

DRUG & ALCOHOL TEAM

Cornwall and Isles of Scilly

Reducing Harm | Promoting Recovery

SAFER CORNWALL

Kernow Salwa



CORNWALL & ISLES OF SCILLY DRUG AND ALCOHOL NEEDS ASSESSMENT

Our Treatment System
Update 2025/26

Acknowledgments

This update to the Drugs Needs Assessment for Cornwall and the Isles of Scilly was prepared by the **Amethyst Community Safety Strategic Intelligence Team**, with support from the Drug and Alcohol Team, Cornwall Council.

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Introduction

In December 2021, the government published their **10-year UK Plan¹ 'From Harm to Hope'** to combat illegal drugs, backed by additional funding for 2022 to 2025, to start to **reverse the impact of disinvestment** in drug treatment over the previous decade.

The national strategy seeks to deliver the recommendations of Dame Carol Black's landmark **independent review of drugs.**² It sets out the expectations of how **Government and public services will work together** and share responsibility for delivery. This includes specific **guidance**³ for **local partners.**

Every area is required to have a local **Combating Drugs Partnership** to drive effective delivery of the national Drugs Strategy. This partnership must **agree priorities** through a **strategic needs assessment** and develop and deliver a local **drug strategy and action plan.**

In Cornwall, that responsibility is discharged through the **Community Drugs Partnership.** Oversight and governance is provided by the **Safer Cornwall Strategic Board** and the Chair is the Senior Responsible Officer.

Local drug and alcohol strategies continue to be included under the umbrella of the **Safer Cornwall Partnership Plan.**

Identifying local priorities

The strategic needs assessment aims to provide a **shared understanding of local needs and evidence** for drug and alcohol provision. This informs the design of local services and enables individuals, their families and the wider community to have their **needs met more effectively.**

We undertake a **full needs assessment every 4 years** and the first iteration in this cycle was published in 2023.⁴ We undertake an **annual review and refresh** to ensure that our evidence base keeps pace with emerging trends.

This latest update focuses on **what has changed** since the last assessment and is provided as a set of three thematic papers:

- Our treatment system
- The Drug Market, exploitation and other criminality
- Consultation and Surveys

In addition, in 2025, we published a comprehensive report on [drug-related deaths in 2024.](#)

Local plans responding to these needs assessments **consider both drug and alcohol-related harms,** and how to meet the complex needs of people who use alcohol as well as other drugs. Alcohol is included alongside drugs in all relevant activity and performance monitoring and reporting.

¹ [From harm to hope](#), UK Government, December 2021

² Dame Carol Black's [Independent Review of Drugs](#), Home Office and DHSC

³ [Drugs Strategy Guidance for Local Delivery Partners](#), Home Office, June 2022

⁴ The 2022/23 strategic needs assessment and 2024/25 update are published in the Safer Cornwall library under [Drugs Needs Assessments](#)

Policy update

Dual Diagnosis

New guidance has been published by the Department of Health and Social Care⁵ which sets out the Government's plan to improve support for people with co-occurring **mental health and substance use** needs. The plan represents a system-wide shift towards integrated, **no-wrong door support** that reduces health inequalities.

The new framework sets out a national push for a **person-centred approach** and has direct consequences for Community Drug Partnerships, including:

- A **statutory responsibility** to collaborate and demonstrate multi-agency coordination.
- Better data and **intelligence sharing** to identify people early and prevent harm.
- A more **skilled workforce**.
- Greater influence on **commissioning** and strategy.
- Stronger **expectations to align** community safety, public health, mental health, and substance misuse approaches.

The guidance highlights how **fragmented services often leave people unsupported**, leading to crisis, criminal justice involvement, vulnerability and increased risk of suicide. The 10-year health plan

aims to ensure that **care is no longer split into separate services** that are hard to access and unable to meet individual needs.

This includes expanding mental health support teams in **schools** and colleges, investing in **mental health emergency departments**, transforming mental health services into **neighbourhood care models** and improving outreach care and treatment.

The framework strengthens local partnership responsibilities to **share intelligence** that support the identification of co-occurring needs among vulnerable people (such as repeat victims, rough sleepers, frequent criminal justice contacts). It also seeks to **improve data linkage** across agencies, reducing duplication and missed risk indicators.

All staff working with people with mental health and substance use issues will be required to have **basic competency training**. Police, community wardens, housing officers, and local authority staff will increasingly be expected to **understand co-occurring needs**.

While the plan focusses on adults, it also emphasises the **importance of prevention and early intervention** for children and young people which will form the next phase of this programme.

⁵ [Co-occurring mental health and substance use delivery framework](#), Department of Health and Social Care, December 2025

Workforce transformation

In July 2024 the Department of Health and Social Care partnered with NHS England to deliver a national drug and **alcohol treatment and recovery workforce transformation programme**.⁶

This programme is based around the **10-year strategic plan** for drug and alcohol treatment recovery which sets out how it aims to transform the local and national workforce.

The plan is designed to guide national, local, and employer workforce planning for the next decade. It aims to bring **consistency, clarity, and standardisation** to workforce development, education, and training across the sector.

Inclusion health groups

These are groups who are **socially excluded** and likely to have **experienced multiple risk factors for poor health**, such as poverty, violence and complex trauma.

The new **Inclusion health data and intelligence resource**⁷ for England has been published and includes local data on the health needs and outcomes for these populations, that are not otherwise routinely available.

The tool includes **benchmarking data for local authorities** including prevalence, numbers in treatment and deaths in treatment so that local partnerships can compare outcomes.

As well as bringing together statistics that are already in the public domain, it provides **accompanying narrative and resources to support informed decision-making** and the development of tailored solutions to the challenges faced by inclusion health groups.

People with drug and alcohol dependency **experience extreme health inequalities** and as such are part of the NHS Inclusion Health Groups. **Other vulnerable populations** include people who experience homelessness, people with experience of care, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in the criminal justice system and victims of modern slavery.







Populations are diverse but can share common experiences such as social disadvantage, poor health and barriers to accessing services. Health inequalities experienced by belonging to one or more inclusion group can be further exacerbated if **more than one inequality domain** is experienced.

⁶ [10 year strategic plan for the drug and alcohol treatment and recovery workforce](#), NHS England, July 2024

⁷ [Inclusion health data and intelligence resource](#), Office for Health Improvement and Disparities, January 2026

National Drugs Outcomes Framework

All figures relate to the latest data published, compared with the 2021/22 baseline and, unless otherwise stated all figures are for Cornwall and Isles of Scilly.

Reduce drug use 	Reduce drug-related crime 	Reduce drug-related deaths and harm 	Reduce drug supply 	Increase engagement in treatment 	Improve recovery outcomes 
<p>Headline metrics</p> <p>8.7% of people used drugs People aged 16-59 reporting any drug use in the last year Crime Survey 2025 (England & Wales only)</p> <p>2,348 opiate/crack users Estimated local population 6.9 per 1000 population ▼ -10% England 8.5 ▼ -11% (2022/23 estimate compared with 2019/20)</p>	<p>Headline metrics</p> <p>1,742 neighbourhood crimes 3.0 per 1000 population ▲ +21% England 11.2 ► -3% Recorded by police, year to Sep-25</p> <p>0 drug-related homicides 0 per 1000 population Recorded by police, year to Sep-25</p>	<p>Headline metrics</p> <p>112 deaths related to drug misuse (2022-2024) 7.1 per 1000 population ▲ +13% England 5.2</p> <p>Substance misuse hospital admissions (Jul-25) 26 per 100,000 aged 15-24 ▼ -24% England 32.9 24.3 per 100,000 aged 25+ ▼ -16% England 25.8</p>	<p>Headline metrics</p> <p>6 County Lines closed Recorded by police, year to Sep-25</p> <p>20 Disruptions against Organised Crime Groups 19 minor disruptions, 1 moderate Recorded by police, year to Sep-25</p>	<p>Headline metrics</p> <p>65% prison leavers With a drug-related need picked up by community services within 3 weeks England 58%</p> <p>4,024 adults ▲ +15% 148 young people ▲ +83% Numbers in treatment in the last year (Oct-25)</p>	<p>Headline metrics</p> <p>48% treatment progress ► -4%</p> <p>People in treatment showing substantial progress England 46% (Oct-25)</p>
<p>Supporting metrics</p> <p>206 households Owed a homeless duty, citing drug use 13% of households owed a duty, England 10%</p> <p>275 drug and/or alcohol-related exclusions ► +3% 13 permanent exclusions / 5.3% of all exclusions - England 5.0% (2023/24) 262 suspensions / 1.6% of all suspensions - England 2.2% (2023/24)</p> <p>Children's Social Services Where drugs was identified as a factor 415 referrals ▼ -9% 5.2% of all referrals/39.2 per 10,000 children in Cornwall</p> <p>661 assessments completed 8.3% of all assessments/62.5 per 10,000 children in Cornwall</p> <p>% 11-15 year olds who think it's ok to take drugs "To see what it's like" - cannabis 11%, cocaine 4% "Once a week" - cannabis 6%, cocaine 4% NHS Digital SDD 2023 (England only)</p>	<p>Supporting metrics</p> <p>Proven reoffending rates within 12 months 2023/24 cohort vs 2021/22 23.2% of adults ► +0% England and Wales 28.0% 19.1% of young people ▼ -5.6% England and Wales 31.8%</p> <p>655 drug possession crimes 1.1 per 1000 population ▼ -7%</p> <p>291 drug trafficking crimes 0.5 per 1000 population ▲ +14%</p> <p>Recorded by police, year to Sep-25</p> <p>50 Hospital admissions for assault with a sharp object ▲ +25% from 2021/22 20% are under 25 years of age</p> <p>Devon and Cornwall Police Force Area, 2023/24 (NHS Digital, rounded to nearest 10)</p>	<p>Supporting metrics</p> <p>49% Hepatitis C infection in people who inject drugs (South West, 2023); England and Wales 53% [latest published]</p> <p>39 people died whilst in contact with treatment (2022-2024) 35% of drug-related deaths ► -3% England 26% ► 0%</p>	<p>Supporting metrics</p> <p>1,796 drug seizures 34% Class A / 57% Class B / 9% Class C/other Recorded by police, year to Sep-25</p> <p>3 NRM referrals People referred into the National Referral Mechanism for County Lines Recorded by police, year to Sep-25</p>	<p>Supporting metrics</p> <p>847 unmet need People using opiates and/or crack users not in treatment (estimate) 36% of prevalence estimate England 53%</p> <p>No local data (no prisons in Cornwall)</p> <p>People in treatment in prisons and secure settings</p> <p>Community or Suspended Sentence Orders with Drug Treatment Requirements</p> <p>Adults starting treatment in the establishment within 3 weeks of arrival from the community or other custodial settings</p>	<p>Supporting metrics</p> <p>84% no housing problems ▼ -4% Adults reporting no housing problems in the last 28 days England 87% (Oct-25)</p> <p>25% adults in work, training or study ► -2% Adults completing at least 1 day of paid work, voluntary work, education or training in the last 28 days England 27% (Oct-25)</p> <p>14% adults ▼ -6% Adults with an unmet mental health treatment need England 18% (Oct-25)</p> <p>6% parents ► +2% Parents that have received a specific family or parenting intervention England 15% (Oct-25)</p>

Reference: [National Combating Drugs Outcomes Framework: supporting metrics and technical guidance](#) Sources: Police recorded crime (Devon and Cornwall Police), includes burglary (residential), robbery of personal property, vehicle offences and theft from the person; [Deaths related to drug poisoning by local authority](#), England and Wales (ONS, 2025); [Public Health Profiles](#) (OHID); inpatient finished [admission episodes](#) with a cause code of 'assault with a sharp object', by Police Force Area, NHS Digital; [NHS Smoking, Drinking and Drug Use among Young People 2023](#), NHS Digital (2024) - the survey report for the 2025 survey is scheduled for autumn 2026; [Proven reoffending statistics](#), Ministry of Justice, published January 2026 (cohort 2023/24 compared with cohort 2021/22); [Unlinked Anonymous Monitoring Survey of HIV and viral hepatitis](#) among people who inject drugs, UK Health Security Agency 2024; [Suspensions and permanent exclusions in England](#), statistics for state-funded schools academic year 2023/24, Department for Education, July 2025

What does this tell us about our system?

Highlights

- **Local prevalence of opiate and/or crack use** is estimated to be lower than national rates; **drop in OCUs** compared with the last estimates (in line with the national picture) – within the estimates we are seeing **more crack use** and less opiates.
- **Lower rates of unmet need** than the England rates across all drug groups which indicates that the **system is performing well** at attracting and engaging people who need treatment into services.
- More likely to **identify and meet mental health** needs than the England average.
- **Hospital admissions** for substance misuse have **reduced and below** England rates, particularly amongst **15-24 year olds**.
- **Low rates of neighbourhood crime** (thefts) but some types of crime have increased.
- **Reoffending rates** for both adults and young people

consistently track below the England average.

- Significant **improvement in continuity of care** in 2024, now stable at 65% and above the national rate.
- Fewer **drug and/or alcohol-related exclusions** and referrals to Children's Social Care where drugs is recorded as a factor.

Challenges

- Above average rate of **drug related deaths** with a rising trend; the percentage of deaths in treatment is also above England rate.
- Overall **progress in treatment** is above national average but has seen a small decline. Progress for **non-opiates and alcohol** is third quartile and a priority to improve.
- **Housing and employment outcomes** for people in drug and alcohol treatment are stable but continuing to **fall just below the national benchmark** rates.



Trends in Drug Use

Based on the latest estimates⁸ from the Crime Survey for England and Wales, in 2024/25 **8.7% of people** aged 16-59 had taken an illicit drug within the last year. This equates to around **26,000 people in Cornwall and Isles of Scilly**, with cannabis being the most prevalent at an estimated 19,000 users.

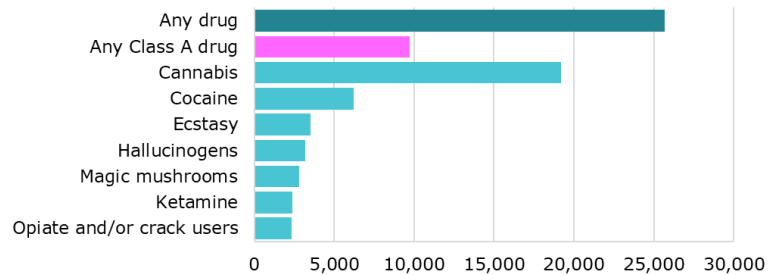
Around **10,000 people** (just over a third) are estimated to have taken a **class A drug** within the last year, with **cocaine and ecstasy** the most frequently used.

National research into the prevalence⁹ of problem drug use estimate that there are **2,348 adults using opiates and/or crack cocaine** in our local population. This is explored in more depth in [Understanding Unmet Need](#).

Successive Drugs Needs Assessments have highlighted the **escalation of crack use and associated harms** in the last 5 years – numbers have increased in people accessing treatment for crack use only, and to a lesser extent for crack use adjacent to opiate use. In contrast, there has been **almost no change in the number of opiate users** over the same time period.

⁸ Using a combination of estimates derived from the [Crime Survey for England and Wales](#) (2023) and OHID local estimates

⁹ Data from NDTMS Unmet Need Toolkit - estimates of prevalence of drug (opiates and/or crack cocaine) users aged 15-64 by area, from the latest prevalence estimates



We saw the emergence of **synthetic and counterfeit drugs** during the pandemic, alongside high strength illicit benzodiazepines, increased use of cannabis and illicit prescription drugs. We also saw a rapid **rise in drugs bought online**. Synthetics now appear across a range of different drugs and present a **very high risk of overdose** to users.

Drug-related deaths continue to rise – there were 59 deaths in 2024¹⁰ compared with 41 in 2023.

Synthetic opioids pose a significant and growing threat. 4 deaths in 2024 involved synthetic opioids, none of whom were engaged in treatment at the time. **Deaths may be significantly undercounted** – due to not being tested for specifically/ not detected due to rapid post-mortem degradation.

A recent police assessment indicated, with **high confidence**,

found at [https://www.ndtms.net/resources/secure/Prevalence and unmet need documents/OCU prevalence methodology.pdf](https://www.ndtms.net/resources/secure/Prevalence%20and%20unmet%20need%20documents/OCU%20prevalence%20methodology.pdf)

¹⁰ Drug Related Deaths Report 2024 (Drug and Alcohol Action Team, September 2025)

that a supply line is **adulterating their heroin** with synthetic opioids.

Other drugs affected include **pharmaceutical drugs** that a wider cohort of people are buying from the illegal market, including young people. Synthetic drugs have also been found in **adulterated vapes**. This requires harm reduction messages that are **targeted to different groups**.

Risk around **illicit benzodiazepines** has been one of the emergent **themes in drug related deaths** over the last few years. It was previously indicated that users **unable to afford or obtain heroin** are using illicit benzodiazepines instead and this is common amongst drug users in **supported accommodation** due to their affordability.

Another key trend is the **rise in ketamine use**, with more **young people** in treatment citing ketamine as a problem drug, alongside significant **emerging health harms**. We recorded the **first ketamine-related death** in 2024, with increased risk of overdose when mixed with other substances.

This increase **reflects a national trend**, not limited to Cornwall, with widespread concern across the UK.



FOCUS ON: Crack

Increasingly crack use is coming to the attention of support services and, given the difficulty associated with engaging users in treatment, it suggests that we are only seeing the 'tip of the iceberg'.

Engaging crack users in treatment is extremely challenging due to the extreme effects of both its use and withdrawal. Behaviours are hard to manage and often result in users being **excluded from housing and other forms of help**. Methods employed to stabilise users require more resource intensive, creative approaches that will target them at points in their journey when they are most receptive.

The Hospital Outreach Team is seeing more presentations for **dysregulated behaviour and psychological issues** exacerbated by crack use.

We are seeing **crack use amongst young adults** (18-30 years) but not amongst young people under the age of 18 at the moment.

Police report evidence of **powder cocaine being sold with bicarbonate** for conversion into crack rocks. These can be **sold very cheaply** due to localised, low level production. Increased accessibility increases use, leading to **dependency and linked health and crime related harms**.

The Drug and Alcohol Team is aware of increasing community intelligence regarding **crack cocaine being aggressively marketed to vulnerable** people, including people who are rough sleeping and/or street drinking in some of our larger towns.

Services working with vulnerable women are reporting **sexual exploitation and abuse linked to crack** and in several cases, this has also come to the attention of the MARAC¹¹ as a feature of coercive relationships.



FOCUS ON: Ketamine

The current intelligence picture suggests that **use of ketamine has increased**. Concerns have been raised particularly about its prevalence **amongst young people**, with the drug predominantly supplied in **peer-to-peer settings** or through **social media platforms** though many intelligence gaps remain.

Ketamine is known to cause **significant health harms**, both mental and physical.

Cannabis is still the most used substance amongst our young people but **ketamine use has increased** and we have also seen the **use of solvents and aerosols re-emerge**.

At the end of February 2026, **93 adults and 16 under-18s** who were using ketamine had engaged in **structured treatment** in the past year. **Adult users have increased** in number by 24%, the number of **young people has dropped** by 36%.

We have previously seen a rise in **young people in treatment citing ketamine** as a problem drug, although this has dropped back within the current year. **Polydrug use** commonly features in ketamine use amongst young people known to treatment.

The young people's drug service reports that **ketamine tolerance** has led to escalating use and increased the risk of dependency. A **pain-use cycle** can develop, where users take more ketamine to relieve pain from previous use.

Prolonged ketamine use can result in **permanent and irreversible bladder damage** and nasal complications and there have been some cases of young adults affected locally. **Collaboration with a Urologist** at Treliske is underway to develop **clinical advice for GPs** who may not link presenting physical symptoms to drug use.

We continue to see a frequent **references to ketamine** in relation to young people referred for

¹¹ Multi Agency Risk Assessment Conference (MARAC) involves the active participation of all of the key statutory and voluntary

agencies who are supporting a person(s) experiencing domestic abuse. It is used primarily to manage high risk cases.

safeguarding interventions¹² for **exploitation**.

Deaths linked exclusively to ketamine toxicity are rare – but we recorded our **first ketamine-related death in 2024**. Risk of overdose increases when it is mixed with other substances.

Workshop Insights: Ketamine

The young people's drug service have seen a notable increase in ketamine use as part of **recreational, poly-drug use**, reportedly often used to 'take the edge off' post-cocaine consumption.

The feeling that **ketamine gives can also help to medicate distress** which is particularly prevalent amongst young people. Ketamine has **no discernible smell so is less** detectable by parents or school, which poses challenges around harm reduction and referrals for support. Partners were **not aware of any school reporting concerns** about ketamine use amongst their students.

Education on drugs harms

provided in school settings can only engage the young people who are in school. These messages may not reach young people who are absent or excluded and **more vulnerable** to drug use.

There appears to have been a widespread **misconception that ketamine is a 'soft' drug**.

Information about the permanent health harms linked to ketamine are now accessible across social media platforms, but this was **slow to establish** and problems may have escalated in the interim.

Ketamine users often ignore the symptoms of **stomach pains and bladder issues**, increasing use to alleviate pain, perpetuating the cycle.

The **dissociative effects** of ketamine use means that users require **intensive, long-term support** to disengage from use.

Further Reading:

A thematic update on the [Drugs Market, exploitation and other Criminality](#) is published as a partner paper to this one.

¹² Missing and Child Exploitation Panel – operational safeguarding response for young people experiencing or at risk of exploitation.

Our local treatment system

What does the Local Outcomes Framework tell us?

The Local Outcomes Framework provides every local area with information to **monitor their performance** against the aims of the national [Drugs Strategy](#). This information is produced by the Office for Health Improvement and Disparities using data from the National Drug Treatment Monitoring System.

The Local Outcomes Framework has been developed to **increase transparency and accountability** within local authorities for their treatment recovery outcomes. This included the development of a **new treatment measure** that broadened the focus from successful completion of treatment to include progress for those still in treatment.

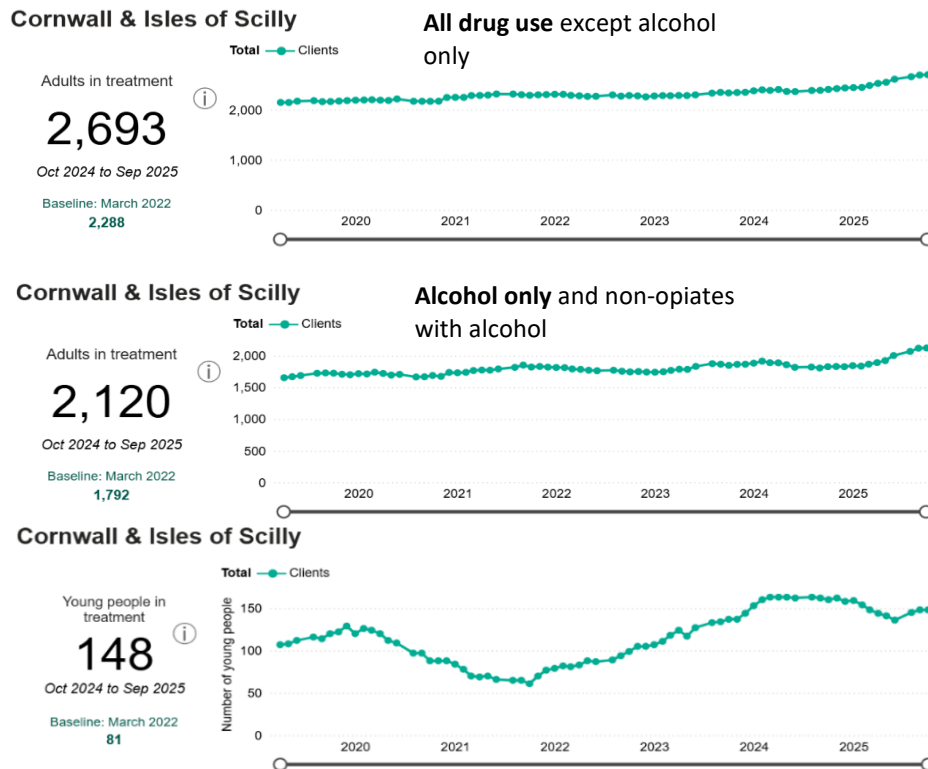
<p>Note: People in treatment are categorised into one of six groups that describe their drug use. The Local Outcomes Framework on-line reporting functions allow outcomes and trend data to be reviewed and compared for different drug groups, as well as demographics such as gender and age. We also use the term Opiate and/or Crack User (or OCU) which is the sum of the top 3 groups.</p>	Opiates only
	Crack (no opiates)
	Opiates AND crack
	Non-opiates and alcohol
	Non-opiates only (no crack)
	Alcohol only

Numbers in the treatment system – quick facts



- Overall the number of adults in treatment is **up by 14%**.
- The number of people in **treatment for drug use has increased by 13%** compared with last year and 18% from the March 2022 baseline. There has been **growth in all drug groups** except for people who use 'opiates only'.
- The number of people in **treatment for alcohol use has increased by 17%** compared with last year and 18% from the baseline. Both 'alcohol only' and 'non-opiates and alcohol' groups have increased.
- The number of **young people** in treatment has reduced by 9% over the last year, following the spike in 2024. The **rise since the baseline is 81%**.
- **New presentations** (people engaging in treatment for the first time) make up around **half of our local treatment cohort**, in line with the national trend. Previously this was lower but has caught up over the last year.
- **Engagement and retention rates are high** (top quartile)
- At 3% in each, rates of **residential and in-patient treatment** are above England rates and the 2% national target.

People in treatment



The latest data from NDTMS shows: **2,693 adults¹³ were in structured treatment for drug dependency** (any drug) in the 12 month period to September 2025, a 13% increase over the past year and an 18% rise from the March 2022 baseline.

The fastest **growth has come from crack users (+49%) and non-opiate users (+37%)**; the trend for opiate users (including opiate use with adjacent crack use) has also risen but not so quickly¹⁴. The largest growth by volume can be seen amongst the non-opiate and alcohol clients with an additional 120 people in the treatment cohort.

2,120 adults were in structured treatment for alcohol dependency in the 12-month period to September 2025, a **17% increase** on the previous year (+190 clients) and an 18% increase from the baseline.

This figure reflects **rising demand** among those using both **alcohol and non-opiates** (+18%), alongside an increase in individuals engaged in treatment for **alcohol as their only reported substance** (+17%).

The treatment service report that **drinkers are presenting with high levels of complexity and very**

¹³ NDTMS Local Outcomes Framework, latest data: 12 months to September 2025 compared with the same period in 2024/25.

¹⁴ Opiates with crack up by 12% in the year ending September 2025

poor physical health (such as stage 4 liver disease) suggesting that non-specialist services **may not be identifying problem drinkers at the earliest opportunity** using the recommended screening tools and making referrals.

148 young people under the age of 18 were in structured treatment with the young people's service in the 12 month period to September 2025. This figure has **decreased by 9%** across early 2025, further to a rise of 38% in 2023/24.

Compared with the national profile, we see **some significant differences** in the local profile across three of the drug categories:

- **Higher rate of opiate dependency only.** One in four

people in treatment in Cornwall are receiving treatment for opiate dependency only, compared with one in five across England.

- **Much lower rates of crack dependency amongst people in treatment for opiates.** 6% of our local cohort are in treatment for both drugs together, compared with 22% nationally. This may indicate a lower prevalence (or disclosure) of crack use amongst opiate users.
- **More people in treatment for non-opiates and alcohol together,** almost 800 people (20%), appear in our local cohort than in the national dataset (13%), with numbers growing at a faster rate over the last year.

Drug group	Cornwall and Isles of Scilly			England		
	Adults in treatment	% by drug group	Annual change %	Adults in treatment	% by drug group	Annual change %
Opiates only	1,098	27%	-1%	63,760	19%	-3%
Crack (no opiates)	186	5%	49%	12,999	4%	15%
Opiates and crack	241	6%	12%	72,377	22%	0%
Alcohol only	1,330	33%	17%	99,810	30%	2%
Non-opiates and alcohol (no crack)	790	20%	18%	43,070	13%	8%
Non-opiates only (no crack)	378	9%	37%	39,225	12%	17%
Total adults in treatment	4,023		14%	331,241		4%

New presentations

As of September 2025, there were **4,023 adults in treatment overall.** There has been an increase in treatment numbers of 14% since September 2024 and 15% since the March 2022 baseline.

The overall **proportional share of new presentations** within the local

treatment cohort in Cornwall is now **similar to the England average,** at around half of the overall treatment population, with new presentations having increased by almost 44% over the 12 months to September 2025.

Drug Category	Cornwall and the Isles of Scilly				England			
	New Presentations	Adults in Treatment	% of New Presentations by Drug Category	% of All New Presentations	New Presentations	Adults in Treatment	% of New Presentations by Drug Category	% of All New Presentations
Opiates only	229	1098	21%	12%	13773	63760	22%	8%
Crack (no opiates)	118	186	63%	6%	8834	12999	68%	5%
Opiates and crack	196	241	81%	10%	23295	72377	32%	14%
Alcohol only	752	1330	57%	38%	65990	99810	66%	39%
Non-opiates and alcohol	442	790	56%	22%	28951	43070	67%	17%
Non-opiates only (no crack)	245	378	65%	12%	28712	39225	73%	17%
Total	1982	4023	49%	100%	169555	331241	51%	100%

This is against a backdrop of **unmet need estimated to be lower locally** than nationally for most drug groups.

As of September 2025, our local OCU treatment cohort had **grown by an additional 6%**, 81 additional users, outpacing national growth, which had stalled. This small amount of growth primarily comes from **people seeking help for crack (no opiates)**.

Whilst the **largest share of new presentations** continues to come from people seeking help for **alcohol dependency** (with no adjacent drug use, 38%), this is now the fastest growing treatment area.

Having previously sat at lower level locally, overall **OCUs now make up a similar proportion of new presentations** (27%) as the England average.

Although new presentations for crack use only (no opiates) are about the same as the national level (around 5%), we are now seeing **much higher levels of adjacent crack use** in new opiate presentations with around 8 in ten people in this group

presenting recently. In the last 12 months just under half of new opiate presentations were using crack, whereas nationally the proportion is closer to 65%.

This would suggest that Cornwall has been doing better recently when attempting to **attract people who use both opiates and crack into treatment with unmet need falling across each of the OCU drug groups**,¹⁵ including people presenting with crack as their only drug of choice which has reduced by 35%.

While numbers are still relatively small, the number of people using both opiates and crack presenting to treatment in Cornwall had been rising steadily from late 2023 and that growth accelerated across 2024 and into 2025, rising by 12% in the year to September.

The recent rise seen across Cornwall's overall treatment population appears to be similar to that seen across the rest of England in 2023 and 2024.

¹⁵ With the exception of the 'Opiates only' group which has risen by 4% to 34% overall

Inpatient Treatment and Residential Rehab

In 12 month period to September 2025, 116 people accessed a medical **Inpatient Treatment Intervention**, making up 2.9% of people in structured treatment population.

Although this represents a 9% drop from the baseline in number of people accessing this type of intervention, and a 0.8% drop as a proportion of people in treatment, we are still exceeding the national rate of 1.1%.

	Baseline	2024/25	Latest
In patient treatment	Mar-22	Mar-25	Sep-25
Cornwall & IoS <i>n</i>	128	119	116
Cornwall & IoS %	3.6%	3.3%	2.9%
England	1.6%	1.9%	1.8%
Residential Rehab			
Cornwall & IoS <i>n</i>	75	112	108
Cornwall & IoS %	2.1%	3.1%	2.7%
England	1.1%	1.1%	1.1%

We have seen the growth in the **uptake of Residential Rehab stabilise**, further to a steady incremental rise over the last 3 years. 108 people accessed this provision in the last year, equating to 2.7% of the total treatment population. The number of people has increased by 44% from the March 2022 baseline (from 75 to 108 people), and the proportion of the people in treatment has increased by 0.5%. Nationally this figure has remained fairly constant at around 1.1% of people in treatment, with numbers rising in line with overall growth.

Having a **block contract with a detox in-county** helps us achieve better numbers than other areas. During 2026/27 the budget has been set to achieve but not exceed the 2% national target, based on a **predicted level of 80 places** required. While this may result in longer waiting times, our **priority is to strengthen community treatment** so that fewer people require residential placements. Breakdown of treatment population by drug category

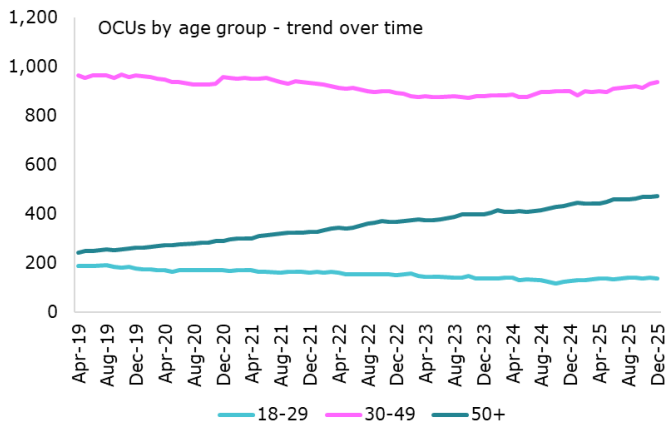
Who is in treatment?

Like the national profile, a large **majority are people in treatment over the age of thirty** (84%) and most people tend to be between the ages of 30-49 years.

All people in treatment	CIOS	England
18-29	16%	14%
30-49	53%	56%
50+	31%	30%
Total population	4,023	331,241
OCUs in treatment	CIOS	England
18-29	9%	6%
30-49	60%	63%
50+	30%	32%
Total population	1,525	149,136

Looking at OCUs specifically, the age profile is more strongly concentrated in the **30-49 age group** (60%).

Of the **4,023 adults in treatment** during the year to September 2025, approximately **just over a third are female** and this is **higher than the national average**. This is true to some extent across all age groups.



Longer term trends both locally and nationally have shown **the 'aging out' of the 30-49 age cohort** into the 50+ group. This would suggest that we are seeing people staying in treatment for longer and work around **tackling longer term health issues**, such as blood borne viruses, is improving the quality of life of these service users.

Over the past year, however, **numbers in all age groups have increased.**

Focus on Protected characteristics

Women

Drug using communities are often small and with women making up one in three service users, it is common for women to encounter their former partner or abuser in group settings.

Better **engagement and outcomes for women** in treatment are supported by:

¹⁶ [Learning from Loss: Ensuring the lessons from domestic homicide reviews](#)

- **Commissioning women-only services** and ensuring that all women can access women-only spaces including peer groups and peer mentors.
- **Promoting trauma training** for service providers.
- **Involving women with lived experience** in service design, delivery and evaluation.
- Providing an option of having a **female keyworker**
- Ensuring that **services are child and family friendly** – offering women additional household and parenting support if needed
- Ensuring **reduced caseloads** for workers engaging with women with the most complex needs.

NICE guidance recommends **domestic abuse routine enquiry** in drug and alcohol services, and this should be evidenced through contract review meetings.

The **Domestic Homicide Oversight Mechanism Report 2025**¹⁶

highlights several cross-cutting issues where problematic drug and alcohol use intersects with domestic abuse and homicide. Although **drugs and alcohol are not isolated as standalone themes**, they emerge as significant factors in many domestic abuse-related deaths.

The report underscores the importance of understanding how **drug and alcohol use contributes to vulnerability and risk** in

[lead to change](#), Domestic Abuse Commissioner's Office, July 2025

domestic abuse scenarios. It calls for improved identification and response strategies among professionals and agencies involved in safeguarding and support services.

The learning suggests that **drug and alcohol care and treatment should be integrated into broader frameworks** for domestic abuse prevention and intervention to ensure comprehensive care and protection for victims.

- **Targeted training** to better identify drug and alcohol use in domestic abuse cases.
- **Culturally competent services** that understand how drug and alcohol use intersects with trauma, race, gender, and other social determinants.
- **Improved information sharing** between drug and alcohol services, mental health providers, and safeguarding teams.
- Multi-agency collaboration and investment in systems that support **real-time data sharing and joint decision-making**.

Comparing the *Learning from Loss* recommendations with those from our local Domestic Abuse Related Death Reviews demonstrate close alignment with regard to **avoiding siloed “substance-misuse-only” focus** and embedding **screening tools**. They both advocate for addressing engagement barriers with **trauma-informed approaches** and

improving **multi-agency discharge planning**.

The national report clearly locates drug and alcohol services within the **wider health thematic picture as “allied health services”**– requiring accessibility, routine enquiry, information sharing and training. It also highlights **capacity barriers** and abandoned/incomplete actions for several agencies due to national or IT constraints.

Learning from our local Domestic Abuse Related Death Reviews supports the **commissioning of women-only services** for detox/rehab and placing **workers in Emergency departments**.

Also recommended are:

- Introduction of **assertive outreach**
- **A standardised discharge process** with a named lead, safety plan, referral to specialist services and housing.
- **Quarterly multi-agency reviews** for repeat Emergency Department attendances and suicide attempts.

Learning disabilities

4.3%¹⁷ of adults in treatment is recorded as having a **learning disability**, which equates to around 1 in 10 people in treatment who are recorded as having a disability. The national rate of learning disability in treatment is 3.4%.

¹⁷ Community Adult Partnership Activity Report (Beta Release, February 2026) –

Profile of adults in treatment by protected characteristics

People with learning **disabilities** **face unique barriers** to accessing the help that they need, including:

- **Lack of recognition in services** – drug and alcohol services not identifying that someone has a learning disability and may need a different approach and learning disability services not detecting drug and alcohol problems.
- **A lack of clear pathways and protocols** between services reducing the effectiveness of inter-agency working.
- A lack of recognition of learning disabilities in **substance misuse guidance and policies**.
- **Health promotion messaging** is too complex.

Research shows that neither learning disability services nor drug and alcohol services have all the **skills and training resources** to support people with learning disabilities who are problem drinkers or use drugs.

There is **lack of evidence-based guidance** about effective treatment for this group, but some useful approaches have been suggested. This is a priority for attention and improvement, including:

- **Screening for learning disabilities** in drug and alcohol services and screening for substance use in learning disability services, as part of initial assessments.
- **Training for staff in drug and alcohol services** in how to tailor

their approach to those with learning disabilities. Training for learning disabilities services around substance use.

- **Tailored information and interventions** to meet individual communication and learning needs. Messaging and topics need to be simplified.
- A **one-to-one approach** rather than group work.
- **Shorter sessions** but a longer time in treatment with maintenance sessions.
- A **patient, flexible, teaching approach** using repetition and fixed goals set over short time frames; incentives, role play, quizzes, pictures and games.
- Widening a person's **social support network**.
- Involving **family/carers** in treatment.
- **Access to other support services** to help people address the reasons they may be using substances e.g. sexual abuse and bereavement.

Sexual orientation

5% of people in treatment are recorded as being Lesbian, Gay or Bisexual, in line with the national rate for people in treatment¹⁸ but slightly above the population figure of 3.2% from the 2021 Census.

Data on sexual identity is patchy, however – for 20% of people in

¹⁸ Based on [national estimates taken from the Annual Population Survey](#), 3% of the

population aged 16-74 identify as LGB (Office for National Statistics, 2020)

treatment this information was not recorded.

People who identify as LGB often believe that non-specific services are 'not for them' and fear and/or anticipate being **misunderstood or discriminated** against by services.

A Stonewall publication¹⁹ about health in the LGBT community identified **specific issues in healthcare settings**, including:

- Experiencing inappropriate curiosity (25%).
- Being 'outed' without their consent by staff in front of other staff or patients (10%).
- Experiencing a lack of understanding of specific LGB health needs by healthcare staff.

National research indicates that **chemsex**²⁰ is a trend amongst some gay men. The drugs used include crystal meth, mephedrone and GHB/GBL.

Dame Carol Black's Review²¹ highlighted **people who engage in chemsex as a particularly 'at risk' group**, who do not receive an adequate, or any targeted, service. The report also noted the **lack of robust evidence as to the extent** of risk sex-related drug use and associated harms.

Locally, whilst community services show good engagement of LGBT

users, and awareness has been raised amongst staff so they can assess and help to reduce the risks linked to sex-related drug use, we **do not have robust knowledge around the extent** to which this is occurring.

Further, staff report that this is **as much a risk for heterosexual people** as LGBT.

Further to research published by the Metropolitan Police Central Serious Sexual Offences Team, a more in-depth topic paper was produced for the 2024/25 assessment.

Locally chemsex is not being highlighted as a risk factor within serious and organised crime in Devon and Cornwall. The drugs linked to chemsex are **infrequently cited as problem drugs** within the treatment system.

The **recommended approach to providing advice and support** to people involved in chemsex is a **collaboration** between sexual health services, drug and alcohol services and relevant 'by and for' VCSE support organisations.

The Topic Paper *Chemsex, exploitation and organised crime* is included as an Appendix to the thematic update on the Drug Market, exploitation and other criminality.

¹⁹ [LGBT in Britain Health Report](#), Stonewall (2020)

²⁰ Chemsex is defined as "engaging in sexual activities while under the influence of drugs

and often involves group sex or a high number of partners in one session"

²¹

<https://www.gov.uk/government/publication/s/review-of-drugs-phase-two-report>

People from minority ethnic groups

2% of people in treatment are recorded as being from a minority ethnic group, compared with 11% nationally. This increases to 5% if we include people of 'Other White' ethnicity.

This largely reflects that our local population is significantly **less ethnically diverse** than the national profile. 3.2% of people in the 2021 Census stated that their ethnicity was from a Black, Asian, Mixed or Other ethnic group, compared with 19% in England.

The needs of people from ethnic minority groups **should not be considered as one homogenous group**, as this acts as a form of discrimination by not recognising that different groups have different experiences and needs.

This is **challenging in an area like Cornwall** where the proportion of people in the population who are not White British, or Cornish, is very low and the additional information that would be needed to understand needs is sensitive to small changes and the data is patchy.

Our ethnicity profile of people in treatment reflects this, with the **majority of people recorded as identifying as White British** with the majority of the rest being made up of Other White ethnic groups. The most represented non-White Group is "Other Mixed".

Adults in treatment - stated Ethnicity	No.	%
Asian	8	0.2%
Indian	<5	
Pakistani	0	
Bangladeshi	<5	
Other Asian	5	
Black	7	0.2%
Caribbean	<5	
African	<5	
Other Black	<5	
Mixed	49	1.2%
White and Black Caribbean	10	
White and Black African	8	
White and Asian	6	
Other mixed	25	
White	3,962	96.4%
White British	3,842	93.5%
White Irish	11	0.3%
Other White	109	2.7%
Any Other	14	0.3%
<i>Gypsy, Roma and Traveller</i>	<5	0.1%
<i>Unknown/not stated/missing</i>	67	1.6%

NB any number less than 5 is suppressed

What we can say is that people from minority ethnic communities are likely to **face extra barriers** to receiving help, which will include a mix of the following:

- **Socio-economic factors** – reliance on partner/family
- **Language constraints**, particularly if English is not the first language
- Immigration **status**
- **Social isolation**; fear of being ostracised from the community
- Lack of understanding about **welfare benefits** and help
- **Fears about lack of confidentiality**, empathy and support.

These are compounded by poor understanding in services of the issues in minority ethnic groups, including perceived (and experienced) lack of knowledge about cultural/religious needs, fear of discrimination and shame.

The Council has a responsibility to ensure that Cornwall's Gypsy, Roma and Traveller residents have **equal access to services and facilities** and this is in accordance with the [Council of Europe Framework Convention for the Protection of National Minorities](#). This group of residents, however, often find it more difficult to obtain employment and access health and social care, housing, education and other public services – which has led to **significantly worse health and living outcomes** for them.

The 2021 Census estimates that we have around **1,000 people from Gypsy, Roma and Traveller communities** living in Cornwall, although this is likely to be an underestimate. Figures from the most recent Traveller Caravan count²² show **403 caravans on authorised and unauthorised sites** in Cornwall in July 2025, this is the highest figure in the South West. The treatment population indicates that **less than 5 people** from Gypsy, Roma and Traveller communities are **known to structured treatment**. We have in the past identified a higher count

²² Signposted from [Inclusion health data and intelligence resource](#), Office for Health Improvement and Disparities, January 2026

across the whole system including unstructured interventions.

Migrants in vulnerable circumstances

There were **1,465 asylum seekers** housed in Cornwall in the 12 months period ending September 2025: 1,267 asylum seekers under the Homes for Ukraine scheme, 181 under the Afghan Resettlement Programme and 17 supported asylum seekers.

This represents **0.25% of Cornwall's population** which is lower than all other local authorities within the South West with the exception of the Isles of Scilly.

There were also **47 unaccompanied asylum-seeking children** aged under 18 living in Cornwall away from parents/ or a responsible adult.

While there is general agreement that **substance use prevalence is lower among first-generation migrants** compared with non-migrants, data on illicit drug use is difficult to obtain. There are, however, **several risk factors** that make migrants particularly vulnerable to problematic drug use including **traumatic experiences** pre-migration or during the journey, racial **discrimination and stigma**, social disengagement, **poverty** and unemployment.²³

²³ Drug use and access to drug dependency services for vulnerable migrants who use drugs in the European Union, August 2023,

Progress in treatment



Progress in treatment – quick facts

- Overall **progress in treatment** is above the national average but has seen a small decline since the March 2022 baseline.
- Progress is **highest for people in treatment for opiates** (56%, placing us in the top performing quartile nationally) and this is the only drug group to see an increase from the baseline. Positive **outcomes improve with age**.
- Progress is **lower for people in treatment for crack** but the local rate is above the national rate (42% vs 34%).
- Progress for **non-opiates and alcohol is comparatively low** (third quartile) and has seen the **greatest decline** since the baseline.
- **Housing and employment outcomes** for people in drug and alcohol treatment are stable but continuing to fall just below the national benchmark rates for England.
- Examining individual cohorts highlights that those receiving **Rough Sleeping** and **Housing Support Grant** interventions have the lowest rate of progress in treatment (around 35%).

The **Treatment Progress Measure** was developed to give a more granular view of progress during treatment. The measure includes information from **treatment reviews** as well as **treatment exits**, to give a picture of people who are still in treatment as well as those who have completed it. It also factors in **housing needs** while in treatment.

48%²⁴ of people in drug treatment are showing substantial progress²⁵ in treatment, which is just above the national average (46%). There has been a **small decline in performance** since the March 2022 baseline (-4%).

<https://www.sciencedirect.com/science/article/pii/S0955395923001354>

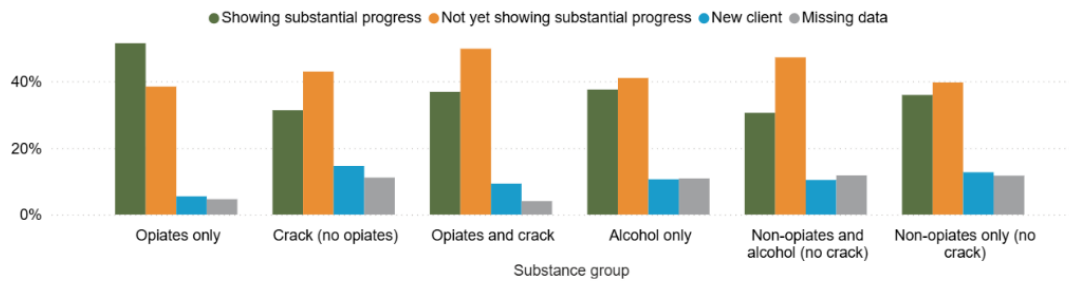
²⁴ NDTMS Local Outcomes Framework, 12 months to Nov-2025 (excludes new starters and clients with missing data)

Of those in treatment in Cornwall and the Isles of Scilly, **opiate users** have demonstrated the **most progress** with 57% of clients showing substantial progress (close to national rate of 58%).

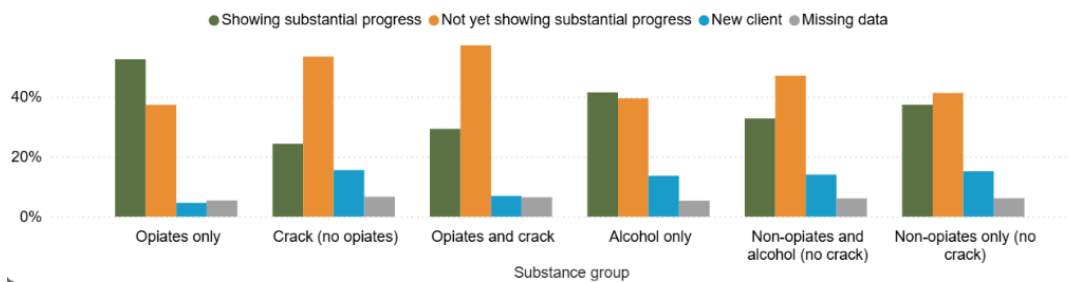
The highest proportion of clients making 'substantial progress' are **OCUs in the older age groups** (50+). 33% of OCUs in the 18-29 age group make substantial progress, rising to 43% of 30-49 year olds and 53% of people aged 50+.

²⁵ Successfully completed treatment or in treatment and stopped/substantially reduced use

Cornwall & Isles of Scilly



England



People in treatment for **crack cocaine** (both crack only and with adjacent opiate use) show **lower levels of progress** in treatment. Our local cohort is doing better than the national rate (42% compared with 34%).²⁶

Locally people in treatment for alcohol dependency are doing less well compared with national rates with a rate of 45% vs 48%.

The measure also looks at small cohorts receiving specific housing and employment support. As would be expected, people in **rough sleeper and housing support interventions** are less likely to making substantial progress in treatment – as well as these groups supporting some of **our most**

vulnerable people, positive housing outcomes are factored into the measure.

People receiving support to **access employment opportunities** whilst in treatment (Individual Placement and Support or IPS) are more likely to be making substantial progress in treatment, which will in part reflect where they are in their treatment journey.

Cohort (Nov-25)	No. in cohort	Progress in treatment %	England %
Rough Sleepers	121	33%	27%
Housing Support	179	37%	43%
Individual Placement & Support	108	57%	59%
All adults	4,084	48%	46%

Housing and employment are discussed in more detail in the next sections.

²⁶ Treatment in progress by substance type, Local Outcomes Framework, 12 months to November 2025

Housing



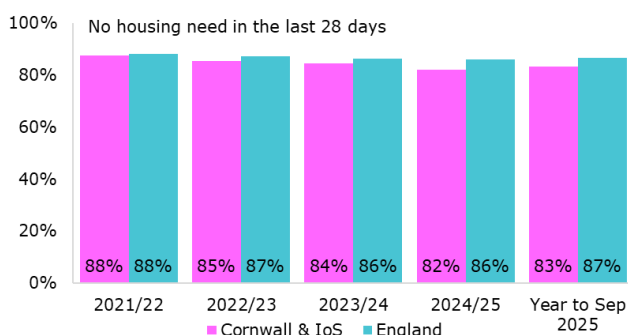
Quality of treatment: Housing – quick facts

- Positive outcomes in treatment are **below the national average** and have declined over time. 83% are in stable and suitable accommodation (below England 87%); **declined** from the baseline but small uptick in the last year.
- Highest **housing stability** for those in alcohol treatment; **lowest for crack**. **Increases with age**, highest (88%) for those aged 50+.
- Higher rate of **homeless households citing alcohol or drug dependency** than national average and increasing
- Increasing proportion of **clients with multiple vulnerabilities** (3+ support needs)
- **9.5%** of adults are receiving a **Rough Sleeping** intervention (vs England 5%). Retention is good but **progress in treatment is predictably lower**.

Housing is essential to progress in treatment. Providing help to access suitable housing is a **core part of the support offered**.

83%²⁷ of those in treatment in Cornwall and the Isles of Scilly are in stable and suitable accommodation.

This is **below the national average** of 87% and has declined year on year since the March 2022 baseline, compared with a fairly stable national trend.



The most recent data, however, indicates an uptick within the current year, with rates showing a **modest but consistent improvement** across the year — the first time this has occurred since early 2020.

The proportion of people housed is **highest** for those in treatment for **alcohol only** and **lowest** for those in treatment for **crack**. Those in treatment for crack are also the least likely to make 'substantial progress' which supports our understanding that **crack has a substantial negative impact on positive outcomes**.

The **proportion of those housed increases with age**, with the highest proportion (88%) of those in housing in the 50+ age group.

For some people there are **extra barriers to accessing housing** that require specialist support.

²⁷ Local Outcomes Framework, October 2024 – September 2025

Achieving better outcomes for people with complex multiple needs, including drug/alcohol dependency, is a shared priority in the **Preventing Homelessness and Rough Sleeping Strategy** adopted by Cornwall Council in March 2025.

Cornwall has received **two specific grants to address homelessness** and accommodation issues amongst those with drug and alcohol problems – the Rough Sleeper Grant and the Housing Support Grant.

The aims of the **Rough Sleeper grant** are:

- Increase **access to treatment** for those rough sleeping
- **Reduce the number** of rough sleepers due to drugs and alcohol
- Reduce **drug and alcohol related deaths** amongst rough sleepers.

The **Housing Support grant** (HSG) is a 'test and learn grant', **helping people to progress** in their treatment by ensuring they have suitable and stable accommodation. Many of this cohort have **multiple vulnerabilities** and would otherwise fall through gaps in services.

Housing Support workers were employed in community treatment and a women's specialist organisation as vulnerable young women were especially identified in this cohort. Our hypothesis is that the additional support put in place through the Housing Support grant has had a **positive impact on overall**

housing outcomes in treatment.

For example, in the first 6 months of 2025/26, **153 people** were supported with 97 (64%) either successfully maintaining their current accommodation or gaining access to more suitable accommodation.

37% of people with an open HSG intervention in the last 12 months have **made substantial progress** in treatment, slightly below the England rate of 43%.

Our hypothesis is that HSG teams have worked hard to **reduce the drop-out rate** in treatment amongst a **very complex cohort** by preventing homelessness (evictions) or finding accommodation that was more suited to their needs. Now these clients have appropriate accommodation, reducing problematic substance use is more attainable.

Homelessness

The **Rough Sleeper Outreach** team in drug and alcohol treatment take an assertive approach to engaging with clients. They are **flexible and follow clients around** the county due to the transient nature of rough sleeping.

An **outreach nurse** in treatment conducts joint visits providing wound care and rapid prescribing. When the local **Severe Weather Emergency Protocol** (SWEP) is activated, the team work intensively to move prescriptions and support clients to access this accommodation.

33% of people with an open RSDATG intervention have made substantial progress in treatment, and this is **above the England rate of 27%**. The team have strong relationships with the Rough Sleeper Resettlement Service in Housing Options and participate in many multi-agency forums such as Safer Towns and the Cornwall Rough Sleeper Operational group.

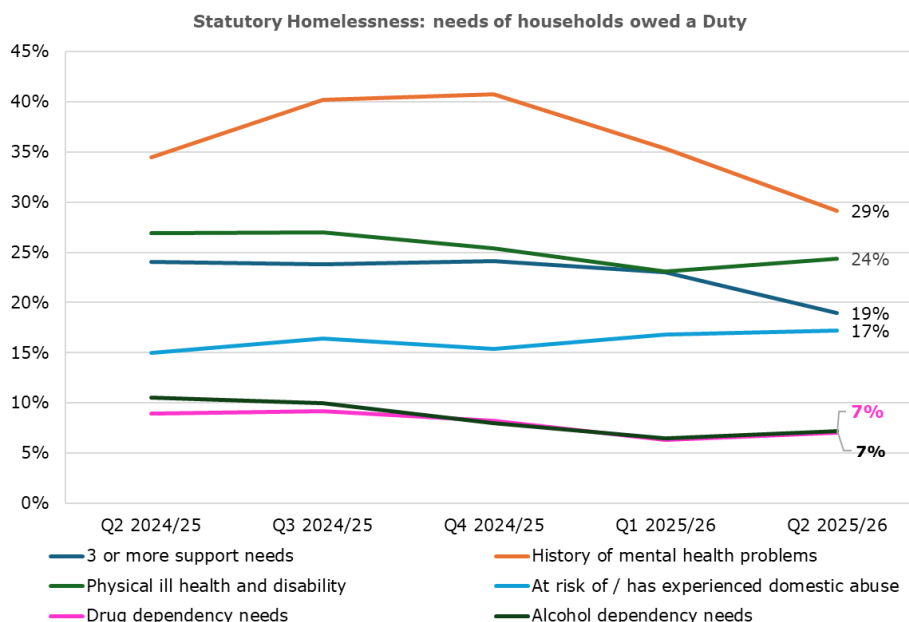
Experience of homelessness is one of the **five key factors of disadvantage** identified by central government – the others are drug/alcohol dependence, mental health issues, domestic abuse, and contact with the criminal justice system. **Multiple disadvantage** refers to experience of **three or more** of the five.

In the period July to September 2025, **29%** of people owed a

homelessness duty and disclosing support needs, cited **3 or more support needs**. Having consistently been above the national rate for several years, this is the first time that our local rate has dropped below the national rate (34%).

Cornwall has slightly **higher rates than nationally** of households owed a statutory housing duty citing an **alcohol dependency** (7% vs 5%) but this has reduced over the last year.²⁸ The percentage of households citing a **drug dependency has also reduced** to 7% and is now fairly close to the national rate (6.4%).

Recorded experience or risk of **domestic abuse** is also above England rates and has increased over the last year.²⁹



²⁸ [Statutory homelessness statistics](#): July to September 2025 – % of households owed a statutory duty with support needs

²⁹ July to September 2025 – % of total households owed a statutory duty; At risk of

/ has experienced domestic abuse (Cornwall 17%, England 14%).

Very few clients present for housing support with drug or alcohol dependency as the sole issue. This cohort has **multiple vulnerabilities** as evidenced by the prevalence of three or more support needs. We also have a high number of **rough sleepers** with multiple and complex needs.

People experiencing housing problems, especially if they are rough sleeping, are much **less likely to make progress** in treatment.

National ambitions for substantial progress in treatment set the **same performance targets** for rough sleepers and non-rough sleepers in treatment. Whilst we aim for **outcomes for rough sleepers** to be as good as those in the general treatment population, this can be challenging due to the **complexity of needs** amongst the cohort and **barriers** to accessing wider services.

Housing instability continues to be a significant contributing **factor in drug-related deaths**.

In 2024, **8 of the 43 men** who died (19%) had a **history of homelessness**. Notably, 6 of these men were homeless at the time of their death, highlighting the risks associated with rough sleeping and insecure accommodation among males with complex substance use needs.

2 of the 16 women who died (12%) were living in **temporary**

accommodation at the time of death. These placements were not suitable for women with multiple vulnerabilities, and this has been identified as a recurring concern in several female deaths. The **lack of gender-appropriate, trauma-informed housing options** appears to compound risk and may contribute to poorer outcomes for vulnerable women.

Homelessness Needs Assessment

Source: Health for Homeless

Homeless and rough sleeping populations experience **significant health inequalities** – unfair differences in health outcomes. **Life expectancy is 30-40 years lower** than the general population – 44 years for men and 42 years for women compared with 76 years and 81 years respectively.

In 2024/25³⁰ **13% of people** owed a relief Duty due to homelessness had **left an institution with no accommodation** available (prison, psychiatric hospital, Armed Forces, asylum support) compared with the national rate of 6%.

Acquired brain injury is a significant factor experienced with 42% of Health for Homeless patients reporting a head injury. People with brain injuries are more vulnerable to becoming homeless and have unrecognised neuropsychological and

³⁰ Updated [Statutory homelessness statistics](#): initial assessments of statutory homelessness

duties owed, detailed Local Authority data, April 2024 to March 2025.

cognitive needs that fall between gaps and bounce between services.

26% of registered patients have had safeguarding concerns raised in the last 6 months.

Homeless and rough sleepers face many **barriers accessing the universal healthcare offer**. This includes access (location, times, documentation), lack of integration across primary healthcare and social services, criminal justice and the voluntary sector, social barriers from prior personal experience, and competing priorities.

All of these can be **compounded by poor mental health and drug and alcohol use disorders** that complicate access to healthcare and adherence to treatment plans.

Health for Homeless **patient feedback** highlighted specific challenges including:

- **Moving around** in emergency or temporary accommodation – one person moved GP 3x in one year
- **No one knew me** (continuity of care)
- **No smart phone** to book appointments
- **No credit on phone** to call and wait to get through
- **Transport** to get to appointments is **expensive and difficult**

Housing: insights from partners

Some of **our most vulnerable people are repeatedly excluded** from critical services, such as housing and mental health support, due to **high risk behaviours** that present a risk to themselves and others (such as drug use, drinking and violence).

This often leaves them on the street, highly vulnerable with **escalating needs and behaviours**. We are particularly worried about the exploitation and abuse of **young women** in this position. **Sexual exploitation** is understood by partners to be a **common feature** in drug-related exploitation.

When Outreach workers are concerned that an individual is being exploited, **safeguarding procedures are followed** to prevent further harm.

Advocacy is essential for those in crisis, who very often cannot reach out to find support on their own. **Flexibility and adaptability of approach** is needed to engage and retain the most vulnerable, including out-of-hours provision, outreach and wrap-around support. Current commissioned supported housing provision is viewed as **not meeting the high end of needs**.

The **most vulnerable people** are not being offered or being excluded from support due to presenting with multiple behaviours that are considered **a risk to themselves and others** (such as drug use, violent episodes and/or anti-social

behaviour). Supported accommodation and floating support is being commissioned to increase access to suitable accommodation for those in need.

Due to most provision being “dry” and **subject to strict rules**, drug and alcohol use is **not being disclosed**, and eviction follows when discovered later.

Training has been provided to managers of accommodation so that they understand the law in relation to management of substance use on premises, with **emphasis on screening** and person-centred risk management for harm reduction.

Understanding risk and vulnerabilities

Problem drinking and drug use is often part of a **complex interplay of factors** at an individual and family level, and at a wider community and society level. These collectively contribute to risk of

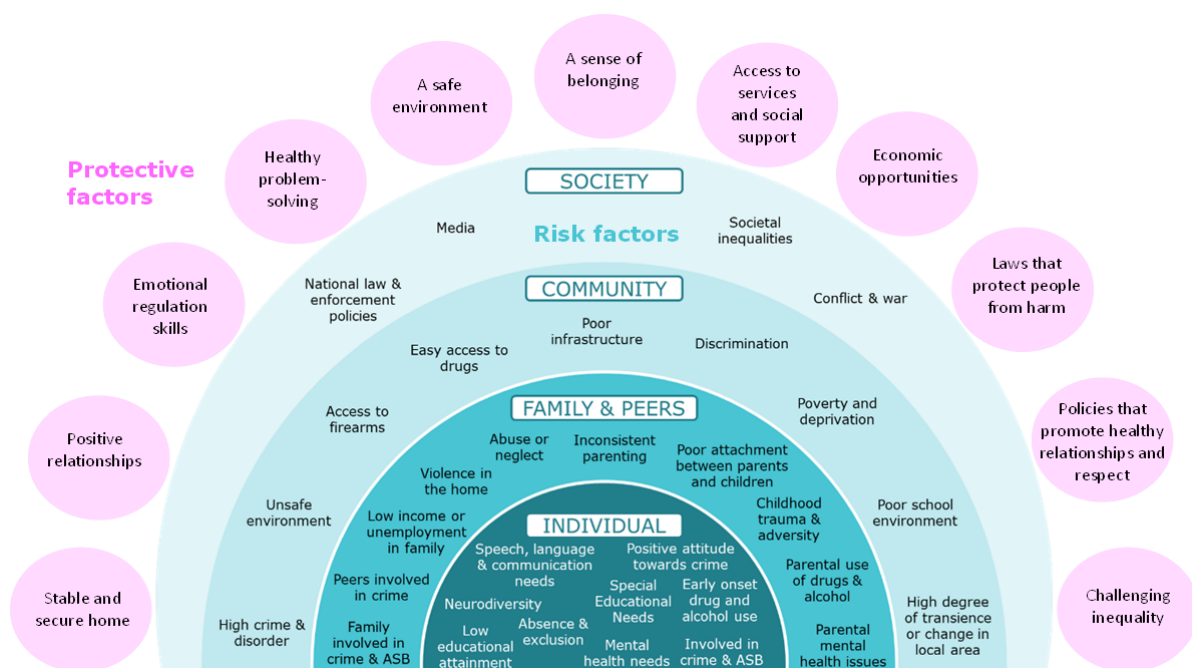
harm, including involvement in violence and other criminality, and poor health outcomes.

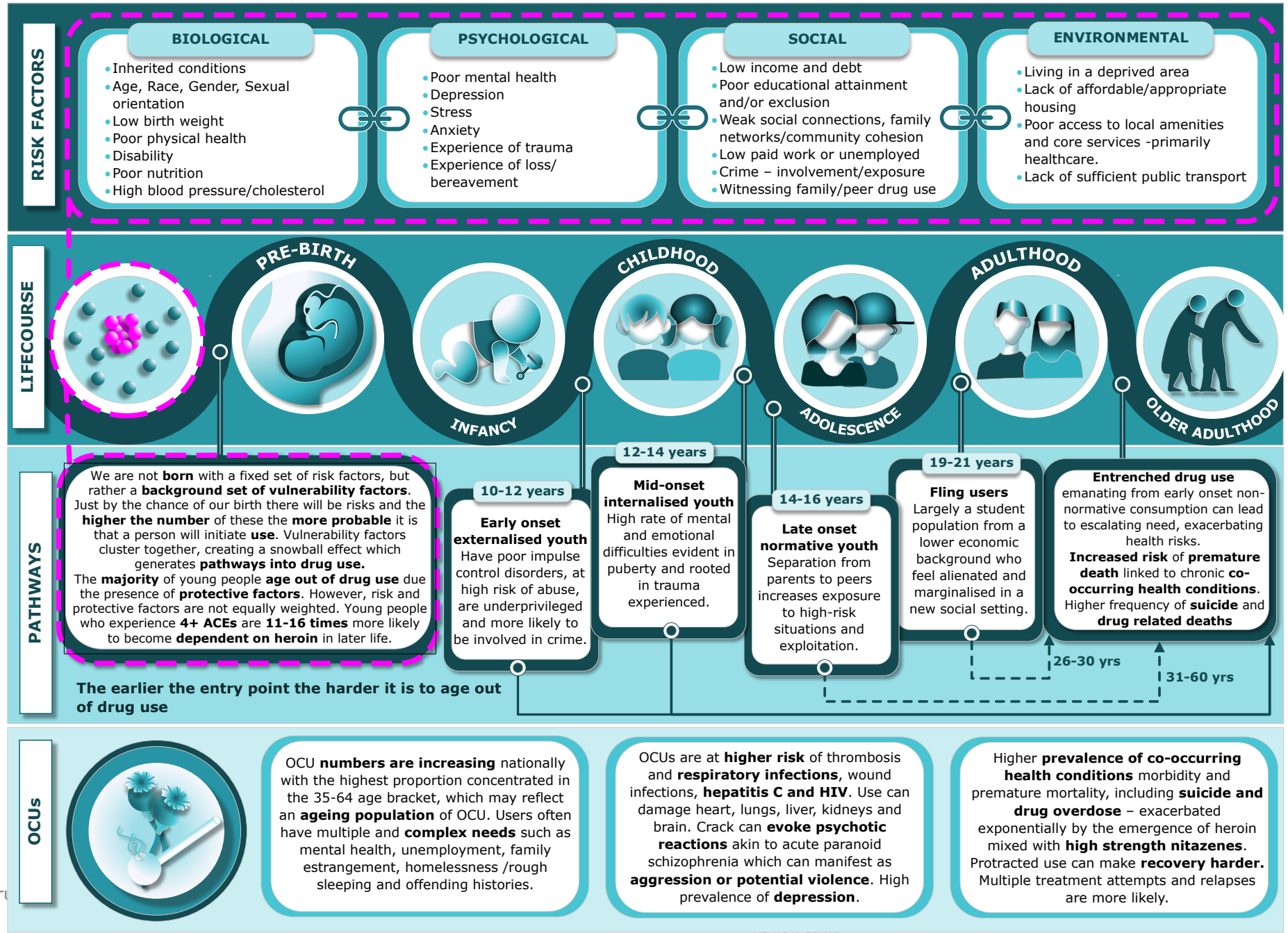
Risk factors often occur in clusters (and interact with each other within the broader social, cultural and economic contexts. These **factors can change over time**, depending on other factors like age.

Some of the risk factors relate to [Adverse Childhood Experiences](#) and these are discussed in more detail under Children and Families.

Protective factors act against risk factors and can explain why people who face the same level of risk are affected differently. A combination of protective factors can **prevent the harmful influence of risk factors** that have accumulated over a person’s lifetime.

The **next infographic** shows risk factors and pathways over a person’s lifetime.





Work and education



Quality of treatment: employment – quick facts

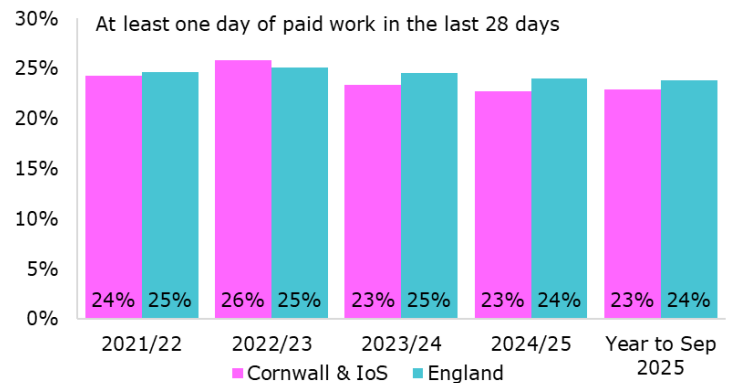
- 23% of people in treatment are in paid work. This falls just **below the national average** and trend remains fairly static.
- People in treatment for **non-opiates and alcohol** are more likely to engage in paid work. OCU's have the lowest rate at 14%. More success with **young people** (18-29 age group, 31%)
- Employment support is provided alongside clinical treatment through the **Individual Placement and Support (IPS) Grant** – **treatment progress** rates better for this cohort (57%) and just below England rate (59%)
- Rates of engagement in **voluntary work** continue to track above the national average (2.6% vs 1.5%).

Drug dependency has acute and chronic health impacts upon vulnerable individuals and can lead to **significant hardship** and **lack of regular income**.

Employment is essential in supporting people to improve their financial and social status and is **often a recovery goal** for people with drug and alcohol dependency. There are **significant barriers**, however, to accessing the workplace and sustaining employment.

As with Housing, employment should be addressed whilst people are actually **in treatment and not wait until they complete**.

Of those in treatment, **23%**³¹ **had worked one day or more** in the past 28 days which is close to the national rate of 24%. The **trend has been flat (not improving)** over the last three years.



Employment outcomes are **highest in the 18-29 age group** (32%) and lowest in the 50+ age group (18%). Men fare slightly better than women (24% vs 21%).

Employment outcomes are **lower for opiate and/or crack users** (around 14%). At the other end of the scale, around **31% of non-opiate and alcohol users** are engaging in paid work.

Individual Placement and Support (IPS) is a model that works by

31 Local Outcomes Framework, October 2024 – September 2025

providing employment support alongside clinical treatment, with an **Employment Specialist integrated into treatment** to help make employment a key aim of recovery. It was rolled out more widely across the country after an OHID research study and pilot. Finding work in the 18 months of the study follow-up was the study's primary outcome measure.

The [research study undertaken by OHID](#) found that **IPS was effective** in helping people find a job and improving quality of life – however, this was **not consistent across drug groups**. The findings were clear for people with alcohol dependence or 'other drug' (non-opiate) dependence but there was **no evidence** of the same positive impacts on people with **opiate dependency**.

The latest IPS data (Q3 2025/26) showed that the team has received **60 new referrals and 3 job starts**. 7 placements achieved 13 weeks in sustained placement. Whilst referrals are meeting the targeted level (60-75 referrals), the number of **job starts is achieving only 20% of the target** (15 starts).

Employment support has a **positive impact on progress in treatment** with a higher percentage of the IPS cohort seeing substantial progress – 57% vs 48% for the whole population. This is broadly in line with the national picture.

Successful placements can be achieved where the client is willing to

share some of their personal information with their employer which **enables IPS to advocate for their needs**. A **supportive and inclusive environment** is also key to the placement being sustained. The care industry has been one sector which has been successful in placing IPS clients.

Local challenges remain in engaging the support of local employers, largely due to the **stigma** associated with working with people in recovery and limited capacity to proactively approach businesses.

The **IPS team are actively working with employers** to reduce concerns and any possible stigma. They use case studies and discuss individuals rather than their drug and alcohol issues to **emphasise personal stories**.

Employment Specialists (ES) are fully integrated into local services. In Torbay the ES working with local job centres, employers and other relevant organisations. The ES in mid-Cornwall is fully integrated into job centres and attends their morning huddles. The ES also attended wellbeing events and the Vulnerable Customer Network.

An **employer engagement booklet** has been created to support relationship building and job outcomes. The next focus will be on marketing.

The IPS team continue to experience **challenges with vacancies** within

the team and capacity for proactive engagement with employers.

Other **positive work and education outcomes** show slightly above average rates, compared with the national rates. **2.6% of people engaged in voluntary work** between October 2024 and September 2025, compared with the national rate of 1.5%. Rates of volunteering have **consistently tracked above the national rate.**

1% of people in treatment completed **at least one day of training or education** in the last 28 days, just below the national rate of 1.2%. The main driver of the lower rate reflects the **18-29 age group** (2.5% of our local cohort vs 3.7% nationally). The number of people in training or education **dropped during the pandemic** and have returned to pre-COVID levels nationally but are still slightly lower in Cornwall.

Mental Health



In Cornwall and the Isles of Scilly the current level of **unmet mental health treatment need** in adults across all substances is 14%, notably lower than both the Southwest and England average of 18%. **Unmet need has seen a small increase** (around 2%) across the whole treatment population compared with the last assessment.

Men have a higher percentage of unmet need (16%) than women (10%). The highest percentage of **unmet need by age** is in the **18-29 age range** at 18% (young men at 23% and young women at 10%).

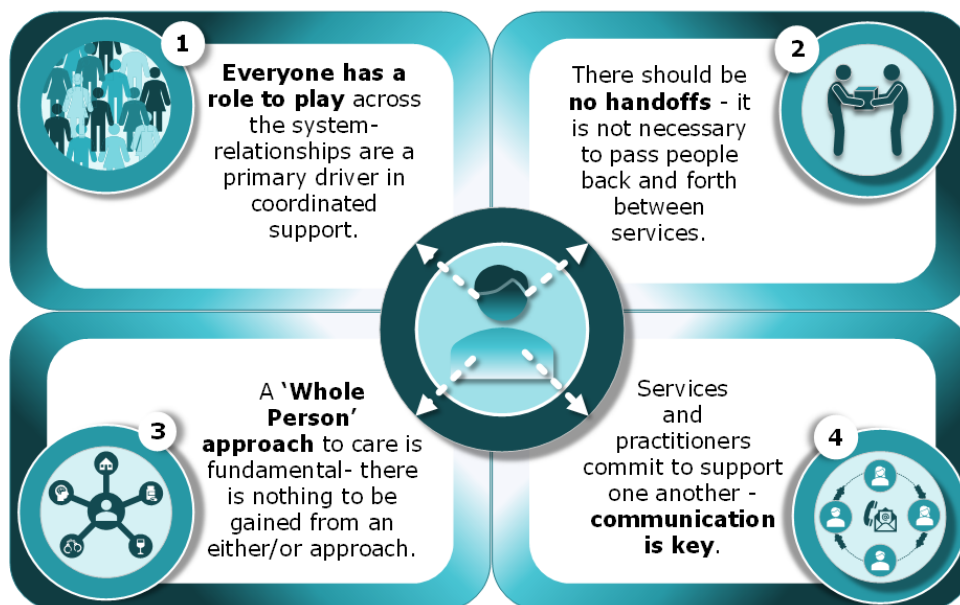
Across all substance types the **highest level of unmet need is found amongst crack users** at 20% closely followed by non-opiate only (no crack) users at 18%.

Dual Diagnosis is used broadly to describe the existence of **co-occurring mental health difficulties and drug/alcohol use issues** in a person. It is, however, widely recognised that other impactful challenges experienced by people termed as having dual diagnosis are often at play.

The **Dual Diagnosis** multi-agency steering group, implementation plan and escalation process are in place but challenges continue to be raised by service users and staff around promoting this approach and multi-agency working.

Guidance has been developed through a multi-agency dual diagnosis steering group and sets out a **clear set of overarching principles**. The four key areas act as a framework within which practitioners seek to work collaboratively to improve the experience of people impacted by co-occurring conditions.

Agreed Principles



Key considerations for supporting people with Dual Diagnosis:

An approach to **assessment** that can be used **across** a broad range of **services** including the voluntary sector needs to be developed to enable everyone who works with individuals to make **a meaningful contribution** to their **health and wellbeing**.

Adoption of **DIALOG+³²** to enable a **holistic view** of people in need which will also foster effective **communication, collaborative work** and **appropriate signposting**.

No wrong door - It is critical that whoever a person seeking support comes into **contact with first** should respond positively and **link into a wider system of help**. All

further interactions need to be co-ordinated from this point for continuity with **no hand-offs**.

People with dual diagnosis may well have additional needs originating from **experienced trauma** which can make their **needs complex** and entrenched, it is imperative, therefore, that services work together to provide **whole person support**.

An analysis of **drug related deaths** highlights how **prevalence of poor mental health** (76% 2021, 84% 2022 and 79% in 2023) and is considered to be a contributing factor.

Actively support individuals to **move between services** as their needs change **without disruption**. Treatment should not be withheld because of mental health difficulties or substance/alcohol use issues.

³² DIALOG + make routine patient-clinician meetings therapeutically effective. It is based on quality-of-life research, concepts of

patient-centred communication, IT developments, and components of solution-focused therapy, and is supported by an App.

A **robust escalation process** needs to be developed to ensure, where an individual's needs cannot be addressed through a 'My Team Around Me' approach, there is an additional tier of support.

Dual Diagnosis is often understood to be **greater than the sum of its parts**; trauma, homelessness, vulnerability to abuse and criminal behaviour are but a few complexities found within this population.

Identifying needs and treating them in isolation of one another or prioritising one need over another without considering a collaborative approach, furthers a **binary approach** to the treatment of this population, which has **proven unsuccessful historically**.

Treatment, care and support that **captures the wider context** around a person should be the aim. It is important to acknowledge the benefits of adopting this approach as early as possible, especially when planning for transitions from young people's services into adult services.

New national guidance has been published by the Department of Health and Social Care³³ sets out the Government's plan to improve support for people with co-occurring **mental health and substance use** needs. The plan shows a system-wide shift towards integrated, **no-wrong door support** that reduces health inequalities.

³³ [Co-occurring mental health and substance use delivery framework](#), Department of Health and Social Care, December 2025

Alcohol-Related Brain Damage (ARBD)

ARBD is caused by **long-term heavy drinking** leading to thiamine deficiency which damages brain nerve cells and blood vessels. It includes **several related conditions under one umbrella**.



It affects memory, executive function, attention, learning and problem-solving, and increases risk of stroke and head injuries due to falls and violence.

People with ARBD often have **complex health needs**, frequent hospital admissions, and may struggle to engage with treatment. They **face risks** including self-neglect, exploitation, domestic abuse and financial hardship, sometimes requiring intervention under the Mental Capacity Act.

ARBD places significant pressure on health, social care, housing, police, and the wider economy. It usually **presents between age 40–60**, but cases can occur earlier especially in women with local examples in their 30s. It is **widely underdiagnosed** and often mistaken for Alzheimer's; an estimated **2,322 local residents may be affected**³⁴. Unlike dementia, **ARBD is treatable**:

- 1 in 4 fully recover
- 1 in 4 recover significantly
- 1 in 4 recover partially

³⁴ [Brain lesions in alcoholics. A neuropathological study with clinical correlations](#), Torvik et al. (1982)

Workshop Insights- Alcohol and the brain

ARBD often first **comes to attention at crisis point** alongside multiple unmet needs. It goes unrecognised for long periods. Early identification via **universal alcohol screening would reduce the risk** of dependent drinking, therefore ARBD.

Dependent drinking impacts on a person's ability to engage with support but this is poorly understood – the difference between consuming alcohol to avoid withdrawal versus intoxication. **Stigma** impacts this too. Although any professional can conduct a capacity assessment, practitioners lack confidence and there is a **lack of specific training locally**.

A **lack of an ARBD pathway** and specialist provision in-county mean we are not maximising people's recovery potential.

Roles in social care and health with an ARBD specialism would benefit identification, diagnosis and short- and long-term care planning.

Different accommodation needs are required depending on where someone is in the recovery timeline and when their recovery potential has been fully realised.

35 Determined by those with parental responsibility (living with children or not), based on the PARENT, PRNTSTAT,

Children and families

Families are key to recovery, but family are not always included in the recovery process/journey.

46% of people in treatment in locally are parents³⁵ and this represents a **greater proportion** of our local treatment population than the national average (35%).

People in treatment for **opiates are more likely** to be parents, whereas people in treatment for **alcohol**, particularly alcohol only, are **least likely** (38%).

The Local Outcomes Framework provides a measure of **parental support provided** which looks at the percentage of parents receiving any parenting or family support interventions at any point in their treatment journey.

Reported **rates of parental support are comparatively low** at only 6% of the parent population. There are some **substantial variations by sex and age**.

- 12% of women in treatment receiving parental support and only 2% of men (compared with 18% and 12% nationally).
- The proportion of **younger parents** (aged 18-29) accessing parental support are **in line with the national average** at 11%. This reduces to 6% and 4% for the 30-49 and 50+ age groups respectively.

CIRPARENT, and CIRPRTST fields at any point in their treatment journey.

Drug group	Cornwall and Isles of Scilly			England	
	Parents in treatment	% by drug group	Parental support	% parents by drug group	% parental support
Opiates only	553	50%	7%	42%	23%
Crack (no opiates)	93	50%	4%	31%	8%
Opiates and crack	130	54%	9%	32%	20%
Alcohol only	506	38%	6%	31%	9%
Non-opiates and alcohol (no crack)	389	49%	5%	36%	9%
Non-opiates only (no crack)	179	47%	5%	38%	9%
Total parents in treatment	1,850	46%	6%	35%	14%

Parental Drug Use and Affected Others

It is estimated that there were between **200,000 and 300,000 children in England and Wales where parents or carers are dependent on drugs.**

This can compromise **children's health and development** from conception onwards, though the risks of **harm may be reduced through treatment.** Support for the affected adult as well as the presence of at least one other consistent parent or carer, a stable home with adequate finances, maintenance of family routines and activities, and regular attendance at a supportive school.³⁶

Parental substance use is the **third most common reason** (after domestic abuse and parental mental ill health) children are **referred to children's social care.** The experiences of children living with substance using parents are

complex and risk factors are multiple.³⁷

The challenges experienced are compounded by the **decade-long impact of austerity measures,** which have reduced early intervention services, resulting in practitioners prioritising the needs of younger children to the detriment of older children.

The research has highlighted the impact of parental substance use on older children with their **increased risk of significant harm due to criminal exploitation and/or child sexual exploitation.**³⁸

Based on a national study,³⁹ 10,990 children in Cornwall (10.3% of the population aged 0-17 years) are projected to be living in a household where an adult reports any substance misuse (broad estimate). An estimated **3,980 children** live in a household where an **adult has**

³⁶ Advisory Council on the Misuse of Drugs (ACMD) (2003) Hidden Harm - responding to the needs of children of problem drug users.

³⁷ Todman H, McLaughlin H, (2024) Understanding the Needs of Children Living with Parental Substance Misuse: Perspectives from Children and Practitioners. The British Journal of Social Work, Volume 54, Issue 7. May 2024

³⁸ Todman H, McLaughlin H, (2024) Understanding the Needs of Children Living with Parental Substance Misuse: Perspectives from Children and Practitioners. The British Journal of Social Work, Volume 54, Issue 7. May 2024

³⁹ [Estimating the prevalence of the 'toxic trio'](#), Children's Commissioner's Office (Chowdry, 2018)

reported an alcohol or drug dependency (narrow measure).

Of the 10,990, around **14% (940 children)** are predicted to be in a household with **all three vulnerabilities** – domestic abuse in the last year, an adult reporting drug and/or alcohol dependency and an adult with severe symptoms of mental or psychiatric disorders.

We explored this in detail in the 2022/23 needs assessment and estimated that **around 75% were not identified in local datasets**. Drug and alcohol use **commonly occurs with other vulnerabilities**, such as domestic abuse and mental health issues.

Adverse Childhood Experiences

When individuals have **secure foundations from early childhood** there is a real opportunity for growth. Many will experience problems throughout their life which will cause instability in one or more areas but **most will recover** because they have a strong support network, particularly family and friends.

Conversely when children are subject to multiple **Adverse Childhood Experiences** (ACEs) growth is suspended and the trajectory of their life is influenced by the trauma they have experienced.

'Adverse childhood experiences (ACEs) are traditionally understood

as a set of **10 traumatic events** or circumstances **occurring before the age of 18** that have been shown through research **to increase the risk of adult mental health problems and debilitating diseases**.

Five ACE categories are forms of **child abuse and neglect**, which are known to harm children and are punishable by law, and five represent forms of **family dysfunction** that increase children's exposure to trauma'.⁴⁰

The 10 ACEs are:

- Physical abuse
- Sexual abuse
- Psychological abuse
- Physical neglect
- Psychological neglect
- Witnessing domestic abuse
- Having a close family member who misused drugs or alcohol
- Having a close family member with mental health problems
- Having a close family member who served time in prison
- Parental separation or divorce

To understand how **early trauma** experienced in childhood **impacts the course** of someone's **life** we undertook a series of journey maps across a broad and diverse range of people.

⁴⁰ [Adverse childhood experiences: What we know, what we don't know, and what should happen next | Early Intervention Foundation](#)

Some key areas that emerged were:

Family

- Journey mapping has shown the prevalence of Adverse Childhood Experiences for people with complex needs. The **lack of a secure base and absence of positive parental modelling** (often as a result of parents being subject to childhood trauma themselves) has a detrimental and far-reaching effect on self-worth.
- This in turn leads to **poor relationship choices** and poses challenges for raising children, particularly in the absence of a supportive wider family network. The **intergenerational play out of trauma** is evident in the journeys that we looked at, and a reliance on alcohol/drugs to self-soothe.

Education

- **Poor school engagement** is a common thread running through the stories documented. People with complex needs talk of bullying, being singled out or marginalised due to 'acting up' and eventually dropping out.

Friendships and social networks

- **School and activities** provide a pivotal role in developing positive and healthy friendships. When these avenues are closed to young people there is a real chance that the connections that they make will be with people who have also experienced

trauma can lead to criminality and possible exploitation.

Money

- The **limiting effect of financial constraints** on choices and mental health is omnipresent in all journeys. In several there was a direct **correlation between lack of money and criminal activity**. It was also identified as a trigger, exacerbating poor mental health and contributing to relapse.

Housing and Environment

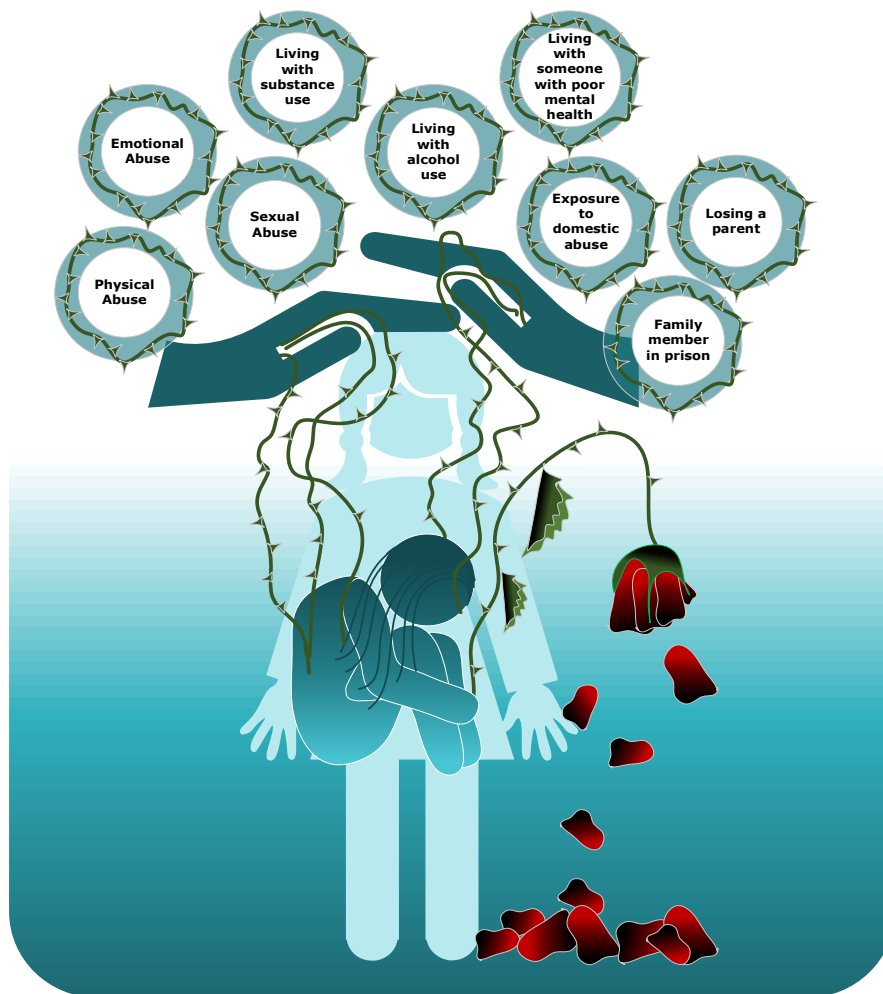
- Without a family network or a stable home, **in times of crisis people are left open to homelessness**. The stories demonstrate that individuals are moved frequently because of a significant **lack of appropriate housing** and to places and types of accommodation out of necessity rather than choice.
- **Housing providers are not always able to meet the needs of highly complex individuals** or adjust placement terms and conditions to accommodate them, making them more vulnerable and exacerbating their situation. Lack of a stable base for protracted periods **prevent people from establishing roots** and accessing consistent support.

Health and Wellbeing

- The **sense of isolation and loneliness** was evident in all stories. In most cases the person

at the centre had either attempted suicide or were suicidal at points in their journey. All displayed a **high degree of vulnerability** which for some led to significant self-neglect.

- The presence of **multiple socio-economic and family challenges** contributed to their sense of hopelessness which was further exacerbated by drug and/or alcohol use.



Understanding unmet need

Unmet need – quick facts

- **Much lower rates of estimated unmet need** than England averages across all drug groups
- The **lowest** unmet need estimate is for **opiate users** (34%). The highest estimates are for **crack** (48%) and **alcohol** (67%), consistent with but better than the national picture
- Those not engaged with treatment are **more likely to be male and younger**
- **Self-referral** continues to be the main route into treatment, suggesting that **wider services could do more** to identify, screen and refer
- Engagement and retention rates for Cornwall and Isles of Scilly are high so the OHID Toolkit suggests a **focus on case finding to reduce the level of unmet need**.

The Office for Health Improvement and Disparities provide local areas with estimates of the prevalence of illicit opiate and/or crack cocaine use as well as the estimated number of people with alcohol dependency.

Comparing the estimated prevalence with the number of people known to treatment helps us to understand for which specific cohorts treatment access is working well and those where it isn't.

Prevalence estimates⁴¹ of opiate and/or crack use and alcohol dependency were updated since the last assessment.

National estimates put our local level of opiate and/or crack dependency (OCUs) at **2,348 people**, which equates to a rate of **6.9 people per**

⁴¹ [Opiate and crack cocaine use: prevalence estimates](#), Office for Health Improvement

Drugs Group	Unmet need	
	CloS	England
OCUs	36.1%	53.4%
Opiates only	33.6%	56.8%
Crack only	48.0%	74.1%
Opiates & crack	35.5%	40.6%
Alcohol	66.6%	75.5%

1,000 population aged 15 to 64 years. The estimate has **reduced by 10%** or 214 people since the last figures were published for 2019/20.

The **England rate is higher** at 8.5 people per 1000 population, reflecting **higher rates of crack use nationally**, but it has reduced by a similar percentage over the same time period.

The prevalence estimates indicate **increased crack use** and **decreased levels of opiate use** (including opiates with adjacent

and Disparities and UK Health Improvement Agency, October 2023.

crack use) – which concurs with the profile of our treatment population.

64% of the estimated number of people who use **opiate and/or crack** is receiving help through local treatment services, leaving an **unmet need of 36%** (around 847 people). Unmet need is substantially below the national average (53%).

Waste water epidemiology⁴² will provide a more accurate measure of drug use prevalence in the future. OHID does not have a date for introducing this as yet but it is progressing.

Based on prevalence figures provided for each drug, **unmet need is higher for people using crack cocaine** only, at 48% - but still significantly outperforming the national rate (74%).

The prevalence estimates by age indicate the **highest use** of opiates and opiates with crack in the **35-44 age group**. Crack use has a younger profile with similar rates for the 25-34 and 35-44 age groups.

- The rates of crack use in the 35+ age group are much lower than the national average and this may reflect **trends in availability of crack cocaine** in Cornwall over the last couple of decades.
- **Men have much higher rates of opiates and/or crack use**

⁴² Drug consumption can be estimated by measuring human excretion products in untreated wastewater, known as wastewater-based epidemiology (WBE). Over the last

than women based on national estimates.

- Estimates of **opiate injecting** in Cornwall are above national rates.

Meeting unmet need

Meeting unmet need means addressing 3 basic issues:

- **Case finding** - finding people where they are
- **Engagement** – bringing them into treatment
- **Retention** – supporting them to stay in treatment

OHID's Unmet Need Toolkit indicates that for all substance groups, Cornwall and the Isles of Scilly has a **lower proportion of unmet need** than the England average. This suggests that we are **successful at finding and engaging OCUs** in treatment.

The toolkit indicates the highest levels of unmet need in the youngest age group (aged 15 to 24) – **as OCUs increase in age they are more likely to be engaged with treatment**. 66% of OCUs aged 15-24 are not in treatment services compared with 32% of 35-64 year olds.

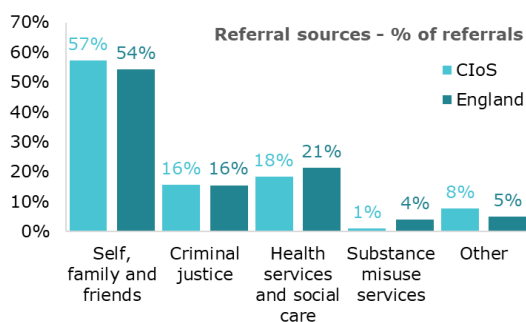
- **Unmet need is estimated to be substantially lower amongst women** (10%) than men (44%) and the extent of the difference is

decade, the use of WBE to monitor illicit drug use has increased and WBE is currently applied on a global scale.

greater than the national profile (41% estimated unmet need for women and 57% for men).

- Those not engaged with treatment are therefore **more likely to be male and younger** and this would support finding unmet need in our Criminal Justice population (which is largely male-dominated).

The chart shows the breakdown of referrals by source in Cornwall compared with the England average. A **lower proportion** of clients are referred into treatment from **criminal justice agencies** in Cornwall than nationally.



We continue to see **very high levels of self-referral** into treatment and this suggests that **wider services could do more** to identify, screen and refer people into treatment for help with their drug and alcohol use, specifically health, social care and criminal justice agencies.

When we look at alcohol specifically, rates of self-referral are higher at 59% compared to 53% for all other drug groups. Our local self-referral

rate for alcohol is also higher than the national rate of 56%.

Whilst local **alcohol referrals from health and care** are higher than for other drugs (24% versus 16%), we have a **lower referral rate than nationally** (28%).

Looking in more detail:

- Referral rates from **GPs and Hospitals** locally are slightly lower than nationally
- The referral rate for **'Other health services and Social Care'** is 2.8 times lower locally.

As such, **continued emphasis on screening and early identification in health and care** is required (especially adult social care, primary care and VCSE community health roles). Bespoke training for these professionals began in 2025/26 with the introduction of a local alcohol pathway based on screening outcomes and will continue. This includes implementing the ASSIST-Lite alcohol, drugs and tobacco screening tool in Adult Social Care safeguarding teams and secondary mental health services as recommended in the National Co-occurring Mental Health and Substance Use Framework⁴³.

Communications will continue to **dispel widespread myths** such as self-referral being required to demonstrate motivation.

⁴³ [Co-occurring mental health and substance use delivery framework](#). OHID. December 2025

Continuity of care



Continuity of care – quick facts

- Criminal justice referrals make up **15% of all referrals** into treatment, in line with the national rate. The number of criminal justice referrals has **increased by 76%** over the last two years.
- People who enter treatment via a criminal justice route are **most likely to have had previous experience** of treatment (61%).
- **Prison referrals** account for around **40%** of criminal justice referrals. **17 different prisons** referred into community services in the last year (173 referrals). 65% from Exeter (51%) and Channings Wood (14%).
- **65% are picked up in treatment within 3 weeks**, 53% nationally. Significant improvement over last 18 months (from 36% March 2024). Pick-up rates are highest for opiate users (71%), lowest for non-opiate users including crack (55%).
- **No prison leavers were amongst the drug related deaths** recorded 2022-2024 (measured within 21 days of release).

For people leaving prison with a continued treatment need, the **period immediately after their release** can be difficult because they are at **high risk of harm or death** from overdose, as well as **reoffending**. It is important that people leaving prison are **transferred swiftly** to a community treatment provider for structured treatment interventions – and other support – and that they successfully engage to ensure that their **journey to recovery continues**. This is called continuity of care.

Improving continuity of care is one of the **national drug strategy priorities**⁴⁴ as part of the drive to modernise and improve the treatment and recovery system in

England. People leaving prison should be given a **priority appointment** with a community treatment service to help them stay engaged. This appointment should be **within 3 weeks of leaving prison** for the person's care to be classed as continuity of care.

Referral data shows **17 different prisons** referring into our community services in the last 12 months (173 referrals). **65% come from 2 main locations**, however – Exeter (51%) and Channings Wood (14%).

- The number of **people coming out of prison** and getting straight into treatment has **increased significantly** in the last 18 months, further to a drop

⁴⁴ [From Harm to hope: A 10-year drugs plan to cut crime and save lives](#)

in 2023/24. It is currently 65% and above the national rate of 58%.

- There were **no drug related deaths amongst prison leavers** (within 21 days of leaving prison) in the period 2022-2024.

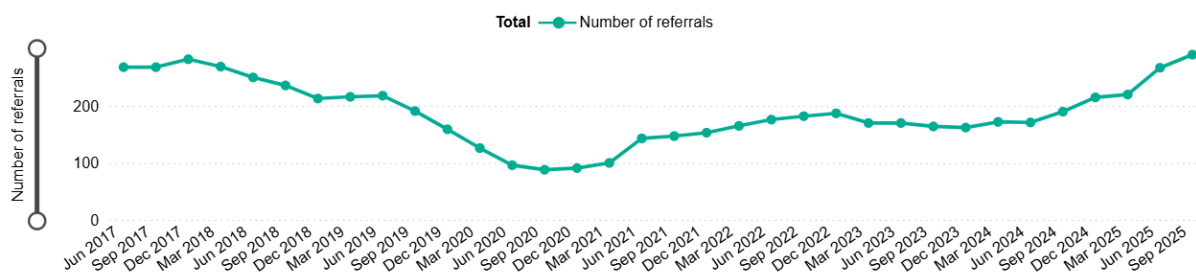
There are a **range of community treatment orders** available and **drug testing on arrest** will also provide mandated referral into community services. It was noted that there is some resistance to what

could be perceived as enforced engagement with treatment. A Dependence and Recovery pilot providing **Rehabilitation Activity Requirements for people under Probation supervision** has been running over the last 18 months and is working well. **282 referrals** have been made between the programme launch in April 2024 and October 2025 and the service maintains an active caseload of around 30 clients at any given moment.

The latest available data shows that around **83% of referrals engaged with the service.**

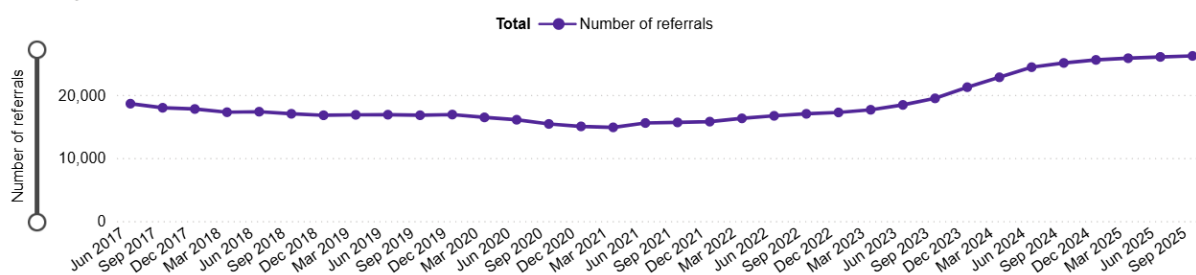
Cornwall & Isles of Scilly

Criminal justice



England

Criminal justice



Referrals into services via **criminal justice routes** have increased significantly over the last two years, **growing by 76%** to 290 referrals for the 12 month period ending September 2025.

Prison referrals make up the largest proportion at 40%, 23%

relate to Alcohol/Drug Treatment Orders, 21% are from Probation and 13% are from Arrest Referral.

Specialist treatment workers go into prisons regularly (such as Exeter and Eastwood Park) to help facilitate engagement and prepare

people for release. **Mixed quality of referrals** and preparation for transfer impact negatively upon rates of engagement; with concerns that the right people may not be being referred.

Short notice referrals have increased over the last few years, due to changes in policy and practice around prison releases. When release dates are brought forward, this provides **limited time for planning essentials** on release such as prescriptions and housing support (which can result in a swift return to prison). **Good relationships** between the prison and community services are helping to reduce the problems that that this causes.

Current and previous use of a comprehensive range of drugs is recorded within Probation assessments. The **mandatory drug and alcohol screening tool** has been adopted by the Probation Service, and it is a requirement that all staff work through this with their clients – local experience, however, suggests that **its use is currently limited**.

The latest data⁴⁵ shows that **1,030 people** in Cornwall and the Isles of Scilly are being **supervised by Probation** in the community. The majority are male (88%).

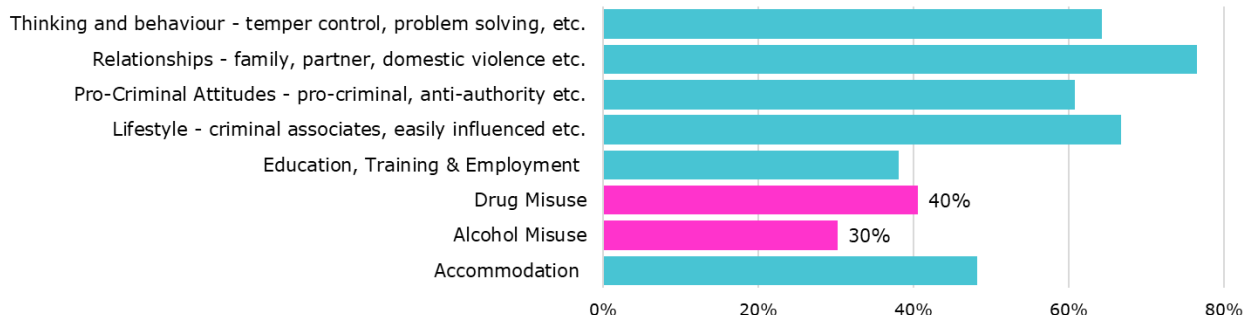
Criminogenic needs are identified as part of their comprehensive assessment. These are characteristics, traits, problems, or issues an individual faces that are **directly related to their likelihood of reoffending**, also known as key life areas.

The **most commonly identified needs** are related to Relationships, Lifestyle, Thinking and Behaviour.

40% of people are identified with a drug-related need and 30% with an alcohol-related need. The number of people identified with **drug-related needs** has **increased each quarter** over the last 12 months, whereas the number of people identified with alcohol-related needs has been fairly stable.

There are **higher levels of need amongst women** for both drugs

Criminogenic needs - Cornwall & IOS



⁴⁵ Probation Service South West Region, January 2026

(49%) and alcohol (37%) but much smaller numbers.

The Criminal Justice Team within the community drug and alcohol service work with a very small cohort of **women with complex needs** (around 5% of referrals from Probation are for women).

The [Criminal Justice Act 2003](#) introduced **community sentence treatment requirements** (CSTRs), including mental health treatment, alcohol treatment and drug rehabilitation.

Under this legislation, the court can impose either a community order or a suspended sentence order with CSTRs. The court can also impose other requirements (such as unpaid work) alongside these.

The purpose of CSTRs is to **reduce drug, alcohol and mental health needs** that are related to offending behaviour and so reduce reoffending.

To be eligible for an alcohol treatment requirement (ATR) or drug rehabilitation requirement (DRR), the court must be satisfied that the person:

- Is **dependent** on their main substance of use and would benefit from treatment
- Can **access and attend** drug treatment
- Is **willing to comply** with the requirement

A joint experimental statistics report⁴⁶ was published by the Ministry of Justice and OHID in 2023, which provided recommendations to improve continuity of care and ensure that **people sentenced to ATRs and DRRs were engaging in treatment**. Where people accessed treatment, it reported **substantial reductions** in their main substance of use and in the frequency that they reported using these substances.

A snapshot of CSTRs (Q3 2025/26) currently being managed in Cornwall and Isles of Scilly are shown below.

Requirements (Q3 snapshot)	Currently managed	Successfully completed in quarter	% successfully completed
Mental Health Treatment Requirements	134	12	9%
Drug Rehabilitation Requirements	31	5	16%
Alcohol Treatment Requirements	58	17	29%

⁴⁶ [Pathways between probation and addiction treatment in England](#), MoJ/OHID, March 2023

Hospital Admissions

Admissions to hospital for alcohol and other drug related reasons **provide insight into the wider harms experienced** by our population. From the latest Public Health Profiles,⁴⁷ we drew the following conclusions for drugs locally:

- A rate of 17.5 for **poisoning by drug misuse** which is similar to the national rate. By sex, rates are very similar and have decreased.
- The rate for **drug-related mental and behavioural disorders** is 7.7, with men almost 2.5 times more likely to be admitted. Rates have fallen.
- The rate of admissions where **drug-related mental and behavioural disorders are a factor** is much higher at 180.9 and have changed little. Men are over 2 times more likely to be admitted for this reason.

All admission rates are per 100,000 residents and for the year 2023/24. The long-term trend is compared with 2019/20.

For alcohol-related admissions⁴⁸:

- **Men are more likely to be admitted** for an alcohol-specific or related reason, than women (both nationally and locally)
- Admission rates for **alcohol-related conditions** are now slightly below the England rate. This is positive as for many years prior to 2020/21 the Cornwall rate was significantly higher.
- Those aged 65 and over are most likely to be admitted.

Data is also available for certain alcohol-related conditions:

- Admission rates for **unintentional injuries** are in line with 2019/20 rates suggesting Night-Time Economy activity has returned to pre-pandemic levels.
- Our rate of admissions for **alcohol-related liver disease** is 15.5% above the national rate. Rates are particularly high for women (29.7% above the England rate).

Alcohol-related Condition	Local Trend	National Trend	Local rate vs national rate	Comparison by sex
Unintentional Injuries	▲	▲	Similar	Male rate 16 times higher
Mental and behavioural disorders	▶	▶	Lower	Male rate 2 times higher
Intentional self-poisoning	▼	▼	Similar	Female rate slightly higher
Cardiovascular disease	▲	▲	Similar	Male rate 6 times higher
Liver disease	▲	▲	Higher	Male rate around 2 times higher

⁴⁷ [Adult mental health and wellbeing profile](#), Office for Health Improvement and Disparities. Accessed March 2026

⁴⁸ [Alcohol Profile](#), Office for Health Improvement and Disparities. Accessed February 2026

Drug and Alcohol Related Deaths

Drug related deaths – quick facts

- **112 deaths** (2022-2024) and rising; **58 deaths in 2024** - 42 men (up by 35%) and 16 women (up by 60%).
- **Local rates are high**, 7.1 per 100,000 compared with 5.8 for England
- Higher than average proportion of **deaths in treatment**
- **Key drugs:** Cocaine, benzos and prescribed drugs, including methadone. **Poly Drug Use is a significant factor**, with 81% of deaths involving multiple drugs. **Synthetic opioids** linked to 4 deaths. First **ketamine** related death.
- **Complexity factors:** mental and physical health, neurodiversity, early onset drug use, trauma and multiple adverse experiences.
- **Prevention:** Uptake of **long-acting buprenorphine** is above the national rate (12% vs 5%). **Abstinence rates** for opiates are good (72% vs 65%).
- **High coverage of naloxone** (82%); 22% administration rate, which appears high (England 11%)

The Cornwall and Isles of Scilly (CIOS) **annual Drug-Related Death Report** reviews all deaths in the year, highlights emerging themes, and identifies service gaps to strengthen local prevention.

In 2024, CIOS recorded its highest number of drug- and alcohol-related deaths, reflecting national trends.

A review of OHID's **drug and alcohol death checklist** indicates that Cornwall and Isles of Scilly is performing very well against the recommended criteria for addressing drug and alcohol related deaths.

The checklist confirms full compliance in four of six **governance** domains; two require improvement. Four of five **harm-reduction** areas are met, one

requires minor development. In **treatment and recovery**, six areas are fully in place and six need slight improvement; and within **partnership working**, four of eleven areas are met, four require minor improvement, and three need further clarification.

Actions needed for the areas requiring improvement are summarised below.

Partnership work would benefit from **stronger and more consistent identification of non-fatal overdoses**, with improved referral rates from ambulance crews, clearer high-risk response protocols across supported housing, and enhanced training resources.

There is a need to **address ongoing gaps in high-risk data**, particularly

for Cornwall residents attending Derriford Hospital, by developing **mechanisms to flag repeat presentations** and strengthening discharge pathways for individuals leaving mental health wards.

Monitoring of sub-optimal prescribing within Opioid Substitution Treatment (OST) services should continue to improve, ensuring that recent data-quality gains are embedded into routine oversight.

Alcohol pathways, while established, require wider utilisation, particularly in relation to increasing uptake of home detox options.

Tailored support for stimulant use needs broadening beyond crack and SCRA, including finalising the ketamine pathway with relevant clinical services.

Health assessments should be strengthened through **consistent use of PHQ-GAD7** across all teams and implementation of a **pain management pathway**, ensuring more reliable identification and referral for co-occurring physical and mental health needs.

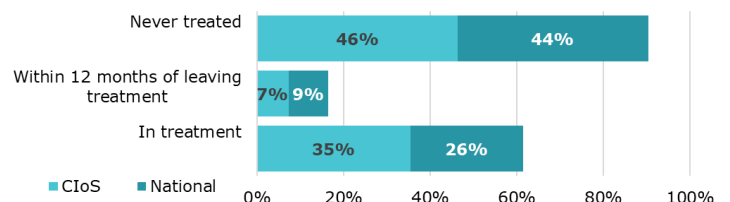
Finally, **safeguarding arrangements** across the partnership would benefit from a review of agencies' internal drug and alcohol policies, routine screening for substance use within partner organisations, and a more consistent, system-wide understanding of safeguarding responsibilities.

Drug misuse deaths

112 deaths from drug misuse were reported by the Office for National Statistics for Cornwall and Isles of Scilly in the **period 2022-2024**.

At 7.10 deaths per 100,000 people, our local rate for this period was **22% above the national rate** (5.80 deaths per 100,000). The number of deaths had increased compared with the previous 3 year period, both locally and nationally.

Over this 3 year period, the proportion of deaths that **occurred during treatment** was higher than the national average (35% vs 26%) but had seen a small 3% percentage reduction compared with the previous 3 year period. There were **no deaths of prison leavers** within 21 days of leaving prison.



Deaths in treatment

The most recent data shows that **64 deaths occurred during treatment** in the 12 months to October 2025. This number has seen a small drop since the baseline in March 2025 and is in line with the national rate.

91% of clients were in **treatment for 12 weeks or more**, compared with 82% nationally.

A third of people starting treatment reported that they were **smoking** at this time, well below the national rate of 43%. Very few people in treatment are recorded as being referred for smoking cessation support.

4% of people in treatment are receiving mostly or all **digital contact**, which is below the national rate of 14%.

Local data shows that of the 95 suspected suicides in Cornwall in 2025, **11 people had previous contact with drug and alcohol services**, highlighting suicide as a key risk factor for those in treatment.

Opiates

26 opiate-related deaths during treatment in the 12 month period to October 2025 and this number has reduced by 26% since the baseline in March 2025. This equates to 2% of people in treatment for opiates which is in line with the national average.

50% of opiates clients in treatment are receiving **supervised consumption of methadone OST** and this is well above the national rate of 29%. The number of people receiving supervised consumption (662 people) has risen significantly this year, up by 51% since March 2025, and the proportion is up by 17%. Nationally supervised consumption has remained stable as

a proportion and the number has reduced by 3%
12% of opiates clients are **prescribed long-acting buprenorphine** and this is also well above the national rate (5%). The number of people on buprenorphine (163 people) is up by 35% from the baseline in March 2025 and the proportion is up by 3%. It has also increased nationally over the same time period.

82% of clients, with a naloxone status recorded, already have or have been recently **issued with naloxone**. This has remained stable this year and is in line with the national rate and trend.

Naloxone was administered to **293 clients** in the last 12 months (to October 2025) and this is similar to the level recorded in March 2025. This equates to **22% of people** (where a "naloxone administered" status recorded at assessment) which is twice the national average of 11%.

71% of people who reported problematic opiate use at the start of treatment reported **no opiate use** on their latest outcomes form. This is similar to the baseline in March 2025, and above the national rate of 65%.

Further Reading:

Our comprehensive annual report on [drug-related deaths in 2024](#)

Alcohol-related deaths – quick facts

- **99 alcohol specific deaths** in the 12 months to December 2025, up by 12% from March 2025 baseline.
- **32 people died in treatment**, equating to 2% of people in treatment.
- **Our local rate is above the national rate** – 17 deaths per 100,000 population vs. 13 per 100,000.
- **Prevention:** Referrals for **alcohol related liver disease screening** are above the national rate (42% of people in treatment vs 29% in England), and have increased by 20% since the March 2025 baseline.
- **Alcohol abstinence rates for people in treatment** are below the England average (35% vs 38%).

99 alcohol specific deaths in the last 12 months and the number has increased by 12% compared with the March 2025 baseline. Our local rate of 17 deaths per 100,000 population is above the national rate of 13 per 100,000. **30 people died whilst in treatment**, equating to 2% of the relevant treatment population, just above the national rate of 1%.

51% of clients were **using alcohol at a high risk level** at the start of treatment and this is substantially below the national average of 66%. The **number of people at risk** through their drinking has increased by 16% to 384 people – this is due

to a rise in the number of people coming into treatment.

Referrals for **alcohol related liver disease screening** are substantially higher than the national rate at 42% of people in treatment (vs 29%) and the number has increased by 20% since the March 2025 baseline.

35% of clients who reported problematic alcohol use when they started treatment reported that they were **alcohol-free** on their latest outcomes form. This is just below the national rate of 38%.

Appendices

[Appendix A: Further reading](#)

[Appendix B: Glossary](#)

A: Further reading

- [Drugs Needs Assessments](#) including the comprehensive 2022/23 assessment and subsequent updates.
 - Cornwall and Isles of Scilly Drugs Needs Assessments – 2022/23 and 2024/25 update
 - Young People’s Substance Use Needs Assessment 2024/25
 - Alcohol Needs Assessment 2022
- [Drug Strategy Reports](#) showcasing the work done locally in the in support of the national Drug Strategy. **Three consecutive years** are available.
- Annual [Drug Related Deaths Report](#) for Cornwall and the Isles of Scilly, covering the calendar year 2024. It follows the guidance and requirements by the Department of Health and the Home Office for all areas to have in place a system of recording and conducting confidential inquiries into drug related deaths within their specific areas.
- [From harm to hope](#): A 10-year drugs plan to cut crime and save lives (cross-Government Strategy, launched in 2021)
- [Independent review of drugs](#) by Professor Dame Carol Black, parts 1 and 2. Home Office and Department of Health and Social Care (2020).
- Alcohol and drug misuse and treatment statistics (collection), Office for Health Improvement and Disparities. [National statistics](#) to support improvements in decision making when planning alcohol and drug misuse treatment services.

B: Glossary of key terms and acronyms

Term	Description
ACE(s)	Adverse Childhood Experience(s)
ACMD	Advisory Council on the Misuse of Drugs
Acquisitive crime	Crime grouping consisting of burglary, shoplifting, vehicle offences and other types of thefts
ASB	Anti-Social Behaviour
CDP	Combatting Drugs Partnership – see JCDU
CHB	Clear, Hold, Build – a national Home Office programme and a multi-agency led initiative to tackle organised crime
CSA/E	Child Sexual Abuse/Exploitation
CSEW	Crime Survey for England and Wales
CSP	Community Safety Partnership. Statutory partnership established further to the Crime and Disorder Act 1998 to tackle crime and disorder issues. Responsible authorities are Council, Police, Fire, Health and Probation. In Cornwall, the CSP is called Safer Cornwall. There is a separate CSP for the Isles of Scilly.
DA(SV)	Domestic Abuse (and Sexual Violence)
Hate incident/crime	Any incident where the victim or a witness feels that they were targeted because of disability, race, religion, gender identity or sexual orientation; if the behaviour constitutes a criminal offence, it becomes a hate crime
HMIC(FRS)	Her Majesty's Inspectorate of Constabulary, expanded to include Fire and Rescue Services in 2018
IPS	Individual Placement and Support. IPS works by providing employment support alongside clinical treatment.
JCDU	Joint Combatting Drugs Unit – the cross-government unit responsible for the national Drug Strategy. It works across the the Department of Health and Social Care, the Ministry of Justice, the Department of Work and Pensions, the Department of Levelling Up, Housing and Communities, the Department for Education and the Home Office. Local partnerships are referred to as CDPs (Combatting Drugs Partnerships)
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer (or Questioning) and others with gender expressions outside traditional norms, including nonbinary and intersex.
MARAC	Multi-Agency Risk Assessment Conference, used to manage high risk domestic abuse cases
MHTR	Mental Health Treatment Requirement

Term	Description
MoRiLE	Management of Risk in Law Enforcement - accredited models to assess threat, risk and harm developed through the national MoRiLE programme
Naloxone	Opioid antagonist that reverses the effects of an opiate overdose
NDTMS	National Drug Treatment Monitoring System
Neighbourhood Crime	Crime grouping made up of domestic burglary, personal robbery, vehicle offences and theft from the person.
NICE	National Institute of Clinical Effectiveness
NPS	Novel/new psychoactive substances – synthetic drugs
NRM	National Referral Mechanism – a framework for identifying and referring potential victims of modern slavery and ensuring they receive support
OCG	Organised Crime Group
OCU	Opiate and/or crack cocaine user. A drug user who does not use opiates or crack is sometimes referred to as a non-OCU
OHID	Office for Health Improvement and Disparities
ONS	Office for National Statistics
OCLP	Organised Crime Local Profile – detailed profile developed by Devon and Cornwall Police with local partners for serious and organised crime themes
OPCC	Office of the Police and Crime Commissioner
SCRA	Synthetic Cannabinoid Receptor Agonist
SDD	NHS Smoking, Drinking and Drug Use (SDD) report – a biennial survey of young people
SOC	Serious and Organised Crime
THC	Tetrahydrocannabinol – the psychoactive component of cannabis
UNODC	United Nations Office on Drugs and Crime
VCSE	Voluntary, Community and Social Enterprise (Sector)
YJS	Youth Justice Service