Joint Strategic Needs Assessment

Updated June 2023

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1. Introduction, Aims and Objectives

1.1 Background and Introduction

The cross-government 10-year drugs strategy: From Harm to Hope aims to cut crime and save lives by committing the whole of government and public services to work together and share responsibility for creating a safer, healthier, and more productive society[1].

Bristol City Council is responsible for commissioning drug and alcohol treatment and recovery services as part of their statutory public health responsibilities. However, in order to have a successful impact we need a system-wide approach to prevention, early intervention, as well as drug and alcohol treatment and recovery services with stakeholders from local authority, NHS, police, community and voluntary organisations, probation, prisons and many others.

1.2 Local Strategy

Bristol Drug and Alcohol Strategy 2021-2025 was developed, in partnership with stakeholders from across the city, including voluntary and community organisations, Avon and Somerset Police, University of Bristol and the University of the West of England, Bristol. It continues to be delivered in partnership, with oversight from members of the Keeping Communities Safe group (a delivery group of the Keeping Bristol Safe Partnership) and Bristol's Health and Wellbeing Board[2].

1.3 Aim and Scope of this Needs Assessment

The aims of this needs assessment are as follows:

- To meet the requirements of the Government's 10-year drugs plan by completing a joint needs assessment through our established Combatting Drugs Partnership in Bristol.
- To conduct an initial assessment of evidence and data to understand better the local issues and patterns of alcohol and other drug-related harm in Bristol.
- To identify how we can reduce alcohol and other drug related harm, supply, and related crime.
- To assess the needs of this population, identifying health inequalities, unmet need, and barriers to accessing services.
- To outline what best practice looks like, to explore how we can improve outcomes of the current service delivery model and impact, including service user feedback.

1.5 Objectives to meet the Aims of the Needs Assessment

- Analyse prevalence, patterns and trends of alcohol and other drug use, supply, harms, and related crime in Bristol.

- Present relevant local, national, and international policy, guidance and legislation related to alcohol and other drugs.
- Describe local service provision related to alcohol and other drug use, identify unmet needs, areas for improvement, and how prevention can be strengthened.

1.5 Who is at Risk and Why?

The health harms arising from drugs and alcohol, are diverse and need to be considered within the culture and context of their use among specific populations. That is, alcohol and drug-related harms do not only vary according to the different types of drug or drugs being used; alongside this, it is the way a drug is used for example by injection or smoking, the way it is used in combination with other substances, and the social context in which it is used that contribute to risk[3]. The motivation for drug taking is very wide ranging from recreational use to those compensating or self-medicating for past and present trauma.

There are many wider social determinants which are associated in heightened risk of drug or alcohol dependence. Social factors, particularly homelessness, unemployment, socioeconomic deprivation and Adverse Childhood Experiences (ACE'S), are associated with more harmful patterns of alcohol and other drug use and these social factors moderate drug treatment outcomes.

1.6 Terminology

Throughout this Needs Analysis we refer to specialist terms, as well as everyday terms used in sector-specific way. We have included a Table of Definitions as an appendix to explain what these terms mean.

1.7 Recommendations

Our needs analysis includes many recommendations which have emerged from our findings, including from external research and stakeholder feedback. The list below has direct links to where these can be found in this document by category.

Addressing Stigma
Alcohol Harms
Alcohol Policy
Children and Young People
Crime and Drug Markets
Criminal Justice System: Diversionary Recommendations
Criminal Justice System: In-Prison and After-Prison Recommendations
Criminal Justice System: Probation Recommendations
Drug and Alcohol Related Deaths
Drug Harms
Drug Policy
Local Demographics, Vulnerabilities and Other Risk Factors

2. Key Data Sources Analysed

The table below shows the key data sources we have analysed with a description of what each source tells us. Other evidence sources are shown as numbered footnotes which are detailed in the References section at the end of this document.

Title	Description
The Crime Survey for England and Wales	Includes estimates for the prevalence of drug use amongst the general population[4]. Recent research has demonstrated these surveys may significantly underestimate levels of drug use, potentially related to concerns of respondents in admitting illegal behaviours.
Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use	Taken from Liverpool John Moores University because people who use opiates and/or crack cocaine are less likely to respond to the Crime Survey for England and Wales, the size of this population is estimated by studying their interactions with different services.
The Bristol Quality of Life (QoL) Survey	A survey posted to 33,000 households chosen at random across Bristol. It measures key indicators including markers of inequality and provides an annual snapshot on what life is like for people living in the city. The results of the 2021 survey include 180 indicators, on topics including health, lifestyles, community, and living in Bristol. The results are used to help plan local services, track change and improve the quality of life in Bristol.
Numbers of drug-related deaths	Data gathered from the Office for National Statistics in England and Wales, National Records of Scotland in Scotland, and the Northern Ireland Statistics and Research Agency in Northern Ireland.
The Unlinked Anonymous Monitoring Survey of HIV and Hepatitis among People who Inject Drugs	Monitors the prevalence of HIV, hepatitis, and risk factors for drug-related harm amongst people who use drugs in contact with specialist services.
The National Drug Treatment Monitoring System (NDTMS)	Monitors the number of people in structured drug treatment and their outcomes.
Hospital Episodes Statistics	Sourced via NHS Digital and Index of Multiple Deprivation via Ministry of Housing, Communities and Local Government. It is a data warehouse containing details of all admissions, outpatient appointments and A and E attendances at NHS hospitals in England.
The Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care System-System (ICS) Wide Dataset Dashboard for Alcohol and other Drugs.	The BNSSG Integrated Care Board Population Health Management Team undertook a population health analysis focused on people experiencing issues with alcohol and drugs. The purpose was to identify opportunities to prevent harm and reduce preventable deaths. See Appendix A for further detail on the data sources used for the System Wide Dataset.
Theseus	Caseload management and referral system used by Bristol City Council. The Theseus system records all clients assessed for substance use services in Bristol. Detailed information is collected about a) substances used; b) housing need at referral and c) need for and engagement with mental health services.
'Health harms of Drugs'	The Department of Health document on provides a useful glossary of terms used in this document.
Smoking, Drinking and Drug Use among Young People in England, 2021 - GOV.UK (www.gov.uk)	The survey report presents information on the percentage of pupils who have ever smoked, tried alcohol, or taken drugs and on their regular use.

Every Child Matters in Bristol	The Bristol Pupil Voice survey for primary and secondary school pupils asks questions across a broad range of topics relating to health and wellbeing.
Qlik Sense	Avon and Somerset Constabulary crime recording database.
Problem Profile for Bristol Drugs Market 2020-2021	Avon and Somerset Constabulary commissioned report in 2020/21.
Public Health Outcomes Framework	Key indicators from some of these data sets are summarised by the Office for Health Improvement & Disparities.
Joint Strategic Needs Assessment	Each year, local data pertaining to drug use and related harm in Bristol is summarised in the relevant.
World Drug Report	On an annual basis the UN Office on Drugs and Crime publish an international drug report.
European Monitoring Centre for Drugs and Drug Addiction	Reports on drug use, harm and service provision in Europe
Global State of Harm Reduction	Harm Reduction International produce this report which outlines levels of support for and provision of harm reduction interventions in different countries.

3. Addressing Stigma

There is increasing recognition of the role of stigma in the description of alcohol and other drug-related harm. Stigma, whilst variously defined, refers broadly to discrimination and prejudice against certain groups of people, who are associated with negative stereotypes because of certain characteristics or behaviours they undertake[5]. Many people who use alcohol or other drugs face high levels of stigma, which can be internalised, impacting their mental health and wellbeing, sometimes leading to escalating drug use; perceived, as they are treated poorly by healthcare and other service providers; or importantly, anticipated, which can reduce willingness to access support in the future[6].

The UN Common Position on Drugs, and the UK Drugs Strategy highlight the need to challenge stigma to improve the treatment of people who use drugs[7,8].

Independent campaigns, including from the NHS Addictions Provider Alliance[9] the Scottish Drug Deaths Taskforce[10] have been instituted to tackle this issue, however, as previous President of Faculty of Public Health, Professor Maggie Rae, has highlighted, much more work is necessary[11].

The language and discourses used to describe alcohol and other drug use and the people who use them can serve to propagate stigma and negative stereotypes. In the writing of this health needs assessment, we have drawn on guidance from the International Network of People who Use Drugs (INPUD) and Scottish Drugs Forum[12,13] to avoid potentially stigmatising terms.

It is important, however, to note that opinions on appropriate language are evolving, as evidence of the impacts of different framings on public perception grows. Most people who use terms that others may find stigmatising probably do not mean to propagate stigma. And within communities of people who use drugs opinions differ on what language is more appropriate. Key points we have considered in the writing of this document include the following:

- Spectrums of alcohol and drug use – it is important to recognise that the significant proportion of the population who use drugs do so for different reasons, in different settings and in different ways. Implying commonalities between people who use drugs risks propagating stereotypes, which, when negative, can lead to prejudice and discriminatory behaviours.

- Spectrums of recovery – we understand the term ‘recovery’ to mean different things to different people, and not necessarily complete abstinence from alcohol or other drugs if this is not desirable for an individual.

- Person first language – referring to a ‘person who uses drugs’, not defined by their drug use, as opposed to a ‘user’, ‘misuser’ or ‘abuser’.

- Amoral language – referring to ‘drug use’ or ‘substance use’, as opposed to ‘misuse’ or ‘abuse’. Some groups contend the latter terms imply moralistic judgements that may propagate stigma, and that they are inaccurate, given most illegal drugs are used as intended.

- Language of dependence – referring to ‘drug dependence’ as opposed to ‘addiction’ or ‘substance use disorder’. Whilst the latter terms are widely used, particularly in the medical community, INPUD suggest historical discourses, and the disease model of addiction, can be disempowering and stigmatising. Whilst not criticising others who might use this term, particularly communities with lived experience, in this health needs assessment we have used the term ‘dependence’ in line with INPUD guidance.

The media may perpetuate negative stereotypes about people who use drugs (and could play a key role in reducing them). The Scottish Families Affected by Alcohol & Drugs have recently published a toolkit, aiming to encourage responsible reporting, which may be of use to press partners[14].

3.1 Recommendations

- Reduce stigma faced by people who use alcohol or drugs through trauma-informed approaches to treatment and recovery services.
- Address the stigma-related barriers that people face when accessing drug and alcohol services access to services.
- Tackle inequalities and stigma by anchoring support within our communities which is responsive to the local population need
- Prioritise prevention interventions which utilise place-based approaches.

> *"A hurt is at the centre of all addictive behaviours. . . . The wound may not be as deep and the ache not as excruciating, and it may even be entirely hidden—but it’s there. As we’ll see, the effects of early stress or adverse experiences directly shape both the psychology and the neurobiology of addiction in the brain"*
>
> *Gabor Mate*

4. Alcohol - Policy and Strategy Background

4.1 Introduction

Alcohol is fundamental part of many cultures. Alcohol is extremely accessible and drinking it is as socially acceptable as drinking tea or water. Alcohol is everywhere you look it's positioned in the aisles of supermarkets to encourage impulse purchases, it's in advertisement, television, and radio broadcasts. People enjoy drinking alcohol for several reasons such as its symbolic meaning (wedding, bereavement, achievement), its taste, and the sense of belonging when drinking with friends and family as well as the physical effects.

Most people do not think of alcohol as a drug and although it is arguably one of the most harmful drugs in use, its consumption by adults is accepted and encouraged.

There is increasing awareness of the adverse health, social and economic impacts of alcohol consumption which is causing concern among health professionals and policy makers. With this, comes improved understanding of the changes in patterns of drinking and behaviour in the UK.

4.2 What is Problem Drinking?

The National Institute for Clinical Excellence (NICE) defines problem alcohol use as that which exceeds the low risk drinking guidelines set out by the Chief Medical Officer[15]. A unit of alcohol is defined as 10ml (8 grams) of pure ethanol and is roughly equivalent to half a pint of lower strength beer or cider (3.6% ABV), a small pub measure of spirit (25ml, 40% ABV)[16].

4.2.1 Low Risk Drinking

The Chief Medical Officer low risk drinking guidelines set out in 2016, are as follows:
In order to keep health risks from alcohol to a low level, it is safest for both men and women not to drink more than 14 units of alcohol a week, on a regular basis[17].

People who drink more than 14 units of alcohol a week, on a regular basis, are at greater risk of developing a wide range of health problems including cancers of the mouth, throat and breast. People who drink as much as the 14 units of alcohol a week should aim to consume the units evenly over 3 days or more. Avoiding alcohol during pregnancy is the safest approach.

4.2.2 Hazardous Drinking

This refers to the patterns of drinking that puts a person at increased risk of harm from alcohol. The harm related to hazardous drinking is different for men and women as follows:
For women, drinking more than 14 units of alcohol a week, but less than 35 units a week, is considered to put women at greater risk of harm.

For men, drinking more than 14 units of alcohol a week, but less than 50 units a week for men, is considered to put men at greater risk of harm[18].

4.2.3 Alcohol-use Disorder (AUD)

This term encompasses both *Harmful (Higher Risk) Drinking* and *Alcohol Dependence*.

Harmful (Higher Risk) Drinking

This term describes a pattern of alcohol consumption that causes health problems directly related to alcohol e.g., psychological problems (such as depression), alcohol-related incidents, or physical illness (such as acute pancreatitis). In the longer term, a person drinking at this harmful level, may also go on to develop high blood pressure, cirrhosis, heart disease and cancers (such as mouth, liver, bowel or breast cancer)[19].

Alcohol Dependence

Alcohol dependence is defined as being a craving, tolerance, preoccupation with alcohol, and continued drinking in spite of the harmful consequences e.g., liver disease or depression caused by harmful drinking.

AUD is categorised into mild (2 to 3 symptoms), moderate (4 to 5 symptoms) or severe (6 or more symptoms) depending on the number of symptoms the person experiences in a 12-month period:

Problematic Symptoms Relating to Alcohol Use :
Alcohol is often taken in larger amounts or over a longer period than was intended.
There is a persistent desire, or unsuccessful efforts, to cut down or control alcohol use.
A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
Craving, or a strong desire or urge to use alcohol.
Recurrent alcohol use resulting in a failure to fulfil major role obligations at work, school, or home.
Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
Recurrent alcohol use in situations in which it is physically hazardous.
Alcohol use is continued, despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.

Tolerance, as defined by either of the following: • A need for markedly increased amounts of alcohol to achieve intoxication or the desired effect. • A markedly diminished effect with continued use of the same amount of alcohol.
Withdrawal, as manifested by either of the following: • The characteristic withdrawal syndrome for alcohol. • Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

NICE Guidelines, 2022 [20]

4.3 National Strategy

4.3.1 The Government Alcohol Strategy (2012)

The most recent Government strategy was published in 2012 by the Conservative and Liberal Democrat coalition government. It aims to take firm and fast action where immediate and universal change is needed' by:

- Ending the promotion and availability of cheap alcohol and introducing a minimum unit price for alcohol. However, to date only Scotland and Wales have introduced Minimum Unit Pricing for Alcohol while England and Northern Ireland have not made any plans to introduce this.
- Ensuring that local areas are able to tackle local problems, reduce alcohol-fueled violent crime on our streets, and tackle health inequalities through new extensive Police and Local Authority licensing powers.
- Securing industry's support in changing individual drinking behaviour by building on 'The Responsibility Deal' to drive greater industry responsibility and action to prevent harmful alcohol use.
- Supporting individuals to make informed choices about healthier and responsible drinking, so it is no longer considered acceptable to drink excessively by reviewing the alcohol guidelines for adults and detailed support system for those that require particular help in changing their behaviour[21]

> *'Binge drinking isn't some fringe issue; it accounts for half of all alcohol consumed in this country. The crime and violence it causes drains resources in our hospitals, generates mayhem on our streets and spreads fear in our communities.*
>
> *When beer is cheaper than water, it's just too easy for people to get drunk on cheap alcohol at home before they even set foot in the pub.'*
>
> *The Rt Hon David Cameron, MP, Prime Minister, 2012* [22]

4.4 Legislation

4.4.1 Purchasing and Consuming Alcohol

You can be stopped, fined or arrested by police if you're under 18 and drinking alcohol in public.

If you're under 18, it's against the law:

- for someone to sell you alcohol
- to buy or try to buy alcohol
- for an adult to buy or try to buy alcohol for you
- to drink alcohol in licensed premises (such as a pub or restaurant)

However, if you're 16 or 17 and accompanied by an adult, you can drink (but not buy) beer, wine or cider with a meal.

If you're 16 or under, you may be able to go to a pub (or premises primarily used to sell alcohol) if you're accompanied by an adult. However, this isn't always the case. It can also depend on the specific conditions for that premises.

It's illegal to give alcohol to children under 5.

4.4.2 Marketing

Marketing is the promotion and selling of products or services. It is normally made up of product, price, where it is sold and promotion. Alcohol marketing is through advertisements as well as product placement in TV shows, placement within supermarkets, social media and the packaging itself.

In the UK there is a co- and self-regulatory system where alcohol companies have a degree of control over how the industry is regulated. There are three main regulatory organisations:

- Advertising Standards Authority which oversees alcohol advertising (funded by advertising industry)
- Ofcom which oversees sponsorship of TV
- Portman Group, which oversees alcohol packaging and labelling (funded by the alcohol industry)

Minimum unit pricing has been in place in Scotland since 2018 and Wales since March 2020. There are no plans to introduce minimum unit price in England.

4.4.3 Licensing

The Licensing Act, 2003 replaced earlier controls of alcohol and introduced a more permissive and flexible regime. The act establishes a single integrated licensing scheme for

businesses, organisations and individuals who want to sell or supply alcohol in England and Wales. They must have a licence and pay the appropriate fee or other authorisation from a licensing authority - usually a local council. The law and policy governing this area is overseen by the Home Office[23].

4.4.4 Other legislation

Other pieces of legislation that apply to alcohol or drugs include:

- The Road Traffic Act 1988, which includes penalties for driving under the influence of alcohol or drugs.
- The Transport and Works Act 1992, under which it is a criminal offence for employees to be under the influence of alcohol or drugs whilst working on transport systems
- The Health and Safety at Work Act 1974, under which employers could be liable to charges if knowingly allowing employees to work under the influence of drugs, if leading to safety risks.

4.5 Licensed Premises in Bristol

There are approximately 2,125 licensed premises in Bristol which include, breweries, cafes, casinos, church halls, corner shops, takeaways, hotels, supermarkets, nightclubs, off licenses and many others.

4.6 Recommendations

1. Use planning and design to create public places and spaces which support healthy behaviours and reduce harms.

2. Reduce the appeal, affordability and availability of alcohol within communities in Bristol and detect health impacts from these behaviours earlier.

3. Support the re-invigoration and re-design of the night-time economy, and other social events such as festivals, through consideration of alcohol-free spaces and other public health principles.

5. Drugs- Policy and Strategy Background

5.1 International Drug Policy

The cultivation, use and trade of alcohol and other psychoactive drugs has a long history and the prohibition of drugs through legislation has been used in many contexts to prevent the use of some psychoactive substances outside of a clinical care.

The use of some substances came to be seen as less acceptable whereas markets for others – including alcohol, tobacco, and coffee - rapidly expanded. Commentators have suggested this was primarily related to the social status of the groups associated with

different types of drug use, and which drugs were more profitable for powerful individuals (ibid).

In 20th century, the United States led the prohibition movement with the War on Drugs. International controls on the production, trade and use of some psychoactive substances were strengthened through United Nations Drug Control Conventions, which continue to underpin contemporary domestic drug policies internationally:

- The Single Convention on Narcotic Drugs of 1961, as amended by the 1972 Protocol[24]
- The Convention on Psychotropic Substances of 1971[25]
- The Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988[26]

The Conventions placed drugs in different schedules, intended to reflect their harmfulness and addictiveness, balanced against their utility as medicines.

Following the introduction of the Conventions, many countries pursued punitive policies and criminal sanctions for the possession or use of drugs for non-medical and non-scientific purposes. Commentators, however, including the Lancet Commission on Public Health and International Drug Policy, have argued that punitive drug policies often exacerbate levels of harm and are incompatible with human rights norms[27].

In recognition of these issues, many countries have pursued alternative legislative approaches utilising the flexibility of the UN Conventions or prioritising other commitments to promote human rights and public health. In Portugal, for example, the possession of drugs for personal use was decriminalised in 2001[28]. In the USA, some states have decriminalised the possession of drugs and/or regulated cannabis markets; and at a federal level, people who were incarcerated for cannabis possession have been pardoned[29].

In the UK, since the 1st of November 2018, it has been legal for doctors on the General Medical Council's specialist register to prescribe cannabis-based products for medicinal use, where clinically appropriate and in the best interests of patients[30].

Regardless of the domestic legality of drug use and possession, many countries to some degree endorse approaches characterised as 'harm reduction'[31]. These include "policies, programmes and practices that aim to minimise the negative health, social and legal impacts associated with drug use, drug policies and drug laws"[32], without requiring drug use cessation (recognising that this isn't always feasible or desirable for the person who uses drugs). Harm reduction approaches gained traction in Europe in the latter 20th century, largely in response to the HIV crisis[33].

5.2 National Drug Legislation

There are two main pieces of legislation pertaining to drug use in the UK: the Misuse of Drugs Act 1971 and the Psychoactive Substances Act 2016. Other pieces of relevant legislation include:

- The Medicines Act 1968, which controls the supply of medicines for humans and animals. Under this act, possession of a prescription only drug is not an offence, unless the drug is also controlled under the Misuse of Drugs Act 1971.
- The Customs and Excise Management Act 1979, pertaining to the import and export of controlled drugs.
- The Drug Trafficking Act 1994, pertaining to selling articles for the preparation of controlled drugs, and punishments for drug trafficking.
- The Crime and Disorder Act 1998, which introduced drug treatment and testing orders for people who were deemed to have committed crimes to maintain their drug use.

5.2.1 Misuse of Drugs Act 1971

The Misuse of Drugs Act 1971 was introduced to prevent the non-medical use of certain drugs. It designates the drugs considered under its auspices to one of three classes: A, B and C, which broadly reflect the schedules of the UN drug conventions[34]. The classes are intended to reflect the risks of using the different substances, and the severity of punishments to be applied for possessing, producing, or supplying them. Some bodies, including the Royal Society of Public Health, have criticised these classes, suggesting that they do not accurately represent the levels of harm caused by different drugs[35].

Since the Misuse of Drugs Act was introduced, more than three million criminal records have been generated for drug offences[36].

- Class A - includes heroin, cocaine, ecstasy (MDMA) and LSD – with penalties of up to seven years in prison for possession and life imprisonment for supply and production.
- Class B - includes amphetamines, cannabis, and ketamine – with penalties of up to five years in prison for possession and 14 for supply and production.
- Class C - includes gamma hydroxybutyrate (GHB) and non-prescribed benzodiazepines – with penalties of up to two years in prison for possession and 14 for supply and production. Anabolic steroids are included in Class C, however only their supply, and not their possession is criminalised[37].

Under the Misuse of Drugs Act 1971, the Advisory Council on the Misuse of Drugs (ACMD) was established - a statutory body with the mandate to review issues related to drug use and harm in the UK.

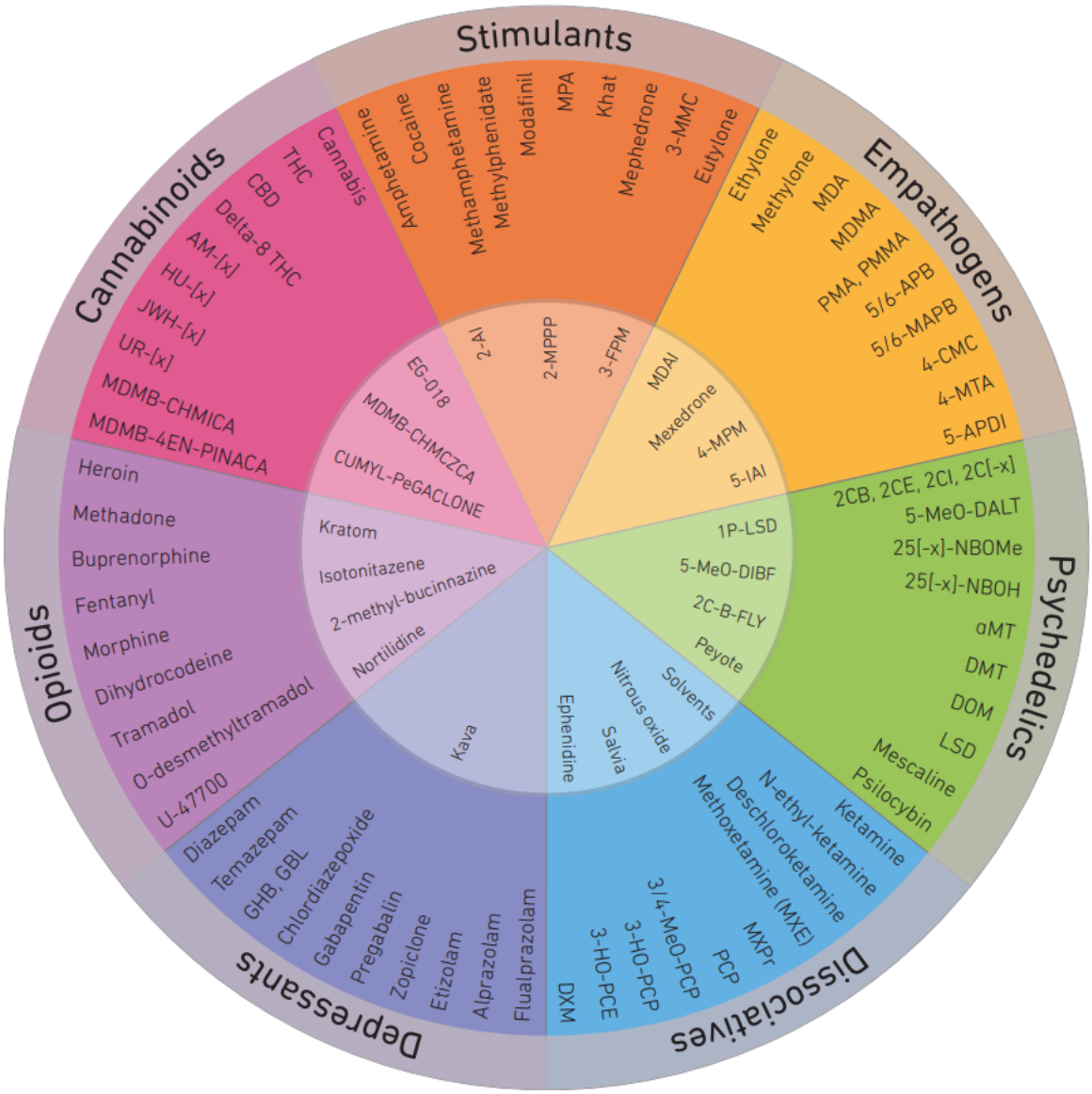
5.2.2 Psychoactive Substances Act 2016

The proliferation of so called ‘new’ or ‘novel’ psychoactive substances (NPS) in recent decades[38] led to the drafting of new legislation to control their production and sale in the UK

– the Psychoactive Substances Act 2016. Under this act, criminal charges can be applied for producing or supplying any substance deemed to be ‘psychoactive’, exempting food, alcohol, nicotine, caffeine, poppers, medicine, and drugs controlled under the Misuse of Drugs Act 1971. Possession of these substances, however, does not attract punishment, unless the individual is in prison[39].

Whilst some of the drugs controlled under the Act are ‘new’ synthetic drugs, it also covers some drugs that have been in longstanding use, such as nitrous oxide (laughing gas) and peyote – a natural psychedelic (Figure 1). The Act has been criticised by some academics for its broad scope, difficulties defining ‘psychoactive’, and a lack of attention to the relative risks of different drugs controlled under its auspices[40]. The Home Office Review of the Act in 2018 was favourable, pointing to reduced use of NPS, and seemingly reduced levels of NPS-related harm[41]. Subsequent to the Act’s introduction, however, yearly NPS-related deaths have more than doubled, from 123 in 2016, to 258 in 2021[42], concentrated amongst groups experiencing higher levels of socioeconomic deprivation[43].

Figure 1. Mark Adley's 'Drugs Wheel', highlighting the legislation under which different drugs are controlled[44].



5.4 UK Drug Strategies

Historically, the UK was a staunch advocate of what would later be referred to as harm reduction. In the 1920s, the staple treatment for opioid dependence in the UK was the prescription of diamorphine (a strong injectable opioid painkiller) – referred to as the 'British System'[45]. A global move towards prohibition following the institution of the UN drug conventions led to the UK amending legislation in the 1960s to require doctors to have specific licenses to prescribe diamorphine for this purpose[46]. Although now uncommon, a small number of individuals in the UK still receive take home injectable diamorphine in line with national guidance[47]. In the 1980s, the UK again became a global leader in harm reduction in response to the emerging HIV epidemic, after a seminal report from the ACMD highlighted the need for needle and syringe programmes to prevent the spread of the virus[48].

Subsequently, the focus of drug strategies has varied in their relative attention to harm reduction, public health, abstinence and criminality[49]. In the 2000s, 'recovery' became a focus in strategy documents, which was initially equated with abstinence. This was a source of contention for harm reduction advocates who highlighted the benefits of substitution therapies for people with drug dependence (ibid). The UK Government appointed Recovery Champion has argued that recovery should be understood as having control over levels of substance use – without stating this necessarily requires abstinence - in tandem with improved physical and mental health[50]. The same report highlights the importance of providing a range of interventions, which would include harm reduction interventions for people who continue to use drugs (ibid).

5.4.1 The Dame Carol Black Review

In the context of a significant rise in drug related deaths over the previous decade[51,52,53] , in 2019, Professor Dame Carol Black was appointed by the Government to lead an independent review of drugs in the UK. Part One of the review examined the illicit drug trade in the UK.

An estimated three million people had used drugs in the previous year; the drug market was estimated to be worth £9.4 billion annually; and the report highlighted concerning trends in the levels of violence and exploitation associated with drug trafficking[54].

Part Two examined existing drug treatment and prevention systems. Notably, it highlighted the impact of significant disinvestment in treatment services over the previous decade, leading to disparate and insufficient provision, with a need for increased funding and greater cross-agency coordination[55].

5.4.2 The 2021 Drugs Strategy – From Harm to Hope

In response to the Black Review, in 2021, the Government published the 10-year Drugs Strategy – *From Harm to Hope*[56], which is structured around three pillars:

- ‘Breaking drug supply chains’ – intending to tackle international and domestic illicit drug markets, with a particular focus on ‘county lines’ dealing, when drugs are trafficked across county borders, orchestrated with a mobile phone ‘line’.
- ‘Delivering a world-class treatment and recovery system’ – including a significant increase in funding for drug treatment services, an intention to boost recruitment of drugs workers, and to improve employment and housing opportunities for those in treatment.
- ‘Achieving a generational shift in the demand for drugs’ – with the intention of applying ‘tougher and more meaningful’ consequences to deter drug use.

With these measures, the Strategy aspires to reverse the upward trend in drug-related deaths by 2024-25 and reduce levels of drug-related criminality. The drug treatment community has welcomed the elements of the Strategy aiming to improve drug treatment and strengthen our prevention approach to alcohol and drug use particularly for children and young people and other measures intended to improve the health and wellbeing of people who use drugs[57].

5.4.3 Drug diversion and the Swift Certain Tough White Paper

The 2021 Strategy endorsed drug diversion schemes, which aim to divert people caught in the possession of drugs from the criminal justice system to receive alternative interventions, including education, support, and treatment[58]. These schemes have been implemented in at least 13 police forces in England and Wales[59].

Since the Strategy’s publication, the *Swift Certain Tough* white paper was published, which outlined the Government’s vision for escalating sanctions for the possession of drugs[60].

These proposals include some diversionary approaches, including referring those caught in the possession of drugs for drugs awareness courses. They also, however, include new punishments for drug possession, including passport and driving license confiscations, alongside criminal sanctions.

Feedback on the consultation is currently under consideration by the Government, including by the Faculty of Public Health and Association of Directors of Public Health, who have advocated for non-punitive responses to drug use[61].

5.5 UK Guidelines

The latest national guidelines on the clinical management of drug dependence were published in 2017 – a document commonly referred to in the field as ‘the Orange Book’[62].

5.6 Recommendations

1. Reduce the appeal, affordability, and availability of illicit drugs within communities in Bristol and detect health impacts from these behaviours earlier.

6. Prevalence of Alcohol Use, Unmet Need and Related Health and Social Harms

6.1 Alcohol Issues at a National Level

Harmful drinking is one of the biggest risk factors for death, ill-health and impairments among 15–49-year-olds in the UK, and the fifth biggest risk factor across all ages. Each year there are over a million admissions to hospital for alcohol-related conditions across England and Wales[63]. The health, social and economic consequences of alcohol use in the UK are estimated at between £21 and £52 billion a year.

Europe has the highest per capita consumption of alcohol of all regions globally, and the highest level of alcohol-related harms. Harmful use of alcohol contributes not only to the burden of non-communicable diseases (NCDs), but also to the burden of communicable diseases, as well as violence and injuries.

6.2 Alcohol Prevalence at a Bristol Level

There are an estimated 7,164 dependent drinkers over the age of 18 living in Bristol according to NDTMS data[64]. Estimate numbers (prevalence) of alcohol users, later than 2018/19 are not yet available but we expect that these rates have continued to increase according to NDTMS modelling.

In the Bristol Quality of Life survey for 2022, it was reported that overall 15% of residents live in a house where someone was at higher risk of alcohol-related health problems. This rate is higher in the 10% most deprived areas of the city where 17% of residents reported living with someone at higher risk. This was an increase of 4% since the QoL survey for 2020/2021[65].

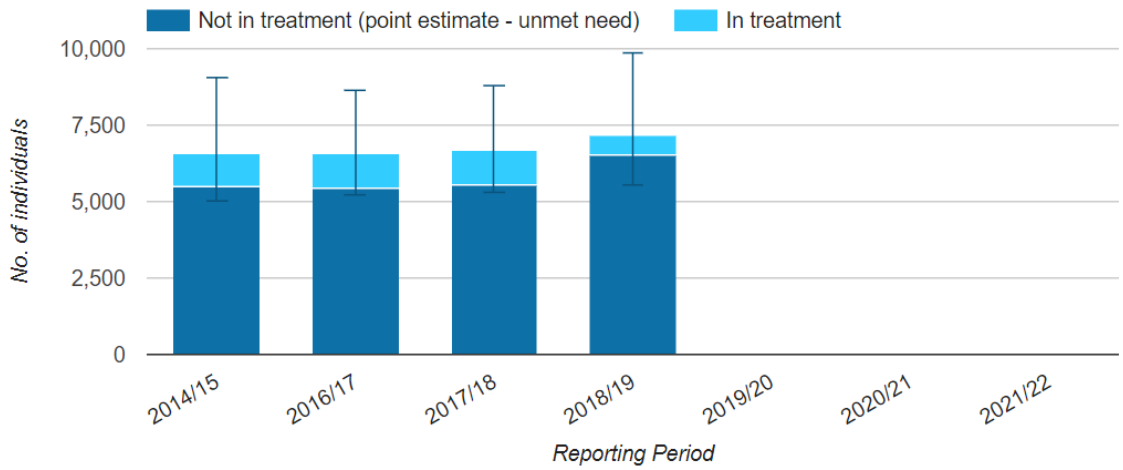
The table below shows there are also significant differences in the extent to which people in Bristol consider themselves to be at higher risk of alcohol related health problems, depending on their protected and other relevant characteristics:

Indicator	% at a higher risk of alcohol related health problems
Bristol Average	15.8
Most Deprived 10%	9.2
16 to 24 years	15.8
50 years and older	14.6
65 years and older	11.1
Disabled	11.1
Black, Asian and minoritised ethnic	9.4
Asian/Asian British	5.6
Black/Black British	7.8
Mixed/Multiple ethnic groups	15.9

Indicator	% at a higher risk of alcohol related health problems
White	16.6
White British	17.0
White Minority Ethnic	13.9
Female	11.1
Male	20.5
Christian	12.3
Other religion	10.0
No religion or faith	18.3
LGB+	20.6
No qualifications	10.8
Degree qualification	15.9
Non degree qualifications	16.9
Full-time Carers	9.0
Part-time carer	17.4
All Carers	15.0
Owner Occupier	15.8
Rented from housing association	12.3
Rented from private landlord	17.4
Rented from the council	12.5
Single parent household	18.2
Two parent household	14.5
All Parents	15.0

Quality of Life Survey 2022

Figure 2. Prevalence of Dependent Alcohol Drinkers in Bristol



Prevalence	2014/15	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Prevalence (point estimate)	6572	6592	6677	7164	-	-	-
Upper bound (prevalence)	9055	8638	8792	9862	-	-	-
Lower bound (prevalence)	5019	5220	5302	5544	-	-	-

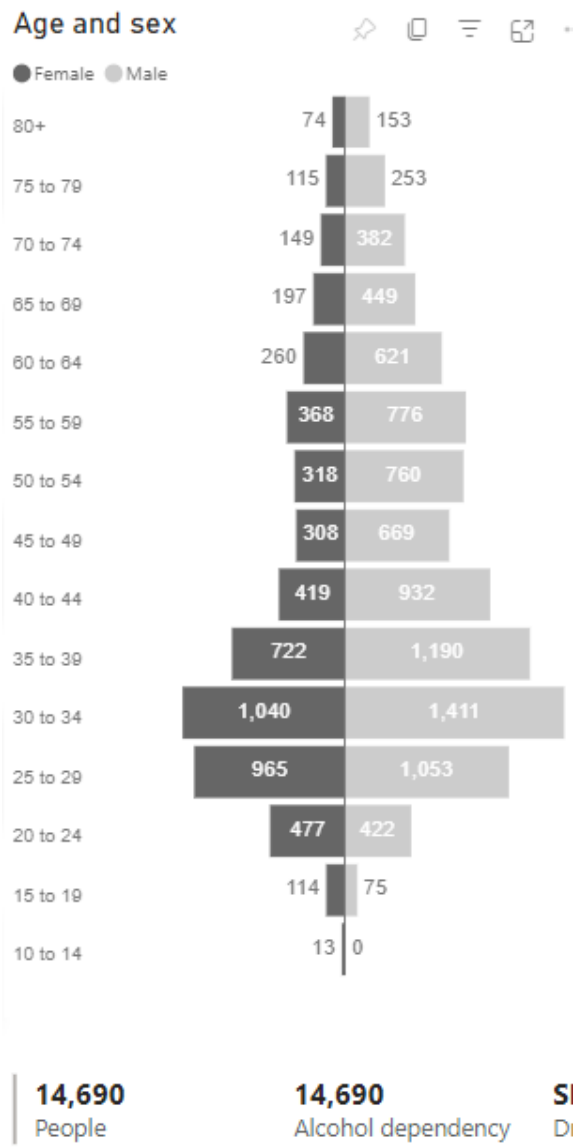
6.3 Population Health Management and Alcohol Dependence

Population Health Management is about working together to understand and improve the health of people and communities using joined-up health and social care records.

The new system wide dataset created by the Business Intelligence Team within the BNSSG ICB links data from primary care, hospitals, mental health services, community services and maps it with other sources of information, such as the Index of Multiple Deprivation. Linked data can help us to build a holistic picture of the circumstances of ill health for the 'whole person', rather than focusing on individual conditions. This informs opportunities to improve the health of the population we serve.

The BNSSG System Wide Dataset shows a much higher number of people with identified alcohol dependency in Bristol, 14,690 compared to 7,164 estimated in NDTMS. Figure 3. shows the spread of dependent drinkers in Bristol, according to age and sex. The data shows that greatest number of dependent drinkers are aged between 24-45 and more male dependent drinkers than females in all categories except 15–19-year-olds.

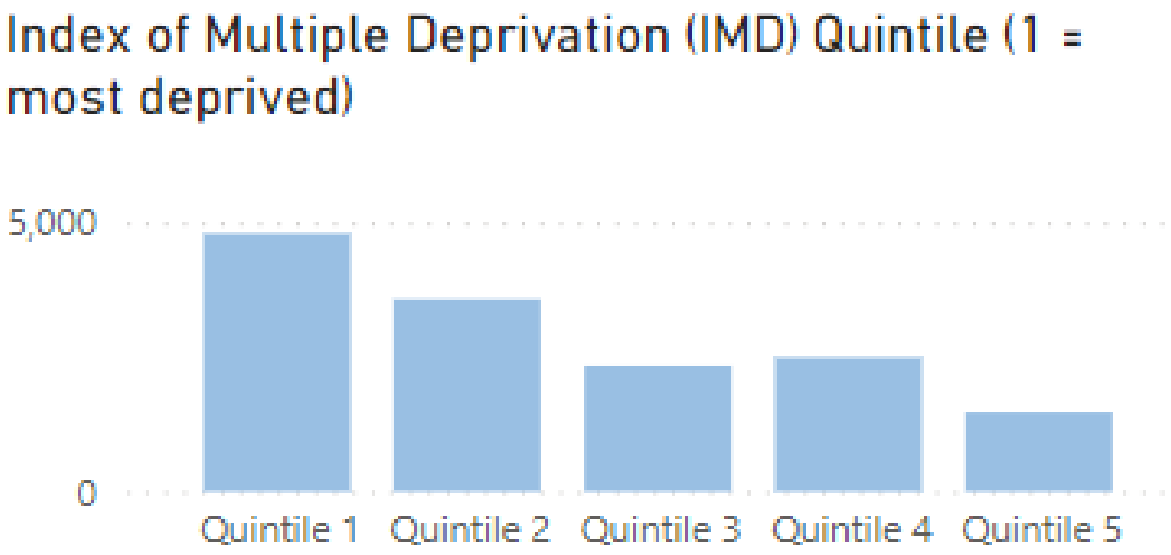
Figure 3. Spread of Dependent Drinkers in Bristol according to Age and Sex.



We can also see that deprivation has an influence on the number of dependent drinkers in our city with the greatest number of dependent drinkers living in our most deprived wards with number of dependent drinkers reducing as the deprivation index increases, as shown in Figure 4. below. The alcohol-harm paradox, the observation that people of low socioeconomic status tend to experience greater alcohol-related harm than those of high socioeconomic status, even when the amount of alcohol consumption is the same or less

than for individuals of high socioeconomic status continues to present a public health problem[66].

Figure 4. Number of Dependent Drinkers according to Index of Multiple Deprivation.

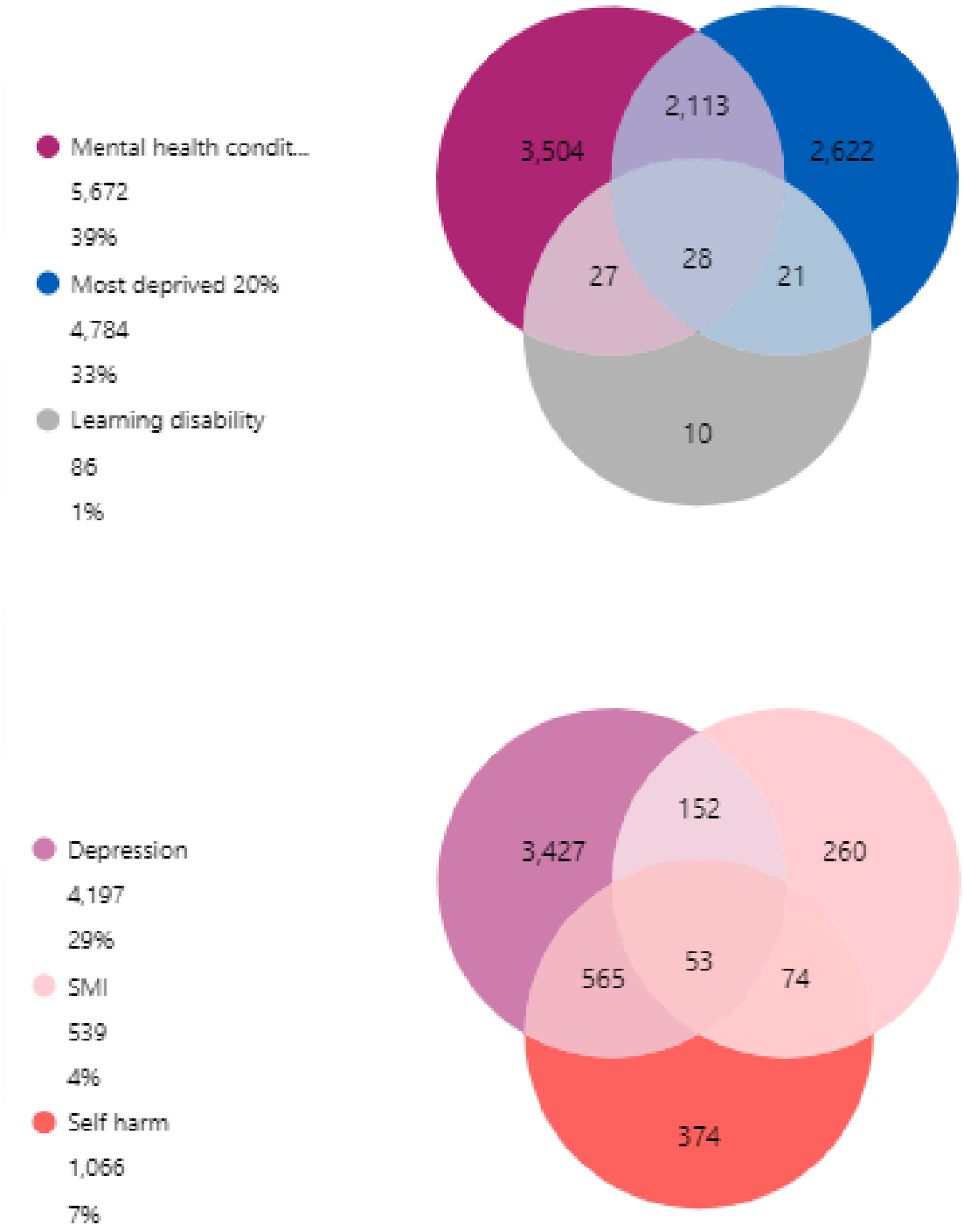


6.4 Alcohol Dependence and Multiple Disadvantage

The system wide dataset is a very valuable tool in illustrating the number of alcohol dependent drinkers recorded in the City and those experiencing multiple disadvantage which includes combinations of homelessness, substance use, mental health issues, domestic abuse and contact with the criminal justice system[67].

Figure 5. below shows the multiple disadvantages experienced by dependent drinkers in Bristol. Most significant is those experience mental health conditions (39%) and living in the most deprived areas of the City (20%).

Figure 5. Multiple Disadvantage experienced by Dependent Drinkers in Bristol

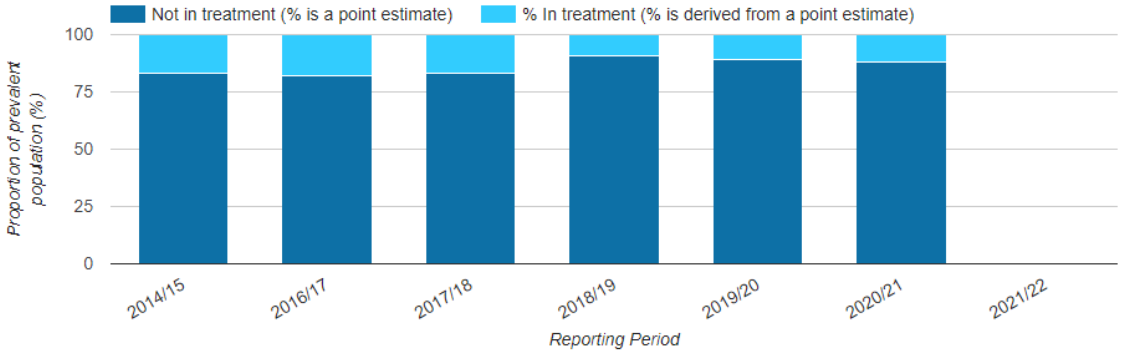


6.5 Rate of Unmet Need in Treatment

The prevalence estimate from NDTMS gives an indication of the number of adults in England and each local area that are in need of specialist alcohol treatment and the rate of unmet need gives the proportion of those not currently in treatment.

The number of clients in specialist alcohol treatment slowly reduced between 2014/15 and 2018/19. Since 2018/19, we anticipate that we are seeing a small increase in people accessing specialist alcohol treatment. However, it is important to note that the rate of unmet need figures have been estimated using the 2018/19 alcohol prevalence estimates. Our unmet need remains high at 88% for 2020/21 and is higher than the national average of 82%. In comparison to other Core Cities, the rate of unmet need in Liverpool is 88%, Newcastle is 83%, Birmingham is 85% and Leeds is 75%. In addition to this, according to NDTMS data, treatment waiting times in Bristol 41.9% waiting longer than 3 weeks for alcohol treatment in Bristol compared to 2% nationally[68].

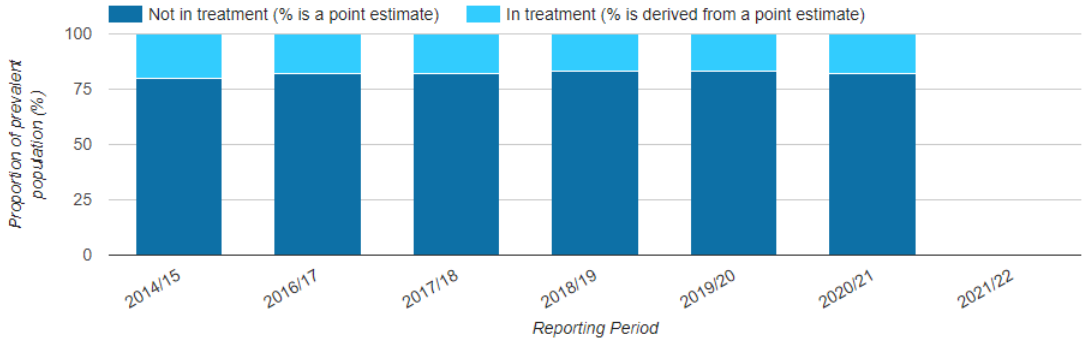
Figure 6. Unmet need for Alcohol Users in specialist alcohol treatment in Bristol



Unmet need	2014/15 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)	2020/21 (%)	2021/22 (%)
Not in treatment (% is a point estimate)	83	82	83	91	89	88	-
% In treatment (% is derived from a point estimate)	17	18	17	9	11	12	-

*** Estimated numbers (prevalence) of alcohol users, aged 18+, later than 2018/19 are not yet available. Thus, for each year between 2019/20 - 2020/21, the rate of unmet need figures have been estimated using the 2018/19 alcohol prevalence estimates.**

Figure 7. Unmet need for Alcohol Users in specialist alcohol treatment in England



Unmet need	2014/15 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)	2020/21 (%)	2021/22 (%)
Not in treatment (% is a point estimate)	80	82	82	83	83	82	-
In treatment (% is derived from a point estimate)	20	18	18	17	17	18	-

*** Estimated numbers (prevalence) of alcohol users, aged 18+, later than 2018/19 are not yet available. Thus, for each year between 2019/20 - 2020/21, the rate of unmet need figures have been estimated using the 2018/19 alcohol prevalence estimates.**

6.6 Alcohol Specific and Alcohol Related Hospital Admissions, in Bristol

NDTMS reports that 1,057 people were admitted to hospital in Bristol due to alcohol-specific conditions e.g., liver disease. This is much higher than the South West (621) and England (626). Trend data was not available at the time of publishing.

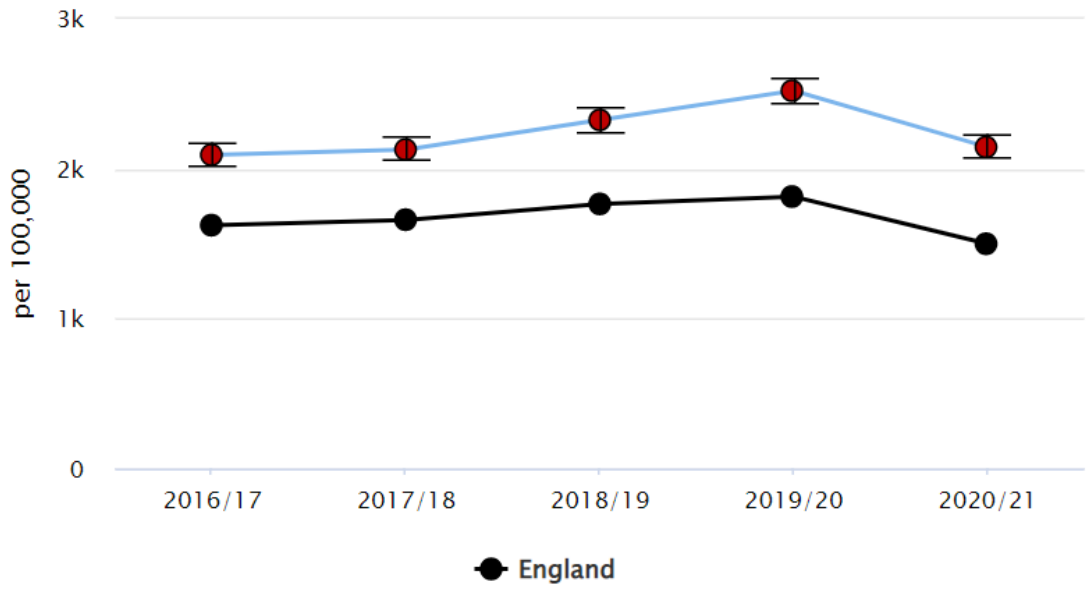
The number of admission episodes for alcohol-related conditions for Bristol is increasing and getting worse according as can be seen in Figure 8. below. This is calculated using a 'broad' definition: a measure of hospital admissions where either the primary diagnosis (main reason for admission) or one of the secondary (contributory) diagnoses is an alcohol-related condition. Our rates are significantly worse than the South West and England.

Figure 8. Rates comparison for Alcohol related hospital admissions across Bristol, South West and England

Period		Bristol Count	Value	99.8% Lower CI	99.8% Upper CI	South West	England
2016/17		7,420	2,093	2,017	2,171	1,557	1,624
2017/18		7,576	2,129	2,052	2,207	1,557	1,657
2018/19		8,316	2,326	2,246	2,408	1,640	1,766
2019/20		8,975	2,521	2,438	2,606	1,691	1,815
2020/21		7,784	2,145	2,069	2,223	1,442	1,500

Source: Calculated by OHID: Population Health Analysis (PHA) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

Figure 9. Admission episodes for alcohol-related conditions



Source: Public Health Outcomes Framework, OHID

6.7 Alcohol- related Conditions resulting in Hospital Admissions, difference between males and females, in Bristol

According to the 202/21 data, greater male hospital admissions (69%) for alcohol related conditions were recorded than female admissions (31%). This difference was greater than admissions recorded in the South West (Male, 59% and Female 41%) and significantly greater than the England estimates (Male 54% and Female 46%).

6.8 Admission episodes for mental and behavioral disorders due to use of alcohol in Bristol

The number of admission episodes for mental and behavioural disorders due to alcohol use in Bristol is increasing and getting worse according as can be seen in Figure 10. below. Our rates are significantly worse than the South West and England.

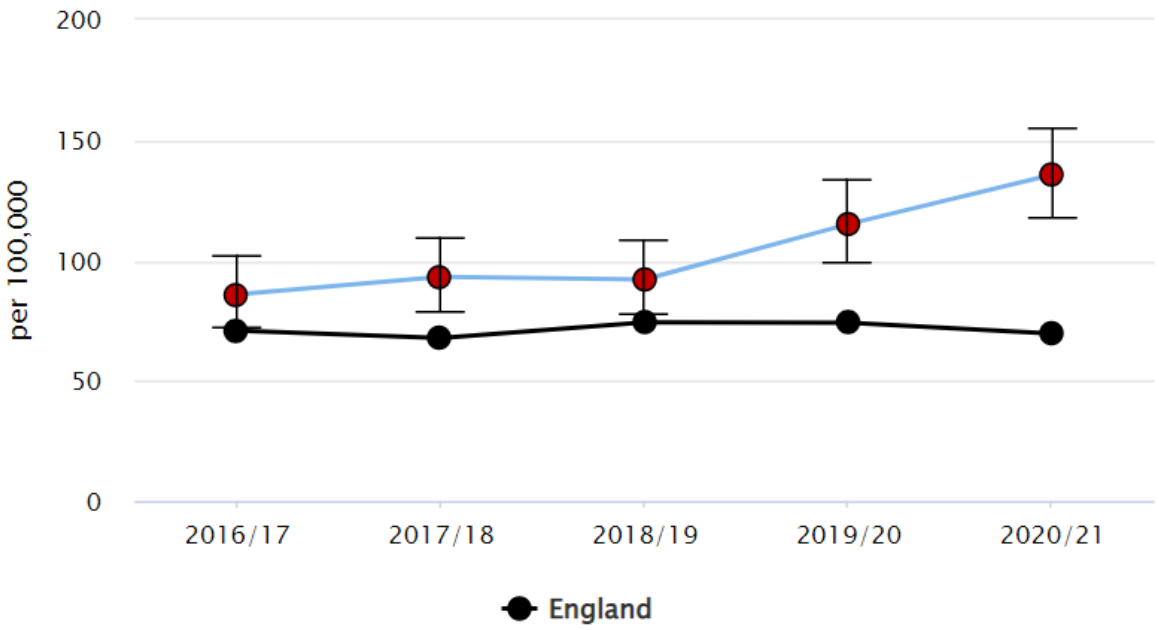
In this category, we also see a greater number of males (67%) than females (33%) being admitted.

Figure 10. Rates comparison for mental and behavioural disorders due to alcohol across Bristol, South West and England

	Bristol						
Period		Count	Value	99.8% Lower CI	99.8% Upper CI	South West	England
2016/17	●	358	86.0	72.1	101.5	58.5	70.8
2017/18	●	386	93.2	78.7	109.4	60.4	67.8
2018/19	●	381	92.1	77.7	108.2	65.0	74.2
2019/20	●	463	115.1	98.8	133.2	64.7	74.1
2020/21	●	540	**135.7**	117.9	155.3	64.5	69.7

Source: Calculated by OHID: Population Health Analysis (PHA) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

Figure 11. Admission episodes for mental and behavioural disorders due to alcohol use



6.9 Other Alcohol-related Hospital Admissions

For Alcohol-related admissions to hospital for unintentional injuries, self-poisoning and alcoholic liver disease, our rates have remained relatively the same since 2016/17 with no significant changes. However, Bristol's rates are still significantly higher than the South West and England average.

6.10 Recommendations

1. Increase engagement with the large cohort of dependent drinkers who are not accessing any form of support or treatment.
2. Improve monitoring of the number of dependent drinkers in Bristol in order to understand need at any given time. NDTMS data is only available up to 2018 estimates only half the number of dependent drinkers that have been identified through our local monitoring system- the System Wide Dataset (which is also likely to be an under-estimate.
3. Work closely with the ICS using their data records to address need and ensure that this is fed back into the system.
4. Work with local health commissioners, and other Local Authorities, to ensure the prevention of substance use is prioritised in the delivery of physical and mental health services.

5. Improve the use and availability of data and public health intelligence in a number of areas, including ROADS performance to inform alcohol licensing decisions.
6. Address the wider health implications that arise from the use of alcohol - such as chronic liver disease, bacterial infections, and impacts on cardiovascular and respiratory health - so as to reduce hospital admissions.

7. Prevalence of Drug Use, Unmet Need and Related Health and Social Harms

7.1 Who is at risk?

There are major challenges to the assessment of health-related harms from drug use. There may be difficulties in interpreting evidence of harm due to uncertainties whether the substance used is a direct or indirect cause of the acute and chronic adverse effects or it may be difficult to quantify the risk of experiencing these health harms among people who use the drugs[69].

7.2 Drug Issues at a National Level

The most recent surveys on drug use covering England and Wales, and Scotland reported the highest prevalence of drug use in the past ten years. The report highlighted that drug use among 15-year-olds has risen over the past 5 years. In 2018, 38% of 15-year-olds in England, and 21% of 15-year-olds in Scotland, said that they had ever used drugs.
It also highlighted that the most commonly used drugs have not significantly changed over time. Cannabis is the most prevalent, followed by powder cocaine, MDMA, ketamine and amphetamine with synthetic cannabinoid receptor agonists, such as Spice, are widely used in prisons.

The UK has the largest reported opioid-using population in Europe. In 2017, 57,430 people started treatment for primary opioid use in the UK, which was 35% of everyone starting treatment throughout the European Union (although the total did not include Germany). Similarly, powder cocaine is the most commonly used stimulant in the UK and accounts for 13% of people entering drug treatment in Great Britain and makes up 65% of the European treatment system for crack alone. The prevalence of use in England and Wales in 2018 to 2019 (2.9%) was the highest since 2008 to 2009[70].

The most recent NDTMS national estimates of opiate and crack use were published in 2019 covering the period from 2010 to 2017. In England, the number of users of opiate and crack was estimated to be 313,971.

7.3 Type of Drug Use in Bristol

The University of Bristol published a briefing[71] which looked at types of drugs being used across the Southwest and trends among young people. The report found that cannabis was the illicit drug which the most respondents reported having used in the last year, and

amphetamines the least used – which is reflective of national usage. Approximately 11.7% of people in the Southwest reported using illegal drugs in the year 2018-2019, the highest for England and Wales. The average across the country was 9.4%. A higher proportion of MDMA and cannabis was also reported compared to other regions. Reported use of hallucinogens and amphetamines were among the highest in England and Wales. 9.4% of people in the Southwest claimed to have used cannabis in the past year[72,73].

Figure 12. Proportion of 16- to 59-year-olds reporting use of illicit drugs in the last year in the South West

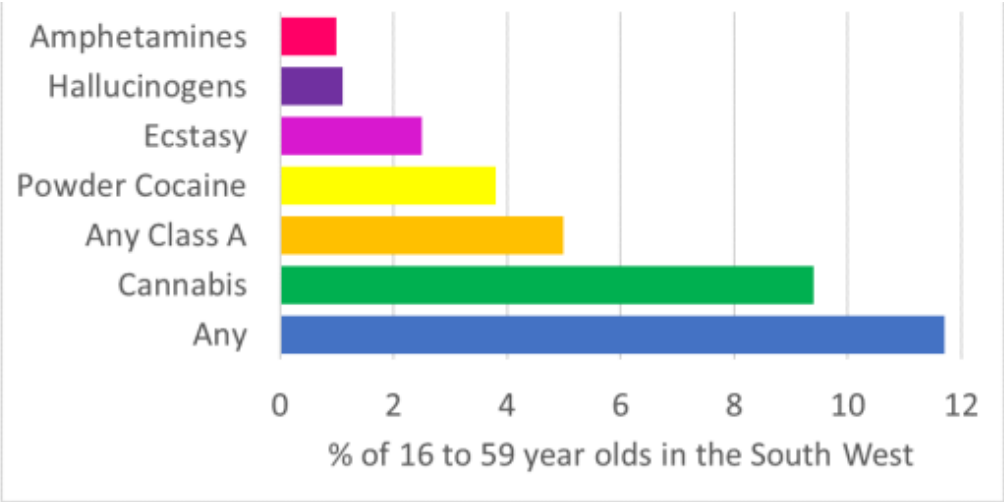


Figure 1 – Self-reported drug use in the South West (source: UK Home Office drug misuse findings from 2018 to 2019).

The report also found that drug use among University students in Bristol is particularly high. An anonymous survey of 300 University of Bristol students revealed that 77% had taken illicit drugs for recreational purposes – however this figure may be very high because of the sampling approach and/or limited number of respondents. Figure 13. below outlines that scale of drug use in Bristol Universities.

Figure 13. Drug use by students in Bristol Universities

University	Drug	Ranked in the UK	% of students
University of the West of England	MDMA	1st	82%
	Nitrous oxide	1st	82%
	Cocaine	3rd	66%
University of Bristol	Cannabis	3rd	84%
	Nitrous oxide	3rd	71%
	Ketamine	2nd	48%

Table 2: drug use in Bristol universities (source: nationwide 2017 survey of students).

Interestingly, while around a third of students who report negative drug-related health impacts claimed that their mental health worsened due to taking drugs, two thirds claimed that drug use improved their day-to-day experience of existing mental health conditions. The propensity for young people to use illicit drugs to self-medicate should be of major concern to health practitioners.

7.4 Opiate and Crack Use Prevalence at a Bristol Level

The most recent national estimates of opiate and crack cocaine use were published in 2019 covering the period from 2010 to 2017. There were an estimated 5,000 people who use opiates and crack cocaine in our city[74,75]. This rate is almost double the national average.

Opiate use in Bristol has remained much the same over this period, with an estimated 4,449 people using opiates in 2010 and 4,130 in 2017 (a 7% decrease over seven years.)[76]. Crack cocaine use appears to have declined slowly over this period. An estimated 4,327 people used crack in 2010 and 3,378 in 2017 (a reduction of approximately 22%). These estimated are measures from interactions with services and does not include those who don't interact with services.

It is important to note that these figures are now outdated. Since 2017 there have been significant rises in drug related deaths and it's possible that harmful patterns of drug use have increased, or that we have an ageing cohort of users in Bristol.

Whilst the proportion of Bristol residents using drugs, that we know of, is relatively small the impact can be extensive. Bristol has the second largest estimated rate of opiate and/or crack users (per 1,000 population) of the English core cities and the largest proportion of very high complexity clients which makes them more likely to be in treatment for longer and need specific support.

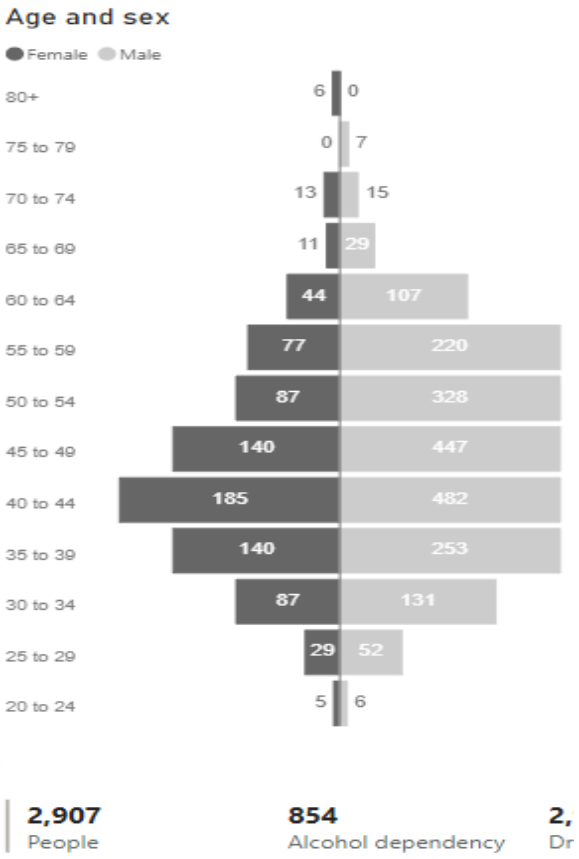
7.4.1 Local trauma-informed approach

A significant proportion of people who develop dependency on drugs and/or alcohol are known to have experienced trauma, often in early childhood. Furthermore, many people who as adults use drugs and alcohol, come from socially deprived communities. Given these facts, Bristol City Council and strategic partners take a trauma-informed view when developing services which support people who use substances. Over the last three years there have a been a number of initiatives to develop a trauma-informed approach, and to address the specific needs of individuals experiencing multiple disadvantage.

7.5 Population Health Management and Drug Dependence

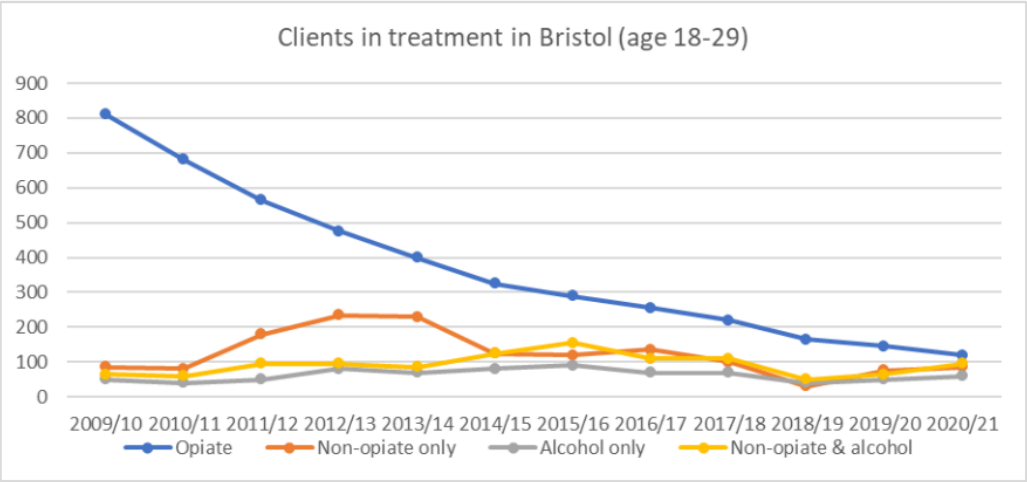
The BNSSG System Wide Dataset shows there are 2,907 opioid dependent users in Bristol, which is significantly less than what is estimated by NDTMS. Figure 14. shows the spread of dependent opioid users in Bristol, according to age and sex. The data shows that greatest number of opioid users are aged between 35-59 and more male dependent users than females in all categories. It does highlight the older user population where dependence is still high between 60-64.

Figure 14. Spread of Dependent Opioid Users in Bristol according to Age and Sex.



NDTMS reports that there has been a significant reduction in the number of people who use opiates aged 18-29 in treatment over the last 10 years. This may mean less people of this age group are commencing opiate use or services aren't attracting those that need it the most.

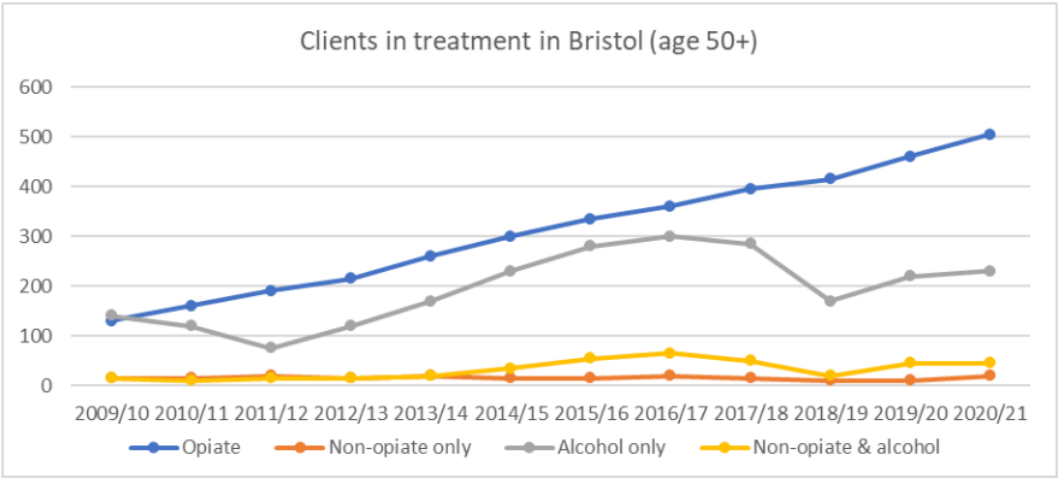
Figure 15. Number of clients in treatment age 18-29.



Source: NDTMS

Over the same time period there has been an increase in the number of people who use opioids aged over 50 in treatment, which may reflect an ageing cohort of people who use opiates.

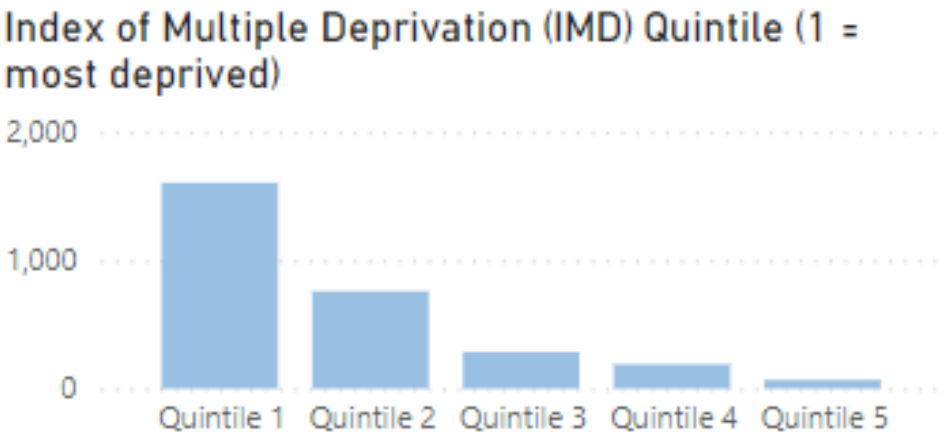
Figure 16. Number of clients in treatment age 50+.



Source: NDTMS

According to our system wide dataset, we can also see that deprivation has an influence on the number of dependent opioid users in our city. More than 50% of our opioid users are users living in our most deprived wards with number of opioid users reducing as the deprivation index increases, as shown in Figure 17. below.

Figure 17. Number of Dependent Opioid Users according to Index of Multiple Deprivation.



7.6 Opioid Substitution Therapy (OST)

People who become dependent on heroin or other illicit opioids often benefit from opioid substitution treatment (OST)[77]. The same is true, but much less common, for people who become dependent on opioids prescribed for pain.

OST has 2 core elements: pharmacological and psychosocial:

- The pharmacological element involves replacing illicit opioids with a prescribed replacement opioid, such as methadone or buprenorphine.
- The psychosocial (talking) element supports people to stabilise on the replacement opioid, to then make positive changes to their lives and recover from their drug use. OST is most commonly used for illicit heroin use so that is the focus of this guidance.

The long-term goal of OST is for the service user to completely stop using illicit opioids. In the shorter term, reduced illicit opioid use can reduce risk. OST is effective in reducing:

- illicit opioid use
- drug-related injecting

- blood-borne virus (BBV) transmission
- offending
- premature mortality (early death)

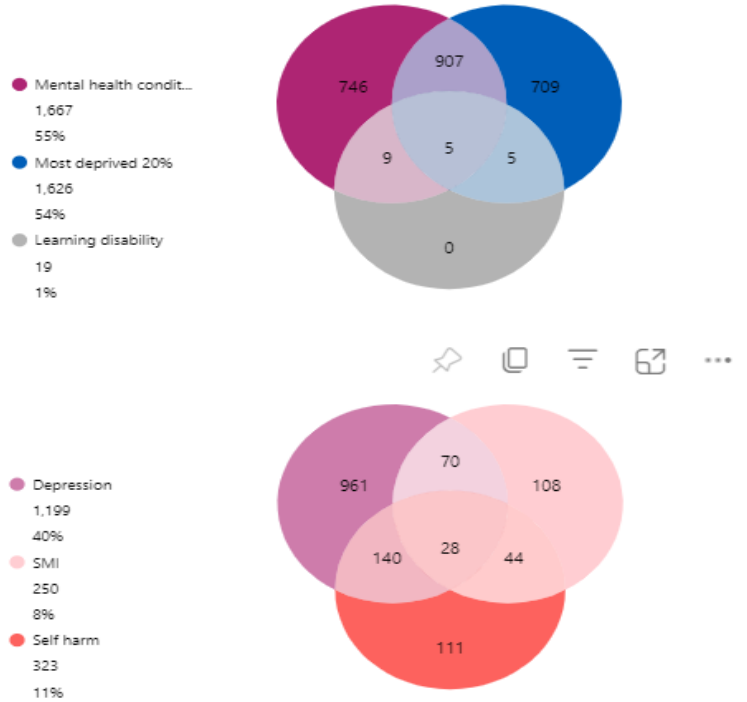
Bristol's Shared Care Service delivers OST in Bristol through Bristol Drugs Project as part of ROADS. The Shared Care Team work alongside GPs in selected surgeries across Bristol to support people with their alcohol or drug use[78].

There were 2,120 clients receiving OST in 2022-2023 in Bristol through Shared Care Service. 15% of those clients were simultaneously using Needle Exchange at some point during their OST treatment, also known as 'using on top' [79].

7.7 Drug Dependence and Multiple Disadvantage

Figure 18. below shows the multiple disadvantages experienced by dependent opioid users in Bristol according to the system wide dataset. Most significant is those experience mental health conditions (55%) and living in the most deprived areas of the City (20%).

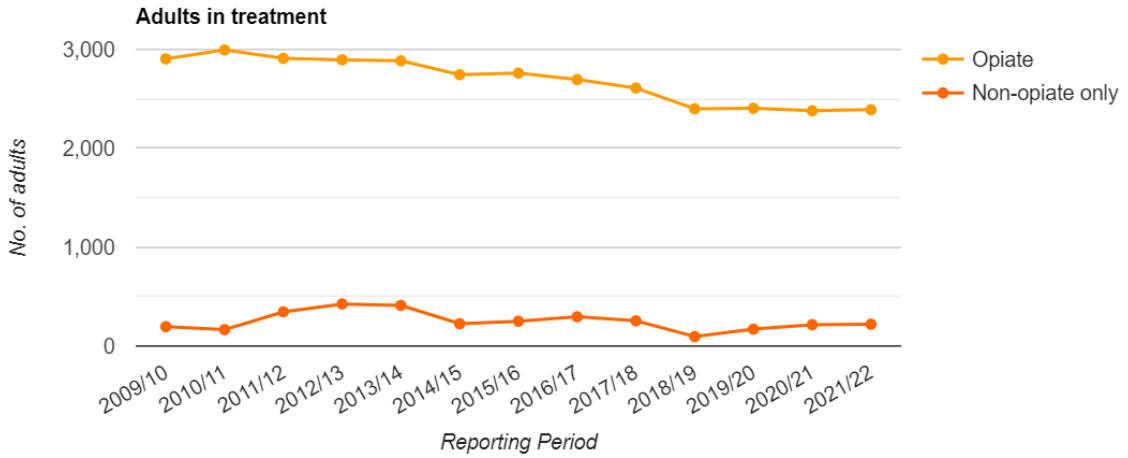
Figure 18. Multiple Disadvantage experienced by Dependent Opioid Users in Bristol



7.8 Rate of Unmet Need in Treatment

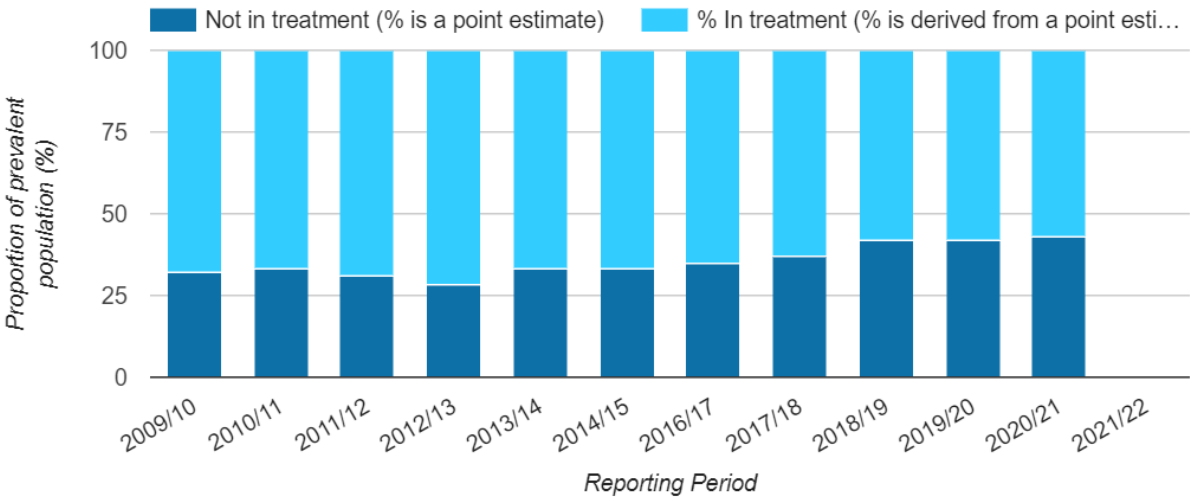
NDTMS reports there to be 2,390 adults in specialist drug treatment in Bristol for opiate use and 220 for non-opiate use. Figure 19. below shows the decreasing trend in the number of people in this treatment service for opiates since 2018/19 but a slightly increased trend for clients in treatment for non-opiates. This may reflect the slightly reducing number of opioid dependent clients as reported nationally and in Bristol.

Figure 19. Declining Number of Adults in Treatment for Opiates



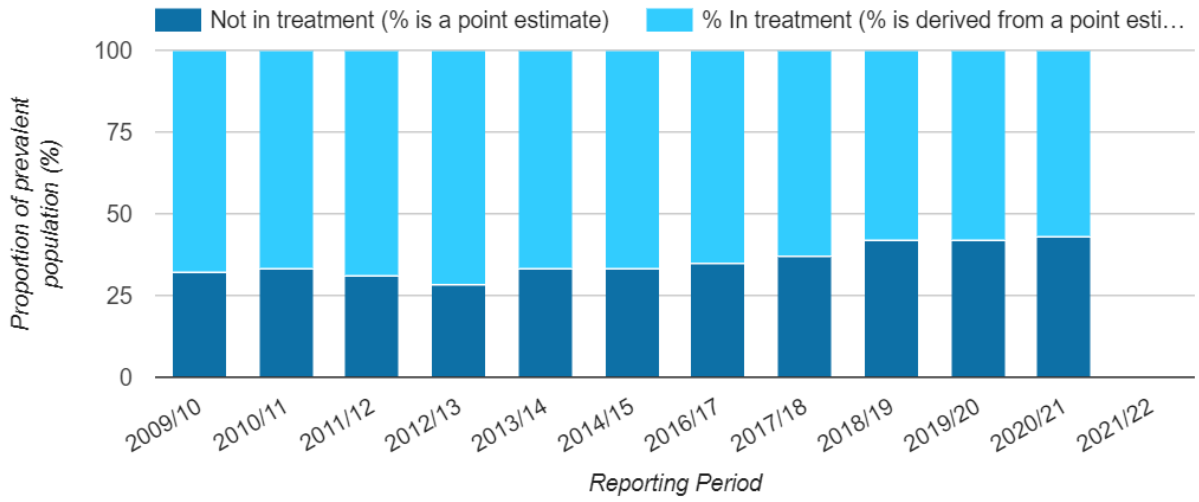
However, our unmet need according to NDTMS data available to us until 2016/17 shows our unmet need for opiate treatment as being 43% for 2021/22 according to NDTMS prevalence modelling as seen in Figure 20. below.

Figure 20. Unmet need for Opiate Users in specialist treatment in Bristol



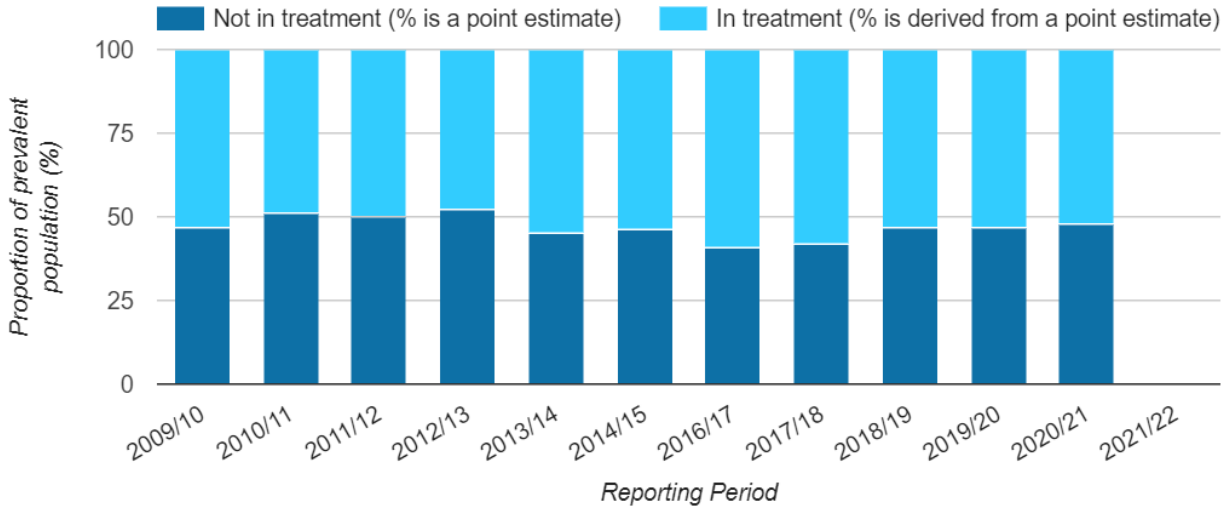
However, our unmet need according to NDTMS data available to us until 2016/17 shows our unmet need for opiate treatment as being 43% for 2021/22 according to NDTMS prevalence modelling as seen in Figure 21. below.

Figure 21. Unmet need for Opiate Users in specialist treatment in Bristol



For Crack users, our unmet need is predicted to be even higher at 48% for 2021/22 according to NDTMS prevalence modelling as seen in Figure 22. below.

Figure 22. Unmet need for Crack Users in specialist treatment in Bristol



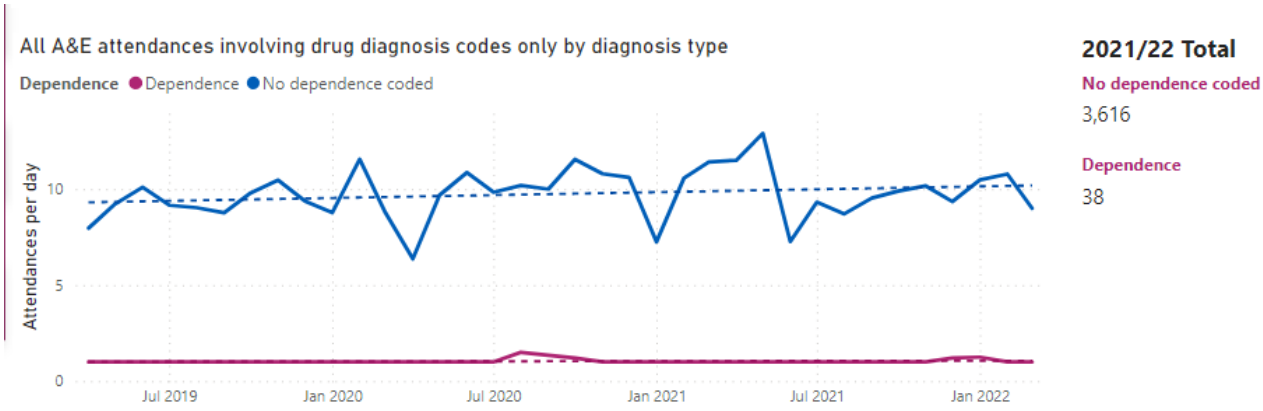
7.8.1 Unmet Need for Crack and Opiate Users in Bristol compared to Core Cities.

For opiate and crack users combined, our unmet need is estimated to be 51%, which is lower than other Core Cities including Liverpool (unmet need 54%), but slightly more than Newcastle (43% unmet need), Birmingham (49% unmet need), Leeds (48% unmet need).

7.9 Drug Related Hospital Admissions, in Bristol

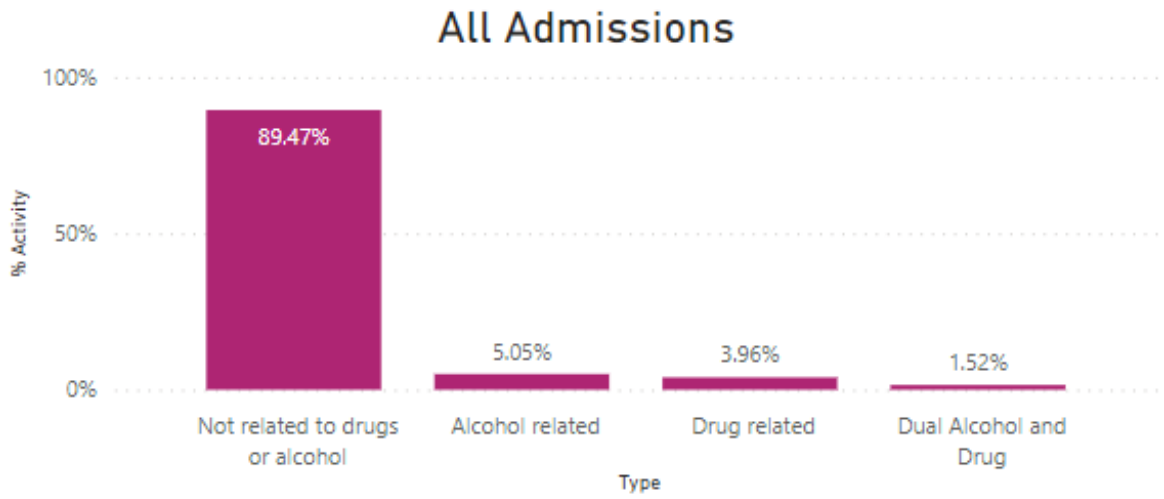
In comparison to alcohol, we don't have the same data on drug related hospital admissions however, we do have local data from our system wide dataset about accident and emergency (A&E) admissions. The data tells us that there were a total of 3,616 A&E admissions in Bristol related to drugs in 2021/22 (accounting for 1.66% of all A&E admissions).

Figure 23. Number of A&E drug related admissions in Bristol 2021/22



However, as seen in Figure 24. below what is significant is that nearly 12% of all hospital admissions in Bristol are related to alcohol and/drugs which is a significant proportion of hospital admissions.

Figure 24. All hospital admissions in Bristol



7.10 Recommendations

1. Increase awareness amongst health practitioners of the propensity for young people to use illicit drugs to self-medicate
2. Work with education providers to prevent and reduce the harm of substance use in student populations.
3. Undertake further analysis to understand the extent to which we have a reducing cohort of opiate users, or an ageing cohort of dependent users. (Prevalence data available through NDTMS is only available for 2010 to 2017 which is an under estimate of current prevalence of both drug use and dependent users.)
4. 55% of dependent drug users have a mental health need and 54% are in our most deprived wards. There is work to be done to address the mental health need of dependent drug users.
5. We have a significant rate of unmet need for opiate and crack users in the treatment system, though not hugely different to other Core cities. There is work to be done to explore how we can engage with those dependent users that are not accessing treatment.
6. Undertake further analysis to understand hospital admissions. No national data is available on hospital admissions, only local data. Local data is still an under estimation and work needs to be done to unpick, who is being admitted, and if they are known to the treatment system.

8. Drug and Alcohol Related Deaths

8.1 Alcohol Related Deaths

Smoking, poor diet, physical inactivity and harmful alcohol use are leading risk factors driving the UK's high burden of preventable ill health and premature mortality. All are socio-economically patterned and contribute significantly to widening health inequalities[80]. Deaths related to alcohol use in Bristol are increasing. Alcohol use has an impact on families and communities, as well as being a key contributor to both crime and long-term illness[81].

Nearly 200 people in Bristol are known to die each year from a condition related to their alcohol use, these figures have remained similar since 2016. Often, these people have no record of having accessed any specialist treatment for their alcohol use. In 2021, 56 people died from alcohol-specific conditions, (40 of which were deaths due to alcoholic liver disease in under 75's). During the same period 148 people (76% male and 24% female) died from alcohol-related conditions. This equates to 40.7 people per 100,000 which is higher than the South West average of 34.7 per 100,000 and the England average of 38.5 per 100,000. 10 people were reported to have died while in alcohol treatment in Bristol in the last year.

8.2 Drug Related Deaths

Drug use is a significant cause of premature mortality in the UK. Drug deaths related to poisoning have risen significantly in England and Wales over the last decade with data collected by the Office for National Statistics[82] (ONS) suggesting a 57% increase in deaths from drug poisoning related to illicit drug use in England and Wales over the past 10 years. Deaths classified as a drug poisoning must have an applicable International Classification of Diseases (ICD) code assigned as the underlying cause of death. This includes a broad spectrum of substances, including controlled and non-controlled drugs, prescription medicines and over-the-counter medications. As well as deaths from drug abuse and dependence, figures include accidents and suicides involving drug poisonings and complications of drug abuse such as deep vein thrombosis or septicaemia from intravenous drug use.

8.3 England and Wales Profile of Drug Poisoning Deaths[83]

4,859 deaths related to drug poisoning were registered in 2021 in England and Wales, equivalent to a rate of 84.4 deaths per million people; this is 6.2% higher than the rate recorded in 2020 (79.5 deaths per million).

Mortality rates from drug poisoning increased for both males and females in 2021. Among males, there were 115.1 drug poisoning deaths registered per million in 2021 (3,275 deaths), compared with 54.1 deaths per million among females (1,584 deaths).

According to the ONS, 3,060 (out of 4,859) drug poisoning deaths registered in 2021 were identified as drug misuse, accounting for 53.2 deaths per million people. Deaths classified as drug misuse must meet either one (or both) of the following conditions:

- the underlying cause is drug abuse or drug dependence
- any of the substances involved are controlled under the Misuse of Drugs Act 1971.

Information on the specific drugs involved in a death is not always available, therefore figures on drug misuse are underestimates.

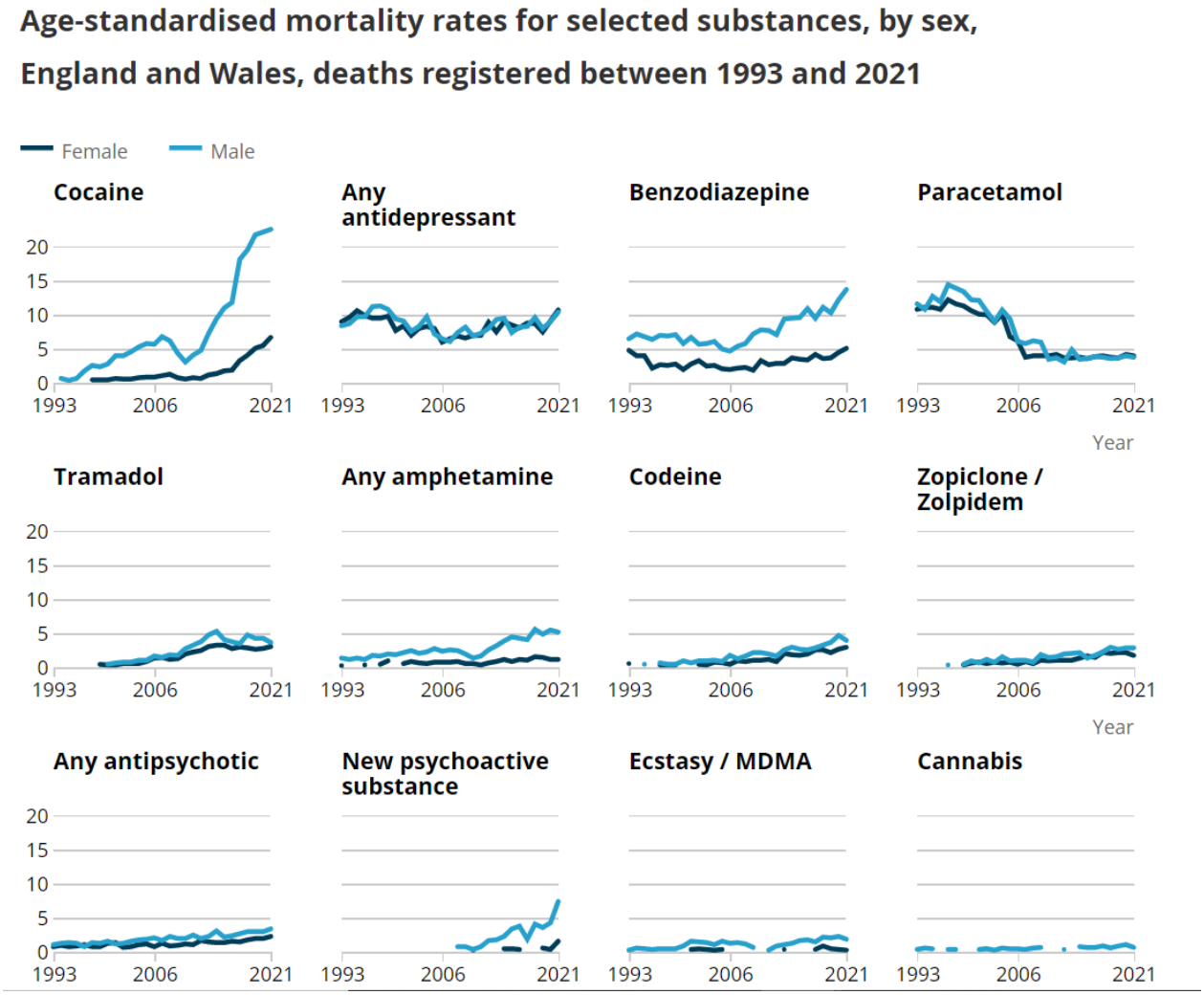
Approximately half of all drug poisoning deaths registered in 2021 involved an opiate (45.7%; 2,219 deaths). 840 deaths involved cocaine, which is 8.1% more than 2020 and more than seven times the amount recorded a decade ago (112 deaths in 2011).

8.3.1 Drug Poisoning Deaths by Substance

Over half of all drug poisoning deaths involve more than one drug, and it is not possible in those cases to tell which substance was primarily responsible for the death, however it is known that almost half of all drug poisonings continue to involve an opiate. Nationally, for deaths registered in 2021, a total of 2,219 drug poisoning deaths involved opiates.

As seen in **Figure 25.** there have been significant increases in deaths involving cocaine and new psychoactive substances in 2021. There has also been a reported increase in the number of deaths from methadone in 2021. There were 663 deaths involving methadone registered in 2021, which is 28.5% higher than the previous year (516 deaths) and a statistically significantly higher rate than the previous year (11.7 deaths per million in 2021 compared with 9.1 in 2020)[84].

Fig 25. Drug Poisonings by Substance



Drug-related deaths have been on an upward trend for the past decade. The reasons behind this are complex and differ by drug type. As seen above, the overall trend is driven primarily by deaths involving opiates but also by an increase in deaths involving other substances like cocaine. The rise in deaths involving cocaine is likely to be a direct consequence of the increasing prevalence in cocaine use[85].

8.4 Bristol Profile of Drug Related Deaths

In England alone, the rate of drug poisoning deaths is known to be 7.9 per 100,000 and 5.1 per 100,000 deaths relating to drug misuse between 2019 and 2021.

Compared to this national data, Bristol has seen the number of drug poisoning deaths gradually increase year on year from 28 deaths in 2011 to 49 in 2021. This is in line with national trends in drug poisoning deaths increasing over the last decade. Of the 49 deaths, 41 were classified as being related to drug misuse. This is equivalent to a rate of 11.8 per

100,000 population (70% male and 30% female) between 2019 and 2021 for deaths relating to drug poisoning and 9.1 per 100,000 for deaths relating to drug misuse, both of which are higher than the England average[86].

8.5 Comparison to other English Core Cities

Comparing drug related deaths in Bristol with other English core cities provides a better comparison as their population demographics are more similar. As shown in the below table, the rate of drug related deaths in Bristol is similar to most of the other core cities, except for Nottingham, who have a rate more closely aligned with the national average. In 2021 Bristol ranked third when compared to six other core cities with both Liverpool and Manchester having a higher rate of drug related deaths[87].

Figure 26. Rate of drug related deaths per 100,000 population among the English core cities.

	Liverpool	Manchester	Bristol	Leeds	Sheffield	Birmingham	Nottingham
All	12.6	10.1	9.1	8.1	8	7.9	5.7
Males	17.3	14.4	13	11.1	11.1	12.4	8.4
Females	8	5.7	5.1	5.2	5	3.4	2.9

Source: ONS

8.6 Local Data on Drug Related Deaths

Bristol City Council, in collaboration with BDP collected local data on the number of deaths relating to drugs and/or heavy alcohol use, among people who were known to local drug treatment providers or were notified by the Police, between 2018 and 2021.

During this period, BDP were notified of 224 deaths (74% male and 26% female), 74% White British and 19% undefined ethnicity. The average age of people who died, increased over the period from 38 years in 2018/19 to 47 years over the period in 2020/21.These figures will still be an underestimation of the number of deaths relating to drugs and/or heavy alcohol use. This is due to an unknown number of younger drug users (under 18 years), hospital deaths and those not known to the local drug treatment system.

8.6.1 Local Causes of Death

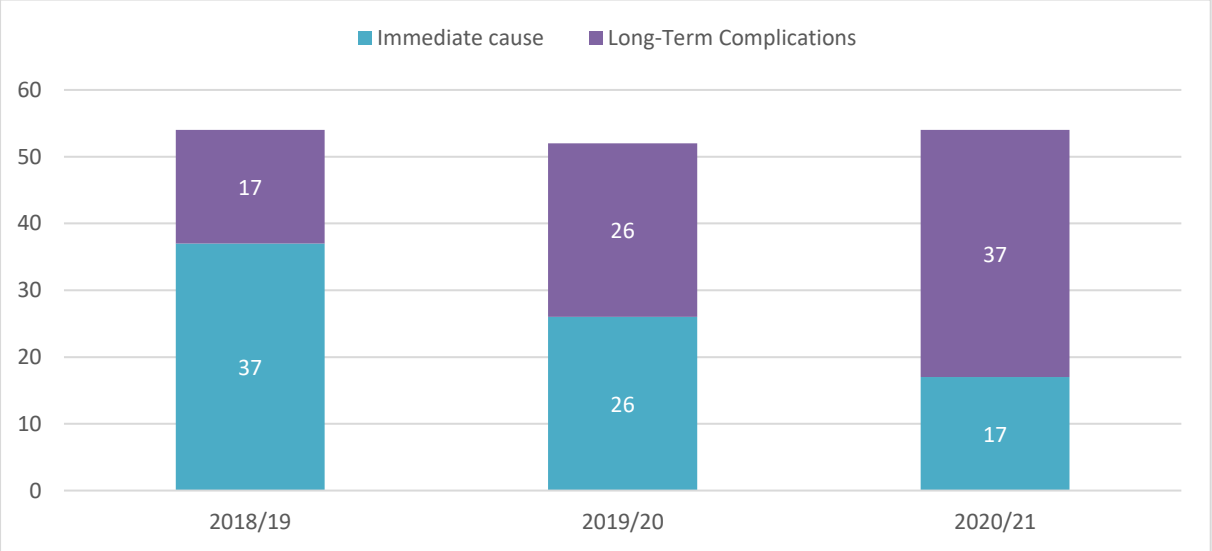
48% of the deaths notified (107) were considered ‘immediate cause’ deaths. This included overdoses (88), accidental poisonings and deaths related to volatile substances (19).

36% (80) of deaths were considered a result of a ‘long-term complications’. This included deaths associated with the longer-term effects of drug use and related ill health. 34% (27) of the deaths were as a result of ‘long-term complications’ related to heavy alcohol use. A further 17% (37) are reported as ‘other’ which includes deaths by suicide, smoking related disease, natural causes or deaths were the cause has not been determined.

Figure 27. below shows the differentiation between 'Immediate' and 'Long-Term Complications' from drug and/or alcohol use between 2018 and 2021. An increase in the number of deaths associated with long-term conditions can be seen across the three years from 17 in 2018/19, to 26 in 2019/20 to 37 in 2020/21. This may be related to the increasing age of people who use opiates in the city.

A reduction in the number of 'immediate cause' deaths from 37 in 2018/19, to 26 in 2019/20 to 17 in 2020/21 may be explained, in part, by the measures taken to increase the availability and accessibility of opioid substitution treatment (OST) during the COVID-19 pandemic. This would appear consistent with the evidence that suggests that opioid substitution treatment is associated with substantial reductions in all cause and overdose-related mortality (O'Connor., et al, 2020)[88] but requires further investigation to understand the local reasons in Bristol.

Figure 27. Number of Deaths caused by 'Immediate' versus 'Long-Term Complications from Drug and/or Alcohol Use.



Source: Bristol City Council

8.6.2 Deaths in Treatment

Amongst the drug-related deaths reported between 2018-21, at the time of death:

- 84% of individuals were known to the local treatment system. Of these, 50% were receiving treatment when they died.
- 77% of individuals were known to use heroin. 42% of them had been issued naloxone during the three-year period.
- 47% of all drug-related deaths occurred in the individual's home (which is where we understand the majority of overall drug-related deaths occur).
- 21% occurred in hospital
- 8% occurred in a homeless hostel
- 8% occurred in a public place.
- While drug-related deaths occur across Bristol, they occur more frequently in some areas. In Ashley, Central Eastville and Lawrence Hill Wards there were between nine and 15 drug-related deaths between 2018 and 2021. In Hillfields, Southville and St George there were more than five.
- It is important to note that available funding for drug treatment services had also declined in this period[89].

8.7 Why is there an increase in the number of drug related deaths and what can we do about it?

There is some evidence to suggest that drug related death have increased because people with drug dependencies are older, with comorbidities increasing overdose risk. Two recent studies, however, demonstrated ageing alone does not explain the increase[90,91]. There are a number of other potential contributory factors including:

- increasing polydrug use, with the risk of opioid overdose increasing with benzodiazepine, gabapentinoid, and alcohol use.
- increasing homelessness and incarceration, which are associated with mortality risk.
- human immunodeficiency virus (HIV) and hepatitis C (HCV) transmission.
- changing patterns of socioeconomic deprivation, which is strongly associated with drug-related harm.
- cuts to services that protect against all-cause and drug-related mortality[92,93,94,95,96].

8.7.1 Naloxone

Naloxone is the emergency antidote for overdoses caused by heroin and other opiates or opioids (such as methadone, morphine and fentanyl). The main life-threatening effect of heroin and other opiates is to slow down and stop breathing. Naloxone blocks this effect and reverses the breathing difficulties. Naloxone is a medication that can temporarily reverse the effects of an opioid overdose giving emergency services more time to respond to an emergency. Naloxone can work within 5 minutes and can last for between 20 and 40

minutes[97]. This could be the difference that might save a person's life in an overdose situation. Naloxone comes in both pre-measured syringes and a nasal spray[98].

Naloxone is a prescription-only medicine, so pharmacies cannot sell it over the counter. However, drug services can supply it without a prescription to anyone who can use it to save a life in an emergency, including:

- an outreach worker
- a hostel manager
- a drug user at risk
- a carer, a friend, or a family member of a drug user at risk
- any individual working in an environment where there is a risk of overdose for which the naloxone may be useful e.g., Police

Naloxone is available in Bristol through BDP, commissioned by Bristol City Council, and can be ordered online or picked up from their offices. It is available for free to anyone who may come into close contact with an individual who uses opioids. Training is available for anyone who wishes to take it up[99].

According to ADDER data, Bristol distributed 1126 Naloxone kits among the 'out of treatment' population between April 2021 and December 2022 which is significantly above the higher target of 445 for the period. During the period July 2022 and Jan 2023 approximately 60% of Naloxone distributed was among the out of treatment population with 40% being issued to those in treatment.

Naloxone is also routinely available to those in custody as contractually required. Following an assessment of need and with individuals consent Naloxone is placed in their personal belongings ready for their release. An overdose prevention session which including information on how to use Naloxone is delivered and a refresher provided prior to release.

8.7.2 Limitations of Naloxone

Naloxone, although known to be effective at reversing the effects of opiate/opioid toxicity has limitations in its role in preventing drug-related deaths. One particular limitation is related to users who accidentally overdose while at home alone.

The effectiveness of Naloxone is grounded in the social context and relies on the presence of a third party being present to administer the drug in the event of a suspected overdose. Those at risk of overdosing at home, are a population of growing concern, and better surveillance is required to understand how best to protect this group. Further work is needed to tailor existing interventions towards this group while continuing to explore innovative approaches in this area.

8.8 What else are we doing to address drug related deaths in Bristol?

- Developing a ‘real-time’ surveillance system to monitor sudden and preventable deaths including drug and alcohol related deaths, suicides and deaths among people who are homeless as these groups inter-relate. This will enable the early identification of trends and clusters and inform preventative actions.
- Developing a Local Drug Information System (LDIS) to establish consistent and efficient processes for receiving, assessing and sharing information about dangerous, new/novel, potent, adulterated or contaminated drugs – the presence of which has visibly increased over the last decade.
- Enhancing our capacity for forensically testing substances of concern by developing new relationships with local universities and commissioning a Drug Safety Checking service to provide people who use drugs in Bristol with the opportunity to have a substance tested and reduce the risks associated with taking unknown drugs.
- The effectiveness of Opioid Substitution Treatment (OST) in reducing the risks of overdose and mortality is well known. Work is underway to increase the number of opiate users in effective treatment and it is important that this continues to be supported financially and with resource.
- Giving more people the opportunity to overcome and sustain their recovery from dependence by optimising access to abstinence based residential treatment and making recovery more visible throughout Bristol’s Recovery Oriented Alcohol and Drugs Service (ROADS).

8.9 Priority actions to address drug and alcohol related deaths

1. Complete the development and implementation of the 'real-time’ surveillance system to enhance our ability to identify emerging patterns and trends and inform preventative actions together with providers and other stakeholders.

2. Ensure harm reduction is fully embedded within abstinence-based treatment pathways in recognition of the increased risk of fatal overdose among those who have lost tolerance following detoxification or a period of residential treatment.

3. Enhance the provision of overdose awareness training and ensure that it is tailored to specific populations e.g., opiate users, cocaine users etc.

4. Continue to promote and delivery Naloxone for overdose prevention in the social context. Explore innovative approaches to protecting those at risk of overdosing at home, alone.

5. Develop a local overdose awareness campaign to communicate the key facts and figures to practitioners and service users alike, ensuring the risk of overdose is visible within services and features regularly in conversations with clients.

6. Strengthen existing initiatives that mitigate against the risk from injecting drug use, and consider the evidence base behind new harm reduction measures such as drug consumption rooms.

7. Strengthen referral pathways between UBHW/NBT for problematic/dependent alcohol users who may benefit from specialist treatment.

9. Local Demographics, Vulnerabilities and Risk Factors Associated with Alcohol and Drug Use

This section provides a direction to the already published documents which describe the local population profile of Bristol, the current and future health needs of the population.

Due to the range of social determinants and risk factors outlined below associated in some way with alcohol and other drug use, it is essential that partners from a range of organisations are required to address drivers of substance use issues.

There is currently a number of streams of work underway that this needs assessment will feed into and draw on conclusions from as outlined below.

9.1 Joint Strategic Needs Assessment

An annual summary of the Health and Wellbeing Profile for the City of Bristol is produced. The latest report for 2021/22 describes the population and identifies current and future health and care needs.

9.2 Population Profile

The Bristol Key Facts 2022 provides a summary of major facts and infographics about Bristol and the population, including what it is living in the city.

9.3 Socio-economic Deprivation

The Deprivation in Bristol 2019 report gives a summary of the findings of the 2019 Indices of Deprivation within the Bristol local authority area. Socioeconomic deprivation is strongly associated with more harmful patterns of alcohol and other drug use. Furthermore, people in more deprived areas may face greater barriers to accessing services and experience poorer health outcomes.

9.4 Homelessness

'Homelessness' includes people without shelter of any kind ('rough sleeping'), those sleeping in temporary accommodation (such as hostels) and those living in insecure or inadequate housing[100].

The National "Adult Substance Use Treatment Statistics 2020 to 2021: Report" conducted by OHID found that over one-sixth (17%, or 22,493) of adults entering treatment last year said they had a housing problem. This proportion varied by substance group, ranging from 1 in 10 (10%, or 4,941) of those starting treatment for alcohol problems alone, to almost a third (30%, or 11,286) of those starting treatment for problems with opiate use. As in previous years, people starting treatment for problems with new psychoactive substances (NPS) had the highest proportion of housing need of any substance group (45%)[101].

The number of people sleeping on the streets has risen significantly in Bristol since 2013. The government has adopted annual 'snapshot' counts or estimates on any one given night in the autumn prior to December as their preferred methodology for quantifying the levels of people sleeping rough in geographical areas. The highest annual count was 98 in November 2019, other snapshot counts that year found as many as 130 people (July 2019). The impact of 'Everyone In' reduced levels of rough sleeping in the city (50 in September 2020), however, there has been an increase in the levels of rough sleeping again in 2021 with 62 people found in September 2021.

Data from Bristol City Council's Rough Sleeping Service presented the following profile information on the people sleeping rough in our City:

- The average age of death of homeless men is 47 years old and even lower for homeless women at 43 years old.
- People who end up sleeping rough often experience barriers in accessing both health and care services and experience poor health outcomes in comparison to the rest of society. In 2019-20, 40% of people coming onto the streets were 'returners' to rough sleeping.
- Leaving prison is consistently one of the top three reasons for people rough sleeping.
- Mental health, drugs, alcohol, physical health, and benefits/finances are the top five areas that people identified as needing support within 2019-20.
- Using broad ONS ethnicity categories there are higher proportions of Black/African/Caribbean/Black British people, and White Other people; and lower levels of Asian/Asian British people engaging with the service compared to their relative representation in the Bristol population overall

9.4.1 Housing and Unmet Need

There is increasing concern for the client group in Bristol whose needs are multiple and complex, and where an alternative to traditional supported housing must be explored.

The recently published Health Needs Analysis for People Experiencing Homelessness by Public Health at Bristol City Council was produced to support the city to achieve these better outcomes by informing future planning, alignment, and commissioning of services in Bristol. The analysis found that **21%** of people triaged by ROADs, Bristol's drug and alcohol treatment system, were assessed as being in a category of homeless or at risk of homelessness.

In 2019-20, 10% (252 people) of all Theseus clients were recorded as having 'acute housing need'. This figure dropped to 7% in 2020-21 – this variation may be linked to the 'Everyone In' programme in response to COVID-19, during which people who were homeless were urgently housed. In 2019-20, 3% of Theseus client (89 people) were recorded as having 'housing risk', with this figure remaining at 3% for 2020-21 (71 people).

Over half (54%) of people experiencing homelessness report having used drugs in the last year which is far higher than estimates for the general population (8%). In addition, dual

diagnosis of mental health and a drug or alcohol problems are common amongst people experiencing homelessness and 45% of respondents to the latest health needs audits nationally reported using drugs or alcohol to help them cope[102].

9.5 Multiple Disadvantage

A Health Needs Assessment relating to multiple disadvantages is currently being undertaking by Changing Futures. Key headlines relating to alcohol and other drugs will be included here once it has been published.

Changing Futures is a 3-year, £64 million programme aiming to improve outcomes for adults experiencing multiple disadvantage which launched in 2021. Changing Futures is testing new ways of bringing together public and community sector partners to help people change their lives for the better.

9.6 Mental Health

The association between mental ill health and substance use is complex. Sometimes mental health issues may be attributable to drug use. In other instances, drugs may be used to self-medicate for pre-existing mental health issues. Or there may be risk factors which predispose to both harmful patterns of drug use and mental ill health.

The National “Adult substance misuse treatment statistics 2020 to 2021: report” conducted by OHID found that nearly two-thirds (63%, 82,613) of adults starting treatment said they had a mental health treatment need. This is an increase from 53% in 2018 to 2019. Over half of new starters receiving treatment across substances needed mental health treatment. This need ranged from 57% in the opiate group to nearly three-quarters (71%) of the non-opiates and alcohol group .

Introducing data on mental health needs shows the levels of people with all three of housing, mental health and substance misuse need. Figure 28. below shows clients in the treatment system in Bristol with both mental health and substance use needs by accommodation type at the point of assessment[103].

Figure 28. Number of Theseus Clients by Type of Housing Need & Has Mental Health Treatment Need from 2019-2021

Year Assessed	Short-term or emergency accommodation	Rough sleeping/ NFA	Supported accommodation, AP	Housing Problem	Total
2019-20	171	80	227	27	505
2020-21	157	48	233	28	466

9.7 Sexual Health

Alcohol and other drug use can lead to riskier behaviours as judgement is clouded and inhibitions are lowered. This can include risky sexual behaviour and /or increased risk being

a victim of sexual violence and exploitation. potentially leading to exposure to sexually transmitted infections, blood borne viruses as well as unplanned pregnancies[104].

A sexual health needs assessment is currently being undertaken and key headlines from the document will be included here once it has been published.

9.8 Recommendations

1. Work with local health commissioners, and other Local Authorities, to ensure the prevention of substance use is prioritised in the delivery of physical and mental health services.
2. Provide holistic, person-centred treatment and support that addresses any needs in relation to housing, unemployment, child safeguarding, mental health etc.
3. Re-define, and strengthen resilience in, the multi-agency city-wide approach to addressing harmful use of alcohol and other drugs amongst at-risk groups and those with complex needs, such as the homeless.
4. Strengthen support for emotional and mental health conditions in Bristol, reflecting the impacts of the Covid-19 pandemic on unemployment, social isolation etc., and the effects on drug and alcohol behaviours.
5. An alternative to traditional supported housing must be explored for Bristol clients in need of alcohol or drug treatment to receive specialist support that includes their housing need.
6. Promote harm reduction on-street offer for people sleeping rough and using substances.
7. Reduce level of unused bed spaces (voids) in Bristol substance use supported housing provision (Homelessness Pathway 4).
8. Further analysis of the impact of alcohol and other drug use on; infectious disease such as iGAS, MRSA, HIV and social care need to be explored and included in future iterations of this document.

10. Commissioning Treatment and Support Services in Bristol

10.1 Clinical Guidelines for Drug Treatment Services

The drug use and dependence UK guidelines on clinical management prepared by Clinical Guidelines on Drug Misuse and Dependence were last updated in 2017. Local commissioners and providers have a responsibility to develop services that enable the guidelines to be applied. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities.

UK guidelines for the clinical management of drug misuse and dependence were last revised in 2007. Since then, there have been developments in the evidence for drug treatment, in the demands on services and in the treatment delivered. These developments include:

- an ageing cohort of those with heroin dependence in treatment needing a focus on improving their morbidity and mortality

- legislative changes to allow non-medical prescribers to assess, diagnose and independently prescribe for the treatment of drug dependence

- emerging risks from new psychoactive substances and changing patterns of drug use, and the need to address new needs of diverse populations

- a more explicit focus on individually defined recovery journeys with an enhanced focus on key-working and care planning that integrates support for pharmacological and psychosocial interventions, and peer engagement and mutual aid.

10.2 Commissioned Drug and Alcohol Treatment Services in Bristol

In 2017, Bristol commissioned a multi-agency joined up service known as Bristol ROADS (Recovery Orientated Alcohol and Drugs service). The contract is for 5 years from 1 April 2018 until 31 March 2023 with the option of a 2 x 2-year extensions. This year we enacted the first 2-year extension, from 2023-2025.

Bristol ROADS, costs around £6.5 million per year and is a joined-up service of 3 main partners.

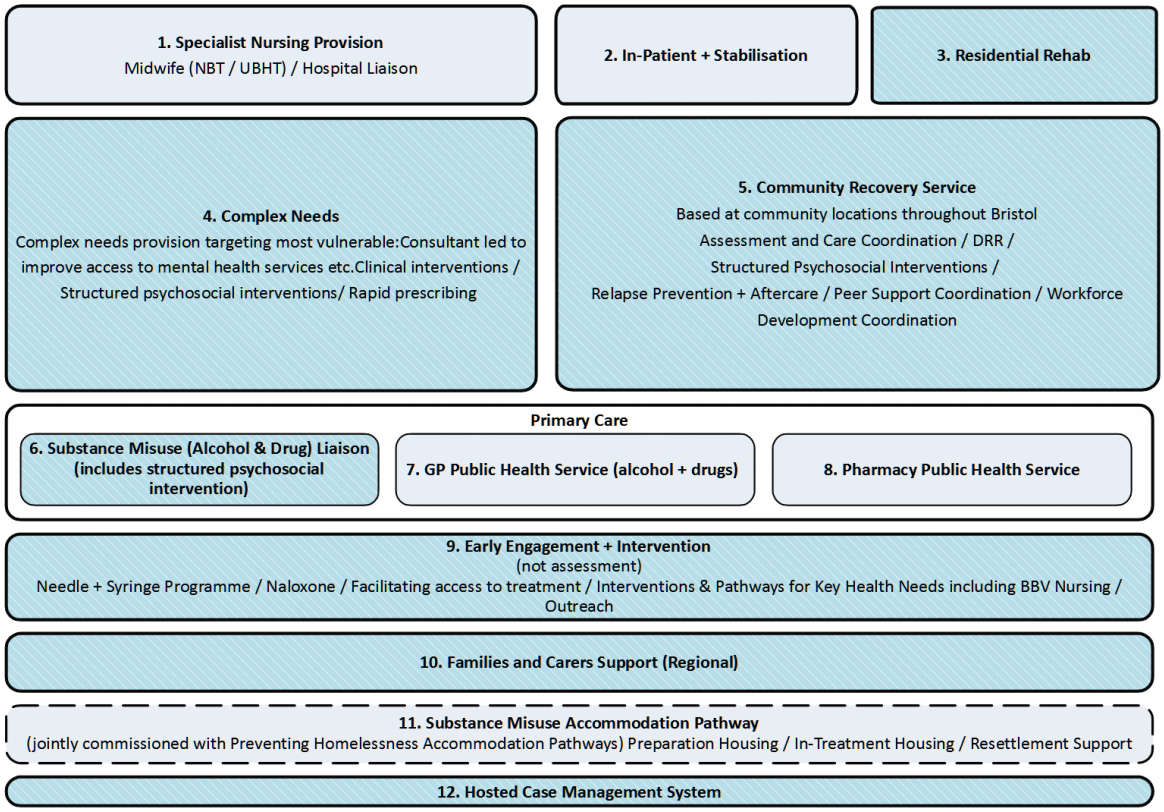
- BDP (Bristol Drugs Project)
- DHI (Developing Health and Independence)
- Avon and Wiltshire Mental Health Partnership NHS Trust

ROADS provides general drug and alcohol use advice, advice on detoxing, residential rehabilitation or getting an opioid substitute prescription, harm reduction advice, a needle exchange, nursing support including wound care, naloxone supply and blood-borne virus support.

10.3 Bristol ROADS Model of Delivery

Bristol ROADS offers a single point of contact for a range of medical and psychological treatment and support options, delivered through a consortium of specialist organisations. There is also a targeted provision for individuals from underserved populations with complex needs. The existing model can be seen in Figure 29. below.

Figure 29. Existing model of ROADS Services



10.4 Overview of Service Provision

10.4.1 Specialist Nursing Provision

This service is provided by:

<u>The Substance Use Support Team (SUST) within Bristol City Council.</u>
They provide specialist support for those experiencing substance and accommodation issues.

<u>One 25- Specialist Substance Use Worker</u>
They are commissioned to provide a Specialist Substance Use Worker to support women engaged with One25 who have substance use support needs.

<u>Nelson Trust</u>
They provide specialist vulnerable support for women and can refer them into structure substance use treatment and support.

<u>Midwifery Specialist Support</u>
They provide specialist midwife support to parents, prenatally and antenatally. This service is delivered in the community by AWP and at St. Michael's, UHBW.

10.4.2 In-Patient and Stabilisation

The main service is offered through the ACER Unit delivered by AWP, and we also have one bed available through a consortium at Broadway Lodge (rehab and detox provider in Weston Super-Mare).

These services provide a clinically safe inpatient detoxification or stabilisation regime for the most complex individuals whose needs cannot be met in the community or through a residential rehab detox. The ACER Unit is modelled on a planned regime of 24-hour; medically directed evaluation, care and treatment of substance related disorders in an acute care inpatient unit at Southmead Hospital, North Bristol.

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

10.4.3 Residential Rehab

Residential treatment is a well-established, high intensity intervention and recommended in UK guidelines on clinical management for those who may be seeking abstinence, have experienced multiple previous failures at sustaining abstinence, and have significant comorbid physical/mental health and social care problems[105].

Residential treatment is an integral part of a recovery-oriented system of care. It is recommended that all drug and alcohol practitioners discuss residential treatment openly, without bias and present it as part of a menu of treatment options that are available to clients. Assessment for residential treatment should be available and offered to everyone that meets the local eligibility criteria and has the desire to benefit from treatment in a residential setting.

The Inclusion Health team at Bristol City Council contract residential treatment providers via a procurement framework and we currently have approximately twenty providers on the framework to support a variety of needs.

DHI are commissioned to deliver the co-ordination of residential rehab assessment support, referrals, decision making, approval, placement and case management of residential placements within the ROADS system.

10.4.4 Complex Needs

This service is provided by the Specialist Advisory Service at AWP which includes a:

- Consultant Psychiatrist and Clinical Lead for ROADS
- Clinical Psychologist
- Specialist Social Worker and Safeguarding Lead for ROADS

Consultant Psychiatrist and Clinical Lead for ROADS Role:

This is a consultant-led specialist advisory service, which alongside specialist treatment aims to support the management of clinical complexity across the entire ROADS treatment system, in a sustainable way. The specialist advisory service aims to offer specialist addiction treatment expertise to all ROADS service users and not just those being treated within the complex needs service.

The service is on offer to all GP's, treatment partners, and their staff across ROADS, along with secondary physical and mental healthcare specialists, social care staff and their teams. The service offers telephone advice and support around specialist prescribing and clinical management. This service plays an essential role in supporting the delivery of alcohol & opiate detoxification and Opiate Substitution Treatment (OST) in primary care alongside the substance misuse liaison service (previously Shared Care).

Clinical Psychologist Role:

This service offers:

- Key working
- Prescribing
- Psychological intervention
- Medical assessment
- Guided self-help for mental health problems
- Trauma informed interventions
- DBT informed interventions
- Psychological formulation that leads care

10.4.5 Community Recovery Service (CRS)

This service is delivered by DHI, and the service includes:

- Psycho-social interventions, including – group work and one to one's.
- Peer support service & training opportunities to become a peer.
- SPOC (Single Point of Contact) - Take referrals, assess clients, answer general enquiries.
- Transitions Service – Specialist role supporting young people to transition from children & young people's services into adult services.
- Residential Rehab Specialist Support – Assess and case manage people throughout the process of residential rehab treatment.
- Workforce Development – Ensure that training and learning opportunities exist across the ROADS workforce and wider stakeholders.
- Criminal Justice Interventions Team – Offer treatment and support to those involved with the criminal justice system. Interventions include psycho-social interventions including group work and one to one's. Also, pre prison release planning and partnership working with the Probation Service and courts
- Responsible for delivering 'out of court' disposal orders; MHTR, ATR and DTR.

10.4.6 Substance Misuse Liaison

This service is delivered by BDP who are responsible for delivering:

Opiate Substitute Therapy (OST), often referred to as 'Shared Care'
This is delivered from forty-one of the forty-two GP practices across the city. There are approximately 1,800 people using this part of the Substance Misuse Liaison service at any one time.

Community Alcohol Detox Offer
This is a community detox offer, though not offered by all GP practices.

The GP is responsible for prescribing and clinical oversight of the patient. The Substance Misuse Liaison (Shared Care) worker is responsible for psycho-social interventions and support.

There are some additional subcontracting arrangements with BrisDoc, Homeless Health Service and After Prison Prescribing Service (APPS) for additional OST prescribing.

10.4.7 GP Public Health Service

This service is delivered by Homeless Health who are responsible for:

- Wet Clinic: Offers walk in GP appointments and nurse care to those who are alcohol dependent and not registered at a GP practice in the city. Referrals to ROADS and other appropriate services.
- Buvidal Pilot: Prescribing and administering Buvidal for up to forty people from specific cohorts across the city. Additional psycho-social support to run alongside.

10.4.8 Pharmacy Public Health Service

- We commission a number of pharmacies in Bristol to delivery supervised consumption of OST and provision of needle exchange. They are paid per delivery.

10.4.9 Early Engagement and Intervention

This is predominantly a harm reduction service for those using drugs and alcohol. This service is delivered by BDP who are responsible for:

- Needle exchange at BDP Brunswick Square and several pharmacies across the city
- Naloxone provision and training
- Blood Borne Virus testing and other health interventions including respiratory and renal screening
- Specialist nurses delivering wound care and harm reduction advice
- Advice and information
- A presence at events across the city including Pride, Love Saves the Day and other festivals.
- Outreach
- In reach

- Rapid reengagement for clients who have dropped out of treatment within the last twenty-one days.

10.4.10 Families and Carer's Support

This service is delivered by DHI who:

Work with adults who are affected by someone else's substance use, including family, carers, close friends and significant others. They offer help and support to these people, sometimes referred to as 'affected others', to learn more about substance misuse and treatment, and give them new skills to better cope with problems as they arise. The service also offers opportunities for peer support and promote 'affected others' involvement in treatment services where appropriate.

10.4.11 Substance Misuse Accommodation Pathway

This service is referred to as Pathway 4 Housing and delivered by Ara who provide:

- Specialist substance use supported housing across the city
- Specialist accommodation floating support for and dual diagnosis support across the city

10.4.12 Hosted Case Management System

We pay for the license for Theseus which is the case management system for our specialist treatment and recovery services and is hosted by Bristol City Council.

10.4.13 Additional Non- Commissioned Support

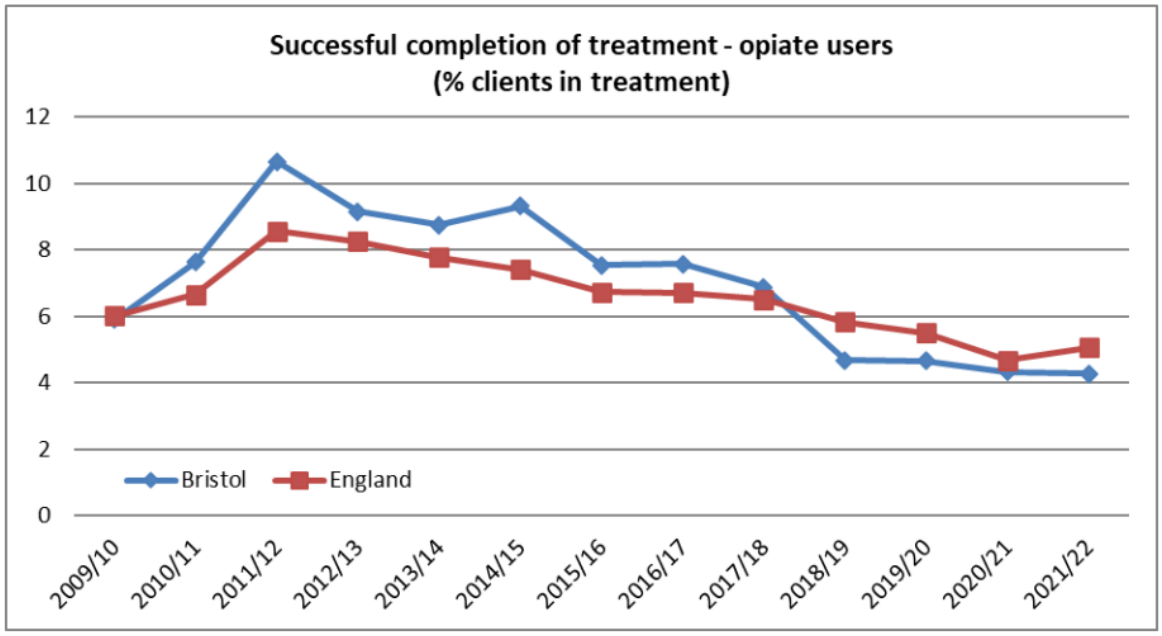
Bristol also has a significant 'Recovery Community'. This includes mutual aid and faith-based organisations that offer support with substance use. These include:

- Alcoholics Anonymous
- Narcotics Anonymous
- Cocaine Anonymous
- SMART Recovery
- Believers in Recovery
- Celebrate Recovery
- Life Recovery – InHope/Crisis Centre Ministries

10.5 Treatment Completion Data

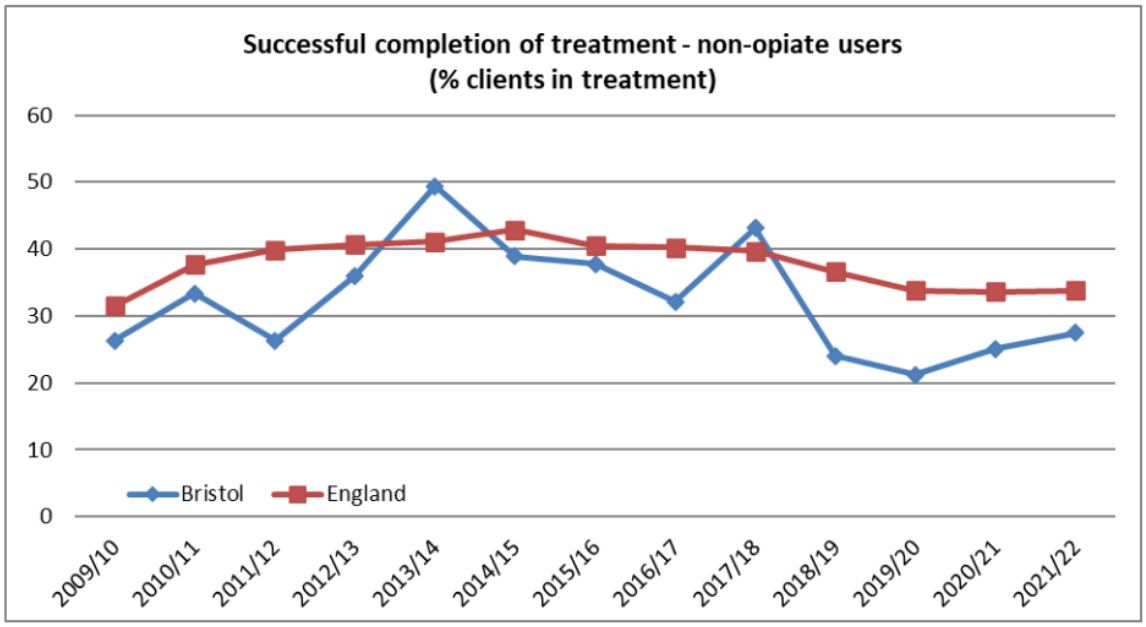
In 2021/22, Bristol had approximately 2,390 clients in treatment for opiate use, 595 for alcohol use, 300 for Alcohol and Non Opiate and 220 for Non-Opiate. The percentage of opiate drug users that left drug treatment successfully and did not re-present to treatment within 6 months has been falling in recent years and by 2021/22 was down to 4.26%, below the national average (5.06%) in Figure 30.

Figure 30. Treatment success rates – opiate; Source National Drug Treatment Monitoring System (Jan 23)



The success rate for non-opiate users (who left drug treatment successfully and did not re-present to treatment within 6 months) was 27.47%, lower than the national average (33.84%) as can be seen in Figure 31.

Figure 31. Treatment completion rates – non-opiate users; Source National Drug Treatment Monitoring System (Jan 23)



11. Bristol Drug Market, Alcohol and Other Drug Related Crime

11.1 Introduction

Drugs, alcohol and crime form part of a complex relationship. This in part because alcohol and other drugs use can affect a person's judgement and self-regulation and some people end up locked in a cycle of addiction, offending and criminalisation. Drug related health and associated harms in the UK are at their highest, and Bristol is no exception.

In order to understand the landscape of drugs and crime it is important to understand contributing factors such as poverty, trauma and deprivation. There is strong evidence that drugs, trauma and neighbourhood deprivation are linked[106] and this analysis will aim to identify the geographic footprint of drug and alcohol related crime in Bristol. In environments where resources are limited, and social exclusion is high, crime flourishes. Alcohol and other drugs can lead to people making bad choices in the moment, but continued investment in innovative diversionary approaches[107] which recognise this and seek to rehabilitate rather than punish will lead to longer term benefits for individuals, families, and neighbourhoods in Bristol.

11.2 Bristol Drug Market - Problem Profile 2020-2021

Avon and Somerset Constabulary published a review of the illegal drug market in Bristol in May 2021. This provides a strategic assessment of the class A and B drugs markets across Bristol including:

- The number of people who use drugs and the amount of money spent on drugs in Bristol
- Long term trends in problematic drug use and emerging patterns of other use.
- The prioritisation of Police resources and identification of key drug markets.
- Organised criminal gangs, individual suppliers and facilitators involved in Bristol's drugs markets.
- The impact of drugs markets on the Bristol's crime levels and the links to violent crime.

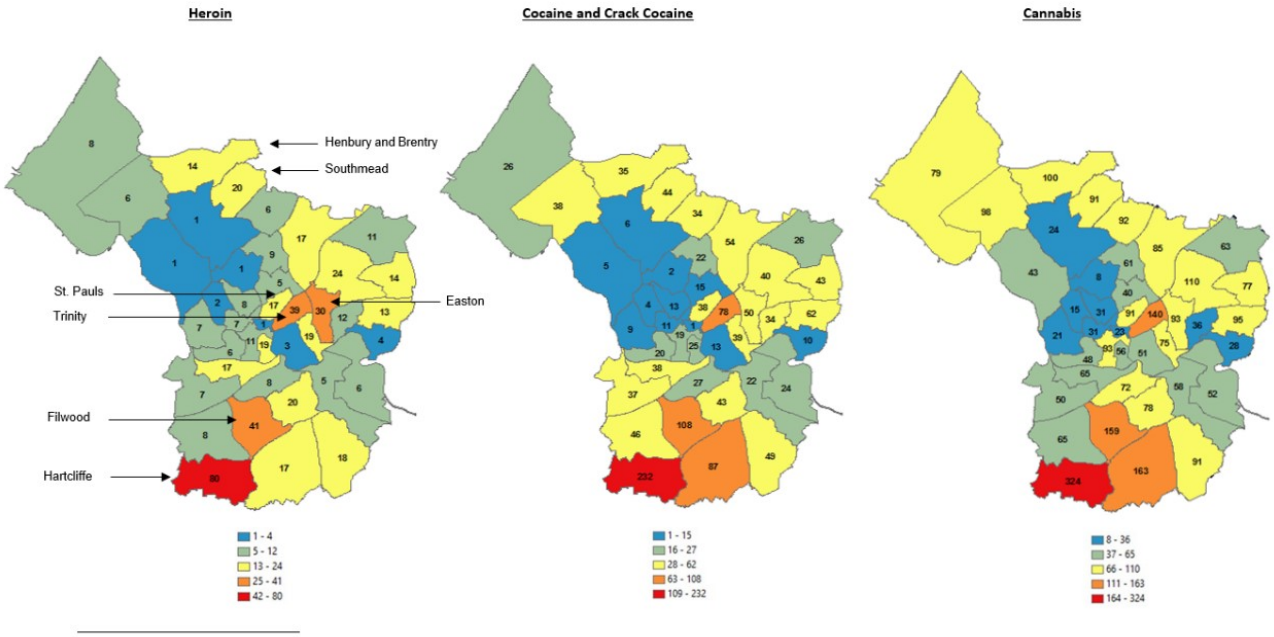
Key Findings from the Report are as follows:

- People who use opiates and/or crack cocaine in Bristol are estimated to spend approximately £108 million on the drugs each year. This sum is significantly higher than in comparable core cities such as Manchester and Sheffield.
- The highest proportion of Bristol's population who use opiates and/or crack cocaine live in the wards of Lawrence Hill, Hartcliffe and Withywood and Filwood.
- Bristol's most entrenched drugs markets include the *closed*[1] markets of Hartcliffe and Filwood in South Bristol and Southmead and Henbury/Brentry in North Bristol - and the *open* markets in St Pauls and Easton.
- The former markets are thought to be controlled by an older generation of individual wholesale dealers who exploit younger males to deal drugs at retail level. They are well established and difficult to change. The latter are thought to be controlled by

organised criminal gangs who import class A drugs and launder their proceeds in legitimate businesses.

- Only a small proportion of serious violent crimes are tagged as drugs related and the trend for drug related violent crime has remained stable over the last four years.
- Nevertheless, serious violent crimes such as murder, grievous bodily harm and wounding geographically correlates to Bristol's most entrenched class A and B drugs markets.
- Organised criminal gangs control the recreational cocaine market in Bristol and supply to other areas of the Avon constabulary footprint outside of the city. These gangs are thought to be diversifying into wholesale cannabis production, which has been related to human trafficking and modern slavery.

Figure 32. Three Main Classes of Drugs in Supplied in Bristol at Ward Level (01/03/20 to 28/02/21)



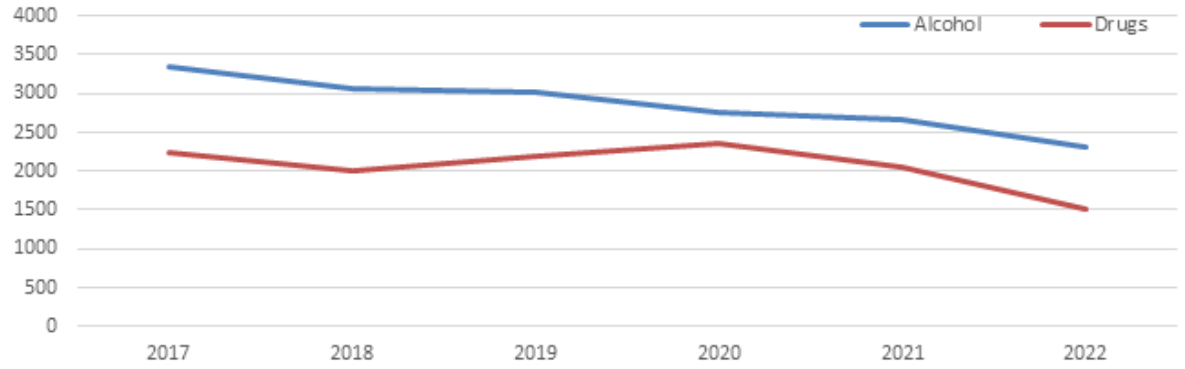
[9] Maps are based on a combination of incidents, intelligence and webstorm logs pertaining to the three main classes of drugs. Key words were used in the MO fields and logs to extrapolate as much data as possible. In addition, see Appendix B for a map of Bristol showing all of the beats labelled.

11.3 Prevalence of Alcohol and Other Drug Related Crime in Bristol

The total crime rate of England and Wales in 2020/21 was 105.5 crimes per thousand population[108]. This represents the highest crime rate in more than ten years. In Bristol, the crime rate is slightly higher than the England and Wales average at 111 crimes per thousand population. Rates of crime in Bristol have remained fairly stable for the last five years, decreasing during the pandemic before returning to pre-pandemic levels in late 2021.

Figure 33. below shows all crimes recorded in Bristol *where drugs or alcohol are linked to the offending behaviour*. This indicates that both alcohol and other drug related crime is falling since 2017, from 3337 alcohol related crimes recorded in 2017, to a predicted 2321 in 2022. Drug related crime follows a similar trajectory, declining by 33% over a five-year period. Avon and Somerset Police classifies alcohol and other drug related crime to include drug offences such as possession and supply, but also any other crime in which substances played a role e.g., including assault, burglary, driving offences and similar.

Figure 33. All Crimes in Bristol Linked to Alcohol or Drug Use



Source: Avon and Somerset Constabulary

11.4 Alcohol and Other Drug Related Crime during the COVID-19 pandemic

Despite the national lockdowns imposed by the government due to the COVID-19 pandemic, drug markets in Bristol remained resilient, and the use of many types of drugs continued.

Figure 34. shows the trend for the number of people arrested for the supply of class B drugs slightly increased between March 2020 and February 2021 in comparison for the previous year (+36 offences) and represents a 23% increase in the proportion of those arrested.

Meanwhile, more striking is the upward trend in arrests for the supply of class A drugs with an increase of 160% (+140 offences) between 2020 and 2021 in comparison for the same period between March 2019 and February 2020.

It is interesting to note that peaks in arrests for both class A and B supply offences correspond to periods when the UK was subject to the national COVID-19 lockdowns, suggesting that the lockdowns did not deter offenders from dealing and that the demand for illegal drugs in Bristol, specifically class A, remained. It should be noted that arrests can also be the result of increased police proactive activity (and in lockdown periods evading law enforcement was more difficult due to the restrictions in place).

Figure 34. Number of arrests in Bristol for the Supply of Class A drugs and Class B drugs between March 2019 and February 2021

Key: Class A drug supply — Trend ····· Class B drug supply — Trend ·····
Periods when the UK was under lockdown ←→

11.5 Drug Related Crime by Substance Type

Figure 35. displays the number and proportion of total drug arrests for heroin, cocaine and crack, and cannabis in Bristol between March 2017 and February 2021.[2] The percentage of people arrested for the possession and/or supply of heroin[3] account for only a small proportion of all Bristol drug arrests and has remained relatively unchanged over the last four years.

The proportion of people arrested for heroin offences dropped to 2.6% (12 offences) in March 2019 - February 2020 in comparison to 6.1% in 2018-2019, before rising to 4.3% (27 offences) in 2020-2021. In contrast, the number of people arrested for the possession and/or supply of cocaine and crack cocaine more than doubled from 52 to 126 between 2019-20 and 2020-21 when it accounted for a fifth of all drug arrests.

Finally arrests pertaining to possession and/or supply of cannabis accounted for approximately 47% of all drug arrests in March 2017-February 2020. In 2020-21, although the number of arrests for possession and/or supply of cannabis increased, this accounted for 11.8% less of the total drug offences compared to the previous year.

Figure 35. Number of arrests and proportion of total drug arrests for heroin, cocaine and crack cocaine, and cannabis possession and supply in Bristol from March 2017 - February 2021

Year	Heroin	%	Cocaine & crack	%	Cannabis	%	All drug arrests
Mar 17 - Feb 18	25	5.9	65	15.4	198	46.8	423
Mar 18 - Feb 19	24	6.1	51	13.0	184	46.8	393
Mar 19 - Feb 20	12	2.6	52	11.4	219	47.8	458
Mar 20 - Feb 21	27	4.3	126	19.9	228	36.0	633

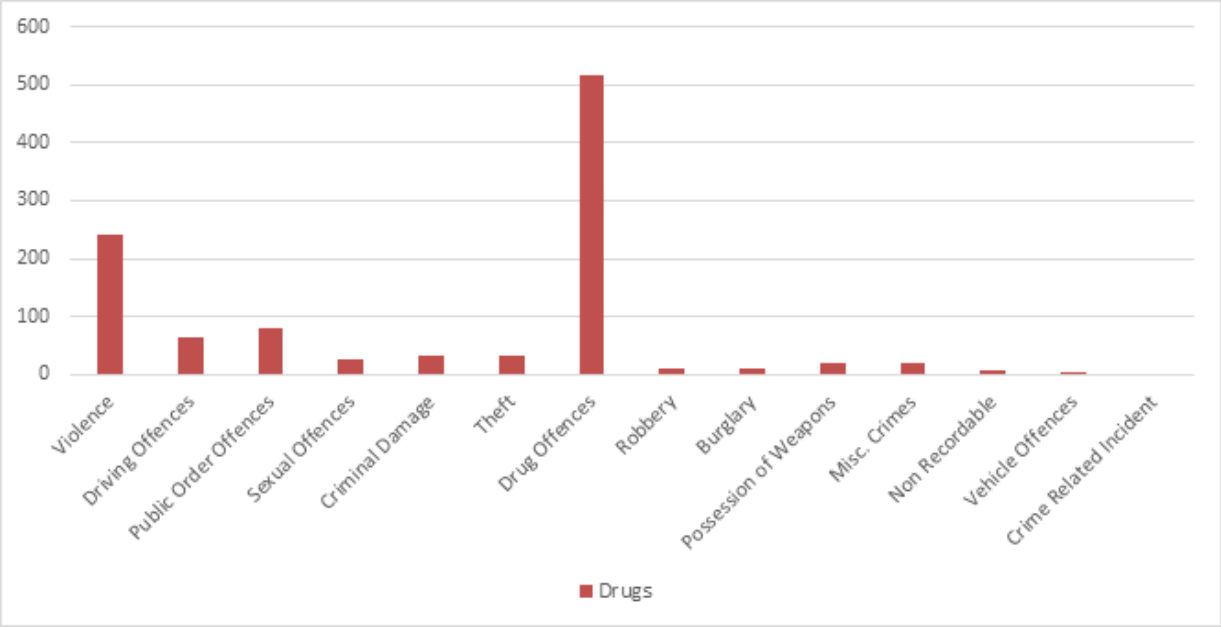
11.6 Type of Alcohol and Other Drug Related Crime

The graph below shows alcohol and other drug related crime in Bristol in 2022[109] by offence type, as classified by Avon and Somerset Police. Alcohol and other drugs are primarily linked with violent crime in Bristol which makes up 57.2% of all alcohol linked offences, and 49.7% of drug related crimes[110], followed by public order offences for both alcohol and drugs.

Sexual offences make up 5% of alcohol linked crime, while the next most prevalent category in drug related crime is 'Arson and Criminal Damage' which makes up 6% of drug related crime. There were almost 900 recorded violent crimes involving alcohol between January and August 2022, across the same period drugs were involved in around 250 violent crimes.

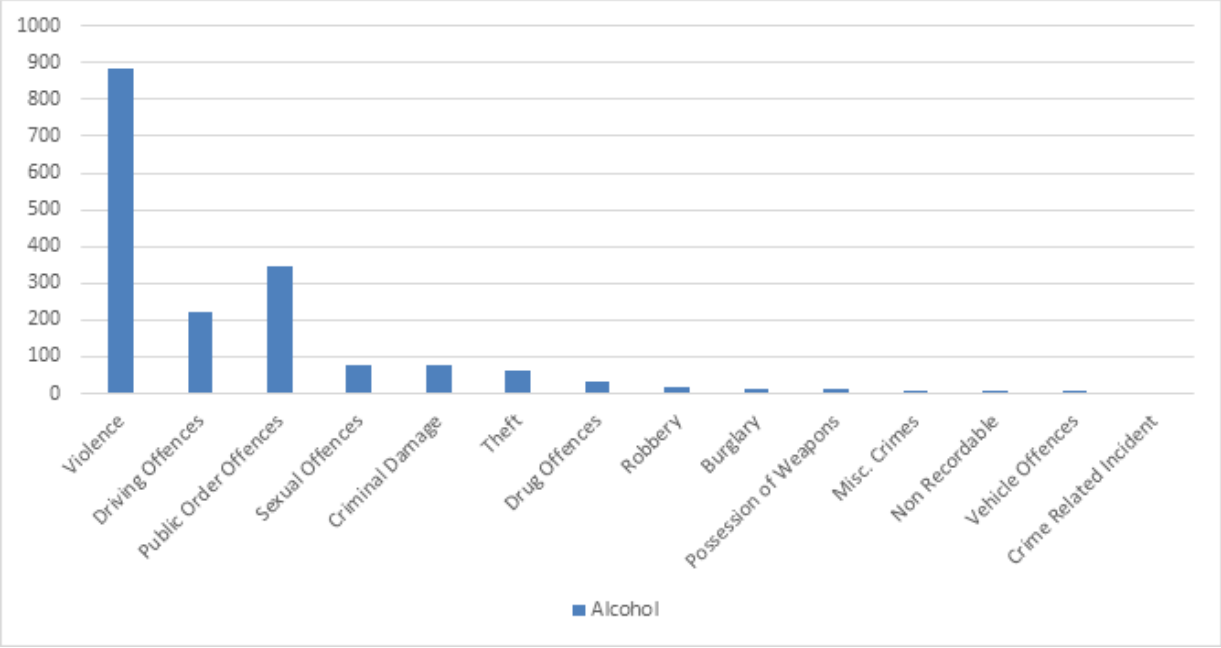
Some caution should be taken with defining whether an offence is related to alcohol or drugs as it is not always obvious. Other quantitative data includes results from drug testing in custody, approximately 60% of the arrests for theft, burglary, Class A possession or Class A supply test positive for cocaine or opiates which is consistent with the national picture. Alcohol is not tested for (other than for drink driving offences).

Figure 36. Bristol Drug Related Crime by Category in 2022



Source: Avon and Somerset Constabulary

Figure 37. Bristol Alcohol Related Crime by Category in 2022



Source: Avon and Somerset Constabulary

11.7 Alcohol and Other Drugs linked to Serious Violent Crime in Bristol

Murder, grievous bodily harm (GBH) and wounding, are regarded as serious violent crimes against a person (SVAP) and harassment, slavery and assault without injury are regarded as violent crimes against a person (VAP).

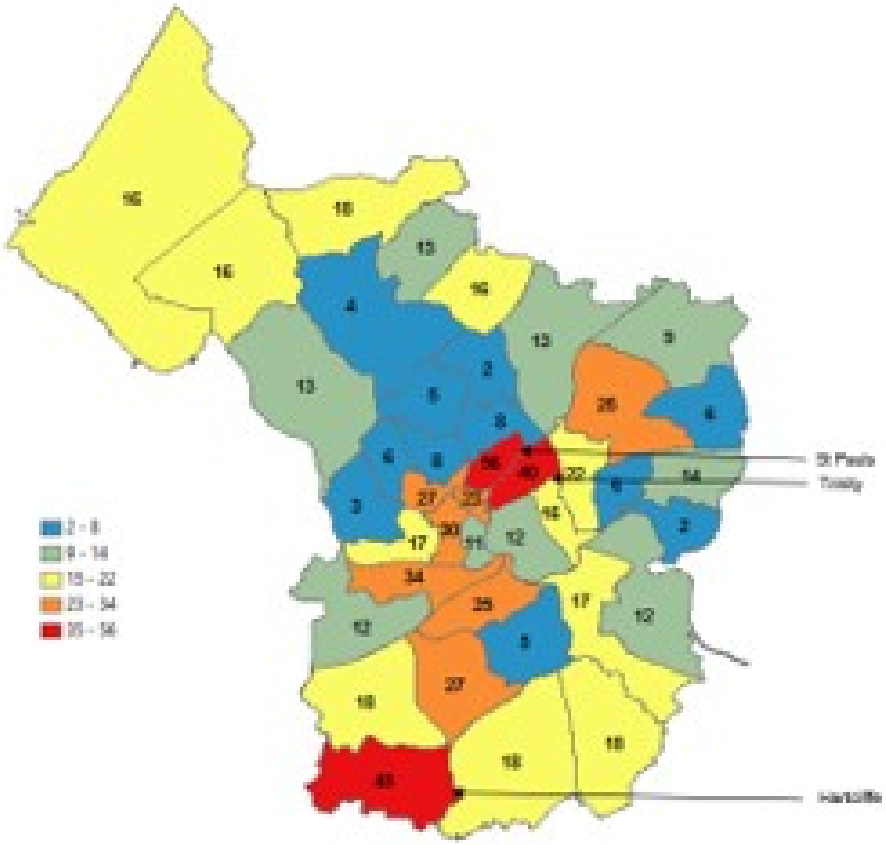
Figure 38. shows that only a small proportion of all offences that involve VAP and SVAP in Bristol are tagged as being 'drugs' related, and rates have remained fairly stable for the last four years. Between March 2020 and February 2021, the proportion of VAP offences recorded by Avon and Somerset Police as being linked in some way to 'drugs' was 3.5% and was the highest proportion over the last 4 years. However, it is interesting to note that the proportion of SVAP offences involving drugs is higher than that for VAP and accounted for 7.9% of all SVAP offences committed in Bristol in 2020/21. There is a seasonal pattern to offending with small relative peaks in activity in December and June/July.

Figure 38. The number and proportion of VAP and SVAP offences recorded as 'Drugs Delated' between March 2017 and February 2021

Year	VAP	%	SVAP	%
17/18	491	3.2	21	4.7
18/19	465	2.9	33	7.3
19/20	514	3.1	28	5.9
20/21	534	3.5	26	7.9

The number of serious violent crimes recorded as being related to drugs are committed in areas of Bristol that correspond to Bristol's primary class A and B drug markets. This is demonstrated by the map in Figure 39. which shows the number of these offences recorded in different areas between March 2017 and February 2021. The markets associated with the most serious harms in terms of violence and threat to life are St. Pauls; Trinity and Hartcliffe.

Figure 39. Where Drug-Related Serious Violent Crimes have been committed in Bristol between 01/03/17 and 28/02/21

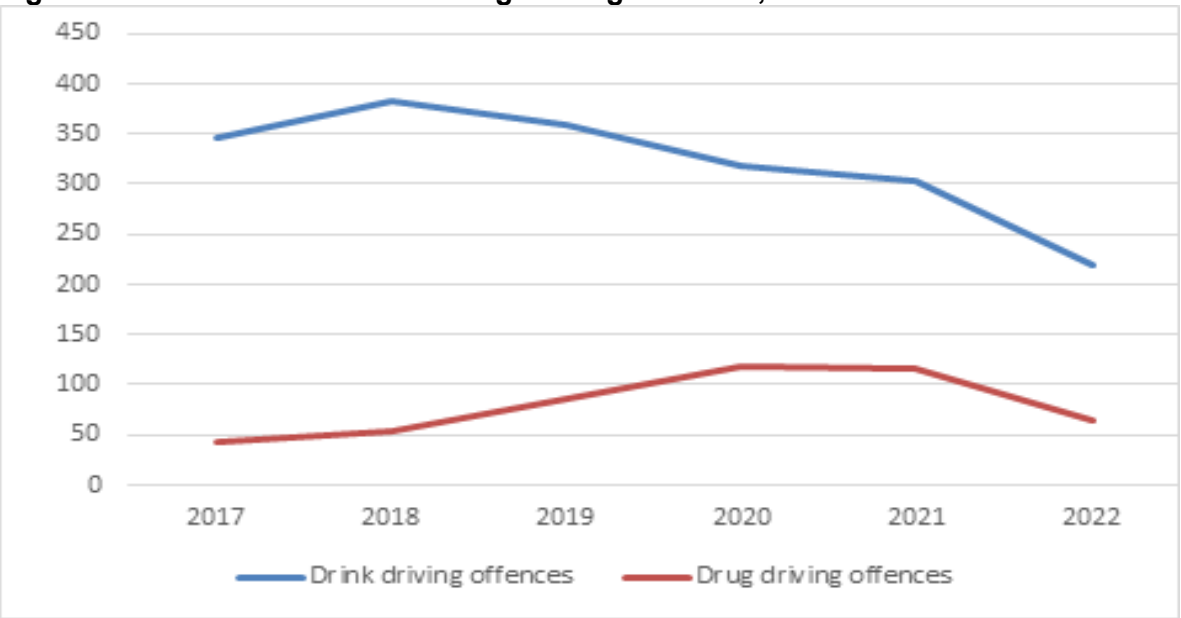


11.8 Drink Driving and Drug Driving Offences

A criminal conviction for driving under the influence of alcohol or drugs can result in imprisonment, a driving ban and / or a fine, usually determined by the Magistrate's Court. In some cases, if banned from driving for 12 months or more, there is an offer to undertake a drink-drive rehabilitation scheme (DDRS) course.

Rates of alcohol and other drug related driving offences have been declining since 2018 potentially due to the impact of public health messaging and perceived social unacceptability. However, this may also reflect reduced reporting, as capacity for drink driving enforcement has reduced during this time[111]. The number of Bristol residents arrested for drink-driving offences from 2017 to 2022 can be seen in Figure 40. below.

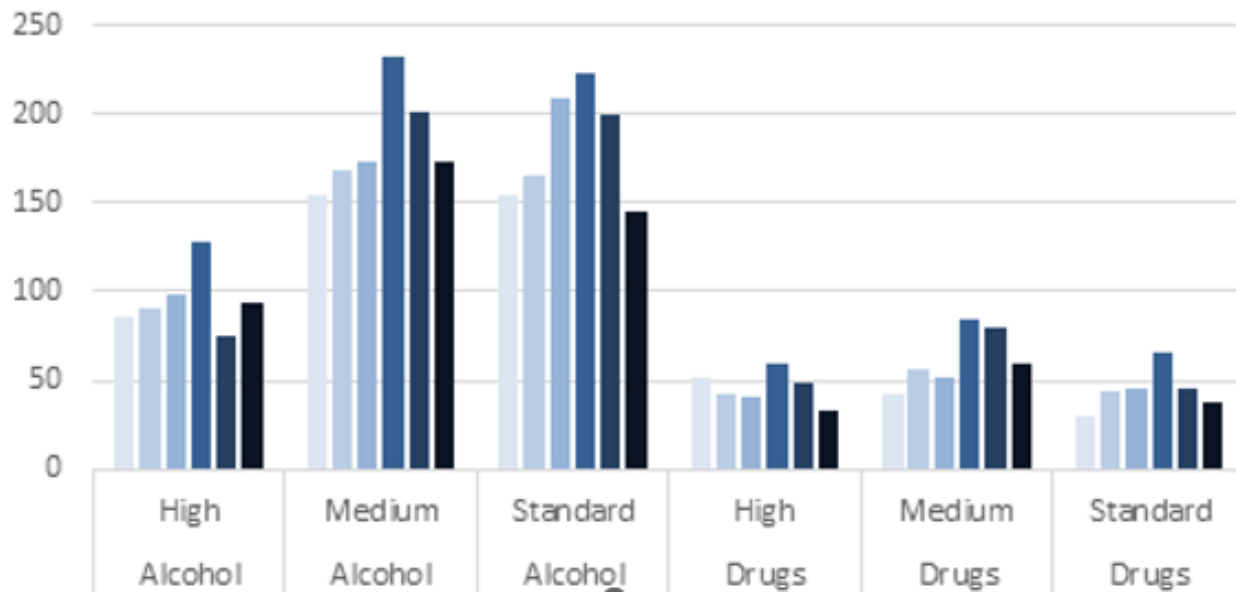
Figure 40. Number of Drink and Drug-Driving Offences, 2017-2022



11.9 Domestic Abuse, Stalking, and Honour Based Violent (DASH) Crimes Surveillance

The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model is used to assess and manage risk in cases where women and children are more likely to be killed. Figure 41. shows high, medium and standard risk categories and the number of cases involving alcohol and drugs which appears to be increasing in the years up to the pandemic and falling since[112].

Figure 41. Number of Crimes recorded according to DASH Risk Level from 2017 to 2022



2017 to 2022

Source: Avon and Somerset Constabulary, 2022

11.10 Exploitation through County Lines and Modern Slavery

11.10.1 Country Lines

The 2018 Home Office Serious Crime Strategy states the National Police Chief's Council (NPCC) definition of a County Line is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas [within the UK], using dedicated mobile phone lines or other form of "deal line". They are likely to exploit children and vulnerable adults to move [and store] the drugs and money and they will often use coercion, intimidation, violence (including sexual violence) and weapons[113].

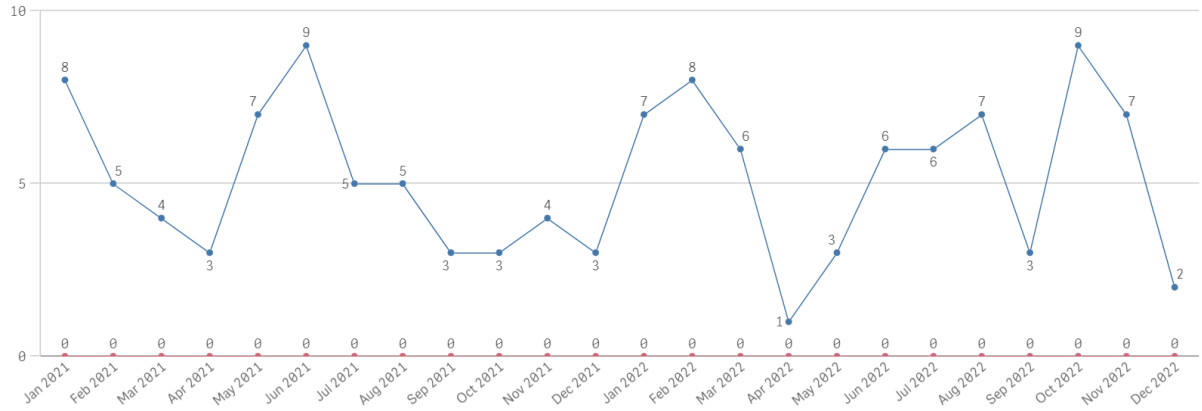
It is important to note that this can occur inside Bristol with both the organised crime groups and those they exploit to service the "deal line" both based inside the city.

11.10.2 Modern Slavery

The National Referral Mechanise (NRM) is a framework for identifying and referring potential victims of modern slavery. The prime reason for making an NRM referral is that someone has been coerced to supply drugs. Figure 42. below shows the number of NRM referrals made by Avon and Somerset Police in the two years. A total of 124 referrals were made during this time, with number of referrals fluctuating month to month with the highest numbers of referrals (9) made in May 2021 and October 2022. The lowest number of

referrals was 2, made in December 2022. 48% (53 referrals) were made for young people between the ages of 13 and 21 years old. Most referrals 36% were made for people who were white.

Figure 42. Number of NRM referrals made per month since Jan 2021

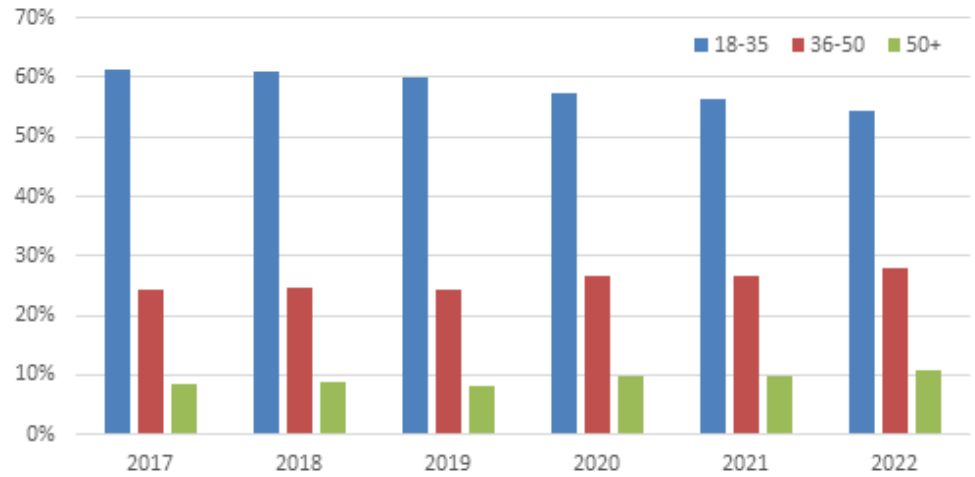


Source: Avon and Somerset Constabulary

11.11 Alcohol and Other Drug Related Crimes by Age

Figure 43. below shows that more than 55% of crimes related to alcohol and other drugs in 2022 were committed by people aged 18-35, 28% by people aged 35-50 and 11% by people aged over 50[114]. The proportion of crimes related to alcohol and other drugs committed by 18–35-year-olds has decreased slightly since 2017, from 61%. The proportion committed by 36–50-year-olds has increased over the same period, possibly reflecting the changing age structure of the cohort of people who inject drugs.

Figure 43. Drug and Alcohol Crimes by Age Group



Source: Avon and Somerset Constabulary, 2022

11.12 Alcohol and Other Drug Related Crimes by Locality in Bristol

Across the city most crimes related to alcohol and other drugs take place in urban, central locations, including the Old City Docks and Harbourside; the East, including St Paul's and Trinity, Stokes Croft and St Paul's; and the South, including Hartcliffe and Withywood. Figure 44. below shows the top 10 areas ranked by number of recorded drug or alcohol-related offences over a 5-year period.

Figure 44. Drug or Alcohol linked offences by locality, 2017 to 2022

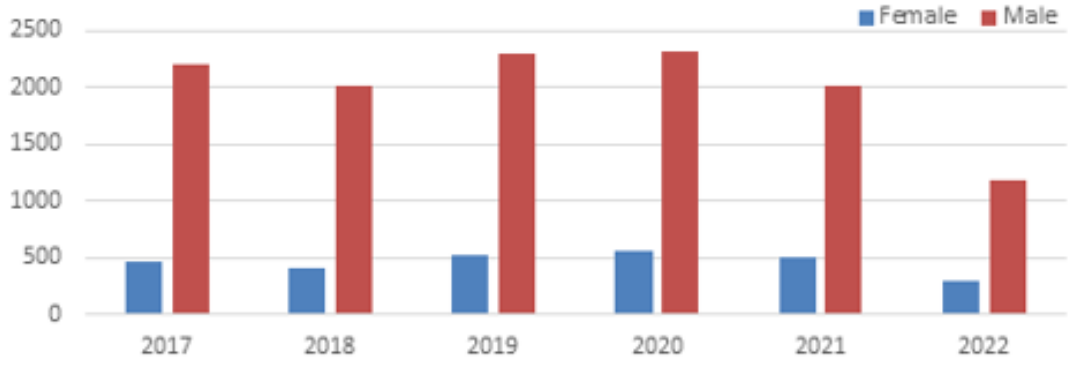
Rank	Area	Drug or Alcohol Linked Offences 2017-2022
1	Old City Docks	2664
2	Harbourside & Hotwells	2029
3	St Paul's	1375
4	Trinity	1287
5	Broadmead	1177
6	Stokes Croft & St Michael's	1117
7	Hartcliffe & Withywood	1052
8	Southville	1032
9	Easton & Redfield	874
10	Eastville	864

Source: Avon and Somerset Constabulary, 2022

11.13 Alcohol and Other Drug Related Crimes by Gender

The majority of drug and alcohol related crimes are committed by men in Bristol; in the last five years around four times as many crimes were committed by men than women [115]. The proportion has remained fairly consistent over this period, only varying by around 3%.

Figure 45. Crimes with a Drug or Alcohol Marker by Gender



11.14 Recommendations

1. There remain high rates of violent crime linked to alcohol use in East Central Bristol, Stokes Croft, Southville and Bedminster, and Hartcliffe and Withywood. Focused public health interventions around the night-time economy and alcohol use in these areas could support Policing efforts to address issues in these locations.
2. This analysis is limited, in that no information was available about the types of drugs involved in specific crime categories, and the characteristics of the people involved. Furthermore, the category 'Drug Offences' conflates both possession and supply – more could be known about possession, supply, types of substances involved in possession and supply and the characteristics of people involved in these offences.
3. Further engagement could be undertaken with young people involved in drug markets to understand more about personal and individual motivations and better design interventions to meet the needs of this group.
4. Target those areas in the city that are identified as having the greatest needs for enforcement (i.e., Lawrence Hill and Hartcliffe as well as some of the open street dealing involving children).
5. Strengthen our enforcement capabilities.
6. Maintain a good understanding of the areas of the most need and target those who exploit others.
7. Further analysis of drugs offences to be split by supply and possession to understand the characteristics of those who are involved in these offences as well as the substances involved.

12. The Criminal Justice System and Substance Use Treatment and Recovery Services

12.1 Introduction

The criminal justice services refer to arrest, courts and prison. An important consideration across the city is to ensure there is a clear and accessible pathway from criminal justice services into community-based substance use treatment services.

The 2021 Independent Review of Drugs by Dame Carol Black[116] highlighted that drug use in prison is driven by "a widespread sense of boredom, hopelessness and lack of purposeful activity". The same applies to many of the same people's lives once they leave prison. For treatment to be effective it must address a wide range of social issues: including access to physical and mental healthcare, meaningful activities, employment, opportunities to build prosocial relationships, creative skill building, trauma focused therapy, physical activities, access to housing and financial benefits, family interventions and much more. Bristol has some of the most deprived areas in the country[117], and predictably some of the highest levels of drug use in the country.

The Dame Carol Black Review recognised the cyclical nature of drugs and offending for many people: "Spending an average of £40 to £50 per day on drugs, these users cycle in and out of prison. Initiating treatment for this group has a rapid effect on reducing offending and alleviating some of the pressure on our prison system. Yet referrals from the criminal justice system into drug treatment have fallen sharply".

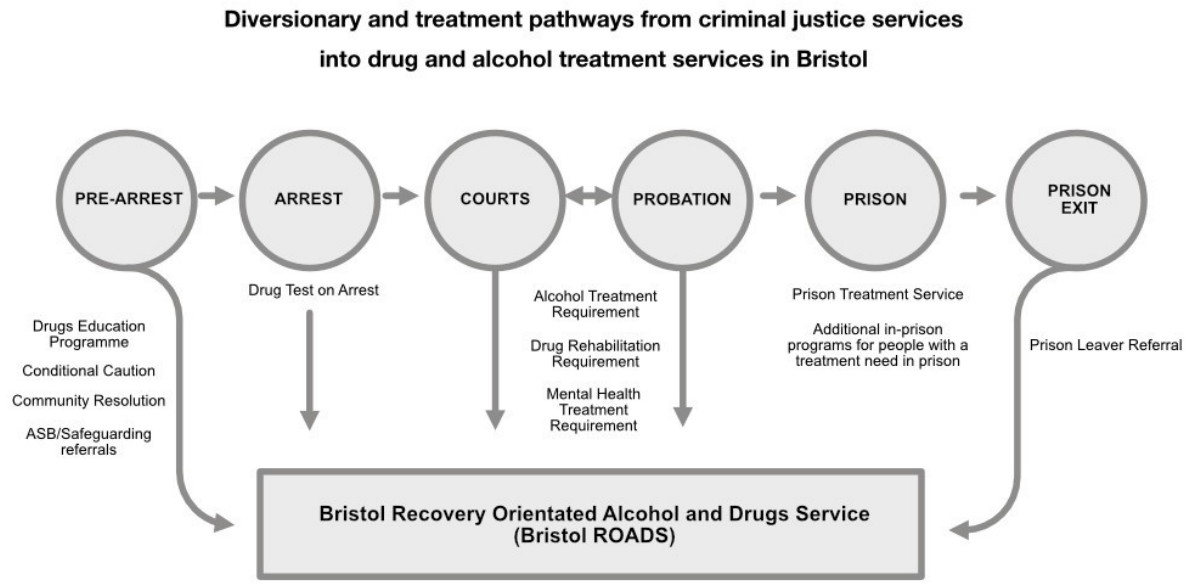
This mirrors the local landscape in Bristol where we have seen a drop in referrals from criminal justice services into community treatment services. In 2014, 14.7% of the total in-treatment population were referred from the Criminal Justice System, this dropped to 7.1% in 2019, and 6.6% by 2021[118]. In part this likely is due to disinvestment in criminal justice services in Bristol (as in many local authorities across the UK)[119].

Following the publication of the Dame Carol Black review in 2021, the Government committed to implement the many recommendations contained within the report, and following many years of disinvestment in addiction services, have now allocated new funding for drug and alcohol treatment to all local authorities in the UK. The first part of this funding, the Project ADDER grant was offered to those local authorities with the highest levels of need, which includes Bristol. Project ADDER (Addiction, Diversion, Disruption and Enforcement) is a two-year £4.9 million fund shared between Bristol City Council and Avon and Somerset Police designed to improve pathways between criminal justice services (including police, probation, courts and prison) and community treatment services. At the time of writing Bristol has completed the first year of the two-year program.

12.2 Pathways into Community Treatment Services

Figure 46. illustrates where in the criminal justice pathway where a person can be diverted/referred into community-based specialist drug and alcohol treatment services. Effective drug and alcohol treatment provided in prison is an important part of the wider picture but is excluded from this assessment.

Figure 46. Pathways from Criminal Justice Services into Drug and Alcohol Treatment Services in Bristol



Diversionary and Treatment Pathways from Criminal Justice Services in Bristol are carried out a number of stages where individuals can be diverted/referred into community-based specialist treatment services as follows:

12.3 Pre-Arrest- Diversionary Approaches[120]

An out of court disposal (OOCD) is a method of resolving an investigation for offenders of low-level crime and anti-social behaviour such as graffiti and low-level criminal damage when the offender is known and admits the offence. An OOCD can only be used in limited circumstances. Avon and Somerset Constabulary use a range of out of court disposals to deliver meaningful education, prevention or diversion programmes for some drug related offending.

In Bristol these programs include:

Drugs Education Program This is by far the most widely used OOCD for drugs offences. It is primarily aimed at those caught in possession of drugs and is an educational program that is free to access and if completed the criminal investigation is dropped. Around 300 people are offered this program per year with a 70% attendance rate.

Druglink This is an 'offender pays' drugs education course and used if the offender is not eligible for the drugs education program (i.e., they have already attended that, or it is not

their firsts offence). A conditional caution is issued with the condition to pay for and attend the course otherwise they would be charged to court for the offence.

Alcohol Awareness Similar to the above drugs education programme, but where alcohol use is a factor in the offending/

One25 Support This intervention is used in cases of soliciting and is a conditional caution to attend support sessions with the One25 Project, it is now rarely used as soliciting is rarely pursued criminally with good pathways to a range of appropriate services for women in place.

Project SHE Provided by the Nelson's Trust, this is a point of arrest diversion scheme for women in Avon and Somerset. SHE offers an opportunity for some women who have been arrested to avoid a charge, a court appearance and potentially a prison sentence by agreeing to engage with SHE and a range of support intervention around reducing reoffending.

Community Resolutions

A Community Resolution is the nationally recognised term for the resolution of a less serious offence or anti-social behaviour incident through informal agreement as opposed to progression through the traditional criminal justice process. They can be flexible and can include the above programs but also more informal approaches such as self-presenting to BDP or going on the 'Talk to Frank' website[121]. They are not enforceable and are an informal agreement.

Anti-Social Behaviour (ASB)/Safeguarding Referrals

Where a child or vulnerable person is at risk, a safeguarding referral is made which can ultimately lead to a multi-agency meeting to look at how best to safeguard that child/vulnerable person.

Where persistent drug related ASB is reported action may be taken using ASB legislation which can include positive requirements, civil orders and ultimately closure orders. Before this happens a multi-agency case conference occurs and supportive measures around promoting drug treatment are one of the priorities before a closure would be sought.

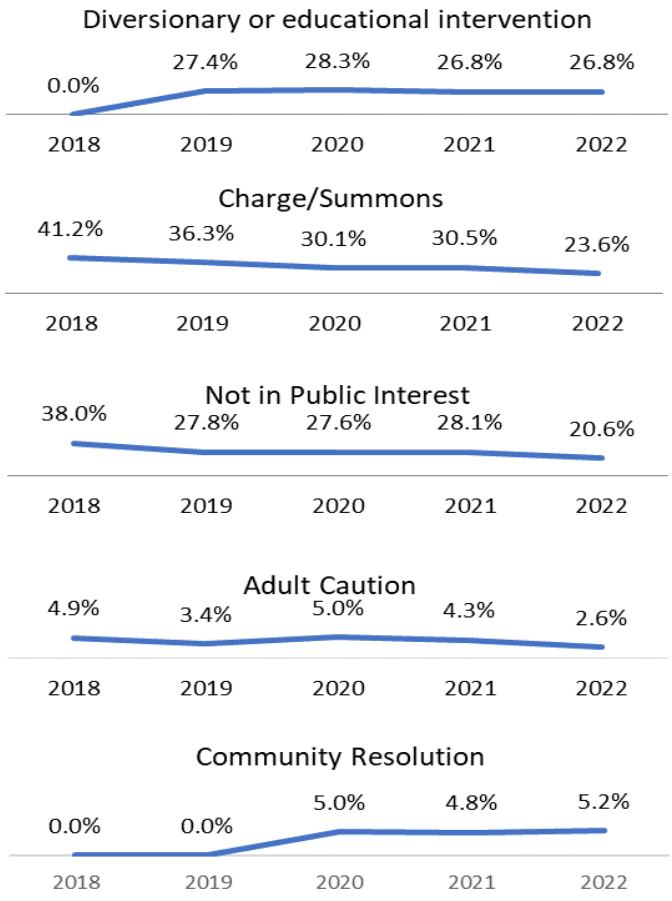
Alcohol tags

Since April 2021, courts have also been able to order offenders to wear an alcohol tag as part of a community sentence when their crime was driven by alcohol. The tag takes a sample of their sweat every 30 minutes and alerts the Probation Service if the offender has been drinking. By 2025 it is estimated that 12,000 offenders will have had their drinking monitored by the tags – part of the Government's £183 million expansion of electronic monitoring.

12.4 Diversionary Activity undertaken by Avon and Somerset Police and the Bristol Courts

Figure 47. below shows % of OOCD, charges and cautions issued by Avon and Somerset Police and the Courts since 2018, following arrest for possession or supply of drugs. It illustrates that there has been a gradual increase in the number of diversionary or education interventions and community resolutions while the number of charges, summons, cautions and cases not pursued in the public interest have all reduced since 2019 (the figures for diversionary/educational interventions were not captured prior to 2019). This is a positive trend and represents a move towards a public health approach to possession and supply of drugs. The use of diversionary approaches, since 2019 has remained steady, an average of 27% of outcomes per year, and more could be done to ensure that a wider range of diversionary approaches exist across the city.

Figure 47. Avon and Somerset Constabulary and Court Activities regarding Drug Related Offences



12.5 Drug and Alcohol Test on Arrest

Drug testing on arrest (DToA) has been used to various degrees nationally as a method to identify people who may have a drug treatment need, using the threat of more serious

sanctions as a motivator for treatment engagement. For example, after testing positive for drugs after being arrested, people can avoid being charged if they agree to engage with community drug treatment. There is some mixed evidence to suggest that the point of arrest can be an opportunity to prompt behaviour change and, DToA programs attempt to leverage this opportunity to support treatment engagement .

Nevertheless, many implementations of DToA fail to produce satisfactory outcomes, and are deemed to be unethical as they target the same small cohort of people from deprived backgrounds, who fail to engage in treatment, are further criminalised and remain locked in cycles of drugs, offending and prison. An internal report (not publicly available) written by the Bristol Office of the Police and Crime Commissioner in 2019 reviewed the use of DToA both locally and through interviews with a number of UK police forces in England and Wales. This report found DToA to be inefficient, expensive for police forces, delivering poor outcomes, and raising “questions of an ethical nature”. The report concludes that the process should be “removed in its entirety”. Below the table shows historical data around test on arrest in Bristol, it was not possible to determine how many of these people, were then engaged in treatment services.

Figure 48. Avon & Somerset Police – Bristol Drug Test on Arrest - August 2018 – 2019

No of detainees tested	No of detainees tested positive	No of detainees charged for breach of non-compliance of initial assessment	No of detainees charged for breach of non-compliance of follow up appointment
1852	1205 (65%)	19[122]	7

In 2021 following national guidance that all police forces should bring back DToA, Avon and Somerset Police are currently trialling an implementation which is aimed at supporting people to access specialist treatment, without punitive approaches for those who fail to engage. This pilot started in the second quarter of 2022, and an evaluation of this approach is expected towards the end of 2023.

From April to June 2022, Avon and Somerset police tested 200 people after being arrested in Bristol.

- 66% of perpetrators of theft offences tested positive for cocaine or opiates
- 50% of perpetrators of burglary offences tested positive for opiates or cocaine
- 51% of perpetrators of drug possession/supply offences tested positive for opiates or cocaine.

These statistics are consistent with the national picture[123]. Some additional offences may be related to drug use despite negative drug tests, either because of false negative results, or no recent drug use. Additionally, some crimes may be related to alcohol use, which is not tested for.

Of those 200 tested with positive results the majority were given an assessment in custody and offered a referral to community treatment services, 17 people took up this offer of a referral however only 2 attended. This approach is being looked at to try to improve those take up rates and collect more data.

12.6 Community Sentence Treatment Requirements (CSTR's)

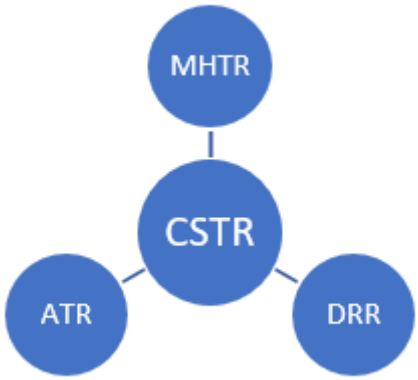
Community Sentence Treatment Requirements (CSTRs) is the collective name given to Court ordered Mental health Treatment Requirements (MHTRs), Alcohol Treatment Requirements (ATRs) and / or Drug Rehabilitation Requirements (DRR).

Many individuals who offend have underlying mental health problems and/or issues with drug or alcohol use that contribute to their offending behaviour.

CSTRs were introduced as part of the Criminal Justice Act 2003 to offer an alternative to custodial sentences for these individuals.

The aim is to reduce re-offending and short-term custodial sentences by addressing the underlying causes of offending. There is a particular focus on supporting women and individuals with learning disabilities into community treatment.

The image below shows how the three elements (ATR, DRR and MHTR) fit together under the CSTR umbrella.



A CSTR can be made when an individual has been convicted of an offence that crosses the Community Order or Suspended Sentence Order sentencing threshold - as long as the individual meets the eligibility criteria for the relevant requirement, and they express a willingness to comply with the requirement.

A Community Order is a sentence that will be carried out in the community, rather than in prison. A Suspended Sentence will initially be carried out in the community, but an individual can be sent to prison if they do not meet the requirements set out by the judiciary.

Magistrates and Judges follow national sentencing guidelines that provides sentencing ranges, which include guidance based on the seriousness and mitigating factors of an offence. These sentencing guidelines place Community Order offences into Low, Medium and High categories. The sentence given must be proportionate to the level of offence of which someone has been found guilty.

A CSTR can last a maximum of three years as part of a Community Order and two years as part of a Suspended Sentence Order, depending on the severity of the offence. The length of treatment will be set by the Judge or Magistrate.

These requirements are intended to provide access to a tailored treatment programme that can last between six months and three years. The intention is to reduce the individual's offending by addressing the underlying wellbeing issue that is contributing to their offending behaviour, and to help individuals understand and break the link between their addiction and their offending.

In Bristol most CSTRs are delivered by Developing Health Independence (DHI). DHI and the probation practitioner will meet with the individual as soon as possible after the Order is made at court, to agree the treatment plan. The treatment plan can include attending a set of 1:1 or group interventions, alongside wrap-around support for an individual's practical and emotional needs.

For ATRs and DRRs, testing may be carried out where required to ascertain whether someone is drinking or using substances while on their order. An individual's engagement with their treatment will be monitored by the treatment provider and discussed with the individual's probation practitioner. Their probation practitioner will monitor any risks and is responsible for deciding if an individual is meeting the requirements of their Order. If an individual is not engaging with the support offered, they may be returned to court to either revoke and resentence or amend the order. This may result in a custodial sentence, where the individual is in breach of their Suspended Sentence Order.

Once the Order is complete, the treatment provider will complete an assessment of the individual's on-going needs. The treatment provider and probation practitioner will then work with the individual to make a plan to meet these needs. Often, an ATR or DRR will support an individual to meet their treatment goals around alcohol or substance use but will not necessarily address wider factors that lead them to misuse alcohol or substances - for example complex mental health challenges. So, it is important that individuals are supported to access on-going support from the community substance misuse service and/or community mental health services.

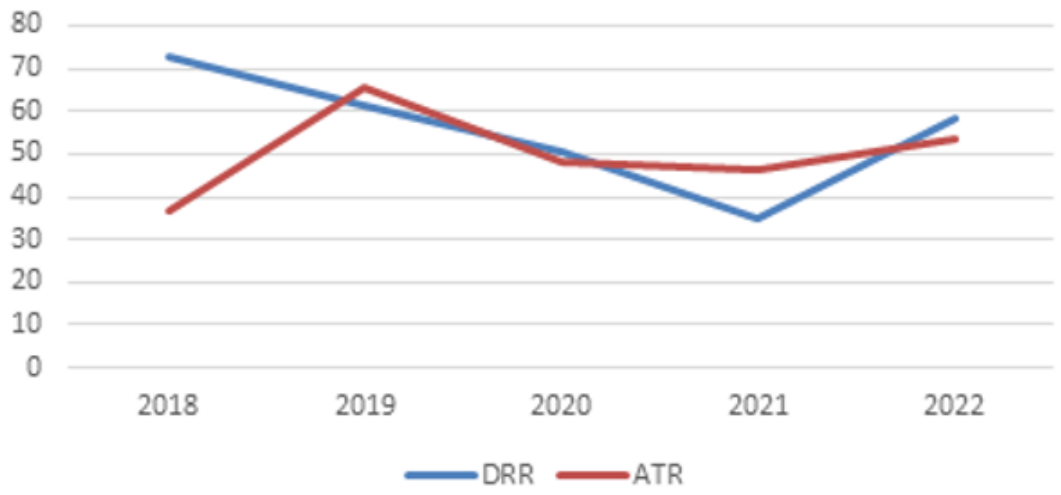
An MHTR can be used in relation to any mental health issue including personality disorders. This includes any mental health condition which is susceptible to treatment such as low-level depression or anxiety. The type of treatment is not defined and can cover a wide range of interventions. MHTRs may be sentenced by the court in conjunction with an ATR or a DRR if that is deemed appropriate and without up tariffing. Referrals for MHTRs can come from a

number of agencies. DHI will assess for the MHTR once a referral is completed and sent to them. Advice and Support in Custody and Court (ASCC) may also screen whilst the individual is in police custody or at Court.

The MHTR requirement is divided into primary or secondary care MHTRs. Secondary Care MHTRs are provided and overseen by secondary care services, for individuals whose mental health issues can only be supported through specialist services. This requires local clinicians to complete court reports to evidence the level and nature of mental health needs and act as the responsible clinician(s) for the delivery of treatment during the Order. Unless this is specifically commissioned as a local pathway, this means Secondary MHTRs are not common for individuals not already known to secondary mental health services. However, if the individual is receiving a secondary care MHTR the type of support an individual completing an MHTR will receive is very similar to the type of interventions offered by community mental health services.

Primary care MHTRs are a new service, co-commissioned by NHS England and local partners, for individuals whose mental health issues don't reach the threshold of secondary care services. Primary care MHTRs have been designed to meet a gap in provision for those with lower-level mental health and dual diagnosis issues in the community. MHTRs provide a psychological treatment intervention, overseen by a clinical lead who is usually a clinical psychologist. In Bristol, Primary MHTRs are delivered by DHI.

Fig 48. ATRs and DRRs issued by courts in Bristol and South Gloucestershire to Bristol residents[124]



The use of ATRs and DRRs has declined over the last few years, however recent investment in drug and alcohol services, and improvements in court, probation and treatment pathways have increased the number of ATRs and DRRs issued in 2022 and will likely increase this treatment option further across the next year.

MHTRs have been underused nationally due to the absence of mental health treatment options available in the community. Bristol has commissioned a MHTR treatment service via NHS England, which launched in late 2022. This will be delivered through drug and alcohol treatment services and will now mean that courts can provide a meaningful diversionary option for those whose mental health issues are linked to their substance use, and offending behaviour. It is hoped this will become a key diversionary route, mitigate the need for a custodial sentence, and provide quality mental health treatment in the community for this group of people.

12.7 People in the Criminal Justice System (CJS) who are in contact with Substance Use Treatment Services

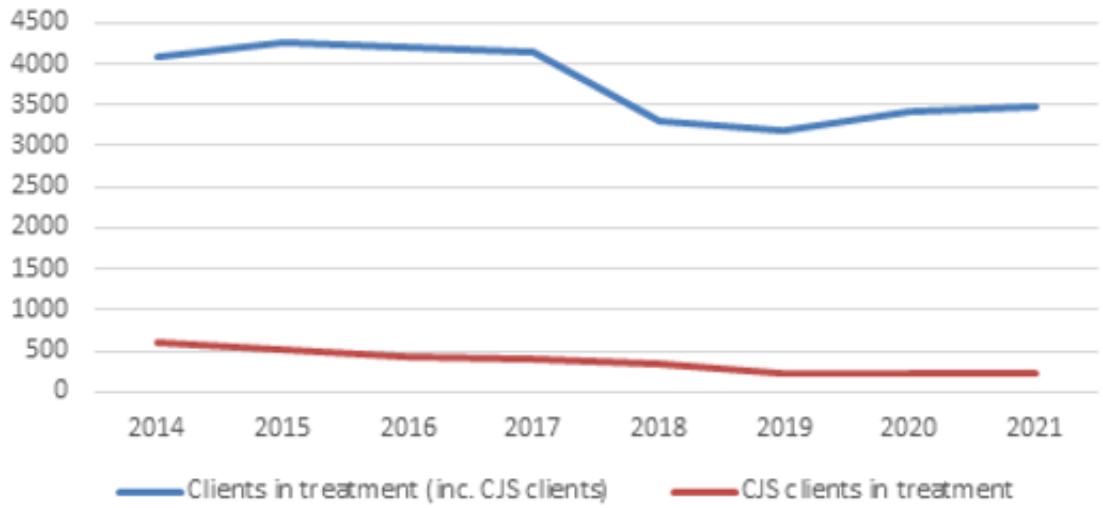
The proportion of clients referred into Bristol substance use treatment services has declined over the last seven years, at a consistent year on year rate, from around 15% in 2014 to close to 6.5% in 2021, a drop of about 50%. These figures and trends are illustrated in Figure 49. and Figure 50. below.

Figure 49. Number of People in the CJS in Substance Use Treatment Services in Bristol

	2014	2015	2016	2017	2018	2019	2020	2021
Total number of people in treatment in ROADS	4097	4257	4197	4139	3309	3181	3430	3484
People in the CJS in treatment	603	527	422	403	331	228	236	232
Proportion of the treatment population in contact with the CJS (%)	14.72%	12.38%	10.05%	9.74%	10.00%	7.17%	6.88%	6.66%

Source: NDTMS

Figure 50. Trend of People in the CJS in Substance Use Treatment Services in Bristol from 2014 to 2021



During this period criminal justice intervention teams were decommissioned from mainstream treatment services, these teams included workers who would meet people at police custody suites, in prison or at the prison gate – building relationships when motivation for change is likely to be at its highest. The removal of these specialist practitioners has likely contributed to this reduction in criminal justice clients accessing treatment. Positively, the increased funding since 2021, has brought back some of this specialism to Bristol with around £1 million new services, and a change of direction is expected here in the coming years – the additional resource will mean there are significantly higher numbers of people able to access drug or alcohol treatment, hopefully resulting in a reduction in the number of drug related deaths across the city.

12.8 Probation

The Probation Service in Bristol is part of the wider Bristol and South Gloucestershire Probation Delivery Unit (PDU) and has several specialists' teams working with Women; 18-25s; Stand-alone Unpaid Work Cases; Integrated Offender Management as well as general sentence management and a large, dedicated Court team serving Bristol Magistrates and Bristol Crown Courts. The service works with people at Court at the sentencing stage as well as managing and supervising individuals serving community sentences, pre-release prisoners, and those on licence. Throughout the stages, Probation liaises with treatment providers, including DHI but not exclusively and are involved with referrals to treatment housing via the local authority accommodation pathway.

Court Officers are responsible for assessing people who have been convicted of offences, to provide guidance to the Court for the most appropriate disposal. This could involve a range of Community Sentence Options where the Custody threshold has not been passed.

Improving the quality of reports provided to the Courts is a priority to the Probation Service in Bristol and a gatekeeping tool will be rolled out in July 2023 to ensure practice is improved. The aim is to increase the take up of CSTRs, in particular DRRs and MHTRs in the area

through clear targeting and recommendation at Court, increasing sentencer confidence and improved management of sentences.

In 2023 the possibility of the introduction of a Substance Misuse Problem Solving Court (PSC) at Bristol Crown Court is being explored. This will trial a tougher approach to community sentences for low-level criminals who would otherwise face short jail terms. Under unique orders which can be issued by the PSCs, people convicted of drug offences will see the same judge at least once a month, have intense support and supervision from the Probation Service, and get wraparound services tailored to their individual needs - such as from substance misuse agencies, housing support and educational services. They must also get treatment and undertake frequent, random drug testing where appropriate. Historically only those on a Drug Rehabilitation Requirement could be tested in the community. Judges and magistrates sitting in the PSCs will use incentives such as relaxing conditions to recognise good progress, as well as sanctions, such as increased drug testing and court reviews, when behaviour fails to meet agreed standards. They can also jail offenders for failure to stick to their sentence by imprisoning them for up to 28 days, up to a maximum of three times.

The PDU has committed to focus on Improving the quality of pre-release work to support People on Probation to transition from custody into Community. By increasing the use of the Effective Proposal Framework to better use additional licence conditions to improve compliance with treatment pathways. There is a further commitment to re-visit recall thresholds and alternatives to custody, with a focus on reducing short-term (drug related) recalls to Prison. Further to this the Short Sentence Function (SSF) from HMP Eastwood Park & HMP Bristol is being rolled out. The SSF is an enhanced approach to sentence management that focuses on individuals who are sentenced at Court to a custodial sentence of 20 months or less, and therefore have at the point of sentence less than 10 months to serve in prison.

The SSF function is about improving pre-release work and planning to enable a better transition from custody to community. Practitioners holding these cases will do more enhanced work and engagement prior to someone's release with the view that managing the sentence should then flow from initial release. The subsequent hope is there will be less recalls given the preparation for release. This new enhanced approach is required because this cohort are less likely to comply, more likely to re-offend and more likely to be recalled to custody than other cohorts of people on probation. This approach will provide greater opportunity for partnership working as it will be necessary to forge excellent relationships with the Offender Management Units within custody and Pre-release teams. This will include ensuring Duty to Refers and relevant Commissioned Rehabilitative Services / intervention referrals are in place and fast tracked.

12.9 Prisons

12.9.1 Introduction

This section will introduce the prisons that serve Bristol, give an overview of the scale of drugs issues in prison and provide recommendations about what could be done to increase

the number of people in prison to access specialist substance use treatment services and how to better support these people when they leave prison to access or continue their treatment.

Some evidence suggests that prison is not an effective solution to reduce drug use or harms in communities and has negative social and public health impacts. A Beckley Foundation report[125] on the incarceration of drug users states “given the significant costs of incarceration as a way of reducing drug problems, (in budget terms, but also in terms of the negative impact on community relations, social cohesion and public health), it is hard to justify a drug policy approach that prioritises widespread arrest and harsh penalties for drug users on grounds of effectiveness.”

12.9.2 HMP Bristol and Other Prisons

There are a number of prisons in the South West that have close links with Bristol, both in terms of accepting residents of Bristol, and releasing people back into Bristol. The only prison within the city of Bristol is HMP Bristol located in Horfield.

Prison Name	Description	Capacity
HMP Bristol	Adult Male Cat B - remand and sentenced	580
HMP Portland	Adult Male Cat C - sentenced	500
HMP Eastwood Park	Adult Female - Women’s Closed Category Prison- remand and sentenced	400
HMP Channings Wood	Adult Male Cat C - sentenced	700
HMP Guys Marsh	Adult Male Cat C - sentenced	500
HMP Ashfield	Adult Male Cat C - sentenced	400
HMP Leyhill	Adult Male Cat D - open prison	526
HMP Erlestoke	Adult Male Cat C - sentenced	460

12.9.3 Prison-Based Treatment Services Provision

Drug treatment in prison is a priority both locally, regionally and nationally. As of December 2022, all of the male prisons in the South West now receive their healthcare provision from Oxleas NHS Foundation Trust.

Oxleas have an established history of providing healthcare services in community and custodial settings. Oxleas provide clinical substance use teams to oversee prescribing, detoxing, and other medical interventions for prisoners who use, or have used, drugs and alcohol. However, for accompanying psycho-social services in prisons, they sub-contract to a separate organisation, Change Grow Live (CGL). CGL are a national charity that provide drug and alcohol support services, often integrated with other services including family support, homelessness, and sexual health services.

In the southwest custodial setting, CGL aim to provide a range of interventions for prisoners, including individual case work sessions, group work (including supporting mutual aid fellowships), peer mentor development, through-the-gate support, and family engagement.

As is often the case with recommissioning and contract mobilisation under a new provider, both Oxleas and CGL have experienced challenges with regards to retaining staff from the previous providers. Recruiting into prisons is often a slow process, and it is likely to be the case that several institutions will not be able to offer a fully staffed model until the middle of 2023, impacting on service provision in the short and medium term.

12.9.4 Scale of the Substance Use Problem in HMP Bristol

HMP Bristol's population averages between 525 and 550 residents every day and is expected to increase to 600. The average stay is about 6 weeks (but can be much shorter or longer depending on the circumstances).

On average the prison substance use team, have been working with at least 160 men a month (approx. 1/3 of population). On average just under 20% of men are prescribed some form of daily opioid substitution therapy for opioid dependence (mostly methadone).

In 2022 an average of 45 men entered the prison each month and declared a substance use problem for which they then produced a positive urine drug test upon entry (85% of these men test positive for opiates, which includes men on opioid substitution therapy).

There is very little self-disclosure or confirmation testing for men with cannabis or alcohol issues at the reception stage.

Sources of data that informed the previous strategy included the most recent Her Majesty’s Inspectorate of Probation (HMIP) inspection in 2019. At that time, 35% of the men surveyed by inspectors explained that they arrived at HMP Bristol with a drug problem, and 19% of residents stated they had developed a drug problem whilst in prison care.

The percentage of all new receptions beginning some form of treatment for substance use was 37% for 2021/22 (426). Of that number, 40% required support for problems with alcohol. At present, we also know that roughly 20% of the prison population have an opiate addiction that needs active management.

Figure 51. Total Numbers in Treatment at HMP Bristol Q4 2022 by Substance Category

Opiate users		Non-opiate only users		Alcohol and non-opiate users		Alcohol only users	
231	47%	84	17%	129	26%	52	10%

12.10 Enhanced Support for In-Prison Substance Use Treatment Services

The following services provide enhanced support to the in-prison substance use treatment services.

12.10.1 PACT

A significant amount of independent and co-commissioned research suggests that promoting positive family relationships alongside the prison population can impact on reoffending rates, violence and self-harm, as well as enhancing the recovery capital of those battling addiction[126].

PACT was commissioned from ADDER funding in 2021. PACT is a pioneering national charity that supports prisoners, people with convictions, and their children and families. They provide advice and support at every stage of the criminal justice process: in court, in prison, on release, and in the community. PACT work to reduce the significant impact of incarceration on families, and work to ensure that on release people remain in contact with and supported by their family. PACT services are integrated with all of the functions of HMP Bristol to assist in the delivery of these outcomes.

12.10.2 Prison In-Reach Teams (CJIT) - DHI

DHI provide a prison in-reach service to those who are on short-term custody sentences with a drug and/or alcohol problem. They aim to support prisoners by giving them the best chance of addressing problematic substance use and stopping the cycle of re-offending and preventing a return to a custodial sentence. They do this by supporting those who are ready to leave prison to successfully connect with appropriate agencies in the community. They establish peer-based, meet-and-greet services, to greet people on the day they leave prison to bring them into treatment or other community support agencies.

DHI understands that prison leavers may be suspicious of ‘authority’, but that peers are known to be viewed differently. Through this, engagement can be optimised and therefore increase recovery, boost motivation and support for prison leaver.

12.10.3 Prison In-Reach Teams (CJIT) – The Nelson Trust

The Nelson Trust are an organisation who are delivering a similar intervention to DHI, in Bristol, funded by Bristol City Council. Their program works only with women in the criminal justice system, and primarily takes referrals from HMP Eastwood Park. The Nelson Trust delivers an intensive ‘custody to community’ holistic intervention service which aims to

disrupt the cycle of substance use and offending, and support women to sustain engagement with mainstream provision such as substance use treatment in the community.

Building a trusting therapeutic relationship with women is known to be key to engagement with support following release, and engagement in this service begins in custody in order to build a bridge into community treatment services. Women's Recovery Coordinators work alongside substance use professionals in HMP Eastwood Park, and in the local community to promote continuity of care.

12.10.4 Inside Out Restorative Justice

Inside Out Restorative Justice are a local community interest company who are already commissioned by HMP Bristol to provide some restorative work in the prison. They concentrate on delivering restorative practices between prison residents at HMP Bristol and their families or significant others. They seek to promote dialogue and understanding in the important period prior to a resident's release, with a view to assisting the individual's reintegration back into the community.

12.10.5 St. Giles Trust

St. Giles Trust have been funded by the Police through the ADDER grant to provide an in-reach worker to support those who have been caught up in drug supply offences and to support them making positive changes to their lives including dealing with any of their own substance use issues. The cohort they have worked with are young males, primarily from ethnic minorities.

12.11 Continuity of Care after Prison

All Local Authorities in the UK are monitored by the Department of Health and Social Care on the number of 'people leaving prison and entering structured treatment within three weeks'.

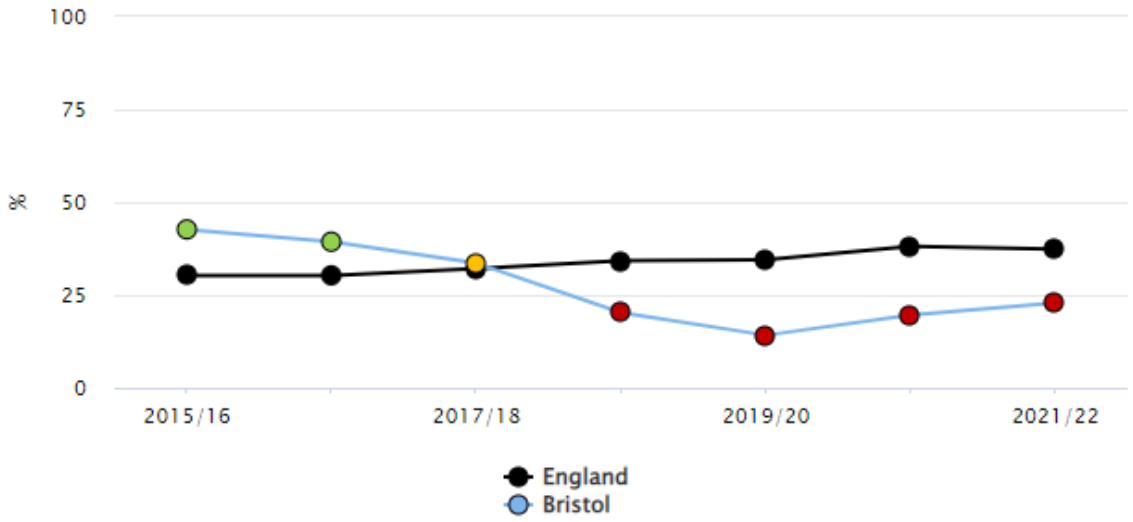
Figure 52. below shows the numbers of adults being referred into structured treatment in Bristol from a number of prisons around Bristol. Figure 53. shows the declining trend in the number of adults with a substance use need who successfully engage in community-based structured treatment in Bristol, within three weeks of release from prison. Since 2021, there has been a small but notably increase. However, on average, four out of five adults who leave prison with a treatment need don't make it into community services within three weeks.

At 22.8%, Bristol performs significantly worse than the South West average of 31.5% and the national average of 37.4%.

Figure 52. Referrals from Primary Referring prisons across the Southwest into Bristol Community-Based Structured Treatment Services in 2021/2022

Secure Establishment Referrer	Number of people transferred to Bristol local authority with a treatment need	Number of people in treatment within three weeks	% of people in treatment within three weeks
HMP Bristol	154	24	15.6%
HMP Portland	50	15	30%
HMP Eastwood Park	48	7	14.5%
HMP Channings Wood	38	16	42%
HMP Guys Marsh	12	7	58%
TOTAL	302	69	22.8%

Figure 53. Adults with a Substance Use Treatment Need who successfully engage in Community-Based Structured Treatment following release from Prison.



Source: Public Health Outcomes Framework

12.12 Residential Rehab after Prison

Part of the additional funding since 2021, has allowed for renewed focus on better routes to help people go straight from prison into a detox and/or onto residential treatment. Residential treatment is not for everyone, but for those particularly motivated to engage in more intensive treatment, ensuring that people can move on to a residential treatment provider can be a real building block to help people move into recovery.

For some, being ‘out’ in the community can come with additional risks and pressures which can lead to relapse at a time when people are known to be particularly vulnerable. For people who go straight from prison to rehab, consideration will need to be made about a post-rehab package of support as people reintegrate into the community after being institutionalised for a considerable period of time, recognising the vulnerability to relapse.

12.13 Recovery and Support Services to Enhance Continuity of Care after Prison

See Probation section - the majority of those released from prison are subject to management on licence by the probation service. This includes conditions related to accessing drug treatment, drug and alcohol testing and referral to appropriate services.

HMP Bristol now has a ‘Resettlement Hub’ and pre-release team within the Reducing Reoffending department. These services aim to co-ordinate release planning for prisoners across several areas of need, including accommodation, employment, finances, and community drug treatment. The team works to engage stakeholders and community partners prior to release to provide a holistic approach to supporting successful community reintegration. This area of practice is still being embedded and developed but demonstrates an intention on behalf of the prison to better assist individuals with their transition through the gate. There has been continuous reviews of the Pre-release boards around ensuring these meetings are well attended by partners and seeing the clear added value form a well-attended meeting. There has been some contention around partners attending, where there is an identified need for Secondary/ Community Mental Health services like the Richmond Fellowship, Integrated Health co-ordinators and Adult Social Care leads to fulfil a palliative and safeguarding function within treatment plans. Accelerator roles like employment leads, housing specialists and Neurodiversity leads have been showing a clear value to organising and enhancing levels of care for prison leavers for housing pathways and attaching individualised care plans.

The future for promoting better engagement with community drug treatment services for those leaving HMP Bristol looks positive, with DHI’s in-reach team increasing their footprint in the prison, and CGL developing their own ‘through-the-gate' provision to buttress and compliment ongoing release planning processes. Currently Health and Justice Partnership Co-ordinators are supporting to organise a memorandum of understanding between commissioned ‘Through the gate services’ which share a similar specification. This would be the ‘Meet at the Gate’ service commissioned by ADDER with Developing Health and Independence CJIT team, Reconnect and CHL’s ‘Through the gate’ provision. There is recognised overlap in specifications, and further conversations with Public Health in the Local Authority to integrate services for Through the Gate provision to encourage a ‘One Right Door’ approach to continuity of care.

This includes the use of ‘telemeds’ video conferencing software on designated laptops, which allows prisoners to ‘virtually’ meet prescribing and treatment providers whilst still in the

prison. It will also include the return of pre-release groups in the prison for those with an identified drug treatment need in the community.

As part of Health and Justice commitments around improving engagement with community services, there has been an increased focus on adding value to DRRs and CSTRs within Liaison and Diversion Services. Part of this has been mapping the referral pathways from Prison Healthcare and in-reach services, and potential pathways to integrate adult social care, and early interventions pathways prior to release back into the community. There is forward planning over the next year to implement IPS (Individual Placement and Support) to support prison leavers with severe mental health difficulties into employment. It involves intensive, individual support, and works on a 'place then train model'. Relationships are being explored with Integrated and Community Mental Health services on how to develop partnerships with VSCEs as onward referrals for the GP, and how pathways into engaging with partners such as the Richmond Fellowship can implement IPS employment support. This plays a large role in engaging with meaningful employment and activity and is relevant to the comorbidities of Mental Health seen within the CJS cohort that may need Substance Treatment Requirements.

In the future, there is a plan for implementation of HEP C/ BBV and community liver health to co-locate with PDUs across the SW region, to continue screening and treatment of identified health issues on Probation sites, as well as continued work within HMP estates, Approved Premises and community providers.

For the foreseeable future, Reconnect services are embedding within HMP estates, and are due to offer a full service throughout 2024 nationally. There is an ongoing steer to embed Reconnect referrals into Probation colleague offices, and over the last six months has embedded well within HMP Bristol. There are some discussions needed around support of Peer-led teams, and a growing recognition on the value of peer support within HMPPS services. For the coming year, there may be better held reviews on Peer pathways and improvements made upon unpaid peer support; some of which we can see trialled with the imminent Through the Gate provisions. Currently Memorandum of understanding steering groups are bring facilitated to discuss remits and services of upcoming Meet at the Gate and Through the gate Services in the continuity of care space.

12.13.1 Co-Financing Organisation (CFO) Activity Hubs (Intervention Alliance)

CFO Activity Hubs is a new project funded by CFO, HM Prison and Probation Service (HMPPS) and part funded by the European Social Fund. The hubs aim to provide a safe space for ex-offenders to build a healthier, more stable and fulfilling life. Linking community engagement activities with key support, the hubs provide a place to learn, develop new skills and meet new people. At the CFO Activity Hub in Bristol, activities are tailored around participants needs and they offer a safe space to develop life skills, interests, hobbies, and employability aspirations.

The hub will work with any person over the age of 18 that is subject to Probation (either on a Community Sentence or on Licence after being released from custody). Participants must be unemployed with the Right to Work in the UK and able to travel to the hub location in central Bristol.

12.13.2 One25

One25 are a Bristol based organisation who work with women who are deeply traumatised from childhood abuse and violence. This leads to life situations where they are stigmatised, marginalised, locked out of society. Many are in crisis, and many are street sex-working. Yet these courageous women show tremendous skills and potential: in their supportive peer relationships, their creativity and humour, and their survival. One25 worked with 234 women in 2021-22, 75% of which were homeless, 86% were addicted to drugs or alcohol. Many will have interfaced with the criminal justice system at one or more times in their life. One25 provide a night outreach service, practical and emotional support, specialist caseworkers, and trauma informed group programs.

12.14 Recommendations for Improving Access to Substance Use Treatment and Recovery Services, during and after contact with the Criminal Justice System

12.14.1 Diversionary Recommendations

1. Explore what, if any, new diversionary approaches are available or are utilised by other areas of the UK.
2. Review any ‘lessons learnt’ from other areas to understand if any of these can be applied in Bristol.
3. Build in an evaluation of any new diversionary activities, from the beginning, to understand the impact from the start.
4. Improve the collection and reporting of demographic and diversity monitoring information available for those engaging in diversionary treatment services to enable us to inform what work could be done to improve the outcomes of diversionary and educational interventions.
5. Improve the recording of information about ‘the primary offence’ when someone is arrested and/or charged who are identified as having a drug and/or alcohol need. E.g., it the primary offence burglary rather than specifically drug related.
6. Increase the use of ATRs and DRRs in Bristol courts which have seen a decline in recent years.
7. Continue to improve the upward trend of referrals into diversionary and educational services in Bristol. Diversionary approaches, which are more than ‘treatment as usual’ and address a wider range of social and individual issues should be invested in.

12.14.2 Probation Recommendations

1. Increase and support the number of people in probation services who have multiple disadvantages i.e., a mental health need, learning difficulties & needs arising from neurodivergent conditions.
2. Increase the number of DTR & ATRs

12.14.3 In-Prison and After-Prison Recommendations

1. Conduct a review of the referral and support mechanisms in prison with a view to increasing the number of people referred into structured drug or alcohol treatment services in Bristol.
2. Increase the number of adults who leave prison and engage with structured treatment services in Bristol. Currently, four out of five adults who leave prison with a treatment need don't make it into community services within three weeks.

12.14.4 Top 3 Recommendations

1. Increase the number of adults who leave prison and engage with structured treatment services in Bristol. Currently, four out of five adults who leave prison with a treatment need don't make it into community services within three weeks.
2. Continue to improve the upward trend of referrals into diversionary and educational services in Bristol. Diversionary approaches, which are more than 'treatment as usual' and address a wider range of social and individual issues should be invested in.
3. To increase support to the number of people in probation services who have multiple disadvantages i.e., a mental health need, learning difficulties & neurodiversity needs. A wider range of diversionary activities could be trialled, recognising that most alcohol and other drug related crime is committed by men 18-35 years old. Interventions which take account of the psychological and social needs of men, including a trauma informed socially aware view, rather than generic interventions would potentially reduce and tackle drug related crime and offending.

13. Children and Young People

The three core priorities within the national drugs strategy[127] apply differently to children and young people than they do to adults, requiring a different focus:

1. Reducing the demand for drugs, including universal and targeted approaches to prevention among children and young people.
2. Investing new money in drug treatment services, including separate services that reflect the developmental differences between children/young people and adults.
3. Focusing on organised crime to disrupt criminal gangs, particularly activity involving county lines networks in which vulnerable children and young people can be exploited.

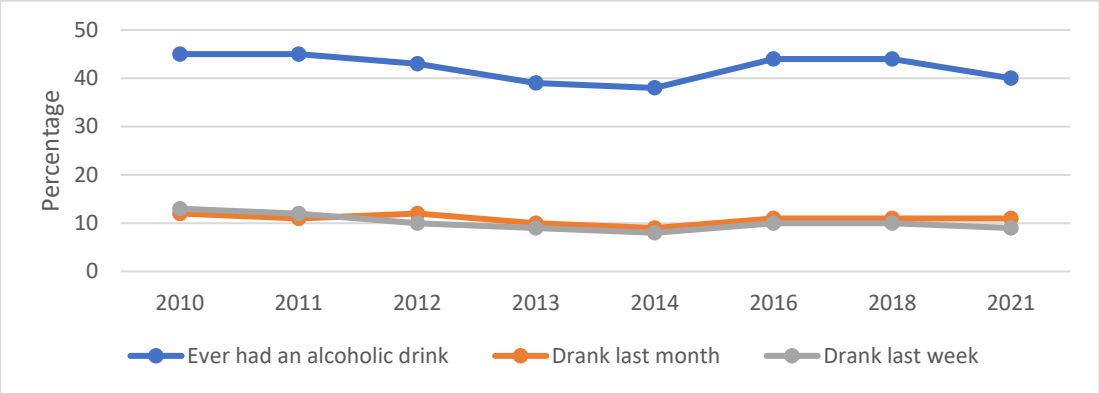
13.1 National Prevalence

In 2021 40% of 11–15-year-olds in England said that they had ever had an alcoholic drink and 9% said they drank alcohol in the last week. 40% reported never having had an alcoholic drink[128].

Prevalence of drinking alcohol has reduced significantly since 2003 when 61% of 11–15-year-olds said they had ever drunk alcohol. However, there was a rise between 2014 and 2016, from 38% to 44%. This may be due in part to a change in the survey questions, but in

2021 the level of 40% is still higher than in 2014. The proportion who last drank alcohol in the previous month and the previous week also showed a small rise after 2014 but has remained relatively stable since then[129] (Fig 54).

Fig 54. Proportion of young people aged 11-15 in England who have ever drunk alcohol, drunk alcohol in the last month and drunk alcohol in the last week, by year[130]



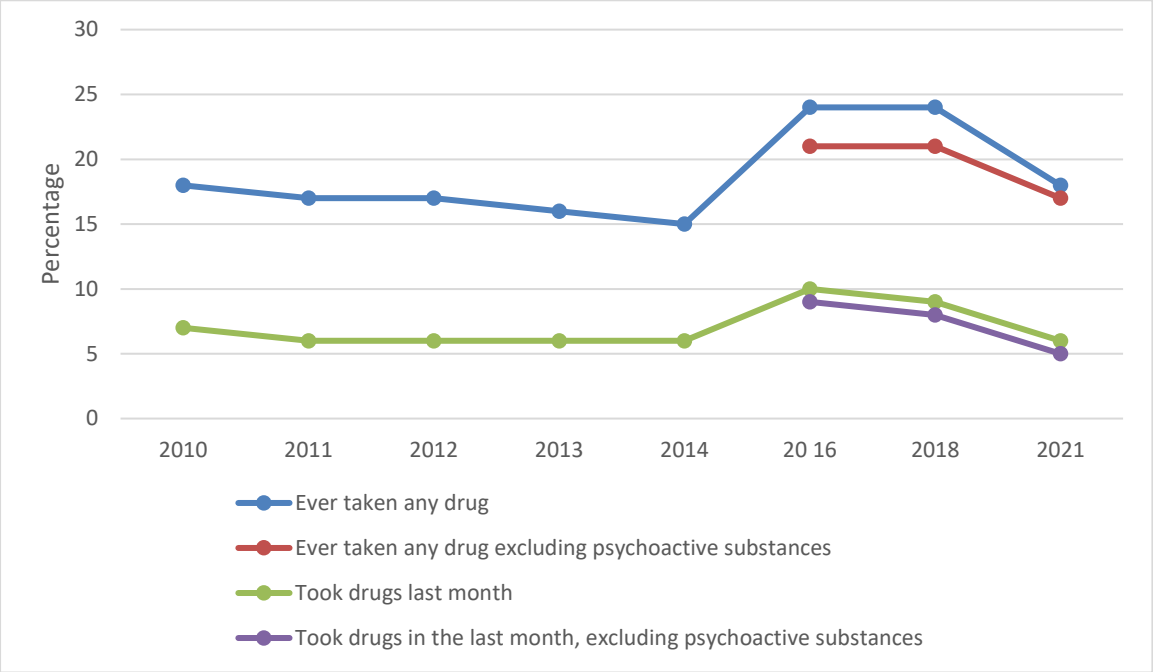
Among 16–24-year-olds in England and Wales, 23% do not drink alcohol. This is the highest proportion of adults who are abstinent from alcohol by age, level only with those aged 65 and over. However, although they are less likely to drink than any other age group, those who do drink are more likely to adopt risky drinking behaviours than older age groups[131].

Like alcohol, the prevalence in the use of illicit and other drugs among 11–15-year-olds in England has fallen significantly over the past 20 years. In 2003, 30% of young people said they had ever taken drugs whereas in 2021 this had fallen to 18%. 12% had taken drugs in the last year and 6% had taken drugs in the last month[132].

The exception to this continuous reduction was again the period between 2014-2016, when the percentage of young people who had ever taken drugs rose steeply from 15% to 24%. This is partly because psychoactive substances, including new psychoactive substances and nitrous oxide, were added to the questions for the first time at this point. However, even when psychoactive substances are excluded, there was an increase from 15% in 2014 to 21% in 2016.

In 2021 the proportion who had ever taken drugs when psychoactive substances were excluded was 17%, suggesting that drug use among young people has fallen again, although it probably remains slightly above the 2014 level[133] (Fig 55)

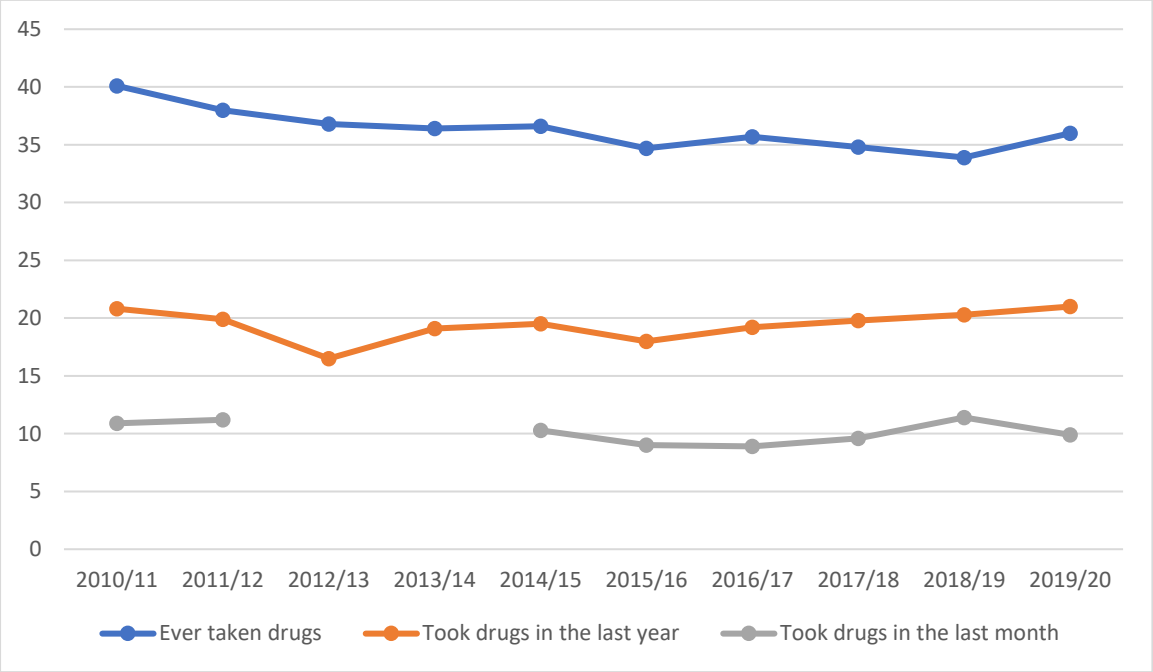
Fig 55. Proportion of young people aged 11-15 in England who have ever taken drugs and taken drugs in the last month, including and excluding psychoactive substances, by year [134]



Drug use among young adults aged 16-24 is higher than among the school aged population. In 2019/20 36% of this age group said they had ever taken drugs, significantly lower than in 2001, when it was 49.1%. However, the year-on-year reduction has not continued in recent years and the 2020 figure of 36% is the highest since 2014/15, when prevalence was 36.6%.

The prevalence among 16–24-year-olds who have taken drugs in the last year has also been rising over the past 5 years. In 2015/16 this figure was 18% but in 2019/20 it had risen to 21%. Very recent drug use, in the last month, remains fairly level among this age group, although in 2018/19 it rose to 11.4% but reduced again in 2019/20 to 10%[135]. (Fig 56)

Fig 56: Proportion of 16-24 year olds in England and Wales who have ever taken drugs, taken drugs in the last year and taken drugs in the last month, by year[136]



NB Data not available for last month use in 2012/13 and 2013/14

13.2 Who is at Risk and Why?

13.2.1. Risks associated with individual substances

Young people who take drugs and drink alcohol face higher risks than the adult population because of the impact that these substances have on immature organs, including the liver, lungs and heart and particularly on the brain, which continues to develop until the age of 25[137]. The substances they use may therefore be more likely to have a serious detrimental impact on their neurological, physical and social development.

The substances that are most frequently used by young people are alcohol, cannabis and nitrous oxide. Use of cocaine and MDMA ecstasy are highest among the 16-24 age group.

1. Alcohol

The most common substance used by young people in England is alcohol. In 2009, the Chief Medical Officer for England advised that an alcohol-free childhood is the healthiest and best option, and this advice is still relevant for parents of children and young people. He also advised that if children do drink alcohol, it should not be until at least the age of 15 years and that if young people aged 15 to 17 years consume alcohol, it should always be with the guidance of a parent or carer or in a supervised environment [138]. This is because alcohol is particularly harmful to the developing brain and is linked to short term risks such as injury from accidents, risky sexual activity, violence and use of other drugs. It is also associated with long term risks such as developing alcohol dependence in young adulthood, drug

dependence and involvement in crime. Alcohol can also have a negative impact on young people's relationships and on their engagement with education, employment, and training[139].

Deaths among those aged 24 and under which are specifically caused by alcohol or are attributable in part to alcohol, are very unusual. However, drinking behaviour at this age contributes to cumulative harm and therefore impacts directly on outcomes for older groups.

2. Cannabis

Cannabis is the most frequently used illegal substance among young people. 5.6% of 11–15-year-olds in England [140] and 18.7% of 16-24 year olds in England and Wales[141] say they have used cannabis in the previous 12 months. When the secondary school age group is broken into individual ages, a high prevalence of cannabis use is evident among 15-year-olds, with 15.7% saying they took this substance in the previous 12 months. Smoking cannabis increases the risk of lung disease in later life and may exacerbate existing conditions such as asthma. Those who take frequent, higher quantities of cannabis are also at risk of developing dependence[142]. Cannabis is also known to present significant risks to mental health, including psychosis. People who are younger and those who are already vulnerable to mental ill health face higher levels of risk[143].

3. Nitrous Oxide

Nationally, the proportion of 16–24-year-olds who say they have used nitrous oxide in the previous 12 months has risen from 6.1% in 2012/13 to 8.7% in 2019/20[144]. The percentage of young people of secondary school age who have used nitrous oxide in the previous 12 months is much smaller, at about 1.8%, down from 4% in 2016 and 5.1% in 2018[145]. In 2021 3.7% of 15-year-olds and 2.5% of 14-year-olds used nitrous oxide in the previous 12 months. Prolonged or heavy use of nitrous oxide can cause neurological harm, and if it is inhaled directly from cannisters, it can cause lung and bronchial damage. In a very small number of cases nitrous oxide use may be associated with dependence. However, most people who use this substance do so infrequently and they inhale it from balloons. In March 2023 the government announced that the possession of nitrous oxide for personal use will be made a criminal offence in the UK.

4 Cocaine

The Review of Drugs carried out by Carol Black[146] identifies powder cocaine as a key substance in the illicit drugs market, with links to criminal behaviour, and increased use being driven by young people under 30.

In 2019/20 9.9% 16–24-year-olds said they had used powder cocaine at some point; 5.3% had used it during the previous 12 months and 1.4% had used it in the previous month. This is a small reduction from 2017/18 and 2018/19, when 10.8% and 11% respectively said they had ever used powder cocaine[147]. Among 11–15-year-olds 0.8% said they had used cocaine in the previous year, including 2.5% of 15-year-olds[148].

Use of cocaine is associated with damage to the cardio-vascular system and the number of deaths in England and Wales, where cocaine is mentioned on the death certificate has risen significantly in recent years including among young people. In 2012 the number of young

people under 20 whose death was recorded as cocaine related was 1. This rose to 11 in 2021. Among those aged 20-30 the number was 32 in 2012, rising to 102 in 2021. Young men are at higher risk than young women[149].

5 MDMA (Ecstasy)

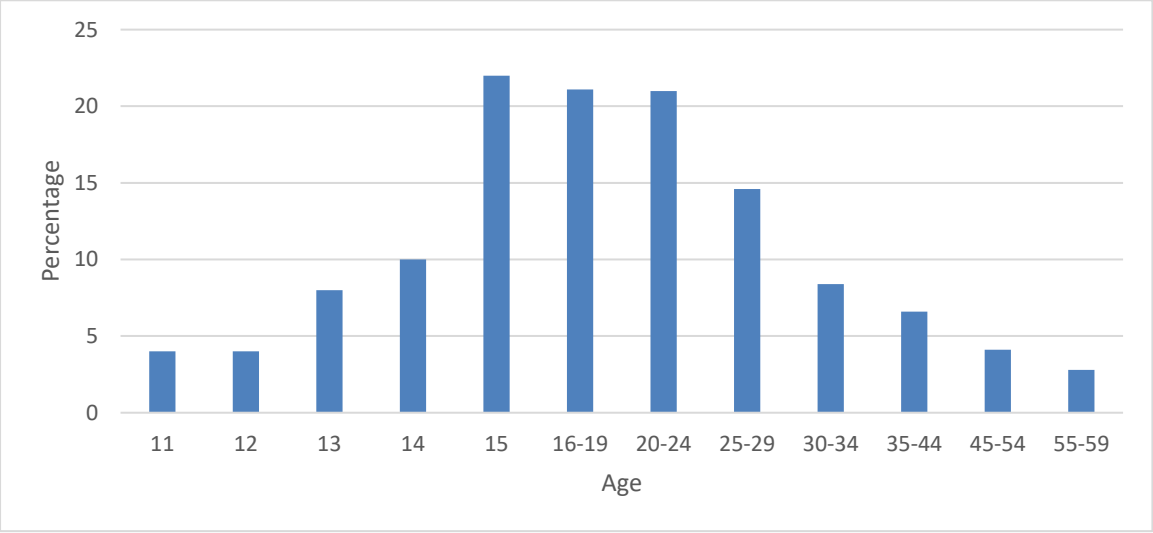
In 2021 2.4% of 15-year-olds said they had used MDMA (ecstasy) in the previous 12 months[150] and in 2019/20 3.7% of 16–19-year-olds and 4.2% of 20–24-year-olds said they had used ecstasy in the last 12 months. This is much higher than the 16-59 population where 1.4% had used ecstasy in the last 12 months[151] but it is the lowest level among 16–24-year-olds since 2013/14 when the figure was 3.9%. In high doses, MDMA can affect the body's temperature regulation, leading to organ dysfunction and death.

13.2.2 Risks Associated with Demographic Factors

1. Age

Young people aged 15- 24 have significantly higher levels of drug use than the rest of the population. Drug use prevalence rises sharply at the age of 15 and decreases after the age of 24 [152]. (Fig 57).

Fig 57. Proportion of 11-15 year olds (2021) and 16-59 year olds (2019/20) who took drugs in the last year by age[153,154].



However, the higher prevalence of all drug use among 15–24 year olds masks some very high risks among very young people. OHID categorises early onset of substance use as the use of any drug before the age of 15. This is a key risk factor for subsequently developing problems related to drug use and requiring drug treatment[155]. Those who first use substances aged 13 or younger are more likely to have used a Class A substance at this point, and those who first used drugs at age 12 or younger have a significantly higher level of volatile substance use as their first substance. First drug use at 14 or 15 is significantly

more likely to be cannabis, although use of Class A drugs at this point is still high[156] (Fig. 58).

Fig 58. Drugs taken at first drug use, by age of first drug use[157]

	11 years or younger	12 years	13 years	14 years	15 years	Total
Cannabis only	3%	15%	30%	44%	65%	27%
Volatile substances only	61%	31%	8%	4%	3%	30%
Any Class A drugs	19%	32%	36%	22%	10%	21%
Other drugs	18%	22%	26%	31%	22%	21%

Alcohol use among 11-15 year olds also rises with age. In 2021 13% of 11 year olds said they had ever had an alcoholic drink, compared to 65% of 15 year olds.

2. Gender and Ethnicity

In 2021 girls aged 11-15 were slightly more likely to have ever taken drugs (19%) compared to boys (17%) and to have taken them in the last year (13% compared to 11%), but levels of drug use in the last month were estimated at 6% for both boys and girls[158]. Although the proportions of male and female 11-15 year olds who have used drugs have always remained very close, this is the first time since 2001, that a higher proportion of girls has used drugs than boys.

In 2021 girls aged 11-15 were also slightly more likely to have ever drunk alcohol (42%) than boys (39%) and to have drunk it during the previous 4 weeks (12% compared to 9%). Prevalence of drinking during the previous week was closer at 9% for girls and 8% for boys[159].

Looking at the broad aggregated ethnicity categories available in NHS Digital data: Black 11-15 year olds are slightly more likely than others to have ever taken drugs and young people of Mixed heritage are more likely to have taken drugs in the last year or the last month. Levels of drug use in the last year and in the last month were very similar for young people from Black and White ethnic groups. Asian young people had the lowest levels of drug use overall[160].

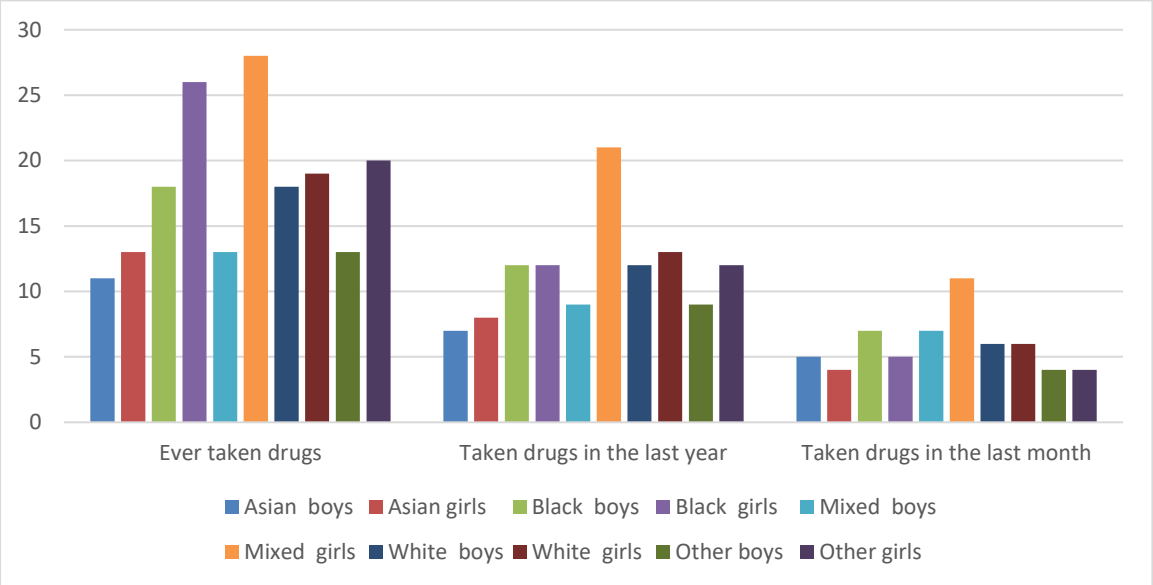
When both ethnicity and gender are considered, it is evident that girls in all ethnic groups are more likely to have ever taken drugs than boys. The highest levels can be seen among girls of Mixed Heritage (28%) and Black girls (26%)[161].

In all ethnic groups there are higher percentages of girls who used drugs in the last year, except for young people who are Black, where the proportions were the same as boys.

For young people who used drugs in the last month, boys had slightly higher or the same levels as girls in most ethnic groups, except young people who are Mixed, where girls had much higher levels of risk than boys (Fig. 59).

Overall, girls who are from a Mixed heritage background appear to experience a significantly higher risk of using drugs.

Fig 59. Proportion of 11-15 year olds who have taken drugs by ethnicity and sex[162]



Pupils who have ever drunk alcohol are highest among White girls (51%), girls from a mixed heritage background (49%) and White boys (47%). The lowest prevalence of ever drinking alcohol can be seen among Asian boys (15%) and Asian girls (11%). However recent drinking, in the week before the survey, is highest among White girls (12%) and White boys (11%), with all other groups having levels at 5% or lower[163].

3. Sexual orientation

Rates of use of all substances are considerably higher among lesbian, gay and bisexual people than for those who identify as heterosexual[164]. This includes young people: among 15-year-olds, those who identify as lesbian, gay, or bisexual report higher levels of drug and alcohol use than those who identify as heterosexual[165].

13.2.3 Risks Associated with Family Attitudes

Family attitudes are an important influential factor in young people's drug use. Young people who believe that their family would try to stop them using drugs are far less likely to take

drugs than those who think their family would do nothing or may even encourage them. (Fig. 60)

Fig.60 Young people's drug use by perceived family attitudes[166]

	Percentage of young people who believe their family do or would try to stop them from taking drugs %	Percentage of young people who believe their family do or would try to persuade them not to use drugs %	Percentage of young people who believe their family would do nothing or would encourage them to take drugs % (NB. small numbers)
YP has never taken drugs.	95	87	32
YP has taken drugs once	1	2	11
YP has taken drugs 2-5 times	2	2	11
YP has taken drugs 6-10 times	1	1	27
YP has taken drugs more than 10 times	2	7	20

The risks associated with family attitudes to alcohol are different. 11–15-year-olds who believe their parents would stop them from drinking consume fewer units of alcohol than others and report fewer episodes of being drunk. However, young people who think their parents wouldn't mind them drinking if they did not drink too much appear to consume the highest number of units and there is no information about how much alcohol parents would consider to be too much. This is not in accordance with the Chief Medical Officer's advice[167] and may indicate a lack of awareness among parents of the risks associated with young people drinking alcohol.

Those who think their parents would let them drink as much as they like, are more likely to report episodes of being drunk[168] (Fig. 61).

Fig 61. Number of units of alcohol consumed and episodes of being drunk by perceived parental attitudes.

	Young people who think their parents wouldn't like them drinking	Young people who think their parents wouldn't mind them drinking if they did not drink too much	Young people who think their parents would let them drink as much as they like
Percentage of young people who drank <1 unit in the last week	53%	46%	2%
Percentage of young people who drank 1-<5 units in the last week	5%	90%	5%
Percentage of young people who drank 5-<10 units in the last week	4%	79%	17%
Percentage of young people who drank 10 units or more in the last week	7%	64%	29%
Percentage of YP who have drunk alcohol in the last 4 weeks and report being drunk in the last 4 weeks*	1%	14%	45%

**Some YP did not answer this question and therefore the percentages do not add up to 100.*

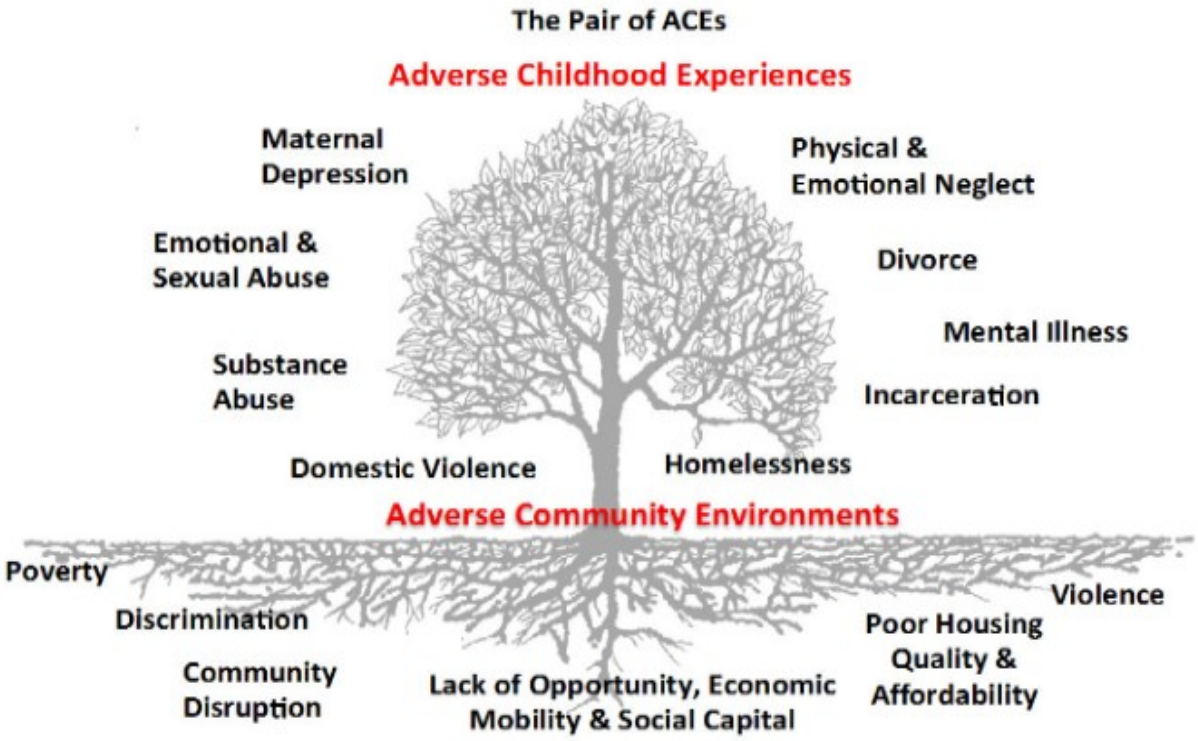
13.2.4 Risks Associated with Adversity and Trauma

The highest prevalence of substance use occurs among vulnerable groups who are more likely than other young people to adopt high risk behaviours and to experience poor health and social outcomes as a result. In her Review of Drugs, Carol Black pays particular attention to vulnerability factors and highlights the increase in the exploitation of children and young people by criminal gangs, particularly those involved in county lines activity[169]. This is also picked up as an important strand in the national strategy[170].

These young people are more likely to have faced adverse childhood experiences (ACEs) and trauma and to live in adverse community environments[171]. The relationship between ACEs and adverse community environments is illustrated in Fig.62 below, where community

environments are represented by the tree roots and the childhood experiences by the leaves.

Fig.62 The Relationship Between Adverse Childhood Experiences and Adverse Community Environments[172]



Several studies have highlighted the increased risk to these young people of developing health harming behaviours. Public Health Wales estimates that adults who have experienced four or more ACEs during childhood are four times more likely to develop high risk drinking patterns, 11 times more likely to have smoked cannabis, and 16 times more likely to have used crack cocaine and heroin[173]. Several reports have identified those who are particularly vulnerable to substance use, and people who have experienced trauma are visibly identified in data showing referrals into substance use treatment services[174]. This includes looked after children, children in need and those with a child protection plan; those who experience domestic abuse, including as a witness; those with mental ill health; those who experience or are at risk of child sexual and/or criminal exploitation; those who are not in education, employment or training (NEET) and those who are excluded from school; those who have housing problems; those whose parents and carers misuse drugs and alcohol; those involved in antisocial behaviour and criminal activity.

Evidence of these increased risks can be seen by looking at young people who have truanted or have been excluded from school as an example. The relationship between trauma, mental health and school exclusion is becoming clear[175],[176]. Data show that these pupils are estimated to be 8 times more likely to use drugs at least once a month and 9 times more likely to have used Class A drugs in the previous 12 months than those who

have not truanted or been excluded[177]. Many of these young people experience multiple vulnerabilities and face complex problems. Recurrent studies highlight that those who belong to more than one vulnerable group experience wide inequalities and have significantly higher levels of substance use than people who belong to just one group[178,179,180].

13.3 What is the local need?

13.3.1 Estimated Prevalence

The school census for October 2022 records 60,678 pupils aged 4-15 (reception to year 11) attending state schools in Bristol. This includes 35,532 primary school aged children and 22,108 secondary school aged young people. There are also 3,038 students aged 16-19 in post 16 settings[181].

Assessing the size of the drug and alcohol issue among children and young people in Bristol is not straightforward. Data about substance use are collected from the school age population via the Pupil Voice health survey. This can be completed by pupils in all school years, but for comparative purposes over time, the published report focuses on years 4 and 6 in primary schools and years 8 and 10 in secondary schools. Most of the older respondents are therefore aged 14 (year 10), missing the sharp increase in substance use among 15-year-olds reflected in national data.

In 2021/22 approximately 4,600 pupils in Bristol schools completed the Pupil Voice survey. This is thought to give a representative sample, but it was a lower response than in 2019 when almost 6,700 pupils took part. This reduction is due to pressure on schools associated with the Covid19 pandemic.

The most recent data based on health behaviours of 15-year-olds are from the What About Youth survey, which was carried out in 2014/15 [182] and is now quite old. There are no data showing the rate of substance use among 16–24-year-olds in Bristol.

A range of methods have therefore been used in this needs assessment to estimate the prevalence of drug and alcohol use among young people in Bristol, including comparing Pupil Voice data with the national data for 12- and 14-year-olds and applying national percentages to the Bristol population according to age. However, these data sets are not wholly comparable, partly because the surveys ask different questions and partly because the national survey is targeted at young people by age and the Bristol survey is targeted at young people by school year. Where possible, survey data have been used as the primary source.

If the prevalence of drinking alcohol is estimated using both national data[183] and the school census as a guide, the number of young people aged 11-15 in each category of frequency can be seen in Fig 63.

Fig 63. Number of young people in Bristol by frequency of drinking alcohol estimated according to national data

Usual frequency of drinking alcohol	Percentage of 11-15 year olds in England	Estimated number of 11-15 year olds in Bristol
Usually drinks at least once a week	6%	1,330
Usually drinks about once a fortnight	5%	1,100
Usually drinks about once a month	6%	1,330
Only drinks a few times a year	18%	3,980
Does not drink	66%	14,600

The prevalence of alcohol consumption among young people in Bristol aged 14 and under is falling. In the 2022 Pupil Voice survey, when asked if they drink alcohol,14% of respondents in primary school year 6, said they did, compared to 17% in 2019 and 31% in 2015.

Among secondary pupils, 28% of respondents in years 8 and 10 said they drink alcohol. This was among the lowest prevalence in recent surveys and compares to 36% in 2019 and 34% in 2015[184]. In national data, 31% of young people in similar age groups (12 and 14 year olds) said they drink alcohol[185].

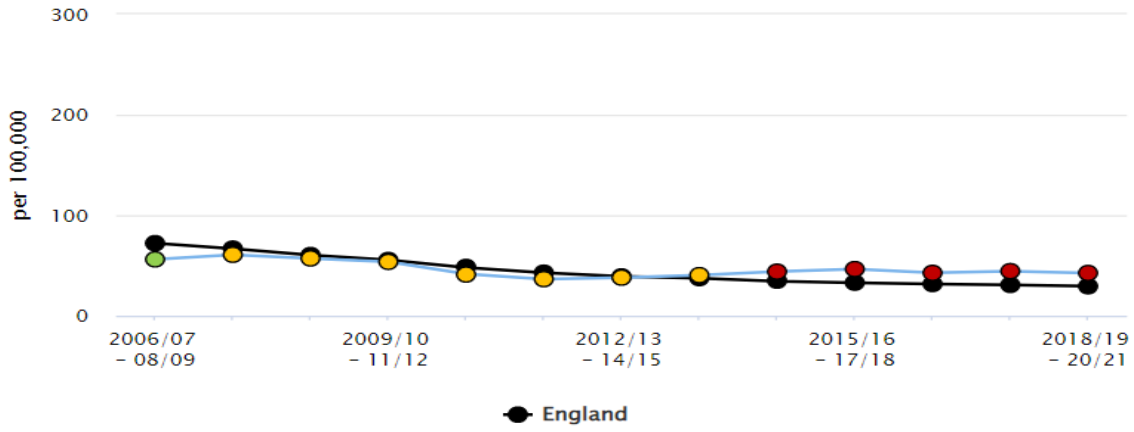
6% of year 6 pupils reported that they drank alcohol in the last 4 weeks. 6% of all year 6 pupils in Bristol equates to approximately 310 10 and 11 year olds. In secondary schools, 11% of year 8 pupils and 25% of year 10 pupils reported that they drank in the last 4 weeks[186]. This compares to an estimated 9.5% of 12 and 14 year olds in the national survey[187], suggesting that secondary school pupils in Bristol who do drink alcohol, are more likely to have done so recently, (and possibly more frequently) compared to pupils their age outside of Bristol.

In line with national data, female secondary pupils in Bristol were more likely to report drinking alcohol in the last four weeks (21%) than male secondary pupils (14%). Also, in line with the national figures, White young people were more likely to report drinking than those belonging to Black, Asian and minoritised groups[188].

Between 2018/19 and 2020/21 the rate of hospital admission episodes among people under 18 in England for alcohol specific conditions was 29.3 per 100,000, falling from 34.2 per

100,000 in 2014/15 - 16/17. The rate for young people under 18 in Bristol is higher at 42.5 per 100,000, falling from 44.3 in 2017/18-19.20[189] (Fig 64)

Fig 64. Admission episodes for alcohol-specific conditions in under 18s in Bristol and England (rate per 100,000)



There is no Bristol data for alcohol use among 16-24 year olds. Nationally the proportion of men and women in this age band who drink over the recommended maximum number of units on the heaviest drinking day in the previous week in 2017 was 30% for males and 31% for females. This is close to the average for both groups over the last 5 years[190]. According to the 2021 census data for Bristol[191] there are 72,679 people in Bristol aged 16-24. It can therefore be estimated that approximately 21,800 people in this age group drink over the recommended maximum number of units.

The prevalence of illicit drug use among young people in Bristol aged 14 and under is also falling. The 2022 Pupil Voice survey recorded the lowest level of reported use of illicit drugs in Bristol since this survey was first conducted in 2008. 10% of pupils in secondary years 8 and 10 said that they had ever taken an illegal drug, down from 13% in 2019. Cannabis remains the most frequently used illicit substance, followed by nitrous oxide[192].

If the prevalence of drug use, including volatile substances, among 11-15 year olds in Bristol is estimated using both national data[193] and the school census as a guide, the estimated number of young people aged 11-15 in each category of frequency can be seen in Fig 65.

Fig 65. Number of 11-15 year olds in Bristol who have taken drugs, including volatile substances, by recency of drug use, estimated according to national data[194]

	Percentage of 11-15 year olds in England	Estimated number of 11-15 year olds in Bristol
Ever taken drugs	18%	3,980
Took drugs in the last year	12%	2,650
Took drugs in the last month	6%	1,330

In the 2022 Pupil Voice survey girls in years 8 and 10 in Bristol were significantly more likely to report that they had ever taken drugs, with 12% reporting that they had used drugs, compared to 7% of secondary boys[195].

Cannabis use among secondary school age pupils in Bristol is probably higher than the national picture. 2% of year 8 pupils who responded to the 2022 Pupil Voice Survey said they had ever used cannabis[196], higher than 0.5% of 12-year-olds nationally[197]. 22% of year 10 pupils said they have been offered cannabis and 11% said they have ever taken it. 10% have used it in the last year and 7% have used it in the last month[198]. In the national data 7.7% of 14-year-olds had ever taken cannabis, 6.5% took it in the last year and 3.5% took it in the last month. This suggests that the prevalence of cannabis use among young people in Bristol is higher than the prevalence among young people in England.

The What About Youth survey in 2014/15 suggested that the prevalence of cannabis use in Bristol was among the highest in England[199]. 17.7% of 15-year-olds in Bristol reported using cannabis, compared to 10.7% for England. 8.9% had used cannabis in the last month, compared to 4.6% for England (Fig 66). According to the 2022 school census, 8.9% of 15-year-olds in Bristol is approximately 370 young people.

Fig 66. Percentage of 15-year-olds who have taken cannabis in the last month- England, Bristol and nearest statistical neighbors[200]

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	-	4.6	4.5	4.8
Neighbours average	–	-	-	-	-	-
Bristol	–	-	-	8.9	7.0	10.7
Liverpool	–	3	-	6.4	4.8	7.9
Manchester	–	8	-	6.1	4.6	7.6
Leeds	–	2	-	6.0	4.5	7.5
Salford	–	6	-	5.5	4.0	7.0
Bolton	–	12	-	5.2	3.9	6.6
Medway	–	9	-	5.0	3.7	6.3
Sheffield	–	1	-	4.9	3.7	6.2
Newcastle upon Tyne	–	5	-	4.5	3.3	5.7
Rochdale	–	14	-	4.4	3.2	5.6
Plymouth	–	10	-	4.2	3.0	5.4
Kirklees	–	11	-	4.1	3.0	5.2
Swindon	–	15	-	4.0	2.9	5.2
Coventry	–	4	-	3.8	2.7	5.0
Derby	–	7	-	3.5	2.4	4.6
Leicester	–	13	-	1.6	0.9	2.3

In the 2022 Pupil Voice survey[201], 0.9% of year 8 pupils and 1.2% of year 10 pupils said that they had ever used cocaine. However, because this included a very small number of pupils, these results are indicative rather than reliable. Nationally, in the equivalent age groups only 0.3% of 12 year olds and 1.1% of 14 year olds reported that they had ever used cocaine[202].

In Bristol 2% of year 10 pupils have ever used MDMA ecstasy and 1% used it in the last year[203]. This is slightly higher than national figures where 1.5% of 14 year olds have ever used ecstasy and 1.2% have used it in the last year[204].

6.1% of year 10 pupils in Bristol said they had been offered nitrous oxide and 5.8% said they had used it. It is unusual for such a high percentage of those who are offered a substance to report that they have used it. The reason that such a high proportion accepted nitrous oxide is not known, but it may suggest that that the perception of harm is lower than for other substances. 4% said they had used it in the last year and 2% said they had used it in the last month[205]. This is higher than national figures for 14 year olds where 3.4% have used nitrous oxide, 1.2% in the last year and 0.4% in the last month[206].

Pupil Voice reports that among secondary pupils, those who identified as LGBT+, young carers, those with a disability or long-term illness, those living in single parent families and pupils with special educational needs and disabilities were all significantly more likely to report illegal drug use.

The survey also found that female pupils in secondary schools were more likely to report having used an illegal substance than male pupils.

13.3.2 At risk population- children and young people in Bristol who experience trauma and adversity.

Bristol has high numbers of vulnerable young people who have experienced adversity and trauma and are at higher risk of using drugs and alcohol. These young people are more

likely to have faced trauma through adverse childhood experiences and living in adverse community environments[207].

- **Children who have not reached a good level of development at the end of reception year.**

  Evidence shows that generic pre-school programmes that improve literacy and numeracy have a strong outcome in preventing drug and alcohol misuse in later life[208]. Children who have not reached a good level of development at the end of their reception year are therefore more likely to face a higher risk of substance misuse as they grow older than other reception children. By the age of 5 many children in Bristol are already affected by wide inequalities, which puts them at higher risk of poor health outcomes during their life course. In 2018/19 70.7% of children in Bristol were assessed as having reached a good level of development at the end of reception year, close to 71.8% in England[209]. However, areas which have greater experience of factors associated with adverse community environments had a much lower percentage of children who reached a good level of development at the end of reception year; they include Hartcliffe and Withywood (56.1%), Central (59.7%) Brislington West (60.5%) and Lawrence Hill (61.2%), Southmead (62.6%) and Filwood (64.7%). Wide inequalities are evident when comparing these to other areas of Bristol. The highest rates can be seen in wards in the north of the city, including Westbury-on-Trym and Henleaze, Bishopston and Ashley Down, Cotham and Redland and in Southville in the South of the city. These wards frequently have over 80% of children reaching a good level of development at the end of reception[210]. For more information on recommended actions to improve the health outcomes for babies see the policy paper The best start for life: a vision for the 1,001 critical days, developed as part of the early years healthy development review.

- **Children and young people known to Children and Family Services.**

  Trauma is a substantial factor for children in care and they are identified by OHID as one of the groups who are most vulnerable to substance misuse[211]. On 31 March 2022, there were 2036 children in Bristol who were known to social care, including 1088 children in need, 257 children with a child protection plan and 691 children in care. Children in care are estimated to have about a fourfold risk of drug and alcohol use compared to those not in care[212]. This risk is likely to be highest among those who have experienced abuse and neglect. 68% of the children in care on 31st March 2022 (n= 472) had their category of need recorded as abuse or neglect[213]. The number of children in care for abuse and neglect in Bristol has risen in recent years from 399 in 2017/18 to 472 in 2021/22[214].

  In 2019/20 199 children were as assessed as a Child in Need with abuse or neglect identified as a safeguarding factor[215]. The 2022 Pupil Voice survey found that 25% of children in care who responded to the survey said they had used illegal drugs, compared to 10% of all respondents. Fewer children in care (8%) reported drinking alcohol in the last 4 weeks, compared to 12 % of all pupils. This suggests a very high proportion of children in care in Bristol are using drugs. However, the number of children in care who

took part in this survey was very small and therefore, it is not possible to say with certainty that this is a significant difference.

- **Children and young people who experience domestic abuse**
  Children and young people who experience domestic abuse are identified by OHID as among the most vulnerable to substance use[216]. The Children's Commissioner estimates that in 2019/20 there were 7,300 children aged 0-17 living in households in Bristol where there was domestic abuse. This is a rate of 77 per 1000 0-17 year olds[217]. This includes 286 Children in Need. 21% of secondary school pupils in years 8 and 10 who responded to the 2022 Pupil Voice Survey reported that they were worried by shouting and arguing at home during the month before the survey. 6% of pupils said that they had been worried by bullying or controlling behaviour at home in the month before the survey. 8% of secondary pupils said that there was violence at home in the month before the survey[218].

- **Children and young people with mental ill health**
  The links between mental ill health and substance misuse are frequently cited and are highlighted by OHID[219] and by Carol Black in her report. According to NHS Digital data, 18% of 7-16 year olds (approximately 9,000 children and young people in Bristol) and 22% of 17-24 year olds (approximately 15,000 young adults in Bristol) are estimated to have a probable diagnosable mental health condition[220]. The numbers may be higher in Bristol because the city has high numbers of children and young people who experience risk factors for mental ill health, including inequality and trauma.

- **Children and young people living in households where a parent has a severe mental health problem**
  The Children's Commissioner estimates that there are 13,900 children aged 0-17 in Bristol who are living in households with a parent who has a severe mental health problem. This is a rate of 147 per 1000 children and young people, compared to a rate of 134.5 per 1000 for England[221].

- **Children and young people who experience, or are at risk of, child sexual and/or criminal exploitation**
  OHID identifies child sexual exploitation as a factor which increases vulnerability to substance use[222]. Bristol City Council (BCC) identifies drug supply as an influential factor in child criminal exploitation[223]. Between 1st January 2021 and 30th November 2021 780 individual children were identified in Bristol as being harmed through extra-familial abuse. 444 of these cases related to child criminal exploitation and/or serious violence and 380 related to child sexual exploitation[224]. Between 2016 and 2022 an average of 123 children and young people per year, who were identified as victims of child sexual exploitation, required Children and Families Service involvement because of ongoing safeguarding concerns. This is likely to be lower than the real number because many of these children are difficult to identify[225].

- **Young people who are not in education, employment or training (NEET)**
  OHID identifies young people who are NEET as one of the groups who are most vulnerable to substance misuse[226]. 6.8% of 16 and 17 year olds in Bristol were recorded as NEET in 2020. This is significantly worse than 5.5% in England[227]

- **Children and young people who are excluded from school**
  National data highlight school exclusion as a vulnerability factor for drug and alcohol misuse among young people, with these young people being 8 times more likely than the wider school age population to use illegal drugs[228]. During the three school years between 2016/17 and 2018/19 there were a total of 15,900 school exclusions in Bristol schools, relating to 4,405 individual pupils, from reception to year 11. This gives a mean average of 3.6 exclusions per person. During the three school years between 2018/19 and 2020/21 there were a total of 12,455 exclusions, relating to 3,934 individual pupils from reception to year 11. This gives a mean average of 3.2 exclusions per person. However, although this is a lower number, affecting fewer pupils, it should be noted that this includes the years when there were school closures due to the COVID-19 pandemic, when numbers of exclusions would be likely to be lower. There are wide inequalities across the city, with the highest rate of exclusion affecting pupils living in Filwood at 151.1 exclusions per 1,000 pupils, and the lowest rate affecting pupils living in Redland at 4.8 exclusions per 1,000 pupils[229].

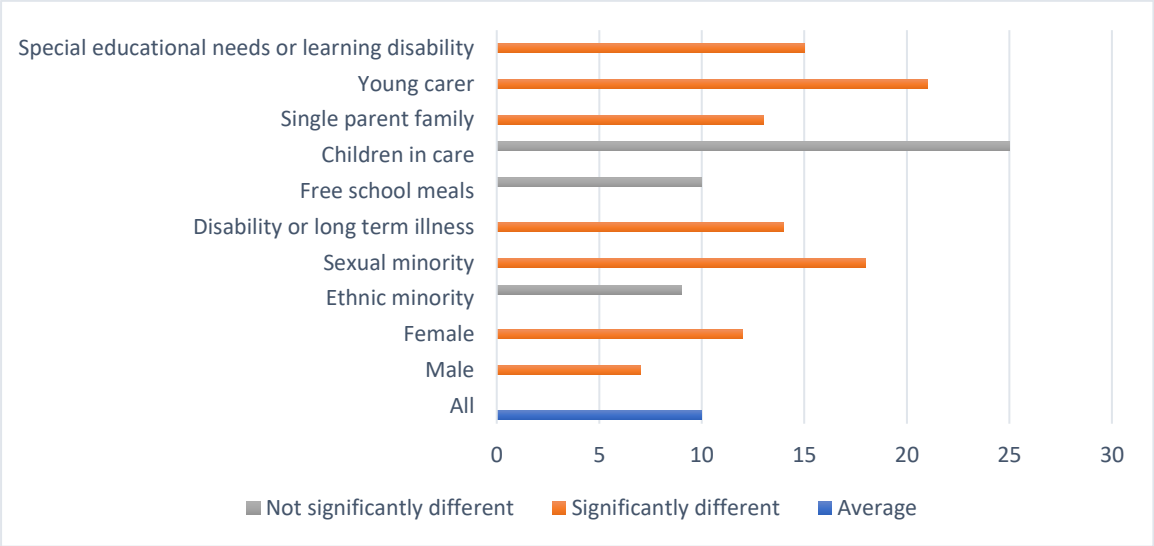
- **Young people with housing problems**
  The link between homelessness and substance use is well established and OHID highlights the vulnerability of children with housing problems[230]. In 2020/21 there were 596 households with dependent children in Bristol that were owed a duty under the Homelessness Reduction Act. This is a rate of 11.8 per 1000 households with dependent children, close to the rate of 11.6 per 1000 for England. Both the number and rate have reduced in Bristol since 2019/20, when there were 747 households with dependent children who were owed this duty, which was a rate of 14.8 per 1000[231].
  In 2020/21 there were 470 households in Bristol that were owed a duty under the Homelessness Reduction Act, where the main applicant was aged 16-24. This is a rate of 2.4 households per 1000. This has risen from 1.8 per 1000 in 2018/19. This is close to the rate for England which has remained at 2.6 per 1000 since 2018/19[232].
  In the 2022 Pupil Voice survey 4% of all secondary respondents said they were living in temporary accommodation[233].

- **Children and young people whose parents and carers are dependent on drugs or alcohol**
  Parental problematic drug and alcohol use has long been recognised as a risk factor for substance use among young people[234]. These children are difficult to identify, and estimates vary on the number living in Bristol. The Children's Commissioner for England estimates that in 2019/20 there were 4,600 children and young people aged 0-17 living in

households in Bristol with a parent who has alcohol or drug dependence, which is a rate of 48.9 per 1000 children. This is much higher than the estimated rate for England, which is 39.76 per 1000[235]. Public Health England estimated that in 2018/19 the number of children aged 0-17 living with at least one adult with alcohol dependence was between 2,289 and 2,490. This is a rate of 24-26 per 1000, again higher than the rate for England, which is 16-17 per 1000. It is also higher than the average rate for areas that were benchmarked as like Bristol, which is 19-21 per 1000. It is evident that many of these children have not been identified and these families may therefore not be receiving appropriate support. There are several reasons for this. Firstly, data recorded by the Bristol Recovery Orientated Alcohol and Drug Service (ROADS) is primarily focused on the number of adults in treatment rather than children: in 2019/20 only 800 adults engaging with ROADS were recorded at their assessment as parents who have a child or children living with them for at least one night each week[236]. Secondly, there may be some double counting, where both parents are accessing ROADS services and are recording the same individual children. Thirdly, children who are born after their parents entered treatment may not be recorded, as this information is usually collected at initial assessment. Male clients who are new parents are more likely to be missed in these cases. Finally, many parents who have problematic use of drugs and alcohol will not be receiving support and treatment and will therefore be unknown to ROADS.
In 2019/20 949 children aged 0-17 who were assessed as a child in need in Bristol had substance misuse by a parent or someone else in the household identified as a safeguarding factor during this assessment[237]. Some of these children's parents are likely to be recorded within the ROADS data, but this still leaves a very large number of children unidentified when this is compared to the estimated prevalence.

- **Young Carers**
  Young carers look after parents with a range of health needs, but parental drug and alcohol misuse and parental mental ill health are significant factors for many of these children and young people. Inequalities for this group are evident in the data from the 2022 Pupil Voice Survey. 18% of respondents who were young carers had drunk alcohol in the 4 weeks before completing the survey, significantly higher than 12% for all pupils (Fig 64). Among secondary school respondents, 21% of young carers reported ever taking illegal drugs, significantly higher than 10% of all secondary pupils[238] (Fig 63). Similar inequalities were seen in the 2019 Pupil Voice survey[239], where 18% of young carers in secondary schools reported ever taking illegal drugs, significantly higher than 12% of all secondary pupils. In 2019, drinking alcohol in the previous 4 weeks was higher among young carers, but not significantly higher.

Fig 63. Pupil Voice 2022 Variation Chart: percentages of respondents in secondary schools who reported ever taking illegal drugs, all and by group



- **Young people who are involved in antisocial behaviour and criminal activity.** In 2020/21 there were 147 young people aged 10-17 in Bristol who entered the youth justice system. This is equivalent to 3.8 per 1000. This rate has been decreasing since 2014, but remains significantly higher than the rate for England, which is 2.8 per 1000[240]. Health data for Bristol show an increased risk across a range of factors for young people who are engaging with the Youth Justice Service, including drug and alcohol misuse. 74% report using illegal drugs, 61% smoke cannabis, and 48% drink alcohol regularly or occasionally[241]. Young people who are engaging with the Youth Justice Service experience wide inequalities and this is evident when comparing these data with Pupil Voice data[242]. 90% of 14 and 15 year olds who were engaged with the Youth Justice Service between 2020 and 2021 say they regularly use illegal drugs compared to 14% of 14 and 15 year old Pupil Voice respondents (2021-22) who report that they have ever used illegal drugs. 81% of 14 and 15 year old young people engaged with the Youth Justice Service regularly use cannabis, while 7% of 14 and 15 year old Pupil Voice respondents used cannabis in the previous month. 50% of 14 and 15 year old young people engaged with the Youth Justice Service reported drinking alcohol regularly, compared to 25% of 14 and 15 year olds in Pupil Voice who drank in the last 4 weeks[243]. More widely, Bristol City Council reports an increase in serious violence following the lifting of each period of COVID-19 lockdown, including an increase in youth violence and knife crime. Drug supply and neighbourhood rivalry were identified as influential factors in these cases[244].

- **Young People who experience discrimination**

Discrimination based on race

National data suggest that young people from some ethnic minoritized groups may be more vulnerable to drug use, particularly girls of mixed heritage[245]. According to the 2019 School Census approximately 40% of the Bristol school age population belongs to ethnic minoritized groups. Data from Bristol drug services shows low numbers of young people from these groups accessing support. However, this is difficult to analyse correctly because most performance data are not broken down further than the very large and diverse group of all Black, Asian and minoritized young people and, as national data shows, not all these groups have high levels of drug and alcohol use. In the 2022 Pupil Voice survey the proportion from Black, Asian and minoritized groups who drank alcohol in the previous 4 weeks (9%) was lower than all respondents (12%) and the number who reported ever taking illegal drugs (9%) was close to all respondents (10%)[246].

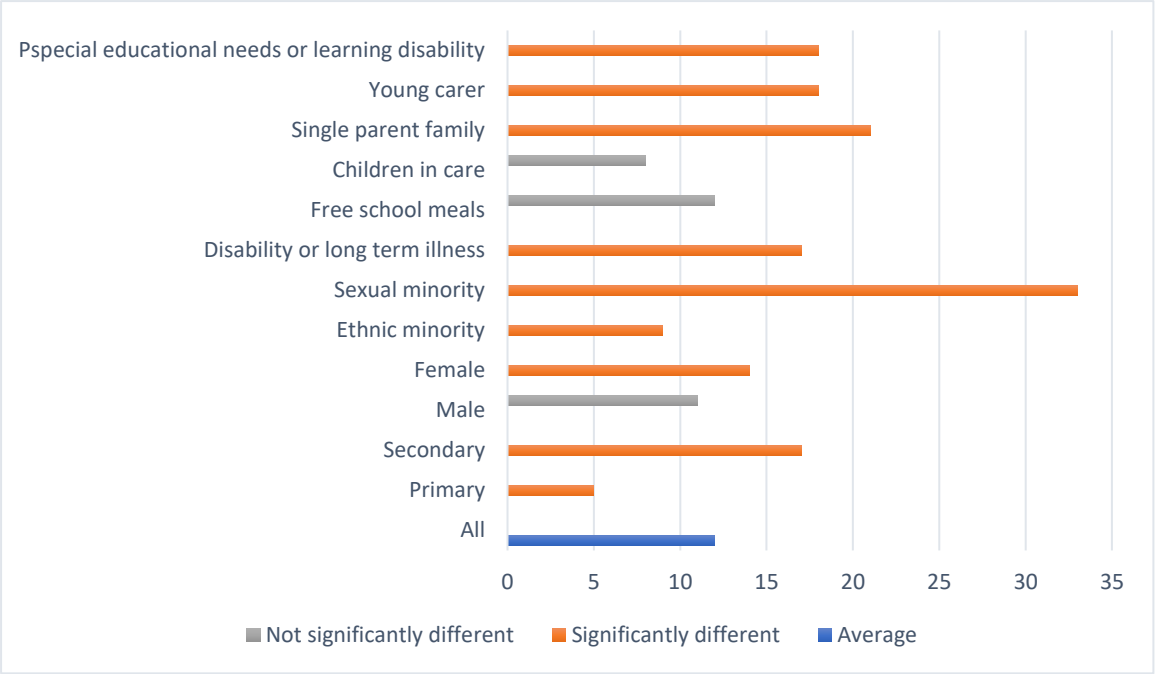
Discrimination based on sexual orientation

Drug and alcohol use is significantly higher among people who identify as LGBTQ+ than in the population as a whole[247],[248]. LGBTQ+ led groups identify discrimination as one of the most significant drivers of drug and alcohol use within this community[249],[250].

In the 2022 Pupil Voice survey[251] 17% of secondary school respondents identified as lesbian, gay, bisexual or other. This is a considerable increase from 12% in the previous survey in 2019. These pupils were categorised as a sexual minority group, along with pupils that identify as non-binary in respect of their gender.

These pupils had the highest percentage who reported drinking alcohol within the last four weeks. 33% of respondents in the sexual minority group reported that they had drunk alcohol in the 4 weeks before the survey, significantly higher than 12% of all pupils.

Fig 64. Pupil Voice 2022 Variation Chart: percentages of respondents who reported drinking alcohol in the last 4 weeks, all and by group



These pupils also had a significantly higher percentage who have ever used drugs, (Fig 63). 18% of pupils in the sexual minority category said they had ever taken illegal drugs, compared to 10% of all pupils. This was the second highest percentage, with only young carers reporting a higher percentage.

13.3.3. Knowledge of Drug and Alcohol Services

Knowledge about local drug and alcohol support for young people in Bristol is at its lowest since the Pupil Voice survey began. In 2022 only 7% of secondary school pupils in Bristol were aware of support services[252], compared to 22% of pupils in 2010. In 2022 year 10 pupils (8%) were slightly more aware than year 8 pupils (6%), but drug and alcohol use is much higher in year 10 so there is potentially a much higher need among older pupils. This may mean that young people in need of support have no knowledge about how to access this.

13.4 What is the evidence of what works?

This evidence has been considered in the context of interventions based in two categories; the first is prevention and the second is treatment.

13.4.1. What works in Prevention?

Drug prevention interventions have been classified into three separate categories[253]:

- **Universal** prevention, directed at a whole population.
- **Selective** prevention, directed at those who have a higher risk of substance misuse than others, including those who experience trauma and adversity.
- **Indicated** prevention, aimed at people who are already using substances, and are beginning to experience associated problems.

PHE has summarised the United Nations Office of Drug Control (UNODC) International Standards on Drug Use prevention to highlight the importance of prevention interventions throughout the whole life course[254]. The UNODC scale classes efficacy under the categories of limited; adequate; good; very good; and excellent. PHE also uses this scale to indicate the level of effectiveness shown in the evidence.

PHE found that in all prevention activities, having staff who are qualified and competent to deliver the interventions was a strong factor in positive outcomes[255].

1. Early Years Education Settings

PHE identifies **selective** prevention interventions during the early years phase as having most impact among all prevention interventions, particularly generic pre-school programmes, improving literacy and numeracy. These were categorised as very good and were found to have a long-term effect[256].

2. Family Interventions

PHE identifies multi-component **universal** and **selective prevention** programmes involving parenting interventions and support for individuals and families, as having very good efficacy when the children in these families are in middle childhood or early adolescence[257]. These stages of childhood are not explicitly defined by age, but it is reasonable to assume that this refers to the 5-16 age group.

3. Prevention In Schools

a) Whole School Approach

The whole school approach to substance misuse prevention incorporates **universal, selective** and **indicated** prevention. Evidence indicates that a whole school approach is the best way of achieving and sustaining improved health and education outcomes for children and young people. This evidence is available from national sources, including NICE [258],[259], [260] and PHE[261], and from international sources [262],[263]. PHE also draws on UNODC evidence to discuss the effectiveness of some of the elements within this framework[264]. A whole school approach aims to provide an environment which promotes health and enables pupils to feel safe, happy and prepared for life beyond school. It has effective leadership as its central core[265] and focuses on the interrelationship between all systems in school including curriculum delivery, school policies and awareness of differing needs within a diverse population. It encourages proactive relationships between the school, the pupils and their parents or carers, as well as with outside agencies and the wider community[266]. It also includes staff professional development to ensure the curriculum is taught by those with appropriate qualifications and competence, and importantly, it involves enabling students to have a role in decision making.

Fig 65 Whole School Approach[267]

b) Drug and Alcohol Education

Evidence shows that drug and alcohol education is more effective if it is incorporated into a whole school approach, rather than existing as an isolated strand (see above). In September 2020 changes were introduced to the Personal, Social, Health and Economic (PSHE) curriculum for England and a new curriculum was introduced, which includes 3 statutory elements:

- relationship education in primary schools
- relationship and sex education in secondary schools
- health education in state funded primary and secondary schools

The statutory guidance on Relationships Education, Relationships and Sex Education (RSE) and Health Education[268] states that drugs, alcohol and tobacco education should be placed in the health education element of this subject in both primary and secondary settings, and it establishes the breadth of the curriculum for primary and secondary age groups (Fig 66). In line with evidence, the statutory guidance promotes the importance of setting these subjects within a whole school approach.

Fig 66 Drug, Alcohol and Tobacco Education Curriculum[269]

By the end of **primary school** pupils should know:	• the facts about legal and illegal harmful substances and associated risks, including smoking, alcohol use and drug-taking.
In secondary education, schools should continue to develop knowledge on topics specified for primary as required and in addition cover the following content so that by the end of **secondary school** pupils should know:	• the facts about legal and illegal drugs and their associated risks, including the link between drug use, and the associated risks, including the link to serious mental health conditions. • the law relating to the supply and possession of illegal substances. • the physical and psychological risks associated with alcohol consumption and what constitutes low risk alcohol consumption in adulthood. • the physical and psychological consequences of addiction, including alcohol dependency. • awareness of the dangers of drugs which are prescribed but still present serious health risks. • the facts about the harms from smoking tobacco (particularly the link to lung cancer), the benefits of quitting and how to access support to do so.

The national drug strategy emphasises the significance of drug and alcohol education in schools, identifying it as one of the key prevention interventions for children and young people. As a statutory element in state funded primary and secondary schools it is the broadest programme of universal drug and alcohol prevention in England.

The PSHE Association states that the aim of teaching children and young people about these substances is to support them in delaying their first use, to reduce harm, and to prevent the development of harmful patterns of substance use into adulthood[270]. Evidence of its effectiveness in prevention should therefore be measured against these aims.

In its evidence review of effective drug and alcohol education[271] the PSHE Association draws together key research, including the NICE, UNODC and PHE findings to promote the positioning of the new curriculum as one element of a whole school approach.
The review promotes the following evidence-based principles to inform the delivery of drug and alcohol education to ensure that it meets its aims and that lessons are effective, relevant and safe:

- Drug and alcohol education should be taught within a planned, spiral curriculum in PSHE education lessons to ensure teaching is enhanced by, and enhances, the wider PSHE education curriculum and to facilitate progression of learning that is age and developmentally appropriate.
- Teaching should equip pupils with the knowledge, skills, attitudes and attributes that contribute to self-efficacy and enable students to develop a range of skills, including seeking help and support.
- Activities should focus on positive social norms to support behaviour change and promote safe and healthy choices.
- Content must be developmentally appropriate, including planning to teach substance-specific information only as the average age of first use approaches or ages in which use of a substance increases, responding to local and national data, baseline assessment.
- The use of external visitors should be considered carefully. If external visitors are used, this should be embedded within a planned, developmental approach to drug and alcohol education within the school's PSHE education curriculum.

In addition to this guidance, PHE found that in all prevention activities, having staff who are qualified and competent to deliver the interventions was a strong factor in positive outcomes[272].

The PSHE Association also encourages the use of national data to inform the introduction of substance specific information at an age-appropriate point. However, it points out that social and cultural factors may differ across different communities and areas, and this may alter the point at which the introduction of substance-specific information is most effective, so baseline assessment and local data sources are also important. On this point the statutory guidance encourages flexibility, pointing out that this enables schools to respond to local public health and community issues, by adapting materials and programmes to meet the needs of pupils. Pupils who have truanted or have been excluded from school, for example, are much more vulnerable to misusing drugs and alcohol and to adopting riskier behaviours than other pupils[273]. It would be appropriate, therefore, and in accordance with PHSE Association evidence-based guidance[274] when teaching in settings such as alternative learning provision, to reflect this pupil experience and adapt the programme to cover some

substance specific information earlier in the curriculum and incorporate some selective prevention elements into the universal approach.

NICE, PHE and the PHSE Association found evidence that the following are not effective[275,276,277]:

- Information-only approaches or those based solely upon mass media campaigns, as these do not equip pupils with the skills needed to deal with real life situations involving substances.
- Shock or fear-arousal tactics, as evidence shows that these can be both ineffective and harmful.
- Ex-substance user testimonials, as these may unintentionally glamorise the use of substances, or draw attention away from the types and patterns of substance use that will be more relevant to pupils' own experiences.
- Sessions delivered by the police if this has not been built into a wider prevention programme.
- peer mentoring schemes that are not evidence-based

Joining up universal, selective and indicated prevention across all settings

PHE has developed a broad framework for working with young people in all settings to encourage a focus on improving health. This model incorporates the principles of a whole school approach but builds this further to reflect a systemwide child/young person-centred focus which must therefore include **universal, selective** and **indicated** substance misuse prevention. PHE has built on the existing evidence of what works and has developed a model of six principles, which, they argue, should be embedded in all work with young people, to build resilience and strengthen the effectiveness of interventions[278] (Fig 67).

Fig 67. Six Principles to Build Thinking about Young People's Health[279]

Principle 1 - Relationships

The central core of this model is relationships. The importance of relationships is clearly relevant to young people's drug and alcohol misuse and can be seen in several related factors, including peer influence; bullying; parental attitudes to drugs and alcohol; parental substance misuse and other ACEs; coercion and exploitation; trauma informed approach and the role of trusted adults, including the importance of a healthy relationship between professionals and the young people they work with. A focus on relationships also emphasises the importance of the interconnection between substance misuse and other health areas such as mental health and sexual health.

Education settings are key in the work to embed healthy relationships in children and young people's learning and experience, supporting them to build resilience and reduce vulnerability. The factors that contribute to this principle will be supported by the whole school approach to health. Health services, such as primary care and school nurses, and community based practitioners, including those in substance misuse services, also have an important role in embedding this principle outside of school settings.

Principle 2 - Focusing on what makes children and young people feel well and able to cope

This is a major factor in building resilience among children and young people, helping them to understand safety and enabling them to develop skills to cope with adversities. These are important elements all areas of health, but they are especially important in the context of a trauma informed approach. Public Health England draws on evidence related to this principle to include strengthening life skills, enhancing self-efficacy, nurturing creativity and ensuring that resources are available when additional support is required. Again, education settings are key to this and the factors that contribute to achieving this principle also support a whole school approach to health. Other community settings and youth services also have a role in supporting young people to develop these skills, including those preventing and reducing the harm related to drug and alcohol misuse.

Principle 3 - Reducing Health Inequalities

Inequality drives a wide range of poor health outcomes, including mental ill health and other problems associated with drug and alcohol misuse. Young people have also been particularly badly affected by widening inequalities resulting from the Covid19 pandemic[280],[281].

Reducing health inequalities within this model involves ensuring that **universal** and mainstream services are accessible to all but are closely linked to additional resources that provide **selective** and **indicated** substance misuse prevention as well as treatment interventions. This principle therefore highlights groups of young people who are particularly vulnerable to drug and alcohol misuse, and especially those who have experienced trauma. This principle is relevant to commissioners, education settings, primary care settings and voluntary sector providers in communities.

Principle 4 - Championing integrated services

This principle is built on the understanding that young people's lives involve a range of behaviours, which often overlap, particularly during adolescence. PHE gives the example of early substance use being associated with risky sexual behaviour, antisocial behaviour and academic failure. This principle is built on the understanding that for services to be effective and produce positive outcomes, they need to provide seamless connections so that young people are not disadvantaged further by having to find their own way through complicated referral systems. PHE argues that services need to take responsibility for identifying need and referring young people to other appropriate sources of help. Much of the responsibility for embedding this principle lies with commissioners and service providers.

Principle 5 - Understanding changing health needs as young people develop

This principle demands awareness of different needs at different stages of a child and young person's development. Particular attention is drawn to stages of transition, such as between child and adult services.

This principle should also steer the content of drug and alcohol education in schools.

Principle 6 - Accessing Young People Friendly Services

This principle draws on the You're Welcome standards[282] so that young people have easy access to age-appropriate services that they have helped to design and where staff are non-judgemental and understanding.

13.4.2. What works in specialist substance misuse treatment for young people?

Specialist substance misuse treatment interventions are needs based, care-planned packages of support for individual young people, who have complex needs, often based on their experience of trauma, and multiple vulnerability factors. Treatment includes medical, psychosocial or specialist harm-reduction interventions and should aim to build young people's resilience and reduce the harm caused by substance misuse[283], [284].

NDTMS requires that all treatment provision is reported on the NDTMS young people's data set. Treatment services are required to fulfil 3 conditions:

- They should have a service level agreement for providing specialist substance misuse treatment to young people under the age of 18 and their families
- They will have been established as part of the young person's substance misuse treatment needs assessment and treatment planning and commissioning process to provide specialist substance misuse treatment interventions to young people under the age of 18
- They should be delivering specialist treatment interventions for young people.

The clinical guidelines on providing treatment interventions for people with drug and alcohol problems are predominantly adult focused, containing only a very short section of advice for those working with young people[285]. This section emphasises the need to operate within a different framework, including a range of pharmacological interventions as well as age-appropriate assessment and a partnership approach in response to multiple needs that may exist alongside substance use.

Public Health England and the Children's Society have worked together to produce a different framework for commissioners of young people's drug and alcohol treatment services, offering guidance based on four evidence based principles, drawn from a rapid mixed methods review[286]. These principles build on the Six Principles to Build Thinking about Young People's Health, discussed above, but they include additional evidence based

guidance, tailored to focus on the complex needs of the young people supported through treatment services.

Commissioning principle 1: Young people and their needs are at the centre of services

As in the earlier model of Six Principles to Build Thinking about Young People's Health principles, 'You're Welcome' quality standards should be embedded in all commissioned treatment services, to ensure that services are accessible and meet young people's needs.

Commissioning principle 2: Quality governance is in place for all services

This principle emphasises the importance of young people's treatment interventions being delivered in compliance with local safeguarding policies and national guidelines, clinical guidance and national standards. This includes the OFSTED and CQC inspection processes where this is appropriate, reflecting the additional needs of young people accessing treatment services.

In accordance with other PHE evidence[287] this principle also stresses the importance of having staff that are trained, competent and supported to assess and manage risk, to deliver interventions and escalate safeguarding issues when necessary.

This principle also emphasises the importance of delivering within a reporting system which is compliant with the local and national requirements, including the National Drug Treatment Monitoring System (NDTMS) and the Young People's Outcome Record (YPOR)[288].

Commissioning principle 3: Addressing multiple vulnerabilities and complex needs

This principle is built on evidence showing that treatment services are most effective when they adopt a collaborative and multi-agency approach with clear roles and responsibilities and clear lines of communication and accountability. This enables them to be responsive to the most vulnerable young people who have complex needs.

Commissioning principle 4: appropriate transitional arrangements for young people becoming young adults

These arrangements should be led by NICE guidance (NG43)[289], and should recognise the different needs of a young person from other adults in the services commissioned to deliver drug and alcohol treatment to those age 18 and over. This is particularly relevant to drug and alcohol services because patterns of use are very different between adults and young people, and young people are at risk of withdrawing from services at this point if their needs are not met.

13.5 What services / assets do we have in Bristol to prevent and meet this need?

13.5.1 Prevention -Early Years

Health Visiting service

Health visiting is part of the Public Health nursing service commissioned within the Children's Community Health Partnership contract and provided by Sirona Care and Health. Health visitors support families with children from birth to 5 years. This is a mandatory **universal** service, providing universal prevention, but families with additional needs are prioritised for selective early intervention. Safeguarding is embedded in this service, including identifying children who are at risk because of parental substance misuse and referring adults into appropriate treatment services. Health visitors will also work closely with Family Hubs.

Family Hubs

Bristol has recently been awarded funding to develop **family hubs,** which aim to improve health and education outcomes for babies, children and their families. They will offer services to families with children aged 0 to 19 or up to 25 for those with special educational needs and disabilities. The detail for this new resource is still being planned, but they will provide a single point of access to a range of services offering early help to families and incorporating **universal, selective** and **indicated** prevention. This will include parenting programmes, infant-parent mental health support, relationship building and drug and alcohol misuse support.

Generic pre-school programmes.
These programmes focus on improving literacy and numeracy and are part of the early years education delivery. They provide a **universal prevention** intervention in pre-school settings. Public Health England found evidence that these programmes had positive outcomes and a long-term effect. However, wide inequalities are evident across the city, with a large proportion of reception age children in areas of highest deprivation, having not reached the expected level of development.
Early years settings in Bristol have a quality improvement framework called The Bristol Standard. Work has recently begun with partners, including health providers and the local authority, to embed health and wellbeing to the dimensions within this framework. This includes a trauma informed approach. When this is complete it should provide parents and carers in these families with access to advice and support for drug and alcohol use and misuse.

13.5.2 Universal Prevention - School Age

1. Drug and Alcohol Education
The launch of the new relationships, relationships and sex and health education statutory curriculum coincided with the COVID-19 pandemic - a period when schools were closed to

most pupils due to lockdown. Schools have been severely affected by the impact of this pandemic across most of their systems and anecdotally this has included the introduction and delivery of the new curriculum. To inform this needs assessment, consultation was carried out in the form of a survey with PSHE leads in Bristol schools, to assess assets, barriers and needs in delivering drug and alcohol education.

Consultation with PSHE leads in Bristol schools about drug and alcohol education.
The survey was sent out to PSHE leads in Bristol state schools to assess how school staff were managing to deliver drug and alcohol education within this new statutory programme, including access to resources, and confidence in the subject matter. 16 schools responded, incorporating primary, secondary and alternate provision settings, giving an indication of assets and challenges across the school age range and different types of setting. However, responses from 16 schools does not give a representative sample of all school settings in Bristol so these findings can only be used as an indication of some of the factors identifying needs in the delivery of evidence-based drug and alcohol education.

Responses to the survey questions have been analysed in the context of the PSHE Association evidence-based guidance. They suggest that schools need much more support in delivering effective drug and alcohol education.

a) **Whole school approach**
   Respondents were asked whether the curriculum, teaching and learning about drugs, alcohol and tobacco in their school part of a whole school approach to health and wellbeing. 13 respondents said that it was and 3 were not sure. However, it was clear from some other answers that not all the 13 schools did have a whole school approach. For example, the guidance document for the curriculum says that effective practice is underpinned by clear responsibility for these subjects by a senior teacher in leadership position[290]. This was absent in some of the schools. There were also no references given to baseline assessments of need within these schools to underpin the drug and alcohol education, whereas identifying need is an important element of a whole school approach. Also, 11 of the schools said that they did not find it easy to find appropriate resources for pupils with special needs and disabilities, whereas identifying and responding to need within a diverse school population is threaded through a whole school approach. This suggests that schools may benefit from support to understand the value of a whole school approach and assistance to put this in place.
b) **Staff training and confidence**
   PHE highlights UNODC evidence stressing the importance of staff who are qualified and competent to deliver any prevention intervention they provide, emphasising that this as a strong factor in positive outcomes[291]. Only 8 of the schools that responded to this survey said they had a PSHE specialist in their school. In schools that operate within a whole school approach, having this person on the staff should ensure that schools have good leadership around the RSE/PSHE curriculum, with a senior teacher having responsibility with dedicated time to lead specialist provision. This

leadership and oversight are more likely to encourage professional development and strengthen the delivery of drug and alcohol education within this programme, making it more likely that the subject is delivered by staff who are qualified and competent to deliver these interventions.
Having qualified teachers should help to meet part of the criteria of staff who are qualified and competent to teach this subject: they are highly trained to understand the processes of delivering classroom-based education, such as equipping pupils with the knowledge, skills, attitudes and attributes that contribute to self-efficacy, but some of the qualitative data in the survey suggest that they were not always confident in their knowledge of the subject matter. 9 respondents identified barriers to delivering good quality drug and alcohol education, and 8 of these mentioned the need for additional training, lack of confidence and lack of knowledge in the subject matter. Extra training and support for teachers to deliver this fundamental element of universal prevention within a whole school approach is essential.

c) Spiral curriculum linking into wider PSHE lessons

Schools were asked whether their drug and alcohol education is taught within a planned, spiral curriculum using resources that enhance and are enhanced by the wider PSHE curriculum to facilitate progression of learning that is age and developmentally appropriate.
Just over half of the schools that responded said they were able to find resources that helped them connect the drug and alcohol element of the curriculum to the wider PSHE content, and just under half said they did not have these resources, or they weren't sure about this.

d) Focus on knowledge, skills and attitudes using quality approved resources

The PSHE Association guidance advises that teaching should equip pupils with the knowledge, skills, attitudes, and attributes that contribute to self-efficacy and enable students to develop a range of skills, including seeking help and support.
All respondents said that their school had resources to draw on to support the development of knowledge, skills and attitudes among pupils. However, only 6 drew on the main guidance from the Department for Education (DfE) and 4 said they drew on the PSHE Association. The PSHE Association has quality assured a range of resources, assessing them against the new statutory curriculum requirements and schools in Bristol are encouraged to focus on these. DfE guidance also includes a template for training staff.

Six of the responding schools used curricula that were set before the introduction of the statutory curriculum, some of which no longer have PSHE quality assurance. While this is not necessarily going to stop pupils from developing some key skills, schools are now encouraged to have a more flexible approach and to develop their own curricula based on the needs in their school, identified by baseline assessment.

It is also possible to triangulate responses with evidence from Pupil Voice[292], which shows that secondary pupils' awareness of a local drug and alcohol support for young people is now at its lowest among all year groups, at 7%, compared to 10% in 2019 and 22% in 2010, which raises questions about outcomes relating to skills focusing on help seeking and support. While this is only one of a range of skills, it is nevertheless very important in the context of drug and alcohol education.

e) Positive social norms

The PHE Association guidance encourages schools to use activities that focus on positive social norms to support behaviour change and promote safe and healthy choices. Schools are encouraged to look at national and local data to support this. Only 5 schools said they found it easy to access data about this and sometimes this raised questions about whether what they use is reliable:

‘Occasionally will do a search for something, success of this varies a lot’ (School 13)

However, there was evidence of a small number of schools having better understanding of this and using the Healthy Schools resource to access these data:
‘We use you when needed!’ (School 1)

There was also evidence that some schools may not understand the importance of these data:
‘But not necessarily relevant to KS2’ (School 4)

In fact, the 2019 and 2022 Pupil Voice surveys reported that in key stage 2, 7% and 6% of Year 6 pupils respectively drank alcohol in the 4 weeks before the Pupil Voice Survey went out, and in both reports 2% did this without their parents’ knowledge[293],[294].

None of the schools who responded to the PSHE leads survey referred to their own survey of pupils, or of involvement in Pupil Voice, which would have given them their own baseline data in the form of an individual school report, including additional data about their local community.

f) Content is developmentally appropriate

Guidance states that content must be developmentally appropriate, including planning to teach substance-specific information only as the average age of first use approaches or ages in which use of a substance increases, responding to local and national data, baseline assessment.

Many responding schools, mainly primary schools, appear to struggle with an age and developmentally appropriate focus. Qualitative responses from primary schools suggested that substance-specific information may be being taught to children too early, rather than in line with guidance.

"Street" language - often, pupils know different terminology' (School 12)

'Vocab and knowing what you can and can't say'. (School 5)

It is possible to infer from these responses that some primary schools may be focusing on illegal street drugs, which is not in line with the average age of first use, rather than focusing on staying healthy and safe and considering substances that are relevant to primary school activities, such as household products, prescription and non-prescription medication and age relevant approaches to discussions about substances that children may see people use in everyday life, such as alcohol, tobacco and nicotine. Many responses showed low levels of confidence when focusing on illicit drugs.

g) External visitors

The PSHE Association encourages schools to consider very carefully the use of external visitors, advising that if external visitors are used, this should be embedded within a planned, developmental approach to drug and alcohol education within the school's PSHE education curriculum. Use of visitors should be to enhance teaching by an appropriate member of the teaching staff, rather than as a replacement for teaching by those staff.

Responses showed that some schools continue to use external visitors to deliver at least part of their drug and alcohol education. Evidence shows that sessions led by the police generally have poor outcomes[295], although the PSHE Association suggests they can have a carefully planned contribution, such as considering the laws relating to these subjects. The law relating to the supply and possession of illegal substances is in the guidance for the secondary curriculum. Two primary schools said that they used the police, and in both cases, it is possible to infer that the contribution was quite frequent:

'Class teachers deliver [the drug, alcohol and tobacco element of the school PSHE/RSE curriculum] with some support from PCSOs for UKS2 pupils.' (School 12)

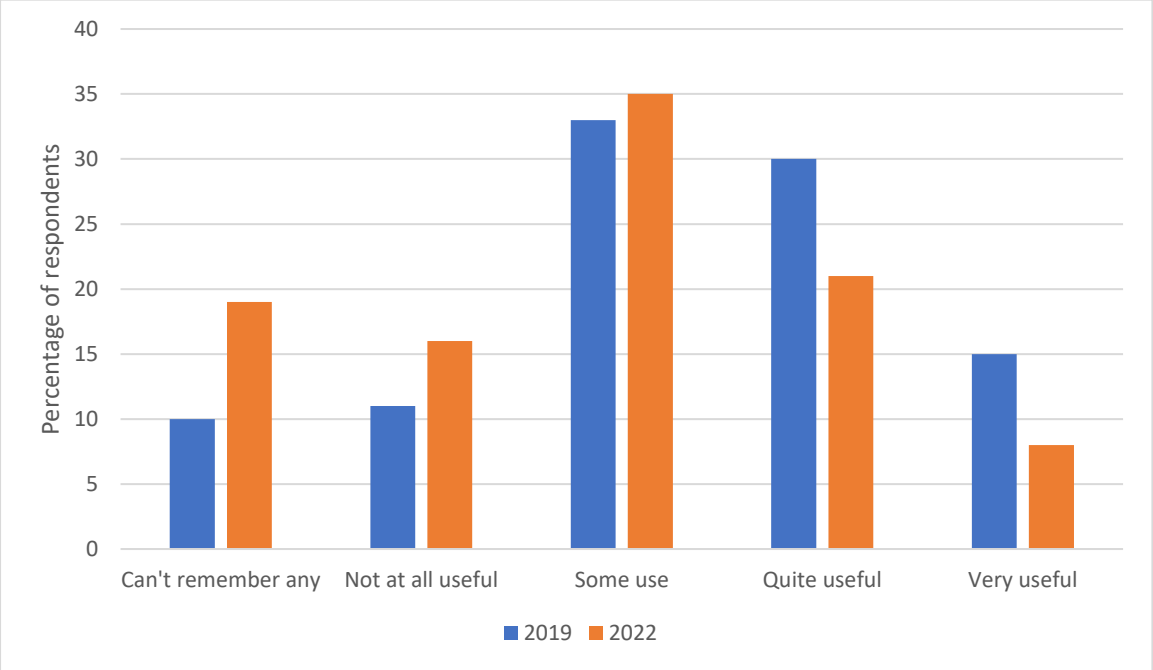
'Class teachers. Sometimes PCSO' (School 15)

One school listed a specialist drug and alcohol worker. It wasn't clear in this case whether this was a primary or secondary setting or how frequently this visitor was invited to contribute. The PSHE Association points out that these professionals can be helpful in talking about support services and how to access them, but they can also mislead pupils about social norms. It is impossible to say whether this or these sessions were part of a well-planned age-appropriate curriculum or not. Other contributors included the school nurse and the NSPCC.

None of the schools who responded said they had worked with the Bespoke Education Project consultant (described below), although one school said they were hoping to book one session for year 6 pupils.

Responses to the Pupil Voice survey[296] also suggest that drug and alcohol education in secondary schools is less effective than most other PSHE topics, and recollection of lessons and perceived usefulness has reduced since the last survey in 2019. This may be due in some part to the interruptions to the curriculum caused by the Covid pandemic (Fig 68).

Fig 68. Percentage of all secondary pupils (12-15) who rated the usefulness of drug, alcohol and tobacco education.



Bespoke Education Project (BE Project)

The BE Project was commissioned with police ADDER funding to deliver drug education and training for schools in Bristol in 2021/22 and 2022/23.

The project offers input for a range of education settings:

- For primary schools- 1 session delivered to year 6 pupils by the BE Project with additional resources for teachers to follow this up in PSHE lessons.
- For secondary schools- 1 session delivered to year 9/10 pupils by the BE Project with additional resources for teachers to follow this up in PSHE lessons.
- For alternative learning provision settings- 1 session for secondary age pupils delivered by the BE Project with additional resources for teachers to follow this up in PSHE lessons.

- Drug education training sessions for staff.
- For primary schools- 1 training session to support safeguarding and pastoral staff to work from a trauma informed approach with children who are affected by parental substance use.

Since November 2021 the BE Project has delivered the following drug and alcohol education sessions [297]:

- Year 9 and 10 pupils in 16 secondary settings, to 26 year groups.
- Year 6 pupils in 32 primary schools delivering 58 sessions.
- Secondary aged pupils in 9 alternative learning provision settings

BE Project has also delivered staff training in:

- 5 secondaries
- 9 secondary alternative learning provision settings

and

- 25 sessions for safeguarding and pastoral staff focusing on how to support children and families affected by substance misuse. These were attended by 49 mainstream primary schools and 3 alternative learning provision primary settings.

The school PSHE lead survey above shows that schools have an essential need for training to deliver a drug and alcohol curriculum that meets PSHE guidance. The BE Project has not been commissioned in line with a whole school approach and closer working with the Healthy Schools team in Bristol City Council (below) could ensure that both parties benefit from an integrated approach which will also have an impact on outcomes for schools across the city.

13.5.3 Universal/Selected Prevention

1. Healthy Schools Programme

The Bristol Healthy Schools programme[298] is underpinned by The One City Belonging Strategy for Children and Young People[299], and particularly by the Belonging in Education theme[300], which focuses on relationships, learning and structure, reflecting much of the Six Principles to Build Thinking about Young People's Health[301].

Bristol Healthy Schools is an evidence-based programme which aims to improve the health of the school age population in Bristol. It promotes a **whole school approach** (Fig 67) to health[302] and brings together several of the effective prevention interventions identified by UNODC[303]. It highlights relevant documents to ensure there are strong links with safeguarding guidance[304] and the OFSTED inspection framework[305]. It also encourages schools to understand the association between the health of pupils and other outcomes such

as attainment, attendance and behaviour and between the health of staff and outcomes such as staff absence rates and their ability to deliver effective education and offer appropriate support for pupils.

Within the Bristol Healthy Schools Programme, schools are encouraged to work towards and achieve a variety of awards which are based on criteria associated with specific health topics. This includes the first step Essential Award. One of the criteria for achieving the Essential Award is to take part in the Pupil Voice survey, so that schools have baseline data on which to plan and build their strategy. Once they have achieved this, they can progress to meet additional criteria to achieve a range of specialist awards, including the Understanding Substances Specialist Award. This award supports schools to develop a whole school approach to preventing substance use, including advice and support for RSE/PHSE curriculum, developing an environment and policies that support substance misuse prevention within a trauma informed approach, identifying and responding to all levels of need and working with parents. Schools will also need to demonstrate that they have a referral route for young people who use drugs and alcohol and need additional support. Stronger relationships between all schools and support services are required to ensure this is available to all pupils who need it.

The awards are accessible for all schools in Bristol, but schools in areas of highest deprivation (quintiles 1 and 2), special schools and alternative learning provision settings get additional support, helping to reduce inequalities across the city. This programme is therefore set up in line with principles 1, 2 and 3 of the Six Principles model to Build Thinking about Young People's Health[306].

The new Healthy Schools award programme was launched in January 2020 and was immediately interrupted by the impact of the Covid 19 pandemic on schools. The ongoing interruption to education since then has resulted in very few schools engaging in the Healthy Schools programme since 2019. In February 2023 8 schools, comprising of 5 primaries and 3 special schools, had achieved the first step Essential Award and 3 primaries have gone on to achieve specialist awards, but none of these is the Understanding Substances Specialist Award. It is not possible therefore to say whether any schools in Bristol have a whole school approach to substance misuse prevention.

There has been better engagement from schools in the Healthy Schools programme for 2022/23, and several schools are expected to achieve the Essential Award in 2023.

13.5.4. Selected Prevention

Services that support families where children are affected by parental drug misuse include the following:

1. Families in Focus

Families in Focus is part of the Strengthening Families Early Help offer. This service offers early interventions with families who benefit from extra support. This includes referrals to

ROADS and to CABS services (see below), where parents are using drugs and alcohol. The number of families who have been supported because of drug and alcohol use is not recorded because Families in Focus teams record outcomes for families in a different way.

2. Children Affected by Substances (CABS)

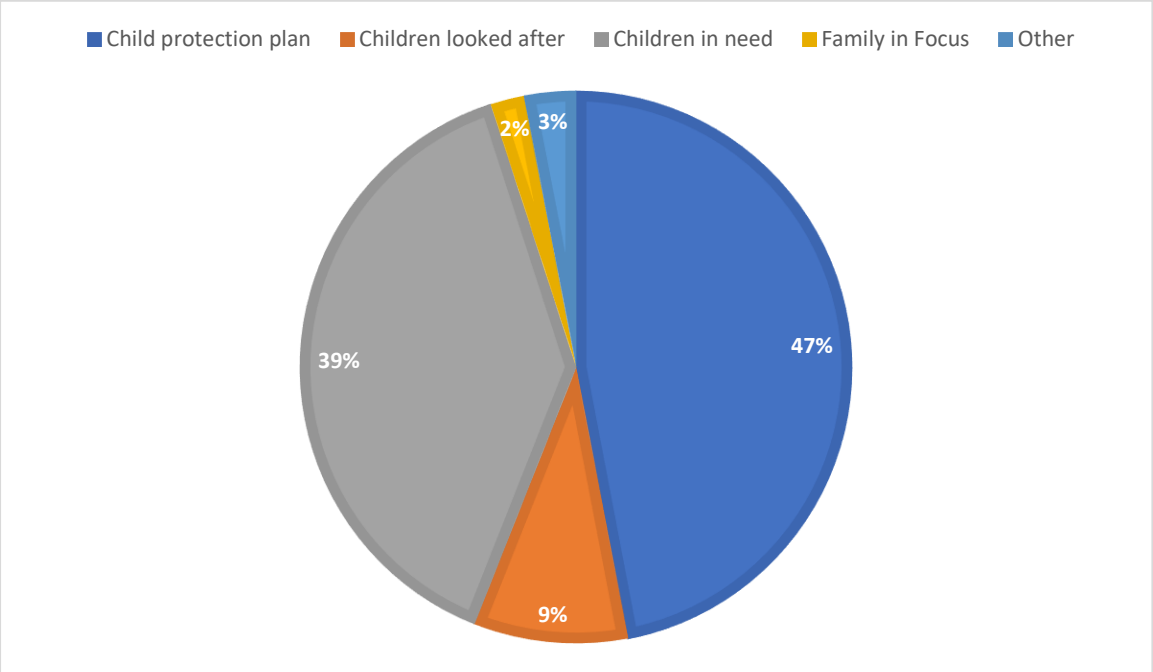
Bristol has several services that support children and young people who are affected by parental drug and alcohol misuse. These services work in close partnership to avoid duplication. They are known in the city as **CABS** services.

- **Targeted Youth Service CABS** This service is delivered by BDP and is for young people aged 11-18, or 25 where there are special needs or learning disabilities. Part of this service is dedicated to CABS support, but the expected proportion is not specified. In the first 3 quarters of 2022/23 43% of referrals to the BDP part of Targeted Youth Services were CABS referrals[307].
- **M32 Club CABS** The M32 Club is also delivered by BDP and provides support for primary aged (5-11) and secondary aged (11-16) children. It is delivered according to the Six Principles to Build Thinking about Young People's Health[308] and delivers work focusing on healthy relationships, resilience building and coping strategies, reducing health inequalities for children experiencing trauma, and developing integrated services through shared referral pathways. It also shows an understanding of changing health needs as the young people who engage with this service develop, providing two distinct age targeted groups for primary and secondary ages.

  Since 2019/20 the M32 Club has supported 73 children and young people, delivering a median average of 23 sessions per year to the 5-11 age group and 12 sessions per year for 11-16 year olds. Median averages have been used in this needs assessment. This is because activity was reduced in 2020/21 as a result of the covid 19 pandemic but returned to pre-pandemic numbers, or slightly higher, during 2021/22. This prevents averages being skewed by low outliers during that period.

  The funding for this service has always come from a variety of sources, making longer term planning more difficult. In the last 3 years this has included some grant funding, donations from charitable fund-raising events, gifts and BDP reserves.
- **Hawkspring CABS** Hawkspring is a community project in Hartcliffe, providing some drug and alcohol related support for people in south Bristol. This includes CABS support for young people. No data is available to identify how many young people are supported by this service. Funding sources are unknown.
- **The Drugs and Young People Project (DYPP) CABS** DYPP is a specialist safeguarding service working with children and young people who are engaged with social care across all categories of legal status. (Fig 69). The staff team includes specialist social workers, and youth workers. DYPP provides two distinct services, a treatment service, which is discussed below, and a CABS service. The CABS service works with young people aged 5-17. The funding for DYPP is from the Public Health grant.

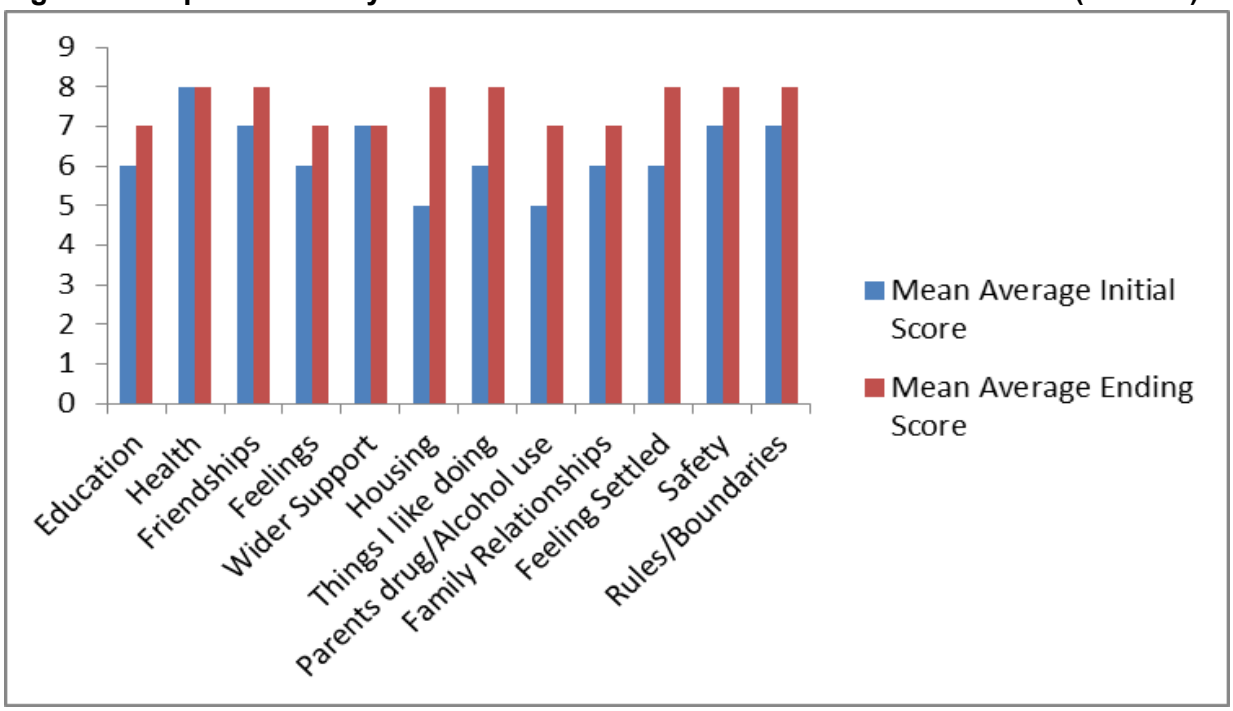
Fig 69. Children's engagement with DYPP CABS support by legal status



DYPP CABS service works within all the Six Principles to Build Thinking about Young People's Health[309], focusing on the breadth of healthy relationships as a priority. It also supports children with resilience building and developing coping strategies to say safe and healthy (Fig 70).

The service is part of the Children and Family Service in Bristol City Council and as such, is integrated across the system, working very closely with social workers, and providing pathways into a range of services to meet children and young people's needs.

Fig 70. Example of end of year outcomes for children in DYPP CABS service (2020/21)



Between 2017/18 and 2021/22 DYPP had an average of 41 children and young people per year referred into the CABS service. Demand has increased in recent years, with 49 children receiving a service in the first 3 quarters of 2022/23.

The average age of children and young people when they enter the DYPP CABS service is 10, reflecting good targeting of the most vulnerable children.

Between 2017/18 and 2021/22 48% of children and young people referred into DYPP CABS were male and 52% were female.

During this period 78% of young people who were referred were White UK, 3.8% were White other and 18% were Black, Asian and other minoritised group. This is a low percentage of young people from minoritised groups, compared to the population of the city.

13.5.5. Indicated prevention

There are several services in Bristol that support young people who are already using drugs problematically. These projects have been commissioned separately and in isolation by different commissioning bodies, resulting in some duplication of services and some gaps, particularly in earlier intervention. It may also be the case that young people are not always being supported in the most appropriate service, specifically where there are mental health and safeguarding factors involved, or other indications of complex needs. These services are not commissioned to provide treatment and contracts and agreements have not stated any requirement to report interventions on the NDTMS system. They have therefore been

listed here under indicated prevention interventions, although some young people in these services may have considerably higher levels of need.

1. BDP Targeted Youth Service

Between 1st June 2018 and 31st May 2023 the citywide Targeted Youth Service (TYS) was commissioned by the children's commissioning team in Bristol City Council to provide specific services to support vulnerable young people.

In 2018 the contract for this service was awarded to Creative Youth Network (CYN), who subcontracted the drug and alcohol support element to Bristol Drugs Project. This drug and alcohol service works with young people aged 11-19 (or 25 for Disabled young people with a learning disability) who use drugs and alcohol themselves or who are affected by a parent or carer's use of drugs or alcohol, where there is no social care involvement. Young people are offered up to 12 weeks support.

Due to a reduction in local authority funding, Public Health has agreed to fund this service with ADDER funding from when the TYS current contract ended in May 2023.

The TYS agreement is based on a target of working with 450 individual young people each year who either use drugs and alcohol themselves or who are affected by someone else's substance use. This can be at any level of need.

Between 1st June 2018 and 31st December 2022, BDP has delivered 2,052 TYS 1:1 drug and alcohol interventions offering young people up to 12 weeks support, which is 99.5% of the cumulative target. They aim to deliver at 123% of quarterly targets to take account of young people who represent to the service during the year, and they usually see over the 100% of the target number.

This project also delivers workshop activities in a range of settings and detached work to support their 1:1 offer.

According to TYS cannabis is the main substance of interest, although they have not been contractually required to provide data on contact by substance type. They report that other key substances are alcohol, cocaine, MDMA, nitrous oxide and ketamine, but again there are no figures to give more detail about any of these. Based on both national and local data, this suggests that referrals for alcohol use misuse may be low.

Case studies for this service identify complex and multifactorial needs among clients. This suggests that there may be some duplication of targeting between TYS and the Bristol treatment services. It may also mean there is a gap in provision for earlier intervention with young people who are in the earlier stages of using drugs and alcohol, to prevent escalation into more risky behaviour.

This project meets many of the Six Principles to Build Thinking about Young People's Health[310]. The case studies demonstrate that healthy relationships, coping strategies and

building resilience are all significant factors in these sessions. The whole Targeted Youth Service contract has been developed to target vulnerable young people and therefore it has a strong role in reducing inequalities. The EYES BCC referral system is a multiagency system offering an integrated approach to supporting needs at one level, but treatment needs are not part of this system and referrals into the CAMHS drug and alcohol treatment service (see below) have dropped from 16 in 2017/18 to 5 in 2021/22.

2. BDP New Leaf

This service is funded from a grant from the CHK Foundation. It works with young people adversely affected by cannabis use, targeting those most at risk from child criminal exploitation, child sexual exploitation and serious youth violence, including knife crime. The project specifically targets young people aged 11 to 19 who are referred to as 'at risk' and' risk taking'. They are offered 1:1 and small group work and can be supported for up to 24 weeks.

These issues are highly likely to occur among young people whose needs include safeguarding. It is not clear how this service links with the DYPP safeguarding treatment service.

Child sexual exploitation is a specific factor of need identified in the NDTMS guidance[311,312] suggesting that this level of complexity should be supported by services that fulfil the conditions for NDTMS reporting, which are the Bristol treatment services. The CHK foundation has not commissioned this service according to NDTMS requirements.

3. BDP New Leaf Rapid

This service is commissioned by the BNSSG ICB and is one of 7 Vanguard Pathways, delivering the Framework for Integrated Care. This framework was introduced as a response to the NHS Long Term Plan, which made a commitment to provide additional support for the most vulnerable children and young people up to the age of 18, across multiple domains.

The aim of the New Leaf Rapid service is to ensure a rapid response to young people who are risk of exclusion from school, either because of their own drug use, or because of parental or familial drug use, which affects their behaviour in schools. It is not clear why this aim is not an integral part of the TYS offer.

The funding is for 2 years, but there is an expectation of continued sustainability for 10 years. The New Leaf Rapid Service was launched in Bristol in December 2021. Vanguard funding will end on 31st March 2024.

In the first year of delivery the service worked with 58 children & young people, the majority of whom (number not specified) were able to remain in mainstream education and none have been permanently excluded due to a school drugs incident. Several (number not specified) young people have successfully completed the intervention.

The Framework for Integrated Care is based on six key principles which underline the service and are very similar to the Six Principles to Build Thinking about Young People's

Health[313]. Within this framework it aims to build integrated trauma-informed and responsive systems that enable CYP with complex needs to thrive.

In addition to the six key principles, these services are required to align to the iTHRIVE Framework[314] , which underpins mental health support in Bristol. This raises a question about pathways into the specialist substance misuse treatment service in CAMHS, which should provide the Getting More Help element, but this does not appear to be integrated into the New Leaf Rapid service.

This Vanguard Project is being evaluated by UWE, which will enhance knowledge about the evidence of what works to improve the health of the most vulnerable children and young people.

4. BDP Youth Alcohol and Drugs Diversion

This service is funded by the PCC office. It targets young people who are arrested for the first time for a drug or alcohol offence and offers them a single intervention. This helps to keep young people out of the Youth Justice Service. Those who need additional help are referred to the most relevant youth service. This is a small service supporting a small number of young people.

The evidence for single education sessions which are not joined up with other services suggests that these sessions may not be effective, but this needs to be weighed against the increased risks of poor health and education outcomes for young people who are engaged with Youth Justice Services, as discussed above.

5. Youth Justice Service (previously Youth Offending Team) drug and alcohol support

Young people who are engaged with the Youth Justice Service can be referred for 1:1 support and advice from a substance misuse worker based in that service. No automatic referral process is in place, and most young people are supported only by their case worker. Based on the evidence of the health report for these young people[315], showing their extreme vulnerability to health inequality, including drug and alcohol misuse, it may be appropriate to explore how to ensure a more integrated approach to supporting these young people with a range of issues, including substance misuse. This should include a clear referral pathway into the CAMHS specialist drug and alcohol treatment service, or DYPP where this is more appropriate. Referrals into drug and alcohol treatment services from the Youth Justice Service have been reducing each year since 2017/18, when 11 young people were referred. In 2021/22 there were no Youth Justice Service referrals into specialist treatment services.

13.5.6 Treatment services

Young people's specialist substance misuse treatment is defined as a care planned medical, psychosocial or specialist harm reduction intervention aimed at alleviating current harm caused by a young person's substance misuse[316]. Services are required to report their activity and outcomes into NDTMS.

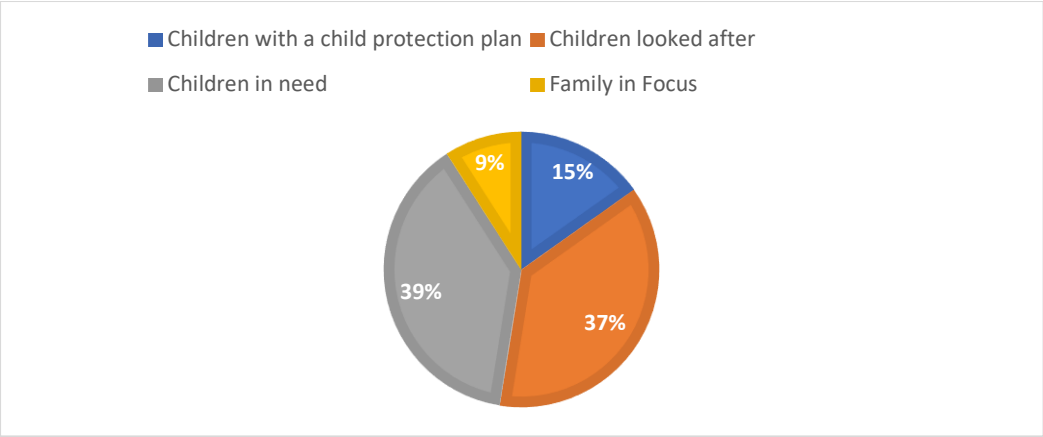
There are two specialist services in Bristol who provide drug and alcohol treatment for young people reporting to NDTMS.

1. Drugs and Young People Project (DYPP) At Risk Service

The DYPP At Risk service offers specialist safeguarding and substance misuse interventions supporting young people aged 11-17 who use drugs and alcohol and who are engaged with social care across all categories of legal status, including children who are open to the Strengthening Families Team, Families in Focus team (Fig 71). These young people face the highest levels of risk associated with substance misuse and safeguarding.

The service offers psychosocial and specialist harm-reduction interventions which focus on building young people's resilience and reducing the harm caused by substance misuse. The service is part of the Children and Family Service in Bristol City Council and is therefore joined up with Children and Family interventions at all levels of need. Performance is underpinned by local safeguarding policies and national guidelines, including OFSTED's framework for inspecting local authority children's' services[317], in accordance with Public Health England and the Children's Society evidence for good practice in commissioning[318].

Fig 71. Children's engagement with DYPP At Risk support by legal status



The service is funded from the Public Health grant through an internal transfer within Bristol City Council.

Between 2016/17 and 2021/22 the DYPP At Risk service worked with approximately 110 young people, 90 of whom were referred during this period. This number is lower than might normally be expected because of a fall in referrals due to the Covid 19 pandemic. In 2021/22 referrals rose again to pre-pandemic numbers[319].

Between 2017/18 and 2021/22 6% of young people were referred because of their alcohol use, 80% were referred because of their cannabis use, 8% because they were misusing alcohol and cannabis and 6% because they were misusing other substances. Other substances included MDMA, cocaine, Xanax and benzodiazepines. Based on both national and local data, this suggests that referrals for alcohol use misuse may be too low.

The median age of young people as they enter the At Risk service is 14, reflecting the high vulnerability of these young people and the importance of this service. This also suggests successful targeting of young people who experience early onset drug and alcohol use.

Between 2017/18 and 2021/22 63% of young people referred into the At Risk service were male and 37% were female. This does not reflect local prevalence according to gender, suggesting that referrals of young females, may not reflect need.

During this period 77% of young people who were referred were White UK, 2% were White other and 21% were Black, Asian and other minoritised group. This is a low percentage of young people from minoritized groups, compared to the population of the city and suggests that this service may be less accessible for young people from minoritised ethnic groups.

2. Young People's Specialist Substance Misuse Treatment Service (YPSSMTS). YPSSMTS is a specialist substance misuse treatment service within Children and Adolescent Mental Health Services (CAMHS) delivered by AWP. This is part of the Community Children's Health Partnership (CCHP) contract and funded through the Public Health Grant. The main provider for this contract is Sirona Care and Health, and they subcontract the CAMHS element to AWP.

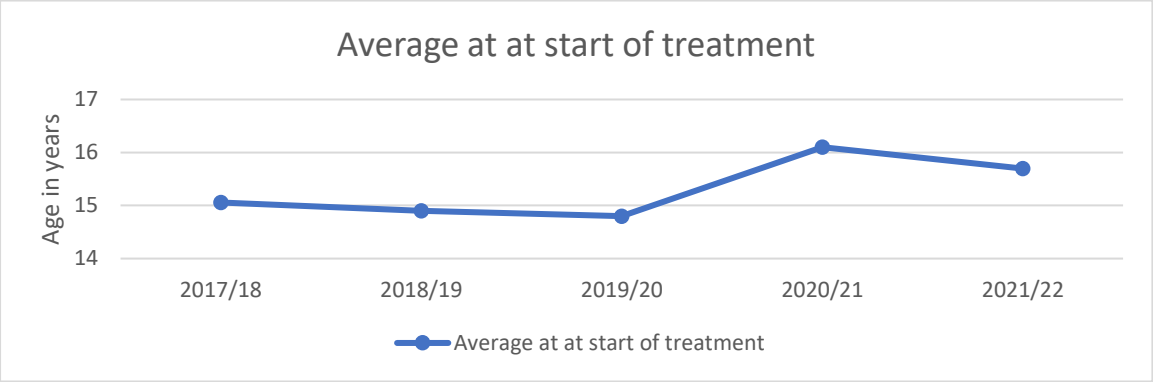
This service was set up in the early 2000s in response to the strong association between mental ill health and drug and alcohol problems in children and young people. YPSSMTS offers interventions to young people who are facing the highest levels of risk associated with substance misuse, mental health and other complex issues. The service works closely with other drug and alcohol partners in Bristol, including DYPP, to ensure that young people are offered the most appropriate service to meet their needs.

YPSSMTS accepts referrals from a broad range of partners. In the years leading up to and including 2020/21 most young people were referred into YPSSMTS by BDP, but since April 2021 referrals from BDP have dropped sharply resulting in most referrals coming from other CAMHS teams, including the CAMHS Intensive Outreach Team (CIOT), the CAMHS locality teams and the YOT CAMHS nurse, as well as the Getting Advice front door to mental health services. Referrals from some sources that support the most vulnerable young people are small; this includes housing services (<5 since 2017/18), and the Youth Justice service (< 5 referrals since 2019/20). Referrals from GPs are also very low.

Between 2017/18 and 2021/22 YPSSMTS has received 320 referrals and has worked with a median average of 74 young people per year. Numbers were lower during 20/21 and 2021/22 due to the impact of Covid 19 pandemic. The highest factors in terms of mental health during this period were emotional dysregulation and low mood with an occasional spike in other occurrences including ADHD, self-harm and suicidal ideation.

Between 2017/18 and 2020/21 the mean average age for young people at referral was 15, this has risen slightly in the past two years, suggesting that the service may be missing some young people with early onset drug and alcohol use. However, this may have been due to the impact of the Covid 19 pandemic, when access to treatment was more difficult and performance figures were lower than before the pandemic (Fig 72).

Fig 72. Average age of young person at start of treatment



Between 2017/18 and 2021/22 60% of young people who were referred to this service were male and 39% were female. In 2021/22 for the first time in this five year period there were more females referred (52%) than males (45%), which is in keeping with the national and local picture. The remaining young people identified as Trans and non-binary.

Between 2017/18 and 2021/22 21% of clients were from Black and minoritised groups, which is lower than the need suggested by both national and local data.

Between 2017/18 and 2021/22 most young people were referred because of their cannabis use, with alcohol as the second highest reason for referral. This does not reflect national and local patterns of substance misuse, suggesting that referrals for alcohol use misuse may be too low.

13.5.7 Stakeholder involvement- Assessment of Bristol services against Young People Friendly Criteria

Evidence shows that services are more effective if they are delivered in compliance with the DoH You're Welcome standards[320] . These standards lay out the quality criteria for young people friendly health services and they continue to be widely recognised as the best standard for all young people's health related services.

The requirement for young people friendly services is firmly embedded in both the Six Principles to Build Thinking about Young People's Health[321] and in the Public Health England and the Children's Society guidance for commissioners of young people's substance misuse treatment services[322].

Between 2011 and 2018, Bristol City Council worked with a broad range of partners to monitor and assess NHS and voluntary sector health services that were commissioned to improve young people's health, to ensure that they met the DoH You're Welcome standards[323]. During this period in Bristol the name was changed to the Bristol Young People Friendly standards. The assessment and monitoring ended in 2018 due to a reduction in

resources, but all services were encouraged to continue to self-assess themselves against these criteria, as a measure of good practice.

DYPP was the first service in Bristol to be awarded You're Welcome status in 2011 and in 2016 it was reverified as Young People Friendly. In 2016 YPSSMTS was also awarded Young People Friendly status and BDP achieved verification for many of its school settings, which were at that time the most frequent setting for the delivery of the BDP youth service.

Since 2018 there have been many changes in the model and delivery of drug and alcohol services for young people in Bristol and therefore, for the purpose of this needs assessment, a new brief questionnaire was designed to measure current services against Young People Friendly quality criteria. It was sent out to young people who were engaging with any of Bristol's drug and alcohol services during Dec 2022 and January 2023. This is therefore a snapshot, focusing on the experience of young people who were using these services at that time.

A total of 28 young people responded, representing YPSSMTS, BDP Targeted Youth Service, New Leaf Rapid and M32 Club.

All young people reported that the service they received was improving their health. 18 respondents said that the sessions they attended made them feel a lot better and 10 said it made them feel a little bit better. No one said that it made them feel the same as before or worse.

All young people identified positive outcomes from their session (Fig 73)

Fig 73. Outcomes of sessions with drug and alcohol services

Outcome: My worker has helped me to:	Number of young people
Understand how to stay safer with drugs and alcohol	14
Make choices that I am happy with	21
Understand what drugs and alcohol can do to someone's body (physical health)	16
Understand what drugs and alcohol can do to the way a person feels (mental health)	17
Understand how drugs and alcohol can affect relationships	14

Most respondents seemed to feel that the sessions with their worker were led by the young people themselves. 23 respondents said that they found their sessions useful, and they focused on what the young person wanted to work on. 4 said this happened sometimes and 1 didn't know about this. 24 said they could give honest feedback about their sessions, 1 said they could do this sometimes and 3 did not know whether this was the case.

All respondents said they felt welcome and safe, and all said that they felt respected by their worker.

Young people were less certain about involvement in service coproduction and design. When asked whether they had the opportunity to comment or contribute to service design or change, 13 said they did have this opportunity, 3 said they sometimes had this opportunity, 5 said they did not have this opportunity and 8 did not know. (1 person ticked two answers to this question). However, when they were asked to give examples, many people talked instead about what they did in their own 1:1 sessions. Only two young people gave responses that showed that they had contributed in some way to service design, including the environment in which the service was delivered, and to be invited to help design a partner campaign:

> *'Changes [to the] room for M32 after flood' (Respondent 6)*
>
> *'Asked to contribute to a police campaign about CABS' (Respondent 3)*

This snapshot showed a high degree of satisfaction among those who took part with a high number of positive outcomes. However, drug and alcohol services need to ensure that they improve the suitability of drug and alcohol services for young people by putting mechanisms in place for young people's involvement in all aspects of the service coproduction and design including commissioning and evaluation.

13.5.8 ROADS Young People's Transitions Service

Young people's drug and alcohol services work in close partnership with the ROADS transitions worker. This service is part of the ROADS system and is delivered by DHI. Close partnership work enables young people to move through this transition as smoothly as possible.

The model is built on a trauma informed and young people friendly approach. Young people who need support after their 18th birthday are identified and referred when they reach 17 ½. Three-way working begins at this time so that by the time the young person reaches 18 they are familiar with their new adult services worker and understand the process of the referral. Within the DHI ROADS service, the worker continues to offer a young people friendly approach, appropriate to all young people until they have reached maturity at 25 [324].

Until recently this resource was limited to one full-time post, but a second worker has now been appointed. The service only accepts referrals of those transitioning directly from young people's services. There are other people up to the age of 25 in ROADS who do not benefit from a young people friendly approach, although evidence suggests that this is the best way to improve health [325].

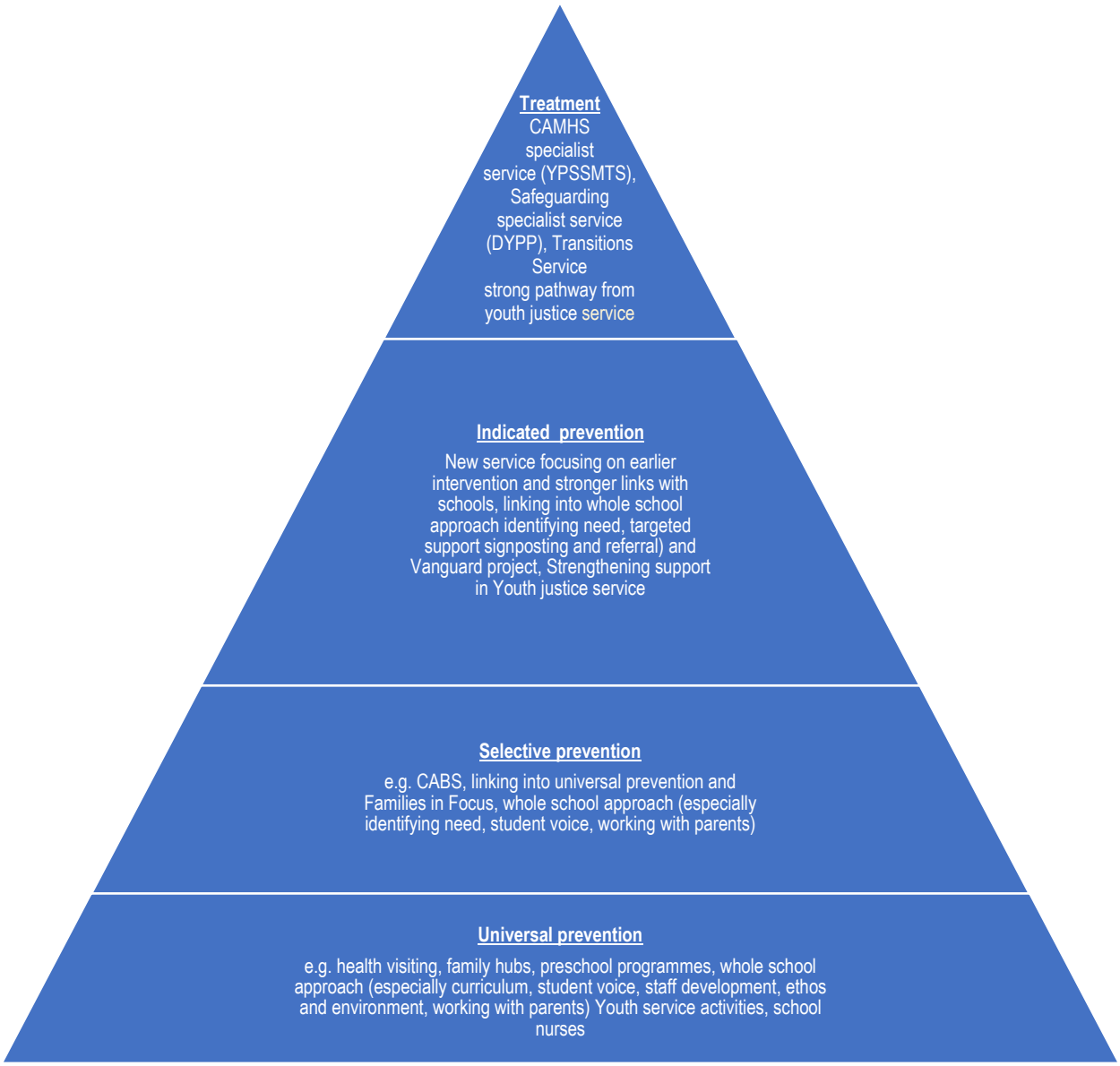
13.6 Discussion

The Young people's substance misuse services in Bristol have been funded through several separate commissioning and funding processes, working to different requirements and often without consideration of what is already in place. This has resulted in a gap in terms of early

intervention or indicated prevention and probable duplication of what is offered by specialist treatment services.

It may be useful to use a model based on Fig 74 below to refocus services, ensuring that indicated prevention and early intervention is a strong part of delivery. This will require robust partnerships working within a framework that reflects all levels of need and where upper and lower thresholds meet to avoid the development of further gaps, creating the possibility of unmet need.

Fig 74. Possible commissioning model for Bristol, ensuring that substance misuse services operate alongside and link into other existing services



13.7 Recommendations:

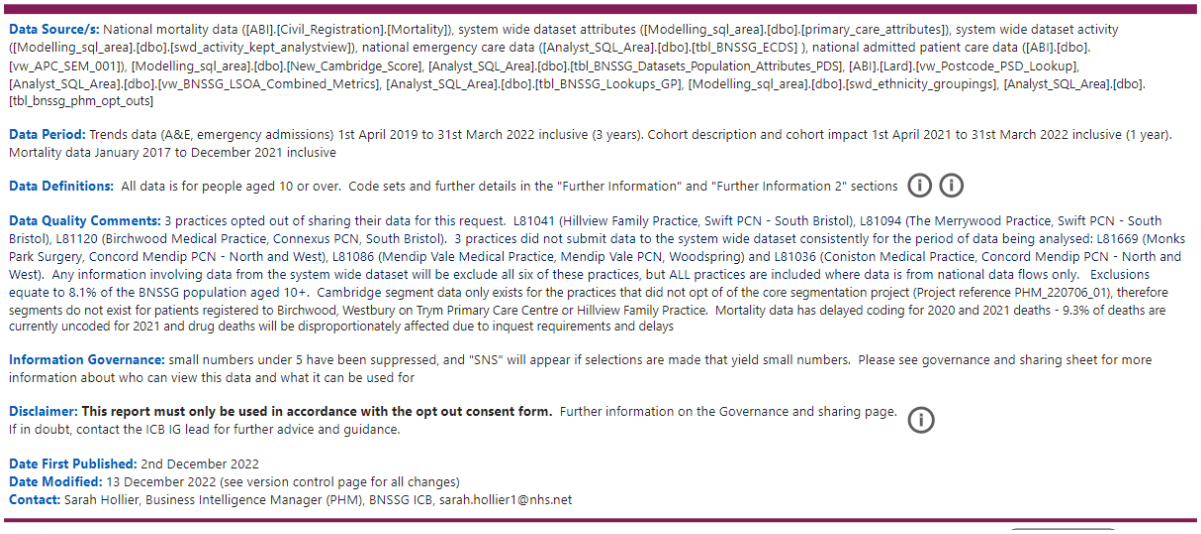
1. Drug and alcohol services should be delivered to ensure that they focus on the best start in life for children and young people. This should include Family Hubs offering:
    - support and advice to pregnant clients and new parents,
    - support and advice for other parents, either in relation to their own drug and alcohol behaviour or that of their children and other family members. This should include the Chief Medical Officer's Guidance for parents about young people and alcohol.
    - referring young people to drug and alcohol services where appropriate.
2. Children who are affected by parental drug and alcohol misuse are not being easily identified
    - Explore the possibility of using ROADS data to identify children more accurately
    - Include question in Pupil Voice to give an indication of the size of need
3. The prevention resource to target children affected by parental problematic substance use is very small.
    - Explore the possibility of putting reliable funding in place for services which target children affected by substance use
4. Working with schools
    - Schools should be supported with the Healthy Schools programme to develop a whole school approach to preventing drug and alcohol misuse, ensuring that:
        - the Healthy Schools website shows what best practice should include, incorporating evidence-based guidelines and quality approved PSHE resources.
        - all additional work in schools is commissioned according to a whole school approach
        - all schools are encouraged to take part in the Pupil Voice survey to provide individual baseline data to guide their decision making and work
5. Referrals into services to support young people who are drinking alcohol should increase.
6. Work with parents should begin to increase knowledge around the harm to young people of drinking alcohol (Not sure if this should include work with schools, training or a campaign. Not sure if these will even be effective)
7. Young people's drug and alcohol services should be refocused according to Fig 74 above so that:
    - There are stronger links with secondary schools so that people are referred at the earliest possible opportunity, and substance misuse services are linked into a whole school approach
    - There are clear criteria for assessment in the treatment services, relating to levels of substance use, mental health needs and safeguarding concerns.

- There should be much stronger links between the specialist CAMHS service and the Youth Justice Service, including a clear referral pathway. Consider an additional post in the specialist service, focusing on YJS referrals and support.
- All contracts should require services to meet appropriate young people friendly standards and this should be regularly assessed at performance meetings. This could also include mystery shopping.

Appendix A: System Wide Dataset- Data Quality Information

In general terms, it is recognised that the information provided in the system wide dataset is an underestimation of prevalence and need.

Figure 55. Information about data sources and quality.



Data Source/s: National mortality data ([ABI].[Civil_Registration].[Mortality]), system wide dataset attributes ([Modelling_sql_area].[dbo].[primary_care_attributes]), system wide dataset activity ([Modelling_sql_area].[dbo].[swd_activity_kept_analystview]), national emergency care data ([Analyst_SQL_Area].[dbo].[tbl_BNSSG_ECDS]), national admitted patient care data ([ABI].[dbo].[vw_APC_SEM_001]), [Modelling_sql_area].[dbo].[New_Cambridge_Score], [Analyst_SQL_Area].[dbo].[tbl_BNSSG_Datasets_Population_Attributes_PDS], [ABI].[Lard].[vw_Postcode_PSD_Lookup], [Analyst_SQL_Area].[dbo].[vw_BNSSG_LSOA_Combined_Metrics], [Analyst_SQL_Area].[dbo].[tbl_BNSSG_Lookups_GP], [Modelling_sql_area].[dbo].[swd_ethnicity_groupings], [Analyst_SQL_Area].[dbo].[tbl_bnssg_phm_opt_outs]

Data Period: Trends data (A&E, emergency admissions) 1st April 2019 to 31st March 2022 inclusive (3 years). Cohort description and cohort impact 1st April 2021 to 31st March 2022 inclusive (1 year). Mortality data January 2017 to December 2021 inclusive

Data Definitions: All data is for people aged 10 or over. Code sets and further details in the "Further Information" and "Further Information 2" sections

Data Quality Comments: 3 practices opted out of sharing their data for this request. L81041 (Hillview Family Practice, Swift PCN - South Bristol), L81094 (The Merrywood Practice, Swift PCN - South Bristol), L81120 (Birchwood Medical Practice, Connexus PCN, South Bristol). 3 practices did not submit data to the system wide dataset consistently for the period of data being analysed: L81669 (Monks Park Surgery, Concord Mendip PCN - North and West), L81086 (Mendip Vale Medical Practice, Mendip Vale PCN, Woodspring) and L81036 (Coniston Medical Practice, Concord Mendip PCN - North and West). Any information involving data from the system wide dataset will be exclude all six of these practices, but ALL practices are included where data is from national data flows only. Exclusions equate to 8.1% of the BNSSG population aged 10+. Cambridge segment data only exists for the practices that did not opt of of the core segmentation project (Project reference PHM_220706_01), therefore segments do not exist for patients registered to Birchwood, Westbury on Trym Primary Care Centre or Hillview Family Practice. Mortality data has delayed coding for 2020 and 2021 deaths - 9.3% of deaths are currently uncoded for 2021 and drug deaths will be disproportionately affected due to inquest requirements and delays

Information Governance: small numbers under 5 have been suppressed, and "SNS" will appear if selections are made that yield small numbers. Please see governance and sharing sheet for more information about who can view this data and what it can be used for

Disclaimer: **This report must only be used in accordance with the opt out consent form.** Further information on the Governance and sharing page.
If in doubt, contact the ICB IG lead for further advice and guidance.

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Contact: Sarah Hollier, Business Intelligence Manager (PHM), BNSSG ICB, sarah.hollier1@nhs.net

Appendix B: Service User Feedback

As part of this Needs Assessment, an online survey was created to understand from ROADS service users what their experiences are of using the services available through ROADS. The survey was live from 6th September 2022 to 31st October 2022 and a total of 82 service users completed the survey. They were rewarded with a £10 supermarket voucher for their time. The results are presented below, further analysis on the results will be completed in 2023 as well are more detailed service user feedback.

A summary of the main points raised by service users are listed below:

- Respondents were mainly aged between 30 and 49 years old (65%), 52% male, 42% female, 8% responded as ‘other or prefer not to say’ and were predominantly ‘White-British’ (78%). 67% of respondents considered themselves to have a disability and 78% identified as ‘single, never married’.

- Most respondents found out about drug and alcohol treatment services through their GP (31%), followed by 'word of mouth' (28%).
- Over 50% were satisfied with their experience of the service they received citing their key workers as being very knowledgeable and helpful with a large variety of interesting groups to attend.
- They noted that a 'high turnover rate of staff' hindered their progress, having to repeat their story felt like starting again.
- The respondents described a wide range of problems that affect them due to their drug and/or alcohol use, or complex and often chaotic lifestyles. It was recognised that anxiety, depression and bipolar disordered compounded drug and/alcohol use.
- Physical health concerns were also wide ranging and likely due to previous or current drug and/or alcohol use or associated lifestyles. Clients most common concern was relating to blood, (cholesterol concentration, blood pressure, bloodborne viruses, hypoglycaemia, deep vein thrombosis), some of which are caused by intravenous drug use.
- Overall, clients listed conditions that were chronic, rather than acute. This reflects the responses of the professional survey that clients often present to them with chronic conditions that cause them discomfort or impede their ability to carry out their day-to-day activities.
- Respondents cited 'adequate housing' as their most common need (just under 50%), followed by family and needing to improve relationships at home.
- The commonly cited reasons for not accessing services were mental health, ongoing substance use or not being ready, previous experiences, stigma and physically accessing the services being too difficult.
- 58% respondents indicated that it was harder to access treatment since the COVID-19 pandemic and cited 'moving online (and not being properly equipped)', groups being stopped, isolation, longer waiting lists for services and struggling to be able to see a doctor/GP, as being some of the reasons to explain this.

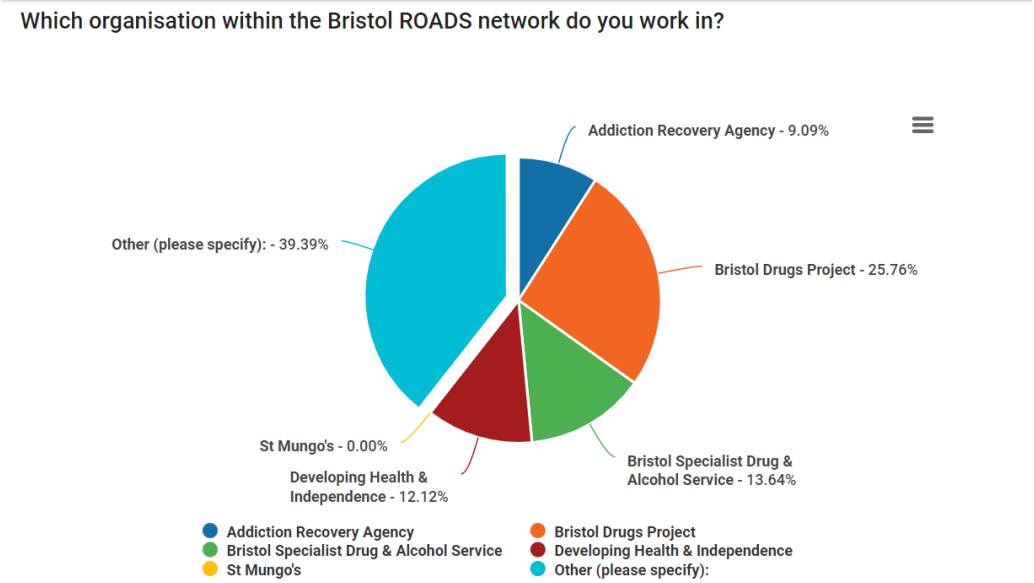
A full transcript of the survey and associated results is available on request.

Appendix C: Professionals Feedback – Drug and Alcohol Services (Workforce)

A questionnaire was distributed to staff who have a role in organisations that deliver Drug and Alcohol Treatment and Recovery services in Bristol. Staff were given the opportunity to give feedback via a survey, anonymously, with an open text option.

In total, 66 ROADS staff members responded to the survey spread across providers as detailed in Figure 56. below.

Figure 56. Survey respondents by Organisation



A summary of the main points raised by service users are listed below:

Issues relating to health

- Added complexity of some ROADS clients was predominantly linked to their housing/living situation, their employment status and financial situation, mental health and physical health.
- Physical health of ROADS clients is considered to be very poor, with many presenting to the homeless health service with infectious diseases (Hepatitis C and B, HIV, Sepsis, iGAS etc) perceived to be as a result of injecting drug use.
- Poor emergency accommodation or access to somewhere to keep clean if rough sleeping was perceived as contributing to poorer outcomes from infections such as venous ulcers, necrotising fasciitis and ultimately amputations arising from clients delaying accessing treatment from healthcare providers.
- Many clients tend to present to health services at the last possible moment when there is an acute or emergency need for intervention as looking after their wider health is seen as a low priority.
- Dental health issues is a common problem for clients. Cost and lack of availability of dental care are barriers to getting help.

- Clients are typically undernourished and have little access to healthy food, due to cost, access to cooking facilities or lack of cooking skills.
- Many clients do not take any exercise and would benefit from specialist advice about how to begin exercising. The majority are eligible for the exercise referral scheme into local leisure centres but do not feel confident in accessing this, concerned about their bodies and how they will be judged and not having money to buy clothes or trainers to exercise in.

Client 'drop-out' and retention rates

We asked ROADs workforce what they felt were the reasons that ROADS clients were "dropping-out" of the structured treatment. They are summarised below:

- Length of time waiting to access treatment or sitting on waiting lists
- It is difficult to reach and engage with clients who have past trauma and require many attempts at being contacted
- Clients get tired of repeating their stories to multiple professionals, particularly those who have a substance use and mental health need
- Inadequately trained staff at the point of referral meaning clients sometimes receive confusing information and are unsure what to access, when and how
- Lack of consistency in support workers meaning clients often see multiple support staff which impacts trust and rapport
- Clients fear that they will be referred or reported to other agencies e.g., social services
- Clients do not feel safe e.g., female clients accessing groups which of mixed gender
- Clients feel intimated by 'addicts' hanging around services
- Travel and costs associated with accessing services
- Poor mobility or cognitive impairment
- Remembering appointments

Feedback on the existing ROADS service provision

- **"ROADS set up is too complicated**, too divided between different providers, and not co-ordinated well."
- Some **services are "invisible" and "hard to reach"** for both clients and other professionals.
- The structured treatment offer is seen as **not being a clear journey for clients** and many enter treatment not really knowing what to expect and become overwhelmed quickly. **Client not ready or prepared for what is involved in treatment**
- **Communication** about what services are on offer **is** also **not** often **clear.**
- A **disagreement on what constitutes "recovery"** within the ROADs system.
- **Access to mental health support is problematic for many people.** They get turned away as they "have to be sober" to receive any psychological support.

- Current service provision **does not address wider determinants of the client** physical and mental health needs.

Suggest improvements to the ROADS service

- **First point of contact process needs to be simplified**
- **Greater visibility and promotion of services** that are available
- **Less fragmented treatment system.** There is perceived to be too much competition between providers and politics which gets in the way of focusing on delivering the best quality care.
- **Better pay** for those working in services, also improvements needed to train and supervision of the workforce.
- **Ongoing commissioning oversight of the system** and a holding to account of providers about how their money is being spent and transparency about this combined with more research and evaluation so that we can better understand what really works, using evidence to drive services.
- **Building better links with community providers** so that life isn't so empty for people when they complete treatment that they're at risk of relapse
- **Evening and weekend service provision** to reach out to those who work, have childcare responsibilities etc
- **Better provision for those with alcohol** problems away from drug treatment services
- **A focus on women's only spaces** e.g., relapse prevention groups and drop-in sessions to reach out to vulnerable and at-risk women
- **Assessments should be face to face**, they are a crucial intervention reaching out to someone who decides to access a service
- **More of a focus on adult and child safeguarding issues** - all service users need to be asked regularly about their contact with under 18's, impact on parenting etc
- **Dual-diagnosis treatment provision needs** to be accessible for those with comorbidities/ physical and mental health needs

A full transcript of the survey and associated results is available on request.

Appendix D: Definitions

The following definitions have been adopted from the 'Drugs of Dependence, Role of Medical Professionals', document produced by the Board of Science and Education and will be the terms that you see used throughout this document[326].

Definition	Description
Drug	A term of varied usage. In medicine, it refers to any substance with the potential to prevent or cure disease or enhance physical or mental welfare, and in pharmacology it refers to any chemical agent that alters the biochemical or physiological processes of tissues or organisms. Hence, a drug is a substance that is, or could be, listed in a pharmacopoeia. In common usage, the term often refers specifically to psychoactive drugs, and often, even more specifically, to illicit drugs, of which there is non-medical use in addition to any medical use. Caffeine, tobacco, alcohol and other substances in common non-medical use are also drugs in the sense of being taken, at least in part, for their psychoactive effects.
Psychoactive substance	The tendency of a particular psychoactive substance to be susceptible to abuse. It is defined in terms of the probability that use of the substance will lead to social, physical, or psychological problems for an individual or society.
Illicit drug	A psychoactive substance, the possession, production, sale, or use of which is prohibited.
Licit drug	A drug that is legally available, either to purchase, or by medical prescription.
Drug misuse v use	Use of a substance for a purpose that is not consistent with legal or medical guidelines, as in the non-medical use of prescription medications. The term drug use is a preferred, non-judgmental term and will be the term used throughout this report.
Drug-related problem or Alcohol related problem	Any of the range of adverse accompaniments of alcohol or drug use, particularly illicit drug use. 'Related' does not necessarily imply causality.
Harmful use	A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (e.g., hepatitis following injection of drugs) or mental (e.g., depressive episodes secondary to heroin use) and may have adverse social consequences.
Addiction	Repeated use of a psychoactive substance or substances, to the extent that the user is periodically or chronically intoxicated, shows a compulsion to take the preferred substance (or substances), has great difficulty in voluntarily ceasing or modifying substance use, experienced withdrawal symptoms if consumption is interrupted and exhibits determination to obtain psychoactive substances by almost any means. The term is often used interchangeably with dependence.
Controlled substances	Psychoactive substances, and their precursors, whose distribution is forbidden by law or limited to medical and pharmaceutical channels. The substances actually subject to this control differ between countries.

Harm reduction	In the context of alcohol or other drugs, harm reduction describes policies or programmes that focus directly on reducing the harm resulting from the use of alcohol or other drugs.
Decriminalisation	A process in which the seriousness of a crime or of the penalties the crime attracts is reduced. More specifically, it refers to the move from a criminal sanction to the use of civil or administrative sanctions. An example in relation to Illicit drugs would be where possession of cannabis is downgraded from a crime that warrants arrest, prosecution and a criminal record to an infraction to be punished with a warning or fine.
Dependence	As a general term, dependence is the state of needing or depending on something or someone for support or to function or survive. As applied to alcohol and other drugs, the term includes psychological and physiological aspects.
Psychological dependence	Involves impaired control over drug use and a need (craving) for repeated doses of the drug, to feel good or avoid feeling bad.
Physiological dependence	Physical dependence is associated with tolerance, where increased doses of the drug are required to produce the effects originally produced by lower doses, and development of withdrawal symptoms when the drug is withdrawn.
Detoxification	A controlled process of providing symptomatic relief to assist patients to complete withdrawal from a drug, while minimising the associated adverse effects. In the context of illicit drug use, the aim of detoxification is to reverse or reduce dependence on and tolerance to a psychoactive drug.
Diversion	The term used in a criminal justice context refers to measures that take an arrestee out of the criminal justice system and into education, medical management or another type of intervention.
Maintenance treatment	A method of medical management that involves prescribing and administration of a pharmaceutical drug as a 'substitute' for an illicit drug, to patients who have become dependent. It is most commonly used for opioid dependence (e.g., treatment with methadone or buprenorphine – commonly called Opioid Substitution treatment). The aim is to attenuate withdrawal symptoms, diminish opioid craving and arrive at a tolerance threshold, while preventing euphoria and sedation from overmedication.
Opiate	An opiate is an addictive drug, derived from the opium poppy, which reduces pain, induces sleep and may alter mood or behaviour. This term excludes synthetic opioids.
Opioid	A generic term applied to alkaloids from the opium poppy (opiates), their synthetic analogues and compounds synthesized in the body that interact with specific receptors in the brain and reduce pain, induce sleep and may alter mood or behaviour. In high doses they can cause stupor, coma and respiratory depression. Opium alkaloids and their semi-synthetic analogues include morphine, diacetylmorphine (diamorphine, heroin), hydromorphine, codeine and oxycodone. Synthetic opioids include buprenoprhine, methadone, pethidine, pentazocine and tramadol.
Overdose	The use of any drug in such an amount that acute adverse physical or mental effects are produced. It usually implies an amount that constitutes a mortal risk.
Recreational use	Use of a drug, usually an illicit drug, in sociable or relaxing circumstances, by implication without dependence or other problems.

	The term is not favoured by those seeking to define all illicit drug use as a problem.
Recovery	In the context of drug dependence, recovery involves achievement of the individual user's goals for making positive changes in their life. This usually includes improved family and social relationships, living in appropriate housing and being gainfully employed. It is likely to be achieved by treatment to reduce or eliminate dependence on illicit drugs.
Residential rehabilitation	Prolonged residential treatment in a home, hostel or hospital unit, for dependence, usually on a psychoactive drug. There is a positive and highly structured drug-free environment with strict rules, where residents are expected to participate in a programme of rehabilitation, based on self-help and mutual support.
Open drug market	There are few barriers to access and anyone who looks like a plausible buyer can purchase drugs. Often supply will occur in the open in streets and parks.
Closed drug market	Both buyers and sellers are generally known to each other, and trust has been built up. Often supply will occur from vehicles and residential addresses.
Alcohol-specific deaths	Presents statistics on the number of deaths and the age-standardised mortality rates for deaths from causes known to be exclusively caused by alcohol consumption, otherwise known as wholly attributable deaths. Apart from deaths due to poisoning with alcohol (accidental, intentional or undetermined), this definition excludes any other external causes of death, such as road traffic and other accidents. A list of the conditions can be found here.
Alcohol- related or partially attributable deaths[327]	Presents statistics on the number of deaths which includes underlying causes of death regarded as those being most directly due to alcohol consumption. The definition does not include diseases that are partially attributable to alcohol, such as cancers of the mouth, esophagus and liver. However, all deaths from chronic liver disease and cirrhosis (excluding biliary cirrhosis) are included, even when alcohol is not specifically mentioned on the death certificate.
Underlying cause[328]	Defined by WHO as "the disease or injury which initiated the train of morbid events leading directly to death, or the circumstances of the accident or violence which produced the fatal injury", in accordance with the rules of the International Classification of Diseases.
Trauma	Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as harmful or life threatening. While unique to the individual, generally the experience of trauma can cause lasting adverse effects, limiting the ability to function and achieve mental, physical, social, emotional, or spiritual well-being[329].
Trauma-informed practice	Trauma-informed practice is an approach to health and care interventions which is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development[330].

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