Consultation and Engagement

Drug and Alcohol Strategy 2020-2024

Consultation Report

Contents

Executive Summary

ES1 Bristol City Council Drug and Alcohol Strategy 2020-2024

Bristol's existing alcohol strategy expires in 2020. This presents an opportunity to develop a new, city-wide strategy which looks to address issues relating to all substances (not just alcohol, but all drugs) within one document.

Bristol City Council has worked with partners across the city to draft a proposed new Drug and Alcohol Strategy, on behalf of the Keeping Communities Safe Group (of the Keeping Bristol Safe Partnership). This draft strategy was subject to public consultation.

ES2 The Drug and Alcohol Strategy 2020-2024 consultation

The Drug and Alcohol Strategy 2020-2024 consultation took place between 27 November 2020 and 8 January 2021 and sought views from the public (including service users and stakeholders) on the strategy's vision and six priority areas.

The Drug and Alcohol Strategy 2020-2024 consultation sought citizens' views on the strategy's vision and six priority areas. Respondents were asked to rate their level of agreement or disagreement with the vision and each priority area on a scale from "strongly agree" to "strongly disagree".

Respondents were then asked to provide their comments on the strategy using a free text box. Respondents were provided with a second free text box to provide their comments on the draft Equalities Impact Assessment and to suggest any ways to make the Drug and Alcohol Strategy more inclusive and accessible.

Finally, respondents were asked for their postcode and equalities information was collected.

ES3 Scope and use of this report

This report describes the methodology and presents the outcome of the Drug and Alcohol Strategy 2020-2024 consultation. It includes quantitative data and analysis of free text comments from the consultation survey responses.

This consultation report does not contain the council's recommendations for the Drug and Alcohol Strategy 2020-2024, nor an assessment of the feasibility of any of the suggestions received. The consultation feedback in this report is taken into consideration by officers in developing final proposals for the Drug and Alcohol Strategy 2020-2024. The final proposals are included in a separate document.

ES4 Drug and Alcohol Strategy 2020-2024 consultation - Key findings

ES4.1 Response rate

The Drug and Alcohol Strategy 2020-2024 consultation survey received 150 responses, all of which were completed online.

107 responses (71%) were received from postcodes within the Bristol City Council area, 6 (4%) responses were from South Gloucestershire, North Somerset, and Bath & North East Somerset (B&NES). A further one (0.7%) response was from an unspecified location within the four West of England authorities and one response was from further afield.

33 (22%) did not provide a postcode.

Analysis of respondents' postcodes shows that there was an under-representation of responses from the most deprived 20% of the city, and response rates from the least deprived 30% of the city were over-represented.

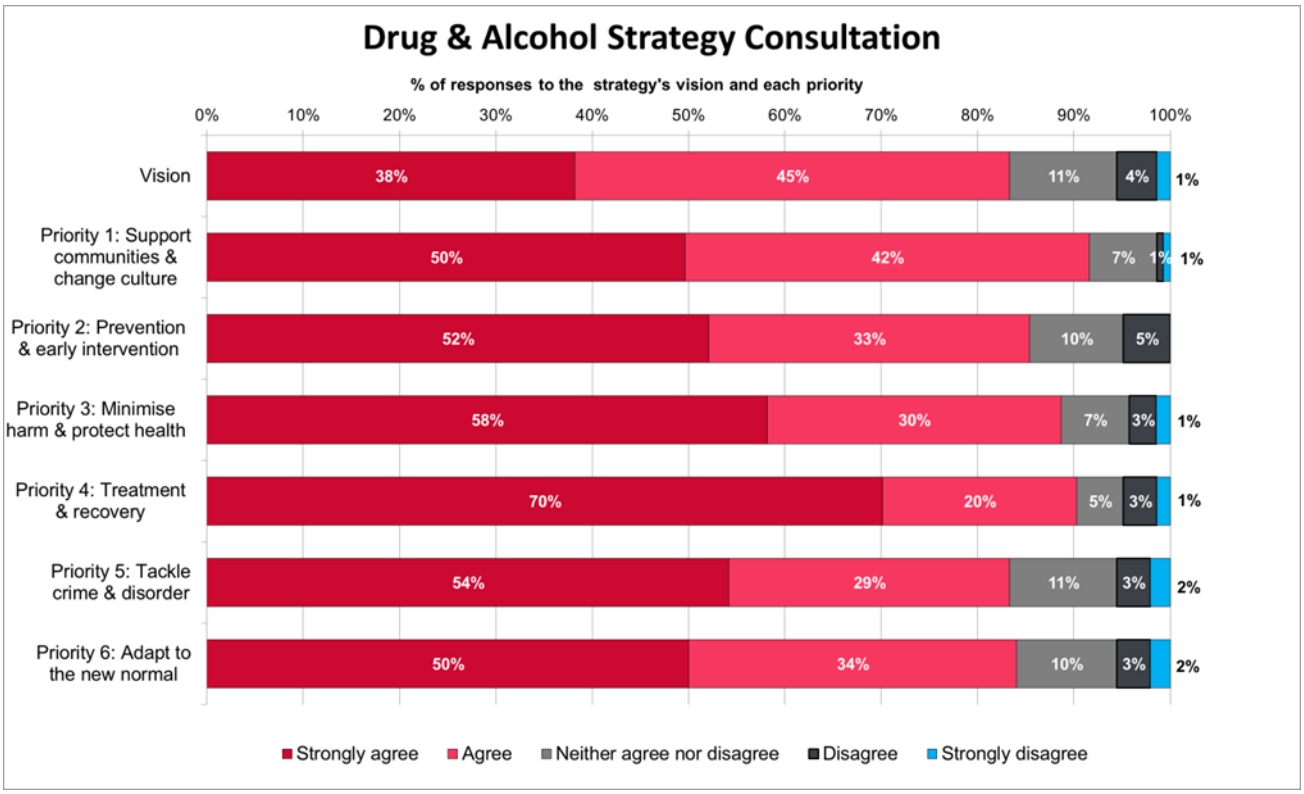
Response rates from young people (aged 24 and younger), black, Asian & minority ethnic (BAME) citizens, and people of faith were under-represented compared to these groups' proportions of Bristol's population. A map of response rate by ward for the Bristol respondents is presented in Chapter 3 along with the details of age profile, sex and other respondent characteristics.

ES4.2 Drug and Alcohol Strategy 2020-2024

Respondents were asked to rate their level of agreement or disagreement with the Drug and Alcohol Strategy's vision and six priority areas (Figure ES1).

- 144 (96%) respondents expressed a view on the strategy's vision
- 143 (95%) respondents expressed a view on Priority 1: Support communities and change culture
- 144 (96%) respondents expressed a view on Priority 2: Prevention and early intervention
- 141 (94%) respondents expressed a view on Priority 3: Minimise harm and protect health
- 144 (96%) respondents expressed a view on Priority 4: Treatment and recovery
- 144 (96%) respondents expressed a view on Priority 5: Tackle crime and disorder
- 144 (96%) respondents expressed a view on Priority 6: Adapt to the new normal

Figure ES1: Agreement or disagreement with the Drug and Alcohol Strategy Vision and Priorities



A majority of respondents agree or strongly agree with the strategy's vision and each of the six priority areas.

ES4.4 Differences in views on the Drug and Alcohol Strategy Vision and Priority Areas in areas of high and low deprivation

Views on the Drug and Alcohol Strategy vision and six priority areas were compared for respondents from the 20% most deprived areas of Bristol (deciles 1 and 2) and the 20% least deprived areas of Bristol (deciles 9 and 10) as well as all Bristol respondents (Figures ES3 to ES9).

Figure ES3: Vision

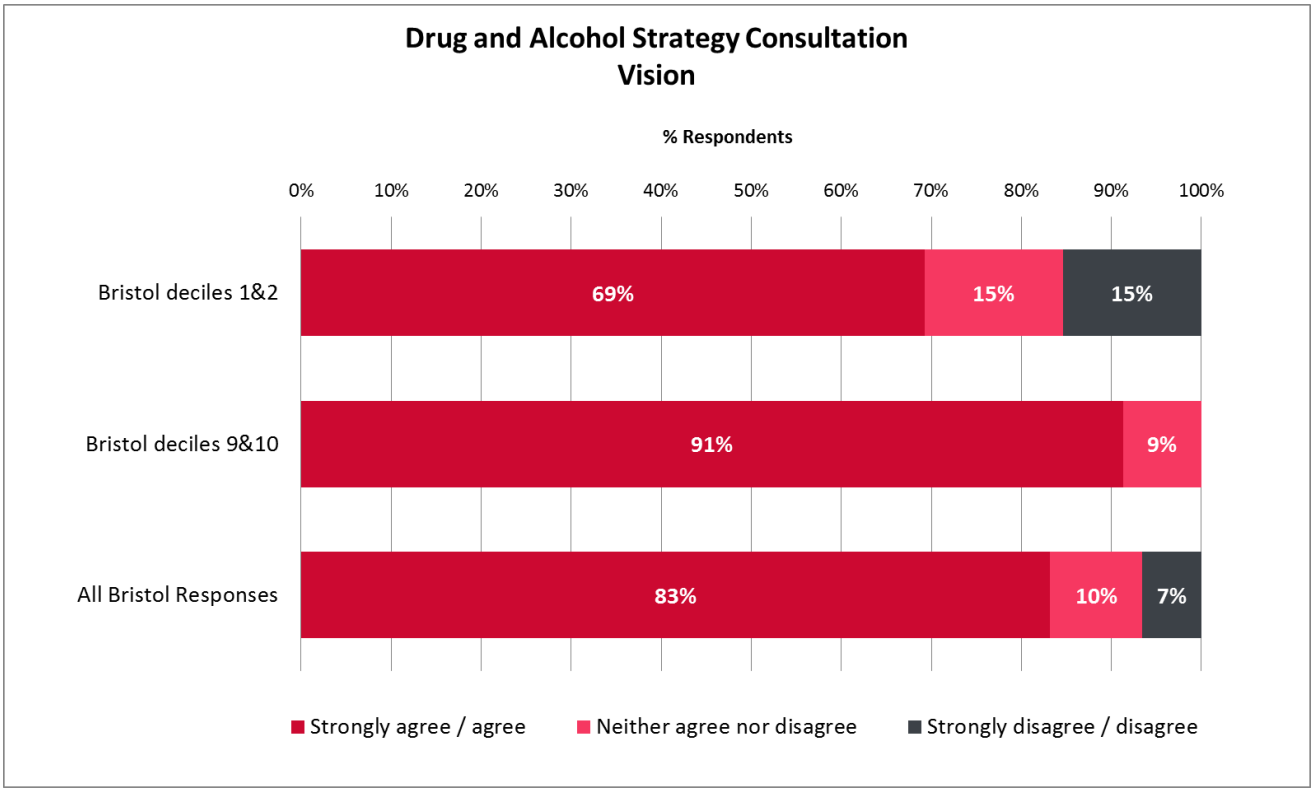


Figure ES4: Priority 1

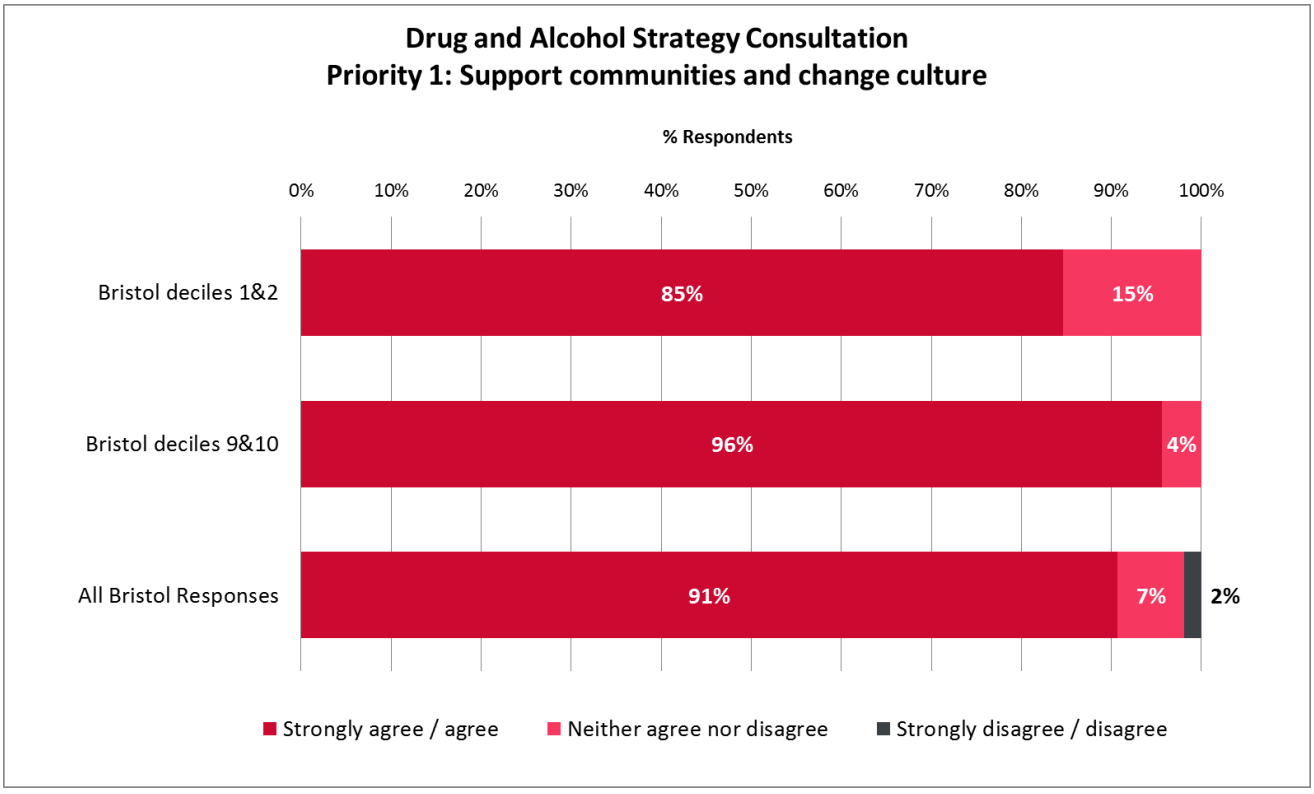


Figure ES5: Priority 2

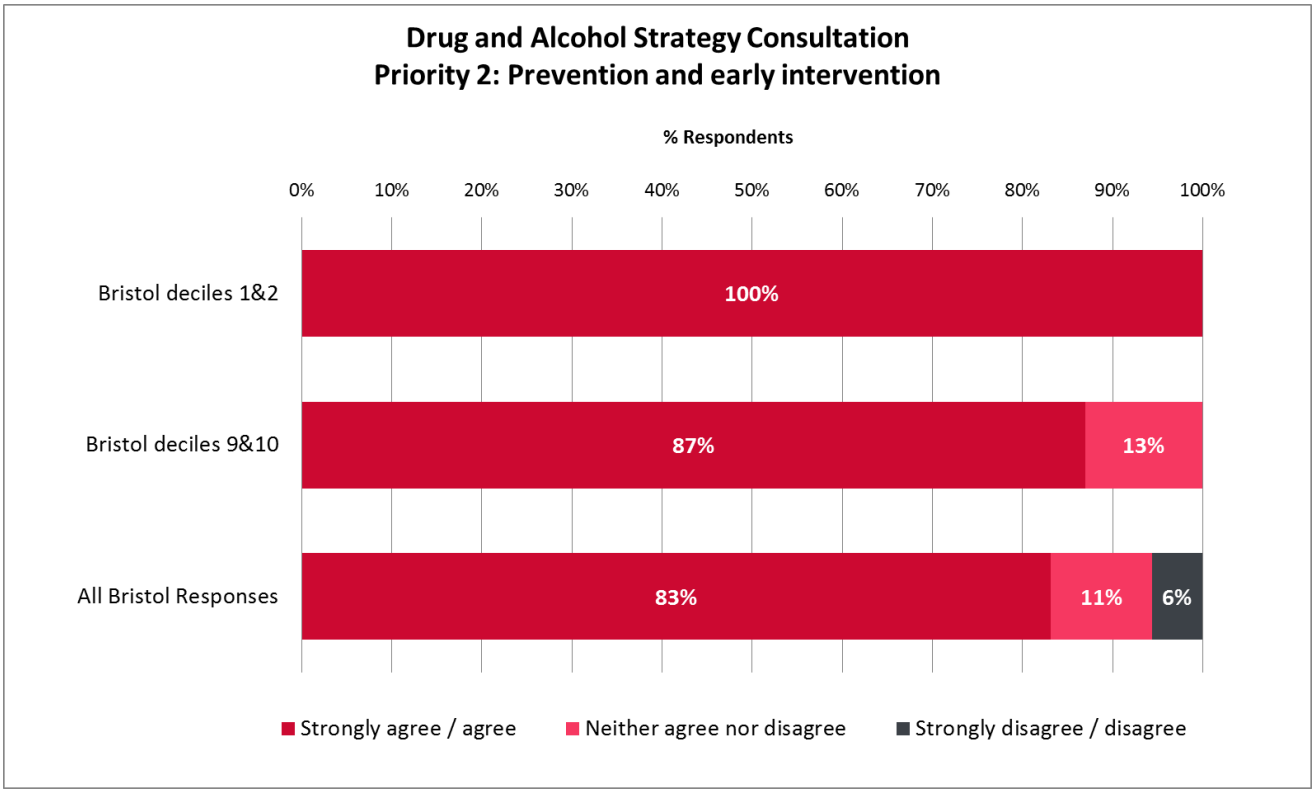


Figure ES6: Priority 3

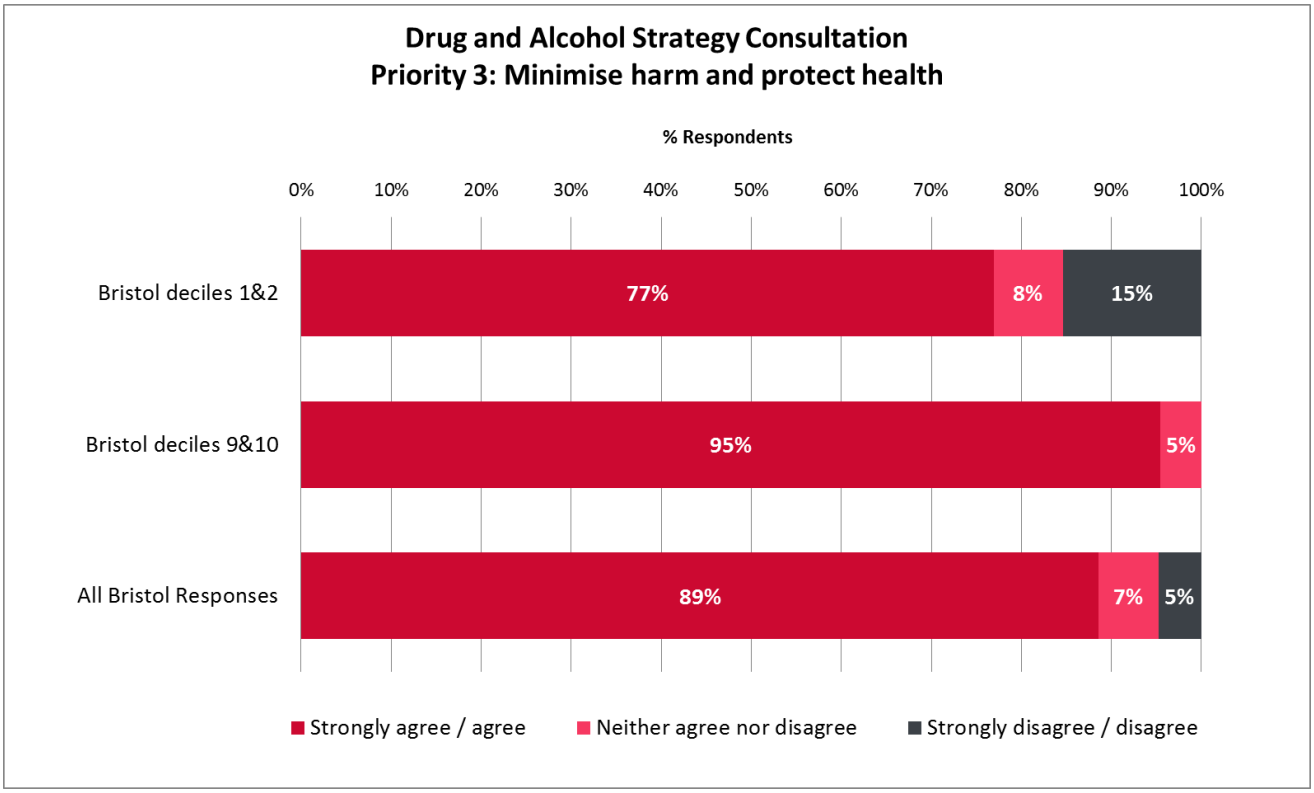


Figure ES7: Priority 4

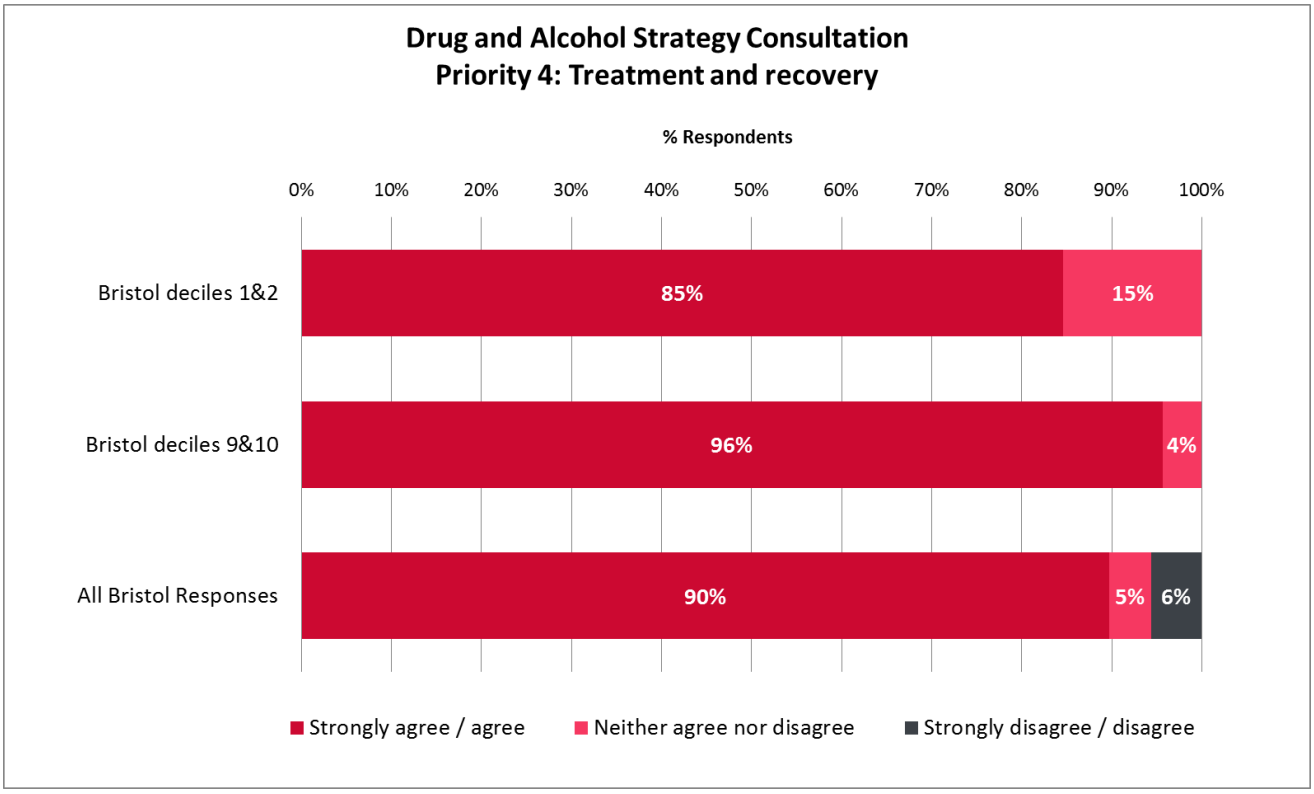


Figure ES8: Priority 5

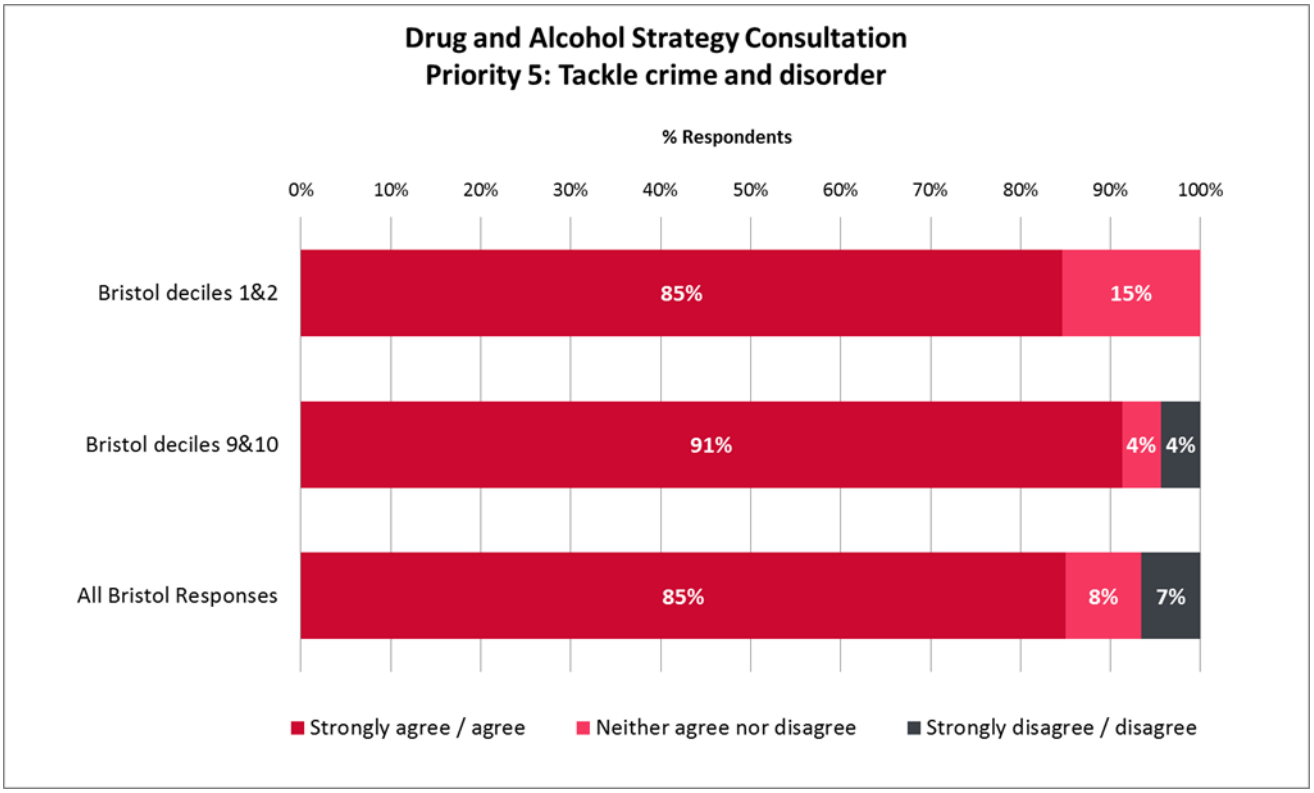
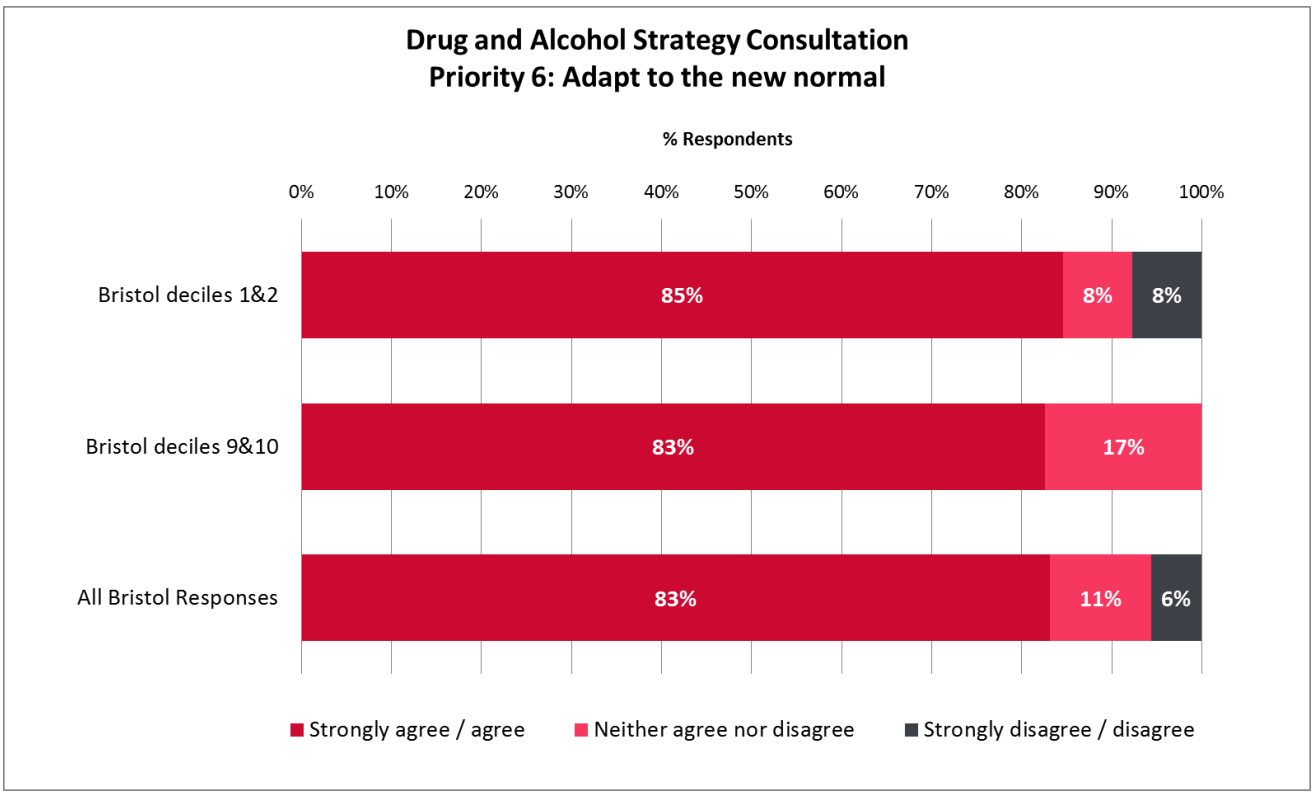


Figure ES9: Priority 6



Agreement with the strategy's vision and six priority areas is similar in the most deprived 20% areas of Bristol compared with the least deprived 20% areas of Bristol.

However support for the strategy's vision and Priority 1, Priority 3, Priority 4 and Priority 5 is higher in Bristol deciles 9 and 10 than it is in Bristol deciles 1 and 2. Support for Priority 2 is higher in Bristol decile 1 and 2 than it is in Bristol deciled 9 and 10.

1 Introduction

1.1 Context

Bristol's existing alcohol strategy expires in 2020. This presents an opportunity to develop a new, city-wide strategy which looks to address issues relating to all substances (not just alcohol, but all drugs) within one document.

Bristol City Council has worked with partners across the city to draft a proposed new Drug and Alcohol Strategy 2020-2024, on behalf of the Keeping Communities Safe Group (of the Keeping Bristol Safe Partnership). This draft strategy was subject to public consultation.

The Drug and Alcohol Strategy 2020-2024 consultation took place between 27 November 2020 and 8 January 2021 and sought views from the public (including service users and stakeholders) on the strategy's vision and six priority areas.

This consultation report describes the consultation methodology and the feedback received.

1.2 Drug and Alcohol Strategy Vision and Priorities

The consultation sought views from the public on the Drug and Alcohol Strategy's proposed vision and six priority areas. The proposed vision for the strategy stated:

"Bristol aspires to be a vibrant, inclusive and compassionate city, where prevention is prioritised, and everyone has the right to a healthy life safe from the harms of alcohol and other drugs.

Individuals and their families - regardless of starting points - are well-informed and empowered to reach their full potential, access treatment if needed, and reduce harm within their community."

The six priority areas that consultation respondents were asked to provide feedback on were:

- Priority 1: Support communities and change culture
- Priority 2: Prevention and early intervention
- Priority 3: Minimise harm and protect health
- Priority 4: Treatment and recovery
- Priority 5: Tackle crime and disorder
- Priority 6: Adapt to the new normal

1.3 Drug and Alcohol Strategy 2020-2024 consultation

The Drug and Alcohol Strategy 2020-2024 consultation sought citizens' views on the strategy's vision and six priority areas. Respondents were asked to rate their level of agreement or disagreement with the vision and each priority area on a scale from "strongly agree" to "strongly disagree".

Respondents were then asked to provide their comments on the strategy using a free text box. Respondents were provided with a second free text box to provide their comments on the draft Equalities Impact Assessment and to suggest any ways to make the Drug and Alcohol Strategy more inclusive and accessible.

Finally, respondents were asked for their postcode and equalities information was collected.

The consultation information and questions are summarised in section 2.1.1 and the full consultation survey can be viewed online.

1.4 Structure of this report

Chapter 2 of this report describes the Drug and Alcohol Strategy 2020-2024 consultation methodology.

Chapters 3 to 6 present the Drug and Alcohol Strategy 2020-2024 consultation survey results:

- Chapter 3 presents the survey response rate and respondent characteristics;
- Chapter 4 describes the survey feedback on the level of agreement or disagreement with the strategy's vision and six priority areas;
- Chapter 5 summarises respondents' reasons for their preferences and other comments provided as free text.

Chapter 6 describes feedback received in other correspondence (emails and letters).

Chapter 7 describes how this report will be used and how to keep updated on the decision-making process.

2 Methodology

2.1 Survey

2.1.1 Online survey

The Drug and Alcohol Strategy 2020-2024 consultation survey was available on the council's Consultation and Engagement Hub (bristol.gov.uk/consultationhub) between 27 November 2020 and 8 January 2021.

Survey information

The survey contained the following information as context for the survey questions:

- Information on the need for a Drug and Alcohol Strategy, including that the existing Alcohol Strategy for Bristol had expired and the importance of addressing drug and alcohol issues in the city
- Information on the work which had been carried out with city partners and stakeholders to draft the proposed Drug and Alcohol Strategy
- Information on the purpose and scope of the Drug and Alcohol strategy
- An outline of the Drug and Alcohol Strategy's proposed vision and six priority areas
- A link to the proposed Drug and Alcohol Strategy
- Information on the purpose of a public consultation and how respondents' views would be taken into account

Survey questions

The survey questions sought respondents' views on the following:

- Level of agreement or disagreement with the strategy's proposed vision
- Level of agreement or disagreement with the strategy's Priority 1: Support communities and change culture
- Level of agreement or disagreement with the strategy's Priority 2: Prevention and early intervention
- Level of agreement or disagreement with the strategy's Priority 3: Minimise harm and protect health
- Level of agreement or disagreement with the strategy's Priority 4: Treatment and recovery
- Level of agreement or disagreement with the strategy's Priority 5: Tackle crime and disorder

- Level of agreement or disagreement with the strategy's Priority 6: Adapt to the new normal
- Respondents' comments on the proposed Drug and Alcohol Strategy
- Respondents' comments on the Equalities Impact Assessment and on the accessibility and inclusivity of the strategy

The 'About you' section requested information which helps the council to check if the responses are representative of people across the city who may have different needs.

- Respondents' postcode – this identifies if any parts of the city are under-represented in responding to the consultation and it can show if people from more deprived areas of the city have different views compared to people living in less deprived areas;
- Equalities monitoring information – this enables the council to check if we receive responses from people with protected characteristics under the Equality Act 2010;
- Other information about respondents; for example whether they are a Bristol resident, a councillor or MP, or a professional working in Bristol;
- How respondents found out about the consultation – to help the council publicise future consultations effectively.

Respondents could choose to answer some or all of the questions in any order and save and return to the survey later.

2.1.2 Alternative formats

The consultation was available in paper copies and alternative formats (Easy Read, braille, large print, audio, British Sign Language (BSL) and translation to other languages) on request.

2.1.3 Other correspondence

Six emails were received in response to the consultation. These are reported separately to the survey responses in Chapter 6.

2.2 Publicity and briefings

2.2.1 Objective

The following programme of activity was carried out to publicise and explain the Drug and Alcohol Strategy 2020-2024 consultation. The primary objective was to involve residents and stakeholders across the city in the Drug and Alcohol Strategy by ensuring that

information was shared across a wide range of channels, reaching as broad a range of audiences as possible in order to maximise response rates.

2.2.2 Bristol City Council channels

Copy and electronic materials were shared via the following council and partner channels and networks:

- Ask Bristol e-bulletin – 4,923 recipients;
- Bristol City Council website
- Emails to over 100 stakeholders in the city

2.2.3 Members

An email containing information about the consultation was sent directly to members.

2.2.4 Bristol City Council Partners and Voluntary Sector Organisations

Council officers attended several meetings with Bristol City Council partners and voluntary sector organisations in the city to promote the consultation, including Bristol@Night, Youth Council and meetings with equalities representatives. The consultation was also advertised on partner websites, including Bristol Health Partners and the Carers Support Centre.

2.2.5 Media engagement

Press releases were distributed to media contacts and local community newsletters on detailing how to take part in and promote the consultation.

2.2.6 Social Media

Regular posts on Bristol City Council's social media channels (Twitter, Facebook, Next Door and Instagram) were made for the duration of the consultation, with increased posts at launch, 'two weeks left' and in the final days.

3 Survey response rate and respondent characteristics

3.1 Response rate to the survey

The Drug and Alcohol Strategy 2020-2024 consultation survey received 150 responses, all of which were completed online.

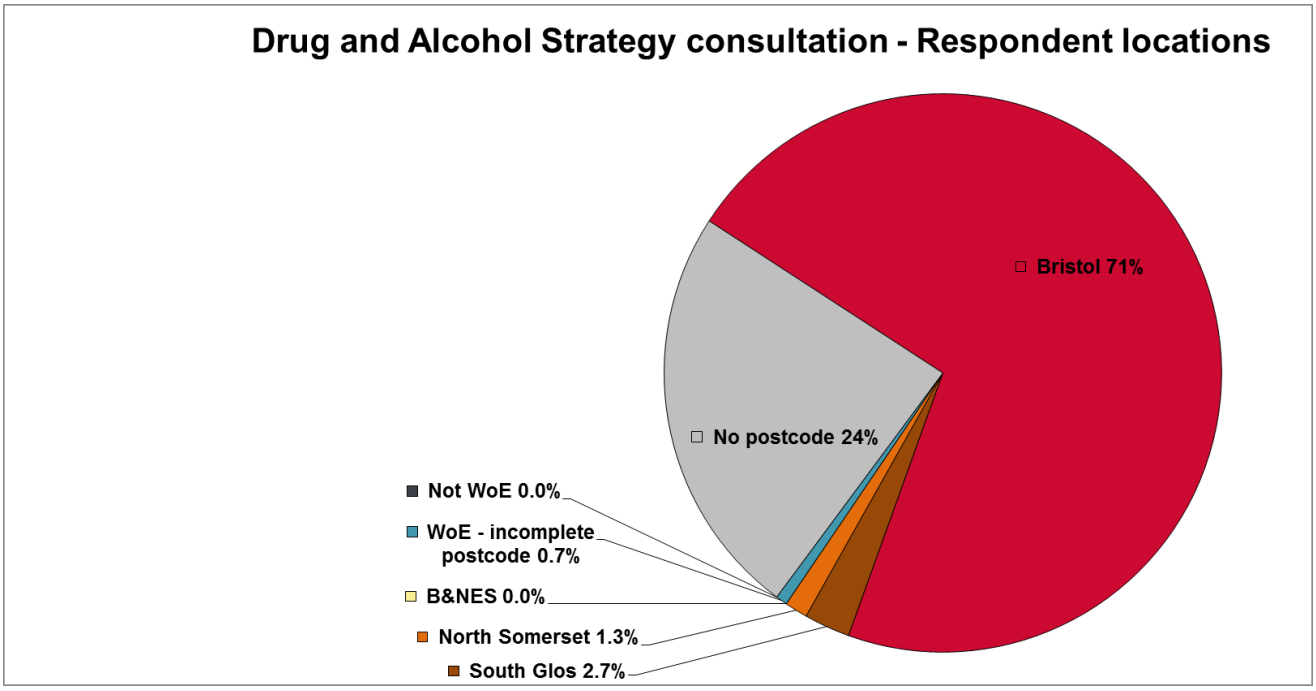
3.2 Geographic distribution of responses

107 responses (71%) were received from postcodes within the Bristol City Council area, 4 (2.7%) responses were from South Gloucestershire, two (1.3%) were from North Somerset, and none (0.0%) were from Bath & North East Somerset (B&NES). A further one (0.7%) response was from an unspecified location within the four West of England authorities[1] and no responses were received from further afield (Figure 1).

33 (22%) did not provide a postcode.

Of the 107 responses from within the Bristol City Council area, 104 provided full or partial postcodes from which the ward of origin could be identified[2] (Figure 2).

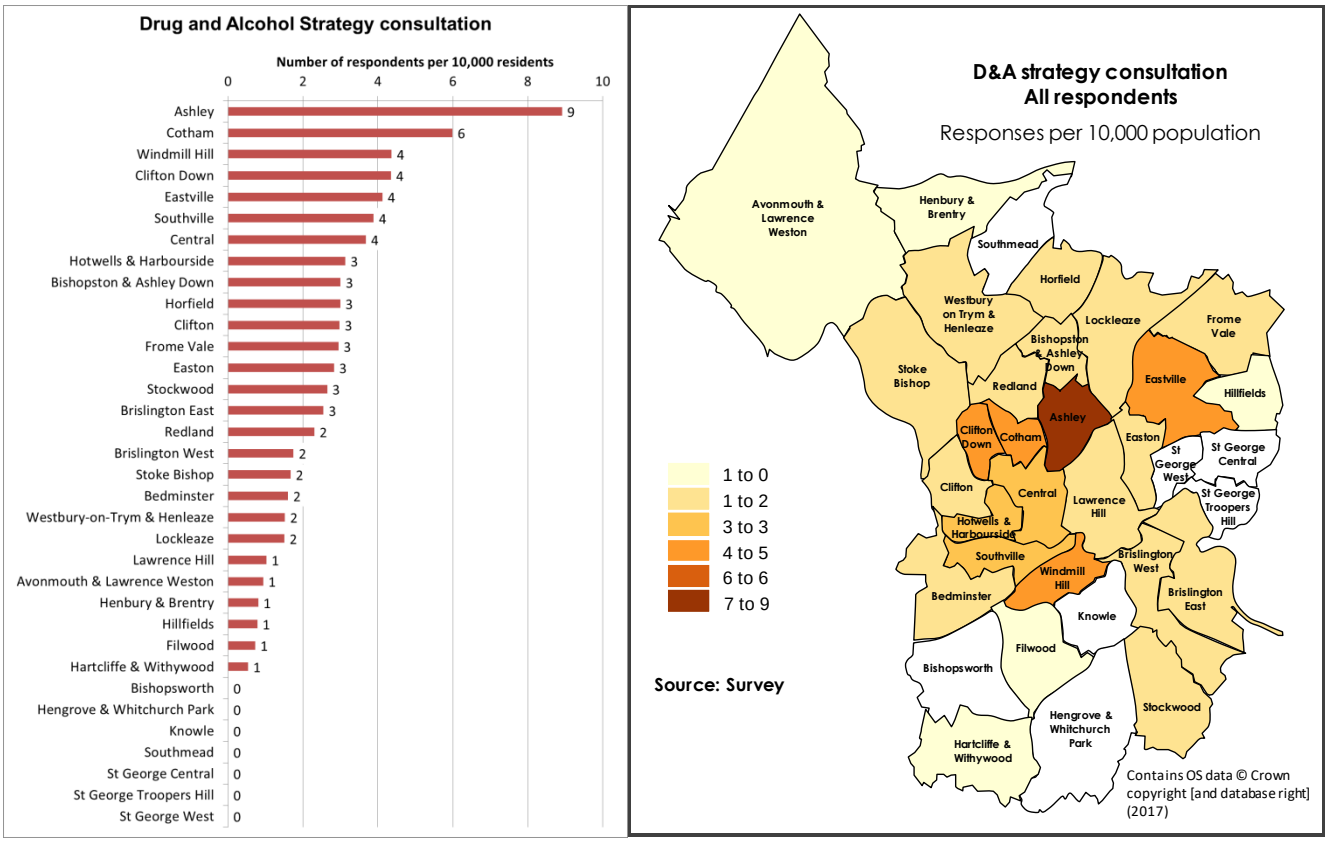
Figure 1: geographic distribution of responses



[1] Incomplete postcodes identified the home location as within the WOE authorities area (Bristol, B&NES, North Somerset and South Gloucestershire), but not which authority.

[2] The other 3 responses included incomplete postcodes which are within Bristol but do not include enough information to identify a specific ward.

Figure 2: geographic distribution of responses in Bristol



3.3 Response rate from areas of high and low deprivation

The home location of respondents in Bristol was compared with nationally published information on levels of deprivation across the city[3] to review if the responses received include a cross-section of people living in more deprived and less deprived areas. This helps the council to know if the views of citizens in more deprived areas differ from people living in less deprived areas.

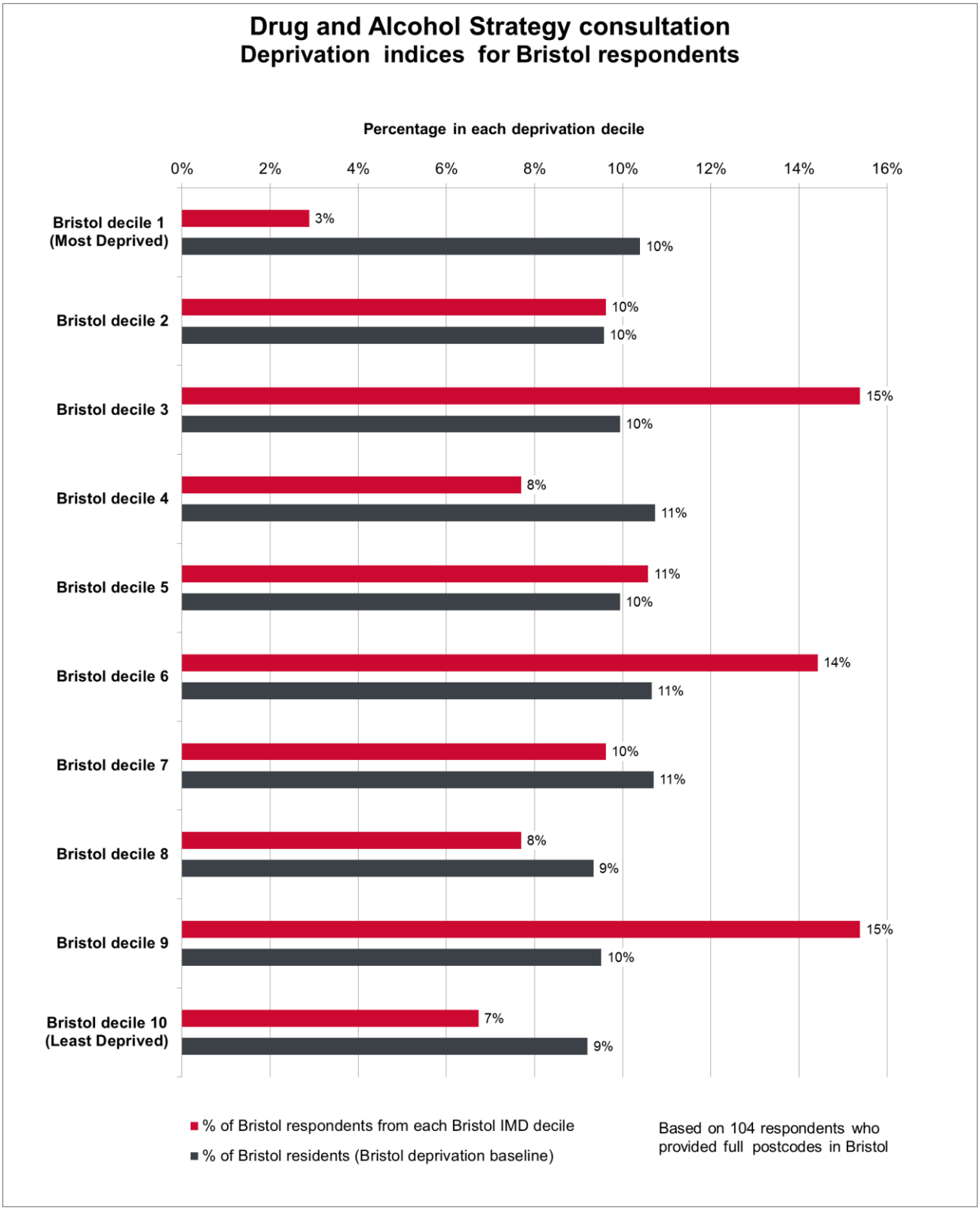
The comparison looked at levels of deprivation in 10 bands (known as 'deciles') from decile 1 (most deprived) to decile 10 (least deprived). Figure 3 compares the percentage of Bristol respondents[4] living in each of the deprivation deciles (red bars) to the percentage of all Bristol citizens who live in each decile (grey bars).

[3] The Office for National Statistics (ONS) publishes information about deprivation for 32,844 small areas - known as 'Lower Super Output Areas' (LSOAs) - throughout England. For each of these areas, a measure of deprivation is published called 'Indices of Multiple Deprivation' (IMD), which takes into account 37 aspects of each area that cover income, employment, education, health, crime, barriers to housing and services, and living environment. The postcodes provided by respondents to the consultation enabled each respondent to be matched to one of the 263 Lower Super Output Areas that cover the Bristol City Council area and thus to one of the deprivation deciles. Note that postcodes provide approximate locations; they are not used to identify individuals or specific addresses.

[4] Based on 104 respondents who provided full postcodes in the Bristol administrative area from which deprivation decile can be identified.

Figure 3 shows that there was under-representation of responses from the most deprived 10% of the city (decile 1) and in the least deprived 10% of the city (decile 10). Response rates from deciles 3, 4, 6 and 9 were over represented. Response rates from deciles 2, 5, 7 and 8 closely match the proportion of Bristol citizens living in these deciles.

Figure 3: Comparison of response rate from areas of high and low deprivation



(Percentages in Figure 3 are given to the nearest integer. The length of bars in the chart reflects the unrounded percentage; hence bars shown as 10% may be slightly different in length.)

3.4 Characteristics of respondents

144 (96%) people answered one or more of the equalities monitoring questions. Respondent characteristics are summarised below. The charts compare:

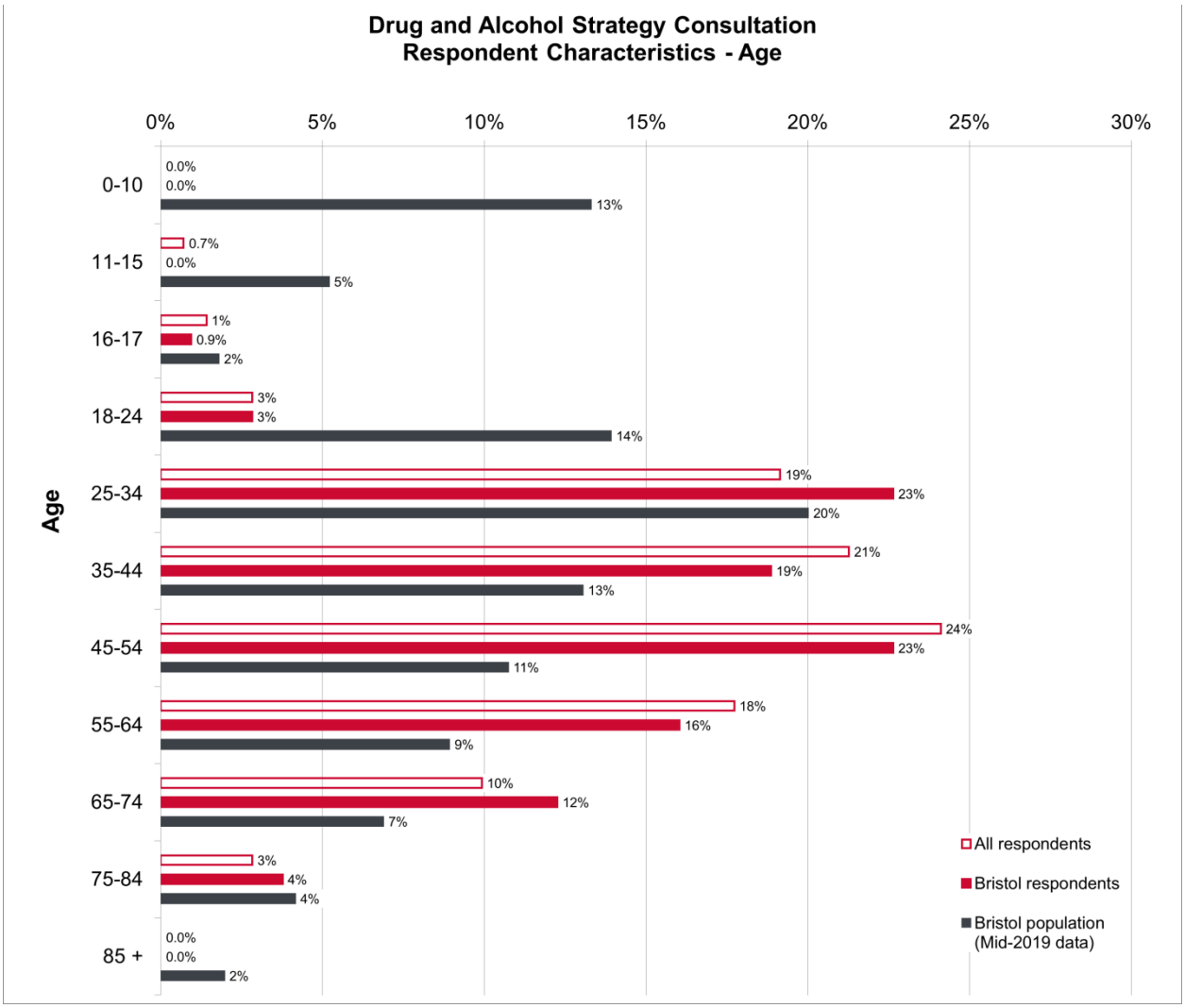
- Characteristics for all respondents who answered the equalities questions;
- Characteristics of respondents who provided a Bristol postcode;
- Characteristics of all Bristol citizens. This is available for five protected characteristics (age, sex, disability, ethnicity and religion/faith) for which population data are available from the 2011 Census and subsequent updates.

Note that many of the respondents who did not provide postcodes may also live in the Bristol administrative area, but are not included in figures for 'Bristol respondents'

Age

The highest number of responses were from respondents aged 45-54 years (24%), followed by 35-44 (21%).

Figure 4: Age of respondents

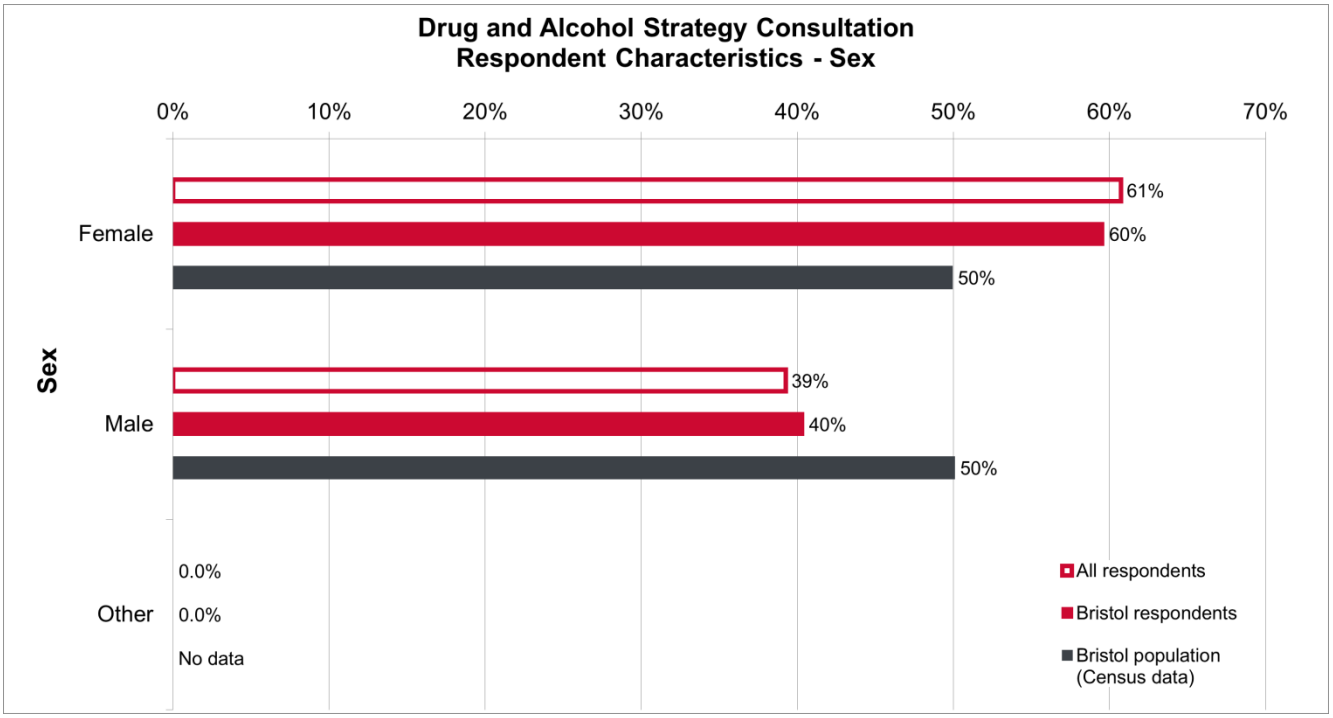


The proportion of responses in the age categories 25-34 years, 35-44, 45-54, 55-64 and 65-74 was higher than these age groups' proportion of the population in Bristol. Survey responses from children (under 18), young people aged 18-24 and people aged 75-84 and 85 and older were under-represented. In each age category, the proportions of 'all respondents' and 'Bristol respondents' were similar.

Sex

61% of all responses were from women and 39% were from men. 0.0% were from people who identified as 'other'. These percentages exclude the 6% of respondents (2.8% of Bristol respondents) who answered 'prefer not to say')

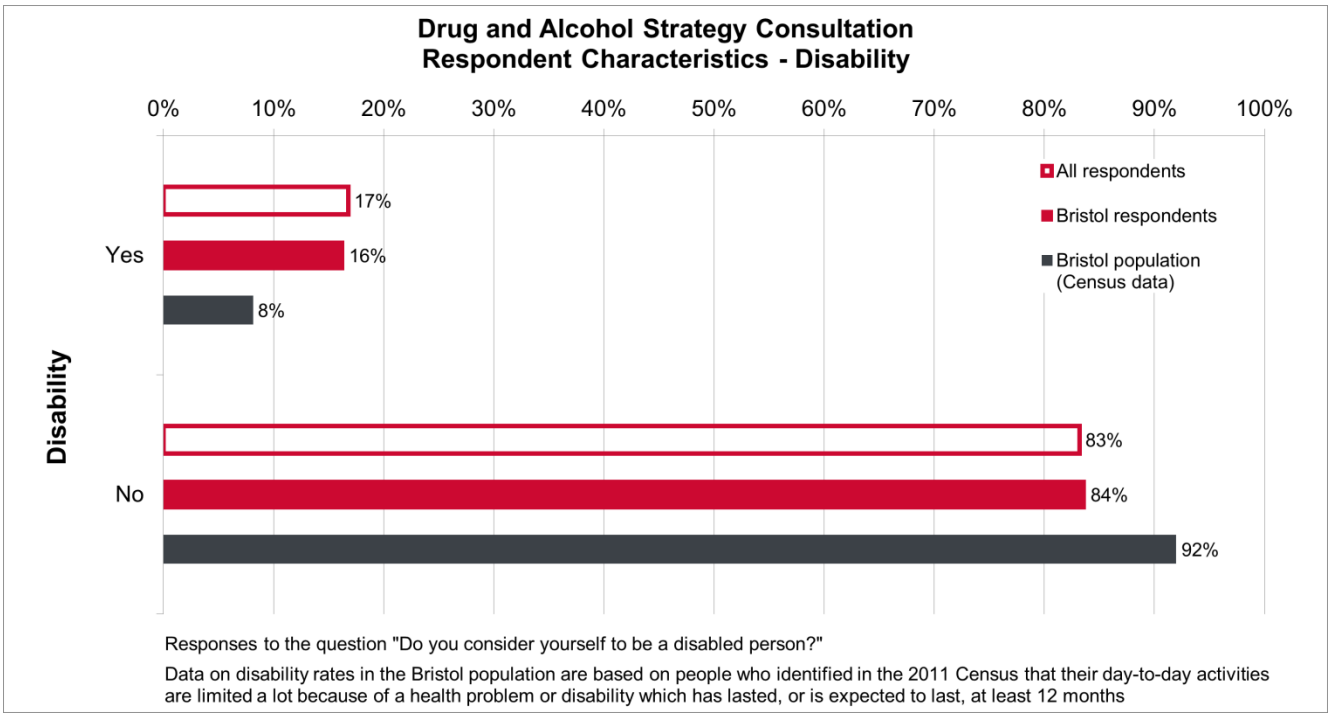
Figure 5: Sex of respondents



Disability

The proportion of disabled respondents (17%) is higher than the proportion of disabled people living in Bristol.These percentages exclude the 8.4% of respondents (7.5% of Bristol respondents) who answered ‘prefer not to say’)

Figure 6: Disability



Ethnicity

The response rate from White British respondents (82%), Other White respondents (9%) and Other Ethnic Backround respondents (1%) is higher than the proportion of these citizens in the Bristol population.

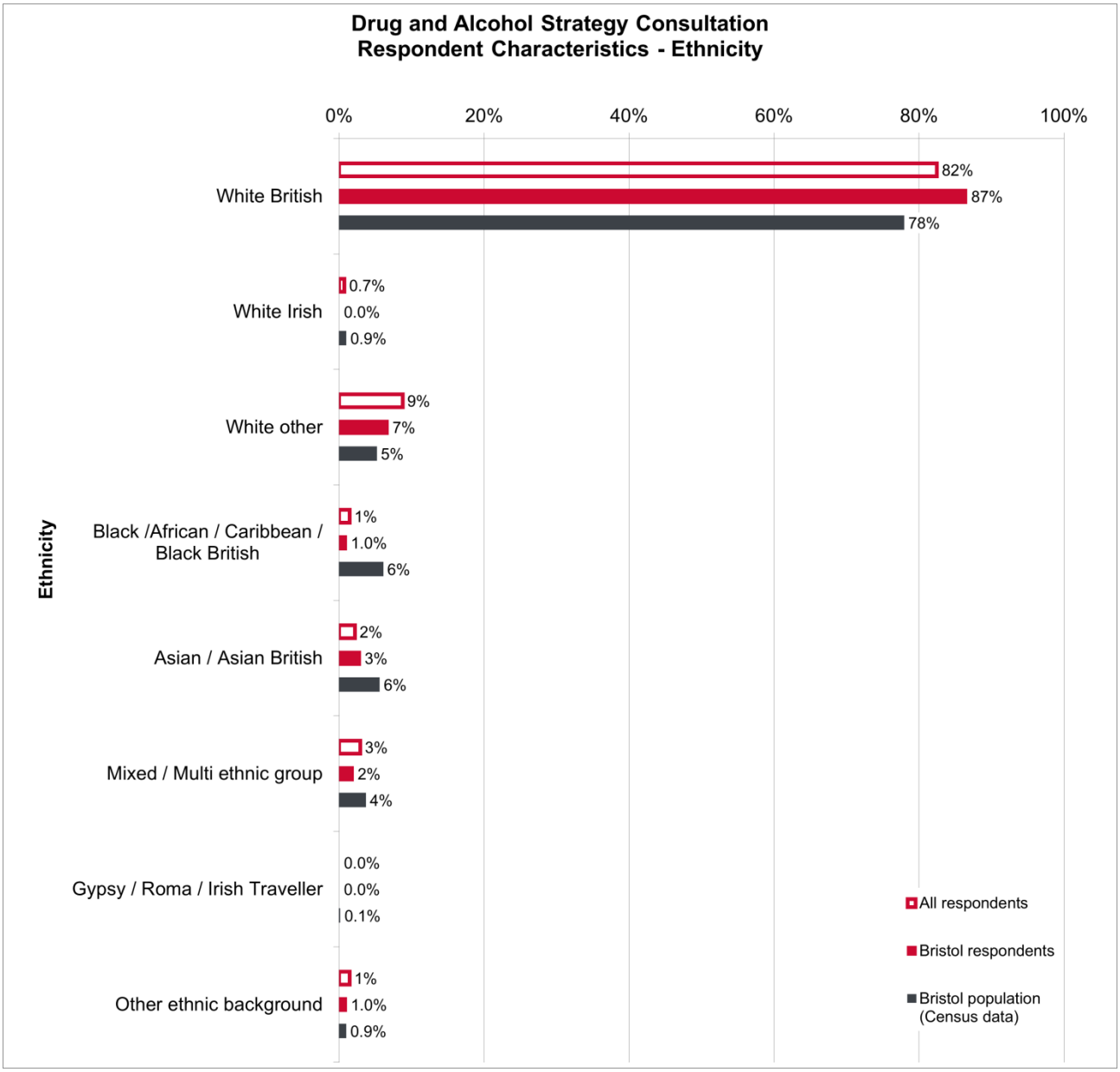
The proportion of White Irish people (0.7%) is just under the proportion of these citizens in the Bristol population.

All black, Asian and minority ethnic (BAME), mixed/multi-ethnic respondents and Gypsy, Roma and Traveller respondents were under-represented in the response rates compared to the proportion of BAME citizens and mixed/multi-ethnic citizens living in Bristol.

These percentages exclude the 4.9% of respondents (2.8% of Bristol respondents) who answered ‘prefer not to say’)

The proportion of each ethnicity for all respondents closely matches Bristol respondents.

Figure 7: Ethnicity of respondents



Religion/Faith

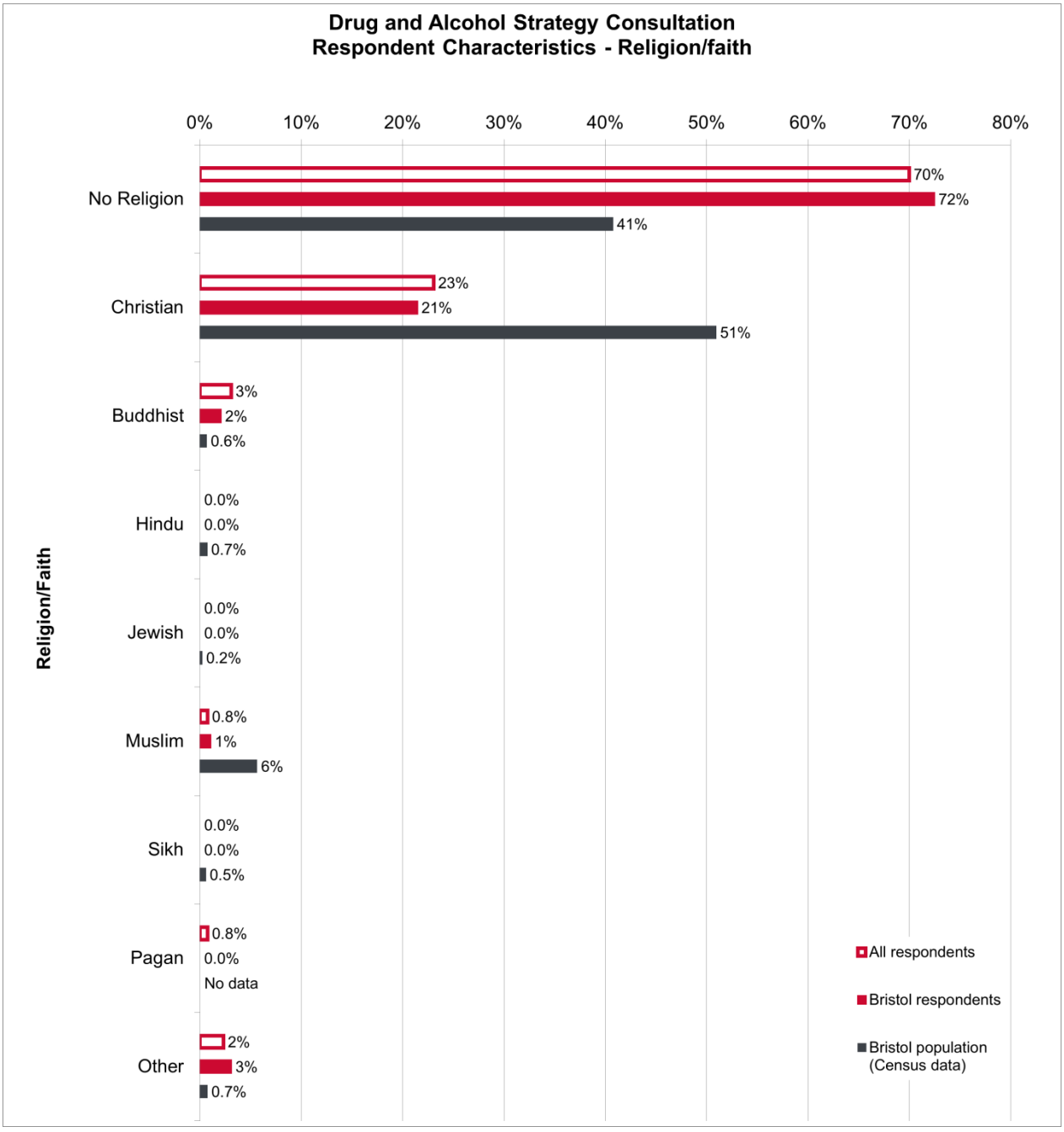
People with no religion (70% of respondents) responded in higher proportions than people of no religion in Bristol's population (41%). Buddhists (3%), and people of Other religions respondents (2%) also responded in greater numbers than the proportions of these faiths in Bristol.

Christians (23%), Muslims (0.8%), Hindus (0.0%), Jewish people (0.0%) and Sikhs (0.0%) were under-represented compared to the proportions of these faiths living in Bristol.

These percentages exclude the 9.1% of respondents (7.5% of Bristol respondents) who answered 'prefer not to say').

The proportion of each religion/faith for all respondents closely matches Bristol respondents.

Figure 8: Religion/faith of respondents



Other protected characteristics and refugee/asylum status

The survey also asked respondents about three other protected characteristics (sexual orientation, gender reassignment, pregnancy and recent maternity) and if they are a refugee or asylum seeker.

Census data are not available for the proportion of people with these characteristics living in Bristol. Figures 9, 10, 11 and 12 show the proportions of all respondents and Bristol respondents for each of these characteristics. The proportion of each characteristic for all respondents closely matches the proportion for Bristol respondents.

Figure 9: Sexual orientation

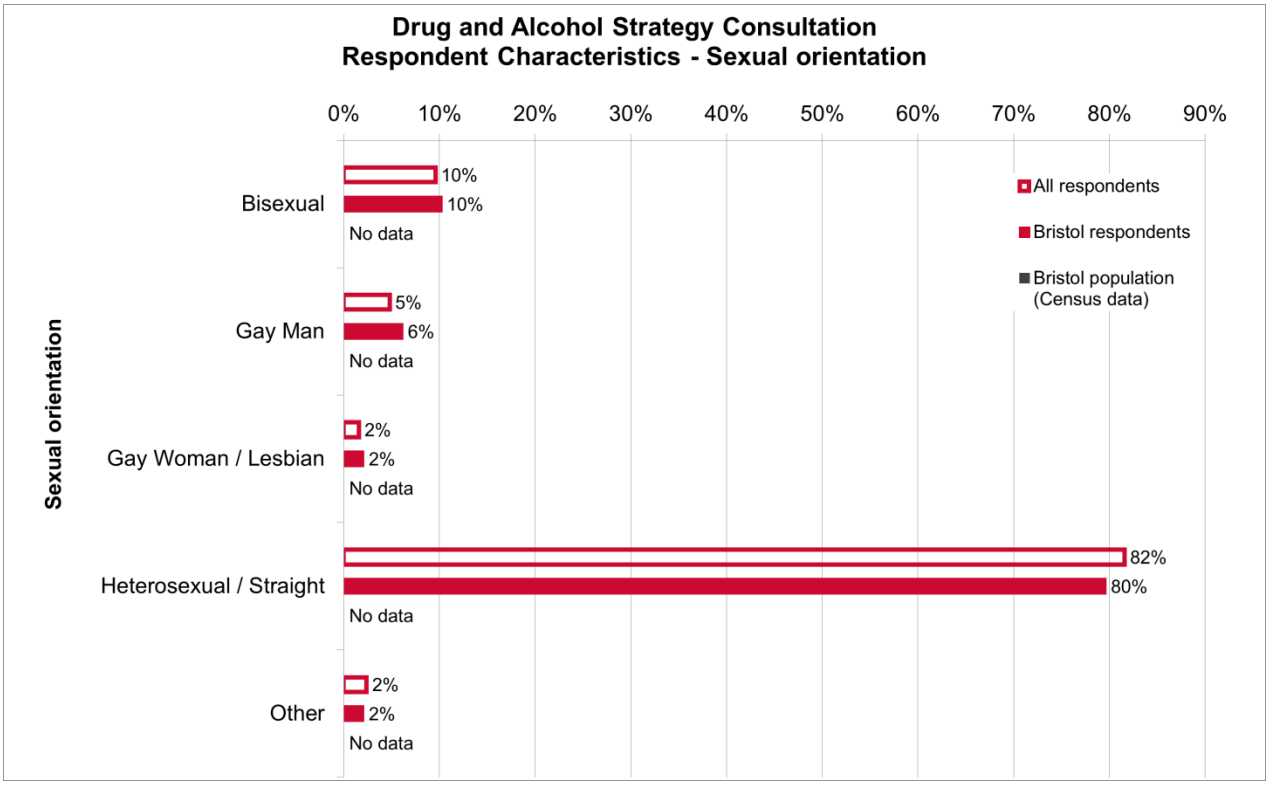


Figure 10: Gender reassignment

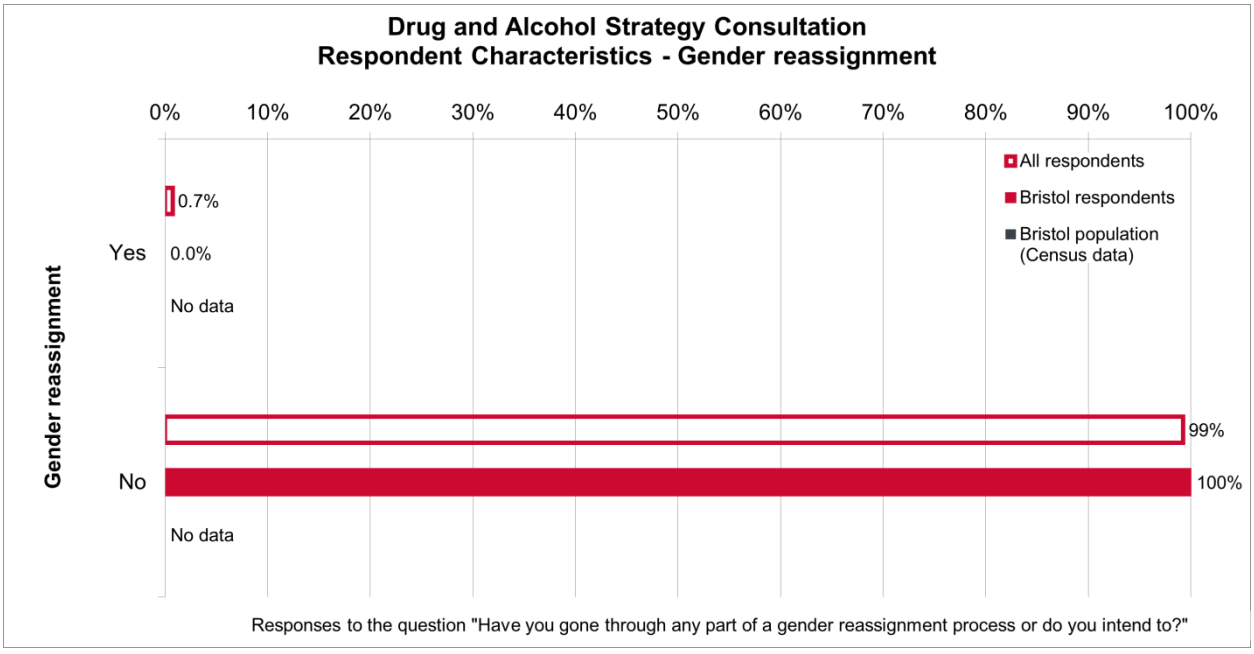


Figure 11: Pregnancy/Maternity

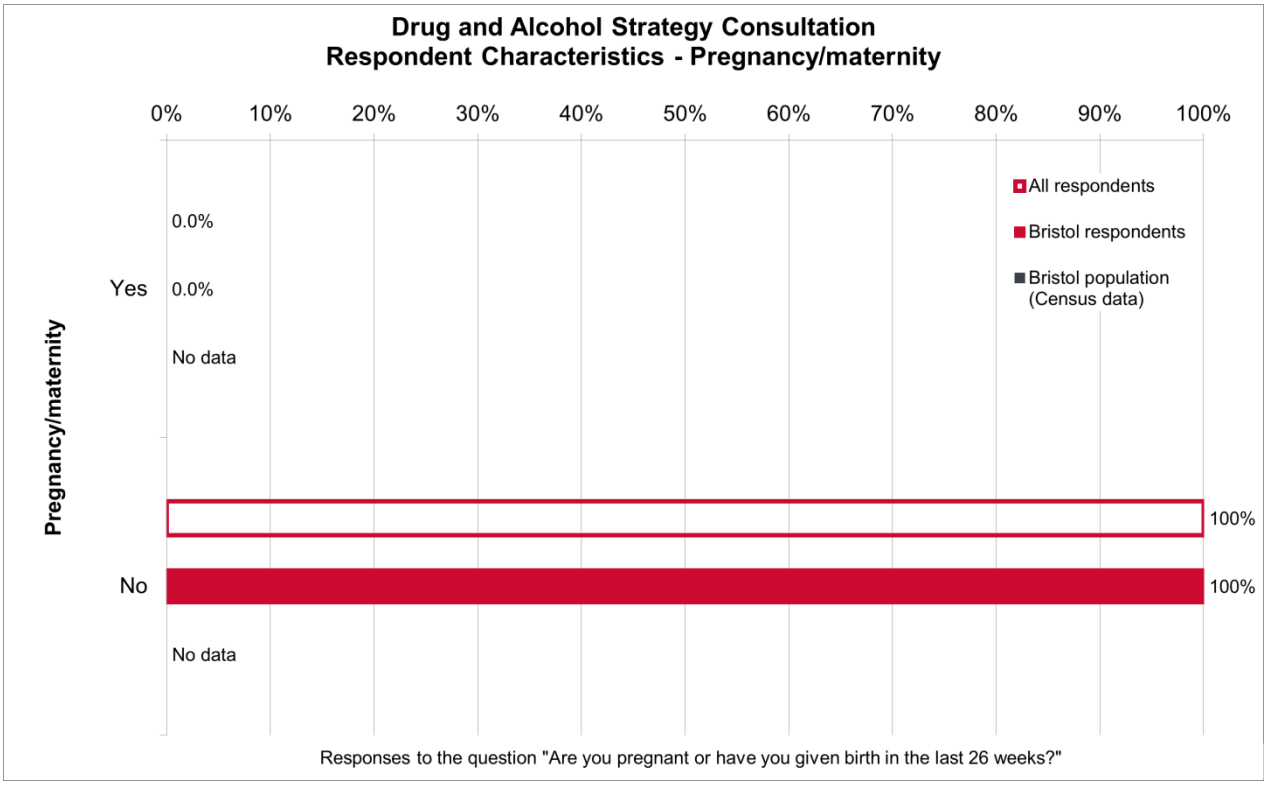
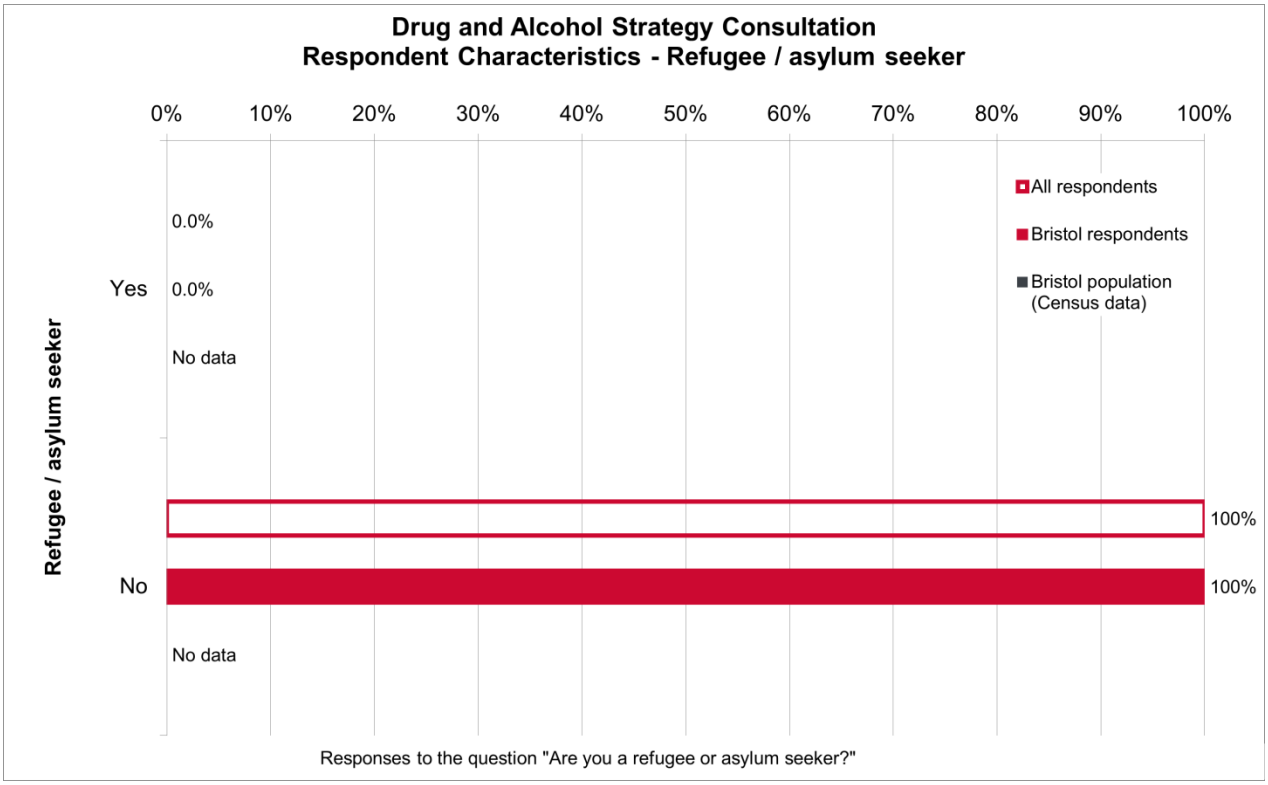
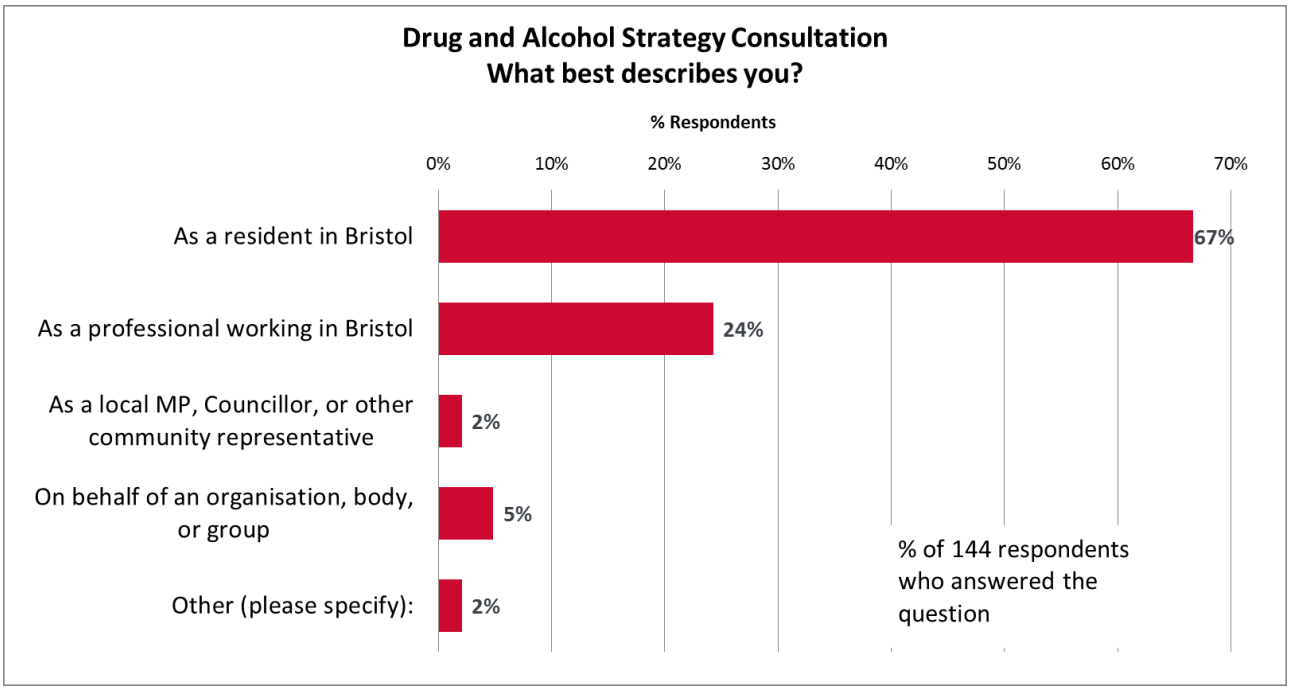


Figure 12: Refugee or asylum seeker



Other respondent characteristics

Figure 13



144 (96%) respondents provided other details of their personal situation, selecting from the following list of 11 options:

- 96 (67% of the 144 respondents who answered the question) are Bristol residents;
- 35 (24%) are professionals working in Bristol;
- 3 (2%) responded as a local MP, Councillor or other community representative
- 7 (5%) responded on behalf of an organisation, body or group
- 3 (2%) responded in another capacity

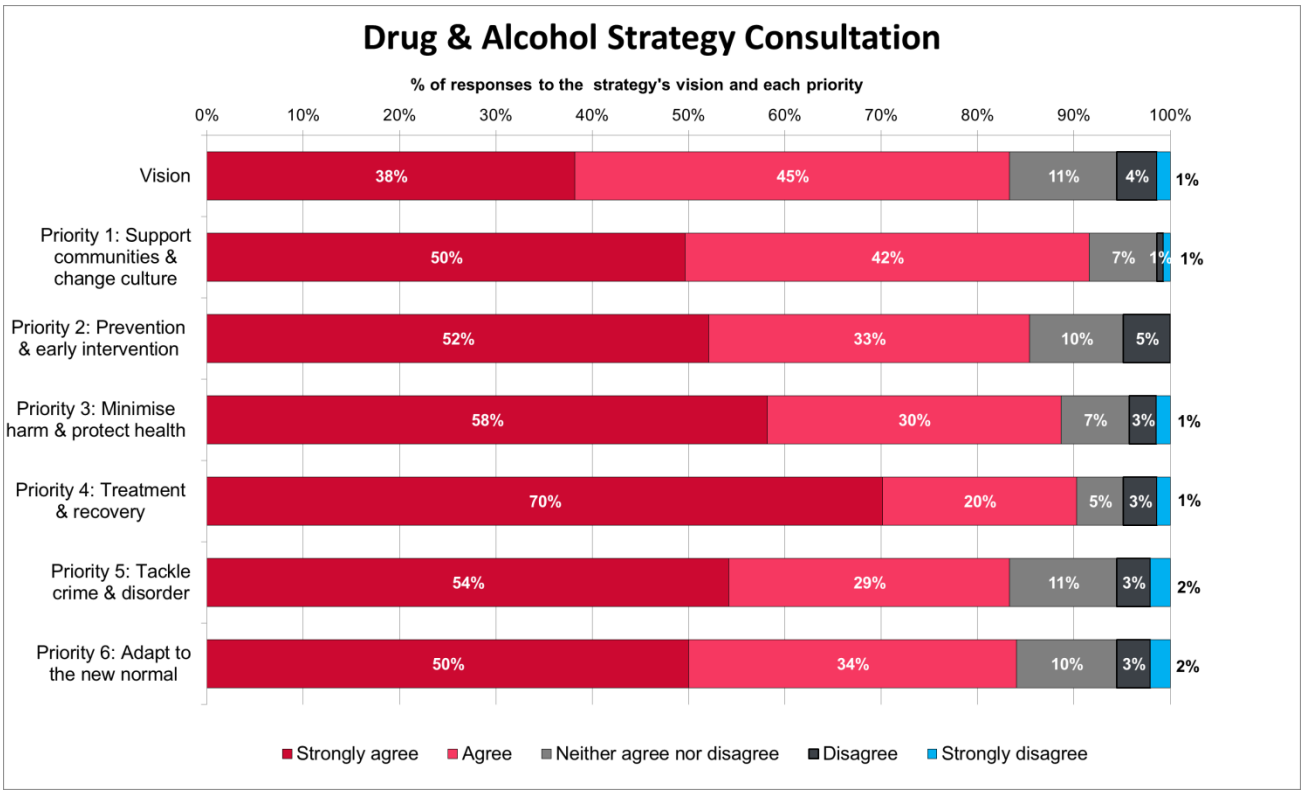
4 Survey results: Drug and Alcohol Strategy Vision and Priorities

4.1 Drug and Alcohol Strategy Vision and Priorities – all respondents

Respondents were asked to state the extent to which they agree or disagree with the Drug and Alcohol Strategy's vision and the following six priorities (Figure 14):

- Priority 1: Support communities and change culture
- Priority 2: Prevention and early intervention
- Priority 3: Minimise harm and protect health
- Priority 4: Treatment and recovery
- Priority 5: Tackle crime and disorder
- Priority 6: Adapt to the new normal

Figure 14: Agreement or disagreement with the Drug and Alcohol Strategy Vision and Priorities



144 (96%) respondents expressed a view on the Drug and Alcohol Strategy's vision, of these:

- 55 (38%) of respondents strongly agree with the vision
- 65 (45%) of respondents agree with the vision
- 16 (11%) of respondents neither agree nor disagree with the vision
- (4%) of respondents disagree with the vision

- 2 (1%) of respondents strongly disagree with the vision

143 (95%) respondents expressed a view on the Drug and Alcohol Strategy's Priority 1: Support communities and change culture. Of these:

- 71 (50%) of respondents strongly agree with this priority
- 60 (42%) of respondents agree with this priority
- 10 (7%) of respondents neither agree nor disagree with this priority
- 1 (1%) of respondents disagree with this priority
- 1 (1%) of respondents strongly disagree with this priority

144 (96%) respondents expressed a view on the Drug and Alcohol Strategy's Priority 2: Prevention and early intervention. Of these:

- 75 (52%) of respondents strongly agree with this priority
- 48 (33%) of respondents agree with this priority
- 14 (10%) of respondents neither agree nor disagree with this priority
- 7 (5%) of respondents disagree with this priority
- 0 (0%) of respondents strongly disagree with this priority

141 (94%) respondents expressed a view on the Drug and Alcohol Strategy's Priority 3: Minimise harm and protect health. Of these:

- 82 (58%) of respondents strongly agree with this priority
- 43 (30%) of respondents agree with this priority
- 10 (7%) of respondents neither agree nor disagree with this priority
- (3%) of respondents disagree with this priority
- 2 (1%) of respondents strongly disagree with this priority

144 (96%) respondents expressed a view on the Drug and Alcohol Strategy's Priority 4: Treatment and recovery. Of these:

- 101 (70%) of respondents strongly agree with this priority
- 29 (20%) of respondents agree with this priority

- 7 (5%) of respondents neither agree nor disagree with this priority
- (3%) of respondents disagree with this priority
- 2 (1%) of respondents strongly disagree with this priority

144 (96%) respondents expressed a view on the Drug and Alcohol Strategy's Priority 5: Tackle crime and disorder. Of these:

- 78 (54%) of respondents strongly agree with this priority
- 42 (29%) of respondents agree with this priority
- 16 (11%) of respondents neither agree nor disagree with this priority
- (3%) of respondents disagree with this priority
- 3 (2%) of respondents strongly disagree with this priority

144 (96%) respondents expressed a view on the Drug and Alcohol Strategy's Priority 6: Adapt to the new normal. Of these:

- 72 (50%) of respondents strongly agree with this priority
- 49 (34%) of respondents agree with this priority
- 15 (10%) of respondents neither agree nor disagree with this priority
- (3%) of respondents disagree with this priority
- (2%) of respondents strongly disagree with this priority

4.2 Views on The Drug and Alcohol Strategy Vision and Values with different levels of deprivation

Respondents' agreement or disagreement on the Drug and Alcohol Strategy's vision and values were compared for respondents from areas with different levels of deprivation (figures 14 to 20). The comparison used the postcodes provided by respondents in Bristol to match each response to one of 10 deprivation bands (deciles) as described in section 3.3.

Each chart shows the percentage of respondents who either agree / strongly agree, neither agree nor disagree or disagree / strongly disagree with either the strategy's vision or its priorities. The charts compare respondents' views in the most deprived 20% areas of Bristol (deciles 1 & 2), respondents' views in the least deprived 20% areas of Bristol (deciles 9 & 10) and all Bristol respondents' views.

Figure 14

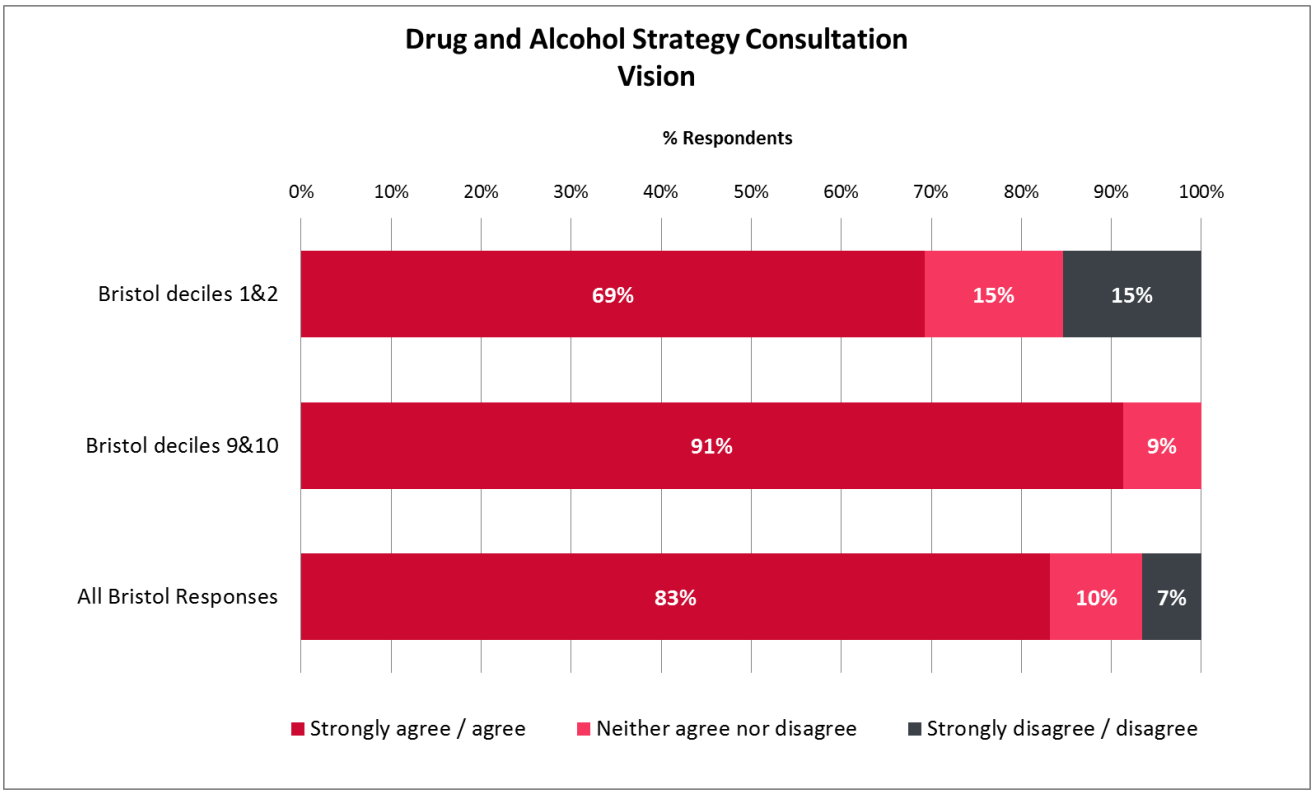


Figure 14 shows the percentage of respondents from deciles 1 and 2, deciles 9 and 10 and all Bristol respondents who stated their views on the Drug and Alcohol Strategy's vision. This is based on 13 respondents from deciles 1 and 2, 23 respondents from deciles 9 and 10 and 107 Bristol respondents. Figure 14 shows that there is much higher support for the strategy's vision in the 20% least deprived areas of Bristol (91%) than in the 20% most deprived areas of Bristol (69%).

Figure 15

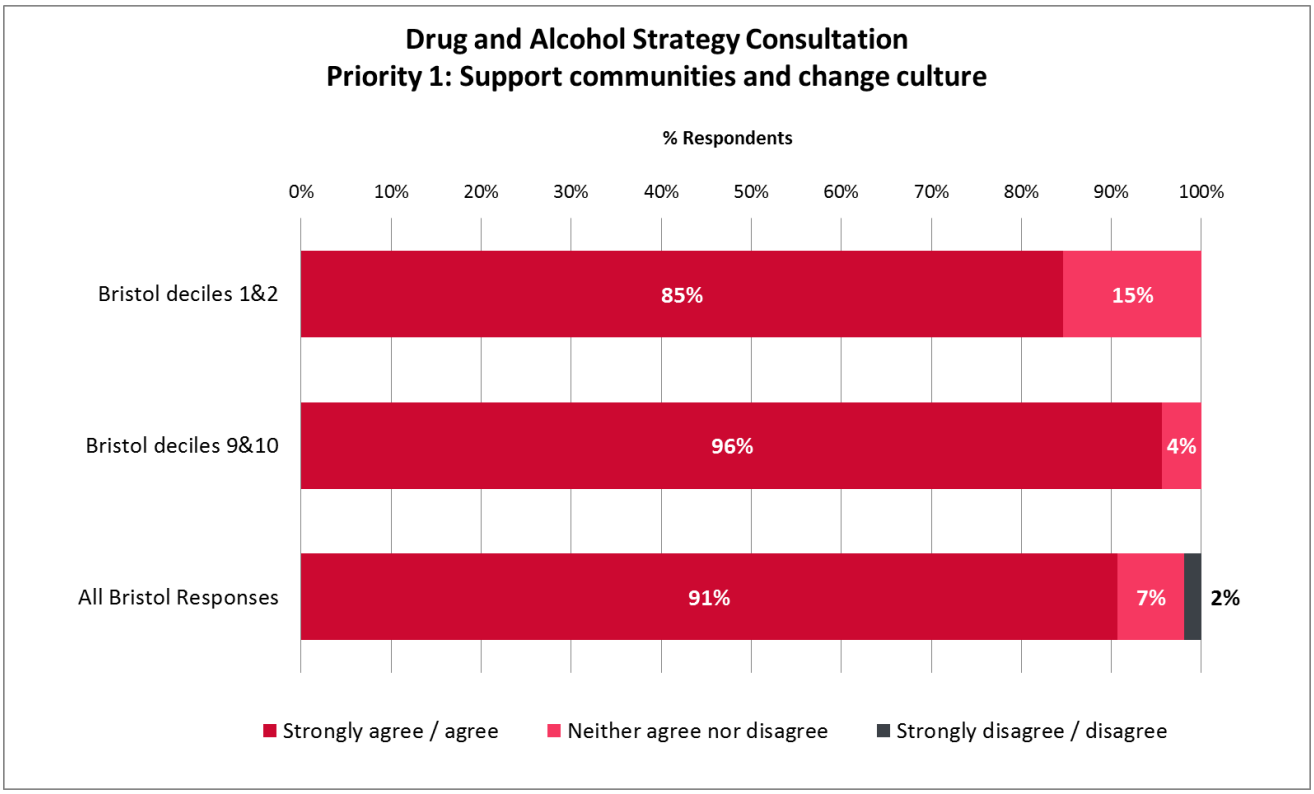


Figure 15 shows the percentage of respondents from deciles 1 and 2, deciles 9 and 10 and all Bristol respondents who stated their views on the Drug and Alcohol Strategy's Priority 1. This is based on 13 respondents from deciles 1 and 2, 23 respondents from deciles 9 and 10 and 107 Bristol respondents. Figure 15 shows that there is higher support for Priority 1 in the 20% least deprived areas of Bristol (96%) than in the 20% most deprived areas of Bristol (85%).

Figure 16

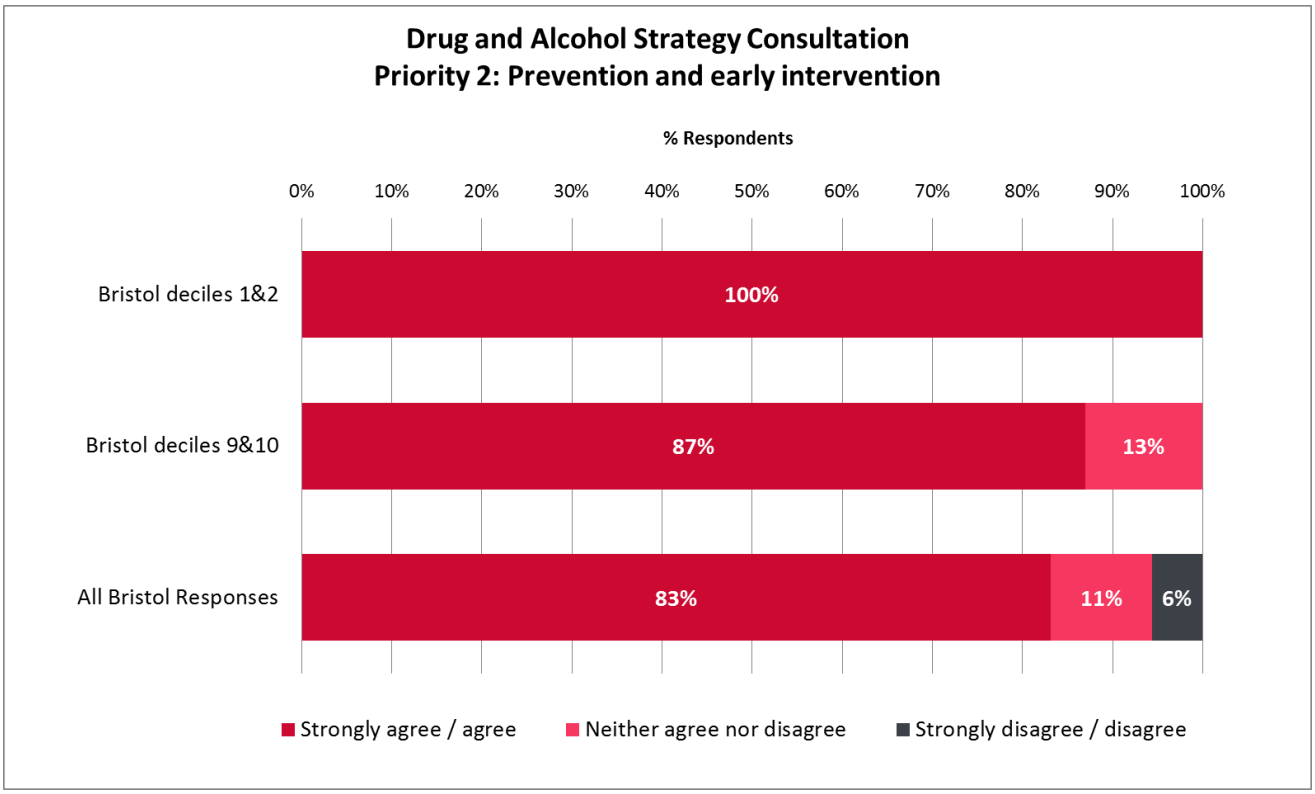


Figure 16 shows the percentage of respondents from deciles 1 and 2, deciles 9 and 10 and all Bristol respondents who stated their views on the Drug and Alcohol Strategy's Priority 2. This is based on 13 respondents from deciles 1 and 2, 23 respondents from deciles 9 and 10 and 107 Bristol respondents. Figure 16 shows that there is much higher support for Priority 2 in the 20% most deprived areas of Bristol (100%) than in the 20% least deprived areas of Bristol (87%).

Figure 17

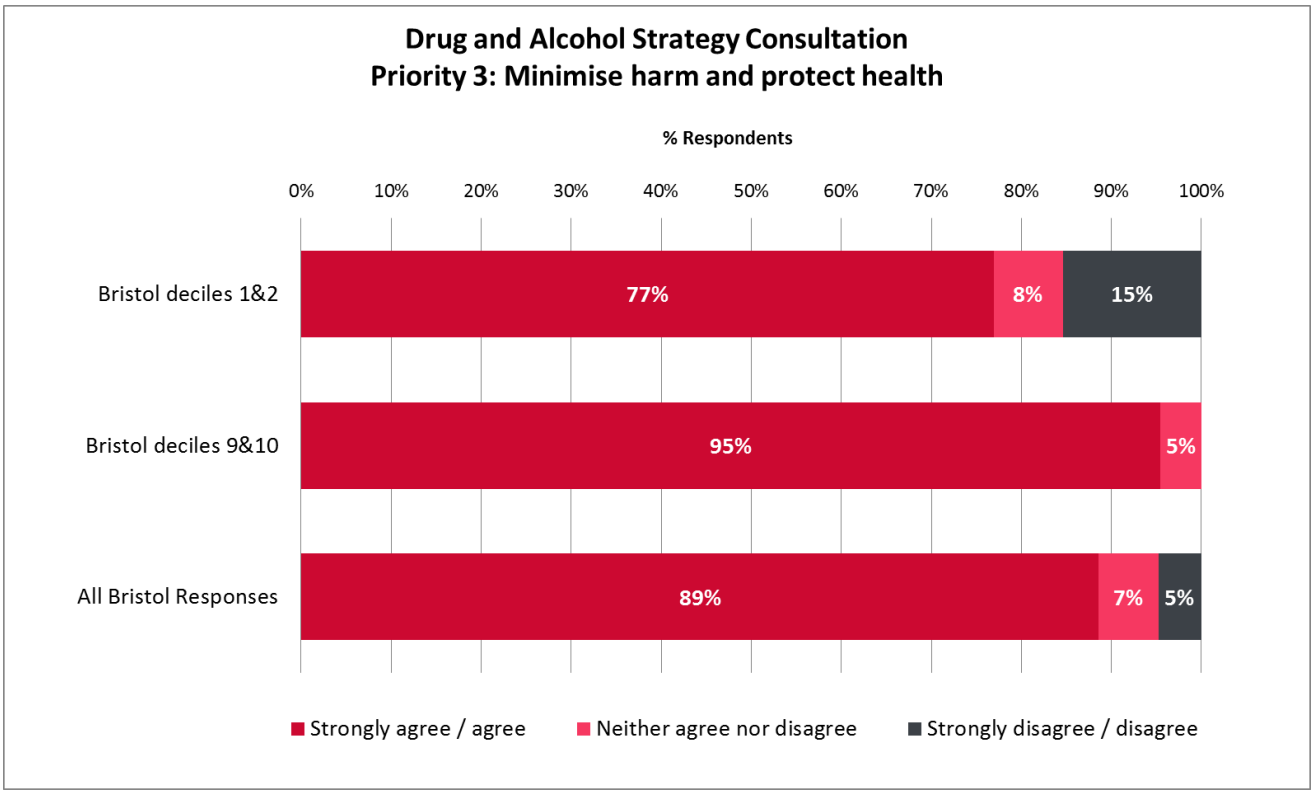


Figure 17 shows the percentage of respondents from deciles 1 and 2, deciles 9 and 10 and all Bristol respondents who stated their views on the Drug and Alcohol Strategy's Priority 3. This is based on 13 respondents from deciles 1 and 2, 22 respondents from deciles 9 and 10 and 105 Bristol respondents. Figure 17 shows that there is higher support for Priority 3 in the 20% least deprived areas of Bristol (95%) than in the 20% most deprived areas of Bristol (77%).

Figure 18

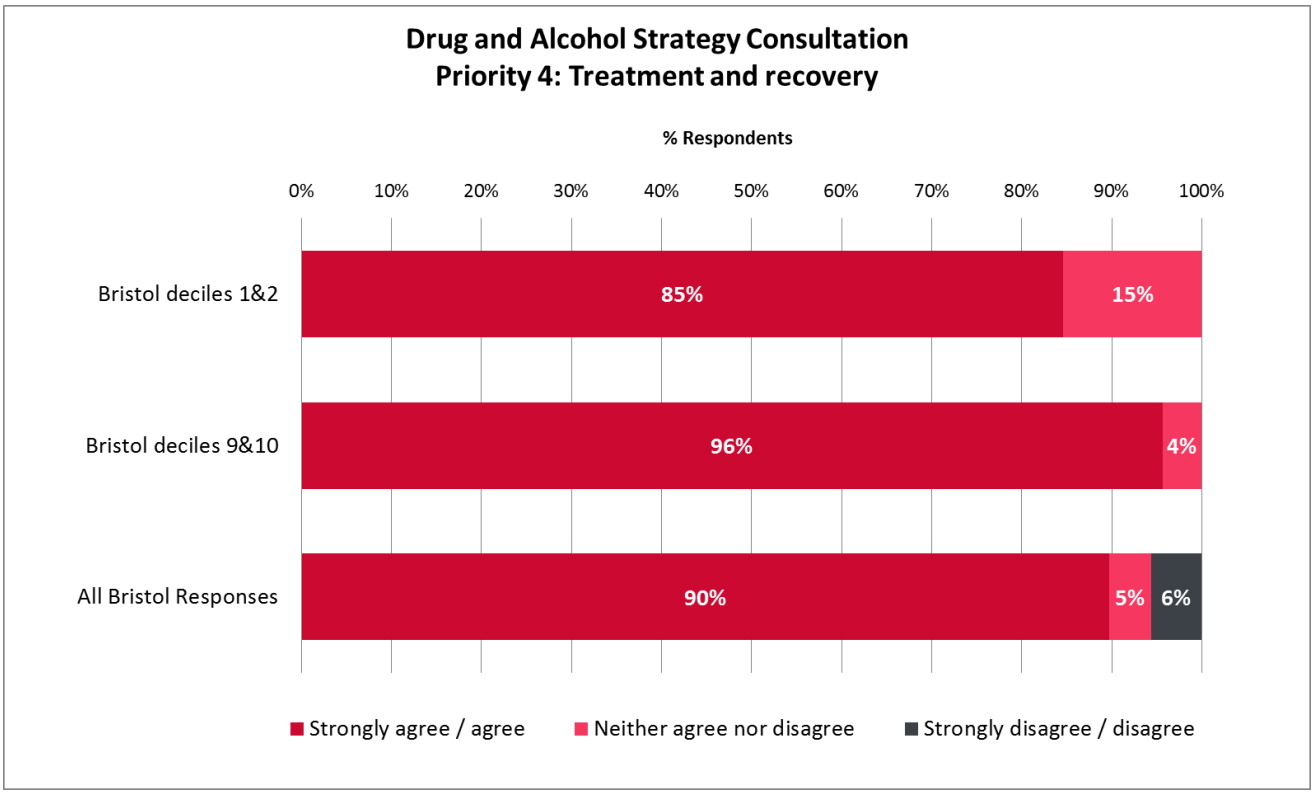


Figure 18 shows the percentage of respondents from deciles 1 and 2, deciles 9 and 10 and all Bristol respondents who stated their views on the Drug and Alcohol Strategy's Priority 4. This is based on 13 respondents from deciles 1 and 2, 23 respondents from deciles 9 and 10 and 107 Bristol respondents. Figure 18 shows that there is higher support for Priority 4 in the 20% least deprived areas of Bristol (96%) than in the 20% most deprived areas of Bristol (85%).

Figure 19

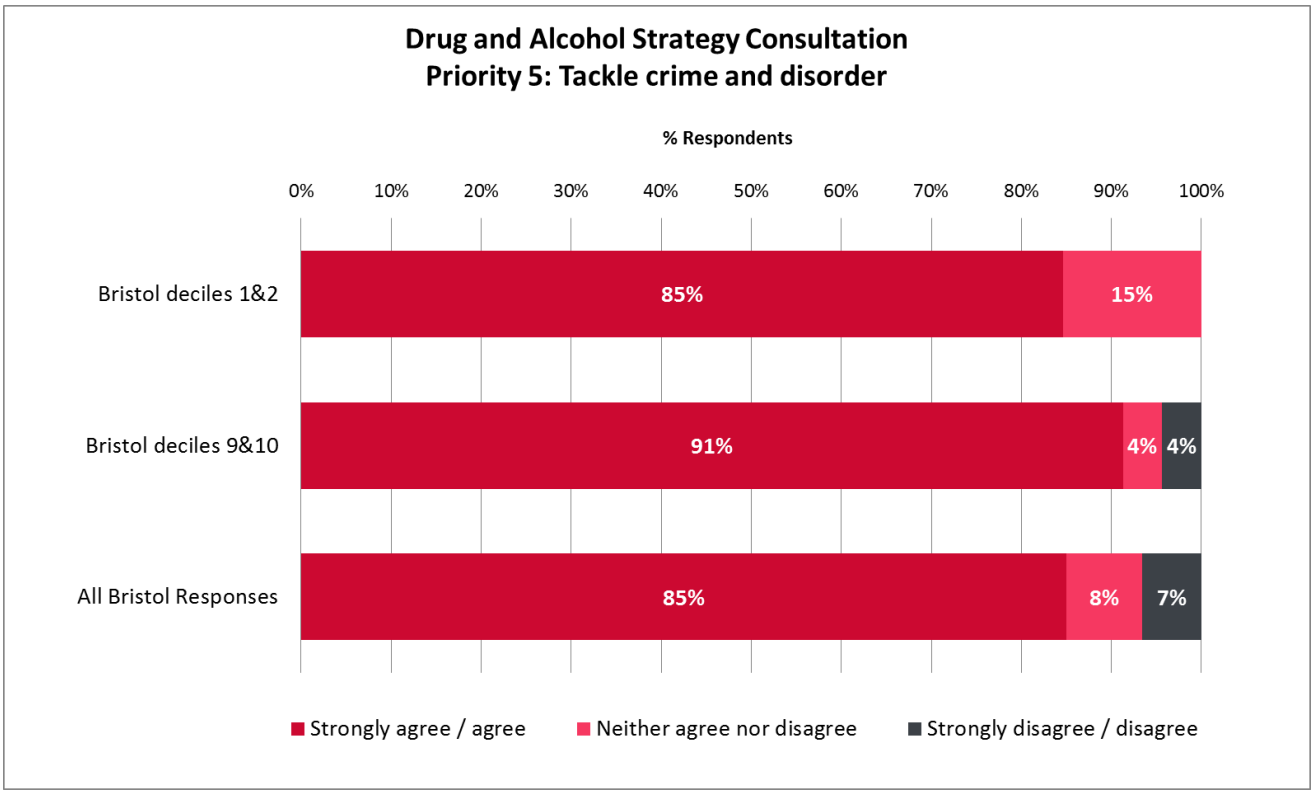


Figure 19 shows the percentage of respondents from deciles 1 and 2, deciles 9 and 10 and all Bristol respondents who stated their views on the Drug and Alcohol Strategy's Priority 5. This is based on 13 respondents from deciles 1 and 2, 23 respondents from deciles 9 and 10 and 107 Bristol respondents. Figure 19 shows that there is higher support for Priority 5 in the 20% least deprived areas of Bristol (91%) than in the 20% most deprived areas of Bristol (85%).

Figure 20

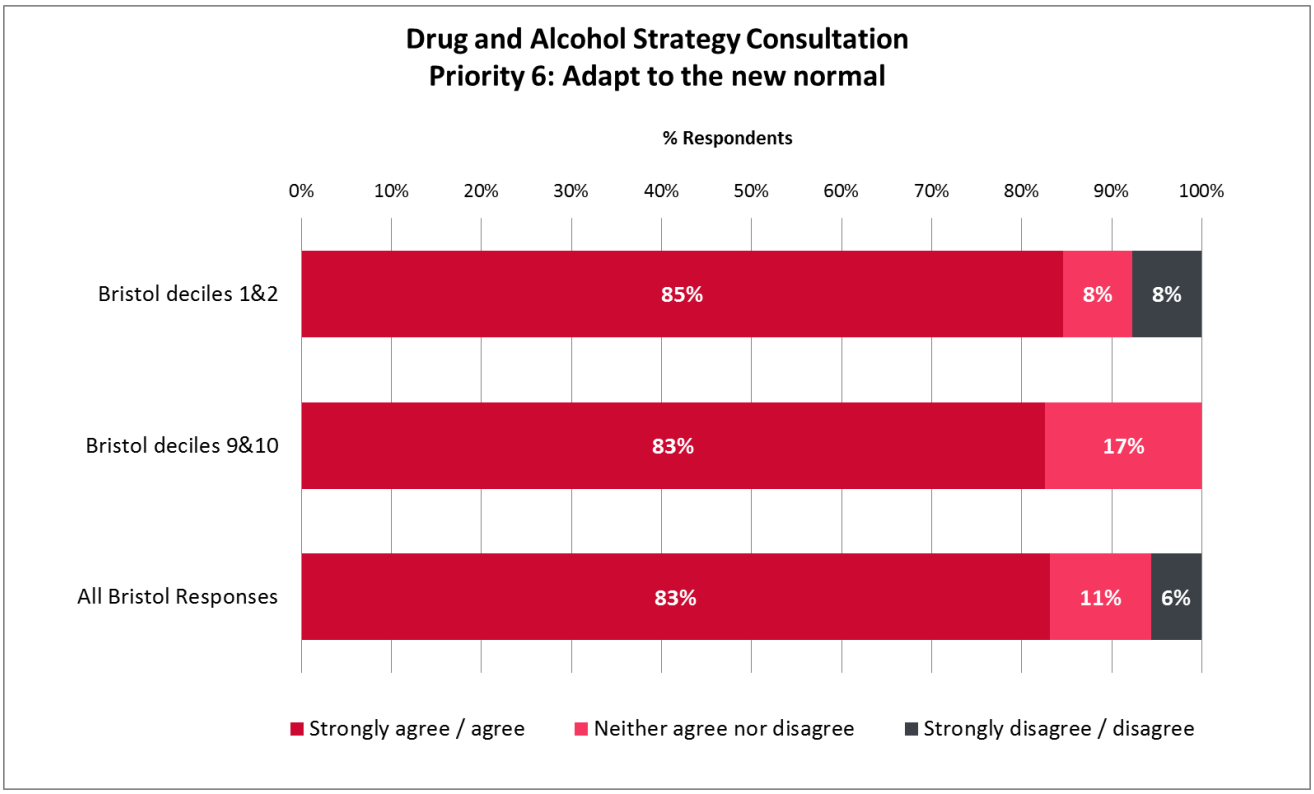


Figure 20 shows the percentage of respondents from deciles 1 and 2, deciles 9 and 10 and all Bristol respondents who stated their views on the Drug and Alcohol Strategy's Priority 6. This is based on 13 respondents from deciles 1 and 2, 23 respondents from deciles 9 and 10 and 107 Bristol respondents. Figure 20 shows that there is a slightly lower level of support for Priority 6 in the 20% least deprived areas of Bristol (83%) compared with the 20% most deprived areas of Bristol (85%).

4.3 Views on The Drug and Alcohol Strategy Vision and Values – other characteristics

Respondents' level of agreement or disagreement with the Drug and Alcohol Strategy's vision and values was also compared for respondents from BME and non BME background, respondents who described themselves as disabled compared with those who did not and respondents who identified as LGBT compared with respondents who identified as heterosexual / straight.

Figures 21 to 41 show the proportion of respondents who either agree / strongly agree, neither agree nor disagree or disagree / strongly disagree with the vision or values from each characteristic.

Figure 21 Ethnicity - Vision

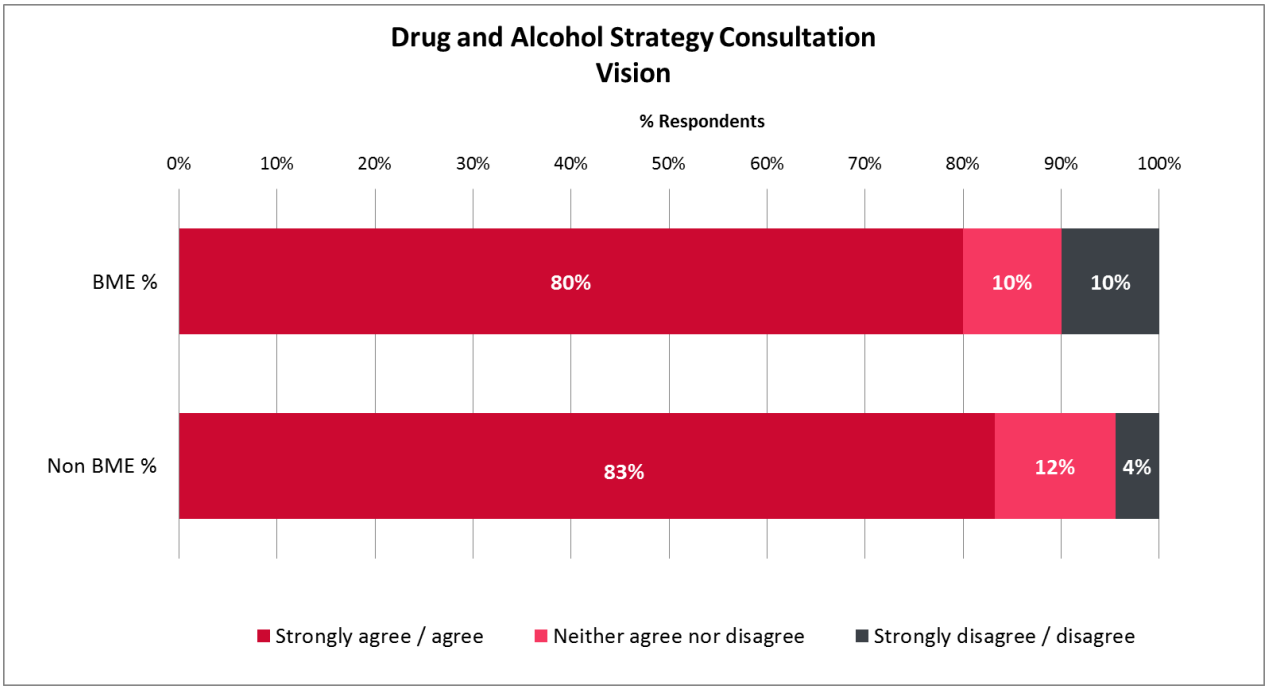


Figure 22 Ethnicity - Priority 1

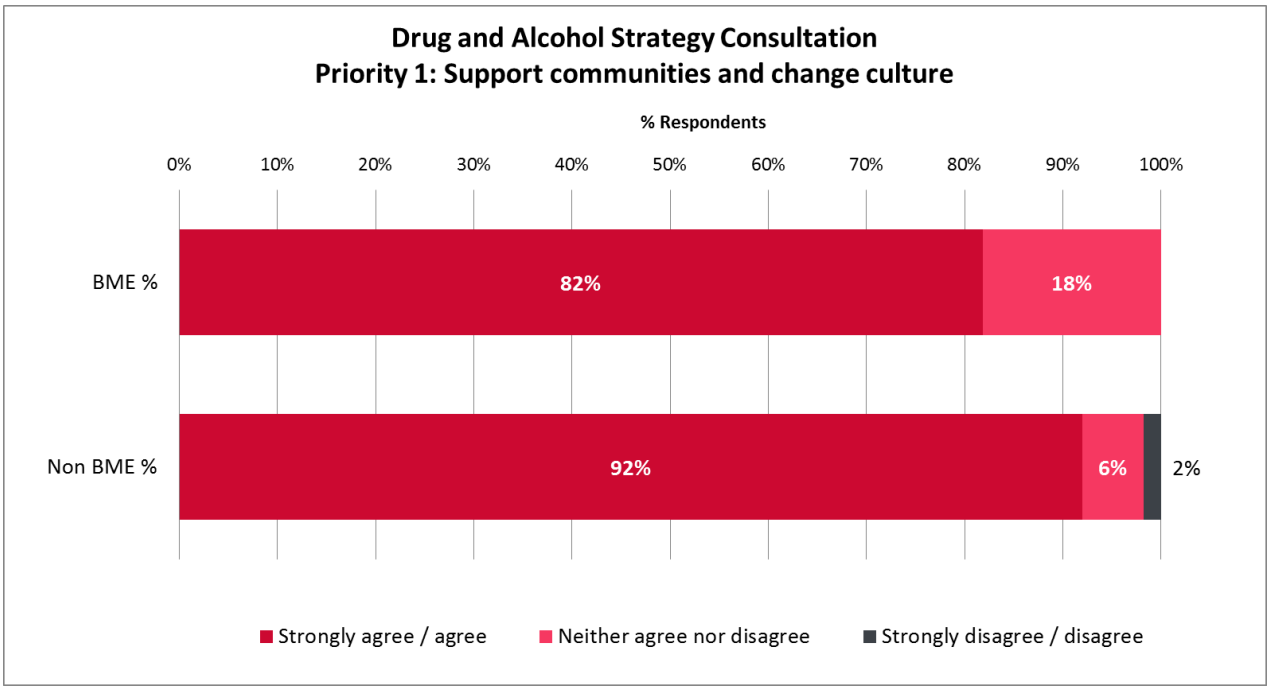


Figure 23 Ethnicity - Priority 2

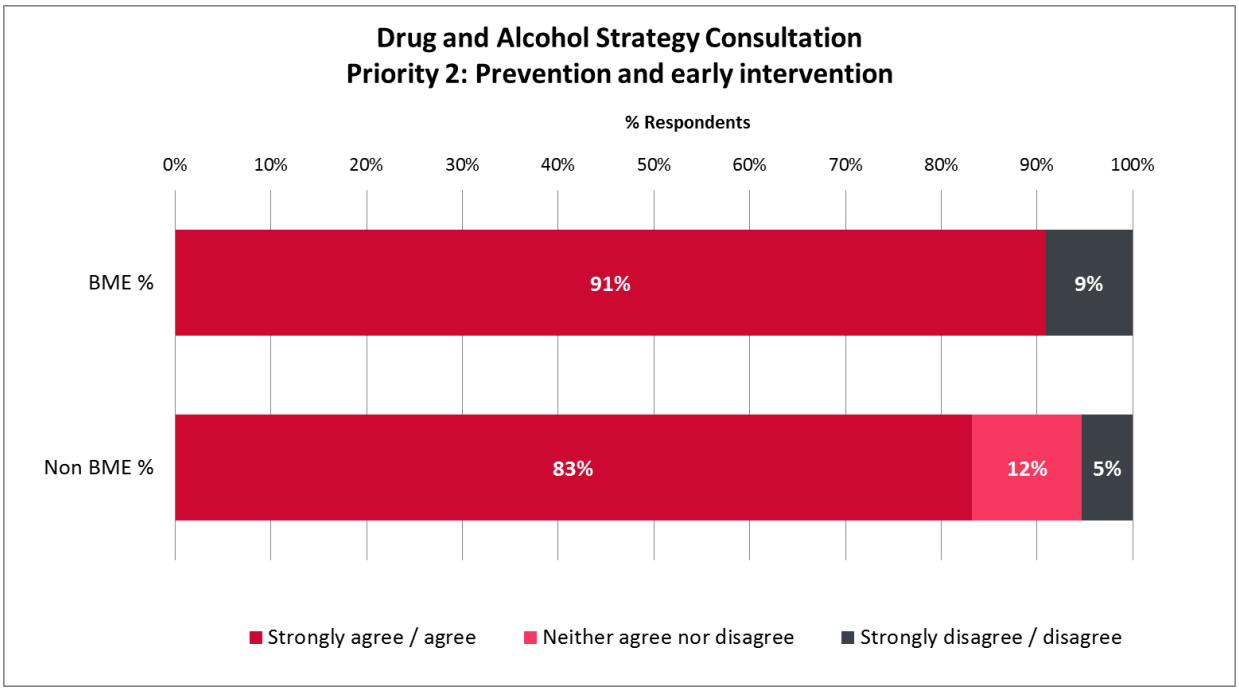


Figure 24 Ethnicity - Priority 3

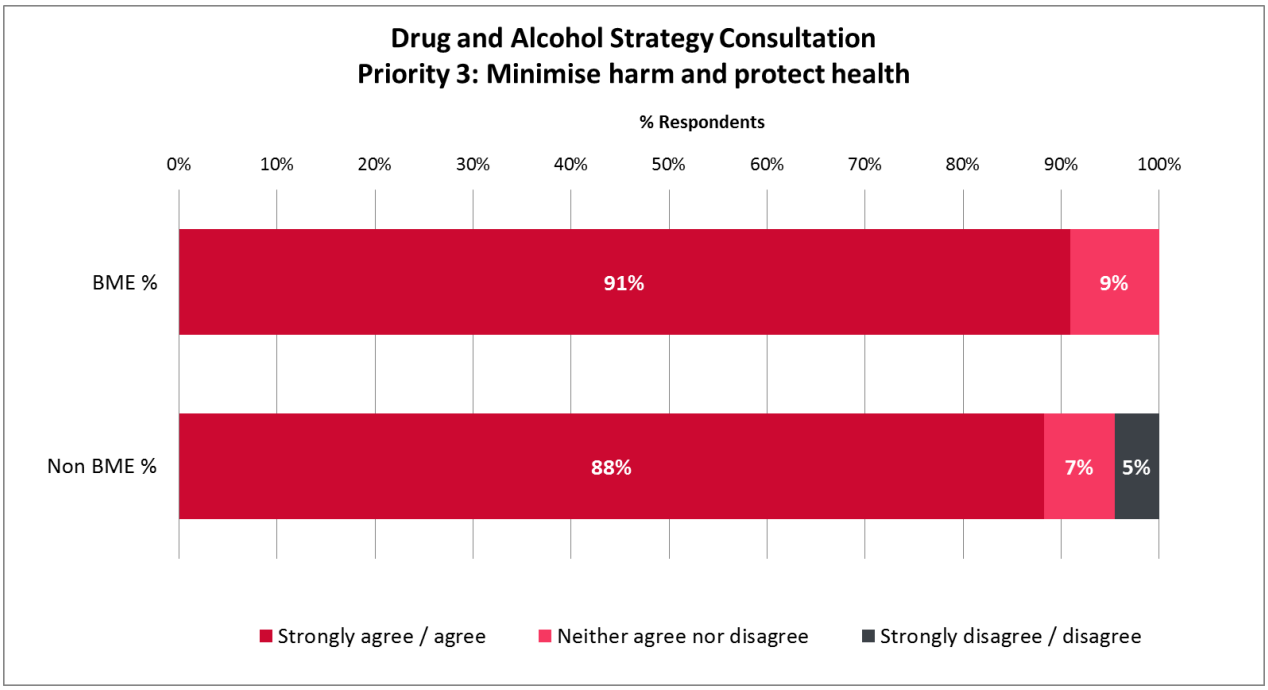


Figure 25 Ethnicity - Priority 4

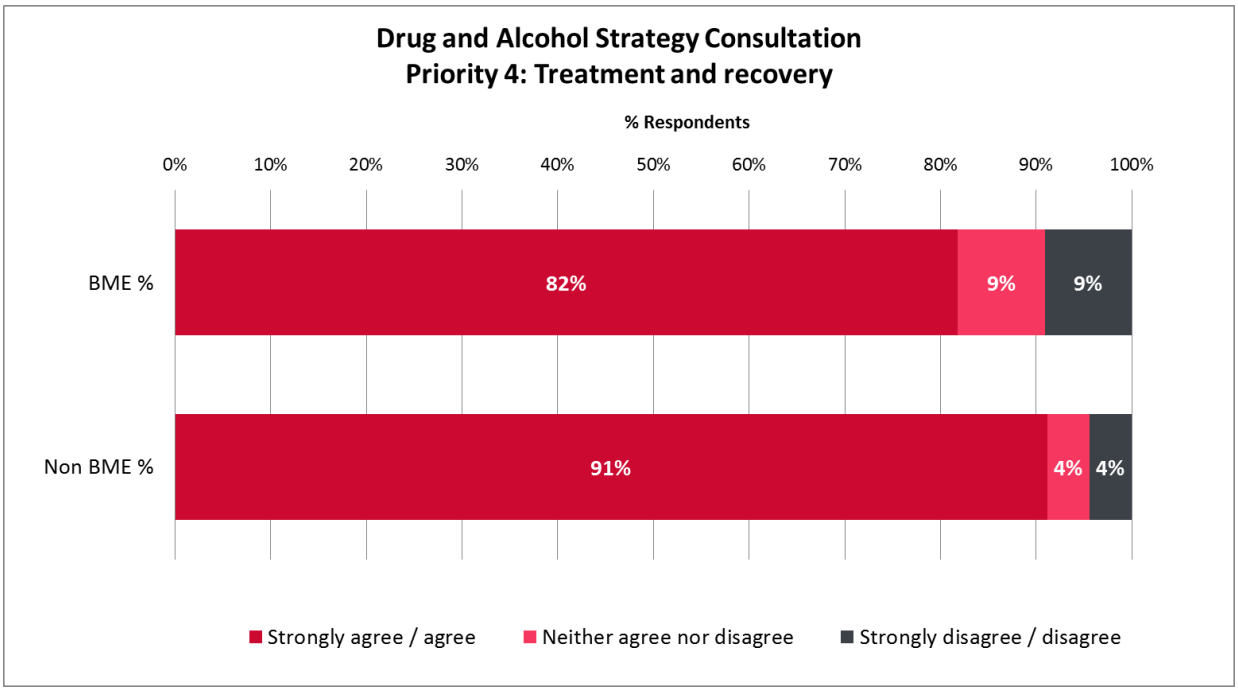


Figure 26 Ethnicity - Priority 5

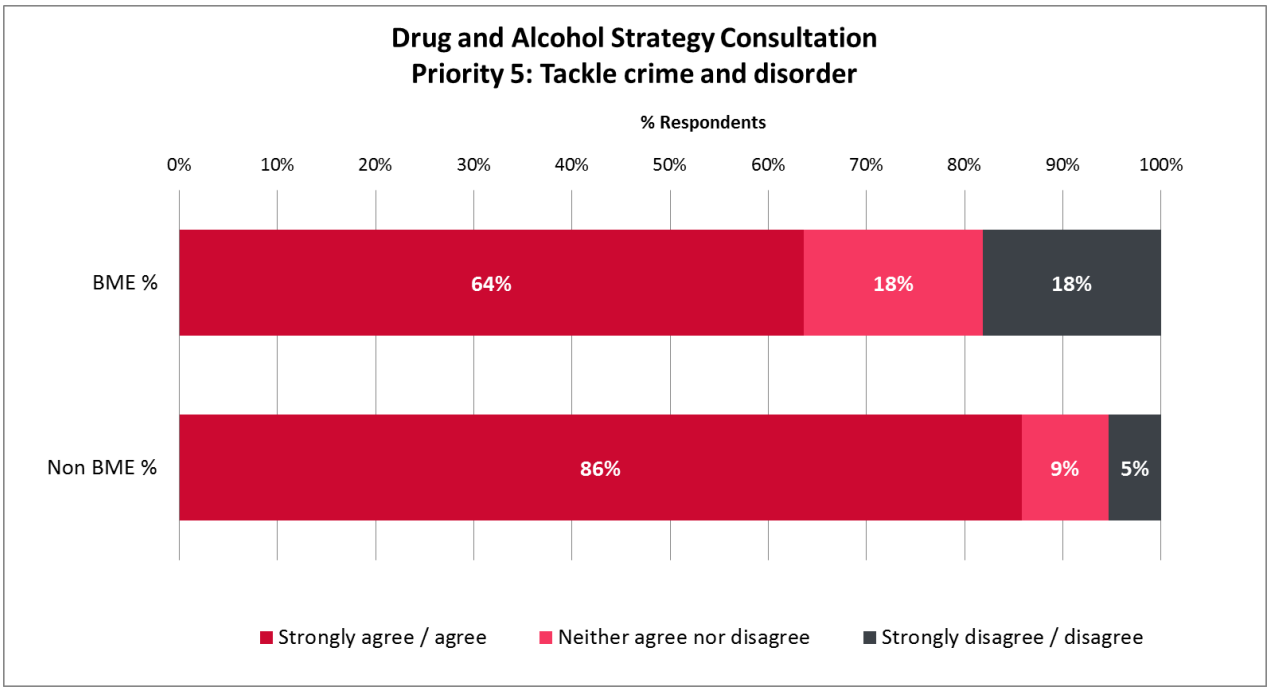


Figure 27 Ethnicity - Priority 6

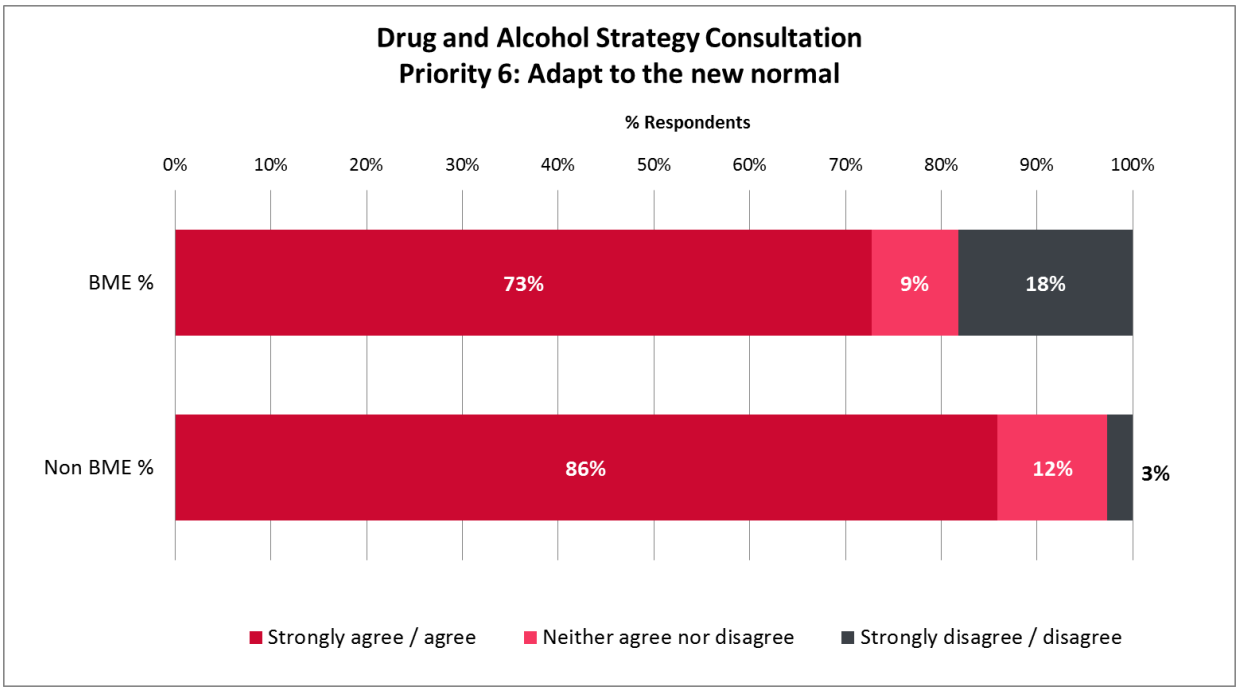


Figure 28 Disability - Vision

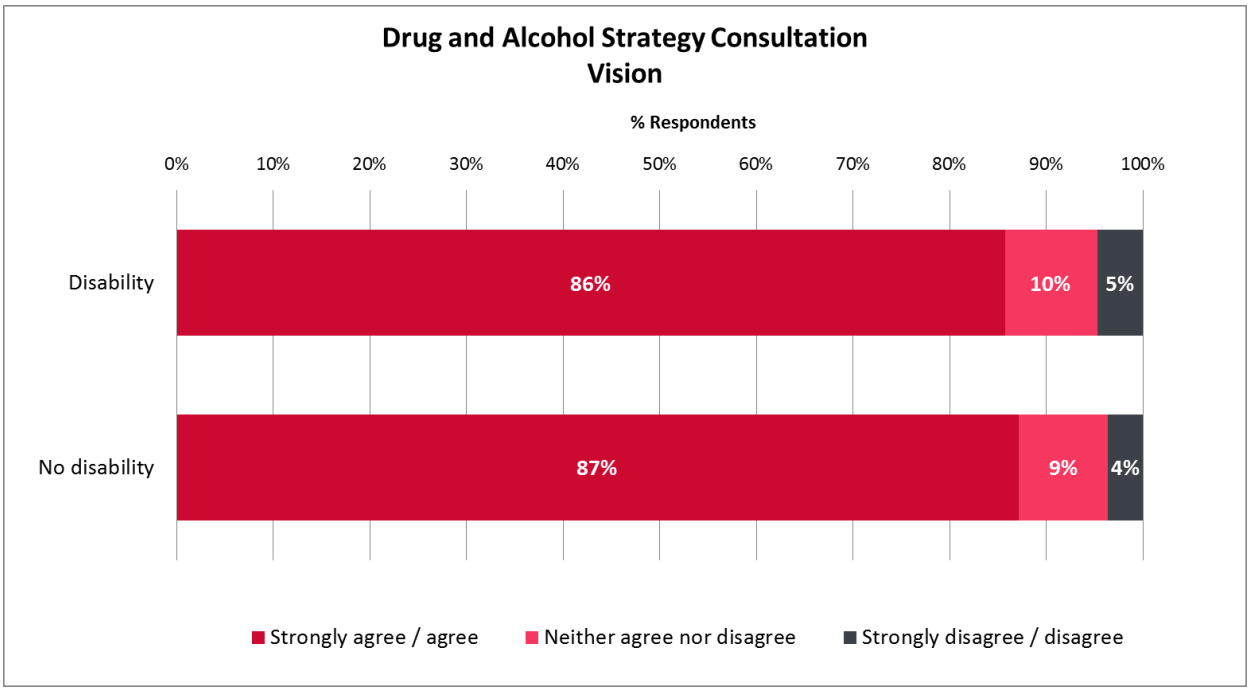


Figure 29 Disability - Priority 1

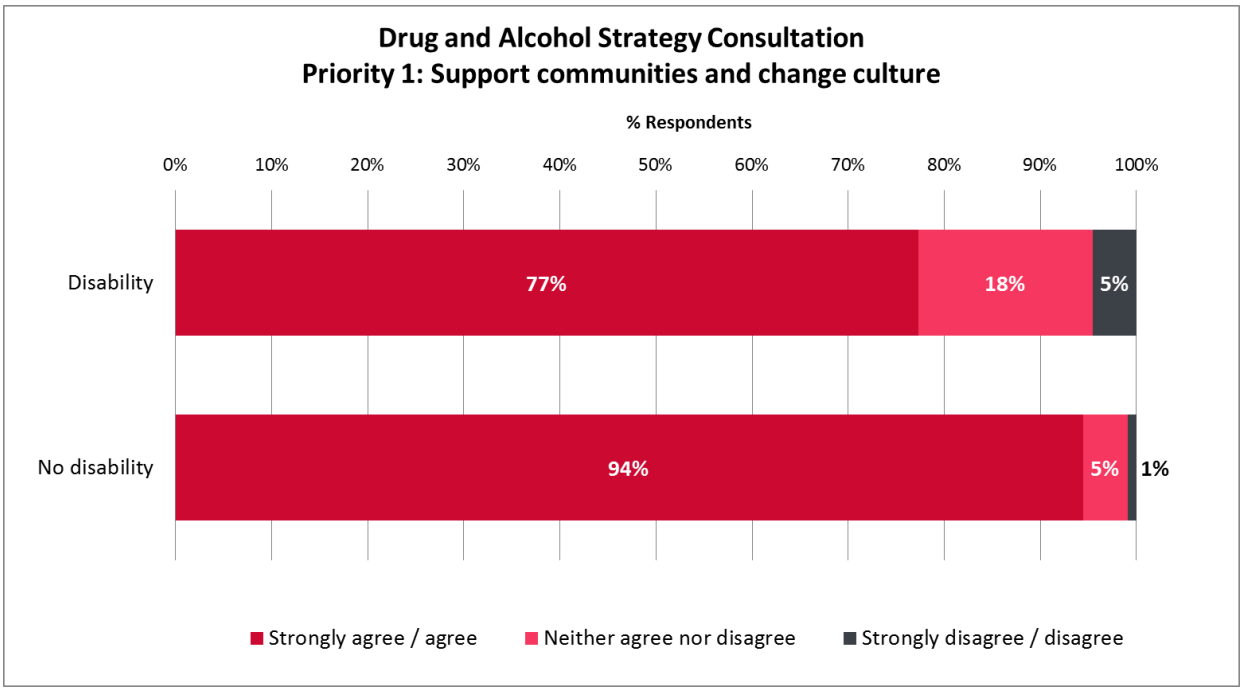


Figure 30 Disability - Priority 2

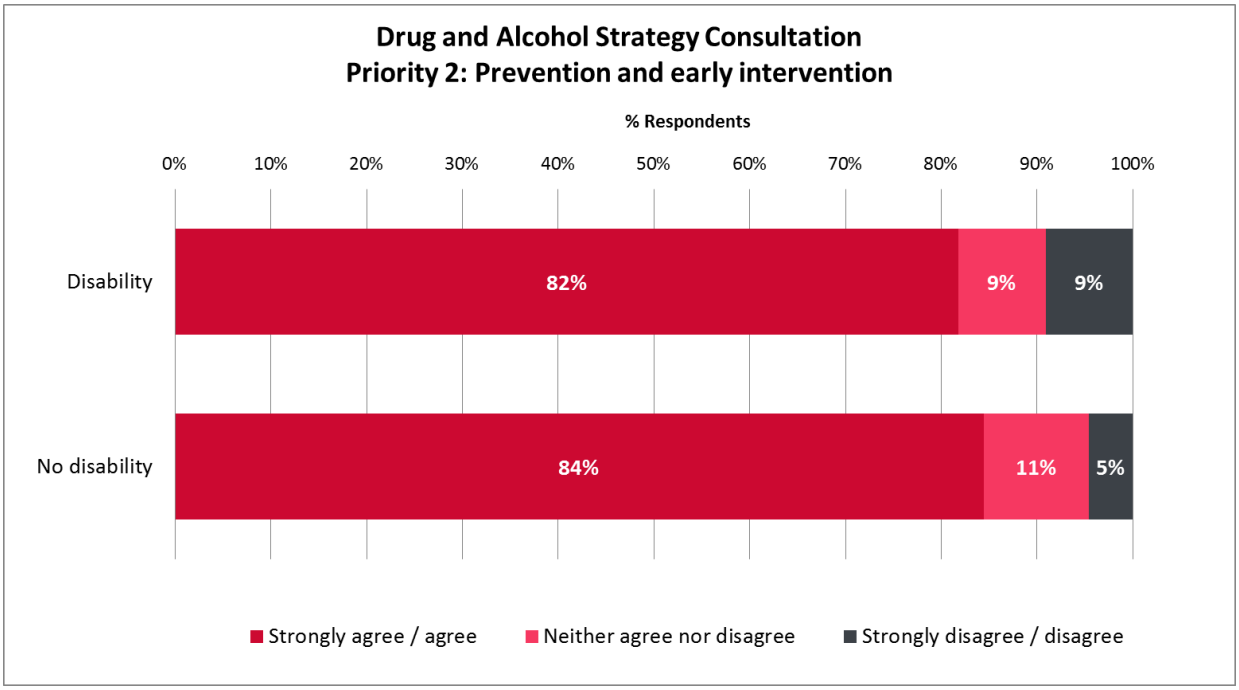


Figure 31 Disability - Priority 3

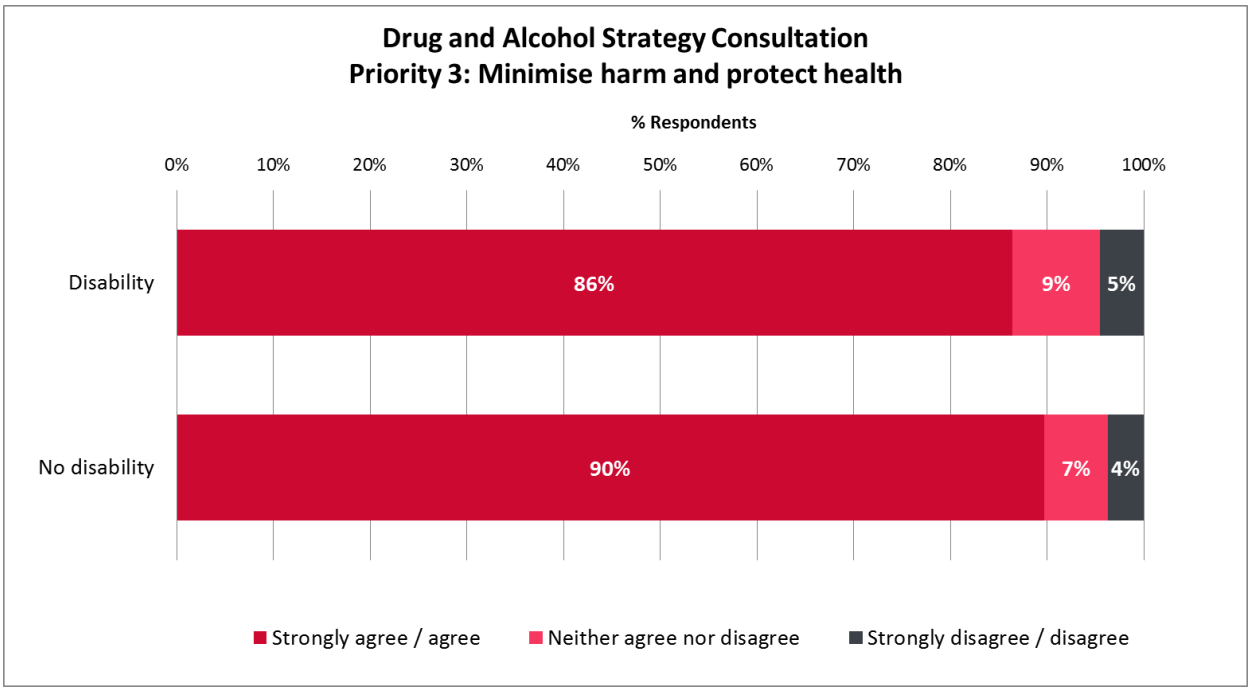


Figure 32 Disability - Priority 4

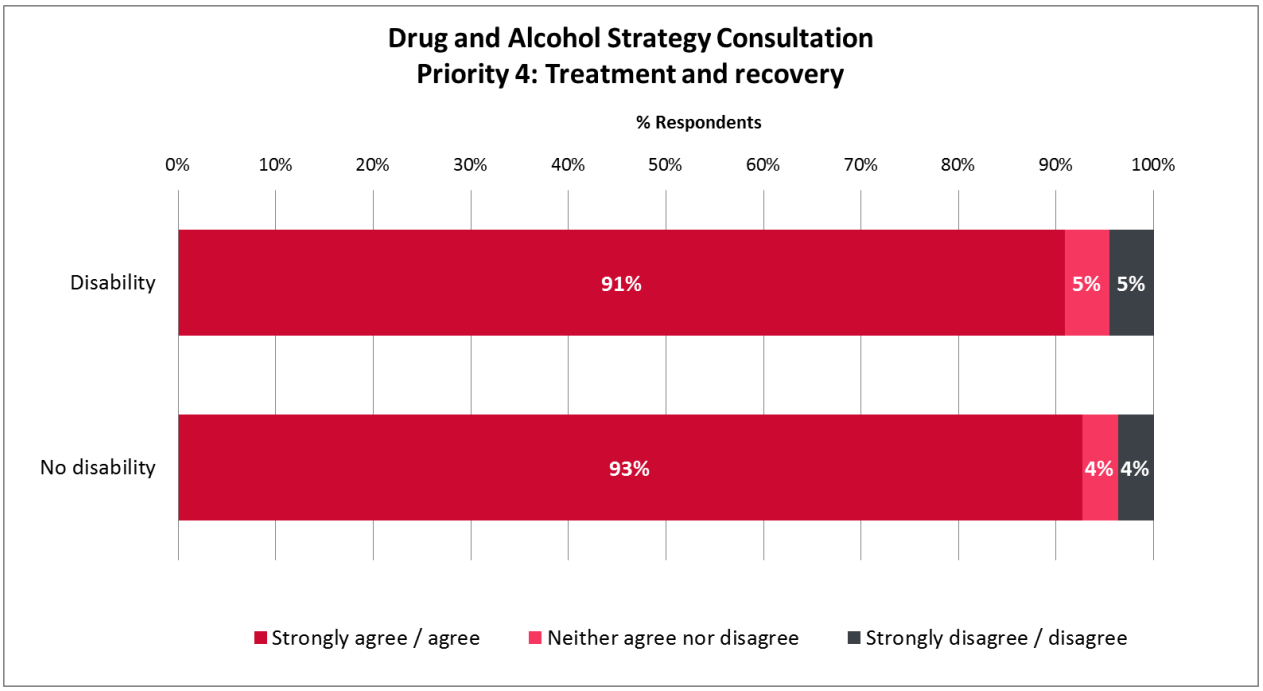


Figure 33 Disability - Priority 5

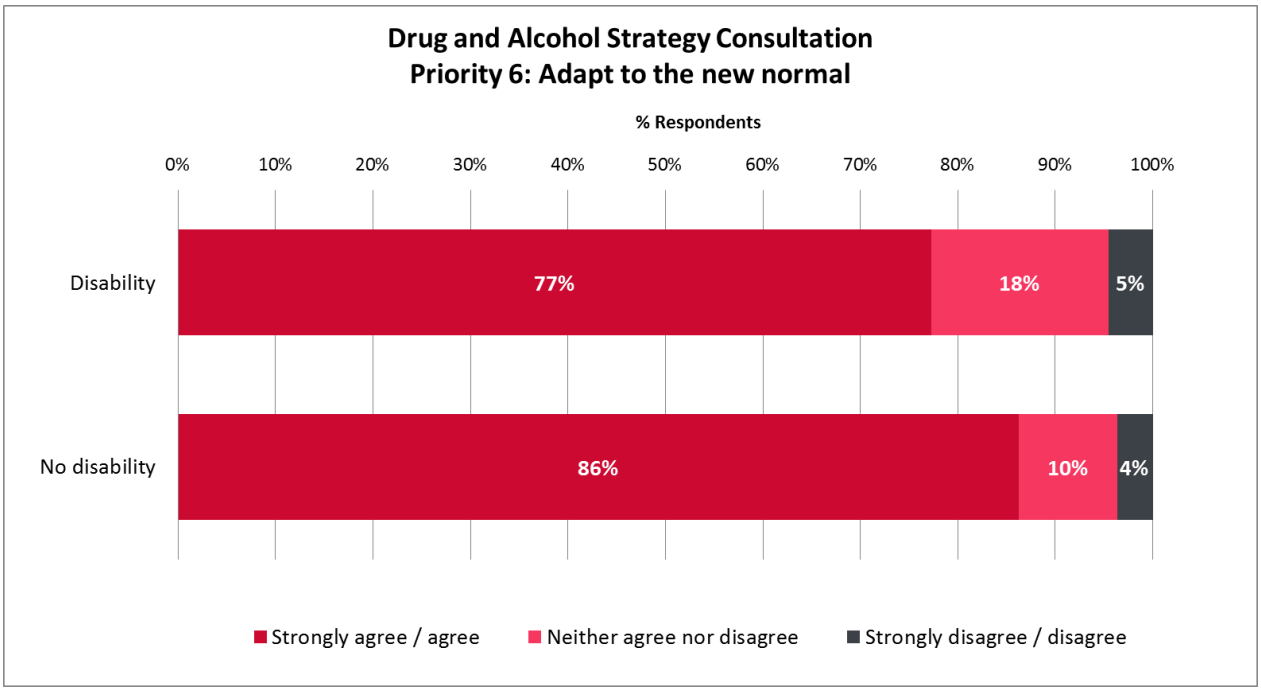


Figure 34 Disability - Priority 6

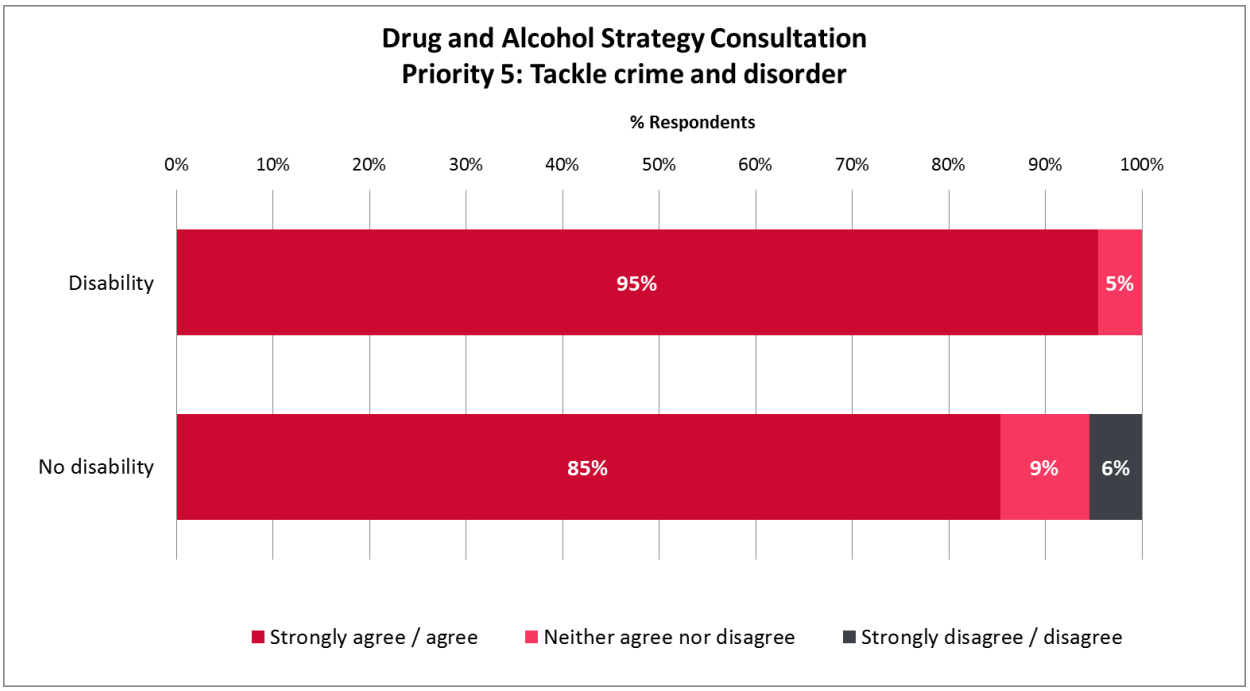


Figure 35 LGBT - Vision

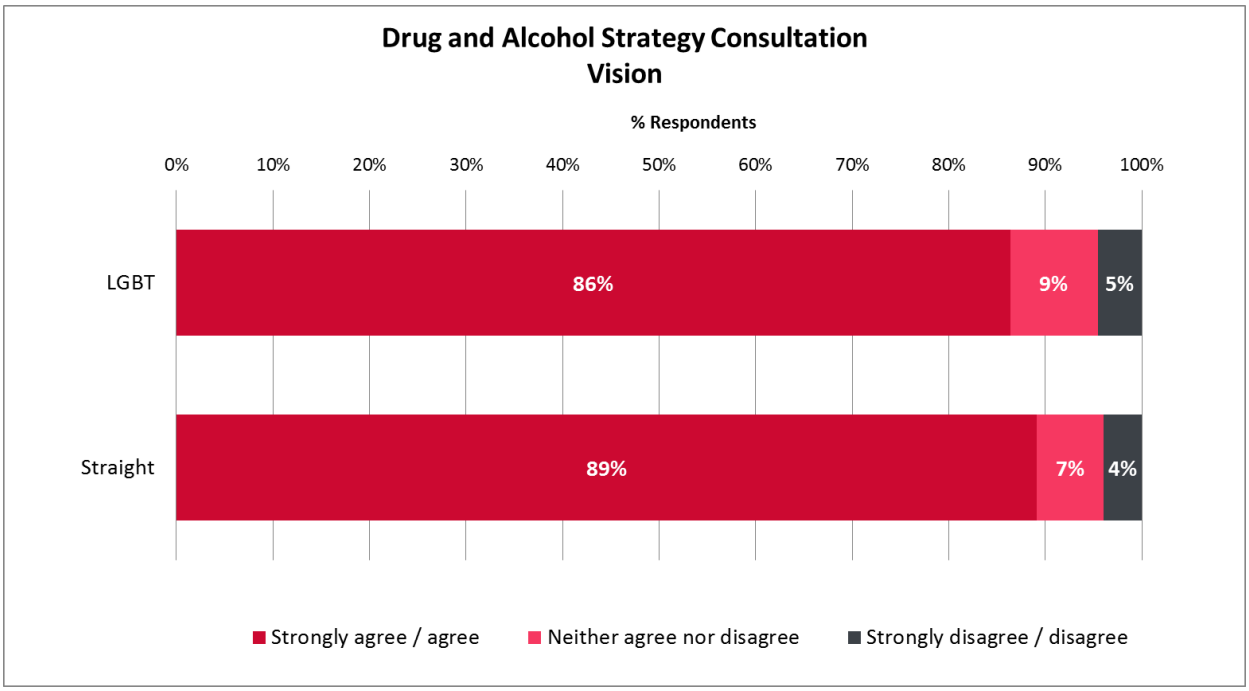


Figure 36 LGBT - Priority 1

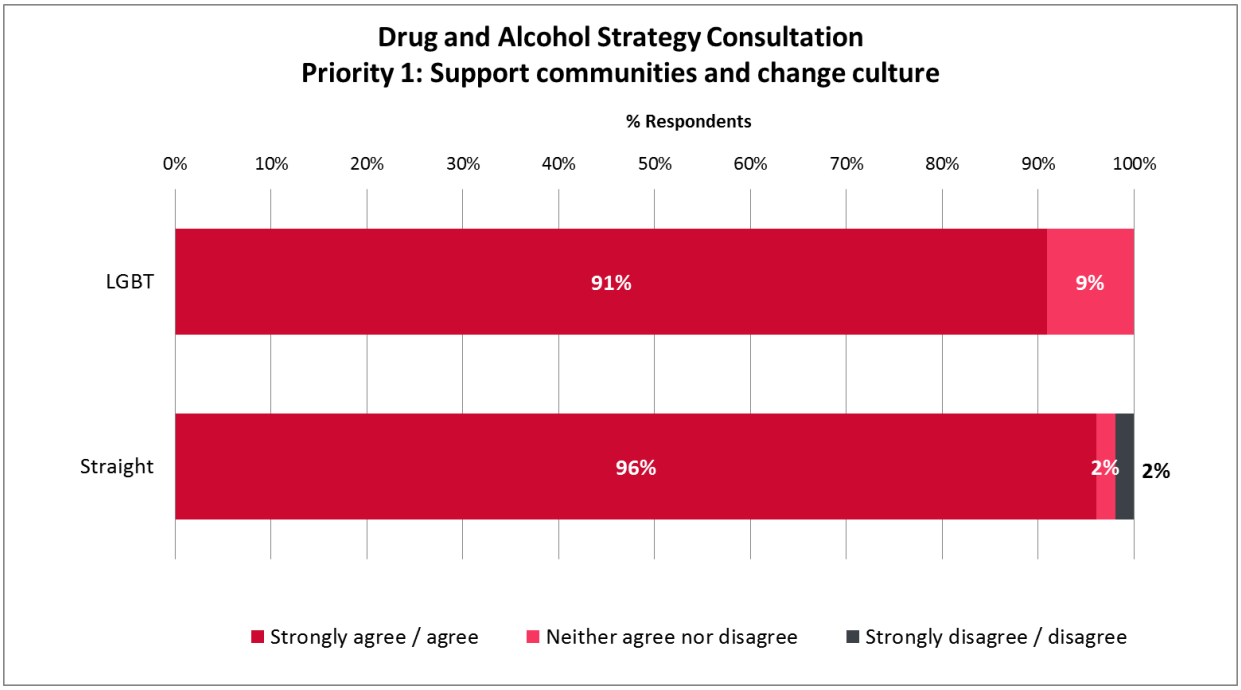


Figure 37 LGBT - Priority 2

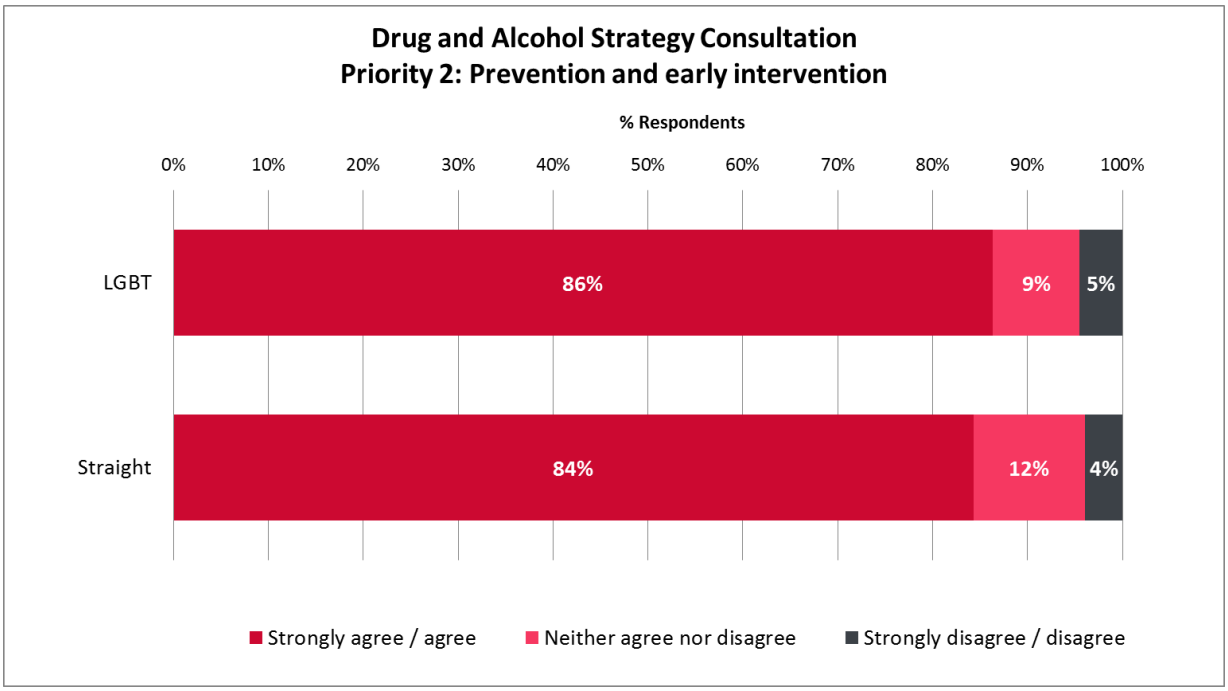


Figure 38 LGBT - Priority 3

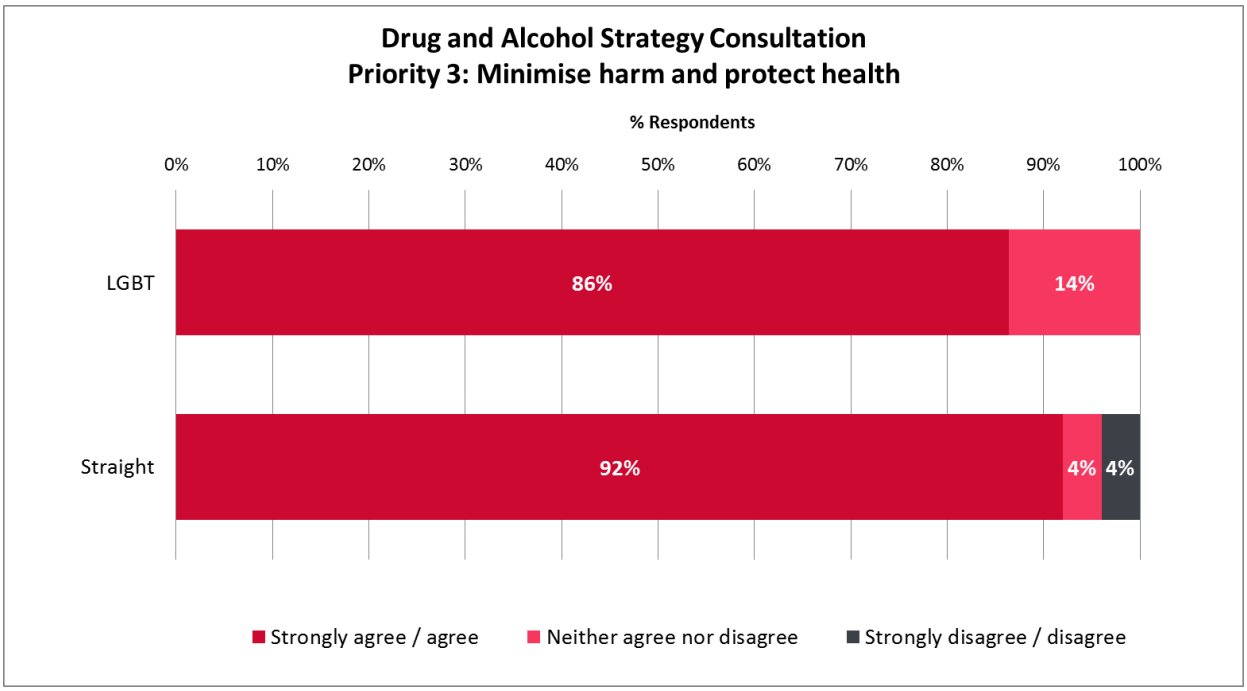


Figure 39 LGBT - Priority 4

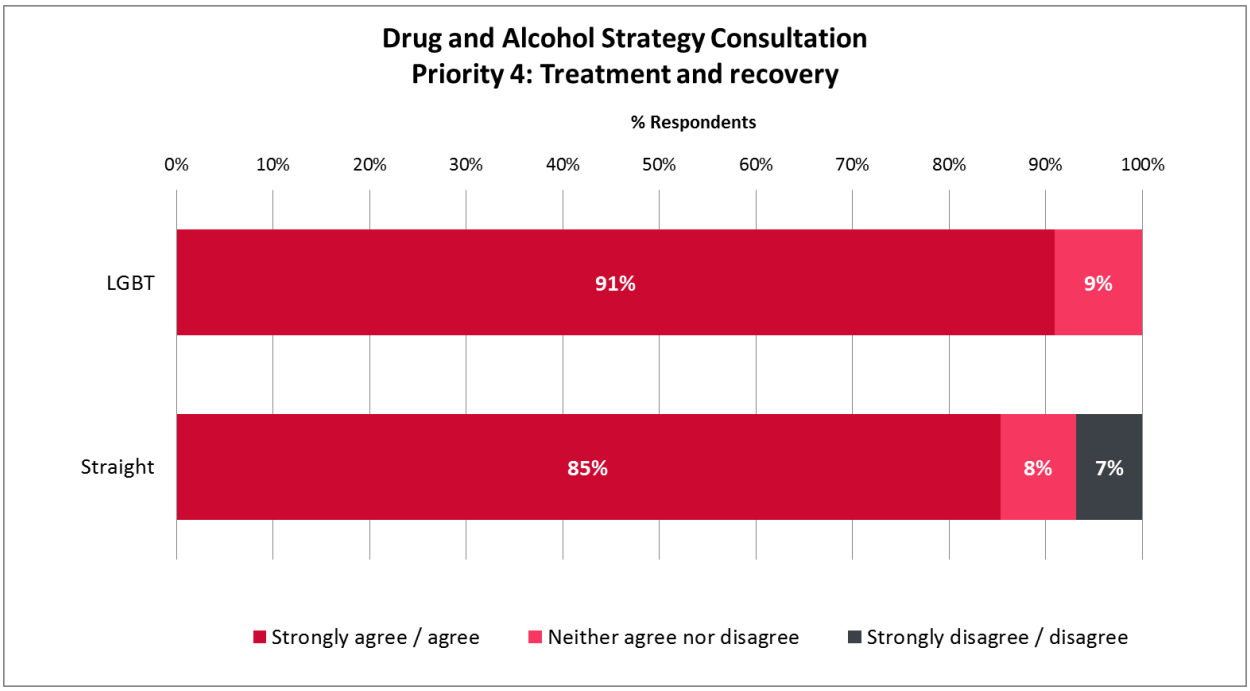


Figure 40 LGBT - Priority 5

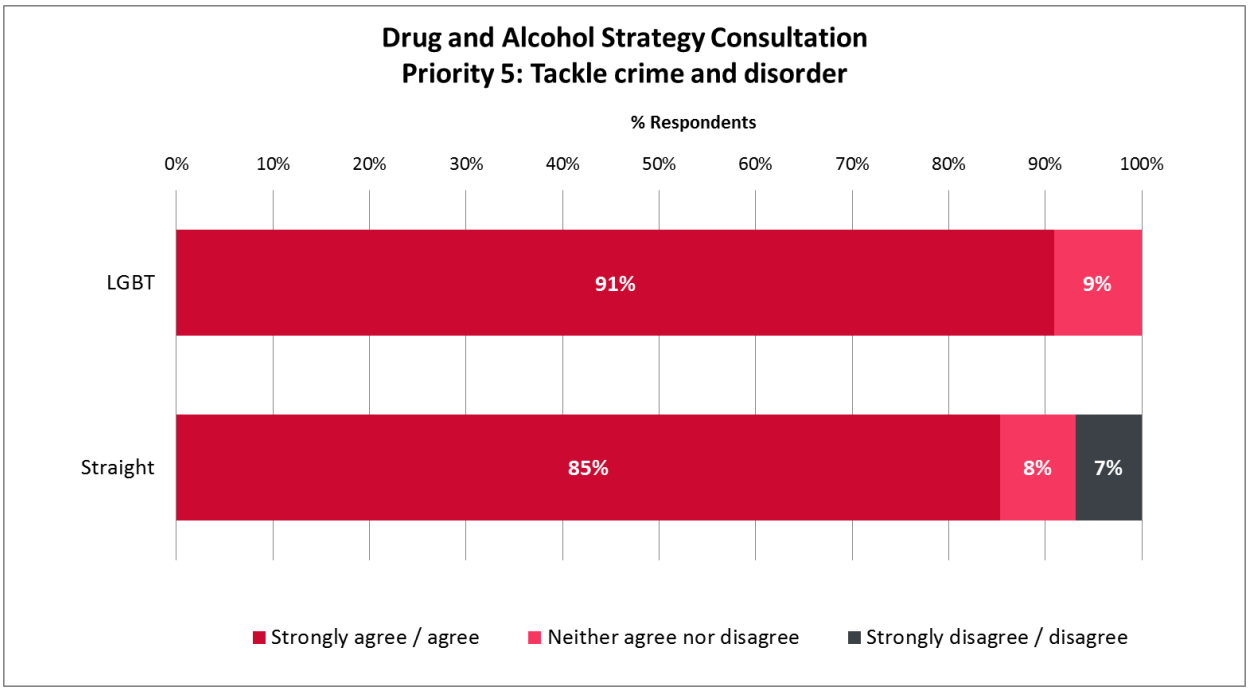
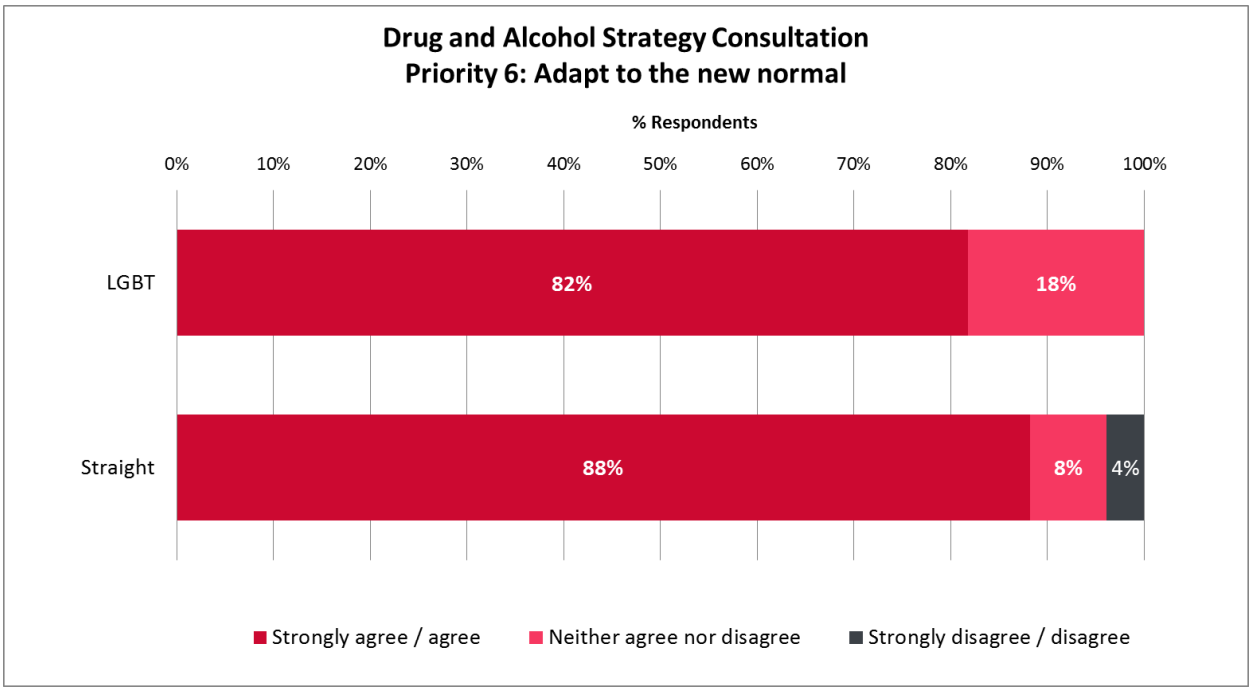


Figure 41 LGBT - Priority 6



5 Survey results: Comments on the Drug and Alcohol Strategy

5.1 Overview

In question 10, respondents were invited to provide their comments on the draft drug and alcohol strategy.

In question 11, respondents were invited to provide their comments on the draft equalities impact assessment and to provide suggestions on how to make drug and alcohol support more accessible and inclusive.

Respondents provided a view on both the drug and alcohol strategy and the equalities impact assessment in question 11, therefore responses to questions 10 and 11 have been analysed and summarised together.

137 (91%) of the respondents provided free text feedback to these questions. All comments were categorised into themes which are summarised below[5].

- 51 comments were categorised under the theme Priority 1: Support communities and change culture
- 87 comments were categorised under the theme Priority 2: Prevention and early intervention
- 25 comments were categorised under the theme Priority 3: Minimise harm and protect health
- 173 comments were categorised under the theme Priority 4: Treatment and recovery
- 47 comments were categorised under the theme Priority 5: Tackle crime and disorder
- 4 comments were categorised under the theme Priority 6: Adapt to the new normal
- 29 comments were categorised under the theme Equality, Diversity and Inclusion
- 49 comments were categorised under the theme Other

5.2 Priority 1: Support communities and change culture

- 10 comments said the strategy should recognise differences between communities and cultures and offer tailored or culturally appropriate support
- 9 comments said the strategy should focus on reducing the stigma of D&A use and/or increasing compassion towards D&A users

[5] Because respondents commented on multiple issues, the total number of comments is greater than the 137 respondents

- 8 comments said communities need to be strengthened/ invested in / better resourced to increase resilience against effects of D&A use and /or reduce community-based causes of D&A use (e.g. poor community resources)
- 8 comments said the strategy should commit to working with night time economy businesses to reduce D&A consumption, change binge drinking culture and reduce harms
- 5 comments said the strategy should focus on reducing D&A consumption by promoting or rewarding alternative behaviours
- 3 comments said alcohol and drug use are a problem in the UK
- 3 comments said place-based approaches (e.g. alcohol-free spaces) won't have an impact on city-wide consumption and/or are difficult to enforce
- 3 comments said the strategy too accepting of D&A use and/or should focus on reducing the acceptability of D&A use
- 1 comment said to reduce the number of sex establishments in Bristol to reduce D&A consumption
- 1 comment said the strategy's focus on changing culture is patronising / nanny state

5.3 Priority 2: Prevention and early intervention

- 26 comments said the strategy should take (more of) a trauma / Adverse Childhood Experiences / mental health informed approach to D&A prevention and early intervention
- 12 comments said the strategy should acknowledge the role of mental health support for CYP in reducing D&A use later in life
- 11 comments said early intervention is important and/or effective in reducing D&A use
- 8 comments said educating (young) people on safe / less harmful D&A use is more effective than education that focuses on abstinence
- 8 comments said the strategy should include a commitment to provide support for families and children of D&A users (preventing later in life D&A use among children of users)
- 7 comments said the strategy should acknowledge the role of holistic support for CYP / families in reducing D&A use later in life / reducing impacts of ACE
- 4 comments said D&A education should be delivered to adults as well as CYP
- 4 comments said D&A education should be delivered to younger (primary-aged) CYP
- 4 comments said prevention and/or early intervention does not work or does not reduce D&A consumption
- 2 comments said the strategy needs to reference the prevention of violence against women (D&A are used to facilitate VAW)
- 1 said drug education should be more honest about the harms of alcohol

5.4 Priority 3: Minimise harm and protect health

- 8 comments said drug testing should be (more widely) available
- 6 comments said safe drug consumption rooms should be offered
- 4 comments said the strategy should focus more on reducing harm and less on promoting abstinence
- 2 comments said offer women-only consumption rooms should be offered
- 2 comments provided ideas for reducing harms associated with alcohol
- 2 comments said the strategy needs to be clearer on what drugs are the priority or what drugs cause the most harm
- 1 respondent said the strategy should include a focus on reducing suicide among (young) D&A users

5.5 Priority 4: Treatment and recovery

- 25 comments said the council should increase the quantity / quality of D&A support available, or increase funding for D&A services, or said there is poor service provision currently
- 21 comments said D&A services must be made more accessible
- 13 comments said D&A service users need more holistic support or that D&A services need to provide more holistic support (e.g. housing, employment)
- 13 comments said to provide D&A users with mental health support in addition to D&A support (dual support) as part of their treatment
- 11 comments said D&A services need to work in a more mental health-informed way and / or that mental health services need to work in a more D&A informed way
- 8 comments said better after-care is needed for those in recovery
- 8 comments said D&A services need to be more targeted at people with additional needs or those who experience more barriers to support
- 7 comments said community services need to be more joined up, talk to each other more, train each other and / or work more closely with the council
- 7 comments said community services need to be more localised or said to increase availability of local community services
- 7 comments said D&A services need to be more patient-centred or patient-led and / or need to empower service users
- 7 comments said D&A support needs to be more bespoke and / or responsive to individual needs
- 7 comments said more 1:1 or link-worker model support is needed

- 7 comments said the strategy needs to focus on plugging gaps in provision to stop patients "falling through" gaps
- 6 comments said the strategy should commit to providing more or better quality treatment services for CYP (separately from adult services)
- 5 comments provided ideas for D&A treatment
- 3 comments said D&A services need to be better regulated and / or more transparent
- 3 comments said GPs need more training as gatekeepers of support
- 3 comments said more focus is needed on recreational drug use (as opposed to long-term addiction) in the strategy
- 3 comments said to provide more support for cannabis users or users of less harmful drugs
- 2 comments said more information is needed on how the D&A strategy will approach people who do not want help or provided suggestions for enforced treatment
- 2 comments said multiple D&A services creates barriers (being passed back and forth), or said support should be streamlined with fewer service providers
- 2 comments said the strategy should focus on increasing support for those who want help (rather than "nudging" people who haven't sought help)
- 2 comments said the strategy should focus more on treatment than on prevention
- 1 comment said support for drugs and support for alcohol should be separate services

5.6 Priority 5: Tackle crime and disorder

- 17 comments requested improvements to the safety of or police presence in neighbourhoods or the centre
- 13 comments said to approach drug use as a health and / or social issue, not a criminal one, or said drugs should be decriminalised
- 6 comments said the strategy should focus on reducing crime and disorder associated with D&A use (ASB, street drinking, graffiti)
- 4 comments said to approach drug use as a criminal issue (not health/social) or asked for a crackdown on drug use
- 4 comments asked for a crackdown on drug dealing
- 1 comment said to allow communities to report drug dealing anonymously
- 1 comment said to approach drug misuse as both health and criminal issue; that balance is needed between the two
- 1 comment said the strategy should commit to providing support for victims of D&A-associated crime

5.7 Priority 6: Adapt to the new normal

- 1 comment said national government campaigns to support the night time economy post-COVID would be counterproductive to the aims of the D&A strategy
- 1 comment said drinking in public places (e.g. parks) has increased due to COVID
- 1 comment said funding cuts (to staffing/provision) post-COVID should be avoided (priority 6.3)

5.8 Equality, Diversity and Inclusion

29 people provided feedback on the equalities impact assessment, or made recommendations to make drug and alcohol support more accessible and inclusive.

The comments are summarised in table 1.

Table 1

Characteristic	Number of comments	Summary of comments
LGBT	9	• LGBT-specific support/prevention is needed (high D&A use among group) • Use of party drugs in LGBT community not referenced in strategy • Use of party drugs in LGBT community not referenced in strategy - needs targeted approach • More trans/gender-identity specific support need to be provided
Disability	4	• Hidden disabilities (LD, autism) needs to be a focus/ more tailored support required • Support venues need to be more accessible for physical disabilities
Gender	4	• Need to recognise that women are less likely to seek help (more stigma, risk of children being removed) – need tailored services and prevalence data is unrepresentative • Need more services tailored to women • Strategy needs to focus more on D&A use

		among pregnant women (addressing FAS)
Ethnicity	2	• Alcohol use in BME communities should be an area of focus • D&A use among GRT not mentioned
Age	1	• Older people need tailored support
Equality / diversity of D&A services	3	• D&A service providers need to be more diverse/ less discriminatory/ more reflective of the communities they serve • ED&I should be built into contracts/KPIs • Need an independent review of inequality in D&A service provision
Feedback on the Strategy / EqIA	3	• EqIA not reflective of the D&A problem in Bristol • Strategy needs to be informed by views of a diverse range of D&A users • Use of date rape drugs not mentioned in strategy
Other	3	• Sex workers need tailored support • More support needed for asylum seekers/refugees (including MH/trauma support) • Prisoners/ex-prisoners need tailored support

5.9 Other comments

- 14 comments said the strategy lacks detail, or data or is not specific enough
- 10 respondents provided positive feedback on strategy
- 9 comments said the strategy is too long, has inaccessible language and/or uses too much jargon
- 7 comments said the strategy should focus on ways to incorporate service users into decision-making
- 4 comments said the strategy should commit to learning from approaches / interventions in other countries
- 2 comments said the strategy is not deliverable at local level (needs changes at national level)
- 2 comments said the strategy should commit to leading on or advocating for new approaches / interventions

- 1 comment said method in which the success of the strategy will be measured is not mentioned in the strategy

6 Other correspondence on the Drug and Alcohol Strategy

6.1 Meetings

6.1.1 Overview

Council officers held meetings with six partner organisations across the city to review the draft Drug and Alcohol Strategy and invite comments. The organisations who took part in these meetings is summarised in table 2.

The meetings held during the consultation period were in addition to engagement workshops and development meetings attended by numerous stakeholders throughout 2020, which helped to inform the consultation draft strategy. A full list of these stakeholders is provided within the strategy acknowledgements.

Table 2

Type of organisation	Name of organisation
Interest groups / boards	Keeping Children Safe Group (of the KBSP) Bristol City Youth Council Bristol at night board
Clinical Commissioning Group Partnership Board	South Bristol BNSSG Partnership Board
Universities	UoB/UWE Multi-agency drugs group

Analysis followed a similar approach to analysis of the feedback in open text questions of the questionnaire. Respondents' comments were grouped and categorised.

Comments are categorised into the following four main themes[6]:

- Priority 1: Support communities and change culture
- Priority 2: Prevention and early intervention

[6] Because attendees commented on multiple issues, the total number of comments is greater than the six meeting attendees

- Priority 3: Minimise harm and protect health
- Other

Each of these is summarised in the following sections 6.1.2 – 6.1.5.

6.1.2 Priority 1: Support communities and change culture

The comments and suggestions made by attendees on supporting communities and change culture are summarised below:

- One attendee suggested that the strategy should consider contextual and place-based safeguarding approaches for children and young people (e.g. police presence in parks)
- One attendee said the council should involve wider communities (not just drug and alcohol users and services) in developing and implementing the Drug and Alcohol Strategy
- One attendee said the council should work closely with voluntary and community sector in developing and implementing strategy

6.1.3 Priority 2: Prevention and early intervention

- One attendee said children and young people need to be represented and involved in the strategy moving forward
- One attendee said the council should focus on reducing the accessibility of drugs and alcohol for children and young people
- One attendee said the strategy should focus on reducing the number of children and young people who drink in parks
- One attendee said the strategy should focus on providing children and young people with alternative, healthy activities
- One attendee called for better drug and alcohol education for children and young people
- One attendee said the strategy should focus on drug and alcohol use among all young people, not just university students

6.1.4 Priority 3: Minimise harm and protect health

- Drug testing should be provided in universities
- The strategy should focus on the excess amount people drink before and / or after going to an event
- The strategy should consider alcohol delivery companies
- Venues and establishments need support (from the council) to provide drug testing
- Intelligence on the amount, content and / or safety of seized drugs need to be shared with the public

- Venues would like a more coordinated approach to drug possession that moves away from zero tolerance
- Drug consumption near to venues should not be included in data on consumption within venues
- Road safety teams need more involvement in preventing drink driving

6.1.5 Other

One meeting attendee queried whether the “prevention” focus in the vision includes prevention of harm.

6.2 Email responses

6.2.1 Overview

The consultation received six email responses from partner organisations in the city and one survey response from University of Bristol which has been analysed with the email responses. The organisations that provided email responses summarised in table 3.

Table 3

Type of organisation	Name of organisation
Police and crime	Avon and Somerset Police Bristol Probation Service
Universities	University of Bristol
Local Authority	Bristol Public Health

Analysis followed a similar approach to analysis of the feedback in open text questions of the questionnaire. Respondents’ comments were grouped and categorised.

Comments are categorised into the following four main themes[7]:

- Priority 1: Support communities and change culture
- Priority 2: Prevention and early intervention

[7] Because attendees commented on multiple issues, the total number of comments is greater than the six meeting attendees

- Priority 3: Minimise harm and protect health
- Priority 4: Treatment and recovery
- Priority 5: Tackle crime and disorder
- Priority 6: Adapt to the new normal
- Other

Each of these is summarised in the following sections 6.2.2 – 6.2.9

6.2.2 Priority 1: Support communities and change culture

- The council should work with other city councils on reversing drug-related trends
- The strategy should make a stronger reference to promoting low-alcohol alternatives

6.2.3 Priority 2: Prevention and early intervention

- Youth drug use is underestimated in population data
- Cannabis, amphetamine (including MDMA) and cocaine have the highest prevalence among children born in the 90s, therefore these drugs should be a focus in drug education
- Public health messaging and education around cannabis should focus on potency of cannabis (e.g. skunk) as well as frequency of use

6.2.4 Priority 3: Minimise harm and protect health

- Opioid agonist treatment (OAT) should be included in the harm reduction priority of the strategy
- Retention in Opioid agonist treatment (OAT) and managing “complex needs” / comorbidity is important to reducing overdose deaths, therefore should be emphasised in the strategy
- The strategy should commit to outreach provision of physical healthcare services targeted to people who inject drugs
- The strategy should commit to creating opportunities for supporting sterile injection and expand reach of effective harm reduction
- Strategy should focus on cost-effective tools to reduce the spread of the Hepatitis C Virus in people who inject drugs (e.g. needle programmes, offer both fixed and detachable low dead space syringes, providing training to pharmacy staff)
- The strategy should include the priority area of preventing invasive bacterial infections among people who inject drugs in and around Bristol

6.2.5 Priority 4: Treatment and recovery

- Evidence-based services need to be developed for managing alcohol use disorders in primary care
- The strategy should commit to providing support to people who use party drugs less harmfully (e.g. education, drug testing, safer places)
- Commissioners of drug and alcohol treatment services should consider how to communicate alternative routes to treatment, particularly in instances of domestic abuse.
- Bristol City Council should ensure the ROADS substance misuse treatment services are promoted through the city's business and commercial sector through Public Health's annual targeted health promotion campaigns.
- The strategy should include a commitment to provide separate treatment and support for patients dependent on prescribed drugs and to improve GP prescribing practices.
- The strategy should highlight the importance of trauma-informed drug treatment services for street sex workers

6.2.6 Priority 5: Tackle crime and disorder

- The strategy should include providing or enforcing drug and alcohol support for ex-offenders in the community or when leaving prison
- More information is needed in the strategy on the impact of reduced drug and alcohol use on offending / reoffending
- Policing of cannabis should focus on the highest potency cannabis (e.g. skunk)
- The strategy's intention to work more closely with Integrated Offender Management and join up services is welcome

6.2.7 Priority 6: Adapt to the new normal

- Needle and syringe street outreach programmes should be increased during COVID and pharmacy services should be maintained
- Overdose prevention efforts including Naloxone should be scaled up during COVID
- Changes to Opioid Substitution Treatment (OST) during the first lockdown (including less frequent collection, removal of supervised consumption and, rapid prescribing) should be maintained
- A mobile phone scheme should be provided to drug and alcohol users who lack phone/internet access in order to stay in touch with services during COVID
- The council should ensure outreach of mental health care during this time

6.2.8 Other

- The infographic in the strategy that provides data on drug and alcohol use (page 7) should focus on hazardous consumption, early exposure and public health harm
- Tobacco use should be included in strategy (harm reduction through vaping, preventing a gateway to substance use)
- The strategy should commit to improving the evidence base and supporting policy relevant research
- The strategy should refer to "drugs including alcohol" not “drugs and alcohol”

6.2.9 Equalities workshop

On 16 December 2020 an equalities workshop was held between council officers and professionals working in Drug and Alcohol, equalities and other organisations in Bristol. The meeting was held to collect feedback on the draft Drug and Alcohol strategy in relation to characteristics protected by the Equality Act 2010. Meeting attendees included:

- Public Health, Bristol City Council
- Equalities and Inclusion, Bristol City Council
- The Care Forum
- Bristol Drugs Project
- Bristol Women’s Voice

The points raised in the equalities workshop are summarised in table 4.

Table 4

Please find below a bullet point summary of discussions and points raised in relation to each equality group (as defined in the equalities act).

Age

- Impact of digital services, especially in a Covid-19 climate, has the potential to impact on access for older people and those who can’t afford it
- Greater focus towards prevention risks further stigmatising older people accessing services. Need services to be visible, e.g. with GP practices
- Young people often exploited as part of serious organised drug crime
- Need to link up with city-wide safeguarding work - if a young person is flagged for safeguarding issues, need to consider exposure to substances
- Housing of young people with unsecure housing (e.g. within hostels) could further expose them to alcohol and drug misuse

Gender

- Stigma experienced by women accessing treatment services, including risk of association with social services etc. if self-identifying issues
- Need for women-only and men-only services/groups

- Previously suggested that women highlighted lack of aftercare when completing treatment; women often have additional support needs related to the family unit
- Prevention activities also need to focus on violence against women and girls secondary to alcohol use. Need more data on this
- Using shared-cared approach for alcohol means that services can be localised, but also results in greater risk of being associated/seen with drug users
- Need to highlight the link between alcohol and sexual violence and exploitation towards women

Pregnancy and maternity

- Women less likely to attend treatment/services unless childcare is available
- Risk of missing opportunities for intervention and spotting concerns if Covid-19 has led to barriers to antenatal care/ health visitor visits etc.
- Link in with the Pause project from One25

Disability

- Individuals with learning disabilities and mental health needs benefit more from one to one work, which is flexible, for longer durations (not a lot of one to one available within the Community Recovery Service)
- However, group work does allow possibility for increasing tools for recovery and building networks
- Overall, flexibility is needed within the general support offer, as well as targeted treatments
- Accessible information is needed. Costs of accessibility rarely factored into funding; could be based on previous reasonable adjustment requests
- Mental health support needs to continue after drug and alcohol treatment; suggestion that the thresholds are currently too high for this, and therefore likely missing opportunities to prevent relapse
- Intersection of multi-disability (physical and mental) and therefore increased risk of substance issue and additional levels of complexity. Individuals with multi-morbidity continue to have to see multiple specialists/support services for their varying needs.
- There is a need to raise awareness of interactions of alcohol/drug use with prescription medication

Race

- The time, and day, of support sessions will be important to different communities
- Importance of language barriers - certain communities not served by named ROADS worker with language skills, or through sessions that are culturally sensitive.
- Given the sensitivity of issues, use of community translators often not appropriate
- The costs of interpreters etc. needs to be factored into funding; there is a potential for technology to address this gap
- Feasibility and balance between offering multiple bespoke services that are targeted to specific communities vs general services that are “accessible to all”

Faiths / religions

- There is a significant barrier to the acknowledgement of an individuals’ substance misuse if their faith forbids use of drug and alcohol; often requires a discussion around spirituality
- Faith leaders are important in accessing communities, but should be the sole representation as may not reflect reality. Can be denial from faith leaders of issues in their community.

- There is greater value from support services when designed from the bottom up

Sexual orientation

- The LGBTQ cohort is diverse; people cannot be catered for in one contingent. Gay males tends to dominate LGBTQ groups in terms of numbers
- There are few LGBTQ venues / socialisation opportunities not focused around alcohol
- Chemsex is a particular issue for this population; especially gay men
- PRISM and Freedom Youth are useful groups to link with

General discussion on other topics

- Accessibility of technology (especially important in a Covid-19 climate)
- Need flexibility of services - not everyone has internet / phone
- Mental health difficulties, such as anxiety, can be further barrier to technology use
- Older people - may not have access / feel comfortable using it
- Joined up data/technology between sectors
- Big barrier to treatment is people having to repeat their story multiple times; need one system (Theseus, RIO, EMIS)
- Intersectionality of equalities considerations, and the compounding effect of them on marginalisation
- There was not time to explore the role of the criminal justice system

7 How will this report be used?

The consultation feedback in this report is taken into account by officers in developing the final Drug and Alcohol Strategy 2020-2024.The final proposals are included in a separate report which, together with this consultation report, will be considered by the Keeping Bristol Safe Partnership, Keeping Communities Safe Group, the Health and Wellbeing Board, the Bristol Clinical Commissioning Group and the Bristol City Council Cabinet.

How can I keep track?

You can always find the latest consultation and engagement surveys online at www.bristol.gov.uk/consultationhub where you can also sign up to receive automated email notifications about consultations and engagements.