Alcohol & Drug Treatment 2012-2015 Commissioning Strategy

Reducing Harm, Promoting Recovery

A Drug and Alcohol treatment system that:

1. is simple for people to access;

2. has a clear range of pathways, options and choices that are easy for people to navigate;

3. is delivered through co-ordinated partnership working,

and

4. achieves positive outcomes by supporting recovery and community integration for services users, children, families and local communities.

INTRODUCTION:

Cornwall & Isles of Scilly Drug and Alcohol Action Team:

Cornwall & Isles of Scilly Drug and Alcohol Action Team (CIOS DAAT) is the Partnership Board responsible for delivering the national and local alcohol and drug strategies for the people of Cornwall & the Isles of Scilly (CIOS). The Board is Chaired by the Director of Public Health. Membership consists of Children's Services and Families, Adult Care and Support, Safer Cornwall (Community Safety), Housing, NHS Cornwall & Isles of Scilly (CIOSPCT), Devon and Cornwall Police and Probation Trust.

The DAAT Joint Commissioning Group (JCG) is responsible for discharging the commissioning functions of the DAAT, including:

- an annual assessment of needs in CIOS,
- identifying commissioning priorities based upon those assessments,
- drafting plans to meet those priorities,
- setting and managing the partnership budget, contracts and performance reviews to achieve the outcomes required.

It is responsible for involving key stakeholders at every stage of commissioning

See References: Involving Service Users at Every Stage of Commissioning

A number of DAAT Groups contribute to the continued improvement of the treatment system locally:

- The Needs Assessment Export Group
- The System Re-design group- made up of service providers, service users and key stakeholders, which develops the system locally to meet needs
- The Pharmacy & Prescribing Group
- The Blood Borne Virus Task Group
- The Criminal Justice Managers Group
- The Electronic Case Management (HALO)and Data Quality Board
- (as well as any other time-limited Task Groups required to deliver priorities.)

What is commissioning?

Commissioning is a partnership between the DAAT, local service users, their families, communities and services. Its purpose is to make the best use of the resources available to meet local needs. It is a process of constant improvement. Commissioning should put local people at its heart, making it possible to have more choice and the most up to date services because it constantly learns from the best evidence.

Every year we seek to improve our knowledge and understanding of local needs and review the evolving evidence to know how best to meet those needs. Our success depends upon everyone working together.

See References: Models of commissioning

Drug and alcohol commissioners must work closely with all relevant partners to ensure all services promote and support successful recovery journeys, especially to deliver the challenges with regard to

housing, education, training and employment.

Successful recovery journeys are initiated by maintaining (and where necessary, improving) access to early and preventative interventions and treatment.

Treatment must be recovery-orientated, effective, high quality and protective.

Treatment supports sustained recovery by developing and using networks of support and other community assets, such as mutual aid, peer support, community groups and recovery communities.

See References: Commissioning for Recovery

What is a commissioning strategy?

A formal statement of plans for securing, specifying and monitoring services to meet people's needs. It applies to services provided by the local authority, NHS, other public agencies and the private and voluntary sectors.

A commissioning strategy is concerned primarily with effecting change. It should ensure services are designed primarily to meet the needs of users and carers.

This strategy seeks to make a better balance of services, to improve the effectiveness of prevention and early intervention services, so that users will be better served, and demand for complex and expensive health and care services can be reduced.

Why a new strategy?

The need for a more recovery oriented treatment system

Over the past 20 years, a number of local alcohol and drugs services have developed in Cornwall. The 2002 national framework ('Models of Care') specified a range of evidence based interventions and required services to work together **as a system**. Local providers started to work together more, but there remained significant gaps in the services required and referrals between agencies were low.

In 2008, the PCT and strategic partners adopted a commissioning strategy of Re-design, facilitating local providers to work together as an integrated system, with the aim of taking the full range of treatment options to local areas and transferring the majority of community specialist prescribing to primary care. This strategy delivered new locality bases in Liskeard, Bodmin, Penzance, Truro and St Austell to act as a single point of contact for local communities and services for people to drop in to, along with many improvements. However, local services still do not feel like an integrated system on the ground to the general public, people with alcohol and drug problems or local stakeholders, as our annual consultations make clear.

People still do not know what is available, how to access it and how it can help.

Delivery of the full range of interventions is neither complete nor equitable, discharge rates and successful completions remain low. Management and infrastructure costs are currently spread over 5 community

adult suppliers (in addition to the primary care LES schemes), with a lack of full integration and co-ordination slowing further progress. This puts future funding at risk.

Risk to funding and investment:

Local alcohol and drug treatment investment has been made up, historically, of the National Pooled Treatment Budget (PTB NHS and Home Office), National Drug Intervention Programme (DIP) (Home Office), CIOS PCT investment and, to a much lesser degree, contributions from Cornwall Council Adult Care and Support, Community Safety Partnership and Devon and Cornwall Police.

- For the last couple of years Cornwall and the Isles of Scilly have managed to secure small increases from the national Pooled Treatment Budget, not the anticipated reductions. However, these small increases have been offset by losses from other sources. Overall the budget has reduced by a few percent each year.
- The national Pooled Treatment Budget has always been ring fenced; however this ring fence will be removed after March 2013.
- Future commissioning arrangements have not yet been confirmed but it is anticipated that competition for funds will be intense.

The **2012-13** formula for allocating the national PTB will be dependent upon performance in:

- increasing numbers into treatment;
- increasing successful completions;
- reducing re-presentations to treatment.

The national pot will not get bigger. In order to continue to increase the allocation from the pooled treatment budget Cornwall providers will have to perform better in the above indicators than other areas. A failure to deliver will result in a reduced allocation.

The Drug and Alcohol Action Team Board and Drug and Alcohol Action Team Joint Commissioning Group have been planning how to manage funding reductions for the last couple of years. They agreed that before front line staff would be reduced infrastructure and back office costs would be cut.

Major changes in the pubic sector/strategic landscape:

- The Government has approved the Health and Social Care Bill and as a consequence the Primary Care Trust will cease to exist on 31st March 2013. Kernow Clinical Commissioning Group will undertake the commissioning function that the PCT previously managed.
- It is understood that the National Treatment Agency will be merged into Public Health England.
- Public Health will move into Cornwall Council. Public Health will then be responsible to Ministers for the commissioning of drug and alcohol services.
- The Health and Well Being Board will provide the strategic leadership and governance framework for drug and alcohol services from 1st April 2013. Transition planning has started.
- In November a Police and Crime Commissioner will be elected for the peninsula. He or she will

have a budget and will commission services for drug and alcohol using offenders using money from the Drug and Alcohol Action Team budgets.

- The Drug and Alcohol Action Team Board and Drug and Alcohol Action Team will not continue in its current form as the commissioning function is currently embedded in the Primary Care Trust.

Legal requirements:

The GPs with Special Interest Service (drug misuse) previously employed by the Primary Care Trust was moved in 2011 to Cornwall Partnership Foundation Trust as an interim measure for a year. A condition of this move was a re-tender.

The majority of contracts for local services have come to an end or do so 31st March 2013. There is a requirement under European Law to competitively tender, especially as some of our local contracts have never been put to this process.

We wish also to meet our responsibilities with regard to legislation brought in since our last strategy, such as the *Equality Act (2010).*

What do we want to achieve? – Outcomes:

National Outcomes – Public Health Outcome Framework

CIOS DAAT has responsibility for delivering the following 3 national outcomes locally:

"Successful completion of drug and alcohol treatment" **Public Health Domain 2.15**	**"Reducing Alcohol-related admissions to hospital"** **Public Health Domain 2.18**	**"Identifying people entering prison with substance dependence issues who are previously not known to community treatment and engaging them in treatment"** **Public Health Domain 2.16**

CIOS DAAT also contributes to the delivery of :

1.8	Securing Employment for those with a long term health condition
1.11	Reducing Domestic Abuse
1.13	Reducing Re-Offending
1.15	Reducing Statutory Homelessness
2.8	Improving the emotional wellbeing of looked after children
2.10	Reducing Hospital admissions as a result of self-harm
2.23	Self-reported wellbeing
4.3	Reducing Mortality from causes considered preventable
4.8	Reducing Mortality from communicable diseases
4.6	Mortality from liver disease
4.10	Preventing Suicide
4.11	Reducing Emergency re-admissions within 30 days of discharge from hospital

Key Facts about alcohol in Cornwall & Isles of Scilly:

- **A quarter of Cornwall's population aged 16 and over are estimated to drink at above the recommended safe limits, at increasing risk levels or above.**
- **22,400 adults (5%) are drinking at higher risk levels, double the recommended safe levels or above.**
- **18,600 adults (4%) are estimated to be alcohol dependent, meaning that once someone falls into the high risk drinking category they are very likely to become alcohol dependent.**
- **1,341 people engaged with treatment services in 2011/12, accounting for 7% of the estimated prevalence of dependent drinkers.**
- **60% of clients are aged 40 or older, with 60% in this age group entering treatment for the first time, implying that their alcohol issues are well established before entering treatment.**
- **Raised blood pressure is a factor associated with high risk drinking in deprived areas, whereas in non-deprived areas, patients were more likely to have increased cholesterol levels alongside higher risk drinking.**
- **69% of Arrest Referral contacts in police custody present with alcohol as a factor.**
- **Alcohol is the 2nd most common substance for young people after cannabis.**
- **In 2010/11 Cornwall's community hospitals carried out 116 alcohol detoxes, and in the first 10 months of a new residential detox, 102 dependent drinkers were supported with 80% successful completions, well above the national average.**
- **Half of all violent crime reported to the police, including domestic violence, is recorded as linked to alcohol.**
- **Approximately 5 residents known to misuse alcohol die each year by suicide, 15% of all suicides of local people. Around 12 people (31% of all suicides) each year die having consumed alcohol at the time of carrying out the act of suicide.**

Key Facts about Drugs in Cornwall & Isles of Scilly:

- **There are between 2,100 and 2,500 opiate and / or crack users (OCUs) in Cornwall and the Isles of Scilly.**
- **Contrary to the national picture, we are not seeing a drop in opiate and / or crack users in the 15-24 age group and injecting prevalence is estimated to have increased.**
- **Young adults make up a larger proportion of the "unmet need" group" than the known to treatment groups.**
- **In the 12 month period to August 2011[1] we had 1,635 adults and 1,242 OCUs (any age) in effective treatment.**
- **The rising trend in effective treatment numbers levelled off last year and there was a small reduction in the total number of adults in 2010/11.**

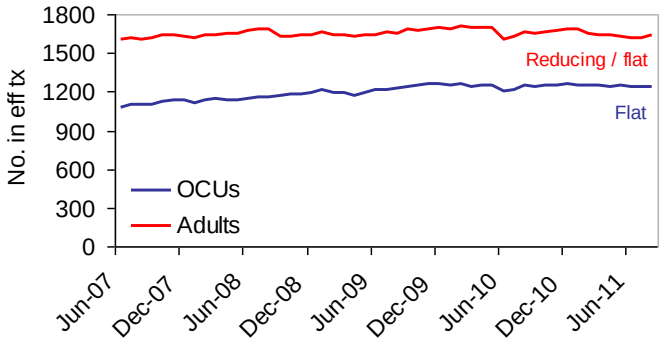
[1] www.ndtms.net

QUICK FACTS – ADULTS IN DRUG TREATMENT

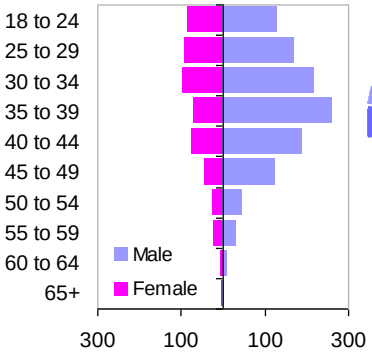
Opiate and / or crack users are referred to throughout as OCUs

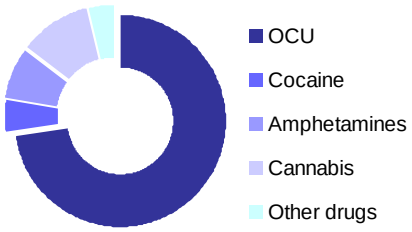
Prevalence (OCU only)	2,285 / 6.8 OCUs per 1,000 resident population
In effective treatment (latest, November 2011)	OCUs (all ages) – 1,242 / 3.7 per 1,000 population All adults – 1,635 / 5.2 per 1,000 population

General trend – numbers in effective treatment



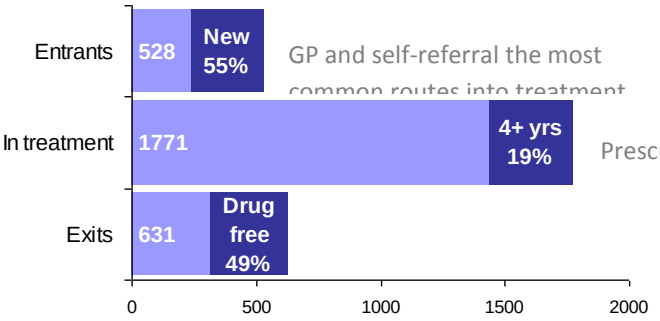
Service user profile





OCU: opiates and / or crack as primary or adjunctive problem drug; all other drugs categorised by primary drug only

People in the treatment system 2010/11



GP and self-referral the most common routes into treatment

Prescribing the most

References:

***Safer Cornwall Partnership* Strategic Assessment 2011-12:**
http://safercornwall.liminalspaces.co.uk/wp-content/uploads/downloads/2012/05/Community-Safety-Partnership-Strategic-Assessment-_evidence-paper_-2011_12.pdf
CIOS Alcohol Needs Assessment 2010-11:
https://www.amethyst.gov.uk/Download_Documents/Strategies_Audits/CIOS%20Alcohol%20Needs%20Assessment%202010-11%20FINAL.pdf
CIOS Drug Needs Assessment 2011-12:
http://www.cornwall.gov.uk/idoc.ashx?docid=58f85473-f07c-442f-8074-fd3135e113f0&version=-1

Outcomes:

In commissioning local services,
the key service outcomes for services users are:

1. Freedom from dependence on drugs or alcohol
2. Improvement in mental and physical health and wellbeing and reducing drug related deaths
3. Prevention of blood borne viruses
4. A reduction in crime and re-offending
5. Sustained employment
6. The ability to access and sustain suitable accommodation
7. Improved relationships with family members, partners and friends
8. Improved capacity to be an effective, caring parent
9. Delivering value for money

Equality and human rights are key in all 8 of these areas, with implications for equitable service delivery and access, encompassing gender, sexual orientation, disability, age, isolation, vulnerability, ethnicity, religion and beliefs.

Outcome1: Freedom from Dependence on Drugs and Alcohol:

The drug and alcohol treatment system is ambitious for individuals to leave treatment free of their dependence, equipped with the skills and resources they need to maintain their recovery.

Effective treatment and support is offered in a menu of options that includes psychosocial and pharmacological, residential and non-residential, professional and peer-supported.

Packages of care and support are tailored to the needs of those in treatment and orientated to their individual recovery.

What we know:

- Whilst levels of self referral improved in 2011/12 considerably, they remain lower in Cornwall than the national or regional average.
- People using illegal drugs are more reticent to disclose to statutory professionals than people experiencing problems related to alcohol and legally available substances. Thus, they may develop more complex or entrenched problems before seeking help.
- Young adults, in particular, are underrepresented within our treatment system.
- Whilst many people do well in our treatment system, by comparison with other areas in the country, others still do not. The rate of growth for successful completions for opiate users continues to track above the national average but below the average for our complexity cluster.
- The rate of growth in successful completions seems to have come to an abrupt end for people with non opiate problems and this has led to an overall fall in the rate of growth in successful completions for the Partnership. Currently growth in successful completions for people with non-opiate problems is significantly lower than our complexity cluster average and has dropped from 14% in the previous quarter to 1%.
- There also seems to be a decline in the number of non-opiate users in treatment in CIOS which is significantly larger than the national trend. Currently the numbers of non-opiate users has dropped from 469 to 399 a drop of 70 individuals (-15%).
- Looking at CIOS in comparison to other areas in complexity group B (for those Partnerships with sufficient Treatment Outcome Profile (TOP) data), CIOS has the lowest rate of people achieving opiate abstinence and reliably improved: 6 month review in last 12 months', and does not seem to deliver within the range of expected performance for amphetamine users.
- We have an established and developing alcohol treatment system, with multiple care planned pathways. 81% of people in treatment for alcohol problems are alcohol only clients. 7% of the estimated number of dependent drinkers in Cornwall is in treatment.
- In 2010/11 Cornwall's community hospitals carried out 116 alcohol detoxes, and in the first 10 months of a new Cornish specialist residential detoxification unit, 102 people were supported to withdraw from alcohol dependency, with its successful completions well above the national average at over 80%.

Unplanned exits (drop outs

- Whilst more people actually left treatment in 2010/1, successes as a proportion of all treatment exits remained around the same at 49% (a little above the regional and national averages)
- A third of people leaving treatment in 2010/11 dropped out. This has increased for a second year in a row and is now around 10% higher than the regional and national averages. This finding is of particular concern because Cornwall is considered to be fairly low level in terms of service user

complexity.

- Injecting behaviour appears to be one of the key influencing factors in drop-out rate – particularly those who presented to treatment as currently injecting and were receiving prescribing treatment from a GP. Frequent drop-outs are typically male, aged in their late twenties and opiate users with a history of injecting
- Confusion persists about how to get into treatment and who does what, despite specifying in contracts and issuing a service directory.
- In some areas, some agencies co-operate to deliver a local treatment system, whereas others do not. There is considerable duplication in some towns, with entire gaps in others.
- Similarly, there is confusion about pathways through treatment. Referrals and joint working between local organisations remains low, as are the number of agencies involved in an individual's care plan.
- Care Plans are not as recovery oriented and care co-ordination functions remain undeveloped, as evidence and best practice would recommend.

What we are doing:

- A 'Recovery Map' to describe the treatment system and pathways through it;
- Developing Care Co-ordinators through a local network of champions to improve Care Co-ordination and bring together all the services a person requires to support them in their recovery and reintegration;
- Increasing the range and availability of community detoxification options for opiate users;
- Ensuring there are pre and post detox and aftercare group in each locality[2];
- Improving preparation, aftercare and support for people going into residential detoxification and rehabilitation services;
- More flexible open access support and provision -increasing the amount of face to face time available for people, so it is possible to get daily help and attend daily programmes in localities;
- Including one evening and weekend session in each locality;
- Introducing the accredited Intuitive Recovery course in each locality to teach people the skills to come off and stay off;
- The creation of an online network to support people out of hours and at distances and Breaking Free Online support resources;
- Introducing Recovery Champions from people who have successfully completed treatment
- Introducing the Mutual Aid Programme (MAP) for service users to support each other in remaining drug and alcohol-free;
- Developing an inspiring, recovery-oriented workforce through a continuing professional training and development programme;
- Introducing a specific programme for non-opiate users;
- Developing Recovery Care plans to make each person's plans more goal oriented and to make progress more visible;
- Extending the introduction of Identification and Brief Advice (IBA) across all community services such as the criminal justice system, health, housing, employment, and domestic abuse, as well as in hospital and A&E.
- Introducing 'Breaking Free Online' for people to use to support themselves I naddditionato the

[2] Liskeard, Bodmin, St Austell, Newquay, Truro, Redruth and Penzance.

services available

- Intuitive Recovery programmes- skills based classes to learn how to come off and stay of drugs and alcohol

What we aim to do:

- Attract and proactively engage people in treatment earlier, increasing self referrals.
- Increase the number of young adults referred into and engaged in treatment through open access services, including outreach and detached work.
- Continue to increase the number of people accessing treatment and encourage self referral to free, confidential and credible help at the earliest opportunity, attracting and engaging through:
- Improved accessibility for vulnerable and hard to reach groups, such as the LGBT, disabled, hearing impaired and those with learning difficulties through targeted information, advice and services

Outcome 2: Improvement in Mental and Physical Health & Wellbeing:

Problematic substance use and dependence is frequently associated with harm to an individual's mental and physical health and wellbeing. Even small changes to substance misuse made in the initial stages of treatment can bring linked improvements to a person's overall health and wellbeing, while other health problems may require access to specific and often specialist interventions. Better physical and mental health are themselves an important platform for sustained recovery. Alcohol and drug services must be able to identify and provide, or facilitate access to, the appropriate treatment for these associated mental and physical health problems

What we know:

Drug-related deaths

- The number of recorded drug related deaths reduced by 7 (38%) compared with 2010. Included within the currently recorded drug related deaths are three suspected heroin/morphine deaths.
- Of the 11 recorded drug related deaths 5 were in treatment for drug dependency at the time of their death and one other had been discharged from treatment following residential de-toxification. The other 5 had no previous involvement with any known treatment provider nor were they awaiting appointments for assessment for any such treatment.

Drug use and mental health

- The complexity of dual diagnosis issues makes all aspects from diagnosis to care to treatment all the more important. This is made more so by ongoing challenges and risks which include:

  - Re-admission rates to hospital being high

  - Engagement and drop out rates in treatment are high

  - High suicide rates

- Increased rates of substance misuse are found in individuals with mental health problems, affecting around half of people with severe mental health problems
- Alcohol misuse is the most common form of substance misuse and where drug misuse occurs it often co-exists with alcohol misuse
- Community Mental Health Teams (CMHTs) typically report 8-15% of their clients have dual diagnosis problems although higher rates are found in inner city areas.
- Local data indicates that service users with a dual diagnosis made up 12% of new treatment journeys in 2010/11, which was in line with the regional average and a little lower than the national average.
- Local research into the distribution of mental health prevalence drew on data from the Indices of Multiple Deprivation (2010, mood and anxiety disorders). Areas with the highest prevalence included St Austell Mount Charles Ward North West, Camborne West Ward East Central and Penzance Lescudjack and Ponsandane. The majority of areas highlighted tend to be located in the West of the county.
- Mosaic consumer profiling suggests that the best way to communicate with households that are likely to experience long term mental health issues is to use word of mouth techniques rather than internet communications (due to lack of access).
- Many of the households have good access to local services via walking or local transport as they do not have access to a car. This therefore emphasizes the importance of locally based services.

Drug misuse and the risk of suicide and self harm

- People who misuse drugs are at increased risk of mental health problems, self harm and suicide.
- Hospital admissions in the South West due to self harm (overdose) by drugs of abuse have been rising for males and females.
- Opportunities for ASIST training should be promoted for staff working with people who misuse drugs and suffer from depression.

What we are doing:

Preventing Drug Related Deaths

- Overdose Prevention and Basic Life Support classes in locality bases
- Information and dvd to all people coming into treatment
- Introducing naloxone for all service users and their families/carers/affected others
- Suicide ASIST training for treatment staff
- All Drug Related deaths are reviewed through the DRD Review Panel to develop services in the light of learning from experience

Dual Diagnosis

- People identified within RCHT and Derriford hospitals can be assessed by the Psychiatric Liaison Service and referred into treatment where suitable.
- We have developed the Dual Diagnosis pathway to describe the services available and pathways for people with dual diagnoses to reduce gaps in provision and promote recovery. This includes a new conflict resolution process which can be triggered by any stakeholder experiencing obstacles or barriers to delivering recovery for people with dual diagnoses.

What we aim to do:

- Reduce drug and alcohol –related deaths
- Reduce the number of people who report that they feel they fall between services (alcohol, drugs and mental health)
- Introduce naloxone through the Health for the Homeless services and in projects that are classified as stage 1 or stage 2 in the supported housing model for people with complex needs.

Outcome 3: Prevent the Spread of Blood Borne Viruses (BBVs):

An effective treatment system prevents and reduces the spread of blood borne viruses. People who inject drugs or have injected drugs historically are at risk and have a high prevalence of blood borne viruses. Given the demonstrable impact that substance misuse treatment can have on preventing spread and reducing deaths all services which are part of a recovery-orientated system will be able to deliver evidence based interventions.

What we know:

- Combined data from across the UK suggest that around one in six people who inject drugs (PWID) have been infected with hepatitis B and about half with hepatitis C. They also indicate that at around one in 100 has HIV. Interventions that aim to prevent infections among PWID therefore need to be sustained and the levels of provision reviewed to ensure adequate coverage.
- The HPA estimates that there are approximately 410 current (and 643 former) People Who Inject Drugs (PWID) infected with Hepatitis C in Cornwall. Between 62 and 92 new cases are diagnosed per year. In total, approximately 600 cases have been diagnosed over the last 12 years.
- Services to prevent and treat blood borne viruses (BBV) are developing, and access to HBV immunisation and HCV testing have improved significantly in the past year. However, the national target for Immunising against Hepatitis B is 90% of new presentations to treatment accept HBV vaccinations. In 2011-12 CIOS achieved a rate of 47%, against a national rate of 34%.
- The national target for HXCV testing is 90% of people in treatment previously or currently injecting. In 2011-12, CIOS reached 75% against a national rate of 66%.
- The main factor in this low testing rate is the difficulty of venous access in this client group, and often people may agree to being tested but do not proceed to the stage of having blood taken because either a further appointment has to be scheduled purely for the venepuncture, or they are required to attend elsewhere (e.g. a GUM clinic) if an attempt to take blood at the initial appointment was unsuccessful. This does suggest that HCV infection remains under diagnosed in Cornwall and that screening of IDUs is, at best, *ad hoc*.
- There is good Needle and Syringe Exchange scheme coverage in Cornwall and the Isles of Scilly, which include infection control advice.
- Numbers accessing needle exchange services has remained stable, although the number of client visits has dropped. This discrepancy may be explained by an increasing number of steroid users in the client base, who visit less frequently.
- New presentations continue to be predominantly male and heroin users. The age profile for new clients is younger than for treatment services, particularly in terms of young adults (under 25 years of age).

Bacterial Infections

- People who inject drugs (PWID) are also vulnerable to a wide range of viral and bacterial infections. These infections can result in high levels of illness and in death.
- Around one-third report having a symptom of a bacterial infection (such as a sore or abscess) at an injecting site in the past year. Staphylococcus aureus and Group A Streptococcal infections continue to cause severe illnesses among people who inject drugs in the UK.
- Since 2000 there have been 163 cases of wound botulism, 93 of Clostridium novyi infection, 52 confirmed cases of anthrax and 35 of tetanus associated with injecting drug use in the UK.

What we are doing:

- The priority for 2012/13 is to ensure 90% of people accessing our treatment services that have a history of injecting have been immunised against Hepatitis B and tested for hepatitis C. To improve testing for

hepatitis C, it has been agreed to introduce Dry Blood Spot Testing for Hepatitis C screening in a pilot in pharmacies and local drug treatment services.

- Sustaining Pharmacy based needle exchanges
- Increasing community outlets through locality bases, including extension of outreach with and services for the homeless
- Training all specialist staff to reduce injecting related risk and facilitate pathways to treatment for injectors
- Raising immunisation rates for HBV through a peripatetic immunisation services
- Raising testing rates for HCV

What we aim to do:

- Reduce the incidence of hepatitis B and prevent the spread of hepatitis C
- Engage people with Hepatitis C earlier in treatment.

Outcome 4: A Reduction in Crime and Re-offending:

A joint NTA/HO study (Estimating the crime reduction benefits of drug treatment and recovery, NTA 2012) estimates that drug treatment and recovery systems in England prevented 4.9 million crimes in 2010-11, with an estimated saving to society of £961 million in costs to the public, businesses, the criminal justice system and National Health Service (NHS).

Given the demonstrable impact that substance misuse treatment can have on reducing crime there is a shared interest for health and criminal justice partners to commission effective substance misuse treatment interventions that ensure people are encouraged into treatment at every stage of the criminal justice system, in custody and the community

What we know:

Drug use, particularly of class A drugs such as heroin, is strongly associated with crime and offending. Offenders with drug problems are more likely to commit acquisitive crimes, such as burglary and thefts, to provide funds for their addiction and to be convicted of drug-specific crime, such as possession and supply offences. Reoffending risk for this group is very high.

Locally, the most prevalent issues amongst adult offenders are **alcohol problems** (69%), **domestic abuse** (51%) and **drug problems** (46%).

Just over half of offenders with drug problems are current or previous opiate users. **Problem drug use is much more common amongst PPOs.**

- Half of all violent crime reported to the police, including domestic violence, is recorded as linked to alcohol.
- 60% of alcohol-related violence occurs in larger towns, which comprise only 40% of the population. These problems peak at weekends and in the summer months. This can negatively affect local businesses and the way in which residents and visitors use and enjoy our town centres.
- 71% of assault presentations in A&E involve alcohol, and the timing of these incidents follows the pattern of the weekend and Night Time Economy, with hotspots for alcohol related violence in specific town centres.
- Problem alcohol use is the most prevalent issue amongst supervised offenders assessed as most likely to reoffend (69% of offenders). This rises to 83% amongst violent offenders; but these offenders are less likely than drug using offenders to be engaged with treatment services.
- There is a need for increased use of accredited alcohol identification tools in criminal justice settings, where 69% of offenders contacted in Police custody said that alcohol was a factor in their arrest; in Court, targeted sentences involving alcohol interventions in the community have reduced individuals' violence and reoffending in Cornwall.
- There were a total of 2,769 offences recorded as linked to alcohol in 2010/11, making up just under half of all recorded violent crime. Domestic violence is slightly more likely to be alcohol-related than non-domestic violence at 51%.

Domestic Violence:

- 29% of all alcohol related violence in Cornwall in 2010/11 was recorded as domestic violence.
- Domestic violence usually involves a female victim (78%), although the proportion of male victims has

slightly increased to around 20% over the last two years.

- Domestic violence is slightly more likely to be alcohol-related than non-domestic violence (51% compared with 47%). This does not prove alcohol as the cause of domestic violence, as the correlation is complex.

Drugs Intervention Programme (DIP):

Criminal justice referrals into community treatment services have increased but remain **substantially below national and regional averages**.

Performance reports for our local DIP indicate that the level of engagement with offenders in Cornwall is lower than would be expected in comparison with the national picture. This has consistently been the case since the Adult Drug Treatment Needs Assessments began in 2006. The latest reports from the National Drug Treatment Monitoring System (NDTMS) also indicate that we are also less successful than average at getting them through the treatment system successfully.

30% of adult offenders with alcohol problems and 45% with drug problems engaged with community treatment services (last 17 months); **the majority therefore are not engaged**.

Drug users and PPOs:

Our local cohort of known drug using offenders is much smaller than the national average (2% of adult offenders compared with 12%) and this may be an issue of identification as well as actual prevalence of drug use amongst offenders. PPO cohorts, by their nature, account for only a small proportion of the total offender population and in Cornwall this is 1%.

Due to the small numbers involved, trends are interpreted with caution.

- The proportion of offenders that commit further offences and the number of re-offences committed per offender was similar to the national average for both the drug using and PPO cohorts.
- Between July 2009 and June 2010, almost 60% of the 71 drug using offenders identified reoffended and they committed almost twice the number of re-offences per offender than the average adult offender.
- The proportion that reoffend has remained fairly static when viewed over the longer term but an increase of 0.8 percentage points was noted in the last 12 months.
- In the same period, 30 out of our 40 PPOs reoffended and they committed an average of 5.4 offences each.

What we are doing:

We deliver an alcohol related Court Requirement aimed at low level violence. Probation work with groups of offenders, helping them to understand the consequences of their actions for themselves and other people. This has resulted in a proven track record of reduced violent and other offences.

Another Court Order targets dependent drinkers, taking individuals who have not previously voluntarily engaged with help on offer, and providing increased support as they enter alcohol treatment.

We are improving the alcohol identification and advice services offered in the Criminal Justice System, in line with the alcohol identification and advice toolkit mentioned earlier. This will be used by Probation, Arrest Referral, and other criminal justice services within the Turnaround scheme, in line with the national Integrated Offender Management model.

We deliver services in courts and custody suites through the Drug Intervention Programme to engage people with alcohol & drug problems who are not already in treatment and deliver a Drug Rehabilitation Requirement treatment order for offenders dependent upon opiates.

- As we know that Domestic Abuse and Sexual Violence services and Alcohol and Substance Misuse services have clients and families in common, we ran a series of training and networking events. This began the process of building a common understanding and improved connections between these services, creating more consistent assessments and referral pathways.
- Alcohol and Substance Misuse services now participate in the Multi Agency Risk Assessment Conferences (MARAC) which works to identify and care plan the highest risk domestic abuse cases in partnership. Cases have now started to be addressed in a more coherent way, with improved cross referencing between the case management systems in each service area.
- We have an excellent established network of services in Cornwall (such as the Independent Domestic Violence Advocacy service) supporting victims of domestic abuse and their families, with a view to helping them to improve their safety, recover and move on. Staff in these services have been prioritised in the alcohol Identification and Brief Advice training, allowing them to identify alcohol problems, work with these issues, and refer to appropriate services where necessary.

What we aim to do:

TurnAround Integrated Offender Management

Integrated Offender Management (IOM) builds on previous multi-agency work with PPOs and drug-using offenders through the Drugs Intervention Programme (DIP), and both of these programmes have been brought into TurnAround.

- Introducing IBA for all offenders to screen for alcohol problems
- Broaden the Drug Intervention programme (DIP) locally to consider the wider interface between substance misuse and offending, there are a number of areas where need is either not being met or being met in a limited way, including:
- Substance misusers (both in treatment and not) prior to their CJS involvement
- Alcohol misusing offenders not otherwise in programmes (e.g. not under ATR, PPO, DRR, DIP, etc)
- Offenders misusing drugs other than opiates and stimulants (e.g. solvents, alcohol)
- Ex-prisoners who are not opiate or crack/cocaine users
- Substance misusing offenders no longer under any kind of licence, e.g. some ex-prisoners, ex-DRRs, etc
- Further develop active police involvement in arrest referral and feeding into TurnAround
- Assertive outreach approaches, including gate ‘pick-ups’ for prisoners being released
- Agree if and how ex-prisoners on licence are monitored
- Ensure TurnAround service users are involved in all developments involving peer support
- Further strategic development and oversight of offender health and associated pathways
- Links and pathways to be developed between alcohol provision and domestic abuse and anti-social

behaviour provision

- Ensure mental health pathways and provision are integrated into TurnAround planning
- Ensure safeguarding for children of substance misusers has a sufficiently high profile in TurnAround planning.
- Maintain the benefits of integration and co-location within a dual-site approach for TurnAround/DIP
- Continue to improve the evidence gathered from our alcohol related criminal justice interventions, such as community sentences and the Alcohol Arrest Referral scheme, to demonstrate value to the community via reduced reoffending rates;
- Improve the screening and referral tools used within the Criminal Justice System and TurnAround and increase the capacity for criminal justice alcohol interventions;
- Contribute to the South West Public Health Observatory target for increasing the rate of care planned alcohol interventions for offenders in the South West.
- Create better linkage between Criminal Justice System alcohol interventions, the alcohol treatment system, and anti-social behaviour interventions, in order to reduce alcohol related harm and offences.
- Continue the development of a care co-ordination approach between alcohol and substance misuse services, criminal justice agencies, and service users.
- Improve the use of the Alcohol Diversion Scheme run by Druglink, in order to increase the proportion of relevant offenders offered the scheme, and to maximise its impact in reducing alcohol related reoffending.
- Continue to network domestic abuse and substance misuse services together to create consistent assessment and screening processes for alcohol, drugs and domestic abuse and sexual violence issues in all the relevant services.
- Continue to integrate alcohol and substance misuse services into the MARAC process, to improve referral pathways between alcohol, drugs and domestic abuse and sexual violence services.
- Continued training for frontline staff in settings addressing domestic abuse and sexual violence, so that they are able to use alcohol identification and brief advice tools with confidence.
- Make alcohol Identification and Brief Advice standard in IDVAs and Domestic Abuse services.
- Continue the development of a care co-ordination approach between alcohol and substance misuse services, domestic abuse service providers, and service users.
- Establish improved cross referencing between the case management systems in domestic abuse and substance misuse services, in order to facilitate effective multi-agency working in vulnerable families.
- Continue to improve the A&E alcohol identification culture and pathways for adults and young people, in order to identify and respond to domestic abuse cases as they present at A&E.
- Seek funding to extend the ARID system for gathering information about the location, nature and sources of alcohol related violence into the Minor Injury Units in Cornwall, in order to generate a consistent and thorough picture across the whole of Cornwall.
- Work with other A&Es serving Cornwall (Derriford and Barnstable) to share data about the location, nature and sources of alcohol related violence, in order to generate a consistent and thorough picture across the whole of Devon and Cornwall.

Outcome 5: Sustained Employment:

Local drug and alcohol services need to ensure that they continue to work closely with Jobcentre Plus to address the employment related needs of people in treatment. The Work Programme was launched in June 2011 and replaces much of the previous employment support provision, including Progress to Work and it is important for Work Programme providers to deliver appropriate levels of support to people with substance misuse issues, integrating this with local treatment provision.

In addition in Cornwall, If you are over 16, not working and someone in your family is getting a benefit from Job Centre Plus, then Cornwall Works for Families can help. They provide 12 months of support and a further 6 months in work support to help you overcome any barriers to finding and sustaining employment.

Routes to JC+ and Cornwall Works for Families are within the pathway to move clients closer to the labour market.

What we know:

- The most recent studies commissioned by the Department for Work and Pensions estimate that there are approximately 267,000 opiate and/or crack users and 160,000 dependent alcohol users accessing the main DWP benefits in England. Routes into work are a key feature of recovery. There are very clear benefits to the individual in getting a job, with the employment helping to sustain the gains that are made whilst in treatment.
- Alcohol problems can affect people's ability to enter and remain in work, especially if they are disqualified from driving. Although people in alcohol treatment are more likely than drug users to be in regular employment – 19% compared with 9% of drug users, an estimated 90,000 to 140,000 working days were lost in Cornwall due to alcohol related sickness in 2007; parts of Cornwall were also amongst the highest in the country for incapacity benefit claims due to alcohol.
- The CAB recorded a 56% increase in clients presenting with debt issues between 2007 and 2010, as well as a related 86% increase in problems with benefits. Of these, 15% of single people and carers also reported turning to alcohol or drugs as a means of escape, thereby adding to their financial pressure.
- In a survey of Migrant Workers in Cornwall it was found that 29% are not registered with a GP. As Primary Care is the main starting point for a range of treatment options and pathways, this must act as a barrier to alcohol treatment pathways. Over a third of respondents stated that they drank more in Cornwall than they had in their country of origin, with 6% of those asked admitting to drinking daily. As 40% declined to answer how often they drank in a week the real figure will be much higher. Very few migrant workers are accessing treatment services, with huge issues such as translation to overcome.
- 22% of people in treatment in CIOS in 2010/11 undertook one or more days of paid work in the 28 days prior to a review, with a mean number of days worked of 18 days. This is a 3% rise on last year
- 9% were recorded as having attended school or college on one or more days in the 28 days prior to a review. The mean number of days is 9 days, although the most common is 4 days. Again this is up 3% on last year

What we are doing:

- As unemployment can be related to alcohol issues, staff from Cornwall's Job Centres have been prioritised in the alcohol Identification and Brief Advice training. This has trained them to use proven IBA tools, giving them confidence in raising the subject in their normal appointments, providing supportive interventions, and where necessary helping them to refer people for help from relevant specialist services.

- More effective links and pathways were put in place between alcohol and drug treatment services and Job Centre Plus staff to refer substance misusing claimants into treatment from the 27th April 2009. Although it was initially a requirement to refer only opiate and / or crack users (OCUs) into treatment, Addaction as the single point of contact, accepted referrals for all substances, including alcohol.
- We have started to improve volunteer mentor and support services, to increase connections with local social enterprise schemes and training opportunities, as well as minority and under-served groups.
- The Health Promotion team support local employers in training their management and staff in identifying and responding to alcohol issues in their workforce, putting good policies in place to address these issues without endangering employees' careers.
- Gather better information and data about drug and alcohol presentations in employment services in Cornwall through a data collation tool, to enable us to gain evidence to commission early intervention services in the right settings and locations.
- Assist substance misuse services in gathering better information and data about clients' employment issues, to ensure that services identify, understand and address their needs.

What we aim to do:

- Increase referrals from treatment providers to JC+ (TPR2 forms)
- Continue the development of a care co-ordination approach between treatment services, employment service providers, and service users
- Continue to encourage referrals from JC+ into treatment (TPR1 forms)
- Make alcohol Identification and Brief Advice standard in Job Centres, Occupational Health and employment services.
- Improve pathways to alcohol services for Migrant Workers in Cornwall
- Match people in treatment who are eligible with the Cornwall Works for Families programme to develop their skills, confidence and employability
- Increase the education, training and skills components of recovery care planning and regularly review outcomes as a result.
- Continue to develop the employment and training module of the assessment process to more fully understand the needs
- Embrace opportunities for JC+ and other employment providers to explain the range of options available
- Embrace opportunities for JC+ to explain how the Welfare Reforms are expected to impact

Outcome 6: The ability to access suitable accommodation:

Housing has a key role to play in supporting recovery outcomes for people with substance misuse issues and it is important that local Health and Wellbeing Boards address this issue as they become fully operational.

Ensuring access to housing and housing related support services at the different stages of recovery can present a number of challenges for local partners as people may have a range of complex housing-related needs and therefore require a wide range of responses.

An individual may find it difficult to become stable in their treatment programme without access to suitable housing or housing support. They may also find it difficult to sustain their recovery post treatment, without a stable place to live.

What we know:

- The National Drug Treatment Monitoring System annual report for 2010/11 indicates that 9% of clients starting treatment had No Fixed Abode and a further 15% of clients had other housing problems such as staying with friends or family, or living in short-term hostel.
- There is an increase of people presenting to treatment services with housing needs from 19% to 24%.
- 31% of people accessing treatment have accommodation problems.
- 9% of people in treatment in 2010/11 had been at risk of eviction at some point since 01 April 2010 and 16% were recorded as having an acute housing problem. This is consistent with findings the previous year.
- 14% of people who presented to treatment in 2010/11 had an immediate need for accommodation-related support; 4% were homeless and 10% had problems with unsettled or unsuitable accommodation.
- Supported housing provision has yet to be re-commissioned so there continues to be significant gaps in provision for clients at an earlier stage of their recovery journey, particularly for those who may still be using drugs. This remains the single most significant gap in our ability to deliver recovery locally.
- In order to successfully support people through alcohol treatment it is vital that they obtain and remain in suitable accommodation; relapse can often lead to the loss of accommodation, causing problems in maintaining contact with treatment and support.
- One of the key themes highlighted by the service analysis within the SP Substance misuse sector review was the level of unplanned moves from services due to either eviction or abandoned tenancies; this averaged at 35% with roughly half of these due to evictions.
- Anecdotal evidence also indicated that there is a high level of clients representing at one or more services highlighting the “revolving door” syndrome.
- Staff reported that referrals were increasingly received for individuals with more chaotic or complex needs than services were resourced or designed to support effectively, and that people had to be turned away or later evicted for the very issue for which they were seeking support (SP Substance Misuse sector Review, 2011).

What we are doing

- Pathways have been developed for care co-ordinators and key workers to access housing provision for clients who are in housing need and to ensure care co-ordination includes housing providers.
- The accommodation related support services have been mapped across each locality and this

mapping information can be found on the DAAT website.

- Work has been and continues to be undertaken between the FreshStart project, the Probation Service and the DAAT to ensure joint working between organisations that best meets the needs of substance using offenders.
- In addition a Recovery Care Planning (RECAP) pilot has been underway since March 2012 to improve the joint working between Stonham complex needs housing and treatment providers so lessons learned can be rolled out across the treatment system
- Some issues have been identified when clients are, or at risk of becoming homeless on leaving Chy Colom residential rehabilitation project. A solution to this is being considered in Partnership with Cornwall Housing Limited, where potential housing issues are identified at the earliest possible stage and the best solution is sought through joint working with the Housing service.
- Support implementation of the service delivery model evolving from the Supporting People sector reviews In order to reduce evictions and increase successful outcomes in supported housing a range of commissioning recommendations were made following the SP Substance misuse sector review:
- Strategically implemented staged approach with clear pathways towards independent living;
- Services that are tolerant within the limits of the law, with clear eligibility criteria and eviction policies, and staff who are trained in how to minimise evictions in respect of clients' presenting needs;
- Increased provision generally countywide, with particular need in the North and East of the county and to increase Stage 1 and Stage 2 service provision;
- Harm reduction approaches at a strategic level (e.g. wet houses) and at appropriate service/individual level (e.g. Naloxone initiatives, safer injecting training etc.) that recognise that not all clients will be clean and dry;
- Services that can support those with complex needs (particularly those with a dual diagnosis) or for whom a substance misuse specific accommodation based service may not be appropriate or currently widely available (e.g. people with dependent children, 16-17 year olds, older people with other needs, people with pets etc);
- Services that can support older people with substance misuse needs, who may also have mental health needs (dual diagnosis). This client group is increasing client group; service design of substance misuse and older people services needs to be flexible and responsive to ensure these needs can be met regardless of age;

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Promoting recovery

- Services that address clients' holistic needs (practical, emotional, physical), supplemented by specialist staff based at one or more services where appropriate, to help clients build recovery capital to achieve and sustain recovery.
- In order to prepare strategic services and their managers to work with current drug users, training sessions were organised by the DAAT on the 'eyes wide open' approach to supported housing. This was positively received by all statutory services and many provider organisations and addressed some of the myths and bad practice that prevail about Section 8 of the Misuse of Drugs Act.
- Where possible and/or appropriate to jointly commission specialist posts/functions that may serve one or more services, including pre and post tenancy;
- Alternative service delivery model options should be considered when commissioning substance misuse services to help in embedding personalisation. For this sector, a "core and flex" funding model is likely to be the most appropriate solution at this point, offering clients choice and control while ensuring services are able to provide value for money. Feasibly one or two pilots could be trialled to test such an approach.
- Further work is required to explore what more can be done to support individuals to obtain

qualifications to improve their employment prospects and, ultimately, their ability to better support themselves financially.

- Continue to develop the accommodation module of the assessment process to more fully understand the needs of clients, and provide direction to appropriate services.

Outcome 7: Improved Relationships with Families, Partners and Affected others

Evidence shows that treatment is more likely to be effective, and recovery to be sustained, where families, partners and carers are closely involved. A whole family approach to the delivery of recovery services should be taken, and consideration should be made to the provision of support services for families and carers in their own right.

What we know

- Substance misuse is a key risk factor in families with complex multiple problems and vulnerabilities.
- A key factor in recovery for adults is involvement, support and interventions for their families.
- The impact of someone's drink or drug problem on their family and friends is often overlooked, but it's estimated that almost one in five of us are likely to have a family member affected in this way.
- Coping with a loved one's problem drug or alcohol use can take a toll on their family's health, wellbeing, their finances, social lives and relationships with others.
- Evidence suggests that effectively supporting and involving family members and carers can lead to improved outcomes for the whole family.
- For the drug user, effective involvement of family members and carers helps increase the chances of:
  - Entering treatment
  - Reducing or stopping their drug misuse
  - Engaging with treatment if they do enter
  - Being retained in treatment
  - Successfully concluding treatment
  - Drug users are also less likely to suffer major relapses. This leads to better quality of service provision overall.
- There is a strong positive correlation between mental health disorders and domestic abuse incidents where the child is resident. This means that LSOAs that experience high rates of domestic abuse are likely to experience higher rates of mental health disorders.
- There is also a significant relationship between substance misusing parents and mental health disorders. There is a moderate relationship between the two variables, meaning that areas with high percentages of substance misusing parents may also have high rates of mental health disorders.
- The relationship between substance misusing parents and domestic abuse incidents is also significant, although it is weaker than between other variables.
- **Best and Gilman (2010)** have argued that the growth of recovery has a ripple effect that confers benefits on families but also serves to generate 'collective recovery capital' that provides support and hope for those in recovery and that engages people in a range of activities in the local community.
- This process translates into active participation in community life and 'giving something back' by creating a collective commitment in recovery groups to community engagement and immersion. In other words, the recovery community acts and is seen as a positive force in the local community and a resource for that community that goes beyond managing substance misuse issues.

What we are doing:

- We have a wide range of interventions in Cornwall that are tailored to the needs of different family types. Interventions are both for the individual (parenting for example) and collective (family group work) **Telephone advice**, and **drop-in information and support** is available to people affected by

someone else's drug use through Addaction and Freshfield services.

- **Family groups** are available in Liskeard, Truro and Penzance on a weekly basis.
- **Breaking the Cycle pilot sites** have been jointly funded by Zurich International for 3 years in partnership with Addaction to deliver family support, including:
    - Prioritisation, assessment and care planning
    - A range of motivational and solution focused interventions
    - Advice and information
    - One-to-one and family support
    - Group work
    - Family mediation
    - Signposting
    - Advocacy
    - Home visits
    - Work with children through coordination with partner agencies and schools
    - Systemic family therapy

- Breaking the Cycle seeks to achieve **three key outcomes**:
    1. Reduction in the number of parents and children at risk of the significant harm associated with problematic substance use.
    2. Improvement in family functioning.
    3. Improvement in the health and wellbeing of parents and their children.

- **Family Conferencing** has been introduced into Chy Colom to improve outcomes for those leaving residential rehabilitation, by involving families prior to completion, to facilitate resolution of outstanding or pertaining issues.

    Aim:

    To improve the outcomes for children and families affected by substance misuse through:

    - Training staff in services for children and families in screening and identification for substance use
    - Establish a single point of contact and pathways into treatment
    - Increasing joint working between children, families and treatment services
    - Delivery of parenting and family interventions for families affected by substance misuse

- **Troubled Families:** In December 2011, the government announced a new, determined, cross-government drive intended to turn around the lives of 120,000 of some of the country's most "troubled" families by the end of this Parliament.

A troubled family is one that has serious problems and causes serious problems. Typically in these families, there will be a range of factors including parents out of work, mental health problems, truanting and exclusion from school, family involvement in crime and anti-social behaviour and high demand placed on local services in routinely responding to these problems. New figures from national research indicate that troubled families cost an

estimated £75,000 per family per year.

- **The headline goals and the areas in which success will be measured are:**
  - Children back into school
  - Parents on the road back to work
  - Reduced crime and anti-social behaviour
  - Reduced costs to the taxpayer and local authorities.

DCLG have provided local authorities with the estimated number of troubled families based on indicative numbers from the Indices of Multiple Deprivation and Child Deprivation Index.

In Cornwall it is estimated that our cohort size is **1,270 families**. We are in the process of confirming this figure with our local data across the three key themes (out of school, out of work and involved in crime / anti-social behaviour) with a view to identifying the actual cohort that the programme will work with by the end of March. This will form part of the business case to DCLG that is required to commence the programme.

- **Cornwall Works With Families**

Prior to this announcement, the Department of Work and Pensions announced that some European Social Fund funding will be used to help some of the country's most disadvantaged families get back on their feet and into jobs. This programme, which locally is called Cornwall Works With Families, provides targeted and personal support to families where the parents are out of work. There are four lead providers who provide the keyworker role and co-ordinate the family action plan, working alongside the local authority and a range of other organisations to deliver programmes designed to overcome barriers to employment.

These include:

- Better parenting and improving family relationships
- Mentoring
- Tackling addiction
- Money management
- Work tasters, work placements and internships
- Healthy living and life skills
- Tackling social exclusion
- Building confidence and motivation

The DWP Programme has subsequently been brought in under the overall umbrella of the Troubled Families Programme. To ensure that these work streams are integrated, both with each other and with other key programmes, the criteria for prioritising families will include mapping against the locally developed Complex Families Index (discussed in detail in the next section) and cross-referencing with the TurnAround cohort and the Neighbourhood Harm Register.

Outcome 8: The Capacity to be an effective and caring parent:

What we know

- The National Drug Treatment Monitoring System (NDTMS) estimates one-third of the treatment population as having parental responsibility for children. Many of these families require specialist support to help them stabilise, keep children safe, and maximise the life chances of those affected by substance misuse.
- It is vital that services provide effective responses for those with parental responsibilities who need treatment. This will be crucial to strengthening these families and protecting children from harm and damaged futures, particularly when delivered within a whole family approach and in collaboration with children's and adults social care.
- Parental drug use, along with poor parental mental health and domestic abuse, is a factor in around two-thirds of child protection cases and Serious Case Reviews. Parental involvement in the criminal justice system is also a risk factor (162,000 children have a parent in prison).
- There is a strong positive correlation between mental health disorders and domestic abuse incidents where the child is resident. This means that LSOAs that experience high rates of domestic abuse are likely to experience higher rates of mental health disorders.
- There is also a significant relationship between substance misusing parents and mental health disorders. There is a moderate relationship between the two variables, meaning that areas with high percentages of substance misusing parents may also have high rates of mental health disorders.
- The relationship between substance misusing parents and domestic abuse incidents is also significant, although it is weaker than between other variables.

What we are doing

- We have a wide range of interventions in Cornwall that are tailored to the needs of different family types. Interventions are both for the individual (parenting for example) and collective (family group work), moving us towards a comprehensive family work programme;
- The DAAT Local Protocol between Drug and Alcohol Treatment Services and Children Schools and Family Services (CFS) 'Working Together to Safeguard Children', describes the joint working relationship between treatment and CFS.
- We have introduced a Single Point of Contact in treatment services to liaise with CFS and steer joint working and resolution of any issues arising outside of the protocol.
- Dedicating staff to work in the new multi-agency Referral Unit to advise and develop joint approaches.
- Trained staff in treatment services in the Solihull Parenting programme, which is now delivered in treatment services and available to all parents in treatment.
- Safeguarding audits are carried out with all commissioned specialist alcohol and drug treatment providers on a quarterly basis.
- Improving screening and assessment of alcohol and drug problems in Children and Families services and referrals to the treatment system.
- **Breaking the Cycle** pilot sites have been jointly funded by Zurich International for 3 years in partnership with Addaction to deliver family support, including:
    - Prioritisation, assessment and care planning
    - A range of motivational and solution focused interventions

- Advice and information
- One-to-one and family support
- Group work
- Family mediation
- Signposting
- Advocacy
- Home visits
- Work with children through coordination with partner agencies and schools
- Systemic family therapy

- Breaking the Cycle seeks to achieve three key outcomes:
  - Reduction in the number of parents and children at risk of the significant harm associated with problematic substance use.
  - Improvement in family functioning.
  - Improvement in the health and wellbeing of parents and their children.
- Family Conferencing has been introduced into Chy Colom residential service to improve outcomes for those leaving residential rehabilitation, by involving families prior to completion, to facilitate resolution of outstanding or pertaining issues.

What we aim to do:

- To improve the outcomes for children and families affected by substance misuse through:
  - Training staff in services for children and families in screening and identification for substance use
  - Increasing joint working between children, families and treatment services
  - Delivery of parenting and family interventions for families affected by substance misuse improve the use of CAFs with families
  - Improve joint care planning between Children and Families Services and Alcohol and drug treatment services

Outcome 9: Delivering value for money

What we know:

- The Cost Effectiveness Tool (CET) brings together 2010/11 expenditure, output and outcomes data from areas across England enabling Partnerships to determine the cost effectiveness of all the treatment pathways within their treatment system. The CET also facilitates comparisons against national averages, and the average for the best performing areas (Top quartile areas).

Expenditure

- Expenditure for 2010-11 is set out below. While all treatment costs were collected, the CET has only used the expenditure from the six structured interventions (highlighted in bold) to cost the treatment pathways.

Expenditure profile	Expenditure	Cornwall & IoS %	National %
1. Structured community prescribing	£3,299,519	39.2%	27.8%
2. Structured community day programmes	£214,028	2.5%	4.9%
3. Structured community psychosocial interventions	£554,474	6.6%	7.9%
4. Other structured drug treatment	£134,930	1.6%	6.8%
5. Inpatient treatment	£222,000	2.6%	3.3%
6. Residential rehabilitation	£209,930	2.5%	3.9%
7. Alcohol services	£1,949,370	23.2%	9.5%
8. Unstructured treatment (formerly Tier 2)	£348,977	4.2%	8.6%
9. Drug Interventions Programme (DIP)	£820,088	9.8%	11.4%
10. Prison based drug treatment	£0	0.0%	5.7%
11. Treatment overhead costs	£613,560	7.3%	8.7%
12. Below the line	£40,000	0.5%	0.3%
Total	**£8,406,876**	**100%**	**100%**

COST PER DAY

In the CET, the cost per day of the six treatment interventions is used to calculate the cost of each treatment pathway. The cost per day has been calculated by dividing the treatment intervention expenditure by the total number of days clients received that intervention in 2010-11. We have adjusted the cost per day using the Department of Health's Market Forces Factor to account for the unavoidable cost variations of providing drug treatment in different Partnership localities. Adjusting for such differences ensures a level basis across the country when making comparisons.

The cost per day is just one building block in the CET to help Partnerships understand the value for money of their treatment system. It should not be used on its own to make judgements about the treatment system, but rather in combination with information on local outcomes.

EXPENDITURE PROFILE	COST PER DAY		
	Cornwall & Isles of Scilly	Top quartile	National
1. Structured community prescribing	£10.10	£4.88	£5.43
2. Structured community day programmes	£5.20	£11.24	£20.78
3. Structured community psychosocial interventions	£10.44	£7.22	£10.47
4. Other structured drug treatment	£2.91	£6.54	£11.22
5. Inpatient treatment	£108.31	£343.76	£357.05
6. Residential rehabilitation	£43.32	£155.13	£145.66

What we are doing:

- Investment in 2012-13 has been slightly re-balanced to increase the availability of structured daily activities in localities to provide increased support for recovery.
- This includes:
    - One daily programme per locality base
    - Pre and post detox groups and programmes to make better use of detoxification by ensuring better preparation and a consistent level of aftercare to maximise the gains made.
    - The introduction of 'Breaking Free Online' as an online resource to support recovery goals.
    - Intuitive Recovery classes, an accredited and certified course for service users.
    - Increasing the availability of community detoxification for drug users in particular

What we aim to do

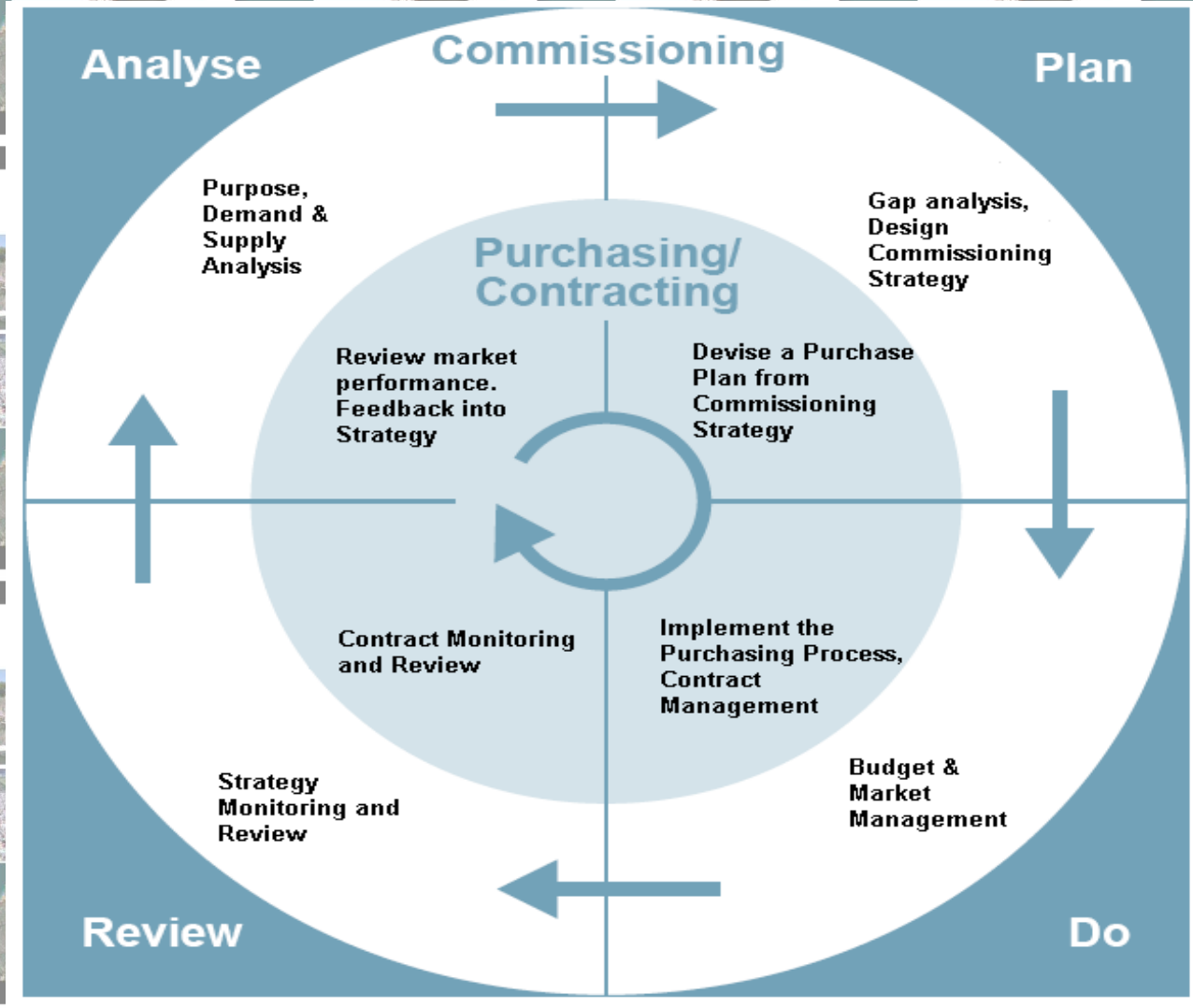
- The high day costs of community specialist prescribing continue to be a priority to reduce, despite the efficiencies delivered over the past 3 years.
- Increasing the preparation and aftercare support available to maximise the effectiveness of structured treatment, the gains from treatment and promote sustainable recovery
- Deliver the full range of structured psychosocial interventions described by NICE
- Review the provision of specialist prescribing interventions in the light of the publication of 'Medications in Recovery' (NTA, 2012)

References, Resources and Background Reading:

Appendix 1 IC Model of Commissioning

(NHS Health and Social Information Centre 2008)

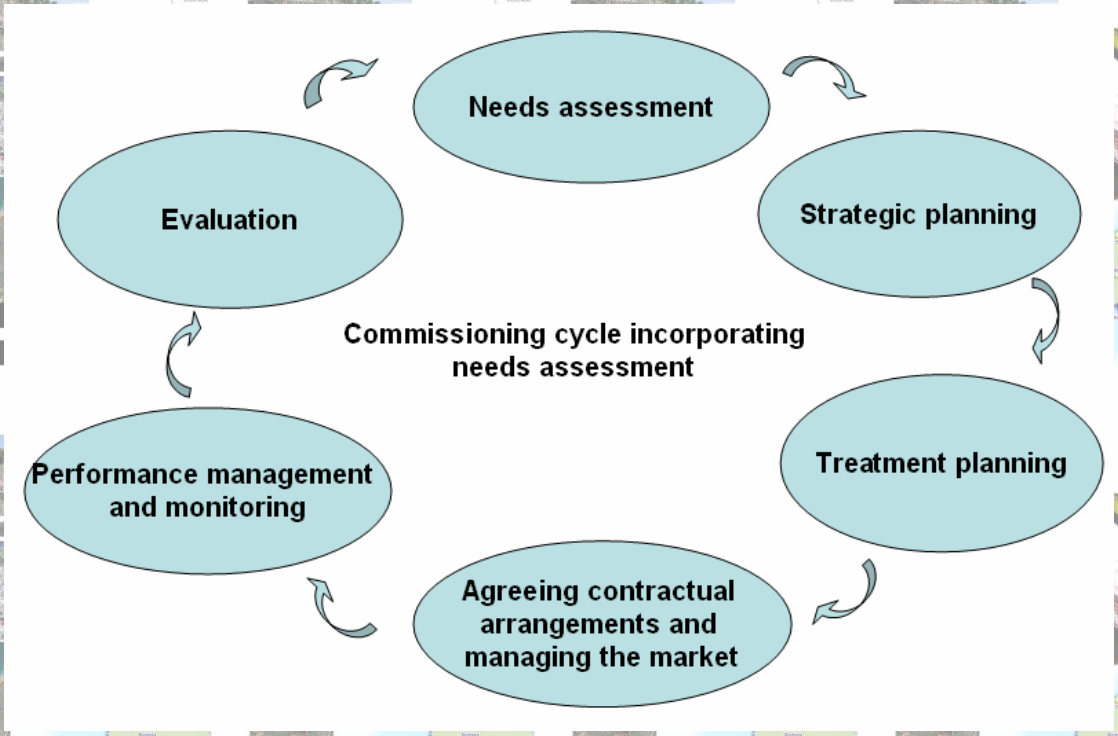
Appendix 2 IPC Model of Commissioning



Appendix 3

Involving Service Users and Carers at Every Stage of Commissioning

The Commissioning Cycle- Involving Service Users at every stage of commissioning



1. Service Users & Needs Assessment

Are service users represented at the Expert Advisory group for Needs Assessment?

Have representatives been selected according to their skills and abilities with regard to information and analysis?

Have representatives been trained and enabled to participate in Needs Assessment processes?

Are service users involved in setting questions/hypotheses to test through the needs assessment process?

Are service user surveys and focus groups carried out to test needs assessment findings?

Are service users consulted with regard to the findings of the needs assessment?

2. Strategic Planning

Are service users trained, supported and enabled to participate at the strategic level?

Are service users represented at/involved in the Strategic Partnership level?

Has the partnership mapped how service user views will be comprehensively involved in strategic planning?

Are service users involved in setting strategic priorities?

3. The Treatment Plan/Commissioning plans[3]

Are service users involved in drawing up the Commissioning plan?

Does the plan include a plan for service user involvement and representation?

[3] In commissioning terms, for drugs and alcohol, the 'Treatment Plan' is the title given to the Commissioning plan

Are service users consulted at each stage of planning?

Would service users recognise the CIOS Plan if it were presented anonymously along with the plans of other partnerships?

Are service users involved in reviewing progress against targets within the plan?

Are service users trained, supported and enabled to participate in planning?

Is involvement truly representative across the strands of equality and diversity?

4. Agreeing contractual arrangement and managing markets

Are SUs trained and supported to be able to participate in tendering, contracting, procurement and market management?

Are SUs involved in tendering processes from the start of the process (design)?

Are service users represented on panels to award contracts?

Are SUs involved in exploring innovative ways of stimulating the market?

Is a requirement re: user involvement part of every contract?

5. Performance Management and Monitoring

Are SUs trained, supported and developed to participate in performance management, review and monitoring?

Are SUs involved in reviewing performance with providers?

Do performance reviews include a review of SU involvement in the agency, structured formal feedback from SUs, actions taken as a result of user consultation or complaints?

6. Evaluation/Review

Are SUs trained, supported and the sustainability of their involvement developed to be able to participate in evaluation, as with all other stages of the commissioning process?

Are SUs involved in setting evaluation criteria and evaluating services and plans?

Is service user involvement and representativeness evaluated on an annual basis?

Are the findings from any evaluation fed back into the needs assessment, planning and delivery processes?

7. Training, development and support

Are service users trained to be able to be involved and representative?

What initiatives have been taken to develop their skills and abilities in year?

How are service users supported in their development?

What are the indicators of a sustainable service user body?

8. Representative-ess

How do we ensure SUs comprehensively represent the views of people using treatment, who have used treatment and would like to use treatment?

- Gender
- Age
- Locality
- Mental Health problems
- Substance
- Disability
- Ethnicity

REFERENCES

Commissioning for Recovery

- Recovery-orientated drug treatment: an interim report by Professor John Strang, chair of the expert group [NTA, 2011]

Looks at how opioid substitution and other treatments can have a clearer recovery-orientation. Recommends 12 immediate steps. With further detail in:

- Medications in Recovery- Reorienting Drug Dependence Treatment (NTA, 2012) http://www.nta.nhs.uk/uploads/medications-in-recovery-main-report.pdf,

- JSNA support pack for commissioners [NTA, 2012] PDF (210kb)

Intended to support the development of local recovery-oriented treatment planning and delivery during 2012-13, this document sets out a range of principles and operational prompts to assist local areas in planning integrated approaches to recovery. Local treatment systems will be most effective where they are developed in response to local need and integrated with new Joint Health and Wellbeing Strategies.

- Drug misuse and dependence: UK guidelines on clinical management [DH & devolved administrations, 2007]

Guidance (based on evidence and professional consensus) on drug treatment in the UK. It looks at clinical governance, treatment provision, psychosocial and pharmacological treatment interventions, and health considerations.

- Drug misuse: psychosocial interventions (NICE clinical guideline 51) (NICE, 2007)

An essential guide for the implementation of evidence based psychosocial interventions for treating people who misuse opioids, stimulants and cannabis.

- Recovery-orientated methadone maintenance [White WL and Mojer-Torres L, 2010]

Reviews the history and context of methadone maintenance treatment, and its place within a recovery-orientated system

- Residential drug treatment services: good practice in the field [NTA, 2009]

This report highlights good practice in commissioning and providing effective Tier 4 services. It is based on interviews with local drug partnerships and treatment services that performed well in the 2007-08 service review on Tier 4, carried out by the NTA and Healthcare Commission.

- Methadone & buprenorphine for the management of opioid dependence (NICE technology appraisal guidance 114) (NICE, March 2010)

Recommends methadone and buprenorphine as first line medicines for maintenance options in the management of opioid dependence. It includes information on evidence, implementation, clinical need and practice

- Drug misuse: opioid detoxification (NICE clinical guideline 52) (NICE, July 2007)

Evidence-based recommendations to ensure that people are detoxified from opioid drugs safely and effectively in the community, inpatient units, residential and prisons.

Quality Innovation Productivity and Prevention (QIPP)

The Government's 2010 White Paper, 'Equity and Excellence: Liberating the NHS' recognises the financial challenges the NHS faces and the role Quality Innovation Productivity and Prevention (QIPP) will play in supporting the NHS in identifying efficiencies whilst driving up quality.

There are a number of national workstreams designed to help NHS staff successfully deliver these changes in three key areas, commissioning and pathways, provider efficiency and system enablers. Within each SHA, QIPP Leads have been appointed to develop a regional response to the quality and productivity challenge.

A Reduction in Crime and Re-offending

- Breaking the link: the role of drug treatment in tackling crime [NTA, 2010]

It is well known that effective drug treatment can have a positive impact on reducing drug related crime. Here, the link between drug and crime is examined and the evidence supporting the effectiveness of prison based drug treatment is summarised. Although some of the data is historical, the key points remain relevant.

- Breaking the cycle: effective punishment, rehabilitation and sentencing of offenders [Ministry of Justice, 2010]

- Reducing drug-related crime and rehabilitating offenders. recovery and rehabilitation for drug users in prison and on release: recommendations for action [Patel, Prof. Lord, 2010]

Sets out a vision for a more recovery based, locally commissioned and outcome focused approach to prison based treatment. Includes a comprehensive examination of the evidence base and proposed outcome framework that is heavily influencing the commissioning and re-tendering of prison based treatment.

Offender Health and Identification and Brief Advice (IBA)NOMS 2008

Screening for alcohol problems, using the Offender Assessment System (OASys) and a validated alcohol screening tool, such as the Alcohol Use Disorders Identification Test (AUDIT), is quick. So are brief interventions. Both require minimal training. There is significant evidence that early detection and intervention is effective in reducing alcohol-related harm. (NOMS 2008)

Pilot programme to examine the effectiveness of Offender Health Trainers in delivering 'Brief Advice' for alcohol harm-reduction

PCT's are being encouraged to make strides in implementing "High Impact Changes " to impact on the rate of alcohol hospital admissions. This includes:

"Developing Identification and Brief Advice (IBA) in criminal justice by persuading the Crime Reduction Partnerships of the importance of IBA to delivering crime reduction and savings across the public sector".

- Clinical management of drug dependence in the adult prison setting [DH, 2006]

A key document setting out a framework and providing guidance for the implementation of evidence based clinical and psychosocial drug treatment interventions throughout the English prison estate. It underpinned the development and implementation of the Integrated Drug Treatment System (IDTS) between 2006-2010. Updated in March 2010 setting out the Government's position on the use of maintenance prescribing and clinical review for longer term prisoners.

Setting out the government's vision for a recovery oriented approach to prison based drug treatment the NOMS Green Paper, published shortly after the 2010 Drug Strategy, introduces the concept of drug recovery wings and promotes the development of alternatives to custody, including enhanced community sentences for drug misusing offenders.

Preventing BBVs

- Drug misuse and dependence: UK guidelines on clinical management [DH & devolved administrations, 2007]

Provides comprehensive guidance for the UK drug treatment workforce on drug misuse treatment, including evidence-based measures to prevent drug-related deaths and blood-borne virus transmission. These include guidance on blood-borne virus testing, diagnosis and treatment, overdose prevention and training, and access to needle and syringe programmes.

- Needle and syringe programmes: providing people who inject drugs with injecting equipment (NICE public health guidance 18) [NICE, February 2009]

Needle and syringe programmes (NSPs) are vital in preventing the spread of blood-borne viruses. This is NICE's formal guidance for optimal NSP provision. The six recommendations relate to over-

18 injectors of illicit substances and non-prescribed anabolic steroids. It will help local areas provide appropriate public health services for injectors.

- Drug-related deaths: setting up a local review process [NTA, 2011]

Reviewing the causes of drug-related deaths can make a vital contribution to preventing future deaths. This document contains ideas and examples of local practice in reviewing drug-related deaths. It is for people who commission and plan local strategic responses to drug misuse, including service providers.

- Unlinked anonymous monitoring survey of people who inject drugs (PWID) [HPA, 2011]

Blood-borne virus surveillance is key for understanding the level and type of response needed for injectors at risk. The annual survey measures injectors' blood-borne virus prevalence, and risk and protective behaviours. The data are used to develop preventative and health education campaigns, evaluate their impact, and assist in service provision.

- The NTA overdose and naloxone training programme for families and carers [NTA, 2011]

Naloxone can be part of local responses to prevent drug-related deaths. The NTA naloxone programme found that naloxone provision is beneficial for carers and service users, and may prevent drug-related deaths. The report describes the evaluation findings, including the benefits of, and challenges in local naloxone provision.

- Deaths related to drug poisoning in England and Wales, 2010 [ONS, 2011]

Understanding trends in drug-related deaths is important, for determining the type and level of response to prevent future deaths. This annual report presents official statistics for England and Wales on deaths related to drug poisoning and drug misuse, by cause of death, sex, age and substance(s) involved.

- Hepatitis C in the UK: 2011 report [HPA, 2011]

Drug injectors are at risk of contracting hepatitis C. The HPA's annual reports provide current surveillance data and evidence on hepatitis C incidence and prevalence, access to treatment, and recommendations for prevention, diagnosis and treatment.

- Good practice in harm reduction [NTA, 2008]

Highlights good practice in preventing drug related deaths and blood borne viruses based on the results of a 2006-7 NTA/Healthcare Commission service review.

Sustained Employment

- Joint-working protocol between Jobcentre Plus and treatment providers [NTA, 2010]

The 'Joint-working protocol between Jobcentre Plus and treatment providers' [NTA, 2010] is being updated to reflect changes in JCP's operational model and to include the Work Programme providers within the customer journey. The revised protocol will be jointly agreed with DWP by Summer 2012 and will be uploaded to the Recovery Resources website then.

- Working towards recovery: getting problem drug users into jobs [UKDPC, 2008]

Focuses on getting problem drug users 'fit for the job', enabling employers to manage any

perceived risks in employing ex-drug users (including those still on opioid substitution treatment), and addressing the stigma associated with drug use. Also raises the possibility of legal protection and small financial incentives for employers.

The Ability to access suitable accommodation

- Clean break [Homeless Link, 2008]

A toolkit developed to assist commissioners, service providers and strategic leads for drug and housing services. It focuses on creating more integrated housing and care pathways for those engaging in treatment.

- A guide to improving practice in housing for drug users [Home Office, 2009]

Offers an insight into the development, planning and delivery of housing and related support service for drug users. Includes new ways of joined up working to improve practice.

- Drug misuse and dependence: UK guidelines on clinical management [DH & devolved administrations, 2007]

Guidance on the treatment of drug misuse in the UK. Highlights the role that treatment has in addressing the mental and physical health needs of drug users and improving wellbeing. Specifies the goals of treatment, the processes by which they may be achieved and the range of harm reduction, physical health and psychosocial interventions that can achieve them.

- Drug misuse: psychosocial interventions (NICE clinical guideline 51) [NICE, 2007]

Recommended psychosocial interventions for drug misuse. States that psychological interventions for co-existing common mental health problems are effective and should be available for people with drug problems. These interventions should be in line with the general NICE recommended interventions for common mental health problems. Highlights the value of brief opportunistic motivational interventions for clients not in formal treatment to achieve physical health improvements.

- Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE Guidance 115) [NICE 2011]

Recommended interventions for alcohol dependence and harmful drinking. States that treatment for co-existing common mental health problems is effective and should be available for people with alcohol problems when problems persist following treatment for alcohol problems. This treatment should be in line with the general NICE recommended interventions for common mental health problems.

- Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications (NICE clinical guideline 100) [NICE, 2010]

Recommended interventions for key alcohol related physical health conditions including the treatment of alcohol related liver disease and alcohol related pancreatitis. The guidance recommends hospital (or similar) based medical treatment for those in acute alcohol withdrawal assessed to be at high risk of alcohol withdrawal seizures or delirium tremens.

- Alcohol-use disorders - preventing harmful drinking (public health guidance 24) [NICE, 2010]

Public health guidance on preventing alcohol related physical and mental health harms. Public health guidance aims to reduce overall levels of alcohol consumption and therefore lower whole

population risk of harm. The guidance includes three policy recommendations; price, availability and marketing and nine practice recommendations including: screening, structured brief advice and extended brief interventions.

- Mental health policy implementation guide: dual diagnosis good practice guide [DH, 2002]

Substance misuse is common among people with severe mental health problems, and mental health problems are common among those with substance misuse problems. This guide summarises policy and good practice for providing mental health services to people with severe mental health problems and problematic substance misuse.

- Dual diagnosis in mental health inpatient and day hospital settings [DH, 2006]

Many mental health patients also have substance misuse problems, so mental health service staff need to be skilled to provide simple prevention and treatment interventions, assisted by drug and alcohol specialists. This guidance covers the key principles and points that local policies and procedures should address to achieve this.

Improved Relationships with Families, Partners and Affected others

In addition to the guidance and evidence listed here, the Alcohol Learning Centre is a well developed resource. For more information see the Children and young people section of the Topics and Resources page.

- Think family: improving the life chances of families at risk [Cabinet Office, 2008]

Looks at the notion of 'thinking family' in the delivery of adult services. The document emphasises the wider needs of adults, such as family circumstances, and the difference this can have on their life chances and those of their family and children.

- Supporting and involving carers: A guide for commissioners and providers [NTA, 2008]

Produced to improve services for families and carers, this guidance is for those involved in the planning, commissioning and delivery of services for families and carers, and drug treatment services. The document covers commissioning themes, developing services specific to families and carers, and involving families and carers in drug users' treatment.

- NTA guidance for local partnerships on user and carer involvement [NTA, 2006]

Highlights the need for and principles behind user and carer involvement, and the importance of this involvement at a regional and partnership level, as well as in reviewing treatment plans.

The Capacity to be an effective and caring parent

In addition to the guidance and evidence listed here, the Alcohol Learning Centre is a well developed resource. For more information see the Children and young people section of the Topics and Resources page.

- Supporting information for the development of joint local protocols between drug and alcohol partnerships, children and family services [NTA, 2011]

Helps support local partnerships develop joint protocols between drug and alcohol partnerships and children and family services. Such joint working is fundamental to identify, assess, refer, support and treat adults, whilst protecting children and improving their outcomes.

- Joint guidance on development of local protocols between drug and alcohol treatment services and local safeguarding and family services [DCSF, DH and NTA, Nov 2009]

Aims to support those working in adult drug and alcohol treatment services, as well as children, parenting and family services, to protect the children of drug users from harm, and ensure their welfare needs are met. It provides commissioners and providers with up-to-date information and highlights good practice.

- Think family: improving the life chances of families at risk [Cabinet Office, 2008]

Looks at the notion of 'thinking family' in the delivery of adult services. The document emphasises the wider needs of adults, such as family circumstances, and the difference this can have on their life chances and those of their family and children.

- SCIE report 2: working with families with alcohol, drug and mental health problems [Kearney P, Levin E and Rosen G, June 2003]

Focuses on the policies and practices that can promote integrated services to families and gives recommendations for improving practice. It is particularly concerned with effective collaboration and focusing on the family as whole.

- When to suspect child maltreatment (clinical guidance 89) [NICE, 2009]

Provides a summary of clinical features associated with child maltreatment (alerting features) that may be observed by a healthcare professional. Its aim is to raise awareness and help those who are not specialists in child protection identify maltreatment.

- Alcohol-use disorders - preventing the development of hazardous and harmful drinking

This National Institute for Health and Clincial Excellence (NICE) guidance addresses alcohol-related problems among people aged 10 years and older. The guidance identifies how policies on alcohol pricing.

Alcohol-use disorders - preventing the development of hazardous and harmful drinking

Added on 31/08/2010

National Institute for Health and Clincial Excellence (NICE) June 2010

This National Institute for Health and Clincial Excellence (NICE) guidance addresses alcohol-related problems among people aged 10 years and older.

The guidance identifies how policies on alcohol pricing, its availability and how it is marketed could be used to combat alcohol-related harm.

The guidance covers:

- Licensing.

- Resources for identifying and helping people with alcohol-related problems.
- Children and young people aged 10 to 15 years - assessing their ability to consent, judging their alcohol use, discussion and referral to specialist services.
- Young people aged 16 and 17 years - identification, offering motivational support or referral to specialist services.
- Adults - screening, brief advice, motivational support or referral.

Alcohol-use disorders: physical complications

National Institute for Health and Clincial Excellence (NICE) June 2010

This National Institute for Health and Clincial Excellence (NICE) guidance covers the care of adults and young people (aged 10 years and older) who have any of the following physical health problems that are completely or partly caused by alcohol use:

- acute alcohol withdrawal (which occurs if a 'dependent' drinker suddenly stops drinking)
- lack of thiamine (also called vitamin B1) in the body, which can cause a condition called Wernicke's encephalopathy
- liver disease
- inflammation of the pancreas (called pancreatitis).

Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence

Clinical guideline on evidence-based advice on the diagnosis, assessment and management of harmful drinking and alcohol dependence in adults and in young people aged 10-17 years.

Drugscope Maternity and Pregnancy Guide

Information Sources and Weblinks:

Local Evidence Sources:

1: Cornwall & Isles of Scilly Drug and Alcohol Action Team Adult Drug Treatment Needs Assessment 2011/12

http://safercornwall.co.uk/wp-content/plugins/download-monitor/download.php?id=19

2: Cornwall Alcohol Strategy 'Taking Responsibility for Alcohol'

http://www.cornwall.gov.uk/default.aspx?page=19538

3: CIOS DAAT/Amethyst 'Alcohol Needs Assessment' 2010/11

https://www.amethyst.gov.uk/Download_Documents/Strategies_Audits/CIOS%20Alcohol%20Needs%20Assessment%202010-11%20FINAL.pdf

4: Cornwall Public Health Alcohol Health Equity Audit 2009

http://www.cornwall.gov.uk/idoc.ashx?docid=49c792bb-6fbc-41f1-8d6d-ba6ee98ee261&version=-1

5: Safer Cornwall Partnership Strategic Assessment

http://safercornwall.co.uk/wp-content/plugins/download-monitor/download.php?id=6

National Evidence and Guidance:

1: Signs for Improvement Department of Health Alcohol Commissioning Guide

http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_104854.pdf

2: National Alcohol Strategy 2012

http://www.homeoffice.gov.uk/publications/alcohol-drugs/alcohol/alcohol-strategy

http://www.homeoffice.gov.uk/publications/alcohol-drugs/alcohol/alcohol-strategy?view=Binary

3: National Drug Strategy 2010

http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/drug-strategy/drug-strategy-2010?view=Binary

4: National Drug Strategy Annual Review 2012

http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/annual-review-drug-strategy-2010/drug-strategy2010-review-may2012?view=Binary

International Evidence and Guidance:

1: W.H.O. Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm

http://www.euro.who.int/__data/assets/pdf_file/0020/43319/E92823.pdf

2: W.H.O. Handbook for Action to Reduce Alcohol Related Harm

http://www.euro.who.int/__data/assets/pdf_file/0012/43320/E92820.pdf

Local Drug and Alcohol Services:

1: Cornwall Alcohol services short list

http://www.cornwall.gov.uk/idoc.ashx?docid=2f0f1b88-89e3-4697-9ca4-a8a5fd710fea&version=-1

2: Cornwall Alcohol services list

http://www.cornwall.gov.uk/idoc.ashx?docid=f14c33f5-b88c-4de6-8972-74883611003d&version=-1

3: Cornwall Drug and Alcohol services full lists

http://www.cornwall.gov.uk/default.aspx?page=19536 http://www.cornwall.gov.uk/default.aspx?page=19531

4: Cornwall Drug and Alcohol services directory pdf (updated version imminent)

http://www.cornwall.gov.uk/idoc.ashx?docid=9474d5e6-1219-415f-9766-23eb50801429&version=-1

Additional Matters requiring further

The extra measures we would like to look at across the Health and Wellbeing domain include interventions relating to sexual health, child safeguarding, hospital presentations, mental health, smoking and other cardio-vascular disease prevention initiatives, but these would have to be funded via additional health/QIPP investment. We believe that the inclusion of these measures is cost effective and more appropriately responds to the outcomes specified in the National Drug Strategy 2010

Measuring outcomes

The outcomes will be measured against individual patient achievement with the exception of the Reduced Offending outcome for which a cohort measure will be used, as data has to be collated via the National Drug Treatment Monitoring System (NDTMS) and cross matched with Home Office data recorded on the Police National Computer (PNC).

Payment by Results

We will use both interim and final outcome measures to ensure that providers are able to access funding during the course of a treatment journey so they can respond to the immediate needs of patients.