

# South Gloucestershire Drugs Needs Assessment

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## Glossary of Terms

Adverse childhood experiences (ACEs)	ACEs are those experiences that directly harm a child (e.g. physical, sexual or emotional abuse) or affect them through the environment they live in. This includes: growing up in a household where there is alcohol misuse, drug misuse, parental separation/loss, mental illness, domestic abuse or where someone has been incarcerated.
Chronic non-cancer pain (CNCP)	A painful condition lasting for 3 months or longer, not associated with a diagnosis of cancer. CNCP is a major public health problem that causes significant distress, negatively affects quality of life and limits how people function both personally and socially.
Class A drug	Class A drugs are considered to be the most harmful. Class A drugs include: crack cocaine, cocaine, ecstasy (MDMA), heroin, LSD, magic mushrooms, methadone, methamphetamine (crystal meth). An offence involving a Class A drug results in the most serious penalties.
County lines	The process of transporting illegal drugs from one area to another, often across police and local authority boundaries. County lines usually involve children or vulnerable people who are exploited, coerced and intimidated into moving and storing drugs and money by gangs and organised criminal networks. The 'County Line' is the mobile phone line used to take the orders of drugs.
Cuckooing	A form of crime in which drug dealers take over the home of a vulnerable person in order to use it as a base for drug dealing.
Multi-Agency Risk Assessment Conference (MARAC)	A victim focused information sharing and risk management meeting attended by all key agencies, which discusses the highest risk domestic abuse cases.
PWIDs	People who inject drugs

## Executive Summary

The misuse of drugs has a negative impact on individuals, families and communities, and is often a symptom of wider personal and societal issues. While the proportion of the population who are affected by drug misuse is relatively small, its impacts are significant and often felt across the wider community. Previously, South Gloucestershire has had a single substance misuse strategy to cover both drugs and alcohol. However, public health approaches to alcohol use are often population-wide, whereas addressing drug misuse often requires more targeted interventions. As a result, a decision has been taken to separate South Gloucestershire's drug and alcohol strategy. In order to develop a standalone drug strategy for South Gloucestershire, we have conducted a comprehensive needs assessment to assess the health, wellbeing and social effects of drug use across South Gloucestershire across the life course; identify gaps in current service provision; and make recommendations for changes to meet people's needs. This needs assessment was conducted during the COVID-19 pandemic, with the impacts of COVID-19 considered through this report, where relevant.

Across England and Wales, approximately one-third of adults report having taken drugs at some point in their lifetime, with drug use most commonly occurring among young people aged 16-24. In South Gloucestershire, trends in substance use among people entering drug treatment have been relatively consistent over the past decade. However, there are growing concerns both nationally and locally about people becoming dependent on prescribed opioids. 5.6 million adults in England were prescribed an opioid pain medication in 2017/18, equivalent to 13% of the adult population (1). In March 2018, 36,483 patients across Bristol, North Somerset and South Gloucestershire (BNSSG) received an opioid prescription. Individuals requiring support from drug services for prescribed opioid dependency are less likely to access traditional substance misuse services and often report barriers to accessing treatment, both of which need to be considered when planning services for this group.

This 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. A wide range of professionals and service users reported poor communication and pathways 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.

The damaging effects of drugs are not limited to the individuals using them. Drugs also impact upon families, communities and wider society. Parental drug misuse has been identified as an adverse childhood experience (ACE), with long-term negative impacts throughout the life course. Drug use is also associated with crime, although the relationship between the two is complex and multi-factorial. Nevertheless, it is well documented that a disproportionate number of crimes are committed by a small group of dependent drug users. This is particularly true for acquisitive crime. Across the Avon and Somerset Police Force area, there was an estimated 26% reduction in crime once individuals began drug treatment, suggesting a clear return on investment for the criminal justice system to support individuals to access drug treatment.

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. The Online Pupil Survey (OPS) collects data

from children and young people from Year 4 to post-16 and includes specific questions around drug use. A total of almost 20,000 children and young people have completed the OPS across 2014, 2017 & 2019 totalling almost 20,000 children and young people from year 4 to post 16. Data from the 2019 OPS suggests that 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.

In contrast, approximately three-quarters of adults in structured drug treatment services in South Gloucestershire were in treatment for opiate use. Nevertheless, there is a high unmet need for treatment among individuals using opiates and crack cocaine. Through engagement with professionals, this needs assessment identified a need for a further emphasis on harm reduction taking place alongside structured treatment interventions. The uptake of naloxone kits has substantially increased during COVID-19 and should continue to receive focus beyond the pandemic. Injecting drug use in particular increases the risk of transmission of blood-borne viruses (BBVs) such as HIV, hepatitis B and hepatitis C; primary and secondary prevention through needle exchange, vaccination, testing and rapid access to specialist treatment for those who test positive are all vital and need to be particularly targeted towards those not already accessing drug services.

Drug services have been rapidly reconfigured during the COVID-19 pandemic, with the system having to work quickly and collaboratively with partners to be as adaptable as possible. While some service users have struggled with the lack of face-to-face contact, others have found more regular telephone contact valuable and have found that changes such as the relaxation of prescribing regimens have made them feel more trusted and given them more autonomy and freedom in their recovery path. The pandemic has provided an opportunity to consider how we might offer drug services differently in the future, and this needs assessment highlights that a combination of face-to-face and telephone appointments may be beneficial for service users even when COVID-19 restrictions are no longer in place.

## Introduction

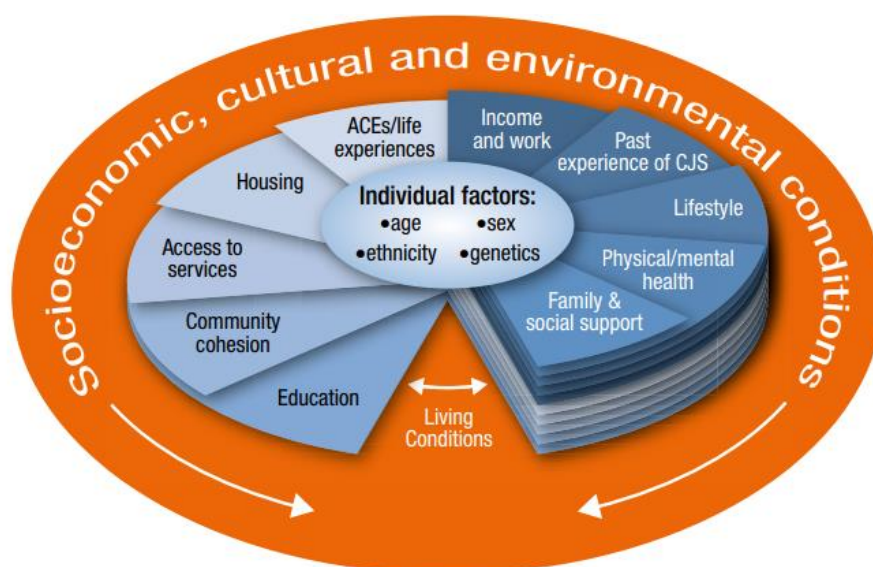
### Background and rationale

The misuse of drugs impacts negatively on individuals, families, children and young people (CYP) and communities across the country. In South Gloucestershire, problematic drug use affects a relatively small number of our population. However, where it does occur, it significantly impacts on people's lives. People who need treatment for their drug use are much more likely to suffer the effects of wider inequalities and start to use drugs as a coping mechanism to escape the difficulties they face in life. Drug use is therefore commonly a symptom of wider problems within our society that then develops to become a problem in itself, often leaving people trapped in a cycle of drug misuse that is difficult to recover from.

When most people think of drug use, thoughts tend to focus on illegal drugs such as heroin and cocaine. However, this is not the only issue facing our communities. Prescription medications that are either prescribed by GPs or available over the counter can also be highly addictive and cause huge problems in people's lives. A strategic approach that tackles both illicit and prescribed drugs is therefore essential.

This needs assessment aims to assess the level of need within South Gloucestershire for interventions to prevent and reduce the risks of using drugs, and to treat those who are dependent on them or struggling to control their drug use on their own. It looks at the level of need across the life course, and for communities and individuals with particular needs. The influence of some environmental, individual and social factors known to impact on health and how these might relate to drug use locally are considered based on Dahlgren and Whitehead's model of the social determinants of health, shown in Figure 1 below.

Figure 1: Dahlgren and Whitehead's model of the social determinants of health



Adapted from the Dahlgren and Whitehead model, 1991

Where available, local and national data for prevalence of drug use amongst different demographic groups (particularly those known to be more at risk), its associations with inequalities, and its harmful effects on health and the wider community is examined. The project team aimed to co-produce this needs assessment with all relevant organisations, partners and stakeholders in South Gloucestershire. An engagement process was therefore undertaken with stakeholders to establish



their strategic priorities, and some sections have been co-written and developed through conversations with these individuals and subsequently endorsed by them.

## COVID-19

This needs assessment has been written during the COVID-19 pandemic. COVID-19 has drastically altered daily life and has led to a sudden and rapid reconfiguring of drug services. This is discussed in more detail in the Adult Treatment Services section of this report. While we have made all possible efforts to ensure that this needs assessment is as comprehensive as possible, COVID-19 has inevitably impacted our ability to conduct this needs assessment and this has been acknowledged throughout this report, where applicable. The impacts of the current pandemic have been particularly felt in our engagement with both professionals and service users, with planned face-to-face engagement being replaced with engagement by telephone and online. We have also chosen to ask both groups about their experiences of and perspectives on drug services both before and during COVID-19, in order to capture lessons learned and consider ways in which we may wish to deliver services differently in future, whilst also acknowledging the long- and short-term tragedy and disruption that COVID-19 has brought with it.

Much of the data included in this needs assessment was collected prior to the COVID-19 pandemic. The consequences of the pandemic, and the necessary restrictions in order to curb the spread of the disease, will be far-reaching and felt for decades to come. It is therefore important to acknowledge that needs may change as a result of the current situation, in ways that this needs assessment may not have been able to predict or capture.

## Local priorities

The South Gloucestershire Sustainable Community Strategy was developed by the South Gloucestershire Partnership to provide a long-term, strategic vision for South Gloucestershire (2). Members of this partnership include Avon and Somerset Police and Crime Commissioner, the Bristol, North Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Group (CCG), University of the West of England (UWE), Airbus, Town and Parish Councils and The Care Forum. The strategy articulates a strategic vision for the next twenty years to make South Gloucestershire a “*great place to live and work*”. For this purpose it includes ambitions to:

- Give children the best start in life
- Improve educational standards in schools
- Reduce the level of crime and disorder
- Reduce health inequalities
- Ensure health needs of residents are met
- Help people to make healthy choices

There are currently no plans to update the sustainable community strategy 2036. Last year the partnership considered a review of the Plan deciding that the priorities remain relevant and that the vision still stands.

One of the four themes of the current South Gloucestershire Council Plan 2016-2020 is to “*promote personal well-being, reduce health inequalities and deliver high quality physical and mental health and social care services which protect our most vulnerable*” (3). There are no specific aims in the plan that directly relate to drugs, but related aims include:

- To improve the health of our poorest communities at a faster rate than average to reduce the gap in health inequality.

- To advocate for the best possible health and social care services to our residents.
- For the residents of South Gloucestershire to enjoy the best possible physical and mental health.
- To have healthy communities that are leading healthy lifestyles.
- To focus on early intervention which prevents problems escalating.
- To ensure our children and vulnerable adults are protected from harm and neglect.
- To ensure that our children have the best possible start in life.
- To reduce the attainment gap in schools, associated with lower incomes.
- To reduce the number of children living in poverty in South Gloucestershire.

Currently there is a focus upon development of a new council plan 2020-2024. This plan is out to consultation at the time of writing this needs assessment. The plan will be supported by action plans which are being developed alongside. Key themes included in the consultation are: creating the best start in life for our children and young people, helping people to help themselves, promoting sustainable, inclusive communities, infrastructure and growth and realising the full potential of our people and assets.

The South Gloucestershire Joint Health & Wellbeing Strategy 2017-2021 promises to *“commit to continued investment in evidence-based programmes that promote the physical and mental health and wellbeing of children and young people, and minimise the use of drugs, alcohol and tobacco”* (4). The South Gloucestershire Health and Wellbeing Board have prioritised four areas for collective action. These are to:

1. Improve educational attainment of children and young people and promote their wellbeing and aspirations.
2. Promote and enable positive mental health and wellbeing for all.
3. Promote and enable good nutrition, physical activity and a healthy weight for all.
4. Maximise the potential of our built and natural environment to enable healthy lifestyles and prevent disease.

A new Joint Health & Wellbeing Strategy will be developed in 2021.

Parental drug use can clearly impact on the health and wellbeing of children, whether as a result of parents being emotionally absent due to their drug use, or its impacts on family finances, leading people to prioritise their drug use over food and supplies for the family. Drug use in children and young people is associated with lower educational attainment, truancy and exclusion from school (5). The need to fund illicit drug use, in particular heroin and crack cocaine, lead to much of the acquisitive crime that takes place across the country. Finally, there are strong associations between health, social and economic inequalities and both drug use and drug-related harm (6).

### Adverse childhood experiences

We acknowledge that drug services in South Gloucestershire and the information surrounding drugs and their impact on health, both short term and long term, need to be accessible for all residents in order to prevent adverse childhood experiences (ACEs) in future generations. ACEs are those experiences that directly harm a child (e.g. physical, sexual or emotional abuse) or affect them through the environment they live in. This includes: growing up in a household where there is alcohol misuse, drug misuse, parental separation/loss, mental illness, domestic abuse or where someone has been incarcerated.

In South Gloucestershire we understand that stressful experiences in childhood can have an impact throughout people's lives. As a result of this, we are working towards having an ACE-informed approach with our work. We recognise that ACEs have a profound impact on an individual's life chances and are working to develop a holistic ACEs approach that aims to:

- Prevent ACEs in future generations, including breaking the cycle of ACEs within families
- Support and build resilience in families and children who are at risk of exposure to ACEs
- Recognise the signs and symptoms of ACEs to enable appropriate early intervention
- Recognise the impact of ACEs on adults.

Research has shown that people with ACEs are at greater risk of a range of negative health, social and economic outcomes. The research also shows that the more ACEs people have, the greater the risk. It is important to understand that those outcomes are not inevitable, but for many people those outcomes may be more likely.

From a service user perspective, an ACE-informed approach asks: 'What happened to you?' rather than, 'What's wrong with you?' and goes on to ask, 'How has this affected you?' and 'Who is there to support you?' It is a change in culture away from a system that labels people as symptoms or behaviours. Instead, it is about being aware and responsive about recognising that what happened in childhood can impact the journey of people's lives today. It is also about taking the time to listen and understand.

### Strategic context

The national Drug Strategy 2017 sets out how the government and its partners, at local, national and international levels, will take new action to tackle drug misuse and the harms it causes (5). It focuses on four key areas: Reducing Demand, Restricting Supply, Building Recovery and Global Action. Reducing Demand primarily focuses on prevention and education of groups to stop people from using drugs and pays attention to vulnerable groups who are likely to be worst affected. Restricting Supply focuses on the legal aspects of drug use and production, setting out the ways the government plans to reduce the volume and availability of drugs on British soil. Building Recovery focuses on treatment and recovery in communities for those where drug use has become an issue causing them harm and Global Action sets out Britain's plans internationally to reducing drug harm.

The previous Substance Misuse Needs Assessment (SMNA) was completed in 2016. Due to the different approaches needed to tackle alcohol and drug harm, and their different places on key stakeholder agendas, the decision was made to complete separate needs assessments for each to ensure due time and consideration is given to both. The documents will however connect with each other.

The South Gloucestershire Drug and Alcohol Programme (DAP) was established in October 2017 when the previous Drug and Alcohol Action Team (DAAT) and the Young People's Drug and Alcohol Service joined together. The change of name reflected the aim for drugs and alcohol to be dealt with in a strategic fashion across the life course. The DAP vision is "To provide a **strategic, preventative and treatment based, life course** approach to **drug and alcohol** harm in South Gloucestershire that meets the **needs** of the **population, including those who are most vulnerable** for the best **value for money**." Historically we have been, perhaps necessarily, very focused on treatment and we know that both young people and adults in treatment in South Gloucestershire tend to do well. However, our estimates for unmet need suggest that there are a proportion of people in our population who are not receiving the treatment they need, and we are therefore not being successful in our aim of preventing people from needing treatment in the first place.

## Methodology

This needs assessment blends an epidemiological, comparative and corporate approach. The methods used to capture each need are listed in Table 1. More details about the needs assessment approach are provided in Appendix 1.

*Table 1: Methods used in this needs assessment to capture need*

<b>Need</b>	<b>Method</b>
Normative	Literature review. Engagement with partner organisations and key local professionals.
Felt	Engagement with partner organisations; providers; key local professionals; groups with protected characteristics; and service users
Expressed	Review of service performance data.
Comparative	Comparison of population and service data to the 'nearest neighbours' (16 similar Local Authorities (LAs) such as Bath and North East Somerset, Swindon and Wilshire), as defined by The Chartered Institute of Public Finance and Accountancy (CIPFA); regional; and national data.

## Stakeholder engagement

### Key informant interviews

Semi-structured interviews were conducted with individuals or representatives of key organisations involved in preventing and addressing the health and social impacts of drug use in South Gloucestershire. These conversations were conducted before commencing the needs assessment in full, with the outcomes of these conversations informing the key questions that the needs assessment aimed to address. A full topic guide is available in Appendix 2. Key informants included representatives from the Public Health & Wellbeing Division and Safer & Stronger Communities teams at South Gloucestershire Council, adult and children's social care, the CCG, probation services, the police, drug service providers, the lead GP for drugs and homeless services.

### Online questionnaire for professionals

An online questionnaire was circulated to key individuals and organisations involved in providing services for people who use drugs in South Gloucestershire. The questionnaire asked about the services provided by the individual or organisation, the challenges faced in providing that service, their perceptions of the needs of people who use drugs in South Gloucestershire, potential gaps in service provision and any recommendations for improvement (see Appendix 3 for the full questionnaire).

### Engagement sessions with drug service staff

Three specific engagement sessions were held with staff from Developing Health & Independence (DHI), our current drug and alcohol service provider. Due to the COVID-19 pandemic, these sessions were held online using videoconferencing software. Staff were asked the same questions as were included in the online questionnaire for professionals (see Appendix 3), but this was done through these interactive sessions so that we could explore the responses from this group of professionals in more depth. We also felt that it was important to separate out the responses from drug service staff, as they were likely to have a different perspective on current drug service provision to other professionals not working for the service.

### Service user engagement

People who use our services were asked to discuss their experiences of treatment by having 1:1 sessions with members of the drug services team or South Gloucestershire Council's DAP programme. Unfortunately, as a result of the COVID-19 pandemic these discussions had to take place by telephone rather than face-to-face. An online questionnaire was offered to those who preferred this option. A further outcome of the pandemic meant that we were unable to get views from people who may benefit from using our services, but who are currently not in structured treatment. The full set of engagement questions for service users is available in Appendix 4.

## Drug Usage

### *National data*

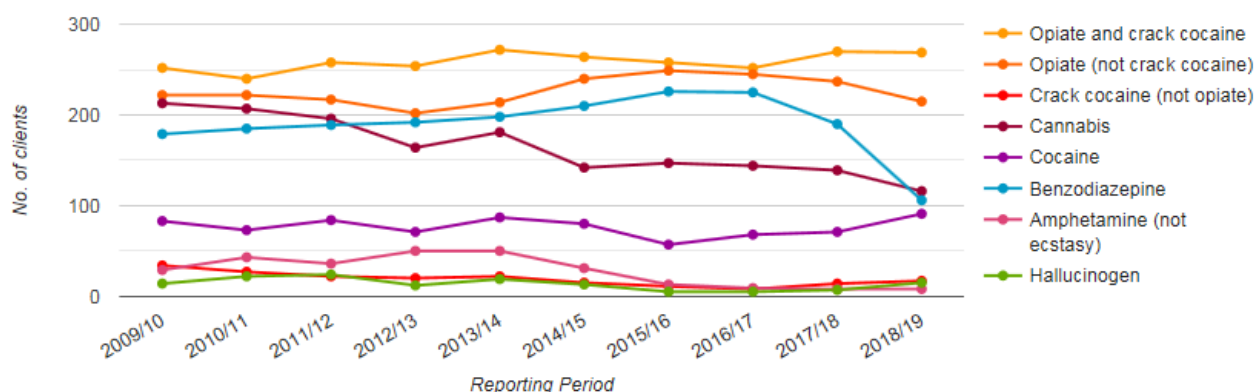
Evidence suggests that drug use across England and Wales has been reducing for several years. In 2018/19, 9.4% adults in England and Wales aged 16-59 had taken a drug in the past year, rising to 20.3% among young people aged 16-24 (7). 3.7% of adults aged 16-59 had taken a Class A drug in the last year, with this figure being 8.7% among those aged 16-24. Approximately one-third (34.2%) of adults report having taken drugs at some point in their lifetime.

Interim results from the Global Drug Survey suggest that COVID-19 is affecting drug use across the world (8). 40,000 people had completed the survey at the time of publication of the survey's interim results, 1,300 of whom lived in the UK. Drug usage has varied by drug, increasing for drugs such as cannabis which are commonly used alone and where local production is possible. People who reported increased usage of drugs such as cannabis listed having more available time and boredom as the main reasons for their increased use. Benzodiazepine use has also increased, thought to be as a coping strategy and to compensate for access to other drugs. In contrast, the use of stimulants such as cocaine and MDMA has reduced. This was largely the result of COVID-19 restrictions which have prevented social gatherings rather than specifically as a result of having less access to these drugs. A report produced by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) reports similar findings, with an overall reduction in the use of drugs across Europe in the first three months of the pandemic (March – May 2020), but with some variation by drug and between countries (9). Concerns have also been raised about increases in drug use once COVID-19 restrictions are eased, with the National Police Chiefs Council's drugs lead stating that the return of the night-time economy was likely to lead to "an influx of drug use and strain the emergency services" (10). Drug services will need to work flexibly around any changes in drug use in order to respond to need.

### *Local data*

**Error! Reference source not found.** displays the breakdown of substances that people have reported using when entering drug treatment in South Gloucestershire over the past decade, according to data from the National Drug Treatment Monitoring System (NDTMS). In 2018/19, fewer than five people reported problematic use of ecstasy, mephedrone, novel psychoactive substances (NPS) or other substances; these have therefore been excluded from Figure 2: Substances that service users reported having a problem with when starting treatment in South Gloucestershire, 2009-10 to 2018-19. **Error! Reference source not found.** In general, trends across the past decade appear relatively consistent. However, there has been a gradual, year-on-year reduction in the number of people in drug treatment services reporting cannabis use from 2009-10 to 2018-19, as well as a more dramatic reduction in the use of benzodiazepines across the last two reporting years. The reduction in the use of benzodiazepines may be due to the fact that prior to 2018, benzodiazepine treatment was provided by a specialist provider: Battle Against Tranquilisers. In 2018/19, this provision ended and Avon and Wiltshire Partnership Mental Health Trust (AWP) now provide this service within their sub-contract with DHI, rather than this being a dedicated and separate service.

Figure 2: Substances that service users reported having a problem with when starting treatment in South Gloucestershire, 2009-10 to 2018-19.



National Drug Treatment Monitoring System (NDTMS) data estimates that the prevalence rate of opiate and/or crack users in South Gloucestershire is 6.99 per 1000 people, lower than national estimates of 8.85 per 1000. The same is true when looking at opiates separately, with a rate of 4.59 per 1000 for South Gloucestershire compared to 7.37 for England as a whole. However, the rate of crack cocaine use in South Gloucestershire (5.31 per 1000) is slightly higher than the national average (5.10 per 1000).

## Prescribed Opioids

### Background

Opioid analgesics are a class of pain medication used to treat moderate to severe pain. They have been shown to be effective for the treatment of acute pain (for example pain following surgery) and in palliative care, particularly for cancer related pain. Increasingly, opioid analgesics have been used for the treatment of chronic non-cancer pain (CNCP). CNCP is defined as a painful condition lasting for 3 months or longer, not associated with a diagnosis of cancer (11). Chronic pain is a major public health problem that causes significant distress, negatively affects quality of life and limits how people function both personally and socially (1). Between 35% and 53% of people in the UK are estimated to be affected by CNCP (12).

There is limited evidence that prescribed opioids actually reduce chronic pain or improve quality of life (13–17). In recent years, significant concerns have also been raised about their long-term safety. Studies have shown that using prescribed opioids for more than two weeks is associated with several serious adverse events, including dependence, overdose and deaths related to using these drugs (13,18–20). Dependence on prescribed opioids could lead to individuals misusing their medication (for example, taking too high a dose) or trying to obtain these medicines illegally once they are no longer prescribed, or prescribed in insufficient doses to manage their dependency (1).

The National Institute for Health and Care Excellence (NICE) are currently developing guidelines for managing chronic pain (21), but their existing advice recommends that opiates should not be prescribed for chronic low back pain due to the concerns outlined above (22).

### Prescribed opioid usage

Despite concerns about their safety, there has been a substantial increase in opioid prescribing over the last twenty years (23,24). Rates of prescriptions for high-dose opioids vary across England, but are highest in rural areas, areas of greatest deprivation and among larger GP practices (1,23). Public Health England (PHE) recently published a review of prescribed drug dependence and withdrawal. This review found that in 2017-18, 5.6 million adults in England were prescribed an opioid pain

medication, equivalent to 13% of the adult population (1). However, there has been a slight reduction in the number of prescriptions for opioid pain medicines since 2016.

Table 2 (below) displays data from PHE, detailing the number of patients receiving an opioid prescription across BNSSG.

Table 2: Opioid prescription use across Bristol, North Somerset and South Gloucestershire (Source: PHE)

Drug	Number of patients receiving an opioid prescription in March 18	Proportion of patients in receipt of a prescription for at least 12 months (%)	CCG Rank (1 = highest proportion, 195 = lowest proportion)
Opioid pain medicines	36,483	47.4	122

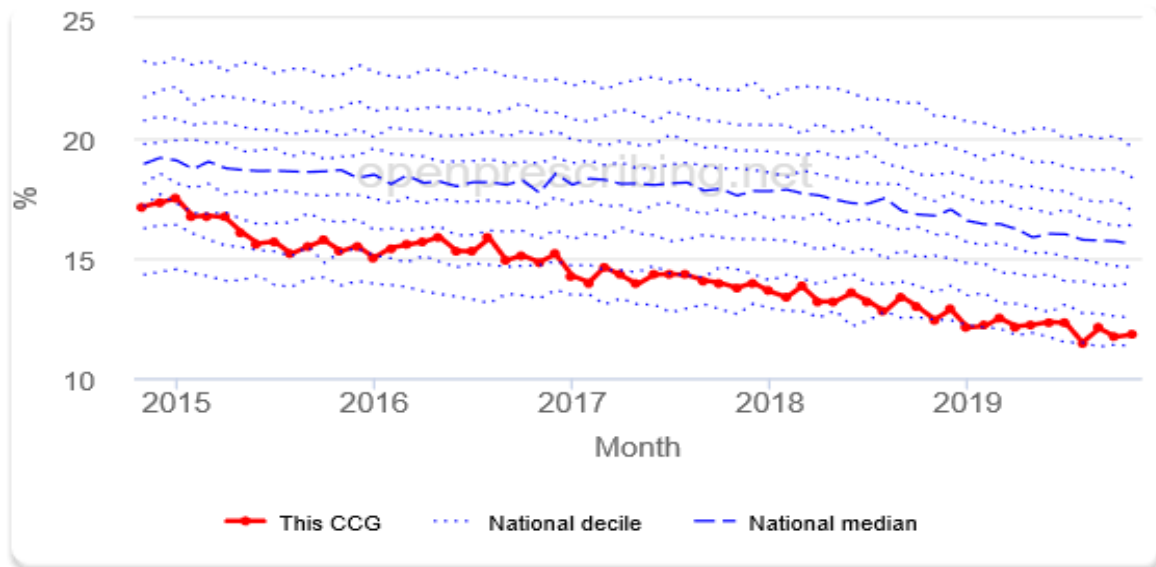
This suggests that the BNSSG CCG benchmarks well nationally and that patients are generally not remaining on these medicines in the long term. Slightly fewer patients are being prescribed opiates across BNSSG than would be expected, given the age and sex breakdown of the population.

29% of the population of BNSSG live in South Gloucestershire; using the above data, we can therefore make a crude assessment that approximately 10,120 patients in South Gloucestershire received an opioid prescription in March 2018. However, it is important to note that the populations living across these three local authority areas are different and so prescribing patterns across the three areas are unlikely to be the same.

The risk of harm from taking prescribed opioids significantly increases in those who take more than 120mg morphine (or equivalent) per day, without much increase in benefit in reducing pain. Figure 3 shows the proportion of patients in BNSSG being prescribed opioids who are likely to be taking 120mg morphine or more per day. This shows that a lower percentage of patients in BNSSG are taking high doses of opioids compared to national figures, and that this percentage has been gradually reducing since 2015.



Figure 3: Opioids with likely daily dose of  $\geq 120\text{mg}$  morphine equivalence compared with prescribing of all doses of these opioids



Data are available on the number of adults in drug treatment for use of prescription-only and over-the-counter medicines. These categories of drugs include prescribed opioids, benzodiazepines, z-drugs, analgesics, other prescribed drugs and over-the-counter opiates (25). These data do not differentiate between those using prescribed opiates and other forms of medication, but it is reasonable to assume that a large number of these individuals will be receiving treatment for prescribed opiate use. 22% (n = 146) of all people using drug treatment services in South Gloucestershire in 2018-19 reported using prescription-only or over-the-counter medicines, compared to 14% of all people in drug treatment nationally. Just over one-third (36%, n = 53) were also using illicit drugs alongside these medicines. However, these data are not necessarily an indication that the use of prescription-only and over-the-counter medicines is more of a problem in South Gloucestershire than in other areas of the country. The pain pilot may have raised awareness of the problem among GPs and drug service staff in South Gloucestershire, resulting in more people receiving treatment.

#### Opioid and pain review service pilot

In 2016, in response to increasing national concerns around prescribed opioid dependence, South Gloucestershire began a two year-long pilot of a pain review service for patients receiving long-term opioid medications for CNCP. Full details of these studies can be found in published papers by Kesten et al (2019) and Scott et al (2019) (26,27). The service aimed to help service users understand their relationship with opioids and support alternative, non-drug based pain management strategies. This service was delivered by two project workers, working on a one-to-one basis with service users across two GP practices in South Gloucestershire. Service users underwent a comprehensive and holistic assessment, exploring both the medical and psychosocial factors involved in their use of prescribed opioids. An individually tailored pain management plan was then co-created with service users, encouraging use of non-pharmacological strategies for pain management. Techniques such as goal setting, education and counselling were used in conjunction with referrals to community-based services for physiotherapy and relaxation and mindfulness groups. The individual's use of prescribed opioids was also reviewed and service users were supported to reduce their dose of these medications where appropriate.

Thirty-four individuals were enrolled in this pilot service. Results showed that patients reported improved health, wellbeing and quality of life following their engagement with the service. Service users reported developing a greater understanding of their pain and of the effectiveness of opioids for chronic pain, and were able to develop different techniques for managing their pain (26). The proportion of service users who were misusing opioids reduced from 86% at baseline to 68% at follow-up. 44% of those using the service also reduced their opioid dose, with three individuals stopping their use of opioids altogether. Positive aspects of the service, reported by stakeholders and service users, included the tailoring of the service to individual needs, taking focused time to discuss pain management and providing an alternative to the traditional medical model for managing pain. The relationship between the project worker and service user was also considered key to the success of the service. GPs reported that the service enabled them to make more considered decisions about prescribing opioids to patients and both GPs and service users reported reductions in the number of GP consultations. However, the pilot did not save GPs' time. The numbers using this service were also small and therefore the effectiveness of the service needs to be more formally tested.

Originally, it had been hoped that a successful pilot would lead to ongoing work around pain relief and opioids to become embedded in the general drug and alcohol community services contract. However, this did not happen. This was primarily due to the cost of having individualised 1:1 sessions with a project worker to build relationships with people using the service and provide expert knowledge and continuity of approach. With the amount of funding available, it was not possible to have a team of staff implementing the work across all GP surgeries and the original plan of rolling out the work to all Primary Care Workers was not felt to be an effective way of proceeding. Another factor was that both the main worker who had led on the project, along with the manager who had overseen it, had both left the organisation, therefore meaning that there was no one directly involved with the project still at the provider in order to continue the work. It was therefore felt that the most sensible approach was to include an assessment of the provision of the pilot in this drug needs assessment and to consider all of the factors to help inform our future commissioning intentions. Due to DHI recognising that they are receiving an increased number of people who need support in this area, DHI have continued to look into ways of enhancing service for this group of opioid dependent patients. This has included training for staff, although no extra funding has been made available from the Council.

### [Services for prescribed opioid dependence](#)

Individuals who are dependent on prescribed opioids should have access to treatment pathways that support their needs in terms of managing dependence and withdrawal, and which reduce the risk of relapse and harm. However, people with prescribed opioid dependence report barriers to accessing and engaging with treatment services (1) and are less likely to access traditional specialist substance misuse services (28).

National guidance recommends that commissioners should provide separate addiction services to treat prescription opioid dependence (29). However, PHE's review of prescribed drug dependence found insufficient evidence to make any specific conclusions about the most effective approach for preventing and treating prescribed opioid dependence, particularly over the longer-term (1). The authors therefore concluded that more high-quality research is needed to determine the effectiveness and cost-effectiveness of services to treat prescribed opioid dependence. Nevertheless, they recommended that common components of current services – involving primary care services, helpline telephone support, tapering support, counselling and support groups, and individualised plans and programmes - should be considered when considering support services for

these individuals as they were well received by current service users. In addition, they concluded that “effective, personalised care should include shared decision making with patients and regular reviews of whether treatment is working. Patients who want to stop using a medicine must be able to access appropriate medical advice and treatment, and must never be stigmatised” (1).

#### Actions to Consider

1. Opioid prescribers should provide information to patients about risks and benefits of this type of medication in the treatment of CNCP, and the availability of other treatment options for the management of pain. The Council’s Drug and Alcohol Programme should work with GPs to provide training on having these conversations in order to support this.
2. Prescribers should familiarise themselves with the BNSSG guidance for management of CNCP, together with the “Opioids Aware” information from the Faculty of Pain Medicine (<http://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware>).
3. GPs should be given training and support materials to help them to have the difficult conversations with their patients on pain management and opiate prescribing.
4. Patients should receive regular reviews of their opiate prescriptions to ensure that their medication is still clinically appropriate and relevant.
5. The drug treatment services currently commissioned by the Public Health and Wellbeing Division from DHI should continue to work with people with these types of dependencies. South Gloucestershire Council’s DAP should explore funding options (including co-commissioning) for recommencing the Opioid and Pain Review Service and discuss where this service should best sit with stakeholders and service users.

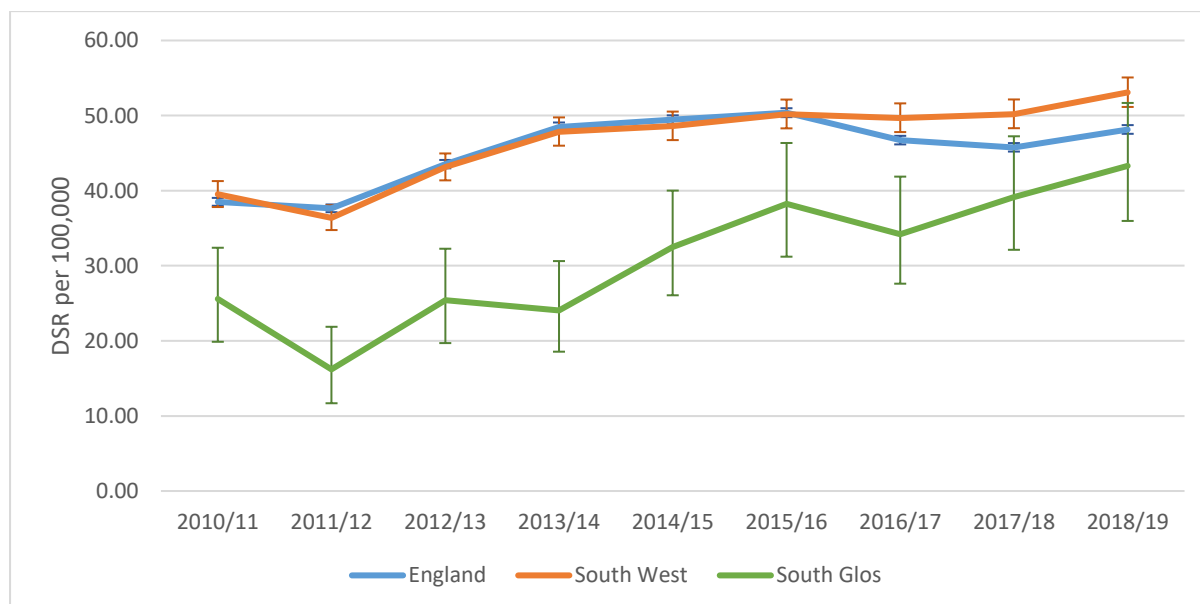
## Impacts of Drug Use

### Hospital Admissions

Hospital admissions for drug-specific substance misuse are defined as hospital admissions where the primary diagnosis is of a mental or behavioural disorder resulting from drug use, poisoning by a specific drug (including narcotics such as heroin, methadone, cocaine and cannabis), or the toxic effects of drugs such as solvents.

In 2018/19, the rate of drug-related hospital admissions in South Gloucestershire was 43.3 per 100,000 population. For seven of the last nine years, rates of drug-related hospital admissions in South Gloucestershire have been significantly lower than both national and regional rates – 48.2 per 100,000 and 53.1 per 100,000 in England and the South West respectively in 2018/19. However, despite this, there has been a gradual increase in drug-related hospital admissions in South Gloucestershire since 2010/11. This increase is statistically significant, and is replicated both across England and the South West region. While overall numbers of drug-related hospital admissions in South Gloucestershire are low and must therefore be interpreted with caution, it appears that the extent of the increase in drug-related hospital admissions is greater in South Gloucestershire than is seen both nationally and regionally. In South Gloucestershire, admissions in 2018/19 were 69% higher than in 2010/11, but were 25% higher in England and 34% higher in the South West over the same time period. As a result, drug-related hospital admissions in South Gloucestershire were no longer significantly lower than for England by 2017/18, nor the South West by 2018/19. These trends are displayed in Figure 4 (below).

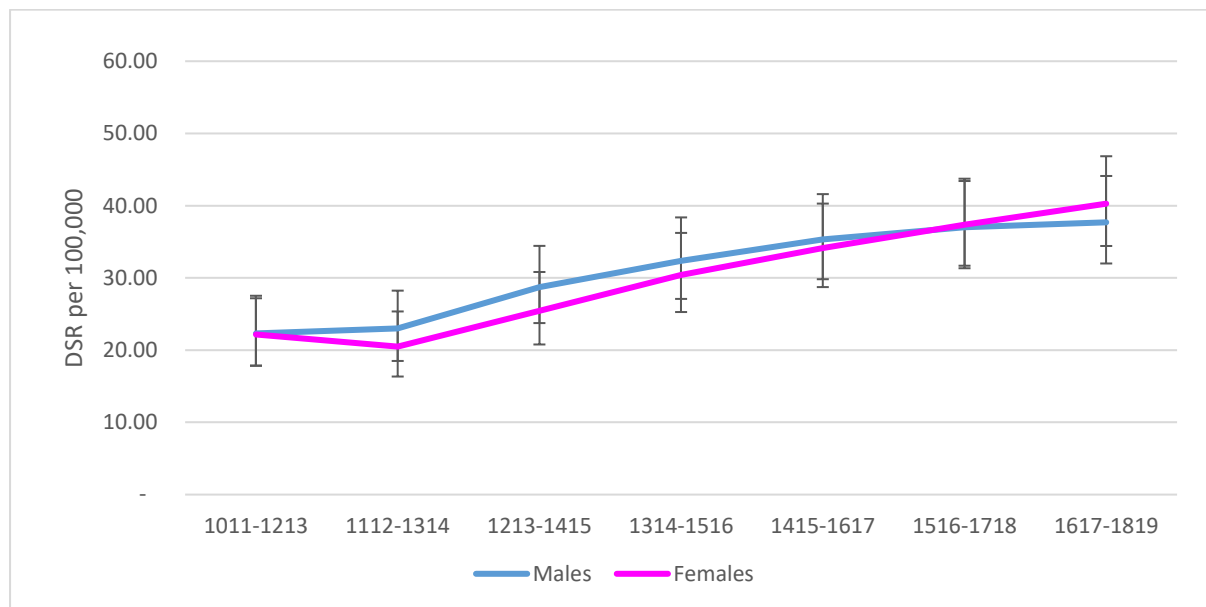
Figure 4: Hospital admissions for substance misuse (drug-related) in South Gloucestershire, the South West and England, 2010/11 to 2018/19.



The increase in drug-related hospital admission rates has been seen among both males and females. 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 (in 2018/19, drug-related admissions rates in South Gloucestershire were 40.3 per 100,000 in females compared to 37.7 per 100,000 in 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. This is displayed in Figure 5.

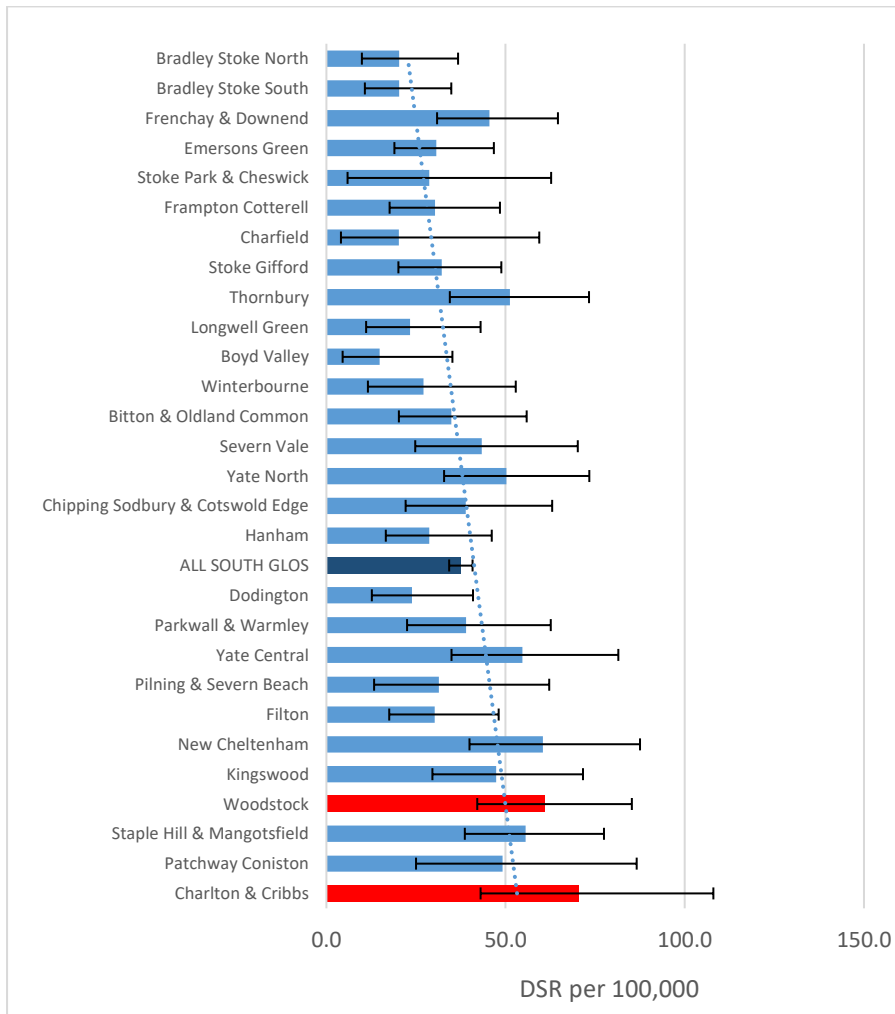
Figure 5: Trend in hospital admissions for substance misuse (drug-related) by sex, South Gloucestershire, 2010/11 - 2018/19, three year rolling averages.



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.

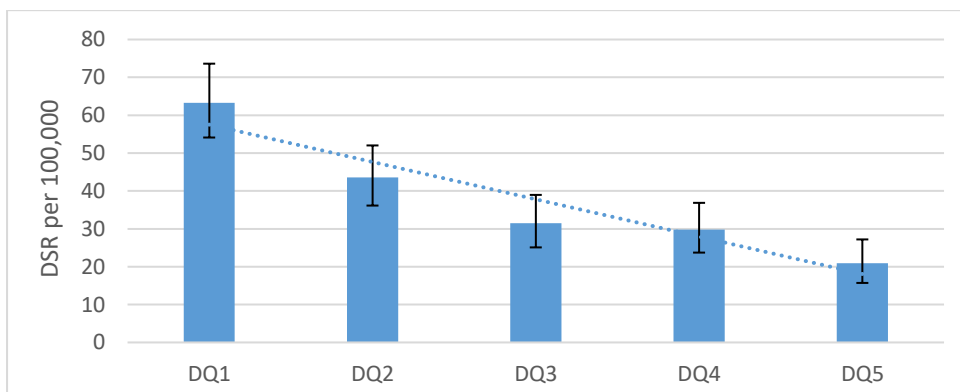
When looking at admission rates by ward, two wards had drug-related admissions rates higher than the South Gloucestershire average: Woodstock and Charlton & Cribbs (see Figure 6, with these two wards marked in red). It should be noted that hospital admissions data only includes information at LSOA-level, and data has therefore been adjusted to fit to ward boundaries using a 'best fit' approach. Five years of data has been pooled to enable more detailed categorical analysis of these relatively uncommon events. Despite this, some wards still experienced fewer than 10 admissions over a five-year period and these data were therefore suppressed in order to comply with disclosure rules.

Figure 6: Hospital admissions for drug-related substance misuse by 'proxy' ward, ordered by average Index of Multiple Deprivation 2019 deprivation score, 2014/15-2018/19 (5 year pooled rates)



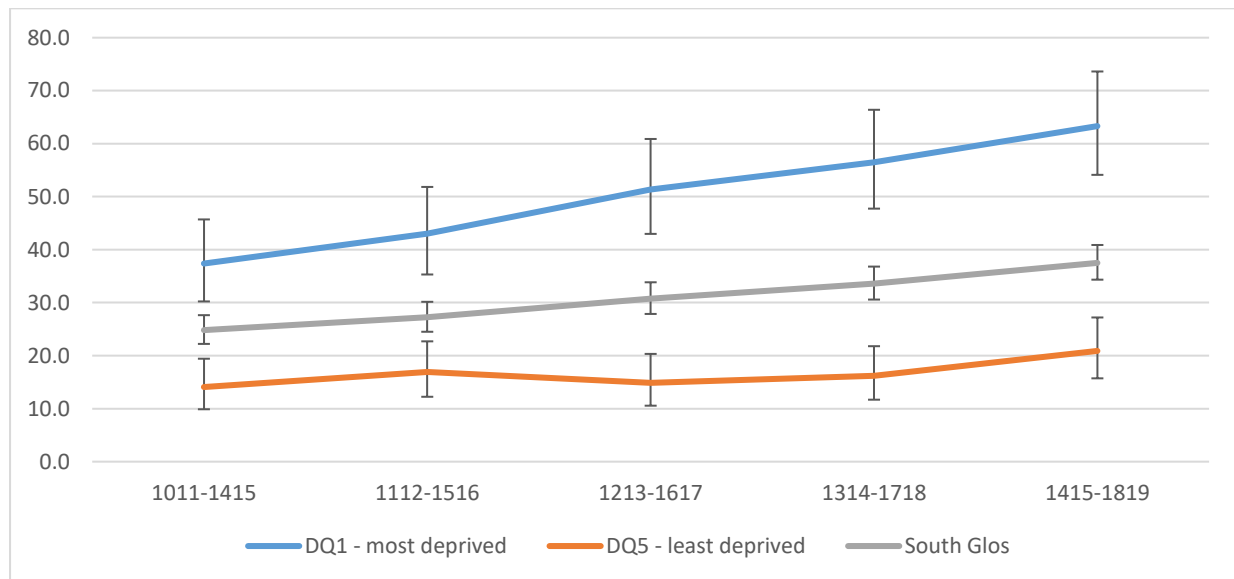
As shown in both Figure 6 (above) and Figure 7 (below), there appears to be an association between drug-related hospital admissions and local area deprivation in South Gloucestershire. Admissions rates pooled across the past five years were 37.4 per 100,000 population in the most deprived quintile, significantly higher than rates seen across all other areas. In comparison, pooled admissions rates in the least deprived quintile were 20.1 per 100,000. This association is displayed in Figure 7.

Figure 7: Hospital admissions for drug-related substance misuse by local deprivation quintile, South Gloucestershire, 2014/15-2018/19 (5 year pooled rates).



When examining the trend in this relationship between local area deprivation and drug-related hospital admissions over time, inequalities by area deprivation have widened over the past ten years (see Figure 8). From 2010/11 to 2014/15, the absolute inequality gap in hospital admissions was 23.3 per 100,000 – or 266% - higher in the most deprived compared to the least deprived areas. Over the most recent five year period, from 2014/15 to 2018/19, this absolute inequality gap in admissions increased to being 42.4 per 100,000 – or 303% - higher in in the most deprived compared to the least deprived areas of South Gloucestershire.

Figure 8: Hospital admissions for drug-related substance misuse by most and least deprived local area deprivation quintile, South Gloucestershire, 2010-2018 (5 year rolling averages)



Between 2010/11 to 2018/19, there have been 765 hospital admissions in South Gloucestershire residents that were primarily due to drug misuse. These were most commonly due to opioids, accounting for 40% (n = 308) of all drug-related admissions during this period. This was followed by other synthetic narcotics (15%, n = 118), psychostimulants (6%, n=43) and cocaine (4%, n=30).

#### Actions to Consider:

1. Further investigate potential reasons for the marked increase in drug-related hospital admissions amongst females.
2. Target prevention and intervention measures in areas of multiple deprivations in order to reduce the widening inequality gap in hospital admission rates.

#### Infectious Diseases

People who inject drugs (PWIDs) are at a disproportionately high risk of blood-borne viruses (BBVs) and are vulnerable to a range of bacterial infections. These largely result from unsterile injecting practices and the sharing of needles, syringes and other injecting equipment, but are often exacerbated by delays or difficulties in accessing healthcare and poor wound care. While much rarer, contaminated drugs may also leave PWIDs at risk of contracting life-threatening infections with bacteria such as anthrax and botulism.

#### BBVs

##### HIV

HIV is relatively uncommon among PWIDs in the UK, with 1.2% of PWIDs living across England, Wales and Northern Island estimated to have HIV (30). However, it is important to note that this is

higher than the prevalence of HIV among the general population in the UK, which is currently estimated at 0.18% (31). In the South of England region – which comprises both the South East and South West PHE regions – there were 18 new HIV diagnoses among PWIDs in 2018. Despite both the prevalence and incidence of HIV remaining low, outbreaks of HIV among PWIDs continue to occur.

HIV testing is vital for ensuring that people are aware of their status and able to access treatment and support. The majority of PWIDs in England, Wales and Northern Ireland report having been tested for HIV and are aware of their HIV status (32). However, late diagnosis of HIV is a problem in this group, with 49% of new diagnoses in 2018 occurring at a late stage of infection (32). The risk of dying within a year of diagnosis is ten times higher in those diagnosed late compared to those diagnosed promptly (33). Importantly, data suggests that there are missed opportunities for potentially diagnosing HIV in PWIDs at an earlier stage of infection, with those who have not ever been tested for HIV or who have not been tested within the past two years reporting having attended their GP, receiving drug treatment or having used a needle exchange programme within the past year (34). Drug services in South Gloucestershire began routinely testing for HIV in April 2019. Between April 2019 and March 2020, 108 people were tested for HIV, all of whom were negative.

Detailed local data is also not available on access to antiretroviral therapy (ART) by PWIDs. However, national data shows that ART coverage in this group in 2018 was high, at 96%. However, a lower proportion of PWIDs (93%) are virally suppressed compared to other at-risk groups, such as those who acquired HIV through heterosexual contact (97%) or men who have sex with men (98%) (34). PHE suggest that this may be the result of factors such as their drug-taking behaviour affecting adherence to medications or access to and engagement with healthcare services, mental health issues or other personal circumstances (34,35).

### *Hepatitis B*

Similarly, there are low levels of hepatitis B transmission among PWIDs in the UK. In 2018, 0.4% of PWIDs across England, Wales and Northern Ireland had active hepatitis B infection, with 9% of PWIDs estimated to have ever been infected with hepatitis B (32). 10% of PWIDs in the South West region had ever been infected with hepatitis B, consistent with the national figure above (32).

Hepatitis B is preventable through vaccination. Vaccination is recommended for people who currently inject drugs - including those who inject intermittently and who are likely to 'progress' to injecting, e.g. people who are currently smoking heroin or crack cocaine – together with all sentenced prisoners and new inmates entering prison in the UK (36). Four doses of the vaccine are recommended – usually given at 0, 1, 2 and 12 months, but an accelerated course can be given at 0, 7 and 21 days, with a booster at 12 months, for those who face difficulties in engaging with services (36).

In 2018-19, 68% (n = 97) of adults in South Gloucestershire who were new to drug treatment and also eligible for a hepatitis B vaccination accepted one - higher than the national proportion of 40%. However, fewer than five of these individuals went on to either start or complete a course of vaccination. This is likely to be due to the vaccination schedule, requiring individuals to visit their GP on multiple occasions over the course of several months. Many service users consent to being vaccinated, but the attrition rate to actual vaccination is poor. There is therefore a need to explore options for how uptake of these vaccinations can be improved.



## Hepatitis C

Hepatitis C is now curable through an eight to twelve week course of oral treatment with direct-acting antivirals (DAAs). In 2016, the World Health Organisation (WHO) introduced the first ever global targets for viral hepatitis, aiming to eliminate viral hepatitis as a public health threat by 2030 (37). NHS England are aiming to meet this target by 2025, but this will require the expansion of testing and treatment provision across a range of settings. DAAs are now available for PWIDs in the UK, without restrictions (38). Across England, 22 Operational Delivery Networks (ODNs) have been established to support hepatitis C treatment provision and access in local areas. South Gloucestershire falls within the Bristol and Severn ODN.

People who either currently or previously injected drugs are most significantly affected by hepatitis C, with approximately 90% of hepatitis C infections in England acquired through injecting drug use (30) and more than 50% of PWIDs having ever been infected with the virus (32). 27% of PWIDs in England, Wales and Northern Ireland were found to be currently infected with hepatitis C in 2018 (32); this is a slight reduction from the previous year, which PHE have suggested may be the result of increased uptake of DAAs (38). The prevalence of chronic hepatitis C infection among PWIDs in the South West region was 32% in 2018 (39).

In South Gloucestershire in 2018-19, 86% (n = 60) of previous or current injectors who were new to drug treatment services and eligible for a hepatitis C test received one, compared to 76% of this group nationally. 31% (n = 10) tested positive for hepatitis C antibodies, indicating that they were ever-infected with hepatitis C. Fewer than five individuals were hepatitis C RNA-positive, which indicates current infection with the virus. All of these individuals were referred to specialist services for treatment, although some individuals did not then engage with these services and consequently did not receive treatment for hepatitis C. Given that injecting drug use is the most important risk factor for hepatitis C (39), drug services have a vital role to play in achieving the hepatitis C elimination targets. While the proportion of eligible individuals in South Gloucestershire who received a hepatitis C test is high, reasons for not testing should be explored with individuals and addressed where possible. Crucially, these data only reflect testing for people who are accessing drug services; more focus needs to be given to providing testing and treatment support to those individuals who are at risk of contracting and transmitting hepatitis C but who are not in treatment, and particularly for injecting drug users. Furthermore, all individuals who have a positive RNA test should be promptly referred for treatment, for the benefit of their own health and to limit further transmission of the virus.

## Bacterial infections

Bacterial infections in PWIDs can result in significant mortality and morbidity, with research estimating that one in ten PWIDs are admitted to hospital each year with a bacterial infection (40). Outcomes in these individuals can be worsened by delays in accessing healthcare, increasing the risk of wounds developing into invasive infections that may result in sepsis. More than half (54%) of PWIDs in England, Wales and Northern Ireland reported having a sore, open wound or abscess at an injecting site in 2018 (30).

The number of bacterial skin, soft tissue and vascular infections in PWIDs has been increasing over the last five years (41). In particular, increasing numbers of PWIDs have been infected with invasive Group A *streptococci* (iGAS) and methicillin-sensitive and –resistant *Staphylococcus aureus* (MSSA, MRSA). The reasons for this are thought to be multifactorial, but are likely related to increases in the proportion of PWIDs who have reported being homeless over the same time period. 47% of PWIDs in England reported being homeless during 2018, compared to 36% in 2016 (32), with homelessness

being associated with unsterile injecting practices and poorer general hygiene. Studies have shown that bacterial infections are also more likely with injecting more frequently, having injected for a longer period of time, skin popping and poor vein health, with the latter leading to multiple attempts to find a vein that can result in missed hits (42–46). Cleaning injecting sites before injecting protects against skin and soft tissue infections (42).

Injecting into the groin and other higher risk injecting sites is particularly associated with bacterial infections. This is because of higher natural bacterial carriage in the groin and other higher risk areas, increasing the risk of contamination, together with poorer wound healing at these sites (46). Groin injection also increases the risk of developing non-infectious complications such as deep vein thrombosis (47). 40% of PWIDs in the South West region reported injecting into their groin in 2018 (32). This proportion has increased over the past decade, thought to be largely due to an increasingly ageing cohort of PWIDs in the UK (48).

The 'Design in the Public Sector' (DiPS) programme is delivered in partnership between the Local Government Association (LGA) and the Design Council and focuses on equipping local authorities to apply design principles to complex public health challenges. Across BNSSG, the DiPS programme has focused on developing novel interventions for preventing invasive bacterial infections among PWIDs in and around Bristol. The DAP team at South Gloucestershire Council are involved in this work and attend DiPS group meetings.

### Actions to Consider

In line with PHE recommendations for Directors of Public Health, commissioners and service providers in England (49), we recommend the following:

1. South Gloucestershire Council's DAP should work with drug services, the CCG and other partner organisations to ensure that opportunities for BBV testing in primary care and drug services are not missed, scoping whether pharmacies or other health professionals could support this area of work.
2. Drug services should continue to provide dried blood spot testing for BBVs to those coming into treatment, and regularly re-test those at risk.
3. South Gloucestershire Council's DAP should explore the possibility of commissioning a service which offers hepatitis B vaccination in alternative settings, such as pharmacies, in order to improve vaccine uptake among PWIDs.
4. South Gloucestershire Council's DAP should work with the local ODN to explore options for offering hepatitis C outreach services to at-risk individuals not currently accessing drug services.
5. Drug services should encourage people with skin lesions or other signs of infection to access healthcare services.
6. Drug services should report any clusters of PWIDs with bacterial infections to PHE, in order to enable outbreaks to be identified and appropriate control measures established.
7. Drug services should continue to provide easy access to needle and syringe programmes and emphasise the importance of safe injecting practices. These should include information about using as little acidifier as possible and rotating injection sites in order to minimise the risk of damaging veins.

### Pregnancy

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).

The BNSSG CCG facilitate the local maternity system (LMS), which brings together individuals and organisations involved in providing, receiving or commissioning maternity care. The aim of the LMS is to deliver safer care to pregnant women across the BNSSG area through the development of a strong, cohesive maternity system. Providers of both maternity and neonatal care are brought together to ensure that services are person-centred, safe and of high quality.

For uncomplicated pregnancies the normal pathway is for a minimum of 10 maternity care contacts with a healthcare professional. At their booking appointment, pregnant women attending services are asked about their drug use. Across the BNSSG area, women disclosing current drug use are referred to a specialist maternity midwife for substance misuse and are placed under Consultant care for closer screening. The woman's keyworker, specialist midwife and community midwife work closely together throughout the pregnancy. If necessary and appropriate, the specialist midwife will refer the woman to social services once they are more than 20 weeks' pregnant, and the professionals involved will then work together to plan treatment. However, there is concern for those who do not disclose current drug use.

Young people in particular may engage in a cluster of unhealthy behaviours such as smoking, drinking or using other drugs. The Maternal Early Childhood Sustained Home-visiting (MECSH) programme is a structured programme of sustained nurse home visiting for vulnerable families, including young people, at risk of poorer maternal and child health and development outcomes (51). The programme starts during the antenatal period and supports families until the child is aged two. Focus is on prevention and early intervention with management of high risk needs such as drug and alcohol in conjunction with other services. Public health nurses (health visitors) in South Gloucestershire will be trained to implement MECSH. Training will take place in July 2020 and the programme will then be rolled-out in the area following this.

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%.

#### Actions to Consider

1. The DAP should develop working relationships with maternity services commissioners and providers across BNSSG through the LMS.
2. Collaborate with the LMS and local authority Public Health teams across the BNSSG to develop a more detailed understanding of maternity provision across the BNSSG area. This should include an audit of current practice across the local system to identify priority areas for development and help with effective planning.
3. Work towards developing and sharing agreed protocols and evidence-based pathways for pregnant women who disclose currently using drugs at their booking appointment and any other contact with a maternity healthcare professional.
4. Provide pre-conception education about the risks of drug use in pregnancy including within schools and sexual health settings.

5. Develop partnerships with antenatal and postnatal services, e.g. health visitors. Train and upskill health visitors, and collaborate on the development of patient information leaflets and apps etc.
6. Request data for pregnancy status on presenting for specialist drug treatment for the last five years and compare it with the national proportion.
7. Monitor improvements and outcomes regularly over time.

## Sexual Health

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.

PWIDs are also at risk of contracting and transmitting STIs. In 2018, 60% of PWIDs in England and Wales reported having sex (anal or vaginal) during the previous year (32). 40% of these individuals reported having two or more sexual partners, with only 19% of those with two or more sexual partners reporting always using a condom. This proportion was similar for both males and females, and did not vary with age. This is particularly relevant when considering the increased risk of PWIDs contracting BBVs, as discussed above.

## Chemsex

PHE describe chemsex as “the use of drugs before or during planned sexual activity to sustain, enhance, disinhibit or facilitate the experience” and is practised mainly by gay, bisexual and other MSM (53). The drugs involved are most commonly crystal methamphetamine, GHB/GBL and mephedrone, often in combination. They may be taken orally, snorted or injected (also known as ‘slamming’). Chemsex sessions often take place over several days and involve multiple partners, with increased risks of HIV transmission resulting from unprotected anal intercourse, delayed access to post-exposure prophylaxis and reduced adherence to antiretroviral medication. This is particularly concerning given that reports suggest that chemsex is more common among HIV-positive MSM and may therefore be linked to HIV transmission (54–58).

While chemsex is becoming increasingly common, there is currently very little evidence surrounding interventions or appropriate care pathways for those engaging in chemsex. PHE have developed a Chemsex Action Plan which focuses on developing evidence, collecting data and raising awareness of chemsex as a public health problem. PHE recommend an integrated approach between sexual health and drug services to caring for those who require treatment.

It is important to note that not all MSM requiring treatment for their drug use participate in chemsex and only a minority of MSM use drugs. Nevertheless, surveys suggest that a higher proportion of MSM use drugs compared to the average for the adult population. In addition, drug use has been linked to outbreaks of bacterial infections such as *Shigella flexneri*, other bacterial STIs and BBVs among MSM (59–63).

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.

### Local sexual health and drug services

Sexual health services in South Gloucestershire ask patients about their drug use, not as a formal brief intervention, but in order to refer people to specialist drug services where necessary. Services have an important role in providing information and signposting, and should therefore collaborate with both sexual health and drug service commissioners to coordinate this work. In addition, commissioners themselves should also collaborate with one another in order to ensure the more effective delivery of sexual health services across the local area.

Current Personal, Social and Health Education lessons in secondary schools don't consistently include information about how drug use can influence sexual activity, both in relation to consent and condom use. The introduction of a new statutory Relationships, Sex and Health Education curriculum in September 2020 represents a good opportunity to address this shortcoming.

### Actions to Consider

1. Effective collaboration between drug, alcohol and sexual health specialists in Public Health so that schools receive the support, guidance and resources required to include education about the effects of drug use on sexual health and relationships. Consideration should also be given to how these messages can be communicated to those not in mainstream education.
2. Collaboration between drug, alcohol and sexual health specialists in Public Health to ensure that sexual health services are trained to provide information that highlights the link between drug use and poor sexual health outcomes, and signpost sources of useful advice, including clear information about self-referral options.
3. Drug, alcohol and sexual health specialists in Public Health should work together with drug services and the LGBTQ+ community to ensure that services are appropriately tailored to meet their needs.

### Mental Health

Mental and physical wellbeing are closely linked. People with mental health problems are more likely to smoke, be overweight, use drugs and drink alcohol to excess, have a disrupted education, be unemployed, take time off work, fall into poverty, and be over-represented in the criminal justice system (4). It is therefore crucial that mental health is given equal priority to physical health in order to improve health and reduce inequalities in the population.

At least one in four people in the UK experience a mental health problem at some point in their lives, with one in six adults in England experiencing a common mental health problem (such as anxiety or depression) in any given week (64). In South Gloucestershire, 13.6% of the population aged 16 and over are estimated to have a common mental disorder, lower than both the national average (16.9%) and regional average (15.6%) (65). 0.6% of the population in South Gloucestershire are thought to have severe mental illness (65). However, these figures are likely to be underestimates as they are based on the prevalence among individuals living in private households. This therefore excludes those who are homeless or living in institutional settings (e.g. prisons), who are likely to have poorer mental health.

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.

This data suggests that there is an unmet need for mental health treatment among those receiving drug treatment in South Gloucestershire. More collaborative working between local drug treatment services and specialist mental health services is required in order to prevent those with complex needs falling through any gaps in the system.

Prior to this needs assessment, work was conducted to scope potential issues in joining up drug and alcohol services and mental health services. This included a survey of practitioners who saw people with a dual diagnosis. 11 of 54 practitioners (8 substance misuse workers, 1 social worker, 1 alcohol specialist nurse, and 1 mental health service worker) responded to the survey. 7 reported having had referrals rejected because the service user had a dual diagnosis of a mental health and substance misuse disorder.

#### Actions to Consider

1. Ensure all local drug services are available, accessible and equitable for people with mental illness.
2. South Gloucestershire DAP and local drug and alcohol services should work with mental health colleagues and commissioners to ensure everyone across the life course with a dual diagnosis is offered a package of concurrent mental health and substance misuse treatment, co-commissioning services where appropriate.
3. Explore options to support mental health and wellbeing for all people in drug services, including those without a dual diagnosis. This should include embedding mental wellbeing in treatment and care plans, and ensuring that drug services are aware of the availability of lower-level mental health support through services such as One You South Gloucestershire.
4. Conduct a review of those self-reporting mental illness; to ensure that they have received a referral to specialist mental health services to ascertain if an official diagnosis and treatment course is required.



## Mortality

The number of drug-related deaths across England and Wales has been steadily rising across the past three decades, with a particularly notable increase since 2012, and are now at the highest levels on record. In 2018, there were 4,359 registered deaths due to drug poisoning in England and Wales – a 16% increase from those seen in 2017 (19). Approximately two-thirds of these deaths (2,917 deaths) were due to drug misuse, a rate of 50.9 deaths per million people. This is a statistically significant increase compared to 2017, where the mortality rate due to drug misuse was 43.9 deaths per million people. The rate of deaths due to drug misuse was more than two and a half times greater among males than females and was highest in those aged between 40 and 49 years (19).

More than half of deaths due to drug poisoning (51%) involved an opiate, the most common of these being heroin and morphine. The number of heroin deaths has more than doubled since 2012 (69) and is thought to be the primary driver for the increase in drug-related deaths seen across England and Wales. Deaths related to cocaine have also increased year-on-year for the past seven years and are now significantly higher than during any other year on record, with an age-standardised rate of 11.1 deaths per million people in 2018. The National Crime Agency reports that purity levels of heroin are consistently high, while cocaine purity is at “historically high levels”, contributing to the high death rates seen related to both substances (70).

Rates of drug-related deaths vary considerably across England and Wales. Between 2016 and 2018, there were 4.9 deaths due to drug misuse per 100,000 people in the South West region, higher than the national rate in England of 4.5 deaths per 100,000 (71). South Gloucestershire has one of the lowest rates of death due to drug misuse of all local authorities in the South West, at 2.6 deaths due to drug misuse per 100,000 people in 2016-2018 (71). This was also the lowest rate among South Gloucestershire’s Chartered Institute of Public Finance and Accountancy (CIPFA) nearest neighbours.<sup>1</sup> Reflecting the patterns seen in the national data, the rate of deaths due to drug misuse in South Gloucestershire was higher in males (2.9 per 100,000 people) compared to females (2.3 per 100,000 people).

NDTMS data only captures those who have died whilst in structured treatment (deaths in service (DIS)). However, it is important to note that not all of those who have died in service will have died from a drug-related cause. Annual data provided by the Office for National Statistics (ONS) comes from information collected when a death is certified and registered and therefore provides a more realistic overview of drug-related deaths than NDTMS data. However, the vast majority of drug-related deaths are certified by a coroner, with the time generally taken for inquests to be completed meaning that almost half of all deaths registered in 2018 occurred in earlier years and many deaths occurring in 2018 will be included in data that has not yet been released. As a result, there is a considerable time lag in the annual ONS data.

While there is no statutory requirement to review drug-related deaths, such reviews are recommended as good practice by PHE (72). This is particularly important given that drug-related deaths are often premature and preventable; to quote an NHS Scotland report, “each one of these deaths is a tragedy, and every one is preventable, not inevitable” (73). Reviewing drug-related deaths can identify lessons learned and also provide a risk management process for those at highest risk of drug-related death. The DAP maintains a secure database of individuals who have died either while known to our commissioned drug service(s) (people receiving support either on a non-structured pathway or in structured treatment) or whose details have been sent to the DAP by the

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<sup>1</sup> CIPFA define ‘nearest neighbours’ as 16 Local Authorities (LAs) across England with similar socio-economic indicators. These include York, Bath and North East Somerset, Shropshire and Wiltshire.

Coroner's Office or Police. Given the relatively low number of drug-related deaths that occur in South Gloucestershire, the DAP are able to review all of these cases rather than only those where drugs and/or alcohol have been the immediate causal factor in a person's death (e.g. through overdose). This would be much more difficult in an area with a larger population. These cases are reviewed at the South Gloucestershire DAP's Clinical Governance Group meetings, where decisions are made about whether this was officially defined as a drug- or alcohol-related death, or a preventable death outside of the official definition, and potential lessons learnt are identified and captured.

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. 12 (63%) of those who died were in structured drug treatment when they died. Information was available on the length of drug use for 13 individuals, with an average length of drug use of 14 years (range: 18 months – 39 years), suggesting that there was significant time for a potential opportunity to alter the outcome for these individuals. A more detailed breakdown of drug-related deaths and DIS by year is not possible due to the small number of deaths (<5) recorded in several of the years between 2015 and 2019.

There have been fewer than five deaths by suicide of people in drug treatment in South Gloucestershire in the period 17/18 – 19/20. However, it is possible that some drug overdoses could in fact be suicides, as coroners will only specify suicide on a death certificate if there is significant evidence to support this. Suicide prevention training is available to staff in our drug and alcohol services and many of the drug and alcohol staff have attended the ASIST programme.

### Actions to Consider

1. The local review of people known to the Integrated Drug and Alcohol Service and the DAP Clinical Governance Group who have died because of their drug use or whilst in treatment for it should be continued. This is primarily to gain information to enable risk assessments of people known to be at risk and to develop plans to mitigate the risk and a risk flagging system should be developed to try to achieve this.
2. Provide education about drug-related harms to young adults.
3. Identify as soon as possible people who are highest risk of dying as a result of their drug-use. Motivate and support them to reduce their drug use and, where appropriate, to complete a course of structured treatment.
4. Ensure that all staff in drug and alcohol services are given suicide prevention training.

### Relationships

The damaging effects of drugs are not limited to the individuals using them. Drugs also impact upon families, communities and wider society.

### Impact on families

It is important to note that the majority of parents who use drugs do not neglect or cause harm to their children. However, parental dependent drug use can negatively affect the physical and emotional wellbeing, development and safety of children (75). Research has identified parental drug



misuse as an ACE, with long-term negative impacts on emotional wellbeing and life satisfaction (76). One in 25 adults lived with someone who misused or was dependent on drugs at some point in their childhood (77). Drug misuse was a factor in 38% of serious case reviews and 21% of assessments for children in need in 2018/19 nationally, and 19% of assessments in South Gloucestershire (78,79).

Experiencing parental drug misuse and other ACEs also influence a child’s own drug use. Research has shown that adults with four or more ACEs were eleven times more likely to go on to use crack cocaine or heroin (80), and the children of parents with a drug dependency are more likely to become dependent themselves in later life (81). Parental drug misuse is therefore both a result of and a contributor to ACEs and demonstrates the fact that problematic drug use can become intergenerational.

Box 1 (below) displays the parental status of individuals entering drug treatment in both South Gloucestershire and across England. 28% (n = 63) of those newly presenting to drug treatment in South Gloucestershire were living with children, compared to 18% nationally. The proportion of female service users living with children was also higher than the national average, 34% in South Gloucestershire compared to 27% nationally. A total of 115 children were living with adult drug users who began drug treatment in South Gloucestershire in 2018-19.

*Box 1: Parental status of individuals entering drug treatment, 2018-19.*

Parental status	Local	Proportion of new	National	Proportion of new
	n	presentations	n	presentations
Living with children (own or other)	63	28%	14,515	18%
Parent not living with children	58	26%	26,936	34%
Not a parent/no child contact	103	46%	38,065	48%
Missing / incomplete	0	0%	301	0%

14% (n = 17) of service users with child contact had children who were classified as being ‘looked-after children’ (children under the care of the local authority), more than double the proportion nationally (6%). 8% (n = 10) had children who were receiving early help, compared to 3% nationally. 6% (n = 7) had a child with a child protection plan in place. Fewer than five service users had children who were considered to be a child in need, defined as a child who requires services and support in order to have the same health and development opportunities as other children (82). These figures suggest that social care provision is available in South Gloucestershire for the children of those receiving drug treatment, and that families are receiving early intervention and support to help protect against the development of drug-related ACEs.

*Actions to consider:*

1. Continue to ensure that the South Gloucestershire DAP and local drug services work together to ensure that drug services are trauma-informed.
2. Aim for families to receive early interventions and support before the child has need for a child protection plan, and to protect against the development of drug-related ACEs.
3. More prominence needs to be given to identifying and treating drug-dependent parents. There is therefore need to develop greater partnership working with other agencies such as Preventative Services and social services teams.
4. Obtain data for the last five years relating to the number of children identified both by local drug treatment services and by local children’s social care services where parental drug use has been identified as an issue.

5. Consult with local higher risk and dependent drug users and/or previous service users with children over potential barriers to treatment.
6. Work with Children's Social Care to undertake a safeguarding audit of children whose parent(s) is receiving drug treatment.

## Domestic abuse

### *Current situation*

The Government define domestic violence and abuse (DVA) as “any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members, regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial and emotional (83).”

Across England and Wales, 5.7% of adults (2.4 million people) were estimated to have experienced domestic abuse in the year ending March 2019 (84). Across the Avon and Somerset Police Force area, 17,296 domestic abuse-related crimes were reported during the same time period (85). In 2017, the Joint Strategic Needs Assessment (JSNA) chapter on DVA suggested that, applying national prevalence rates to the population, we would expect 6000 women in South Gloucestershire to have experienced DVA in the previous 12 months, with approximately 300 women per year identified as being at high risk of serious harm or death (86).

The relationship between drug use and DVA is complex and poorly understood. Results from the Crime Survey for England and Wales indicate that victims believed that the perpetrator was under the influence of drugs in approximately 11% of incidents of DVA (87). In addition, people who have experienced DVA are themselves thought to be at higher risk of becoming dependent on both alcohol and drugs (88).

The Multi-Agency Risk Assessment Conference (MARAC) is a regular meeting to discuss those at high risk of serious harm or death. In 2018/19, 499 cases were referred to MARAC – a 66% increase from the previous year (89). The victim or perpetrator was reported to have issues with using alcohol and/or drugs in 1% (n = 5) of those cases. Up until 2014, an annual report was produced by the South Gloucestershire Safer and Stronger Communities team, which included drug-related data. In 2014, responsibility for MARAC was returned to the police and the last known data collated was for 2015/16. It showed that current or previous alcohol and/or drug use by the victim was identified in only 19% of cases but was relevant for 66% of perpetrators (86). Responsibility for MARAC was returned to South Gloucestershire Council in April 2019 and now sits within the Children, Adult and Health (CAH) Directorate.

Next Link is the provider for supporting victims of DVA but their current client management system does not have the facility to report alcohol and drug information. The South Gloucestershire Senior Community Safety Project Officer will raise this issue with the Joint Commissioning Group and propose this as information we require for future reports.

### *Support for DVA victims and perpetrators with problematic drug use*

Although there is no evidence that drug use causes DVA, it may be a trigger factor. An intention to support families to reduce trigger factors for DVA, including drugs, is included in the South Gloucestershire Domestic Violence and Abuse Strategy (90).

Our drug treatment services are flexible and sensitive to the needs of those experiencing DVA and staff have received training on identifying DVA, completing standard screening and onward referral. Referrals are made to MARAC from DHI and one of our Specialist Health Improvement Practitioners

(SHIP) in the DAP is our MARAC representative, processing referrals and attending meetings where appropriate. The DAP also has a place on the MARAC steering group.

As the provider for DVA services in South Gloucestershire, Next Link offer support ranging from telephone support and advice to a place in a safe house. Next Link provide the Freedom Programme, which is a 12-week course that examines the roles played by attitudes and beliefs on the actions of abusive men and the responses of victims and survivors. The aim is to help these individuals to make sense of and understand what has happened to them. However, there is currently a waiting list for the programme, and it is not known whether people using drug services are regularly signposted to the Freedom Programme.

In 2014/15 a small amount of community safety funding was secured by DHI to provide a perpetrator programme. Named the *Reducing Substances and Violence Programme (RSVP)*, it aimed to work with perpetrators of domestic abuse and violence who also had substance misuse issues on a voluntary basis. Perpetrators were identified from Probation or from DHI. The programme offered 8 structured 1:1 sessions to support people to make changes in their behaviour. It worked in partnership with Survive, the commissioned provider of Domestic Abuse Services in South Gloucestershire at that time, to enable a joined up approach to working with these kinds of issues in families. However, the funding for this programme was discontinued and the project was therefore forced to end earlier than planned. During the time that RSVP was running, 19 service users were referred and 10 commenced the programme. Of those 10 individuals, 8 successfully completed the programme. All of these individuals reported a reduction in the severity and frequency of their abusive behaviours. However, a full evaluation of the programme was never conducted.

Colleagues in the Safer and Stronger Communities team are currently exploring provision for perpetrators. DVA Prevention Programmes are well placed to help perpetrators recognise that their actions have an impact on their home life. We believe that a proactive approach should be adopted when targeting perpetrators, along with the use of appropriate tools and powers to target those who are not willing to change their behaviour, helping to protect the most vulnerable. Those who are willing to change their behaviour will be signposted or referred to appropriate perpetrator interventions. These include Reprovide, a RESPECT-accredited, trauma-informed programme recognised by the Family Courts. The programme provides support groups for perpetrators of domestic abuse, but also includes a family support worker that works with the partners of perpetrators to help build self-esteem and develop safety plans. Any professional can refer to this programme, although at the time of writing, all referrals have come from the police or social care, and no referrals from DHI. This suggests that not enough has been done to publicise or create adequate pathways between these services, and that more focus needs to be given to ensuring that those who may be supported to change their behaviour are given the opportunity to do so. Beyond Reprovide, there is limited provision for other perpetrator programmes outside the criminal justice or social care systems.

#### *Actions to Consider:*

1. Contact the MARAC lead in South Gloucestershire CAH services and request that data be extracted for the numbers and proportions of victims and perpetrators where drugs (and/or alcohol) is mentioned to have featured in DVA cases; and how many (and what) drug (or alcohol)-related referrals have been made.
2. Next Link to begin recording drug data for their service users.
3. Explore whether a Freedom Programme could be run from Drug and Alcohol services.
4. Develop stronger links between drug and alcohol services and perpetrator programmes to ensure adequate provision.

5. Work with the Safer and Stronger Communities team to obtain data on numbers of people from South Gloucestershire attending DVA perpetrator programmes and their outcomes.

## Crime

Drugs have a significant impact on communities, particularly in relation to crime and disorder. An independent review of drugs commissioned by the UK Home Office found that the total cost of harms related to illicit drug use in England in 2017-18 was £19.3 billion. The main driver, accounting for more than half of these costs, was drug-related crime, costing approximately £9.3 billion (91).

The New Policing Vision 2025 sets out the country's plan for policing over the course of the ten years up to 2025 (92). This aims to develop a new approach to policing which works collaboratively across organisations, including public health teams, to develop whole place approaches to commissioning and work better together to develop preventative services to support individuals, including those with complex dependencies such as drugs (93).

The relationship between crime and drug use is complex and multi-factorial. While drug use may lead to crime (for example, in order to fund someone's drug use), crime has often been found to precede drug use (94). Equally, attempting to establish a direct cause-and-effect link between crime and drug use fails to acknowledge the role of other factors, such as social exclusion, in increasing the risk of both crime and drug use (95). It is also important to acknowledge that only a small proportion of those who use illicit drugs are dependent on Class A drugs such as heroin and crack cocaine, with those using heroin and crack cocaine in particular committing significantly more crime than offenders not using these drugs (96).

Nevertheless, it is well documented that a disproportionate number of crimes are committed by a small group of dependent drug users. This is particularly true for acquisitive crime – an offence where the offender derives material gain from the crime, e.g. shoplifting, burglary (97). Evidence suggests that the prevalence of opiate and crack cocaine use specifically may drive national crime rates (98) and that individuals using heroin and crack cocaine commit 45% of all acquisitive crimes nationally (99). Links between drug use and violent crime are less clear (100–102). The most recent data from England and Wales indicates that victims believed that the perpetrator(s) were under the influence of drugs in 21% (305,000) of violent incidents (103). No further breakdown is available on the nature of these offences.

Across the Avon and Somerset Police Force area, a total of 520,909 crimes were committed by individuals before they entered drug treatment in 2017/18. This is 95 times higher than the estimated number of crimes committed by service users before entering treatment for alcohol use. Shoplifting accounted for half of these crimes (50%, n = 259,257), with drug offences the next most commonly reported crimes (29%, n = 148,846). Across the police force area, there was an estimated 26% reduction in crime once individuals began drug treatment, equating to 132,893 crimes prevented per year after commencing treatment. The average social and economic costs of crime committed by service users before starting drug treatment are £29,442 compared to £21,916 after starting treatment. There is therefore a clear return on investment for the criminal justice system to support individuals to access drug treatment.

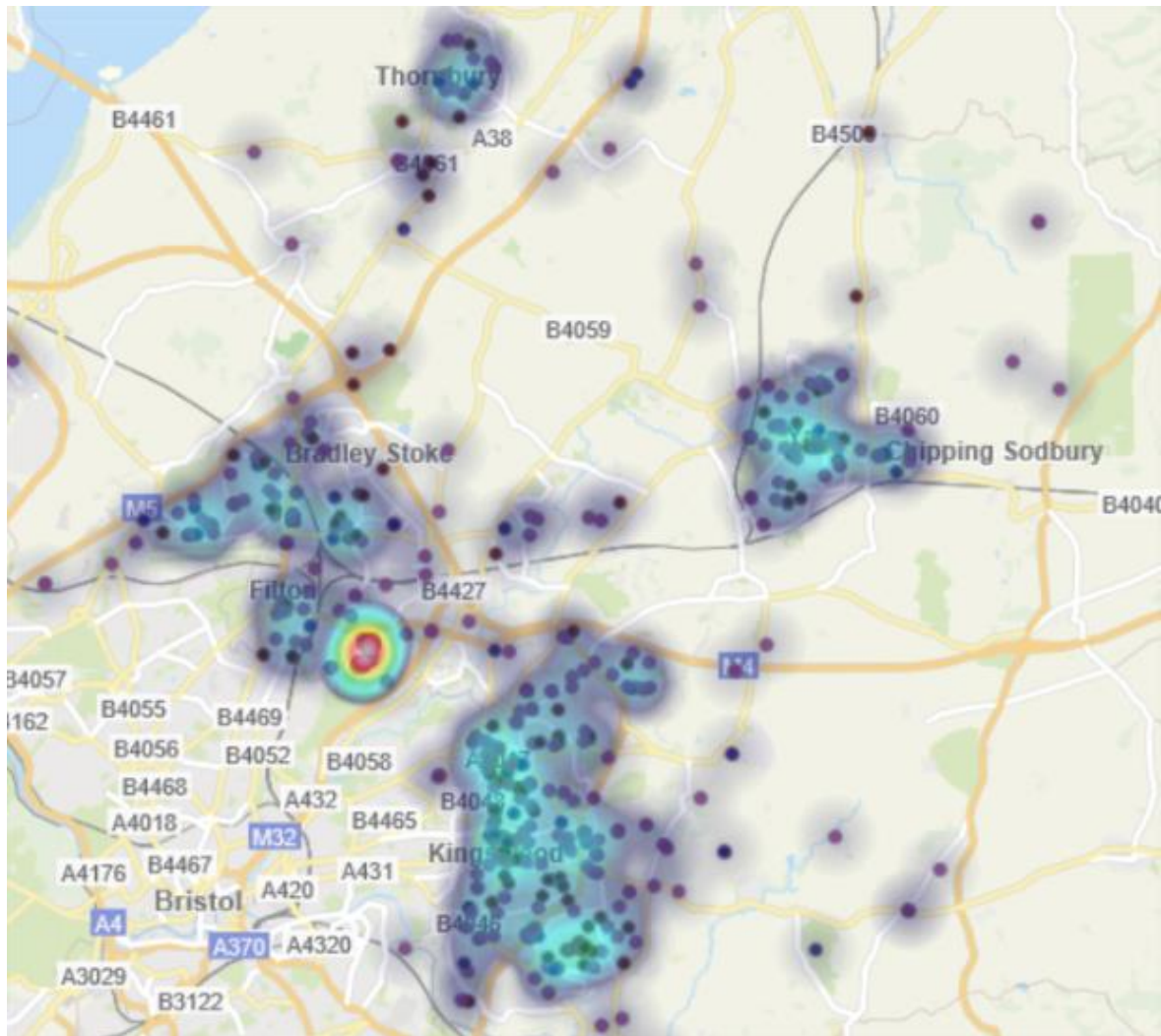
In South Gloucestershire, more than two-thirds of (69%) of individuals seen by the Criminal Justice Intervention Team (CJIT) had committed an acquisitive crime. This is higher than is seen nationally, where this figure is 41%. When looking at acquisitive crime figures for South Gloucestershire as a whole, there were 113 offences related to robbery in 2018/19 – 98 offences of personal robbery and

15 offences of business robbery. This was a 12% decrease compared to the previous year. Burglary is another form of acquisitive crime which we know is often committed to fund drug purchases. There were 841 dwelling burglary and kindred offences in 2018/19, down from 864 in 2017/18. This equates to 16 such offences per calendar week. In addition, there were 146 attempted dwelling burglaries, 17 distraction burglaries (including 5 attempted offences) and 9 aggravated burglaries throughout 2018/19. However, there was a 6% increase in non-dwelling burglary offences in South Gloucestershire in 2018/19, up from 315 in 2017/18 to 336 in 2018/19.

Across England and Wales, Police and Border Force made a total of 153,135 drug seizures in 2018/19. This was 12% higher than in the previous year and represented the first annual increase in drug seizures that had been seen since 2011/12 (104). Similarly, there was an 11% increase in the number of drugs offences (including possession and trafficking) reported across England and Wales in 2018/19 compared to the previous year, although this increase is thought to be the result of an increase in stop and search by police forces (105). When looking at longer-term trends, the number of drug offences and drug seizures have both decreased by 38% since 2008/09 (104).

South Gloucestershire also saw a reduction in the number of drug offences in the year 2018/19. Excluding drug offences related to cannabis, there were 89 offences in 2018/19 compared to 105 drug offences in the previous financial year. When looking specifically at offences for possession of cannabis, there were 179 offences in 2018/19 compared to 231 specific cannabis misuse offences in 2017/18, a reduction of 22.5%. In direct contrast to what has been seen nationally, this may be the result of a decrease in the use of stop and search in South Gloucestershire due to Police demand in other areas. Figure 9 (below) is a heat map displaying drug possessions data for South Gloucestershire. While this map shows a hot spot at the University of the West of England (UWE) campus, this is likely due to the monitored nature of campus dorms, meaning that offences are more likely to be detected on the UWE campus and therefore exaggerating the likely scale of the issue compared to the wider community.

Figure 9: Heat map displaying drug possession offences in South Gloucestershire in the 12 months prior to February 2020 [Source: Avon and Somerset Police Force]



South Gloucestershire’s Safer and Stronger Communities Strategic Partnership has identified drugs (including drugs other than cannabis) as strategic priorities for 2019/20, following the completion of a strategic assessment of crime and disorder in the area (89). The Partnership’s 2019/20 Delivery Plan highlights the links between serious organised crime, serious violence and anti-social behaviour and is therefore making county lines, cuckooing and related crimes the focus of their annual Action Plan (106).

While there has been some county lines drugs activity in South Gloucestershire, there are no current active county lines within the area. The last identified county line was disrupted in August 2019 in Yate. However recent anti-social behaviour hotspots in Thornbury, and now Bradley Stoke/Patchway, are linked to the activities of so called “home grown” dealers who employ county lines characteristics in the way young people are exploited by adults for drug running, debt enforcement and as general couriers. This is primarily related to cannabis, but there is recent evidence of cocaine use within the Patchway area (107). There are also concerns over the potential impact of known gangs in Bristol East and Bristol North, as well as active county lines activity in Bath and North East Somerset.



South Gloucestershire Council have developed a problem profile for serious violent crime, which identified gaps in existing data (107). This highlighted the current lack of information about the drugs market hierarchy in South Gloucestershire, making it difficult to disrupt the exploitation of young people by those higher up the drugs supply chain. The problem profile recommends that the newly established Violence Reduction Unit work to address the use of controlled drugs among young people in South Gloucestershire, with particular reference to strong and frequent cannabis usage.

Actions to consider:

1. Perpetrators of crime who are dependent on drugs or are using drugs in a problematic way should be identified by the criminal justice system and encouraged to enter drug treatment.
2. The DAP and Avon and Somerset Police Force should continue to work together to address issues in the community at an early stage.

## Children and Young People

### National prevalence data

NHS Digital conducts a biennial national survey of smoking, drinking and drug use among young people (108). In the most recent survey, 24% of secondary school pupils in England aged 11-15 reported having ever taken drugs. This figure varied by age, with 9% of 11 year olds having ever taken drugs compared to 38% of those aged 15. 9% of pupils nationally reported having taken drugs in the last month.

The most common drug that pupils had ever taken was cannabis (9.5%), followed by psychoactive substances including nitrous oxide and other novel psychoactive substances (7.1%). 3.9% reported having taken Class A drugs. The odds of having taken drugs in the last month were approximately 20 times higher in pupils who were regular smokers compared to those who didn't smoke (OR = 19.61, 95% CI: 10.53–36.55).

Nationally, 50% of secondary school pupils said that they had first taken drugs because they wanted to see what it was like. 22% had done so because they wanted to get high or feel good, and 16% because their friends were doing it. The same proportion (16%) reported first taking drugs because they wanted to forget their problems. Pupils' reasons for first taking drugs were similar for both boys and girls. Among pupils who had taken drugs on more than one occasion, 42% said that they had most recently taken drugs to get high or feel good, compared to 29% who reported wanting to see what it felt like. This is not surprising, given the fact that these young people had already taken drugs on at least one occasion previously. 25% of pupils who had taken drugs on between two and five previous occasions had most recently taken drugs in order to get high or feel good, compared to 60% of those who had taken drugs on more than ten occasions.

Pupils' perceived acceptability of drug use depended on the drug in question. 13% of pupils said that it was OK to try taking cannabis to see what it's like, compared to 10% who felt that it was OK to try sniffing glue and 3% who felt the same way about cocaine. However, fewer pupils felt that it was acceptable to take these drugs once a week, with 7% of pupils feeling it was OK to take cannabis once a week, 4% agreeing with the same statement about sniffing glue and 1% feeling that it was OK to take cocaine on a weekly basis. These proportions were relatively similar for both boys and girls.

The majority of pupils (53%) believed that only a few people their age take drugs. 32% believed that nobody their own age took drugs, while 10% felt that about half did. 5% felt that most did and only 1% believed that all people their own age took drugs. These proportions have remained relatively stable since 2004.

9% of pupils who had ever truanted or been excluded from school took drugs at least once a month, compared to 1% of pupils who had never truanted or been excluded. Similarly, 10% of pupils who had ever truanted or been excluded from school had taken Class A drugs in the last year, compared to 1% of pupils who had never truanted or been excluded.

When considering familial attitudes towards young people's drug taking, 87% of pupils reported that their families either do, or would try to, stop them taking drugs and 12% said that their family either did, or would try to, persuade them not to. 1% of respondents felt that their family do or would do nothing, while nobody reported that their family encourage them to use drugs.

### Local prevalence data

Young people in South Gloucestershire schools have completed three Online Pupil Surveys (OPS) in 2014, 2017 & 2019, totalling almost 20,000 children from year 4 to post-16. The surveys consist of a



wide range of questions related to health and wellbeing and include specific questions around substance use. The data from these surveys provides information about the prevalence of substance use, in relation to other related behaviours and among specific groups. The responses are anonymous in order to try to elicit honest responses from young people.

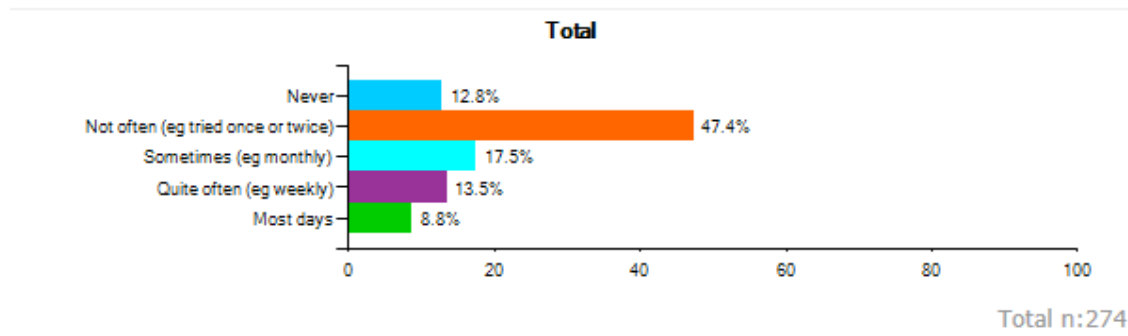
In 2019, 24% (n = 3,276) of young people who took part in the survey from secondary schools and post-16 settings reported that they had been offered illegal drugs. This proportion has been relatively stable over time, being 22% (n = 2,331) in 2014 and 28% in 2017 (n = 2,605).

In 2019, 9% (n = 3,277) of respondents reported having tried an illegal drug, compared to 13% (n = 2,598) in 2017 and 8.5% (n = 2,338) in 2014. In 2019, these figures were highest among students in year 12 (15.2% (n=112)), reducing slightly to 14.6% (n = 1, 557) in year 10 and 3% (n = 1,608) in year 8.

In 2019, the gender split across year 8, 10 & 12 for having tried an illegal substance was 8.6% for girls and 9.1% for boys.

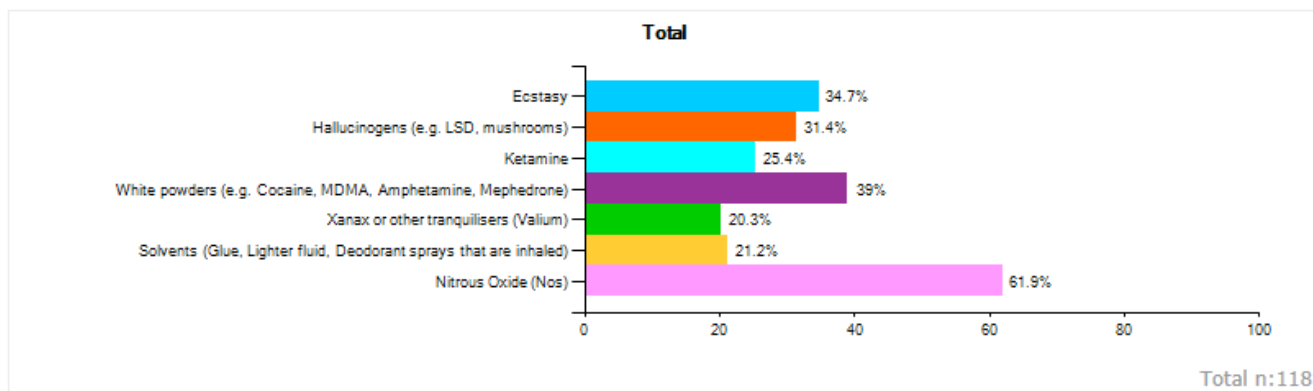
Students who responded that they had tried an illegal substance were asked a further question relating to frequency of use. Figure 10 represents 274 responses across all year groups. 61 students reported using illegal drugs either quite often or most days, constituting approximately 1.8% of those who completed the survey in 2019.

Figure 10: Reported frequency of drug use among students who reported having tried an illegal substance [Source: OPS, 2019]



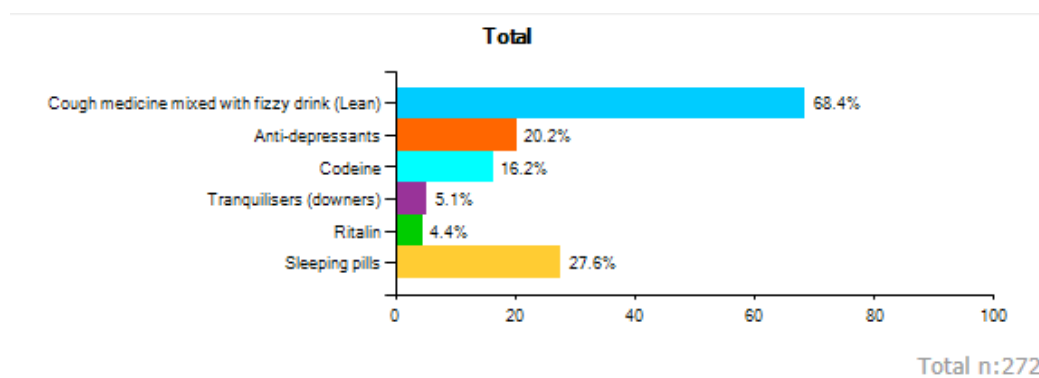
Young people who indicated that they had tried an illegal substance were asked to identify which substances other than cannabis that they had used. Figure 11 provides a breakdown of substances from 118 young people. Nitrous oxide was the substance that young people most commonly reported having used, reported by approximately two-thirds of respondents. It is important to note that while nitrous oxide has traditionally been considered relatively harmless, the Advisory Council on the Misuse of Drugs concluded that there is evidence that it can cause harm (109). It became illegal to consume or supply nitrous oxide for recreational use in 2016. Critically, a parliamentary report found that, following household solvents, drug use in young people aged 11 and under most commonly starts with nitrous oxide (110).

Figure 11: Substances other than cannabis that young people reported having used [Source: OPS, 2019]



In all three surveys, young people were asked if they had been offered or taken a medication that was not their own for recreational purposes. 14% (n = 3,226) of respondents in 2019 reported that they had tried a medication in this way. This has steadily increased over time, with this proportion being 11% (n = 2,554) in 2017 and 8.5% (n = 1,091) in 2014. Figure 12 provides a breakdown of the medications reportedly taken by 272 young people in 2019. This shows that cough medicine was the substance that the greatest proportion – approximately 68% - of young people reported using.

Figure 12: Substances reported being used by young people who had taken a medication that was not their own for recreational purposes [Source: OPS, 2019]



### Vulnerable young people

Vulnerable young people are individuals who are more at risk of harm than their peers. They can be vulnerable in terms of deprivation (food, education, and parental care), exploitation, abuse, neglect, violence, and mental and physical ill health. The OPS enables data to be collated on substance use by young people who have specific vulnerabilities. However, as the survey is completed by young people in educational settings, it does not include vulnerable young people who may have been excluded or who are not in mainstream education. As a result, the OPS is likely to underestimate drug taking vulnerabilities and behaviours among young people.

The following data is taken from the 2019 survey and relates to the number of children who have reported trying an illegal drug. It covers vulnerable groups and young people exhibiting other self-harming behaviours. Increased numbers of young people reporting all vulnerabilities and behaviours report having tried illegal substances, as seen in Table 3. Smoking often or on most days is a particularly important risk factor, with 70% of young people in this cohort reporting illegal drug use. The proportion of young people who had tried an illegal drug was twice as high in those who had

parents in the armed forces compared to their peers. Not smoking, eating breakfast, enjoying school and having an average or high wellbeing score are shown in this data to be protective factors in young people choosing not to take drugs.

*Table 3: Use of illegal drugs by young people reporting specific vulnerabilities and behaviours, broken down by vulnerability [Source: OPS, 2019]*

Vulnerability/behaviour	Have tried an illegal drug	Vulnerability/behaviour	Have tried an illegal drug
Smoke tobacco quite often/most days	70% (n=119)	Smoking never/not often	5% (n=3050)
Eat breakfast - Never/not often	15.4% (n=897)	Eat breakfast – Yes/usually	5.3% (n=1992)
Wellbeing score low/very low	13.5% (n=785)	Wellbeing score high/average	6.9% (n=1064)
Enjoy school - disagree	14.3% (n=1072)	Enjoy school - agree	5.5% (n=2060)
Young Carer	13.6% (n=235)	Young carer - No	8.4% (n=2973)
SEN - Yes	11.3% (n=257)	SEN – No	8.6% (n=2934)
Disability - Yes	14.2% (n=267)	Disability - No	8.4% (n=2927)
Looked after child – Yes or have been	13.4% (n=82)	Looked after child – No or never	8.7% (n=3185)
Free school meals - Yes	12.9% (n=294)	Free school meals - No	8.2% (n=2596)
Parents in armed forces - Yes	19.7% (n=61)	Parents in armed forces - No	8.7% (n=3203)

*Actions to consider:*

1. Further develop support to all schools (primary, secondary, colleges and special) to deliver drugs education in line with best practice and NICE guidance.
2. Ensure that the above support is also offered to those young people who are not in education.
3. To continue to invest in the OPS and work with colleagues to ensure relevant questions are included about drug use in young people.
4. Consider targeted education on drug use for young people who smoke.
5. Consider targeted education for young people with vulnerabilities, together with their parents and carers. Specific options should be explored for targeted education with young people whose parents are in the armed forces, as well as young carers.

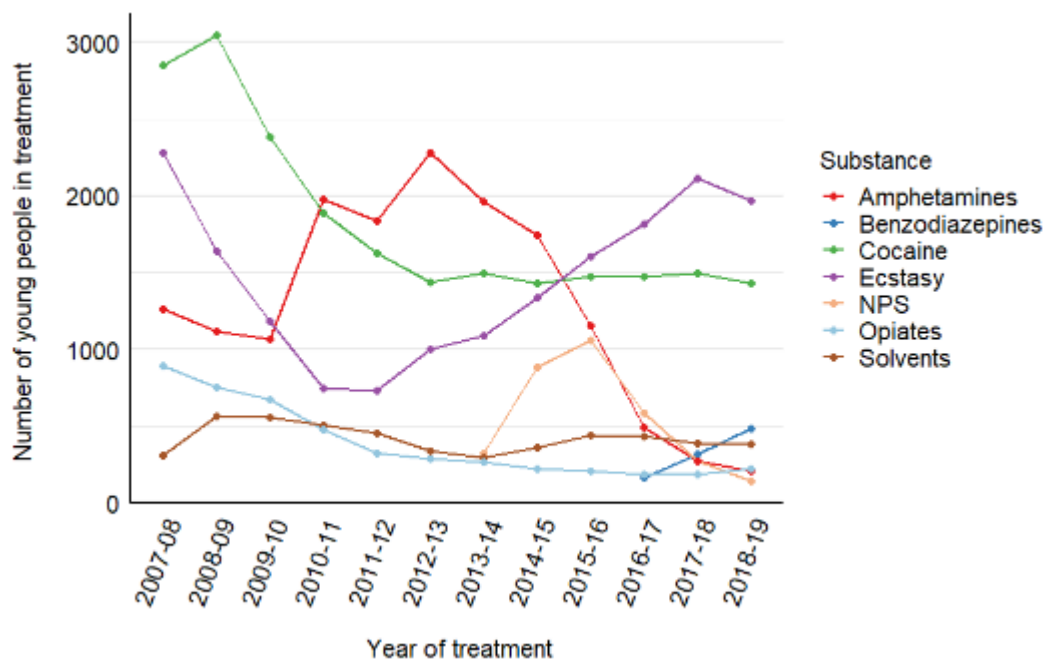
## Young People’s Treatment Services

### National data

Treatment data collected by the NDTMS has recorded a 40% fall in the numbers of young people entering treatment since 2008-9. Treatment is defined as a care-planned and goal orientated intervention using specific techniques and approaches designed to reduce harm and promote behavioural change.

Nationally, cannabis remains the most common substance that brings young people into treatment (88%). This proportion has remained similar for the last three years. 14% of young people within treatment reported using ecstasy, with 10% reporting cocaine use. The number of young people who reported ecstasy as a problem substance has been on an upward trend since 2011-12, reaching a peak in 2017-18. Young people reporting amphetamine use increased rapidly from 2007-08 until 2012-13, but has since decreased year-on-year and is now at a historic low. There was a slight increase in the number of young people seeking help for opiates such as heroin (216 young people compared to 187 in the previous year), but these individuals represent less than 1% of those young people in treatment. There was a 53% increase in young people reporting a problem with benzodiazepines from the previous year, with this being triple the number recorded in 2016-17. The number of young people who reported a problem with new psychoactive substances has fallen substantially from a peak in 2015-16 and was at the lowest recorded level last year. Figure 13 plots these changes in substance use from 2007-08 to 2018-19. The most notable changes are the decrease in amphetamine, opiate and cocaine use, contrasting with the increase in ecstasy and more recent increases in benzodiazepine use.

Figure 13: Changes in substance use reported by young people between 2007-08 and 2018-19.



Nationally, the most common route (32%) for young people into specialist treatment services was via a referral from education services (such as mainstream education or alternative education). Referrals from the youth justice system were the second largest source of referral (20%). Social care services accounted for 17% of referrals and health services referrals for 10%. 12% of referrals were by self, family and friends.

Two-thirds of those in 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 14 and under) in treatment remained relatively low, at 9%.

Most young people – 94% - who started a treatment intervention received psychosocial interventions during their time in treatment. These are ‘talking therapies’ to encourage behavioural

change. 61% received structured harm reduction interventions such as support to manage risky behaviour associated with substance misuse, such as overdose or accidental injury. Less than 1% of young people in specialist treatment services received a pharmacological intervention during treatment. These interventions involve medication prescribed by a clinician and include detoxification, stabilisation, relapse prevention and substitute prescribing for opiates.

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%). The most common vulnerability reported by young people in treatment was early onset of substance use (77%), meaning that the young person started misusing substances before the age of 15. This was followed by poly-drug use (56%). Proportionally, girls tended to report more vulnerabilities than boys, particularly self-harming behaviour (29% compared with 10%) and sexual exploitation (11% compared with 1%).

Two-thirds (67%) of young people in treatment exited the treatment system. Of those who left, 80% successfully completed their treatment and 13% dropped out. A further 5% were referred to another provider for treatment and 2% declined the treatment offered. 78% exited treatment drug-free.

## Young People's Treatment Services

### *Specialist treatment services*

In South Gloucestershire, structured interventions for young people are provided by a number of providers; the Youth Offending Service (YOS) – provided by South Gloucestershire Council; the Young People's Specialist Substance Misuse Treatment Service (YPSSMTS) – provided by AWP; and the Young People's Drug and Alcohol Service (YPDAS) – also provided by South Gloucestershire Council.

YPDAS works with young people across the community and engages the largest proportion of young people within treatment. It delivers harm reduction, psychosocial and relapse prevention interventions and works with education, health, social care and the voluntary sector to deliver holistic interventions that support the young person and their family.

YPSSMTS accept referrals for young people who require a higher level of service due to complexities around mental health, behavioural issues or physical dependency. The team provide pharmacological and psychosocial interventions to young people in South Gloucestershire and are a specialist CAMHS service.

The YOS provides non-treatment interventions to young people aged 10-17 whose drug use is risky or linked to an offence. The YOS are involved if a young person gets into trouble with the law, is charged with a crime and has to go to court or if they are convicted of a crime and given a sentence. Through their work, the team aim to prevent youth crime and reduce re-offending.

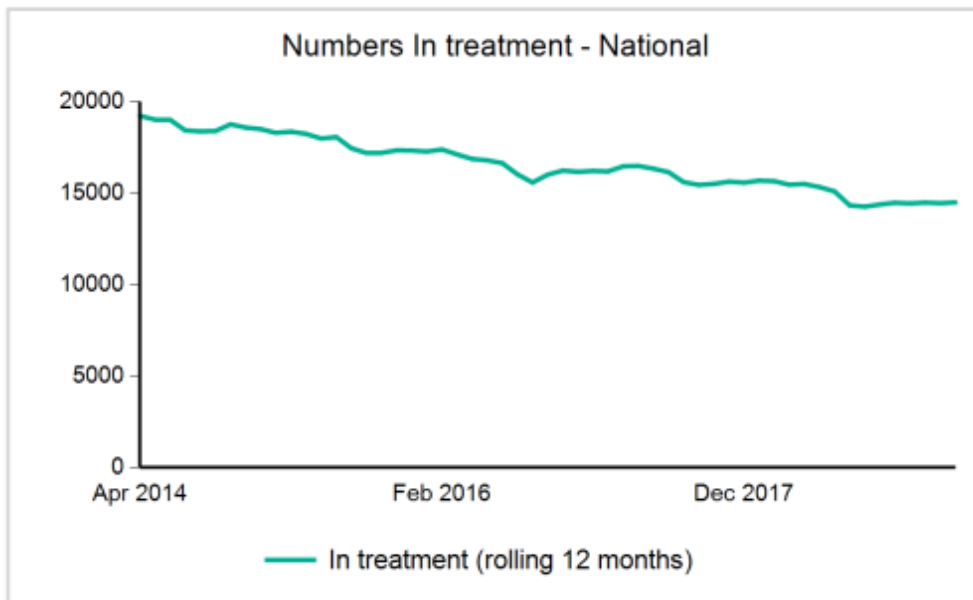
### *Treatment data*

Local data is submitted to NDTMS monthly by YPDAS and YPSSMTS. Treatment data for this section is taken from the JSNA support pack. As the YOS data is recorded separately, there is a cohort of male offenders who are aged 16-17 and not in education, employment and training (NEET) who are not captured by NDTMS. The local data within this section reflects this when compared to the national profile. Data from the YOS is presented later in this section.

### Numbers in treatment

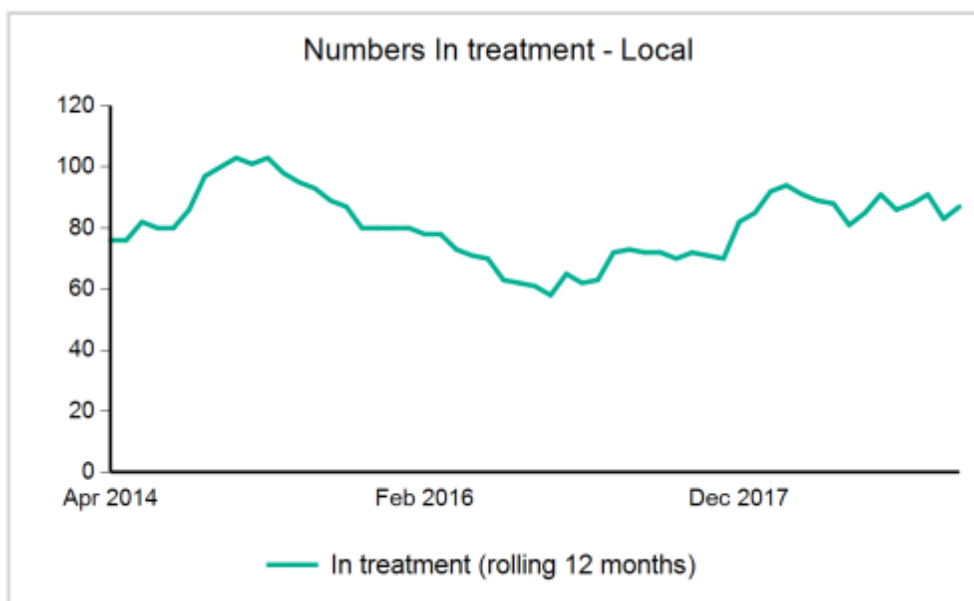
Nationally there has been a steady decline in the numbers of young people accessing treatment (see Figure 14).

Figure 14: Numbers of young people in specialist drug treatment across England, April 2014 - April 2018.



This reduction has not been mirrored locally (Figure 15) with fluctuations that are more likely to be observed within a small cohort of individuals. In 2018/19, there were 97 young people in specialist drug services in South Gloucestershire.

Figure 15: Numbers of young people in specialist drug treatment across South Gloucestershire, April 2014 - April 2018.

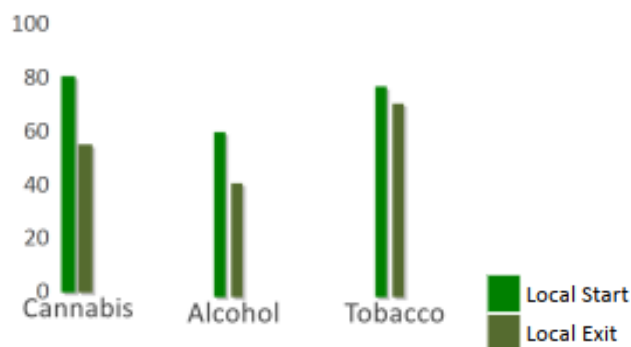


### Substance use profile

88% (n = 85) of young people in treatment in South Gloucestershire have presented with cannabis as a problematic drug, followed by 25% (n = 24) with stimulants. Five young people were in treatment for using heroin and/or crack cocaine. In South Gloucestershire, the majority of service users (52%, n = 50) were aged between 14-15 years. Just over three-quarters (76%) of young people entering treatment services in 2018/19 reported using two or more substances.

68% (n = 62) of young people in South Gloucestershire cited tobacco use at the start of treatment, higher than the proportion seen nationally (52%). However, just 8% (n = 5) of these young people received a smoking cessation intervention. This data is not collected again on treatment exit and we therefore do not know the proportion of young people in drug treatment who smoke tobacco at the end of treatment. However, data is available for a smaller cohort of young people who have completed both treatment start and treatment exit (n = 42). Precise numbers are not available, but Figure 16 below demonstrates that the reduction in the number of young people who report smoking at the end of treatment is small.

Figure 16: Percentage of young people who were using a substance at the start and exit of treatment.



Young people are offered smoking cessation support at the point of assessment and at other stages, when their care plan is reviewed. Some possible reasons for young people not wanting support for smoking cessation include: young people not wanting to stop smoking as it feels too difficult when they are also working to reduce their use of cannabis and other substances; young people are less likely to want to make a change when they are not experiencing a significant negative impact from smoking; and young people often struggle with the idea of a 'quit date' which doesn't fit with the harm reduction approach that is taken for other substances.

Young people who do access smoking cessation often follow similar patterns. These include: not using nicotine patches every day; finding it difficult to prepare for a 'quit date' and committing to it; smoking more cannabis to manage their reduction in cigarette smoking; being around people who smoke and will therefore smoke intermittently whilst using nicotine replacement therapy; not experiencing support from other people to continue not smoking.

Given that 88% of young people in young people's drug services in South Gloucestershire have presented with problematic cannabis use, smoking is part of the lifestyle of the vast majority of young people in drug treatment locally. An evidence review conducted by South Gloucestershire Council into the co-use of cannabis and tobacco found that dual tobacco and cannabis cessation programmes built around motivational interviewing, cognitive behavioural therapy and self-control strategies are acceptable, feasible and were associated with increased abstinence post-intervention, together with significant decreases in the frequency of using both tobacco and cannabis (111).

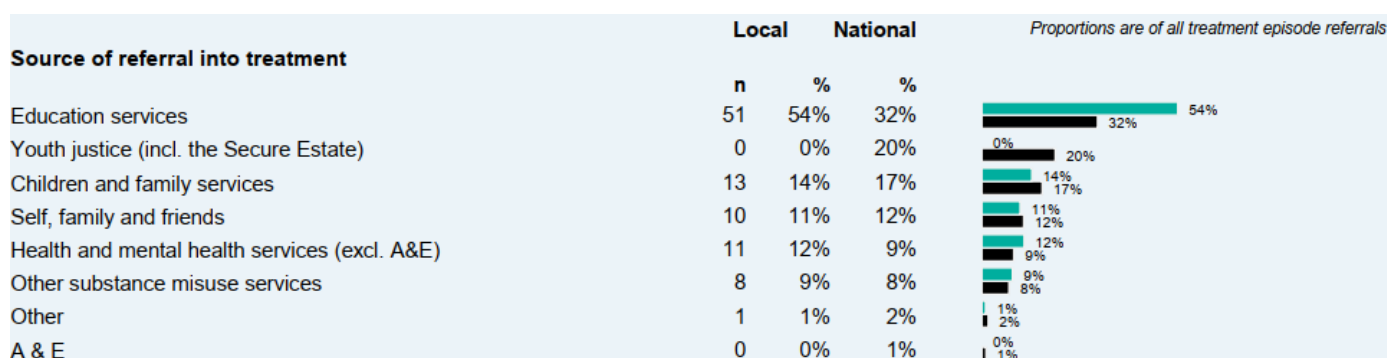
### Demographics of young people in treatment

In 2018/19, 45% of young people in treatment in South Gloucestershire were female compared to 34% across England. 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, Asian 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).

### Referral sources

Figure 17 provides a breakdown of the source of referral into treatment for young people. South Gloucestershire has over half of referrals being received from education, which is substantially higher than the proportion seen nationally. There are no young people referred from Youth Justice as this data is not recorded on NDTMS. Referrals from Children and Family Services and Health and Mental Health Services are slightly lower than the national average.

Figure 17: Sources of referral into drug treatment for young people in South Gloucestershire



Any particular vulnerabilities that a young person may have are recorded at the initial assessment. Fewer young people in South Gloucestershire were NEET, had an identified mental health need or report offending behaviour than seen across England as a whole. However, the numbers of young people included in each of these categories are very low and it is therefore difficult to draw any specific conclusions from these findings.

### Time in service

In general, young people require less time in drug services than adults as their drug use is not as entrenched. Young people in South Gloucestershire tended to be in drug services for slightly longer than was seen nationally, with the average length of time in service being 28 weeks, compared to 22 weeks nationally. Local decisions around keeping young people in services are impacted by the availability of, and thresholds for, other services.

Planned exits in South Gloucestershire are higher than those nationally, with 98% (n = 56) of young people in South Gloucestershire leaving specialist services in a planned way compared to 80% nationally. No young people represented for treatment within six months in 2018-19. 39% left treatment drug free compared to 30% nationally.

### Outcome data

NDTMS collect additional behavioural, health and wellbeing data at the start and end of treatment to provide a pattern profile of change. Figure 18 shows changes in substance use by time of day, both at local and national level. At the start of treatment, 57% of young people in South Gloucestershire reported using a substance during the daytime, falling to 27% at treatment exit. 87%



reported using a substance during the evening on a weekend at the start of treatment, with this reducing to 65% at treatment exit. These reductions were more substantial than those seen nationally.

Figure 18: Substance using patterns by time of day at treatment start and exit.

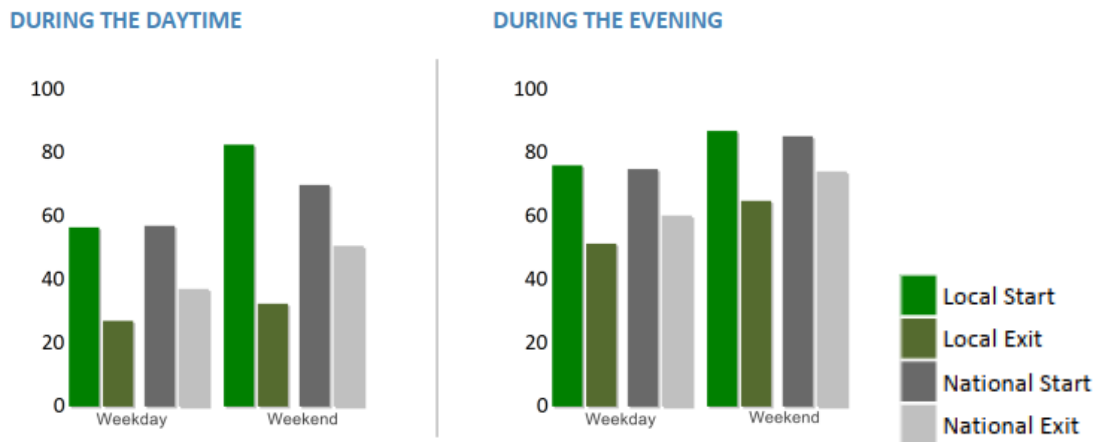


Figure 19 shows the change in young people reporting using substances alone - an indicator of substance use that is problematic. 67% reported using substances on their own at treatment start, reducing to 32% at treatment exit. Again, this was a greater reduction than seen nationally.

Figure 19: Proportion of young people reporting using substances alone at treatment start and exit, local and national data.

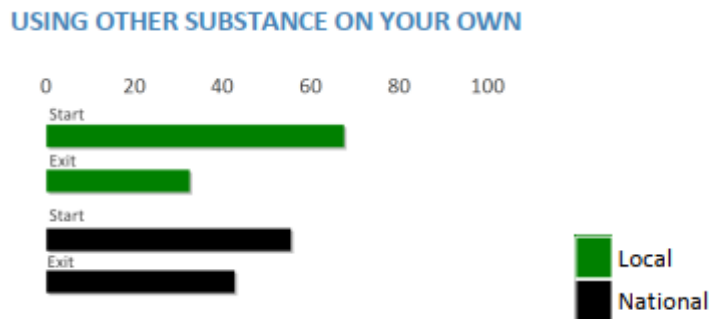
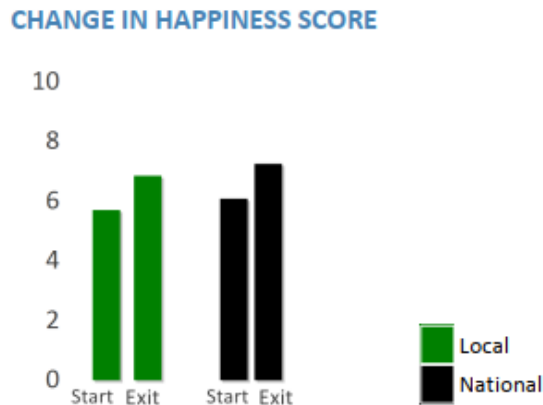


Figure 20 shows the change in happiness score as reported at treatment start and exit. Young people's happiness score improved by 1.2 points in South Gloucestershire, the same change as seen nationally.

Figure 20: Changes in happiness score among young people at treatment start and exit, local and national data.



Actions to consider:

1. Consider options for expanding smoking cessation support to young people in drug treatment services, particularly those around stopping smoking of cannabis and tobacco together

Non-treatment drug interventions for young people

The 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. 26 of these 32 individuals (81%) were between 15 and 18 years old.

The most commonly reported vulnerability among young people seen by the YOS was being NEET, reported by approximately one-third of this group (31%, n = 10). Nine young people (28%) reported being affected by others’ substance use, six (19%) reported experiencing housing problems and five (16%) were Looked After Children. Due to small numbers, we are unable to present a more detailed breakdown of the wider vulnerabilities reported by these individuals.

Young people seen by the YOS most commonly reported using cannabis (88%, n = 28). Six individuals (19%) reported using MDMA. Fewer than five individuals reported using cocaine, amphetamines or any other drug.

In addition, a further 27 young people who were found in possession of a controlled drug accessed the Drug Education Programme delivered by the YOS. Following this, these individuals received a community resolution. The programme covers the risks and effects of using substances, as well as providing information on the law and the consequences of further offending. These sessions were delivered individually in a bespoke way to best suit the learning style and needs of each young person.

Transition to adult services

NICE guidance sets out best practice for the transition of young people across services within health and social care (113). South Gloucestershire’s drug and alcohol transition protocol uses these overarching principles to set out in practice how young people can transition from young people’s to adult treatment services. YPDAS works with young people who have been in service prior to turning

18 through their 18<sup>th</sup> year, meaning that there are very few young people who make the transition to adult services. Young people who have been receiving treatment from YPSSMTS who are becoming 18 can be transitioned to either YPDAS or adult services as appropriate.

YPDAS can support care leavers up to the age of 25. In reality, however, young people do not generally access the service over the age of 20. YPDAS have a role in supporting young people aged 18 or over and care leavers to access adult services where these are most appropriate.

### Public Health Nursing

The public health nursing service, commissioned by South Gloucestershire Council's Public Health and Wellbeing Division provides information and support to children, families and communities, including schools and early years settings. The aim of this universal service is to empower families, children and young people to make healthier choices for themselves by providing evidence-based information, supporting behaviour change and facilitating access to services available in the local community. The service is easily accessed at any time by children aged 0-19 and their family. Public Health Nurses use advanced communication skills to work in partnership with children and their families to assess their health strengths, needs and risks to future outcomes and to identify opportunities with parents and children for health improvement. Public Health Nurses receive training on the delivery of brief interventions for young people who present with substance use.

### Mental health & wellbeing

Young people who need support for their mental health and emotional wellbeing can self-refer to counselling, which is provided by Off the Record and Kooth. Young people with more complex needs can be referred to NHS Child and Adolescent Mental Health Services via a GP. Waiting lists for CAMHS have a direct impact on the levels of complexity that some young people present to drug and alcohol services with, and the amount of time needed by drug and alcohol specialists to support this wider need. South Gloucestershire has a specific website, 'Mind You', which is a mental health and emotional wellbeing hub for young people. Young people accessing treatment who have additional complexities around mental health can be referred to the YPSSMTS which is commissioned as part of the Children's Community Health Partnership.

### Early help & preventative services

South Gloucestershire's Early Help Strategy (2019 -2024) sets out the vision and strategic priorities for partners within South Gloucestershire to enable all young people to have the best start in life, thrive and be prepared for a successful adult life (114). Early Help is a provision that works across the stages of childhood and adolescence to build resilience in individuals and families and in doing so works to prevent the educational and health harms of risky behaviours such as problematic substance use. In practice, support can be accessed across universal, targeted and specialist services from pregnancy until young adulthood, providing a lead professional and a team around the child where needed.

Referrals for drug treatment are made through the Compass Partnership Team (Early Help). This process seeks to support families to access appropriate services from across the Council and its partners using a common assessment process.

### Children's Social Care

Children's Social Care support family members who have additional needs beyond that which health, education, early help and preventative services can provide. They also have a duty to safeguard children who may be at risk of harm, whether from family members or others. Levels of support can

vary according to need but the law defines what the duties are and the 'thresholds' as to when they will provide a service. South Gloucestershire Council provides the following services:

- Referral, Assessment & Review
- Child Protection & Care Proceedings
- Children Looked After & Care Leavers
- Corporate Parenting
- Private Fostering
- Fostering and Adoption
- 0 - 25 Special Educational Needs (SEN) and Disability Service

NICE guidance recognises the increased likelihood of problematic substance use among young people within the care system (115). An annual health assessment with access to advice, information and support therefore forms part of best practice. South Gloucestershire Council employs a nurse for Looked After Children who provides an annual health assessment and works closely with paediatric staff to support health and medical needs. The nurse is able to screen for substance use and to seek guidance and onward referral to specialist services as required.

#### Schools and other settings for young people

South Gloucestershire has 94 primary, 17 secondary and 7 special schools. These are supported by many partner organisations to promote health and wellbeing and develop resilience in children and young people. The Health in Schools Programme (HiSP) is an award scheme open to all primary, secondary and special schools which brings together the best evidence-based health promotion practice and sets achievable challenges to improve the health and wellbeing of everyone within the school community. It commences with a self-review of health and wellbeing, capturing what is working well and identifying areas for further development and seeks to enable school settings in South Gloucestershire to be health promoting and engage in healthier behaviour change initiatives.

#### School based interventions

YPDAS provide a core offer of prevention, treatment and CPD interventions to schools. This begins in primary school and continues to post-16 students. YPDAS encourage schools to use the offer to develop and compliment the curriculum; to facilitate timely targeted education to vulnerable young people; to identify and access treatment where drug use is problematic and to offer guidance around policy and best practice.

#### Youth activity offer

More than 2000 young people per year use youth services in South Gloucestershire. These services are delivered by four lead organisations: Creative Youth Network, Southern Brooks Community Partnerships, Learning Partnership West and Diversity Trust CIC (LGBTQ+ provision). Centre-based youth provision (open access) is available in each of the five priority neighbourhoods - Patchway, Yate, Kingswood, Staple Hill and Cadbury Heath, weekly sessions for young people with learning difficulties and/or disabilities in Kingswood, Yate and Little Stoke and provision for LGBTQ+ young people across the area. There are also additional centre-based and some detached youth work sessions outside of priority neighbourhoods. These services support young people to access advice and guidance, to take part in positive activities, to build trusting relationships with adults who know their communities well and to develop life skills and resilience.

#### Actions to consider:

1. Ensure that Public Health Nurses are involved in the development of plans to reduce drug-related harms in young people and are given any necessary training and support.
2. Look into the feasibility of a specific drug component/award as part of the HiSP which could support schools to develop interventions that deliver targeted work on drug-related harm.
3. To explore ways in which all secondary schools and colleges can be encouraged to take up the offer of targeted and preventative education.
4. YPDAS to further develop links with youth providers to promote joint working.
5. To use the findings of this needs assessment to further explore how treatment services in South Gloucestershire can be developed to better meet the needs of young people.

## Adult Treatment Services

“Treatment” in this section refers to a course of structured treatment delivered by specialist drug and alcohol staff. It includes triage, assessment, brief interventions and biopsychosocial interventions. Interventions are delivered in a community setting, either on a one-to-one basis or as part of a group session. Treatment is commissioned by the South Gloucestershire DAP and provided by a specialist provider. Currently, the lead provider for community-based treatment in South Gloucestershire is the charity Developing Health & Independence (DHI), who sub-contract to other providers to deliver different elements of the service. The contract with DHI was for 3 years from April 2017 with an optional 2 years extension (3 years, plus an optional one year, plus another optional year). The decision has recently been approved to extend the contract for the maximum term of two years, up until the end of March 2022. Treatment centres, or ‘hubs’ as they are referred to by the provider, are based in Warmley, Yate and Patchway – which is where groups would normally be accessed. The treatment centres are all able to be accessed by wheelchair users.

As a result of the COVID-19 pandemic, services have had to adapt extremely quickly to be able to continue to deliver appropriate and safe services for people who need support around drugs and alcohol. This has been a considerable challenge due to the need to limit face to face contact and maintain social distancing. For the purposes of this needs assessment, we begin by setting out what the commissioned drug service was providing prior to COVID-19. We then outline how the service has adapted since COVID-19. This is so that services can be compared and, crucially, that we can learn the valuable lessons from how services have changed and adapted, whilst acknowledging the tragic and considerable negative impact of the pandemic.

### Data – NDTMS and Illy entry

Data regarding service users accessing services for drug related dependence is collected by PHE using the National Drug Treatment Monitoring System (NDTMS). All services working with those who misuse substances are required to have a case management system compatible with NDTMS, with the system used by DHI in South Gloucestershire known as Illy. The purpose of NDTMS is to monitor and predict trends around drug-related harm, as well as to offer guidance and learning about best practices. DHI upload NDTMS on a monthly basis, enabling commissioners and analysts to manage the performance of the service and identify any variances with neighbouring authorities, including those neighbours who are grouped by similar socioeconomic status.

### Accessing treatment

There is a single point of access for individuals to access treatment staffed by DHI during working hours (9:00 – 17:00, Monday to Friday), and a message can be left on their answerphone at any time. The contact information including a freephone number is available online on the DHI website and the One You South Gloucestershire Website, as well as through a wide range of public sources including Wellaware, IMHN, Talk to Frank, BNSSG CCG, nhs.uk, CVS SG. There is also a website dedicated to the SPACED service, which supports people with issues with Stimulant, Psychoactive, Alternative, Club and Experimental Drugs. CLear (Challenge services, Leadership and Results) is a PHE service improvement tool which aims to prevent and reduce alcohol-related harms at local level (116). Our CLear peer reviewers suggested the single point of contact (SPOC) for treatment services could be better promoted and suggested it would be helpful to determine the demand outside working hours. Although this was in relation to alcohol, it is equally applied to people needing support for other drug use. DHI has a community development worker who has been increasing the profile of SGDAS in the local community by attending outreach events, community stalls and advertising through social media. This role has also been important in relation to attendance at key

stakeholder teams meetings, bespoke professional training, multi-agency meetings and Priority Neighbourhood groups in order to integrate with other pathways and organisations. DHI also take an Asset-Based Community Model approach which is delivered in partnership with Southern Brooks. The role of Southern Brooks has been important to ensure a community based approach to case finding and service promotion. Southern Brooks have facilitated engagement & awareness raising in liaison with the DHI community development worker. The Southern Brooks DHI worker also supports training and workshops for peers, individuals with lived experience volunteering within the DHI service. Through Southern Brooks, posters and leaflets were distributed across Priority Neighbourhoods. Posters are now displayed on toilet doors in public places, community noticeboards, and pubs through the South Gloucestershire Council Licencing Officer. Furthermore, Southern Brooks support the re-integration of clients into the community through development of wellbeing action plans, and by supporting individuals into community based activities as part of their holistic DHI recovery support plans.

There is a balance in trying to advertise services but also being aware that services are already under pressure in terms of capacity and to encourage more people to make contact with services with no more resources may be counterproductive.

50.1% of the population in South Gloucestershire are rated as amongst the 40% most deprived nationally in terms of physical access to services (112), likely due to the rural nature of much of South Gloucestershire. Travel and public transport are an issue in South Gloucestershire. The urban, most densely populated, areas of South Gloucestershire are not all geographically close together, making it less effective and less equitable to have a central hub for services. This is why much of the drug service offered to people needing support with misuse of opiates takes place in GP surgeries. The availability of reliable and affordable transport, particularly for those living in rural areas, will influence on service uptake. The commissioning team provides a ring-fenced budget to the provider for service user subsistence which includes service user activities and travel budget. This is essential for supporting access to treatment. Many individuals would not be able to access support if DHI were unable to reimburse bus fares and taxi fares for individuals with physical disabilities.

Additionally, GP practice areas do not match the Local Authority border responsibilities, which means that there are some residents of South Gloucestershire who are registered with a Bristol GP surgery. In these situations, the GP surgery, and therefore Bristol, would be responsible for providing their drug treatment. For commissioning purposes, a cross-border agreement for the Opiate Substitute Therapy Programme has therefore been in place for some years to allow people who are registered with a Bristol GP but who have a South Gloucestershire address (and vice versa) to receive treatment in their GP practice rather than having to re-register with a South Gloucestershire GP.

#### Actions to Consider

1. Develop a plan with DHI on how to improve awareness of the service for other professionals and support the development of better pathways between them.
2. DHI to continue to audit the number of messages left on their answerphone outside of working hours to determine the demand for service(s) at the weekend/evenings.
3. Continuation of the Bristol/South Gloucestershire cross-border agreement to allow patient choice to determine where they receive their opiate substitute therapy (OST) treatment.
4. To explore options with Bristol about joint commissioning of services where this would benefit the people using the service.

## Numbers in treatment

During 2018-19, there were 659 adults in structured drug treatment services in South Gloucestershire. Approximately three-quarters of these individuals (73%, n = 484) were in treatment for opiate use. 18% (n = 120) were being treated for non-opiate use, and the remaining 8% (n = 55) were being treated for combined non-opiate and alcohol use. Individuals may seek treatment for opiate use as they can then be prescribed opiate substitution therapy, and it is therefore unsurprising that they form the majority of those in drug treatment services.

In comparison to the 2017-2018 period, there were 9% fewer people in drug treatment in South Gloucestershire overall and fewer people receiving treatment for all three categories of drug use (opiates, non-opiates and combined non-opiates and alcohol). The biggest reduction was among people being treated for non-opiates, where 24% fewer people were in treatment in 2018-19 compared to the previous year. The reasons for this are unclear, but are currently being explored with DHI.

Critically, a large proportion of those individuals in South Gloucestershire who are using opiates, crack cocaine and both in combination are not currently accessing treatment. Unmet need was highest among crack cocaine users; 69% of people in South Gloucestershire requiring specialist treatment for crack cocaine were not currently in treatment, compared to 60% nationally (117). For those using opiates and crack cocaine in combination this figure was 59% (compared to 54% nationally), with a 40% unmet need for specialist treatment among those using opiates alone (compared to 47% nationally) (117).

## Substance use profile

This data is presented in the earlier section on Drug Usage.

## New presentations

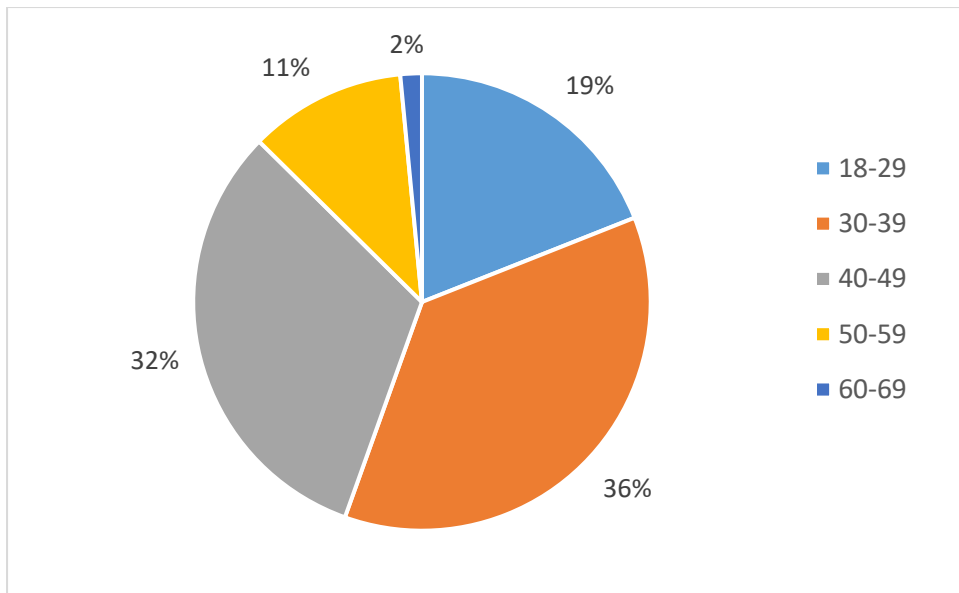
There were 224 new presentations to drug treatment services in South Gloucestershire in 2018-19, 10% fewer than in the previous year. The largest reduction in new presentations was among those presenting for treatment for opiate use, where there were 16% fewer new presentations compared to 2017-18. There was a small reduction in new presentations for non-opiate treatment (2%) and no change in the number of new presentations for combined non-opiate and alcohol treatment.

## Demographics of adults in treatment

Of the 659 individuals in 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. The age breakdown of adults in treatment services is also representative of the national picture, and is detailed in Figure 21.

*Figure 21: Age breakdown of adults in drug treatment services in South Gloucestershire, 2018-19\**





*\*There were fewer than 5 individuals aged 70-79 and 80 years+ in drug treatment services. These age categories are therefore not displayed in Figure 21.*

Data on ethnicity and nationality is available for those newly presenting to drug treatment services. 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, 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.

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.

Data on the sexual orientation of people entering drug treatment is presented in the Sexual Health section of this report.

#### *Actions to consider:*

1. Work with Stand Against Racism & Inequality (SARI) and the South Gloucestershire Race Equality Network to explore and understand experiences of black and minority ethnic groups, both accessing and not accessing drug services, in order to ensure that drug services are accessible to all.
2. Link in with community connectors across Bristol and South Gloucestershire to ensure that voices from the BAME community are heard and that treatment services are adapted according to the community's experiences and perspectives.
3. Explore the potential reasons for the overrepresentation of people with disabilities in adult drug services.
4. Explore how drug services might need to adapt in order to be more accessible for people with learning disabilities.

#### Referral routes

There are various potential routes into drug treatment, grouped by PHE into six categories: 1) self-referral (including referral by family or friends); 2) referred through the criminal justice system (police custody or court-based referral scheme, prison or National Probation Service/community rehabilitation company); 3) referred by a GP; 4) hospital/A&E referral; 5) referred from social services; or 6) all other sources of referral. The large majority (84%, n = 189) of referrals into drug treatment in South Gloucestershire were classified as being via 'all other referral sources', compared to just 13% of referrals nationally. It is unclear what these referral sources consist of; more work is currently being undertaken to understand local routes into drug treatment. If this additional information indicates that referrals from other organisations are unusually low, these organisations should be consulted to try and understand possible reasons for the low referral rates and develop an action plan to address these.

The very small proportion of self-referrals is also notable; just 4% (n = 9) of referrals to drug treatment services in South Gloucestershire were self-referrals, compared to 59% of referrals nationally. The number of self-referrals had been relatively stable since 2010-11, but has declined in the previous two financial years. This data could suggest that individuals may not know how to access help in South Gloucestershire and that increased awareness of the service is needed. However, it may also reflect a recording issue as we do not know what the 'all other referral sources' route refers to. For example, it could be the case that people have made an initial call to triage but have been told about the service (and therefore "referred" by another person).

A breakdown of referral routes by source for each separate category of drug are displayed in Figure 22, Figure 23 and Figure 24. Data displayed in these graphs has been rounded to the nearest 5 and these rounded sub-totals have been summed to create higher level totals. This method ensures that low numbers (i.e. 1-4) are suppressed and cannot be deduced from totals.

*Figure 22: Proportion of referrals into drug treatment services for use of opiates, by source. South Gloucestershire, 2009-10 – 2018-19.*

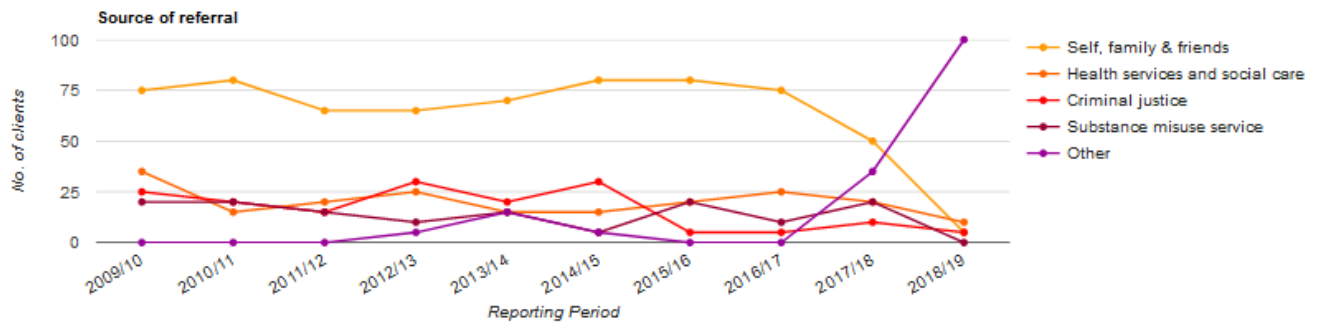


Figure 23: Proportion of referrals into drug treatment services for use of non-opiates, by source. South Gloucestershire, 2009-10 – 2018-19.

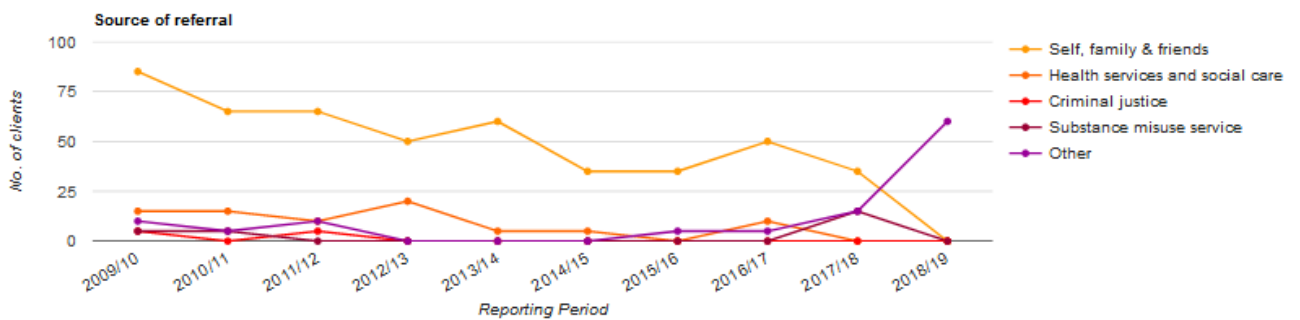
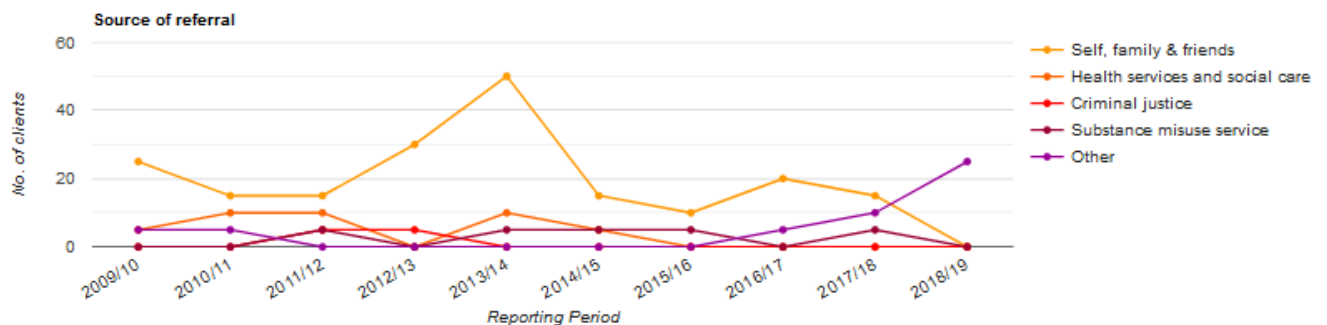


Figure 24: Proportion of referrals into drug treatment services for the combined use of alcohol and non-opiates, by source. South Gloucestershire, 2009-10 – 2018-19.



### Waiting times

Waiting times for drug treatment services need to be as short as possible to facilitate recovery from dependence. Ideally, individuals would be referred to drug services when they feel ready for change, and any delays in accessing treatment may therefore miss this potential window of opportunity for engagement and recovery (122). It is recommended that individuals should be in treatment within three weeks of being referred. In 2018-19 in South Gloucestershire, 97% (n = 253) of individuals waited less than three weeks to start their initial drug treatment. This is slightly lower than the national figure of 99%. However, it is important to note that while overall waiting times for structured treatment are short, we know that other components of drug services – particularly for unstructured treatment - are under considerable pressure. As a result, waiting times are longer for teams such as the Engagement Team (non-opiate, and non-alcohol clients) and Throughcare Team (housing and benefits-related support).

## What services are provided?

Once someone is referred or self-referred to DHI for treatment, they will begin by having a telephone appointment with a triage worker. This appointment constitutes a very detailed pre-assessment which aims to ascertain what the person's needs are in relation to treatment and how best their referral should be processed. There are two main teams that the person will be directed to. If a person is using opiates, benzodiazepines or alcohol, they would be picked up by the Primary Care team. If they are using any other drug - for example cocaine, crack cocaine, ketamine, spice or cannabis - they would be picked up by the Engagement Team and taken through the Stimulant, Psychoactive, Alternative, Club, Experimental Drugs (SPACED) pathway. The SPACED pathway was started as a pilot in 2014/15 as a multi-agency response to those using other drugs aside from opiates.

## Interventions

The vast majority – 95% (n = 628) - of individuals in drug treatment services received a high level treatment intervention (pharmacological, psychosocial and/or recovery support) in the community. 23% (n = 153) received at least one of these interventions in a primary care setting, 3% (n = 21) in residential rehabilitation and 2% (n = 12) in a hospital inpatient unit. No individuals were reported to have received interventions within a recovery house or young person setting.

## Engagement Team

The Engagement Team works with all those requesting support for using drugs that are not opiates or alcohol. Some of these individuals will not need a long term intervention and will therefore be seen on a non-structured programme of support. This means that they will not be reported to NDTMS as being in structured treatment. Once a person has had their initial triage and been allocated to a worker within the Engagement Team, a worker will contact them for a 60 minute appointment where their support needs will be discussed. At this appointment they will identify their treatment goals, agree whether they will be seen on a structured or non-structured pathway and set expectations of the service. Their care plan, including group work, is completed. Any signposting to other services will be included. These services may include mental health services, One You South Gloucestershire, mutual aid or Southern Brooks. Information about Breaking Free Online – an online treatment and recovery programme - will also be provided.

If the individual is not yet ready to make changes or does not want to stop using drugs, they will receive a further 45 minute appointment which focuses on harm reduction and how to continue using as safely as possible. They will then be discharged from service. If they have made changes and have stopped using drugs, where that was their treatment goal, they will be offered 45 minutes of 1:1 relapse prevention support and then be referred into a six week relapse prevention course. Once this is completed they will be discharged from service. Flexible and extended support may be offered even when someone is not ready to make changes, particularly where there is social services or mental health services involvement. This would be reviewed on a case by case basis.

If someone has ongoing support needs but is motivated to make changes, they will be taken through the structured treatment SPACED pathway. This involves the initial 60 minute appointment, followed by a second assessment appointment where their care plan will be created. If they are not suitable for group work for reasons of anxiety for example, they will be offered four, 30 minute phone or face to face appointments and then discharged from service. If they are willing to go to groups, they will be offered one of the following: a six week Up in Smoke group programme for cannabis users, a six week End of the Line group programme for cocaine users or the eight week Preparation for Change group programme prior to these if they need more preparation for what groups entail and what to

expect from treatment. Halfway through their group work programme, the individual will have a 30 minute telephone appointment where their goals will be reviewed. The same will happen once the group programme has been completed. They will then be offered up to two more 30 minute telephone appointments, a treatment outcomes profile (TOPS) will be completed and they will be discharged from service.

It should not be assumed that because the Engagement Team work with people who do not use opiates that those people have less complex lives than their counterparts in the OST service. Many of those people accessing the support of the Engagement Team also struggle with complex issues and therefore need time to be spent with them to overcome their challenges.

#### *Actions to Consider:*

1. To do more work around exploring the complexity of people who access the Engagement Team and whether this team has the capacity to meet the needs of the people who access non-opiate and non-crack use support.

#### *Primary Care/Opioid Substitution Therapy (OST) programme*

Individuals who present to treatment requiring support for opiate addiction, including prescribed opiate dependency, come through the Primary Care pathway within DHI. This involves the service user working alongside both their GP and a drug worker from drug services, and includes the dispensing of medication from a pharmacist. If the individual first presents to their GP, the GP will make a referral to the DHI SPOC, who will arrange a triage call and an appointment for a full assessment of need and a drugs test to confirm that the individual is taking opiates. This will occur within an official target of fifteen working days of the referral (but usually happens more quickly, within three working days and with an aspirational target of 24 hours, followed by a comprehensive assessment within five working days). Once it is confirmed that opiates are present in the person's system, by way of a urine sample, the drug worker and the GP will work together to titrate the service user to the correct level of Opiate Substitute Therapy (OST).

For the first 12 weeks of OST prescribing, the service user will be required to attend the pharmacy daily to collect their medication and be supervised whilst they take it. This is following good practice guidance from the Drug Misuse and Dependence UK Guidelines on Clinical Management, also known as the "Orange Book" (123), which sets out this necessary measure to ensure the person is safe, reduce risk to family members (including children) and reduces the risk of diversion of the medication into the community. Following this, the individual's care plan will be reviewed, and any risks will be considered with the intention that daily supervision can be stopped and the number of times that they attend the pharmacy can be reduced. If the person provides two clear drug screens, this usually relaxes to daily pick up without supervision in the first instance, followed by twice weekly collection from the pharmacy and then weekly collection once it is considered that the risk is minimal and the person is taking their medication correctly and safely. The service user will then have regular meetings with the drug worker and decide the best course of action to reduce their OST over time. The drug worker and the GP, together with the pharmacist, will monitor their progress to ensure they are receiving an optimal dose of medication and they are no longer using illicit opiates on top of their OST prescription. If the individual fails to collect their OST medication for three days in a row, the pharmacist is required to contact the drug worker and/or GP to advise them and they will not be able to dispense the medication until the service user has spoken with the drug worker or GP to ensure that the level of OST is appropriate for them, due to the risk of overdose. A re-test would be required at this point before confirming a restart on the prescription.

The service user will meet with their drug worker at least once a month, although the official guidance is for a meeting every three months. These meetings may occur more frequently, depending on the complexities involved in the service user's presentation – they may be seen weekly or fortnightly for a period until the service user, drug worker and GP feel confident that the service user is more stable in their presentation. Throughout their treatment, individuals will be encouraged to attend group work and mutual aid sessions (see below). Once the individual is stable and is able to address the problems associated with their opiate dependency, the drug worker, GP and service user will work together to make a plan for reducing the level of OST and begin to drop their OST levels down or prepare for detox. It is important that monitoring of the person continues with the aim of reducing to a point where the service user stops taking opiates, either illicit or prescribed. Achieving this stability can, in some cases, take months and years and rarely follows a stable trajectory.

#### *Medication options*

A range of medications are available for service users to address their opiate dependency, through a process known as “medically assisted recovery” (124). Methadone and buprenorphine are the most commonly used OST medications. National Institute for Health and Clinical Excellence (NICE) guidelines states that “the decision about which drug to use should be made on a case by case basis” (124). This decision should be based on service user choice, as well as consideration of the individual's history of opioid addiction, their commitment to the long-term management of their addiction and an assessment of the risks and benefits of the different medication options. However, a PHE evidence review of drug treatment outcomes found that some local drug treatment services remain “too focused” on methadone and pharmacological alternatives such as buprenorphine should be more available (25).

Espranor 2mg and 8mg Oral Lyophilisate is a freeze-dried wafer form version of buprenorphine and is taken differently to the normal tablets. It is placed on a wet tongue and dissolves much more quickly. This has been accepted onto the BNSSG CCG formulary and is used in some areas, particularly in prisons but has not yet been rolled out widely across South Gloucestershire. A wider roll-out was planned but was put on hold at the beginning of the COVID-19 pandemic. This will be revisited as and when it becomes safe and reasonable to do so.

Buvidal is an injectable form of buprenorphine and can be injected on either a monthly or weekly basis. This has been rolled out in Wales and anecdotal evidence suggests that Buvidal shows early signs of being very beneficial for patients with complex needs. A working group is currently making enquiries into the cost-effectiveness and viability of using this medication in South Gloucestershire and across BNSSG.

#### *Local OST data*

Detailed information is available on supervised pharmacological interventions. Supervised OST consumption is the best possible means of ensuring that OST is taken as prescribed (123), as well as being shown to reduce OST-related deaths (125). In South Gloucestershire in 2018-19, 39% of service users (n = 183) were prescribed supervised methadone compared to 30% (n = 140) who were prescribed supervised buprenorphine. NDTMS states that 3% (n = 15) were prescribed supervised combined buprenorphine/naloxone; however, combined buprenorphine/naloxone is not generally prescribed in South Gloucestershire and we therefore believe that this figure is a data entry error. Fewer than five individuals received only a pharmacological intervention, not in combination with either a psychosocial intervention or recovery support, an approach that is not recommended in current guidance (123). This may also be a data entry error, or it may be that the person has refused

to engage with other forms of treatment, but it has been agreed that they will continue to be prescribed as a risk assessed intervention with their GP and drugs worker.

#### *Actions to consider:*

1. Continue working with others across the system to explore the potential for using Buprenorphine in South Gloucestershire.
2. Request that DHI conduct an audit of the few people who are recorded as having only a pharmacological intervention to check whether this is a data error or risk-assessed practice.

#### *Harm reduction*

Harm reduction is an essential component of drug treatment services and should occur alongside structured treatment interventions. Harm reduction focuses on preventing harm, rather than on preventing drug use itself. Interventions include preventing, testing and treating blood-borne viruses (BBVs); encouraging safer injection practices and the use of clean injecting equipment; and preventing overdose through the provision of naloxone and overdose training.

#### *Needle and syringe programme*

Orange Book guidelines state that “treatment services and public health services need to maintain the broad range of public health interventions that help to reduce drug-related infections including adequate availability of needle and syringe/equipment programmes and access to drug treatment” (123).

DHI offers a needle and syringe programme from the treatment centre in Warmley, and coordinate this provision at a number of pharmacies across South Gloucestershire. A wider range of equipment is available from the treatment centre in Warmley compared to pharmacies, with the latter tending to offer just grey packs which contain some needles, a sharps bin, some alcohol wipes and a condom. NICE guidance states that a full range of needle and syringe types should ideally be made available to people who inject drugs, in order to minimise harm and maximise engagement in treatment (126). This guidance advises that services “provide people who inject drugs with needles, syringes and other injecting equipment. The quantity provided should not be subject to a limit but, rather, should meet their needs. Where possible, make needles available in a range of lengths and gauges, provide syringes in a range of sizes and offer low dead-space equipment” (126). This suggests that our current provision of mainly grey packs may not be meeting the needs of our injecting drug users and should be reviewed to ensure the service is maximised.

DHI employ a Needle and Syringe Programme (NSP) pathway. If someone is new to receiving the service, the worker seeing them will give them the supplies they need. The Engagement Team will also make contact with the service user if they require more information and advice beyond just the needle exchange (NX) transaction. The Engagement worker will call the person within 3 working days to discuss their needs. This may merely be a harm reduction phone call, or could lead to a harm reduction outreach visit to their home, or an appointment at one of the hubs. The harm reduction support may include BBV or pregnancy testing, issuing of naloxone or a safe storage box or safer injecting advice. These interventions will be continued regularly, as appropriate, to give regular provision of clean needles and returns, along with harm reduction advice and encouragement into structured treatment wherever possible. These appointments may take place at the treatment centre, or as a mobile outreach scheme where someone lives more rurally. If the person is in treatment in the Primary Care team, they would usually obtain their equipment through their Primary Care worker at the GP surgery. The usual safeguarding rules apply in terms of protection of vulnerable adults and children and any concerns would be referred to social care.



Pharmacy provision is also overseen by the Engagement Team Leader who works proactively with pharmacies and pharmacists in six pharmacies across South Gloucestershire. This provision reduced from nine pharmacies in 2019, when contracts with three pharmacies were discontinued due to lack of activity. The contract with pharmacies to provide this service is with South Gloucestershire Council's Public Health Division, however the funds and responsibility for managing the day-to-day service lies with the provider. This can make adequately monitoring the service more complicated. The needle exchange budget managed by DHI is ringfenced within the contract. However, in the past two years, this budget has been increasingly overspent and the DAP has an agreement with the provider to "top-up" this budget at the end of the financial year. However, in 2019/20 the budget was overspent despite the top up. The service is therefore in need of urgent review to understand what is causing this increase, clarify what the current need is in South Gloucestershire and to consider the most cost-effective way of meeting this. This review is underway at the time of writing this needs assessment.

Numbers through the service are inputted on the Pharmoutcomes system. Currently there are 43 people accessing the NX service through DHI and 346 transaction for 102 separate individuals in the last year at pharmacies. Due to this being an anonymous service, it is not possible to know whether these people are also in structured treatment.

DHI used to run a wider programme for steroid users, offering needles and equipment for people who injected metabolic steroids for exercise and body building purposes. Due to the constraints on the NX budget mentioned above, this was discontinued and now steroid users are given limited supplies and a leaflet and signposted to where they can buy needles themselves if they access the service. NICE guidance suggests that we should be providing an enhanced service to performance enhancing injecting drug users (126).

#### *Actions to Consider:*

1. To enhance NX provision so that the widest range of NX supplies possible is available for those that need it.
2. To scope whether in the next round of commissioning, total responsibility for contracting with pharmacies should sit with the provider.
3. Review NX service provision to ensure best value for money and encouraging those using it into treatment wherever possible.
4. Consider reintroducing the service for people who inject image and performance enhancing drugs and scope possibilities for wider funding of this programme from health colleagues.
5. Scope whether there could be an increase in needle exchange service availability at community hubs such as Ridgewood Community Centre and Coniston Community Centre, where DHI are currently based.

#### *BBV testing and vaccination*

Detailed information and data regarding BBVs and other infectious diseases can be found in the 'Infectious Diseases' section of this needs assessment.

BBV testing is available to everyone who is at risk who comes into contact with the service and is used as an "opt-out" option at assessment. This means that it is done as a normal part of the assessment and if the person does not want it, they have to actively decline testing. Until 2019, service users were only routinely tested for Hepatitis B and C, and only offered extra testing for HIV and syphilis, if they particularly requested it or were recognised as being at high risk of contracting these infections (i.e. they were sex workers or people who knew they had been exposed to someone



who had the infection.) The test takes the form of a dried blood spot test, where a pin prick is applied to the finger and drops of blood are placed on a piece of card. This is then sent off to the PHE laboratory, with results sent back securely to DHI who then record the outcome and inform the individual of their result. If positive, there are recognised pathways within treatment to ensure that they get the treatment that they need. If someone tests positive for Hepatitis C, they are assigned a worker from AWP to talk them through the process, support them with making a decision about treatment and, where appropriate, refer to the Hepatology department at Southmead Hospital.

From financial year 2019/20, we worked with sexual health colleagues to agree that testing would also include routine HIV testing for all, in line with recommendations in NICE guidelines (127). This is as a direct response to NICE guidance which states we should: “Routinely offer and recommend an HIV test to everyone attending their first appointment (followed by repeat testing) at drug dependency programmes” (127).

It was also agreed that routine syphilis testing would be rolled out in drug services. Syphilis is a bacterial infection that is usually sexually transmitted, but it may also be possible to contract syphilis through sharing needles. Testing is particularly important as syphilis may be asymptomatic, but can cause serious complications if left untreated. The incidence of syphilis has substantially increased in England in recent years (128). This has been mirrored in the South West, with a particular increase seen across the region – but particularly in Bristol – in 2018. This was managed through a regional multi-agency health protection outbreak control group, but there continue to be syphilis outbreaks in the BNSSG area in 2020. The South Gloucestershire Relationships and Sexual Health Strategy 2020 recommends that syphilis is routinely tested in those who have had unprotected sex.

### *Naloxone*

Naloxone is a life-saving medication which temporarily reverses the effects of an opiate overdose. Evidence shows that providing take-home naloxone to heroin users can support in reversing overdoses, as well as in the effectiveness of training family and friends to recognise an overdose and respond, including the administration of naloxone (129). Naloxone is available to any person at risk of opiate overdose and for family members and friends of those at risk, without requiring a prescription. Wherever possible, naloxone is made available with training on how to use it and it is recorded that a kit has been given and what the expiry date is. Packs are replenished when used, lost or past their use by date. Not all people in the OST service have naloxone and the reasons for this vary. Some people do not see themselves as being at risk so refuse a kit. Other reasons cited for refusal have been not wanting to keep naloxone in the house over concerns of it indicating that they are using an opiate, thereby requiring that they explain it to loved ones. Some people also use drugs when they are alone and therefore would be unconscious by the time they realised the need for it, and have refused naloxone for this reason. People are always advised not to use drugs alone for this reason.

NDTMS data reports that in 2018-19, 25 individuals in treatment in South Gloucestershire were issued with take-home naloxone and overdose training, representing 5% of opiate users. This is substantially lower than the national rate of 19%, suggesting that provision of naloxone and overdose training needed to be increased in South Gloucestershire. However, data taken from the local drug service’s client management system (Illy) shows that the true rate of naloxone provision is higher than reported by NDTMS, reaching 26% in Quarter 4 of 2018/19. Uptake of naloxone has also substantially increased during the COVID-19 pandemic. As of 8<sup>th</sup> June 2020, 413 service users in active treatment for their opiate use have been offered naloxone kits, of whom 188 accepted, 225 refused; it should be noted that this is across the wider system and not just those who are currently engaged in structured treatment. Some kits will have been given to those in recovery as they are still

at risk of relapse. Within structured treatment, local data shows that in Q4 of 2019/20 (coinciding with the first few months of the pandemic), provision of naloxone and overdose training had increased to covering 47% of at-risk service users in South Gloucestershire.

#### Actions to Consider:

1. Explore why a significant proportion of people in treatment for an opiate dependency do not have naloxone and work to maximise the coverage of this in the system.
2. Work to understand why so many people refuse naloxone kits in South Gloucestershire.
3. Work to understand reasons for the discrepancy between data on naloxone and overdose training provision between NDTMS and Illy.
4. Look for opportunities to increase provision of naloxone and lock boxes in other appropriate settings.

#### Tobacco use

Individuals experiencing drug dependency tend to have very high smoking rates and consequently face a disproportionate risk of mortality and morbidity from tobacco-related disease (124). This is primarily due to the effects of smoking on cardiovascular and respiratory health, but the risk of death from opioid overdose may also be increased by reduced lung function (118). These impacts may be exacerbated in people who also have a history of smoking other substances, such as heroin and crack cocaine. Studies have shown that smoking causes more deaths among service users than either heroin or alcohol (125), and many people who successfully complete treatment for drug use will then go on to die from their continued dependence on tobacco. This is not acceptable and we must work with together with partners, taking action to change this.

While the majority of people in drug treatment services reportedly wish to stop smoking, smoking cessation therapy is rarely offered to service users (118). This may be the result of staff concerns about needing to delay smoking cessation until recovery from drug dependency (124,126,127), although evidence shows no association between drug treatment outcomes and being offered smoking cessation therapy during drug treatment (124). NICE guidelines highlight the need for drug treatment services to promote or support engagement in local smoking cessation or to provide smoking cessation support directly (118).

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). However, just 15% (n = 22) of this group were abstinent from smoking tobacco at the end of their treatment period. Nationally, this figure was 24%. When broken down by substance category, this figure was 12% for who used opiates, 15% for those using non-opiates and 24% among people who used non-opiates and alcohol in combination.

Worryingly, some service users who didn't smoke at the start of treatment began smoking during their time in drug treatment services. Approximately one third (33%, n = 16) of South Gloucestershire service users who were abstinent from tobacco at the start of treatment were identified as smoking tobacco at the end of their treatment period. This is almost identical to the proportion nationally (32%).

Fewer than five service users who reported smoking tobacco at the beginning of their treatment were provided with smoking cessation interventions during their drug treatment, the same proportion as were offered nationally. Whilst everyone is offered a SmokeFree referral at the point of triage and signposted to the OYSG service, this needs to be revisited at regular intervals. It is clear

that more needs to be done to offer support to stop smoking to individuals in drug treatment in South Gloucestershire. We should aim to follow best practice in embedding smoking cessation services in drug treatment services in the next commissioning round, whilst looking for all opportunities to improve outcomes for people currently in treatment to stop smoking in the shorter term. Funding options should be discussed with the Smoke Free team.

1. To scope funding options for smoking cessation services for individuals in drug services.
2. Ensure that DHI promote smoking cessation services available through One You South Gloucestershire and provide information to service users about smoking cessation.

### Group work

The more variety a person adds to their treatment, the more they are able to determine what they need in order to achieve recovery. There is no 'one size fits all' approach when someone wants to stop taking drugs. Unfortunately, funding cuts to services result in services having to become more generic, making individual programmes of treatment more challenging to provide. Several group programmes are in place to support service users through every stage of recovery in South Gloucestershire. Some of the groups are substance specific (although it does not have to be the service user's main drug, it can be something they have taken or are taking at the time) and others look at the wider issues around taking drugs more generally. Not all courses require service users to be abstinent of their drug; however, to ensure safety of staff and other service users, heavily intoxicated service users may not be admitted. The following groups are available in South Gloucestershire at each hub:

- Preparation for Change - an eight-week rolling programme for those wishing to explore making positive changes
- Up in Smoke – a six-week course designed for cannabis and Spice users
- End of the Line – a six-week course for powder cocaine users
- Detox group – a four-week course to prepare service users for how detox works and prepare service users for successfully stopping taking substances
- Relapse Prevention – a six-week course for those who are new to recovery and are now abstinent
- Self-Management and Recovery Training (SMART) - SMART is a group programme that provides training and tools for people who want to change their behaviour, including addiction to drugs, alcohol and cigarettes. The groups are delivered by trained peer support facilitators
- Therapeutic group sessions – auricular acupuncture sessions, reflexology and mindfulness sessions

### Criminal Justice clients

Service users may be required to attend treatment as part of a court-ordered decision, with a Drug Rehabilitation Requirement (DRR) sometimes made as part of a community order. Previously, a minimum requirement was set for DRRs but these are now more flexible in addressing the individual needs of the service user and the resources available from drug services in the local area. Service users on DRRs will be incorporated into regular groups and receive 1:1 sessions in the same way that regular service users would. In the past, a Criminal Justice Intervention Team (CJIT) was commissioned to support people into treatment. However, this team was disbanded and replaced by a dedicated Criminal Justice worker due to resource reductions. This Criminal Justice worker was removed in the current commissioning cycle and so there is now no dedicated Criminal Justice role within our treatment system. Given the low rates of successful treatment completions in this cohort

we need to explore whether this pathway is sufficient to meet the needs of criminal justice clients. Despite not having a dedicated CJIT team or worker, DHI have dedicated required assessment slots for those identified by the Advice, Support, Custody and Courts service as part of test on arrest. These are booked directly and bypass the usual triage system. They also support Alcohol Treatment Requirements, Drug Rehabilitation Requirements and Rehabilitation Activity Requirement days. Referrals are also received from Probation workers directly.

#### *Actions to Consider:*

1. Review the criminal justice pathway into and through treatment to ensure it is fit for purpose and meets the needs of this specific service user group. Consider the specifics of this service user group when it comes to recommissioning, including gaining the views of Criminal Justice clients on their views on how best to support them.

#### *Prison releases*

There are three adult prisons in South Gloucestershire. HMP Leyhill is a category D open prison, which in December 2015 held 511 prisoners. HMP Ashfield is a category C male prison for those serving sentences for sexual offences (397 prisoners in December 2015) (130). HMP Eastwood Park is a female closed local prison (343 prisoners, December 2015) (130). Prison populations are not static. The churn rate or the number of times a prison place is used each year is 1.24 for HMP Leyhill, 0.49 for HMP Ashfield, and 4.49 for HMP Eastwood Park. In 2015, the average length of stay at HMP Eastwood Park is 49 to 60 days (130).

110 individuals were in treatment for substance misuse at HMP Leyhill in 2018/19, 79% (n = 110) of whom were receiving treatment for drug misuse. 85 individuals were in treatment for substance misuse at HMP Ashfield over this same time period, 67% (n = 57) of whom were receiving treatment for drug misuse. Numbers were far higher at HMP Eastwood Park, with 813 individuals in treatment for substance misuse, 93% (n = 755) of whom were receiving treatment for drug misuse. Heroin was the main drug used by 61% (n = 496) of substance misuse clients at HMP Eastwood Park, with crack reported as the second drug for 54% (n = 441) of clients and benzodiazepines the most common third drug (20%, n = 166).

In 2018/19, fewer than five clients from both HMP Leyhill and HMP Ashfield were transferred from prison to a community treatment provider. 13 individuals were transferred from HMP Eastwood Park to the community during the same time period. None of these individuals across all three prisons were released to community drug services in South Gloucestershire, and were instead transferred to other areas across the country. Despite this, it is important to continue to monitor transfers from prison to community drug services, with just 26% of clients transferred from prison to community treatment in the South West, and 34% of those individuals in England, commencing treatment in the community within three weeks of their release from prison (131).

However, individuals may be referred into community drug treatment in South Gloucestershire from prisons other than the three prisons in the South Gloucestershire area. The most recent quarterly data from DHI, for Quarter 4 of 2019/20, shows that 78% of adults with a substance misuse treatment need who return to South Gloucestershire following their release from prison successfully engage with community-based structured treatment. This is substantially higher than the national average of 34%, but it is important to note that these proportions refer to very low numbers of individuals each year. In addition, this figure is higher than the equivalent figure for 2018/19, when 42% of adults with a substance misuse treatment need who returned to South Gloucestershire following their release from prison successfully engaged with community-based structured treatment. This improvement may be the result of the focused efforts of DHI to engage in more pre-

release prison visits, but may also be affected by the low numbers of individuals that this figure refers to. Currently, the Community Rehabilitation Company (CRC) works alongside the National Probation Service (NPS) to act as a conduit between prisons and the community. CRC's are commissioned to co-ordinate and care plan 'Through the Gate' resettlement services including housing, employment, finance and debt advice for those sentenced to less than 12 months in prison and who are at greatest risk of re-offending.

These two providers are in the process of being merged and a framework is being produced at the time of writing this needs assessment. There has been considerable change in terms of roles and responsibilities in this area and there is a need for the DAP to further understand how the system fits together once these changes are made and to facilitate closer multiagency working between the CRC and drug and alcohol services. It has been suggested by colleagues in the prison system that the development of a multi-agency care plan for each person should be central to this method.

Collaboratively the prisons were offering (pre-COVID) a 'discharge board', which was a multi-agency attempt to bring partner agencies to the table to communicate final arrangements before release. Drug and alcohol services (AWP) were central to the provision of the discharge board as many of the prisoners were reliant on after-care arrangements for the continuation of Substitute Prescribing for opiate addiction; or for non-prescribed clients, continued harm minimisation and psychosocial engagement. However, in truth, discharge boards were limited in their scope as partner agencies were not working from the same integrated plan throughout a prisoner's sentence, and attendance at the discharge board or communicating arrangement was consistently difficult.

CRC link in with prison health services. The drug and alcohol treatment is provided in the three prisons in South Gloucestershire by AWP and Hanham Health, in a partnership. AWP also provide a Through the Gate worker within HMP Eastwood Park who supports the discharge board .

If a prison can facilitate the opportunity, and DHI capacity allows, service users who are being released from prison into the South Gloucestershire area are met by one of the DHI team prior to their release date in order for them to build up a rapport with the drug worker who will be working with them after release. There is also a rapid pathway for people needing opiate support which includes pre-release in reach and a joint AWP and DHI appointment on release. This means that prison release clients do not have to complicate separate triage, assessment, and prescribing appointment as it is combined, therefore reducing barriers. It also means individual doesn't have to be registered at a GP on day of release.

Anyone in the OST programme who is released from prison will work with someone from the specialist team for a month after release, during which time they will receive rapid access to OST if required. The specialist team will also work with the individual regarding the services that are available to them and ensure that any medication is being properly prescribed and collected. Once the service user has accessed treatment for a month and hopefully achieved stability in the community, they will be transferred to the Primary Care Team within DHI to complete the usual pathway, set out above.

DHI have identified an issue with pathways and communications from prisons, citing issues with last minute alerts about releases and not receiving the necessary paperwork. There is a need to look at transition pathways from prisons into community settings to ensure a smooth transition for those leaving prison who have an ongoing treatment need. In Quarter 3 of 2018/19, the provider did some analysis of prison referrals which showed that there were 47 referrals of which only 14 were appropriate. The remaining 33 were either coded as being released to the wrong area, remained in

custody, or were transferred. DHI request investment and support from the South Gloucestershire DAP team and/or PHE for this.

An audit of linkage between prisons and community treatment providers for individuals discharged from a London prison with a substance misuse treatment found issues with referrals being received by treatment providers, low attendance at treatment after release and low follow-up of those who did not attend for this treatment. Clients who were visited or phoned by treatment services pre-release were almost three times more likely to engage in community treatment than those who were not contacted. Guidance was developed by PHE as a result of this audit, which includes recommendations to develop a standard referral form, agree a referral protocol and improve links between services.

#### *Actions to Consider:*

1. Aim to increase the numbers of those released from prison who successfully engage with our treatment services.
2. Multi agency care plans should be developed for each person prior to their release to ensure effective transition into the community.
3. Agree the use of a standard referral form and referral protocol between our local prisons, other feeder prisons and local service providers.
4. Review the links between the DAP, our treatment provider and the CRC and probation services to see how they wider system can work together to improve engagement in the community and reduce reoffending rates. Treatment for clients in contact with the criminal justice system should be maximised to ensure it meet the needs of this vulnerable client group.
5. Ensure accurate recording of NDTMS data by all who provide treatment to prisoners pre- and post-release.
6. Faxing prisoner details to providers should be discouraged and instead replaced with secure email.

#### *Throughcare*

The Throughcare Team at DHI are made up of four team members (one of whom is funded by the West of England Works contract, with the remaining three individuals commissioned by the DAP as part of the commissioned service). The team provides a wraparound and aftercare service for service users who are both abstinent and non-abstinent from drugs, in order to achieve or maintain their recovery. They provide support in three main areas:

1. Work, training and volunteering
2. Benefits and housing; and
3. Recovery support, peer support and mutual aid.

The Throughcare Team aims to enable and empower service users to be independent and offers support to assist with work placements - both paid and voluntary, advice on housing and benefit-related problems, and encourages attendance at mutual aid and recovery support groups. SMART meetings are available through the DHI hubs, together with signposting to other meetings in different areas. The Throughcare team are able to work with clients whose recovery capital may have been jeopardised by the challenges to daily life which some people may be unable to overcome without a supportive person to help them.

One important barrier to recovery for someone with housing issues can be the lack of a deposit for a rented property. There is therefore an access scheme to an interest-free loan to support individuals to secure a tenancy. The loan can be used to pay a deposit and the first month's rent, and can be used for both private rental and social housing tenancies. The loan must be paid back, in full, within three years. To be eligible for this scheme, an individual must:

- Be homeless, threatened with homelessness, or live in unsuitable accommodation or in a hostel
- Be unable to obtain housing in any other way
- Be engaged or recently engaged (in the past 3 months) in drug/alcohol treatment services
- Be regularly turning up to scheduled appointments with Key Worker
- Be able to demonstrate how they will repay the loan within 3 years

The deposit portion of any money loaned must be registered with a tenancy deposit protection scheme; therefore the Landlord must be appropriately registered. Applications can be submitted at any time and all applications will be reviewed within 2 weeks by the Throughcare Team Leader and Service Manager. If an application is successful, it remains valid for 12 months. If the applicant does not find a suitable property within this time frame, they are able to submit a new application. If an application is not successful, DHI will state areas that the applicant should work on in order to improve their score, should they wish to reapply to the scheme in the future.

The maximum amount that can be applied for through the Access Scheme is £1500. If an individual's deposit requirements are above this amount, they should continue to make an application and provide evidence as to why the additional amount is required. In exceptional circumstances, additional funds may be granted by a DHI Director. Further financial support may be available from South Gloucestershire Council through the Tenancy Start-up Scheme.

The Throughcare team often begin working with service users in a moment of crisis and assist them in dealing with incidents that could potentially cause them to fall on old coping strategies and return to misusing substances. The team will offer guidance and support to the service user so that the road to recovery is smoothed and the risk of relapse is lessened. For those service users who are not yet abstinent, the Throughcare team will work with them to identify pathways to treatment if they do not feel ready to stop using drugs. During their sessions they will identify needs and areas of support – this may include completing forms and making telephone calls, advocating with council and benefit offices, supporting and advocating at tribunals, with law agencies and with debt agencies. Other support agencies will be contacted to ensure any joined up working is efficient, and client centred. Based on their individual need, pathways are identified if treatment is required for health-related problems or BBV testing and treatment. If other substances are being used and there is a need for them, signposting to needle exchange services can be done through the team.

### Employment

40% (n = 89) of people in South Gloucestershire who newly presented to drug treatment services were in regular employment at the start of treatment. This is considerably higher than the national figure of 23%, but should be considered in the context of a national working age employment rate of 76.3% (132). 33% (n = 74) were unemployed or economically inactive and 25% (n=55) were long-term sick or disabled. Fewer than five people were in education or doing unpaid voluntary work.

However, there is very little change in the proportion of individuals in employment at the start and exit from treatment, regardless of whether their treatment exit was planned or not. For those with planned exits from treatment, the proportion of people who were in full-time, part-time or irregular



work either did not change or showed only a single percentage point change from the start to the end of treatment. This data suggests that more should be done to support people in treatment to find employment, particularly given the evidence that being in work is associated with positive treatment outcomes, including reduced drug use, a lower risk of relapse and longer periods of abstinence (133–136). PHE’s treatment evidence review recommended that offering employment support as part of, or alongside, drug treatment can improve treatment engagement, reduce the severity and frequency of relapse and improve employment prospects post-treatment (25). The West of England Works contract goes some way to address this, by aiming to engage those further from the work market, who face multiple barriers to employment.

### Housing

PHE state that “a safe, stable home environment enables people to sustain their recovery” (137). A lack of access to stable housing not only impacts on an individual’s motivation to recover and treatment engagement, but also on their access to treatment through issues such as not being registered with a GP or having access to transport (25). Homelessness in particular is known to predict unplanned exits from treatment and relapse (138,139).

75% (n = 167) of adults newly presenting for drug treatment in South Gloucestershire did not report having a problem with housing, equivalent to the national figure of 73%. 17% (n = 37) reported having a housing problem, compared to 14% nationally. A housing problem may include issues such as staying with friends/family as a short-term guest, using a night winter shelter, squatting or staying in a short-term hostel, B&B or hotel (140). 8% (n = 17) had no fixed abode, lower than the 11% of those with no fixed abode reported across England.

Among those in South Gloucestershire who had initially reported a housing problem and who successfully completed treatment, 50% (n = 8) no longer had a housing problem at the end of their treatment. This is lower than the 84% who no longer had a housing problem nationally.

#### *Actions to consider:*

1. To work with housing colleagues to maximise opportunities for people with drug and alcohol problems to access safe and secure housing.
2. Improve links and pathways between drugs services and housing.

### Detoxification

Both community or residential detoxification (dependent on assessed need and domestic circumstances) and/or specialist pharmacological interventions are offered within the treatment service. Community detoxification forms part of the commissioned package administered by the Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) as part of their subcontract with DHI. Both forms of detoxification are normally two-week packages and require the service user to be motivated to change and to have done the preparatory work to understand that detox is not recovery itself, but the starting block on the way to recovery, with much commitment and hard work needing to follow it. Longer detoxes are offered on a case by case basis usually due to the wider health needs of the individual, for example if their mental health would benefit from a slower detox.

In the financial year 2019/20, 8 community detoxifications were undertaken by the drug service. This is in contrast to alcohol detoxes, where 37 community detoxes took place. This is because there are many more referrals to the specialist team for alcohol, compared to drugs. The reasons for this are not clear, but is likely to be due to the fact that alcohol clients tend to experience more physical consequences of their dependence and are, at least initially, more motivated in stopping their use. People who are using opiates are also more likely to be stable on a methadone or buprenorphine



prescription, making the need to detox less pressing as the risk is lower than someone drinking alcohol chaotically. Of the two, an opiate detox is more straightforward and less physically risky than an alcohol detox.

Community detoxifications are mainly provided from Kingswood Health Centre (KHC), with a small number taking place in Thornbury. Since moving the community detoxes from the Blackberry Centre to Kingswood, uptake has increased significantly. However, there are still geographical limitations to providing the service from only one regular location and it would be preferable to be able to provide detoxes from many more GP surgeries across South Gloucestershire.

Planned specialist detoxifications are provided on a residential basis at Broadway Lodge as part of a sub-contract with DHI. There are fortnightly detox clinic appointments in Patchway and Yate hubs to ensure that individuals can access the initial appointment and the specialist team will support them to arrange travel to KHC where appropriate. This is to get access to both residential and community detox.

AWP are co-located with DHI and have integrated team meetings and referral meetings, meaning that people using the service experience a smoother pathway into detox. DHI has pointed out that they are seeing an increasing number of complex detox cases where people's needs are not able to be met by the contracted detox service at Broadway Lodge. Specialist detoxes, such as those for pregnant women or those with complex needs that means they would need hospital level care, can take place at the ACER unit at Blackberry Hill hospital. There have been cases where even the ACER unit does not feel able to facilitate the detox as the individual's physical health means that they need to be in hospital. There is also a small budget for complex care which can be used either to fund a stay at the ACER unit or for extra healthcare provision to be put in to Broadway Lodge to help facilitate a detox there, but only a small amount of funding is available for this and there is a concern that there is not widespread provision to enable access to detox provision for those most in need.

In 2019/20 there were 10 opiate admissions to Broadway Lodge for residential detox. Only 5 of these admissions were total detoxes, the others were stabilisations and a High Dose Transfer. In contrast, there were 12 inpatient alcohol detoxes carried out in the same period.

#### *Actions to Consider:*

1. Explore ways of widening the reach of community detoxes and for more GPs to offer this as part of the shared care service.
2. Scope ways of providing an equitable detox service to those with complex needs.
3. Explore ways to increase the number of drug detoxes.
4. Ensure that end of life pathways are created for those who are too unwell to detox.

#### *Residential rehabilitation*

Residential rehabilitation provides 24-hour, structured support for those who wish to achieve abstinence. There is limited evidence of their effectiveness or cost-effectiveness, but they produce positive outcomes for some individuals. NICE guidelines recommend residential rehabilitation for individuals seeking abstinence, who have not have not benefited from previous community-based psychosocial treatment, and who have complex physical, social or mental needs (123).

Most of the placements for residential rehabilitation were for alcohol, and those seeking treatment for their drug use were much lower. Nine people were placed in residential rehabilitation for drug issues in the three last financial years from 17/18. Fewer than five of these individuals successfully completed their treatment. This raises a question as to whether residential rehabilitation treatment

is working for those seeking drug treatment in South Gloucestershire and further research is needed to see why less people are referred for drug treatment compared to alcohol.

#### *Actions to consider:*

1. Look into individual cases to see the reasons for why drug treatment in residential settings were not successful
2. Look at opportunities to increase referrals for residential rehabilitation for drug users, if it can be shown it is worthwhile and value for money.

#### *Complex needs*

Service users with complex needs include pregnant women, individuals with multiple substance misuse, those in very poor physical health, mental ill health or people with learning disabilities. These individuals are referred for assessment to AWP as part of the DHI sub-contract. AWP will then make recommendations and either refer the service user back to DHI, provide specialist treatment, or recommend that they be assessed for residential rehabilitation by a suitably qualified member of the South Gloucestershire Council DAP team. Residential rehabilitation funding is held in-house (by the Council) and is commissioned using a person-centred approach. Currently, funding for community and residential rehabilitation (but not hospital-initiated detoxification) drug treatment is met from the public health budget and not from, for example, adult social care or maternity services.

It is recognised that there are some people with complex and multiple issues (such as drug misuse, mental health, housing and criminal justice issues) who find it difficult to navigate the different systems and services in place which are designed to meet their needs and therefore “fall through the gaps” of treatment. In Bristol, a Creative Solutions Board has been created to attempt to work more creatively with people to whom this applies.

It is an operational meeting for strategic leaders with the aim of working differently together to identify creative, long-term solutions for people with highly complex needs, risks and presentations. As the Local Authority looks for ways to work in partnership across BNSSG, it could be a solution to develop the Bristol Board to include South Gloucestershire residents, particularly because many South Gloucestershire residents who find themselves homeless will cross the border into Bristol to access services anyway.

#### *Actions to Consider:*

1. Explore opportunities for joint commissioning for people with complex needs, with services focusing on the individual needs of these individuals and wrapping support around them.
2. Explore opportunities for multi-disciplinary team working to support people with complex needs, based on the ‘my team around me’ approach
3. Explore whether a South Gloucestershire Creative Solutions Board could be set up, or whether the Bristol board could be expanded to include South Gloucestershire.

#### *Peer mentorship and other recovery-supporting activities*

At the end of their treatment, a service user has the option to become a peer mentor, for which they receive two-days training and six-weekly supervision. There are currently 20 peers in the service, 16 of whom are active on a weekly basis. Once trained, peer mentors are able to co-facilitate a treatment group, facilitate creative activity groups, train to run SMART sessions or may be placed in a voluntary organisation, such as Southern Brooks – to act as a bridge into treatment for their peers. Their participation in groups provides visible recovery and valuable support for the DHI staff. Additionally, they support outreach events and share their experiences at workshops and drop-in

sessions in the community. Several peers have also progressed into voluntary roles with partner organisations or achieved paid employment through the support of DHI. There are also other activities that people accessing the service can get involved in to aid confidence, combat boredom and increase chances of sustained recovery. These include craft club, gardening group, auricular acupuncture, reflexology and meditation.

### Students

South Gloucestershire is home to the University of the West of England (UWE), and their main campus, Frenchay Campus. Other UWE campuses are located in surrounding local authorities. UWE provide higher education to over 27,000 students and accommodate over 3,000 first year students on-site at Frenchay Campus.

As part of the South Gloucestershire Drug and Alcohol Service, DHI were providing an engagement worker to provide support for half a day a week. As it became apparent that increased support would be utilised, UWE funded a full time Drug and Alcohol Worker, through DHI, who sits within the Wellbeing Team at UWE. This position has been in place since September 2018 and has been well utilised, and was extended for a further year. If the student needs structured treatment their data would be submitted to NDMTS, but most of them follow an unstructured pathway. All students are entered onto the Illy system.

Another useful tool in monitoring UWE students' drug use is the Breaking Free Online app. Access to the app is funded by South Gloucestershire DAP and is currently only available for use through the UWE Drug and Alcohol Worker. As of June 2020, 56 students were using the app, 32 of whom were using the app to access support with using drugs. The app allows individuals access to a comprehensive online treatment and recovery programme, that supports them to resolve the psychological and lifestyle issues that drive their use of drugs from their phone or computer. Access to the app means 24/7 support is available and may encourage more people to access support or think about their drug use and behaviours, particularly those who do not feel traditional community support is appropriate for them.

At the end of 2018, a harm reduction poster campaign was run at UWE with design from South Gloucestershire Council. The posters covered the main drugs that students take and gave advice about how to reduce harm when taking them, along with where to get help through the DHI SPACED service. These were displayed around the University campus and halls of residences. Anecdotal evidence suggests a positive response to the posters, but their impact was not formally evaluated.

A multiagency drugs meeting is held every quarter between UWE and the University of Bristol, together with outside agencies including drug services, student accommodation and Public Health staff. These meetings are used to discuss and deliver joint approaches to tackling drug use among students wherever possible.

### *Actions to Consider:*

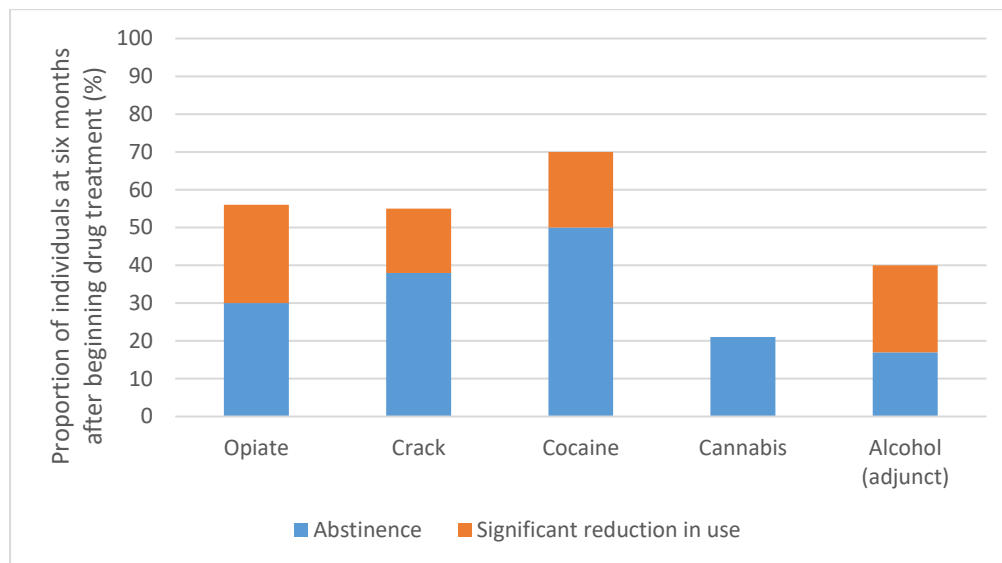
1. Continued funding of a specific drug and alcohol post at UWE.
2. Continued multi-disciplinary approach to drug use by students, and promotion of harm reduction.
3. Increased access to Breaking Free online for the student population.

### Treatment outcomes

Figure 25 displays the in-treatment outcomes for service users at six months after beginning drug treatment. Fewer than five people were in treatment for amphetamine use, with these figures therefore not being displayed. Fewer than five individuals had significantly reduced their use of

cannabis at six months after treatment commencement and this is therefore not displayed in Figure 25. In general, six month treatment outcomes in South Gloucestershire were similar to those seen nationally, other than for the adjunctive use of alcohol. The proportion abstinent from alcohol at six months was substantially lower in South Gloucestershire than across England as a whole – 17% in South Gloucestershire compared to 32% nationally. However, the proportion of individuals in local drug treatment reporting a significant reduction in their alcohol use at six months was higher than the national average (29% in South Gloucestershire compared to 18% nationally), balancing out these apparent differences.

Figure 25: Outcomes at six months after beginning drug treatment. South Gloucestershire, 2018-19.



57% of adults in drug treatment in South Gloucestershire were no longer injecting at the time of their six month review. It is notable that the proportion of females no longer injecting at six months was approximately half that of the proportion of males, 33% compared to 65%. This is different to the situation nationally, where the proportion is relatively similar between males and females, and suggests that more focus should be given to reducing injecting among women in drug treatment services.

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.

Despite the 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.

#### *Actions to consider:*

1. Explore the injecting behaviour of individuals in more depth.
2. Explore in more detail why males appear to be less successful in completing treatment than their female counterparts.

#### Provision of drug services during COVID-19

As mentioned above, this needs assessment is being written during the COVID-19 pandemic. During this time, DHI Drug and Alcohol Services are working outside of their agreed contract terms and conditions and also, in some cases, the existing national guidance. These are exceptional times and the system has had to work quickly and collaboratively with partners to be as adaptable as possible. This has happened to ensure that measures could be taken to support the Government response to slowing the spread of COVID-19, whilst also protecting our service users and ensuring that they can still receive a service. As a result, some normal service delivery (as described above) is not being provided at the time of writing this needs assessment.

Our clinical decisions to adapt services due to this have been discussed and agreed by our lead Drug GP, the South Gloucestershire Principal Medicines Optimisation Pharmacist at the CCG, Local Pharmaceutical Committee (LPC), the South Gloucestershire Council DAP and our service provider.

Below is a summary of the key changes that have been made together as a partnership. Together, as a collaborative, we hold the risks related to safeguarding, health and wellbeing and service continuity.

- Relaxing of prescribing regimes. This is to limit the contact that vulnerable people who use our services have with pharmacies. Each person in the service has been risk assessed to ensure that safe practice still applies and where risk is deemed too high for the regime to be relaxed, they have remained on supervised consumption.
- Stopping groups and all non-essential face to face contact, including peer support. Groups are now being done over Zoom and initial feedback is that some people are preferring this as an option for group work going forward.
- Moving to telephone support wherever possible, with the frequency of appointments increased to fortnightly (where previously monthly for opiate clients).
- Stopping drug detoxes, both in-patient and community. We are currently looking at ways to safely reintroduce these.
- Ceasing residential rehabilitation referrals. We are currently working alongside residential settings to see whether re-opening referrals is safe and would provide value-for-money.
- Diverting the SPOC to a work mobile so that there is no longer a need for someone to be in the office to answer the phone. Staff continue to work from home wherever they can and this appears to be working well.

- Ensuring all urine testing for new starters is conducted through an air lock system at Tower Road North, thereby enabling safe starts of people on the OST programme but reducing human contact.
- Accepting verbal consent for care plans and risk assessments.
- Ceasing BBV testing. We are currently looking at safe ways to reintroduce testing, particularly with people who have been housed through the government COVID-19 “Everyone In” housing directive.
- Continuing needle exchange support as safely as possible via drop offs and collection with no contact.
- During COVID-19, DHI have been offering prison pre-release telephone assessments which means that triage and assessments for non-local prisons can be completed over the phone in advance. The specialist team continues to prescribe for extended period for OST prison-release clients
- Provision of daily Facebook Live events including harm reduction advice, wellbeing activities and signposting.

Stakeholder and service user engagement has taken place as part of this needs assessment, with the findings from these activities outlined later in the report. Stakeholders and service users were both asked about changes to drug services during the COVID-19 pandemic in order to capture their perspectives on these changes, and whether any of the new changes that have been implemented should be continued even when current restrictions are lifted.

## Engagement with Professionals

### 1:1 Interviews

One-to-one interviews were conducted with nineteen professionals working on issues related to drug use in South Gloucestershire. These individuals worked in a variety of different roles across organisations including the Young People's Drug and Alcohol Service, the Drug and Alcohol Service provided by Developing Health and Independence (DHI), South Gloucestershire Council's Public Health and Wellbeing Division, social workers, primary care, Community Safety Team, Youth Offending Team, Avon and Somerset Police and PHE's Health and Justice team.

The information presented here is focused on the key themes that emerged from these interviews.

### Stigma

Many professionals highlighted stigma as being a key challenge in tackling drug-related harms. Stigma was felt to be far more significant for drugs compared to alcohol use, with the feelings of many professionals summarised by one interviewee, who commented that *"issues around drug use are morally loaded."* Professionals spoke of the need to collectively behave more kindly towards people using drugs, shifting away from a punitive approach that regards people who use drugs as criminals and instead treating drug use as a symptom of wider issues.

While professionals discussed the issue of stigma towards people who use drugs from members of the public, they also highlighted that stigma commonly came from professionals. This was particularly expressed as professionals having low hope and low expectations of people who use drugs, leading to a reluctance among people who use drugs to engage with services and vice versa. Related to this is the need to ensure that services do not stigmatise people because they do not behave in the way that the service requires, or meet the service's expectations of them as a service user. For example, professionals mentioned the need to consider the additional support that service users might need to attend appointments, taking into account the fact that service users may have different priorities to the service itself. In addition, several interviewees spoke of the need for a change in culture, away from expecting people who use our services to engage with those services in a way that suits the professional, rather than considering the needs of the individual requiring the service.

Similarly, interviewees emphasised the need for service users to be treated like any other individual who would access services for a medical need. Professionals felt that providing drug treatment services in GP surgeries was vitally important for this, normalising drug services for everyone. One interviewee described the problem of treating people in central, specialist services as *"adding to the impression that people in drug treatment should be cast aside from normal society."* Others highlighted the challenges that a more centralised model would pose for service users themselves, being surrounded solely by other service users rather than fellow GP patients when attending for appointments. This was expressed in the following statement from one interviewee: *"Really, it's about trying to get people back into society - people need to be given a chance and the opportunity for change."*

Several professionals felt that differing perceptions of addiction meant that people were far less likely to recognise and accept that they had a problem with drugs compared to a problem with alcohol. This was thought to be a particular issue among individuals aged 45 years and older, who are more likely to have comorbidities resulting from the combined effects of both longstanding drug use and their age.



## Prevention

Many professionals expressed concern that services did not place sufficient focus on prevention and were instead largely providing reactive, high-end service provision for individuals with the most severe and complex needs. Professionals described a pattern of spending a large amount of money on a small number of people who tend to stay in the system for a long period of time, rather than focusing on preventative services which may prevent the development of more significant – and costly – needs at a later stage. A large number of interviewees felt that more assertive outreach could be done, working with people in a pre-contemplative state to prevent things from reaching a crisis point.

Not only was prevention seen as important to prevent people from beginning to use drugs, but also spoken of in terms of preventing relapse. Many interviewees felt that drug services should not simply be isolated treatment services, but needed to be linked to the bigger system and provide *“whole life support”*. This was described by one interviewee in the following quote: *“services need to look at the causal factors in all of this and help people build the resilience they need to be able to live the life they want to lead. Services shouldn’t purely exist to stop them from taking drugs.”*

Professionals expressed a strong need for services to incorporate other elements of care, key to helping someone achieve recovery. Similarly, several professionals raised concerns around funding constraints having led to a reduction in holistic, wraparound support and activities for people who use drug services. This meant that treatment centres were now often only attended if somebody has an appointment, rather than to provide a safe space to people throughout the day.

The final element of prevention that professionals discussed was the prevention of further health-related harms that could result from drug use and addressing the wider health needs of this population. Several professionals highlighted a particular need to improve smoking cessation support for people who use drug services, with *“missed opportunities”* to prevent further adverse health outcomes in this group of individuals. Others discussed the need to increase our focus on health protection, and to do this more effectively. For example, one interviewee expressed the need to move beyond simply telling people to clean their injection sites and wash their hands, with this not being an effective means of preventing skin and soft tissue infections.

## Prescription drug use

Dependence on prescribed medication was a widespread and increasing concern among professionals, with services needing to keep up with changes in drug use in order to avoid seeing an unmet need. Interviewees explained that those individuals who were dependent on prescription medication tended to be a very different cohort of people to those historically accessing drug services. This created a challenge for staff working in treatment services, who may need a different approach to that which has been used previously, but also an issue for encouraging individuals to access the support that they need. This is largely related to issues of stigma, as discussed in more detail above.

A further challenge for providing services to those who are dependent on prescribed medication is the capacity of both GPs and the wider healthcare system. Patients currently face substantial challenges to accessing services that help them to manage pain, with long waiting lists for non-pharmacological pain management services such as physiotherapists. As a result, patients can be dependent on pain medication by the time they receive definitive treatment. Alternative services are required, but professionals described GPs as being *“overwhelmed”*, without the time or resources to manage those with existing dependencies. However, GPs did feel that they were better able to

manage new patients presenting with pain, working with them to prevent them becoming dependent on prescription medication.

### Mental health

A large number of the professionals interviewed raised significant concerns about the links between mental health services and drug services, with a “*constant revolving door*” existing for individuals with a dual diagnosis that was leading to “*people slipping through the net.*” Interviewees reported problems with service users with a dual diagnosis unable to access both mental health support and support for their drug use simultaneously, with both services operating in isolation from one another. This was of particular concern given that drugs or alcohol are often either a symptom or a cause of poor mental health in a lot of people who use services, with joint care planning therefore suggested as a more appropriate approach.

In terms of mental health services themselves, several professionals expressed concern that services in South Gloucestershire tended to be focused on psychiatry and had high thresholds for being eligible for treatment. Waiting lists for psychological therapies were described as being long, which was seen as a particular barrier when you may have a narrow window within which an individual feels ready and able to engage with services. Professionals felt that primary mental health services in South Gloucestershire were limited, leading to many individuals accessing the system during a time of acute crisis, rather than being able to prevent issues before they arise. Finally, the lack of counselling for people who use drug treatment services was seen as problematic, given the trauma that many of these individuals will have experienced.

The links between mental health and drug services were not just a problem for treatment services. Several interviewees felt that not enough was being done to build the public health links between mental health and drug programmes within South Gloucestershire Council, with the two teams often working in isolation on their specific area of work. Given the overlap of people who require both mental health and drug services, together with the common risk factors for the two issues and the limited capacity of staff within the Council, professionals felt that there were clear opportunities to work more closely together. Suggestions included developing a joint communications approach, as well as ensuring that mental health workers received training on working with people who use drugs, and vice versa.

### Life course approach

Many professionals spoke of the need for the local drug programme and drug treatment services to take a life course approach, considering the experiences they may have had over the course of their life and acknowledging that behaviour is shaped by the wider social, economic and cultural environment. Given that many individuals who use drug services have experienced significant trauma, interviewees emphasised that services should be ACE-informed and recognise that drug use is often a symptom of wider challenges that a person may be experiencing.

Many of these issues also linked in with the need for interviewees’ calls for a greater focus on prevention. The links between ACEs and drug use are clear, and professionals therefore felt that we should be doing more to identify individuals and families at potential risk, intervening early to try and prevent future drug use rather than working with people once a crisis had already arisen. In particular, several interviewees mentioned concerns about engagement with and access to services for young people who were not in employment, education or training (NEET) and who were not linked in with the services or organisations who would usually refer people into YPDAS.

In line with the need for a life course approach, professionals highlighted potential issues in the transition between young people's and adult drug services. Interviewees spoke of seeing a gap between people leaving YPDAS and then coming back into services as older adults, suggesting that there may be issues with the transition that result in individuals falling through the cracks between these two separate services.

### Exploitation of young people

Multiple interviewees expressed concerns around the exploitation of young people. While county lines activity was not currently seen as a problem in South Gloucestershire, professionals were concerned about significant, localised issues in Thornbury, Bradley Stoke and Patchway where there was clear evidence of older adults in the community supplying drugs to young people. However, one interviewee felt that the exploitation of young people was not a new phenomenon, but described a shift in how it was viewed and discussed as a problem: *"there's a lot more focus on exploitation now. Exploitation in itself is nothing new, but people's thinking on it has been really challenged in relation to how they treat these kids and the idea of their drug use being a simple choice that they have consciously made."*

Specific concerns were raised in relation to cuckooing – a form of crime in which drug dealers take over the home of a vulnerable person in order to use it as a base for drug dealing (141).

Professionals reported an increasing number of safeguarding referrals involving financial abuse and cuckooing. This was particularly in relation to people with learning disabilities being exploited for these purposes, but also involved vulnerable young adults without a learning disability. Some interviewees felt that while county lines had received substantial media attention over the last few years, cuckooing was more common but less discussed and more cases of cuckooing were likely to be occurring than we were officially aware of.

The permanent and fixed period exclusion rates in state-funded primary, state-funded secondary and special schools in South Gloucestershire are all higher than the average rates for both the South West region and England as a whole (142). Professionals interviewed felt that high school exclusion rate in South Gloucestershire was a potential contributory factor to drug use among young people in the area, with exclusions presenting a substantial risk to young people and leaving them vulnerable to exploitation.

### Online survey for professionals

31 respondents sent in questionnaires from an online survey for the drug needs assessment.

Professions for those that responded included: Teachers and those in education including the university; Drug and alcohol staff; Hospital staff; Violence reduction unit; Probation; School nurse; Pharmacist; GP; Public health; Police; Health visitor; Adult safeguarding ; Housing; Over 50's forum; Court liaison; Foster placement support.

Professionals were asked the following questions, with the key themes outlines in response to each question:

#### **During the current COVID-19 situation, what are we doing well to tackle drug-related harm in South Gloucestershire?**

- Keeping in touch - continuing contact with service users despite the COVID-19 pandemic was seen as positive, whether that be by phone or other mediums.

- Vulnerable people – a number of people mentioned that YPDAS, in particular, was working hard to continue to engage vulnerable young people during the crisis.
- Working in partnership – teams were seen as having communicated well to ensure services could still be delivered. Communication with GPs and Pharmacists was particularly highlighted.
- Technology – embracing new technology, for example using Zoom to move meetings and groups online.
- Harm reduction – the provision of dial-a-needle needle exchange services and increased naloxone distribution was also seen as positive.
- Adapted quickly to change – the speed at which services adapted to the new challenges posed by COVID-19 was also seen to have gone well.
- Unsure or unaware - some professionals reported being unaware of the changes in structure since COVID-19 – this may have been down to them not having the need for very close links with the service or that this was an area where there could have been improved communication to ensure agencies knew about changes to service, or that service provision was still available.

**Prior to COVID-19, what were we doing well to tackle drug-related harm in South Gloucestershire?**

- Young People’s service - a number of respondents praised the Young People’s service for their engagement of vulnerable young people especially around wider issues such as child sexual exploitation (CSE) and their safety. A community safety event was cited as good practice to bring agencies together to work with vulnerable young people.
- Adult treatment - support provided by the adult service was also praised in terms of having a wide range of treatment options in place as well as signposting to other agencies.
- Wraparound support – other support given by the provider that was not direct drug support, such as supporting people with their housing.
- Multi-agency working- this was seen as something that worked well in services in relation to YPDAS’ work with schools and social care and in the OST service, between adult drug services, GP practices and pharmacies.
- Ease of access – the adult service was seen as being easy to access and flexible in its approach. This was particularly in relation to the shared care scheme, with good communication reported between the drug service, GP surgery and pharmacy.
- Other positive aspects of the service mentioned by respondents included harm reduction and support for family members of those who use drugs.

**During the COVID-19 situation, what are the problems, gaps and challenges in tackling drug-related harm in South Gloucestershire?**

- Lack of face-to-face contact – this was seen as the biggest challenge and gap during the COVID-19 pandemic. The lack of ability to see people face-to-face was brought up by a large number of respondents, with numerous challenges caused by the lack of face-to-face contact. These included having to rely on self-report for how people were coping, building relationships with people new to service being difficult over the phone, not being able to provide face-to-face interventions such as BBV testing and people feeling that there was no substitute for face-to-face work. The inability of the young people’s service to see people face-to-face was seen to have led to a gap in service for vulnerable children who have still been attending school.

- Increased risk – respondents raised concerns that new ways of working during COVID-19 had led to increased risks. For example, the relaxing of people’s prescribing regimes, coupled with not being able to see those individuals face-to-face to check that they were coping with these changes. Risk to children of people using the drug service was also cited as a concern.
- Lack of technology – although the move “online” was positive for many service users, some did not have the appropriate technology (either smartphones or a computer) to now access services.
- Lack of privacy – this was also cited as a challenge, with some service users finding it difficult to find a quiet and confidential space that they would usually expect from the drug service, due to them being at home with family members.
- Multi-agency working – it was noted by some respondents that the remote working made some multi-agency working more difficult.
- Decreased intelligence – from a community safety perspective it was raised that there have been challenges in gathering community intelligence about drug activity, which would ultimately lead to disruption activity. As a result, our knowledge about whether drug use has gone up or down has been impaired.

**Prior to COVID-19, what were the problems, gaps and challenges in tackling drug-related harm in South Gloucestershire?**

- Concerns about exploitation of young people – numerous respondents brought up concerns about the increase in risk to young people from drug use and gangs in South Gloucestershire.
- Mental health and complex needs– a number of respondents raised the lack of support for people with complex needs and a dual diagnosis, feeling that this was gap in service provision. Working with people with complex needs was also raised as a challenge.
- Preventative work- people often come into treatment late in life and therefore the focus has to be on harm reduction rather than recovery. Respondents felt that more links into preventative services were needed, as some services were not aware of where to signpost. The lack of preventative work was seen as a gap.
- Funding – challenges with funding, staffing not being sufficient and high turnover of staff was also mentioned as a challenge.
- Multi agency working – issues were reported with adequate information sharing between services, with a need to find better ways of sharing intelligence to keep people safe. Respondents reported the need to improve joined up working between adult and children’s social care and drug services.
- Other gaps and challenges included: a lack of appropriate housing for people who use drugs; hospital support within the emergency department for drug users; and the border between South Gloucestershire and Bristol creating challenges in transferring people between services.

**Do you have any recommendations for improving the lives of people who use drugs in South Gloucestershire?**

There were a wide range of opinions brought about by this question so it should be noted that some of these recommendations were made by a small number of respondents. The main themes were:

- Access to housing – this was seen by some respondents as essential with the Housing First model being given as an example of how this could work to better support those with complex needs.
- Links with mental health – a dual diagnosis pathway or services to be commissioned with mental health support embedded was a recommendation by respondents.
- Prevention and early intervention – this included trying to educate people and recognise the signs and risks earlier, in order to prevent further illness and premature death. More information on where to get help was also mentioned.
- Harm reduction – having harm reduction initiatives alongside recovery options.
- Access to support– professionals felt that a wide range of support options should be on offer for people. In particular, more support for vulnerable people, together with more wraparound support, was recommended.
- Multi agency working and improved intelligence and data sharing was something that respondents felt could improve the lives of people who use drugs, particularly in relation to safety of young people, young people having a “safe space” that they could go to and working together on disrupting criminal activity around drugs. Joint commissioning of services, in particular young people and adults to aid transitions was also a recommendation.
- More than one respondent recommended that reform of the Misuse of Drugs Act would help and that we should lobby in support of this. Other recommendations included: more engagement with people who use drugs; a greater focus on people with protected characteristics in order to ensure a fair access to services; taking a family approach; developing a specific prescription opioid service/pathway; and better pay for drug workers to slow down staff turnover rates which can be disruptive to the treatment of people who use drugs.

**Bearing in mind what you’ve told us, how do you think we should be prioritising the issues that you’ve mentioned in our drug strategy?**

This question included a wide range of different opinions, so it should be noted that some of the recommendations were made by a small number of respondents. The key priorities were:

- Education was as a priority, in relation to young people in schools and other settings, but also for adults to help increase knowledge.
- Housing, with the Housing First model again being cited as something that should be explored.
- Prevention and early intervention, with reference to enabling people to access support before it was too late.
- Ensuring agencies were working better together to share intelligence and protect vulnerable people. This included specific mention of information and intelligence sharing with the police and mental health colleagues.
- Working with mental health colleagues to ensure people who use drugs who have co-existing mental health issues get the support they need.
- Ensuring that there are preventative and treatment options for people who use other drugs that are not opiates.
- Continued access to GP and the primary care scheme.
- Other priorities mentioned included: legislation; tackling stigma; talking to people who use drugs to get their views; reviewing the spend on drug treatment to ensure we are as efficient as possible; support groups for young people; an easy referral pathway for those

using the emergency department; and ensuring a specified standard of training and professional pay is set out in the next commissioning round.

### DHI staff engagement sessions

We also held three online Zoom events with workers from the drug service. These included workers from all teams from both DHI and AWP.

Participants were asked:

#### **During the current COVID-19 situation, what are we doing well to tackle drug-related harm in South Gloucestershire?**

- Peer befriending scheme – this had been set up during COVID-19 to increase the support for people who are isolated during the lockdown
- Increased telephone and online support, as a result of not being able to see people face-to-face
- Lockdown has meant some people have reduced or stopped drug use
- Increased outreach work, including harm reduction initiatives like mobile needle exchange and distribution of lock boxes and naloxone
- Liaising more closely with pharmacies – this was seen as something that had worked well and had been necessary due to people needing their prescriptions but not being able to get to the pharmacy regularly
- Linked to this, the relaxing of regimes for those in the OST service was seen as positive
- Positive risk taking was seen to have worked well during lockdown
- Homeless people being housed

#### **Prior to COVID-19, what were we doing well to tackle drug-related harm in South Gloucestershire?**

- An increase in the number of detoxes completed compared to the last contract.
- Extra groups like acupuncture, gardening groups etc. had acted as a “soft” way into the more structured groups for some.
- Face-to-face support – the therapeutic relationship built up by having one worker that a service user would see regularly was stated as something that was positive.
- The move to the hubs to include Patchway was seen as having increased access to service.
- Single point of contact- having a single team that is experienced in directing people through the service and to the right team was seen as something that was going well.
- Wraparound support – this was seen as very important and good to have this as part of the wider service.
- Mutual aid on site- having groups like SMART and AA, as well as the visible recovery of peer mentors.
- Integrated specialist service – having the specialist drug and alcohol service embedded within the wider service was seen as better for clients. Clients often they did not know they were being transferred between services as they all worked together seamlessly.
- No waiting list for clients for OST.
- Running services from GP surgeries was also seen to have increased access to the service across the area.

#### **During the COVID-19 situation, what are the problems, gaps and challenges in tackling drug-related harm in South Gloucestershire?**



- Challenge of not having face-to-face contact – more complex conversations around domestic violence and abuse and mental health were seen as much more difficult to have over the phone
- The impact on people's mental health due to isolation was a concern
- Technology – not all people using the service have access to the technology to access online services. Staff also struggled as they did not have access to EMIS to update GP notes.
- Lack of spontaneous drug tests – this was seen as something that was a gap in treatment
- Unable to detox – this was seen as a big gap and there was a will to be able to offer these as soon as is safe

**Prior to COVID-19, what were the problems, gaps and challenges in tackling drug-related harm in South Gloucestershire?**

- The service was not fit for all, groups did not cater for everyone and the lack of childcare was an issue for some
- Although community detoxes were seen as positive, it was felt that these should be offered in other areas aside from Kingswood
- Joined-up working with mental health services was seen as a significant challenge
- Hepatitis B vaccinations were seen as difficult to do without dedicated resource
- Although the Hub model was seen as a positive, it was also seen to have challenges as the pressure to provide services across three sites meant that staff are spread thinly
- Having little capacity for outreach
- Complex needs support. It was suggested that these services should be co-commissioned to ensure those with dual diagnosis get the support they need
- The lack of a criminal justice team or specific role or focus on supporting those in contact with criminal justice
- Lack of adequate housing support and appropriate housing for those with complex needs and people who use drugs.
- Inpatient detox for complex needs was seen as not having enough funding allocated to it for the amount of people with complex needs who could benefit from this kind of treatment
- Pathways in and out of hospital were thought to need strengthening
- End of life pathways were seen as a gap, particularly for our increasing older population of drug users
- How we support those with protected characteristics was seen as a gap. There is no specific support for any of these groups in our current treatment services and it was felt not enough was known about meeting individual's needs.
- Transitions from 18-25. DHI staff felt that there needed to be a focus on this age group as adult services would not be able to meet their needs, but officially these individuals are outside the age bracket for young people's services.

**Do you have any recommendations for improving the lives of people who use drugs in South Gloucestershire?**

- It was felt that the needs of people using cocaine and crack cocaine were not catered for in current drug services as they are not engaging in treatment. It was recommended that more information be made available, particularly around the risks of mixing cocaine and alcohol.
- Prescribed medication service – it was recommended that a specialist service be set up to address the needs of those people who are using prescribed and over-the-counter opiates as opposed to illicit drugs.
- It was recommended that services were developed specifically for younger adults to stop young people falling through the gaps when transitioning to adult services.

- Better work around sexual health for those in drug services.
- People leaving prison should be better supported by improving links with prison leavers to aid their transitions back into the community
- Provide more support around finances and linking in with Citizens Advice services
- To run a Freedom programme for victims of domestic abuse from drug and alcohol services
- Providing more mindfulness support
- To consider widening the hub model to include Thornbury.

**Bearing in mind what you've told us, how do you think we should be prioritising the issues that you've mentioned in our drug strategy?**

- Better links with mental health, to ensure that people with dual diagnosis get the support they need.
- Similarly, appropriate services for those with complex needs should be prioritised.
- Harm reduction and prevention was felt to need more resource, including services such as the mobile needle exchange. Professionals recommended prioritising a review of the pharmacy needle exchange service, as it was felt this often just involved giving equipment rather than providing an in-depth harm reduction intervention. It was felt that people using the exchange should be targeted to try to get them into treatment and support them with their wider health needs.
- Having a service that caters for those who are using prescription and over the counter medications.
- Ensuring safe face-to-face contact can resume post-COVID-19, with this being integral to the therapeutic relationship.
- More assertive outreach was suggested as a priority to ensure access to those with childcare issues, poor mental health and mobility issues.
- To offer variety and the widest range of options possible in treatment for people.
- Links with schools and education for young people around drugs.
- Taking a trauma-informed approach to those who use drugs.

**Actions to consider:**

- Ensure agencies work together to ensure pathways between services are seamless and that intelligence is shared, particularly between mental health and drug services, prisons and sexual health services.
- Ensure a wide range of treatment and harm reduction options are offered, including good quality "wraparound" support and outreach.
- Ensure that issues around remote working are addressed in the light of COVID-19, making sure it is understood that not everyone has access to the technology necessary to access services online or over the phone.
- Support work to develop better services for vulnerable people with complex needs.
- Ensure that the needs of young people in relation to drug use and wider vulnerabilities are met.
- To develop a preventative agenda that works on stopping people from developing more serious problems with drugs, including better education in schools.
- Work with housing colleagues to maximise housing options for people who use drugs and consider implementing a Housing First approach for those with complex needs.
- Review and audit the shared care service to ensure consistency across the service and to establish that this is the best way of delivering OST.

- Continue working closely with Bristol colleagues to reduce the challenges of the border between the two authorities.
- Develop ways of engaging directly with people who use drugs and ensure their voices are heard and integral to the development of drug services and the commissioning process.
- Develop a specialist prescription and over-the-counter opioid service.
- Review support and wider public education for those using cocaine and crack cocaine.
- Ensure specific services for young adults are considered when recommissioning services.

## Service User Engagement

### Adults

A total of 47 adult service users completed the service user survey, either online or by phone. Service users most commonly reported using crack cocaine (n = 18) and/or heroin (n = 16), followed by cocaine (n = 6). Fewer than five respondents reported using cannabis, ketamine, amphetamines or other prescribed medications.

Service users had been receiving support around their drug use for a very variable period of time, ranging from 3 months to approximately 25 years. The average number of years in treatment for service users who completed the survey was 7.5.

Service users were asked the following questions, with key themes outlined in relation to each question.

#### **Is there anything that you would like to tell us about you and how drugs have affected your life?**

All respondents spoke of the negative effects of drugs, with many service users specifically stating that drugs had ruined their lives. The impacts were felt across every aspect of life, including: the breakdown of relationships with both family and friends, largely due to a loss of trust that can take years to repair, even once in treatment and recovery; loss of contact with children; housing and homelessness; mental health impacts, particularly depression; crime and having to spend time in prison; financial difficulties; employment; education, particularly among those who began using drugs at a young age; and health, both in terms of the lived experience of poor health, as well as constant concerns about the damage that drugs may do to future health.

A sense of loss was talked about consistently by service users. This encompassed the loss of opportunities, including the loss of opportunities to better oneself; the loss of control and the “humiliation” that service users spoke of with the constant need for more and more of their chosen drug; the loss of self-worth, self-esteem and a sense of identity; and finally, through the loss of those that they cared about, including the loss of friends who also used drugs to situations such as overdose. Several service users described feeling as though they had lost their whole lives to drugs, with everything revolving entirely around their next fix.

#### **Think back to before COVID-19 started, at the start of March. How were things going for you then? What were your experiences of services like until that time - both positive and negative? Did you experience any challenges with accessing or using those services? Was there anything that you felt was missing?**

All service users reported having a positive experience of services, even if they also had suggestions for where things could be improved. Key themes around positive experiences of the service were as follows:

- Short waiting times, with many service users saying that they found it quick and easy to receive support and begin OST, if required.
- Consistency – this was largely provided through one-to-one, face-to-face support, which many service users described as the aspect of services that they got the most from. Service users spoke of the positive relationships that they had developed with their key worker, and the benefit they found in not having to regularly repeat potentially traumatic or upsetting experiences to new key workers. Even when service users did not have specific appointments scheduled, they felt able to get in touch with their key worker, as summarised

by one service user: *“I know where the service is when I need it and can contact a number of staff when needed. I’ve never had an issue getting in touch with someone.”*

- Flexibility – a key theme in feedback was that appointments were flexible and at times that fit with people’s lives. This was particularly important in supporting people to feel as though their lives were not limited by or focused solely around being in treatment, enabling people to fit appointments around other commitments such as work. This was supported by having a GP-based model of care, with service users easily able to access and attend evening appointments at GP surgeries. Similarly, service users who had difficulties with both their physical and mental health described key workers being very understanding and flexible in response to this, offering telephone appointments where these were easier.
- Ensuring that the basic needs of service users were met through the provision of wraparound support such as access to housing and benefits. This was essential for helping to facilitate recovery.

Service users did report some negative aspects to services, summarised as follows:

- Daily supervised OST pick-ups were something that many service users described negatively, finding these inconvenient and making service users feel as though their reliance on OST dominated their daily lives and was difficult to find around full-time employment.
- Several service users spoke of their initial anxieties around attending face-to-face groups, preferring a one-to-one approach. Many of these individuals did, however, feel that their confidence around attending groups increased over time. A particular concern was raised about mixed groups, where users of different drugs and/or alcohol attended together, and where individuals were at different stages in their treatment and recovery, with service users potentially finding it difficult to establish common ground when there were such a variety of different outlooks and stages of addiction present.
- Challenges in accessing services were described in two key ways:
  - o Their accessibility, given the geography of South Gloucestershire and difficulties with public transport links. Groups, in particular, were often difficult to access for those living in particular areas. This was made more difficult still for those with physical and mental health conditions.
  - o A lack of awareness about the ability to self-refer until people were already in services, with people tending to think that they had to be referred by their GP. Similarly, UWE students described the need for more advertising of the service, with students unaware of the support that was available to them. Within the university environment specifically, more advertising to educate on drug-related harms and harm reduction were felt to be important, with concerns raised around the tendency for messages among students to focus on cocaine and cannabis only.

Key aspects of the service that were felt to be missing were:

- Mental health support for those accessing drug services. Service users described mental health support often being provided by the police and A&E staff in a crisis, rather than from trained mental health specialists. This was felt to be particularly important, given the situations that had led people to begin using drugs in the first place. Low-level mental health support for everyone in treatment was felt to be missing, in order to prevent isolated incidents of emotional distress from developing into a more significant mental health condition or crisis. Several service users mentioned a specific wish for counselling.
- Additional wellbeing support, outside of groups or one-to-one appointments.

**Now think about the services that you are getting now, with COVID-19 happening. What has your experience of services been like during this time – both positive and negative? What are the good things that have changed about the service that you would like us to keep doing when COVID-19 is over? Is there anything that you feel is missing?**

Service users were overwhelmingly positive about their experience of using services during COVID-19 and recognised how rapidly DHI had responded to a situation that was beyond their control. Key themes in relation to the positive aspect of drug services during COVID-19 were:

- The switch from face-to-face to telephone support has meant that appointments are more regular and accessible than they had been prior to COVID-19, with service users not needing to spend time and money to have appointments with their key worker. Many service users felt that the service was essentially the same as they had been receiving before in both intensity and thoroughness, but simply in a different format. Service users also felt able to access the service whenever they needed to talk to somebody, with the current situation actually making them feel more confident in being able to call their key worker for a brief “pep talk”, in a way that they may not have done previously.
- Online groups were newly introduced at the time of conducting the engagement and were helpful in enabling people to feel less isolated. For those who found face-to-face groups made them anxious, online groups were helpful and they felt more able to engage.
- Changes in OST prescriptions to weekly pick-ups were positively regarded by everyone using them. Service users reported that weekly pick-ups provided them with flexibility, enabling them to take their OST at their preferred time of day rather than having to fit daily pharmacy visits around work commitments. Importantly, many service users felt that this change allowed them to show people that they could be trusted with collecting their medication on a weekly, rather than daily, basis.
- Harm reduction support was seen as helpful, with needle exchange, naloxone kits and safe boxes all being delivered directly to service users at home.
- Wider support was particularly welcomed by service users, especially with accessing food parcels and specific wellbeing courses that are now being offered and easy to access.

However, it is important to note that people’s feelings about services during COVID-19 depended on their personal preference for face-to-face, rather than telephone contact. Negative aspects of services during the pandemic were solely focused on the lack of face-to-face support, with some people missing the personal aspects of face-to-face contact with others and finding telephone calls less helpful. Online groups were not beneficial for everybody, with some service users finding the flow of conversation more difficult and it therefore being harder to engage with the group. Others raised concerns about what would be done if somebody was visibly distressed in an online group, how that would be followed-up and whether having to see yourself on camera in a state of distress would potentially cause more harm to the individual.

Going forward, the strong consensus was for a combination of telephone and face-to-face appointments once COVID-19 is over. Many service users suggesting alternating the two, as well as having the option of online groups available to people.

## **What do you think could be done to prevent young people from having problems with drugs in later life?**

The vast majority of service users felt that education was essential in preventing young people from developing future problems with drug use, with current education not seen to be going far enough. Critically, almost every service user who mentioned the need for more education suggested that drugs education in schools should be delivered by service users in treatment and who have recovered, rather than from teachers or the police. Service users felt that the power of hearing lived experiences would be substantially more hard-hitting than simply providing facts and figures about drug use and would help combat the *“glorification of drugs”*. As one service user described, *“if someone would have shown me what life is like using heroin, I would have thought twice before using it.”*

Equally, service users also suggested the importance of education programmes recognising that many people do experiment with drugs at some point in their life. Perceived issues of morality around drug taking have increased stigma and can therefore create barriers to accessing support. As one service user described *“drug education at school was “if you take drugs your teeth will fall out, and then you’ll die” and I think that sort of messaging detracts young people from asking questions about using drugs, how to reduce risks and having honest conversations about it due to fear of shame, ridicule or punishment.”*

Service users also felt that providing mental health support at a younger age could have prevented them from developing significant problems with drug misuse. Some service users described experiencing multiple traumas at a young age and yet receiving no support in dealing with these.

Specific suggestions were made around the need for early intervention in university accommodation, including having support available on-site to discuss harm reduction and managing difficult emotions.

However, several service users felt that there was a limited amount that could be done to prevent young people from using drugs. This was particularly true for individuals who had grown up in families where drug use was normalised. The influence of peers was regarded as being particularly strong, with some service users saying that there is very little that would have stopped them from using drugs with their friends and that they did not want help and would not have willingly spoken to anybody about their drug use as a young person.

## **What are your aspirations for the future? Where do you want to get to and what support would you need from services to help you get there?**

When asked about their future aspirations, service users commonly expressed a desire for “normality”, which they felt could be achieved through the following:

- Becoming completely drug-free, including no longer needing to be maintained on OST. Many service users spoke of their desire to no longer be dependent on any substances and felt that freedom from addiction would help them to achieve both stability and happiness. Those service users who did not specifically aspire to be completely drug-free expressed the wish to be more in control of their own decision making around substance use. Many individuals wanted to reach a point where they did not feel as though their identity was defined by drug use.



- Building and restoring relationships with family members, and particularly being reunited with their children. Several service users with children wanted to be in a position where they could personally ensure that their children were well, safe and did not develop similar problems with drugs in the future.
- Access to stable, permanent accommodation, in an area of the service user's own choosing.
- Securing employment, and particularly in relation to being able to establish a career for themselves that they are interested in rather than just having a job that they had not chosen for the sake of needing income. Some service users were already qualified in specific careers that they wanted to return to, whereas others wanted to receive additional education and training as part of a pathway to employment.
- Using their own life experiences as a positive force for others, with several service users specifically wanting to explore the possibility of helping others in their position through becoming drug workers or peer support volunteers.
- Improved ability to cope with stress and other low-level mental health issues
- Increased independence through learning to drive and other experiences of travelling.

In order to achieve these aspirations, service users felt that the following support was needed from services:

- Continued guidance and support, recognising the risk of relapse being a constant fear for many service users.
- Improved links between different services, with service users expressing their wish not to have to access multiple different services or workers for each of their different issues. This was a particular concern in relation to the links between drug services and mental health services. Service users felt that working in silos failed to recognise that drug use was often the product of difficulties that an individual had with another specific issue. As one respondent described, *"if I could get support from one service or worker to address all these intertwined issues at once, I think I would be able to move forward a lot quicker."*
- Support with accessing housing, employment, education and providing any necessary referrals to support agencies (with it being important to note that service users felt that this support was already being provided but was necessary to continue).

During COVID-19, DHI have also been doing spot check calls to people using the service to find out how they are experiencing the changes since the crisis began. Again, overall comments have been very positive, with service users stating they are appreciating the increased telephone contact and relaxed prescribing regimes. There has also been some feedback about the groupwork programme being offered online, with many people finding they can engage better through this forum. Over half of those surveyed wanted to continue with online groups once the threat from COVID-19 had passed. However, it was raised that some service users do not have access to the right technology so are unable to engage and there were some issues with consistency throughout the groups provided online. This work has continued throughout the COVID-19 pandemic to ensure that views are captured from those using the service and that DHI can continue to learn lessons and use it to inform future practice.

In 2019, DHI conducted a service-wide survey across their areas of business to assess client satisfaction with the service received. In South Gloucestershire, the response was overwhelmingly positive with the main recommendations being around trying to ensure there were improved links and pathways with other services that support people into recovery. No protected characteristic information was gathered during this survey as it was designed to be a brief snapshot. It has been

requested that this is included in future. DHI are also completing their Equalities Impact Assessment, which will consider ways to better assess people's protected characteristics.

#### Actions to consider:

1. Using a combination of telephone and face-to-face appointments once COVID-19 is over, together with the option of online groups. However, face-to-face appointments should be reinstated as soon as it is safe to do so, particularly for those individuals who have limited access to technology.
2. Continue to capitalise on progress made in harm reduction support (through measures such as mobile needle exchange and naloxone kit provision) once COVID-19 restrictions are eased.
3. To ensure a return to supervised consumption for those service users who have had their regimes relaxed is based on a new assessment and not put in place unless it is seen as necessary due to risk.
4. Work with UWE to raise awareness of drug-related harms and services available to UWE students who need support with their drug use.
5. Improve mental health support for those accessing drug services. This includes building links between drug services and specialist mental health services, but also ensuring that low-level mental health support is available for everyone in treatment. Explore options for making counselling and additional wellbeing support available to those in drug services.
6. Work with schools to provide more education on drug-related harms, including the lived experiences of those in treatment and recovery.
7. Continue to emphasise the importance of wraparound support with housing, finances, employment and education to support service users to successfully complete treatment and reduce the risk of relapse.

#### Young People

We were unfortunately unable to conduct engagement with young people for this needs assessment as planned, due to the COVID-19 pandemic. YPDAS did attempt to complete questionnaires with young people by phone, but the vast majority of service users did not wish to engage with these questions by phone. However, some of the feedback received through engagement with young people for the alcohol needs assessment is also relevant to drugs, as outlined below.

#### **Feedback from engagement sessions with small groups of young people:**

#### **In what ways can drug and alcohol services reach lots of young people to give them information and help to keep them safe?**

- Social media was considered key – if young people saw adverts and had access to credible information, this could be impactful. Assemblies are ineffective as people skip them, lessons are better and young people feel starting harm minimisation work earlier, from years 6 and 7, would be better than starting when people are already using substances. Young people suggested a website with links – some had used Frank and gave positive reports, but many had not heard of Frank.
- Harm reduction information delivered across lessons by experts felt more appropriate than teachers delivering information – young people would rather approach an independent body than talk to a teacher, feeling that they may 'get into trouble' and that there is no confidentiality. Young people would like more and better education in school which is also

delivered to families. Young people said they would talk to a sibling or parents if they needed support.

- The information delivered in school and by some media assumes that young people are naïve to drugs and alcohol – they are not and this assumption can mean young people ‘turn off’ during sessions. Also a lack of local knowledge can affect the reception of information. Sessions and information delivered by peers would be more appealing than teachers and outside agencies who appear much older than the young people they are speaking with. More information is needed within schools.

**How do you think drug and alcohol services could help people to make changes? What would you want if you were the client?**

- Most responses asked for confidential meetings with a professional away from school, for appointments to be a mixture of talking and practical activities, for sessions to comprise information about drugs and their effects especially when used together/mixed with real case studies which are relevant. Young people also suggested that they would like access to regular therapy.
- Young people feel harm reduction is an important message.
- Young people felt that they did not have knowledgeable people to talk to – parents give advice, but they don’t know what they’re talking about. Adults were seen as giving bad advice, inaccurate information and having little experience of the social circumstances of their children or pupils.
- Some young people felt that they could challenge friends more easily than they could challenge a boyfriend/girlfriend, and it was easier to say no to friends.
- Some young people said that they and their friends would broadly have the same approach to drugs and alcohol and that they wouldn’t be with strangers or people out of their social group. They can rely on friends to look after them if they become unwell, most felt that they could tell parents or older siblings if they needed help.
- Several responses were for clients to be removed from their environment e.g. go to rehab.
- The views of some people who are in the care system were also gained at an event where the Programme Lead was present. There were recommendations made about YPDAS workers developing better relationships with social workers and for social workers to receive more training about drugs and alcohol as it was felt that they did not want to ask, or they asked at the first meeting and not again. Activities around drug and alcohol use were also mentioned as something that would be useful rather than just talking to someone about problems.

**Feedback from stakeholder engagement sessions conducted with 11 service users of the South Gloucestershire Young People’s Drug and Alcohol Service** facilitated in the spring/ summer 2019 is as described below:

In general, young people reported the referral into YPDAS being very easy. Several respondents reported being surprised at how fast the referral was, with their first meeting taking place within a few days of a referral being made or their conversation with a professional. However, some service users were nervous about the service or others finding out.

Despite this, feedback about meeting with their drug worker was very positive. Many young people reported feeling excited, ready and motivated to make change at the time of first meeting their drug worker. It was important to young people to feel as though they were being listened to, and several service users valued the fact that their drug worker was friendly and made them feel that they were not in trouble. Young people also felt that it was their choice to engage and work together.

Young people felt that their drug worker helped them to progress and work towards their goals, with many young people reporting that they had either stopped using drugs or cut down their use and felt more in control. People reported that their progress was not always linear but that they could see that they had made progress over the longer-term, and that the support from YPDAS helped them to better understand their drug use. Having a drug worker to talk to made a real difference to many young people, and the flexibility of workers in being able to see young people when they needed support was valued by service users.

When asked for suggestions for improvements, young people felt that taking a holistic approach was helpful. Young people spoke very highly of the service, with several young people suggesting that they would have liked to have met with their drug worker more regularly. It was suggested that it would be helpful for those transitioning to adult services if their worker could remain with them for a period while settling in to the new service. There was also a suggestion that more safety advice would be helpful, as well as the timing of appointments not clashing with other things such as revision sessions.

#### Actions to consider

1. A range of alternative activities for young people to decrease the attractions of alcohol or drugs.
2. How to make school-based drugs education more accurate, balanced, pupil-centred and based on their current knowledge, and to include awareness of the '*Frank*' website.
3. Drugs training for children's social workers including the need to ask about drug use during the care package/journey through the care system.
4. Stronger links between YPDAS and children's social services.
5. Explore options for improving transition between YPDAS and adult drug services.

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## Appendix 1: Needs Assessment Approach

### Needs assessment approach

The National Institute for Health and Clinical Excellence (NICE) define a health needs assessment as a “systematic method for reviewing the health needs of a particular population, leading to agreed priorities and resource allocation, which will lead to improved health and reduced health inequalities” (143).

Bradshaw’s taxonomy of social need (144), categorises needs as:

2. **Normative** – defined by a professional(s) as good practice
3. **Felt** – discovered by asking a population what they want. People can however be clouded by unrealistic desires, and/or prior knowledge of what is available, and/or reticence to admit a problem.
4. **Expressed** – felt needs translated into action such as accessing services. One measure of an unmet expressed need could be numbers on a waiting list.
5. **Comparative** – identified by comparing populations receiving a service with similar populations not in receipt.

Public Health Scotland (145) categorise needs assessments as:

1. **Epidemiological** – where data is used to estimate the size and demography of the population; incidence and prevalence of disease within it; the social determinants of health; and to review current provision and effectiveness of provided services.
2. **Comparative** – the population receiving services are compared with those receiving services in a different area or time or to a population with different characteristics.
3. **Corporate** – a qualitative method to elicit stakeholder views about current needs and priorities for future improvements.

## Appendix 2: Topic Guide for Key Informant Interviews

- Could you describe your work and how it relates to drug use and access to services and support in South Gloucestershire?

- What do you think the key issues are around drug use and access to services and support in South Gloucestershire?
- What do you think the current and potential future needs are around drug use and access to services and support in South Gloucestershire?
- What are the key questions that you would want answered from this needs assessment?
- What data do you have that would be relevant to this needs assessment?
- Are there any particular groups that you would recommend that we talk to as part of this needs assessment?
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## Appendix 3: Questionnaire for Professionals

South Gloucestershire Council is conducting a comprehensive needs assessment of drug use and how we can best support people who use drugs. This aims to assess the health, wellbeing and social effects of drug use in South Gloucestershire across the life course; to identify gaps in current service provision; and to make recommendations for change that meet the needs of people who use drugs and their families.

Understanding the experiences, views and needs of professionals and people who use our services is a critical part of the needs assessment. The current COVID-19 situation has changed how we provide drug services. We are keen to get your views on what is currently working well during COVID-19 and how this may influence how we work in the future. However, it is also important that we capture your opinions on what was working before and what we should be prioritising for the future as the information that you provide will help inform our wider commissioning intentions.

This survey should take no more than 10-15 minutes to complete. Thank you for taking the time to complete this survey.

### Your role

What is your role in relation to drugs?

### Current situation

During the COVID-19 situation, what are we currently doing well to tackle drug-related harm in South Gloucestershire?

Prior to COVID-19, what were we doing well to tackle drug-related harm in South Gloucestershire?

### Gaps

During the COVID-19 situation, what are the problems, gaps and challenges in tackling drug-related harm in South Gloucestershire?

Prior to COVID-19, what were the problems, gaps and challenges in tackling drug-related harm in South Gloucestershire?

### Recommendations

Do you have any recommendations for improving the lives of people who use drugs in South Gloucestershire?

### Going forward

Bearing in mind what you've told us, how do you think we should be prioritising the issues that you've mentioned in our drug strategy?

## Appendix 4: Engagement Guide for People Who Use Our Services

### **NOTE FOR STAFF HOLDING THESE DISCUSSIONS:**

The aim of this engagement is to have a conversation with service users about their experience of services and how these services can be improved. These questions do not need to be asked word-for-word or in any specific order. Service users do not need to answer any questions that they don't wish to or don't feel comfortable answering. Bullet point responses to each question are absolutely fine.

Thank you for your help in gathering feedback from the people you work with.

### ***Introduction***

South Gloucestershire Council is doing some work to understand drug use and how we can best support people who use drugs. We want to understand the experiences of people who use our services, what you need and how we can improve drug services in our area.

COVID-19 has changed how we provide drug services. We want to get your views on what is currently working well during COVID-19 and what you are missing about how we usually provide our services. However, it is also important that we hear your views about what was working before and what we should focus on in the future. The information that you give us will help us understand what our future drug services should look like.

All of the information that you give us will be kept anonymous and no identifiable information will be shared with South Gloucestershire Council.

Are you happy to answer these questions with me? You do not have to take part in this if you don't want to. Alternatively, someone from the Drug and Alcohol team at the Council can phone and complete the questions with you if you prefer?

We have also put together an online version of this survey. If there is anything else that you would like to add at a later stage, we can email you the link to this survey.

Thank you for taking the time to share your experiences with us.

### ***What is your drug(s) of choice?***

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### ***How long have you been getting support around your drug use?***

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### ***Is there anything that you would like to tell us about you and how drugs have affected your life?***

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***Think back to before COVID-19 started, at the start of March. How were things going for you then? What were your experiences of services like until that time - both positive and negative? Did you experience any challenges with accessing or using those services? Was there anything that you felt was missing?***

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***Now think about the services that you are getting now, with COVID-19 happening. What has your experience of services been like during this time – both positive and negative? What are the good things that have changed about the service that you would like us to keep doing when COVID-19 is over? Is there anything that you feel is missing?***

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***What do you think could be done to prevent young people from having problems with drugs in later life?***

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***What are your aspirations for the future? Where do you want to get to and what support would you need from services to help you get there?***

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