CORNWALL & ISLES OF SCILLY DRUGS NEEDS ASSESSMENT 2016/17
Needs Assessment prepared by:

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<th>Organization</th>
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Executive summary

Overview: key trends

What’s happening nationally?

- National surveys indicate that **drug use is reducing**, including class A drugs which are considered to present the greatest risk of harm to society;
- **Drug seizures** saw an 11% decrease compared with the previous year and the **fourth consecutive annual fall**. Over the same time period, there was a 13% decrease in the number of police recorded drug offences, which is highly correlated with the number of drug seizures. Although it should be noted that this may be **indicative of a reduced focus by police forces** to uncover drug-related criminal activity;
- Rates of **theft offences** (burglary, shoplifting, vehicle crimes), commonly associated with drug use as a means of funding an addiction, **continue to fall**;
- Against this backdrop, however, **drug-related deaths have risen to the highest rate since comparable records began** in 1993, driven by a sharp increase in heroin/morphine related deaths, particularly in men;
- In 2015, the Home Office identified a growing body of intelligence that vulnerable people are being exploited in order to facilitate the running of **street level drug dealing**;
- Research highlights risk factors associated with an **aging population** and increasing levels of **poverty** in communities.

What’s happening locally?

- **Drug markets and use are changing**. There is evidence of wider availability of **higher purity heroin** and notification of increased availability and use of **crack cocaine and methamphetamine**;
- There are signs that **crack use is escalating quickly through our local opiate using population**, bringing with it a greater risk profile of more crime and health related harms, particularly related to injecting;
- There have been local cases of **vulnerable people** being **targeted by Organised Crime Groups** (OCGs) to use them and their home to sell illicit drugs. Drug offences increased last year, reflecting police focus on OCGs;
- Rates of **theft offences** saw a further fall in 2015/16 but with some localised spikes. The latest data, however, indicate **emerging negative trends in all types of theft** except vehicle crime;
- There are increasing reports of **vulnerable adults with complex needs**, **homeless drug and alcohol users** and associated problems with drug litter and anti-social behaviour;
- **Numbers entering drug and alcohol treatment** are on an **upward trajectory** and above contracted capacity for the service;
- Cornwall has one of the **highest rates of drug related death in the South West**. **Poly-drug use** is a key contributing factor to the increase in deaths, in particular an increase in people using **heroin and crack** in combination, and people using **illicit drugs with prescribed medicines**. Other factors include **higher purity heroin** within the drug market and increases in **street homelessness**.
Our current treatment system

- **Local services are cost effective.** Cornwall and the Isles of Scilly pays significantly less per successful outcome than the national benchmarks;
- We are **better than average** locally at getting the most complex problem drug users (opiate users) into treatment;
- We are **good at achieving abstinence/reduced drug use** in treatment, **positive housing outcomes** and **successfully engaging people in treatment** in the crucial first 12 weeks;
- We need to improve the proportion of people **completing treatment successfully**, which has **declined across all drug groups**. Key themes impacting on successful completions include housing, employment, injecting, family and relationships and drug use whilst in treatment. **Increased complexity** within our service user population related to **crack cocaine use** is also starting to impact;
- We need to **reduce/prevent injecting**, which is **higher than average at all stages of the treatment journey** and this will be having an impact on successful completions;
- The treatment population is aging and becoming more complex. The **proportion of people in treatment with entrenched dependence and complex needs will increase** and thus the proportion successfully completing treatment will continue to fall. All indications suggest that it is **challenging to help people with complex needs and a long treatment history to achieve recovery**;
- Numbers accessing **residential rehabilitation** services are lower than expected (based on national estimates) but the **successful completion rate is high**. Negative factors include being unable to manage lump sum PIP payments, relationship issues and lack of sufficient preparation.

What people say about it

- **Outreach** is highly valued;
- The **quality of support** from staff is high;
- Services are **flexible and accessible** and there is a **wide range of support** offered, but **communication** about what is available could improve;
- The services cited by service users as being **most helpful to recovery** were the Mutual Aid Programme (MAP) groups, volunteering, training and extra activities;
- Stakeholders said that **stronger joint working between agencies is helping to support people more effectively**, particularly vulnerable people;
- The DAAT training is enabling staff in a range of other agencies to **identify substance misuse** and can offer an intensive support package **working closely together to promote recovery** and community integration;
- **Naloxone delivery** to service users and in supported housing **is saving lives**;
- **Better access to and joint working with mental health services** was universally identified as a priority for improvement;
- Other areas to improve include more **childcare/child friendly** services, help with **transport costs** and developing a **better service offer to vulnerable women** with multiple needs;
- Stakeholders want to see an **expansion of assertive outreach** and better range, **co-ordination and supervision of supported accommodation options**.
Mental and physical health

- Drug and alcohol problems are **usual rather than exceptional amongst people with mental health conditions** but the relationship between the two is complex. Health guidance stresses the importance of drug/alcohol and mental health services working together effectively, otherwise both will fail;
- **Violence and abuse**, particularly when experienced in childhood, is strongly associated with later onset and persistence of **mental health conditions and problematic use of drugs and alcohol**;
- Although we have higher than average levels of concurrent contact with mental health and drug/alcohol services, local data indicates that there is **significant unmet need, particularly in the offender population** that commonly present with this combination of issues;
- A survey with staff across a range of community safety services found that **experiences of successfully referring into mental health services were mixed**, with dual diagnosis, increasing thresholds, ease of contact and unclear pathways being described as the barriers;
- The delivery of **Mental Health First Aid training** has been successful in raising staff confidence and knowledge when working with someone with a mental health condition;
- The rise in crack use introduces a **higher risk profile for health harms** (including blood borne viruses, injecting site infections, risky sexual behaviour and drug related death). Crack use, and in particular **groin injecting**, has been linked to an increase in **MRSA in drug users** in the South West.
- Rates of **Hepatitis C testing are excellent** and pathways to treatment are working well. Rates of Hepatitis B vaccinations could continue to improve;
- People **who inject steroids and those who engage in ‘slamsex’** tend to see themselves as different to other people who inject drugs. Often they are **unaware of the risks** of injecting and do not seek harm reduction advice.

Housing and employment

- **Homeless presentations to treatment** have seen a small rise year on year and whilst these are not large numbers, those presenting in housing need are becoming **more complex and requiring a lot of additional support**. A rise in **vulnerable females** is a particular concern;
- **Housing outcomes are good locally**. The vast majority of people exiting the treatment system successfully have no reported housing need;
- **Rough sleeper numbers are rising**. Problems with mental health, alcohol and drugs are the biggest issues faced by the homeless community;
- Although we have complex needs housing provision, **some very complex clients are banned from all provision** due to previous behaviour. Budget pressures could further reduce housing options for the most vulnerable clients;
- Huge **changes in the welfare system** have been and will continue to provide significant challenges for people with drug and alcohol problems. Public Health England recognises that client engagement with employment support often focuses on maintaining benefits and avoiding sanctions;
- The proportion of people leaving treatment having achieved **10 days of paid employment** in the month before leaving treatment successfully is below the national average and the proportion achieving this target has **declined**;
- That being said, Cornwall has a **strong track record of effective partnership working** between drug and alcohol services and employment service providers and many clients are making **positive steps towards employment** that are not captured in current performance metrics.
Commissioning priorities

Priority Outcomes

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<th>Freedom from dependence on drugs or alcohol</th>
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<td>2</td>
<td>Improvement in mental and physical health and wellbeing</td>
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<td>3</td>
<td>Reducing drug related deaths</td>
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<td>4</td>
<td>Reduced hospital admissions</td>
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<td>5</td>
<td>Prevention of the spread of blood borne viruses</td>
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<td>6</td>
<td>A reduction in crime and re-offending</td>
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<td>7</td>
<td>Sustained employment</td>
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<td>8</td>
<td>The ability to access and sustain suitable accommodation</td>
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<td>9</td>
<td>Improved relationships with family members, partners and friends</td>
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<tr>
<td>10</td>
<td>Improved capacity to be an effective, caring parent</td>
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<td>11</td>
<td>Delivering value for money</td>
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Equality and human rights are key in all of these areas, with implications for equitable service delivery and access, encompassing gender, sexual orientation, disability, age, isolation, vulnerability, ethnicity, religion and beliefs.

Complex needs

Working more effectively with people who have multiple complex needs is an overarching priority that cuts across a wide range of commissioning areas.

We have a large and apparently growing number of people are experiencing alcohol and drug dependence, homelessness, domestic abuse and sexual violence, offending and poor mental health.

"Commissioners responsible for existing different service elements will work together to commission a joined up ‘whole system approach’ to support people with multiple needs. This will ensure services are integrated around the needs of the person, improving individual outcomes whilst also ensuring best use of resources."

Making Every Adult Matter [http://meam.org.uk](http://meam.org.uk)

Right Care\(^1\) identified 1,764 complex patients costing the health system in Cornwall £32 million per annum; this did not include social care, criminal justice, welfare and social costs.

\(^1\) Right Care gives local health economies in England practical support in gathering intelligence, data, evidence and tools to help them improve the way care is delivered for their patients and populations.
A growing number of people don’t ‘fit’ any one service;
Many are repeat attenders at hospital, sometimes getting multiple unplanned detox;
Some are ‘handed off’ by services and often end up in the least appropriate setting until they escalate to crisis care levels or death.

Whilst there are pockets of excellence, there is no systematic response, with duplication, an inefficient use of resources, limited joined up working and poor access to mental health services and appropriate accommodation.

There are challenges in relation to increases in complexity, secure information sharing, shared management of risks and missed opportunities for timely interventions.

Drug and alcohol treatment needs cannot be seen in isolation, but need to be addressed within the wider context of multiple problems, to deliver sustained recovery.

- Create a ‘whole system’ approach through an Adult Complex Needs Commissioning Plan providing an improved offer to people with multiple needs;
- Develop a more efficient system through a model of support that reduces duplication and delivers an improved client experience with positive outcomes;
- Oversight provided by a single multi-agency group which can problem solve and overcome barriers and obstacles and embed learning and change;
- Create a contractual environment where outcomes are, at a minimum, mirrored across all contracts (e.g. DASH and alcohol and drug screening by all, mental health pathways for all) and, at best, where suppliers share responsibility for achieving outcomes and are mutually supportive, making decisions based on the best outcome for the service user.

Utilising Integrated Personalised Commissioning to provide flexible responses outside of the norm:

- Supported by a Workforce development programme to ‘up skill’ staff, enabling specialist services to be more targeted whilst improving service delivery and outcomes;
- Increase capacity in the system through applications for grant funding and exploration of social capital investment programmes.
Overview of Recommendations for Commissioners

The following recommendations have been drawn from the evidence presented within each section of the Needs Assessment. Not all are within the remit of the DAAT or drug and alcohol services to address but have been included to inform the commissioning of services that work with people who use drugs and/or alcohol.

The treatment system

Services were mapped against the relevant NICE guidance. The majority of pathways and services are in place, with the following **gaps and priorities for improvement** identified:

- **Families and Carers** - whilst services are available a ‘an assessment of needs’ is not provided as such;
- **‘Affected other’ groups** are provided and individual support. We do not have access in every locality yet;
- **Community Detoxification** – updating skills of community staff is required to encourage take up and ‘Stepped approach to Drug Detox’ is required to match the alcohol detoxification programme.

In addition, service users identified the following as important:

- Help with **transport and parking costs** to get to treatment every day;
- Help with **childcare**, especially in school holidays;
- Drugs and alcohol and mental health services working together. Getting **counselling for early life trauma** prior to detox.

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<tr>
<td>1.</td>
<td>Ensure drug treatment <strong>continues to address a broad range of outcomes</strong>, including harm reduction, social integration and recovery, through integrated treatment and recovery support systems;</td>
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<td>2.</td>
<td>Expand the use of drug treatment outcomes to better <strong>reflect the breadth of the benefits</strong> of drug misuse interventions;</td>
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<td>3.</td>
<td>Develop strategies to address the recent increases in <strong>drug-related deaths</strong>, including <strong>integrating healthcare with drug treatment</strong> for people who use drug and <strong>improving local processes</strong> for reviewing incidents;</td>
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<td>4.</td>
<td>Ensure that there are arrangements to meet the <strong>physical and mental health needs</strong> of people who use drugs, particularly for older people in treatment;</td>
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<td>5.</td>
<td>Closely <strong>monitor changing patterns</strong> of drug use, including use of New Psychoactive Substances (NPS) and problematic use of medicines, and <strong>use multi-faceted responses</strong>, including managing prescribing practice, developing workforce skills and developing new service pathways for specific sub-populations;</td>
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<td>6.</td>
<td>Access to <strong>Healthy Relationships programmes</strong> and <strong>joint couples interventions</strong> are a priority to improve outcomes;</td>
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2 NICE pathways – drug misuse
7. Use **Outcome Rating Scales and Session Rating Scales** for all episodes or psychosocial intervention in order to ensure treatment responsiveness and strong alliance factors are maintained;

8. **Counselling resources and a trauma informed approach** is required to assist people striving to overcome early life trauma.

9. Redesign the treatment pathways to allow for a **more intensive approach in the first six months of treatment**;

10. **Separate drug treatment outcome indicators** for both opiate users new into treatment and for existing cohorts, to allow tracking of the progress of those for whom evidence tells us we can expect higher recovery rates;

11. Maintain a **realistic recovery ambition for the ageing cohort of heroin users with complex needs**, accepting that the proportion of people who successfully complete treatment is likely to continue to fall;

12. Provide **longer-term employment and housing support**, including in-work support, to help people gain and maintain employment and appropriate housing.

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**Criminal Justice System**

1. Sustain **robust and integrated pathways** between drug treatment and all points of the **criminal justice system**, including pathways between prison and community-based treatment;

2. Establish whether and how rates of referral and engagement of people identified by the **Liaison and Diversion and offender management services** could be improved.

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**Families**

1. Support earlier identification and intervention through embedding **routine screening for drug and alcohol problems** in all health, children and family services and Child and Adolescent Mental Health Services (CAMHS);

2. **Develop and deliver targeted interventions to build resilience and reduce harm** for children and young people most at risk of Adverse Childhood Experiences, including parental substance use and domestic abuse;

3. **Improve the effectiveness of the Together for Families pathway** and establish the impact that this is having on outcomes for families;

4. Undertake a robust evaluation of the **new residential unit for young people and families**, and continue to develop interventions using a **co-production model**.

5. Support earlier identification and intervention through embedding **routine screening for drug and alcohol problems** in all health, children and family services and Child and Adolescent Mental Health Services (CAMHS);
### Physical Health

1. Target interventions to **improve injecting prevention and abstinence**;

2. **Increase provision of safe disposal facilities** such as drop boxes and sharps bins across localities, and **increase safe return** rates and disposal of injecting equipment thereby reducing the rate of reported drug litter finds;

3. Provide **dedicated support to pharmacies delivering needle exchange** in areas of high usage to encourage referral into treatment;

4. Provide **targeted support to people who use image and performance enhancing drugs and those who engage in ‘Slamsex’,** as they tend to see themselves as separate and different to other people who inject drugs and are therefore more reticent about approaching agencies. Thus, they risk being unaware of the risks they are placing themselves under.

5. A **preventative strategy** aimed at reducing the cumulative risk of **drug interactions** whether they are of legal or illegal origin is required and should be **developed jointly** with the Clinical Commissioning Group and hospitals;

6. **Continuation of the naloxone programme** to remain a priority for the contribution it is making to reducing death by overdose locally;

7. All drug and alcohol service staff to participate in **ASIST training to aid suicide prevention** amongst this high risk group;

8. Further embedding the NHS England initiative **Making Every Contact Count (MECC)** approach which aims to support people in **making positive changes to their physical and mental health and wellbeing.** Specifically, within the treatment population, this should focus on:
   - Smoking cessation
   - Alcohol consumption amongst dependent drug takers, and as a relapse risk
   - Physical activity
   - Sexual health

### Mental Health

1. Identify and agree the **priority areas and outcomes to improve mental health** across each community safety strategy, team and service at a partnership level and report performance on a quarterly basis;

2. Improve **skills and confidence in the workforce** to identify, assess and refer people with complex needs;

3. Improve understanding of service demands of adults and young people with complex needs, including an **agreed mental health assessment** within each service’s assessment, recording processes and case management systems (where applicable), alongside DASH risk assessments and alcohol and drug screening and assessment;

4. Understand and better capture the **impact of Adverse Childhood Experiences (ACEs)** both in early years and as an adult. Include questions within assessments and ongoing work as to **the number** of
ACEs experienced by the individual, what **impact** they have had, and what **help has been received or is required**; Achieve **system improvement in children’s, families and adult services** through enabling citizens and services to navigate local systems via an online pathway mapping tool and routinely reviewing system failures.

### Homelessness and housing need

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<td><strong>1.</strong></td>
<td><strong>Further analysis</strong> of the various cohorts of clients identified as having poor outcomes would help us to understand how to improve them. This could include additional analysis of the responses in the <strong>rough sleeper survey</strong> for people who had <strong>previously been in private rented accommodation or supported housing</strong> to better understand the circumstances that led to their rough sleeping;</td>
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<tr>
<td><strong>2.</strong></td>
<td><strong>Enhanced funding to the complex needs sector</strong> providing security of contracts and enabling the development of a model that will accommodate the most complex people;</td>
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<td><strong>3.</strong></td>
<td>Additional <strong>female only provision</strong> to accommodate complex and vulnerable females;</td>
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<td><strong>4.</strong></td>
<td>Facilitate the <strong>continuation of the naloxone project</strong> across complex needs services;</td>
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<td><strong>5.</strong></td>
<td>Continuation of the <strong>Homelessness Hospital Discharge protocol</strong> work;</td>
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<td><strong>6.</strong></td>
<td>Provision of <strong>accommodation for clients in close proximity to support services</strong> with access to good transport links;</td>
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<td><strong>7.</strong></td>
<td><strong>Establish a co-ordinated partnership approach to complex needs clients</strong> by implementing the learning from the new rough sleeper proposal, and <strong>provide a balance between enforcement and assistance</strong> in local areas, to prevent future occurrences and meet the statutory requirement to protect vulnerable people;</td>
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<td><strong>8.</strong></td>
<td><strong>Additional support within the treatment programme for vulnerable service users</strong> to minimise the impact of welfare reforms and subsequent homelessness;</td>
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<td><strong>9.</strong></td>
<td>A <strong>pilot treatment service in close proximity to Boscarn</strong> would make treatment more accessible to the Gypsy and Traveller population and could result in more people being engaged in treatment.</td>
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### Worklessness

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<tr>
<td><strong>1.</strong></td>
<td>Service mapping and <strong>pathways for all new employment services</strong> that are being implemented, with <strong>Single Points of Contact</strong> across employment and treatment organisations;</td>
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<td><strong>2.</strong></td>
<td>Continued delivery of <strong>cross-agency training workshops</strong> to build shared skills and knowledge amongst both treatment providers and employment providers, to include Welfare Reforms, DEA employment support and identification of drug/alcohol problems and other needs.</td>
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<td><strong>3.</strong></td>
<td>Target <strong>client friendly employment sectors</strong> in order to maximise the local employment opportunities for clients recovering from drug and alcohol issues and also those with a history of offending;</td>
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| **4.** | Create a **network of peer mentors to act as advocates and visible symbols of recovery**, tasked with encouraging safe
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<td><strong>5.</strong></td>
<td>Disclose and engagement and providing appropriate support which would have the potential to increase the number of referrals between organisations;</td>
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<td><strong>6.</strong></td>
<td>Ask clients if they have a <a href="#">claimant commitment</a> when they first access treatment so early links can be made across organisations to provide support;</td>
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<td><strong>7.</strong></td>
<td>Introduce 3-way <a href="#">case conferencing</a>;</td>
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<td><strong>8.</strong></td>
<td>Capturing <a href="#">case studies</a> to highlight what is working well and the additional challenges that still need to be addressed. Videos could be used to <a href="#">capture success stories and employment and recovery journeys</a> that can be shared with other clients;</td>
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<td><strong>9.</strong></td>
<td>Trial a process of contact with DWP prior to client exit from treatment so that more <a href="#">intensive support can be offered at this crucial time</a>;</td>
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<td>A number of data and performance management improvements have been identified, including:</td>
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Introduction

Cornwall Council and Cornwall’s Community Safety Partnership, Safer Cornwall, are responsible for reducing the harm related to drugs and alcohol locally. As such it is important to review local needs and evidence for drug and alcohol provision and assess the impacts upon individuals, families and local communities. This information is used to inform the commissioning of a range of services and system improvements that seek to make a positive impact.

The majority of the drug and alcohol services currently commissioned have contracts in place until March 2018. The Drug and Alcohol Action Team (DAAT) intends to undertake a procurement process to re-commission services for a revised system to be in place from April 2018 onwards. This needs assessment is a key part of that process.

Drawing on a wide range of data sources (including self-reports, research and service level data) the needs assessment provides a series of recommendations for consideration (Commissioning Priorities). How Cornwall chooses to respond to these recommendations will be detailed within the Commissioning Strategy.

What is needs assessment?

Needs assessment is the cornerstone of evidence-informed commissioning.

NICE (National Institute of Clinical Effectiveness) defines health needs assessment as a ‘systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities’

It is based on:

- Understanding the needs of the relevant population from reliable data sources, local intelligence and stakeholder feedback;
- Systematic and comprehensive analysis of legislation, national policy and guidance;
- Understanding what types of interventions work, based on analysis of impact of local services, research and best practice.

It is:

- A way of estimating the nature and extent of the needs of a population so services can be planned accordingly;
- A tool for decision making;
- To help focus effort and resources where they are needed most.

A robust needs analysis provides commissioners with the range of information required to feed into and inform planning and prioritisation.

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3 NICE guidance on Health Needs Assessment – www.nice.org.uk
Key themes from research show that effectively configured services:

- Are **accessible**
- Are **acceptable**
- Are as **non-stigmatising** as possible
- Focus on **early interventions**
- Address the **whole person**
- Are **based on evidence** of what works
- Build upon existing successful networks and are **sustainable**
- Have **effective assessment, planning and care co-ordination** systems.
- Prioritise those most in need.
- Improve based upon real time feedback.
- Are only as effective as the therapeutic relationship between the worker and the person seeking help.

**Aims and objectives**

The purpose of needs assessment is to examine, as systematically as possible, what the **relative needs and harms are within different groups and settings**, and make evidence-based and ethical decisions on how needs might be most **effectively met within available resources**.

Through undertaking a rigorous needs assessment, we aim to continue to ensure that **systems and services are recovery focused**, provide **value for money** and **meet the needs** of local communities.

An effective needs assessment for drug interventions, treatment, support, recovery and reintegration involves a process of identification of:

- **What works well**, and for whom in the current system, and what the unmet needs are across the system
- **Where there are gaps** for clients in the wider reintegration and treatment system
- **Where the system is failing** to engage and / or retain people
- **Who the hidden populations are** and their risk profiles
- What are the **enablers and blocks** to treatment, reintegration and recovery pathways
- What is the **relationship** between treatment engagement and harm profiles?

This will provide a **shared understanding of the local need for services**, which then informs treatment planning and resource allocation, enabling residents to have their needs met more effectively, and ultimately benefiting the communities in which they live.

Such an assessment will need to take full account of the gender, ethnicity and other **diverse needs of the target population and any unmet needs** from this perspective. The assessment also needs to be undertaken in accordance with the requirements of national guidance on undertaking equality impact assessments.

**Joint Strategic Needs Assessment support pack 2017/18: commissioning and good practice prompts**

The **national guidance from Public Health England** for the needs assessments to support 2017/18 commissioning for drugs, alcohol and young people’s services is
comprehensive and challenging. The DAAT Needs Assessment Expert Group has stretched to incorporate these new areas into its needs assessment each year.

As before, we have rated ourselves against the national checklist, which has assisted us in mapping what is working well, what needs to improve and gaps for future development.

The recommendations are wide ranging and indicate where we require the assistance of partners as well as commissioned services.

Our self-assessment against the checklist for 2017/18 is available as part of the separate supporting documentation set for this needs assessment.

National context

Strategy 2010 “Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life”

The national drug strategy has two overarching aims:
- Reduce illicit and other harmful drug use, and
- Increase the numbers recovering from dependence.

The Government aims to offer ‘every support’ for people to choose recovery as an achievable way out of dependence and recognises that the causes and drivers of drug and alcohol dependence are complex and personal and that their solutions need to be holistic and centred around each individual.

The 2013 review of the National Strategy, ‘Delivering within a New Landscape’, moves the recovery focus and requirements of partners very much towards the housing and employment initiatives that are required to deliver sustainable recovery for 2014/15 and beyond.

At the time of writing, a new national Drug Strategy is due for publication and its recommendations will need to be taken in to account locally.

Healthy Lives, Healthy People our strategy for public health in England (2010)

This paper recognises that drugs and alcohol represent a large proportion of the Public Health budget (approximately one third). Previous funding made available nationally was brought into the Public Health Grant in 2013. The local Health and Wellbeing Boards and the Director of Public Health have become jointly accountable for ‘strong leadership’ of alcohol and drug treatment.


The 2012 ACMD Report on Recovery from Drug and Alcohol Misuse highlighted three overarching principles – “wellbeing, citizenship, and freedom from dependence’ and describes recovery as an individual, person-centred journey, as opposed to an end state, and one that will mean different things to different people”.

One of the best predictors of recovery being sustained is an individual’s ‘recovery capital’ – the resources necessary to start, and sustain recovery from drug and alcohol dependence. These are:

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

In order to deliver recovery-oriented services, there is an acknowledgment that links with housing, employment and family services are essential and must be firmly established and integrated into overall treatment services and supportive relationships with families, carers and social networks must be promoted.

The Public Health Outcomes Framework (2016)

**Vision:** To improve and protect the nation’s health and wellbeing, and improve the health of the poorest fastest.

The Public Health Outcomes Framework focuses on the two high-level outcomes to achieve across the public health system and beyond. These two outcomes are:

**Outcome 1: Increased healthy life expectancy.**
Taking account of the health quality as well as the length of life (Note: This measure uses a self-reported health assessment, applied to life expectancy.)

**Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities.**
Through greater improvements in more disadvantaged communities.

Drugs and alcohol form part of the set of supporting public health indicators that help focus our understanding of how well we are doing year by year nationally and locally on those things that matter most to public health, which we know will help improve the outcomes stated above.

The 2 overarching indicators that the Drug and Alcohol Action Team are responsible for delivering against are:

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<tr>
<td>2.15</td>
<td>Drug and alcohol treatment completion and drug misuse deaths</td>
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<tr>
<td>2.18</td>
<td>Alcohol-related admissions to hospital</td>
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4 Public Health Outcomes Framework 2016-2019, Department of Health (August 2016)
Successful completion of drug treatment is defined as the number of drug users that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a proportion of the total number in treatment.

Two new sub-indicators have been added from 2016:

- 2.15iii – Successful completion of alcohol treatment
- 2.15iv – Deaths from drug misuse

Successful completion of alcohol treatment has been added as an additional sub indicator to reflect the fact that drug and alcohol services are increasingly commissioned together and the data that is used to report on access and provision all comes from the same monitoring system.

The number of deaths from drug misuse has also now been included as there has been a rising trend in drug related deaths over the last few years. Local authority action, including the quality and accessibility of the drug services they commission and how deaths are investigated and responded to has an impact on drug misuse death rates. Including this sub-indicator alongside those on treatment outcomes will help local authorities and others to consider the impact of treatment in addiction to recovery outcomes.

Substance misuse has serious health implications and treatment is proven to reduce the strain on local health services. The impact of substance misuse is far reaching and contributes to 32 of the 70 indicators currently reported through the Public Health Outcomes Framework.
<table>
<thead>
<tr>
<th>Domain 3: Health protection</th>
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<tr>
<td>3.04 People presenting with HIV at a late stage of infection</td>
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<th>Domain 4: Healthcare public health &amp; preventing premature mortality</th>
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<td>4.03 Mortality rate from causes considered preventable</td>
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<td>4.06 Under 75 mortality rate from liver disease</td>
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<td>4.08 Mortality rate from a range of specified communicable diseases, including influenza</td>
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<td>4.10 Suicide rate</td>
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<td>4.11 Emergency readmissions within 30 days of discharge from hospital</td>
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<td>4.14 Hip fractures in people aged 65 and over</td>
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Public Health England is committed to continue to improve recovery rates for both drug and alcohol treatment and to reduce health-related harms, HIV, hepatitis, TB transmission and drug-related deaths. This action was included within Public Health England's Annual Plan 2015/16 and these indicators directly contribute.

**Building Recovery in Communities 2012**

This introduced the **national recovery–oriented service framework**, which seeks to make recovery more visible to local communities. Essential components of effectively configured services include:

- Tailoring responses more to individual needs and journeys;
- Recovery-oriented induction / coaching for all service users;
- The employment and housing support required to make recovery happen;
- Family support and involvement essential to maximising recovery capital;
- Mutual aid and recovery pathways;
- Targeting client groups;
- An inspirational recovery oriented workforce.
Troubled Families Programme

In 2011, the government unveiled plans for a programme to turnaround the lives of families with ‘serious problems’ including parents not working, mental ill health, children not in school, and causing crime and anti-social behaviour. In March 2012 the DCLG formally announced the “Troubled Families” programme: a financial framework for the payment-by-results scheme for local authorities.

This programme is delivered in Cornwall under the name Together for Families in Cornwall.

To be targeted for help under the Troubled Families Programme in Phase 1, families had to meet three of the following national criteria:

- Are involved in youth crime or anti-social behaviour;
- Have children who are regularly truanting or not in school;
- Have an adult on out of work benefits;
- Cause high costs to the taxpayer.

Local criteria were also allowed to be set and in Cornwall these were domestic violence, mental health and drugs/alcohol problems.

In Phase 2 of the programme, from 2016 onwards, the criteria and numbers to be engaged increased greatly and a local evaluation is pending. There is more information on the programme in the Families section.

Transforming Rehabilitation

Transforming Rehabilitation is the reform programme that has changed the way in which offenders are managed in the community, with the aim of bringing down reoffending rates while continuing to protect the public.

The key aspects of the reforms are:

- A new public sector National Probation Service to work with the most high-risk offenders;
- 21 new Community Rehabilitation Companies (CRCs) to work with medium and low-risk offenders;
- The extension of statutory supervision and rehabilitation in the community to every offender released from custody, including 50,000 of the most prolific group of offenders (those sentenced to less than 12 months in custody);
- A nationwide ‘through the prison gate’ resettlement service to give most offenders continuity of support from custody into the community; a network of resettlement prisons ensures that offenders continue to be managed by the same provider as they move from custody into the community;
- Opening up the market to a diverse range of new rehabilitation providers to get the best out of the public, voluntary and private sectors and giving them the flexibility to do what works;
- Only paying providers in full for real reductions in reoffending.
Offenders have a high ratio of dependence problems. They fall into 3 groups:

- Those who have already received treatment within the treatment setting and require **Recovery Support** within the community;
- Those who are partway through treatment who require a ‘seamless’ **transfer to treatment** within the community;
- “New” users - those whose alcohol and drug use has not been previously identified but becomes apparent on discharge.

**Immediate access to treatment** is required to support the rehabilitation plans for those on release. There are no available national estimates at present as to these numbers.

**Offender Rehabilitation Act 2014**

The new Act means that, for the first time, virtually all offenders receive at least 12 months supervision in the community on release from custody. The provisions in the Act have been implemented as part of the Transforming Rehabilitation reforms.

**The Drug Interventions Programme (DIP)**

DIP is a key part of the government’s strategy for tackling drugs and reducing crime which seeks to facilitate access to help at any point in the criminal justice system. This has been extended to allow the inclusion of problem alcohol use and drugs other than Class A.

**Integrated Offender Management (IOM)**

The national IOM project is delivered under the name **TurnAround** in Devon, Cornwall and the Isles of Scilly. It is an overarching framework that brings local and partner agencies together to ensure that the offenders, whose crimes and behaviour cause the **most damage and harm** locally, are managed in a **coordinated way**.

**Modern Crime Prevention Strategy (2016)**

This sets out how to prevent drug-related crime by focusing on three areas: **treatment, diversion and enforcement**.

It recognises that **getting users into treatment is key**, as being in treatment itself reduces levels of offending. It advocates for **full recovery from dependence** being the aim of treatment and that this is more likely to be achieved and sustained if users are given support to improve their ‘recovery capital’ – particularly around **housing and meaningful employment**.

For a small cohort of **entrenched, long-term opiate users** who have not achieved recovery through optimised oral substitution treatment, there is evidence that **heroin assisted treatment** (supervised injectable heroin) **reduces crime**.

**An evidence review of the outcomes that can be expected of drug misuse treatment in England PHE (2017)**

In March 2015, the Department of Health commissioned Public Health England (PHE) to “**review the evidence on: what can be expected of the drug treatment and recovery system and provide advice to inform future policy**”.
The review found that treatment outcomes in England are comparable with or better than other countries and in comparison to the scientific literature, as follows:

- The **treatment penetration rate** (60%) is among the highest reported;
- **Access to treatment** (97% within three weeks) is comparable to other countries;
- The rate of **drug injecting** among all 15-64 year olds (0.25%) is relatively low;
- The rate of **drop out from treatment** before three and six months (18% and 34%, respectively) is comparable to the literature (28% on average);
- England has a **very low rate of HIV infection** among the injecting drug user population (1%), which compares favourably internationally the rate of HCV infection (50%) is lower than several other countries with available data;
- The rate of **stopping injecting** (52% after three months; 58% after six months; 61% after one year) is comparable with, or better than, the scientific literature;
- Treatment in England is associated with a **marked reduction in convictions** (47% among those retained in treatment for two years or successfully completed treatment);
- **Successful completion of treatment rates** for non-opiate drug users, who only receive psychosocial interventions, have increased from 14% in 2005/06 to 37% in 2014/15 for non-opiate drug and alcohol users, and from 13% in 2005/06 to 42% in 2014/15 for users of non-opiate drugs alone.

While several key treatment indicators are comparable or better in England, there are opportunities for further reductions in the use of illicit opiates during treatment and drug-related mortality: the rate of illicit opiate abstinence after 3 and also 6 months of treatment in England (46% and 48%, respectively) points to relatively poorer performance in comparison with the literature (56% on average).

PHE estimates that the proportion of people in treatment with entrenched dependence and complex needs will increase and thus the proportion successfully completing treatment will continue to fall.

The proportion of older heroin users, aged 40 and over, in treatment with poor health has been increasing in recent years and is likely to continue to rise. An ageing cohort of heroin users (many of whom started to use heroin in the 1980s and 1990s) is now experiencing cumulative physical and mental health conditions. Older heroin users are also more susceptible to overdose. It is important to help these people access appropriate general healthcare services.

All indications suggest that it is challenging to help people with complex needs and a long treatment history to achieve recovery.

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5 An evidence review of the outcomes that can be expected of drug misuse treatment in England, Public Health England (2017)
There are reports of increasing problems of misuse and dependence associated with some prescription and over-the-counter medicines. The use of new psychoactive substances (NPS) is also increasing, and is a particular problem in prisons.

The review provides the following advice to inform policy and practice for national and local government:

- Ensure drug treatment continues to address a broad range of outcomes, including harm reduction, social integration and recovery, through integrated treatment and recovery support systems;
- Expand the use of drug treatment outcomes to better reflect the breadth of the benefits of drug misuse interventions. The current primary outcome measure (successful treatment completion and no return to treatment, used as the proxy measure of success) should be augmented to better reflect progress made by individuals, through the national and local monitoring of:
  - The proportion of people in need who are in treatment
  - Good treatment access
  - Incident rates of bloodborne viral infections
  - Cessation of illicit opiate use while in treatment
  - Longer-term rates of treatment re-presentation
  - Treatment entry rates following prison release
  - Access to employment and housing support services
- Separate drug treatment outcome indicators for both opiate users new into treatment and for existing cohorts, to allow tracking of the progress of those for whom evidence tells us we can expect higher recovery rates;
- Maintain a realistic recovery ambition for the ageing cohort of heroin users with complex needs, accepting that the proportion of people who successfully complete treatment is likely to continue to fall;
- Provide longer-term employment and housing support, including in-work support, to help people gain and maintain employment and appropriate housing;
- Develop strategies to address the recent increases in drug-related deaths, including integrating healthcare with drug treatment for people who use drug and improving local processes for reviewing incidents;

The guidance for commissioners and providers of local drug treatment and recovery systems indicates that local provision should:

- Ensure that there are arrangements to meet physical and mental health needs of people who use drugs, particularly for older people in treatment;
- Implement evidence-based interventions to reduce the use of illicit opiates at the start of and throughout treatment;
- Provide evidence-based treatment interventions recommended by NICE;
- Note that a policy of limiting the time that people are able to spend in treatment is not supported by scientific evidence and can be counterproductive;
- Ensure there are robust and integrated pathways between drug treatment and all points of the criminal justice system, including pathways between prison and community-based treatment;
- Closely monitor changing patterns of drug use, including NPS use and problematic use of medicines, and use multi-faceted responses, including managing prescribing practice, developing workforce skills and developing new service pathways for specific sub-populations.
A changing delivery landscape

Changing national priorities, driven by a new government (and most recently a new Prime Minister), fast evolving legislation and the impacts of the economic downturn and austerity measures have had a significant impact on our communities and on Community Safety Partnerships and our delivery environment.

Further substantial cuts are expected in public sector funding. The cumulative impact of reduced resources across all partner agencies is creating gaps in service provision, increasing risk and limiting our options for putting mitigating action in place. The following factors have been identified as particularly crucial in influencing Partnership responses over the next commissioning cycle.

**Cornwall Devolution Deal** and the delivery of the Case for Cornwall: £5 billion of devolved government funding, with key development areas including the integration of health and social care and co-location and sharing of resources by blue light services.

Conversely, many public sector agencies (such as Police and Probation Services) are working across wider geographical areas, to achieve efficiencies and harmonise working practices.

**New Housing legislation** – including Housing and Planning Act, Welfare Reform and Work Bill, reforms to Local Housing Allowance, Universal Credit and the Immigration Bill – expected to increase demand for housing support, alongside a decline in housing stock, reduced operating budgets for services and potential for adverse responses in the rental market, particularly for our key client groups who are particularly vulnerable but perceived as more challenging to house.

Predicted to impact on rough sleeping and use of temporary accommodation (particularly for young people) with knock on effects on crime and reoffending and increased demands on health and social care services.

Every health and care system in England is required to produce a five year **Sustainability and Transformation Plan (STP)**, showing how local services will evolve and become sustainable over the next five years. Our local STP provides limited focus on the key community safety issues identified as wider determinants of health, in particular domestic abuse and sexual violence. This limits the STP’s scope to engage wider partners in addressing the underlying causes of poor health and deliver radical transformation.

Public sector plans to increase use of Voluntary, Community and Social Enterprise (VCSE) sector capacity to make savings and build community resilience - VCSE sector reports, however, that existing supporters are “getting older” with difficulties in recruiting young people. Plus, reduced grant income due to budget cuts compromises their ability to recruit and retain quality (paid) staff.

Increasing threat presented by on-line environments as locations for criminality and the challenges that this presents for safeguarding people, detecting and investigating crime. Potential for massive rise in recorded crime as we improve identification, recording and response.
All agencies are reporting that people presenting to services have **increasingly complex, multiple needs**. Responding effectively requires partners to work together to address those needs holistically and provides opportunities for **joint commissioning, co-design and delivery** of services. But **“silo” working** due to pressures on budgets and resources is a **major barrier** to achieving this.

**Additional demands are being placed on local partnerships** to contribute intelligence and expertise to the development of the new **Serious and Organised Crime Profiles** and to co-ordinate local responses, with **no additional resources or funding**. This creates five new strands of work that are **complex and overlapping** and include Modern Slavery, Child Sexual Exploitation and the Trafficking of Drugs, People and Weapons.

The transition of the majority of **adult offender management services** to the **private sector**, alongside a much smaller public sector Probation Service, has resulted in **reduced budget and resources** to deliver offender management in Cornwall, requiring partners to **rethink how we work together** to reduce reoffending. There is national uncertainty over the future of the **Youth Justice Board and local partnerships**, pending the delayed results of the departmental review and plans to transform the youth justice system. A **White Paper and consultation** process is likely and we anticipate that the concept of **‘secure schools’** replacing the current Youth Offending Institutions will continue to be explored.

**The local partnership is well placed to address these challenges**, drawing on the combined resources and strong leadership of the six responsible authorities to deliver **effective joint responses**.

**The UK’s decision to leave the European Union** has created uncertainty over the future of EU funded projects. Although the Treasury will honour agreements signed before the 2016 Autumn Statement, this still leaves **£300 million of investment at risk** that has been earmarked for growing businesses, creating jobs and boosting skills, including **work programmes** for those furthest from the workplace.

The predicted drop in income for **supported housing** providers, due to Government plans announced last year to **cap housing benefit** in the social sector at the same levels paid to private landlords, puts **future service provision at risk**. Implementation has been deferred until 2018 whilst a review is conducted into funding for the supported housing sector.

The number of **hate crimes reported in the UK** rose by 57% in the week following the EU Referendum result, with higher increases in areas that were strongly pro-leave. Although the impact locally has been less clear, there is an **increased risk of victimisation** for our minority communities, requiring agencies to work together proactively to **safeguard those who are most vulnerable**, build confidence to report and promote unity and tolerance. This will be particularly important as we start the **resettlement of refugees** in Cornish communities.
Cornwall: a brief description (2015)...

Cornwall is the second largest local authority area in the South West region, covering an area of 3,559 sq. km, and has the longest coastline of all English counties at 697 km. It is an area of many contrasts, with varied landscapes including remote rural, coastal and environmentally sensitive areas, interspersed with villages and historic market towns; where affluence sits alongside some of the most disadvantaged areas in England.

- Over 40% of the population living in settlements of less than 3000 people
- 230,400 households

Population and Settlements

- Cornwall's population is growing but growth isn't consistent across all areas of Cornwall
- 697km is the length of Cornwall's coastline
- 359 is the area of Cornwall in square kilometres
- 30% of Cornwall is within an Area of Outstanding Natural Beauty
- Over 40% of the population living in settlements of less than 3,000 population
- 20% are under 18
- 56% aged 19-64
- 24% are 65 or over
- Population density is one of the lowest in England at 1.5 persons per hectare
- In-migration is predominately for economic and lifestyle reasons, not retirement purposes

Deprivation

- Deprivation is a persistent problem - Cornwall as a whole is not deprived but there are areas where there are very high levels of deprivation and this has not changed for some years
- Around 11% of the population of Cornwall live in the 20% most 'deprived' communities in England. This equates to approx. 34,400 households
- 15.9% of children in Cornwall live in low income families
- Hidden rural deprivation is not identified by national measures due to the dispersed nature of rural population

Health and Wellbeing

- Health inequalities continue in areas of deprivation - higher rates of obesity, teenage pregnancy and levels of sickness and disability benefit claims are closely linked to areas where there is known inequality
- Average life expectancy continues to be generally higher than the national average
- One in ten residents (53,366 people) say they have a long-term health problem or being disabled
- 11.9% of 63,102 people provide unpaid care to a family member, friend or neighbour
- Large number of people with mental health needs, as well as a large number of people at increased risk of mental health problems
- Cancer, respiratory disease, musculoskeletal problems and cardiovascular disease, cause the majority of deaths

Households and Housing

- Housing need in Cornwall is high with housing unaffordable for many
- 230,400 households with an average household size of 2.27 persons
- Over 230,400 households
- Over 10% the average (median) income of £16,354.8
- Over 10x the average house price £194,000
- Cornwall has one of the highest rates in the country of sleeping per head of population
- 8,800 live in communal establishments (1.7%)
- There are around 9,000 new regulations on the Cornwall Homeless Register per year, indicating increasing demand
- In 2013 approximately 34,998 (14%) of households in Cornwall were calculated to be in fuel poverty
What did we achieve in 2015/16?

New initiatives and development based upon priorities identified in last year’s needs assessment

Increased accessibility and availability

- The availability of **outreach provision has increased** in localities and improved success in attracting and engaging the more hard to reach. This has included embedded workers in supported housing provision (including wet hostel, bail hostel and Prolific Offenders Provision). There has also been an outreach service to prisons where assessment and residential referrals have been completed. The Outreach Model piloted in Truro has gained recognition as a **model of good multi-disciplinary practice**;
- **Needle Exchange provision has increased and improved** to include a two tier model at Penzance where service users can receive an augmented service to include more in-depth harm reduction. There is also a new community needle exchange provision at Camborne and small needle exchanges have been set up in GP surgeries;
- **Mutual aid meetings** are available at 12 sites across Cornwall where people who have successfully completed treatment can meet and support each other to sustain their recovery;
- Chy Colom have **secured funding for a kennel** and, alongside kennelling arrangements at Bosence and Boswys, this has **removed the barrier to accessing residential rehabilitation for people who have dogs** and no one to care for them.

Improved targeted support into housing and employment

- The drug and alcohol service has worked alongside housing providers and Cornwall Council to provide a range of supported housing packages for individuals in housing need including **supporting people in their own accommodation** and **taking services into hostel provision**;
- Addaction provided a **direct daily service into the Cold Weather Provision** and there is a homelessness lead in both Camborne and Truro. The service is part of the Task Force in St Austell;
- **Addaction staff are based in stage 1 supported housing projects** to engage as many clients as possible; to support the naloxone project in supported housing and to offer support and advice to supported housing teams;
- A **Cornwall guidance document on the use of naloxone** in supported housing has been developed and agreed by all partners (7 housing providers, Addaction and DAAT);
- The **tier 4 protocol has been expanded** to include St Petroc’s, Stonham Homegroup, Cornwall Housing Limited, Bosence Farm and Addaction Chy. This supports clients to access supported accommodation on discharge from rehabilitation;
- In 2015/16 **employment pathways continued to support clients** into treatment from employment and into employment from treatment;
- The first **Active Plus course** was delivered within the residential rehabilitation service, run by veterans;
- **Housing and Job Centre Plus** staff participated in DAAT multi-agency training sessions.
Improved responses to individuals and families with complex needs

- A **joint DAAT/DASV protocol** has been developed to improve outcomes for people affected by both issues. This is **now in the process of implementation**. All drug and alcohol service staff have attended the DASH Training. Drug and alcohol services work closely with the IDVA Service and police in order to provide a rapid response to individuals who are at high risk as a result of domestic abuse and continue to participate in the MARAC process;

- A **Dual Diagnosis Strategy** is in place for drug and alcohol treatment and mental health services to work together to better support people affected by both of these issues. The pathway and implementation plan now need to be progressed. Outcome reports for people in treatment show **significant improvement in mental and physical wellbeing**;

- Partnership working with Community Mental Health Teams continues to remain challenging. The Multi-Agency Safeguarding Meeting at Bolitho, however, is piloting ways of joint working in relation to **vulnerable adults with dual diagnosis** who are being exploited in their own homes;

- The number of people in treatment for 4 years or more has now reduced to **below the national average**, having been above for many years. This represents a considerable period of intensive work being undertaken with this group to facilitate recovery;

- The **Criminal Justice Team has extended its coverage of custody** to include five days a week with rapid assessments being offered the following day. Addaction is now providing a service **directly to Crown Court** as well as its regular service to the Magistrates’ Court. **Restorative Justice** is being incorporated into drug and alcohol treatment;

- A multi-agency response was piloted in Truro, involving the Council’s Anti-Social Behaviour team, Addaction and police, which demonstrated the benefits that could be achieved by a **joint approach to tackling with alcohol and drug-related anti-social behaviour and homelessness** and which can be built upon and rolled out to other localities;

- The **Community Safety training programme**, co-ordinated by the DAAT, has built upon the success of the multi-agency DASH training, and provided multi-agency training in **Mental Health First Aid, Motivational Interviewing, Drug and Alcohol Awareness** and **Young People’s Substance Use Screening Tool (SUST)**, to **facilitate interagency working** with people with combined problems.

Expanded Naloxone provision to reduce overdoses

- Whilst Cornwall **leads the way nationally with its Drug Related Death review** process, excellent working relationship with HM Coroner and issuing naloxone to service users, 2015/16 nevertheless saw an increase in drug related deaths locally;

- In 2015/16 we **introduced naloxone into supported accommodation** for people with complex needs. Drug Related Deaths reviews indicated hotspots where there had been high rates of overdose. **Overdose prevention, life support and training** to use naloxone were delivered along with supplies of naloxone. Addaction staff are now based in some of the bigger supported housing projects to support this work. Expansion of this pilot has been funded by an Innovation and Evaluation grant from Cornwall Fire and Rescue Service;

- **Training packages** supporting **dispensing of naloxone and harm reduction** have been offered to a wide range of frontline staff including hostel and housing staff and staff in daycentres.
Targeted interventions to reduce harm to individuals and the community

- Rates for **Hepatitis C testing are amongst the highest nationally**;
- In 2016 the **first instances of MRSA** were identified amongst injecting drug users in Cornwall, which required the **provision of new swabs and cleansing materials** through needle and syringe exchanges as well as enhanced and updated injecting advice;
- Community safety developed a scheme to respond to any local intelligence about injecting (needle finds) which triggered a joint response from waste and cleansing service, targetted **intelligence-led outreach service** to visit sites and engage service users, who were often homeless, in conjunction with homeless services and other community safety staff, to reduce the risk to others in the community;
- Development of **in-house detox in Cold Weather Provision** and other Housing Provision.

Developed the criminal justice pathway within the new arrangements for offender management

- For the first time, the rate of **referrals into treatment through criminal justice routes is comparable with national** rates;
- Prison releases and court orders along with MAPPA referrals and arrest referrals continue to come directly to the drug and alcohol service. Prolific and Priority Offenders continue to be worked with via the Turnaround Model;
- A **specialist presence in the Crown Court** has led to improved communication and engagement as has an Enhanced Custody liaison role;
- Addaction has been **working with HMP Eastwood Park** to ensure **safe escort of women** back into Cornwall from prison on discharge, as means of reducing risk and increasing their engagement in treatment.
What our people say

Every year, we undertake a survey of service users, staff, stakeholders and affected others to see how well or not we have responded to the feedback we have received in previous years and to identify the priorities for improvement in the future.

Service users can respond through a survey (as provided in Appendix B) or through their local Community Service User Forum meeting. Alternatively, they can contact the DAAT team directly by telephone or email. A total of 118 surveys were returned by service users this year and five focus groups were held across the area, attended by 43 people.

Service users

What is good and most helpful about drug and alcohol services in Cornwall?

- Quality of support from staff – safe and non-judgemental;
- Having offices across the county and easy access;
- Volunteering, training and extra activities to give constructive things to do with time outside of treatment, particularly Lifeskills and Cookery Club;
- MAP (Mutual Aid Programme) groups.

What is not helping or is a barrier to your recovery?

- Recovery café needed, especially at the weekends to support people to maintain abstinence;
- Childcare needed in holiday time in order to attend;
- Travel costs can be high to attend;
- Communication with and understanding of Mental Health services could be improved;
- Breathalyser needed in each office;
- Difficulties when transferring from one Addaction service to another;
- Availability of detox and rehab places;
- Waiting times for counselling;
- Having workers who have experienced and recovered from addiction.

- MH, drugs and alcohol have a stigma and need extra focus
- People are scared about getting help and coming off. They need help not to be scared
- You can’t see mental health services while you’re drinking or on prescription and vice versa, it’s a catch 22
- Everyone’s friendly
- Being accepted
- School holidays are a barrier for me as I just can’t come because of the children. If there were some kind of group here they could go to whilst I attended mine it would help
- I didn’t realise how many other services were available
- I feel I can trust people in the group
- Seeing my Recovery Coordinator at the GP’s
- The cost of travelling to and from the office for groups – I would come more often if I could afford
- When you’re in hospital after an OD you need something in place and support when you leave
- MH, drugs and alcohol have a stigma and need extra focus
- You can’t see mental health services while you’re drinking or on prescription and vice versa, it’s a catch 22

MH, drugs and alcohol have a stigma and need extra focus

People are scared about getting help and coming off. They need help not to be scared

You can’t see mental health services while you’re drinking or on prescription and vice versa, it’s a catch 22
Service providers

What are the strongest aspects of drug and alcohol services in Cornwall?

- **Locally based services** to make treatment more accessible in localities;
- Stronger links between drug and alcohol and *Domestic Abuse and Sexual Violence* services to jointly support people affected by both;
- Stronger joint working with *supported accommodation*, the *Anti-Social Behaviour Team* and other services to support people, particularly vulnerable women with multiple needs;
- Partnership working with the *Alcohol Liaison Team*; creation of treatment loops from hospital to Boswyns;
- *Intelligence-led outreach* and engagement activity;
- *Criminal justice* pathways;
- *Preparation for Treatment* groups;
- *Mutual Aid and recovery support* has increased;
- *Volunteer* provision;
- *Women only* groups;
- *Naloxone* delivery to service users;
- *Hepatitis C* screening and treatment;
- *Lifeskills* programme to support recovery;

What are the weakest aspects of drug and alcohol services in Cornwall?

- *Dual Diagnosis* – joint working with people with combined mental health and substance misuse issues is still widely *inconsistent and challenging to manage*;
- The *burden of recording* and reporting is too great;
- *Internet access* to enable record keeping in remote areas with poor access places a high demand upon recovery workers;
- *More support is required for home detox from drugs* (although provision for alcohol is well developed);
- *Lack of creative use of digital technology* particularly in remote areas.

Stakeholders

The Stakeholder Survey was circulated twice and 10 responses were received, spanning Police, Supported Accommodation, domestic abuse and sexual violence services services, Town Council and Hospital Liaison. Consultation of wider stakeholders is also delivered through the Safer Cornwall Partnership Groups.

What is working well/has been most helpful in helping reduce risks and promote recovery from drug and alcohol related harms in Cornwall and Isles of Scilly to date?

- The range of *support services offered* in groups and 1:1;
There has been increasing inter-agency cooperation, founded on confidence that a service user will be supported promptly – essential when issues have been identified but service users are vulnerable and anxious about approaching another agency;

- **Flexibility and accessibility** of services;
- Following the DAAT training, staff are able to identify substance misuse and can offer an intensive support package working closely together to promote recovery and community integration;
- Better understanding of services and information about what help is available;
- Improved information, communication and relationships between different agencies to support joint working to protect vulnerable people;
- **Homelessness and begging appear to have reduced** in St Austell Town centre;
- Supported housing has been able to accommodate a higher number of more challenging drug users than before because of a combination of naloxone provision and a drug and alcohol use policy;
- **Regular visits** from Addaction worker to see clients on site in supported accommodation.

What has not been working so well or needs to improve?

- Community support for those with a dual diagnosis of both mental health difficulties and drug/alcohol problems, where it is unclear of which the primary issue is;
- **Better links between domestic abuse services, drug and alcohol service and the mental health team** to support women in refuge with a combined package of support (hospital);
- Support safeguarding children of substance misusers. An increase of **treatment services and domestic abuse services working jointly to deliver family interventions** for families and children affected by substance misuse and DASV, including aftercare so that people leaving refuges can maintain recovery;
- Consideration of more women-only provision to attract, engage and promote recovery for women specifically. Mixed provision is tending to deter in some circumstances. This includes support for women seeking supported housing to ensure they can secure and sustain the accommodation suitable to their needs and promote recovery;
- **Access to evening and weekend drug and alcohol services** to encourage women to engage with the help that is available;
- A general need for specific and practical training on managing drug use at a refuge;

*Addaction are a very valuable resource for Penzance with the amount of issues we have with drugs and alcohol. We find that staff are always willing to help*

*Dedicated outreach workers have been putting in the time with some of the most problematic adults and this is having a huge impact upon the Police’s workload and the associated problems that are prevented by targeted outreach/support work*
• **Limited alternative** for those who feel that Addaction and AA does not meet their personal needs;

• The Town Council has recently taken responsibility for a number of parks and open spaces and have reported needles and drug paraphernalia finds but would like feedback as to any actions taken as a result of these reports;

• Crime linked to **drugs and drug sales** has been a problem in St Austell in recent years with an increasing amount of **violence** associated with it;

• Lack of expansion of the services that are needed to address the increase in **rough sleepers**: many of them already have substance misuse issues and those that do not will soon turn to drugs and / or alcohol as an escape mechanism from their desperation;

• **Public perception of people with substance misuse issues** and the effects on the community of the services that help them;

• Better **co-ordination provision for people leaving prison**, many of whom return with drug dependency issues;

• Better **co-ordination and supervision of supported accommodation** with the full range of ‘wet’ and ‘dry’ houses being utilised alongside the pathways to recovery. An increase in ‘dry’ houses or tougher control of drug use within supervised accommodation would assist during transitional phase;

• More **dedicated outreach** provision.

If we could improve **only 3 things in 2017-20**, what would your top priorities be?

• **Better access to mental health services** for people with active addictions and a recognition that drug and alcohol misuse often results from, or leads to, mental health problems so that the two cannot be separated;

• **More supported accommodation** for people with drug and alcohol issues in order to get them off the streets and into a safe and non-judgemental environment where they can be encouraged to address those issues;

• **Greater public awareness** about the causes of substance misuse and the benefits to the community of helping people with substance misuse issues to address their problems;

• More general availability of **Naloxone** in places frequented by drug users;

• Provision of **“fix rooms”** in centres of highest drug use;

• Greater availability of **acute/out of hours services**;

• Training in **managing drug and alcohol misuse** in a residential setting where there are other **vulnerable residents living with their children**;

• **Better links between housing and drug and alcohol teams** that provide psychosocial intervention, groups and structured day programmes;

• **Better communication between all healthcare settings** i.e GP surgeries, Paramedics, Social Services, Hospital, Substance Misuse support and Mental Health Services;

• **More police resource** and a greater police presence in and around the town centre in St Austell;

• Planning and/or commissioning restrictions to **restrict the number of hostels and rehabilitation centres** that may be located in any one area;

• **Improved supervision levels** for recovering addicts /alcoholics trying to reintegrate themselves into society;

• **Funded places on Recovery Programmes outside of Cornwall** to break the cycle and provide specialist support. Each placement should be awarded on
merit, based on the commitment to change of the subject, and likelihood of success of the programme with them;

- **Better promotion of the work carried out by DAAT**, providing frontline staff with information on services available, and contact details for the locally responsible representative. Addaction are known by everyone, having a strong operational presence on the street, however DAAT are not so readily known, being more strategic, so need to push their public image to ensure everyone is aware of the work they do, and how their efforts can practically benefit us in our day to day work.
Why invest in treatment?

Drug use is widespread, but addiction is concentrated

There are strong links between poverty, deprivation, widening inequalities and problem drug use but the picture is complex. It may involve fragile family bonds, psychological discomfort, low job opportunities and few community resources. Not all marginalised people will develop a drug problem, but those at the margins of society, such as the homeless and those in care, are most at risk.

Drug misuse damages health

- Substance misuse has serious health implications and treatment is proven to reduce the strain on local health services;
- Blood borne viruses among injectors, with risk of spread to wider population;
- Liver damage and increased health costs of undiagnosed and untreated hepatitis C;
- Increasing drug related deaths and poisoning. Deaths among heroin users are 10 times the death rate in the general population; deaths involving new drugs and some prescription medicines are rising;
- Arthritis and immobility amongst injectors;
- Lung damage and cardiovascular disease;
- Mental health conditions - depression, anxiety, psychosis and personality disorder.

Drug use impacts upon families and communities

- Parental drug use is a risk factor in 29% of Serious Case Reviews;
- The annual cost of looking after the children of drug using parents that have been taken into care is £42.5 million
- Heroin and crack addiction causes crime and disrupts community safety;
- A typical heroin user spends around £1,400 per month on drugs (2.5 times the average mortgage);
- Drug treatment prevents an estimated 4.9 million crimes every year;
- Treatment saves an estimated £960 million costs to the public, businesses, criminal justice and the NHS;
- The general public value drug treatment because it makes their communities safer and reduces crime. 82% said treatment’s greatest benefit was improved community safety;
- Cornwall has higher than average number of benefits claimants with alcohol and drug problems and higher than average positive outcomes for employment from those in treatment;
- Early intervention saves costs downstream in, the health and wellbeing of children, housing and homelessness, reoffending, crime, employment, benefits and hospital admissions;
- Every £1 spent on treatment achieves £2.50- £4.50 in savings.
How cost effective are our local services when benchmarked nationally? Are we getting value for money?

Putting our local data into the Public Health England Commissioning Tool, the outputs – using the latest available cost effectiveness data – are favourable.

This shows that at a system and intervention level – Cornwall and Isles of Scilly pays less per successful outcome than the national benchmarks.

We have evidence of increasing demand and increasing purity and volume of supply that includes crack, and, consequently, a higher risk profile for blood borne viruses, crime and drug related death. We expect to see increased rates of injecting site infection and ill health associated with increased crack use.

This also significantly increases the period needed to generate recovery within treatment, as crack and opiate combined make this much more complex and difficult. The research supports this – and therefore we have a combined picture of good cost effectiveness and increasing pressures which are likely to impact.

**Opiates**

The most cost-effective pathway for opiate users in Cornwall and Isles of Scilly is Psychosocial only, with a spend of £1,115 per successful completion.

Below are the 5 least cost-effective pathways for opiate users in Cornwall & Isles of Scilly. From the left, the graph shows pathways with the highest spend per successful completion in the 5 pathways.

![Graph showing cost effectiveness of different pathways](image)

Each bar shows the intervention pathway and the estimated spend per successful completion. The grey benchmark columns present a comparative average based on the expected performance of areas of similar complexity profiles.
Overall in Cornwall and Isles of Scilly, the most common pathway for opiate clients was Pharmacological and Psychosocial, with 936 (or 77%) clients attending, costing an estimated £2,593 per client. There were 47 (or 5%) clients who successfully completed this pathway, costing an estimated £51,630 per successful completion.

What this also shows is that local services are consistently more cost effective than the national benchmarks. The least cost effective pathways nationally are the pharmacological and psychosocial.

For opiate users across whole system Cornwall and Isles of Scilly spend per successful outcome is £31,912 and the national benchmark is £55,260, showing that local cost is **42% lower per outcome for opiate users than the national benchmark** data.

This is a **significant improvement on the 2009/10 Cost Effectiveness exercise** where, whilst the majority of our costs were less than the national average, Cornwall’s prescribing interventions (the most costly aspect of drug treatment) were twice the national average, making us a significant outlier.

**Non-opiates**

The **most cost-effective pathway** for non-opiate users in Cornwall and Isles of Scilly is **Psychosocial only**, with spend per successful completion at £775.

Below are the 5 least cost-effective pathways for non-opiate users in Cornwall and Isles of Scilly. From the left, the graph shows pathways with the highest to lowest spend per successful completion in the pathway.

Each bar shows the intervention pathway and the estimated spend per successful completion. The grey benchmark columns present a comparative average based on the expected performance of areas of similar complexity profiles.
Overall in Cornwall and Isles of Scilly, the most common pathway for non-opiate clients was Psychosocial only, with 235 (or 73%) clients attending, costing an estimated £287 per client. There were 87 (or 37%) clients who successfully completed this pathway, costing an estimated £775 per successful completion.

Cost effectiveness is largely similar – although we have some pharmacological and psychosocial at nearly twice the national average for a historic cohort of people dependent on amphetamines who were diagnosed as having ADHD in childhood.

For non-opiate users across whole system Cornwall and Isles of Scilly spend per successful outcome is £3,115 and the national benchmark is £5,361, showing that local cost is also 42% lower per outcome for opiate users than the national benchmark data.

Drug and alcohol treatment represents just over a quarter (26%) of the Public Health Grant, from the period when drug and alcohol services were transferred into public health and into Local Authorities in 2013.

Costs were reduced by 1.6% in 2015/16 and a further 8.6% in 2016/17, due to the national cut to the Public Health Grant.

As a result, we discontinued the following:

- **Intuitive Recovery Thinking Skills** (requiring Addaction to sub-contract from within their existing contract price);
- **Dry Blood Spot testing** (requiring Addaction to sub-contract from within their existing contract price);
- **Family Interventions** were discontinued initially, but subsequently funded at a reduced amount by the Together for Families programme;
- Further efficiencies were delivered through the Addaction contract.

It was identified at this time that any further reductions would necessitate a reduction in treatment places available and significant changes to the drug and alcohol treatment system locally.

Further incremental cuts to the Public Health Grant are anticipated over the next three years (at around £650,000 per annum), although the last 2 years are still indicative. In 2018/19 and 2019/20, if a proportionate cut was made of one third to the drug and alcohol element of the grant, this would amount to a cut of £219,000 in 2018/19 and a further £214,000 in 2019/20 totalling £433,000.

The only remaining area identified for savings without reducing treatment places are premises costs for delivery – if multi-agency hubs could be developed at greater speed in localities, this could reduce spend across the area significantly.
Trends in drug use

Key findings

What’s happening nationally?

- National surveys indicate that drug use is reducing, including class A drugs which are considered to present the greatest risk of harm to society;
- Against this backdrop, however, drug-related deaths have risen to the highest rate since comparable records began in 1993, driven by a sharp increase in heroin/morphine related deaths, particularly in men;
- Research highlights risk factors associated with an aging population and increasing levels of poverty in communities.

What’s happening locally?

- Numbers entering drug and alcohol treatment are on an upward trajectory and above contracted capacity for the service;
- The Drug and Alcohol Action Team, service users and stakeholders are reporting signs of changing behaviours over the last year or so including a re-emergence of heroin use and reports of crack cocaine becoming a more regular feature;
- Consequently we are transitioning to a higher risk profile that features blood borne viruses, high risk injecting behaviour, crime and drug related death;
- Services are also reporting a growing trend of problems with street diazepam;
- There are increasing reports of vulnerable adults with complex needs, homeless drug and alcohol users and associated problems with drug litter and anti-social behaviour;
- Cornwall has one of the highest rates of drug related death in the South West.

Recommendations

1. Ensure drug treatment continues to address a broad range of outcomes, including harm reduction, social integration and recovery, through integrated treatment and recovery support systems;
2. Expand the use of drug treatment outcomes to better reflect the breadth of the benefits of drug misuse interventions;
3. Develop strategies to address the recent increases in drug-related deaths, including integrating healthcare with drug treatment for people who use drug and improving local processes for reviewing incidents;
4. Ensure that there are arrangements to meet the physical and mental health needs of people who use drugs, particularly for older people in treatment;
5. Closely monitor changing patterns of drug use, including use of New Psychoactive Substances (NPS) and problematic use of medicines, and use multi-faceted responses, including managing prescribing practice, developing workforce skills and developing new service pathways for specific sub-populations.
National

- Nationally the trend in drug use “in the last 12 months” has been relatively stable but the long term trend shows a significant drop over the last ten years;
- Young people are more than twice as likely to use drugs but there has been an even stronger decline in drug use over the last ten years and across all types of drugs.

An individual’s drug use or dependency can significantly impact the people around them, including their families, friends, communities and society. The drugs shown to be most likely to cause difficulties are heroin and crack cocaine, which are also linked to economic deprivation, crime and poor health. Drug dependency rarely exists in isolation from other problems.

According to the Crime Survey for England and Wales (CSEW), heroin and crack cocaine use in England is falling, particularly amongst young people. The chart below shows trends in illicit drug use between 1996 and 2015/16.

The CSEW found that that 1 in 12 adults aged 16 to 59 (8.4%) had taken a drug in the last year, equating to around 2.7 million people. Although the trend has been fairly flat for the last 7 years, this level of drug use is significantly lower than a decade ago. Use of all types of drugs has reduced over the last 10 years, with the greatest declines seen in use of cannabis, amphetamines and hallucinogens.

1 in 5 young adults aged 16 to 24 (18%) had taken a drug in the last year, which is more than double that of the wider age group, and equates to around 1.1 million people. Use of LSD, ketamine, mephedrone and anabolic steroids reduced significantly compared with 2014/15.

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Although there has been some fluctuation over the last couple of years, with the estimate in 2012/13 in particular appearing out of line with recent results (anomalously low), the recent trend is relatively flat.

Over the long term, however, this level of drug use amongst young people has seen a faster decline than the wider population: it was at its highest at the end of the 1990s at 32% but had fallen to around 16% by 2012/13. Use of cocaine, crack cocaine, heroin, hallucinogens, amphetamines and cannabis have significantly decreased over the last 10 years.

As a household survey, the CSEW provides a good and robust way to measure general population prevalence of drug use amongst users contained within the household population. Estimates from the CSEW must be considered, however, within the context of survey methodology and the operational challenges of obtaining information from respondents on self-declared drug use.

The ability of the survey to reach and capture the experience of the more “hard to reach” people in the community however, is questionable – particularly those with chaotic lifestyles, who do not live in conventional “households” or who are transient or homeless.

To illustrate, the latest CSEW findings provide an estimate of 264,000 people having used opiates in their lifetime, but only 42,000 people using in the last year. This is significantly less than the Glasgow estimates, which puts the number of people dependent on heroin and/or crack in England between 291,000 and 302,000 people.

The Glasgow estimates continue to be used by Public Health England to estimate treatment penetration, which is just over 50% based on 150,000 having received treatment in 2015/16 who had presented with a dependency on opiates.

That being said, the overall trends indicated by the CSEW are also reflected in the treatment population numbers.

In all, 288,843 individuals were in contact with drug and alcohol services in England in 2015/16; this is a 2% reduction on last year and continues the trend in falling numbers in treatment that began in 2009/10.

Individuals that presented with a dependency on opiates continue to make up the majority of the treatment population (149,807 people, 52%) but there was a fall of 2% since last year and substantial reduction (12%) since the peak in 2009/10.

The decrease in opiate clients in treatment is most pronounced in the younger age groups with the number of individuals aged 18 to 24 starting treatment for opiates having reduced from 11,351 in 2005/06 to 2,367 now – a drop of 79%.

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7 Estimates of the prevalence of opiate use and/or crack cocaine use (2011/12), Glasgow Prevalence Estimation Limited with Centre for Public Health, Liverpool John Moore’s University, April 2014
**Emergence of Legal Highs/Novel Psychoactive Substances (NPS)**

Since 2006 there has been a growing interest in, and availability of, a new generation of drugs collectively known as Novel or New Psychoactive Substances (NPS) or more colloquially, 'legal highs' and less frequently 'research chemicals.'

The arrival of NPS has been something of a ‘game-changer’ in that traditional models of drug diffusion and supply (e.g. for heroin or cocaine) have been joined by the internet as a new route of wholesale and retail supply, distribution and information exchange.

From 2006 until 2016, many of these substances have been legally available on the high street, both from 'head shops' and a range of other retail outlets. However, the Psychoactive Substances Act which came into effect on 26th May 2016, bans the manufacture, sale and distribution of any and all psychoactive substances accompanied by a list of exemptions including tobacco and alcohol.

The main group of drugs are the synthetic cannabinoid receptor agonists (SCRAs) which are currently presenting serious problems in prisons and young offender institutions, among the homeless and existing service users.\(^8\)

New patterns of drug use and health risk behaviour are also becoming established including NPS used by injection, and drugs used alongside high-risk sexual behaviour (including chemsex and slamsex).

**Wider risk factors - age and poverty**

Between 2001 and 2031, there is projected to be a 50% increase in the number of older people in the UK.

Research by the Royal College of Psychiatrists\(^9\) identified that both alcohol and illicit drugs are among the top ten risk factors for mortality and morbidity in Europe and substance misuse by older people is now a growing public health problem.

Older people with substance use problems are likely to have more complex health issues and mortality rates linked to drug and alcohol use are higher in older people compared with younger people.

Although the level of poverty in the UK has remained relatively unchanged overall\(^10\) over the last ten years, there has been a dramatic change in who is most at risk compared with a decade ago. There has been a big rise in poverty among young people, and a big fall among the over-75s. More people in poverty are living in working families and more in private rented housing.

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\(^8\) [NPS Come of Age: A UK overview](https://www.drugwise.org.uk/resources;jsessionid=DE235A05B762108D72F05B74C0D70F35), Shapiro H. (DrugWise, 2016)


A literature review on drugs and poverty\textsuperscript{11}, produced by the Scottish Drugs Forum (SDF) on behalf of the Scottish Association of Alcohol and Drug Action Teams identified the following key links between socioeconomic situation and drug use:

- There are strong links between poverty, deprivation, widening inequalities and problem drug use but the picture is complex. It may involve fragile family bonds, psychological discomfort, low job opportunities and few community resources;
- Relative poverty, deprivation and widening inequalities, such as income, are important factors that need to be given a more central role within the drug policy debate as they weaken the social fabric, damage health and increase crime rates;
- Not all marginalised people will develop a drug problem, but those at the margins of society, such as the homeless and those in care, are most at risk.

**Local**

Extrapolating the findings from the CSEW to provide local estimates of drug use, suggests that 24,100 in Cornwall used an illicit drug in the last year, of which just under half (10,100 people) were aged 16-24 years.

These figures are provided with the same caveat that they significantly underestimate drug use in the population, due to issues around survey reach and disclosure.

<table>
<thead>
<tr>
<th>CSEW 2015/16 Drug use in the last year</th>
<th>16-59 years</th>
<th>CIOS estimate</th>
<th>16-24 years</th>
<th>CIOS estimate</th>
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</thead>
<tbody>
<tr>
<td><strong>Class A</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any cocaine</td>
<td>2.3%</td>
<td>6,510</td>
<td>4.4%</td>
<td>2,480</td>
</tr>
<tr>
<td>- Powder cocaine</td>
<td>2.2%</td>
<td>6,390</td>
<td>4.4%</td>
<td>2,480</td>
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<tr>
<td>- Crack cocaine</td>
<td>0.1%</td>
<td>270</td>
<td>0.0%</td>
<td>10</td>
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<tr>
<td>Ecstasy</td>
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<td>4.5%</td>
<td>2,530</td>
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<td>Hallucinogens</td>
<td>0.5%</td>
<td>1,440</td>
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<td>- LSD</td>
<td>0.2%</td>
<td>500</td>
<td>0.6%</td>
<td>310</td>
</tr>
<tr>
<td>- Magic mushrooms</td>
<td>0.4%</td>
<td>1,140</td>
<td>1.3%</td>
<td>700</td>
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<td>Opiates</td>
<td>0.1%</td>
<td>370</td>
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<tr>
<td>- Heroin</td>
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<td>230</td>
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<td>0</td>
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<tr>
<td>- Methadone</td>
<td>0.1%</td>
<td>220</td>
<td>0.1%</td>
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<td><strong>Class A/B</strong></td>
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<tr>
<td>Any amphetamine</td>
<td>0.6%</td>
<td>1,750</td>
<td>1.1%</td>
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<td>- Amphetamines</td>
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<td>1,740</td>
<td>1.1%</td>
<td>630</td>
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<tr>
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<tr>
<td><strong>Class B</strong></td>
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<td></td>
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<tr>
<td>Cannabis</td>
<td>6.5%</td>
<td>18,700</td>
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<td>Ketamine</td>
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<tr>
<td>Mephedrone</td>
<td>0.3%</td>
<td>780</td>
<td>0.9%</td>
<td>520</td>
</tr>
</tbody>
</table>

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\textsuperscript{11} **Drugs and Poverty: A literature review**, Scottish Drugs Forum (March 2007)
Local intelligence also provides some evidence that trends in Cornwall may not mirror the national picture.

Historically, Cornwall has had comparatively minor problems in relation to crack cocaine and this has been reflected in both police activity and the profile of the treatment population. The Drug and Alcohol Action Team, service users and stakeholders are reporting signs of changing behaviours over the last year or so including a re-emergence of heroin use and reports of crack cocaine becoming a more regular feature in the local drug market and impacting on crime and anti-social behaviour.

- Consequently we are transitioning into a higher risk profile that features greater threats from blood borne viruses, high risk injecting behaviour and related health issues, crime and drug related death.

After a sustained period of decline, locally numbers in treatment are increasing and this is across all types of drug use. The treatment population grew by 6% overall in 2015/16 compared with the previous year and continues to grow.
Opiates

- Up until 2012, the number of opiate users in treatment was steadily declining, in line with the national trend. This trend flattened out around July 2013 and since then has followed an **upwards path**, increasing by 2% in both 2014/15 and 2015/16;
- The growth in opiate users in 2015/16 was predominantly in users aged between 35 and 54 years and this trend has stabilised in 2016/17. Opiate presentations for the **18-24 age group** dipped down to 5% in 2015/16 but has returned to a **similar level to previous years**, 9%, in the year to date;
- Whilst there has been a numerical rise in opiate users presenting to treatment, the **proportion of people starting treatment and citing opiates as a problem substance has reduced**.
- Review of people coming into treatment over the last three years shows **more problematic crack use amongst opiate users**.

Non-opiates

- The change in non-opiate users has seen the most fluctuation, with numbers dropping massively for the last couple of years, compared with a rise reported nationally. Numbers significantly recovered in 2015/16, although have not reached the same levels as pre-2013/14.

In response to the previous decline, the service improvement plan specifically **targeted an increase in the number of non-opiate users** in treatment, and this included making services more accessible and more varied, including a range of unstructured support interventions (such as breakfast clubs, drop-ins, and volunteer support). This will undoubtedly have been a **key driver** in the upwards trend.

- The growth in non-opiate users shows a greater skew towards the 18-24 age group, but presentations in users aged 35 to 54 have also increased. Increases in users seeking help for **powder cocaine and cannabis** use account for the majority of the rise, alongside a **small increase in benzodiazepines**;
- Numbers presenting with **NPS** recorded as a problem substance continue to be small, **accounting for around 2%** of all new presentations to treatment. Locally NPS presentations peaked at the end of 2015/16 and have since started to drop this year.

Boswyns residential assessment, stabilisation and detox unit reports a growing trend of clients experiencing **increased problems with street diazepam**.
Drugs and Crime

Key findings

Drugs and crime

- We have seen levels of recorded drug offences and seizures rise and fall, largely reflecting levels of police focus and activity to uncover drug-related criminal activity;
- In line with the national picture, rates of theft offences (burglary, shoplifting, vehicle crimes), commonly associated with drug use as a means of funding an addiction, have fallen year on year. The latest data, however, indicate emerging negative trends in all types of theft except vehicle crime;
- There have been local cases of vulnerable people being targeted by Organised Crime Groups to use them and their home to sell illicit drugs, including those in recovery;
- There is evidence of wider availability of higher purity heroin and notification of increased availability and use of crack cocaine and methamphetamine.

Drug users in the criminal justice system

- Further to the transition of offender management services, there has been no progress with either the public sector National Probation Service or private sector Community Rehabilitation Company in re-establishing information sharing arrangements, leaving a gap in the evidence base around the needs of adult offenders;
- Based on limited data provided by the Community Rehabilitation Company, identification of drug and alcohol related needs have significantly declined and this could signify a skills gap to screen, identify and refer drug and alcohol related needs appropriately, but could also be a reflection of a lack of capacity;
- 28% of the 900 people accessing the (mental health) Liaison and Diversion service in courts and police custody were identified as having a drug problem. Although two thirds of this group were not in current contact with specialist services, only 10% were referred to treatment, 28% received advice and 14% refused help;
- For the first time, the rate of referrals into treatment through criminal justice routes is comparable with national rates. Successful completions amongst CJS clients tend to be lower than the wider treatment population;
- The use of new psychoactive substances (NPS) is a particular problem in prisons.

Recommendations

1. Sustain robust and integrated pathways between drug treatment and all points of the criminal justice system, including pathways between prison and community-based treatment;
2. Establish whether and how rates of referral and engagement of people identified by the Liaison and Diversion and offender management services could be improved.
Drugs impact on crime in many ways; from the economic necessity to obtain money to fund drug use to the psychopharmacological effects of taking the drugs and the actions of organised crime groups supplying them.

The economic and social cost of drug use and its supply is estimated to be around £10.7 billion per year, of which £6 billion is attributed to drug-related crime.\(^\text{12}\)

**Acquisitive crime**

There is a notably **strong link between drugs and acquisitive crime**.

Nationally, an estimated **45% of acquisitive crimes**, with the exception of fraud, are **perpetrated by regular heroin/crack cocaine users**. This association is perhaps made more obvious when Public Health England suggests that a typical heroin user spends around £1,400 per month on drugs. This amounts to more than two million offences.

1. Rates of serious acquisitive crime (burglary and vehicle offences) are **significantly lower** in Cornwall than the averages for our most similar family. The number of crimes has **dropped year on year**: this reflects national trends and is largely attributed to **improvements in both vehicle and household security**;
2. Thefts of vehicle, however, which make up the lesser part of vehicle offences (24%) saw a number of **localised spikes** last year and due to the base level of crimes being fairly low, this had the effect of increasing the number of crimes by just under 20%;
3. The latest data (reviewed in December 2016), however, indicate **emerging negative trends in all types of theft** except vehicle crime.

**Offences relating to the possession of drugs** is a further area of criminality that is an inherent risk for drug users. Involvement in trafficking of drugs is also a risk but drug supply is usually controlled through serious organised crime networks, where the drug user is at the lower reaches of this hierarchy.

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\(^{12}\) *Modern Crime Prevention Strategy*, Home Office (March 2016)
Drug trafficking and supply

Drug trafficking is a term used to describe a global trade which is involved in the cultivation, manufacture, distribution, illegal importation and sale of illegal drugs such as heroin, crack cocaine, amphetamines and cannabis.

Drug trafficking is one of the serious and organised crime themes identified in the National Security Strategy as a threat to national security, requiring an effective cross-government and law enforcement response. In November 2014, a requirement was created for Serious and Organised Crime Local Profiles to be created and a Guide for their use by local partnerships was published.

Locally we chose to produce five separate profiles covering the serious and organised crime themes and these are as follows:

- Modern Slavery
- Child Sexual Exploitation and Abuse
- Cyber Crime, Fraud and Counterfeit Goods
- Organised Acquisitive Crime
- Trafficking of People, Drugs and Firearms

The trafficking of People, Drugs and Firearms were grouped together because the mechanisms for transporting people, drugs or firearms are very similar, whether it is on a national, regional or local level. The profile had not been completed at the time that this assessment was drawn together.

Emerging threats

‘County Lines’ is a national issue involving the use of mobile phone ‘lines’ by Organised Crime Groups (OCGs) to extend their drug dealing business into new locations. This generally involves a group from an urban area expanding their operations by crossing one or more police force boundaries to more rural areas, setting up a secure base and using runners to conduct day to day dealing.

A ‘county lines’ enterprise almost always involves exploitation of vulnerable persons; this can involve both children and adults who require safeguarding, and who may or may not have had any involvement in drug use previously. The National Crime Agency produced an intelligence assessment in 2015 examining this issue in detail. The assessment has identified the need for a multi-agency approach at a national, regional and local level.

The issue of safeguarding was raised as a major concern as many gangs form their secure base in the homes of vulnerable people and force assistance by using violence or exploitation, including an addiction to drugs. This is often described by the term “cuckooing”.

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13 Home Office (November 2014), Serious and Organised Crime Local Profiles: A Guide
14 County Lines, Gangs, and Safeguarding, NCA August 2015
Targets are socially isolated and vulnerable and include people with learning or other disabilities, recovering drug users and people living in sheltered accommodation.

Similarly, the exploitation of young people is a common factor, with groups often recruiting children to work as runners.

A sample of areas affected by county lines activity found that the most common area type were coastal towns (42%), rising to 57% when including towns close to the coast. The areas were characterised by being predominantly white British with lower than UK average numbers of ethnic minorities and an older than average population. These areas typically had at least one issue with either deprivation, low levels of educational attainment amongst residents, unemployment, high levels of mental health issues or crime.

Dorset, Somerset and Wiltshire have all reported particular problems with cuckooing in the last year.

OCGs operating in this way in Cornwall is a relatively new threat and Police focus on identifying and disrupting these operations have driven up reported crime figures for drug trafficking.

From a police perspective, there is continued concern about “cuckooing” but it has been difficult to identify the vulnerable persons being used as a base in Cornwall. This is partly due to their reluctance to pass details of those using them or even to recognise that they are being used in this way.

They are in a difficult position where any revelation may also act as evidence of offences committed by them. It is common place for the vulnerable person to be quite deeply involved in supply offences, likely to result in significant sentencing if found guilty.

This can be compounded by the following factors: their reliance on the OCG supplier for their own supply of heroin/crack cocaine, a sense of “loyalty”, not wishing to be seen as a “grass” and fear of repercussions.

Where vulnerable people have been identified, suitable support and protective measures have been offered but are generally not taken up – unfortunately accepting support does not exclude them from prosecution and this is often their main concern whilst engaging with police.

Custody links have been reintroduced and may be assisting in the support of potentially vulnerable persons in a custody setting where they feel unable to speak freely to officers. There is particular concern that targets appear to be recruited through recovery support groups. A local case study is provided at Appendix A.

A further concern is the safeguarding of vulnerable young people to prevent their recruitment into drug trafficking. Alcohol and/or drug problems was found to be a factor in just under half of all risk assessments undertaken by professionals where a child or young person is believed to be at risk of child sexual exploitation and just over half of all cases that are referred on to the Missing and Sexual Exploitation Forums for action.
- Males are more likely than females to be identified with problem use of drugs and alcohol;
- “Other” exploitation is more commonly identified for young males, in place of or alongside CSE, and **anecdotally this has been linked to exploitation for the purposes of drug trafficking** – this requires further investigation to clarify.

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>All assessments</th>
<th>Referred to MACSE</th>
<th>Females</th>
<th>Males</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n %</td>
<td>n %</td>
<td>n %</td>
<td>n %</td>
</tr>
<tr>
<td>Alcohol and drug misuse</td>
<td>128 48%</td>
<td>38 54%</td>
<td>91 45%</td>
<td>37 56%</td>
</tr>
<tr>
<td>Experimenting with drugs and alcohol. Indicators of CSE in conjunction with chronic alcohol and drug abuse?</td>
<td>98 36%</td>
<td>35 49%</td>
<td>65 32%</td>
<td>33 50%</td>
</tr>
<tr>
<td>Substance misuse by Parents/Carers?</td>
<td>62 23%</td>
<td>12 17%</td>
<td>51 25%</td>
<td>11 17%</td>
</tr>
</tbody>
</table>

Drug offences are categorised within a group of crimes regarded as “victimless” that also includes Weapons Possession and Public Order Offences. Where there is no **victim**, the crime is usually identified as a result of police activity. The main implication is that these types of crime **may increase because police officers are being more active**, rather than because more crimes have happened.

We have **seen levels of drug crime rise and fall** accordingly. Trafficking saw a substantial rise in 2013/14, following an upturn in proactive policing in this area (heroin and cannabis offences saw the most growth) but this dropped quickly the following year.

<table>
<thead>
<tr>
<th>Crime / incident type</th>
<th>Trend</th>
<th>Rate per 1000</th>
<th>2015/16</th>
<th>2014/15</th>
<th>Annual change</th>
<th>Comparison ‘Most similar family’</th>
<th>Trend ‘Most similar family’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possession of Drugs</td>
<td>▼</td>
<td>1.4</td>
<td>773</td>
<td>922</td>
<td>-16%</td>
<td>Below average</td>
<td>▼</td>
</tr>
<tr>
<td>Trafficking of Drugs</td>
<td>▲</td>
<td>0.4</td>
<td>219</td>
<td>183</td>
<td>20%</td>
<td>Above average</td>
<td>▲</td>
</tr>
</tbody>
</table>

Recorded police activity provides **supporting evidence** of increased availability of crack cocaine and heroin, but with the caveat that police focus on Organised Crime Groups (OCGs), as previously described, has been a driving factor.

- Offences related to class A drugs increased to similar levels to those seen in 2013/14, when the last peak in police activity was apparent. There was a particular **focus on heroin, making up a third of trafficking offences recorded** (around 7-10% when it is not a priority);
- There were 6 **recorded offences for crack dealing/possession** in 2015/16, whereas in previous years there have only been 1 or 2. There were 9 seizures of
crack in 2015/16; although this is the highest number recorded in the last 10 years, it should be noted that this represents 1% of all drugs seizures made.

The next table shows the number of drug investigations initiated in Cornwall over the last 12 months, with crack cocaine continuing to feature.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Trafficking</th>
<th>Possession</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>West</td>
<td>East</td>
</tr>
<tr>
<td>Heroin</td>
<td>14</td>
<td>9</td>
</tr>
<tr>
<td>Cocaine</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>Crack cocaine</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>MDMA</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Ketamine</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Herbal Cannabis</td>
<td>33</td>
<td>28</td>
</tr>
<tr>
<td>Cannabis Resin</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Cannabis production</td>
<td>17</td>
<td>16</td>
</tr>
<tr>
<td>LSD</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Temazepam</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Nbome</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Diazepam</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>103</strong></td>
<td><strong>86</strong></td>
</tr>
</tbody>
</table>

Individual case reviews by the police has identified 15 potential county line/cuckooing type investigations this year; 10 in East Cornwall and 5 in West Cornwall. All of these investigations involve seizures of crack cocaine and heroin and there are strong suspicions of involvement of London Organised Crime Group links.

The high numbers of investigations in East Cornwall may be explained by a couple of particularly active OCG members who have turned up at a number of different premises, with regards to the identified County-lines type jobs there has been significant success rate in prosecuting those involved, although this will include the persons who we may also consider vulnerable.

From a police perspective, it is not known whether the Cornish links consider themselves vulnerable or being used; they may consider the lifestyle of allowing their premises to be used in exchange for their drugs acceptable.
Drug markets

The market place is where demand meets supply, and clearly represents an opportunity to reduce the supply of illicit drugs. Therefore, it is important to be aware of the market and its workings.

The National Crime Agency reports that the UK illegal drugs market remains extremely attractive to organised criminals. The prices charged at street level are some of the highest in Europe, and are sufficient to repay the costs of smuggling the drugs into the UK.

The traditional distinction between international importers and the UK-based wholesalers is becoming more blurred, with some regional wholesalers travelling to the continent to arrange their own imports.

British organised criminals are active at all levels of the UK drugs trade, from importing to street-level distribution. A large number of foreign nationals are also heavily involved in the illegal drugs trade in the UK. Some have cultural and familial ties to the countries the drugs come from or travel through – this makes it easier for them to take major roles in the trade.

Once the drugs have been successfully brought into the UK, they have traditionally been transported to major cities such as London, Liverpool and Birmingham before being distributed. Many other cities and large towns act as secondary distribution points, with drugs moved in bulk before being sold on to local dealers. Its close proximity geographically means that Bristol also plays a significant part in the channelling of drugs into Cornwall.

Cornwall has an established drugs market and all types of illicit drugs are available. Traditionally, all of the drug markets in Cornwall and Isles of Scilly are closed. This means that an individual wishing to either supply or purchase drugs would need to be introduced to the drug network before any transaction could take place. There are some exceptions in towns such as Newquay, where there is a street market. The movement of OCGs into Cornwall has caused significant disruption to traditional markets. OCGs identified thus far have been London-based.

As well as physical drug markets, drugs are the primary traded commodity on the dark web. We currently rely on evidence identifying this supply route via phone messaging conversations relating to those arrangements. Investigation into digital media has its limitations and this may not give a true picture to full extent of the use of the dark and deep web.

There is little evidence, however, to suggest the more traditional trafficking routes are being avoided.

Cornwall’s lively festival scene also provides a market for traffickers. MDMA and Ketamine were prevalent on the festival scene along with Alprazolam, Diazepam and cannabis and, to a lesser extent, cocaine. All of these are widely seen in the general market more so. Heroin and crack cocaine, as usual, were not prevalent in the festival scene.

Characteristics of drug markets by drug type
This section examines the characteristics of the drug markets by drug type. It is based on intelligence and the knowledge of the Drug Liaison Officers within Devon and Cornwall Police.

**Heroin and crack cocaine**
Heroin and crack cocaine continues to feature heavily all across Cornwall with particular areas of concern being Newquay, Bodmin, St Austell, Camborne, Penzance, Truro and Falmouth. Most larger towns also feature but to a lesser extent at the moment.

**New Psychoactive Substances**
There are few NPS being seized and little intelligence to suggest that there are large quantities in Cornwall.

**Spice and other synthetic cannabinoids** have become apparent in prison populations across the country and Devon is no exception with Dartmoor and Exeter prisons having identified a certain amount in their respective establishments.

Devon has identified there is a cohort of synthetic cannabinoid users in their area this may be due to a resettled prison population with an addiction to these substances or it may just be a larger city population that supports this addiction at present.

Anecdotally there appears not to be an issue currently with prisoners resettled in Cornwall but it may be seen to pervade other areas such as Cornwall in the future.

**MDMA, Ketamine and other drugs**
“Club” drugs are most popular in Newquay, Falmouth and to a lesser extent, Bude.

The general usage of MDMA has been strong with the earlier part of the year continuing to show a lot of MDMA crystal but in the mid to later stages of the year a resurgence of tablets seems apparent.

This may be as a result of the perceived better quality MDMA Crystal initially taking over from tablets which in turn may have caused producers to improve tablet quality in an attempt to combat this. We do not have any purity data to back this up.

Evidence that Ketamine, MDMA, Diazepam and NPS have been obtained via the internet by some lower level suppliers has been seen.

**Pregabalin** is turning up intermittently but very limited seizures still.

**Price and purity of available drugs**
The purity of drugs varies and can be a major issue of concern to the health and well-being of users. If a batch of drugs of a greater purity than normal appears in a local drug market there is a chance of overdosing occurring. That said, if a market is established it is usually the case that purity remains fairly constant. In terms of price, the laws of the market operate and in times of scarcity prices will rise.

The movement of OCGs into Cornwall has brought in cheaper pricing deals to undercut the established market, either by quantity or price.
The heroin drought of 2010 resulted for a while in low grade heroin on the streets, averaging in percentage from mid-teens to low twenties. By 2014, this had climbed in some areas to 40% while today, purity levels at 60%\(^\text{15}\) and upwards are being quoted. Triangulating data from three forensic laboratories reveals an average UK purity for heroin at 43%\(^\text{16}\);

This will be a factor in the increase in overdose and drug related deaths nationally and locally.

### Drug users and the Criminal Justice System

Fundamental changes have taken place in the last couple of years in policy, legislation and service delivery structure for the management of offenders under the Transforming Rehabilitation agenda.

Although this presented massive challenges in terms of business continuity, we had hoped that it would present opportunities to improve and move towards a more integrated working model with the new service providers, as well as improving information recorded, information sharing and the evaluation of delivery.

Offender management is now split between a public sector National Probation Service that works with high risk offenders, predominantly those managed under MAPPA\(^\text{17}\), and a network of private sector regional Community Rehabilitation Companies (CRCs) that work with the remainder of the offender population.

The Dorset, Devon and Cornwall CRC has been operational since June 2014 and is working alongside existing services but within a changing environment. The expansion of supervision arrangements to include short term custody prisoners from 1 February 2015 (under the new Offender Rehabilitation Bill), coupled with a new sentencing framework, and lower than anticipated funding income from the Ministry of Justice, has resulted in significant changes in how offenders are managed in the community, with the key implication being more offenders to manage with a lot fewer dedicated resources.

It is important to note that information sharing arrangements with offender management services have not been reinstated post-transition and this leaves a gap in the evidence base around the needs of adult offenders.

This issue is highlighted in our local Reducing Reoffending Strategy and one of the key strategy objectives identified is to:

- Collect and share good quality local data to inform local needs assessment and to monitor performance and outcomes.

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\(^{15}\) A report from the National Crime Agency received by Peninsula DAAT Group quoted a range of 60-85%

\(^{16}\) DrugWise “How pure are street drugs?” (January 2017)

\(^{17}\) Multi Agency Public Protection Arrangements (MAPPA) is the name given to arrangements in England and Wales for the “responsible authorities” tasked with the management of registered sex offenders, violent and other types of sexual offenders, and offenders who pose a serious risk of harm to the public.
Research shows that engaging drug users into treatment has been shown to **effectively reduce levels of offending**, even for those most entrenched users.

The traditional profile of drug-related crime features offenders with heroin or other class A drug problems committing acquisitive crimes to **provide funds for their addiction** and these drivers continue to mean a **particularly high risk of reoffending**. In Cornwall, it has always been the case that most of our prolific offenders\(^{18}\) have a drug problem that is a key risk factor in their reoffending and this is confirmed by the latest figures from TurnAround (65%).

Historically reoffending rates\(^{19}\) for prolific offenders have been published annually as part of the Ministry of Justice suite of proven reoffending statistics. In Cornwall our local rates saw little change over the ten years that these were measured (a reduction of 0.2 percentage points since 2005) and were lower than the national average, which is in line with our general reoffending profile. The latest reoffending figures for the TurnAround cohort indicate that **62% of the Cornwall cohort reoffended** over the last 12 month monitoring period, but there is no national comparator available.

Further to the split of offender management services under Transforming Rehabilitation, Integrated Offender Management schemes are managed by private sector Community Rehabilitation Companies. At 33%, the **reoffending rate for Dorset, Devon and Cornwall is in line with the national average**.

**Identification**

Historically we have examined the extent of drug and alcohol problems identified through offender assessments undertaken by Probation services and compared this with those in contact with community treatment services.

This has **consistently identified a gap**, with a significant number of offenders assessed as having a drug and/or alcohol problem, but not engaged in treatment. The

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\(^{18}\) Offenders that meet the criteria in the Prolific and Other Priority Offender matrix to come under intensive supervision by TurnAround IOM

\(^{19}\) [Proven Reoffending Statistics](#), Ministry of Justice
rates of engagement for **non-opiate users were lowest** – in 2013/14 when this could last be established it was 21% for structured treatment only, 44% including non-structured interventions.

Prior to the new arrangements for offender management being established in 2014, offenders were managed by Devon and Cornwall Probation Trust.

Criminogenic needs relating to drugs and alcohol amongst offenders under supervision by Probation **remained fairly static** over the 5 years preceding the new arrangements being put in place, with averages of 37% and 58% respectively.

Some limited information on offender needs across the cohort supervised by the CRC was provided for this assessment. Note that not all offenders will receive a full criminogenic needs assessment.

Of the 723 offenders on the current caseload that have had an assessment, **15%** (111 individuals) are identified as having a criminogenic drug-related need.

This appears to show a reduced level of need compared with previous years but the extent to which the cohort has changed means that we cannot make a robust comparison.

Similarly alcohol-related needs have also seen a significant drop in reported levels, down to 36%. Concerns have been raised by the Needs Assessment Expert Group that the drop in identification of drug and alcohol-related needs could **signify a skills gap** to screen, identify and refer drug and alcohol related needs appropriately; particularly when considered alongside other measures of drug use in offenders (such as the Liaison and Diversion Service), but it could also reflect a **lack of capacity**.

Figures are provided for 3 key cohorts - Engage (low risk) and Change (Medium risk and Turnaround, a small cohort of the most prolific offenders) in East and West Cornwall. There is massive variance in prevalence across the different cohorts.

Drug issues are **most prevalent** amongst the **TurnAround cohort** (a small cohort of the most prolific offenders) at 65%. Prevalence of criminogenic risk factors are higher across most types of need in the **West of Cornwall** – 22% of offenders in the West have a drug-related need, compared with only 9% in the East of Cornwall.

We are unable to ascertain at present the the nature of the drug use, any associated risk factors or the levels of engagement with community treatment services. It is
understood that **some research nationally is planned** that will examine the cross over between the two cohorts and effectiveness of engagement.

### Liaison and Diversion Service

The Liaison and Diversion service gives screening assessments to all-age defendants and detainees in the courts and police custody with suspected mental health, learning disability, drug or alcohol problems. It began as a trial in 2013.

This service also extends to any **individuals** who the police come into contact with who they suspect also falls into this category.

Data collected by the service provides a further measure of the prevalence of problem drug use in the offender population, particularly in combination with other needs. Data was made available to us that included anonymised information for **approximately 900 individuals** referred to the service from 1 April 2015 to 31 March 2016. The data is recorded against fields in a national NHS recording framework.

- **Alcohol and drug problems were common** in people accessing the Liaison and Diversion service with levels of 48% and 28% of the total cohort respectively;
- Nearly three quarters (73%) of individuals had **current or previous contact with mental health services** and this was higher still (79%) amongst those identified as having drug and alcohol problems;
- 1 in 5 had been a **victim of abuse** (domestic and/or sexual, either as a child or an adult);
- 26% were suspected or charged with **violence against the person**;
- The percentage of people with **depression** (23%) is almost equal to the PHE estimate of all people in Cornwall with any mental health problems (24%). 27% were recorded as having two mental health problems;
- **A quarter (24%) were at risk of suicide**.

Of those individuals identified as having a drug problem, **50% had been in contact with specialist treatment services**, either currently or previously.

Where an individual **was not in current contact** with specialist treatment services, the following intervention outcomes were recorded:

- 10% were referred for **specialist drug treatment**;
- 28% were given **advice**;
- In **just under half of cases, no referral was made**. The majority of these were recorded as intervention “**Not Applicable, no need identified**” which appears to be contradictory to the assessment of problematic or dependent drug use; this requires further clarification;
- **14% refused help** with their drug problem.
Of those individuals identified as having a drug problem a significant proportion (79%) had either **previous or current contact with mental health services** and the proportion was similar for both problematic and dependent drug users.

The mix of current and previous contact was different, however, with **problematic drug users more likely to be in current contact** (39%) than dependent drug users (22%).

**How do offenders fare in treatment?**

At the start of 2014/15, the criminal justice drug and alcohol team were identified as a separate entity from Addaction adult services. Offenders in treatment were previously recorded within community treatment episodes rather than as a separate criminal justice function.

In the first year, the number of people showing as in treatment with the team saw steady month on month growth (as would be expected), and the proportion of clients in contact with the Criminal Justice System (CJS) steadily increased. The impact of this stabilised the following year and the level of growth has matched the growth seen across the whole treatment population, with the proportion in contact with the CJS staying relatively stable.

- At the end of September 2016, the rates for Cornwall were **below the national average for drug users** (opiates and non-opiates) but **above for alcohol users** (both alcohol only and in combination with non-opiates).
Referral and engagement

The local rate of referrals into treatment via the Criminal Justice System (CJS)\textsuperscript{20} has been lower than the national average for the last ten years. In the last needs assessment cycle, however, we reported that the gap had narrowed.

In 2015/16 24% of referrals into treatment were through a CJS route and for the first time this was in line with the national average of 22%.

Note, however, that over the same time period the proportion of CJS referrals nationally has dropped, albeit not to an equivalent degree.

Performance metrics with respect to how quickly CJS referrals are picked up in the system compare favourably with the national average, although the low numbers mean that this fluctuates.

Treatment outcomes

Successful completions amongst CJS clients tend to be lower than the wider treatment population.

- Local outcomes for offenders are in line with the national average for opiates and non-opiates;
- Offenders presenting with alcohol problems, however (either alcohol only or combined with non-opiates), are less likely to complete treatment successfully with our local CJS Team than the national average.

<table>
<thead>
<tr>
<th>Drug group</th>
<th>CJS</th>
<th>All</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiates</td>
<td>4.9%</td>
<td>7.9%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Non-opiates</td>
<td>60.0%</td>
<td>25.5%</td>
<td>39.5%</td>
</tr>
<tr>
<td>Non-opiates and alcohol</td>
<td>26.9%</td>
<td>22.6%</td>
<td>37.0%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>26.3%</td>
<td>25.4%</td>
<td>40.9%</td>
</tr>
</tbody>
</table>

The number of re-presentations to treatment by offenders following a successful completion outcome is too low to make any comparisons - there were less than 5 individuals in the last 12 month period.

\textsuperscript{20} Referred via the Criminal Justice System means referred through a police custody or court based referral scheme, prison or the probation/CRC service
Prisons

A new report\textsuperscript{21} from policy innovation hub volteface “provides a forensic examination of the current mounting problem of the abuse of New Psychoactive Substances in prisons.” Prisons are described as in crisis with record levels of suicides, violence and self-harm. Traditional drugs have been replaced by a family of drugs called synthetic cannabinoid receptor agonists, generically referred to as ‘black mamba’ or ‘spice.’

The report reviews the rise of spice in men’s prisons in England and argues that the many substances which go under that term have risen to prominence globally in response to international prohibition of popular illicit substances, in particular cannabis. These new substances have relatively unknown risk profiles and many induce paranoia, behavioural disturbances, violence, seizures and convulsions. They are particularly popular in prisons due to their low cost, difficulty to detect and “bird [prison sentence] killing” effects.

Cornwall’s resettlement prisons are Exeter, Channings Wood (located in Newton Abbot) with female prisoners continuing to come through Eastwood Park in Gloucestershire.

HMP Exeter was last inspected in 2016\textsuperscript{22} and Channings Wood in 2012.\textsuperscript{23} The problem of NPS in prisons is considered to have taken hold from around 2012 onwards. More recent inspections talk more explicitly about issues with NPS. Report on an unannounced inspection of HMP Exeter by HM Chief Inspector of Prisons Peter Clarke said the Category B jail faced a challenge to reduce the supply of drugs, such as new psychoactive substances and cannabis.

Hooch, the name given to illicitly brewed alcohol, was also found to be a serious problem.

"Physical security measures were generally proportionate, but the prison faced the almost daily challenge of items such as drugs being thrown over the wall," the report said.

In the six months prior to the visit, there had been 96 assaults, 45 fights and 173 self-harm incidents.

Reported availability of illicit drugs in Channings Wood was assessed as unacceptably high with 59% of main prisoners (those not on vulnerable prisoner wings) saying it was easy or very easy to get illegal drugs. Prisoners also reported problems with diverted medication such as gabapentin and pregabalin.

27% were coming in to prison with a drugs problem and 11% were developing a problem inside. There were significant concerns being voiced about lack of provision of education and purposeful activity.

\textsuperscript{21} High stakes: an inquiry into the drugs crisis in English prisons, volteface (December 2016)
\textsuperscript{22} Report on an unannounced inspection of HMP Exeter by HM Chief Inspector of Prisons (2013)
\textsuperscript{23} Report on an unannounced inspection of HMP Channings Wood by HM Chief Inspector of Prisons (2013)
This provides an **increased challenge for treatment services** to manage across the prison/community interface and to manage and secure sustained recovery. The challenge is made greater by the concomitant reduction in offender management services.

"Many of the people who end up in custody are themselves victims. If you consider women in custody – most have committed petty, albeit persistent, offences and most are victims of violent crimes: domestic violence, sexual abuse or rape.

Largely due to family breakdown and neglect, almost a third of the women and one quarter of the men in prison were taken into care as children compared with 2% of the general population.

*Far more likely to have no qualifications, be homeless and unemployed, to have lived in poverty, to have used class A drugs and to suffer from a psychotic illness, none of these is excuses for offending but this is not a group of happy, healthy people who suddenly turn to crime”*  
Prison Reform Trust (2013), Bromley Briefings Prison Fact File

A large proportion of the in-reach caseload is taken up with people with personality disorder. There is currently **no formal provision of services for people with personality disorder in prison**, despite the fact that such services are available in the community. In addition, there is no coherent and agreed inter-departmental approach to the management of personality disorder within the criminal justice/health sector.

Effective work with offenders with **dual diagnosis and complex needs** depends on **better assessment and information sharing** between various agencies involved with an individual’s care, so as to get a complete picture of their needs. **Drug treatment plays only one part** in supporting rehabilitation and re-integration. Stakeholders have informed the review that the link between the Drug Interventions Programme and mental health services is just not being made.

Many services that support offenders, for example drug treatment and mental healthcare, are **more effectively delivered if partners work together** to plan, commission and provide such services. Together, partner organisations must consider the potential for **aligning commissioning and pooling of resources** to ensure that effective services are available.

Given the high prevalence of dual diagnosis (mental health problems combined with drug and/or alcohol problems) in offenders, careful consideration must be given as to how both issues can successfully be dealt with in **specialist drug and mental health courts**. The holistic approach of domestic violence and community courts seems to better address the typically multiple needs of offenders.
Families

Key findings

Parental drug and alcohol use

- **Witnessing alcohol and/or drug use** is identified as one of the key **Adverse Childhood Experiences (ACEs)** which also include poor mental health of a parent, witnessing violence/abuse and experiencing the incarceration of a parent;
- Children and young people who have experienced four or more ACEs are significantly more likely to **adopt unhealthy behaviours** themselves and more likely to **establish homes with similar harmful behaviours**;
- There are 700 people in drug and alcohol treatment (27% of the population total) that are living with children, which is in line with the national average. These households are recorded as having a total of **1,300 children**;
- Living with children has a **positive impact on treatment outcomes** for parents, for all drug groups, but the level of **successful completions amongst drug users** (opiates and non-opiates) living with children has declined.

Together for Families Programme

- It is **likely that the families of many of the people in treatment** (where there are children in the household) **would be eligible** for the Together for Families programme due to the prevalence of other programme criteria within this cohort, but **engagement in the programme is low at just under 10%**;
- The **pathway** between drug and alcohol services and the Together for Families programme has taken some time to establish and is **not currently resulting in referrals** in either direction or engagement of eligible families;
- The Complex Families Index indicates that families in the locality areas of **Penwith and Restormel**, particularly in areas categorised as **deprived**, are most likely to **present complex multiple needs** and these areas are where we would expect to identify the greatest numbers of eligible families;
- Overall the **priority Community Network Areas** identified are: Bodmin, Penzance, Marazion and St Just (West Penwith), St Austell and Mevagissey, St Blazey, Fowey and Lostwithiel, Camborne and Redruth.

Transitions and young adults in treatment

- The established structured **transition protocol and process** ensures that young people are **safely and successfully transferred into adult services**;
- Young people in the adult service who had **previously engaged** with the young people’s service showed **higher levels of multiple need**. Key themes include previous traumatic events, homelessness, having been in care and mental health conditions;
- 85% of young people in the adult drug and alcohol service were not previously known to the young people’s service, despite the majority **starting using before the age of 18**. How we **identify and engage** these young people remains a challenge.
Recommendations

- Support earlier identification and intervention through embedding routine screening for drug and alcohol problems in all health, children and family services and Child and Adolescent Mental Health Services (CAMHS);
- Develop and deliver targeted interventions to build resilience and reduce harm for children and young people most at risk of Adverse Childhood Experiences, including parental substance use and domestic abuse;
- Improve the effectiveness of the Together for Families pathway and establish the impact that this is having on outcomes for families;
- Undertake a robust evaluation of the new residential unit for young people and families, and continue to develop interventions using a co-production model.
The impacts of parental substance use

National research shows that substance misuse is often a burden not just on the user, but also on other family members, including spouses, parents, siblings and children.

**Dependent children are especially affected** – albeit differently at different ages – by a parent’s substance problem, since parents’ ability to rear, protect and care for their children, attend to their health, feed them and financially support them may be **greatly diminished by their drug and/or alcohol use**. Furthermore, being preoccupied about substance supplies can compromise parents’ abilities to be consistent with their parenting and emotionally responsive to their children’s needs.

Brandon et al.24 looked into 47 serious case reviews and found that families shared many characteristics with **domestic abuse, mental health conditions** and **drug and alcohol problems** being most prevalent among parents and carers. This was reinforced in the findings of the Munro Review of Child Protection (2011) and ‘A Deeper Analysis of the Findings into the Serious Case Review of Daniel Pelka’.

Witnessing alcohol and/or drug use is identified as **one of the key Adverse Childhood Experiences (ACEs)**, which also include poor mental health of a parent, witnessing violence /abuse and experiencing the incarceration of a parent.

Those people with **four or more ACEs** are significantly **more likely to adopt unhealthy behaviours** which could themselves **lead to mental health illnesses and diseases in later life**.25

Specifically people in this group are:

- 4 times more likely to be a *high-risk drinker*;
- 6 times more likely to have had or caused *unintended teenage pregnancy*
- 6 times more likely to *smoke* e-cigarettes or tobacco;
- 6 times more likely to have had *sex under the age of 16 years*;
- 11 times more likely to have *smoked cannabis*;
- 14 times more likely to have been a *victim of violence* over the last 12 months;
- 15 times more likely to have *committed violence* against another person in the last 12 months;
- 16 times more likely to have *used crack cocaine or heroin*;
- 20 times more likely to have been *incarcerated* at any point in their lifetime.

Significantly, the research also shows that **people who have experienced ACEs are more likely to establish homes with similar harmful behaviours**. This research shows the importance of early intervention and support for families to reduce the risk and impacts of ACE.


In particular, it shows the importance of **early identification and intervention** for mental health amongst young people, highlighting the need to approach mental health problems with a **broader awareness** of **potential contributing factors** and other co-existing needs.

### Living with children

Just over **a quarter of individuals in treatment are living with children** under the age of 18, and this is similar to the national average for all drug groups.

<table>
<thead>
<tr>
<th>Drug group</th>
<th>People</th>
<th>% in treatment</th>
<th>National %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiate</td>
<td>369</td>
<td>29%</td>
<td>28%</td>
</tr>
<tr>
<td>Non-opiate</td>
<td>45</td>
<td>29%</td>
<td>24%</td>
</tr>
<tr>
<td>Non-opiate and alcohol</td>
<td>90</td>
<td>26%</td>
<td>22%</td>
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<tr>
<td>Alcohol</td>
<td>193</td>
<td>25%</td>
<td>24%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>697</strong></td>
<td><strong>27%</strong></td>
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</table>

Source: DOMES Q2 2016/17

- Halo records the **number of children living with people in treatment**, and for the current treatment population the total is just under **1,300 children**.

Living with children has a positive impact on treatment outcomes for parents, for all drug groups, with **those living with their children more likely to complete treatment successfully** than the population average. Conversely, clients who are parents but not living with their children are less likely to complete treatment successfully.

The level of **successful completions amongst drug users** (opiates and non-opiates) living with children has **declined**, however, and to a **greater degree than the overall treatment population**. For alcohol users, the level of successful completions amongst those living with children are unchanged.

**Effective communication and collaboration** between services in touch with families, where family members are engaged in drug and alcohol treatment, are important to ensure that the **wider needs of the family are a key consideration** of joint service interventions.

Early intervention through a “whole family” approach is a strong feature in the new Children and Young People Partnership Plan **One Vision26**, particularly supporting one of their Priority Outcome 1: **Strengthening children, young people, their families and communities**

**Effective referral pathways and joint working arrangements** between alcohol/drug services and children/family services where alcohol or drug misuse is a factor was identified as a commissioning priority further to the last needs assessment.

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26 **One Vision**: Partnership Plan for the Children and Young People Transformation Plan 2017-2020, Cornwall Council (2017), currently being consulted on.
One of the key delivery mechanisms is the local Troubled Families Programme, provided locally under the name **Together for Families**. The DAAT has worked alongside the programme since its inception to identify families where drug and alcohol problems are a factor, provide family interventions and monitor outcomes.

One Vision identifies the programme as the principal means of **identifying children and families most at risk** of ACEs, in particular **neglect and domestic abuse**.

The Plan also recognises the **causal link** between the **emotional wellbeing and mental health** of children and young people and **parental alcohol and drug misuse**.

The new **Young Persons / Family Service at Bosence**, which will open in April 2017 with its first cohort of service users, will provide **young people and families with options for residential treatment** for the first time. It will be the only facility of its kind in the country.

The service aims to provide the **best possible environment** for people to receive treatment, and the high specification new building has been designed specifically for young people and families, with young people involved in its design. Interventions supporting the young people and families in the unit are also being **developed using a co-production model**.

### Together for Families Programme

The national Troubled Families Programme, known in Cornwall as the **Together for Families Programme**, is now in Phase 2 of delivery which involved a broadening of the eligibility criteria and a significant increase in the number of eligible families. The programme is currently co-ordinated through Cornwall Council’s Education, Health and Social Care Directorate and governance sits with the Health and Wellbeing Board.

- Cornwall is expected to identify, engage and achieve positive outcomes for **4,050 families** between April 2015 and March 2020.

Phase 1 of the Together for Families programme worked with 1,450 families, against the original government set target of 1,270 families, with 85% of families achieving successful outcomes according to set criteria.

There are 6 criteria identified for Phase 2 of the programme:

- Parent and children involved in **crime and anti-social behaviour**
- Children who have **not been attending school** regularly
- Children who **need help**
- Families affected by **domestic violence and abuse**
- Parents and children with a range of health problems, including **mental health and drug and alcohol problems**
- Adults **out of work/at risk of financial exclusion**; young people at risk of worklessness
The financial framework\textsuperscript{27} for the expanded programme (2015-2020) outlines the additional elements of the programme and includes new requirements to produce a Family Outcomes Plan and a framework by which to evidence positive outcomes. The Together for Families Programme has expanded the eligibility criteria in the Family Outcomes Framework to include ‘an individual currently undergoing or who has undergone treatment for a drug and alcohol issue in the last 12 months’.

In order to ensure that all individuals receive the right support, the pathway requires two processes to be in place:

- Households in which an individual is already receiving drug or alcohol treatment and additional programme criteria are met by the family are entered onto the programme. This process has been hampered by a lack of clarity about the "whole family" offer and consent to share information;
- Families referred to the programme through other routes should be screened, using accredited screening tools, for drug and alcohol needs and referred to specialist services where this is required. Since the move to a keyworker-led model, this is not being co-ordinated.

Currently neither process is resulting in engagement of eligible families.

The first process will be managed by specialist Drug and Alcohol services. The Service Level Agreement between the Together for Families Programme and Safer Cornwall’s Drug and Alcohol Services states that specialist services will check all new clients for programme eligibility and seek explicit consent for individuals to be involved. They will then take on the role of key worker, and information on the family will be reported to the programme team.

This process has only recently got underway and there have yet to be any families entered onto the programme through this process. This is supported by a regular data matching process, undertaken by Amethyst in a secure environment, which checks families that have met other programme criteria against the caseload for drug and alcohol services, and acts as an engagement ‘prompt’ for specialist services.

Phase 1 of the programme funded a number of Together for Families Advocates to engage and support families on the programme, and co-ordinate contact with services. Advocates were trained in Identification and Brief Advice (IBA) to enable them to undertake basic alcohol screening.

This is one of the simplest and most effective interventions aimed at individuals who are at risk through drinking above the guidelines, but not typically seeking help for an alcohol problem. It includes screening for problem drinking using an accredited tool, identification of the level of problem and brief advice to reduce alcohol-related harm (or onward referral for more intensive intervention if required).

- Three referrals to specialist services were received from the programme in financial year 2015/16.

\textsuperscript{27} Financial Framework for the Expanded Troubled Families Programme (Department for Communities and Local Government, last updated March 2015)
With the move to a keyworker-led model, the SLA provides a more **general commitment to workforce development opportunities**, enabling staff involved in delivery of the programme to access the appropriate training for the role, including screening and brief interventions training.

The development of a **single family assessment**, which is one of the features of the delayed implementation of the proposed Phase 2 model, could provide the opportunity further imbed drug and alcohol screening across programme partners.

**National context**

The government evaluation of Phase 1 of the programme found that:

- 11% of all families included an adult assessed by a keyworker as dependent on alcohol;
- 5% had a clinical diagnosis of alcohol dependency; and
- 4% were receiving treatment for alcohol dependency.

The picture for drug use is similar:

- 11% included an adult with a keyworker assessment of dependence on non-prescription drugs;
- 6% with a clinical diagnosis of dependence on non-prescription drugs
- 4% receiving treatment for drug dependency.

In addition, **12% of families included a young person with substance misuse issues** that reach the threshold for structured treatment.

The report does not give information on the concurrence of these issues, or how many of the young people were undergoing treatment. The information provided by local authorities comes from a variety of sources and there may be deficiencies in some of the quality of the data.

**Drug and Alcohol Needs recorded by Council Services**

- In the 12 month period to 30th June 2016, Action for Children’s Family Intervention Project supported 294 children on the Together for Families Programme. They identified that of these children only two needed to reduce or stop using harmful substances and a further nine required protection from poor care associated with parental substance misuse;
- The **Early Help Hub does not have any recording mechanism for referrals** to specialist drug and alcohol services. It is therefore not possible to know if referrals are being made;
- Cross-referencing individuals that are already part of the programme with people who are currently in contact with drug and alcohol treatment services indicate that, of the 188 young people in YZUP, **22% (42 young people)** have been identified as being part of the programme. Furthermore 29 adults on the Together for Families Programme have engaged in structured treatment within the past year\(^\text{28}\), and a further **111** have been in treatment since 2012.

\(^\text{28}\) In the 12 month period to October 2016
Wider needs of individuals in Drug and Alcohol services

353 individuals with current open episodes of structured treatment have children living with them. It is likely that many of these individuals would be eligible for the programme due to the prevalence of other programme criteria within this cohort, but engagement in the programme is low at just under 10% (32 people).

- 63% were unemployed, or economically inactive on presentation to treatment;
- 4% are recorded as having a disability and 13% cited low self-ratings of psychological health at their last TOP;
- 3% were recorded as having a housing problem;
- Police data shows that 4% were charged with or suspected of committing domestic abuse in 2016 and 3% committed a crime in 2015/16.

Young people in treatment for drug and alcohol issues also face other vulnerabilities:

- 29% are involved with Childrens Social Care;
- 24% are affected by domestic abuse;
- 24% have an identified Mental Health Problem;
- 20% are not in education, employment or training;
- 20% are affected by others substance misuse;
- 13% are involved in offending or anti-social behaviour.

The families of 22% of young people engaged with YZUP are currently on the Programme and although this appears to be a significant percentage, given that across Cornwall approximately 1% of all households are on the programme, the high levels of multiple need suggest that this should be higher.

Engagement and Outcomes

Individuals on the programme that have been in Drug and Alcohol Treatment

Overall 25% of all families that have been involved in the Together for Families Programme were provided with intervention through the Family Intervention Project (FIP), 10% worked with Together for Families Advocate (Phase 1) and 20% have been supported by a Together for Families Employment Advisor (TFEA).

A review of engagement levels of the families that are known to drug and alcohol services indicates that lower levels of FIP engagement for these families but are getting higher than average levels of support for advocates and TFEAs.

Of the 29 adults that have been involved in the programme:

- 3 (10%) have also received an intervention from the Family Intervention Programme;
- 8 (28%) engaged with a Together for Families Advocate;
- 10 (34%) received support from a TFEA.

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29 Looked after Child, Child in Need or subject to a Child Protection Plan.
Of the 42 programme families that contain young people referred to specialist drug and alcohol services:

- 11% received FIP engagement;
- 36% engaged with a Together for Families Advocate
- 40% received support from a TFEA.

8% of families in Phase 2 of the Programme have achieved a Payment by Results claim (where they have met all relevant criteria to be counted as “turned around”). In our identified cohort of 29 adults and 42 young people, where one or more family members are in drug and alcohol treatment, **3 families achieved Payment by Results claims** but the numbers are too small to be draw further conclusions.

### Identifying families with multiple needs

The **Complex Families Index** was developed by Amethyst in 2011, originally to inform the drug treatment needs assessment process. It started as a combined small area measure that identified geographical areas that are most likely to experience co-morbidity of domestic abuse with parental drug use and mental health issues.

This methodology has since been utilised within a range of annual needs assessment processes, including for the Together for Families Programme, to **identify geographical areas of high multiple need**, map against services delivered and **highlight potential unmet need** in local populations at a small area level.

The 2015/16 Together for Families Needs Assessment featured a version of the Complex Families Index based upon small area measures for 7 key themes reflecting Phase Two eligibility criteria.

This year this has been further refined to incorporate at least one indicator for each of the six areas on the programme and now includes:

- Youth Crime Offences
- Pupils persistently absent from school
- Child in Need Plans
- Individuals claiming an Out of Work Benefit.
- Domestic Abuse victims recorded by the Police
- Individuals in Drug and Alcohol Treatment
- Mood and Anxiety disorders
- Households with children in Housing Need on the Homechoice housing register

Each indicator is expressed as an index in relation to Cornwall and then averaged to give a single combined index for each area. Each indicator is given equal weighting.

**Table 1** shows the **15 areas in Cornwall with the highest combined index score**. The colours within the index identifies where an LSOA is ranked within each variable.

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30 The geography used is Lower Super Output Area, or LSOA, which typically contains 1,500 people
31 Where an index of 100 means the area has exactly the same prevalence as Cornwall overall; less than 100 indicates lower prevalence and more than 100 indicates higher prevalence.
(i.e. if an area is red it is in a top 5% for that variable). The table also includes the number of families identified as eligible for Phase One of the programme.

Table 2 shows the additional areas where the largest clusters of families were identified for Phase One, but were not identified as areas of high multiple need using the matrix.

This includes several areas that were previously identified in the 2015/16 Needs assessment and correlates highly with the Index of Multiple Deprivation.

- The two areas within the top 15 scores that have not previously featured in either index are St Blazey Gate, Biscovey and Eden Project, and Camelford South. These areas have had a higher than average number of Children in Need cases and youth offenders.
Table 1: areas with highest combined index score

<table>
<thead>
<tr>
<th>2011 LSOA Local Name</th>
<th>Eligible Families n</th>
<th>Youth Crime</th>
<th>Attendence Issues</th>
<th>Children in Need</th>
<th>OOW Benefits</th>
<th>Domestic Abuse</th>
<th>Drug and Alcohol treatment</th>
<th>Mental Health</th>
<th>Housing Need</th>
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<td>Bodmin Town Centre and Berryfields</td>
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<td>St Blazey Gate, Biscovey and Eden Project</td>
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Key

- **Top 5%**
- **Top 10%**
- **Top 20%**
<table>
<thead>
<tr>
<th>2011 LSOA Local Name</th>
<th>Eligible Families</th>
<th>Youth Crime</th>
<th>Attendance Issues</th>
<th>Children in Need</th>
<th>OOW Benefits</th>
<th>Domestic Abuse</th>
<th>Drug and Alcohol treatment</th>
<th>Mental Health</th>
<th>Housing Need</th>
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<td>Redruth North, Close Hill, Strawberry Fields and Treleigh</td>
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<td>St Austell Alexandra Road and East Hill</td>
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<tr>
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<td>Illogan East Pool Park</td>
<td>17</td>
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<td>Stenalees West and Bugle</td>
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<td>Launceston College and Stourscombe</td>
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<tr>
<td>Penryn town, Saracen Way and Glasney</td>
<td>15</td>
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<tr>
<td>Falmouth Laburnum Close, Acacia Road, Draceana Avenue</td>
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<tr>
<td>Liskeard Charter Way and Lake Lane</td>
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<td>Roche South and St Wenn</td>
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<td>Truro Trelander East and Penair</td>
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</tbody>
</table>

Table 2: areas (excluding those above) with the highest numbers of families identified as eligible for Phase Two

Key

<table>
<thead>
<tr>
<th>Top 5%</th>
<th>Top 10%</th>
<th>Top 20%</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
The distribution of eligible families for Phase Two was compared with the Complex Families Index to highlight any areas where we may find clusters of families that have not previously been engaged / targeted by the programme.

This highlighted that generally, there is a strong significant relationship between the number of eligible families for Phase Two and the Complex Families Index score for Phase Two meaning that in general the programme worked with the highest numbers of families in the areas where we estimate there is the greatest need, this can be seen by the large numbers of white areas where the number of identified families are within the predicted range (shown in white in map 2).

There are some exceptions, however:

- In some of the areas such as Newquay Town Centre, St Austell Poltair, St Blazey Gate, Biscovey and Eden Project, Truro Highertown and Malabar, Liskeard Lamellion and Old Road, and Launceston St Stephens., there appears to be relatively few eligible families considering the multiple areas of need identified within the matrix;
- Areas where there are a high number of identified families and low complexity scores are Hayle South and High Lanes, St Column Major South, Launceston College and Stourscombe and Penzance Treneere.

Looking at town level shows a surprising level of need in the North and East of the Cornwall. The highest average levels of need are found in St Blazey, Camelford and Bodmin. This is in part as these towns do not have any LSOAs which have lower levels of need to reduce the average.

Despite this, the index indicates that at locality level, families in Penwith and Restormel, particularly in areas categorised as deprived, are most likely to present complex multiple needs and these areas are where we would expect to identify the greatest numbers of eligible families.

The priority Community Network Areas identified are:

1. Bodmin
2. Penzance, Marazion and St Just (West Penwith)
3. St Austell and Mevagissey
4. St Blazey, Fowey and Lostwithiel
5. Camborne and Redruth

Map 1 shows combined complex needs index scores. This shows higher levels of need in urban areas and slightly higher levels of need in the west of Cornwall.

Map 2 shows the areas with a significant difference between the actual number of Phase 2 families identified and the number predicted by the complex needs index score. Negative residuals (in green) have fewer identified families than the index would predict whereas positive residuals (red) have more than expected identified families.
Transitions and young adults in treatment

Supporting young adults who need to move from young person’s services into adult treatment services is an important process to manage successfully.

Adult treatment services are set-up to deal with the whole spectrum of age groups from 18-plus and therefore this phase of change can be difficult for a young adult to cope with as they reach their late teens. Barriers such as a change of support worker and venue can lead to disengagement with services.

To facilitate this and to ensure that people were in the most age appropriate service, a structured transition protocol and process was introduced in 2010.

In order to combat this, services in Cornwall have, in the past, retained clients in young people’s services after they reached the age of 18. At the end financial year 2015/16 YZUP had 5 clients with an open modality that were over the age of 18, 10% of the young people treatment population. Four of these young adults were 19 or 20 years of age and one was 24.

YZUP, the young person’s drug and alcohol service, will retain a client over the age of 19 if there are specific reasons such as mental health issues or if the client displays cognitive learning difficulties.

While transitions are no longer an issue for treatment service providers, there is evidence to suggest that they may be in other services. Our case study32 demonstrates what problems can be caused in situations when a transition between young person and adult services doesn’t work effectively.

As this picture has improved, services attention is now being drawn to a cohort of young adults presenting to treatment with established drug and/or alcohol problems, having previously not been known to young people’s services.

The 2011 Young Persons Needs Assessment identified that the majority of young adults in adult services had never previously been known to YZUP, despite having started using prior to 18 years of age. It was recommended that the young people’s service explores how they could attract young drug users, particularly opiate users, into treatment at an earlier age.

In 2010/11 there were 254 young adults in adult treatment services (drugs and/or alcohol), of which 85% (217 young people) had never presented previously to YZUP. The latest data appears to indicate an unchanged picture.

- In 2015/16, numbers are very similar, there were 225 young adults aged 18 to 24 years engaged in our adult service, of which 78% had never presented previously to YZUP.

32 See Appendix A Case Study 1 “J”
Referral routes for young adults into adult services, for the period April 2013 to March 2016 are shown below.

- Total referrals for this group have dropped by a fifth since 2013/14, down to 97 in 2015/16;
- The majority of referrals for these young people not known to YZUP are self referrals (43%), followed by referrals through the Criminal Justice System (25%).

Whilst referrals through Criminal Justice routes have declined slightly in 2015/16, this still represents a large proportion of the presenting cohort that are likely to have been displaying escalating criminal tendencies and anti-social behaviours linked with their substance misuse in the years prior to their referral.

Of the 59 clients making up the CJS referrals, 7 (12%) have been previously known to the Youth Offending Service (YOS). As the pathway between the YOS and YZUP is well established and appears to be working well, we might assume that their substance use was not a factor in their offending and/or that it did not reach the threshold for specialist treatment.

The following chart depicts the age of first use (by primary substance) for the 178 young adults who have been referred into treatment services during 2015/16 and the first half of 2016/17.

Of this group 44% (78 young people) are non-opiate users, 36% (64 young people) are alcohol users. Opiate users make up the remaining 20% of the group with 36 users.

As you would expect, the chart identifies that the teenage years up to and including 18 are critical for our service users, as this is when they are most likely to begin experimenting with substances. Over 70% of these individuals began using their substance of choice under the age of 18.
This can be broken down by substance as follows:

- Alcohol – 97%
- Non-opiates – 72%
- Opiates – 36%

The alcohol and non-opiate groups are the most prominent prior to the age of 18, based on age of first use of primary substance. Opiate use becomes more prevalent from the age of 18 onwards, **opiate users are most likely to first use at 18**. Non-opiate users are most likely to begin using between the ages of 14 and 16. All substance groups show a dip in the age of first use at 17, this is most pronounced in the opiate and alcohol categories and possibly indicates an issue around disclosure.

Complexity factors for young adults referred into the adult service over the 12 month period to October 2016 were reviewed. We also looked at four factors known to impact upon successful engagement and completion of treatment; mental health, housing problems, unemployment/worklessness and injecting status.

- This showed that for housing, unemployment and injecting status, young people who had previously been known to YZUP were **more likely to be experiencing problems with these issues**;
- Those clients with a mental health issue were equally proportionally represented within both cohorts;
- Nine out of ten clients appearing in adult services that were previously known to YZUP demonstrate **no change or an escalation** in their substance misuse.

A review of a dip sample of 17 cases highlighted a number of key themes, including coming to terms with a past life event and mental health problems.
Mapping the treatment system

Key findings

What is working well?

- **Abstinence rates for opiates, crack and cocaine** at 6 month review are **within the expected range** for the complexity of our treatment population, as shown in the table below, which indicates that our local system is providing a **stable platform from which to build recovery**;

- Around 95% of people successfully completing treatment have **no housing need** reported on exit and this is in line with the national average. Just under 1 in 5 clients present to treatment with a housing problem and **the majority see an improvement** in their housing situation by the time they leave;

- **Early unplanned exits are better than the national profile** across all drug groups. This indicates that the system is initially **meeting the needs of service users**, and **successfully promoting engagement** with services;

- It is a notable success that **our profile for opiate users in long term treatment is now in line with national average**, having been significantly higher for many years. Our focus on assessing the recovery potential of this group and redesigning the treatment offer over the last couple of years appears to have enabled opportunities for recovery;

- **Our testing rates for Hepatitis C are very high** with only 1 in 20 people in treatment who are eligible for a test not having had one, compared with 1 in 5 nationally.

What needs to improve

- **Injecting abstinence rates** are comparatively low. 52% of people who were still using opiates at their 6 month review were also injecting; this compares with 29% nationally. Local prevalence of **injecting behaviour is higher than average at all stages of the treatment journey** and this will be having an impact on successful completions;

- The proportion of people **completing treatment successfully**, as a proportion of everyone in treatment, has **declined across all drug groups**. A further key factor impacting on this performance measure is that whilst numbers in treatment have been increasing (the denominator of this performance measure), the rate of exits from treatment has not kept the same pace;

- Key themes impacting on successful completions include **housing, employment, injecting, family and relationships and drug use whilst in treatment**. The first journey through treatment offers the best chance of success, with those having had multiple previous episodes being a lot less likely to complete;

- **Increased complexity** within our service user population related to **crack cocaine use** is also starting to impact, and will reduce opiate performance particularly;

- **Dual Diagnosis does not impact on the likelihood of successful completion**, despite frequently being cited as problematic. Poor self-ratings of psychological health at last TOP, however, was strongly associated with leaving treatment unsuccessfully.
Tier 4

- 63 people accessed residential services in 2015/16, of whom 49 (78%) completed successfully. This is half the expected number to require residential rehabilitation but a very high rate of completion;
- Particular challenges include re-emergence and management of physical and psychological pain, particularly of early life trauma; families and/or partners where relationships are dysfunctional or there are dependence issues; additional complex needs such as learning disability or homelessness;
- Retrospective payment of Personal Independence Payments, providing a lump sum of £1,000 or more, has created too much temptation for people newly in recovery;
- Some service users are still not adequately psychologically prepared, or have enough of their life in order to be able to make the best use of the experience.

Recommendations

1. Access to Healthy Relationships programmes and joint couples interventions are a priority to improve outcomes;
2. Use Outcome Rating Scales and Session Rating Scales for all episodes or psychosocial intervention in order to ensure treatment responsiveness and strong alliance factors are maintained;
3. Counselling resources and a trauma informed approach is required to assist people striving to overcome early life trauma.
4. Redesign the treatment pathways to allow for a more intensive approach in the first six months of treatment;
5. Separate drug treatment outcome indicators for both opiate users new into treatment and for existing cohorts, to allow tracking of the progress of those for whom evidence tells us we can expect higher recovery rates;
6. Maintain a realistic recovery ambition for the ageing cohort of heroin users with complex needs, accepting that the proportion of people who successfully complete treatment is likely to continue to fall;
7. Provide longer-term employment and housing support, including in-work support, to help people gain and maintain employment and appropriate housing.
‘Map and gap’ of existing services

NICE guidance (2014) Drug Misuse pathways – Adult Treatment Services

Services have been mapped against the relevant NICE guidance. The majority of pathways and services are in place, with the following gaps and priorities for improvement identified:

- **Families and Carers** - whilst services are available a ‘an assessment of needs’ is not provided as such;
- **‘Affected other’ groups** are provided and individual support. We do not have access in every locality yet;
- **Community Detoxification** – updating skills of community staff is required to encourage take up and ‘Stepped approach to Drug Detox’ is required to match the alcohol detoxification programme.

The national framework for drug treatment, Models of Care, delineates 4 tiers of a treatment system to be available locally.

**Tier 1: Non-substance misuse specific services requiring interface with drug and alcohol treatment**

All services work with a wide range of clients including drug and alcohol misusers, but their sole purpose is not drug or alcohol treatment. The role of non-specialist services, includes, as a minimum, screening drug misusers and referral to local drug and alcohol treatment.

Critical to the effective use of the available services is good screening and assessment of drug users’ needs. The development of consistent screening, triage, assessment and referral protocol:

- Allows generic agencies to identify drug problems and conduct a basic level assessment (screening)
- Defines a simple ‘map’ of local services and the processes of referral into the system
- Backs up the operation of this system with a programme of training for assessors (in line with Drug and Alcohol National Occupational Standards – DANOS) and information-sharing protocols.

Such professionals need to be sufficiently trained and supported to work with drug (and alcohol) misusers who, as a group, are often marginalised from, and find difficulty in, accessing generic health and social care services.

The DAAT training programme is available to non-specialists to develop awareness and the ability to identify, screen and refer Children, Young people and Adults. A training report that shows the level of delivery and range of professionals

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33 NICE pathways – drug misuse
who have accessed the training to date is available as part of the separate supporting documentation set for this needs assessment.

- Take up amongst Housing, Job Centre Plus and domestic abuse and sexual violence services has been high. Take up across Adult social care and children’s services remains low and routine screening has yet to be established and should be a priority for these services.

There may be a need for a specialised drug treatment or ‘addiction’ liaison service to provide a co-ordinated response. Models of such services include drug misuse pregnancy and antenatal liaison nurses.

There is a well-established Pregnancy and Substance Misuse pathway that was revised and updated in 2015 and 2016.

A similar pathway and process has yet to be established with health visiting.

**Tier 2: Open Access drug and alcohol treatment services**

The aim of the treatment in Tier 2 is to engage drug and alcohol misusers in drug treatment and reduce drug-related harm. Tier 2 services do not necessarily require a high level of commitment to structured programmes or a complex or lengthy assessment process.

Tier 2 services require competent drug and alcohol specialist workers. This tier does not imply a lower skill level than in Tier 3 and 4 services. Indeed, many of the functions within this tier require a very high level of professional training and skills. Often drug and alcohol misusers will access drug or alcohol services through Tier 2 and progress to higher tiers.

Drug users must and do have access to the following Tier 2 open-access specialist drug interventions in Cornwall:

- **Drug and alcohol-related advice, information and referral services** for misusers (and their families), including easy access or drop-in facilities;
- **Services to reduce risks caused by injecting drug misuse**, including needle exchange facilities (in drug treatment services and pharmacy-based schemes);
- Other services that minimise the spread of blood-borne diseases to drug users, including service-based and outreach facilities;
- Services that minimise the risk of overdose and other drug and alcohol-related harm;
- **Outreach services** (detached, peripatetic and domiciliary) targeting high-risk and local priority groups;
- **Criminal justice screening, assessment and referral** services (e.g. arrest referral);
- **Motivational and brief interventions** for drugs and alcohol;
- **Recovery support** for people leaving structured treatment to support them in sustaining the gains of treatment and their recovery.

Tier 2 can also include low-threshold prescribing programmes aimed at engaging opioid misusers with limited motivation, while offering an opportunity to undertake motivational work and reduce drug-related harm. This is a priority for exploration in 2017/18, given the increasing demands upon services.
Recording of activity related to non-structured treatment is not mandated for the National Drug Treatment Monitoring System and Public Health England measures treatment system effectiveness based on structured treatment activity only. Performance and other diagnostic reports provided by PHE for the purposes of needs assessment thus include structured treatment figures only. However, in April 2013, non-structured treatment was added to our case management system (Halo) to allow us to examine numbers of clients in non-structured treatment alongside those in structured treatment.

Including individuals in non-structured treatment:
- There was a total of **1,483 opiate users and 711 non-opiate users** in treatment for the 12 month period ending September 2016;
- **Non-opiate numbers have seen the greatest growth** since the last assessment and around **35% are placed in non-structured treatment interventions**.

**Tier 3: Structured treatment**

This includes the provision of community-based specialised drug assessment and co-ordinated care planned treatment and drug specialist liaison.

**Community structured services** include psychosocial interventions and structured counselling, cognitive behavioural therapy, motivational interventions, methadone maintenance programmes, community detoxification, or day care provided either as a drug- and alcohol-free programme or as an adjunct to methadone treatment.

- Tier 3 services require the drug and alcohol misuser to receive a **comprehensive assessment and to have a care plan** which is agreed between the service provider and client;
- People in community structured services will have a **Recovery Care co-ordinator**, responsible for co-ordination of that individual’s care;
- Tier 3 services and mental health services should work closely together to meet the needs of drug misusers with **dual diagnosis** (psychiatric co-morbidity);

Drug users must have access to the following structured drug treatment services, and the vast majority of these interventions are available in Cornwall:

- Specialist structured **community-based detoxification** services;
- A range of specialist structured **community-based stabilisation and maintenance prescribing** services;
- **Shared-care prescribing** and support treatment via **primary care**;
- A range of structured, care planned **counselling and therapies**;
- Structured **day programmes** (in urban and semi-urban areas);
- Other structured community-based drug misuse services **targeting specific groups** (e.g. stimulant users, young people in transition to adulthood, black and minority ethnic groups, women drug misusers, drug misusing offenders, drug misusers with psychiatric problems);
- **Liaison** drug misuse services for **acute medical and psychiatric sectors** (e.g. pregnancy, mental health);
- **Liaison** drug misuse services for local **social services and social care sectors** (e.g. child protection, housing and homelessness, family services);
Local gaps and challenges that require further development and improvement are:

- Increased community detoxification provision;
- Helping people to access daily intensive support, with the challenges of transport costs;
- Providing services specifically for women across a wide geographical area;
- Co-ordinating services for people with multiple needs across housing, mental health and drug services.

**Tier 4 services: Residential services**

Residential services are aimed at individuals with the highest level of presenting need. Tier 4 treatment covers in-patient detoxification and residential rehabilitation interventions.

Services in this tier include: inpatient drug and alcohol detoxification or stabilisation services; drug and alcohol residential rehabilitation units; and residential drug crisis intervention centres.

Tier 4 services usually require a higher level of commitment from drug and alcohol users than is required for services in lower tiers. Residential services are rarely accessed directly by clients; referral is usually via community services.

The estimated need for in-patient interventions (assessment, stabilisation, and detoxification) is 10% of those in treatment, so approximately 120 in Cornwall (drugs) per annum. At least 9 out of 10 of these will be for detoxification.

Outcomes are usually better in specialist dedicated facilities, but these are historically more expensive. By building a local facility at Boswyns, with a capital grant received from the Department of Health, within the third sector, specialist provision was made available locally for the first time and at a lower cost.

**Numbers in treatment**

**How successful are we at getting people into structured treatment?**

National prevalence estimates for adults indicates that we are better than the national average at getting the most numerous and complex problem drug users into treatment.

- Based on a prevalence estimate of 1,882 in Cornwall and 1,300 opiate and/or crack users in treatment, we have a treatment penetration rate of 69%. This is significantly higher than the national estimate of 51%.

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34 National Tier 4 Needs Assessment estimates (2003-2004), NTA, 2005
35 Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2011/12 (Public Health England)
In 2015/16, our local treatment system engaged 2,323 adults in structured treatment.

Compared with 2014/15, there were:

- **2% more opiate users** (n=+26) – nationally numbers fell by 2%
- **26% more non-opiate users** (n=+29) - nationally numbers increased by 3%
- **21% more non-opiate and alcohol users** (n=+47) – nationally numbers were static
- **4% more alcohol users** (n=+26) – nationally numbers fell by 5%

Provisional mid-year performance figures indicate, however, that **these increasing trends may be starting to plateau**.

A prompt response for help plays an important part in supporting the best chances for recovery. Until recently, **waiting times for treatment had remained exceptionally low**, despite the increases in demand across the system over the last 12 months.

- In 2015/16, **every client was able to start treatment within three weeks**.

In **effective treatment** is a term used to describe drug users that have been in treatment for a period of 12 weeks or longer or have completed treatment successfully in less than 12 weeks.

Although numbers accessing treatment are increasing, the **proportion in effective treatment has remained fairly stable at around 95%**; this means that for every 100 people in treatment 95 engage with treatment for long enough to receive a benefit from it.

The proportion of non-opiate users in effective treatment is much higher than the national average; for opiate users it is the same.

<table>
<thead>
<tr>
<th>Number in effective treatment</th>
<th>Baseline 2015</th>
<th>Latest period</th>
<th>Direction of travel</th>
<th>% in all treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiate users</td>
<td>1,212</td>
<td>1,239</td>
<td>2% ▲</td>
<td>96%</td>
</tr>
<tr>
<td>Non-opiate users</td>
<td>110</td>
<td>142</td>
<td>29% ▲</td>
<td>94%</td>
</tr>
<tr>
<td>Non-opiate and alcohol users</td>
<td>238</td>
<td>286</td>
<td>20% ▲</td>
<td>92%</td>
</tr>
<tr>
<td><strong>All drug users</strong></td>
<td><strong>1,560</strong></td>
<td><strong>1,667</strong></td>
<td>▲</td>
<td><strong>95%</strong></td>
</tr>
</tbody>
</table>

Latest period: 01/07/2015 to 30/06/16
What is working well?

Reduced drug use, positive Housing and Employment outcomes

Treatment outcomes are monitored through an assessment tool called the Treatment Outcomes Profile or TOP. The TOP is conducted at the start of treatment, in care plan reviews at approximately three month intervals throughout the client’s treatment journey and on treatment exit.

The tool looks at four key domains for drug treatment:
- Drug and alcohol use
- Physical and psychological health
- Social functioning
- Offending and criminal involvement

As well as being used as a therapeutic tool with the client, the data collected provides a valid and robust means to evaluate progress across the whole treatment population.

Being abstinent or ‘improved’ at 6 month review is associated with eventual successful completion from treatment. NDTMS calculates ‘abstinence’ as zero days use in the previous 30 days and ‘reliably improved’ as a reduction in using days of:

- 13 or more for opiates
- 12 or more for crack
- 8 or more for cocaine
- 10 or more alcohol
- 15 or more for injecting

Abstinence rates for opiates, crack and cocaine at 6 month review are within the expected range for the complexity of our treatment population, as shown in the table below, which indicates that our local system is providing a stable platform from which to build recovery.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Abstinent People</th>
<th>Abstinent %</th>
<th>Expected range Lower</th>
<th>Expected range Upper</th>
<th>Reliably improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiate</td>
<td>66</td>
<td>34%</td>
<td>32%</td>
<td>46%</td>
<td>23%</td>
</tr>
<tr>
<td>Crack</td>
<td>8</td>
<td>38%</td>
<td>19%</td>
<td>61%</td>
<td>14%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>16</td>
<td>70%</td>
<td>36%</td>
<td>77%</td>
<td>9%</td>
</tr>
<tr>
<td>Alcohol (adjunctive)</td>
<td>96</td>
<td>24%</td>
<td>17%</td>
<td>25%</td>
<td>19%</td>
</tr>
<tr>
<td>Injecting</td>
<td>44</td>
<td>42%</td>
<td>53%</td>
<td>72%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Source: DOMES Q2 2016/17

Opiate clients that were not also citing crack cocaine use reported a greater reduction in average number of days of opiate use – a difference of 11 days (from 21 to 10 days) compared with a reduction of 5 days for opiate users also using crack (from 14 to 9 days). Levels of abstinence and improvement were similar for both groups of opiate users, taking into account the low number using crack.

12 month reviews indicate continued positive outcomes for opiate users, with a higher percentage abstinent (41%) and a similar percentage improved (22%).
Those who had stopped using opiates by their 6 month review rated themselves more highly for physical health (+2.6), psychological health (+3.5) and overall Quality of Life (+3.2). Self-rated improvement in psychological health was above the national average (+2.9).

Improvement in all three areas was also reported for clients that had reliably improved but the level of improvement was below the national average.

For non-opiate clients, the highest rates of abstinence were for cocaine and amphetamines but the review sample was too small to say that this is likely to be representative of these groups of users. Taking the low numbers into consideration, rates of both abstinence and improvement were similar to the national average.

Self-rated health and quality of life was more likely to improve than deteriorate for all non-opiate users and regardless of whether they had stopped using. This is likely to be an artefact of the volatility of reviewing a small sample so not conclusive.

The only area where we are not performing well, however, is in injecting abstinence and this has been a consistently problematic area, which has been raised in previous needs assessments. This is examined in more detail later in this section.

<table>
<thead>
<tr>
<th>Outcome at exit</th>
<th>People</th>
<th>%</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Opiate clients</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reported housing need</td>
<td>66</td>
<td>93%</td>
<td>95%</td>
</tr>
<tr>
<td>10+ days paid work</td>
<td>11</td>
<td>15%</td>
<td>23%</td>
</tr>
<tr>
<td><strong>Non-opiate clients</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reported housing need</td>
<td>88</td>
<td>95%</td>
<td>96%</td>
</tr>
<tr>
<td>10+ days paid work</td>
<td>21</td>
<td>21%</td>
<td>34%</td>
</tr>
</tbody>
</table>

Source: DOMES Q2 2016/17

Around 95% of people successfully completing treatment have no housing need reported on exit and this is in line with the national average.

Just under 1 in 5 clients present to treatment with a housing problem. Although the majority see an improvement in their housing situation by the time they exit treatment, they are less likely to complete successfully and a quarter will be in housing need when they leave.

Employment outcomes indicate that lower than average levels of paid work are being undertaken in the month prior to exit, for both opiate (15% vs 23%) and non-opiate clients (21% vs 34%).

Employment is one of the most strongly positive factors in successful completion and then sustaining recovery – with both being employed on presentation to treatment and undertaking paid work at last TOP review increasing the likelihood of leaving treatment successfully. Progress into work is a significant challenge, however - of those who commence treatment out of work, only 10% have progressed to undertaking 10+ days paid work when they leave.

Housing and homelessness and worklessness are discussed in more detail later in this assessment.
Early Unplanned Exits

An early unplanned exit relates to a client who, within the first 12 weeks of treatment, left in an unplanned way (dropped out, moved away, died) or were transferred but did not continue their treatment journey.

Overall around **10% of people leave treatment in an unplanned way and before 12 weeks.**

- Early unplanned exits are **better than the national profile** across all drug groups. This indicates that the system is initially **meeting the needs of service users**, and **successfully promoting engagement** with services.

<table>
<thead>
<tr>
<th>Outcome at exit</th>
<th>People</th>
<th>%</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiates</td>
<td>43</td>
<td>11%</td>
<td>16%</td>
</tr>
<tr>
<td>Non opiates</td>
<td>6</td>
<td>7%</td>
<td>17%</td>
</tr>
<tr>
<td>Non opiates and alcohol</td>
<td>25</td>
<td>12%</td>
<td>17%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>37</td>
<td>8%</td>
<td>14%</td>
</tr>
</tbody>
</table>

Source: DOMES Q2 2016/17

Successful completions, however, is an area of underperformance for us locally. This means that where clients are leaving treatment in an unplanned way, it is after a longer period in treatment rather than in the early phase of engagement.

Unplanned exits for non-opiate users were higher in the latter half of 2015/16 but have now settled at 8-10% (compared with 17% nationally).

Time in treatment

Historically we have consistently had a **high proportion of people in long term treatment** (upwards of 6 years). We know that this group are “more sticky” and less likely to leave treatment successfully – they are older, more complex and less healthy and may have greater problems with social functioning due to having started using at a young age.

- It is a notable success that **our profile for opiate users is now in line with national average**.

<table>
<thead>
<tr>
<th>Time in treatment</th>
<th>People</th>
<th>%</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Opiate clients</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 2 years</td>
<td>432</td>
<td>44%</td>
<td>41%</td>
</tr>
<tr>
<td>6 or more years</td>
<td>289</td>
<td>29%</td>
<td>32%</td>
</tr>
<tr>
<td>Average years in treatment</td>
<td>4.6</td>
<td>4.7</td>
<td></td>
</tr>
<tr>
<td><strong>Non-opiate clients</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 or more years</td>
<td>21</td>
<td>27%</td>
<td>8%</td>
</tr>
<tr>
<td>Average years in treatment</td>
<td>3.1</td>
<td>0.8</td>
<td></td>
</tr>
</tbody>
</table>

Source: DOMES Q2 2016/17

We have undertaken a significant amount of work to assess the recovery potential of this group and redesign the treatment offer. This focus over the last couple of years appears to have enabled opportunities for recovery.
Average years in treatment for the **non-opiate cohort**, however, is significantly longer than the national average and this is due to a higher than average proportion in long term treatment.

Including clients using non-opiates and alcohol as well as non-opiate only produced a cohort of 70 individuals who have been in treatment for more than two years, and this was flagged as an area for closer scrutiny, to identify likely contributory factors.

A random sample of 35 (half of them) were taken and looked at in more detail on HALO.

The results highlighted three key issues:

- A small cohort of people receiving **dexamphetamine prescribing** for amphetamine use;
- Clients that presented to treatment as non-opiate users but have since **switched to heroin** and are receiving Opiate Substitution Treatment (OST) – these accounted for the majority;
- A small cohort of people who are not receiving prescribing treatment and have **highly complex needs**, including severe mental health problems, self-harming and heavy drinking.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Detail</th>
<th>People</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiate Substitution Treatment</td>
<td>Long term script (4+ years)</td>
<td>19</td>
<td>54%</td>
</tr>
<tr>
<td></td>
<td>Methadone or Buprenorphine</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Recent presentation as non-opiate</td>
<td>2</td>
<td>5%</td>
</tr>
<tr>
<td>Dexamphetamine</td>
<td>Recent presentation as non-opiate</td>
<td>8</td>
<td>23%</td>
</tr>
<tr>
<td>Not on script</td>
<td></td>
<td>6</td>
<td>17%</td>
</tr>
<tr>
<td><strong>Sample total</strong></td>
<td></td>
<td>35</td>
<td></td>
</tr>
</tbody>
</table>

**Harm reduction**

Preventing the spread of blood borne viruses is a key health priority outcome to be delivered in drug treatment. People who inject drugs are vulnerable to a wide range of viral and bacterial infections. These infections can result in high levels of illness and in death. Immunisation against Hepatitis B and testing for Hepatitis C form part of the treatment plan for drug users with a history of injecting behaviour.

Information about blood borne virus interventions with drug users in treatment is recorded in NDTMS. Immunisation against **Hepatitis B and testing for Hepatitis C** form part of the treatment plan for all drug users, particularly those with a history of injecting. People who inject drugs are vulnerable to a **wide range of viral and bacterial infections**. These infections can result in high levels of illness and in death.

- Our **testing rates for Hepatitis C are very high** with only 1 in 20 people in treatment who are eligible for a test not having had one, compared with 1 in 5 nationally;
- Recording of courses of **Hepatitis B vaccinations is considerably lower**, with only around a third of eligible clients having a record of receiving one. This is comparable with the national average.

**Blood borne viruses** are discussed in more detail later in this assessment.
What needs to improve?

Successful completions

People completing treatment successfully (and not subsequently returning to treatment) is used as an indicator of how effective our treatment system is and is measured in a number of different ways:

- The number of people that successfully complete treatment;
- The proportion that successful completions accounts for in the total number of people in treatment;
- We also take into account the number of people who come back to treatment again after only a short period of time (indicating that their recovery has not been successful).

The quarterly Diagnostic Outcomes Monitoring Executive Summary (or DOMES) report presents our performance information in the context of other Local Authorities with similar characteristics in terms of the complexity of their service user cohort and geographical areas. The latest figures are for Quarter 2 2016/17 (12 month period ending 30th September 2016).

- Information from NDTMS shows that 7.5% of opiate clients in the latest 12 month period completed treatment successfully (95 people out of a total of 1,260 in treatment) and this is just outside the range of the top performing quartile nationally (8.0% - 13.1%) but above the national average of 6.6%;
- Over the same time period 24.6% of non-opiate clients completed treatment successfully (102 people out of a total of 414 in treatment). This falls well below the threshold for the top performing quartile (40.2% - 53.8%) and is below the national average of 38.2%;
- There has been a decline in performance for all groups, both from the previous quarter and baseline and figures are low compared with our outcome comparator group.

Although performance has declined, in terms of a lower proportion of people completing successfully, a further key factor impacting on this performance measure is that whilst numbers in treatment have been increasing (the denominator of this performance measure), the rate of exits from treatment has not kept the same pace.

This is illustrated by the next chart, which shows a rolling 12 month total of people entering and exiting treatment and successful completions.\(^{36}\) The trend for successful completions has remained fairly static (not improving).

\(^{36}\) Note that this chart counts every start and exit so clients that have engaged with the treatment system more than once in any given 12 month period will be counted as many times as they appear
In people terms, we are **falling short of our target** to be within the top quartile of performance for our Local Authority comparator group by **70 successful completions** (6 opiate users and 64 non-opiate users).

This is most likely due to the **increased complexity** within our service user population related to **injecting crack cocaine use**, which impacts upon every level. This is likely to be present in a significant proportion of our opiate using population now and will have an enormous impact upon performance.

Contributory factors include addressing **concurrent mental health problems** and the need to build recovery capital in **employment, training and housing**.

Added to this, **our drug treatment population** is aging and older people with substance use problems are likely to have **more complex health issues** and mortality rates linked to drug and alcohol use are higher in older people compared with younger people.

The chart (below) plots average age for everyone in treatment in the relevant 12 month period, by drug group.

**Average age has increased across the board, except for the non-opiates only group.**

The proportion of the drug treatment population (excluding alcohol users) aged 40 years and above has increased from 38% in 2013/14 to 45% in the 12 month period ending 31\(^{st}\) October 2016.
Increasing complexity is recognised as a major factor impacting on the outcomes of treatment in the Public Health England evidence review.\(^{37}\) This estimates that the proportion of people in treatment with entrenched dependence and complex needs will increase and thus the proportion successfully completing treatment will continue to fall.

All indications suggest that it is challenging to help people with complex needs and a long treatment history to achieve recovery.

Treatment discharge outcomes were reviewed across a wide range of factors to examine what has contributed to the decline and the degree of impact each may have had on the outcome. The analysis looked at two groups – all drug users and non-opiate users (including non-opiate and alcohol) and compared the last 18 months covered by this assessment (April 2015 to October 2016) with 2014/15.

For all drug users, just under a third of all exits are successful completions.

The key areas where the successful completion rates have decreased are:

- Non-opiate users - specifically users of crack, cocaine, ecstasy and NPS
- **Young adults** (18-24 year olds)
- Clients who presented to treatment in supported housing
- Clients with a physical disability
- Clients with **early onset drug use** (under the age of 10)*

Some client groups, however, have seen an increase in the proportion completing treatment successfully and these were:

- **Benzodiazepine** users
- Clients identifying as from an ethnic group that is not **White British***
- Clients disclosing that they are **Lesbian, Gay, Bi-sexual or Transgender***
- Clients who are **pregnant***
- Clients who own their **own home**
- **Clients referred** between treatment services

* Note that these cohorts are comparatively small in size so interpret with caution\(^ {38}\)

The next chart shows the positive and negative factors in successful completion for all drug users.

- Key themes include housing, employment, injecting, family and relationships and drug use whilst in treatment;
- Being in treatment for **6 or more years** has been highlighted as a positive factor (as it was in the last assessment) but this is likely to be an artefact of the continued drive to move long term service users on and out of treatment,

\(^{38}\) Base number of exits: early onset drug use n=33, not White British n=82, LGBT n=39 exits, pregnant=19
showing that those who did leave treatment in the last eighteen months were ready to go;

- Historically age has not been a positive or negative factor but this year, there is a **positive skew towards older clients** (which may be linked to the focus on long term clients leaving treatment). Gender did not notably impact in either a positive or negative way;

- **Dual Diagnosis** was another factor that **did not impact** on the likelihood of successful completion with an average of 33% of exits being successful for people with Dual Diagnosis and 31% for those without. **Poor self-ratings of psychological health at last TOP**, however, was **strongly associated** with leaving treatment unsuccessfully;

- A further factor that is known to reduce the chances of successful completion is the number of **previous treatment journeys**[^39], with the best chances of success being for people on their first journey through treatment.

Strongly positive
- Employment – presenting to treatment as employed;
  10+ days paid work reported at last TOP
- Older clients (55+)
- Parent living with a child
- No injecting history

Moderately positive
- Referred by GP
- In a relationship
- Having been in treatment for more than 6 years
- Not White British ethnicity

All drug users
Successful completions
32% of all exits

Moderately negative
- History of injecting (not currently)
- Using opiates
- Has any kind of disability
- Drinking (1-200 units; 1000+ units)
- Parent not living with child
- Presenting to treatment as unemployed/NEET
- Other drug use (not opiates/crack) at last TOP

Strongly negative
- Current injecting – presenting to treatment currently injecting; injecting reported at last TOP
- Housing problems – presenting to treatment NFA/temporary/supported housing; housing problem reported at last TOP
- Gypsy or Traveller
- Criminal Justice referral
- Opiate and/or crack use reported at last TOP
- Drinking daily reported at last TOP
For non-opiate users, just under a half of all exits are successful completions.

There has been a drop in successful completions rate across a wide and mixed range of factors, but the most significant contributors are:

- **Self-referrals**
- Clients in the **25-34 age group**
- **Women**, particularly if they are a parent living with child(ren) – the rate in 2014/15 was higher than for men, it has now dropped slightly below the average rate
- **Cocaine** users
- Clients in **North and East or West locality** services
- Clients with a **physical or learning disability**

Some client groups, however, have seen an increase in the proportion completing treatment successfully and these were:

- **Benzodiazepine** users
- Clients disclosing that they are **Lesbian, Gay, Bi-sexual or Transgender**
- Clients who are **pregnant**
- **Clients referred** between treatment services

* Note that these cohorts are comparatively small in size so interpret with caution

The next chart shows the positive and negative factors in successful completion for all drug users.

- Key themes include **housing, employment, injecting, family and relationships** and drug use/heavy drinking whilst in treatment;
- **Age and gender did not notably impact** in either a positive or negative way, although it is noted that successful completion rates for women have dropped from above the population average to just below;
- As was the case for all drug users, **Dual Diagnosis** was another factor that did not impact on the likelihood of successful completion with an average of 45% of exits being successful for people with Dual Diagnosis and 46% for those without. It was not possible to explore any differences between mental health conditions due to this information being recorded in only 5% of cases. **Poor self-ratings of psychological health at last TOP**, however, was strongly associated with leaving treatment unsuccessfully;
- A further factor that is known to reduce the chances of successful completion is the number of **previous treatment journeys**, with the best chances of success being for people on their first journey – this applies equally to opiate and non-opiate users.

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40 Base number of exits: physical disability n=40, learning disability n=24, LGBT n=14, pregnant n=5
Strongly positive  
- Referrals between treatment services

Moderately positive  
- Referred by GP  
- In a relationship  
- Parent living with child  
- Presenting to treatment as employed  
- Presenting to treatment as economically inactive

Non-opiate users only  
Successful completions  
46% of all exits

Moderately negative  
- Has any kind of disability  
- Cocaine user  
- Presenting to treatment drinking 200-399 units  
- Parent not living with child  
- Presenting to treatment as unemployed/NEET  
- History of injecting (not currently)

Strongly negative  
- Housing – presenting to treatment with a housing problem; housing problem reported at last TOP  
- Presenting to treatment drinking 1000+ units  
- Presenting to treatment currently injecting  
- Amphetamine users  
- Drug use reported at last TOP  
- Drinking daily reported at last TOP
Injecting abstinence and using on top

Continued injecting in treatment represents a significant barrier to recovery, and indicates that some people are not gaining the full intended benefit of opiate substitute treatment.

Although rates of opiate abstinence during the first six months in contact with treatment are within the expected range for our complexity profile, rates of injecting cessation continue to be lower than anticipated.

- 52% of people who were still using opiates at their 6 month review were also injecting; this compares with 29% nationally;
- Local prevalence of injecting behaviour is higher than average at all stages of the treatment journey and this will be having an impact on successful completions.

<table>
<thead>
<tr>
<th>Time in treatment</th>
<th>People</th>
<th>%</th>
<th>National %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2 years</td>
<td>33</td>
<td>24%</td>
<td>15%</td>
</tr>
<tr>
<td>2-3 years</td>
<td>21</td>
<td>21%</td>
<td>14%</td>
</tr>
<tr>
<td>3-4 years</td>
<td>9</td>
<td>16%</td>
<td>13%</td>
</tr>
<tr>
<td>4+ years</td>
<td>61</td>
<td>18%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Source: Recovery Diagnostic Toolkit PHE November 2016

The review of people coming into treatment over the last three years shows more problematic crack use amongst opiate users and there are greater risks associated with crack injectors – the need for more frequent injecting, more risky injecting, poorer self-care, increased mental health problems and greater risks of sharing works (which leads to increased risks of blood borne viruses and other health risks).

Injecting and on-top use were identified in the previous assessment as an area for improvement. In September 2015 feedback from DOMES indicated good outcomes in many areas, but we were still above the national average for clients injecting and using on top of their scripts (including alcohol).

In the first audit, we found that on-top use/ongoing injecting was spread throughout the service, but it was highest in the Addaction Criminal Justice Team, and in those people seen by the psychiatrists – and these are the people with the most complex needs.

There was a slight trend for on-top use (including alcohol) to be more common in people new to treatment, but it was nearly as high in people who had been in treatment more than ten years. There was no evidence that people using on top are seen more frequently than those who don’t, but this is almost certainly explained by high rates of non-attendance (DNA) rates in this group.

In 2016, data was obtained for more prescribers, including two Non Medical Prescribers (NMPs), a GP with Special Interest (GPwSI) and a Senior House Officer in addition to the two psychiatrists. This related to over 100 clients (n=110) who were recorded as injecting on-top of their scripts.
The larger dataset also allowed us to **compare methadone doses in different parts of the service**, and to also look at individual prescribers in more detail.

The mean dose for this cohort was 64.3mg. 55% of clients on methadone were on 60mgs or over, and 79% on 50mg or over.

Mean doses were highest amongst prescribers in the Addaction Adult service (68.3mg) and lowest for the NMPs and Criminal Justice Team (53.7mg and 53.8mg respectively).

These dosages **fall within the optimal range, but could also be usefully higher**.

As well as being asked to record dose of methadone, prescribers were asked to comment why the dose isn’t higher.

<table>
<thead>
<tr>
<th>Reason why client’s dose isn’t higher</th>
<th>People</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>DNAing appointments</td>
<td>23</td>
<td>21%</td>
</tr>
<tr>
<td>Titrating up</td>
<td>21</td>
<td>19%</td>
</tr>
<tr>
<td>Not injecting/old data</td>
<td>15</td>
<td>14%</td>
</tr>
<tr>
<td>Doesn’t want increase/doesn’t like methadone</td>
<td>14</td>
<td>13%</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>7%</td>
</tr>
<tr>
<td>Very infrequent on top use</td>
<td>7</td>
<td>6%</td>
</tr>
<tr>
<td>Script already very high</td>
<td>4</td>
<td>4%</td>
</tr>
<tr>
<td>Recently changed prescriber</td>
<td>4</td>
<td>4%</td>
</tr>
<tr>
<td>Too risky (drinking or using benzos)</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>i.v. use is legal highs or cocaine or steroids</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>Already spontaneously reducing on top use</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>110</strong></td>
<td></td>
</tr>
</tbody>
</table>

Guidance for the substitute prescribing from the Royal College of General Practitioners\(^41\) states that the optimal daily dose for maintenance is usually between 60 and 120mg for methadone and 12 and 32mg for buprenorphine.

While research evidence suggests these as optimal doses for most people, **some people will need more and some need less** due to a range of individual factors such as size, gender, age, other health problems and metabolic clearance rates. Doses between 60 and 120 mg may exert clinical effects for 24 to 36 hours; low doses exert clinical effects for only a few hours.

NICE guidance\(^42\) states that higher doses of Methadone Maintenance Therapy (MMT, for example, 60mg or more) were found to be more effective than doses of less than 50mg for improving retention on treatment.\(^43\) Higher doses of MMT (more than 50mg) were also more effective in reducing self-reported illicit opioid use.

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\(^{41}\) Guidance for the use of substitute prescribing in the treatment of opioid dependence in primary care – Royal College of General Practitioners (2011)

\(^{42}\) [Methadone and buprenorphine for the management of opioid dependence](https://www.nice.org.uk/guidance/ta114), NICE (TA114, 2007)

\(^{43}\) For example, 60–109mg compared with 1–39mg resulted in a relative risk of remaining on treatment of 1.36 (95% confidence interval 1.13-1.63)
The 2015 report from the Advisory Council on the Misuse of Drugs (ACMD)\textsuperscript{44} that followed the most recent UK clinical guidelines also states that doses over 60mgs are most effective.

- On the basis of all the available information there is no reason to believe that we use unusually low doses of methadone in Cornwall, or that a substantial proportion of this client group of ‘on-top users’ are on insufficient medication;
- In some parts of the service, where doses were lower this may reflect the fact that these are clients newer to treatment who are ‘titrating up’. The most common reason given by the prescribers for not increasing doses, was because client wasn’t attending prescribing reviews. This was a noticeable issue for the Criminal Justice Team, and can be addressed;
- Very few clients on buprenorphine were identified as using on top. This may be an effect of the drug itself, or because people with better prognoses tend to choose to have it (i.e. clients who want to use on-top of their script opt for methadone);
- Some of the data needed updating (15 cases out of the 110 reviewed) because it reflected out of date TOP data. This only accounted for slightly over 10% of the injecting on top data.

The ACMD report on optimising therapy includes: increasing dose, increasing supervision, increasing psychosocial interventions and drug testing. ACMD highlights that clients in shared care (GP prescribing) miss out on group-work and other psychosocial input.

- Recommendations of the ACMD report include use of injectables and Morphine Sulphate Tablets for people who fail on first line treatment. “ACMD wishes to restate that choice of OST is required in every service.” The impact that this could deliver should be reviewed;
- The ACMD report also indicates that more contact with keyworker and more psychosocial input also improves outcomes for those on Opiate Substitution Treatment (OST). Strang reports and clinical guidelines emphasise layering treatment i.e. increasing level of intervention for clients with more complex needs. There is an argument for making more use of the Criminal Justice Team for outreach dual diagnosis clients who are using on top and difficult to engage;
- The ACMD report states that there should be more Cognitive Behavioural Therapy for common mental health problems (clinical psychologists) – and dual diagnosis clients should be part of a ‘layered’ treatment system. There should also be access to detox;
- Criminal Justice Team clients could be subject to much tighter controls to ensure that are seen by a prescriber before any script is issued, with consideration given to paying for travel arrangements to ensure

\textsuperscript{44} How can opioid substitution therapy (and drug treatment and recovery systems) be optimised to maximise recovery outcomes for service users? Advisory Council on Misuse of Drugs (October 2015)
appointments are kept. **More use could be made of NMPs and GPwSIs** with prison releases;

- There is **some evidence that NMPs tend to use lower doses** – this is a training and supervision issue, but it is also cultural: the nurses need to feel confident they will be supported by the organisation if something goes wrong;
- **Additional administrative support** for key workers in areas where staff are on leave, off sick or in an induction period would be helpful in getting people to appointments.

**Improving our approach**

**Use on top of substitute prescribing** may have little to do with physical discomfort or with psycho-social stress but be primarily a boredom issue. Therefore, adherence to treatment regimes could be more a **motivational issue** as opposed to medical or psychological one.

Rather than taking a polar approach to permissive or regimented positions on prescribing compliance it appears that the **introduction of treatment consequences may prove more beneficial** to treatment gains. Treatment consequences can be arranged on a spectrum from rewarding compliance and engagement to increasing aversive consequences for non-compliance. This is referred to as **stepped motivated care**.

A stepped motivated approach will be trialled to evaluate its impact upon reducing use on top.

**Aftercare**

Research demonstrates that treatment gains in after care should not be related to the intensity of the intervention but duration.**Clients who remain in after care services for three months show the highest long term treatment gains.**

However few clients remain in treatment for this period of time. It has often been assumed that treatment attendance in aftercare is related to the inherent motivation of the client- i.e. those who drop out subsequently relapse because they were less motivated to attend treatment in the first instance.

Research, however, suggests that this is not the case. Treatment attendance tends to produce positive long term outcomes rather than being symptomatic of clients who are successful.**Retaining people in aftercare for three months therefore becomes imperative but the actual attendance rate can be highly flexible as it is the duration and not intensity that appears to be most important.**

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45 Moos and Moos 2003
47 See Vannicelli 1978; Costello 1980
Mutual Aid and Recovery Support

‘Building Recovery in Communities’ (2012) identified further requirements to increase the recovery orientation and success of drug treatment, including peer mentoring and that ‘Active promotion of mutual aid networks are essential’. There is wide availability and choice of mutual aid in Cornwall. The Addaction Mutual Aid programme (MAP) group are available across 16 localities in Cornwall and Alcoholics Anonymous meetings are available in 27.

Ambitions for recovery

The second report of the ACMD Recovery Committee\textsuperscript{48} suggests that our optimism about recovery should be tempered. Evidence suggests that different groups are more or less likely to achieve recovery outcomes. For some people, with high levels of recovery capital (e.g. good education, secure positive relationships, a job), recovery may be easier. For others, with little recovery capital or dependent on some types of drugs (especially heroin), recovery can be much more difficult and many will not be able to achieve substantial recovery outcomes.

We can increase recovery potential by helping people achieve outcomes in recovery domains such as positive relationships, education and training, health and wellbeing, meaningful activity.

Recovery is very ambitious as it is asking some people to achieve more than they had before they became dependent on drugs or alcohol. Many people who develop severe dependence have pre-existing problems or issues. People whose lives are dominated by drug and alcohol dependence often incur significant collateral damage in addition, e.g. health harms. Overcoming drug or alcohol problems is a difficult enough process for most people but this ‘extra stretch’ of overcoming pre-existing problems and coping with the collateral damage incurred through years of substance dependence is a huge leap and our ambition for recovery should be tempered with realism.

For those with severe and complex dependence and other problems, recovery can take years and is a long-term battle requiring long-term support. It may not be possible to tell whether someone has achieved stable recovery until five years after they have overcome their dependence on drugs or alcohol.

Drug and alcohol treatment is an important and sometimes critical part of a recovery journey for many with severe dependence and other problems. Treatment has been demonstrated to be cost effective and the investment and prioritisation of recovery-orientated substance misuse treatment in the UK is welcomed. Evidence shows the quality of treatment makes a difference to recovery outcomes and should ideally be person-centred, optimistic, designed to help in a number of outcome domains, well-managed, and delivered by a skilled workforce.

\textsuperscript{48} What recovery outcomes does the evidence tell us evidence tell us we can expect? Second report of the Recovery Committee, Advisory Council for the Misuse of Drugs (2013)
Treatment and recovery systems need to be designed to help people make progress, though multiple relapses are the norm: a recovery process can require long-term support over many years and systems should be designed to take a long term or ‘extensive’ approach – especially for the UK population of ageing heroin users. If people cannot overcome their drug or alcohol dependence, they should be encouraged to act responsibly and protect themselves and others from harm.

Tier 4 Review

Residential Rehabilitation

These are structured residential programmes with rehabilitative goals and typically expect residents to be drug and alcohol free before they start. Beyond these common factors, programmes may differ according to their philosophy, intensity, inclusion criteria, programme content, and duration. As residential care is a social service, it is means tested and clients must make a contribution to the costs.

Approximately 5% of the treatment population will require residential rehabilitation services (approximately 130 people per annum). Placements are for an average of 12 weeks. The average cost of a placement is £7,500.

63 people accessed residential services in 2015/16, of whom 49 (78%) completed successfully. This is half the expected number to require residential rehabilitation but a very high rate of completion.

Of the 14 people who did not complete successfully:
- 7 engaged back into community treatment
- 1 died
- 1 went into custody
- 5 returned to their partners and families

Whilst the majority leave in a planned and successful fashion, a review of all early leavers and unplanned discharges revealed a number of problems in the system that still require some attention to make more effective use of this provision:

- Being adequately prepared for the experience. Some service users are still not adequately psychologically prepared, or have enough of their life in order to be able to make the best use of the experience;
- As opiates are effective pain relief, managing pain during withdrawal for people who have physical ailments or histories of injuries (and became addicted to pain medicines) is a challenge;
- It is not only physical pain that becomes apparent, psychological pain, particularly of early life trauma, can become uncovered and prove to distressing for the individual to cope with. A trauma informed approach is required, which helps people to recover from the underlying issues;
- The emergence and management of mental health problems during withdrawal. As heroin and methadone can have anti-psychotic properties a range of psychiatric disorders may present during this period;
- Negative aspects of external relationships start to impact – families and partners requiring attention or trying to undermine the success of treatment. There is evidence that families or partners may hinder recovery outcomes (if they are dysfunctional or have dependence issues themselves).
or aid recovery outcomes (if they are supportive). Many are in coercive or co-dependent relationships which impact upon their ability to achieve recovery, often leading to leaving treatment early. Healthy Relationships programmes and joint couples interventions can improve outcomes for couples in treatment;

- Lack of clear discharge and aftercare plans which can be communicated to people confused during their withdrawal. There is a need to review and update plans during withdrawal or once the worst of withdrawal has been achieved, in the light of sobriety;

- The lack of self-esteem and self-care, particularly of the street homeless, once they no longer have the dependence on the substance to mask their life experience;

- The challenges for people with learning difficulties, many of whom have become very distressed and/or violent during and after withdrawal and may have been ‘self-medicating’ to self manage a range of issues;

- In several instances, the person was suddenly in receipt of a retrospective Personal Independence Payment, ranging from £1,400 - £4,000, which was created too much temptation. Relapse prevention needs to prepare people for this and for what steps they can take to minimise this derailing their recovery. Greater awareness of the debt people are in may also assist;

- Problem alcohol users can find themselves too unwell to participate or manage, due to the long term effects of dependent drinking. These patients often require palliative care and an end of life plan.

In April 2017 we will open our new Young Persons / Family Service at Bosence to the first cohort of service users. The building, funded through a Capital Grant from Public Health England, has been under construction since June 2016.

The service aims to provide the best possible environment for people to receive treatment, and the high specification new building has been designed specifically for the purpose of residential treatment for young people and families. The building has been furnished with young people and families in mind wherever possible made it homely and non-institutional and involved young people in the process.

Interventions supporting the young people and families in the unit are being developed using a co-production model. A full evaluation will be undertaken in 2017/18.

Integrated Treatment Systems

Developing the model

Substance misuse occurs on two principal axis. Physical dependence is indicated by the presence of tolerance/withdrawal. Social complications are the breakdown in social functioning that arises as a consequence of use. Effective treatment requires

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49 Personal Independence Payment (PIP) is a benefit that helps with some of the extra costs caused by long-term ill-health or a disability if you’re aged 16 to 64.
the medical provision of prescribing to manage tolerance and withdrawal as well as psycho-social intervention to repair ruptures in social functioning.

Both alcohol and drug problems occur on a spectrum of severity though are initiated at different times in the life course. Drug use tends to be associated with a younger onset in adolescence whereas alcohol problems tend to have a later onset in middle age. This means problem drinkers tend to have a broader range of social functioning prior to the onset of their problems.

Research on the recovery process reflects the classification of substance misuse problems. Successful change is demonstrated in the **abolition of withdrawal**, the **reconstruction of broken social attachments** as well as a **shift in values** in the individual.

**Motivation for change may vary greatly.** Purely internally driven motivation for change is the least enduring form of motivation. External pressures and negative consequences are intrinsic to the change process.

Variance in severity of problems allows for greater titration of psychosocial treatment interventions.

Assessment should map the exact ruptures in social functioning that sustain use and allow for the creation of domain specific care plans that target improvements in every area of the clients life that is assessed. Treatment interventions can be harmonised to ensure they are relevant to the explicit goals of the clients care plan.

**Treatment for alcohol problems should be delivered within a stepped care framework.** This offers rapid access to effective and briefer interventions for less severe problems.

Treatment for opiate users on substitute prescriptions should utilise a **motivated stepped care model** of high or low treatment intensity.

- This allows **scarce psychosocial interventions to be targeted at those most receptive** to it in high intensity;
- Those in the **low intensity treatment arm** will have a **harm reduction care plan and no immediate access to psychosocial support** within their agreed contract. This will be available to them through tier 2 services or by requesting a transfer to high intensity.

Previously **lost treatment time on pursuing unengaged clients can be reallocated** to the development of a broader range of treatment modalities of increasing intensity. It should also allow for the development of treatment interventions that are able to assist clients achieve the stated goals in the care plans.

**Counselling resources** may accommodate a wider range of stated interventions that will assist clients with specific goals. This may include **behavioural couple therapy** amongst others. More generalised counselling models can be deployed with goals outlined in the care plan.

**Treatment responsiveness and common alliance factors** are central in treatment delivery and its success. Treatment interventions can be enhanced
significantly by paying specific attention to these factors regardless of modality delivered.

The use of **Outcome Rating Scales and Session Rating Scales** is advised for all episodes or psychosocial intervention in order to ensure treatment responsiveness and strong alliance factors are maintained.
Physical Health

Key findings

Blood Borne Viruses

- Rates of **Hepatitis C testing are excellent** and pathways to treatment are working well;
- Rates of **Hepatitis B vaccinations** indicate that these could continue to improve;
- Areas such as St Just, Camelford and Looe currently lack a Needle Exchange provision, yet are known to have a number of injecting drug users within their resident populations;
- There are a **number of gaps within the data**, including the issue of various drug related paraphernalia such as vitamin C, citric acid, spoons, foil and sterile water, and recording of needle returns;
- **Crack use**, and in particular groin injecting, has been linked to **MRSA incidence** in drug using population in the South West;
- People who use image and performance enhancing drugs and those who engage in ‘slamsex’ tend to see themselves as separate and different to other people who inject drugs and are therefore more reticent about approaching agencies. Thus, they risk being unaware of the risks they are placing themselves under;
- There is evidence that rates of injecting and injecting related risks remain high in Cornwall and are a priority for attention.

Drug related deaths

- There were **29 deaths in 2016**, representing a 17% increase from 2015 and a 46% increase from 2014. Cornwall and the Isles of Scilly has one of the **highest rates of drug related death in the South West**;
- **Opioids** are by far the largest cause of drug related deaths in Cornwall;
- **Poly-drug use** is a key contributing factor to the increase in deaths, in particular an increase in people using heroin and crack in combination, and people using illicit drugs with prescribed medicines. Other factors include availability and purity of heroin and crack within the drug market and increases in street homelessness;
- Individuals can be in receipt of large amounts of various medicines for physical and mental issues. The combination of prescribed medicines and illicit drugs can proving fatal.
- Naloxone has potentially **prevented 46 overdoses from being fatal** in the last two years.

Suicide

- **Drug and alcohol use are amongst the particular risk factors for suicide**, including untreated depression, unemployment, family and relationship problems, social isolation and low self-esteem.
Recommendations

1. Target interventions to improve injecting prevention and abstinence;
2. Increase provision of safe disposal facilities such as drop boxes and sharps bins across localities, and increase safe return rates and disposal of injecting equipment thereby reducing the rate of reported drug litter finds;
3. Provide dedicated support to pharmacies delivering needle exchange in areas of high usage to encourage referral into treatment;
4. Provide targeted support to people who use image and performance enhancing drugs and those who engage in ‘Slamsex’, as they tend to see themselves as separate and different to other people who inject drugs and are therefore more reticent about approaching agencies. Thus, they risk being unaware of the risks they are placing themselves under.
5. A preventative strategy aimed at reducing the cumulative risk of drug interactions whether they are of legal or illegal origin is required and should be developed jointly with the Clinical Commissioning Group and hospitals;
6. Continuation of the naloxone programme to remain a priority for the contribution it is making to reducing death by overdose locally;
7. All drug and alcohol service staff to participate in ASIST training to aid suicide prevention amongst this high risk group;
8. Further embedding the NHS England initiative Making Every Contact Count (MECC) approach which aims to support people in making positive changes to their physical and mental health and wellbeing. Specifically, within the treatment population, this should focus on:
   o Smoking cessation
   o Alcohol consumption amongst dependent drug takers, and as a relapse risk
   o Physical activity
   o Sexual health
What is the level of need?

Physical ill health has been identified as having a **significant impact on the recovery** potential of people accessing treatment services. This section will look at the mortality and morbidity associated with substance use, the prevalence of comorbid conditions and a **focus on injecting related harm.**

It is worth noting that whilst this section looks exclusively at physical health and the subsequent section mental health we acknowledge that the conditions and issues arising do not occur in isolation. There is an **intrinsic link between physical and mental health**; poor physical health can adversely affect a person’s mental health and poor mental health can negatively affect physical health.

Whilst great effort is being made to bring health and social care responses together within the Health and Wellbeing strategy the **current structures of support still tend to deal with these needs in isolation.** As such, the data available to inform this needs assessment is primarily focussed on either physical or mental health.

It is equally important to recognise the fact that the **relationship between physical health and substance misuse is complex.** It is accepted that for many people, the route into substance misuse was as a way of dealing with health issues. The use of **prescribed medications, chronic pain and self-medication** for other symptoms, including mental health, often **leads to dependency** forming on the substances used. It is likewise true that for many individuals their physical health has been affected by the use of substances. **Chronic liver disease, respiratory illness and blood borne viruses,** caused as a **result of using substances,** are commonly identified within alcohol and drug using populations.

Consideration needs to be given to further embedding the NHS England initiative Making Every Contact Count (MECC) approach which aims to **support people in making positive changes** to their physical and mental health and wellbeing.

MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations.

Specifically, within the treatment population, this should focus on:

- Smoking cessation
- Alcohol consumption amongst dependent drug takers, and as a relapse risk
- Physical activity
- Sexual health
Blood Borne Viruses

In the UK, around one in 100 people who inject drugs is living with HIV. Most have been diagnosed and will be accessing HIV care. However, HIV is often diagnosed at a late stage among people who inject drugs. HIV transmission continues among people who inject drugs, and both injecting and sexual risks remain common. The emergence of injecting drug use around or during sex among some groups of HIV positive men who have sex with men is a concern, as is the recent HIV outbreak among people injecting heroin in Glasgow. Late stage diagnosis is a priority in Cornwall and priority for screening within the treatment population.

Many hepatitis C infections remain undiagnosed. Hepatitis C remains the most common infection among people who inject drugs, and there are significant levels of transmission among this group in the UK. Two in every five people who inject psychoactive drugs are living with hepatitis C and around half of these infections remain undiagnosed. Around one in 20 of those who inject image and performance-enhancing drugs have hepatitis C.

- Cornwall performs exceptionally well in screening for hepatitis C amongst the treatment population, having one of the highest rates in the country, which is a priority to continue.

Pathways to treatment for hepatitis C are well established and supported. People who continue to inject drugs are not a barrier for treatment. Priority is given to those that have cirrhosis or advanced disease and those that are committed to treatment due to the monthly run-rate whatever their injecting status.

There are currently two dedicated treatment places per month for people in drug treatment services, although when more places become available from other centres, the Hepatology team at Royal Cornwall Hospital will ask the Addaction Specialist nurse for additional nominations.

Hepatitis B remains rare, but vaccine uptake needs to be sustained.

In the UK, around one in every 200 people who injected psychoactive drugs is living with hepatitis B infection. About three-quarters of people who inject psychoactive drugs report taking up the vaccine against hepatitis B, but this level is no longer increasing. Uptake of the hepatitis B vaccine is much lower among people who inject image and performance-enhancing drugs. It remains a priority to increase Hepatitis B vaccinations rates.

Bacterial infections continue to be a problem. One-third of people who inject psychoactive drugs report having a recent symptom of a bacterial infection.

Outbreaks of infections due to bacteria are continuing to occur in this group. Some of these infections are severe and can place substantial demands on the healthcare system.
MRSA prevalence

**Intravenous drug use** (IVDU) is a known risk factor for community associated MRSA colonisation and infection. Cases tend to have worse prognosis – protracted hospital admissions, and high morbidity and mortality following infection e.g. endocarditis.

In 2016, the health community in Cornwall identified a number of MRSA bacteraemia occurring in people who inject drugs attending Royal Cornwall Hospital. Cases were predominantly groin injectors and homeless.

**Cornwall has an estimated 900-1,000 people who inject drugs.** Cornwall has a high rate of groin injecting; mainly for the use of heroin and crack cocaine “speedball” injections. Groin injecting is associated with deep vein thrombosis, leg ulcers, groin abscess and other injection related infections, increasing the risk of MRSA bacteraemia.

Concerns given the challenges to influencing improved hygiene around injecting (to reduce all manner of skin and soft tissue infections) are:

- **Increase in numbers of street homeless people** (amongst whom the proportion of injecting drug users is very high) – harder to be hygienic and only one of more pressing concerns;
- **Poly drug use including pregabalin and synthetic cannabinoids** – increasing disinhibited behaviour – and reduced awareness/concern about hygiene in the moment.

The current evidence base around the causes of MRSA bacteraemia and prevalence of MRSA colonisation among people who inject drugs is currently poor. The steps taken locally to prevent spread have been awareness raising with keyworkers around MRSA, signs of sepsis, tissue viability and wound assessment, which are a priority to keep under review.

**Changing patterns of psychoactive drug injection remain a concern.** The increased injection of a range of stimulants, particularly crack cocaine, is a concern. People injecting stimulants often report higher levels of injecting and risky sexual behaviours.

**Provision of effective interventions** which act to reduce risk and prevent infections needs to be maintained. These interventions include needle and syringe programmes, opioid substitution therapy and other treatments for drug use.

Local areas need to be responsive to changes in drug use and risk and offer these interventions in appropriate settings. **Vaccinations and diagnostic tests for infections need to be accessible** and routinely and regularly offered to people who inject or have previously injected drugs in line with guidance. Care pathways and treatments should be available to those testing positive.

Bristol Drugs Project is currently leading an investigation to increase knowledge around this issue and Bristol Clinical Commissioning Group is monitoring identification of MRSA bacteraemia through its Healthcare Acquired Infection (HCAI) group.
Needle Exchange

NICE guidance^{50} requires us to commission services to meet local need and provide a mixture of needle exchange services through pharmacies, custody centres, outreach, detached and fixed site services. These services should provide a mix of the following levels of service to meet local needs:

<table>
<thead>
<tr>
<th>Level</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td><strong>Distribution of injecting equipment</strong> either loose or in packs, suitable for different types of injecting practice, with written information on harm reduction. For example, telling people about specialist agencies, or giving them details about safer injecting practices, including how to prevent an overdose.</td>
</tr>
<tr>
<td>Level 2</td>
<td><strong>Distribution of 'pick and mix' (bespoke) injecting equipment</strong> and <strong>referral to specialist services</strong> plus health promotion advice. This includes <strong>advice and information</strong> on how to reduce the harms caused by injecting drugs. Some level 2 services might also offer additional services, such as blood-borne virus testing or vaccination.</td>
</tr>
<tr>
<td>Level 3</td>
<td><strong>Level 2 plus provision of, or referral to, other specialist services</strong> (for example, specialist clinics, vaccinations, drug treatment and secondary care).</td>
</tr>
</tbody>
</table>

**Level 1 services are delivered through contracted pharmacies** in Cornwall and **Levels 2 and 3 are delivered through Addaction.**

Links and referral pathways between the different levels of service to promote integration and to share learning and expertise is generally good and services are co-ordinated to ensure **testing for hepatitis B and C and other blood-borne viruses is readily available** to everyone who uses a needle and syringe programme.

Services must be coordinated to **ensure injecting equipment is available at times**, and in places, that meet the needs of people who inject drug and we must ensure that services offering opioid substitution therapy also make needles and syringes available to their service users.

**All services should be required to collect data on the delivery of this service**, with regular audit and analysis of reported activity.

This year, we focussed upon Pharmacy Needle Exchange, as this currently costs £120,000 to deliver and we had commissioned a data system to support review and analysis.

There are currently **44 pharmacies across Cornwall participating in the Needle Exchange Scheme**, since April 2015 data has been recorded through these pharmacies on the national PharmOutcomes system provided by Pinnacle Health Partnership LLP.

^{50} **Needle and syringe programmes**, Public health guideline [PH52] (March 2014)
This is the first time we have had access to the data recorded and we aim to investigate how well this data can inform us of the effectiveness of the provision, the level of data that we can gather and if there are any improvements that can be made to the data collection process.

Of the 44 pharmacies registered to the Needle Exchange Service on PharmOutcomes, 27 have reported needle exchange activity.

In 2015/16, these 27 pharmacies issued **26,000 packs of syringes** between them, where each pack contains 10 needles and an incinerator (CIN) bin.

- This is a 30% increase on 2013/14;
- As in 2013/14 the top 3 busiest sites are in St Austell, Bodmin and Camborne;
- The share of packs provided by the busiest 3 pharmacies as a proportion of the Cornwall total has reduced from 50% to 40% in 2015/16, indicating that other areas, such as Truro, are increasing their provision.

The total number of **visits to our pharmacies was 5,072**. From the data it is difficult to tell how many individuals make up these visits as the recording is usually anonymised down to just two initials, however **numbers can be estimated to be as high as 1,350 individuals**.

The total number of CIN-bins **returned** across the county was 7762 for the year, with the top 3 busiest sites located in Bodmin, St Austell and Camborne and accounting for **49%** of the total.

- Assuming that each of these bins was full (10 needles), this only accounts for 72,600 needles out of 260,000, or 28%. This means that there are potentially **187,000 used needles that have not been returned to a needle exchange**. This figure is likely to be much higher as not all of the CIN-bins returned will have been full.

The PharmOutcomes data also indicates that there are **13 pharmacies** that are registered to offer the service but have **yet to record a transaction**, with a further 3 recording less than 10 transactions.

This could potentially indicate a **recording issue**, that the **service provision is not being promoted well enough** in these local areas or that there is another **barrier to people accessing services**. Investigating the reasons behind this and bringing these services online would increase provision throughout the county.

Areas such as **St Just, Camelford and Looe currently lack a Needle Exchange provision**, yet are known to have a number of injecting drug users within their resident populations. Engaging pharmacies within this area to participate in the service would encourage safer use amongst the injecting population.

Our analysis has also shed light on a **number of gaps within the data**, previous Needs Assessments have had access to data from Addaction relating to the issue of various drug related paraphernalia such as vitamin c, citric acid, spoons, foil and sterile water.
The system does not clearly indicate how needle returns, recorded as number of CIN-bins, should be completed as this currently sits under the ‘Supplies’ heading. This may be a confusing factor for some system users at a pharmacy level and would benefit from clarification.

**Supported Housing – reports of Discarded Needles**

The supported housing projects run by Coastline in Camborne and Cosgarne Hall in St Austell regularly report issues in cleaning up discarded drug litter from in and around their sites. We currently do not have access to information relating to the types of litter found and the number of needles within them.

There are two pharmacies in the immediate area which provide needle exchange services but the volume of drug litter being reported by supported housing services indicates that the service provided by the pharmacies in these areas is not meeting the needs of clients within the supported housing projects. Coastline have expressed an interest in running a needle exchange service in Camborne themselves.

Potentially there is scope for supported housing projects to link up with the needle exchange providers so that the service provided by the pharmacies is reaching those clients who are unable or unwilling to utilise the needle return facilities themselves.

The map below shows distribution of Needle Exchange participating pharmacies and Drug Litter Reports for Cornwall in 2014/15.
Public Reported Needle Litter – Case studies

Public reports of discarded needles have been collated across Cornwall for the period April 2014 to March 2015. The data on needle finds can only be mapped to a granularity of LSOA\textsuperscript{51} so does not provide an exact picture of where the needle finds were but is sufficient to examine general proximity to needle exchange provision.

The areas where most finds were recorded were Truro, St Austell, Liskeard and Camborne/Redruth.

**Truro** and the surrounding areas have had a total of **13 finds (18% of the Cornwall total)** with 5 of those finds being in close proximity to the railway station and County Hall sites, this area also contains a primary school.

We know that there are **three pharmacies** offering needle exchange in this general area. Of the three, **only one appears to be actively engaging in the Needle Exchange Programme**, however, dispensing a total of 2,894 (11%) packs from 649 transactions in 2015/16.

We estimate that the service is being used by up to 180 (13%) individuals, who between them have returned 583 (8%) CIN-bins. In terms of distance to a pharmacy offering the service, each of the areas where the needle finds were reported, either had a Needle Exchange participating pharmacy located within its boundaries or were adjacent to one. In no instances was any drug litter found farther than **1.5 miles** from a participating pharmacy.

The area in and around **St Austell** is served by two pharmacies, however only one has any data recorded under the Needle Exchange Programme in PharmOutcomes. This particular pharmacy **doesn’t record individual transactions**, but adds them all together into one monthly figure, meaning that there are **no client details recorded**, and therefore we cannot tell how many transactions are actually taking place or how many individuals are utilising the service.

An estimate of numbers may be produced by looking at the Cornwall average for number of clients and transactions against the number of packs dispensed, this methodology gives an estimated figure of **192 clients**.

**St Austell had a total of 12 (17%) needle finds reported**, split between 6 different LSOAs, 5 of these finds were in the Trenance area and **there is participating pharmacy** at the edge of this area. In terms of needle packs dispensed, this is **Cornwall’s busiest pharmacy** with 3718 (15%) recorded. 1070 (15%) CIN-bins were returned to this site in 2015/16.

Of those areas where needle finds have been reported, none of their boundaries fall outside of a two mile radius of one of the two participating pharmacies. If we discount the second pharmacy, however, which does not appear to currently actively providing a needle exchange service, and look at the case of the Duporth,

\textsuperscript{51} Lower Super Output Area – a statistical geography that typically contains 1,500 people
Charlestown, Carlyon Bay and Tregrehan area, distance to a service is increased.

Liskeard is another town that has a high level of reported drug litter finds, with 10 being reported during 2014/15. Half of these have been reported in the Liskeard Town Centre East, Sungirt, Plymouth Road LSOA in which sits two participating pharmacies. Between them they account for almost 1,000 packs (4% of the Cornwall total) and 155 (2%) CIN-bins returned in 400 separate transactions. From the data it is estimated that there are 124 (9%) individuals using these sites.

None of the finds in Liskeard were outside a 1.5 mile radius of either of our participating pharmacies.

Camborne and Redruth had 11 reported needle finds in 2014/15 with 8 of these within Camborne. There are three Needle Exchange pharmacies in this area but we have no data recorded for two of them. The one that has recorded activity is one of the busiest services in Cornwall with 762 (15%) transactions making up 11% of the total packs dispensed and 9% of the returned CIN-bins. We estimate that 162 individuals have used this service in 2015/16 (12% of the Cornwall total).

All finds reported in Camborne were made within a 1 mile radius of the three pharmacies. Three finds were made within neighbouring Redruth which is served by three participating pharmacies. Two of the three pharmacies have made entries into PharmOutcomes, recording 1230 (5%) packs and 432 (6%) CIN-bin returns between them.

- In three out of the four areas case studied where we had a high volume of needle finds the percentage of total packs was higher than the percentage of total CIN-bins returned;
- The exception here is St Austell where percentage of CIN-Bins returned and Needle Packs dispensed were equal, however there are large parts of St Austell which may be a greater distance from a participating pharmacy than we see in other areas;
- 61% (27/44) of pharmacies registered for Needle Exchange on PharmOutcomes are recording that they have provided a needle exchange service. Further investigation is needed to discover why some pharmacies are not providing data, there may be additional training required or another issue causing a delay in starting provision;
- Not all pharmacies are recording the data on a ‘per client’ basis and therefore it is difficult to establish numbers using the service, e.g. Day Lewis, Bodmin. This issue could be resolved with one recording practice being put into place Cornwall-wide;
- There is potential for confusion when recording the number of CIN-bins returned and we are therefore unable to measure the success of this measure. Given the large difference in needle provision and needles returned, this is something that needs attention. This ‘question’ could be adjusted in the PharmOutcomes service;
- Each needle exchange, while improving the overall safety of its clients, is put in a difficult situation in that they are possibly adding to local the drug litter problem. There is difficulty in establishing the ‘source’ of used needles found in public areas, although a CIN-bin can be traced back to the issuing service;
• Each of our areas had at least one pharmacy where used needles could be disposed of, so it would be useful to talk to service users about the **perceived barriers to using this service**;

• Drug litter data does not contain the **postcode** which would allow much more accurate mapping of data. The data could be improved by **adding reports from refuse/cleaning teams** in relation to number of needles found;

• We don’t currently have access to data from Addaction, who run a separate set of needle exchange services at various sites throughout Cornwall.

**Steroid users**

People who use image and performance enhancing drugs are users of needle exchange services but tend to see themselves as different from people who inject street drugs such as heroin. This means that frequently they are **not aware of the risks around injecting behaviour** and may be **disinclined to seek harm reduction advice**.

Historically we have seen an increasing trend in use of needle exchange by steroid users. Consultation with service providers at the time of the last needs assessment highlighted that there was a need to **improve the knowledge of staff** delivering needle exchange services to steroid users.

Unfortunately, information on needle exchange use is no longer collected in a way that allows us to distinguish steroid users from street drug users.

Based on the assumption that steroid users favour a 2ml needle, demand for a 2ml needle was examined using data recorded in PharmOutcomes.

Overall for the period April to August 2016, the number of 2ml needles supplied through needle exchange **reduced by 6%** compared with the previous year.

<table>
<thead>
<tr>
<th>Month</th>
<th>2016/17</th>
<th>2015/16</th>
<th>Change n</th>
<th>Change %</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>694</td>
<td>740</td>
<td>-46</td>
<td>-6%</td>
</tr>
<tr>
<td>May</td>
<td>974</td>
<td>586</td>
<td>388</td>
<td>66%</td>
</tr>
<tr>
<td>June</td>
<td>537</td>
<td>717</td>
<td>-180</td>
<td>-25%</td>
</tr>
<tr>
<td>July</td>
<td>526</td>
<td>734</td>
<td>-208</td>
<td>-28%</td>
</tr>
<tr>
<td>August</td>
<td>587</td>
<td>753</td>
<td>-166</td>
<td>-22%</td>
</tr>
<tr>
<td>Apr-Aug</td>
<td>3,318</td>
<td>3,530</td>
<td>-212</td>
<td>-6%</td>
</tr>
</tbody>
</table>

There was, however, a huge spike in demand in May, which can be attributed to four locations in Bodmin, Helston, Newquay and Wadebridge.

Due to the limitations of the data, **we cannot make the assumption that this means that there are fewer injecting steroid users** accessing services.
Chemsex and Slamsex

Chemsex describes the use of psychoactive substances in sexual settings. It is defined as "engaging in sexual activities while under the influence of drugs and often involves group sex or a high number of partners in one session."

Recent evidence indicates that this behaviour has become a trend amongst some gay men. The drugs used include crystal meth, mephedrone and GHB/GBL. The drugs can be used in a variety of ways including snorting, smoking, injecting (termed ‘slamming’), inserting into the rectum and mixing with drinks. The study reports that there is emerging evidence that use of these drugs are putting men who have sex with men at higher risk of STIs.

Those addicted to Class A drugs such as opiate and crack are at higher risk of poor sexual relationships, STIs and blood borne viruses. Evidence suggests that gay and bisexual men who use particular illegal drugs (as well as alcohol) are more likely to engage in risky sex. Illegal drug use is higher in gay and bisexual men – the crime survey found that 33% of gay men had taken illegal drugs in the previous year, compared with 11% of heterosexual men.

The Positive Voices Survey for England and Wales found that nearly a third (29%) of gay male patients reported engaging in chemsex (defined by the researchers as “the use of drugs to increase disinhibition and arousal”) in the past year and that one in ten reported ‘slamsex’ (injecting/ being injected with drugs).

Figures were higher for some subgroups:

- 37% of Londoners reported chemsex and nearly one in five (19%) of men on anti-retroviral therapy (ART) reported slamsex;
- Chemsex users were more likely to be middle-aged: 34% of men aged 35-54 reported chemsex, compared with 20% for those aged 18-34 and 19% for over 55s;
- Of the 29% reporting chemsex, mephedrone or drugs of its type (cathinones) were the most commonly used at 23%, ; 20% reported using GHB or GBL, 15% methamphetamine and 11% ketamine;
- Of the 10% reporting slamsex, 7% injected methamphetamine, and 6.5% mephedrone-type drugs. Injecting ketamine or GHB/GBL was rare.

Whilst community services show good engagement of LGBT users, and awareness has been raised amongst staff to be able to assess and help to reduce the risks associated with sex-related drug use, we do not have a more robust understanding of the extent to which this is occurring. Further, staff report that this is as much a risk for heterosexual people as LGBT.

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52 The Chemsex study: drug use in sexual settings among gay & bisexual men in Lambeth, Southwark & Lewisham. Bourne et al (Sigma Research, London School of Hygiene & Tropical Medicine, 2014)
53 Drug misuse: Findings from the 2013/14 Crime Survey for England and Wales, Home Office (2015). This was the last year that information was presented with sexual orientation as a factor.
54 Self reported co-morbidities among people living with HIV in England and Wales, Public Health England (2014). ‘Positive Voices’ is a survey of the healthcare needs, lifestyle and sexual behaviours of people living with HIV. The survey was piloted between May and November 2014 at 30 HIV clinics.
Sex Working

Sex workers are a group particularly at risk of drug related harm and sexual ill health.

A recent study commissioned for the Inclusion Health programme reviewed the existing evidence on sex workers in the UK paying particular attention to health alongside wider issues of social exclusion, such as poverty, homelessness and substance misuse.

The review found that the majority admit to having a history of alcohol and/or drug use. Over half of respondents stated they entered sex work specifically to fund drug addictions and many continued to use drugs whilst pregnant. It is claimed that drug and alcohol use amongst sex workers is used for self-medication; to help mask some of the negative feelings associated with sex work.55

Drug and alcohol addiction can cause serious damage to people’s health. Many drug addicts are undernourished and homeless. Some of the most prominent health concerns facing sex workers as a group are communicable diseases, such as HIV and other blood borne viruses.

Outreach work remains a priority, as it can provide the opportunity to engage sex workers in treatment and harm reduction. Where initiatives are taken to eradicate ‘brothels’, these should be paired with offers of assistance, assessments of vulnerability and alcohol and drug screening.

55 A Review of the Literature on Sex Workers and Social Exclusion, UCL Institute of Health Equity for Inclusion Health, Department of Health (April 2014)
Drug related deaths

Drug misuse is a significant cause of premature mortality in the UK. Analysis of the Global Burden of Disease Survey 2013 shows that drug use disorders are now the third ranked cause of death in the 15–49 age group in England. Nearly one in nine deaths registered amongst people in their 20s and 30s in England and Wales in 2014 were related to drug misuse. Deaths from drug misuse substantially increased in England in 2013 and 2014, with a 42% total increase in these two years.

Cornwall and the Isles of Scilly has one of the highest rates of drug related death in the South West.

The table below shows the Drug Related Deaths (DRDs) in 2016. Some are still subject to investigation at this point, so the information may change as toxicology and other detail is awaited in some cases.

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total drug related deaths</td>
<td>18</td>
<td>17</td>
<td>24</td>
<td>29</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· 17 Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· 1 Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· 15 Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· 2 Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· 22 Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· 3 Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· 24 Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· 5 Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% change</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28% decrease from 2012</td>
<td></td>
<td></td>
<td>6% decrease from 2013</td>
<td>29% increase from 2014</td>
</tr>
<tr>
<td>6% decrease from 2013</td>
<td></td>
<td></td>
<td></td>
<td>17% increase from 2015</td>
</tr>
<tr>
<td>Heroin / Morphine present</td>
<td>12 (9 Heroin &amp; 3 Morphine)</td>
<td>11 Heroin</td>
<td>14 (12 Heroin &amp; 2 Morphine)</td>
<td>18 Heroin</td>
</tr>
<tr>
<td>Methadone present</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>· (all illicit-3 of the deaths where methadone is a significant factor)</td>
<td>(3 x prescribed &amp; 2 illicit)</td>
<td>(3 x prescribed, 2 illicit)</td>
<td>(6 x prescribed, 1 x illicit)</td>
<td></td>
</tr>
<tr>
<td>· 1 of the illicit in combination with lethal levels of prescribed meds</td>
<td>1 of the illicit where methadone caused death i/c alcohol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other controlled drug</td>
<td>1 x DHC</td>
<td>1 x MDMA</td>
<td>0</td>
<td>3 x MDMA (includes 1 x poly drug)</td>
</tr>
<tr>
<td>· 1 x prescribed Fentanyl &amp; Oxycodone</td>
<td>1 x Subutex</td>
<td>1 x NPS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>· 1 x NPS</td>
<td>1 x Ketamine</td>
<td>1 x Cocaine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Underlying cause drug related (not overdose) eg. Long history of drug use. New category for 2014</td>
<td>Not recorded</td>
<td>1</td>
<td>3</td>
<td>1 x Amphetamine</td>
</tr>
<tr>
<td>· 1 x bronchial pneumonia &amp; opiate abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RTC/Suicide (+ CD as included above)</td>
<td>0</td>
<td>0</td>
<td>2 x RTC, 1 x suicide</td>
<td></td>
</tr>
</tbody>
</table>

29 deaths in 2016 represent a 17% increase from 2015 and a 46% increase from 2014. This upward trend bears out a similar trend being reported in the Office for National Statistics annual reports over the past three years.
Examination of the main toxicological results within the 2016 deaths are shown below. The drugs listed are the main agents that have been significant in the cause of death but the main agents may have featured as part of a combination with other drugs.

There are 7 toxicological screens outstanding so the results have come from 22 of the 29 cases.

<table>
<thead>
<tr>
<th>Substance</th>
<th>Number of deaths</th>
<th>Also present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Methadone</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Amphetamine</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Cocaine</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>New Psychoactive Substances</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

**Opioids**, although rarely without combination of other central nervous system depressant substances such as alcohol or benzodiazepines, are **by far the largest cause of drug related deaths** in Cornwall.

- Of the 29 overdoses recorded in 2016, **19 are directly attributable to heroin and/or methadone**. The other substances, that are not an opioid, to be designated the causal factor in a death are amphetamines, cocaine, MDMA and a New Psychoactive Substance, accounting for one death each.

The increase in deaths attributed to opiate overdose is considered to be multifactorial. Cornwall has a history of **poly-drug use** and an **increase in people using heroin and crack in combination**. Increases in the **availability and purity of heroin and crack** within the drug market and increases in **street homelessness** are also believed to be negative factors in influencing the number of drug related deaths.

Cocaine has not routinely been monitored in drug related deaths as it is rarely the cause of death in itself, particularly when compared with opiate drugs. However, there have been 10 cases in 2016 where cocaine has been present in the deceased as identified by toxicology.

One of these cases involved a fatal amount. One case had significant levels which interacted with other drugs and the remaining 8 cases had lower amounts that were not independently fatal but would have had some effect on the deceased to a greater or lesser extent.

- The 2016 increase in cases where cocaine has been identified post-mortem seems to **confirm the anecdotal evidence that cocaine and crack cocaine has become more prevalent** within the drug using community in 2016.

Only 2 of the 29 cases involve alcohol at levels deemed to be toxic in most people. Another 8 cases involve alcohol at levels around the national drink/drive limit or slightly above. **Previous years have seen alcohol levels feature at more significant levels** in more cases.
The average age for males dying in this period is 42 with the oldest being 62 and the youngest being 21. The average age for females dying is 40 with the oldest being 55 and the youngest being 30. The **male average age has increased slightly** from 40 in 2015 whilst the female average age has remained constant. The complications arising from ageing drug users, which is being cited nationally as one of the main reasons for the increase in drug related deaths, does not account for the increase locally.

The areas where the 2016 deaths have occurred are shown below and include those deaths where death has actually occurred in hospital but has been recorded as the area where the incident took place. The incident will inevitably have been a drug overdose.

<table>
<thead>
<tr>
<th>Location of death</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>15</td>
</tr>
<tr>
<td>Home address of another</td>
<td>6</td>
</tr>
<tr>
<td>Hospital</td>
<td>4</td>
</tr>
<tr>
<td>Supported accommodation</td>
<td>3</td>
</tr>
<tr>
<td>Public toilet</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>29</strong></td>
</tr>
</tbody>
</table>

Overwhelmingly again this year the **main venue for a drug related death has been the home address of the deceased** or at the home address of another as shown in 21 out of the 29 cases.

Locality rarely gives us any useful information, as the numbers are so small. The table below demonstrates that **deaths tend to occur in our larger towns**.

<table>
<thead>
<tr>
<th>Town</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newquay</td>
<td>5</td>
</tr>
<tr>
<td>Penzance</td>
<td>4</td>
</tr>
<tr>
<td>St Austell</td>
<td>3</td>
</tr>
<tr>
<td>Truro</td>
<td>3</td>
</tr>
<tr>
<td>Falmouth</td>
<td>3</td>
</tr>
<tr>
<td>Wadebridge</td>
<td>2</td>
</tr>
<tr>
<td>Redruth</td>
<td>1</td>
</tr>
<tr>
<td>Torpoint</td>
<td>1</td>
</tr>
<tr>
<td>Hayle</td>
<td>1</td>
</tr>
<tr>
<td>Bude</td>
<td>1</td>
</tr>
<tr>
<td>Penryn</td>
<td>1</td>
</tr>
<tr>
<td>Saltash</td>
<td>1</td>
</tr>
<tr>
<td>Camborne</td>
<td>1</td>
</tr>
<tr>
<td>Helston</td>
<td>1</td>
</tr>
<tr>
<td>Liskeard</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>29</strong></td>
</tr>
</tbody>
</table>

13 males and 3 females (55% of the total number of cases) have either been in drug treatment or within 6 months of leaving treatment when they died. This is similar to last year.
11 males and 2 females (45%) were not known to drug treatment.

This indicates a need to keep under review the risk factors and assessments of those in treatment, their discharge reasons, particularly reasons for unplanned exits to establish their reason for leaving and the level of risk at exit and whether or not they were in possession of naloxone.

The UK research evidence base\textsuperscript{56} clearly highlights who is most likely to die from an overdose and when death is most likely to occur. This type of death is particularly noted amongst opioid using people who use drugs with a reduced tolerance. These people are particularly vulnerable in the transitional periods of their drug using career, for instance when:

- Leaving prison
- Exiting drug treatment, especially ‘unplanned’ exits
- Leaving residential drug treatment or inpatient detoxification

Measures have been in place locally for some years to contingency plan with people leaving these settings, but a greater focus may be required on those leaving community treatment, particularly where crack is a factor.

Not all cases have the level of detail required to compare every case but there are a number of instances where drug treatment records give us an idea of the life of the deceased. Early use in childhood is often a feature, as illustrated by some of the cases highlighted below.

\begin{itemize}
  \item Ed
    - Introduced to alcohol and ecstasy at age 11 by father;
    - Started using LSD aged 13 and heroin aged 17;
    - Died from a heroin overdose aged 28.
  
  \item Ann
    - First used alcohol aged 9;
    - Mother was a heavy drinker
    - Started using heroin aged 13;
    - Died of a heroin overdose aged 46.
  
  \item Jane
    - First involved with drugs at 15 years, after being the victim of serious sexual violence. Used NPS and cannabis;
    - Died from a heroin overdose aged 33.
  
  \item Joe
    - Care leaver
    - Had first used heroin aged 16
    - Died from a heroin overdose aged 53
\end{itemize}

\textsuperscript{56} ‘Preventing drug related deaths and blood-borne viruses’, Public Health England (2010)
Multiple needs

Year on year the people involved in a drug related death are presenting with more complex issues. These involve combinations of early childhood trauma and early drug/alcohol use, a range of abuse, prescribed medicines for a range of illnesses and disorders, poly drug use, parental responsibility complicated by drug and alcohol issues, physical and mental disabilities, involvement in crime, housing issues and partners also using substances.

A third of those who died (10 people) had additional serious physical illnesses or disorders including co-existent Hepatitis B and C, liver cancer, pneumonia, chronic fatigue syndrome, throat cancer, COPD, type 2 diabetes and PTSD. 12 people had diagnoses of mental illness as well as drug dependence.

The synergistic effects of drugs is more prevalent with the number of toxicological screens showing a wide range of drugs being lawfully possessed having been prescribed for a range of issues. The combination of opiates, alcohol, benzodiazepines, anti-depressants, anti-psychotic drugs and others presents a new challenge to those trying to prevent drug related deaths.

14 people had a profile of being prescribed a range of depressant drugs that would have multiplied their risk and made for a more complex picture to help with.

Suicide

Drug and alcohol use are amongst the particular risk factors for suicide, including untreated depression, unemployment, family and relationship problems, social isolation and low self-esteem.

- **Men** of all ages* - men are at three times greater risk of suicide than women. The highest risk is age 45-59. The main aims are to: reduce stigma, encourage help-seeking, provide appropriate support;
- **Children and young people** - suicide is one of the main causes of mortality in young people and for families the impact is particularly traumatic;
- **Users of drugs and alcohol** - 80% of those in treatment for alcohol use conditions and 70% of people in drug treatment are thought to have co-existing mental health problems.

The **Cornwall and Isles of Scilly Suicide Prevention Action Plan** identifies several key actions required to reduce the risk of suicide in high risk groups, which include the following for action by alcohol and drug treatment:

<table>
<thead>
<tr>
<th>Recovery-based services</th>
<th>Improvement of dual diagnosis pathway designed by DAAT/CFT via the Crisis Care Concordat.</th>
<th>CCC, Addaction, DAAT, Cornwall Partnership NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>b</td>
<td>Improve access to services for patients with dual diagnosis</td>
<td></td>
</tr>
</tbody>
</table>
**Universal actions and communications**

<table>
<thead>
<tr>
<th></th>
<th>Promote mental wellbeing across the lifecourse</th>
<th>Promote the 5 ways to wellbeing or adapted versions relevant to specific groups: Connect, Be active, Take notice, Learn, Give.</th>
<th>Public Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>Ensure parity of esteem between mental health and physical health</td>
<td>Advocate for parity of esteem, ensure this is reflected in strategies, polices and practice.</td>
<td>MSPG, CCC all partners</td>
</tr>
<tr>
<td>b</td>
<td>Community-based awareness campaigns</td>
<td>Tackle the stigma that is related to mental illness, suicide, or other characteristics. Encourage open discussion about mental health, e.g. through supporting Time to Change and Time to Talk.</td>
<td>TZ</td>
</tr>
<tr>
<td>c</td>
<td>Raise awareness and understanding of mental illness and suicide</td>
<td>Provide training, including Mental Health First Aid, ASIST, Listening skills….</td>
<td>Public Health, Samaritans, Cornwall Partnership NHS Foundation Trust</td>
</tr>
<tr>
<td>d</td>
<td>Preventing opiate overdose - Naloxone Programme</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Naloxone is an **opiate antagonist** that temporarily reverses the effects of an opiate overdose and can therefore **save a life until the arrival of emergency services**.

Provision of naloxone in settings where there may be increased risk of overdose, and training in how to manage and administer it, forms part of the DAAT’s strategy in Cornwall to reduce the number of drug related deaths.

In December 2009, a pilot project to provide naloxone in one complex needs accommodation provider started. In April 2016 this programme was **rolled out across all complex needs accommodation services**, involving 7 different providers and more than 30 different supported accommodation services.

- In the first 9 months, 208 clients, staff and volunteers have been trained;
- There were 19 known uses of naloxone in 2015 and 27 in 2016 (46 in total), each one potentially preventing an overdose from being fatal.

These projects are quite literally saving the lives of these often complex and very vulnerable clients and without their involvement many more clients would be losing their lives to overdose. Due to the success of the intervention, the provision of naloxone will be part of a continued strategy to reduce drug related deaths.
In addition to the cost to these individuals and their families there is a huge financial cost to society of a death. This has recently been calculated by the Department of Transport as £1.8 million per death.57

The ONS 2015 report Deaths related to poisoning in England and Wales reported that deaths related to heroin and morphine has more than doubled since 2012. 58 In Cornwall deaths related to heroin and morphine have risen by around 50% since 2012. Potentially the widespread naloxone programme has prevented numbers of deaths from escalating as much as elsewhere in the country.

Cost effectiveness of providing naloxone to heroin users

A study in the US59 examined the cost effectiveness of naloxone in reducing drug-related deaths by simulating a range of scenarios whereby heroin users were provided with naloxone “kits” and associated training. Results were synthesised by reach (percentage of the population provided with naloxone) and by characteristics of users (usage and overdose history).

The research found that “whatever feasible assumptions were made, naloxone distribution reduced the rate of overdose death among active users and across all active and former heroin users in the simulated samples.”

As an example, it was estimated that “if naloxone were distributed to a fifth of heroin users, over the entire heroin-using careers of all the users 6.5% of overdose deaths would be prevented. The preventive impact would increase proportionately the more heroin users were supplied naloxone.”

The analysis, which incorporated recurrent overdoses and a secondary analysis assuming heroin users are a net cost to society, showed that cost-effectiveness was largely unaffected by differences in how widely an area distributed naloxone, the cost of medical services, or in rates of overdose, other drug-related deaths, abstinence or relapse.

Although constructed for a US context, the Effectiveness Bank concluded that the implications of this analysis are likely to apply broadly to the UK.

This view is echoed by experts convened by the World Health Organization (WHO), who have judged the “risk-benefit profile to be strongly in favour of naloxone distribution”, and strongly recommended naloxone provision and associated training for people likely to witness an opioid overdose.

WHO’s experts cautioned, however, that because naloxone “does not address the underlying causes of opioid overdose” further reducing the number of deaths would

57 Reported road casualties Great Britain, annual report: 2015, Accidental and Casualty Costs, Department for Transport (2016)
58 Deaths related to drug poisoning in England and Wales: 2015 registrations, ONS (2016)
also entail **monitoring and curbing inappropriate opioid prescribing** and over-the-counter sales, and **extending treatment for opioid dependence**. Wider initiatives of this kind are also amongst those recommended by Public Health England in its guidelines on preventing drug-related deaths.

There is some additional learning coming from the findings on Scotland’s national naloxone programme\(^6^0\), where the focus was deaths occurring in the first four weeks after release from prison, and after discharge from hospital, both of which are high-risk transition periods. Kits were prescribed by prisons and GPs.

- There was **strong evidence of reduction** in the proportion of all opioid-related deaths in offenders in the period of **four weeks after release from prison**;
- The study was unable to show that post-hospital deaths, which accounted for 9 out of all 10 deaths, had been reduced by the programme, despite this being a high-risk period;

It was noted that the study may have been undermined to a degree by **reluctance by heroin users to carry the naloxone kit with them** – the kits issued were bulky and brightly coloured and only 5% of those subsequently surveyed at needle exchange were carrying them.

This would only impact, however, if the overdose occurred away from the home. In the Scotland study, the majority of deaths (around two-thirds) involved drugs taken at home or occurred at home and **home address** is also the **most common location for deaths in Cornwall**.

Mental Health

Key findings

- Drug and alcohol problems are usual rather than exceptional amongst people with mental health conditions but the relationship between the two is complex;
- Health guidance stresses the importance of drug and alcohol services and mental health services working together effectively, otherwise both will fail;
- Men and women may experience different stressors, in particular women are more at risk of experiencing domestic abuse or sexual violence and men are more likely to drink excessively;
- Violence and abuse, particularly when experienced in childhood, is strongly associated with later onset and persistence of mental health conditions;
- Local research confirms that mental health conditions are highly comorbid with alcohol and drug abuse;
- Cornwall has higher than average levels of concurrent contact with mental health and drug/alcohol services but despite this, comparison between the prevalence estimate and the actual number of people accessing services indicates a significant gap;
- In particular, there appears to be a substantial unmet need in the offender population that present with this combination of issues;
- A survey with staff across a range of community safety services found that experiences of successfully referring into mental health services were mixed, with dual diagnosis, increasing thresholds, ease of contact and unclear pathways being described as the barriers;
- The delivery of Mental Health First Aid training has been successful in raising staff confidence and knowledge when working with someone with a mental health condition.

Recommendations

1. Identify and agree the priority areas and outcomes to improve mental health across each community safety strategy, team and service at a partnership level and report performance on a quarterly basis;
2. Improve skills and confidence in the workforce to identify, assess and refer people with complex needs;
3. Improve understanding of service demands of adults and young people with complex needs, including an agreed mental health assessment within each service’s assessment, recording processes and case management systems (where applicable), alongside DASH risk assessments and alcohol and drug screening and assessment;
4. Understand and better capture the impact of Adverse Childhood Experiences (ACEs) both in early years and as an adult. Include questions within assessments and ongoing work as to the number of ACEs experienced by the individual, what impact they have had, and what help has been received or is required;
5. Achieve system improvement in children’s, families and adult services through enabling citizens and services to navigate local systems via an online pathway mapping tool and routinely reviewing system failures.
National guidance on dual diagnosis

Public health guidance\(^6^1\) tells us that approximately **40% of people with psychosis misuse drugs and/or alcohol at some point in their lifetime**, at least double the rate seen in the general population.

People with psychosis commonly take various non-prescribed substances as a way of coping with their symptoms, and **in a third of people with psychosis, this amounts to harmful or dependent use.**

In responding effectively to dual diagnosis, pathways into care\(^6^2\) state that:

- Adults and young people with psychosis and coexisting substance misuse **should not be excluded** from age-appropriate mental healthcare because of their substance misuse. Nor should they be excluded from age-appropriate substance misuse services because of a diagnosis of psychosis;
- **Treatment for both conditions** should be provided by healthcare professionals in **secondary care mental health services** such as community-based mental health teams.

While it is by no means essential for the provision of services to be by the same provider, a **closer relationship between commissioners may help to provide a more joined up service for those with a dual diagnosis.** While the system in general works well, there are some issues of bouncing from one provider to the other and not taking responsibility for treatment.

Improved management of mental illness and substance misuse comorbidity has been a National Health Service priority for well over a decade, supported by studies such as the **Co-morbidity of Substance Misuse and Mental Illness Collaborative study\(^6^3\)** which found that:

- 75% of users of drug services and 85% of users of alcohol services were experiencing mental health problems;
- 30% of the drug treatment population and over 50% of those in treatment for alcohol problems had ‘multiple morbidity’;
- 38% of drug users with a psychiatric disorder were receiving no treatment for their mental health problem;
- 44% of mental health service users either reported drug use or were assessed to have used alcohol at hazardous or harmful levels in the past year.

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\(^{6^1}\) Psychosis with coexisting substance misuse: Assessment and management in adults and young people - Clinical guideline 120 (NICE 2011)

\(^{6^2}\) Pathways into care, ref. 1.4.3, 1.4.4 and 1.4.5

\(^{6^3}\) Comorbidity of substance misuse and mental illness in community mental health and substance misuse services, Comorbidity of Substance Misuse and Mental Illness collaborative (COSMIC) study team (British Journal of Psychiatry, 2003, 183:304-313)
In their Dual Diagnosis Good Practice Guide\textsuperscript{64}, the Department of Health states that \textbf{substance misuse is usual rather than exceptional amongst people with severe mental health problems} and the relationship between the two is complex.

- Services are advised to \textbf{generate focused definitions} which reflect the target group for whom their service is intended;
- Defining target client groups and agreements on provision must be achieved through \textbf{inter-agency collaboration across mental health and substance misuse services}, both statutory and voluntary, and the criminal justice system;
- \textbf{Alcohol} is the most commonly misused substance by people with mental illness. Misuse of \textbf{illicit substances} will reflect local availability, of which \textbf{mental health services should develop an awareness};
- Significantly \textbf{poorer clinical outcomes are expected} among psychiatric clients who also misuse substances: nonetheless \textbf{an optimistic approach to treatment is both warranted and appropriate}.

Individuals with these dual problems deserve \textbf{high quality, patient focused and integrated care}. This should be \textbf{delivered within mental health services}. This policy is referred to as “mainstreaming”.

\textbf{Patients should not be shunted between different sets of services} or put at risk of dropping out of care completely. “Mainstreaming” will not reduce the role of drug and alcohol services which will continue to treat the majority of people with substance misuse problems and to advise on substance misuse issues.

Unless people with a dual diagnosis are dealt with effectively by mental health and substance misuse services these services as a whole will fail to work effectively. In addition, \textbf{all mental health provider agencies should designate a lead clinician for dual diagnosis issues and all health and social care economies should designate a lead commissioner}.

The guidance states that it is \textbf{not acceptable for services to automatically exclude people with personality disorder}. Personality disorder is seen as a separate dimension – which can coexist with a mental health problem or a substance misuse problem, or both. A diagnosis of personality disorder does not necessarily predict poor treatment outcome.

People with \textbf{borderline personality disorder} can often present to services in a crisis; indeed this is characteristic of many people with the disorder.\textsuperscript{65} They present with a range of symptoms and behaviours, including \textbf{behavioural disturbance, self-harm, impulsive aggression}, and \textbf{short-lived psychotic symptoms}, as well as with intense anxiety, depression and anger. As a result they can be regular users of psychiatric and acute hospital emergency services.

\textsuperscript{64} Mental Health Policy Implementation Guide - Dual Diagnosis Good Practice Guide: aimed at all those who commission and provide mental health and substance misuse services, Department of Health (2002)

\textsuperscript{65} Borderline Personality Disorder: Treatment & Management. National Clinical Practice Guideline Number 78 (NICE 2009)
Contributing factors

Men and women may experience different stressors, in particular women are more at risk of experiencing domestic abuse or sexual violence which has a strong impact on their mental health.

- A quarter of women will experience domestic abuse in their lifetime and research suggests that 35% to 75% of abused women experience depression or anxiety disorders;
- Estimates suggest that 50-60% of women within mental health services have experienced domestic violence and 70% of female psychiatric inpatients and 80% of those in secure settings have histories of physical or sexual abuse;
- Problem drinking is higher amongst men than women. Problem drinking is heavily associated with mental illness (from anxiety and depression through to schizophrenia) and personality difficulties;
- Heavy drinkers are more than twice as likely to die from suicide as non-drinkers. Between 16% and 45% of suicides are thought to be linked to alcohol and 50% of those ‘presenting with self-harm’ are regular excessive drinkers.

Research by Women’s Aid\(^6^6\) highlighted that women experiencing domestic abuse are up to fifteen times more likely to misuse alcohol and nine times more likely to misuse other drugs than women generally.

Some women are introduced to substances by their abusive partners as a way of increasing control over them; and when a woman’s partner is also her supplier, it will be particularly difficult for her to end the relationship. When a woman seeks support, information or treatment for her substance misuse, her partner may become even more abusive, or may actively prevent or discourage her attendance at a substance misuse service.

Women whose partners misuse substances may minimise or excuse their abuse on those grounds; it is important to emphasise that even if substance use ceases, the violence and abuse usually continues.

Women with problematic substance use who also experience domestic abuse are particularly likely to feel isolated and doubly stigmatised.

They may find it even harder than other women to report or even to name their experience as domestic abuse; and when they do, are in a particularly vulnerable position, and may be unable to access any suitable sources of support. In most areas, specialist refuge provision for women with drug or alcohol issues is not available; but all refuge organisations will offer support and information, and will assist women who have been abused in accessing appropriate service provision.

\(^6^6\) Principles of Good Practice for working with women experiencing domestic violence: Guidance for those working in the Drug and Alcohol sectors (Women’s Aid 2005)
Abuse and violence are of **major relevance** to the **wider public health agenda**.  
Local authorities, that have the responsibility for public health, should note that this evidence clearly links the experience of extensive physical and sexual abuse with being disabled, alcohol dependent, drug dependent and a regular smoker.

The Department of Health evidences that **violence is associated with significant mortality and morbidity**, including injuries, chronic physical illness, poor reproductive and sexual health, adverse perinatal outcomes, substance misuse, mental illness and suicidal behaviour.

It states that the **risk of violence in people with serious mental illness** such as schizophrenia has consistently been shown, using different study designs in different settings, to be **elevated by substance use**.

Evidence from a Swedish cohort suggests that the risk of violence is 'minimal' in people with schizophrenia without co-morbid substance use; it is only the presence of substance misuse that increases the risk of violence. Therefore **mental illness alone is not a reliable predictor of violence**, and more research is required on the **contextual and situational factors** that precede the violent incident.

A national inquiry into suicide and homicide by people with mental health conditions also found that **substance use can cause or exacerbate psychotic symptoms**. A reported history of drug and alcohol misuse in those with psychosis was examined. There was a significant increase in the number of homicides by people with psychosis who also had a history of drug misuse. There was also a significant increase in the number of homicides by people with psychosis who also had a history of alcohol misuse.

Both studies note that **further research would be required to examine cause and effect**.

As previously discussed under **Adverse Childhood Experiences** in the Families section, **violence experienced in childhood or adulthood** is associated with the subsequent development of mental illnesses.

Childhood physical and sexual abuse is associated with adult onset common mental disorders and psychosis and it has been estimated that between a quarter and a **third of the burden of adult psychiatric disorders is attributable to the effect of childhood abuse**.

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67 Commissioning services for women and children who have experienced violence or abuse – a guide for health commissioners, Department of Health (2011)
69 National Confidential Inquiry into Suicide & Homicide by people with Mental Illness (2010)
70 Public Mental Health Priorities: Investing in the Evidence, Annual Report of the Chief Medical Officer, Department of Health (2013)
In addition, being a victim of sexual or domestic violence in adulthood is associated with the onset and persistence of depression, anxiety, eating disorders, substance misuse disorders, psychotic disorders and suicide attempts.

The recent Department of Health guidance for improving the mental health of children and young people\(^{71}\) reinforces that experiencing or witnessing violence and abuse or severe neglect has a major impact on the growing child and on long term chronic problems into adulthood.

Many mental health service users of all ages have problems directly attributable to severe neglect and/or trauma in the early years. Some vulnerable children and young people are more likely to have been affected during childhood and adolescence – including those who are adopted, looked-after children, those in contact with the youth justice system and substance misusing young people.

The guidance states that provision of mental health support should not be based solely on clinical diagnosis, but on the presenting needs of the child or young person and the level of professional or family concern. Some children and young people will benefit from services which tackle problems across all family members, including adult mental health, substance misuse issues or complex cases that do not have a clear clinical diagnosis.

There is an expectation that the national Troubled Families Programme (delivered in Cornwall under the name Together for Families) will provide a means of identifying underlying health problems once intensive work with the family is underway.

Priority health problems that the programme is advised to consider include:

- Emotional and mental health problems
- Drug and alcohol misuse
- Long term health conditions
- Health problems caused by domestic abuse
- Under 18 conceptions

How does this impact locally?

The recent Mental Health Needs Assessment\(^{72}\) for Cornwall confirmed that mental health conditions are highly co-morbid with alcohol and drug abuse and recommended a greater exploration of the joint delivery of co-morbid services such as drug and alcohol and mental health issues.

\(^{71}\) Future in Mind: Promoting, protecting and improving our children and young people’s mental health and wellbeing, Department of Health (2015)

\(^{72}\) Mental Health Needs Assessment, Kernow Clinical Commissioning Group (April 2014)
Anecdotally and evidentially, mental health problems have been increasingly highlighted as a contributing factor to offending behaviour and recovery and as a presenting need to commissioned services in a community safety setting.

In 2015 Safer Cornwall commissioned a research project\textsuperscript{73} to test the impact of mental health problems upon community safety and crime in Cornwall and our capacity and competence to respond effectively.

**Mental Health and Community Safety Research Project**

The project sought to identify what is known about the impact of mental health conditions and ways in which we could improve the approach within community safety settings, focused particularly on our top two priorities of domestic abuse and alcohol, but also included anti-social behaviour, drugs and reoffending. It was also supported by a detailed literature review.

The key findings are presented here and the full report is available on request from Amethyst.

Although the rate of depression in Cornwall is in-line with the national average, Cornwall has higher rates of mixed anxiety and depression. We also have higher levels of new cases of psychosis, people being treated by early intervention teams and people receiving assertive outreach services.

The suicide rate has been increasing and is higher than the national rate. There is a rising trend amongst those who are not engaged in secondary mental health care.

Cornwall has higher levels of concurrent contact with mental health and drug/alcohol misuse services compared with nearest neighbours and national rates.

<table>
<thead>
<tr>
<th>Dual Diagnosis CIPFA Nearest Neighbour</th>
<th>England</th>
<th>Cornwall</th>
<th>East Riding of Yorks</th>
<th>Northumberland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug misuse</td>
<td>21.0%</td>
<td>27.5%</td>
<td>20.7%</td>
<td>18.5%</td>
</tr>
<tr>
<td>Alcohol misuse</td>
<td>20.0%</td>
<td>23.5%</td>
<td>18.6%</td>
<td>15.4%</td>
</tr>
</tbody>
</table>

Despite this, comparison between the prevalence estimate of people with mental health conditions and drug and/or alcohol problems and the actual number accessing treatment services indicates a significant gap.

For those in structured treatment for drug or alcohol problems, 30\% had concerns about their mental health but only 7\% were currently involved with mental health services. Self-rated improvement of emotional health while in contact with drug and alcohol services was high.

Over a third of domestic abuse/sexual violence victims are recorded as having one or more mental health problems. Victims of abuse were more likely to have

\textsuperscript{73} Mental Health and Community Safety, Munro M. (Safer Cornwall, 2016). Available on request from Amethyst.
multiple mental health problems. They were also more likely to have mental health problems such as anxiety/phobia/panic/PTSD/OCD.

In commissioned services (DASV, DAAT), mental health problems are common in combination with domestic abuse or drug and alcohol problems but only a small proportion of individuals have mental health problems in combination with both domestic abuse and drug and alcohol problems.

Prevalence of the “toxic trio” was much higher, however, in the offender population. Approximately half of the Liaison and Diversion caseload had a suspected or diagnosed mental health problem alongside a drug or alcohol problem and a history of being an abuse victim. Just under a third of adult offenders have mental health issues, of which two thirds had also identified alcohol and/or drug problems and a history of abusive relationships.

Amongst youth offenders the key finding was the high proportion of individuals recorded as coming to terms with a past event which has increased from 2014 to 2015.

Mental health problems are common amongst individuals on the Anti-social Behaviour Team caseload and is often part of a picture of wider and complex needs.

A survey with staff across a range of community safety services found that experiences of successfully referring into mental health services were mixed, with dual diagnosis, increasing thresholds, ease of contact and unclear pathways being described as the barriers.

The survey also found that:

- Half of all respondents felt their confidence in identifying mental health problems was adequate;
- A third felt they had adequate confidence making referrals to mental health services;
- A quarter of respondents identified more training, possible shadowing opportunities and more detailed information of thresholds and referral pathways as potential means of improving the knowledge, skills and confidence.

As part of the project the delivery of Mental Health First Aid (MHFA) training was evaluated. MHFA is a nationally recognised and accredited two day course which looks at mental health and wellbeing, depression, anxiety, suicide and psychosis, with brief looks at eating disorder and self-harm.

The course looks at how to recognise the signs and symptoms of common mental health problems and to look at ways to help and intervene with

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74 As determined by two mental health indicators that can be extracted from OASys – history of self-harm / suicide attempts and current psychiatric problems (recorded as none, some or significant). This reflects legacy data from the last Devon and Cornwall Probation Trust caseload snapshot in March 2014, prior to transition of offender management services. Offender level data is no longer shared.
individuals who are experiencing mental health distress. This course was made available to all community safety staff and commissioned services. At the point of writing, **155 people had undertaken the training.**

- Before and after scores for **confidence and knowledge** when dealing with people with a mental health problem increased by **59% and 62% respectively** for those who completed the training.

**What’s next? Priorities for Improvement**

The report made a number of **recommendations to improve outcomes** across all of our strategies.

It notes that the risk is that we are not able to deliver our strategies and priorities without a continued focus upon mental health but we do not commission mental health services.

1. **Outcomes**

Identify and agree the **priority areas and outcomes to improve mental health** across each community safety strategy, team and service at a partnership level and report performance on a quarterly basis.

2. **Workforce development**

Improve skills and confidence in the workforce to identify, assess and refer people with complex needs.

   2.1 **Repeat of the survey** to see how Mental Health First Aid training has impacted upon frontline workers’ confidence and knowledge when dealing with individuals with mental health problems after 6 months;

   2.2 **Continuation of Mental Health First Aid training** until all staff are trained across Community Safety services;

   2.3 Commissioning of **Safer Cornwall accredited DASH training** (not the chargeable shorter courses also available);

   2.4 **Additional courses to enable Community Safety staff to build their skills to manage common mental health problems** (that do not meet the thresholds for secondary mental health services) within services, specifically Motivational Interviewing and Dual Diagnosis, as these may never meet the thresholds for secondary care and may never be accepted for primary care provision, and the VCSE mental health contracts are being decommissioned.

3. **Improved understanding of service demands of adults and young people with complex needs**

   3.1 Include an **agreed mental health assessment** within each service’s assessment, recording processes and case management systems (where applicable), alongside DASH risk assessments and alcohol and drug screening and assessment.

   3.2 Understand and better capture the **impact of Adverse Childhood Experiences (ACEs)** both in early years and as an adult. Include
questions within assessments and ongoing work as to the number of ACEs experienced by the individual, what impact they have had, and what help has been received or is required.

4. System improvement in children’s, families and adult services

4.1 Produce an online version of the services and pathways to enable citizens and services to navigate local systems;

4.2 Review system failures as part of contract review and quarterly performance review processes to identify means of improving and reducing system blockages.
Wider complex needs

Key findings

Housing and homelessness

- Housing is a critical component to successful treatment outcomes. Housing issues have a marked negative impact on successful completion and exacerbate the risk of relapse, particularly after prison release and rehab;
- **Housing stability**, associated with improvements in quality of life, is a positive outcome in itself for some;
- DCLG figures for 2016 indicates that the rough sleeper count for Cornwall has risen by 50% since the last count 12 months ago, identifying 99 individuals. As a Local Authority, Cornwall has the 3rd highest number of rough sleepers and is ranked in the worst decile for the rate per 1,000 households;
- Problems with mental health, alcohol and drugs are the biggest issues being faced by the homeless community nationally and this is also reflected in our local cohort;
- One in five people presented to treatment with a housing need, of which around half were homeless. Homelessness has seen a small rise year on year and whilst these are not large numbers, clients presenting in housing need are becoming more complex and requiring a lot of additional support. The rise in vulnerable females is a particular concern;
- Housing outcomes are good locally. The vast majority of people exiting the treatment system successfully have no reported housing need, which means that any presenting housing problems are generally resolved;
- Completion rates for people presenting to treatment in supported housing, however, are very low and this requires further investigation;
- Although we have complex needs housing provision, some of the very complex clients are banned from all provision due to previous behaviour. Threats to and withdrawal of funding will further reduce housing options for the most vulnerable clients;
- Over the last year, we have seen a marked rise in reports of homeless drug and alcohol users, anti-social behaviour caused by street drinkers and problems with drug litter. This has highlighted safeguarding concerns for some particularly vulnerable adults with complex needs;
- Cornwall’s Gypsy and Traveller Liaison Officer believes there to be around 1,100 men, women and children with a culture or way of life as a Roma Gypsy, Irish Traveller or New Traveller in Cornwall. There is very limited literature on the health needs of this population;
- Based on those accessing treatment, drug and alcohol issues are three times more prevalent amongst Gypsies and Travellers. They are most likely to be heroin users and engaged in treatment for a moderate period of time (6 months to 4 years). Dual diagnosis is more common amongst this cohort.
Recommendations

1. **Further analysis** of the various cohorts of clients identified as having poor outcomes would help us to understand how to improve them. This could include additional analysis of the responses in the **rough sleeper survey** for people who had **previously been in private rented accommodation or supported housing** to better understand the circumstances that led to their rough sleeping;

2. **Enhanced funding to the complex needs sector** providing security of contracts and enabling the continued development of a model that will accommodate the most complex people, including provision for those who still use drugs;

3. Additional **female only provision** to accommodate complex and vulnerable females;

4. Facilitate the **continuation of the naloxone project** across complex needs services;

5. Continuation of the **Homelessness Hospital Discharge protocol** work;

6. Provision of **accommodation for clients in close proximity to support services** with access to good transport links;

7. **Establish a co-ordinated partnership approach to complex needs clients** by implementing the learning from the new rough sleeper multi-disciplinary team proposal, and **provide a balance between enforcement and assistance** in local areas, to prevent future occurrences and meet the statutory requirement to protect vulnerable people;

8. **Additional support within the treatment programme for vulnerable service users** to minimise the impact of welfare reforms and subsequent homelessness;

9. A **pilot treatment service in close proximity to Boscarn** would make treatment more accessible to the Gypsy and Traveller population and could result in more people being engaged in treatment.

Worklessness

- Employment is one of the **strongest positive factors in successful completion** and has a key role to play in **sustaining recovery**; it should be an integral element in drug and alcohol treatment;

- **Huge changes in the welfare system** (including Universal Credit, the Benefit Cap, Social Housing rents provisions and the under 35s Single Room Rate) have been and will continue to provide **significant challenges for people with drug and alcohol problems**. Public Health England recognises that during engagement with employment support client focus has been on maintaining benefits and avoiding sanctions as opposed to meaningful activity;

- Cornwall has a **strong track record of effective partnership working** between drug and alcohol services and employment service providers. A range of **local and national employment initiatives** are being delivered, including interventions to support those furthest from the workplace;

- People leaving treatment are **less likely than the national average to achieve 10 days of paid employment** in the month before leaving treatment successfully. The proportion of people achieving this has also **declined for both opiate and non-opiate users** over the last two years but has remained stable for problem drinkers. This could be due to the gap in ESF funded projects that supports those furthest from employment.
Recommendations

1. Service mapping and **pathways for all new employment services** that are being implemented, with **Single Points of Contact** across employment and treatment organisations;

2. Continued delivery of **cross-agency training workshops** to build shared skills and knowledge amongst both treatment providers and employment providers, to include Welfare Reforms, DEA employment support and identification of drug/alcohol problems and other needs.

3. Target **client friendly employment sectors** in order to maximise the local employment opportunities for clients recovering from drug and alcohol issues and also those with a history of offending;

4. Create a **network of peer mentors to act as advocates and visible symbols of recovery**, tasked with encouraging safe disclosure and engagement and providing appropriate support which would have the potential to increase the number of referrals between organisations;

5. Ask clients if they have a **claimant commitment** when they first access treatment so early links can be made across organisations to provide support;

6. Introduce 3-way **case conferencing**;

7. Capturing **case studies to highlight what is working well** and the additional challenges that still need to be addressed. Videos could be used to **capture success stories and employment and recovery journeys** that can be shared with other clients;

8. Trial a process of contact with DWP prior to client exit from treatment so that more **intensive support can be offered at this crucial time**;

9. A number of data and performance management improvements have been identified, including:
   - Improve recording of employment related information within the Halo case management system and DAAT **reviews with Addaction** to include employment outcomes and progress being made;
   - Collection of outcomes for clients accessing **the Big Lotteries Building Better Opportunities Fund (BBO) services and Reed in Partnership Work Route’s programme** and other employment providers in order to enhance understanding of longer term outcomes;
   - **Develop and pilot a recovery measure** to capture the range of progress being made by clients in advance of an expanded recovery model being implemented by government.
Homelessness and housing need

The government has recognised housing as a critical component to successful treatment outcomes for many years. The National Drugs Strategy\textsuperscript{75} stated that housing had a key role to play in maintaining recovery. Also the review of the National Strategy in 2013\textsuperscript{76} moved the recovery focus and the requirements of partners very much towards housing and employment initiatives required to deliver sustained recovery.

The Public Health Evidence Review on treatment outcomes highlights that housing problems have a marked negative impact on treatment outcomes and exacerbate the risk that someone will relapse after treatment, particularly after prison release and residential rehabilitation. This review also highlighted a variation in housing difficulty, with less access in areas of high housing cost and high demand.\textsuperscript{77}

The recently published DWP Independent Review on the impact of drug and alcohol addiction on employment outcomes refers to housing 39 times, highlighting its importance to achieving recovery from addiction as well as facilitating progression in other areas of life such as that of employment.

The review states that ‘It is difficult for someone to make progress in treatment of dependence, and sustain their recovery, if they do not have stable, suitable housing’ and that ‘having a housing problem hampers engagement in addiction treatment and reduces the likelihood of successfully completing it, or of subsequently going on to find employment.’

The report went on to say that ‘housing issues were particularly significant in predicting that opiate clients would not be in employment’.\textsuperscript{78}

Despite the importance of appropriate housing options, however, there are many changes in the wider landscape that will impact on the delivery of housing and homelessness services locally, such as:

The Welfare Reform and Work Act 2016 is impacting on the housing sector in a variety of ways, for example through Universal Credit, the Benefit Cap; the under 35s Single Room Rate and the Local Housing Allowance Exemption which currently benefits supported housing providers.

\textsuperscript{76} Drug Strategy Annual Review: delivering within a new landscape, Home Office (2013)
\textsuperscript{77} ‘Public Health Evidence Review; An evidence Review of the outcomes that can be expected of drug misuse treatment in England’, Public Health England (2017)
\textsuperscript{78} ‘An Independent Review into the impact on employment outcomes of drug or alcohol addiction, and obesity’, DWP (2016)
The Homeless Reduction Bill 2016/17 is currently going through parliament and is expected to be the **biggest change in homelessness legislation since 1977**.

It is anticipated that by October 2017 Local Authorities will have **additional duties to prevent and relieve homelessness** for up to 112 days. The detail of this Bill or additional resources to Local Authorities to support the new requirements have not yet been confirmed.

**What has been achieved?**

Over the past 9 years in Cornwall, the DAAT has worked closely with supported housing commissioners and providers in **analysing need and developing a staged model** of supported accommodation that best meets the identified needs of those with drug and/or alcohol issues at various stages of their treatment/recovery journey. These services, although having sustained massive budget cuts in recent years, are **crucial in supporting clients with complex needs** through their treatment journey towards recovery.

The roll out of the **naloxone programme** (which started in Cosgarne Hall in December 2009) to all complex needs service providers in April 2016 has resulted in **38 lives being saved** since its inception, 13 of which were in the year to date.

This programme forms a key part of the DAAT’s strategy in Cornwall to reduce the number of drug related deaths, which has risen exponentially across the country in recent years. Potentially the widespread naloxone programme has prevented numbers of deaths from escalating as much in Cornwall as elsewhere in the country.

The DAAT has also supported the development of a **pathway for those in Tier 4 residential rehabilitation services** to ensure clients find suitable accommodation on completion of their programme. Cornwall Housing Limited, St Petroc’s and the West Cornwall Stonham complex needs service, Addaction Chy and Bosence Farm have also all contributed to the development and delivery of this pathway.

Since September 2016, **36 clients have utilised this pathway** process. The largest number moved into supported housing (11 people), 8 people moved into private rented accommodation and 8 moved in with family/friends. 1 person left early and ended up rough sleeping so was linked in with St Petroc’s Outreach and 2 left Addaction Chy and sofa surfed with friends.

The DAAT and Addaction regularly engage with the Homeless Hospital Discharge protocol advisor. Between 2014 and 2016, **450 homeless patients were discharged from hospital with a support plan in place** and on third were safely discharged into accommodation, which generated **£280,500 savings for NHS**.

A local **Rough Sleeper Strategy** for Cornwall is being developed by CHL who have secured £850,000 from reserves to support the development of the work with rough sleepers in Cornwall. Additionally, Cornwall has successfully secured £292,000 from the **DCLG Rough Sleeper programme** through a joint bid between Cornwall Housing Limited, Coastline Housing and St Petroc’s.

This bid will support the **development and delivery of a Homeless Prevention Outreach service** and will formulate an offer to prevent rough sleepers returning to the streets. This project is also intended to engender greater churn in supported
housing by facilitating Housing First and a Private Sector Access Scheme. This work will expand on the No Second Night Out and other Rough Sleeper initiatives previously implemented.

Cornwall Housing Limited has recently tried different approaches to tackling housing difficulties and provided accommodation for two homeless drug users, with agreed support packages provided by the treatment provider and the outreach service.

This accommodation was provided away from damaging networks in an attempt to remove them from ‘temptation’. So far, however, this has had very limited success. In relation to location of accommodation, the Public Health Review highlighted two studies with contradictory findings: one stated that living further from drug treatment and other services achieved poorer outcomes whilst the other study said those living further away achieved better outcomes.

Regardless, access to good transport links is consistently rated by drug users to be associated with positive treatment outcomes. These case studies also highlight the need for the type of intensive support that would come with the Housing First approach. The review also found that longer term housing support is required to enable people to maintain appropriate housing.

The Public Health Evidence Review identified the following essential components of a homelessness response:

- Suitable housing should be available at important points in an individual’s pathway, particularly where it is known that failure to provide this is likely to result in homelessness, withdrawal from treatment, greater drug use or relapse;
- The pathway should be defined by the individual’s needs and choice and should be personalised rather than prescribed by policy, programmes or processes;
- Assistance is likely to be needed to access and sustain appropriate housing along the recovery journey, including provision for those who continue to use drugs. Integrated approaches to meeting housing and other needs are more likely to enable navigation through an often complex system of housing;
- Treatment, health care, social care and other support will help to achieve better outcomes;
- Housing stability, associated with improvements in quality of life, is a positive outcome in itself for some – even if their drug use continues it is less likely to increase and people are more likely to access services. Housing stability is a particularly important outcome for people who have a long history of homelessness including rough sleeping, and for people with multiple and complex needs;
- Achieving housing outcomes necessitates consideration of income, including addressing debt, and enabling access to, and support to sustain, employment. Bearing this in mind, housing must be affordable.

Housing needs and data

The housing status of clients accessing treatment in Cornwall is recorded on the National Drugs Treatment Monitoring System (NDTMS), at the point of presentation
to treatment and at regular intervals during a client’s treatment journey and on exit from the treatment system through the Treatment Outcomes Profile (TOP).

Housing need and homelessness data are also captured by Cornwall Housing Limited through client presentations at Housing Options services and rough sleeper counts. St Petroc’s outreach service also gathers information about rough sleepers from across Cornwall.

Additionally, outcome evidence gathered by the Education, Health and Social Care commissioning team highlights details of access to supported accommodation and the progress made by clients during their time in such support services.

**Homelessness**

In autumn 2015, the national rough sleeping counts and estimates in England identified 3,569 people and this was an increase of 30% compared with the previous year, continuing an established rising trend.

Levels of rough sleeping in Cornwall have been consistently measured over the past 6 years. The autumn 2015 count in Cornwall identified 65 individuals, which was a rise of almost two thirds compared with 2014. Cornwall was ranked in the worst quartile for rate of rough sleepers per 1,000 households.

The DCLG figures for Cornwall for 2016 indicates that the rough sleeper count has risen again by over 50% since the last count 12 months ago, now identifying 99 individuals. Cornwall has risen from the 5th to the 3rd Local Authority with the highest numbers of rough sleepers.

The chart (right) shows the numbers of rough sleepers identified in the Cornwall counts over the past 7 years.

Most were male (although this time the percentage of females rose from 10% to 17%) and in the 35-54 age range. Truro and Penzance were the areas where the most rough sleepers were counted, accounting for around half the total for Cornwall.

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79 Rough Sleeping Statistics Autumn 2016, England (DCLG, 2017). Rough sleeping counts and estimates are single night snapshots of the number of people sleeping rough in local authority areas. The rough sleeping figures are now established as a consistent time series, since 2010, and provide a reliable way of assessing changes over the years.
One rough sleeper was under 17 years and 4 were over 65 years. The majority of rough sleepers had been sleeping rough between 1-6 months or over a year. The table below highlights the percentage change in rough sleeping over the 6 years that it has been consistently counted.

<table>
<thead>
<tr>
<th>% change in RS estimates in Cornwall on previous year</th>
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<tr>
<td>23%</td>
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In addition to this single night count on the 13th November there is also a rough sleeping survey carried out during the month of October.

In October 2016, 126 single people stated they were homeless. Of these 74 claimed to have slept rough, 20 slept in a tent, 6 slept in car and 13 stayed with family or friends.

One of the questions in the survey considered an individual’s last accommodation and the most common ones cited were private rented and supported accommodation, 25% and 20% respectively. Additional analysis of their situation prior to rough sleeping could be an indicator of services and support required.

In the rough sleeper survey, 26% stated that they had an issue with drugs and 12% stated that they got support with this issue. Similarly 29% declared an issue with alcohol with 17% getting support. This lack of support seemed to be a particular issue between 1-6 months of rough sleeping. After 6 months of rough sleeping there appeared to be a decline in numbers stating that drugs or alcohol were causing problems. Perhaps by this stage they started to normalise their chaotic drug and alcohol use.

A snapshot of the outreach caseload for St Petroc's Society also provides some insight into one group of 130 single homeless clients. The information was gathered at around the same time of the rough sleeper count, in November 2016, and there will be a significant cross-over between the two groups.

Clients are predominantly male and in the 18-44 age range. Compared with the rough sleeper profile, there is a greater proportion in the under 35 age group in contact with St Petroc’s.

There have been anecdotal comments from St Petroc's

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80 St Petroc's Society provides accommodation, support, advice, training and resettlement services to single homeless people in Cornwall
that some clients are refusing access to the Cold Weather Provision as they are not meeting their needs by enabling them to drink or use drugs.

Historically the Society has rarely worked with clients under the age of 18 but their latest report says that there have been more approaches from under 18s in recent months. There was one being actively worked with in November 2016. The Society expects to see an increase in clients aged 18 to 34 struggling to find accommodation due to the changes in housing benefit.

**Clients aged 65** and over accounted for 5% of the active caseload and, although still small numbers, this is an increase on previous years. Traditionally this age range has been accommodated through the Local Authority as they would have been “priority need” due to age. There has also been an abundance of ‘hard to let’ older persons accommodation available through the housing register.

Problems with **mental health, alcohol and drugs** are the biggest issues being faced by the homeless community nationally and this is reflected in our local cohort.

- 78% (101 clients) reported that they felt that they suffered from mental health issues. Two thirds, however, had no formal diagnosis. 52 clients reported having physical health issues;
- 52% (68 clients) reported that they felt that they had an alcohol issue, of which 21 clients reported using alcohol every day;
- 28% (36 clients) stated that they had a drug problem. Cannabis is the most commonly used illegal drug (69% of those who disclosed a drug problem) with heroin and crack/cocaine also being frequently used (42% and 39% respectively). Note that clients may have disclosed use of more than one drug.

**Complex needs commissioned services**

There are **285 units of complex needs services** across Cornwall. This includes all staged provision, which accommodates clients when they are still using substances, through their recovery journey and into other provision that supports them when they are clean and dry. In the first two quarters of 2015/16 these services reported 93% occupancy. Waiting lists run around a total of 150 people.

St Austell and the Camborne, Pool, Redruth area have the largest numbers of complex needs services, St Austell having the highest number of stage 1 units. Interestingly, St Austell had one of the lowest numbers of rough sleepers reported in a large town at the last count, 6 compared with 25 in Penzance and 26 in Truro.

In the first two quarters of 2016/17, **162 clients were refused access to this accommodation** and this was for a multitude of reasons, but the main ones were that were considered to be too high risk or their level of emotional and mental health needs were too high.

Although 63% clients were reported to leave in a planned way, 34% left in an unplanned way and for 5% this was not stated. 48% of the early exits were evictions; 13% were said to be due to substance misuse issues.

It is not clear, however, to what degree substance misuse contributed to the evictions or other stated reasons such as disengagement from support, breach of
tenancy, anti-social behaviour or violent or threatening behaviour. Further analysis of this cohort could enhance our understanding of their needs.

The breakdown of exit reasons can be seen in the next chart.

### Accommodation needs in the treatment population

The housing status of clients accessing treatment in Cornwall is established during the comprehensive assessment process for new clients and is reported on the National Drugs Treatment Monitoring System (NDTMS).

<table>
<thead>
<tr>
<th>Accommodation need</th>
<th>2016/17 YTD</th>
<th>2015/16</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>NFA/acute housing need</td>
<td>8%</td>
<td>7%</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td>Housing problem</td>
<td>9%</td>
<td>9%</td>
<td>11%</td>
<td>16%</td>
</tr>
<tr>
<td>No housing problem</td>
<td>81%</td>
<td>82%</td>
<td>81%</td>
<td>76%</td>
</tr>
<tr>
<td>Not completed</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Presentations in year</strong></td>
<td><strong>993</strong></td>
<td><strong>1,397</strong></td>
<td><strong>1,245</strong></td>
<td><strong>1,314</strong></td>
</tr>
<tr>
<td>Any housing problem</td>
<td>17%</td>
<td>16%</td>
<td>17%</td>
<td>22%</td>
</tr>
<tr>
<td>Employment status recorded</td>
<td>99%</td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
</tr>
</tbody>
</table>

- This year, **17% of people presented to treatment with a housing need**; the level of overall housing need has reduced compared with 2013/14 but there has been little change over the last couple of years;
- Just under **one in ten people present to treatment in acute housing need** (NFA/homeless) and this has seen a **small rise year on year**; conversely fewer people are presenting with a (non-acute) housing need.

Addaction reports that although there are not large increases in numbers, those clients presenting in housing need are becoming **increasingly complex**, requiring a lot of housing support as part of the treatment intervention. They also reported a particular increase in **vulnerable females sleeping rough** which
reflects the findings of the recent rough sleeper count. Many of these clients are banned from all services across the county with few or no options available to them.

The review found that prevalence of housing problems varies by drug type and region but average 12% of opiate users and 5% non-opiate users present as homeless.

Our local figures appear to be in line with the national average for opiate users but slightly higher than average for non-opiate users.

- In people terms, the number of people presenting NFA has increased from 83 in 2013/14 to 96 in 2015/16 and **projected to reach around 100 in 2016/17**;
- **Homelessness is more common amongst opiate users** (11%) but this cohort is the only one to see a slight reduction in the level of NFA presentations compared with 2013/14 (-2%).

Additionally, data is captured through regular Treatment Outcomes Profile assessments completed during a client’s treatment journey and on exit from the treatment system.

The TOP records whether the client has a housing need and/or is at risk of eviction at the time of the exit assessment.

The latest quarterly DOMES report indicates that the vast majority of people exiting the treatment system in Cornwall have no reported housing need (around 95%) and this is **in line with national average**.

Further analysis of our local data shows that the proportion exiting treatment successfully, with no reported housing need, has declined for both opiate and non-opiate users since 2014/15 but it has remained **stable for problem drinkers**.

**This trend will need to be closely monitored** as we are aware that resolution of housing issues not only predicts successful treatment outcomes but also successful outcomes in other areas of life such as employment.

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81 The **Treatment Outcomes Profile** (TOP) measures change and progress in key areas of the lives of people being treated in your drug and alcohol services.

82 Diagnostic Outcomes Monitoring Executive Summary or DOMES; a detailed performance report covering the whole treatment system provided by Public Health England Quarterly.
Comparing reported housing need on exit with recorded need on presentation shows that for the majority, **pre-existing housing problems are resolved by the time they leave** the treatment system.

<table>
<thead>
<tr>
<th>Accommodation need on presentation to treatment</th>
<th>Housing need outcome on exit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>At risk of eviction</td>
</tr>
<tr>
<td>NFA</td>
<td>2%</td>
</tr>
<tr>
<td>Housing problem</td>
<td>2%</td>
</tr>
<tr>
<td>No housing problem</td>
<td>0%</td>
</tr>
<tr>
<td>Exits in year</td>
<td>1%</td>
</tr>
</tbody>
</table>

The table above shows all successful completions from April 2015 to date (18 months) where an exit TOP assessment provided details of housing need on exit, related to their presenting housing need.

- **Overall 4% of people report having a housing need on successful completion and exit** from treatment, which equates to around 30 people. A more detailed look at this small sample could give us greater insight into the reasons for their lack of housing progress enabling us to make recommendations to housing commissioners and providers;
- **Three out of every four people presenting to treatment as NFA had no reported housing** need on successful completion and exit from treatment. Outcomes are similar for those presenting to treatment with housing need;

More detailed information about housing status was captured in Halo for around 50% of all people leaving treatment in the last 18 months.

- **Looking across all outcomes** (so not just successful completions) indicates that **successful completion rates for people presenting to treatment in supported accommodation are very low** at only 15% (compared with 32% for the whole population of drug users). This also represents a decline from last year.

**Limitations and Gaps**

Although there seems to be a reduction in housing need of those presenting to treatment, there is an **increasing cohort of complex individuals**, including females, where finding accommodation is becoming an ever increasing challenge.

Although there are 285 complex needs units, only 44 of these are stage 1 services that will accommodate those who have current issues with drugs and alcohol. Many clients are either being refused access due to high levels of presenting need or are being asked to leave for a variety of reasons. **Some of the very complex clients are banned from all provision due to previous behaviour.** We are seeing escalating rough sleeping numbers year on year.

Although 17% of the rough sleepers counted were female there is no **female only provision** for people requiring stage 1 accommodation. Treatment providers are reporting increased complex and vulnerable females sleeping rough and who are also banned from all provision. Bosvean in Launceston is the only female only provision and it is stage 3 so accommodates clients that are more advanced in their recovery journey.
The **Welfare Reform and Work Act 2016** is having a massive impact on the housing sector. Universal Credit, the Benefit Cap and the under 35s Single Room Rate is already causing both Private Landlords and Registered Social Landlords to **reconsider accepting clients on benefits**, especially those under the age of 35 years, further limiting the options for this cohort. Supported Housing services are currently exempt from the Local Housing Allowance cap but are anxious about their long term security as the current intensive housing management funding will in future be subject to local commissioning processes.

Continual threats to funding is adding to the uncertainty for these complex needs providers and causing them to re-evaluate their position in delivering a service to this complex client group.

In using hard to let properties to accommodate drug users could have limited effectiveness in Cornwall if clients do not continue to have easy access to treatment and other support and very accessible transport links.

### Street life: impacts on communities

Over the last year, we have seen a marked rise in reports of **homeless drug and alcohol users, anti-social behaviour** caused by street drinkers and problems with **drug litter**. This has highlighted **safeguarding concerns for some particularly vulnerable adults** with complex needs. Although this behaviour is not always connected to homelessness there are cohorts of homeless people within these populations.\(^8\)

This is against a **backdrop of a huge rise in homelessness** generally. Both local and national data indicate that problems with **mental health conditions, alcohol and drugs** are the biggest issues being faced by the homeless community.

The overall trend in **anti-social behaviour reported to the police** has been fairly flat for several years but started to increase in January 2015 and has continued to rise at a moderate pace since then. There was a 4% rise overall in 2015/16 compared with the previous year and in the last 12 months there has been a further rise of 2%. The greatest percentage rise is in **street drinking with rowdy or nuisance behaviour**.

**Street drinking incidents make up 6%** of the total number of anti-social behaviour incidents recorded, however due to its nature they are a visible type of incident, which causes concern amongst local residents and affects their feelings of safety in their local area. This has been reflected in resident surveys that have been conducted over the past 3 years.

The greatest increases in **street drinking incidents** have been seen in the **main population centres of Cornwall** with the number of incidents in Camborne,
Falmouth and Penzance in particular more than doubling over the last couple of years.

Comparing current levels of anti-social behaviour, in our chosen types most likely to be linked to alcohol, across all towns with a population of 9,500 or above, identifies Truro, Camborne, Newquay, St Austell, Penzance and Bodmin as the most significant hotspots.

Although anti-social behaviour in combination with a range of other issues are being experienced to some extent across Cornwall, the impact on some communities in has been particularly significant, with strong concerns expressed by residents, elected members and local businesses. Some examples are detailed below.

**Truro**
- **Increased prevalence of rough sleeping**, including car parks and outside business premises;
- **Deaths** of vulnerable homeless people;
- These have been matched by a combined outreach intervention involving Police, Addaction and the Council’s Anti-social Behaviour Team, that is being developed with the assistance of Localism and homelessness services and will need to continue;
- A multi-agency tasking group is being established to address the needs of individuals affected by multiple problems.

**Penzance**
- In summer/autumn 2016, a homeless community was residing behind the Fire Station in unsafe and unsanitary conditions. The crew at Penzance fire station delivered fire safety and overdose prevention advice and then joined up with Breadline to issue homeless welfare packs;
- The 15-20 rough sleepers that were congregating there have since been dispersed, and views are mixed as to whether or not this was a success. One criticism was that the response focused on moving people on rather than trying to engage individuals in services;
- A subsequent call out to an overdose in Penzance bus station because the ambulance service was too far away has given rise to consideration of the Fire and Rescue Service staff carrying naloxone in future.

**St Austell**
- There have been a number of reports of injecting in public toilets, needle finds and recently a needle stick injury to a minor after the discovery of a discarded needle in a park;
- The devolution of the public toilets introduced a payment mechanism to some toilets which resulted in the safe disposal bins for needles being shut behind locked doors and requiring payment to access;
- A group of homeless drug and alcohol users from St Austell have been moved to Camborne, thereby increasing difficulty in follow-up intervention work and an example of shifting a problem rather then helping to solve.

The combination of these responses has highlighted the need for a co-ordinated response between enforcement and assistance in local areas, to prevent future occurrences and meet the statutory requirement to protect vulnerable people.
The **needle find policy**, which triggers waste management, cleansing and assertive outreach has been updated to ensure that it reflects the changes happening through devolution of waste management, cleansing and toilets to local areas, as the transfer occurred without the changes being reflected within the community safety response.

As this is a constantly changing picture, the **pathway and response must be kept under review** to ensure that they are delivering the required outcomes and reflecting community safety and public health priorities.

### Gypsy, travelling and migrant worker communities

Cornwall’s Gypsy and Traveller Liaison Officer believes there to be around **1,100** men, women and children with a culture or way of life as a Roma Gypsy, Irish Traveller or New Traveller in Cornwall spread across the 3 authorised sites; 100 private sites; 10 unauthorised sites and some bricks and mortar provision.

There is **very limited literature on the health needs of this population**. In Cornwall Southern Horizons UK\(^8^4\) carried out a needs assessment but this focused entirely on their accommodation needs as opposed to support needs.

A **Race Equality Foundation briefing paper** on the health of Gypsies and Travellers in the UK highlighted that alcohol consumption was often used as a coping strategy and drug use was widely reported among young Travellers although this was feared by the elder Traveller population.

She also reiterated that there has been **little research into the extent of substance misuse amongst Gypsy and Traveller populations** in the UK but that anecdotally evidence suggests that it is on the increase as in other communities, especially if families have been re-housed on run-down estates or where there is a high incidence of unemployment or depression.\(^8^5\)

The South West Public Health Observatory, in their report in 2011 on the Health and wellbeing of Travellers and Gypsies in the South West observed that there were still **concerns over the provision of services for drugs and alcohol and other health issues** to this population. They also reported that literature in this area is still very limited, making it difficult to draw conclusions although the health of this population is still said to be worse than the national average.\(^8^6\)

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\(^8^4\) Southern Horizons UK Limited (2015) Supporting an assessment of the accommodation needs of Gypsies and Travellers in Cornwall

\(^8^5\) ‘The Health of Gypsies and Traveller in the UK; Health briefing 12’, Race Equality Foundation, Matthews, Zoe (November 2008)

\(^8^6\) ‘Health and Wellbeing of Gypsies and Travellers in the South West’, South West Public Health Observatory (October 2011)
Profile of Gypsies and Travellers in the treatment system

This analysis considered all ‘open’ drug and alcohol clients from 1\textsuperscript{st} April 2014 to 31\textsuperscript{st} August 2016. During this time there were 7,088 people in the treatment system; 43 of these were Gypsies and Travellers.

- Based on those accessing treatment, drug and alcohol issues are \textbf{three times more prevalent} amongst Gypsies and Travellers.

<table>
<thead>
<tr>
<th>Whole Population</th>
<th>Gypsy &amp; Traveller (persons)</th>
<th>Gypsy &amp; Traveller (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population in Cornwall</td>
<td>549,400</td>
<td>1,100</td>
</tr>
<tr>
<td>Number in treatment</td>
<td>7088</td>
<td>43</td>
</tr>
<tr>
<td>%</td>
<td>1.3%</td>
<td>3.9%</td>
</tr>
</tbody>
</table>

Gypsies and Travellers are accessing treatment from a \textbf{range of diverse locations} and not just one or two sites. The green dots on the map below show the spread of referrals.

The gender split for Gypsies and Travellers accessing treatment is very similar to the main treatment cohort with a third female and two thirds male.

The cohort in treatment does not include anyone under the age of 19 years but generally service users are \textbf{more skewed towards the ‘younger’ end}, 19-44 years, than the treatment population as a whole.
A slightly lower percentage of the Gypsy and Traveller cohort in treatment are parents when compared with the main cohort (19% against 22%), with an average of 2 children (similar to the treatment population average).

In the Gypsy and Traveller cohort, one in four is recorded as having a dual diagnosis, which is what we would expect based on national research. The prevalence of dual diagnosis in the whole treatment population is just over one in ten, which is much lower than expected.

Putting the national statistics aside, this indicates that dual diagnosis is more common amongst the Gypsy and Traveller cohort.

<table>
<thead>
<tr>
<th>Dual diagnosis (persons)</th>
<th>Dual Diagnosis (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Population</td>
<td>826</td>
</tr>
<tr>
<td>Gypsies &amp; Travellers in treatment</td>
<td>10</td>
</tr>
</tbody>
</table>

Prevalence of recorded disability is similar to the main treatment population.

**Substance profile and time in treatment**

Gypsies and Travellers in the treatment population are more likely to be heroin users and engaged in treatment for a moderate period of time (6 months to 4 years).

<table>
<thead>
<tr>
<th>Drug Group</th>
<th>All</th>
<th>Gypsies &amp; travellers in treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>37%</td>
<td>33%</td>
</tr>
<tr>
<td>Non opiates</td>
<td>12%</td>
<td>7%</td>
</tr>
<tr>
<td>Non opiates and alcohol</td>
<td>16%</td>
<td>17%</td>
</tr>
<tr>
<td>Opiates</td>
<td>35%</td>
<td>43%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time in treatment</th>
<th>All</th>
<th>Gypsies &amp; Travellers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Persons</td>
<td>%</td>
</tr>
<tr>
<td>0-6 months</td>
<td>4,128</td>
<td>58%</td>
</tr>
<tr>
<td>7-12 months</td>
<td>991</td>
<td>14%</td>
</tr>
<tr>
<td>1-2 years</td>
<td>742</td>
<td>10%</td>
</tr>
<tr>
<td>2-4 years</td>
<td>612</td>
<td>9%</td>
</tr>
<tr>
<td>2+ years</td>
<td>615</td>
<td>9%</td>
</tr>
<tr>
<td>Total</td>
<td>7,088</td>
<td>43%</td>
</tr>
</tbody>
</table>

87 [‘Mental Health facts and statistics’ Mind (2016)]
Specialist support

Cornwall Council’s adult commissioning team currently commissions a **Gypsy and Traveller support worker** through the complex needs prevention services. Around 100 clients are being supported each quarter across authorised and unauthorised sites.

- During the first six months of 2016/17, the Gypsy and Traveller support worker reported that **14 people she was working with had issues with drugs or alcohol**, with the majority (10/14) having **accessed appropriate treatment services and reduced their intake** of drugs and/or alcohol;
- 43 people are managing their **mental health and symptoms** have reduced or they have accessed services to support with these mental health needs;
- 112 people have been helped to manage their **physical health** and access to primary healthcare;
- 14 people have **reduced their access to emergency services** and 8 people have reduced their hospital admissions;
- 21 people have **reduced their offending and anti-social behaviour**;
- 29 people are **complying with statutory orders**.

This is clearly a very valuable service, supporting Gypsies and Travellers to access various mainstream services that they may not otherwise access. It is noted that any **further cuts to the prevention budget will place this support service at risk**.

Both the Gypsy and Traveller workers and the strategic Gypsy and Traveller Group have identified a gap left by the **withdrawal of police support** – when this was provided, it was considered to be a very valued resource to the residents and support services accessing the sites.
Worklessness

The government has recognised employment as a key component to successful treatment outcomes for many years. The National Drugs Strategy\(^88\) stated that employment had a key role to play in maintaining recovery. Also the review of the National Strategy in 2013\(^89\) moved the recovery focus and the requirements of partners very much towards housing and employment initiatives required to deliver sustained recovery.

The recently published Department for Work and Pensions Independent Review\(^90\) on the impact of drug and alcohol addiction on employment outcomes highlights that employment needs to be a more integral element of addiction treatment. There are several recommendations about how to make this possible which includes work with employers and significant changes to the benefit system ensuring the offer of support that is much more robust.

The Welfare Reform and Work Act 2016 received Royal assent on 16 March 2016 building on the measures introduced in the Welfare Reform Act 2012. This includes many elements such as Universal Credit, the Benefit Cap, Social Housing rents provisions and the under 35s Single Room Rate as well as Troubled Families and Life Chances provisions. It also extends to the State Pension with changes set out in the Pensions Act 2014 that are now being introduced.

The government’s aim with the reforms is to encourage claimants to take more responsibility and make the benefits and tax credits systems fairer and simpler by:

- Creating the right incentives to get more people into work
- Protecting the most vulnerable in our society
- Delivering a welfare system that is affordable and fair to the tax payers as well as benefit claimants

The government is planning to deliver a new Health and Work programme that clients with drug and alcohol issues will need to be enabled to access. This will mean that the ambitions, aspirations and needs of those with drug and alcohol issues will be supported by more active, integrated and individualised support that wraps around them. This is intended to improve their health and wellbeing, benefit our economy and enable more people to reach their potential.

The Work Routes programme is a newly commissioned service delivered by Reed in partnership. It may be appropriate for some treatment clients to participate in this programme as part of their journey back to work as it includes work experience and in work support.

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\(^88\) Drug Strategy; Reducing demand, restricting supply, building recovery: Supporting people to live a drug free life (Home Office, 2010)

\(^89\) Drug Strategy Annual Review: delivering within a new landscape (Home Office, 2013)

\(^90\) An Independent Review into the impact on employment outcomes of drug or alcohol addiction, and obesity (2016), DWP
For those clients who are further from the labour market, the **Big Lottery ESF Programme is starting in 2017**. Pluss\(^91\) have been awarded the contract in Truro and Redruth. Change Coaches and Community Engagement workers will be recruited to implement this contract.

As a Core Partner for Pluss, Addaction will be delivering the new Big Lottery/ESF funded Employability programme, Positive People from March 2017 to December 2019. This contract is for the Coast to Coast region of Cornwall which includes Truro, Camborne/Pool/Redruth and Falmouth. The Addaction employability service will be delivered to over 250 participants by two Change Coaches and a Community Engagement Trainee.

The programme is aimed at unemployed and economically inactive individuals who have **significant barriers to work** such as disabilities, mental health issues, drug and alcohol and offending backgrounds. By securing a key role in the partnership Addaction has ensured that a **dedicated, specialist end-to-end route** is available for people with substance misuse issues.

**Change Coaches** will work with participants to agree and regularly review an action plan which will target progression in terms of training, job search and employment. There will be access to a substantial pot of money to engage other partners to deliver specialist interventions and to cover participants travel expenses. The Big Lottery is currently making their final decisions about which Lead Partners have been successful in the remaining three geographic areas of Cornwall and the announcement is anticipated in early February 2017.

Additionally, employment support for those with drug and alcohol issues will be further enhanced by the new team of **Disability Employment Advisors** (DEAs) across Cornwall. Their key role is to upskill work coaches and work with partner organisations to meet client needs. Under this banner they will be aiming to build relationships with organisations such as Addaction.

They will also look for any gaps in provision/support that may be filled through joint working with Job Centre Plus (JCP) provision. Their particular **target group will be clients on Employment Support Allowance** (ESA) but they could also include those **recovering from addiction but requiring further support** – ie.on Job Seekers Allowance, Universal Credit or Income Support.

All claimants aged between 18-65 will be engaged with an employment provider at some point and next year’s new delivery processes will **expect all to have claimant commitments**, with many taking forward ‘activities’

**Achievements so far**

In Cornwall since 2009, a lot of partnership work has been undertaken by DAAT, JCP, treatment and Work Programme providers. This included the **development of pathways** between JCP and other employment providers and treatment services,

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\(^91\) **Pluss** is an award-winning Social Enterprise that supports thousands of people with disabilities and other disadvantages move towards and into employment each year.
using the TPR1 and TPR2 processes. **Single points of contact** were established across providers and some excellent relationships were formed between treatment, JCP and Work Programme provider staff.

In addition drug and alcohol **training programmes were rolled out across JCP** and other employment providers, including Basic Drug Awareness, Alcohol Identification and Brief Advice; Young People’s Substance Use Screening Tool; Mental Health First Aid and Motivational Interviewing.

Some of this work **greatly enhanced the relationships** between treatment and employment teams and subsequently **supported positive outcomes** for clients.

### Case study

This case study, which can be read in full in Appendix A, highlights an individual, L, with a **long term, successful teaching career**, who after **deteriorating mental and physical health** and the development of an **alcohol addiction** ended up signed off sick from work.

This **challenging period lasted for many years** where L fell in and out of treatment. L reported that the **dehumanised benefit system and stressful appeals processes** exacerbated his drug and alcohol issues. However, L also reported that positive engagement and structure with the Addaction Life Skills Team and a **positive relationship with his JCP Advisor** in Cornwall supported L to manage more recent challenging benefit issues.

Additionally, these relationships also helped L **develop his volunteering work** in order to make a **sustainable re-entry** into the world of employment.

This experience evidences a different, more positive outcome to what is reported as a typical experience in the Public Health Evidence Review. Participants said experiences with JCP were rarely positive, with unfriendly staff and unwelcoming attitudes, often showing few signs of knowledge about drug use and recovery.

Finally, the **Cornwall Works with Families programme** through the last tranche of ESF funding achieved employment outcomes for clients and the Government’s Troubled Families agenda, known as **Together for Families in Cornwall** has worked with clients with drug and alcohol issues. There were Addaction, DWP and Council Advocates supporting this programme.

### Employment needs in the treatment population

The employment status of clients accessing treatment in Cornwall is established during the comprehensive assessment process for new clients and is reported on the National Drugs Treatment Monitoring System (NDTMS).

- **Three out of four people were not in work when they started treatment** and this has remained fairly constant over the last four years;
- The balance between economically inactive and unemployed has switched, however, with a decline in those presenting simply as unemployed and **an increase in people presenting as economically inactive**, and thus further from the workplace. This is the case across all types of substance use.
This reflects the overall population trend of reduced JCP claimants. Either claimants have moved from JSA to ESA or they have stopped claiming benefits altogether. Addaction has anecdotal evidence of the latter due to changes in benefit processes etc;

- There has been a **small uplift of 3% since 2013/14** in the proportion of people in employment presenting to treatment but little change over the last two years. The rise relates to non-opiate users (+6%) and problem drinkers (+4%) only.

<table>
<thead>
<tr>
<th>Employment need on presentation</th>
<th>2016/17 YTD</th>
<th>2015/16</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economically inactive</td>
<td>41%</td>
<td>39%</td>
<td>34%</td>
<td>33%</td>
</tr>
<tr>
<td>Employed</td>
<td>21%</td>
<td>20%</td>
<td>20%</td>
<td>18%</td>
</tr>
<tr>
<td>In education</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Not known</td>
<td>1%</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
<td>6%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Unemployed/NEET</td>
<td>32%</td>
<td>33%</td>
<td>39%</td>
<td>42%</td>
</tr>
<tr>
<td><strong>Total presentations in year</strong></td>
<td><strong>993</strong></td>
<td><strong>1,397</strong></td>
<td><strong>1,245</strong></td>
<td><strong>1,314</strong></td>
</tr>
</tbody>
</table>

**Not in work** 73% 72% 73% 75%
**Employment status recorded** 78% 81% 91% 95%

Note that **data completeness has declined significantly** from 95% in 2013/14 to 78% in the year to date, which means that the results should be regarded as estimates. The HALO electronic case management system has undergone significant changes in recent months and employment status is now an optional field.

The majority who are economically inactive are recorded as **long term sick or disabled** (80%) with the remainder split fairly evenly between retirees and homemakers.

Although overall, **problem drinkers are most likely to be employed** when they present to treatment, if they are not in work they are more likely to be economically inactive rather than unemployed, with a slightly **higher proportion of retirees** (18%).

Additionally, data is captured through regular Treatment Outcomes Profile\(^2\) assessments completed during a client’s treatment journey and on exit from the treatment system.

\(^2\) The Treatment Outcomes Profile (TOP) measures change and progress in key areas of the lives of people being treated in your drug and alcohol services.
The TOP records the number of days of paid employment in the preceding 28 day period; a positive outcome is considered to be at least 10 days in the last 28.

The latest quarterly DOMES report indicates that those exiting the treatment system in Cornwall are less likely than the national average to meet this target. However, the DOMES report also indicates that Cornwall is within the anticipated range for our complexity group.

15% of opiate users and 21% of non-opiate users who left treatment successfully had engaged in 10 or more days of paid work in the 28 days preceding their exit assessment – compared with 23% and 34% nationally.

Figures for problem drinkers are not included within this section of the DOMES report. Our local data, however, indicates that 29% of problem drinkers leaving treatment successfully engaged in paid employment in the 28 preceding days.

Further analysis of our local data shows that the proportion engaged in 10+ days paid work has declined for both opiate and non-opiate users since 2014/15 but it has remained stable for problem drinkers.

Comparing engagement in paid work on exit with employment status on presentation shows that in the majority of cases there is no change (i.e. a person presenting as out of work remains out of work) but where there is a change, it is more likely to be negative than positive. Many drug and alcohol clients will require intensive support to help them return to the workplace.

There has previously been support in place through ESF funding but this funding ended and the new services are not yet in place. This means that no new referrals have been taken for clients to access such support since December 2014 which may explain low numbers of clients returning to the workplace.

The next table shows all successful completions from April 2015 to date (18 months) where an exit TOP assessment provided details of engagement in paid work in the preceding 28 days, related to their presenting employment status.

<table>
<thead>
<tr>
<th>Employment status on presentation to treatment</th>
<th>Employment outcome on exit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Paid Days = 0</td>
</tr>
<tr>
<td>Employed</td>
<td>34%</td>
</tr>
<tr>
<td>In education</td>
<td>60%</td>
</tr>
<tr>
<td>Economically inactive</td>
<td>92%</td>
</tr>
<tr>
<td>Unemployed/NEET</td>
<td>81%</td>
</tr>
<tr>
<td>Total</td>
<td>74%</td>
</tr>
</tbody>
</table>

150 people were excluded from this analysis due to no employment status being recorded at presentation to treatment.

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93 Diagnostic Outcomes Monitoring Executive Summary or DOMES; a detailed performance report covering the whole treatment system provided by Public Health England Quarterly
• 10% of people who presented to treatment out of work had moved into employment at exit (10+ days);
• A third of people who presented to treatment in work had not engaged in any paid work in the preceding 28 days when they exited treatment.

This is what we would expect to see. Many people present to treatment at the start of a crisis point. The threat of losing a job can act as a trigger seeking help and, once a person has recognised their problems and committed to recovery, things often get worse before they get better – holding down a job at the same time is not always feasible and can even slow down progress.

We would anticipate that many of those within the 34% will go back into work in the 2-3 months following successful completion but this is the next step and leaving treatment is an important stepping stone along the way.

This is supported by the Public Health Evidence Review, where it said that employment rates tend to remain static during treatment with the largest gains in employment levels being evident in those who exited treatment successfully, with increases for both opiate and non-opiate users.94

Limitations and Gaps

Although, Cornwall is not achieving as high employment outcomes as nationally, it has been recognised that many clients are making positive steps towards employment during their recovery from drug and/or alcohol issues.

Many are participating in structured day programmes, life skills activities, peer mentoring and volunteering. The current NDTMS and JCP data systems are limited and do not capture such levels of progress. These limitations have been highlighted by Dame Carol Black in her Independent Review into the employment outcomes of drug or alcohol addiction and obesity (2016), 95 with a recommendation for government to adopt an expanded recovery measure to include work and meaningful activity (including volunteering).

Additionally, there is a lack of data gathered about longer term outcomes and sustained employment or recovery outcomes of service users. This facility would also to help us understand if clients, once completing their treatment programme then manage to engage or re-engage with work.

Some of the partnership work carried out previously had limited success, such as the TPR processes as very few clients were counted as accessing services using these pathways. Clearly additional measures are required to maximise and monitor employment or progress towards employment for a larger cohort of

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95 An Independent Review into the impact on employment outcomes of drug or alcohol addiction, and obesity, DWP (2016)
clients with drug and alcohol issues. Dame Carol Black recommended peer mentors to enhance engagement and disclosure.

Since the development and delivery of these extensive pieces of partnership work, there have been many changes to the benefit system and to employment and treatment contracts and teams. Due to all these changes most of these previous work streams need to be updated; new relationships between new providers need to be formed; new service maps and pathways need to be developed and training is required to be delivered to both treatment staff around the benefit changes and to employment staff around the needs of those with drug and alcohol issues.

Changes to the welfare system are having and will continue to have a significant impact on clients with drug and alcohol issues affecting their housing and homelessness status, their mental health, their levels of debt and their ability to work, which all have an impact on their treatment outcomes.

In the Public Health Evidence Review the welfare reforms and sanction regime was said to have shaped participants engagement with employment support, resulting in a focus on maintaining benefits and avoiding a sanction. Even in areas where JCP coaches were located with treatment teams and viewed positively, the focus was still on sanction avoidance.

The Public Health Evidence Review also highlighted that despite provisions in the Rehabilitation of Offenders Act, those with criminal records still felt excluded from the job market.⁹⁶

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Appendices

Appendix A: Case studies
Appendix B: Survey questions
Appendix C: Notes on the data
Appendix D: Further reading
Appendix A: Case studies

Case Study 1 J

Background
A young woman was permanently excluded from school due to behaviour. She attended a pre-16 course at college and the Short Stay School for her GCSE work. She has been involved in some anti-social behaviour in the community and although she attends the local youth centre regularly, she finds it difficult to build relationships with professionals. Her family describes her childhood as being ‘normal’ at this stage and were supportive.

Presenting Need
The young person uses Cannabis on a daily basis and has heavy usage of Amphetamine and MDMA over the summer holidays.

Interventions Delivered
YZUP started their intervention with the young person with motivational interviewing and solution focussed therapy. As the young person stopped using all substances within 4 to 5 months, relapse prevention work was also undertaken.

The young person’s case was kept open on a preventative basis, due to complex issues relating to building relationships with workers, school exclusion, escalation of ASB and possible relapse.

Positive Activities: The young person took part in group work through Aspire project and was involved in the Summer Holiday activities programme.

Mental Health: YZUP made a referral to Child and Adolescent Mental Health Services (CAMHS), due to a query about whether the young person could have ADHD. It was classed as a ‘late diagnosis’ as the ADHD had apparently been present since the young person was much younger.

Housing: Due to her behaviour at home and in the community, the young person was asked to leave. She was supported by her YZUP worker to access supported accommodation.

Crime and Anti-Social Behaviour (ASB): YZUP offered support for the young person at police interviews, court hearings and advocated for in the ASB process when they were considering a full ASBO application. YZUP have been working jointly with the Youth Offending Service.

Anti-Social Behaviour: There was a massive escalation in her substance use and ASB since living in supported housing, together with a severe deterioration in her mental health.

Timeline
She was sectioned under the Mental Health Act and held in hospital (out of county) until her 18th birthday when she was immediately moved to an adult unit in Cornwall. She was quickly discharged after 1 week to the care of her family and
completely after two weeks. **No adult mental health support has been offered** and her case was closed by Child and Adolescent Mental Health Services (CAMHS) at this time.

Art psycho-therapy intervention and daily support were provided by YZUP and were attended by the young person.

**Further deterioration in her mental health** later resulted in regular **serious self-harm** events. The YZUP worker liaised with Specialist Residential Rehab and worked to persuade the young person to visit rehab. The young person was admitted to Longreach House in Plymouth shortly after.

After **nine months in a rehab unit outside of Cornwall** and a diagnosis of **Borderline Personality Disorder**, regular fortnightly contact with YZUP worker was introduced. Although the young person was now 18, it was agreed that she would **remain in the young people’s drug and alcohol service**, due to the nature of Borderline Personality Disorder (BDP) and her **need for consistent relationships with professionals**. This approach was taken to ensure her positive outcomes continued.

The **YZUP worker offers continued support** to ensure the young person settled back into the community, **although she has decided not to return to Cornwall**.

The young person is attending a **funded day programme**, which gives her access to weekly counselling, daily attendance at groups, a meal each day and a bus pass. She is now living in **supported accommodation specifically for those in recovery**. She has also been referred to IceBreak, a **personality disorder group**, although nothing like this is available in Cornwall.

**Challenges**

The **mental health transition did not happen**. There was **poor communication** when workers were seeking clarification about what needed to be done to access this support.

The young person’s chaotic behaviour resulted in hours spent by the YZUP worker supporting her in hospital. This was due to serious self-harm events, where she refused to access treatment, and advocating for support from mental health team.

There was a **significant risk to self and keeping young person safe**. At many points, the young person was being seen daily to ensure the risk was mitigated as far as possible.

There has been an impact on the team in terms of capacity due to the **intensive one to one support and advocacy with other services**. The nature and complexity of the case, together with the transitions failures have also had an emotional impact on the team.

**Outcomes**

The young person completed **nine months of rehab** and now has a **diagnosis of Borderline Personality Disorder**.
This has allowed the young person to learn to understand her behaviour and why these things have happened to her. The young person is now engaged in a day programme and started to make a new life away from Cornwall.

The young person is now able to ask for and accept support, including from her family, which is a huge accomplishment.

The young person is no longer self-harming or using substances, although she is still on her recovery journey and is now has a full time job.

Case Study Two L

L had enjoyed a successful career as a tutor, working in the further and higher education sectors in the UK and delivering training overseas. Throughout these 17 years, L had struggled with his alcohol issues, and by 2011, his physical and mental health had also deteriorated and he was signed off sick. For the first time in his life, L was now claiming benefits.

As an ESA claimant, L attended a work capability assessment. His symptoms at that stage were significant – severe depression, alcohol misuse and physical pain. Despite this, L was awarded zero points and told he was fit for work. The process of appealing the decision caused L further anxiety and stress and in the end he abandoned his claim and was no longer able to claim benefits. L was in this position for 5 months and not surprisingly, his condition worsened – to such an extent that he felt he was no longer in control of his alcohol intake. L knew that he needed help and took positive action by removing himself from his current location and moving down to Cornwall.

L signed up with his local GP and was referred to Addaction to access treatment. His recovery journey included the usual ups and downs. After a number of community interventions, L was referred in to a community hospital for detox. He completed this successfully and returned to Bristol feeling ready to get back on with his life. He started looking for full-time employment but without much success, triggering further stress and anxiety and a return to drinking.

Over the next 3 years this cycle continued with regular ESA claims but due to the pressure he felt from the benefits system and his strong work ethic he would sign on JSA to pursue employment. He says he was seeking support and help but “felt totally dehumanised by the system” and the anxiety and stress experienced resulted in an increased dependence on alcohol to manage the uncomfortable feelings. In 2014, L again reached the point of people able to make a major change in his life - he returned to Cornwall and referred himself to Addaction.

After a period of engaging with Addaction’s community services L was referred to residential rehabilitation to do 3 months in depth work on his addiction issues and to develop strategies to manage his anxiety and depression. L successfully completed the programme and started claiming ESA again upon completion. Life post-rehab presented some challenges for L and he started another period of drinking. He managed to stop drinking and realised he needed more help so referred himself back in to Addaction.
L started attending the Addaction Life Skills service one day per week. As well as enjoying the activities themselves, L recognised that what he really responded to was the structure. This has been key to his success in rehab and moving away from this has been a major factor in his lapse. Being in a learning environment again was a real boost for L and he was able to access much needed support, information, advice and specialised career guidance.

L reflects that being in a positive learning environment with people who understood addiction and who were themselves on a recovery journey was invaluable. He felt supported, accepted and valued and this enabled him to create achievable goals without the pressure, which had in past perpetuated his substance misuse issues.

Quickly he was able to create an action plan to become a volunteer within the service and work towards running life skills groups. He completed volunteer training and began to co-facilitate groups in 3 areas of Cornwall on a weekly basis. He said that as well as using his skills to work towards employment he also felt the therapeutic value was very important to his own personal journey an creating a sustainable recovery.

Things were definitely on the up for L but after about a year, his benefits were stopped due to a change in living circumstances. This could very easily have triggered a downward spiral but the progress that he had made, together with the support of his Addaction Life Skills Worker helped to keep him on an even keel. On this occasion, L began to work with a Work Advisor at his local JCP who was very supportive. This helped L to feel valued and whilst he was very upset about his financial situation he was able to work with the Advisor and Addaction Life Skills to develop a plan to develop his volunteering work further in order to make a sustainable re-entry into the world of employment.

Through the Addaction Life Skills service, L was able to access support in writing applications and his volunteering work gave him a much needed current reference. Over the coming months L was able to secure a number of part-time roles in tutoring and health and social care support.

The challenges L faced are not uncommon. We are all too aware of the flaws in a system where people who have been assessed as fit for work have to sign on for JSA in order to claim any benefits, even though they know themselves they are not well enough to accept a job in good faith. However, in L’s case the positive attitude of the JCP advisor and the structure and support offered by the Addaction Life Skills service helped him turn things around.
Appendix B: Survey questions

1. What is good and most helpful about drug and alcohol services in Cornwall?
2. What is not helping or a barrier to your recovery?
3. How many people do you know who have drug problems but are not getting help?
4. Why are they not seeking help?
5. Additionally, drug related deaths are going up sharply nationally and locally. Why do you think that is?
6. What more could be done to prevent drug related deaths in Cornwall?
7. If we could change only 3 things to improve help to reduce harm and promote recovery from alcohol and drug problems, what would they be?
Appendix C: Notes on the data

Classification of drug and alcohol users in the treatment population

In April 2014, Public Health England changed the way in which they classified drug and alcohol users. Previously any client with a primary alcohol episode and a primary drug episode was reported in separate treatment journeys even if the episodes occurred at the same time or were concurrent within 21 days.

This needed to be addressed as it could have been portrayed as double counting. The treatment journeys for clients in drug and alcohol treatment are now combined and reported as one pathway, with the outcomes and profile information for the client reported only once rather than twice as before.

Clients presenting to structured treatment are now grouped in one of the following four categories:
- Opiate users – a client with any opiate use in any episode;
- Non-opiate users – a client using non-opiate substances and not using alcohol;
- Non-opiate and alcohol users – a client using non-opiate substances and alcohol in any drug (1, 2 or 3) in any episode in their treatment journeys;
- Alcohol users – a client with alcohol use and no mention of any other substances.

Crime Survey for England and Wales


As a household survey, the CSEW provides a good and robust way to measure general population prevalence of drug use amongst users contained within the household population. Estimates from the CSEW must be considered, however, within the context of survey methodology and the operational challenges of obtaining information from respondents on self-declared drug use.

CSEW estimates are based on a sample of the population that is considered large for a government household survey. The survey has a high response rate: 72% to the main survey and 97% of those who were eligible for the self-completion module (giving a true response rate of 70%) in 2015/16.

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97 For more information see ‘Consultation 2013/14 – Note on reporting methodology changes’. Public Health England
98 The statistics presented in the Home Office’s annual bulletins on Drug Misuse are based on responses from those who gave their age and were aged 16 to 59.
The drug misuse estimates from the CSEW are produced from responses to a **self-completion module of the survey** that is completed at the end of the face-to-face interview (which mainly covers questions on experiences of crime victimisation and perceptions of crime-related issues).

**Respondents generally complete the drugs module on the interviewer’s laptop by themselves** (CASI, computer-assisted self-interviewing). This keeps **responses confidential** from the interviewer, encouraging respondents to answer questions honestly, which is likely to **result in better estimates**. In about 3% of cases, however, respondents may elect for the interviewer to continue administering the questions. When complete, answers are encrypted and cannot be retrieved by the interviewer.
Appendix D: Further reading

Key assessments, strategies and information sources are shown below with links to their current locations.

The **Safer Cornwall website** holds a [library of publications](#) relevant to community safety and our priorities. These assessments provide the evidence that underpins all of our various strategies and commissioning activity, including the over-arching Safer Cornwall Partnership Plan as well as all of the individual thematic work.

You will find the latest versions of:

- Safer Cornwall Strategic Assessment
- Drugs Needs Assessment
- Alcohol Needs Assessment
- Young People’s Substance Use Needs Assessment
- Peninsula Strategic Assessment
- Domestic Abuse and Sexual Violence Needs Assessment
- Together for Families Needs Assessment

The detailed evidence base that underpins the Safer Cornwall Reducing Reoffending Strategy is available from Amethyst on request.

The **Risk Based Evidence Profile** is produced each year to provide Cornwall Fire, Rescue and Community Safety Service with a comprehensive understanding of risks relating to fire, rescue and road safety. It includes a wide range of information about incidents responded to by the service along with information about high risk groups for fires and road traffic collisions.

All of these assessments form part of the evidence bank and online resource library of assessments and focus papers included in the [Joint Strategic Needs Assessment](#).

The following Organised Crime Local Profiles have been developed with partners and can be provided on request from the Serious and Organised Crime Partnership:

- Child Sexual Abuse and Exploitation
- Modern Slavery
- Cyber Crime and Fraud (including Counterfeit Goods)
- Organised Acquisitive Crime
- Trafficking of People, Drugs and Weapons
If you would like this information in another format please contact:

Community Safety Team, Cornwall Council

Cornwall Fire, Rescue and Community Safety Service HQ, Boswithian Road, Tolvaddon, Camborne, TR14 0EQ.

Telephone: 0300 1234 100 email: mail@safercornwall.co.uk

www.safercornwall.co.uk