **For Approval** - the revised governance structure for monitoring Bristol's Better Care programme

## **2. Executive Summary**

### **Better Care Policy Framework update – Page 3**

Nationally, the £5.3bn Better Care Fund was announced by the Government in June 2013, to ensure a transformational change in integrated health and social care. The Better Care Fund (BCF) has been described as “one of the most ambitious ever programmes across the NHS and Local Government. It creates a local single pooled budget to incentivise the NHS and Local Authorities to work more closely together around people, placing their well-being as the focus of health and care services.”

The BCF is a critical part of the NHS operational plans, strategic plans and local government planning. Previously in Bristol the fund was circa £41.7m with the majority of the money coming from existing sources within Bristol CCG and Bristol City Council (BCC).

Each year, the CCG and BCC are required to jointly submit BCF plans to NHS England. These plans set out our targets, advise how the money is to be spent and are formally agreed through the HWB. Although the BCF policy framework, outlining the key changes was released in March 2017, the BCF planning templates have not yet been released.

### **Revised governance for Bristol's Better Care Programme – Page 6**

The Better Care Fund was created to transform local services and drive the integration of health and social care. The initiative tasked organisations to work together in a different way and consider how together they could allocate resources and finances to improve care for their residents.

The internal governance arrangements of the Better Care Fund were left for each Clinical Commissioning Group (CCG) and Local Authority to jointly agree, and vary across the country. In Bristol the Better Care Programmes governance arrangements have changed over time as the programme has become more established.

With increasing pressures across the system and with the introduction of the Sustainability Transformation Plan (STP) the Better Care Team were asked to review the programmes current governance and reporting arrangements and propose how best to streamline the process.

The amended governance arrangements were presented and agreed by the Better Care Commissioning Board on 16<sup>th</sup> February 2017. At which time the board advised that the new governance should be presented to the Health and Wellbeing Board for formal agreement.

### **3. Better Care Policy Framework update**

#### **Existing arrangements:**

The focus for the Better Care Fund (BCF) remains to be the following;

- Achieving the targets for the national Better Care metrics
- To achieve and demonstrate working towards the BCF National Conditions

#### **New arrangements:**

- The Better Care plans will be a two year plan
- There is a reduction in the number of National Conditions, with a new condition being introduced for Managing transfers of Care
- Only national metrics will be reported to NHS England (NHSE), however local areas can still monitor local metrics
- New grant for adult social care (Improved Better Care Fund – iBCF) to be included in the BCF

These are covered in more detail below.

#### **National BCF Conditions 2017/19**

The National Conditions to be achieved are;

#### **Existing conditions**

- Plans to be jointly agreed
- NHS contribution to adult social care is maintained in line with inflation
- Agreement to invest in NHS commissioned out-of-hospital services

#### **New condition**

- Managing Transfers of Care

The reduction in the number of National Conditions from eight to four is to reflect the wider changes in the national policy.

In line with the introduction of the Managing Transfers of Care National Condition, further supporting information has been released on the expectations of local areas to implement the High Impact Change Model (**Appendix 1**) this is to support system-wide improvements in transfers of care.

Local areas are encouraged to continue working towards the previous National Conditions, as they are seen to be critical enablers for integration and should feature within the local Better Care plans. The previous National Conditions are;

- Agreement for the delivery of 7-day services across health and social care
- Better data sharing between health and social care, based on the NHS number
- Ensure a joint approach to assessments and care planning
- Agreement on the consequential impact of changes on the providers
- Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan

## **Metrics in 2017/19**

Local areas will no longer be required to report the performance of their local metrics, although they can be included in the Better Care plans and monitored through the assurance process. The national metrics are;

- Delayed transfers of care
- Non-elective admissions (General and Acute)
- Admissions to residential and care homes
- Effectiveness of reablement

## **New Grant for Adult Social Care – iBCF**

In 2015 the Government's Spending Review announced new money for the Better Care Fund. This additional money has been badged as the Improved Better Care Fund (iBCF). In Bristol the iBCF allocation for 2017/18 is £8,712,302, decreasing to £5,761,433 in 2018/19.

The new iBCF grant will be paid directly to local authorities via a Section 31 grant from the Department for Communities and Local Government (DCLG). The Government has attached a set of conditions to the grant which are listed below:

- Grant paid to a local authority under this determination may be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.
- A recipient local authority must:
  - Pool the grant funding into the local BCF, unless an area has written Ministerial exemption;
  - Work with the relevant Clinical Commissioning Group and providers to meet National Condition 4 (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19; and
  - Provide quarterly reports as required by the Secretary of State.

- The Government has made clear that part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in local care systems. Local authorities are therefore able to spend the grant, including to commission care, subject to the conditions set out in the grant determination, as soon as plans have been locally agreed with Clinical Commissioning Groups involved in agreeing the Better Care Fund Plan.
- The authority must maintain a sound system of internal financial controls.
- If the authority has any grounds for suspecting financial irregularity in the use of any grant paid under this funding agreement, it must notify the Department immediately, explain what steps are being taken to investigate the suspicion and keep the Department informed about the progress of the investigation. For these purposes “financial irregularity” includes fraud or other impropriety, mismanagement and use of grant for purposes other than those for which it was provided.
- Breach of conditions – If an authority fails to comply with any of these conditions, the Secretary of State may reduce, suspend or withhold grant payments or require the repayment of the whole or any part of the grant monies paid, as may be determined by the Secretary of State and notified in writing to the authority. Such sum as has been notified will immediately become repayable to the Secretary of State who may set off the sum against any future amount due to the authority from the Government.

In terms of the wider context, the funding is also intended to support councils to continue to focus on core services, including maintaining adult social care services, which could not otherwise be maintained, as well as investing in new services, such as those which support best practice in managing transfers of care.

### **The Assurance and approval of the local Better Care Fund plans**

The assurance process for the approval of the local Better Care plans will take a two stage approach, which remains consistent with previous years. Work has already started in Bristol and a breakdown of the stages is listed below;

#### **First stage of the process**

- First submissions are assured by regional panels.
- All areas to confirm that agreed spending plans for market capacity and stabilisation from new IBCF element are in place.
- Cross-regional calibration.
- Plans are rated ‘compliant’ ‘on track’ or ‘off track’.
- Moderation will take place at NHS regional level after first stage.

## Second stage

- All second submissions to be approved by Health & Wellbeing Board.
- Assured by regional panels.
- Cross-regional calibration.
- Plans rated ‘approved’ or ‘not approved’.
- If no agreed plan then escalation will commence immediately in order to address issues quickly.

As the release of the planning guidance and templates has been delayed, submission dates have not yet been released; however **Appendix 2** indicates the process of approval for Better Care plans.

Leads from the three CCG’s within BNSSG have been meeting to discuss how the Better Care Plans can align; this has identified the possibility for BNSSG to submit one narrative Better Care plan across BNSSG. It’s important to note that the plan would address the needs of each area, whilst highlighting themes or work streams that span across BNSSG.

## 4. Revised governance for Bristol’s Better Care Programme

The Better Care Fund’s reporting arrangements required by NHSE consist of a quarterly submission. Each submission includes:

- An update on the Better Care Fund’s expenditure against plan
- An update on the performance against the metrics
- An update on the performance against the national conditions and
- A short narrative on Bristol’s successes challenges and concerns.

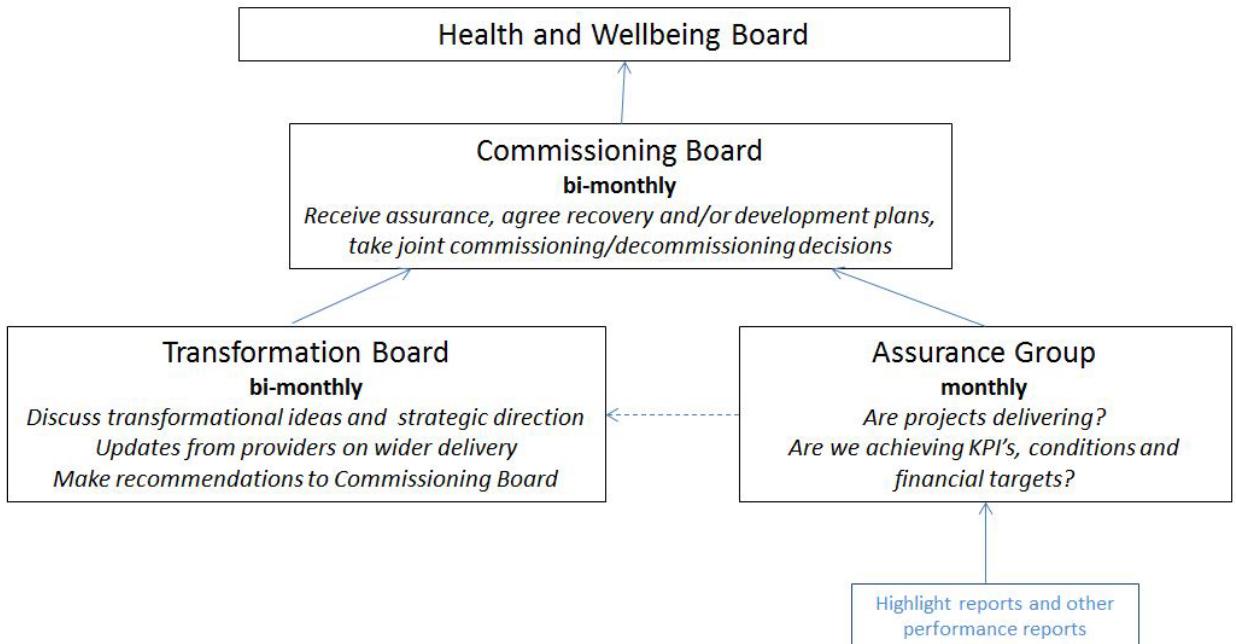
The iBCF will also be required to report quarterly to the Secretary of State, however at this time there is no guidance as to the level of detail required.

NHSE have confirmed that the internal governance arrangements for the 2017/19 Better Care plans are once again for each CCG and Local Authority to agree.

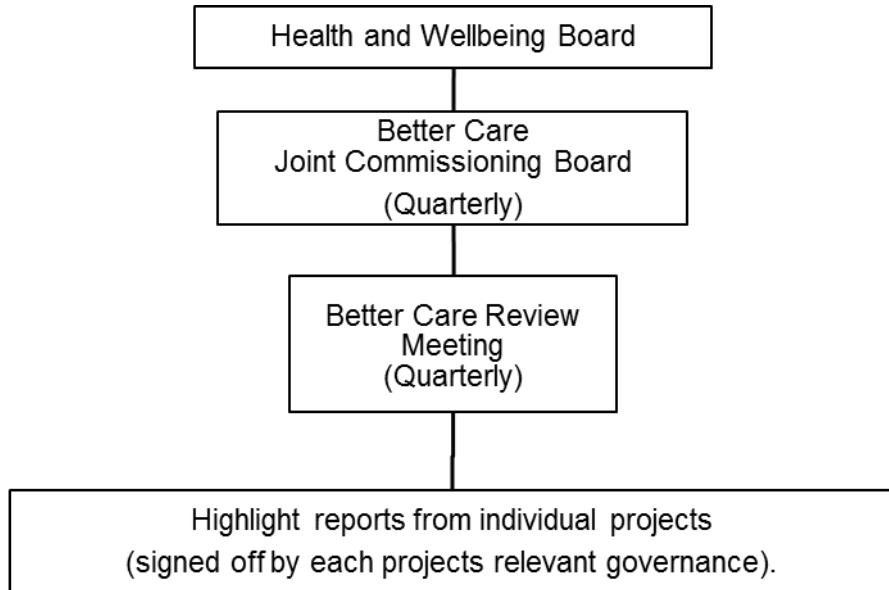
It was felt that the current governance model created duplication as each project funded by Better Care has its own governance arrangements within either Bristol CCG or Bristol City Council. It is within these governance channels that each project is performance managed and more importantly challenged by those who can impact the project and make decisions.

The diagrams below illustrate both the current and revised governance structure for the management of the Better Care Programme. All meetings include both Bristol CCG and Bristol City Council representatives.

## Current Governance Arrangements



## Revised Governance Arrangements



As illustrated the revised governance continues to have the Better Care Joint Commissioning Board feed into the Health and Wellbeing Board.

In the revised governance arrangements the Better Care Joint Commissioning Board will meet quarterly to align with NHSE's quarterly submission dates and the iBCF reporting.

Better Care Bristol Joint Commissioning Board scope and responsibilities will remain the same and the board will continue to provide leadership and strategic direction to develop stronger and deeper integration between health and social care also to enhance joint working, including the pooling of budgets where appropriate.

The Better Care Bristol Joint Commissioning Board will ensure that joint commissioning issues for all adults, including the allocation of available funds and the commissioning and/or decommissioning of joint or aligned services, are handled openly and transparently, with attention being given to the strategic plans of Bristol City Council, Bristol CCG and the Bristol Health & Wellbeing Board.

All projects funded through Better Care will continue to report via its own governance structure. Please refer to **Appendix 3** for more detail on each project's governance arrangements.

Each project funded through the Better Care Fund for 2017/18 and 2018/19 will be required to submit a quarterly highlight report to the Better Care Team. The report will include;

- Key activity during that quarter
- Deliverables for the next quarter,
- Risks and issues and
- KPI/ Metric information.

Outside of the regular reporting arrangements projects will escalate any appropriate issues/risks by exception to the Better Care Team.

The reports will inform the quarterly review meeting between Bristol City Council and Bristol CCG. This meeting will be an opportunity for both partners to align work, review exceptions and challenge. Both the Council and CCG have the opportunity to invite Project Managers to attend these review meetings to report on their individual projects where appropriate.

A finance report will continue to be generated on a monthly basis and discussed at the monthly Better Care Finance Meetings. This meeting is attended by Bristol CCG and Bristol City Council.

The report/meeting will cover:

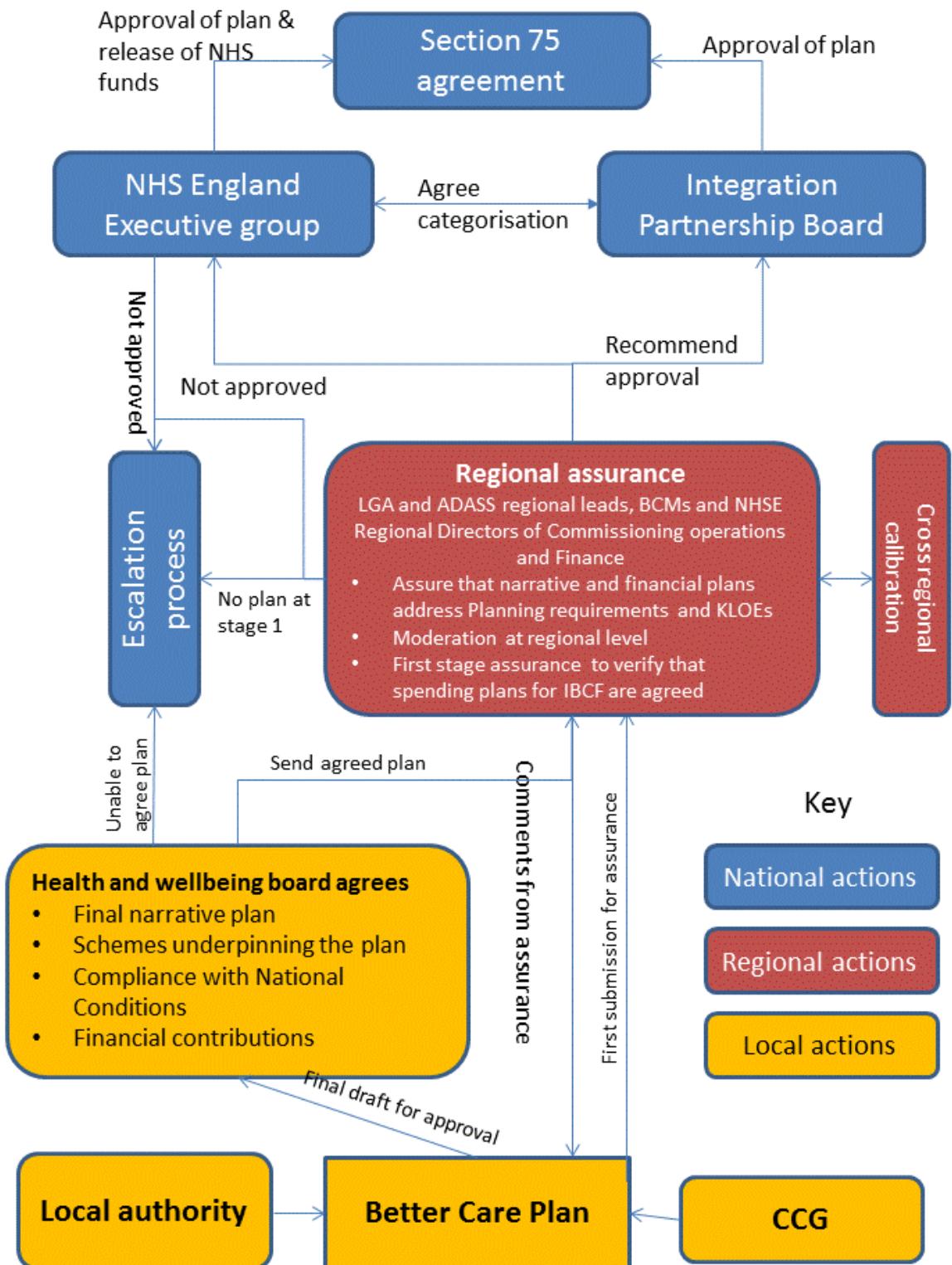
- Better Care Fund Overview
- Budget movements from previous month
- Financial risks
- Recommendations

The finance reports will be circulated to the Better Care Joint Commissioning Board.

## **Summary**

The revised governance arrangements allow for a light touch approach ensuring there is no duplication in reporting whilst meeting the requirements of NHSE.

## Appendix 2



## Appendix 3

<b>Better Care Fund Bristol</b>	
Listed below are the projects funded through the Better Care Fund for 2016/17. This table is to show each project's agreed governance arrangements. In addition to these arrangements, each project will produce a quarterly highlight report to the Better Care Team for review.	
BAU – Business as Usual	
<b>Bristol CCG Projects</b>	
<b>Project name</b>	<b>Project reporting arrangements &amp; governance</b>
Community Webs pilot	<p>This pilot is being managed by Bristol Aging Better and Bristol Community Health with the support of a Better Care Project Manager.</p> <p>The learning from this pilot will feed into the Prevention, Early Intervention &amp; Self Care (PEISC) STP work stream.</p>
Integrated Nursing pilot	<p>This pilot is being managed by Bristol Community Health with the support of a Better Care Project Manager.</p> <p>The learning from this pilot will feed into the Integrated Primary and Community Care (IPCC) STP work stream.</p>
BPCAg	<p>This project reports monthly through the CCG's Primary Care Progress, Oversight &amp; Development Group (PC POD), who reports to the Finance, Planning and Performance Committee (FPP).</p>
Care Home Support Team	<p>The team reports monthly to the Bristol CCG Care Home Quality Group which feeds into the BNSSG Enabling Discharge/Frailty Group.</p>
Section 117	<p>Project will report monthly to the CCG Mental Health Commissioning Governance Meeting.</p>
Discharge to Assess	<p>Reports into BNSSG's Enabling Discharge Group which feeds into the A&amp;E Delivery Board</p>
GPSU / GPST	<p>Reports to BNSSG's ED streaming group/Admission Avoidance which feeds into the A&amp;E Delivery Board</p>
Homeless Discharge	<p>Reports into UHB Hospital Flow Working Group which feeds into BNSSG's A&amp;E Delivery Board.</p>
Community Services (BAU)	<p>These are managed via monthly performance reports provided by Bristol Community Health. Exceptions are also managed through the Quality and Governance meeting.</p>

<b>Bristol City Council Projects</b>	
<b>Project name</b>	<b>Project reporting arrangements &amp; governance</b>
Care Act	The Care Act is now reported on though BCC's Adult Social Care Strategic Plan meetings.
7 Day Social Care in ED	Reports monthly into the following meetings as covers both acutes: NBT – System Flow Partnership (South Glos) UHB – Urgent Care Working Group (Bristol) These groups feed into the BNSSG A&E Delivery Board.
Wellbeing Partners (BAU)	This project was funded by a successful bid to South West Health Education England (SW HEE). Quarterly reports are provided to SW HEE and the Better Care team.
Disabled Facilities Grant (BAU)	Bristol City Council (BCC) monthly performance updates through SPAR.net. Report goes to Cabinet Member for Homes, Neighbourhoods, Councillors & Directorate Leadership Team (DLT). An annual update is shared with the People DLT.
Carers (BAU)	Reports to the Carers Strategy Implementation Group (CSIG) and Bristol Carers Voice. Additionally the CCG and LA meet monthly.
Prevention and Maximising Independence (BAU)	Reports to Bristol City Council's Senior Responsible Officer (SRO) meetings for homecare.
Intermediate Care & Reablement Service	Reports to the CCG's Enabling Discharge group and Bristol City Council's Senior Responsible Officer (SRO) Meetings
Community Equipment (BAU)	Bi-monthly BCC Equipment Management Board



## Bristol Health & Wellbeing Board

JSNA update	
Author, including organisation	Joanna Copping: Consultant in Public Health, Bristol City Council Nick Smith: Strategic Intelligence & Performance Manager, Bristol City Council
Date of meeting	28 June 2017
Report for Discussion	

### 1. Purpose of this Paper

To update the Health and Wellbeing Board regarding progress and plans for the Bristol Joint Strategic Needs Assessment (JSNA)

### 2. Executive Summary

The JSNA is a statutory duty for the local authority and Clinical Commissioning Group (CCG). Bristol JSNA includes a large data profile giving an overarching view of health and wellbeing data.

The JSNA is now supplemented with chapters of more in-depth needs assessment which aim to better drive planning and commissioning. Some of these chapters have recently been published but others have been delayed due to time pressures of authors and limited co-ordination capacity.

A new web page has recently been developed to improve access to JSNA products and other relevant data profiles and needs assessments.

Whilst the Bristol JSNA has progressed over the last year it does not yet fully drive planning and commissioning processes nor include all equalities issues.

### 3. Context

Bristol City Council (BCC) and the Bristol CCG, through the Health and Wellbeing Board, have an equal and joint statutory duty to prepare and publish a JSNA. In Bristol we have a JSNA Data Profile which provides an overarching view of health and wellbeing data for Bristol. Since 2016, JSNA Chapters have been developed to focus on priority areas in more detail and to complement the JSNA Data Profile. As well as the quantitative data, these chapters include details of current services, evidence of effectiveness of interventions and stakeholder feedback in order to identify key issues and make recommendations for future action. See [www.bristol.gov.uk/jsna](http://www.bristol.gov.uk/jsna)

Governance is provided via the JSNA Steering Group to lead the JSNA process on behalf of the HWB. See Appendix C for membership.

## 4. Main body of the report

### 4.1 Progress since last summer

- **Data Profile.** The [JSNA 2016-17 Data Profile](#) was published in Jan 2017 with a number of new sections & included a gendered approach
- **JSNA Chapters:** The JSNA Steering Group agreed 11 priority JSNA Chapters to be developed over 2016/17. Additional chapters were planned as required for public health work-streams. The process to produce JSNA Chapters has begun, with 5 published and a number due to be published over the next few months further to sign off by their reference groups (see Appendix A). Some chapters are still in development. For an example of a JSNA Chapter 2016/17, see: [Alcohol misuse: adults 2017](#)
- **Board paper templates.** In order to ensure that explicit reference is made to the JSNA in commissioning plans and decision making processes, the JSNA is now referenced within the new Health and Wellbeing Board template for papers. It is also reflected in the current CCG Governing Body template but it is not in the new Bristol City Council Decision Making Pathway documentation.
- **Webpage.** The JSNA webpage (hosted on the BCC public website) has recently undergone some significant changes to make the JSNA more accessible. This includes access to the Data Profile, new chapters and useful information products (such as ward profiles, Public Health England data profiles and other health and wellbeing needs assessments). The link for the new JSNA webpages is: [www.bristol.gov.uk/jsna](http://www.bristol.gov.uk/jsna)
- **Informing strategies.** The JSNA has informed and influenced key strategies: e.g. Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Plan (STP), the HWB Strategy revision, Children's, Young People and Families Strategy.
- **Impacting planning and commissioning.** The JSNA has influenced planning and commissioning. For example the JSNA was used explicitly in determining the outcome of bids for the Bristol Impact Fund, the children's epilepsy chapter has directly informed the work around improving access to epilepsy specialist nursing and the young people substance misuse chapter has informed the recommissioning of treatment services and delivery of training.
- **Internal restructure (BCC)** – JSNA coordination is now part of a new Bristol City Council (BCC) Strategic Intelligence & Performance team that links the Council intelligence function with performance reporting, so there is potential to improve data connections, including via a new Open Data Platform.

## **4.2 Current plans for JSNA development in 2017/18**

- JSNA Priority Chapters- there are some outstanding chapters to be completed, plus new Priority Chapters for 2017/18 – see Appendix A
- JSNA website- this is due to go live at the end of June
- Open Data Platform – BCC has now completed procurement of a new Open Data Platform (also due live at the end of June 2017), so we can progress with plans to improve the JSNA data offer and enable people to access up to date data on health and wellbeing needs in Bristol.
- To explore shared work with Bristol, North Somerset and South Gloucestershire (BNSSG) colleagues around the development of specific joint JSNA chapters.

## **5. Key risks and Opportunities**

- **Chapter development.** A recent survey of chapter authors and leads has explored the barriers to development of JSNA. This survey found that the most significant barrier to completing the chapter in the required timescale was lack of time. Other issues including lack of a reference group to steer the chapter, access to data and authors spending time implementing initial actions rather than completing the Chapter. Key actions suggested to address these barriers included more co-ordination support and for some, more clarity around why a chapter was ranked a priority by the JSNA Steering Group. The JSNA working group will be developing a plan to address these issues.
- **Ethnicity data.** At the JSNA presentation to the HWB in December 2016 there was a discussion around whether we can improve ethnicity data in the JSNA. Access to ethnicity and other equalities data remains a challenge though, as mostly this is not available as routine data. To progress this discussion we have prepared a review of equalities data in routine health data sources - see Appendix B.
- **Quality of Life (QoL) Survey 2017.** The QoL survey provides a key source of local, ward level data for the JSNA. Due to budget pressures, a new, on-line focussed methodology has been used in 2017. There is a risk this new process may not provide sufficient response and significantly impact on ward & equality group level data. We are actively trying to mitigate that risk through additional publicity and now a targeted mailing.
- **Resources.** Whilst the BCC internal restructure (see 4.1) should improve data integration, staffing capacity has been a challenge in delivering and co-ordinating the JSNA Chapters. Currently we are looking to mitigate the impact via JSNA coordination support, but will need to ensure capacity longer term with resources prioritised to deliver the priority chapters.
- **Changing priorities.** The JSNA Steering Group need to be able to review priority chapters and the ability to influence resources accordingly to adapt to new & evolving priorities from BCC e.g. budget savings consultations and the Corporate Strategy and from partners e.g. via CCG turnaround and STP priorities.

- **Geographical footprints.** The Bristol JSNA is focussed on Bristol and is the responsibility of Bristol City Council and NHS Bristol CCG, but NHS commissioning is increasingly focussed on a BNSSG footprint as a result of the STP. Some chapter topics may be more relevant to a West of England Combined Authority footprint. Different areas may take a different approach to their JSNA process due to resource constraints.

## **6. Implications (Financial and Legal if appropriate)**

Bristol City Council and Bristol CCG, via the Health and Wellbeing Board, have a statutory duty to prepare and publish a JSNA. This duty is being met via the JSNA Data Profile, but the chapter approach provides the additional evidence base to more effectively influence commissioning and service provision.

## **7. Evidence informing this report.**

JSNA Chapters are designed to provide data and evidence to inform further work such as targeting / re-commissioning services or enhanced integration / early intervention if appropriate, including the wider determinants of health.

## **8. Conclusions**

Whilst the development of the Bristol JSNA has shown progression over the last year there is a need for continued senior leadership support to enable the JSNA to fully drive planning and commissioning processes and to ensure we have a better understanding of the equalities issues.

## **9. Recommendations**

The Health and Wellbeing Board are asked to:

- Agree proposed new JSNA Priority Chapters for 2017/18 – see Appendix A
- Provide a steer around improving access to ethnicity data
- Endorse the proposed changes to the JSNA webpage
- Continue to provide leadership support and influence to ensure adequate resources and capacity for developing JSNA chapters

## **10. Appendices**

Appendix A – JSNA Priority Chapters 2017/18: proposed

Appendix B - Equalities data in routine health data sources

Appendix C – JSNA SG membership

## Appendix A – JSNA Priority Chapters 2017/18

Chapters continued from 2016/17	
Priority Chapters	Progress
Healthy life expectancy	Due autumn 2017
Employment and health	Completed, publish July 2017
Healthy weight - children	Completed, publish July 2017
Healthy weight - adults	Due autumn 2017
Mental health and wellbeing - children	Completed, publish July 2017
Mental health and wellbeing - adults	Due autumn 2017
Respiratory disease	Due by July 2017
Cancers	Due by July 2017
Women's health	Due by July 2017

New Priority Chapters for 2017/18 – proposed	
Priority Chapters	Why a priority? / Progress
Suicide Prevention	<b>NEW</b> – Priority area from Mental Health Chapter (adults) – due summer 2017
SEND (Special Educational Needs and Disabled children)	<b>NEW</b> - Priority for BCC. Joint Public Health and People.
Air Pollution	<b>NEW</b> - National & BCC priority. Joint Public Health and Place.
Fuel Poverty	<b>NEW</b> - joint Public Health and Place / Housing.
Breastfeeding	Prioritised from 2016/17 to support re-commissioning of services – due summer 2017
Childhood injury	Prioritised from 2016/17 to support re-commissioning of services – due summer 2017

Note – there are also a further 12 non-priority Chapters planned for 2017/18

JSNA Chapters 2016/17 – published	
Alcohol misuse – adults	Priority Chapter
Substance Misuse / Drugs - Young people	Other chapter
Epilepsy - children	Other chapter
Children and young people with social and communication interaction needs (including autism)	Other chapter
Sexual health	Other chapter

## **Appendix B - Availability of equalities protected characteristics data in routine health data sources**

### **Introduction**

Further to queries raised at the Health and Wellbeing Board in December 2016, the Bristol City Council's Public Health Knowledge Service have looked at a number of routine data sets to examine the possibility of cutting the data by the equalities protected characteristics:

- age
- disability
- race
- sex
- religion or belief
- sexual orientation
- marriage and civil partnership
- gender reassignment
- pregnancy and maternity

Generally routine data sources do not provide details on many protected characteristics apart from age and sex. For a lot of data sources this is unlikely to change as most of these sources are contracting or administrative data sets, which public health (and others) use opportunistically but do not have any control of what is actually collected.

A summary of data availability is listed at the end of the document. Please note – this is not an exhaustive set of all potential data-sets, but the most relevant.

### **Data sets examined**

**Births registrations** – all births in the UK must be registered. After the birth is registered the Office for National Statistics (ONS) append other clinical data to the record (such as birthweight) and produce a data file (which used to be called the public health births file) which is available (via NHS Digital) to local authority public health departments. Protected characteristics available are **sex** (of child) and **age** (of mother).

**Death registrations** – all deaths in the UK must be registered. Data is available via Primary Care Mortality Database (PCMD) from NHS Digital and is available to local authority public health departments. Data set contains patient details such as date of birth, sex, usual address and date of death and clinical details such as cause of death. Protected characteristics available are **sex** and **age**.

**Hospital inpatient data** – all admissions to acute hospitals are recorded on hospital patient administration systems, which are then regularly submitted to the NHS Digital Hospital Episodes Statistics (HES) system, a country wide repository of hospital activity data. Patient details are recorded (such as DOB, date of admission, sex, place of residence, ethnicity) and clinical details (such as diagnoses, and operative procedures) are also recorded. Protected characteristics available are **sex**, **age**, **ethnicity** (~70% of records have valid ethnicity recorded) and it may also be possible to identify if a patient is **pregnant** through diagnostic codes (not all may be captured).

**General practice data (via EMIS)** – it is possible to extract data from GP practice administrative systems. The data is extracted from 3<sup>rd</sup> party system called EMIS, accessed via the South Commissioning Support Unity (CSU). Restrictions are placed on what queries can be performed on the data and the data is sometimes of poor quality. The data systems are primarily for GP patient management system rather than population health. GP systems can record a wide range of protected characteristics but are not comprehensively recorded. Protected characteristics available are **age**, **disability** (only ~ 10% recorded), **ethnicity** (~ 70% valid records), **sex**, **belief** (not well recorded), **sexual orientation** (not well recorded) and **marital status** (not well recorded).

**Quality Outcomes Framework (QOF)** – QOF data is provided via GP registers of specific health conditions, and is a standard source of routine health indicators used in the JSNA. It provides local data but does not provide any equality monitoring breakdowns – all data is just a total for the GP Practice. This is a national limitation to the QOF indicators.

**Census (2011)** – the national census is taken every 10 years and collects a large amount of personal population data from almost everybody in Britain. There are limited health questions (there is a question about limiting long term illness and also one about general health) but a lot of personal characteristic questions and also housing, economic and transport question amongst others. Protected characteristics are **sex**, **age**, **ethnicity**, **belief** and **marital status**.

**Population estimates** – ONS estimate the resident population every year (around June / July) based upon the latest census, birth and deaths and known migration. Protected characteristics available are **sex** and **age**.

**Bristol Quality of Life survey** – not strictly a routine data source but a valuable source in Bristol for information on citizens for a variety of topics. Up until this year the quality of life survey was a random sample survey of adults in Bristol. Protected characteristics available are **age**, **disability**, **ethnicity**, **gender**, **belief**, **sexual orientation** and **pregnancy**.

**Cancer registration data** – all new cancer diagnoses are recorded on the national cancer register, managed by NCRAS (National Cancer Registration and Analysis Service). All cases of cancer are then followed through to survival or death. At a local authority level protected characteristics available are **age** and **sex**.

**National Child Measurement Programme** – annual measurement of all children in Reception Year and Year 6 in state schools in Bristol. Protected characteristics available are **age**, **sex** and **ethnicity**.

**Bristol school census** – Not health data, but a comprehensive data-set (updated 3x /year) of all pupils in Bristol schools (including academies but excluding independent schools or Bristol children at school in other authority areas). Protected characteristics are **sex**, **age** and **ethnicity** (with 99+% completions). The equalities data can cross-reference with other school census data (eg free school meals by ethnicity) if required, and in principle could match with external data-sets if appropriate data-sharing in place (NB would need resource).

## Other health and care providers

The Equality Act places an Equality Duty on public bodies- it intends to ensure that public bodies are proactive in eliminating unlawful discrimination, advancing equality of opportunity and fostering good relations. They must consider equality issues in everything they do with regard to the protected characteristics. Whilst collecting and monitor equalities data will be a requirement within contracts, it is not a legal obligation.

A new Mental Health Minimum data set (MHMDS) is being developed by NHS Digital which should contain all mental health activity. MHMDS contains **age, sex and ethnicity**.

## Summary of data availability

Dataset / Characteristic	Age	Disability	Ethnicity	Gender	Belief	Sexual orientation	Marital status	Gender reassignment	Pregnancy & maternity
Births	No (doesn't give gestation length)	No (stillbirth diagnosis only)	No (only mother's country of birth)	Yes	No	No	No	No	No
Deaths (for mortality stats and life expectancy)	Yes	No (unless recorded as a cause of death)	No	Yes	No	No	No	No	No
Hospital inpatients	Yes	No	Yes (77% of inpatients have ethnicity recorded)	Yes	No	No	No	No	Yes (should be included in diagnosis fields)
General Practice data (EMIS)	Yes	Yes (but poorly recorded <10%)	Yes (70% coverage typically, 90% for Health Check data)	Yes	Yes (but poorly recorded <10%)	Yes (but poorly recorded <10%)	Yes (but poorly recorded <10%)	No (may appear in patient notes)	Should be recorded in patient notes
Quality Outcomes Framework (QOF)	No	No	No	No	No	No	No	No	No
2011 Census	Yes	No (does not include limiting long term illness)	Yes	Yes	Yes	No	Yes	No	No
Mid-year population estimates	Yes	No	No	Yes	No	No	No	No	No
Quality of life	Yes	Yes (self reported disability and LLTI)	Yes	Yes	Yes	Yes	No	No	Yes (posss by pregnancy)
Cancer registration data (incidence, prevalence & survival)	Yes	No	No (may be available at national level)	Yes	No	No	No	No	No
National child measurement programme	Yes	No	Yes (Only Yr 6 pupils in Bristol)	Yes	No	No	No	No	No
Mental Health Minimum Data Set (MHMDS)	Yes	No	Yes	Yes	No	No	No	No	No
Public Health commissioned services - Sexual health services	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No
Public Health contracts - Drug and alcohol services	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes

Colour rating: Red = Data not available by this characteristic / Yellow = available to a limited extent / Green = Data is available

## Appendix C – JSNA Steering Group membership

<b>Position</b>	<b>Current name</b>
Director of Public Health (Chair) Bristol City Council (BCC)	Becky Pollard
Service Director, Strategic Commissioning and Commercial Relations – People (BCC)	Netta Meadows
Service Director for Strategy and Policy (BCC)	Tbc (Was Di Robinson to May 2017)
Programme Manager for Housing and Energy - Place (BCC)	Sarah Sims
Head of Service Improvement (NHS Bristol CCG)	Adwoa Webber, (since April 2017)
Director for Communities (at The Care Forum) Healthwatch Bristol	Morgan Daly (since April 2017)
Voluntary and Community Services – Voscur	Tbc (was Sue Brazendale to Mar 2017)
Public Health Consultant (lead for JSNA) (BCC)	Jo Copping
Bristol Strategic Intelligence and Performance Manager (BCC)	Nick Smith



## Bristol Health & Wellbeing Board

Health and Wellbeing Roundtable Discussions	
Author, including organisation	Becky Pollard, Director of Public Health, Bristol City Council
Date of meeting	28 <sup>th</sup> June 2017
Report for Information and Discussion	

### 1. Purpose of this Paper

To update the Bristol Health & Wellbeing Board (HWB) on the outcomes and developments which are emerging from recent Health and Wellbeing Roundtable Discussions hosted by the Mayor of Bristol, Marvin Rees.

### 2. Executive Summary

Three roundtable discussions have been set up on behalf of the Mayor of Bristol to explore ways to strengthen local health system leadership across the city.

These workshops have engaged with local provider and commissioning health system leaders and members of the HWB. The specific aim and purpose of these discussions are to:

- Explore current health and wellbeing system leadership and delivery in Bristol;
- Map existing Health and Wellbeing systems leadership networks in Bristol;
- Consider and define the role of the HWB for Health and Wellbeing in Bristol in light of current arrangements.

The scope of the workshops includes:

- What do we want from the health system in Bristol?
- What does the health system leadership need to deliver for Bristol?
- What systems leadership is needed for health in Bristol?

- What is the role of the HWB in Bristol?
- What is the way forward with Health and Wellbeing in Bristol?

A third roundtable discussion has been arranged to take place on the 13<sup>th</sup> July 2017. It will be hosted by Marvin Rees and Dr Martin Jones (as joint Chairs of the HWB) and invitations have been sent to local health and social care systems leaders and HWB members. This session aims to discuss Health and Wellbeing outcomes identified in the previous workshops and to identify and agree a way forward to strengthen health system leadership across the city.

A proposed forward plan will be presented to the HWB at its next meeting in August 2017.

### **3. Context**

The Health and Social Care Act 2012 set out a statutory duty for unitary local authorities and clinical commissioning groups across England to set up local Health and Wellbeing Boards to improve the health and wellbeing of their local populations.

The Bristol HWB was established in 2013 and is currently co-chaired by the Mayor, Marvin Rees and Dr Martin Jones, Clinical lead for Bristol Clinical Commissioning Group (CCG). It is made up of local health and social care commissioners and representatives of the community and voluntary sector. At present, the Board does not include representatives from NHS providers.

Since 2013, the strategic landscape for health and social care commissioning has changed considerably, in particular with the establishment of joint working across Bristol, North Somerset and South Gloucestershire (BNSSG) CCGs and with the introduction of BNSSG Sustainability and Transformation Plan (STP). In light of these changes, the Mayor invited local health system leaders and members of the HWB to review local system leadership to ensure most effective partnership working arrangements are in place to improve health and wellbeing and reduce health inequalities.

Bristol City Council commissioned Joe Simpson from the Leadership Centre to facilitate a series of group discussions and provide feedback to the Mayor and the HWB. The first of three events took place on the 3<sup>rd</sup> May 2017 for local NHS and social care providers. The second event took place for HWB members on 12<sup>th</sup> May 2017. A third and final event is planned on 13<sup>th</sup> July for all health and system care leaders to review outcomes of all discussions and agree a way forward.

Appendix 1 sets out invitees for all discussion events for information.

#### **4. Main body of the report**

##### **3<sup>rd</sup> May Roundtable Discussion**

Marvin Rees (Mayor) outlined Bristol's ambition for Health and Wellbeing and the challenges. Alison Comley (Strategic Director, Neighbourhoods), Becky Pollard (Director, Public Health, Neighbourhoods) and John Readman (Strategic Director, People) set the scene by discussing the background and context for Health and Wellbeing in Bristol. The minimum statutory legal requirements for Boards were discussed, and the free scope for membership. Commissioning and provider roles were explored. Bristol's Health and Wellbeing priorities, the refresh Strategy, the Joint Strategic Needs Assessment (JSNA), and the wider determinants of health were outlined.

Themes which emerged from discussion

- Health and Wellbeing beyond illness into health
- Health and Wellbeing into employment
- Bristol's Health and Wellbeing footprint.

Participants identified the need to:

- Develop a shared system wide vision for health and wellbeing in Bristol and wider area;
- Outline a structure and culture that enables Bristol to deliver this vision;
- Develop a City Plan for health and wellbeing in Bristol.

##### **12<sup>th</sup> May Roundtable Discussion**

Marvin Rees (Mayor) discussed three main themes with Board members:

1. Developing Bristol's Health and Wellbeing footprint;
2. Systems leadership for Health and Wellbeing in Bristol and who should be involved;
3. The role of the Health and Wellbeing Board (HWB).

Outcomes from the discussion identified the need to:

- Influence and change attitudes to health in Bristol;
- Take a population based approach to tackle health inequalities;
- Refresh the Health and Wellbeing Strategy for Bristol;

- Establish where the Sustainability Transformation Plans (STP) fit within the strategy;
- Encourage elected members to take on a role to champion health in Bristol;
- Further community engagement with health and wellbeing;
- Take opportunities with current health and wellbeing community events to promote key health and wellbeing messages;
- Further integrated partnership working;
- Review the existing scrutiny system for health in Bristol;
- Further policy development for Health and Wellbeing in Bristol;
- Create a new forward plan for Health and Wellbeing in Bristol;
- Engage with local employers to promote a healthy workforce in Bristol.

## **5. Key risks and Opportunities**

These discussions provide an opportunity to explore and further develop Bristol's Health and Wellbeing Vision to improve health and wellbeing of the local population.

## **6. Implications (Financial and Legal if appropriate)**

N/A

## **7. Evidence informing this report.**

N/A

## **8. Conclusions**

The outcomes of these roundtable discussions will provide evidence and direction in how we can develop the role of the HWB and inform the development of a new City Plan for Health and Wellbeing for Bristol.

## **9. Recommendations**

- Consider the outcomes of these roundtable discussions
- Agree to consider these outcomes as a way to further develop a shared Health and Wellbeing vision for Bristol

## **10. Appendices**

Appendix 1 – List in invitees to the three roundtable events

## **Appendix 1**

### **Invitees to HWB Workshops**

#### **Workshop one – 3.5.2017**

Mayor, Marvin Rees

Anna Klonowski, Chief Executive, Bristol City Council

Alison Comley, Strategic Director, Neighbourhoods, Bristol City Council

John Readman, Strategic Director, People, Bristol City Council

Becky Pollard, Director of Public Health Bristol City Council

Julia Ross, Chief Executive, BNSSG CCG

Robert Woolley, Chief Executive, UHB NHS Trust

Dr Hayley Richards, Chief Executive, Avon and Wiltshire Partnership NHS Trust

Julia Clarke, Chief Executive, Bristol Community Health

Joe Simpson, Director, The Leadership Centre

Cllr Gill Kirk, Bristol City Council

#### **Workshop two – 12.5.2017**

Marvin Rees, Mayor

Alison Comley, Strategic Director, Neighbourhoods

Becky Pollard, Director of Public Health

Cllr Asher Craig, Deputy Mayor, Communities

Cllr Helen Holland, Cabinet Member for Adult Care

Cllr Gill Kirk, Bristol City Council

Steve Davies, South Bristol locality group, Bristol CCG

Elaine Flint, Voluntary Sector rep.

Dr Pippa Stables, Inner City and East Bristol Locality Group

Mike Hennessey, Service Director Care and Support Adults

Vicki Morris, Health Watch rep.

Andrea Young, Chief Executive, North Bristol NHS Trust

Joe Simpson, Facilitator, The Leadership Centre

#### **Workshop 3 – 13.7.2017**

Mayor –Marvin Rees, Co - Chair

Dr Martin Jones- Co-Chair

Julia Ross, CEO, BNSSG CCG

Alison Comley, Strategic Director, Neighbourhoods  
John Readman, Strategic Director, People  
Cllr Asher Craig, Deputy Mayor, Communities  
Cllr Helen Godwin  
Cllr Helen Holland  
Terry Dafter, Service Director Care and Support Adults  
Linda Prosser, Director, NHS England  
Vicki Morris, Health Watch rep.  
Elaine Flint, Elaine Flint, Voluntary Sector rep.  
Keith Sinclair, Carers Forum  
Steve Davies, South Bristol locality group  
Justine Mansfield  
Pippa Stables, Dr Pippa Stables, Inner City and East Bristol Locality Group  
Andrea Young, CEO, NBNHS Trust  
Natalie Cridland – PA to Andrea Young  
Robert Woolley, CEO, UHB NHS Trust  
Yvonne Quinn, PA to Robert Woolley  
Dr Hayley Richards, CEO, AWP  
Julia Clarke, CEO Bristol Community Health  
Anna Klonowski, CEO, Bristol City Council  
Joe Simpson – Director, Leadership Centre, (Facilitator)



## Bristol Health & Wellbeing Board

<b>Thrive Bristol – developing a city-wide approach to mental health and wellbeing</b>	
<b>Author, including organisation</b>	Victoria Bleazard Mental Health & Social Inclusion Programme Manager, Bristol City Council
	Leonie Roberts Public Health Consultant, Bristol City Council
	Dr Jo Copping Public Health Consultant, Bristol City Council
<b>Date of meeting</b>	28 <sup>th</sup> June 2017
<b>Report for Information/Discussion/ Decision</b> For discussion and decision	

### 1. Purpose of this Paper

This paper provides an update on plans to develop a city-wide Mental Health and Wellbeing Programme. Specifically, it offers an overview of the 'Thrive' model and proposes developing a 'Thrive Bristol' programme, led by city leaders and coproduced with individuals and groups from across the city.

### 2. Executive Summary and context

Mental health is a top priority, both nationally and here in Bristol (as identified by the Health and Wellbeing Board and the city's Corporate Strategy). We have particular issues in Bristol that need to be acted upon, such as high rates of illness and suicide and a low self-reported 'happiness score'. There is a great deal of good work being undertaken in the city, but through this not being coordinated and 'mainstreamed' then we are missing opportunities to improve our residents' mental health and wellbeing.

In February, members of the Health and Wellbeing Board agreed to champion this programme and help to develop a Task and Finish Group to develop a strategy. Since then, two key changes have taken place:

- Nominated councillor ‘champions’ are no longer on the Health and Wellbeing Board.
- We have explored new, innovative approaches to improving mental health and wellbeing (the ‘Thrive’ model). This moves away from creating a single strategy, to creating an agile programme that is owned and led by diverse partners from across a city, and able to ‘test and learn’ to develop effective interventions and approaches.

Based on what we have found, we propose creating a more ambitious programme (using the ‘Thrive’ model) which we believe will enable us to more effectively meet the city’s current and future mental health and wellbeing needs.

### **3. Main body of the report**

#### **- Proposed approach: the ‘Thrive’ model**

Our mental health is influenced by a huge array of factors – the family we are born into; the house we live in; the job we have (or don’t have); our friends and communities; and our access to mental health care when we need it. As such, to improve mental health and wellbeing across the city we need to consider the role different agencies can make – teachers, employers, housing bodies, rather than just focusing on the role of the NHS.

We have sought advice from national leads around the approaches being used elsewhere. One model has been repeatedly cited: ‘Thrive’. This began in New York (led by Mayor Bill de Blasio) which brought city leaders together to set out a roadmap for the city to both reduce the impact of mental illness and promote mental health and protect citizens’ resiliency, self-esteem and family support. Whilst this model had a large budget, many cite its great strength as its ability to mobilise a city – including leaders from across sectors - around mental health and wellbeing.

It has a heavy focus on data collection and evaluation, and initiatives include training large numbers of people in mental health first aid; screening and treating all pregnant mothers with depression; strengthening mental health provision in primary care and substance misuse, as well as in schools; and scaling up community-based parent coaching and social and emotional education.

The West Midlands has since developed its own version of the ‘Thrive’ model, they published their strategy in January. This was led by the West Midlands Combined Authority’s (WMCA’s) Mental Health Commission and created an integrated action plan to improve the mental health of people in the region (adults-only). They undertook an economic assessment which found that mental ill health was costing the region £12.6bn a year. In doing so local businesses, Local Enterprise Partnerships and industry leaders were motivated to join forces with the NHS, local authorities, voluntary sector and

police to develop a shared approach. Their focus was on improving the treatment of those who are already ill, as well as preventing ill health, a deterioration of health, and promoting good mental health and wellbeing.

Similar to New York they have set to train 500,000 citizens in Mental Health First Aid. They have also launched a West Midlands Workplace Wellbeing Commitment and are trialling a ‘Wellbeing Premium’, which is a tax incentive for employers who show their commitment to staff wellbeing. They also aim to offer a Housing First service to people who are homeless, more widespread use of the Mental Health Treatment Requirement (this provides mental health support to people who have offended); better mental health support for people as they leave prison; ambitious suicide prevention plans and community engagement schemes. It has a citizens’ jury which shaped the way the Commission was undertaken and its findings.

The Mayor of London is also developing a London version of ‘Thrive’ which is launching imminently and a programme is being developed to embed this approach globally.

### **- Proposed scope**

Based on Public Health England’s approach and wider strategies in this area, we propose a three tiered approach that would focus on:

- a.) Universal Interventions to improve public mental health and wellbeing, building resilience and promoting wellbeing **at all ages** (using a life course approach).
- b.) Targeted work to prevent mental ill health and early intervention for people at risk of mental health problems (including suicide prevention). This could include a focus on the mental health and wellbeing of looked after and vulnerable children, young offenders or refugees, for example.
- c.) Public mental health support for people with mental health problems. For example, including a focus on tackling health inequalities affecting people with serious mental illness (e.g. NHS / public health joined-up smoking cessation), or supporting recovery and inclusion.

To note, Public Health England’s ‘Prevention Concordat’ guidance will be published imminently, which this work will align with.

As a programme, ‘Bristol Thrive’ would encompass a range of themes. This may include some of the following:

- Support from birth and early years
- Children and young people
- Further education
- Employment and skills (supporting people into work and whilst in work)
- Housing

- Criminal justice
- Public mental health (including the physical health of people with mental illness / suicide prevention)
- Art, sport and nature

It would be useful to gain feedback on which of the above should be prioritised within the programme. Feedback from local and national partners as so-far prioritised mental health and employment, and young people's mental health.

Principles to be prominent throughout all work:

- Tackling stigma and discrimination
- Tackling health inequalities / equalities
- Capacity and capability
- The role of digital
- Community engagement and coproduction
- Openness and transparency
- Public engagement and voices of experience

National partners are interested in working with us, such as the Centre for Mental Health, which would help to ensure we have the strongest evidence base to inform this work.

### **- Aims of Bristol Thrive**

Based on the political mandate set locally, national guidance and local feedback we propose that this programme aims to:

- Improve mental health and wellbeing across Bristol, gaining clarity around what improvement looks like and how we will achieve it (for example, agree city-wide goals for improvement, with clear metrics to indicate progress).
- Shift our focus from care to prevention, early intervention and resilience.
- Ensure that this work helps to tackle our city's health inequalities.
- Take a universal population-based approach across each stage of the life course.
- Simplify and strengthen leadership and accountability across the whole system.
- Create a shared vision for the city around better mental health and wellbeing, led by a diverse range of partners – for example business leaders, teachers, housing leads.
- Involve people across the city, especially community leaders, in co-producing plans.
- Create an action plan which is owned by agencies across the city – created by them, with a clear mechanism to deliver.
- Is both aspirational in its goals, but pragmatic to the context in which these will be delivered – creating a vision for a mentally healthy Bristol in 2050, as well as acting on immediate priorities.
- Builds upon the good work already being undertaken in the city.

- **What does this mean for Bristol?**

Mayor Marvin Rees and Deputy Mayor Asher Craig have indicated an enthusiasm for the ‘Thrive’ model to be brought to Bristol.

Based on feedback from those who have developed this model elsewhere, we consider the following to be key aspects of a successful programme:

- **A clear case for change**
  - Develop Mental Health and Wellbeing JSNA (Summer 2017)
  - Undertake economic analysis of the economic cost of mental ill health for Bristol (by Autumn 2017)
- **Support from senior leaders**
  - This agenda needs to be ‘owned’ by leaders from across the city, both within statutory agencies and beyond (e.g. business, education, housing). Whilst public health will support the development and delivery of the programme this would ideally move from being seen as a ‘public health strategy’ to a city-wide programme.
- **Inclusive ‘co-production’ approach**
  - This needs to offer multiple ways for individuals, communities and organisations to shape this work to ensure it meets the needs of all of Bristol, particularly those facing the greatest health inequalities.
- **Transparent, specific goals for success**
  - Creation of clear city-wide goals for improved mental health and wellbeing, which are evidence based\* and measurable. Full transparency would enable the city’s residents to see the progress being made.

*\*It would draw on evidence that currently exists, and where we identify gaps in our knowledge then we would seek to innovate and evaluate.*

Should the Health and Wellbeing Board agree to this approach, a full programme plan with timeframes would be developed.

## **4. Key risks and Opportunities**

### **Opportunity:**

- To build upon what has been developed in other areas of the world to develop an ambitious and innovative approach to improve mental health and wellbeing.
- To create a single vision to align our resource and identify duplication.
- To galvanise support from different parts of the city who have a great deal to contribute to improving mental health and wellbeing, e.g. employers.
- To create a coordinated approach to improving mental health – for those currently experiencing it, as well as preventing future ill health – which is greatly needed, particularly in an environment of reduced budgets.

- To focus on the wider determinants of mental wellbeing and positive mental health, rather than mental health services alone.

**Risks:**

- A whole-city approach may be more complex, require engagement and support of more stakeholders and potentially require more time and investment.
- This may be ‘too big’ and we will need to prioritise some areas to undertake first.
- We need to ensure that we don’t raise expectations that cannot be met.
- We may lack investment to develop new approaches to improving mental health and wellbeing.
- Mental health stigma does still exist and we may struggle to gain the support from different agencies that is needed. Senior level championing from the Health and Wellbeing Board will help to mitigate this.

## 5. Implications (Financial and Legal if appropriate)

A full analysis will be developed if we secure agreement for this approach.

## 6. Background information and evidence for ‘Thrive’

- Overview of ‘Thrive NYC’:  
<https://thrivenyc.cityofnewyork.us/>
- West Midlands’ Thrive Action Plan:  
<https://www.wmca.org.uk/media/1723/wmca-thrive-full-report.pdf>  
 (this drew upon data from leading academics, including economists).
- London ‘Thrive’  
[www.london.gov.uk/what-we-do/health/london-health-board/thrive-london-improving-londoners-mental-health-and-wellbeing](http://www.london.gov.uk/what-we-do/health/london-health-board/thrive-london-improving-londoners-mental-health-and-wellbeing)

## 7. Suicide Prevention and Self Harm Strategy

To be aware, in parallel to this work we are developing a Suicide Prevention and Self Harm JSNA and revised Strategy. Both will be completed by the end of 2017 and will be brought back to the Health and Wellbeing Board for their approval. This will inform, and be informed by, the wider Mental Health and Wellbeing Programme.

## **8. Recommendations**

- It is recommended that the Health and Wellbeing Board adopt and support the delivery of a 'Thrive Bristol' programme, as a way of addressing its key priority to improve mental wellbeing and health across the city.



## Bristol Health & Wellbeing Board

### Progress update – Bristol alcohol strategy

Author, including organisation	Blanka Robertson, Public Health Principal, Bristol City Council
Date of meeting	28 <sup>th</sup> June 2017
Report for Information	

#### 1. Purpose of this Paper

**To update the Health and Wellbeing Board (HWB) on progress on the delivery of the Bristol alcohol strategy.**

#### 2. Executive Summary

Alcohol misuse presents a major problem in Bristol that requires a system-wide response. The Bristol Alcohol Strategy 2016-2020 has been the culmination of a wide range of stakeholders working collaboratively to identify key issues and propose solutions to ensure that Bristol is a healthy and safe place to live, work and visit. Since its first presentation to the HWB in October 2016, many actions and interventions have been implemented with the focus on prevention, effective treatment and safe environment.

#### 3. Context

Bristol is a large, diverse and vibrant City with a thriving night time economy. It is also host to a number of large public events and sporting occasions throughout the year, where thousands of people come together to enjoy what Bristol has to offer.

Maintaining a safe environment, particularly when alcohol is involved, is essential for people to be safe and feel safe. To help achieve this, everyone has their part to play. Unfortunately, alcohol can cause people to act in a negative way, leading to physical and verbal assaults and ultimately, arrest or serious injury. This can have a dramatic impact on those involved and they may live to regret an alcohol fuelled moment for the rest of their lives. It is also

important to recognise the impact such behaviour has on society as a whole as it can be felt by the wider community in terms of experiencing anti-social behaviour, detrimental quality of life as well as the health and cost implications.

#### **4. Main body of the report**

Bristol City Council's Public Health Team works in partnership with other agencies to reduce the negative impacts of alcohol consumption on the lives of people living and working in Bristol. In July last year Alcohol Summit was held by the Bristol City Council bringing together a wide range of partners to take a collaborative approach to tackling this issue. A 'Vision for Bristol' and a five year strategy were presented at the Summit, commencing a consultation period. Final draft of the Bristol Alcohol Strategy 2016-2020 was presented to the HWB for a decision in October 2016. With the support of the HWB, a multi-agency alcohol strategy group has continued to deliver actions agreed in the strategy action plan.

For example:

- We have incorporated the national Dry January Campaign into a roadshow across the City and set up Twitter account to enable public communication about the benefits to stay clear of alcohol; we worked with Bristol organisations to support their staff to participate in the campaign
- The Bristol Big Drink Debate was delivered across the City using a variety of techniques, including on-line surveys, focus groups, workshops, stands and social media to engage individuals and communities in thinking and talking about alcohol and the impact of drinking
- We are developing new alcohol badge as part of the Healthy Schools Programme to encourage local schools to adopt a whole school approach to reducing alcohol use among young people and to promote awareness about alcohol harm among families
- We have trained staff in more than 30 community pharmacies in Alcohol Identification and Brief Intervention. Many of these are located in areas of high deprivation and

provide opportunities for local people to gain awareness about their level of alcohol use and to access appropriate interventions early if and when needed

- We have delivered training and awareness campaigns to more than 40 local organisations to increase their employees knowledge of the impact of alcohol consumption on health, safety and wellbeing
- A Substance Misuse health needs assessment was carried out to provide an overview of current service provision against treatment need and identify how services can meet the needs of service users
- A Substance Misuse commissioning strategy was produced to provide evidence base for the current substance misuse treatment re-commissioning process
- We are developing a system approach to alcohol liver disease treatment that will include non-invasive measurement of fibrosis and outreach management of cirrhosis complications

## **5. Key risks and Opportunities**

Delivering the actions set out in the strategy provides a great opportunity to improve public health outcomes for the City by:

- increasing the effectiveness of working together with other partners to achieve common goals
- strengthening the engagement with local communities to change attitudes toward alcohol and to the current drinking culture, and to support local people in changing their behaviour.

## **6. Implications (Financial and Legal if appropriate)**

## **7. Evidence informing this report.**

Bristol Alcohol Strategy 2016-21  
Substance Misuse Needs Assessment 2016  
JSNA Alcohol in Adult Population 2017

## **8. Conclusions**

Achieving the Vision for Bristol to reduce alcohol-related harm cannot just be the responsibility of public services. Individuals and our communities also need to review their own relationship with alcohol and make judgements as necessary. Changing drinking culture needs a multipronged approach. This can be achieved by raising awareness through social marketing, working with businesses to promote social responsibility, utilising expertise and powers to create the right environment and providing the right interventions at the right time.

The Bristol Alcohol Strategy Group will continue to work in partnership with other agencies and with the local communities to achieve the main goals: to reduce alcohol consumption in Bristol and reduce the harm associated with drinking.

## **9. Recommendations**

- Continue to engage with local communities to increase understanding of the negative impacts of alcohol and of safer drinking using national and local campaigns
- Use the strength of the partnership working to support implementing these messages across a range of services and local communities
- Continue to deliver Identification and Brief Advice interventions in health care settings and Pharmacies
- Utilise the Health Checks for 40-70 years old as an opportunity to access people's current level of drinking and take appropriate actions/early interventions
- Work with partner agencies to ensure that health and social care providers are able to identify risks early
- Increase focus on the impact of alcohol consumption in vulnerable groups, for example in Black and Minority Ethnic communities, "high-performance drinkers".
- Reduce gender health inequalities related to alcohol consumption.

## **10. Appendices**

1. Bristol Alcohol Strategy 2016-20
2. Substance Misuse Health Needs Assessment 2016
3. JSNA Alcohol in Adult 2017



# **BRISTOL CITY-WIDE ALCOHOL STRATEGY 2016 – 2020**

October 2016

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## FOREWORD



*Becky Pollard, Director of Public Health, Bristol City Council*

The consumption of alcohol is an established part of life in the UK. There are many people who choose not to drink but, for the majority of adults, alcohol is accepted in the routines of daily life.

Yet, alcohol can bring a whole world of harm. For the individual, regular drinking increases the risk of developing illnesses such as cancer, liver cirrhosis and heart disease, and excessive alcohol consumption can lead to dependence. For families, alcohol consumption can lead to relationship breakdown, domestic violence and become a significant factor in poor parenting. For communities alcohol can fuel crime and disorder and can transform parts of the City into no-go areas. For the society, the cost of alcohol consumption includes huge financial burden on public services as health, social care and criminal justice agencies all have to invest a significant amount of resources providing response to the effects of drinking. Alcohol-related work absence due to alcohol consumption and the loss of productivity impact on the local economy and can reduce the ability of our City to thrive and achieve its potential.

The Bristol Alcohol Strategy aims to make our City safer, healthier and happier place to live, to work, and to visit by working with individuals and communities to reduce alcohol consumption and alcohol-related harm. While we have already made a considerable progress in developing effective ways we deal with alcohol misuse in the City, we recognise the great potential for us to work with partner organisations to promote a positive behavioural change leading to improved health and wellbeing for everyone.



*Dr Martin Jones, Chair Clinical Commissioning Group, NHS Bristol Clinical Commissioning Group*

Alcohol misuse presents a major problem in Bristol that requires a system-wide response. Nationally liver disease is the only major cause of death still increasing year-on year and this statistic is also reflected in our local population with deaths caused by or associated with alcohol higher than the England average. This strategy has been the culmination of a wide range of stakeholders working collaboratively to identify key issues and proposed solutions to ensure that Bristol is a healthy and safe place to live work and visit.



*Rhys Hughes, Superintendent, Avon and Somerset Police*

Bristol is a large, diverse and vibrant City with a thriving night time economy. It is also host to a number of large public events and sporting occasions throughout the year, where thousands of people come together to enjoy what Bristol has to offer.

Maintaining a safe environment, particularly when alcohol is involved, is essential for people to be safe and feel safe. To help achieve this, everyone has their part to play.

Unfortunately, alcohol can cause people to act in a negative way, leading to physical and verbal assaults and ultimately, arrest or serious injury. This can have a dramatic impact on those involved and they may live to regret an alcohol fuelled moment for the rest of their lives. It is also important to recognise the impact such behaviour has on society as a whole as it can be felt by the wider community in terms of experiencing anti-social behaviour, detrimental quality of life as well as the health and cost implications.

This workstream brings together a number of partner agencies to identify ways to protect vulnerable people, reduce demand on public services and work with events organisers to make sure their visitors can have an enjoyable and safe time. It has to be a team effort and some of our work has already had tangible success in reducing the number of alcohol related incidents at large events.

I am confident that working with the other leads, to deliver the Bristol Alcohol Strategy, will reduce the harm alcohol can cause and bring real benefits to the city.

# 1 EXECUTIVE SUMMARY

## 1.1 Introduction: Alcohol, public health problem

Alcohol is a complex issue. In recent years the sale of alcohol has shifted from the on-trade to the off-trade, as supermarkets take over dominance of sales and more people choose to drink at home. Alcohol has become more affordable over time and the amount of alcohol being sold has been increasing.

Excessive intake of alcohol has clear effects on crime and health; on communities, children and young people. Levels of alcohol-related harm to the health and wellbeing of individuals, families and communities have risen, and health problems caused by heavy drinking are now being identified in young people.

### Alcohol consumption in Bristol

About 84% of Bristol population aged 16 years and over engage in drinking. Of those, 20.3% drink at increasing levels that risk harm in the long term, and 7.5% drink at higher risk levels that harm themselves and others. Furthermore, 26.3% reported to binge drink, hence are vulnerable to the acute effects of intoxication such as assault, falls and poisoning. The percentage of binge drinkers in Bristol is higher than the regional and national average. It should be noted that people are likely to underestimate the amount they drink in self-reported surveys.

The pattern of alcohol misuse over Bristol is varied and complex, sensitive to cultural and socio-economic characteristics that greatly differ across the City. In deprived areas people who misuse alcohol are also more likely to also smoke tobacco, hence at increased risk of developing complicating medical condition such as cancer. This increased risk results in a higher burden of mortality caused by alcohol in deprived areas, despite less people in the areas misusing alcohol.

### Health harms

Excessive drinking is a major cause of wide range of diseases and injuries. Alcohol and drug use was identified to be the fifth leading risk factor of the burden of disease in England. Alcohol consumption was the third leading behavioural risk factor overall, and the leading behavioural cause of injury. About a third of deaths from cirrhosis could categorically be assigned to alcohol as the underlying cause.

In Bristol there were 5,408 persons admitted to hospital due to alcohol-related conditions in 2013/14 where alcohol-related condition was the primary diagnosis or any of the secondary diagnoses with an alcohol-attributable code. Bristol alcohol-related admissions has been consistently higher than the England average, with 1,513 persons per 100,000 population admitted (broad measure) in 2013/14 compared to the England rate of 1,253 admissions per

100,000. The most common reasons for alcohol-related admission episodes in Bristol were cardiovascular disease and mental & behavioural disorders due to use of alcohol.

Similarly the alcohol-specific hospital admissions where the primary diagnosis or any of the secondary diagnoses were an alcohol-specific code, have been consistently higher than the England average over the past few years (e.g. the rate of 555 per 100,000 locally versus 374 per 100,000 nationally in 2013/14). Furthermore the number of alcohol-specific admissions was more than double in men than women (1,505 versus 650 in 2013/14).

There were 187 alcohol-related deaths in Bristol in 2014, which corresponds with the rate of 53.2 per 100,000 population (significantly higher than the England rate of 45.5 per 100,000). It is a bigger problem in males where the rate of alcohol-specific mortality was 28.5 deaths per 100,000 men in 2012-14, compared to females with 7.9 deaths per 100,000 women.

Bristol has a problem with the hospital admissions for alcoholic liver disease among men; the Bristol rate of 96 admissions per 100,000 male population was significantly higher to the national rate of 44 for 2013/14. Similarly the deaths from alcoholic liver disease among men under 75 years dominated in Bristol in 2012-14, corresponding with mortality rate in males of 20.9 per 100,000 which was significantly higher the England rate of 11.5 per 100,000.

It is known that alcohol-related harm is placing increasing demands on the NHS and potentially avoidable strain on ambulance trusts, Accident and Emergency (A&E) departments and hospital services. In England, A&E attendance rates due to alcohol poisoning doubled from 2008/09 to 2013/14. Three in four people who attended A&E due to alcohol poisoning arrived by ambulance and one in three were subsequently admitted to hospital overnight. The cost of alcohol misuse to the NHS is estimated to be £3.5 billion every year.

In Bristol there is unprecedented demand for alcohol treatment services since the launch of Recovery Orientated Alcohol & Drugs Services (ROADS). Unfortunately there are also high attrition rates of alcohol clients from assessment to engagement. Bristol had a significantly lower proportion of individuals leaving alcohol treatment successfully as a proportion of all treatment exits compared to the national figure (44% versus 61%).

## **Social & economic harms, crime & disorder**

Alcohol misuse also places a significant cost burden on society. The estimated cost of alcohol harm to society is £21 billion per year which takes into account the impact alcohol has on health and other public services, the cost of alcohol-related crime and disorder, the impact of alcohol misuse on worklessness and lost productivity, and the estimated social costs as a result of alcohol misuse. The cost of alcohol-related crime itself was estimated at £11 billion.

In Bristol there were 3,461 alcohol-related offences recorded in 2012/13. The rate of recorded crime per 1,000 population attributable to alcohol has been consistently higher than the regional and national average (e.g. in 2012/13 the Bristol rate of 8.08 per 1,000 compared to the national rate of 5.74 and regional rate of 4.90). Comparing the core cities, Bristol had the third highest rate of alcohol-related recorded crime in 2012/13. There is a

strong correlation between alcohol-related crimes and the night-time economy that brings many Bristol residents and visitors into the city.

Alcohol is one of the leading factors contributing to accidents, from domestic to traffic related. There is also a well-known link between alcohol misuse and offending.

### **Harms to children and families**

Alcohol misuse can affect families in a range of ways. Parental alcohol misuse can impact on relationships and family functioning, and can impact on a child's environment in many social, psychological and economic ways. It can also be linked to a variety of mental health problems for family members and domestic violence and abuse.

Around 30% of children under 16 years of age (3.3-3.5 million) in the UK are living with at least one binge drinking parent. In 2000 it was estimated that 22% lived with a hazardous drinker and 6% with a dependent drinker. Substance misuse, mental health problems and domestic abuse are key factors in many child protection and safeguarding cases.

### **Alcohol multi-faceted problem**

On the one hand alcohol causes significant harm and contributes to health inequalities; on the other it brings benefits to the community and enhances the economy. Well-run community pubs and other businesses form a key part of the fabric of neighbourhoods, providing employment and social venues in local communities. Balancing the two facets of alcohol (use and misuse) requires us to work in partnership across the sectors to ensure that the benefits are felt and the harms are minimised.

This strategy attempts to address the key points by bringing all partners together and setting out a vision for Bristol. It aims to facilitate the establishment of a safe, sensible and harm-free drinking culture in Bristol, and set a direction of travel to achieve this.

## **1.2 Where are we now? Current responses to alcohol-related harm in Bristol**

Bristol has higher than the national average alcohol related crime as well as higher alcohol related morbidity and mortality.

Current responses to alcohol-related harm in Bristol comprise prevention work, provision of specialist treatment and care, and response to alcohol-related crime and disorder.

### **Prevention work**

The preventative approach to tackling alcohol misuse through education and campaigns is targeted at all children and young people in the city and is incorporated into other work focusing more widely on substance misuse, with an awareness that alcohol is by far the

most likely substance that young people will use. The majority of alcohol prevention with young people in Bristol is delivered in schools. The influence of parents over young people's substance use is also taken into account and campaigns and information are incorporated into other public health work.

Identification and Brief Advice (IBA) is a cornerstone of adult prevention work. This means that people are screened using set questions to find out their level of alcohol use. If they are found to be drinking above guidelines, they are given information and signposted to appropriate services. Furthermore social marketing campaigns have been carried out to raise awareness about alcohol and its risks.

### **Treatment and care**

Alcohol treatment and care for children and young people is delivered through early intervention work with young people as part of the Bristol Youth Links programme. Young people who misuse alcohol and have more complex needs are referred into the young people's substance misuse treatment services.

The Recovery Orientated Alcohol and Drug Service (ROADS) is an integrated adult substance misuse service available across Bristol for access to structured interventions aimed at overcoming physical and psychological dependence on alcohol and drugs as well as offering support around housing, education and employment. Support for families and carers who are affected by the alcohol use of others are provided as part of ROADS to reduce the wider impact alcohol has on communities.

In Bristol hospitals there are alcohol nurses who provide support and extended interventions for dependent drinkers and work with self-harmers whose harming is linked to alcohol. Furthermore alcohol-related problems are a big and increasing part of the primary care workload. Some Bristol GPs offer community detoxification in partnership with the treatment services.

### **Response to alcohol-related crime and disorder**

The Police have developed their operational approach to policing the night-time economy, combining public order policing with uniformed officers entering specific licensed premises to identify drunkenness or underage drinkers. The police response to alcohol-related violent crime offences and incidents of anti-social behaviour involves the deployment of a significant number of additional officers on these nights.

The Police also work with licensed premises to seize and return identity documents used by underage people to gain entry to licensed premises. The Police Public Protection Unit delivers a specialist approach to incidences of domestic violence, and there is a defined referral process for children at risk within chaotic households.

As part of their work, Probation Services in Bristol assess the people they supervise to find out whether the misuse of alcohol contributes to their offending behaviour. People can be

referred to a range of interventions around problematic alcohol use. Other structured interventions are available as part of community orders or post-release Licences.

The Bristol City Council Licensing Service has two key areas of responsibility for alcohol: administration of the Licensing Act and enforcement work. They conduct proactive inspections at alcohol licensed premises to ensure legislation compliance. The Trading Standards Service enforces legislation regarding the sale, supply and use of illicit alcohol products and underage sales. The Crime Reduction and Substance Misuse Team works with retailers to improve the management of the night-time economy and operates the CCTV presence in the city centre.

## **1.3 Where do we want to be? Vision for Bristol and our strategy**

Our vision for Bristol is to create safe, sensible and harm-free drinking culture, through partnership working and using the best available evidence in order to ensure the following:

- Bristol is a healthy and safe place to live, work and visit.
- People of Bristol are drinking within the nationally recognised guidelines.
- Individuals and families are able to access the right treatment and support at the right time.

The overarching aim of the strategy is to prevent and reduce the harm caused by alcohol to individuals, families and communities in order to ensure Bristol is a healthy and safe to live work and visit. This can be achieved through partnership working and using the best available evidence of what works.

There are three broader aims of the Strategy:

1. Increase individual and collective knowledge about alcohol, and change attitudes towards alcohol consumption.
2. Provide early help, interventions and support for people affected by harmful drinking.
3. Create and maintain a safe environment.

## **1.4 How do we get there? Deliverables and action plan**

The aims of the Strategy will be achieved through close collaboration of three Alcohol Workstreams:

1. Alcohol Prevention Workstream
2. Alcohol Intervention Workstream
3. Alcohol Environment Workstream

Each Workstream suggested the desired outcomes and proposed an action plan to be pursued.

### **Alcohol Prevention Workstream**

*Suggested Outcome(s):*

- Reduce alcohol consumption causing harm to individuals, families and communities in Bristol.

*Suggested Actions:*

- Social marketing
  - Deliver a large-scale social marketing campaign across Bristol City
  - Deliver preventative campaigns using social marketing tools and methods
  - Use social marketing tools to gather intelligence about attitudes to alcohol use and drinking behaviour
- Education in schools
  - Implement alcohol education in schools
  - Develop work with schools about delivering training for parents
  - Work with young people and adults with caring responsibilities
- Workplaces
  - Work in partnership with businesses across the city to promote and support the development and implementation of workforce alcohol policies and interventions to reduce alcohol-related harm in the workplace
- Alcohol Workplace policies
  - Review Bristol City Council alcohol policy and support available for employees with alcohol problems.
- Workforce (Making every contact count)
  - Deliver Alcohol Identification and Brief Advice training (IBA) to groups including but not limited to pharmacists and tenancy support officers
  - Workforce development in alcohol IBA - (making every contact count)
- Community
  - Encourage parents to have conversations with their children through a social marketing campaign
  - Develop training on supporting parents to talk to their children on the harms of alcohol.
  - Develop community engagement strategies.

## **Alcohol Intervention Workstream**

*Suggested Outcome(s):*

- Reduce alcohol related harm to individuals.
- Earlier identification of health harm caused by alcohol.
- High quality evidence-based treatment to reduce alcohol related harm.
- Children and young people free from alcohol related harm.

*Suggested Actions – Planning:*

- Needs assessment
  - Provide an overview of current service provision of Bristol Recovery Orientated Alcohol & Drug Service (ROADS) against need and identify how services can meet the identified needs
- Mapping of existing services

- Mapping of patient pathway – specialist services
- Evidence review and economic evaluation
- Primary care review
  - Review of screening and identification used within primary care to include alcohol and liver disease
- Activity data
  - Review of secondary care data (Commissioning for Value datasets) and explore opportunities

*Suggested Actions – Delivery:*

- System approach to alcohol and liver disease
  - Development of a system approach to alcohol treatment and liver disease (all causes)
- Harm minimisation for high risk groups
- Young People
  - Promoting the young people's substance misuse pathway across all agencies working with children and young people
- Training and education – Healthcare staff
  - GP training
  - Explore the opportunities for online training for ambulance staff and information sharing with primary care
  - Develop Paramedic training at UWE in IBA
  - Mutual aid training for practice based staff (PMs/Community resource co-ordinators)

## **Alcohol Environment Workstream**

*Suggested Outcome(s):*

- Reduce individual and community impact from alcohol related crimes and anti-social behaviour.
- Protect vulnerable people from alcohol related harm.
- Reduce demand on public and emergency services.
- Safe events held within the City; reduce alcohol related incidents.

*Suggested Actions:*

- Wider use of technology
  - Increase the availability of technology to improve the quality of information and evidence
- Diversionary events/activities
  - Provide an alternative to traditional night time economy activities
- Brio night time economy operation
  - Continue to develop this operation into a multi-agency approach to Bristol night time economy
- Intelligence sharing between agencies
  - Enabling an intelligence led, effective and efficient multi-agency approach to dealing with alcohol related issues across the City
- Identification and management of problematic licensed premises

- Improving the safety of establishments
- Training and awareness for licensed trade staff
  - Raising awareness of CSE and other vulnerability issues. Early recognition by staff
- Alcohol Recovery Centre
  - Reducing demand for NHS and police. Improved early care for users.
  - Demographic data will assist other work streams
- Re-invigoration of the Pub-Watch Scheme
  - Improve the cooperation of licensed premises to ensure a safer environment
- Management of Cumulative Impact areas
  - To ensure areas are monitored to manage the number of licensed premises
- Structured approach to licensing implications for larger events
- Providing support for people using and working in the City Centre during the night time economy
  - Identification of vulnerable people due to alcohol consumption, providing a safe environment
- Providing support to vulnerable people within the street drinking community

## 2 INTRODUCTION

Alcohol is a complex issue. In recent years the sale of alcohol has shifted from the on-trade to the off-trade, as supermarkets take over dominance of sales and more people choose to drink at home. The overall trend of alcohol affordability has been increasing over time. In 2014 alcohol was 53.8 per cent more affordable than it was in 1980<sup>1</sup>.

Licensing laws have changed allowing the trade to operate late into the early hours. National HM Revenue & Customs data<sup>2</sup> shows that the amount of alcohol being sold is increasing, however this picture may be confounded by the amount of smuggled and counterfeit alcohol. In more recent years tax and duty receipts from alcohol have been noticeably higher due to sustained periods of good weather, or major outdoor/sporting events, which typically increase alcohol receipts<sup>2</sup>.

Over the last decade there has been a culture grow where it has become acceptable to be excessively drunk in public and cause nuisance and harm to ourselves and others<sup>3</sup>.

Excessive intake of alcohol has clear effects on crime and health; on communities, children and young people. Levels of alcohol-related harm to the health and wellbeing of individuals, families and communities have risen, and health problems caused by heavy drinking are now being identified in young people.

In England in 2013, 18% of men and 13% of women drank at an increased risk of harm, and 5% of men and 3% of women at higher risk levels. There were about 1,059,210 alcohol-related hospital admissions in England in 2013/14, where an alcohol-related disease, injury or condition was the primary reason for hospital admission. This was a 5% increase from 2012/13. There were 6,592 alcohol-related deaths in 2013, a 1% increase from 2012. About 194,706 items for the treatment of alcohol dependence were prescribed in 2014 (in a primary care setting or NHS hospital), at the Net Ingredient Cost of £3.43 million<sup>1</sup>.

At the same time alcohol plays an important part in our social lives and in the local economy. Well-run community pubs and other businesses form a key part of the fabric of neighbourhoods, providing employment and social venues in local communities<sup>3</sup>.

On the one hand alcohol causes significant harm and contributes to health inequalities; on the other it brings benefits to the community and enhances the UK economy. Balancing the two facets of alcohol (use and misuse) requires us to work in partnership across the sectors to ensure that the benefits are felt and the harms are minimised.

This strategy attempts to address the key points by bringing all partners together and setting out a vision for Bristol. It aims to facilitate the establishment of a safe, sensible and harm-free drinking culture in Bristol, and set a direction of travel to achieve this.

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<sup>1</sup> Statistics on Alcohol, England, 2015. Health and Social Care Information Centre. June 2015. Available from: <http://www.hscic.gov.uk/catalogue/PUB17712/alc-eng-2015-rep.pdf>. (Accessed 24/02/2016)

<sup>2</sup> Tax and Duty Bulletins. HM Revenue and Customs. Available from: <https://www.uktradeinfo.com/Statistics/Pages/TaxAndDutyBulletins.aspx>. (Accessed 24/02/2016)

<sup>3</sup> The Government's Alcohol Strategy. HM Government. March 2012. Available from: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/224075/alcohol-strategy.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224075/alcohol-strategy.pdf).

## 2.1 Safer levels of drinking

The UK Chief Medical Officers' (CMOs) proposed new guidelines to inform the public about the known health risks of different levels and patterns of drinking, and to limit the health risks associated with the consumption of alcohol. These guidelines should help people to make informed choices and judge the risks they are willing to accept from alcohol, whether to drink alcohol, and how much and how often to drink<sup>4</sup>.

The guidelines include the following three main recommendations<sup>4</sup>.

<b>1/ A weekly guideline on regular drinking (for both men and women):</b>
<ul style="list-style-type: none"> <li>• You are safest not to drink regularly more than 14 units per week, to keep health risks from drinking alcohol to a low level.</li> <li>• If you do drink as much as 14 units per week, it is best to spread this evenly over 3 days or more. If you have one or two heavy drinking sessions, you increase your risks of death from long term illnesses and from accidents and injuries.</li> <li>• The risk of developing a range of illnesses (including, for example, cancers of the mouth, throat and breast) increases with any amount you drink on a regular basis.</li> <li>• If you wish to cut down the amount you're drinking, a good way to help achieve this is to have several drink-free days each week.</li> </ul>
<b>2/ Advice on single episodes of drinking, i.e. advice on short term effects of alcohol (for both men and women):</b>
<p>You can reduce the short term health risks from a single drinking occasion to a low level by:</p> <ul style="list-style-type: none"> <li>• limiting the total amount of alcohol you drink on any occasion;</li> <li>• drinking more slowly, drinking with food, and alternating with water;</li> <li>• avoiding risky places and activities, making sure you have people you know around, and ensuring you can get home safely.</li> </ul> <p>The sorts of things that are more likely to happen if you don't judge the risks from how you drink correctly can include: accidents resulting in injury (causing death in some cases), misjudging risky situations, and losing self-control. These risks can arise for people drinking within the weekly guidelines for regular drinking, if they drink too much or too quickly on a single occasion; and for people who drink at higher levels, whether regularly or infrequently. Some groups of people are likely to be affected more by alcohol and should be more careful of their level of drinking on any one occasion: young adults; older people; those with low body weight; those with other health problems; those on medicines or other drugs. As well as the risk of accident and injury, drinking alcohol regularly is linked to long term risks such as heart disease, cancer, liver disease, and epilepsy.</p>
<b>3/ A guideline on pregnancy and drinking:</b>
<ul style="list-style-type: none"> <li>• If you are pregnant or planning a pregnancy, the safest approach is not to drink alcohol at all, to keep risks to your baby to a minimum.</li> <li>• Drinking in pregnancy can lead to long-term harm to the baby, with the more you drink the greater the risk.</li> </ul> <p>Most women either do not drink alcohol (19%) or stop drinking during pregnancy (40%). The risk of harm to the baby is likely to be low if a woman has drunk only small amounts of alcohol before she knew she was pregnant or during pregnancy. Women who find out they are pregnant after already having drunk during early pregnancy, should avoid further drinking, but should be aware that it is unlikely in most cases that their baby has been affected. If you are worried about how much you have been drinking when pregnant, talk to your doctor or midwife.</p>

<sup>4</sup> UK Chief Medical Officers' Alcohol Guidelines Review. Summary of the proposed new guidelines. January 2016. Available from: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/489795/summary.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/489795/summary.pdf).

In short, the guidelines change the safe alcohol units for men who should not drink more than 14 units of alcohol per week (compared to 21 units in the previous guidelines), the same level as for women. It recommends to spread the 14 units over 3 or more days as 1-2 heavy drinking sessions each week increase the risk of death from long term illnesses, accidents and injuries. It updates the guidelines for pregnant women, clarifying that no level of alcohol is safe to drink in pregnancy.

A unit of alcohol is roughly half a pint of normal strength lager (4.1% ABV). A unit is calculated by reference to the amount (or volume) of the drink and the alcoholic strength (Alcohol by Volume (ABV))<sup>5</sup>.

$$\frac{\text{Volume (ml)} \times \text{Strength (ABV \%)} }{1,000} = \text{Number of units}$$

A unit is 10ml of pure alcohol (i.e. the amount of alcohol that would be left if other substances were removed). For example 1 litre (i.e. 1000ml) bottle of whisky at 40% ABV has 400ml, or 40 units of alcohol.

The alcohol risk levels as described by Public Health England are defined in the table below. These definitions were amended in line with the new guidelines.

Drinker type	Men	Women
<b>Lower risk drinkers</b>	Men and women who regularly drink less than 15 units of alcohol per week	
<b>Increasing risk drinkers</b>	Men who regularly drink between 15 and 50 units per week	Women who regularly drink between 15 and 35 units per week
<b>Higher risk drinkers</b>	Men who regularly drink more 50 units per week	Women who regularly drink more than 35 units per week
<b>Binge drinkers</b>	Consumption of at least twice the daily recommended amount of alcohol in a single drinking session	

<sup>5</sup> How to keep health risks from drinking alcohol to a low level: public consultation on proposed new guidelines. January 2016. Available from: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/489796/CMO\\_alcohol\\_guidelines.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/489796/CMO_alcohol_guidelines.pdf).

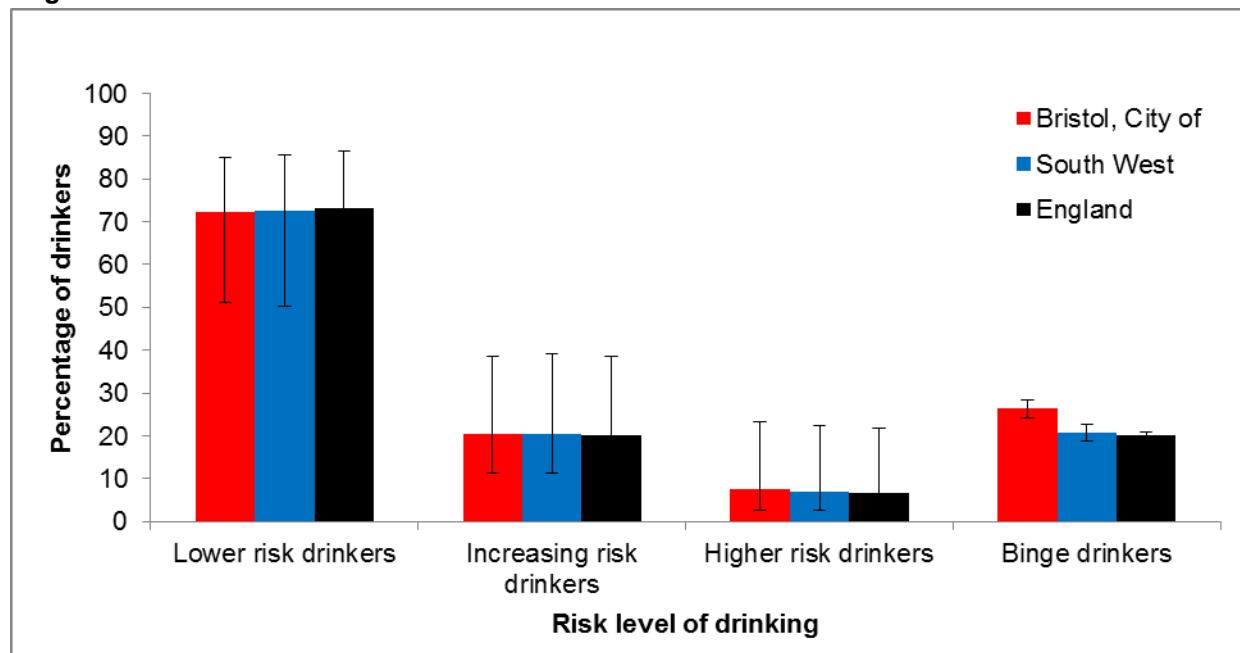
## 2.2 Alcohol consumption in Bristol

Estimates of local alcohol use are based on national self-reported surveys. The mid 2009 synthetic estimates produced by Public Health England, Local Alcohol Profiles for England (LAPE)<sup>6</sup>, reported that;

- 16.0% of Bristol population aged 16 years and over abstain from drinking;
- The remaining 84.0% of Bristol population aged 16 years and over who drink reported to engage in drinking at different levels:
  - 72.2% stay within the national low risk limits;
  - 20.3% drink at increasing levels that risk harm in the long term;
  - 7.5% drink at higher risk levels that harm themselves and others (this includes dependent drinkers);
  - 26.3% binge drink and are vulnerable to the acute effects of intoxication such as assault, falls and poisoning.

Figure 2.2a compares the Bristol percentages of drinkers with the South West and England estimates. There is some evidence that the percentage of binge drinkers in Bristol is higher than the regional and national percentage. There are no significant differences between Bristol, the South West and England in the other percentages.

**Figure 2.2a: Mid 2009 synthetic estimate of the percentage within the drinking population (not including abstainers) aged 16 years, by risk level of drinking; Bristol, South West and England<sup>6</sup>**



Some research evidence indicates that these estimates could be too low as they do not marry with the Revenue and Customs data that describes the amount sold or brought into Britain<sup>7</sup>. It is likely that people underestimate the amount they drink in self-reported surveys

<sup>6</sup> LAPE (Local Alcohol Profiles for England). Public Health England. Available from: <http://www.lape.org.uk/data.html>. (Accessed 20/02/2016)

<sup>7</sup> Boniface S, Shelton N. How is alcohol consumption affected if we account for under-reporting? A hypothetical scenario. European Journal of Public Health 2013. Feb 26 2013.10.1093.

and the true amount may be as high as 60 % more than stated. Given this it is likely that many people who describe themselves as low risk drinkers may in fact be drinking at higher levels and misusing alcohol.

Alcohol use is sensitive to cultural and socio-economic characteristics that greatly differ across the City of Bristol. Some communities have traditions that dissuade alcohol misuse; these communities include some ethnic and religious groups. For instance many observant Muslims are abstinent. The socio-economic effect of alcohol use includes:

- People from lower socio-economic classes are less likely to misuse alcohol, however if they do drink to excess they tend to develop very severe drinking problems.
- More affluent people with higher income much more likely to drink alcohol daily<sup>8</sup>.

Thus the pattern of alcohol misuse over Bristol is varied and complex. In deprived areas people who misuse alcohol are also more likely to also smoke tobacco. This combination of smoking and drinking results in a higher risk of getting cancer. Evidence suggests that non-smokers who drank alcohol were around a third more likely to develop mouth and upper throat cancer than those who didn't drink alcohol. But people who were (ex-) smokers and also drank alcohol, were around 3 times as likely to develop the disease. Furthermore the risk of liver cancer was found almost 10 times greater in people who smoked and drank heavily<sup>9</sup>. This increased risk results in a higher burden of mortality caused by alcohol in deprived areas, despite less people in the areas misusing alcohol.

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<sup>8</sup> Adult Drinking Habits in Great Britain, 2013. Office for National Statistics. Available from: [http://www.ons.gov.uk/ons/dcp171778\\_395191.pdf](http://www.ons.gov.uk/ons/dcp171778_395191.pdf).

<sup>9</sup> Alcohol facts and evidence. Cancer research UK. Available from: [http://www.cancerresearchuk.org/about-cancer/causes-of-cancer/alcohol-and-cancer/alcohol-facts-and-evidence#alcohol\\_facts6](http://www.cancerresearchuk.org/about-cancer/causes-of-cancer/alcohol-and-cancer/alcohol-facts-and-evidence#alcohol_facts6). (Accessed 25/02/2016)

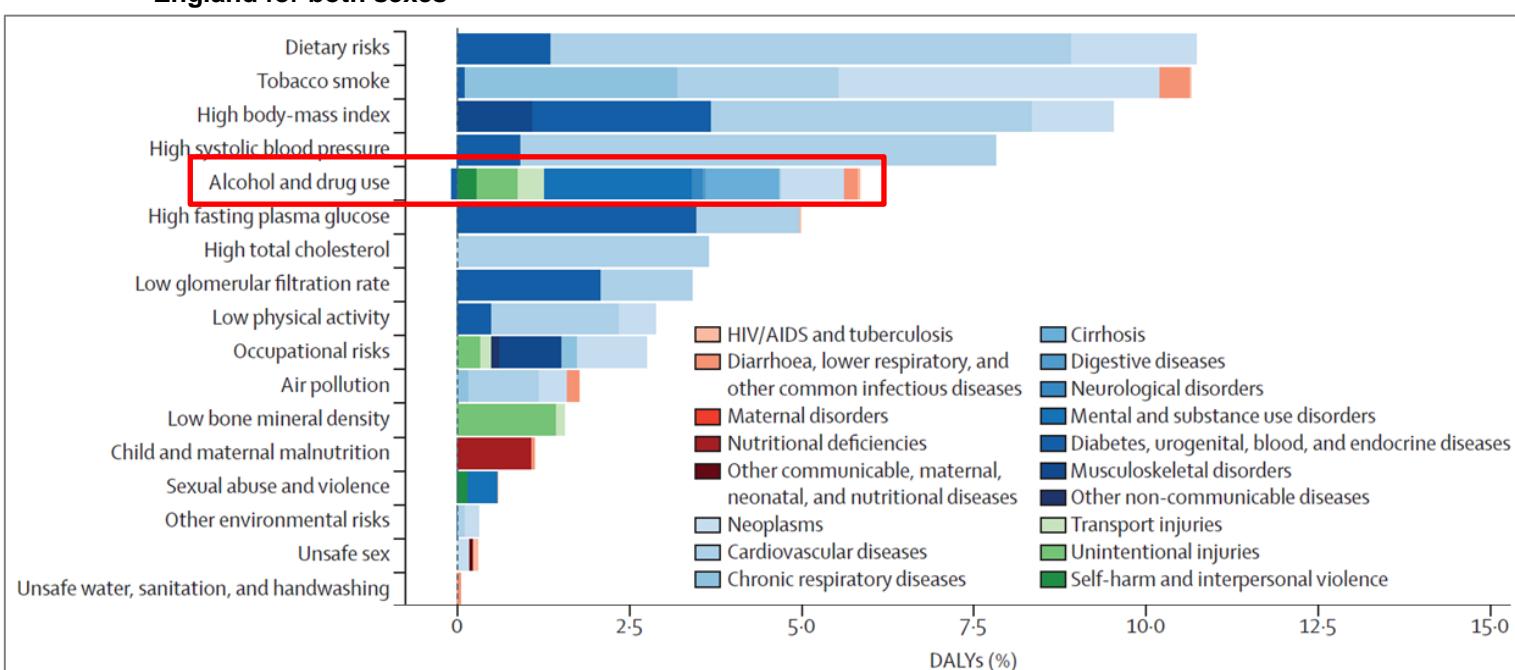
## 2.3 The impact of alcohol misuse

### 2.3.1 Health harms

Excessive drinking is a major cause of wide range of diseases and injuries in the UK. In the Global Burden of Disease Study 2013 (GBD 2013)<sup>10</sup>, alcohol and drug use was the fifth leading risk factor of the burden of disease in England, and accounted for approximately 6% of disability-adjusted life years (DALYs) (Figure 2.3.1a). Alcohol and drug use caused a greater proportion of total DALYs in men than in women (8% versus 4%). Alcohol, high body-mass index and high fasting plasma glucose were the only leading risks for which attributable burden did not fall between 1990 and 2013<sup>10</sup>.

In GBD 2013, alcohol consumption was the third leading behavioural risk factor overall, but was the leading behavioural cause of injury. About a third of deaths from cirrhosis could categorically be assigned to alcohol as the underlying cause (cirrhosis due to alcohol accounted for 29% of DALYs due to cirrhosis). However, alcohol also contributed to cirrhosis where it was not the underlying cause. Therefore, the overall proportion of cirrhosis of the liver DALYs attributed to alcohol was 70% in England in 2013<sup>10</sup>.

**Figure 2.3.1a: Disability-adjusted life-years (DALYs) attributed to level 2 risk factors in 2013 in England for both sexes<sup>10</sup>**



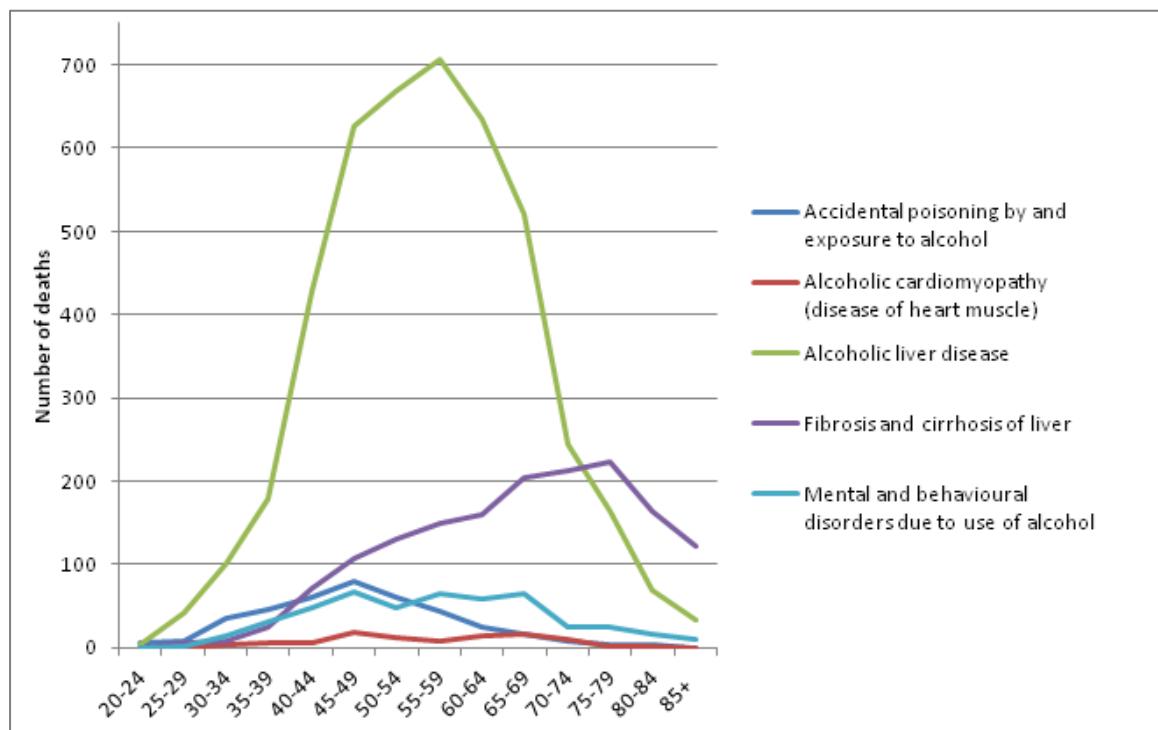
<sup>10</sup> Newton JN, Briggs ADM, Murray CJL, et al. Changes in health in England, with analysis by English regions and areas of deprivation, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. *The Lancet*. 2015. Published Online September 15, 2015. [http://dx.doi.org/10.1016/S0140-6736\(15\)00195-6](http://dx.doi.org/10.1016/S0140-6736(15)00195-6).

Alcohol is linked to, or causes, a range of serious and preventable diseases<sup>11</sup>, including the following:

- Causally related to a range of acute and chronic medical conditions, including cancers, cardiovascular disease, and obesity;
- A significant cause of morbidity and premature death;
- Associated (through heavy drinking by pregnant women) with a range of preventable mental and physical birth defects (collectively known as Foetal Alcohol Spectrum Disorders);
- Implicated in many areas of mental ill health, including depression, anxiety and suicide;
- Linked to unintentional injuries and trauma due to violence.

The age-standardised rate of alcohol-related deaths in the UK rose steeply from 1994 to 2008 when it peaked. It has reduced since then, but the 2014 rate of 14.3 deaths per 100,000 population (i.e. 8,697 alcohol-related deaths) was still higher than the rate in 1994 (9.1 deaths per 100,000 population). About 65% of alcohol-related deaths (65%) in the UK in 2014 were among males<sup>12</sup>. Figure 2.3.1b shows the top five alcohol related deaths by causes and age group in 2012<sup>13</sup>.

**Figure 2.3.1b: The top 5 alcohol related deaths by causes and age group, England and Wales, 2012<sup>13</sup>**



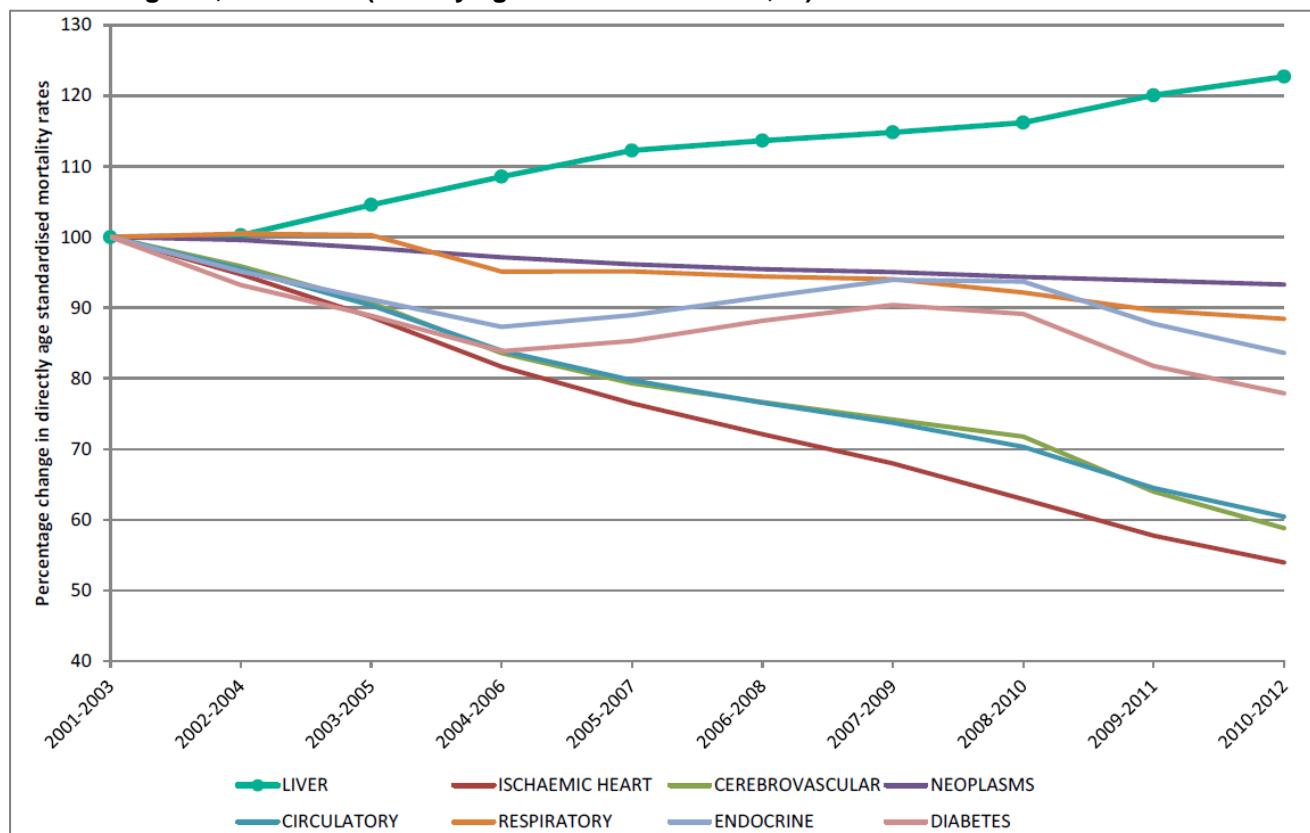
<sup>11</sup> Alcohol misuse: tackling the UK epidemic. BMA Board of Science. February 2008. Available from: <http://www.dldocs.stir.ac.uk/documents/Alcoholmisuse.pdf>.

<sup>12</sup> Alcohol-related deaths in the UK, registered in 2014. Office for National Statistics. Available from: [http://www.ons.gov.uk/ons/dcp171778\\_431695.pdf](http://www.ons.gov.uk/ons/dcp171778_431695.pdf).

<sup>13</sup> Liver disease biggest cause of alcohol-related deaths in England and Wales. February 2014. Available from: <http://www.ons.gov.uk/ons/rel/subnational-health/alcohol-related-deaths-in-the-united-kingdom/2012/sty-alcohol-related-deaths.html>. (Accessed 25/02/2016)

In 2014 the All-Party Parliamentary Hepatology Group report<sup>14</sup> stated that liver disease is rising at an alarming rate. Between 2001 and 2012, deaths with an underlying cause of liver disease have risen by 40% in the UK and by 23% in the South West<sup>15</sup>. Liver disease is the only major preventable killer disease where annual deaths are on the rise, both nationally and regionally (Figure 2.3.1c)<sup>15</sup>. Liver disease is mainly caused by alcohol misuse (but can be also caused by obesity and viral hepatitis).

**Figure 2.3.1c: Trend percentage change for the main preventable causes of mortality in South West of England, 1995-2012 (directly age standardised rates, %)**



### 2.3.1.1 Hospital admissions

#### Alcohol-related hospital admission episodes and admissions

The trend in hospital admission episodes for alcohol-related conditions (broad measure) in Bristol was rising from 2008, until it peaked in 2011/12. Since then it has reduced to 2,487 admission episodes per 100,000 population in 2013/14 (Figure 2.3.1.1a). This rate was significantly higher than the 2013/14 England average of 2,111 admission episodes per 100,000 and has been consistently higher than England since 2008/09.

<sup>14</sup> Liver disease: today's complacency, tomorrow's catastrophe. The All-Party Parliamentary Hepatology Group (APPHG) Inquiry into Improving outcomes in Liver Disease. March 2014. Available from: <http://www.appghep.org.uk/download/report/APPHG%20Inquiry%20into%20Outcomes%20in%20Liver%20Disease.%20March%202014.pdf>.

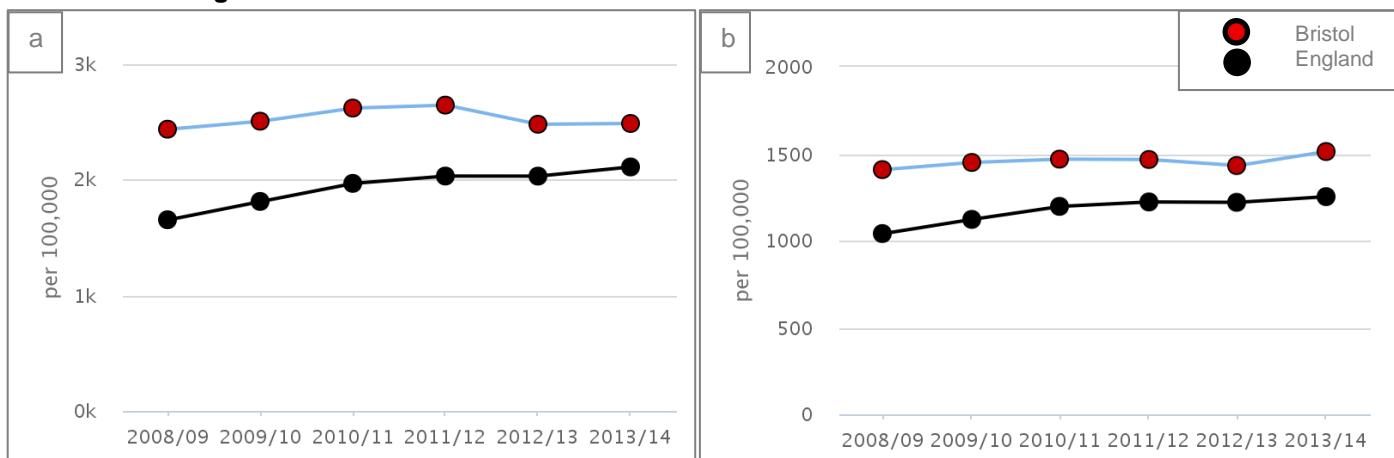
<sup>15</sup> Public Health England. (2015) Liver Disease in the South West Centre: A health needs assessment. Public Health England: South West. July 2015.

Similarly a rising trend, though with a less significant recent decline, can be observed in alcohol-related admissions (broad measure), with 1,513 persons per 100,000 population admitted to hospital due to alcohol-related conditions in Bristol in 2013/14 (Figure 2.3.1.1b). Again the Bristol rate was significantly higher than the England rate (1,253 admissions per 100,000), as it has been in the past few years.

In crude numbers, there were 8,750 hospital admission episodes for alcohol-related conditions in Bristol in 2013/14. This corresponds to 5,408 persons admitted to hospital due to alcohol-related conditions in the same year.

Alcohol-related conditions comprise all alcohol-specific conditions, plus those where alcohol is causally implicated in some but not all cases of the outcome<sup>16</sup>. These patients might have conditions linked to alcohol use, for example hypertensive diseases, various cancers and falls. Alcohol-related admission episodes and admissions include the primary diagnosis or any of the secondary diagnoses with an alcohol-attributable code. Attributable fraction values are the proportion of a health condition or external cause that is attributable to alcohol consumption<sup>16</sup>. Therefore these indicators refer to alcohol misuse in the population rather than admissions caused directly/specifically by alcohol.

**Figure 2.3.1.1: a/ Admission episodes for alcohol-related conditions (broad measure)<sup>17</sup>, and b/ alcohol-related hospital admissions (broad measure)<sup>18</sup>, Bristol, 2008/09-2013/14; compared with England**



### Alcohol-specific hospital admissions

In Bristol the trend in alcohol-specific hospital admissions was fairly stable around 500 admissions per 100,000 population between 2008/09 and 2012/13, but increased to 555 admissions per 100,000 in 2013/14 (Figure 2.3.1.1c). The local rates have been significantly higher than the England rates during the same time period (for example the rate of 555 per 100,000 locally versus 374 per 100,000 nationally in 2013/14).

<sup>16</sup> Public Health England. (2015) Local Alcohol Profiles for England: 2015 user guide. Public Health England: knowledge and Intelligence Team (North West). Available from: [http://www.lape.org.uk/downloads/Lape\\_guidance\\_and\\_methods.pdf](http://www.lape.org.uk/downloads/Lape_guidance_and_methods.pdf)

<sup>17</sup> Public Health England (PHE), Local Alcohol Profiles for England (LAPE). Available from:

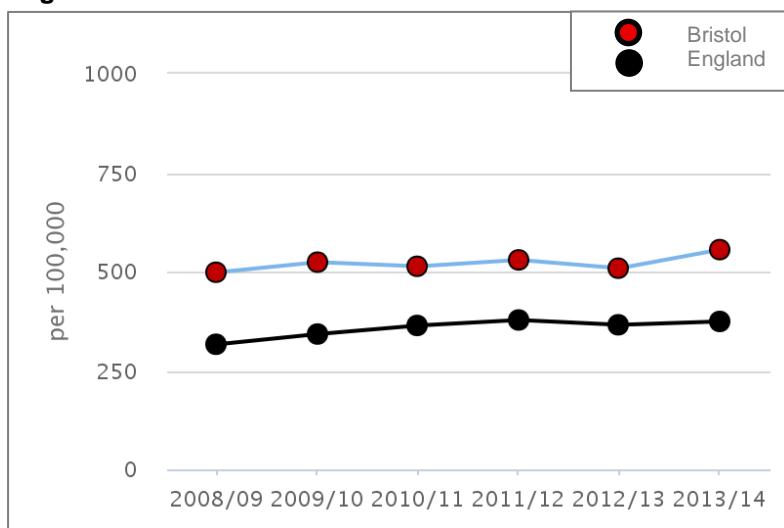
<http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/4/gid/1938132833/pat/6/par/E12000009/ati/102/are/E06000023/iid/91409/age/1/sex/4>

<sup>18</sup> PHE. LAPE. Available from: <http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/4/gid/1938132833/pat/6/par/E12000009/ati/102/are/E06000023/iid/91385/age/1/sex/4>

In crude numbers, there were 2,160 persons admitted to hospital due to alcohol-specific conditions (where the primary diagnosis or any of the secondary diagnoses were an alcohol-specific code) in Bristol in 2013/14.

Alcohol-specific conditions include those conditions where alcohol is causally implicated in all cases of the condition; e.g. alcohol-induced behavioural disorders and alcohol-related liver cirrhosis. The alcohol-attributable fraction is 1.0 because 100% of cases are caused by alcohol<sup>16</sup>.

**Figure 2.3.1.1c: Alcohol-specific hospital admissions, Bristol, 2008/09-2013/14; compared with England<sup>19</sup>**

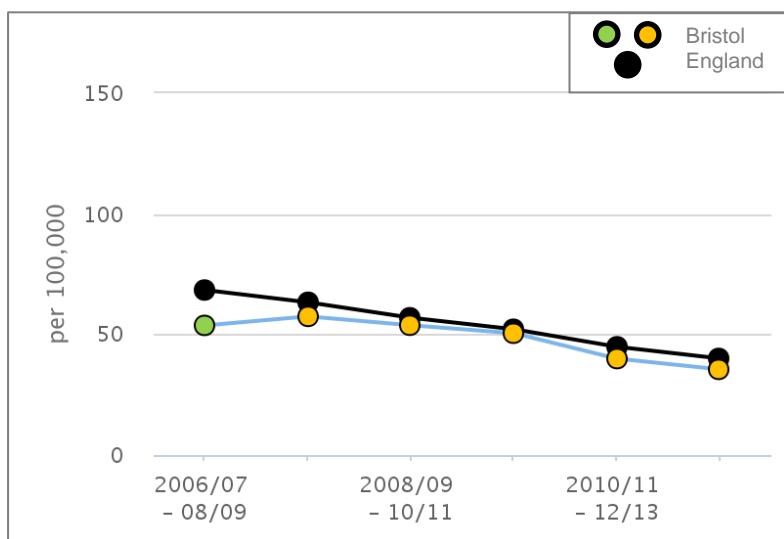


In 2013/14 in Bristol, the number of admissions due to alcohol-specific conditions was more than double in men than women (1,505 versus 650). The trend in alcohol-specific hospital admissions among men looked similar to the overall trend shown in Figure 2.3.1.1c. It was fluctuating around 750 admissions per 100,000 male population between 2008/09 and 2011/12, then slightly dropped to 712 per 100,000 in 2012/13, and increased to 798 admissions per 100,000 in 2013/14. The trend among women was steadily rising, from 261 admissions per 100,000 female population in 2008/09 to 321 admissions per 100,000 female population in 2013/14. The Bristol figures for both males and females were higher than the national average (for example the rate per 100,000 of 798 in males and 321 in females locally versus 515 in males and 241 in female nationally in 2013/14).

Figure 2.3.1.1d shows that in Bristol between 2006/07 and 2013/14, the (three-year average) rates of hospital admissions for alcohol-specific conditions among under 18's were lower than or similar to the national figures. The Bristol rate peaked at 57.5 per 100,000 under 18 population in 2007/08-09/10, and has declined since. In 2011/12-13/14 there were 95 persons aged less than 18 years admitted to hospital due to alcohol-specific conditions in Bristol, which corresponds to a rate of 35.5 admissions per 100,000 population under 18s.

<sup>19</sup> PHE. LAPE. Available from: <http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/4/gid/1938132833/pat/6/par/E12000009/ati/102/are/E06000023/iid/91384/age/1/sex/4>

**Figure 2.3.1.1d: Alcohol-specific hospital admissions among under 18s (3-year averages), Bristol, 2006/07-2013/14; compared with England<sup>20</sup>**



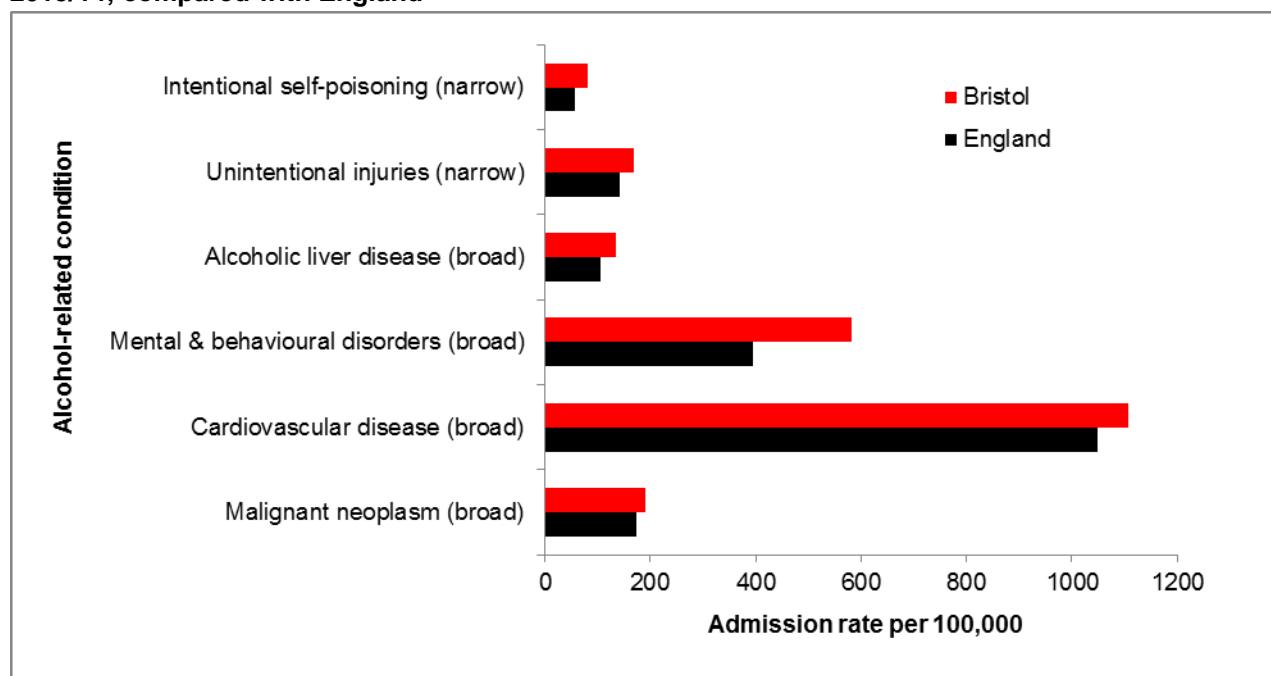
#### Admission episodes by alcohol-related condition

Figure 2.3.1.1e shows that in Bristol in 2013/14, the most common reasons for alcohol-related admission episodes, i.e. partially attributable to alcohol, were cardiovascular disease (1,108 admission episodes per 100,000 population) and mental & behavioural disorders due to use of alcohol (581 admission episodes per 100,000 population).

The rates of admission episodes for all alcohol-related conditions listed in Figure 2.3.1.1e were significantly higher than the England rates for the same conditions in the same year.

<sup>20</sup> PHE. LAPE. Available from: <http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/4/gid/1938132833/pat/6/par/E12000009/ati/102/are/E06000023/iid/90856/age/173/sex/4>

**Figure 2.3.1.1e: Admission episodes for alcohol-related conditions by condition group, Bristol, 2013/14; compared with England<sup>21</sup>**



Broad measure refers to admissions to hospital where the primary diagnosis or any of the secondary diagnoses were an alcohol-attributable condition code (e.g. alcohol-attributable malignant neoplasm code);  
Narrow measure refers to admissions to hospital where the secondary diagnosis was an alcohol-attributable external cause code (e.g. alcohol-attributable unintentional injuries code).

### 2.3.1.2 Mortality

In Bristol, the trend in the alcohol-related mortality (i.e. deaths from alcohol-related conditions) was fairly stable between 2008 and 2012, with a rate fluctuating between 52.5 per 100,000 in 2012 to 55.1 per 100,000 in 2008. During this time period the Bristol rates were similar to the national rates. In 2013, the rate of alcohol-related mortality rose to 56.0 per 100,000 (corresponding to 196 alcohol-related deaths) and then dropped again to 53.2 per 100,000 in 2014 (corresponding to 187 deaths). In these last two years the Bristol rates were higher than the rates in England (e.g. in 2014 a rate of 53.2 locally versus 45.5 per 100,000 nationally) (Figure 2.3.1.2a).

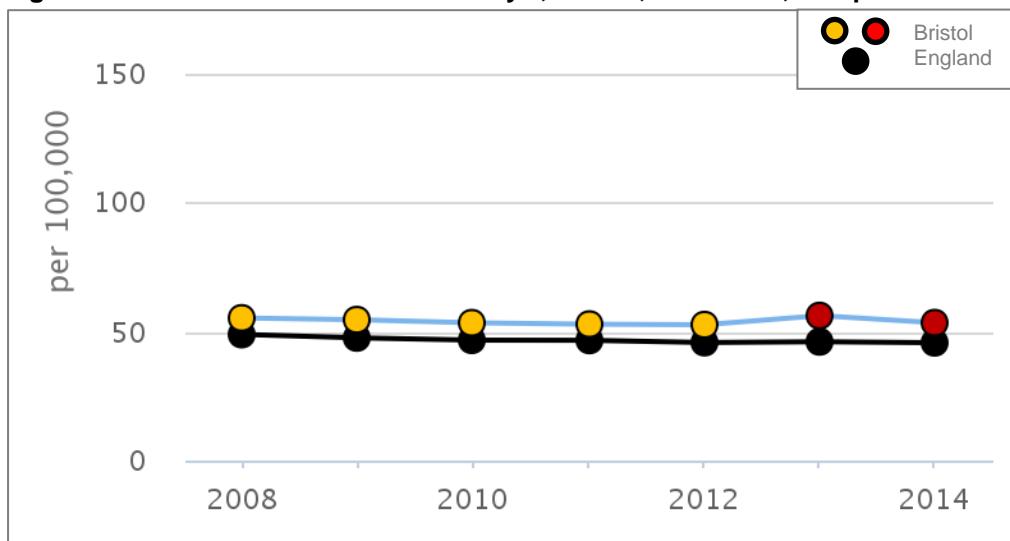
The alcohol-specific mortality refers to deaths from alcohol-specific conditions and due to low numbers is reported as three-year pooled estimates. The rate of alcohol-specific mortality has been slightly increasing since 2009-11, from 14.7 per 100,000 in 2009-11 (corresponding to 157 alcohol-specific deaths) to 18.3 per 100,000 in 2012-14 (corresponding to 200 deaths).

As shown in Figure 2.3.1.2b, the Bristol rates have been consistently higher than the England average since 2006-08 (e.g. in 2012-14 a rate 18.3 locally versus 11.6 per 100,000 nationally). This was mainly because of a problem with alcohol-specific mortality in males. In Bristol, the rates among men have been significantly higher than England since 2006-08. For

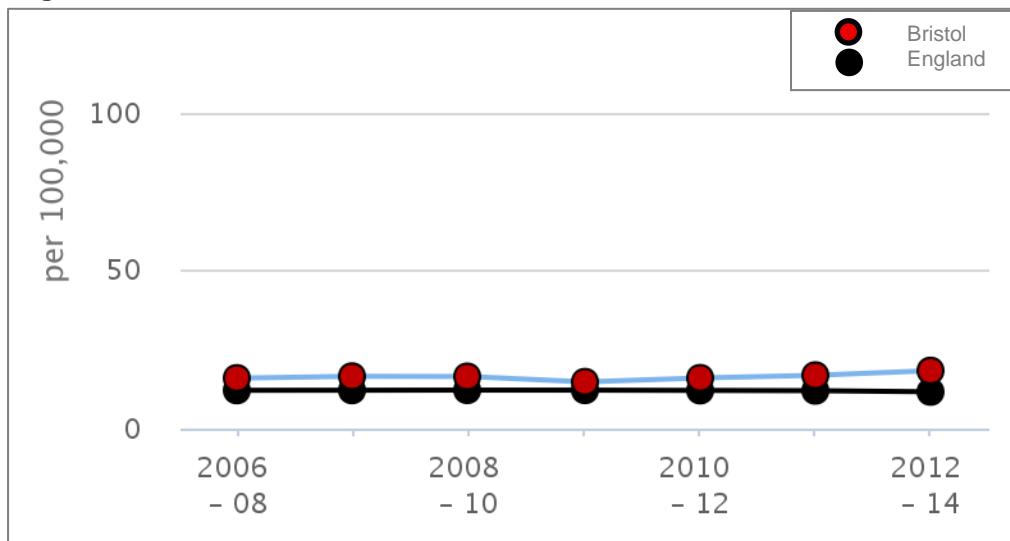
<sup>21</sup> PHE. LAPE. Available from: <http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/0/gid/1938132848/pat/6/par/E12000009/ati/102/are/E06000023/iid/91410/age/1/sex/4>

example there were 28.5 deaths per 100,000 men in 2012-14, compared to the national rate of 16.1 per 100,000. In females the rate of alcohol-specific mortality was 7.9 per 100,000 in the same period (similar to the national rate of 7.4). In crude numbers, there were 157 alcohol-specific deaths among Bristol men in 2012-14 compared to only 43 deaths among Bristol women.

**Figure 2.3.1.2a: Alcohol-related mortality<sup>22</sup>, Bristol, 2008-2014; compared with England**



**Figure 2.3.1.2b: Alcohol-specific mortality<sup>23</sup>, Bristol, 2006-08 to 2012-14; compared with England**



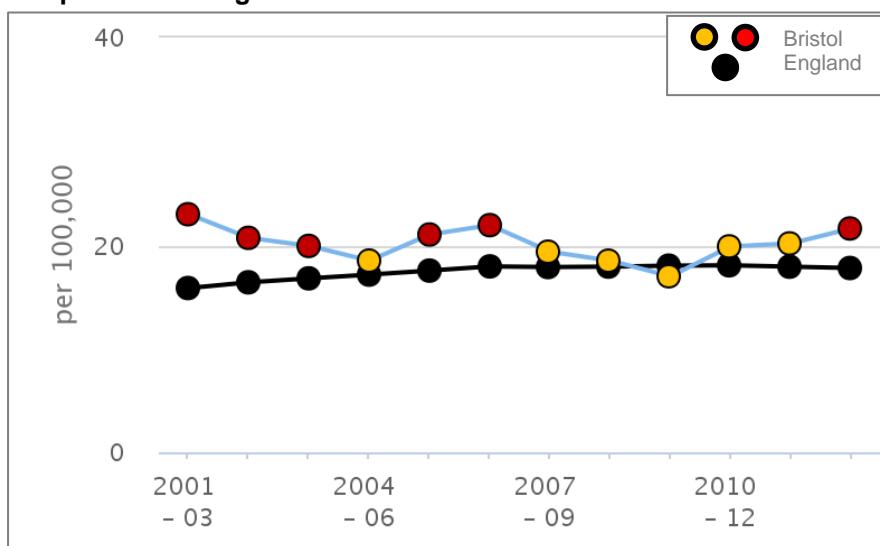
<sup>22</sup> PHE. LAPE. Available from: <http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/4/gid/1938132832/pat/6/par/E12000009/ati/102/are/E06000023/iid/91382/age/1/sex/4>

<sup>23</sup> PHE. LAPE. Available from: <http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/4/gid/1938132832/pat/6/par/E12000009/ati/102/are/E06000023/iid/91380/age/1/sex/4>

### 2.3.1.3 Alcoholic liver disease

The increasing trend in mortality from preventable liver disease was shown earlier in Figure 2.3.1c. Figure 2.3.1.3a compares the trend in the under 75 mortality from liver disease in Bristol and England during 2001-03 and 2012-14. The red circles on the Bristol trend line indicate rates higher than the England average. To understand the impact of alcohol on the liver disease burden the hospital admission rates for alcoholic liver disease (i.e. number of admissions with a primary diagnosis of alcoholic liver disease) and the under 75 mortality rates from alcoholic liver disease (i.e. number of deaths from alcoholic liver disease in people aged under 75 years) are presented below.

**Figure 2.3.1.3a: Under 75 mortality rate from liver disease, Bristol, 2001-03 to 2012-14; compared with England<sup>24</sup>**

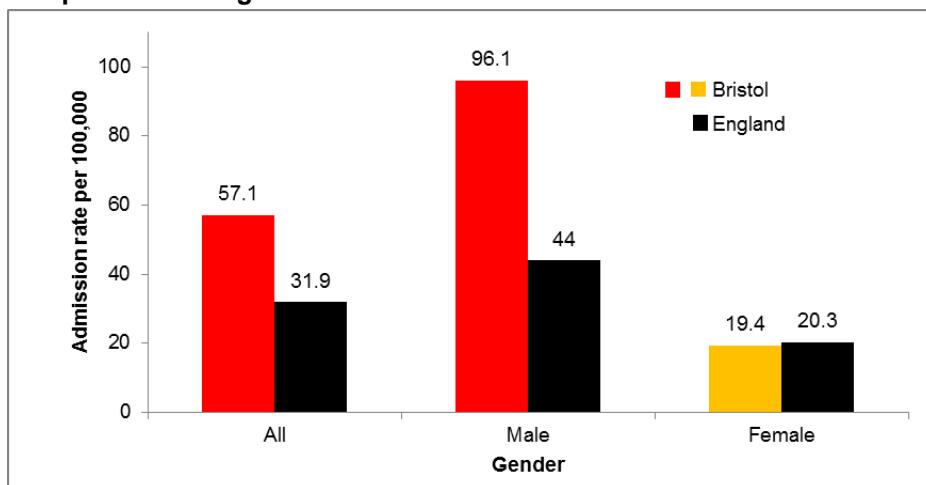


The hospital admission rates for alcoholic liver disease were reported in 2012/13 and 2013/14 only, thus time trend comparisons cannot be made. In Bristol in 2013/14, the admission rates for alcoholic liver disease were 57.1 per 100,000 population which was much higher than the England rate of 31.9. Figure 2.3.1.3b shows that Bristol has a problem with the hospital admissions for alcoholic liver disease among men; the Bristol rate of 96 admissions per 100,000 male population was significantly higher to the national rate of 44 for 2013/14. In females the rate of admissions for alcoholic liver disease was 19.4 per 100,000 in the same period (similar to the national rate of 20.3).

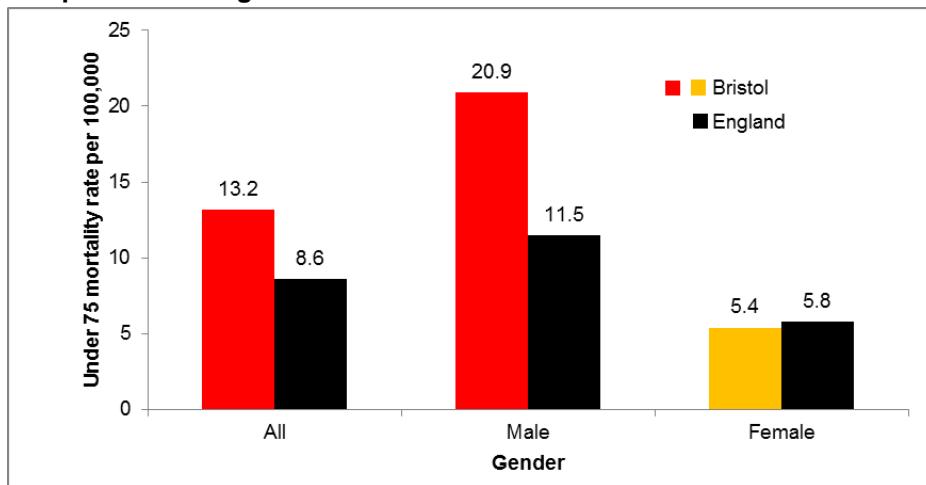
The under 75 mortality rates from alcoholic liver disease are due to low numbers reported as three-year pooled estimates. In Bristol in 2012-14, the deaths from alcoholic liver disease among men under 75 dominated, a similar picture to that described above for the admission rates. The mortality rate in males was 20.9 per 100,000, which was significantly higher than England (11.5 per 100,000); whereas the mortality rate in females was only 5.4 per 100,000, similar to the national rate of 5.8 (Figure 2.3.1.3c).

<sup>24</sup> PHE. Liver Disease Profiles. Available from: <http://fingertips.phe.org.uk/profile/liver-disease/data#page/4/gid/8000063/pat/6/par/E12000009/ati/102/are/E0600023/iid/90929/age/1/sex/4>

**Figure2.3.1.3b: Hospital admission rate for alcoholic liver disease by gender, Bristol, 2013/14; compared with England<sup>25</sup>**



**Figure2.3.1.3c: Under 75 mortality rate from alcoholic liver disease by gender, Bristol, 2012-14; compared with England<sup>26</sup>**



<sup>25</sup> PHE. Liver Disease Profiles. Available from: <http://fingertips.phe.org.uk/profile/liver-disease/data#page/4/gid/8000063/pat/6/par/E12000009/ati/102/are/E06000023/iid/90929/age/1/sex/4>

<sup>26</sup> PHE. Liver Disease Profiles. Available from: <http://fingertips.phe.org.uk/profile/liver-disease/data#page/4/gid/8000063/pat/6/par/E12000009/ati/102/are/E06000023/iid/90861/age/163/sex/4>

### **2.3.1.4 Accident and Emergency burden**

It is known that alcohol-related harm is placing increasing demands on the NHS and potentially avoidable strain on ambulance trusts, Accident and Emergency (A&E) departments and hospital services<sup>27</sup>.

In England, A&E attendance rates due to alcohol poisoning doubled from 2008/09 (rate of 72.7 per 100,000 population) to 2013/14 (rate of 148.8 per 100,000). Three in four people who attended A&E due to alcohol poisoning arrived by ambulance. One in three of those attendees were subsequently admitted to hospital overnight (compared to one in five admissions among people attending A&E for other reasons). In 2013/14, approximately 1 in 20 emergency admissions were for alcohol-specific conditions<sup>27</sup>.

The highest rates of emergency admissions related to alcohol were seen in men in the older age groups (45–64 years of age) which may reflect the chronicity of alcohol-related problems. In 2013/14, 90% of people who attended A&E due to alcohol poisoning and 72% of those who had an alcohol-specific emergency admission, only attended hospital once in that year. This presents a ‘teachable moment’ and an opportunity to intervene, identify issues of alcohol dependency and provide a specialist advice to prevent progression into alcohol-related chronic disease<sup>27</sup>.

A&E attendance rates due to alcohol poisoning and hospital emergency admissions specific to alcohol has been three to four times higher in the poorest fifth of the population over the past five years<sup>27</sup>.

### **2.3.1.5 Alcohol treatment**

There is unprecedented demand for alcohol treatment services in Bristol since the launch of Recovery Orientated Alcohol & Drugs Services (ROADS). Unfortunately there are also high attrition rates of alcohol clients from assessment to engagement<sup>28</sup>.

#### Routes into treatment

Understanding the routes into alcohol treatment gives an indication of the levels of referrals from various settings into specialist treatment. In Bristol in 2014/15, 50% (308/614) of all referrals in alcohol treatment were made by GPs, followed by 22% (135/614) of self-referrals. Nationally these proportions were inverted, with 45% of self-referrals and 19% of GP referrals<sup>29</sup>.

#### Demographic and social characteristics of individuals in treatment

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<sup>27</sup> Currie C, Davies A, Blunt I, Ariti C, Bardsley M. Alcohol-specific activity in hospitals in England. Research report. Nuffield Trust. December 2015. Available from: [http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/alcohol-specific-activity\\_final-web.pdf](http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/alcohol-specific-activity_final-web.pdf).

<sup>28</sup> Bristol Substance Misuse Needs Assessment. Substance Misuse Team. September 2016.

<sup>29</sup> Alcohol data: JSNA support pack. Key data to support planning for effective alcohol harm prevention, treatment and recovery in 2016-17. Bristol. Public Health England.

Demographic characteristics of people in alcohol treatment in Bristol are similar to the national picture. In 2014/15, there were 716 adults in alcohol treatment in Bristol. Of those, 63% were male, similar to the national proportion of 62%. The proportion of adults starting the treatment in 2014/15 was 86% (614/716) which was higher than the national proportion of 69%<sup>29</sup>.

Both locally and nationally, the 40 to 49 year age group is the most represented among adults in alcohol treatment (around 33%), followed by the 50-59 and 30-39 year age groups (around 24% and 23% respectively)<sup>29</sup>.

The employment status at the start of alcohol treatment differed locally compared to the national picture. In Bristol in 2014/15, 47% of adults starting treatment reported 'long term sickness or disability', 25% were in 'regular employment' and 24% were 'unemployed or economically inactive'. Nationally these proportions were distributed differently (22%, 27% and 37% respectively)<sup>29</sup>.

#### Length of time in treatment

NICE Clinical Guidance CG115 suggests that harmful drinkers and those with mild alcohol dependence might benefit from a package of care lasting three months while those with moderate dependence might need a six month package and those with severe dependence or those with complex needs may need a package of care lasting up to a year.

Nationally the length of a typical treatment period is around 6 months. However in Bristol the rates of early treatment drop out were high. In 2014/15, 24% of adults in treatment exited in less than a month and further 46% in less than 3 months (compared with much lower national proportions of 12% and 26% respectively)<sup>29</sup>.

#### Treatment outcomes

The data on successful completions of alcohol treatment provides an indication of the effectiveness of the treatment system. A high number of successful completions and a low number of re-presentations to treatment indicate that treatment services are responding well to the needs of those in treatment.

In Bristol, 35% (249/710) of all adults in alcohol treatment successfully completed the therapy in 2014/15<sup>30</sup>. In comparison, nationally the proportion of individuals leaving alcohol treatment successfully was 39%<sup>29</sup>. However Bristol had lower proportion of individuals leaving alcohol treatment successfully as a proportion of all treatment exits compared to the national figure (44% versus 61%)<sup>29</sup>.

There is a wider issue in Bristol with high numbers of unplanned exits from alcohol treatment. The Bristol proportion of new treatment presentations that had an unplanned exit or transferred and not continuing a journey before being retained for 12 weeks was 38% between October 2014 and September 2015<sup>30</sup>. This is much higher than the national

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<sup>30</sup> The Diagnostic and Outcome Monitoring Executive Summary (DOMES). Quarter 3 2015-2016. Bristol.

average of 14% and an audit is underway locally to look into the circumstances for people leaving treatment early.

In terms of re-presentations to treatment, Bristol had 27% of individuals in alcohol treatment leaving the treatment successfully (between 1st Jan 2014 and 31st Dec 2014) and not returning within 6 months. This proportion was much lower than the national proportion of 38% during the same time period<sup>29</sup>.

Waiting times for alcohol treatment are an issue in Bristol. The percentage of patients who waited over three weeks to start first intervention was 39% in quarter Oct-Dec 2015, compared to the national average of 4%<sup>30</sup>. Recently some additional funding has been agreed to increase treatment group work capacity in Bristol.

### **2.3.1.6 Alcohol and mental health**

There are close links between alcohol misuse and mental health problems. Some people with mental ill health drink alcohol to alleviate their difficult feelings or cope with their mental illness (called ‘self-medication’<sup>31</sup>). Some people with alcohol problems may subsequently develop some mental health problems, such as anxiety and depression, as alcohol may exacerbate these conditions or caused for example alcohol induced dysphoria.

Earlier presented Figure 2.3.1.1e showed that in Bristol, 2013/14, the second highest rate of admission episodes for alcohol-related conditions were for mental and behavioural disorders due to use of alcohol (581 per 100,000 population)<sup>21</sup>. A similar picture can be seen nationally when in England in 2013/14, the second highest number of admissions (19%) was for mental and behavioural disorders due to alcohol<sup>1</sup>. Also between 2003 and 2013 about 45% of suicides occurred in patients with a history of alcohol misuse<sup>32</sup>.

### **2.3.1.7 Combination of alcohol and other drugs**

People in treatment for alcohol misuse in Bristol are more likely to use alcohol alongside other drugs, which can make treatment challenging. Figure 2.3.1.7a compares the English averages with Bristol for adjunctive drug use<sup>33</sup>.

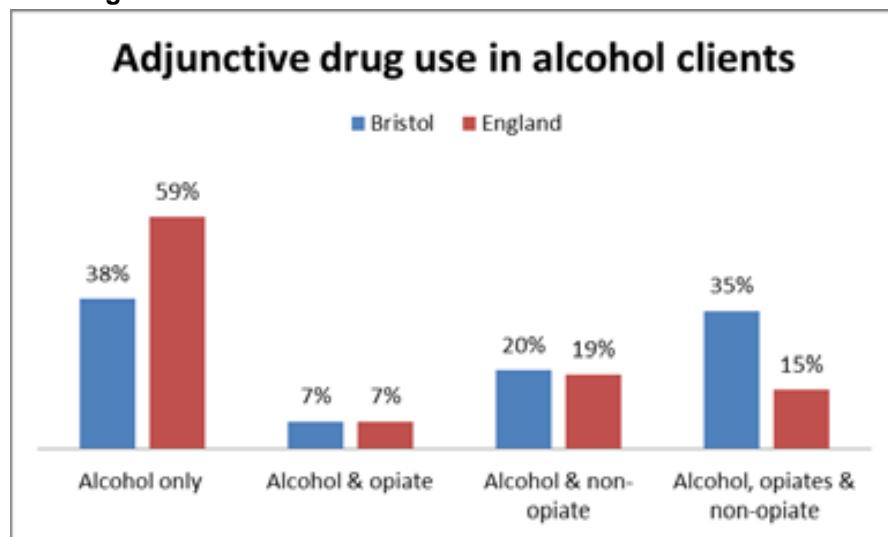
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<sup>31</sup> Mental Health Foundation. Alcohol and mental Health. Available from: <https://www.mentalhealth.org.uk/a-to-z/a/alcohol-and-mental-health>. (Accessed 05/04/2016)

<sup>32</sup> National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report – July 2015. Healthcare Quality Improvement Partnership. Available from: <http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/NCISHReport2015bookmarked2.pdf>.

<sup>33</sup> Joint Strategic Needs Assessment (JSNA) report 2015. Data profile of Health and Wellbeing in Bristol. Available from: <https://www.bristol.gov.uk/documents/20182/305531/JSNA+2015+v4/fc4df8f4-5c65-4b2e-8ee3-e6ad56f1004f>.

**Figure 2.3.1.7a: Additional drug use in alcohol clients of ROADS, Bristol, 2014/15; compared with England<sup>33</sup>**



Most young people up to age of 18 years, who attend young people's substance misuse services, report that they use a combination of substances, mainly alcohol and cannabis. Patterns of substance misuse in Bristol are also changing among adults. There is an aging population of opiate and crack users, and fewer young adults joining the cohort. It is thought to be due to an increasing use of a range of substances in combination, including alcohol and 'novel psycho-active substances'.

The population of Bristol is relatively young with a median (average) age of 33 years compared to 39 years for England and Wales<sup>33</sup>. It is therefore important for the drug and alcohol treatment system to ensure appropriate targeting of services towards the younger population.

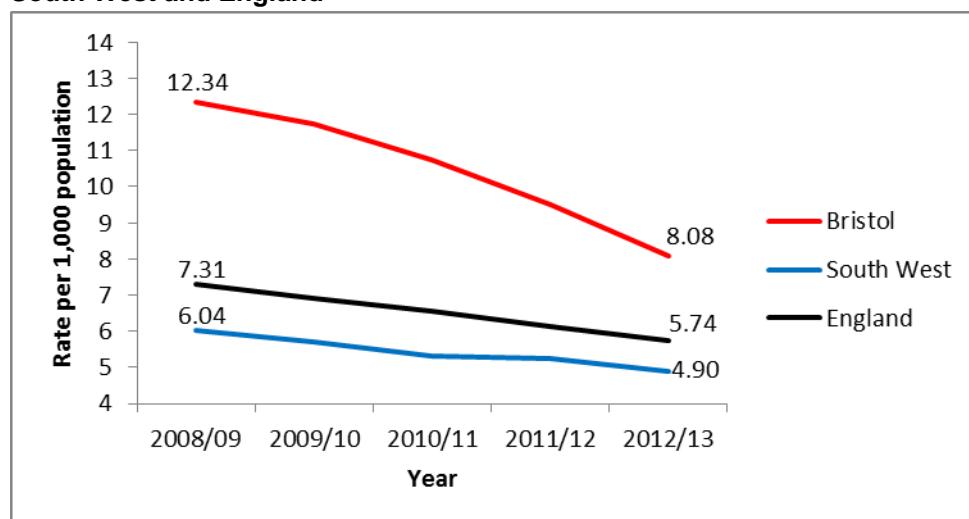
## 2.3.2 Crime and disorder

### 2.3.2.1 Alcohol-related crime

Figure 2.3.2.1a shows that alcohol-related recorded crimes (based on the Home Office's former 'key offence' categories) have decreased in Bristol in the recent years. The rate of recorded crime per 1,000 population attributable to alcohol dropped from 12.34 per 1,000 in 2008/09 to 8.08 per 1,000 in 2012/13. However the Bristol rate of 8.08 per 1,000 was still significantly higher than the regional and national average in the same year (4.90 and 5.74 per 1,000 respectively).

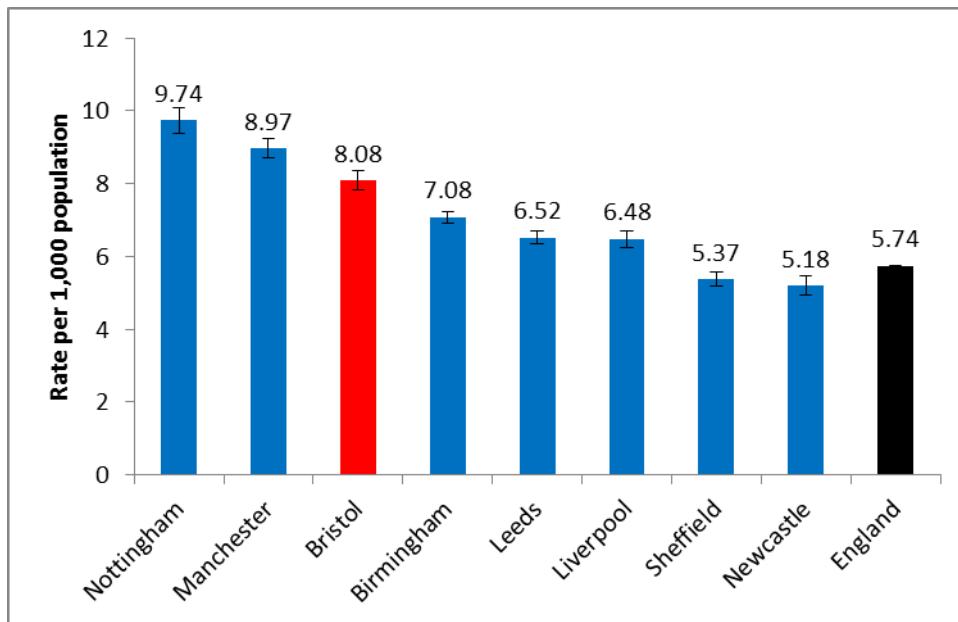
In crude numbers, there were 5,081 alcohol-related offences recorded in Bristol in 2008/09 and 3,461 offences in 2012/13. There is a strong correlation between alcohol-related crimes and the night-time economy that brings many Bristol residents and visitors into the city.

**Figure 2.3.2.1a: Alcohol-related recorded crimes, Bristol, 2008/09-2012/13; compared with South West and England<sup>34</sup>**



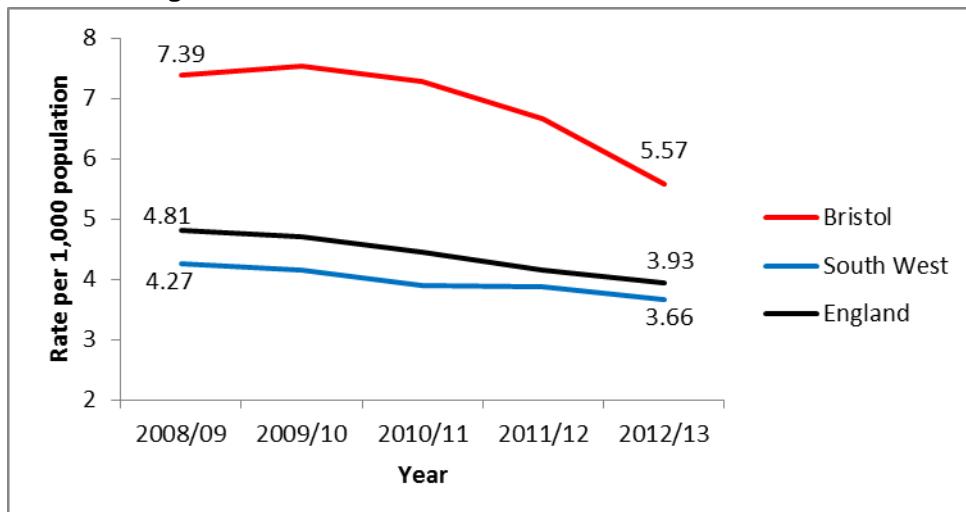
Comparing the core cities, Bristol had the third highest rate of alcohol-related recorded crime in 2012/13 (Figure 2.3.2.1b). To some extent, this could be due to different arrest policies in the different police forces which lead to different reporting outcomes, and to different recording practices by different forces. For example, reporting of domestic violence has increased in Bristol due to the excellent work by operation Bluestone, which has resulted in more victims feeling confident to come forward and report incidences to the police.

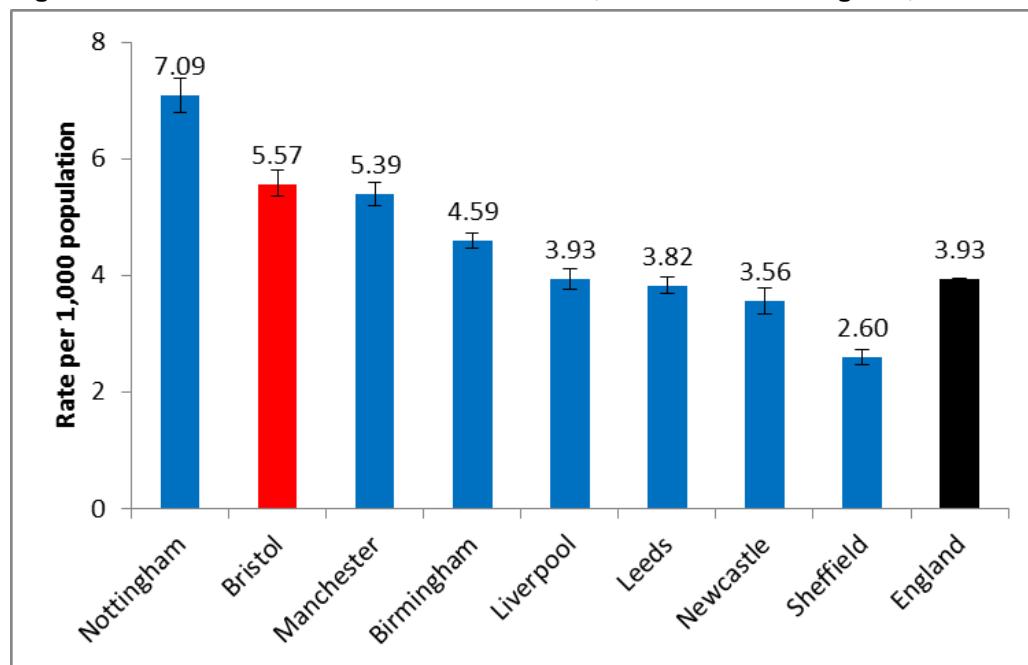
<sup>34</sup> PHE. LAPE. Available from: <http://www.lape.org.uk/data.html>

**Figure 2.3.2.1b: Alcohol-related recorded crimes, core cities and England, 2012/13<sup>34</sup>**

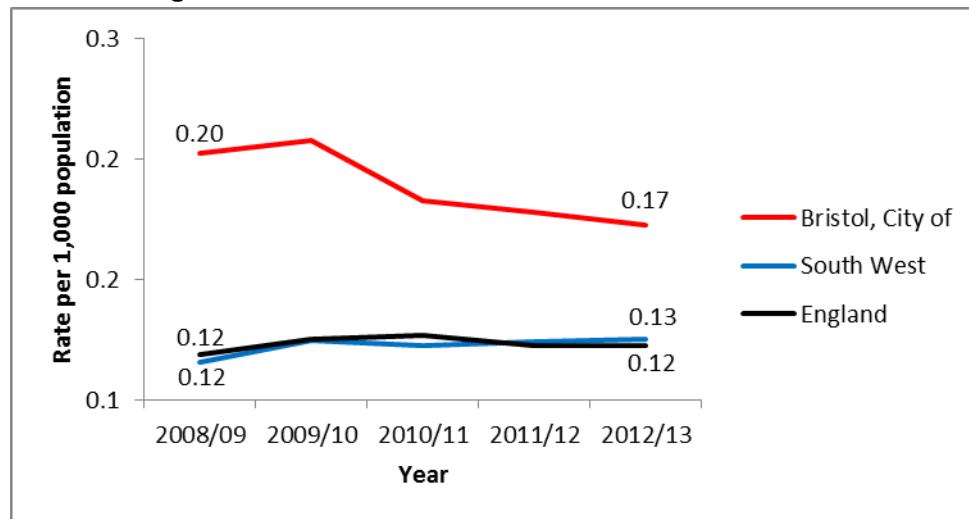
Also the Bristol rate of alcohol-related violent crime reduced from 7.39 per 1,000 in 2008/09 (corresponding to 3,043 offences) to 5.57 per 1,000 in 2012/13 (corresponding to 2,385 offences). Despite the decline, Bristol rates remained significantly higher than those of the South West (3.66 in 2012/13) and England (3.39 in 2012/13) (Figure 2.3.2.1c).

Furthermore, Bristol had one of the highest alcohol-related violent crime rates out of all the core cities in 2012/13 (Figure 2.3.2.1d).

**Figure 2.3.2.1c: Alcohol-related violent crimes, Bristol, 2008/09-2012/13; compared with South West and England<sup>34</sup>**

**Figure 2.3.2.1b: Alcohol-related violent crimes, core cities and England, 2012/13<sup>34</sup>**

In terms of alcohol-related sexual crimes, the number of offences and rates are much lower, locally and nationally. For example, in 2012/13 there were 74 sexual crimes related to alcohol reported in Bristol, corresponding to a rate of 0.17 per 1,000 population which was higher than the national and regional rate in the same year, but the difference was not statistically significant (Figure 2.3.2.1e).

**Figure 2.3.2.1e: Alcohol-related sexual crimes, Bristol, 2008/09-2012/13; compared with South West and England<sup>34</sup>**

### 2.3.2.2 Anti-social behaviour

Data about community perceptions of anti-social behaviour is gathered in the annual Quality of Life in Bristol survey.

In 2013, 29% of Bristol residents perceived anti-social behaviour was a problem in their local neighbourhood. This indicator measures concern with anti-social behaviour in the neighbourhood that is likely to include vandalism, graffiti, rowdiness, drunkenness, harassment, drug dealing, prostitution etc. People with lower educational qualifications, Black and minority ethnic people and people living in social housing were more likely to report anti-social behaviour was a problem in the local area<sup>35</sup>.

Survey respondents experienced a greater problem specifically from drunk and rowdy behaviour. 50% of residents felt drunk and rowdy behaviour in public places was a problem in the city. This indicator measured a perceived problem in the city rather than in the local neighbourhood. The 2013 percentage represented an improvement since 2009, when the indicator measured 54%, however it still indicated that in the perception of the community alcohol is considered to play a greater role than the data indicates. The highest proportion of concerned residents were from the inner city and deprived areas<sup>35</sup>.

### 2.3.2.3 Alcohol misuse in offenders

A link between alcohol misuse and offending is well known. Overall, the rate of alcohol use among prisoners was slightly lower than that of general population, when comparing those who said they drank on at least one occasion in the previous 12 months (78% of prisoners versus 83% of the general population)<sup>36</sup>. However, amongst those prisoners who drank alcohol in the four weeks before custody, the amount of hazardous drinking was higher than in the general population. They drank alcohol on a median 12 days in the month before custody, and reported consuming similar amounts of alcohol on days on which they drank, a median of 12 units. 63% of prisoners who drank alcohol in the four weeks before custody would be classified as binge drinkers and a third of them said they drank on a daily basis<sup>36</sup>.

19% of prisoners (who drank alcohol in the year before custody) reported needing help for an alcohol problem. Alcohol use among prisoners was also associated with reconviction on release (although to a lesser extent than drug use)<sup>36</sup>.

In 2009/10, an analysis of 19,225 prison based Offender Assessment System assessments found that 19% of prisoners who received an assessment were reported to have needs in relation to alcohol misuse. Furthermore, 36% of prisoners who received an assessment were reported to have exhibited violent behaviour related to their alcohol use<sup>36</sup>.

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<sup>35</sup> Quality of Life in Bristol. Quality of Life in your neighbourhood survey results 2013. Bristol City Council. April 2014. Available from: <https://www.bristol.gov.uk/documents/20182/33896/qol2014final.pdf/f9b9cb4a-7dc4-4f6c-9dca-5b11d893217d>.

<sup>36</sup> Light M, Grant E, Hopkins K. Gender differences in substance misuse and mental health amongst prisoners. Results from the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study of prisoners. Ministry of Justice Analytical Series. 2013. Available from: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/220060/gender-substance-misuse-mental-health-prisoners.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220060/gender-substance-misuse-mental-health-prisoners.pdf).

The Bristol Youth Offending Team carried out 1,350 assessments of young people in 2012/13. Of these, 199 (15%) assessments identified that alcohol use was a re-offending risk factor for 114 individuals (some were assessed more than once).

Between April 2012 and March 2013, Avon & Somerset Probation Trust assessed some of their clients to see if they have an alcohol need linked to their offending behaviour. They found that of the Bristol offenders who were supervised in the community and assessed, 54% had alcohol needs.

Prisoners are screened for substance misuse issues at the reception screen. In 2014/15 in HMP Bristol, 36% of new receptions began a drug treatment episode. Of those, 13% were alcohol only users and further 16% alcohol and non-opiate users. There are occasions where prisoners are not honest at reception about their alcohol use, and initially do not receive any intervention. They usually re-present a few days later when they start feeling unwell without any clinical support. In 2014/15, the outcome of the secondary screen showed that monthly additional 38% of prisoners were referred onto Integrated Drug Treatment Service. Of those referrals, 29% were alcohol only users and further 27% alcohol and drug users<sup>37</sup>.

#### **2.3.2.4 Alcohol and victims of crime**

Evidence suggests that drinking may increase vulnerability to crime, especially among young adults. Over the last decade, in around half of all violent incidents the victim believed the offender(s) to be under the influence of alcohol at the time of the offence. This proportion increases in incidents that occurred in the evening and night, at weekends, and in public places<sup>38</sup>.

Alcohol can increase the risk of being a victim of crime such as assault or mugging. Certain population groups are identified as being particularly at risk from these types of crimes, such as students. The Bristol Royal Infirmary A&E department produces monthly reports on the number of people attending A&E after an assault. This is shared with the council crime reduction team and the Police. The data contributes to the intelligence available for police to use to target poorly managed licensed premises.

Alcohol can also be used by victims of domestic abuse as a coping mechanism. In some cases, alcohol can be used by perpetrators to further control and stigmatise victims.

#### **2.3.2.5 Alcohol and accidents**

Alcohol is one of the leading factors contributing to accidents, from domestic to traffic related.

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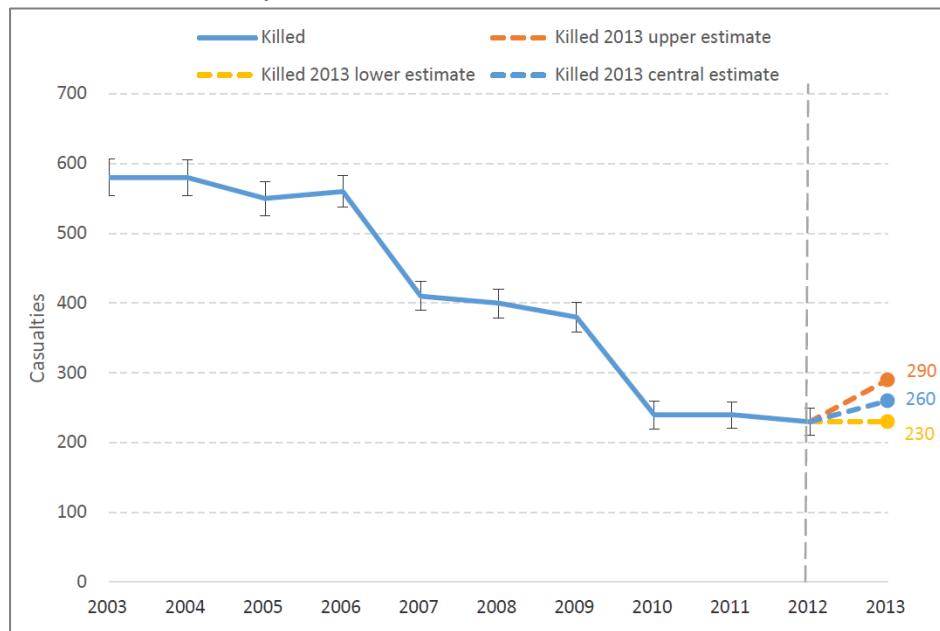
<sup>37</sup> Prison Health and Social Care Needs Assessment. HMP Bristol. S Squared Analytics. 2015.

<sup>38</sup> Modern Crime Prevention Strategy. Home Office. March 2016. Available from: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/509831/6.1770\\_Modern\\_Crime\\_Prevention\\_Strategy\\_final\\_WEB\\_version.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/509831/6.1770_Modern_Crime_Prevention_Strategy_final_WEB_version.pdf).

The effect of alcohol or drugs on casualty rates in accidental dwelling fires is well known. In England in 2011/12, there were 8% (2,483) of accidental dwelling fires where impairment due to suspected drug or alcohol use was recorded as a contributory factor. Impairment due to alcohol or drug use resulted in 41 deaths and 1,208 injuries from these fires. The fatality rate is three times higher and the rate of serious injuries is four times higher where drug or alcohol impairment was a contributory factor than where alcohol or drug impairment was not a factor<sup>39</sup>.

Alcohol is a recognised contributory factor in road accidents. In the UK in 2013, about 15% of all deaths in reported road traffic accidents involved at least one driver over the drink drive limit. Over the last 10 years, the number of drink drive deaths has been decreasing (Figure 2.3.2.5a). However, there were still about 260 drink drive deaths reported in 2013 which might have been prevented if drivers did not consume alcohol. Furthermore, 8,290 casualties of all types in drink drive accidents were reported in the UK in 2013, of which 1,100 were seriously injured casualties<sup>40</sup>.

**Figure 2.3.2.5a: Killed casualties in reported drink drive accidents (error bars show 95% confidence intervals), UK, 2003-2013<sup>40</sup>**



<sup>39</sup> The effect of alcohol or drugs on casualty rates in accidental dwelling fires, England, 2011-12. Department for Communities and Local Government. December 2012. Available from:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/35829/effect\\_of\\_alcohol\\_on\\_casualty\\_rates\\_in\\_fires\\_in\\_the\\_home\\_FINAL\\_2.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/35829/effect_of_alcohol_on_casualty_rates_in_fires_in_the_home_FINAL_2.pdf).

<sup>40</sup> Estimates for reported road traffic accidents involving illegal alcohol levels: 2013 (second provisional). Self-reported drink and drug driving for 2013/14. Statistical release. Department for Transport. February 2015. Available from:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/402698/rrcgb-drink-drive-2013-prov.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/402698/rrcgb-drink-drive-2013-prov.pdf)

## 2.3.3 Harms to children and families

Alcohol misuse can affect families in a range of ways. Parental alcohol misuse can impact on relationships and family functioning, and can impact on a child's environment in many social, psychological and economic ways. It can also be linked to a variety of mental health problems for family members, such as anxiety, depression and social exclusion. Adults who are considered to be 'vulnerable' can be adversely affected either through their own alcohol misuse or because they are at increased risk of abuse and neglect from family members or carers who are misusing alcohol.

Around 30% of children under 16 years of age (3.3-3.5 million) in the UK are living with at least one binge drinking parent, 8% with at least two binge drinkers and 4% with a lone (binge drinking) parent. In 2000 it was estimated that 22% (2.6 million) lived with a hazardous drinker and 6% (705,000) with a dependent drinker<sup>41</sup>. Substance misuse, mental health problems and domestic abuse are key factors in many child protection and safeguarding cases.

In a series of case reviews done by the National Society for the Prevention of Cruelty to Children (NSPCC) it was found that babies are at risk of sudden infant death syndrome if their parents/carers co-slept with their child when under the influence of alcohol or drugs, this was due to overlaying. Children were also at higher risk of accidents (fire, drowning) due to a lack of adequate supervision from an intoxicated parent/carer<sup>42</sup>.

The normalisation of alcohol misuse in some families means that children may be more likely to develop alcohol problems themselves in later life, thus continuing the cycle. Intervening can build greater family resilience, which in turn can lead to better outcomes for children.

### 2.3.3.1 Domestic violence and abuse

The relationship between alcohol and domestic abuse is complex. While it is not possible to state a direct causal relationship that alcohol misuse automatically results in domestic abuse, there is evidence that where domestic abuse exists, alcohol is often present, either for the perpetrator or the victim<sup>43</sup>. Alcohol misuse can increase the severity of violence<sup>44</sup> and is often used as an excuse for violence.

In Bristol in 2012/13, there were 595 Multi Agency Risk Assessment Conferences (MARAC) cases, of those 185 recorded perpetrator alcohol misuse (31%). MARACs are organised for the most serious and high risk cases of domestic violence and abuse.

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<sup>41</sup> Manning V, Best DW, Faulkner N, Titherington E. New estimates of the number of children living with substance misusing parents: results from UK national household surveys. BMC Public Health. 2009; 9(1):377-389.

<sup>42</sup> Learning from case reviews involving parental substance misuse. NSPCC Briefing. November 2013. Available from: <https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/parents-misuse-substances>.

<sup>43</sup> Galvani S. Grasping the nettle: alcohol and domestic violence. Alcohol Concern's information and statistical digest. June 2010. Available from: [http://www.alcoholconcern.org.uk/wp-content/uploads/woocommerce\\_uploads/2014/12/Grasping-the- nettle-factsheet-revised-June-2010.pdf](http://www.alcoholconcern.org.uk/wp-content/uploads/woocommerce_uploads/2014/12/Grasping-the- nettle-factsheet-revised-June-2010.pdf).

<sup>44</sup> Gilchrist E, Johnson R, Takriti R, Weston S, Beech A, Kebbell M. Domestic violence offenders: characteristics and offending related needs. Findings 217. Research, Development and Statistics Directorate. Home Office London. 2003. Available from: <http://webarchive.nationalarchives.gov.uk/20110218135832/http://rds.homeoffice.gov.uk/rds/pdfs2/r217.pdf>.

### **2.3.3.2 Parental substance misuse**

Children whose parents/carers misuse alcohol can suffer a range of poor outcomes, including behavioural and/or psychological problems, poor educational attainment, low self-esteem, offending behaviour, and risk of sexual exploitation.

Drug and alcohol misuse is a factor in a significant number of children in need and child protection cases. Evidence suggests that alcohol is a factor in at least 33% of child protection cases, and drug and alcohol misuse is a factor in up to 70% of care proceedings<sup>45</sup>.

An analysis of serious case reviews of children found that parental substance misuse was featured in 25% (47/189) of cases reviewed<sup>46</sup>. This may be an underestimate as there is currently no routine screening by children and families services for parental alcohol misuse. Local experience is that parental mental health issues and domestic abuse also commonly featured in serious case reviews, in many cases concurrently with substance misuse.

Maternal alcohol misuse in pregnancy can also be linked to Foetal Alcohol Spectrum Disorders (FASD). These are a series of preventable mental and physical birth defects resulting from maternal alcohol consumption during pregnancy. FASD are lifelong conditions that can significantly impact on the life of the individual and those around them.

### **2.3.3.3 Young people's alcohol misuse**

Young people's misuse of alcohol is addressed as part of a wider range of responses to substance misuse. Alcohol and cannabis are the substances most commonly used by young people. Alcohol use among children and young people can result in a range of adverse outcomes, including organ damage, increased risk of unsafe or regretted sex, teenage pregnancy, unintentional injuries, and being a victim or perpetrator of crime or antisocial behaviour. Early use of alcohol is also a predictive factor in problematic use of alcohol in adulthood.

As shown earlier in Figure 2.3.1.1d, there were 95 persons aged less than 18 years admitted to hospital due to alcohol-specific conditions in Bristol in 2011/12-13/14, which corresponds to a rate of 35.5 admissions per 100,000 population under 18s. This was similar to the national figure in the same time period<sup>20</sup>.

There were 196 young people under the age of 18 years in treatment for substance misuse in Bristol in 2011/12. Of those, 101 used alcohol (16 used alcohol only, 85 used alcohol and cannabis).

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<sup>45</sup> Supporting information for the development of joint local protocols between drug and alcohol partnerships, children and family services. NHS National Treatment Agency for Substance Misuse. 2011. Available from: <http://www.nta.nhs.uk/uploads/supportinginformation.pdf>.

<sup>46</sup> Brandon M, Bailey S, Belderson P, et al. Understanding Serious Case Reviews and their Impact. A Biannual Analysis of Serious Case Reviews 2005-07. Department for children, school and families. June 2009. Available from: [http://www.haringeylscb.org/sites/haringeylscb/files/biennial\\_review\\_scrs\\_200507 Brandon-3.pdf](http://www.haringeylscb.org/sites/haringeylscb/files/biennial_review_scrs_200507 Brandon-3.pdf).

Bristol Drug Project provides the Bristol Youth Links Substance Misuse Service, which supports young people who have lower levels of need than those in the treatment services. The service aims to target young people in the earlier stages of substance use in order to prevent escalation into more problematic patterns. In the first three quarters of 2013/14, they saw 215 young people about substance misuse issues, of those 72 (33%) recorded alcohol as the substance that they use most frequently.

## 2.3.4 Social and economic harms

### 2.3.4.1 Worklessness

While the alcohol industry brings benefits to Bristol, alcohol misuse also has a damaging effect on the performance and productivity of our local economy. It can be a barrier to rejoining the labour market for those out of work, and can impact on the workplace through absences and reduced productivity.

It is estimated nationally that up to 17 million working days are lost each year through sickness absence attributed to alcohol<sup>32</sup>. Alcohol misuse may also affect productivity of workers in their workplace and may result in shorter working lives and early retirement.

Alcohol can be responsible for inability to work and unemployment. The prevalence of dependent drinkers among benefit claimants is twice the prevalence in the general population<sup>47</sup>. Being out of work can put people at increased risk of ill health and premature mortality, and can be linked to increased substance misuse and mental ill health, as well as reduced psychological wellbeing.

In Bristol, 47% of patients who started alcohol treatment in 2014/15 self-reported long-term sickness or disability, and 24% of patients were unemployed or inactive. Improving job outcomes for this group is essential to sustaining recovery and requires improved multi-agency responses<sup>29</sup>.

### 2.3.4.1 Homelessness

Links between alcohol misuse and homelessness are well established, both as a cause and a consequence. Alcohol misuse can impact on an individual's ability to maintain a tenancy; conversely, lack of stable accommodation is considered by many homeless alcohol misusers to be a significant barrier to their recovery.

Physical and mental health problems are prevalent among the homeless population, and evidence suggests that one third of all deaths among the homeless population are a result of drugs or alcohol<sup>48</sup>. In Bristol, housing problem was self-reported by 7% of adults who started alcohol treatment in 2014/15, and urgent housing problem by additional 3% of new treatment starters<sup>29</sup>. Also the Bristol Compass Health, which provides the primary care for homeless people, estimates that 18% of their clients have problematic alcohol use or are dependent drinkers.

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<sup>47</sup> Hay G, Bauld L. Population estimates of alcohol misusers who access DWP benefits. Department for Work and Pensions. 2010. Available from: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/214391/WP94.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214391/WP94.pdf).

<sup>48</sup> Homelessness: a silent killer. A research briefing on mortality amongst homeless people. Crisis. December 2011. Available from: <http://www.crisis.org.uk/data/files/publications/Homelessness%20-%20a%20silent%20killer.pdf>.

## 2.4 Cost of alcohol misuse

Alcohol misuse places a significant cost burden on society and a strain on our NHS services.

The estimated cost of alcohol harm to society is £21 billion per year<sup>1,3</sup>. This figure takes into account the impact alcohol has on health and other public services, the cost of alcohol-related crime and disorder, the impact of alcohol misuse on worklessness and lost productivity, and the estimated social costs as a result of alcohol misuse. The cost of alcohol-related crime itself was estimated at £11 billion<sup>38</sup>.

Information on estimated cost to the NHS of alcohol misuse shows that it costs £3.5 billion every year, which is equal to £120 for every taxpayer. This estimate of £3.5 billion is an updated figure to the one given in 2008 when it was estimated that the cost of alcohol harm to the NHS in England was £2.7 billion (in 2006/07 prices). This updated estimate takes into account increases in unit costs as well as more recent and accurate data on alcohol consumption and harm<sup>1</sup>.

## 3 CURRENT RESPONSES TO ALCOHOL-RELATED HARM IN BRISTOL

### 3.1 Education, prevention and campaigns

#### 3.1.1 Prevention work for children and young people

##### Prevention

The main focus of the approach to tackling alcohol misuse in young people is prevention. This is targeted at all children and young people in the city and is incorporated into other work focusing more widely on substance misuse, with an awareness that alcohol is by far the most likely substance that young people will use. In England in 2013, 39% of young people aged 11-15 years said they had drunk alcohol at least once, compared to 16% who said they had ever taken drugs<sup>49</sup>.

The majority of alcohol prevention with young people in Bristol is delivered in schools. Alcohol education is statutory within the school science curriculum, it is often taught within personal social and health education (PSHE), which is non-statutory. PSHE is part of a programme focusing on substance misuse more broadly, under the guidance of the Bristol City Council's Healthy Schools team manager. The guidance focuses on high quality, evidence based drug and alcohol education and knowledge of best practice. It is advised that alcohol education should be part of a whole school approach and should be delivered in both primary schools at Key stages 1 and 2 and secondary schools at Key stages 3 and 4.

Outside of schools, other colleagues within the wider children and young people's workforce are also encouraged to deliver good quality education focusing on the prevention of alcohol misuse among young people. Bristol City Council's Public Health team deliver training on basic drug and alcohol awareness (level 1) and delivering drug and alcohol education (level 2) as part of the 4YP programme and all workers are encouraged to attend these sessions.

##### Working with Parents

The influence of parents over young people's substance use is also taken into account and campaigns and information are incorporated into other public health work. Examples include advice to pregnant women about alcohol use, advice and information to parents of teenagers based on the guidance from the Chief Medical Officer<sup>50</sup>. Training is delivered through the 4YP training programme for those working with parents, carers and families on how to support their clients to talk effectively to children and young people about alcohol and drugs.

<sup>49</sup>Fuller, E and Hawkins, V. Smoking, drinking and drug use among young people in England in 2013. Health and Social Care Information Centre. 2014. Available from: <http://www.hscic.gov.uk/catalogue/PUB14579/smok-drin-drug-youn-peop-eng-2013-rep.pdf>

<sup>50</sup>Donaldson, L. Guidance on the Consumption of Alcohol by Children and Young People. Department of Health. 2009. Available from: [http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_110256.pdf](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_110256.pdf)

The Safeguarding Children's Substance Misuse Group, which reports to Bristol Safeguarding Children's Board, has produced a protocol for agencies working with drug using parents to ensure that the safeguarding of children is prioritised and that recommendations from previous serious case reviews become part of service delivery. The council's Safer Bristol team commission Hidden Harm work from the Drugs and Young People Project to reduce risk and build resilience with young people who have child protection concerns. This work has recently been evaluated and there is significant evidence to show that it effective in reducing risk and building resilience among these young people, reducing the likelihood that these young people will grow up with substance misuse problems.

Hidden Harm work is also offered within Bristol Youth Links service for those aged 9-19 years who fall outside the threshold for social care involvement.

Training for the children and young people's workforce on working with children affected by Hidden Harm issues is available through the 4YP programme.

### **3.1.2 Adult prevention work**

Identification and Brief Advice (IBA) is a cornerstone of adult prevention work. This means that people are screened using set questions to find out their level of alcohol use. If they are found to be drinking above guidelines, they are given information and signposted to appropriate services.

IBA services have been developed and are operational in:

- Bristol Royal Infirmary Accident and Emergency Department, the Medical Assessment Unit, and some wards;
- Some wards in North Bristol NHS Trust;
- GP practices who operate the National Direct Enhanced Service (for new registrations), or the Public Health Alcohol Service (for patients with hypertension, newly diagnosed depression, or who have been to hospital with an alcohol misuse related injury);
- Custody suites.

An IBA service is being developed for pharmacies, aimed at people who buy hangover cures for gastric problems.

In addition Public Health trains front-line workers to deliver IBAs. Workers already trained include: Support to Stop Smoking workers, sexual health services staff, health visitors, community workers for older people, and children's centre staff.

Social Marketing campaigns have been carried out to raise awareness about alcohol and its risks. The DrinkSmart campaign has been operational since 2010, and includes self-help materials for people who are concerned about their alcohol use and want to make changes. Targeted campaigns include: a series of campaign aimed at young people using the

council's Ministry of Cheer web site, a safeguarding vulnerable people campaign aimed at carers who drink, and pharmacy campaigns targeting people with high blood pressure.

Alcohol awareness sessions have been developed for front-line workers.

## **3.2 Treatment and care**

### **3.2.1 Treatment and care for children and young people**

#### Early Intervention

Funding is in place to deliver early intervention work with young people as part of the Bristol Youth Links programme. This is provided by Bristol Drug Project and is mainly delivered in secondary schools. The Youth Links Service is the first point of referral for young people aged 19 and under living in Bristol who need extra support because of their alcohol or drug use. They may be offered up to six 1:1 sessions or they may attend group work. The worker helps them to think about how they can make positive changes to their alcohol use, including cutting down and stopping, in order to reduce risks. Referral into this service can be made by anyone and the referral pathway is dealt with in detail in the 4YP level 1 training.

#### Treatment

Young people who misuse alcohol and have more complex needs are referred into the young people's substance misuse treatment services. Bristol City Council's Safer Bristol team commissions two treatment services, with funding from Bristol Public Health and the Police and Crime Commissioner.

The first is the Young People's Substance Misuse Treatment Service, which supports young people with mental health problems and other health needs and is based in Children and Adolescents Mental Health Service (CAMHS). The second is the Drugs and Young People's Project, which supports young people who have social work involvement and is based in the council's Children and Families Service. There is also a treatment worker in the council's Youth Offender Team (YOT). Current practice is for these agencies to work together as one treatment service. Treatment is care planned with the young person and may include psychosocial elements, harm reduction, prescribing and family support, depending on the young person's needs.

### **3.2.2 Treatment and care for adults**

The "Recovery Orientated Alcohol and Drug Service" (ROADS) is an integrated adult substance misuse service available across Bristol for access to structured interventions aimed at overcoming physical and psychological dependence on alcohol and drugs as well as offering support around housing, education and employment. Support for families and carers who are affected by the alcohol use of others are provided as part of ROADS to reduce the wider impact alcohol has on communities.

ROADS is comprised of 5 Clusters designed to operate as a single integrated treatment system (Appendix 1). The 3 treatment clusters (Engagement, Change and Completion) deliver appropriate interventions dependent on a client's stage of change. Engagement focuses on engaging individuals into treatment and delivers low threshold brief interventions. Change provides higher tier structured treatment interventions including specialist services for people with complex needs and inpatient detoxification & access to residential rehab. Completion offers post-treatment support around training, education, volunteering and employment to enable people to re-integrate with their community.

Advocacy and support for families and carers is delivered by the Support cluster whilst Housing Support provides accommodation and support for people to sustain their tenancies.

There are multiple referral routes into ROADS, including self-referral, GPs, hospital, Job Centre and the criminal justice system to ensure services are accessible for all the people in need of them. The services on offer respond to the varying needs of Bristol's problematic drinkers and work to motivate and support people to achieve sustained recovery from addiction. This reduces the negative impact alcohol has in Bristol.

In the hospitals there are alcohol nurses in the Bristol Royal Infirmary and at Southmead. These nurses provide support and extended interventions for dependent drinkers and work with self-harmers whose harming is linked to alcohol, some also provide symptom triggered prescribing for patients. There are sound safeguarding processes in place for children and vulnerable adults, and good working relations with the mental health team. The alcohol nurses cover A&E, the hepatology ward and the medical assessment unit.

Alcohol-related problems are a big and increasing part of the primary care workload. Most practices screen new registrations for alcohol misuse, and some operate a local alcohol service targeting people with specific ailments.

Some GPs offer community detoxification in partnership with the treatment services. ROADS Complex Shared Care nurses work in primary care in areas where there are high numbers of problem drinkers. They support GPs to work with clients with complex needs to enable their care to remain within their local practice and GPs have further support from the ROADS lead consultant to support the delivery of primary care based interventions.

The Clinical Commissioning Group commissions hospital services and there are a number of planned care pathways that relate to alcohol, for instance inpatient and outpatient hepatology services for cirrhosis of the liver.

### **3.3 Alcohol-related crime & disorder; night-time economy**

#### **3.3.1 Police**

The Police have developed their operational approach to policing the night-time economy. Called 'Brio' this approach combines public order policing, which uses identification and

targeting of problem areas, with uniformed officers entering specific licensed premises to identify drunkenness or underage drinkers.

On a typical Saturday or Sunday night (22.00-04.00), in the Bristol city-centre night-time economy area, the police deal with an average of six violent crime offences. Of these three are recorded as involving Actual Bodily Harm with the bulk of the remainder being for more minor violent crime or disorder offences. In addition to this there are usually more than ten reported incidents of Anti-Social Behaviour which the police respond to, they also deal with spontaneous demand from bad behaviour observed by patrolling officers. For the overwhelming majority of these crimes and incidents alcohol is deemed to be a significant factor. The police response to this demand involves the deployment of a significant number of additional officers on these nights.

The Police also work with licensed premises to seize and return identity documents used by underage people to gain entry to licensed premises.

The Police Public Protection Unit delivers a specialist approach to incidences of domestic violence, and there is a defined referral process for children at risk within chaotic households.

### **3.3.2 Probation**

Since June 2014 Probation Services in Bristol have been delivered by two organisations – the National Probation Service (responsible for advice to the courts and the supervision of offenders assessed as high risk of harm) and a Community Rehabilitation Company (covering Bristol, Somerset, Bath, Gloucester and Wiltshire, and responsible for the supervision of offenders assessed as low and medium risk of harm). Their responsibility is to protect the public and reduce reoffending by delivering the punishment and orders of the courts and supporting rehabilitation by helping offenders to change their lives.

As part of this work they assess the people they supervise to find out whether the misuse of alcohol contributes to their offending behaviour. People can be referred to a range of interventions around problematic alcohol use, including the Drink Impaired Drivers Programme, the Low Intensity Alcohol Programme or the Building Skills for Recovery Programme.

Other structured interventions are available as part of community orders or post-release Licences and if the person is drinking at dependent levels they can be referred to specialist services sometimes by using the Alcohol Treatment Requirement associated with a community order.

The National Probation Service also supervises offenders included in the IMPACT (serious acquisitive offenders often with multiple substance misuse) and IRISS cohorts (dangerous offenders).

### **3.3.3 The Bristol Council's services**

#### **Licensing Service**

This service has two key areas of responsibility for alcohol: administration of the Licensing Act and enforcement work. The Licensing Service conducts proactive inspections at alcohol licensed premises to ensure compliance with premises licence conditions and other related legislation. The Service undertakes to work with licence holders in effecting compliance, recommending and ensuring improvements where necessary, but takes punitive action where necessary.

#### **Trading Standards Service**

This service enforces legislation regarding the sale, supply and use of illicit alcohol products and underage sales. They use an intelligence led approach to achieve compliance and respond to complaints alleging the illegal sale of alcohol products. The Service can undertake checks for compliance for underage sales and works in partnership with other enforcement agencies to tackle the problem of underage sales, and of counterfeit and smuggled alcohol products.

#### **Crime Reduction and Substance Misuse Team**

This team works with retailers to improve the management of the night-time economy through initiatives like Pubwatch. They operate the CCTV presence in the city centre which contributes to reducing alcohol fuelled disorder.

### **3.3.4 Joint working**

Partners in Bristol have a co-ordinated approach to dealing with licensed premises that sell alcohol illegally or irresponsibly. The regulatory authorities: council licensing, Police licensing, planning, pollution control, environmental health work together to identify problem premises and take action through a Joint Tasking process. Problem premises are 'Red' tagged and worked with to improve their performance against the National Licensing Objectives. There are joint enforcement visits involving the Police, council licensing and trading standards staff.

Bristol's management of its lively and attractive night-time economy has resulted in the award of Purple Flag Status for the last three years.

## **3.4 Targeting and protecting vulnerable groups**

### **3.4.1 People with complex needs and chaotic lifestyles**

Police and council workers address street drinking issues by supporting the work of the Streetwise Team (a joint police/council team) who use the integrated offender management method to assist street drinkers to change their offending behaviour and address their alcohol misuse.

Bristol runs two ‘wet sessions’ a week where street drinkers can access, health services, housing advice and mental health workers. The Wet Clinic is the only GP lead health clinic for street drinkers in England.

The Big Lottery ‘Fulfilling Lives – Multiple Needs’ project started in 2014, it will enable people with chaotic lives and complex health and social issues to access help, and be case managed by specialist workers.

The re-commissioning of Bristol Mental Health services in 2014 will result in a new Assertive Engagement Service for people with chaotic lifestyles and complex needs, many of the most vulnerable dependent drinkers will be able to access this service. Formerly the mental health services were unable to assess or treat dependent drinkers.

### **3.4.2 Children, young people and families**

Young people’s treatment services are delivered by three agencies, forming an integrated treatment team. These are:

- The Young People’s Substance Misuse Treatment Service (YPSMTS), which is part of Children and Adolescent Mental Health Service (CAMHS) and works with young people up to the age of 18 years with substance misuse problems and complex needs.
- The Drugs and Young People Project (DYPP), which is part of Children and Young People’s Services (CYPS) and works with young people who misuse substances and have social workers.
- The Youth Offending Team which supports young offenders who also misuse drugs and alcohol.

DYPP also supports young people with social workers whose parents and carers misuse drugs and alcohol. The child protection concerns for most of these families are closely related to their parents’ substance misuse.

Early intervention work is delivered by Bristol Drugs Project, as part of ‘Bristol Youth Links’ targeted work. They work with young people who are using drugs and alcohol and with those whose parents use drugs and alcohol where there is no social care involvement.

Support for families of alcohol misusers is provided by Developing Health and Independence (DHI) in the new ROADS service.

## 4 VISION FOR BRISTOL

Our vision for Bristol:

**To create safe, sensible and harm-free drinking culture in Bristol,**  
through partnership working and using the best available evidence  
in order to ensure the following:

- Bristol is a healthy and safe place to live, work and visit.
- People of Bristol are drinking within the nationally recognised guidelines.
- Individuals and families are able to access the right treatment and support at the right time.

## 5 OUR STRATEGY

### 5.1 Aim of the strategy

The overarching aim of the strategy is to prevent and reduce the harm caused by alcohol to individuals, families and communities in order to ensure Bristol is a healthy and safe place to live, work and visit.

This can be achieved through partnership working and using the best available evidence of what works.

There are three broad aims:

- |   |  |
|---|--|
| <b>1 Increase individual and collective knowledge about alcohol, and change attitudes towards alcohol consumption.</b><br><br>(PREVENTION/CAMPAIGNS)      | <i>Alcohol Prevention Workstream</i>   |
| <b>2 Provide early help, interventions and support for people affected by harmful drinking.</b><br><br>(ACCESS TO SERVICES AND PATHWAY FOR LIVER DISEASE) | <i>Alcohol Intervention Workstream</i> |
| <b>3 Create and maintain a safe environment.</b><br><br>(REDUCTION OF AVAILABILITY AND ACCESSIBILITY, SAFE NIGHT TIME ECONOMY)                            | <i>Alcohol Environment Workstream</i>  |

## 6 STRATEGY WORKSTREAMS

	ALCOHOL PREVENTION (Workstream 1)	ALCOHOL INTERVENTION (Workstream 2)	ALCOHOL ENVIRONMENT (Workstream 3)
Aim	Increase knowledge and change attitudes towards alcohol	Provide early help, interventions and support for people affected by harmful drinking	Create and maintain a safe environment
Team Lead	Becky Pollard	Dr Martin Jones	Supt Rhys Hughes
Coordinator	Leonie Roberts	Dr Kate Rush, Kath Williams	Insp Martin Rowland, Nick Carter
Members	Sarah Westlake, Cllr Claire Hiscott, Petra Manley, Blanka Robertson, Jackie Beavington, Geraldine Smyth, Liz McDougall, Rob Bennington	Lynn Stanley, Dr Anne McCune, Dr Tim Williams, Sally Arnold-Jones, Jude Carey, Blanka Robertson	Michelle Phillips, Sally Arnold-Jones
Suggested outcomes	<ul style="list-style-type: none"> <li>Reduce alcohol consumption causing harm to individuals, families and communities in Bristol</li> </ul>	<ul style="list-style-type: none"> <li>Reduce alcohol related harm to individuals</li> <li>Earlier identification of health harm caused by alcohol</li> <li>High quality evidence-based treatment to reduce alcohol related harm</li> <li>Children and young people free from alcohol related harm</li> </ul>	<ul style="list-style-type: none"> <li>Reduce individual and community impact from alcohol related crimes and anti-social behaviour</li> <li>Protect vulnerable people from alcohol related harm</li> <li>Reduce demand on public and emergency services</li> <li>Safe events held within the City; reduce alcohol related incidents</li> </ul>
Suggested outputs	<ul style="list-style-type: none"> <li>Improve community discussion about alcohol leading to change of attitude and behaviour to alcohol consumption</li> <li>Increase knowledge about recommended limits and about the health risk of not drinking in moderation</li> <li>Increase staff information and training on alcohol awareness and harm</li> <li>Reduce stigma and shame associated with alcohol dependence</li> <li>Increase skills of people to drink within the recommended guidelines</li> <li>Advocacy role to reduce the availability of alcohol and increase the price</li> </ul>	<ul style="list-style-type: none"> <li>Improve screening and detection of alcohol-related health harm in primary care</li> <li>Reduce alcohol related hospital admissions</li> <li>Improve individual and family access to treatment and support</li> <li>Increase successful completion of treatment</li> </ul>	<ul style="list-style-type: none"> <li>Develop multi-agency information sharing at tasking meetings</li> <li>Enforcement of alcohol related violence</li> <li>Increase knowledge of legal and social responsibilities within the licensed trade</li> <li>Effective monitoring of cumulative impact areas</li> <li>Reduce community impact of the street drinking community</li> </ul>

## 7 DELIVERABLES AND ACTIONS

Alcohol Prevention (Workstream 1)					
Suggested Actions	Evidence and/or Baseline	Activity/Targets	Timescale	Lead Agency	Contributing Agencies
<b>Social marketing</b> Deliver a large-scale social marketing campaign across Bristol City	The Government's Alcohol Strategy, HM Government, 2012	Scoping document produced – steering group formed. Target audience identified.	2016	Public Health and Addictions Health Integration Team	Public Health England
	UK Chief Medical Officers' Alcohol Guidelines Review, DoH, 2016	Development of a social marketing plan.	Start 2017		
	EU Social marketing guidance <a href="#">Evidence\social-marketing-guide-public-health.pdf</a>	Implementation e.g. social media, media stories.	2018		
		Evaluation report produced, e.g. number of campaigns, number of people reached, feedback from stakeholders.			
<b>Social Marketing</b> Deliver preventative campaigns using social marketing tools and methods  Use social marketing tools to gather intelligence about attitudes to alcohol use and drinking behaviour		Implement Public Health England OneYou campaign across Bristol	2016/2017	Public Health delivery teams/Public Health England	Public Health England
		Dry January Campaign		Public Health Strategic and Delivery Teams	
		Promote use of Drinkaware Application		Bristol City Council Events Team	
		Introduce Alcohol Free Zones at public events		Public Health Strategic and Delivery Teams	
		Host the Alcohol Big Debate			

<b>Education in schools –</b>  Implement alcohol education in schools  Develop work with schools about delivering training for parents  Work with young people and adults with caring responsibilities		Increase the number of schools delivering alcohol education within PSHE, according to best practice recommendations.	2016/17	Public Health- Children and Young People's Strategic Team and Children and Young people's Delivery team	
<b>Workplaces</b>  Work in partnership with businesses across the city to promote and support the development and implementation of workforce alcohol policies and interventions to reduce alcohol-related harm in the workplace  184	Health and Safety Executive  <a href="https://www.bhf.org.uk/publications/health-at-work/health-at-work-guide-to-alcohol">https://www.bhf.org.uk/publications/health-at-work/health-at-work-guide-to-alcohol</a> <a href="http://www.alcoholconcern.org.uk/wp-content/uploads/woocommerce_uploads/2015/03/Alcohol-and-the-Workplace.pdf">http://www.alcoholconcern.org.uk/wp-content/uploads/woocommerce_uploads/2015/03/Alcohol-and-the-Workplace.pdf</a> <a href="http://www.cipd.co.uk/NR/rdonlyres/EFE87A7D-B088-43C0-A0B5-B6F71DA1E678/0/mandrgalcmisuseg.PDF">http://www.cipd.co.uk/NR/rdonlyres/EFE87A7D-B088-43C0-A0B5-B6F71DA1E678/0/mandrgalcmisuseg.PDF</a>	Provide alcohol awareness training for local employers (first priority – organisations signed up to the Workplace Wellbeing Charter. Currently 30 organisations who employ 30,000 staff).	January 2017	Public Health	
		Support Charter organisations to achieve the Alcohol standard (this includes policy, practice and support to staff - target 20 organisations).			
		Provide brief intervention training for Charter organisations.			
		Provide materials and resources to assist organisations to promote awareness amongst their own staff (using One You materials).			
		Include guidance and campaigns which promote alcohol awareness in monthly Health at Work Newsletter.			
<b>Alcohol Workplace policies</b>  Review Bristol City Council alcohol policy and support available for employees with alcohol problems.	Alcohol and Substance Misuse Policy  NICE Guidance PH24 <a href="https://www.nice.org.uk/guidance/ph24">https://www.nice.org.uk/guidance/ph24</a>	Policy reviewed Brief intervention and e-learning module developed.	2016/17	Public Health	

<b>Workforce (Making every contact count)</b>  Deliver Alcohol Identification and Brief Advice training (IBA) to groups including but not limited to pharmacists and tenancy support officers  Workforce development in alcohol IBA - (making every contact count)	NICE Guidance PH24 <a href="https://www.nice.org.uk/guidance/ph24">https://www.nice.org.uk/guidance/ph24</a>  <a href="http://www.alcohollearningcentre.org.uk/eLearning/IBA/">http://www.alcohollearningcentre.org.uk/eLearning/IBA/</a>	Commission Pilot Pharmacy Alcohol Identification and Brief Advice Service (IBA)  Plan the roll out of IBA to professionals in health care and non-health care settings.  Develop and implement mechanism for training follow-up	2016/17	Public Health	
<b>Community</b>  Encourage parents to have conversations with their children through a social marketing campaign  Develop training on supporting parents to talk to their children on the harms of alcohol.		4YP parents' campaign launched April 2016. Evaluate after 6 months. Re-promote every six months through schools, GP surgeries, parent support groups, Think Family, Early Help etc.		Launch April 2016. Evaluate Oct 2016. Re-promote Nov 2016. Evaluate March 2017	Public Health- Children and Young People's Strategic Team and Children and Young people's Delivery team
<b>Community</b>  Develop community engagement strategies.		Alcohol will be included in redesigned 4YP training programme, especially in the course focusing on supporting parents to talk to children and young people about difficult issues.	New courses launched 2017	Public Health- Children and Young People's Strategic Team and Children and Young people's Delivery team	
		Enable Neighbourhood Partnerships to develop local action plans to address the harms related to alcohol.  Promote community events that don't involve alcohol.  Encourage local licensed businesses to promote alcohol-free hours during opening times.	2016/17	Public Health Strategic and Delivery Teams	Bristol City Council

<b>Alcohol Intervention (Workstream 2)</b>					
<b>Planning</b>					
<b>Suggested Actions</b>	<b>Evidence and/or Baseline</b>	<b>Activity/Targets</b>	<b>Timescale</b>	<b>Lead Agency</b>	<b>Contributing Agencies</b>
<b>Needs assessment</b>	Needs assessment	Health needs assessment Review current service provision (multidisciplinary) Identify unmet needs Identify how services can address unmet needs	Complete 2016	Substance misuse team	Public Health
<b>Mapping of existing services</b>	None	A comprehensive mapping exercise to capture all existing services (primary care, secondary care, specialist)	End 2016/2017	Substance misuse team	CCG
<b>Mapping of patient pathway – specialist services</b>	None	Consider service provision from patient perspective  Identify potential changes/improvements to inform re-commissioning process		Substance misuse team	Healthwatch
<b>Evidence review and economic evaluation</b>		Understand the current evidence base including cost effectiveness in relation to specific services/interventions (e.g. alcohol nurses)  Collaborative working with South Gloucestershire. Short life working group to be established to define parameters of work	To commence Autumn 2016	Bristol CCG/Public Health	In conjunction with South Gloucestershire CCG
<b>Primary care review</b>  Review of screening and identification used within primary care to include alcohol and liver disease	NICE CG115  Audit will provide baseline	Audit of current practice  Repeat audit	Apr - Jul 2016  Apr 2017	CCG	
<b>Activity data</b>  Review of secondary care data (Commissioning for Value datasets) and explore opportunities	Right Care – Commissioning for value datasets	Initial review of opportunities and deep dive to test initial findings	End 2016	CCG	

<b>Alcohol Intervention (Workstream 2)</b>					
<b>Delivery</b>					
<b>Suggested Actions</b>	<b>Evidence and/or Baseline</b>	<b>Activity/Targets</b>	<b>Timescale</b>	<b>Lead Agency</b>	<b>Contributing Agencies</b>
<b>System approach to alcohol and liver disease</b>  Development of a system approach to alcohol treatment and liver disease (all causes)	NICE CG115  Lancet 'Addressing Liver disease in the UK'	Develop a standardised approach for screening and identification within primary care using outcomes from audit	Jul - Oct 2016	CCG	Secondary Care (UHB and NBT)  Secondary Care, Local Authority Commissioning, GP practices, Service providers
		Develop clear pathways between primary care, community care and secondary care services	Jul 2016 – Jul 2017		
		Explore new models of working including non-invasive measurement of fibrosis and outreach management of cirrhosis complications e.g. elastography		Public Health – pilot, CCG – longer term	
<b>Harm minimisation for high risk groups</b>	Needs assessment	Identify treatment resistant cohort  Address through harm reduction strategies incorporated into re-commissioning process	Jul-Oct 2017	Substance misuse team	
<b>Young People</b>  Promoting the young people's substance misuse pathway across all agencies working with children and young people	Baseline to be determined following review of training delivery	Training programme delivered by Public Health  Number of people in the children and young people's workforce who are trained to screen young people, identify those who are using alcohol and refer them into the Bristol Youth Links early intervention service	Apr 2016 – Mar 2017	Public Health- Children and Young People's Strategic Team and Children and Young people's Delivery team	

<b>Training and education – Healthcare staff</b>					
GP training	NICE CG115	Update for GPs on current pathways and best practice in relation to alcohol/liver disease incl. mutual aid	October 2016	CCG	Secondary care (UHB and NBT)
Explore the opportunities for online training for ambulance staff and information sharing with primary care	None	Review online Identification and Brief Advice (IBA) training		Public Health	
		Develop electronic information sharing with primary care		South West Ambulance Service	
Develop Paramedic training at UWE in IBA	None	Scoping		South West Ambulance Service	
Mutual aid training for practice based staff (PMs/Community resource co-ordinators)	Measure through representations – Proportion who successfully completed treatment in the first 6 months of the latest 12 month period and re-presented within 6 months	Run a specific Facilitated Access to Mutual Aid training session for all practice managers		Substance misuse team Bristol City Council	

Alcohol Environment (Workstream 3)					
Suggested Actions	Evidence and/or Baseline	Activity/Targets	Timescale	Lead Agency	Contributing Agencies
<b>Wider use of technology</b>  Increase the availability of technology to improve the quality of information and evidence		Real time Sec 35 dispersal information sharing with partners (app to circulate photos of those issued orders to increase likelihood they will actually disperse)	6-12 months	Police	Bristol City Council
	Number of incidents reported by taxi marshals 15/16	Issuing of body-worn cameras to taxi marshals		Bristol City Council	
<b>Diversionary events/activities</b>  Provide an alternative to traditional night time economy activities		Diversionary events/activities in areas of high alcohol use and/or proliferation of licensed premises – use links to events managers	6-12 months	Bristol City Council	Police
<b>Brio night time economy operation</b>  Continue to develop this operation into a multi-agency approach to Bristol night time economy		Enhancement to Police Night Time Economy Operation through implementation of mini multi-agency operations and thematic leads within police teams for issues such as taxis, drugs, underage sales etc.	6 months	Police	
<b>Intelligence sharing between agencies</b>  Enabling an intelligence led, effective and efficient multi-agency approach to dealing with alcohol related issues across the City		Monthly review meetings Weekly Brio debrief/review meetings	Immediate	All agencies	All agencies
<b>Identification and management of problematic licensed premises</b>  Improving the safety of establishments	Number of 'red' premises in 15/16 and average time at red	Police and Bristol City Council Joint Enforcement Team tasking group delivering targeted multi-agency work towards problem premises	Immediate	Bristol City Council	Police
		Monitor length of time premises stay as 'red or high risk'			
<b>Training and awareness for licensed trade staff</b>  Raising awareness of CSE and other vulnerability issues. Early recognition by staff		Training for Licensing Sub-Committee members on aims of strategic plan  Adoption of Child Sexual Exploitation awareness training by Security Industry Association	6-12 months	Bristol City Council	
<b>Alcohol Recovery Centre</b>  Reducing demand for NHS and police. Improved early care for users. Demographic data will assist other work streams	Number of Alcohol Recovery Centre (ARC) users for 15/16	Monitor demographic data of users. Number of users Night Time Economy	3-6 months	South Western Ambulance Service NHS Foundation Trust	
	Number of days ARC deployed	Consider signposting to other care paths where appropriate			

<b>Re-invigoration of the Pub-Watch Scheme</b>  Improve the cooperation of licensed premises to ensure a safer environment		Review of current process involving all stakeholders to suggest new approach	6-12 months	All agencies	All agencies plus Trade
<b>Management of Cumulative Impact areas</b>  To ensure areas are monitored to manage the number of licensed premises		Review of current zones for effectiveness and scoping for potential new areas (Stapleton Road/Church Rd/Arena)	6 months	Bristol City Council	Police
<b>Structured approach to licensing implications for larger events</b>		Joint Enforcement Team to review events calendar and suggest suitable events for approach and protocol for managing licensing applications	6-12 months	Bristol City Council	Police
<b>Providing support for people using and working in the City Centre during the night time economy</b>  Identification of vulnerable people due to alcohol consumption, providing a safe environment	Number of incidents reported to Bristol Stand against Racism and Inequality (SARI) by staff working in the Night Time Economy  Number of hate crimes reported	Develop strategies and interventions to help people working in the Night Time Economy e.g. taxi/bus drivers  Education re CSE and vulnerability	12 months	Bristol City Council	Police, Bristol Stand against Racism and Inequality, Transport providers
<b>Providing support to vulnerable people within the street drinking community</b>	Number of homeless people recorded (Charity and BCC data)  ASB and other crime related calls	Deliver on the joint strategy for the homelessness situation  Provide interventions and support for street drinkers  Enforcement activity to reduce ASB/criminality	12 months	Bristol City Council	

# APPENDICES

## Appendix I

### Bristol Recovery Orientated Alcohol & Drugs Service (ROADS)

The new Bristol ROADS was launched in November 2013 following a competitive tendering process. It is a single service consisting of 5 clusters delivered by different providers working together to deliver the Public Health Outcome 2.15: Increase the number of problematic substance misusers who successfully complete drug treatment, and Public Health Outcome 2.18: Decrease the numbers of alcohol related admissions to hospital.

All providers are supported by SARI & The Diversity Trust to ensure delivery of culturally competent services responsive to the needs of Bristol's population.

ROADS links with different forms of Mutual Aid including SMART, AA, NA, CA and FA in order to support clients' recovery journey.

Breaking Free Online an on-line treatment and recovery programme offers support and tools to sustain individual treatment benefits is also offered to all clients.

#### Engage Cluster

Delivered by St Mungo's subcontracting with Bristol Drugs Project (BDP) and AWPT Bristol Specialist Drug & Alcohol Services (BSDAS).

Engagement offers people their route into ROADS treatment and support services and is designed to work with people experiencing problems with a broad range of substances:

- primary alcohol users
- opiate users (OUs)
- non -opiate users (NOUs) including users of New Psychoactive Substances (NPS)
- prescribed and over the counter medicines.

A key role for Engagement is to 'set the tone' for an individual's treatment and recovery journey, whether this is their first contact or the most recent over, perhaps, a long period. Service users will be encouraged to 'try change' through asset-based assessment and high visibility of recovery – through images, conversations, Peers involvement in service delivery and through 2 Trainee posts which will offer progression into work opportunities for Peers and other volunteers who have a history of problematic drug or alcohol use.

The key elements of Engagement are:

#### **1. Triage, comprehensive assessment and Recovery planning**

Service users are assessed using an asset-based assessment system – which assesses individual need at the point of initial referral and then refers to appropriate ROADS interventions.

It's important to stress that this single system isn't a single physical point of contact – which would make it more difficult for people across Bristol to access – but a service delivered at multiple locations including over 50 GP Surgeries. BDP's main premises at 11 Brunswick Square, BS2 8PE will offer direct access for self-referrals Monday – Friday 9am – 8pm and Saturday 10am – 5pm.

Referrals from other agencies will be made using a simple faxed referral form and many will continue to be self-referrals.

## **2. Assertive Outreach**

Targeting individuals and groups who aren't in treatment but who can benefit from advice and information to reduce risk - and, where appropriate, can be supported into treatment.

Reaching out to particularly vulnerable or under-represented populations' e.g. street homeless, female sex workers as well as early adopters of 'new' substances e.g. LGBT community and student population through regular involvement in night time economy events.

## **3. Low threshold and brief interventions**

There are separate routes for primary alcohol and primary drug users – to offer maximum choice for people.

Primary alcohol pathway:

AUDIT will be used to identify severity of alcohol use and the most appropriate interventions:

- AUDIT score 8-15 Alcohol Brief Intervention (ABI) at assessment or single 30 min session if needed;
- AUDIT score 16-19 ABI at assessment plus onward referral to Controlled Drinking Group or up to 3 x 1-1 sessions;
- AUDIT score 20+ ABI at assessment then onward referral to CHANGE.

Group work for Controlled Drinking, Preparation for Alcohol Detox and Alcohol Detox Support groups are held weekly at venues in North (Gloucester House, Southmead Hospital); Central (Colston Fort) and South Bristol (Knowle West Media Centre).

Primary drug pathway offers:

- Brief interventions for users of non-opiates or new psychoactive substances– with integrated Itep mapping.
- And Preparation for Recovery groups (2 groups a week). These build motivation for change and offer a clear pathway for criminal justice referrals.

## **4. Needle and Syringe Programme**

## **5. Harm reduction and healthcare interventions**

Interventions designed to reduce harm and death including:

- Dry Blood Spot Testing for HBV/HCV testing will be offered 'there and then' to people who express interest in having a test;

- ‘Super Accelerated’ HBV vaccination (course complete in 21 days), targeting at-risk populations;
- Safer Injecting, Overdose Prevention and Naloxone training and supply: Naloxone reverses the effect of opiates/opioids and can save lives if rapidly administrated.

Other groups for targeted harm reduction work are people using controlled substances like Ketamine – which can cause significant urinary tract damage and those using New Psychoactive Substances – where little may be known about their chemistry or effects.

## **6. Transitions from Young People’s Drug Treatment Services**

BSDAS will have a dedicated role to ensure the safe transition of young substance users from Bristol’s Young People’s Drug Treatment Service to adult services – where appropriate. This will involve joint working during a 4-6 month period before a young person needs to move into ROADS but the main aim of this work will be to secure a successful exit from treatment wherever possible.

### **Change Cluster**

Delivered by BSDAS with sub-contractor BDP.

The Change Cluster provides the core treatment elements of ROADS working with both drugs and alcohol and focus on detoxification and abstinence. It will be client-focused and offer a range of psychosocial group work and individual care packages to support the effectiveness of the clinical interventions offered.

Services will be delivered from Colston Fort (which will retain an alcohol and abstinence focus), Stokes Croft (which will take on a ‘Complex’ focus and continue the dispensing function), and a number of BDP sites. There will also be satellite group work provision in the North, South and Centre of the city to increase access.

Following assessment in the Engagement Cluster, service users will have an individual care plan which will contain a number of the following treatment options. Care will be co-ordinated and reviewed throughout the Change Cluster and on exit.

#### **1. Shared Care:**

The Change Cluster will increase support for primary care, enabling people to be cared for by their GP, rather than needing referrals to specialist provision.

This service offers a layered approach including an Enhanced Shared Care service for people pursuing abstinence. There will also be a Complex Shared Care element which will provide nurses with six surgeries to work with clients with alcohol and dual diagnosis issues.

#### **2. Specialist Prescribing:**

This includes detoxification, substitute prescribing and prescribing to prevent relapse. Daily dispensing will run every weekday morning from Stokes Croft. Pharmacy links will be further developed to strengthen delivery and practice.

#### **3. Group work:**

Group work will contain a number of options within the Change Cluster (in addition to those offered within Engagement and Completion Clusters):

- 12-step programme – Three times a week co-facilitated by group workers and peers;
- Structured Recovery Programme – This operates daily and contains both topic-based and psychosocial interventions;
- Alcohol Detox Support Group - Run from satellite sites and open to people pursuing alcohol detox through specialist services and shared care.

#### **4. Psychosocial Interventions:**

This follows a mind-mapping format Motivational interviewing techniques will be used alongside ITEP/BTEI approaches.

#### **5. Specialist Psychological Interventions:**

A limited number of intensive, specialist interventions such as DBT will be available for those service users who would most benefit from this approach.

#### **6. Maternity and Family Support Services:**

This covers both drug and alcohol problems and is delivered by a multi-disciplinary team, comprising of Midwives, Social Workers, Family Liaison workers and Specialist Drugs workers with named leads for professional liaison and client work. The focus of this service is to minimise the harm to mother and baby from problematic misuse, focusing on any Safeguarding concerns.

#### **7. Inpatient Services:**

There are seven beds on Acer Unit, Blackberry Hill Hospital, for stabilisation and detoxification. Whilst the majority of detoxification will happen in community settings, ROADS aspires to increase demand for detox and with this will come a proportion of complex cases, requiring inpatient treatment.

### **Completion Cluster**

Delivered by BDP subcontracting with Business in the Community, VOSCUR & Volunteer Bristol, Windmill Hill City Farm, Demand Energy Equality, The Community Farm.

There are three key elements in Completion:

#### **1. Recovery Sustainment Programmes**

These offer real choice for individuals – with separate programmes for primary alcohol and primary drug users as well as one combining drug and alcohol users.

##### **1.1. Combined Drug & Alcohol pathway**

Individuals can access:

- 12-Step aftercare programme  
With two groups a week delivered at Colston Fort, supporting 12 Step Fellowship meetings;
- Community Reinforcement Approach (CRA) programme

An individual programme for 8 weeks running alongside a weekly group which promotes individual engagement with their family and community. This builds on BDP's successful Boost CRA programme.

#### 1.2. Primary Drug Pathway

- A Relapse Prevention group programme – running each week in North, Central and South Bristol - including evening and Saturday sessions.

#### 1.3. Primary Alcohol Pathway

- A Relapse Prevention group programme – running each week in North, Central and South Bristol – including evening and Saturday sessions.

### 2. Targeted programmes to support individuals

#### 2.1. Parenting Workshops

These offer support for people with a drug or alcohol problem who are also a parent. Their primary aim will be to help individuals identify with their role as a parent more strongly than with their role as a user of drugs or alcohol. These will be available across ROADS and with partners external to ROADS e.g. Children's Centres.

#### 2.2. Peer Recovery check-ups

These are structured follow-ups of individuals who have successfully completed treatment in the Change cluster. Undertaken by Peers this involves a proactive structured intervention by telephone, using ITEP guided maps to support service users successfully exiting ROADS by reinforcing success and offering opportunities to re-engage early if needed.

#### 2.3. Peer HCV support

Peers will offer individual support to service users who are starting HCV treatment – walking alongside them to maximise the opportunity for individuals to stay engaged with treatment through 'rough patches' and to successfully complete HCV treatment. Increasing the number of people completing HCV treatment is the only effective way of reducing HCV prevalence (number of people who have Hepatitis C) and the consequent future health care costs – so has important Public Health impact as well as improving individuals' quality of life.

#### 2.4. Naltrexone Prescribing

Bristol City Council Substance Misuse commissioning team will be working with the Change Cluster to initiate and expand prescribing of Naltrexone (opiate-blocking drug) as part of an individual's recovery support plan. This is currently under-used in Bristol – but can offer tangible support to individuals during the early months of their recovery to reduce the risk of relapse.

### 3. Training Education Volunteering & Employment (TEVE) Opportunities

These offer meaningful occupation at a time of great vulnerability for individuals who approaching the end of their treatment, or who have just successfully left it.

3.1. TEVE-Lite: short-term focused sessions (1-3) to explore options, sign-posting and referrals e.g. completing TPR3's to engage JCPlus in conversation about an individual's recovery plan and opportunities to increase their readiness for work.

3.2. TEVE-Contingency Management (CM) – “rewards for recovery”

This service will in reach into Change to establish TEVE CM prior to successful exit from treatment. This will be targeted at individuals in the Enhanced Shared Care stream who are completing their detox over a 6 month period as well as those completing alcohol detox.

A TEVE CM contract will be developed over 3-5 sessions which identifies behaviours and activities which are meaningful to an individual and can earn them ‘rewards for recovery’ e.g. successful completion of programmes in Completion, completing a volunteering placements, negative drug screens.

Individuals can accumulate ‘rewards for recovery’ as credits on a ‘Capital Card’ for which can be used against a range of training programmes run by City of Bristol college or other relevant source.

### **Support Cluster**

Developing Health and Independence (DHI) will be delivering a new and innovative service in Bristol, called the ‘Support Service’, which will work closely with the other Recovery Orientated Integrated Substance Misuse Treatment (ROIS) providers.

The Support Service will have four main elements:

**1. Tackling discrimination and Stigma**

During the journey of recovery and social reintegration, service users may face discrimination and stigma. DHI will be engaging with local communities to dispel misunderstandings around drugs and alcohol. This will include promoting closer working with the treatment service, those being supported in recovery and the communities in which they live.

**2. Carer Support**

Holistic recovery means supporting the families and carers of those with drug and alcohol issues. DHI will be providing advice, information, one to one and group support for families in need, and will also be providing training for family members to become ‘family champions’ who can help run peer led family groups to support one another.

**3. Peer Support**

Recovering service users can often be the best support for those a little further behind in their own recovery. DHI will be providing a comprehensive recruitment, training, and support package to those in recovery so that they can provide the best encouragement to others in their recovery and develop skills for their own future.

**4. Advocacy**

Service Users can sometimes lack confidence to raise their own voice when things go wrong or services do not meet their expectations. DHI has teamed up with The Care Forum who will provide advocacy support for individuals to resolve issues in relation to their treatment and thereby maximise their chances for a prolonged successful recovery.

### **Housing Support Cluster**

Delivered by Addiction Recovery Agency (ARA) with sub-contractors, The Junction Project and the Salvation Army, the housing support cluster provides accommodation based and floating support.

Appropriate and safe housing is an integral part of a person's recovery and the Housing Support Cluster provides:

- Preparation Accommodation  
For those people where the treatment provider has a clear pathway for recovery in place but advocates that the service user is unable to maintain non problematic substance misuse use without stable housing.
- In Treatment accommodation  
For those people stabilised and engaged and working on their recovery plan with the Change provider, on stable medications and working towards non problematic use
- Abstinent Accommodation  
For those people who are totally abstinent after detox programme and needing an abstinent environment supporting their abstinent programme.

Floating support work with service users at all stages of engagement with ROADS where there person is a risk of homelessness or treatment breakdown which would jeopardise the tenancy.

- This service will be cross tenure and include owner occupiers, licensees and tenants.  
Floating support services will work with a range of private and social landlords including registered social landlords and Bristol City Council.

For further information, please go to: <http://www.bristol.gov.uk/page/community-and-safety/drug-and-alcohol-misuse-treatment>

**Bristol Substance Misuse Needs Assessment**

**Produced in September 2016**

**Substance Misuse Team**

**www.bristol.gov.uk**



**This Needs Assessment has been signed off by the Substance Misuse Joint Commissioning Group.**

**Feedback has been sought from a wide range of stakeholders to ensure that the substance misuse needs within Bristol are accurately reflected.**

**The Needs Assessment does not consider the model for delivering treatment services - it is primarily focussed on ascertaining levels of need.**

**The next stage will be to develop the Commissioning Strategy and stakeholders will play a key role in shaping the model for treatment services to meet the identified needs.**

**It is our intention that the Commissioning Strategy will be drafted in December 2016.**

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## **1. Overview of Recommendations for Commissioners**

The following recommendations have been drawn from the evidence presented within each section of the Needs Assessment. Not all of these recommendations are within the remit of the Substance Misuse Joint Commissioning Group to address but have been included to inform the commissioning of services that work with people who use drugs and/or alcohol. Two overarching recommendations have been developed to address the need to commission an effective treatment system whilst the other recommendations directly relate to sections of this report:

1. Bristol needs a structured treatment system that provides a range of evidence based interventions to maximise recovery opportunities. Commissioners need to ensure the system can manage a broad range of conditions and client complexities. Treatment options should include access to a range of psychosocial and pharmacological interventions, including relapse prevention.
2. Within structured treatment there needs to be an enhanced focus on the delivery of health protection and harm reduction interventions.

## **Physical Health**

1. Continue to support the provision of naloxone.
2. Continue to support the police/coroner coordination to ensure that timely analysis of deaths and changes in trends inform treatment delivery.
3. Increase strategic priority for delivery of health protection and harm reduction interventions (including optimised doses and maintenance prescribing in line with PHE/ACMD advice) within structured treatment and opiate substitution therapy (OST).
4. Clear governance structures are needed to ensure auditability of key interventions (naloxone supply, optimised prescribing, etc.).
5. Request a full, public health led, health needs assessment, including matching of health/hospital records, of the opiate and crack using cohort
6. Consider the retention of primary care based provision of OST to ensure easy access to healthcare and to reduce burden on secondary health care, particularly Emergency Departments.
7. Continue to support homeless health services.

8. Retain a hospital based service to provide support to drug and alcohol users who are admitted to wards.
9. Continue to support a maternity service for pregnant substance misusing women and their partners. Investigate effectiveness and efficiency of various delivery options to maximise outcomes for both drug and alcohol users.
10. Continue to support needle and syringe provision to be delivered within NICE guidance. Investigate effectiveness and efficiency of various delivery options to maximise outcomes.
11. Ensure chemsex/slamsex participants and IPED are included in priority groups for targeting interventions.
12. Continue to support hepatitis specialist clinical leadership within treatment services.
13. Continue to support dry bloodspot testing – including HCV, HBV and HIV.
14. Explore ways of increasing opportunistic availability of HBV vaccinations throughout the treatment system.
15. Ensure HBV vaccinations are included in GP contract as a priority intervention and that data is recorded and shared appropriately.
16. Continue to work with PH colleagues to improve access to HCV treatment for clients.
17. Explore opportunity with sexual health commissioners of co-commissioning accessible services for MSM/LGBT clients with focus around chemsex/slamsex.
18. Continue to support hospital based alcohol liaison work.
19. Continue to support homeless alcohol services.
20. Ensure investment enables the provision and uptake of evidence-based specialist treatment for at least 15% of estimated dependent drinkers in line with DH guidance.
21. Ensure capacity allows comprehensive assessments for all individuals scoring 16 and over on Alcohol Use Disorders & Identification Test (AUDIT).

## **Mental Health**

22. Explore opportunities for increased joint working with the CCG (BMH Commissioners) to develop more effective service provision for dual diagnosis clients going forward. There is a need here to focus on how to work with substance misusers with less severe MH needs.
23. Improved data monitoring is required to understand the needs of dual diagnosis in Bristol. Further work is required as to how we can demonstrate good outcomes for this cohort in order to build these into future service specifications.
24. There needs to be further consideration regarding the offer of services for dual diagnosis clients when presenting in primary care to ensure that their needs are being best met.
25. Explore opportunities for co-location of staff to improve joint working and improve outcomes for dual diagnosis clients.
26. Explore opportunities for joint referral meetings between SM & MH services to improve joint recovery care planning.
27. Explore how feasible it is for social prescribing services to work with substance misuse clients with low level mental health needs and link with commissioners.
28. There is a need for improved workforce development for both substance misuse and mental health professionals around dual diagnosis issues. This needs to encourage confidence of when to refer between services and how to manage levels of risk appropriately.
29. Increase the strategic priority of dual diagnosis across SM and MH by holding 6 monthly dual diagnosis workshops with key stakeholders.

## Housing

30. Consider the possibility of having an outreach team for engaging substance misusing people into community treatment.
31. Co-locate SM professionals in Level 1 hostels to engage potential clients
32. Deliver a training package to preventing homelessness staff/staff in frontline services receiving prison leavers, such as hostels and homeless health services, in Spice use, its effects and treatment options.

33. Explore the potential for co-commissioning substance misuse housing with Preventing Homelessness services to benefit from economies of scale, fewer contracts and better pathways.
34. Further work with the Preventing Homelessness is required to explore the increases in homelessness in Bristol.
35. Work with BCC colleagues to understand whether substance misuse is a factor in evictions as well as whether substance misuse is a refusal reason for housing providers in the Preventing Homelessness pathway.
36. Consider increasing Preparation housing units to respond to levels of demand.

## **Relationships**

37. Safeguarding children is paramount and remains a key priority within substance misuse services.
38. Review what happens when children who have been exposed to parental substance misuse are taken into care.
39. Continue to link with the commissioners of young people's substance misuse services and the Drugs and Young People project to meet the needs of children effected by parental substance misuse.
40. Maintain close working with young people's treatment services to ensure a smooth transition for young people moving from young peoples into adult treatment.
41. Work closely with young people's services to identify young adults coming into treatment who are unknown to young people's services. This will identify gaps and strengthen prevention and harm reduction
42. There is a continued need to support clients to be good parents and to address the stigma that parents face as this could continue to prevent vulnerable clients accessing appropriate services.
43. The Think family/Early Help overlap with substance misuse services should be reviewed. All practitioners need a clearer view of the support clients are receiving to ensure services can work together effectively.

44. Work with colleagues in Children and Family Services to ascertain whether the following challenges that have been identified in research are in issue in Bristol. For professionals working with families where substance misuse is a factor the barriers presented were: engagement, conflicting agency focus, inter-agency communication, conflicting assessment needs, children having significant needs but remaining largely invisible.
45. Review the substance misuse knowledge/skills of those practitioners who are the main contact with families to meet the parents and children's needs. This needs to consider drug and alcohol awareness.
46. Further work is needed to map out how information sharing does/does not take place when working with families who have substance misuse issues.
47. Treatment services have a relationship with over 100 suspected domestic violence perpetrators and could be well placed to address the issues that contribute to the cycle of abuse.
48. Victims of domestic violence and abuse may also benefit from targeted support.
49. The combined impact of domestic violence, substance misuse and mental health is recognized. The services offered to these vulnerable individuals need to be sufficiently resourced. Learning from the Golden Key initiative will be critical in informing the approach.
50. Peer support offers considerable benefits to both the peers and those receiving their support. This should be considered as a fundamental part of a treatment system.
51. The availability of peer supporters does need consideration to ensure plans are realistic.
52. Explore the possibility of co-commissioning peer support with other commissioners in recognition of the fact that people using drugs and alcohol are likely to experience a number of issues.
53. It is important to continue to support those who are caring for friends/family members with substance misuse issues. Commissioners could consider whether on line support would be viable for carers services and the role that peer support could play within carers and family services.

54. Explore the opportunity for joint commissioning carers and family services with substance misuse commissioners from neighbouring authorities.

### **Training, Education, Volunteering and Employment**

55. Opportunities for training, education, volunteering and employment are a critical part of recovery and the specific challenges that substance misuse presents need to be catered for either in specific TEVE services or within wider TEVE provision.

56. Communication between all relevant agencies including commissioners, JCP and WP should be written into protocols which are acted upon and included in performance management of agencies.

57. Consider a one stop shop so that clients who are more chaotic and have more difficulty accessing training can be engaged in TEVE services and other training opportunities across the city.

58. Continue close working relationships with VOSCURs Sustain Programme.

59. Explore joint working opportunities to address the stigma faced by former drug users from potential employers, relating to previous drug use and criminal history.

### **Criminal Justice**

60. As a result of the new licensing arrangements as directed by the Transforming Rehabilitation Act, there is a need for clear working protocols and information sharing agreements between treatment providers and the National Probation Service and the Bristol Gloucestershire Wiltshire and Somerset Community Rehabilitation Company in order to ensure that the needs of service users' substance misuse needs are met.

61. Commissioners of SM treatment within HMP Bristol to ensure that referrals to existing psychosocial services as well as substitution therapies are offered to clients. Pathways to OST are good, whereas fewer people attend psychosocial services.

62. Commissioners of AIRS and ROADS to develop a joint working protocol to better meet the needs of clients leaving the custody suites. Consider an in-reach services by ROADS or a peer led meet and greet service in custody.
63. Targeted work by ROADS for AIRS clients already in treatment.
64. There should be guaranteed and immediate ongoing substitute prescribing for people returning to Bristol from custody, including locally, regionally and nationally.
65. Further explore how Substance Misuse services and Streetwise teams can work better together.

## 2. Introduction

Bristol City Council is responsible for reducing the harm caused by substance misuse. As such it is important to review the needs of drug and alcohol users and assess the impact their substance misuse is having on themselves, their families and their communities. This information is used to inform the commissioning of a range of services that aim to impact on substance misuse.

The majority of the adult substance misuse services currently commissioned have contracts in place until September 2017. The Substance Misuse Joint Commissioning Group intends to undertake a procurement process to re-commissioning services for a revised treatment system to be in place by October 2017 onwards. This needs assessment is a key part of that process and has been structured to consider all of the needs a person may have. Regardless of whether people use heroin, ketamine, cocaine or alcohol the impact of their substance misuse can be wide ranging. As such this needs assessment considers physical and mental health, housing status, links to the criminal justice system, access training, education and volunteering opportunities and relationships.

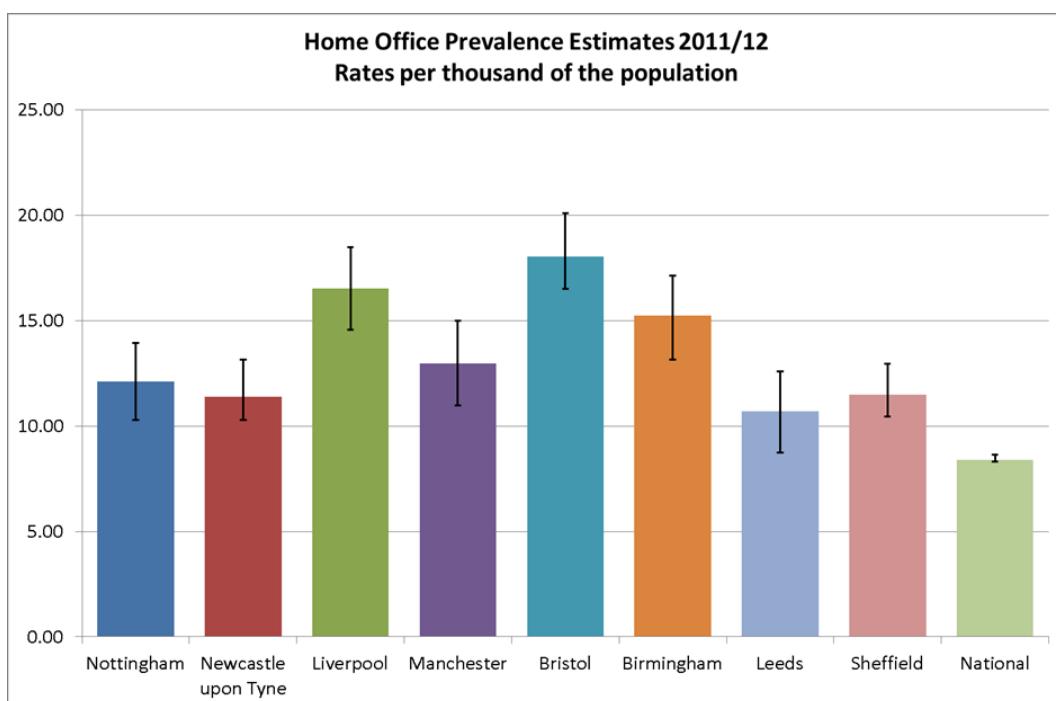
Drawing on a number of data sources (including self-reports, hospital admissions and service level data) the needs assessment provides a series of recommendations for consideration by commissioners. How Bristol chooses to respond to these recommendations and shapes services to meet these needs will be detailed within the Commissioning Strategy which is the next stage of the process and will involve widespread stakeholder consultation.

Whilst a wealth of information is available on clients who engage in services it is harder to assess the needs of people who, for a number of reasons, are underrepresented in current service provision. Addressing these gaps will be a specific focus in the wider consultation and will be factored in to any future commissioning decisions.

### **Context:**

Bristol has an estimated 5,400 opiate and/or crack users in Bristol. This equates to approximately 18 of every 1000 adults in Bristol using opiates and/or crack. Whilst the proportion of Bristol residents using drugs is relatively small the impact can be extensive. The chart below shows that Bristol has the highest estimated rate of opiate and crack users of all the core cities and the largest proportion of very high complexity clients which makes them more likely to be in treatment for longer and need specific support. Accordingly, Substance Misuse (alcohol, drugs and tobacco) is one of Bristol Public Health's top 10 priority work areas to improve and protect the health and wellbeing of people in Bristol, and to reduce health inequalities within the population.

**Chart 2.1: Core cities estimated opiate & crack prevalence**



### **Impact and contribution to inequalities:**

Substance misuse has serious health implications and treatment is proven to reduce the strain on local health services. Having reviewed the Public Health Outcomes Framework it is evident that the impact of substance misuse is far reaching and contributes to 92 of the 224 indicators and sub-indicators currently reported through the Public Health Outcomes Framework. The most obvious links are with measures:

- 2.15i - Successful completion of drug treatment - opiate users
- 2.15ii - Successful completion of drug treatment - non-opiate users

These indicators are defined as the number of drug users that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a proportion of the total number in treatment. Two new sub-indicators have been added for 2016:

- 2.15iii – Successful completion of alcohol treatment
- 2.15iv – Deaths from drug misuse

Successful completion of alcohol treatment has been added as an additional sub indicator to reflect the fact that drug and alcohol services are increasingly commissioned together and the data that is used to report on access and provision all comes from the same monitoring system.

Deaths from drug misuse has also now been included as there has been a rising trend in drug related deaths over the last few years. Local authority action, including the quality and accessibility of the drug services they commission and how deaths are investigated and responded has an impact on drug misuse death rates. Including this sub-indicator alongside those on treatment outcomes will help local authorities and others to consider the impact of treatment in addiction to recovery outcomes. Public Health England is committed to continue to improve recovery rates for both drug and alcohol treatment and to reduce health-related harms, HIV, hepatitis, TB transmission and drug-related deaths. This action was included with the Public Health England's Annual Plan 2015/16 and this indicator directly contributes.

The following list gives an indication of the wide ranging impact substance misuse has on public health outcomes:

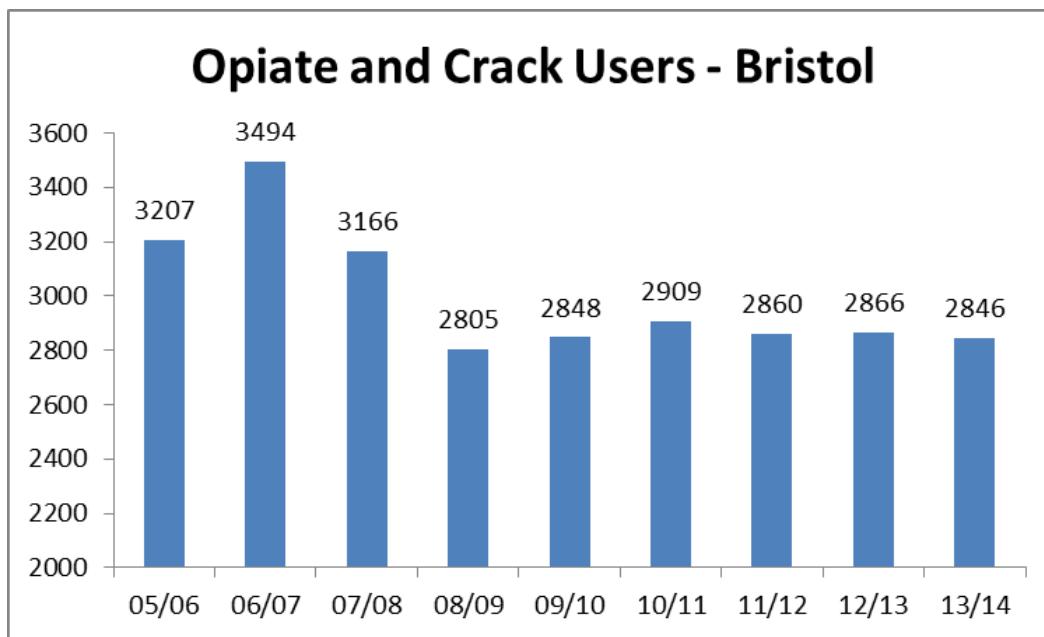
- Blood borne virus vaccinations
- Hospital admissions/readmissions
- Employment rates, Sickness absence
- Injuries due to falls, Hip fractures
- Injuries in children, Low birth weight babies, Smoking at the time of delivery, Pupil absence, Child poverty, Entrants to the youth justice system
- Life expectancy, Mortality rates
- Smoking prevalence
- Mental illness
- Social Isolation
- Suicide rates
- Stable and appropriate accommodation, Statutory homelessness
- Domestic abuse
- Violent crime
- Perceptions of community safety
- Re-offending levels

### **Trends:**

To provide an overview of clients accessing treatment services in Bristol during 2015-16 the full details of the demographics are included in Appendix 1. It is recognised that this data does not necessarily capture the level of substance misuse needs across those with protected characteristics but it does reflect the current treatment systems population. Further analysis will be presented in the full equalities impact assessment that will form part of the Commissioning Strategy.

In line with national trends, the number of new clients with opiate issues is gradually reducing. The Public Health England Local Drug Profile indicates the population of opiate and crack users in Bristol declined by 18% from 3,494 in 2006/07 to 2,846 in 2013/14.

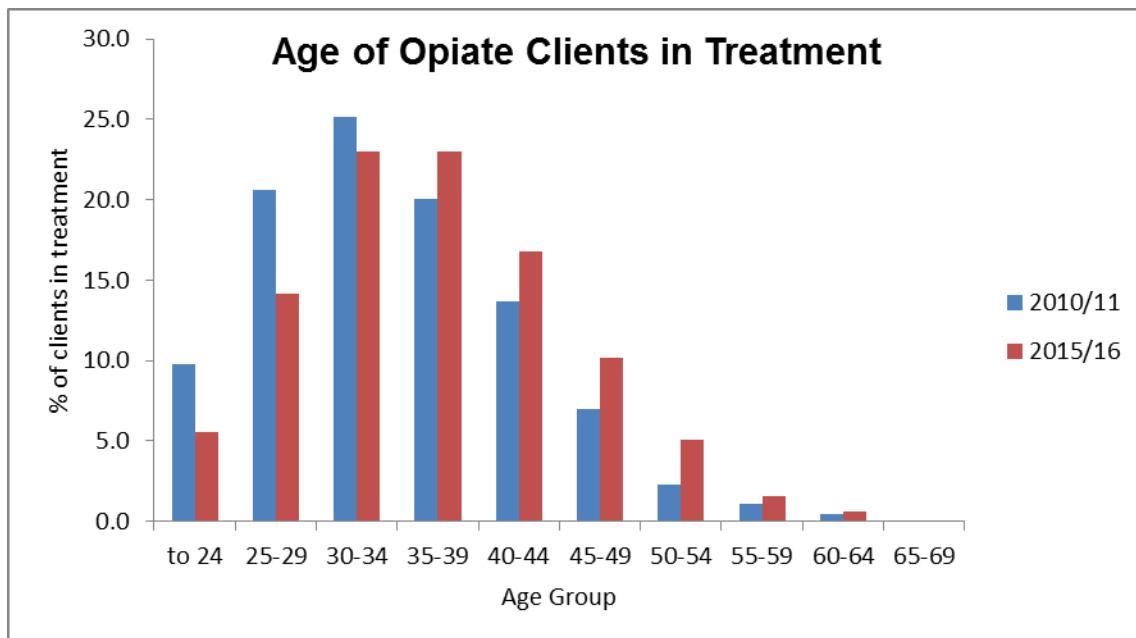
**Chart 2.2 Number of opiate and crack users in Bristol**



The Public Health England Quarter 4 2015/16 Adult Partnership Activity Report indicates a further decrease in 2015/16 to 2,751 clients classified in the opiate substance category. Whilst some of this reduction may be due to changes in the classification of client groups that were introduced in 2014/15 it is widely accepted that fewer people are starting to use opiates.

The ageing population of opiate users in treatment presents a number of challenges. The chart below compares the age profile of opiate users clients in treatment in 2010/11 to 2015/16 by considering what percentage of opiate clients in treatment that year are within each of the different age groups. The 2015/16 data shows that the percentage of clients in each age group over 35 years has increased. This supports the notion of an ageing cohort of opiate users in treatment. The physical health needs of an ageing client group can put increased pressure on services and impact on their recovery outcomes. The likelihood of clients who have been using for long periods of time to make sustained behavioural change is also a consideration.

**Chart 2.3 Age comparison between 2010/11 and 2015/16 cohorts for opiate clients in treatment**



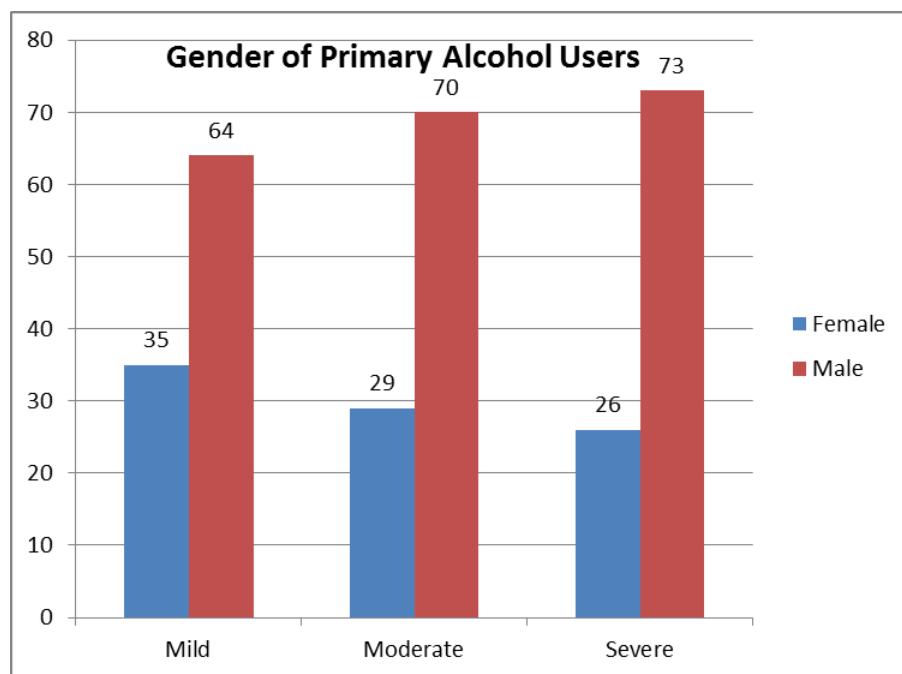
The Local Alcohol Profile for England (LAPE) estimates the rate of alcohol consumption against known risk levels in Bristol to be:

- Abstainers- 57,588 people (16.01% of the population aged 16 and over – ranked 85 out of 332 Local Authorities)
- Lower Risk drinking- 259,847 people (72.24% of the population – 269/332 Local Authorities)
- Increasing Risk drinking- 73,019 people (20.30% of the population – 163/332 Local Authorities)
- Higher Risk drinking- 26,870 people (7.47% of the population – 305/332 Local Authorities)
- Binge drinking 94601 people, 26.3% of the population (306/332 Local Authorities)

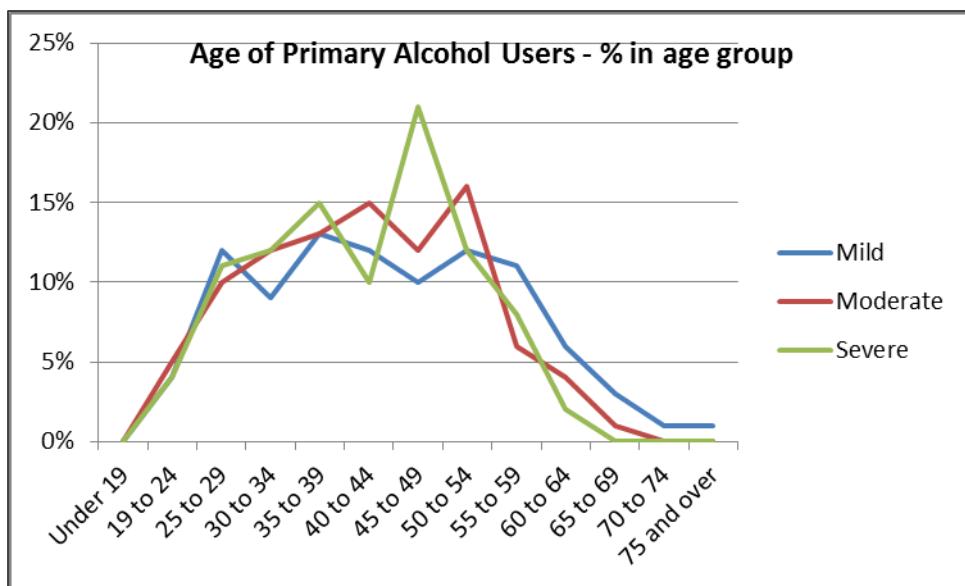
The number of alcohol users presenting to treatment has increased dramatically. During 2015/16 ROADS (Recovery Orientated Alcohol & Drugs Service) received a total of 3,300 referrals for 2,433 clients. Of this number 30% of the referrals were for primary alcohol clients (754/2433). When considering the referral source 43% of the clients referred (385/754) were from GPs and a further 30% (232/754) were self-referrals.

Following an assessment 181 were mild dependent drinkers, 286 moderate dependent and 360 severe dependent. The age and gender profiles are outlined below.

**Chart 2.4 Gender profile of primary alcohol users presenting to treatment**



**Chart 2.5 Gender profile of primary alcohol users presenting to treatment**



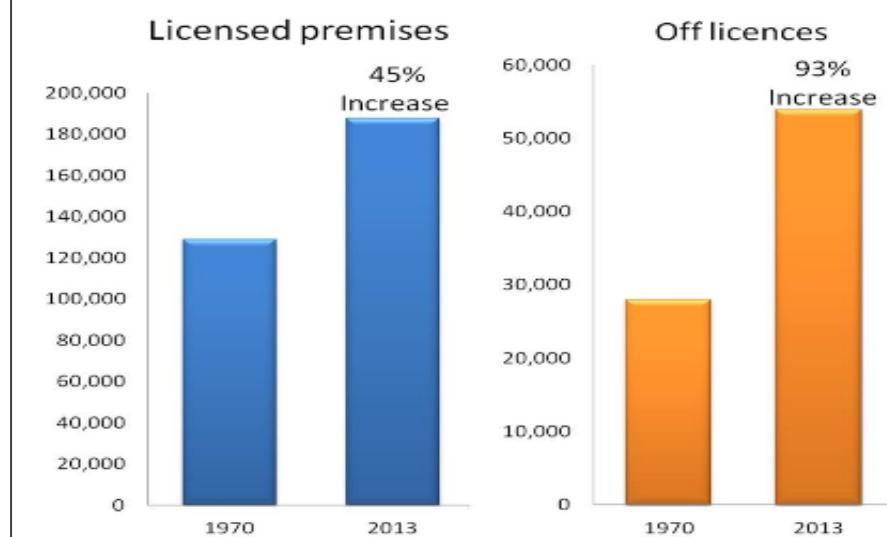
Alcohol Concern reports that alcohol consumption in the UK amongst people aged 15+ has fallen from a peak of 11.6 litres of alcohol per person per year in 2004 to 9.4 litres per person per year in 2013. However, this is nearly a third (32%) more than people were drinking in 1970 (7.1 litres per person) and more than double the amount in the 1950s.

Teetotalism amongst adults in Great Britain aged 16 to 44 has increased (19% of adults in 2005 vs 21% of adults in 2013). Teetotalism amongst young adults (aged 16 to 24) has increased by 43% during this period

The number of places where alcohol is sold has increased markedly over the last few decades. In 1970, there were 128,957 licensed premises in England and Wales; in 2013 there were 187,700, an increase of 45%, and up 6% since 2000.

### **Chart 2.6 Availability of alcohol sales in licenced premises and off licences between 1970 & 2013**

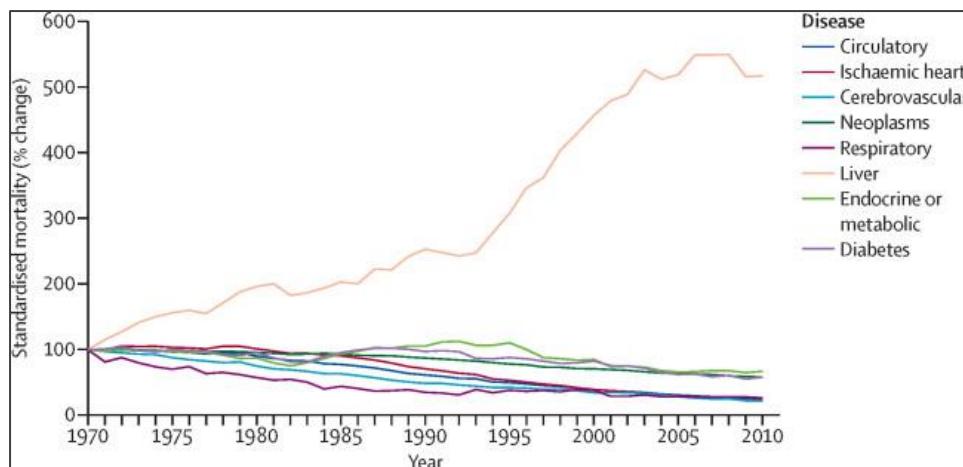
## Availability



In 2013 there were 8,416 alcohol-related deaths registered in the UK, an age standardised rate of 14.0 deaths per 100,000 population. This is considerably higher than the rate of 9.0 deaths per 100,000 population recorded in 1994.

Liver disease is the only major cause of mortality and morbidity which is on the increase in England. Alcohol is the most common cause of liver disease, and alcoholic liver disease is the most prevalent cause of alcohol-related death in the UK. The last decade has seen a 117% rise in alcoholic liver disease admissions in England amongst the under 30 age group, rising to 400% in the north east of England.

**Chart 2.7 Leading causes of mortality in England**



## **The Bristol Public Health “Young People and Substance Misuse in Bristol Needs Assessment”**

Levels of drug and alcohol use among young people in England have been falling since the early part of the 21st century. The proportion of secondary school aged pupils (11-15 year olds) who say that they have ever had an alcoholic drink for themselves has fallen from 61% in 2003 to 38% in 2014. The proportion of 11-15 year olds who say they have ever taken drugs during the same period has fallen from 30% to 15% (HSCIC, 2015a).

There has also been an improvement in patterns of alcohol use among 16-24 year olds with 29% reporting binge drinking in 2005, compared to 18% in 2013 (HSCIC, 2015b).

The WAY survey (HSCIC, 2015c) identified that 66.7% of 15 year olds in Bristol said that they have ever had an alcoholic drink, compared to the benchmark for England, which is 62.4%.

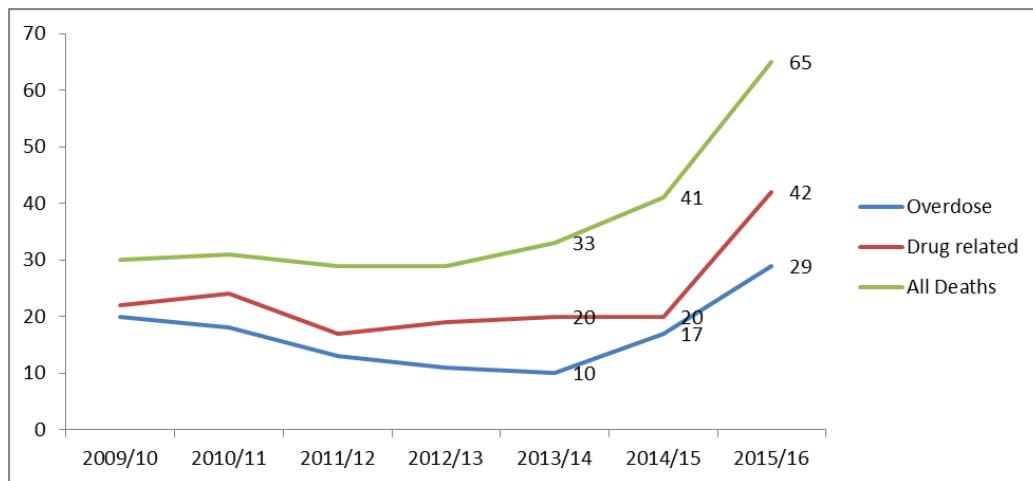
Bristol has the second lowest percentage for the South West of young people who have ever had an alcoholic drink. The percentage of regular (at least once a week) drinkers (6.1%) is very close to the national percentage (6.2%) and the percentage of 15 year olds that have been drunk in the last 4 weeks (16.6%) is recorded as slightly higher than the national average (14.6%)

### **Drug related deaths**

In the last two years there has been an increase in the number of deaths of adults known to Bristol’s substance use treatment, from an average of 30 deaths per year

for 2007/08- 2013/14 to 41 in 2014-15 and 65 2015-16. On average 60% remain as drug-related, following the conclusion of the coroner's investigation, with opiate overdose the biggest causal factor.

**Chart 2.8 Drug related deaths trend in Bristol**



### **Emergence of Legal Highs/Novel Psychoactive Substances**

Since 2006 there has been a growing interest in, and availability of, a new generation of drugs collectively known as Novel Psychoactive Substances (NPS) or more colloquially, 'legal highs' and less frequently 'research chemicals'.

The arrival of NPS has been something of a 'game-changer' in that traditional models of drug diffusion and supply (e.g. for heroin or cocaine) have been joined by the internet as a new route of wholesale and retail supply, distribution and information exchange.

From 2006 until 2016, many of these substances have been legally available on the high street, both from 'head shops' and a range of other retail outlets. However, the Psychoactive Substances Act which came into effect on 26<sup>th</sup> May 2016 banning the manufacture, sale and distribution of any and all psychoactive substances accompanied by a list of exemptions including tobacco and alcohol.

The main group of drugs are the synthetic cannabinoid receptor agonists (SCRAs) which are currently presenting serious problems in prisons and young offender institutions, among the homeless and existing service users. This is also the case in Bristol. Relatively few people are coming forward to treatment services in the

community citing an NPS as their primary drug problem in 2016. Workers see more of the problem out in the community with clients who are not accessing treatment, for example homeless and rough sleepers.

These trends will be explored in more detail in the relevant sections of this document.

### **Impact on crime**

Drugs impact on crime in many ways; from the economic necessity to obtain money to fund drug use to the psychopharmacological effects of taking the drugs and the actions of organised crime groups supplying them.

The economic and social cost of drug use and its supply is estimated to be around £10.7bn per year, of which £6bn is attributed to drug-related crime<sup>1</sup>.

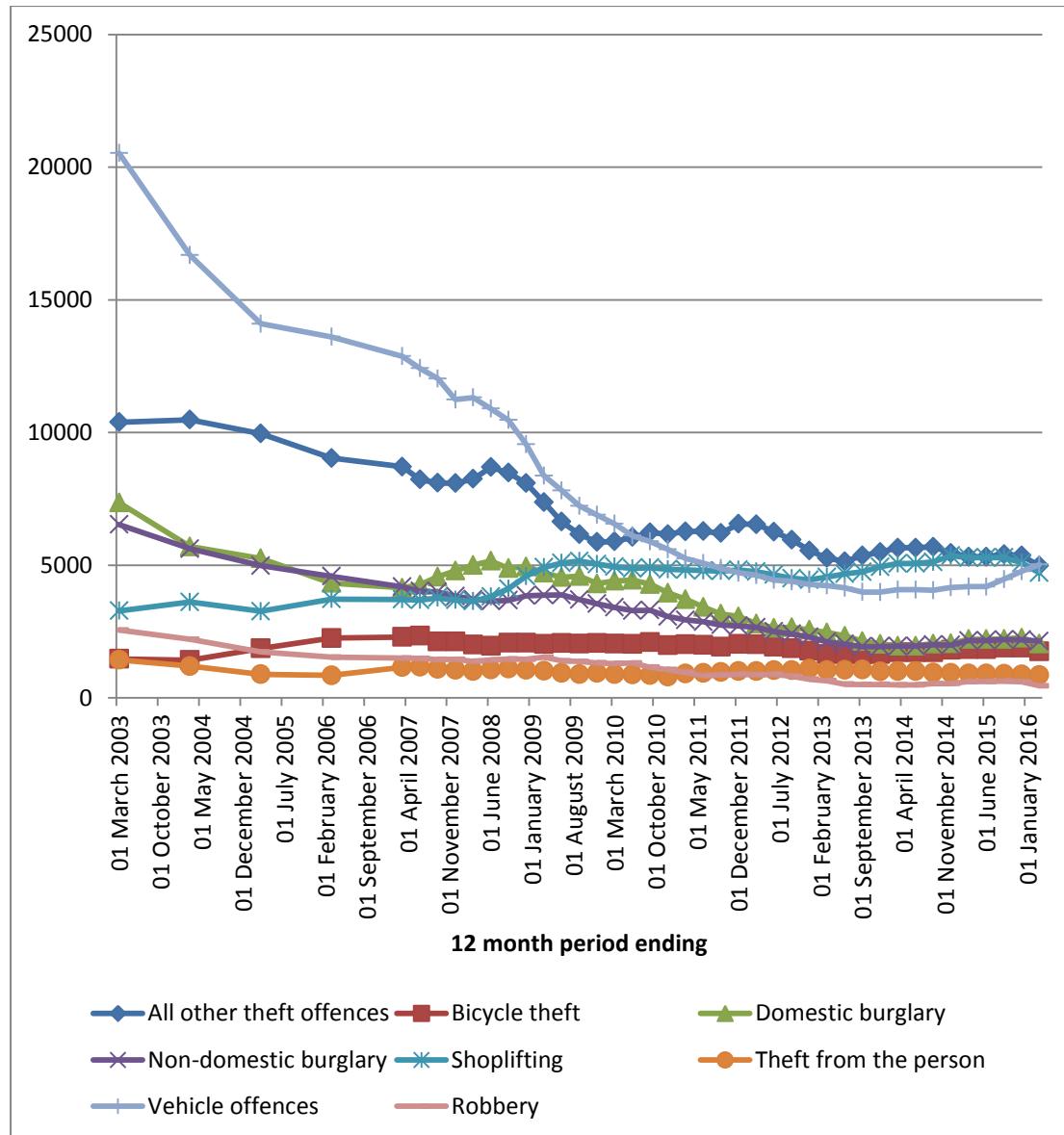
There is a noticeably strong link between drugs and acquisitive crime. Nationally, an estimated 45% of acquisitive crimes, with the exception of fraud, are perpetrated by regular heroin/crack cocaine users. This association is perhaps made more obvious when Public Health England suggests that a typical heroin user spends around £1,400 per month on drugs. This amounts to more than two million offences.

In Bristol, levels of acquisitive crime have decreased across the board over the last 13 years and shown in the graph below.

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<sup>1</sup> Home Office (2016) Modern Crime Prevention Strategy

**Chart 2.9 Acquisitive crime rates in Bristol**



Alcohol misuse places a strain on already overstretched emergency services, with the latest figures showing the cost of alcohol-related crime to be £11bn. Over the past 10 years, in almost half of all violent incidents, the victim believed the offender(s) to be under the influence of alcohol at the time of the incident. This proportion increases during the evening and at night, at weekends, with occurrences between strangers, and in public places.

Engaging drug users into treatment has been shown to effectively reduce levels of offending. For a small group of long-term, entrenched opiate users who have not reached recovery through oral substitution treatment, there is evidence that heroin assisted treatment (supervised injectable heroin) reduces crime.

In Avon and Somerset, problematic drug use continues to be a significant causal factor of offending. Although heroin and crack use has been in general decline during the 2000's, there are suggestions that prevalence and associated risks of these drugs may be on the increase, particularly in Bristol, Weston super Mare and Yeovil. Over the last year, the purity of heroin has increased in some instances from 20% to 60% and from 30% to 90% purity for crack cocaine - leading to a greater risk of harm and drug related death<sup>2</sup>.

Outcomes from the Crime Survey for England and Wales (CSEW) suggest that self-reported Class A drug use in South West of England and Wales is on the rise with a rate that has exceeded the national average since 2011/12. This amounts to 3.8% of the adult population in the area or over 50,000 adults estimated to have used a Class A substance in the last year.

As previously mentioned, the Psychoactive Substances Act may have a positive impact on the supply and availability of NPS. The CSEW in 2014/15 indicates that over 11,500 people in Avon and Somerset are likely to have used an NPS in the last year, with young men aged 16 to 24 accounting for over 35% of these users. The incidences of Synthetic Cannabinoids ('Spice') use is on the increase particularly, generating ongoing risks of violent and unpredictable behaviour.

As demonstrated in Safer Bristol Crime and Disorder Strategic Assessment<sup>3</sup> in Bristol around 2,700 drug offences were recorded (-5% compared to previous year) and over 4,400 offences were believed to involve alcohol. This figure reflects enforcement and does not include undetected activity. Estimates suggest that around 8.08 alcohol related offences occur per 1,000 population in Bristol.

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<sup>2</sup> Avon and Somerset Police and Crime Needs Assessment (2015)

<sup>3</sup> Safer Bristol Crime and Disorder Strategic Assessment (2015)

The societal impact of drug use in Bristol should not be under-estimated, particularly in more deprived wards. The Bristol Quality of Life Survey explores perceptions of drug use being a problem and found around a quarter of Bristol residents felt drug use was a problem in their area, with higher percentage reporting this in more deprived areas, with 63 per cent of residents in Hartcliffe & Withywood and 52 per cent of residents in Filwood reporting this to be the case; areas where crime rates are higher<sup>4</sup>.

### **Opportunities for prevention and self-care**

Supporting people to identify issues with drugs and alcohol at an early stage is a key part of early intervention. Consideration needs to be given to further embedding the NHS England initiative Making Every Contact Count (MECC) approach which aims to support people in making positive changes to their physical and mental health and wellbeing. MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations.

Substance misuse is hugely stigmatised and it is crucial that when someone seeks support they receive it in a timely manner. One in five referrals received by the ROADS Engagement service in 2015 were self-referrals with all the others being made by professionals. GPs accounted for nearly half of all referrals. Early referral and intervention are crucial to maximising successful outcomes with age of initiation and length of using career having a real effect on people's recovery potential. 97% of opiate clients and 92% of non-opiate clients in Bristol access treatment within three weeks.

Needle and syringe provision (NSP) to prevent the spread of blood borne viruses (BBVs), including hepatitis C, hepatitis B and HIV, is accessible across 20 pharmacies, Bristol Drug Projects (BDP) specialist NSP, a mobile Harm Reduction Service and outreach. NSP also provides a gateway into services for individuals with complex treatment needs to ensure they are able to benefit from the protective qualities of treatment.

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<sup>4</sup> The Bristol Quality of Life Survey (2015)

Early Intervention services and substance misuse treatment for young people are available in Bristol. In 2015/16 880 young people accessed Bristol Youth Links service for early interventions and 169 young people accessed one of Bristol's specialist young people's treatment services.

Manualised/web based interventions may be appropriate in some cases but it is important to recognise the potential limitations. The circumstances that some clients will be living in would not fit web based interventions but they could have a role in supporting some clients and carers/family members.

Bristol has a thriving mutual aid recovery network including Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Cocaine Anonymous (CA) and SMART Recovery. Between these groups there are over 130 meetings a week held in Bristol, including specific groups for women and the Lesbian, Bisexual, Gay & Transgender (LGBT) community. ACT (Acceptance & Commitment Therapy) Peer Recovery another Public Health England recognised mutual aid support group are hoping to become established locally over the coming months.

## **Performance**

Bristol's drug treatment system has a good track record of engaging opiate users with 52% of the estimated number of opiate users accessing treatment services. This accounts for almost 2,800 people and is the 3rd highest number of the 8 English Core Cities.

Below is a selection of funnel charts created by Public Health England that show Bristol's performance in successful completions against other core cities. The yellow line of these charts denotes the inner control limits and any city/point within the yellow lines are within the 'normal' range. The red lines denote the upper and lower limits and any city/point within the red lines are considered to be outliers.

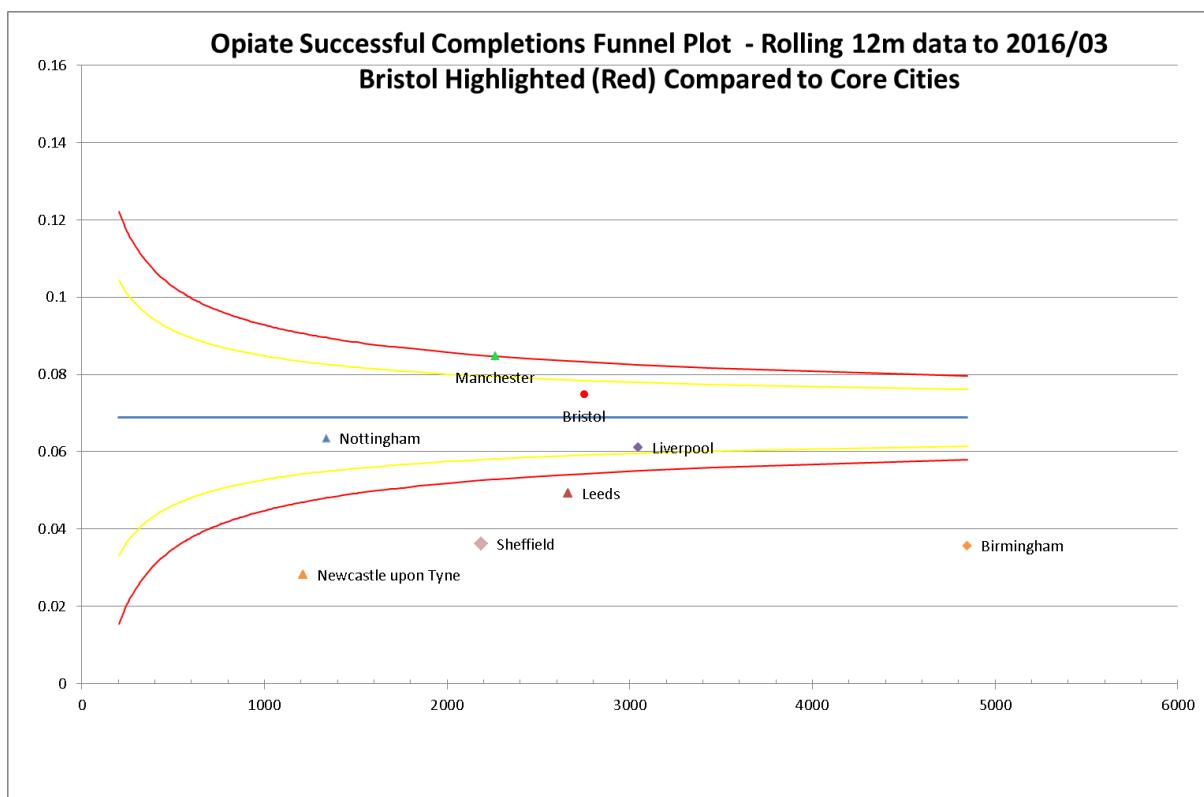
The blue line is the national average and the funnel is based on all 149 local authorities with only the core cities highlighted within it.

The horizontal axis shows the size of the treatment population for that cohort of people and the vertical shows the successful completions as a percentage of that

cohort ( $0.6 = 6\%$ ,  $0.8 = 8\%$  etc) For example, on the opiate cohort funnel, there are roughly 2800 opiate clients in treatment, of which roughly 7.5% have completed treatment successfully.

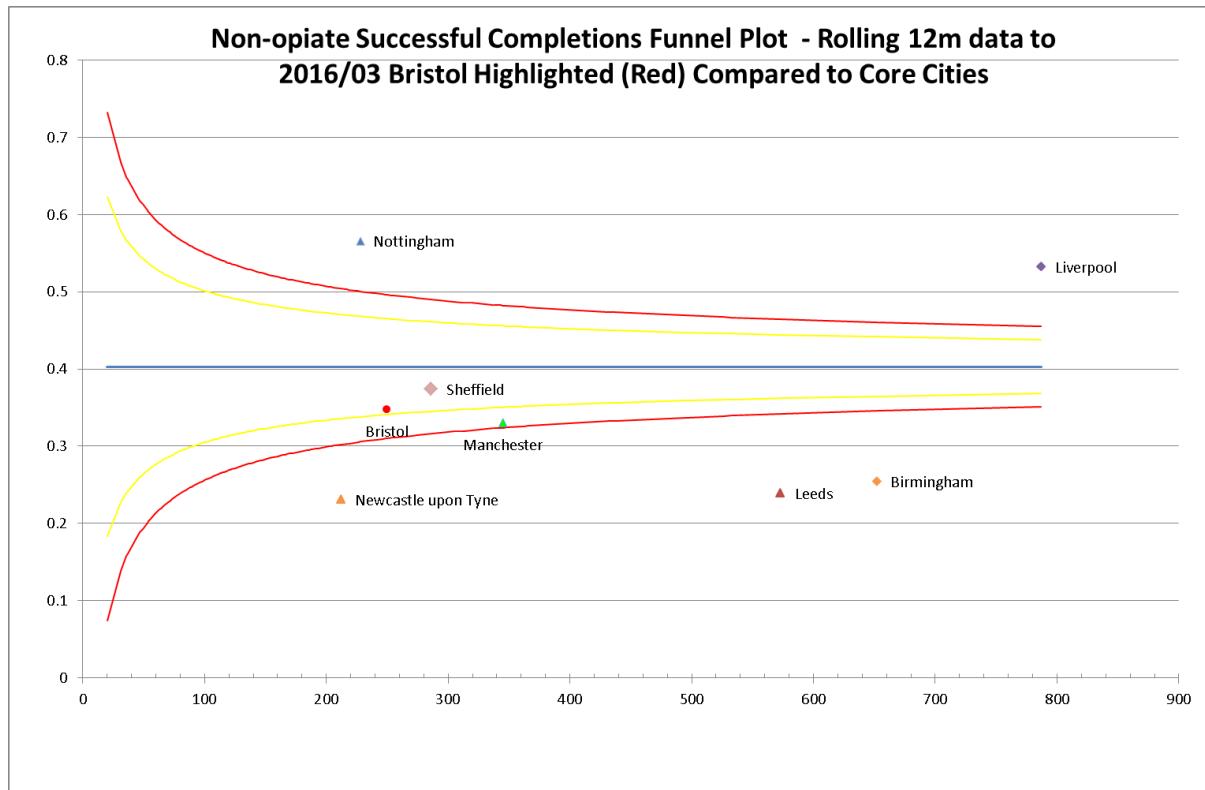
\* The data as presented may not align with the national statistics because of differences in period, or when the data was extracted

### Chart 2.10 Opiate Successful Completions Funnel Plot



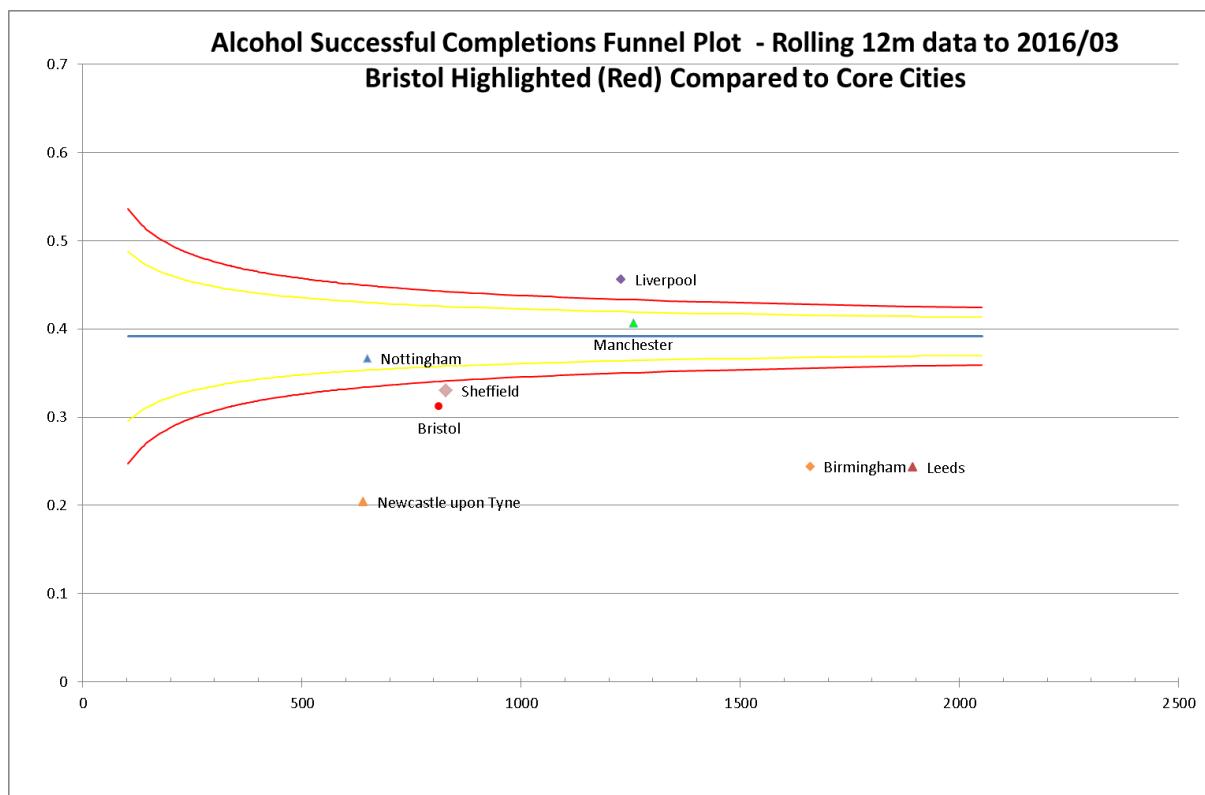
Bristol is above the national average in successful completions for opiate clients.

**Chart 2.11 Non- opiate Successful Completions Funnel Plot**



Bristol is below the national average in successful completions for non-opiate clients but still within the normal range.

**Chart 2.12 Alcohol Successful Completions Funnel Plot**



Bristol is below the national average in successful completions for alcohol clients and being beyond the red line, is seen as being an outlier and needing further investigation.

### **3. Who is at risk and why?**

*Drug-related harms do not only vary according to the different types of drug or drugs being used; alongside this, it is the way a drug is used, the way it is used in combination with other substances, and the social context in which it is used that contribute to risk.<sup>5</sup>*

It is pertinent to consider the pharmacological properties of a drug, the characteristics of the person using the drug as well as the social and physical environment in which the drug is used.

The 2015 Welsh Adverse Childhood Experience (ACE) study<sup>6</sup> was carried out to ascertain the impact of Adverse Childhood Experiences (ACEs), such as abuse, maltreatment and witnessing domestic abuse, on the health and wellbeing of adults. The study found that adults who experienced 4 or more ACEs compared to those who experienced none, were:

- 4 times more likely to be a high risk drinker
- 6 times more likely to smoke e-cigarettes or tobacco
- 11 times more likely to have smoked cannabis
- 15 times more likely to have used heroin and crack
- 20 times more like to have been incarcerated at any point in their lifetime.

The study concluded that reducing ACEs in future generations could reduce levels of heroin/crack cocaine use (lifetime) by 66%; incarceration by 65%; cannabis use by 42%; high risk drinking by 35%; and smoking tobacco or e-cigarettes by 24%.

“Drugs and poverty: A literature review”, produced by the Scottish Drugs Forum (SDF) on behalf of the Scottish Association of Alcohol and Drug Action Teams identified the following key links between socioeconomic situation and drug use:

- There are strong links between poverty, deprivation, widening inequalities and problem drug use but the picture is complex. It may involve fragile family bonds, psychological discomfort, low job opportunities and few community resources.

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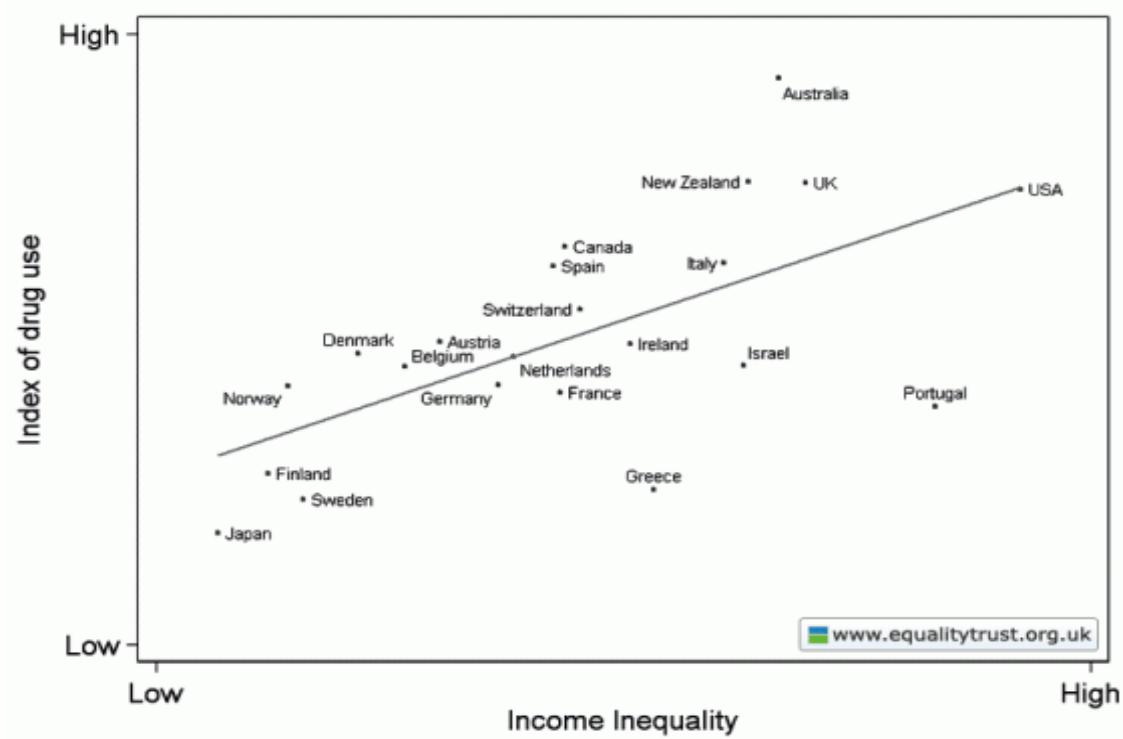
<sup>5</sup> A summary of the health harms of drugs (2011)

<sup>6</sup> Welsh Adverse Childhood Experience (ACE) study (2015)

- Relative poverty, deprivation and widening inequalities, such as income, are important factors that need to be given a more central role within the drug policy debate as they weaken the social fabric, damage health and increase crime rates.
- Not all marginalised people will develop a drug problem, but those at the margins of society, such as the homeless and those in care, are most at risk.

The Equality Trust <sup>7</sup>combined the data collected from the World Drug Report 2007, compiled by the United Nations Office on Drugs & Crime (which contained the results of sample surveys on the prevalence of the use of opiates, cocaine, cannabis, ecstasy and amphetamines) into one index, giving them equal weights, and found a strong tendency for drug abuse to be more common in more unequal countries.

**Chart 3.1 Drug use index of countries by income inequality**



<sup>7</sup> Equality Trust Drug Index (2009)

The Older Persons' Substance Misuse Working Group of the Royal College of Psychiatrists report "Our Invisible Addicts"<sup>8</sup> identified that both alcohol and illicit drugs are among the top ten risk factors for mortality and morbidity in Europe and substance misuse by older people is now a growing public health problem. Between 2001 and 2031, there is projected to be a 50% increase in the number of older people in the UK. The proportion of older people in the population is increasing rapidly, as is the number of older people with substance use problems. Mortality rates linked to drug and alcohol use are higher in older people compared with younger people.

According to Wadd et al (2011)<sup>9</sup>, "evidence suggests that the UK may be on the cusp of an epidemic of alcohol related harm amongst older people." Those aged 65 and over form a small proportion of those in alcohol treatment – 3% of both men and women. However, an estimated 1.4 million people in this age group currently exceed recommended drinking limits.

The Recovery Diagnostic Toolkit (RDT) is a tool developed by PHE that presents analysis of different groups and factors in Bristol. As well as an overview of successful completions and non re-presentations, it breaks down local treatment data into themed sections about factors linked to outcomes<sup>10</sup>.

It highlights comparative issues and treatment history as factors that contribute to a client's complexity and the level of need they present with. The following graphs have been taken from the Recovery Diagnostic Toolkit (PHE) to demonstrate the levels of need.

This chart below shows the proportion of non-treatment naïve clients who reported each of the factors that increase their complexity. The complexity factors from left to right are:

- Heroin user
- Methadone user
- Other opiate user

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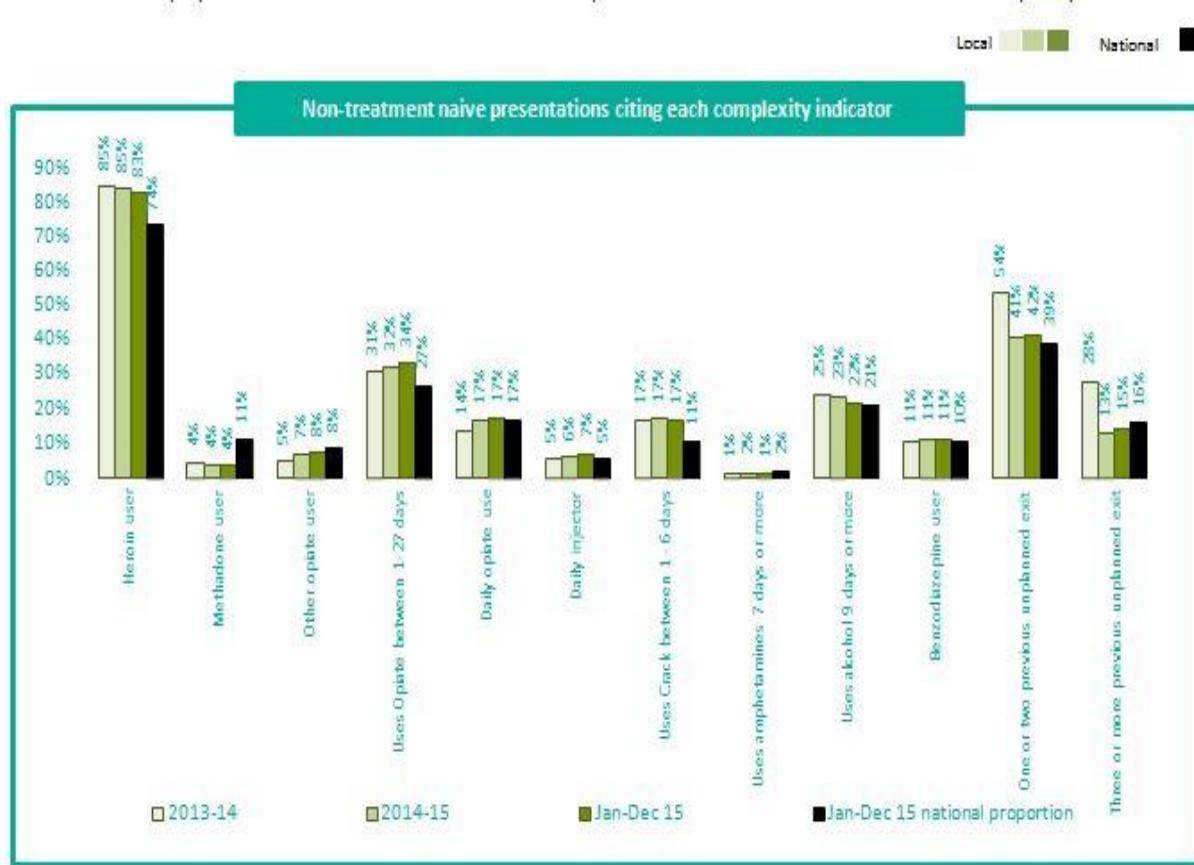
<sup>8</sup> Our Invisible Addicts (2011)

<sup>9</sup> Working with older drinkers (2011)

<sup>10</sup> Recovery Diagnostic Toolkit Overview

- Uses opiates between 1-27 days
- Daily opiate user
- Daily injector
- Uses crack between 1-6 days
- Uses amphetamines 7 days or more
- Uses alcohol 9 days or more
- Benzodiazepine user
- One or more previous unplanned exit
- Three or more previous unplanned exits

**Chart 3.2 Non-treatment naïve presentations by complexity indicator**



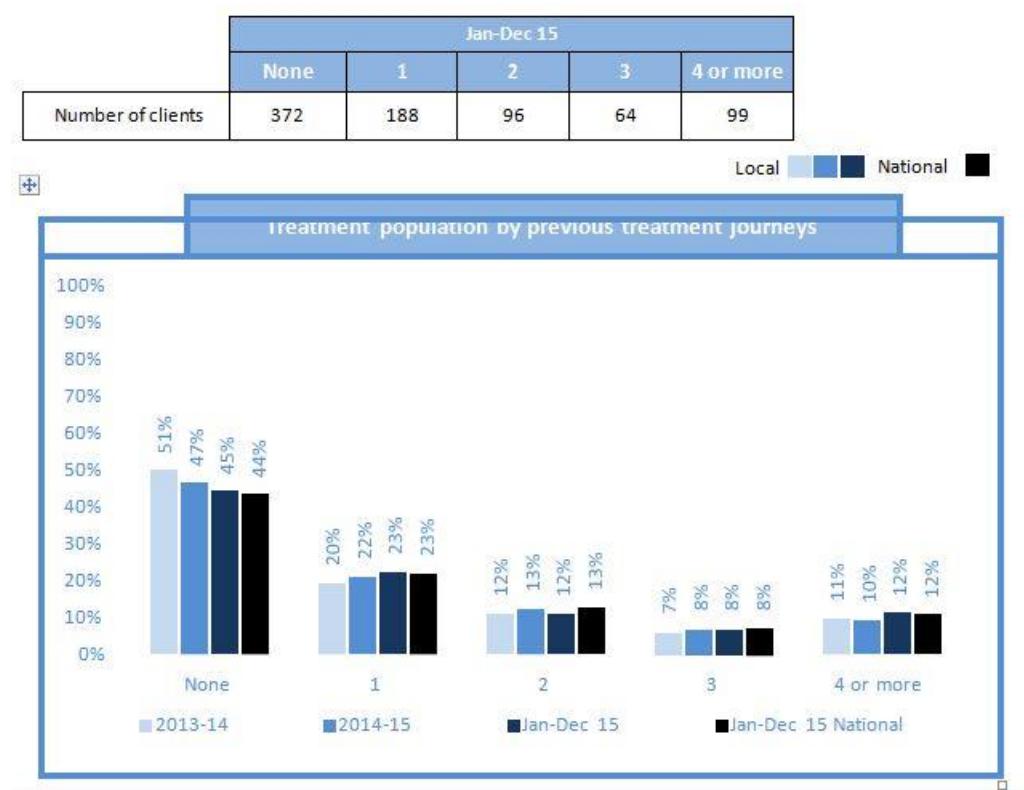
Whilst the percentage of treatment naïve clients presenting with complex indicators has reduced locally over the past three years, Bristol still has a higher percentage of complex presentations than the National comparator. Treating people with high and multiple complexities is traditionally more difficult and takes longer compared to

those with fewer and less severe complexities. The one exception to this is methadone. This could be in some part due to Bristol's accessible prescribing regime engaging people in shared care, when compared to other areas with high GP led prescribing and more diverted street methadone availability.

Bristol also has a marginally smaller percentage of clients returning after three or more previous unplanned exits down by almost half from 2013-14 to end of December 2015.

The table below shows the number of alcohol clients in treatment at the end of Jan-Dec 15 by the number of previous treatment journeys they had in England to that point, from no previous journeys through to four or more. The chart underneath shows the changes in the proportion of clients in treatment by number of previous journeys over time.

### Chart 3.3 Number of treatment journeys for alcohol clients

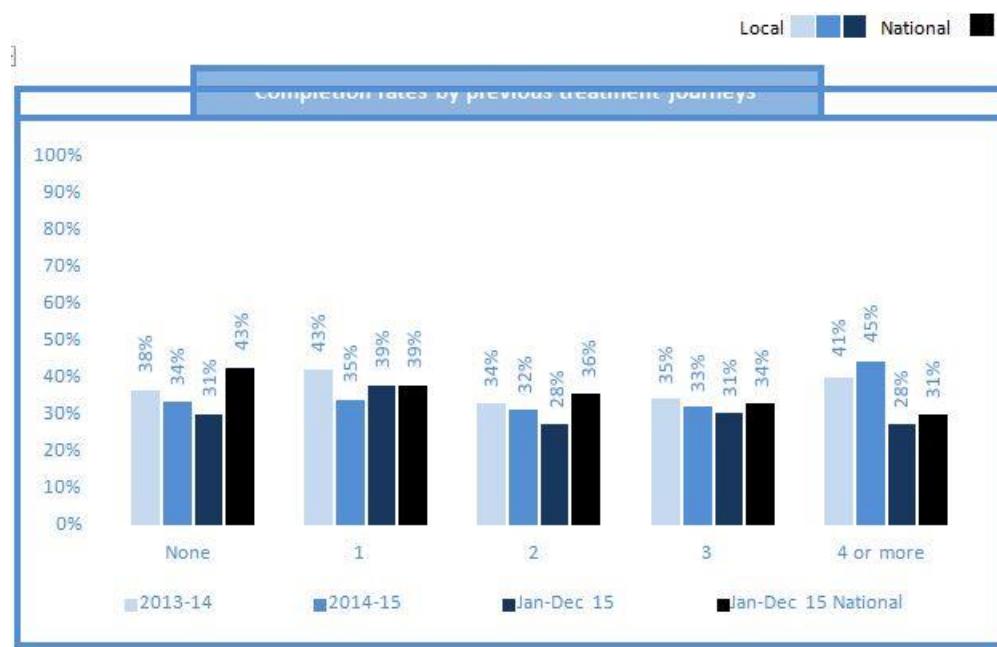


Whilst most levels have stayed relatively constant throughout the years and close to the National comparator, there has been a marginal decrease in the percentage of the treatment population having had no previous treatment journeys. This could be

due to the enhanced alcohol treatment offer in ROADS and the resulting increase in alcohol referrals, especially from the GP pathway.

The table below shows the proportion of clients who left the treatment system successfully and the number of previous treatment journeys they have had, from no previous journeys through to four or more.

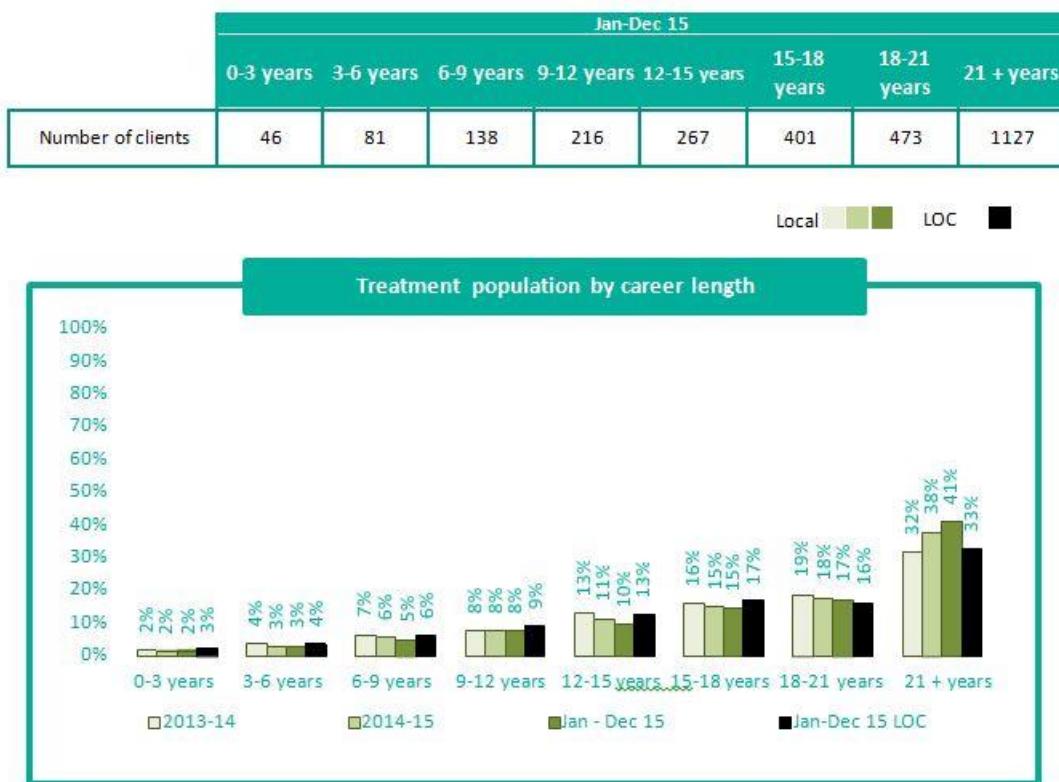
**Chart 3.4 Completion rates for alcohol clients**



Bristol has a smaller percentage of people leaving treatment successfully than the national average. This may be down to the unprecedented demand for alcohol services since the launch of ROADS and the high attrition rates of alcohol clients from assessment to engagement.

The table below shows the drug using career length of opiate clients in treatment during Jan-Dec 15, reported in three year periods, from under three years through to 21 years and over.

### Chart 3.5 Treatment population by career length



Bristol has a comparatively higher percentage of clients whose drug using career exceeds 18 years. This is likely due to the higher than average complexity of clients presenting to treatment and the longer time necessary to treat them.

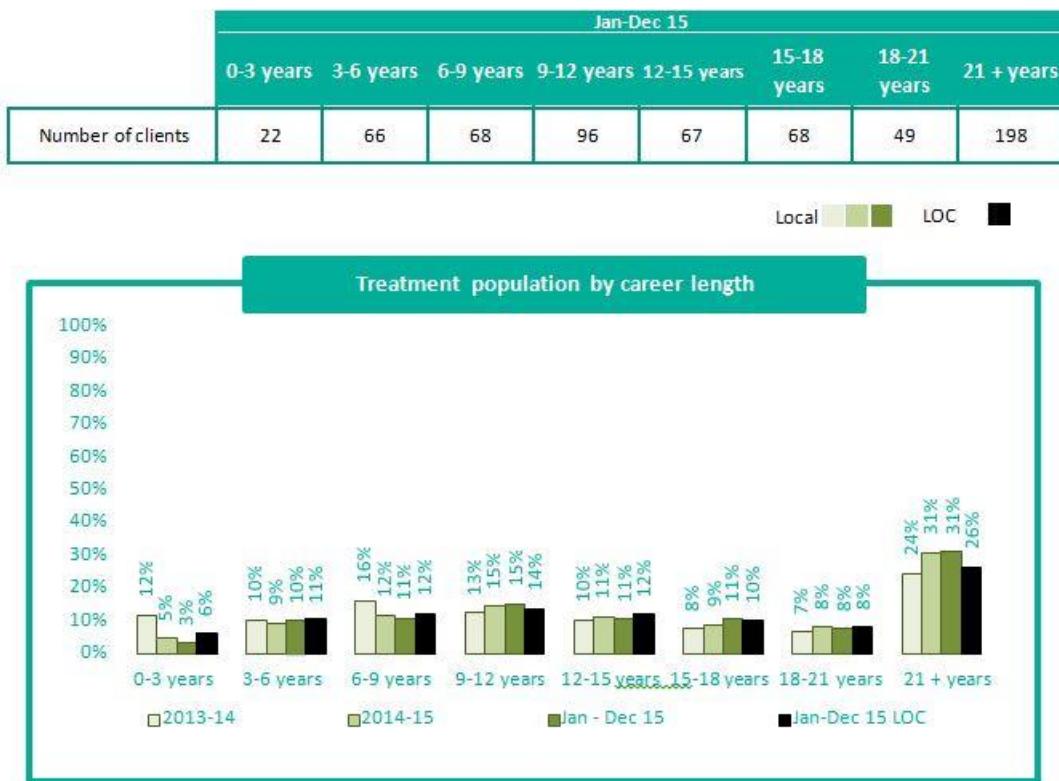
The table below shows the number of opiate clients in treatment in Jan-Dec 15 and the number of previous treatment journeys they have had that ended in an unplanned way, reported from none to four or more. The chart below shows the changes in proportion of opiate clients in treatment by number of previous unplanned exits over time.

### Chart 3.6 Percentage of treatment population with previous unplanned journeys



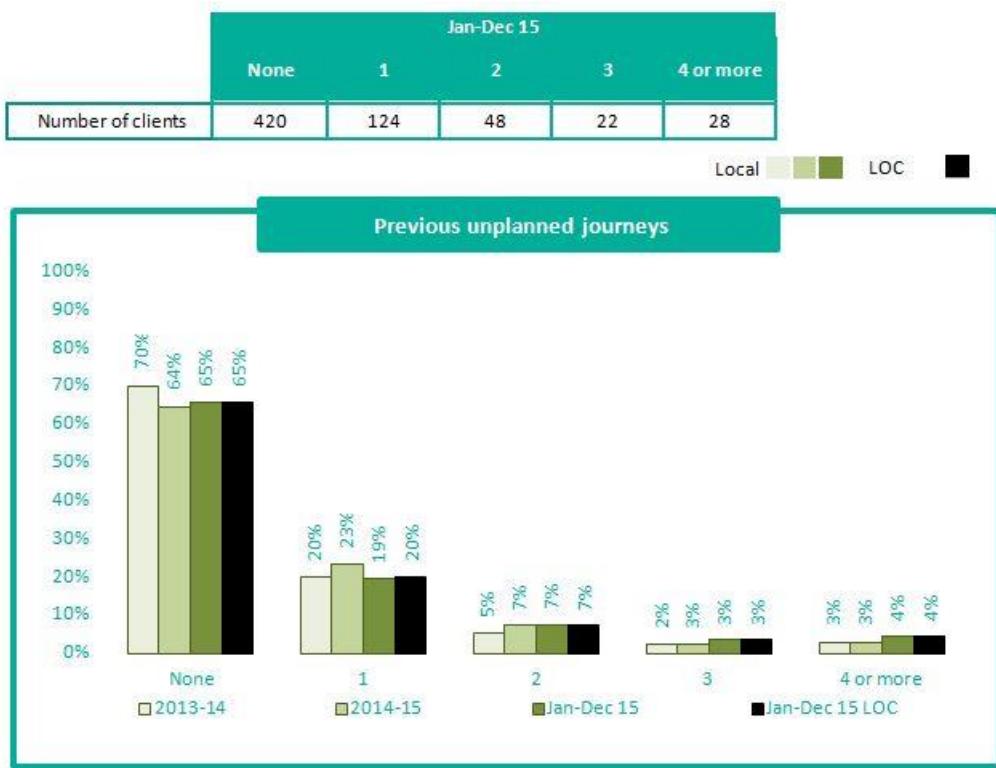
This table shows the drug using career length of non-opiate clients in treatment during Jan-Dec 15, reported in three year periods, from under three years through to 21 years and over. It is followed by a chart which shows the changes in the proportion of non-opiate clients in treatment by career length.

### Chart 3.7 Treatment population by career length



The table below shows the number of non-opiate clients in treatment in Jan-Dec 15 and the number of previous treatment journeys they have had that ended in an unplanned way, reported from none to four or more. The chart below shows the changes in proportion of non-opiate clients in treatment by number of previous unplanned exits over time.

### Chart 3.8 Percentage of treatment population with previous unplanned journeys



#### **4. What is the cost effectiveness/return on investment?**

##### **PHE Value for Money 2013**

According to the Value for Money calculation every £1 spent on substance misuse in Bristol will derive £2.50 of benefit in terms of crime reduction and increased health and wellbeing. This benefit is above the national average of £2.

##### **PHE Commissioning Tool 2014/15**

This PHE 2014/15 Commissioning Tool is a cost effectiveness analysis of the local substance misuse treatment system and is based on costs broken down by spend on drugs and alcohol only clients and by NDTMS interventions (pharmacological, psycho-social, inpatient detoxification and residential rehabilitation) reported in 2014/15.

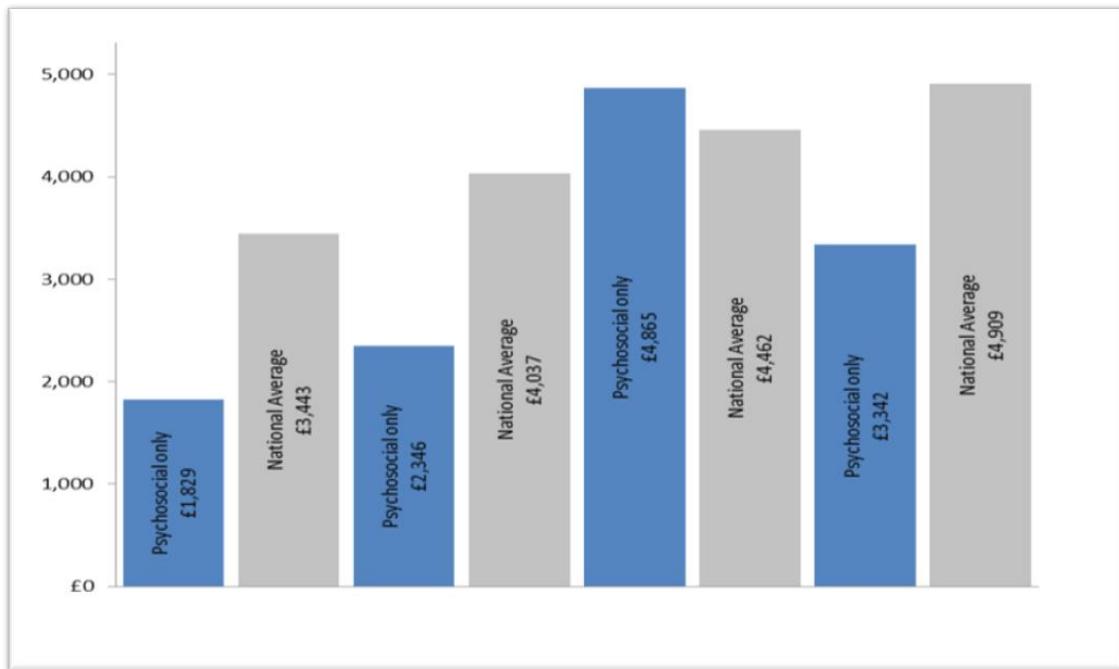
*Please note that findings from this tool do not offer an argument to stop investing in more expensive interventions but instead are used to identify ways of improving the future cost effectiveness of interventions.*

Based on information from this tool the most cost-effective pathway for opiate users in Bristol is 'Psychosocial only', with a spend of £443 per successful completion. Overall in Bristol the most common pathway for opiate clients was 'Pharmacological & Psychosocial', with 2,193 (or 81%) clients receiving these, costing an estimated £1,681 per client. There were 134 (or 6%) clients who successfully completed this pathway, costing an estimated £27,508 per successful completion.

For non-opiate users the most cost-effective pathway is 'Psychosocial only', with a spend of £369 per successful completion (179 clients). This was also the most common pathway for non-opiate clients with 393 (or 86%) clients attending, costing an estimated £168 per client.

The graph below shows the most common intervention pathways for the different severity/complexity groups of alcohol only clients and the estimated spend per successful completion for each group. A national average for the group is presented to the right (in grey) as a comparator for each pathway:

**Chart 4.1 Cost by type of interventions**



## **5. Physical Health**

### **What is the level of need?**

Physical ill health has been identified as having a significant impact on the recovery potential of people accessing treatment services<sup>11</sup>. This section will look at the mortality and morbidity associated with substance use (drugs and alcohol), the prevalence of comorbid conditions and a focus on injecting related harm.

It is worth noting that whilst this section looks exclusively at physical health and the subsequent section mental health we acknowledge that the conditions and issues arising do not occur in isolation. There is an intrinsic link between physical and mental health; poor physical health can adversely affect a person's mental health and poor mental health can negatively affect physical health.

Whilst great effort is being made to bring health and social care responses together within the Health and Wellbeing strategy the current structures of support still tend to deal with the these needs in isolation. As such, the data available to inform this needs assessment is primarily focussed on either physical or mental health.

It is equally important to recognise the fact that the relationship between physical health and substance misuse is complex. It is accepted that for many people, the route into substance misuse was as a way of dealing with health issues. The use of prescribed medications, chronic pain and self-medication for other symptoms, including mental health, often leads to dependency forming on the substances used. It is likewise true that for many individuals their physical health has been affected by the use of substances. Chronic liver disease, respiratory illness and blood borne viruses, caused as a result of using substances, are commonly identified within alcohol and drug using populations.

### **Drug Related Deaths**

There were 3,346 drug poisoning deaths registered in England and Wales in 2014, the highest since comparable records began in 1993. Of these, 2,248 (or 67%) were drug misuse deaths involving illegal drugs. The mortality rate from drug misuse was the highest ever recorded at 39.9 deaths per million population. Males were over 2.5 times more likely to die from drug misuse than females (58.0 and 21.9 deaths per million population for males and females respectively)

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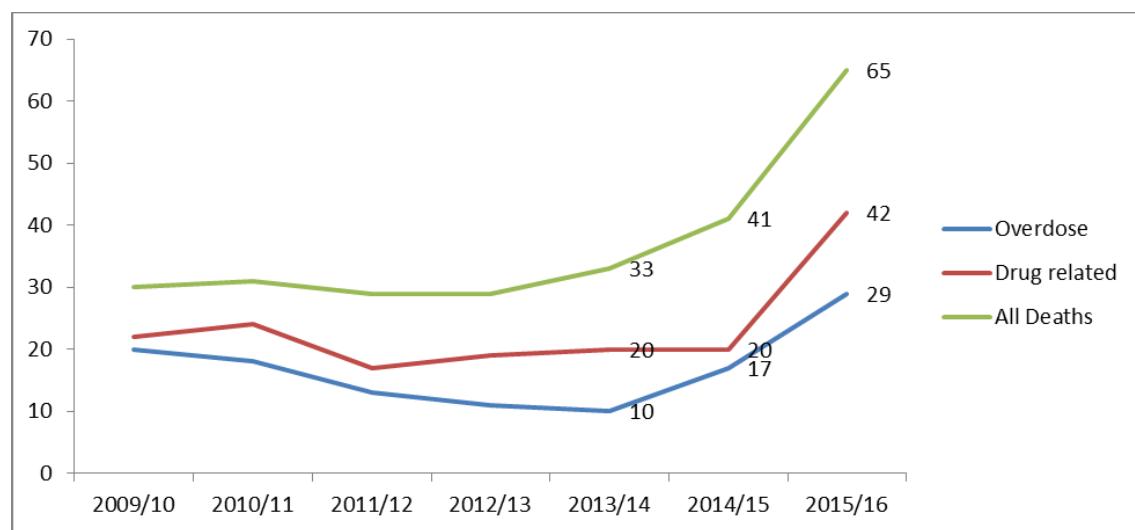
<sup>11</sup> Medications in Recovery(2012)

Deaths involving heroin and/or morphine increased by almost two-thirds between 2012 and 2014 from 579 to 952 deaths. Deaths involving cocaine increased sharply to 247 in 2014 – up from 169 deaths in 2013. People aged 40 to 49 had the highest mortality rate from drug misuse (88.4 deaths per million population); followed by people aged 30 to 39 (87.9 deaths per million)

In England there was a 17% rise in the drug misuse mortality rate in 2014, to 39.7 per million population, while in Wales the rate fell by 16% to 39.0 deaths per million, the lowest since 2006. Out of the 3,346 drug-related deaths registered in 2014, half (1,682) occurred in years before 2014<sup>12</sup>

Drug related deaths in Bristol had been stable from 2009-2015 with an average of 20 cases reported each year. Within this time period the proportion that was caused by opioid overdose had halved (from a high of 20 in 2009/10 to 10 in 2013/14). However this trend was reversed in 2014/15 with 17 opioid overdose deaths (an increase of 70%).

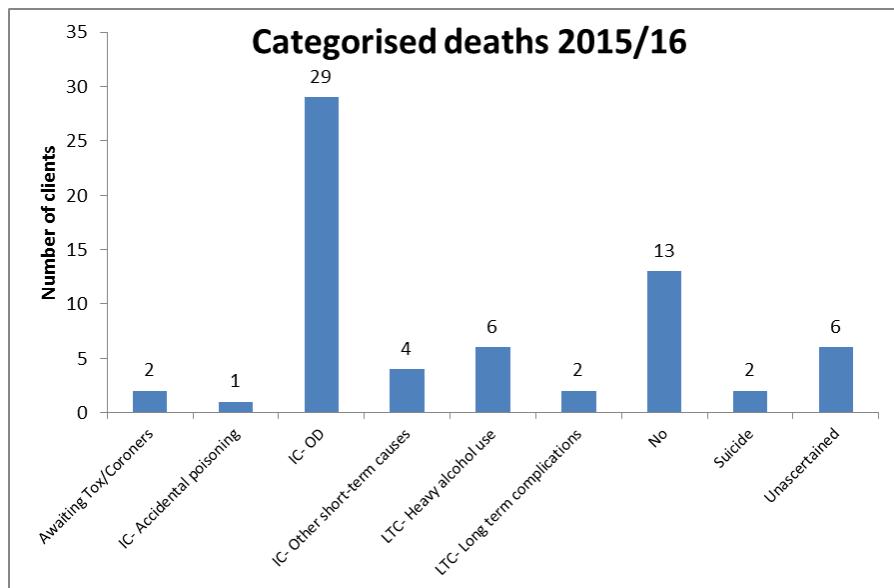
**Chart 5.1 Bristol Drug Related Deaths Trend**



29 overdose deaths have been identified for 2015/16 and a further 13 which are also related to the use of drugs. As of April 2016 2 further deaths are awaiting toxicology or a cause of death to be attributed by the Coroner's Office.

<sup>12</sup> Deaths Related to Drug Poisoning in England and Wales: 2014 registrations (2016) 41

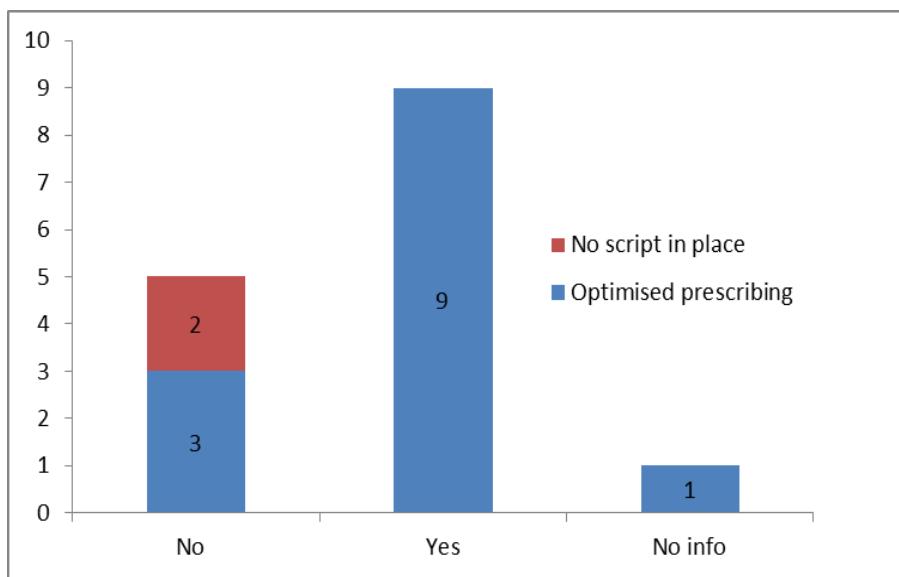
**Chart 5.2 Cause of death for Bristol drug related deaths in 2015/16**



Opioids (although rarely without combination of other central nervous system depressant substances such as alcohol or benzodiazepines) are by far the largest cause of drug related deaths in Bristol. Of the 29 overdoses recorded so far in 2015/16, 25 are directly attributable to heroin and/or methadone, one to Oxycodone and one to Tramadol. The only other substances, that are not an opioid, to be designated the causal factor in a death are MDMA and pregabalin, accounting for one death each.

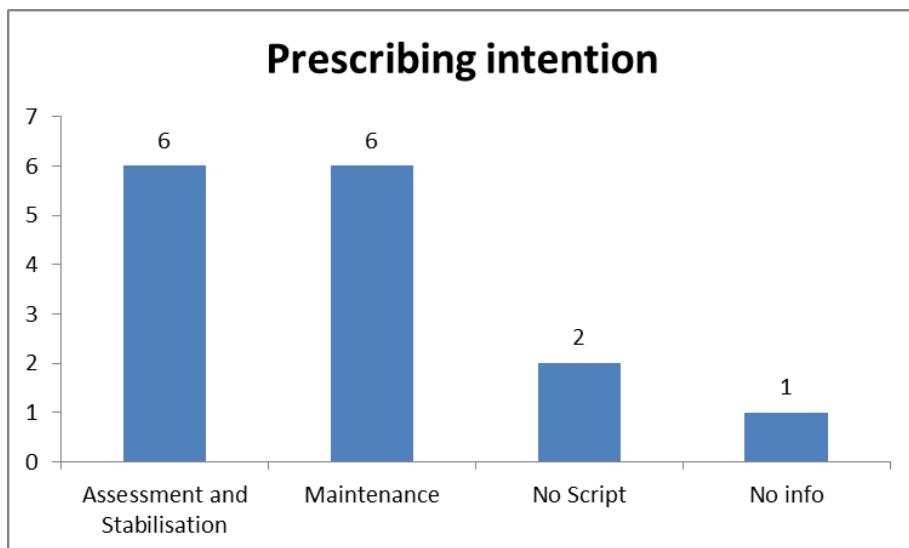
15 of the overdoses involved clients in treatment at the time. Of these, 60% (n=9) were in receipt of a prescription within the optimal range; 20% (n=3) received a sub-optimal dose of OST medication and a further 2 clients (13.3%) were in treatment but in receipt of no prescription at all.

**Chart 5.3 Optimised prescribing of Bristol drug related deaths in 2015/16**



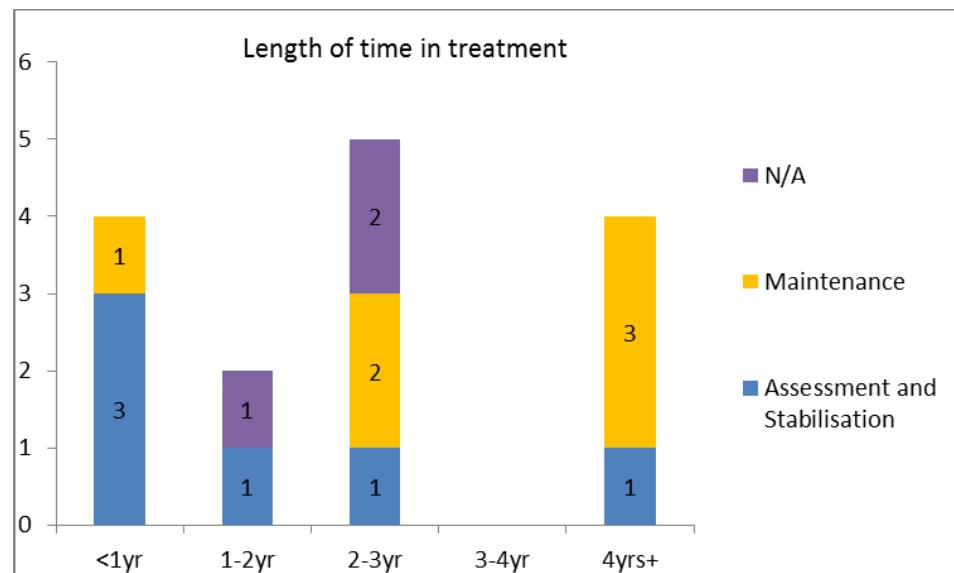
6 of these clients were considered to be in the Assessment and Stabilisation phase of OST; 6 within the Maintenance phase of treatment [n.b. several were reporting using heroin so would be more accurately recorded in the Assessment and Stabilisation phase]; 2 were without any OST medication; and one client had no information available.

**Chart 5.3 Prescribing intentions of Bristol drug related deaths in 2015/16**



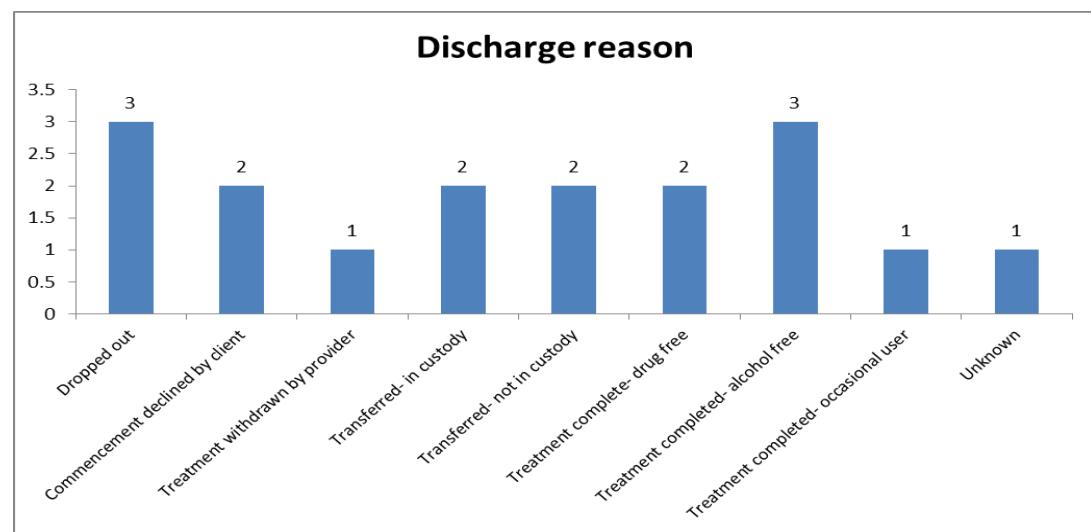
26.7% of these overdoses involved clients whose current treatment episode was less than 1 year; 13.3% current treatment episode 1-2 years; 33.3% 2-3 years; and 26.7% four years or longer.

**Chart 5.4 Length of time in treatment for Bristol drug related deaths in 2015/16**



Of the 17 drug related fatalities who were known to services but not in treatment at the time of their death 35.5% had previously successfully completed treatment and 47.1% had a previous unsuccessful treatment journey.

**Chart 5.5 Discharge reason from treatment for Bristol drug related deaths in 2015/16**



The demographics of the 44 individuals in 2015/16 whose death are drug related or still awaiting toxicology are broken down as followed:

Gender- Males accounted for 82% (n=36) and females 18% (n=8).

Age- 18-19 No deaths (0%); 20-24 3 deaths (6.7%); 25-29 no deaths; 30-34 8 deaths (17.8%); 35-39 4 deaths (8.9%); 40-44 13 deaths (28.9%); 45-49 9 deaths (20.0%); 50-54 4 deaths (8.9%); 55-59 1 deaths (2.2%); 60-64 1 deaths (2.2%); 65+ 1 death (2.2%)

Ethnicity- White British 84.1% (n=37); Mixed- Black Caribbean and White 4.5% (n=2); White Irish 2.3% (n=1); White Other 2.3% (n=1); and Not known 6.8% (n=3)

Sexuality- Heterosexual 79.5% (n=35), Gay/Lesbian 2.3% (n=1), Not Stated 9.1% (n=4) and Not Known 6.8% (n=3)

Disability- No 63.6% (n=28), Yes 22.7% (n=10), Not Stated 6.8% (n=3) and Not Known 6.8% (n=3)

The increase in deaths attributed to opiate overdose is considered to be multifactorial. Bristol has a history of poly-drug use. Nationally the proportion of clients using heroin and crack in combination is 39% of the overall opiate and crack using population; in Bristol the proportion is 69% [All in treatment bulls eye data, PHE/National Drug Evidence Centre] and up to 73% for hospital admissions.

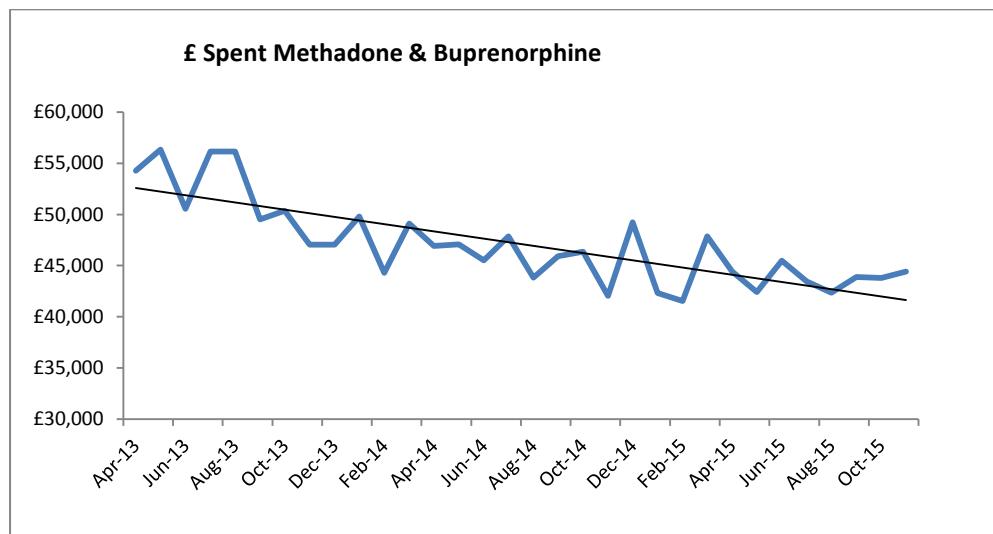
Recent changes in drug trends have seen reported increases in the use of pregabalin and Spice being reported to treatment providers and the Substance Misuse Team. Whilst there is no pharmacological evidence to suggest a link between these drugs and increased opiate toxicity, the influence on disinhibited behaviour and risk taking makes the introduction of these drugs within the opiate using population a public health concern. University of Bristol pharmacology dept. is

currently conducting research into the effect of pregabalin on opiate overdose to discover if there is a causal link. Due to the wide spectrum of substances being branded with the name, the same opportunity is currently not available for Spice.

Increases in the availability and purity of heroin within the drug market and increases in street homelessness are also believed to be negative factors in influencing the number of drug related deaths.

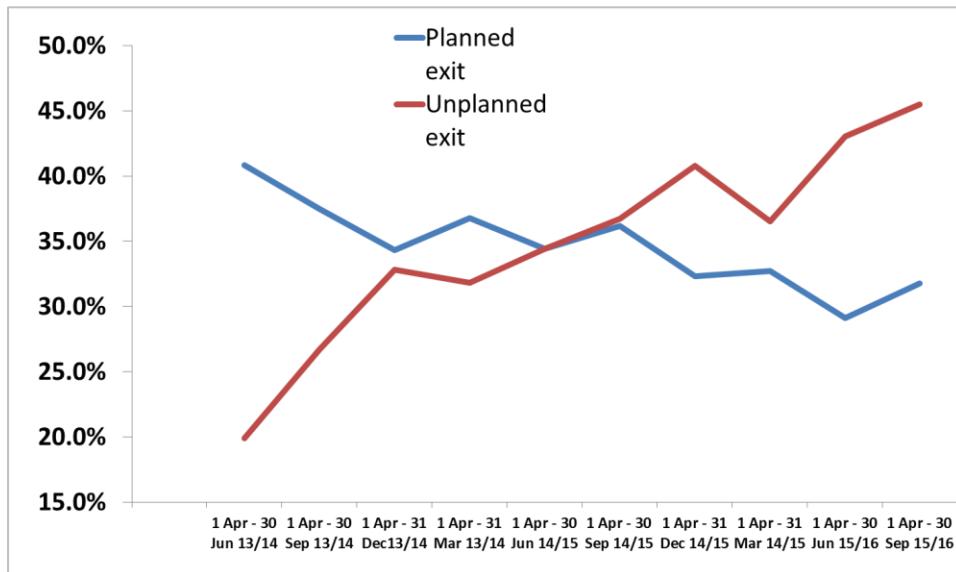
Several characteristics of the ROADS treatment system are also correlated with the recorded increase in drug related deaths. Since April 2013 there has been a 16% reduction in spend on opiate substitution medication whilst client numbers in that time period have only reduced by 8%. This possibly indicates less protection is currently available to those at risk of overdose due to fewer doses being within the recommended optimal ranges.

#### Chart 5.6 Money spent on OST medication



Based on PHE's Partnership Activity Reports (Q1 2013/14-Q2 2015/16) the proportion of opiate clients who leave treatment in a planned way has decreased from 40.8% in Q1 of 2013/14 to 31% in Q2 15/16. This has been mirrored in the number of clients leaving in an unplanned way; increasing from 19.9% to 45.5% in the same time period.

### Chart 5.7 Exit status of clients leaving the Bristol treatment system



The UK research evidence base<sup>13</sup> clearly highlights who is most likely to die from an overdose and when death is most likely to occur. This type of death is particularly noted amongst opioid using people who use drugs with a reduced tolerance. These people are particularly vulnerable in the transitional periods of their drug using career, for instance when:

- leaving prison
- exiting drug treatment, especially 'unplanned' exits
- leaving residential drug treatment or inpatient detoxification

Of the 121 people who inject drugs who responded to questions around overdose in the 2015 Unlinked Anonymous Monitoring Survey<sup>14</sup> 21.5% reported to have overdosed in the previous 12 months. Of those who had overdosed, 41.7% reported to have done so on more than one occasion in that time period.

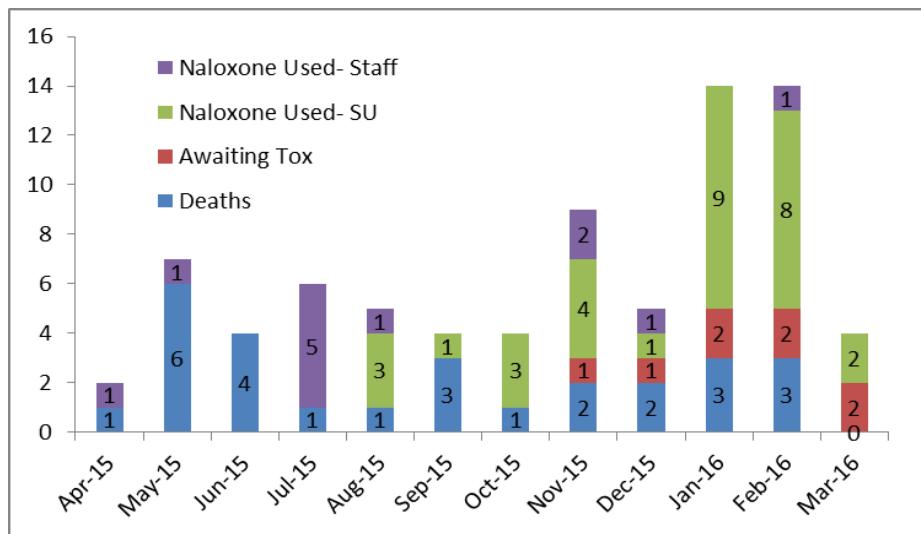
The provision of naloxone to at-risk service users is thought to have a positive effect on limiting the number of overdose deaths. In 2015/16 there were 42 known uses of

<sup>13</sup> Preventing Drug Related Deaths- Sudden Onset Deaths(2014)

<sup>14</sup> Unlinked Anonymous Monitoring Survey of HIV and Hepatitis in People Who Inject Drugs (2015)

the overdose antidote- each one potentially preventing an overdose from being fatal. Due to the success of the intervention, continuing the provision of naloxone will need to be part of a continued strategy to reduce drug related deaths.

**Chart 5.7 Naloxone usage in Bristol 2015/16**



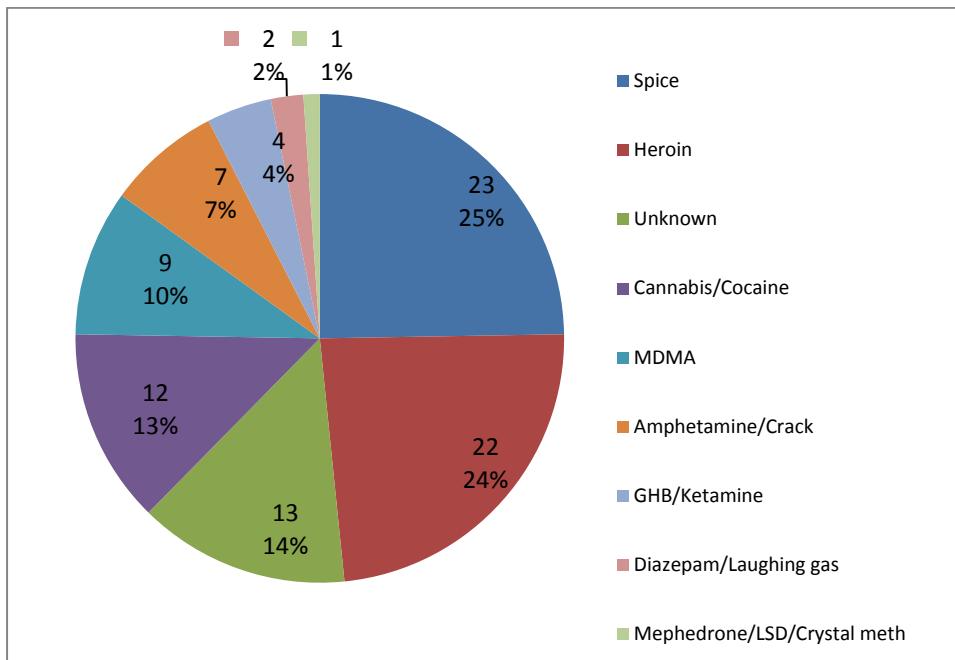
### Novel Psychoactive Substances

Although there have been no deaths recorded associated with the use of novel psychoactive substances (NPS) there is increased concern regarding their use in Bristol. The lack of NPS within coroner's toxicology reports may be due to the inability to accurately test for these emerging compounds. Several people have witnessed NPS use directly before deaths occurred yet none of the substances were found during the coroner's investigations.

6 reported incidents from treatment and homelessness services of clients suffering adverse effects, often necessitating being taken to A&E, from the synthetic cannabinoid Spice have been received by the Substance Misuse Team since 12/01/2016. Previously no reports had been made.

A snapshot of presentations to the BRI Emergency Department in December 2015 showed those due to Spice use outnumbered those due to heroin (which traditionally was the most common drug of admission).

**Chart 5.7 Drug of admission to the BRI Emergency Department in December 2015**



The BRI (Bristol Royal Infirmary) Drug Specialist Team has recorded 9 clients reporting Spice as their primary drug admitted to the BRI since 3<sup>rd</sup> September 2015 for treatment for a variety of health problems, including neurological, trauma, and accidental overdose. A further 7 clients reported spice as a secondary or tertiary drug with the earliest presentation being in June 2015.

### Comorbid conditions

Of the 2552 unique clients who in 2015 completed an assessment for structured treatment in Engagement or Change 19% (n=485) self-reported as having a disability although information regarding the detail of clients' conditions are not captured as part of the dataset.

Medications in Recovery (2012) states that “*for some people – and especially as the treatment population ages – physical health problems may be a persistent barrier to recovery*”.

Bristol’s opiate using population is often described as an aging cohort with increasing complexities impacting on their ability to recover, although data relating to their health has not been available. A snapshot of comorbid conditions affecting clients of shared care was undertaken in March 2016 in order to begin quantifying the level of physical health conditions affecting the client group.

The snapshot was designed to gather information from Shared Care practitioners on conditions they were aware of, rather than as a more thorough, investigative study which would include the examination of client notes or the matching of medical records. As such the results of the snapshot are likely to underrepresent the scale of prevalence of all identified conditions and in all probability missed conditions that practitioners are unaware of. A full public health needs assessment into the impact of physical ill health of clients of OST is recommended to fully understand the issues identified.

1520 clients accessing Shared Care were considered within the snapshot and 58 separate conditions affecting the lives of the service users were identified. The most common condition was hepatitis C (HCV) affecting 14.1% of clients, followed by respiratory problems (excluding chronic obstructive pulmonary disease(COPD)) 8.2%; mobility issues 7.1%; COPD 5.7%; and ulcers/abscesses 5.5%. 6.5% (n=99) of the clients considered within the snapshot were known to have needs around pain management; 4.1% (n=63) had been admitted to hospital in the last 3 months; 3.8% (n=58) had visited A&E; 5.2% (n=79) were considered to be at risk of hospital admission due to their current physical health; and 0.9% (n=13) were known to have had a non-fatal overdose in the last 12 weeks.

Shared Care workers were asked to consider the number of their clients for whom they would not be surprised if they died within the next 12 months. The practitioners indicated that this applied to 7.8% (n=119) of the caseload considered within the snapshot.

A similar snapshot, conducted at the same time, of 150 clients accessing the Housing Support service (accommodation and floating support) showed the most common health issues affecting service users, out of a total of 34 identified (appendix ii), were mobility issues 22%; HCV 10.7%; respiratory problems (excluding COPD) 10.7%; COPD 7.3%; and deliberate self-harm injuries 6% 20% (n=30) of the Housing Support clients had needs around pain management; 8.7% (n=13) had been admitted to hospital in the last 3 months; 7.3% (n=11) had visited A&E; and 4.7% (n=7) were considered to be at risk of hospital admission due to their current physical health.

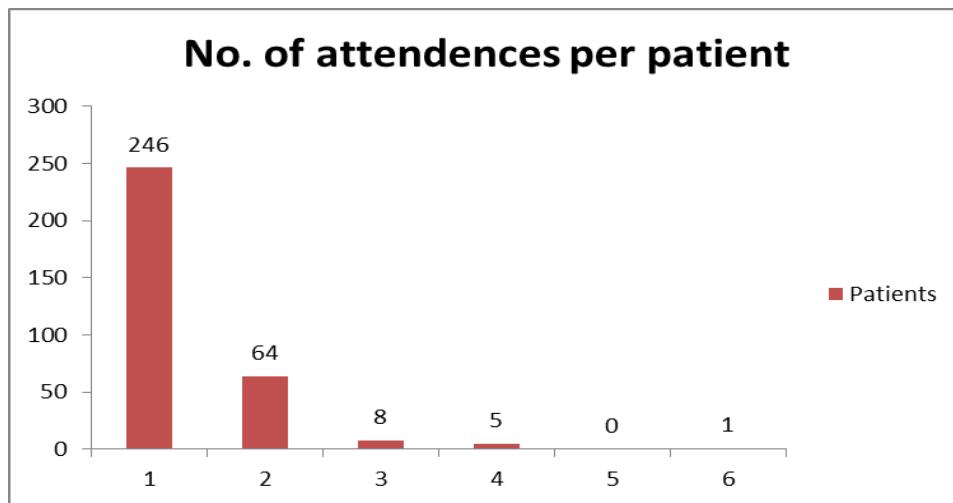
2.7% (n=4) of clients were known to have overdosed in the last 3 months and staff indicated that they would not be surprised if 8% (n=12) of their clients died within the next 12 months.

It should be noted that many of the clients considered within the Shared Care and Housing snapshots could be accessing both services and are not unique cohorts. In spite of the limitations of the survey it is apparent that clients of Shared Care and Housing Support collectively suffer from numerous conditions and illnesses that may represent a persistent barrier to recovery unless appropriately supported. Many of the problems identified were the direct result of problematic drug use (e.g. hepatitis C and ulcers through injecting drug use, COPD through smoking heroin, crack and/or tobacco) and indicate that a treatment system needs to be able to support the prevention of physical health problems from occurring as well as developing appropriate pathways to facilitate care for particular conditions when they are diagnosed.

The impact of physical health problems is further demonstrated through the activity of the BRI Drug Specialist Team- a dedicated hospital based team supporting drug related attendances to reduce repeat admission and improve the care pathway with community treatment.

In 2015 the team dealt with 424 drug related admissions to the BRI for 324 patients. 75.9% (n=246) of patients were admitted once; 19.8% (n=64) admitted twice; 2.5% (n=8) admitted three times; 1.5% (n=5) admitted 4 times; and 0.3% (n=1) admitted 6 times

**Chart 5.7 Drug of admission to the BRI Emergency Department in December 2015**



The admissions to the BRI were due to a broad range of conditions:

Admitting Condition	No.	%
Injecting injuries	57	11.9%
Abdominal + Gastrointestinal	56	11.7%
Chest conditions	49	10.3%
Neurological	43	9.0%
Infection/sepsis	37	7.7%
Cardiac	34	7.1%
Trauma	27	5.6%
Overdose-intentional	25	5.2%
Mental health	25	5.2%

Circulatory	22	4.6%
Overdose-accidental	17	3.6%
Other	11	2.3%
Planned admission	8	1.7%
Cancer	6	1.3%
Pain	4	0.8%
Urology	2	0.4%
(blank)	1	0.2%

The total length of stay for drug users in the BRI in 2015 was 2758 days, with an average stay of 6.6 days (maximum stay –325 days). Whilst the true cost of a hospital admission varies according to the treatment required, type of service needed and location, the estimated cost of a hospital stay is £400 per day (data.gov.uk) indicating that drug related admissions cost in the region of £1,103,200 in 2015. The average stay had a cost of £2640 and the longest £130,000. Access to healthcare for people who use drugs, particularly those who inject, is poor and often hospital attendance is required. Interventions are needed to reduce morbidity, healthcare burden and delays in accessing treatment.<sup>15</sup> Improving the focus on physical health in community drug treatment to improve early healthcare interventions, particularly around conditions caused by injecting drug use, could reduce the number of hospital admissions and reduce the impact on bed-days in hospital.

The most common primary drugs of use for clients admitted to the BRI were:

Primary Drug	No.	%
Heroin	207	48.9%
Alcohol	59	13.9%
Nil – Previous known drug use	37	8.7%
Crack	25	5.9%
Cannabis	20	4.7%

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<sup>15</sup> Healthcare seeking and hospital admissions by people who inject drugs in response to symptoms of injection site infections or injuries in three urban areas of England (2015)

Cocaine	20	4.7%
Spice	8	1.9%
Diazepam	8	1.9%
Amphetamine	7	1.7%

N.B. –of the primary heroin users 73.4% had crack recorded as their secondary drug.

### Pregnancy

Alcohol, prescribed medications and illicit drugs commonly used in Bristol (heroin, crack, and benzodiazepams) can, when taken during pregnancy, be the cause of complications and harm to the unborn child. Foetal alcohol syndrome (which can result in developmental delay, height and weight deficiencies, autistic traits, and maxilo-facial deformations), neonatal abstinence syndrome, placental abruption and fetuses' small for gestational age are all potential risks for mothers misusing substances during pregnancy.

In 2015/16 15 of the 623 women starting treatment were recorded as pregnant at the start of their treatment journey. During this period a total of 89 pregnant women worked with the Bristol Maternity Drug Service (BMDS) in order to monitor the health of mother and baby during pregnancy and following birth.

### Sexual Health

Public Health Bristol conducted a Sexual Health Needs Assessment<sup>16</sup> in 2015 which highlighted the following in relation to sexual health and substance misuse:

*Alcohol consumption can result in lower inhibitions and poor judgements regarding sexual activity, vulnerability and risky sexual behaviour. Associations have been found between alcohol consumption and an increased likelihood of sex at a younger age, a greater number of sexual partners, more regretted or coerced sex and increases the risk of sexual aggression, sexual violence and sexual victimisation of women (DH, 2013).*

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<sup>16</sup> Bristol Sexual Health Needs Assessment (2015)

*Evidence suggests that gay and bisexual men who use particular illegal drugs (as well as alcohol) are more likely to engage in risky sex. A survey found that 51% of gay men had taken illegal drugs in the previous year, compared with 12% of men in the wider population (DH, 2013)*

*Those addicted to Class A drugs such as opiate and crack are at higher risk of poor sexual relationships, STIs and blood borne viruses.*

### **Chemsex**

*Chemsex is defined as engaging in sexual activities while under the influence of drugs and often involved group sex or a high number of partners in one session (Bourne et al., 2014). Recent evidence indicates that this behaviour has become a trend amongst some gay men. The drugs used include crystal meth, mephedrone and GHB/GBL. The drugs can be used in a variety of ways including snorting, smoking, injecting (termed ‘slamming’), inserted into the rectum and mixed with drinks. The study reports that there is Emerging evidence that use of these drugs are putting MSM at higher risk of STIs.*

The Positive Voices Survey for England and Wales 2014<sup>17</sup> found that nearly a third (29%) of gay male patients reported engaging in ‘chemsex’ (defined by the researchers as “the use of drugs to increase disinhibition and arousal”) in the past year and that one in ten reported ‘slamsex’ (injecting – or being injected with – the drugs).

Figures were higher for some subgroups: 37% of Londoners reported chemsex and nearly one in five (19%) of men on antiretroviral therapy (ART) reported slamsex. Of the 29% reporting chemsex, 15% reported using methamphetamine; 20% GHB or GBL; 11% ketamine; and 23% mephedrone or drugs of its type (cathinones). Of the 10% reporting injecting, 7% injected methamphetamine, and 6.5% mephedrone-type drugs. Injecting ketamine or GHB/GBL was rare.

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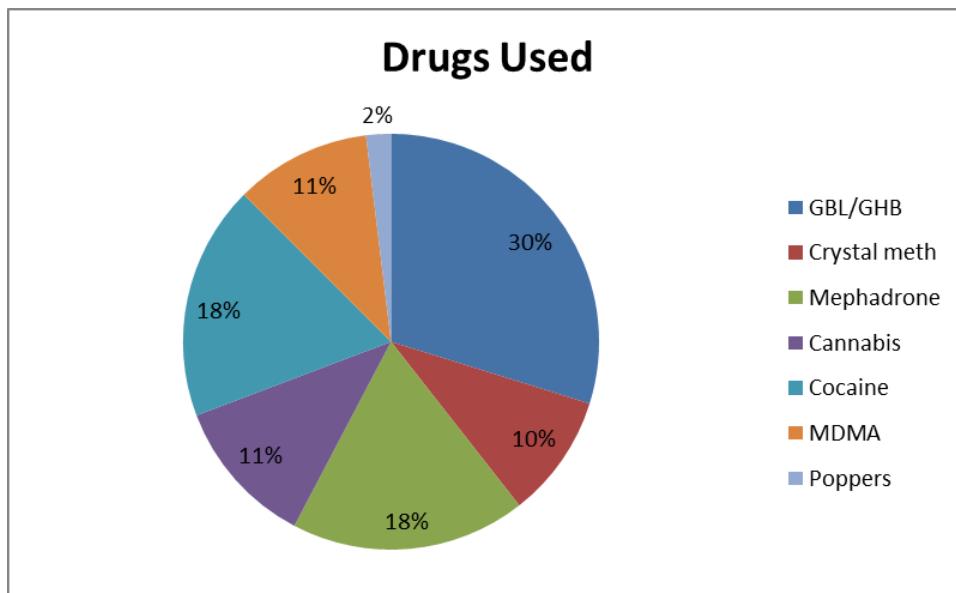
<sup>17</sup> Positive Voices survey for England and Wales (2014)

Chemsex users were more likely to be middle-aged rather than young: 34% of men aged 35-54 reported chemsex, as opposed to those aged 18-34 (20%) or over 55 (19%).

BDP conducted a survey of drug use and sexual behaviour with attendees of the 2016 Bristol Pride event. Of the 365 completed surveys 104 (28.5%) identified as LGBT+ and using drugs. 72% of respondents were male, 23% female, 4% gender fluid and 1% transgender. 13% identified as lesbian, 59% as gay and 28% as bisexual. The following primary drugs of use were identified, although this was commonly as part of a poly-drug pattern, with GBL and crystal meth and/or mephedrone frequently used in combination.

GBL/GHB	31
Crystal meth	10
Mephedrone	19
Cannabis	12
Cocaine	19
MDMA	11
Poppers	2
Total	104

**Chart 5.8 Drugs Used at Bristol Pride Event**



Whilst the majority (60%) of respondents either agreed or strongly agreed with the statement "I am able to enjoy sex without using drugs" a similar proportion (61%) agreed or strongly agreed with the statement "when I use drugs I can put myself in sexually risky situations" indicating that substance use increases risk taking behaviours within the context of sex. This is further supported with 61% of respondents agreeing or strongly agreeing with the statement "I am more likely to have sex without a condom when I'm high".

17% (n=18) of the respondents reported injecting drugs. Fourteen males and four females all reported to be injecting either crystal meth or mephadrone. Fifteen participants reported frequency of use between daily and a few times a month and three participants reported using drug less than once a month.

Ten of the injecting respondents reported that they felt their drug use was having a negative impact on their life. Eleven reported that they were unable to enjoy sex without drugs. Twelve reported that they put themselves in high risk sexual situations due to their drug use and another 12 participants reported that they are more likely to have unprotected sex due to their drug use.

In terms of clients engaged with BDP's needle and syringe programme 51 individuals self-identified as gay/lesbian, homosexual or bi-sexual at NSP Triage. Of these

clients, 8 disclosed injecting drugs commonly (although not exclusively) associated with chemsex (mephedrone- n=7 and GHB/GBL- n=1).

The Diversity Trust identified that “*LGB people, who are substance dependent, are more likely to seek help, but they are less likely to seek help from generic treatment services and are more likely to seek help from informal networks: friends, partners and family, online, through leaflets and the media*”.<sup>18</sup>

In June 2016 BDP launched Prism, a drug and alcohol service for people identifying as LGBT+ and are currently developing a partnership with Terence Higgins Trust and the Central Sexual Health Clinic to offer access to assessment, harm reduction advice and information, and brief interventions to reduce the harms identified with chemsex.

### **Sex Working**

Sex workers are a group particularly at risk of drug related harm and sexual ill health. A Review of the Literature on Sex Workers and Social Exclusion By the UCL Institute of Health Equity for Inclusion Health, Department of Health (April 2014) identified a study by Jeal and Salisbury (2004) which explored the health of on-street sex workers in Bristol:

*All interviewees admitted to having a history of alcohol and/or drug use. Over half of respondents stated they entered sex work specifically to fund drug addictions and many continued to use drugs whilst pregnant. It is claimed that alcohol use amongst sex workers is used for self-medication; to help mask some of the negative feelings associated with sex work, including distress, anxiety and experiences of selling sex (Brown, 2013). However... this is likely to be lower for migrant groups.*

*Drug and alcohol addiction can cause serious damage to people's health. Many drug addicts are undernourished and homeless. Some of the most prominent health concerns facing sex workers as a group are communicable diseases, such as HIV*

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<sup>18</sup> Lesbian, Gay, Bisexual and Trans Research Report prepared for the Recovery Orientated Alcohol and Drugs Service (2015)

*and other Blood borne Viruses. In addition, common health complaints by this group have included abscesses, as a result of intravenous drug, poor dental care and premature death through overdose (Ward and Day, 2006).*

Capture recapture data for Street Sex Workers (SSW) in Bristol<sup>19</sup> estimates a total SSW population in Bristol of 269 women (231 – 357 95% CI) with 65 (27 – 153 95% CI) thought not to be in contact with any service (One25, Bristol Drugs Project or Police).

### **Injecting Drug Use**

The Home Office has estimated number of OCUs in Bristol has been stable, at 4,800 in 2009/10 and 5,400 in 2011/12.

Of the 5,400 OCUs in 2011/12, 4,200 were opiate users, 4,300 were crack users, and 1,500 were injecting<sup>20</sup> (although the injecting population has been estimated by the University of Bristol as being as high as 2770<sup>21</sup>

Bristol has an estimated rate of 18.0 OCUs per 1,000 population, over twice the national average of 8.4<sup>22</sup>.

In 2015 there were 846 people who inject drugs (PWID) who accessed BDP's NSP. The demographics of these individuals are as follows:

### **Chart 5.9 Age of clients accessing NSP in 2015**

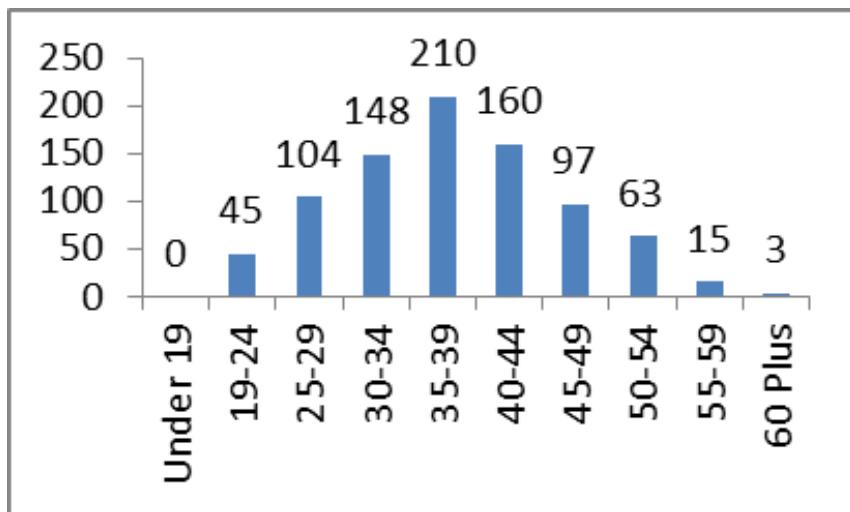
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<sup>19</sup> The multiplicity and interdependency of factors influencing the health of street-based sex workers: a qualitative study (2008)

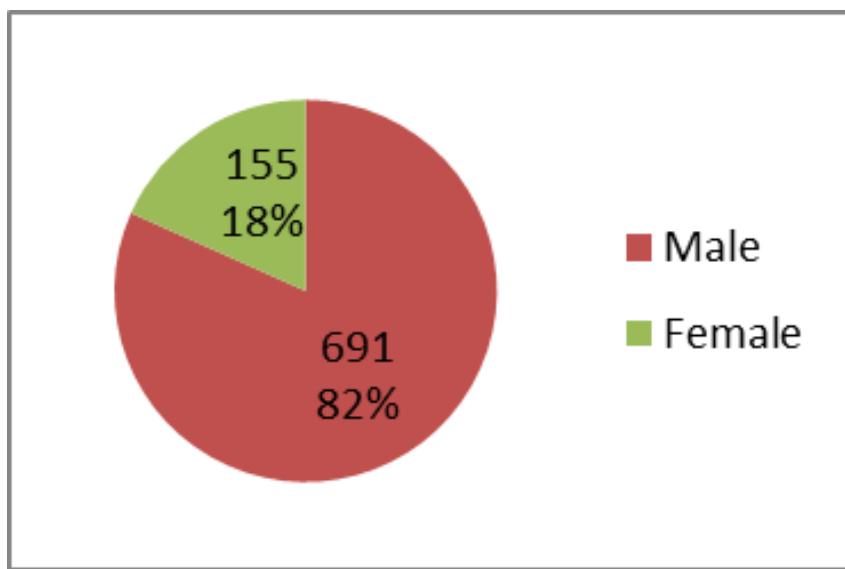
<sup>20</sup> Estimates of the prevalence of opiate use and/or crack cocaine use (2011/12) (2012)

<sup>21</sup> Problem drug use prevalence estimation revisited: heterogeneity in capture-recapture and the role of external evidence (2015)

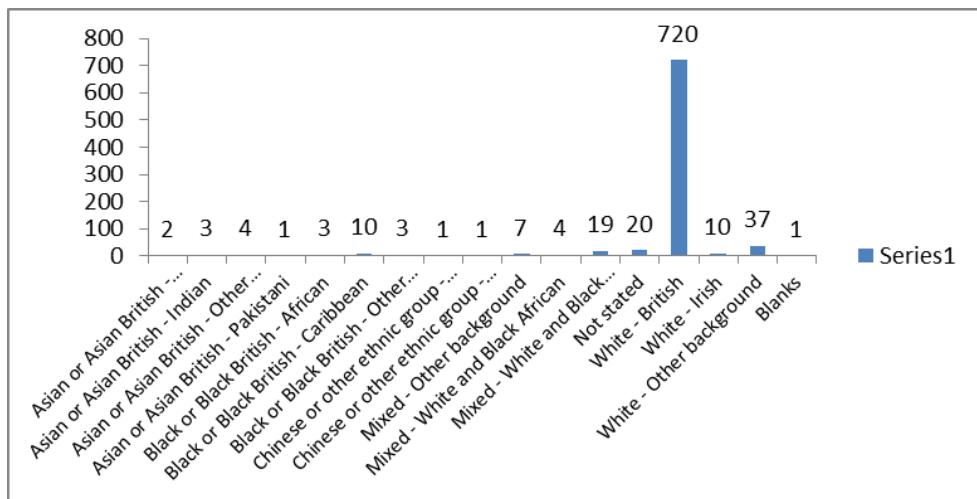
<sup>22</sup>Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2011/12 (2012)



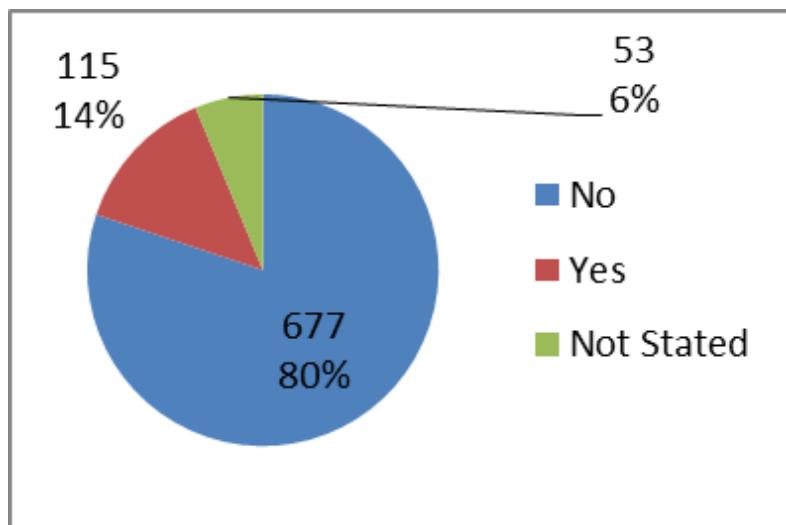
**Chart 5.10 Gender of clients accessing NSP in 2015**



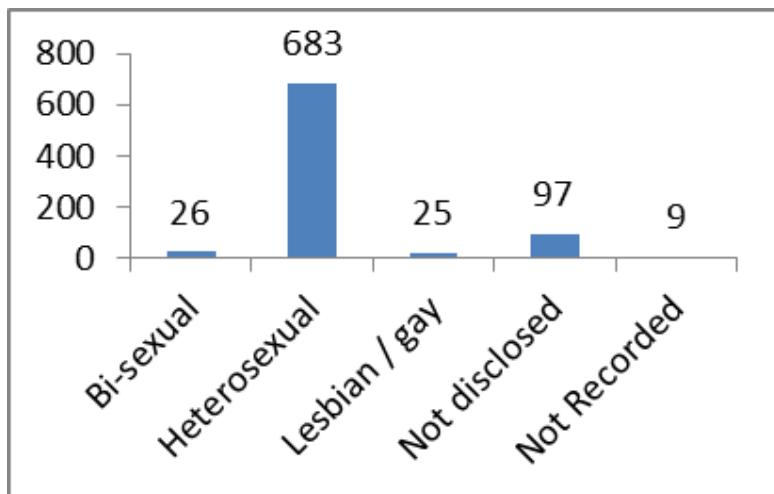
**Chart 5.11 Ethnicity of clients accessing NSP in 2015**



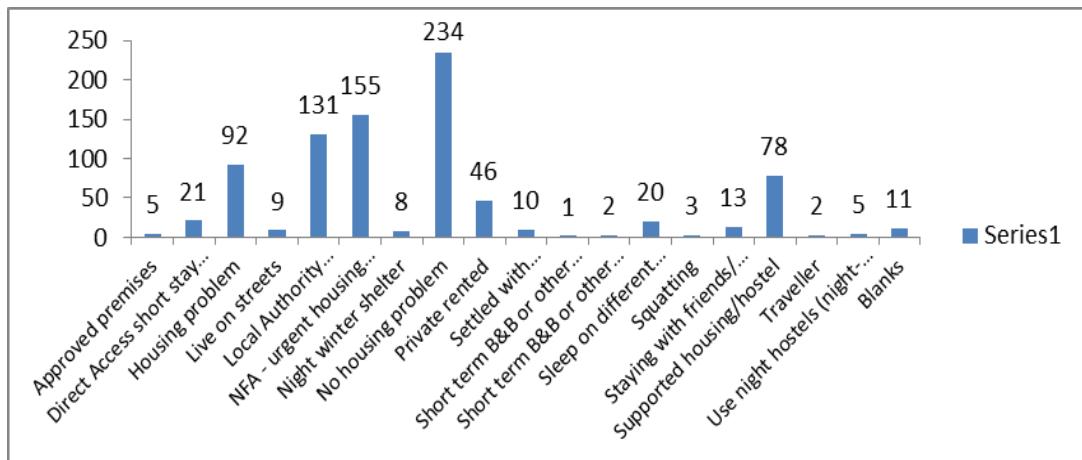
**Chart 5.12 Disability status of clients accessing NSP in 2015**



**Chart 5.13 Sexual orientation of clients accessing NSP in 2015**



**Chart 5.14 Housing status of clients accessing NSP in 2015**



176 assessments for illicit drug injectors (88% male, 12% female) and 125 assessments for image and performance enhancing drugs (98% male, 2 % female) were completed in the 6 months between Sept 15 and March 16. BDP estimate that 70-80% of assessments are carried out on people new to the service and 20-30% on people returning to the service.

Whilst the demographics of the clients accessing pharmacy-based needle exchange is not available it is thought a similar number of people who inject drugs access pharmacies to obtain sterile injecting equipment as access BDP.

Heroin is the most common primary drug of injection with 82% of clients accessing NSP reporting to be injecting the drug. 64% of heroin injectors also report to inject crack cocaine. This trend –due to the vasoconstrictive properties of crack and the

likelihood of more regular, repeated injections due to the short half-life of the drug – increases the risk of injecting related harm (e.g. vein damage, soft tissue infections and blood borne viruses).

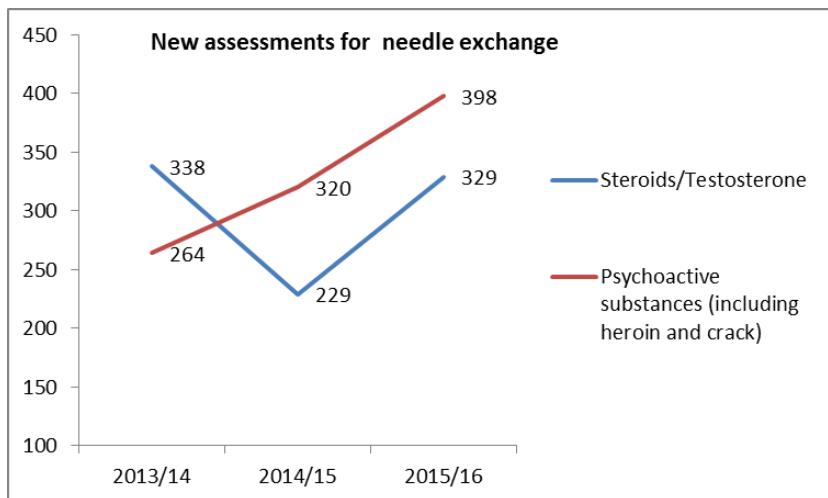
Currently 55% of PWID who access specialist NSP are engaged with the ROADS treatment system and are either accessing NSP during their current treatment episode or are previous injectors currently engaged with treatment but have not accessed the NSP in the past 12 weeks. This figure varies considerably depending on the substances injected; 75% of opiate injectors are engaged with treatment; 58% of non-opiate injectors; and 1% of image and performance enhancing drug injectors.

In 2015 Bristol ROADS had 1116 new episodes of treatment commence. Of those clients (for whom alcohol was not the primary substance) 31% (n=346) reported at Triage to have never injected, 42.5% (n=474) reported to have previously injected but did not any longer, and 26.5% (n=296) reported being current injectors – a total of 69% of clients having an injecting history. Analysis of the NSP client group has identified a cohort of clients (n=148) who are obtaining injecting equipment and engaged with treatment yet are reporting zero injecting on their latest Treatment Outcome Profile (TOP) form. This indicates a significant gap in the ability of treatment to reduce injecting related harm, including the spread of blood borne viruses.

### **Blood Borne Viruses**

Risky injecting behaviour, such as sharing needles & other paraphernalia, among vulnerable drug users puts them at an increased risk of getting HIV, hepatitis C (HCV), hepatitis B (HBV) and other infections. Injecting drug use is a declining feature of most areas in the UK, however Bristol and the Southwest region continues to have increased prevalence of injecting drug use leading to higher risk factors for the transmission of HCV. Increasing numbers of people who inject psychoactive drugs (predominately heroin and crack have been accessing BDP's needle exchange since 2013/14 as reported through the Theseus case management system.

### Chart 5.15 New assessments for needle exchange



The 2015 Unlinked Anonymised Monitoring Survey of People Who Inject Drugs (UAM) reported 62.4% of people who inject drugs (PWID) were positive for HCV antibodies; 14.4% for HBV antibodies and 5.6% for core surface antigen; and 2.4% for HIV.

The results are similar to the 2012 HCV prevalence estimates (60% antibody positive) and indicates that Bristol continues to have a significantly higher prevalence of HCV than the national average (49% in England, Wales and Northern Ireland).

Two sero-surveillance surveys were conducted in Bristol in 2006 and 2009<sup>23</sup>. HCV prevalence in both was greater than 50%; but HCV incidence in 2006 was ~40% reducing to ~10% in 2009. The reduction in HCV incidence coincides with increases in OST and NSP coverage, and reductions in injecting risk behaviour. Since 2013 NSP coverage has grown with sterile injecting equipment increasing by 42% between 2013/14 and 2014/15. However, indications suggest that OST coverage has dropped over the same time period with more clients dropping out of treatment and less OST medication being dispensed (See Drug Related Deaths section).

<sup>23</sup> Measuring the incidence, prevalence and genetic relatedness of hepatitis C infections among a community recruited sample of injecting drug users, using dried blood spots. (2010).

Access to treatment for HCV is poor (less than 4% per year of the chronically infected population) and NHS England are currently reviewing the treatment pathway. Bristol City Council Public Health specialists are supporting NHS England's newly established Operation Delivery Network to ensure the needs of PWID are considered within the pathway to increase availability of treatment amongst this cohort.

The 2015 HIV rate is significantly higher than previous years' UAM surveys (0% in 2012, 2013 and 2014) and potentially indicates a new risk to people who inject drugs in Bristol. As well as the direct risk of contracting HIV through injecting drug use, of the 58.6% of respondents to the 2015 UAM reporting sexual activity in the previous 12 months only 25% of those reported always using a condom.

A recent outbreak in Glasgow, a city with similar case mix of people who inject drugs and drug using trends, has recently experienced a three-fold increase in HIV rates among their injecting population. Until 2016, HIV tests were not routinely offered by ROADS providers to PWID in Bristol due to low rates of HIV so further data is currently unavailable regarding HIV rates in the wider injecting population.

These trends underline the need to ensure the treatment system maintains the ability to identify, and make use of, the opportunities for regularly offering tests to those at risk of blood borne viruses.

Sustaining and improving NSP coverage and increasing coverage of OST should be a strategic priority for the prevention of BBV transmission.

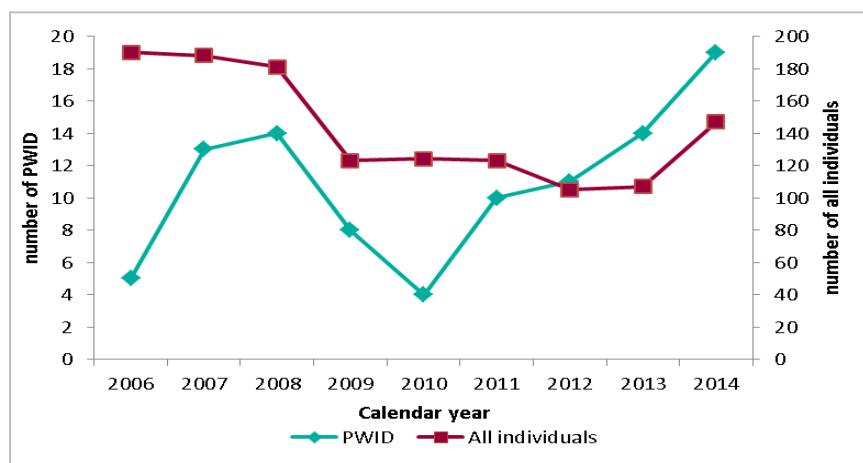
## **MRSA**

Intravenous drug use (IVDU) is a known risk factor for community associated MRSA colonisation and infection. Cases tend to have worse prognosis – protracted hospital admissions, and high morbidity and mortality following infection e.g. endocarditis.

Public Health England epidemiologists have reported that in the second half of 2014 the Bristol Royal Infirmary identified an increase in the number of MRSA

bacteraemia occurring in people who inject drugs (PWID). The number of cases rose from 4 in 2013 to 8 in 2014 and PIR found that cases were predominantly groin injectors and homeless.

**Chart 5.16 Annual number MRSA isolates overall and amongst PWID 2006 to 2014- PHE-2016**



Bristol has an estimated 1500-2700 PWID. Bristol has a high rate of groin injecting; mainly for the use of Heroin-crack cocaine “speedball” injections. Groin injecting is associated with deep vein thrombosis, leg ulcers, groin abscess and other injection related infections, increasing the risk of MRSA bacteraemia.

Concerns given the challenges to influencing improved hygiene around injecting (to reduce all manner of skin and soft tissue infections) are:

- Increase in numbers of street homeless people (very high % IDUs) – harder to be hygienic and only one of more pressing concerns
- Poly drug use including pregabalin and synthetic cannabinoids – increasing disinhibited behaviour – and reduced awareness/concern about hygiene in the moment.

The current evidence base around the causes of MRSA bacteraemia and prevalence of MRSA colonisation among PWID is currently poor. Bristol Drugs Project is currently leading an investigation to increase knowledge around this issue and

Bristol CCG is monitoring identification of MRSA bacteraemia through its Healthcare Acquired Infection (HCAI) group.

### **Impact on health system**

Injecting of illicit drugs forms a significant burden on acute health providers. For people identified as drug users, injecting injury accounted for 11.7% (n=56) of all admissions to the BRI and was the 2<sup>nd</sup> highest cause of being in hospital.

Admissions resulted in a total of 330 days in hospital with an average stay of 6.1 days (maximum stay – 55 days). Based on an average cost of £400 per hospital bed day this has a potential cost to Bristol's hospital trusts of £132,000 (average stay £2440, maximum stay £22,000)

Infections and sepsis (primarily caused by injecting drug use) accounted for 9% (n=43) of admissions. These admissions totaled 675 days in hospital with an average stay of 16 days (maximum stay – 325 days) with a potential cost of £270,000 to the hospital trusts (average stay £6400, maximum stay £130,000).

### **Image and performance enhancing drugs (IPEDS).**

People who use IPED (anabolic steroids, human growth hormone, etc.) comprise of 25% of the client base of BDP's NSP and account for 8.7% of needles supplied through this service. The UAM 'Survey of IPED: 2012-2013 Data Report- All Centres' reported that HIV rates among IPED users at 2%, HCV prevalence 3.6% and HBV antibodies 2.6%.

The rate for HIV is significantly above the national rate (2.8 per 1000 population<sup>24</sup>) and similar to the prevalence rate (2.4%) reported in the 2015 Bristol UAM survey among people who inject illicit drugs. Prevalence rates for HCV and HBV, whilst being significantly lower than that found among PWID, are higher than the national prevalence for these diseases within the general population (HCV 0.4% of the adult

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<sup>24</sup> HIV in the United Kingdom (2014)

population<sup>25</sup> and HBV between 0.1% and 0.5% of the UK population<sup>26</sup>). As such, users of IPED represent a risk group for health protection interventions to be directed towards and their needs should be considered within a health protection strategy.

### Alcohol harm and mortality

Alcohol use has health and social consequences borne by individuals, their families, and the wider community. In 2006, the former North West Public Health Observatory gathered routine data and intelligence from a range of sources (including the Department of Health and the Home Office), to provide a national indicator set intended to inform and support local, sub-national and national alcohol policies. These indicators provide measures to help prioritise and target local areas of concern.

The latest update, Local Alcohol Profiles for England 2015, was released on 2 June 2015 and continues to reflect the wide range of domains that are affected by alcohol use.

The Alcohol-related Mortality indicators show that Bristol residents lose significant months of life due to alcohol consumption compared with England as a whole

**Chart 5.17 Months of life lost due to alcohol – Bristol**



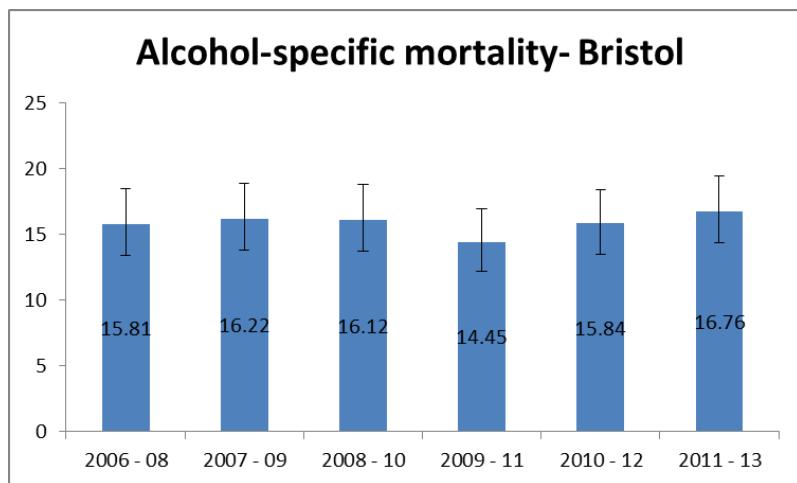
<sup>25</sup> Hepatitis C in the UK (2015)

<sup>26</sup> Health & Safety Executive (2015)

	Males - Bristol	Males - England	Females - Bristol	Females - England
2006-08	14.4	12.5	5.85	5.79
2011-13	16.11	11.97	5.92	5.58

The alcohol specific mortality rate for Bristol was 15.81 deaths per 100,000 population in 2006-08 (lower and upper CI 13.39-18.38) and 16.76/100,000 in 2011-13 (lower and upper CI14.36-19.44). England remained relatively unchanged with 11.90 (lower and upper CI 11.72-12.08) deaths to 11.93 (lower and upper CI 11.75-12.10)

**Chart 5.18 Alcohol Specific Mortality Bristol**

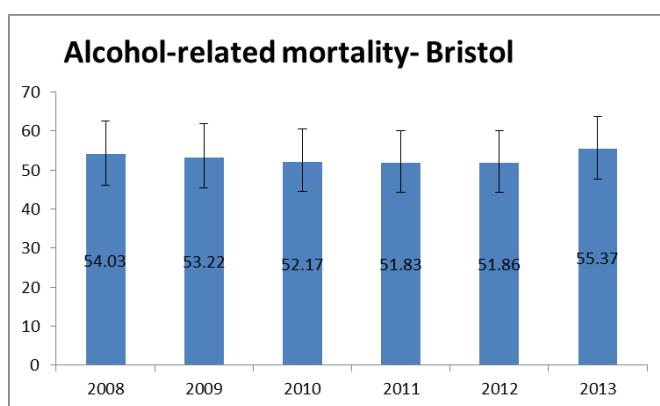


	Males - Bristol	Males - England	Females - Bristol	Females - England
2006-08	24.84	16.57	6.96	7.48
Lower and Upper CI	20.5- 29.67	16.27- 16.88	4.79-9.54	7.28-7.68
2011-13	25.96	16.61	7.42	7.47
Lower and	21.75-	16.31-	5.27-10.15	7.28-7.67

Upper CI	30.73	16.88		
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The alcohol related mortality rate for Bristol was 54.04 deaths per 100,000 population on 2008 (lower and upper CI 46.11-62.68) and 55.37 deaths in 2013 (lower and upper CI 47.59-63.3). England's alcohol related mortality rate was 47.81 deaths per 100,000 in 2008 (lower and upper CI 47.18-48.45) and 45.29 in 2013 (lower and upper 44.7-45.89)

**Chart 5.19 Alcohol Related Mortality Bristol**

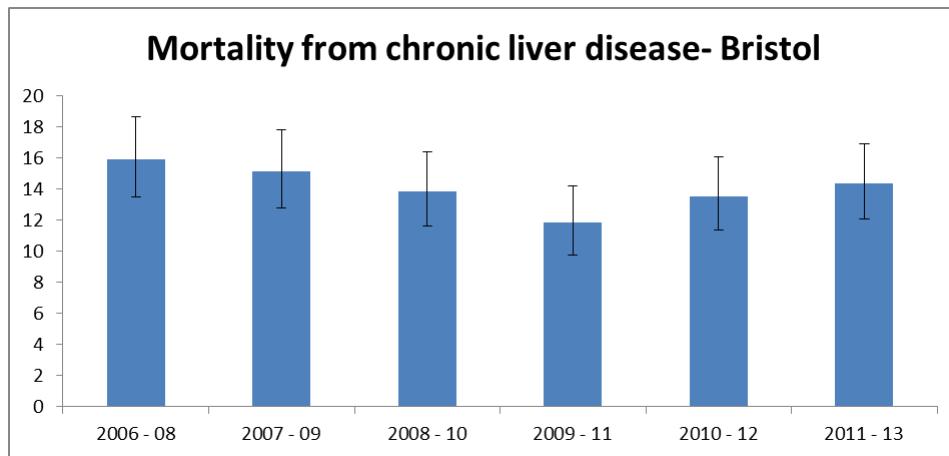


	Males- Bristol	Males - England	Females - Bristol	Females - England
2008	83.96	69.29	29.54	30.46
Lower and Upper CI	68.83- 101.13	68.11- 70.49	21.77- 38.57	29.78-31.15
2013	83.53	65.43	30.7	28.42
Lower and Upper CI	69.33- 99.05	64.35- 66.51	22.83-39.8	27.78-29.07

Mortality from chronic liver disease in England has fallen from 12.59 deaths per 100,000 population in 2006-08 (lower and upper 12.41-12.78) to 11.72 deaths per 100,000 in 2011-13 (lower and upper CI 11.55-11.90).

Bristol deaths from chronic liver disease were 15.91(lower and upper CI 13.47-18.66) to 14.36 (lower and upper CI 12.1-16.92) per 100,000 population between 2006-08 and 2011-13

**Chart 5.20 Alcohol Mortality from Chronic Liver Disease Bristol**



The Public Health Outcome Framework (PHOF) indicators for alcohol show Bristol residents experience a higher degree of harm resulting in hospital admissions compared to the national average:

- Admissions for alcohol-related conditions – narrow (persons)- Bristol 774 admissions per 100,000 population (England 645/100,000)
- Admissions for alcohol-related conditions – narrow (male) Bristol 1036 admissions per 100,000 population (England 835/100,000)
- Admissions for alcohol-related conditions – narrow (female) 530 admissions per 100,000 population (England 475/100,000)

The North Bristol Trust Alcohol Liaison Service reported 668 referrals in 2015. The majority of referrals were from hospital wards for admitted patients (58.4%) or the emergency department (27.4%) with the remainder coming from other hospital

departments including Emergency Department Assessment Unit (4.5%) and ICE (2.8%).

Of these referrals 516 (77%) were seen by the Alcohol Liaison team and 152 (23%) left the hospital prior to the service engaging with them.

283 presenting illnesses were recorded due to free text being utilised in the recording of each patient's conditions. The recorded conditions include: fall, seizure alcohol withdrawal, pancreatitis, collapse, unwell, abdominal pain, chest pain and overdose.

323 (63%) of admissions were recorded as being due to alcohol, 114 (22%) not due to alcohol and the remaining 79 (15%) for unknown reasons. The following intervention were delivered to patients:

Given Alcohol Service Contact Details	279	35.09%
AA	144	18.11%
Given Controlled Drinking Information	136	17.11%
Given Relapse Prevention	90	11.32%
SMART	62	7.80%
Referral Onward Made	51	6.42%
LIFT	23	2.89%
Given Outpt Appt	10	1.26%
Detox Continued as an Outpatient With Specialist Service or GP	0	0.00%
Other Intervention	0	0.00%
No Interventions Recorded	0	0.00%

Of the 516 clients seen 108 (20.9%) were already in contact with treatment services, 354 (68.6%) had no treatment contact and 54 (10.5%) patients' treatment engagement was unknown. Of the 51 onward referrals made 27 were direct referrals to Bristol ROADS in 2015 with the others being to other local authority/CCG areas.

Due to separate case management systems used within the hospital and community treatment services we are not able to match hospital clients with the treatment referrals to better understand the characteristics of this cohort.

Alcohol was the 2<sup>nd</sup> highest primary drug of clients in contact with the BRI Drug Specialist Team with 13.9% (n=59) of all admissions. Primary alcohol clients accounted for a total of 318 days in a hospital bed (average 4.7).

<b>Admitting condition</b>	<b>No.</b>	<b>%</b>
Abdominal + Gastrointestinal	21	35.6%
Infection/sepsis	8	13.6%
Neurological	7	11.9%
Mental health	4	6.8%
Trauma	4	6.8%
Other	3	5.1%
Circulatory	3	5.1%
Chest conditions	3	5.1%
OD - intentional	2	3.4%
Cardiac	2	3.4%
Cancer	1	1.7%
Injecting injuries	1	1.7%

The LAPE estimates the rate of alcohol consumption against known risk levels in Bristol to be:

Risk Category	Number	%	Local Authority Ranking (out of 332)
Abstainers	57,588	16.01%	85
Lower risk drinkers	259,847	72.24%	269

Increasing risk drinkers	73,019	7.47%	305
Binge drinkers	26,870	26.30%	306

In 2015 2,590 referrals for alcohol related treatment have been received by ROADS. Of the 1,139 people who attended for an assessment, the following proportions of risk groups have been identified by treatment workers:

Risk Group	Audit Score	No. of Clients	%
Abstinent/Low risk	0 to 7	24	2.10%
Harmful	8 to 15	84	7.40%
Hazardous	16 to 19	103	9.00%
Dependent	20+	928	81.50%
TOTAL		1139	

The AUDIT scores for assessed clients indicate the vast majority of clients accessing ROADS for treatment are drinking at dependent levels and possibly in need of an assisted alcohol withdrawal. This is further evidenced by the subsequent assessment of 824 individuals who undertook a follow-up SADQ in 2015:

Risk Group	SADQ Score	No. of Clients	%
Mild dependence	0 to 15	174	21.10%
Moderate dependence	16 TO 30	267	32.40%
Severe dependence	31+	383	46.50%
TOTAL		824	

NICE Clinical Guidance 115 (Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence) categorises the following pathways based on SADQ scores:

- *People with mild dependence (those scoring 15 or less on the Severity of Alcohol Dependence Questionnaire; SADQ) usually do not need assisted alcohol withdrawal.*
- *People with moderate dependence (with a SADQ score of between 15 and 30) usually need assisted alcohol withdrawal, which can typically be managed in a community setting unless there are other risks.*
- *People who are severely alcohol dependent (with a SADQ score of more than 30) will need assisted alcohol withdrawal, typically in an inpatient or residential setting.*

As such, 383 of all physically dependent drinkers were assessed as having severe needs which should typically be dealt with by an intensive treatment intervention. A further 267 dependent drinkers were identified as being in need of a community based medically assisted withdrawal.

The Bristol Health Needs Assessment<sup>27</sup> – Homelessness, jointly produced by NHS England and Public Health Bristol, identified a significant level of harm suffered by street drinkers:

*Street drinkers are often, though not always, homeless. As dependent drinkers, they would feel physically and mentally uncomfortable without a small supply of alcohol.*

*A review of the service between September 2013 and March 2014 showed that there were 22 sessions held at each venue during this time. There were 307 client contacts, and a total of 112 clients seen. 47 of the clients seen at the Compass Centre and 5 at the Wild Goose café were rough sleeping. During this time 35 patients were referred for detoxification. Details of other referrals that were made are in appendix.*

#### *Health conditions*

*Earlier data from an evaluation of the wet clinic in 2010-2011 (Porter 2011) shows the conditions that were treated over a year. The most common conditions were related to malnutrition/thiamine treatment, alcohol*

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<sup>27</sup> Bristol Health Needs Assessment (2015)

*dependency, diseases of the gastrointestinal tract, and those related to external causes such as injury or poisoning.*

[Bristol Health Needs Assessment – Homelessness, NHS England, Sub Region, South West, Public Health Bristol 2016]

### **What services/assets do we have to meet and prevent this need?**

#### **Drug Related Death**

Opiate Substitution Therapy remains the first line intervention to reduce and prevent drug related deaths. ROADS Primary care based shared-care and specialist prescribing services are able to offer methadone and buprenorphine prescribing, with an average wait for a prescription of just 5 days. 2007 opiate users were referred into ROADS in 2015.

However, the ROADS commissioning process resulted in a reduction in the number of shared care workers operating in Primary Care (approx. 33%) limiting the support available.

Efforts to increase the number of shared care clients accessing secondary psychosocial interventions have not resulted in increased uptake and this remains a primary focus of strategic planning along with increasing resources aimed at those with the most risk factors through segmentation of the client population.

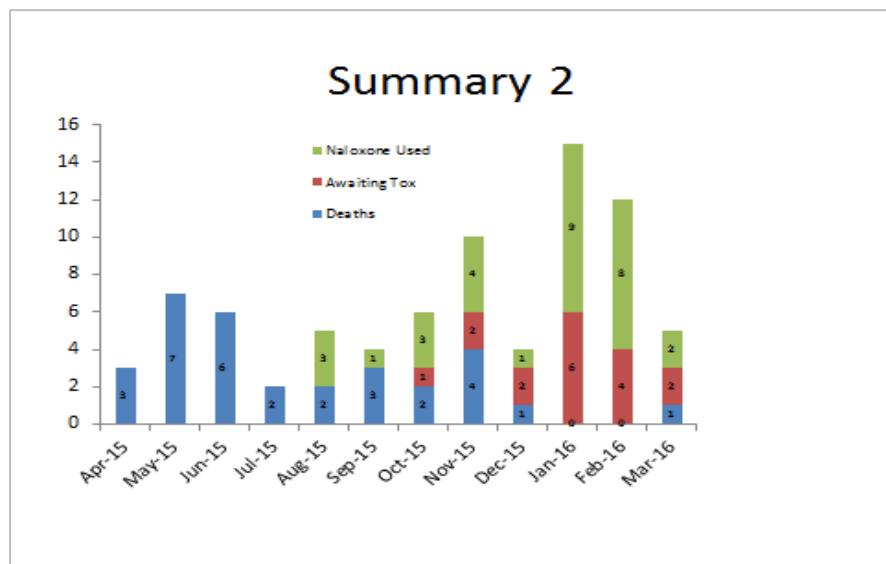
ROADS assertive engagement and assessment teams continue to engage with current drug users to offer harm reduction information & advice, pathways to treatment as well as liaison with partners working with high risk clients (e.g. homeless hostels)

#### Naloxone supply

Since July 2015 540 events have been recorded on Theseus for 355 unique clients (clients may have been supplied more than one dose and/or had replacement doses due to packs being lost).

In the same time period 31 events for 25 unique clients have been recorded for naloxone having been used for the purposes of saving a life. This indicates that drug related deaths may have been significantly higher in 2015/16 had the supply of naloxone not been available.

**Chart 5.21 Bristol drug related deaths and naloxone used**



#### BRI Drug Specialist team

A specialist nurse team that ensures that there is continuity of care for people who require drug treatment services whilst they are in hospital.

#### Compass Health

Compass Health provides confidential healthcare, advice and support for homeless people in Bristol. As well as providing primary health care, the supervised methadone and resettlement team (SMART) run a prescribing service for clients who are homeless and opiate dependent. The Health Link team provide specialist advice, guidance and support to clients with long term and severe health problems.

## **Physical health**

Commissioned services plus activity

Shared Care services are delivered in 45 of the city's 54 GP practices in order to allow for accessible pathways between treatment for opiate dependency and healthcare provision. Primary care based alcohol detox provision is delivered from 23 of the city's GP practices.

The specialist element of ROADS, provided by Bristol Specialist Drug and Alcohol Service (BSDAS), delivers treatment to service users with severe or complex substance use, including physical health problems.

The Drug Specialist Team based in the Bristol Royal Infirmary (BRI) operate to provide expert support to people admitted to hospital who also are known to be problematic drug and/or alcohol users.

Bristol Maternity Drug Service currently provides specialist maternity service to women and their families/significant others with problematic substance misuse in order to minimise harm to the mother and baby. 89 pregnant women (51 at St Michaels hospital and 38 at Southmead hospital) and 9 partners were supported in 2015/16.

61% (n=31) of St Michaels, and 45% (n=17) of Southmead expectant mothers were heroin and crack users whose substance use posed a significant risk to the health of the unborn child.

## **Injecting drug use**

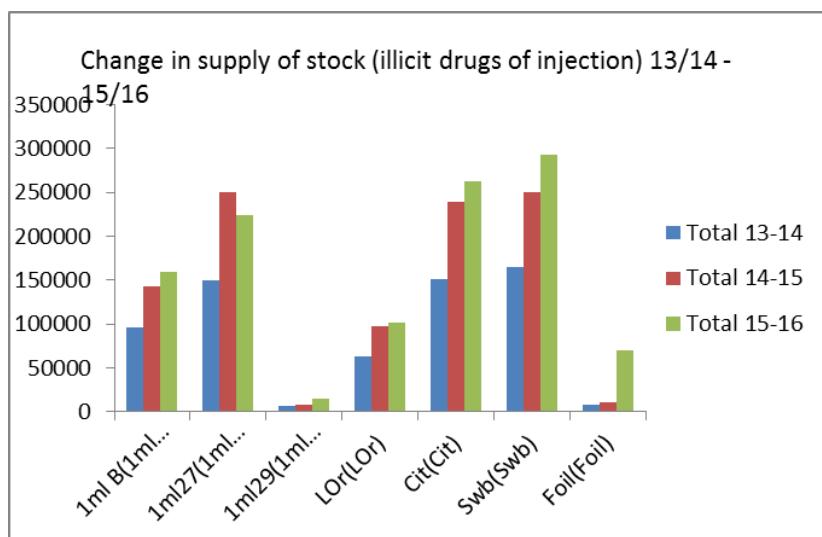
Commissioned services plus activity

NSP

1,003,957 syringes were distributed through BDP and pharmacy needle exchanges in 2015. 92% of all distributed injecting equipment was supplied for the injection of an illicit drug and 8% for an IPED.

BDP needle and syringe distribution has grown by 70% since 2013/14 due to a greater focus on increasing the coverage rate (i.e. the percentage of injections of illicit drugs for which a new needle and syringe has been provided) for individual injectors of illicit drugs

### Chart 5.22 Changes in NSP supply stock

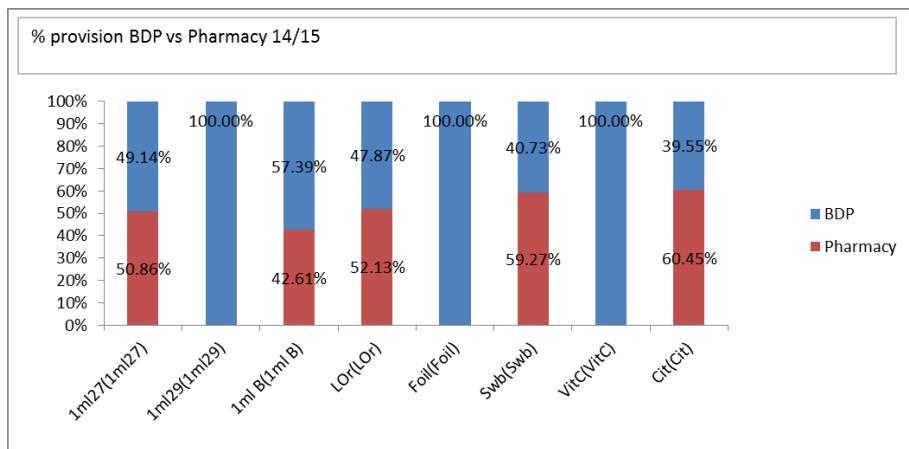


The coverage rate stands at 66% for 2015/16<sup>28</sup> indicating that:

- There is a new syringe available for 1 out of every 1.51 injections;
- Injectors have, on average, 0.64 syringes per day; and
- The average syringe is used 2 times.

### Chart 5.22 % provision BDP vs Pharmacy NSP stock

<sup>28</sup> Harm Reduction Works Needle and Syringe Coverage Calculator (2010)



## Dry Blood Spot Testing

Testing for HCV and HBV is available for all clients who are identified as at-risk of blood-borne viruses. PHE recognises that testing for HCV in Bristol is amongst the best in England:

### Chart 5.22 Clients with no record of a HCV test as a proportion of all clients in treatment and the end of the reporting period who were eligible to receive one

2.7 Clients with no record of a HCV test as a proportion of all clients in treatment at the end of the reporting period who were eligible to receive one

(n) = number of clients who have no recorded HCV test on NDTMS / all clients in treatment at the end of the reporting period previously or currently injecting who were eligible to be offered a test for HCV

	Latest period		National average
	(%)	(n)	
All clients in treatment	4.1%	52 / 1270	19.2%
New presentations to treatment	6.3%	17 / 272	30.3%

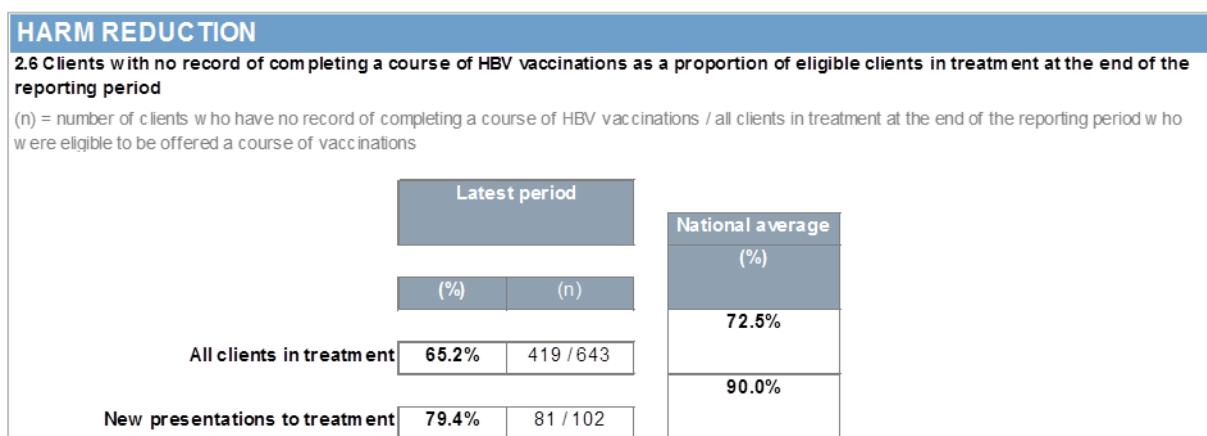
Public Health Bristol are currently undertaking a review of the HCV treatment pathway to develop a clear and transparent route to treatment is available for all client testing positive for chronic infection of the virus and ensure resources are directed at those most in need of the new medications available to cure the disease.

Improving the HBV vaccination rate in Bristol for at-risk clients remains a strategic priority. Whilst performance is significantly above the national average<sup>29</sup>, a lack of opportunistic availability of vaccine across the treatment system and primary care

<sup>29</sup> Diagnostic Outcome Monitoring Executive Summary Q4 (2015/16)

reduces the likelihood of people who inject drugs receiving a course of HBV vaccine and risks increasing the potential size of an infected population if a HBV outbreak occurred, as has previously happened in Bristol.

### **Chart 5.23 Clients with no record of completing a course of HBV vaccinations as a proportion of eligible clients in treatment at the end of the reporting period**



Engagement Assessment

Shared Care

Other assets in the community

**Alcohol harm and mortality**

Commissioned services plus activity

ROADS alcohol detox (community and inpatient)

Detox support for clients undergoing a GP led detox is available. Group work and key working sessions are offered to client to support them before, during and after a medically assisted withdrawal from alcohol. Pathways to relapse prevention, 12 step group work and training, education, volunteering & employment opportunities are offered to clients to build recovery.

In 2015 there were 29 inpatient detoxes for 29 clients scoring over 30 on SADQ as well as 106 detoxes for another 89 clients through Bristol Specialist Drug and Alcohol Service's specialist community alcohol detox (intensive, medic-led, community detox).

There were also an additional 37 inpatient detoxes for 36 clients, and 96 specialist community alcohol detoxes for 83 clients, who scored below the SADQ threshold, although who may have had significant comorbid conditions (such as mental health needs) that warranted an inpatient/specialist detox.

Brief Interventions and Controlled Drinking workshops are available to lower risk drinkers (scoring under 20 on Audit and under 16 on SADQ) to lower alcohol consumption and related health harms. In 2015 (add no) clients accessed ROADS services.

Other assets in the community

GP Public Health Alcohol Detox

Alcohol wet clinic

There are two wet clinics in Bristol that run a weekly drop-in service at Compass Health and at the Wild Goose Café. These are funded by Bristol City Council Public Health.

The wet clinics are staffed by a GP and a nurse and are supported by agencies including Outreach, Streetwise and Wellbeing Service. They provide general medical care, detox planning and referral, and vitamins including injectable forms when required. They can also offer support with housing and benefits and signposting towards other agencies.

### **What do staff/users/carers think?**

#### *Summarise views*

The physical health snapshot from March 2016 of Shared Care and Housing clients asked the practitioners to comment on the difficulties they have encountered in providing their services with regard to the support clients require, with two main themes emerging from the responses received.

The first theme indicated by practitioners across both services was that the structures for healthcare and treatment are not flexible enough to encourage meaningful engagement with the clients. This included:

- Not having the same GP each time- no one gets to know the client
- Appointments not being long enough, nor frequent enough, to meet the clients needs
- Long waits at surgery put off clients from attending
- Appointment times not taking into consideration lifestyle, e.g. early morning slots
- Hospitals communicating with clients by letter and not including the GP

The second theme to emerge was that of clients' health and lifestyle affecting a client's ability to engage with the healthcare offered. This included:

- Clients being too chaotic to make appointments made
- Struggling to attend specialist appointments, e.g: hospital appointments, due to transport reasons. One client had an appointment where she had to take 3 buses' to attend.
- Cancellations from clients who are particularly unwell (renal failure, daily epileptic fits and osteoporosis)

The combination of an inflexible system and a client group with a compromised ability to engage raises concerns over the potential for the most complex clients falling through the gaps of the safety net provided.

Consultation with the IF group and residents of ARA Housing Support accommodation also identified that the structures of support and chaotic lifestyles affected their ability to engage:

- After assessment people don't ask about physical health needs
- Wanted to see the same GP rather than different ones each time. Fed up of having to tell my story each time.
- Looking for reasons to kick people off waiting lists.
- Shared care workers are too busy and are flat out. Clients are presenting with a lot of chaos. Caseloads are too big and time with clients is too short.

Pain management was another theme to emerge from the snapshot survey with practitioners indicating that clients with chronic health needs whilst accessing OST:

- No structured pain management or a clear referral pathway
- Clients can feel seeing a drug worker is pointless while they have unresolved

pain issues

- Some clients on OST may have sub optimal pain relief, as their pain issues may not been taken as seriously, or their seeking appropriate pain relief dismissed as drug seeking behaviour

## **What are the projected needs for the future?**

### **Drug Related Deaths**

With opiate and crack use remaining stable in the city drug related deaths will remain a risk for individuals using the drugs. Whilst the provision of naloxone has stabilised opiate related deaths in Bristol the rate of which naloxone is reported to be being used in overdose situations indicates that the potential for

### **Physical Health – comorbid conditions**

Whilst the national picture is of a reducing opiate and crack using population this cohort has remained stable in Bristol and has an estimated rate of 18.0 OCUs per 1,000 population, over twice the national average of 8.4<sup>30</sup>.

Injecting drug use remains significantly more prevalent in Bristol and the Southwest than the rest of England<sup>31</sup>.

As such it is expected that comorbid physical health conditions will remain at the current level or increase due to the aging profile of the heroin and crack using population.

### **Injecting Drug Use**

Injecting drug use remains significantly more prevalent in Bristol and the Southwest than the rest of England, with 69% of clients accessing ROADS for drug treatment in 2015 reporting being current or previous injectors.

### **Blood Borne Viruses**

HCV prevalence remains high, as does injecting drug use. Previous research (include ref to MH paper) has indicated that the only way of lowering prevalence is through increasing access to treatment (which is currently low). Whilst the incidence rate was evidenced in 2012 to have fallen by 75% it is still deemed high enough to sustain current prevalence without significantly upping the numbers of clients being successfully treated.

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<sup>30</sup> Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use (2012)

<sup>31</sup> Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use (2012)

HBV vaccination coverage remains high among PWID with ~50% vaccinated.

Chronic HBV infection is rare and

### **Alcohol harm and mortality**

Bristol has higher than the national average alcohol related harm as well as higher alcohol specific, and related, mortality. The prevalence of alcohol use, particularly at the higher levels of risk, within the city indicates that this need is unlikely to reduce within the timescale of the new contracts and is likely to grow with the city's population.

### **What are the unmet needs?**

#### **Drug Related Deaths**

External and internal factors to ROADS remain a negative influence over drug related deaths and the trend seen in 2015/16 is expected to continue. An increase in competition within the Bristol drug market due to new organised criminal gangs seeking to gain a market share have introduced purer heroin, albeit at a higher price, onto the streets and the changes in using patterns, particularly pregabalin and Spice, are thought to contribute to the increase in deaths.

Sub-optimal doses of clinical and therapeutic treatment, coupled with less frequent appointments and more clients choosing to disengage with treatment, indicate that fewer protective measures to prevent drug related deaths are available within ROADS to reverse these trends and highlight a need to refocus opioid substitution therapy more in line with established guidance.

#### **Physical Health – comorbid conditions**

More information is needed to be gathered to investigate the impact of comorbid conditions on recovery and mortality rates, particularly hepatitis C and respiratory problems. The snap shot of physical health conditions in Shared Care and Housing Support has demonstrated a wide range of comorbid conditions affecting the health and recovery of clients

#### **Injecting Drug Use**

A significant number of injecting drug users accessing the specialist and mobile NSP do not disclose their injecting status to their Shared Care worker. In March 2016 there were 148 clients obtaining injecting equipment but disclosing no injecting on their current TOP. Between 01/04/15 and 31/03/16 only 170 clients in treatment

disclosed injecting so this signifies a significant unmet need within the current treatment system as potentially beneficial interventions are not being targeted to the right clients.

### **Blood Borne Viruses**

Access to Hep C treatment for clients remains low and the HCV treatment pathway needs to be reviewed.

Uptake of HBV vaccines remains low and has been identified by PHE as a strategic priority

### **Alcohol harm and mortality**

Current levels of detox are significantly below the NICE recommended capacity of 15% of the dependent drinking population per year. A lack of capacity within Primary Care and specialist services (including inpatient detox for the severely dependent) has led to a lack of availability for medically assisted withdrawal.

Alcohol referrals currently account for 50% of all referrals into treatment each month

## **6. Mental Health**

### **What is the level of need?**

The 2014 “Projecting Adult Needs and Service Information”<sup>32</sup> 16 estimated that 46,600 adults in Bristol had a “common mental health disorder” (19.7% of women and 12.5% of men). This estimate includes people not requiring GP treatment, as well as those that do.

The 2012 Mental Health Needs Assessment for Adults in Bristol<sup>33</sup> estimated that 29,000 adults were expected to have common mental health disorders requiring treatment. GP data indicates that over 23,600 Bristol patients (6.2% of patients, all ages) are registered as having had depression (since 2006), higher than the 5.8% England average (QOF, 2012-13). This needs assessment also identified that there was a lower than average rate of mental health referrals via GPs and community mental health teams for BME (Black & Minority Ethnics) people. Whilst conversely BMEs were over 40% more likely than average to be referred to mental health services via the criminal justice pathway.

Almost a third of the 29,000 people expected to have common mental health disorders are likely to have more than one condition, known as co-morbidity (approximately 10,000). This can often mean individuals will suffer from more severe symptoms over a longer duration and have an increased demand on services. Co-morbidity has been found to be most common in both genders for 16-24yr olds and women aged 45-54.

### **Types of mental health problems co-existing with substance misuse**

The term ‘dual diagnosis’ is used in a variety of ways by people working in health and social care in the UK. In the NHS, it usually refers to the occurrence of a mental illness alongside substance misuse. Some studies have used the term to refer to any co-existing mental illness, whereas others have restricted it to ‘severe’ mental illness. The latter usually includes schizophrenia, bipolar affective disorder and personality disorders and severe depression<sup>1</sup>.

The most common associations for substance misuse are with depression, anxiety and schizophrenia, but eating disorders, post-traumatic stress, attention deficit,

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<sup>32</sup> Projecting Adult Service Needs and Service Information (2016)

<sup>33</sup> Mental Health Needs Assessment (2012)

hyperactivity and memory disorders also occur. Mental health problems associated with alcohol include bipolar disorders, schizophrenia, and personality disorders. Furthermore impairments on the brain as a result of a thiamine deficiency on long term dependent drinkers can lead to the development serious brain deficiencies such as Wernicke–Korsakoff syndrome. Symptoms of this include mental confusion, paralysis of the nerves and difficulty with muscle coordination that severely affect the users mental cognition.

Estimates of prevalence of dual diagnosis are difficult to come by at both a local and national level because various studies have used different diagnostic criteria.

Therefore prevalence and incidence rates for substance misuse coexisting with mental health problems in the published literature vary widely.

A study on mental health centres and substance misuse services in the UK, showed that 75% of drug service users and 85% of alcohol service users had mental health problems, mostly affective disorders and anxiety disorders. Approximately 33% of the drug treatment population and 50% of the alcohol treatment population also had multiple morbidity, i.e. the co-occurrence of several psychiatric disorders or substance misuse disorders.

There are established links between substance misuse and childhood/early life trauma. This has been attributed to individuals attempting to self-medicate and medically dissociate themselves from painful memories. Research conducted in Cornwall (B. Charnaud, V. Griffiths, 2000) found that of a 111 randomly selected clients seen in substance misuse treatment, 46% of males and 73% of females reported childhood abuse to a degree that would have placed them on the at-risk register. Child sexual abuse was reported by 1.85% of males and 43% of females. This provides evidence that there is a high incidence of early life trauma and abuse in the substance misusing population.

Links have also been identified between the risk of suicide and substance misuse. The “National confidential enquiry into suicide and homicide by people with mental illness”<sup>34</sup> found that suicides among patients with a history of alcohol or drug misuse (or both) accounted for 54% of the total sample, an average of 671 deaths per year (PHE Scope).

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<sup>34</sup> National confidential enquiry into suicide and homicide by people with mental illness (2016)

In ‘Reducing social isolation across the life course’<sup>35</sup> they identified that inadequate social networks may contribute to both causes and consequences of substance misuse by straining social support relationships leading to social isolation. Social isolation was addressed as a priority in the Bristol Health & Wellbeing Strategy<sup>36</sup>, with a particular focus on reducing social isolation among older people. There is a need to address this given both the diminished social networks among some substance misusers as well as an increasingly older cohort of clients accessing substance misuse treatment.

*For the purpose of this document, dual diagnosis is used henceforth to describe clients with both substance misuse and mental health needs regardless of any clinical assessments.*

### **National Dataset for Substance Misuse and Mental Health**

The co-existing substance misuse and mental health issues website by Public Health England<sup>37</sup> profiling tool collates and analyses data in relation to both substance misuse and mental health at a national, regional, and local level.

The latest figures from 2014/15, highlight that a higher percentage of people have concurrent contact with mental health services and substance misuse services for drug misuse at both a national (21%) and regional (19.7%) level than at a local one (15.5%). When comparing this to the core cities, Bristol is second lowest behind Nottingham.

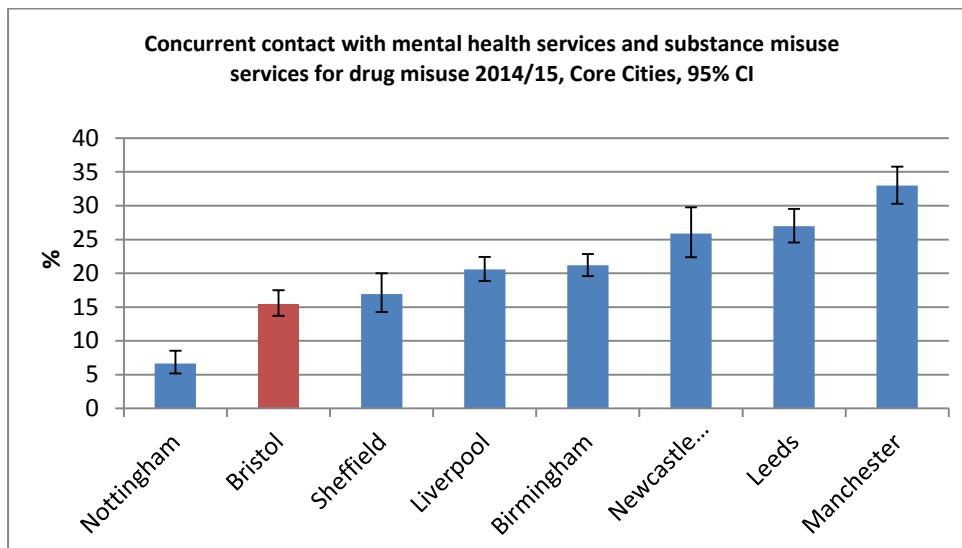
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<sup>35</sup> Reducing social isolation across the life course (2016)

<sup>36</sup> Bristol Health & Wellbeing Strategy (2013)

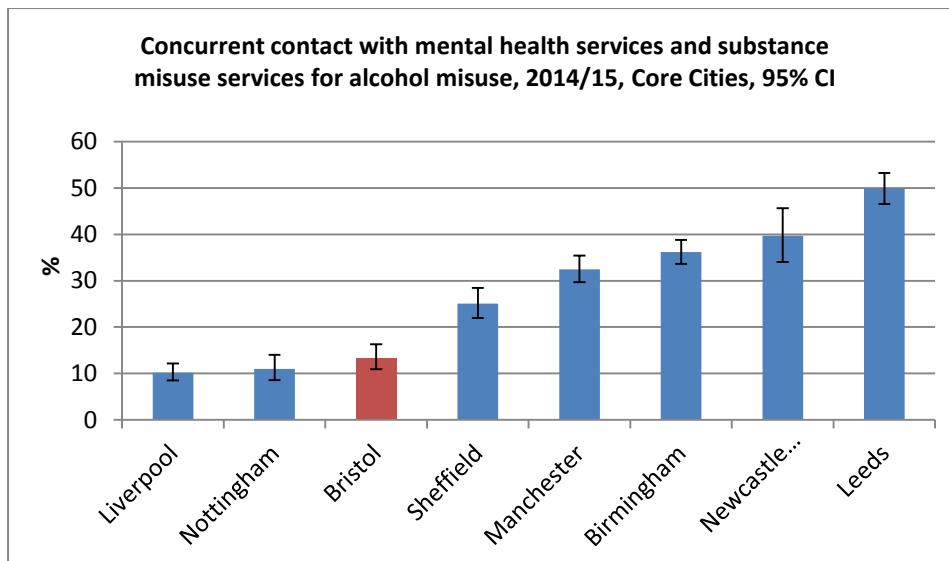
<sup>37</sup> Co-existing Substance Misuse and Mental Health Issues Profiling Tool (2016)

### **Chart 6.1 Concurrent contact with mental health services and substance misuse services for drug misuse (2014/15)**



This trend is repeated for the same indicator for alcohol clients, with national (20%) and regional (18.3%) figures being higher than Bristol (13.4%). See below.

### **Chart 6.2 Concurrent contact with mental health services and substance misuse services for alcohol misuse (2014/15)**



However caution should be applied here when interpreting this data. This may not necessarily reflect a lower need for clients to be in both substance misuse and mental health services concurrently, but instead could indicate a difficulty with accessing these services in Bristol as has been indicated by some stakeholders anecdotally. Alternatively this could highlight how services have been commissioned differently in other areas (e.g. mental health and substance misuse services being co-located compared to two different services in Bristol.)

### **Need from Hospital Admissions**

An analysis was completed on the number of patients admitted to the BRI hospital with the diagnosis of “mental and behavioural disorders due to use of drugs and noxious substances”<sup>38</sup> (inclusion of one of these ICD10 codes: F11, F12, F13, F14, F15, F16, F18, F19 in any diagnosis field) recorded between 2013-2015.

<b>Sex</b>	<b>2013</b>	<b>2013 Rate per 100,000</b>	<b>201</b>	<b>2014 Rate per 100,000</b>	<b>2015</b>	<b>2015 Rate per 100,000</b>
Male	511	233.9	694	314.1	816	369.4
Female	240	109.6	311	140.4	368	166.1
Total	751	171.7	100 5	227.1	1184	267.6

This analysis indicates an increasing trend year on year of patients being admitted with this diagnosis for both male and females in Bristol. Further information was provided by the BRI for admissions to the Emergency Department for self-harm or suicide attempts where drugs and/or alcohol were involved. This totalled 99 clients in 2015.

The Bristol Suicide Prevention Strategy (2015)<sup>39</sup> reported that between 2012 and 2014 a mixture of drugs (29.6%) and opioids (25.9%) were the most frequent to be taken in fatal overdoses.

<sup>38</sup> Mental and Behavioural Disorders due to the use of Drugs and Noxious Substances (2013 – 2015)

<sup>39</sup> The Bristol Prevention Suicide Strategy (2014-2017)

### **Need from criminal justice pathways**

Information provided over a 6 month period (August 2015 – February 15) by the Arrest Intervention & Referral Service (AIRS) (custody based service assessing and referring clients to community provision) detailed that of the 53 clients that were identified as having ‘additional support needs for mental health intervention’, 38 of these also underwent a full substance misuse assessment. This equates to 12.2% of the overall total seen in this period (n=434) for mental health and 8.7% for dual diagnosis.

Data provided by the mental health service in HMP Bristol indicated that 54% of prisoners in 2015/16 referred to their service had a current (37%, n=1202) or past (17%, n=564) substance misuse need.

### **Need from substance misuse services**

Based on triages for the ROADS substance misuse services in 2015, 14% (533/3720) were recorded as dual diagnosis. Caution must be taken with this figure however as there are concerns regarding the consistency of when this field is completed across the commissioned services.

Based on the risk screening of clients in substance misuse treatment in 2015 (currently only completed by the community provider of Change, the majority of which would be in the GP Liaison Service), 34% (1050/3115) of clients reported having a current or past serious mental health problem. 53% (1640/3115) of clients had expressed having previous or current suicidal ideations. When considering lower level mental health problems, 88% (2730/3115) of clients in substance misuse treatment reported having feelings of hopelessness and helplessness currently or in the past.

### **Need from mental health services**

Bristol Mental Health services currently record the use of drug and alcohol use through an initial form of ‘Substance Alcohol Use Form’. In 2015 2,859 of these forms were completed. If a specific need is identified through this initial triage a further form titled ‘Problematic Substance Alcohol Form’ is completed. In 2015 534 of these forms were completed.

These forms however contain very little quantitative data to inform this needs assessment. The absence of this quantitative monitoring is currently being reviewed which will help to inform future needs assessments in relation to dual diagnosis.

### **What services/assets do we have to meet and prevent this need?**

#### **ROADS**

Recovery Orientated Alcohol & Drugs Service (ROADS) was commissioned in November 2013. There was a clear expectation of the providers to create strong pathways with mental health services outlined in the service specifications. The specification recognised that some service users would present with needs that would require more immediate attention than others and therefore serious health needs in relation to mental health would be prioritised for accessing treatment.

#### **ROADS Engagement**

All referral routes into ROADS are recorded locally by the Engagement contract prior to a client accessing a triage, comprehensive assessment and/or recovery planning. The table below details all mental health related referrals from a range of services in to ROADS in 2015.

Referral Source	January	February	March	April	May	June	July	August	September	October	November	December	2015 Total
Lift Psychology							1	1			9	9	20
MH Services	11	8	14	15	5	10	9	15	17	21	15	8	148
Psychiatry services				1									1
Psychological Services	5	7	2	2							1		17
Wellbeing	1	2	2				1				3		9
Total	17	17	18	18	5	10	11	16	17	22	27	17	195

During 2015 there were a total of 5068 referrals made to ROADS. Referrals from mental health sources therefore only represent 4% (n=195) of the total of all referrals

in 2015. It is important to note however that 47% of referrals originated from GPs. It is unclear what proportion of these referrals would have been made to ROADS to address the needs of dual diagnosis clients. Based on overall prevalence figures and anecdotal reports it is likely that a significant proportion of these referrals would be for this cohort.

### ROADS Change

The ‘Specialist Treatment Provision’ components of the Change contract within ROADS delivers high level consultant led treatment for service users with severe or complex substance use, including those with mental health problems. They also provide clinical leadership and advice to the ‘GP substance misuse liaison’ service component of this contract. This contract is required to provide a range of evidence-based psychological interventions for coexisting mental health problems. In 2015, 899 unique clients had a ‘Specialist Psychosocial Intervention’ in Change. However it should be noted that not all of these clients would have been seen in this service due to their mental health needs alongside their substance misuse (e.g. a client’s complexity may be high due to other factors such as physical health problems). A small cohort of clients (n=15) who have Post-Traumatic Stress Disorder (PTSD) have accessed either the “Trauma and substance misuse” group (This treatment lasts 24 - 27 sessions over a 6 month period) in 2015. Whilst 12 women have accessed the Women Only DBT (Dialectic Behaviour Therapy) groups (delivered over a 12 month period) which is aimed at those who have borderline personality disorders.

Through NDMTS sub-intervention reporting, 139 clients were recorded as having an evidence-based psychological intervention for co-existing mental health problems in 2015.

90 clients were recorded as having a Community Care Assessment for access to residential rehabilitation through this contract in 2015. Although no quantitative data is collected for clients accessing residential rehabilitation in relation to mental health, given that this intervention is delivered to those ‘who have significant co-morbid physical, mental health and social problems’ it is highly likely that most, if not all,

would be experiencing some form of mental ill health in order to access this intervention.

A large proportion of clients in ROADS access the ‘GP Substance Misuse Liaison’ element of the Change contract (approximately 2000 clients on caseload at any one time). This component of the contract delivers opiate substitution therapy across Bristol in partnership with GPs and pharmacies. As identified in the earlier section, a number of clients have recorded mental health needs via risk assessments in this service. Further analysis to identify the need of dual diagnosis for this cohort was also completed on prescribing regimes in relation to this. This analysed what mental health related prescribing took place in primary care alongside OST (those on methadone or buprenorphine) prescribing in 2015:

<b>Prescribing Regime</b>	<b>Number of clients prescribed</b>	<b>% of Bristol population</b>	<b>Number of patients prescribed MH related medication alongside OST prescription</b>	<b>% prescribed MH related medication alongside OST prescription</b>
<b>Prescribed methadone/buprenorphine (OST)</b>	2031	0.4%	N/A	N/A
<b>Prescribed antidepressant</b>	46,626	9.8%	954	47%
<b>Prescribed anxiolytic/hypnotic</b>	12,778	3%	514	25.3%
<b>Prescribed antipsychotic</b>	7,258	1.5%	206	10.1%

### **ROADS Best Practice Outcome**

The Change Cluster has the lead responsibility for delivering the system wide outcome of “Improvement in mental and physical health and well-being”. The mental health element is reported by analysing the psychological improvement scores of the TOP forms completed by clients who have accessed ROADS. In 2015, clients self-reported on average, an improvement in their psychological score of 1.5 in their Review TOPs (completed with client between 12 and 26 weeks in treatment) compared to their Start TOPs. The Review score for this indicator is lower locally

(10.8/20) than the national average (12.2/20) which could indicate a higher complexity of clients within ROADS in relation to psychological health.

### **Other assets in the community**

#### Compass Health

Compass Health provides confidential healthcare, advice and support for homeless people in Bristol.

As well as providing primary health care, supervised methadone and resettlement team (SMART) run a supportive prescribing service for clients who are homeless and opiate dependent. The homeless cohort are known to have a high prevalence of dual diagnosis needs.

#### Bristol Mental Health

Bristol Mental Health (BMH) is the mental health system commissioned by the Clinical Commissioning Group (CCG). BMH has a number of lead and partnership organisations delivering primary care (Improving Access to Psychological Therapies (IAPT) service) and a range of secondary care services (Assessment and Recovery Service, Crisis Service, Early Intervention in Psychosis, Complex Psychological Interventions etc) across 6 Lots.

As already identified there is little formal monitoring in most Bristol Mental Health services regarding levels of need around substance misuse so it is difficult to currently quantify the level of substance misusers accessing these services. One of the Lots from the Bristol Mental Health Service is the Assertive Contact & Engagement (ACE) service that is particularly pertinent for dual diagnosis. This service was set up to support people who find it difficult to access mainstream mental health services for a variety of reasons or who are under-represented within those services, this includes street drinkers or people who take drugs or drink problematically. During the first 6 months of 2015/16 the ACE service received approximately 300 referrals, of which 85 had a substance misuse need identified as part of their referral.

#### The Golden Key

The Golden Key is a strategic partnership programme in Bristol funded by the National Lottery. This partnership was set up to support individuals who faced significant blocks and barriers to accessing effective support and/or who are unable to engage effectively with services that are currently available to them. Eligibility for clients to be opened in this service requires clients to have significant or extreme needs in at least three of the following areas: Substance Misuse, Homelessness, Mental Health and Offending.

98 clients were opened in Golden Key in 2015 of which all were identified as being 'dual diagnosis'. These clients as presented as poly substance users with a range of mental health needs, including anxiety, depression, psychosis, OCD, agitation and emotional instability.

#### Nilaari

Nilaari is a community based organisation providing culturally appropriate services primarily to BME adults with complex needs. This service works with those at risk of re-offending, those with problematic substance misuse as well as those experiencing mental health issues.

#### Social Prescribing

Social prescribing is a way of linking patients in primary care with sources of support within the community. It provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and well-being.

A number of social prescribing projects have emerged in Bristol over the past few years, including Pathways to Health and Branching Out. These projects adopt a holistic approach to improving health and wellbeing and have been designed to support primary care provision. As well as other health related issues, this work has focussed on supporting those with low level mental health needs. No work in Bristol is currently taking place under the social prescribing banner for substance misusers. Given the number of clients in primary care accessing substance misuse services this is an area for further development.

#### **What do staff/users/carers think?**

Meeting with Dr Ben Watson, Consultant Addiction Psychiatrist, Bristol Specialist Drug & Alcohol Service, AWP

- Assessing the need

Held the view that the prevalence of the co-occurrence of substance misuse and mental health problems (with varying degrees of severity) are huge across the treatment system. This did not mean that every service user requires a clinical mental health assessment but that most individuals who come in to drug or alcohol treatment have mental health needs that require support.

- Meeting the needs across Bristol

This is challenging given the current level of need. In terms of mild to moderate mental health problems, GPs are usually able to manage a patient's mental health in the community. Sometimes an assessment is needed e.g. for diagnostic clarity, however the majority of cases are manageable with GP advice and support available from the consultants in BSDAS. BSDAS consultants also provide weekly support to Shared Care workers to assist them with the management of their clients.

Clients with severe mental health needs require a clinical mental health assessment and a 'Care Programme Approach' (CPA) level of support from secondary mental health services. Due to difficulties encountered in accessing secondary mental health services, GPs or shared care workers sometimes refer clients with severe mental health needs to BSDAS for support. CPA level support is not available via BSDAS but instead needs to be provided by secondary mental health services within Bristol alongside support from ROADS in relation to their substance misuse.

He advocated a liaison style approach from BSDAS to support primary care and secondary mental health services rather than BSDAS being viewed as a community mental health team for people who are misusing substances. This a more pragmatic approach that allows BSDAS to advise, support and educate professionals to manage clients with complex needs. Some real progress has been made with both shared care workers and GPs in this area over the past year.

## Meeting with Richard Edwards, Consultant Nurse for Dual Diagnosis, AWP

- Assessing the need

From a national perspective, there is evidence to suggest that a third of clients in mental health services are problematic drug and alcohol users. This prevalence was supported at a local level from an internal audit that showed a third of all clients in mental health inpatient units were problematic drug and alcohol users. Further research conducted by AWP found that 26% of 100 clients in mental health services across AWP services were problematic drug and alcohol users.

- Meeting the needs across Bristol

We will continue to raise awareness with practitioners in MH Assessment services for substance misuse (“If they meet the thresholds they need to be offered a service regardless of their drug and alcohol needs”). We also need to consider how we can support the Recovery Teams for dual diagnosis clients (“We need to remain optimistic but also pragmatic about this”) and there would likely be funding implications for this (“I would like to see commitments of allocations from both substance misuse and mental health commissioners going forward”).

He believed that there are opportunities in workforce development that could be built in to future commissioning whereby the skills and competencies of delivering on dual diagnosis could be built in to job descriptions for both drug and alcohol and mental health workers (“This could support a sense of ownership and practitioners being more confident of referral criteria and when to refer”)

There is learning that Mental Health services can take from Drug and Alcohol services, particularly around elements of recovery, such as mutual aid groups.

Moving towards more psychosocial and recovery support interventions could help with capacity issues across both systems.

## Meeting with the IF Group (The Golden Key service user involvement group), 3 IF Group Members present.

The group discussed the multiple barriers experienced when accessing services for their dual diagnosis (Drug and alcohol supported housing doesn't help me with my mental health needs.)

Expressed their frustrations for multiple assessments at different services and requested that services were able to share more information between them so that they are all aware (“Clients don’t want to tell their personal story due to traumatic experiences, I would like it if my story could be saved in a document for workers to read.”)

When assessed as being “complex”, they would like to have a dedicated GP at their surgery who they can create a relationship with and build trust to hold private talks. It’s difficult to do this if you have a different doctor each time you go to the surgery. We need to consider how we can better utilise peers to support us in our recovery from both mental health and substance misuse.

You should consider having more tailored group work programme for dual diagnosis clients.

From ARA Consultation, In Treatment House, Hughengden Road. 8 Residents Present.

General consensus was that there is a need for medium care support, either you are in Crisis or low level CBT you get a service. Do not get adequate feedback following assessment, as to why they do or do not get a service. Scaling assessment (e.g. TOPS) are too subjective and not helpful. Cut off from services when feeling better, difficulty re-engaging with service when leaving, seeing different professionals all the time (including GPs and other MH professionals). Services not joined up and slow long waiting lists. General consensus is that there is not enough support.

### **What are the projected needs for the future?**

The Bristol Mental Health Needs Assessment<sup>40</sup> predicted that people living with mental health conditions are likely to increase in forthcoming years. Given the estimated population increases in both young people and BMEs in Bristol it would suggest that there will be a higher need of dual diagnosis in these cohorts given the higher prevalence of mental health needs identified in these groups. However caution must be applied here because rates of substance misuse vary greatly within these groups (e.g. recent decline in young people using substances, different rates of substance use prevalence between BME groups).

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<sup>40</sup> Bristol Mental Health Needs Assessment (2012)

As already highlighted, the high prevalence of clients in substance misuse services with current or past mental health conditions suggest the need for some levels of mental health support will remain going forward. Furthermore the increase in alcohol clients accessing substance misuse services in ROADS suggests an increase in mental health needs within the services given the higher prevalence rate with this client group (85%).

### **What are the unmet needs?**

-More work is needed to address the gaps in the monitoring of information of dual diagnosis clients in substance misuse and mental health services. Being able to effectively monitor this data will inform future needs assessments and identify gaps in service provision.

-Feedback from both professionals and service users have indicated that there is a gap for 'medium level' mental health support for substance misusers. It has been suggested that if substance misusers are experiencing either a mental health crisis (high level) or require some low level mental health interventions (e.g. IAPT) then they are able to access these levels of services however a gap still exists for clients requiring more structured mental health interventions in substance misuse services.

-Despite the high prevalence of both mental health and substance misuse needs demonstrated in a range of data sources concurrent contact with both mental health and substance misuse services remain relatively low when compared with other core cities.

## 7. Housing

### What is the level of need?

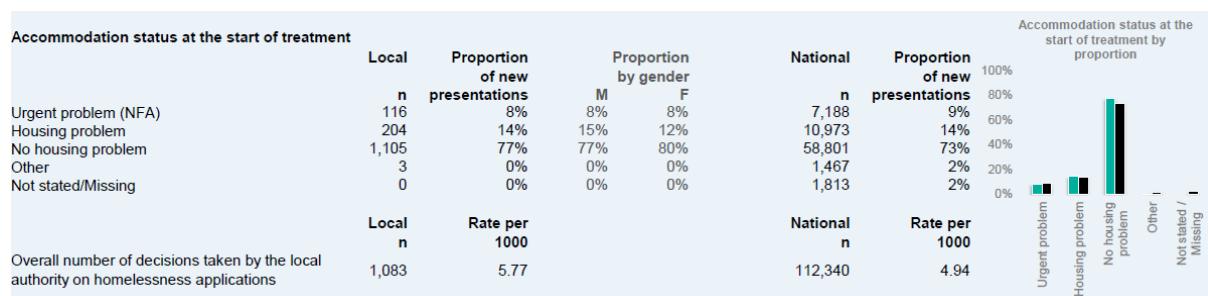
Having somewhere stable to live is a fundamental part of life and can significantly affect health outcomes. According to the Department for Community and Local Government (DCLG) figures, Bristol has seen one of the highest rises in rough sleeping in the country between 2014 and 2015. Of those, an estimated 49% problematically use either drugs or alcohol or both. This is a big increase from the years 2010-12 when the figure was in single digits.

**Chart 7.1 Changes in rough sleeping rates between 2014 and 2015**

Local Authority	Region	2014	2015	Change from 2014	% change on 2014
Westminster	London	265	265	0	0%
Bristol	South West England	41	97	56	137%
Brighton & Hove	South East England	41	78	37	90%
Manchester	North West England	43	70	27	63%
Cornwall	South West England	40	65	25	63%
Brent	London	11	55	44	400%
Luton	East England	33	53	20	61%
Bedford	East England	25	51	26	104%
Croydon	London	30	51	21	70%
City of London	London	50	48	-2	-4%

Using the latest data from The Joint Strategic Needs Assessment<sup>41</sup> by Public Health England, we can see that nearly a quarter of drug users, 23%, have either an urgent or other housing problem at the start of their substance misuse treatment.

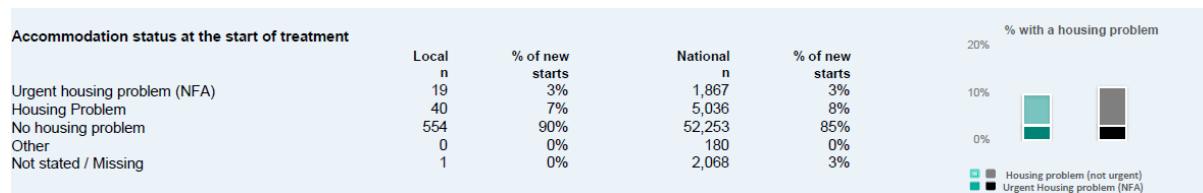
**Chart 7.2 Accommodation at the start of drug treatment**



<sup>41</sup> Joint Strategic Needs Assessment (2015)

Using the same data source for alcohol clients, we can see that there is still a need but that proportionally fewer have either an urgent or other housing problem at the start of their substance misuse treatment.

### Chart 7.2 Accommodation at the start of alcohol treatment



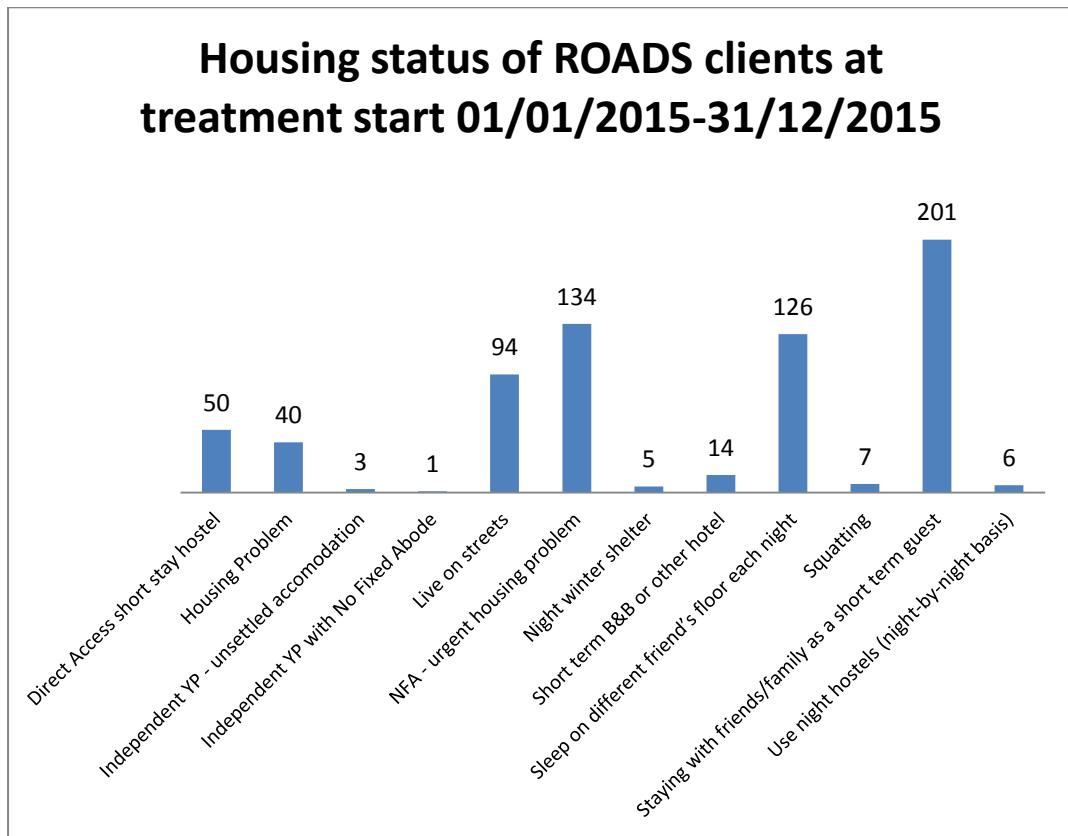
In the local population, more specifically within the drug and alcohol sector, there are consistently high numbers of individuals being assessed for treatment who at time of assessment are either registered as statutory homeless, at risk of homelessness or living in a situation which is detrimental to their recovery. A range of recorded housing status' are able to be noted against a client's record when they access treatment, and a number of these fall into the categories mentioned above and should trigger a referral to appropriate housing services. These status' such as living on streets and squatting are detailed in Table 2.

The table below shows the total number of people triaged for substance misuse treatment between 01/01/2015 and 31/12/2015 and whether or not their housing status was deemed to put their recovery at risk and trigger a referral to Housing Support (HS)

Total triaged	3326
Suitable for HS referral	681
% suitable for referral	20.5

The table below provides more detail on the 681 individual people triaged for substance misuse treatment with ROADS during the period 01/01/2015 and 31/012/2015 whose housing status was deemed detrimental to their recovery.

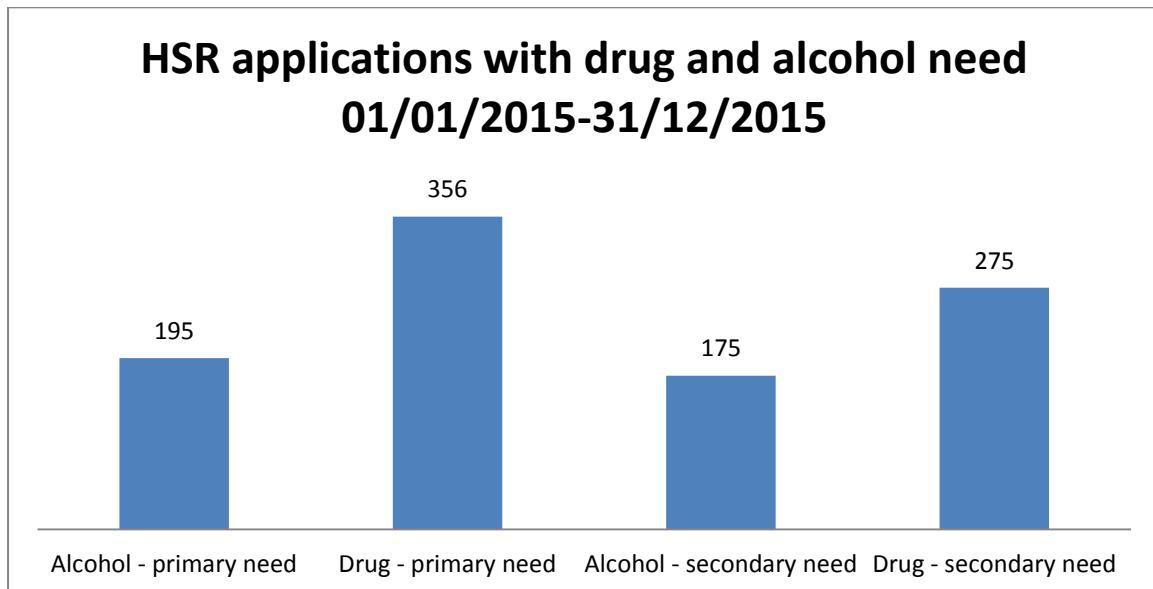
**Chart 7.3 Housing status of clients starting ROADS treatment**



Through the single point of access for all housing applications in Bristol City Council, the HSR, we can see that there is a similarly large group of 1001 individual people who cite alcohol and drug use as a primary and secondary need on their applications.

The chart below provides a breakdown between substances and level of need.

**Chart 7.4 HSR applications with drug and alcohol need in 2015**



Comparing the total figures in Chart 7.3 and 7.4 we can see that there are more people with a drug and/or alcohol need accessing housing directly through the HSR than there are disclosing a housing issue upon assessment with ROADS. There are a number of possible reasons for this:

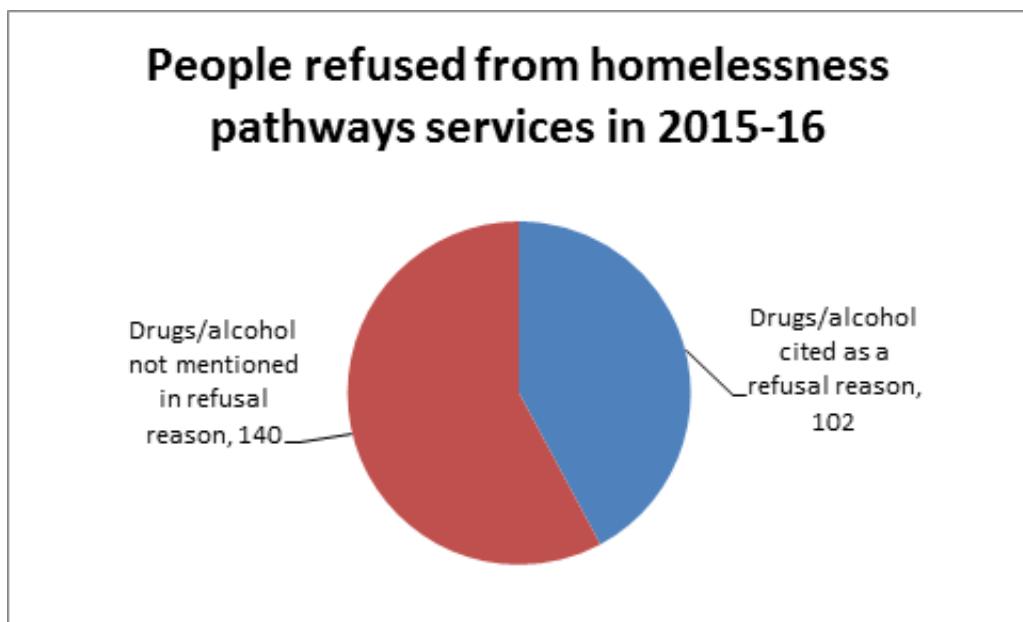
- Their housing situation is more of a priority than tackling their drug and/or alcohol need at that time
- Although they have a drug and/or alcohol need, they do not want to address it
- They were assessed and engaged with ROADS prior to 01/01/15 and their housing status became an issue after that time
- ROADS providers are not always making referrals to HSR when identifying a housing need with a client.

It is interesting to see that the numbers identifying a drug need at either primary or secondary need level accounts for nearly two thirds of all applicants. In ROADS, over the same timeframe, the number of alcohol and alcohol & non-opiate new presentations accounted for nearly half of all referrals with drug only (opiate and non-opiate) representing 52%. There are a number of possible reasons for this:

- Although there has been a considerable shift in the substance use of new presentations over this time period, the numbers of drug users in effective treatment are far greater than those using alcohol. People's housing situation changes during their time in treatment so applicants to the HSR need not necessarily be new presentations.
- People with an alcohol need may have a more stable and appropriate housing status.

Drug and alcohol use, and its associated risks, are also a major factor in refusals for acceptance into the homelessness pathway. In 2015-16 there were 242 refusals from Levels 1,2,3 and 4 of homelessness services because of risk. In the notes explaining why someone was refused, drugs and/or alcohol are mentioned in 102 (42%) of them. The actual number is probably higher because some are simply recorded as 'too high risk' without giving details. In addition, there are lots of refusals that are recorded as 'inappropriate referrals', some of which are considered to be inappropriate because the person's drug and alcohol use is inappropriate for the service.

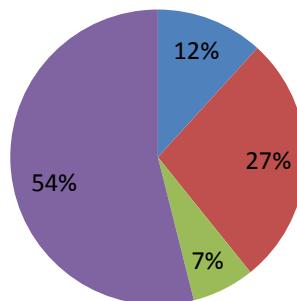
**Chart 7.5 Number of people refused from homelessness pathways due to drugs or alcohol**



**Chart 7.6 Percentage of people refused from homelessness pathways due to drugs or alcohol by housing level**

### **Drugs/Alcohol cited as a refusal reason (N=102) by housing level**

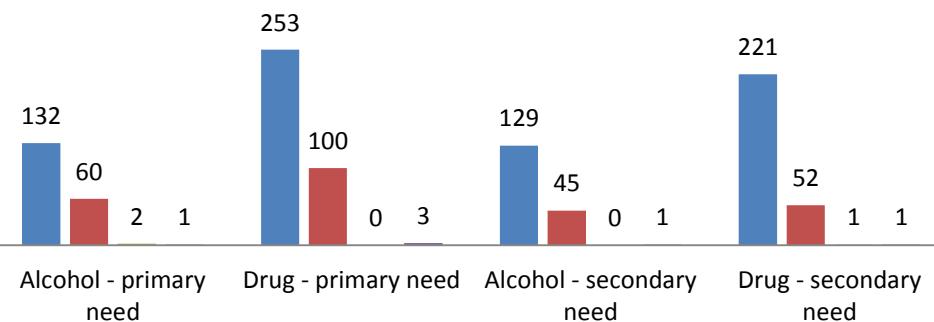
■ Level 1 ■ Level 2 ■ Level 3 ■ Level 4



**Chart 7.7 Gender of HSR applicants with a drug or alcohol need**

### **Self defined gender of HSR applicants 01/01/2015-031/12/2015**

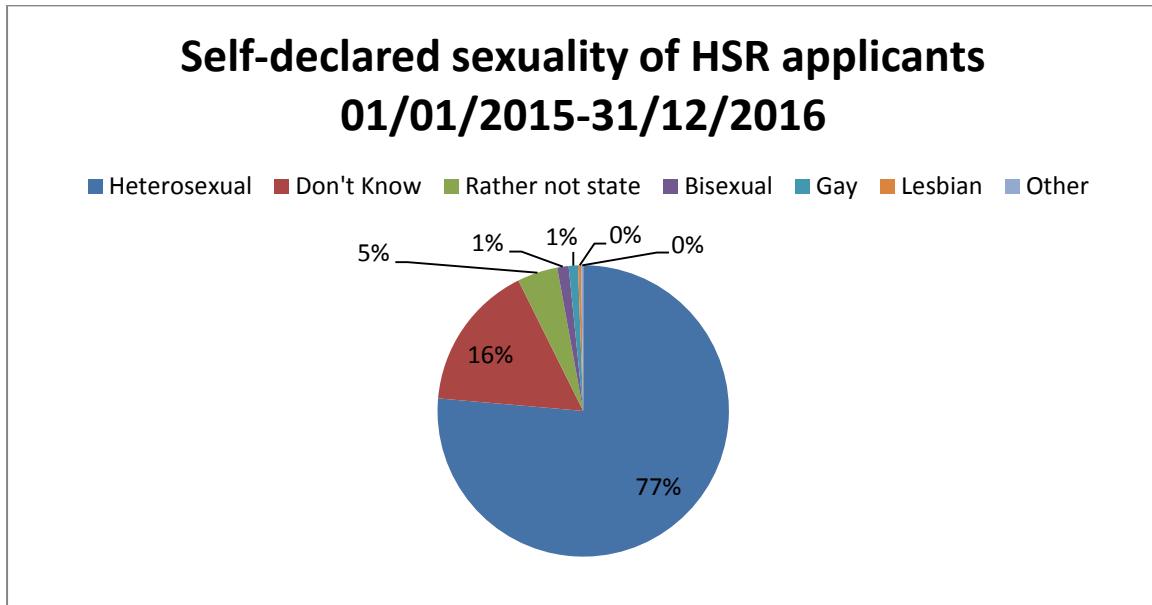
■ male ■ female ■ transgender ■ prefer not to say



The male/female gender percentage split of HSR applicants with a drug and/or alcohol need is very similar to that of clients within ROADS at 73% male and 26%

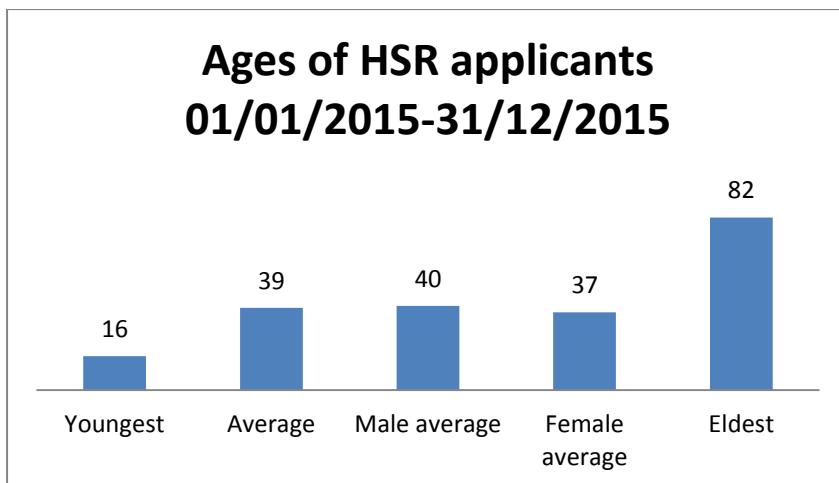
female. Less than 1% of applicants self-defined as being transgender which is representative of the transgender numbers in the UK.

**Chart 7.8 Sexual orientation of HSR applicants with a drug or alcohol need**



There is a slightly lower percentage of both lesbian/gay and bisexual clients accessing the HSR with figures of 1.5% and 1% respectively being recorded in ROADS.

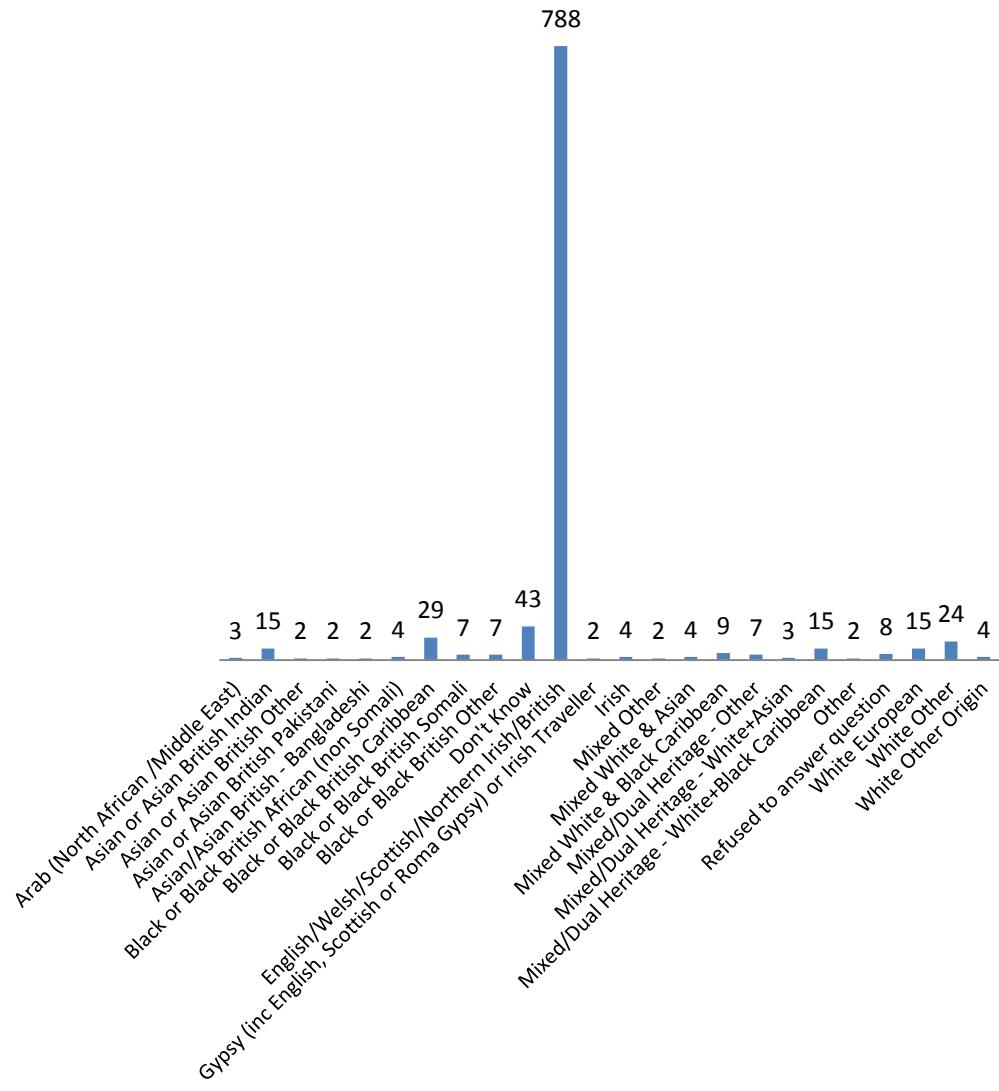
**Chart 7.9 Age of HSR applicants with a drug or alcohol need**



The age ranges for HSR applicants with cited drug and alcohol issues are very similar to the ROADS cohort with the largest group of individuals being in the 35-44 year old age bracket at time of assessment.

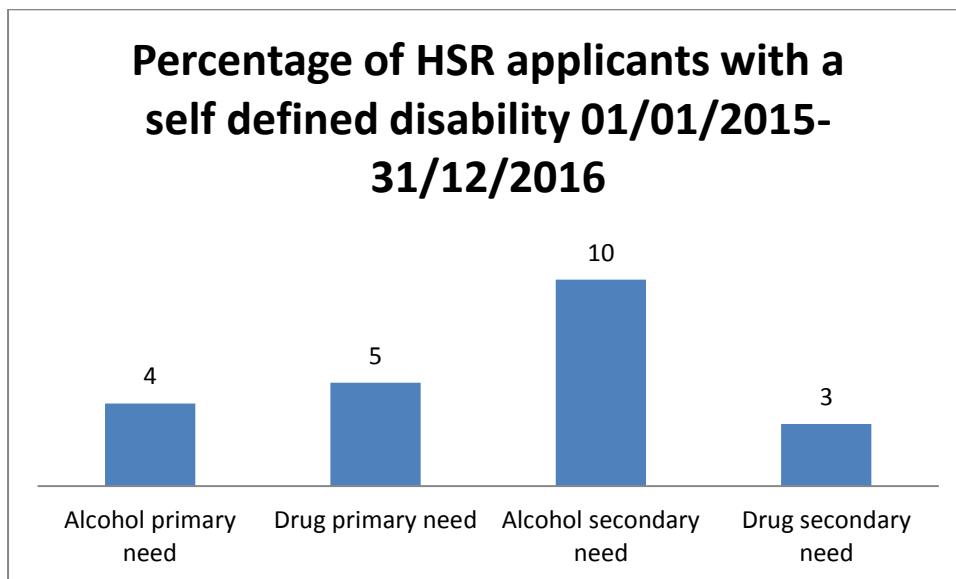
**Chart 7.10 Ethnicity of HSR applicants with a drug or alcohol need**

## Self defined ethnicity of HSR applicants 01/01/2015-31/12/2015



The self-defined ethnicity of applicants to the HSR is similar to the ethnicity breakdown of clients in ROADS with 79% identifying as White British compared with 85% in ROADS. There are no statistically significant differences between clients' ethnicity within ROADS and applicants to the HSR.

**Chart 7.11 Percentage of disabled HSR applicants with a drug or alcohol need**

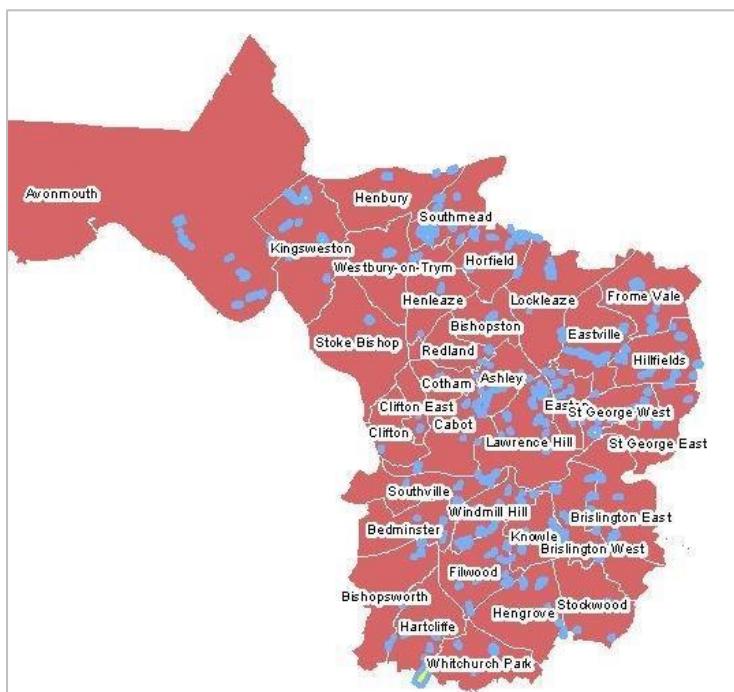


Of the 1001 HSR applicants citing a drug and/or alcohol need, just over 5% or 53 people self-declared as having a disability. This is significantly lower than the 18% of individuals within ROADS over the same time period who self-declared a disability.

### **Location**

Of the 681 clients who were appropriate for Housing Support referral as identified through ROADS triage, 302 gave a current address. Of those, 283 were in the Bristol Local Authority Area and have been plotted in blue by ward below. It is important to note that the wards with the 3 largest blue areas contain hostels and supported housing sites that account for a majority of the current addresses in that ward.

**Chart 7.12 Drug and alcohol HSR referrals by location**



**What services/assets do we have to meet and prevent this need?**

The Substance Misuse Team currently commission 140 units/beds of single person specialist drug & alcohol housing across Bristol through the Housing Support cluster of ROADS. Via a lead contractor sub-contractor arrangement, the service operates across three organisations and incorporates a three tier model for clients and referrers to access.

The Substance Misuse Team also commissions via the same contract 218 units of floating support for individuals and families with substance misuse issues to maintain their tenancies.

**Preparation Housing** is split into sub levels; preparation and preparation intake. Preparation intake offers 19 units of intensively supported housing. There is daily contact with staff including evenings and is for those whose treatment is unlikely to advance until accommodation is secured. Referrals for this service are mostly from HMP Bristol, street outreach teams and providers within ROADS. The usual stay is up to 2 months.

Preparation housing offers 35 units of supported housing. There is engagement with a peer mentor and is for those free from Class A drugs working towards recovery with a treatment package in place. The usual stay is up to 6 months. In March 2016, the most recent data available shows that 79% of clients (10/13) left with a planned exit.

**In Treatment Housing** is also split into sub levels; in treatment and in treatment abstinent.

In Treatment Housing offers 21 units of accommodation for those fully engaged in a structured treatment programme. It is for those on stable medications and working towards non-problematic use. Most residents are likely to come from Preparation accommodation, prison, detox or dry accommodation where their abstinence is at risk. The usual stay is up to 12 months.

In treatment abstinent housing offers 36 units for those who are totally abstinent and need an abstinent environment to support their recovery. The usual stay is up to 12 months.

In March 2016, the most recent data available shows that 100% of clients (9/9) left with a planned exit.

**Abstinent Housing** offers 29 units of accommodation designed to reinforce recovery and independence and is for those who have completed a substance misuse treatment programme and achieved abstinence. Residents are expected to attend regular house meetings, community involvement, budgeting and resettlement sessions. Most referrals are likely to come from In Treatment housing. The usual stay is up to 6 months.

In March 2016, the most recent data available shows that 100% of clients (1/1) left with a planned exit.

**Floating Support** offers 218 units support for service users at all stages of engagement with ROADS where there is risk of homelessness or treatment breakdown which would jeopardise the tenancy. The usual period of engagement is up to 6 months.

In March 2016, the most recent data available shows that 78% of clients (7/9) were able to maintain their tenancy.

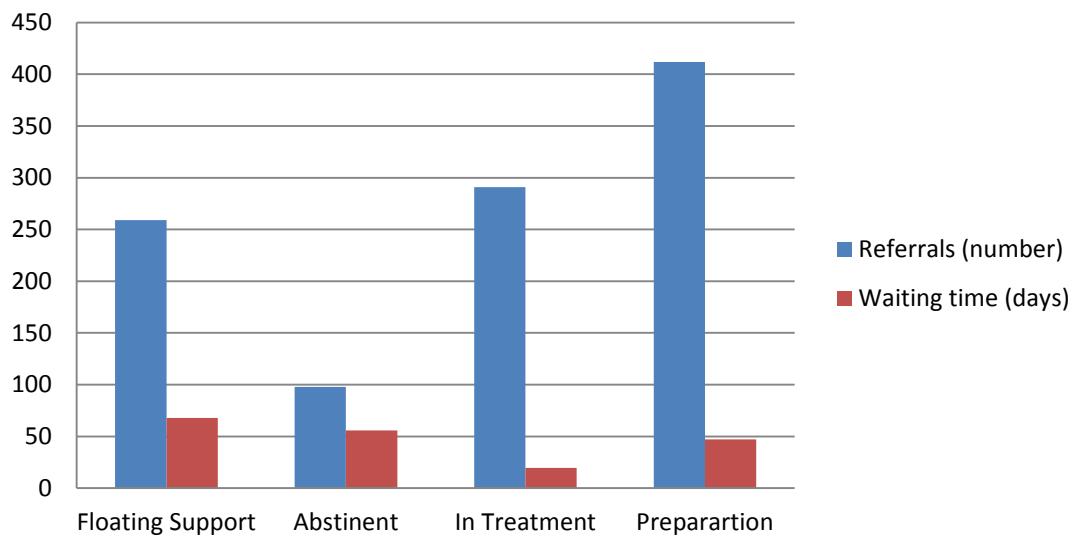
## **Referrals**

Referrals and waiting times for housing support vary greatly between stages. There is a much greater need for, and far more referrals to, Preparation housing than there is to Abstinent. In developing a recovery orientated treatment system, provision was made for clients to access safe and appropriate housing throughout their treatment journey and the property portfolio reflects that with appropriate housing for each stage.

Table 7 below shows the difference in referral numbers to the HSR between the stages and the amount of time in days between the referral being made and the outcome of that referral.

**Chart 7.13 Referral numbers and days waiting from referral to outcome**

## **Referral numbers and days waited from referral to outcome 01/01/2015- 31/12/2015**



ROADS holds drop-in sessions for clients to come in and apply in person for housing as well as discussing their housing need with their keyworker and having a professional referral completed on their behalf.

In the wider community there are other services available to those with a substance misuse and housing issue:

- Street outreach teams who access the homeless population in Bristol and refer clients into Housing Support account for 15% of total HS referrals in Q4 2015/16.
- Prison re-settlement workers at HMP Bristol who refer clients into Housing Support account for 5% of total HS referrals in Q4 2015/16.
- Homeless Level 1 hostels commissioned by colleagues in Bristol City Council who provide support and beds for the city's most at risk clients, a good proportion of whom (61% at Salvation Army's Logos House) are seeking help for their drug misuse. These accounted for 3% of total HS referrals in Q4 2015/16.

- Medium and low-level supported housing as well as floating support services commissioned by various teams across Bristol City Council
- Non-commissioned dry and wet houses throughout the city offering beds and support
- Golden Key programme offering support for people with substance misuse, Mental Health, Criminal Justice and housing issues
- Probation Support Hub – Liaising with offenders pre and post release to assist with housing, MH and SM issues.
- One25- Provides a safe space for women to access support for their needs. Having clear routes into stable accommodation provides the starting blocks for women in accessing treatment for their addiction.

### **What do staff/users/carers think?**

Through consultation with colleagues incorporating feedback from wider partners and a pool of roughly 30 service users, a number of points were noted about the current housing support provision and its pathways. These points refer to the Housing Support provision commissioned by Safer Bristol in its own right as well as its part in meeting the overall need of people with substance misuse and housing needs in Bristol.

### **What's working well?**

- The offer of preparation housing, good number of referrals from services & good link with referral services.
- Number of HMP referrals and the resettlement pathway
- Agreements with ROADS Engagement service going to places people live, for pre – contemplative work.
- Drug & Alcohol champions in hostels.

### **4. What do we need to look at?**

- Number of clients in accommodation, not enough units/beds in Preparation housing to meet demand.

- How we facilitate client's access to Housing Support services. What are the barriers to having a Drug & Alcohol housing referral?
- High need-low referrals. The number of referrals from homeless hostels for people with drug and/or alcohol issues is very small compared to the apparent need.
- Perceived lag between referral and a service makes some referrers, especially those from homelessness hostels hesitant to refer to Drug & Alcohol housing.
- Quality of referral information into Drug & Alcohol housing is poor from some services. This makes assessment a more lengthy process as further information needs to be gathered.
- Some Service User's (SUs) view that the quickest way to getting their own tenancy is via the homelessness pathway rather than the Drug & Alcohol housing pathway.
- Some SUs view that the expectations of ROADS engagement as a condition of Drug & Alcohol housing is too demanding.
- Clients needing Preparation stage housing are waiting too long to be assessed and housed. The motivation to change needs to be capitalised upon quickly and a safe and secure place to live is of paramount importance to this.
- Substance misusing clients being released from Prison are often doing so without suitable accommodation in the community to return to. This is often an unidentified need as Prison leavers are not asked about their housing status. Without suitable accommodation, the likelihood of accessing appropriate SM treatment is considerably reduced
- The majority of clients in level 1 hostels are misusing substances. Referrals from these hostels are negligible. There is a need for referrals to suitable accommodation for these clients to assist their recovery.
- Rough sleepers are generally not having their substance misuse needs met through contact with homelessness and health services. Feedback suggests that signposting and referral to ROADS via these services is very rare. Clients have to actively seek SM treatment of their own accord in order to access them.

- Housing Support clients who are evicted often find themselves in hostels or crash pads in which substance misuse and un-managed MH is rife. There is a need for appropriate, managed housing for those who have been evicted to try and maintain their recovery
- Anecdotal feedback suggests that clients are hesitant to access SM housing for fear of relapse and eviction. Explore this in questionnaire to hostels.
- Appropriate housing for sex-working women. The majority of women worked with by One25 have experienced difficulty accessing and maintaining suitable housing. For those on the drug and alcohol pathway, stable accommodation provides a crucial foundation for moving forward. While the first hurdle of engaging these hard to reach women has been overcome through assertive night time outreach, the second hurdle can be in getting access to emergency housing. Women who street work throughout the night and take shelter with punters or in crack houses, will as a result be deemed to have an address without regard to how inappropriate it may be. For the same reasons, these women are often overlooked as being 'rough sleepers' and therefore lack the same access to rough sleeping initiatives.

### **What are we going to do about it?**

- Put together a questionnaire to go out to hostels regarding people not wanting to attend drug & alcohol housing.
- Offer training for staff – provide information, knowledge and skills on how to support drug and alcohol clients.
- Open referral pathway up to all support workers in hostels.
- Look at the repeat revolving door clients.
- Clarity of expectations of clients entering Drug & Alcohol housing.
- Expand the role of peer support – more understanding and identification for potential clients.

### **5. What are the unmet needs**

- Clients needing Preparation stage housing are waiting too long to be assessed and housed. The motivation to change needs to be capitalised upon quickly and a safe and secure place to live is of paramount importance to this.
- Substance misusing clients being released from Prison are often doing so without suitable accommodation in the community to return to. This is often an unidentified need as Prison leavers are not asked about their housing status. Without suitable accommodation, the likelihood of accessing appropriate SM treatment is considerably reduced
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## **8. Relationships**

### **What is the level of need?**

#### **Parental Substance Misuse**

Parental substance misuse can be an emotive topic and it is worth highlighting that drug and alcohol use does not automatically make someone a bad parent. Research does show that the social, legal and financial pressures associated with substance misuse do make it more difficult to parent adequately<sup>42</sup>. As such it is crucial that support is available to work with parents to deal with the challenges they face.

The following points set the scene at a national level:

- The UK Drug Policy Commission report noted that 1.5 million adults are affected by someone else's drug use and other Government bodies estimate 350,000 children are affected by parental drug use and 1.3M by alcohol.
- 705,000 children are living with dependent drinkers, according to Alcohol Concern and the Children's Society.
- A DrugScope/ICM poll found that 1 in 5 people have direct or indirect experience of drug addiction.
- Figures from the National Treatment Agency for Substance Misuse show that 1.2 million people are affected by drug addiction in their families, and 120,000 children have a parent currently engaged in treatment services.

The Hidden Harm report<sup>43</sup> sets out the findings of an inquiry carried out by the Advisory Council in 2011, focusing on children in the UK with a parent, parents or other guardian whose drug use has serious negative consequences for themselves and those around them. Whilst the enquiry specifically focussed on drug use the findings can also be related to alcohol use. The following 6 key messages are highlighted:

- there are between 250,000 and 350,000 children of problem drug users in the UK - about 1 child for every problem drug user. This represents about 2–3% of children under 16

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<sup>42</sup> The impact of domestic violence, parental mental health problems, substance misuse and learning disability on parenting capacity (2009)

<sup>43</sup> Hidden Harm – Responding to the needs of children of problem drug users (2011)

- parental problem drug use causes serious harm to children at every age from conception to adulthood
- reducing the harm to children from parental problem drug use should become a main objective of policy and practice
- effective treatment of the parent can have major benefits for the child
- by working together, services can take many practical steps to protect and improve the health and well-being of affected children
- the number of affected children is only likely to decrease when the number of problem drug users decreases

The Hidden Harm report states that:

*Parental problem drug use can and often does compromise children's health and development at every stage from conception onwards.*

*After birth, the child may be exposed to many sustained or intermittent hazards as a result of parental problem drug use. These include poverty; physical and emotional abuse or neglect; dangerously inadequate supervision; other inappropriate parenting practices; intermittent or permanent separation; inadequate accommodation and frequent changes in residence; toxic substances in the home; interrupted or otherwise unsatisfactory education and socialisation; exposure to criminal or other inappropriate adult behaviour; and social isolation. They often interact with and exacerbate other parental difficulties such as educational under-attainment and mental health problems.*

It is also recognised that:

*Because problem drug use affects an individual's state of mind or behaviour, many of its effects on a parent and her or his child-rearing capacity have similarities to those resulting from parental mental health problems and problem alcohol use. Each may affect the parent's practical skills, perceptions, attention to basic physical needs, control of emotion, judgement and attachment to or separation from the child.*

*Parenting capacity can be further compromised if one or both parents also have mental health or alcohol problems.*

A large number of studies show the negative effects that parental substance misuse can have on children/adolescents<sup>44</sup>. In the more extreme scenarios being exposed to high levels of violence, mood swings, inconsistency from one or both parents and taking on a parenting/responsible role at an early age will impact on the child's social and emotional development. Again from the Hidden Harm report:

*Substance misuse by teenagers whose parents have serious drug problems becomes ever more likely as they get older. Feelings of isolation and low self-esteem may generate a wish to escape either physically or through drink or drugs, thus potentially placing the young person in a very vulnerable position. Teenage offending is also strongly associated with early substance misuse. Early sexual activity is much more likely among those who misuse substances at an early stage, with the consequent risk of pregnancy or sexually transmitted diseases. Young female problem drug users in particular may resort to prostitution or sexual favours to pay for drugs or unpaid debts as drug use escalates. A disadvantaged childhood is likely to culminate in the young person's failure to achieve his or her full potential at school, thereby seriously affecting future opportunities for work and personal advancement.*

In Bristol between 2009 – 2016 there have been 8 serious case reviews as death/serious injury to a child has taken place. In 4 of these cases substance misuse was a factor. In 2 of those cases drugs were identified as the direct cause of death and in the other two cases it was a feature.

A qualitative study<sup>45</sup> with 40 professionals from a range of settings identified five types of challenges that arise when these families are seen by professionals in substance misuse and/or child-care services:

1. Engagement - access to the children is often denied
2. Conflicting agency focus (adult needs or child needs)
3. Inter-agency communication (especially related to the issue of confidentiality)
4. Conflicting assessment needs (assessment of substance misuse vs. assessment of parenting)

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<sup>44</sup> Neglect and Parental Substance Misuse (2011)

<sup>45</sup> Working with parental substance misuse: dilemmas for practice (2004)

5. Children having significant needs but remaining largely invisible.

These themes present real barriers to effective work and need to be acknowledged before they can be addressed.

Quarter 4 DOMES reports that approximately a quarter of opiate clients in treatment live with children under the age of 18. This is a smaller proportion than the national average and the same is seen for different drug groups when compared to the national average. In summary, 931 of the 4,254 clients in treatment (21.9%) live with children under the age of 18. The data is likely to under represent clients living with children as under recording is an issue.

**Chart 8.1 Proportion in treatment who live with children under the age of 18**

2.8 Proportion in treatment who live with children under the age of 18		
(n) = number of clients in treatment who live with children / all in treatment Latest period: 01/04/2015 to 31/03/2016		
	Latest period (%)	National average (%)
Opiate	24.9%	28.9%
Non-opiate	18.8%	23.7%
Alcohol	17.0%	24.7%
Alcohol and non-opiate	13.9%	23.0%

**Proportion who successfully complete and represent (DOMES Q4 Latest Period)**

	Successful Completions		Successful completions & represent	
	All	Living with children	All	Living with children
Opiate	7.5% (206/2751)	7.3% (50/685)	21.9% (32/146)	14.3% (5/35)
Non – opiate	34.8% (87/250)	31.9% (15/47)	7.5% (3/40)	0% (0/4)
Alcohol	31.2% (254/813)	31.9% (44/138)	13.8% (18/130)	0% (0/23)

Alcohol and non opiate	21.8% (96/440)	24.6% (15/61)	23% (14/61)	25% (2/8)
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Of the 685 opiate users living with children 50 of them successfully completed treatment in the latest period. The proportion of clients successfully completing in the two cohorts is very similar (e.g. 7.5% of all opiate users and 7.3% of opiate users living with children) which suggests that the likelihood of completing successfully does not appear to be affected by whether or not they live with children.

In terms of successful completions and subsequent representation to treatment the outcomes for clients living with children are difficult to interpret due to the small numbers.

Of the 35 opiate users living with children who successfully completed 5 then represented (14.3%). This is a smaller proportion than those not living with children (21.9%). 0 of the 23 alcohol clients living with children who completed have represented.

### **Children and Family Services Targeted Support**

In April 2016 the Substance Misuse Team reviewed the overlap between clients in treatment and children who are registered with Children & Families Services as: having an open Child Protection Plan, Children in Need and Looked After Children status. The aim of this was to ensure treatment services have an accurate record of clients who are living with children who are considered to be at risk.

There were 242 matches of unique children known to have an open Child Protection Plan (CPP), Children in Need or Looked After Children. For the 242 children there were 190 adults known to treatment. 95 of 242 matches were identified as current child protection cases and 74 adults were linked to the 95 children on CPP. The DOMES data states that 931 clients live with children therefore if we know that 190 live with a child who is in receipt of social worker support this represent 20% (190/931) of clients in treatment who live with a child in the house.

### **Links with Social Work Teams**

During 2015/16 financial year BSDAS have attended 62 child protection conferences for 34 unique clients, the vast majority of which were accessing the Maternity Drug

Service. Bdp attended 17 initial child protection conferences and were invited to 84 child protection reviews and 9 child in need meetings of which they attended the majority.

Referral data suggests that Early Help teams are not regularly referring into ROADS. It seems unlikely that there is not the need for substance misuse services but it would be useful to explore how many Early Help families are already engaged in treatment. For those that are not we need to consider how best to engage families in treatment services and how services can use their expertise to support workers to recognise and respond to drug/alcohol issues.

### **Supervised Consumption**

As stated in the Supervised Consumption Protocol all clients who live with children under 5 who are subject to a child protection plan are expected to be on a 7 day a week supervised consumption programme. Following an audit of prescribing regimes in 2016 which intended to establish how the protocol for prevention of child exposure to synthetic opiates was being applied in practice. The Protocol stated that:

- *Adults on OST who spend one or more nights per week in a household where a child of 5 years or under also lives, 6-day supervised consumption of dispensed OST is the ideal and recommended arrangement. In cases where this recommendation is not applied, the reasons should be documented clearly in the case record and safe storage advice should also be given. Exceptions where 6-day supervision is not implemented may include:*
  - *Working parents*
  - *Those who have shown proven stability and good engagement*
  - *Those attending college or further education*
  - *Those who have other caring responsibilities*
- *In cases where a child protection plan is in place: 7-day supervised consumption of dispensed OST is the ideal and recommended arrangement where local pharmacy provision is available. Where 7-day supervision is not available, then 6-day supervision should apply.*

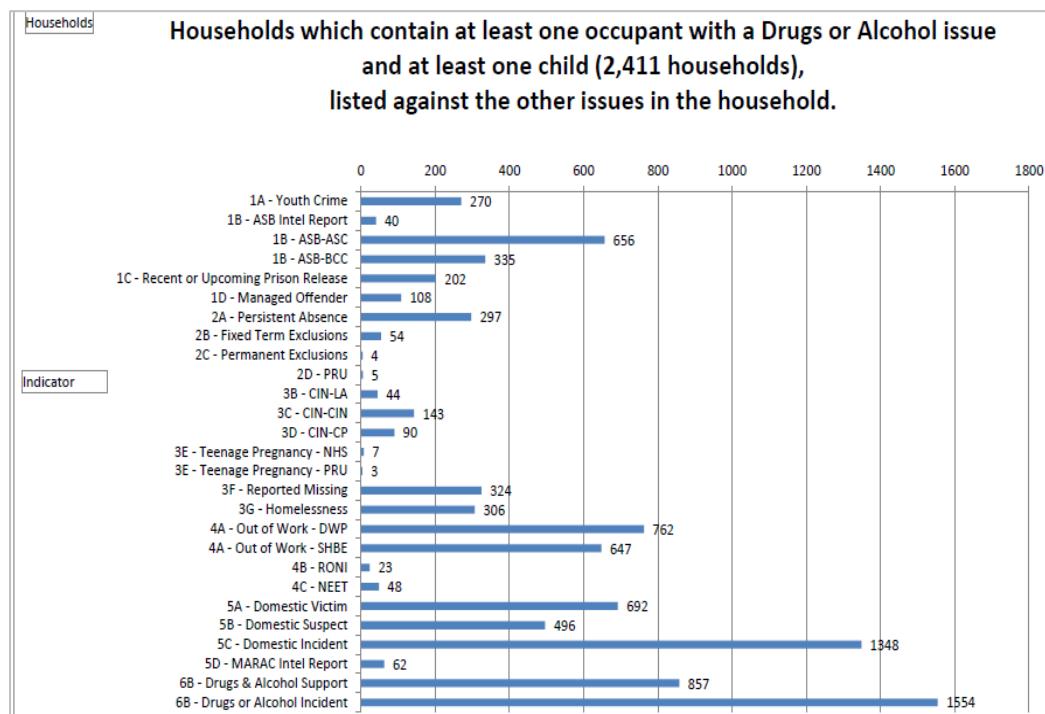
The ability to conduct an audit based on information recorded on the Theseus case management system was limited. Information and details related to children living with clients for at least one night per week, and details of ongoing safeguarding proceedings, were not routinely entered into Theseus and whilst they were accurately recorded elsewhere by treatment providers this is a current priority to resolve.

Data recording aside the audit did demonstrate a strong adherence to the protocol. 94% receive supervised consumption and, upon reviews conducted during the audit, 95% of supervised consumption regimes were at least 6 days. There is further work to be done to strengthen the prescribing protocol and implement a process for exceptions where there is a justifiable reason (i.e. mobility, ill health work etc.) to be dealt with. The number of these exceptions and the circumstance surrounding them need to be considered in more detail as they provide a direct insight into the complexities that families, their treatment providers and social workers are all dealing with.

### **Overlap with Think Families**

The Think Family Team combines Substance Misuse Support data with approximately 30 other indicators. The following chart shows the extent of other issues in households with children where at least one occupant has an existing substance misuse issue. This is defined as receiving drug or alcohol support from ROADS services or committing an offence where drugs or alcohol were a primary factor.

## Chart 8.2 Households which contain at least one occupant with a drugs or alcohol issue and at least one child



In total 2,411 households with at least one child were identified as containing at least one occupant with drug/alcohol issues. This is out of 7,500 households who meet the two or more criteria of the think family programme. The data suggests that key combination factors seem to be Anti-social behaviour, Out of Work and Domestic Incidents. In terms of assessing unmet demand, further work may include looking into why perpetrators of drug and alcohol offences are not currently receiving support from treatment services. For the 857 households who are in contact with treatment services it could prove beneficial for the treatment services to know they are Think Families clients for the purposes of joining up care plans and sharing risk information.

### Domestic Violence and Abuse

Substance misuse, domestic and sexual violence and mental health issues often co-exist. Women's Aid Research shows that women experiencing domestic violence are

up to fifteen times more likely to misuse alcohol and nine times more likely to misuse other drugs than women generally<sup>46</sup>.

It is important to highlight that substance use does not ‘cause’ domestic violence and abuse; it may however disinhibit perpetrators and can be a coping mechanism for victims. Research suggests that 21% of people experiencing partner abuse in the past year thought the perpetrator was under the influence of alcohol and 8% under the influence of illicit drugs<sup>47</sup>. In addition, partner assaults are 4 to 8 times higher among people seeking treatment for substance misuse (Murphy & Ting, 2010). The complex relationship between victim and perpetrator is also heightened when substance misuse/drug supply is involved and sex working can also be part of the dynamic.

A UK study<sup>48</sup> showed that 51% of respondents from domestic violence agencies claimed that either themselves or their partners had used drugs, alcohol and/or prescribed medication in problematic ways in the last five years. A UK study<sup>49</sup> of 60 women using crack cocaine found that 40% reported being regularly physically assaulted by a current partner and 75% being physically assaulted by a current or past partner.

Almost two thirds of survivors drawn from domestic violence agencies showed that they began their problematic substance use following their experience of domestic violence (Bury et al, 1999). Overall, women who have experienced at least one form of gender-based violence are at least three times more likely to be substance dependent than women who have not experienced this kind of abuse (Rees et al, 2011).

Bristol Police recorded 7,503 incidents of domestic abuse in 2010-11 and attend approximately 600 incidents of domestic violence a month (roughly 20-30 a day). 6,888 DVA cases were referred to Bristol Children and Young Peoples Social Care Teams in 2010-2011.

Bristol Multi Agency Risk Assessment Conference has been running since 2007, 1,195 referrals were made to MARAC in 2014, 568 were discussed at a MARAC

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<sup>46</sup> Women at Risk, Domestic Violence and Women's Health (1996)

<sup>47</sup> Domestic violence and abuse: multi-agency working (2012)

<sup>48</sup> Domestic Violence and Substance Use: Tackling Complexity (2005)

<sup>49</sup> An examination of the needs of women crack users with attention to the role of domestic violence and housing (1999)

meeting and 627 at a Pre MARAC meeting. In total this averages 100 referrals being made each month. Approximately five of these referrals come from substance misuse treatment services. In reviewing cases referred to the North and South Bristol MARACs in 2012/13, 11.5% of the female victims had an unmanaged heroin/crack dependency and 15% had a problematic alcohol dependency. A review of MARAC cases since 05/03/2015 – 17/03/2016 showed that 313 of the cases involved clients known to treatment services. There were 119 victims and 194 perpetrators. The number of children or young people exposed to domestic violence in these cases is unknown but the detrimental effects are well documented.

### **Carers Needs**

There is a substantial body of evidence to support the statement that drug and alcohol use has a significant impact on individuals and their families. According to the UK Drug Policy Commission, at least 1.5m adults in the UK are affected by a relative's drug use. These families experience harms amounting to £1.8 billion per year, and provide support for drug users which would cost the state £750m to provide.

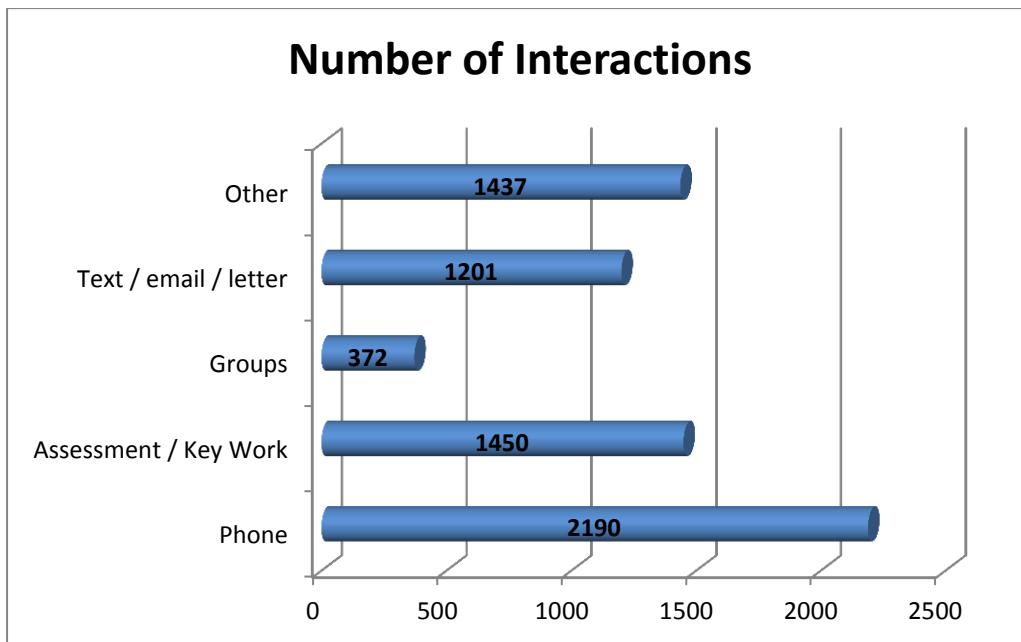
In a review of previous research Copello, Velleman and Templeton<sup>50</sup> conclude that individuals who develop a serious problem with their use of alcohol or drugs can and often do behave in ways that have a significantly negative impact on family life in general, and on other members of the family. It is also recognised that family members commonly develop problems in their own right, often manifested in high levels of physical and psychological symptoms. In terms of the effectiveness of working with families and carers Copello et al reviewed a range of family interventions and conclude that working directly with those concerned about someone else's substance use can lead to engagement of the user in treatment. If interventions are offered to family members in their own right (e.g. to help them cope better, or help them to develop improved social networks), there are significant effects in terms of reduced symptoms and altered coping mechanisms which in turn impact on users behaviour.

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<sup>50</sup> Family Interventions in the treatment of alcohol and drug problems (2005)

The ROADS Family and Carers Service has been running since 2013 and since the service was set up there have been 6,650 interactions recorded with family and carer clients

**Chart 8.3 Number of interactions with family and carers**



Of the 87 family members and carers on current caseload. 81% are female, 43% aged 45-65 and 86% are White. In terms of their relationship to the substance misuser 54% are parents, 28% spouse and 18% are other.

Considering the wider pool of 172 clients on caseload since 1<sup>st</sup> April 2015, 65 (38%) had their loved one in treatment pre-assessment and 98 (57%) had their loved one in treatment post-assessment.

Since the service started the number of family and carer clients who have accessed the services shows a good spread of wards with the most represented being: (taken from a sample of 377 clients entering the service).

Ward of Residence	Number of Family and Carer Clients
'No ward' specified	28

Ashley	21
Lawrence Hill	15-19
Lockleaze	15-19
Hillfields	15-19
Eastville	15-19

86% have had a successful completion ('mutually agreed discharge'). 97 family members and carers have completed three or more Carers Support Outcome Profile(CSOP) assessments. These consist of 22 questions under eight themes about the carer's wellbeing. Comparison of the first and most recent CSOPs completed show these aggregate results:

Theme	Knowledge re substance misuse	Relationship with loved one	Relationship with family	Safety of household	Relationship with community	Physical & psychological health	Coping with daily life	Tackling the problem	TOTAL AVERAGE
Improvement in score (%)	35	36	10	12	9	29	14	35	24

### Peer Support

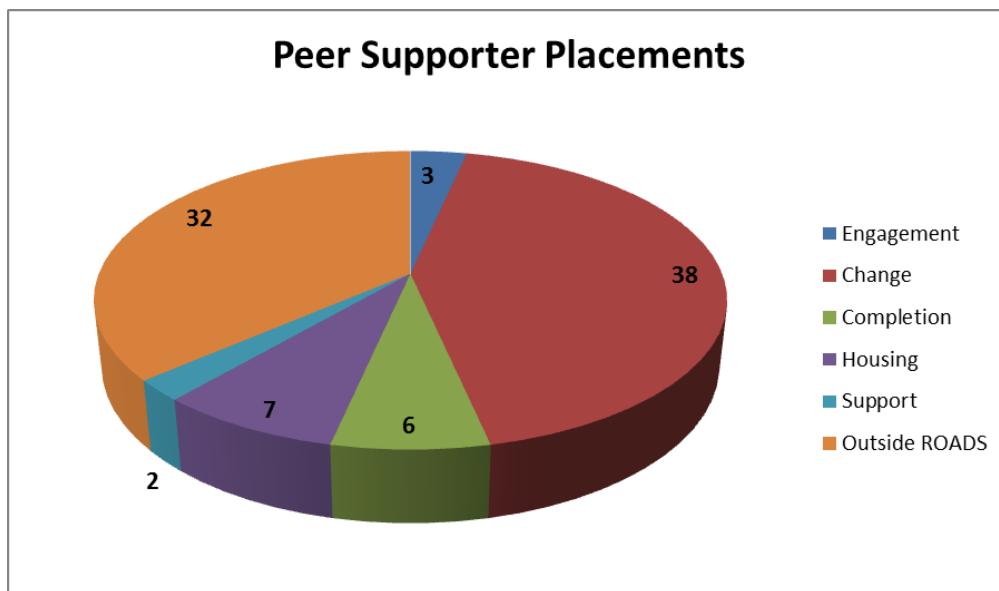
The peer support intervention was developed by Developing Health & Independence (DHI) in 2014 to respond to the concept that people with lived experience of, and in recovery from, problematic substance misuse have much to offer other people who are beginning their own recovery journeys.

The intended outcomes for peer supporters include:

1. Successful completion of the training intervention.
2. Continued engagement in recovery journeys.
3. Increase between the start of the peer support experience and six months in self-esteem, wellbeing and resilience – where these psychosocial outcomes are lower than expected at the start.

129 peer supporters have received full induction training since November 2013. 88 peer support placements have taken place across 34 different services involving 62 peer supporters

**Chart 8.3 Number of peer support placements**



Placement activities include:

Being present and visible / Sharing experiences / Providing guidance and signposting / Accompanying people to appointments / Supporting people through detoxes / Co-facilitating mutual aid groups / Carrying out office admin and receptionist duties / Helping to deliver activities and events / Tending the BDP allotment / Organising meetings and providing 1-2-1 support for dry house residents / Helping to run the ARC Cafe / Filling prison greet roles / Providing low level advocacy / Leading film groups, art projects and other similar activities.

Of 129 peer supporters trained through the service 28 have secured paid employment (22%) and 32 have commenced further education/training (25%)

There are currently 20 peer supporters involved in targeted support for 59 ROADS clients who have been on scripts for more than four years. The peers work in twos on a half-day basis providing various support to the clients as needed. Since the project started seven weeks ago:

- 9 clients have received face to face support
- 9 clients have been accompanied to appointments
- 22 clients have been provided with telephone support

A recent evaluation aimed to identify whether the intended outcomes for peer supporters had been achieved. Semi-structured interviews were conducted with ten peer supporters who had engaged in their role between three and twelve months. The themes and the verbatim responses suggest that the intended outcome for peer supporters in the continuation of their recovery journeys appears to be achieved. This is because participants identified the experience of being a peer supporter as being an *essential* factor in continuing to engage in their recovery journeys. This is further supported by the outputs of this service where unplanned withdrawal and/or relapse from the peer support role was not a common experience for the service users. Tentatively speaking with this relatively small sample size, the findings to date provide support that the intended outcome for increased self-esteem between the two time points has been achieved, on average, amongst peer supporters. Over the last seven years, the RSA<sup>51</sup> has been exploring how the role of social networks within communities can enhance the health and wellbeing of local residents. Their research recommends that peer support should be a central component to recovery programmes rather than marginal added value. It is argued that emphasis should be placed not only on peers' current expertise through experience but their wider capacities and potential for employment progression. To this end, greater investment is needed in coaching and upskilling recovery peers, both in terms of commissioning models and investment in enabling treatment services.

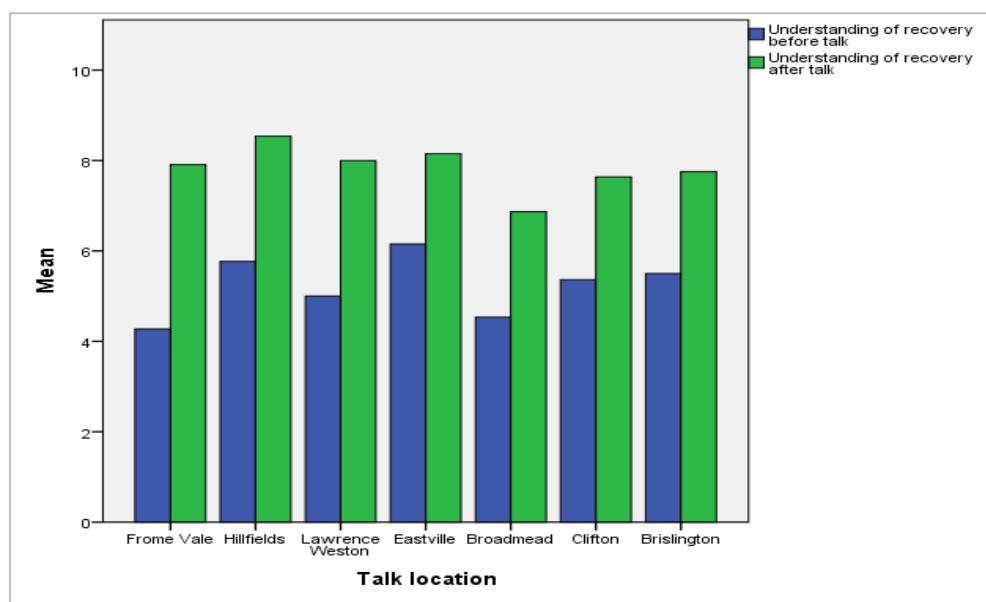
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<sup>51</sup> Whole Community Recovery - The value of people, place and community (2015)

## **Community perceptions of substance misuse**

The ROADS Support Service works with a range of local providers to help tackle stigma. 35 stigma busting events have been delivered in the past year. Examples include neighbourhood partnership talks, University lectures, workshops for trainee police officers, the BBC and DWP, and sharing best practice with local GPs. In terms of increasing people's understanding of recovery from substance misuse the impact is shown below based on feedback from 81 event participants:

**Chart 8.4 Understanding of recovery by location**



## **What services/assets do we have to meet and prevent this need?**

To ensure Early Help (EH) are aware of ROADS delivery BDP has made presentations at Multi Agency Network meetings in North, East/Central and South areas. To support referrals to ROADS from EH, Bdp has a programme of training/skill-sharing sessions with EH staff in each area to support them in having 'difficult conversations' about families' alcohol and drug use.

### **Intensive Family Support Service**

- Parental substance misuse
- Children at home and subject to child protection plan

- Home visits
- Twice a week for 3-6 months
- Practical and therapeutic support. Flexible.
- Support and guidance around talking to children about substance misuse and referral to Youth Services.

### Parenting Workshops

- Substance misusing parents, do not need to be living with child
- Substance use can be recent or current
- 2 hour workshops, once a week for 6 weeks
- Central focus is affect of parental substance misuse on family. How does your child feel?

### Fathers R Important: Fortnightly Wednesday, 11am-1pm

- Service developed by fathers
- Facilitated by BDP Workers
- Peer support
- Lunch/ bus tickets reimbursed/crèche

### Mentoring

- Children & young people aged 8-16
- Weekly activities for a year with a trained Mentor
- Parent to be engaging with a drug/alcohol agency
- Child to be living with substance using parent
- Activities & relationship building

### M32 Youth Group

- Children & young people aged 5-10 & 11-16
- Recreational activities- shared meal
- Staffed by BDP Youth Workers and volunteers
- Travel provided
- Not essential for parents to engage, but must give consent

### Youth Links

- Young people aged 9-19 years (25 where there is LDD)

- Own or someone else's substance misuse
- Short term interventions (up to 8 sessions) city-wide

#### Bristol maternity drug service

- BSDAS - Service Co-ordinator, Drug & Alcohol Practitioners & Psychiatrist
- Two Specialist Midwives - for Southmead & St Michael's Hospitals
- Two Specialist Social Workers (CYPS)
  - Work closely with Obstetricians and Neonatologists, Community Midwives & Health Visitors
  - Specialist antenatal clinics at Southmead and St Michael's Hospitals
    - Once a week to provide enhanced antenatal care
      - Regular growth scans
      - Virology & STI screening
    - Multi-professional holistic approach
    - Triage assessment & direct access to drug treatment, support, advice and information
    - Referral on to other services
  - Assessment of parenting capacity
    - On-going process
    - Regular sharing of information
  - Joint home visits
    - With midwife or social worker
  - Regular partnership meetings to discuss cases and service development
  - Resource for other professionals
    - Training
    - Advice & Support



## **9. Training, Education, Volunteering & Employment**

### **What is the level of need?**

Employment status is very influential over health outcomes and has been included in the Public Health Outcome Framework as one of the wider determinants of health.

Substance misuse is a long term health condition which can contribute to the barriers preventing people from accessing and sustaining employment. Public Health England state in their JSNA guidance<sup>52</sup> that getting a job can enable people to sustain their recovery.

Black (2015)<sup>53</sup> supports this and argues that dependence on drugs and alcohol can have a damaging impact on employment status and can seriously affect people's chances of both taking up and remaining in employment. Black cites evidence that suggests that as many as 1 in 15 working-age benefit claimants is dependent on drugs such as heroin and crack cocaine and 1 in 25 experience alcohol dependency and argues that that their health condition that makes them unable to work is primarily due to their drug or alcohol dependence.

Black also states that for around 90,000 people claiming Employment and Support Allowance, their illness is primarily due to their drug or alcohol addiction. Failure to receive specialist employment support keeps "many people out of work – trapping them in worklessness and welfare dependency". This is supported by information from Public Health England which estimates the UK loses £7bn in lost productivity annually due to misuse of alcohol.

According to a Public Health England report published in January 2016, volunteering is intrinsic to many people's success because it provides training with a lower degree of fear and offers peoples an opportunity to sample a number of different roles. As well as providing content for CVs and references, volunteering offers the chance to develop the critical, very basic skills in a 'real' context. The report also emphasises the need to offer a wide range volunteer opportunities that are not limited to the treatment sector.

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<sup>52</sup> Joint Strategic Needs Assessment Guidance (2015)

<sup>53</sup> An independent review into the impact on employment outcomes of drug or alcohol addiction, and obesity (2015)

BCC JSNA<sup>54</sup> records the economic activity rate in Bristol in 2014 as 77.3% which is almost exactly level with 77.4% in England. However, the Public Health Outcomes Framework shows that the gap in the employment rate between those with long term health conditions and the overall employment rate in Bristol is 12.5% compared to a national gap of 8.6%.

The level of employment within the ROADS treatment system is significantly lower than both the national and local figures. The employment rate recorded for Bristol in 2014 is 70.9%, which is marginally lower than the rate for England, which is 72.5%.

8.3% of the Bristol population are recorded as unemployed, compared to 6.4% in England. Within ROADS the proportion of clients who are unemployed is much higher at 24%. This group (unemployed and seeking work) is the second largest group among ROADS clients as recorded by employment status.

The proportion of the population in Bristol who are of working age but are not working and claiming benefits in 2014 is 11%. This is slightly higher than the figure for England, which is 9.6%. Within the ROADS population those recorded as 'long term sick or disabled', represent 29% of the clients in ROADS. This is the largest group recorded by employment status and is more than 3 times the national proportion and over 2.5 times the Bristol proportion.

In addition, those who do work are likely to be in part time, rather than full time, employment. Data showing the average number of days worked for those in ROADS services are collected on the treatment outcome profiles (TOPS) at treatment start, six month review, treatment exit and post discharge follow up. During 2014/15 1,226 clients completed a TOPS assessment at the beginning of treatment.

Table 2

Stage of treatment journey indicated by TOPS	Number of clients who completed TOPS	Average number of days worked during last 28 days
Treatment start	1226	17.6
Six month review	630	18.2
Treatment exit	1113	17
Post discharge follow up	310	18.1

<sup>54</sup> Bristol Joint Strategic Needs Assessment (2015)

These findings are in-line with statistics reported by NDTMS of adult substance treatment activity, (pub Dec 2015). This states that at the start of treatment, the average number of days worked was 17.7, this rises to 17.9 as a national average number of days at 6 month review. In this regard, the Bristol picture shows a greater improvement.

### **Partnership work to strengthen access to employment within ROADS**

The following partnership work has been developed between the substance misuse team in Bristol City Council, ROADS providers, Job Centre Plus (JCP) and the Work Programme (WP) to enable those in substance misuse treatment to have better access to work and training opportunities:

- The substance misuse team, JCP and the WP are currently looking at opportunities for joint commissioning.
- The needs of drug and alcohol misusers are included in DWP, JCP and WP strategies in Bristol.
- TEVE performance is included in monthly reports to commissioners recorded via Theseus

There is a protocol in place between ROADS providers, JCP and WP which sets out a process of joint working between agencies, including arrangements for three-way meetings and co-location. This includes jointly delivered training sessions between JCP, WP and treatment providers focusing on structures, service offers and the mutually beneficial relationship between treatment and employment outcomes.

Promotional materials and service directories are actively promoted by JCP, WP and ROADS providers and shared among their clients.

There is a single point of contact within ROADS and assessment will identify ETE needs where relevant. However, this does not exist in JCP and WP.

TEVE workers have a role as employment champions in treatment teams, liaising with JCP and WP, and to negotiate opportunities for their clients

Data sharing and recording is only partially effective. Data for 2015/16 shows that 38 cases were signposted to ROADS from JCP but no TPR1 forms were completed.

Only 4 TRP2 forms were completed and sent from ROADS. This indicates a need to

strengthen effective data sharing and increase the completion of TPR 1 & 2 forms. This situation is further complicated by changes to the benefit system, with specific reference to ESA and JSA.

TEVE have contracts with 6 local agencies that facilitate access to other local employers. JCP and the WP providers have a statutory duty to engage with local employers.

Within the completion cluster of the ROADS contract DHI provides 'stigma busting'. This aims to reduce judgement and negative attitudes towards drug and alcohol users in the workplace.

It may be useful to share case studies of successful employment outcomes and interventions between ROADS, JCP and WP as a means of sharing good practice and increasing levels of access to the workplace.

Assessments are carried out at the point of engagement to identify education, training and employment needs and ongoing discussions take place where appropriate throughout a client's journey.

Training is provided to ROADS clients about appropriate disclosure of drug and alcohol use within JCP and WP. This includes disclosure to current and prospective employers.

A comprehensive training programme is in place for ROADS clients, which includes courses run by City of Bristol College and other programmes available through local employers.

## **What services and assets do we have to meet and prevent this need?**

### **1. Commissioned services**

A specific programme of training, education, volunteering and employment (TEVE) was commissioned as part of the completion cluster within ROADS to improve access to employment for service users. This is divided into two types of support, which are TEVE Lite, consisting of information sessions focusing on accessing training and employment opportunities and TEVE Contingency management, which is an incentive based programme, centred on rewards for compliance with treatment and includes such incentives as credits towards education programmes, tools and resources to start businesses etc. TEVE services are usually targeted at those in the

completion cluster of ROADS. In addition to this VOSCUR have a service agreement with TEVE, to run Sustain workshops employability workshops looking at overcoming some of the barriers that service users face.

TEVE services are delivered by BDP. There are four practitioners who see clients on a one to one basis. They also run an information drop –in. They have established strong relationships with Volunteer Bristol, Windmill Hill Community Farm, Chew Valley Community Farm, Demand Energy Equality and Business in the Community, City of Bristol College. Workers support clients to access opportunities for gaining work experience or education within these organisations.

#### Activity for TEVE clients in ROADS 2015-16

Targets for the number of clients reporting an increase in days of paid work is 130 per year. The following provides an overview of activity:

180 TEVE Lite clients

52 TEVE Contingency Management Clients

112 appointments attended

85 clients currently open on TEVE

57 clients are currently referred but have not attended a TEVE advice session

589 appointments offered but not attended

1:1 Appointments:

241 successful TEVE CM appointments

44 unsuccessful TEVE CM appointments

414 successful TEVE Lite appointments

96 unsuccessful TEVE Lite appointments

Data for the first three quarters of 2015/16 show that 129 clients increased their number of days in paid work.

## 2. Other services

The Voscur website in Bristol lists 60 services who offer advice and support on employment, education, learning and training.

There are numerous assets within the community to specifically support people with substance misuse issues. Some of these are listed below:

Job Centre Plus Statutory Organisation supporting Bristol residents to find employment and access appropriate benefits.

St Mungo's Recovery College (Compass Centre)

Crisis Centre Ministries Host advisory sessions about employment and citizens' rights in partnership with local statutory and voluntary organisations. They also provide appropriate work and support for volunteers.

The Haven - A therapeutic outdoor space for growing, crafting, wildlife watching and relaxation.

There are a number of online opportunities for education and training.

There are a variety of volunteering opportunities offered across Bristol.

## **What do staff and service users think?**

### **Service users**

Three focus groups were carried out with Bristol residents who had the opportunity to access to TEVE services. Fifteen people attended in total. Thirteen were ROADS clients. These focus groups took place with service users at an ARA prep house, the IF Group and an ARA in-treatment house.

All attendees felt that it was important for people in recovery to have 'TEVE' opportunities and that peer mentoring and receiving peer support was an aid to recovery. Most expressed an interest in being trained as peer supporters.

Some attendees stated that they were aware of the TEVE service and that they would engage with it when they felt ready.

They also felt it was important to have TEVE embedded within the substance misuse service as some people would not be familiar with what was on offer in Bristol or how to access it.

All of those questioned agreed that there were problems accessing employment for those who had criminal records and were required to have a DBS.

They also felt that benefits such as ESA and accommodation costs were a barrier to employment.

One resident felt that the placements on offer in TEVE were not for them and would have preferred an opportunity to be involved with sports.

Several members of the group expressed difficulties in accessing computers in order to apply for jobs, training, employment and education.

All attendees stated that the opportunity to both receive and offer peer support was important to recovery. Several attendees felt that a structured peer support programme within treatment services were one of the most beneficial interventions on offer.

### **Staff**

Eight members of staff from ROADS gave feedback about TEVE in 1:1 interviews.

These people represented a range of ROADS services. They all supported TEVE as part of people's recovery. Difficulties identified by professionals were:

- Access to work for people who have a history of engagement with the CJ services is often difficult due to criminal history shown through DBS checks.
- Previous chaotic and transient lifestyles while using drugs and alcohol means that people do not have the necessary documents to prove that they have lived at an address for enough time. They are also unlikely to have the necessary documents like passports, bank accounts, driving licence etc.
- Access to computers to fill in job applications can be difficult for some people.
- Training needs to address the fact that many of these clients left school early and therefore have no school qualifications and may have poor reading and writing skills, learning difficulties.

The TEVE service sought feedback from ROADS clients around the TEVE service, with particular focus on employability workshops being offered as part of the ongoing relationship with Volunteer Bristol. There were 65 respondents from across ROADS services including DHI, ARA, BDP, INROADS and The Junction. 86% of respondents stated that they would like support with finding voluntary work. 52 of the 65 respondents expressed a need for interview skills with 42 identifying a need for mock interviews. Just over half wanted support around disclosing criminal convictions. 53 of the 65 (82% of respondents) stated that they would like support around identifying barriers and how to overcome them.

### **What are the projected needs for the future?**

The size of the treatment population in Bristol suggests that there continues to be need for TEVE in order to support recovery. While patterns of drug use are changing, and fewer people are using opiates and crack cocaine, problematic alcohol use continues to affect high numbers with increasing numbers of alcohol users entering ROADS treatment.

There is little support for clients as they transition from benefits into work which can be incredibly daunting, particularly for those who have been in receipt of benefits for a sustained period. Initial support is needed in terms of practical support i.e. travel money, appropriate clothes for interview and budgeting/ benefits advice. Currently there is a lack of provision of advice around 'better off in work calculations' or clear, accessible information around allowed work/ work trials and how this will effect clients.

Once in employment, clients would benefit from ongoing support, both practical and emotional support. This could be from business professionals, peers that have moved out of services and are now stable in their recovery and working, community volunteers or ETE workers.

Changes to the benefit system, particularly the role out of Universal Credit from 2018 and the freeze in LHA allowance will have a major impact of service users in the treatment system. The freeze in LHA allowance will shrink the pool of affordable housing considerably, thus intensifying the need to return to work to earn additional money.

Key gaps:

- Communication between commissioners, providers, JCP and WP. Even where protocols exist these are not always followed.
- There are still key groups who are having difficulty accessing employment such as those with a criminal history and a previous transient lifestyle.
- Those with recurrent health problems find access to employment very difficult, especially when these relate to their substance misuse.
- Training does not always address low educational attainment and skills.

## 10. Criminal Justice

### What is the level of need?

*In the local population*

Bristol has three main referral routes for Criminal Justice (CJ) clients into treatment: Probation, AIRS and HMP system. For a CJ client to be recorded as such in ROADS, they will have to have been referred by a CJ agency; self-declared CJ involvement at self-referral for example will not count toward the recording figures. Between 01/01/2015 and 31/12/2015, 12.4% of ROADS clients were in contact with the Criminal Justice system.

**Chart 10.1 Bristol criminal justice referrals in to substance misuse treatment**

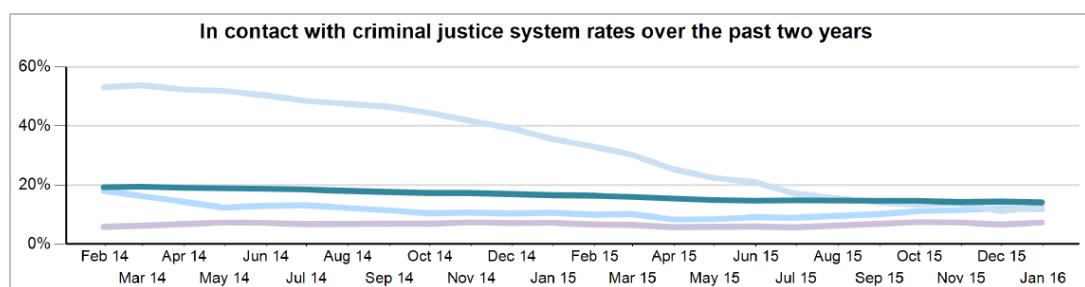
	Latest period		National average
	(%)	(n)	(%)
Opiate	14.1%	391 / 2781	22.9%
Non-opiate	12.5%	28 / 224	19.3%
Alcohol	7.2%	59 / 819	6.5%
Alcohol and non-opiate	11.7%	49 / 418	14.2%

Due to changes in powers of arrest under Code G of the Police & Criminal Evidence Act (PACE), the relocation of custody suites to outside Bristol and the disinvestment in CJ services in Bristol following the appointment of the Police & Crime Commissioner (PCC) for Avon & Somerset, the numbers of CJ clients in ROADS has fallen. Whilst the effect of the changes has been felt to some extent by other LAs in the Force area, the majority of substance misuse associated crime in the region was

and is committed in Bristol. This effect bares most importance when comparing our in-treatment figures, by associated substance type, with National ones.

The timeline below shows the gradual effect of the changes on ROADS CJ clients in treatment figures over the last 2 years. Most notable is the steady decline of non-opiate CJ clients in treatment from over 50% to just over 10%.

### Chart 10.2 CJ clients in contact with substance misuse treatment

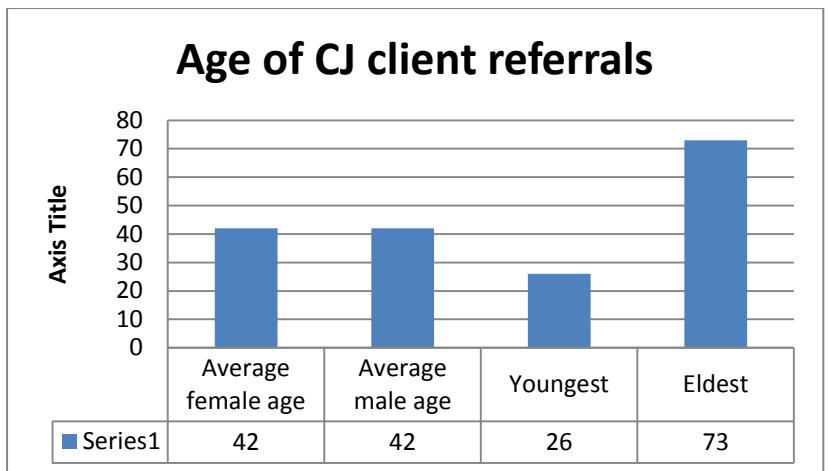


This isn't to say that the need for CJ substance misuse treatment has decreased at the same rate, more that with almost 50% fewer arrests made by Avon & Somerset police in the year following the opening of the new custody suites, fewer potential ROADS clients have had their first intervention with CJ services.

It is perhaps more important to now focus energy and resources on engagement and preventative treatment such as Drug Education Programmes. This is a Police initiative with Swanswell commissioned to deliver the workshop intervention. The aim is to in order to deter potential offenders and manage the crime causing behaviour of those who offend to support a substance misuse problem.

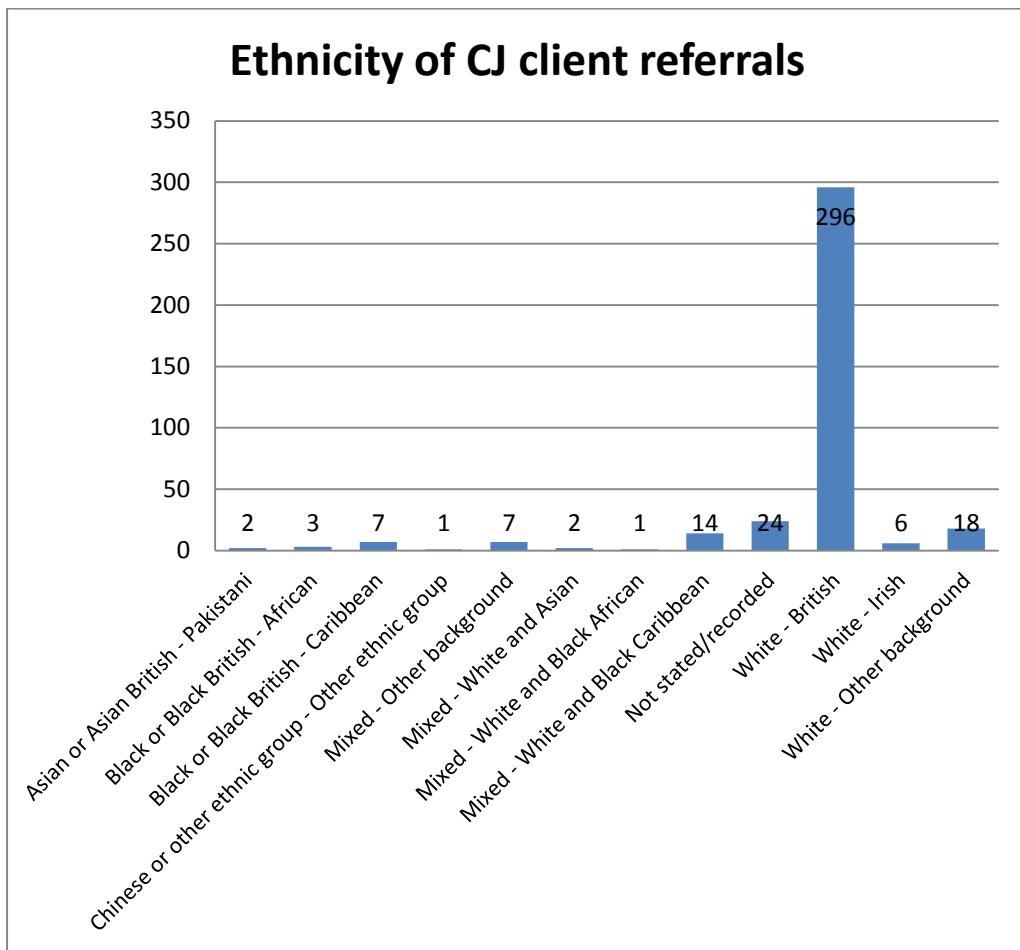
During 2015/16, ROADS received 494 referrals from CJ services of which 381 were unique clients. The graphs and tables below give more detail on these individuals. There is a slightly higher proportion of male CJ clients than in ROADS overall with the split being 72% male to 28% female.

### Chart 10.3 Age of CJ Clients



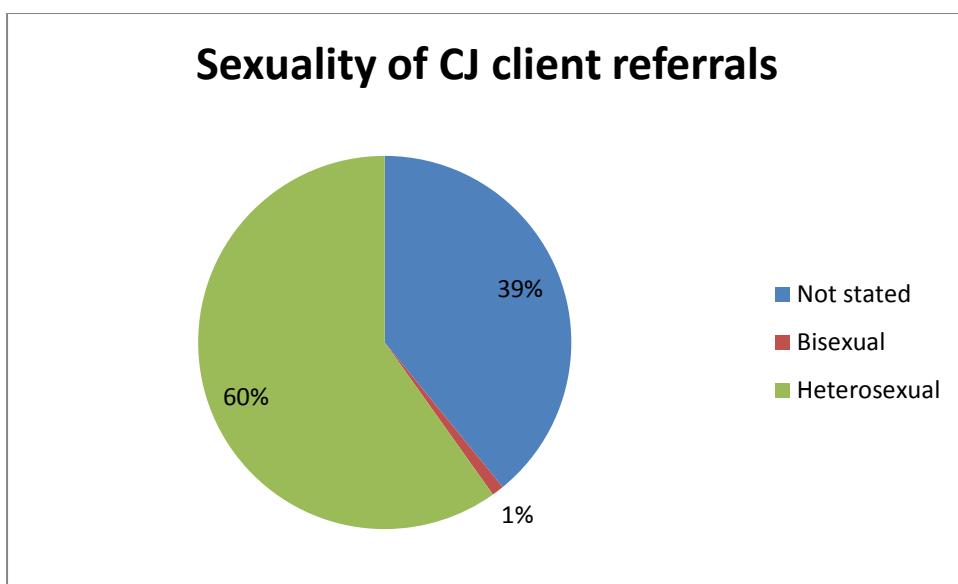
With only 2% of CJ clients under 30 compared with 12% across ROADS, it would suggest that involvement with CJ and SM services affects an older cohort. The median age of the CJ client is also older with the majority of clients in ROADS being in the 35-39 year old bracket.

**Chart 10.4 Ethnicity of CJ clients**



There are proportionally fewer White British clients amongst the CJ cohort than in mainstream ROADS with an 8% difference. There was a marginally higher representation amongst the Black or Black British Caribbean cohort than in ROADS but there were no other outliers.

**Chart 10.5 Sexual Orientation of CJ clients**

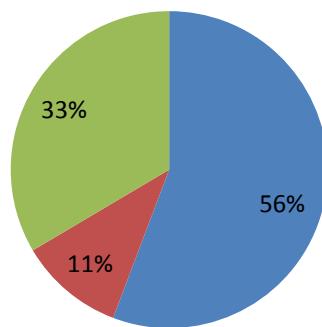


There was a significant amount of 'Not stated' replies amongst the CJ cohort making it difficult to draw comparisons with other groups. The recording pathways for this field are being investigated by Safer Bristol.

**Chart 10.6 Disability status of CJ clients**

## Disability status of CJ client referrals

■ No ■ Yes ■ Not Stated/blank



As with the Sexuality recording, the large amount of 'Not stated or Blank' replies makes analysis very difficult. Every effort will be made to enable referrers to complete these fields in the future.

### **What services /assets do we have to meet and prevent this need?**

*Commissioned services plus activity*

#### **ROADS**

As a part of all ROADS contracts, there is an expectation that certain high risk groups are afforded priority access. Included within this group are many of the CJ cohort:

- Prison leavers or prison day release
- IMPACT (Bristol's Integrated Offender Management unit) service users
- Service users subject to a Drug Rehabilitation Requirement or Alcohol Treatment Requirement

Having these clients as an integral priority group throughout ROADS helps us quickly and effectively engage and treat them.

As part of the Engagement cluster in ROADS, there is dedicated capacity within the team to fast track the assessment of CJ clients and ensure the pathway for Criminal Justice referrals, especially from the AIRS are prioritised.

In Q3 2015/16, 95 referrals were received for CJ clients via AIRS who were not already engaged in treatment. Of the 35 clients for whom a treatment pathway(s) was established on referral, the treatment type is listed below:

<b>Treatment type</b>	<b>Count</b>
Alcohol Detox Support Group	6
Alcohol Extended Brief Interventions	2
ARA Housing drop-in	2
Brief Interventions (Drugs)	4
Controlled Drinking Workshop	4
Preparation for Recovery Group	13
Relapse Prevention (Alcohol)	1
Relapse Prevention (Drug)	1
Standard Shared Care (Monthly)	2
TEVE light	2

The variety of treatment types highlight the differing needs of the clients and the mix of drugs and/or alcohol. In the Change cluster of ROADS, there is a dedicated Rapid Prescribing (RP) team who provide rapid access prescribing to service users re-integrating in to the community from the criminal justice system. As part of this Rapid Access provision, the team provide case management/care co-ordination sessions which contain an element of psychosocial brief intervention work to maximize engagement and motivation.

In Q3 2015/16, the RP team received 114 referrals for the continued community prescribing of Bristol residents. Overall during that quarter, less than half (42%) attended that appointment and received an ongoing prescribing regime. Second to DNAs, which can be attributed to many things including a change of heart on behalf of the client and being recalled to prison, 18% of clients did not attend their first appointment due to not being released from custody. There are a number of clients who are either released early from court or not released prior/on the referral day for whom there is an un-met need. Work is on-going between Public Health England, commissioners of the clinical prescribing service in many of the prisons and HMP

Bristol, being the main referrer, to ensure an appropriate and necessary service for these clients is delivered.

Prison	Referrals received	Assessment Appointment Offered	Attended	DNA	Not released from custody	Outcome unknown	Total number of F2F client contacts within month of referral
Bristol	60	35	27	16	15	5	31
Bullingdon	7	5	3	1	1	0	6
Channings Wood	2	1	1				5
Chelmsford	1	1	1	0	0	0	0
Eastwood Park	19	13	7	6	3	3	11
Exeter	4	6	2	2	1	1	0
Guys Marsh	11	8	4	2	0	2	3
Hewell	3	2	1	1	0	0	2
Norwich	1	1		1			0
Portland	4	4	2	1	1	0	0
Swansea	1	1					1
Thameside	1	0	0	0	0	0	0
<b>TOTAL</b>	<b>114</b>	<b>77</b>	<b>48</b>	<b>30</b>	<b>21</b>	<b>11</b>	<b>59</b>

NB: due to appointments sometimes being set across different months/quarters, not all referral numbers will have an outcome.

#### *Other assets in the community*

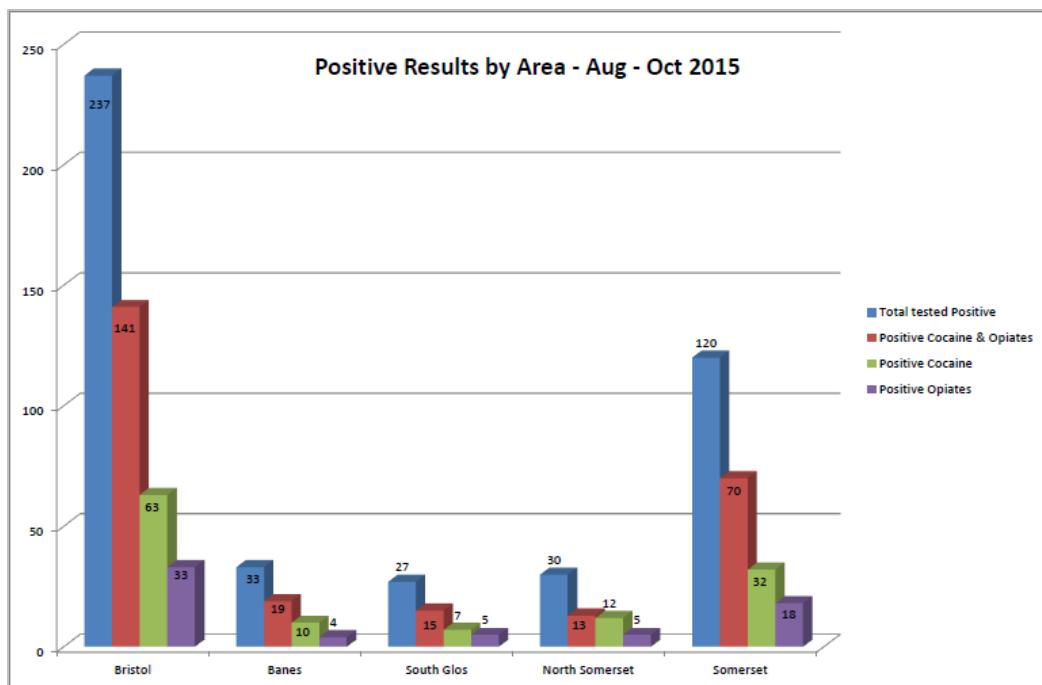
#### AIRS

The PCC commissioned Arrest Intervention Service (AIRS) operates from the 4 custody suites in the Avon & Somerset Police force area. It operates a Test on Arrest (ToA) system whereby anyone arrested for an acquisitive crime such as burglary or shoplifting will be tested for Class A drugs upon arrival at the custody suite. If a positive test is given, the person will be legally required to attend an appointment in the community with ROADS if an ongoing treatment need is identified by an AIRS worker. 50% of clients do not require a community appointment as Brief Interventions are deemed sufficient by the AIRS worker.

It also delivers a cell sweep function whereby any one brought in to custody who shows signs of having a substance misuse issue is offered a voluntary brief intervention and onward referral to ROADS.

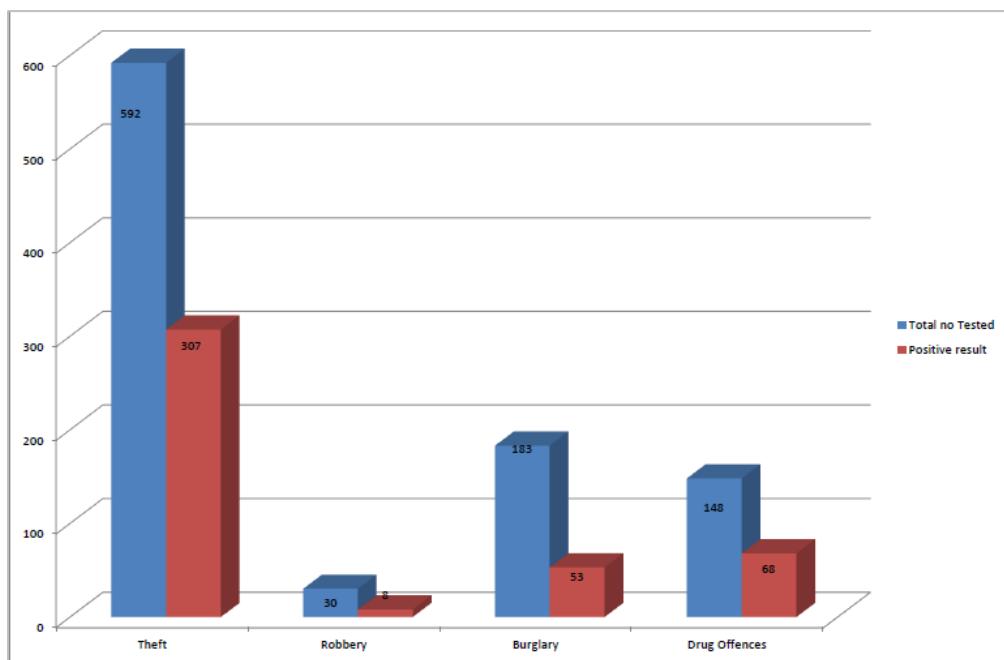
The graph below shows the high amount of positive tests given by Bristol residents and the amount of high complexity of poly drug ( opiates and cocaine) use that is characteristic of Bristol's drug using population.

**Chart 10.7 Positive tests by area**



The graph below shows, as a force area, the offence by type over the same period.

**Chart 10.7 Type of offences by force area**



Not only are the referral numbers for required and voluntary assessment fewer for reasons outlined in section 4, but the number of people attending the appointments is also low at 22% for the 3 month period between mid-March and mid-June as detailed below

Referral Outcome	Count
Attended	17
Cancelled	11
Cancelled and re-booked	2
DNA	49
Total	79

The introduction of 2 Bristol specific workers from AIRS to facilitate the custody to community transition is expected to see the attendance percentage increase over time.

A targeted snapshot audit was carried out by Safer Bristol to identify the revolving door clients who were assessed through ToA by AIRS but were already engaged with treatment in ROADS. This treatment is not meeting their needs if they continue to offend to support a drug habit. The audit noted that the majority of these clients were poly drug using White British males in their late thirties on high methadone

prescriptions. The care-coordinators of these clients are now routinely re-visiting client situations and prescribing doses at care plan reviews to better meet their needs and hopefully break the cycle of substance related crime causing behaviour.

### **The Bristol, Gloucestershire, Somerset and Wiltshire Community**

#### **Rehabilitation Company Limited (CRC)**

BGSW co-deliver with ROADS a weekly group work session for up to 10 statutory probation service users as an introduction to ROADS treatment services. This includes information giving about being subject to statutory supervision, what is available to service users in ROADS, options for mutual aid etc. When a service user completes the 3 session programme they will be given an appointment to commence an appropriate treatment modality the following week.

### **Streetwise**

Streetwise is part of the Council and Police's ASB Team that deals with "street-based" ASB. This is largely begging, street drinking and rough sleeping. The approach of the project is to engage with individuals who are involved in such behaviours and get them into support to address the underlying issues that are causing such behaviour. Where this support is not taken up and/or the behaviour continues the team look to use enforcement powers (normally an Injunction) to try and prevent the behaviour continuing.

In a case study of 72 individuals, 71 of them have substance and alcohol misuse issues. In this case, 99% of individuals who are causing street based ASB have alcohol and substance misuse issues as a major causal factor. These individuals have a disproportionate effect on the wider community. As an example of this, in 2015, the Police received 1105 calls for service from members of the public regarding such behaviours.

The Streetwise team are regularly told by members of the public that such behaviour makes them feel very intimidated and threatened and will lead to members of the public actively avoiding areas that they associate with such behaviour.

One of the key elements to the Streetwise team dealing with this cohort is being able to effectively work with partners. Currently, the team perceive the biggest gap in that partnership is substance misuse services and feel that the needs of this client group

would be better met with a multi-agency approach. This is particularly important when dealing with individuals who are resistant to treatment and recovery and needs to be explored further.

### **One25**

One25 is a charity that specialise in enabling women to break free from street sex-work, addiction and other life-controlling issues and build new, independent lives. In 2015/16 they worked with 235 women, of which nearly two-thirds (152) were supported around their addiction. Many of the women One25 support who have high levels of drug/ alcohol use also commit acquisitive crime as a means by which to fund their addictions. As a result, some of these women find themselves involved in the Criminal Justice System, either in the community or serving short custodial sentences. Due to their chaotic, often nocturnal lifestyles these women can find appointment-based systems difficult to engage with. They can end up missing appointments relating to their opiate substitute prescribing, requiring multiple re-starts. They can also find it difficult to meet the requirements of community orders leading to breach. Being sentenced to a community order through the courts does not necessarily mean that the women's level of drug or alcohol use reduces, therefore often their offending behaviour continues despite their ongoing involvement in the Criminal Justice System.

### **What do staff/users/carers think?**

Through consultation with colleagues incorporating feedback from wider partners and service users, a number of points were noted about the current Criminal Justice provision and its pathways. These points refer to the Criminal Justice provision commissioned by Safer Bristol in its own right as well as its part in meeting the overall need of people with substance misuse and Criminal Justice needs in Bristol. In summary, feedback suggests:

- That the inconsistent release practices of prisons makes it difficult for people needing ongoing substance misuse treatment to make community appointments

- That the range of services available to clients since the advent of ROADS puts some clients off engaging with treatment
- That the RP service works well and gets clients quickly onto a prescribing regime in the community
- That the introduction to ROADS sessions for CJ clients helps get people engaged in services quickly and maintains motivation to change
- That not having a substance misuse team presence at The Bridewell police station now makes co-working clients less easy for Police and Probation staff
- That Prison staffing levels have had a negative effect on substance misuse treatment in HMP Bristol and a knock on effect for continuing community treatment. Often, inmates are unable to attend psychosocial services as there are no officers to escort them.
- That substance misuse training for Police and Probation staff would better aid referral
- SM treatment in prisons often falls short of clients' requirements. Substitute medication is offered, but group work and other psychosocial interventions are often not taken up. This is due to some inmates not knowing they are available and some wanting to attend, but not being able to due to low officer number to escort them. This is a particular unmet need in HMP Bristol
- Prison leavers are often not properly needs assessed on exit leading to many coming out without suitable accommodation and in some cases a continued SM treatment plan
- Substance Misusing CJ clients coming through AIRS and being assessed as needing further treatment in the community are often not attending their follow up appointments. A need is being identified within the custody environment but not being met by community services

## **Criminal Justice**

### **What are the projected needs for the future?**

- A huge increase in the use of Spice and NPS amongst the Prison cohort has led to a greater number of people using these substances as well as illegal

drugs in the community. There is a need to effectively engage these clients in community treatment as quickly as possible

- With CJ Non-Opiate users engaged in ROADS falling from 50% to 10% over the last two years to January 2016, there is a need to identify and engage this particular cohort in community treatment
- With more of the Prison cohort starting or continuing to misuse drugs whilst inside, more housing and better referrals are needed to SM Supported Housing, especially for those leaving Prison as active users.
- Changes to the Offender Rehabilitation Act is potentially having an impact on homelessness. The suggestion is that as the rehabilitation act now requires everyone to have a probation worker, clients who live chaotic lives (such as those with substance misuse issues) aren't making their probation appointments which results in a breach and recall to prison for short periods which means losing their room in a hostel and their script

### **What are the unmet needs?**

- SM treatment in prisons often falls short of clients' requirements. Substitute medication is offered, but group work and other psychosocial interventions are often non-existent. This is a particular unmet need in HMP Bristol
- Prison leavers are often not properly needs assessed on exit leading to many coming out without suitable accommodation and in some cases a continued SM treatment plan
- Substance Misusing CJ clients coming through AIRS and being assessed as needing further treatment in the community are often not attending their follow up appointments. A need is being identified within the custody environment but not being met by community services
- A number of clients being picked up through the AIRS are already in treatment in ROADS, usually in OST. This treatment is not meeting their needs if they continue to offend to support a drug habit.
- Substance Misuse services and Streetwise teams need to work better together in engaging this often resistant client group in treatment.



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[health%20problems%2C%20substance%20misuse%20and%20learning%20d  
isability%20on%20parenting%20capacity&f=false](#)

43. Advisory Council on the Misuse of Drugs (2011) Hidden Harm – Responding to the needs of children of problem drug users  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/120620/hidden-harm-full.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/120620/hidden-harm-full.pdf)
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## **Glossary**

AIRS – Arrest Intervention Referral Service  
ARA – Addiction Recovery Agency  
AUDIT- Alcohol Use Disorders & Identification Test  
BBV - Blood borne viruses  
BDP- Bristol Drug Projects  
BMH – Bristol Mental Health  
BRI - Bristol Royal Infirmary  
BSDAS – Bristol Specialist Drug & Alcohol Service  
CCG - Clinical Commissioning Group  
CPA - Care Programme Approach  
CPP - Child Protection Plan  
DCLG - Department for Community and Local Government  
DHI - Developing Health & Independence  
ETE – Education, Training & Employment  
HBV – Hepatitis B  
HCV - Hepatitis C  
HSCI – Health & Social Care Information Centre  
HSR – Housing Support Register  
IPED - Image and performance enhancing drugs  
IVDU - Intravenous drug use  
JCP – Jobcentre Plus  
LAPE – Local Alcohol Profile for England  
MECC - Making Every Contact Count  
NOCU – Non Opiate & Crack User  
NSP- Needle and syringe provision  
OCU – Opiate & Crack User  
PCC – Police & Crime Commissioner  
PHOF - Public Health Outcome Framework  
PTSD - Post-Traumatic Stress Disorder

PWID – People who inject drugs

RDT - Recovery Diagnostic Toolkit

ROADS – Recovery Orientated Alcohol & Drugs Service

TOP – Treatment Outcome Profile

TEVE – Training, Education, Volunteering & Employment

WP – Work Programme

## Appendices

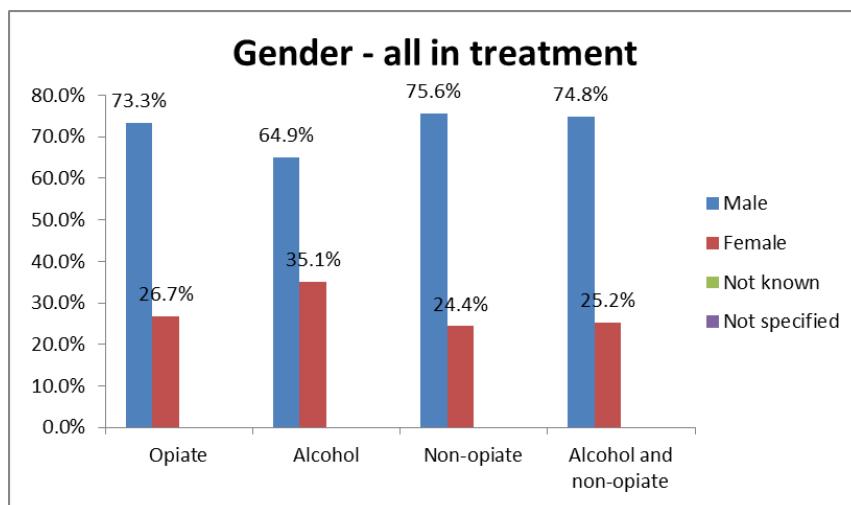
### Appendix 1

#### Appendix 1: Demographic Overview

##### Demographics

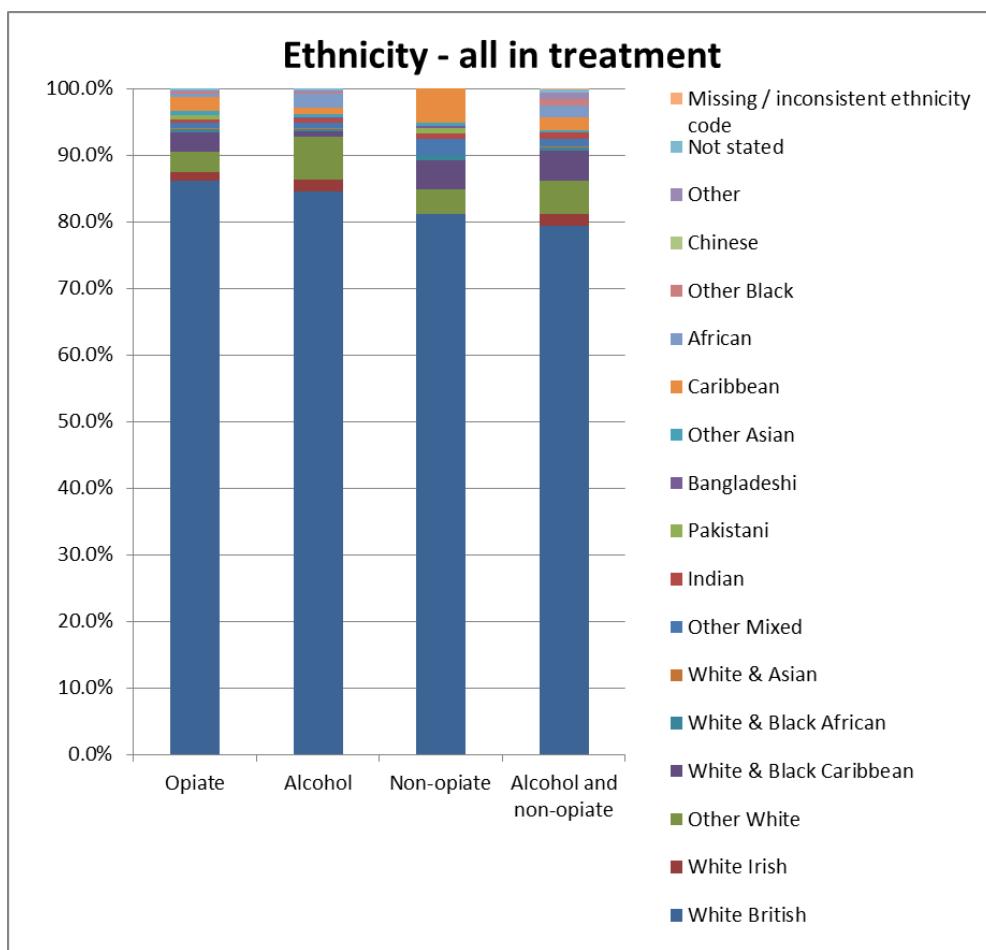
###### Gender (all in treatment)

	Opiate	Alcohol	Non-opiate	Alcohol and non-opiate
Male	73.3%	64.9%	75.6%	74.8%
Female	26.7%	35.1%	24.4%	25.2%
Not known	0.0%	0.0%	0.0%	0.0%
Not specified	0.0%	0.0%	0.0%	0.0%



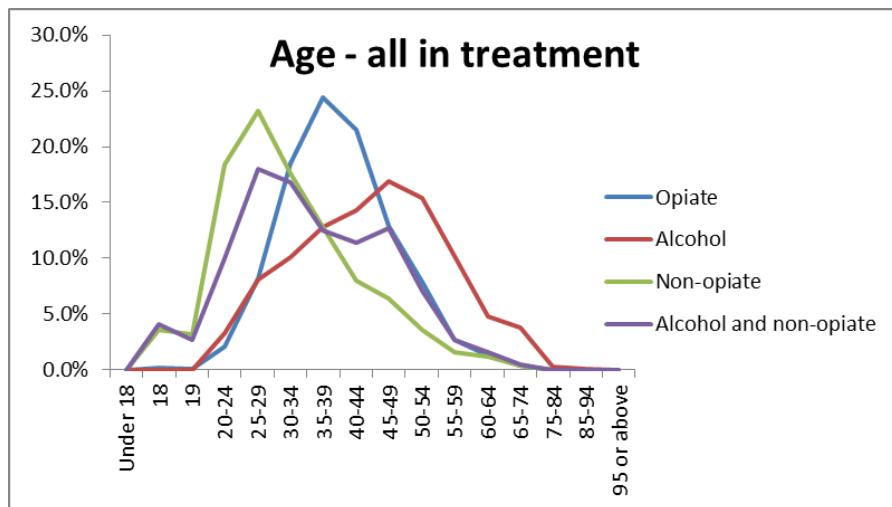
###### Ethnicity (all in treatment)

	Opiate	Alcohol	Non-opiate	Alcohol and non-opiate
White British	86.2%	84.5%	81.2%	79.3%
White Irish	1.2%	1.8%	0.0%	1.8%
Other White	3.1%	6.4%	3.6%	5.0%
White & Black Caribbean	3.0%	0.9%	4.4%	4.5%
White & Black African	0.5%	0.2%	0.8%	0.5%
White & Asian	0.2%	0.2%	0.0%	0.2%
Other Mixed	0.8%	0.7%	2.4%	1.1%
Indian	0.5%	0.6%	0.8%	0.9%
Pakistani	0.5%	0.0%	0.8%	0.0%
Bangladeshi	0.1%	0.2%	0.4%	0.0%
Other Asian	0.6%	0.5%	0.4%	0.2%
Caribbean	2.1%	1.0%	5.2%	2.0%
African	0.4%	2.1%	0.0%	1.8%
Other Black	0.3%	0.1%	0.0%	0.9%
Chinese	0.0%	0.0%	0.0%	0.0%
Other	0.3%	0.2%	0.0%	0.9%
Not stated	0.3%	0.4%	0.0%	0.5%
Missing / inconsistent ethnicity code	0.0%	0.0%	0.0%	0.2%



### Age (all in treatment)

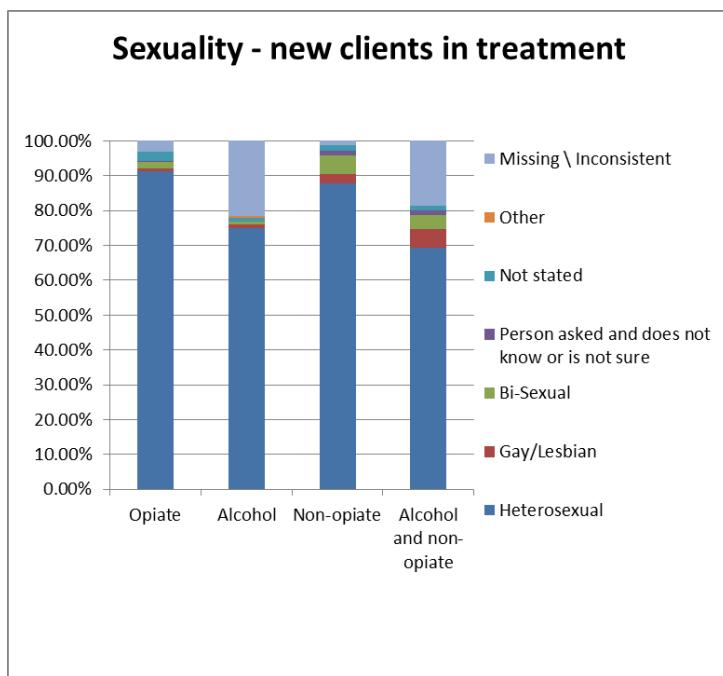
	Opiate	Alcohol	Non-opiate	Alcohol and non-opiate
Under 18	0.0%	0.0%	0.0%	0.0%
18	0.1%	0.0%	3.6%	4.1%
19	0.1%	0.0%	3.2%	2.7%
20-24	2.0%	3.3%	18.4%	10.0%
25-29	8.2%	8.1%	23.2%	18.0%
30-34	18.5%	10.1%	17.6%	16.8%
35-39	24.4%	12.8%	12.8%	12.5%
40-44	21.5%	14.3%	8.0%	11.4%
45-49	12.9%	16.9%	6.4%	12.7%
50-54	7.9%	15.4%	3.6%	7.0%
55-59	2.7%	10.2%	1.6%	2.7%
60-64	1.3%	4.8%	1.2%	1.6%
65-74	0.3%	3.8%	0.4%	0.5%
75-84	0.0%	0.2%	0.0%	0.0%
85-94	0.0%	0.1%	0.0%	0.0%
95 or above	0.0%	0.0%	0.0%	0.0%



### Sexuality (new treatment journey / episode)

	Opiate	Alcohol	Non-opiate	Alcohol and non-opiate
Heterosexual	91.32%	75.00%	87.67%	69.33%
Gay/Lesbian	0.75%	1.14%	2.74%	5.33%
Bi-Sexual	1.89%	0.57%	5.48%	4.00%
Person asked and does not know or is not sure	0.38%	0.00%	1.37%	1.33%
Not stated	2.64%	1.14%	1.37%	1.33%
Other	0.00%	0.57%	0.00%	0.00%
Missing \ Inconsistent	3.02%	21.59%	1.37%	18.67%

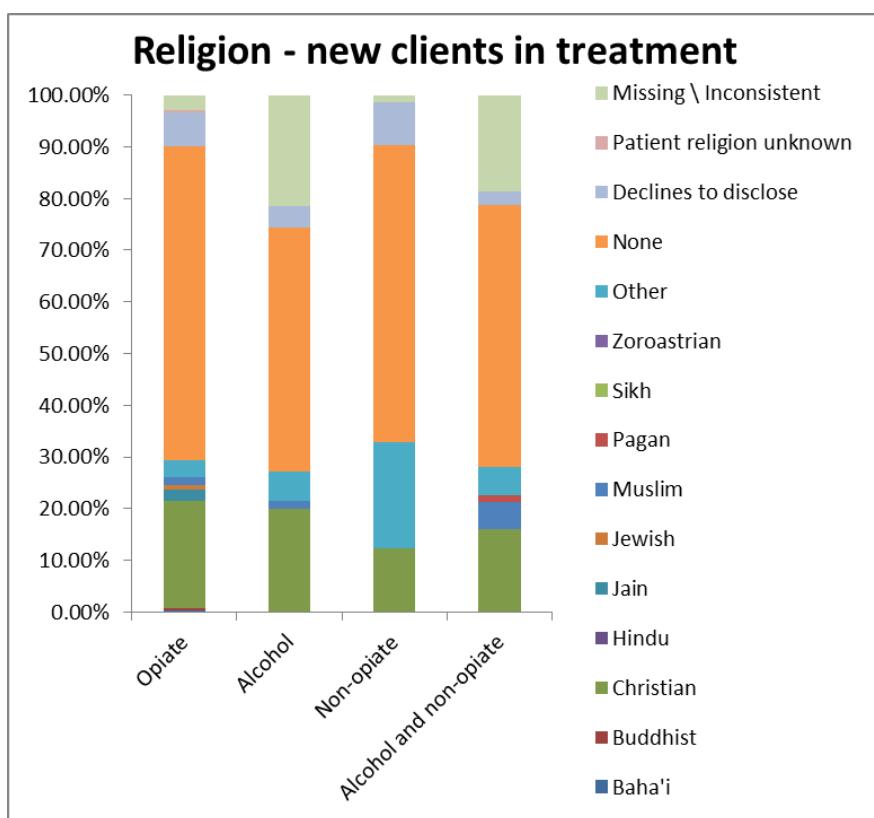
Data from Q1 2015/16 Provider Activity Report – data not previously collected



Religion (new treatment journey / episode)

	Opiate	Alcohol	Non-opiate	Alcohol and non-opiate
Baha'i	0.38%	0.00%	0.00%	0.00%
Buddhist	0.38%	0.00%	0.00%	0.00%
Christian	20.75%	19.89%	12.33%	16.00%
Hindu	0.00%	0.00%	0.00%	0.00%
Jain	2.26%	0.00%	0.00%	0.00%
Jewish	0.75%	0.00%	0.00%	0.00%
Muslim	1.51%	1.70%	0.00%	5.33%
Pagan	0.00%	0.00%	0.00%	1.33%
Sikh	0.00%	0.00%	0.00%	0.00%
Zoroastrian	0.00%	0.00%	0.00%	0.00%
Other	3.40%	5.68%	20.55%	5.33%
None	60.75%	47.16%	57.53%	50.67%
Declines to disclose	6.42%	3.98%	8.22%	2.67%
Patient religion unknown	0.38%	0.00%	0.00%	0.00%
Missing \ Inconsistent	3.02%	21.59%	1.37%	18.67%

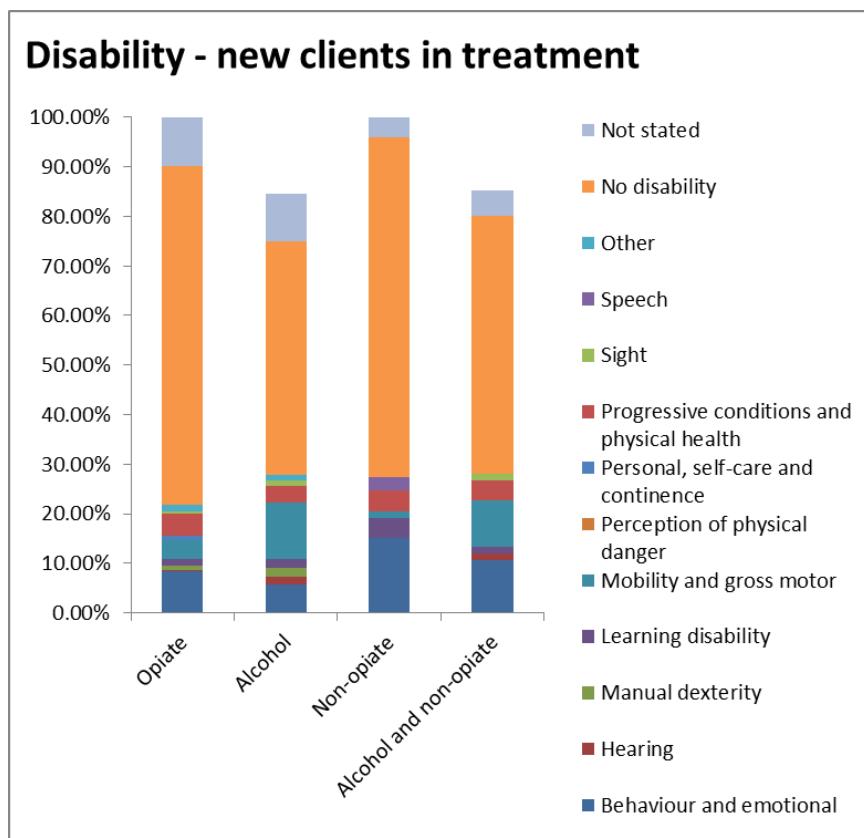
Data from Q1 2016/17 Provider Activity Report – data not previously collected



## Disability (new treatment journey / episode)

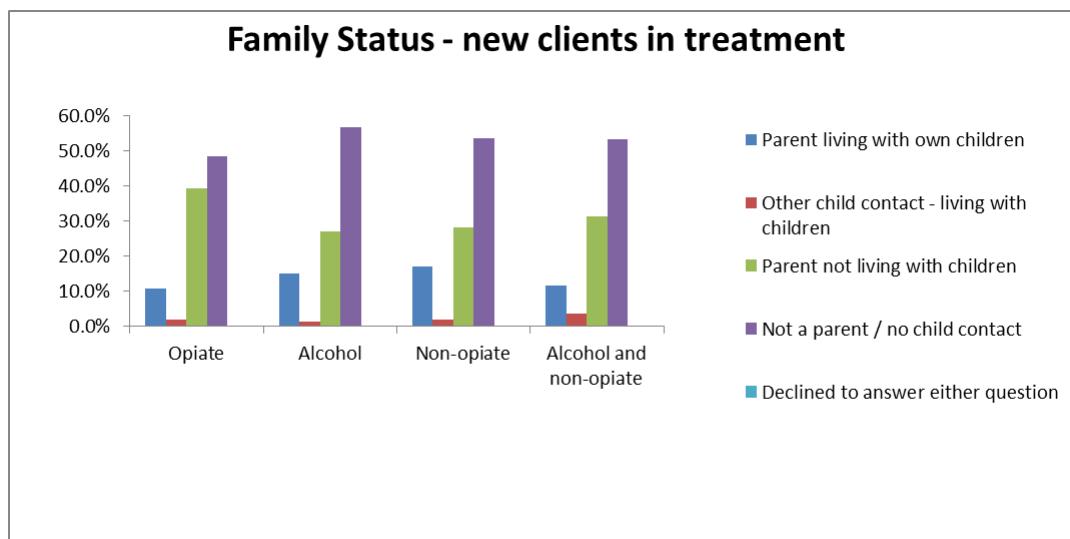
	Opiate	Alcohol	Non-opiate	Alcohol and non-opiate
Behaviour and emotional	8.30%	5.68%	15.07%	10.67%
Hearing	0.38%	1.70%	0.00%	1.33%
Manual dexterity	0.75%	1.70%	0.00%	0.00%
Learning disability	1.51%	1.70%	4.11%	1.33%
Mobility and gross motor	3.77%	11.36%	1.37%	9.33%
Perception of physical danger	0.00%	0.00%	0.00%	0.00%
Personal, self-care and continence	0.75%	0.00%	0.00%	0.00%
Progressive conditions and physical health	4.53%	3.41%	4.11%	4.00%
Sight	0.38%	1.14%	0.00%	1.33%
Speech	0.00%	0.00%	2.74%	0.00%
Other	1.51%	1.14%	0.00%	0.00%
No disability	68.30%	47.16%	68.49%	52.00%
Not stated	11.70%	9.66%	4.11%	5.33%

Data from Q1 2016/17 Provider Activity Report – data not previously collected



### Family status (new treatment journey / episode)

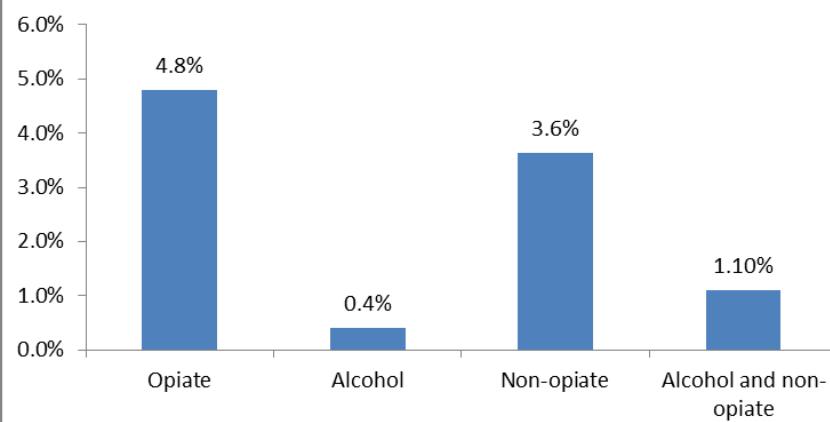
	Opiate	Alcohol	Non-opiate	Alcohol and non-opiate
Parent living with own children	10.6%	15.0%	16.9%	11.6%
Other child contact - living with children	1.8%	1.4%	1.8%	3.6%
Parent not living with children	39.1%	26.9%	28.0%	31.3%
Not a parent / no child contact	48.4%	56.7%	53.3%	53.2%
Declined to answer either question	0.1%	0.0%	0.0%	0.3%



### Pregnant (female new treatment journey / episode)

	Opiate	Alcohol	Non-opiate	Alcohol and non-opiate
Pregnant	4.8%	0.4%	3.6%	1.10%

### Pregnant - new clients in treatment

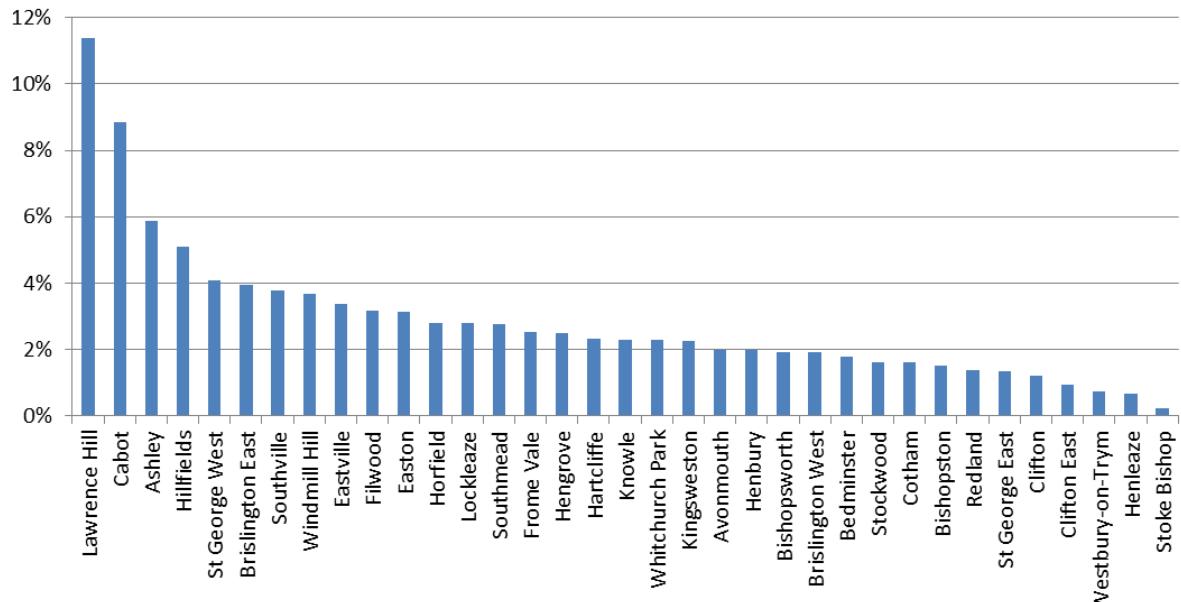


## Geographic distribution of new treatment referrals 2015/16 by ward

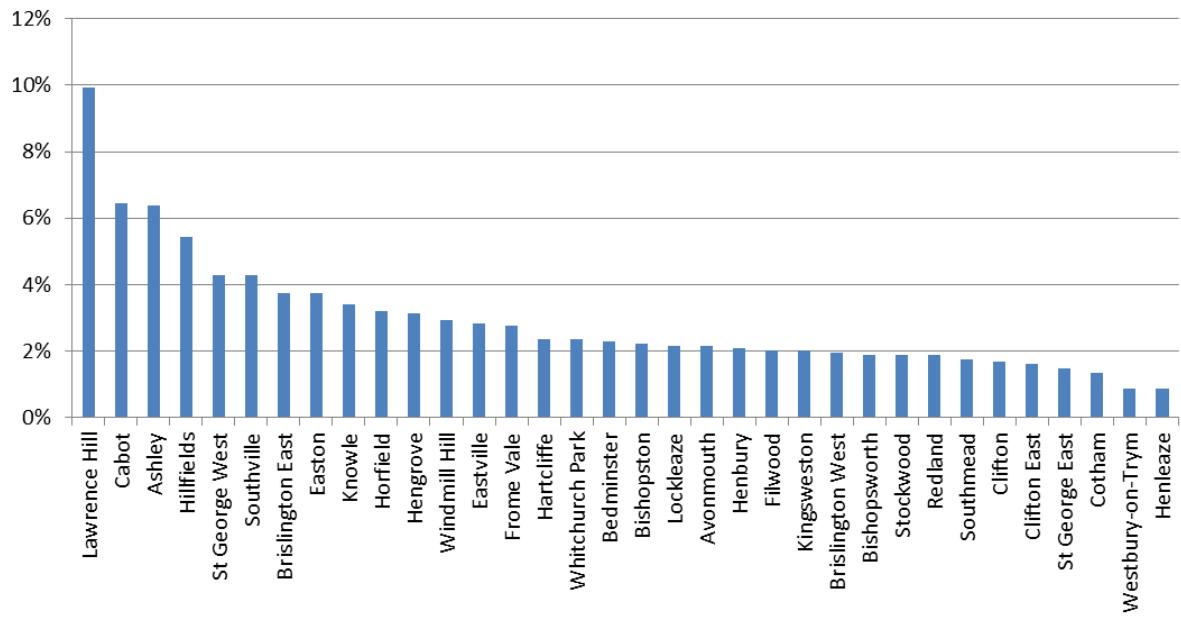
Ward	% All	Alcohol	% Alcohol	Opiate	% Opiate	Non-opiates	% Non-opiate
Lawrence Hill	11%	146	10%	188	14%	42	9%
Cabot	9%	95	6%	153	11%	44	9%
Ashley	6%	94	6%	66	5%	34	7%
Hillfields	5%	80	5%	68	5%	21	5%
St George West	4%	63	4%	51	4%	21	5%
Brislington East	4%	55	4%	67	5%	9	2%
Southville	4%	63	4%	47	3%	15	3%
Windmill Hill	4%	43	3%	63	5%	16	3%
Eastville	3%	42	3%	52	4%	18	4%
Filwood	3%	30	2%	60	4%	15	3%
Easton	3%	55	4%	36	3%	13	3%
Lockleaze	3%	32	2%	41	3%	20	4%
Horfield	3%	47	3%	31	2%	15	3%
Southmead	3%	26	2%	52	4%	14	3%
Frome Vale	3%	41	3%	36	3%	7	2%
Hengrove	3%	46	3%	27	2%	10	2%
Hartcliffe	2%	35	2%	21	2%	21	5%
Whitchurch Park	2%	35	2%	31	2%	10	2%
Knowle	2%	50	3%	18	1%	8	2%
Kingsweston	2%	30	2%	29	2%	16	3%
Henbury	2%	31	2%	30	2%	5	1%
Avonmouth	2%	32	2%	19	1%	15	3%
Bishopsworth	2%	28	2%	28	2%	8	2%
Brislington West	2%	29	2%	25	2%	9	2%
Bedminster	2%	34	2%	15	1%	10	2%
Stockwood	2%	28	2%	21	2%	5	1%
Cotham	2%	20	1%	27	2%	6	1%
Bishopston	2%	33	2%	7	1%	10	2%
Redland	1%	28	2%	11	1%	7	2%
St George East	1%	22	1%	19	1%*	*	*
Clifton	1%	25	2%	13	1%*	*	*
Clifton East	1%	24	2%	7	1%*	*	*
Westbury-on-Trym	1%	13	1%*	*		8	2%
Henleaze	1%	13	1%*	*		5	1%
Stoke Bishop	0%	5	0%*	*	*	*	*

Values below 5 have been suppressed

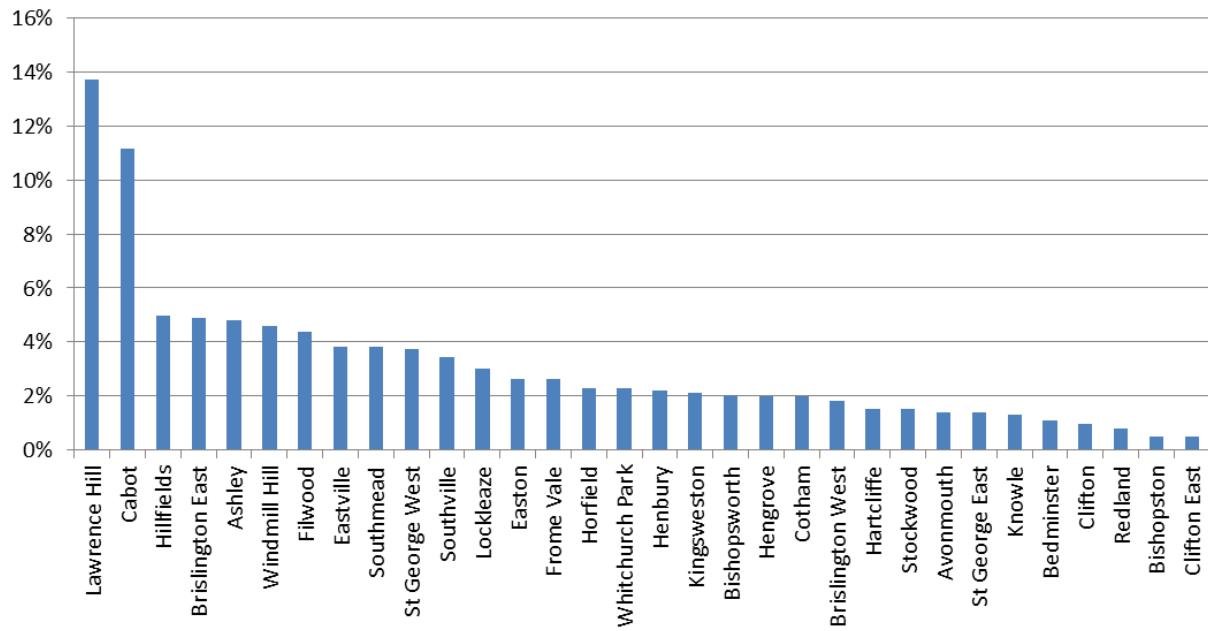
## % New referrals to treatment by Ward - All Substances



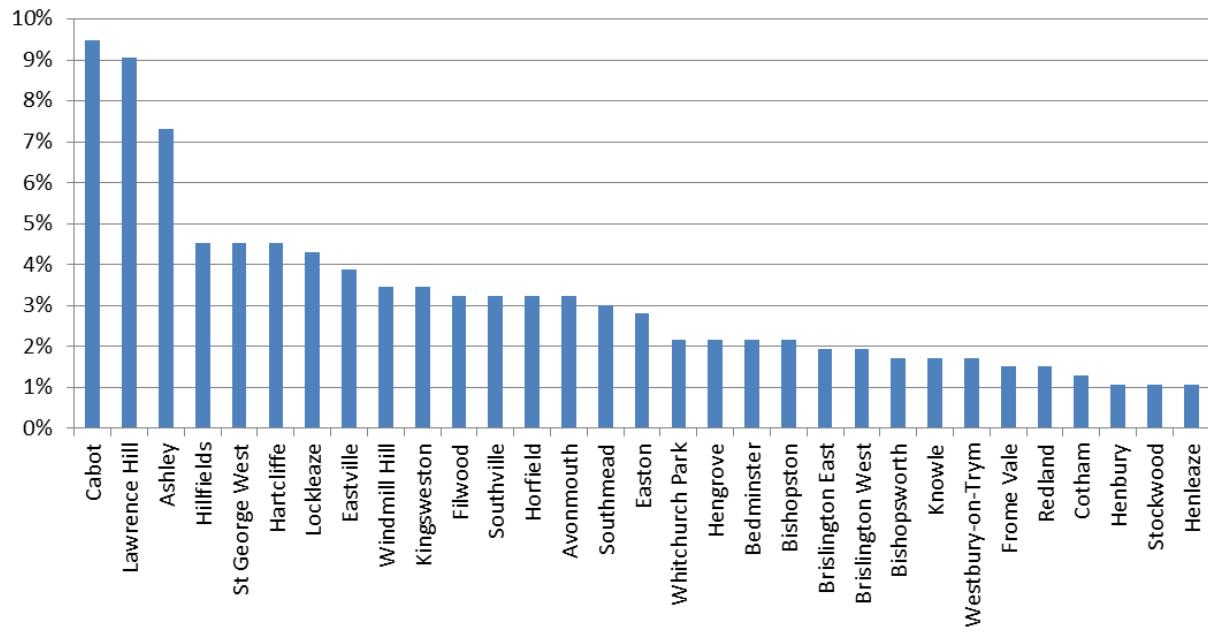
## % New referrals to treatment by Ward - Alcohol



### % New referrals to treatment by Ward - Opiates



### % New referrals to treatment by Ward - Non-opiates



## **Appendix 2: What Works- what is the evidence base?**

### **Physical health**

Drug misuse and dependence - UK guidelines on clinical management (Orange Book) is guidance intended for all clinicians, especially those providing pharmacological interventions for drug misusers as a component of drug misuse treatment

[http://www.nta.nhs.uk/uploads/clinical\\_guidelines\\_2007.pdf](http://www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf)

Medications in recovery: best practice in reviewing treatment

[http://www.nta.nhs.uk/uploads/medications\\_in\\_recovery-reviewing\\_treatment.pdf](http://www.nta.nhs.uk/uploads/medications_in_recovery-reviewing_treatment.pdf)

PHE Turning evidence into practice - Optimising opioid substitution treatment:

<http://www.nta.nhs.uk/uploads/teip-ost-14.pdf>

PHE -Take-home naloxone for opioid overdose in people who use drugs

<http://www.nta.nhs.uk/uploads/phetake-homenaloxoneforopioidoverdosefeb2015rev.pdf>

PHE - The Overdose and Naloxone Training Programme for Families and Carers

<http://www.nta.nhs.uk/uploads/naloxonereport2011.pdf>

Drug Related Deaths – setting up a local review process

[http://www.nta.nhs.uk/uploads/drug\\_related\\_deaths\\_setting\\_up\\_a\\_local\\_review\\_process.pdf](http://www.nta.nhs.uk/uploads/drug_related_deaths_setting_up_a_local_review_process.pdf)

Reducing Deaths in A&E

[http://www.nta.nhs.uk/uploads/nta\\_reducing\\_deaths\\_a\\_and\\_e\\_resource\\_2004\\_aem\\_ag01.pdf](http://www.nta.nhs.uk/uploads/nta_reducing_deaths_a_and_e_resource_2004_aem_ag01.pdf)

ACMD – How can OST (and drug treatment and recovery systems) be optimised to maximise recovery outcomes for service users?

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/470399/ACMD\\_RC\\_OPTIMISING\\_OST\\_REPORT\\_231015.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/470399/ACMD_RC_OPTIMISING_OST_REPORT_231015.pdf)

Drug misuse and dependence - UK guidelines on clinical management (Orange Book) [http://www.nta.nhs.uk/uploads/clinical\\_guidelines\\_2007.pdf](http://www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf)

PHE Turning evidence into practice - Preventing blood-borne virus transmission among people who inject drugs: <http://www.nta.nhs.uk/uploads/teip-bbv-2015.pdf>

PHE Turning evidence into practice - Optimising opioid substitution treatment:  
<http://www.nta.nhs.uk/uploads/teip-ost-14.pdf>

Good Practice in Harm Reduction

[http://www.nta.nhs.uk/uploads/nta\\_good\\_practice\\_in\\_harm\\_reduction\\_1108.pdf](http://www.nta.nhs.uk/uploads/nta_good_practice_in_harm_reduction_1108.pdf)

The current evidence base for preventing MRSA bacteraemia in PWID is lacking; BDP were recently successful in obtaining funds to develop knowledge around this issue and are working in partnership with PHE, University of Bristol and Bristol City Council.

Neptune –Clinical Guidance on the Clinical Management of Acute and Chronic Harms of Club Drugs and Novel Psychoactive Substances  
<http://neptune-clinical-guidance.co.uk/wp-content/uploads/2015/03/NEPTUNE-Guidance-March-2015.pdf>

EMCDDA – European Drug Report –Trends and Developments 2015  
<http://www.emcdda.europa.eu/system/files/publications/974/TDAT15001ENN.pdf>

PHE Turning evidence into practice - Providing effective services for people who use image and performance enhancing drugs  
<http://www.nta.nhs.uk/uploads/providing-effective-services-for-people-who-use-image-and-performance-enhancing-drugs2015.pdf>

NICE - Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence <https://www.nice.org.uk/guidance/cg115>

Alcohol prevention, treatment and recovery for adults: JSNA support pack. Good practice prompts for planning comprehensive interventions in 2015-16  
<http://www.nta.nhs.uk/uploads/jsna-adult-alcohol-final-300914.pdf>

## Government Alcohol Strategy 2012

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/224075/alcohol-strategy.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224075/alcohol-strategy.pdf)

## Mental Health

There are two pieces of relevant NICE guidance in relation to severe mental ill health and co-existing substance misuse:

1. Psychosis with substance misuse in over 14s: assessment and management NICE guidelines [CG120]. The NICE guideline covers: Adults and young people (14 and 1 older) who have a clinical working diagnosis of schizophrenia, bipolar or other affective psychosis, in conjunction with substance misuse. It includes specific consideration of the needs of people from black and minority ethnic groups. The guidance contains evidence-based recommendations which are divided into 6 areas of key priority, and within these there are 9 recommendations.
2. Severe mental illness and substance misuse (dual diagnosis) - community health and social care services. *This guidance is under development and is due to be published November 2016. This will need to be considered in the final development of the service specifications following the consultation period.*

Relevant NICE guidance in relation to mild to moderate mental illness and co-existing substance misuse is:

1. Drug misuse in over 16s psychosocial interventions. This includes information relating to delivering brief interventions for substance misuse in mental health services as well as advocating for more formal psychosocial interventions, such as CBT, for common comorbid problems. Inpatient/residential settings should also be considered for people who are seeking abstinence and who have significant comorbid physical, mental health or social (for example, housing) problems.

A framework for practice around dual diagnosis was produced by the Department of Health in 2002: Dual Diagnosis Good Practice Guide. The Handbook summarised current policy and good practice in the provision of mental health services to people with severe mental health problems and problematic substance misuse. This

guidance stated that treatment for dual diagnosis should be delivered within mental health services, known as 'mainstreaming'.

For less severe cases not eligible for psychiatric care, substance misuse services are seen as taking the lead. The suggestions the guidance include the following key points:

- Local services must be developed according to need with care pathways and clinical governance guidelines drawn up.
- Specialist dual diagnosis workers should provide support to mainstream mental health services where they exist.
- There should be adequate staff training around dual diagnosis.
- A Care Programme Approach (CPA), including the concept of a keyworker and full risk assessment, should be used in clients with dual diagnosis.

This approach was adopted locally by AWP through the Bristol Dual Diagnosis Strategy 2012.

A draft document has recently been released by PHE "Co-existing alcohol and drug misuse with mental health issues: guidance to support local commissioning and delivery of care". This document aims to support commissioners and service providers to work together to improve access to services which can improve health and recovery outcomes and life chances for all individuals who experience alcohol and/or drug misuse with co-existing mental health issues.

"The Five Year Forward View for Mental Health" report was produced for the NHS by an independent mental health task force in February 2016. This document makes a series of recommendations around improving mental health. In particular relevance to drugs and alcohol it identifies the need to develop a national Prevention Concordat programme to support all Health & Wellbeing Boards, Joint Strategic Needs Assessment process that will include mental health and co-morbid alcohol and drug misuse.

## **Housing**

There are a number of published papers and case studies directly addressing substance misuse and homelessness.

<https://www.york.ac.uk/media/chp/documents/2008/substancemisuse.pdf>

[http://www.emcdda.europa.eu/attachements.cfm/att\\_231402\\_EN\\_UK47\\_homelesspeople.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_231402_EN_UK47_homelesspeople.pdf)

[http://www.housinglin.org.uk/\\_library/Resources/Housing/Support\\_materials/Reports/Substance\\_users\\_report2.pdf](http://www.housinglin.org.uk/_library/Resources/Housing/Support_materials/Reports/Substance_users_report2.pdf)

<http://www.cih.org/resources/PDF/Policy%20free%20download%20pdfs/Role%20of%20housing%20in%20drugs%20recovery%20-%20final%20version.pdf>

Any many more generic papers that have a section on homelessness

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/98010/recovery-roadmap.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98010/recovery-roadmap.pdf)

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/98026/drug-strategy-2010.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98026/drug-strategy-2010.pdf)

Most of these papers advocate for a whole systems approach with joint working, co-commissioning and effective partnership working being the key to success.

Currently there are good links between Homelessness Prevention and Safer Bristol that include complimentary commissioning and joint team meetings in a bid to better meet the needs of our clients.

These links are not necessarily as well established on a provider level where feedback suggests there are gaps in knowledge around complimentary housing provision as well as referral criteria and pathways between services. Training amongst providers of generic housing in dealing with the substance misusing population is also something that needs to be improved upon. Consultation with SUs also highlights the fact that there needs to be more clarity around housing options for clients and the corresponding expectations for both client and provider for each option.

Evidence suggests that a sizeable percentage of the homeless population are either taking or recovering from drugs and/or alcohol, 39% and 27% respectively, and that with homelessness figures on the rise in Bristol, these needs have to be met. The identification of these clients at their first point of contact with homelessness services (usually hostels or street outreach) needs to be followed up with an appropriate referral to Drug & Alcohol housing in cases where the client wants to address their substance misuse. This can be achieved through increased awareness and training to hostel teams, a more visible presence by Drug & Alcohol housing in the housing support partnership and giving clients the right information to make an informed choice about their housing options.

Similarly, whilst there are good links between providers in ROADS with regards to substance misuse treatment, there is less understanding and co-working around the subject of wraparound support such as family and carer involvement and housing.

Co-location, secondments and drop-in sessions have made this pathway better but there are improvements that can be made.

## **Relationships**

Hidden Harm Report:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/120620/hidden-harm-full.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/120620/hidden-harm-full.pdf)

Add links from main section.

## **Training Education Volunteering and Employment**

National Guidelines

NICE guidelines [NG44]

Community engagement: improving health and wellbeing and reducing health inequalities

This guideline covers recommendations on:

overarching principles of good practice – what makes engagement more effective?  
developing collaborations and partnerships approaches to encourage and support alliances between community members and statutory, community and voluntary organisations to meet local needs and priorities

involving people in peer and lay roles – how to identify and recruit people to represent local needs and priorities

making community engagement an integral part of health and wellbeing initiatives  
making it as easy as possible for people to get involved

NICE Quality Standard 23, Guidance on Drug Use Disorders includes Quality Statement 7, Recovery and Reintegration, which recommends that people in drug treatment are offered support to access services that promote recovery and integration including housing, education, employment, personal finance healthcare and mutual aid.

What the quality statement means for each audience

## **Criminal Justice**

[http://www.nta.nhs.uk/uploads/nta\\_criminaljustice\\_0809.pdf](http://www.nta.nhs.uk/uploads/nta_criminaljustice_0809.pdf)

[http://centreforsocialjustice.org.uk/UserStorage/pdf/Pdf%20reports/CSJ\\_Green\\_paper\\_criminal\\_justice.pdf](http://centreforsocialjustice.org.uk/UserStorage/pdf/Pdf%20reports/CSJ_Green_paper_criminal_justice.pdf)

<http://www.icpr.org.uk/media/31487/Rapid%20review%20-%20engaging%20and%20retaining%20substance%20users%20final.pdf>

<http://www.nta.nhs.uk/uploads/theimpactoftreatmentonreconviction.pdf>

### Appendix 3: Contribution to Public Health Outcomes

	Indicator	Period	Bristol		England
			Count	Value	Value
Overarching Indicators	0.1i - Healthy life expectancy at birth (Male)	2012 - 14	-	63.3	63.4
	0.1i - Healthy life expectancy at birth (Female)	2012 - 14	-	64.2	64
	0.1ii - Life expectancy at birth (Male)	2012 - 14	-	78.4	79.5
	0.1ii - Life expectancy at birth (Female)	2012 - 14	-	82.9	83.2
	0.1ii - Life expectancy at 65 (Male)	2012 - 14	-	18.1	18.8
	0.1ii - Life expectancy at 65 (Female)	2012 - 14	-	20.9	21.2
	0.2i - Slope index of inequality in life expectancy at birth based on national deprivation deciles within England (Male)	2012 - 14	-	-	9.2
	0.2i - Slope index of inequality in life expectancy at birth based on national deprivation deciles within England (Female)	2012 - 14	-	-	7
	0.2ii - Number of upper tier local authorities for which the local slope index of inequality in life expectancy (as defined in 0.2iii) has decreased (Male)	2012 - 14	-	-	80
	0.2ii - Number of upper tier local authorities for which the local slope index of inequality in life expectancy (as defined in 0.2iii) has decreased (Female)	2012 - 14	-	-	67

	0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Male)	2012 - 14	-	9.6	-
	0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Female)	2012 - 14	-	7	-
	0.2iv - Gap in life expectancy at birth between each local authority and England as a whole (Male)	2012 - 14	-	-1.1	0
	0.2iv - Gap in life expectancy at birth between each local authority and England as a whole (Female)	2012 - 14	-	-0.3	0
	0.2v - Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England (Male)	2012 - 14	-	-	19
	0.2v - Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England (Female)	2012 - 14	-	-	20.2
	0.2vi - SII in healthy life expectancy based within local authorities, based on deprivation within Middle Super Output Areas (Male)	2009 - 13	-	16.3	-
	0.2vi - SII in healthy life expectancy based within local authorities, based on deprivation within Middle Super Output Areas (Female)	2009 - 13	-	16.7	-
	0.2vii - Slope index of inequality in life expectancy at birth within English regions, based on regional	2012 - 14	-	-	-

Wider Determinants of Health	deprivation deciles within each area (Male)				
	0.2vii - Slope index of inequality in life expectancy at birth within English regions, based on regional deprivation deciles within each area (Female)	2012 - 14	-	-	-
	1.01i - Children in poverty (all dependent children under 20)	2013	20,275	22.10%	18.00%
	1.01ii - Children in poverty (under 16s)	2013	18,170	22.60%	18.60%
	1.03 - Pupil absence	2013/14	797,636	5.05%	4.51%
	1.04 - First time entrants to the youth justice system	2014	278	809	409
	1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Persons)	2014/15	710	74.00%	73.30%
	1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Male)	2014/15	435	64.00%	73.20%
	1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Female)	2014/15	270	62.10%	73.10%
	1.06ii - Percentage of adults in contact with secondary mental health services who live in stable and appropriate accommodation (Persons)	2014/15	-	49.40%	59.70%
	1.06ii - Percentage of adults in contact with secondary mental health services who live in stable and appropriate accommodation	2014/15	-	47.40%	58.40%

	(Male)				
	1.06ii - Percentage of adults in contact with secondary mental health services who live in stable and appropriate accommodation (Female)	2014/15	-	51.80%	61.30%
	1.07 - People in prison who have a mental illness or a significant mental illness	2013/14	-	-	5.55%
	1.08i - Gap in the employment rate between those with a long-term health condition and the overall employment rate	2014/15	-	12.5	8.6
	1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate (Persons)	2014/15	-	66.6	66.9
	1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate (Male)	2014/15	-	67.6	71.8
	1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate (Female)	2014/15	-	67.8	62.3
	1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (Persons)	2014/15	-	65.2	66.1
	1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (Male)	2014/15	-	68.1	72.6

	1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (Female)	2014/15	-	61.8	59.3
	1.09i - Sickness absence - the percentage of employees who had at least one day off in the previous week	2011 - 13	-	1.30%	2.40%
	1.09ii - Sickness absence - the percent of working days lost due to sickness absence	2011 - 13	-	0.90%	1.50%
	1.10 - Killed and seriously injured (KSI) casualties on England's roads	2012 - 14	373	28.4	39.3
	1.11 - Domestic abuse	2014/15	-	17.3	20.4
	1.12i - Violent crime (including sexual violence) - hospital admissions for violence	2012/13 - 14/15	904	60.4	47.5
	1.12ii - Violent crime (including sexual violence) - violence offences per 1,000 population	2014/15	8,447	19.3	13.5
	1.12iii- Violent crime (including sexual violence) - rate of sexual offences per 1,000 population	2014/15	811	1.85	1.4
	1.13i - Re-offending levels - percentage of offenders who re-offend	2013	1,662	29.60%	26.40%
	1.13ii - Re-offending levels - average number of re-offences per offender	2013	5,488	0.98	0.82
	1.14i - The rate of complaints about noise	2013/14	4,226	9.7	7.4
	1.15i - Statutory homelessness - homelessness acceptances	2014/15	872	4.6	2.4
	1.15ii - Statutory homelessness - households in temporary	2014/15	454	2.4	2.8

	accommodation				
	1.18i - Social Isolation: percentage of adult social care users who have as much social contact as they would like	2014/15	-	45.50%	44.80%
	1.18ii - Social Isolation: percentage of adult carers who have as much social contact as they would like	2014/15	-	33.30%	38.50%
	1.19i - Older people's perception of community safety - safe in local area during the day	2014/15	-	-	97.60%
	1.19ii - Older people's perception of community safety - safe in local area after dark	2014/15	-	-	67.60%
	1.19iii - Older people's perception of community safety - safe in own home at night	2014/15	-	-	94.30%
Health Improvement	2.01 - Low birth weight of term babies	2014	151	2.60%	2.90%
	2.02i - Breastfeeding - breastfeeding initiation	2014/15	5,403	82.20%	74.30%
	2.03 - Smoking status at time of delivery	2014/15	721	11.10%	11.40%
	2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2014/15	847	108	109.6
	2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	2014/15	438	141.1	137.5
	2.07ii - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)	2014/15	1,070	147.1	131.7

	2.08 - Emotional wellbeing of looked after children	2014/15	-	15	13.9
	2.12 - Excess weight in Adults	2012 - 14	-	56.90%	64.60%
	2.14 - Smoking prevalence	2014	-	18.90%	18.00%
	2.14 - Smoking prevalence - routine and manual	2014	-	31.80%	28.00%
	2.15i - Successful completion of drug treatment - opiate users	2014	258	9.30%	7.40%
	2.15ii - Successful completion of drug treatment - non-opiate users	2014	197	32.80%	39.20%
	2.16 - People entering prison with substance dependence issues who are previously not known to community treatment	2012/13	460	47.10%	46.90%
	2.17 - Recorded diabetes	2014/15	19,854	5.00%	6.40%
	2.18 - Admission episodes for alcohol-related conditions - narrow definition (Persons)	2014/15	3,018	776	641
	2.18 - Admission episodes for alcohol-related conditions - narrow definition (Male)	2014/15	1,859	990	827
	2.18 - Admission episodes for alcohol-related conditions - narrow definition (Female)	2014/15	1,159	576	474
	2.21i - Antenatal infectious disease screening – HIV coverage	2014/15	-	-	98.90%
	2.21ii - Antenatal screening for Hepatitis B - coverage	2013	-	-	97.90%
	2.22iii - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check	2013/14 - 14/15	36,600	35.20%	37.90%
	2.22iv - Cumulative percentage of the eligible population aged 40-74	2013/14 - 14/15	14,846	40.60%	48.90%

	offered an NHS Health Check who received an NHS Health Check				
	2.22v - Cumulative percentage of the eligible population aged 40-74 who received an NHS Health check	2013/14 - 14/15	14,846	14.30%	18.60%
	2.23i - Self-reported wellbeing - people with a low satisfaction score	2014/15	-	6.80%	4.80%
	2.23ii - Self-reported wellbeing - people with a low worthwhile score	2014/15	-	5.70%	3.80%
	2.23iii - Self-reported wellbeing - people with a low happiness score	2014/15	-	10.80%	9.00%
	2.23iv - Self-reported wellbeing - people with a high anxiety score	2014/15	-	19.20%	19.40%
	2.23v - Average Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) score	2010 - 12	-	-	37.7
	2.24i - Injuries due to falls in people aged 65 and over (Persons)	2014/15	1,639	2,501	2,125
	2.24i - Injuries due to falls in people aged 65 and over (Male)	2014/15	523	2,147	1,740
	2.24i - Injuries due to falls in people aged 65 and over (Female)	2014/15	1,116	2,855	2,509
	2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79 (Persons)	2014/15	502	1,250	1,012
	2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79 (Male)	2014/15	213	1,136	826
	2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79 (Female)	2014/15	289	1,364	1,198
Health Protection	3.03i - Population vaccination coverage - Hepatitis B (1 year old)	2014/15	13	86.7%*	-

Healthcare & Premature Death	3.03i - Population vaccination coverage - Hepatitis B (2 years old)	2014/15	-	0.0%*	-
	3.05i - Treatment completion for TB	2013	66	75.90%	84.80%
	3.05ii - Incidence of TB	2012 - 14	284	21.6	13.5
	3.07 - Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies	2014/15	-	100%	95.20%
	4.03 - Mortality rate from causes considered preventable (Persons)	2012 - 14	2,021	208.4	182.7
	4.03 - Mortality rate from causes considered preventable (Male)	2012 - 14	1,258	262.4	230.1
	4.03 - Mortality rate from causes considered preventable (Female)	2012 - 14	763	154.9	138.4
	4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Persons)	2012 - 14	434	53	49.2
	4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Male)	2012 - 14	322	79.6	74.1
	4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Female)	2012 - 14	112	27.2	25.6
	4.05ii - Under 75 mortality rate from cancer considered preventable (Persons)	2012 - 14	777	92.9	83
	4.05ii - Under 75 mortality rate from cancer considered preventable (Male)	2012 - 14	423	103.9	90.5

4.05ii - Under 75 mortality rate from cancer considered preventable (Female)	2012 - 14	354	82.4	76.1
4.06ii - Under 75 mortality rate from liver disease considered preventable (Persons)	2012 - 14	191	20.6	15.7
4.06ii - Under 75 mortality rate from liver disease considered preventable (Male)	2012 - 14	144	30.9	21
4.06ii - Under 75 mortality rate from liver disease considered preventable (Female)	2012 - 14	47	10.2	10.6
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (Persons)	2012 - 14	189	23.6	17.8
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (Male)	2012 - 14	94	23.9	20.1
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (Female)	2012 - 14	95	23.3	15.7
4.08 - Mortality from communicable diseases (Persons)	2012 - 14	646	64	63.2
4.08 - Mortality from communicable diseases (Male)	2012 - 14	278	76.6	74
4.08 - Mortality from communicable diseases (Female)	2012 - 14	367	56.7	56.4
4.09 - Excess under 75 mortality rate in adults with serious mental illness	2013/14	-	424.9	351.8
4.10 - Suicide rate (Persons)	2012 - 14	137	10.5	8.9
4.10 - Suicide rate (Male)	2012 - 14	99	15.2	14.1
4.10 - Suicide rate (Female)	2012 -	38	5.9	4

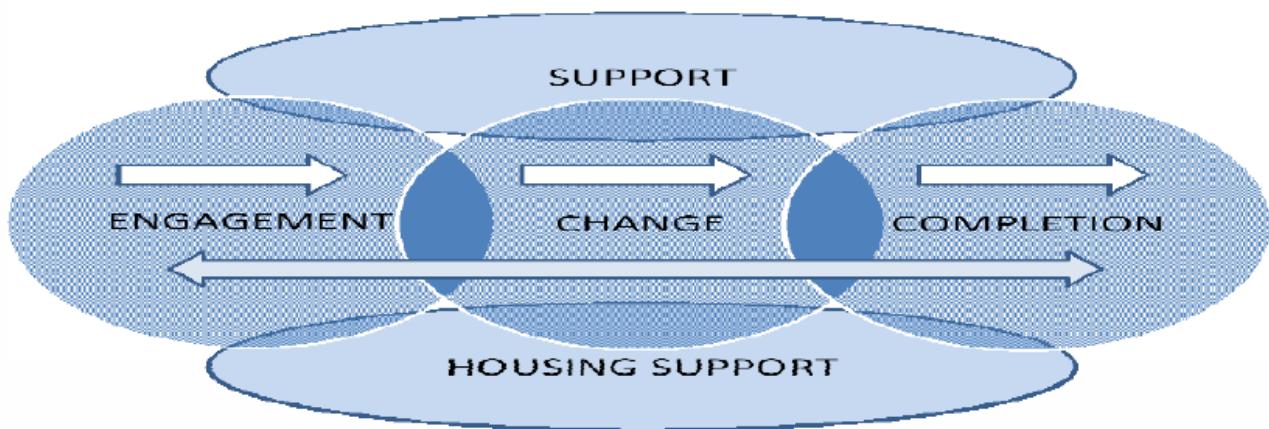
	14			
4.11 - Emergency readmissions within 30 days of discharge from hospital (Persons)	2011/12	4,937	11.50%	11.80%
4.11 - Emergency readmissions within 30 days of discharge from hospital (Male)	2011/12	2,527	12.10%	12.10%
4.11 - Emergency readmissions within 30 days of discharge from hospital (Female)	2011/12	2,410	10.90%	11.50%
4.12iii - Preventable sight loss - diabetic eye disease	2013/14	5	1.3	3.4
4.13 - Health related quality of life for older people	2013/14	-	0.713	0.727
4.14i - Hip fractures in people aged 65 and over (Persons)	2014/15	354	527	571
4.14i - Hip fractures in people aged 65 and over (Male)	2014/15	99	419	425
4.14i - Hip fractures in people aged 65 and over (Female)	2014/15	255	635	718
4.14ii - Hip fractures in people aged 65 and over - aged 65-79 (Persons)	2014/15	86	213	239
4.14ii - Hip fractures in people aged 65 and over - aged 65-79 (Male)	2014/15	31	170	167
4.14ii - Hip fractures in people aged 65 and over - aged 65-79 (Female)	2014/15	55	257	312
4.15i - Excess winter deaths index (single year, all ages) (Persons)	Aug 2013 - Jul 2014	76	7.2	11.6
4.15i - Excess winter deaths index (single year, all ages) (Male)	Aug 2013 - Jul 2014	45	8.6	10
4.15i - Excess winter deaths index (single year, all ages) (Female)	Aug 2013 -	32	5.9	13.2

	Jul 2014			
4.15iii - Excess winter deaths index (3 years, all ages) (Persons)	Aug 2011 - Jul 2014	420	13.2	15.6
4.15iii - Excess winter deaths index (3 years, all ages) (Male)	Aug 2011 - Jul 2014	171	10.8	13.7
4.15iii - Excess winter deaths index (3 years, all ages) (Female)	Aug 2011 - Jul 2014	250	15.6	17.5

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## Appendix 4: ROADS Treatment Model

Support			
Tackling discrimination and stigma in the community	Advocacy	Support for carers & concerned/significant others	Peer support opportunities



Housing Support	
Accommodation based support	Floating support

Engagement	Change	Completion
Triage, comprehensive assessment and recovery planning	Care coordination and recovery planning	Access to training, education and employment
Low threshold and brief interventions	Specialist treatment provision	Relapse prevention/Aftercare
Needle and syringe provision	GP substance misuse liaison workers	
Transition from YP services	Inpatient/community detox and stabilisation	
	Structured psychosocial interventions	
	Family support	
	CCA for access to residential rehab	

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# Bristol JSNA Chapter 2016-17

## Alcohol Misuse in Adult Population

Chapter information	
<b>Chapter title</b>	<b>Alcohol Misuse in Adult Population</b>
<b>Chapter reference group</b>	Bristol Alcohol Strategy Group
<b>Chapter author(s)</b>	Blanka Robertson, Public Health Principal Mental Health and Social Inclusion
<b>Quality reviewed by who/date</b>	Bristol Alcohol Strategy Group / May 2017
<b>Chapter endorsed by</b>	Bristol Alcohol Strategy Group / May 2017
<b>Chapter approved by</b>	JSNA Steering Group / May 2017
<b>Linked JSNA chapters</b>	Young People and Substance Misuse

## Executive summary

### Introduction

Alcohol is a prominent commodity in the UK marketplace. It is widely used in numerous social situations. For many, alcohol is associated with positive aspects of life; however there are currently over 10 million people drinking at levels which increase their risk of health harm. Among those aged 15 to 49 in England, alcohol is now the leading risk factor for ill-health, early mortality and disability and the fifth leading risk factor for ill-health across all age groups.

In Bristol, the pattern of alcohol misuse is varied and complex, sensitive to cultural and socio-economic characteristics that greatly differ across the City. In deprived areas people who misuse alcohol are also more likely to also smoke tobacco, hence at increased risk of developing complicating medical condition such as cancer. This increased risk results in a higher burden of mortality caused by alcohol in deprived areas, despite less people in the areas misusing alcohol.

The Public Health England, Local Alcohol Profiles for England (2017) estimates that:  
<http://fingertips.phe.org.uk/profile/local-alcohol-profiles>

- 15.6% of Bristol population aged 16 years and over abstain from drinking alcohol
- Out of the 84.4% of those who drink, 72.2% stay within the national low risk limits
- 20.3% drink at increasing levels that risk harm in the long term
- 7.5% drink at higher risk levels that harm themselves and others (this includes dependent drinkers)
- 26.3% binge drink and are vulnerable to the acute effects of intoxication such as assault, falls and poisoning.

On one hand alcohol causes significant harm and contributes to health inequalities; on the other it brings benefits to the community and enhances the economy. Well-run community pubs and other businesses form a key part of the fabric of neighbourhoods, providing employment and social venues in local communities. Balancing the two facets of alcohol (use and misuse) requires us to work in partnership across the sectors to ensure that the benefits are felt and the harms are minimised.

The public health burden of alcohol is wide ranging, relating to health, social or economic harms. These can be tangible, direct costs (including costs to the health, criminal justice and welfare systems), or indirect costs (including the costs of lost productivity due to absenteeism, unemployment, decreased output or lost working years due to premature pension or death). Harms can also be intangible, and difficult to cost, including those assigned to pain and suffering, poor quality of life or the emotional distress caused by living with a heavy drinker. Many of these harms impact upon other people, including relationship partners, children, relatives, friends, co-workers and

strangers.

In recent years, many indicators of alcohol-related harm have increased. There are now over 1 million hospital admissions relating to alcohol each year, half of which occur in the lowest three socioeconomic deciles. Alcohol-related mortality has also increased, particularly for liver disease which has seen a 400% increase since 1970, and this trend is in stark contrast to much of Western Europe. In England, the average age at death of those dying from an alcohol-specific cause is 54.3 years. The average age of death from all causes is 77.6 years. More working years of life are lost in England as a result of alcohol-related deaths than from cancer of the lung, bronchus, trachea, colon, rectum, brain, pancreas, skin, ovary, kidney, stomach, bladder and prostate, combined.

Parental alcohol misuse can impact on relationships and family functioning, and can impact on a child's environment in many social, psychological and economic ways. It can also be linked to a variety of mental health problems for family members and domestic violence and abuse. Around 30% of children under 16 years of age (3.3-3.5 million) in the UK are living with at least one binge drinking parent. Substance misuse, mental health problems and domestic abuse are key factors in many child protection and safeguarding cases.

## **Key issues and gaps**

### **Alcohol-related deaths**

While there has been a slight decrease in alcohol-related mortality in England since 2014, Bristol remains at the same and above the national average level for alcohol-related deaths for both, men and women. Local Alcohol Profiles (March 2017) show Bristol has a significant problem with alcohol-related mortality particularly in men (Bristol rate of 26 deaths per 100,000, England rate 15.9 for 2015). The rate of alcohol-related mortality in women in Bristol was 7.4 in the same period (7.3 in England). Alcohol-related chronic liver disease contributes most to the mortality rates. These deaths were preventable.

### **Hospital admissions**

The rate of hospital admissions for alcohol-specific conditions (narrow measure) in Bristol (2014-15) was 570 per 100,000 population which is significantly higher than the England average (364 admissions per 100,000) and has been consistently higher than England since 2008/09.

There are 48 health conditions that are specifically caused by or contributed to by alcohol misuse. The most common alcohol-related conditions are circulatory diseases, notably high blood pressure and heart disease. The 'broad' measure of alcohol-related admissions measures this. In 2014/15 the Bristol rate was 1,541 per 100,000 compared to the English rate of 1,258; both figures remaining at a similar level since 2013.

Since 2014 there were estimated 23,000 deaths related to alcohol use in England. Approximately 6,000 of these were due to alcohol-specific causes. The rate of alcohol-related mortality for men (65.4 per 100,000) is more than double the rate for women (28.8 per 100,000). This **gender health inequality** needs to be addressed urgently using multi-agency approach.

**Physical ill health** has been identified as having a significant impact on the recovery potential of people accessing treatment services. **There is an intrinsic link between physical and mental health;** poor physical health can adversely affect a person's mental health and poor mental health can negatively affect physical health.

While great effort is being made to bring health and social care responses together within the Health and Wellbeing strategy the current structures of support still tend to deal with these needs in isolation.

The relationship between **physical health and substance misuse** is complex. It is accepted that for many people, the route into substance misuse was as a way of dealing with health issues. The use of prescribed medications, chronic pain and self-medication for other symptoms, including mental health, often leads to dependency forming on the substances used. It is likewise true that for many individuals their physical health has been affected by the use of substances. Chronic liver disease, respiratory illness and blood borne viruses, caused as a result of using substances, are commonly identified within alcohol and drug using populations.

Communication with and feedback from both professionals and service users have indicated that there is a gap for 'medium level' **mental health support for substance misusers.** It has been suggested that if substance misusers are experiencing either a mental health crisis (high level) or require some low level mental health interventions (e.g. IAPT) then they are able to access these levels of services however a gap still exists for clients requiring more structured mental health interventions in substance misuse services.

However, estimates of prevalence of dual diagnosis are difficult to come by at both a local and national level because various studies have used different diagnostic criteria. Therefore prevalence and incidence rates for substance misuse coexisting with mental health problems in the published literature vary widely.

A study on mental health centres and substance misuse services in the UK, showed that 85% of alcohol service users had mental health problems, mostly affective disorders and anxiety disorders. Approximately 50% of the alcohol treatment population also had multiple morbidity, i.e. the co-occurrence of several psychiatric disorders or substance misuse disorders.

The Bristol Mental Health Needs Assessment (2012) predicted that people living with mental health conditions are likely to increase in forthcoming years. Given the estimated population increases in both young people and BMEs in Bristol it would suggest that there will be a higher need of dual diagnosis in these cohorts given the higher prevalence of mental health needs identified in these groups. However caution must be applied here because rates of substance misuse vary greatly within these groups (e.g. recent decline in young people using substances, different rates of substance use prevalence between BME groups).

### **Recommendations**

**In their Strategy 2016-2021, the Bristol Alcohol Strategy Group develops a plan of actions to achieve the following objectives:**

Promote and support changes in attitudes and behaviour.

Ensure alcohol is sold responsibly.

Improve access to early interventions and treatment.

Protect children and families from alcohol-related harm.

Reduce alcohol-related crime and disorder.

**Further recommendations were made in the Bristol Substance Misuse Needs Assessment 2016:**

More work is needed to address the gaps in the monitoring of information of dual diagnosis clients in substance misuse and mental health services. Being able to effectively monitor this data will inform future needs assessments and identify gaps in service provision.

Address the gap for 'medium level' mental health support for substance misusers.

Address gender health inequalities, in particular focusing on alcohol-related mortality.

Support people to identify issues with drugs and alcohol at an early stage; consideration needs to be given to further embedding the NHS England initiative Making Every Contact Count (MECC) approach.

## JSNA chapter report

### A: What do we know?

#### 1) Who is at risk and why?

In England, alcohol misuse is the biggest risk factor attributable to early mortality, ill-health and disability for those aged 15 to 49 years; for all ages it is the fifth most important. The harm caused by alcohol is determined by levels of alcohol consumption at both the individual- and population-level. These levels are heavily influenced by access to alcohol, which comprises three variable factors: how easy it is to purchase or consume alcohol (availability), how cheap alcohol is (affordability) and the social norms surrounding its consumption (acceptability). These drivers are largely determined by economic and social structures, politico-legal structures and corporate/market structures.

Alcohol consumption can have adverse health and social consequences for the drinker, as well as for other individuals. Its consumption has been identified as a component cause for more than 200 health conditions covered by the International Classification of Disease and injury codes and is associated with social consequences such as loss of earnings or unemployment, family or relationship problems and problems with the law. Many of these harms affect associates of the drinker, such as a partner, child, relative, friend, co-worker or stranger.

Aside from environmental factors, the health and social harm caused by alcohol is determined by three related dimensions of drinking:

- the volume of alcohol consumed
- the frequency of drinking occasions
- the quality of alcohol consumed

For most alcohol-related diseases and injuries, there is a clear dose-response relationship between the volume of alcohol consumed and the risk of a given harm. With increasing dose, there is increasing risk. For example, all alcohol-related cancers exhibit this relationship.

As well as the volume of alcohol consumed, the frequency of drinking occasions affects the risk of harm. For example, repeated heavy drinking is associated with dependence whereas, a single bout of heavy drinking is associated with injuries and risk of cardiovascular disease. The latter relates to the fact that any cardio protective effect of low-risk patterns of alcohol consumption, are completely undone in the presence of heavy episodic drinking. In addition to the volume and pattern of drinking, a number of individual risk factors moderate alcohol-related harm, such as:

**Age:** children and young people are more vulnerable to alcohol-related harm

**Gender:** women are more vulnerable to alcohol-related harm from higher levels of alcohol use or particular patterns of drinking

**Familial risk factors:** exposure to abuse and neglect as a child and a family history of alcohol use disorders is a major vulnerability

**Socioeconomic status:** people with lower socioeconomic status experience considerably higher levels of alcohol-related harm

**Culture and context:** the risk of harm varies with the culture and context within which the drinking takes place, for example drinking while driving can result in serious penalties and harm

**Alcohol control and regulation:** a critical factor in determining levels of alcohol-related harm in a country is the level and effectiveness of alcohol control and regulations.

According to the Health Survey in England: Adult Alcohol Consumption (2016), in 2015, 83% of adults in England had drunk alcohol in the last 12 months. A higher proportion of men than women drank alcohol in the last year (87% and 80% respectively). For men and women, the proportions of non-drinkers were highest in the youngest and oldest age groups. For men, the prevalence of drinking in the last year was between 87% and 90% among men aged 25 to 74. Similarly, for women between the ages of 25 and 64, the prevalence of drinking in the last year was relatively similar (82% or 83%).

Over half (52%) of adults usually drank alcohol once a week or more often, with men more likely than women to do so (60% and 44% respectively). The proportion who drank once a week or more increased with age among both men and women before gradually decreasing, from the age of 75 for men, and the earlier age of 65 for women. Within every age group a higher proportion of men than women drank alcohol once a week or more.

In an average week, adults drank a mean of 11.9 units of alcohol; men drank a mean of 14.9 units, and women drank a mean of 8.9 units.

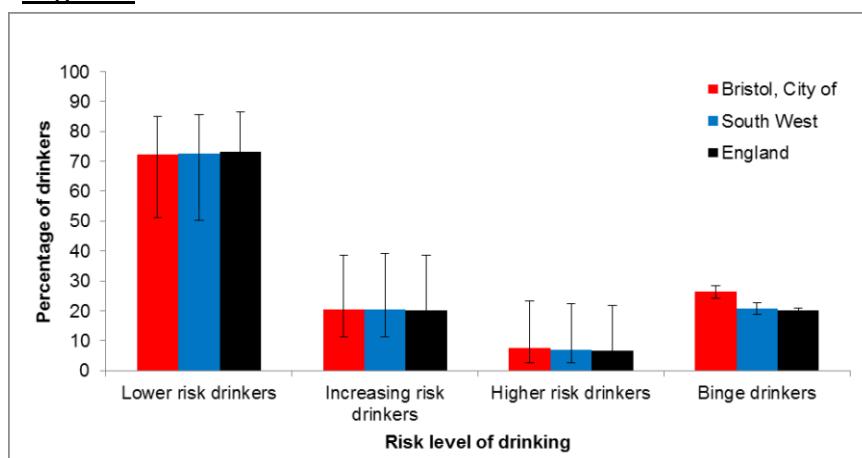
A minority of adults, 13% of men and 20% of women, did not drink in the last 12 months. 55% of men and 64% of women drank at levels which put them at lower risk of alcohol-related harm, that is, 14 units or less in the last week. Twice as many men than women drank at an increasing risk level (27% and 13% respectively); for men this was defined as more than 14 units and under 50 units, and for women more than 14 units and under 35 units. A higher proportion of men than women also drank at higher risk levels; 4% of men drank over 50 units and 3% of women drank over 35 units in the last week.

## 2) What is the size of the issue in Bristol?

Available data (2011-2014) indicate that approximately 15.6% of Bristol population abstain from drinking alcohol; 84.4% of adults engage in drinking. 18.4% of those binge-drink on heaviest drinking day and 22.3% adult population drink over 14 units of alcohol a week. It should be noted that people are likely to underestimate the amount they drink in self-reported surveys.

Fig 1 compares the Bristol percentages of drinkers with the South West and England estimates. There is some evidence that the percentage of binge drinkers in Bristol is higher than the regional and national percentage.

Fig 1: Percentage of drinkers within risk level-categories across the South West and England.



Bristol has higher rates than the national average of alcohol related harm as well as higher alcohol-specific and alcohol-related mortality. The prevalence of alcohol use, particularly at the higher levels of risk, within the city indicates that this need is unlikely to reduce in the next few years and is likely to grow with the city's population.

26.3% of alcohol users reported to binge drink, hence are vulnerable to the acute effects of intoxication such as assault, falls and poisoning. The percentage of binge drinkers in Bristol is higher than the regional and national average. In Bristol there are approximately 5,408 admissions to hospital due to alcohol-related conditions a year, where alcohol-related condition is the primary diagnosis or any of the secondary diagnoses with an alcohol-attributable code. Bristol alcohol-related admissions has been consistently higher than the England average, with 1,541 persons per 100,000 population admitted (broad measure) in 2014/15 compared to the England rate of 1,258 admissions per 100,000. The most common reasons for alcohol-related admission episodes in Bristol were cardiovascular disease and mental & behavioural disorders due to use of alcohol.

In 2014 there were 187 alcohol-related deaths in Bristol, which corresponds with the rate of 53.2 per 100,000 population (significantly higher than the England rate of 45.5 per 100,000). It is a bigger problem in males; the rate of alcohol-related mortality was 26.3 deaths per 100,000 men in 2015, compared to females with 7.4 deaths per 100,000 women in the same year.

Bristol has also a problem with the hospital admissions for alcoholic liver disease among men; the Bristol rate of 243.8 admissions per 100,000 male population was significantly higher to the national rate of 152.2 for 2014/15. Bristol rate of 66.3 admissions per 100,000 female population was similar to the national average rate of 67.9 for the same year.

Similarly the deaths from alcoholic liver disease among men under 75 years dominated in Bristol in 2013-15, corresponding with mortality rate in males of 20 per 100,000 which was significantly higher the England rate of 15.4 per 100,000. For female the Bristol rate was 7.8 per 100,000 and only slightly below the national average rate of 8.2.

### **3) What are the relevant national outcome frameworks indicators and how do we perform?**

Substance misuse has serious health implications and treatment is proven to reduce the strain on local health services. It is evident from the Public Health Outcomes Framework that the impact of substance misuse is far reaching and contributes to 92 of the 224 indicators and sub-indicators currently reported through the Public Health Outcomes Framework. The most obvious links are with measures:

2.15i - Successful completion of drug treatment - opiate users

2.15ii - Successful completion of drug treatment - non-opiate users

These indicators are defined as the number of drug users that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a proportion of the total number in treatment. Two new sub-indicators have been added for 2016:

2.15iii – Successful completion of alcohol treatment

2.15iv – Deaths from drug misuse

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Successful completion of alcohol treatment has been added as an additional sub indicator to reflect the fact that drug and alcohol services are increasingly commissioned together and the data that is used to report on access and provision all comes from the same monitoring system.

Deaths from drug misuse have also now been included as there has been a rising trend in drug related deaths over the last few years. Local authority action, including the quality and accessibility of the drug services they commission and how deaths are investigated and responded has an impact on drug misuse death rates. Including this sub-indicator alongside those on treatment outcomes will help local authorities and others consider the impact of treatment in addiction to recovery outcomes.

Public Health England is committed to continue to improve recovery rates for both drug and alcohol treatment and to reduce health-related harms, HIV, hepatitis, TB transmission and drug-related deaths. This action was included with the Public Health England's Annual Plan 2015/16 and this indicator directly contributes.

The following list gives an indication of the wide ranging impact substance misuse has on public health outcomes:

- Blood borne virus vaccinations
- Hospital admissions/readmissions
- Employment rates, Sickness absence
- Injuries due to falls, Hip fractures

- Injuries in children, Low birth weight babies, Smoking at the time of delivery, Pupil absence, Child poverty, Entrants to the youth justice system
- Life expectancy, Mortality rates
- Smoking prevalence
- Mental illness
- Social Isolation
- Suicide rates
- Stable and appropriate accommodation, Statutory homelessness
- Domestic abuse
- Violent crime
- Perceptions of community safety
- Re-offending levels.

#### **4) What is the evidence of what works (including cost effectiveness)?**

In 2016, following a review of existing evidence on the health effects of alcohol and a public consultation, the UK Chief Medical Officers published new guidelines on low risk drinking. In a move away from daily limits, it is now recommended that men and women should not regularly (defined as most weeks) drink more than 14 units a week. Drinking at this level is considered to be 'low risk', and adults who regularly drink up to this amount are advised to spread their drinking over three or more days. Above this level is considered to be 'increased risk', for men this is now above 14 units and up to 50 units, and for women over 14 units and up to 35 units per week. Men who regularly drink more than 50 units a week and women more than 35 units, are described as 'higher risk drinkers' and are considered to be at particular risk of alcohol-related health problems.

The revised guidance questioned the usefulness of daily limits given that many people don't drink every day and that, to some extent, the daily amounts are misunderstood and seen as a maximum amount of alcohol to drink on a single day or occasion. The revised guidelines instead provide advice for alcohol consumption on single occasions, with the intention of helping individuals to reduce the short-term risks and harm caused by drinking. Adults are advised to limit how much they drink on single occasions, consume alcohol with food and water, and drink alcohol slowly.

The number of alcohol users presenting to treatment has increased dramatically. During 2015/16 ROADS (Recovery Orientated Alcohol & Drugs Service) received a total of 3,300 referrals for 2,433 clients. Of this number 30% of the referrals were for primary alcohol clients (754/2,433). When considering the referral source 43% of the clients referred (385/754) were from GPs and a further 30% (232/754) were self-referrals.

Following an assessment 181 were mild dependent drinkers, 286 moderate dependent and 360 severe dependent. The age and gender profiles are outlined below.

Fig 2: Gender profile of primary alcohol users presenting to treatment

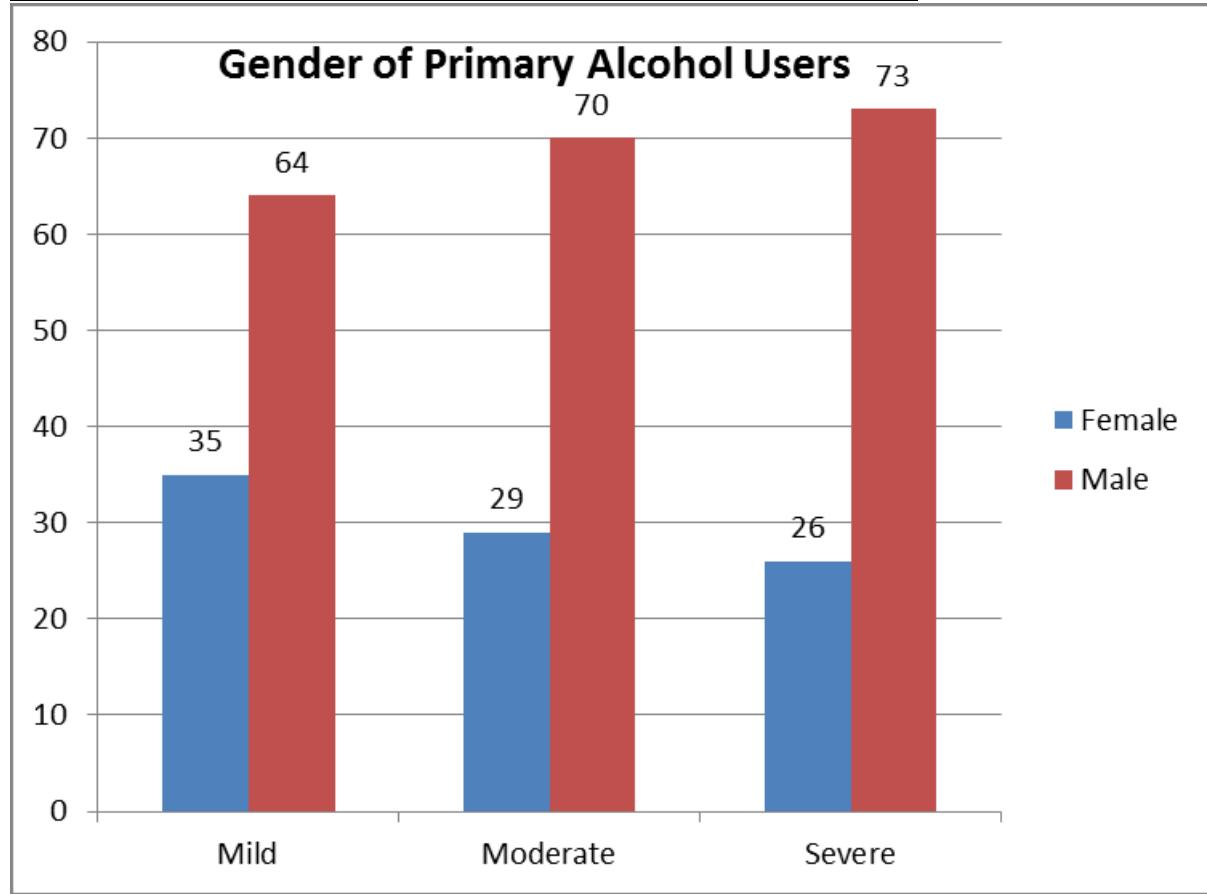
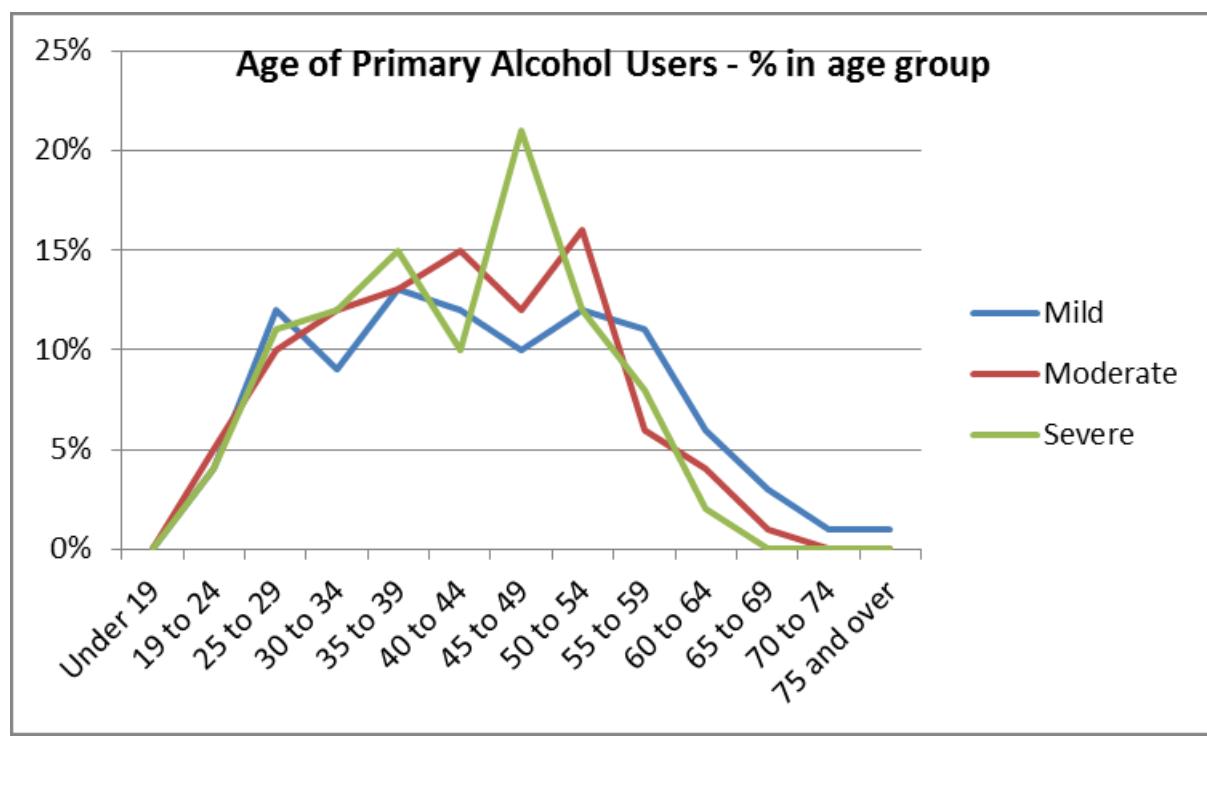


Fig 3: Gender profile of primary alcohol users presenting to treatment



## **5) What services / assets do we have to prevent and meet this need?**

Bristol has the "**Recovery Orientated Alcohol and Drug Service**" (**ROADS**), an integrated adult substance misuse service available across the City for access to structured interventions aimed at overcoming physical and psychological dependence on alcohol and drugs as well as offering support around housing, education and employment. Support for families and carers who are affected by the alcohol use of others are provided as part of ROADS to reduce the wider impact alcohol has on communities.

In the hospitals there are **Alcohol Nurse Specialists**, based in the Bristol Royal Infirmary and at Southmead. These nurses provide support and extended interventions for dependent drinkers and work with self-harmers whose harming is linked to alcohol, some also provide symptom triggered prescribing for patients. There are sound safeguarding processes in place for children and vulnerable adults, and good working relations with the mental health team. The alcohol nurses cover A&E, the hepatology ward and the medical assessment unit.

**Substance Misuse Specialist Midwives** operate from the city's maternity units to co-ordinate the midwifery care for women who misuse substances in pregnancy or pregnant women who are in substance misuse treatment. The midwives liaise closely with the consultant obstetricians, neonatologists and Complex Needs service when planning care for these women and their families.

Inpatient (Detox and Stabilisation) and Residential Rehab (Detox, Primary and Secondary) Inpatient provides **a clinically safe inpatient detoxification** or stabilisation regime to the most complex individuals whose needs cannot be met in the community or through a residential rehab detox. This provision requires a planned regime of 24-hour medically directed evaluation, care and treatment of substance related disorders in an acute care inpatient unit, staffed by designated addiction accredited physicians, as well as clinicians and recovery workers.

This service provides **medically supervised prescribing**, assessment, care and treatment to individuals requiring detoxification from either drugs or alcohol.

**Residential rehabilitation** is a specialised service offering accommodation, support and rehabilitation to people with complex drug and/or alcohol and other health needs. This is provided according to a recovery plan and includes intensive and structured programmes delivered in a residential environment.

In order to reflect the increasing levels of complexity for substance misusers at both a local and national perspective, an established complex needs provision identifies and case- holds the most **vulnerable and chaotic clients** across the city who are affected by substance misuse (we predict this cohort to be in the region of 20% of the overall treatment population). Key to this success is to proactively link with local physical and mental health services to collaborate and optimise the treatment offer for complex clients.

**A planned substance misuse liaison service (SML)** will operate out of GP practices participating in the Alcohol Detox and/or OST primary care local enhanced contracts. The

SML will care coordinate primary alcohol and opiate clients attending their GP practice for pharmacological interventions, deliver appropriate psychosocial interventions commensurate to need and facilitate pathways with the Recovery Centres.

The SML will be expected to enable capacity for 1,488 primary alcohol clients to undertake community alcohol detoxes per year. It is expected that the SML will prepare clients for detox, support them through the withdrawal process and offer brief post-detox support to facilitate access to a Recovery Centre for ongoing psychosocial interventions, relapse prevention and aftercare. It is envisaged that the SML will work with clients for a maximum of 4-6 weeks.

**A GP Public Health Service (Shared Care)** is being negotiated to increase the availability of prescribing for alcohol withdrawal within Primary Care. The Substance Misuse Liaison service will support the delivery of this service by delivering care coordination, psychosocial interventions and facilitating the onward pathway to other services to support the success of the detox.

**The Early Engagement and Intervention Service** operates across Bristol in order to engage with drug and alcohol users, including those who are not in contact with ROADS services. Interventions to improve health and reduce the harms associated with drug and alcohol use are delivered as well as supporting those furthest away from services to access treatment in a timely manner.

**Contact with non-treatment seeking drug and alcohol users** will be established to ensure early interventions can be delivered to reduce health complexities and support people to access services to improve the wellbeing of individuals not currently accessing ROADS services. This will need to include in-reach to hostels and non-commissioned dry-houses as well as effective partnership working with allied services (e.g. homelessness, mental health, etc.) and facilitate access to help meet individuals' needs.

Some **GPs offer community detoxification** in partnership with the treatment services. ROADS Complex Shared Care nurses work in primary care in areas where there are high numbers of problem drinkers. They support GPs to work with clients with complex needs to enable their care to remain within their local practice and GPs have further support from the ROADS lead consultant to support the delivery of primary care based interventions.

The Clinical Commissioning Group commissions hospital services and there are a number of planned care pathways that relate to alcohol, for instance **inpatient and outpatient hepatology services for cirrhosis of the liver**.

**Identification and Brief Advice (IBA)** is a cornerstone of adult prevention work. This means that people are screened using set questions to find out their level of alcohol use. If they are found to be drinking above guidelines, they are given information and signposted to appropriate services.

IBA services have been developed and are operational in:

- Bristol Royal Infirmary Accident and Emergency Department, the Medical Assessment Unit, and some wards
- Some wards in North Bristol NHS Trust
- GP practices who operate the National Direct Enhanced Service (for new registrations), or the Public Health Alcohol Service (for patients with hypertension, newly diagnosed depression, or who have been to hospital with an alcohol misuse related injury)
- Custody suites.

**Licensing Service.** This service has two key areas of responsibility for alcohol: administration of the Licensing Act and enforcement work. The Licensing Service conducts proactive inspections at alcohol licensed premises to ensure compliance with premises licence conditions and other related legislation. The Service undertakes to work with licence holders in effecting compliance, recommending and ensuring improvements where necessary, but takes punitive action where necessary.

**Trading Standards Service.** This service enforces legislation regarding the sale, supply and use of illicit alcohol products and underage sales. They use an intelligence led approach to achieve compliance and respond to complaints alleging the illegal sale of alcohol products. The Service can undertake checks for compliance for underage sales and works in partnership with other enforcement agencies to tackle the problem of underage sales, and of counterfeit and smuggled alcohol products.

**Crime Reduction and Substance Misuse Team** This team works with retailers to improve the management of the night-time economy through initiatives like Pubwatch. They operate the CCTV presence in the city centre which contributes to reducing alcohol fuelled disorder.

**Social Marketing campaigns** have been carried out to raise awareness about alcohol and its risks. The DrinkSmart campaign has been operational since 2010, and includes self-help materials for people who are concerned about their alcohol use and want to make changes. Targeted campaigns include: a series of campaigns aimed at young people, a safeguarding vulnerable people campaigns aimed at carers who drink, and pharmacy campaigns targeting people with high blood pressure.

## 6) What is on the horizon?

In the Bristol Joint Health and Wellbeing Strategy (2016 Re-fresh), 'Tackling alcohol misuse' emerged as one of the three priorities for the Health and Wellbeing Board. The 'Bristol City-wide Alcohol Strategy' and its Action Plan attempts to address the key points by bringing all partners together and setting out a vision for Bristol. It aims to facilitate the establishment of a safe, sensible and harm-free drinking culture in Bristol, and set a direction of travel to achieve this.

One of the broad aims of the new Strategy is to increase individual and collective knowledge about alcohol, and change attitudes towards alcohol consumption. It includes the

commitment to use social marketing tools and other techniques to gather intelligence about attitudes to alcohol use and drinking behaviour to inform strategic actions.

## 7) Local views

### Bristol's Big Drink Debate

From October 2016 to the end of January 2017, Bristol Public Health led the ***Bristol's Big Drink Debate***, an initiative to get people thinking and talking about alcohol, using a variety of techniques such as online survey, focus groups, workshops, stands and social media. It aimed to inform actions that would create an environment within which the consensus about acceptable drinking behaviour and culture is moved towards a less harmful relationship with alcohol.

The Debate and survey engaged with people who are at early stages of the behavioural change cycle. Over 1600 people took part in the survey and more than 300 participated further in focus groups and community engagement, debating about alcohol consumption in the City. We have seen a good representation from all Wards, however, the higher percentage of responses received were from central Bristol Wards, Lawrence Hill, Central and Ashley. People as young as 16 and up to 60+ took part. BME communities were somewhat under-represented.

The results from the debate showed that the majority drink within the government guidelines, mainly to socialise, relax and unwind. Nearly as many people drink at home as in public houses and bars. However nearly 53% of residents think drinking is a problem in Bristol. Frequent comments were concerning issues such as social acceptability, binge drinking, impact on public services, anti-social behaviour, role of parents and schools in education, negative personal and family history and the role of government in licencing legislation and alcohol pricing.

Data gathered from the survey were analysed and presented to the Bristol Alcohol Strategy Group where a number of recommendation for action were made. A report was produced and is due to be published in May 17.

### What do staff/users/carers think?

The physical health snapshot from March 2016 of Shared Care and Housing clients asked the practitioners to comment on the difficulties they have encountered in providing their services with regard to the support clients require, with two main themes emerging from the responses received.

The first theme indicated by practitioners across both services was that the structures for healthcare and treatment are not flexible enough to encourage meaningful engagement with the clients. This included:

- Not having the same GP each time - no one gets to know the client
- Appointments not being long enough, nor frequent enough, to meet the clients' needs
- Long waits at surgery put off clients from attending

- Clients being too chaotic to make appointments made
- Struggling to attend specialist appointments, e.g.: hospital appointments, due to transport reasons. One client had an appointment where she had to take 3 buses' to attend.
- Cancellations from clients who are particularly unwell (renal failure, daily epileptic fits and osteoporosis)
- After assessment people don't ask about physical health needs
- Looking for reasons to kick people off waiting lists
- Shared care workers are too busy and are flat out. Clients are presenting with a lot of chaos. Caseloads are too big and time with clients is too short.
- No structured pain management or a clear referral pathway

### B: What does this tell us?

## 8) Key issues and gaps

Communication with and feedback from both professionals and service users have indicated that there is a gap for 'medium level' mental health support for substance misusers. It has been suggested that if substance misusers are experiencing either a mental health crisis (high level) or require some low level mental health interventions (e.g. IAPT) then they are able to access these levels of services however a gap still exists for clients requiring more structured mental health interventions in substance misuse services.

However, estimates of prevalence of dual diagnosis are difficult to come by at both a local and national level because various studies have used different diagnostic criteria. Therefore prevalence and incidence rates for substance misuse coexisting with mental health problems in the published literature vary widely.

A study on mental health centres and substance misuse services in the UK showed that 85% of alcohol service users had mental health problems, mostly affective disorders and anxiety disorders. Approx 50% of the alcohol treatment population also had multiple morbidity, i.e. the co-occurrence of several psychiatric disorders or substance misuse disorders.

The Bristol Mental Health Needs Assessment predicted that people living with mental health conditions are likely to increase in forthcoming years. More work is needed to address the gaps in the monitoring of information of dual diagnosis clients in substance misuse and mental health services. Being able to effectively monitor this data will inform future needs assessments and identify gaps in service provision.

In 2014 there were an estimated 23,000 deaths related to alcohol use in England. Approx 6,000 of these were due to alcohol-specific causes. The rate of alcohol-related mortality for men (65.4 per 100,000) is more than double the rate for women (28.8 per 100,000). This gender health inequality needs to be addressed urgently using multi-agency approach.

Physical ill health has been identified as having a significant impact on the recovery potential of people accessing treatment services. There is an intrinsic link between physical and mental health; poor physical health can adversely affect a person's mental health and poor mental health can negatively affect physical health.

Whilst great effort is being made to bring health and social care responses together within the Health and Wellbeing strategy the current structures of support still tend to deal with these needs in isolation.

It is equally important to recognise the fact that the relationship between physical health and substance misuse is complex. It is accepted that for many people, the route into substance misuse was as a way of dealing with health issues. The use of prescribed medications, chronic pain and self-medication for other symptoms, including mental health, often leads to dependency forming on the substances used. It is likewise true that for many individuals their physical health has been affected by the use of substances. Chronic liver disease, respiratory illness and blood borne viruses, caused as a result of using substances, are commonly identified within alcohol and drug using populations.

## 9) Knowledge gaps

The following are recommendations made in the substance misuse strategic needs assessment, carried out by the BCC Substance Misuse Team:

<https://www.bristol.gov.uk/documents/20182/33003/Final+Report+Substance+Misuse+Needs+Assessment.pdf>

Bristol needs a structured treatment system that provides a range of evidence based interventions to maximise recovery opportunities. Commissioners need to ensure the system can manage a broad range of conditions and client complexities. Treatment options should include access to a range of psychosocial and pharmacological interventions, including relapse prevention.

Within structured treatment there needs to be an enhanced focus on the delivery of health protection and harm reduction interventions.

Retain a hospital based service to provide support to drug and alcohol users who are admitted to wards.

Continue to support a maternity service for pregnant substance misusing women and their partners. Investigate effectiveness and efficiency of various delivery options to maximise outcomes for both drug and alcohol users.

Continue to work with PH colleagues to improve access to HCV treatment for clients.

Continue to support hospital based alcohol liaison work.

Improve data monitoring is required to understand the needs of dual diagnosis in Bristol. Further work is required as to how we can demonstrate good outcomes for this cohort in order to build these into future service specifications.

Explore how feasible it is for social prescribing services to work with substance misuse clients with low level mental health needs and link with commissioners.

Review what happens when children who have been exposed to parental substance misuse are taken into care.

Continue to link with the commissioners of young people's substance misuse services and the Drugs and Young People project to meet the needs of children affected by parental

substance misuse.

Maintain close working with young people's treatment services to ensure a smooth transition for young people moving from young peoples into adult treatment.

Review the substance misuse knowledge/skills of those practitioners who are the main contact with families to meet the parents and children's needs. This needs to consider drug and alcohol awareness.

The combined impact of domestic violence, substance misuse and mental health is recognized. The services offered to these vulnerable individuals need to be sufficiently resourced. Learning from the Golden Key initiative will be critical in informing the approach.

Peer support offers considerable benefits to both the peers and those receiving their support. This should be considered as a fundamental part of a treatment system.

### C: What should we do next?

## 10) Recommendations for consideration

The Bristol Alcohol Strategy aims to make our City safer, healthier and happier place to live, to work, and to visit by working with individuals and communities to reduce alcohol consumption and alcohol-related harm. While we have already made a considerable progress in developing effective ways we deal with alcohol misuse in the City, we recognise the great potential for us to work with partner organisations to promote a positive behavioural change leading to improved health and wellbeing for everyone.

Our vision for Bristol is to create safe, sensible and harm-free drinking culture in Bristol, through partnership working and using the best available evidence in order to ensure the following:

- Bristol is a healthy and safe place to live, work and visit.
- People of Bristol are drinking within the nationally recognised guidelines.
- Individuals and families are able to access the right treatment and support at the right time.

There are 3 broader aims of the Strategy:

1. Increase individual and collective knowledge about alcohol, and change attitudes towards alcohol consumption.
2. Provide early help, interventions and support for people affected by harmful drinking.
3. Create and maintain a safe environment.

Partners in Bristol have a co-ordinated approach to dealing with licensed premises that sell alcohol illegally or irresponsibly. The regulatory authorities - Council licensing, Police licensing, planning, pollution control, environmental health work together to identify problem premises and take action through a Joint Tasking process. Problem premises are 'Red' tagged and worked with to improve their performance against the National Licensing

Objectives. There are joint enforcement visits involving the Police, council licensing and trading standards staff.

Supporting people to identify issues with drugs and alcohol at an early stage is a key part of early intervention. Consideration needs to be given to further embedding the NHS England initiative Making Every Contact Count (MECC) approach which aims to support people in making positive changes to their physical and mental health and wellbeing. MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations.

Substance misuse is hugely stigmatised and it is crucial that when someone seeks support they receive it in a timely manner. One in five referrals received by the ROADS Engagement service in 2015 were self-referrals with all the others being made by professionals. GPs accounted for nearly half of all referrals. Early referral and intervention are crucial to maximising successful outcomes with age of initiation and length of using career having a real effect on people's recovery potential. 97% of opiate clients and 92% of non-opiate clients.

Bristol has a thriving mutual aid recovery network including Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Cocaine Anonymous (CA) and SMART Recovery. Between these groups there are over 130 meetings a week held in Bristol, including specific groups for women and the Lesbian, Bisexual, Gay & Transgender (LGBT) community. ACT (Acceptance & Commitment Therapy) Peer Recovery another Public Health England recognised mutual aid support group are hoping to become established locally over the coming months.

## 11) Key contacts

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