Bath and North East Somerset

Adult Substance Misuse Treatment Needs Assessment 2019

Final Version

28th August 2019

Executive Summary

Bath and North East Somerset Council (B&NES) is responsible for commissioning local drug and alcohol treatment services. These play a vital role in reducing the harms associated with drug misuse for individuals, families and local communities. They also help clients to recover and to rebuild their daily lives.

This document provides an overview of key drug and alcohol issues affecting our local population, a profile of people engaged in treatment and a review of treatment outcomes against national standards.

It has been produced through a mix of literature and data analysis and discussion with local professionals. We now wish to consult on these findings with a range of local professionals and also to talk with local service users to hear their views too.

The findings from the report will inform the future priorities of commissioners, treatment services and key partners in B&NES.

Key Findings:

- The local treatment system performs well in a number of areas. For example, no clients wait for longer than three weeks to commence drug treatment (5.3.1).
- There are also some good harm reduction outcomes, for example, Hepatitis C testing rates (6.7.2) and Hepatitis B immunisation rates (6.7.3).
- The number of adults in contact with local drug and alcohol services fell by 20% between 2013/14 and 2017/18. This is double the fall seen nationally over the same period. The fall in the number of clients in treatment over this period has been greater for alcohol only and non-opiate clients - a 39% and 30% fall respectively (3.4.1).
- Throughout 2018 there were 226 people in treatment who were living with children (3.4.2). That's around 1 in 4 clients.[1] Estimates suggest a further 133 opiate dependent parents in B&NES could benefit from treatment but were not in treatment (3.5.2).
- B&NES has a slightly higher percentage of complex - more likely to be injecting and also using alcohol - drug treatment clients than the England average (5.3.4).
- The majority of people (59%) in treatment in 2017/18 were opiate clients, of whom half are now aged over 40 years compared to one third in 2009/10 (4.2.1). Among alcohol only clients, 74% are aged 40 or over (compared to 57% in 2009/10) (4.5.1). Physical long-term conditions are likely to be an increasing issue for these clients (5.3.8).
- Around half of all drug and alcohol client groups have a mental health treatment need on presentation in B&NES (7.3), and just under one third are not having these needs met (7.4).
- The number of opiate clients seen in Shared Care by SDAS and GPs has reduced by nearly half since 2012 (5.3.2). The complex service is very appropriate for complex and recovering clients but maintaining stable opiate clients in the complex service may be missing opportunities for physical care and local recovery support and may be a less cost effective approach.

[1] Throughout 2018 there were 955 clients in treatment.

- Opiate clients are in treatment longer than the national average, although this may reflect the slighter higher complexity of clients in B&NES (5.3.5).
- Measures of drug-related deaths have been rising over the last few years in B&NES, as well as nationally, and are now one of the leading causes of death in men aged 15-49 years (6.2).
- Housing needs appear to be a more significant problem for drug treatment clients in B&NES compared to national averages (5.3.4 and 5.3.7).
- There are estimated to be around 180 people who are high impact 'blue light' service users (3.3.2).
- An important emerging issue appears to be the recent rise, and greater rate in the local treatment population compared to national, of clients recorded with problematic illicit and licit use of prescription-only and/or over-the-counter medicines (5.3.3).

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Contents

Glossary of Terms

Addiction	A chronic, relapsing disorder characterised by compulsive drug seeking, continued use despite harmful consequences, and long-lasting changes in the brain.
Adverse Childhood Experiences (ACEs)	Are stressful experiences occurring during childhood that directly hurt a child (e.g. maltreatment) or affect them through the environment in which they live (e.g. growing up in a house with domestic violence). ACEs can continue to harm the health of children throughout their life.
Anabolic steroids	Are one of a group of misused substances often referred to as image and performance enhancing drugs or IPEDs.
Anesthetic	Technically a drug that results in a total or partial loss of sensation (importantly to pain) as well as the potential loss of consciousness.
Benzodiazepines	Are a class of drugs that act as a sedative – slowing down the body's functions – and are used for both sleeping problems and anxiety.
Cannabis	Also known as marijuana, weed, pot, dope or grass is the most widely used illegal drug in the UK.
'Chemsex'	Is a term for the use of drugs before or during planned sexual activity to sustain, enhance, disinhibit or facilitate the experience. 'Chemsex' commonly involves crystal methamphetamine, GHB/GBL and mephedrone, and sometimes injecting these drugs (also known as slamming).
Class A controlled drugs	Are considered by Parliament to be the most harmful. Among others, this category includes heroin, methadone, cocaine (including crack cocaine) and ecstasy. An offence involving a Class A substance carries the harshest penalties.
Class B controlled drugs	Are considered by Parliament to be less harmful than Class A drugs and include, among others, cannabis.
Class C controlled drugs	Are considered by Parliament to be the least harmful of the controlled drugs. These include, among others, steroids.
Cocaine	A powerful stimulant that's snorted as a powder (coke) or smoked from small rocks (crack).
Dependence	A strong desire or sense of compulsion to take a substance, a difficulty in controlling its use, the presence of a physiological withdrawal state, tolerance of the use of the drug, neglect of alternative pleasures and interests and persistent use of the drug, despite harm to oneself and others.
Drug	Any substance (with the exception of food and water required for nutritional support) which, when taken into the body, alters the body's function either physically and/or psychologically. Drugs may be legal (e.g. alcohol, caffeine and tobacco) or illegal (e.g. cannabis, ecstasy, cocaine and heroin).
Drug misuse	Defined by the WHO as the use of a substance for a purpose not consistent with legal or medical guidelines, for example the non-medical use of prescription medications or the recreational use of illegal drugs. It may lead to problematic drug use, including dependence.
'Dual Diagnosis'	Refers to the complex needs with coexisting mental health and substance misuse problems.
Ecstasy (MDMA)	Common name for MDMA.
Heroin	A powerful opiate that's usually sold as a white or brown powder.

Housing First	Housing First is an evidence-based approach to successfully supporting homeless people with high needs and histories of entrenched or repeat homelessness to live in their own homes. The overall philosophy of Housing First is to provide a stable, independent home and intensive personalised support and case management to homeless people with multiple and complex needs.
Ketamine	An injectable and short-acting anesthetic.
Methadone	Methadone is a synthetic opiate manufactured for use as a painkiller and as a substitute for heroin in the treatment of heroin addiction.
MDMA	3,4-Methylenedioxymethamphetamine (MDMA), commonly known as ecstasy (E), is a psychoactive drug used primarily as a recreational drug.
Naloxone	An emergency antidote to opiate overdose. It counteracts the effects of opioid drugs (such as heroin, methadone and fentanyl) and reverses the life-threatening effects of an overdose.
Non-opiate	Any drug other than those that act on opioid receptors.
non-White-British	Any ethnic classification other than White British. Examples include: Irish, French, Polish, Romanian, Turkish, Pakistani, American, Australian.
Opiate	The subset of opioids that are naturally occurring or semi-synthetic, and includes heroin and morphine, but excludes methadone.
Opioids	A class of psychoactive substances derived from the poppy plant (including opium and morphine), as well as semi-synthetic forms (including heroin) and synthetic compounds (including methadone) with similar properties.
Opioid substitution therapy (OST)	Administration of a prescribed (daily) dosage of opioid medicines to patients with opioid dependence problems. Today, drugs used in substitution therapy in the UK are guided by NICE, which endorses mainly methadone and buprenorphine.
Polydrug misuse	The use of several drugs either in succession or at one time to achieve a certain effect.
Psychoactive drug	A chemical substance that changes brain function and results in alterations in perception, mood, or consciousness.
Rough Sleepers	People sleeping, about to bed down (sitting on/in or standing next to their bedding) or actually bedded down in the open air (such as on the streets, in tents, doorways, parks, bus shelters or encampments). People in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations or 'bashes'.
Shared Care	The joint participation of specialists and General Practitioners (and other agencies as appropriate) in the planned delivery of care for patients with a drug misuse problem, informed by an enhanced exchange of information beyond routine referral and discharge letters. It may involve the day-to-day management by the GP of a patient's medical needs in relation to his/her drug misuse, and may involve prescribing substitute drugs. Such arrangements would make explicit which clinician was responsible for different aspects of treatment.
'Spice'	'Spice' is a nickname for any type of herbal mixture that has been coated with an SCRA.
Steroids	Anti-inflammatory medicines used to treat a range of conditions.
Stimulants	A class of drug that excites any bodily function, but more specifically those that stimulate the brain and central nervous system, for example, cocaine. However, caffeine is also a common stimulant, as is nicotine.
Successful completion	A term that describes a client that completes treatment successfully as either:

	(i) 'treatment completed drug free' – no longer requiring any structured drug treatment interventions and judged by the clinician not to be using heroin (or any other opioids) or crack cocaine or any other illicit drug; or (ii) 'treatment completed occasional user (not heroin and crack)' – the client no longer requires structured drug treatment interventions and is judged by the clinician not to be using heroin (or any other opioids) or crack cocaine. There is evidence of use of other illicit drug use but this is not judged to be problematic or to require treatment.
Treatment naïve	Is a term used by Public Health England to describe those who enter treatment services for the very first time.
Waiting time	The period from the date a person is referred for a specific treatment intervention and the date of the first appointment offered. Referral for a specific treatment intervention typically occurs within the treatment provider at, or following, assessment.

List of Acronyms and Abbreviations

ACEs	Adverse Childhood Experiences
ACMD	Advisory Council on the Misuse of Drugs
AIRS	Arrest Intervention Referral Service
AWP	Avon & Wiltshire Mental Health Partnership NHS Trust
B&NES/BaNES	Bath and North East Somerset
BAT	Battle Against Tranquillisers
BSW	BaNES, Swindon and Wiltshire
BSW STP	BaNES, Swindon and Wiltshire Sustainability and Transformation Plan
CCG	Clinical Commissioning Group
CJIT	Criminal Justice Intervention Team
CSEW	Crime Survey for England & Wales
DHI	Developing Health & Independence
DOMES	Diagnostic Outcomes Monitoring Executive Summary
DRD	Drug-Related Death
DRR	Drug Rehabilitation Requirement Order
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
HARS	HIV and AIDS Reporting System
IPED	Image and Performance Enhancing Drug
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LAPE	Local Alcohol Profiles for England
LSCB	Local Safeguarding Children's Board
NDTMS	National Drug Treatment Monitoring System
NICE	National Institute for Health and Care Excellence
NTA	National Treatment Agency (no longer exists and functions transferred to PHE on 1st April 2013)
NPS	New Psychoactive Substances
OCU	Opiate and Crack cocaine Users
ONS	Office for National Statistics
OST	Opioid substitution therapy
PHE	Public Health England
PHOF	Public Health Outcomes Framework
PSA	Psychoactive Substances Act
PWID	People who inject drugs
RDT	Recovery Diagnostic Tool
RSVP	Resolve to Stop the Violence Programme
SAMHSA	Substance Abuse and Mental Health Services Administrations
SARSAS	Somerset & Avon Rape & Sexual Abuse Support
SCRA	Synthetic Cannabinoid Receptor Agonists
SDAS	Somerset Drug and Alcohol Service
SDU	Sexualised Drug Use
SOPHID	Survey of Prevalent HIV Infections Diagnosed
SPoE	Single Point of Entry
SSW	Street Sex Worker
STP	Sustainability and Transformation Plan
TNT	'Street' name of the drug fentanyl
TOP	Treatment Outcomes Profile

1.0 Background and National Context

1.1 Introduction

This chapter defines the scope and purpose of this adult substance misuse treatment needs assessment and describes the methodology adopted to produce it. It also sets out the national context, including an overview of the legislation and national policy.

1.2 Scope

The scope of this needs assessment includes misuse of all substances, but focuses on alcohol and illicit substances, which include New Psychoactive Substances (NPSs), for residents over 18 years of age in Bath and North East Somerset Council (B&NES). The key focus is on adult substance misuse as a Children and Young People's Substance Misuse Needs Assessment was undertaken in 2015.[2]

While it has not been possible to cover every aspect of B&NES's local substance misuse treatment services in this document, the following gaps could be filled by smaller focused pieces of work following publication:

- An analysis of those who present for treatment, but who do not start treatment. This would have the potential to better understand unmet need.
- Further analysis of the Needle and Syringe Programme (NSP) user data, particularly the incorporation of community pharmacy data to the analysis already carried out in 6.7.6.[3] This would have the potential to better understand the effectiveness of this commissioned harm reduction service in keeping injecting drug users safe.
- Further analysis of those receiving opioid substitution therapy (OST) to supplement existing analysis (6.8) to address an outstanding question as to whether clients are on OST for longer, as well as collecting additional data to discover whether clients receiving OST are on optimal doses.
- A transition pathway analysis of young people people who move between the locally commissioned young people and adult treatment services. This would have the potential to provide evidence of how effective local treatment services are at providing continuity of effective treatment.
- An analysis of the tier 4 residential and community based treatment cohort. This would have the potential to provide evidence of whether there is sufficient capacity, appropriateness of placements, and effectiveness in terms of costs and outcomes.
- Further analysis of criminal justice clients who are in treatment, particularly building on the analysis outlined in 5.2 for adults with a substance misuse treatment need who successfully engage in community-based structured treatment following release from prison.
- A more detailed analysis of the alcohol only treatment cohort, particularly expanding on the successful completion statistics outlined in 5.4. However, it should be borne in mind that the primary purpose of this assessment of needs (1.3) is not to inform any future separate alcohol harm reduction strategy.

[2] B&NES (2015a), *Children and Young People's Substance Misuse Needs Assessment*, available from: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/substance-misuse

[3] Noting that DHI completed an audit of NSP activity in relation to coverage rate and spend during early 2019.

- A review of notified possible drug-related deaths since the last local review was undertaken (6.2.3), i.e. to include notified deaths from April 2017. This could be combined with an investigation as to why there has been an increase in hospital admissions for poisoning by drug misuse, i.e. overdoses (6.4.1).
- An investigation to establish whether the urgent housing and other related needs of the more complex client cohort (5.3.4) are being effectively addressed, particularly since the introduction of Housing First (2.8.3).

1.3 Purpose

The purpose of this document is to:

- provide an overview of national and local policy to provide context;
- assess prevalence and unmet need for substance misuse treatment in B&NES;
- assess the characteristics of those currently in substance misuse treatment services in B&NES; and
- provide an overview of the performance of the treatment system, in particular focusing on outcomes.

1.4 Methodology

This substance misuse needs assessment will use a combination of two approaches:

- Epidemiological;[4] and
- Corporate.

1.4.1 Epidemiological

This information is based on the available data and analytical sources, including:

- a range of data sources, including, but not limited to the following:
    - National Drug Treatment Monitoring Service (NDTMS)[5] data and service level data and self-generated reports, for example, Diagnostic Outcomes Monitoring Executive Summary (DOMES) reports and the Recovery Diagnostic Toolkit (RDT);
    - PHE's Joint Strategic Needs Assessment (JSNA) Support Packs for drugs and alcohol;
    - PHE's Local Alcohol Profiles for England (LAPE);
    - Office for National Statistics (ONS) deaths related to drug poisoning in England and Wales statistical bulletins;
    - NHS Digital's statistics on drug misuse publications;
    - Hospital admission statistics; and
    - PHE's Public Health Outcomes Framework (PHOF).[6]
- where appropriate, national and regional benchmarking (desk-top review).
- the mapping of the current treatment and intervention provision (desk-top review).
- service user feedback (focus group), which is outlined in section 5.6.
- national and local contextual data, for example, mapping geographical locations where populations are at greater risk of substance misuse.

[4] Epidemiological information is used to plan and evaluate strategies to prevent illness and as a guide to the management of patients in whom disease has already developed.

[5] https://www.ndtms.net/

[6] PHE (2019), *Public Health Outcomes Framework*, available from: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework

This report was written during the period January to March 2019, and as such includes the latest research and statistics that were available at that time, i.e, treatment service statistics up to the end of quarter 3 2018/19.

1.4.2 Corporate

To consult with, and elicit the views of key local professionals. This was undertaken during the consultation phase of the needs assessment process, including at a workshop held on 21st March 2019 to present and discuss key findings and other emerging issues (summarised in 5.5).

1.5 Legislation

1.5.1 Misuse of Drugs Act 1971

The Misuse of Drugs Act 1971[7] as amended regulates the production, supply and possession of "controlled" drugs. Controlled drugs are classified in one of three ways - Classes A, B and C - with Class A considered to be the most harmful.

The Misuse of Drugs Regulations 2001[8] allow for the lawful possession and supply of controlled drugs for legitimate purposes. They set out how these substances will be prescribed, administered and stored. Substances are listed in Schedules of the regulations, depending on their therapeutic usefulness, and the potential harms.

The Misuse of Drugs Regulations 2018[9] allows for the wider use of cannabis-based products for medicinal use in humans, essentially for medical purposes.

1.5.2 Psychoactive Substances Act (PSA) 2016

The Psychoactive Substances Act (PSA) came into force on the 6th April 2016.[10] The PSA makes it an offence to produce, supply or offer to supply any psychoactive substance if the substance is likely to be used for its psychoactive effects and regardless of its potential for harm. The only exemption from the Act are those substances already controlled by the Misuse of Drugs Act, nicotine, alcohol, caffeine and medicinal products. One of the main aims of the Act was to shut down shops and websites that traded in 'legal highs'.

1.6 National Policy

1.6.1 Summary of Drugs Policy (pre-2017)

In 1998, the New Labour Government published their national drug strategy titled '*Tackling Drugs to Build a Better Britain*'.[11] This strategy saw a significant investment in drug treatment services across the country, which stressed the use of diversion into drug treatment from the criminal justice system. The main focus of the strategy was problematic drug users, which included those who injected drugs

[7] *Misuse of Drugs Act 1971*, c.38, available from: https://www.legislation.gov.uk/ukpga/1971/38/contents

[8] *The Misuse of Drugs Regulations 2001*, No. 3998, available from: http://www.legislation.gov.uk/uksi/2001/3998/contents/made

[9] *The Misuse of Drugs (Amendments) (Cannabis and Licence Fees) (England, Wales and Scotland) Regulations 2018*, No. 1055, available from: http://www.legislation.gov.uk/uksi/2018/1055/made

[10] *Psychoactive Substances Act 2016*, c. 2, available from: http://www.legislation.gov.uk/ukpga/2016/2/contents/enacted

[11] Home Office (1998), *Tackling Drugs to Build a Better Britain*, available from: https://www.gov.uk/government/publications/tackling-drugs-to-build-a-better-britain

and those using opioid drugs and crack cocaine. Since the 1998 drug strategy there have been a number of revisions on a national level, with a fundamental change of focus from maintenance to recovery.

The Coalition Government's 2010 Drug Strategy, '*Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug-free Life*',[12] set out to respond to emerging drug threats, for example, from prescription and over-the-counter medicines; and to tackle severe alcohol dependency[13] as well as reduce drug use and dependence. In particular, the strategy was framed around the following three themes:

(i) reducing demand;
(ii) restricting supply; and
(iii) building recovery in communities.

This strategy has two overarching aims to:

(i) reduce illicit and other harmful drug use; and
(ii) increase the numbers recovering from their dependence.

The 2010 drug strategy sought a rebalancing of the treatment system to give fresh impetus to promoting individual recovery, measured by successful completion of treatment, alongside continuing provision of harm reduction services and a recognition that for many individuals their journey to recovery would involve lengthy periods being supported by opioid substitution therapy (OST).

A key element of the then government's reforms was to give local areas the freedoms and powers necessary to develop a holistic, joined-up recovery system that goes beyond drug treatment and addresses the wider needs of those with dependence on drugs and/or alcohol. The reforms that saw public health come into upper tier and unitary local authorities in April 2013 and take on responsibility for commissioning the full range of drug and alcohol prevention, treatment and recovery services enabled this to happen.

The 2012 '*Medications in Recovery: Re-orientating Drug Dependence Treatment*' report[14] detailed a review of evidence contextualised within the ambitions of the 2010 Drug Strategy (*see 1.6.1*). This strategy expressed concern that "…*for too many people currently on a substitute prescription, what should be the first step on the journey to recovery risks ending there*…", and wanted to "…*ensure that all those on a substitute prescription engage in recovery activities*."[15] The 2010 strategy reached a clinical consensus which would guide clinicians and agencies in helping opioid substitution patients achieve their fullest personal recovery, improve support for long-term recovery, and avoid unplanned drift into open-ended maintenance prescribing.

[12] Home Office (2010), *Drug Strategy*, available from: https://www.gov.uk/government/publications/drug-strategy-2010

[13] Also taken forward in the Coalition Government's 2012 Alcohol Strategy. Source: Home Office (2012), Alcohol Strategy, available from: https://www.gov.uk/government/publications/alcohol-strategy

[14] Strang, J. (2012), *Medications in Recovery: Re-orientating Drug Dependence Treatment*, available from: https://webarchive.nationalarchives.gov.uk/20170807160631/http://www.nta.nhs.uk/uploads/medications-in-recovery-main-report3.pdf

[15] Home Office (2010), *op. cit.*

Recovery has been identified as a primary goal for behavioural health care. Figure 1 is a useful illustration of what recovery encompasses and the fact that recovery is at the heart of treatment.

Figure 1: Elements of what Recovery from Substance Misuse Encompasses

Source: Substance Abuse and Mental Health Services Administrations (SAMHSA)

1.6.2 2017 Drugs Strategy

In July 2017 the Conservative Government published an updated drugs strategy.[16] It maintains the recovery ambition at its heart, whilst recognising that for many of the increasingly vulnerable older cohort of heroin users interventions need to be matched to their individual needs. Alongside this updated strategy, the (now) Department of Health and Social Care, published new clinical guidelines titled '*Management and Treatment of Drug Dependence, UK guidelines on clinical management 2017*' (often referred to as the 'Orange Book').[17] This emphasises the very clear commitments in the updated strategy to follow the clinical evidence of what works in responding to drug dependence.

This updated strategy identifies local authorities as ideally suited to integrate the clinical care drug and alcohol misusers need with housing, employment, and other social supports. Alongside the Home Secretary's leadership, across Whitehall will sit a revitalised process of accountability and support to local authorities from central government and Public Health England (PHE) to deliver the aspirations of the strategy. Local authorities will continue to report on a series of key indicators, identifying: investment in treatment, the outcomes this achieves, their success in getting people into work, improving access to housing, reducing drug-related deaths and integrating the drug and alcohol treatment system with wider physical and mental health NHS provision.

Additionally, there is a fourth strand to the three themes that comes across from the 2010 drug strategy - reducing demand, restricting supply, building recovery in communities (1.6.1) – which is on global action. This additional theme sets out the government's international role, including sharing best practice and promoting an evidence-based approach. The two overarching aims remain the

[16] Home Office (2017), *Drug strategy 2017*, available from: https://www.gov.uk/government/publications/drug-strategy-2017

[17] Department of Health and Social Care (2017), *Drug misuse and dependence: UK guidelines on clinical management*, available from: https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management

same, i.e. to reduce illicit and other harmful drug use and increase the numbers recovering from their dependence.

2.0 Local Context

2.1 Introduction

This chapter provides local context to this substance misuse treatment needs assessment by outlining relevant local strategies, describing the current substance misuse treatment services and local expenditure, as well as summarising the demographics of B&NES and highlighting the relative sizes of various high priority and high risk population cohorts.

2.2 Previous Adult Substance Misuse Needs Assessment for B&NES

The last comprehensive adult substance misuse treatment needs assessment was carried out during 2012 and was used to inform the 2012/13 treatment plan.[18] While rather old, there may nevertheless be some recommendations that are still pertinent to the future treatment service remodelling.

2.3 Local Strategies and Strategic Plans

Substance misuse is a key issue across a range of public health, criminal justice and social care concerns. This needs assessment can be reviewed alongside a range of other locally produced documents. These include the following local strategies and strategic plans.

2.3.1 Alcohol Harm Reduction Strategy 2014-2019

The strategic vision of the Alcohol Harm Reduction Strategy is to create "*a cultural environment where everyone can have fun and enjoy themselves safely, with or without alcohol*." There are four key outcomes outlined in the strategy:

- children grow up free from alcohol related harm;
- communities are safe from alcohol related harm;
- people can enjoy alcohol in a way that minimises harm to themselves; and
- people can access support that promotes and sustains recovery.[19]

The key priorities identified under the fourth outcome are as follows:

- capacity and engagement: increase alcohol treatment capacity and engagement by priority group alcohol client.
- client outcomes: increase the % of alcohol clients who successfully complete treatment.
- support the workforce: drug and alcohol training programme focus – alcohol & mental health, older people.
- treatment resistant drinkers project (known as 'Blue Light') – complete workshops and respond to findings / recommendations.

[18] Spencer, L. (2012), *Bath & North East Somerset Needs Assessment for Adult Substance Misuse 2011/12*, B&NES, unpublished

[19] B&NES (2014a), *Alcohol Harm Reduction Strategy 2014-2019*, available from: http://www.bathnes.gov.uk/services/public-health/guide-programmes-strategies-and-policies/alcohol-harm-reduction-strategy-2014

2.3.2 Joint Community Safety Plan 2018-2021

This plan[20] fulfils a specific recommendation of a B&NES Scrutiny Inquiry Day on Community Safety[21], which identified the benefits of a partnership approach to focus on tackling crime, disorder and anti-social behaviour in B&NES. The Bath and North East Somerset Responsible Authorities Group (RAG), which is the Community Safety Partnership, and the Police and Crime Commissioner (PCC), have worked closely together to prepare the plan, alongside the other key partners involved in keeping people safe. As such, it reflects their shared priorities and serves as both the Community Safety Plan and the local Police & Crime Plan for B&NES. It sets out the following three priorities:

- protect the most vulnerable from harm;
- strengthen and improve local communities to improve outcomes for local people; and
- work together effectively to respond to community safety challenges.

Protecting the most vulnerable from harm should be one of the outcomes of a well functioning substance misuse treatment service, whether this be successfully treating substance misusing parents to ensure children do not suffer maltreatment, or working in close partnership with domestic abuse services in treating both victims and perpetrators of abuse.

The multi-agency Night-Time Economy Group in B&NES works together to ensure people living, working and visiting B&NES are able to enjoy a safe and positive experience of the night-time economy. The group does this through providing expert advice alongside direct management of the night-time economy through taxi marshals and the night watch programme for example, and the promotion and maintenance of standards of good practice such as Purple Flag accreditation for Bath City Centre. Night marshals and voluntary ambulance staff play an important role in minimising harm and keeping people safe, for example, by being trained in delivering naloxone to prevent deaths from overdose.

2.3.3 Multi-Agency Neglect Strategy 2017-2020

The Multi-Agency Neglect Strategy,[22] aimed at children and young people, sets out the strategic approach to tackling and reducing the impact of neglect and identifies the key principles under which work around neglect should be undertaken. The strategy identifies key priority areas of work in order to improve our collective response to neglect. Parental substance misuse is recognised as one of the parental risk factors for neglect of children.

One of the guiding principles in the strategy is to take a 'whole family approach', i.e. practitioners working alongside the entire family to identify support needs and to facilitate change. This will include providing high quality and effective treatment for substance misusing parents.

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[20] B&NES (2018b), *Joint Community Safety Plan 2018-2021*, available from: http://www.bathnes.gov.uk/services/neighbourhoods-and-community-safety/crime-prevention-and-community-safety/community-safet-0

[21] B&NES (2017c), *Community, Transport & Environment Policy Development & Scrutiny Panel Community Safety Scrutiny Inquiry Day*, 12th October, available from: https://democracy.bathnes.gov.uk/documents/s49068/Community%20Safety%20Scrutiny%20Inquiry%20Day%20report.pdf

[22] B&NES (2017a), *Multi-Agency Neglect Strategy 2017*, available from: http://www.bathnes.gov.uk/services/children-young-people-and-families/early-help-services/safeguarding-child-protection

2.3.4 The Children and Young People's Plan 2018-2021

One of eleven stated priorities is to "*increase the proportion of children and young people living in safe, supportive families and communities*."[23] This will include reducing the number of children at risk with substance misusing parents and carers. The plan highlights the need for a greater focus on early help, a '*Think Family*' approach, support for complex families and those in need of increased support and safeguarding.

2.3.5 Local Safeguarding Children's Board (LSCB) Strategic Plan 2018-21

The Local Safeguarding Children's Board (LSCB) Strategic Plan 2018-2021[24] states as one of its priorities "*...assurance that children at risk experiencing the following are identified early and safeguarded: children living with parents with mental health, domestic abuse and substance use (focus on hidden harm, disguised and non-compliance).*" This means it is essential that all services, including adult substance misuse services, are identifying, recording and notifying appropriate practitioners where there is parental substance misuse confirmed or suspected.

2.3.6 Health and Wellbeing Strategy 2015-2019

The Health and Wellbeing Board (HWB) is the body responsible for improving the health and wellbeing of people in Bath and North East Somerset. The Joint Health and Wellbeing Strategy (JHWS)[25] sets out how the HWB will improve local health and priorities for action based on the health and wellbeing needs. It does this by assessing the evidence, setting the strategic direction and deciding how to make the best use of collective resources. There are three main themes and eleven priorities in the current JHWS, which were identified in 2015 (Figure 2).

A high quality and effective substance misuse treatment service is clearly an essential part of addressing many of the stated priorities in the current HWB Strategy. For example, effectively treating parents who misuse substances will clearly be supporting families with complex needs. At the same time though, tackling this issue will also meet other stated priorities, for example, reducing rates of alcohol misuse in the general population and also likely reduce the health and wellbeing consequences of domestic abuse.

[23] B&NES (2018a), *The Children and Young People's Plan 2018-2021*, available from: http://www.bathnes.gov.uk/services/children-young-people-and-families/strategies-policies-planning/children-and-young-peoples

[24] B&NES LSCB (2018), *LSCB Strategic Plan 2018-21*, available from: https://www.safeguarding-bathnes.org.uk/sites/default/files/lscb_strategic_plan_june_18.pdf

[25] B&NES (2015b), *Bath and North East Somerset Health and Wellbeing Strategy 2015-2019*, available from: http://www.bathnes.gov.uk/services/neighbourhoods-and-community-safety/working-partnership/health-and-wellbeing-board

Figure 2: Themes and Priorities, B&NES Joint Health and Wellbeing Strategy 2015-2019

Source: B&NES (2015b), *Bath and North East Somerset Health and Wellbeing Strategy 2015-2019*, available from: http://www.bathnes.gov.uk/services/neighbourhoods-and-community-safety/working-partnership/health-and-wellbeing-board

2.3.7 BaNES, Swindon and Wiltshire Sustainability and Transformation Plan (BSW STP) 2016

In response to increasing financial pressures, rising healthcare costs and patient demands, the B&NES, Swindon and Wiltshire (BSW) five year Sustainability and Transformation Plan (STP)[26] has been developed. The BSW STP aims to provide a mechanism for accelerating improvements to health and care planning and delivery for BSW residents in a financially sustainable way. Changes will be made to services in the following five key areas:

- create locality-based integrated teams supporting primary care;
- shift the focus of care from treatment to prevention and proactive care;
- develop efficient infrastructure to support new care models;
- a modern workforce establish a flexible and collaborative approach to workforce; and
- enable better collaboration.

2.4 Overview of Current Services

Drug and Alcohol treatment services are currently provided by Developing Health & Independence (DHI) and Avon & Wiltshire Partnership NHS Trusts' (AWP) Specialist Drug and Alcohol Services (SDAS). SDAS deliver complex services under a local authority contract for prescribing, immunisation and testing to prevent the spread of blood borne viruses; Shared Care services in conjunction with GP practices throughout B&NES; medically assisted community detoxification programme; and assessments for residential treatment programmes. DHI deliver drug and alcohol recovery services for young people and adults under a Virgin Care contract, providing assessments and access to psychosocial and counselling services; peer support; relapse prevention; needle and syringe

[26] BaNES CCG (2016), *BaNES, Swindon and Wiltshire's Sustainability and Transformation Plan*, available from: https://www.bathandnortheastsomersetccg.nhs.uk/get-involved/project/onesystem

programmes, and programmes to reduce re-offending, such as Alcohol Treatment Requirements, or Drug Rehabilitation Requirements. DHI support clients to access housing services; debt advice; education and employment support; and to link with mutual aid organisations (AA, NA, SMART Recovery), DHI and SDAS deliver Alcohol Liaison Services from the RUH and, in addition, supervised Opiate Substitution Therapy (OST) and needle and syringe programmes (NSP) are provided from pharmacies throughout B&NES.

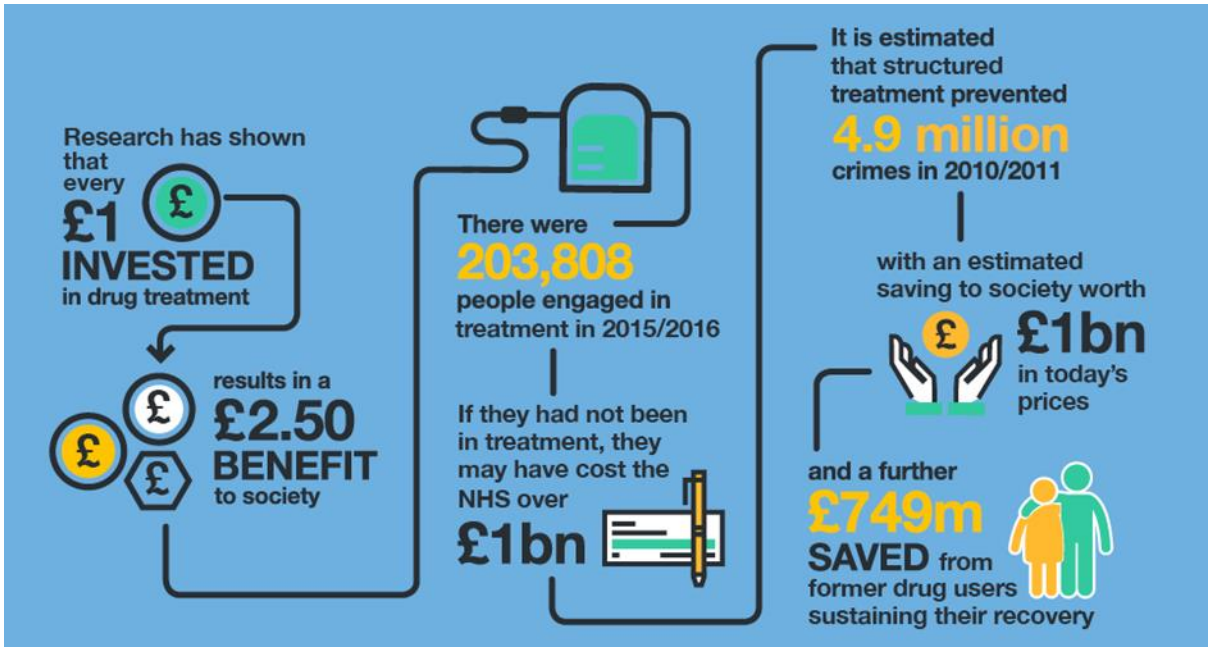
Services are delivered across B&NES through two city centre sites (The Beehive and Riverside); from a Hub in Midsomer Norton; and Shared Care services are delivered from GP practices across B&NES.

2.5 The Cost of Addiction: why invest?

The 2017 Drugs Strategy states that "*the social and economic cost of drug supply in England and Wales is estimated to be £10.7 billion a year – just over half of which (£6 billion) is attributed to drug-related acquisitive crime (e.g. burglary, robbery, shoplifting).*" Investing in treatment services to reduce drug misuse and dependency will not only help to save lives, but will also substantially reduce the economic and social costs of drug-related harm.

Research has shown that for every £1 invested in drug treatment results in a £2.50 benefit to society (Figure 3). This includes an estimated prevention of 4.9 million crimes, with an estimated saving to society of £1 billion in costs to the public, businesses, criminal justice and the NHS (Figure 3). For many drug users, engaging in treatment can be the catalyst for getting the medical help they need to address their physical and mental health problems.

Figure 3: Why Invest in Drug Treatment Services?



Source: PHE (2017a), *Guidance: Health matters: preventing drug misuse deaths*, available from: https://www.gov.uk/government/publications/health-matters-preventing-drug-misuse-deaths/health-matters-preventing-drug-misuse-deaths

The public values drug treatment because it makes their communities safer and reduces crime – 82% said that the greatest benefit of treatment was improved community safety.[27]

Substance misuse treatment is a key measure in reducing crime, and investment in drug and alcohol treatment is estimated to have generated key benefits for B&NES. For example, fewer crimes are committed when people are in treatment, which bring both social and economic benefits potentially totalling an estimated £6.7 million in 2016/17.[28] There are also additional benefits that can be monetised attributable to savings to the NHS (e.g. fewer GP appointments, A&E attendances and hospital admissions), as well as cost savings to B&NES (e.g. fewer opiate users using needle and syringe programmes, improved housing conditions, fewer people needing support from adult social care and fewer families needing support from children's social care) - both totalling an estimated £735,000 during 2016/17.[29] There are additional benefits to be accrued over time while clients remain in treatment and/or in recovery.

2.6 Substance Misuse Treatment Services Expenditure

Figure 4 shows that the expenditure for B&NES's substance misuse treatment services has fallen from £3.1 million in 2015/16 to £2.6 million in 2017/18, a fall of 17% in two years. This reduction in expenditure on substance misuse treatment services is likely to have resulted in a reduction in capacity, either reducing the number of clients in treatment and/or leading to a reduction in the level of services clients receive. Looking forward to 2020, the substance misuse expenditure is forecast to level out. However, the cost of buprenorphine (an OST prescribed drug) has recently soared, thus pushing up local authority substance misuse treatment services expenditure.[30]

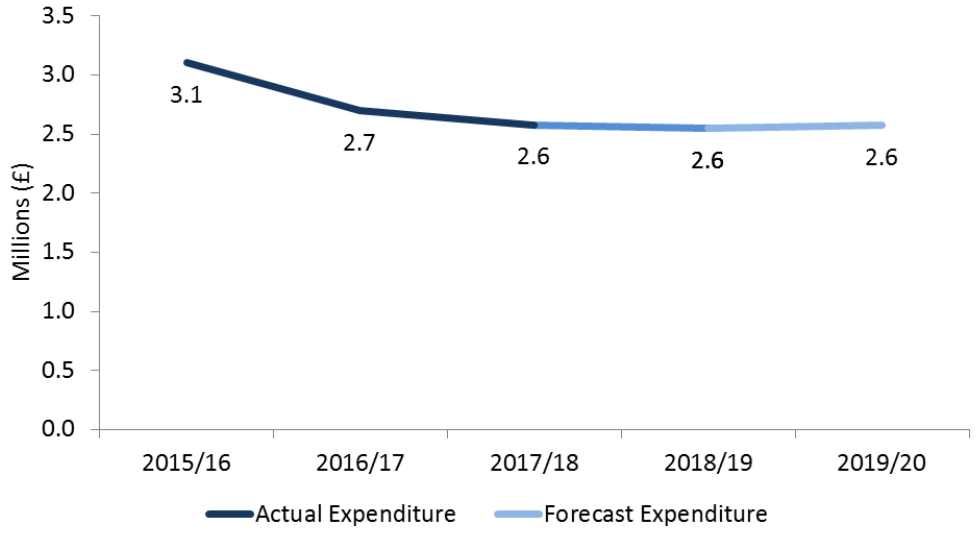
[27] PHE (2017a), *Guidance: Health matters: preventing drug misuse deaths*, available from: https://www.gov.uk/government/publications/health-matters-preventing-drug-misuse-deaths/health-matters-preventing-drug-misuse-deaths

[28] PHE (2016a), *The social return on investment (SROI) of treatment for alcohol and drug dependency*, available from www.NDTMS.net [password protected]

[29] *Ibid.*

[30] Praities, N. (2018), Drug rehab services face 'serious pressure' after 500% increase in buprenorphine price, Opioid substitution Drug rehab services face 'serious pressure' after 500% increase in buprenorphine price, *The Pharmaceutical Journal*, 7 Nov, available from: https://www.pharmaceutical-journal.com/news-and-analysis/news/drug-rehab-services-face-serious-pressure-after-500-increase-in-buprenorphine-price/20205694.article

Figure 4: B&NES Substance Misuse Expenditure (£ millions), 2015/16 to 2019/20

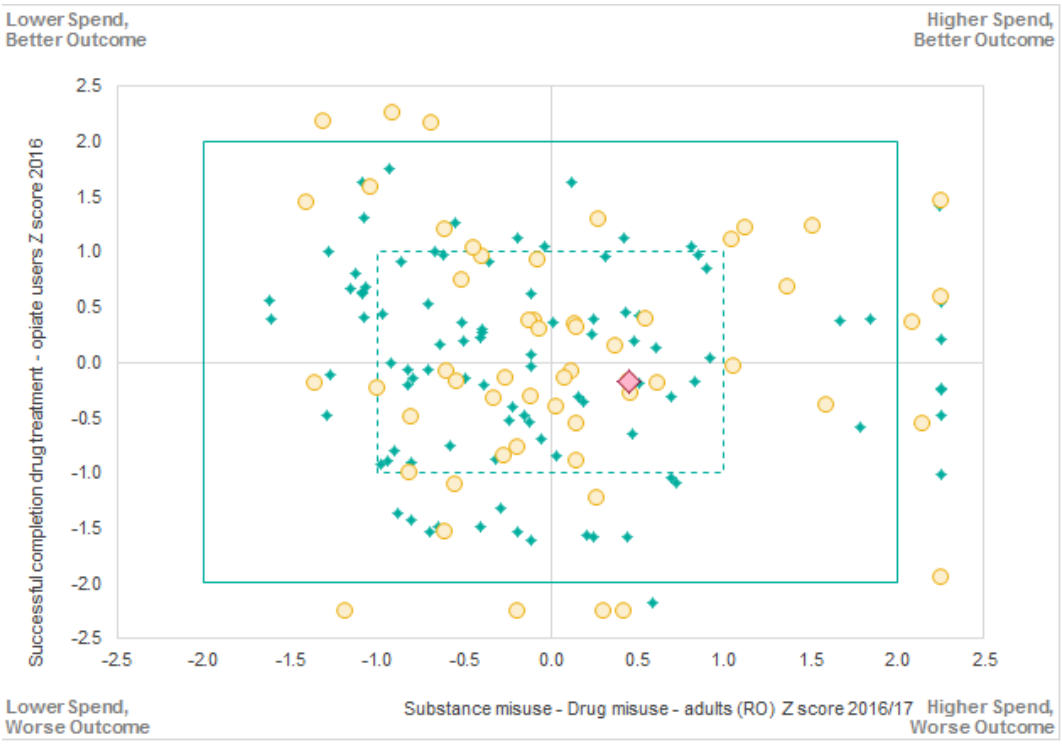


Source: FOI 57/10, B&NES.

Note: while the bulk of the expenditure comes from the Public Health Grant, contributions also come from BaNES CCG, B&NES Council, the local Better Care Fund and Wiltshire Council (the latter to fund joint posts).

Figure 5 illustrates that B&NES's drugs misuse treatment spend[31] remains relatively high, while outcomes[32] are slightly lower than average.

Figure 5: Spend and outcome tool: Detailed quadrant chart, Drug Misuse, B&NES, 2016/17



Source: PHE (2018), Spend and outcome tool (SPOT), available from: https://www.gov.uk/government/publications/spend-and-outcome-tool-spot

Notes: The red diamond represents the selected organisation, with the orange circles representing organisations within the selected organisation's chosen comparator group. The green dots represent the spread of all organisations in England. A programme lying outside

[31] SP_376_RO _Substance misuse - Drug misuse - adults (RO). £1.9 million in 2016/17.

[32] PHOF_2.15i_P_Successful completion drug treatment - opiate users. 6.3% in 2016.

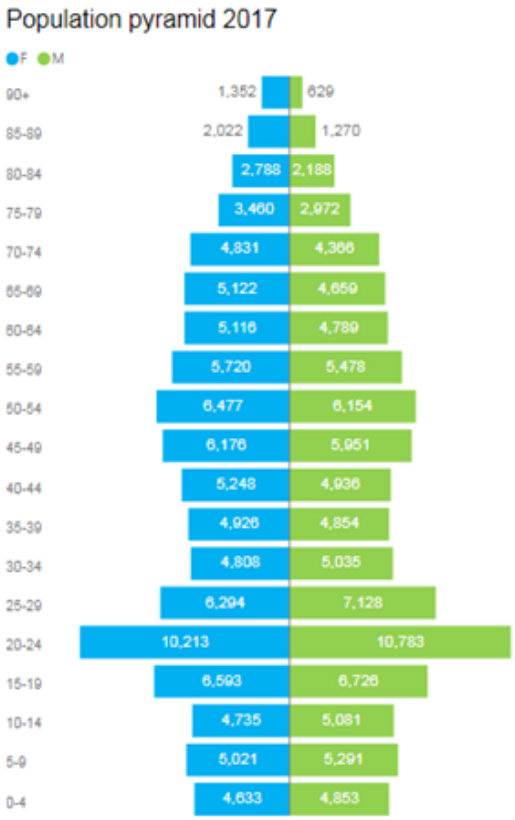
the solid +/- 2 z scores box, may indicate the need to investigate further. If the programme lies to the left or right of the box, the spend may need reviewing, and if it lies outside the top or bottom of the box, the outcome may need reviewing. Programmes outside the box at the corners may need a review of both spend and outcome. Programmes lying outside the dotted/thin +/- 1 z score box may also warrant further exploration. A z score essentially measures the distance of a value from the mean (average) in units of standard deviations. A positive z score indicates that the value is above the mean, whereas a negative z score indicates that the value is below the mean. A z score below -2 or above +2 may indicate the need to investigate further. Each dot represents a programme budget category.

2.7 Local Population

As a local authority area Bath and North East Somerset (B&NES) was formed in 1996 and covers approximately 135.2 square miles. In 2017 there were an estimated 188,678 people resident in B&NES, of which an estimated 153,120 were aged 18 or over.

Bath is the largest urban settlement in the area and forms the main urban centre, acting as the commercial and recreational centre of the district. It is home to just over 50% of the population and is one of the few cities in the world to be named a UNESCO World Heritage Site. Keynsham lies to the west of Bath, a traditional market town with a population of just over 9% of the total population of B&NES. Midsomer Norton and Radstock are small historic market towns, located in the south of the district with approximately 12% of the total population split between them. They both have a strong heritage of mining and industry stemming from the North Somerset coalfield. The rest of the district consists of 69 diverse rural communities of varying sizes and characteristics, including a line of villages along the foothills of the Mendips, the Chew Valley and Cotswolds villages around Bath.

Figure 6: Population Pyramid for Bath and North East Somerset, mid-2017



Source: ONS (2018b), *Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland*, mid-2017, available from: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland

The Office for National Statistics (ONS) project that the Bath and North East Somerset population will increase to 199,100 by 2037, an increase of 12% from 2012. This increasing population has already led to increased demand for health services. Depending on the need profile of this new population, this may also impact adult substance misuse treatment services, which combined with recent expenditure reductions (2.5), could continue to present challenges.

2.8 High Priority Adult Groups

2.8.1 Introduction

The current national drugs strategy, in addition to universal preventative action, states that a more targeted approach is needed for those most at risk of misusing drugs and to tackle the threats of new types of drug misuse. The strategy highlights that local areas are best placed to understand their local needs and the services required. Government expects local partners and agencies to identify groups at risk in their communities and take appropriate action. High priority adults identified in the strategy are as follows:

- older people;
- families (including those with parents dependent on substances, and those involved with the 'troubled families' programmes);
- people who are homeless;
- veterans;
- sex workers;
- perpetrators and victims of intimate partner violence and abuse; and
- offenders.

The Advisory Council on the Misuse of Drugs (ACMD) recently reported on the factors that make vulnerable people misuse drugs and what could be done to prevent misuse and protect these groups from associated harms.[33] One important key point from this is the following:

> "*One way of understanding the key 'transition' points at which people might change their substance use behaviour, or might be more likely to experience harm is to consider significant life transitions related to changes in individual roles and responsibilities, social change, and social structure. These transition points can provide an opportunity for intervention and support, but if left unresolved may make it more likely that there is a long-term change in substance use behaviours towards harmful outcomes.*"

Thus, reducing harm in 'vulnerable' groups requires action across multiple levels of society and should always combine individually targeted actions with actions further 'upstream', thus partly picking up the early help and prevention recommendations in the Children and 2015 Young People's Substance Misuse Needs Assessment.[34]

[33] Bowden-Jones, O. (2018), Letter to Victoria Atkins MP, 4 December, available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/761123/Vulnerability_and_Drug_Use_Report_04_Dec_.pdf

[34] B&NES (2015a), *Op. Cit.*

2.8.2 Parents Living with Children

Addressing alcohol dependency among women, and particularly pregnant women, has the potential to reduce cases of Foetal Alcohol Spectrum Disorder (FASD), an issue covered in more detail in the 2015 Children and Young People's Substance Misuse Needs Assessment.[35]

The Munro review of child protection identified the relationship between parental problems, such as poor mental health, domestic violence and substance misuse, and abuse and neglect.[36] The 2017 national drug strategy also recognises that parental drug and alcohol dependence can have a significant impact on families, particularly children, and can limit the parent's ability to care for their child(ren). Families, including those with parents dependent on substances and those involved with the 'troubled families' programmes (locally known as Connecting Families), are identified as a high priority group.

Troubled families often require intensive, costly and repeated interventions at points of crisis – they may need support but have very little access to it before they reach crisis point. Mental health, substance abuse, physical health and domestic violence are key issues for this group. To be eligible for the 2015-2020 Troubled Families Programme,[37] each family must include dependent children and have at least two of the following six problems:

1. Parents or children involved in crime or anti-social behaviour.
2. Children who have not been attending school regularly.
3. Children who need help: children of all ages who need help, are identified as in need or are subject to a Child Protection Plan.
4. Adults out of work or at risk of financial exclusion or young people at risk of worklessness.
5. Families affected by violence against women and girls.
6. Parents or children with a range of health problems (including an adult with parenting responsibilities or a child with a drug or alcohol problem).

A results payment can be claimed by a local authority if it can demonstrate that an eligible family has either: (i) achieved significant and sustained progress against all problems identified at the point of engagement and during the intervention; or (ii) an adult in the family has moved into continuous employment.

At the time of the 2011 Census there were 19,111 households in B&NES with dependent children (including single parent households).[38]

Modelling has been undertaken to estimate the number of substance misusing parents living with children, both nationally and in every local authority area. In addition, treatment services identify parents living with children in their data recording, which in turn is analysed separately and reported

[35] B&NES (2015a), *Op. Cit.*

[36] Department for Education (2011), *The Munro Review of Child Protection*, available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/175391/Munro-Review.pdf

[37] Ministry of Housing, Communities & Local Government (2017), *Financial framework for the Troubled Families Programme: January 2018 onwards*, available from: https://www.gov.uk/government/publications/financial-framework-for-the-troubled-families-programme-january-2018-onwards

[38] ONS (2011), *2011 Census: Household composition, local authorities in the United Kingdom*, Table KS105UK, available from: https://www.ons.gov.uk/census/2011census

by NDTMS. Therefore, it is not only possible to identify treatment outcomes for this cohort, but also to estimate the potential scale of unmet need in the community. This also provides useful intelligence for local LSCBs and local authority children's social care teams.

2.8.3 Homeless (including Rough Sleepers)

Homelessness takes a wide range of forms and can include people who have temporary shelter such as staying with friends / family, in a hostel or other temporary accommodation. Rough sleeping is the most visible form of homelessness and is often associated with substance misuse, though this is obviously also present in other forms of temporary and permanent accommodation.

In August 2018 the Ministry of Housing, Communities & Local Government published their '*Rough Sleeping Strategy*'.[39] The Rough Sleeping Strategy sets out the Government's strategy for halving rough sleeping by 2022 and ending it by 2027. The Rough Sleeping Strategy recognises the fact that drug and alcohol affects many people who sleep rough, and can be both a cause and consequence of homelessness. This strategy highlights the need for people to access treatment, as well as restrict supply of harmful drugs (referring to the measures in the 2017 Drug Strategy). Also covered is a commitment to tackle street drinking (the Government's Alcohol Strategy is in development).

The complex and chaotic nature of the homeless population means that it is hard to provide accurate estimates as to the genuine overlap between homelessness and substance misuse at a population level. For people who are traditionally some distance from services, national research has demonstrated significant overlap of needs between homelessness and substance misuse with 70% of homeless people experiencing substance misuse service as a significant risk factor to their 'deep social exclusion'.[40]

With regards to substance misuse behaviours, recent national research based on the Crime Survey for England and Wales has shown that homeless people experience a particularly high prevalence of SCRA ('Spice') use than the general population.[41] There is no evidence to suggest that the local B&NES population will experience dramatically different levels of need amongst this cohort.

Although difficult to provide a definitive figure, Local Authorities are required by the Ministry of Housing, Communities and Local Government (MHCLG) to provide an annual estimate of the number of people sleeping rough in their area. In B&NES, effective partnership working across Third Sector and statutory services means we have as robust a process as possible for estimating rough sleeping levels. Outreach Workers know all rough sleepers by name and have regular, daily contact with them, which enables a clear picture to be built up of who has slept rough. This, combined with a 'hot-spot' check on the night of the estimate, leads to a verifiable list of individuals with whom an action plan is agreed for ending their time on the streets. The latest figure for B&NES estimates that there were 20

[39] Ministry of Housing, Communities & Local Government (2018b), *The rough sleeping strategy*, available from: https://www.gov.uk/government/publications/the-rough-sleeping-strategy

[40] Fitzpatrick, S., Bramley, G. and Johnsen, S. (2012), *Multiple exclusion homelessness in the UK: an overview of findings*, Briefing paper no. 1. (Multiple Exclusion Homelessness in the UK: Briefing Papers), Edinburgh: Heriot Watt University, Figure 1, available from: https://researchportal.hw.ac.uk/en/publications/multiple-exclusion-homelessness-in-the-uk-an-overview-of-findings

[41] PHE (2018a), *United Kingdom Drug Situation: Focal Point Annual Report 2017*, available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/713101/Focal_Point_Annual_Report.pdf

people sleeping rough on the night between 1st October and 30th November 2018 - 13 (65%) males and 7 (35%) females; with the vast majority, 18 (90%), aged 26 and over.[42] The rate per 10,000 households of rough sleepers is higher in B&NES compared to national - 2.6 and 2.0 respectively in 2018.[43] The number of people sleeping rough in B&NES will inevitably fluctuate throughout the year.

Since November 2018, Julian House has been delivering a project called Housing First, which ensures the most vulnerable rough sleepers have a permanent home to call their own, and are able to move off the streets for good. Housing First is an internationally evidence-based approach, which uses independent, stable housing as a platform to enable individuals with multiple and complex needs to begin recovery and move away from homelessness.[44] In Bath and North East Somerset Housing First is a partnership between Julian House, DHI and Curo that aims to meet the accommodation and support needs of the most complex rough sleepers.

Statutory homelessness describes those households that, due to their falling within certain legally defined 'priority need' groups, may be owed a duty by the Local Authority to provide accommodation. Priority need is most often associated with households that include dependent children, but can include single people whose complex needs arise from substance misuse. Where a household is deemed to be homeless and likely to be in priority need, temporary accommodation, in the form of either a B&B or hostel, must be provided. At the end of June 2018 there were 40 households in temporary accommodation in B&NES.[45] Since April 2018 there has been an increase in the number of larger households and single people with complex needs approaching housing services for support.[46]

2.8.4 Veterans

Veterans sometimes use alcohol and/or drugs to cope with the physical and psychological effects of military service. These are exacerbated if the person does not have fulfilling employment and/or secure accommodation.

In Autumn 2018 ONS published estimates of the size and characteristics of UK armed forces veterans (16 to 64 years of age).[47] There were an estimated 1,903 working age veterans in B&NES as of the 2011 Census. This amounted to 2% of the usual resident population and is the same as the national proportion but lower than the South West figure of 3%.

Local authorities were reminded in a letter to the Chairs of HWBs dated 13th November 2018 from the Department of Health & Social Care and NHS England to use all available data on veterans to maximum effect. While this report has been able to provide an estimate of the number of veterans resident in B&NES, it is unable to report on the local prevalence of substance misuse or the number

[42] Ministry of Housing, Communities & Local Government (2019), *Rough sleeping in England: autumn 2018*, available from: https://www.gov.uk/government/statistics/rough-sleeping-in-england-autumn-2018

[43] *Ibid.*

[44] https://hfe.homeless.org.uk/about-housing-first

[45] Ministry of Housing, Communities & Local Government (2018a), *Live tables on homelessness*, TA1: Local authority breakdowns of households in temporary accommodation at the end of the quarter by type, available from: https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

[46] Housing Services, Bath and North East Somerset Council.

[47] ONS (2018a), *Census 2011: Working age UK armed forces veterans residing in England and Wales,* available from: https://www.gov.uk/government/statistics/census-2011-working-age-uk-armed-forces-veterans-residing-in-england-and-wales

of local veterans who may be in drug and alcohol treatment services through current NDTMS reporting mechanisms.

2.8.5 Older People

Substance misuse among older adults is generally different from that of younger adults. As people age, their bodies metabolize alcohol more slowly. Therefore, older adults have increased sensitivity to and decreased tolerance for alcohol. Furthermore, the misuse of medications is far more common among older adults because they have more chronic medical conditions and are prescribed more medications. Interactions between medication and alcohol are also of particular concern among older adults as they can cause serious medical and psychological problems.[48]

A recent update to a 2011 Royal Society of Psychiatrists report titled '*Our Invisible Addicts*' was published in March 2018.[49] This study found that the proportion of older people with substance misuse continues to rise more rapidly than can be explained by the rise in the proportion of older people in the UK. It is the "baby boomer" population born between 1946–1964 (now aged between 54 and 72 years old) that is at the highest risk of substance misuse which is rising within the older population.

A recent systematic review found the following findings for older opioid users:[50]

- while opioid treatment numbers are decreasing, the average age of treatment admissions has been increasing;
- there is no consensus on what 'old' is;
- two distinct types of older opioid substance users exist (early/late onset);
- older clients achieve better treatment outcomes than younger counterparts; and
- older women achieve better treatment outcomes than men.

Figure 4 provides the gender and age profile of the local B&NES resident population.

2.8.6 Sex Workers

Sex workers are recognised as a group that experience poor health and have a high prevalence of drug and alcohol misuse. Furthermore, Street Sex Workers (SSWs) use heroin and crack cocaine as their main drug of dependence, as well as experience worse health than sex workers in off-street settings.[51]

It is extremely difficult to get accurate figures on the number of Commercial Sex Workers (CSWs) either resident in, or selling sex, in B&NES. This is due to a number of factors, including:

- There is no on-street site for CSW in B&NES so targeting is very difficult; off-street sites are now moving towards mobile/ad-hoc venues such as AirBNB rentals rather than fixed venues, such as traditional parlours/massage venues.
- Source data which identify women and men through contact sites and sex work apps is highly inconsistent and likely to be an underestimate of total numbers; additionally there is a wider

[48] Royal College of Psychiatrists (2011), *Our invisible addicts*, CR165, available from: https://www.nationalelfservice.net/cms/wp-content/uploads/2011/06/CR165-Our-Invisible-Addicts.pdf

[49] Royal College of Psychiatrists (2018), *Our Invisible Addicts (2nd edition)*, CR211, available from: https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2018-college-reports/our-invisible-addicts-2nd-edition-cr211-mar-2018?searchTerms=our%20invisible%20addicts

[50] Carew, A. and Comiskey, C. (2018), Treatment for opioid use and outcomes in older adults: a systematic literature review, *Drug and Alcohol Dependence*, Vol. 182, 1 January, pp.48-57, available from: https://doi.org/10.1016/j.drugalcdep.2017.10.007

[51] Jeal, N. and Salisbury, C. (2004), A Health needs assessment of street-based prostitutes: cross-sectional survey, *Journal of Public Health*, **26**:147-51, available from: https://academic.oup.com/jpubhealth/article/26/2/147/1572801

trend of sex work being advertised and arranged through Facebook and Twitter which makes it is hard to identify total numbers. CSWs may also have multiple listings across different platforms.

- Women and men who list B&NES as their residence or place of work may be working and living across numerous locations including areas outside of B&NES.
- There is evidence that some women and men, especially younger women, may move in and out of CSW in a transitory way depending on their personal, health and financial circumstances.
- There will be 'unofficial' CSW where vulnerable women and men may utilise CSW as a method of bartering to access other items, for example, substances, housing or personal protection.

The Riverside Clinic estimates attendances of 12 women and 3 men per year who identified as CSWs. A review of Adultwork and PunterNet, two of the main contact sites, in February 2019 indicated 23 profiles of women who either indicated they provided CSW, or were based in B&NES; there were 9 profiles of men who either indicated they provided CSW or were based in B&NES.[52]

2.8.7 Offenders

The prisoner population is characterised by a high burden of disease and social disadvantage, and ex-prisoners are at increased risk of death following release. Much of the excess mortality can be attributed to an increased risk of unnatural death, particularly from drug overdose. Research has shown that there is an increased risk of drug-related death during the first 2 weeks after release from prison and that the risk remains elevated up to at least the fourth week.[53]

2.9 Children and Young People

Although the scope of this report is adults in drug and alcohol treatment, clearly children and young people who are using substances are at risk of becoming the next adult treatment cohort. There is a growing body of evidence that is revealing the long-term impacts that experiences and events during childhood have on individuals' life chances. Adverse Childhood Experiences (ACEs) such as abuse, neglect and dysfunctional home environments have been shown to be associated with the development of a wide range of harmful behaviours including smoking, harmful alcohol use, drug use, risky sexual behaviour, violence and crime.[54] They are also linked to diseases such as diabetes, mental illness, cancer and cardiovascular disease, and ultimately to premature mortality.[55] For adults affected by Adverse Childhood Experiences (ACEs), which includes substance misuse, reducing ACEs in future generations could, among other benefits, reduce levels of heroin/crack cocaine (lifetime) use by 66%, incarceration (lifetime) by 65%, cannabis (lifetime) use by 42%, high risk (current) drinking by 35% and smoking tobacco or e-cigarette (current) use by 24% (Figure 7).

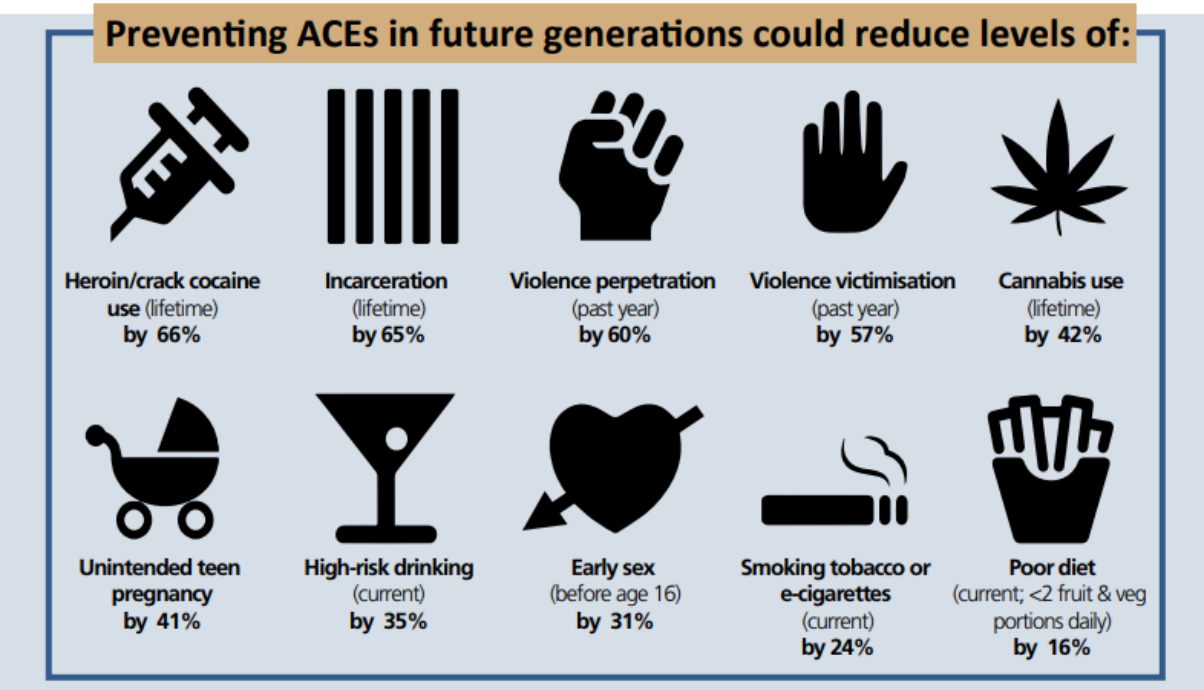
[52] B&NES (2019), *Sexual Health Needs Assessment*, unpublished (at the time of preparing this document).

[53] Merrall, E., et. al. (2010), Meta-analysis of drug-related deaths soon after release from prison, *Addiction*, **105**(9):545–1554, available from: https://www.ncbi.nlm.nih.gov/pubmed/20579009

[54] Public Health Wales (2018), *Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population*, available from: http://www.wales.nhs.uk/sitesplus/888/page/88504

[55] Hughes, K., et. al. (2017), The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis, *Lancet Public Health*, **2**:8, pp.356-366, available from: https://doi.org/10.1016/S2468-2667(17)30118-4

Figure 7: Impacts of Reducing Adverse Childhood Experiences (ACE)



Source: Public Health Wales (2018), *Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population*, available from: http://www.wales.nhs.uk/sitesplus/888/page/88504

B&NES' Children and Young People's substance misuse needs assessment was published in 2015.[56] Project 28, the local treatment provider, were treating 149 children and young people aged under 18 at the end of 2017/18.[57] However, there are concerns from Project 28 that there is a growing number of younger people coming into treatment, and also the now more prominent issue of what has become known as 'County lines'.[58] County lines is the police term for urban gangs supplying drugs to suburban areas and market and coastal towns. This is a major safeguarding issue. It involves child criminal exploitation (CCE) as gangs use children and vulnerable people to move drugs and money. Children affected by County lines may present with multi-faceted presentations involving drugs, violence, gangs, safeguarding, criminal and sexual exploitation, modern slavery, and going missing.

2.10 Other High Substance Misusing Adult Groups

2.10.1 Introduction

Although not identified in the national strategy as high priority cohorts, there are nevertheless several local population cohorts that have greater prevalence of substance misuse. For example, B&NES has a high proportion of university students, a substantial proportion of whom are likely to be using and misusing substances. Other groups, for example certain BAME groups and LGB minorities, experience greater health inequalities, while at the same time have greater prevalence of substance misuse.

[56] B&NES (2015a), *Children and Young People's Substance Misuse Needs Assessment*, available from: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/substance-misuse

[57] PHE(2018m), *Young people - substance misuse commissioning support pack 2019-20: key data*, B&NES, unpublished as restricted statistics.

[58] Project 28 (2019), *Report for the PDG*, 25th February 2019.

2.10.2 Students

There have been several research reports that indicate a relatively high proportion of the university student population in the UK are currently using illicit drugs, perhaps even becoming normalised behaviour.[59,60]

B&NES has a higher number and proportion of people aged between 20 and 24, highlighting the areas notable student population (Figure 6). Between 2001 and 2017, the growth in the 20-24 age range accounted for nearly 50% of the area's population growth.

2.10.3 Black and Minority Ethnic (BAME)

Differential drug use exists between ethnic groups,[61] thus likely leading to inequalities in rates of harm.

B&NES is less ethnically diverse than the UK as a whole, 90% of local residents define their ethnicity as White British. This is followed by 3.8% defining as White Other and 1.1 % defining as Chinese.

2.10.4 Lesbian, Gay or Bisexual (LGB)

Various reports have been published that highlighted a key health inequality for many sexual minority groups was a greater prevalence of alcohol, drugs and tobacco use.[62,63] Section 6.8 highlights the issue of sexualised drug use (SDU)/'Chemsex', believed to be particularly prevalent among certain sexual minority cohorts.

Over the last five years the proportion of the UK population identifying as lesbian, gay or bisexual (LGB) has increased from 1.5% in 2012 to 2.0% in 2017, although the latest figure is unchanged from 2016.[64] In 2017 PHE published their modelled estimate of 2.5% of the population who self-identifying as LGB (including other, but not transgender or intersex people), as aggregated from 22 key surveys.[65] Applying the higher modelled 2.5% as a 'synthetic' estimate to the local population of B&NES provides a local aged 16 and over estimate of LGB of approximately 3,900.

[59] NUS (2018), *Taking the hit: student drug use and how institutions respond*, available from: https://www.nusconnect.org.uk/resources/taking-the-hit-student-drug-use-and-how-institutions-respond

[60] HEPI (2018), *Most students think taking illegal drugs causes problems for users as well as society and want their universities to take a tougher stance*, available from: https://www.hepi.ac.uk/2018/06/12/students-think-taking-illegal-drugs-causes-problems-users-well-society-want-universities-take-tougher-stance/

[61] NHS Digital (2018a), *Ethnicity facts and figures: illicit drug use among adults*, available from: https://www.ethnicity-facts-figures.service.gov.uk/health/physical-and-mental-health/illicit-drug-use-among-adults/latest

[62] Government Equalities Office (2018), *LGBT Action Plan 2018: Improving the lives of Lesbian, Gay, Bisexual and Transgender people*, available from: https://www.gov.uk/government/publications/lgbt-action-plan-2018-improving-the-lives-of-lesbian-gay-bisexual-and-transgender-people

[63] PHE (2014), *Promoting the health and wellbeing of gay, bisexual and other men who have sex with men*, available from: https://www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-gay-bisexual-and-other-men-who-have-sex-with-men

[64] ONS (2019), *Sexual orientation, UK: 2017*, available from: https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2017

[65] PHE (2017b), *Producing estimates of the size of the LGB population of England*, available from: https://www.gov.uk/government/publications/producing-estimates-of-the-size-of-the-lgb-population-of-england

2.11 Deprivation

B&NES is one of the least deprived authorities in the country, ranking 247 out of 326 English authorities (where 1 is most deprived) in the 2015 English Indices of Deprivation.[66] At a small area level there are differences in deprivation within B&NES, thus highlighting areas with a higher concentration of households living in poverty. As a consequence, these households are more likely to experience a lack of basic necessities and poorer outcomes, for example, lower household incomes and poor health.

Persistent and systematic multiple deprivation is more important than economic poverty or disadvantage experienced for short periods of time in determining health outcomes.[67]

The relationships between deprivation and drug misuse have been highlighted in a number of research studies. Social factors, including housing, employment and deprivation, are associated with substance misuse and these social factors moderate drug treatment outcomes.[68]

Factors that can increase the likelihood of opiate users successfully completing treatment include:

- being in education or employment;
- being in good physical health; and
- not drinking alcohol everyday.[69]

Factors that can decrease the likelihood of opiate users successfully completing treatment include:

- using opiates everyday on top of any prescription medication;
- having housing problems;
- living in an area of higher deprivation; and
- previously dropping out of treatment.[70]

Research has shown that people in deprived communities have higher levels of alcohol-related ill health than people in non-deprived communities, despite drinking the same amounts of alcohol - *the alcohol harm paradox*.[71] However, there appears to be a lack of evidence as to precisely what mechanisms and pathways might underlie this difference in risk.[72]

2.12 Police Recorded Drug Offences and Drug Seizures

Drug-related and drug-enabled activities are key drivers of both new and traditional crime, for example, the possession of illicit substances, crimes committed to fund drug dependence and violent crimes associated with drug trafficking. Drugs can also play a part in facilitating child sexual

[66] Ministry of Housing, Communities and Local Government (2015), *English Indices of Deprivation 2015*, available from: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

[67] PHE (2017a), *op. cit.*

[68] *Ibid.*

[69] *Ibid.*

[70] *Ibid.*

[71] Bellis, M., Hughes, K., Nicholls, J., Sheron, N., Gilmore, I. and Jones, L. (2016), The alcohol harm paradox: using a national survey to explore how alcohol may disproportionately impact health in deprived individuals, *BMC Public Health*, **16**:111, available from: https://doi.org/10.1186/s12889-016-2766-x

[72] Alcohol Change (2015), *Understanding the alcohol harm paradox*, available from: https://alcoholchange.org.uk/publication/understanding-the-alcohol-harm-paradox

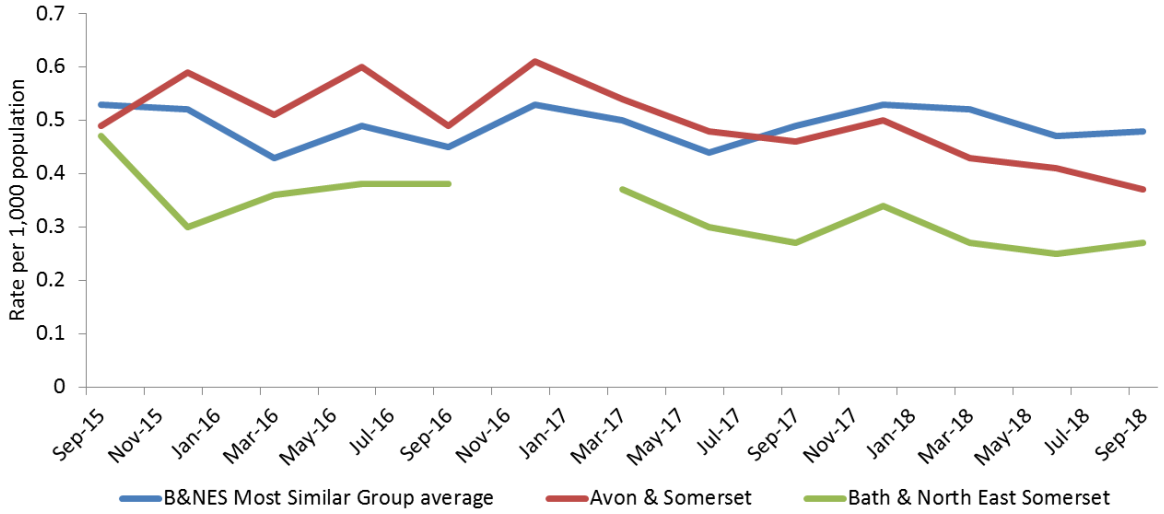
exploitation and abuse. Furthermore, alcohol misuse plays a significant part in violent crimes, including domestic abuse.

We know that people who misuse drugs and alcohol are more likely to have been involved in crime, but treatment can also help to prevent it (2.8.7).

Since the peak in 2008/09, the number of drug offences recorded by the police in England & Wales has decreased by 44% (from 243,536 to 136,355), and the number of drug seizures by police forces has decreased by 45% (from 233,793 to 129,183).[73]

There has been a falling trend in the rates of recorded drug offences (trafficking and possession) in B&NES and in the Avon & Somerset force area (Figure 8). The drug offence rate for B&NES has been consistently lower compared to the force and most similar group averages (Figure 8).

Figure 8: Police Recorded Drug Offence Rate, June 2015-June 2018 (quarterly), B&NES compared to Avon & Somerset Police Force Area and Most Similar Group Average



Source: www.police.uk

Notes: (1) the most similar group consists of 15 local authority areas, including South Gloucestershire, Bracknell Forest, Charnwood, Canterbury, Epping Forest, Rugby, Maidstone, Chelmsford, Colchester, Hertsmere, York, Cheshire West, Dacoram and Welyn & Hatfield; (2) drug offences recorded by the police include offences involving trafficking of drugs and possession of drugs. (3) there is an error in the November 2016 quarterly figure for B&NES, so this has been removed.

During 2018, the B&NES district within the Avon & Somerset constabulary arrested 828 individuals in relation to drug offences, a slight increase compared to the previous year (Table 1). Of the 828 individuals arrested for drug offences during 2018: 549 were charged, 113 were cautioned, 136 received a warning and 30 were 'no further actioned' (Table1). Between 2017 and 2018 there has been an increase in the number charged and cautioned of 12% and 13% respectively, but a 30% fall in the number of warnings issued (Table 1).

[73] Home Office (2018c), *Seizures of drugs in England and Wales, financial year ending 2018*, available from: https://www.gov.uk/government/statistics/seizures-of-drugs-in-england-and-wales-financial-year-ending-2018

Table 1: Drug Offence Arrest Summary, B&NES, 2017 and 2018

Drug Offence Arrest Summary	2017	2018	Percentage difference (between 2017 and 2018)
Individuals arrested	**808**	**828**	**+2%**
(i) charged	490	549	+12%
(ii) cautioned	100	113	+13%
(iii) warnings	198	136	-31%
(iv) 'no further actioned'	20	30	+50%

Source: Force Drug Expert Lead, Drug Expert Action Team, Avon & Somerset Police.

The Arrest Intervention Referral Service (AIRS), which is commissioned by the Avon & Somerset Police and Crime Commissioner, assesses the needs of clients following arrest and are based in custody suites across Avon & Somerset Constabulary. All detainees have the option to speak to an AIRS worker in relation to their drug use. This intervention can vary from basic advice about drug use to signposting or assistance in obtaining other programs (detox, etc.). This also enables staff to consider other options, as opposed to entering the Criminal Justice System, for example, conditional caution to attend drug intervention or entry onto the Drug Education Programme. If detainees are charged, then a report can give the Magistrate guidance on a suitable disposal, for example, Drug Rehabilitation Requirements. The AIRS staff in Avon & Somerset also identify other issues, for example, trafficking, mental health & abuse and are able to signpost detainees of provide them with help whilst in custody. Referral numbers from AIRS into the local treatment service is included in section 5.3.1.

3.0 Prevalence, Local Treatment Population and Unmet Need

3.1 Introduction

This chapter assesses the various national and local measures of prevalence of drug use and drug misuse. The scale of the issue of drug use is highlighted by European statistics, indicating that the UK is among the highest reported in Western Europe.[74]

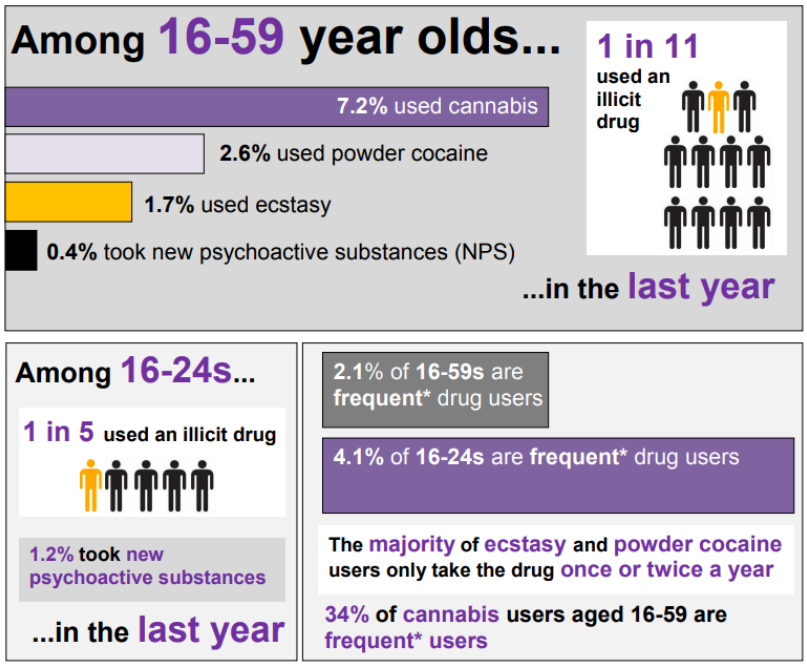
This chapter uses these estimates of prevalence to compare with the numbers known to be in treatment services, thus estimating unmet need, i.e. the size of various cohorts who it is believed would benefit from being in treatment, but who currently are not.

3.2 National Prevalence

3.2.1 Crime Survey for England & Wales (CSEW)

The 2017/18 Crime Survey for England & Wales (CSEW) found that, while not statistically significant from year to year, there is an upward trend apparent in the use of Class A drugs, particularly among 16 to 24 year olds. Although there was no significant change from the 2016/17 estimate for this age group, there was an increase from the 2011/12 survey estimate (6.2% to 8.4%). This was mainly driven by an increase in powder cocaine and ecstasy use.[75]

Figure 9: Crime Survey for England & Wales (CSEW) Infographic



Source: Home Office (2018a), *Drug misuse: findings from the 2017 to 2018 CSEW*, available from: https://www.gov.uk/government/statistics/drug-misuse-findings-from-the-2017-to-2018-csew

[74] EMCDDA (2018), *United Kingdom - Country Drug Report 2018*, available from: http://www.emcdda.europa.eu/publications/country-drug-reports/2018/united-kingdom_en

[75] Home Office (2018a), *Drug misuse: findings from the 2017 to 2018 CSEW*, available from: https://www.gov.uk/government/statistics/drug-misuse-findings-from-the-2017-to-2018-csew

Figure 9 illustrates that one in eleven 16-59 year olds and one in five 16-24 year olds used an illicit drug. Cannabis was the most common illicit drug taken among 16-59 year olds (7.2%), followed by powder cocaine (2.6%), ecstasy (1.7%) and NPS (0.4%).

Key findings around frequent drug use were as follows (frequent drug use being defined as taking an illicit drug more than once a month in the last year):[76]

- 2.1% of all adults aged 16 to 59 were classed as frequent drug users. This was similar to the previous year.
- As with drug use in general, young adults (16 to 24 year olds) were more likely to be frequent drug users than the wider age group (16 to 59 year olds). The proportion of young adults who were classed as frequent drug users was 4.1%. This was similar to the previous year.
- As in previous years, of the three drugs with specific questions on frequency of use, cannabis was the most likely to be frequently used, with 34% of cannabis users aged 16 to 59 years old classed as frequent users.
- There has been a long-term decrease in the frequent use of powder cocaine: for example, the proportion of frequent drug users of powder cocaine fell from 21.8% in the 2007/08 survey to 12.8% in 2017/18. Frequent use of both powder cocaine and ecstasy has not changed significantly compared with the 2016/17 survey.
- The majority of ecstasy and powder cocaine users reported having taken the drug only once or twice a year rather than frequently (68% for ecstasy and 54% for powder cocaine users).

3.2.2 Review of the Psychoactive Substances Act (PSA) 2016

In November 2018 the Home Office published their 30 month review of the PSA.[77] This found that there was a considerable reduction in NPS use among the general adult population since the PSA, mainly driven by a reduction in use among those aged 16 to 24 who already use 'traditional' drugs. Overall, there is insufficient evidence to identify whether there has been any displacement from NPS use to other drugs in the general adult population.

The prevalence of NPS among vulnerable users appears to be more mixed, with qualitative evidence suggesting a significant fall in NPS use in some areas, and other areas remain unaffected by the Act. There is a range of qualitative evidence suggesting that there has been some displacement from NPS to 'traditional' drugs for vulnerable users, although there is a lack of quantitative data on the magnitude of this displacement.

3.2.3 Opioid and Crack Cocaine Users (OCU)

In August 2018 PHE published their latest modelled population prevalence estimates report for opioid and crack cocaine users (OCU) for local authority areas across England, based on data relating to the financial year 1st April 2014 to 31st March 2015.[78] This report also refers to the prevalence estimates of previous periods, for 2013/14, 2012/13 and 2011/12.

[76] *Ibid.*

[77] Home Office (2018b), *Review of the Psychoactive Substances Act 2016*, available from: https://www.gov.uk/government/publications/review-of-the-psychoactive-substances-act-2016

[78] PHE (2018b), *Opiate and crack cocaine use: prevalence estimates by local area*, available from: https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates-for-local-populations

During 2014/15 in England there were around 300,000 opioid and crack cocaine users, made up of some 257,500 opioid users and 183,000 crack cocaine users.

3.2.4 Parental Substance Misuse

The Advisory Council on the Misuse of Drugs (ACMD) *'Hidden Harm'* report in 2003 estimated that there were between 250,000 and 300,000 children with at least one parent who had a serious drug problem – representing 2-3 percent of children under 16 nationally.[79]

More recent modelling that was undertaken by Liverpool John Moores University (LJMU)[80] estimated that during 2014/15 in England there were 48,000 children living with a female opiate user and some 93,000 children living with a male opiate user (it was not possible to combine the number of children who live with a female opiate user and the number who live with a male opiate user to give an overall total estimate of the number who live with at least one opiate user).

Research undertaken by the University of Sheffield and King's College London estimated there to be 120,419 adults with alcohol dependence living with children in 2014/15.[81] They also estimated there to be between 189,119 and 207,617 children living with at least one adult with alcohol dependence in the household, and between 14,390 and 32,888 children living with two adults with alcohol dependence.

3.3 Local Prevalence

3.3.1 Opioid and Crack Cocaine Users (OCU)

During 2014/15 it is estimated there were 1,007 OCUs in B&NES, with the most likely number to lie between 809 and 1,608. This is equivalent to a rate of 8.46 [*6.79-13.50*] per 1,000 people aged 15-64 (Table 2). B&NES had significantly higher numbers (and rates) of OCUs and opiate users compared to crack users in 2014-15 (Table 2).

Table 2: Estimated numbers and rates of Opiate and/or Crack Users (OCU), 2014/15

	Number of users								
	OCU	Lower bound 95% CI	Upper bound 95% CI	Opiate users	Lower bound 95% CI	Upper bound 95% CI	Crack users	Lower bound 95% CI	Upper bound 95% CI
Bath and North East Somerset	1,007	809	1,608	984	782	1,599	449	322	750
South West	26,622	25,586	29,474	23,545	22,834	25,830	15,380	13,116	17,255
England	300,783	297,986	311,128	257,476	255,440	266,643	182,828	176,675	190,782

	Rate per thousand of the population									
	OCU	Lower bound 95% CI	Upper bound 95% CI	Opiate users	Lower bound 95% CI	Upper bound 95% CI	Crack users	Lower bound 95% CI	Upper bound 95% CI	15-64 population
Bath and North East Somerset	8.46	6.79	13.50	8.26	6.57	13.43	3.77	2.70	6.30	119,089
South West	7.86	7.55	8.70	6.95	6.74	7.62	4.54	3.87	5.09	3,389,047
England	8.57	8.49	8.86	7.33	7.28	7.60	5.21	5.03	5.43	35,102,533

Source: PHE (2018b), *Opiate and crack cocaine use: prevalence estimates by local area*, available from: https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates-for-local-populations

[79] ACMD (2011), *'Hidden harm' report on children of drug users*, available from: https://www.gov.uk/government/publications/amcd-inquiry-hidden-harm-report-on-children-of-drug-users

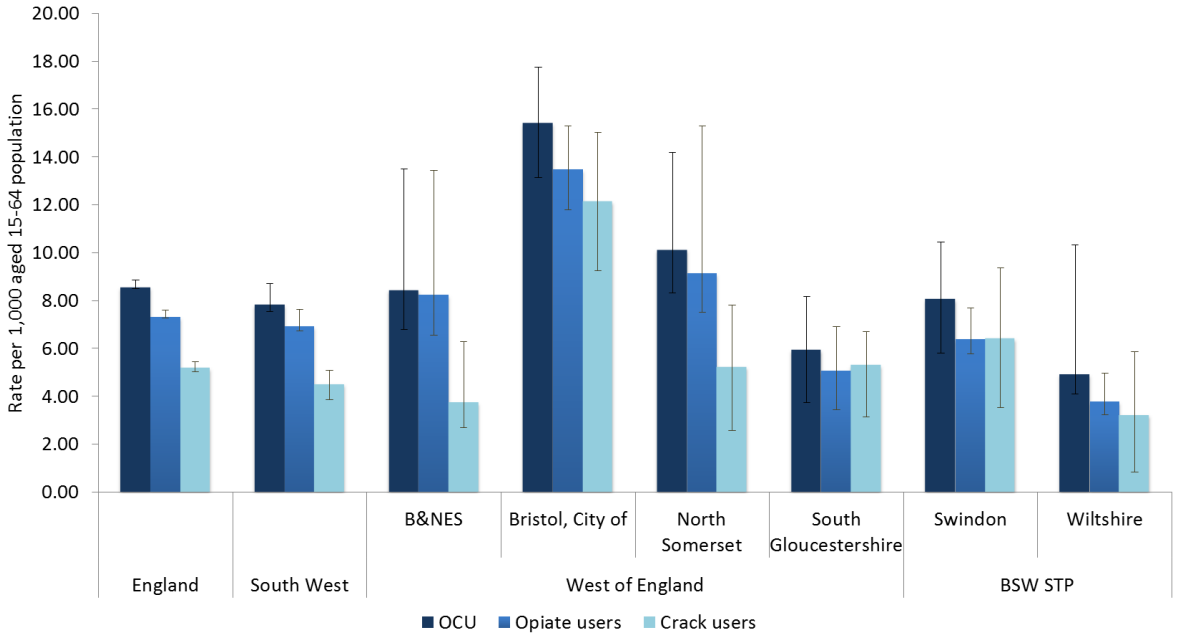
[80] LJMU (2018), Estimates of the number of children who live with opiate users, England 2014/15, available from: http://allcatsrgrey.org.uk/wp/download/public_health/substance_misuse/parental-report-March-2018-VH.pdf?platform=hootsuite

[81] Pryce, R., *et. al.* (2017), *Estimates of Alcohol Dependence in England based on APMS 2014, including Estimates of Children Living in a Household with an Adult with Alcohol Dependence: Prevalence, Trends, and Amenability to Treatment*, available from: https://www.sheffield.ac.uk/polopoly_fs/1.693546!/file/Estimates_of_Alcohol_Dependence_in_England_based_on_APMS_2014.pdf

Notes: 'OCU' refers to use of opiates and/or crack cocaine. **It does not include the use of cocaine in a powder form, amphetamine, ecstasy or cannabis.** Although many opiate and/or crack users also use these drugs it is very difficult to identify exclusive users of these drugs from the available data sources. It must be stressed that these figures are estimates. They should always be interpreted in conjunction with their associated confidence intervals, which are specified in each table. The confidence intervals show the range within which there is a 95% certainty that the true value exists, though it is most likely to lie near the estimate itself. Where significant changes have been marked, this should be interpreted as indicative of some possible change rather than as evidence of a definite change. For the same reasons caution should be used when making inferences from comparisons between areas. The estimates are designed to be used in conjunction with local knowledge as a guide to service planning. All prevalence rates stated show the number of OCUs in that local authority area per thousand people in the population. It is advisable to look at the prevalence rate as well as the actual numbers, because any significant changes in the number of OCUs may simply reflect fluctuations in the general population for that area.

As seen in Table 2 and Figure 10, during 2014/15 B&NES had statistically similar (i.e. overlapping confidence intervals) estimated rates of OCU, opiate users and crack users compared to comparable rates in the South West and England. Of the four local authority areas in the West of England, the only statistically significant difference during 2014/15 was that B&NES had a significantly lower rate of crack users compared to Bristol - 3.77 [*2.70-6.30*] and 12.15 [*9.25-15.02*] per 1,000 people aged 15-64 respectively (Figure 10). Of the three local authority areas in the BSW STP during 2014/15, the only statistically significant difference was that B&NES had a significantly higher rate of opiate users compared to Wiltshire - 8.26 [*6.57-13.43*] and 3.80 [*3.23-4.96*] per 1,000 people aged 15-64 respectively (Figure 10).

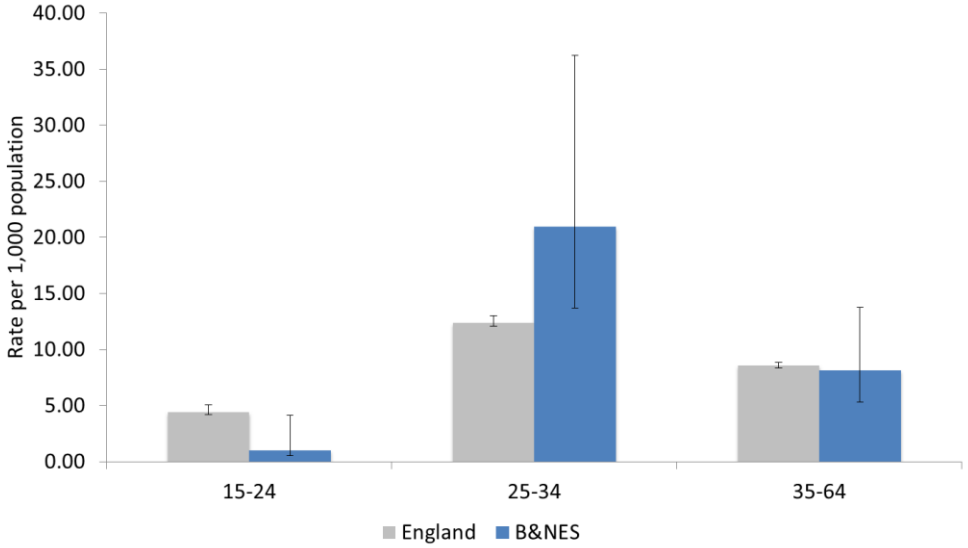
Figure 10: Rates of Opiate and/or Crack Users per 1,000 aged 15-64 population, National, Regional, West of England and BSW STP, 2014/15



Source: PHE (2018b), *Opiate and crack cocaine use: prevalence estimates by local area*, available from: https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates-for-local-populations
Notes: see notes for Table 2.

Figure 11 illustrates that during 2014/15 B&NES had a significantly higher rate of 25-34 year olds who were estimated to be OCUs compared to national - 20.93 [*13.68-36.24*] and 12.36 [*12.07-12.98*] per 1,000 people aged 25-34 respectively.

Figure 11: Rates of Opiate and Crack Users (OCUs) per 1,000 population, Age Groups, 2014/15



Source: PHE (2018b), *Opiate and crack cocaine use: prevalence estimates by local area*, available from: https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates-for-local-populations
Notes: see notes for Table 2. It should be noted that due to B&NES's relatively large HE student population the B&NES rate of OCUs for 15-24 year olds - 1.03 [0.56-4.11] per 1,000 population - will be higher when only the non-term time HE student population is used in the denominator of the calculation.

3.3.2 Alcohol Dependence Prevalence

The 2016/17 modelled estimate for B&NES is there are 1,732 adults aged 18 or over dependent on alcohol.[82] This equates to a rate of 1.14 [*0.90-1.50*] per 100 aged eighteen and over population in B&NES, which compares to 1.29 in the South West and 1.35 [*1.11-1.71*] in England (i.e. the estimated rate for B&NES is not significantly different to the comparable for England). Since 2010 the modelled estimates of adults over the age of 18 dependent on alcohol have not significantly changed.

It is believed that in B&NES there are some 180 to 190 people who are high impact 'blue light' service users, i.e. people with an alcohol dependency who have frequent contact with one or more services, for example A&E, GPS, probation, children's social care, etc.[83] Bath & North East Somerset Council's (B&NES) Drug and Alcohol Commissioning Team (DAAT), Public Health and the local treatment provider worked in partnership to deliver training to encourage colleagues to adopt alternative approaches and care pathways for treatment resistant drinkers who place a significant burden on public services. This programme of training aligned with the key messages and information from Alcohol Concern's national Blue Light project, which works to challenge the myth that people with alcohol problems can only be helped to change if they want to change. The initiative developed out of a long-known concern that people with entrenched alcohol problems cause a lot of damage to themselves and others.

[82] PHE (2018c), *Alcohol dependence prevalence in England*, available from: https://www.gov.uk/government/publications/alcohol-dependence-prevalence-in-england

[83] B&NES (2014b), *Improving the response to treatment resistant problem drinkers who place an excessive burden on public services: A draft outline strategy for Bath & North East Somerset*, unpublished.

3.3.3 PHE Local Alcohol Consumption Survey

During early 2016 IPSOS Mori surveyed a sample of adults in 25 local authorities across England, including B&NES.[84] The results appear to indicate that frequent alcohol consumption in B&NES, four or more times a week, is higher than the overall LA sample group - 18% and 12% respectively. Furthermore, the proportion of adults in B&NES who were drinking alcohol who drank ten or more units of alcohol in a typical day was also higher than the overall LA sample group - 8% and 6% respectively.

3.3.4 Voicebox Survey (alcohol only)

Nearly 4,000 randomly selected B&NES households were sent a questionnaire late 2018 and 1,207 residents took part with a response rate of 32%.[85] In relation to alcohol, people were asked how often they drank 6 units or more (female) and 8 units or more (male) of alcohol on one occasion.

- 36% of men and 22% of women said they drink 8/6 units or more on a single occasion respectively monthly or more often.

3.3.5 Parental Substance Misuse

The LJMU modelled estimates for 2014/15 suggests that there were 305 adults with an opiate dependency, living with 543 children in B&NES.[86] Furthermore, The University of Sheffield and King's College modelled estimates for 2014/15 suggests that there were 351 adults with an alcohol dependency, living with 621 children in B&NES.[87] As it is not possible to determine the number of parents who have both an opiate and alcohol dependency from these modelled estimates, so the total number of substance misusing parents cannot be arrived at by adding these two sets of figures.

During 2017 a project run by B&NES Council to develop a better understanding of the support and safeguarding being provided to B&NES families with children where at least one parent/carer is experiencing one or more of mental health, domestic abuse and substance misuse; with particular focus on those that are experiencing all three (otherwise known as toxic- or complex-trio).[88] The aim was to identify the strengths and weaknesses within the system to help develop more effective, coordinated and targeted support and interventions. From the 22 services that provided suitable data, there are 1,110 parent/carers identified with one or more toxic-/complex-trio needs. Figure 12 illustrates that 366 parents were identified to have a substance misuse need, a third of parents identified. Due to methodological differences and gaps in services unable to provide data it is not possible to compare this figure against the previous modelled prevalence estimates. Hower, due to gaps in data it is almost certain that the true figure of the number of parents in B&NES with a substance misuse issue will be higher than 366.

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[84] PHE (2017c), *Alcohol consumption survey results: Bath and North East Somerset*, unpublished.

[85] Marketing Means (2019), *Bath & North East Somerset: Voicebox 27*, Section 8:Alcohol, Headline version 1 draft report, unpublished.

[86] PHE (2018d), *Parental alcohol and drug use: understanding the problem: a toolkit for local authorities*, available from: https://www.gov.uk/government/publications/parental-alcohol-and-drug-use-understanding-the-problem

[87] *Ibid.*

[88] B&NES (2017b), *Toxic/Complex Trio and Parental Needs*, B&NES JSNA, available from: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/parental-needs-and-capacity

Figure 12: Number of Parents Known to Services to Experience a Mental Health, Domestic Abuse or Substance Misuse Issue, B&NES, 2017

Source: B&NES (2017b), *Toxic/Complex Trio and Parental Needs*, B&NES JSNA, available from: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/parental-needs-and-capacity

3.4 Numbers in Drug and Alcohol Treatment

3.4.1 All Adults

There were a total of 268,390 individuals aged 18 to 99 in contact with structured drug and alcohol treatment services in England in 2017/18.[89]

Figure 13 illustrates there were 984 adults in contact with B&NES's drug and alcohol treatment services at the end of 2017/18, which is broadly the same as in 2016/17 (978), but 240 fewer than the recent peak four years previously (1,224 in 2013/14). This represents a drop of 20% in the number of adults in contact with the local drug and alcohol treatment services between 2013/14 and 2017/18.[90] This is almost twice the proportionate drop witnessed nationally, which is down 11% over the same period.[91]

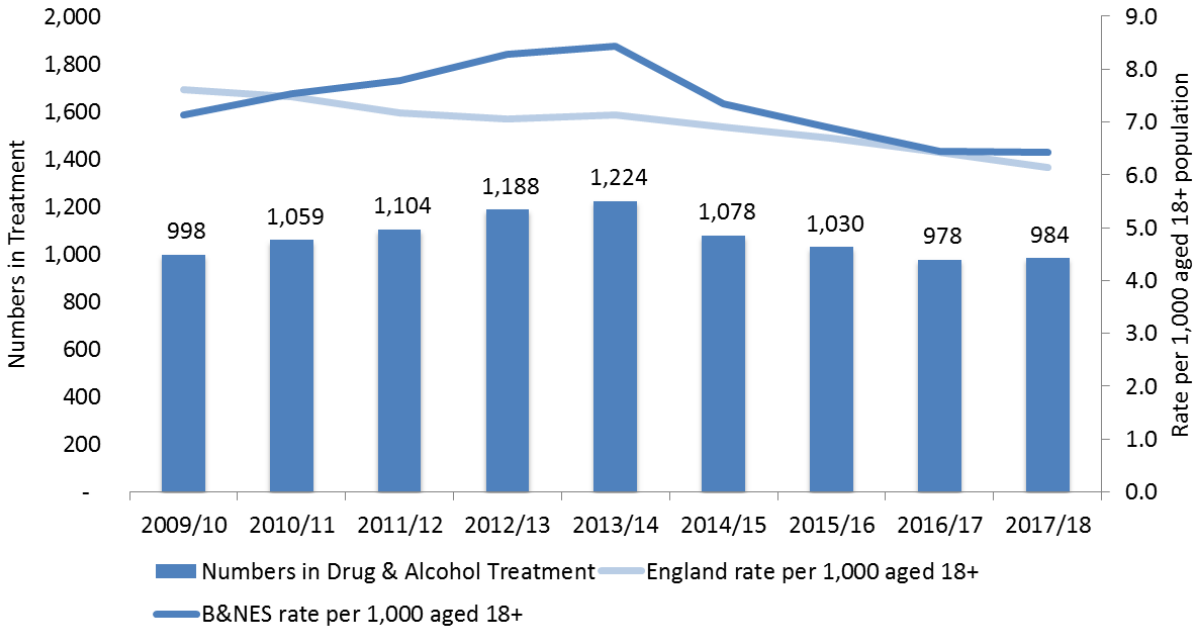
The rate of adults in drug and alcohol treatment services in B&NES at the end of 2017/18 is similar to national - 6.4 and 6.1 per 1,000 aged 18 and over respectively (Figure 13). This follows a period when the local rate of adults in treatment services was rising much faster than national, i.e. during the period 2011/12 to 2013/14 (Figure 13).

[89] PHE (2018e), *Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS): 1 April 2017 to 31 March 2018*, available from: https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2017-to-2018

[90] *Ibid.*

[91] PHE (2018e), *Op. Cit.*

Figure 13: Numbers and Rates in Drug & Alcohol Treatment Services, B&NES, 2009/10 to 2017/18



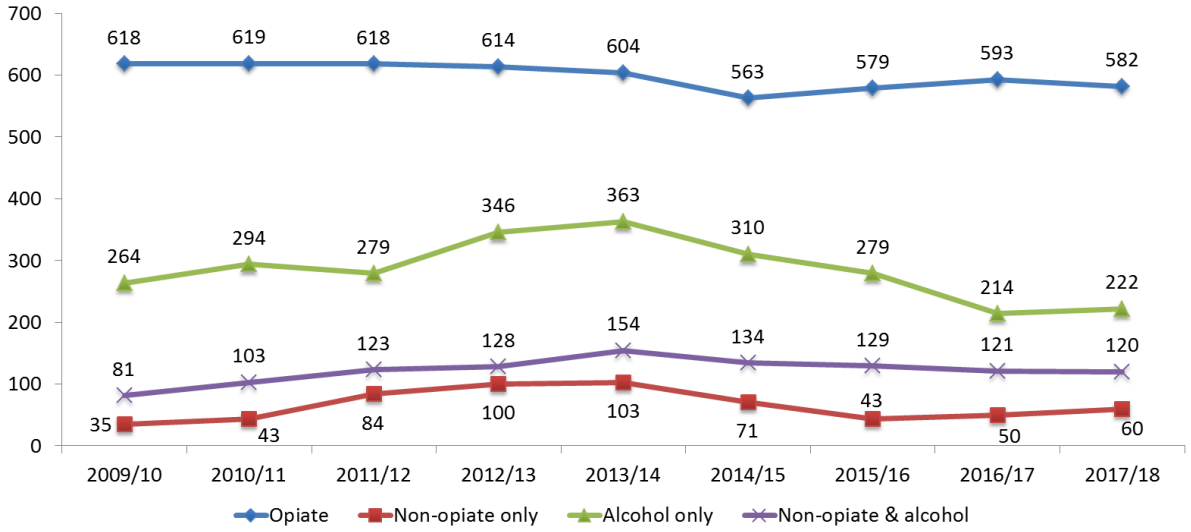
Source: Local analysis from National Drug Treatment Monitoring System (NDTMS) [ViewIt].
Note: all figures as at end of financial year, i.e. 31st March.

At the end of 2017/18 the majority of adults (59%) in receipt of treatment for drugs and alcohol misuse were in receipt of services for their misuse of opiates (Figure 14). At the end of 2017/18 there were 762 adults in treatment for drug misuse - 582 for opiate misuse, 60 for non-opiate misuse, and 120 for non-opiate and alcohol misuse (Figure 14). There were an additional 222 alcohol only clients at the end of 2017/18.

While there has been a decline in the number of opiate clients in treatment from 618 in 2019/10 to to 582 in 2017/18 (a fall of 5.8%), Figure 16 also illustrates the much larger fall in the numbers of alcohol only clients in treatment - from a peak of 363 in 2013/14 to 222 in 2017/18 (a 39% fall). This drop-off in the numbers in treatment of alcohol only clients is much greater when compared to national, which witnessed a comparable fall of 17% over the same period. This issue is examined in greater detail in section 5.2.

There has also been a decline in non-opiate only and non-opiate and alcohol clients in treatment locally - from a peak of 257 in 2013/14 to 180 in 2017/18, a 30% fall in four years (Figure 14). This is a much larger fall than seen nationally, which over the same period was 6%.

Figure 14: Number of Adults in Drug & Alcohol Treatment by Substance Category, B&NES, 2009/10 to 2017/18



Source: Local analysis from National Drug Treatment Monitoring System (NDTMS) [ViewIt].
Note: all figures as at end of financial year, i.e. 31st March.

3.4.2 Parents Living with Children

Throughout the period 1st January to 31st December 2018 in B&NES there were 226 clients in drug and alcohol treatment who were living with children under the age of 18.[92]

During the period 1st January to 31st December 2018 55 parents who live with children entered drug and alcohol treatment in B&NES (Table 3). Across all substance categories the proportion of new presentation into treatment who live with children is below comparable figures nationally (Table 3).

Table 3: Parents Living with Children Entering Treatment by Substance Classification, Q3 2017/18, B&NES and England

Client Substance Classification	Bath and North East Somerset (B&NES)		England
	Number of parents entering treatment living with children	Proportion of new presentations into treatment who live with children under the age of 18	
Opiate	12	7.6	12.9
Non-opiate only	8	21.6	24.4
Alcohol only	23	16.1	24.0
Alcohol and non-opiate	12	17.6	21.5
Total entered treatment	**55**		

Source: NDTMS (2019), *Diagnostic Outcomes Monitoring Executive Summary (DOMES)*, 2.12, Q3 2018/19.

[92] NDTMS (2019), *Diagnostic Outcomes Monitoring Executive Summary (DOMES)*, 2.13, Q3 2018/19. Consisting of 142 opiate clients, 13 non-opiate clients, 22 alcohol and non-opiate clients and 49 alcohol only clients.

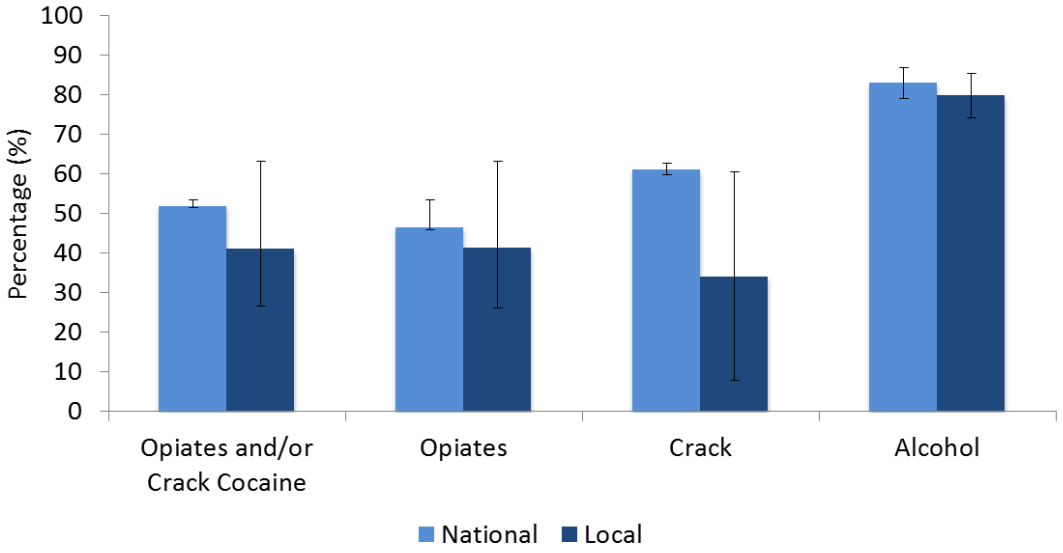
Note: Parents living with children under the age of 18 entering treatment during the period 1st January to 31st December 2018.

3.5 Unmet Need

3.5.1 Opioid and Crack Cocaine Users (OCU) and Alcohol Dependents

Estimates of unmet need are arrived at comparing the prevalence estimates of OCU (3.3.1) and numbers in treatment (3.4.1).

Figure 15: Estimates of Unmet Need of Drug & Alcohol Users, B&NES, Q3 2017/18



Source: NDTMS (2019), *Diagnostic Outcomes Monitoring Executive Summary (DOMES)*, 2.3, Q3 2018/19.
Notes:(1) Prevalence period is 1st April 2014 to 31st March 2015. (2) Estimated unmet need rate period is 1st January to 31st December 2018. (3) Alcohol unmet need rate calculated using alcohol only and alcohol and non-opiate substance groups.

At any one time the majority of problem drinkers are not engaged in services. Figure 17 illustrates that unmet need of alcohol users is high, both nationally and locally at around 80%.

Unmet need for opiate users in B&NES is slightly lower compared to national (41% and 52% respectively), but not significantly so (Figure 15). Unmet need for crack cocaine users is around half that in B&NES compared to national (34% and 61% respectively), but again not significantly so (Figure 15). This would appear to suggest that some 4 in 10 opiate users and 1 in 3 crack cocaine users in the local adult population are not currently in treatment, but would benefit being doing so (some 400 people in total using opiates and /or crack cocaine).

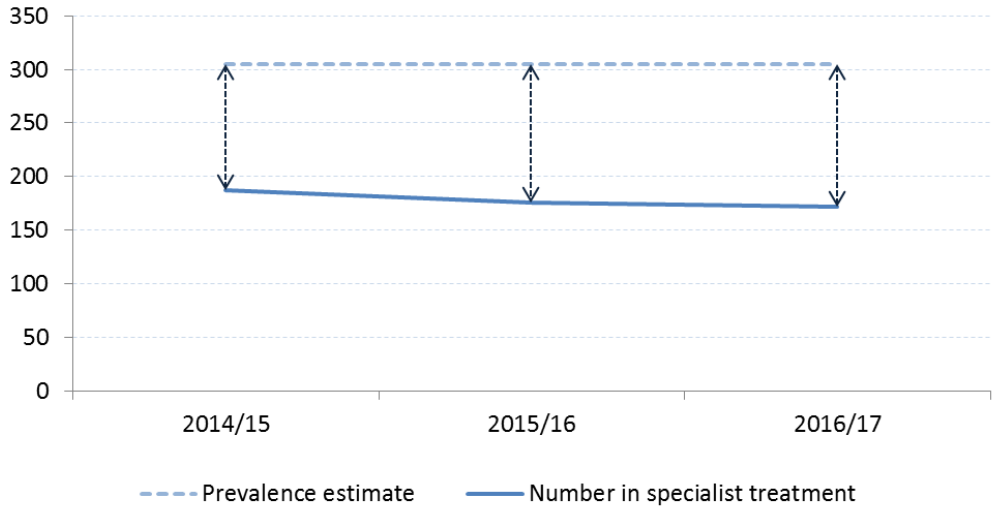
Furthermore, local figures would indicate that unmet need for opiate and/or crack users is much higher for males than females in B&NES - 48% and 6% respectively.[93]

3.5.2 Parents Living with Children

Figure 16 illustrates that there were an estimated 133 opiate dependent parents in B&NES in 2016/17 who would potentially benefit from being in treatment, but who were not in treatment.

[93] PHE(2018f), *Adults - drugs commissioning support pack 2019-20: key data: planning for drug prevention, treatment and recovery in adults*, B&NES, unpublished as restricted statistics.

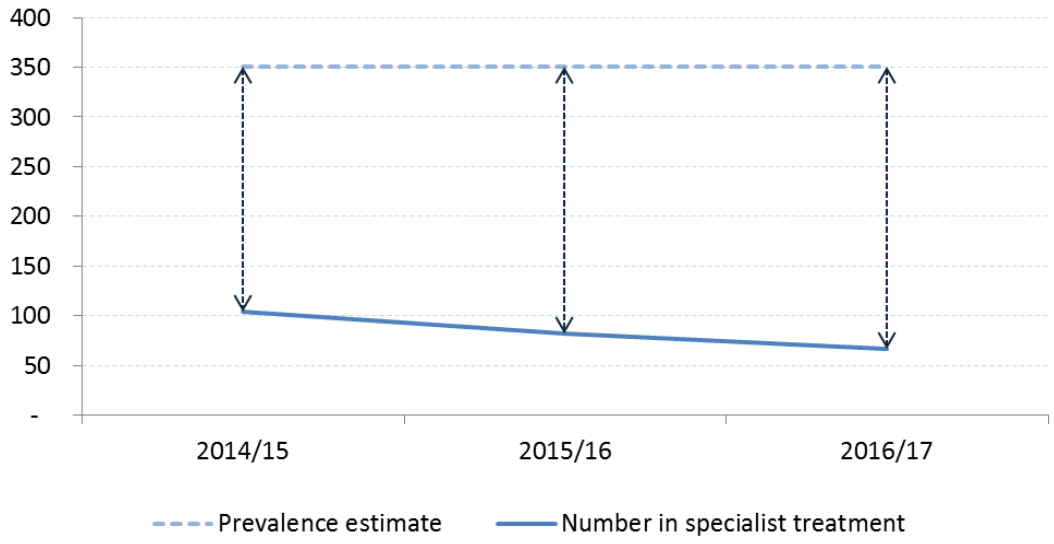
Figure 16: Annual Unmet Treatment Need Trends, Opiate Dependency, B&NES, 2014/15 to 2016/17



Source: PHE (2018d), *Parental alcohol and drug use: understanding the problem: a toolkit for local authorities*, available from: https://www.gov.uk/government/publications/parental-alcohol-and-drug-use-understanding-the-problem

Figure 17 illustrates that there were an estimated 284 alcohol dependent parents in B&NES in 2016/17 who would potentially benefit from being in treatment, but who were not in treatment.

Figure 17: Annual Unmet Treatment Need Trends, Alcohol Dependency, B&NES, 2014/15 to 2016/17



Source: PHE (2018d), *Parental alcohol and drug use: understanding the problem: a toolkit for local authorities*, available from: https://www.gov.uk/government/publications/parental-alcohol-and-drug-use-understanding-the-problem

4.0 Demographic Characteristics of those in Drug and Alcohol Treatment

4.1 Introduction

Understanding the demographic characteristics - age, gender, ethnicity and sexual orientation - of clients in treatment is crucial, especially as high priority cohorts (2.7) are more likely to experience poor health outcomes.

This chapter provides a breakdown of age and gender of the substance misuse in treatment cohort under the following three broad substance categories:

1. those in the substance misuse category of opiate (referred hereafter as the '*opiate drug treatment cohort*');
2. those in the substance misuse categories of non-opiate only and non-opiate & alcohol (referred hereafter as the '*non-opiate drug treatment cohort*'); and
3. those in the substance misuse category of alcohol only referred hereafter as the '*alcohol only treatment cohort*').

In addition, this chapter provides a summary of ethnicity and sexual orientation of the substance misuse in treatment cohort by the broader drug and alcohol substance categories.

Finally, while age and gender statistics are presented for the entire cohort in treatment during each financial year, ethnicity and sexual orientation are presented for the cohorts who have newly entered into treatment in each financial year.

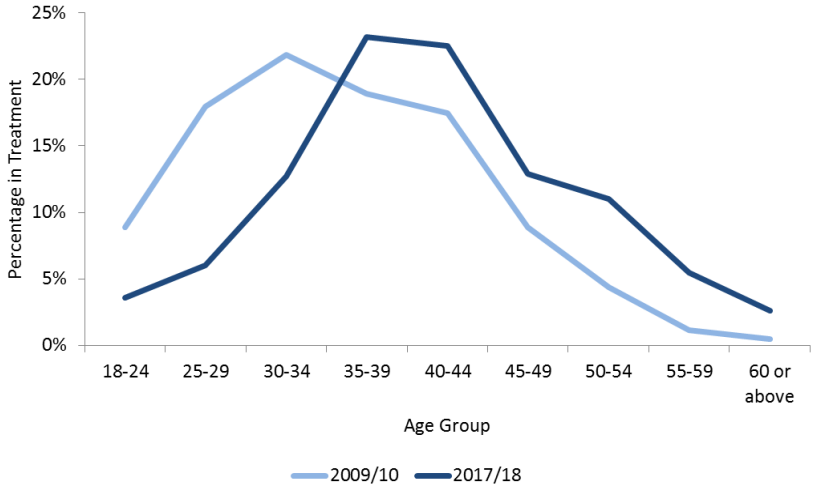
4.2 Opiate Drug Treatment Cohort

During 2017/18 there were 582 opiate dependent adults in treatment (Figure 14).

4.2.1 Age (all in treatment)

Figure 18 highlights the older age profile of opiate dependent adults in treatment over time in B&NES, with a particularly noticeable drop in the proportion of younger adults in treatment. Over half (54%) of opiate clients are now aged 40 or over, whereas in 2009/10 this age group made up 32% of the opiate treatment cohort. The two largest quintile age groups in treatment in 2017/18 were those aged 35-39 and 40-44, accounting for 23% each of the total cohort.

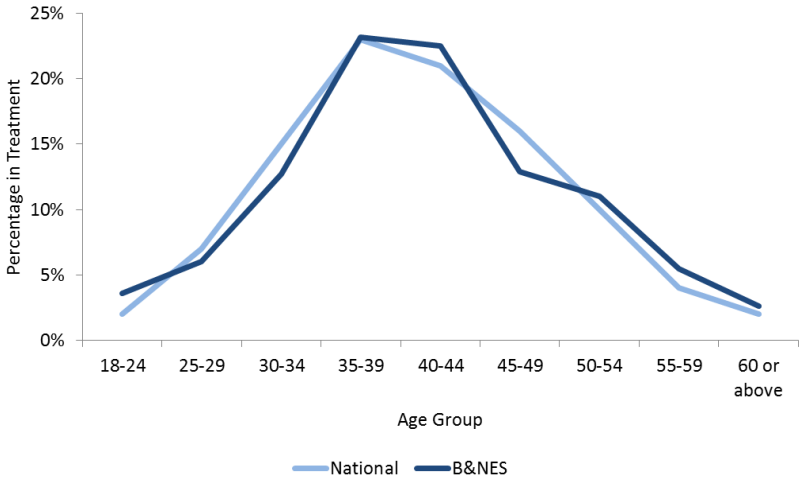
Figure 18: Age Profile of Opiate Dependent Adults in Treatment Over Time, B&NES, 2009/10 and 2017/18



Source: Local analysis from National Drug Treatment Monitoring System (NDTMS) [ViewIt].

Figure 19 highlights that the age profile of opiate dependent clients in treatment in B&NES is very similar to national.

Figure 19: Age Profile of Opiate Dependent Adults in Treatment, B&NES and England, 2017/18



Source: Local analysis from National Drug Treatment Monitoring System (NDTMS) [ViewIt].

4.2.2 Gender (all in treatment)

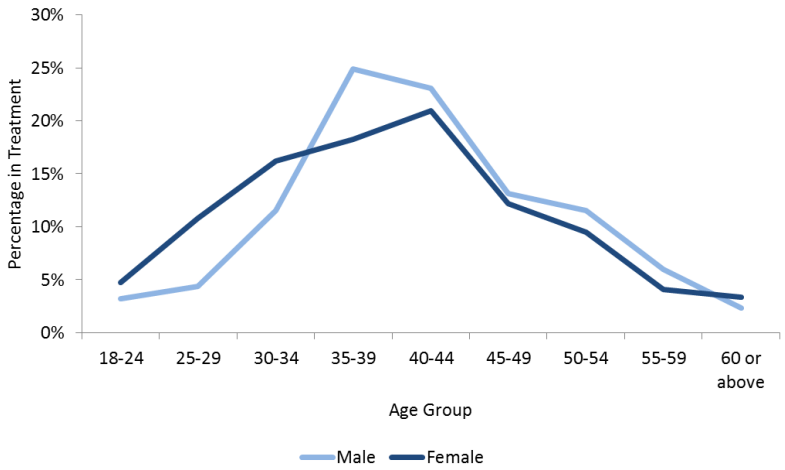
Of the 582 opiate dependent adults in receipt of treatment in B&NES in 2017/18, 434 were male (75%) and 148 were female (25%).[94] This gender split is broadly similar to the national gender split, which was 73% male and 27% female during the same period.[95]

This gender split has changed little since 2009/10.

5.2.3 Gender and Age (all in treatment)

Figure 20 illustrates that the opiate dependent female client cohort is somewhat younger compared to the opiate dependent male cohort (in proportionate profile terms across the age ranges).

Figure 20: Age and Gender Profile of Opiate Dependent Adults in Treatment, B&NES, 2017/18



Source: Local analysis from National Drug Treatment Monitoring System (NDTMS) [ViewIt].

[94] PHE(2018f), *Op. Cit*.

[95] *Ibid.*

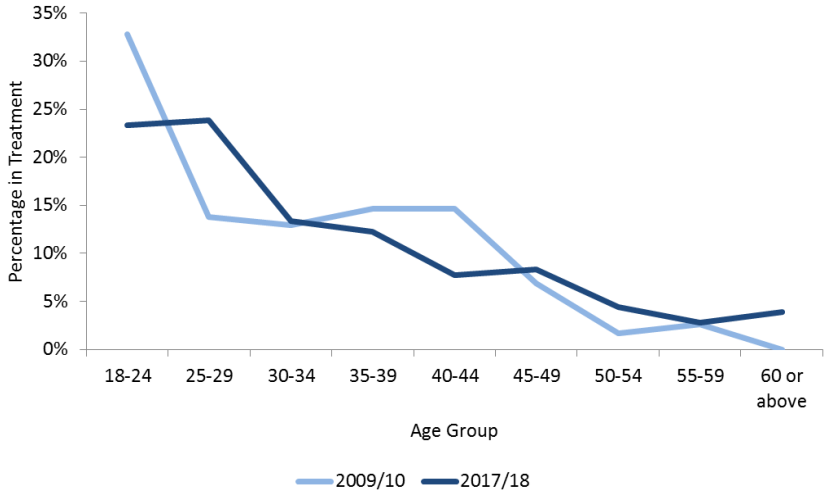
4.3 Non-Opiate Drug Treatment Cohort

During 2017/18 there were 180 non-opiate classified adults in treatment (Figure 16).

4.3.1 Age (all in treatment)

Figure 21 highlights the much younger age profile of opiate dependent adults in treatment, which has which has remained broadly the same since 2009/10. Nearly half (47%) of non-opiate clients are aged 18-30, the same as in 2009/10.

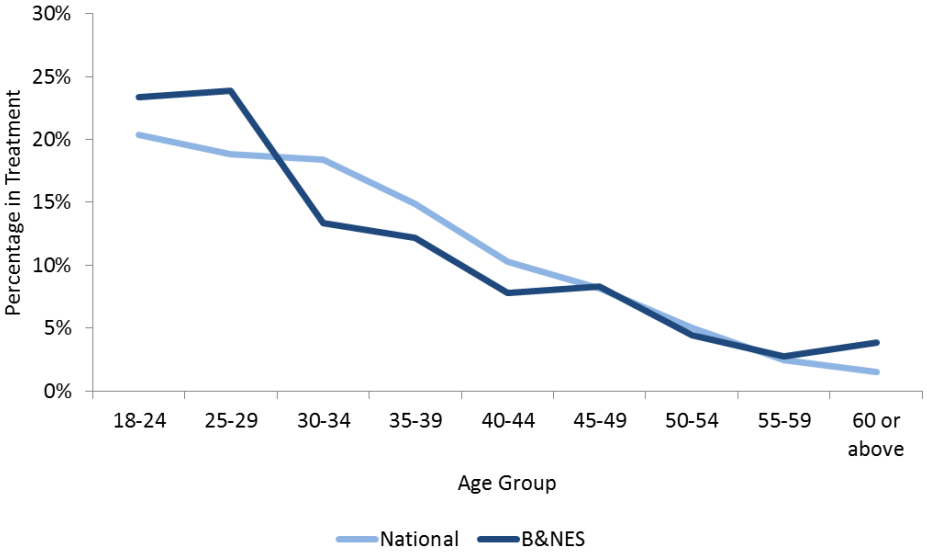
Figure 21: Age Profile of Non-Opiate Dependent Adults in Treatment Over Time, B&NES, 2009/10 and 2017/18



Source: Local analysis from National Drug Treatment Monitoring System (NDTMS) [ViewIt].

Figure 22 highlights that the age profile of non-opiate dependent clients in treatment in B&NES is somewhat younger compared to national.

Figure 22: Age Profile of Non-Opiate Dependent Adults in Treatment, B&NES and England, 2017/18

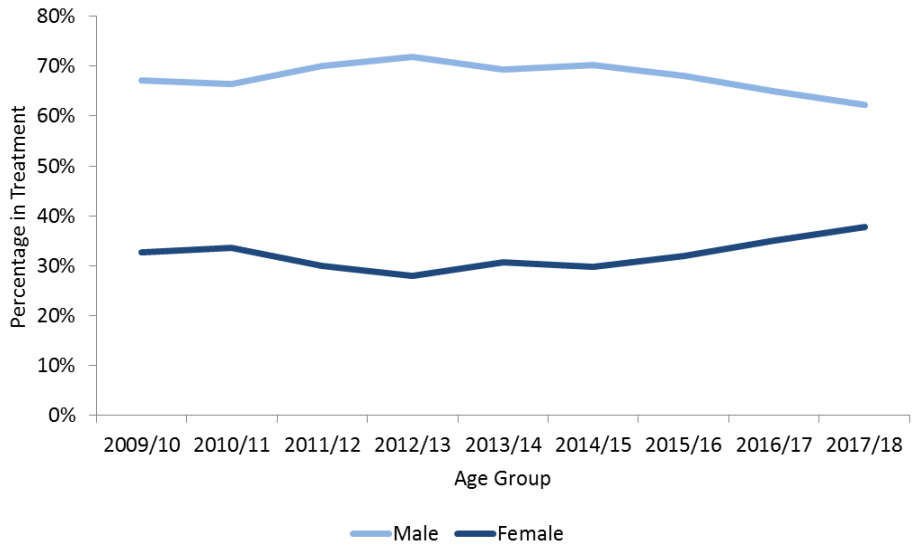


Source: Local analysis from National Drug Treatment Monitoring System (NDTMS) [ViewIt].

4.3.2 Gender (all in treatment)

Of the 180 non-opiate dependent adults in receipt of treatment in B&NES in 2017/18, 112 were male (62%) and 68 were female (38%).[96] This gender split is different to the national gender split, which was 73% male and 27% female, i.e. more likely to be female in B&NES.[97] Figure 23 illustrates this increasing trend in the proportion of non-opiate dependent females in B&NES to be in treatment.

Figure 23: Gender Split of Non-Opiate Dependent Adults in Treatment, B&NES, 2009/10 to 2017/18

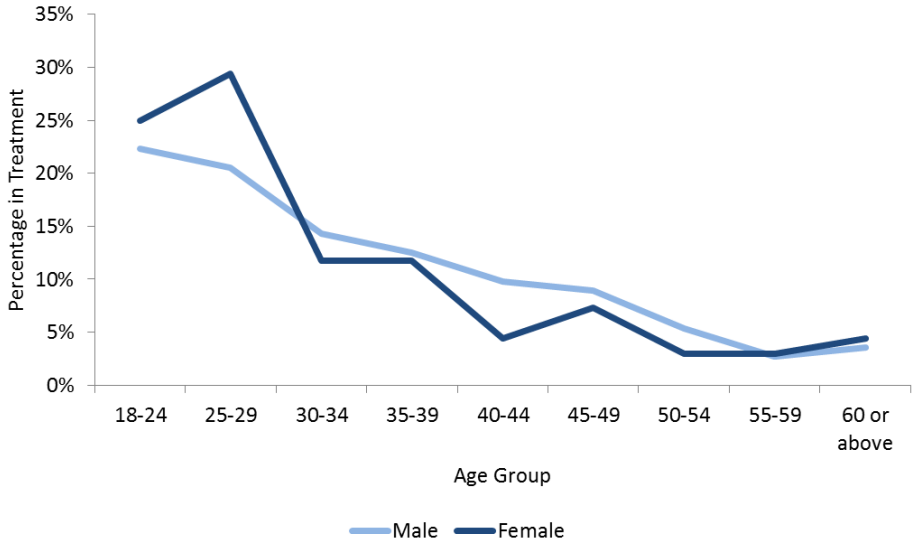


Source: Local analysis from National Drug Treatment Monitoring System (NDTMS) [ViewIt].

4.3.3 Gender and Age (all in treatment)

Figure 24 illustrates that the the non-opiate dependent female client cohort is somewhat younger compared to the non-opiate dependent male cohort (in proportionate profile terms across the age ranges).

Figure 24: Age and Gender Profile of Non-Opiate Dependent Adults in Treatment, B&NES, 2017/18



Source: Local analysis from National Drug Treatment Monitoring System (NDTMS) [ViewIt].

[96] *Ibid.*

[97] *Ibid.*

4.4 Opiate and Non-Opiate Drug Treatment Cohort

During 2017/18 there were 180 non-opiate classified adults in treatment (Figure 14).

4.4.1 Ethnicity (new presentations only)

The data quality in reporting of ethnicity has improved post-2014, with 99% of clients presenting during 2017/18 having a valid ethnicity recorded. During 2017/18 261 of the 289 (90%) new presentations into drug treatment were classified as White British.[98] This proportionate split is in line with the local general population (2.9.3).

4.4.2 Sexuality (new presentations only)

Local treatment statistics indicate that during 2017/18 3% of new presentations into drug treatment were LGB,[99] broadly similar to national modelled estimates would suggest is in the general population (2.9.4). The comparable rate nationally for new presentations into drug treatment was 4%, i.e. slightly higher than in B&NES.[100]

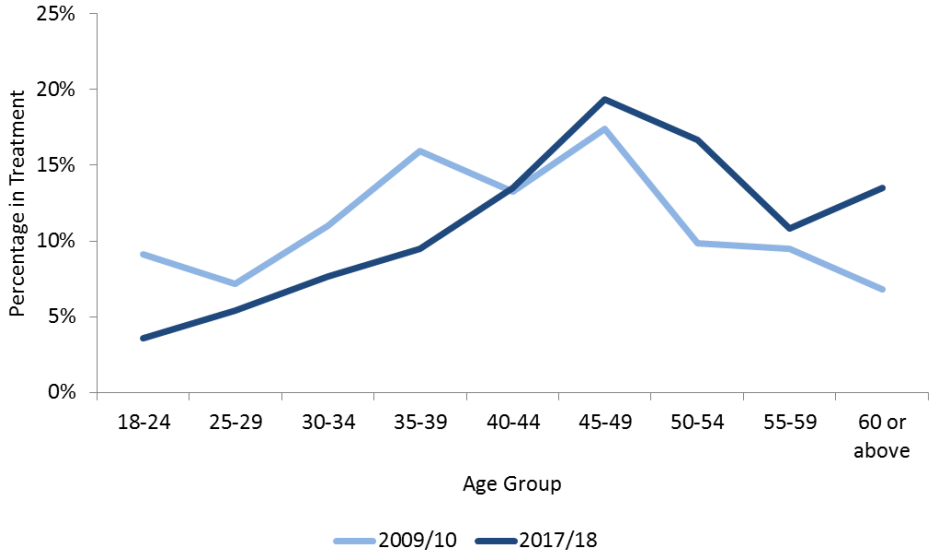
4.5 Alcohol Only Treatment Cohort

During 2017/18 there were 222 adults in treatment for dependence on alcohol only (Figure 16).

4.5.1 Age (all in treatment)

Figure 25 highlights the older age profile of adults in alcohol only treatment over time in B&NES, with a particularly noticeable drop in the proportion of younger adults in treatment. Three quarters (74%) of service users are now aged 40 or over, whereas in 2009/10 this age group made up 57% of the alcohol only treatment cohort. The two largest quintile age groups in alcohol only treatment in 2017/18 were those aged 40-49 and 50-54, accounting for 19% and 17% of the total cohort respectively. Also notable is the older profile of the alcohol only treatment cohort compared to the drug treatment cohort.

Figure 25: Age Profile of Adults in Alcohol only Treatment, B&NES, 2009/10 and 2017/18



Source: Local analysis from National Drug Treatment Monitoring System (NDTMS) [ViewIt].

[98] *Ibid.*

[99] *Ibid.*

[100] PHE (2018e), *Op. Cit.*

4.5.2 Gender (all in treatment)

Of the 222 adults in receipt of alcohol-only treatment in B&NES in 2017/18, 137 were male (62%) and 85 were female (38%).[101] This gender split is broadly similar to the national gender split in drug treatment, which was 60% male and 40% female during the same period.[102]

This gender split has changed little since 2010/11.

4.5.3 Ethnicity (new treatment presentations only)

The data quality in reporting of ethnicity has improved post-2014, with 99% of clients presenting during 2017/18 having a valid ethnicity recorded. During 2017/18 125 of the 222 (91%) new presentations into alcohol only treatment for were classified as White British.[103] This proportionate split is in line with the local general population (2.9.3).

4.5.4 Sexuality (new treatment presentations only)

Local treatment statistics indicate that during 2017/18 5% of new presentations into alcohol only treatment were LGB,[104] higher that the national modelled estimates would suggest is in the general population (2.9.4) and higher than the newly presenting drug treatment cohort (4.4.2). The comparable rate nationally for new presentations into alcohol only treatment was 4%, i.e. slightly lower than in B&NES.[105]

[101] PHE(2018g), *Adults - alcohol commissioning support pack 2019-20: key data: planning for alcohol harm prevention, treatment and recovery in adults*, B&NES, unpublished as restricted statistics and local analysis from National Drug Treatment Monitoring System (NDTMS).

[102] *Ibid.*

[103] *Ibid.*

[104] PHE(2018f), *Op. Cit*.

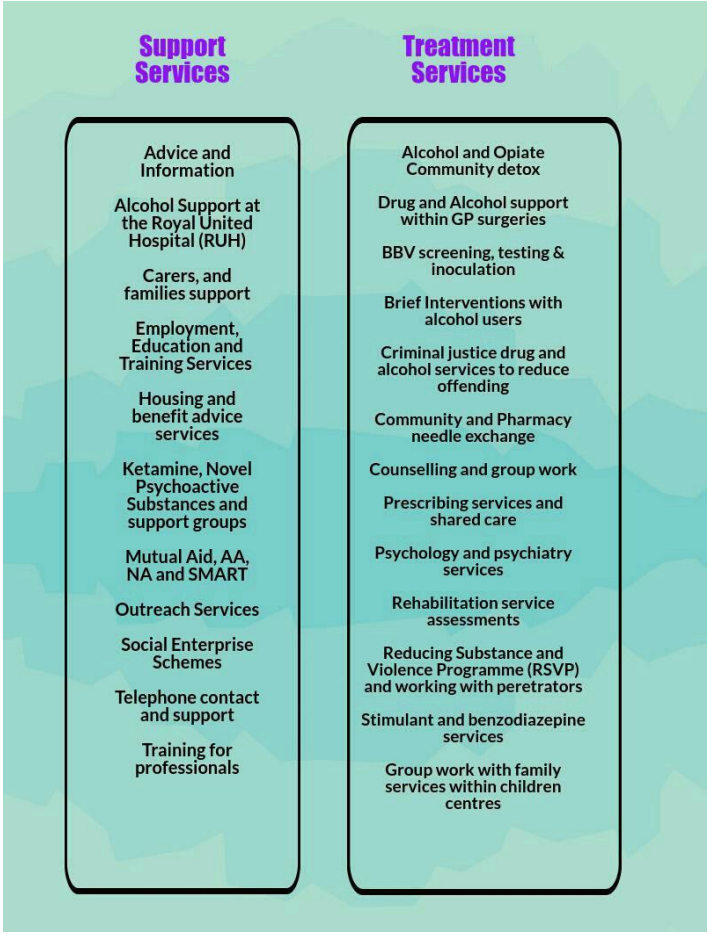
[105] PHE (2018e), *Op.Cit.*

5.0 Treatment System and Outcomes

5.1 Introduction

A substance misuse treatment service may include medication, counselling, and other supportive services designed to enable an individual to reduce or eliminate alcohol and/or other drug use, address associated physical or mental health problems, and restore the patient to maximum functional ability (Figure 26).

Figure 26: Range of Possible Support and Treatment Services Available to Clients



Source:

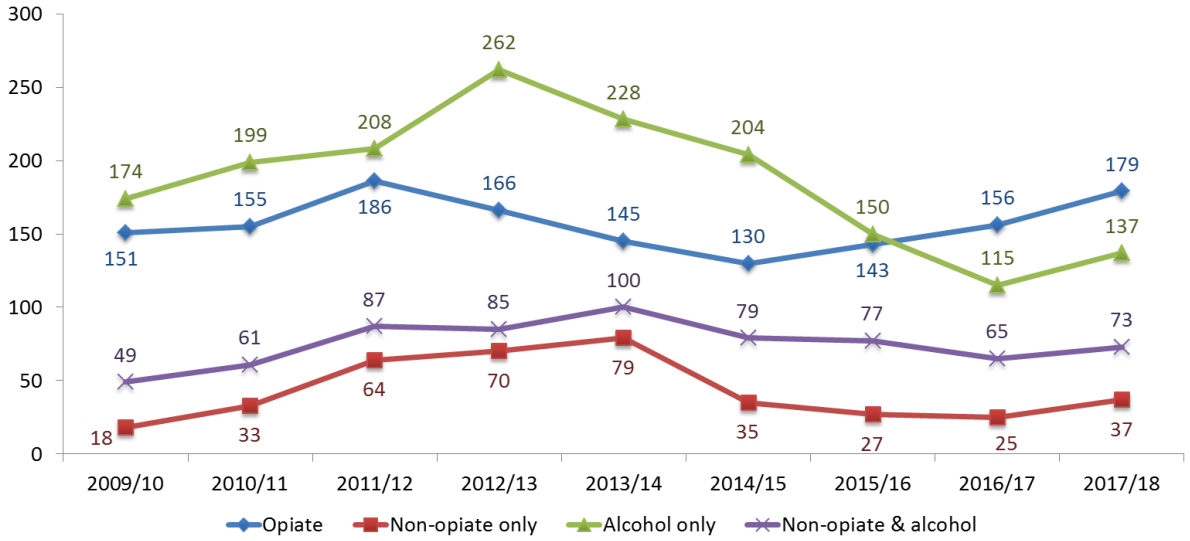
Early access and engagement in treatment means earlier safeguarding assessments, blood-borne virus testing, harm reduction advice such as safer injecting and provision of naloxone pens. All of these interventions are intrinsic to the health and wellbeing of the client and their families as they move through to recovery. Clients need prompt help if they are to recover from dependency, with simple access to specialised services and short waiting times facilitating the recovery process in the local community.

5.2 Numbers Entering Drug and Alcohol Treatment

There were 426 adults who commenced treatment with B&NES's drug and alcohol treatment services during 2017/18, which is 65 more than the previous year (2016/17), equivalent to a rise of 18% in new

presentations in one year.[106] The number of new presentations into treatment remains below the peak during 2012/13 of 583, representing a fall of 27% between then and during 2017/18.[107]

Figure 27a: Number of Adults Presenting into Drug & Alcohol Treatment by Substance Category, B&NES, 2009/10 to 2017/18



Source: Local analysis from National Drug Treatment Monitoring System (NDTMS) [ViewIt].

Figure 27a confirms the big fall in the number in treatment for alcohol dependency - down from 262 new presentations during 2012/13 to 137 during 2017/18 (representing a 48% drop). However, the number entering treatment for opiate misuse has been increasing once again - from a low of 130 during to 2014/15 to 179 during 2017/18 (a 38% increase). People who misuse opiates now make up the largest cohort presenting for treatment, when for most of the period since 2009/10 it was alcohol only clients.

The large fall in the number of alcohol only clients entering substance misuse treatment in B&NES is not only a local phenomenon, but has been seen in many other areas around England. This fall in numbers of alcohol only clients is particularly concerning when viewed against a context of 80% unmet need (3.5.1).

Public Health England conducted a rapid inquiry in 2018 to better understand what was behind the fall in numbers of people in treatment for alcohol dependence in England.[108] The inquiry included a 'deep dive' followed by a wider consultation. The deep dive involved visits to 14 local authorities across 6 PHE regional centres, including 9 local authorities where there had been a fall in numbers in alcohol treatment and 5 where there had been an increase between 2013 to 2014 and 2016 to 2017. Local areas were selected on the basis of large changes in numbers in alcohol (but not drug) treatment, and to make sure local authorities from as many different PHE regional centres were represented in the sample. PHE's analysis suggests that the context in which treatment is currently commissioned and provided, including financial pressures and service reconfiguration, has affected

[106] Local analysis from National Drug Treatment Monitoring System (NDTMS) [ViewIt].

[107] *Ibid.*

[108] PHE (2018), *PHE inquiry into the fall in numbers of people in alcohol treatment: findings*, accessed from: https://www.gov.uk/government/publications/alcohol-treatment-inquiry-summary-of-findings

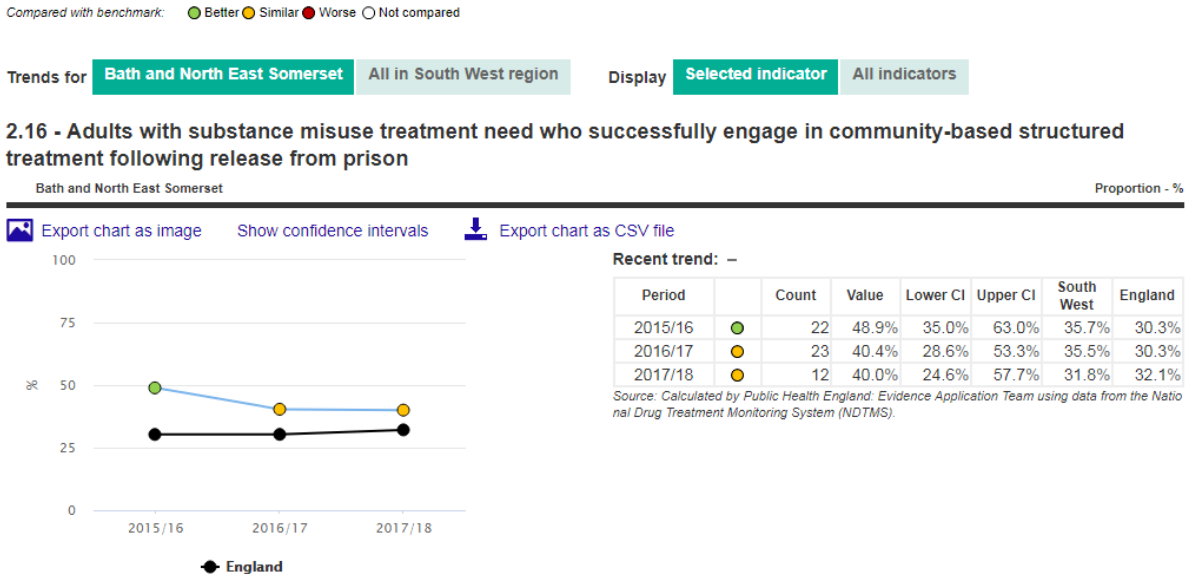
alcohol treatment numbers more than treatment numbers for other substances. The main, but not only, motivation for service re-configuration was reduced local substance misuse budgets.

Criminal Justice Clients Entering Treatment

There is a Public Health Outcomes Framework (PHOF) indicator (2.16, 'Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison') measuring adults with a substance misuse treatment need who successfully engage in community-based structured treatment following release from prison. This indicator measures the proportion of adults released from prison (into B&NES) with substance misuse treatment need who go on to engage in structured treatment interventions in the community within 3 weeks of release.

Figue 27b illustrates that B&NES had 12 adults who successfully engaged in community-based structured substance misuse treatment following release from prison during 2017/18, representing 40% of those with an identified substance misuse need (compared to 32% nationally). This represents a drop in performance locally compared to 2015/16, when the figure was 49%, and was significantly better compared to national.

Figure 27b: Adults with Substance Misuse Treatment Need Who Successfully Engage in Community-Based Structured Treatment Following Release From Prison, B&NES, 2015/16 to 2017/18



Source: PHE (2019), *Public Health Outcomes Framework (PHOF)*, available from: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework

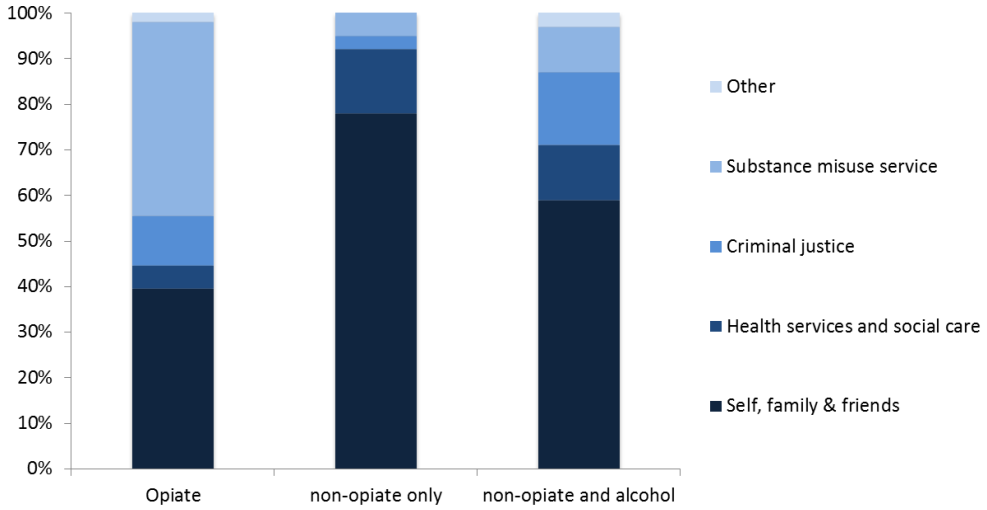
Note: engagement is defined as having started a treatment intervention.

5.3 Drug Treatment Cohort

5.3.1 Routes into Treatment and Waiting Times

The B&NES drug and alcohol treatment system has a single point of entry for all referrals, which includes self-referrals into treatment. For opiate users, by far the most common routes into treatment are from the treatment services themselves or self-referrals - 43% and 40% respectively during 2017/18 (Figure 28). For non-opiate only users, the overwhelming majority, 78% during 2017/18, self-referred into treatment (Figure 28). Finally, for the non-opiate and alcohol cohort who commenced treatment during 2017/18, the majority - 59% - self-referred, while 16% came from criminal justice services, 12% from health and social services and 10% from substance misuse services (Figure 28).

Figure 28: Routes into Treatment (Referrals) of Adults Presenting into Drug Treatment by Substance Category, B&NES, 2017/18



Source: Local analysis from National Drug Treatment Monitoring System (NDTMS) [ViewIt].
Note: This chart relates to all opiate, non-opiate and non-opiate & alcohol clients.

Table 4 shows the number of referrals from the Arrest Intervention Referral Service (AIRS) between 2016 and 2018. During 2018 there were 55 referrals from AIRS, including 10 voluntary referrals.

Table 4: Referrals from Avon & Somerset Police Arrest Intervention Referral Service (AIRS) into Drug Treatment, B&NES, 2016 to 2018

Year	Required Assessments	Voluntary Assessments
2016	68	13
2017	31	9
2018	45	10

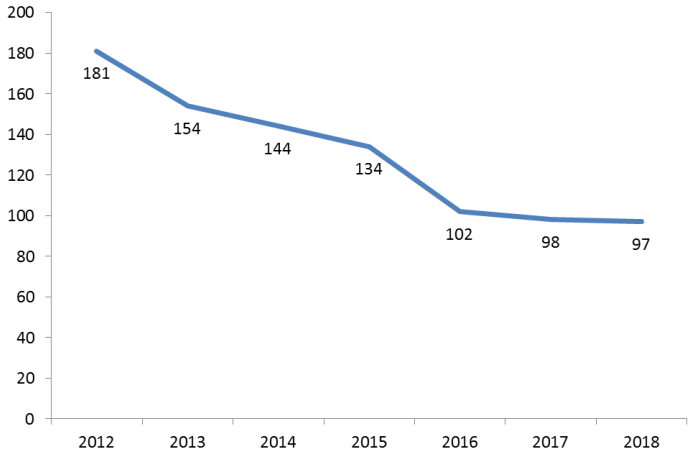
Source:DHI

During 2017/18, 100% of drug treatment clients had initial waits of under 3 weeks to start treatment in B&NES.

5.3.2 Shared Care

Shared Care is a well established model of delivering treatment in primary care, in the local communities close to people's homes. B&NES has a relatively stable number of opiate clients in treatment (Figure 14), while at the same time those clients in Shared Care have declined by nearly half between 2012 and 2018 (Figure 29). At the time of the last needs assessment it was anticipated that there would be an increase in the number in Shared Care.

Figure 29: Number of Opiate Clients in Treatment who are in Shared Care, B&NES, 2012 to 2018



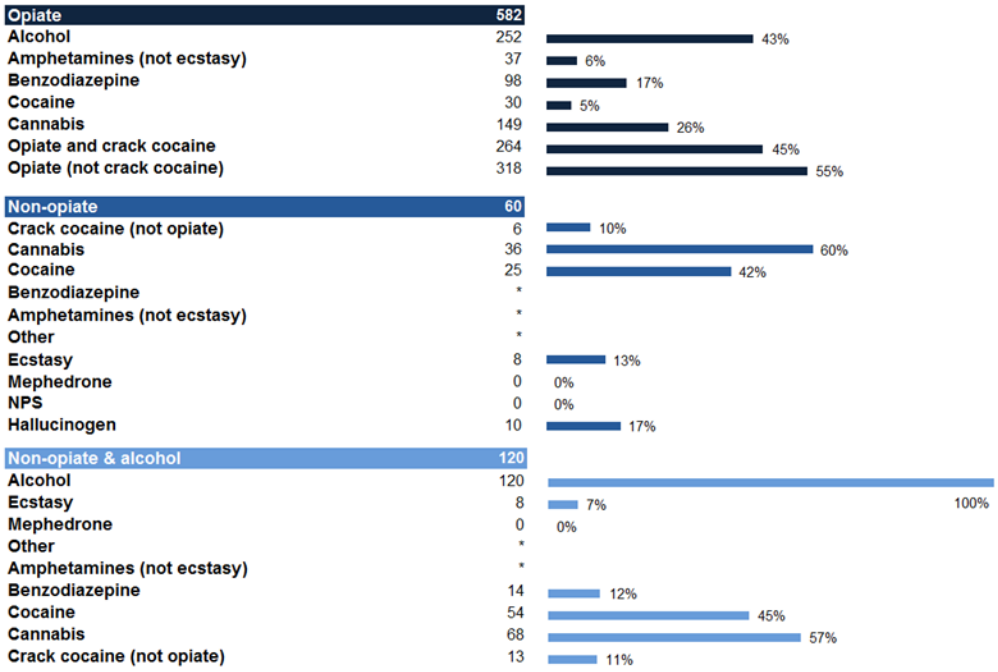
Source: Drugs, Alcohol and Sexual Health Commissioning Manager, Virgin Care.
Note: Snapshot as at second Friday in October each year.

5.3.3 Substance Use Profile

All in Treatment

The additional substances clients present to treatment with differ by the main drug groups. Opiate clients tend to also present with crack cocaine and problematic alcohol use, compared to non-opiate clients (either alone or in conjunction with alcohol) who tend to present with cocaine and cannabis misuse (Figure 30).

Figure 30: Substance Breakdown for all Drug Clients in Treatment, B&NES, 2017/18



Source: NDTMS (2018), Local Area Trend Report 2017-18.
Notes: (1) Individuals may present to treatment with problems with more than one substance (including alcohol), therefore percentages may sum to over 100%. (2) * represents suppressed numbers.

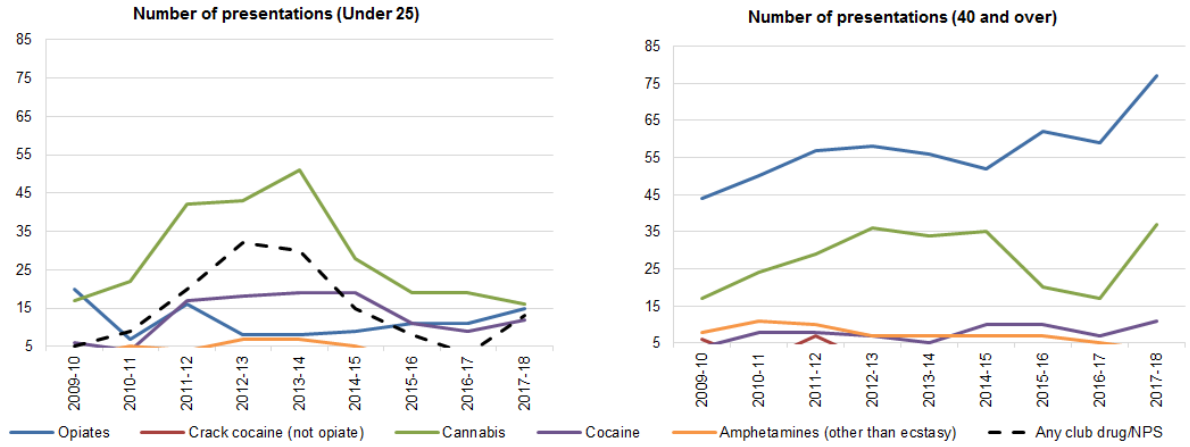
New Clients to Treatment (presenting substance)

Different age groups experiencing different substance misuse patterns.

Nationally, the number of under 25 year olds entering treatment between 2009/10 and 2017/18 citing any opiate use has fallen by 70%. Locally, numbers of under 25 year olds entering treatment citing opiate use remain relatively small (Figure 31), so there is no similar pattern to that witnessed nationally. Locally the number of under 25s presenting to treatment have remained below five every year from 2009/19 (Figure 31).

In comparison, nationally there has been a 34% increase in the number aged 40 and over citing opiate use. Locally, this increase has been greater (77%), increasing from 44 to 77 new presentations of 40+ year olds citing opiate use in B&NES between 209/10 and 2017/18 (Figure 31).

Figure 31: Trends in Presenting Substances under-25s and 40+ age ranges, B&NES, 2009/10 to 2017/18



Source: NDTMS (2018), Local Area Trend Report 2017-18.
Note: Y-axis starts at 5 due to requirement to adhere to suppressions guidelines.

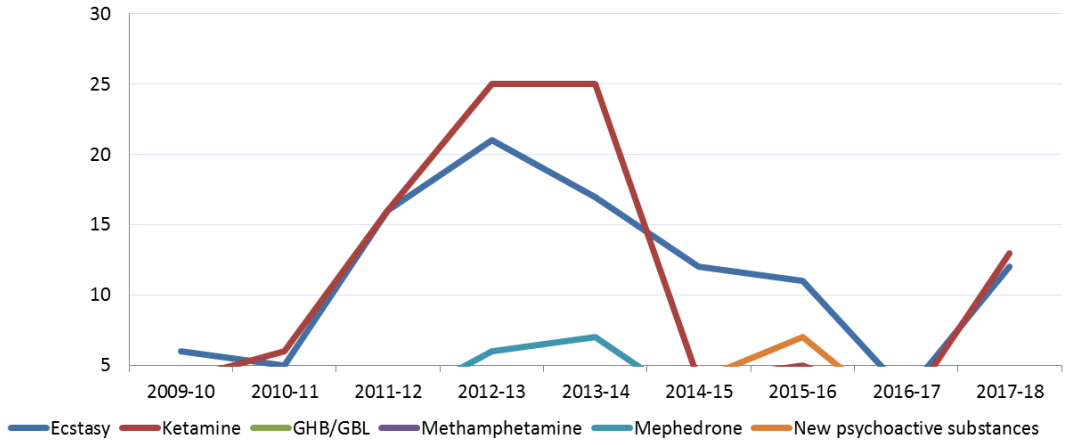
'Club Drugs' and New Psychoactive Substances (NPSs)

'Club drugs' and NPS brings together a number of different substances typically used by people in bars and nightclubs, at concerts and parties, before and after a night out.

Nationally there has been a large drop in the number of clients in treatment citing the use of mephedrone. There has also been a drop in the number stating the use of NPS. In contrast, there has been a slight increase in the number stating ketamine use.

Trends in the use of 'club drugs' and new psychoactive substances (NPS) locally relate to small numbers and could represent random change. However, notable fluctuations can be seen in presentations relating to ketamine and ecstasy in particular, having risen again during 2017/18 to 13 and 12 presentations respectively (Figure 32). Trends in new presentations for NPS are of sufficiently small numbers that in all but one year they cannot be published within NDTMS suppression guidelines (Figure 32).

Figure 32: Trends in New Presentations Citing 'Club Drugs', B&NES, 2009/10 to 2017/18



Source: NDTMS (2018), Local Area Trend Report 2017-18.
Note: Y-axis starts at 5 due to requirement to adhere to suppressions guidelines.

Prescription-Only Medicines or Over-the-Counter Medicines (POM/OTC)

In 2017/18 there were 157 clients recorded with problematic illicit (133) and licit (24) use of POM and/or OTC. This represents 21% of the local treatment population, compared to 14% nationally.[109]

The Parliamentary Under Secretary of State for Public Health and Primary Care commissioned PHE to review the evidence for dependence on, and withdrawal from prescribed medicines.[110] The review was launched in January 2018 and is due to report in spring 2019. In addition, a second major review of opioid medicines has been launched by the Government medicines regulator, with the aim of cutting overprescribing and drug misuse.[111]

5.3.4 Complexity of Drug Treatment Clients

More complex[112] clients are more likely to be in treatment longer and are less likely to successfully complete their treatment. Complexity factors include housing risk, poor education or employment status and poor quality of life scores. Other factors include low levels of social support, and physical and mental health problems.

[109] PHE(2018f), *Op. Cit*.

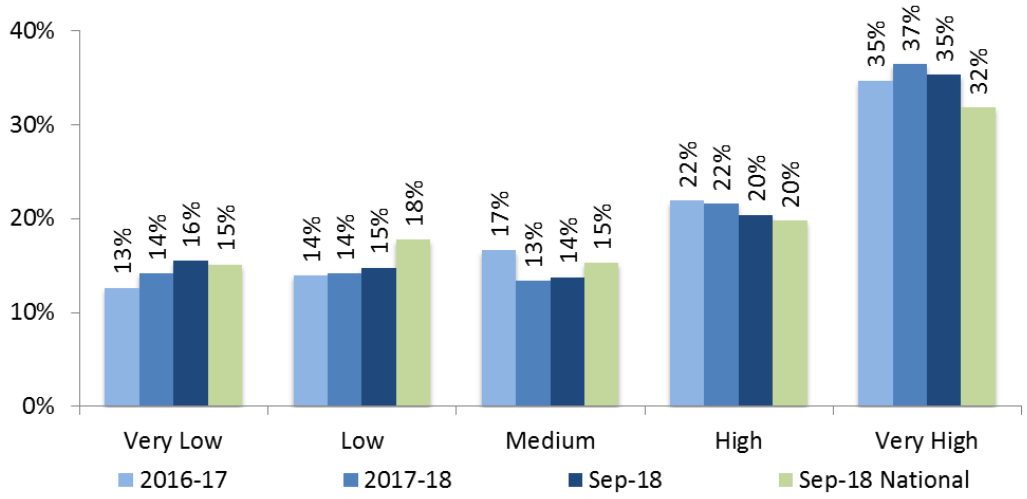
[110] PHE (2018o), *Prescribed medicines review: scope*, available from: https://www.gov.uk/government/publications/prescribed-medicines-review-scope

[111] Medicines and Healthcare products Regulatory Agency (2019), *Opioid Expert Working Group meets at MHRA*, press release, 13 February, available from: https://www.gov.uk/government/news/opioid-expert-working-group-meets-at-mhra?utm_source=164d1f71-32a5-4efc-b4ca-4d4acea4d670&utm_medium=email&utm_campaign=govuk-notifications&utm_content=immediate

[112] Complexity is assigned to clients individually using a scoring system. In this, a score is assigned to an individual based on variables collected in TOP and NDTMS. There are separate scores for "new clients", i.e. clients that started treatment in the year and "existing clients", i.e. where the person was already in treatment at the start of the year. These are summed up for each individual and the resulting scores are then grouped into the five complexity groups shown from very low to very high. If the person is a new client then a combination of the start TOP and NDTMS triage information from the first episode is used to determine a client's complexity. If the person is an existing client the most recent available TOP data (providing there is a TOP within the 12 months for the person) is used as a proxy for their circumstances at the start of the year. Opiate use is a significant factor in this calculation and for this reason data is only provided for all clients and not broken down by opiate/non-opiate.

B&NES has a higher percentage of 'very high' complex drug treatment clients compared to the national comparator, 35% and 32% respectively as at 30th September 2018 (Figure 33). However, the proportion of clients with 'very low' complex drug treatment clients has also been increasing and is nearly identical to national, 15% and 16% respectively as at 30th September 2018 (Figure 33).

Figure 33: Complexity of Drug Treatment Clients, B&NES (Q4 2016/17, Q4 2017/18 and Q2 2018/19), England (Q2 2018/19)



Source: NDTMS (2018), *Recovery Diagnostic Toolkit*, Q2 2018/19.
Note: This chart relates to ALL opiate, non-opiate and non-opiate & alcohol clients in treatment.

There is evidence that new presentations of treatment naïve clients in B&NES has been becoming less complex, whereas new presentations of non-treatment naïve clients in B&NES has remained broadly similar in terms of their complexity.[113]

Figure 34 shows the proportion of non-treatment naïve drug clients reporting each of the following factors that increase their complexity:

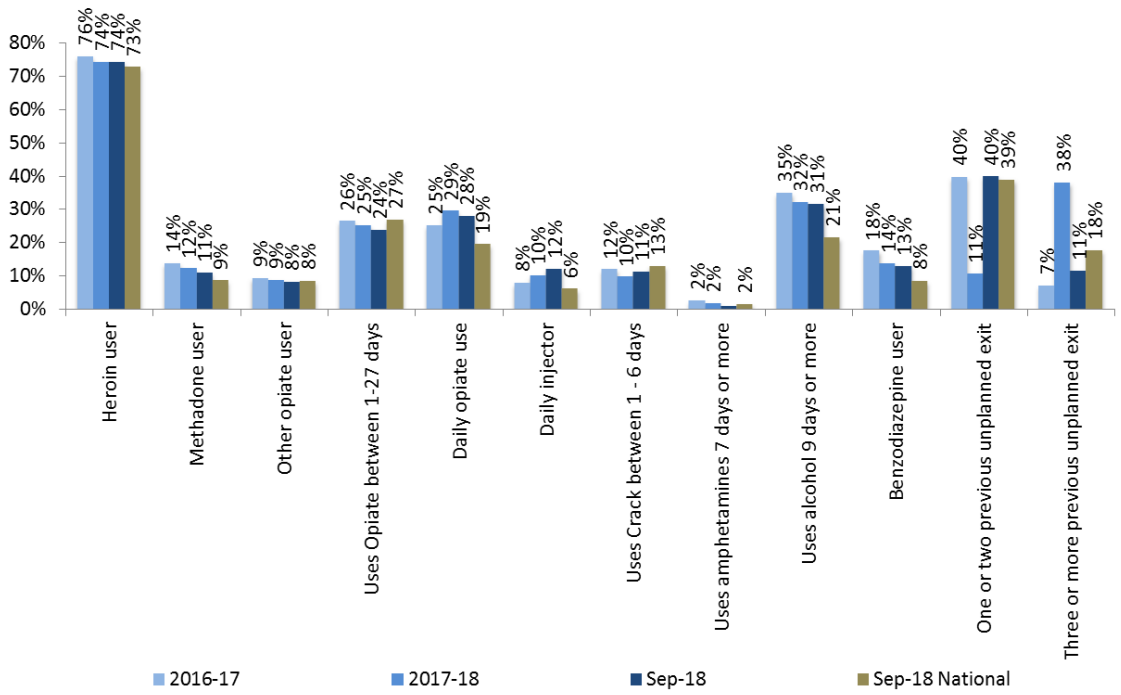
- Heroin user;
- Methadone user;
- Other opiate user;
- Uses opiates between 1-27 days;
- Daily opiate user;
- Daily injector;
- Uses crack between 1-6 days;
- Uses amphetamines 7 days or more;
- Uses alcohol 9 days or more;
- Benzodiazepine user; and
- One or more previous unplanned exit.

Figure 34 identifies that heroin use is the most prevalent complexity factor, identified in three in every four non-treatment naïve drug clients in B&NES. Figure 34 also illustrates that daily opiate use has been increasing for this cohort and is higher compared to national. Also, daily injecting has been

[113] NDTMS (2018), *Recovery Diagnostic Toolkit*, Q2 2018/19.

increasing, and the latest figures indicate that twice the proportion of this cohort compared to national are daily injectors (Figure 34).

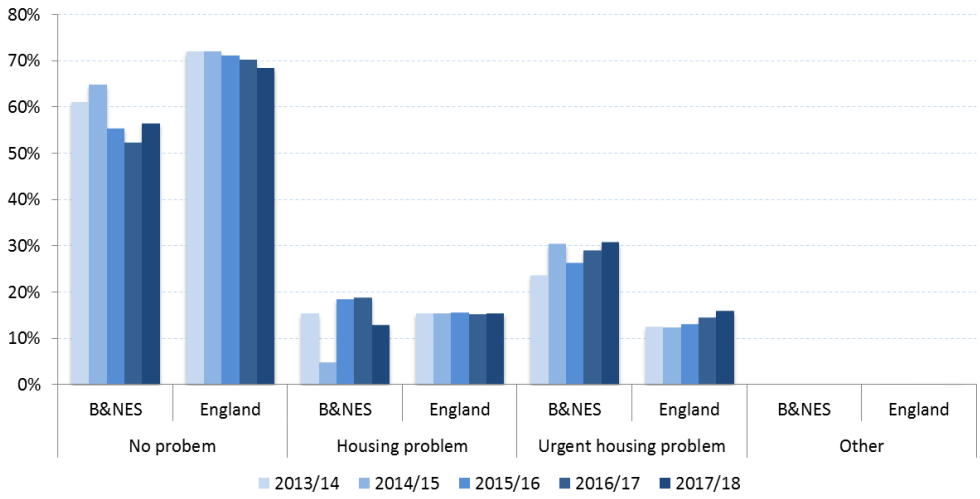
Figure 34: Non-treatment naïve drug clients citing each complexity indicator, B&NES (Q4 2016/17, Q4 2017/18 and Q2 2018/19), England (Q2 2018/19)



Source: NDTMS (2018), *Recovery Diagnostic Toolkit*, Q2 2018/19.
Notes: (1) This chart relates to ALL opiate, non-opiate and non-opiate & alcohol clients in treatment. (2) Figure for Q2 2018/19 for 'uses amphetamines 7 days or more' has been suppressed.

One of the factors that particularly affects drug treatment clients presenting for treatment in B&NES is the level of their high level housing need, thus increasing complexity. Figure 35 illustrates that twice the proportion of newly presenting drug treatment clients are deemed to have an urgent housing problem at the start of their treatment compared to national - 22% and 11% respectively during 2017/18. Locally, this accounted for 64 newly presenting drug treatment clients during 2017/18 in B&NES - 55 opiate clients and 9 non-opiate only/non-opiate and alcohol clients.

Figure 35: Proportion of New Drug Client Presentations by Housing Need, B&NES, 2013/14 to 2017/18



Source: Local analysis from National Drug Treatment Monitoring System (NDTMS) [ViewIt].

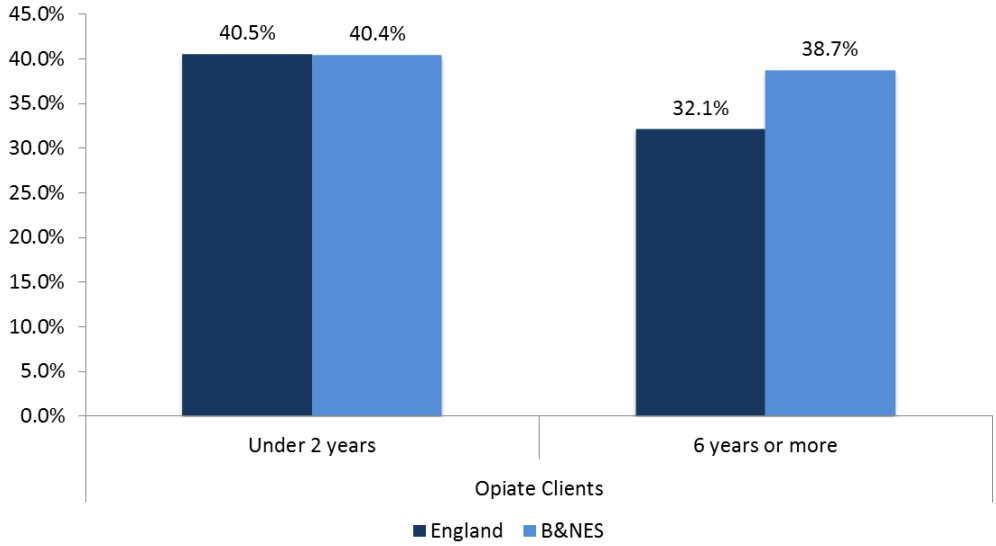
Notes: (1) This chart relates to all opiate, non-opiate and non-opiate & alcohol clients. (2) Urgent housing problem is defined by NDTMS as "*lives on streets/rough sleeper, uses night shelter (night-by-night basis)/ emergency hostels; sofa surfing/sleeps on different friend's floor each night*".

5.3.5 Length of Time in Treatment

Clients that have been in treatment for a long period of time (six years or over for opiate using clients and over two years for non-opiate using clients) are most likely to be entrenched users who will find it harder to successfully complete treatment. Current research shows that that opiate using clients who successfully complete within two years of first starting treatment have a higher likelihood of achieving a sustained recovery.

Figure 36 illustrates that as at 31st December 2018, while 2 in every 5 opiate using clients in B&NES were in treatment for under two years, the same proportion had been in treatment for six years or more. Between 31st March 2015 and 31st December 2018 the average length of time in treatment for opiate clients in B&NES increased from 5 to 5.7 years.[114] Furthermore, opiate using clients in B&NES are more likely to be in treatment for longer compared to national (Figure 36). However, this is not due to an older local opiate client profile compared to national (Figure 19). What is more likely to explain this is a more complex client profile compared to national (Figure 33).

Figure 36: Length of Time in Drug Treatment of Opiate Clients, B&NES, Q3 2018/19



Source: NDTMS (2019), *Diagnostic Outcomes Monitoring Executive Summary (DOMES)*, 2.5, Q3 2018/19.

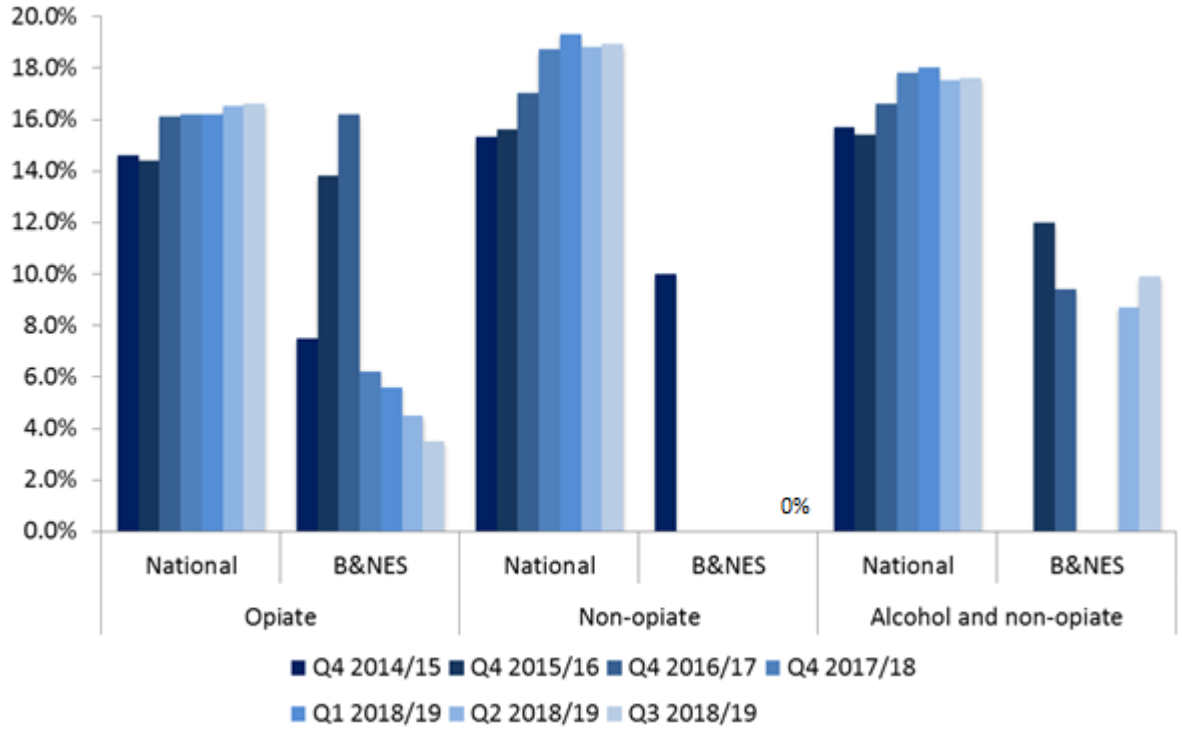
5.3.6 Treatment Engagement

When engaged in treatment, people use less illegal drugs, commit less crime, improve their health, and manage their lives better - which also benefits the community. Preventing early drop out and keeping people in treatment long enough to benefit contributes to these improved outcomes. As people progress through treatment, the benefits to them, their families and their community start to accrue.

[114] NDTMS (2018), *Diagnostic Outcomes Monitoring Executive Summary (DOMES)*, 2.5, Q4 2014/15. NDTMS (2018), *Diagnostic Outcomes Monitoring Executive Summary (DOMES)*, 2.5, Q2 2018/19.

The proportion of new presentations who had an unplanned exit or transferred and not continuing a journey before being retained for 12 weeks is relatively low in B&NES compared to national (Figure 37). This is especially so since 2017/18. During the 12 month period up to the end of 30th September 2018, 6 newly presenting opiate clients, 7 newly presenting alcohol and non-opiate clients had an early unplanned exit. There were no early unplanned exists of non-opiate only clients.

Figure 37: Proportion of New Drug Treatment Clients with an Unplanned Exit, B&NES, Q4 2014/15 to Q3 2018/19



Source: NDTMS (2019), *Diagnostic Outcomes Monitoring Executive Summary (DOMES)*, 2.4, Q3 2018/19 and similar for Q4 2014/15, Q4 2015/16, Q4 2016/17, Q4 2017/18, Q1 2018/19 and Q2 2018/19.
Notes: (1) Figures have been suppressed for B&NES non-opiate clients due to small numbers (below 5) for the following reporting periods: Q4 2015/16, Q4 2016/17, Q4 2017/18, Q1 2018/18 and Q2 2018/19 (Q3 2018/19 is 0%, i.e. not suppressed). (2) Figures have been suppressed for B&NES alcohol and non-opiate clients due to small numbers (below 5) for the following reporting periods: Q4 2014/15, Q4 2017/18 and Q1 2018/19.

5.3.7 In Treatment Outcomes

NDTMS and research evidence shows that many of the benefits of treatment often occur early – most clients show substantial improvements within the first six months of treatment.

The Treatment Outcomes Profile (TOP) measures change and progress in key aspects of the lives of people being treated in B&NES and in areas across the UK. TOP consists of 20 simple questions focusing on the areas that can make a real difference to clients' lives - substance abstinence, injecting risk behaviour, crime, health and quality of life. It produces outcomes data that can be used with individual service users, with staff, with services across a treatment system. TOP can help predict expected outcomes for individual clients and lets providers and partnerships see whether they are performing within expected ranges, given the complexity of the clients they treat.

TOP can also help predict the achievement of key outcomes, for example, people abstinent after six months of treatment are much more likely to go onto successfully to complete treatment and not re-

present. In contrast, people who start using drugs at this stage are much less likely to do so. By reviewing TOP outcomes, measurements can be put in place to tackle clients on a poor trajectory and enhance their recovery potential.

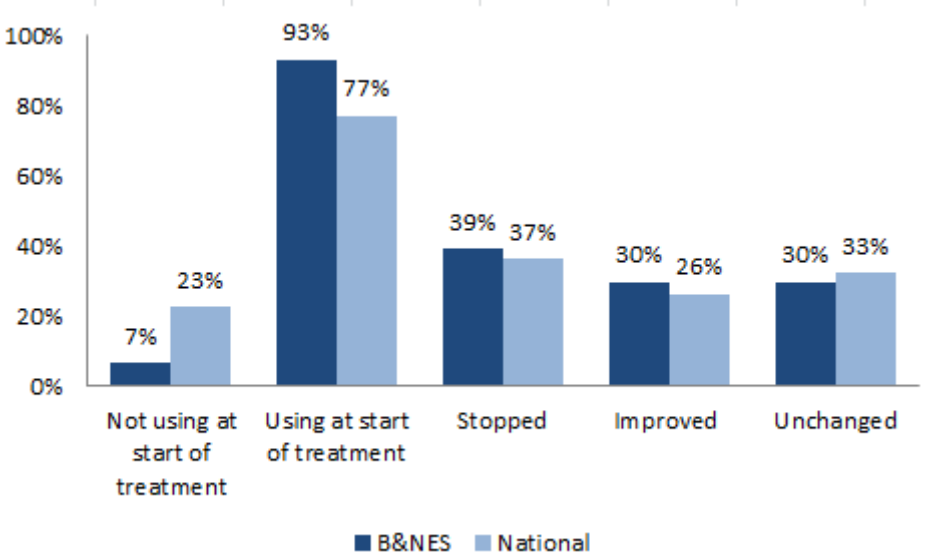
By tracking housing, education and employment information in the TOP, local areas can help identify whether further service provision is needed to address these areas and improve people's recovery chances.

Abstinence at 6 months

Nationally, rates of illicit opiate abstinence after three and six months of treatment points to relatively poorer performance in comparison with international literature.[115]

Figure 38 illustrates the proportion of opiate clients using opiates at the start of treatment, and then whether their opiate use had stopped, improved or remained the same by their 6 month review. During 2017/18, 39% of opiate clients had stopped using opiates by the 6 month review and a further 30% had reduced their use, which compares with the national figures of 37% and 26%, respectively.

Figure 38: Abstinence Outcomes for Opiate Clients at 6 mth Review, B&NES, 2017/18

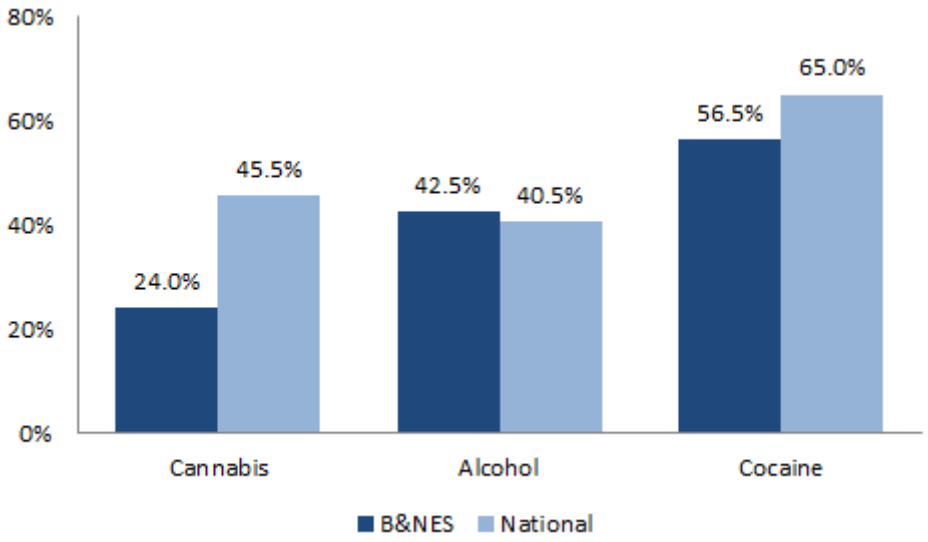


Source: NDTMS, Recovery Diagnostic Toolkit.

Some of the substances reported as problematic for non-opiate clients were cocaine, cannabis and alcohol (Figure 30). Figure 39 shows where substance misuse had stopped or improved, for B&NES non-opiate clients by their 6 month review, and compares this with national figures. Around a quarter (24.0%) of non-opiate clients had stopped or reduced their use of cannabis, nearly half the national rate (45.5%). Around 40% of non-opiate clients had stopped or reduced their use of alcohol, and over half (56.5%) had stopped or reduced their use of cocaine (Figure 39).

Figure 39: Abstinence (Stopped and Improved) Outcomes for Non-opiate Clients at 6 mth Review, B&NES

[115] PHE (2017e), *Op. Cit.*

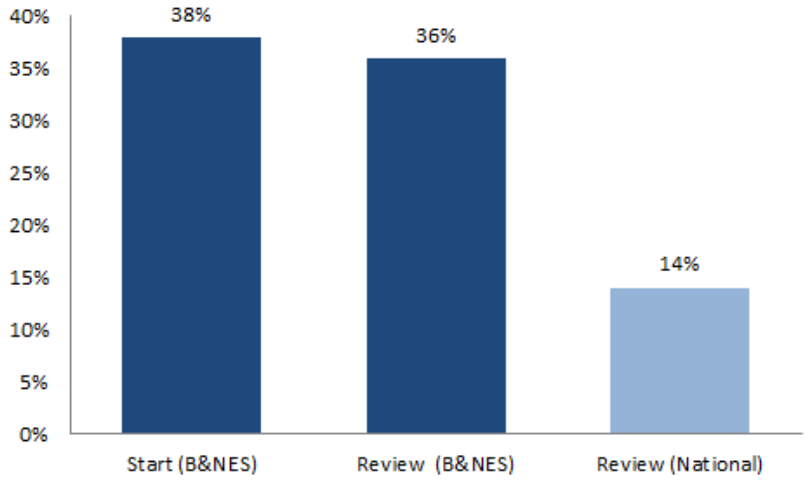


Source: NDTMS, Recovery Diagnostic Toolkit.

Housing Issues at 6 Months

There was a small decrease in opiate clients with an acute housing risk by their 6 month review, dropping from 38% at the start of treatment, to 36% (34 clients) at the 6 month review (Figure 40). This is more than twice the national comparable figure at the 6 month review of 14% (Figure 40). It is not known if the clients reporting an acute housing risk at the 6 month review are the same clients reporting a risk at the start of treatment. Stable housing is an important factor in recovery capital.

Figure 40: Opiate Clients with an Acute Housing Risk at the Start of Treatment and at the 6 Month Review, B&NES, Q2 2018/19



Source: NDTMS (2019), Quarterly Outcome Commentary Report 6 Month Review, Table 12.

As at quarter 2 2018/19, opiate clients at risk of eviction dropped from 17% at the start of treatment to 7% (7 clients) at their 6 month review.[116]

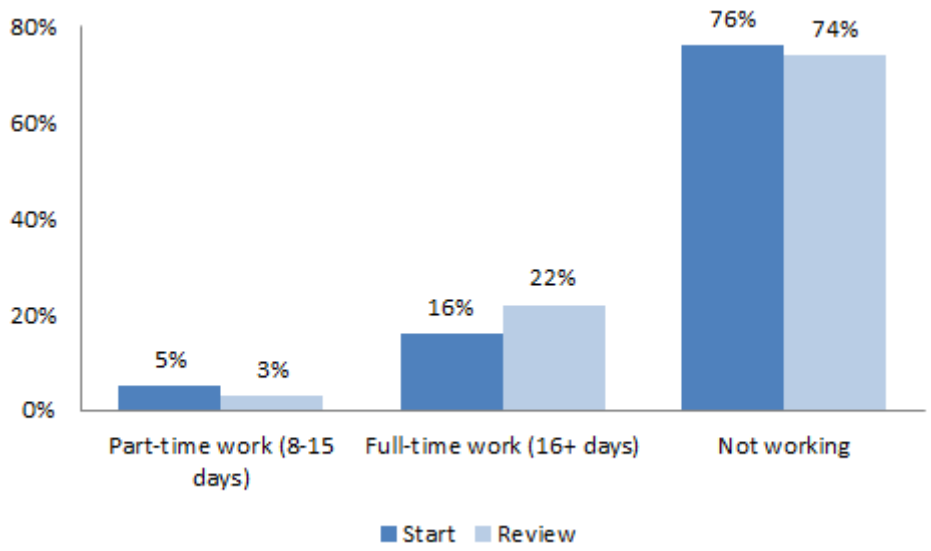
Employment at 6 months

[116] NDTMS (2019), Quarterly Outcome Commentary Report 6 Month Review, Table 12.

Improved job outcomes is one of the key components to sustaining recovery. Self-reported employment status at the start of treatment in 2017/18 was collected, along with their employment status at review, from TOP.

Figure 41 also shows a large majority of clients are not in employment at either the start of treatment or the 6 month review. Figure 41 shows an increase in the proportion of drug clients in full-time employment at their 6 month review and a small decrease in the proportion not working by the time of their 6 month review.

Figure 41: Employment Status of Drug Clients at the Start of Treatment and at the 6 Month Review, B&NES, 2017/18

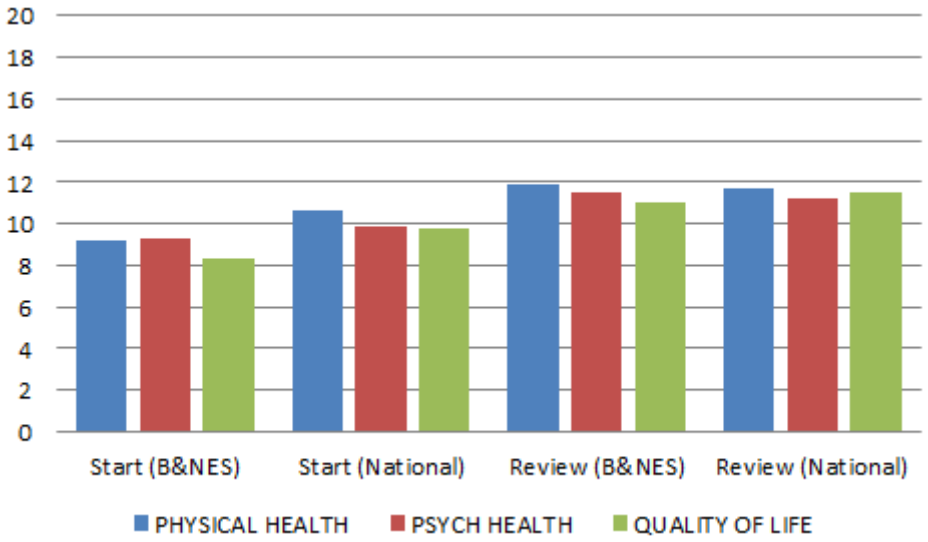


Source: PHE(2018f), Adults - drugs commissioning support pack 2019-20: key data: planning for drug prevention, treatment and recovery in adults, B&NES, unpublished as restricted statistics.

Health Status at 6 months

Clients rate their physical health, psychological health and quality of life at the start of the treatment process and then again at the 6 month review. There is an increase in the average scores at the 6 month review for opiate clients in their reported physical health, psychological health and quality of life (Figure 42). Furthermore, while the health status average scores for opiate clients at the start of treatment are lower compared to national (probably owing to a more complex cohort), by the time of their six month review, opiate clients are reporting similar or better health status compared to national (Figure 42).

Figure 42: Mean Scores Given by Opiate Clients at the Start and at the 6 Month Review, B&NES, Q2 2018/19



Source: NDTMS (2019), Quarterly Outcome Commentary Report 6 Month Review, Table 12.

5.3.8 Successful Completions

All Drug Clients

Individuals who successfully complete treatment demonstrate a significant improvement in health and well-being in terms of increased longevity, reduced blood-borne virus transmission, improved parenting skills and improved physical and psychological health.

The Public Health Outcomes Framework (PHOF) has two key indicators which are aligned to drug treatment success rates, as detailed below:

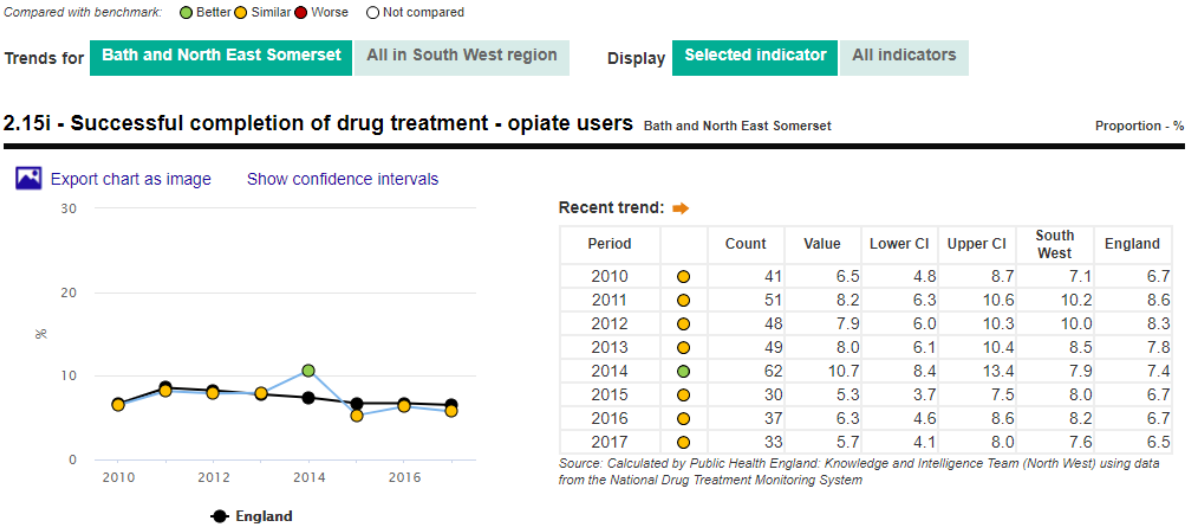
- 2.5i – '*successful completions of drug treatment – opiate users*'; and
- 2.5ii – '*successful completion of drug treatment – non-opiate users*'.

These indicators are defined as the number of drug users that left drug treatment successfully (free of drugs(s) of dependence) who do not then re-present to treatment again within 6 months as a proportion of the total number in treatment.

These indicators align with the ambition of both public health and the Government's drug strategy of increasing the number of individuals recovering from addiction. It also aligns well with the PHOF reducing re-offending outcome indicator (1.13) as offending behaviour is closely linked to substance use and it is well demonstrated that cessation of drug use reduces re-offending significantly. This in turn will have benefits to a range of wider services and will address those who cause the most harm in local communities.

Figure 43 shows show a steady decline in performance since 2011, with 5.7% of opiate clients successfully completing treatment during 2017 - a total of 33 out of 579 opiate clients in treatment during 2017. Furthermore, successful completion of opiate clients in B&NES has recently been tracking just below national, rates of which have also been falling (Figure 43).

Figure 43: Successful Completion of Drug Treatment (Opiate Users), B&NES, 2010 to 2017



Period		Count	Value	Lower CI	Upper CI	South West	England
2010		41	6.5	4.8	8.7	7.1	6.7
2011		51	8.2	6.3	10.6	10.2	8.6
2012		48	7.9	6.0	10.3	10.0	8.3
2013		49	8.0	6.1	10.4	8.5	7.8
2014		62	10.7	8.4	13.4	7.9	7.4
2015		30	5.3	3.7	7.5	8.0	6.7
2016		37	6.3	4.6	8.6	8.2	6.7
2017		33	5.7	4.1	8.0	7.6	6.5

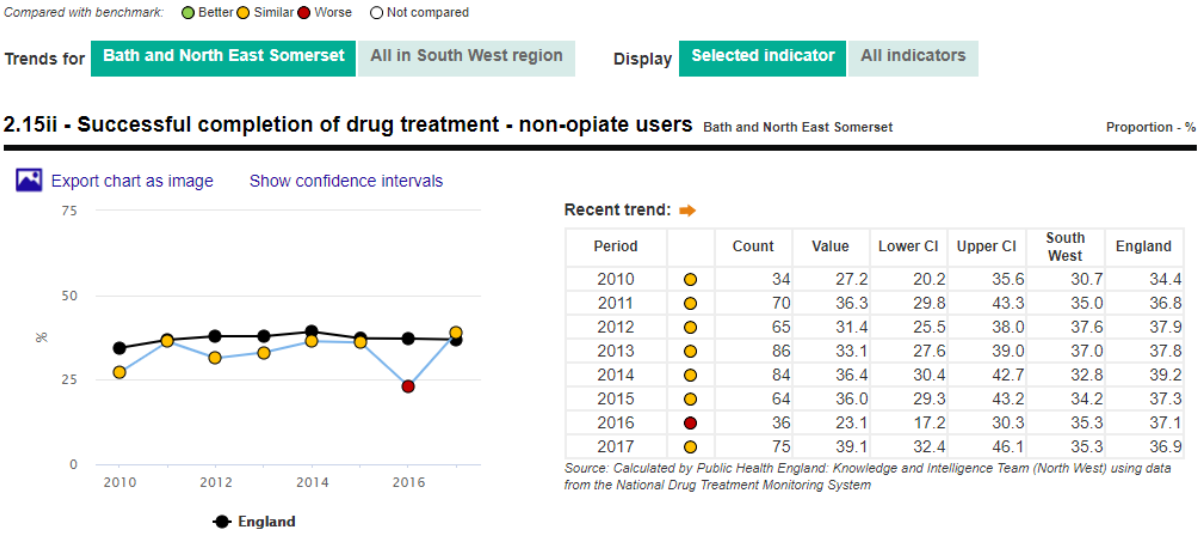
Source: PHE (2019), *Public Health Outcomes Framework (PHOF)*, available from: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework

The older opiate client cohort (2.8.5 and 4.2.1) means that many are now more likely to be experiencing cumulative physical and mental health conditions. Achieving complete recovery for many of these more complex clients is challenging, especially so when several people each year will require end-of-life care rather than treatment towards an unrealistic end goal of full recovery. There is clearly a balance to be struck between keeping these people safe in the treatment system, as opposed to focusing too heavily on a treatment system that might have too narrow a focus on recovery above all else. Indeed, the successful completion rate for opiate clients nationally is projected to continue to fall in the future.[117]

Apart from a sharp dip in 2016, Figure 44 generally tracks a slightly improving trend in successful completions for non-opiate clients in treatment, from 27.2% in 2010 to 39.1% in 2017. Generally, as with opiate clients, successful completions for non-opiate users have been tracking below national (Figure 44).

[117] PHE (2017e), *An evidence review of the outcomes that can be expected of drug misuse treatment in England*, Figure 52, available from: https://www.gov.uk/government/publications/drug-misuse-treatment-in-england-evidence-review-of-outcomes

Figure 44: Successful Completion of Drug Treatment (Non-Opiate Users), B&NES, 2010 to 2017



Source: PHE (2019), *Public Health Outcomes Framework (PHOF)*, available from: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework

The latest DOMES Report for Q3 2018/19 shows that during the period 1st October to 31st December 2018, 89% of opiate clients and 91% of non-opiate (including non-opiate and alcohol) clients no longer reported a housing need at successful completion of treatment (compared to 96% and 97% respectively for England).[118]

Drug Clients Living with Children

Figure 45 illustrates that for opiate client parents living with children in B&NES rates of successful completions have been falling, and indeed, although the latest reported figure for the period 1st January to 31st December 2018 is suppressed, B&NES's performance is lower than all the reporting periods shown in the chart and substantially lower than the comparable national rate (7.1%).

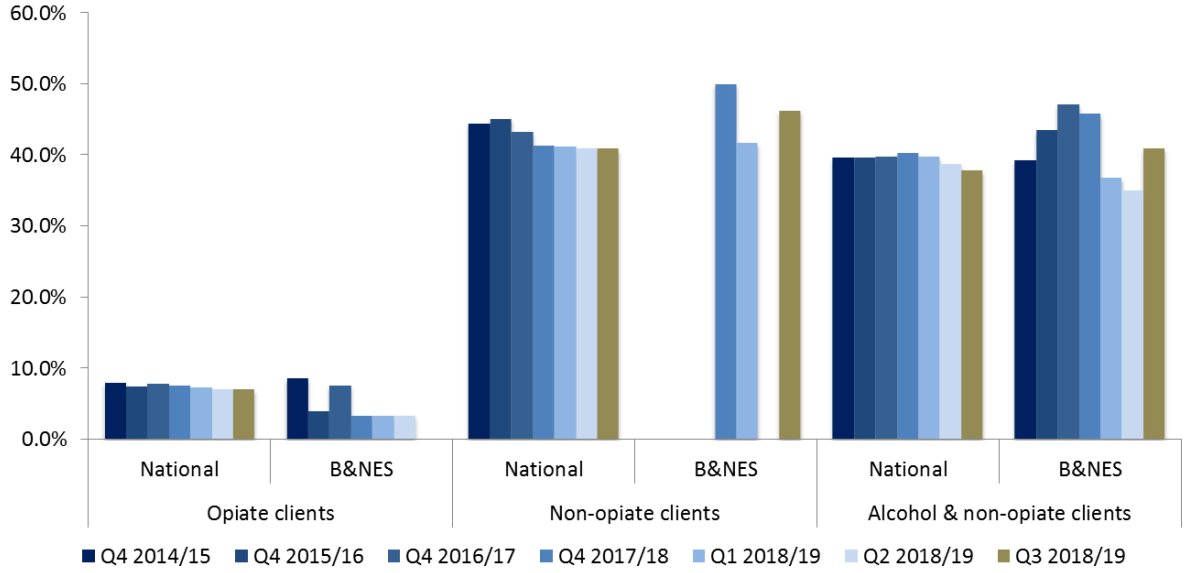
Figure 45 also illustrates, nationally at least, that successful treatment outcomes for non-opiate client parents living with children have been falling. While successful completion figures in B&NES for the latest reporting period, Q3 2018/19, are higher than national; it remains the case that fewer than half of non-opiate client parents living with children in treatment successfully complete.

These figures mean that 90% of drug clients living with children in treatment during 2018 were not successfully treated.[119]

[118] NDTMS (2019), *Diagnostic Outcomes Monitoring Executive Summary (DOMES)*, 1.6, Q3 2018/19.

[119] Representing 159 out of 177 drug clients living with children in treatment during the period 1st January to 31st December 2018.

Figure 45: Successful Completions of Drug Clients who Live with Children, B&NES, Q4 2014/15 to Q3 2018/19



Source: NDTMS (2019), *Diagnostic Outcomes Monitoring Executive Summary (DOMES)*, 2.4, Q3 2018/19 and similar for Q4 2014/15, Q4 2015/16, Q4 2016/17, Q4 2017/18, Q1 2018/19 and Q2 2018/19.
Notes: (1) Figures have been suppressed for B&NES non-opiate clients due to small numbers (below 5) for the following reporting periods: Q4 2014/15, Q4 2015/16, Q4 2016/17 and Q2 2018/19. (2) Figures have been suppressed for B&NES opiate clients due to small numbers (below 5) for the following reporting period: Q3 2018/19.

5.3.9 Re-Presentations

Re-presentations are reported as the proportion who successfully complete treatment in the first six months of the latest 12 month period and re-presented within 6 months. Over the longer term (since April 2012), re-presentations of opiate users back into treatment ranges from between 10% to as high as 40%. However, it would appear that the trend of representations is increasing for opiate users.[120] In terms of benchmarking opiate user re-presentations, B&NES appears to perform well below that of top quartile comparator local authorities.[121]

Re-presentations for non-opiate and non-opiate and alcohol clients is in the range of 0% to around 10%.[122]

5.4 Alcohol Only Treatment Cohort

5.4.1 Successful Completions

All Alcohol Only Clients

The Public Health Outcomes Framework (PHOF) has an additional indicator to measure the successful completion of alcohol only clients in treatment (2.15iii, '*Successful completion of alcohol treatment*'). As with drug clients, successful treatment is defined as those who do not re-present within 6 months.

[120] NDTMS (2019), *Diagnostic Outcomes Monitoring Executive Summary (DOMES)*, Q3 2018/19, 1.3.
[121] *Ibid.*
[122] *Ibid.*

Figure 46 illustrates that while nationally, rates of successful completions for alcohol only clients in treatment have been slowly increasing, or at least have plateaued, in B&NES rates of successful completions for alcohol only clients have been falling over time (to 38.3% in 2017).

Figure 46: Successful Completion of Alcohol Only Clients in Treatment, B&NES, 2010 to 2017

Recent trend:

Period		Count	Value	Lower CI	Upper CI	South West	England
2010		127	44.9%	39.2%	50.7%	31.0%	31.4%
2011		109	41.4%	35.7%	47.5%	39.3%	34.8%
2012		127	39.6%	34.4%	45.0%	42.2%	37.1%
2013		152	42.7%	37.7%	47.9%	41.5%	37.5%
2014		134	42.8%	37.4%	48.3%	36.4%	38.4%
2015		119	40.3%	34.9%	46.0%	35.6%	38.4%
2016		87	39.2%	33.0%	45.7%	39.2%	38.7%
2017		82	38.3%	32.1%	45.0%	39.0%	38.9%

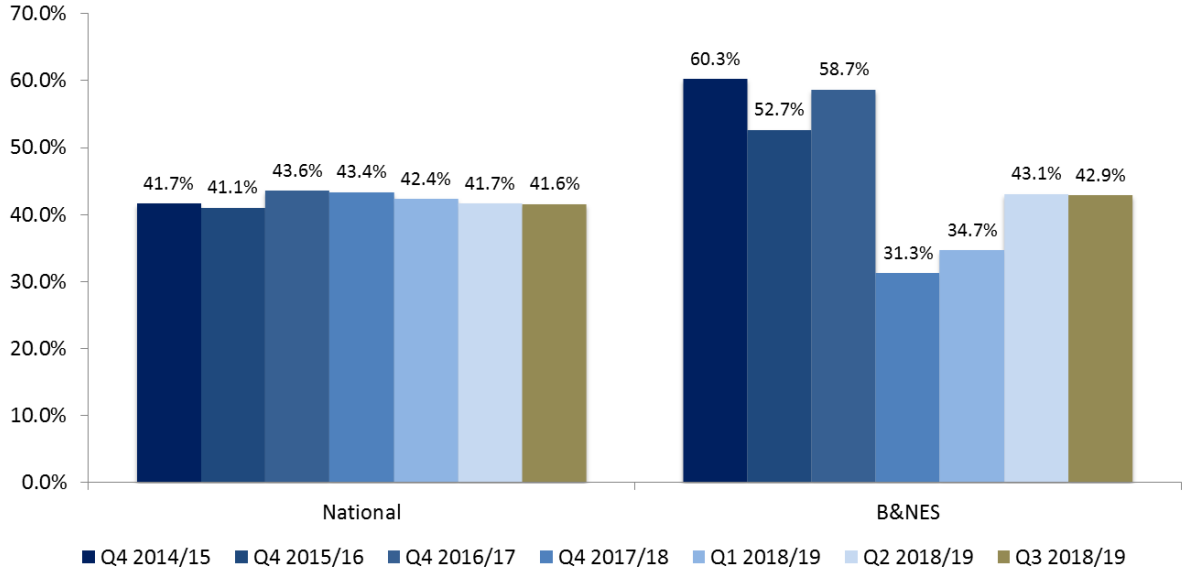
Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the National Drug Treatment Monitoring System

Source: PHE (2019), *Public Health Outcomes Framework (PHOF)*, available from: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework

Alcohol Only Clients Living with Children

Figure 47 illustrates that B&NES has seen a reduction in the successful completion rates for alcohol only client parents living with children, from around 60% during the period 2014/15 to 2016/17 to just over 40% in the most recent reporting period (1st January to 31st December 2018). Although local rates of successful completion are now similar to national, this fall in the rate of successful completions locally, combined with increasing unmet need (Figure 17) and falling numbers entering treatment (Figure 27a), mean that it is likely there are an increasing number of alcohol dependent parents living with children who are not getting their needs met.

Figure 47: Successful Completions of Alcohol Only Clients who Live with Children, B&NES, Q4 2014/15 to Q3 2018/19



Source: NDTMS (2019), *Diagnostic Outcomes Monitoring Executive Summary (DOMES)*, 2.4, Q3 2018/19 and similar for Q4 2014/15, Q4 2015/16, Q4 2016/17, Q4 2017/18, Q1 2018/19 and Q2 2018/19.

5.5 Feedback from Professionals

A workshop to seek the views of local professionals was held on 21st March 2019. A range of issues were discussed with a number of key themes being identified, which were as follows:

- **Safety of clients and relevant outcomes**:
  - People were keen to redefine recovery, taking into account client safety.
  - Having more tailored approaches to different substances and also to different client sub-groups, including a greater focus on physical health issues, for example using liver scans and lung function tests; and mental health self-care tools.
  - There were a number of issues that professionals were keen to review, including shared care of clients with GPs, optimised prescribing, supervised consumption and naloxone use.
- **Meeting the needs of parents in treatment**: one in four clients in treatment are parents living with children. However, outcomes appear to be worse in B&NES than national averages for this client group. Opportunities discussed, included:
  - early referral of parents to DHI by wider agencies;
  - a review of whether drug and alcohol services are being consistently proactive about identifying the needs of children of parents in treatment and seeking early help support;
  - redefining successful treatment that engages clients, keeps families safe and reduces harm; and
  - clear pathways for contraception advice and support, parents are not engaging so need to seek their views on what they would attend (despite excellent opportunities on offer such as 'Families in Recovery'), mentoring work around drugs, alcohol and sexual health work, a more clearly defined 'female only' offer within DHI and a more tailored LGBT offer.

- **Improving outcomes for alcohol clients**: number of alcohol only clients has fallen in recent years, leaving more complex clients and additional focus on safeguarding needs with consequent call on resources and time. A number of questions were posed, in particular:
    - are services working in isolation, and could there be better multi-agency work?
    - are services relevant and / or acceptable for different sub-groups of alcohol clients?
    - are outcomes balanced between reducing harm and promoting completion?
- **Housing and wider social issues**:
    - Early identification of needs and better integration of services across all agencies.
    - Domestic abuse, coercion, sex working.
    - Issues relating to housing, homelessness, prison release and the housing needs of older people in treatment.
    - Loneliness and isolation.
    - Debt support, training and employment pathways and tackling stigma or discrimination by employers.

5.6 Service User Feedback

A focus group discussion took place on 27th March 2019 consisting of around ten service users. They were a mix of males and females, who were mainly in recovery. The main themes to come out of this discussion were as follows:

- **Quality of substance misuse treatment services**: generally very positive feedback, with an emphasis on staff being supportive and non-judgemental. Members of the focus group also commented that they did not have to repeat their story, as well as reflecting that group work was very beneficial for learning, sharing experiences and feeling less lonely. It was felt that marketing of group work could be improved by better explaining what the groups are about. Furthermore, a request was made for a review of the mixed recovery based groups as these can be a struggle for people, and it was also felt that it would be better to have more groups for different stages of recovery.
- **Provision of substance misuse treatment services**: it was felt there is a lack of service provision outside of normal office hours, with evening and night-time support needed. Members of the focus group felt that more people would access treatment if appointments after normal office hours were offered, phone support in the evenings, more evening groups, etc. Finally, there was a feeling that monthly appointments were not frequent enough.
- **Coordination and communication between services**: a lack of coordination between addiction and mental health services, no crisis support (recovery and crisis teams available via phone, support to talk to people through situations) and long waiting lists for services outside of DHI (e.g. AWP and SARSAS) were all highlighted as important issues to address. Also highlighted was a view that communication needs to improve between SDAS and DHI, particularly co-locating.

6.0 Harm Reduction

6.1 Introduction

Harm reduction refers to policies and practices that try to reduce the harm that people do to themselves or others from their drug use. It can be contrasted with primary prevention which tries to prevent people using drugs in the first place, or to stop them using once they've started.

There are a wide range of different harm reduction initiatives in place. These can include among others:

- needle exchange schemes;
- supervised consumption;
- drug testing in clubs and at festivals;
- 'blue light' services for treatment resistant drinkers;
- drug testing facilities;
- drug-related mortality and morbidity and the overdose response, as well as naloxone peer distribution in the community; and
- providing information on safer drug use.

Some of these harm reduction initiatives are covered in more detail in this chapter.

6.2 Drug-Related Deaths (DRDs)

Drug misuse is a significant cause of premature death and the ultimate harm when it comes to misusing drugs. Understanding and preventing drug-related deaths (DRDs) is an important function of a recovery-orientated drug treatment system. Furthermore, understand learning from local DRDs will improve harm reduction initiatives.

6.2.1 Definitions

Deaths from drug poisoning include accidents, suicides and assaults involving drug poisoning, as well and deaths from drug abuse and drug dependency (both legal and illegal drugs). Some of these deaths may also be from complications of drug abuse, such as deep vein thrombosis or septicaemia from intravenous drug use, rather than acute drug overdose.

Drug misuse deaths are defined as deaths where the underlying cause is drug abuse or drug dependence or is drug poisoning involving one or more substances controlled under the Misuse of Drugs Act 1971. This is a subset of deaths from drug poisoning.

Although there is no accepted international definition of the term 'drug-related deaths', the ONS and many others use the 'wider' definition of all drug poisoning deaths, i.e. deaths coded to accidental poisoning, and intentional self-poisoning by drugs, medicaments and biological substances, whether or not a drug listed under the Misuse of Drugs Act was present in the body.

6.2.2 National Picture

In August 2018 ONS released their latest annual publication of registered deaths related to drug poisoning (DRDs) in England and Wales.[123] There were 3,482 DRDs in England during 2017, the highest number since the beginning of the time series in 1993. Between 2012 and 2017 there was a 47% increase in the number of DRDs in England.

During 2017 two-thirds of DRDs in England were related to drug misuse (2,310), a proportion that has increased steadily since 1993, when it stood at 38%. Other findings relating to drug misuse deaths in England during 2017 include:

- 8 out of 10 deaths were due to accidental poisoning (with the remainder being due to suicide [15%] or mental and behavioural disorders due to drug use [5%]);
- the male mortality rate was two and a half times higher than the comparable female rate (60.1 and 23.4 per 1 million respectively);
- one in three were aged 40-49, the age group with the highest mortality rate (102.2 per million); and
- deaths involving diamorphine (heroin) and/ or morphine doubled between 2012 and 2017, increasing from 579 to 1,164 deaths respectively;[124]
- a marked increase in deaths involving cocaine (112 deaths in 2011 to 432 deaths in 2017) and 75 fatalities involving the synthetic opioid fentanyl.[125]

In addition, further national analysis by PHE found that drug misuse accounted for nearly 1 in 8 deaths among people in their 20s and 30s registered during 2015.[126]

Figure 48 illustrates the older age profile of drug misuse deaths in England & Wales, with mortality rates highest among those aged between 30 and 49 years old. In addition to the long-term increase in mortality rates among this age group there has been a particularly sharp increase in the mortality rate since 2012. However, some of this steeper increase could be a return to trend following a period in 2010 to 2012 when there was a reduction in the availability of street heroin.[127]

[123] ONS (2018c), *Deaths related to drug poisoning in England and Wales: 2017 registrations*, available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2017registrations

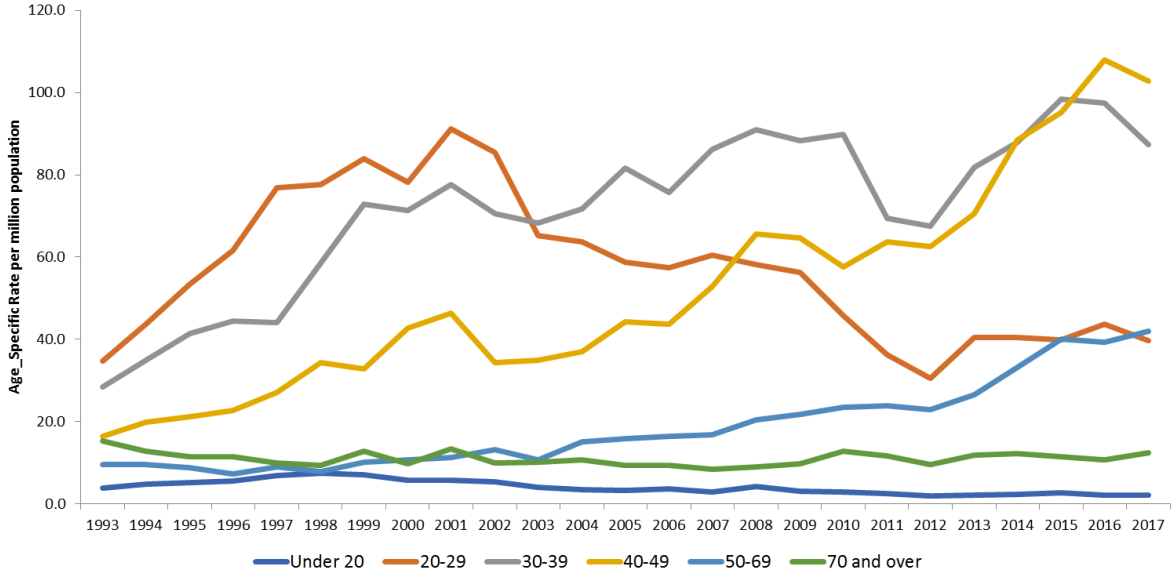
[124] This finding relates to deaths in both England & Wales rather than just England.

[125] *Ibid.*

[126] PHE (2017), *op. cit.*

[127] Home Office (2016), *Impact of the reduction in heroin supply between 2010 and 2011*, available from: https://www.gov.uk/government/publications/impact-of-the-reduction-in-heroin-supply-between-2010-and-2011

Figure 48: Age-Specific Mortality Rates of drug misuse deaths in England & Wales by age group, 1993 to 2017



Source: ONS (2018c), *Deaths related to drug poisoning in England and Wales: 2017 registrations*, available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2017registrations

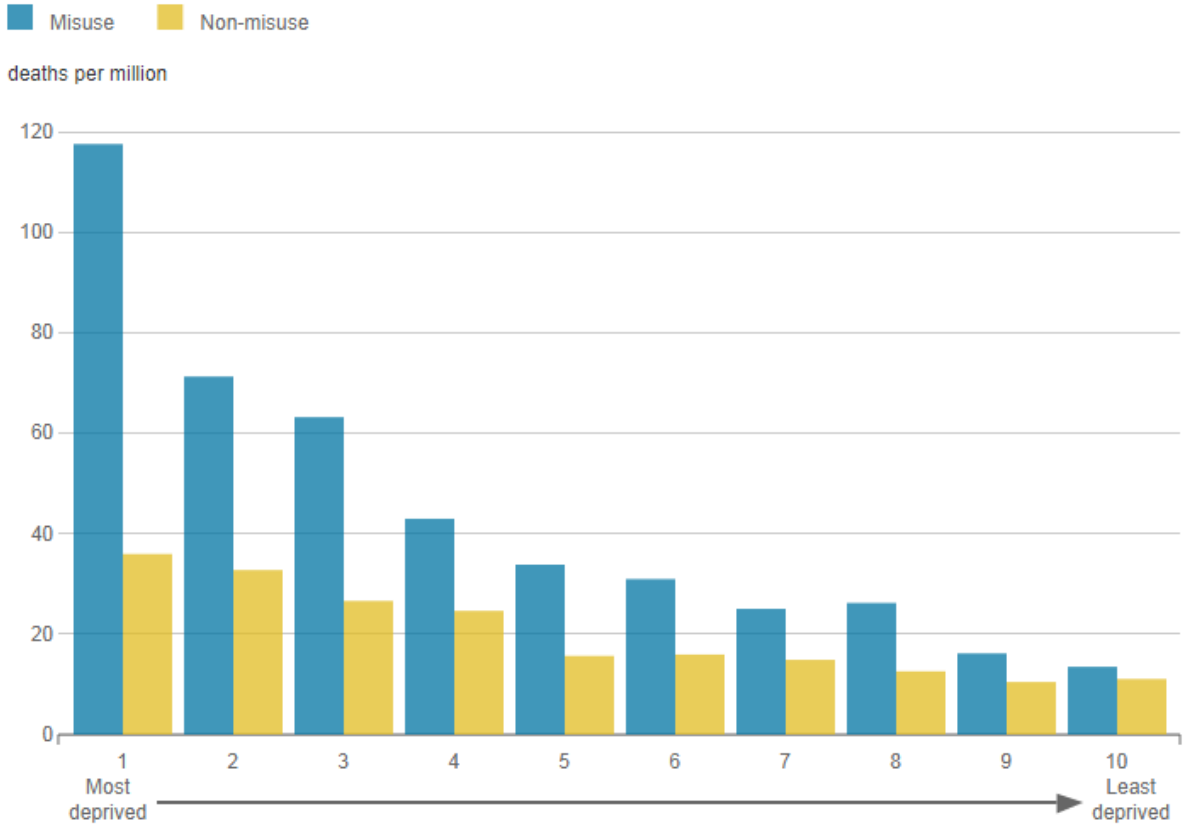
The more general increasing trend of deaths is likely due to older long-term diamorphine (heroin) and morphine users with failing health and higher overdose risks.[128] Indeed, the Advisory Council on the Misuse of Drugs (ACMD) reported in December 2016 that a probable cause of the recent increase in DRDs was the existence of prematurely ageing cohort of people who have been using heroin since the 1980s and 1990s.[129] There are a number of other related or contributory effects, including: increasing suicides, increasing deaths among women (though these are still a minority of all deaths), improved identification and reporting, an increase in polydrug and alcohol use, and an increase in the prescribing of some medicines (though it's not yet clear that there is any causal link with the rise in DRDs).[130]

[128] PHE (2018h), *Drug misuse deaths fall but still remain too high*, Public Health Matters, available from: https://publichealthmatters.blog.gov.uk/2018/08/08/drug-misuse-deaths-fall-but-still-remain-too-high/

[129] ACMD (2016), *Reducing Opioid-Related Deaths in the UK*, available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/576560/ACMD-Drug-Related-Deaths-Report-161212.pdf

[130] PHE (2016b), *Understanding and preventing drug-related deaths: the report of a national expert working group to investigate drug-related deaths in England*, available from: https://www.gov.uk/government/publications/preventing-drug-related-deaths

Figure 49: Death Rates by Deprivation Decile for Drug Misuse and Non-Misuse, England, 2016



Source: ONS (2018d), *More than half of heroin/morphine misuse death hotspots in England and Wales are seaside locations*, available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/halfofheroinmorphinemisusedeathhotspotsinenglandandwalesareseasidelocations/2018-04-04

Notes: (i) Drugs misuse deaths – Deaths coded to mental and behavioural disorders due to psychoactive substance use or death where a controlled substance is mentioned. (ii) Deaths from non-misuse of drugs – Not coded to mental and behavioural disorder due to psychoactive substance use and no mention of a controlled substance.

Figure 49 illustrates that DRDs in England is very strongly associated with deprivation. The ONS also found that six of the 10 local authority districts in England and Wales with the highest rates of heroin- and/or morphine-misuse deaths are coastal holiday resorts, for example, Blackpool.[131]

In August 2018 the ONS published a 'deep-dive' study into a sample of 115 coroners' records of drug-related deaths in seven coroners' areas throughout England).[132] The attributes most commonly observed were:

- White;
- single or divorced;
- living alone;
- unemployed;

[131] ONS (2018d), *More than half of heroin/morphine misuse death hotspots in England and Wales are seaside locations*, available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/halfofheroinmorphinemisusedeathhotspotsinenglandandwalesareseasidelocations/2018-04-04

[132] ONS (2018e), *Drug-related deaths "deep dive" into coroners' records*, available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/drugrelateddeathsdeepdiveintocoronersrecords/2018-08-06

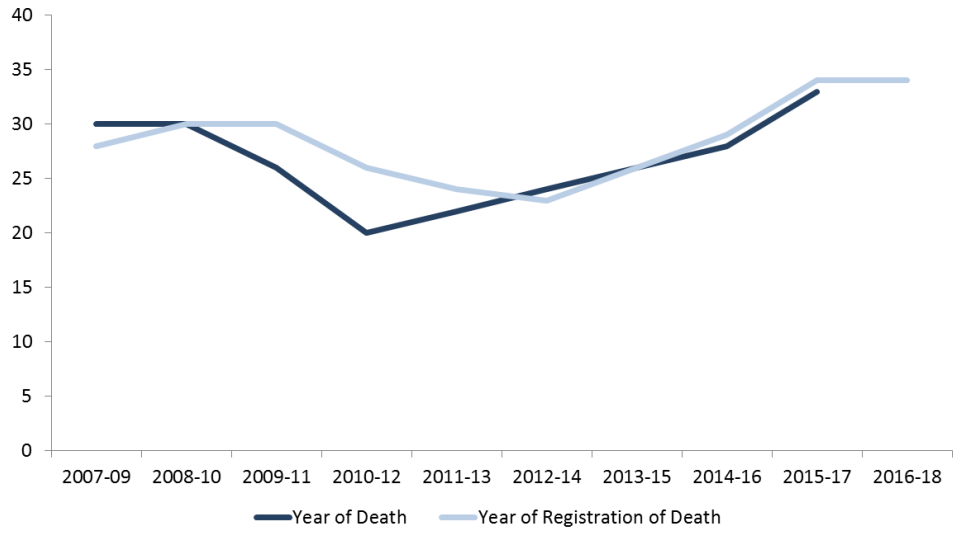
- male;
- prior history of drug use;
- found having already died; and
- history of mental health issues.

This suggests a vulnerable, at-risk population engaging in unsafe drug-taking practices such as taking drugs alone and consuming multiple different types of drug alongside alcohol.

6.2.3 Local Picture

Figure 50 shows the number of DRDs that occurred and were registered during a three year rolling period between 2007-09 to 2016-18 where the person who died was a usual resident of B&NES. There is a clear rising local trend in the number of DRDs since 2011-13.

Figure 50: Number of Drug-Related Deaths (DRDs), B&NES, 2007-09 to 2016-18



Source: Local analysis of Primary Care Mortality Data (PCMD).
Notes: (1) deaths where the underlying cause of death has been coded to one of the following categories: (i) accidental poisoning by drugs, medicaments and biological substances (***X40–X44***); (ii) intentional self-poisoning by drugs, medicaments and biological substances (***X60–X64***); (iii) poisoning by drugs, medicaments and biological substances, undetermined intent (**Y10–Y14**); (iv) assault by drugs, medicaments and biological substances (***X85***); and (v) mental and behavioural disorders due to drug use (excluding alcohol and tobacco)(***F11-F16, F18-F19***). (2) The number of deaths that occurred during the period 2016-18 is not shown due to delays in registering deaths, particularly DRDs.

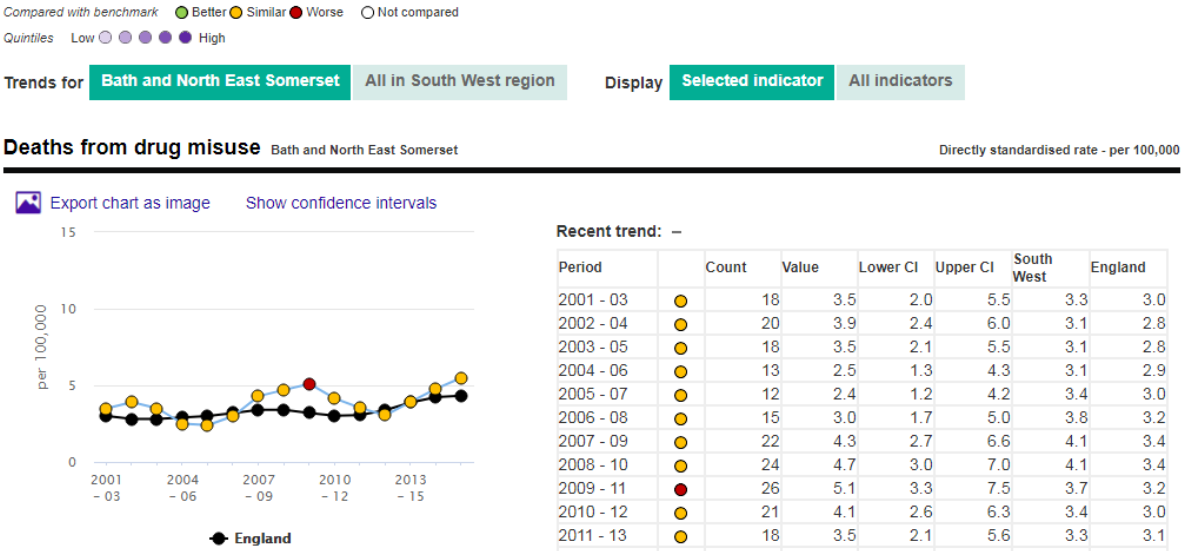
Following a recent multi-agency meeting to review suspected DRDs in B&NES it is likely there will be a further increase in the number of DRDs, probably registered during 2019, i.e. once inquest verdicts have been reached and death certificates issued.

During the decade 2009-2018 there were 96 DRDs registered in B&NES. Seven in ten (69%) DRDs in B&NES during this period were aged 40 or over when they died, somewhat higher than the comparable for England (58% for the period 2008-2017). This may suggest a slightly older profile of deaths compared to England. Furthermore, 73% of DRDs in B&NES during this period were male, similar to the comparable for England during the period 2008-2017 of 69%.

B&NES is an area of relatively low deprivation, thus indicating B&NES should also have relatively low rates of drug misuse deaths (Figure 49). However, this is not the case (Figure 51).

Figure 51 illustrates the rising trends in national and local deaths from drug misuse. In B&NES the death rate from drug misuse peaked in 2009-11 (5.1 deaths per 100,000 population) before falling to a recent low of 3.0 per 100,000 in 2012-14. However, the more recent steep rise locally has seen the death rate from drug misuse once again peak, but this time to a historical high of 5.5 deaths per 100,000 population (higher compared to national death rate of 4.3 per 100,000 population, but not significantly so).

Figure 51: Deaths from Drug Misuse, B&NES and England, 2001-03 to 2015-17



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	South West	England
2001 - 03		18	3.5	2.0	5.5	3.3	3.0
2002 - 04		20	3.9	2.4	6.0	3.1	2.8
2003 - 05		18	3.5	2.1	5.5	3.1	2.8
2004 - 06		13	2.5	1.3	4.3	3.1	2.9
2005 - 07		12	2.4	1.2	4.2	3.4	3.0
2006 - 08		15	3.0	1.7	5.0	3.8	3.2
2007 - 09		22	4.3	2.7	6.6	4.1	3.4
2008 - 10		24	4.7	3.0	7.0	4.1	3.4
2009 - 11		26	5.1	3.3	7.5	3.7	3.2
2010 - 12		21	4.1	2.6	6.3	3.4	3.0
2011 - 13		18	3.5	2.1	5.6	3.3	3.1
2012 - 14		15	3.0	1.7	5.0	3.4	3.4
2013 - 15		19	3.9	2.4	6.2	3.8	3.9
2014 - 16		23	4.8	3.0	7.2	4.3	4.2
2015 - 17		28	5.5	3.6	8.0	4.6	4.3

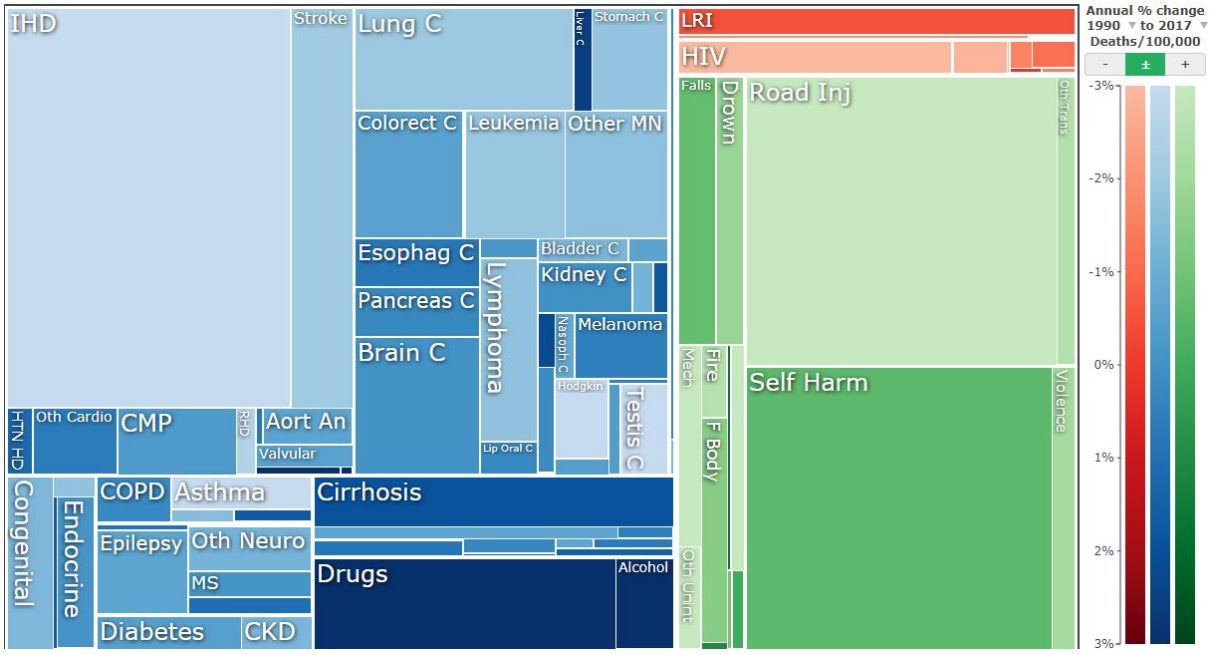
Source: Office for National Statistics (ONS)

Source: PHE (2019), *PHOF*, 2.15iv - Deaths from drug misuse, available from: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework

Notes: deaths where the underlying cause of death has been coded to one of the following categories and where a drug controlled under the Misuse of Drugs Act 1971 was mentioned on the death certificate: (i) accidental poisoning by drugs, medicaments and biological substances (***X40–X44***); (ii) intentional self-poisoning by drugs, medicaments and biological substances (***X60–X64***); (iii) poisoning by drugs, medicaments and biological substances, undetermined intent (**Y10–Y14**); (iv) assault by drugs, medicaments and biological substances (***X85***); and (v) mental and behavioural disorders due to drug use (excluding alcohol and tobacco)(***F11-F16, F18-F19***).

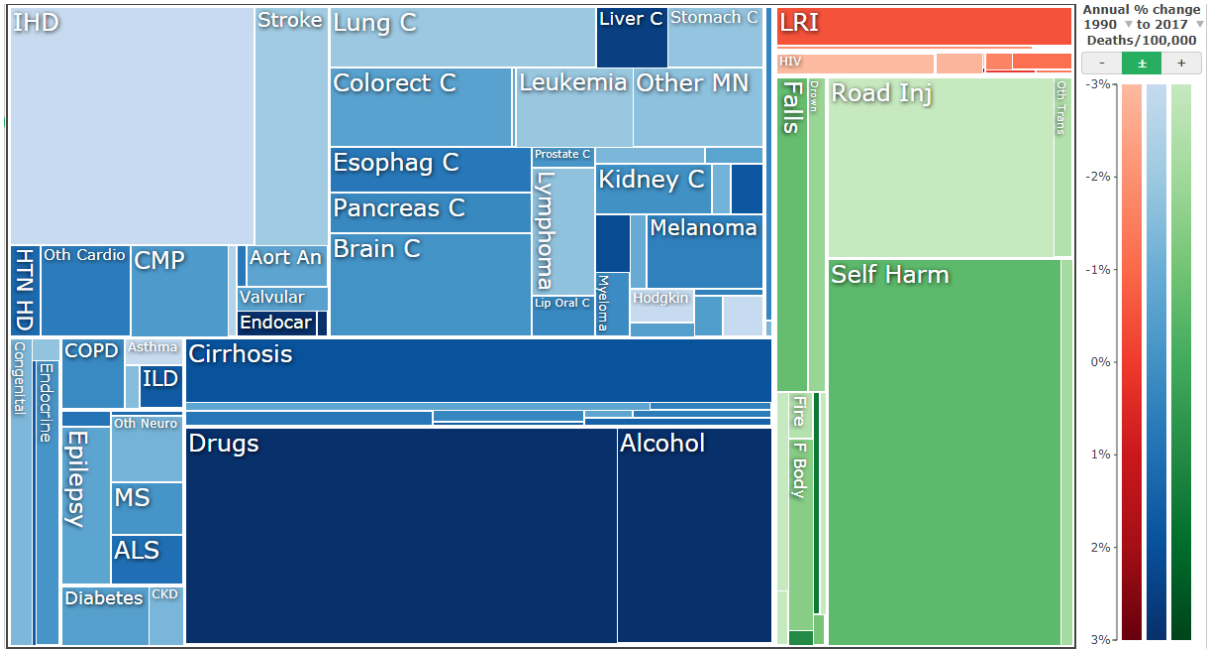
Figure 52 and Figure 53 illustrate the mortality burden of drugs on male younger and middle aged adults (aged 15-49) – in 1990 drugs and alcohol accounted for 1 in 20 (4.9%) deaths of this cohort, which by 2017 accounted for nearly 1 in 5 of total deaths (18.84%). This also means that drugs and alcohol are one of the leading causes of death for males aged 15 to 49 in B&NES.

Figure 52: Causes of Death, B&NES, Males, 15-49 years, 1990



Source: Global Burden of Disease Tool, available from: https://vizhub.healthdata.org/gbd-compare/

Figure 53: Causes of Death, B&NES, Males, 15-49 years, 2017



Source: Global Burden of Disease Tool, available from: https://vizhub.healthdata.org/gbd-compare/

The following are findings from a local review of notified DRDs in B&NES during the period April 2015 to March 2017:[133]

- there were 13 sudden onset[134] DRDs in B&NES that we know of during the period April 2015 to March 2017, an average of 6 or 7 each year;

[133] Scott, P. (2017), *Drug-related deaths in B&NES:A brief analysis of data from April 2015 to March 2017.*

[134] Sudden onset deaths are commonly associated with overdose caused by a combination of opioid drugs (heroin or methadone) and other drugs such as benzodiazepines and alcohol.

- the majority of deaths were amongst young to middle aged men, in touch with treatment services and in the city of Bath;
- most sudden-onset (directly drug-related) deaths were from intoxication with morphine or methadone;
- gradual onset[135] deaths were mainly due to suicide or poor lung or heart health;
- self-harm and mental illness were common features; and
- overdose prevention or harm reduction through naloxone seems to be the most important actions for the group of people with sudden onset deaths.

6.3 Alcohol-Specific Deaths

Alcohol misuse can be directly attributed to deaths from certain types of diseases, for example, alcoholic liver disease. This section presents information on the number of deaths that are specific to alcohol consumption. The data source is the ONS which uses the new National Statistics (NS) definition of alcohol-specific deaths.[136] This definition only includes conditions where each death is a direct consequence of alcohol misuse. The definition[137] is primarily based on chronic (longer-term) conditions associated with continued misuse of alcohol and, to a lesser extent, acute (immediate) conditions.

In December 2018 ONS released their latest annual publication of registered deaths specific to alcohol in England and Wales.[138] The findings are as follows:

- In 2017, there were 7,697 alcohol-specific deaths in the UK, an age-standardised rate of 12.2 deaths per 100,000 population.
- For the UK, alcohol-specific death rates have increased in recent years to similar rates observed in 2008 where they were at the highest recorded.
- Since the beginning of the time series in 2001, rates of alcohol-specific deaths among males have been more than double those observed among females (16.8 and 8.0 deaths per 100,000 in 2017 respectively).

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[135] Gradual onset deaths are caused by a range of health harms that arise due to the vulnerability created by the underlying drug use. These harms include blood borne viruses and respiratory disease and can lead to cardiovascular, respiratory and liver related deaths. Poor mental health and suicide risk are also common issues.

[136] Until 2017 all deaths where alcohol poisoning was mentioned on the death certificate have been included in both PHE's alcohol-specific mortality measure and the alcohol-related mortality measure. The alcohol-specific measure is designed to count all deaths which have been wholly and exclusively caused by alcohol consumption whereas the alcohol related measure includes a proportion of deaths from conditions which are known to be partially attributable to alcohol. New analysis from the Office for National Statistics (ONS) has revealed that, in the majority of cases where alcohol poisonings (ethanol poisoning, methanol poisoning and the toxic effects of alcohol - ICD10 codes T51.0, T51.1 and T51.9 respectively) are mentioned on the death certificate, drug poisoning is also mentioned. Hence, it is not possible to conclude that all deaths involving these forms of alcohol poisoning have exclusively been caused by alcohol consumption. As a result of this new finding, and to align the PHE definition of alcohol-specific mortality with the ONS definition, deaths involving these alcohol poisonings have been removed from the alcohol-specific measure.

[137] Including: ***E24.4*** Alcohol-induced pseudo-Cushing's syndrome; ***F10*** Mental and behavioural disorders due to use of alcohol; ***G31.2*** Degeneration of nervous system due to alcohol; ***G62.1*** Alcoholic polyneuropathy; ***G72.1*** Alcoholic myopathy; ***I42.6*** Alcoholic cardiomyopathy; ***K29.2*** Alcoholic gastritis; ***K70*** Alcoholic liver disease; ***K85.2*** Alcohol-induced acute pancreatitis; ***K86.0*** Alcohol induced chronic pancreatitis; ***Q86.0*** Foetal induced alcohol syndrome (dysmorphic); ***R78.0*** Excess alcohol blood levels; ***X45*** Accidental poisoning by and exposure to alcohol; ***X65*** Intentional self-poisoning by and exposure to alcohol; ***Y15*** Poisoning by and exposure to alcohol, undetermined intent.

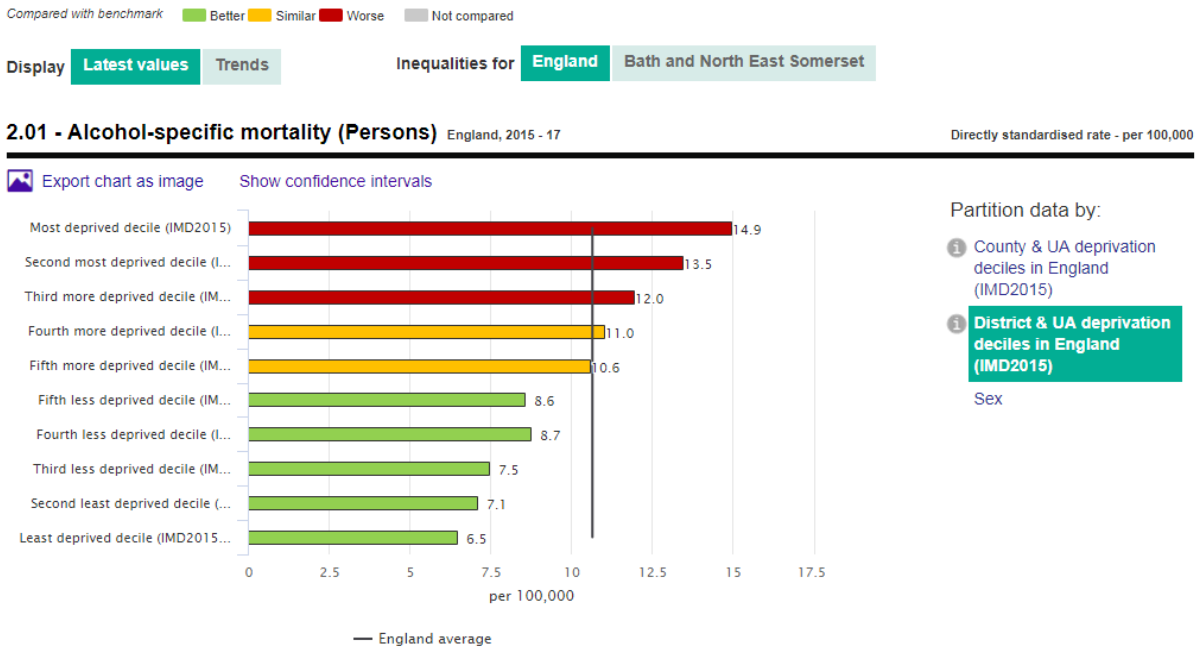
[138] ONS (2018f), *Alcohol-specific deaths in the UK: registered in 2017*, available from: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/alcoholrelateddeathsintheunitedkingdom/registeredin2017

- In 2017, alcohol-specific death rates were highest among 55- to 59-year-old females and 60- to 64-year-old males.

NHS Digital report that during 2016 alcoholic liver disease accounted for 82% of alcohol-specific deaths in England.[139]

Figure 54 illustrates that alcohol-specific mortality in England is strongly associated with deprivation, with the rate in the most deprived decile being over twice the rate in the least deprived decile – 14.9 and 6.5 per 100,000 population respectively.

Figure 54: Inequality in Alcohol-Specific Mortality, England, 2015-17

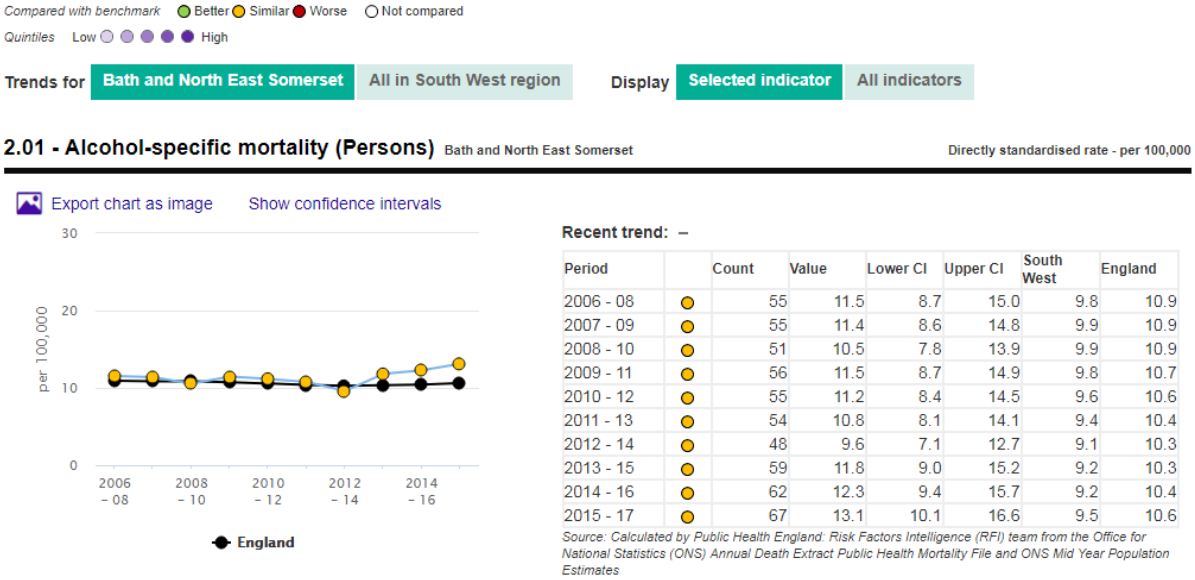


Source: PHE (2018), *Local Alcohol Profiles for England*, available from: https://fingertips.phe.org.uk/profile/local-alcohol-profiles

Figure 55 illustrates that rates of alcohol-specific deaths have been increasing in B&NES since 2013-15, having previously been tracking the national trend. The latest rate of alcohol-specific mortality during 2015-17 for B&NES is the highest it has been since 2006-08 and is higher than the comparable national mortality rate (13.1 and 10.6 per 100,000 population respectively).

[139] NHS Digital (2018b), *Statistics on Alcohol, England, 2018 [PAS]*, available from: https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-alcohol/2018/part-2

Figure 55: Alcohol-Specific Mortality, B&NES and England, 2006-08 to 2015-2017



Period		Count	Value	Lower CI	Upper CI	South West	England
2006 - 08		55	11.5	8.7	15.0	9.8	10.9
2007 - 09		55	11.4	8.6	14.8	9.9	10.9
2008 - 10		51	10.5	7.8	13.9	9.9	10.9
2009 - 11		56	11.5	8.7	14.9	9.8	10.7
2010 - 12		55	11.2	8.4	14.5	9.6	10.6
2011 - 13		54	10.8	8.1	14.1	9.4	10.4
2012 - 14		48	9.6	7.1	12.7	9.1	10.3
2013 - 15		59	11.8	9.0	15.2	9.2	10.3
2014 - 16		62	12.3	9.4	15.7	9.2	10.4
2015 - 17		67	13.1	10.1	16.6	9.5	10.6

Source: Calculated by Public Health England: Risk Factors Intelligence (RFI) team from the Office for National Statistics (ONS) Annual Death Extract Public Health Mortality File and ONS Mid Year Population Estimates

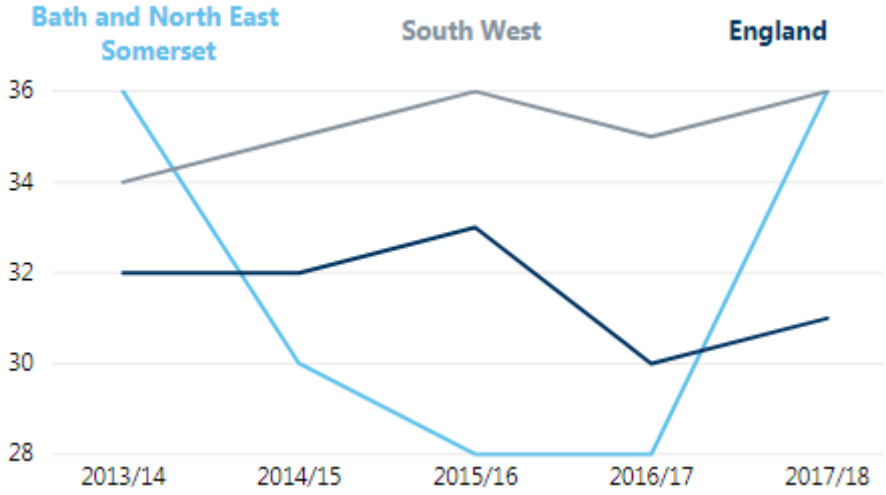
Source: PHE (2018), *Local Alcohol Profiles for England*, available from: https://fingertips.phe.org.uk/profile/local-alcohol-profiles
Notes: deaths from alcohol-specific conditions (three years pooled) based on underlying cause of death registered in the calendar year for all ages. All causes of deaths from ethanol poisoning, methanol poisoning and the toxic effect of alcohol are now excluded from this indicator.

6.4 Morbidity

6.4.1 Hospital Admissions for Poisoning by Drug Misuse

Figure 56 illustrates that the rate of hospital admissions for B&NES increased between 2016/17 and 2017/18 from 28 per 100,000 to 36 per 100,000 population. There were 70 admissions for poisoning by drug misuse during 2017/18 among B&NES GP registered patients.

Figure 56: Hospital Admission Rates per 100,000 population for Poisoning by Drug Misuse, B&NES South West and England, 2013/14 to 2017/18



Source: NHS Digital (2018c), *Statistics on Drug Misuse, England, 2018 (November update)*, available from: https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-drug-misuse/november-2018-update

6.5 Deaths of Clients Engaged in Treatment Services

The first nine months of the financial year 2018/19 has seen more deaths of clients engaged in treatment than in 2014/15, 16 to date (Table 5).

Table 5: Number of Deaths of Clients Engaged in Treatment Services, B&NES, 2014/15 to Q3 2018/19

2014/15	2015/16	2016/17	2017/18	year to date, end of Q3 2018/19
<5	9	12	<5	16

Source: NDTMS (2019), *Diagnostic Outcomes Monitoring Executive Summary (DOMES)*, 2.11, Q3 2018/19 and similar for Q4 2014/15, Q4 2015/16, Q4 2016/17 and Q4 2017/18.

6.6 Drug-Related Overdose and Naloxone

In 2014 the World Health Organization produced guidelines recommending that countries expand naloxone access to people likely to witness an overdose in their community in order to reduce the global burden of death from overdose.[140] Naloxone is a prescription-only medicine, so pharmacies cannot sell it over the counter. But drug services can supply it without a prescription. Anyone can use it to save a life in an emergency.

An expansion of naloxone provision is critical to address rising drug-related deaths.

Training in overdose prevention, care of the unconscious patient and the administration of naloxone has been an on-going initiative within B&NES. The training programme targets people who inject drugs, as the group at highest risk; it also prioritises training of people who are most likely to have contact with this group, including friends, partners, family and staff of services where contact with people at higher-risk of overdose is likely.

Table 6 shows there are some 150 naloxone kits issued every year for 2017 and 2018, including some 120 clients in treatment. The average period of time before expiry of syringe kits at the date of issue is eighteen months to two years. Therefore, it is assessed there are likely to be around 250 naloxone kits in circulation at the moment in B&NES.

Table 6: Naloxone Syringe Kits Training (including issue), B&NES, 2016 to 2018

Year	Clients trained	Staff trained	Total
2016	103	9	**112**
2017	125	23	**148**
2018	121	32	**153**

Source: Avon & Wiltshire Mental Health Partnership (AWP).

[140] WHO (2014), Community management of opioid overdose, available from: https://www.who.int/substance_abuse/publications/management_opioid_overdose/en/

Staff groups that have been trained over the past 18 months include the following organisations:

- Julian House Night Shelter
- Barnabas House
- Corn Street
- New King Street
- Rackfield House
- DHI
- SDAS
- Project 28
- Big Issue
- Night Marshalls and voluntary ambulance service
- Lifestyle Pharmacy (Westgate Street)

6.7 Blood-Borne Viruses (BBVs)

Blood-borne viruses (BBVs) are infections that can be transmitted through a number of routes, including blood-to-blood contact. They comprise Hepatitis C, Hepatitis B and HIV. People who live with a BBV may show little or no symptoms of serious disease, though all of these viruses – if untreated – are associated with severe ill health. Since people can live with these infections for long periods of time without experiencing symptoms there are two important risks that should be considered; firstly, that the individual's health could have been seriously damaged before medical attention is sought, and secondly, that there is an extended period of time over which the infection could be transmitted to others.

People who inject drugs (PWID) are vulnerable to a wide range of viral and bacterial infections, which can result in high levels of morbidity and mortality. Human Immunodeficiency Virus (HIV), hepatitis B virus (HBV) and hepatitis C virus (HCV) are very effectively transmitted through the use of shared needles and syringes. Unsterile injection practices are also associated with bacterial infections such as Staphylococcus aureus and Group A streptococci. Rare but life-threatening infections with spore-forming bacteria such as tetanus, botulism and anthrax can be associated with contaminated drugs.

NICE Public Health Guidelines 52 titled '*Needle and Syringe Programmes*' was published in March 2014.[141] The second recommendation is for health and wellbeing boards, directors of public health, commissioners and public health practitioners to collate and analyse data on injecting drug use. This section achieves this recommendation.

6.7.1 Prevalence of Injecting Behaviour

Across England, Wales and Northern Ireland the level of needle and syringe sharing among those currently injecting psychoactive drugs has fallen from 23% in 2007 to 18% in 2017.[142]

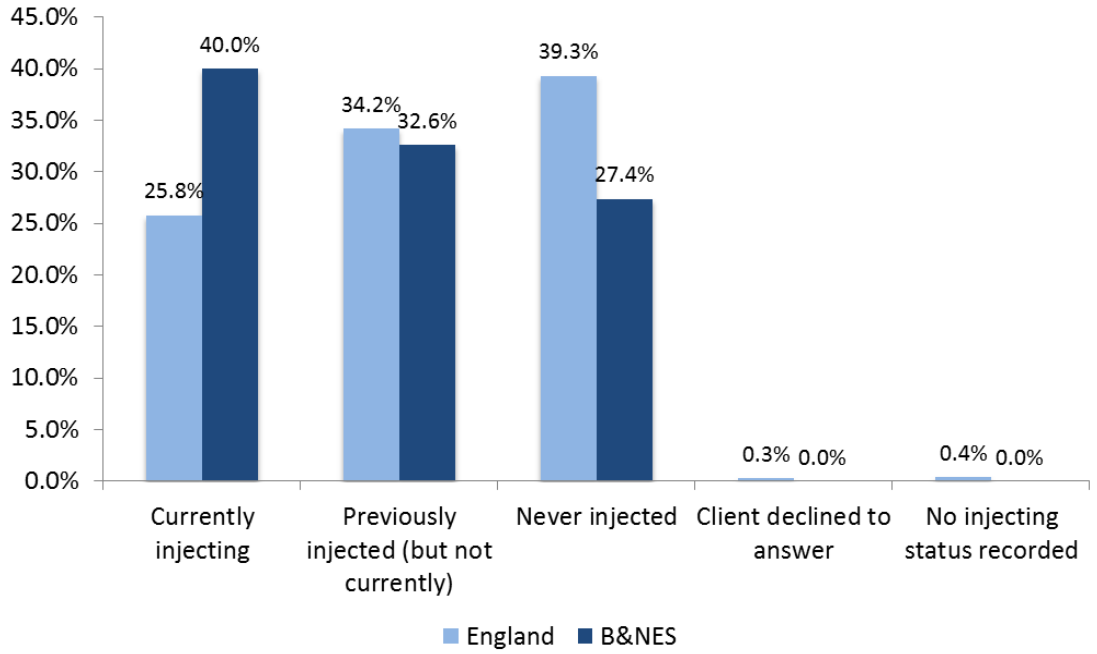
Figure 57 illustrates that B&NES's opiate clients newly entering during 2017/18 were nearly twice as likely to be currently injecting compared to England - 40.0% (70 out of 175 clients) and 25.8%

[141] NICE (2014a), *Needle and Syringe Programmes*, PH52, available from: https://www.nice.org.uk/guidance/ph52

[142] PHE (2018i), *Shooting Up: infections among people who inject drugs in the UK*, Accompanying Data, Table 3a, available from: https://www.gov.uk/government/publications/shooting-up-infections-among-people-who-inject-drugs-in-the-uk

respectively. A third of opiate clients entering treatment in B&NES during the 2017/18 had previously injected, similar to national. Therefore, almost three-quarters of opiate clients entering treatment in B&NES during 2017/18 were either currently injecting or had previously injected. These statistics would suggest that clients entering drug treatment services in B&NES are more likely to at risk of BBVs compared to national.

Figure 57: Injecting Status of Opiate Clients New into Treatment, England and B&NES, 2017/18



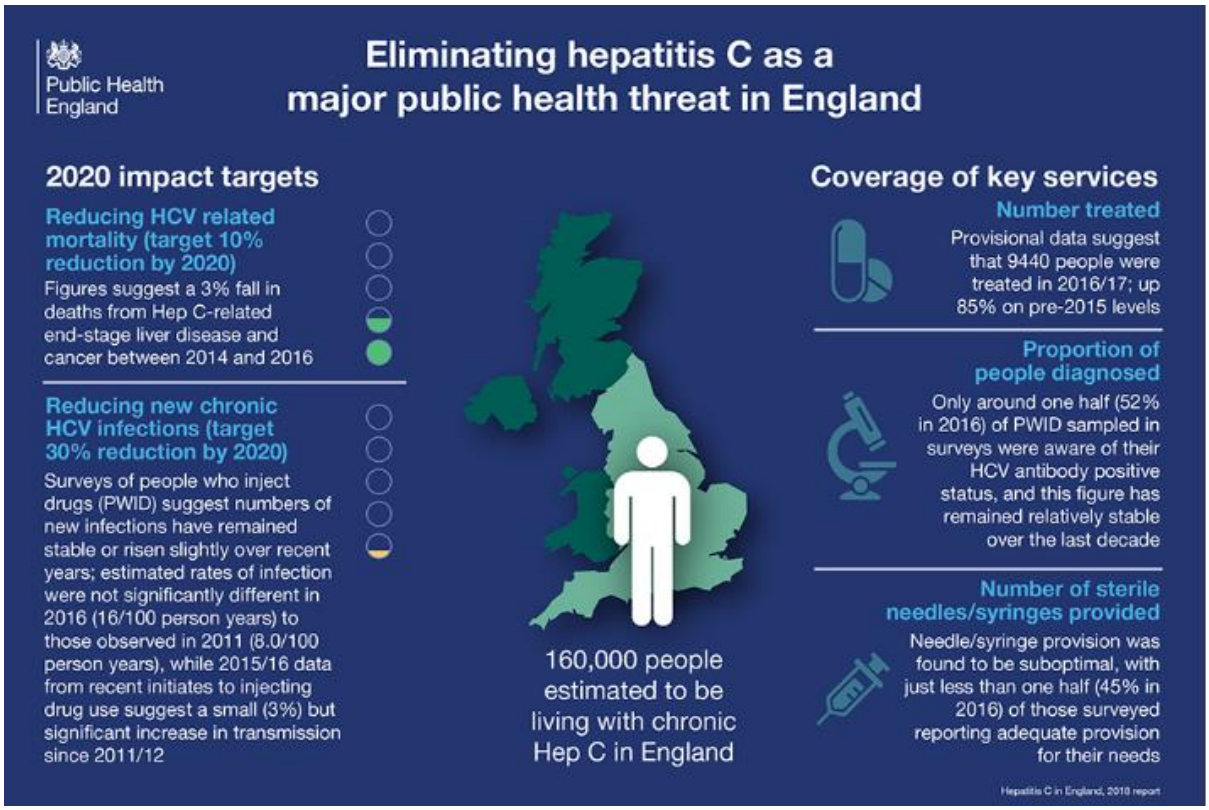
Source: NDTMS (2018), *Adult Partnership Activity Report*, Q4 2017/18.
Note: There were 175 clients new into treatment during 2017/18 who's drug use was classified as either: (i) opiate only; (ii) opiate and non-opiate; (iii) opiate and alcohol; and (iv) opiate alcohol and non-opiate. Non-opiate and non-opiate & alcohol clients were excluded due to the very small number currently injecting.

6.7.2 Hepatitis C Virus (HCV)

In May 2016, the UK signed up to the World Health Organization (WHO) Global Health Sector Strategy (GHSS) on Viral Hepatitis[143] which commits participating countries to the elimination of HCV as a major public health threat by 2030. To move towards elimination, the WHO set interim targets of a 30% reduction in infections and a 10% reduction in mortality by 2020 (Figure 58).

[143] WHO (2016), *Global health sector strategy on viral hepatitis 2016-2021*, available from: https://www.who.int/hepatitis/strategy2016-2021/ghss-hep/en/

Figure 58: Hepatitis C in England, 2018 Infographic



Source: PHE (2018j), Hepatitis C in England: 2018 infographic, available from: https://www.gov.uk/government/publications/hepatitis-c-in-the-uk/hepatitis-c-in-the-uk-2018-infographic

Injecting drug use continues to be the most important risk factor for HCV infection, being cited as the risk in around 90% of all laboratory reports in the UK where risk factors have been disclosed.[144] In England, PHE's vision is that all people at risk of HCV infection should have access to testing and, once tested, that action should be taken to reduce their risk of infection and to prevent further transmission of the virus, or – if they are infected – to place the patient on a treatment pathway.[145]

There were 15 new cases detected of Hepatitis C in B&NES during 2017, representing a rate of 8.0 per 100,000 population. This is substantially lower than detection rates during the period 2012 to 2015, when the rates for B&NES were between 20.0 and 30.0 per 100,000 population.[146]

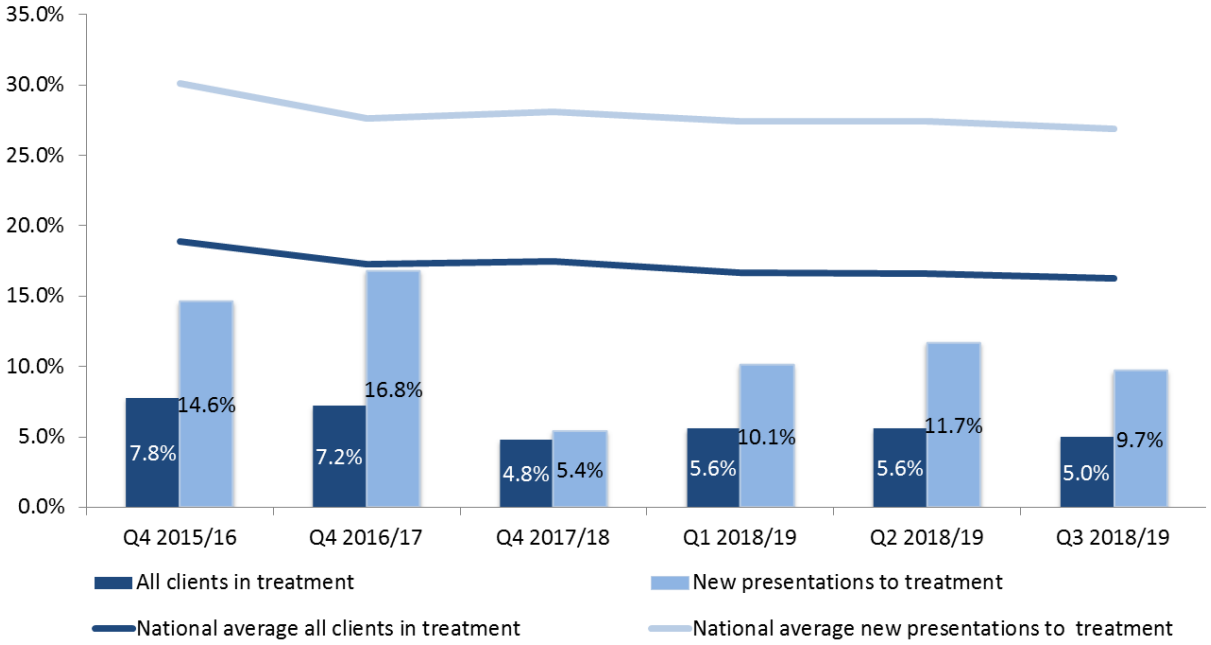
Hepatitis C testing is monitored across the treatment service for all clients who are current or previous injectors, regardless of substance group. In B&NES HCV testing rates among eligible drug and alcohol clients in treatment are consistently better than national (Figure 59). For example, as at the end of Q3 2018/19, 5.0% of all previously or currently injecting drug and alcohol clients in treatment who were eligible for testing had **no** record of a HCV test, which compares very well to the national comparable rate of 16.3%.

[144] PHE (2018j), *Hepatitis C in England and the UK*, available from: https://www.gov.uk/government/publications/hepatitis-c-in-the-uk

[145] *Ibid.*

[146] PHE (2019), *Hepatitis C Annual Report: Supporting Charts*, January 2019v1.2, Lab Reports-UTLA.

Figure 59: Proportion of All and New Eligible Clients in Treatment with No Record of a HCV Test, B&NES, Q4 2015/16 to Q3 2018/19



Source: NDTMS (2019), *Diagnostic Outcomes Monitoring Executive Summary (DOMES) Report*, 2.7, Q3 2018/19 and similar for previous quarters.
Note: the proportion of clients in treatment at the end of the reporting period who were eligible for a HCV test but have no record of one taking place.

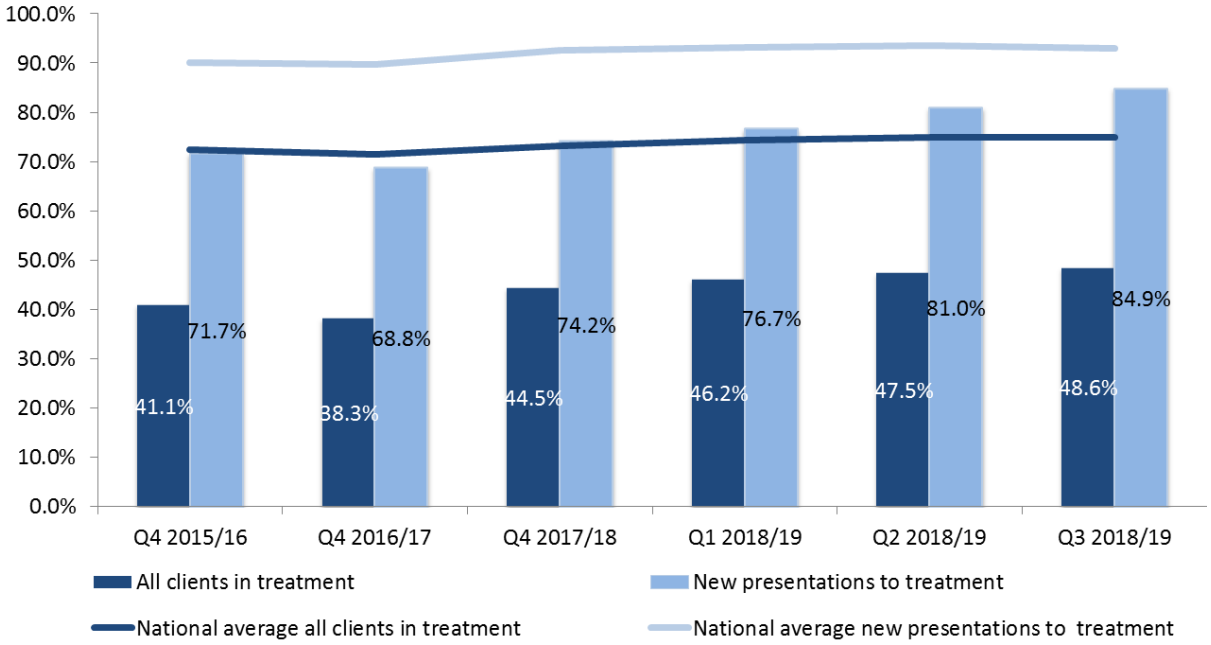
6.7.3 Hepatitis B Virus (HBV)

The proportion of PWID who have ever been infected with hepatitis B virus (HBV) in England, Wales and Northern Ireland has declined slightly over the last 10 years, falling from 16% in 2017 to 20% in 2017.[147] This underlines the continued need to ensure that the treatment system maintains the ability to identify, and make use of the opportunities for regular offering tests to those at risk. B&NES has a dedicated nurse across the integrated treatment system and Dried Blood Spot (DBS) testing is available for all clients who are identified as at risk of BBVs.

Courses of completed hepatitis B vaccinations are monitored across the treatment service for all clients regardless of substance group. In B&NES HBV vaccination rates among drug and alcohol eligible clients in treatment are consistently better than national (Figure 60). As at the end of Q3 2018/19, 48.6% of all drug and alcohol clients in treatment who were eligible had no record of completing a course of HBV vaccinations, which compares very well to the national comparable rate of 75.0%. However, there is a rising trend in the proportions of all and new clients with no record of completing a course of HBV vaccination locally.

[147] PHE (2018i), *Shooting Up: infections among people who inject drugs in the UK*, Accompanying Data, Table 1b, available from: https://www.gov.uk/government/publications/shooting-up-infections-among-people-who-inject-drugs-in-the-uk

Figure 60: Proportion of All and New Eligible Clients in Treatment with No Record of an HBV Vaccination Course, B&NES, Q4 2015/16 to Q3 2018/19



Source: NDTMS (2019), *Diagnostic Outcomes Monitoring Executive Summary (DOMES) Report*, 2.6, Q3 2018/19 and similar for previous quarters.
Note: the proportion of clients in treatment at the end of the reporting period who were eligible for a HBV vaccination course but have no record of completing a course.

6.7.4 Human Immunodeficiency Virus (HIV)

Human Immunodeficiency Virus (HIV) can be acquired through unprotected sex, injecting drug use, mother to child and blood/blood products.

In the UK, around 1 in 100 PWID are living with HIV.[148] Most have been diagnosed and will be accessing care. However, often HIV is diagnosed at a late stage among PWID.[149] The latest national notification data show that, in 2017, there were 115 new HIV diagnoses among PWID in the UK.[150] This is the smallest number since 1998, when there were 229 new HIV diagnoses among PWID.

B&NES continues to be a low prevalence area for HIV, with 0.86 infections per 1,000 population aged 15-59 years (2017), compared to 1.27 per 1,000 in the South West region and 2.32 per 1,000 in England.[151]

In B&NES all injecting drug users are offered HIV screening.

6.7.5 Ceasing or Reducing Injecting Behaviour

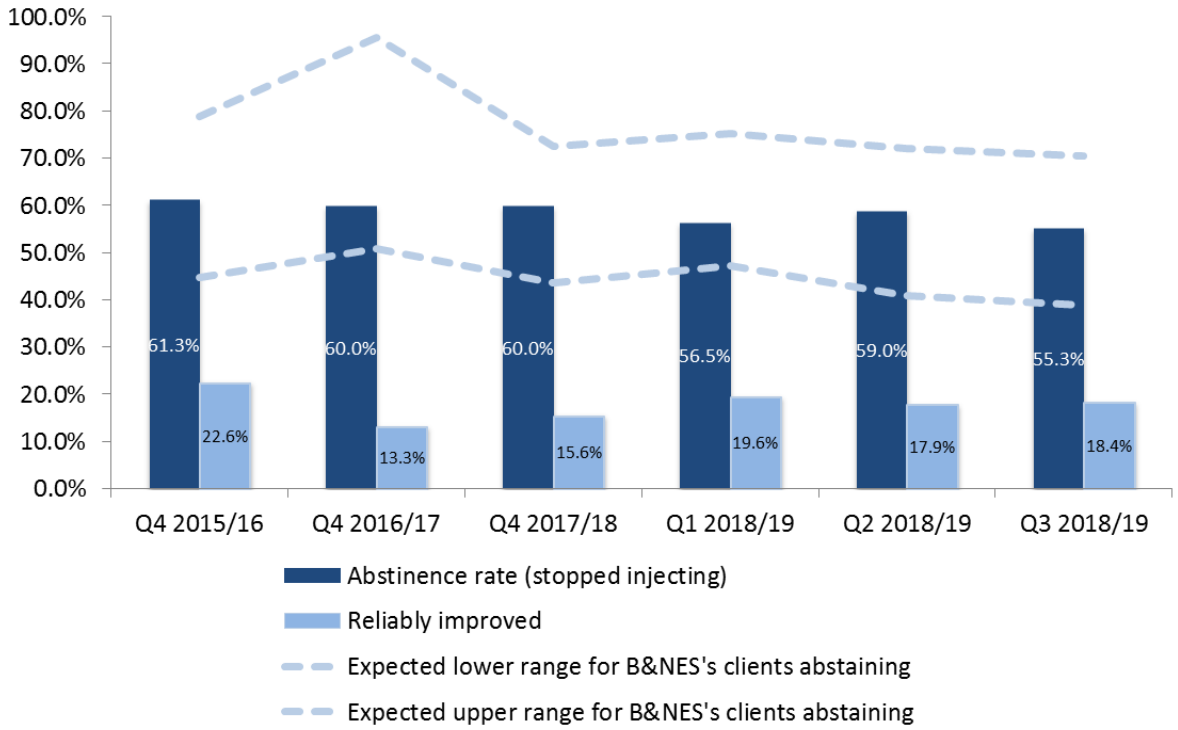
Data from NDTMS indicates that the English drug treatment system performs favourably when compared to the average level of cessation of injecting seen in other international research studies of

[148] *Ibid.*
[149] *Ibid.*
[150] PHE (2018k), *HIV: annual data tables*, available from: https://www.gov.uk/government/statistics/hiv-annual-data-tables
[151] SOPHID/HARS (Survey of Prevalent HIV Infections Diagnosed/HIV and AIDS Reporting System).

treatment system outcomes, increasing from 52% for those in treatment for three months, to 58% and 61% for those in treatment for six months and one year, respectively.[152]

Figure 61 illustrates that clients in drug treatment in B&NES who were injecting at the start of their treatment were in the expected range for ceasing injecting at their 6 month review, with between 55% and 60% consistently having stopped injecting altogether since 2015/16. Furthermore, the proportion of clients in drug treatment who had sufficiently reduced their injecting behaviour is also reported, for example, during the 12 months up to the 31st December 2018 a further 18.4% of injecting drug clients had reliably improved (but not abstained) their injecting behaviour.

Figure 61: Proportion of Injecting Clients at the Start of their Drug Treatment who Report Having Ceased or Reduced Injecting at their 6 Month Review, B&NES, Q4 2015/16 to Q3 2018/19 (12 month rolling)



Source: NDTMS (2019), *Diagnostic Outcomes Monitoring Executive Summary (DOMES) Report*, 2.6, Q3 2018/19 and similar for previous quarters.

6.7.6 Needle and Syringe Programme (NSP)

For those in treatment who are unable or unwilling to cease injecting, and for those injecting drug users in the community who are not in treatment, then there is a long standing recognition of the importance of encouraging people who inject drugs to inject more safely and to use clean injecting equipment. One such policy often adopted is to provide needle and syringe programmes (NSP) to assist users in reducing the risk of acquiring and transmitting BBVs. A number of European studies,

[152] PHE (2017e), *An evidence review of the outcomes that can be expected of drug misuse treatment in England*, available from: https://www.gov.uk/government/publications/drug-misuse-treatment-in-england-evidence-review-of-outcomes

outlined in a recent Cochrane review,[153] shows that NSPs are associated with a 50% to 60% reduction in the risk of PWID acquiring hepatitis C.

Eight community pharmacies in B&NES, as well as two static DHI bases, provide the local NSP. Six of the eight pharmacies are located in the Bath (including Bathavon) area, with the other two located in the Somer Valley area.[154] The pharmacy service supplements the two NSPs delivered by DHI from bases in Midsomer Norton (The Hub, which is open from 1pm to 3pm Mondays and Thursdays) and Bath City Centre (Riverside Health Centre, which is open from 3pm to 5pm Tuesdays and Fridays and 4pm to 7pm Thursdays). The two static needle exchanges provide a full range of 'pick and mix' injecting equipment including needles and syringes, water amps, spoons, filters, swabs, sharps boxes, Vit C and Citric Acid. The needle exchange is staffed by members of the Engagement Team who provide harm reduction advice, naloxone training and BBV interventions, alongside the injecting equipment. Clients are also able to return used injecting equipment for safe disposal. The pharmacies stock two pre-made packs, an opiate pack and a stimulant pack. Each pack contains enough equipment for ten injections. The pharmacists will also deliver brief harm reduction interventions and signpost to specialist services.

Table 7 shows there are around 100 clients who inject every year accessing NSP services from the two static bases (Riverside Health Centre and The Hub). Each client who injects has an average of four transactions every year. However, the data shows that the majority of injecting clients who use the two static basis have only one or two transactions per year, while some one in eleven injecting clients have ten or more transactions per year.

Table 7: Number of Clients and Transactions, Needle and Syringe Programme (NSP), DHI Static Bases, B&NES, 2016 to 2018

	Unique Clients	Transactions	Average Number of Transactions
2016	94	418	4
2017	81	289	4
2018	104	415	4

Source: Sam Blacker, DHI.
Note: numbers only apply to the two DHI static bases at Riverside Health Centre and The Hub, Midsomer Norton.

6.7.7 People who Inject Image and Performance Enhancing Drugs (IPEDs)

The key focus and provision of pharmacy needle exchange in B&NES focuses on intravenous using clients in treatment. However, people who inject image and performance enhancing drugs (IPEDs) may not be in treatment and require different equipment and advice in order to facilitate harm

[153] Platt. L., Minozzi. S., Reed J., et. al. (2017), Needle syringe programmes and opioid substitution therapy for preventing hepatitis C transmission in people who inject drugs, *Cochrane Database of Systematic Reviews*, Issue 9, Art. No.: CD012021, DOI: 10.1002/14651858.CD012021.pub2.

[154] B&NES (2018c), *Bath and North East Somerset Pharmaceutical Needs Assessment 2018 to 2021*, section 3.5.6, available from: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/pharmacies

reduction and safer injecting practice. NICE Guidance PH52[155] recommends that syringes and specialist advice is available for IPEDs, but acknowledges that there is a lack of local evidence about the number of people who inject these drugs, how this group uses needle exchange, and the effectiveness and cost effectiveness of providing programmes to these groups.

Over the past decade NSPs have seen a changing profile of those accessing their services. Broadly speaking, nationally many NSPs have reported an increase in the number of steroid users, particularly among men aged 18-25, presenting in the last few years, fuelled by the increasing pressures to look good.[156]

The likely risks taken by opiate users are reasonably well understood and methods of harm reduction including behaviour change and provision of correct equipment are widely implemented. Until recently the evidence base around BBV epidemiology, harm reduction and best practice among IPED users has been less well understood. This picture is now beginning to change. For example, research found that of 395 men known to 19 NSPs across England and Wales who injected IPEDs, 1 in 20 (5%) had been exposed to hepatitis C, 1 in 11 (9%) exposed to hepatitis B and 1 in 65 (0.5%) were diagnosed with HIV. Overall this indicated that 1 in 10 of this cohort had been exposed to one or more BBVs.[157]

Within the B&NES area building an epidemiological profile of BBV rates among IPEDs has presented a challenge. To address this, members of the DAAT worked in partnership with the treatment service to set up a pilot with a local gym in February 2016. Liver and kidney testing and dietary advice were offered as an incentive to attract people to have BBV screening. Of a total of 21 IPEDs seen, 18 consented blood-borne virus screening. No cases of exposure to Hepatitis B, Hepatitis C or diagnoses of HIV were identified. When asked, no one within the group reported re-using any injecting equipment, sharing of vials with others or other likely means of exposure (for example, allowing one's self to be injected by others). The sample size is too small to extrapolate from and a more representative picture of BBV prevalence among this group will require screening of IPEDs across a range of settings within B&NES, including NPSs. Notwithstanding this, these initial findings of no cases of BBV exposure are encouraging.

6.8 Opioid Substitution Therapy (OST) and Supervised Consumption

In the UK, pharmacists play a frontline role in the delivery of opioid substitution therapy (OST). The pharmacist or registered technician supervises the consumption of methadone, naltrexone, buprenorphine or the combination drug of naloxone and buprenorphine at the point of dispensing in the pharmacy ensuring that the dose has been administered appropriately to the service user. There are many individual and societal benefits of supervised consumption, but few more so than reduced deaths.[158]

[155] NICE (2014a), *op. cit.*

[156] NICE (2014b), *Limit spread of blood-borne viruses among steroid users*, available from: https://www.nice.org.uk/news/article/limit-spread-of-blood-borne-viruses-among-steroid-users

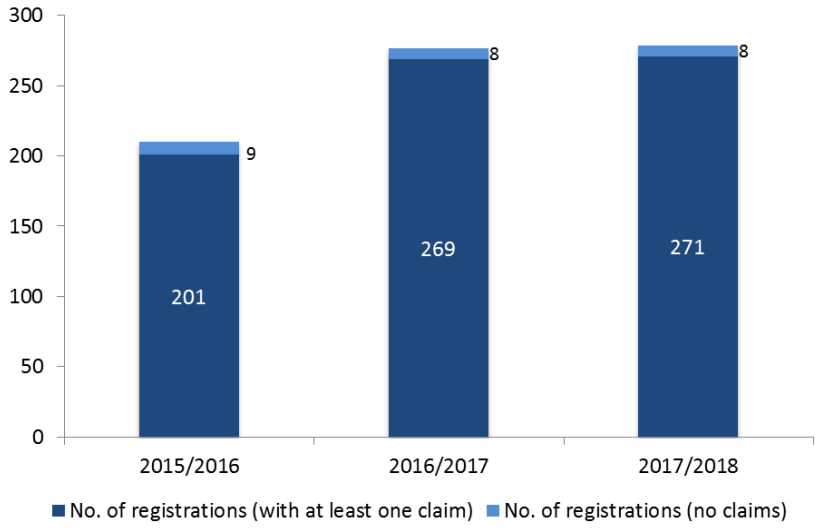
[157] Hope, V. D., McVeigh, J., Marongiu, A., et al. (2013), Prevalence of, and risk factors for HIV, hepatitis B and C infections among men who inject image and performance enhancing drugs: a cross-sectional study, *BMJ*, available from: https://bmjopen.bmj.com/content/3/9/e003207

[158] Strang, J., Hall, W., Hickman, M. & Bird, S. (2010), Impact of supervision of methadone consumption on deaths related to methadone overdose (1993-2008): analyses using OD4 index in England and Scotland, *BMJ open*, 2010;341:c4851.

In February 2019 there were 31 community pharmacies providing this service, out of 34 accredited providers and 39 community pharmacies in B&NES.[159] This represents an increase in the number of community pharmacies delivering this service since March 2017, when 25 community pharmacies were providing the service.[160]

The annual number of new registrations where there was at least one supervised consumption is currently running at around 270 per year (Figure 62). It is probable that the smaller number of newly registered clients during 2015/16 was dues to recording onto a relatively new system.

Figure 62: Newly Registered Supervision Consumption Clients, B&NES, 2015/16 to 2017/18



Source: PharmOutcomes, accessed 6 February 2019.

The age and gender profiles of those registering for supervised consumption, as you would expect, are very similar to the age and gender profiles of opiate users in treatment, i.e. middle-aged (most common age being 35-39) and male (70%).[161]

Over a third of all registrations (36%) during the three year period 2015/16 to 2017/18 were at four of the larger community pharmacies in Bath city centre.

There is a consistent pattern of around 80% of supervised consumption claims being made for methadone, and 20% for Buprenorphine.

Figure 63 illustrates that there has been an increase in the number of claims per month over the period January 2015 to November 2018, from an average of 200 claims per month during 2015 and 2016 to around 300 claims per month during 2017 and January to November 2018. This growth appears to be mainly from a rise in methadone administration claims. This is at the same time as there have been no increase in the number of new registrations. There are likely to be a number of possible explanations for this, namely:

(i) there has been an increase in the length of time clients are on OST (we already know there has not been an increase in the number of new clients registering); and/or

[159] PharmOutcomes, accessed 6 February 2019.

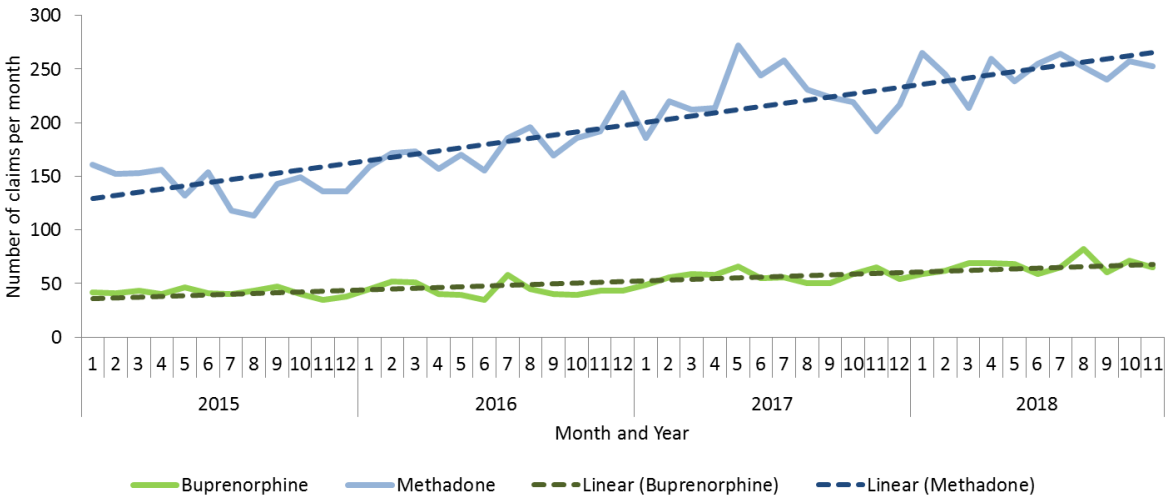
[160] B&NES (2018c), *Bath and North East Somerset Pharmaceutical Needs Assessment 2018 to 2021*, section 3.5.6, available from: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/pharmacies

[161] PharmOutcomes, accessed 6 February 2019.

(iii) there has been an increase in the number of claims that pharmacists have been submitting for payment (i.e. having not previously been submitting all claims that could have been submitted).

Until further detailed enquiries and analysis can be carried out it is not possible to determine which of these possible reasons are behind this increase.

Figure 63: Number of Monthly Claims for Supervised Consumption, Jan 2015 to Nov 2018, B&NES



Source: PharmOutcomes, accessed 6 February 2019.

6.9 Sexualised Drug Use (SDU) and 'Chemsex'

Sexualised drug use (SDU), the use of drugs in a sexual context, has emerged as a marker of high-risk sexual activity and poor sexual health, particularly among gay, bisexual and other men who have sex with men. Patterns of drug use among these sexual minority cohorts have changed over time - shifting from the use of 'club drugs' such as cocaine and ecstasy to the use of drugs associated with 'Chemsex', namely Mephedrone, GHB/GBL and methamphetamine. A review of the available academic literature, published in 2018, concluded that the prevalence estimates that exist vary considerably due to differences in the definition used and population assessed.[162]

While further research is needed, there are no reasons to doubt that some residents in B&NES are taking part in SDU and/or 'Chemsex', thus placing these people at greater risk of harm.

6.10 Drug Test Facilities

Addaction has announced that it has opened the UK's first drug safety checking facility licensed by the Home Office in Weston-Super-Mare. The facility opened on 22nd February 2019 and is being run in partnership with the University of Hertfordshire and The Loop.

Since 2016, drug safety checking has been on offer at some UK festivals and city centres, but never before has it received Home Office backing.

[162] Edmundson, C., et. al. (2018), Sexualised drug use in the United Kingdom (UK): A review of the literature, *International Journal of Drug Policy*, **55**:131-148, available from: https://doi.org/10.1016/j.drugpo.2018.02.002

7.0 Co-occurring Mental Health and Alcohol/Drug Use ('Dual Diagnosis')

7.1 Introduction

The term 'dual diagnosis' describes the coexistence of mental health problems and the problematic use of substances including alcohol and drugs. People with 'dual diagnosis' are a very vulnerable group.

7.2 Substance Misuse Treatment Cohorts

Alcohol and drug dependence are common among people with mental health problems and the relationship between them is complex. The majority (70% or more) of community substance use treatment clients have co-occurring mental health problems.[163]

Table 8 shows that local clients entering treatment during 2017/18 are more likely than nationally to have been identified with a mental health treatment need - 53% and 41% respectively. Considering the greater complexity of local clients in treatment compared to national (5.3.4), this finding would be expected. Locally, non-opiate (only) clients appear to be the client group with the highest rate of co-occurring mental health need, around 3 in 5 (Table 8).

Table 8: Adults who Entered Treatment Identified with a Mental Health Treatment Need, 2017/18

Client Substance Category	Number of new presentations (B&NES)	% of new presentations with a mental health treatment need (B&NES)	% of new presentations with a mental health treatment need (England)
Opiate	89	50%	39%
Non-opiate	22	59%	41%
Non-opiate and alcohol	38	52%	47%
All drug clients	**149**	**52%**	**41%**
Alcohol only	76	55%	41%
All clients	**225**	**53%**	**41%**

Source: PHE(2018f), Adults - drugs commissioning support pack 2019-20: key data: planning for drug prevention, treatment and recovery in adults, B&NES, unpublished as restricted statistics.

[163]PHE (2017d), *Better care for people with co-occurring mental health, and alcohol and drug use conditions*, available from: https://www.gov.uk/government/publications/people-with-co-occurring-conditions-commission-and-provide-services

7.3 Substance Misuse Clients Receiving Mental Health Treatment

Of the 149 drug clients who entered treatment during 2017/18 with an identified mental health treatment need (Table 8), 107 (72%) were receiving treatment[164] for their mental health need (compared to 71% nationally).[165]

Of the 76 alcohol only clients who entered treatment during 2017/18 with an identified mental health treatment need (Table 8), 54 (71%) were receiving treatment for their mental health need (compared to 79% nationally).[166]

The majority of clients entering treatment during 2017/18 who were receiving mental health treatment were doing so through their GP - 76% of drug clients[167] and 65% of alcohol only clients.[168]

7.4 Unmet Need

From the analysis presented in 7.3 there would appear to be 42 drug clients (28%), and a further 22 alcohol only clients (29%), who entered treatment during 2017/18 whose mental health needs were not being met.

7.5 Future Plans for Community Mental Health Services

The new NHS Long Term Plan proposes new and integrated models of primary and community mental health care that will support adults and older adults with severe mental illnesses.[169] A new community-based offer will include access to psychological therapies, improved physical health care, employment support, personalised and trauma-informed care, medicines management and support for self-harm and coexisting substance use.

In the meantime, however, Bath and North East Somerset (B&NES) Council and Clinical Commissioning Group (CCG) are currently looking at the way community mental health services are delivered locally to decide what improvements need to be made. The Thrive approach has been identified as the preferred model of mental health provision in B&NES. This approach has recently been adopted to support children and young people locally and builds on a needs based, whole system approach to supporting people's mental health. The Thrive approach replaces the current 'tier' pathway or model of care with 3 'clusters' or 'groups.' These are staying well, getting help and crisis. The consultation closed in February 2019, the results of which will be available in summary form in Spring 2019.[170] This review builds on the priorities that were identified in Your Care, Your Way review of community health

[164] Includes: (i) already engaged with the Community Mental Health Team/other mental health services; (ii) engaged with IAPT (Improving Access to Psychological Therapies); (iii) receiving mental health treatment from GP; (iv) receiving NICE-recommended psychosocial or pharmacological intervention provided for the treatment of a mental health problem; and (v) has an identified space in a health-based place of safety for mental health crises.

[165] PHE(2018f), *Op. Cit.*

[166] PHE(2018g), *Op. Cit.*

[167] PHE(2018f), *Op. Cit.*

[168] PHE(2018g), *Op. Cit.*

[169] NHS (2019), *The NHS Long Term Plan*, available from: https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

[170] BaNES CCG (2019), *Community Mental Health Services Review*, available from: https://www.bathandnortheastsomersetccg.nhs.uk/get-involved/project/mental-health-services-review

and care services in 2015-17, and should help achieve positive changes in mental health and wellbeing provision for people living in B&NES.

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