DRUG & ALCOHOL ACTION TEAM
Cornwall and Isles of Scilly
Reducing Harm | Promoting Recovery

SAFER CORNWALL
Kernow Salwa

CORNWALL & ISLES OF SCILLY ALCOHOL NEEDS ASSESSMENT 2022

CORNWALL COUNCIL

Acknowledgements

Alcohol Needs Assessment prepared by:
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- Amethyst Community Safety Intelligence Team, Cornwall Council
- With support from Safer Cornwall thematic specialists, drug and alcohol treatment service providers and service users.

We would like to thank the following agencies, partnerships and organisations who also provided data, material and/or comment on this profile's content and supported us in its production:
- Cornwall Council – thematic specialists, commissioners and practitioners in: Community Safety (including the Domestic Abuse and Sexual Violence and Complex Needs Teams), Together For Families, Adult Social Care, Public Health, Housing, Cornwall Housing Limited, Licensing and Cornwall Fire and Rescue Service.
- Devon and Cornwall Police
- Probation Service
- Royal Cornwall Hospitals NHS Trust
- NHS Kernow/Integrated Care Board
- Cornwall Partnership NHS Foundation Trust
- Devon and Cornwall Sexual Assault Referral Centre

Contents

Abbreviations and Terms

A&E / ED	Accident and Emergency also known as Emergency Department
ALT/ACT	Alcohol Liaison Team/ Care Team, based at the Royal Cornwall Hospital
ARBD	Alcohol related brain damage
ASC	Adult Social Care
ATR	Court ordered alcohol treatment requirement
AUDIT-C	Alcohol use disorders identification test, screening tool
CHAD	Community hospital alcohol detox
CHL	Cornwall Housing Limited
CIoS, IoS	Cornwall and Isles of Scilly, Isles of Scilly
CIZ	Cumulative Impact Zone
CJS	Criminal Justice System
CMHT	Community mental health team
CSP	Community Safety Partnership, locally named 'Safer Cornwall'
CSTR	Court ordered community sentencing treatment requirement
DAAT	Drug and Alcohol Action Team, Cornwall Council
DASH	Domestic abuse, stalking and honour-based violence risk assessment tool
DASV	Domestic Abuse and Sexual violence
DRR	Court ordered drug rehabilitation requirement
Dual Diagnosis	Co-occurring mental health issues and problem drinking and/or drug use
EoLC	End of life care
Halo	Case management system in local drug and alcohol treatment
HILT	Health Impact Licensing Tool
HOT	Hospital Outreach Team based at the Royal Cornwall Hospital
IBA	Identification and brief advice
MAP groups	Mutual aid partnership
MAPPA	Multi-agency public protection arrangements
MHTR	Court ordered mental health treatment requirement
MIU	Minor Injuries Unit
MoRiLE	Management of risk in law enforcement, series of workshops
NDTMS	National drug treatment monitoring system
NICE	National Institute for Health and Care Excellence
OHID	Office for Health Improvement and Disparities, formerly Public Health England (PHE)
RCH	Royal Cornwall Hospital often referred to as Treliske
RCHT	Royal Cornwall Hospital Trust
SARC	Sexual Assault Referral Centre
Tier 1	Services which may work with problem drinkers and/or drug users but this is not their core business. E.g. GP, Housing, Job Centres, Adult Social Care and family services.
Tier 2	Open access community alcohol and drug treatment services. Drop-ins, needle exchange, advice & information and brief interventions.
Tier 3	Structured community drug and alcohol treatment.
Tier 4	Inpatient stabilisation and detox and residential rehabilitation.
With You	Local community drug and alcohol treatment provider.
YZUP	Local community young persons' drug and alcohol treatment provider.

Introduction

Problem drinking across the UK is a **significant public health problem** with major health, social and economic consequences, estimated at between **£21 and £52 billion a year**. The **harms** caused by alcohol are far-reaching and **impact on the drinker and others** including children and family members, co-workers, strangers, neighbourhoods, communities, and society.

For these reasons reducing the harms related to alcohol is a priority in Cornwall. Our current alcohol strategy "Taking Responsibility for Alcohol", draws on evidence compiled for the last Alcohol Needs Assessment and has three overarching objectives:

1. Enable people to make **informed choices** about alcohol
2. Improve services to **reduce the harms** caused by alcohol
3. **Promote partnerships** to reduce alcohol's impact on the community

Cornwall Council and Cornwall's Community Safety Partnership (CSP), **Safer Cornwall**, are responsible for reducing the harm related to drugs and alcohol locally. That responsibility is discharged through the Drug and Alcohol Action Team (DAAT) who sit in Cornwall Council.

The statutory framework regulating CSPs requires partnerships to analyse and assess levels of problem drinking and drug use in both adults and young people and the changes in these areas since the last strategic assessment and why.

What is a needs assessment and how is it used?

This needs assessment aims to provide a **shared understanding of how alcohol is impacting on the population of Cornwall and the Isles of Scilly.** It forms part of the Joint Strategic Needs Assessment which assess the health and wellbeing needs of the local population[1].

We will outline the local needs and evidence relating to alcohol, which will inform the development of local services and enable individuals, their families and the wider community to have their **needs met more effectively**.

How Cornwall & Isles of Scilly chooses to respond to the **priorities identified** through this needs assessment will be detailed within our subsequent **Alcohol Strategy**.

This needs assessment is:

- A way of estimating and understanding the nature and extent of need across the whole population and within different groups;
- A tool for evidence based and ethical decision making to help focus effort and resources where they are needed most.

[1] The JSNA identifies and monitors changes in local health and wellbeing needs and inequalities in the population to inform future service planning. The collection of evidence forming the CIoS JSNA can be found here.

The needs assessment is based on:

- Local intelligence: what do our people say about how alcohol impacts on the CIoS population? (Residents, service providers, service users, staff and partners).
- What does legislation, national policy, guidance and research say is best practice in relation to reducing alcohol harms?
- What does local data tell us about how alcohol is impacting locally and how does this compares to national data?

Isles of Scilly specific information continues to be enormously challenging to both obtain and describe, due to the identifiable data risks associated with the small population. Unfortunately, most national datasets combine figures for Cornwall and the Isles of Scilly. However, locally we have been able to obtain specific IoS quantitative data for alcohol treatment and community safety and these topics have a separate section for IoS in this needs assessment.

An effective needs assessment for alcohol interventions, treatment, support, recovery and reintegration considers:

- What works well, and for whom in the current system, and what are the unmet needs are across the system;
- Where are the gaps in our local service response;
- Where is the system failing to engage and/or retain people;
- Who are the hidden populations and their risk profiles;
- What are the enablers and barriers to engaging in services;
- What is the relationship is between treatment engagement and harm?

The assessment will take full account of the diverse needs of the population. It will recognise that individuals do not belong to separate single groups e.g. women, carers, people of colour, but instead that characteristics overlap creating nuanced experiences and needs.

Findings and Priorities

As in previous years, findings from this needs assessment are grouped in to **eight themes**. These themes will be translated into our **Alcohol Strategy**. Findings and priorities from this needs assessment, grouped by these themes, begin on the next page.

1. Prevention, Advice and Information

The most evidence-based helpful preventative and early intervention activities, including Identification and Brief Advice, population level messaging and targeted social marketing.

2. Children, Young People, Parents and Families- prevention and response

Education, youth, family and household interventions, including the Supporting Families programme.

3. Community Safety Schemes

Reducing the harmful impacts of alcohol on our streets, including crime, anti-social behaviour and drink driving.

4. Licensing, Alcohol Retail and the Night-Time Economy

Promoting and supporting a safe, responsible, successful alcohol trade; including a Public Health approach to licensing and training for bar staff.

5. Domestic Abuse and Sexual Violence

Good pathways between alcohol, domestic abuse and sexual violence services; including Multi Agency Risk Assessment Conferences (MARAC) referrals and sentencing pathways.

6. Health, Treatment, Aftercare and Recovery

Easy access to treatment, and effective care throughout; including hospital admissions, mental health and the treatment system.

7. Criminal Justice Interventions

Appropriate interventions to reduce alcohol-related crime; including diversionary and sentencing pathways.

8. Employment, housing, accommodation, homelessness and rough sleeping

Interventions to reduce alcohol-related employment problems; including social care, homelessness and housing.

Findings and Priorities

To be reflected and addressed in the Alcohol Strategy and Delivery Plan.

1. Prevention, Advice and Information

1.1 All available evidence suggests people in Cornwall and the Isles of Scilly (CIoS) are drinking at higher levels than nationally. An estimated 134,660 people in CIoS drink above recommended levels (over 14 units a week).

1.2 Identification and Brief Advice (IBA) includes alcohol screening (AUDIT-C). There is extensive and consistent evidence that brief advice in health and care settings reduces alcohol-related harm and that brief interventions are cost–effective.

1.3 Locally you are least likely to receive an alcohol check (screening) as part of an NHS Health Check in comparison to other elements of the check.

1.4 NICE guidance recommends embedding routine IBA and alcohol screening in all health and care services and a range of other services. There is limited evidence of this occurring locally and no data is collected.

1.5 An evaluation of the DAAT's IBA training highlighted that training groups of professionals together and offering refresher courses would be useful.

1.6 The DrinksMeter app can be used by individuals to monitor their drinking. Whilst there are a range of similar apps available, DrinksMeter is our preferred option locally as we have the ability to access CIoS-specific data. Partners are signposting to a range of different alcohol apps through their messaging and training.

Our priorities

- Embed consistent IBA and alcohol screening in all non-alcohol specialist services (specifically health and care services) and Health Checks, as recommended by NICE guidance, and improve how this is recorded.
- Refocus IBA training, prioritising: training professional groupings together; refresher courses; incorporation of digital approaches to increase flexibility; and promotion of the DrinksMeter app.
- Ensure consistency in the tools promoted by partners (e.g. alcohol apps).
- Link IBA with other brief interventions such as smoking cessation and other health promotion activities.

2. Children, Young People, Parents and Families- prevention and response

2.1 NICE guidance recommends schools and colleges include alcohol education in the curriculum and that parents, carers, children and young people are included in initiatives to reduce alcohol use. A deep dive workshop on county lines in CIoS found that inclusion of child exploitation in the curriculum was inconsistent and feedback from stakeholders to inform this needs assessment highlighted the need for more early intervention around drugs and alcohol in schools. YZUP deliver workshops in schools and colleges around alcohol and drugs, but coverage is not universal (a priority for development).

2.2 Feedback from the Isles of Scilly indicated that there was uncertainty over future plans to include drugs and alcohol in the curriculum and young people said that the information they receive is too basic and not very interactive.

2.3 In CIoS YZUP deliver drug and alcohol treatment for young people some of whom will transition into adult treatment. 77% (50 people) of 18–20-year-olds in adult alcohol treatment (April 2018 to March 2021) had not previously been in young people's treatment suggesting earlier identification of young people problematically drinking is needed.

2.4 Up to 2,958 children living with an alcohol or drug dependent adult in CIoS may be unidentified. This is based on mapping research from the Children's Commissioner for England against local datasets (social care, health visiting and drug and alcohol services).

2.5 Our ability to use local datasets to understand the extent of need around children affected by parental problem drug and/or alcohol use is limited as we do not know:

- Whether a validated screening tool was used (e.g. AUDIT-C);
- The level of drinking or drug use (i.e. whether the adult was dependent);
- If the adult should have been, and was, referred to specialist support. (Only 2% of referrals to adult alcohol treatment are from children's social care.)

In addition, some recording does not distinguish between drugs and alcohol instead stating 'substance misuse'.

2.6 As a result, we are still unable to populate the Office for Health Improvement and Disparities (OHID) toolkit around parental alcohol use as we do not have an accurate picture of the number of children affected locally.

2.7 Best practice from Sheffield used screening in a number of family services resulting in an increase in referrals to adult alcohol treatment and more timely support offered to children affected.

2.8 The Supporting Families programme has led to some improvements in local data maturity and the delivery of trauma-informed practice by the Family Team in local drug and alcohol services.

2.9 Whilst we are unable to obtain data on the number of local women impacted by repeat removal of children into social care, there is significant evidence of this occurring locally. The Pause programme operating in other areas is an example of best practice in supporting women who have had children removed from their care (43% of women involved in Pause report problem drinking). The estimated cost benefit of reducing the number of infants entering care is that for every £1 spent on Pause, £4.50 is saved over four years and £7.61 over 18 years.

Our priorities:

- Continue implementation and increase coverage of NICE guidance relating to alcohol education in schools and colleges.
- Embed IBA and alcohol screening in family services with appropriate recording.
- Obtain a more accurate picture of the number of children affected by parental (or other adult) alcohol use locally and be able to complete the OHID toolkit.
- Implement the Pause programme in CIoS.

3. Community Safety

3.1 Alcohol was recorded as a factor in around 1 in 5 crimes in CIoS in the year ending September 2021. This increases to 1 in 3 crimes when looking at violent crimes.

3.2 Alcohol related crimes for domestic abuse, sexual offences, violence without injury and criminal damage in CIoS have all risen whereas alcohol

related violence with injury has fallen (Oct-Sept 2020 versus Oct-Sept 2021). This is believed to reflect the extended periods with the Night-Time Economy shut down.

3.3 Concerns about street drinking and associated anti-social behaviour (ASB) are consistently high on the public agenda and have escalated over recent years. In the year 2020/21 there were 861 recorded incidents of ASB linked to street drinking, an increase of 19% compared with 2019/20. However, street drinking accounts for only 6% of all reported ASB.

3.4 Over 2 in 3 assaults reported through the Assault related injuries database in A&E and Minor Injuries were said to involve alcohol. 86% of assaults occurred over the weekend and between the hours of 9pm and 4am were said to be alcohol-related emphasising the strong link between assaults and the Night-Time Economy. 22% of all victims reported being assaulted in or immediately outside a specific named premises.

3.5 In response to a rise in concerns around spiking test kits were given to all late-night premises in Devon and Cornwall. Only 2 of 120 kits used between August to October 2021 returned a positive result. The majority of allegations in Cornwall were in Falmouth with university staff noting inexperience with alcohol/drugs (due to lockdowns) and hesitancy to take tests due to recreational drug use. There have been no subsequent reports of spiking incidents.

3.6 There is very little research on perpetrators of spiking but all available research suggests the motivation is to humiliate or prank someone for fun rather than to facilitate sexual violence.

3.7 In Cornwall we have the highest rate of any county in England of Killed or Seriously injured road collisions caused by a drink driver. The number of drink drive incidents locally increased from 2010 to 2019 whereas nationally there was a decrease. The majority of drink-drivers live in Devon and Cornwall meaning tourists are not the main offenders. Most incidents involved male drivers aged 20-24.

3.8 A total of 8 people were killed in an alcohol-related road traffic collision in 2019 and 2020 in Cornwall.

3.9 Drink drive courses are commissioned by Central Government and no data on activity or effectiveness is currently collected.

Our priorities:

- As alcohol related violence impacts highly locally, we will continue to look at the evidence around what works and adopt a test and learn approach to all local measures.
- Although there have been no recent reports of an increase in spiking, we will continue to monitor incidents and maintain comms about why it is important to get a test as soon as possible and how potential victims can do this.
- Seek to obtain data on re-offending and justice outcomes for drink drinking.
- Consider the benefits of a focussed campaign on drink driving aimed at young males.

4. Licensing, Alcohol Retail and the Night-Time Economy

4.1 NICE guidance on preventing alcohol disorders makes recommendations around licensing including the role of Public Health.

4.2 Our Health Impact Licensing Tool (HILT) is an example of national best practice in using health data to assess alcohol licensing cases.

4.3 NICE guidance recommends conducting test purchasing ('mystery shoppers') for underage alcohol sales. We are unable to do this locally as for on-license premises intense police support is required and for off-license premises a covert surveillance authority from the Courts is required. NICE guidance has not been updated to reflect changes in legislation around covert surveillance. Obtaining up-to-date and reliable evidence to present to the Court is challenging.

4.4 A number of projects associated with the Violence Against Women and Girls (VAWG) Strategy, and subsequent Safer Streets fund, aim to improve the safety of the local Night-Time Economy. We have a student led VAWG group and Bystander training is continuing to be rolled out after successful sessions with pubs, bars and clubs in Falmouth.

Our priorities:

- The recommencement of SMART (Substance Misuse and Alcohol Retail Training) which is delivered to promote best practice in selling alcohol, for staff and management in CIoS Licensed premises.
- Review Cumulative Impact Zone boundaries and assess whether polices should be set outlining a maximum number of licenced premises in each Zone.
- Support and actively promote VAWG and Safer Streets projects in addition to reviewing and learning from these initiatives in terms of Night-Time Economy safety.

5. Domestic Abuse and Sexual Violence (DASV)

5.1 Alcohol alone is not a cause of domestic abuse and is never an excuse. There are however a number of ways in which alcohol and DASV are related including: increasing the risk of, and escalating the severity of, abuse; victims using drinking as a coping mechanism; alcohol being used as a control mechanism by those displaying abusive behaviours; and children experiencing or witnessing domestic abuse being more likely to be problem drinkers later in life.

5.2 Around a third of clients in local DASV services stated that the person displaying abusive behaviour had a problem with alcohol in the previous year (476 people).

5.3 Of the 9,700 domestic abuse incidents recorded by police in Cornwall in the year ending September 2021, 1 in 5 were identified as alcohol related. It appears from this data that the more high-risk an incident, the more likely it is to be alcohol related.

5.4 Research around those engaging in sexual violence suggests that alcohol interacts with personality and aspects of the situation, adding to the risk of perpetration among men already predisposed to engaging in sexual aggression.

5.5 Of the 314 referrals to the Devon and Cornwall Sexual Assault Referral Centre in 2021, 40% of referrals stated alcohol and/or drugs were used during the offence and 13% of victims said they had a drug and/or alcohol-related need themselves.

Our priorities:

- To continue to develop the DAAT-DASV protocol which includes implementing all best practice guidance that outlines the need for: routine enquiry for domestic abuse in drug and alcohol services; multi-agency working

agreements; specific training and support to ensure staff are competent and confident; and staff knowledge of local policy, thresholds and pathways into domestic abuse services for both victims and those displaying abusive behaviour.
- Following NICE guidance, incorporate the AUDIT screening tool in DASV services through IBA training to increase staff competence and confidence.
- Ensure staff in drug and alcohol services are competent in new recording around domestic abuse (victims and those displaying abusive behaviours) by reviewing data completion of the new National Drug Treatment Monitoring System requirements.
- Investigate the needs of those engaging in sex work, in relation to problem drinking and other health and care needs including sexual health and multiple complex needs.

6. Health, Treatment, Aftercare and Recovery

Mortality and hospital admissions

6.1 Similar rates of people locally are dying of alcohol related causes as nationally with the rate twice as high for men than women. Locally and nationally, 2020 saw an increase in the number of people dying for an alcohol related reason compared to 2019.

6.2 People in CIoS are more likely to be admitted to hospital for an alcohol related reason than nationally, especially the over 65s. We also have admission rates for alcohol-related liver disease. Men are more likely to be admitted to hospital for an alcohol related reason than women, like nationally.

6.3 Those who frequently attend hospital for an alcohol related reason often have multiple complex needs, co-occurring mental and physical ill-health and a history of trauma. The Hospital Outreach Team based at the Royal Cornwall Hospital does intense work with patients but is limited by pressures faced by mental health, Adult Social Care and housing services.

6.4 End of life care (EoLC)- those who are drinking and in need of EoLC can be in a lot of pain and face additional stigma. A local pilot in 2021 of an EoLC bed in supported accommodation for residents or homeless individuals was very successful.

6.5 Those who died whilst in alcohol treatment in 2020/21 often had co-occurring poor mental and physical health alongside other complex needs and a history of trauma and abuse. Of the deaths reported by services in 2021/22, 59% were long-term drinkers aged 50 or over and 35% of those who died had liver disease.

Our priorities:

- Obtain more frequent alcohol related hospital admissions data, including for those who live in the east accessing services in Plymouth and Devon, to monitor how this impacts locally and develop this as an indicator.
- Multi-discliplinary team meetings to develop and improve the care of people experiencing mutliple complex needs.
- End of Life Care- continuation of the 2021 pilot in supported accommodation and a rollout across a wider range of settings.

Mental Health

6.6 Alcohol can be a coping mechanism for poor mental health and drinking can also exacerbate the symptoms of poor mental health.

6.7 Those with co-occurring mental health issues and an alcohol and/or drug need are historically described as 'Dual Diagnosis' clients. Often these clients have multiple issues and complex needs.

6.8 All those with Severe Mental Illness should receive an NHS Health Check with includes alcohol screening as well as a blood pressure test and blood tests, measurement of height and weight and questions on smoking and physical activity. Locally, patients are least likely to receive an alcohol check in comparison to all other elements of the Health Check.

6.9 71% of those in local drug and alcohol treatment in the first half of 2021/22 had a mental health need with 30% of those not receiving any mental health treatment.

6.10 There have been improvements locally with a Dual Diagnosis multi-agency steering group, implementation plan and escalation process but still some challenges remain around promoting this approach and multiagency working as raised by both service users and staff in drug and alcohol services.

6.11 Those with coexisting mental health issues and problem or dependent drinking need to be identified at the earliest opportunity, then referred and supported to access and engage in appropriate services.

6.12 Of all suspected and registered suicides in CIoS between 2018 to 2020, 17% of people who died had consumed alcohol at the time of death.

6.13 In our local drug and alcohol services, 30% of clients had either a history of suicidal ideation or had recently had suicidal ideas; and 27% had either historically attempted, or recently attempted, suicide.

6.14 Long-term drinking can cause brain damage. For those with alcohol related brain damage, local case studies illustrate delays in diagnosis, a lack of understanding regarding alcohol and mental capacity and difficulties in securing appropriate care.

Our Priorities:

- Joint comms around mental health and drinking with Public Health.
- Continued development of the Dual Diagnosis Steering Group and implementation plan in addition to recruiting a dual diagnosis co-ordinator.
- Promote with partners that mental health is 'everybody's business' in preventing, identifying and supporting those with low level mental health needs. This includes developing the role of the Voluntary and Community sector and increasing awareness amongst social prescribers on how to support someone both with poor mental health and problem drinking.
- Addressing the risk factors for those with low and moderate mental health problems and working with partners to ensure that health checks for those with serious mental illness include alcohol screening, with advice and guidance, linked to the work investigating tobacco cessation in this population.
- Implement mental health screening tools in drug and alcohol services and interventions for common mental health problems.
- Review prescribing in mental health services to asses awareness around the interaction of medication with alcohol and/or drugs and prescribing practice.
- Continue to use, and evidence use of, risk assessments and suicide safety planning in drug and alcohol services.

- Collaborate through the suicide prevention programme on an upcoming work around avoidable deaths (drug related deaths, domestic homicides and deaths in treatment) to include suicide and self-harm.
- Develop local provision for alcohol related brain damage to improve quality of care and outcomes for residents impacted.

Alcohol treatment

6.15 Local drug and alcohol treatment is currently 25% over capacity and in 2020/21 capacity was exceeded by 38%. Caseload sizes are much higher than those recommended through the Independent review of Drug Treatment (ref) of 45, which is negatively impacting the quality, effectiveness and successful outcomes of treatment.

6.16 Locally more dependent drinkers are engaged in treatment than nationally (around 25% compared to 20%). However, there are significantly more problem drinkers in the local population than problem drug users and local problem drinkers are less likely to access treatment than drug users.

6.17 Two in three referrals to local alcohol treatment are by 'self, family or friend' suggesting that other agencies may be unclear around professionals having a role in identifying and referring to treatment.

6.18 We have maintained our local residential detox and rehab (tier 4) provision whereas nationally this has declined. In response, new national guidance has said that 2% of clients should be accessing residential rehab but locally we already exceed this with 4% of clients accessing residential rehab. However, local waiting times for detox and rehab have increased

6.19 Black, Asian and ethnic minority residents, Gypsies and Travellers, LGB residents and Veterans are under-represented in local treatment.

6.20 Around two thirds of the treatment cohort are men but services are seeing a significant number of young female drinkers with additional complex needs.

6.21 Research demonstrates that individuals with learning disabilities are less likely to receive treatment or remain in treatment for problem drinking and/or drug use.

6.22 Alcohol treatment clients tend to be older than drug clients and recently the majority of those who died whilst in alcohol treatment were over 50.

6.23 Service users have given positive feedback on Mutual Aid Provision (MAP groups) and said that there is a range of activities to support recovery. However, they said that this could be improved with more Recovery Support and Aftercare.

Our priorities:

- Increase referrals to alcohol treatment from primary care and other services.
- Improve access to treatment for Black, Asian and ethnic minority residents, Gypsies and Travellers, Veterans, older people, neurodiverse residents. LGBTQ+ residents and women, based on national research and best practice.
- Review our 'Stepped approach to alcohol detox' and develop detox in supported accommodation as well as enhanced home detox for more complex clients to reduce waiting times for residential detox.
- Reduce the caseload size of the drug/alcohol treatment workforce to 45 or under and improve retention and recruitment of staff.
- Review Mutual Aid provision and increase the availability of aftercare and recovery support to ensure to promote sustained recovery and maximise the impact of treatment.

Adult Social Care (ASC) and Safeguarding

6.24 The validated tool AUDIT for alcohol screening is not used in Adult Social Care (ASC) and currently ASC data is not able to distinguish between alcohol and/or drug use.

6.25 There is a specific gap in practitioner knowledge about applying the Mental Capacity Act (2005) and the Care Act (2014) to those who have an alcohol problem, particularly alcohol related brain damage, as illustrated by local case studies.

Our priorities:

- Embed consistent use of IBA and AUDIT screening in ASC as recommended by NICE guidance (see 1.4).
- Increase practitioner knowledge and competency in working with problem drinkers as recommended by a national review of Safeguarding Adults Reviews, through specific Alcohol and Safeguarding training.

7. Criminal Justice Interventions

7.1 The new national Drugs Strategy aims to ensure that every offender with an addiction has a treatment place.

7.2 A similar proportion of clients in local treatment are in contact with the criminal justice system (CJS) as nationally. However, offenders in local alcohol treatment are less likely to complete treatment successfully than nationally and fewer prison leavers successfully engage in local treatment.

7.3 There is a specific specialist CJS team in our local drug/alcohol treatment service that works in the custody suites and Magistrates Courts. This enables continuity of care, rapid referrals and early identification of when a Community Treatment Sentencing Requirement (CSTR) – court ordered treatment- may be suitable.

7.4 CSTRs for alcohol treatment, drug treatment and mental health treatment have been very successful with Cornwall having the highest number of combined orders in the country.

7.5 Fundamental changes have taken place within Probation in the last year. Around a quarter of offenders currently known to probation were assessed as having an alcohol criminogenic need. Information sharing arrangements with offender management services are being updated which will provide more detailed information about the needs of adult offenders in the future.

7.6 A number of clients have been released from prison without accommodation. Whilst the CJS team work closely with housing services, it is difficult to find accommodation for offenders and this has been exacerbated by the local housing crisis.

Our Priorities:

- Improve outcomes for offenders in treatment (including through housing) and increase the number of prison leavers accessing treatment.
- Introduce screening tools within probation to identify the number of offenders who are drinking problematically to refer into treatment,to ensure that ‘every offender with an addiction has a treatment place’.
- Map all diversionary interventions for those with alcohol needs at each stage of the criminal justice system to identify where we are working successfully and where there are any gaps to prioritise resources.

- Obtain more information on the needs of MAPPA clients in the criminal justice system in relation to problem drinking.

8. Employment, housing, accommodation, homelessness and rough sleeping

8.1 The Dame Carol Black Review highlighted that employment needed to be a more integral element of addiction treatment.

8.2 Those who are problem drinkers tend to develop a problem with alcohol later in life and therefore tend to have accrued more social capital in comparison to those with drug problems. Therefore, problem drinkers are less likely to have a housing problem and more likely to be employed.

8.3 Local treatment appears to have little impact on changing the employment status of alcohol clients with both 1 in 3 clients in employment at the start and end of treatment. This does not take into account other positive outcomes such as engagement in education, training or volunteering.

8.4 Those who were long-term sick/disabled are less likely to complete local treatment successfully.

8.5 Local case studies highlight that large retrospective back payments of Personal Independence Payments can destabilise recovery. This is now being raised as a national campaign by Citizens Advice.

8.6 There are a number of employment initiatives locally involving partnership work between drug and alcohol services, JobCentres, voluntary and community organisations and employers.

8.7 Fewer alcohol clients enter treatment with a housing need than drug clients. The majority of local alcohol clients enter treatment with no housing problem (89%) and 99% leave with no housing problem. However, the proportion of alcohol clients with an initial housing problem are less likely to complete treatment successfully than those with no initial housing problem.

8.8 Service users highlighted the issues of HomeChoice banding but a comparison between those who declared alcohol/drug dependency on their application and all other applications found little difference suggesting that HomeChoice is challenging for all residents.

8.9 Around a third of all local commissioned and non-commissioned beds of supported accommodation are alcohol/drug tolerant. This helps engage people in treatment, however services and service users have highlighted the need for accommodation that is drug and alcohol free for those completing treatment successfully, in order to aid recovery.

Our priorities:

- Work with Public Health in the re-commissioning of Mental Health Employment Advisors in DWP Job Centres to incorporate alcohol Identification and Brief Advice (IBA) and a Making Every Contact Count (MECC) approach.
- Increase the number of alcohol clients in employment when leaving treatment.
- Development of the existing Tier 4 housing pathway to ensure appropriate accommodation post detox and rehab (alcohol and drug free) as part of recovery.

Gaps in our knowledge and priorities for further investigation

There are areas of focus that we have identified which at present we do not have a full understanding of, therefore require further investigation as a priority:

1. At present we cannot obtain data from local mental health services relating to the prevalence of clients problematically drinking and/or using drugs amongst their caseloads.
2. Whilst local case studies and partners have highlighted how alcohol related brain damage is impacting and provinjg enormously challenging to provide health and care for, we do not have an accurate number of those affected.
3. We do not have an accurate number of the children affected by adult problem drinking (parent, carer or other adult) and to what level those adults may be drinking i.e. whether they are alcohol dependent.
4. Data on justice outcomes and reoffending rates for drink driving courses.
5. Consistency of AUDIT-C screening in all non-specialist services and as part of Health Checks.

Finding your way around

The main body of the alcohol needs assessment has 4 sections:

Section 1: Setting the scene

- National strategies, policies and legislation
- The delivery landscape
- What we have achieved
- What our people say

Section 2: Levels of drinking

- National and local trends
- Why people may drink problematically
- Impact of the pandemic

Section 3: Impacts of alcohol

Harms to the drinker

- Physical health
- Mental health- dual diagnosis, suicide and self-harm and alcohol related brain damage
- Impact on hospitals- admissions, frequent attenders and the Hospital Outreach team and Alcohol Care Team
- Employment and housing.

Harms to others

- Children, young people, parents and families
- Domestic abuse and sexual violence
- Crime and community safety

Section 4: Reducing alcohol harms

Prevention:

- Identification and Brief Advice including screening
- Messaging and communications
- Education- young people
- Licensing and retail
- Community safety schemes

Treatment, aftercare and recovery:

- Getting people into treatment and outcomes
- The needs of different groups
- Criminal justice system
- Adult Social Care and Safegurading
- Residential detox and rehab
- Mutual Aid
- Isles of Scilly
- Workforce

Section 1: Setting the scene

This section gives an overview of the key national policies and legislation relating to alcohol. A full version can be found in Appendix B which includes relevant local strategies.

Independent Review of Drugs by Dame Carol Black[2]

This national review stated that the drug and alcohol **treatment and recovery system** urgently needed repair, highlighting that challenges are likely to have worsened due to the pandemic. There were 32 recommendations setting out a whole system approach.

The Government's response came in the form of a 10-year **National Drugs Strategy** for both drugs and alcohol, to overcome the previous decade of disinvestment and a loss of expertise in the sector.

Local Authorities will receive new funding over the next three years to: increase treatment capacity and quality; improve access to employment and accommodation; improve pathways between treatment and the criminal justice system; increase provision of residential rehabilitation and detox; improve responses to physical and mental health needs; increase the competency and size of the workforce; and reduce drug and alcohol related deaths.

National Alcohol Strategy

There has been **no new specific national Alcohol Strategy since 2012**. Plans for a new strategy were announced in 2018 but the Government has since argued that this is not needed due to existing work. The Commission on Alcohol Harm have called for a new comprehensive strategy **urgently**[3].

Changes to the **alcohol duty system** were announced in the February 2021 Budget and Spending Review. The Government has also introduced some other key legislative and policy changes including the new Domestic Abuse Act and the **Serious Violence Duty** being introduced under the new Police, Crime Sentencing and Courts Bill.

Guidance

The National Institute for Health and Care Excellence (NICE) produces evidence-based guidance and advice for health, public health and social care practitioners. There are several pieces of guidance that relate to alcohol covering prevention, treatment and co-occurring conditions.

UK guidelines on the clinical management of problem drinking and dependence are forthcoming. The equivalent for drug use and dependence (the 'Orange Book') has existed for many years.

[2] Independent review of drugs by Professor Dame Carol Black, Home Office and Department of Health and Social Care. (2021). The review also analysed the challenges posed by drug supply and demand and the way in which drugs fuel serious violence and the exploitation of children and vulnerable adults through county lines.

[3] 'It's Everywhere'- Alcohol's Public Face and Private Harm, Commission on Alcohol Harm (2020)

Our delivery landscape

As well as policies and legislation a number of global, national and local factors have affected our delivery.

The pandemic has led to a dramatic loss of human life worldwide and presents an unprecedented challenge to **public health, food systems and working life**.

COVID-19 pandemic

The economic and social disruption caused is devastating and has most affected those who were already disadvantaged, further **widening inequalities in wealth and health**.

Alongside the impacts on our **health and wellbeing** and the **damage to our children's education**, for many families the pandemic has meant loss of employment, food insecurity and lower standards of living, debt and housing risk.

Housing crisis

More people are in temporary housing, having to live in poor conditions or **becoming homeless**, and this is coupled with a **housing shortage**, with pressures on the market exacerbated by a surge in people moving into and within Cornwall for a better quality of life.

The **underlying factors of poor health** are the **same that increase risk of crime** – poverty, vulnerability, previous experience of crime, unemployment and low education levels, reinforcing the importance of a **joined-up partnership approach** moving forward.

Lockdown restrictions have resulted in **increased isolation, loneliness, anxiety and depression**, cutting people off from normal social networks and support.

Perpetrators of crime have sought to take advantage of **people's increased vulnerability** and changed the ways in which they operate – such as increasing activity online and expanding covert networks.

Increased vulnerability

Vulnerable people spent lockdown at home with their abusers, at heightened risk of harm with limited opportunities to seek help. The legacy impact on young people due to **Adverse Childhood Experiences** will be significant.

Community strengths & tensions

Our towns are experiencing high levels of **anti-social behaviour and problems with street drinking and drugs**, and we have seen more Organised Crime Group activity and exploitation of vulnerable adults and children (issues reflected across the UK).

Cornwall has a **strong social infrastructure** with an active network of local councils, a large and vibrant voluntary sector and high levels of volunteering. **During the lockdown periods, we saw this come to the fore** with people from all walks of life coming together to help and support each other.

These positive factors play a major role in **boosting the safety and resourcefulness** of our people and our communities.

Rural communities

60% of the people in Cornwall live in small settlements of 3,000 people or less. **Rural isolation** is a challenge in accessing social networks and essential services.

Although Cornwall's population continues to grow overall, some **coastal and rural communities**

are showing **population decline and/or aging** that will add to the pressures on existing services in these areas.

Connectivity

Digitisation is driving profound changes, including reducing use of high streets, as more of us shop online and work from home.

The pandemic has pushed our **work, education and social interactions on-line** and, whilst this provides opportunities for **greener, more flexible lifestyles** it also brings with it risks of increased **isolation** and exposure to **exploitation** in on-line environments.

While there has been **significant investment in superfast broadband**, one in ten residents are not online. The Department for Education provided **1,300 devices to disadvantaged children** in Cornwall to support their education on-line during lockdown.

Global, national & local

The internet provides **connectivity on a global scale**, especially on high profile issues such as the pandemic, climate change, social justice and inequalities.

Examples include the huge momentum gained by the **Black Lives Matter** movement, following George Floyd's murder in the US in May 2020, and the upsurge in support to tackle **violence against women and girls** after Sarah Everard was murdered in 2021.

Probation services were re-nationalised in June 2021 to improve the help available to offenders and support more effective integration into society and reduce repeat offending.

Health and social care services are being brought together through **integrated care systems**. These partnerships will join-up services across local councils, the NHS, and other partners to co-ordinate the support that people need.

Our people: key statistics

Age & Gender	**573,300 people,** 49% women, 51% men [2020] Projected to **increase by 9%** to 627,300 by 2030 - 5% across England **26%** are aged **under 25** - England 30% **25%** are aged **over 65** - England 19%
Ethnicity & Sexual Identity	**1.7%** Black / Asian / Mixed / Other ethnic groups - England 14.6% **2.5%** White non-British – England 5.7% **-** 0.1% Gypsy/Traveller (635 people) **2.7%** Lesbian, Gay or Bisexual (South West estimate) – 13k people in Cornwall [2019]
Vulnerable Groups	**70,000** (12%) live in areas defined as the **20% most deprived** in England [2019] **22,000 children** (18%) living in poverty - England 19% [2019] **11.5%** of households (29.120) in **fuel poverty** - England 13.5% [2019]
Housing	**9.2x** annual wage for average house – England 7.8x [2020] **19,018** h/holds on Home Choice register [Sep20] **585** households in **temporary housing** [Sep20] **34 rough sleepers** [2020]
Economy	**4%** unemployed – England 5.4% [Aug21] **14.2%** Universal Credit - England 14.7% [Aug21] **£602** avg. personal debt – England £659 [Jun20] Annual household income – **85% England average** [2017/18]
Health & Wellbeing	**5.3%** incapacity benefit – England 4.4% [Aug21] **21%** of people have a **limiting long-term illness -** England 18% **13.1** suicides per 100,000 – England 10.5 [2018-2020]

Population statistics Census 2011 © ONS unless otherwise stated

What our people say

As part of the Needs Assessment process, we held five **focus groups** (online and face-to-face) with a total of 34 service users participating. A **survey**, on Cornwall Council's online consultation platform Let's Talk, had 73 responses from service users, partner organisations, specialist staff and stakeholders.

The same three open ended questions were asked in the survey and focus groups. **Responses from service users, staff, partners and stakeholders were very similar** and are grouped by common themes and priorities below:

1. What is working well?

Treatment and support

- Service approach: **flexible**, **holistic** (offering more than just drug and alcohol support), **solution focused** and **responsive** plans for individuals enabling them to achieve their goals. **Trauma-informed** working.
- **Recognition of complex needs and the inter-relationship between all needs.**
- Referrals are quick and responsive.
- **Home support from key workers, mentors, social workers and volunteers.**
- Weekly **key workers** sessions, also able to talk to a key worker whenever you need to.
- **Outreach services**
- Flexible treatment system - fits different phases of substance use and life for the long haul.
- **MAP groups-** share stories and support each other's recovery.
- **Access to learning and other activities to support recovery and provide routine.**
- Plan following recovery and a way to replace the hole left by the 'hobby' of addiction.
- Access to counselling
- Prescribing service
- Positive People [employment programme]
- Hep C testing
- **Staff going above and beyond in the Pandemic.**
- Residential rehab gives services users time away from adverse or high-risk environments that may contribute to their substance use.

Children, young people and families

- Staff in YZUP are **knowledgeable**, and the work that they do is informative and therapeutic.
- YZUP- **Adaptable service**, e.g. redesign of schools program, offering a range of online and face to face options. Team are able to flex and offer creative solutions to meet high levels of multiple vulnerabilities and the impact of Covid.
- Family support team

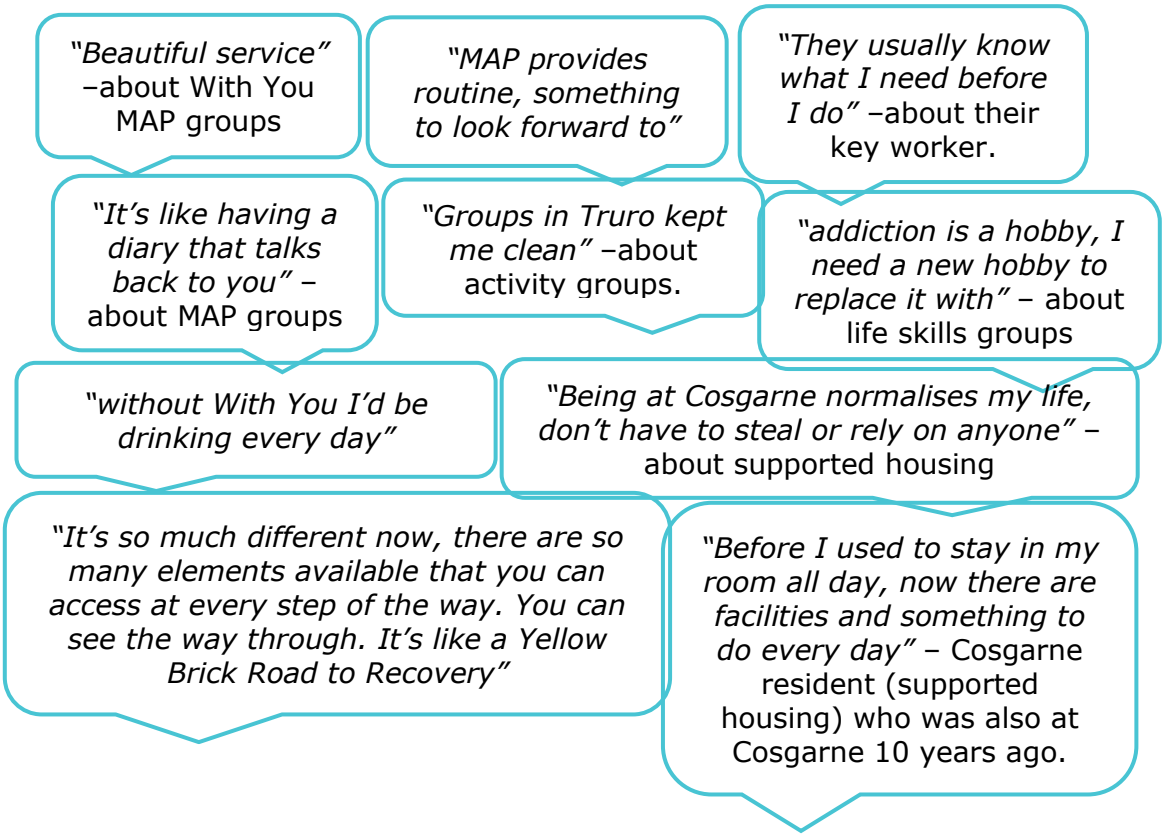
Multi-agency working

- Key workers work with other services and support clients to access services e.g. mental health support, medical appointments, bus passes and activities.
- Ability to refer people to Street Kitchen and Breadline [Penzance].
- **Links with pharmacy** are supportive and communicative.
- **Shared care** is a benefit.
- **Housing outreach** giving on the spot help.
- **Response to needle reports** and rapid information sharing.

Workforce

- The ability to become a **volunteer** and the training scheme for volunteers.
- Staff understanding and awareness as a result of **training** and **development** opportunities.
- Naloxone training for all frontline staff.

Service user quotes



2. What is not working well or needs to be improved?

Children, young people and families

- Services for **trauma affected parents**- think family and the impact on children.
- Whole family approach and increased capacity to support young people both prevention and treatment.
- Lack of **understanding of domestic abuse and sexual violence** in drug and alcohol services.
- Lack of work to reduce impact of harm on children impacted by complex needs until safeguarding thresholds are met.

Mental Health

- **Access to mental health services** for those with alcohol and/or drug needs- not enough capacity, long wait times or lack of support from CMHT.
- A lack of meaningful counselling with Outlook SW only doing 3-4 sessions, not enough to build rapport.
- Those with low levels of depression and anxiety being turned away from services because it is not 'long or severe enough'.

Multi-agency working

- **Lack of joined up working** means service users need to **retell their story** repeatedly to multiple agencies/people.
- **Poor communication** between services.
- Some transitions between services are not handled well leading to gaps in provision.
- **Support from GP services** is a challenge. No shared care or prescribers in Falmouth who understand the client group.
- **Social care capacity** and resources are low.
- **Safeguarding** processes are very **delayed**.

Residential detox and rehab

- **Not enough provision**- long wait times.
- **Housing pathway** for people in residential detox and rehab.
- Need animal/pet care during rehab.
- Lack of **support post-detox** e.g. check-in call or visit.

Treatment

- **Long-winded processes** delay support.
- More flexibility in prescriptions
- Issues post recovery e.g. debt/no money.
- **Funding**- lack of and short-term nature.
- Lack of premises/ venues to see clients in a safe space.
- **Remote appointments challenging for some**. Support in using online technology e.g. training before first session.
- **More frequent appointments** needed at the start of treatment.
- Increased **service user input/feedback** needed.
- **Awareness of the service** and the support that is available. Need communications about positive stories and advertisement of service.
- **Language barrier** with clients, it is difficult to find interpreters/ people to support.
- Lack of face-to-face support due to the pandemic.
- Training for licensed premises.
- Need more drug and alcohol services **outreach to specific hotspot areas** known in the town, not just when drug litter is found.
- Long-term recovery support is not as good.

Workforce

- **More staff** are needed as teams are stretched with high caseloads affecting staff wellbeing, morale and retention.
- **Recruitment** challenges- low pay and fixed-term contracts linked to short-term funding.
- Some volunteers under/overused.

Community support and activities

- Issues accessing day groups due to work commitments- need **evening and weekend options**.
- Lack of supervised social and safe contexts, breakfast clubs, drop-ins.
- **More post-treatment support** required in the community including activities to reduce boredom.
- Improve links to social prescribing.
- A physical activity and nutrition programme for clients would be good.

Housing and accommodation

- Lack of **housing options**- shortfall in emergency housing and **adapted supported accommodation** with ground floor access and wheelchair access.
- People with complex needs housed in B&B's.
- **No in-between provision**- straight from supported accommodation to independent living.
- Funding lost for tenancy course.
- HomeChoice banding.
- Better relationships are needed between service users in supported accommodation and residents in the community.

Service user quotes

"stop constant explaining and retelling my story, it brings it all back and makes it fresh again" – about needing more joined up services.

"Felt left to my own devices for a little while." –about their Key worker leaving

"Mental health services are useless. When I see them, they are like 'you don't have a mental health problem' but my doctor says I have. Might be because they are full or not taking me seriously or both. Maybe the person doesn't know what it is like until they have been in my shoes"

"We Are With You has been slow, I like to do things quick" –about referrals to community hospital alcohol detox

3. If we can only change or improve 3 things, what should be our top 3 priorities?

Treatment and services

- **Better preparation** before commencing treatment which can avoid revolving door culture.
- **More support/aftercare** at the end of treatment
- Access to sustained mentoring support, not just a few sessions.
- **More MAP groups**
- **Life skills** groups- budgeting, cooking, benefits applications etc.
- More **therapeutic interventions** and activities
- More bespoke meetings e.g. family groups or the option for breakout rooms as well as evening meetings, breakfast clubs, drop-ins and the funding needed for them.
- **Case coordinators**- someone to co-ordinate all the services/support from different organisations that a person may need.
- More **consistency in key workers**.
- Offer **1-1 support** for those who don't want to access groups.
- **Improved referral pathways, smaller wait times and smoother transitions** between services
- Better **links with mental health services**.
- **Improved communication** between support services and clients.
- **Increased and sustained funding** to allow for strategic planning in relation to the outcomes of this needs assessment.

Residential detox and rehab

- **Female only** residential detox.
- **Discharge pathway** for people coming out of detox and rehab.
- **More detox and rehab beds**.

Workforce

- **More staff and volunteers**
- Permanent **contracts** or at least longer-term contracts.
- Increased **pay** scales to improve retention.

Housing and accommodation

- Pathway, more permanent housing available as well as move-on accommodation.
- More 24 hour staffed, high tolerance, complex needs supported housing.

Mental health

- **Better access** to mental health services.
- Better **dual diagnosis understanding** and more dual diagnosis training.

Multi-agency working

- Stricter **licensing enforcement**.
- More efficient and effective **safeguarding process** with reduced thresholds to pick people up before needs escalate.
- **Better working relationships** with other services such as Mental Health. More collaborative working.
- **GP's input and awareness**, training, health conditions and complex needs awareness, compassion, support with referrals with CMHT.
- **Co-located services** in a physical space.
- Services **adopt a trauma-informed approach**.
- Use **Time Credits**
- **Collaboration with police** in delivering a place based, public health approach with prevention-focus to drug and alcohol harm especially drug related deaths- **sharing of relevant data and information**.

Children, young people and families

- Increase in **early intervention** (Affected Other/CE/Schools - in particular alternative provision academies).
- **Improved transitions** between services. Make interventions longer term so that young people have consistent support for their transition to adulthood.
- Training to include Safety Planning/Managing Risk with service users aged 11-25 years.
- **Whole family approach**.

What we have achieved collectively since the last needs assessment

Prevention

- 477 more people trained in alcohol awareness and IBA between 2018-2020.
- Follow up evaluation of the training and implementation, resulting in recommendations to build effective implementation upon.

Improved access to treatment

- Extended hours for Outreach Services.
- Developed our 'Stepped Approach to Alcohol Detox' with Hospital Detox available on the Isles of Scilly and enhanced Home Detox for people who want to detox at home but do not have sufficent support.
- Introduction of the Hospital Outreach Team to engage and support alcohol-related frequent attenders to the Royal Cornwall Hospital.
- Online provision of Mutual Aid Groups to increase access to recovery support
- Development work to improve transitions from young people's treatment (YZUP) to adult treatment services, where required.
- A specific Veteran's team to meet the specific needs of veterans.
- A successful pilot of an End of Life care bed in supported accommodation for residents or homeless individuals using a joint care approach.

New and improved treatment and recovery interventions

- Provision of Naloxone, dry blood spot testing for Hepatitis C and Hepatitis B vaccination for all attending detox.
- New evidence based psychosocial interventions for those undergoing inpatient detox or stabilisation with a focus on freedom from dependence, and mental and physical wellbeing.
- Development of horticulture / ecotherapy and use of the outdoor environment to enhancethe treatment programme as well as skills development in residential detox and rehab.
- Implementation of Outcomes Rating Scales and Session Rating Scales as real-time feedback tools to enhance the therapeutic alliance.
- Advanced practitioners in community treatment are better able to support workers with complex cases after alcohol-specific training.
- Improved and more co-ordinated medical cover and pathways arrangements with doctors from community treatment also covering inpatient detox and stabilisation.
- 6 month aftercare service for those leaving rehab to help sustain recovery and provide post treatment support.
- Development of the volunteer scheme–recent residential detox and rehab service users can engage in work like activity and skills development.

Complex needs and increased vulnerability

- Utilisation of Blue Light approach to treatment resistant drinkers in community treatment services. With You are now partnering with Alcohol Change UK on a project to improve outcomes for alcohol-related Cognitive Impairment.
- Advocacy for older drinkers for faster detox and home visits where needed.

- Family Workers in community treatment are Trauma Informed Mental Health Practitioners and deliver 1-1 and group work with affected families.
- Daily attendance at the Safeguarding Adults Triage Meeting by the Complex Needs Operational Manager within treatment services has identified drinkers not previously known to the service and resulted in direct referrals from partner agencies.
- An Independent Domestic Violence Advisor (IDVA) now works with the alcohol and drug outreach team.

Housing, rough sleeping, homelessness and accommodation

- A new Outreach Team to engage people who are rough sleeping, or at risk of, into treatment and sustained accommodation. Also in-reach into supported accommodation.
- Support for new housing initiatives, e.g. temporary accommodation, where there are people with alcohol and drug problems
- Further development of the Tier 4 housing pathway to improve access to suitable housing post residential detox and rehab.

Mental Health

- A Partnership Dual Diagnosis Strategy and Dual Diagnosis Steering Group working through an Implementation Plan to develop closer and more effective inter-agency working between drug and alcohol services and mental health.
- This is supported by a joint Management Group where practice issues that are not resolved can be escalated as well as a senior operational group.
- Introduction of Mental Health Treatment Requirements as part of community sentencing which can be issued as joint orders with Alcohol Treatment Requirements and Drug Rehabilitation Requirements.

Criminal Justice System (CJS)

- A high uptake of Community Sentencing Treatment Requirements for alcohol, drugs and mental health- Cornwall has the highest rate of combined orders in the country.
- Regular presence of the drug and alcohol specialist CJS team in Custody and Courts leading to an increase in referrals, continuity of care and sicussions with solicitors and probation around to recommend appropriate sentencing.
- More robust management of alcohol treatment requirements and improved joint working relationships with Probation.
- Prison visits and support have increased with targeting of known high level alcohol clients with more assertive and supportive release plans. Close working with the Prison Substance Misuse Teams to identify individuals, whose offences were linked to drinking, not previously known to services.
- Reports for alcohol litter are received by the Intelligence-led Outreach Team to assess areas of concern. Reports of street drinking and rough sleeping are monitored to identify anyone requiring additional support to engage.
- Partnership work between With You and Konnect Cornwall for additional peer mentoring support and access to services and courses such as Cognitive Behavioural Therapy and Restorative Justice for clients in the CJS.

Section 2: Levels of drinking

Different levels of drinking- definitions

In 2016 the UK Chief Medical Officers released new guidance on the recommended weekly consumption of alcohol. The unit level was reduced from 21 units a week for men to 14, in line with the previous amount recommended for women. This is calculated to reduce the risk of an alcohol-related health issue to 1% across a lifetime. The guidance also contained advice on single episodes of drinking and alcohol consumption during pregnancy.

14 units equates roughly to:

- 5 Pints of normal Beer/Lager/Cider
- 6 glasses of Wine
- 1 and a ½ bottles of Wine
- 7 doubles of Spirits.

In summary, the message is:

- 2 drinks is a normal amount for a day if you are drinking;
- 3 days (at least) to drink the full amount each week, if you do want to drink the full amount (14 units in total, per week);
- 3 days (at least) without drinking each week, to remain in control and to give your body a rest.[4]

Consuming **no more than 14 units a week** spread evenly over 3 or more days is classed as **low-risk drinking**[5]**.** Above this is:

- **Increasing risk/hazardous drinking**- more than 14 units per week, up to 35 units for women and 50 units for men;
- **High-risk/harmful drinking**- over 35 units a week for women or over 50 units for men;
- **Higher-risk drinking**- regularly consuming over 50 units per week for men or over 35 units for women;
- **Dependent drinking** is a cluster of behavioural, cognitive and physiological factors that typically include a strong desire to drink alcohol and difficulties in controlling its use. Someone who is alcohol-dependent may persist in drinking, despite harmful consequences. They will also give alcohol a higher priority than other activities and obligations. A person will experience **tolerance and withdrawal** (see page 41).

Whilst there are benefits to consuming alcohol associated with social interaction, the common misconception that 'a little bit of alcohol is good for you' has been disproven by many studies. There is no safe level of alcohol consumption i.e. consuming even very small amounts of alcohol carries some risk[6].

[4] UK chief medical officers' low risk drinking guidelines, Department of Health and Social Care (2016)
[5] Alcohol-use disorders: prevention, Glossary, NICE (2010)
[6] Alcohol use and burden for 195 countries and territories, 1990–2016: a systematic analysis for the Global Burden of Disease Study, Griswold et al. (2018)

Local and national drinking patterns and trends

National figures

The latest **Health Survey for England** figures[7] show that in 2019, 80% of participants reported drinking alcohol in the past year, and 48% reported drinking alcohol at least once a week.

The youngest age group (16-24) were the least likely to drink at least once a week and those aged 55-74 were the most likely to do so. Within every age group, a higher proportion of men than women drank alcohol in the last year and once a week or more.

Figure 1[8] shows the decline since 1998 in the proportion of adults who have drunk alcohol in the last week. This decreased the most amongst those aged 16 to 24 (from 65% in 1998 to 41% in 2019) but has remained fairly stable at around 55% for those aged 65+.

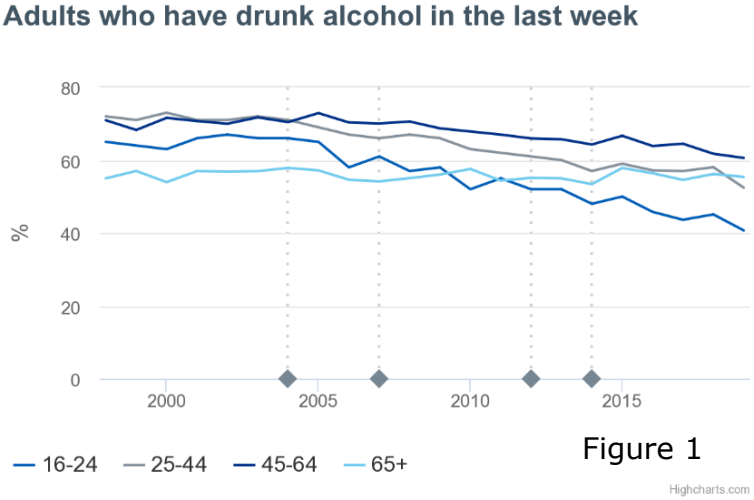


Figure 1

Drinking **over 14 units in a week** in 2019 varied across age groups but was **most common among men and women aged 55 to 64** (38% and 19% respectively). From the age of 65 the proportion of men and women drinking over 14 units per week decreased. Across all age groups, **men were more likely than women to drink at increasing and higher risk levels**. Overall, these results fall within the context of a long-term trend of **decreasing alcohol consumption nationally**.

Despite this trend in reduced consumption, the **harm caused by problem drinking is rising**. Over 10 million people are drinking at levels above the official guidelines and putting themselves at extra risk. Alcohol in the UK has become 74% more affordable since 1987, including 13% more since 2008[9].

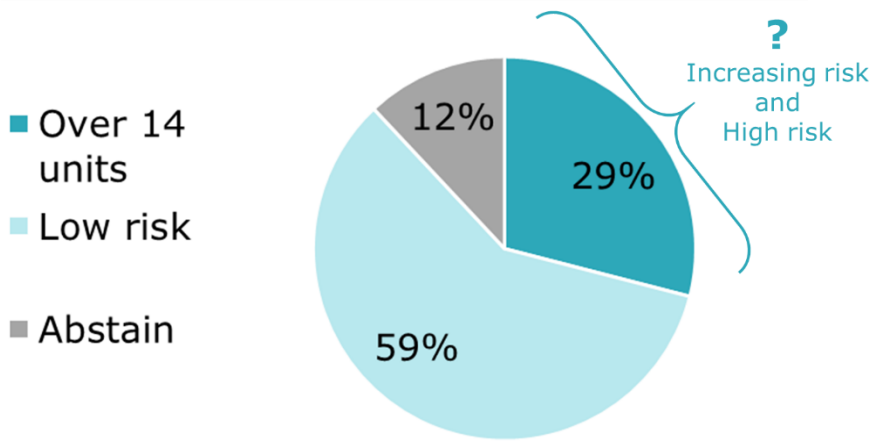
Drinking in Cornwall and the Isles of Scilly (CIoS)

An aggregation of 2015 to 2018 **Health Survey for England** results for Cornwall[10], show that:

[7] The Health Survey for England has been carried out annually since 1994 and measures health and health-related behaviours in adults and children. Statistics on Alcohol, England 2020, NHS Digital (2020)
[8] Adults who have drunk alcohol in the last week, NHS Digital (2020)
[9] Relative affordability of alcohol is calculated by comparing the relative changes in the price of alcohol, with changes in households' disposable income per capita over the same period (allowing for inflation). Statistics on Alcohol, England 2020, NHS Digital (2020)
[10] Local Alcohol Profiles for England, Cornwall Profile, Public Health England (2021). Note that Health Survey for England data does not include the Isles of Scilly.

- **Significantly fewer adults in Cornwall abstain from drinking** alcohol compared to national figures (11.9% and 16.2% respectively).
- 28.6% of respondents drink **over 14 units per week** in Cornwall and the Isles of Scilly compared to 22.8% nationally.
- 20.2% of adults in Cornwall **binge drink** on their heaviest drinking day compared to 15.4% nationally.

From this we can assume that around 60% of the CIoS population are low risk drinkers (14 units or less per week). The 29% equates to 134,660 adults in CIoS[11] drinking over 14 units per week and of these we do not know who is 'increasing risk' versus 'high risk'.



Older research on estimated levels of drinking in CIoS broke down those drinking over recommended levels into 'increasing risk' and 'higher risk' and was based on pre-2016 guidance on units (Appendix C).

A local alcohol consumption study in 2016 by Public Health England[12], sent postal surveys to residents of 25 local authorities (LAs). Out of a total of 9,683 respondents, 348 were residents in CIoS.

- CIoS ranked the second lowest out of the 25 LAs in the survey in terms of the percentage of respondents reporting that they abstain from alcohol (14.5%).
- CIoS ranked 4th highest out of the 25 LAs in terms of the percentage of drinkers who said they drank more than 6-8 units of alcohol daily or in a single occasion weekly (15.9%).
- CIoS ranked third highest out of 25 LAs in terms of the percentage of drinkers who drink on 4 or more days each week (20.3%).
- The average percentage of respondents with an AUDIT score above 8 (indicates drinking above low risk) across all 25 LAs was 24.8% compared to 25.5% for respondents in CIoS.

Both findings from the Health Survey for England and the 2016 PHE study **suggest higher levels of alcohol consumption in CIoS than nationally**. It should be noted that the sample size of the PHE study was small and that household surveys are known to under-estimate alcohol consumption when compared with tax returns and sales data.

[11] Estimate calculated from CIoS population aged 18 and over in 2020, Midyear Population Estimates, Office for National Statistics.
[12] Local alcohol consumption survey: national report, Public Health England (2017)

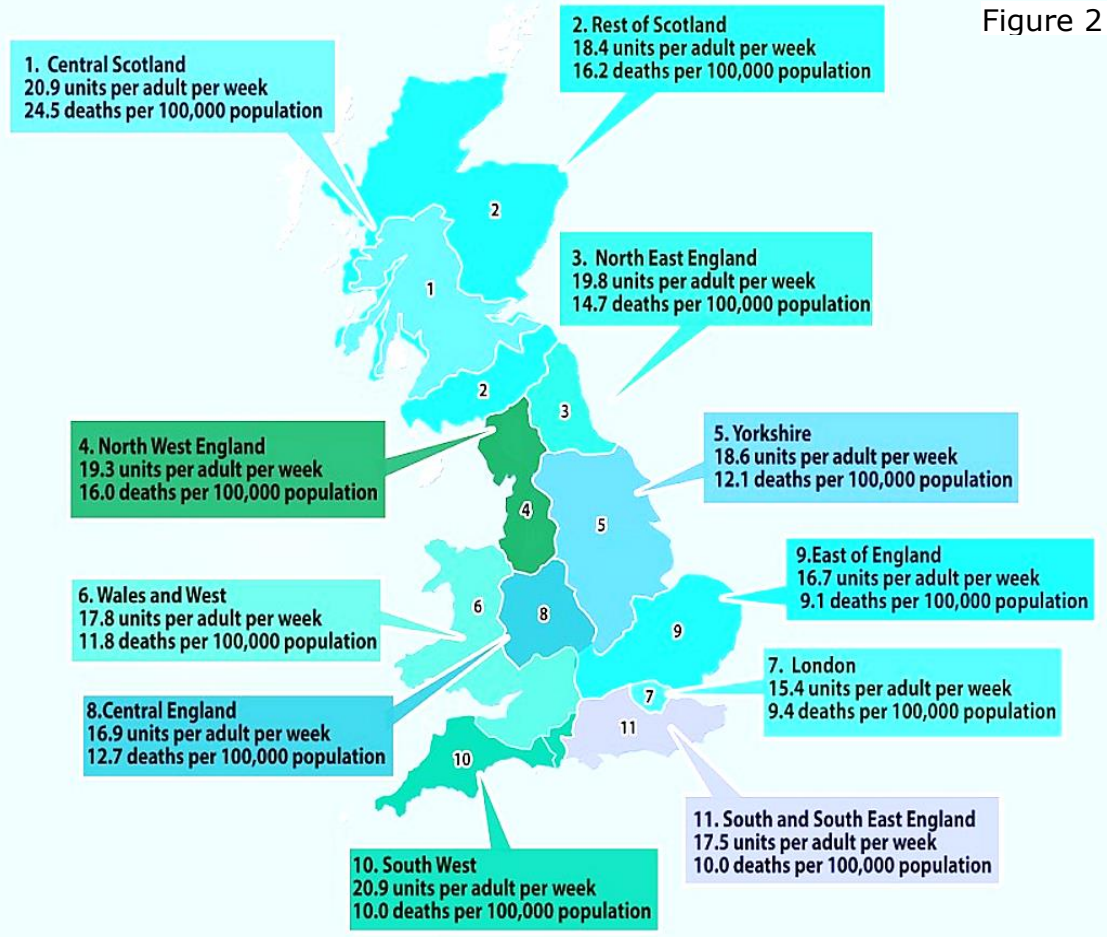
Sales as an indicator of drinking levels

PHE analysis of the **volume of pure alcohol sold through the off-trade** in 2014 is the most recent data available. Off-trade premises are those that sell alcohol to be consumed off-site e.g. supermarkets. Results for Cornwall can be compared against those of our 15 nearest statistical neighbours (areas similar to Cornwall in terms of a range of socio-economic indicators e.g. Shropshire and Herefordshire). Results indicated:

- The **volume of pure alcohol sold through the off-trade** in Cornwall was **significantly higher than nationally** and second highest when compared to our 15 nearest statistical neighbours.
- When looking at **beer, wine and spirits** sold through the off-trade, Cornwall ranked second highest, third highest and top, respectively, in comparison to our 15 nearest statistical neighbours. For all three types of alcohol, off-trade sales in Cornwall were **significantly higher than nationally**.

Other research put the **South West in the highest consumption bracket**, based on retail and Her Majesty's Revenue and Customs (HMRC) returns, but with low alcohol-related mortality in the resident population (Figure 2).[13]

Figure 2



"A high level of consumption in South West England was driven by on-trade sales of cider and spirits and off-trade wine sales."

[13] Regional alcohol consumption and alcohol-related mortality in Great Britain: novel insights using retail sales data, Robinson et al., (2015)

Overall, this research was in line with previous findings;[14] that all estimates of alcohol intake are self-reported which means that estimates presented in this needs assessment are likely to be an underestimate of alcohol consumption.

The research also noted that the high volume of **tourism** in South West probably contributed to the high volume of alcohol sold in the region.

High consumption rates in CIoS are likely to be influenced by tourism and second home ownership.

Dependent drinkers

Estimates from Public Health England indicate that there are around **6,968 dependent drinkers** in CIoS (2018/19), equating to **1.5% of the adult population**. This is similar to the national rate of 1.4%[15].

Hospital admissions can also be used as a proxy indicator for consumption. The latest figures are explored in section 3.

Population Increase

The Office of National Statistics (ONS) predicts that there will be 477,524 adults living in CIoS in 2025 and 507,963 in 2035[11]. Assuming the proportion of adult dependent drinkers remains at 1.5%, this could indicate:

- an estimated 7,162 dependent drinkers in 2025;
- 7,619 dependent drinkers in 2035.

Impact of the pandemic on drinking

PHE analysis[16] of HMRC alcohol duty receipts and retail purchases concluded that:

- There was only a small decrease (-1.2%) in the volume of alcohol bought through the on-trade in 2020/21 compared to 2019/20 despite the closure of on-trade premises during national lockdowns.
- Conversely, in 2020/21 off-trade volume sales (supermarkets) were 25% higher than in 2019. The people who bought the most alcohol two years before the accounted for 68% of the total increase in on-trade sales during 2020/21 compared to 2019/20.
- There were many national surveys in 2020 that aimed to measure changes in self-reported drinking throughout the pandemic, suggest that those who reported drinking more during the pandemic tended to be those who were heavier drinkers pre-pandemic.

[14] Finding the missing units: identifying under-reporting of alcohol consumption in England, Boniface (2013)
[15] Alcohol dependence prevalence in England, Public Health England (2021)
[11] 2018 Based ONS Population Projections for both Cornwall and the Isles of Scilly by Single Year of Age, ONS.
[16] Monitoring alcohol consumption and harm during the *COVID-19* pandemic. Public Health England (2021)

Both the findings from off-trade sales and surveys suggest that **alcohol consumption during the pandemic increased amongst those who were the heaviest drinkers pre-pandemic**.

Levels of drinking

The latest evidence from sales and self-reported surveys, suggests **higher levels of alcohol consumption in Cornwall and the Isles of Scilly than nationally**. Approximately 134,660 adults (29%) in CIoS drink over 14 units per week. Higher sales may be in part due to tourism but **self-reported surveys indicate more adults in CIoS drink above recommended levels**. Self-reported surveys are known to underestimate alcohol consumption therefore potentially people are drinking at higher levels than reported.

Why may people have a problem with drinking?

People drink for a wide range of reasons: to celebrate, commiserate or socialise, for courage or to cope with stress and worry. We often drink because we want to alter our mood. Both societal factors and individual factors impact on levels and patterns of alcohol consumption:

Societal

- Alcohol pricing, availability and regulation
- Drinking context
- Culture
- Socio-economic status

Individual

- Age
- Gender
- Familial factors
- Trauma
- Mental health
- Homelessness
- Employment and finances

Childhood, adolescence and family context

Research has consistently shown that a young person's tendency towards problem drinking and drug use is predicted by the presence of risk factors and protection factors in their life. The **probability of experiencing alcohol and drug problems increases as exposure to risk factors increases**.

Longitudinal studies[17], which have tracked young people and their use of substances over the life course, have revealed three main trajectories[18] with 92% of people with alcohol and/or drug issues falling on one of the **three pathways**.

The first group are '**early onset, externalised youth**'[15] characterised by common factors of **inter-generational poverty**, exposure to **trauma from a young age** and being raised by **low-resourced parents**. Children in this group tend to start smoking between the ages of 10 and 12 then rapidly move on to alcohol and cannabis. They show high rates of externalised disorders and poor

[17] The Dunedin Study, Dunedin Multidisciplinary Health & Development Research
[18] Choices: A Review of a Developmentally Informed Substance Misuse Treatment System for Young People, Phil Harris (2013)

impulse control. These **'acting-out' behaviours** are illustrated through offending and high rates of truancy. Externalising behaviours are extremely difficult for low-resourced parents to manage especially in poverty. The age of initiation into smoking tends to be highly predictive of subsequent drug and alcohol involvement.

The second group are '**internalised youth**'[19] experiencing **depression and anxiety disorders around the ages of 12 to 14**. At this age 50% of the brain is going through transition and young people see themselves through the eyes of others. **Previous trauma or abuse** can be causal or a trigger of underlying disorders. This trauma will be understood by the young person differently at this age and seen through the eyes of others creating a sense of shame and fear of judgement. Problem alcohol and drug use amongst this group is a means of coping with their mental health difficulties.

The third group are '**late onset normative users'** aged between 14 to 16 who first use substances due to peer pressure. This group tend to have experienced stable life situations and good educational achievement prior to substance use. Problem alcohol and drug use may lead these young people into traumatic experiences for example they become more vulnerable to exploitation.

Adverse Childhood Experiences (ACEs) are highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. They can be a single event, or prolonged threats to, and breaches of, the young person's safety, security, trust or bodily integrity[20]. ACEs include:

- Domestic abuse;
- Losing a parent through divorce, separation, death or abandonment;
- A parent with a mental health condition;
- Being the victim of, or witnessing abuse (physical, sexual and/or emotional);
- Being the victim of neglect (physical and emotional);
- A member of the household being in prison;
- Growing up in a household in which there are adults experiencing alcohol and drug use problems.

In a 2014 study in England, 47% of the population had experienced at least one ACE with 9% having 4+ ACEs[21]. Research consistently demonstrates that ACEs are strongly associated with increased risk of poor health and other problems later in life. 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.[22]

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**

[19] Childhood externalizing and internalizing psychopathology in the prediction of early substance use, King, Iacono and McGue (2004)
[20] Addressing childhood trauma and adversity, Young Minds (2018)
[21] National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviours in England. Bellis et. al. (2014)
[22] Welsh Adverse Childhood Experiences (ACE) Study: Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population, Public Health Wales NHS Trust (2015)

- 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.

The prevalence of high-risk drinking increases with ACEs. **Problem drinking** in individuals with a history of ACEs can be a **coping strategy** used to address insecurities and anxieties rooted in a legacy of abuse, neglect and other sources of chronic childhood stress[23] [24]. Of the 1,723 people in alcohol treatment in 2020/21, 26% completed an **ACEs questionnaire**. Of these, 51% reported experiencing 4 or more ACEs. It should be noted that this questionnaire is **not routinely embedded** yet therefore the sample may not be representative of the whole treatment cohort meaning we cannot make any conclusions about the prevalence of ACEs amongst the whole treatment population.

Adulthood

Adult-onset alcohol dependence is associated with **poor mental health** and a coping strategy for **stress**[25]. Research has demonstrated that 70% of alcohol problems develop after the age of 30 (later than for other drugs) with men likely to become heavy drinkers in their 30s and women in their 40s. Stress can be caused by many factors for example relationship problems or unemployment. Drinking is strongly associated with unemployment for both men and women[26]. The age profile of our treatment population also shows that people do not seek help until later on in life – when the harm has already established. However, these adults may have had the chance to develop more protective factors to assist recovery than those who develop earlier onset of dependence (other drugs), thereby improving their recovery potential.

Different groups of the population are more or less likely to drink at harmful levels than the general population. It is important to remember that individuals do not belong to separate single groups e.g. women, LGBTQ+, people of colour, but instead that characteristics overlap creating nuanced experiences and needs.

The needs of different groups in relation to treatment are explored in Section 4.

Neurodiversity

Being neurodivergent means that an individual may think and learn in a different way to others. Neurodiversity has a wide spectrum that covers a range of

[23] Associations between adverse childhood experiences, psychological distress, and adult alcohol problems, Strine et. al. (2012)
[24] Adverse childhood experiences predict earlier age of drinking onset: results from a representative US sample of current or former drinkers, Rothman et. al. (2008)
[25] Prospective developmental subtypes of alcohol dependence from age 18 to 32 years: Implications for nosology, etiology, and intervention. Meier et. al. (2013)
[26] Does Unemployment Lead to Greater Alcohol Consumption? Popovici and French (2013)

neurological conditions such as, but not limited to, the Autistic Spectrum, Attention Deficit Hyperactive Disorder (ADHD), Dyslexia, Dyspraxia, Tourette's and social anxiety.

It is estimated that around 1 in 10 people in the UK are neurodivergent[27].

Autism

There is little research on drinking amongst those with autism and existing studies have differing results[28]. Alcohol may be used as a **coping strategy** to manage social demands and help develop and maintain relationships or cope with anxiety[29]. However due to poor peer contact, young people with autism may be less exposed to social settings where alcohol is consumed therefore may be less likely to drink or drink problematically[30]. One study found that those with autism were at increased risk of problem drinking if they also had ADHD[31].

Learning disabilities

A learning disability is a lifelong condition that affects the way a person learns new things in any area of life. It affects people's understanding of information and their communication skills[32]. A learning difficulty (e.g. dyslexia, dyspraxia and ADHD) is different as it does not affect general intellect.

Public Health England guidance[33]outlines that there is limited research about substance use amongst those with learning disabilities. Most studies find **lower rates of alcohol use** compared to the general population. However, **those with learning disabilities that drink alcohol are more likely to do so problematically**.

People with learning disabilities are more likely to drink problematically or use drugs if they:

- Have borderline to mild learning disabilities;
- Are young and male;
- Have mental health problems;
- Are socially isolated;
- Desire social acceptance;
- Have experienced stressful or traumatic life events;
- Live independently;
- Live in non-urban areas;
- Are not engaged with learning disability services.

Having a supportive family is a strong protective factor.

[27] The national strategy for autistic children, young people and adults: 2021 to 2026, Department of Health and Social Care and Department of Education (2021)
[28] Low prevalence of risk drinking in adolescents and young adults with autism spectrum problems, Kaltenegger et al. (2021)
[29] Asperger syndrome and alcohol: Drinking to cope? Tinsley and Hendrickx (2008)
[30] ADHD symptoms, autistic traits, and substance use and misuse in adult Australian twins, de Alwis et al. (2014)
[31] Attention-deficit/hyperactivity disorder, autistic traits, and substance use among Missouri adolescents, Mulligan, Reiersen and Todorov (2014)
[32] Learning Disability Needs Assessment Summary, Cornwall Council Public Health (2017)
[33] Substance misuse in people with learning disabilities: reasonable adjustments guidance, Public Health England (2016)

Those with learning disabilities compared to the general population:

- Start using substances later in life;
- Are at greater risk of peer influence;
- Adopt an 'all or nothing' principle to alcohol consumption;
- Are less likely to receive treatment or remain in treatment.

LGBTQ+

There is little research on alcohol use among LGBTQ+ people. However, it has been suggested that socialisation and culture within the commercial gay scene, as well as coping with LGBTQ+-specific stressors such as stigma and discrimination, may be factors contributing to increased drinking[34].

Drinking patterns vary among different sexual orientations and gender identities. However, findings from studies and surveys suggest that overall alcohol is consumed not only by a greater proportion of LGB people compared to the general population, but also in greater amounts and at a higher frequency. One study concluded that there was a **higher prevalence of hazardous drinking among the LGBTQ+ population**, particularly among women[35].

A 2021 report by NHS Digital found that LGB adults were more likely than heterosexual people to drink over the national guidelines of 14 units per week.[36] Another study found that LGBTQ+ people experience around **double the odds of alcohol dependence** compared to the general population, and also experience a higher prevalence of mental illnesses that can co-occur with problem drinking[37].

Older People

The Older Persons' Substance Misuse Working Group of the Royal College of Psychiatrists[38] identified that both alcohol and illicit drugs are among the top ten risk factors for mortality and morbidity in Europe and **problem drinking and drug use by older people is a growing public health problem**.

Between 2001 and 2031, there is projected to be an increase of 50% in the number of older people in the UK. The proportion of older people in the population is increasing rapidly, as is the number of older people with substance use problems.

The Drink Wise, Age Well programme ran in 5 areas (not including CIoS) from 2015 to 2020 and aimed to reduce alcohol-related harm in the over 50s. A survey of 16,700 over 50s in the UK using AUDIT found that[39]:

[34] LGBTQ+ People and Alcohol. Institute of Alcohol Studies (July 2021)
[35] Sexual orientation identity and tobacco and hazardous alcohol use: findings from a cross-sectional English population survey. Brown et al. (2017)
[36] Health and health-related behaviours of Lesbian, Gay and Bisexual adults, NHS Digital (2021)
[37] A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people, King et al. (2008)
[38] 'Our invisible addicts', Royal College of Psychiatrists, College Report CR165 (2011)
[39] Drink Wise, Age Well: Alcohol Use and the Over 50s in the UK. (2015)

- The majority of over 50s were low risk drinkers, but 17% were increasing risk and 3% high risk;
- 92% of lower risk drinkers drink with someone else compared to only 62% of higher risk drinkers;
- 78% of higher risk drinkers said they drank to take their mind off their problems, compared to just 39% of lower risk older respondents;
- Amongst those who said they were drinking more than in the past five years, the most frequently reported reasons for this increase are age-related. These were **retirement** (40%), **bereavement** (26%), **loss of sense of purpose** in life (20%), fewer opportunities to socialise (18%) and a change in financial circumstances (18%);
- Other factors associated with increased drinking in older age included living alone, not having a partner, being widowed and having a chronic illness or disability.

The report also highlighted a major issue around lack of understanding and knowledge in relation to units and recommended alcohol guidance amongst the over 50s.

Ethnicity

Generally, it is believed that people from minority ethnic groups drink less and are more likely to abstain from alcohol than those who are White-British. However, studies have identified **higher consumption among Indian women, Chinese Men, older Irish men and south-Asian men**, especially those from the **Sikh religion**. Other studies have found that people from black and minority ethnic backgrounds have similar rates of alcohol dependency as the white population but they are **under-represented in alcohol treatment and advice services**[40].

Some minority ethnic groups experience more alcohol harm. For example, White Irish men experience higher rates of alcoholic liver disease and other alcohol-related diseases, and Sikh men experience higher rates of liver cirrhosis.

It is important to note that service providers believe that the high levels of abstention amongst minority communities cited in research is misleading and that the **prevalence of harmful drinking in these communities is underestimated**[41]. Drinking can also differ within ethnic groups by gender and between first, second and third generations.

Young people from minority ethnic groups with strong religious ties that forbid drinking, or are less tolerant of drinking among women, may **hide their drinking** for fear of repercussions and bringing **shame** on their families. This is evident among some belonging to the Muslim, Sikh and Hindu faiths[42].

[40] Drinking patterns and alcohol service provision for different ethnic groups in the UK: a review of the literature, Bayley and Hurcombe (2010)
[41] 'It's Everywhere'- Alcohol's Public Face and Private Harm, Commission on Alcohol Harm (2020)
[42] Ethnicity and alcohol: A review of the UK literature, Bayley, Goodman and Hurcombe (2010)

Gypsies, Roma and Travellers

There are an **estimated 1,500** Gypsies, Roma and Travellers (GRT) in Cornwall spread across three authorised sites (owned and managed by CHL), 80 private sites and unauthorised encampments. Roma Gypsies are the largest minority ethnic group in Cornwall. They majority of GRT families live in conventional housing dispersed across the county[43].

There is very **limited literature on the health needs** of this population. Research has found that health issues such as high infant mortality rates, high maternal mortality rates, low child immunisation levels, mental health issues, problem substance use and diabetes are prevalent in GRT communities. In addition, GRTs are widely recognised as being marginalised and socially excluded with many experiencing discrimination, stigma and hate crime.

There has been **little research into the extent of problem drinking and drug use** amongst GRT populations in the UK but anecdotal evidence suggests that it is on the increase, especially if families have been re-housed on run-down estates or where there is a high incidence of unemployment or depression.

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**. In a study[44] interviewing 10 Travellers and 2 professionals:

- Travellers cited a general use of alcohol as part of celebrations with working commitments limiting how much people could drink. Some likened their drinking to the rest of the population;
- **Young girls** are not traditionally allowed to drink before marriage and doing so would lead to a poor reputation and consequences ranging from a 'telling off' to scandal. Mixing with non-Travellers was associated with a fear around girls assimilating behaviours such as drinking and having sex;
- Drinking amongst **boys** was seen as acceptable before marriage;
- Women, once married, did not drink as much or as often as men;
- Some described alcohol as a means of dealing with **emotional problems** especially **women in difficult marriages**.

Veterans

A Veteran is defined as anyone who has served for at least one day in Her Majesty's Armed Forces (Regular or Reserve). An estimated 5% of household residents (16 and over) in Britain are Veterans[45]; this equates to 23,902 people in CIoS. The South West Peninsula has strong military ties and heritage arising from both serving personnel being stationed here and veterans living locally[46].

Compared to civilians, those who have served in the military are **much more likely to be classed as having a drinking problem**[47]. The most common

[43] Gypsy, Roma, Traveller & Migrant Women Project, The Women's Centre Cornwall(2021)
[44] Perspectives on alcohol use in a Traveller community: An exploratory case study, Hurcombe et al. (2012)
[45] Annual population survey: UK armed forces Veterans residing in Great Britain 2017, Ministry of Defence (2019)
[46] Veteran Health Needs Assessment, Cornwall Council Public Health (2019)
[47] Armed forces and mental health, Mental Health Foundation (2017)

disorders in the UK armed forces post-deployment are depression, problem drinking and anxiety disorders. One study found that 67% of men and 49% of women in the military drink at levels considered increasing risk compared to 38% of men and 16% of women in the general population[48].

Some Veterans have reported some adverse mental health outcomes, which have been compounded by other factors such as financial and welfare problems and associated problem drinking, particularly younger men and those in lower ranks or those leaving service early[49].

There is a well-established connection between problem drinking, PTSD and other common mental health disorders. In one study, Veterans who screened positive for **PTSD or depression** were **two times more likely to report problem drinking** relative to Veterans who did not screen positive for these disorders[50].

It is thought that the higher levels of alcohol dependency in Veterans is due to a combination of **military culture**, **distressing service experiences** (including moral injury- experiences that violate one's moral or ethical code) and **mental health** difficulties with problems associated with 'adjusting back' to civilian life.

In addition, levels of adverse childhood experiences amongst those with a history of military service have been found to match or exceed prevalence within the general population. ACEs are associated with poorer mental health outcomes among service members and Veterans[51]. Studies have shown that many of those who join the Armed Forces, particularly in the lower ranks, would likely have developed issues with alcohol regardless of military service due to high levels of deprivation, ACEs, poor educational attainment and family breakdown.

The treatment needs of the groups discussed above are included in Section 4.

[48] Patterns of drinking in the UK Armed Forces, Fear et al. (2007)
[49] The Veteran's Transition Review, Lord Ashcroft (2014)
[50] PTSD symptom clusters in relationship to alcohol misuse among Iraq and Afghanistan war Veterans seeking post-deployment VA health care, Jakupcak et al. (2010)
[51] Prevalence of Adverse Childhood Experiences Among Veterans, laird and Alexander (2019)

Section 3: The Impacts of Alcohol

Harms to the drinker- Physical Health

Drinking has both short and long-term physical and psychological effects.

The short-term risks associated with drinking are summarised in Figure 3[52]. Accidents and injuries; violent behaviour or being a victim of violence; and unprotected sex that could lead to sexually transmitted infections or unplanned pregnancy, are also risks.

The risks of drinking alcohol increase with age. Over the age of 50 it takes twice as long to process a unit of alcohol.

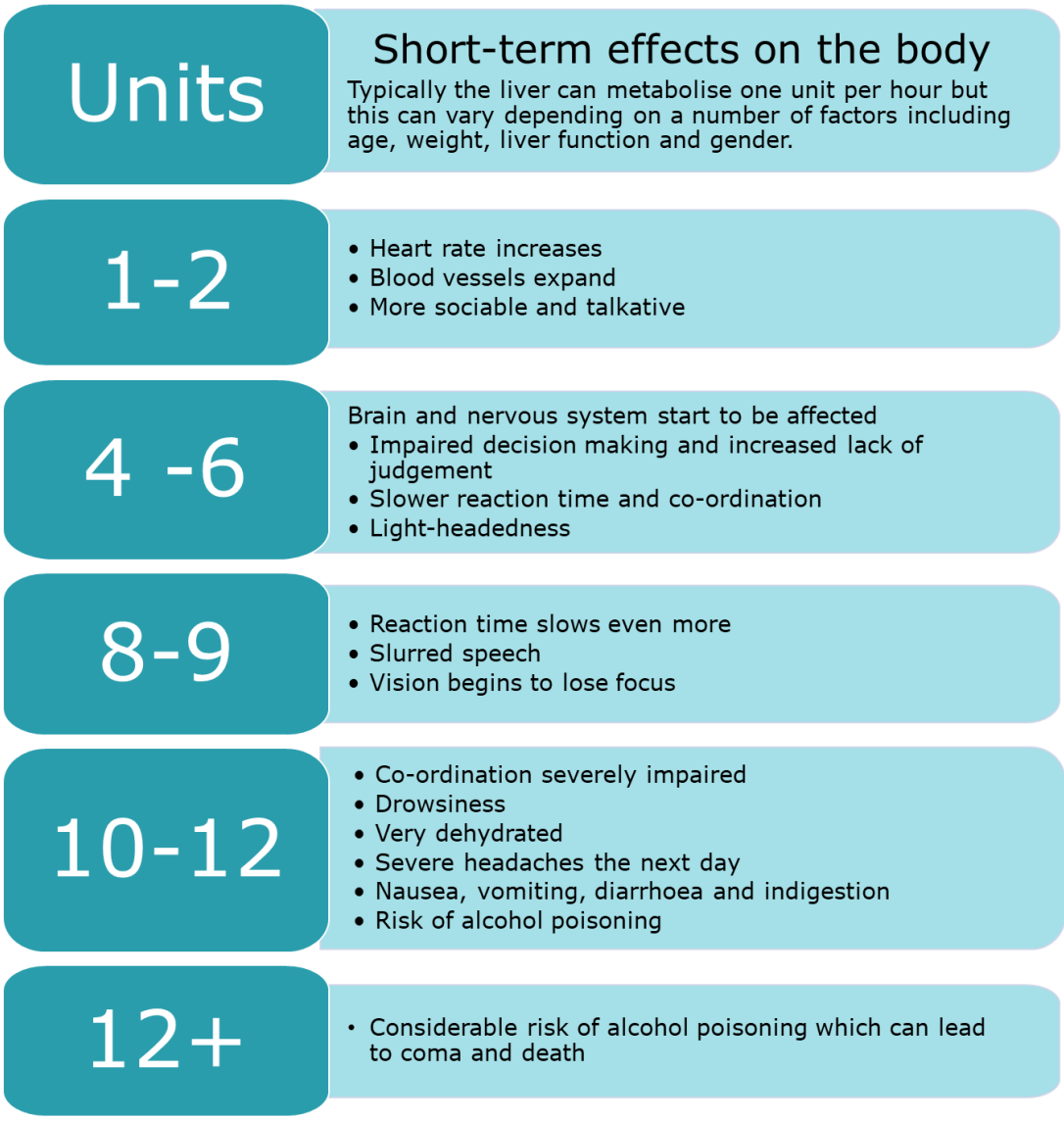
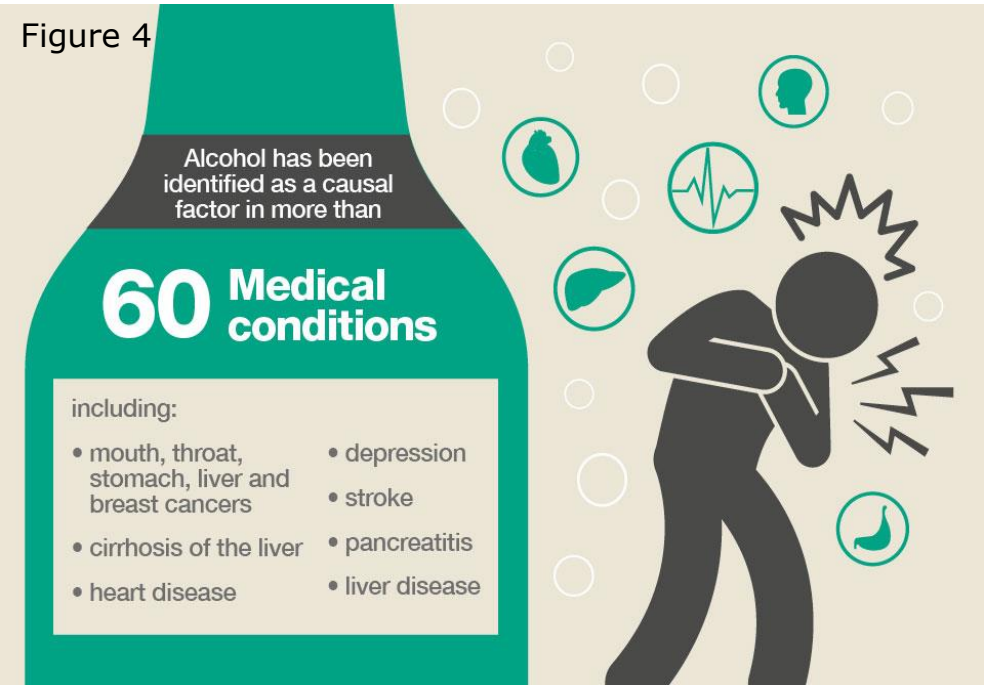


Figure 3

[52] Alcohol Misuse- Risks, NHS

Drinking large amounts of alcohol over many years is associated with **long-term health risks** with damage to the brain, nervous system, heart, liver and pancreas. Long-term heavy drinking can also weaken the immune system and weaken bones. Many long-term health conditions are associated with long-term problem drinking as outlined in Figure 4[53].

Figure 4



Dependent drinkers: tolerance and withdrawal

Unlike heavy drinkers, those who are dependent drinkers experience tolerance and withdrawal.

Alcohol dependency is largely a **neurological process** with a strong, often uncontrollable, desire to drink. Drinking plays an **important role in day-to-day life** with a person worrying about where their next drink will come from and planning their activities around this. **Fear of withdrawal symptoms will lead a drinker to ruminate and obsess about alcohol** and do anything to gain access to it. For some this may result in stealing or participating in sex work.

Tolerance is when over time the body does not react to a substance in the same way it did when a person first consumed it. The body becomes less sensitive to the physical effects of alcohol therefore requires higher quantities to achieve the same effects as before.

When someone who is alcohol dependent suddenly reduces their drinking significantly, or stops drinking, they experience **withdrawal** with symptoms such as nausea and vomiting; anxiety; hallucinations; shaking and seizures. **Dependent drinkers should never try to reduce their alcohol intake alone**. Severe symptoms such as delirium tremens have an anticipated mortality rate of 37% without an appropriate intervention[54].

[53] Health matters: harmful drinking and alcohol dependence, PHE (2016)
[54] Delirium Tremens, Rahman and Paul (2021)

Hospital Admissions

From this year's LAPE[55] [56], we drew the following conclusions about the impacts of alcohol on the health of people in CIoS. These are based on 2019/20 rates as many figures for 2020/21 now appear to either be lower than, or similar to, national rates as local hospital admissions decreased to a greater degree than nationally during the pandemic.

- Men are more likely to be admitted to hospital, or die of an alcohol specific or related reason, than women (a national and local trend);
- Alcohol-related liver disease rates are higher locally than nationally and pre-pandemic were increasing;
- Alcohol-specific deaths locally rose by 16% from 2019 to 2020. There was a 19% increase nationally.
- Mortality from alcohol related liver disease rose locally by a much smaller degree than nationaly from 2019 to 2020;
- More women aged 40-64 are being admitted to hospital locally than nationally for an alcohol-related reason;
- More over 65s are being admitted to hospital because of an alcohol-related condition locally and before the pandemic this was increasing;
- Men in Cornwall are 8 times more likely than women to be admitted to hospital with an alcohol-related unintentional injury;
- Women in Cornwall are more likely than men to be admitted to hospital for alcohol-related intentional self-poisoning.

In 2019/20 there were 3,531 **alcohol-related** admissions locally (577 per 100,000 residents). This is **greater than the national and regional rate**. The local rates for females and males were 21% and 7% higher than their equivalent national rates. Over the latest 4-year period the local trajectory appears to fluctuate compared to a slight rising trajectory nationally (Figure 5).

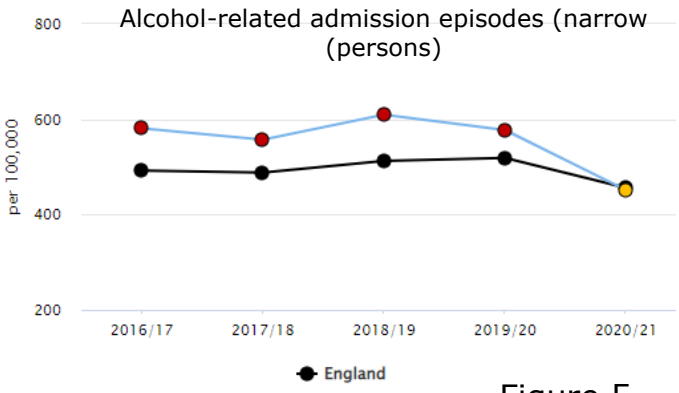


Figure 5

[55] The Local Alcohol Profiles for England are produced by the Office for Health Improvement and Disparities (OHID) to monitor alcohol-related impacts on health, the NHS and local communities. This dataset allows you to see local factors alongside national and regional comparisons.
[56] Alcohol related hospital admissions are classed as 'broad' and 'narrow'. Narrow measures estimate the number of hospital admissions which are primarily due to alcohol consumption therefore provide the best indication of trends in alcohol-related hospital admissions. Broad measures are an indication of the full impact of alcohol placed on the NHS.

Age

Alcohol-related admissions (narrow) rates for the **under 40s, 40-64s and over 65s** are **higher locally than nationally and regionally** (pre-pandemic). Amongst the **40-64s** age group this is **driven by the local female** rate which is higher than nationally whereas the local male rate is similar to the national rate.

Only the **rate for the 65+** age group is **increasing** and this appears to be on a steeper trajectory than nationally before the pandemic where we saw a greater reduction locally than nationally (Figure 6).

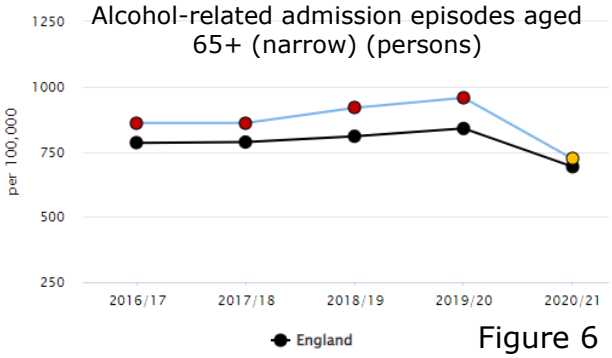


Figure 6

Alcohol-specific admission rates for **under-18s** have been **decreasing** both locally and nationally. The rate is now **similar to that observed nationally** and lower than the regional rate.

Conditions

Table 1 summarises the local rates for 2019/20 and trends (2016/17 to 2019/20) for a range of admissions for alcohol-related and alcohol-specific conditions. Where the rate or trend differs by gender this is noted.

Table 1 **Admissions indicator**	**Local gender difference**	**Local 2019/20 rate compared to national rate & change in 2020/21**	**Trend**
Alcohol-related unintentional injuries (narrow)	Male rate 8 times higher than female	Higher- male Similar- female Still the case for both in 2020/21.	Stable
Mental and behavioural disorders due to use of alcohol (narrow)	Male rate twice that of female rate	Higher- female Lower- male Both rates are now lower in 2020/21	Stable
Intentional self-poisoning by and exposure to alcohol (narrow)	Female rate around 1.5 times higher than male	Higher Similar in 2020/21	Fluctuates
Alcohol-related cardiovascular disease (broad)	Male rate 6 times higher than female	Lower Still lower in 2020/21	Stable

Whilst the male rate for alcohol-related unintentional injuries is 8 times higher than the female rate, the gender split for alcohol-related violence with injury crime figures is around 50/50 with men more likely to be victims of street violence and women more likely to experience domestic abuse.

Local and national rates of alcohol-related cancers are (2017-2019) similar. However, national data shows the strong associated between alcohol and cancer with **cancer accounting for 28% of all alcohol related admissions in England in 2019/20**[57]. There is now sufficient evidence to conclude that alcohol causes cancer of the mouth, upper throat and voice box, oesophagus, colorectum and liver[58]. Alcohol is also a risk factor for other types of cancer including cancer of the pancreas and breast.

Impact of the pandemic

The LAPE shows that from 2019/20 to 2020/21 admission rates locally and nationally decreased for all indicators when looking at admissions over a year.

OHID calculated the monthly national rates of alcohol-specific emergency hospital admissions, per 100,000 people, during 2020 and 2021 to compare to a 2018 and 2019 baseline[59]. This reveals patterns of increase and decrease throughout the pandemic.

Locally we have obtained data on the number of alcohol-specific emergency admissions for Cornish residents including those who live in the east who tend to access hospitals in Devon.

Admission numbers locally **mirrored national patterns of increase and decrease** during the pandemic (2020 and 2021)[60]**.** For example, admissions deceased rapidly both locally and nationally at the start of the first lockdown (spring 2020) then rose with the easing of restrictions (summer 2020). However, numbers of admissions locally **never exceeded or returned to pre-pandemic levels** (2018 and 2019 baseline) whereas nationally rates exceeded pre-pandemic levels during the easing of restrictions in 2020 and during the third lockdown in the first half of 2021.

More detailed trends and comparisons between local and national data, with graphs, can be found in Appendix D.

The makeup of all local alcohol-specific **admissions** (not just emergency) **by age has changed very little** for 2020/21 and 2021/22. The greatest change was for the 55-64 age group which accounted for around 2% more of admissions in the first half of 2021/22 than in 2019/20.

[57] Statistics on Alcohol, England 2021, NHS Digital (2022)
[58] Consumption of Alcoholic Beverages, World Health Organization International Agency for Research on Cancer (2012)
[59] Monitoring alcohol consumption and harm during the COVID-19 pandemic. Public Health England (2021)
[60] The comparisons made between local fata and the OHID national data should be interpreted with caution as our local data looks at numbers of admissions whereas national data looks at rates of admissions per 100,000 of the population.

Alcohol and mortality[61]

Local **alcohol-related morality rates** are similar to national rates. Both locally and nationally a small increase in the overall rate from 2019 to 2020 was driven by an increase in the female rate. Locally this was an increase of 9.3%.

Nationally **alcohol-specific mortality was the highest in 2020 than any other year since 2001** (Figure 7). In 2020, there was a 19.2% increase in the rate of alcohol-specific deaths compared to 2019. Rates from May 2020 onwards were significantly higher and a third of deaths occurred in the most deprived group. The South West saw a 32.2% increase in rates from 2019 to 2020 (Figure 7).

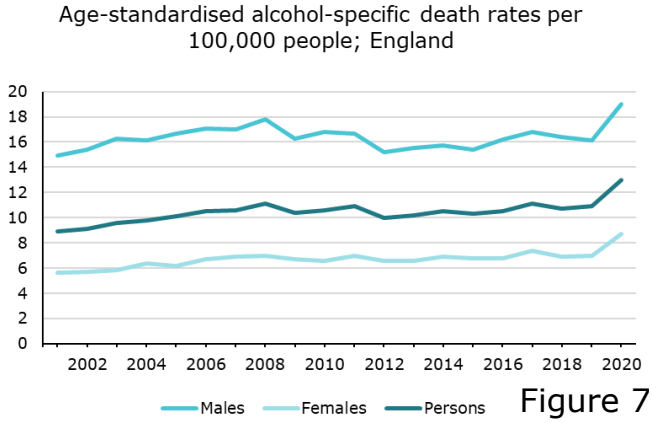


Figure 7

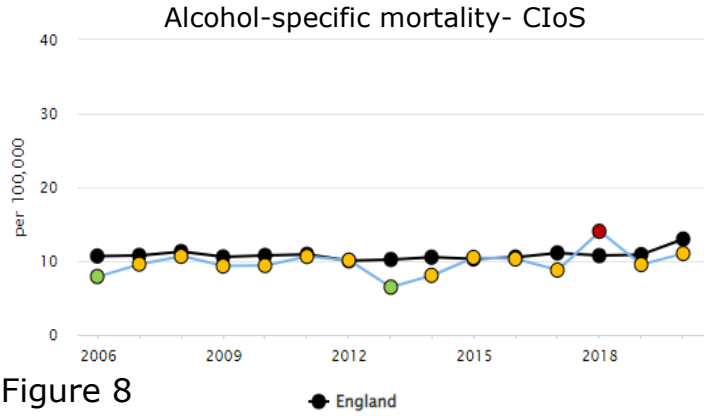


Figure 8

Locally, we saw a **15.8% increase in the rate of alcohol-specific mortality** from 2019 to 2020 (Figure 8). CIoS saw the third lowest increase out of all local authorities in the South West (see Appendix F).

The latest figures by gender (2017-19) indicate that the male rate locally is twice that of the female rate (14.7 and 7.2 per 100,000 respectively) which is in line with the national picture.

Alcohol-related Liver disease

Alcohol-related liver disease refers to liver damage caused by excess alcohol intake. There are three main stages to the condition:

1. **Alcoholic fatty liver disease**. Drinking a large amount of alcohol, even over a few days, can cause a build-up of excess fats in the liver. Fatty liver disease is reversable after no alcohol intake for around 2 weeks.
2. **Alcoholic hepatitis** is caused by problem drinking over a longer period. A mild version of this stage may be reversable but severe alcoholic hepatitis is a life-threatening illness.
3. **Cirrhosis** relates to significant scarring of the liver. It is irreversible but stopping drinking can prevent further damage and increase life

[61] There are two definitions of alcohol deaths: alcohol-related and alcohol-specific. See Appendix E for more information.

expectancy. A person who has alcohol-related cirrhosis and does not stop drinking has a less than 50% chance of living for at least 5 more years[62].

Hospital **admissions for alcohol-related liver disease locally are higher than nationally** and regionally. Both locally and nationally rates have been rising but locally we appear to be on a **steeper trajectory** (Figure 9). From 2017/18 to 2019/20 the local rate increased by 13.5% compared to a 6% increase nationally. Locally and nationally the rate for **males is around double the rate for females**.

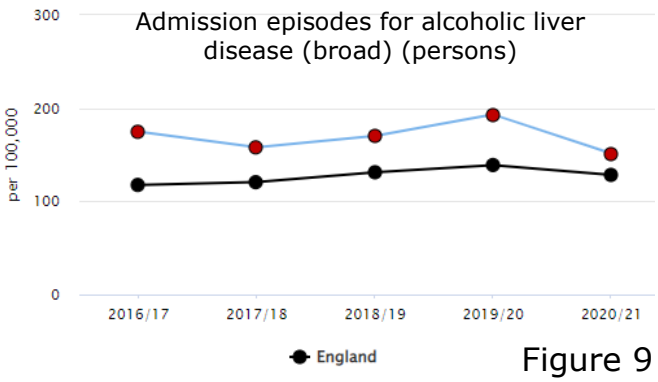


Figure 9

In 2020/21 local rates were still higher than nationally despite reduced admissions.

Impact of the pandemic

We have obtained local numbers of **emergency admissions for alcohol-related liver disease** in 2020/21 to assess the impact of the pandemic. Local admissions mirror the patterns of increase and decrease seen in national rates throughout the pandemic. However, national rates exceeded pre-pandemic rates throughout most of 2020 and 2021[63] whereas local numbers of admissions never exceeded pre-pandemic levels in 2020 after a rise in May (Figure 10).

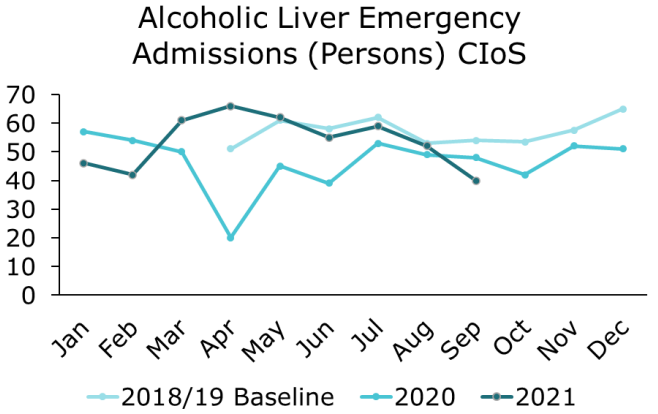


Figure 10

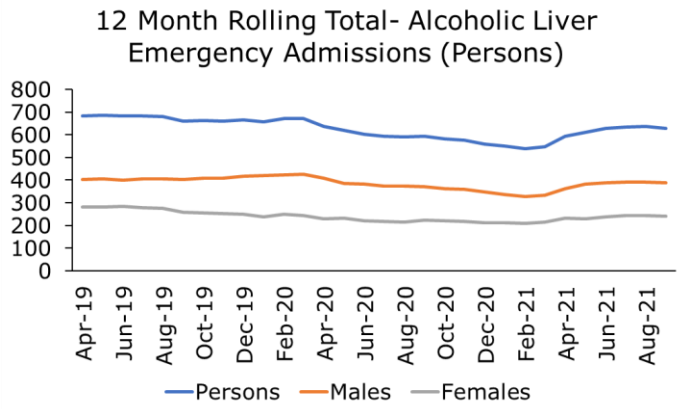


Figure 11

By gender, the number of local emergency alcoholic liver admissions for females remained relatively stable compared to those for **males who were the main driver of the overall changes** during the pandemic (Figure 11).

[62] Overview, Alcohol-related liver disease, NHS (2018)
[63] Wider Impacts of COVID-19 on Health (WICH) monitoring tool, OHID (2021). Behvaioural risk factors, alcohol, alcohol specific emergency admissions, alcoholic liver disease.

Nationally, **80% of alcohol-specific deaths in 2020 were caused by alcoholic liver disease**[64]. Liver mortality rates nationally have risen 43% from 2001 to 2019 but the pandemic has compounded this increase.

Although alcohol-related cirrhosis (stage 4 alcohol-related liver disease) can take a decade or more to develop, deaths occur as a result of acute-on-chronic liver failure due to recent alcohol intake, which is strongly linked to heavy drinking. This links to national consumption trends during the pandemic where those who reported drinking more tended to be those who were the heaviest drinkers pre-pandemic.

Local alcoholic liver disease mortality rates, amongst the under 75s, rose by a much smaller degree from 2019 to 2020 than nationally (4.8% versus 18.7%). However, looking at the **long-term trend**, local rates have risen since 2012-14 becoming similar to the national rate (Figure 12). This is mainly driven by an increase in the female rate.

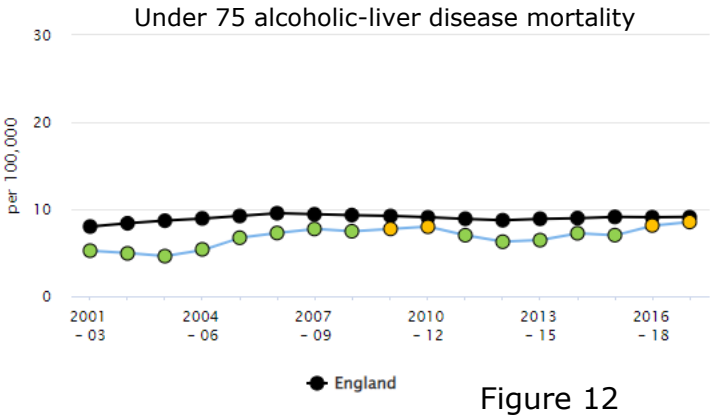


Figure 12

Given CIoS had a higher admission rate for alcohol-related liver disease than nationally in 2019/20, rising faster than nationally, we might have expected to see a greater increase in emergency admissions at the same time as this was observed nationally.

Care pathways for alcohol related liver disease

The hepatology department at RCH assesses patients with abnormal liver function tests and cares for patients with acute and chronic liver disorders. They provide inpatient care and outpatient services (face-to-face, virtual and telephone clinics). Liver transplants are mainly through Derriford hospital in Plymouth or occasionally King's College hospital in London. There is currently a programme of ongoing service and quality improvement to gain accreditation with the national IQILS[65] programme.

To improve the identification of liver disease work has been carried out to raise awareness amongst GPs to increase early identification. As the early stages of liver disease can be asymptomatic, GPs are now encouraged to refer anyone to RCH with an abnormal liver test unless it is an intercurrent illness in which case the patient should be re-tested.

End of life care

End of life care is care that helps all those with advanced, progressive, incurable illness to **live as well as possible** until they die. It enables the supportive and

[64] Alcohol-specific deaths in the UK: registered in 2020, Office for National Statistics (2021)
[65] Improving Quality in Liver Services Programme, Royal College of Physicians

palliative care **needs of both patient and family** to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support[66].

Those who are problem drinkers can often have multiple complex health problems some of which are related to their drinking. This population will therefore potentially need greater access to palliative and end of life care (EoLC) services and many other agencies.
Following a successful pilot in 2020/21 of an EoLC bed at Cosgarne Hall (supported housing for complex needs), for use by either one of their residents or homeless individuals, we wish to review and extend this provision. A GP co-ordinates the individual's care with joint working involving RCHT and our commissioned community drug and alcohol treatment provider.

Ongoing research by Manchester Metropolitan University around supporting those with substance problems recommends[67] developing a **coordinated care model** with a case manager or care worker that is designed, implemented and evaluated by those with **lived experience**. Other recommendations include:

- **Agreed definitions** and understanding of the terms 'substance use', 'palliative care' and 'end of life care' across agencies;
- Avoiding a narrow interpretation of EoLC;
- Specific support for **family members and affected others**. Affected others for those dying of alcohol-related issues can have additional needs due to the challenges of supporting someone who is drinking. After death they can experience feelings of guilt or anger so opportunitities for ongoing psychological and social support should be made available, for instance **bereavement counsellors may need additional training[68]**;
- Close **partnership working** between agencies;
- **Assertive outreach and engagement** with those who have dropped out of care or need home visits.

Services need to:

- Have **low thresholds** with minimal restrictions on normal patterns of behaviour;
- Deliver care in settings familiar to individuals;
- Develop **safety plans** for those whose problem drinking/drug use is high risk or have EoLC needs;
- Drug and alcohol services do a **self-audit** of clients using for example the Supportive and Palliative Care Indicators Tool (SPICT);
- Palliative care and EoLC services use the **AUDIT-C** tool;
- Provide **wellbeing support to staff** and ensure **caseload sizes are appropriate** given the intense work staff are doing with complex clients;
- Gain **consent to share information** to avoid the individual having to repeat the same information frequently.

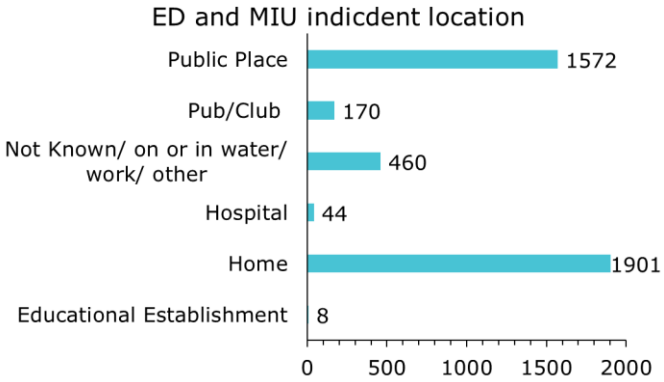
[66] National Council for Palliative Care (2006)
[67] Supporting people with substance problems at the end of life, Manchester Metropolitan University (2019)
[68] Getting it Right: Improving End of Life Care for People Living with Liver Disease, Kendrick (2013)

Emergency Department (ED) and Minor Injuries Unit (MIU)

There were 4,155 alcohol related attendances to ED (RCH) or MIU (West Cornwall) from October 2015 to September 2020. Of these, 90% arrived by either ambulance (air or road) or police vehicle, demonstrating the impact alcohol intoxication has on emergency services.
A total of 20 people accounted for around 1 in 10 attendances over the period with 1 individual attending 80 times.
In the first 9 months of 2019, 12 people accounted for 16% of all attendances which is similar for the same period in 2020 (14%). This suggests that those attending on a one-off bases still visited ED and MIU during the pandemic alongside frequent attenders.

The majority of incidents occurred at home or in a public place (Figure 13). Pubs and clubs accounted for only 4% of incidents but some incidents classed as public place will be those that occurred outside venues or after a person has visited a venue. In 2020 there was a slight decrease in the number of incidents in a public place or pub/club and a slight increase in the number of incidents at home.

Figure 13



Analysis of the 2019 incident data, chosen to be more representative of the Night-Time Economy due to an absence of lockdowns, revealed that five areas[69] accounted for 1 in 5 of all ED attendances (232/1047 attendances in 2019). Table 2 provides an overview of these areas:

Table 2

#	Area	Incidents
1	Pool and Illogan Highway	71
2	Truro South and Central	55
3	Falmouth North	38
4	Grampound Road, St Newlyn East and Cubert (includes the area south of Newquay)	34
5	Newquay East	34

It should be noted that 56 incidents did not have location recorded and that incidents in east Cornwall are less likely to appear in the data as residents are more likely to access services in Devon.

Frequent Attenders

The last needs assessment[70] identified that those frequently attending Royal Cornwall Hospital (RCH) for alcohol-related issues were often very **vulnerable**

[69] Middle Layer Super Output Area (MSOA) which typically contains around 7,000 residents.
[70] CIoS Alcohol Needs Assessment 2016/17, Safer Cornwall (2017)

individuals with **multiple health and mental health needs.** Many were found to have a chaotic lifestyle and demonstrate **problems with engagement, often being resistant to treatment and change.**

In 2019 a **Hospital Outreach Team** (HOT) at RCH was established to engage with patients who have presented to ED 5 times within the last year and/or been admitted twice for reasons associated with alcohol.

HOT provides intense support to meet client's needs. This includes but is not limited to:

- Home and hospital visits;
- Accompanying clients to appointments;
- Liaising with other agencies (including safeguarding, housing and mental health) as part of a multi-disciplinary team;
- Harm reduction and relapse prevention;
- 1:1 psychosocial interventions.

An interim review of the service was carried out by Manchester Metropolitan University pre-COVID-19. The evaluation stated that workers 'excelled at building a **therapeutic alliance** and personalising the service to the client's needs'. Clients interviewed as part of the evaluation shared that:

- They feel **valued** and that staff take time to get to know them, unlike any other service;
- They appreciated the **realistic** way the team worked with them and that workers never made them feel like a failure, which is important in building a trusting relationship;
- Workers were always **transparent** and there was a sense of belonging that comes with the trust;
- They felt **encouraged** as they were never pressured into disclosing any details about their lives until ready to do so. Workers never tried to force a relationship but instead treated them as 'a **real person**'.

Workers were described as innovative and solution focused, caring about clients and working hard to ensure that the individual has access to the services they need. They are the key to partnerships within other services. However, it remains difficult for HOT to access support from mental health services for clients.

HOT have provided cases studies for 12 of the top 20 frequent attenders to RCHT[71]. Figure 14 indicates some of the reoccurring themes, based on the information provided.

These case studies reflect that these people often experienced multiple vulnerabilities. Childhood trauma and ACEs often featured in their lives as did involvement with multiple services. Many clients have mental health needs. There are examples of **good joint care planning** between mental health services and HOT but in some cases, people who do not meet the thresholds for

[71] The top 20 is based on the combined total costs of ED attendances and inpatient admissions 12 months prior to a client engaging with HOT.

secondary mental health services and are referred to other services (such as IAPT[72]) still often falling between the gaps due to **high levels of complexity**.

Figure 14

Hospital attendance and admissions 12 months prior to engagement with HOT and 7 and 18 months post engagement are closely monitored.

Since HOT was established, 315 individuals have been referred to the service. Of those, 133 clients have reached their 18-month engagement point as of January 2022. Data for 126 of those clients who have been engaged with HOT for 18 months showed:

- A 13% reduction was achieved in client's average monthly costs (related to hospital care and treatment) compared to average monthly costs 12 months prior to engagement.
- This reduction increases to 19% when looking at the 20 most costly frequent attenders prior to engaging with HOT.

We are achieving our 60% cost reduction target (set by the funder) with almost half (45%) of the costliest patients, increasing to 70% of all patients if we look at cases in which we make any saving over the 18 months.

It should be noted that initially average monthly costs increase in the first 7 months of engagement, compared to costs in the 12 months prior to engagement, but by the time the client reaches 18 months savings have been made. This may be because patients are receiving the support they need for complex physical health conditions as patient activity rates show a decrease after 7 months of engagement (both for ED attendances and inpatient admissions) suggesting that the cost per hospital visit increases initially.

[72] Improving Access to Psychological Therapies services provide treatment for common mental health needs including: depression, generalised anxiety disorder; obsessive-compulsive disorder; panic disorder; PTSD; social anxiety disorder; specific phobias; and body dysmorphic disorder. In CIoS, IAPT is delivered by Outlook South West. It is not a crisis or emergency service.

Some activity and costings which have been included may not be alcohol-related, for example routine appointments or maternity visits. Going forward we may look to exclude some of these visits, in discussion with partners.

However, the full potential of the project is limited by the pressures faced by other services involved in meeting the needs of these individuals to further reduce hospital attendance and admission, such as mental health support, adult social care and accommodation availability.
The pandemic and resulting operational pressures in the hospital means HOT have had to adapt. For example, working with people in ambulances waiting outside the hospital. There have also been the well-recognised issues with care due to challenges around arranging adult social care pre-discharge.

RCHT Alcohol Liaison Team (ALT)

Hospital Alcohol Care Teams are a recommended element of NICE guidance and recommended by NHS England as part of an effective alcohol treatment system. They also form part of the NHS Long Term Plan.

Our local ALT was established in December 2015 at RCH. A team of alcohol-specialist nurses provide clinical support to patients who attend hospital with either direct or indirectly related alcohol harm and health related issues. ALT nurses provide frequent attender care management plans for patients who regularly present to hospital due to problem drinking. For patients who develop alcohol withdrawal and associated complications, ALT provide clinical treatment plans, with regular input and advice.

In the first 11 months of being established (December 2015 to October 2016) 30 patients on average were referred to ALT each month. By 2019/20 this had risen to an average of 99 referrals a month.

2020/21 saw a decrease to an average of 76 referrals but the first 6 months of 2021/22 indicate this recovered with an average of 96 referrals per month. An increase in referrals may mean that more patients are coming to RCH with alcohol related issues, but this could also be an impact of increased awareness of ALT within RCH.

What is working well:

- A strong team that is well established;
- Good relationship with HOT that avoids duplication: ALT's input is clinical and HOT's psychosocial;
- Greater awareness of ALT within the hospital;
- Patients feel ALT acts as an advocate for them whilst in hospital and frequent attenders say it is good to see familiar faces;
- Finding patients through having a presence on the wards and in ED as well as using prescribing alerts (make contact with anyone with certain prescriptions).

Challenges:

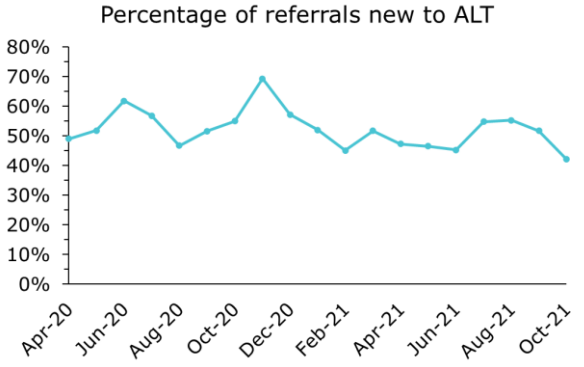


Figure 15

- Staff report that a higher proportion of referrals are new to the service since the pandemic. This has been recorded since April 2020, an average of 52% of all referrals are new (Figure 15);
- Cases are of increasing complexity which alongside frequent attenders is limiting the team's ability to carry out preventative work like providing brief alcohol advice;
- A lack of knowledge amongst hospital staff regarding IBA and the need for training but finding the time to do this is difficult;
- Some patients do not want to be referred to community alcohol treatment services with some never having engaged in treatment whilst others have previously tried;
- Difficulties in obtaining appropriate Adult Social Care support for those with multiple complex needs including alcohol related brain damage (see pages 65 and 66).

The majority of ALT patients are already known to community drug and alcohol treatment therefore referrals to community services from ALT appear low at an average of 14% per month in 2020/21 and 10% so far in 2021/22.

Harms to the drinker – Mental health

Mental health in Cornwall and impact of the pandemic

Mental health is defined as a state of well-being in which every individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community[73]. This includes mental health conditions, illnesses and disorders through to mental wellbeing or positive mental health[74].

In England one in four adults experience at least one diagnosable mental health problem in any given year. In CIoS, 12.3% of adults have a diagnosis of depression[75] and 0.9% of the population are affected by a serious mental illness[76]. CIoS had a higher rate of hospital admissions for intentional self-harm than nationally pre-pandemic[77], and a higher suicide rate than nationally.

Multiple national studies revealed the negative affect the pandemic has had on mental health and wellbeing. Healthwatch Cornwall carried out a survey in

[73] Mental health: strengthening our response, WHO (2018)
[74] Mental health and prevention: Taking local action for better mental health, Mental health Foundation (2016)
[75] Number of patients with a diagnosis of depression on practice registers in 2020/21. Fingertips, OHID.
[76] Number of patients with schizophrenia, bipolar affective disorder and other psychoses as recorded on practice disease registers in 2020/21. Fingertips, OHID
[77] Emergency hospital admissions for intentional self-harm 2019/20, Fingertips, OHID

Summer 2020[78] with 64% of respondents stating that the pandemic had a negative impact on their mental health and wellbeing. Anxiety, separation, isolation and financial worries were the top 4 negative experiences cited.

Alcohol's interaction with mental health

Alcohol is a central nervous system depressant meaning it can contribute to a person experiencing negative emotions even if they were in a good mood when they started drinking. Drinking heavily and regularly is associated with symptoms of **depression[79]**, although it can be difficult to disentangle cause and effect. For example, alcohol dependence **increases an individual's risk of developing anxiety** and vice versa[80] with some individuals using alcohol as a coping-mechanism for their anxiety[81] [82]. Also, studies have shown that depression can follow from heavy drinking and that reducing or stopping drinking can improve mood[83].

The term 'Dual Diagnosis' is commonly used to describe the coexistence of one or more mental health disorders in individuals who also have drug and/or alcohol related problems.

'Dual diagnosis' can suggest that there are only two needs. However, many people with a dual diagnosis have **multiple complex needs** which may include: one or more significant physical health problems (e.g. liver disease and poor mobility); high risk behaviours & mortality; a history of early life abuse; experience of domestic abuse and/or sexual violence; and a range of social issues such as poor housing, low income, unemployment and social isolation.

It is usual, rather than the exception, to find people with co-occurring mental health and substance use across health and care settings. Research estimates that approximately:

- 30% of people in community mental health services[84] and 50% of those in inpatient mental health settings[85] have a co-occurring alcohol/drug use condition;
- 70% of people in drug services and 86% in alcohol services have a co-occurring mental health issue[86].

People who have psychosis are often diagnosed with schizophrenia or bipolar disorder. Approximately **40% of people with psychosis experience problem**

[78] Cornwall Coronavirus Survey 2020, Full Report, Healthwatch Cornwall (2020)
[79] Comorbidity between substance use disorders and psychiatric conditions, Schuckit (2006)
[80] Prospective Analysis of the Relation Between DSM-III Anxiety Disorders and Alcohol Use Disorders, Kushner et al. (1999)
[81] The Self-Medication Hypothesis of Substance Use Disorders: A Reconsideration and Recent Applications, Khantzian (1996)
[82] Martin's story: "Alcohol was the way I coped with anxiety and depression", Alcohol Change (2020)
[83] Alcohol and depression, Boden and Fergusson (2011)
[84] Drug and Alcohol Problems among Individuals with Severe Mental Illnesses in South London, Menezes et al. (1996)
[85] Drug and Alcohol Misuse among In-patients with Psychotic Illnesses in Three Inner-London Psychiatric Units, Philips and Johnson (2003)
[86] Comorbidity of substance misuse and mental illness in community mental health and substance misuse services, Weaver et al. (2003)

drug and/or alcohol use 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 this amounts to harmful or dependent use[87]**.

This is important to consider because of the health inequalities experienced by this vulnerable population. Outcomes[88] for those with psychosis and alcohol-related problems are worse than for those solely diagnosed with psychosis. Alcohol and other substances may exacerbate the symptoms of psychosis and/or interfere with treatment- both psychological interventions and the prescribed drugs used to treat the symptoms of psychosis[76]. Prescribers in local drug and alcohol treatment carefully consider, and discuss with the individual, the interaction between prescribed medications. At present, we do not know if prescribing in mental health services routinely considers the **interaction of prescriptions with alcohol and/or drugs**. An audit of this is a priority.

Substance use amongst some of those with personality disorder can be impulsive and chaotic largely driven by emotional intensity leading to large doses and poly-substance-use[89].

Local Data

Amongst the GP registered population in CIoS[90], 1,021 people, and a further estimated 312 people, are recorded as both a **problem drinker[91] and as having a diagnosis of depression or anxiety**. This represents **0.2% of the GP registered population**.

In CIoS, 5,270 people have a diagnosed severe mental illness[92]. It is estimated that **7-15.5% of those with severe mental illness are drinking at a harmful level or are alcohol dependent**[93]. This could equate to 369-817 people in CIoS. Amongst the GP registered population in CIoS:

- 44 people (0.008%) are recorded as a problem drinker with a personality disorder (diagnosed);
- 26 people (0.004%) are recorded as problem drinker with a psychotic disorder (diagnosed).

[87] NICE Clinical Guidance (CG120) Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings, NICE (2011)
[88] Worsening psychiatric symptoms, poorer physical health, increased use of institutional services, poor medication adherence, homelessness, increased risk of HIV infection, greater dropout from services and higher overall treatment costs.
[89] Impulsivity, Coping Styles, and Triggers for Craving in Substance Abusers with Borderline Personality Disorder, Kruedelbach et al. (2011)
[90] 596,008 people
[91] Recorded by a GP as either a 'dependent drinker', 'problem drinker' or 'alcoholic'.
[92] The number of patients with schizophrenia, bipolar affective disorder and other psychoses as recorded on practice disease registers in 2020/21. Fingertips, OHID
[93] The epidemiology, and current configuration of health and social care community services, for people in the UK with a severe mental illness who also misuse substances: A systematic review, NICE (2015)

In local drug and alcohol treatment whether a client has a mental health need, and if they are receiving treatment for this, is recorded[94]. The national dataset does not break down 'mental health need' into specific conditions.

Overall, Table 3 shows that **71% of those in local drug and/or alcohol treatment had a mental health need** (772/1,094), with **30% of those not receiving any mental health treatment**.

A total of **15% of drug and alcohol clients** (open to treatment from April to September 2021) were **recorded as having a 'dual diagnosis'** (164/1,094). Of these, **27% were not receiving any mental health treatment**.

Table 3	April to September 2021	
Drug group	National	Local
Opiates	62%	68%
Non-opiates	68%	75%
Alcohol only	67%	66%
Alcohol and non-opiates	73%	76%
AVERAGE	**68%**	**71%**

Local drug and alcohol treatment does not record which specific mental health condition(s) a client has in a way which we can analyse. However, research[95] has suggested the following prevalence amongst clients in drug and alcohol services (table 4):

Table 4 **MH condition**	Drugs	Alcohol
Psychotic Disorders	8%	19%
Personality Disorder	37%	53%
Severe Depression	27%	34%
Mild Depression	40%	47%
Severe Anxiety	19%	32%

At present we cannot obtain data from local mental health services relating to the prevalence of clients using alcohol and/or drugs amongst their caseloads.

Support for those with mental health and alcohol/drug use

Historically, dual diagnosis guidance has mostly focused only on the needs of those with 'Severe Mental Illness' that meet the criteria for specialist secondary care mental health services. More recently, guidance has begun to recognise the need to ensure earlier access to effective treatment & care for the larger number of people with drug & alcohol problems whose mental health problems are not considered 'severe' enough to meet the threshold for specialist secondary Mental Health care, yet may also have multiple and complex needs, may use a wide range of services - often in crisis, and may be equally vulnerable and at risk.

[94] Those in structured treatment are individuals who are dependent drinkers or drinking at high risk levels. Mental health need may relate to a diagnosed or undiagnosed mental health problem.
[95] Comorbidity of substance misuse and mental illness in community mental health and substance misuse services, Weaver et al. (2003)

National policy and guidance[96] clearly state that mental health is 'everyone's job' and that commissioners and providers of mental health and alcohol and drug services have a joint responsibility to meet the needs of individuals by working together.

NICE has produced two pieces of guidance relating to dual diagnosis (CG120[97] and NG58[98]). NICE Quality Standard 188[99] outlines that this should be delivered through 4 quality statements:

- **Initial identification of coexisting problem drinking and/or drug use** through asking people as soon as possible when they attend services such as mental health, emergency departments, general practice and within the criminal justice system.
- People with a severe mental health illness and problem drinking/drug use are **not excluded** from either service upon referral or presentation.
- **Care coordinators** working in mental health services in the community can liaise with the different services (e.g. health, social care and housing services) and act as a central point of contact for the person, their carers and service providers.
- Any **missed appointments** are promptly and actively **followed up**.

The *Improving Access to Psychological Therapies Manual*[100] for all commissioners, providers and clinicians outlines that IAPT and drug/alcohol treatment services should work together to address a person's needs.

Locally, the Adult mental health strategy for Cornwall and the Isles of Scilly[101] includes a continued focus on problem drinking and/or drug use and mental health. The **CIoS Dual Diagnosis Strategy 2019-22[102]** outlines the principles and local commitment for supporting those experiencing these combined issues, based on national guidance.

The strategy promotes an attitude of 'no gaps' in service provision to ensure that everyone receives a humane professional response, and an offer of continuing help appropriate to their presenting needs and abilities in all cases.

Figure 16 provides the framework to identify the appropriate **lead agency** for each person with a dual diagnosis. Professionals should discuss where a person falls within this framework and consider the **diversity and complexity of a patient's wider needs, as well as their preferred choice** of setting. If professionals cannot agree the care pathway then this should be escalated to the multi-agency team leaders group, then if required, the senior operations group.

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[96] Better care for people with co-occurring mental health, and alcohol and drug use conditions, PHE (2017)
[97] NICE Clinical Guidance (CG120) Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings, NICE (2011)
[98] NICE Guideline (NG58) Coexisting severe mental illness and substance misuse: community health and social care services, NICE (2016)
[99] Coexisting severe mental illness and substance misuse, Quality Standard [QS188], National Institute for Health and Care Excellence (2019)
[100] The Improving Access to Psychological Therapies Manual, NHS (2018)
[101] Futures in Mind, Adult mental health strategy (2019-2024), Cornwall and Isles of Scilly Health and Care Partnership.
[102] CIoS Dual Diagnosis Strategy (2019)

Figure 16

Lead Agency for care coordination	Severity of mental health problem Low	High
Low Severity of problematic substance misuse	**Drug & Alcohol worker leads/co-ordinates care within primary care** **Support, advice, assessment or review from CMHT** **(illustration:** a person who undertakes recreational misuse of stimulants with low mood and some risk of self-harm)	**CMHT worker leads/coordinates care under Care Program Approach framework** **Support, advice, assessment or review from Drug & Alcohol Service** **(illustration:** a person with a psychotic illness whose occasional binge drinking and experimental misuse of other substances de-stabilises their mental health)
High	**Drug & Alcohol worker leads/co-ordinates care** **Support, assessment or treatment interventions from CMHT** **(illustration:** a person who is physically dependent upon alcohol who experiences anxiety)	**CMHT worker leads/coordinates care under Care Program Approach framework** **Support, advice, assessment or treatment interventions from Drug & Alcohol Service** **(Illustration:** a vulnerable person with schizophrenia who injects heroin on a daily basis). [1]

National guidance and evidence are clear that **specific 'dual diagnosis' services should not be created**. However, dedicated co-ordination can impact positively on reducing handoffs and gaps, and improving joint working. The Dual Diagnosis steering group are looking to develop a co-ordinator role.

Any lead agency and care coordinator should expect **timely support, guidance, and appropriate specialist interventions from the othe**r in order to coordinate care and manage risk successfully.

Assessment & treatment interventions from both mental health and drug & alcohol services should **not be carried out in a linear fashion**, as the complex needs of this group usually require a **range of interventions simultaneously** to reduce risk, minimise harm, and improve treatment engagement.

One exception to this is where problem substance use may be causal of mental health problems. This is most often found in the case of alcohol and neurotic disorders when a reduction in alcohol consumption (or abstinence) may have a

direct effect to reduce significantly symptoms of anxiety or depression arising simply from alcohol use.

Whilst there are excellent examples of joint working both before the strategy was created and currently, still those with mental health problems and substance use report difficulties in accessing the support they need:

- Long waiting lists for mental health services such as IAPT, demand for mental health services is very high outstripping capacity;
- Services such as drug and alcohol treatment, domestic abuse and sexual violence, Housing and voluntary sector organisations having to 'hold' extremely complex mental health cases with little support from secondary mental health services;
- Delays in assessments due to a person's drinking and/or drug use.

The **Dual Diagnosis Multi-Agency implementation Group** was formed in Autumn 2021 with representatives from across mental health and drug and alcohol services with an implementation plan in progress. The group provides an opportunity for joint learning and discussion between services to develop professional relationships. This Group is supported by an escalation process, to managers and commissioners, should practitioners be unable to unblock any obstacles or overcome any challenges.

Nationally the **Community Mental Health Transformation Plan** (CMHTP, part of the NHS Long Term Plan[103]) seeks to develop a new integrated model of primary and community mental health for people with severe mental illness. Locally this will focus on creating an integrated mental health system between primary care, secondary care, the voluntary and community sector, and the Local Authority (Public Health, Adult Social Care and Housing). This is a three-year programme that commenced in 2021. The need for culture change; co-production with those who have lived experience; and large changes to the management of data are all acknowledged.

In terms of prevention and identification, all those with a severe mental illness (SMI) should be offered a Health Check which includes alcohol screening using AUDIT. In 2020/21, 1,480 SMI patients in CIoS received an alcohol check some of which would have been part of a full health check. Table 5[104] indicates that SMI patients were **least likely to receive an alcohol check** compared to all other types of physical health check.

Table 5
Count of patients to have had each physical health check- CIoS

Alcohol	Blood Glucose	Blood lipid	Blood pressure	BMI Weight	Smoking
1,480	1,937	1,674	1,825	1,970	2,097

Addressing the risk factors for those with low and moderate mental health problems and raising the need to work with partners to ensure that health checks for those with serious mental illness include alcohol screening, with

[103] The NHS Long Term Plan (January 2019)
[104] Physical Health Checks for people with Severe Mental Illness, NHS England (2022)

advice and guidance, are priorities. This could also be joined up with the work investigating tobacco cessation in this population.

Providers and services supporting this vulnerable population have an important role in identifying and supporting their health and wellbeing needs. Working collaboratively with wider voluntary and community sector has the potential to provide additional capacity. Increasing the prevention agenda and supporting those with low level mental health needs are a priority for development.

Self-harm and Suicide

Suicide **rates for CIoS are significantly higher** than in both England (10.0) and the South West (11.6) at 13.1 per 100,000 people aged 10 years and over (2018-2020). Local rates of emergency hospital admissions for intentional self-harm are also higher than nationally.

Each death by suicide represents an individual tragedy and a devastating bereavement with every death estimated to affect **135 people** who knew the person[105] including family, friends, co-workers, peers and those in the wider community.
As suicide is associated with a range of factors, **prevention requires a joined-up, whole system approach** which includes health and care, local government, criminal justice services, the voluntary and community sector as well as action by individuals- suicide prevention is everyone's business.

Cornwall has an effective and efficient **Real Time Surveillance System** (RTSS) which tracks anonymised data relating to suspected and registered suicides[106] in order to implement postvention support and identify themes and risks. The learning from this is used to implement suicide prevention in a timelier manner and is reviewed by the Suicide Surveillance Group to inform suicide prevention strategies.

A CIoS system wide suicide prevention strategy is planned to be launched later in 2022 and is currently out for consultation. The vision is a CIoS with zero suicides where people live healthy, happy and fulfilling lives; and where anybody in need and in crisis is supported by their communities and services that work together to improve wellbeing and prevent suicide. This is underpinned by the aim of reducing the suicide rate in CIoS to be in line with the national average or lower by 2027[107].

[105] How Many People Are Exposed to Suicide? Not Six, Cerel et al. (2018)
[106] The confirmation and registration of a suicide is a matter for the Coroner and occurs some months after the death. Therefore, RTSS figures are likely to be an overestimate due to the inclusion of suspected suicides. See Appendix G for more detail on suicide data.
[107] Draft Suicide Prevention Strategy 2022-2027, Public Health, Cornwall Council (2022)

Local data

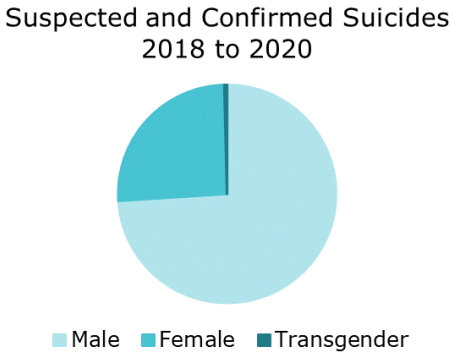

Figure 17

From January 2018 to December 2020 there were 246 suspected or registered deaths by suicide in CIoS (RTSS database). Both locally and nationally suicide rates for **males are 3 times higher than for females** (Figure 17). The majority of deaths occurred amongst those **aged 47-60** (29%) followed by those aged 33-56 (22%). Whilst rates are lower among young people, suicide remains a leading cause of avoidable death in this group.

Due to delays in the registration of suicides, compounded by the pandemic, it is too early to draw any conclusions from local data about the impact of the pandemic on suicide. For 2020 as a whole, rates were lower nationally than in 2019 but around half the deaths reported will have occurred in 2019[108].

Public Health undertake a *Suicide Audit* using RTSS data with the most recent edition in 2018[109] considering deaths from 2013 to 2017. The audit found that generally trends in CIoS conformed to those observed nationally. An Audit of deaths (suspected and registered) in 2021 is currently being finalised. Characteristics below are those identified in the audits as increasing the risk of death by suicide:

- Males, however the proportion of female deaths in 2021 was higher than in recent years and was mainly within the 50-59 year age group;
- LGBTQ+;
- Those who are single;
- Unemployed;
- History of self-harm;
- Those with a mental health diagnosis in the 12 months before death.

The audit has highlighted a number of recommendations:

- A focus on women, with suicide awareness to be included in menopause guidance and training programmes;
- Employment, including linking in with the Department for Work and Pensions and Job Centres and Pentreath;
- Collaboration with Domestic Abuse and other services to better understand risk factors in these areas;
- The need for more robust data collection around self-harm and suicide attempts.

The relationship between alcohol, self-harm and suicide

There is a strong association between problem drinking (either long-term or acute) and suicidal thoughts, suicide attempts, and death from suicide[110]. **The**

[108] Suicides in England and Wales: 2020 registrations, ONS (2021)
[109] Suicide surveillance in Cornwall and Isles of Scilly, Cornwall Council Public Health (2018)
[110] Alcohol use disorder and risk of suicide in a Swedish population-based cohort, Edwards et al. (2020)

risk of suicide is as much as eight times greater when someone is a problem drinker[111]. Alcohol may decrease inhibitions and increase impulsivity, increasing the risk of suicidal behaviour[112]. Furthermore, acute alcohol use may be associated with use of more lethal methods[50].

Men are at higher risk of suicide and are more likely than women to turn to alcohol when they are in distress[113]. In addition, people living in the poorest communities are often the most affected—with higher rates of suicide[114].

Whilst not everyone who self-harms intends to end their life, self-harm is considered as a risk factor for suicide as there is clear evidence to support a link between the two. The relationship between alcohol and self-harm is complex. A study looking at hospital admissions for self-harm found that alcohol use was associated with a greater risk of self-harm repetition[115]. Another study found that amongst females, alcohol consumption increased substantially around the time of self-harm [116]. Research that conducted interviews with eleven people with a history of self-harm revealed that[117]:

- Alcohol can be an enabler for self-harm through lowering inhibitions;
- Drinking was used by some as a prevention strategy;
- Self-harm can be exacerbated by drinking at the time or lead to more severe injuries;
- Some classed drinking itself as a form of self-harm.

Local data- alcohol, suicide and self-harm

Alcohol was reported to have been taken at the time of death in 22.6% of cases in 2013-17. This increases to 29% when excluding missing, incomplete cases and those not known. Looking at RTSS figures for **2018-2020, 17%** of suspected and registered suicides are recorded as having taken **alcohol at time of death** (42/246). However, this rises to 33% when excluding missing, incomplete cases and those not known.

The intention behind the use of alcohol at time of death is unknown, but the act would be likely to reduce inhibitions and increase impulsive behaviour. Amongst **all local drug related deaths** in 2020, 11 (27.5%) cases had alcohol present at time of death of which only 2 deaths involved an amount of alcohol defined as significant [118]. This continues the downward trend in alcohol use at time of death since 2017. **Previously alcohol was a major factor in drug related deaths**.

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[111] Preventing suicide: a global imperative. World Health Organization (2014)
[112] Alcohol consumption and suicide, Sher (2006)
[113] Gender differences in response to emotional stress: an assessment across subjective, behavioral, and physiological domains and relations to alcohol craving, Chaplin et al. (2008)
[114] Dying from inequality: Socioeconomic disadvantage and suicidal behaviour, Samaritans (2017)
[115] Alcohol use and misuse, self-harm and subsequent mortality: an epidemiological and longitudinal study from the multicentre study of self-harm in England, Ness et al. (2015)
[116] Alcohol dependence, excessive drinking and deliberate self-harm, Haw et al. (2005)
[117] Alcohol and self-harm: a qualitative study, Alcohol Change UK (2021)
[118] Drug related deaths report, Safer Cornwall (2021). Drug related deaths are deaths where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances listed in the Misuse of Drugs Act 1971, as amended, are involved.

Between 2013-2017, **among those who took their lives with ongoing and current mental health conditions** there were 288 diagnoses. The most common diagnosis was depressive illnesses (38%) followed by anxiety disorders (17%), then **problem drinking** (13%)[119].

10% of persons who died by suicide from 2013-2017 had a **current and ongoing diagnosis of problem drinking**. By gender the rate was very similar. The age group with the highest proportion of problem drinking was **30-39** at 20% of those who died (Figure 18). Those aged over 70 or under 20 were the least likely to have a diagnosis of problem drinking.

Figure 18

Another data source is our local drug and alcohol treatment caseload. Information from clients' most recent risk assessment forms, for those in structured drug/alcohol treatment in 2021/22, reveals that out of 3,201 clients:

- 30% had either a history of suicidal ideation or had recently had suicidal ideas;
- 27% had either historically attempted suicide or had recently attempted suicide;
- 19% had either historically self-harmed or recently self-harmed (non-suicidal).

The suicide prevention programme should investigate the relationship between self-harm, suicides and both drug and alcohol use to better understand the local impact and inform future public health interventions. A piece of work around avoidable deaths (drug related, domestic homicides and deaths in treatment) is planned for 2022/23 and this would benefit from working with the Suicide Surveillance Group and Multi-agency Suicide Prevention Group. Consistent collaboration across the suicide prevention programme will help recognise opportunities to intervene to support those at risk of self-harm and/or suicide.

Alcohol related brain damage (ARBD)

Alcohol-related brain damage, or alcohol-related brain injury (ARBI) is an umbrella term used to describe the damage that can happen to the brain as a result of long-term heavy drinking. There are different forms of ARBD:

- **Alcohol-Related Dementia**: symptoms are similar to Alzheimer's Disease.
- **Alcohol Amnesic Syndrome**: involves short-term memory loss, difficulty concentrating, and confabulation (filling gaps in memories with irrelevant or inaccurate information).
- **Alcohol related cognitive impairment** (ARCI): Difficulties with memory, concentration, reasoning, processing information, planning ahead and sense of direction.

[119] These proportions are of the total diagnoses made, not the number of individual's diagnosed with certain conditions, therefore some individuals may have had multiple diagnoses. The impact of multiple diagnosis on risk was not explored in the audit.

- **Wernicke-Korsakoff's Syndrome** (WKS): Associated with thiamine (vitamin B1) deficiency, which if severe may lead to swelling of the brain known as **Wernicke's Encephalopathy** (WE). Symptoms include confusion and impaired eye movement, speech, balance and co-ordination. If untreated WE can lead to a long-term condition known as Korsakoff's Syndrome/ Psychosis which severely affects memory, reduced ability to make new memories and recall past memories alongside confusion and confabulation.
- **Damage to the frontal lobe**: problems controlling impulses, making decisions, setting goals, planning, problem-solving, assessing risk and prioritising activities. The frontal lobe also controls personality and moral conscience.
- **Hepatic encephalopathy**: Damage to the brain may also be a result of hepatic encephalopathy (HE). This occurs when the liver has been severely damaged (often by alcohol).

Heavy drinking damages brain cells and makes it harder for the body to absorb vitamin B1 (thiamine). Drunkenness can lead to falls and fights increasing the risk of brain injury. Alcohol withdrawal can also damage the brain.

Prevalence

Nationally, ARBD is known to be **underdiagnosed** and there are varying statistics on prevalence. ARBD is often mistaken for conditions such as Alzheimer's Disease. However, unlike Alzheimer's ARBD is not progressive and with the right treatment **75% of people can recover to some degree** with the remaining 25% requiring long-term residential care[120].

Research suggests that:

- Around 0.5% of the UK adult population have some changes in their brain as a result of their alcohol use[121]. This could equate to 2,390 people in CIoS;
- Prevalence amongst dependent drinkers could be as high as 35%[122] with 12.5% of those having WKS[123]. This equates to an **estimated 2,439 people in CIoS of whom 871 may have WKS;**
- ARBD accounts for 10-24% of all cases of dementia.

Amongst the GP registered population in CIoS, 0.006% of patients (34) have a diagnosis of WKS and 0.005% (30) a diagnosis of alcohol-related dementia. This is very likely to be an underestimate as it only includes those who have had a formal diagnosis. There can also be delays between receiving a diagnosis and having this added to GP records.

Adult social care data currently **does not record ARBD**. It is likely that ARBD is recorded as dementia then distinguished as ARBD in case notes which we are unable to access/extract.

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[120] Management of Alcohol Korsakoff Syndrome, Smith and Hillman (1999)
[121] An international perspective on the prevalence of the Wernicke-Korsakoff Syndrome, harper et al. (1995)
[122] Brain lesions in alcoholics. A neuropathological study with clinical correlations, Torvik et al. (1982)
[123] What is alcohol-related brain damage?, Alcohol Change UK

Patients with ARBD tend to present at around **40 to 60** years old, with **women seemingly more vulnerable** as they present at a younger age than men, with a shorter period of chronic problem drinking[124].

Prevention and diagnosis

There is no dedicated separate NICE guidance for ARBD. Guidance refers to offering thiamine (vitamin B1) for those at risk of developing, or with suspected, Wernicke's Encephalopathy (WE) undergoing withdrawal from alcohol[125].

Those at risk of, or with ARBD, often are those who are frequent attenders to hospital and/or treatment resistant drinkers with multiple complex health and care needs. People with ARBD can be exposed to risks to their health, safety and wellbeing. This could be through self-neglect, physical health problems, falls or risks posed by others such as domestic abuse and exploitation. In some circumstances interventions using legal frameworks through assessment of mental capacity under the Mental Capacity Act 2005 may be necessary to keep a person safe.

Assessing mental capacity in relation to ARBD can be difficult. Capacity can fluctuate and professionals can find interpreting the legislation in the context of problem drinking challenging. A local case study from Adult Safeguarding has illustrated that a **lack of legal literacy around the Mental Capacity Act and ARBD** has led to a delay in assessing capacity. The multi-disciplinary team (MDT) for this case assumed that the patient needed to be 'sober' in order to conduct an assessment. This rarely happened (only when in hospital) due to the nature of the person's alcohol dependency.

RCHT have clinical guidance in place[126] for patients both at risk of and diagnosed with ARBD covering the administration of thiamine, monitoring of cognition and management of a diagnosis.

A patient affected and diagnosed in hospital, is referred to the ARBI Rapid Response Group- a MDT to support management and discharge consisting of the Alcohol Liaison Team, Hospital Outreach Team (commissioned community treatment provider), adult safeguarding, psychiatric liaison, a mental health and wellbeing nurse, and occupational therapy. The patient is also referred to Adult Social Care to arrange an appropriate care package or long-term placement upon discharge. **A similar process is required in the community.**

Care for those with ARDB

For those with diagnosed WKS, a long-term placement should be offered in[127]:

[124] Alcohol and brain damage in adults with reference to high-risk groups, Royal College of Psychiatrists (2014)
[125] NICE Guidance (CG100) Alcohol-use disorders: diagnosis and management of physical complications, NICE (2017)

[126] Patients diagnosed with Alcohol Related Brain Injury Clinical Guidance, RCHT (2019)
[127] NICE Guidance (CG115) Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence, NICE (2011)

- Supported independent living for those with mild cognitive impairment;
- Supported 24-hour care for those with moderate or severe cognitive impairment.

Both settings should be adapted for people with cognitive impairment and support should be provided to help service users maintain abstinence from alcohol.

Currently, the options available for those with ARBD in Cornwall are:

- Returning **home** with an appropriate care package and support from family for those with mild cognitive impairment;
- **Residential alcohol rehab**, this would be a short-term placement if appropriate;
- Placement at one of a few **specialist ARBD units** in the UK. However, none of these are in Cornwall, they are costly to fund and demonstrate little in the way of therapeutic input. Relocation can negatively impact recovery as continuity of care is broken and patients are isolated from their support network of friends and family;
- A **residential/nursing home** may be suitable for individuals with more significant cognitive impairment and/or higher care needs. This could be short or long-term. However, a lack of specialised rehabilitation options and older residents can prevent improvement in cognition resulting in further functional losses and cause development of mental health problems through isolation and boredom.

As capacity can fluctuate, any care provided must be flexible and understand ARBD and the impacts this can have on a person's behaviour and needs. Those who make a recovery may benefit from long-term follow-up and support in the community to reduce the risk of relapse.

The case study below from the Alcohol Liaison Team at RCH demonstrates the challenges in obtaining appropriate care for those with ARBD and how their care needs change as capacity fluctuates.

Our priorities are to increase our understanding of the number of individuals impacted by ARBD and to develop local provision to improve quality of care and outcomes for residents impacted.

Harms to the drinker – socioeconomic

The national Drugs Strategy emphasises the importance of housing and employment support in treatment and recovery. Areas are expected to enhance collaboration with employment and housing services to create pathways into support.

Employment

Problem drinking may be a cause or a consequence of unemployment. It is a predictor both of unemployment and of future job loss with evidence also suggesting that after job loss alcohol consumption may increase[128]. Drinking is strongly associated with unemployment for both men and women[129]. A report by the Chief Medical officer highlighted that a lack of good quality, stable jobs in coastal communities contributes to poorer health outcomes[130].

Unlike dependence on heroin and crack cocaine, alcohol dependence is not strongly associated with lower socioeconomic status although the harms of alcohol are[131]. The employment rate for those who develop alcohol dependence is much lower than the rest of the population. Only 38% of those in alcohol-only treatment in England in 2019/20 were in regular employment (28 days prior to treatment) compared to the overall UK employment rate of around 75%.

Dame Carol Black's 2016 independent review[132] on the impact of problem drinking and drug use on employment outcomes highlighted that **employment needed to be a more integral element of addiction treatment.** Recommendations included working with employers and making significant changes to the benefit system ensuring a more robust offer of support.

Employment needs of the treatment population

The employment status of clients at the **start of treatment** for alcohol and/or drugs in Cornwall is recorded (Table 6) and is reported through NDTMS[133].

Table 6 Employment status on presentation	2017/18	2018/19	2019/20	2020/21
In regular employment	29%	31%	36%	32%
Unemployed/Economically inactive	42%	42%	43%	48%
Long term sick/disabled	25%	23%	19%	16%
In education	1%	1%	1%	1%
Unpaid/voluntary	0%	0%	0%	0%
Other	3%	2%	1%	2%
Not in work	**67%**	**65%**	**62%**	**64%**

[128] Unemployment as a disease and diseases of the unemployed, Janlert (1997)
[129] Does Unemployment Lead to Greater Alcohol Consumption? Popovici and French (2013)
[130] Chief Medical Officer's annual report 2021: health in coastal communities
[131] Understanding the alcohol harm paradox: what next? Bloomfield (2020)
[132] An independent review into the impact on employment outcomes of drug or alcohol addiction, and obesity, Department for Work and Pensions (2016)
[133] Information on those entering structured treatment is recorded through our case management system, Halo, and forms part of the National Drug Treatment Monitoring System (NDTMS) dataset.

- Around two in three people were not in work when they started treatment;
- A slight increase in those classed as unemployed/economically inactive; (+6%) has been outweighed by greater changes in long term sick/disabled (-9%) and regular employment (+3%);
- When looking at **alcohol only clients** in 2020/21 **a higher percentage enter treatment in regular employment** (36%) and the same proportion of clients are long term sick/disabled (16%) and fewer are unemployed/economically inactive (44%) meaning 60% overall were not in work.

An extract from our case management system (Halo) was used to provide insight for the alcohol only and alcohol and non-opiate treatment cohorts in 2020/21[134].

Categories differ from those reported by NDTMS but looking at employment status prior to treatment (Figure 19), around **1 in 3 clients were employed or in education.**

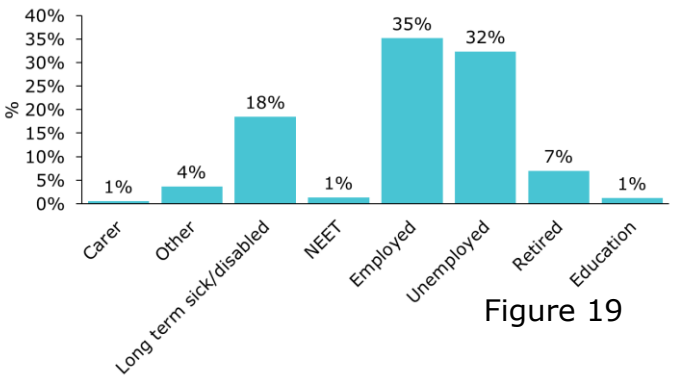


Figure 19

Figures for the alcohol only cohort locally in 2020/21 reported through NDTMS are similar to those observed nationally.

Additionally, data is captured when clients **exit treatment**. A positive outcome is considered to be 10 days in employment out of the previous 28 days. It should be noted that this data **does not capture other positive outcomes** such as engagement in education, training or volunteering.

The latest quarterly DOMES report[135] (Q3 2021/22) indicates that **1 in 3** of those exiting alcohol only and alcohol and non-opiate treatment in Cornwall are meeting the 10 day target which is similar to national figures.

This suggests that **treatment has little impact on changing employment status for alcohol clients** with the same proportion employed at the end of treatment as at the start of treatment (1 in 3).

Successful treatment exits for alcohol only and alcohol and non-opiate clients were analysed by initial employment status. **Those who were long-term sick/disabled made up 23% of unplanned closures compared to 13% of planned closures** suggesting that this employment status has the biggest impact on treatment outcomes. This group made up 16% of the closure population. Many of those who died in alcohol treatment in 2020/21 had long-term health conditions as explored on page 119.

[134] Numbers below differ slightly from those reported by NDTMS, as our extract only relates to those who had an open episode in 2020/21 therefore excludes those who had both an episode open in 2021/22 and 2020/21.
[135] Diagnostic Outcomes Monitoring Executive Summary or DOMES; a detailed performance report covering the whole treatment system provided by OHID quarterly.

Personal Independence Payments (PIP)

Unfortunately, local data on benefit claims due to alcohol dependence is no longer recorded by the Department for Work and Pensions. In 2016 the rate of claimants for alcohol dependence in CIoS was 16% above the regional rate and 23% above the national rate. Local data is however available for PIP claims.

PIP data for July 2021 provides a snapshot of the number of claims and entitlements for 'alcohol misuse' and alcohol-induced cirrhosis (liver disease). Numbers are quite small therefore should be interpreted with caution.

- There were 82 PIP cases with entitlement for 'alcohol misuse' and 14 cases with entitlement for alcohol-induced cirrhosis in July 2021. These figures represent 0.32% and 0.05% of all PIP cases respectively and are very similar to national proportions (0.31% and 0.05%).
- Around **two in three claimants for 'alcohol misuse' are male**. Claims for alcohol-related cirrhosis are even by gender.
- For PIP cases of 'alcohol-misuse', the most likely claimant age is **55-59**.
- The areas of St Austell and Newquay; and Truro and Falmouth have the highest percentages of 'alcohol misuse' cases as a proportion of all PIP cases.

Local case studies (Appendix H) from service providers have highlighted that **retrospective back payments of benefits** including PIP, providing lump sums of thousands of pounds, are a great risk to recovery. Individuals can relapse, disengage with services, their mental health decline and become more vulnerable to exploitation. This is a problem contributing to early leavers and unplanned discharges from residential services (tier 4).

National legislation currently prevents any changes to PIP reimbursements, such as issuing in instalments. Citizens Advice have taken this up as a **national campaign** with local service users being interviewed and sharing their experiences.

Initiatives

Within Jobcentre Pluses Disability Employment Advisors (DEAs) offer direct 1:1 support for 13 weeks to individuals with health conditions seeking work.

The **Work and Health Programme** (WHP) is a national initiative aimed to help people find employment. Those where previous or current problem drinking or drug use is preventing them from getting work are amongst those eligible. Individuals are supported by jobcentres to identify employment needs; engage with employers; upskill and manage their health problems. People are supported for up to 15 months but this may be extended by 6 months to provide in-work support.

The national **Restart** Scheme, funded by DWP, supports Universal Credit Claimants who have been out of work for at least 9 months to find jobs in their local area. An employment advisor offers 1:1 coaching, as well as support to enhance health and wellbeing and priority access to local services e.g. Citizens Advice. They also support individuals once they have found employment.

The **People Hub** in CIoS provides free and confidential information, advice and support to individuals looking to get back into work, employment and training, as well as linking people with support for housing, debt, and mental health. They work with organisations across Cornwall to help break down barriers to employment. People Hub also work closely with another local initiative, **Health Works** Cornwall, who are partnership of local organisations aiming to support those with health-related barriers into employment.

For those clients who are further from the labour market, the **Positive People Programme** is delivered by Pluss in partnership with many Cornish organisations including our commissioned community treatment provider.

Coaches provide bespoke support to individuals and work to agree and regularly review an action plan which will target progression in terms of training, job search and employment. Health and wellbeing support is provided in the form of online activities and 1:1 interventions around improving sleep, diet, mental health and managing stress and anxiety. There is also the opportunity to become a peer mentor for the programme and gain an industry-recognised qualification. The programme was delivered online during the pandemic with workers being creative and flexible to engage individuals and communities.

In 2020/21, 224 clients in community treatment engaged in the programme (46% female; 54% male) of which 63 were ex-offenders. 113 participants (50%) achieved successful outcomes:

- 35 in paid employment
- 74 in education/ training
- 22 into active job search.

Some participants also accessed specialist support including trauma focused therapy for males and group support for female survivors of domestic abuse and sexual violence.

Case Study

This case study can be read in full here. It highlights the story of Kelly, who escaped two abusive marriages and was struggling with complex post-traumatic stress syndrome, eating disorders and alcohol use.

Kelly was deemed too ill to work and this made her feel worthless. Some **services had been dismissive of her mental health**, which left her feeling that she constantly had to prove her experience which was stressful.

Kelly accessed support from With You for her mental health and alcohol use and her worker referred her to Positive People. Kelly reported that **positive relationships** with her **Change Coach and peer mentor** helped her access the volunteer training programme. She has **started an administration role** with Positive People.

For those in problem debt the **Breathing Space** scheme offers legal protections from creditors for 60 days, with most interest and penalty charges frozen, and

enforcement action halted. Individuals will also receive professional debt advice to helps get their finances back on track. For those in a mental health crisis this support is for the full duration of their crisis treatment plus another 30 days.

The new **Individual Placement and Support** programme (IPS), managed by OHID and funded through DWP, is an intensive employment support programme delivered by trained employment specialists within clinical services.

IPS is a well-evidenced approach that aims for sustained employment through mainstream, competitive jobs. It is based on eight principles:

1. Eligibility is based on individual choice;
2. Supported employment is **integrated with treatment**;
3. **Competitive employment** is the goal, (not sheltered placements or volunteering);
4. Rapid job search (within four weeks), minimal prevocational training;
5. Job finding, and all assistance, is individualised;
6. Employers are approached with the **needs of individuals** in mind;
7. Follow-along supports are continuous;
8. Financial planning is provided.

There is a strong focus on sourcing jobs through **local employer networks**. Employers also benefit from on-going in-work support (alongside job seekers) from the employment specialist.

Employment specialists have recently been recruited and the service started in December 2021. A local steering group provides strategic direction and operational oversight.

A recent Public Health intervention, targeting Job Centres and those stating that mental health acts as a barrier to employment, has shown to be cost-effective and was able to support vulnerable populations such as those who are homeless. As this intervention is currently being recommissioned for a further three years, there is an opportunity to work with Public Health to incorporate a Making Every Contact Count (MECC) approach around alcohol. This could include ensuring that Mental Health and Employment Advisors are equipped to screen for problem drinking and offer brief advice (IBA) to support this vulnerable population.

Housing and homelessness

The government has recognised **housing as critical to successful treatment outcomes** in the new National Drugs Strategy[136]. Improving access to accommodation alongside treatment, access to quality treatment for everyone sleeping rough and better support for accessing and maintaining secure and safe housing, are included as part of the Government's elements in striving towards a world class treatment and recovery system.

A Public Health Evidence Review highlighted 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**

[136] From harm to hope: A 10-year drugs plan to cut crime and save lives, HM Government (2021)

residential rehabilitation. This review also highlighted a variation in housing access, with **less access in areas of high housing cost and high demand**[137].

The average age of death of a homeless person is 47 years old for men and 43 for women compared to 77 for the general population. **Problems with alcohol and drugs are particularly common causes of death amongst the homeless population**, accounting for just over a third of all deaths[138].

Many of those who are homeless or sleeping rough have multiple complex needs. Of 3,226 households assessed and **owed a statutory homelessness duty** in 2020/21 in CIoS[139]:

- Domestic abuse was the reason for loss of last settlement for 14.5% of households;
- **7.6% had alcohol dependency needs** (4.8% nationally) and 7.7% drug dependency needs;
- 29% had a history of mental health problems;
- 18.5% had a disability or were in physical-ill health;
- 3.1% were at risk of, or had experienced sexual abuse/exploitation;
- 6% had a learning disability;
- The majority were: single adult males; those aged 25-34; and unemployed.

Accommodation needs in the treatment population

The housing status of clients at the start of treatment in Cornwall is captured.

Table 7

Housing situation at treatment start	**2017/18**	**2018/19**	**2019/20**	**2020/21**
No problem	81%	81%	82%	82%
Housing problem	10%	10%	11%	12%
Urgent housing problem	8%	9%	8%	6%
Other	0%	1%	0%	0%

The **majority of clients have no housing problem upon entering treatment** which has remained fairly stable over the 4-year period (Table 7). **More alcohol only clients had no housing problem** in 2020/21 (+6%) compared to all substance groups. Only 4% of alcohol only clients had an urgent housing problem.

In 2020/21, for local alcohol only clients, proportions by initial housing status were similar to those observed nationally. In CIoS 89% of planned exits from treatment had no housing problem compared to 84% nationally. This figure only relates to 16 clients therefore should be interpreted with caution.

[137] An evidence Review of the outcomes that can be expected of drug misuse treatment in England, Public Health England (2017)
[138] Health matters: harmful drinking and alcohol dependence, PHE (2016)
[139] Initial assessments of statutory homelessness duties owed, England, April 2020 to March 2021, Department for levelling Up, Housing and Communities (2021)

Looking at data for the latest quarter (Q2 2021/22), **99% of alcohol and alcohol and non-opiate clients left treatment with no housing problem**. Nationally this was slightly lower for alcohol and non-opiate clients at 97%.

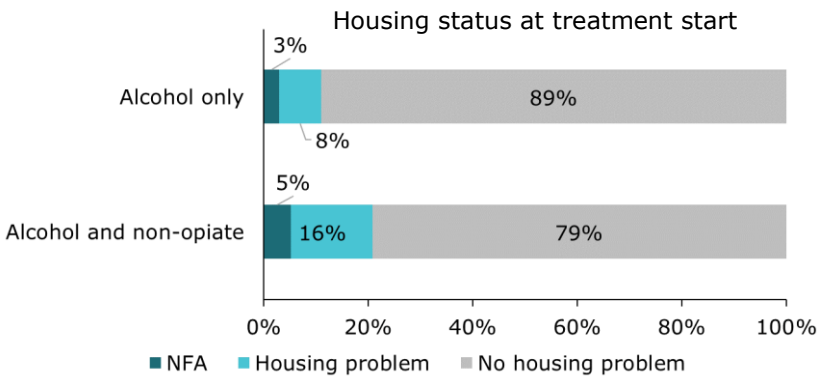


Figure 20

Local data, for those with an open treatment episode in 2020/21, reveals that **alcohol and non-opiate clients are 10% more likely to have a housing problem** than alcohol only clients at the start of treatment (Figure 20).

Those with a housing problem (urgent due to no fixed abode and non-urgent) accounted for 14% of all closures but made up 20% of unplanned closures compared to 11% of planned closures. This suggests that **an initial housing problem can have a negative impact on treatment outcomes**.

The Rough Sleeper Drug and Alcohol Treatment grant provides funds to Local Authorities to enable those who are, or at risk of, rough sleeping to access treatment including detox and rehab. Between October to December 2021, in Cornwall 48 people were sleeping rough with a further 1,837 at risk. Of the 241 people assessed:

- 171 (71%) had an alcohol and/or drug need of which 72 then engaged in treatment;
- Only 28% were registered with a GP;
- The majority of people at risk of rough sleeping either lived with friends or family, privately rented, or were in temporary accommodation provided by the council at the start of engagement;
- All rough sleepers were male and around one in 5 of those at risk were female;
- The majority of rough sleepers and those at risk were aged 30-34;
- 148 (62%) engaged in mental health treatment after being assessed.

HomeChoice

Homechoice is the system for letting council and housing association homes to rent in Cornwall where applicants bid for properties. We have a snapshot of the proportion of current live HomeChoice applications with self-declared alcohol and/or drug dependency. Out of a total of 20,375 live applications:

- 303 are flagged for just alcohol dependency (1.5%)
- 100 are flagged for both alcohol and drug dependency (0.5%)

Out of the 403 applications with alcohol dependency, 8.7% are classed as Homeless-Statutory (owed a duty) and a further 24% Homeless-Other.

Applications are assessed and given a priority banding from A-E. Those banded A are considered to be in greater need of housing therefore are more likely to secure a property.

The same proportion of applicants are banded as A across all three categories (5%, Figure 21).

Alcohol only or alcohol and drug applicants are more likely to be banded B, C and D compared to all applicants and less likely to be banded E.

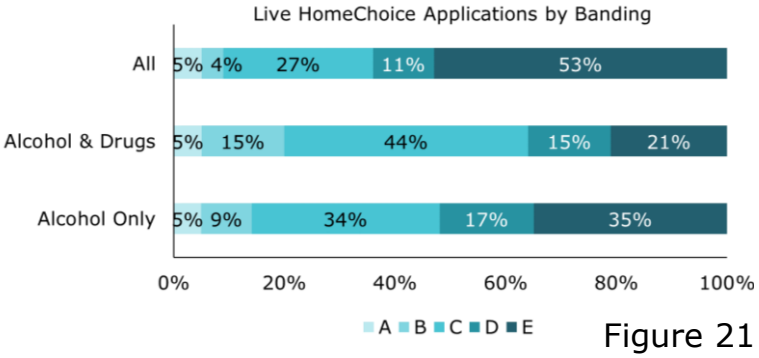


Figure 21

It is difficult to draw any conclusions from this data around whether or not those with an alcohol (and drug dependency) are receiving the correct banding. Other characteristics will affect banding, not just a declaration of an alcohol or drug dependency.

Service users raised the issue of banding with many feeling that it was 'pointless' to bid for properties due to their low banding. Some found that this was because as they had secured temporary accommodation their banding was reduced with many reporting going from a B to a D. The Domestic Abuse Safe Accommodation Needs Assessment found that there was little scope to increase banding. It appears that HomeChoice and banding is challenging for all residents not just those with a drug/alcohol dependency.

Provision

Over many years the DAAT has worked closely with supported housing commissioners and providers in **developing a staged model** of supported accommodation to meet the needs of those with drug and/or alcohol issues. These services, although having sustained massive budget cuts in recent years, are **crucial in supporting clients with complex needs**.

The DAAT has supported the development of a **pathway** for those in community treatment, in Tier 4 residential rehabilitation and those who intend to return from out of county residential placements, to **ensure clients find suitable accommodation on completion of their programme**. The Housing Pathway for those in Drug and Alcohol Treatment is **an integral part of the Council's approach to preventing homelessness**. The pathway is delivered through **joint working** between With You, Bosence, Boswyns and Cornwall Housing Limited (CHL)[140].

The **Empowering Independence service** forms part of Adult Social Care's prevention offer aimed at reducing an individual's need for formal care and support. Community outreach is delivered alongside short-term accommodation

[140] CHL is the provider of Cornwall Council's housing options/homelessness services under Housing Act 1996 Part VII as amended Homelessness Reduction Act 2017 and the Empowering Independence Services, commissioned by Adult Social Care and CHL.

for **clients with complex and/or mental health needs** including acquired brain injury. There is a mixture of accommodation with either limited or high/medium **tolerance to drugs and alcohol**.

Individuals at risk of **homelessness or rough sleeping are prioritised** for accommodation including those discharged from hospital, detoxification, rehabilitation or mental health wards.

CHL's **Nos Da Kernow** service provides brief and intense support to those experiencing housing difficulties which if not addressed may lead to homelessness. This includes those struggling to maintain their accommodation due to mental and/or physical health conditions.

A **Homeless Patient Advisor** based at the Royal Cornwall Hospital provides support and advice to patients that are homeless or are unable to return to their homes. The advisor has a good relationship with RCH's Alcohol Liaison Team.

The rollout of the **Naloxone programme**[141] to all complex needs service providers forms part of DAAT's drug related deaths reduction strategy.

CHL are re-launching the **Housing First** initiative which supports homeless individuals with complex needs. People are offered accommodation first alongside intensive personalised support to meet their needs. Housing is viewed as a stable platform from which other issues can be addressed.

Rough Sleeping Initiative (RSI) 5

Over the past 4 years Cornwall has been awarded RSI which has assisted a range of accommodation based, outreach and support services for rough sleepers. The most recent round of funding, **RSI5**, is a **3-year programme** enabling longer term service delivery with Housing consulting partners, including drug and alcohol commissioners and service providers, as to what should be included in a future bid.

Impact of the pandemic

The pandemic had a **significant impact on homelessness**, including rough sleeping in Cornwall. Rising house prices and rents alongside a staycation boom have impacted the Council's ability to access emergency accommodation and resulted in multiple moves for many households. The **demand profile has changed** from families with children to single people and couples without children. The housing options required to meet that changing demand profile are different as are the support needs of the individual households.

As part of the **Everyone In** approach[142], the Council established emergency accommodation for people sleeping rough, some of which is still operational.

[141] Naloxone is a medicine that can temporarily reverse the effects of an opioid overdose (e.g. heroin, methadone, morphine, codine or buprenorphone) making it a key part of harm reduction. See the CIoS Drugs Needs Assessment for more detail.
[142] On 26 March 2020, the Government asked local authorities in England to "make sure we get everyone in", including those who would not normally be entitled to assistance under homelessness legislation.

Despite this additional **high-tolerance accommodation** provision, the **number of rough sleepers remains at between 20-30,** and fluctuates weekly sometimes reaching as high as 40. High tolerance accommodation requires high staffing levels to manage behaviours. However, the pandemic has resulted in a range of accommodation options for rough sleepers who **previously were often excluded from more mainstream provision** due to their complex needs, challenging behaviour or lack of recourse to public funds.

COVID sites (extra emergency accommodation) and all new and existing accommodation projects work closely with the local drug and alcohol treatment provider and all staff and residents are trained in naloxone administration. The community drug and alcohol treatment service are the joint provider of the Council's **rough sleeping outreach service** with CHL- this represents best practice as recommended in The Kerslake Commission's report[143] evaluating Everyone In.

The report also outlined a number of recommendations for Local Authorities:

- Partnership working and joint commissioning with integrated care systems;
- Longer contracts and funding settlements to allow time to build practice and a culture;
- Take a test and pilot approach adapting to changing circumstances;
- Use of pan-regional commissioning;
- Improve consistency and comparability of datasets;
- Removal of the requirement to verify if someone is rough sleeping before they can engage with a service;
- Specialist workers (mental health and drugs and alcohol) in outreach teams;
- Conduct long-term strategic planning for winter peaks;
- Ensure all services and support (health, housing, benefits advice etc.) are person-centred, trauma-informed and psychologically informed;
- Consider the vulnerabilities of young LGBTQ+ individuals who face unique experiences of abuse, harassment and harm;
- Work with all agencies including housing, healthcare and welfare to enhance understanding of complex needs.

Across all temporary COVID-19 accommodation, **28 clients were evicted in relation to problem drinking** as of August 2021. Many cases had additional complex needs including mental health, sex work, violence and offending. Eviction decisions are not taken lightly and clients are re-considered after a short time or are referred to other sites.

The Council recently delivered 2 further emergency accommodation **Bunkabin schemes** to mitigate immediate and urgent needs. Previous Bunkabin schemes have been very successful with positive feedback from residents.

A Temporary Accommodation Recovery and Reform Plan has been implemented to address the immediate and urgent pressures created by the number of households who have had to be accommodated in temporary accommodation.

[143] A new way of working: ending rough sleeping together, The Kerslake Commission on Homelessness and Rough Sleeping (2021)

Where preventing homelessness was not possible, efforts have increased at **getting to know the rough sleeping cohort** and their **needs and aspirations** through regular multi-agency meetings with all outreach teams.

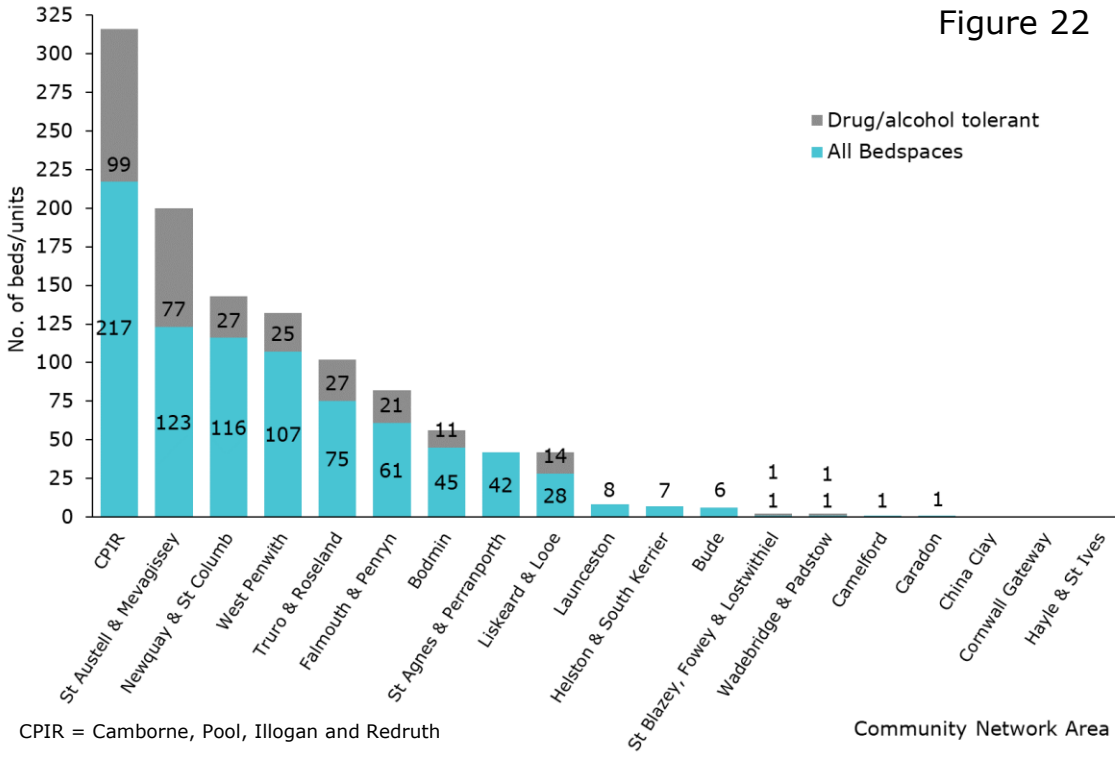
In addition to emergency accommodation, a successful bid means several move on units are currently in development. This provision will help the flow through the accommodation system by accommodating those ready to move out of high support accommodation into more independent living.

Since October 2020, 374 individual rough sleepers have been engaged, many of whom have been accommodated and moved on. A better understanding of the rough sleeping population and providing solutions in partnership was made possible through the development and maintenance of a shared database across outreach teams. Of the 161 current or former rough sleepers on the database from March to August 2021, **75 were linked to drugs and/or alcohol**. At present the database in **unable to distinguish between drug and alcohol needs**. A new cohort of 40 current rough sleepers has been identified to target for solutions and monitor their outcomes.

Provision in numbers

As of July 2021, across all local commissioned and non-commissioned provision there were 839 units/beds of supported accommodation in Cornwall of which **303 (36%) were alcohol/drug tolerant** (i.e. will take those who are not yet abstinent/in treatment). Of the 303 beds, 286 can accommodate mental health needs and 72 beds are for those fleeing domestic abuse. Figure 22 shows the distribution of supported accommodation in Cornwall.
A further 111 units are under acquisition or in development, 54 of which will be alcohol/drug tolerant.

Figure 22



Having around a third of supported accommodation be alcohol/drug tolerant is positive but feedback from both service users and staff has now highlighted the **need for more accommodation that is alcohol and drug free**. This is to support sustained recovery post detox and rehab. This accommodation would still have to meet other complex needs such as mental health. As of July 2021, 352 beds/units for adults (excluding provision for young people aged 16-25 and up to aged 30 in some cases) are not alcohol/drug tolerant. Of these beds/units 278 support at least one of the following needs: mental health, domestic abuse, complex needs or homelessness.

Our priority is to increase the amount of alcohol and drug free accommodation to support recovery.

Harms to others

Domestic Abuse and Sexual Violence (DASV)

DASV is a 'gender-based issue' because whilst both men and women may experience incidents of inter-personal violence and abuse, women are predominantly more likely to experience repeated and severe forms of abuse, with men being more prevalent as the person displaying abusive behaviour. DASV is rooted in women's unequal status in society and is part of the wider social problem of male violence against women and girls. **Alcohol alone is not a cause of domestic abuse or sexual violence and is never an excuse**. There are however a number of ways in which alcohol and DASV are related.

Domestic Abuse

The Domestic Abuse Act 2021 defines domestic abuse as[144]:

- The behaviour of a person towards another where both individuals are over the age of 16 are personally connected[145] and is abusive. Abusive behaviour can be:
    - Physical or sexual;
    - Violent or threatening;
    - Controlling or coercive;
    - Economic;
    - Psychological, emotional or other abuse.
- Children (under 18s) are also recognised as victims of domestic abuse if they witness or experience the effects of the abuse.

One in four women[146] and one in six men[147] will experience domestic abuse in their lifetime. The consequences of domestic abuse are far-reaching and long-lasting, for the victim and family members, particularly children. Aside from physical injuries, the psychological harm can be complex and challenging.

[144] Domestic Abuse Act 2021
[145] Two people are considered personally connected to each other if they are, or have been: married (or have agreed to be); civil partners (or have entered into a civil partnership agreement); in an intimate personal relationship; in a parental relationship in relation to the same child; or related to each other.
[146] Violence against Women and Girls and Male Position Factsheets, Home Office (2019)
[147] Statistics on Male Victims of Domestic Abuse, ManKind Initiative (2021)

It can result in death (domestic homicide and suicide). The pandemic and lockdowns escalated risk of harm for adults and children at risk of or experiencing abuse in the home and confined with their abuser.

There are a number of ways in which alcohol and domestic abuse are related[148]:

1. Abusive incidents can escalate when one or both people involved have been drinking. Alcohol is a disinhibitor. **Being intoxicated can increase risk** and a lack of access to alcohol can make someone irritable or angry which can act as a trigger. Research typically finds that between 25% and 50% of those who perpetrate domestic abuse have been drinking at the time of assault[149] although in some studies the figure is as high as 73%[150]. Locally in the 12 months to September 2021, 32% of domestic abuse crimes reported were recorded as linked to alcohol. This increases to 43% for violence against the person specifically, and 47% for violence with injury.
2. Alcohol can **increase the severity of the abuse**. Nationally, between 2014 to 2015, 16 out of 33 domestic homicides involved alcohol or alcohol and drugs[151].
3. **Controlling access to alcohol can be part of the abuse.** A person engaging in abusive behaviour may exert control by withholding alcohol, or preventing the person from buying it. For someone who is dependent on alcohol this can be extremely distressing and dangerous as withdrawal symptoms can be life threatening.
4. People who experience domestic abuse may use drinking as a **coping mechanism** for impacts of the abuse. Alcohol can also leave someone more vulnerable to further abuse, especially if drinking prevents survivors from accessing support or makes their mental health worse.
5. Those who experience and witness domestic abuse as **children** (an ACE) are **more likely to display harmful drinking patterns later in life**.

Local case studies have demonstrated both alcohol being used as a control mechanism, by the person engaging in abusive behaviour (e.g. Appendix I), and the victim relying on alcohol as a coping strategy.

Many cases of domestic abuse are characterised by **multiple vulnerabilities** around mental health, substance use, physical disability, exploitation and sex work.
An analysis of national domestic homicides between 23rd March 2020 (first national lockdown) and 31st March 2021[152] found that:

- COVID-19 acted as an escalator and intensifier of existing abuse;

[148] Alcohol and domestic abuse, Alcohol Change UK
[149] Substance abuse and intimate partner violence, Bennett and Bland (2008)
[150] Domestic Violence offenders: characteristics and offending related needs, Home Office (2003)
[151] A domestic homicide review is a multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves. Domestic homicide reviews: key findings from analysis, Home Office (2016).
[152] Domestic homicides and suspected victim suicides during the pandemic, Home Office (2021)

- Both victims and those engaging in abusive behaviours ability to manage their mental health and drug/alcohol dependency was reduced;
- Alcohol (mis)use was noted for 23% of suspects making it the **fourth most frequent risk factor identified**. Previously engaging in domestic abuse, having any mental health condition and controlling and coercive behaviour were the top three;
- Heavy alcohol use characterised some cases, sometimes by both victim and suspect;
- Adult family homicide cases included several deaths involving **alcohol-fuelled fights between brothers**.

Locally, 2019/20 saw a slowing of the increasing trend in reported domestic abuse. Previous rises are largely thought to reflect factors related to improved recording, more active encouragement for victims to come forward to report these crimes and greater victim confidence in support services.

However, an estimated two thirds of domestic abuse victims do not report the incident to the police, with higher under-reporting rates for men than women. Under-reporting continues to be identified as a major limiting factor in our understanding of the scale and nature of domestic abuse.

Although reported levels of domestic abuse stayed within a 'normal' range during the lockdown, services reported that, since the easing of restrictions in July 2020, people who had **experienced abuse hidden in lockdown** have come forward for support – the extended period without being able to access help has **caused needs to become more complex**, requiring more intensive support. During the first lockdown Cornwall saw a rise in the number of people fleeing abuse and demand for safe accommodation outweighed capacity. Over the last 12-month period, alcohol related domestic abuse crimes increased by 12%. Alcohol and crime is explored in more detail from page 92.

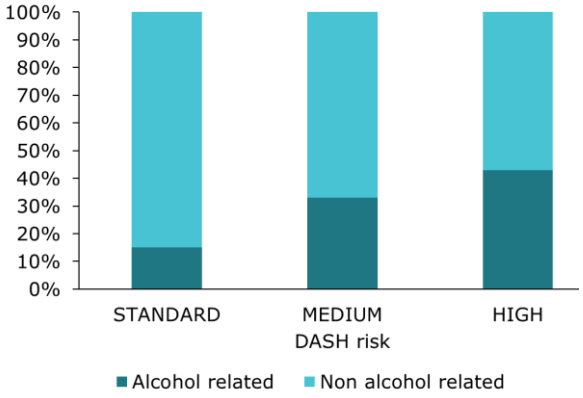
Of 1,386 clients in local DASV services with at least one open episode in 2020/21 where a DASH[153] was completed, **34% stated that the person displaying abusive behaviour had suffered with an alcohol problem in the previous year** (476 people). It is important to note that this does not represent the whole caseload as not all individuals have completed a DASH and not all will disclose that the person displaying abusive behaviour was a problem drinker.

To year end September 2021 there were 9,700 domestic abuse incidents recorded by police in Cornwall of which 6,361 were serious enough to be recorded as a 'crime'.

Of the 9,700 incidents, 20% were identified as alcohol related. 8,378 of these incidents were risk assessed using DASH.

[153] Domestic Abuse, Stalking and Honour Based Violence risk assessment and identification form.

Domestic Abuse Incidents Figure 23



While noting that less than one in twenty incidents were classed as high risk (4%), it appears that the more high risk an incident the more likely it is to be alcohol related (Figure 23).

Training run by our commissioned DASV services aims to increase the use and quality of DASH assessments undertaken by the police. For other organisations, there is a focus on improving routine enquiry and having conversations about risk and safety planning then referring to specialist services. NICE guidance recommends domestic abuse as part of **routine enquiry in drug and alcohol services**[154].

Sexual Violence

Sexual violence is the term used to describe any kind of unwanted sexual act or activity, including rape, sexual assault, sexual abuse, sexual harassment, indecent exposure or flashing, female genital mutilation (FGM) and spiking.

The impacts of sexual violence upon a person are long-lasting and include harm to mental health and emotional wellbeing, alongside other impacts such as reduced social functioning, chronic physical health conditions and negative consequences for sexual health.

National estimates indicate that around **1.8% of the population** aged 16-74 years were victims of a sexual assault in 2019/20- this equates to 7,300 victims in CIoS[155].

The 2012/13 and 2013/14 Crime survey for England and Wales analysis of serious sexual assault found that:

- Victims were more likely to report that offenders where under the influence of alcohol (36%) than drugs (10%);
- Offenders where **more likely to be under the influence of substances for violent offences** compared to serious sexual assault incidences but the ratio of alcohol to drugs was similar;
- 29% of victims reported that they were under the influence of alcohol at the time of the most recent incident of serious sexual assault;
- A higher percentage of victims were under the influence of alcohol when the offender was a stranger (38%) versus a partner/ex-partner (14%).

A person does not consent to sexual activity if they are incapacitated through drink[156]. This does not just relate to unconsciousness, as the ability to consent

[154] NICE Public Health Guideline (PH50) Domestic violence and abuse: multi-agency working, NICE (2014)
[155] Sexual offences in England and Wales overview: year ending March 2020, Office for National Statistics (2020); Mid-2019 population estimate, Office for National Statistics. Estimates are stratified by age and gender.
[156] Rape and Sexual Offences- Chapter 6: Consent, Intoxication and consent, Crown Prosecution Service (2021)

can be absent at any point on the spectrum of sobriety to unconsciousness. Being under the influence of alcohol can make someone more vulnerable to sexual violence, but it is the responsibility of others to think about whether or not a person has the capacity to consent and if there is any doubt then to assume the person is too drunk to consent.

Research around **those engaging in sexual violence** suggests that **alcohol interacts with personality and aspects of the situation**, adding to the risk of perpetration among men already **predisposed** to engaging in sexual aggression[157].

The Transforming Rehabilitation summary of evidence on reoffending[158] profiles sexual violence perpetrators by likeliness to re-offend score (OGRS). **Problematic alcohol use amongst adult males** in the 0-24% OGRS group was low but increased to a **third** in the 25-49% group.

Locally staff from Falmouth universities noted that the presence of alcohol is a regular factor in cases of alleged sexual violence (see page 96 for more detail).

In 2021, Devon and Cornwall SARC[159] received 314 referrals for adult residents in Cornwall. Of the 314 referrals, the total number of people who disclosed:

- Drugs and/or alcohol was used during the offence, 125 (40%)
- They had a problem with drugs and/or alcohol, 40 (13%)
- They had a significant mental health issue, 181 (58%)
- A history or self-harm, 103 (33%)
- Domestic abuse, 107 (34%)
- They had a disability, 62 (20%)
- They were local students, 21 (7%).

There were an additional 9 people who were seen by the Truro SARC who were residents out of area. Of those, 6 disclosed that drugs or alcohol was used during the offence.

Local Action

All best practice guidance outlines the need for: multi-agency working; specific training and support to ensure staff are competent and confident; routine enquiry for domestic abuse; and staff knowledge of local policy, thresholds and pathways into domestic abuse services for both victims and those displaying abusive behaviour.

The **DAAT-DASV protocol** was developed to improve outcomes for people affected by both problem drinking and/or drug use and DASV. This includes consideration of pre-trial therapy for victims of sexual violence to link in with Drug and Alcohol services. This has included bespoke training in domestic abuse

[157] Alcohol's role in sexual violence perpetration: Theoretical explanations, existing evidence and future directions, Abbey (2011)
[158] Transforming Rehabilitation: a summary of evidence on reducing reoffending, Ministry of Justice (2013)
[159] The Sexual Abuse Referral Centre (SARC) offers medical, practical and emotional support for those who have experienced sexual assault.

for drug and alcohol services, and a bespoke Healthy Relationships programme piloted in a complex needs homeless service.

A **DASV assertive outreach worker** has been commissioned to sit within our community drug and alcohol treatment service, and provided shared induction, training and learning workshops with frontline staff, as well as developing bespoke training and models of working.

Alcohol screening has been implemented within DASV service's assessment, recording processes and case management system. However, staff have highlighted a need for refresher training on alcohol screening.

In Cornwall we have specialist **units of accommodation** for those fleeing domestic abuse who have **additional complex needs**, providing **drug and alcohol tolerant housing** with access to specialist support, health care and recovery services on-site and a range of trauma-informed support to promote recovery and independent living. The Vulnerable Women's Unit also now offers a **self-contained unit designed for use by women with disabilities**, the first of its kind in the South West.

The Street Outreach Team (With You and CHL) are working in partnership with Safer Futures to pilot the inclusion of an **outreach IDVA**[160] post.

In addition, from April 2022, NDTMS will change to include mandatory collection of data about domestic abuse regarding both victims and those displaying abusive behaviours in drug and alcohol services. DAAT is working with commissioned services to ensure both staff and case management systems can meet the new requirements.

Children, young people, parents and families

Parental alcohol consumption and attitudes about consumption can have a negative impact on children, young people and the family. This impact can range from instilling unhealthy social norms and attitudes around drinking through to child maltreatment[161].

Emphasis is often placed on parental problem drinking (especially mothers) but **harm to children can occur through contact with any adult** for example step-parents, grandparents or others living in the household.

Children are especially affected 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.

[160] Independent Domestic Violence Advisors are specialist workers that provide emotional and practical advice, guidance and support and seek ways to empower people to make positive safe choices. They can liaise with other professionals on behalf of the person/family.
[161] The public health burden of alcohol and the effectiveness and cost-effectiveness of alcohol control policies: an evidence review, PHE (2016)

Witnessing alcohol and/or drug use is identified as **one of the key Adverse Childhood Experiences (ACEs)**. The impact of childhood, adolescence and family context in the development of problem drinking is explored in Section 2, page 28.

A child can take on many different roles when a parent/carer or household member is a problem drinker (Figure 24[162]).

Role	Motivating Feeling	Identifying Symptoms	Pay Off For Individual	Pay Off For Family	Possible Price
Dependent	Shame	Chemical use	Relief of pain	None	Addiction
Enabler	Anger	Powerlessness or Martyr	Importance Righteousness	Responsibility	Illness Exhaustion
Hero	Inadequacy Guilt	Over-achievement	Attention (positive)	Self-worth	Compulsive drive
Scapegoat	Hurt	Delinquency	Attention (negative)	Focus away from dependent	Self-destruction Addiction
Lost Child	Loneliness	Solitary Shyness	Escape	Relief	Social isolation
Mascot	Fear	Clowning Hyperactivity	Attention (amused)	Fun	Immaturity Emotional illness Addiction

Figure 24

Some children may feel guilt therefore strive to achieve at school whereas others can be used as the scapegoat drawing attention away from the drinker.

Parents/Carers who are problem drinkers may also have **additional complex needs** e.g. drug use, domestic abuse; sexual violence; mental health problems; contact with the criminal justice system and poor physical health. They may also have experienced **trauma or ACEs themselves in their own childhoods** which affects their own parenting making trauma **intergenerational** in nature.

It is important not to judge or stigmatise the choices made by parents, but recognise that choices often come from negative beliefs about who they are and their own ability to parent. It is important to remember that **parents are the experts on their own life experiences and what they need** from services.

How many families/children are affected?

Studies and surveys estimate that between 2-4% of parents in the UK are harmful drinkers and between 12-29% of parents in the UK are hazardous drinkers[163].

[162] The National Association for Children of Alcoholics
[163] Addressing the impact of non-dependent parental substance misuse upon children, McGovern et al. on behalf of Public Health England (2018)

- There are an estimated **1,311 adults in CIoS who are alcohol dependent and living with children** (2018-2019), 65% of which are male and 35% female. It is estimated that of these, **75% of males are not in treatment** compared with 41% of females[164].
- An estimated **2,068-2,292 children** in CIoS live with at least one alcohol dependent adult (2018-2019)[123].

Research commissioned by the **Children's Commissioner for England has estimated** both the number and proportion of 0-17 year-olds in Cornwall[165] living in a household where an adult has one of a number of vulnerabilities[166] (Table 8).

Table 8

Measure	Count	%
Some symptoms of a mental or psychiatric disorder (moderate or high symptoms)	31,930	29.8%
Domestic abuse has ever occurred	26,710	24.4%
Has a clinically diagnosable mental or psychiatric disorder (severe symptoms)	12,670	11.8%
Any form of 'substance misuse'	**10,990**	**10.3%**
Domestic abuse has occurred in the last year	6,620	6.2%
An alcohol or drug dependency	**3,980**	**3.7%**

The red measures reflect the narrow definition of these vulnerabilities and the blue measures reflect a wider definition.

It is estimated that:

- 47,630 children in Cornwall (45%) live in a household where any one of the three BLUE issues is present;
- 3,810 children in Cornwall (3.6%) live in a household where all 3 BLUE measures are present and;
- 940 children in Cornwall (0.9%) live in a household where all 3 RED measures are present.

Figure 25 is a visual representation of the RED measures.

The Camborne and Redruth area has the highest estimated rate of children living with an alcohol or drug dependent parent (5.22%) and the highest overall rate for all three narrow measures (1.07%).

Locally our aim is to identify the families affected by these issues and how many of them are being supported.

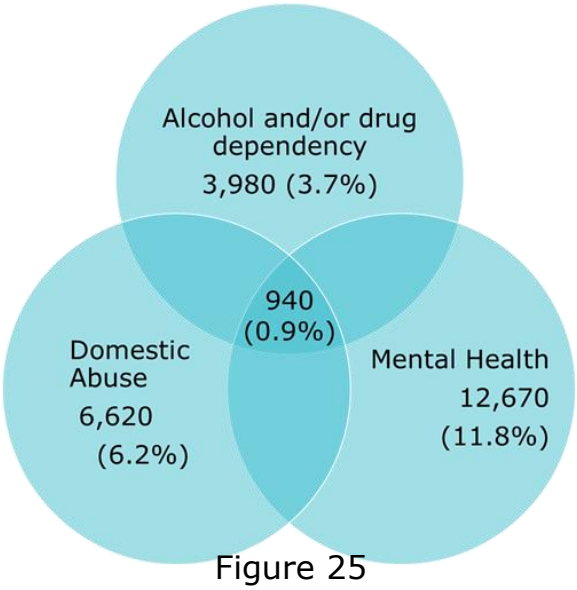


Figure 25

[164] Parents with problem alcohol and drug use: Data for England and Cornwall & Isles of Scilly, 2019 to 2020. Public Health England (2021)
[165] There are around 109,000 children and young people under the age of 18 in Cornwall.
[166] Local vulnerability profiles, Children's Commissioner for England (2020)

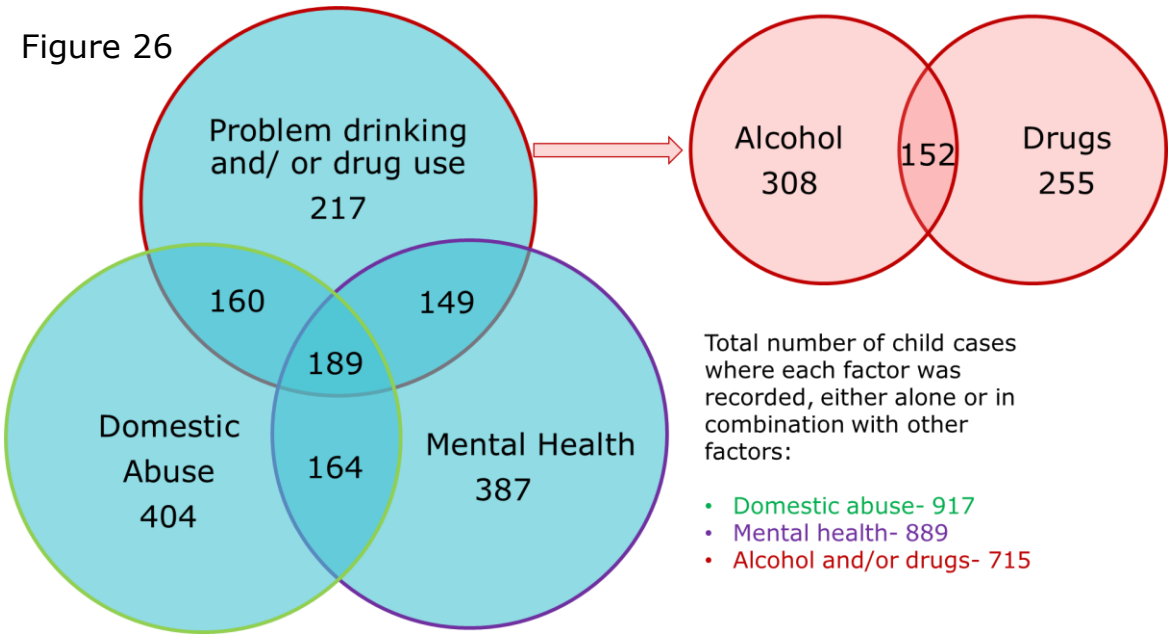
Data from the current local caseload open to **Health Visitors** provides a snapshot of some families with children aged 0-5. A total of **35 child cases had a parental 'substance misuse' flag** out of a total caseload of 13,381 (0.26%).[167] We are **not able to distinguish between alcohol and drugs** in the data.

Health visitors are vital in identifying vulnerabilities and helping families to access support and reduce the risk of harm in the early years. The annual State of Health Visiting Survey in England report[168] highlighted that during 2020, 45% of health visitors reported an increase in 'substance misuse' and 82% an increase in domestic abuse. At the same time COVID-19 restrictions reduced the capacity of the service. Many reported feeling stretched by high caseloads. Locally, universal appointments were over the phone but Targeted and Specialist cases remained face-to-face.

The CIoS Health Visiting service incorporates the recommended alcohol screening tool AUDIT-C into practice but it is not routine enquiry. See page 103 for use of AUDIT-C in family services.

Figure 26 shows the number of local **Children's Social Care assessments**[169] where a parent/carer, or other adult associated with the child, is recorded as using substances[170] (alcohol and/or drugs). It also shows where domestic abuse and/or a mental health need are co-occurring. All data is dependent on how a practitioner recorded each vulnerability and relates to 1,670 cases in total.

Figure 26



[167] Alongside 'substance misuse', 12 cases also had a domestic abuse flag, and 22 cases a parental mental health flag. Only in 8 cases (0.06%) had all three vulnerabilities been flagged.
[168] State of Health Visiting Annual Survey – 2020, Institute of Health Visiting
[169] Assessments carried out in the 8 months from March to October 2021.
[170] We do not know to what degree the adult may be using drugs and/or alcohol, e.g. whether they are drinking at harmful levels or are dependent, as this is not recorded.

It is evident from Figure 26 that in almost 70% of local child cases where a parent/carer or other adult have a drug or alcohol need, the adult also has another vulnerability:

- Only in 30% of cases where problem drinking or drugs were identified were they thought to be occurring alone;
- Around 3 in 4 cases of problem drinking also involved domestic abuse and/or poor mental health.
- In 1 in 4 problem drinking and/or drug use cases, domestic abuse and mental health vulnerabilities are both present.

Our ability to use local information from Health Visitors and Children's Social Care is limited as we do not know:

- Whether a screening tool was used (e.g. AUDIT-C);
- To what degree the adult is using drugs and/or alcohol (i.e. whether they are dependent or not);
- Whether the adult is, or should be, in treatment and if a referral was made.

See page 103 for use of screening in family services.

Data for referrals into the local treatment system for alcohol in 2020/21 showed a total of 15 referrals from children's social care, around 2% of all those starting treatment in the year. This represents only **a very small proportion** of a potential 460 people recorded as having an alcohol-related need.

Bringing together the local Health Visitor, local Children's Social Care and local drug and alcohol treatment data[171], we can start to build a picture of where the 3,980 children in the Children's commissioner (CCO) estimate may be (Figure 27).

We **do not know the degree of overlap** between each dataset.

Table 9 shows that **a maximum of 2,958 children affected by adult problem drinking and/or drug use may be unidentified** (assuming complete overlap between all 3 local datasets).

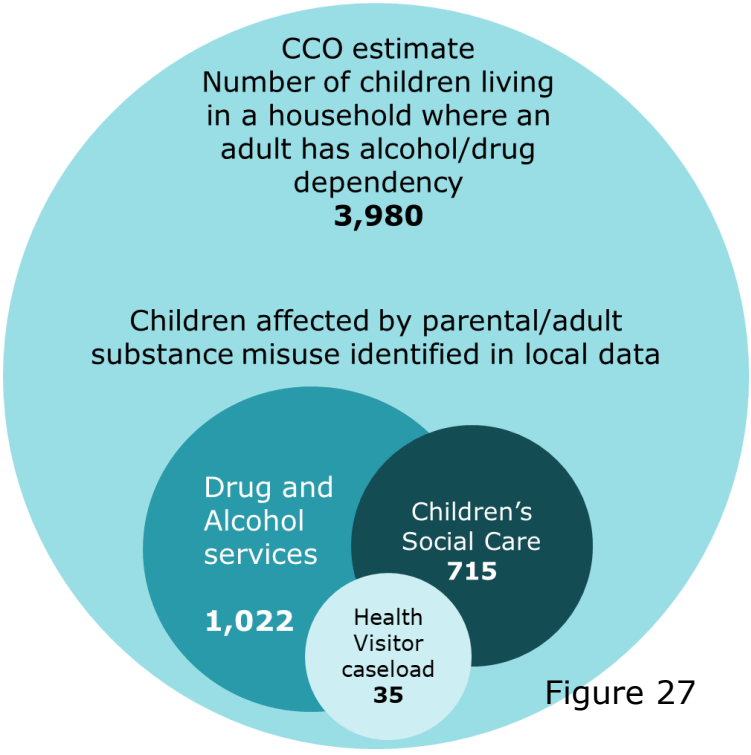


Figure 27

[171] For Health Visitor and Children's Social Care data we do not know to what degree the adult may be misusing drugs and/or alcohol i.e. whether they are dependent or not. In addition, we don't know whether the child is living with the adult.

Table 9 Overlap between local datasets	Number of children identified locally	Difference between local data and CCO estimate	% unidentified
No overlap	1,722	2,258	57%
Complete overlap	1,022	2,958	74%

Parents/carers in alcohol treatment

Around **1 in 5 new presentations to alcohol only and alcohol and non-opiate** treatment in 2020/21 **were parents who lived with a child** under the age of 18. This was slightly lower than national figures but for Q2 2021/22 local figures have slightly increased making them very **similar to national rates**.

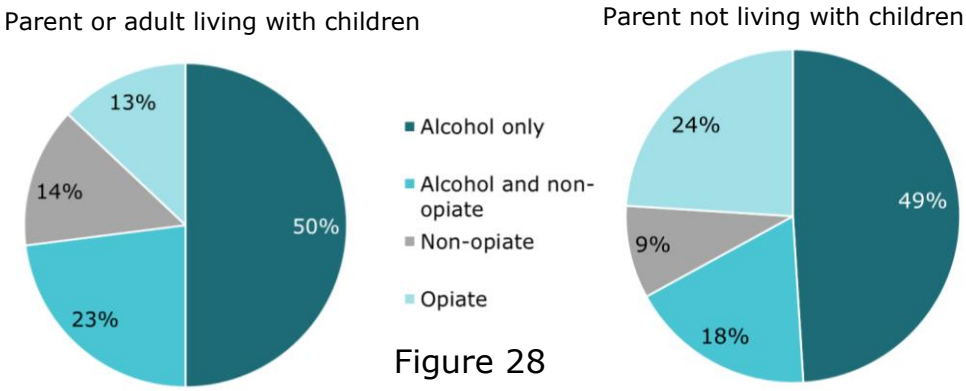


Figure 28

Those in alcohol treatment make up the majority of adults living with children (73%) **or parents not living with children** (67%) across the whole treatment cohort (drugs and alcohol, 2020/21, Figure 25). Therefore, addressing the needs of families where an adult is in alcohol treatment will have the largest impact on the children of the treatment cohort. In other areas alcohol clients make 49% of those who are a parent and not living with children compared to 67% locally.

Looking in more detail at the Halo caseload who had an open structured treatment episode for alcohol only or alcohol and non-opiate in 2020/21:

- 24% of people had at least one child under 18 living with them;
- This equates to potentially 782 children under 18;
- For 52% of those children, the adult in treatment declared that they had parental responsibility. 3% of children lived with an adult who said they had no responsibility. For 45% of children, there was no answer (blank or client declined the question).

Across all substance groups a **lower percentage of local clients** who live with children or have children not living with them, **were receiving early help or support from children's social care than nationally** in 2020/21 (Table 10). Although proportions have increased for Q2 2021/22, they are still lower than nationally (Table 11).

Table 10 **2020/21**	Local	National
Early help	2.3%	4.2%
Child in need	2.3%	5.1%
Child protection plan	5.6%	8.6%
Looked after child	2.8%	4.9%

Table 11 **Q2 2021/22**	Local	National
Early help	5.0%	5.5%
Child in need	4.7%	6.1%
Child protection plan	8.4%	10.0%
Looked after child	3.6%	5.6%

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**. Conversely, clients who are parents but not living with their children are less likely to complete treatment successfully.

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.

Supporting families in treatment

The **Family Team** in our local commissioned community treatment service provide intense support for families with the greatest needs. These families often have multiple complex needs with parents themselves having suffered many traumatic events in their own childhoods.

The team typically has a caseload of 55-60 families. Workers in the team are qualified and **accredited Solihull Parenting and Trauma Informed Mental Health Practitioners**. They deliver 1:1 **work** with parents in their homes to help them understand basic neuroscience. Using Routine Enquiry into Adverse Childhood Experiences, they design psychological interventions as part of the Initial Assessment and action plan. Group work involves The Solihull Parenting Approach- Understanding Your Child, which compliments and reinforces how trauma can impact on a parent's ability to communicate with their children. Family workers are able to underpin these principles when they work with families in their homes.

A **therapeutic alliance** supports a high attendance to parenting groups (65%) with parents being very open and genuine in their participation.

A case study from the team is included in Appendix I. Please note that it includes a client's experience of domestic abuse.

Supporting Families Programme

The national Supporting Families programme aims to work in a new way for families with multiple needs, taking an integrated 'whole family' approach that recognises overlapping and interconnected needs and histories.

The intention is that by working in a more integrated way, there will be a reduction in the number of assessments and plans, co-ordinated interventions that are informed by, and meet families' needs, better co-ordination among

professionals and as a result, demand on resources will reduce and outcomes for families will be improved and sustained.

The programme has run in phases since 2012. As of June 2020, 4,010 families have been supported in Cornwall.

Inclusion of families into phase two of the programme was based on six areas:

- Parents or children involved in crime or anti-social behaviour
- Children who have not been attending school regularly
- Child who need help
- Adults out of work or at risk of financial exclusion, or young people at risk of worklessness
- Families affected by domestic violence and abuse
- Parents or children with a range of health problems

The minimum of two issues required for eligibility can be contributed by either one or multiple household members. Eligible families were prioritised for intervention based on the number and complexity of issues affecting the household. Eligible families must include at least one child under the age of 18 living within the household.

During 2021, 595 people known to the local drug and alcohol service were also known to the Supporting Families programme.

- Just over a quarter were in treatment for alcohol issues only with a further 24% in treatment for alcohol and non opiate use (305 overall);
- 31% or 187 people were in treatment for opiate use with the remaining 102 people in treatment for non-opiates.

The programme focuses on improving local systems by increasing multi-agency working across organisations and services. A key part of that is improving data collection and information sharing. Whilst data maturity has improved locally regarding vulnerable families, we are still unable to populate the OHID toolkit[172] relating to parents with alcohol and drug problems. We are currently unable to gain an accurate picture on the number of children affected by adult drinking (see pages 85 to 87).

Pause Programme- best practice from other areas

Pause currently operates in 38 local authorities including Plymouth and delivers support to women who have, or are at risk of, having **children removed into social care**. Women are **highly vulnerable** and have **multiple complex needs** and experiences of **trauma**.

Across all areas in 2020/21 Pause worked with 1,600 women who collectively have had 4,900 children removed from their care. Of these women, at the beginning of the programme[173]:

[172] Parents with alcohol and drug problems: support resources, OHID (2021)
[173] Knowledge, Evaluation and Learning, Pause

- 95% had or were experiencing domestic abuse;
- 89% had mental health issues;
- 34% were care experienced[174].
- 61% reported drug use;
- 43% reported problem drinking;
- 43% reported homelessness;

The Pause model is built on **trauma-informed intensive relationship-based practice**, driven by women's own perceived needs and priorities, with practitioners working flexibly over 18 months to facilitate change. Activities include support to:

1. Stabilise lives relating to: domestic abuse; finances; housing; alcohol or drug use; offending; engagement in learning or work;
2. Develop a sense of self through: a therapeutic relationship; fun activities; addressing bereavement and loss; mental health support; establishing positive relationships, including appropriate contact with children; improving interaction with professionals;
3. Access effective contraception and have regular sexual health check-ups.

An evaluation of Pause by the Department for Education[175] found that:

- In five areas where Pause has operated since 2015, an equivalent of 215 children over three years were prevented from entering care;
- The estimated cost benefit of reducing the number of infants entering care is that for every £1 spent on Pause, £4.50 is saved over four years and £7.61 over 18 years.

The evaluation also recognised the key characteristics of the programme that enabled positive outcomes:

- A holistic, trauma-informed, relationship-based approach;
- Skilled Practitioners with multi-disciplinary knowledge;
- Small caseloads and continuity of staff;
- Flexible financial resource for each woman- tailored, responsive practice and risk mitigation in emergencies;
- Next-steps support to maintain change over time and provide a 'safety net'.

Findings also revealed that as well as some women **reducing their alcohol intake** to safe levels, the trust built between women and practitioners enabled many to **acknowledge their drinking problem** indicating readiness to change.

Implementing the Pause programme locally is a priority.

[174] Refers to anyone who has been or is currently in care or from a looked-after background at any stage in their life, no matter how short, including adopted children who were previously looked-after.
[175] Evaluation of Pause, Department for Education (2020)

Crime and community safety

Alcohol-related crime

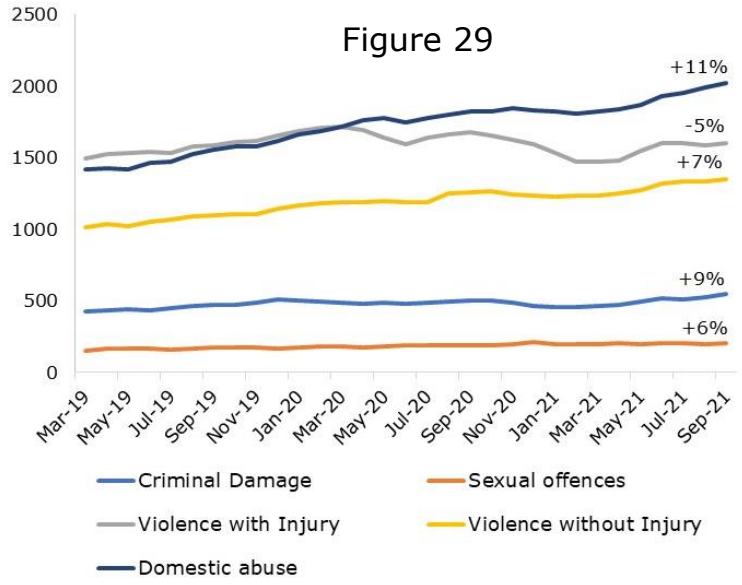
In the year ending September 2021, the police recorded **4,909 crimes** where alcohol was a factor accounting for **18% of all recorded crime**, in line with the previous year. When we look at violence against the person this proportion increases to 34% and increases again to 36% when we focus just on violence resulting in physical injury. The overall proportion of domestic abuse crimes linked to alcohol is higher at 32% - this is partly due to the higher volume of violent crimes in this category, but domestic violence is also more likely to be alcohol-related (43% of violence against the person and 47% of violence with injury).

Alcohol related offences

Alcohol-related crimes increased by 3% compared with the previous 12 month period (October-September 2020) and this is approximately in line with the overall rise in crime of 4%. No national comparator is available.

Figure 29 shows the **increasing trend in alcohol-related crimes** particularly for some offence types and these are against a backdrop of overall rising trends in crime for these types.

Figure 29



There are a couple of points of note, however:

- **Alcohol-related violence with injury fell by 5%** and this is believed to reflect the impact of lockdowns on Night Time Economy activity;
- **Alcohol-related domestic abuse increased by 11%**, with both the volume of offences and the proportion recorded as linked to alcohol increasing (from 30% to 32%);
- **Criminal damage has increased in our town centres** and there has also been a small rise in the proportion of crimes recorded as **linked to alcohol** (from 12% to 13%).

Concerns about **street drinking and associated anti-social behaviour** (ASB) are consistently **high on the public agenda** and have escalated over recent years – particularly in our **larger town centres**, such as Truro, St Austell and Penzance. These trends were apparent pre-COVID but have been notably exacerbated by the challenges of the pandemic. Town centre anti-social behaviour has a **significant impact on local businesses** and the attractiveness of an area for tourism and investment.

In the year 2020/21 there were **861 recorded incidents of anti-social behaviour linked to street drinking**, an increase of 19% compared with 2019/20. However, street drinking accounts for **only 6% of all reported ASB**. Insight gathered from a MoRiLE workshop highlighted:

- **Community impacts** - strong feelings on street drinking from the public and elected members, with **conflicting interests** between those wanting to help and support and those wanting to simply 'remove' the issue; needs of cohort to socialise (meet and drink in public) versus public perception and need for authorities to manage the issues;
- Focus on housing has evolved into **better emergency provision**. However, **groups are becoming larger and more aggressive** toward workers, making them harder to deal with and disperse. This **fuels a cycle of unrest and frustration within the community**, especially if issues are not dealt with quickly, further ostracising the offenders. Some communities have seen the creation of **social media platforms that encourage a vigilante-type approach** from locals;
- Lockdown restrictions and the lack of people out and about in the local area means that **people out on the street have been much more visible** to the local population, fuelling the increasing levels of discontent;
- **It is important not to conflate street drinking with rough sleeping** – not all rough sleepers will have issues with alcohol dependency.

Violence

Alcohol is associated with a range of crimes but plays a particular factor in violent crime. The relationship between alcohol and violence is complex, and is characterised by the interaction of a range of factors, including:

- The **psycho-pharmacological** effects of alcohol, including increased risk taking, impulsive behaviour, heightened emotionality and other effects of intoxication;
- The **individual characteristics** of perpetrators, such as age, gender and predisposition towards aggression;
- **Situational factors** related to the environment in which alcohol is consumed; and
- **Societal attitudes** and values towards drunkenness and what is acceptable behaviour while under the influence of alcohol.

Long-term trends in alcohol consumption have tended to follow those for violent crime: an increase in the second half of the twentieth century, followed by more recent periods of decline.

Reducing the availability of alcohol, providing **targeted treatment and brief advice**, and **prevention approaches** that build life skills and resilience can be effective in reducing alcohol harm.

Good partnership working has been found to underpin the successful implementation of interventions, and **sharing data** on acute harms across health, criminal justice and local authority platforms can also inform crime prevention activity.

2,953 crimes of violence against the person were recorded locally as alcohol-related in the 12 months to September 2021, similar to the previous year. Breaking this down, just over half the crimes relate to violence with injury (54%) and the number of crimes has seen a small reduction (-5%); the remainder relate to violence without injury and have seen a small rise (+7%).

Cornwall has a comparatively high crime rate of violence with injury. This is the case across Devon and Cornwall (except the Isles of Scilly).

Locally, in 31% of violence with injury alcohol is recorded as a factor and this has increased over the last couple of years (it was 26% in 2018/19).

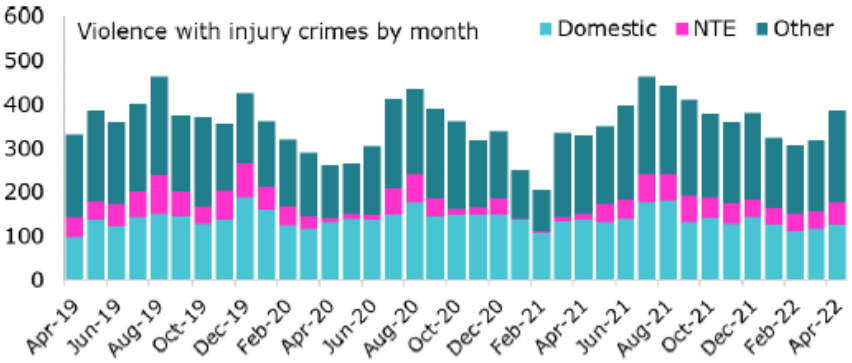


Figure 30

- **Violence linked to alcohol is more likely to result in serious harm** – 14% of alcohol-related violence with injury relates to grievous bodily harm (compared with 10% for all non-domestic violence with injury);
- COVID restrictions forced a drop in alcohol-related violence in public places and a small rise in violence in dwellings;
- Over the last year, levels of **NTE-related violence and alcohol-related violence have re-established** (Figure 30) further to COVID restrictions lifting.
- **Just over half of all violence with injury occurs in the ten Safer Towns**. Hotspots for alcohol-related violence are concentrated in larger town centres, with notable hotspots in Newquay, Truro, Penzance and St. Austell.
- Despite the challenges of the pandemic, positive work with licensing authorities has continued to ensure that the health-related risks of problem drinking are considered alongside other community impacts, such as crime and anti-social behaviour and safeguarding concerns;

Night-Time Economy violence

The NTE environment is consistently a notable generator of violence, particularly linked to alcohol, but the level of crime has reduced year-on-year with NTE responses being well established and managed.

- More reports of **violence is occurring earlier in the day**, with particular hotspots noted between 3pm and 6pm, particularly where young people are involved;
- Potentially much of the violence in the NTE goes unreported, however, as it happens late at night when there are fewer people to witness it, violence may involve people who know each other, or the offenders (and any witnesses) may be intoxicated so less likely to report;
- Extended restrictions due to the pandemic reduced the opportunities for NTE crimes to occur and numbers fell dramatically but this was only temporary. In 2021/22 36% of non-domestic violence with injury took place in the NTE (compared with 39% in 2019/20);
- Analysis[176] of data from 133 NHS Emergency Department, minor injury units and walk in centres showed a "clear link between violence and late-night drinking" and this has consistently been echoed in our own hospital data.

Insight gathered for the Safer Cornwall strategic assessment also reinforces the growing concerns about **violence amongst young people** and violence linked to **drugs and Organised Crime Gangs,** which is less likely to be reported and harder to quantify through police data. It was also noted that after the pandemic there are lots of **daytime events, such as local festivals, which drive daytime drinking**. Violence and public disorder during the daytime have a greater impact on the community, particularly affecting families and other people who would not be regular users of the NTE.

ARID (Assault Related Injuries Database)

Evidence suggests that **police data may under-report alcohol-related assaults**. Hospital admission rates for alcohol-related unintentional injuries have consistently been higher locally than nationally. The rate for men is roughly three times that for women, with key factors including risky drinking, violence and disorder and vulnerable disinhibited behaviour.

The development of the Cardiff Model[177] of data collection found that Emergency Departments (EDs) can contribute effectively to violence prevention by working with Community Safety Partnerships (CSPs) to collect and share anonymised data about violent assaults when the victim has presented at ED.

Nine EDs across Cornwall have installed ARID for this purpose. We also get information from Derriford, Barnstaple and Torbay EDs regarding Cornwall residents[178].

[176] Violent crime falls sharply during Covid lockdown – study, BBC News (2021)
[177] The Cardiff Model, Cardiff University
[178] Data will be focused very much on incident locations in and around the EDs that use ARID (Truro, Exeter, Barnstaple, Torbay, Plymouth, Camborne/Redruth, Penzance, Newquay, Bude/Stratton and St Austell) so does not present a comprehensive picture for Devon and

Monthly reports are provided to police and council licensing to assist with operational targeting of premises where there are repeat incidents, or other issues such as under-age drinking or weapon use. ARID is one of the datasets used in HILT, which is used to assess licensing applications. An annual overview of the ARID data is also produced and shared with Safer Cornwall.

In 2021, **357 people were recorded on ARID** as attending EDs in Cornwall **after being assaulted**, an extra 7 people recorded they had an alcohol-related injury. This equates to a 22% increase from the previous year, although during the pandemic numbers would be much lower. The number of alcohol related incidents is 36% lower (160 incidents fewer) than in 2019.

- Over **two thirds of assaults were said to be alcohol-related** (69%);
- Patterns of time and day emphasise the **link between assaults and the Night-Time Economy**, with the majority of assaults happening over the **weekend** and between the **hours of 21:00 and 04:00**. 86% of assaults occurring in this time period were said to be alcohol-related;
- Use of weapons is uncommon and in the majority of cases (78%) the injury was caused by part of the assailant's body (punch, kick etc), 9 were said to have been bitten. 14 (4%) of assaults involved glass, 9 of which were bottles, and a knife was used in 6 assaults;
- 45% of all assaults were committed by a stranger. Where the assault took place in the home, however, they would mostly come within the definition of domestic abuse (partner/ex-partner or relative);
- **Younger adults aged 18-24 are more likely to be victims**, 36% or 127 people; the next highest reported group is 25-34 with 22% of the total;
- **77 (22%) of all victims reported being assaulted in or immediately outside a specific named premises**. 39% of those recorded at specific premises said they had reported it to the police or had police in attendance.

Drink Spiking[179]

Drink spiking occurs when a **drug or alcohol is added to a drink** without a person's consent. Drink spiking is a crime and carries a maximum 10-year prison sentence, but the sentence will be higher if spiking is used to facilitate an assault, rape or robbery.

Following a rise in concern surrounding spiking, many incidents were announced through social media where people believed that they had been spiked. In the three months from August to October 2021, there were 119 allegations of drink spiking in Devon and Cornwall. Of an estimated 120 test kits used, only 2 returned a positive result. The majority of allegations in CIoS were in Falmouth with staff from universities noting:

- Concerns over spiking are at a higher level than in prior years;
- Increased allegations of drink spiking appeared to be related in part to students lack of experience with alcohol and its interaction with recreational

Cornwall. It does not include any victims of assault who may have consulted their GP about their injuries instead or attended a MIU not covered or any of the other hospitals.

[179] Please refer to the CIoS Drugs Needs Assessment for analysis of needle spiking.

drugs. This is thought to be linked to restricted social lives during the pandemic;
- A number of students have declined to take a test when understanding that it would also identify recreational drugs.

Falmouth is one of the 10 Safer Towns and has also benefitted from Safer Streets funding as part of the national Violence Against Women and Girls strategy. Community safety schemes are outlined on page 112.

The majority of research around spiking focuses on profiling victims or (potential) victims' perceptions of spiking. There is **little research on perpetrators** but existing research outlines that in most cases the **motivation is to humiliate or prank someone for fun rather than to facilitate sexual violence**. Getting the victim more intoxicated is also cited as a motivation[180]. Where motives are related to sex, they include putting someone in the mood for sex and making it easier to approach someone for sex[169].

A study at 3 universities in the US[181] found that female participants were more likely to mention sexual assault as a motive whereas males were more likely to identify motives related to fun. **Getting others more drunk or high** and **getting someone to relax** were also cited.

Spiking may also be linked to **motives of interpersonal aggression** with a perpetrator **exercising power and control** over someone by removing their ability to consent to taking a substance. This can occur even if there is no intent of sexual violence and having fun is instead the motivation[170].
A lack of interventions targeting those who spike is not surprising given the lack of research on perpetrators. Any local messaging aiming to target potential perpetrators, rather than safety messaging for potential victims, would need to be carefully designed and address all motivations whilst reducing the risk of initialising 'copycat' behaviour.

Isles of Scilly

The Isles of Scilly is a separate unitary authority, with its own Community Safety Partnership (CSP).

Overall, IoS has a **lower crime rate than Cornwall.** Prior to the pandemic, the level of crime had shown a small reduction year on year. During COVID-19 restrictions recorded crime dropped substantially on Scilly, as it did across the country. Crime numbers have started to increase since restrictions eased, particularly violence and criminal damage, but they currently remain below pre-pandemic levels.

- In the last 12 months, **12 anti-social behaviour incidents** were reported on the islands, of which three quarters were rowdy/inconsiderate behaviour. The majority of incidents are reported at night (after 9pm into the early

[180] Drink spiking: an investigation of its occurrence and predictors of perpetration and victimisation, McPherson (2007)
[181] Just a dare or unaware? Outcomes and motives of drugging ("drink spiking" among students at three college campuses, Swan et al. (2017)

hours); **alcohol is likely to be a factor**, but we are unable to ascertain to what extent from the data;
- **Criminal damage** makes up a quarter of recorded crime on IoS, with around **1 in 4 crimes linked to alcohol**;
- Over the last 3 years, **45% of violent crimes reported** to the police were recorded as **linked to alcohol** with most offences taking place in a public space and at night; there were also a small number of **criminal damage and theft offences** recorded as linked to alcohol.

Feedback from an IoS MoRiLE workshop revealed the following in relation to alcohol:

Anti-Social Behaviour
- Mostly reported to be **after pub and restaurant closing hours** with after parties taking place on the beach.
- The ambulance service has not seen a significant increase in responding to alcohol or drug related incidents, despite overall numbers going up. Summer months are busier but this is to be expected.
- A Designated Public Place Protection Order was previously in place but lapsed as it was not needed; there is not enough evidence of need to put one in place again.

Domestic Abuse and Sexual Violence
- Participants mentioned that seasonal workers may bring their exisiting issues to the islands, as do visitors spending two weeks in close proximity to each other with higher than normal levels of alcohol consumption.
- The licensed trade reported no incidents of alcohol-related sexual violence.
- The **"Ask Angela" initiative** has been promoted in licensed premises and was well received.

Violence and the impacts of alcohol
- There is a **perception the islands are a heavy drinking** community. **Most drinking happens at home** due to the prohibitive cost of drinking out, and the lack of a nightclub scene.
- It is generally felt that it is **harder for young people to obtain alcohol** as they do not have the same freedom of anonymity.
- Some felt that young people do not get the chance to experiment in the same way as young people on the mainland. There is no youth club provision/place for young people to go and hang out.
- Local young people often socialise with seasonal workers on the islands who tend to be older and the potential safeguarding risks are recognised.
- **Violence is not seen as a concern**. Pubwatch have a few people who are routinely on the list for aggressive behaviour – duration and breadth of restrictions vary.
- Alcohol is a driver for **petty misdemeanours** like bicycle theft rather than violence.

Road safety- drink driving

Cornwall Fire and Rescue Service have assessed road traffic collisions (RTCs) attended by the service as moderate risk. Road safety is one of the Police and Crime Commissioner's four priorities and the Vision Zero[182] project aims to reduce the number deaths and serious injuries on roads in the South West to zero.

Previous versions of the LAPE have highlighted that rates of alcohol related RTCs in Cornwall [183] are higher than both nationally and regionally.

A national report by the 2021 Parliamentary Advisory Council for Transport Safety (PACTS)[184] identified:

- Drink driving is one of the largest causes of road deaths (13%).
- 17% of drink drive offences are committed by a **reoffender**.
- A significant number of reoffenders have **alcohol and mental health issues** with the pandemic increasing the number of people with such issues.
- **Levels of police enforcement have decreased** by 63% since 2009 and there are indications that drivers believe they are less likely to be caught.

Devon and Cornwall Police's Road Collision Investigation Project (RCIP) carried out an in-depth analysis of collisions which occurred from 2010 to 2019 (inclusive) where 'Impaired by Alcohol' had been recorded. The following were identified regarding drink drive collisions:

- In Cornwall 9.8% of all KSI collisions were caused by a drink driver (196/ 1,992 KSI collisions). Although the number of incidents is lower in Cornwall, we have the **highest rate of any county in England**.
- The number of drink-drive collisions in both Devon and Cornwall **increased** over the time period whereas in England & Wales there was a decrease.
- 81% of drink drivers were male with **20-24 year old males** accounting for the majority of collisions.
- 77% of drink drivers involved in a collision in Cornwall, lived in Cornwall and 2.9% lived in Devon. This rate is similar to other counties with less seasonal tourism such as West Midlands.
- The number of collisions was highest during the summer months but figures were still similar to those in spring and autumn.
- **45% of collisions occurred on C class or 'unclassified roads'**. Hotspots amongst classified routes were the A30, A390 and A39 together accounting for 13% of collisions.

As expected, the majority of collisions occur on weekends, in the evenings and at night when the majority of people would be taking advantage of Cornwall's Night-Time Economy.

[182] Vision Zero Partners include: Devon and Cornwall Police, Cornwall Fire and Rescue Service, South Western Ambulance Service NHS Trust, National Highways, Cornwall Air Ambulance, The OPCC, Cornwall Council, Royal Cornwall Hospitals NHS Trust, and the Parliamentary Advisory Council for Transport Safety (PACTS).
[183] Alcohol-related road traffic collisions 2013-2015, rate 48.7 per 100,000 compared with an England rate of 26.0
[184] Drink Driving – Taking Stock, Moving Forward, Parliamentary Advisory Council for Transport Safety (2021)

The high proportion of local residents amongst offenders suggests that **tourism is not the over-riding factor**, in terms of who is offending. However, a temporarily increased population is likely to lead to busier roads and therefore increase the chances of a collision.

The following analysis examines all local Road Traffic Collisions (RTCs) in which alcohol and/or drugs were a contributing factor. Unlike the RCIP, not all of the incidents will have been the result of drink driving as some incidents will involve a collision between a pedestrian and a car in which the pedestrian was under the influence of alcohol and/or drugs, rather than the driver.

- January 2019 to December 2020 saw 200 incidents involving alcohol, resulting in 263 casualties (7 of which were fatal[185]).
- In the same period, 25 incidents involving alcohol and drugs occurred resulting in 35 casualties (1 of which was fatal in 2019).

Looking at RTCs just involving alcohol, fewer incidents in 2019 occurred in the winter months. Coinciding with the first lockdown period, incidents from April 2020 to June 2020 were much lower than for the same period in 2019. The number of incidents sharply increased in July 2020 (higher than July 2019) as restrictions eased and the Night-Time Economy re-opened.

The analysis identified **five areas[186] which accounted for 1 in 5 incidents** (38/200) and 1 in 6 injuries (45/263) (Table 12).

Table 12

Area	Incidents; casualties	Area description
E02003949	10; 11	The town centre of Penzance which sits inside the top 20% most deprived areas in the UK. Adjacent to the railway and bus stations is a busy one-way traffic system which may appear confusing to those unfamiliar with the area.
E02003953	8; 9	East of Newquay containing St Columb Major and Summercourt.
E02003957	7; 0	Contains an approximate 8 mile stretch of the A39, the main link between Newquay and other towns on the north coast such as Wadebridge, Padstow and Camelford. Contains a small stretch of the A30 around Fraddon and Indian Queens.
E02003921	7; 8	Lies north east of St Austell and includes Lostwithial, Penwithick and Bugle. 4 miles of the A391 run through this area as well as 4 miles of the A390.
E02003930	6; 8	The Lizard Peninsula up to the Helford River. It includes the popular tourist destinations of The Lizard and Kynance Cove as well as St Kevern and Coverack. Contains 9 miles of the A3083 between The Lizard and Helston. There are many small, narrow country lanes.

[185] Alcohol: 3 fatalities in 2019 and 4 in 2020. This is in comparison to 40 drug related deaths in 2020

[186] Middle Layer Super Output Area (MSOA) which typically contains around 7,000 residents.

Areas either contain large towns or are adjacent to them. Areas also cover rural localities. This **suggests that alcohol related RTCs tend to occur when people are travelling from towns on either major or rural roads**. The DAATs input into **alcohol licensing** uses the HILT tool (see page 110), which includes area specific drink driving rates, to advise licensing as to when applicants should increase their measures to prevent drink driving.

Cormac's Engineering Design Group's 'top 10' areas in terms of all road collisions (not just those that are alcohol related, Appendix J) also features Newquay. All sites in the 'top 10' feature a junction of roundabout. This is in contrast to the RCIP which found that the majority of drink drive collisions occurred where there was no junction or roundabout. This suggests that road type does not play a large factor in determining if an incident occurs due to drink driving.

Drinking driving interventions

There has been a decrease in the number of drink drive arrests in 2020/21 compared to 2019/20 (Table 13).[187] This corresponds to a decrease in the total number of alcohol related RTCs from 119 in 2019, to 81 in 2020.

Table 13

Year	Drink driving arrests
2018/19	603
2019/20	616
2020/21	529

Currently we **do not have any data on justice outcomes and re-offending** which would enable us to measure the effectiveness of rehabilitative measures.

Those found guilty of drink driving can be offered a **drink-drive rehabilitation course** to reduce their driving ban if it is 12 months or longer. Courses are currently available in Bodmin, Truro, Penzance, St Austell, Bude and Plymouth with courses also available online.
Data on courses in not available at county level, only area level[188].
In 2021, there were 1,241 referrals to courses in area 10 (which includes Cornwall). This was the fourth highest out of all 22 areas.

Obtaining data for CIoS specifically on the number of referrals, completion rates and reoffending after taking a course would help us to understand how effective they are in reducing drink driving. The DAAT, Amethyst and the Community Safety Partnership have explored many avenues to obtain this data. Drink drive courses are commissioned nationally by Central Government, and delivered by the private sector, with no data on outcomes and effectiveness currently collected.

[187] 2020 is missing some data as evidential breath testing machines were a risk some were not prepared to undertake during the pandemic.
[188] Drink Drive Rehabilitation Quarterly Statistics, JAUPT (2022)
Drink drive rehabilitation schemes (DDRS) are over seen by the Driver and Vehicle Standards Agency (DVSA) and monitored by the Joint Approvals Unit for Periodic Training (JAUPT). DDRS are delivered over 22 areas covering England and Scotland with CIoS being part of area 10 which includes Devon, Somerset, Dorset, Wiltshire and Gloucestershire.

Section 4: Reducing Alcohol Harm

Prevention

Identification and Brief Advice (IBA)

IBA is a **simple intervention aimed at individuals who are at risk through drinking above the guidelines** but are not seeking help. It includes screening for problem drinking using an accredited tool, identification of the level of the problem and brief advice to reduce alcohol-related harm (or onward referral to specialist services if required). It is a short interaction between a practitioner and a client aimed at motivating them to reduce their drinking.

In Cornwall we have chosen to use the World Health Organisation **AUDIT tool** (Alcohol Use Disorders Identification Test). This involves a 3 question evaluation of consumption levels (AUDIT-C) and if necessary a further 7 questions. The score produced identifies the risk level of someone's drinking. This then leads to an appropriate brief intervention or referral for more intensive support.

NICE Guidance[189] recommends that alcohol **screening should be undertaken by health and social care, criminal justice and community and voluntary sector professionals in both NHS and non-NHS settings** who regularly come into contact with people who may be at risk of harm from the amount of alcohol they drink.

Table 14 summarises where AUDIT screening is recommended by NICE guidance for use and if there is evidence of this occurring locally.

Table 14 **Recommended for:**	**Local evidence?**
AUDIT Screening	
NHS professionals	
Patients attending with relevant physical conditions e.g. hypertension, gastro-intestinal problems, liver problems.	New registrants at GP practices but likely to have reduced due to the pandemic; Health Checks (see page 106); RCHT in-patients- AUDIT screening is available to be completed as an optional assessment for all inpatients but data may not be being captured.
Patients with relevant mental health conditions: e.g. anxiety, depression, mood disorders	No evidence of routine screening in GP or mental health services.
Those who have been assaulted	No evidence of use in ED or by police (unless through the Alcohol Liaison Team, ALT, or the Hospital Outreach Team, HOT, both at RCHT).
Regular attenders for accidents and trauma, including 'falls'	No evidence of use unless linked with HOT or ALT.
Regular GUM and emergency contraception service attenders	Commissioned sexual health services provide IBA but no evidence of using AUDIT.

[189] NICE Guidance (PH24) Alcohol-use disorders: prevention, NICE (2010)

Non-NHS professionals should focus on groups that may be at an increased risk of harm from alcohol and people who have alcohol-related problems. For example, this could include those:

- at risk of self-harm
- involved in crime or other antisocial behaviour
- who have been assaulted
- at risk of domestic abuse
- whose children are involved with child safeguarding agencies
- with drug problems.

Therefore, the services in Table 15 would be appropriate to use screening in .

Table 15 **Recommended for:**	**Local evidence?**
AUDIT Screening	
Non-NHS professionals	
Domestic abuse and sexual violence services	Incorporated into assessment on case management systems but recording and confidence in using the tool, amongst new staff, needs improving.
Housing support	No evidence of use.
Police, custody and probation	Client may come into contact with workers from the community drug and alcohol treatment service in custody suites and at court. No evidence of use by probation or police.
Liaison and Diversion	Screening is used and recorded.
Children's Social Care	The service reports screening is used but no evidence this is routine enquiry. No data collection.
Health Visitors	Screening is used but not routine enquiry. No data collection.
Adult Social Care	Screening is not part of care assessments.
DWP Job Centre Plus	No evidence of use.
Voluntary sector organisations	No evidence of use.
Health promotion	Used in outreach Health Checks by Healthy Cornwall and in Virtual Lifestyle Assessments.

IBA should be delivered by professionals who have received the necessary training and work in the services listed in Table 16[190].

Table 16 **Recommended for:**	**Local evidence?**
IBA	
Primary healthcare	No evidence of use.
Emergency departments	No evidence of use unless Alcohol Liasion Team engage with those who have an alcohol-related attendance or With You Hospital Outreach Team engage with frequent attenders.
Criminal Justice system	Used by With You CJS team and Liaison and Diversion. No evidence of use for police or probation.

[190] NICE Guidance (PH24) Alcohol-use disorders: prevention, NICE (2010)

Social services	No evidence of use but have attended IBA training.
Higher education	No evidence of use.
Other healthcare services (hospital wards, outpatient departments, occupational health, sexual health, needle and syringe exchange programmes, pharmacies, dental surgeries, antenatal clinics and those commissioned from the voluntary, community and private sector).	Hospital in-patients covered by RCHT Alcohol Liaison Team but IBA is limited due to hospital pressures and increasing complexity of patients. Sexual Health provide IBA but do not use AUDIT. No evidence of use in VCSE or private sector.
Housing support	No evidence of use.

Best practice

The implementation of **alcohol screening** using a web-based tool in **Sheffield** by many services enabled:

- **Quick screening** for problem drinking using a validated tool;
- **Personalised brief advice** for clients depending on the results;
- Immediate **referrals** of clients with a certain score (with their consent) to the alcohol treatment service.

Use of the tool resulted in:

- An **increase in referrals** to adult alcohol treatment from children's services;
- Better and **earlier identification of children** who are affected by parental problem drinking enabling appropriate support to be offered;
- A better understanding of the prevalence of problem drinking amongst the client groups of participating services.

Specifically, the services who implemented alcohol screening were:

- **Children's social care** with parents/carers as part of assessments;
- Domestic abuse services;
- **Community midwifery** with women at the booking meeting for their pregnancy;
- **Health visitors** with **mothers and fathers** when their baby is 6 to 8 weeks old as part of the 'safe sleep' message;
- **Family intervention workers** when a family accesses support.

Also, a significant number of GPs used the tool for new patients, and it was used in community pharmacies, mental health and general hospital services.

191

The majority of services/organisations identified above have been on the DAAT's IBA training. This highlights the need to **improve the implementation of IBA following training.**

[191] Local initiatives: safeguarding in Sheffield and Lewisham, Public Health England (2015)

In addition, the National Fire Chiefs Council (NFCC) has found that an important contributing factor in someone becoming a fatality during an **accidental dwelling fire** is 'Mental and/or physical impairment caused by alcohol and/or drugs'[192]. A Scottish report on fire deaths and safeguarding also highlighted alcohol use and recommended that assessments should include how alcohol use may limit or remove a person's ability to recognise fire risks[193]. The Blue Light Project manual for long-term heavy drinkers also recommends fire risk is assessed for this group[194].

In the last 10 years in Cornwall 20 fatal accidental dwelling fires have occurred with 3 people who dies suspected to be under the influence of alcohol.

Home Fire Safety Visits (HFSV) offer free, personalised advice about fire safety to those who are at greater risk of fire. This can include those with reduced mobility, smokers, and people living alone. The NFCC guidance for HFSVs focuses on a person-centred approach reflecting the needs of the **most vulnerable individuals**. Introducing some form of IBA in this setting is an opportunity to target vulnerable groups identified in the guidance for IBA.

IBA Training

The DAAT has been delivering 3-hour IBA training for many years. An evaluation was undertaken of IBA delivered between 2018-2020 to inform the design of an online and in-person approach to re-launch training in 2022. A total of 477 individuals participated in training between 2018-2020 from a range of organisations. The top 5 types of organisations who participated were:

1. Housing support
2. Mental health
3. Domestic Abuse and Sexual Violence
4. Drug and alcohol services
5. Employment support

Evaluation scores and feedback forms **indicated increased knowledge and positive feedback** around content of the training.

The online follow-up survey, a minimum of a year on, had 31 responses. Only 10% of respondents cited that they frequently used IBA. Reasons included changes to roles and service structures; other staff covering this; phone appointments only; not needed; and difficult to use. 97% of respondents rated the training as good or excellent.

When asked what would help in embedding IBA into practice a **refresher course** and **training groups of professionals together** were most commonly cited.

Priorities identified by the evaluation are:

[192] Person Centred Framework, NFCC. The NFCC are the overarching body for fire and rescue services.
[193] Fire Deaths – a brief analysis of reports and reviews to promote discussion within Adult Protection Committees, Scottish Adult protection Coordinator (2022)
[194] The Blue Light Project Manual, Alcohol Concern (2014)

- Social Care;
- Mental Health staff, who have attended more than many other service area, but are still a priority, with pathways around drugs and alcohol and dual diagnosis a developing area;
- **Refresher Courses** for previously trained staff, especially after the gap in face to face contact through the Pandemic;
- Update for remote working;
- Incorporation of digital approaches into the training, to increase flexibility;
- **Targeting teams**, rather than general event advertising, to cover those recommended in guidance.

Our focus now is to improve the implementation of IBA following training.

DrinksMeter

A digital tool or App can make IBA in community settings more achievable. In Cornwall we have been trialling the DrinksMeter App as a result of Making Every Contact Count (MECC) funding. Between the 1st May 2019 to 13th March 2021, 260 individuals used the App. A similar proportion of males to females used the App with the majority of males being aged 55-64 whereas females were mostly aged 45-54.

The majority of users only recorded a single entry (84%) but for those with multiple entries, 12% recorded a decrease in the number of days in the last 7 on which alcohol was consumed (32 people). A further 1% reported no change and 2% an increase.

The majority of users (46%) reported drinking 14 units or less in the previous 7 days on their earliest entry date. This suggests that the **majority of people who used the app were already low-risk drinkers**. 21% of users however, reported drinking over 50 units in the previous week.

10.8% of users recorded a decrease in the number of units drank in the last 7 days when comparing their first to their last entry (28 people). Overall, **5% of all those who used the app** (12/260) **reduced their drinking to within the national guidelines** (14 units per week).

It is difficult to draw firm conclusions from a small sample size but for those that used the app more than once, **around 2 in 3 reduced their alcohol units**.

To increase use of DrinksMeter it will be incorporated into IBA training and promoted as the preferred alcohol app in Cornwall. Other apps are available but through DrinksMeter we have the opportunity to gain access to local data. Partners are signposting to a range of different alcohol apps through their messaging and training. Therefore, ensuring consistency in the tools promoted locally is a priority.

Health Checks

The NHS Health Check is designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia. Health Checks should be offered to all adults aged 40-74 without a pre-existing condition. They are also offered to

all with a severe mental illness (SMI, see page 59). GP surgeries provide Health Checks but Healthy Cornwall also carry them out as part of health promotion activities.

In 2019/20, 3.9% of eligible adults (aged 40-74) in Cornwall received a health check, compared to 7.7% nationally. Since the start of the pandemic the national NHS Health Check programme has been deprioritised twice and although providers can recommence checks, this is based upon their capacity and resource. In Cornwall more providers are now recommencing health checks.

Alcohol screening using AUDIT is part of a health check.

Locally, in 2017/18[195], like nationally, **only half of patients were screened for alcohol**- a much lower rate compared to other elements of the health check such as recorded BMI and smoking status (missing data for these indicators was 7% and 2% respectively). More recent data, locally and nationally, regarding the number of AUDIT screenings undertaken is unavailable.

We are unable to obtain data on the results of alcohol screening (i.e. AUDIT scores) which would supplement other data relating to levels of drinking in CIoS outlined in section 2.

As the Health Check programme recommences, increasing the proportion of checks that include alcohol screening is a priority.

Making Every Contact Count (MECC)

MECC uses brief and very brief interventions taking from 30 seconds to a couple of minutes, whenever the opportunity arises in routine appointments and contacts. It focuses on behaviour change that can improve health and wellbeing including reducing alcohol intake.

Healthy Cornwall deliver MECC training, for any employer in Cornwall to attend, covering recommended drinking levels and units. Corserv Ltd, Coastline Housing and Cornwall College have all participated. The commissioning checklist for alcohol (appendix A) recommends featuring IBA in MECC training.

Smoking cessation and alcohol

Although socio-economic and environmental factors are the biggest determinants of our health, health behaviours, including drinking and smoking, account for 30% of our health.

Tobacco use is common amongst drug and alcohol users[196] and they are more likely to smoke heavily[197]. Use of both alcohol/drugs and tobacco appears to be more detrimental to health than smoking or substance use alone.

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[195] NHS Health Check programme, NHS Digital (2018)
[196] Improving smoking cessation in drug and alcohol treatment, PHE (2015)
[197] Nicotine dependence and withdrawal in alcoholic and nonalcoholic ever-smokers, Marks et al. (1997)

Some studies have found that quitting smoking whilst in alcohol treatment can have a positive impact on treatment outcomes[198] [199].

Enabling practitioners to deliver brief interventions and advice around both alcohol and smoking as well as other health behaviours such as diet and physical activity (e.g. through MECC) is an area for improvement. In addition, supporting those in alcohol treatment and recovery to quit smoking would enable those who tend to have more complex needs, and who experience some of the worst health inequalities, to access smoking cessation services. This aligns with the one of the ambitions of the CIoS Health and Wellbeing Strategy which is to ensure that everyone has the opportunity to enjoy a healthy lifestyle[200].

Messaging and Comms

The DAAT have run social media campaigns for Alcohol Awareness Week, COVID-19 specific campaigns, Festive Alcohol messaging, Drink Spiking and a *What Will Your Drink Cost* summer campaign. All social media analytics are evaluated for a campaign. Social media posts usually contain information about recommended levels of drinking, signposting to the DrinksMeter app and local support (With You).

Given the links between mental health and problem drinking, joint comms with Public Health covering both these areas in a priority going forward.

Prevention- young people

NICE guidance[201] recommends schools and colleges include **alcohol education** in the curriculum and that schools and colleges involve parents, carers, children and young people in initiatives to reduce alcohol use.

Literature and guidance around what works, in terms of drug and alcohol education for children and young people, has found that scare tactics; facts alone; one-time events; and using non-interactive methods such as lectures are ineffective[202]. Instead, what had been found to work includes:

- Interactive programmes;
- Social competence approaches allowing pupils to model and practice giving feedback and positive reinforcement;
- Correcting 'myth-understandings';
- Involvement of peer educators but not necessarily as the lead.

A recent deep dive workshop on county lines in CIoS revealed that there is no consistent education programme around child criminal exploitation. This links to feedback from stakeholders indicating that there needs to be more early

[198] Smoking Cessation and Alcohol Consumption in Individuals in Treatment for Alcohol Use Disorders, Friend and Pagano (2005)
[199] Impact of quitting smoking and smoking cessation treatment on substance use outcomes: An updated and narrative review, McKelvey, Thrul and Ramo (2017)
[200] Cornwall and Isles of Scilly Health and Wellbeing Strategy, Public Health, Cornwall Council (2021)
[201] NICE Guidance (NG135) Alcohol interventions in secondary and further education, NICE (2019)
[202] School-based alcohol and drug education and prevention – what works?, Mentor Adepis (2017)

intervention around alcohol and drugs particularly for alternative provision academies.

The Schools Programme delivered by the young person's community drug and alcohol treatment service (YZUP) delivers education, awareness raising and risk management within schools, colleges, youth groups and supported housing. In Q3 of 2021/22, 128 sessions were delivered in 19 settings across Cornwall.

Schools workers can also provide dynamic support where needed by settings. For example, this could include a series of drop-ins or support in updating drug and alcohol policies.

There is a link between referrals to the YZUP service and recent attendance in settings. This demonstrates the benefit that working in these settings has in terms of raising awareness of the service. During 2020/21, the suspension of face-to-face work in schools led to a reduction in referrals.

Speak Out Groups are also delivered in schools for young people affected by familial alcohol and/or drug use. This is an 8-week programme which explores what it is to be an affected other and how this feels and affects individuals in different ways. Workshops look at topics such as behaviours and patterns of addiction, parental treatment pathways, positive relationships, coping strategies, mental health and wellbeing and keeping safe.

Isles of Scilly

Feedback from the MoRiLE workshop indicated that prevention work has been delivered in school by YZUP – this was on a regular basis but may have stopped. YZUP visited during "project week" in May. As the school is now an academy there was **uncertainty over future plans to include drugs and alcohol in curriculum/PSHE**.

Young people also shared their views in a session, citing that:

- There is peer pressure to drink;
- They feel 'under the microscope' and that teenagers have 'a bad name';
- People avoid certain places as they know people are drinking there regularly;
- Being under the influence of alcohol can lead to crime e.g. bike theft;
- The information they receive about drugs and alcohol in PSHE is too basic and not very interactive. There is a focus on abstinence rather than advice about how to drink safely or harm reduction for drugs.
- Young people also expressed that going to the mainland is a huge jump and they do not feel prepared

Licensing and retail

Health as a licensing objective

Businesses, organisations and individuals who want to sell or supply alcohol must have a license or other authorisation from Cornwall Council as the licensing authority. Cornwall has approximately **3,000 licensed premises**. In addition, an average of 2,500 Temporary Event Notices are received each year.

The **Licensing Act 2003** has four Licensing Objectives:

1. The prevention of crime and disorder;
2. Public safety;
3. Prevention of public nuisance;
4. The protection of children from harm.

Including Public Health as a fifth licensing objective has been explored but not adopted in England unlike in Scotland. There have been renewed calls for the inclusion of Public Health with the Chief Medical officer concluding that "high rates of excess alcohol use in coastal communities, and specifically issues in resort towns, further strengthens the case that public health should be added as a licensing objective in the Licensing Act 2003"[203].

In 2016 Public Health England (PHE) ran the *Health as a licensing objective* (HaLO) pilot. Cornwall participated and developed an evidence-based tool that generates a risk profile, with comparisons against the Cornwall average, after the user types in a postcode, based on **5 Key Indicators**:

1. Alcohol-related hospital admissions
2. Referrals into alcohol treatment
3. Alcohol related violence
4. Anti-Social Behaviour/street drinking
5. Alcohol-related road traffic collisions

This process has allowed us to identify the 25 highest risk LSOAs[204], so that **resources can be targeted** to these cases specifically.

The tool was subsequently approved by the **Licensing Act Committee** for use in hearings and was invited to be demonstrated at the HaLO end of pilot event and was then presented at the PHE National Licensing Network, The House of Lords Pre-legislative Committee, and the Local Government Association Licensing Conference. Since then, the tool has been remained HILT (Health Impact Licensing Tool).

HILT has been used operationally to evaluate Cornwall's Cumulative Impact Zones (CIZ), and to contribute contextual evidence to a license revocation case against a premises in a violent hotspot within a CIZ.

[203] Chief Medical Officer's annual report 2021: health in coastal communities, Department of Health and Social Care (2021)
[204] Lower Super Output Areas have between 1500 to 2000 residents.

HILT aligns with NICE guidance[205] [206] which states that local authorities should use local data relating to crime, alcohol outlet density, alcohol related-illnesses and deaths to map the extent of alcohol-related problems enabling for use in considering a licence application.

Cumulative Impact Zones (CIZs)

In areas where the number, type and density of licensed premises is high, large concentrations of people queuing, gathering or leaving premises at the same time can lead to conflict, disorder, anti-social behaviour and there may be an increase in the incidence of other criminal activities. Local services such as public transport, public toilets and street cleaning may also be unable to meet demand.

CIZs are intended to create the presumption that applications for grant, or variation, of a Premises License, which are likely to add to the existing cumulative impact, will normally be refused or be subject to certain limitations, unless the applicant can demonstrate that there will be no negative impact on the licensing objectives. There are four CIZs in Cornwall:

- Newquay
- Falmouth
- Truro
- Penzance

CIZs will be under review this year with the objective of aligning their boundaries to those of LSOAs[207] and assessing whether polices should be set regarding the maximum number of licenced premises in each zone.

Underage Sales

NICE guidance[208] recommends in relation to sales to people who are underage, too intoxicated or proxy sales (illegal purchases for someone who is under-age or intoxicated):

- Sufficient resources are available to prevent these sales;
- Partnership work with appropriate authorities to identify and take action against premises that regularly make these sales;
- Test purchasing is undertaken ('mystery' shoppers) to ensure compliance with the law;
- Sanctions are fully applied to businesses that break the law regarding these sales. This includes fixed penalty and closure notices applied to establishments that persistently sell alcohol to children and young people.

Locally we are **unable to conduct test purchases (TPs) at on-licence premises** (pubs, clubs etc.) without significant police support. This is to protect the well-being of the underage volunteers. **Advice visits** are generally caried out to the business as an alternative.

[205] NICE Guidance (PH24) Alcohol-use disorders: prevention, NICE (2010)
[206] Alcohol: preventing harmful use in the community, Quality standard [QS83], NICE (2015)
[207] Lower Layer Super Output Areas (LSOA) which typically contain around 1500 residents
[208] NICE Guidance (PH24) Alcohol-use disorders: prevention, NICE (2010)

TPs to off-licences can be done without police support, but normally a covert surveillance authority from the Courts is required. To obtain this authorisation, intelligence is required- with the **frequency and reliability of this often being an issue**. A recent review has looked at how TPs may be carried out within the law. This may mean writing to all the off-licences in an area to put them on notice that TPs will be carried out. NICE Guidance recommending TPs has not been updated since the introduction of new legislation was introduced around covert surveillance.

The licensing team within the Council ensures that an applicant is including **sufficient age checking processes/policies** as part of their alcohol licence application. The Cornwall Council Licensing Manager also attends the Multi-Agency Child Exploitation (MACE) meetings where intelligence is shared.

Intelligence gathered in relation to underage sales (2018-2021) relates to localities all across Cornwall. Redruth and St Ives were the two most frequently cited locations. Intelligence mainly related to sales of alcohol to those underage as well as not asking for ID.

Training

Previously SMART (Substance Misuse and Alcohol Retail Training) was delivered to promote best practice in selling alcohol, for staff and management in CIoS Licensed premises. The training included:

- Basic Licensing Law and Practice
- Alcohol, Children and the law
- Basic drug and alcohol awareness
- Signs of dealing on the premises
- Alcohol Poisoning
- Alcohol and Driving
- Alcohol services in Cornwall

Currently the DAAT are looking at ways to deliver this training in-house whilst collating information on PubWatches in CIoS.

Community Safety Schemes

Night-Time Economy and DASV

Drink Spiking[209]

A more robust and easily accessible **reporting process** has been developed and advertised through social media and posters in Night-Time Economy venues. Members of the public are advised to report any instances of possible drink spiking to a member of staff at a venue or the police.

Bars who are part of the Best Bar None scheme, Pubwatch and all late-night venues across Devon and Cornwall have been supplied with **drink testing kits** and urine testing kits can be used by officers at any police station up to three days after the incident. As the **majority of cases reported to Devon and Cornwall Police were in University Towns**, the police have engaged with all bars and clubs in Falmouth to supply and train them on the use of drink test kits. Engagement has also taken place through Falmouth Universities to encourage students to take up these tests.

Safer Streets

A successful bid to the Government's Safer Streets fund (part of the Violence Against Women and Girls Strategy, VAWG) will support projects in the **Falmouth area**. The grant has funded a student-led VAWG group to run awareness campaigns and 6 new CCTV cameras.

'Don't be a bystander' training has also been delivered in Falmouth for staff in pubs, clubs and bars to improve the safety of the Night-Time Economy for all. Training will continue with 'Train the Trainer' sessions in 2022 for Night-Time Economy businesses in the Falmouth area.

Police and Crime Plan 2021-25

The Police and Crime Plan 2021-2025[210] focuses on Safer, Resilient and Connected communities with a focus on prevention and partnership working.

The commissioner's priorities are:

- Tackling antisocial behaviour;
- Reducing harm caused by drugs;
- Improving safety on our roads;
- Tackling all forms of violence.

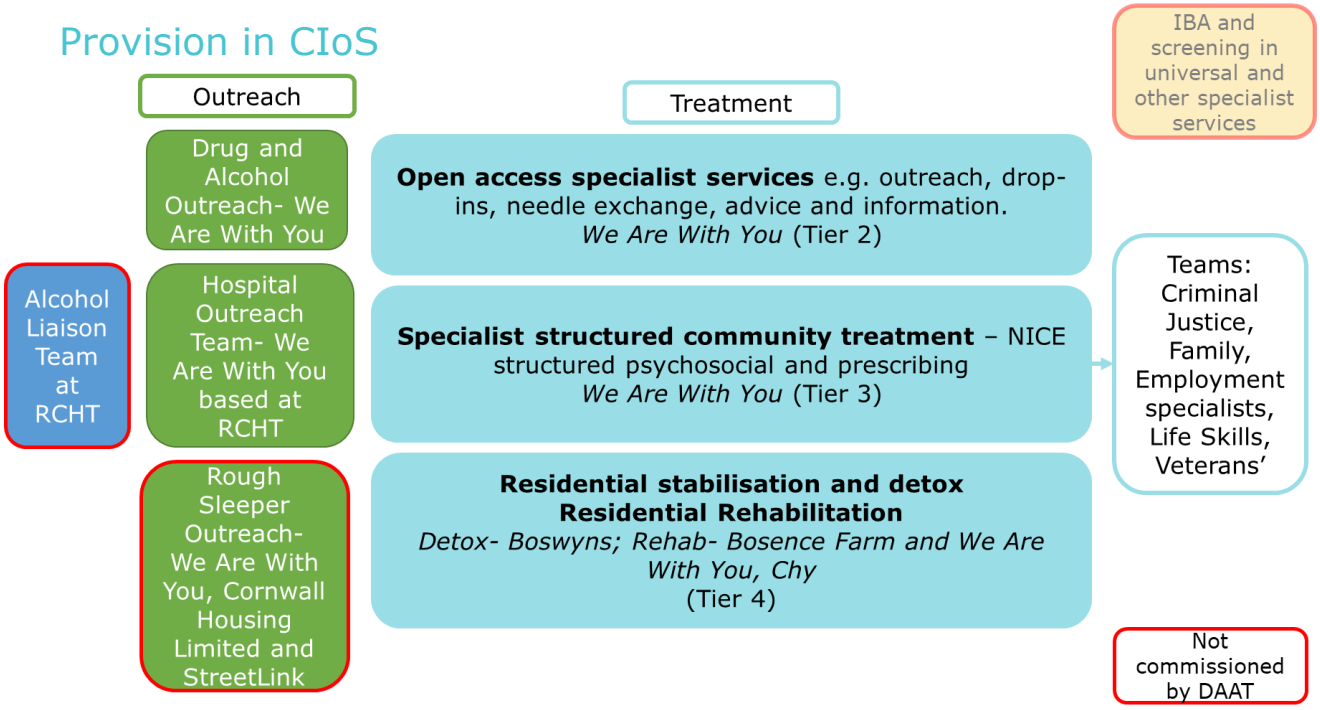
Whilst there is **no specific mention of alcohol in the plan**, or its links with road safety, violence and domestic abuse, all four priority areas are linked to reducing alcohol harm.

The plan does detail the commissioner's intention to continue funding the Assault Related Injuries Database (ARID- see page 95).

[209] Please refer to the CIoS Drugs Needs Assessment for analysis of needle spiking.
[210] Police and Crime Plan 2021-2025. Office of the Police and Crime Commissioner Devon and Cornwall (2021)

Reducing alcohol harm- Treatment, aftercare and recovery

Provision in CIoS



In CIoS the DAAT commission open access specialist services including some outreach (tier 2); structured community drug and alcohol treatment (tier 3); and residential detox and rehab (tier 4). Drug and alcohol treatment involves both **medical and psychosocial interventions** delivered by specialist recovery workers with clinical and medical leads, with doctors and nurses amongst the workforce.

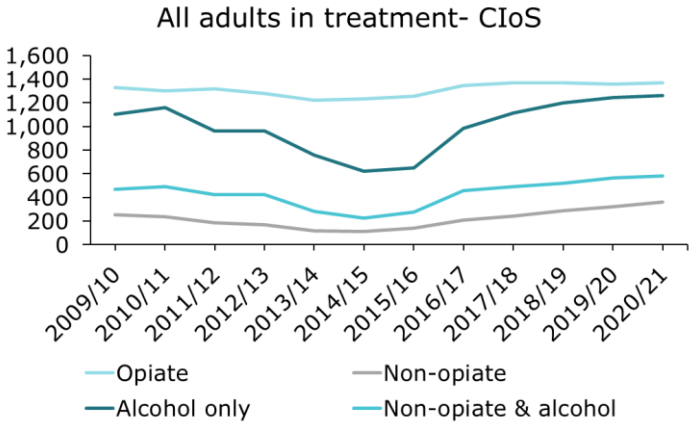
Information on those entering structured treatment is recorded through our case management system (Halo) and forms part of the **National Drug Treatment Monitoring System** (NDTMS) dataset.

Getting people into treatment

In 2020/21, 3,575 adults engaged in structured treatment. Services are commissioned to provide 2,600 placements meaning in 2020/21 they were **37.5% over capacity**. In 2021/22 services were 25% over capacity.

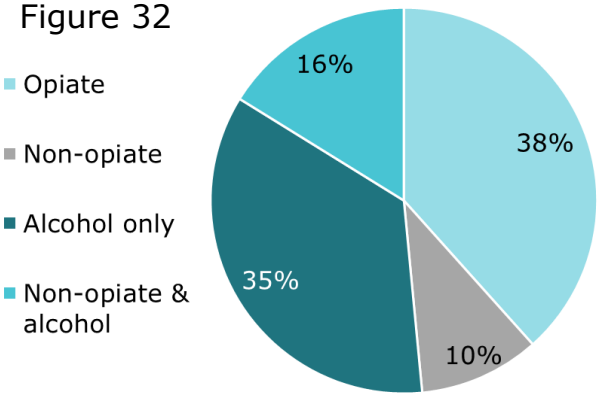
Local **treatment numbers have been rising** since 2014/15 with 2020/21 following this trend (nationally numbers have been rising since 2017/18). The increase in treatment numbers seen since 2015/16 for alcohol only appears to be plateauing (Figure 31).

Figure 31



Those receiving **alcohol treatment accounted for 51% of the treatment population** in 2020/21 (Figure 32). Nationally the treatment population is 25% alcohol only and 11% alcohol and non-opiate (together 36%). The make-up of the treatment population locally by substance remained the same in 2020/21 as in 2019/20.

Figure 32



The make-up of new presentations to treatment by substance in 2020/21 remained the same as in 2019/20. Locally 2% more clients presented to alcohol treatment (only and with non-opiates) in 2020/21 compared to 2019/20 (nationally there was a 1.3% increase).

Locally, a higher proportion of those who are estimated to be alcohol dependent are in treatment- 28% compared to 20% nationally. This suggests that we are **good at engaging people in alcohol treatment**. However, there still remains an **estimated 5,017 dependent drinkers locally who are not engaged in treatment**.

An average of **3 people** per 1,000 of the Cornish population were in structured alcohol treatment in 2020/21. The areas[211] with the highest rates were Liskeard Town Centre, two areas in St Austell, Newquay and Penzance. This is not surprising given that these are towns which all feature neighbourhoods with high levels of deprivation.

Alcohol versus drugs: treatment engagement

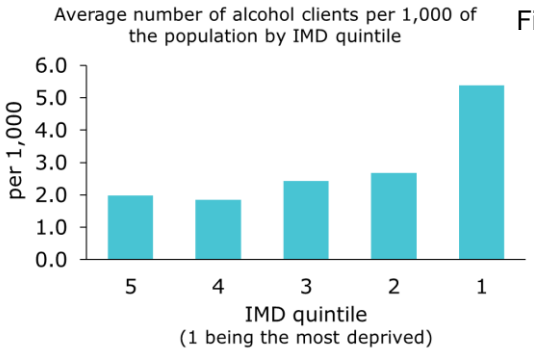
Both locally and nationally a **greater proportion of those estimated to be using crack and/or opiates are engaged in treatment** compared to dependent drinkers.

If the **same proportion of dependent drinkers** were engaged in treatment **as crack and/or opiate users** this would equate to between 2,508 and 4,669 people in local alcohol treatment. In 2020/21, 1,846 people were in treatment for alcohol use (alcohol only and alcohol and non-opiates).

Therefore, an **additional 662 to 2,823 people** in alcohol treatment, compared to 2020/21, would mean that local services would be between **63% and 146% over capacity** as currently 2,600 treatment places are commissioned. See Appendix K for more details on the calculations behind these figures.

[211] Lower Layer Super Output Areas (LSOA) which typically contain around 1500 residents.

Figure 33



The **rate of people in alcohol treatment is higher in the 20% most deprived areas** (quintile 1, Figure 33) at 5.4 per 1,000 of the population compared to an average of 2.2 for all other areas (quintiles 2-5).

In 2020/21 both **locally and nationally around 2 in 3 people in alcohol treatment** (alcohol only and alcohol and non-opiate) **were male**. The same gender profile is seen when looking at new presentations to alcohol treatment.

Across all substance groups the majority of clients, who had an open treatment episode in 2020/21, were aged between 30-39 at the start of treatment (Figure 34). The **alcohol only cohort were slightly older** with those aged between **40-59** accounting for over half of the alcohol treatment cohort.

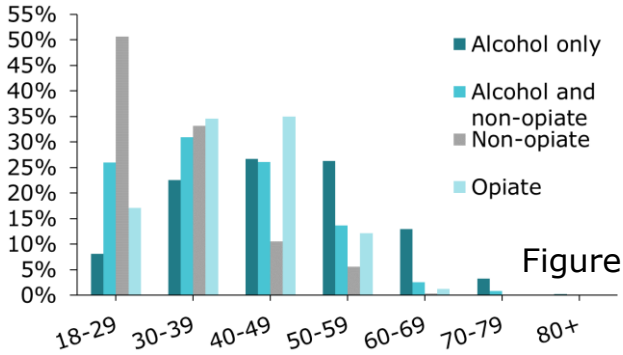


Figure 34

We would expect to see an older cohort in treatment for alcohol as nationally alcohol consumption is decreasing amongst the younger population and those aged 55-64 are the most likely to drink above 14 units per week.

A prompt response for help plays an important part in supporting the best chances for recovery. Local **waiting times for alcohol treatment have remained exceptionally low** despite the difficulties created by the pandemic. Local services continue to **perform better than nationally** in this area.

In 2020/21 all clients were able to start alcohol treatment within 3 weeks. From April to September 2021, only 2 clients for waited more than 3 weeks for treatment. This is still below the national average.

The **main route into alcohol treatment is self-referral** accounting for 65% (nationally 63%) of all referrals in 2020/21 (Figure 35). GP referral accounts for the next largest segment at 9%, followed by the criminal justice system (5%). A high volume of self-referrals suggests that professionals in other agencies may be unclear around whether they can refer a client to treatment rather than making the client aware of treatment to make a self-referral.

Looking at secondary care specifically, referrals through hospital and the Alcohol Liaison Team (based at the Royal Cornwall Hospital) make up 64% and 36% of all secondary care referrals locally compared to 73% and 22% nationally. No referrals were received through ED locally whereas nationally this route accounts for 5% of all secondary care referrals. **Referrals through social care remain low** at 2% compared to 4% nationally.

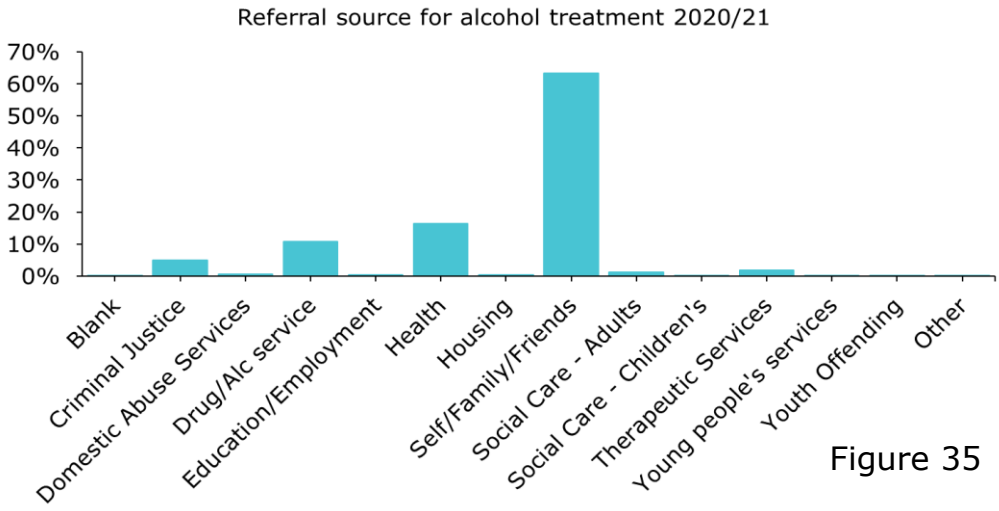


Figure 35

By gender, referral source is largely similar however, 10% more of the female alcohol treatment cohort self-referred whereas **8% more of the male cohort were referred via the criminal justice system**.

Drinking at treatment start

Most people who require alcohol treatment will be drinking at higher risk levels when they start treatment. Drinking levels at the start of treatment may give some indication of the **severity of dependency and potential harm** amongst the treatment population.

Looking at units consumed in the 28 days prior to treatment (Figure 36) for the alcohol only cohort, there was a 3% increase in those drinking 800+ units from 2019/20 to 2020/21. Our consumption profile for those starting alcohol only treatment is similar to the national average.

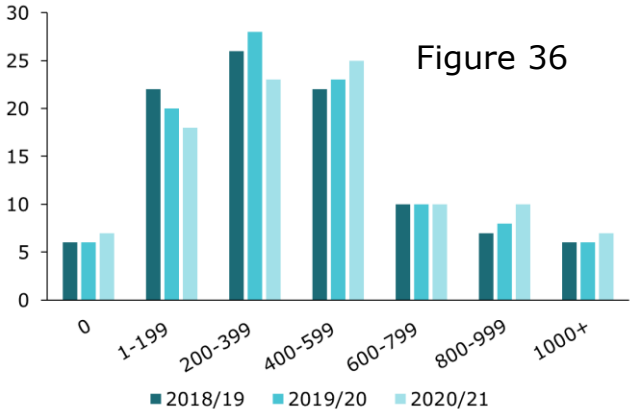


Figure 36

National evidence suggests that alcohol consumption during the pandemic increased amongst those who were the heaviest drinkers pre-pandemic[212]. There has only been a small increase in local consumption amongst those who sought alcohol only treatment. This may **mean that those whose drinking increased during the pandemic where those already engaged in treatment or those who have yet to seek support**.

Leaving treatment and outcomes

Treatment exits

Figures for 2020/21 show that rates of successful treatment completions were slightly below the national average (Table 17). However, in the 12 months to September 2021, **local rates have increased and are now very similar to national rates**:

[212] Monitoring alcohol consumption and harm during the *COVID-19* pandemic. Public Health England (2021)

Table 17	Successful completions as a proportion of all in treatment			
	2020/21		12 months to Sept '21	
	Local	National	Local	National
Alcohol only	33.7%	37.1%	37.4%	37.5%
Alcohol and non-opiate	31.2%	33.5%	32.8%	33.4%

This is positive as the last alcohol needs assessment highlighted that we were falling short of the national average by 106 successful completions for the alcohol only cohort.

We also take into account **re-presentations to treatment within 6 months** of successful completion to somewhat indicate if recovery has been successful. Re-presentations, in the 12 months to September 2021, for **alcohol and non-opiate clients are lower than nationally** (5.8% versus 7.8%) whereas **local alcohol only clients are more likely to re-present** within 6 months than nationally (11.3% versus 9.3%).

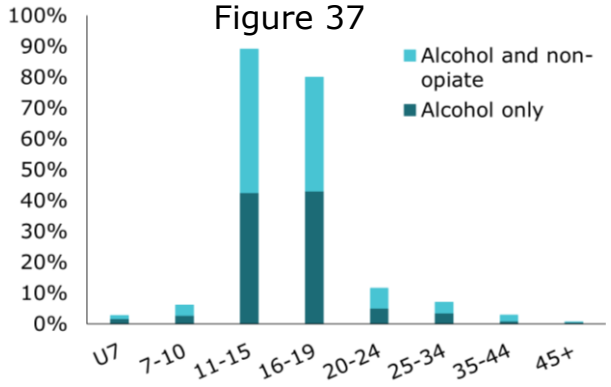
An early unplanned exit relates to a client who, within the first 12 weeks of treatment, dropped out, moved away, died or transferred but did not continue treatment. Early unplanned exits for alcohol users locally accounted for 8.3% of new presentations compared to 26.5% nationally. This suggests that **locally we are initially meeting the needs of service users and successfully promoting engagement with services**. However, the first half of 2021/22 has seen a slight increase locally and nationally in early unplanned exits.

Transitions to adult treatment

From April 2018 to March 2021, 65 people in adult alcohol or alcohol and non-opiate treatment were aged 18-20. Only 23% of those were previously known to young people's treatment services (YZUP). Those who were 18 were more likely to be known to YZUP than those who were older. Even though numbers are quite small this suggests children and young people with a drinking problem need to be identified earlier so that they do not present to treatment as a young adult after their drinking has become more severe.

The majority of clients in structured adult alcohol treatment in 2020/21 said they first tried alcohol between the ages of 11 and 19 (45%, (Figure 37). A total of 34% (589) clients said they first drank alcohol under the age of 15. It is recommended that if children and young people do drink underage then it should not be until at least the age of 15[213].

Figure 37



[213] Should my child drink alcohol?, NHS

Deaths in treatment

In 2020/21 **1.5% of those in alcohol treatment sadly died** (28 people). This is slightly above the national proportion of 1.1%. Both locally and nationally the proportion of alcohol clients dying in treatment rose from 2019/20 to 2020/21. It is likely that changes to treatment, reduced access to broader healthcare services, changes to lifestyle and social circumstances during lockdowns, as well as COVID-19 itself, will have contributed to this increase.

It is important to note that deaths in treatment are also an indicator of often very vulnerable clients receiving the support they need and end of life care. We would be concerned if no clients died in treatment as this would indicate a 'hidden population' in need of support.

Community treatment services provided a brief overview of each of the 34[214] cases who died in alcohol treatment or shortly after. Information was also assessed from each client's latest risk assessment form in case notes. Figure 38 illustrates the reoccurring themes generated from both pieces of information.

Figure 38

Cases reflect that these service users were often vulnerable with **co-occurring poor mental and physical health alongside other complex needs**. Findings are very similar to contributing factors noted for drug related deaths in CIoS in 2020[215].

- 73% had poor mental health, a similar prevalence to the current treatment cohort (71%);

[214] Includes 1 client who died in 2019, 4 in 2021/22 after closure in 2020/21 and 1 whose date of death is unknown. Differs from 28 as some clients may not have consented to having their information shared with NDTMS.
[215] Drug related deaths report, Safer Cornwall (2021)

- 62% had poor physical health compared to 4% of the treatment population[216];
- The majority of clients had multiple treatment episodes over many years;
- 10 disclosed during treatment that they had experienced childhood trauma;
- 10 were known to have children of which some they had no contact with or were now adults themselves.

Local services have reported 37 deaths in 2021/22 of clients in alcohol treatment (or previously in treatment). Some of these were using non-opiates and/or opiates in addition to alcohol. A total of 22 **(59%) clients that died were aged 50 or over**. Like those who died in 2020/21, many were long-term drinkers with physical health problems with 13 (35%) having **liver disease**. There were three deaths of females aged 30 and under. Services report that currently there are a number of **complex young female drinkers**.

Outcomes

The proportion of adults who were alcohol abstinent upon planned exit in 2020/21 was **lower than nationally**. This local disparity was **driven by a lower male rate**. The average number of days in which a client drinks was 7 fewer upon exit compared to treatment start. A reduction by 9 days was observed nationally.

The majority of alcohol clients leave treatment with no housing problem (99%).

Employment rates upon treatment entry and exit are higher than nationally. However, changes in employment locally throughout treatment are lower suggesting that **treatment has little impact on changing employment status for alcohol clients** with employment at the start of treatment the strongest predictor for employment status upon exit.

More information on housing and employment can be found in section 3: harms to the drinker- socioeconomic.

Numbers and needs of different groups in treatment

Treatment resistant drinkers

The traditional approach to treatment resistant drinkers has been the pessimistic belief that nothing can be done for people who do not want to change.

Alcohol Change's '**Blue Light**' approach challenges this view as nationally (and locally) the vast majority of dependent drinkers are not in treatment. Those who are resistant to treatment are some of the most risky and vulnerable members of our communities often with multiple complex needs and are often frequent attenders to hospital.

The Blue Light group are those who meet the following criteria:

[216] % in the alcohol and alcohol and non-opiate open caseload in 2020/21 with at least one of the following disabilities recorded: manual dexterity; mobility and gross motor; personal, self-care and continence; or progressive conditions and physical health.

- Are a long-term heavy drinker;
- Have been referred to services on many occasions or disengaged
- Are a burden on public services e.g. 999, housing agencies, health and social care, ASB, criminal justice and domestic abuse services.

The aim is to work with this group to **build motivation for change** whilst working to **reduce harm and manage risk**.
The Blue Light Project Manual[217] provides detailed guidance on how to identify and support this group. It recommends the AUDIT tool and IBA is used with all clients of frontline services at the earliest stage to avoid missed opportunities and start talking about drinking.

To increase initial engagement with treatment:
- Informing clients that treatment may not mean abstinence;
- Reassure any worries around need to engage in group work;
- Make the referral rather than encouraging self-referral;
- Appointments that are flexible: location, timing, lateness and intoxication;
- Consider if a volunteer or peer mentor could accompany the person to their first appointments;
- Speedily follow-up on disengagement and report this back to the referrer.

Ethnicity

New presentations to local alcohol only treatment in 2020/21 were **mainly White British** (94%, right).

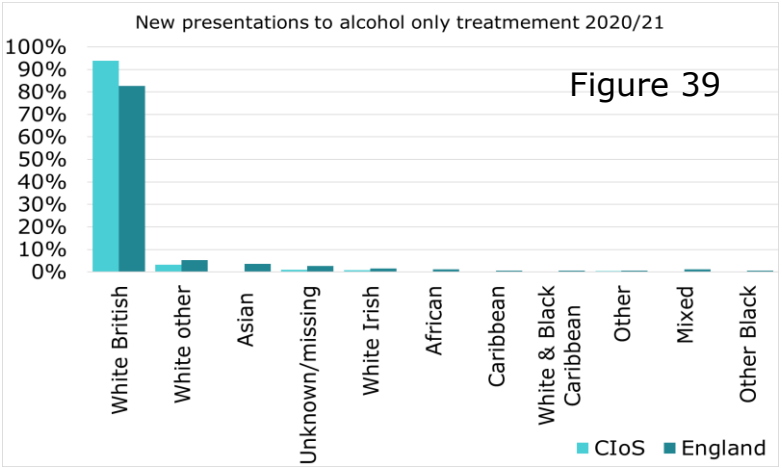


Figure 39

Our local treatment population is less diverse than nationally, but this is in the context of our local population also being less diverse (Figure 39 and Table 18).

Asian, Black and mixed ethnicities are under-represented in our local alcohol treatment population whereas those from White Other (including White Irish) are over-represented at 3.9% compared to 2.1% in the general population (2019[218],Table 18). We would expect to see more of those who identify as White Other in treatment due to higher levels of drinking amongst those included in this group such as White Irish, Gypsies, Roma and Travellers.

Table 18

Ethnicity	Count	%	England %
White British	548,388	95.9	79.8
White Other	122,52	2.1	4.3
Asian	3,928	0.7	8.2
Black	865	0.2	3.7
Mixed	5,425	0.9	2.8
Other	944	0.2	1.1

[217] The Blue Light Project Manual, Ward and Holmes (2014)
[218] Population denominators by broad ethnic group and for White British, local authorities in England and Wales: 2011 to 2019, ONS (2020). These estimates use mid-year population estimates but have not undergone formal Quality Assurance.

Research has identified the following barriers to accessing alcohol support amongst different ethnic minority groups[219]:

- Cultural shame around alcohol and viewing seeking help as a weakness of character;
- Lack of knowledge around alcohol harms and services available;
- Current and former experiences of discrimination and racism;
- Mistrust of services;
- Language barriers;
- Services' lack of understanding of cultural context: world view; attitudes; beliefs; ethnicity; family dynamics; and religious practices.

Key facilitators in helping people to access support from diverse ethnic backgrounds include:

- Developing services with community members;
- Emphasising the confidentiality of services;
- Peer-led support;
- Increased cultural competence of services through staff recruitment and training;
- Materials in other languages.

Gypsies, Roma and Travellers

The Royal College of General Practitioners summarised the barriers to accessing healthcare GRTs experience[220] which were echoed in The Women's Centre Cornwall's 2021 project with GRT and Migrant workers[221]:

- Lack of suitable accommodation;
- Registering with a GP practice or NHS dentist is difficult as some require proof of ID and a fixed address;
- Language barriers mean many are likely to have poorer access to and knowledge of local services;
- Fear of discrimination and harassment results in a reluctance to share information with statutory services;
- Lack of cultural awareness, including racism, perceived judgemental behaviours, or inability to 'explain things properly' often contributes to poor patient experience;
- Limited reading and writing skills or form filling make it difficult to engage.

Additional local findings[97]:

- Letters of appointments or important health information often do not reach the person- Minorca Lane, the largest private site in Cornwall, has a shared mailbox;
- GRT and migrant workers can have mobile phones that cannot receive calls from British numbers;
- Lack of transport available during the day;

[219] Rapid evidence review: Drinking problems and interventions in black and minority ethnic communities, Gleeson et al. (2019)
[220] Improving access to health care for Gypsies and Travellers, homeless people and sex workers, Royal College of General Practitioners (2013)
[221] Gypsy, Roma, Traveller & Migrant Women Project, The Women's Centre Cornwall (2021)

- GRT people feel that services are not for them with a fear of being judged or facing adverse consequences for example engaging in social care will result in the removal of children.

In 2020/21, 8 individuals in alcohol treatment were recorded as a Gypsy or Traveller (0.5%). It should be noted that whether a client was a Gypsy or Traveller was **missing for 56% of clients**. Updates to data collection from April 2022 should improve this.

As the numbers of known Gypsies and Travellers accessing alcohol treatment is so small, drawing robust conclusions from further analysis is difficult and increases the risk of making individuals identifiable.

To overcome this the analysis below considered all 'open' drug and alcohol clients from 1st April 2019 to 30th September 2021. During this time there were 6,611 people in the treatment system; of these 94 were Gypsies and Travellers (Table 18). Again, whether a person was a Gypsy or Traveller was missing for around half of all clients.

- Based on those accessing treatment, drug and alcohol issues are around **6 times more prevalent** amongst Gypsies and Travellers (Table 19).

Table 19	**Whole Population**	**Gypsy & Traveller**	**% Gypsy & Traveller**
Population of Cornwall	575,525	1,500	0.3%
Number in treatment	6,611	94	1.4%
% in treatment	**1.1%**	**6.3%**	

The age profile of Gypsy and Traveller service users is similar to the treatment population as a whole. However, no Gypsies and Travellers in treatment are under the age of 20 or over the age of 70.

Males make up a larger proportion of the Gypsy and Traveller treatment cohort compared to the main treatment cohort (71% versus 64%).

Prevalence of **recorded disability is higher** for Gypsies and Travellers (49%) than the main treatment population (36%).

In both the Gypsy and Traveller and main cohorts, around 1 in 5 people are recorded as having a dual diagnosis (a diagnosed mental health condition in addition to an alcohol and/or drug need, Table 20).

Table 20	**Dual diagnosis (persons)**	**Dual Diagnosis (%)**
Treatment population	1370	21%
Gypsies & Travellers in treatment	17	18%

Gypsies and Travellers in treatment are **most likely to be heroin users** whereas the main treatment cohort are most likely to be alcohol only users (Table 21).

Table 21 Drug group	All	Gypsies & Travellers
Alcohol only	36%	28%
Alcohol and non-opiate	22%	27%
Non-opiates	15%	16%
Opiates	27%	30%

LGBTQ+

Access to treatment

Despite all available research indicating increased levels of problem drinking amongst the LGBTQ+ population, they are **under-represented in alcohol treatment nationally**.

In 2020/21, 2% of those in alcohol and/or drug treatment in CIoS disclosed that they identified as Gay or Lesbian and 2% said they were Bisexual. Nationally this was 3% and 2% respectively.

A total of 0.17% of those in local alcohol treatment in 2020/21 identified as either bigender, intersex or third gender/Pangender. A national comparator is not available.

There is no reliable data on the numbers of non-heterosexual groups and transgender residents in CIoS. Therefore, it is difficult to estimate the prevalence of alcohol dependence in the population and determine the degree to which LGBTQ+ residents may be underrepresented in local alcohol treatment.

In CIoS an estimated 1.5% of adults are dependent drinkers[222]. We could estimate that 3% of the LGB population are dependent drinkers as one study found that alcohol dependence is twice as likely within the LGBTQ+ population.[4] This would equate to an **estimated 387 LGB dependent drinkers in CIoS**[223]. Based on the number of LGB people in structured alcohol only and alcohol and non-opiate treatment in 2020/21, there is a higher rate of unmet need amongst the LGB population than the general adult population (Table 22).

Table 22	CIoS Adults	CIoS LGB
% of population estimated to be dependent drinkers	1.5%	3%
Estimated number of dependent drinkers	6,968	387
Number in alcohol treatment in 2021/22	2,016	78
% in treatment	29%	20%
% unmet need	**71%**	**80%**

Unfortunately, we are unable to complete the same analysis for transgender residents.

[222] Alcohol dependence prevalence in England, Public Health England (2021)
[223] There are an estimated 12,900 LGB residents in CIoS (see the Equality and Diversity section of the Cornwall and the Isles of Scilly Insights Dashboard. This is calculated from a South West estimate generated by the Office for National Statistics in 2019.

Barriers to treatment

Research in Scotland revealed that within drug and alcohol services LGBTQ+ people report that they may not feel safe or welcome because groups mostly comprised of, and **catered to, white, cisgender, heterosexual men**. Respondents also cited that groups may be religious in nature which was uncomfortable. Services assuming that all participants were heterosexual was also cited.[224]

The substance use services that do focus on the unique experiences of LGBTQ+ people have been described as focusing on the experiences of gay and bisexual men, **excluding lesbian and bisexual women, trans, and nonbinary people**.[225]

The Scottish Trans Alliance report[226] revealed that transgender people feared that transgender-specific healthcare services (i.e. hormone access and/or surgery) would be stopped or refused if they engaged with addiction services, or similarly, that recovery services would be stopped or refused due to being transgender.

Improving access to local alcohol treatment for LGBTQ+ individuals is a priority.

Gender

In 2020/21 both **locally and nationally around 2 in 3 people in alcohol treatment** (only and alcohol and non-opiate) **were male**.

Women and men's experience of using drugs, accessing support, and engaging with drug treatment is very different.

National research[227] surveying third sector organisations and interviewing female service users revealed that for many women, drug and alcohol services can be **daunting and intimidating places** especially for those who have experienced domestic abuse.

Early **trauma** in childhood, parent/carer problem drinking and drug use, **domestic abuse** and losing custody of children all contribute to women's alcohol and/or drug use.

Barriers to treatment cited in the research included **male-dominated services**, fear of **losing child custody** and **stigma** around disclosing substance use especially for those who are sex workers too. Women from Black, Asian and ethnic minority communities also face additional anxiety around the shame accessing services will bring upon their family as well as the risk of ostracism.

The report made the following recommendations:

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[224] The social context of LGBT people's drinking in Scotland, Emslie, Lennox and Ireland (2015). This study had 33 participants from the LGBT community.
[225] Substance Misuse — Women's Programme, LGBT Foundation
[226] Transgender Inclusion in Drug and Alcohol Services, Scottish Trans Alliance (2017)
[227] A system designed for women? Understanding the barriers women face in accessing drug treatment and support services, With You (2021)

- Commission **women only services** and ensure all women can access women-only spaces including peer groups and peer mentors. Drug using communities are often small and it is common for women to encounter their former partner or abuser in group settings;
- Promote **gender and trauma training** for service providers;
- Involve women with **lived experience** in service design, delivery and evaluation;
- Provide an option of having a **female keyworker**
- Ensure services are **child and family friendly** offering women additional household and parenting support if needed
- **Reduced caseloads** for workers engaging with complex women.

Learning disabilities

In 2021/22, 5% (153/3,028) of those in local structured drug and alcohol treatment were recorded as having a learning disability. Research outlines that those with learning disabilities are less likely to access treatment or remain in treatment for problem substance use[228].

Barriers include[229]:

- Drug and alcohol services not recognising learning disabilities;
- Learning disability services not detecting alcohol and drug problems;
- A lack of clear pathways and protocols between services reducing the effectiveness of inter-agency working;
- A lack of recognition in drug and alcohol guidance and policies;
- Health promotion messaging is too complex.

Research shows that neither learning disability services nor drug and alcohol services have all the skills and training resources to support people with learning disabilities who are problem drinkers or use substances[180].
There is lack of evidence-based guidance about effective treatment for this group, but some useful approaches have been suggested[230]:

- **Screening** for learning disabilities in drug and alcohol services and screening for substance use in learning disability services,;
- **Training** for staff in drug and alcohol services in how to tailor their approach to those with learning disabilities;
- Training for those in learning disabilities services around substance use;
- Information and interventions tailored to individuals' **communication and learning needs**. Messaging and topics need to be simplified;
- A **one-to-one** approach rather than group work;
- **Shorter sessions** but a longer length in treatment with maintenance sessions;
- A patient, flexible, teaching approach that uses **repetition and concrete goals** set over short time frames;

[228] Disparities in access to substance abuse treatment among people with intellectual disabilities and serious mental illness, Slayter (2010)
[229] Substance misuse in people with learning disabilities: reasonable adjustments guidance, Public Health England (2016)
[230] A literature review on alcohol and substance use in people with learning disabilities, Public Health, Haringey Borough Council (2016)

- Incentives, role play, quizzes, pictures and games;
- Widening a person's social support network;
- Involving **family/carers** in treatment;
- Access to **other support services** to help people address the reasons they may be using substances e.g. sexual abuse and bereavement.

Autism

A national survey of 507 autistic adults[231] found that amongst those who reported problem drinking, 45% would not seek any support with 49% citing that the internet was their most common form of support. Barriers cited included **fear of an unfamiliar chaotic environment** and being **misunderstood and judged** by a therapist. The Centre for Applied Autism Research has 10 tips for working with autistic clients[232]:

- **Understand** autism- the psychological mechanisms including strengths and the impacts of associated conditions such as anxiety;
- **Preparation**- provide a photo of the worker and building/room to the client before the session and consider sensory issues before, during and after the session;
- **Maximise structure and consistency** by having a regular slot with the same person;
- **Flexibility**- sessions may need to be longer and bear in mind that 'motivation to change' activities may be unhelpful;
- Use **plain language** avoiding metaphors, acronyms and jargon and avoid non-literal sayings like 'pull your socks up';
- Be **explicit and explain** WHY something is happening. Have clear aims with reminders throughout and after the session. Allow time for processing (verbal and written);
- Discuss individual hobbies and interests;
- Discuss emotions in terms of lived experience;
- Involve **family, friends or an advocate** but only if agreed with the client.

Veterans

In 2020/21, 43 veterans accessed local alcohol treatment.

Based on the estimated number of Veterans in Cornwall and numbers accessing treatment in (Table 23), adults in the general population are twice as likely to access alcohol treatment compared to Veterans. Given the evidence that Veterans are more likely to have a drinking problem we would expect a higher rate of Veterans to be in treatment than adults in the general population. This suggests that **we need to improve engaging Veterans in treatment**.

Table 23 **2020/21**	**Whole Population**	**Veterans (persons, estimate)**	**Veterans (%)**
Adult Population in Cornwall	478,040	23,902	5.0%
Number in alcohol treatment	1,723	43	2.5%
% in alcohol treatment	0.36%	0.18%	

[231] The Expectancies and Motivations for Heavy Episodic Drinking of Alcohol in Autistic Adults, Brosnan and Adams (2020)
[232] Working with neuro-diverse drinkers, Bronsan (2019)

Those who have served in the military can face many challenges upon leaving the Armed Forces; community and relationships; employment, education and skills; finance and debt; health and wellbeing; making a home in civilian society; and the criminal justice system.

Family members are also affected with over half of service personnel perceiving that their military career has had a negative impact on relationships and their children[233].

Findings related to alcohol interventions and treatment for Veterans are summarised below[234]:

- A US study indicated that more Veterans are able to access effective alcohol support in **primary care settings**;
- Brief **online interventions** can be effective in reducing alcohol intake and intention to drink among **young Veterans**;
- Problem drinking does not reduce receptivity to treatment for PTSD;
- **Treating co-morbidities** can improve overall outcomes, e.g. providing mental health interventions alongside problem drinking support and combining psychological therapies with alcohol and smoking interventions;
- Veterans admitted to hospital are more likely to be **referred for support** with alcohol difficulties **at an older age**.
- In one study Veterans were more likely to acknowledge they had a problem with alcohol (78%) than those currently serving in the Armed Forces (51%)[235].

These findings suggest that **providing support to address mental health alongside alcohol use** and **targeting Veterans at a younger age**, both to prevent problem drinking and engage those that need treatment earlier, may be effective.

The local Veteran's team lead within our drug and alcohol community treatment service also provided insight into Veteran's characteristics and needs:

- Generally older Veterans who served in the 1960s, 70s and 80s drink problematically, whereas drugs are mainly used by the younger generation of Veterans who served in the 2000s. For those who served in the 1990s there is a mixture of problem drinking and drug use;
- They generally prefer to engage in **outdoor, physical activities** with other veterans;
- **Accepting that they are no longer part of the military** and letting go can be challenging for some as can speaking to people as Veterans are used to the autocratic style of communication in the military;
- Some have little **experience of budgeting** as board and meals were previously removed from their salary before they were paid;
- Those who served in **non-British Forces**, e.g. the French Foreign Legion, are not supported by Veterans' charities. With You still help these Veterans to access community support and MAP groups.

[233] Perceptions of the impact a military career has on children, Rowe et al. (2014)
[234] Exploring patterns of alcohol misuse in treatment-seeking UK Veterans: A cross-sectional study, Murphy and Turgoose (2019)
[235] Help-seeking and receipt of treatment among UK service personnel, Iversen et al. (2010)

Anyone identified as a Veteran upon entering community drug and alcohol treatment (mandatory question), is referred to the specialist Veterans' team[236] who themselves are Veterans.

From April to December 2021, across both drugs and alcohol, the team **supported 67 Veterans and made 94 onward referrals**. Four of those supported were family members. The service works to support Veterans throughout treatment and address any other needs.

Veterans are supported to access services such as mental and physical health support; food banks; budgeting advice; social prescribing[237] and activities to reduce isolation. There is a **specific MAP group for Veterans in Cornwall** as well as a national Veterans group which service users are encouraged to join.

Three Veterans since April 2021 have accessed the UK's only **Veteran specific residential rehabilitation** service in Liverpool. This service is for those who may struggle to engage with non-veteran-specific local rehab services.

The Veterans' team have also attended events both as a service provider and employer of ex-Armed Forces personnel to raise awareness of the service.

Case Study

T served in the 1980s and recently lost a close friend who passed away after T had administered CPR. This was a traumatic experience. T has been engaged in With You since December 2018 and lives alone. He was drinking everyday and finding it difficult to manage his finances.

The Veterans' team referred T to a number of services:

- Veteran's Charity- food
- Citizens Advice Money Matters Veteran's service- budgeting support
- With You's LifeSkills team- benefits support
- Veteran's High intensity service- daily contact

T has engaged well with all these services and has reduced his drinking significantly. He will also be referred to Veteran's social prescribing to help reduce isolation.

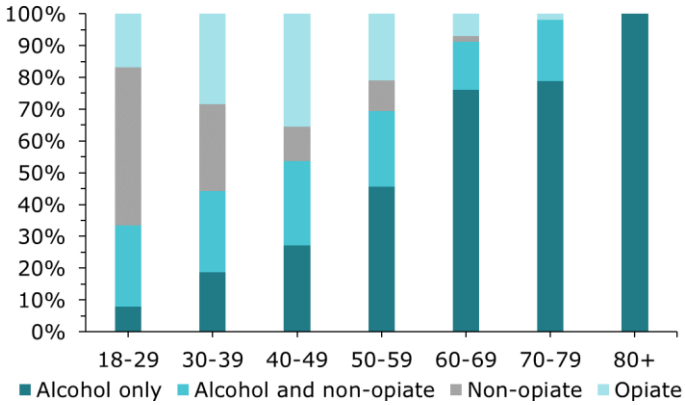
This case study demonstrates the partnership work between With You and external agencies to address all T's needs alongside support for his drinking.

[236] The team is part of With You's national Right Turn project for Veterans.
[237] There are now two Veteran-specific social prescribers in Cornwall who promote and train existing social prescribers in supporting Veterans; they are also able to support 1:1 and have additional funding for Veterans. Cornwall is the only county to have two social prescribers involved in this trial project.

Older People

In our local treatment population (2020/21) the **proportion of clients in receipt of support for problem drinking increases with age** (Figure 40).
The **majority of those aged 50 and over have an alcohol need**. Those aged 80 and over were only in treatment for alcohol.

Figure 40



The Drink Wise, Age Well project in other areas identified that **ageism and assumptions** were a factor in reducing access to treatment. Professionals expressed ideas around older adults being too old to make a change or not wanting to deprive them of alcohol as it was their only pleasure left in life.

Older adults experience **shame, embarrassment and stigma** around problematic drinking with 1 in 4 over 50s revealing that they would not tell someone if they had a problem. In addition, problem drinking can be missed as it can be attributed to old age, for example falls.

What works for older people:

- Non-judgemental and relationship focused approach;
- Age-sensitive screenings and assessments including questions on medication and home safety;
- Home visits and flexible appointments with prompts;
- Identifying age-related motivating factors e.g. maintaining independence, sense of purpose;
- Cognitive screening and adapting intervention;
- Providing sense of purpose and increasing resilience;
- Social activity and community participation;
- Volunteering opportunities and co-production;
- Targeted awareness campaigns;
- Workplace awareness sessions;
- Supporting the whole family;
- Age-specific mutual peer support;
- Staff values and training in age-sensitive practice.

Adult Social Care and Safeguarding

Problem drinking and/or drug use may be the main reason for a person's involvement with social care or it may be one of a number of overlapping needs.

Currently, Adult Social Care (ASC) data is **not able to distinguish between alcohol and/or drugs** as a care and support need with 'substance misuse' is recorded instead.

- Of the 7,119 service users open to ASC in October 2021, 48 had been identified as having a primary or secondary support reason of **'substance misuse' (0.7%).**

An Alcohol Change review of alcohol-related Safeguarding Adults Reviews (SARs)[238] looked at 11 national cases published in 2017[239].
Common characteristics of the people who died included:

- Non-engagement with services including not accepting referrals, not attending appointments and refusing access to their property;
- Self-neglect;
- Exploitation;
- Domestic abuse- current or former including experience in childhood;
- Chronic health problems including alcohol-related brain damage;
- Mental health conditions including depression, personality disorders, self-harm and suicide attempts;
- Traumatic events triggering drinking, bereavement, relationship breakdown and job loss;
- Lack of family involvement.

The report highlighted a specific **gap in practitioner' knowledge about applying the Mental Capacity Act (2005) and the Care Act (2014)** to those who have an alcohol problem. This has also been highlighted in a local safeguarding case study.

The report had a number of recommendations relevant at a local level. These included:

- SAR teams always having access to independent expertise in problem drinking to be able to properly assess the role of alcohol in the incident, and to ensure that lessons are effectively learned;
- Local Authorities should ensure vulnerable adults are actively supported to engage, with services adapting to meet need. A focus on multi-agency systems that can co-ordinate assertive outreach;
- Commissioning of alcohol services should minimise staff turnover and recognise the importance of continuity in supporting complex needs;
- All professionals working with alcohol-dependent adults should be trained to recognise the complicated role that alcohol plays in safeguarding, that 'free choice' is often an unhelpful paradigm, and to avoid stigmatising drinkers.

Locally there are positive examples of safeguarding vulnerable adults who have an alcohol need through services working together to meet a person's needs (case study below). However, a case study has illustrated that a **lack of legal literacy around the Mental Capacity Act and ARBD** has led to a delay in assessing capacity.

Older drinkers can also face challenges in accessing appropriate care due to unstable housing, criminal histories, complex health needs and stigma.

Moreover, for many who drink excessively their care needs vary when they are sober (e.g. a hospital stay) compared to periods of heavy drinking. The current social care system is not flexible nor rapid enough to cope with these changes.

[238] SARs are commissioned following the death or serious harm of an adult with care and support needs.
[239] Learning from tragedies: an analysis of alcohol-related Safeguarding Adult Reviews published in 2017, Alcohol Change (2019)

Patients often find they have care when they are managing but then it is stopped as it is not required. However, when their health/ability deteriorates it is not restarted and so many end up in hospital to start the process of referral and assessment with Adult Social Care again.

There is no specific team within Adult Social Care that has specialist training and knowledge for people in these circumstances.

ALT Case Study 1

J is a 74-year-old man that has been **drinking for many years,** has been **homeless at times** and has been to **prison** twice. He is currently living in a low-cost hostel in Newquay.

He attended A&E as he was becoming frailer, progressively weaker and **unable to cope in his current accommodation**. He has been incontinent so has also developed pressure sores on his buttocks. Due to his drinking and isolated lifestyle, his decline in his physical ability has not been identified in the community and therefore his condition worsened until he was brought into hospital.

J is keen on moving to a care home but due to his **offending history and the stigma around his lifestyle no place has been found for him**. He currently remains in hospital and is awaiting a place at a community hospital to allow for Adult Social Services to assess his care needs. It would not be possible to utilise a package of care in the hostel so this will likely take significant time and long discussions between housing and social services.

ALT Case Study 2

G is a 72-year-old man with **end stage liver disease** who still goes to the pub with friends. He has been advised to avoid alcohol for his health, but he feels it is his link to his social life and one of his last few pleasures left.

G has **attended hospital on numerous occasions** with deteriorating health due to his liver function and **reduced ability to cope at home**. On one occasion, he was admitted following a **fall at home** and struggling to manage due to swelling related to his liver disease. He normally had a package of care visit him four times a day, but this had recently been reduced to 3 times a day as he had missed numerous afternoon visits due to being at the pub. However, when his health and mobility deteriorated again, the **reduced package of care was not enough to maintain his safety at home**.

The Occupational Therapist that reviewed him on that admission felt there was a dilemma when discussing his needs with Adult Social Care as **when he was well his needs were less** and he was able to go to the pub, however when excessive alcohol intake caused him to deteriorate, he needed more care.

Residential detox and rehabilitation (tier 4)

Tier 4 treatment covers in-patient assessment, stabilisation and detoxification and residential rehabilitation interventions. Nationally residential provision has severely decreased with fewer clients than recommended being able to access this aspect of treatment[240]. In Cornwall we have maintained our residential provision and have continued to ensure that those who need to access this provision are able to.

Approximately 10% of the treatment population will require inpatient stabilisation and detox (c.260 people per annum). This is for clients whose needs cannot be met in the community. In 2021/22, 173 clients accessed inpatient detox through our commissioned service, Boswyns, in Cornwall. The need for clients to self-isolate before residential treatment begins and cases of COVID-19 have reduced the service's capacity during the pandemic.

Older national guidance outlines that approximately 5% of the treatment population require residential rehabilitation but new guidance sets this at 2%. Placements are approximately 12 weeks. In 2021/22, 156 clients accessed residential rehabilitation. This represents 5% of the total treatment population (3,361 people) meaning we are meeting the 2% target and not exceeding the 5% estimate of need.

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

- Clients need to be **adequately prepared** for the experience and feel that this is the right option for them and the assessment process is currently being reviewed to reflect this;
- Some experienced **difficulty in understanding and following COVID-19 restrictions**. A review is currently looking at preparation for treatment and development of new materials to give service users a better understanding of what to expect. This includes a walk around video and talk;
- Suitable **accommodation must be arranged,** before residential treatment ends, which is drug and alcohol free to increase likelihood of abstinence;
- For those who already have accommodation but were struggling to maintain it (e.g. cleaning and hoarding) coming out of treatment means they can experience shame around their prior living situation which impacts on recovery. Workers have offered support around **making their accommodation suitable again** but a consistent offer is needed;
- **Psychological pain**, particularly **early life trauma**, can be uncovered and prove **distressing for the individual**. A trauma informed approach is required, helping people to recover from underlying issues and professionals to understand individual behaviour. Provision to meet the needs of complex women is to be looked at specifically;
- Negative aspects of **external relationships can 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)

[240] Review of drugs part two: prevention, treatment, and recovery, Home Office and Department of Health and Social Care. (2021)

or aid recovery outcomes (if they are supportive). Many are in coercive or co-dependent relationships. Healthy Relationships programmes and joint couples interventions can improve outcomes for couples in treatment;

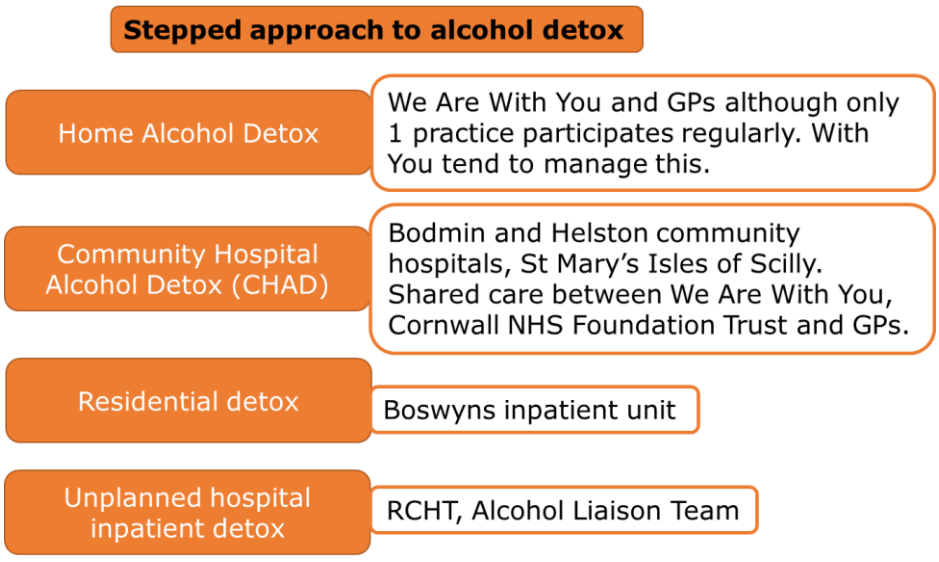
- **Missing or being worried about relatives** e.g. children. Virtual communication and on-site visits can help to maintain motivation;
- **Mental health problems** impacting on behaviour especially those which present during withdrawal. A review is considering how mental health impacts on behaviour and what a person needs to manage this;
- A deeper **review of the clients needs** must be undertaken **pre-admission** to think about how the service can flex to accommodate needs including neurodiversity;
- **Improved communication** between hospitals and residential detox during transfer to ensure a client arrives with all the medication they need;
- Some clients who have more resilience factors, such as higher education and employment, do not consider themselves in the same cohort as other service users and feel that the residential environment is not for them;
- As service users can hide substances on admission, non-intimate searches are required. These must be conducted in a trauma-informed manner; clients must feel able to hand-in substances before and during their stay without judgement; and clients must be clear on expectations before admission.

Feedback from service users and staff has emphasised the **long waiting times for residential provision**. Increasing the number of beds available is a priority and we are exploring developing the stepped approach to alcohol detox (below).

Alcohol detox

The purpose of detoxification is to minimise the severity of the medical symptoms that occur when regular high levels of alcohol consumption are stopped or markedly reduced. These symptoms can be very severe leading to illness, complications and life-threatening conditions. Detox should never take place in isolation and should be part of a planned episode of treatment including an emphasis on the preparation for a detox and post detox provision of support.

In CIoS we have a **Stepped approach to alcohol detox**.



There are clear eligibility and exclusion criteria for each service. Having a range of options allows for cost-effective treatment based on levels of need with clients accessing the service the best supports their needs and level of dependency.

Local services have identified the **need for Home detox that can support more complex clients** who have severe dependence but do not want to detox in residential treatment. A similar pilot service was run in Haringey between 2014 to 2016[241] with all 13 patients completing detox successfully. Patient feedback was positive, safety and risk were appropriately managed and the service was more cost-effective than sending clients to residential detox which did not suit their needs.

Reviewing home detox, establishing detox in supported accommodation settings and developing an offer for more complex patients are priorities going forward.

Recovery

The Dame Carol Black Review highlighted that recovery support has been underfunded. Promoting recovery is a key part of the new national Drugs Strategy. This includes improved access to accommodation and employment as well as developing recovery communities- social support and networks harnessing the expertise of people with lived experience to be peer mentors.

Mutual Aid

Mutual Aid refers to the social, emotional and informational support provided by, and to, members of a group at every stage of recovery. Groups can include people who are thinking about stopping and/or actively trying to stop drinking or those who are abstinent and want help to remain so.

In Cornwall we have both mutual aid delivered by our commissioned community treatment provider (MAP groups) and sessions by Alcoholics Anonymous (AA) are also run in the county.

There are currently 7 weekly local MAP groups three of which are online and four face-to-face. There is also a national online group with most attendees coming from Cornwall. In addition, there is also a national Veterans-specific MAP group with Cornwall attendees. MAP received excellent feedback from service users from our focus groups and survey with people finding them helpful, believing in their confidentiality, feeling like they do not have to talk and finding the feedback and tools useful.

"It's like having a diary that talks back to you" – about MAP groups

"MAP provides routine, something to look forward to"

There are currently 32 in-person AA meetings across the county and online meetings are on offer too. An assessment of mutual aid provision is included in Appendix L.

[241] Haringey Enhanced Community Detox Project 2014-2016, Kerr and Grewal

Criminal Justice System (CJS)

Problem drinking and drug use is common among the offending population. NICE report that an estimated 12% of adults serving community sentences have substantial or severe levels of drug use, and 52% are hazardous drinkers[242]. Another study reported that 46% of offenders on community sentences had an alcohol problem, and nearly a quarter had a drug use problem[243].

Research from the Ministry of Justice (MoJ) found an estimated 29% of adults serving community sentences with a mental health disorder[244]. Among adults with mental health problems serving community sentences, an estimated 72% also screened positive for either an alcohol or drug problem[125].

HMI Prisons survey data revealed that upon entering prison[245]:

- 17% of men and 28% of women reported having an alcohol problem;
- 27% of men and 46% of women reported having a drug problem;
- 47% of men and 71% of women reported having a mental health problem.

The MoJ has highlighted that problematic alcohol consumption is associated with crime (especially heavy/binge drinking and violent crime), although the link between alcohol, crime and reoffending is complex and impacted by factors such as childhood experiences of violence, cultural norms and personality disorders[246].

Criminal Justice clients in treatment

The new National Drugs Strategy aims to ensure that every offender with an addiction has a treatment place.

The proportion of adults in local treatment in contact with the criminal justice system is **similar to national rates** across all drug groups apart from non-opiates (Table 24).

Table 24

Q1-Q3 2021/22	Local count	% Local	% National
Opiates	243	17.8%	18.3%
Non-opiates	15	4.6%	10.7%
Alcohol only	86	6.9%	6.2%
Alcohol and non-opiate	73	11.9%	11.2%

In 2020/21, 5% of those in alcohol treatment were referred through the CJS[247] compared to 6% nationally. Both locally and nationally a **greater proportion of those in drug treatment are referred via the CJS** (12% and 16%

[242] NICE Guidance (NG66) Mental health of adults in contact with the criminal justice system, NICE (2017)
[243] Community Sentences Digest, Solomon and Silvestri (2008)
[244] Results from the Offender Management Community Cohort Study (OMCCS): Assessment and sentence planning, MoJ (2013)
[245] HM Chief Inspector of Prisons for England and Wales, Annual Report 2019–20, (2020)
[246] Transforming Rehabilitation: a summary of evidence on reducing reoffending, MoJ (2013)
[247] Referred via the CJS means an arrest referral scheme, via an Alcohol Treatment Requirement (ATR), prison or the probation service/ Community Rehabilitation Company.

respectively) compared to those in alcohol treatment. Across all drug groups, both locally and nationally, **more men are referred** via the CJS than women.

Successful completions amongst CJS clients are lower than the wider treatment population (Table 25). **Offenders presenting with alcohol problems are less likely to complete treatment successfully** than nationally.

Table 25	% CJS	% All		% CJS national
Opiates	5.6%	7.2%		3.4%
Non-opiates	38.5%	41.9%		34.5%
Alcohol only	23.8%	37.4%		34.9%
Alcohol and non-opiate	25.7%	32.8%		29.8%

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

Our commissioned community treatment service has a Criminal Justice Team who provide specialist support to clients involved in the CJS from arrest to prison release. They have strong relationships with all partners involved at each stage of the CJS and also support the Antisocial Behaviour team regarding criminal behaviour orders and act as an advocate for the individual.

The Criminal Justice Ladder

The needs of those involved in the criminal justice system should be assessed and addressed at all stages of the criminal justice ladder (below). Meeting the needs of offenders as early as possible reduces the likelihood of reoffending both in terms of the number and severity of offences committed. Where appropriate, diversion and community options should be sought over imprisonment to break the cycle of repeat offending. Short prison sentences are especially ineffective as they disrupt the continuity of care with offenders unlikely to receive support from the prison drug/alcohol service if their sentence is shorter than 6 months.

Community policing > Arrest > Custody > Diversion (Pathfinder and Liaison and Diversion) > Courts and Sentencing > Prison or Probation > Prison release.

The DAAT and Cornwall NHS Foundation Trust are currently working together to map all diversionary alcohol interventions at each stage of the criminal justice system.

Arrest and Custody

The CJS team in community treatment cover the custody suites in Camborne and Newquay 5 days a week providing a rapid response for clients in crisis following arrest. Referrals are taken and contact is provided with signposting to other specialist services for support. Out of hours referrals are taken from Liaison and Diversion and the Police via a SPOC. The team also identify where a CSTR may be suitable.

The CJS team received 84 custody referrals in 2020/21 across both drugs and alcohol.

Pathfinder

Pathfinder is a voluntary diversion scheme that holds offenders to account for their behaviour whilst **addressing needs that are directly linked to their offending**. There are two routes based on the seriousness of the offence: Deferred Caution (out of court disposal) or Deferred Charge (alternative to Court).

In Cornwall during 2021, there were 66 Deferred Charge referrals and 142 Deferred Caution referrals. Table 26 gives an indication of some of the needs of the Deferred Charge cohort. **50% (33) of Deferred Charge referrals had an alcohol and/or drug need** and this group were most likely to be male (75%) and aged 26-35. 55% (18) had an additional mental health need and 6% (2) an accommodation need.

Table 26 **Deferred Charge Referrals**

Need		**Additional needs**	
		Mental Health	Accommodation
Alcohol only	8	5	0
Drugs only	16	10	1
Alcohol and Drugs	9	3	1
Total	**33**	**18**	**2**

For Deferred Caution, 42% (60) of referrals had a 'substance misuse' need with males making up 75% of the group. Unfortunately, data capture does not differentiate between alcohol and drug needs for this group. Of those 60[248]:

- 65% have completed successfully and 17% are still engaged in the programme;
- 12% either disengaged or opted out of the scheme;
- 5% reoffended.

Completion data is not available for referrals with an alcohol and/or drug need for Deferred Charge, but overall compliance remains consistently around 90%.

Liaison and Diversion

Liaison and Diversion work with those who are suspected of committing an offence and have mental health needs, learning disabilities, drug and alcohol problems or another vulnerability. The service provides early intervention and aims to address health and social needs in order to reduce re-offending. They also offer advice and guidance to those working in the CJS to help determine the most appropriate level of support required for each service user.

The CJS team in community treatment have strong links with Liaison and Diversion and received 61 referrals from the service in 2020/21. However, some would have been for clients already open to community treatment.

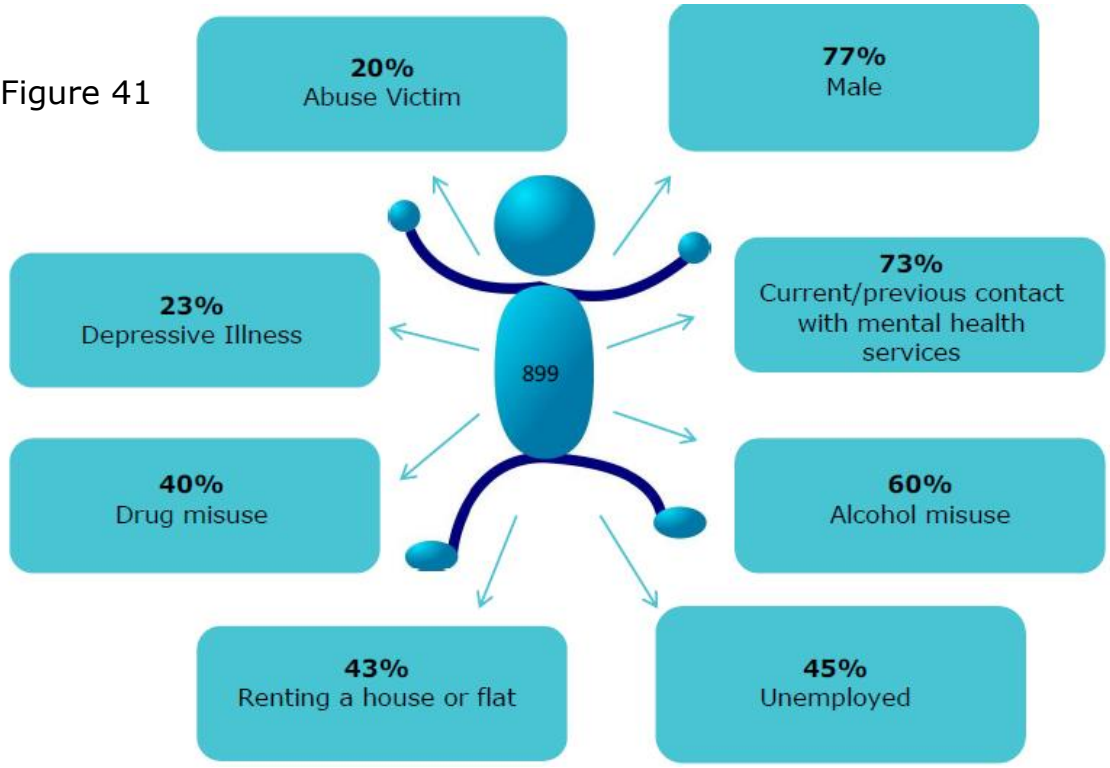
As Liaison and Diversion undertake detailed assessments around need, including an assessment of the client's drinking, the DAAT and Amethyst have requested

[248] 1% were classes as 'other'.

anonymised caseload data to gain a greater understanding of the needs of the offender population.

Data included in the previous Alcohol Needs Assessment, highlighted the prevalence of problem alcohol/drug use in the offender population, particularly in combination with other needs (Figure 41).

Figure 41



The recent joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders[249], noted the good practice of a detailed needs assessment and a tailored intervention plan with statutory partners, third-sector providers and scheme staff in Liaison and Diversion for the Devon and Cornwall Police Force.

Courts and sentencing

The CJS team in community treatment offer face-to-face cover at Magistrates Courts five days a week. Workers act as an advocate for individuals and partner services have provided positive feedback on the support the CJS team are providing.

Direct communication between custody and court in the morning enables the team to prepare to advise Probation and solicitors. Section 31 funding has enabled more robust management of alcohol treatment requirements and has improved joint working relationships with Probation. Funding has also enabled clients to be supported and assessed by the same consistent worker from custody to court to sentence and this has improved engagement and outcomes due to a strong therapeutic alliance being built. Those who want support with alcohol, but who are not eligible for a treatment order are also supported.

[249] A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders, Her Majesty's Inspectorate of Probation (2021)

Community Sentencing Treatment Requirements (CSTRs)

CSTRs are sentences issued by courts where the offender has consented to complete treatment for mental health problems, drug and/or alcohol problems.

A national programme[250] aims to increase the use of CSTRs to reduce reoffending through effective and coordinated health and social care to offer an alternative to custodial sentences.

There are three types of CSTR which in Cornwall are all delivered by the CJS team in our commissioned community treatment service:

1. Mental health treatment requirements (MHTR)
2. Drug rehabilitation requirements (DRR)
3. Alcohol treatment requirements (ATR).

A DRR or ATR can be combined with an MHTR. The majority of combined orders are with an ATR.

A study published by the Ministry of Justice in 2018[251] provided the first evidence to show that including an MHTR or ATR into a community order can have a **positive impact on reducing reoffending**. MHTRs attached to community orders or suspended sentence orders were associated with significant reductions in reoffending, compared with similar cases where MHTRS were not used. ATRs were associated with similar or slightly lower re-offending when compared to similar cases in which they were not used.

In the 12 months from October 2020 to September 2021 in Cornwall there were:

- 46 ATR orders out of 71 referrals (65%);
- 79 MHTRs and combined orders out of 120 referrals (66%);
- 25 DRR orders out of 36 referrals (69%).

Those aged 30-39 were most likely to receive a CSTR. Across all orders, the **majority of those sentenced with a CSTR were male** but the proportion of females was especially low for ATRs at 9%. This reflects the gender split of offenders but still female offenders very often present with more complex needs and are treated unequally in the CJS. Funding has been secured for a specific post in the CJS team to support women in the CJS and link in with projects supporting women delivered by the Safer Stronger Consortium and the Women's Centre Cornwall.

Of the 10 clients who had completed an ATR by the end of September 2021, on average:

- Clients reduced the average number of units they drank per day by 55%;

[250] The Programme is a partnership between the Ministry of Justice, Department of Health and Social Care, NHS England and NHS Improvement, Her Majesty's Prison and Probation Service and Public Health England.

[251] Do offender characteristics affect the impact of short custodial sentences and court orders on reoffending? MoJ (2018)

- Psychological health scores increased by 4.1 points;
- Physical health scale scores increased by 2.8 points;
- Overall quality of life scores increased by 4.4 points.

Although these positive outcomes only relate to a small number of people, they are promising. On a national scale, Cornwall has been very successful with the highest number of combined orders in the country and is recognised as a leader in delivering CSTRs.

Case Study- MHTR as part of a sentence for assault.

L reported that over the past few years he drank alcohol rarely although he previously went through a period of drinking daily for several years. L reported drinking heavily on the day of the assault and felt that his offending behaviour was in part triggered by alcohol, but also that it was due to having had no outlet for his anxiety and stress-related thoughts and symptoms. The MHTR focused on:

- 7/11 Breathing exercises;
- Crooked thinking;
- Anxiety triggers;
- Strategies to support and how to avoid confrontational situations;
- Social isolation and "parental role";
- Keyworker also supported client with Social Services contact and understanding the process. L is now no longer under Social Services but can approach them for support if needed.

L stated that he was '*using the breathing exercises everyday...I have got a lot out of this. I know I was told to do this as part of my order but I am really glad I did; just having someone there to discuss things with and getting strategies suggested has been great*'.

L will receive a follow up check-in call at 3, 6 and 12 months.

Probation and Reoffending

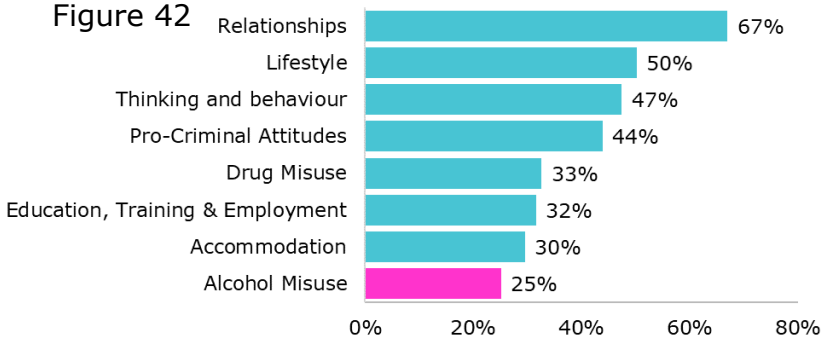
Probation practitioners supervise offenders in the community and oversee their rehabilitation. People on probation are supervised while serving a non-custodial sentence or following their release from prison on licence.

For 2019/20, the proportion of offenders who reoffended in Cornwall was lower than regionally and compared to England and Wales (20.7% versus 23.5% and 25.7% respectively).

Probation services were re-nationalised in June. Information sharing arrangements are now being refreshed, and some summary data on criminogenic needs was provided for this assessment. Obtaining more data from probation on the needs of clients is a priority.

- Figure 42 shows that **25% of adult offenders have an alcohol problem** that is linked to risk of serious harm and/or reoffending (198 offenders of which around quarter have been released from prison on Licence).
  This is **much lower than historical levels of need** (our 2014/15 Reoffending Needs Assessment quoted a figure of 56%). In a MoRiLE workshop on violence, pobation colleagues said that they still see a high number of alcohol-related offences but fewer are related to the Night-Time Economy than previously.
- Problematic drug use (33%) is more common than problem drinking.
- 28% of the Probation caseload are high risk offenders being managed under **MAPPA**.[252] Drug and alcohol needs are less common amongst this group (17% and 11% respectively, so around half the prevalence). We are unable to obtain data around the alcohol needs of the whole MAPPA cohort.

Figure 42



Past drugs needs assessments identified that around **half of the number of offenders** assessed as having criminogenic drug and/or alcohol needs were **being supported** in community treatment services. This raised a question regarding the skills of offender managers is assessing risk around substance use and a lack of liaison with community services about specialist assessment.

Offenders that were not receiving support were **predominantly non-opiate users and problem users of alcohol** but there was also a small number of opiate users. A definitive conclusion regarding **unmet need in this population cannot be established** until we can cross-reference the caseloads accurately.

Prison leavers

The proportion of prison leavers with a drug and/or alcohol need who successfully engage in community treatment is **lower than nationally** (31.3% compared to 37.5%).

A Criminal Justice Single Point of Contact (SPOC) in the CJS team (community treatment) coordinates the continuity of care for prison leavers who return to Cornwall. The SPOC works with prisons in the South West as well as nationally. They ensure appointments and prescriptions are in place and will have appointments with the individual. They attend service events at prisons to offer alcohol support and service information to all clients who are preparing for release.

[252] Multi Agency Public Protection Arrangements (MAPPA) refers to the 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.

Individuals whose offences were linked to problematic drinking that were not previously known to services are also identified and supported. The SPOC also attends service events at prisons to offer alcohol support and service information to all clients who are preparing for release. The CJS team cover HMP Exeter, HMP Dartmoor and HMP Eastwood Park in Gloucestershire (female offenders).

A number of clients have been **released from prison without accommodation**. The SPOC works closely with Outreach Services and Housing to reduce the impact and risks for people before they are released or as soon as possible to ensure they are in the housing system. It is difficult to secure accommodation for offenders as the majority are not owed a statutory homeless duty as they are single males. **Many providers are unlikely to accommodate offenders due to their offending history and complex needs**. The current housing crisis has compounded this. The inability to secure appropriate accommodation increases the chance of reoffending and the prospect of prison providing a roof over their head is a factor for some.

RECONNECT is a care after custody service for vulnerable people leaving prison. It is an NHS service, delivered by Liaison and Diversion, that operates in HMP Exeter and HMP Eastwood Park. A worker from the Women's Centre Cornwall in Eastwood Park makes referrals to the service with Liaison and Diversion then supporting women to engage in health services after release. The service can only work with women with lower levels of complex needs and not with those on remand.

An **accommodation for ex-offenders** project creates and assists clients with private sector tenancies that are for a minimum of 12 months. Konnect and Harbour Housing provide support workers and Cornwall Housing Limited co-ordinates referrals. Work is being done to link with other initiatives and build on this project. Konnect are aiming to map the support needs of offenders 3 months prior to prison release working with probation.

Drug and Alcohol Treatment Workforce

The Dame Carol Black Review[253] found that the treatment workforce nationally has deteriorated significantly in quantity, quality and morale in recent years, due to excessive caseloads, decreased training and lack of clinical supervision.

The review highlighted that the disruption caused by frequent retendering of treatment services has made recruitment and retention difficult. A workforce survey carried out as part of the review showed that drug workers had caseloads of between 50 and 80, sometimes rising as high as 100 people. Good practice suggests a caseload of 40 or less, depending on complexity of need. Such high caseloads reduce the quality of care provided and the effectiveness of treatment.

Feedback from drug and alcohol treatment service managers to commissioners and from the survey conducted as part of this needs assessment, has highlighted that **fixed-term contracts** due to short-term funding has made recruitment difficult. The **housing crisis in Cornwall** has also negatively

[253] Independent review of drugs by Professor Dame Carol Black, Home Office and Department of Health and Social Care. (2021)

impacted recruitment with examples of those being offered a post then turning it down due to being unable to find accommodation.

Staff have also reported that **caseloads are too high** which has impacted worker morale, wellbeing and retention. Overall, **in 2020/21 structured treatment was 37.% over capacity**. Provisional data suggests that capacity was exceeded by 26.3% in 2021/22. Monitoring and reducing caseload sizes is a priority going forward.

The pandemic also affected the workforce due to staff sickness and increased client complexity. Our treatment workforce maintained face-to-face service in order to safeguard vulnerable clients and as one service user described they 'went above and beyond during the pandemic'. To help improve worker wellbeing the DAAT have commissioned the delivery of compassion-fatigue training for staff in our treatment services.

Overall, assessing the needs of the local workforce in more detail regarding size, quality, professional development opportunities, recruitment, retention and wellbeing is a priority going forward.

Treatment- Isles of Scilly

It is estimated that 1.5% of adults in Cornwall are dependent drinkers (6,968). Based on this percentage, **28 adults** on IoS could reasonably be expected to be alcohol dependent.

Prevalence rates of alcohol correlated diseases (stroke, depression, obesity, mental health, smoking, coronary heart disease and cancer) are lower than or similar to the equivalent rates in Cornwall[254].

In **2020/21, 9 people from the Isles of Scilly accessed structured alcohol treatment** (alcohol only and alcohol and non-opiates). This equates to a rate of 4 clients per 1,000 of the population which is slightly higher than the Cornwall average of 3 per 1,000. However, it should be noted that with a low volume of clients and a small population, Scilly rates are more volatile.

A worker from out commissioned community treatment service would usually visit the islands once a fortnight and was based at St Mary's Health Centre but would arrange appointments with clients wherever they felt comfortable. However, **COVID-19 has continued to impact on service delivery** with the worker only making 7 trips during 2021. The service has identified that as the worker is not meeting other professionals face-to-face, **awareness of the service may have decreased**. There is a focus now on strengthening relationships with professionals and delivering face-to-face support again as restrictions are easing.

Staff in St. Mary's Hospital have been **trained to deliver Community Hospital Alcohol Detox** (CHAD) which is beneficial as most treatment clients on Scilly have alcohol as their primary presenting need.

[254] National General Practice Profiles- St. Mary's Health Centre, OHID (2021)

IoS specific information continues to be enormously challenging to both obtain and describe, due to the identifiable data risks associated with the small population. Qualitative data in the form of the MoRiLE workshop with the IoS CSP revealed the following:

- It was felt that residents have a good level of awareness of 'safe' drinking levels and health care professionals routinely ask about drinking behaviours.
- Very good online resources available.
- Third party or self-referral.
- Drop-in clinics have previously been tried but people did not engage.
- Recovery support also available, linked closely with Mental Health services – shared care planning and good support.
- A Multi-Disciplinary Team panel is in place to ensure that issues for the most complex individuals do not escalate.

Case Study

Female living on Scilly who is **alcohol dependent**, has an eating disorder, mental health needs and is facing financial difficulties. She has also previously experienced sexual violence and domestic abuse.

In 2019 she engaged with With You and **successfully completed CHAD on IoS** being discharged in just before the first lockdown in 2020. The subsequent lockdown disrupted the pre-agreed **joint care plan** between With You and the IoS Community Psychiatric Nurse (CPN). This combined with uncertainty and other issues resulted in her beginning to drink again a few weeks post detox.

The client wishes for another detox followed by residential rehab. Between the client, her partner, With You and the CPN it was agreed that a rehab placement that specialises in co-occurring eating disorders would offer the best chance of long-term success.

Therapies, post detox, are planned to help the client around abuse she has suffered in childhood and later life. There is agreement between With You and the CPN that any decisions about a diagnosis of a serious mental illness and potential medications would best be actioned after return from rehab.

This case study demonstrates the importance of joint working between professionals and working with the client and those who are important to them (e.g. a partner).

Appendices

Appendix A: National Commissioning Checklist

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.

1. Effective responses to alcohol harms

Effective local systems are coherently planned by local government, NHS and criminal justice partners to provide effective interventions to address the full range of drinking behaviours and harms to individual drinkers, families and communities.

PHE has developed the alcohol CLeaR system improvement tool to support local government and its partners to review local structures and delivery arrangements, and evaluate what works well to reduce alcohol-related harm. Planning is essential. Successful plans need to be based on the assessment of local needs, to address the harm, costs and burden on public services from alcohol misuse.

1.1 What you will see if you are meeting the principle

You will see population-level approaches that support raising awareness and reducing the aggregate level of alcohol consumed and as a result, the whole population's risk of alcohol-related harm will be reduced.

1.2 Indicators to support the principle

These indicators will help you to establish whether you are following the evidence and best practice that supports the principle:

Local health improvement campaigns are planned, based on and targeted at identified needs in the local population. The expected outcomes of these campaigns are understood, routinely evaluated and supported by the evidence base. Where local alcohol social marketing campaigns are employed, they reflect and amplify national campaign messages when appropriate.	DrinksMeter – app analytics data in order to assess next priorities for use of the app. Alcohol Awareness Week Covid specific campaigns Festive Alcohol messaging Drink Spiking *What Will Your Drink Cost* summer campaign. All social media analytics are evaluated for a campaign.	Routine evaluation? Could do with increasing? Do we have evidence of? Example?
The public health team actively contributes to the local vision for alcohol licensing as set out in the statement of licensing policy and works in effective	Four members of staff in the DAAT work a rota to assess all licensed applications. The primary tool used is the Amethyst/DAAT Health Impact	

partnership with the other responsible authorities.	Licensing Tool (HILT). In the coming year we will be actively participating in the Cumulative Impact Zone review process.	
Local crime, health and social care data is used to map the extent of alcohol-related problems as part of licensing policy. Hospital and ambulance data is shared routinely to inform improvements in community safety and licensing activity. The licensing authority can demonstrate how local licensing policies (including the use of tools and powers) have contributed to successfully managing the night-time and day-time economy. Commissioners make good use of existing legislation to prevent under-age sales, sales to people who are intoxicated, non-compliance with any other alcohol licence condition and illegal alcohol imports. Local partnerships use voluntary and industry-led schemes to achieve their local vision to reduce alcohol harm.	HILT is a postcode responsive tool that assesses the alcohol related risk level of any given area in Cornwall using such factors as alcohol related hospital admissions, drink driving collisions, alcohol treatment referrals, assaults and A&E presentations from alcohol related incidents. This is used to assess license applications and make outlets aware of what they need to do in order to trade responsibly. At present we only get intermittent hospital data, we struggle to get ambulance data and although nationally the LAPE is not well curated it still gives us good enough basic information about hospital admissions. The ARID assault data (embedded within HILT) is now commissioned regionally which we in Cornwall have been lobbying for 6 years. ARID on its own is used increasingly by Police Licensing to respond to hotspots and problem premises. On occasion Police will ask for more information about specific locations for example the rate of violence in a high street in Bude. The combination of HILT and ARID enables us to comment on specific cases all of which means that Public Health/Community Safety are now seen as a valid participant in the licensing arena.	

2. Large scale delivery of targeted brief advice

Targeted interventions aimed at individuals in at-risk groups can help make people aware of the harm and change their behaviour, preventing extensive damage to health and wellbeing.

2.1 What you will see if you are meeting the principle

There is large scale delivery of identification and brief advice (IBA) to people who are most at risk of alcohol-related ill health.

The National Institute for Health and Care Excellence (NICE) recommends delivering IBA in all adult health, social care and criminal justice settings. PHE guidance for local leaders working across sustainability and transformation partnership footprints also recommends that IBA is provided in all primary and secondary healthcare settings.

2.2 Indicators to support the principle

These indicators will help you to establish whether you are following the evidence and best practice that supports the principle.

The partnership has an integrated plan that sets out the partners' agreed roles and responsibilities, including workforce development, making sure IBA is delivered in a range of settings, and having a system in place to monitor this activity.	Recent analysis of IBA training delivery has enabled us to target specific services such as Social Care, Primary Care and Mental Health for the next phase of IBA training delivery. Ideally commissioning processes and service delivery need to implement methods of recording IBA delivery in frontline settings and collating the findings.	Priority for development and improvement, based upon learning from review and evaluation.
The services that deliver IBA collect, analyse and report data to demonstrate the level of delivery. Local Making Every Contact Count (MECC) activity includes evidence-based alcohol IBA.	MECC funding enabled us to promote the DrinksMeter app, this should be especially useful in remote contexts for online interventions. The next step is to learn lessons from the analysis that is included in the Alcohol Needs Assessment in order to use the app more effectively (AUDIT questionnaire is embedded in the app).	
There are specific interventions to raise awareness of the harms of drinking for at-risk groups, such as pregnant women, older people and those with existing long-term conditions or mental health issues.	IBA training has been delivered to all Midwives based in Royal Cornwall Hospital. In the next phase of training we will be targeting Mental Health services and agencies that work with older people.	
The NHS Health Check, GP new-registrations procedures and the Preventing ill health commissioning for quality and innovation (CQUIN) scheme include	The NHS Health Check programme is a mandated service that is commissioned by Public Health. The Audit C and alcohol IBA is a key part of the check.	To link with tobacco cessation.

evidence-based alcohol IBA in line with regulations, contracts and guidance.	Prior to the pandemic the number of health checks offered and completed in Cornwall had been gradually increasing, however, in March 2020 they were nationally deprioritised. Since the start of the pandemic the NHS Health Check programme has been deprioritised twice and although providers can recommence the checks this is based upon their capacity and resource having focused on dealing with Covid-19 for two years. In Cornwall more surgeries are now recommencing NHS Health Checks and are taking up the offer of update training for health check practitioners. The NHS Health Check programme is seen as an important health intervention both as a CVD screening tool but as an opportunity to discuss lifestyles and behaviour change. CQUIN: All CQUINs for 2020/21 were stood down due to the COVID-19 pandemic.	
There is IBA delivery across a range of adult local authority services, criminal justice and healthcare settings.	There has been IBA training across a range of adult local authority services, criminal justice and healthcare settings, but we need commissioning and service support in recording IBA delivery in all these settings.	Exploration of boards and leads. Could include community mental health transformation board and new Integrated Care Board.
There are clear pathways to specialist assessment for those who may be dependent and require structured treatment.	Pathways exist and stakeholders describe these as clear, however the understanding of the ADUIT screening tool and use in referral is not	AUDIT and IBA training to include referral pathway linked to screening tool findings.

	sufficiently understood and required further reinforcement	
There are clear pathways for referring alcohol dependent patients from hospital to specialist alcohol treatment in the hospital or in the community.	Hospital Outreach Team (part of community treatment provider) and Alcohol Care Team in place.	

3. Specialist alcohol care services for people in hospital

Specialist alcohol teams in hospitals reduce alcohol-related hospital admissions and improve quality of care, saving money for the NHS.

3.1 What you will see if you are meeting this principle

All district hospitals have 7-day specialist provision for alcohol, in stand-alone teams or as part of a team with a wider remit, including drugs and psychiatric liaison.

3.2 Indicators to support the principle

There are services to meet the needs of hospital patients who misuse alcohol (or drugs).	There is both the Alcohol Care Team (RCHT) and the Hospital Outreach Team (With You) and regular joint MDTS to review	
Senior medical and nursing support and leadership is provided to the secondary care alcohol (and drug) services to ensure that their role and function is understood and appropriately used by partners in the system.		
There are effective care pathways between hospitals and community services to ensure detoxification and psychosocial interventions continue outside of the hospital.		
A range of services are working to actively support high-need, high-cost alcohol users and reduce frequent hospital attendances and admissions.	Hospital Outreach Team, funded through a Social Impact Bond (Life Chances), the Alcohol Care Team and Boswyns In-patient Unit.	Examples of people who were in the Top 50 Frequent Attenders in 2017 who are now working in local services.
Hospital services collect data to demonstrate service effectiveness,	Good joint working relationship in reviewing	

impact on patient care and value for money.	ACT, HOT and needs assessment information	
Local partners understand how alcohol and drug services for people in hospital are part of the wider treatment system and awareness of the role they play in addressing need.	Regular MDTs (jointly between commissioners and service providers)	LF/JS KH
Patients leaving hospital who need further treatment and recovery support are encouraged to access community alcohol and drug services	A persistent and assertive approach to engagement is delivered through the Hospital Outreach Team.	

4. Quick access to effective and evidence-based alcohol treatment

Successful treatment and recovery is optimised by providing welcoming, easy to access and flexible services that cater for the needs of a broad range of people and problems. They reduce risk of harms, raise recovery ambitions and help service users to progress towards their recovery goals.

4.1 What you will see if you are meeting the principle

Treatment services that are evidence-based and deliver a broad range of effective interventions to meet the needs of the local alcohol-dependent population, making sure that:

- all alcohol dependent adults have quick access to alcohol specific-pathways within the treatment system, with services delivered from non-stigmatising settings
- the treatment system has established care pathways with a range of health, social care, criminal justice and community agencies
- there are individually-tailored packages of psychosocial, pharmacotherapy and recovery interventions that can be accessed by the target populations and which deliver good outcomes for dependent drinkers
- safeguarding practice is continuously monitored, regularly reviewed and reported on to ensure the safety of alcohol and drug users, their families and wider social groups
- the number of people successfully completing treatment is increasing and their recovery from dependence is sustained

4.2 Indicators to support the principle

The alcohol prevention and treatment system is integrated and configured to meet the needs of the local population across community, hospital and prison settings.	Whilst penetration rates are much lower for alcohol than drugs, this is the case nationally and we have higher rates than the national average (locally in 2021, 27% of dependent drinkers are in treatment compared to 19%	

	nationally[255]). We are focusing on improving quality of treatment rather than increasing numbers in treatment as services are already operating at 25% over capacity- the national target is to increase numbers in treatment by 20%.	
There is sufficient capacity in the treatment system to optimally address the needs of the estimated population of alcohol dependent adults in need of specialist treatment, and alcohol services are commissioned to target and treat dependent drinkers, wherever they are located in the community, responding appropriately to presenting risk. Where the estimated rate of unmet need for alcohol treatment appears high when benchmarked against past performance or against local areas with similar needs, or where numbers in treatment for alcohol dependence have fallen, there is a plan to address this.	There is sufficient capacity for Alcohol Treatment orders, however there is insufficient capacity for alcohol detoxification, as waiting lists have started during the pandemic, creating a backlog. To assist with this, a priority is to establish alcohol detoxification in supported accommodation settings.	
Alcohol treatment services in all settings offer evidence-based, effective recovery-orientated interventions in line with NICE guidance CG115 and CG100 and NICE quality standards QS11, including, where appropriate, quality statements 4, 5, 7, 8, 9, 10, 11, 13. Treatment providers have workforce plans that describe how specialist staff are trained and supported to make sure they have appropriate competence and supervision to deliver specialist interventions.	Delivery is being mapped against NICE Guidance.	
Heavy drinkers with high levels of need who are frequent users of hospital and other local services are identified, engaged and supported into appropriate treatment through a co-ordinated multi-agency response.	High Intensity User Group Monthly MDT Hospital Outreach Team	
There are clearly defined and well-functioning care pathways between community alcohol (and drug) services and acute hospital trusts including alcohol care teams, mental health provision, criminal justice agencies as well as social care and safeguarding services (both children's and adult). Where acute hospital trusts and mental health trusts are implementing the Preventing ill health (alcohol and tobacco) CQUIN, there are effective	There are clear pathways between community services and acute hospitals, mental health, criminal justice, social care and safeguarding services. However, in practice, we are still working on and prioritising Pathways for	

[255] Diagnostic Outcomes Monitoring Executive Summary (DOMES), NDTMS, OHID (2022)

referral pathways into community alcohol treatment for patients identified as alcohol dependent.	people with multiple needs, children of parents who have been incarcerated, women who have multiple pregnancies and having multiple children being removed. Further work is also required to increase understanding about fluctuating capacity and the ability to safeguard.	
Explicit information governance and joint working agreements are in place across all services to promote effective care delivery and risk management through the routine sharing of information.	Information sharing agreements are in place.	
There is rapid access, appropriate assessment and care planning to support parents as well as joint working with children and family services.	KH to ask Ben Davies and team	
Links between domestic abuse and alcohol misuse are considered in assessment care planning and reviews. There is joint working with (and effective pathways to) services for domestic abuse victims and perpetrators.	This has been an area of focus over the past 3 years, with a joint working protocol in place.	
Appropriate data is used to identify armed service veterans who have substance misuse problems and they know about local alcohol and drug services and are able to access them.	With You have a specific service for veterans (Right Turn) and high levels of engagement and liaison Something about the NHS lead here	
People's recovery journeys are initiated early and helped by them having access to a range of recovery support interventions and services such as peer support, mutual aid, family and parenting support, employment, training and housing.	Whilst the treatment service facilitates early engagement of referrals, referrals could be made much earlier if screening tools were implemented across all services. A priority to be included within future plans Aftercare and recovery is provided for a minimum of 3 months There are 8 MAP Mutual Aid groups (3 online, 4 face to face and 1 national online) and 32 AA meetings. IPS has been introduced to help with rates of employment and Parenting and Family interventions have been funded through the Supporting Families Grant until 2023.	More support to housing is a priority to increase across RSLs, private sector et al.

	The Rough Sleeper Outreach Grant funds a team to work with people at risk of homelessness as well as rough sleepers and the treatment service and commissioning team provide support to the wider range of housing (e.g. training staff, providing treatment staff, Section 8 support, needle exchange and naloxone).,	
All treatment providers report data to the National Drug Treatment Monitoring System (NDTMS) and this data is analysed locally to inform improvements. Where structured alcohol treatment is provided in settings that do not report into NDTMS, such as by alcohol care teams, there are mechanisms to feed data on this activity into local needs assessment and planning processes. Alcohol treatment provider information systems comply with the NDTMS minimum data set and there is appropriate investment in IT systems to meet the clinical and NDTMS needs of providers where required.		
There are sufficient staff with alcohol specialist expertise in the treatment system.	There are sufficient staff with expertise- evidence of regular training and CPD is provided	An increase in capacity is required. 1,000 structured treatment places commissioned but in 2020/21 1,846 people were in alcohol treatment (alcohol only and alcohol and non-opiate) but still around 75% of dependent drinkers are not in treatment.
Treatment interventions are appropriately tailored to levels of severity of alcohol dependence and complexity of need.	This is described with the Cornwall & Isles of Scilly Stepped approach to Alcohol Treatment and within the segmentation of the treatment population into	

	appropriate interventions.	

5. Working with partners to commission effective alcohol and drug services

5.1 What you will see locally if you are meeting the principle

Effective integrated policies and commissioning of services that achieve positive outcomes for individuals, families and communities by:

- co-ordinated policies to promote less risky drinking and drug use, and to prevent harm
- effective partnership working between local authority-led public health, the NHS (clinical commissioning groups and NHS England health and justice commissioners), mental health services, Jobcentre Plus, Work and Health Programme providers, adult social care, housing and homelessness agencies, children's services, criminal justice agencies and emergency services
- a commissioning system operating transparently according to assessed need
- improving connections between treatment providers and mutual aid organisations
- full involvement of service users and local communities, including through Healthwatch

More people in treatment are supported into work by an effective partnership between the treatment and employment support sectors. There is an integrated support offer involving greater support around training, education, voluntary work and general improvement of skills and work experience.

People with alcohol and drug problems have the best possible access to warm, safe and affordable homes, suitable for their needs in the community that local conditions will allow.

5.2 Indicators to support the principle

Embedding in local systems

There is an explicit link between the evidence of need and service planning within alcohol and drugs needs assessments, alcohol and drug commissioning strategies, clinical commissioning group strategy, and the joint health and wellbeing strategy.	There is an explicit link between needs assessment and service planning, involving CCG and the HAWB strategy. To be worked up in future, through ICS.	
Mechanisms are in place for reporting on alcohol and drugs to the health and wellbeing board, to the police and crime commissioner and to local safeguarding systems for vulnerable adults and children.	Reporting goes to the Community Safety Partnership, Neighbourhoods Overview and Scrutiny (with invitation to Health Portfolio holder to CSP Board and Health OSC to Neighbourhoods OSC).	Future work with ICS is a priority and is under review and development.

	OPCC sits on CSP and regular SLA meetings are held with OPCC on a quarterly basis. Adults and Childrens Safeguarding Partnerships are represented on the CSP and have an evolving tripartite arrangement. Drugs and Alcohol team are involved in SAB and OSCP initiatives.	
Public health commissioners have partnership arrangements with key agencies including clinical commissioning groups, clinical networks, NHS England area teams, children's and adult social care and criminal justice agencies.	We have a number of existing groups which we work through and which involve partners in a comprehensive and meaningful way, in addition to the CSP: 1. The **Needs Assessment Expert Group**, which steers the needs assessment process and identified commissioning priorities is a multiagency partnership which includes wider stakeholders, including the treatment providers and Experts by Experience. 2. The **Joint Commissioning System Optimisation Group** consists of members from the PCC, Probation, NHS Kernow, Adult Social Care, Housing and Homelessness, VCSE representatives, Together for Families and Public Health 3. The **Reducing Reoffending Board** 4. The **Community Sentencing Treatment Requirements Steering Group** includes Service providers, mental health provider (and NHSE/I)	The Needs Assessment Expert group to be developed into a planning and review group, once Needs Assessments are completed, to follow through the commissioning cycle and meet the recommendations of the new Supplemental Substance Misuse treatment and recovery grant (SSMTRG).

	5. The **Individual Placement Support (IPS) Steering Group** 6. **SW Peninsula In-patient Commissioning Consortia** **7.** The **Dual Diagnosis Implementation Group and Operational Managers groups** **8. The Clinical Governance Group** (including Pharmacy and Primary Care) All of these groups are involved in drawing up plans and priorities. <u>Remaining Gaps in membership not covered by existing partnership groups</u> a) There is not a single **Prison or Young offenders Institution** in our Area or with whom we work. We currently work through the Regional OHID lead for prisons, which would be covered off by their attendance at the Board, for which they have an open invitation. Additionally, the local drug and alcohol team commissioners attend the OHID regional network, where liaison with prisons is facilitated.	
Integrating local authority and health planning to reduce alcohol and drugs harm has been supported by introducing place-based sustainability and transformation partnerships and integrated care systems.	Place-based initiatives are in place and being developed.	A priority for the next 3 years is introducing planning to reduce alcohol and drug-related harm more comprehensively and to link with the Integrated care Board when this is set up.

Arrangements are in place for joint commissioning where there is a shared responsibility for commissioning and planning, such as with the NHS for secure settings	No formal joint commissioning arrangements for alcohol and drugs commissioning. Shared responsibility for commissioning and planning discharged currently through the CSP and Joint working through Joint Commissioning Group, Crisis Care Concordat, MHTRs. No local secure settings	Developing our approach through commissioning for Screening, IBA and Alcohol Related Brain Damage requires a joint approach. Priority to link with integrated care board leads when this is set up.
A fully integrated system of health improvement, treatment and recovery for people with alcohol and drug problems has been developed by a formal strategic partnership involving relevant stakeholders and agencies.	This was last articulated in our local Alcohol Strategy, Commissioning Priorities and Delivery Plan in 2017. This needs assessment and review will result in a new Strategy and Delivery Plan from 2022, which involves all stakeholders through a range of processes. This will be discussed with HealthWatch	
The general public, service users and staff in other services understand the alcohol and drug services available locally, the pathways between services and points of entry for treatment.	There is good evidence to support this: Service user and stakeholder consultation 2022 reflects enormous progress. Much reduced and very low numbers asking for information and clarification. Requires sustained communications to maintain.	
Quality governance mechanisms assure the quality and safety of alcohol and drug treatment services and are embedded in public health systems	Clinical Governance Group and processes.	

Needs assessment

The needs assessment includes a comprehensive section on the full spectrum of alcohol and drug-related harm and it acknowledges the impact of alcohol and drug work across the public health and NHS outcomes frameworks.	Community Prevention Panels have been convened. Local needs assessments piloted.	Priorities going forward: Asset-based community development to take into account

There is a shared understanding of the level of demand and need, based on a range of local and national data across a range of public services. The following are identified locally: gaps in delivery of primary, secondary and tertiary prevention for alcohol and drugs the extent of unmet need for alcohol treatment among the estimated population of adult dependent drug users in need of structured treatment unmet need among specific populations such as people with co-occurring mental health conditions or substance misusing parents the impact of services on health and wellbeing, public health and offending Health and public health commissioners use hard and soft intelligence to understand need in relation to misuse of or dependence on prescription and over-the-counter medicines, including dependence arising inadvertently from the prescribed use of a medicine. Data is collected on alcohol and drug interventions provided in hospitals, primary health care and other settings, to inform needs assessment. Levels of alcohol and drug-related admissions to hospital are analysed, to target interventions. Specialist alcohol and drugs treatment data is monitored and analysed, to compare current treatment provision with need. The needs assessment uses a methodology such as asset-based community development to take into account the availability and potential development of existing community support networks and other local assets. The needs assessment takes account of the needs of the local population including: children affected by parental alcohol or drug misuse people (predominantly women and girls) vulnerable to alcohol and drug misuse as a result of domestic abuse, sexual assault, child sexual exploitation, or prostitution prisoners and continuity of care requirements for alcohol and drug-misusing offenders moving between custody and the community		the availability and potential development of existing community support networks and other local assets has commenced and will develop and continue. Women only treatment options Improving assessment in and referral from Primary Care (rather than simply encouraging self-referral). Look at the data generated by the Population Health Management programme to potentially inform future needs assessments. PAUSE programme – a model of therapeutic, practical and behavioural support offered to women who have experienced (or are at risk of experiencing) a cycle of recurrent care proceedings leading to removal of their children into local authority care.

people with protected characteristics under the Equality Act 2010 the carers and family members of people who have alcohol and drug problems people with co-occurring mental health and alcohol and drug use conditions. A mutual aid self-assessment tool has been completed as part of the needs assessment. Finance Investment is sufficient to provide a range of prevention, harm reduction and treatment services commensurate with the level of identified need. Decision-makers have been enabled to understand the potential return on investment from alcohol and drug interventions and the possible cost of under-investment. Tools like the Value for Money Commissioning Support Tool can help commissioners demonstrate the benefits derived from local investment. Decision-makers understand the effectiveness and cost-effectiveness of their commissioned services and can identify ways of improving these where necessary. The Value for Money Commissioning Support Tool is designed to help local areas understand and improve the cost-effectiveness of local treatment systems. Commissioners can identify the total level of local investment by all partners. There is close communication with finance colleagues to ensure that planned and actual expenditure on alcohol and drug prevention and treatment interventions is accurately reported to the Ministry of Housing, Communities & Local Government as part of required local authority financial returns. For help in disaggregating local substance misuse expenditure and estimating unit costs, commissioners can refer to the Value for Money Commissioning Support Tool. Effective commissioning Commissioning is based on evidence based guidelines, such as the drug treatment clinical guidelines and NICE guidance, for		

effective interventions in tackling alcohol and drug-related harm. There is an alcohol and drugs planning document that describes how best to meet local need, which clearly identifies: • the level of demand • existing strengths and assets and ways in which services can be commissioned to build on them • finance and available resource • Investment in alcohol and drug prevention, treatment and recovery is based on an understanding of expenditure, performance and cost-effectiveness. Contracts for commissioned services specify the outcomes to be achieved and these outcomes are regularly monitored and reviewed. Care pathways and services are geographically and culturally appropriate to the people they are designed for. Service users, their families and carers and people in recovery are involved at the heart of planning and commissioning. This is evident throughout needs assessment and key priority-setting processes both for community and prison-based services. Commissioning functions are fit for purpose. There is sufficient alcohol and drug misuse commissioning capacity and expertise, including information management. A workforce strategy and improvement plan ensures that commissioning staff are competent to commission safe and effective services. Service specifications clearly indicate the level of professional competence required to deliver safe and effective services. The transfer of care is managed safely and effectively, when the contracted provider changes, with appropriate communication of patient information to enable seamless management of risks. The commissioning strategy includes the formal evaluation of the range of alcohol and drug interventions. Services for people in contact with the criminal justice system.		

There are clear pathways into assessment, treatment and support services for people in contact with the criminal justice system who have drug or alcohol problems and where possible, integrated pathways for people with co-occurring mental health and alcohol and drug use conditions. There is a collaborative approach with police and crime commissioners and NHS England health and justice commissioners to commission integrated services that support and engage people as they move between prison and community settings, taking the latest guidance into account. Commissioners have engaged with their local National Probation Service and community rehabilitation company to agree capacity for treatment interventions and specific requirements for offenders who are subject to statutory supervision in the community and on release from prison. Mutual aid There is a shared, locally developed vision of recovery where mutual aid is appropriately integrated with all alcohol and drug services including in-patient and residential treatment. People in treatment have access to a range of peer-based recovery support options, including 12-step, SMART Recovery and other community recovery organisations. Local services are encouraged to support service users to engage with mutual aid groups through the inclusion of specific requirements in their service specifications. Housing and homelessness The housing needs of people with alcohol and drug problems in the community, prison and residential treatment have been identified and are used to inform commissioning plans for housing, homelessness and housing related services. The housing needs of people with alcohol and drug problems, and their families and carers where appropriate, are assessed at the right time, to prevent homelessness or to help them move on to a suitable home.		

There is a range of housing options to meet different needs. Housing information and advice are readily available for everyone in treatment. Front-line housing staff are trained to meet the housing and related needs of people who have alcohol and drug problems. The needs of homeless people and rough sleepers are specifically considered as part of local substance misuse commissioning arrangements. The health needs of homeless people who misuse alcohol and drugs have been identified and they are supported to access primary care and other healthcare, such as mental health services. People with lived experience of homelessness are consulted as part of a health needs assessment, to identify gaps in service delivery and solutions. Where an eligible person is homeless or at risk of homelessness, the local housing authority carries out an assessment and agrees a personalised plan to provide tailored support in line with the Homelessness Reduction Act 2017. People who are sleeping rough and have alcohol and drug problems are able to access emergency accommodation and support and are contacted and encouraged to access drug and alcohol treatment and mental health services, where required. Policies and procedures for homeless people with alcohol and drug problems support people to access suitable accommodation on discharge from hospital or residential rehab, or on release from prison. Employment, training and education Joint planning arrangements are in place between treatment commissioners and providers and Jobcentre Plus (JCP) and Work and Health Programme (WHP) leads to meet the employment, training and education (ETE) needs of the alcohol and drug misusing population.		

Relationships have been established with the JCP partnership managers and community partners, including the specialist drug and alcohol community partners in areas where they are in place. Worklessness and employability strategies reflect the ETE needs of people who misuse alcohol and drugs. Commissioners incorporate ETE in their performance monitoring arrangements with treatment providers and providers address ETE in supervision for keyworkers. JCP, WHP and treatment providers have agreed a process of joint working between agencies, including arrangements for three-way meetings and co-location. Local single points of contact have been identified in JCP, WHP and all treatment teams and these details have been circulated. There are employment champions in treatment teams, whose role it is to liaise with JCP and WHP, and to champion ETE. Treatment providers, JCP and WHP routinely engage with local employers to make the case and address negative preconceptions and stigma about employing people with a history of alcohol or drug dependence. Discussions about employability are introduced early on in treatment journeys, and commissioners and treatment providers continually review the extent to which the ETE agenda is prioritised in local recovery provision. Treatment staff encourage clients to consider appropriate disclosure of their alcohol and drug misuse within JCP and WHP to help them get individual support.		

Appendix B: Legislation and policy context- national and local

It is recognised that there is an array of legislative and regulatory interdependencies that inform this needs assessment:

- Police, Crime, Sentencing and Courts Bill
- Crime and Disorder Act 1998
- Welfare Reform Act 2012
- Children's Act 2004
- Children and Families Act 2014
- Health and Social Care Act 2012
- Public Services (Social Value) Act 2012
- Modern Slavery Act 2015
- Sexual Offences Act 2003
- National Mental Health Crisis Care Concordat 2014
- Mental Health Act 1983 Code of Practice, Department of Health, 2008
- Department of Health, 2005 "The Mental Capacity Act". DoH
- Department of Health, 2007 "The Mental Health Act as amended from the 1983 Act"
- Anti-social Behaviour, Crime and Policing Act 2014
- Domestic Violence, Crime and Victim Act 2004
- Code of Practice for Victims of Crime October 2015
- Equality Act 2010
- Data Protection Act 2018 in accordance with GDPR
- Family Law Act 1996
- Counter-Terrorism and Border Security Act 2019
- Domestic Abuse Act 2021
- Human Rights Act 1998
- Housing Act 1996
- Homelessness Reduction Act 2017
- Gender Recognition Act 2004
- Homelessness Act 2002
- Care Act 2014
- Policing and Crime Act 2017
- Local Government Act 2000

NICE Guidance

The following are relevant in preventing and reducing alcohol harms:

- Alcohol use disorders: prevention (PH24);
- Alcohol: preventing harmful use in the community (QS83);
- Alcohol Interventions in secondary and further education (NG135);
- Alcohol use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence (CG115);
- Alcohol use disorders: diagnosis and management of physical health complications (CG100);
- Co-existing severe mental illness and substance misuse: community health and social care services (NG58);
- Co-existing severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings (CG120);
- Domestic violence and abuse: multi-agency working (PH50).

National Public Health England Alcohol Evidence Review

This review[256] was published in 2016 and looked at the impact of alcohol on public health and the effectiveness of alcohol control policies. It concluded that:

[256] The public health burden of alcohol and the effectiveness and cost-effectiveness of alcohol control policies: an evidence review, Public Health England (2016)

- Policies that reduce the affordability of alcohol are the most effective, and cost-effective, approaches;
- Reducing hours for alcohol sales – particularly late night on-trade sale – reduces alcohol-related harm in the Night-Time Economy;
- There is a clear relationship between the density of alcohol outlets and social disorder;
- Self-regulatory systems that govern alcohol marketing practices do not succeed in protecting vulnerable populations.
- Enforced legislative measures to prevent drink-driving are effective and cost-effective;
- Lower alcohol limits for young drivers are economical and effective at reducing casualties and fatalities in this group;
- Large scale, well-resourced health interventions aimed at drinkers who are already at risk (e.g. Identification and Brief Advice) and specialist treatment for people with harmful drinking patterns and dependence, are effective approaches to reducing consumption and harm in these groups, and show favourable returns on investment;
- Combining alcohol polices may create a 'critical mass' effect, changing social norms around drinking to increase the impact on alcohol-related harm, but alcohol policies should be coherent and consistent;
- Warning labels highlighting the risks of alcohol consumption should not be undermined by a unit price that encourages heavy consumption.

Public Health England: Alcohol's harm to others evidence review

Published in June 2019, this review[257] looked at the negative impact of alcohol on those other than the drinker. It concluded that evidence-based policies that reduce alcohol use across society (for example duty increases, a minimum unit price, restrictions on the availability of alcohol, and marketing regulation) are likely to be most effective at reducing the total burden of alcohol-related harm. Targeted interventions aimed at specific issues such as parenting programmes or advice to pregnant women, could also be used to good effect.

Health and Care

The NHS Long Term Plan[258]

Published in January 2019, the NHS Long Term Plan sets out key ambitions for the NHS over the next 10 years. In terms of addressing alcohol misuse, the plan detailed the expansion of Alcohol Care Teams (ACTs) in hospitals. ACTs work in partnership with local authority commissioners of drug and alcohol services to reduce alcohol dependence-related admissions.

CQUIN 2019/20 and 2020/21

NHS England have updated the national Commissioning for Quality and Innovation (CQUIN). A percentage of the total value of an NHS contract is allocated to a provider for sufficient delivery of a specified activity.

[257] The range and magnitude of alcohol's harm to others, Public Health England (2019)
[258] The NHS Long Term Plan (2019)

The 2019/20 guidance[259] incentivises community, mental health and acute providers to carry out alcohol 'Identification and Brief Advice' (IBA) using the AUDIT-C screening tool. The goals were to screen 40-80% of all inpatients and give brief advice to 50-90% of inpatients. Inpatients are those aged 18 and over who are admitted for at least one night (excluding maternity).

2020/21 CQUIN guidance[260] sets a goal of testing 20-35% of all alcohol dependent patients for cirrhosis (end-stage liver disease) and fibrosis in acute and mental health services. However, this was not carried out due to the COVID-19 pandemic.

Reforms to The Mental Health Act[261]

The Mental Health Act sets out when someone can be detained in hospital and treated for a mental health disorder, at times against their wishes. The Government has responded to the recommendations of a 2018 independent review of the Act with a White Paper and consultation. A Bill to progress these changes through parliament is forthcoming. The proposed changes are based on:

- Ensuring the Act's powers are used in the least restrictive way;
- Making sure care and treatment is focused on making the person well;
- Ensuring people have more choice and autonomy regarding their treatment;
- Treating people equally and fairly and disparities experienced by people from black and minority ethnic backgrounds are tackled;
- Better treatment for people with learning disabilities and autism to reduce the reliance on specialist inpatient services for this group.

Community Safety and the Criminal Justice System

Modern Crime Prevention Strategy 2016

This legislation was enacted initially within the Policing and Crime Act 2017 (January 2017). The strategy[262] is based on research into the drivers of crime, including alcohol, and includes such provisions as:

- Late Night Levy improvements to apply to defined areas, rather than whole Licensing Authority areas;
- Cumulative Impact Policy improvements, with more statutory powers to control alcohol sales;
- Consult on Licensing interventions for groups of premises in certain locations, in a group review intervention power (GRIP) which may require improved security or other area license conditions;
- Civilian (police) staff powers of entry to enter and inspect licensed premises;
- Sobriety tagging as a Court Order and improved GPS based electronic monitoring.

Offender Rehabilitation Act

Coming into effect on 1 February 2015, the Act introduced a number of measures intended to support the drive to reduce reoffending, including:

[259] Commissioning for Quality and Innovation (CQUIN) Guidance for 2019-2020, NHS England
[260] Commissioning for Quality and Innovation (CQUIN) Guidance for 2020-2021, HNS England
[261] Reforming the Mental Health Act: summary, Department of Health and Social Care (2021)
[262] Modern Crime Prevention Strategy, Home Office (2016)

- A new drug appointment requirement for offenders who are supervised in the community after release;
- An expansion of the existing drug testing requirement after release to include Class B as well as Class A drugs;
- A more flexible Rehabilitation Activity Requirement for adult sentences served in the community which will give providers greater freedom to develop innovative ways to turn an offender's life around.

Police, Crime, Sentencing and Courts Bill 2021

The Bill is currently being examined in the House of Lords (November 2021). It is the accompanying legislation to the Government's *Beating Crime Plan*[263] which includes:

- Enabling courts to impose an alcohol abstinence and monitoring requirement as part of a community order or suspended sentence order. Offenders can be banned from drinking for up to 120 days and are continuously monitored via an ankle worn tag;
- An increase in funding for community sentence treatment requirements for drug, alcohol and/or mental health;
- An increase the maximum penalty for causing death by careless driving when under the influence of drink or drugs from 14 years imprisonment to life imprisonment;
- The introduction of Serious Violence Reduction Orders (SVROs) in respect of offenders convicted of offences involving knives or offensive weapons. The police will have stop and search powers to target those subject to the orders.

Domestic Abuse Act 2021[264]

The Domestic Abuse Act came into effect on 29 April 2021 with increased provision for victims of domestic abuse as well as changes to the justice system aiming to increase the number of perpetrators bought to justice. The Act does not protect migrants who are victims of abuse. It includes:

- A statutory definition of domestic abuse including emotional, controlling or coercive and financial abuse;
- Recognition of children as victims of domestic abuse;
- Placing a duty on local authorities to provide accommodation based support to victims of domestic abuse and their children in refuges and other safe accommodation;
- All eligible homeless victims of domestic abuse will automatically have 'priority need' for homelessness assistance;
- Ensured that when local authorities rehouse victims of domestic abuse, they do not lose a secure lifetime or assured tenancy.

Tackling violence against women and girls strategy[265]

The strategy aims to increase support for victims and survivors as well as increasing reports to the police and the number perpetrators bought to justice. The long-term aim is to reduce violence against women and girls through increasing awareness and societal behaviour change.

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[263] Beating Crime Plan, Policy Paper, Home Office (2021)
[264] Domestic Abuse Act 2021: overarching factsheet, Home Office (2021)
[265] Tackling violence against women and girls strategy, Home Office (2021)

Local

It is recognised that there is an array of local strategies, plans and protocols that inform the Alcohol Strategy:

- Safer Cornwall Partnership Plan and Delivery Plan
- Cornwall Council's Priorities
- Cornwall Council's Gyllyn Warbarth, Together We Can: The Cornwall Plan
- Cornwall Council's Business Plan
- Cornwall Public Health Annual Report
- Cornwall and Isles of Scilly Health and Wellbeing Strategy
- The Cornwall and Isles of Scilly Long Term Plan for health and care
- NHS Kernow Futures In Mind Adult Mental Health Strategy 2020-2025
- Cornwall and the Isles of Scilly Health and Social Care Plan 2016-2022 – Shaping Our Future
- Adult Social Care Commissioning Strategy for 2022 – 2026
- Safeguarding Adults Board business plan and working practices
- Our Safeguarding Children Partnership business plan and working practices
- Cornwall and the Isles of Scilly Children's Education, Health and Social Care Plan – One Vision partnership plan
- Cornwall Council's Education Strategy for Cornwall 2018-2022
- Cornwall and the Isles of Scilly Drug and Alcohol Strategies and joint DAAT/DASV protocol
- Cornwall Housing DASV Housing Pathway and Refuge Protocol
- Cornwall Council's Localism in Cornwall – The Power of Community 2021
- Any recommendations arising through local domestic homicide reviews, Safeguarding Adult Reviews and/or serious case reviews
- Police and Crime Plan for Devon and Cornwall
- Cornwall Reducing Reoffending Strategy
- Rough Sleeping Strategy
- Anti-Social Behaviour Strategy
- Complex Needs Strategy (2019-2023)
- Cornwall Dual Diagnosis Strategy (2019-2022).

Safer Cornwall Priorities

The Safer Cornwall partnership has identified the following 4 headline outcomes for 2019-2022.

Workforce	Our workforce will know how to assess risk and vulnerability and intervene at the earliest opportunity to prevent escalation of harm Improve outcomes for local communities and increase public confidence, by working more effectively together,
Complex Needs	Our services will work together to provide effective, co-ordinated and accessible support for people with complex and multiple needs
Offenders	We will focus on offenders as well as victims, including prevention and ensuring that those who commit crimes against the most vulnerable are held to account
Communities	Our communities will understand the issues in their local area and will feel empowered to get involved in the solutions

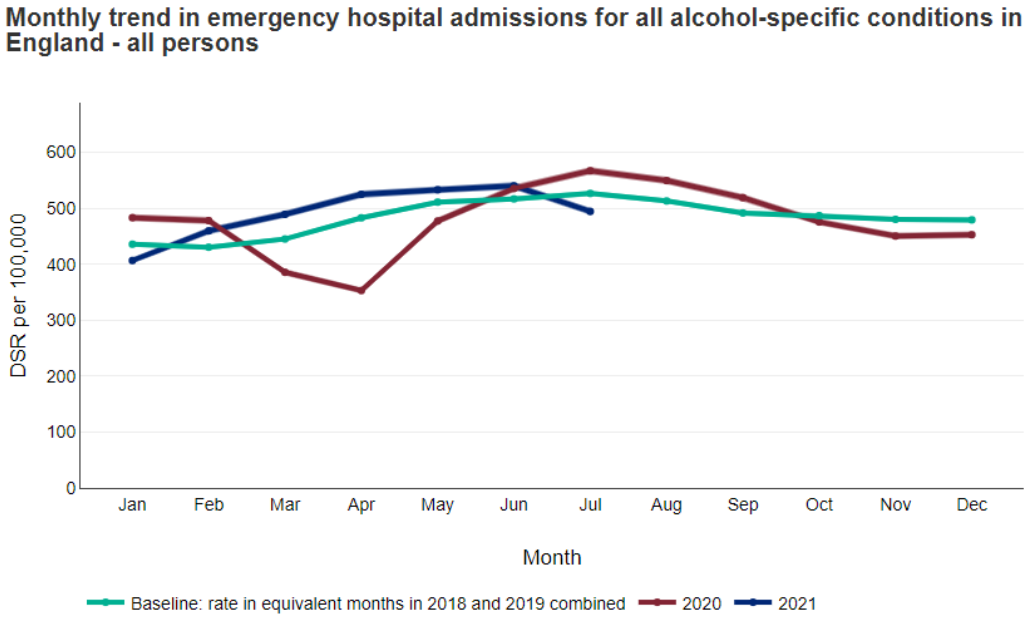
Appendix C: Older estimates on levels of drinking in CIoS

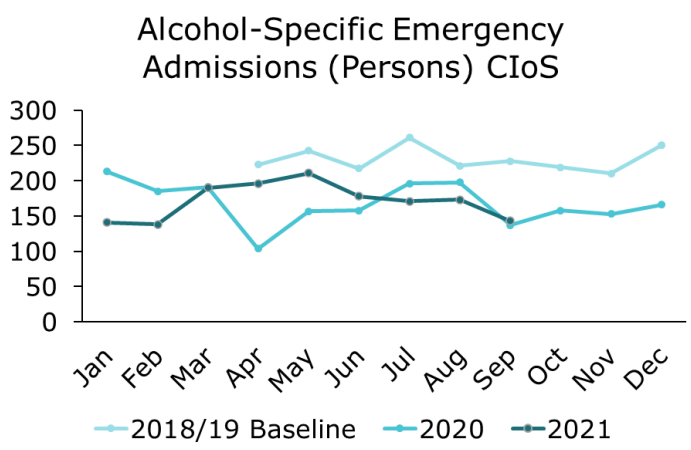
Estimates of levels of drinking risk in the local population were previously based on the outputs of a model developed by the North West Public Health Observatory. They were based on self-reported surveys and have not been updated to fit the reduced 14 unit guidelines for men in 2016. These estimates were included within previous versions of the LAPE and featured in previous CIoS alcohol needs assessments. They put Cornwall and the South West in line with national estimates.

Just under a quarter of people, however, are estimated to drink at above the recommended levels. 6% or 26,300 people are drinking at higher risk levels, double the recommended safe levels or above. In addition, an estimated 84,000 people (19%) are binge drinkers.

Appendix D: Alcohol-specific emergency admissions during the pandemic

The graphs below illustrate the changes in alcohol-specific emergency hospitals admissions seen nationally and locally throughout the pandemic compared to a 2018 and 2019 baseline. Note that national data refers to rates of admissions per 100,000 of the population whereas local data refers to numbers of admissions.

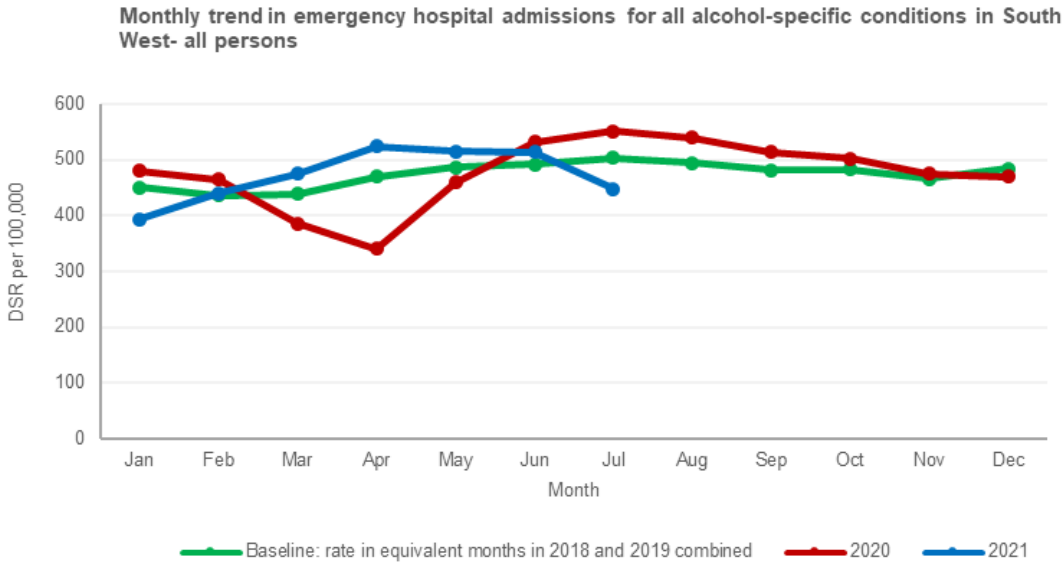




- In 2020/21, numbers of unplanned alcohol-specific admissions locally were lower compared to baseline as observed in national and regional rates;
- Local admissions rapidly decreased at the beginning of the pandemic (around April 2020) akin to national rates;
- The number of admissions locally rose from April 2020 peaking in Summer 2020 like national rates, but unlike national rates, never exceeded baseline;
- Local numbers remained below baseline throughout 2020 and 2021 up to the latest reporting month (September 2021);
- From February 2021 local admissions began to increase peaking in May but remained below baseline. National rates rose from January 2021 peaking in June and were higher than baseline from February to June.

The graph below illustrates the changes in emergency alcohol-specific admissions seen **regionally** before and during the pandemic.

- In 2020, rates of unplanned alcohol-specific admissions were lower compared to baseline;
- Rates for all admissions, not just alcohol, rapidly decreased at the beginning of the pandemic (around February 2020);
- Alcohol-specific rates rose from April 2020 peaking above baseline in July;
- Between November 2020 and February 2021, rates were lower than baseline, but by March 2021 were higher than baseline until June 2021.



Appendix E: Alcohol and mortality, definitions

Alcohol specific deaths are defined as deaths from conditions wholly attributable to alcohol i.e. death is a direct consequence of alcohol misuse. Most of these health conditions are long-term (e.g. alcoholic liver disease) but also include acute conditions (e.g. poisoning, accidental or intended).

Alcohol-related deaths are deaths from conditions which are wholly or partially caused by alcohol. For partially attributable conditions, a fraction of the deaths are included based on the latest academic evidence about the contribution alcohol makes to the condition.

Appendix F: Alcohol-specific mortality 2020- South West

Local Authority	Increase in alcohol-specific mortality from 2019 to 2020
North Somerset	213%
Gloucestershire	89%
Bath and North East Somerset	49%
Dorset	39%
Torbay	38%
Wiltshire	38%
Somerset	37%
Plymouth	33%
Swindon	25%
Devon	24%
Bournemouth, Christchurch and Poole	23%
Cornwall and IoS	**16%**
Bristol	14%
South Gloucestershire	0%
South West average	**32%**
England average	**19%**

Appendix G: Suicide data

In July 2018, the standard of proof used by coroners to determine whether a death was caused by suicide was lowered to the "civil standard" – balance of probabilities – where previously a "criminal standard" was applied – beyond all reasonable doubt. The Office for National Statistics has noted: "It is likely that lowering the standard of proof will result in an increased number of deaths recorded as suicide, possibly creating a discontinuity in our time series." Therefore any differences in suicide data prior to and after July 2018 need to be interpreted with caution. Data is not reported in single years but rather aggregated as small numbers mean trends can be subject to random fluctuations which could be misleading.

Appendix H: Personal Independence Payments case studies from local treatment

Case Study 1

V is in her 40s and moved to Cornwall in 2019. Previous serious problem drinking led V to losing her career and home and she has diagnosed bipolar disorder. Whilst V was homeless she met her partner and they moved in together, she then developed an opiate addiction. Unfortunately, V's partner died, something she had difficulty coming to terms with. V was in treatment before she moved to Cornwall and was mentally stable.

On arrival to Cornwall V engaged well and remained stable mentally, although her drinking started to become an issue and in the next couple of months she had started using heroin again, although not problematically. Later it was established that V's benefits were incorrect and she received a back payment of around £9,000.

V disclosed that she had received the payment and put £5,000 into her parent's account for safe keeping. However, V's drug use spiralled out of control using heroin and crack daily and her mental health declined. She became vulnerable to exploitation as she wanted to help others and was giving money to people she thought were in need. In November 2019 V allowed another service user to stay at her house, she felt threatened and intimidated by the person. Only when this culminated in a safeguarding referral did the person leave. This had a massive impact on V and later that month she entered a period of mania and was admitted to RCHT having a heart attack, possibly owing to the high level of crack use. V was still struggling with her mental health and at that point was using heroin daily although she had stopped using crack.

The back payment was gone by February 2020 including the money put into safe keeping. V was placed under the Mental Health Act in summer 2020 followed by a voluntary admission to Hospital.

Case Study 2

N is a single man in his 50s who is divorced with three adult children. N has experienced poor mental health since he was attacked in his mid-twenties. He has flashbacks which increases his anxiety and promotes isolation. Roughly ten years ago he had both hips replaced due to a road traffic accident. He is currently under the Mental Health Team and has a CPN. A long history of opiate abuse, in 2016 N had relapsed with heroin about a year earlier when his father had died. He has stated that he has tried to overdose twice deliberately. He had spent time in prison and when released was using heroin daily. At the time N was homeless and living in supported temporary accommodation.

N came into the office to say that he was very scared that he had received a back payment of £16,000 and he was frightened that he was going to blow it all. It transpired that he had actually received two payments one of £1,600 and another of £995. Several Staff expressed their concerns as N was known to be vulnerable to overdosing and at risk of serious exploitation. Initially N agreed that his CPN could be contacted in order to set up an appointee. N began to gradually disengage by not picking up his daily prescription. He was also not engaging with other services and he was developing new friendships.

N was given 28 days notice to quit his accommodation as he was found using (with another resident). N left the property shortly after and went under the radar, thought to be staying in a caravan. Staff put out alerts and when contact was made N was helped back into alternative supported accommodation until he could use some of the money to get his own place. However, in a key session it transpired that he had spent all of his back pay and did not have the money for the deposit and rent in advance. He now needed support to have his PIP and other benefits reinstated.

Appendix I: Case Study from the With You Family Team

This case study contains references to domestic abuse.

K is a single mum of 5 children – youngest aged 2 living next door with her friend. 4 other children have 50/50 care with parents. K's mum was an alcoholic and her father was abusive. K has experienced physical, emotional and sexual

abuse from childhood. She has no positive parenting support or protective factors and has been drinking problematically since her early teens. K experienced domestic abuse whilst married to the father of her children. K was drinking daily and her husband used alcohol as part of his power and control.

K has now separated from her husband but during this period the children witnessed abuse and they were also subjected to the abuse as part of the coercion and manipulation to hurt K. Social care had assessed dad as being the protective factor for the children. K tried to convey that this was a persona and that he was a very charismatic person. Dad was given custody of the children and control of contact with K. He then moved in with his girlfriend 4 doors away and continued to psychologically and emotionally abuse K, using the children to perpetuate the abuse, buying her alcohol and taking her benefits. K is aware that the children were being manipulated into telling their father everything she did. Dad would enter K's home unannounced and she was not able to stop him. She was fearful of him and scared of what he may do, possibly even preventing her from seeing the children. She called the Police on several occasions.

Presenting Issue: K found it difficult to put parental boundaries in place as the children's behaviour was challenging. K wanted to learn how to manage their behaviour and was aware she had to address her own emotional problems and fears.

The Work Undertaken: Using a trauma informed approach with K, the Family Worker used a rage of techniques to help her describe her trauma and the difficulties in managing the children's behaviours. K was able to identify the changes she wished to make in her life and why. The Worker used interventions to increase K's self-confidence. She said that for the first time she felt heard and understood and was able to make sense her life and her children's experience.

Outcomes: K was able open up describing events within her life which her children had also experienced. She was able to communicate feelings held since childhood, without fear or judgement, and feel fully supported emotionally.
K has been able to start putting boundaries in place with the children, talking to them rather than shouting and giving up. K is beginning to feel much more confident in her decisions and in herself. This has supported her abstinence from alcohol. She attended and completed the Solihull Parenting Programme. She is open to and takes up offers of support enabling her to move forward.

Appendix J: Cormac's 'Top 10' areas for road traffic collisions

Rank	Area	Route 1	Route 2	Description
1	Truro	A30	A390	Chiverton Cross Roundabout
2	Hayle	A30	*C750	Loggans Moor Roundabout
3	Penzance	A30	B3311	Branwell Lane Roundabout - Jelbert Way Junction
4	St Austell	A390	B3273	Penwinnick Double Roundabout - Penwinnick Road
5	Penzance	A30	C745	Chy-an-Mor Roundabout
6	Camborne	B3303	C92	Trevenson Street Double Mini-Roundabout
7	Newquay	A392	†C51	White Cross
8	Torpoint	A374	U/C	Antony Road
9	Newquay	A3075	C3	Cubert Crossroads
10	Redruth	C776	A3047	East Hill Traffic Signals - Trevenson Road, Pool
*C- classified roads are of lower significance traffic and are primarily of local importance				
†U/C- unclassified roads are of very low significance to traffic, and are of only very local importance				

Appendix K: Alcohol versus drugs: treatment engagement

	2018/19	2020/21				Equivalent number of dependent drinkers in treatment
	Estimate	In treatment count	% in Treatment	Unmet need count	Unmet need %	
Opiate users	2,021	1,354	67%	667	33%	4,699
Opiate & crack users	2,237	1,432	64%	805	36%	4,456
Crack users	764	275	36%	489	64%	2,508
Dependent drinkers	6,968	1,846	26%	5,122	74%	-

National comparison | Lower | Higher

If between 2,508 to 4,699 dependent drinkers were in treatment this would represent an additional 662 to 2,823 people in treatment compared to numbers in 2020/21 (1,846).

Appendix L: Mutual Aid Provision in Cornwall

Annex 1: availability of mutual aid group meetings

	Number of meetings						
What groups are available locally?	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
SMART Recovery							
Alcoholics Anonymous + 30 online per week	x5	x6	x5	x3	x8	x2	x5
Narcotics Anonymous +2 online meetings per week	x2	x2	x2	x1	x1	x1	x1
Cocaine Anonymous + 10 Devon and Cornwall online per week (some social)	x1			x1			
Drug Addicts Anonymous	x1						
Marijuana Anonymous							
Families Anonymous + 1 Online Camborne		x1					
Al-anon + WhatsApp Group by Truro AA	x2	x1	x1	x1		x1	
Local community-based recovery networks MAP + 3 online		x1 (Bude)	x2 (Fal, TR) Arts & crafts group after TR Weds meeting			x1 (TR) Recovery cafe afterwards	