Brighton & Hove City Council

# Health & Wellbeing Board

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| Title: | **Health & Wellbeing Board** |
| Date: | **12 June 2013** |
| Time: | **5.00pm** |
| Venue | **Council Chamber, Hove Town Hall** |
| | **Board Members** |
| Councillors: | Jarrett (Chair), K Norman (Opposition Spokesperson), Meadows (Opposition Spokesperson), Bennett, Bowden, Pissaridou, Shanks |
| BHCC:<br><br><br><br>CCG<br><br>Youth Council<br>HealthWatch | Heather Tomlinson, Interim Statutory Director of Children's Services<br>Denise D'Souza, Statutory Director of Adult Social Care<br>Dr. Tom Scanlon, Statutory Director of Public Health<br>Dr. Xavier Nalletamby, Clinical Lead<br>Geraldine Hoban, Non-clinical member<br>Hayyan Asif<br>Robert Brown |
| Contact: | **Caroline De Marco**<br>Democratic Services Officer<br>01273 291063<br>caroline.demarco@brighton-hove.gov.uk |

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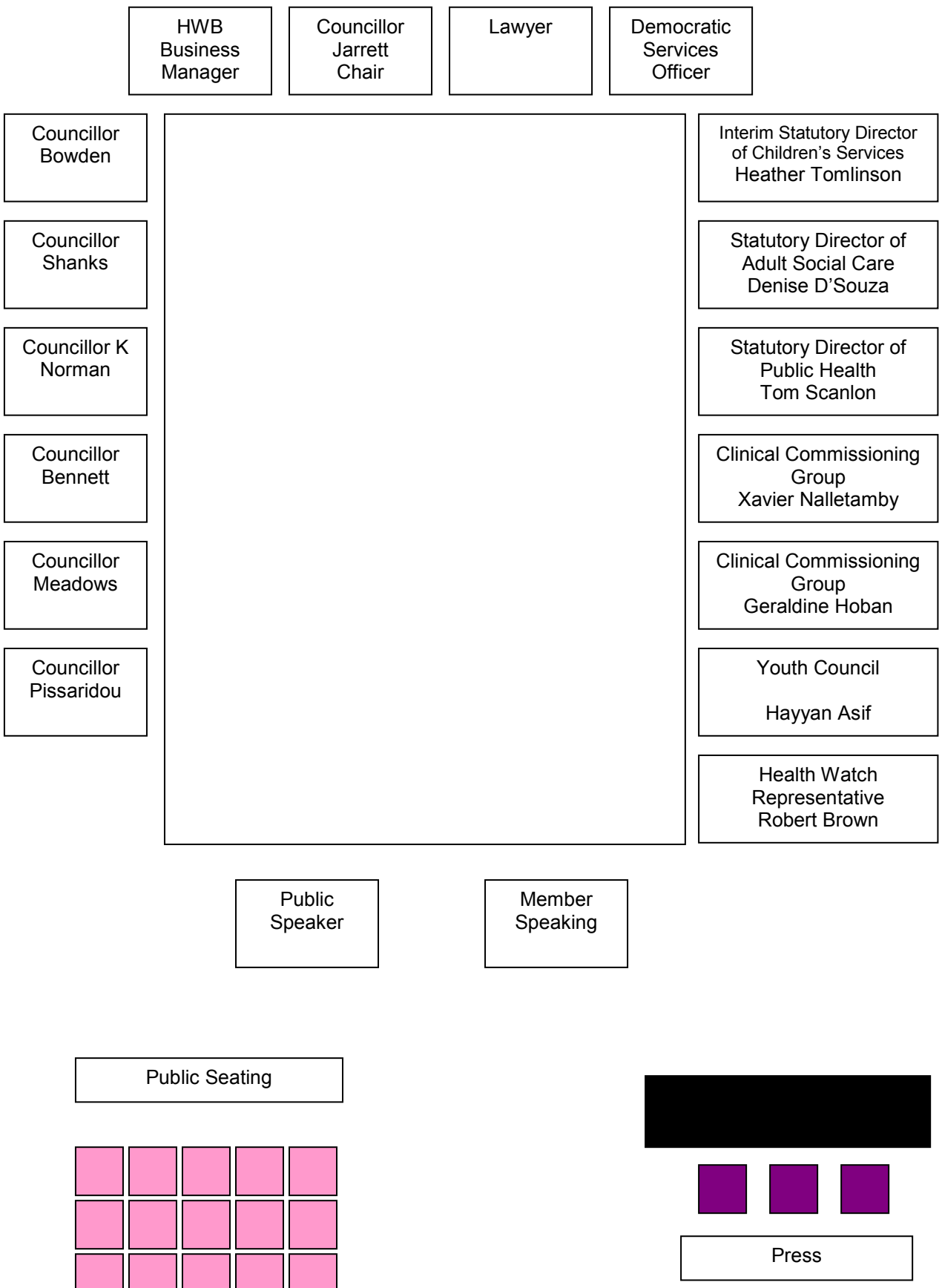
# Health & Wellbeing Board



# AGENDA

**PART ONE** **Page**

## 1. PROCEDURAL BUSINESS

**(a) Declaration of Substitutes** - Where Councillors are unable to attend a meeting, a substitute Member from the same Political Group may attend, speak and vote in their place for that meeting.

**(b) Declarations of Interest** – Statements by all Members present of any personal interests in matters on the agenda, outlining the nature of any interest and whether the Members regard the interest as prejudicial under the terms of the Code of Conduct.

**(c) Exclusion of Press and Public** - To consider whether, in view of the nature of the business to be transacted, or the nature of the proceedings, the press and public should be excluded from the meeting when any of the following items are under consideration.

***NOTE:*** *Any item appearing in Part Two of the Agenda states in its heading the category under which the information disclosed in the report is exempt from disclosure and therefore not available to the public.*

*A list and description of the exempt categories is available for public inspection at Brighton and Hove Town Halls.*

## 2. MINUTES **1 - 10**

Minutes of the Shadow Health & Wellbeing Board meeting held on 20 March 2013 (copy attached).

## 3. CHAIR'S COMMUNICATIONS

## 4. PUBLIC INVOLVEMENT

To consider the following matters raised by members of the public:

- **(a) Petitions** – to receive any petitions presented to the full council or at the meeting itself;
- **(b) Written Questions** – to receive any questions submitted by the due date of 12 noon on the 5 June 2013;
- **(c) Deputations** – to receive any deputations submitted by the due date of 12 noon on the 5 June 2013.

## 5. ISSUES RAISED BY COUNCILLORS AND MEMBERS OF THE BOARD

To consider the following matters raised by councillors and Members of the Board:

**(a) Petitions** – to receive any petitions submitted to the full Council or at the meeting itself;
**(b) Written Questions** – to consider any written questions;
**(c) Letters** – to consider any letters;
**(d) Notices of Motion** – to consider any notices of motion

## 6. PENNY THOMSON BHCC CHIEF EXECUTIVE TO ADDRESS THE BOARD

## 7. '3T' DEVELOPMENT OF THE ROYAL SUSSEX COUNTY HOSPITAL

Presentation by Matthew Kershaw, BSUH Chief Executive and Duane Passman, Director of 3Ts, Brighton and Sussex University Hospital Trust.

## 8. JSNA: UPDATE ON ROLLING PROGRAMME OF NEEDS ASSESSMENTS 11 - 16

Report of the Director of Public Health (copy attached).

*Contact Officer:* *Alistair Hill* *Tel: 01273 296560*
*Ward Affected:* *All Wards*

## 9. EMOTIONAL HEALTH & WELLBEING (INCLUDING MENTAL HEALTH) 17 - 50

Presentation on the Joint Health & Wellbeing Strategy Priority by Clare Mitchison, Public Health Specialist (BHCC), Alison Nuttall, Strategic Commissioner CYPT (BHCC) and Anne Foster, Head of Commissioning, Mental Health & Community Care (CCG) (Copies attached).

## 10. INDEPENDENT DRUGS COMMISSION REPORT 51 - 78

Report of Director of Public Health (copy attached).

*Contact Officer:* *Peter Wilkinson, Linda Beanlands* *Tel: 01273 296562, Tel: 29-1115*
*Ward Affected:* *All Wards*

**HEALTH & WELLBEING BOARD**

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Meeting papers can be provided, on request, in large print, in Braille, on audio tape or on disc, or translated into any other language as requested.

For further details and general enquiries about this meeting contact Caroline De Marco, (01273 291063, email caroline.demarco@brighton-hove.gov.uk) or email democratic.services@brighton-hove.gov.uk

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Date of Publication - Tuesday, 4 June 2013

| SHADOW HEALTH & WELLBEING BOARD | Agenda Item 2<br>Brighton & Hove City Council |
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**BRIGHTON & HOVE CITY COUNCIL**

**SHADOW HEALTH & WELLBEING BOARD**

**5.00pm 20 MARCH 2013**

**COUNCIL CHAMBER, HOVE TOWN HALL**

**MINUTES**

**Present**: Councillor Jarrett (Chair) Councillors Bennett, Deane, Meadows, K Norman, Shanks (Deputy Chair) and Wilson.

**Other Members present**: Heather Tomlinson, Interim Statutory Director of Children's Services, Dr. Tom Scanlon, Statutory Director of Public Health, Dr. Xavier Nalletamby, Clinical Lead, CCG, Ramona Booth, Non Clinical member CCG, Hayyan Asif, Youth Council and Robert Brown, HealthWatch.

**Apologies for absence:** Denise D'Souza, Statutory Director of Adult Social Services.

**PART ONE**

**30. PROCEDURAL BUSINESS**

**30A Declarations of Substitute Members**

30.1 Councillor Deane declared that she was substituting for Councillor Duncan. Ramona Booth declared that she was substituting for Geraldine Hoban.

**30B Declarations of Interests**

30.2 There were none.

**30C Exclusion of the Press and Public**

30.3 In accordance with section 100A(4) of the Local Government Act 1972, it was considered whether the press and public should be excluded from the meeting during the consideration of any items contained in the agenda, having regard to the nature of the business to be transacted and the nature of the proceedings and the likelihood as to whether, if members of the press and public were present, there would be disclosure to them of confidential or exempt information as defined in section 100I (1) of the said Act.

30.4 **RESOLVED** - That the press and public be not excluded from the meeting.

## 31. MINUTES

31.1 Councillor Meadows referred to paragraphs 22.4 and 25.6 with regard to updates Geraldine Hoban was going to provide on CCG developments and the Local Education Training Board. Councillor Meadows further referred to paragraph 28.7 with regard to a question about how the Parent Carers' Council related to the Carers Centre. This matter was going to be checked.

31.2 The Chair explained that Geraldine Hoban was not in attendance to answer questions and that Ramona Booth was substituting. Geraldine could be asked to provide a written response which could be sent to members of the Board.

31.3 The Shadow Health and Wellbeing Manager explained that the Parent Carers' Council and the Carers Centre worked closely together but were organisationally separate.

31.4 Councillor Norman referred to paragraph 29.7 and asked for an explanation of the context of Councillor Shank's statement regarding the importance of supporting women with children. The Chair explained that the context was in relation to preventing safeguarding issues and supporting responsible adults. Councillor Shanks agreed that it was about supporting adults. For example, she felt that it was important to support women who had children taken into care, in order to prevent other children in the family being taken into care. These women often had mental health issues.

31.5 **RESOLVED -** That the minutes of the meeting held on the 5 December 2012 be approved as a correct record of the proceedings and signed by the Chair.

## 32. CHAIR'S COMMUNICATIONS

### Brighton and Sussex University Hospital Trust

32.1 The Chair informed members that there had recently been problems at the hospital trust with bed shortages and increased waiting times in A&E. The Director of Adult Social Services had confirmed that all planned discharges had been completed.

32.2 The Shadow Health and Wellbeing Board Business Manager reported that the Chair of the Health and Wellbeing Overview and Scrutiny Committee (HWOSC) had written to the Brighton and Sussex University Hospital Trust and asked for assurance regarding hospital safety. A letter had also been sent to the Clinical Commissioning Group. The NHS Sussex Area Team had stated that there had been national issues regarding capacity. Any specific issues could be considered at the HWOSC.

32.3 Robert Brown informed members that he had been asked to send a letter to the CCG, the hospital trust and the council. This would be one of the first issues to be considered by HealthWatch.

### HealthWatch

32.4 Robert Brown mentioned that this was the last meeting he would attend before HealthWatch took over from the LINk. He stressed the importance of people becoming involved in HealthWatch. The Chair agreed that the success of HealthWatch depended

on public engagement. He formally thanked Robert and the LINk for all they had achieved.

## 33. PUBLIC INVOLVEMENT

33.1 There were no petitions, written questions or deputations from members of the public.

## 34. ISSUES RAISED BY COUNCILLORS AND MEMBERS OF THE BOARD

34.1 The Chair noted that there were no petitions from Councillors or members of the Board.

(b) Written Questions

34.2 Councillor Graham Cox asked the following question:

'The RNIB has produced a template for local authorities which can assist organisations when developing their needs assessment for blind and partially sighted people. Can you confirm that the City Council's Health and Wellbeing Strategy identifies the need of blind and partially sighted people living in our area and of those at risk of losing their sight? Will the Health and Wellbeing Board be including information on sight loss, and how it will meet the needs of the blind and partially sighted, in the future?'

34.3 The Chair gave the following response:

"Thank you for your recent letter regarding services for blind and partially sighted people and the local Joint Health & Wellbeing Strategy (JHWS).

The Government has granted local areas a good deal of latitude in putting together the local JHWS. In some areas, the JHWS may seek to encompass a very wide range of health and wellbeing services for local residents; in others it will focus on a much smaller range of strategically important issues. The latter approach is the one we have adopted in Brighton & Hove. Using information from the city Joint Strategic needs Assessment (JSNA) we have sought to identify a number of 'highest impact' local issues: matters where there is *both* a very significant impact upon the health of the local population *and* the opportunity to improve outcomes by better and more focused partnership working, especially in terms of joint working between city council and NHS commissioners.

The needs of blind and partially sighted people were considered as part of this prioritisation process, alongside a wide range of other health and wellbeing needs experienced by local people. Specifically, Section 7.4.2 of the 2012 JSNA Summary focuses on Preventable Sight Loss including glaucoma, cataract, diabetic retinopathy and age related macular degeneration. This reflects the inclusion of preventable sight loss as an indicator in the national Public Health Outcomes Framework. In addition information on the predicted number of people with visual impairments is included within the JSNA under Section 7.5.2 Adults with Physical and Sensory Disabilities.

Given the tight focus of the local JHWS it has not proved possible to prioritise every significant health or wellbeing issue in the city, and the needs of blind and partially sighted people do not, in themselves, form one of the JHWS priority areas, although the

priority areas may well include issues that are relevant to this group of service users. The JHWS priority areas are: cancer & access to cancer screening; healthy weight & good nutrition; dementia; emotional health & wellbeing (inc. mental health); and smoking.

An earlier version of the RNIB template was used to inform the 2012 JSNA summary. The Health & Wellbeing Board has not yet decided whether to order a 2013 refresh of the JSNA; but if it does so decide, the latest version of the RNIB template will be used to inform this update."

34.4 Councillor Cox informed the Board that the RNIB had stated that the numbers of people living with sight loss was likely to double to 4m by 2050. They suggested that 50% of these cases could be prevented. It was likely to cost £7.9 billion to deal with the issues arising from sight loss.

34.5 Councillor Cox stated that three factors needed to be taken into account. These were early diagnosis, smoking and obesity. Councillor Cox said he would welcome a statement about sight loss, should there be a refresh of the Joint Strategic Needs Assessment.

34.6 The Chair agreed that this matter could be reconsidered when there was a refresh of the JSNA. The fact that sight loss was not currently included as a priority in the current year, did not preclude it from being included in future years.

34.7 Tom Scanlon agreed that this matter could be looked at when considering the JSNA. He stressed that although it was not included in the current strategy, there was a great deal of work being carried out in this area.

34.8 **RESOLVED-** That the written question be noted.

(c) Letters

34.9 The Chair noted that no letters had been received from councillors.

34.10 The Chair noted that no Notices of Motion had been received from Councillors.

## 35. JOINT HEALTH & WELLBEING PRIORITIES

### a) Cancer & access to cancer screening

35.1 The Board considered a presentation from Dr Max Kammerling, Consultant in Public Health, NHS Sussex and Martina Pickin, Public Health Improvement Principal, NHS Sussex (Brighton and Hove). The presentation set out the main causes of death in Brighton and Hove in 2011 for all ages under 75. Although there had been good national improvement over the past ten years there was a high rate of early deaths from cancer and low one year survival rates for common cancers. There were good results for people being seen within two weeks. There needed to be improved early detection, increased access to radiotherapy and increased oncology manpower.

35.2 Members were shown information regarding NHS Cancer Screening Programmes for bowel, breast and cervical cancer. The bowel cancer target was not being met. Breast cancer targets were being met and cervical cancer targets were improving. An independent review had concluded that breast screening was beneficial and that 1,300 lives were saved per year. Martina also talked about the work that the Brighton and Hove public health department commissioned from Sussex Community Trust to raise awareness of cancer screening programmes and early symptoms of cancer.

35.3 Robert Brown informed the Board that someone from the Radiotherapy Department had spoken to the LINk two years ago. They had stated that the department did not have enough machines to carry out their workload and were not able to have new machines until the new building was in place.

35.4 Mr Brown asked if people from the city were likely to receive treatment out of area in the future and if so asked how they would obtain transport.

35.5 Dr Kammerling explained that there was a commitment to have new machines at the hospital. However, increasing capacity for Brighton people would be dependent on people from outside areas having treatment nearer to home.

35.6 Councillor Meadows referred to the two week target. She knew someone who had waited for 6 weeks to get an appointment. Councillor Meadows referred to bowel cancer screening and asked whether there were plans to extend endoscopy screening to people over 75.

35.7 Dr Kammerling replied that he did not understand why the person Councillor Meadow mentioned had to wait for 6 weeks to get an appointment. Locally 95% of people were seen within two weeks for their first appointment, which was higher than the national average. Martina Pickin said that waiting times for endoscopy had prevented introduction of the age extension for bowel screening across Sussex. However waiting times were now being met and the age extension should be rolled out across Sussex from April 2013.

35.8 Tom Scanlon asked if there were any areas that needed to be developed to help improve results in cancer treatment.

35.9 Dr Kammerling considered that there was an issue in maximising access to radiotherapy. Working with area teams would make a difference.

35.10 Members were informed that the CCG could work with practitioners who were not performing well. Martina Pickin stated that the work delivered by Albion in the Community was excellent but the contract was expiring due to lack of funding; all previous funding for cancer awareness work was as a result of successful bids to the National Awareness and Early Diagnosis Initiative.

35.11 Councillor Shanks stated that she was not convinced about breast cancer screening. She assumed the reference to over diagnosis meant surgery. The cost was quite big for the person and the country. She questioned whether it would be better to spend money in other ways.

35.12 Martina Pickin explained that an independent review committee had not been asked to look at cost. She mentioned that the Cancer Research UK website was the best place to access the cancer review and other information/data about cancer. All screening programmes are introduced following policy reviews by the National Screening Committee hence it was not something individual areas could decide for themselves. The review had considered a number of randomised control random trials and case studies and recommended that screening should continue.

35.13 Councillor Deane raised the issue of equality of access for different groups in society such as gypsies and travellers who had a lower life span. There was a question about how to reach people without an address. Ms Pickin replied that she was not able to answer that question immediately but could find out if there was any specific information about incidence and prevalence in these groups.

35.14 Councillor Meadows reported that Albion in the Community was very active in her area. The Healthy Living Centre had closed in Moulsecoomb and much work was needed. The Brighton & Hove Food Partnership did work in the area but did not connect with older people.

35.15 Tom Scanlon agreed that there was a lot that could be done such as early detection and working with people on housing benefits. The Food Partnership would probably be re-commissioned next year.

35.16 Hayyan Asif asked about the possibility of having mobile treatment units. He suggested that screening should be advertised in places like Churchill Square.

35.17 Dr Kammerling explained that radiotherapy required massive equipment not suited to mobile facilities. Martina Pickin reported that there were mobile units that carried out breast cancer screening. She also reported that the work to raise awareness of early symptoms of cancer did include notices at bus stops on a number of bus routes and at Churchill Square.

35.18 The Chair stated that as a Board it was necessary to keep a close eye on how the cancer pathway would work. He suggested an interim report should be submitted in six months along with a report on the progress with radiotherapy equipment. Meanwhile, the council should be able to reach large numbers of people through housing officers, care workers etc. There should be a corporate council response working alongside voluntary sector partners and the CCG. A healthy diet message was important and needed to be encouraged. There should be a focus on getting screening rates up and the question of how to support the Albion in the Community project should be considered.

35.19 **RESOLVED** – That the presentation be noted.

**b) Dementia**

35.20 The Board considered a presentation from Simone Lane, Commissioning Manager which reported that there were 750,000 people in the United Kingdom with dementia. This figure was expected to double over the next 30 years. In Brighton and Hove in

2012 it was estimated that there were 3,061 people mostly aged 65 years or over with dementia and this was projected to increase to 3,858 by 2030.

35.21 The presentation set out the aims of the Dementia Plan, and stressed the importance of early diagnosis. Members were informed that a new Memory Assessment Service would start in June 2013.

35.22 The presentation gave details of the strategic approach to dementia which would provide more care in the community, and provide support for care homes to improve their ability to care for and support their residents who have dementia. The presentation covered improved quality of care in general hospitals and improving the environment of care for people with dementia

35.23 Robert Brown stated that he had been told that dementia had been put into the End of Life Care Pathway as it had been classed as a terminal illness. He asked if money would be put into a central pool for end of life treatment or whether it would be ring fenced.

35.24 The Commissioning Manager explained that there had been discussion about the End of Life Pathway at the Adult Care and Health Committee. This was an integrated pathway to ensure that people with dementia had appropriate care. It was not related to money in any way and was not ring fenced.

35.25 It was agreed that the report that was submitted to the Adult Care & Health Committee on 18 March should be circulated to Board members. Members noted that a decision on the report had been deferred for further consideration. A revised report would be presented to the next committee in June.

35.26 Mr Brown referred to carers assessments and made the point that there was no point in having assessments if there was no funding in place to support carers.

35.27 The Commissioning Manager reported that there would be advisors in the Memory Assessment Service. This should increase the level of support for people. Officers were working with agencies to assess people's need.

35.28 The Chair stated that there was funding available for carers but there was a need to ensure that the right amount of money was made available.

35.29 Councillor Deane asked how people would access the Memory Clinic and whether it would be like cancer screening. She asked if people would be screened at a certain age or whether it would be left for the person to go themselves to get checked out. Councillor Deane was concerned that if it was left up to the person, it might be diagnosed too late. If clinics diagnosed people at the pre-dementia stage it would slow down the process.

35.30 Xavier Nalletamby explained that the service was accessed through general practice. It was possible that everyone over 75 would be screened. The issue of diagnosis was contentious as not everyone would want to know. There was divided opinion about this matter. The condition could not be prevented but it could be managed.

35.31 Tom Scanlon expressed surprise to hear the predicted increase in the numbers of people with dementia in Brighton & Hove given latest census population projections. He also stated that he would like to hear more detail on what specifically was proposed, for example, how many care homes would be reviewed to assess the appropriateness of prescribing for people with dementia and what sort of reduction in the inappropriate prescribing of anti-psychotic drugs was envisaged.

35.32 The Commissioning Manager explained that there was a plan with more detail which would be submitted to the Joint Commissioning Board. This gave detail about intervention and certain matters that could be prioritised. Tom Scanlon stressed the importance of seeing summary accounts.

35.33 Councillor Shanks asked what measures would help to prevent dementia. Xavier Nalletamby replied that there was not much science known about prevention; however, leading a healthy lifestyle and not having taken mind altering drugs would make it less likely to develop dementia. Tom Scanlon informed members that alcohol could have an effect with regard to the development of dementia but this was not entirely clear.

35.34 The Chair stated that the treatment and prevention of dementia was an emerging field and he expected the Board to discuss the matter again in due course.

35.35 **RESOLVED** – That the presentation be noted.

## 36. JOINT STRATEGIC NEEDS ASSESSMENT UPDATE

36.1 The Board considered a report of the Director of Public Health which explained that from April 2013, local authorities and clinical commissioning groups would have equal and explicit obligations to prepare a Joint Strategic Needs Assessment (JSNA). This duty would be discharged by the Health and Wellbeing Board. The Board were asked to approve the production of the JSNA summary for 2013.

36.2 Alistair Hill, Consultant in Public Health reported that the planned programme of in depth needs assessments for 2013/14 would be brought to the May Board for approval. The JSNA would then be submitted to the September Board meeting. Six month updates to the Board were recommended.

36.3 Heather Tomlinson supported Option 2. With regard to the census information, she asked what level of information was obtained from the 2011 Census regarding the analysis of need. Was the data numerical only or was there an analysis of what those numbers meant with regard to community needs? Alistair Hill, Consultant in Public Health explained that the census data was being released over a period of time. There would be more detailed information in the future. This data could be translated into intelligence. He wanted to take the numbers and link them to knowledge of local people and use them as a base for action.

36.4 Tom Scanlon supported Option 2. He stressed that it was important to focus on priorities when considering the rolling programme of strategic needs assessments. The Consultant in Public Health stated that priorities had not been decided. Dementia had been identified as an area which could be prioritised for a needs assessment.

36.5 Robert Brown noted that the report referred to officers working with the Community and Voluntary Sector Forum. He was worried that people in the community would not be consulted. How would people feed their views into the JSNA? Would the community be able to feed back through HealthWatch? Mr Brown mentioned that Housing Areas Management Panels rarely talked about health issues. He suggested that the Housing Panels could be consulted and their views fed back to HealthWatch and then on to the JSNA.

36.6 The Chair stated that he would discuss the suggestion with the Chair of the Housing Committee. The Consultant in Public Health explained that there was housing representation on the City Needs Assessment Steering Group. There was a great deal of joint working in place.

36.7 Councillor Shanks supported Option 2 and suggested that the Youth Council, and Older Peoples Council and community groups have some involvement in the JSNA.

36.8 Councillor Meadows also considered that the Older Peoples Council and Youth Council should be consulted on the document. Councillor Meadows agreed it made sense for the JSNA to be a live document with accurate information. Councillor Meadows asked for clarification of paragraph 3.4 in relation to the City Needs Assessment Steering Group.

36.9 Councillor Norman supported Option 2. He suggested that the last sentence in bold in paragraph 3.4 be re-worded. This was agreed by the Board. The sentence should now read "With the establishment of the Health & Wellbeing Board, the City Needs Assessment Steering Group will *report to the Health and Wellbeing Board* in relation to JSNA from April 2013.

36.10 **RESOLVED –** (1) That Option 2 be agreed for the 2013 JSNA summary, as set out in paragraph 3.6.2 of the report.

(2) That suggested plan and timetable for the 2013 JSNA summary be approved.

## 37. SHADOW HEALTH & WELLBEING BOARD: ACHIEVEMENTS AND CHALLENGES

37.1 The Board considered a report of the Director of Public Health which described some of the achievements of the Health and Wellbeing Board in its shadow year of operation, and outlined the challenges the Board faced in 2013/14 and beyond. Proposed terms of reference for the Board which were to be submitted for approval to Full Council in March 2013 were included for reference at appendix 1 of the report.

37.2 Councillor Meadows referred to paragraph 3.48 in relation to the communications strategy. She commended the idea of the Board working alongside GP practice Patient Participation Groups. These groups had service user knowledge.

37.3 The Chair suggested that there needed to be a mechanism for the Patient Participation Groups to feed into the Board. The Shadow Health and Wellbeing Board Business Manager replied that he would be discussing this matter with HealthWatch.

37.4 Tom Scanlon considered that there needed to be health provider engagement with the Board. The Shadow Health and Wellbeing Board Business Manager explained that he had discussed this matter with the BSUH and they would be attending the next Board meeting to give a presentation on the 3Ts hospital redevelopment. The Chair suggested that there could be provider forums.

37.5 Councillor Norman referred to paragraph 3.46 relating to developing relationships with key BHCC Committees. He asked for Opposition Spokespersons to be included in the process. The Chair agreed that Opposition Spokespersons should be included.

37.6 The Chair thanked the Shadow Health and Wellbeing Board Business Manager for his support for the Board over the past year.

37.7 **RESOLVED –** (1) That the report be noted.

(2) That members' comments be noted.

**38. CCG AUTHORISATION**

38.1 Ramona Booth, Head of Performance and Planning, CCG gave an update on CCG authorisation.

38.2 The PCT would cease at the end of March and be replaced by the CCG on 1 April. The CCG had been formally authorised by the NHS Commissioning Board following a rigorous authorisation process. In January there had been five areas that the NHS Commissioning Board had wanted to be addressed. Only one issue remained outstanding and this related to a shared Chief Finance Officer post.

38.3 The Chair stated that it was encouraging to hear that the process had gone smoothly. He expected the CCG to give a presentation to the Board on their role at a future meeting. He thanked Ramona for her update and congratulated the CCG on its authorisation.

38.4 **RESOLVED** – That the presentation be noted.

The meeting concluded at 7.15pm

Signed Chair

Dated this day of

| Health and Wellbeing Board | Agenda Item 8<br><br>Brighton & Hove City Council |
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| | | |
|---|---|---|
| **Subject:** | | **JSNA: Update on rolling programme of needs assessments** |
| **Date of Meeting:** | | **12 June 2013** |
| **Report of:** | | **Dr Tom Scanlon, Director of Public Health** |
| **Contact Officer:** | **Name:** | **Alistair Hill** **Tel: 29-6560** |
| | **Email:** | **Alistair.hill@brighton-hove.gov.uk** |
| **Ward(s) affected:** | | **All** |

**FOR GENERAL RELEASE**

## 1. SUMMARY AND POLICY CONTEXT:

1.1 From April 2013, local authorities and clinical commissioning groups will have equal and explicit obligations to prepare a Joint Strategic Needs Assessment (JSNA). This duty will be discharged by the Health and Wellbeing Board. The purpose of this item is to ask the Board to approve the planned programme of needs assessments for 2013/14 and note the requirement to produce a Pharmaceutical Needs Assessment by March 2015.

## 2. RECOMMENDATIONS:

2.1 That the Board approve the following programme of needs assessments for 2013/14:

(i) Dementia needs assessment
(ii) Trans needs assessment scoping
(iii) Homeless Link Health Needs Audit

2.2 That the Board note the requirement for a Pharmaceutical Needs Assessment by March 2015.

## 3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 The needs assessment process aims to provide a comprehensive analysis of current & future needs of local people to inform commissioning of services that will improve health and wellbeing outcomes & reduce inequalities.

3.2 The Health & Social Care Act 2012 states that the responsibility to prepare the JSNA will be exercised by the Health and Wellbeing Board from April 2013. The guidance signals an enhanced role for JSNAs to support effective commissioning for health, care & public health as well as influencing the wider determinants that influence health & wellbeing, such as housing & education.

3.3 In Brighton and Hove, in addition to the annual JSNA summary and resources collated at Brighton & Hove Local Intelligence Service (www.bhlis.org), a rolling programme of more in depth needs assessment work is conducted each year. Examples published in the last 12 months include:

- Dual Diagnosis
- Health Needs Assessment of Gypsies and Travellers
- Physical activity and sport
- Sussex wide military veterans health needs assessment

3.4 In addition, related needs assessments are included on www.bhlis.org/needsassessments, for example:

- Housing and support for young people aged 16-25 needs assessment
- Drugs treatment (adults) needs assessment
- Crime and disorder strategic assessment

3.5 Under the memorandum of understanding between the BHCC Public Health team and the CCG, Public Health will provide needs analysis support in relation to CCG priorities. Detail on this ongoing role is not included in the remit of this paper.

3.6 In order to identify priorities for the rolling programme of needs assessments for 2013/14, the following were considered:

- Recommendations of the Joint Health and Wellbeing Strategy
- Engagement with health, adult social care, children's and housing commissioners
- Recommendations of Scrutiny Reports
- New statutory obligations for the Health and Wellbeing Board

3.7 The following priorities have been identified:

3.7.1 **Dementia needs assessment**
A comprehensive needs assessment to support the Joint Health & Wellbeing Strategy Priority. Timescales will be agreed with commissioners.

3.7.2 **Trans needs assessment scoping**
A number of relevant recommendations were made in the Trans Equality Scrutiny report including:

*Recommendation 11.* The Joint Strategic Needs Assessment (JSNA) should more accurately reflect the needs of trans people, particularly regarding suicide prevention.

*Recommendation 13.* The Panel welcome the Clinical Commissioning Group's commitment to work with the council on commissioning a trans needs assessment for the city. The Panel recommend that as a matter of some urgency a needs assessment needs to be undertaken to identify the size of the trans community and its needs. Trans people must be involved at every stage of this process from design, commissioning, implementation, analysis, reporting and influencing in order to inspire the trust of the trans community.

An initial meeting between Public Health, BHCC Equalities team, and the LGBT Health and Inclusion Project took place in May 2013. It was agreed that the next stage will be to convene a wider group to consider the following:

- Methods
- Scope
- Partners
- Resources
- Timescales

A meeting will be arranged by July to invite the following potential partners to agree the way forward:

- Brighton and Hove Clinical Commissioning Group
- BHCC Public Health; Adult Social Care; Housing; CYP; Community Safety; Leisure; Equalities; Research and Analysis
- LGBT Health and Inclusion Project
- University of Brighton

### 3.7.3 Homeless Link Health Needs Audit

Housing and Homelessness was identified as a high impact issue on health and wellbeing in the 2012 Brighton and Hove JSNA, and the homelessness section cited local evidence indicating that the vulnerable homeless population experience very poor health outcomes and make disproportionate use of unplanned healthcare.

The Council's Homelessness Strategy is being updated in 2013. Overall, needs analysis to support the development of the strategy is being led by Housing.

In order to inform planning actions to improve health and wellbeing, Public Health and Housing have jointly developed a proposal to conduct the Homeless Link Health Needs Audit in Brighton and Hove. This national tool has been designed to strengthen JSNA intelligence on the health needs of the homeless population (a link to further details is provided in the Background Documents section below).

The audit will be agreed and conducted in partnership with homelessness providers. Initial consultation with providers has been positive and the proposal will be discussed at provider groups in June 2013 to agree participation. The data collection process involves front line workers in local hostels and homeless service providers conducting a face to face survey with young adult and adult single homeless people. Topics covered include health service usage, health conditions, health behaviours and demographic questions.

The results will provide evidence to support action in Brighton and Hove to tackle health inequalities and improve the health and wellbeing of the vulnerable homeless population, including informing the commissioning of health services. It is planned to conduct the audit in Summer 2013.

### 3.7.4 Pharmaceutical Needs Assessment (PNA)

The Health and Social Care Act 2012 transfers responsibility for developing and updating Pharmaceutical Needs Assessments to Health and Wellbeing Boards (HWBs) (link to Department of Health guidance for Health and Wellbeing Boards given in supporting documentation).

Specifically, Health and Wellbeing Boards will be required to:

- Produce the first assessment by 1 April 2015;
- Publish a revised assessment within three years of publication of their first assessment; and
- Publish a revised assessment as soon as is reasonably practical after identifying significant changes to the availability of pharmaceutical services since the publication of its PNA unless it is satisfied that making a revised assessment would be a disproportionate response to those changes.

Planning will need to commence in 2013/14 for the needs assessment to be part of the 2014/15 programme. Public Health will work closely with the NHS England Surrey and Sussex Area Team, the responsible commissioners for community pharmacies, in planning and delivering the needs assessment.

3.8 The resources required to conduct the programme described within this paper are identified within the public health work programme for 2013/14. As the Trans needs assessment project involves a scoping stage, further resource implications may be identified when this stage has been conducted. Resource implications related to the production of a Pharmaceutical Needs Assessment in 2014/15 will be identified as part of the planning stage in 2013/14.

## 4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 In order to identify priorities for the rolling programme of needs assessments for 2013/14, the following were considered:

- Recommendations of the Joint Health and Wellbeing Strategy
- Engagement with health, adult social care, children's and housing commissioners
- Recommendations of Scrutiny Reports
- New statutory obligations for the Health and Wellbeing Board

## 5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 The resources required to complete this work are provided for within the 2013/14 public health budget of £18.2 million.

*Finance Officer Consulted: Anne Silley Date: 23/05/13*

Legal Implications:

5.2 The Health and Social Care Act 2012 (s196) requires the function of preparing a JSNA to be discharged by the Health and Wellbeing Board. The recommendations in this report are consistent with this requirement.
S218A of the NHS Act 2006 (as amended) and the NHS Pharmaceutical Services and Local Services Regulations 2013 require Health and Wellbeing Boards to develop and update pharmaceutical needs assessments from 1st April 2015 as set out in this report.

*Lawyer Consulted: Elizabeth Culbert Date: 23/05/13*

Equalities Implications:

5.3 The City Needs Assessment Steering Group, including equalities leads for BHCC & NHS Brighton & Hove, has strengthened the city needs assessment guidance to include equalities strands. Strategies using the evidence in the needs assessment may require an EIA but not the needs assessment. Equalities implications should be considered in all needs assessments; however it is worth noting the relevance of the Trans needs assessment and homeless audit in tackling health inequalities in vulnerable groups.

Sustainability Implications:

5.4 Sustainability related issues are important determinants of health & wellbeing and these are integrated in the summary. The JSNA will support commissioners to consider sustainability issues. There is a close link between the JSNA and the One Planet Living priorities, and these are informing implementation of this initiative.

Crime & Disorder Implications:

5.5 None

Risk and Opportunity Management Implications:

5.6 None

Public Health Implications:

5.7 The rolling programme of needs assessments sets out the key health and wellbeing and inequalities issues for the city and so supports commissioners across the city in considering these issues in policy, commissioning & delivering services.

Corporate / Citywide Implications:

5.8 This supports the city's duty for the City Council and CCGs to work in partnership and produce a JSNA.

## 6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 Not applicable

## 7. REASONS FOR REPORT RECOMMENDATIONS

7.1 It is a statutory duty imposed upon Local Authorities and CCG's to produce the JSNA. It is a core function of the Health and Wellbeing Board to approve the JSNA process from April 2013.

## SUPPORTING DOCUMENTATION

**Appendices:**

None

**Documents in Members' Rooms**

None

**Background Documents**

1. Homeless Link Health Needs Audit. Details available at: http://homeless.org.uk/health-needs-audit

2. Department of Health. Pharmaceutical needs assessments: Information Pack for local authority Health and Wellbeing Boards. May 2013 available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/197634/Pharmaceutical_Needs_Assessment_Information_Pack.pdf

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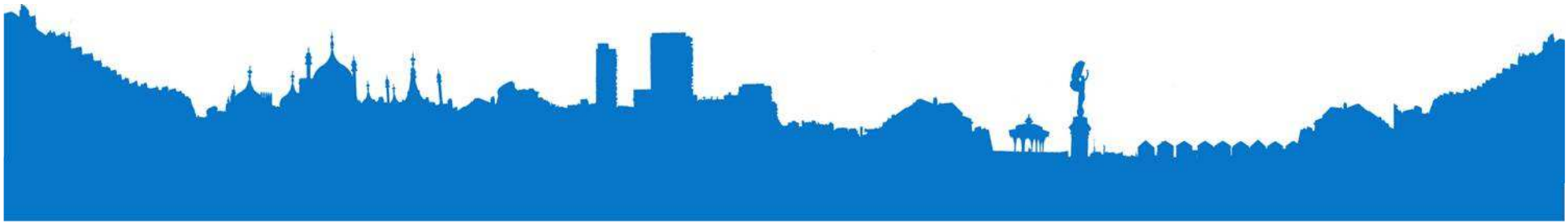
# Brighton & Hove Clinical Commissioning Group and Brighton & Hove City Council

# Emotional Health & Wellbeing including Mental Health

Presentation to Joint Health & Wellbeing Board
June 2013



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# Content

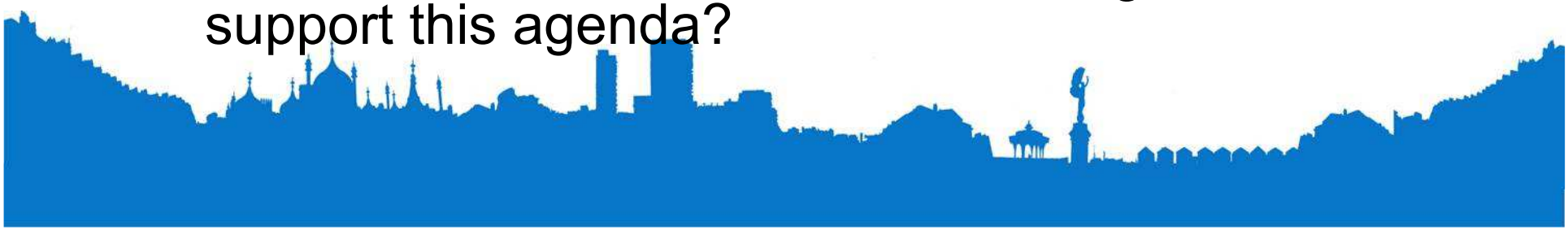
1. Overview & Context

2. Key data – Brighton & Hove

3. What's working well

4. What do we still need to address/ do differently?

5. How can the Joint Health & Wellbeing Board support this agenda?



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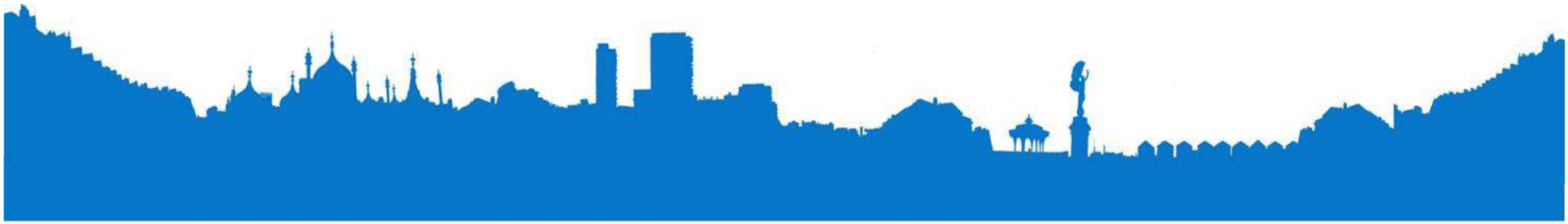
# What do we mean?
# Mental Wellbeing

- '**A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment**'

*No Health without Mental Health, 2011*

- 'A dynamic state, in which the individual is able to develop his or her potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community'

*Foresight report, 2008*



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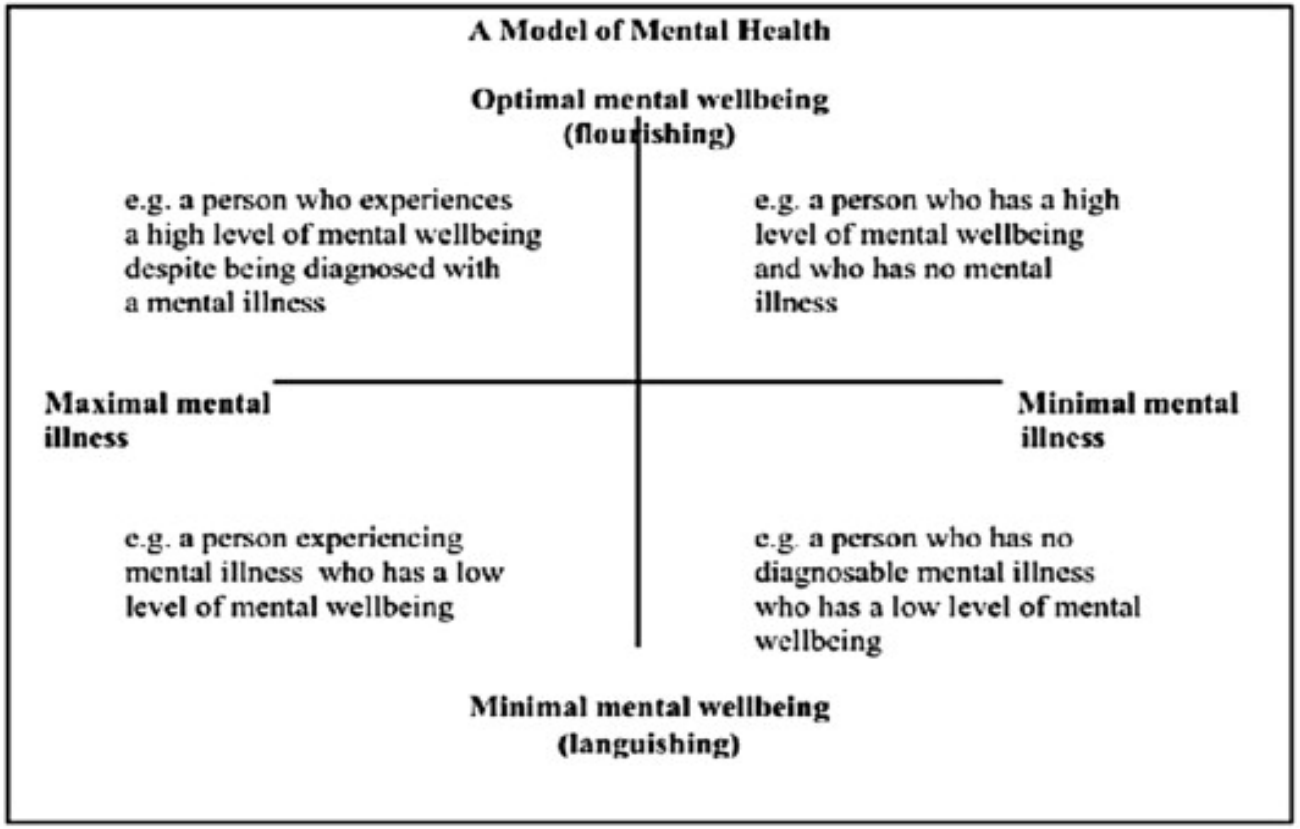


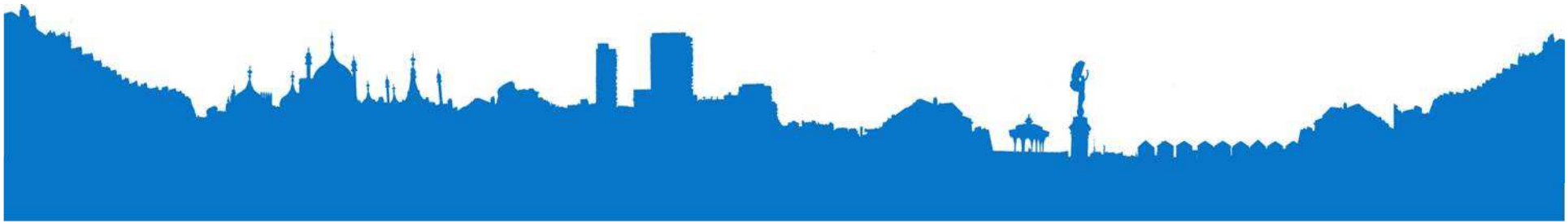

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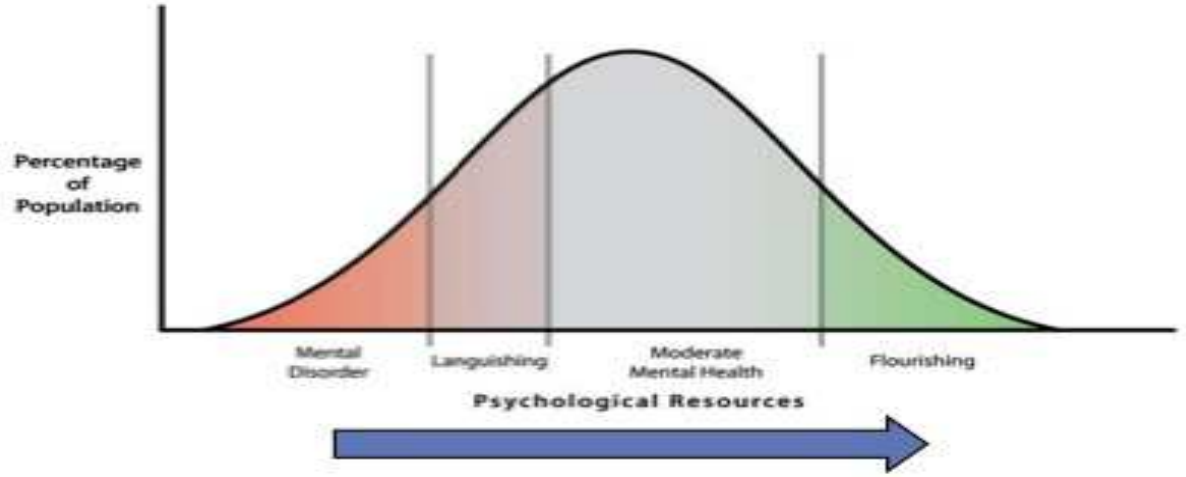
# Mental Health Spectrum




*(Well-being Institute, University of Cambridge, 2011)*

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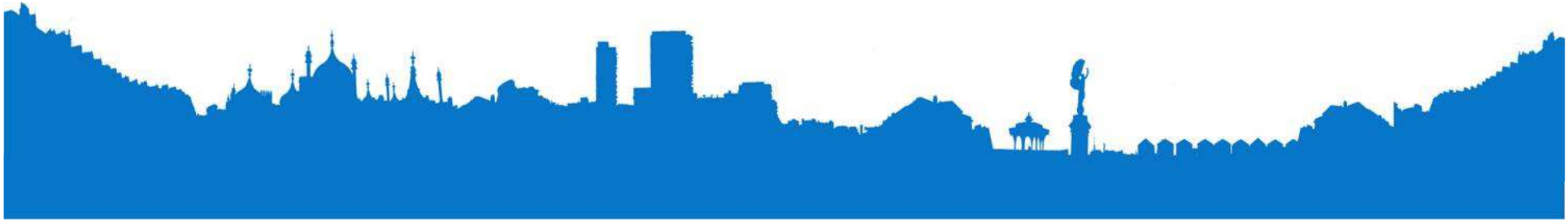
# Context

- **1 in 4 people** experience a mental illness at some point in their lives.
- **Starts at a Young Age**
  - 50% of those with lifetime mental illness first experience symptoms by the age of 14
  - 75% by their mid 20's
- Mental Health Problems – 23% of burden of ill – health **the largest single cause of disability.**
- Mental illness still carries considerable **stigma & discrimination** – this can be as difficult to deal with as the illness itself.



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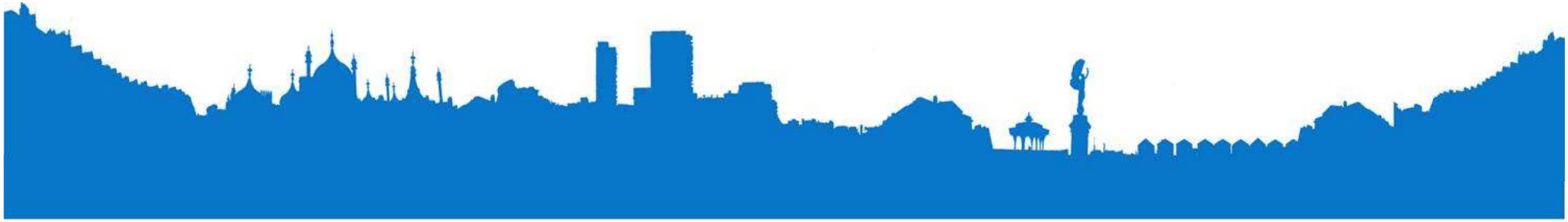
# Brighton & Hove

- **High prevalence of mental illness**
- **Inequalities** – some parts of the population have higher risk of developing mental ill health – e.g. BME, LGBT
- ONS survey 2012/13 – **slightly higher than national average self-reported wellbeing**
  - The Health Counts survey shows that happiness is strongly associated with satisfaction with and belonging to the local area, use of parks and open spaces, strong social connections, relative affluence, a healthy lifestyle and good health.



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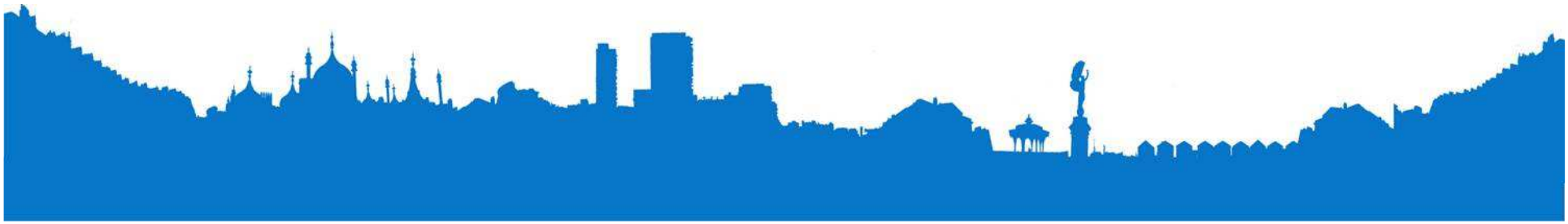
# What are we doing?

- Significant work has been undertaken on ensuring services are as effective as possible & working with partner agencies
- Overall approach ensures that services are provided as early as possible - preventative approach

- **Examples of things working well**

- Tiers 2 and 3 CAMHS work together to support children and young people including offering pre-referral consultation and support in schools. SAWSS survey has increased focus on emotional health and wellbeing
- Celebration of World Mental Health Day to raise public profile
- Strong community and voluntary sector provision



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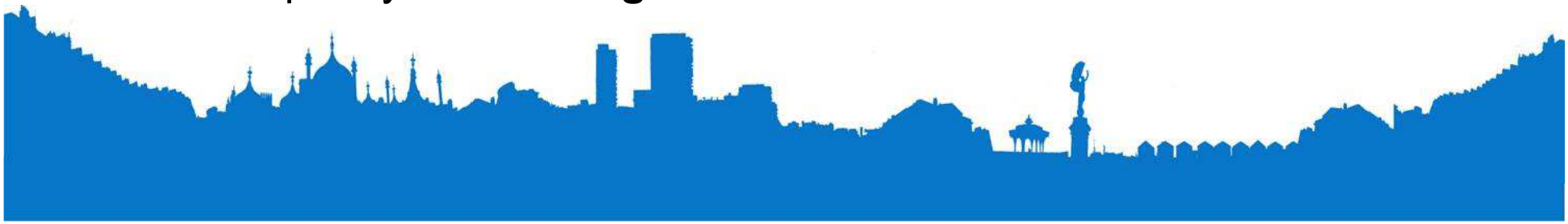
# What do we need to do differently going forward?

- We need to continue to ensure mental health and wellbeing services are effective as possible
- Transition from children to adults
- Continue to address high local rates of self-harm & suicide
- **But strategically we need to change emphasis**

Not just treating people when they become unwell but supporting people to maintain their wellbeing & more explicitly **addressing the wider determinants**.



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# Personal experience

Young man, growing up in Moulsecoomb
Referred to CAMHS
Positive expectations from social worker
Referral to Alternative Centre for Education
Online advice about mental health
Online advice about exercise and diet
Place at Sussex University
Change of social networks

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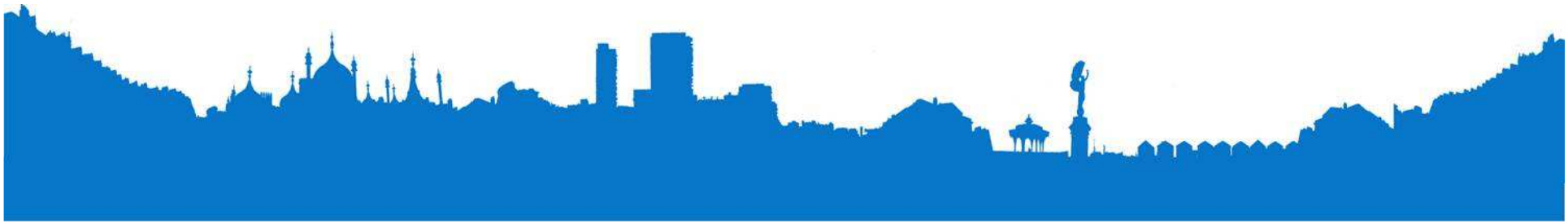
# Plans Going Forward

- CCG and BHCC are working together towards a **new mental health & wellbeing strategy** for 2014
- **Feedback from Community and Voluntary Sector**
  - More community-based services to increase resilience
  - Patient-centred integrated commissioning
  - Improve physical healthcare for those with mental ill-health



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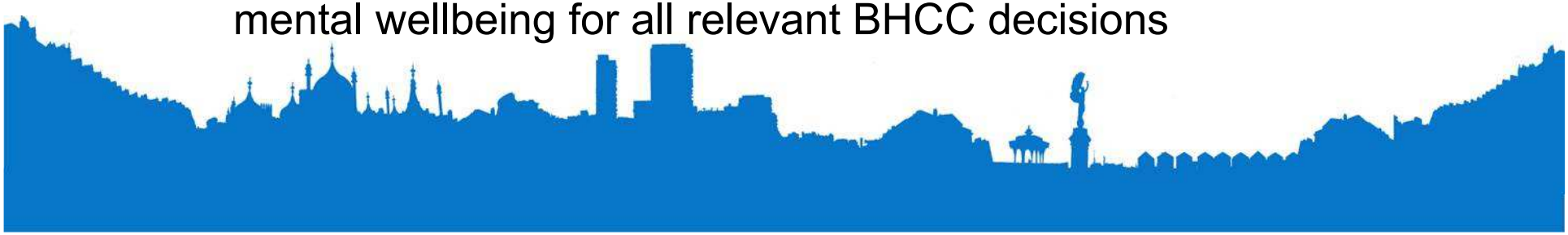
# How Can The JHWB Support this Agenda?

- Many of BHCC's decisions will have an impact on emotional wellbeing.
- Things that are good for promoting positive mental health are largely outside mental health services.
- **What could BHCC do to support?**
  - **Nominate a senior officer** with responsibility for Mental Wellbeing within BHCC
  - Screen new services and policies (eg **mental wellbeing impact assessment**) to ensure positive or neutral impact on mental wellbeing for all relevant BHCC decisions



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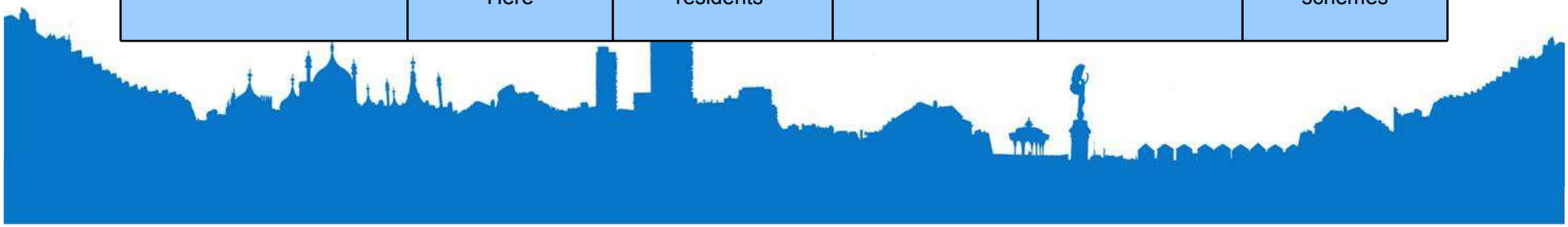
| | Children's services | Adult social care | Planning and transport | Housing and environment services | Work & economy |
|---|---|---|---|---|---|
| **Connect** | Inter-generational activities | Neighbourhood projects eg Hangleton & Knoll project | Car-free public spaces; low traffic residential development | Local growing & cooking projects | Social capital included in procurement |
| **Be active** | Sports support for disabled young people | Health walks, Ping project | Cycle paths, Active travel | Green gym | Workplace health charter |
| **Keep learning** | Breakfast & after school clubs | Adult learners week | Self build projects | Allotments and growing skills | Public sector as employers – professional development |
| **Take notice** | Arts projects with young people eg FFT photo project | Brighton Festival | Parks & gardens | Audit of green space | Values & culture, stress management |
| **Give** | Peer support projects eg Right Here | Timebanking, 'Happy List' of local residents | Walk to school 'buses' | Litter picks or street gardens | Mentoring and volunteering schemes |



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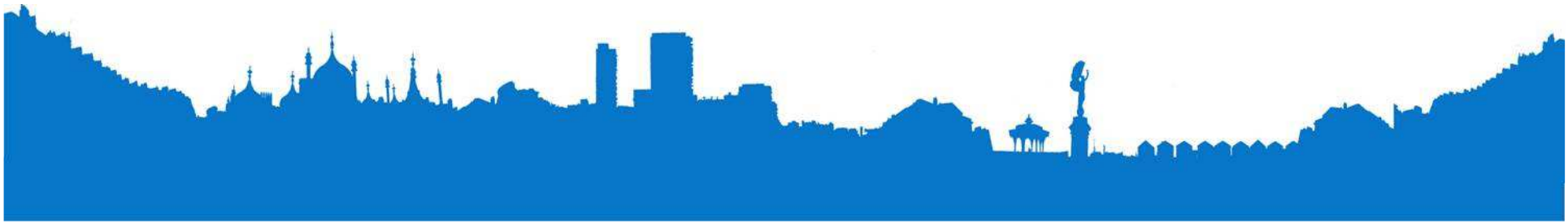
# Summary

- Improving mental health and wellbeing – key issue for the City
- We need to do further work to ensure it has equal priority to physical health
- We need to develop an explicit local strategy that take a broader approach beyond the mental health and wellbeing services
- We need broader BHCC leadership to help achieve this.



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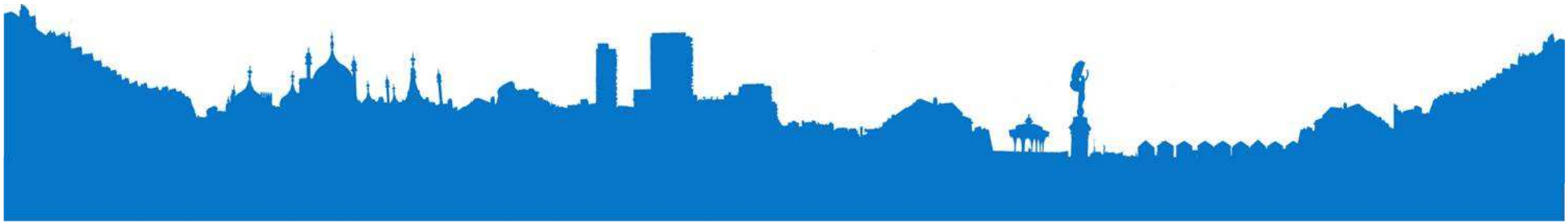
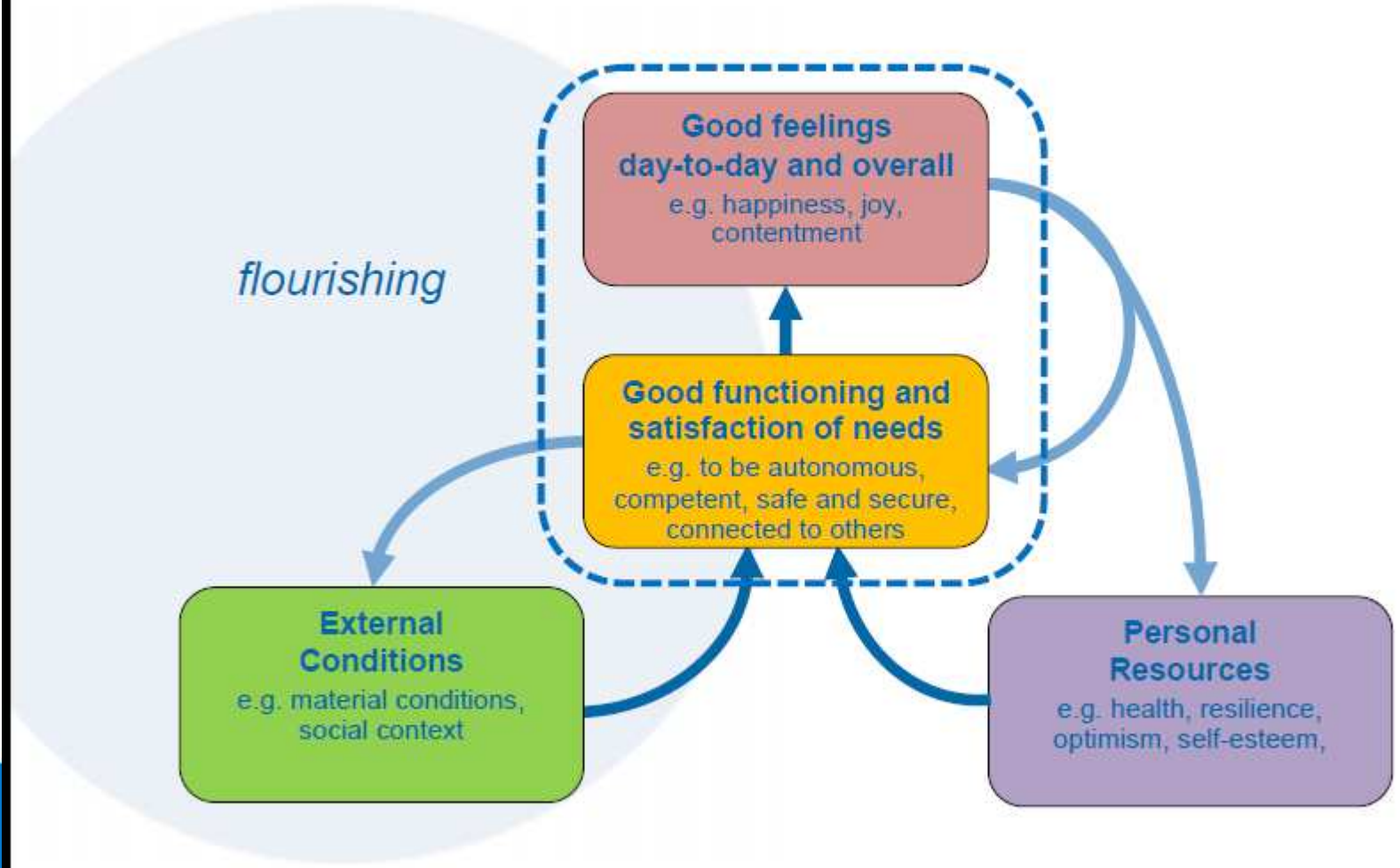
# Emotional Health & Wellbeing including Mental Health

## Background Information Pack



# The dynamic model of well-being

nef
economics as if people and the planet mattered



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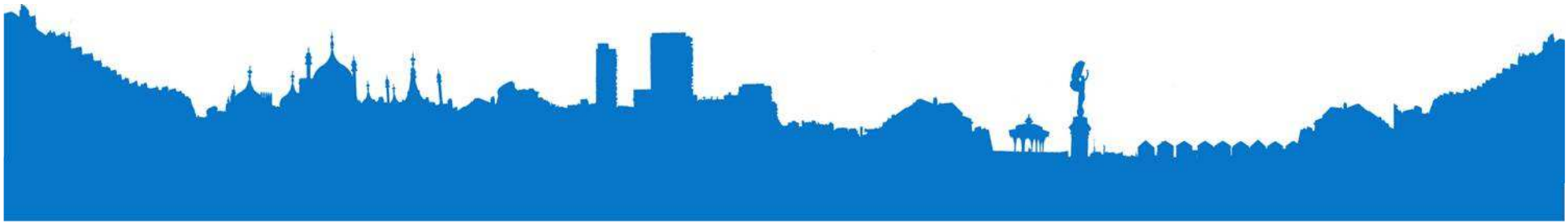
# Five Ways to emotional wellbeing

- Connect
- Be active
- Keep learning
- Take notice
- Give



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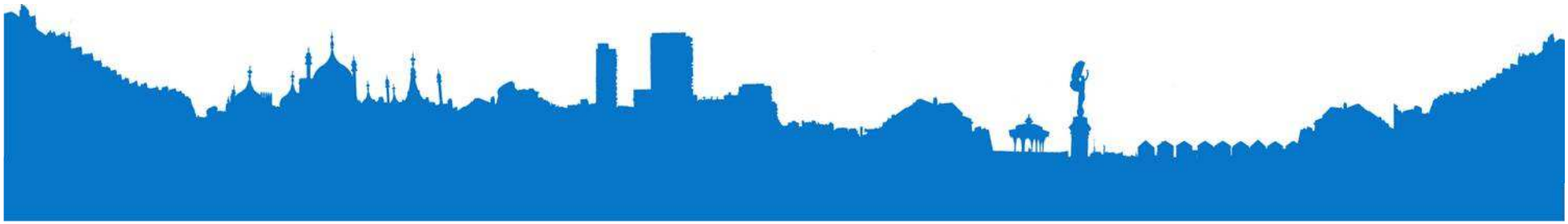
# Brighton and Hove data

- 37% higher SMI, 12% higher depression than England average (GP registers)
- Suicide – 10th worst rate in England & Wales 2009-11
- Self harm – B&H rate for hospital stays for self-harm is 50% higher than national average (950 per year)



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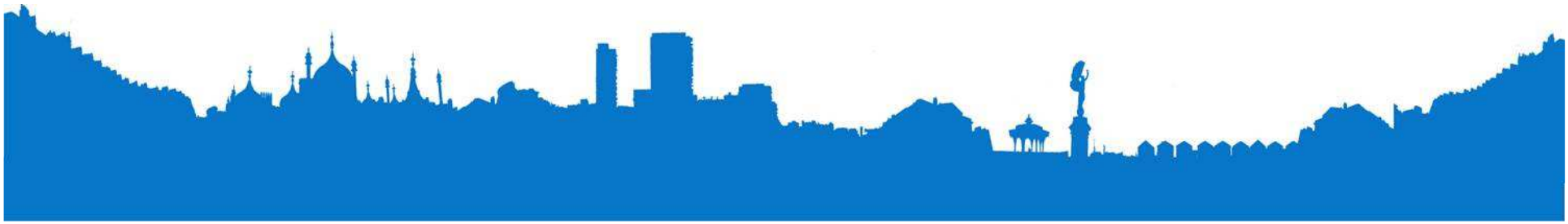
# Satisfaction with Life

- Since 1970, the UK's GDP has doubled, but people's satisfaction with life has hardly changed.
- 81% of Britons believe that the Government should prioritise creating the greatest happiness, not the greatest wealth.



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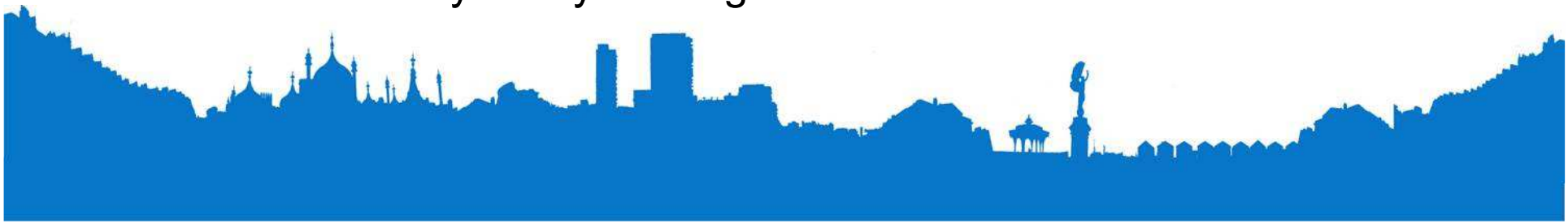
# Self reported wellbeing

- ONS Subjective Wellbeing Survey 2011/12: Brighton & Hove residents reported slightly higher than national average levels of life satisfaction, feeling that things you do are worthwhile, happiness yesterday and anxiety yesterday.
- Health Counts survey 2012/13: slightly lower levels of wellbeing reported.
  - Women are more likely to report life satisfaction and worthwhileness;
  - 65 – 74 year olds are happiest;
  - Happiness is strongly associated with satisfaction with and belonging to the local area, use of parks and open spaces, strong social connections, relative affluence, a healthy lifestyle and good health.



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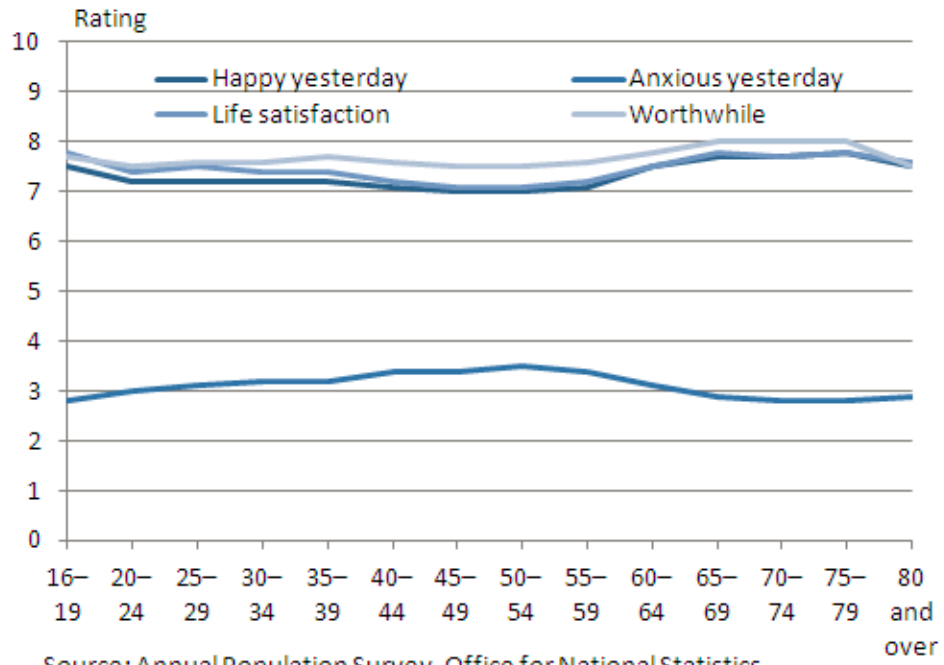
# Age & self reported wellbeing




Source: Annual Population Survey, Office for National Statistics

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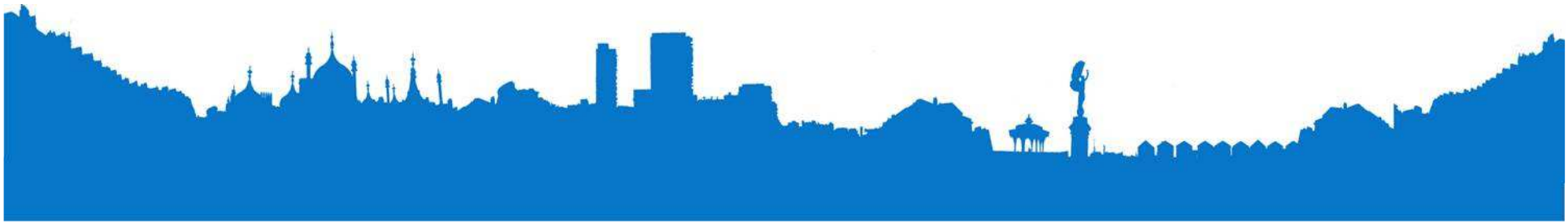
# Groups at higher risk of mental illness

- Socio-economically disadvantaged including unemployed people
- Homeless people
- Offenders
- Certain BME groups
- Military veterans
- Looked after children and young people
- Transgender people
- LG&B community
- Gypsies and travellers

Vulnerable migrants
Victims of violence
People approaching the end of life
Socially isolated older people
Bereaved people
Substance misusers
People with learning disabilities
People with personality disorders

*No Health without Mental Health*



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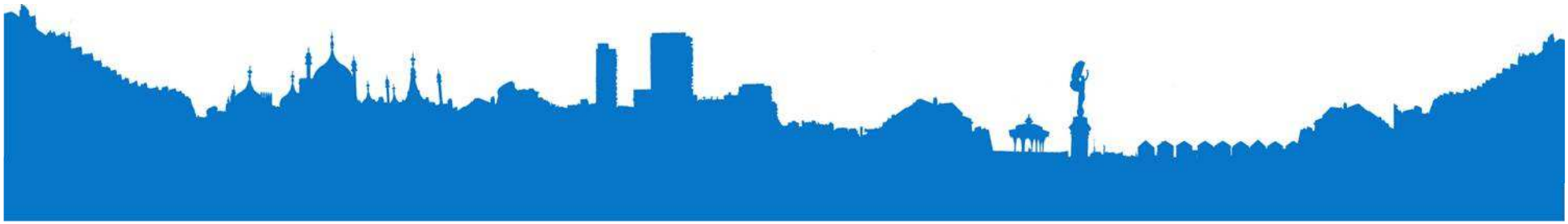
# Mental Wellbeing Impact Assessment

- **Mental Well-being Impact Assessment (MWIA) enables people and organisations to assess and improve a policy, programme, service or project to ensure it has a maximum equitable impact on people's mental well-being.**
- http://www.apho.org.uk/resource/item.aspx?RID=95836





# Emotional Health and Wellbeing (including Mental Health)

## What is the issue/ why is it important in Brighton & Hove?

- The government's strategy, *No Health without Mental Health* defines wellbeing as 'a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment.'[1]

- A national survey carried out by the Office for National Statistics shows that some groups report higher levels of self-reported wellbeing.[2] These include people who are employed, live with a partner/spouse, are in good health, or are aged under 35 or over 55 years.

- One in four people experience a mental health problem at some point in their lives.

- One in 10 children between 5 and 16 has a mental health problem.[3]

- The cost of mental ill health to the economy in England for adults has been estimated at £105 billion. This includes the cost in terms of sickness absence or unemployment.

- Where young people experience significant mental health needs they may miss time in education and risk poorer educational outcomes.

- Poor physical health is a significant risk factor for poor mental health and poor mental health is associated with poor self-management of long term conditions and behaviour that may endanger physical health such as drug and alcohol abuse.

- Mental illness still carries considerable stigma.

<u>Brighton and Hove</u>

- The first local data from the ONS subjective wellbeing survey were published in July 2012.[4] Brighton and Hove residents reported higher average levels of happiness than the national average:

[1] HM Government. No health without mental health: A Cross-Government Mental Health Outcomes strategy for People of all Ages. London, 2011.
[2] Office for National Statistics. First Annual ONS Experimental Subjective Well-being Results. July 2012.
[3] No Health without Mental Health, as above.
[4] Office for National Statistics. First Annual Report on Measuring National Well-being Release. London, 2012.

    - Proportion with medium or high life satisfaction – Brighton and Hove 81.3% (75.9% in the UK)
    - Proportion with medium or high worthwhileness – Brighton and Hove 83.8% (80% UK)
    - Proportion with medium or high happiness yesterday – Brighton and Hove 72.5% (71.1% UK)

- The City Tracker survey[5] shows a high level of satisfaction with Brighton and Hove, and the local area, as a place to live particularly amongst 25 – 34 year olds.

- Despite higher levels of self-reported wellbeing across the city, local prevalence of mental illness continues to be generally higher than the average for England for both common mental health problems, such as anxiety and depression and severe mental illness, such as schizophrenia or bipolar disorder.

- If 10% of those aged 5 – 16 have a mental health problem, this would equate to 3,199 children and young people in Brighton and Hove.

- Over the last 5 years, the number of children and young people presenting at the Accident and Emergency Department of the Royal Sussex County Hospital with serious self harm has increased significantly from 63 per year in 2009 to 91 per year in 2011 and with high numbers predicted for 2012[6]. For adults the numbers of A&E attendances and admissions related to self-harm are also very high.[7] Between 1 April 2011 and 31 March 2012, there were 1703 attendances related to self-harm: the highest number of attendances is from those under 30 years old.[8]

<u>Inequalities</u>

There are a number of risk factors for poor mental health and wellbeing, including:

- Deprivation: on average the prevalence rate for mental illness is up to 2.75 times higher for the most deprived quintile of the population than that for the most affluent.
- Some groups within the population have a higher risk of developing mental ill-health: homeless people, offenders, certain BME groups, LGB people, veterans, looked after children, transgender people, gypsies and travellers, vulnerable migrants, victims of violence, people approaching the end of life, bereaved people, people with a dual

[5] Brighton and Hove City Council. City tracker survey, 2012.
[6] Reporting from Social Work Team, Brighton and Sussex University Hospitals.
[7] Public Health Observatories. Brighton and Hove health profile. 2012.
[8] HES data.

diagnosis or complex needs, and people with learning disabilities have all been identified as at higher risk[9].
Brighton and Hove has relatively high proportions of some of these groups including homeless, LGB and transgender people. The Count Me in Too survey found that 79% of the city's LGBT population reported some form of mental health difficulties.

- Brighton and Hove appears to follow the national trend with BME groups having twice the national rate of mental health hospital admissions along with lower uptake of primary care mental health services[10].

- Brighton and Hove has high numbers of looked after children and child protection cases .Numbers of Looked after children in 2012 was above statistical neighbours and considerably above the England average [11]On average approximately 85 Looked After Children (LAC) are referred to Child and Adolescent Mental Health Services (CAMHS) each year - this is 5% of the total CAMHS population. This is a disproportionate reflection of the number of LAC in the total child population (approximately 1% as of May 2012) and demonstrates the higher propensity of LAC for mental health issues[12].

## What are we doing well already/where are there gaps?

What we are doing well already

Recognition of the role and value of the community and voluntary sector is a strong theme, both in preventive and treatment services, across all ages.

1. Promoting wellbeing working in partnership with the local community and voluntary sector:

During 2012, NHS Brighton and Hove and Brighton and Hove City council consulted on proposals to redesign community mental health support services via the Commissioning Prospectus and have commissioned a new range of services to start in April 2013 including employment support, and targeted out-reach support for the most vulnerable and at risk groups in Brighton & Hove.
Emotional wellbeing has been included in the One Planet Living Health and Happiness action plan.

[9] HM Government. No health without mental health: implementation framework. London: July 2012.
[10] Hazel Henderson. Black and minority ethnic health needs analysis ,Brighton and Hove City PCT, 2008.
[11] http://media.education.gov.uk/assets/files/xls/l/la%20summary.xls
[12] CAMHS monitoring data

A programme of mental health promotion services is commissioned from the voluntary and community sector by the public health team (value approximately £100,000).
A small grants scheme to support local mental health promotion projects was established in 2012. So far 19 proposals have been funded across the city ranging from allotment groups to art and photography.
World Mental Health Day and World Suicide Prevention Day are both celebrated annually.
Children's centres and parenting programmes (e.g. Triple P) promote resilience and early help.
Right Here project for young people 16 – 25 focuses on resilience building and prevention of the escalation of mental health issues.

2. Support and treatment for those with emerging or existing mental health problems:

A new Wellbeing Service has been developed to provide access to psychological therapies in a range of primary care and community settings. Access to the service has been widened through a new option of self-referral.
The supported accommodation pathway has been redesigned – making more flexible use of resources and targeting resources more effectively to those with the most complex needs.
A single point of access to tiers 2 and 3 CAMHS[13] has been established.
A 14-25 service has been developed to bridge the gap between CAMHS and adult services.
Provision of duty service and urgent care for CAMHS services.
A strategy is in development to promote effective liaison between social care team and CAMHS when young people present at A&E with self harming behaviours.
The care pathway for responding to adults with urgent mental health needs has been redesigned. In January 2013 the Brighton Urgent Response Service was launched which provides an improved 24/7 crisis response service for adults with mental health needs. The new arrangements will be evaluated during 2013.

<u>Where are the gaps?</u>

- Both the adult mental health commissioning strategy and the mental health promotion strategy are in need of review and update and a

[13] CAMHS services are arranged in terms of 'tiers' ranging from Tier 1 (community-based support provided by non-mental health professionals such as school nurses or health visitors); through Tier 2 (community support provided by dedicated CAMHS staff); to Tier 3 (clinic-based services delivered by CAMHS staff); and Tier 4 (specialist services, often in-patient services for people with severe mental illness).

commissioning strategy for children and young people needs development.

- We have information about self reported wellbeing from the national ONS survey for the whole city, but need further work on the Health Counts survey to understand the distribution of emotional wellbeing across different neighbourhoods, communities of interest and demographic groups.
- Treatment services for people with complex needs or dual diagnosis need review to ensure better coordination.
- Better understanding of the profile of self harm in the city and improved awareness of the issues and appropriate responses within universal and specialist services.
- Waiting times for psychological services are still too long.

## What we can do to make a difference

- Start to think about emotional health and wellbeing in a different way – as part of everyone's business and as important as physical health.
- Continue to shift the balance of spend between prevention and treatment and focus more on providing support to build resilience and maintain mental wellbeing.
- Take a city-wide approach to improving the wider determinants for good mental health including:
    - Encourage greater uptake of physical activities;
    - Promote mental health and wellbeing in the workplace;
    - Promote mental health and wellbeing in schools, including a focus on the problem of bullying and its impact upon wellbeing;
    - Ensure that the Stronger Families Stronger Communities Partnership addresses issues of mental health and wellbeing as they relate to the city's most vulnerable families.
- Develop more holistic care and treatment for both adults and young people with dual needs – both mental health and alcohol/substance misuse.
- Work across a care pathway to ensure more effective transition from children & young people's services to adult services. Develop more effective links across adult and children's commissioning and services so that the issues of parental mental health, including in the antenatal and post natal phases, are well understood and the impact on child development minimised.
- Ensure emotional health and mental health wellbeing is integrated as far as possible into service provision rather than being separately provided in a medical model by "specialist mental health" service providers.
- Extend access to psychological therapies providing evidence based earlier treatment and support to more people.
- Continue to engage service users in service developments.

## Plans for improvement including key actions

- Map current activity and plans in Brighton and Hove against the recommended actions in the implementation framework for No Health without Mental Health.
- Develop an all-ages mental health and wellbeing commissioning strategy.l
- Engage local people about happiness and wellbeing, focusing on the 'Five Ways':

  Connect – with the people around you, family, friends and neighbours;
  Be active – go for a walk or a run, do the gardening, play a game;
  Take notice – be curious and aware of the world around you;
  Keep learning – learn a new recipe or a new language, set yourself a challenge;
  Give – do something nice for someone else, volunteer, join a community group.
-

## Outcomes

- Improved ONS subjective wellbeing scores (PHOF)
- Better emotional well-being of looked after children (PHOF)
- Reduced hospital admissions for self-harm (PHOF)
- Increased employment for people with a mental illness(PHOF & NHSOF)/ proportion of adults in contact with secondary mental health services in paid employment (ASCOF)
- Reduction in proportion of people in prison with mental illness (PHOF)
- Increased settled accommodation for people with mental illness (PHOF)/ proportion of adults in contact with secondary mental health services living independently without the need for support (ASCOF)
- Improving outcomes for planned procedures – psychological therapies (NHSOF)
- Reduction in premature death for people with serious mental illness - under 75 mortality rate (PHOF)/ under 75 mortality rate in people with serious mental illness (NHSOF)
- Reduction in the suicide rate (PHOF)
- Patient experience of community mental health services (NHSOF)

## Improving mental health by improving life in the city

Improving the context in which people live can improve their mental health, as shown by some of the research-based examples below, taken from the Mental Well-being Impact Assessment, 2011.[1] Addressing these issues can help to improve wellbeing, even if cause and effect are interwoven – mental illness is likely to make people more vulnerable to homelessness, and being homeless may be a contributory cause of mental ill-health, for example.

| | *Research findings:* | *Possible action:* |
|---|---|---|
| Environment, development and housing | People living with a high level of street 'incivilities' such as rubbish, noise and graffiti are twice as likely to report anxiety and 1.8 times more likely to report depression. | Maintain/improve environment in residential streets. |
| | More amenities and fewer 'incivilities' are associated with 32% lower rates of anti-depressant prescriptions after controlling for socio-economic status. | |
| | Crowding, poorly maintained or damp housing are all associated with a higher risk of depression. | Decent homes for all. |
| | Homeless people experience 40 – 50% higher levels of mental health problems than the general population. | Mitigate possible increase in numbers of homeless following changes to benefits system. |
| | Lack of places to stop and chat, lack of recreation facilities and green spaces are associated with a higher risk of depression.<br><br>There is some evidence that exposure to green space is protective against mental illness. | Neighbourhood regeneration, access to green spaces. |
| Community safety | Improved housing has an impact on perceived safety as well as actual crime.<br><br>Association between poor mental health and neighbourhood disorder such as vandalism, high perceived threat from crime. | Address concerns about safety as well as neighbourhood crime. |
| Planning | Residents on busy streets have less than one quarter of local friends compared with those living on similar streets with little traffic. Streets with little traffic have three times the number of 'gathering spots'. | Reduce traffic on residential streets. |
| | People living in walkable, mixed use | Reduce car- |

| | | |
|---|---|---|
| | neighbourhoods are more likely to know their neighbours, participate politically and trust others than people living in car-oriented suburbs. | dependence and increase pedestrian-friendly streets. |
| Communities | Social participation is strongly associated with good mental health. Having three or less close relatives or friends predicts future probability of common mental health disorders, even when a history of mental ill-health is adjusted for. Life satisfaction is linked with commitment to family, friends, social and political involvement.<br><br>Employment generally improves wellbeing, and volunteering or engagement in schemes such as timebanking or social prescribing (such as arts on prescription) have also been shown to improve participation and hence wellbeing.<br><br>Evaluations from the previous government's NRF/NDC areas demonstrated benefits to health and wellbeing of individual residents mostly around social capital, quality of life, mental wellbeing and improved feelings about health services and of their 'neighbourhood' increasing with levels of engagement.<br><br>A good diet protects against depression and high consumption of processed foods is associated with a higher risk of depression. | Continue to strengthen neighbourhood and community networks and to provide opportunities for social engagement, volunteering and cultural participation.<br><br>Maximise opportunities for those most at risk to buy/access affordable healthy food. |
| Education | Low educational attainment is a lifelong risk for common mental health problems, with a 50% reduction in risk of depression for those with the highest qualifications; the effect is particularly strong for women.<br><br>Better daily and long-term academic performance in children who eat breakfast.<br><br>Lifelong (adult) learning enhances self-esteem and social interaction. | Support breakfast provision at schools.<br><br>Support opportunities for lifelong learning especially for those with risk factors for mental ill health. |
| Arts & Leisure | Participation in arts improves wellbeing, health and can support recovery from mental ill-health.<br><br>Regular physical activity is associated with | Enable participation in arts, leisure and physical activities by those most at risk of poor emotional health. |

| | | |
|---|---|---|
| | lower rates of depression and anxiety across all age groups and also enhances emotional well-being. | |
| Financial inclusion | While cause and effect may be entangled, people in lowest income quintile have a threefold risk of mental illness; debt is associated with a threefold risk of common mental illnesses and a fourfold risk of psychosis.<br><br>Improving financial capability reduces the risk of anxiety and depression by 15%. | Continue to address financial inclusion and financial management skills. |

[1] Cooke A, et al. Mental Well-being Impact Assessment: A toolkit for well-being. 3rd ed. London: National MWIA Collaborative; 2011.

| HEALTH & WELLBEING BOARD | Agenda Item 10<br><br>Brighton & Hove City Council |
|---|---|

| | | | |
|---|---|---|---|
| **Subject:** | | **Independent Drugs Commission Report** | |
| **Date of Meeting:** | | **12 June 2013** | |
| **Report of:** | | **Director of Public Health** | |
| **Contact Officer:** | **Name:** | **Peter Wilkinson, Linda Beanlands** | **Tel: 29-6562** |
| | **Email:** | **Peter.wilkinson@brighton-hove.gov.uk, Linda.beanlands@brighton-hove.gov.uk** | |
| **Ward(s) affected:** | | **All** | |

**FOR GENERAL RELEASE**

## 1. SUMMARY AND POLICY CONTEXT:

1.1 In 2012 the Safe in the City Partnership established an Independent Drugs Commission to review the current state of drugs problems in the city and the approach being taken by local services to address these issues. The Drugs Commission addressed four key areas and published its final report with recommendations in April 2013. The final report has been received by the Safe in the City Partnership and a plan for the Substance Misuse Programme Board to address the recommendations has been developed.

1.2 This report asks the Health & Wellbeing Board (HWB) to note the Independent Commission's report and the actions to date of Safe in the City Partnership in response.

## 2. RECOMMENDATIONS:

2.1 That the HWB notes the Independent Drugs Commission report (**Appendix 1**), and the Safe in the City Partnership's responses to the Drugs Commission report recommendations (as set out at Part 3 of this report).

2.2 That the HWB instructs officers to bring back a further report on the progress of the recommendations of the Independent Drugs Commission to a future HWB meeting.

## 3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 The Independent Drugs Commission was established following an invitation from the Safe in the City Partnership with the intention that the Commission would review the city's response to the problems associated with local drug use. The Commission had ten members and was chaired by Peter James, a local author. The vice-chair was Mike Trace, a former Deputy UK drugs czar. Officers from a range of local organisations acted as advisors to the Commission.

3.2 A copy of the Independent Drugs Commission report is attached at **Appendix 1**. The report has been welcomed by the Safe in the City Partnership as a helpful and challenging review of local services and approaches. For several of the recommendations relevant local work is already ongoing.

3.3 The Health and Wellbeing Board is specifically identified in two of the recommendations;

- The Health and Wellbeing Board and Safe in the City Partnership should convene a working group led by the local authority, NHS and Police, to explore and make recommendations about the feasibility of establishing a form of consumption room as part of the range of drug treatment services in the city.
- The Health and Wellbeing Board should investigate the value of rolling out a programme of overdose response/first aid training for drug users, and the professionals who work with them.

3.4 There has already been a great deal of press coverage regarding the possibility of establishing local "drug consumption" rooms. However, the actual recommendation in the report is that the feasibility of establishing a form of consumption room should be explored, not that one should definitely be established. Any proposal to establish drug consumption rooms following the feasibility study would be made to a formal committee of the Council at a future date.

3.5 As regards the second recommendation above, as the Drug Commission report acknowledges, there is already a programme of overdose response and first aid training in place in Brighton and Hove. St John Ambulance provides first aid training for certain service users and their carers or family, as well as for some staff groups. Naloxone is a drug which reverses the effects of opiates such as heroin and is used to reverse the consequences of an opiate overdose. Naloxone is given to certain service users to keep with them. The service user receives training in recognising an opiate overdose, first aid training including how to put someone into the recovery position, the use of Naloxone and the importance of calling an ambulance. Service users prescribed Naloxone sign a consent form for another individual to administer Naloxone in the case of an opiate overdose. During 2012 a total of 631 Naloxone mini-jets were prescribed. The programme is continually expanding. Hostel staff are receiving training. Naloxone is dispensed in the Accident and Emergency Department at the hospital.

3.6 **Progressing the recommendations of the Independent Commission**

The Substance Misuse Programme Board (the partnership body overseeing substance misuse strategy in the city) has identified lead individuals to form a working group to review and progress each of the Drug Commission's recommendations. The lead identified for the drug consumption room recommendation will convene a specific working group to look at the feasibility of establishing a local drug consumption room.

3.7 Implementing some of the recommendations would have significant resource implications and further discussion across a wider audience will be needed once these have been identified.

3.8 Updates on the progress being made will be provided by the Substance Misuse Board to the Safe in the City Partnership and Health and Wellbeing Board over the next year.

## 4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 In considering the four key questions and challenges, the Drugs Commission invited evidence from a number of interested third sector providers and service users at each of its meetings. The lead representative of the drug misuse service user group was also a member of the Commission and was therefore fully involved throughout the process. In addition, a number of young people attended a session to participate in the discussion about what more could be done to prevent and protect young people from the harms caused by substance misuse. Wider consultation will be pursued in the coming months for those specific recommendations of the Commission where the views of service users and the wider community will be able to inform further considerations.

## 5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 The Director of Public Health's 2013/14 budget for prevention and support to drugs abuse in adults is approximately £4.5 million which is committed against a number of contracts. The costs associated with the recommendations from the Independent Drugs Commission would need to be considered against Public Health and Partnership budgets. The progress report will identify future financial commitments.'

*Finance Officer Consulted: Anne Silley Date: 16/05/13*

Legal Implications:

5.2 Any proposals that are brought forward for Council decision pursuant to the recommendations of the Independent Drugs Commission will be reported to the relevant Council committee and should be accompanied by legal and financial advice to support the decision making process. The feasibility study in relation to drug consumption rooms will need to consider and address the legal implications of such an approach.

*Lawyer Consulted: Elizabeth Culbert Date: 10th May 2013*

Equalities Implications:

5.3 There are none to this report for information. The Safe in the City Partnership will consider equalities issues as part of its response to the Drugs Commission report recommendations.

Sustainability Implications:

5.4 There are none to this report for information. The Safe in the City Partnership will consider sustainability issues as part of its response to the Drugs Commission report recommendations.

Crime & Disorder Implications:

5.5 There are none to this report for information. The Safe in the City Partnership will consider crime and disorder issues as part of its response to the Drugs Commission report recommendations.

Risk and Opportunity Management Implications:

5.6 The risks and opportunities relating to the Drugs Commission recommendations will be considered by the Safe in the City Partnership.

Public Health Implications:

5.7 There are none to this report for information. The Safe in the City Partnership will consider public health issues as part of its response to the Drugs Commission report recommendations.

Corporate / Citywide Implications:

5.8 There are none to this report for information. The Safe in the City Partnership will consider corporate priority issues as part of its response to the Drugs Commission report recommendations.

## 6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 This is a report for information so there are no alternative options to be considered.

## 7. REASONS FOR REPORT RECOMMENDATIONS

7.1 This is a report for information; the Safe in the City Partnership is the partnership body charged with responding to the Independent Drugs Commission report recommendations.

## SUPPORTING DOCUMENTATION

**Appendices:**

1. Report of the Independent Drugs Commission for Brighton & Hove

**Documents in Members' Rooms**
None
**Background Documents**
None

# Independent Drugs Commission for Brighton & Hove

April 2013

Published by:

**Safe in the city**
Brighton & Hove Community Safety Partnership

# Report and Recommendations

## Introduction

In the spring of 2012, the Safe In The City Partnership responded to a proposal from Caroline Lucas MP to set up an Independent Drugs Commission to look at the current state of drug problems in the city, and the various efforts to address them. The aim was to bring a fresh look at the city's response to the problems associated with drug markets and drug use, and to suggest ways in which the local agencies could be more successful in reducing the drug related problems that mattered to the citizens of Brighton and Hove.

The membership of the Commission is listed on page 6 of this report: we tried to achieve the right balance between local knowledge and national expertise. The Commission Chair is Peter James, well known Brighton based author, and Patron of Sussex Crimestoppers. The vice-chair is Mike Trace, former Deputy UK Drugs Czar. The Commission membership includes the mother of a young Brighton woman who developed and struggled with a drug addiction in the city, representatives of both universities and community based organisations, and the co-ordinator of the local drug users' and carers representative groups. A group of officers, from Brighton and Hove City Council (including the Community Safety Team and Public Health) and Sussex Police, have acted as advisors to the Commission.

Our priority throughout was to ask **'What are the drug related problems that most concern the citizens of Brighton and Hove, what is currently done to respond to these problems, and are there any other strategies or activities that could potentially fill the gaps, and lead to better outcomes'.** In undertaking this task, we were keen that the Commission did not duplicate or contradict the work already undertaken by the Community Safety Partnership and Drug and Alcohol Action Team: we found the existing range of strategies and activities to be comprehensive, well organized and well delivered.

We took particular care to involve and take the views of local people – young people; those who take drugs, attend treatment and support services or have family members with drug problems; and those who are affected by the presence of drug markets in their city.

**We gave ourselves four key challenges to address. These were:**

- Are the current strategies to prevent drug related deaths sufficient to achieve a significant reduction in the coming years?
- Are the policing, prosecution and sentencing strategies currently pursued, effective in reducing drug related harm?
- Are we doing enough to protect young people and to enable them to make informed decisions around drug use and involvement in drug markets?
- To what extent does the treatment system meet the treatment and recovery needs of the citizens of Brighton & Hove?

For each challenge, we organized a full day meeting to hear local evidence and perspectives, and to discuss possible ways forward. At the end of November 2012, we came together for a two day session to review and refine our recommendations across all four areas.

It is important to recognize that, within the time and resource constraints facing the Commission, we could not claim to be conducting a comprehensive review of all the research and

evidence on responses to drug problems, nor were we able to spend as much time as we would have liked talking to service providers, or the residents of Brighton and Hove.

Notwithstanding these limitations, we managed to stimulate some very interesting discussions, and have reached a consensus on a number of recommendations that we think could make a material difference to tackling the city's drug problems.

Our recommendations were presented in draft form at the end of January 2013. Since then the Commission has sought feedback from the public on some of the key recommendations and the responses have now been incorporated in to the final recommendations in this report. That process was overseen by a special meeting of the Commission on 6th March 2013, which also took into account the views of those who attended a public meeting hosted by Caroline Lucas MP and at which some commission members were also present.

The Safe in the City Partnership will invite the Commission to revisit all the recommendations in April 2014, and to undertake a supplementary progress report for further consideration by the Partnership.

In the interest of transparency, this report is supplemented by a background document that includes a record of the proceedings of each of our meetings, and links to presentations and documents that informed our discussions. This document, and any other background information on the work of the Commission, can be obtained from: linda.beanlands@brighton-hove.gov.uk : or charlotte.farrell@brighton-hove.gov.uk

We would like to put on record here our thanks to our fellow commissioners for their time and commitment, to the officials and experts who gave evidence at our sessions, and to the members of the community who gave us invaluable insights into the situation in the city (in particular the young people who attended our consultation event at the Amex Stadium in September). Finally, we must record our gratitude to Charlotte Farrell and Linda Beanlands, who so capably kept us organized and on track throughout.

Peter James
Chairman

Mike Trace
Vice-Chairman

# Drug Use Patterns in Brighton & Hove

There are an estimated 60,255 people in Brighton and Hove who have used illegal drugs. This represents 36% of all adults. The figures are extrapolated from the nationwide British Crime Survey – last conducted in 2011/12 – that reports on the percentage of adults (aged 16-59). Around a quarter of these 'lifetime users' report using in the last year, and one eighth report using in the last month.

The most popular illegal drug, as in all areas of the country, is cannabis. There is also widespread use of heroin, cocaine and amphetamines, with recent increases in the use of a wide range of new psychoactive substances, some illegal and some not controlled under the Misuse of Drugs Act. It is important to remember that Alcohol remains the most widely used psychoactive substance.

A study conducted in 2010 identified just over 2,000 heroin and cocaine users in the city who could be identified as problem drug users – ie that they were dependent on one or more drugs, or were experiencing health or social problems, or were committing crimes, related to their drug use. This figure does not include those experiencing problems with drugs other than heroin or cocaine.

A total of 1,442 individuals attended treatment services in the city in the financial year 2011-12. The main problem drugs reported by this group were heroin, crack cocaine, powder cocaine, and cannabis. The age profile is spread from teenagers to people in their 50s, but in general opiate and cocaine users were an older cohort than users of other drugs. The majority of treatment clients were male (71%) and white (89%).

Drug related deaths have been high in Brighton and Hove, but with signs of a recent reducing trend. Fifty residents in the city died in this way in 2009, but this figure had reduced to 20 in 2011. There are indications that this welcome decline is arising from positive action by local services in response to recommendations in coroners' reports.

Sussex police made 760 arrests for drug offences in Brighton and Hove in the financial year 2011/12. Just over half of these were for possession offences, around 40% were for supply or importation, and 5% were for production.

While these figures give us some insight into the dynamics of the drugs markets in Brighton and Hove, they do not paint a full and up to date picture of what has become a diverse and rapidly changing situation. In common with many areas of the country, the Brighton and Hove drug scene has experienced a proliferation of new psychoactive substances – some illegal, and some not currently controlled under the drug laws – that come on to the local markets.

With its vibrant nightlife economy, Brighton and Hove will always be a target market for the people who manufacture and distribute these substances – because they are produced in laboratories, and are easy to distribute, it is very difficult for the police to keep a track on which exact substances are being used, by whom, and how they are being supplied.

The same problem faces those who are planning the education, treatment and health responses to drug use in the city – with the ever changing patterns of drug use, and uncertain affects from some of the substances

used, the strategies and programmes developed can quickly become outdated or badly targeted.

That is why one of our central recommendations is the creation of a robust mechanism for the collation of real time information and intelligence on new patterns of drug use and supply. Early insights into new patterns of use can come from police intelligence, seizures, community organisations, health and social services, or drug users themselves. It would be relatively straightforward to set up a mechanism by which information from all of these sources and others is collected and collated, and developed into a constantly updated picture of how the drug scene in the city is changing.

Reports from this analysis can then be made available to inform the planning process for information and education programmes, the design of treatment and pulic health services, and police operations against suppliers. Whatever the response to our other recommendations, we call on the relevant authorities to establish such an information and planning mechanism.

## Members of the Commission

| | |
|---|---|
| Peter James | **Chair** |
| Mike Trace | **Vice Chair** |
| Rick Cook | **Service User Involvement Worker** |
| Karen Jackson | **Brighton University, Head of Student Services** |
| Kate McKenzie | **Mother of recovering addict** |
| Jacob Naish | **Head of AITC's Community Cohesion Division** |
| Claire Powrie | **University of Sussex, Director of Student Services** |
| Tai Ray-Jones | **Vice-President Wellbeing, University of Brighton** |
| Harry Shapiro | **Director of Communications and Information, Drugscope** |
| Arthur Wing | **Management Advisor** |

## Advisors to the Commission

| | |
|---|---|
| Jake Barlow | **Head of Marketing, BHCC** |
| Graham Bartlett | **Chief Superintendent, Sussex Police** |
| Linda Beanlands | **Commissioner, Community Safety** |
| Julian Deans | **Sussex Police** |
| Charlotte Farrell | **Administrative Assistant** |
| Veronica Hamilton-Deeley | **Coroner for the City of Brighton & Hove** |
| Eric Page | **LGBT Community Safety** |
| Tom Scanlon | **Director of Public Health** |
| Richard Siggs | **Sussex Police** |
| Nicola Singleton | **Director of Policy & Research, UK Drug Policy Commission** |
| Graham Stevens | **DAAT Co-Ordinator** |

**Disclaimer:**
The report contains the views of Members of the Independent Drugs Commission who also took into account information and views of from Advisors and invited participants. The Members do not speak on behalf of any organisation but rather express their own conclusions following evidence from these and many other sources. The report is not intended to reflect the entire breadth of the discussions which took place but is a distillation of the many and varied contributions that were made.

For details of those who attended and contributed to the discussion please see the accompanying document 'Process Report of: Independent Drugs Commission for Brighton & Hove'.

# **Challenge 1:** Are the current strategies to prevent drug related deaths sufficient to achieve a significant reduction in the coming years?

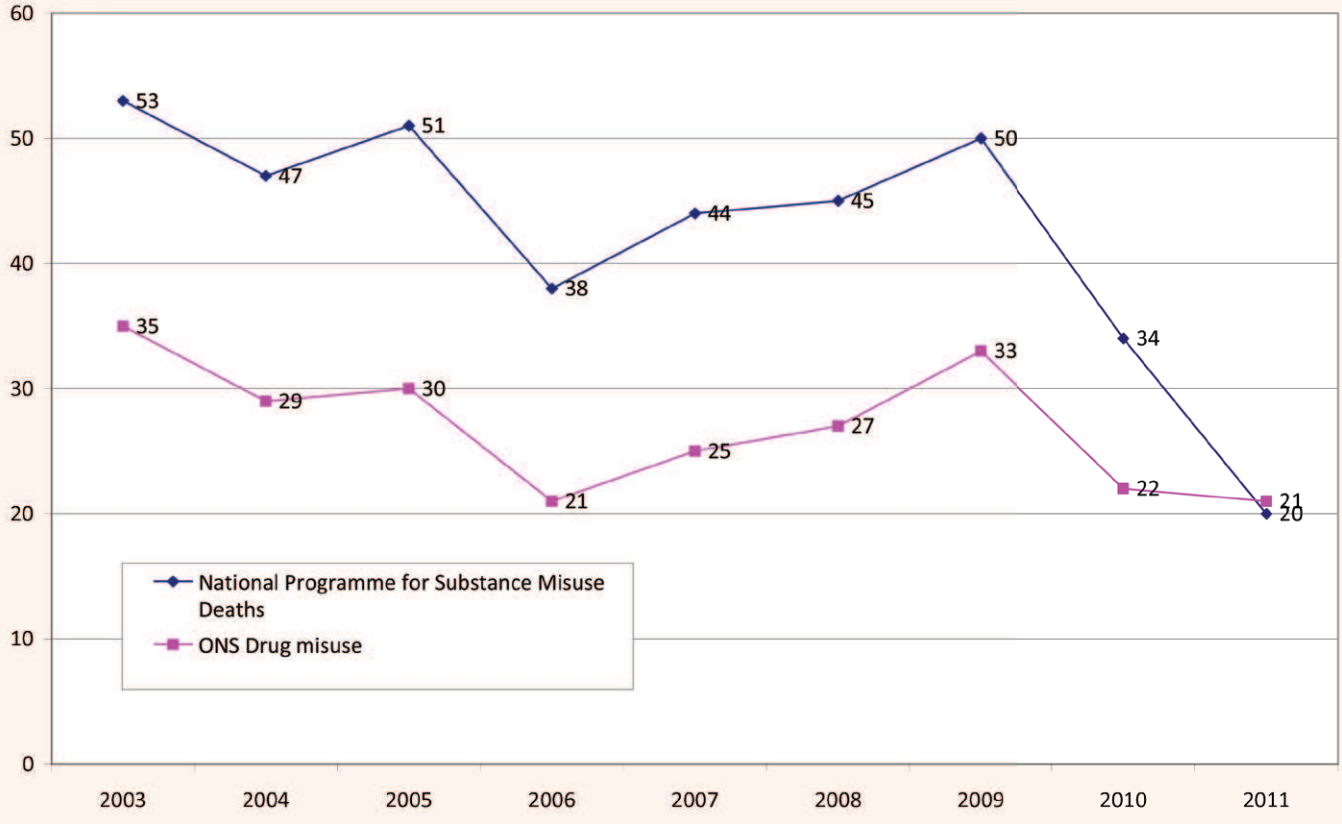
For over a decade, Brighton and Hove has appeared in the top three Coroners' Jurisdictions/Police Force areas in the UK with the highest rate of drug related deaths – that is, deaths through acute poisoning [overdose] or other fatal reactions to the ingestion of one or more psychoactive substances. This statistic was generated from annual reports produced by the National Programme For Substance Abuse Deaths [np-SAD] based at St George's Hospital London.

Local information that is methodologically comparable to the np-SAD data set has been collected through liaison between the Public Health Team and the Coroner's Office. This appears to show a reduction in the annual death rate in 2011 (20 deaths recorded) and, so far, in 2012. Whilst this recent trend is more encouraging, with a 60% reduction in np-SAD reported deaths between 2009 and 2011 [see Figure 1 below], the rate at which citizens of the city are dying, and the distress caused to families and friends, makes it a necessity that better ways are constantly sought to minimise these personal tragedies.

## What We Found

The recent trend in drug related deaths in Brighton and Hove is represented in figure 1, which shows a similar trajectory for both np-SAD and Office of National Statistics [based on a different definition] data.

**Figure 1:** Number of deaths, 2003 – 2011, reported by np-SAD and ONS



A number of reasons have been put forward for a historically high rate of deaths in Brighton and Hove. The characteristics of the city reveal a combination of contributory factors, not least that there is a long standing drug using population as well as a sizeable transient population and a high number of visitors to the city, attracted by a lively leisure culture. The reduction in the number of drug related deaths since 2010 however, is noted as a significant success and if sustained in 2012 (confirming figures awaited) could provide further information about the effectiveness of the integrated working and interventions which have been implemented over the past two to three years.

The Drugs Commission were however, sensibly cautious in their approach and focused on what more action could be identified to sustain the improved performance of Brighton & Hove and drive down the drug related death rate even further.

## Possible Ways Forward

The Partnership in Brighton & Hove [led by the Drug and Alcohol Action Team] recently reviewed the key factors that appeared to contribute to the majority of deaths, and gave a presentation to us on their findings. While the overall picture is complex and the high-risk behaviours that lead to most drug related deaths are not easy to influence, it seems that there are at least five broad areas where the health authorities and drug services can take action to bring down the number of deaths in the coming years:

**Consistently monitor, analyse and report on the complexity of drug related deaths.**
Coroners reports provide information about the complex circumstances of each death, including distinguishing information about chronic and chaotic use, accidental overdoses and suicides related to drug use. The Coroner is of the view that the information can significantly assist in identifying the reasons why some drug users survive and others do not and that information then being the basis of identifying those interventions which will be most effective in extending the protective factors that can prevent drug related deaths.

**Reducing the availability of prescription drugs through tighter control.**
Many of the coroner's reports identified the presence of prescription only drugs in cases of overdose death, either obtained via a GP (usually benzodiazepines or other tranquillizers that are prescribed for stress and anxiety and to help people sleep) or opiate substitutes such as methadone and suboxone prescribed to treat heroin addiction. These were usually present in combination with alcohol or illicitly sourced drugs. Research has shown that a particularly high risk of overdose arises from a combination of different drugs, and that prescribed drugs such as benzodiazepines are particularly dangerous when mixed with other drugs. GPs and drug services, therefore, need to be very cautious about prescribing these substances to patients where there is a risk that they will be misused, diverted to the illicit market, that the patient is using alcohol or illegal drugs in risky ways or that they have underlying respiratory or other health problems. The Commission was informed that there is a work programme looking specifically at reducing the amount

of benzodiazepines prescribed by GPs in Brighton & Hove, which includes the development of guidelines on prescribing, and the training of prescribers, to increase their awareness of the risk of overdose. However, whilst improvements have been made, there remains concerns that repeat prescriptions and stockpiling may be contributing to the availability of illicitly obtained prescription only drugs and that there is scope for greater enforcement activity by the Police and Crown Prosecution Service to intervene in relation to the supply, and illegal possession of, non-prescribed benzodiazepines and other prescription only Class C Drugs.

### Creating a physical environment which reduces the risk of life threatening drug-taking behavior.

The latest data available estimates that there are 2,0931 opiate and/or crack users in Brighton & Hove. In 2011-12, 1,116 [52%] were engaged with treatment services. **Twenty drug related deaths were reported by np-SAD in 2011, and local audit indicates that approximately three quarters of these had a substance misuse treatment history.** This means that a significant proportion of those dying from overdoses and acute reactions had been in contact with the treatment system at some point.

There are a range of treatment services that aim to engage with this group, provide them with health and social support, and encourage them towards recovery. However, it would still appear to be the case that too many people are taking drugs in the most risky ways, mixing different substances of unknown purity, and using on their own with no access to emergency medical help. The Commission believes that it is important that local drug services provide facilities that encourage use in safer ways, and where things do go wrong, to provide emergency medical help. These facilities are usually referred to as 'consumption rooms', which can be controversial, as they involve the toleration by health workers of the use of illegal drugs. The international evidence is clear that the provision of these facilities can significantly reduce overdose death rates, as well as the inconvenience associated with the use of drugs in public, whilst not increasing overall rates of drug use. The Commission believes that, where it is not possible to stop users from taking risks, it is better that they have access to safe, clean premises, rather than to administer drugs on the streets or in residential settings. The Safe in the City Partnership should consider initiating a feasibility process on how to incorporate the provision of consumption rooms into the existing range of drug treatment services in the city.

### Targeting at risk populations.

One of the risk factors correlated with drug related deaths is release from prison, the risk of death, usually from opioid overdose, being greatest within the first few weeks after release when compared with the general population. The Commission regards continuity of care as critical and advocates the provision of in-reach support, including information on the risks of drug related death after release. In addition, there is evidence that the provision of diamorphine to high risk and long-term opiate users via the injectable opioid treatment programme is a protective factor against drug related deaths. The

Commission supports the consolidation of this initiative locally and hopes that its capacity may be increased in due course.

### Minimising the number of fatal overdoses.

The principal substance implicated in deaths was heroin, contributing to 37% of deaths in 2010, compared with 46% in 2009 , a downward trend reflected nationally [41% down from 53%]. Thus the largest number of overdose deaths, although involving the mixing of different substances by the user, are still triggered by the use of too much, or too pure, heroin. Death is caused by the suppression of the respiratory system, which leads to death through lack of oxygen. This process can be prevented, however, by the timely administration of an antidote called Naloxone. This is already made available on prescription throughout the UK, and in Brighton and Hove is also kept in store in the main drug treatment centres. This means that healthcare professionals can administer Naloxone quickly if alerted. However, most fatal overdoses occur in isolated settings, where only the user and their immediate acquaintances are present.

Pilot projects making Naloxone available directly to drug users have generally been shown to be effective in saving lives and with no harmful effects from the relaxation of medical oversight. There has been an intensive programme to roll out the distribution of Naloxone in Brighton and Hove to users of the services. This has included people living in hostels, often some of the most vulnerable individuals. The programme has included training on how to administer the naloxone mini jet, alongside a general first aid course. Training has also been available to staff members where appropriate. This continues to be a priority area in Brighton and Hove: between Oct 11 and Sep 12, a total of 344 naloxone mini-jets were prescribed, building on the distribution which was initiated during 2009. Plans are in place to ensure that naloxone is distributed to as many vulnerable people as possible and coverage now includes all hostels, with 69 mini-jets dispensed to 34 hostel clients between January and October 2012, and 41 used in overdose incidents with 18 people. In addition, dispensing has been introduced in A&E, and following a recent death case review, will be extended to some clients in alcohol treatment.

## Recommendations:

1. That the DAAT and Public Health strengthen the mechanisms for regular auditing, analysis and reporting of Coroners and Serious Incident and Vulnerable Adult reports which provide information on the factors leading to drug related deaths, accidental overdoses and suicides. The mechanisms to include annual audits and enquiry's and to take account of 'lessons learnt' findings. Ensure that all information informs the further development of protective and preventative factors.
2. That the criminal justice agencies, together with the Director of Public Health, take action to reduce the use, diversion and dealing of prescription drugs, in particular:
   - A more proactive and robust enforcement response to the diversion of and dealing in prescription only and Class C drugs (including Benzodiazepines and methadone – Methadone is a Class A drug).
   - The dissemination of clear guidelines, information and advice to G.Ps, drug treatment services and drug users about the risks of overdose and death following the use of alcohol, benzodiazepines and opiates in combination and the heightened risk for users with physical health and respiratory problems. Responses to the receipt of guidelines, information and advice should be monitored by the Harm Reduction Domain Group.
3. The Health and Wellbeing Board and Safe in the City Partnership should convene a working group led by the local authority, NHS and Police, to explore and make recommendations about the feasibility of establishing a form of consumption room as part of the range of drug treatment services in the city.
4. Commissioners and service providers should look at ways of expanding the capacity of the positively evaluated Injectable Opioid Treatment Programme in order to reduce the number of chronic opiate users at particular risk of drug related death. There should be a cost benefit analysis, including consideration of the most economical procurement of injectable opiods. Representation may need to be made to the appropriate national departments about the high cost of Diamorphine in this respect.
5. The Health and Wellbeing Board should investigate the value of rolling out a programme of overdose response/first aid training for drug users, and the professionals who work with them.
6. Commissioners and service providers to ensure that continuity of engagement of prisoners at particular risk of overdose, pre and post release, is effective in reducing drug related deaths. Particular account to be taken of research findings which highlight the increased risk during the first two weeks after release.

# **Challenge 2:** Are the policing, prosecution and sentencing strategies currently pursued effective in reducing drug related harm?

We formed a very strong impression in our discussions that, particularly in relation to heroin and crack cocaine, Sussex Police and the prosecution and probation services have developed a sophisticated and balanced strategy for dealing with those drug markets and the personal possession and use of those drugs in the city. The targeting of arrests and prosecution of heroin and crack cocaine drug users, the assessment and successful diversion of arrestees into treatment, and the gathering of intelligence and targeted intervention in local drug markets, all seem to be encouragingly based on careful analysis and strategic planning.

However, the reality is that the criminal justice agencies have not been able to create the circumstances where the availability of illegal drugs to potential users has been stifled, and there continues to be a small but active cohort of drug users who continue to commit crimes to fund the purchase of drugs.

We also noted that this intelligence led approach did not seem to be extended to a comprehensive response to dealing with the whole range of drug markets and related harms. We do suggest therefore that there is more work to do, to extend the intelligence led approach, using the structured collation and analysis of real time information, from a range of sources, to inform the police and partnership responses to dealing with other drug related harms in the city.

## What We Found

The illicit drug market in the city is diverse, well established and constantly evolving. There is a significant and long standing market for heroin, cocaine and cannabis; a large nighttime economy in which the use of club drugs such as ecstasy and ketamine G is common; and a more recent diversification into a wide range of new psychoactive substances – some of which (such as mephedrone) are illegal, while others, including a range of synthetic cannabis products remain outside of the drug control regulations. Different sections of this market are controlled in different ways by a wide array of supply sources, from self-supply by individuals growing their own cannabis, to social networks of small scale supply amongst friends, to organised groups of dealers who trade larger amounts, many of whose business is controlled from outside the city.

In the year [2011/12], there were 760 arrests under the drug laws in the city. The breakdown of those arrests is:

- 66 people were arrested because they had either direct or indirect involvement in a supply of any class of drug
- 10 people were arrested for importation
- 2 people were arrested for obstruction under the Misuse of Drugs Act
- 179 people were arrested for possession of cannabis out of 682 recorded offences. What this means is that not all offences have led to arrests. Other offences have been dealt with in a number of different ways including charges, Fixed Penalty Notices, Cautions and Cannabis Warnings
- 180 people were arrested out of 655 offences of possession relating to other controlled drugs, not Cannabis
- A further 323 people were arrested out of a further 473 offences relating to supplying / producing and other related offences such as allowing premises to be used for the supply of drugs

We heard evidence that Sussex Police have a well developed intelligence based model for understanding the dynamics of the drug market for cocaine and heroin – what groups are bringing drugs into the city, how they are distributed, and the location and nature of retail markets – and targeting the most dangerous situations and groups. However, given the complexity and fast moving nature of the drug market in the city, and the continuing high demand, it is unsurprising that the law enforcement agencies have not been able to stop the flow of drugs to potential users, but we think that more could be achieved by applying this intelligence led model explicitly to the achievement of a more comprehensive set of objectives, including:

- the minimization of the role of organised crime groups from outside the city in the drug market
- the minimization of violence and intimidation associated with drug markets
- the closing down of particular drug markets that are of concern to local residents
- the reduction of health and social harms within families and to individuals from drug use
- the reduction of instances of dealing to young people

We particularly identified that the effectiveness of the intelligence led model which is the basis of police enforcement action could be further increased if Drugs Intelligence meetings were extended to include a wider range of partners (eg. housing providers) who are able to actively share real time information, and discuss its implications for strategic and operational responses.

We were impressed with what we heard about Operation Reduction, a police led initiative to identify those arrestees whose crimes were driven by their drug dependence, and to refer them into treatment services. This is an effective approach to reducing crime and reoffending, versions of which have been successfully implemented around the country, leading to lower rates of crimes such as burglary, robbery and shoplifting, as drug addicts are successfully treated, rather than continuing their drug use and offending.

Since 2008, Operation Reduction has dealt with a total of 540 cases, all of whom were prolific offenders who were assessed as being dependent on heroin or cocaine. 520 of these cases commenced a structured treatment programme, of whom just under half completed it successfully. In 5 years, therefore, Operation Reduction has turned 250 Brighton and Hove residents away from a life of addiction and crime, contributing to a downward trend in property crime across the city.

We did however note some inconsistency and a lack of coherence in sentencing outcomes. A reason for this may well be a variance in the level of expertise in drug matters and some remoteness from the wider partnership work to deal with drug related harm in the city. We recommend therefore, the urgent implementation of the new sentencing guidelines by the criminal justice agencies in particular.

Similarly, there seems to be some inconsistency in how different actors in the drug market – for example, users, dependent users, user-dealers, 'social' suppliers, suppliers for profit, and those controlling the market – are dealt with in prosecution and sentencing procedures. The new Sentencing Council guidelines on sentencing for drug offences provide a useful framework for a new and clarified approach in Brighton and Hove.

## Possible Ways Forward

The intelligence based strategy of Sussex Police has been effective in allowing them to react to emerging threats and new dealing networks quickly and the principles which underpin Operation Reduction (the clarity with which treatment needs are met within a criminal justice approach) have also been proved to be effective. However, we think that this way of working could be broadened so as to give a more comprehensive (and constantly updated) map of the drug use and markets in the city (including cannabis use), the harms that they are causing, and the opportunities for targeted intervention to achieve a wider range of objectives. Police could work with local health and social service providers, and user groups, to build a fuller picture of local drug markets, and the harms that they cause in order to inform strategic and operational decisions. We propose a revised set of objectives for such an information collation discussion:

- To react more quickly to new dealing groups that are targeting Brighton and Hove consumers, particularly those introducing new substances, or who are engaged in violence and intimidation.
- To target enforcement action on the dealing groups and individuals who are causing the most harm, and on the drug markets that are of most concern to local residents.
- To target enforcement action, and tough punishments, on those dealers who sell drugs to minors for profit.
- To react quickly to drugs arriving on the market that may be particularly toxic, working with public health colleagues to issue warnings to potential users where necessary.
- To use the real time information emerging from this process to inform prevention, health and treatment strategies targeted at drug users.

Similarly, the current well established practice of criminal justice agencies identifying drug dependent offenders at arrest, or during prosecution and court processes, is effective and to be commended, but could be extended and made to be more efficient in diverting more drug dependent offenders into treatment earlier. At the moment, the referral mechanisms rely to a large degree on identifying prolific offenders with heroin or cocaine addictions, and using drug testing and court orders to coerce them into accepting treatment. A more comprehensive and consistent approach to offering diversion, at all stages of the criminal justice process, and at a younger age, would have a bigger impact on drug related crime.

We think that much better use could be made of these referral systems by trying to intervene earlier, creating systems for offering help to young people in the early stages of a criminal career and concentrating more on building offenders' motivation to want to engage with treatment and support. This latter aim can be greatly helped by the use of peer mentors and advisors who can encourage offenders to commit to changing their lifestyles. We heard from the user group representatives who gave evidence to the Commission a great deal of evidence about the positive and in many cases, the life changing effect, of peer mentors as part of an approach which responds to each drug user who has individual and specific needs to be met.

Those discussions extended to recording a high level of concern about the absence of

a clear treatment pathway for those who have dual diagnosis - mental health as well as substance misuse problems. Essentially, those users articulated great difficulty in overcoming the barriers to access and receive services.

Urgent attention is required therefore to 'make real' and clarify the services that we believe may well have been put in place for this vulnerable client group, but which appear to be not well known or remain inaccessible.

## Recommendations:

1. **Sussex Police and the Community Safety Partnership should establish a standing intelligence and information sharing structure that collates real time information from multiple sources on local drug markets and emerging trends.**

2. **That the Community Safety Partnership create mechanisms for the information and analysis that comes out of this process to be used rapidly to inform tactical, strategic and operational planning decisions by the police, prevention and treatment services.**

3. **The effective principles of Operation Reduction (enforcement combined with diversion and treatment) should be extended beyond the focus on opiates and crack cocaine to include the wider range of drugs being used by adults and young people**

4. **The Surrey and Sussex Probation Trust should report to the Community Safety Partnership on the extent to which the new Liaison and Diversion and Health Hub arrangements are being targeted effectively, and achieve high retention and recovery rates. This should include advice on how peer support can be expanded and how to establish a comprehensive diversion strategy for the city.**

5. **That while the diversion strategy will work within legal frameworks already available under the Misuse of Drugs Act and utilize new Sentencing Council Guidelines, where this framework inhibits the effective implementation of the diversion strategy, then the national authorities should be made aware of the constraints.**

6. **Sussex Partnership Foundation NHS Trust should provide information to all partners, drug users and the public about the service capacity, processes and pathways available for those with dual diagnosis (mental health and substance misuse). The Director of Public Health should review this information and respond appropriately.**

# **Challenge 3:** Are we doing enough to protect young people and to enable them to make informed decisions around their own drug use and involvement in drugs markets?

Estimates of levels of drug use amongst young people in Brighton and Hove, based on data from service providers or local surveys, suggests they are higher than the national average but, in tandem with national trends, have been on a downward trajectory during the last 10 years. The types of drugs typically used by young people continue to be cannabis, cocaine, MDMA, mephedrone, ketamine and a range of so-called legal highs, which are constantly changing. While we heard evidence that a wide range of illegal drugs were easily available to young people, it seems that a significant majority of them have never used illegal drugs, and most who did use, never moved beyond experimental or occasional use. There is, however, a core of regular and problematic users who need intervention and support. Young people who used substances tend to move between illegal drugs and alcohol. Alcohol is the biggest problem amongst young people which, it should be remembered is illegal for them, followed by cannabis.

## What we found

Whilst there is a recent downward trend, levels of use, particularly among under 18s, remain of great concern. Evidence presented to the Commission from the annual Safe and Well at School Survey indicated that some of those who reported drug and alcohol use were doing so more harmfully, and at a younger age. This often appeared to be a result of wider family and community contexts and to have a negative impact on their physical and emotional health, leading to a breakdown of family relationships and friendship groups, leaving the young person more at risk. For example, substance misuse is associated with: truancy and school exclusion; a higher level of those not in Education, Employment or Training; homelessness; offending and vulnerability to violence and sexual exploitation.

The Commission hosted a discussion with a group of young Brighton and Hove residents, including young people whose families are or have been using drugs and the professionals that work with them. The discussions provided insights into the local drug scene, and into the risk and protective factors that influence decisions regarding drug use.

Three overriding messages were conveyed in these discussions:

- That a wide range of illegal drugs were easily available to young people in Brighton & Hove. All of the young people at our consultation agreed that they could purchase drugs 'with just one phone call' and that dealers provided access to a number of different drugs. Whilst acknowledging that the discussions were taking place with a group of young people who are involved to an extent in drug use, the idea that illegal drugs are more easily obtained than alcohol or tobacco [where under 18s have to get round sales restrictions and age barriers] is of grave concern.
- That, despite this ease of availability, a significant majority of young people growing up in Brighton and Hove have never used an illegal drug, and amongst those who have experimented, only a small proportion become regular users. These are reassuring statistics, indicating that most young people are already making healthy choices around drug use, despite the easy access to illicit drugs, and the presence of various forms of peer pressure.
- That the factors affecting young people's decisions regarding whether to use drugs -

and if they initiate drug use, whether they become regular or dependent users – were closely intertwined with the wider context of adolescence. Risk factors for those who go on to develop problematic drug use include family and emotional issues; the toleration of cannabis use in some families where there is open parental use; and experience of trauma, and difficulties at school or with the police, while protective factors include positive family and peer support networks; availability of activities which alleviate boredom; and access to specialist support and advice, and opportunities and activities that could make a difference in diverting young people from drug use, including the provision of free or affordable public transport so that they can access the wide range of sports and other facilities in the city.

Data from national surveys on young people's drug use reflects the situation in past years. However, we do have access to up to date treatment data: Brighton & Hove commissions annual, Safe and Well at Schools surveys across all secondary schools. This provides city wide information and individual school based information for the schools themselves to inform their school improvement planning processes.

We are now living in a period where new substances come and go on the market with rapidity, resulting in data being some way behind the situation on the street. Brighton and Hove, with its recreational party scene and night-time economy, is particularly susceptible to the rapid arrival of new and unknown substances that present a challenge to those designing health and education responses. Given the wide availability of drugs to young people, in a drug market and culture that is diverse and well established, it seems that the objective of totally preventing young people's access to illegal drugs must remain a remote and effectively unachievable objective. It is imperative, therefore, that local partners take seriously this rapidly evolving landscape and publicise real time 'early warning' mechanisms, to identify and track new trends, as part of their ongoing data gathering and planning processes.

## Possible Ways Forward

Suggestions have been made in the previous section on how the police could deal with the availability of drugs. The focus should be the provision of credible information for young people on drugs and their risks, the strengthening of protective factors, and the ability to intervene quickly when an individual is showing signs of developing a problem.

### 1. Broadening Drug Education and Information Messages

The authorities have worked hard to limit the availability of drugs to young people, to educate and inform them on the risks, and to intervene quickly and effectively when problems are identified. There exists in Brighton and Hove a good range of young people's drug and general advice services that produce information and advice materials on drugs, their effects and risks. There is a broad based programme of drugs education delivered in the city's schools and a range of specialist youth advice services that can intervene early with individuals who are at risk of developing drug problems. Brighton & Hove's Healthy Schools Advisory Service provides teacher training, resources and support for the planning and delivery of effective drug, alcohol and tobacco education in schools. It works in partnership with the Youth Service and ru-ok? to support schools

to refer young people to targeted group work and specialist services. Most recently guidance and a flowchart have been developed for schools and youth services to support staff to respond effectively to drug and alcohol related incidents. With regard to Higher Education, the Commission has noted that in the past, the Universities provided information and advice around drug and alcohol use through Unisex, commissioned by the Primary Care Trust and universities to work across both sites. However, new commissioning arrangements have refocused resources and advice on contraception and sexual health.

We see the potential, however, for more targeted and 'real-time' drugs education and advice campaigns that inform young people about the rapidly changing range of drugs that are known to be circulating on the market in Brighton and Hove, and provides advice on the related risks and harms. This should use information from the 'early warning' mechanisms that are recommended in the previous section. Any work in this area would need to be very carefully designed and targeted, in order to avoid publicising and promoting new substances to potential new users. The Commission noted that when the local authority is aware of substances which are being used by young people, Ruok trigger an alert system that informs appropriate service providers. One outcome of this is that trigger also produces resources aimed at increasing awareness of the harms that can be caused. The Commission also noted that the Safe and Well at School Survey has also provided evidence that some parents provide substances to young people. It is important therefore that these parents are targeted more effectively with information which aims to discourage or cease their role in providing substances to young people.

### 2. Strengthening Protective Factors

This area of activity is largely outside the drug strategy itself, and contains no easy answers, but there is clear evidence that those whose drug use becomes problematic to themselves and those around them are predominantly experiencing some other form of personal problem or social marginalization: poverty, difficult family relationships, problems at school, or emotional or mental health issues. There is a clear lesson that preventing problematic drug use amongst young people has to start from an understanding of the multiple causes of the drug problem, with interventions that are not drug specific, but aim to tackle these broader problems. The authorities concerned with adolescent welfare in the city should have a target of reducing the number of young people with significant drug and/or alcohol problems, and should work together on an explicit strategy to strengthen protective factors, such as the provision of positive activities and role models, support to parents on how to deal with drug issues, and the quality of general support services for troubled young people. This supports the prevention strategy planning process that is now in place and the need for a single and streamlined pathway between the number of specialist services that work with adolescents. Those specialist services include those which seek to increase young people's access to education, training and employment, to prevent youth crime and first time entry to the criminal justice system, youth service for positive activities and targeted prevention to improve social, emotional and health life skills, teenage pregnancy and prevention for early pregnancies.

### 3. Intervening Early, and Maintaining Support

Most people with drug problems approach drug treatment services for help after many

years' experience of abuse; addiction; health and social problems or those who have specific learning difficulties. Much personal and family misery, and cost to society, could be prevented if it were possible to identify those at risk of developing significant drug problems during adolescence, and intervening with support services that are effective in diverting those individuals from a self-destructive path. This is, however, a difficult task, as most young drug users do not consider their use to be a problem, and are not yet ready to accept help. But it is clear that there are opportunities to intervene: those young people who appear in the care system or on risk registers; are arrested for minor offences or anti-social behaviour; or who are temporarily or permanently excluded from school whose parents are involved in using substances are prime targets for early intervention. Systems to assess these individuals' drug and/or alcohol use, and to intervene in ways that motivate them to avoid a worsening of their problems, should be strengthened.

An issue with the continuity of care for those young people who are receiving support from drug treatment services was identified. Quite appropriately, there are separate treatment services in the city, ensuring that young drug users receive age-specific care, and are not brought into contact with older users in adult services. However, there is a problem with transitions between these two systems when clients reach the age of 18. Work has began to address this issue however, embedding the new arrangements throughout the appropriate services is still required.

## Recommendations:

1. **Drugs information and education should be embedded within the Health and Wellbeing agenda, and in particular should make use of the information arising from the 'real-time' information sharing mechanism referred to in the previous section.**
2. **Commissioners and service providers should respond to the need to invest in the strengthening of protective factors, in particular enabling young people to undertake activities that are alternatives to the problematic use of alcohol and drugs and reduce their sense of being marginalized. Affordable public transport was one plea expressed by young people.**
3. **There should be a coherent continuity of care between generic young peoples services and the specialist drug services, with service delivery reflecting emotional, as well as chronological, age within the context of a person centred approach and which also responds to the wider needs of the family where they impact on the wellbeing of the young person. This approach should include the promotion of a range of social media and electronic technology for accessing information and advice, together with an emphasis on attracting young people from minority groups and those in transition to adult services.**

# **Challenge 4:** To what extent does the treatment system meet the treatment and recovery needs of the citizens of Brighton & Hove?

The system and services for treating drug dependence and related health and social problems in Brighton and Hove are well developed, and generally well regarded, having expanded considerably in the last 10 years. However, the system still faces significant challenges in terms of capacity, accessibility to the target population, the appropriateness of the range of services on offer, and the rapidly changing pattern of drug use in the city. Given the changes to the funding arrangements to these services that are in the process of being implemented, now is a good time for the newly constituted Health and Wellbeing Board (administered by Brighton and Hove City Council) to review the acknowledged successes of the current services, and address any areas for improvement or gaps. It is noted that there has been increasing pressure on treatment service budgets [the under 18s budget has been reduced by 59% between 2008-09 and 2012-13, for example], and it is important that the level of service provision is sustained and improved, if the positive impact on health and crime rates in the city is to continue.

## What We Found

In the financial year 2011-12, 1,442 individuals [1,116 opiate and/or crack users (OCUs) and 326 non-opiate and crack users (non OCUs)] received specialist and structured treatment in the city. Of this total, 70% were male, the same proportion as for England as a whole. For OCUs 54% were over the age of 40 whereas for non-OCUs, 74% were under the age of 40 which illuminates the dual challenge of caring for an aging opiate using cohort, and a younger generation using a wider range of drugs. The most common primary drug of choice for the local treatment population was opiates, accounting for 77% of those in treatment [compared with 81% nationally], followed by cannabis at 9% [8% nationally] and crack at 4% [3% nationally]. The main sources of referral into treatment services in Brighton and Hove were self-referrals, at 54% [40% nationally]; and the criminal justice system, at 26% [22% nationally]. The main type of treatment intervention received was prescribing of opioid substitutes -for 68% of those in treatment [Apr-Oct 2012 data], compared with 49% nationally, followed by structured psychosocial interventions [12%]; structured day programmes [7%]; and residential rehabilitation [7%].

Approximately 200 individuals successfully completed drug treatment in 2011-12 and left the treatment system in a planned way, having overcome their dependency. This represented 12% of the total treatment population, which is lower than the national average (15%), but a figure that has shown an improving trend.

The members of the Safe in the City Partnership co-ordinate budgets of approximately £5.24 million to fund the drug treatment system and are constantly reviewing strategies and expenditures in order to develop an accessible, high quality and cost-effective services.

The core of these services consist of:

- Open access/drop in clinics for initial assessment, allocation of a care co-ordinator, and referral on to the most appropriate service. These clinics also offer harm reduction services such as needle exchange, blood borne virus testing and vaccinations, and take home naloxone, as well as support for families/carers of people with drug and alcohol issues.

- Formal support to address alcohol and substance misuse issues e.g. counselling/ psychosocial interventions; specific support to people in the criminal justice system because of their substance misuse; and specific support to substance misusing parents.
- Substitute prescribing and associated supervised consumption.
- Detoxification support available both in the community and in specialist inpatient unit.
- Residential rehabilitation services available in Brighton and Hove
- A new focus on commissioning aftercare/ follow on services available to people after they successfully complete treatment to support them to continue their recovery and to reduce the risk of relapse.

In recent years, these services have made a contribution to the decline in acquisitive crime in Brighton and Hove, which has reduced year on year since 2006, as well as to the containment of blood borne viruses such as HIV and hepatitis. They have also helped many Brighton and Hove residents tackle their drug use and thereby become better family members and neighbours, as well as more positive members of the community.

However, the Commission also heard about several challenges facing the treatment system that need to be confronted:

**Accessibility:**
The Commission received evidence that some individuals and families who could benefit from treatment services found it hard to get access to the right service at the right time. There also appears to be room for improvement in the ability of services to attract people from the LGBT and BME communities, and those with a disability. In a previous section the reluctance of young people, in particular to make use of 'adult' drug treatment services that seem to be designed for older users of heroin and crack was explored, but there are also problems caused by limited opening times, and occasionally the perceived unwelcoming and bureaucratic nature of some services.
We believe specific attention should be given, within the broad area of complex needs, to the access to services of those people experiencing dual diagnosis [defined by the DoH (2002) as "severe mental health problems and problematic substance misuse"]. There appears to be evidence of mental health assessments being unavailable for people presenting with symptoms of drug or alcohol intoxication, detracting from the provision of a sound clinical care pathway. There would appear to be a need for greater capacity, in part via the provision of training and education of the workforce, to provide timely and skilled person-centred assessments of people with a dual diagnosis, including those people using drugs and alcohol as self-medication for mental health problems. No services in the city should operate a policy of turning clients away because they do not fit criteria around mental health diagnosis, or patterns of substance misuse.

**Recovery Rates:**
One of the key achievements of a drug treatment system is to help individuals to overcome their dependency and live an independent life. This is why successful exits from the treatment system are an important indicator. For the system to remain sustainable, the number of successful exits from the treatment system must keep pace with the number of new clients registered. If too many clients are retained in the specialist

services for too long, the system will become log-jammed. The Health and Wellbeing Board needs to find ways to increase the numbers successfully treated each year and support their recovery in order to prevent relapses and a return to dependence, both on drugs and on the treatment system.

### Changing Patterns of Use:

The treatment system in Brighton & Hove, in line with national policy, was developed in order to meet the needs of heroin and crack users, which were the priority ten years ago. There still exists a significant, and ageing, group of drug users with these characteristics who need continued support. However the pattern of drug use in the city has been changing, with younger users more likely to be experiencing problems with alcohol, cannabis and a range of legal and illegal new psychoactive substances. The challenge to the commissioners and managers of treatment services in Brighton & Hove is to refine the services offered to meet a more diverse range of needs, at a time when the overall resources available are at best stable, and likely to be declining. It was recommended earlier in this report the strengthening of mechanisms to collate real time information on the changing drug scene – this information should also be used to inform treatment strategy. The setting up of a committee – The Emerging Trends and New Psychoactive Substances Group – in December 2012 and the planned introduction by service providers of an evening clinic targeting problematic recreational drug users, who are often in day time employment, are welcome steps in this direction.

## Possible Ways Forward

The treatment system in Brighton and Hove is subject to constant review of needs, resources and service provision by the Joint Commissioning Group, which reports to the Safe in the City Partnership. Our Commission does not want to replicate or undermine the excellent work of the members of that partnership, but we do think that they should address the following key questions as they review the treatment system through 2013, in the context of the establishment of the city's Health and Wellbeing Board:

- Are there adjustments that can be made to the operation of services (for example outreach, opening times, motivational enhancement, or improved 'customer service') that can attract those drug users who do not currently use services, or who drop out through lack of engagement?

- How can the services be reformed so as to produce a higher number of clients each year who leave structured treatment services in recovery and capable of leading independent lives? How can this trend be harnessed to create a 'recovery culture' across all services and communities in the city?

- How can the treatment system be made more appropriate to the needs of younger users, and those developing dependence with a wider range of substances than just heroin and cocaine?

There are well established mechanisms for the authorities in Brighton & Hove to conduct consultations with current users of services, family members of people with drug issues, young people, and drug users in the city who do not currently access services. We suggest that these structures are used to conduct an open conversation on the options for addressing the above questions.

## Recommendations:

1. Public Health should identify and recognise the diversity of people in the city who require access to drug information, advice and treatment services and for whom the current service offers are not sufficiently attractive.

2. Public Health as the lead for the re-tendering of services during 2013 - 2014, should ensure that the service specifications used in that process enable the following developments:
   - New ways of providing information and advice about risks and access to services are put in place which meet the needs of the diverse and hard to reach population; arrangements may include facilities for on line assessment and advice, provision within mainstream GP and other generic service settings
   - That professional and academic bodies in the city include within their educational curriculum, some training which will enable the medical, health, social care and teaching workforce in the city to identify and skillfully respond to the needs of the city's population who are at risk of and/or are using drugs
   - The development of a city wide recovery culture is promoted and embedded throughout the treatment system, and related settings. To facilitate this process, specific support is given to services and groups who are developing structures for those in recovery to provide mutual support to each other, and also social, housing and employment opportunities.
   - The re-orientation of the treatment system to meet the needs of the 18-25 age groups, and other under-represented and minority groups
   - That services are responsive to the changing patters of drug use, with the flexibility to respond to new intelligence written into service contracts.

3. The access needs of individuals with a dual diagnosis should be urgently addressed, supported by the availability of well trained and person-centred staff able to provide combined mental health and substance misuse assessments.

4. The current forums for service user and carer consultation will significantly assist implementing the recommendations in this section. However, a review of the support needs for forum members should be undertaken, particularly to address and avoid the over-reliance on specific individuals, and putting in place arrangements which draw on wider support networks such as Recovery Champions and Peer Mentors.