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SOMERSET County Council

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DRUG AND ALCOHOL TREATMENT NEEDS ASSESSMENT

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On behalf of Somerset County Council Public Health – December 2016

Contents

Key Points ... 1
1. Introduction ... 5
 1.1 Client turnover ... 7
2. Deprivation ... 8
 2.1 Drug Use and Deprivation ... 8
 2.2 Alcohol Use and Deprivation ... 9
3. Age ... 11
 3.1 Opiate Prevalence by Age ... 14
4. Gender ... 15
5. Other Protected Characteristics ... 17
 5.1 Disability ... 17
 5.2 Marital Status ... 19
 5.3 Pregnancy ... 20
 5.4 Race including colour, nationality, ethnic or national origin ... 20
 5.5 Religion, belief or lack of religion/belief ... 21
 5.6 Sexual orientation ... 22
 5.7 Transgender ... 23
6. Domestic Violence ... 24
7. Dual Diagnosis ... 26
8. Criminal Justice ... 28
9. Employment ... 30
10. Housing and Homelessness ... 32
 10.1 Housing, Homelessness and Successful Completions ... 36
 10.2 Housing and Homelessness by substance used ... 37
 10.3 Housing and Homelessness by gender ... 39
 10.4 Dual Diagnosis and Homelessness ... 39
 10.5 Housing and Homelessness by age group ... 40
 10.6 Housing, Homelessness and the Criminal Justice System ... 40
 10.7 Supported Housing ... 41
Appendix 1 ... 43
Appendix 2 ... 44

Key Points

1. There has been a change in the substance profile for those accessing treatment in Somerset over the past few years. Changes in service delivery and commissioning priorities have resulted in large increases in the number of non-opiate and alcohol users accessing services whilst the number of opiate users has remained relatively stable. When compared to national data for 2014/15, Somerset has a slightly larger proportion of alcohol users and a slightly lower proportion of opiate users in treatment.

2. Of those who have presented to treatment since April 2014 where the episode has closed, 58% were recorded as 'Treatment Completed – Drug/Alcohol Free' or 'Occasional User (not opiate or crack)'.

3. Those in treatment for alcohol (only) are generally older than those in treatment for non-opiate use (average ages 47 years and 29 years respectively for those in treatment during 2015/16). The average age for opiate users in treatment is 38 years and for opiate users presenting to treatment it is 34 years; the wide difference between those in treatment and those presenting for treatment for opiate use is largely due to the length of time opiate users tend to spend in treatment.

4. Age distribution locally broadly mirrors the national data with opiate and non-opiate use more prevalent among the younger age bands and alcohol use more prevalent amongst the older age groups. It will be important to ensure that interventions are accessible and relevant across a wide age-range.

5. When prevalence estimates for opiate use by age group are compared to the treatment population it would appear that more than three-quarters of the estimated population aged over 34 are in treatment compared to just over one-third of the estimate for those under 24.

6. Nationally and locally women appear to make up a slightly greater proportion of those in treatment for alcohol (only) than would be suggested by prevalence estimates.

7. 48% of women and 18% of men who presented to treatment in Somerset said that they had been affected by domestic violence; a total of 301 episodes (133 men, 168 women). These figures would certainly suggest that those who misuse drugs and alcohol are more likely to be affected by domestic violence and that this disproportionately impacts on women who misuse drugs and/or alcohol.

8. If more accurate comparisons with national data on domestic violence are required, consideration should be given to the way that domestic violence is recorded and reported using Halo.

9. Local data confirms a greater prevalence of mental health problems amongst those using substance misuse services than the general population and that women are more likely than men to be in receipt of treatment for mental health issues alongside drug and alcohol issues. Somerset appears to have higher rates of dual diagnosis than the national figures but it is likely that this is due to considerable variation in recording practice between different areas.

10. Opiate users made up 81% of all referrals from the criminal justice system in 2014/15 and 74% in 2015/16.

11. Of the referrals from the criminal justice system, over a quarter ended in an early unplanned exit from treatment in 2014/15 and 2015/16 (27% and 28% respectively) with over three-quarters of these resulting from the client being retained in custody (77% and 79%).

12. There is a close association between deprivation and drug use and clear evidence that increased levels of alcohol related harm is associated with socioeconomic status. There is an association between many of the key indicators of deprivation and the factors identified as Recovery Capital by Best and Laudet[1] that underpin the national drugs strategy[2].

13. There are 25 Lower Super Output Areas (LSOA) in Somerset that are in the 20% most deprived areas ('highly deprived'). This equates to around 38,000 people. This is an increase from 14 LSOAs in 2010. Somerset Intelligence state "*Since 2010 there has been a slight shift towards greater deprivation in Somerset relative to the rest of England, particularly in relation to the quality of housing".*

14. For those where there is a record at the start of treatment and at a *planned exit* from treatment, the number who went from not working to some level of work (irregular, part-time or full-time) fell by 5 for drug clients and 20 for alcohol clients (2 percentage points and 7 percentage points respectively). Given the associations between unemployment, recovery capital and deprivation, it would seem that further work is required locally and nationally to improve the employment chances of substance misuse clients in order to achieve sustained recovery.

15. Clients in treatment had higher rates of No Fixed Abode (NFA) than the national average throughout their treatment journey with 16% of those in treatment for 2-3 years reporting that they had no fixed abode compared to 10% nationally.

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[1] Best, D. and Laudet, A.B. (2010) The Potential of Recovery Capital, RSA

[2] Drug strategy 2010 Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life, Home Office 2010

16. The data on housing and homelessness provided with the JSNA support pack[3] indicates that in 2015/16 Somerset had slightly higher rates of new drug using client presentations to treatment who report being either NFA or having a housing problem (14% and 16% respectively for Somerset compared to 9% and 14% nationally).

17. Whilst there appears to have been a reduction in the number of homeless applications to district councils across Somerset overall between 2013/14 and 2015/16, Sedgemoor and Taunton Deane show increases in decisions made and Sedgemoor also had an increase in those accepted.

18. Rough sleeping estimates provided by district councils in Somerset for 2015 suggest that the number of rough sleepers has doubled between 2013 and 2015, albeit that the numbers are small (numbers: 2013 - 28, 2015 - 56. This compares with a 48% increase across England overall and a 73% increase in London over the same time period

19. The number of episodes where the client reported being NFA increased from 94 in 2014/15 to 153 in 2015/16 and 1st quarter data for 2016/17 suggests that the numbers will be higher again in the full year. Although the numbers are too small to draw a strong conclusion, the number of episodes where women were NFA more than doubled from 2014/15 to 2015/16.

20. Successful completions for those who presented with a housing issue are 29% of those that left treatment compared to 68% of those who had no housing issue.

21. Of the 144 successful completions who had a housing issue at the start of treatment, 32 were still recorded as having either a housing problem or being at risk of eviction on their Treatment Outcome Profile.

22. In 2015/16 41% of the referrals from CARATS presented to treatment services as NFA. This represents 39% of all the cases of NFA across SDAS in the year.

23. Further work with the community rehabilitation company delivering Through the Gate services for prisoners from Somerset should be undertaken to ensure that their remit is being fulfilled and to identify any opportunities for joint initiatives to reduce the number of prison releases presenting for drug and alcohol treatment who are homeless.

[3] Adults – drugs JSNA support pack: key data, Somerset, PHE, 2016 (RESTRICTED)

24. SDAS Supported accommodation - in light of the additional difficulties faced by people who present to treatment as homeless, commissioners may want to review the way in which accommodation services are integrated into the substance misuse system.
    This could include:
    - increasing levels of support and supervision within existing provision to reduce attrition;
    - establishing different, or additional, supported accommodation options with lower behavioural expectations and greater levels of support and supervision in order to meet the needs of those presenting to treatment who are homeless and may not be able to maintain their own accommodation or;
    - identifying existing provision that meets the housing needs for this client group and delivering intensive substance misuse support directly within the provision.

1. Introduction

Public Health England have provided key data to Local Authorities to support local development of Joint Strategic Needs Assessments and inform the planning and commissioning of drug and alcohol services[4]. There are two support packs for adults: drugs and alcohol, and each sets out a range of key indicators and recovery outcomes for the local area benchmarked against national data and/or comparator local authority areas.

The bulk of the data in the JSNA Support Packs is derived from the National Drug Treatment Monitoring System (NDTMS), which compiles drug and alcohol treatment information nationally. Additional data in the alcohol support pack is derived from the Local Alcohol Profile for England (LAPE) operated by Public Health England's Knowledge and Intelligence Team (North West). Drug related deaths data has been taken from the Office for National Statistics and hospital admissions due to drug poisoning were supplied to PHE by the Department of Health.

Somerset County Council have also published a section on alcohol as part of their joint strategic needs assessment which can be found at http://www.somersetintelligence.org.uk/alcohol.html

This needs assessment is not intended to replace the key data provided in the JSNA support packs, which are provided to support local commissioning and planning via www.ndtms.net (a secure portal with access restrictions) and not released into the public domain. Many of the key factors that influence recovery have been covered in a separate paper for Somerset that reviewed PHE's Recovery Diagnostic Toolkit[5], which should be read in conjunction with this needs assessment.

Local drug and alcohol treatment data used in this document is derived from the countywide case management system – Halo, which is commissioned by Somerset Public Health and is used by all services working within the integrated drug and alcohol treatment system, Somerset Drug and Alcohol Service (SDAS). Halo numbers will include data for the relatively small number of individuals who have not given consent for their information to be used in the national datasets.

Unless otherwise stated data from Halo is based on the number of episodes during a reporting period. Local data is presented in two ways: open episodes during a given period and new presentations to treatment during a given period. In both these cases it is possible that some individuals will be included more than once if they left treatment and re-presented during the same time period. Whilst some characteristics will remain the same in each episode it is possible that others will be different: for example someone's housing status or involvement with the criminal justice system. Data provided through NDTMS is based on unique individuals and the JSNA key data uses new presentations to treatment during the time period.

[4] Adults – drugs JSNA support pack: key data, Somerset; and Adults – alcohol JSNA support pack: key data ,Somerset PHE, 2016 (both documents are RESTRICTED)
[5] Recovery Diagnostic Toolkit for Somerset: a review and workshop findings, Somerset County Council Public Health, July 2016

Table 1, below show the number of new adult episodes (new presentations to treatment) during each reporting period and the number of individuals this relates to.

Table 1: Treatment Episodes and Individual Clients. SOURCE: Halo

Number of episodes of new presentations to treatment and number of individuals to which this relates			
Reporting Period	Number of adult episodes	Number of adults this relates to	Episodes per individual
2014/15	960	889	1.08
2015/16	1329	1213	1.10
Apr – Jun 2016	337	331	1.02

NB. Clearly for quarter 1 of 2016/17 there is less likelihood of individuals re-presenting in this period than for the whole year data.

Where local data shows the number of open adult episodes, this relates to all treatment episodes that were open at some point during the reporting period. This will include those who had been in treatment prior to 2015/16 and continued their treatment journey for some, or all, of the year. As set out in the work for the Recovery Diagnostic Toolkit, there are a significant number of adults who have been in treatment for several years; therefore analysis that includes service users' ages has been calculated to show the actual age in years as at 31/03/16 or at the point of closure where appropriate. This will therefore include a small number of clients who originally presented to treatment as young people (under 18) but are now adults.

There were 2,605 open episodes where the client was aged 18 or over in 2015/16 made up of 2,345 individuals (an average of 1.1 episodes per individual). Of these, 13 individuals commenced treatment before the age of 18.

As discussed in the Recovery Diagnostic Toolkit review[6] there has been a change in the substance profile for those accessing treatment over the past few years. Changes in service delivery and commissioning priorities have resulted in large increases in the number of non-opiate and alcohol users accessing services whilst the number of opiate users has remained relatively stable. When compared to national data for 2014/15, Somerset has a slightly larger proportion of alcohol users and a slightly lower proportion of opiate users in treatment.

Table 2: Numbers in Structured Treatment. SOURCE: NDTMS

Numbers in Structured Treatment (NDTMS)				
	Apr12 Mar 13	**Apr13 Mar 14**	**Apr14 Mar15**	**Apr15 Mar16**
Opiate	1099	1061	1094	1138
Non-opiate only	78	63	88	204
Non-opiate and alcohol	113	107	160	259
Alcohol only	238	266	423	708
Total	**1528**	**1497**	**1765**	**2309**

[6] Review of the Recovery Diagnostic Toolkit for Somerset & Workshop, Somerset County Council Public Health, June 2016

Tables showing a complete breakdown of clients by substances, age and gender are included at Appendix 1. In order to protect the anonymity of treatment service users, figures have been suppressed if they have a cell value of less than five (5). Such occurrences are indicated by a field containing "*" rather than a numeric value. This is because of the issue of “deductive disclosure”; the possibility (however remote) that information could be combined from several sources to identity individuals in contact with drug and alcohol treatment services.

1.1 Client turnover

In order to get a picture of the turnover of treatment episodes, Table 3 shows the number of new presentations for the past two years and the number and proportion of those episodes that remain open (up to 07/09/2016). Of those where the episode had closed, 58% were recorded as ‘Treatment Completed – Drug/Alcohol Free’ or ‘Occasional User (not opiate or crack)’.

Table 3: Treatment Episodes still open. Source Halo

New adult presentations to treatment that remained open as at 07/09/16			
	Number of new presentations	New presentations still open	Percentage of presentations open
2014-15	960	148	15%
2015-16	1329	347	26%
Apr-Jun 16	337	222	64%

Of the episodes that closed for any reason in 2015/16 the average duration of the episode was 321 days. For opiate users the figure was 540 days and for non-opiates 167 days. Table 4 below shows the average duration of episodes broken down by substance and by successful and unsuccessful completions. It is interesting to note that, on average, the duration of unsuccessful episodes of treatment for all non-opiate client groups were slightly longer than the successful completions.

Table 4: Average duration of closed treatment episodes. SOURCE: Halo

Closed episodes 2015/16			
	Average Duration (days)		
	Overall	**Successful Completion**	**Incomplete**
Opiates	540	800	360
All other substances:	197	188	223
Non-opiates	167	167	180
Alcohol & non-opiates	207	194	222
Alcohol (only)	202	191	242

2. Deprivation

2.1 Drug Use and Deprivation

There are well documented links between deprivation and drug use. In 1998 the Advisory Council on the Misuse of Drugs (ACMD) published a report that stated "the research points strongly to a statistical association between deprivation and problematic drug use…..the ACMD concludes that on a strong balance of probability, deprivation today in Britain is often likely to make a significant causal contribution to the cause, complications and intractability of damaging kinds of drug misuse."[7]

The 2014/15 Crime Survey for England and Wales (CSEW) shows higher rates of any drug use in the last year amongst households with the lowest income; those in the 20% most deprived output areas on the English indices of deprivation (employment) and respondents who were unemployed[8]. The statistical bulletin goes on to say "Use of any drug was highest for those living in the areas defined to be the most deprived (10.2%), and lowest for those living in areas defined to be the least deprived (6.9%). However, use of any Class A drug did not vary with Indices of Deprivation, with similar levels of use in all areas."[9]

The CSEW by its very nature is unlikely to provide an insight into drug use amongst the most marginalised populations and those with the most problematic drug use and this is made clear in the publications: "As a household survey, the CSEW does not cover groups such as the homeless, or those living in institutions such as prisons, or student halls of residences, who have potentially high proportions of drug use, and problematic drug users who are unable to take part in an interview."

A literature review for the Scottish Drugs Forum on drugs and poverty concluded: "Although relative poverty by itself is not the cause of Scotland's drug problem, this literature review supports the view that there is a strong association between the extent of drug problems and a range of social and economic inequalities. Therefore, narrowing these inequality gaps should contribute significantly to a reduction in high levels of damaging drug use."[10]

The JSNA support pack also highlights that there is a strong correlation between rates of hospital admissions due to drug poisoning and area deprivation. Somerset is in the third least deprived decile among local authorities and has a higher rate of hospital admissions for drug poisoning when compared both to the rate for the same deprivation decile and to the national rate per 100,000[11].

[7] http://www.drugwise.org.uk/wp-content/uploads/ACMD-environment.pdf
[8] https://data.gov.uk/dataset/drug-misuse-findings-from-british-crime-survey-2009-10/resource/b11c359b-73c6-45e3-b596-77c64f0d36a1
[9] Drug Misuse: Findings from the 2014/15 Crime Survey for England and Wales, Statistical Bulletin 03/15, Home Office, July 2015
[10] Drugs and poverty: A literature review A report produced by the Scottish Drugs Forum (SDF), March 2007
[11] Adults – drugs JSNA support pack: key data, Somerset, PHE, 2016 (RESTRICTED)

2.2 Alcohol Use and Deprivation

There is clear evidence that alcohol related harm is associated with socioeconomic status. Rates of alcohol-specific mortality, liver deaths and alcohol-attributable hospital admissions all increase from the least to the most deprived. However, the increases in harms do not seem to be directly linked to levels of alcohol consumption. Studies published in the UK suggest that levels of alcohol consumption are relatively consistent across socioeconomic groups and may be lower in those who are in the most deprived groups and yet those in more deprived groups suffer more alcohol related harm[12 13].

Potential explanations for the 'alcohol harm paradox' such as drinking patterns, underreporting of consumption, multiple 'unhealthy' behaviours, access to healthcare and the effects of poverty on health inequalities have been explored although a recent rapid review concluded "*this rapid review identifies a lack of empirical evidence that has examined the relationship between poverty and problem alcohol use, and vice versa. Studies have tended towards hypothesis generation rather than theory testing and we consequently understand little from a UK perspective about pathways and mechanisms linking poverty and problem alcohol use. …. While the literature has established that people of lower social and economic standing are likely to suffer greater harm from alcohol we are at an early stage of understanding why this is.*"[14]

The JSNA support pack uses Local Alcohol Profile for England data on alcohol related harm, which shows comparisons with 'nearest neighbour'[15] local authorities as well as national comparisons. Whilst Somerset has lower harms levels for mortality and months of life lost when compared to both 'nearest neighbour local authorities and nationally, Somerset is in the highest level of harm quartile for the following three indicators:

- Persons admitted to hospital for alcohol-specific conditions – under 18s
- Admission episodes for alcohol-related unintentional injuries conditions (Narrow) - Females
- Admission episodes for intentional self-poisoning by and exposure to alcohol condition (Narrow) - Males

Whilst data provided by the County Council's Somerset Intelligence website[16] indicates that Somerset overall is within the 40% least deprived local authority areas in England, it does include areas of deprivation. There are 25 Lower Super Output Areas (LSOA), accounting for around 38,000 people, in the 20% most deprived areas ('highly deprived'). This is an increase from 14 LSOAs in 2010. The briefing goes on to state that "*Since 2010 there has been a slight shift towards greater deprivation in Somerset relative to the rest of England, particularly in relation to the quality of housing.* "

[12] Alcohol, Health Inequalities and the Harm Paradox, Institute for Alcohol Studies, 2014
[13] Understanding the relationship between poverty and alcohol misuse, John Moores University, Centre for Public Health, 2016
[14] Understanding the relationship between poverty and alcohol misuse, John Moores University, Centre for Public Health, 2016
[15] 15 other local authority areas that are similar across a range of demographic, socio-economic and geographic variables
[16] www.somersetintelligence.org.uk/files/Indices%20of%20Deprivation%202015%20-%20Somerset%20Summary.pdf

There is an association between many of the key indicators of deprivation and the factors identified as Recovery Capital by Best and Laudet[17] that underpin the Building Recovery in Communities component of the 2010 national drugs strategy[18]. Within the key data supplied with the JSNA support packs two themes are highlighted that also cut across recovery and deprivation: employment and housing. Both of these are discussed later in this document.

[17] Best, D. and Laudet, A.B. (2010) The Potential of Recovery Capital, RSA

[18] Drug strategy 2010 Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life, Home Office 2010

3. Age

According to ONS Mid-2015 estimates[19], 51% of Somerset's population overall is aged 45 or over, 20% are under 18 and 16% are aged over 70. In order to compare general population distribution with the adult treatment population in Somerset, the following chart uses mid-year population estimates for those between 18 and 69 (64% of the total population) broken down into age bands. The drug treatment data shows the proportion of adult treatment episodes open in 2015/16 and includes a small number who are over 65 in the final category.

Where ages are shown for open episodes these have been calculated using the date of birth to give either the age at which the person completed treatment or their age at 31/03/16 for episodes that remained open at that time.

As can be seen, more than half of those in treatment were aged under 40 whereas this accounts for around one third of the population of Somerset (aged 18-69).

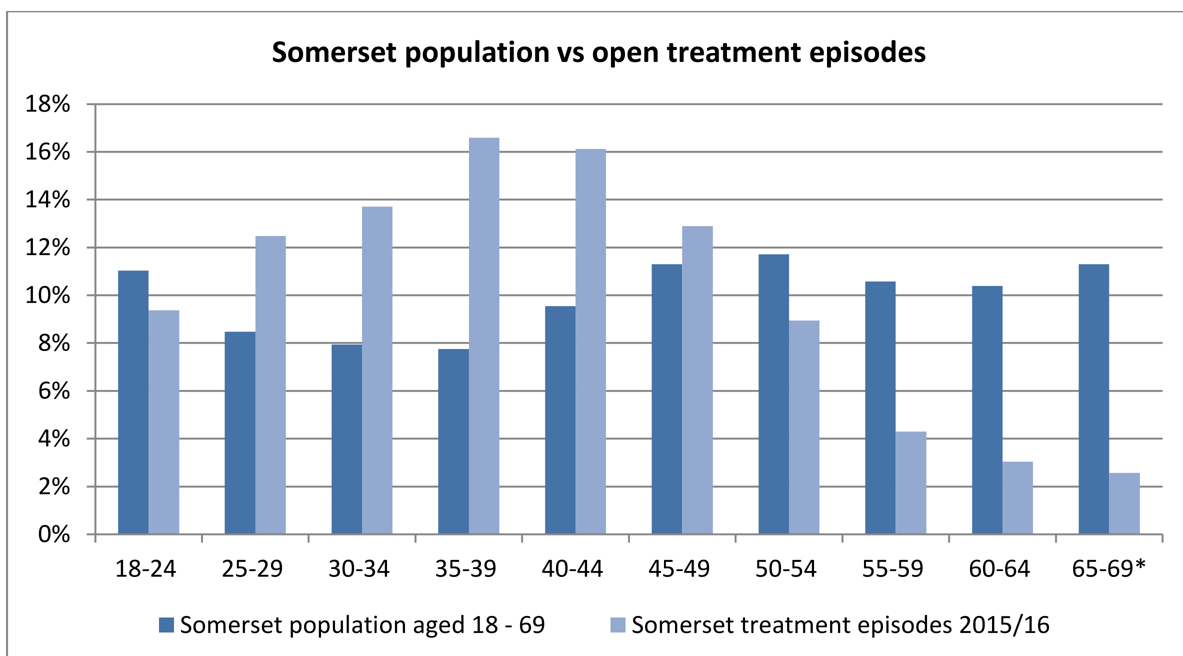

Figure 1 Distribution by age group of Somerset population compared to open treatment episodes

*NB Open Episodes includes all those aged over 65 in this category. SOURCE: Halo and adapted from data from the Office for National Statistics licensed under the Open Government Licence v.3.0.

[19] Population estimates by single year of age and sex for local authorities in the UK, mid-2015, ONS, 2016

The age distribution of Somerset's treatment population is broadly in line with the treatment population for England provided by the NDTMS[20]. Numbers for each age band are relatively small for Somerset but the chart below may suggest that Somerset's age distribution is slightly more evenly distributed than that of England with slightly greater proportions at both the younger and older ends of the graph.

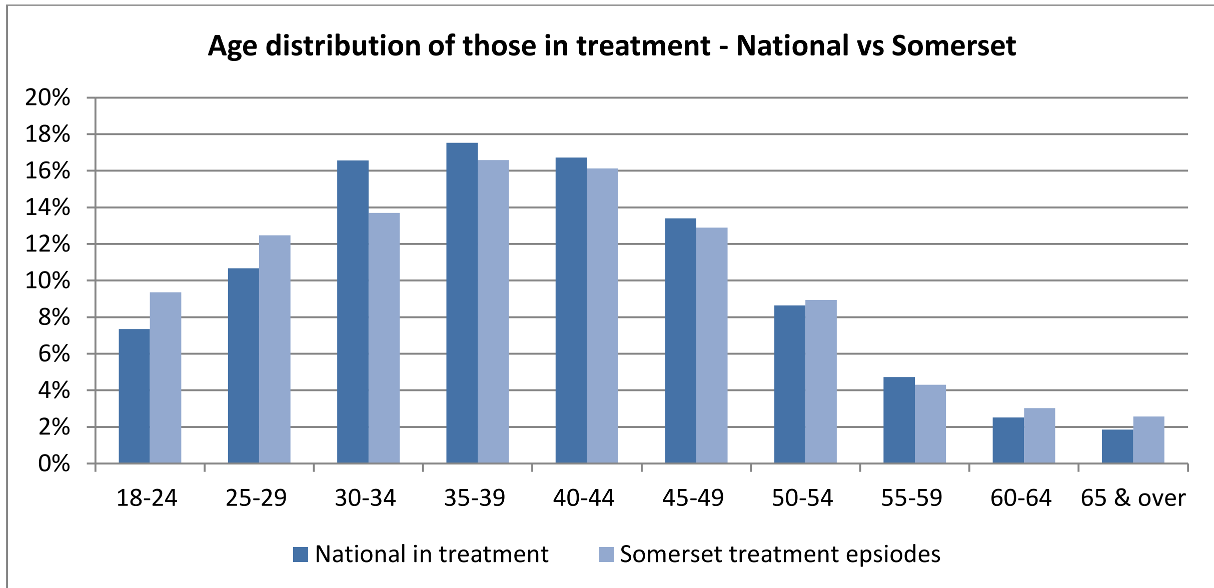

Figure 2 Age distribution of those in treatment – National data compared to Somerset episode data.

SOURCE: Halo and National Drug Treatment Monitoring System (NDTMS) 1 April 2014 to 31 March 2015

When the age bands are further examined by substance it can be seen that those in treatment for alcohol (only) are generally older than those in treatment for non-opiate use (average ages 47 years and 29 years respectively for those in treatment during 2015/16). The average age for opiate users in treatment is 38 years and for opiate users presenting to treatment it is 34 years; the wide difference between those in treatment and those presenting for treatment for opiate use is largely due to the length of time opiate users tend to spend in treatment.

The following charts show the age distribution by substance for Somerset and for England overall. The charts for Somerset are based on episodes of treatment rather than unique individuals.

[20] Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2014 to 31 March 2015, PHE 2015

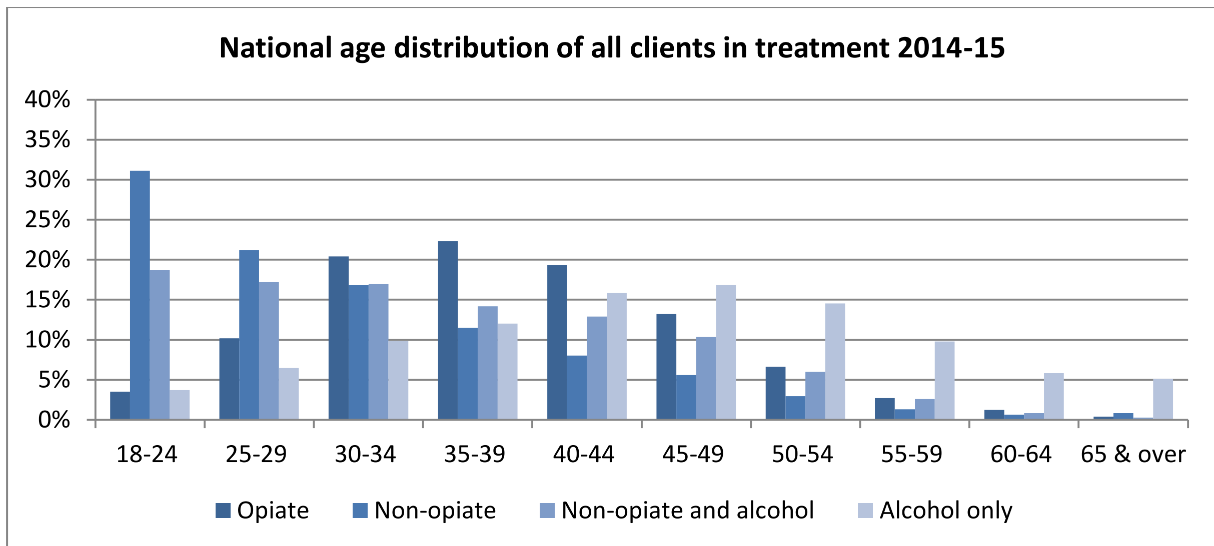

Figure 3 Age distribution of people in treatment 2014/15 in England by substance used

SOURCE: National Drug Treatment Monitoring System (NDTMS) 1 April 2014 to 31 March 2015

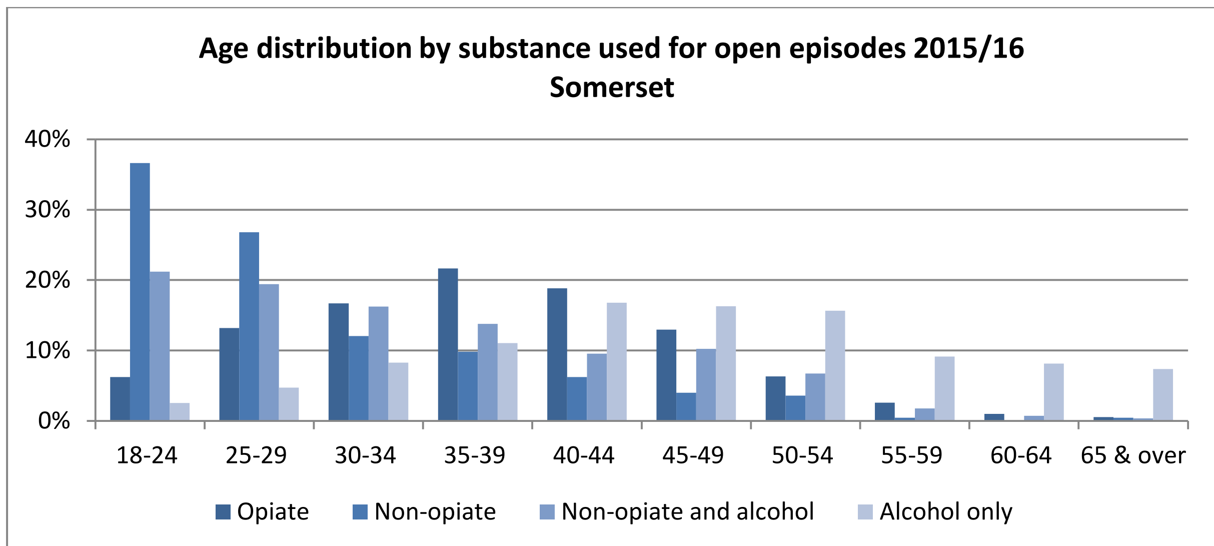

Figure 4 Age distribution for Somerset of treatment epsiodes 2015/16 by substance used

SOURCE: Halo

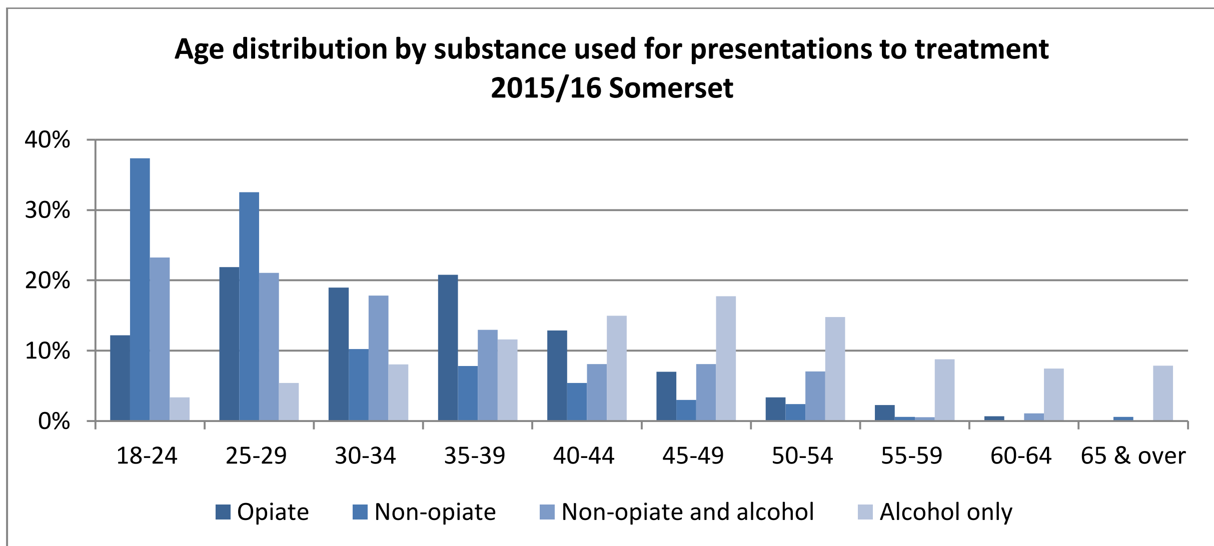

Figure 5 Age distribution for Somerset of new presentations to treatment 2015/16 by substance used

SOURCE: Halo

The age distribution locally broadly mirrors the national data with opiate and non-opiate use more prevalent among the younger age bands and alcohol use more prevalent amongst the older age groups. Clearly there is cross-over, with some younger clients seeking treatment for alcohol use and older clients who are using non-opiates or a combination of alcohol and non-opiates. However, ensuring interventions are accessible and relevant across a wide age-range will present challenges.

3.1 Opiate Prevalence by Age

Prevalence estimates for opiate use indicate that there are 1,753 opiate users aged 15-64 in Somerset (CI 95%, 1,604 - 1,952)[21]. Approximately two-thirds of this figure were in treatment during 2015/16 (1,142 *individuals*). However, when the estimate is broken into in age bands, it can be seen that the proportion of the estimated numbers in treatment varies considerably with more than three-quarters of those aged over 34 in treatment and just over one-third of the estimate for those under 24. The figures are shown in Table 5 below.

Table 5: Proportion of opiate users in treatment 2015/16. SOURCE: Centre for Public Health, JMU and Halo

Proportion of estimated opiate users in treatment during 2015/16				
Age Band	**15-24**	**25-34**	**35-64**	**Total**
Prevalence Estimate 2011/12 (95% CI)	168	606	979	1,753
Individuals in treatment 2015/16	62	316	764*	1,142
Proportion in treatment	37%	52%	78%	65%

* includes small number over 64

[21] Estimates of the prevalence of opiate use and/or crack cocaine use (2011/12), Centre for Public Health, Liverpool John Moores University & Glasgow Prevalence Estimation Limited, April 2014

4. Gender

The gender split for those accessing treatment is consistently shown to be around 70% men and 30% women (ratio 2.3 males: 1 female).

For drug use the different rates between genders is supported by findings from the Crime Survey for England and Wales[22], which indicates 11.9% of males and 5.0% of females had taken an illicit drug in the previous year (male to female ratio 2.4:1).

For alcohol use, ANARP[23] indicated that dependent alcohol use was around 6% of men and 2% of women (ratio 3:1) which might suggest that there would be a similar pattern of treatment take-up. However, other estimates for alcohol use, and therefore treatment take-up provided by ANARP are 38% of men and 16% of women (age 16–64) have an alcohol use disorder (2.4:1) and within this, 32% of men and 15% of women are hazardous or harmful drinkers (2.1:1).

Nationally, among those in treatment for alcohol (only) men make up 62% and women 38% and this is also the case for Somerset (ratio 1.6:1).
The table below shows national data on the proportion of individuals in treatment from NDTMS[24] for 2014/15 compared to the local episode figures for 2015/16.

Table 6: Proportion in treatment by gender and substance. SOURCE: NDTMS and Halo

	National 14/15		Somerset Episodes 15/16	
	Male	Female	Male	Female
Opiate	73%	27%	73%	27%
Non-opiate	75%	25%	72%	28%
Alcohol & non-opiates	74%	26%	69%	31%
Any drug citation	73%	27%	72%	28%
Alcohol	62%	38%	62%	38%
Total	70%	30%	69%	31%

Table 7, below, shows Somerset data for the proportion of each gender who use each substance category. Overall 53% of men in treatment and 44% of women in treatment are there for opiate use whereas 27% of men and 37% of women are in treatment for alcohol (only) use. Again, this is very similar to the national pattern

Table 7: Proportion in treatment by substance and gender. SOURCE: Halo

	Male		Female	
Opiate	954	53%	358	44%
Non-opiate	162	9%	62	8%
Alcohol & non-opiates	194	11%	89	11%
Any drug citation	1310	73%	509	63%
Alcohol	489	27%	297	37%
Total	1799	100%	806	100%

[22] www.gov.uk/government/uploads/system/uploads/attachment_data/file/541542/drug-misuse-1516.pdf
[23] www.alcohollearningcentre.org.uk/_assets/Resources/ALC/OtherOrganisation/Alcohol_needs_assessment_research_project.pdf
[24] Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2014 to 31 March 2015, PHE December 2015

A full table showing gender, age range and substances is included at Appendix 1.

The JSNA support packs note that “Women presenting to treatment often experience poor mental health, domestic violence and abuse, which may impact upon their recovery.” Domestic violence and dual diagnosis are both covered in separate sections of this document.

5. Other Protected Characteristics

The Equality Act 2010 brought together a range of separate legislation into a new act that provides a legal framework to protect the rights of individuals. The Act sets out 9 protected characteristics. Following the roll-out of the latest NDTMS dataset (core dataset M)[25], which commenced in April 2016, some additional fields have been added to capture more of the protected characteristics. In addition there are some local data fields on Halo that record further information. The table below sets out the protected characteristics and whether data is available from earlier NDTMS datasets, the latest dataset (dataset M) or local data.

Protected Characteristic	NDTMS prior to April 2016	Included in core dataset M	Local data entity only
Age	✓	✓	✗
Being or becoming a transsexual person	✗	✗	✓
Being married or in a civil partnership	✗	✗	✓
Being pregnant or on maternity leave	✓	✓	✗
Disability	✗	✓	✗
Race including colour, nationality, ethnic or national origin	✓	✓	✗
Religion, belief or lack of religion/belief	✗	✓	✗
Sex	✓	✓	✗
Sexual orientation	✗	✓	✗

5.1 Disability

Since April 2016 NDTMS dataset M has included fields for recording disabilities which are in line with the approved information standards and collections as set out in the NHS data model dictionary[26]. Although the fields can be updated for those who were in treatment prior to April 2016, full data is only available for new presentations to treatment for the first 2 quarters of 2016/17.

Each episode can have up to 3 disabilities recorded. Data for new presentations to structured treatment indicates that 47% of new presentations reported at least one disability (300 out of 632 episodes) and of these a quarter had more than one disability. In order to provide a perspective on this, the Family Resources Survey[27] (FRS) produced by the Department for Work and Pensions (DWP) indicates that 17% of working age adults have a disability[28]. Similarly Somerset Intelligence[29]

[25] National Drug Treatment Monitoring System (NDTMS) Adult drug treatment business definition NDTMS data set M, PHE, 2016
[26] www.datadictionary.nhs.uk/
[27] Family Resources Survey 2014/15, Disability, DWP, 28 June 2016
[28] Disability: The definition of disability used in the FRS is consistent with the core definition of disability under the Equality Act 2010. A person is considered to have a disability if they have a long-standing illness, disability or impairment which causes substantial difficulty with day-to-day activities. Some people classified as disabled and having rights under the Equality Act 2010 are not captured by this definition, such as people with a long-standing illness or disability which is not currently affecting their day-to-day activities.
[29] www.somersetintelligence.org.uk/health-and-disability.html

suggest that 18.8% of the population report they had a long-term condition or disability which limited their day-to-day activities a lot or a little.
Of those reporting a disability, 72% (n=216) had a behaviour and emotional impairment listed as either disability 1, 2 or 3. This is one third of all presentations to treatment in the first 2 quarters of 2016/17.

In order to support the planning and delivery of services that meet the needs of all clients and potential clients, the following table shows the number of episodes where clients presented to treatment and the number and percentage broken down by the type of disability reported.

Table 8: New presentations to treatment 01 April – 30 September 2016 reporting a disability. SOURCE: Halo

New presentations to treatment Q1 & Q2 2016/17		
	Number	**% of new presentations**
No disability	259	41%
Not stated	71	11%
Blanks	2	0%
1 or more disability reported	300	47%
Total Episodes	632	100%
New presentations reporting at least 1 disability by impairment type	**Number**	**% of new presentations**
Behaviour and Emotional	216	34%
Progressive Conditions and Physical Health	51	8%
Mobility and Gross Motor	41	6%
Learning Disability	22	3%
Other	17	3%
Manual Dexterity	13	2%
Personal, Self-Care and Continence	9	1%
Perception of Physical Danger	5	1%
Sight	5	1%
Hearing	*	*
Speech	*	*

The data items recorded on NDTMS do not exactly match the data items shown in the DWP's Family Resources Survey. The tables below show the percentage of impairment types reported by people with a disability for the UK and for those starting treatment in Somerset 2016/17. In both cases the percentages will total more than 100% as people can record more than one disability.

Table 9: **Impairment types reported by adults of working age with a disability 2014/15, United Kingdom.**
SOURCE: **Family Resources Survey 2014/15**

Impairment types reported by adults of working age with a disability 2014/15, United Kingdom	
Impairment type	**Percentage of disabled working age people**
Mobility	45%
Stamina/breathing/fatigue	34%
Mental health	30%
Dexterity	26%
Other	17%
Memory	16%
Learning	14%
Vision	11%
Hearing	8%
Social/behavioural	7%

Table 10: **Impairment types reported by adults presenting to SDAS with a disability Quarters 2 & 3 2016/17.**
SOURCE: Halo

Impairment types reported by adults presenting to SDAS with a disability Quarters 2 & 3 2016/17	
Impairment type	**Percentage of disabled SDAS new presentations**
Behaviour and Emotional	72%
Progressive Conditions and Physical Health	17%
Mobility and Gross Motor	14%
Learning Disability	7%
Other	6%
Manual Dexterity	4%
Personal, Self-Care and Continence	3%
Sight	2%
Perception of Physical Danger	2%
Hearing	1%
Speech	0%

5.2 Marital Status

Office for National Statistics data[30] indicate that 34.5% of the population of England and Wales aged 16 or over are single, just over half are married and 0.2% are in a civil partnership.

Locally collected data from Halo for the first 6 months of 2016/17 indicate that half of the new presentations to treatment were single and 13% were married or in a civil partnership. The difference in levels of single and married people between the treatment population and the national population will be, in part, due to the age

[30] Population estimates by marital status and living arrangements, England and Wales: 2002 to 2015, ONS, 2016

distribution. The ONS statistical bulletin[31] notes that there has been an increase in the population who are single from 29.6% in 2002 to 34.5% in 2015 and that being single was the most common marital status for men under 35. As described in Section 4 of this document, the age profile of the treatment population does not mirror the overall adult population and has a higher proportion of younger adults.

5.3 Pregnancy

During 2015/16 13 women entered treatment who were pregnant (4% of new female drug presentations and 3% of new female alcohol presentations)[32].

There is a clear need to ensure that specialist knowledge and support is available for women who are pregnant and using drugs and/or alcohol. Guidance is provided by NICE[33] [34] and in the Department of Health's Clinical Guidelines[35] [36]. The way in which such provision is structured and commissioned within Somerset has recently been reviewed and is discussed in more detail in a separate Somerset Public Health paper.

In terms of ongoing reporting and monitoring, a review of locally available data from Halo indicated that services should be clear of the criteria used for recording whether a service user is pregnant as there were a number of records that had a 'yes' in the relevant data field for pregnancy but were recorded as male.

5.4 Race including colour, nationality, ethnic or national origin

The proportion of those starting treatment in 2015/16 who classify themselves as white British (English/Welsh/Scottish/Northern Irish/British) was 93.9%, which is in keeping with the overall population of Somerset, as reported by Somerset Intelligence[37], which indicated that 94.6% were white British. Similarly, using the ONS classification of 'White'[38], 97.5% of those starting treatment identified themselves in this group, compared to 97.8% from the 2011 Census data[39].

Within the White sub-categories there were 40 episodes (3%) where the client identified as 'White – any other white background' making this the second largest grouping after white British.

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[31] Population estimates by marital status and living arrangements, England and Wales: 2002 to 2015, ONS, 2016
[32] Adults – drugs JSNA support pack: key data, Somerset; Adults – alcohol JSNA support pack: key data, Somerset, PHE, 2016 (RESTICTED)
[33] https://pathways.nice.org.uk/pathways/pregnancy-and-complex-social-factors
[34] Clinical guideline [CG110].Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors, NICE 2010
[35] Drug misuse and dependence: UK guidelines on clinical management. Dept. of Health 2007
[36] Drug misuse and dependence: UK guidelines on clinical management Consultation on updated draft 2016 (Dept. of Health 2016)
[37] www.somersetintelligence.org.uk/files/Ethnicity%20Somerset%20briefing%20note.pdf
[38] White: English/Welsh/Scottish/Northern Irish/British; White: Irish and; White: Other White
[39] 2011 Census: Key Statistics and Quick Statistics for local authorities in the United Kingdom, KS201UK: Ethnic group, local authorities in the United Kingdom, ONS 2013

In terms of nationality, 94.1% of clients presenting for treatment were recorded as United Kingdom nationals. There were 37 episodes (2.8%) where the client was from other EU countries and 16 (1.2%) from outside the EU. The two largest non-UK nationalities were Poland and Portugal. Whilst people from Poland make up the largest non-UK population in Somerset, Portugal was listed as the 8th most common non-UK nationality in Somerset according to Somerset Intelligence[40].

It is clear that different cultures, norms, belief and value systems can influence a person's likelihood of using alcohol or drugs and also the likelihood of them using substances problematically[41] [42]. It would therefore be overly simplistic to expect that the ethnic and national background of those requiring treatment for substance misuse should exactly mirror the general population. Somerset is not a very diverse county and therefore demand for services from people with different ethnic and/or national backgrounds is likely to be very small. However, it remains important that service provision is sensitive to the needs of people from diverse cultures and recognises the differential impact that drug and alcohol use may have on people from different backgrounds.

5.5 Religion, belief or lack of religion/belief

13% of new presentations to treatment between April and September said that they were Christian and 66.5% stated that they had no religion. All other religions that were recorded (Buddhist, Muslim, Pagan and Other) made up 4%. The latest census data for Somerset on religion[43] indicated that 64% described themselves as Christian, 26.6% said they had no religion and all other religions accounted for 1.4% of the population.

There is some evidence to suggest that religion and spirituality can be protective factors against drug and alcohol use[44][45] and it is also quite possible that some people with strong religious beliefs will seek help over drug and alcohol issues through their own faith groups and networks rather than accessing mainstream services.

Although 12-step fellowship groups such as AA and NA do not describe themselves as religious, their programmes have a spiritual component and therefore attract a greater proportion of those with a religion or belief system: "Let's make no bones about it; the 12 step programme that members follow has its origins in a Christian group. As a consequence you will see God mentioned quite often…Because it is a spiritual programme (not religious) those who believe in some form of divinity often find it useful to incorporate the programme into their religious practices and vice versa."[46]

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[40] www.somersetintelligence.org.uk/files/Ethnicity%20Somerset%20briefing%20note.pdf
[41] Ethnicity and alcohol; a review of the UK literature. Joseph Rowntree Foundation, 2010
[42] Khat: Social harms and legislation. A literature review. Home Office, 2011
[43] 2011 Census: Key Statistics for local authorities in England and Wales. KS209EW, 2011 Census: Religion, local authorities in England and Wales, ONS 2012
[44] Does Adolescents' Religiousness Moderate Links Between Harsh Parenting and Adolescent Substance Use? Kim-Spoon, Farley, Holmes Longo, Journal of Family Psychology, 2014, Vol. 28, No. 6, 739–748
[45] http://youth.gov/youth-topics/substance-abuse/risk-and-protective-factors-substance-use-abuse-and-dependence
[46] www.alcoholics-anonymous.org.uk/professionals/Frequently-asked-Questions

It is also possible that the circumstances and setting for responding to questions of religion and belief will give different outcomes and some of those who declined to answer or stated they had no religion when seeking help for drug and alcohol problems may provide a different answer when completing a census form. However, it is important that services ensure that they are accessible and welcoming to all those seeking assistance regardless of their religion, belief or lack of religion/belief.

5.6 Sexual orientation

Statistics constructed using estimates from the Annual Population Survey (APS) of self-perceived sexual identity from the household population aged 16 and over in the UK indicate that 93.6% of the population on the South West describe themselves as heterosexual or straight; 1.1% gay or lesbian and; 0.8% as bisexual[47].

There is evidence that suggests the prevalence of drug use is higher among lesbian, gay, bisexual and transgender (LGBT) populations, and men who have sex with men (MSM)[48] than the general population. [Note: Much of the relevant literature adopts the term 'men who have sex with men (MSM)' and this generally refers to sexual behaviour independent of sexual orientation or identity.]

Local data collected on new presentations (episodes) to drug and alcohol treatment between April and September 2016 show that 2.1% (n=13) identify themselves as gay or lesbian and 1.6% (n=10) as bisexual. Numbers are relatively small and therefore direct comparison with national estimates is problematic. However, regardless of whether prevalence of drug and alcohol misuse is higher, lower or the same amongst LGBT populations relative to the general population in Somerset, it is essential that services are delivered that meet the needs of all individuals. As the NEPTUNE guidance states: "*In order to be effective, efficient, acceptable and equitable, any intervention must take into consideration the specific socio-cultural circumstances of the individual. In the case of LGBT populations, this will require a workforce with LGBT understanding and competence, that can make LGBT people feel safe, understood, visible and able to disclose sensitive issues.*"[49]

Public Health England have produced a briefing note on substance misuse services for men who have sex with men involved in chemsex which goes on to observe "*much of the good practice covered also applies to wider MSM and lesbian, gay, bisexual and transgender (LGBT) populations.*"[50]

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[47] Sexual identity in the UK from 2012 to 2015 by region, sex, age, marital status, ethnicity and NS-SEC. ONS, 2016
[48] Novel Psychoactive Treatment UK Network, (NEPTUNE), Club Drug use among Lesbian, Gay, Bisexual and Trans (LGBT) People. The Health Foundation, 2016
[49] Novel Psychoactive Treatment UK Network, (NEPTUNE), Club Drug use among Lesbian, Gay, Bisexual and Trans (LGBT) People. The Health Foundation, 2016
[50] Commissioning and delivering substance misuse services for MSM. PHE, 2015

5.7 Transgender

Local data is now being collected that relates to this protected characteristic. At this stage, numbers are too low to report on. Commissioners should review whether the current data item that focuses on gender reassignment rather than gender identity is suitable to monitor this topic and to ensure services are delivered that are equitable and sensitive to the needs of individuals.

6. Domestic Violence

The Government define domestic violence as:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional"[51]

The Crime Survey for England and Wales (CSEW) provides statistics on domestic abuse, which is defined as "partner / ex-partner abuse (non-sexual), family abuse (non-sexual) and sexual assault or stalking carried out by a current or former partner or other family member"[52]

The CSEW estimates that 8.2% of women and 4.0% of men reported experiencing any type of domestic abuse in the last year. Overall, 27.1% of women and 13.2% of men had experienced any domestic abuse since the age of 16.

Local assessments and records used by drug and alcohol services in Somerset include a specific question on whether the client has ever been affected by domestic violence. Depending on the response, this may then trigger the use of DASH risk assessment (Domestic Abuse, Stalking and Honour Based Violence Risk Identification, Assessment and Management Model)[53]. However, caution is needed when reviewing the records on Halo as the simple yes/no record to "ever been affected" could relate to witnessing domestic violence within a household or historic incidents as well as those who are current or recent victims.

Table 11: Proportion in treatment affected by domestic violence

Proportion of new episodes who responded 'Yes' to having been affected by domestic violence 2015/16		
	M	F
Opiates	18%	53%
Non-opiates	21%	73%
Alcohol & non-opiates	24%	51%
Any dug citation	20%	57%
Alcohol (only)	15%	39%
Total	18%	48%

Data from those presenting for treatment in 2015/16 show that there was no answer in 18% of the episodes (males 20%, females 13%).

[51] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/157800/domestic-violence-definition.pdf
[52] Intimate personal violence and partner abuse, ONS, February 2016
[53] http://www.dashriskchecklist.co.uk/

Of those where an answer was recorded, 48% of women and 18% of men said that they had been affected by domestic violence; a total of 301 episodes (133 men, 168 women). With the caveats already mentioned, these figures would certainly suggest that those who misuse drugs and alcohol are more likely to be affected by domestic violence and that this disproportionately impacts on women who misuse drugs and/or alcohol.

In order to draw a closer comparison to CSEW estimates for the whole population, consideration should be given to the way that domestic violence is recorded and reported using Halo.

The combined issues of domestic violence, mental ill-health and substance misuse have been identified as significant indicators of risk of harm to children[54] [55] and there is a need to ensure that agencies working with each of these issues is aware of the risks, is able to ask clients of their service about the other issues and works closely with services specialising in the other fields. To this end a joint protocol has been developed in Somerset between: Somerset Drug and Alcohol Service (SDAS), Somerset Integrated Domestic Abuse Service (SIDAS) and Somerset Partnership NHS Foundation Trust[56].

[54] www.gov.uk/government/uploads/system/uploads/attachment_data/file/120620/hidden-harm-full.pdf

[55] www.gov.uk/government/publications/learning-lessons-from-serious-case-reviews

[56] Working Together to respond to parents and children affected by the trio of domestic abuse, mental health and substance misuse. A protocol between: Somerset Drug and Alcohol Service (SDAS), Somerset Integrated Domestic Abuse Service (SIDAS), Somerset Partnership NHS Foundation Trust. January 2016

7. Dual Diagnosis

Co-existing mental health and substance (mis)use issues have been identified as an area that requires specific focus for many years. Many publications have highlighted the increased risks and harms and poorer outcomes experience by those with dual diagnosis and the need to develop coherent service responses.[57] [58] [59]

Estimates of the prevalence of dual diagnosis can be problematic to interpret and translate into levels of treatment need. Guidance to support the implementation of the 1999 National Service Framework for Mental Health indicated "increased rates of substance misuse are found in individuals with mental health problems affecting around a third to a half of people with severe mental health problems….CMHTs typically report that 8-15% of their clients have dual diagnosis problems although higher rates may be found in inner cities"

However this guidance focused on people with severe mental health problems and therefore did not include many of the common mental disorders (disorders that cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. They comprise different types of depression and anxiety[60]).

Current draft PHE Guidance on dual diagnosis takes a broader approach to the inclusion of mental health issues and its scope includes: all mental health problems including; common mental illnesses, severe mental illness, personality disorder, dementia, alcohol-related brain damage, including Korsakoff's syndrome[61]. Using this definition, the guidance states "Alcohol and drug misuse is common among people with mental health problems and the relationship between the two is complex. Research indicates that up to 70% of people in drug services and 86% of alcohol services users experienced mental health problems"

Prevalence estimates for the adult population of England suggest that 17.9% of people aged 16-64 meet the criteria for at least one common mental disorder. Overall prevalence of probable psychosis was 0.5%of 16-74 year olds with the highest prevalence observed among those aged 35 to 44 years (0.8%in 2007).[62]

NDTMS data from drug and alcohol treatment services on coexisting mental health issues is collected and the basis of a single Yes/No field in for "Is the client currently receiving care from mental health services for reasons other than substance misuse?"[63] This question meets neither the 2002 Department of Health definition of severe mental illness nor the broader definition proposed in the PHE consultation draft. Access to mental health services is likely to vary across the country according

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[57] Psychosis with Coexisting Substance Misuse, Assessment And Management In Adults And Young People, National Collaborating Centre For Mental Health, 2011

[58] The relationship between dual diagnosis: substance misuse and dealing with mental health issues, Social Care Institute for Excellence, 2009

[59] Mental Health Policy, Implementation Guide: Dual Diagnosis Good Practice Guide, Dept. of Health 2002

[60] Adult psychiatric morbidity in England, 2007, NHS Information Centre for health and social care, 2009

[61] CONSULTATION DRAFT: Co-existing alcohol and drug misuse with mental health issues: guidance to support local commissioning and delivery of care, PHE, 2014

[62] Adult psychiatric morbidity in England, 2007, NHS Information Centre for health and social care, 2009

[63] Adult Drug Treatment Business Definition: NDTMS Data Set L, PHE, 2013

to thresholds and eligibility criteria and interpretation of the data item may be subject to differing perspectives in different areas. It is hoped that once the draft PHE guidance on dual diagnosis is published, this data item can be harmonised with the guidance.

The data provided in the two JSNA support packs[64] show that 30% of new drug presentations were also receiving care from a mental health service for reasons other than substance misuse (27% of males, 41% of females) compared to 22% nationally. Similarly, 27% of new alcohol presentations were currently receiving care from mental health services for reasons other than substance misuse compared to 20% nationally.

When all open episodes during 2015/16 are included, local data shows the following:

Table 12: Dual diagnosis. SOURCE: Halo

Proportion of Somerset open episodes in 2015/16 who were also receiving care from a mental health service for reasons other than substance misuse (of those with an entry)			
	M	F	Combined
Opiates	23%	28%	24%
Non-opiates	37%	41%	38%
Alcohol & non-opiates	33%	52%	39%
Any drug citation	26%	34%	28%
Alcohol (only)	26%	40%	31%
Total	26%	37%	29%

Although there are potential inconsistencies, as mentioned above, it is clear that there is greater prevalence of mental health problems amongst those using substance misuse services than the general population and that women are more likely than men to be in receipt of treatment for mental health issues alongside drug and alcohol issues.

Comparison to the national figures provided through the JSNA support packs may indicate slightly higher prevalence locally or suggest that access to mental health services in Somerset is higher. However, the latest data on new cases of psychosis in Somerset[65] do not seem to indicate that Somerset has a higher prevalence.

[64] Adults – drugs JSNA support pack: key data, Somerset; Adults – alcohol JSNA support pack: key data, Somerset, PHE, 2016 (RESTRICTED)
[65] http://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness/

8. Criminal Justice

Data provided in the JSNA Support Packs[66] indicates that 21% of drug referrals and 5% of alcohol referrals were via the criminal justice system (CJS) in 2015/16 (custody/court based referral schemes, prison, probation/CRC); this compares to 22% and 8% nationally.

Analysis of local episode data provides additional insight into CJS referrals in Somerset. In terms of episodes of treatment when compared to the number of individuals starting treatment at least once during the year there is a clear difference between CJS clients and the overall treatment population. In 2015/16 there were approximately 1.1 episodes for each individual entering treatment overall (1329 episodes from 1213 individuals). However, when looking at the CJS cohort this rises to 1.33 episodes for every one individual (239 episodes from 180 individuals).

The table below shows that, whilst criminal justice referred 18% of all episodes in 2015/16, it accounted for 40% of opiate users referred into treatment. Another way of looking at this data is that opiate users made up 81% of all referrals from the CJS in 2014/15 (107 out of 132) and 74% in 2015/16 (177 out of 239).

Table 13: Criminal justice referrals by substance

Criminal Justice Referrals as a proportion of all referrals broken down by substance

	Opiates			Non-opiates (including alcohol & non-opiate)			Alcohol (only)			Totals		
Referrals	All	CJS		All	CJS		All	CJS		All	CJS	
	n	n	%	n	n	%	n	n	%	n	n	%
2014-15	388	107	28%	197	16	8%	375	9	2%	960	132	14%
2015-16	443	177	40%	351	35	10%	535	27	5%	1329	239	18%
Apr-Jun 16	113	36	32%	93	13	14%	131	8	6%	337	57	17%

As has been previously noted, criminal justice clients tend to generate higher rates of episodes (1.33 episodes per client compared to 1.1 per client overall). One of the factors that will impact on successful completion is previous early unplanned departures from treatment (under 12 weeks). Somerset has lower rates of early unplanned exits with 9% of drug clients and 3% of alcohol clients compared to 16% and 14% nationally based on JSNA support pack figures. Local data on episodes shows an overall rate of early unplanned exits of 8%.

However, of the referrals from the criminal justice system, over a quarter ended in an early unplanned exit from treatment in 2014/15 and 2015/16 (27% and 28% respectively) with over three-quarters of these resulting from the client being retained in custody (77% and 79%). As at 01/09/2016, 94% of early unplanned exits from treatment amongst CJS referrals were as a result of being retained in custody.

[66] Adults – drugs JSNA support pack: key data, Somerset; Adults – alcohol JSNA support pack: key data, Somerset , PHE, 2016 (RESTRICTED)

Of all those retained in custody between April 2014 and June 2016, shown below, there were less than 5 cases where the client was not an opiate user.

Table 14: Early unplanned exits for CJS clients. SOURCE: Halo

Criminal Justice Referrals resulting in an early unplanned exit					
	CJS Referrals	Early Unplanned Exits		Early exits retained in custody	
2014-15	132	35	27%	27	77%
2015-16	239	67	28%	53	79%
Apr-Jun 16*	57	17	30%	16	94%

*early exits up to 1st September 2016

Successful completion rates for referrals from the criminal justice system are similar to those for opiate users presenting to treatment over the same period at around 20% of those who have left the system.

9. Employment

Employment is considered to be one of the factors to sustaining recovery and can make a major contribution to the accrual of recovery capital and in tackling deprivation and social isolation. Data provided in the JSNA support packs[67] suggests that unemployment rates amongst new presentations to drug treatment in 2015/16 were higher in Somerset (56%) than nationally (43%). Similarly, 39% of alcohol presentations were unemployed compared to 34% nationally.

However, the proportion of new presentations for drug use who were recorded as being in regular employment are broadly similar (21% in Somerset, 20% nationally). For alcohol users, Somerset has a higher proportion presenting to treatment who are in regular employment than the national rate (35% and 29% respectively).

Some explanation of the difference in unemployment and employment rates can be found in an additional reporting field for those who are long-term sick or disabled. In Somerset 4% of drug clients and 3% of alcohol clients are recorded under this category compared to 26% and 24% nationally. This apparent inconsistency may be a result of local variations in recording practice or local policy decisions.

If we consider just those who are recorded as in regular employment, unemployed or long-term sick or disabled, 26% of drug clients and 45% of alcohol clients are in regular employment at the start of treatment.

For those where there is a record at the start of treatment and at a planned exit from treatment, the number who went from not working to some level of work (irregular, part-time or full-time) fell by 5 for drug clients and 20 for alcohol clients (2 percentage points and 7 percentage points respectively). These rates are comparable to the reductions nationally and are shown in Table 15 and

[67] Adults – drugs JSNA support pack: key data, Somerset; Adults – alcohol JSNA support pack: key data, Somerset, PHE, 2016 (RESTRICTED)

Table 16 below.

Given the associations between unemployment, recovery capital and deprivation, it would seem that further work is required locally and nationally to improve the employment chances of substance misuse clients in order to achieve sustained recovery.

Table 15: Adult drug client employment status at the start of treatment and treatment exit. SOURCE: JSNA Support Pack

Drugs	Start			Planned Exit		
	Somerset		National	Somerset		National
	Number	%	%	Number	%	%
Irregular work	5	2%	2%	5	2%	2%
Part-time work	22	9%	5%	8	3%	5%
Full time work	46	20%	22%	65	28%	27%
Not working	160	69%	71%	155	67%	67%

Table 16: Adult alcohol client employment status at the start of treatment and treatment exit. SOURCE: JSNA Support Pack

Alcohol	Start			Planned Exit		
	Somerset		National	Somerset		National
	Number	%	%	Number	%	%
Irregular work	16	6%	2%	6	2%	2%
Part-time work	13	5%	5%	18	6%	5%
Full time work	69	24%	22%	94	33%	25%
Not working	184	65%	70%	164	58%	69%

10. Housing and Homelessness

The links between homelessness and substance use are well established. These links are complex and many substance users cite their use as the reason for first becoming homeless: research undertaken by Crisis states that two thirds of homeless people cite drug or alcohol use as a reason for first becoming homeless[68]. However, it is also clear that being homeless can trigger or exacerbate substance use. A survey of homeless drug and alcohol users indicated that more than half of those using heroin had started using since becoming homeless and 70% or more of those using benzodiazepines, other opiates or crack had started since becoming homeless[69].

> *" .. when asked whether they felt their drug use had contributed to their first episode of homelessness, only half believed that it had. More importantly, four in five also said that they had started using at least one new drug while homeless. Drug use may well be a trigger for homelessness then, but homelessness is clearly a stronger trigger for drug use."*
>
> *Crisis – Home and Dry? Homelessness and Substance Use*

In addition, poor physical and mental health are more prevalent amongst homeless people. Homeless Link's Health Audit[70] shows that:

- 73% of homeless people reported physical health problems. 41% said this was a long term problem.
- 80% of respondents reported some form of mental health issue
- 45% had been diagnosed with a mental health issue.
- 35% had been to A&E and 26% had been admitted to hospital over the past six months.

> *"The onset of mental illness can trigger, or be part of, a series of events that can lead to homelessness. Mental health issues might well be exacerbated or caused by the stresses associated with being homeless."*
>
> *Crisis: Home and Dry? Homelessness and Substance Use*

The complex interrelationship between homelessness, substance use and mental health is summed up in an evidence review published by the Scottish Government as follows:

"Research has moved from a position in which homelessness was seen as a consequence of substance misuse, mental health problems or some combination of the two and towards a position in which substance misuse and homelessness are seen as mutually reinforcing, interrelated, social problems. Those who experience homelessness or substance misuse tend to share characteristics and homelessness

[68] http://www.crisis.org.uk/pages/health-and-dependancies.html
[69] Home and Dry? Homelessness and Substance Use, Crisis, London 2002
[70] The unhealthy state of homelessness: Health audit results 2014, Homeless Link, London, 2014

can be both an outcome of substance misuse and a catalyst for substance misuse. People who become homeless, who have no history of substance misuse, are at an increased risk of developing substance misuse problems. People who become involved in substance misuse are, in turn, at increased risk of experiencing homelessness. These populations are in addition characterised by poor social supports, negative experiences during childhood, poor educational outcomes, and sustained worklessness."[71]

The characteristics highlighted in the report can be closely aligned to the concepts of Recovery Capital as predictors of recovery as highlighted in the National Drugs Strategy[72] and the work of Best and Laudet[73].

- **Social capital** - the resource a person has from their relationships (e.g. family, partners, children, friends and peers). This includes both support received, and commitment and obligations resulting from relationships;
- **Physical capital** - such as money and a safe place to live;
- **Human capital** – skills, mental and physical health, and a job; and
- **Cultural capital** –values, beliefs and attitudes held by the individual.

The JSNA Support Pack[74] states that "a safe, stable home environment enables people to sustain their recovery".

Homelessness was identified in Somerset Public Health's workshop and report using PHE's Recovery Diagnostic Toolkit[75] as an area where clients in treatment had higher rates of No Fixed Abode (NFA) than the national average throughout their treatment journey with 16% of those in treatment for 2-3 years reporting that they had no fixed abode compared to 10% nationally.

The data on housing and homelessness provided with the JSNA support pack, which is derived from the National Drug Treatment Monitoring System (NDTMS), indicates that in 2015/16 Somerset had higher rates of new drug using client presentations to treatment who report being either NFA or having a housing problem (14% and 16% respectively for Somerset compared to 9% and 14% nationally).

For alcohol users Somerset also has slightly higher rates. The JSNA support pack shows 4% of alcohol users presenting to treatment were NFA and 9% had a housing problem. The national figures are 3% and 8%.

NDTMS reference data provides the following guidance on these definitions:

NFA – Urgent housing problem:

- Live on streets
- Use night hostels (night-by-night basis)
- Sleep on different friend's floor each night

[71] Effective Services for Substance Misuse and Homelessness in Scotland: Evidence from an International Review, Scottish Government Social Research, 2008
[72] Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life: HM Government, 2010
[73] Best, D. and Laudet, A.B. (2010) The Potential of Recovery Capital, RSA
[74] Adults – drugs JSNA support pack: key data, Somerset, PHE, 2016 (RESTRICTED)
[75] Review of the Recovery Diagnostic Toolkit for Somerset & Workshop, Somerset County Council Public Health, June 2016

Housing Problem

- Staying with friends/family as a short-term guest
- Night winter shelter
- Direct Access short stay hostel
- Short term B&B or other hotel
- Squatting

The pack also provides the number and rate per 1,000 households of decisions on homeless applications taken by the district councils in Somerset. In 2015/16 there were 696 decisions taken which is 2.95 per 1,000 households compared to 5.00 per 1,000 households nationally.

It is important to recognise that the data on decisions, as reported via national statistics[76], reflect the number of households who made homeless applications to the local authority and therefore may not give accurate figures on the number of people who are actually homeless. Each local authority has a clear statement as to those to whom it has a statutory duty to house (as opposed to providing advice and assistance) and the nationally set criteria for priority need. It is therefore likely that many individuals do not apply to the local authority and are 'hidden' from official statistics (see below). An example of the information provided by district councils is included at Appendix 2.

The table below shows the total number of homeless application decisions taken by each district council between 2013/14 and 2015/16.

Table 17: Homeless applications in Somerset.

SOURCE: DCLG - www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

Homeless applications - total decisions taken			
	2013/14	**2014/15**	**2015/16**
Mendip	140	129	103
Sedgemoor	98	98	143
South Somerset	306	240	214
Taunton Deane	155	186	174
West Somerset	144	124	62
Somerset Totals	**843**	**777**	**696**

Table 18: Priority need housing applications.

SOURCE: DCLG - www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

Number and percentage accepted as being homeless and in priority need						
	2013/14		**2014/15**		**2015/16**	
Mendip	82	59%	57	44%	27	26%
Sedgemoor	32	33%	45	46%	64	45%
South Somerset	196	64%	171	71%	150	70%
Taunton Deane	102	66%	133	72%	93	53%
West Somerset	26	18%	37	30%	34	55%
Somerset Totals	**438**	**52%**	**443**	**57%**	**368**	**53%**

[76] www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

Across Somerset overall these figures indicate that the number of homeless applications to the district councils and the number of those who are accepted as being homeless and in priority need has fallen over this period. There are however local variations, with Sedgemoor and Taunton Deane showing increases in decisions made and Sedgemoor also having an increase in those accepted.

Research published by Crisis[77] suggests that 62% of homeless people may be 'hidden' at any one time. This is defined as:

- those who meet the legal definition of homeless but to whom the local authority owes no duty (because they have not approached a local authority or because the local authority has decided they are not owed the main housing duty), AND
- whose accommodation is not supplied by a housing/homelessness provider.

More than a quarter of the homeless respondents to the survey conducted for this research had not approach a local authority as homeless and the study goes on to state:

"*Evidence emerged that single homeless people who may be entitled to accommodation were deterred from applying, many were misinformed about their entitlements, not all were given the opportunity to make a homelessness application, local authorities did not always fulfil their duty to 'advise and assist', and when advice or signposting was offered it was of little or no use. Many respondents were deterred from approaching a local authority because of prior unsatisfactory experience of low expectations."*

Another indicator that can be used to understand changes in homelessness in England is the annual Rough Sleeping statistical release[78]. This provides a snapshot based on either actual counts or estimates on the number of rough sleepers in each local authority area. Clearly there are many difficulties in providing an accurate picture of rough sleeping and the data provided is a snapshot of a single night each autumn. Each of Somerset's 5 district councils has provided estimates based on local intelligence and consultation with other agencies.

Although numbers are very small, they suggest that the number of rough sleepers has doubled between 2013 and 2015 (numbers: 2013 - 28, 2015 - 56) with Mendip and Taunton estimating 21 and 20 rough sleepers respectively. This compares with a 48% increase across England overall and a 73% increase in London over the same time period[79]. Changes in rough sleeping estimates for the same time period in selected comparator Local Authorities are: Devon 74%; Norfolk 40%; Gloucester minus 5%; Suffolk 105% Suffolk.

When the rate per 1,000 households is factored in, both Mendip and Taunton Deane are in the highest 10% of local authorities with rates of 0.42 and 0.43 rough sleepers per 1,000 households compared to 0.16 per 1,000 for England as a whole and 0.27 per 1,000 for London overall.

[77] The hidden truth about homelessness. Crisis/CRESR, May 2011

[78] Rough Sleeping Statistics Autumn 2015, England. Homelessness Statistical Release, DCLG, 25 February 2016

[79] https://www.gov.uk/government/publications/rough-sleeping-in-england-autumn-2015

The estimate for rough sleeping in Bristol indicates that it has the second highest number of rough sleepers (n=97) of all local authorities in England after Westminster which has 265.

Work is ongoing in Somerset to establish alternative arrangements following the decision to cease funding for accommodation support for adults where the council did not have a statutory duty to do so. This funding ceased in May 2016 and it is probably too early to establish whether this has had an impact on homelessness in the county.

Since the re-commissioning of drug and alcohol services in Somerset in 2014, local data has been available on a wide range of issues relating to those accessing services.

The following analysis is based on treatment *episodes* for those commencing structured treatment as opposed to individuals starting treatment. For adults the number of episodes and the number of individuals that these episodes relate to during each time period are as follows:

Table 19: Treatment Episodes and Individual Clients. SOURCE: Halo

Reporting Period	Number of adult episodes	Number of adults this relates to	Episodes per individual
2014/15	960	889	1.080
2015/16	1329	1213	1.096
Apr – Jun 2016	337	331	1.018

Clearly for quarter 1 of 2016/17 there is less likelihood of individuals re-presenting in this period than for the whole year data.

10.1 Housing, Homelessness and Successful Completions

As at 07/09/2016 the following number of the new presentations during each period had been closed.

Table 20: Closed episodes. SOURCE: Halo

New adult presentations to treatment that had closed at 07/09/16		
	Total	Percentage of presentations
2014-15	812	85%
2015-16	982	74%
Apr-Jun 16	115	34%

Overall, 58% of these closures were recorded as ‘Treatment Completed – Drug/Alcohol Free’ or ‘Occasional User (not opiate or crack)’. However, if those who presented as NFA or with a Housing Problem are separated out, there is a significant difference between the outcomes for those with housing issues and those who are in stable accommodation. For those who are recorded as having a housing issue 29% of closures are ‘Treatment Complete’ compared to 68% of those who have no housing issue.

Table 21: Successful completions. SOURCE: Halo

Successful Completions as a proportion of all episodes closed for new presentations to treatment									
	NFA or Housing Problem			No Housing Problems			Overall		
	Closures	Successful Completions	Percentage of closures	Closures	Successful Completions	Percentage of closures	Closures	Successful Completions	Percentage of closures
2014-15	216	54	25%	596	393	66%	812	447	55%
2015-16	248	82	33%	734	501	68%	982	583	59%
Apr-Jun 16	30	8	27%	85	64	75%	115	72	63%
Total	**494**	**144**	**29%**	**1415**	**958**	**68%**	**1909**	**1102**	**58%**

Of the 144 successful completions who had a housing issue at the start of treatment, 32 were still recorded as having either a housing problem or being at risk of eviction on their Treatment Outcome Profile.

10.2 Housing and Homelessness by substance used

The JSNA support packs show a difference in the rates of housing problems between drug and alcohol users in Somerset. This can be further broken down using local episode data to assess differences between the four basic substance types used in NDTMS: Opiates; non-opiates; alcohol and non-opiates and alcohol only.

The overall proportion of new presentations to treatment who have a housing problem or are NFA has remained relatively stable with roughly a quarter of those starting treatment reporting housing issues. However, there was a marked increase in the number of new presentations between 2014/15 and 2015/16 and the 1st quarter's data for 2016/17 suggests that the level of new presentations will remain at this higher level.

Table 22 shows the number and proportion of new episodes reporting a housing issue. As can be seen, the number of episodes where the client reported being NFA increased from 94 in 2014/15 to 153 in 2015/16 and 1st quarter data for 2016/17 suggests that the numbers will be higher again in the full year.

These figures are the number of presentations to SDAS treatment services and individuals may be recorded more than once if they have exited treatment and re-presented in the same period. Further analysis shows that the number of *individuals* presenting to treatment as NFA were:

2014/15	75
2015/16	128
Quarter 1 2016/17	45

Table 22: New presentations with a housing issue. SOURCE: Halo

New adult presentations to treatment							
	Episodes	Housing Problem		NFA		Housing Problem **or** NFA	
2014-15	960	152	16%	94	10%	246	26%
2015-16	1329	179	13%	153	12%	332	25%
Apr-Jun 16	337	44	13%	46	14%	90	27%

As previously shown in Section 2, the proportion of new presentations who are using alcohol only has remained fairly constant at around 4 in 10 new clients. The proportion of new clients using non-opiates (and a combination of alcohol and non-opiates) has increased. In general greater proportions of drug users present with a housing need than alcohol users, as is described in the following paragraphs.

The tables below show the number and proportion of each substance group presenting as NFA or with a housing problem. There were 59 more episodes where the client was NFA in 2015/16 than the previous year. Of these there were 43 more opiate episodes which represent 26% of opiate episodes in 2015/16 compared to 18% of opiate episodes in 2014/15. The proportion of non-opiate users and alcohol users presenting as NFA remained stable.

Table 23 New episodes who are NFA. SOURCE: Halo

Number and proportion of new episodes reporting NFA						
	Opiates		All Non-Opiates		Alcohol (only)	
2014-15	70	18%	10	5%	14	4%
2015-16	113	26%	20	6%	20	4%
Apr-Jun 16	34	30%	6	6%	6	5%

Table 24: New episodes reporting a housing problem. SOURCE: Halo

Number and proportion of new episodes reporting a housing problem						
	Opiates		All Non-Opiates		Alcohol (only)	
2014-15	79	20%	35	18%	38	10%
2015-16	66	15%	65	19%	48	9%
Apr-Jun 16	17	15%	12	13%	15	11%

Table 25: New episodes either NFA or with a housing problem. SOURCE: Halo

Number and proportion of new episodes reporting either NFA or a housing problem						
	Opiates		All Non-Opiates		Alcohol (only)	
2014-15	149	38%	45	23%	52	14%
2015-16	179	40%	85	24%	68	13%
Apr-Jun 16	51	45%	18	19%	21	16%

10.3 Housing and Homelessness by gender

Overall, approximately two-thirds of clients are male, which reflects national patterns. Whilst this distribution is similar for those presenting with a housing problem (Table 26), the proportion of men presenting as NFA is slightly greater (Table 27). Although the numbers are too small to draw a strong conclusion, the number of episodes where women were NFA more than doubled from 2014/15 to 2015/16.

Table 26: Housing problem by gender. SOURCE: Halo

Number and proportion reporting a housing problem					
	Total	Male		Female	
2014-15	152	107	70%	45	30%
2015-16	177	125	71%	52	29%
Apr-Jun 16	44	34	77%	10	23%

Table 27: No Fixed Abode by gender. SOURCE: Halo

Number and proportion reporting NFA					
	Total	Male		Female	
2014-15	94	79	84%	15	16%
2015-16	153	119	78%	34	22%
Apr-Jun 16	46	38	83%	8	17%

10.4 Dual Diagnosis and Homelessness

Research indicates that the prevalence of co-existing mental health and substance misuse issues is significantly higher amongst the homeless population than the general population. The annual health audit published by Homeless Link[80] suggests that 45% of homeless people have a diagnosed mental health condition and that 12% have a dual diagnosis.

Data provided in the two JSNA support packs[81] show that 30% of new drug presentations had also received care from a mental health service for reasons other than substance misuse (27% of males, 41% of females) compared to 22%nationally and 27% of new alcohol presentations were currently receiving care from mental health services for reasons other than substance misuse compared to 20% nationally.

The support packs note that data completeness and variation in local definitions will affect the robustness of any comparisons.

Analysis of local data on new presentations does not show and significant differences between the incidence of dual diagnosis amongst those who are homeless (or have a housing problem) and those who do not.

[80] The unhealthy state of homelessness: Health audit results 2014, Homeless Link, London, 2014

[81] Adults – drugs JSNA support pack: key data, Somerset; Adults – alcohol JSNA support pack: key data , Somerset, PHE, 2016 (RESTRICTED)

Table 28 and Table 29 below show the number and proportion of clients with a dual diagnosis overall and those who present with a housing need.

Table 28: New presentation recorded as dual diagnosis. SOURCE: Halo

All new presentations			
	Total Episodes	Dual Diagnosis	
2014-15	960	372	39%
2015-16	1329	385	29%
Apr-Jun 16	337	91	27%

Table 29: Dual diagnosis presentations with a housing issue. SOURCE: Halo

New presentations who are NFA or have a housing problem			
	Total Episodes	Dual Diagnosis with housing problem/NFA	
2014-15	246	95	39%
2015-16	332	96	29%
Apr-Jun 16	90	22	24%

10.5 Housing and Homelessness by age group

Whilst approximately one in four of all new presentation to treatment were either NFA or had a housing problem, the proportion increases to one in three adults aged between 18 and 35 years. Based on the first quarter's data for 2016/17 it is possible that the proportion of adults in the older age bands may be increasing. Table 30 below show the proportion of each age group that presented with either a housing problem or NFA for 2014/15, 2015/16 and the first quarter of 2016/17.

Table 30: Housing issue by age. SOURCE: Halo

NFA or Housing Problem as a proportion of all new presentations by age group							
	18-25	26-35	36-45	46-55	56-65	Over 65	Total
2014/15	28%	36%	22%	20%	*	*	26%
2015/16	31%	31%	25%	19%	9%	*	25%
Apr - Jun 16	20%	33%	37%	17%	*	*	27%

10.6 Housing, Homelessness and the Criminal Justice System

Since April 2014 around 16% of new episodes have been referred through the criminal justice system (CJS). Recording of the specific names/types of CJS referral source has varied slightly over this time but include: Arrest Referral Service (AIRS), Integrated Offender Management (IMPACT), Probation and CRCs and the Prison Based Services (CARATS)[82].

[82] Counselling, Assessment, Referral, Advice and Throughcare Services in Prisons

Of the above, prison-based substance misuse provision (CARATS) is the largest referring source (10%-11% per year). In 2015/16 41% of the referrals from CARATS presented to treatment services as NFA, which represents 39% of all the cases of NFA across SDAS in the year. Overall, nearly a quarter of all the presentations with a housing issue have been referred by CARATS.

Table 31: CARATS referrals with a housing issue. SOURCE: Halo

CARATS referrals as percentage of all housing issues						
	Housing Problem		NFA		Housing Problem/NFA	
2014-15	23	15%	34	36%	57	23%
2015-16	20	11%	59	39%	79	24%
Apr-Jun 16	5	11%	17	37%	22	24%

The data that is available does not provide any details on the criminal justice status of the presentations and it is possible that some will be individuals who have been recalled to prison for short sentences and others will have been released following a period of remand. However, further work with the community rehabilitation company delivering *Through the Gate* services for prisoners from Somerset should be undertaken to ensure that their remit is being fulfilled and to identify any opportunities for joint initiatives to reduce the number of prison releases presenting for drug and alcohol treatment who are homeless.

10.7 Supported Housing

Supported housing can play an important role in breaking the cycle of homelessness and enabling people to successfully move into, and sustain, independent accommodation.

Table 32 below shows the number of presentations to treatment who stated that they lived in supported housing.

Table 32: New presentations living in supported accommodation. SOURCE: Halo

Adult presentations recorded as living in supported housing						
	Male	Female	Total	%	Of whom, those aged 25 and under	
2014-15	52	21	73	8%	19	26%
2015-16	61	17	78	6%	24	31%
Apr-Jun 16	7	6	13	4%	5	38%

As previously mentioned, there are significant changes to the provision of supported accommodation in Somerset that are ongoing. However, as part of the integrated drug and alcohol service commissioned in 2014 (SDAS), a small amount of substance misuse-specific supported accommodation was commissioned. This is currently comprised of 14 units of accommodation spread across 3 sites with a further 6 units on an additional site being planned (this replaces 4 units that were removed from the provision by the landlord).

The SDAS housing provision is largely aimed at service users who are either already abstinent having completed structured treatment or those who are well engaged with treatment and are stable on substitute prescriptions. This is mainly due to the levels of support and supervision that can be provided within the current funding arrangements. There are 2 full-time support workers spread across the 3 (and potentially 4) sites plus some housing management time funded through service charges/housing benefit and an out-of-hours telephone assistance line.

Even with the comparatively narrow eligibility criteria described above, achieving positive outcomes has proved challenging with 22 residents being evicted and 7 successfully moving into independent accommodation during 2015/16[83].

Clearly the current provision plays an important role for those nearing the end of their treatment journey and can act as a bridge for people to sustain safe, suitable accommodation as part of their recovery. However, in light of the additional difficulties faced by people who present to treatment as homeless, commissioners may want to review the way in which accommodation services are integrated into the substance misuse system.

This could include:

- increasing levels of support and supervision within existing provision to reduce attrition;
- establishing different, or additional, supported accommodation options with lower behavioural expectations and greater levels of support and supervision in order to meet the needs of those presenting to treatment who are homeless and may not be able to maintain their own accommodation or;
- identifying existing provision that meets the housing needs for this client group and delivering intensive substance misuse support directly within the provision.

In light of the potential crossover with criminal justice clients, particularly those leaving prison, further examination of joint arrangements between commissioning agencies may also prove beneficial.

[83] Source: Monthly contract monitoring reports provided to Somerset Pubic Health

Appendix 1

New adult presentations to treatment 2015/16 by gender, age band and substance from Halo

	18-24		25-29		30-34		35-39		40-44		45-49		50-54		55-59		60-64		65 and over		All	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
All	124	53	160	59	119	58	145	46	114	47	94	52	75	36	40	19	25	20	29	14	925	404
	70%	30%	73%	27%	67%	33%	76%	24%	71%	29%	64%	36%	68%	32%	68%	32%	56%	44%	67%	33%	70%	30%
Opiates	37	17	76	21	60	24	76	16	44	13	23	8	*	*	*	*	*	*	0	0	339	104
	69%	31%	78%	22%	71%	29%	83%	17%	77%	23%	74%	26%	80%	20%	90%	10%	67%	33%	N/A	N/A	77%	23%
Non-opiates	45	17	42	12	10	7	8	5	*	*	*	*	*	*	*	*	*	*	*	*	122	44
	73%	27%	78%	22%	59%	41%	62%	38%	78%	22%	80%	20%	100%	0%	100%	0%	N/A	N/A	100%	0%	73%	27%
Alcohol & non-opiates	31	12	25	14	22	11	*	*	9	6	10	5	*	*	*	*	*	*	*	*	130	55
	72%	28%	64%	36%	67%	33%	83%	17%	60%	40%	67%	33%	77%	23%	100%	0%	100%	0%	N/A	N/A	70%	30%
Alcohol (only)	11	7	17	12	27	16	41	21	54	26	57	38	49	30	29	18	21	19	28	14	334	201
	61%	39%	59%	41%	63%	37%	66%	34%	68%	33%	60%	40%	62%	38%	62%	38%	53%	48%	67%	33%	62%	38%

Adult Open Episodes 2015/16 by gender, age band and substance from Halo

	18-24		25-29		30-34		35-39		40-44		45-49		50-54		55-59		60-64		65 and over		All	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
All	162	82	219	106	237	120	307	125	303	117	230	106	167	66	78	34	51	28	45	22	1799	806
	66%	34%	67%	33%	66%	34%	71%	29%	72%	28%	68%	32%	72%	28%	70%	30%	65%	35%	67%	33%	69%	31%
Opiates	52	30	117	56	148	71	204	80	190	57	129	41	67	16	28	6	*	*	*	*	954	358
	63%	37%	68%	32%	68%	32%	72%	28%	77%	23%	76%	24%	81%	19%	82%	18%	92%	8%	100%	0%	73%	27%
Non-opiates	59	23	47	13	15	12	15	7	*	*	*	*	*	*	*	*	*	*	*	*	162	62
	72%	28%	78%	22%	56%	44%	68%	32%	79%	21%	67%	33%	88%	13%	100%	0%	N/A	N/A	100%	0%	72%	28%
Alcohol & non-opiates	41	19	33	22	30	16	31	8	20	7	17	12	*	*	*	*	*	*	*	*	194	89
	68%	32%	60%	40%	65%	35%	79%	21%	74%	26%	59%	41%	79%	21%	80%	20%	100%	0%	100%	0%	69%	31%
Alcohol (only)	10	10	22	15	44	21	57	30	82	50	78	50	78	45	45	27	37	27	36	22	489	297
	50%	50%	59%	41%	68%	32%	66%	34%	62%	38%	61%	39%	63%	37%	63%	38%	58%	42%	62%	38%	62%	38%

In order to protect the anonymity of treatment service users, figures have been suppressed if they have a cell value of less than five (5). Such occurrences are indicated by a field containing "*" rather than a numeric value. This is because of the issue of “deductive disclosure”; the possibility (however remote) that information could be combined from several sources to identity individuals in contact with drug and alcohol treatment services.

Appendix 2

Extract from Sedgemoor District Council Website
(http://www.sedgemoor.gov.uk/index.aspx?articleid=6118)

Are you eligible for assistance?
Not everyone who is homeless is eligible. For example, the Government makes certain people from abroad ineligible for housing assistance. You will not be eligible if you:

- *are a person from abroad who does not have recourse to public funds*
- *are an asylum seeker who has been provided with accommodation elsewhere in the UK; or*
- *are subject to immigration control unless you come under a class prescribed by regulations.*

Your status will be tested if you make a homeless application and you will be advised whether the Council consider you are eligible or ineligible.

Are you homeless?
Homelessness is a term which covers a range of situations. The Council may consider that you are homeless or threatened with homelessness if:

- *you have been staying somewhere but have no legal rights to stay there and are being told to leave;*
- *you have a home but cannot gain entry to it;*
- *you have somewhere to live but are likely to face violence or harassment if you return;*
- *you have been asked to leave by your landlord, bank or building society; or*
- *you have a mobile home, caravan or boat but do not have anywhere to put it.*

The Council will make a decision as to whether you are homeless. People who are not statutory homeless will only be provided with homelessness advice.

Are you in priority need?
The Council does not have to provide accommodation for all homeless people. We will provide temporary accommodation for homeless people who are considered to have a priority need. The law says that the following have a priority need if homeless and:

- *you have dependent children living with you (under 16 or up to 19 if in full time education);*
- *you are an expectant mother;*
- *you are aged 16 or 17;*
- *you are a care leaver aged 18 to 20 and a former 'relevant child' under the Children Act 2000;or*
- *you are homeless as a result of an emergency such as fire or flood*

You may also be in priority need if you are vulnerable:

- *due to old age, disability or mental illness;*
- *having been looked after or fostered and is age 21 or over (other than 'relevant students')*
- *having been a member of her majesty's armed forces;*
- *having served a custodial sentence, been committed for contempt of court or similar offence, or been remanded in custody; or*
- *having had to leave accommodation because of violence or threats of violence from another person that are likely to be carried out.*

What if I make myself homeless?
If the Council decides that you are eligible, homeless and in priority need but have made yourself homeless intentionally, our duty to you will be severely limited. The Council would not be under a duty to provide you with permanent accommodation.
We could decide that you are intentionally homeless if:

- *you deliberately gave up accommodation you could have stayed in;*
- *you deliberately did or failed to do something, which you knew would mean losing your accommodation;*
- *you made arrangements to stay in accommodation on an insecure basis which gave you no legal rights with the intention of making a homelessness application; or*
- *you failed to act on advice and assistance that you find alternative suitable accommodation.*

If you are intentionally homeless you will be offered advice and may be offered temporary accommodation for a reasonable period (usually 28 days) to give you time to secure your own accommodation. You will be entitled to be given a reasonable preference on the Housing Register, unless your behaviour makes you ineligible.

Do I have a local connection?
In order for a homelessness application to be accepted by the Council, you would normally be required to have a local connection with this district.
A local connection is:

- *normal continuous residence in the area for 6 out of the last 12 months or 3 out of the last 5 years;*
- *permanent employment in the district; or*
- *close family living in the area for the last 5 years (mother, father, brother or sister).*

Some forms of residence do not count as establishing a local connection, such as with the armed forces, prison, hospital or institution. If the Council decides that you are unintentionally homeless and in priority need but do not have a local connection with Sedgemoor, it is likely that you will be referred to a Council where you do have a local connection, where it is safe to do so.