

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 in to 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, it's 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.

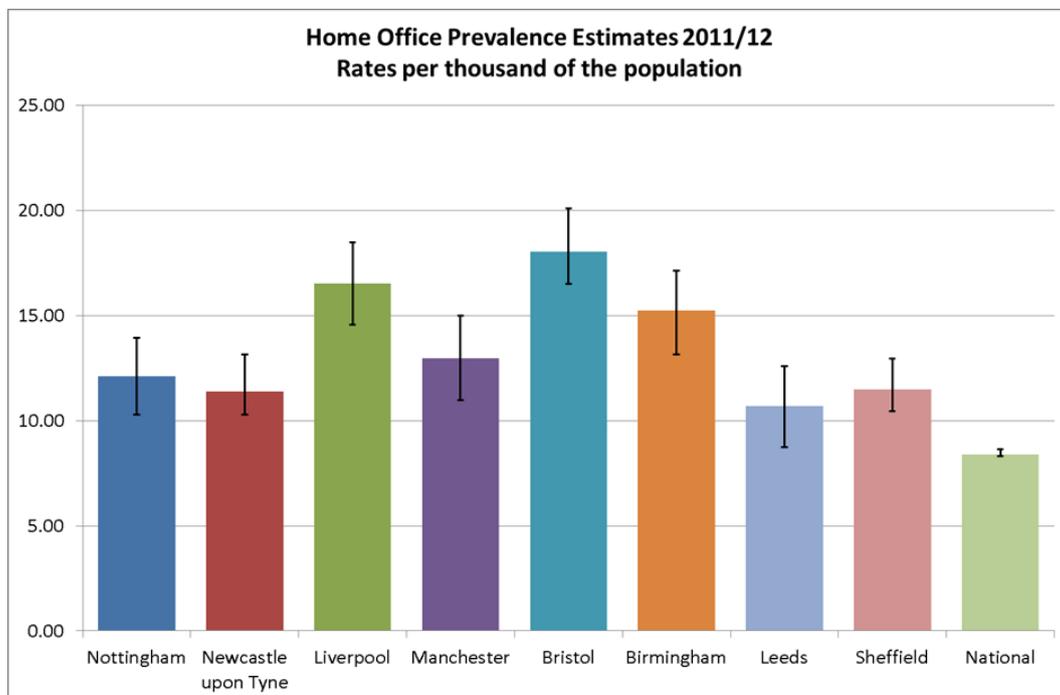
Drawing on a number of data sources (including self-reports, hospital admissions and service level data) the needs assessment provides a series of recommendations for consideration by commissioners. How Bristol chooses to respond to these recommendations and shapes services to meet these needs will be 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 addition 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:

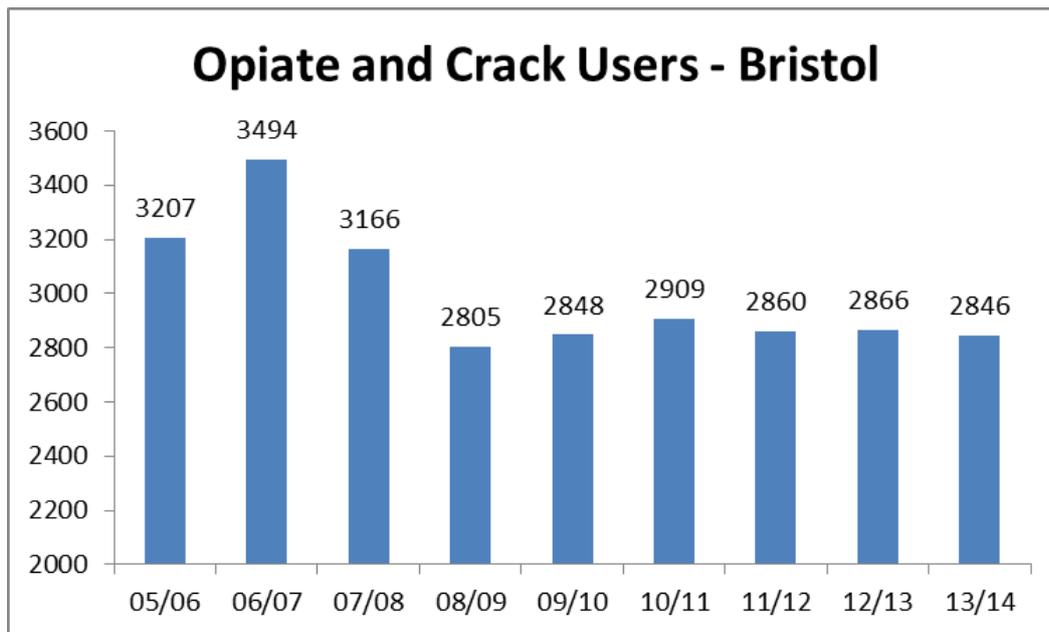
- Blood borne virus vaccinations
- Hospital admissions/readmissions
- Employment rates, Sickness absence
- Injuries due to falls, Hip fractures
- Injuries in children, Low birth weight babies, Smoking at the time of delivery, Pupil absence, Child poverty, Entrants to the youth justice system
- Life expectancy, 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.

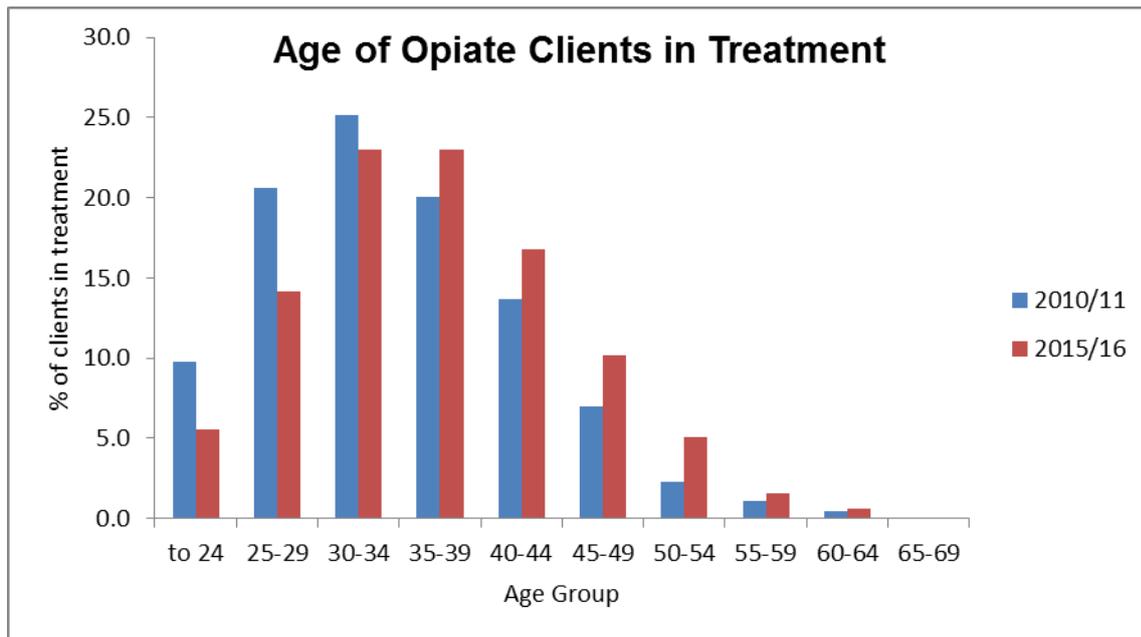
Chart 2.2 Number of opiate and crack users in Bristol



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

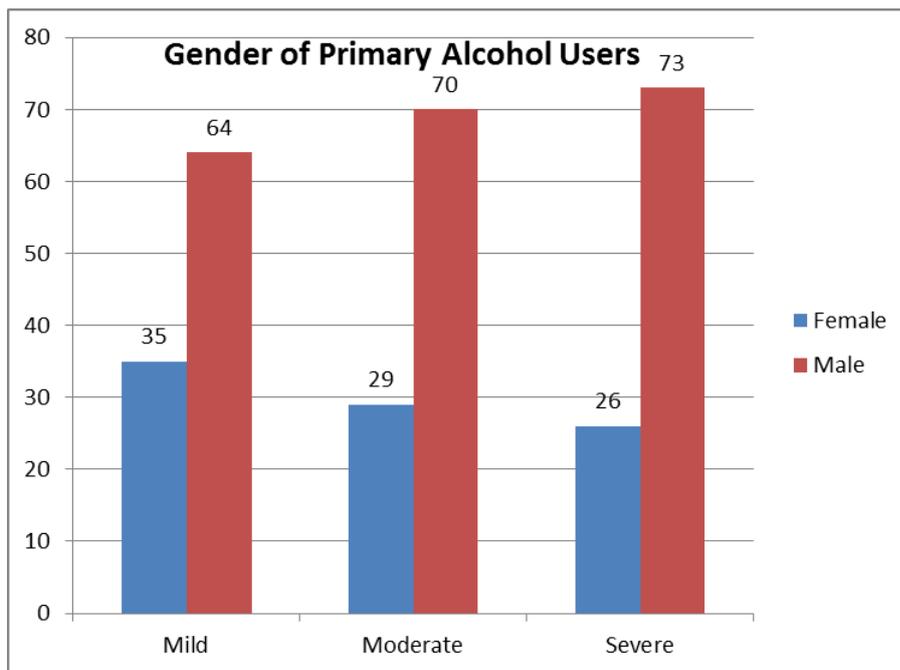
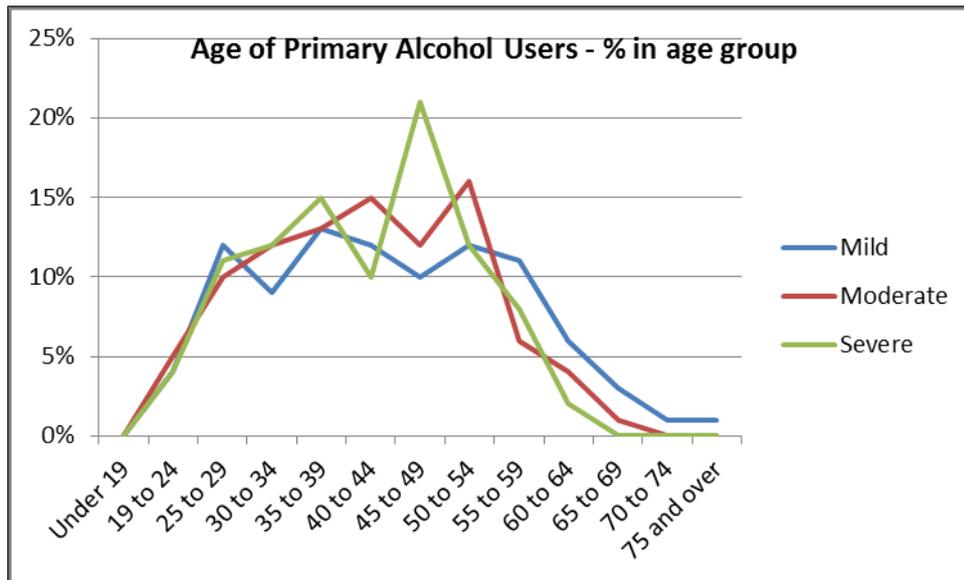


Chart 2.5 Gender profile of primary alcohol users presenting to treatment

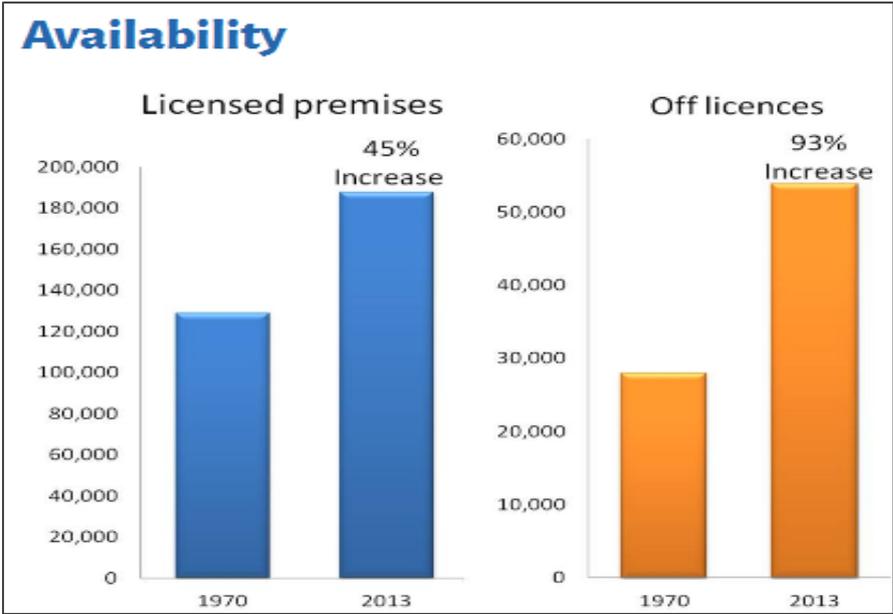


Alcohol Concern reports that alcohol consumption in the UK amongst people aged 15+ has fallen from a peak of 11.6 litres of alcohol per person per year in 2004 to 9.4 litres per person per year in 2013. However, this is nearly a third (32%) more than people were drinking in 1970 (7.1 litres per person) 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.

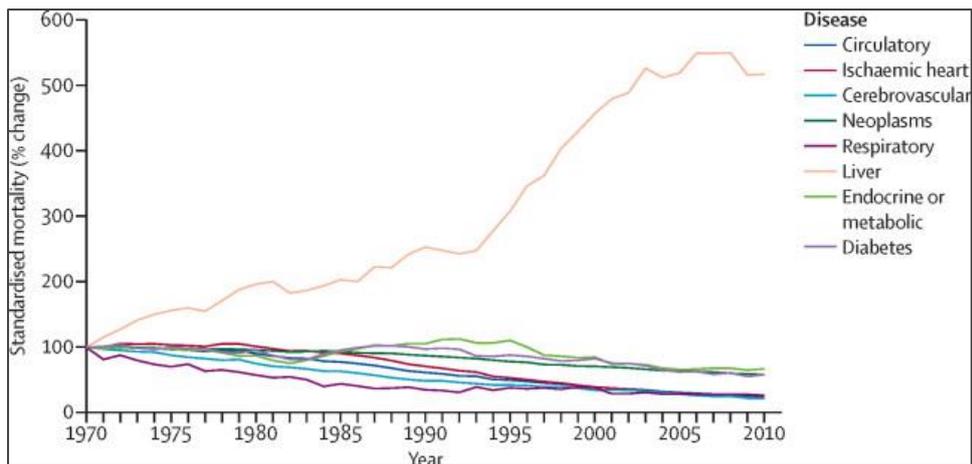
Chart 2.6 Availability of alcohol sales in licenced premises and off licences between 1970 & 2013



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%.

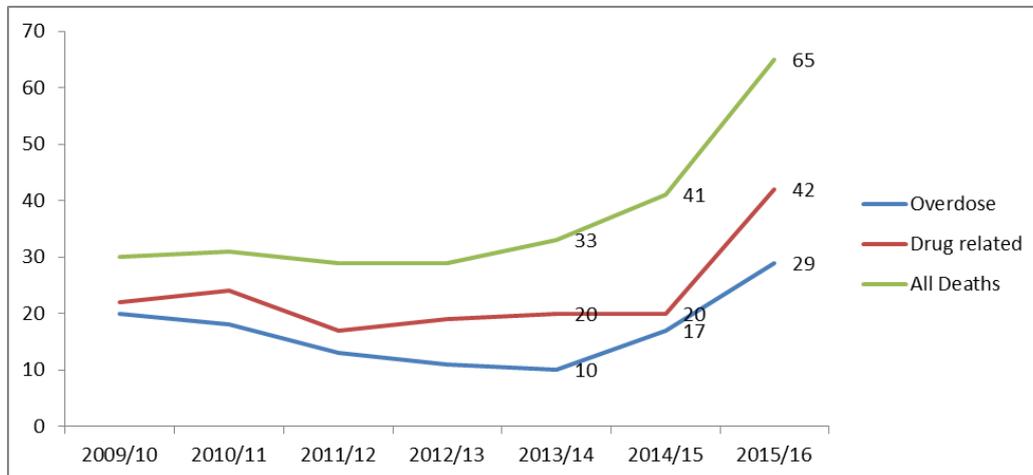
Bristol has the second lowest percentage for the South West of young people who have ever had an alcoholic drink. The percentage of regular (at least once a week) drinkers (6.1%) is very close to the national percentage (6.2%) and the percentage of 15 year olds that have been drunk in the last 4 weeks (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 26th 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.

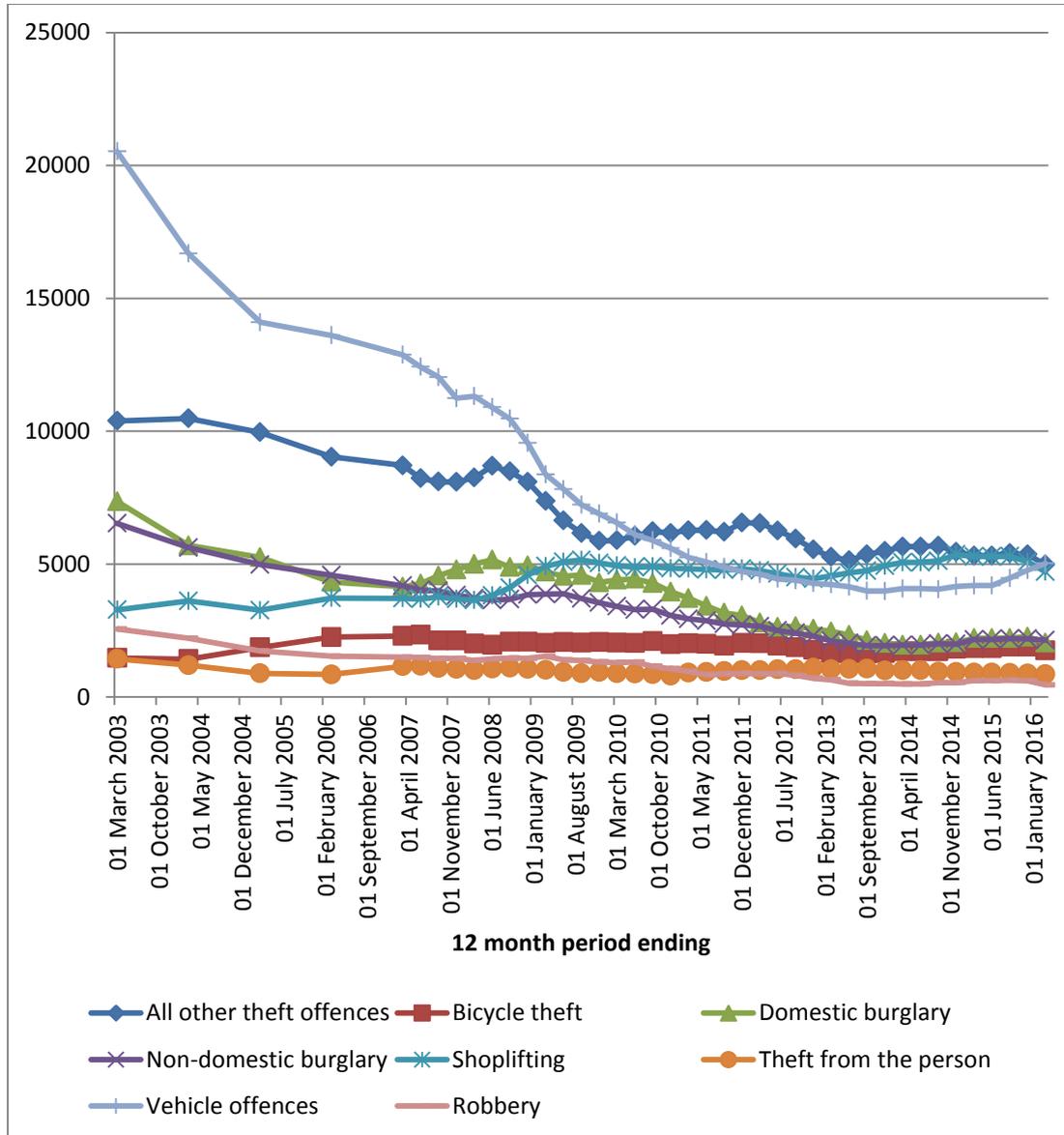
The economic and social cost of drug use and its supply is estimated to be around £10.7bn per year, of which £6bn is attributed to drug-related crime¹.

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.

¹ 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 death².

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 Assessment³ 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.

² Avon and Somerset Police and Crime Needs Assessment (2015)

³ 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 higher⁴.

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.

⁴ 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 (LBGT) 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.

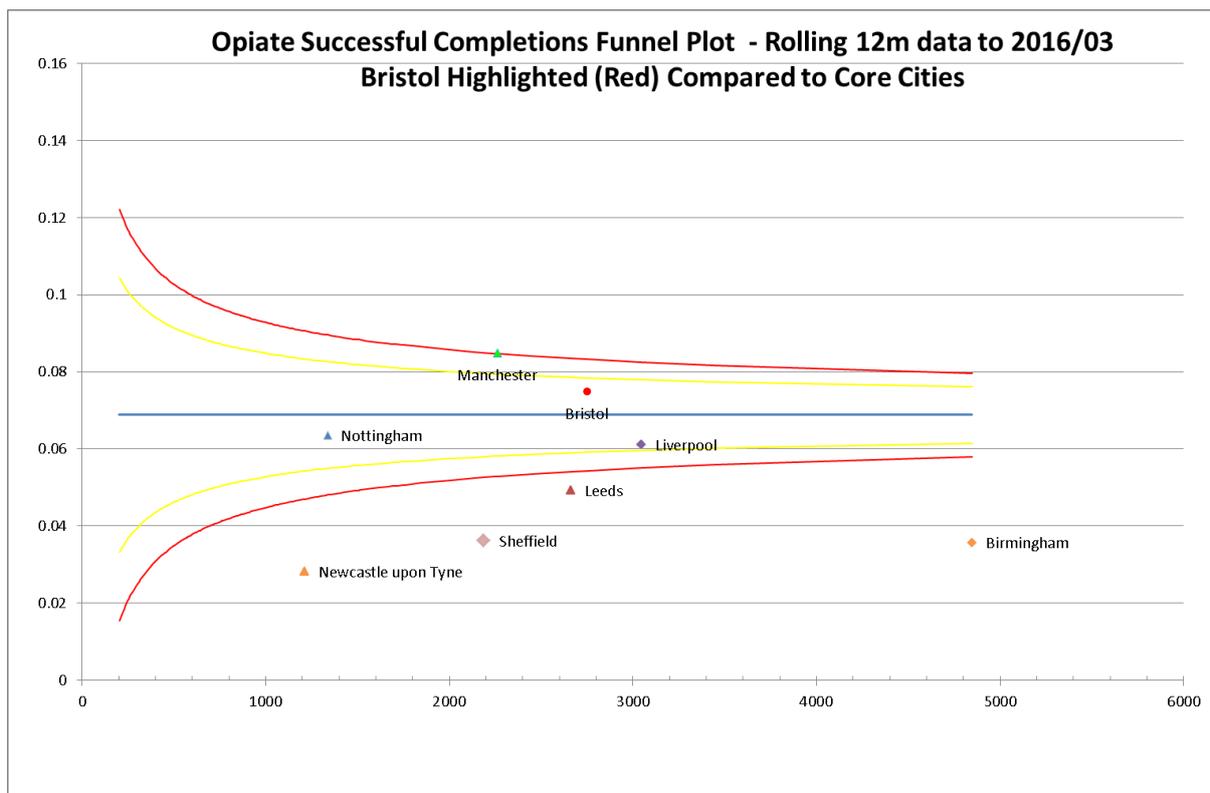
The blue line is the national average and the funnel is based on all 149 local authorities with only the core cities highlighted within it.

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.

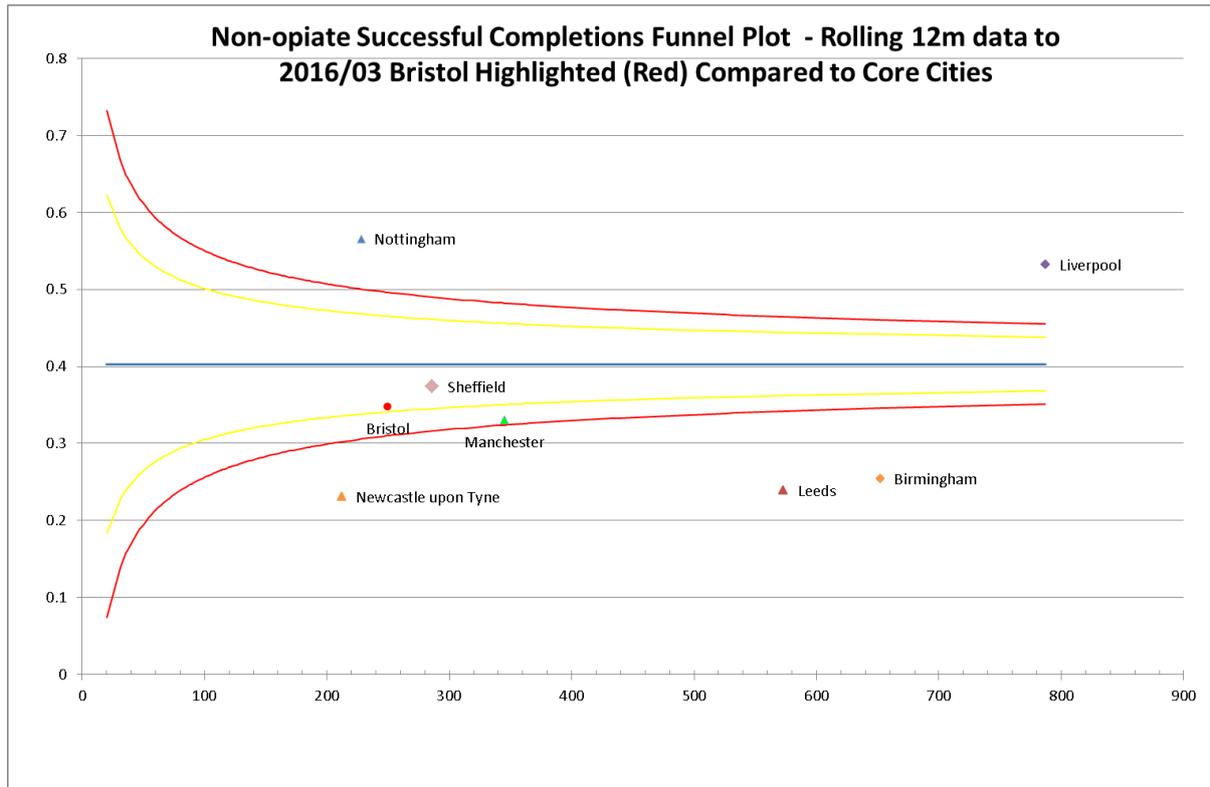
* The data as presented may not align with the national statistics because of differences in period, or when the data was extracted

Chart 2.10 Opiate Successful Completions Funnel Plot



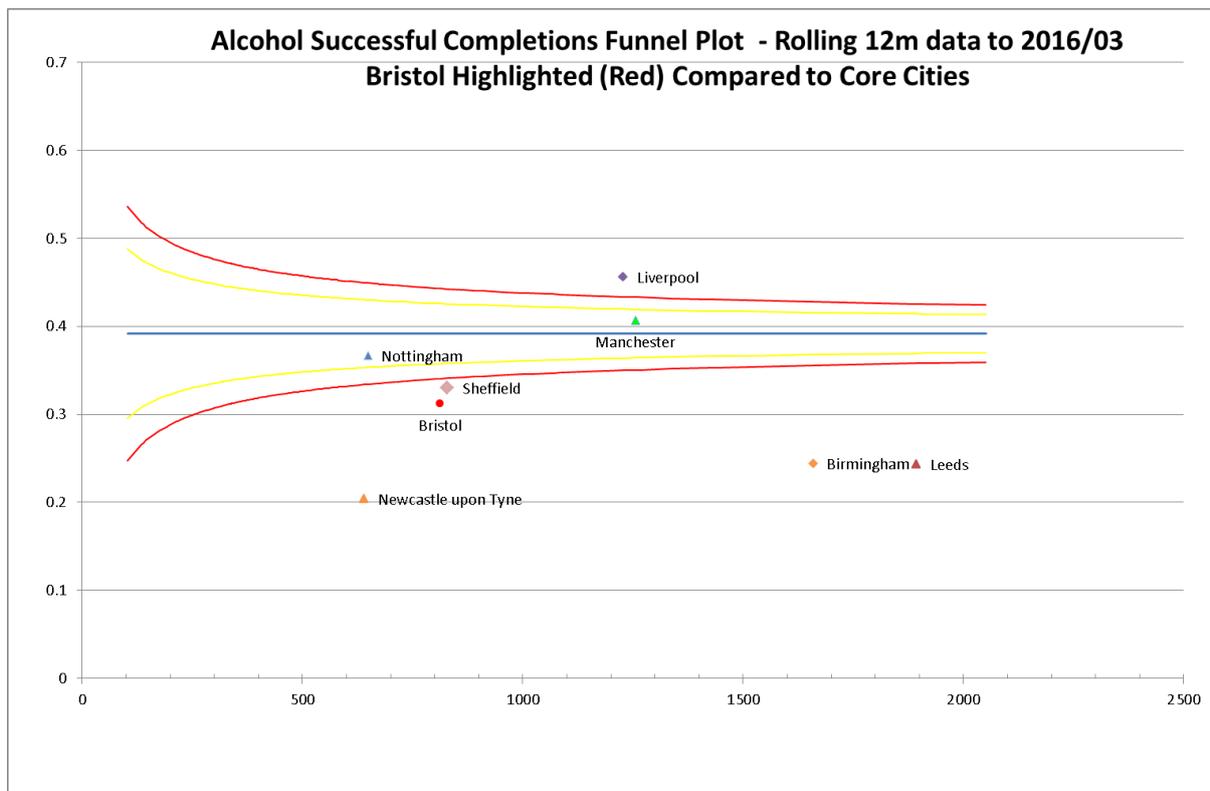
Bristol is above the national average in successful completions for opiate clients.

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.*⁵

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) study⁶ 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.

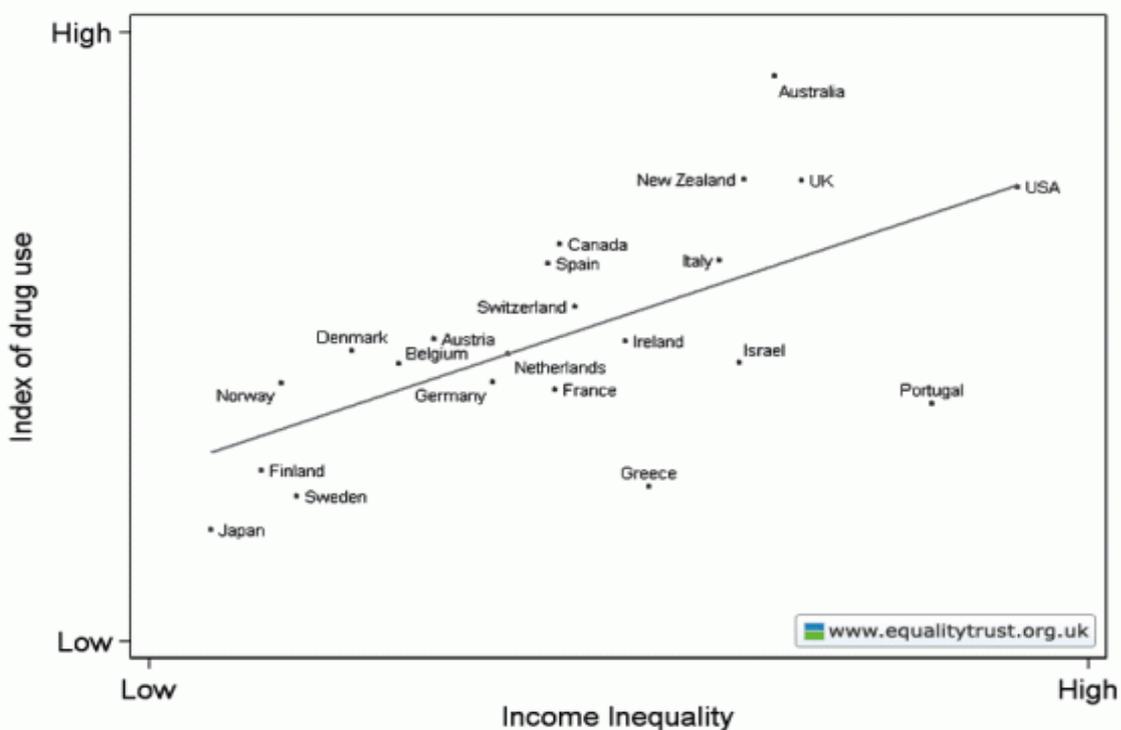
⁵ A summary of the health harms of drugs (2011)

⁶Welsh 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 ⁷ 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



⁷ Equality Trust Drug Index (2009)

The Older Persons' Substance Misuse Working Group of the Royal College of Psychiatrists report "Our Invisible Addicts"⁸ 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)⁹, "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 outcomes¹⁰.

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

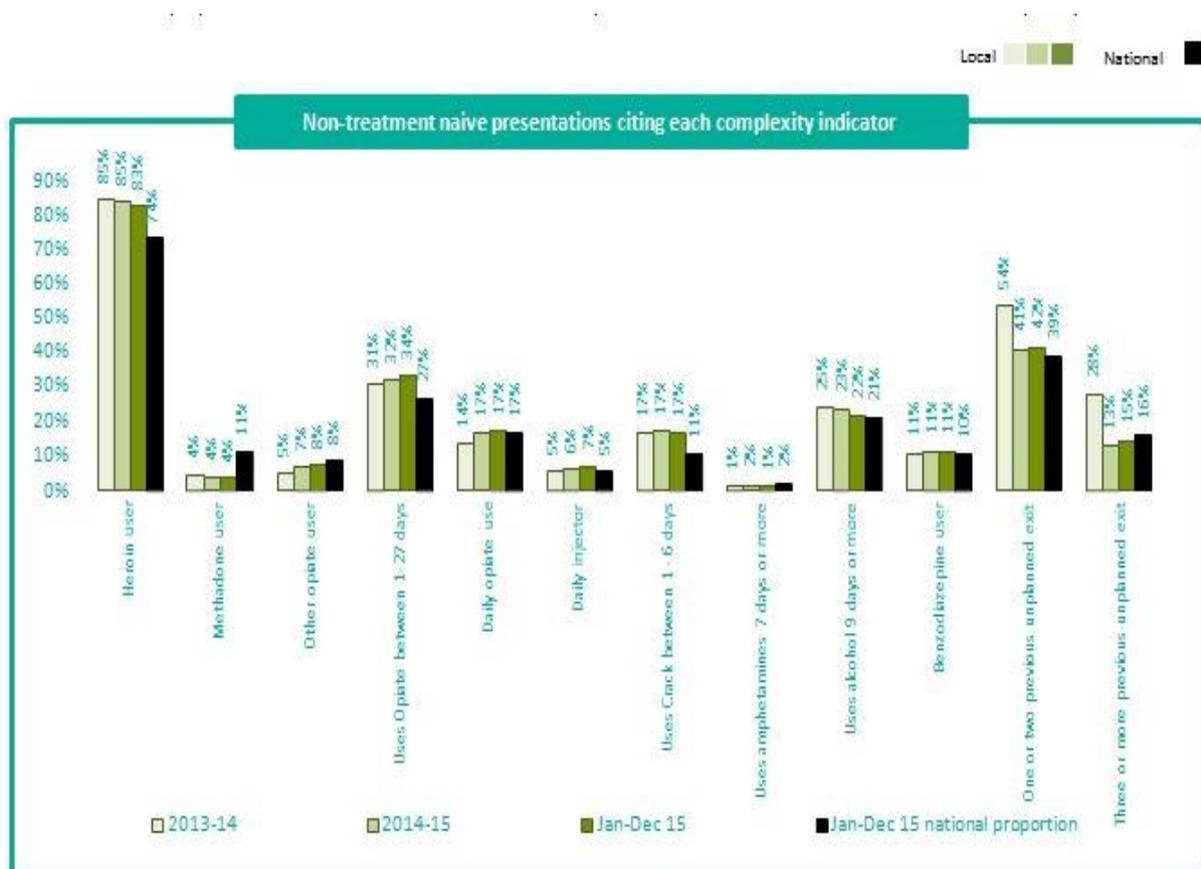
⁸ Our Invisible Addicts (2011)

⁹ Working with older drinkers (2011)

¹⁰ 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



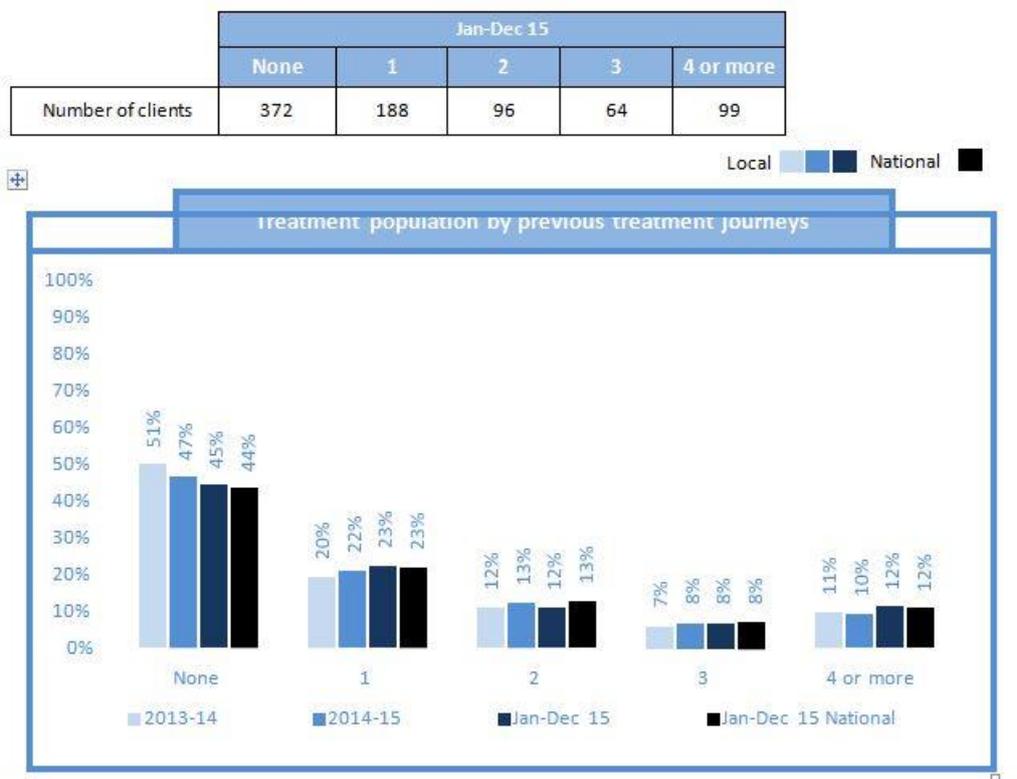
Whilst the percentage of treatment naïve clients presenting with complex indicators has reduced locally over the past three years, Bristol still has a higher percentage of complex presentations than the National comparator. Treating people with high and multiple complexities is traditionally more difficult 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

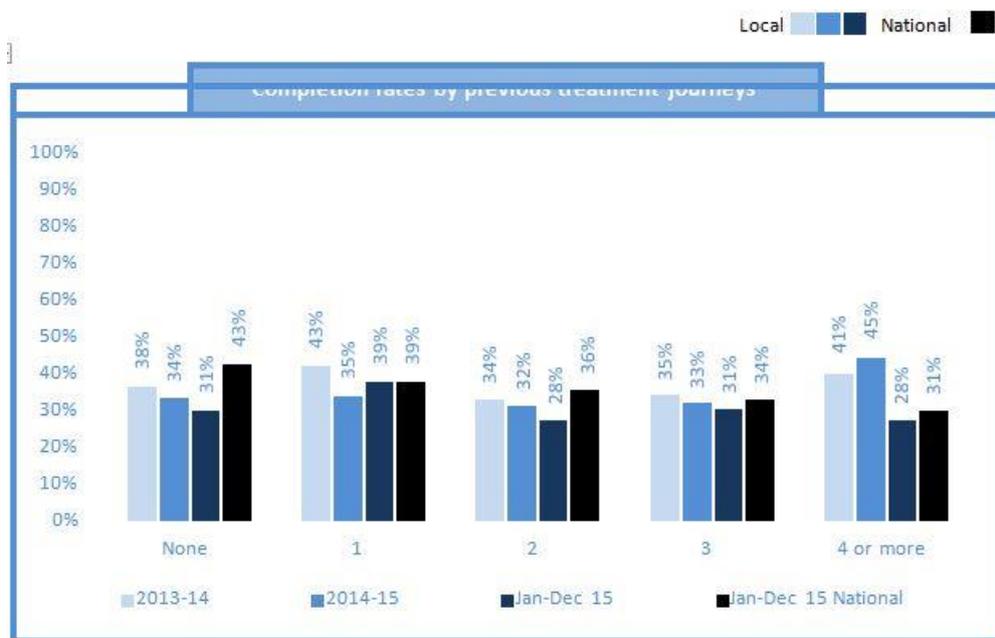


Whilst most levels have stayed relatively constant throughout the years and close to the National comparator, there has been a marginal decrease in the percentage of the treatment population having had no previous treatment journeys. This could be

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

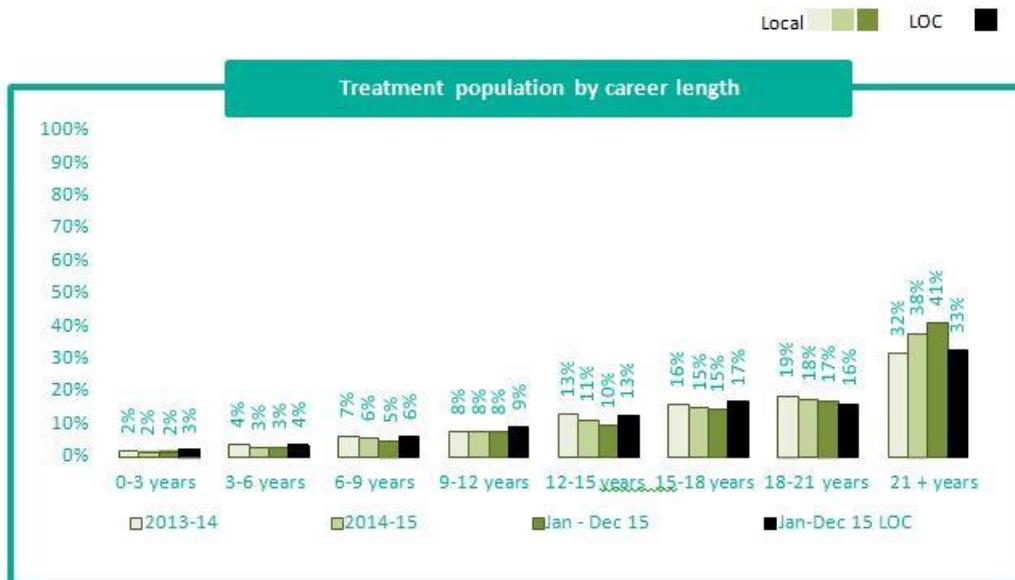


Bristol has a smaller percentage of people leaving treatment successfully than the national average. This may be down to the unprecedented demand for alcohol services since the launch of ROADS and the high attrition rates of alcohol clients from assessment to engagement.

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

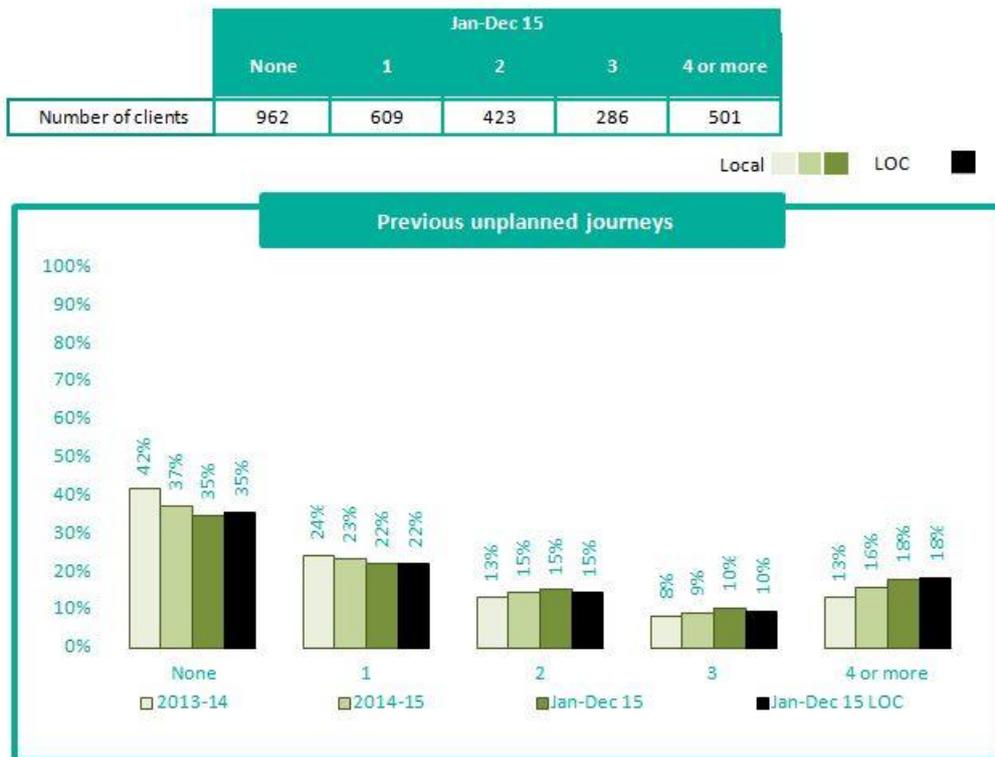
	Jan-Dec 15							
	0-3 years	3-6 years	6-9 years	9-12 years	12-15 years	15-18 years	18-21 years	21 + years
Number of clients	46	81	138	216	267	401	473	1127



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.

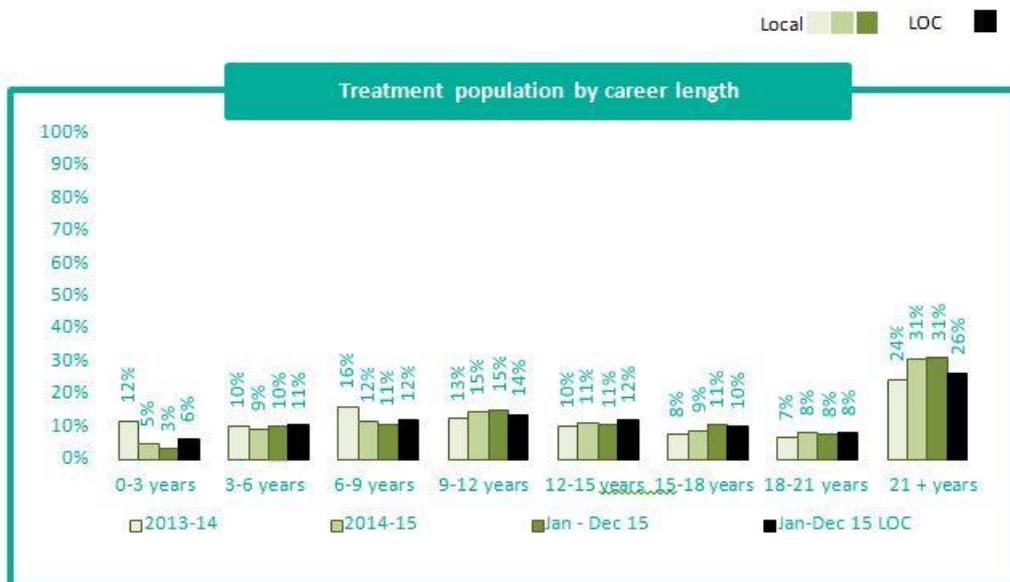
Chart 3.6 Percentage of treatment population with previous unplanned journeys



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.

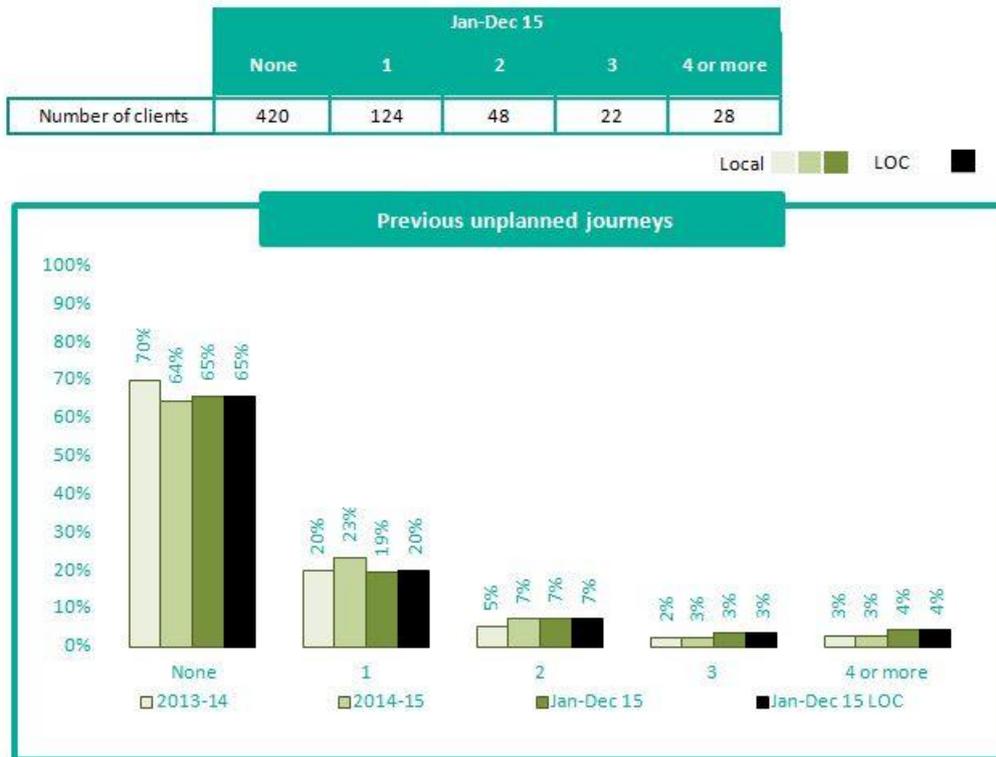
Chart 3.7 Treatment population by career length

Jan-Dec 15								
	0-3 years	3-6 years	6-9 years	9-12 years	12-15 years	15-18 years	18-21 years	21 + years
Number of clients	22	66	68	96	67	68	49	198



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.

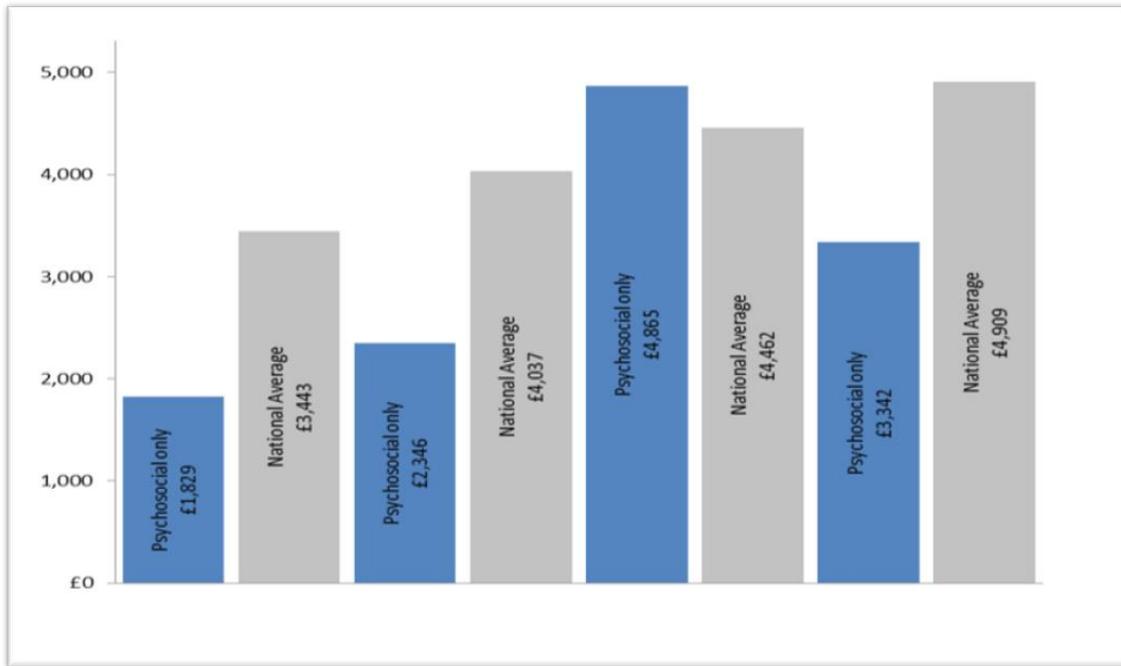
Please note that findings from this tool do not offer an argument to stop investing in more expensive interventions but instead are used to identify ways of improving the future cost effectiveness of interventions.

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 services¹¹. 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 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)

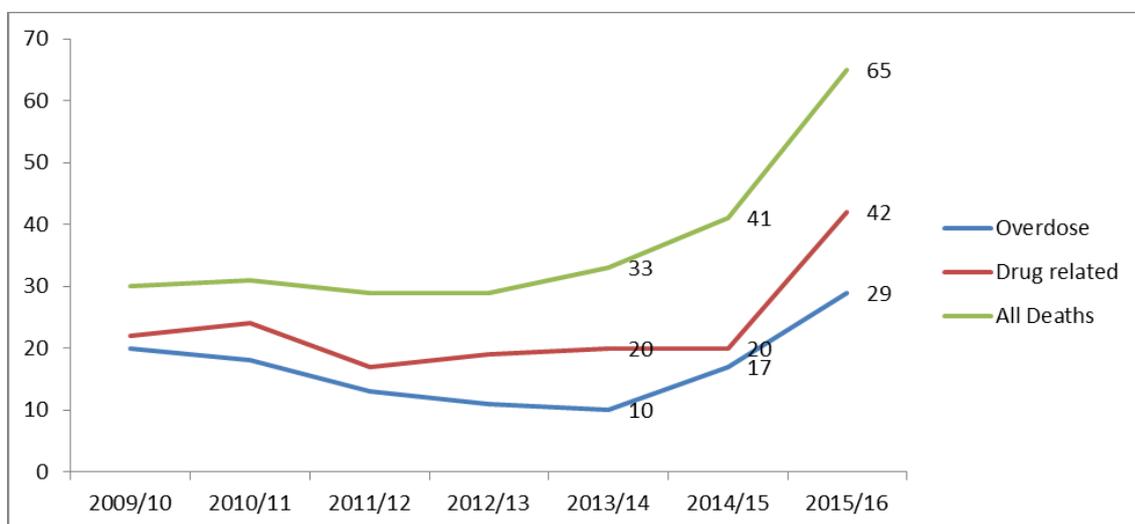
¹¹ Medications in Recovery(2012)

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 2014¹²

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%).

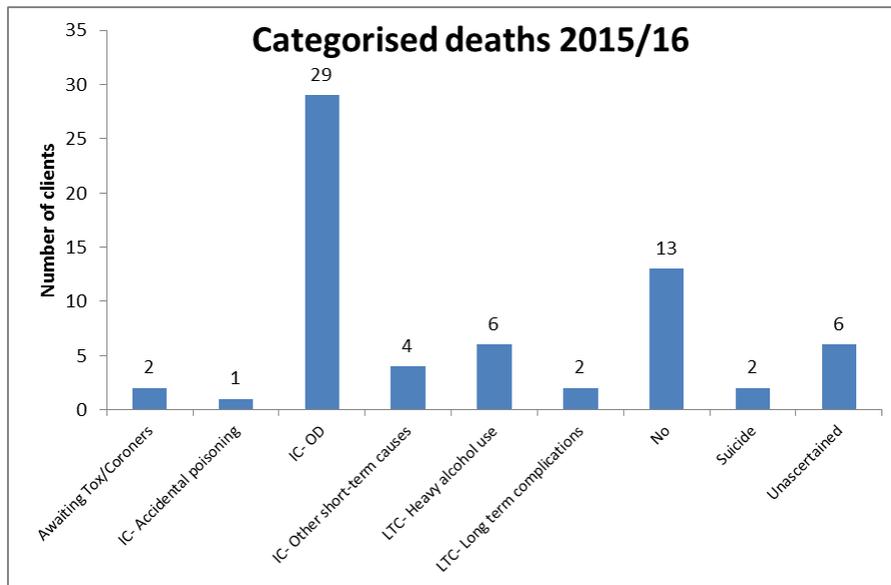
Chart 5.1 Bristol Drug Related Deaths Trend



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.

¹² Deaths Related to Drug Poisoning in England and Wales: 2014 registrations (2016)

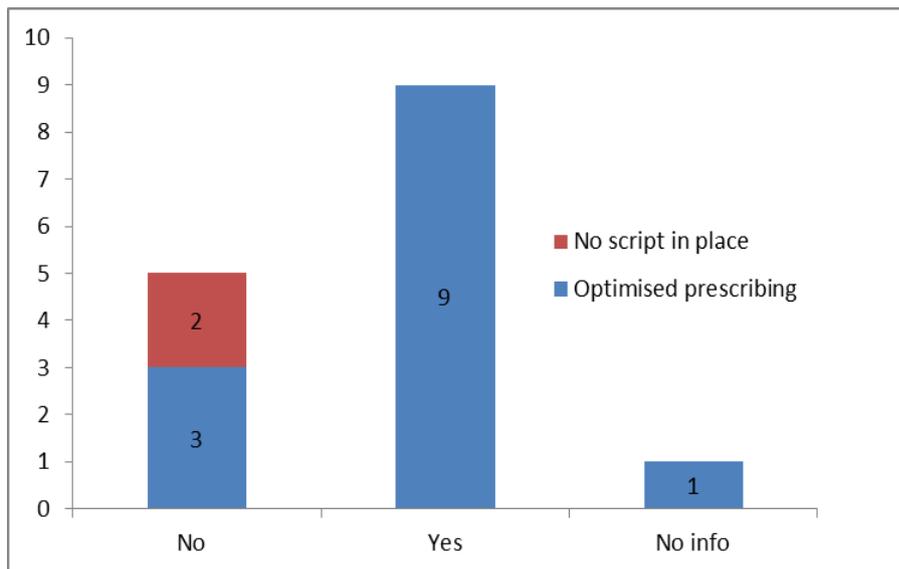
Chart 5.2 Cause of death for Bristol drug related deaths in 2015/16



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.

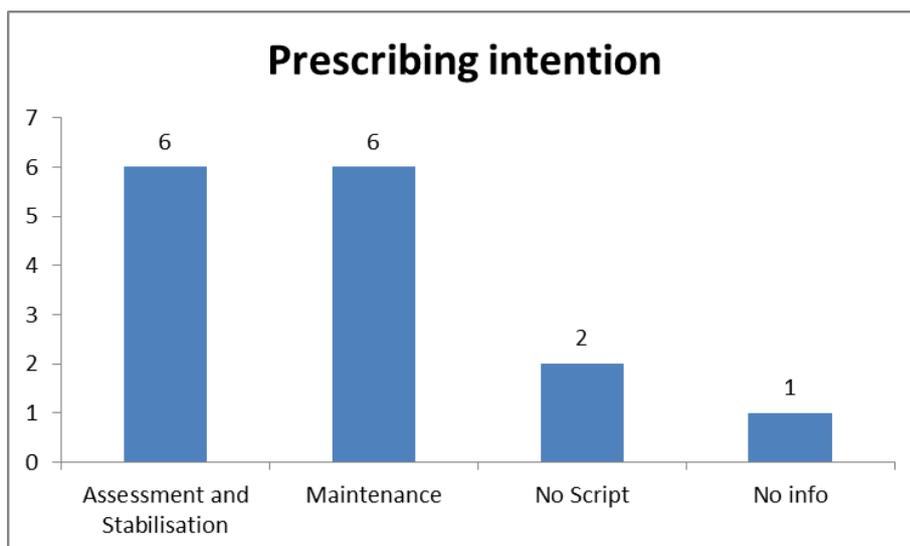
15 of the overdoses involved clients in treatment at the time. Of these, 60% (n=9) were in receipt of a prescription within the optimal range; 20% (n=3) received a sub-optimal dose of OST medication and a further 2 clients (13.3%) were in treatment but in receipt of no prescription at all.

Chart 5.3 Optimised prescribing of Bristol drug related deaths in 2015/16



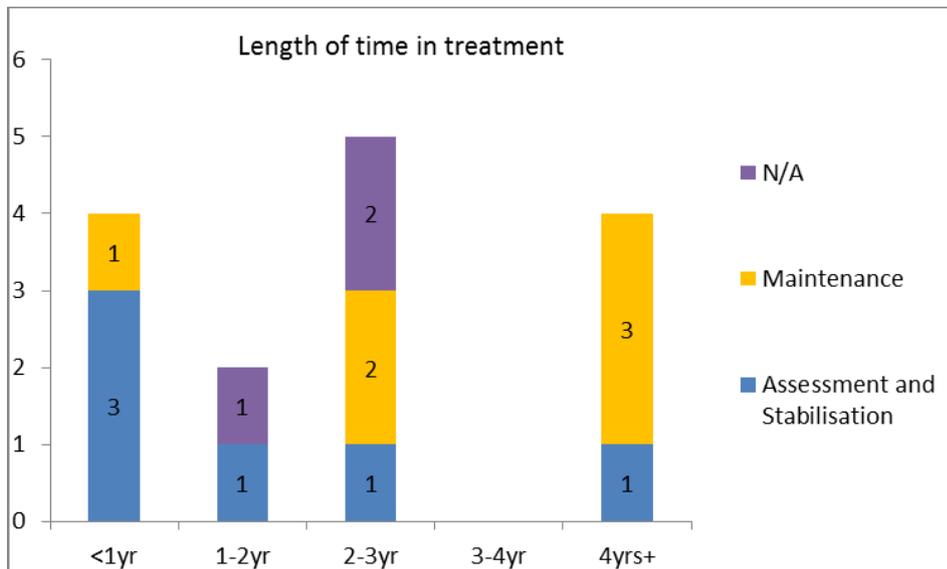
6 of these clients were considered to be in the Assessment and Stabilisation phase of OST; 6 within the Maintenance phase of treatment [n.b. several were reporting using heroin so would be more accurately recorded in the Assessment and Stabilisation phase]; 2 were without any OST medication; and one client had no information available.

Chart 5.3 Prescribing intentions of Bristol drug related deaths in 2015/16



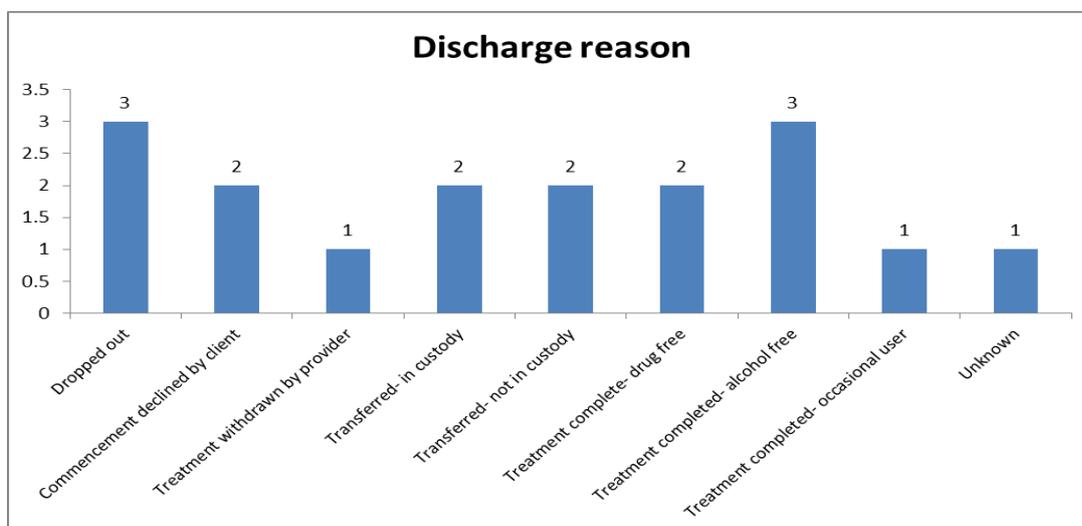
26.7% of these overdoses involved clients whose current treatment episode was less than 1 year; 13.3% current treatment episode 1-2years; 33.3% 2-3 years; and 26.7% four years or longer.

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.

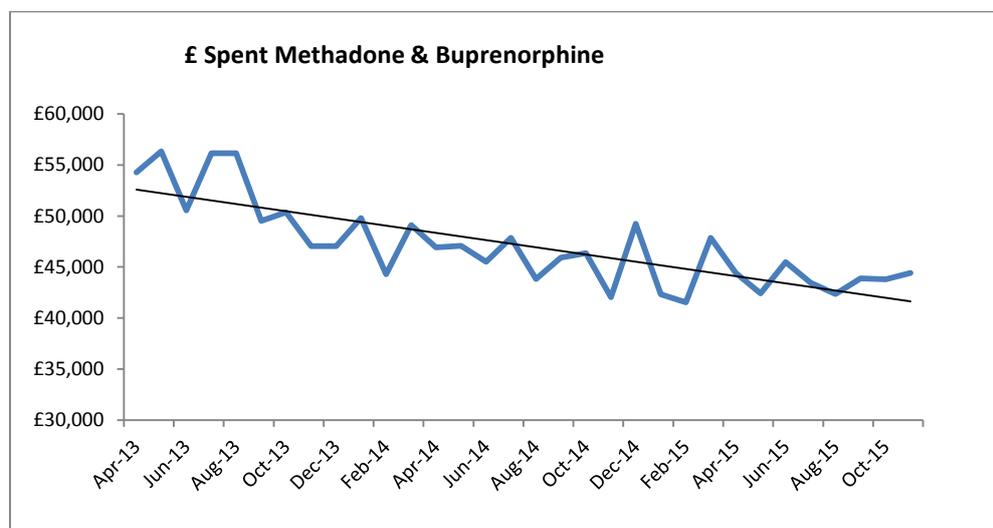
Recent changes in drug trends have seen reported increases in the use of pregabalin and Spice being reported to treatment providers and the Substance Misuse Team. Whilst there is no pharmacological evidence to suggest a link between these drugs and increased opiate toxicity, the influence on disinhibited 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.

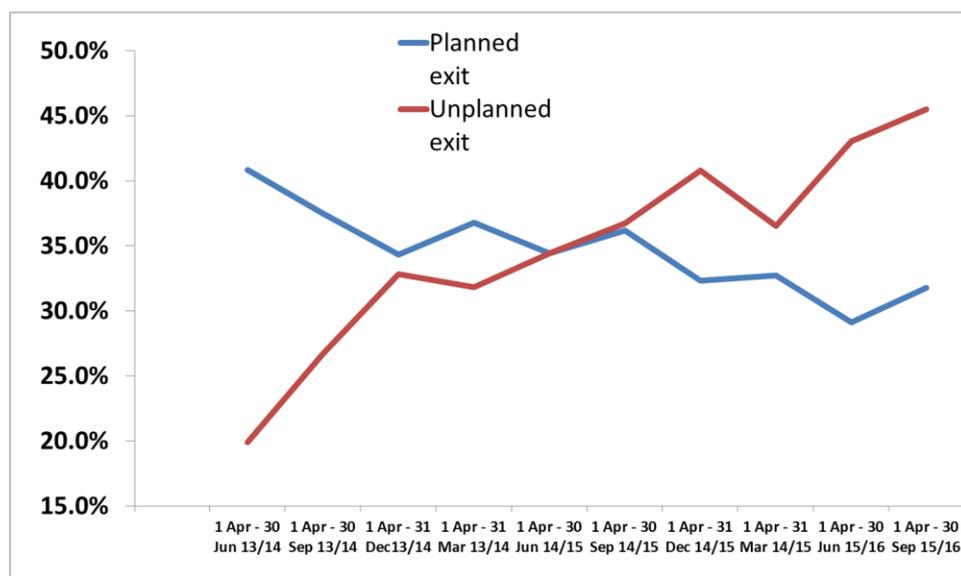
Several characteristics of the ROADS treatment system are also correlated with the recorded increase in drug related deaths. Since April 2013 there has been a 16% reduction in spend on opiate substitution medication whilst client numbers in that time period have only reduced by 8%. This possibly indicates 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 base¹³ 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 Survey¹⁴ 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.

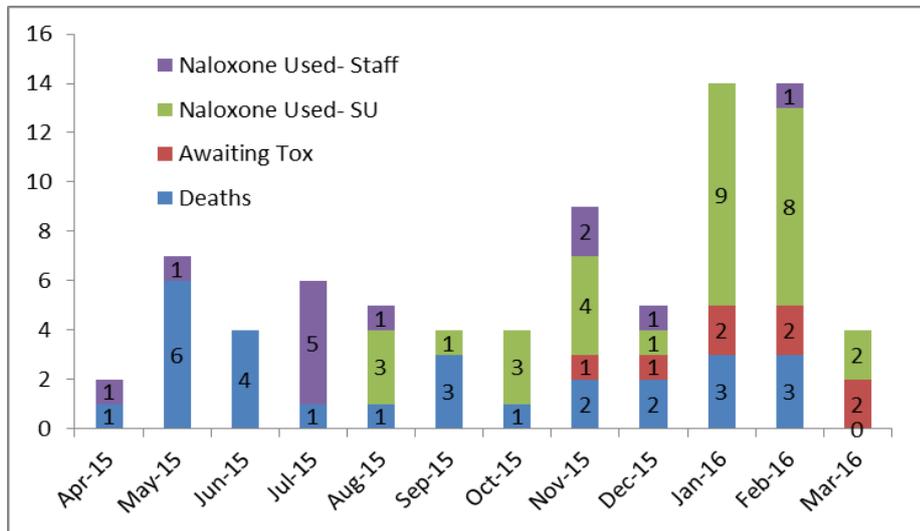
The provision of naloxone to at-risk service users is thought to have a positive effect on limiting the number of overdose deaths. In 2015/16 there were 42 known uses of

¹³ Preventing Drug Related Deaths- Sudden Onset Deaths(2014)

¹⁴ 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



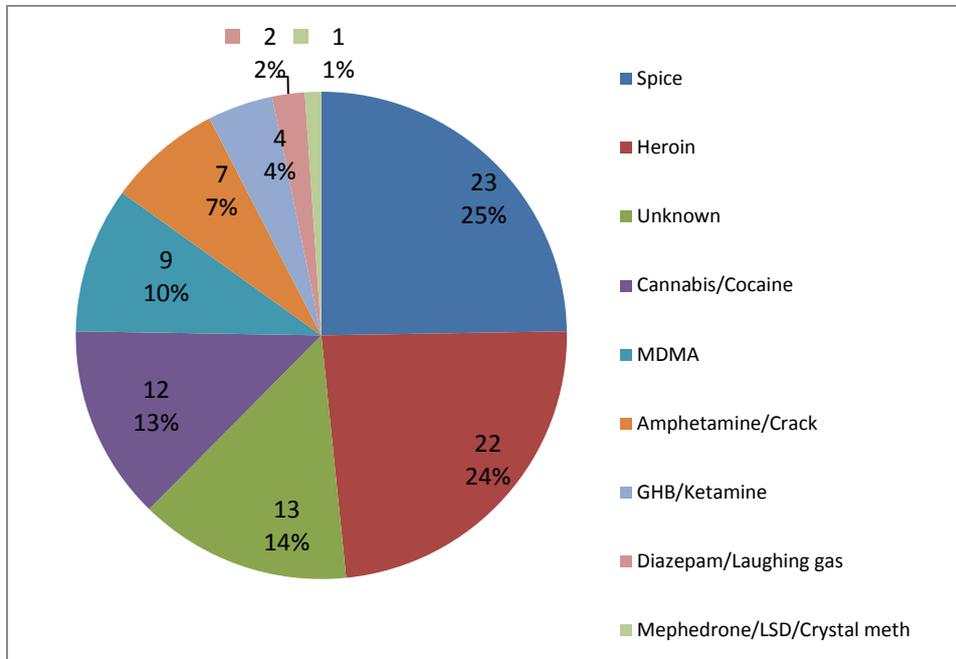
Novel Psychoactive Substances

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 3rd 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.

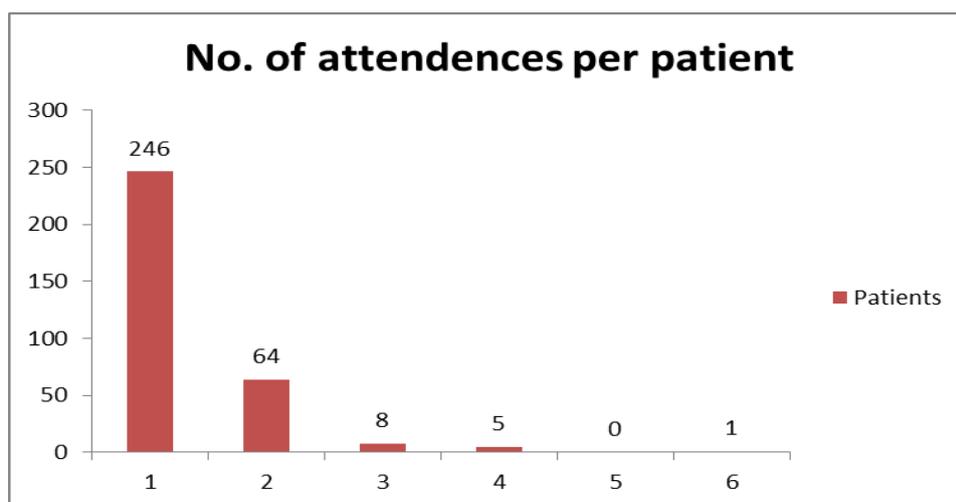
2.7% (n=4) of clients were known to have overdosed in the last 3 months and staff indicated that they would not be surprised if 8% (n=12) of their clients died within the next 12 months.

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.¹⁵

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%

¹⁵ 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 Assessment¹⁶ 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).

¹⁶ 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 2014¹⁷ 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.

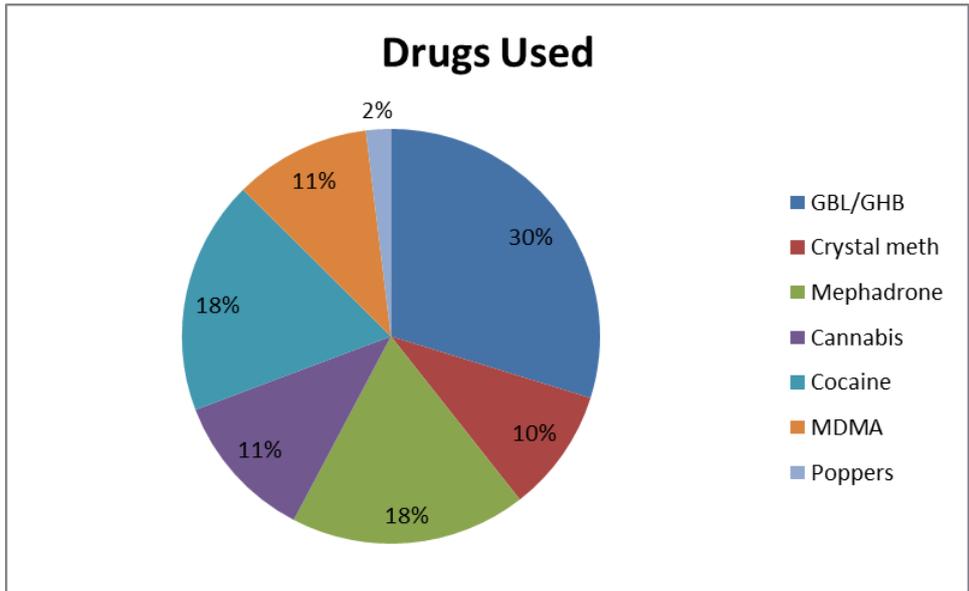
¹⁷ Positive Voices survey for England and Wales (2014)

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
Mephadrone	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 mephedrone. 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”*.¹⁸

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

¹⁸ 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 Bristol¹⁹ 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 injecting²⁰ (although the injecting population has been estimated by the University of Bristol as being as high as 2770²¹

Bristol has an estimated rate of 18.0 OCUs per 1,000 population, over twice the national average of 8.4²².

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

¹⁹ The multiplicity and interdependency of factors influencing the health of street-based sex workers: a qualitative study (2008)

²⁰ Estimates of the prevalence of opiate use and/or crack cocaine use (2011/12) (2012)

²¹ Problem drug use prevalence estimation revisited: heterogeneity in capture-recapture and the role of external evidence (2015)

²² Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2011/12 (2012)

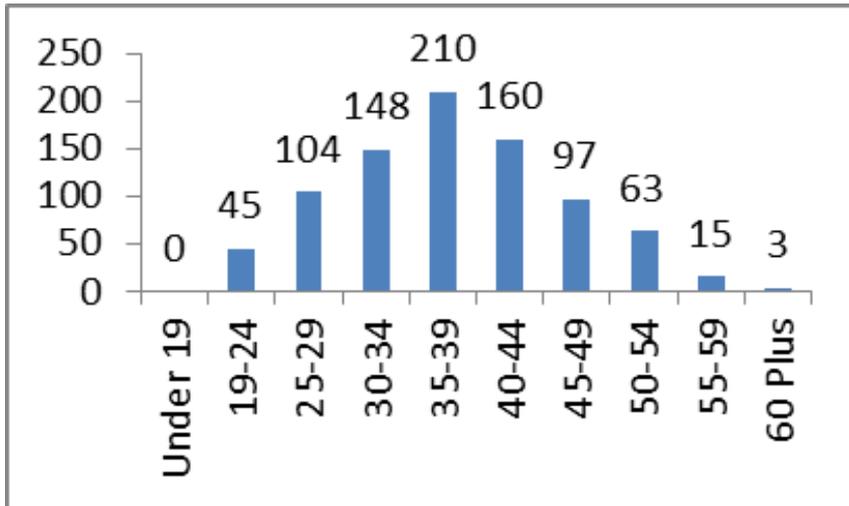


Chart 5.10 Gender of clients accessing NSP in 2015

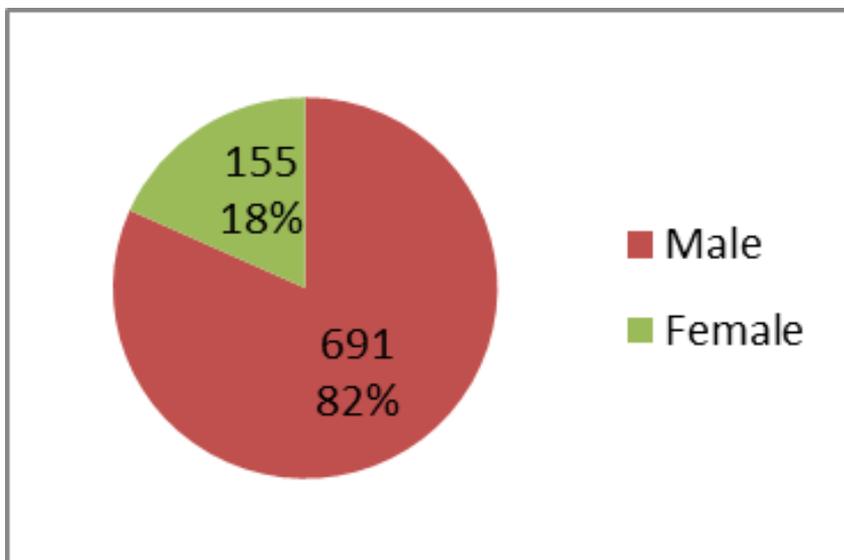


Chart 5.11 Ethnicity of clients accessing NSP in 2015

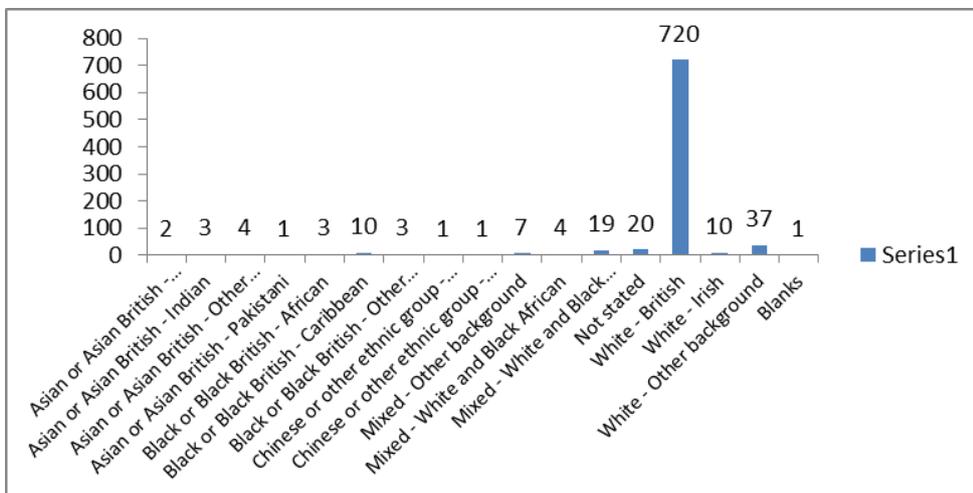


Chart 5.12 Disability status of clients accessing NSP in 2015

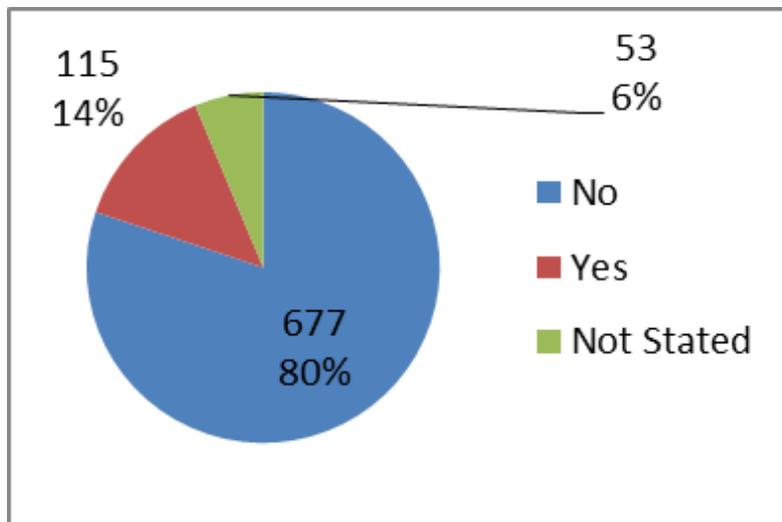


Chart 5.13 Sexual orientation of clients accessing NSP in 2015

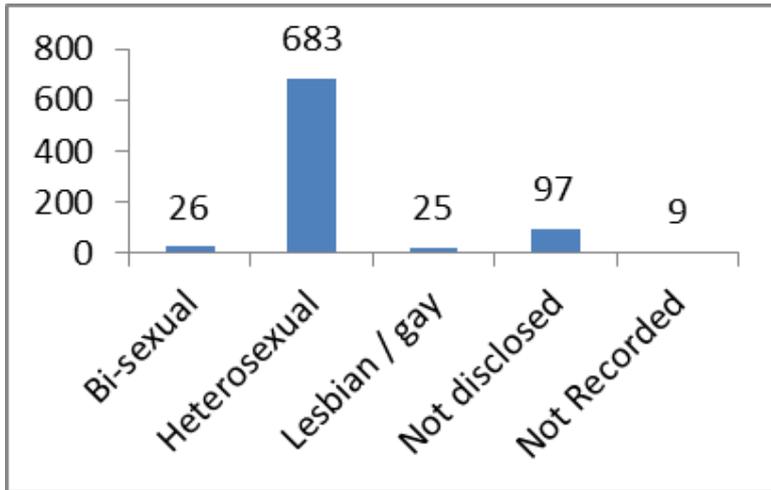
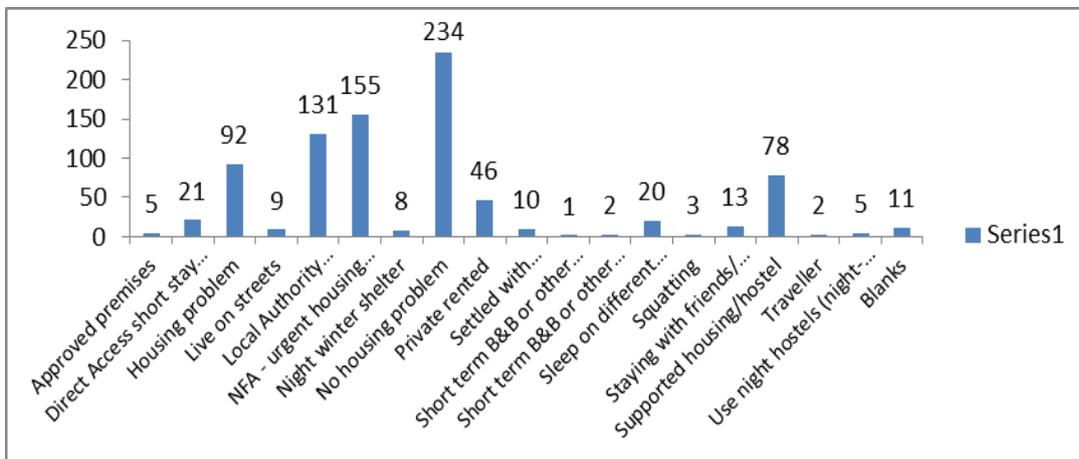


Chart 5.14 Housing status of clients accessing NSP in 2015



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).

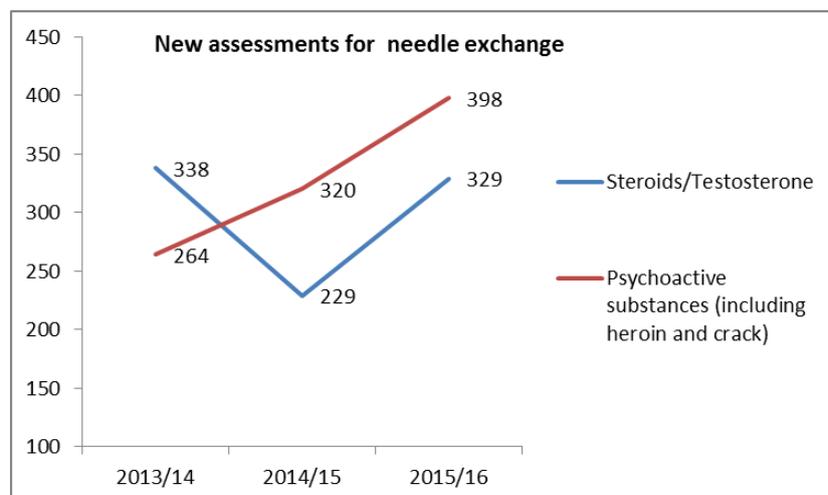
Currently 55% of PWID who access specialist NSP are engaged with the ROADS treatment system and are either accessing NSP during their current treatment episode or are previous injectors currently engaged with treatment but have not accessed the NSP in the past 12 weeks. This figure varies considerably 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 2009²³. 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).

²³ 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.

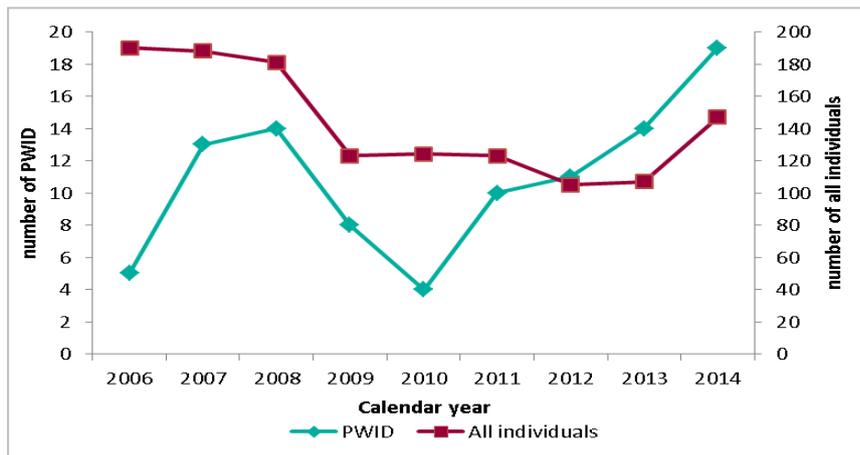
MRSA

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 2nd 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 population²⁴) 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

²⁴ HIV in the United Kingdom (2014)

population²⁵ and HBV between 0.1% and 0.5% of the UK population²⁶). 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.

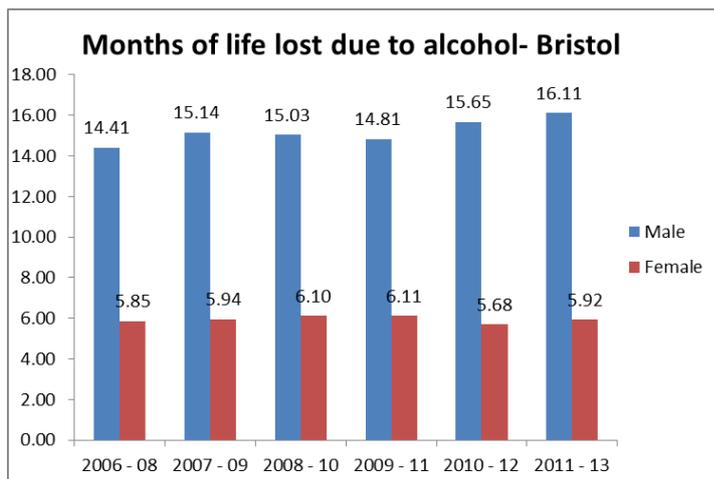
Alcohol harm and mortality

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



²⁵ Hepatitis C in the UK (2015)

²⁶ 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 CI 14.36-19.44). 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

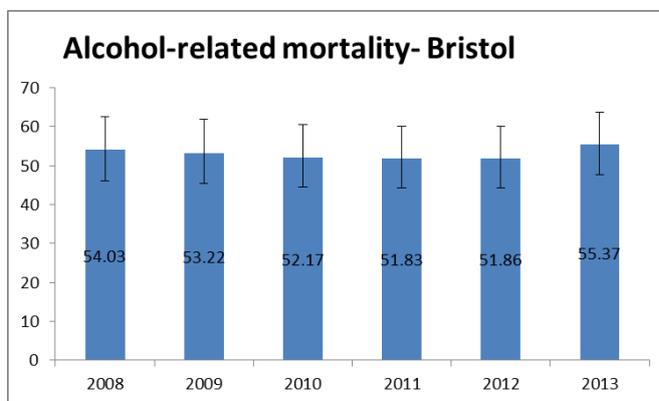


	Males - Bristol	Males - England	Females - Bristol	Females - England
2006-08	24.84	16.57	6.96	7.48
Lower and Upper CI	20.5- 29.67	16.27- 16.88	4.79-9.54	7.28-7.68
2011-13	25.96	16.61	7.42	7.47
Lower and	21.75-	16.31-	5.27-10.15	7.28-7.67

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 CI 44.7-45.89)

Chart 5.19 Alcohol Related Mortality Bristol

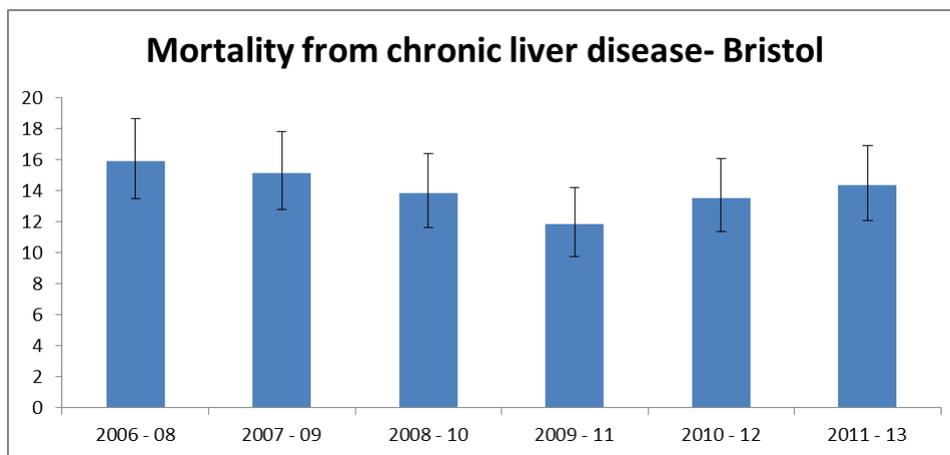


	Males- Bristol	Males - England	Females - Bristol	Females - England
2008	83.96	69.29	29.54	30.46
Lower and Upper CI	68.83- 101.13	68.11- 70.49	21.77- 38.57	29.78-31.15
2013	83.53	65.43	30.7	28.42
Lower and Upper CI	69.33- 99.05	64.35- 66.51	22.83-39.8	27.78-29.07

Mortality from chronic liver disease in England has fallen from 12.59 deaths per 100,000 population in 2006-08 (lower and upper CI 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 2nd 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).

Admitting condition	No.	%
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 Assessment²⁷ – 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

²⁷ 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.

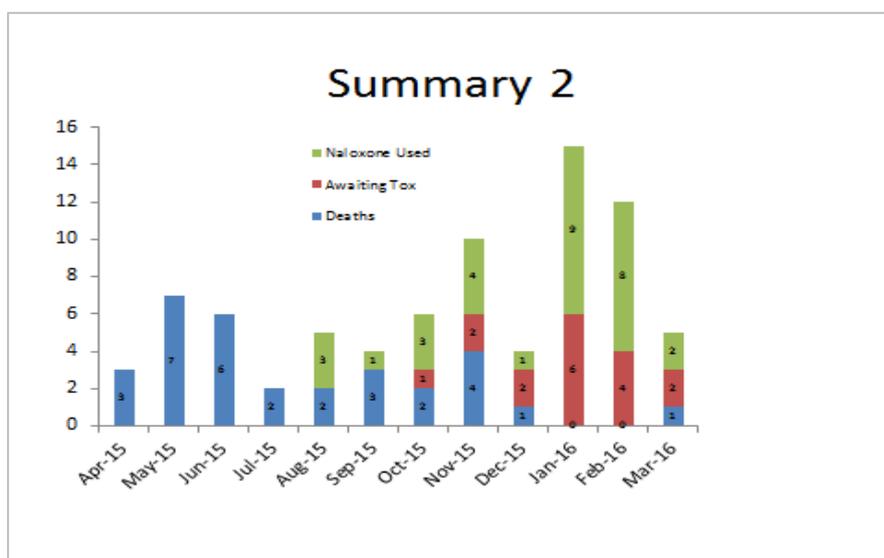
ROADS assertive engagement and assessment teams continue to engage with current drug users to offer harm reduction information & advice, pathways to treatment as well as liaison with partners working with high risk clients (e.g. homeless hostels)

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

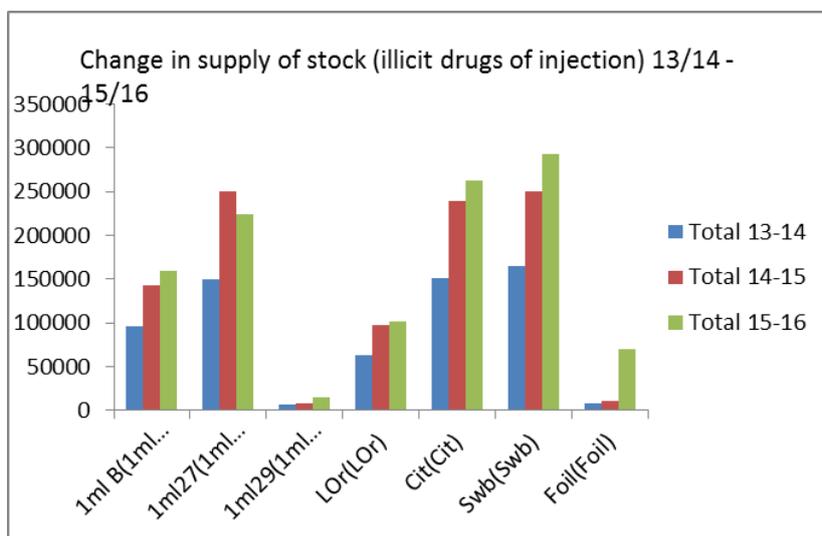
Commissioned services plus activity

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

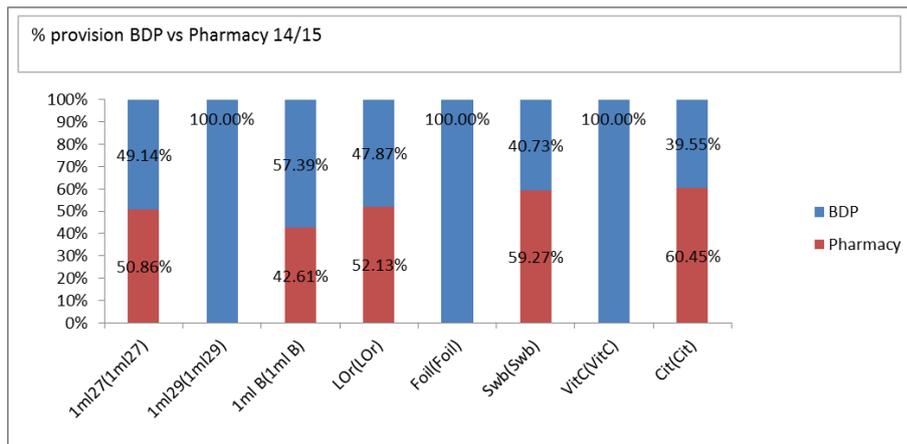


The coverage rate stands at 66% for 2015/16²⁸ indicating that:

- 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

²⁸ 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 average²⁹, a lack of opportunistic availability of vaccine across the treatment system and primary care

²⁹ 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

HARM REDUCTION			
2.6 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			
(n) = number of clients who have no record of completing a course of HBV vaccinations / all clients in treatment at the end of the reporting period who were eligible to be offered a course of vaccinations			
	Latest period		National average
	(%)	(n)	(%)
All clients in treatment	65.2%	419 / 643	72.5%
New presentations to treatment	79.4%	81 / 102	90.0%

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 8.4³⁰.

Injecting drug use remains significantly more prevalent in Bristol and the Southwest than the rest of England³¹.

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.

³⁰ Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use (2012)

³¹ 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”³² 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 Bristol³³ 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 Ethnic) 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 depressionⁱ.

The most common associations for substance misuse are with depression, anxiety and schizophrenia, but eating disorders, post-traumatic stress, attention deficit,

³² Projecting Adult Service Needs and Service Information (2016)

³³ 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”³⁴ 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).

³⁴ National confidential enquiry into suicide and homicide by people with mental illness (2016)

In 'Reducing social isolation across the life course'³⁵ 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 Strategy³⁶, 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 England³⁷ profiling tool collates and analyses data in relation to both substance misuse and mental health at a national, regional, and local level.

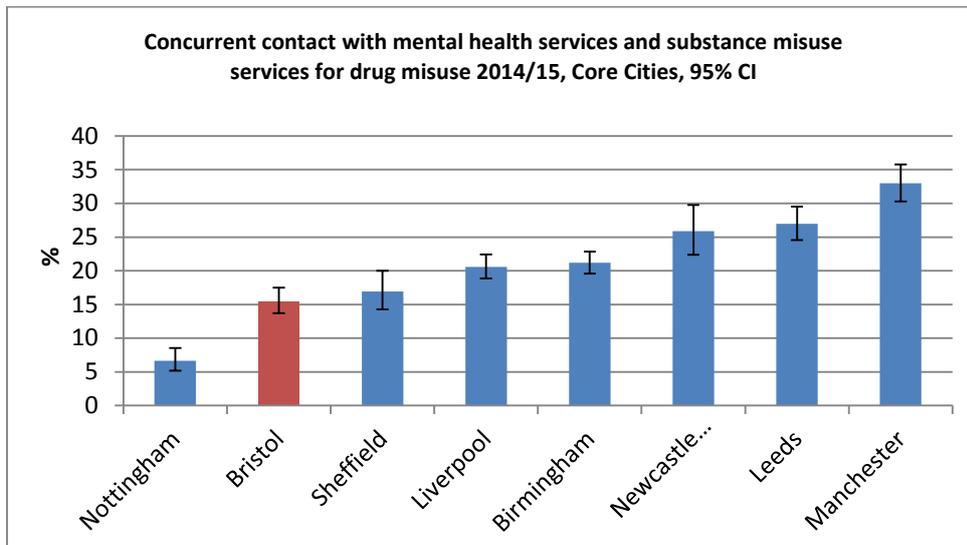
The latest figures from 2014/15, highlight that a higher percentage of people have concurrent contact with mental health services and substance misuse services for drug misuse at both a national (21%) and regional (19.7%) level than at a local one (15.5%). When comparing this to the core cities, Bristol is second lowest behind Nottingham.

³⁵ Reducing social isolation across the life course (2016)

³⁶ Bristol Health & Wellbeing Strategy (2013)

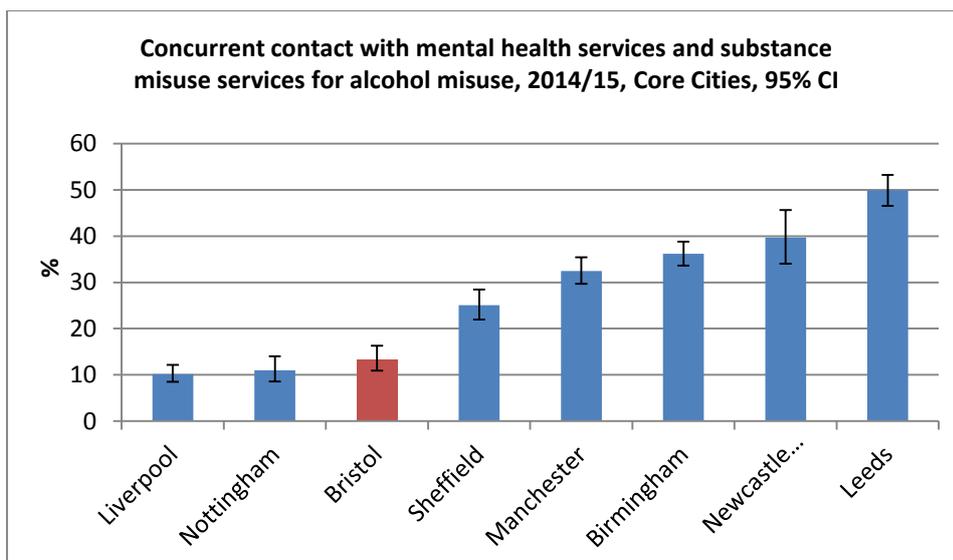
³⁷ Co-existing Substance Misuse and Mental Health Issues Profiling Tool (2016)

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”³⁸ (inclusion of one of these ICD10 codes: F11, F12, F13, F14, F15, F16, F18, F19 in any diagnosis field) recorded between 2013-2015.

Sex	2013	2013 Rate per 100,000	2014	2014 Rate per 100,000	2015	2015 Rate per 100,000
Male	511	233.9	694	314.1	816	369.4
Female	240	109.6	311	140.4	368	166.1
Total	751	171.7	1005	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)³⁹ 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.

³⁸ Mental and Behavioural Disorders due to the use of Drugs and Noxious Substances (2013 – 2015)

³⁹ 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:

Prescribing Regime	Number of clients prescribed	% of Bristol population	Number of patients prescribed MH related medication alongside OST prescription	% prescribed MH related medication alongside OST prescription
Prescribed methadone/buprenorphine (OST)	2031	0.4%	N/A	N/A
Prescribed antidepressant	46,626	9.8%	954	47%
Prescribed anxiolytic/hypnotic	12,778	3%	514	25.3%
Prescribed antipsychotic	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 Assessment⁴⁰ 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).

⁴⁰ 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?

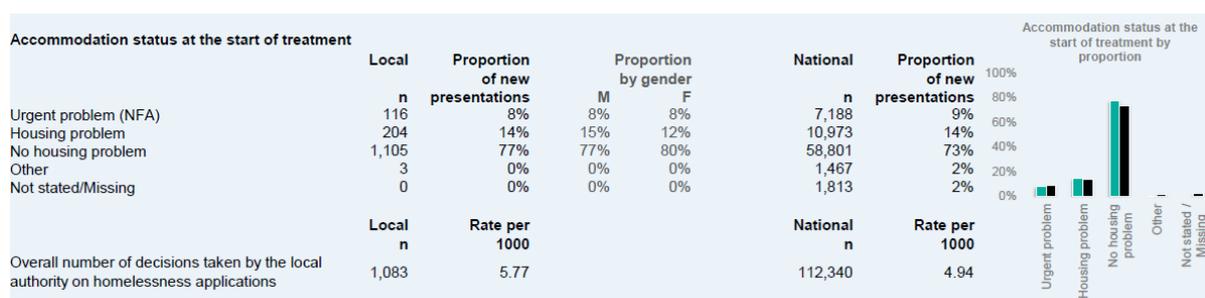
Having somewhere stable to live is a fundamental part of life and can significantly affect health outcomes. According to the Department for Community and Local Government (DCLG) figures, Bristol has seen one of the highest rises in rough sleeping in the country between 2014 and 2015. Of those, an estimated 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 Assessment⁴¹ 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.

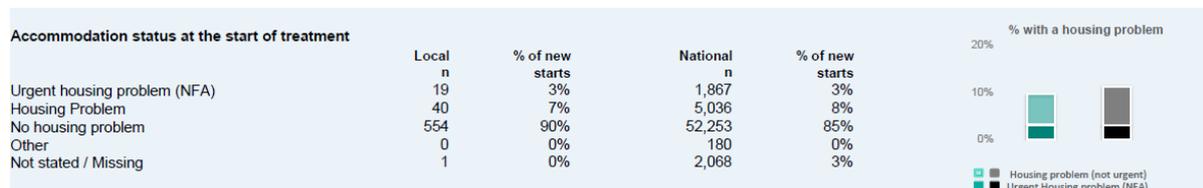
Chart 7.2 Accommodation at the start of drug treatment



⁴¹ 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



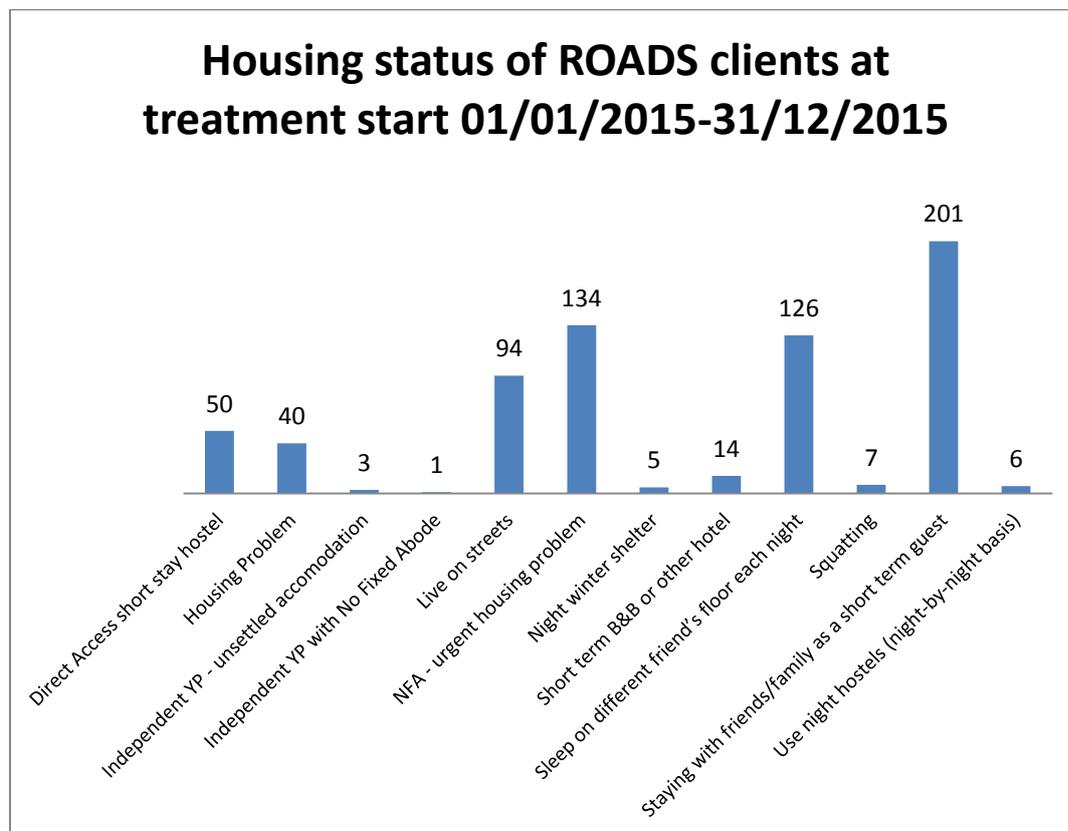
In the local population, more specifically within the drug and alcohol sector, there are consistently high numbers of individuals being assessed for treatment who at time of assessment are either registered as statutory homeless, at risk of homelessness or living in a situation which is detrimental to 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.

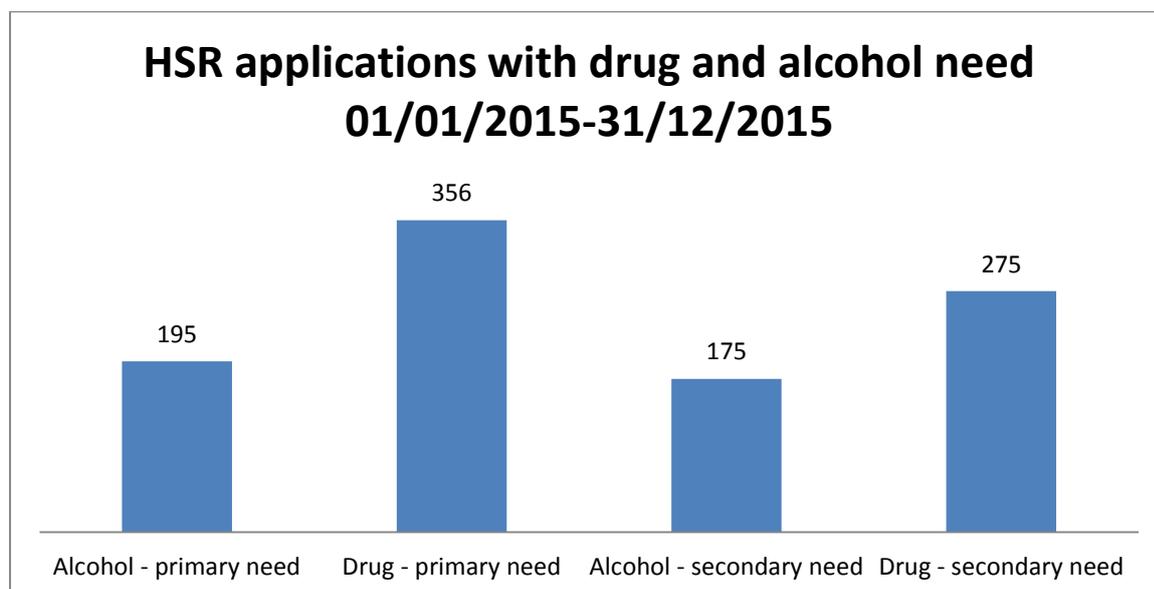
Chart 7.3 Housing status of clients starting ROADS treatment



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

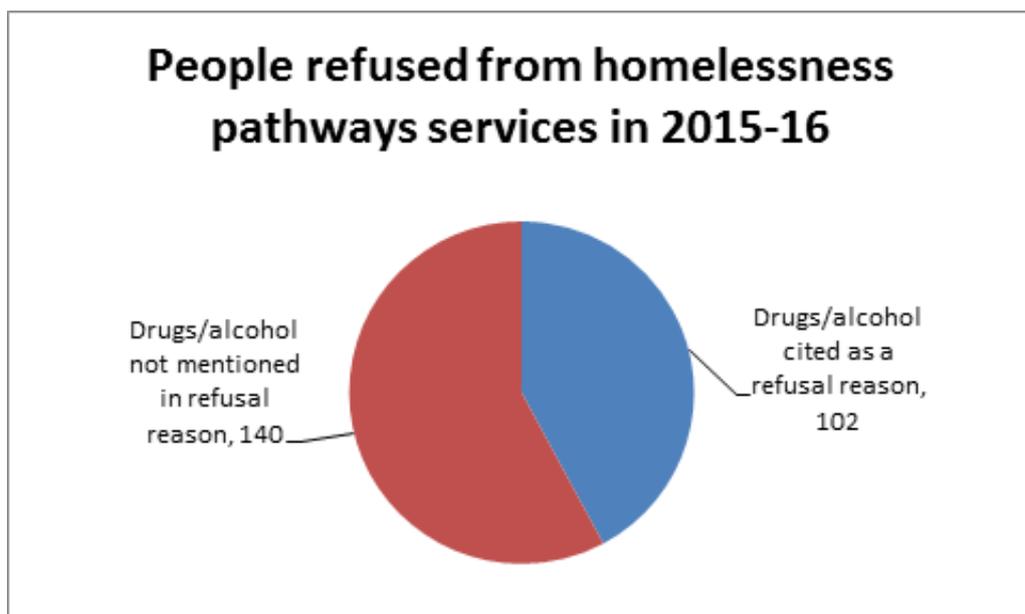


Chart 7.6 Percentage of people refused from homelessness pathways due to drugs or alcohol by housing level

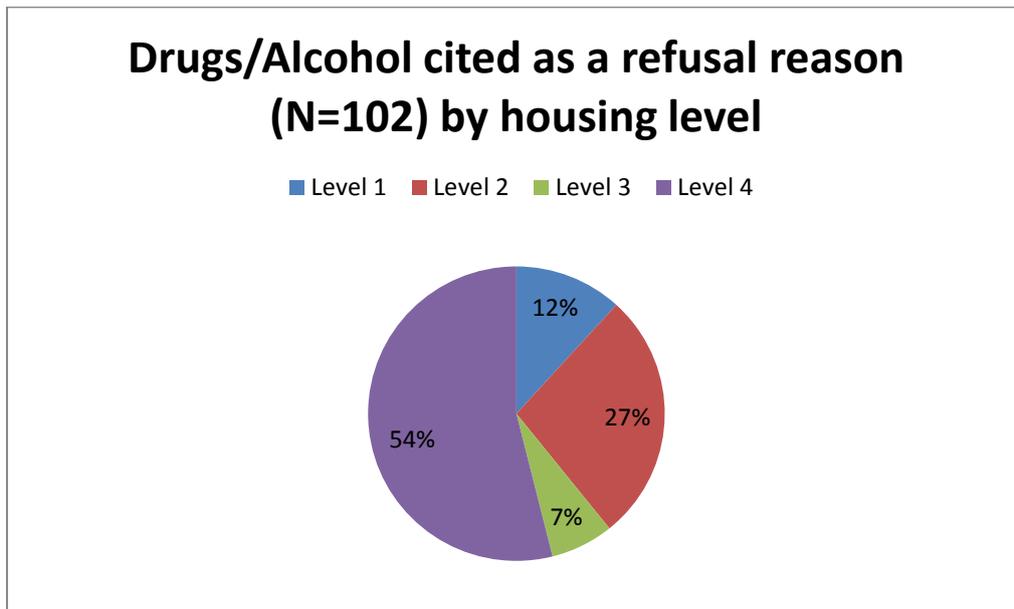
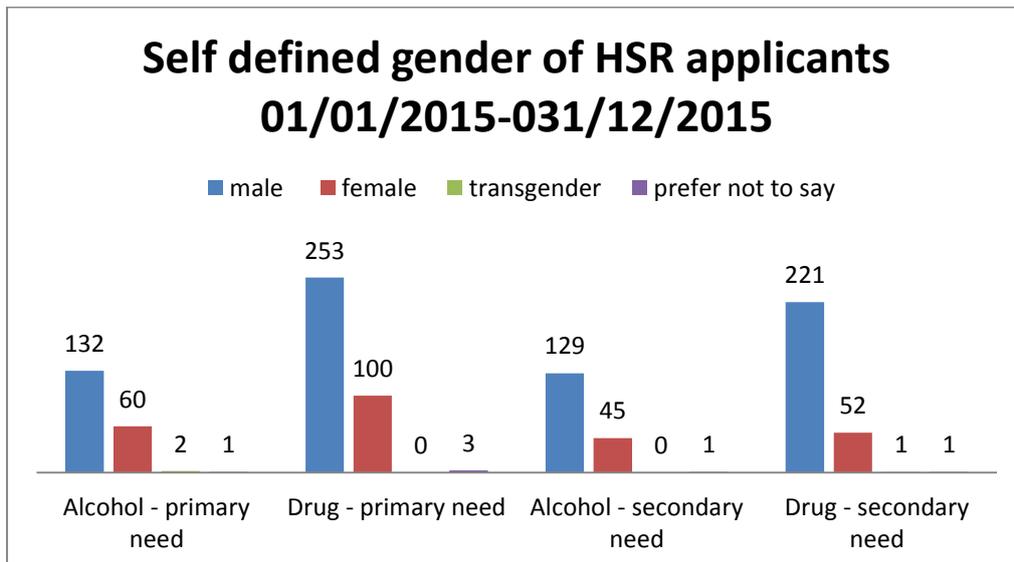


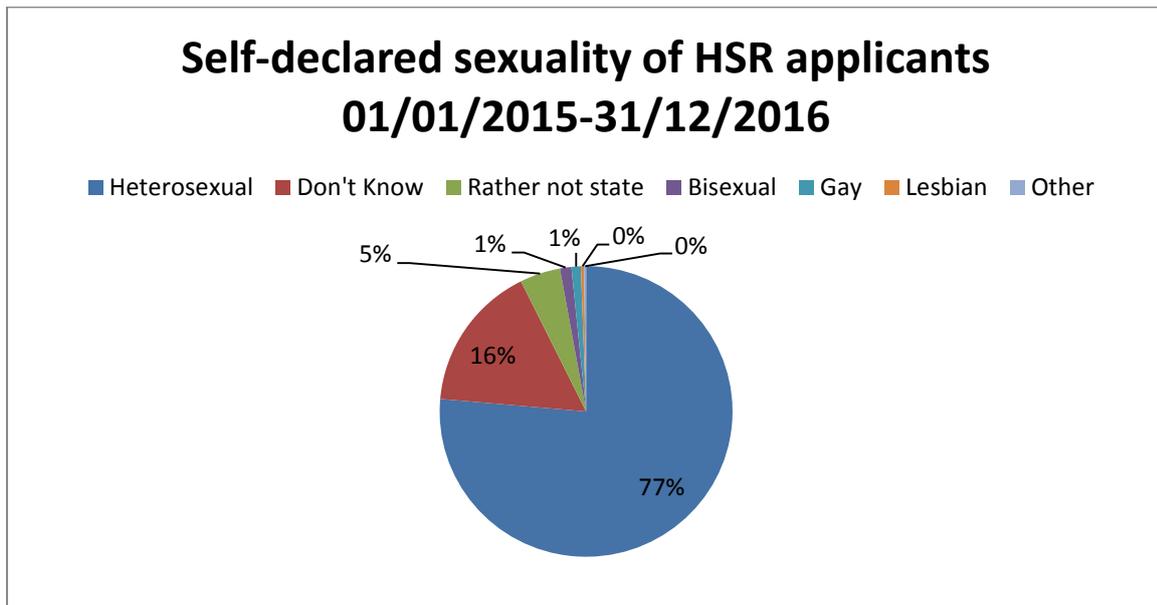
Chart 7.7 Gender of HSR applicants with a drug or alcohol need



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%

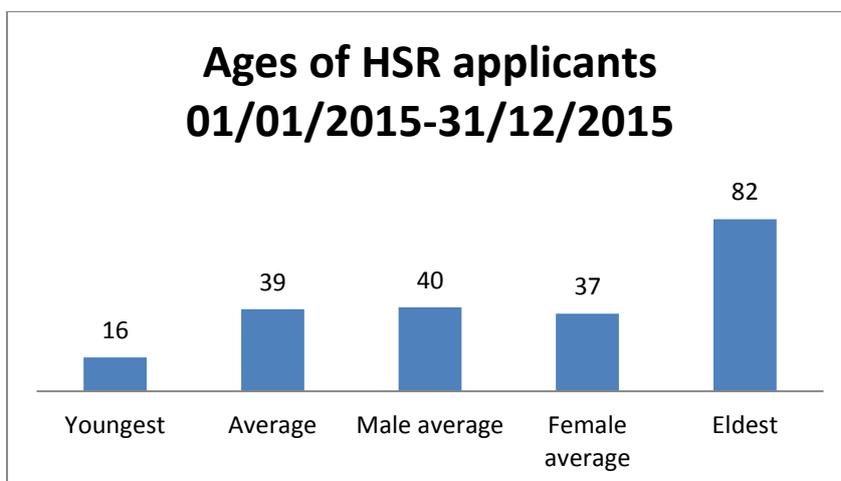
female. Less than 1% of applicants self-defined as being transgender which is representative of the transgender numbers in the UK.

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.

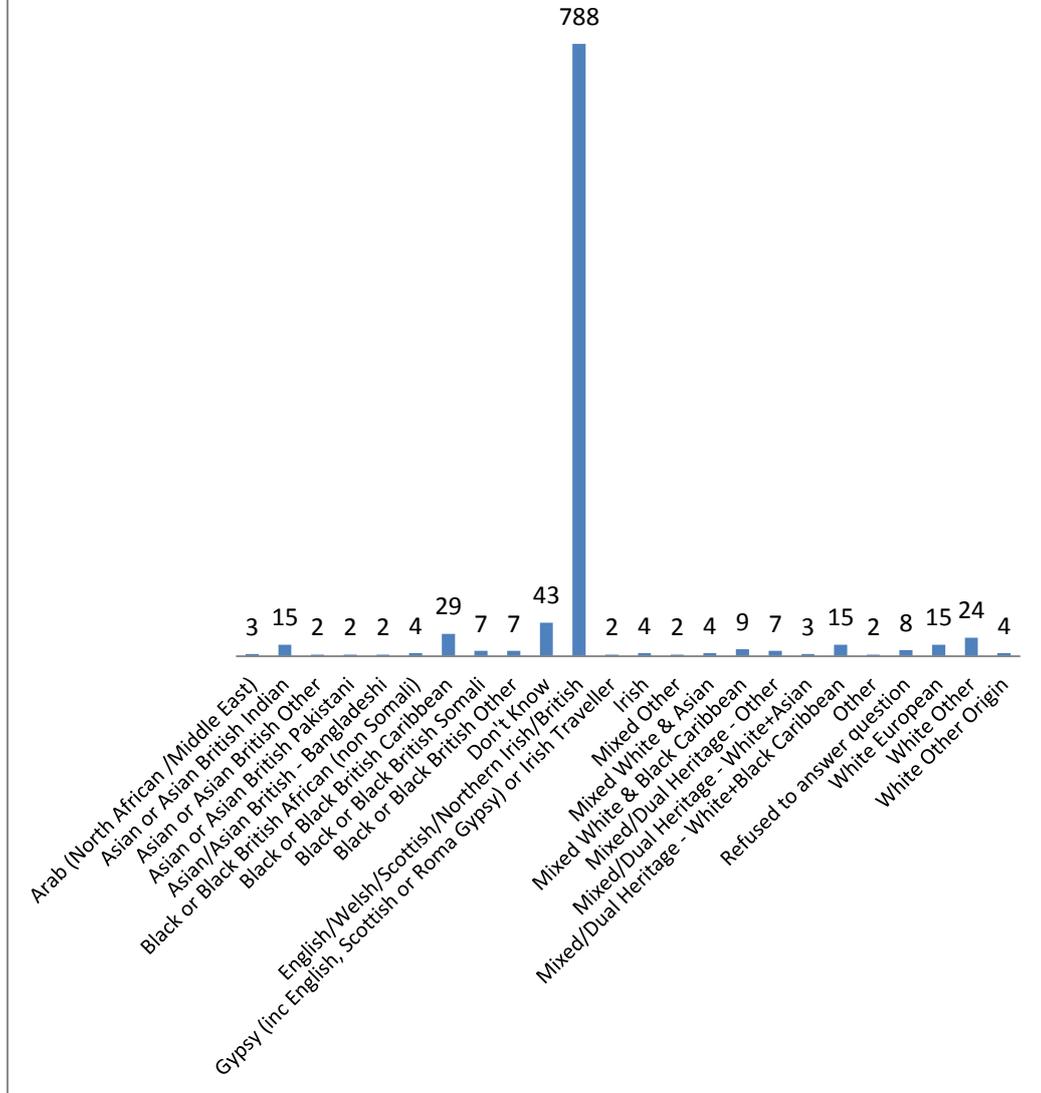
Chart 7.9 Age of HSR applicants with a drug or alcohol need



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.

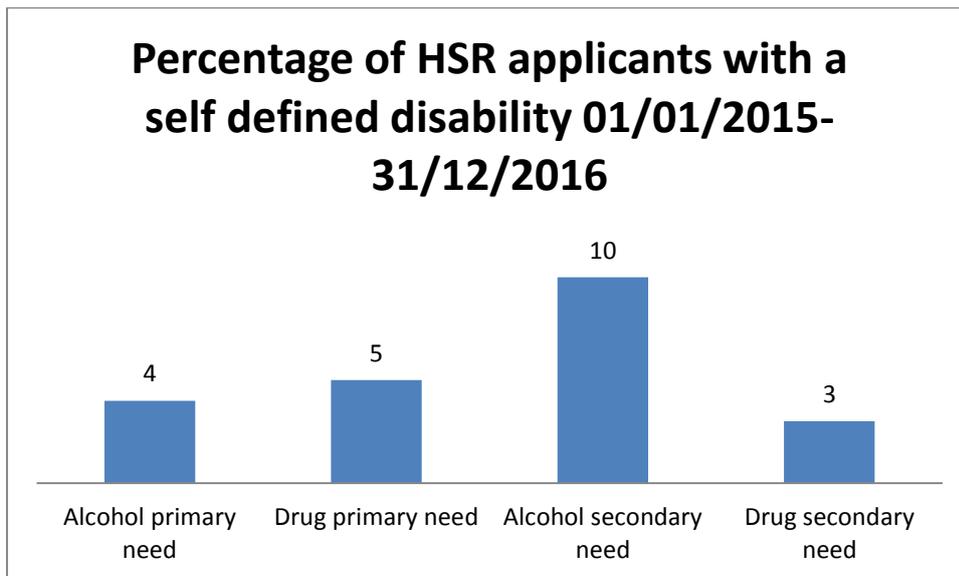
Chart 7.10 Ethnicity of HSR applicants with a drug or alcohol need

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

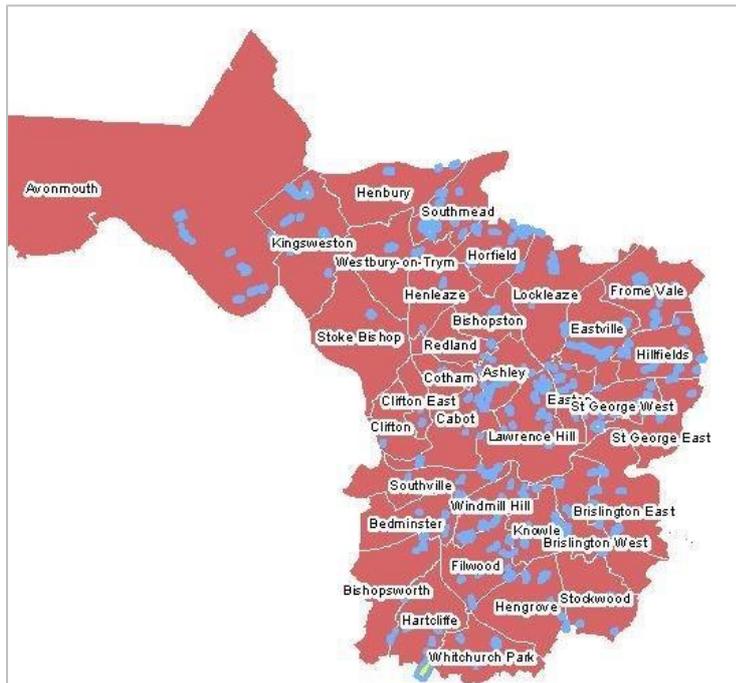


Of the 1001 HSR applicants citing a drug and/or alcohol need, just over 5% or 53 people self-declared as having a disability. This is significantly lower than the 18% of individuals within ROADS over the same time period who self-declared a disability.

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.

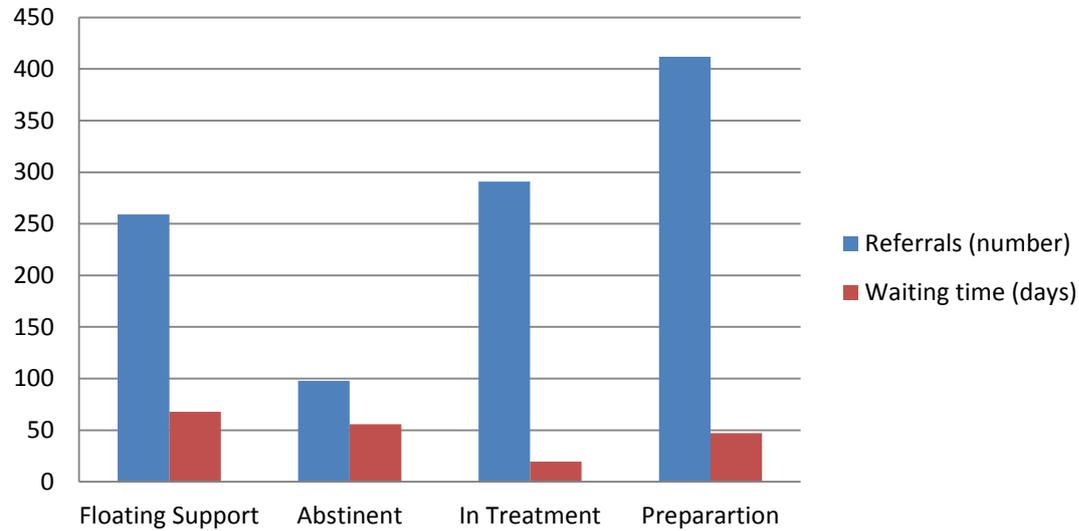
Referrals

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 Abstinence. 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 adequately⁴². 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 report⁴³ 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

⁴² The impact of domestic violence, parental mental health problems, substance misuse and learning disability on parenting capacity (2009)

⁴³ 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/adolescents⁴⁴. 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 study⁴⁵ 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)

⁴⁴ Neglect and Parental Substance Misuse (2011)

⁴⁵ 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
	(%)	(n)	(%)
Opiate	24.9%	685 / 2751	28.9%
Non-opiate	18.8%	47 / 250	23.7%
Alcohol	17.0%	138 / 813	24.7%
Alcohol and non-opiate	13.9%	61 / 440	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 consider 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.*

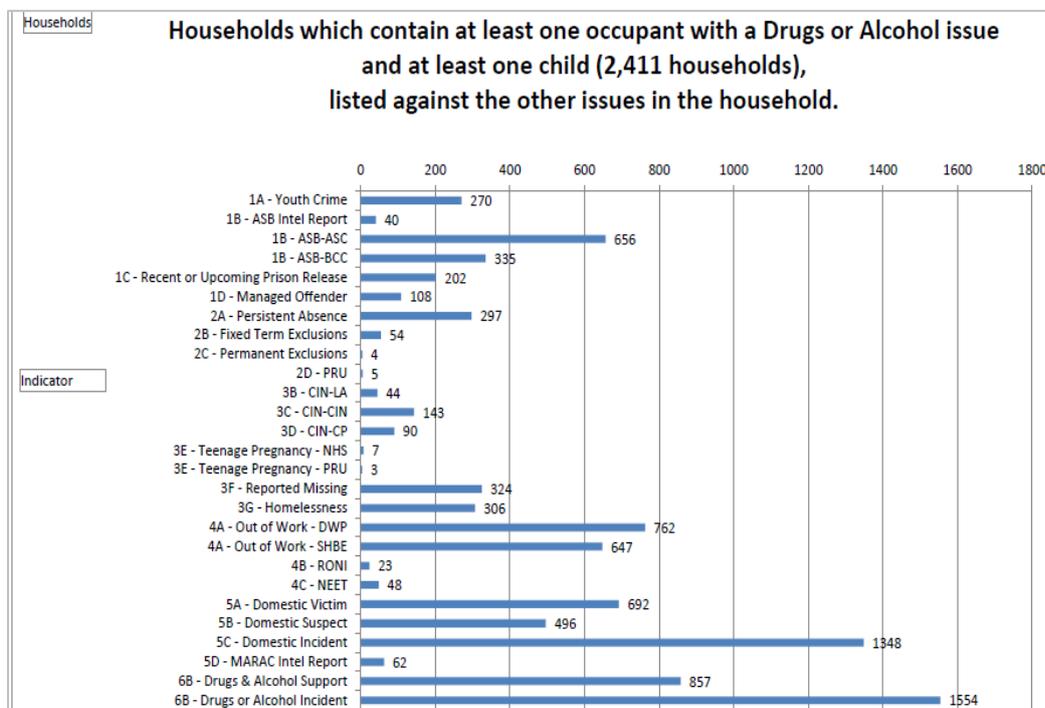
The ability to conduct an audit based on information recorded on the Theseus case management system was limited. Information and details related to children living with clients for at least one night per week, and details of ongoing safeguarding proceedings, were not routinely entered into Theseus and 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 generally⁴⁶.

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 drugs⁴⁷. 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 study⁴⁸ 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 study⁴⁹ 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

⁴⁶ Women at Risk, Domestic Violence and Women's Health (1996)

⁴⁷ Domestic violence and abuse: multi-agency working (2012)

⁴⁸ Domestic Violence and Substance Use: Tackling Complexity (2005)

⁴⁹ 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

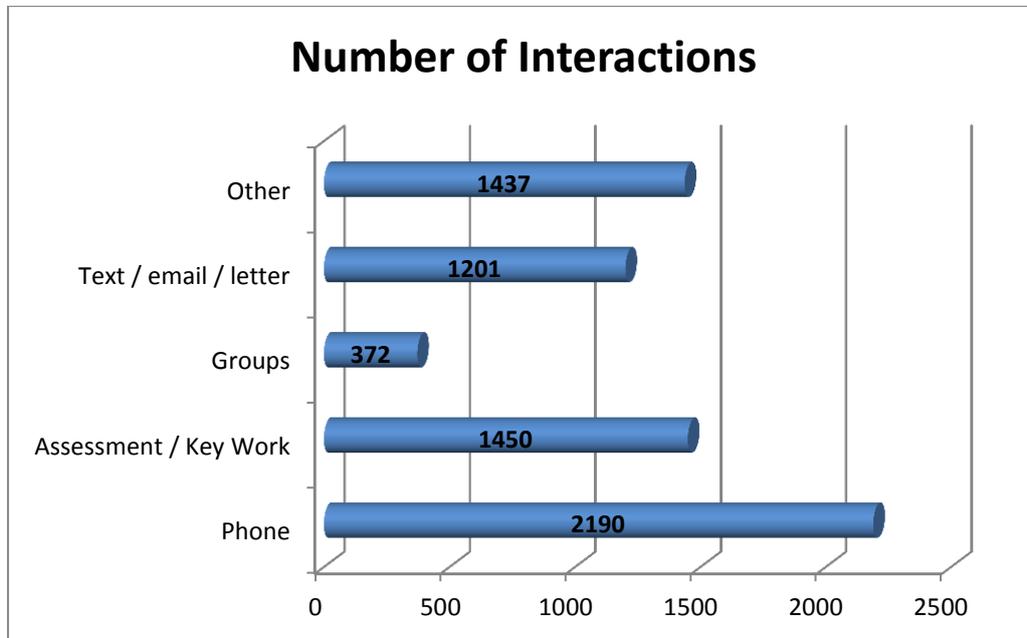
There is a substantial body of evidence to support the statement that drug and alcohol use has a significant impact on individuals and their families. According to the UK Drug Policy Commission, at least 1.5m adults in the UK are affected by a relative's drug use. These families experience harms amounting 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 Templeton⁵⁰ 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.

⁵⁰ 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 1st 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

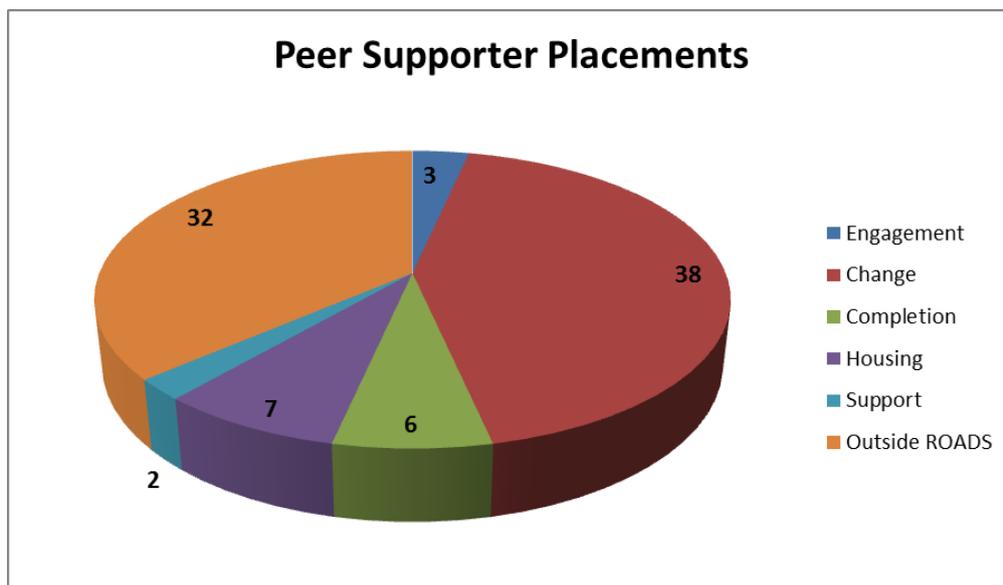
The peer support intervention was developed by Developing Health & Independence (DHI) in 2014 to respond to the concept that people with lived experience of, and in recovery from, problematic substance misuse have much to offer other people who are beginning their own recovery journeys.

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

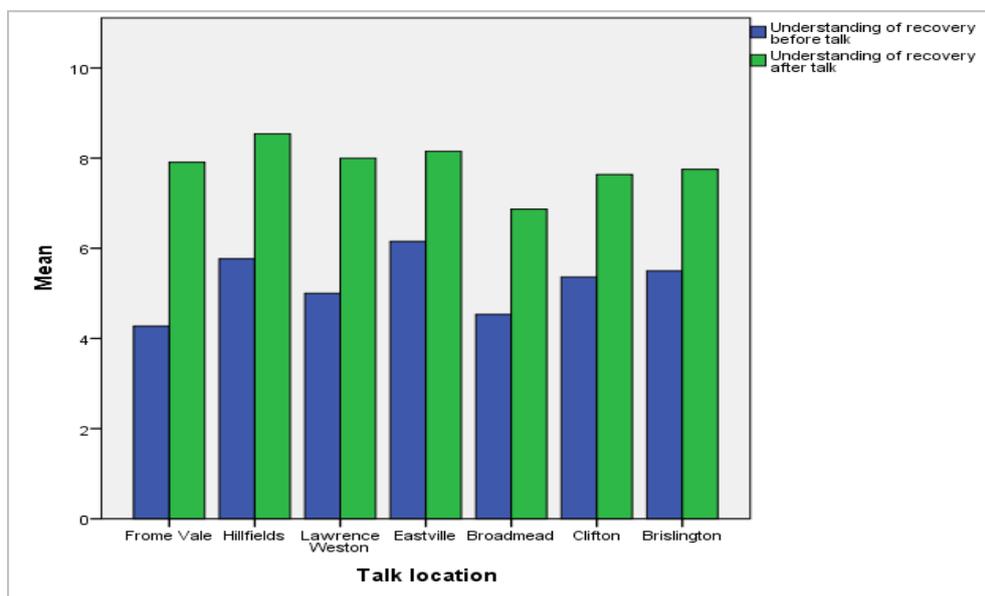
A recent evaluation aimed to identify whether the intended outcomes for peer supporters had been achieved. Semi-structured interviews were conducted with ten peer supporters who had engaged in their role between three and twelve months. The themes and the verbatim responses suggest that the intended 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 RSA⁵¹ 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.

⁵¹ 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 guidance⁵² that getting a job can enable people to sustain their recovery.

Black (2015)⁵³ 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.

⁵² Joint Strategic Needs Assessment Guidance (2015)

⁵³ An independent review into the impact on employment outcomes of drug or alcohol addiction, and obesity (2015)

BCC JSNA⁵⁴ 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

⁵⁴ 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 to 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 respondees from across ROADS services including DHI, ARA, BDP, INROADS and The Junction. 86% of respondees stated that they would like support with finding voluntary work. 52 of the 65 respondees 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 respondees) 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

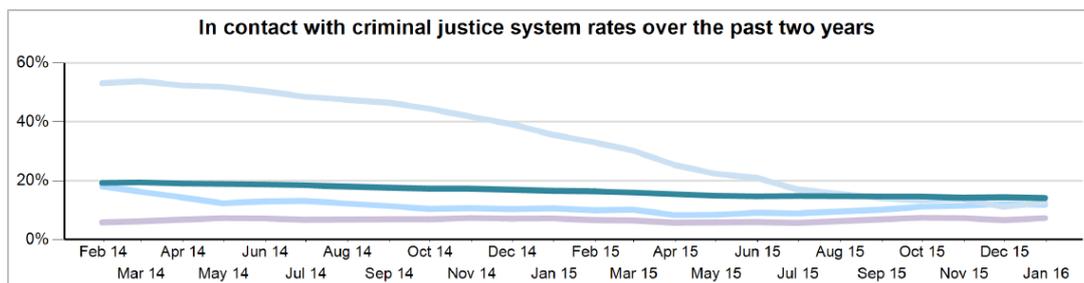
	Latest period		National average
	(%)	(n)	(%)
Opiate	14.1%	391 / 2781	22.9%
Non-opiate	12.5%	28 / 224	19.3%
Alcohol	7.2%	59 / 819	6.5%
Alcohol and non-opiate	11.7%	49 / 418	14.2%

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 bears 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



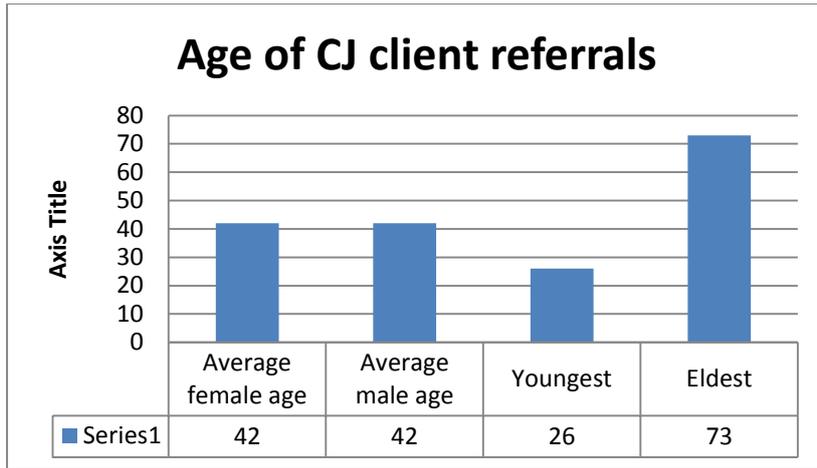
This isn't to say that the need for CJ substance misuse treatment has decreased at the same rate, more that with almost 50% fewer arrests made by Avon & Somerset police in the year following the opening of the new custody suites, fewer potential ROADS clients have had their first intervention with CJ 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.

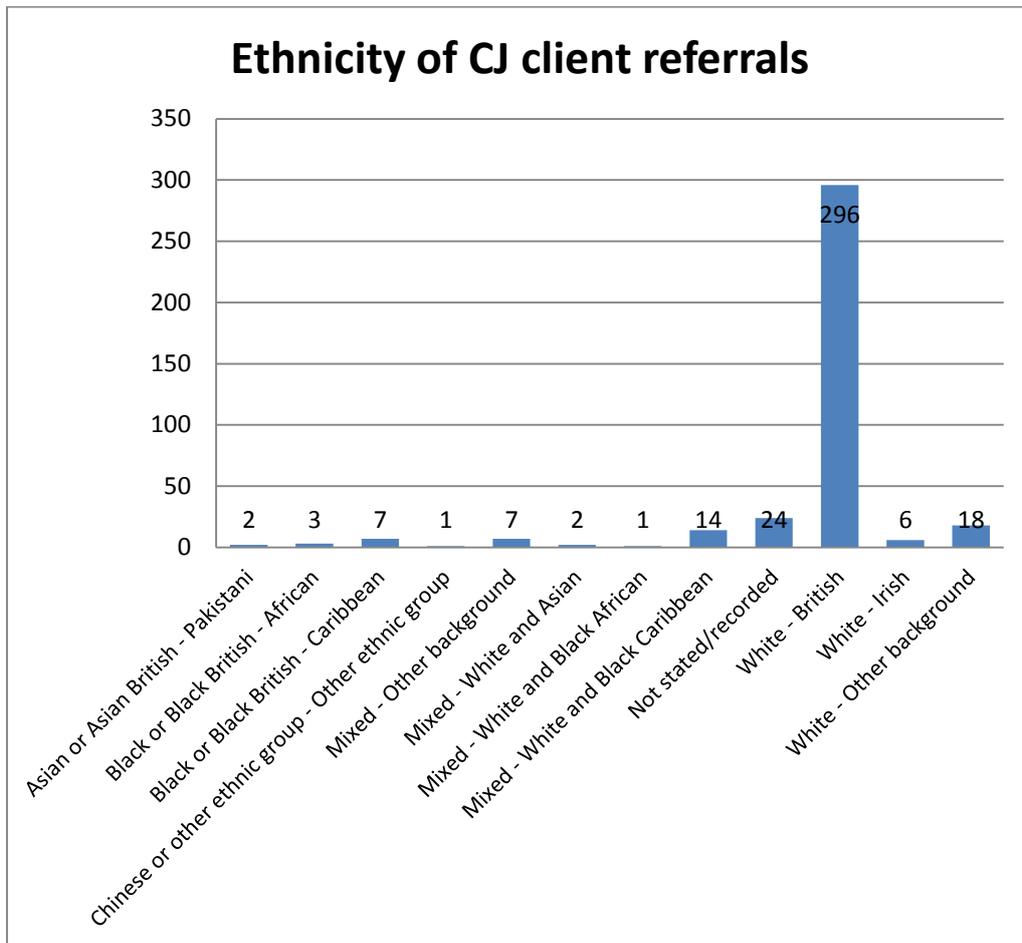
There is a slightly higher proportion of male CJ clients than in ROADS overall with the split being 72% male to 28% female.

Chart 10.3 Age of CJ Clients



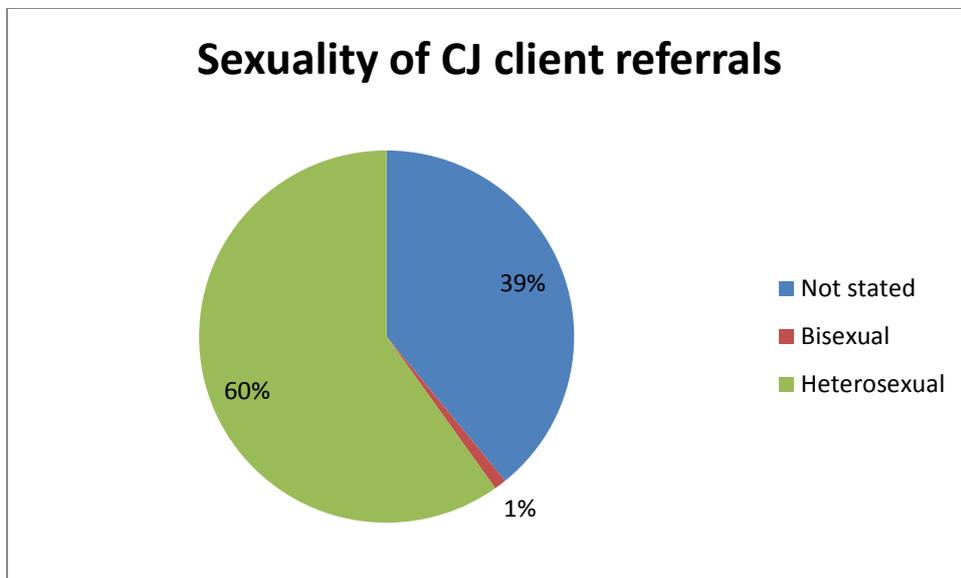
With only 2% of CJ clients under 30 compared with 12% across ROADS, it would suggest that involvement with CJ and SM services affects an older cohort. The median age of the CJ client is also older with the majority of clients in ROADS being in the 35-39 year old bracket.

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

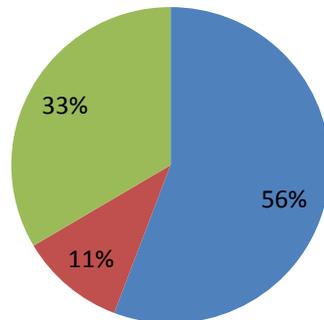


There was a significant amount of 'Not stated' replies amongst the CJ cohort making it difficult to draw comparisons with other groups. The recording pathways for this field are being investigated by Safer Bristol.

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:

Treatment type	Count
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
TOTAL	114	77	48	30	21	11	59

NB: due to appointments sometimes being set across different months/quarters, not all referral numbers will have an outcome.

Other assets in the community

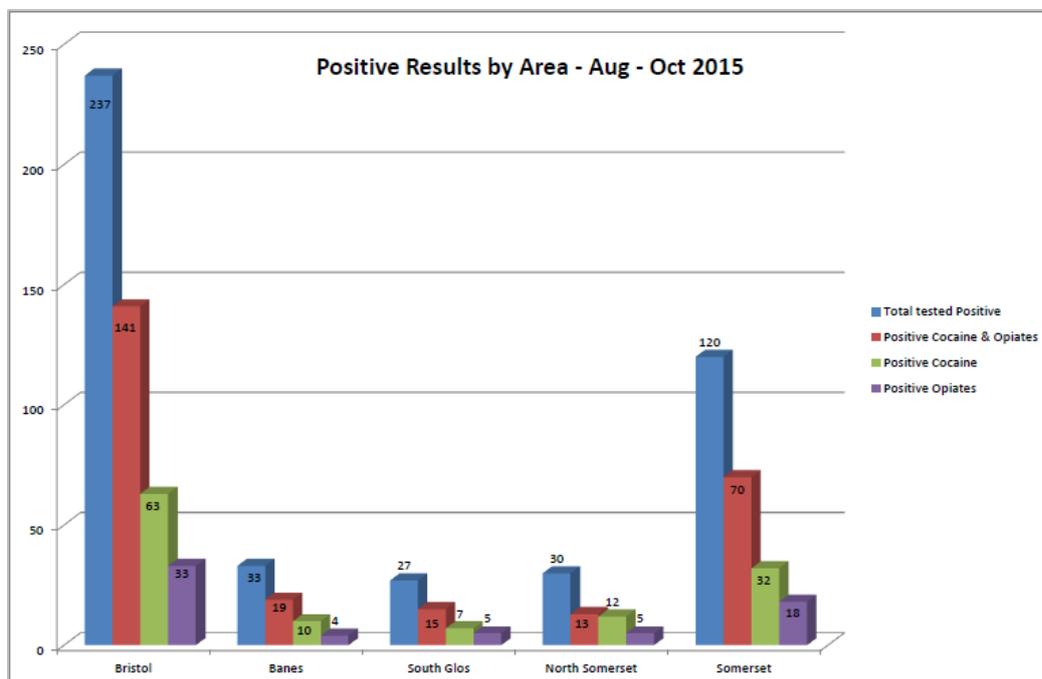
AIRS

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.

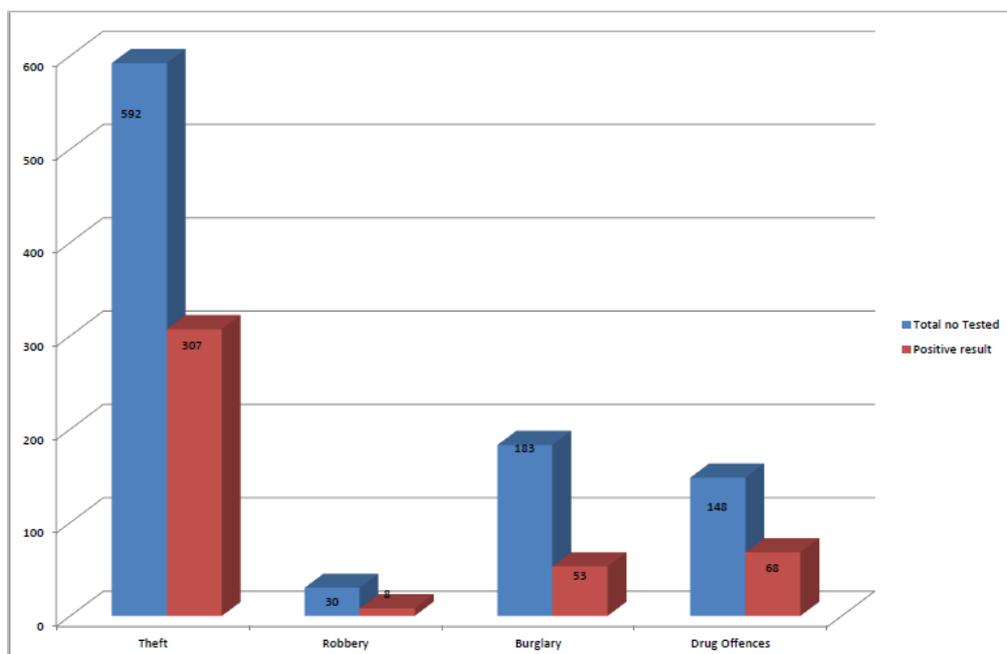
The graph below shows the high amount of positive tests given by Bristol residents and the amount of high complexity of poly drug (opiates and cocaine) use that is characteristic of Bristol’s drug using population.

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 of 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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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

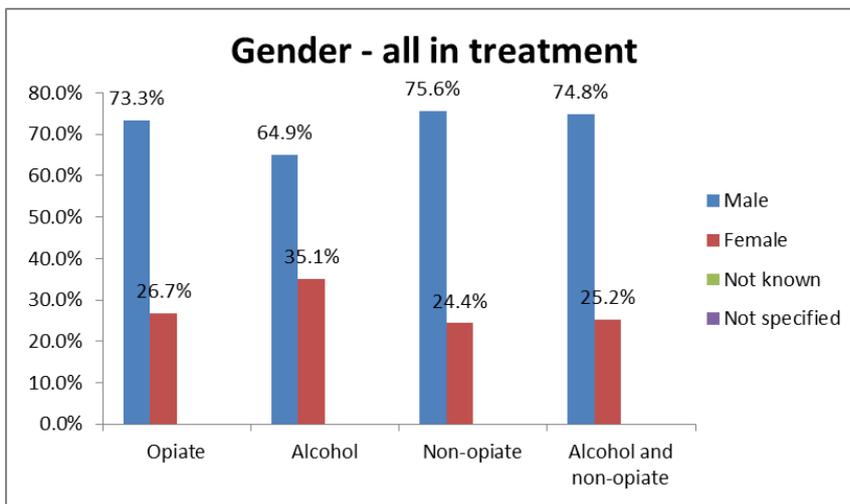
Appendix 1

Appendix 1: Demographic Overview

Demographics

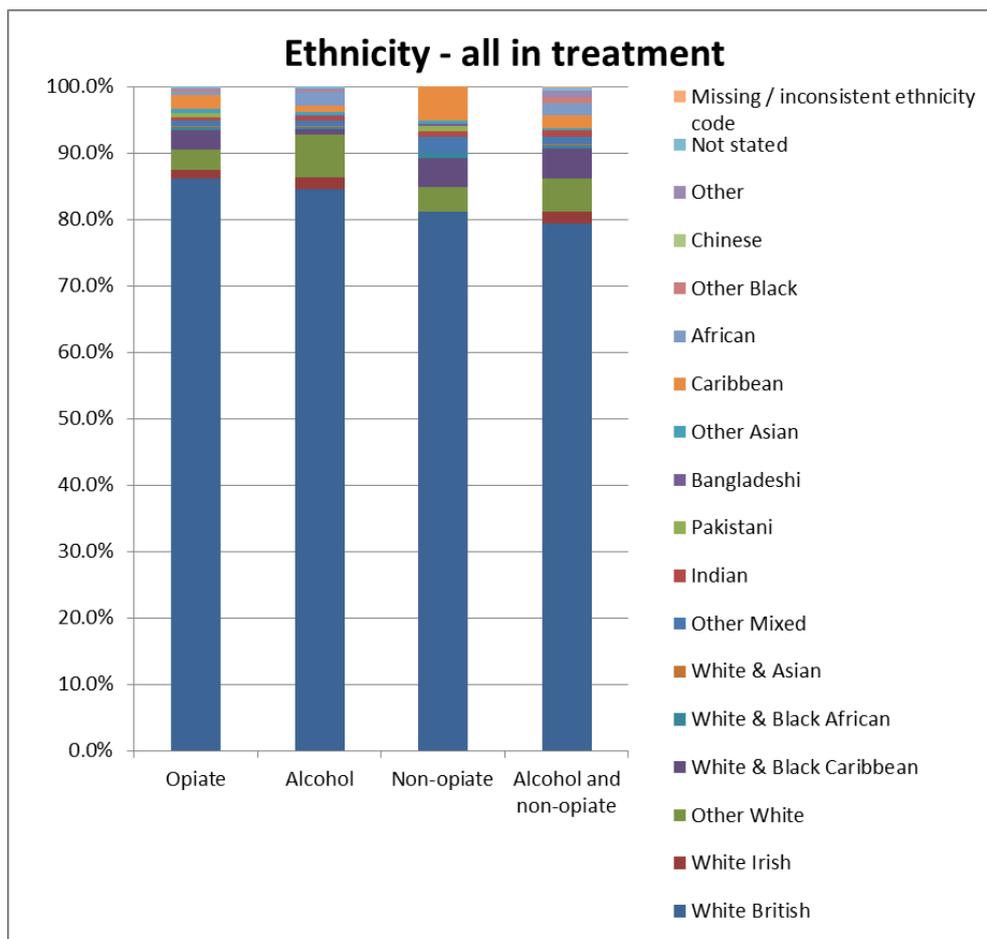
Gender (all in treatment)

	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%



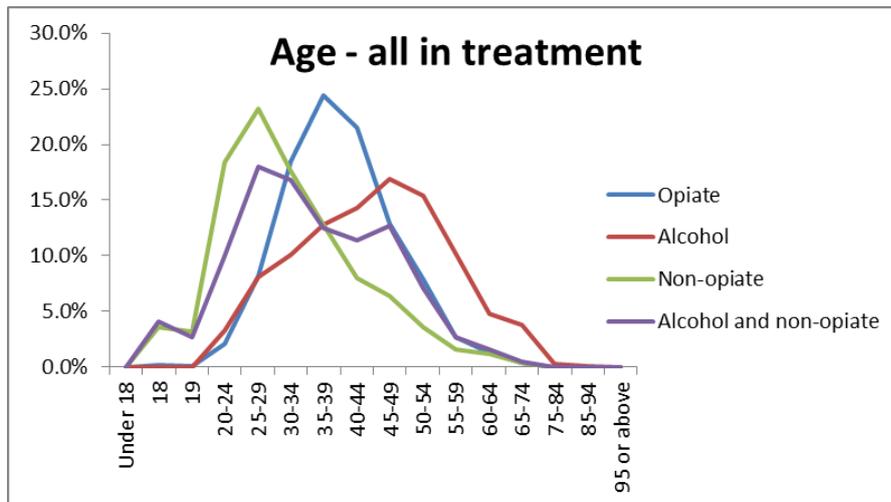
Ethnicity (all in treatment)

	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)

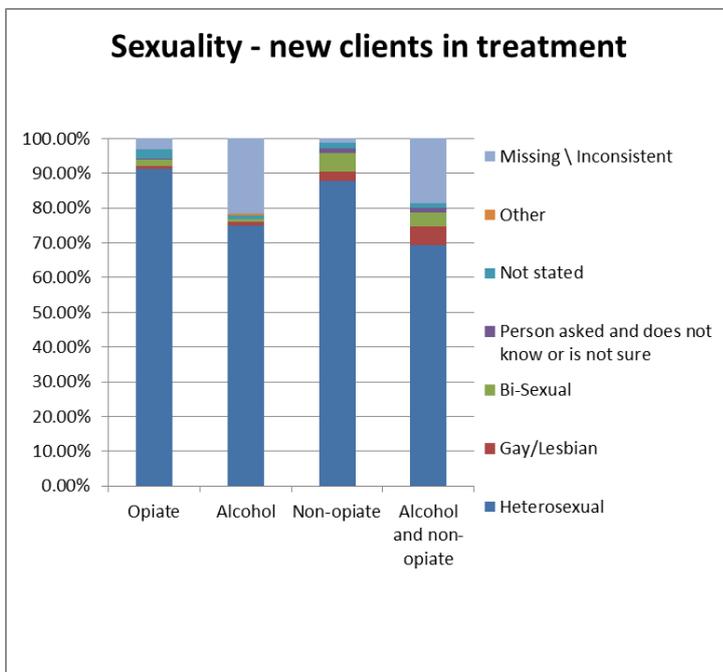
	Opiate	Alcohol	Non-opiate	Alcohol and non-opiate
Under 18	0.0%	0.0%	0.0%	0.0%
18	0.1%	0.0%	3.6%	4.1%
19	0.1%	0.0%	3.2%	2.7%
20-24	2.0%	3.3%	18.4%	10.0%
25-29	8.2%	8.1%	23.2%	18.0%
30-34	18.5%	10.1%	17.6%	16.8%
35-39	24.4%	12.8%	12.8%	12.5%
40-44	21.5%	14.3%	8.0%	11.4%
45-49	12.9%	16.9%	6.4%	12.7%
50-54	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	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%

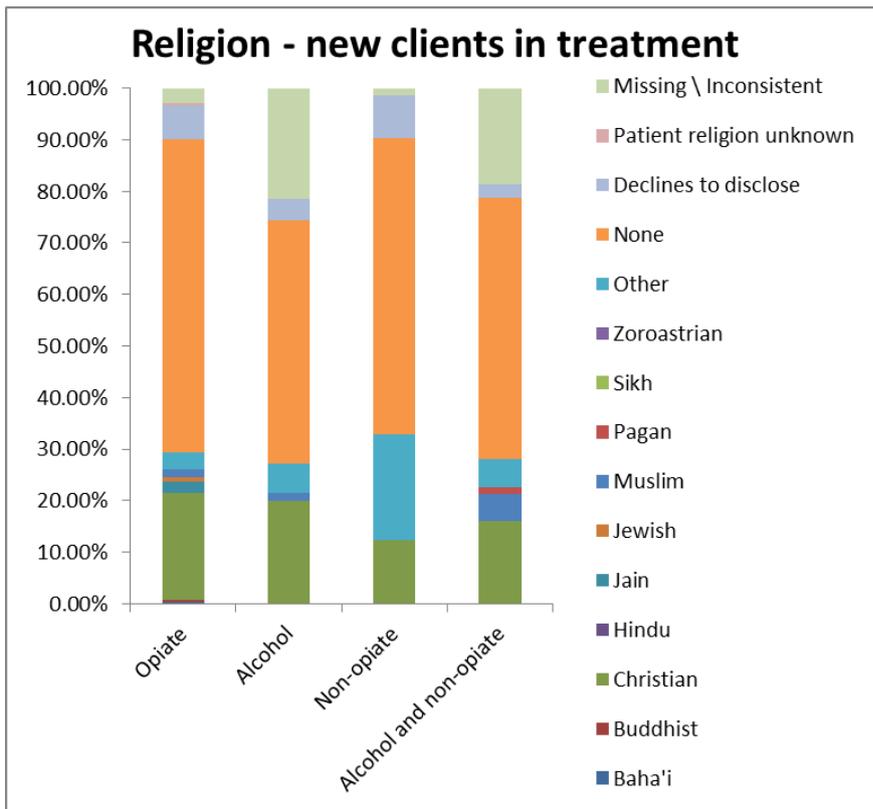
Data from Q1 2015/16 Provider Activity Report – data not previously collected



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%

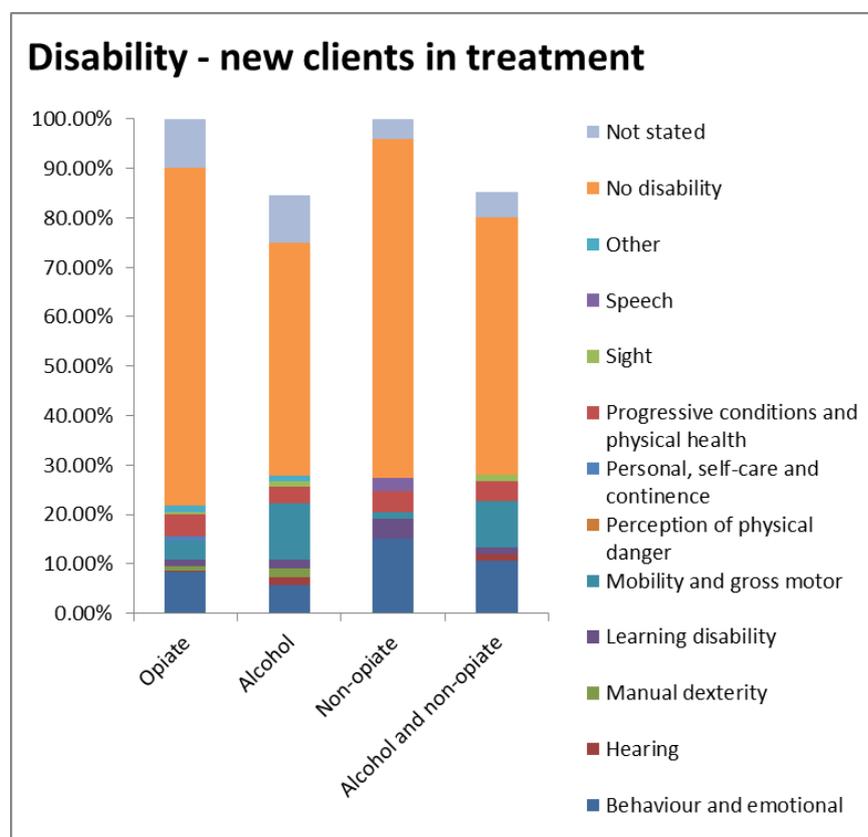
Data from Q1 2016/17 Provider Activity Report – data not previously collected



Disability (new treatment journey / episode)

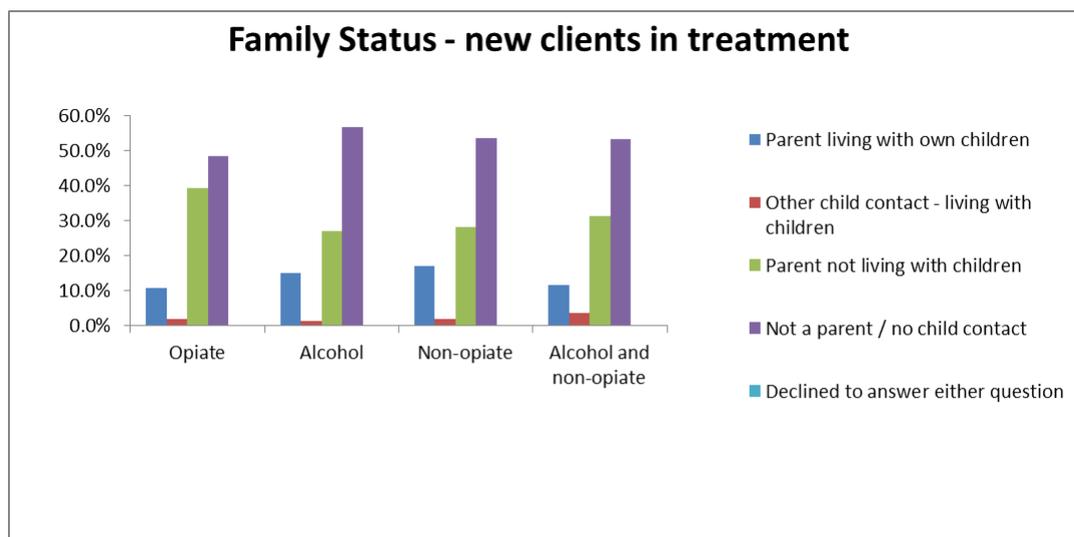
	Opiate	Alcohol	Non-opiate	Alcohol and non-opiate
Behaviour and emotional	8.30%	5.68%	15.07%	10.67%
Hearing	0.38%	1.70%	0.00%	1.33%
Manual dexterity	0.75%	1.70%	0.00%	0.00%
Learning disability	1.51%	1.70%	4.11%	1.33%
Mobility and gross motor	3.77%	11.36%	1.37%	9.33%
Perception of physical danger	0.00%	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



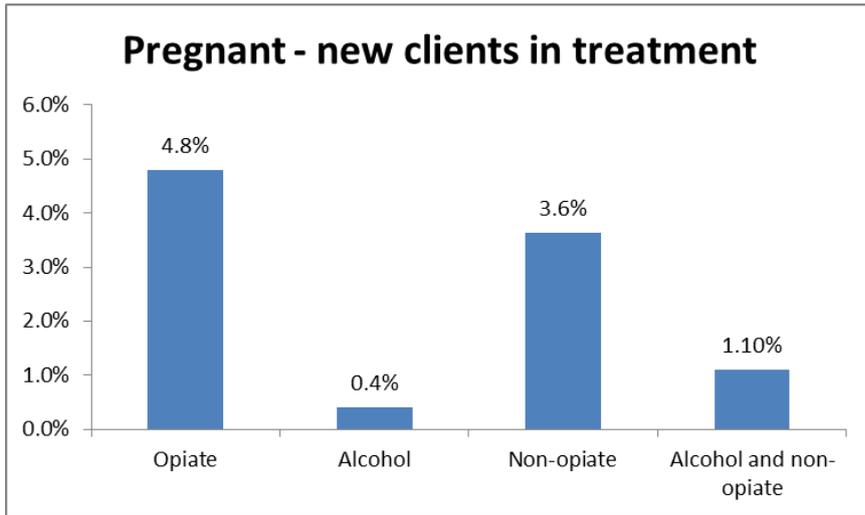
Family status (new treatment journey / episode)

	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)

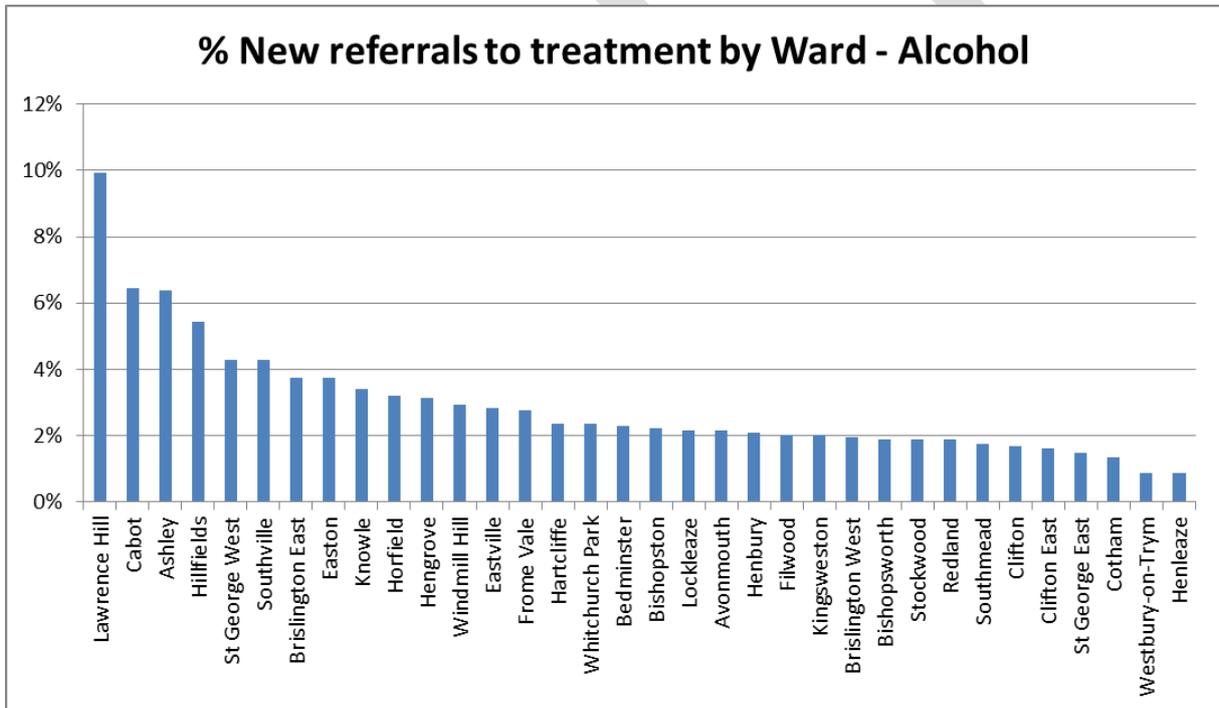
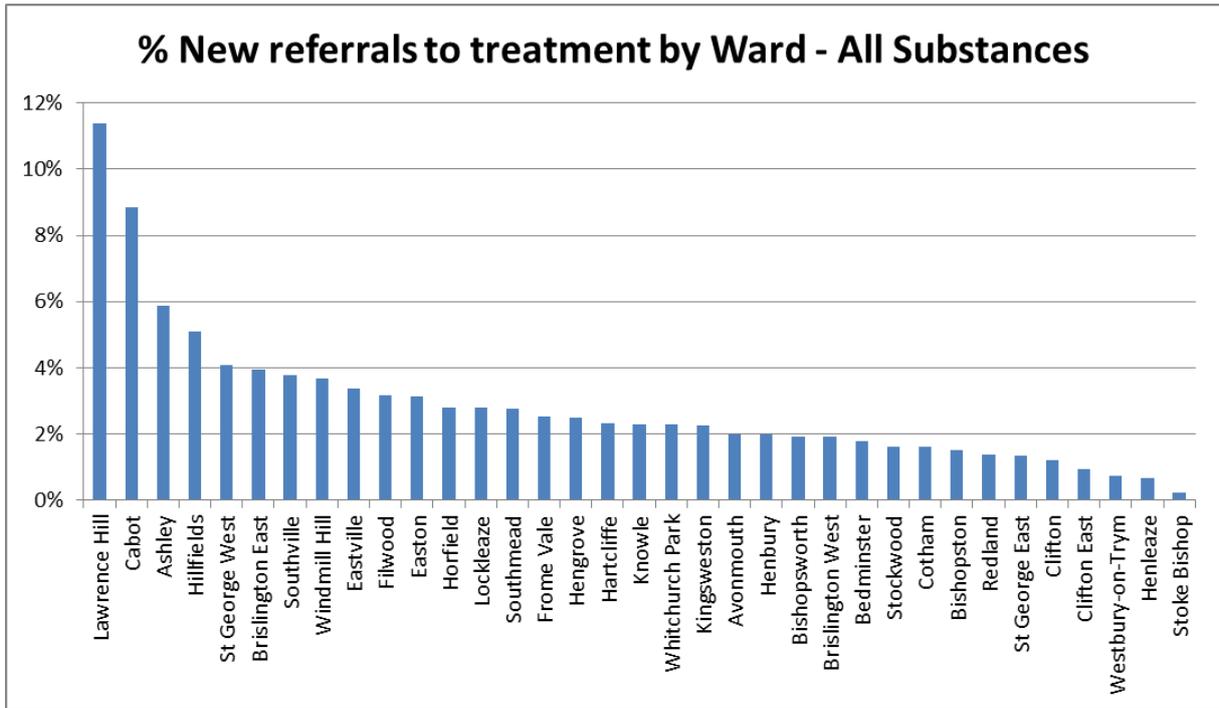
	Opiate	Alcohol	Non-opiate	Alcohol and non-opiate
Pregnant	4.8%	0.4%	3.6%	1.10%



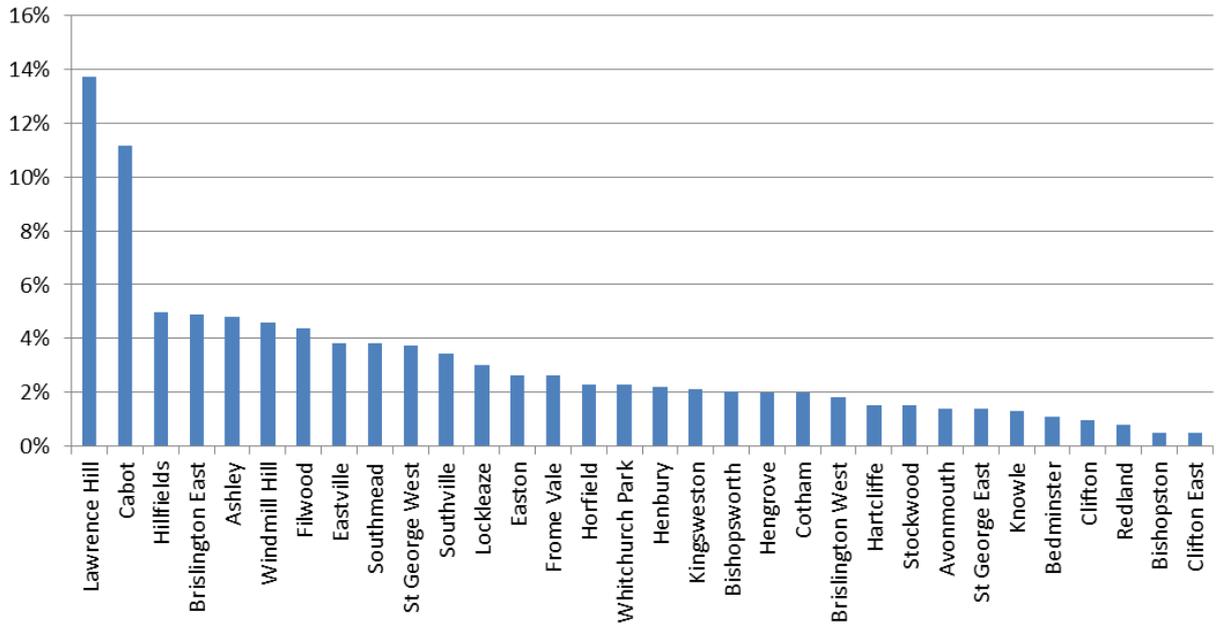
Geographic distribution of new treatment referrals 2015/16 by ward

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% *	*	*	*	*

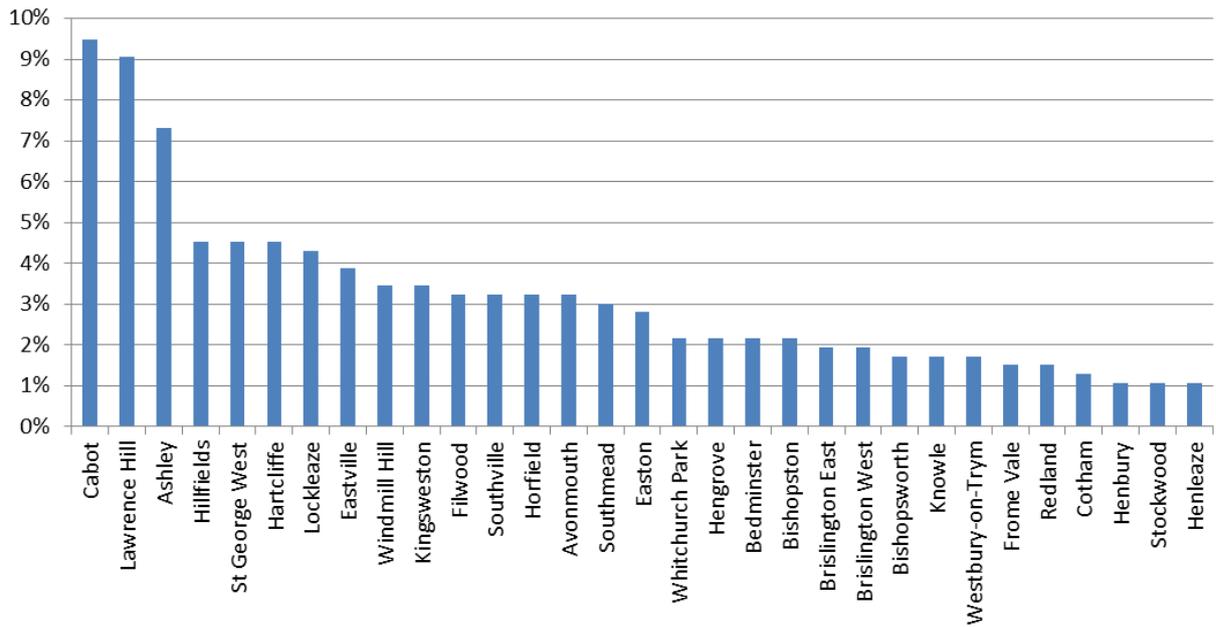
Values below 5 have been suppressed



% New referrals to treatment by Ward - 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

Medications in recovery: best practice in reviewing treatment

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

Reducing Deaths in A&E

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

Drug misuse and dependence - UK guidelines on clinical management (Orange Book) 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

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

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 1older) 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 and 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 for 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.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/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

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://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	-	-	-

	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	-	-	-
Wider Determinants of Health	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%*	-

	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%
Healthcare & Premature Death	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 - 14	38	5.9	4

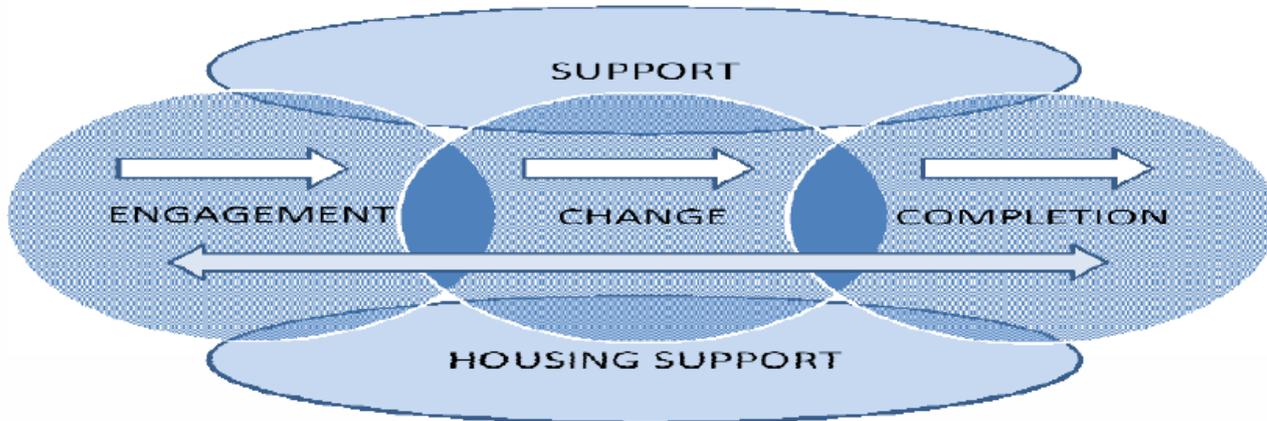
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4.11 - Emergency readmissions within 30 days of discharge from hospital (Persons)	2011/12	4,937	11.50%	11.80%
4.11 - Emergency readmissions within 30 days of discharge from hospital (Male)	2011/12	2,527	12.10%	12.10%
4.11 - Emergency readmissions within 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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