EQUALITY IMPACT ASSESSMENT AND ANALYSIS (EqIAA)

DRUG STRATEGY 2020 – 2025

SECTION 1 – INTRODUCTION

The previous combined substance misuse needs assessment completed by the Drug and Alcohol Programme was developed in 2016 and from it an alcohol strategy was developed but no equivalent for drugs was created. In 2018 it was agreed that we would develop two separate needs assessments and strategies (one for alcohol and one for drugs) because of the different priorities and issues which surround alcohol and drugs and the different ways that these impact on people's lives and our communities. These documents will, however, complement each other and form a strategic approach to tackling drug and alcohol related harm across the life-course in South Gloucestershire. They will also inform our commissioning intentions for the future. The alcohol strategy went out for formal consultation in December 2019 and was due to go to the Health and Wellbeing Board (H&WBB) for approval in March. However, due to COVID-19 this meeting was cancelled and it went to the Board in September and was approved. The drug strategy has now been written following the needs assessment and went out to consultation for 12 weeks from 5th August 2020. Post consultation, it has now been updated and is due to be approved by the H&WBB in December.

SECTION 2 –RESEARCH AND CONSULTATION

The needs assessment has been developed over six months and has combined consideration of best practice guidance and evidence, as well as data related to drug related harm in South Gloucestershire. We have sought input from a wide variety of partners in the development of key sections, including the police, social work staff and our treatment providers. We have also conducted an engagement exercise which has seen us talk to people who use our services and a wide range of stakeholders to understand their views about what the issues are in relation to drugs in South Gloucestershire and what should be prioritised in the new strategy. This has all been brought together in the final needs assessment and the recommendations from it form the basis for the strategy which sets out our ambitions to reduce drug-related harms for the next five years.

The needs assessment has highlighted certain groups with protected characteristics that may be adversely affected by drugs or drug-related harms and we aim to tackle these in our strategy.

During the needs assessment process we undertook engagement of relevant partners and stakeholders. Unfortunately due to the COVID-19 pandemic, we were unable to undertake the levels of engagement that happened during the alcohol strategy, for example holding stakeholder engagement sessions where we could discuss the issues face to face in groups. The alcohol strategy had a shorter consultation period due to the amount of engagement already done, but the drug strategy went out for formal consultation for the recommended 12 week period. We had hoped that by the time the consultation started, we would be able to conduct some face to face events, but unfortunately due to the continuation of the COVID-19 pandemic, this was not possible. However, engagement was still undertaken and this is set out below.

Table 1 sets out the engagement methods undertaken as part of the needs assessment and Table 2 those undertaken as part of the formal consultation of the strategy.

Table 1 – Table to show engagement methods undertaken as part of development of the needs assessment

Event /engagement	Method of engagement	Numbers attended
Staff employed by our provider services (DHI and AWP – 3 sessions over Zoom)	Set questions were asked of each group	22
Individuals or representatives of key organisations involved in preventing and addressing the impacts of drug use in South Gloucestershire	Semi-structured interviews	19
Stakeholders survey - professionals	Online survey	32
Survey of people that use our drug services	Online survey (please note some of these were completed by professionals whilst speaking to the person)	12
One to one interviews of people who use our services by their drug worker	Survey questions as above	35
Young people who use our Young People's drug and alcohol service (YPDAS) • One to one	Engagement with young people was difficult due to COVID-19 restrictions. However, feedback from the alcohol needs assessment engagement was used where relevant to drugs. We are therefore planning to conduct specific assertive engagement activities with young people during the consultation on the drugs strategy.	N/A

Table 2 – Engagement activities undertaken as part of the drugs strategy consultation

Name of meeting	Date
DHI staff event	15 November
SSCSP	9th October
CAH DMT	6th October
CCG Commissioning Executive	8th October
Members Briefing	14th October, 22nd October
CAP	8th September
DAP Strategic Steering Group	21st October
YP Performance group	13th October
Priority Neighbourhoods group	9th September
VRU meeting	30th September
UWE	30th September
Formal consultation survey	Throughout consultation period
Feedback from YP	Individual throughout consultation period

The following sets out information relating to Protected Characteristics which has been researched as part of the development of the needs assessment. This sets out both national and local information. (Please note that footnotes apply to references in the needs assessment and are not referenced here but have been left in for cross referencing purposes.)

Age

Drug use among young people is of particular concern, given the risks of drug-related harm and risk of escalation to more significant drug misuse over time. Data from the Online Pupil Survey suggests that in 2019, 9% of young people in South Gloucestershire attending secondary school and post-16 settings have tried an illegal drug. 9% of those who had tried an illegal drug reported using drugs most days. Risks of drug use were notably higher among young people who smoked tobacco often, as well as those with parents in the armed forces. The vast majority – 88% - of young people in drug treatment presented with cannabis as a problematic drug.

Two-thirds of those in young people's treatment were male (66%), the same proportion as seen over the last 2 years. The median age for both male and female was 15 years old. The number of younger children (aged under 14) in treatment remained relatively low, at 9%.

The age breakdown of adults in treatment services is representative of the national picture.

The highest rates of drug-related hospital admissions are seen amongst those aged 20-29 years, but with some slight variation by location and sex. In men, admission rates across England and the South West region are highest in those aged 20-39. In contrast, in South Gloucestershire there is little difference in admissions rates for 10-19, 20-29 and 30-39 year olds. Amongst females, admission rates were highest in 20-29 year olds.

Between 2015 and 2019, there were a total of 19 drug-related deaths and DIS in South Gloucestershire, nine of which were specifically categorised as drug-related deaths. The majority of those who died were male (n = 11, 58%), similar to the proportions seen nationally (19). The average age of death in this cohort was 42 years (40 years for males and 45 years for females). This is in line with national data, where the highest age-specific drug-related death rates were among those aged between 40 and 49 years for both males and females (19). In contrast, men in South Gloucestershire have an average life expectancy of 81 years, with this increasing to 85 years in women (74). This suggests that drugs are likely to have deprived this cohort of an average of 41 years of life for men, and 40 years for women.

Disability

Evidence suggests that substance misuse is less common among people with disabilities than the general population (118,119). However, it is important to note that people with disabilities are not a homogenous group. In addition we know very little about the majority of adults with disabilities, who have mild disabilities and therefore tend not to be using specialist support services. Research does indicate that this group are more likely to use drugs than those with different forms of disability (119,120). The most recent census data indicates that 16% of the population in South Gloucestershire had a disability that limited their day-to-day activities to some extent (121). In comparison, 30% (n = 67) of individuals presenting to drug treatment services for the first time had at least one disability, suggesting that people with disabilities may be overrepresented in drug treatment services. This may be due to the difference between a self-identified disability and one that is formally diagnosed. We need to ensure that drug services are accessible to people with a learning disability, in order to ensure that these individuals receive the support that they need.

Drug use and mental health are strongly interlinked, with the large majority (70%) of people in community treatment for drug use experiencing mental health problems (66). Individuals who experience poor mental health are more likely to become dependent on drugs, with dependency itself classified as being a mental illness (11). In turn, those who misuse or are dependent on drugs are more likely to experience mental health issues (67). The co-existence of issues with drugs (and/or alcohol) and mental health are often described as 'dual diagnosis'. Individuals who experience these co-occurring conditions often have particular issues with being excluded from services (68).

The majority (71%, n = 159) of individuals who newly presented to drug treatment services in South Gloucestershire in 2018-19 were identified as having a mental health treatment need, compared to 63% nationally. This was highest among those using non-opiates and alcohol in

combination, with almost all of this group needing mental health treatment (97%, n = 34). 74% (n = 48) of non-opiate service users and 62% (n = 77) of opiate service users had a mental health treatment need. For all drug categories, the need for mental health treatment was higher in females than males, which was a trend that was also replicated nationally.
67% (n = 107) of service users in South Gloucestershire with a mental health treatment need received treatment for their mental health. This was a similar proportion to those receiving mental health treatment nationally (71%). Of those receiving treatment, approximately half (52%, n = 82) were receiving mental health treatment from their GP. 16% (n = 26) were already engaged with a community mental health team or other mental health services.

The drug needs assessment identified an unmet need for mental health support among individuals accessing drug services in South Gloucestershire. The majority of people newly presenting to local drug services were identified as having a mental health need, with the highest need (97%) seen among those using non-opiates and alcohol in combination. However, approximately one-third of service users with a mental health treatment need did not receive any treatment for their mental health. Both service users and professionals from a range of backgrounds reported poor pathways and communication between drug services and mental health services, calling for individuals with a dual diagnosis to be offered a package of concurrent mental health and substance misuse treatment, and for services to be co-commissioned where appropriate.

Approximately one-third of young people (32%) who started treatment in 2018-19 reported a mental health treatment need, which is higher than the previous year (27%). A higher proportion of girls reported a mental health treatment need than boys (42% compared to 28%). In 2018/19, 45% of young people in treatment in South Gloucestershire were female compared to 34% across England.

Gender Reassignment

There is currently no South Gloucestershire-specific research information available.

Marriage and Civil Partnership

There is no definitive evidence to suggest that people in a marriage or civil partnership have any specific needs in relation to drugs.

Pregnancy and Maternity

Drug use in pregnancy can lead to both long- and short-term harms to the baby. This includes an increased risk of mortality as well as behavioural and developmental outcomes, with the specific risks depending on the drug being used. Nationally, approximately 1% of pregnant women report currently misusing illicit drugs, solvents or medicines at their antenatal booking appointment (50). There are clear associations between antenatal drug use and inequalities, with this proportion increasing to 2.5% among women living in the most deprived areas and 2.4% among women of mixed ethnicity (50).

Structured drug treatment is available to pregnant women who need support to stop using drugs and is delivered by specialist drug and alcohol staff as described in the Services section of this document. Fewer than five females who were newly presenting for drug treatment in South Gloucestershire in 2018-19 were pregnant. This was lower than the national figure of 4%.

Race

A higher proportion of young people in treatment in South Gloucestershire were White British (88%) than seen nationally (76%). This is not surprising given the small proportion of people from Black and minority ethnic (BAME) groups living in the local area – 90% of South Gloucestershire residents aged both 0-15 years and 16-24 years are White British, suggesting that the proportion of

young people in treatment from BAME groups in South Gloucestershire is representative of the area's ethnic breakdown (112).

The vast majority - 91% (n = 203) - of new presentations in South Gloucestershire in 2018-19 were White British. 3% (n = 6) were categorised as being of 'Other White' ethnicity. There were fewer than five individuals of Black, Caribbean or Mixed ethnicities. This is very closely aligned with the ethnic breakdown of South Gloucestershire as a whole. 97% (n = 218) of those newly presenting to drug treatment services were from the United Kingdom. However, simply comparing these proportions may not tell the full story – there may be particular issues within certain ethnic groups that we are not aware of. We do not know enough about the experiences of black and minority ethnic (BAME) groups, both accessing and not accessing drug services, and we therefore need to work more specifically with these groups to find out more about their experiences. At a recent meeting set up by Bristol Drugs Project and Nilaari with members of the BAME community and people of varying faiths, it was raised that there are issues within those communities in relation to drugs that are not talked about or dealt with. It is very likely that conventional drug services are not accessible or seen as approachable for people in those communities for a whole host of reasons, whether this be stigma, language and cultural barriers, or wider issues around structural racism. It is important to ensure that additional support such as interpreters are available and can be funded where required.

Religion or Belief

The majority of adults newly presenting to drug treatment services in South Gloucestershire in 2018-19 reported having no religion (70%, n = 157). 19% (n = 43) reported being Christian. Fewer than five individuals reported having other religious beliefs, such as being Buddhist or Muslim.

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Sex

Two-thirds of those in young people's treatment were male (66%), the same proportion as seen over the last 2 years.

The Youth Offending Service (YOS) supports young people who are engaged within the Youth Justice system, providing 1:1 non-treatment interventions. During 2018-19, the YOS provided 32 interventions to 26 males and 6 females aged between 12 and 18 years.

Of the 659 individuals in adult drug treatment services during 2018-19, 68% (n = 448) were men. This is similar to the sex profile of individuals accessing drug treatment services across the country.

Despite the fact that there has been a reduction of the numbers of people in treatment and new presentations to drug treatment services, the proportion of people in South Gloucestershire who successfully complete drug treatment is substantially higher than the national average for all categories of drugs. 11.6% of all people using opiates in drug treatment services successfully completed treatment and did not re-present to drug services within six months, compared to 5.8% nationally. The proportion completing treatment for non-opiate use who did not re-present to drug services within six months was almost six times higher – 62%, compared to a national proportion of 34%. For non-opiates, this proportion was similar for both males and females. However, the proportion of males who successfully completed treatment and did not re-present within six months was 8.5%, half that of females (17.9%), although it is important to note that this is likely due to small numbers.

8% of individuals in South Gloucestershire who had newly presented to drug treatment services had an unplanned early exit from the service before the recommended 12 weeks of treatment had been completed. This is lower than the national average of 18%. However, there was a large difference in the proportion of early drop outs between males and females using both non-opiates and alcohol, with 17% of females leaving the service early compared to just 3% of males. This contrasts with the picture nationally, where the proportion of unplanned early exits is higher among males than females for all drug categories and suggests that more focus should be given to retaining females in drug treatment.

Nationally and regionally, males have a higher rate of drug-related hospital admissions than females. However, there is no difference between these rates for males and females in South Gloucestershire, with females actually having a slightly higher rate than males.
This lack of difference appears to be due to a marked increase in drug-related hospital admission rates among females in the area, doubling from 2011/12 to 2018/19. Admission rates for males in South Gloucestershire have increased steadily over the last decade, but remain significantly lower than the national and regional average. In contrast, while admission rates for females in South Gloucestershire were lower than both national and regional averages in 2010/11, the increase in admission rates among this group is so pronounced that drug-related admission rates for females in South Gloucestershire is now similar to the national average.

76% (n = 141) of people in drug treatment in South Gloucestershire reported smoking tobacco at the start of their treatment and smoking levels were relatively similar for males and females. These rates are far higher than the smoking rate among the general population, 16% for males and 13% for females (128).

Sexual orientation

Evidence suggests that drug use is associated with higher risk sexual behaviours, including unprotected sex and consequent sexually transmitted infections (STIs) (52). Young people, men who have sex with men (MSM) and commercial sex workers (CSWs) are thought to be at highest risk.

In South Gloucestershire, 93% of individuals presenting to drug services for the first time described themselves as being heterosexual. There is no accurate, local data on sexual orientation but the government estimate that between 5-7% of the population identify as lesbian, gay, bisexual, transgender or queer (LGBTQ+). 4% of those newly presenting to drug services in 2018-19 were bisexual and fewer than five individuals described themselves as either gay or lesbian, which is consistent with these national estimates. However, given that we know that MSM are more likely to use drugs problematically, services need to ensure that they are appropriately tailored to meet the needs of the LGBTQ+ community. Diversity within the LGBTQ+ community itself also needs to be acknowledged, with those from black and minority ethnic (BAME) communities likely having different needs.

Consultation

Formal consultation took place between 5th August 2020 and 28th October 2020. The consultation specifically requested feedback in relation to inequalities and groups at higher risk of drug related harms as well as the initial EQIAA.

The feedback gained via consultation, in respect of equalities related issues, is shown in Appendix 1 of this EqIAA. In addition, Section 3 of this EqIAA responds to the key equalities related themes emerging from the consultation.

SECTION 3 - IDENTIFICATION & ANALYSIS OF EQUALITIES ISSUES AND IMPACTS

Below are the main recommendations set out in the Drug Strategy:

1. **Protect children and young people (0-19) from drug-related harms.**
    - Prevent the misuse of drugs among young people through education, campaigns and enforcement
    - Reduce dependency and the risk of drug-related harms among those already using drugs by providing specialist services for children and young people
    - Work in partnership with other services for children and young people, such as CAMHS.

This recommendation focuses on young people under the age of 19.

2. **Protect against the development of drug-related ACEs among those at particular risk.**
    - Reduce the numbers of people locally who are misusing drugs using early interventions, throughout the life course.

This recommendation is likely to improve outcomes for people who have multiple disadvantage or have trauma history.

3. **Prevent and reduce the risk of people who use drugs experiencing drug-related harms.**
    - Reduce hospital admissions caused by drugs, particularly for females.
    - Reduce transmission of BBVs and skin and soft tissue infections among people who inject drugs through the provision of needle exchange, vaccination and testing services.
    - Reduce the number of overdoses among people who use opiates through the provision of naloxone kits and overdose training.
    - Reduce smoking-related mortality and morbidity among people who use our services by increasing smoking cessation provision during drug treatment.

This recommendation is likely to improve outcomes for a wide range of people but in particular females in terms of the focus in reduction of hospital admissions.

4. **Promote safer and stronger communities**
    - Reduce drug-related crime including acquisitive crime and domestic violence and abuse through closer working and data sharing with police colleagues.

This recommendation is likely to improve outcomes for all communities but in particular females who are more likely to be victims of domestic violence and abuse.

5. **Reduce inequalities associated with drug-related harms**
    - Offer equitable, available and accessible interventions universally but proportionally, targeted at groups that are at increased risk of drug-related harms. These groups include those experiencing socioeconomic deprivations, those with ACEs, LGBTQ+ communities, care leavers, those from Black, Asian and minority ethnic communities, vulnerable adults and adults with learning and other disabilities.
    - Ensure those who might be isolated due to physical or mental disability and drug use are able to access support.

This recommendation is likely to improve outcomes for those from the LGBTQ+ and BAME communities and people with disabilities.

6. **Provide treatment and recovery from drug dependence whilst promoting health and wellbeing, and providing support for family members**

- Increase the numbers of those who misuse drugs or are dependent on drugs accessing advice, support, treatment and stable recovery;
- Work to overcome barriers to accessing these services and build capacity in treatment services.
- Support those accessing drug treatment with their identified needs for a holistic approach to improved wellbeing.
- Continue supporting family members of those who misuse or are dependent on drugs.
- Include people with lived experience in developing services, and ensure there is visible recovery for those in treatment.
- Shape and develop innovative treatment services which embed the lessons learnt during the COVID-19 pandemic.

This recommendation is likely to have a positive impact on all people regardless of their protected characteristics.

7. **Strengthen and clarify pathways through services**
    - Review, enhance and further develop **joined-up** pathways, particularly between:
        - **i.** Children and young people's drug services and adult drug services
        - **ii.** Early intervention, social services, mental health and treatment services
        - **iii.** Criminal justice, treatment services and other community support services
        - **iv.** Hospital and community services

This recommendation is likely to improve outcomes for many people within the treatment system but in particular young people transitioning between Young People and Adult services and those with mental health issues.

8. **Work in partnership with relevant organisations, networks, collaboratives and workstreams:**
    - Through strategic leadership and implementation of integrated care systems, scope opportunities for joint commissioning and/or pooled budgets for campaigns, early interventions and services. Maximising opportunities for the joint commissioning of services for people with complex needs, particularly poor mental health, should be a priority.
    - Provide training for other departments and colleagues, including those within the Council and our partner organisations.
    - Link with the aims and performance measures stated in other relevant South Gloucestershire strategies and plans, including: the new Council Plan; Joint Health and Wellbeing Strategy; Safer and Stronger South Gloucestershire Plan; Early Help Strategy for Children, Young People and Families; Adult Mental Health and Emotional Wellbeing Strategy; the Domestic Violence and Abuse Strategy and the NHS Long-Term Plan.

This recommendation is likely to have a positive impact on all people regardless of their protected characteristics.

9. **Communicate data and information**
    - Develop a communications and community engagement and insights plan, designed to sit alongside the alcohol communications plan, which sets out our approach to communicating with communities about drug-related harms.
    - Obtain data and information (including feedback and the evaluation of interventions) that is currently not known to the partners involved in developing the needs assessment.
    - Develop a strategic communication system to share data and information to mitigate the wider harms that drugs may cause to families and communities.

- Ensure clarity of the roles and responsibilities of individual partners in agreeing and achieving the identified outcomes and in developing processes for evaluating progress.

This recommendation is likely to have a positive impact on all people regardless of their protected characteristics.

10. Use our resources effectively and transparently

- Identify the proportion of funding within commissioners' overall budgets that is to be spent on drugs and make decisions on how to allocate drug funding between prevention and early interventions and treatment.

This recommendation is likely to have a positive impact on all people, regardless of their protected characteristics.

The key themes emerging as a result of the consultation were:

1. Young people.

The updated Strategy confirms that protecting children and young people (0-25) from drug-related harm will be a key element of the Strategy's action plan for delivery.

2. Adverse Childhood Experiences

The updated Strategy confirms that reducing inequalities associated with drug-related harm will be a key element of the Strategy's action plan for delivery. This specifically includes those with Adverse Childhood Experiences.

3. Disability (including mental health).

The updated Strategy confirms that reducing inequalities associated with drug-related harm will be a key element of the Strategy's action plan for delivery. This specifically includes disability and mental health.

4. Ethnicity.

The updated Strategy confirms that reducing inequalities associated with drug-related harm will be a key element of the Strategy's action plan for delivery. This specifically includes ethnicity.

5. LGBTQ+ communities

The updated Strategy confirms that reducing inequalities associated with drug-related harm will be a key element of the Strategy's action plan for delivery. This specifically includes LGBTQ+ communities.

6. People on low incomes.

The updated Strategy confirms that reducing inequalities associated with drug-related harm will be a key element of the Strategy's action plan for delivery. This specifically includes people experiencing socioeconomic deprivation.

7. Those involved in the criminal justice system.

The updated Strategy confirms that promoting safer and stronger communities will be a key element of the Strategy's action plan for delivery. This specifically includes those involved with the criminal justice system.

SECTION 4 - EqIAA OUTCOME

Outcome	Response	Reason(s) and Justification
Outcome 1: No major change required.	☐	
Outcome 2: Adjustments to remove barriers or to better promote equality have been identified.	☒	The proposed Drug Strategy 2020-2025 clearly identifies a full range of equalities related issues emerging from the Needs Assessment, Consultation & Engagement and the process of conducting this EqIAA. The next step in delivering the Drug Strategy is to develop an action plan for delivery which is comprehensive in delivering against the needs of all protected characteristic groups and which takes full account of the issues raised in Section 3 of this EqIAA.
Outcome 3: Continue despite having identified potential for adverse impact or missed opportunities to promote equality.	☐	
Outcome 4: Stop and rethink.	☐	

SECTION 5 - ACTIONS TO BE TAKEN AS A RESULT OF THIS EqIAA

The key action to be taken is the development of an action plan which is comprehensive in delivering against the needs of all protected characteristic groups and which takes full account of the issues raised in Section 3 of this EqIAA. This action plan will be assessed to ensure comprehensive equalities impact and this EqIAA updated accordingly.

SECTION 6 - EVIDENCE INFORMING THIS EqIAA

Drug needs assessment 2020
Drug strategy 2020
Consultation Output Report, November 2020

APPENDIX 1 – CONSULTATION FEEDBACK RELATING TO EQUALITY

Key Findings

Q4. If you feel that any of the strategy's aims have not been sufficiently addressed by the proposed areas of work above, let us know what else needs to be covered.

The issue of dual diagnosis of alcohol/drug dependency and mental health problems is mentioned in the full strategy document but not listed in the 10 areas of work above. I think joined up help for those with dual diagnoses is really key.

There are gaps that create inequalities like bedroom tax, poverty that isn't fully linked together in the strategy. Children should be taught from the age of 7 as young people living with drug using families know what's going on but no-one talks about it. The age cut off of 21 for YP services is not right as my son who has long term mental issues fell through the gap as he only had services till 21, but then had had a psychotic episode at 25, the crisis team were not able to help and just told us to call the police and then he had a 20 minute assessment which isn't right as he would have been in a cell for 24 hours and he had calmed down by then. People with Mental ill health need to access face to face rather than phone calls. Dual diagnosis clients need to have access to both substance misuse and mental health services because people like me may self-medicate with substances and then that becomes a bigger problem. In relation to prevention - Adverse Childhood Events need to be taken seriously and education of the consequences of all substances should be included in the lessons. People with a lived experience of substance misuse and mental ill health should be used to help with education as you are more likely to understand what they have been through. If someone is just reading it from a book, people can tell and they tend to switch off from learning about it. Throughcare teams are essential to help people with their finances and debt after they have been using drugs. I didn't know how to fill-in forms or anything, the throughcare team helped me to access housing, debt advice. They were a saviour as I would have felt overwhelmed and I may have returned to using drugs. When you come out of rehab treatment, you need ongoing support for a few weeks to get used to living on the outside and someone to help sort you out to carry on going to groups and things - when you're in rehab you have everyone telling you what to do and then when you come out, you have to do it all yourself.

Most people use drugs because of not coping with life. This should be reflected more. Children and young people need specific support and education about how to cope with stress and anxiety. If people knew how to cope with this they wouldn't turn to drugs for quick relief. There needs to be better focus on how to manage emotions across children and adults. If you ask for counselling or mental health support, that should be available even when you are using drugs. But they tell you to stop using drugs, without any therapy or help. How can you cope with panic attacks and not sleeping and anxiety without self-medicating? Counselling should be at the same time as drug support.

Outsource tenders for working with under 18s to provide better cost effective treatment outcomes for this age group.

Strong focus on both prevention and treatment of prescribed medication dependence, particularly opiate-based medications and benzodiazepines. This is touched on in the strategy and it would be great to see a pro-active approach to making drug services more accessible to those who don't necessarily fit the 'traditional' pathways, as they often feel that the model used to support and treat heroin or other non-opiate drug clients does not fit for them and proves to be more of a barrier. It would also be beneficial to work with the local NHS trusts to develop more robust pain management and mental health plans and pathways, working the pain management and mental health support into the client's care plan with DHI so they are able to work on living better with health and mental health conditions and develop tools, instead of feeling adrift after overcoming the dependence on medication.

Q5. The Equalities Impact Assessment sets out information relating to protected characteristic groups. If you feel there are any groups who are at higher risk of harm and

have not been sufficiently covered in the strategy, or there is any additional information that we should include about any group, please let us know:

Focus on women in treatment to support themselves and reduce impact of ACE's on their children. Removal/ threat of/temporary kin ship or foster care, of children is an ACE so should not be measured as a 'success'. Late action from social services contributes to a culture of crisis management which is an inflammatory approach for those women already living with chaotic lives or who due to unaddressed mental health issues are unable to manage adversity without support.

It has been mentioned within BAME but I wonder if special consideration could be given to those from a Muslim background who may have multiple barriers to accessing support for their drug/alcohol use, due to it being something they may culturally hide.

Those with low grade mental health problems and multiple long term health conditions

There is a clear link between substance misuse and inequalities, when I was growing up - we had community centres and people were able to access more support from the community. Inequalities come from the caps like the cap on benefits if you have more children, people I know have then used drugs to escape the pressure and then that makes it worse. There is nothing in particular to invite people who identify as LGBTQ+ to any of the treatment services. It should be more highlighted that they are welcome. There needs to be more wheelchair accessible rooms for people with disabilities. I've only seen one to people from BAME in the last 4 years, I think there needs to be more cultural education as an Asian gentleman I knew talked about the culture and how they drink a lot but I haven't seen many people from an Asian background at the service. If you haven't got a home, you won’t stop using as you don't have anything to do.

The only group I can see that isn't being addressed is for those who have suffered child abuse and when they get older, they may want to talk about and I believe people who have experienced it may turn to drugs to cope.

There should be more of a focus on people that use crack. They cannot get a script and only get short term support. There needs to be more long term support available for all drugs. Support should include special therapy and counselling. Brief intervention is OK if you've just starting using, but if you've been addicted for a while you need more time and support. Six sessions isn't enough. Support should be funded to be there for as long as a person needs it. There should also be detox and rehab available.

The South Glos service would benefit from having a worker leading on LGBT+ support, and in particular one who could provide support to transgender clients. We would also benefit from looking at the diversity of our workers and reviewing strategy at an organisational level to ensure the drug service is visibly diverse and inclusive to our community. The changes to the ways clients are able to access services as a result of the Covid-19 pandemic have shown that services really need to be moving away from traditional models and embracing different communication styles on a permanent basis, as this improves access for those with disabilities, those with mental health concerns such as anxiety, 0 hour contact workers, and families with childcare commitments, that have made it impossible to engage previously. Further work needs to be done in supporting those with 'invisible' illnesses and disabilities in maintaining their engagement, and in particular encouraging a multi-agency approach to support. There needs to be a much more robust effort by services to engage and support those who have contact with the criminal justice system, and to really advocate for a multi-agency approach to break the cycle of offending and allow them to move forward with their lives. This includes working with prison substance misuse providers and housing teams to ensure clients are not released NFA and have access to basic essentials such as clothes and food, plus ways to access community support in getting a phone and upskilling or working on employability skills.

I think the transition from CYP services to adult services needs further investment – this could be addressed on page 6, in items a) and b). Numbers of young people aged 18-25 in treatment are low, and there should be an increased focus on transitions work, and supporting young adults in

early dependency as part of early intervention. As the average age of treatment client is much higher than 25, the adult service can often seem inappropriate for younger cohorts. The DHI service at UWE has shown that providing drop-ins at universities enables young people to access harm reduction information, and support, before things escalate. For those students who are already using problematically or dependently, they can easily access structured treatment, with enhanced 1:1 support. Treatment services for colleges and universities should be reviewed as part of the strategy and commissioned contracts.

Q6. If you have any other comments about this strategy please let us know

I would have liked to hear the voices of those who contributed to the strategy both professional and nonprofessional. All the points made are appropriate and admirable but there was not a clear link with the research project undertaken. As both a professional and parent of a teenager in a South Glos school I have not come in contact with YPDAS and should have. Adult services can support educational projects with its bank of lived experience and this has not happened to my knowledge.

Families definitely need support. I didn't know what to do with myself when I was using, I ended up shop lifting until I was put in prison which is when I was able to stop because I had a roof over my head, I had a short sentence which didn't work but when I had a 6 week sentence, they had enough time to sort out emergency accommodation and someone met me at the gate (Through The Gate) who took me to a different area and that is what saved my life - DHI have a friendly and more understanding approach than other service providers from other areas, I think they are really good - the other area didn’t have a throughcare team either.

I do not understand what a drug related ACE is? This should be clearer if it is the same as an ACE. There needs to be work to make sure prisons and probation provide support when you leave. What support is there for drug users? If you have social services and your children are taken in to care there is no support to cope with this. Needles should be available at lots of venues. Like vending machines. It would stop the shame if you could get them from more places.

Excellent strategy that focuses not only on the drug user but the children and families in particular childhood ACE's where these children often end up in drug services as an adult

I think having young people’s service within the council and only accessible through a safe guarding referral is Dickensian and prevent young people getting support and information before it becomes a safeguarding matter. Investment into engaging harm reduction platforms is needed to move with technology and to ensure young people are willing and able to use the resources provided. Recommissioning every 5 years regardless of outcomes from a service is ridiculous waste of money and doesn’t allow enough time for services to become embedded in the community or to prove themselves and their abilities. Recommission services when they are failing

The Equality and Impact Assessment touches on the potential barriers to those from BAME groups and different faiths accessing services and it would be beneficial to continue engaging with organisations such as Nilaari on ways that we can improve access to drug treatment services for those from different communities and ensure learning is shared and reviewed by frontline workers and community partners. There have been a number of news stories and documentaries looking at drug use in the UK recently, covering topics such as naloxone and OST and continuing to publicise the positive work of substance misuse programmes, needle exchanges etc are doing, and vitally including the voices of services users to help dismantle stigma amongst the general public should be encouraged.

Emails

<u>Email from a local professional:</u>
I think this is a good strategy and am really pleased to see the recognition of OAD as a growing issue and the emphasis on taking a holistic approach to working with drug and alcohol users taking into account fundamental barriers to recovery around housing, finances etc. I think that the lack of affordable accommodation to rent in South Gloss is a particular issue for service users and it is

hard to focus on recovery if you don't have stability in other areas of your life. I was also pleased to see the recognition of the learning from COVID around bringing innovation to and challenging existing methods of service delivery. I agree there is real issue with getting statutory mental health services to respond effectively to clients with long term and complex mental health issues and this is problematic for workers trying to support them especially when they are in crisis. Treatment services can and do deal with lower level mental health issues all the time, part of this is about building a positive and trusting relationship between worker and service user, utilizing some of the evidence based psychological interventions where appropriate and connecting clients with other wellbeing services like IAPT but also really important is encouraging clients to get involved in meaningful occupation or wellbeing activities that can build their social networks, confidence, positivity and self-esteem.

Professional Engagement Events

Young people

- When we talk about Young People and drugs, what about smoking tobacco and harm reduction there? There is a lot of peer pressure to smoke and we need to get education out about the harms to all levels including post 16 education settings.
- Prevention at Young People Drug service level is necessary, education is key should be a priority with the use of people with lived experience also a good idea.
- We need to ensure that there is an adult with lived experience of childhood substance misuse on any Drug strategy Groups because they will add a voice with different context.

Adverse Childhood Experiences

- The link between safeguarding children services and drug services is still not as good as it could be. An example of a young person who has been on the radar of social services and drug services since birth was given. Although services are aware of the activities occurring in the house, there is still Adverse Childhood Experiences which are not being addressed for that young person through early intervention and it might mean that although everyone is aware of them, they will still use substances as a result of their childhood.

People on low incomes

- The smoke free/vaping pilot is going well and people who are accessing the service have been given vapes which initial feedback has shown to be positive. One worker described the positive impact it had when someone she was engaging with stated they couldn't afford a vape and due to her meeting the criteria, she was able to access one through the scheme. 'Although she is still smoking, it's a lot less than she was.' Inequalities gap was identified as she would not have had access to one without intervention.

Disability (including mental health)

- There is a need to focus on resilience and anxiety/early metal ill health. Currently not enough work goes into how to manage group situations, managing life and being in difficult situations. We need a way of providing this holistic approach in lessons (possibly Relationship and Sex Education sessions) so that young people don't use a substance as a crutch when things are difficult and then keeping it on later.

Young People

A briefing of the strategy was made available for young people to comment on. All respondents had similar answers to the questions they were given, summarised below:

- We need to explore the reasons why some people are more likely to use drugs, and work to address these issues.
- We need more education in school, and particularly to teach more about the impact of using drugs (e.g. side-effects and risks of using drugs). Several young people mentioned a specific need for improved education around cannabis use and the harms connected to it.
- Young people need more to do (e.g. youth clubs, events for young people) – many young people start using drugs because they are bored and stressed.
- Ensuring access to support for young people who need it, as well as support for their families.