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

SAFER CORNWALL
Kernow Salwa

CORNWALL & ISLES OF SCILLY DRUGS NEEDS ASSESSMENT 2022/23

one and all · onen hag oll
CORNWALL COUNCIL

Amethyst FINAL April 2023

Contents

Introduction

Cornwall Council and Cornwall's Community Safety Partnership, **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).

Our local drug and alcohol strategies sit under the umbrella of the **Safer Cornwall Partnership Plan**, which provides an **established policy framework** that brings our resources together to address the **issues that present the greatest risk** to the safety of individuals, their families and the wider community.

The current system of drug and alcohol services commissioned by the DAAT has been in place since 1 April 2018, informed by a detailed needs assessment that was undertaken in 2016/17.

The needs assessment aims to provide a **shared understanding of local needs and evidence** for drug and alcohol provision, to inform the development of local services and enable individuals, their families and the wider community to have their **needs met more effectively**.

This needs assessment update brings the prevalence and trend data up-to-date, highlighting **changes in patterns and trends** and any emerging risks. It includes mapping of current services and a review of the **effectiveness of those that we commission** and the wider system, using the latest data from the National Drug Treatment Monitoring System (NDTMS).

How many people are at risk?

What **services** exist, how many people use them and what are their outcomes?

What are the **gaps** in our local response? How important are they?

What are the impacts on **individuals, families** and the **community**?

What are the **unmet needs** and what do we know about them?

What best practice and guidance can help us?

It focuses on four specific areas that have been identified as priorities:

- **What's changed** since the last assessment?
- **What are the gaps** in our knowledge or services to support local delivery of the national Drug Strategy?
- What do partners view as the **challenges, strengths and weaknesses** in Cornwall's drug and alcohol system?
- Service user **experience** and views

This Drugs Needs Assessment is the **partner document to the Alcohol Needs Assessment**[1] and has multiple cross-cutting themes and priorities.

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

1 The Alcohol Needs Assessment can be downloaded from the Safer Cornwall Library

Scene setting

National context

Estimated **314,000 opiate and/or crack users** in England; this number has increased significantly as a likely result of a rise in crack use. [1]

Drug-related deaths are at their highest level ever. Drug-related causes are a significant contributor to deaths in the **20-50 age group** and may be contributing to the slow-down in life expectancy in England. [3]

The total cost of harms related to illicit drug use in England in one year was **£19.3 billion**, of which around half is attributed to drug-related acquisitive crime such as **burglary, shoplifting and robbery** [2]

9.2% of people aged 16-59 years reported taking an illicit drug in the last year; of which around **30% had taken a Class A drug**, equivalent to 0.9 million people [4]

The new **10-year UK Government Plan** to combat illegal drugs From Harm To Hope[2] sets out three strategic priorities:

- **Break drug supply chains**, including tackling county lines and reducing associated violence and homicide
- **Deliver a world-class treatment and recovery system**, with significant additional investment in local drug and alcohol services
- **Achieve a generational shift in demand for drugs**, through a focus on school-based prevention and early intervention and supporting families most at risk

It recognises that addressing the complex relationship between **drugs, crime, health outcomes and deprivation** are key to achieving the Government's. **'Levelling Up' mission.**

[1] Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, LJMU, 2019
[2] Review of Drugs - evidence pack, Dame Carol Black Review, 2020
[3] Deaths related to drug poisoning in England and Wales 2020, ONS, 2021
[4] Drug misuse in England and Wales: year ending June 2022, ONS, 2022

The strategy reflects the **partnership approach** that needs to be taken to tackle drug misuse and its harms, recognising that **drug use is a cause and consequence of wider factors** including physical and mental ill-health, problems relating to employment, housing, family life and crime issues.

It outlines the joint responsibilities of the range of partners needed including **health**, **housing** services, **employment support** providers and **criminal justice** partners.

The Office for Health Improvement and Disparities (OHID) provides Commissioning Support Packs to help commissioners and local authorities develop joint **strategic needs assessment** and **health and**

2 First published in December 2021

wellbeing strategies to reduce the harm caused by drinking and drug use in both adults and children.

These include key data that enables us to compare the needs and trends in our local population with the national picture.

For adults using drugs, the UK has clear clinical guidelines.

Term	Description	Guidelines	Service offer
Drug dependence	A cluster of factors which includes a strong desire to take the substance, difficulties controlling and tolerance to use, withdrawal, a neglect of alternative activities, and persistent use despite harm	Drug misuse and dependence UK guidelines on clinical management (2017); NICE quality standards for drug use disorders in adults (QS23)	Interventions for problematic use, including specialist treatment services
Drug misuse	A pattern of drug use causing health and/or social problems		
Alcohol dependence	See 'Drug dependence'; can be mild, moderate, severe	NICE products on Alcohol-use disorders (CG115, QS11, QS82)	
Higher risk drinking	A pattern of alcohol consumption causing health and/or social problems		
Increasing risk drinking	A pattern of alcohol consumption putting an individual at risk of harm	NICE guideline on Alcohol-use disorders: prevention (PH24)	Identification and Brief Advice

The Social and Economic Backdrop

Cost of Living Crisis

We are living in challenging times. On top of dealing with the lasting **social and economic impacts of the pandemic**, the UK is now experiencing a **cost-of-living crisis**, with **Russia's invasion of Ukraine** adding further uncertainty to global oil and gas prices and supplies. A **prolonged recession** is predicted.

At the same time, we have also seen a period of **relative political instability** and lots of changes in central government.

More vulnerable households

In Cornwall, the pandemic left **many people struggling to manage** financial insecurity, loss of income, employment and housing. More people are now in **temporary housing**, having to live in poor conditions or **homeless**, and this is coupled with a housing shortage.

3 key factors – energy prices, rising inflation and tax increases – are now contributing to a cost of living crisis, with **low-income households being most acutely affected**.

During a recession, people struggle with jobs and finances – scams and **frauds**, shoplifting, **personal thefts** and robberies increase, **black markets** and stealing to order escalates, and these markets are exploited by **organised crime**.

Increased pressures on family life

Drug and alcohol use increases to cope with increased psychological distress, bringing with it all the associated **harms to health and family life** and the costs to society.

Based on previous recessions, we can expect to see a rise in interpersonal violence, specifically **domestic abuse and violence between people who know each other**. Stranger violence, however, is unlikely to be affected.

ASB and Community Tensions

We may see rises in anti-social behaviour and public disorder, with the increase in **rough sleeping** playing a small but visible part.

Visible social disorder drives wider feelings of unrest and **community tensions,** and this also has the potential to drive up **hate crimes**.

The placement of **refugees and asylum seekers** as part of the national resettlement programme, may also increase community tensions in the current climate.

A secure home is critical

Housing is a critical factor in providing a stable and secure base from which to engage and support people who need help. The **lack of affordable and available housing** is having a major impact on people who use our services and also our staff.

The **underlying factors that drive up crime** – poverty, vulnerability, previous experience of crime, unemployment and low education levels – also **contribute to health inequalities**, reinforcing the importance of **a joined-up approach with health partners**.

Active & Engaged Community

Cornwall has a **strong social infrastructure** with an active network of local councils, a **large and vibrant voluntary sector** and high levels of volunteering.

Talking to communities, we hear that there is a strong desire for community action and **wanting to do more together**, particularly to improve our public spaces and provide more positive activities for young people.

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

Rural communities

Over 40% 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

The pandemic 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** on-line.

New Laws and Duties

The Government has brought in some key legislative and policy changes which place **new responsibilities** on local partnerships.

This includes the Domestic Abuse Act, the **Serious Violence Duty**[3] and the new 10-year Drugs Strategy "From Harm to Hope" – providing **new focus and funding** to drive local delivery of national priorities.

Health and social care services are being brought together through **integrated care systems**, which are new partnerships that 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

570,300 people, 51% women, 49% men

Projected to **increase by 10%** to 627,300 by 2030 - 5% across England

25.4% are aged **under 25** - England 27.8%

25.3% are aged **over 65** - England 17.6%

Ethnicity & Sexual Identity

3.2% Black / Asian / Mixed / Other ethnic groups - England 19%

3.2% White non-British – England 7.5%

- 0.2% Gypsy/Roma/Traveller (1,000 people)

3.2% (aged 16+) Lesbian, Gay or Bisexual

Vulnerable Groups

70,000 (12%) live in areas defined as the **20% most deprived** in England

21,300 children (18%) in relative low income families - England 19%

32,400 households (12.6%) in **fuel poverty** - England 13.2%

Housing

11x annual wage for average house – England 9.1x (ONS, 2021)

21,913 households on register for Home Choice (Cornwall Council, Dec 22)

745 households in **temporary housing** (Cornwall Council, Dec 22)

28 rough sleepers (DLUHC, 2021)

Economy

Annual household income – **85% England average**

2.8% unemployed – England 4%

13% on Universal Credit - England 14%

£532 avg. personal debt – England £576

Health & Wellbeing

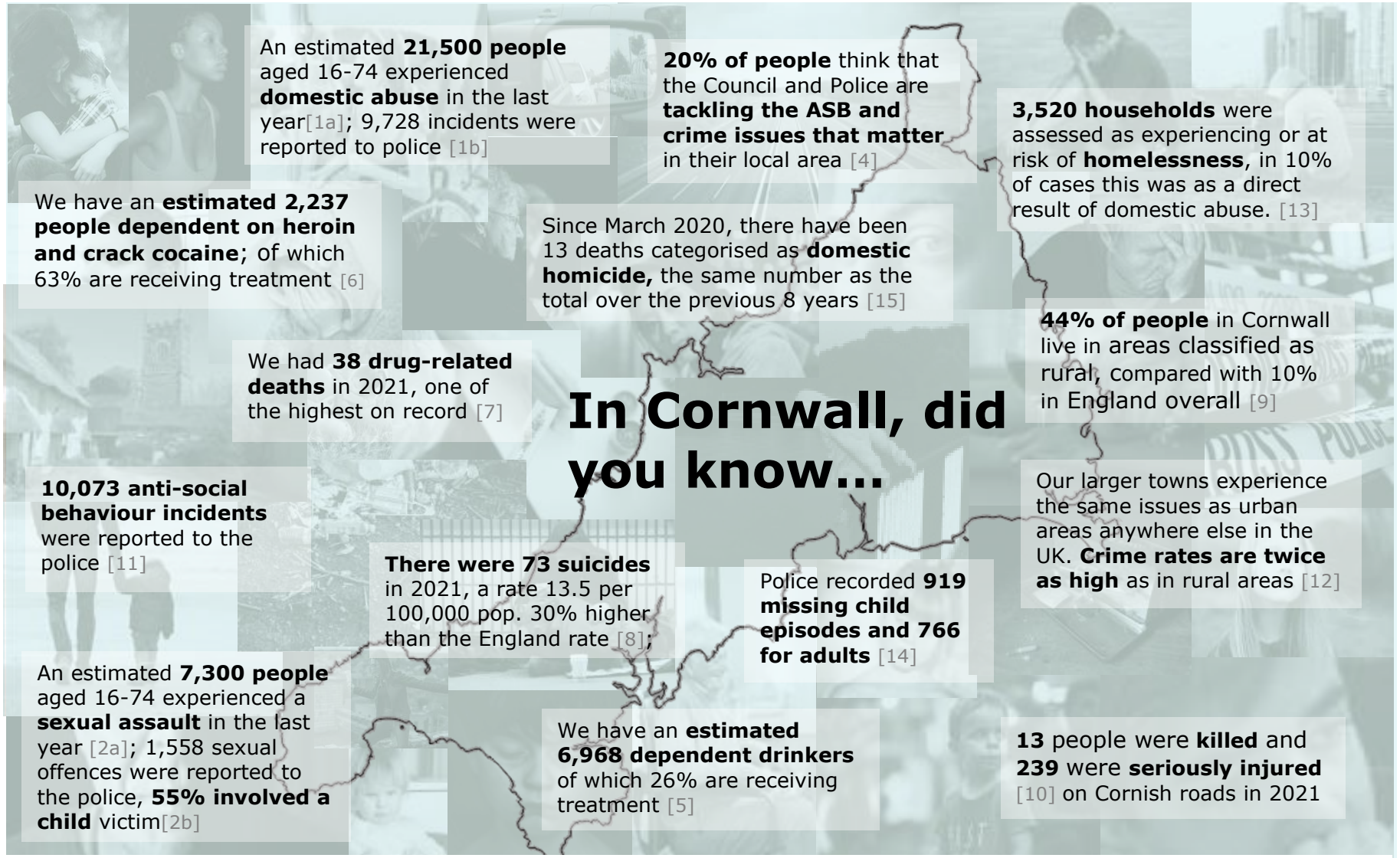
5% on Incapacity Benefit – England 4.2%

21% of people have a **limiting long-term illness -** England 18% (Census 2011)

13.5 suicides per 100,000 – England 10.4 (OHID, 2019-2021)

Population statistics Census 2021 © ONS. Other statistics drawn from Cornwall Community Insights Profile unless otherwise stated.

3 To be introduced in 2023 by the new Police, Crime, Sentencing and Courts Bill 2021



[1a][2a] Estimates for men and women aged 16-74, Crime Survey for England and Wales, March 2020 (latest); [1b][2b][11][12] Devon & Cornwall Police 2021/22; [4] Have Your Say Survey 2022; [5][6] 2021/22 Office for Health Improvement and Disparities; [7] Drug and Alcohol Action Team 2022; [8] ONS Suicides in England and Wales by local authority, 2001 to 2021, rate 2019-2021; [9] ONS Output Area Classification (2011); [10] Department for Transport, Reported road collisions, vehicles and casualties for Great Britain 2021 (RAS0403) [13] Cornwall Housing Ltd. Statutory Homelessness data 2021/22; [15] Safer Cornwall, Domestic Homicide Review notifications up to 30/11/22

Trends in Drug Use

Drug use in our local population

- An estimated **27,500 people** took drugs in Cornwall last year, with **cannabis being the most prevalent** at an estimated 22,200 users.
- Opiate and/or crack use is estimated at **2,237 users in Cornwall**. Local prevalence is **below the national rate** (6.7 per 1,000 population vs 8.9).
- Cornwall has a **higher proportion of opiate and/or crack users in treatment** than the national average and our neighbouring partnership areas.
- **Escalation of crack use and associated harms** in the last 5 years, particularly amongst opiate users. This appears to have peaked.
- Drug availability and use **changed during COVID** - emergence of high strength illicit benzodiazepines, counterfeit drugs and increased use of cannabis and illicit prescription drugs. **More drugs bought online**.
- New presentations show a **steady drop in opiate users** and increase in non-opiate users
- In treatment - **lower levels of crack use** (about a third the national average) and **higher use of most other drugs** including alcohol, cocaine, cannabis, benzodiazepines and illicit prescription drugs.

National trends in drug use

In 2018, an inquiry commissioned by Public Health England and the Home Office concluded that there had been a **resurgence in the use of crack cocaine** alongside a rapid increase in linked crime and health harms.

Socio-economic factors such as high youth unemployment combined with cuts to social and other services under austerity were also cited nationally as contributing to this trend, along with the drug becoming **cheaper and more widely available**.

- The estimated prevalence[4] of opiate and crack use in England is **314,000 people**, equating to a rate of **8.9 per 1000 population** aged 15-64. The highest prevalence is in the 25-34 age group. The latest figure (2016/17) showed a **significant rise of 4.4%** since the previous estimate in 2014/15, as a likely result of **increased crack use**.
- It is estimated that around **46% of OCUs are engaged in the treatment system**, indicating an unmet need of 54%[5].

Pre-pandemic, the Crime Survey for England and Wales also indicated **an upward trend in the use of Class A drugs**, and this was found to be particularly amongst 16- to 24-year-olds and mainly driven by an increase in powder cocaine use.

The ONS paused their reporting on drug use when the pandemic started, with the first report[6] since then being published in December 2022.

The 2021/22 Crime Survey for England and Wales (CSEW) found that **9.2% of 16-to-59-year-olds** in England and Wales reported use of any drugs in the last year; there was no change compared with the year ending March 2020.

4 Estimates of opiate and crack cocaine use prevalence: 2016 to 2017, Public Health England (2019)
5 Adult Drug Commissioning Support Pack: 2023-24, OHID
6 Drug misuse in England and Wales: year ending June 2022, ONS (2022)

2.6% of adults reported being frequent users of drugs (using them more than once a month in the past year); this was similar to the year ending March 2020 (2.1%).

Class A drug use was more prevalent amongst younger people – 2.7% of people aged 16 to 59 years and 4.7% of people aged 16 to 24 years reported using class A drugs; both age groups saw a significant decrease from the year ending March 2020 (it had been 3.4% and 7.4%, respectively).

The survey found **decreases in the use of Class A drugs, ecstasy and nitrous oxide** and suggested that this may have been a result of the coronavirus (COVID-19) pandemic and government restrictions on social contact.

Over the course of the pandemic, the **drug market changed** in both demand and supply. There is some evidence to suggest that **drug use increased during the pandemic** – this largely reflects cannabis use, however, as users of 'party' drugs (such as MDMA and cocaine) were equally likely to report reduced use.

Drug use trends for people accessing treatment services:

- In contrast to previous years, in 2020/21 there was a **fall**[7] **in the number of adults entering treatment for crack cocaine**, both with and without adjacent opiate use. There was a further fall in 2021/22 – but only for people using crack with opiates (down by 12%), whereas those using crack without opiates saw a small increase of 4%.The number of people entering treatment in England for **crack was at the lowest level since 2015/16**.
- People starting treatment in 2020/21 with **powder cocaine problems** also decreased by 10%, ending a rising trend over the last 9 years. This **increased by 11%**, however, in 2021/22 with **numbers close to the peak** observed in 2012/20.
- New entrants with **cannabis problems has increased year on year**; in 2021/22 the number rose by another 4%. After increasing every year since 2018/19, new entrants reporting **problem use of benzodiazepines dropped by 11%** in 2021/22.
- Although the numbers are relatively low, there was an increase in adults entering treatment in with **ketamine problems**. This is part of a trend in rising numbers entering treatment over the last 8 years. The total is now 3.5 times higher than it was in 2014/15.

Just under half of the adults in treatment were there for **opiate dependency**; numbers are **stable** compared with last year and this remains the **largest drug group**. There were **increases in the other 2 drug groups** - a 7% increase in the non-opiate group and 12% rise in the non-opiate and alcohol group.

The local picture

Aggressive targeting by **Organised Crime Groups** (OCGs), particularly via County Lines, meant that **crack became readily available** across all areas of the Devon and Cornwall and its use, particularly amongst opiate users, escalated quickly through our local population.

7 Adult substance misuse treatment statistics: 2020 to 2021, OHID (2021)

This brought with it a greater risk profile, including a rise in **violence and exploitation**, and serious health harms, particularly related to injecting and **drug related deaths**. **Drug-related deaths** reached an all-time high in 2019 and have remained high since then.

This has increased the risks for some of our most **vulnerable populations**, including children and young people. We have seen rising numbers of **vulnerable adults with complex needs**, homeless drug and alcohol users and **visible impacts in the community**, such as public drug taking, drug litter and anti-social behaviour. **Vulnerable people are being targeted by OCGs**, using them and their homes to sell drugs and recruit more users.

Pre-pandemic, the local picture also showed **increased poly drug use**, and **illicit use of prescribed medicines**, particularly amongst young people.

One of the key changes over the course of the pandemic was the rise in harmful counterfeit drugs, high strength **benzodiazepines** and **"designer drugs"** which featured in local overdoses and deaths. Heightened concerns about the illicit use of **prescription only medicines** and more drugs being **purchased on-line**, including via the Dark Web. Concerns escalated about **poly drug use** with interruptions in drug supply causing users to use different combinations of drugs or use contaminated drugs.

- Based on mid-point estimates, there are **2,237 opiate and/or crack users** in Cornwall; **local prevalence rates are below national rates** (OCU 6.7 vs 8.9).
- The latest estimate indicates a 6% increase since the last estimates in 2014/15, similar to the national rise of 7%. However, the **long term rise in prevalence is higher than the national rate** – locally +19% since 2011/12 vs +7% nationally.
- **Good penetration rates** suggest that we are more successful than the national average at attracting OCUs into treatment. In 2022/23, it was estimated that **62% of OCUs in Cornwall were in treatment** (unmet need of 38%).

DOMES Q4 2022/23	Local (%)	National (%)
Opiates and/or crack	38.1%	54.3%
Opiates	35.2%	48.1%
Crack	62.4%	57.4%
Alcohol	74.0%	80.1%

- Cornwall has the **lowest rate of unmet need in the Peninsula** – estimated at 42% in Torbay, 47% in Plymouth and 50% in Devon.
- The crack use estimates also indicate a rise in prevalence of use over time but the **estimated range is very broad** (lower estimate is 174 people, upper estimate is 1,352 people) and thus difficult to draw any clear conclusions.

Using a combination of CSEW-derived and PHE local estimates, we can estimate that there are around **27,500 drug users in Cornwall and the Isles of Scilly**, with the breakdown by drug shown (below).

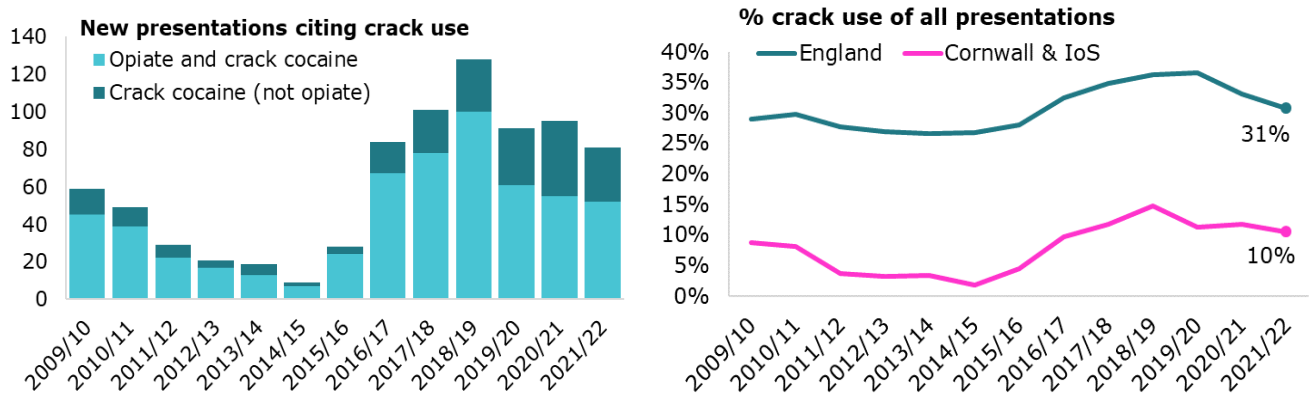
Drug	Estimated users Cornwall & IoS
Powder cocaine	6,121
Ecstasy	2,222
Cannabis	22,182
Crack	764
Opiates	2,021
Crack and/or Opiates	2,237
Any drug	**27,426**

Low confidence is given to the CSEW-derived estimates, however, because they apply data based on a representative sample of the population of England and Wales to the local population without adjusting for demographic

differences (for example, prosperity levels) and are therefore unlikely to be representative.

Drug use trends for people accessing treatment services:

New referrals to treatment in Cornwall citing **crack as a problem drug rose rapidly** to a distinct peak in 2018/19. In the last couple of years, the number of crack users presenting to treatment has **slightly fallen**, but this relates primarily to opiate users with adjacent crack use. The numbers for crack use with non-opiate drugs and/or alcohol has been relatively stable over the last 4 years.

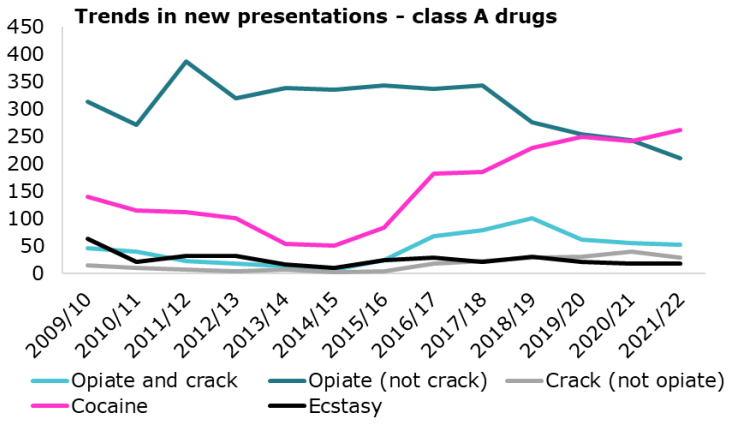


Source: NDMTS ViewIt

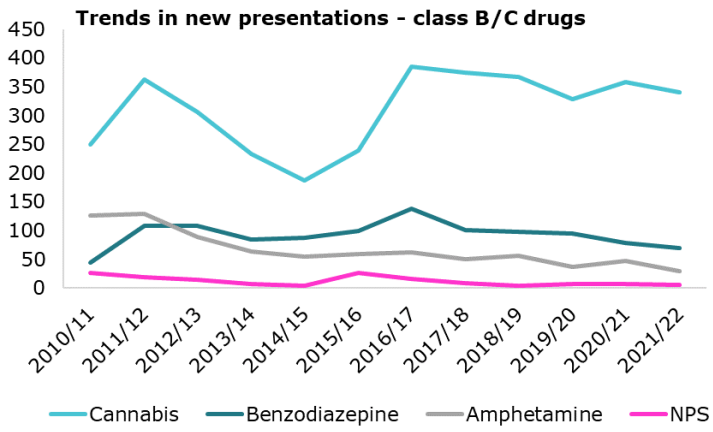
- Despite the increase, the level of crack use remains lower than the national profile. In 2021/22 **20% of new opiate presentations cited crack** as a problem drug, compared with 57% for England. As a percentage of all presentations, crack use made up 10% in Cornwall and the Isles of Scilly and 31% in England. At its peak in Cornwall in 2018/19, crack use was a factor in 27% of new opiate presentations and 15% of all new presentations.
- Looking across the **whole population** in treatment, 12% of people in treatment locally have crack recorded as a problem substance and this has been consistent for the last 4 years.

Referrals' data taken directly from our caseload management system indicates a higher proportion of crack cocaine use on presentation to treatment (27% for new opiate presentations and 15% of all new presentations); this is likely to be explained by differences in methodology and data filters used but could not be resolved in time for this assessment.

- People presenting to treatment with **cocaine as a problem drug has increased significantly** (quadrupling since 2015/16, as shown on the chart to the left). In 2021/22 new presentations for cocaine exceeded those for opiates for the first time.



- **Cannabis is by far the most prevalent of the class B and C drugs** and new presentations saw an uptick in 2020/21, with one theory that increased cannabis use over lockdown may be a factor.



Drug Related Harms

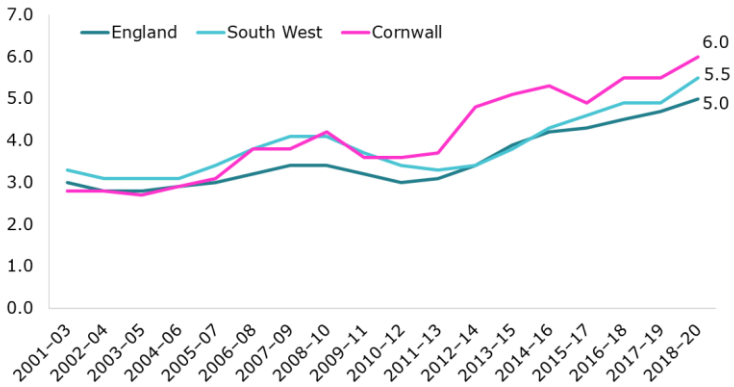
Drug related harms – to the person

- Drug-related **deaths are at their highest** since records began – there were 38 in 2021, an increase is expected to be recorded in 2022 (awaiting confirmation).
- **Cocaine-related deaths** outnumbered heroin-related deaths for the first time in 2021 – significant change in local profile.
- Other key themes – **poly drug use** and **benzodiazepines**, **complexity factors** including mental and physical health, chronic pain, suicidality, trauma and loss (including in childhood).
- **Naloxone coverage is better locally** and available in a range of settings (for example supported housing)– supply and training in this life saving drug continues to increase.
- **Opiate users** in Cornwall are **more likely to inject** (36% vs national 32%) – harm and risk reduction services, including **testing and vaccination** for Blood Borne Viruses, are provided across Cornwall. Testing rates are in line with national averages and **infection rates are lower**.
- **Sexual health and drug treatment services** should work together more closely to identify and meet the needs of people engaging in **sex-related drug use**, including improving **staff knowledge and confidence** to discuss specific risks and deliver brief interventions.

Drug-related deaths

There is a **national ambition to prevent nearly 1,000 deaths** in the next 3 years, reversing the upward trend in drug deaths for the first time in a decade.

- There have been **89 recorded drug related deaths** in Cornwall over the last 3 years, and this is the **highest since records began**: an increase of 43% over the last ten years and 18% in the last 5 years.
- For the last ten years the rate of drug-related deaths in Cornwall has **tracked slightly above the national and South West rates** (but only significantly above in 2012-14);



There were **38 deaths in the calendar year 2021**, and the indicative trajectory is an **increase in 2022**.

- **The majority of deaths feature more than one drug.** The most common combinations are opiates and benzodiazepines (23 deaths / 61%) and heroin and cocaine (11 deaths / 29%). Only one death in 2021 involved a single agent in toxicology and that was cocaine.
- **Benzodiazepines** continue to be a **major concern**.

Over the last couple of years, benzodiazepines have become much **more prevalent** in the substances recorded in drug-related deaths[8] and at strengths higher than pre-pandemic. Illicit benzodiazepines are being **marketed at younger people**, appear in brightly coloured tablets, and offer **substantial financial gain** for those involved in supply. Deaths involving new psychoactive substances are higher locally than nationally, reflecting the prevalence of deaths involving benzodiazepine analogues.

- Cocaine featured in 22 deaths and heroin in 18 deaths, 11 deaths featured both. For the first time since recording began in 1999, **cocaine-related deaths outnumbered heroin-related deaths** and this is a significant change in the local profile. Although **crack cocaine** cannot be identified conclusively through toxicology, a combination of other factors[9] suggest that this is the **primary form of cocaine involved**.
- Deaths involving **methadone remained stable** at 15, with about a third relating to illicitly obtained methadone. There is a **similar trend for gabapentinoid drugs**, such as Pregabalin (13 deaths in 2021, +2 from 2020).
- Despite a continuing downwards trend (24 deaths in 2021, almost two thirds), **alcohol remains a significant factor over a person's lifespan**, including early childhood use, heavy use throughout life and an underlying constant.
- Around **two thirds** of people who died were **known to drug treatment services**, either currently engaged or had left within 6 months before death.
- There is increasing evidence linking drug-related deaths to **suicide**, especially in cases where victim was suffering chronic pain.
- Main contributing factors of note:
  - **Mental ill health** (featuring in around three quarters of all deaths); collateral effects of **COVID pandemic** (not infection by the virus)
  - **Suicidality** (40%)
  - **Physical ill health**/illness leading up to death (53%); **pain** as a result of a physical medical condition (32%).
  - **Bereavement** (29%)
  - **Family and relationship breakdown**; children no longer living with parent
  - Long history of drug use; **early onset drug use** in young adolescents (29%) and **Adverse Childhood Experiences**
  - Criminal justice issues including imprisonment

The Force Drug Market Profile[10] highlights that the **sale of illicit prescription drugs such as benzodiazepines via online platforms** is almost certainly **a growing threat**. The recent increased use of benzodiazepines is likely to have been a reaction to the interrupted supply of opiates during COVID-19 and their relatively low price. Demand and use reportedly remains high in 2022.

It is almost certain that **more drug overdoses are taking place than are being reported to Police**. Intelligence is often insufficient to identify potentially dangerous drug batches in circulation, unless the overdose cause is confirmed by the coroner or hospital.

8 12 deaths involved illicit benzodiazepine drugs (more potent than prescribed benzodiazepines); 18 cases involve diazepam and 25 feature any benzodiazepine being present.
9 Such as known criminal activity, witness testimony, drug treatment records and personal disclosure
10 Force Drug Market Profile, Devon, Cornwall and the Isles of Scilly (Partnership Version), Devon and Cornwall Police, May 2023

Domestic homicides

As previously noted, **drug use often features as a vulnerability** in domestic homicide/suicide reviews for both the victim and the abuser.

Since 2016, Safer Cornwall has undertaken **18 DHRs, in which 7 (39%) were recorded as involving drug use** for the victim, abuser or both people.

In 2 of the 8 domestic homicide/suicide reviews that commenced in 2021/22, the abuser's **drug use is extensive and severe** in interfamilial and intimate partner relationships; use of illegal and controlled drugs is noted, including crack cocaine, heroin, opiate substitute prescription, and alternative hallucinogenic drugs.

In these cases, specialist agencies provided **consistent engagement, support and interventions**.

Professionals are aware of the risks presented by abusers; during the COVID pandemic, despite the challenges of offering face-to-face services, regular face to face and telephone contact was available where there were known risks to others.

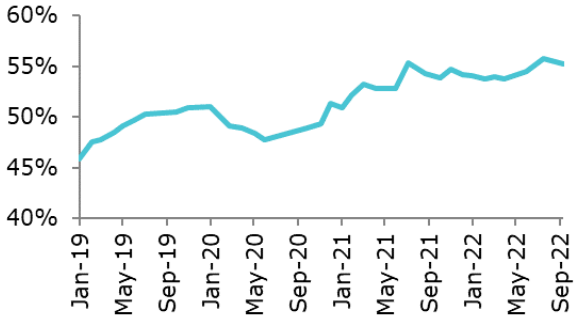
The DHRs highlight that a **stronger focus is needed on support for the person displaying abusive behaviour** to manage risk around vulnerability to drug related harm – and this is being addressed as a priority under Behaviour Change in the new Domestic Abuse and Sexual Violence Strategy 2023-2028.

Another drug-related theme identified within the DHRs is **grooming and exploitation of a victim** from an early age (teenager) linked to the use of illegal drugs. Significant **progress has been made in training the workforce** about signs and understanding of exploitation, but there is a need for a **continual focus and systemic work** in this practice area. Tackling exploitation requires partnership working and each has a role to play, no one agency has sole responsibility.

Naloxone

Naloxone is an **opioid antagonist** that, if administered quickly and correctly, reverses the effects of an opiate overdose. Training and issue of naloxone to people and settings with increased risk of overdose is a vital component of drug related deaths prevention.

- National data suggests that around **61%**[11] of all eligible opiate clients from have been **issued with naloxone** and overdose training at some point in their treatment journey, **above the national average** of 50%.
- Data collected by the local treatment provider (right) indicates **a steadily increasing trend**, from a starting point of 46% in early 2019.
- The national data also shows that **130 people** currently known to treatment have been **administered with naloxone** to reverse the effects of an overdose (12.3%) and this is **also well above average** (7.7%).



11 Diagnostic Outcomes Monitoring Executive Summary, Q4 2022/23; 60.9% or 612 eligible clients

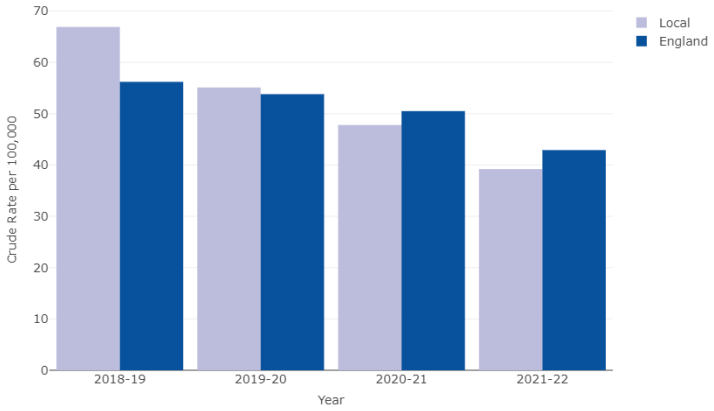
Training and issue of Naloxone continues to increase across a wide range of people and agencies. Nasal naloxone (Nyxoid) has been rolled out in tandem with the already widely available injectable form (Prenoxad) and gives further scope to lifesaving in a wider range of settings and venues. For example, since 2021 Nyxoid has been provided to security **personnel at homeless pod sites** in Cornwall and **four lives have been saved** by these personnel since June 2022.

The latest data (January 2023) indicates that **43 lives have been saved** over the last 12 months in Cornwall.
Anyone trained in the use of naloxone and issued with supplies, must **report every time that it is used**, along with details of the circumstances and action taken. This information is collated by the DAAT and regularly reviewed at the Clinical Governance Meeting, allowing trends and any issues that need unblocking to be identified quickly. The naloxone **reporting form also facilitates the gathering of additional intelligence**, such as other drugs used at the time of an overdose.

Drug-related hospital admissions

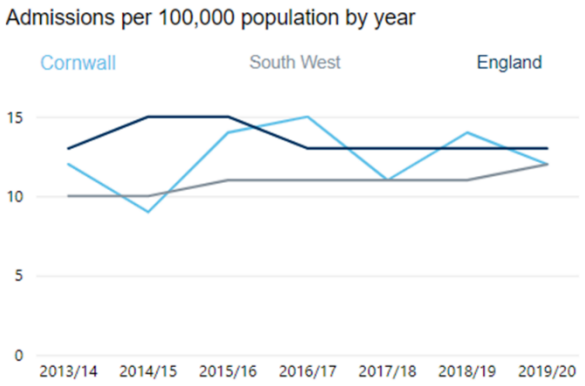
As well as being a key issue to be addressed in themselves, **poisoning admissions can be an indicator of future deaths**. People who experience non-fatal overdoses are more likely to suffer a future fatal overdose.

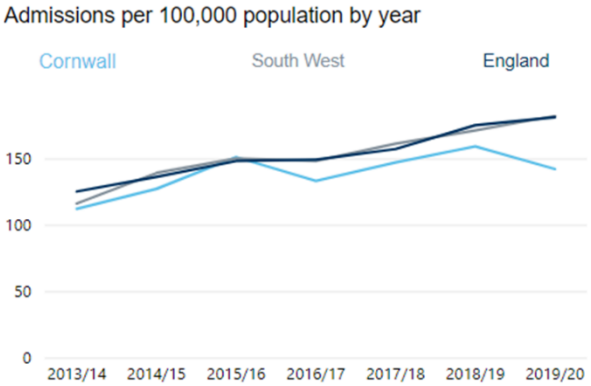
The local rate of hospital admission due to **drug poisoning is just below the national rate**, having dropped from higher levels historically.



- The latest data is for 2021/22 when there were **255 hospital admissions** due to drug poisoning in Cornwall. The rate of admissions has **dropped by 41%** since 2018/19, compared with a national fall of 24% over the same period.

NHS Digital's statistics on drug misuse[12] also provides information on hospital admissions for **drug-related mental and behavioural disorders** – the latest published data is for 2019/20.





12 Hospital Episode Statistics, Crown copyright © NHS Digital 2021 https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-drug-misuse/2020

- Where the **primary diagnosis** is a drug-related disorder, the local rate is **in line with south west and national averages** – there were 60 such admissions in Cornwall in 2019/20, a rate of 12 per 100,000.
- There were **705 admissions** using the broader definition including **secondary diagnosis**[13] equating to a rate of 142 per 1000,000 population. The trend shows a drop locally in 2019/20, contrary to the general trend.

Harm reduction

Sharing injecting equipment can spread blood-borne viruses. Providing opioid substitution treatment (OST), sterile injecting equipment and anti-viral treatments protects people who use drugs and the wider community and provides long-term health savings. There is a global target to **eliminate hepatitis C by 2030** but to do this requires the identification and treatment of many more infected people who use drugs.

Injecting and blood borne viruses

27% of new presentations to treatment in 2021/22 were either injecting or had a history of injecting, which is exactly in line with national rates – 10% currently injecting and 17% previously. In Cornwall and Isles of Scilly this means **208 people with injecting as a risk factor**.

Injecting prevalence is **highest for opiate users** at just under **two thirds of new presentations** and these rates are **higher in Cornwall** than the national average – 36% of opiate users presented to treatment as currently injecting and 27% had previously injected (national rates are 32% and 21% respectively).

- Testing rates for **Hepatitis B are just above the national rate** (currently 30.1% vs 28.4% nationally, Q4 2022/23 DOMES).
- **Testing rates for Hepatitis C are also just below the national average** (currently 51.2% vs 56.2% nationally, Q4 2022/23 DOMES), with a **lower percentage of people testing positive**, both to antibody exposure (16.9% vs 27.2% nationally) and active virus needing treatment (7.4% vs 19%).
- The proportion of the treatment population who are **HIV positive** is low and less than half the national average (0.5% vs 1.6%).

Needle Exchange and Safer Injecting Services

With You Cornwall is the main provider of **Needle Exchange and Safer Injecting Services** in Cornwall. The service is **available to any injecting drug user** who requires equipment.

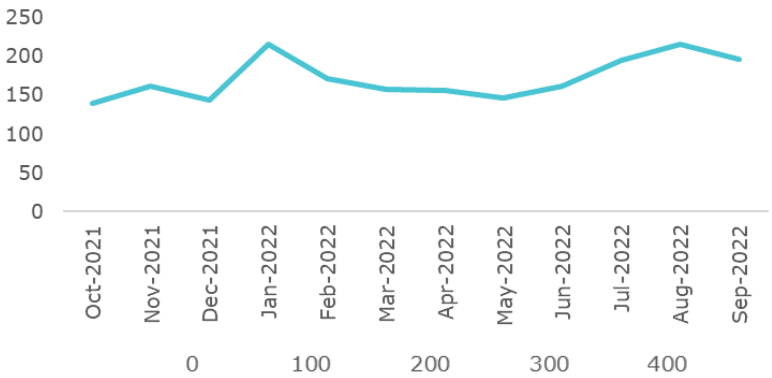
Clients can also access **blood borne virus testing and immunisations**, provision of **naloxone** and advice and information promoting **harm and risk reduction**. As the service is delivered alongside other drug and alcohol services, clients are encouraged to access additional support: **experienced With You Cornwall workers** are familiar with all aspects of services and are able to promote them utilising their skills to **motivate clients to consider positive change**.

13 A secondary diagnosis does not necessarily indicate a drug-related mental and behavioural disorder as a contributing factor but may instead mean that it was relevant to the person's episode of care.

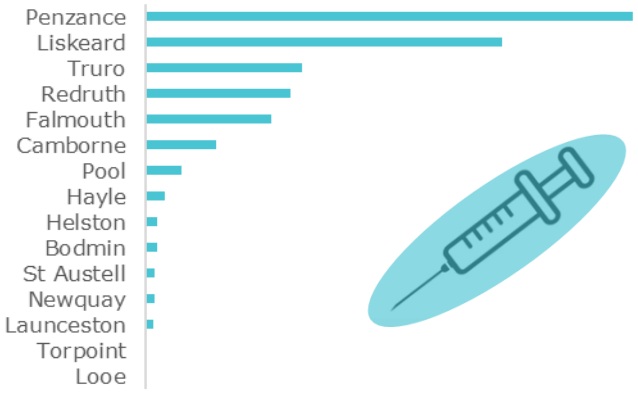
The Needle Exchange and Safer Injecting Service is based at **With You Cornwall's main sites**. This is supplemented by **additional open access clinics**. With You Cornwall workers provide support to clients throughout Cornwall and carry needle exchange equipment and can take the return of used equipment. Further facilities are available via three pharmacies in St Austell, Newquay and Penzance.

2,059 individual activities were facilitated by the With You Team across Cornwall in the twelve months to September 2022, averaging **around 172 per month.**

Spikes in the timeline appear in the months of **January and August 2022** which might indicate that these are busier times for the teams staffing the Needle Exchange sites with these two months accounting for around 30,000 pieces of equipment[14] being distributed to users.



Where a location was recorded the data showed that **Penzance and Liskeard account for more than half** of all transactions, with the majority of the rest taking place across Truro, Redruth and Falmouth.



Chemsex and Slamsex

Chemsex describes the use of psychoactive substances in sexual settings. It is defined as "engaging in sexual activities while under the influence of drugs and often involves group sex or a high number of partners in one session"[15]

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

Those with a dependency on Class A drugs such as opiate and crack are at **higher risk of poor sexual relationships, STIs and blood borne viruses**. Evidence suggests that gay and bisexual men who use particular illegal drugs (as well as alcohol) are **more likely to engage in risky sex**. Illegal drug use is higher in gay

14 14,276 needles; 14,020 barrels
15 The Chemsex study: drug use in sexual settings among gay & bisexual men in Lambeth, Southwark & Lewisham. Bourne et al (Sigma Research, London School of Hygiene & Tropical Medicine, 2014)

and bisexual men – the crime survey found that 33% of gay men had taken illegal drugs in the previous year, compared with 11% of heterosexual men.[16]

The Positive Voices Survey for England and Wales[17] found that 20% of gay male patients reported engaging in chemsex (defined by the researchers as "the use of drugs to increase disinhibition and arousal") in the past three months and that 7% reported 'slamsex' (injecting or being injected with drugs).

Figures were higher for some subgroups:

- Chemsex users were **more likely to be middle-aged**: 28% of men aged 35-54 reported chemsex, compared with 22% for those aged 18-34 and 24% for 55+.
- Of the 20% reporting chemsex, **Crystal Meth** was the **most commonly used** at 13%; 12% reported using GHB or GBL, and 11% Mephedrone.

Dame Carol Black's recent Review of drugs[18], stated that "some very vulnerable groups, such as crack cocaine users, people who use image- or performance-enhancing drugs or **people engaged in 'chemsex', do not receive an adequate or any service, but are at great risk**. In addition, outreach and harm-reduction services, including specialist needle and syringe programmes, have been cut back in many areas."

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

The issue of chemsex crimes was recently raised at a South West substance misuse webinar where it was stated that there are **more than 300 people are in prisons specifically relating to crimes associated with chemsex**. It was also highlighted that findings from Project Sagamore, which looked at chemsex and crimes relating to it "undermined the comfortable story about it being a party drug and about it being fun, because the findings on violence are particularly hard hitting within the chemsex context".

There are some **specific barriers** identified for men who have sex with men (MSM) engaging with drug services:[19]

- MSM may not engage with some healthcare services because they **fear experiencing stigma** or they may feel that service provision is not equipped to help them.
- MSM accessing drug treatment services may benefit from talking about specific sexual practices (for example, sex with multiple partners or fisting) but many are **concerned** that this can cause **staff to be unsympathetic** to their needs

16 Drug misuse: Findings from the 2013/14 Crime Survey for England and Wales, Home Office (2015). This was the last year that information was presented with sexual orientation as a factor.
17 Self-reported co-morbidities among people living with HIV in England and Wales, Public Health England (2017. 'Positive Voices' is a survey of the healthcare needs, lifestyle and sexual behaviours of people living with HIV. The survey was piloted between January and September 2017 at 73 HIV clinics.
18 https://www.gov.uk/government/publications/review-of-drugs-phase-two-report
19 Substance misuse services for men who have sex with men involved in Chemsex, Public Health England (2015) Main heading (publishing.service.gov.uk)

- MSM engaged in chemsex **may feel that sexual health services are more likely to be empathetic and knowledgeable** compared with drug treatment services.
- The needs of MSM using recreational drugs such as cocaine, mephedrone or GHB in social clubbing environments may be different from those using drugs in a sexual setting – although both groups **may be reluctant to engage with traditional substance misuse services** and will require services relevant to their needs.
- People who use drugs occasionally **may be unaware of safer injecting practices and the availability of services**, equipment and advice that can reduce risks.

The European Monitoring Centre for Drugs and Drug Addiction[20] makes the following recommendations for addressing sexual health issues associated with drug use. These are broadly mirrored by the Public Health Guidance[21].

In the absence of an evidence base, there is a need to **start collecting better data** on the extent of the problem in sexual health and drug treatment services in order to:

- **Identify people** with problems related to drug use, including dependence, and sexual health;
- **Understand** their risk behaviours and treatment **needs**;
- **Understand** where **linking or integrating sexual health and drug treatment services may be beneficial**, for example, in services for men who have sex with men that have been developed in some countries.

The two types of services also need to share expertise and develop treatment pathways by:

- **Training sexual health staff** to assess drug use and offer brief interventions where indicated;
- **Training drug treatment staff** to assess sexual health and offer brief interventions for sexual problems related to drug use; and
- **Encouraging services to work together more closely**, for example, through joint training events or staff exchanges.

20 Spotlight on… Addressing sexual health issues associated with drug use | www.emcdda.europa.eu (2021)
21 Substance misuse services for me who have sex with men involved in Chemsex, Public Health England (2015) Main heading (publishing.service.gov.uk)

Impacts on children/families

Drug related harms – to children and families

- An estimated **3,980 children** live in a household where an adult has an alcohol or drug dependency – of which around **75% are not identified in local datasets.**
- Use of **screening tools in wider services** (such as social care) is not routinely recorded, nor outcomes nor referrals. This **limits our understanding** of the broader picture.
- Drug and alcohol use **commonly occurs with other vulnerabilities**. In 1 in 4 cases of parental drug and alcohol use recorded by Children's Social Care, **domestic abuse and mental health** vulnerabilities are also both present.
- Locally we **attract more parents into treatment** and living with a child/parental responsibility is a **strong positive factor in successful completion** of treatment.
- The proportion of parents completing successfully has **dropped over the last two years**, however – the same number of successful completions but a substantial increase in base number of parents in treatment.

Estimating how many children at risk

Harms are under-reported/hidden for the children of parents with drug problems. Parental drug use can lead to neglect, exposure to parental conflict and domestic abuse, inconsistent parenting, attachment issues and problems with school attendance/behaviour, creating a cycle of risk for the child; children of people who use drugs are **young carers** and should have a carer's assessment undertaken.

Parents/Carers who are drug users may also have **additional complex needs** so a **multi-agency approach** is required, rather than just focussing upon the drug/alcohol component.

Research commissioned by the **Children's Commissioner for England** has estimated both the number and proportion of 0-17 year-olds in Cornwall[22] living in a household where an adult has any of the **vulnerabilities collectively described as the "toxic trio"**[23] – substance use, domestic abuse and poor mental health.

- 10,990 children in Cornwall (10.3% of the population aged 0-17 years) are projected to be living in a household where an adult reports any substance misuse. An estimated **3,980 children** live in a household where an adult has an **alcohol or drug dependency**.
- Of the 10,990, around **14% (940 children)** are predicted to be in a **household with all three vulnerabilities** – domestic abuse in the last year, an adult reporting drug and/or alcohol dependency and an adult with severe symptoms of mental or psychiatric disorders.

A snapshot of data of families with children aged 0-5 who were open to **Health Visitors** in Cornwall[24] provided limited information about parental substance use,

22 Estimating the prevalence of the 'toxic trio', Children's Commissioner's Office (Chowdry, 2018)
23 Local vulnerability profiles, Children's Commissioner for England (2020)
24 Note that this does not represent all children aged 0-5 in Cornwall and Isles of Scilly.

where this had been disclosed. There are **three pathways** of increasing support provided by Health Visitors: universal, targeted and specialist.

A total of **35 child cases had a parental substance misuse flag** out of a total caseload of 13,381 (0.26%). In 12 cases parental substance misuse and domestic abuse was flagged and in 22 cases parental mental health had also been flagged. Only in 8 cases (0.06%) had all three vulnerabilities been flagged. 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 to reduce the risk of harm in the early years. The annual State of Health Visiting Survey in England report[25] highlighted that in 2020 45% of health visitors reported a rise in **substance misuse** and 82% a rise in **domestic abuse**.

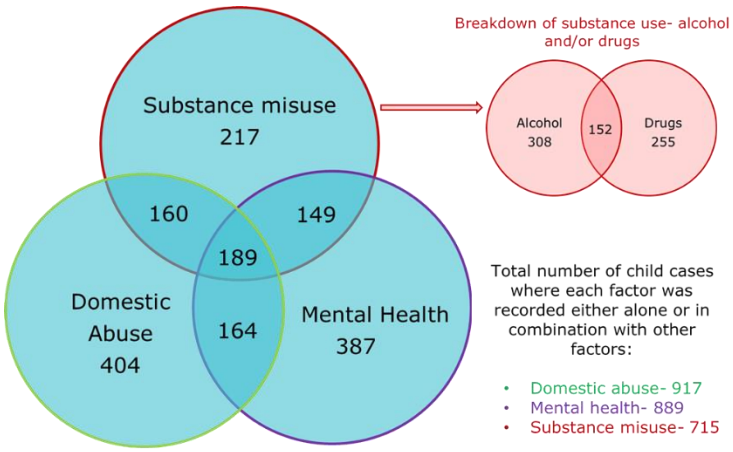
At the same time **COVID restrictions reduced capacity** of the service. Many reported feeling stretched by high caseloads. Locally universal appointments were conducted over the phone, but Targeted and Specialist cases remained face-to-face.

The Cornwall and Isles of Scilly Health Visiting service uses the recommended alcohol screening tool AUDIT-C, but it is not routine enquiry. The **use of DUDIT as a screening tool has not been confirmed**.

Children's Social Care also shared a snapshot of assessments carried out from March to October 2021. Shown below is the number of child cases where a parent/carer, or other adult associated with the child, is using alcohol and/or drugs [26] and where this co-occurs with domestic abuse and/or a mental health need. All **data is dependent on how practitioners recorded** each vulnerability.

It is evident that in **just over half of all child cases** where a parent/carer or other adult have a substance misuse need, the adult also has another vulnerability:

- Only in 30% of cases where substance misuse was identified was it thought to be occurring alone. In **1 in 4 substance misuse cases**, domestic **abuse and mental health** vulnerabilities are also both present.

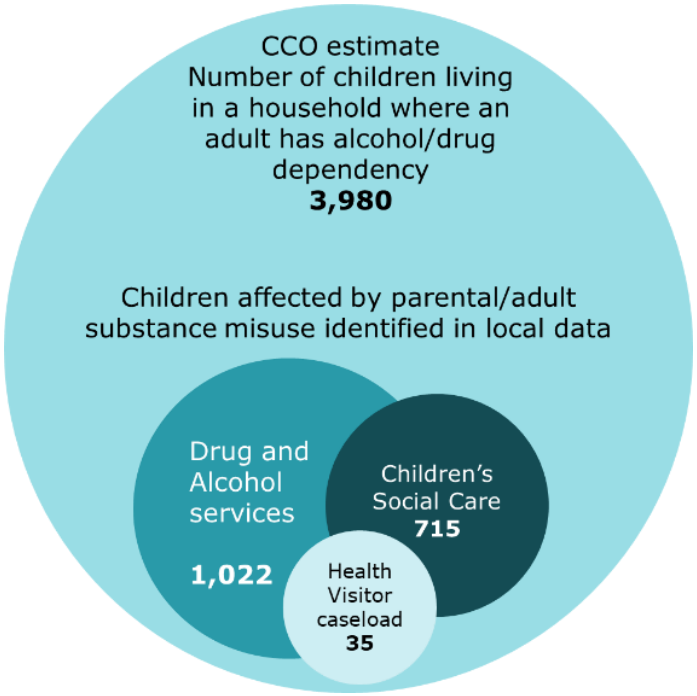


[25] State of Health Visiting Annual Survey – 2020, Institute of Health Visiting

[26] We do not know to what degree the adult may be using drugs and/or alcohol as this is not recorded.

Only **2% of referrals into treatment services come from Children's Services** (under 20 p.a.). This represents only a very small proportion of a potential 407 people recorded as having a drug-related need.

Locally our aim is to identify the families affected by these issues and how many of them are being supported. There are just over **1,000 children to substance using parents recorded** in the treatment system – indicating a **significant shortfall** against the estimated children in need. We know that some of the children may be **known to wider services**, but the parents are receiving help.



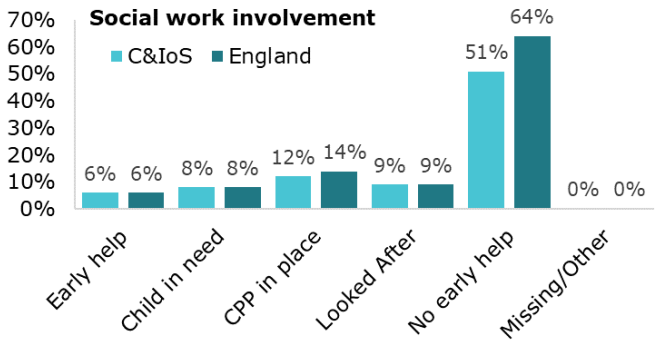
Our ability to use this information to understand the extent of need (or unmet need) in this population is limited as we do not know **whether screening tools were used** (such as DUDIT for drug use or AUDIT-C for alcohol) to ascertain the level of risk related to substance use, what the level of assessed risk was and if this resulted (or should have resulted) in a **referral for specialist support**.

Parents in the treatment system

Data from NDTMS indicates that **350 children** were recorded as living with a drug user entering treatment in 2021/22. Our local treatment system has a **higher representation of parents presenting for treatment** than the average for England, both living with their children (23% vs 15%) and not (32% vs 18%) and a lesser proportion with no parental responsibilities (42% vs 63%).

- **Similar levels of social care involvement** to the England average across all intensities of support.

  Compared with 2019/20, there were higher proportions of children on Child Protection Plans and Looked After Children (CPP 10%, LAC 3%).

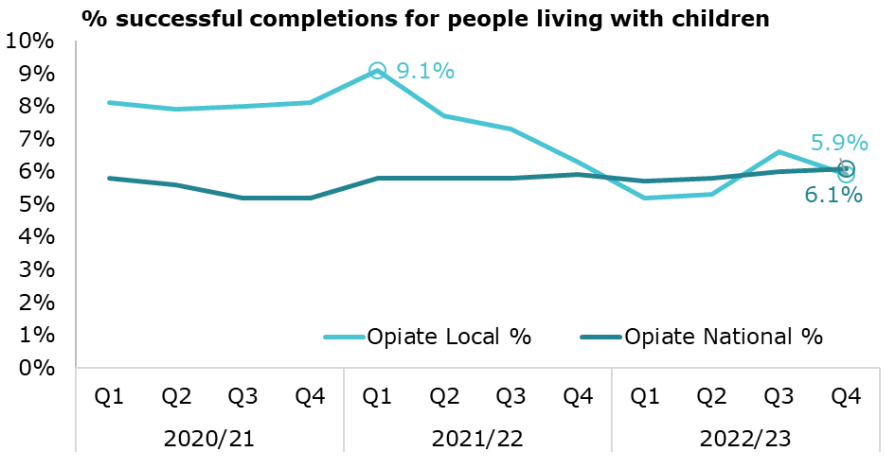


Broadly speaking, being a parent and/or living with a child has a **positive impact on treatment outcomes** – analysis of 3 years of closures found a strong positive effect on successful completion rates for both opiate and non-opiate drug groups.

Compared with the national rates, however, locally people who live with children are slightly **less likely to complete treatment successfully than the national**

average. This is across **all drug groups** – historically we had higher than average rates of successful completion for opiate users in treatment.

We saw the **rate drop for opiate users during 2020/21** and dip below the national average for the first time in the first quarter of 2022/23.



- **The level of successful completions is limited by service capacity to work with families** – there is currently a waiting list for family interventions. The number of parents completing treatment successfully has remained fairly similar over the last three years but the **number of people living with a child** (used in the percentage calculation) has **increased by 15%** over this period.
- This increase in base number of clients living with children in the household my be a general indication that the **increased family focus** within the service may be resulting in **more people being willing to disclose** their parental status than they have in the past.
- There may be other factors to consider, such as **additional vulnerabilities** making it more difficult for this group to progress successfully through treatment – this needs to be explored further with the treatment service.

Drugs and Crime

This section focuses on **drugs as a factor in criminal behaviour**, where this can be identified in our local data – we are limited by the extent to which this is reliably recorded and shared with local partners. There are some areas of data weakness – for example, in our understanding of drugs as a factor in violent crime.

Drug related crime in the community

- Nationally 52% of homicides are drug-related. In Devon and Cornwall, however, it is highly likely that **drugs were linked to only a minority** (14%) of homicides. Local homicide rates are in line with national**; most Cornish homicides are domestic**, drug use is a feature in some of these.
- The rate of **violence is comparatively high**, the higher rate of recorded domestic abuse is a key factor. Police officer survey responses suggest it is **realistic that drug-related violence is increasing** in the Force area.
- **Public space and Night Time Economy violence** have re-established in our town centres; more **day time** violence and ASB which has greater community impact. Violence between **young people** has escalated and risks linked to this include **knife carrying**, gang associations and **exploitation**.
- **Contextual knowledge about serious violent offences is currently limited**. We are unable to explore, for example, the links to organised crime/gangs/drug-related exploitation or develop a better understanding of transition points from involvement in lesser to more serious offences.
- Seeing drug use and dealing in the local area has a **significant impact on how safe people feel**; public perceptions of drug use and dealing as a problem have increased.
- Nationally it is estimated that around 50% of acquisitive crime is drug-related.Types of **acquisitive crimes categorised as 'neighbourhood crime' are very low** in Cornwall, but there may be other areas of drug-related crime that wider partners can help us understand better (e.g. building and other frauds).

Violence and neighbourhood crime

The Government's Levelling Up[27] Mission 11 focuses on tackling **homicide**, serious **violence** and **neighbourhood crime**. Neighbourhood crime encompasses most types of acquisitive crime (domestic burglary, personal robbery, vehicle offences and theft from the person).

- The national homicide rate in 2021/22 was **12 per million population**, the rate increased by 25% compared with the previous year, returning to pre-coronavirus pandemic levels. In **40% of homicides a knife or sharp instrument was used**, similar to the year ending March 2021 (42%).
- More in depth analysis in 2021 showed that **nationally 52% of homicides were linked to drugs** in some way. Almost a third (31%) of homicide victims were known to be **drug users**, and 15% were known to be **drug dealers**. These proportions were higher amongst suspects (45% users and 29% dealers).

[27] Levelling Up the United Kingdom, Department for Levelling Up, Housing and Communities, 2022

The **Crime Survey for England and Wales** (CSEW) is the most reliable indicator for long-term trends in the more common types of crime experienced by the general population, such as theft. However, police recorded crime data can give reliable indications of trends in some offences involving theft (for example, burglary). National reports cite a figure of **around 50%** for the proportion of **acquisitive crime linked to illicit drug use**.

- In 2021/22 neighbourhood crime accounted for around 26% of all crime estimated by the CSEW and **13% of all recorded crime**.
- There were **substantial falls** in most sub-categories of theft due to national lockdown restrictions, with non-essential shops and the night-time economy being closed and people spending more time in their homes. Similar trends were apparent across both data sets (CSEW and recorded crime).

Local crime trends

Recorded crimes and incidents	Risk	Current trend	2021/22 Rate per 1,000	Crimes 2021/22	Crimes 2020/21	Crimes 2019/20	Comparison *'Most similar family'*	Trend *'Most similar family'*
Homicide	High	▶	0.01	6	5	4	Average	▲
Violence with injury	Moderate	▲	8.3	4,750	4,103	4,751	Above average	▲
Violence without injury	Low	▲	8.1	4,631	4,050	3,977	Low	▲
Drug possession	Low	▼	1.2	695	846	809	Average	▼
Drug trafficking	Moderate	▼	0.4	252	342	169	Below average	▼
Possession of weapons	Low	▲	0.5	280	309	265	Below average	▲
Burglary	Standard	▶	1.6	921	983	1,389	Low	▶
Robbery	Standard	▲	0.2	105	112	116	Low	▲
Shoplifting	Standard	▲	2.5	1,433	1,056	1,686	Low	▲
Theft from the person	Low	▲	0.2	114	61	166	Below average	▲
Theft of bicycle	Low	▼	0.1	78	140	123	Low	▲
Vehicle offences	Low	▶	1.4	775	779	1,026	Low	▲
Other theft offences	Low	▲	3.9	2,195	1,944	2,495	Low	▲

*Risk rating relates to the latest MoRiLE assessment (undertaken in summer 2022)

Violence

- In 2021/22, our local homicide rate was also **12 per million population** which is in line with our most similar family group and the national rate.
- The majority of homicides locally are **domestic** (rather than gang-related) but **drug use features often as a vulnerability** for both the victim and the abuser (this is discussed in more detail under Drug Related Harms).

Crimes of violence against the person make up **46% of all recorded crime**. Excluding homicide, violent crimes span a wide range of harm, with crimes resulting in **injury and domestic abuse** crimes presenting the greatest risk. Alcohol is a persistent feature in criminality and particularly strongly linked to violence. Around 1 in 4 people who have committed a violent offence reoffend.

- Violence with injury accounts for just over **1 in 3 violent crimes**. **Violence with injury increased by 16%**[28] in 2021/22 compared with the previous year, returning to around the same level as pre-COVID. Within this, the number of domestic abuse crimes remained stable, with the main increases seen in Night-Time Economy (NTE) and other violence, which were expected as COVID restrictions were lifted (in line with the national trend).

[28] Financial year 2021/22 compared with 2020/21, police recorded crime data

- The rate of **violent crime remains high compared with similar areas** in other parts of the UK (although this has improved in recent months). Our performance relative to other areas is affected by Cornwall having a **higher proportion of domestic abuse** within our recorded crime than our statistical neighbours, particularly during the height of the pandemic when other types of violence were greatly reduced.
- Just over **half of all violence with injury occurs in the ten towns** within the Safer Towns Programme. The make-up of violence with injury differs between each town but, in all cases, we have seen the proportion of NTE incidents increase since COVID restrictions were lifted – other issues linked to the NTE, such as recreational drug use and heavy drinking, are likely to have resumed at the same time.
- Dangerous Drug Networks/County Lines gangs pose a **violent threat to the community**, particularly when this involves 'cuckooing' – where the homes of local drug users and other vulnerable people are forcibly used for drug dealing activity. Violence also occurs in the **enforcement of drug debts** and where Organised Crime Groups (OCGs) **compete for territory and customers**.

Identifying harms associated to or driven by drugs in police data is **challenging due to inconsistent recording** of data. Limitations in the tagging of crimes and incidents as drug-related (in particular, for violence, acquisitive crime, ASB and firearms) mean it is not possible to assess the threat, risk and harm posed and the level of demand placed on the Force by the drugs market at the strategic level.

Research undertaken for the Force Drug Market Profile[29] concluded that it is highly likely that **drugs were linked to only a minority (14%) of homicides** in the Force area. The number of **violent crimes tagged as drugs-related** in the Force area has increased in the last 4 years. From 2019 to 2021, they increased by 80%. Officer survey responses suggest it is a **realistic that drug-related violence is increasing** in Force.

Neighbourhood crime

- Neighbourhood crime accounts for **just 5% of all recorded crime in Cornwall**, less than half the proportion of the national figure of 13%.
- **Acquisitive crime rates are very low** compared with our most similar family of Community Safety Partnerships nationally. Although substantial falls in theft offences were a universal trend due to lockdown restrictions, the reductions in burglary and shoplifting locally were higher than average; we consistently have **one of the lowest burglary rates** in the country.
- **Reoffending rates for people committing theft offences are much higher** than for other types of crime, and drug use is a commonly cited exacerbating factor, but the **lower incidence of theft reduces the overall risk** in Cornwall.

It is important, however, not to let neighbourhood crime disappear off our collective radar, as a rise in acquisitive crime types is one of the **potential risks of the growing cost of living crisis**.

29 Force Drug Market Profile, Devon, Cornwall and the Isles of Scilly (Partnership Version), Devon and Cornwall Police, May 2023

The pandemic left many people in Cornwall facing **financial difficulties and increased disadvantage**, as they struggled to manage financial insecurity, loss of income, employment and housing. 3 key factors – energy prices, rising inflation and tax increases – are now contributing to a **cost of living crisis**, with Russia's invasion of Ukraine adding further uncertainty to global fuel prices and supplies.

We know from previous recessions, that **financial precarity drives a range of harms** related to crime and community safety and the impacts can be long lasting. During a recession, people struggle with jobs and finances – scams and **frauds**, shoplifting, personal **thefts** and robberies increase, **black markets** and stealing to order escalates, and these markets are exploited by **organised crime**.

The **Fair Trading Team** has provided some insight into a type of drug-related criminality that has not previously been considered in any detail as part of our assessments – **building frauds.**

Since the pandemic, the Fair Trading team have seen a tangible rise in the number of consumer reports for alleged consumer protection/fraud in case of home improvement or other building work.

In the 12 month period to 1 October 2022, there were 305 reports of home improvement type complaints. Some of these cases will merely have been as a result of a civil dispute and will not have raised criminal concerns. However, a proportion of these complaints are **multiple reports against a single business/trader** and will meet our threshold for further investigation.

41 reports (13% of those considered for further investigation) demonstrated **some link to previous drug offending** by the trader. Anecdotally, it is suspected that this rate may be considerably higher. The observation is based purely on background checks undertaken for operational tasking purposes and is not a full analysis of the available data.

- The offender records included markers for **'DRUG USE' and 'DRUG DEBTS'. 'DRUG DRIVING'** is also an apparent feature, indicating that the suspect may be a habitual user.
- Of the 41 records viewed, 9 included a **'DRUG SUPPLY'** marker, the most prominent drug being cocaine.
- When all reports are considered, **DRUGS, VIOLENCE and FIREARMS** markers are observed as common themes.

Themes for these alleged building fraud cases **often follow a similar pattern**. **Initially customers receive work that is acceptable** or completed satisfactorily. Subsequent customers begin to notice **a drop in quality, or the amount of work** being completed – accompanied by requests for large upfront payments. Further **customers then agree to paying large deposits** for work that is not started or materials not purchased. The **trader will often disappear or stop responding** to messages.

This pattern is often **observed relatively late in the timeline**, as many customers will not realise the extent of the problem until it is too late. The downward spiral in the trader's behaviour may be indicative of funding a drug use or possible addiction. It is not uncommon to see **tens of thousands of pounds of customer monies being lost** – with a massive impact on the **health and wellbeing of victims**.

Public perceptions of crime

Every year Safer Cornwall invites local people to "Have Your Say" about the **community safety issues that matter** on a day-to-day basis in the local area and what could be done to improve things.

This is achieved via an **on-line survey** hosted on Cornwall Council's Let's Talk public engagement platform and a series of **face-to-face events** held in public venues over the summer and early autumn. In this way the views of the public help **shape local priorities** and how these are tackled through our strategies and plans.

Findings from the 2022 Have Your Say survey[30] indicate a **high level of concern** about drug use and dealing in local areas and that this is having an impact on **public confidence and feelings of safety**.

824 people responded to our on-line survey in 2022. The survey was open for a period of 6 weeks, closing at the end of August 2022.

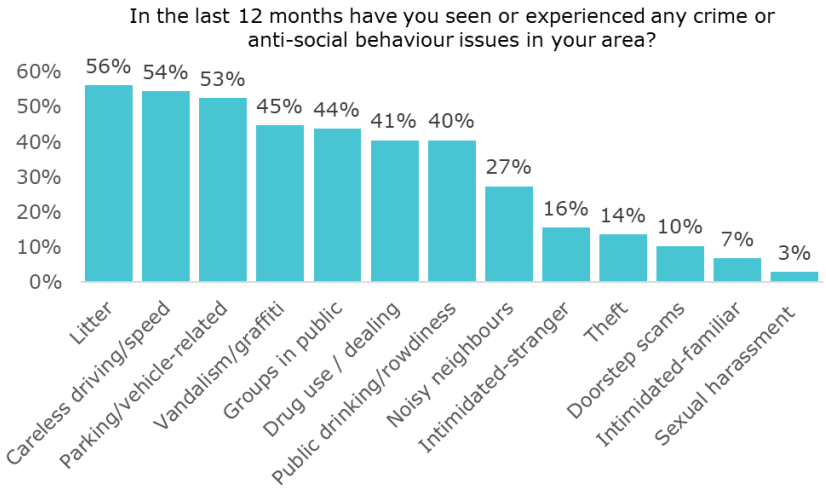
- **Over-represented** – women, 45-74 age groups, residents of Camborne, Truro, Bude, St Agnes and villages
- **Under-represented** – men, under 35s, residents[31] of Bodmin, Launceston, China Clay, rural areas

It is recognised that there is **some inherent survey bias** due to participation being self-selecting, with the rationale that residents are **more likely** to choose to be involved in the survey if they have **negative feelings or experiences** to share about the local area.

The extent to which residents perceive **different issues as a problem** in the local area has **increased from 2021**, with the highest rises in concerns about groups on the streets, vandalism, alcohol-related anti-social behaviour and drug use/dealing.

Despite these increases, **litter**, **speeding** or careless driving, **parking** and vehicle-related anti-social behaviour remain the three most commonly identified issues.

41% of people had seen drug use or dealing in their local area compared with 27% last year across Cornwall.



Witnessing drug use or dealing has a **substantial impact on feelings of safety** – residents who report **feeling unsafe** in their local area are three times more likely to report witnessing drug taking or dealing than those who report feeling safe.

30 After weighting for geographical sample size (10% without weighting, due to over-representation of Camborne residents)
31 The 2022 Have Your Say Report can be viewed and downloaded from the Safer Cornwall website

32% of respondents who said that they felt **unsafe** in their local area associated this with their **experiences of drug related activity** – this was particularly the case if they felt unsafe in the day time, where 39% said it was due to witnessing drug use or dealing.

The examples given included **witnessing drug dealing** on the streets (including in the daytime) and **feeling intimidated by people using drugs** and associated anti-social behaviour – fights, large groups, unpredictable behaviour, shouting, swearing, defecating/urinating. Respondents who felt unsafe in their local area at night, talked about **routinely witnessing violence**.

"Drug taking is publicly visible, drunken behaviour is frequent and general abuse is now normalised".

The key theme emerging from this year's comments is that **problem drinking, and drug use are more in the public eye** generally and a broader cross-section of the community are affected.
Drug-related issues were reported as concerns in towns and some villages across Cornwall. **Open drug dealing** in the street was reported by residents of Camborne, Redruth, Newquay, Penzance, Truro, St Austell and Bude.

In terms of solutions, **75%** of people who said they had seen drug use or dealing said that the **police should provide the solution** – more police on the street, greater visibility, more effective/honest, more responsive, focus on known problem areas, more powers, more connected to the community and quicker/easier/more efficient ways to report.

Other solutions:

- **Punitive** - a zero tolerance approach, more harsh punishment, locking toilets/parks at night, close problem premises/evict dealers.
- **Non-punitive** – invest in young people, more for young people to do, youth groups, engage with young people and develop life skills, better street lighting, more/better/working CCTV, focusing drug and alcohol services [in Camborne], train residents to help combat ASB.

Drug offences

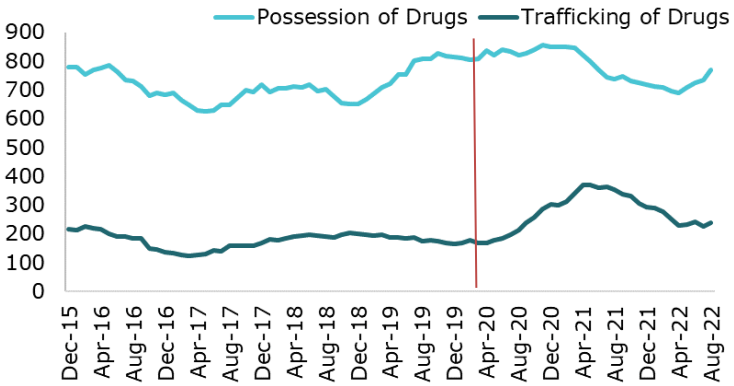
Drug offences are categorised into two broad types – possession and trafficking. Drug trafficking, which covers all offences connected to the supply of drugs is discussed in greater detail under Reducing Drug Supply.

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

Rates of police recorded drug offences locally **fluctuate around the average** for similar areas elsewhere in the UK.

The period April to July 2020 (the national COVID-19 lockdown) saw a **peak in drug-related offending**, almost certainly driven by Police proactivity during pandemic restrictions. **Drug-related stop searches increased** by 76% from April to July 2020 compared with the same period in 2019.[32]

This dropped quickly the following year. The chart indicates an **upturn in activity relating to possession** offences from April 2022.

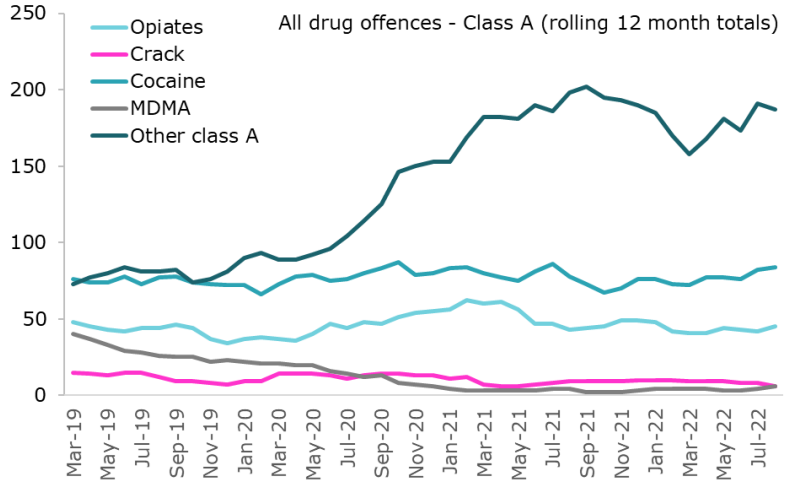


Looking over the last 4 years, **Class A offending has increased slightly** over the last 4 years, Class B has decreased, and Class C remains stable. This trend remains true following the end of the last national COVID lockdown in April 2021.

Around **half of trafficking offences relate to class A drugs** and changes in activities in these drugs determine the direction of the trend.

Examining the drugs involved in these offences:

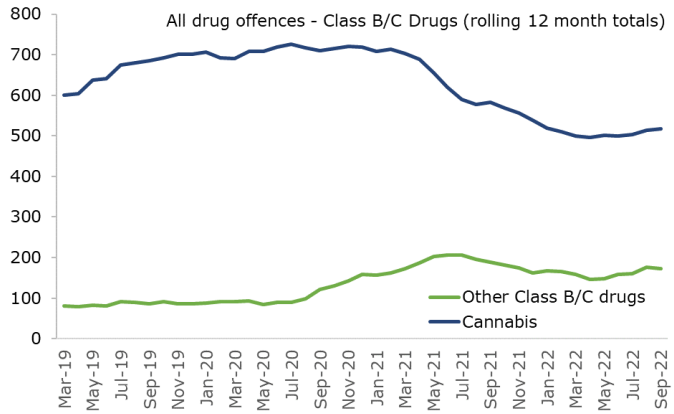
- There was a **large rise in Other Class A drugs** over the pandemic, now accounting for over half of all class A drug offences.
- Activities relating to **heroin, cocaine and crack have been fairly steady** overall.
- **MDMA-related crime has dropped** from around 15% of all Class A drug offences in 2018/19 to just 2% in the last year.



Increased availability and escalation in the use of crack cocaine has had a significant impact on the local risk profile – however, further to a rise around 5 years ago, **crack-related offences have remained at a fairly consistent 1%** of all drug offences recorded.

The rise in Other Class A offences is believed to reflect the **increasing trend in drugs bought online**, which was amplified during the pandemic by greater activity by Border Force staff to scan and intercept suspect parcels. This predictably reduced when staff returned to their regular roles as lockdown restrictions eased, but it has picked up again recently. An element of recording inaccuracy will also be a factor.

32 Force Drug Market Profile, Devon, Cornwall and the Isles of Scilly (Partnership Version), Devon and Cornwall Police, May 2023

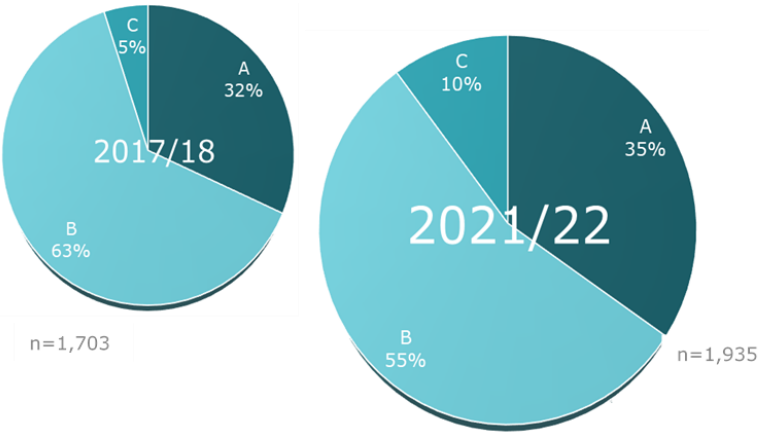


The vast **majority of possession offences relate to cannabis** (around 60%) and this is the primary driver in trends in this type of crime.

Drug seizures

Seizures data provided by the police for the year 2021/22 identify **1,935 individual seizures** made. Sharing of seizures data was paused for a number of years due to changes in recording method and capacity issues, so the most recent comparator year is 2017/18.

Comparing the two years, there is a notable difference in the balance between class B and C and this reflects increased activity relating to **benzodiazepines**.



As well as the increase in volume of seizures over this 4 year time period (+14%), the quantities seized are much larger, highlighting the **significantly increased activity in the local drug market overall**.

Only crack cocaine has been seized in smaller quantities in 2021/22 compared with 2017/18.

The greatest rises are in the volume and quantities of **benzodiazepines and other class A drugs**, echoing findings drawn from the recorded crime data and reports from other partner agencies.

	2021/22			2017/18		
Drug Type	**#**	**Weighed g**	**Counted n**	**#**	**Weighed g**	**Counted n**
Cocaine	368	2,669	20	180	1,011	4
Crack cocaine	21	114	8	19	391	0
Heroin	76	2,951	93	60	739	0
LSD	13	50	108	8	0	75
MDMA	127	1,022	1,275	260	352	1,662
Other opiates	13	0	24	8	0	402
Other class A	51	3,602	151	6	26	8

	2021/22			2017/18		
Drug Type	**#**	**Weighed g**	**Counted n**	**#**	**Weighed g**	**Counted n**
Amphetamine	34	14,080	65	35	165	0
Cannabis	997	38,984	549	1029	15,090	973
Other class B	6	0	8,055	2	0	120
Benzodiazepines	75	2,000	14,326	38	3	5,288
Ketamine	107	1,334	0	36	197	0
NPS	25	50	261	7	443	0
Other class C	14	10	3,032	7	1	1,056
Unknown	8	10	92	8	18	0
Total quantities	1,935	66,876	28,059	1,703	18,436	9,588

Counted items = Cigarettes/ reefers, squares/doses, tablets/capsules, wraps/bags, plants (cannabis)

Lab results from 2022 of drugs seized in the Force area show **relative uniformity in purity** across the Local Policing Areas.[33] The range of purity and the types of cutting agents identified are almost certainly typical.

Other Police data relating to drugs

Drug Related Driving Offences

In the year to October 2020 there was **681 drug related driving offences** committed in Devon and Cornwall. This included offences such as being 'in charge of a vehicle whilst unfit through drugs' and to 'drive a motor vehicle with a proportion of a specified controlled drug above the specified limit'.

Stop and Search

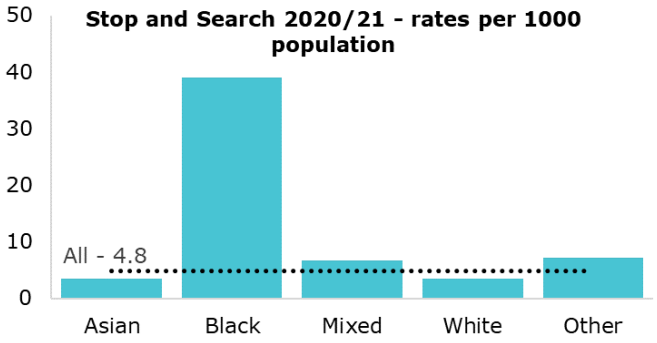
2017	3,631
2018	3,191
2019	3,926

In the year 2019 (the most recent that we have), approximately **70% of all Stop and Searches** conducted by Devon and Cornwall Police were related to drugs. A total of **3,926 drug-related Stop and Searches** were undertaken and this was an 8% increase on the number reported in 2017 (an increase of 295 incidents).

More recent **comparative data on stop and search activities** by Force area are provided within the compendium of Ethnicity Facts and Figures provided by the Office for National Statistics. This data relates to all stop and searches and does not provide separate data for drug-related activities.

[33] Force Drugs Market Profile, Devon, Cornwall and the Isles of Scilly – April 2023 (Partnership Version – Updated May 2023)

In Devon and Cornwall in 2020/21, there were 8,416 stop and searches (excluding vehicle searches) – there were 3.5 stop and searches for every 1,000 white people, compared with **39.0 for every 1,000 black people** – the rate for black people is 8x higher.



A spotlight report was undertaken by HMICFRS in 2021 Disproportionate use of police powers: A spotlight on stop and search and the use of force – this report found **evidence of disproportionality**: Black, Asian and Minority Ethnic people were over four times more likely to be stopped and searched than White people; for Black people specifically, this was almost nine times more likely. Over 35 years on from the introduction of stop and search legislation, no force fully understands the impact of the use of these powers. Disproportionality persists and **no force can satisfactorily explain why**.

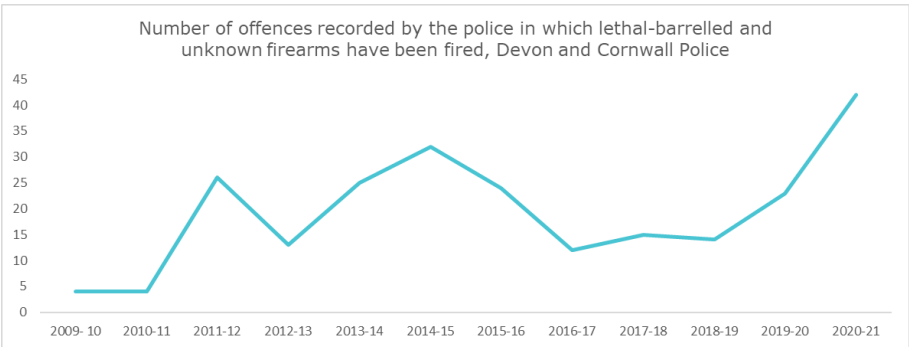
The report notes that **drug searches influence the disproportionality rate more than other types of searches**, and risk damaging police and community relations. When the police use their powers disproportionately – in differing proportions on different ethnic groups – it causes suspicion among some communities that they are being **unfairly targeted**.

The report makes a range of recommendations, specifically with regard to ensuring **officers are appropriately trained**, improving the **quality of the data** collected on use of force and stop and search and improving **monitoring and scrutiny** arrangements.

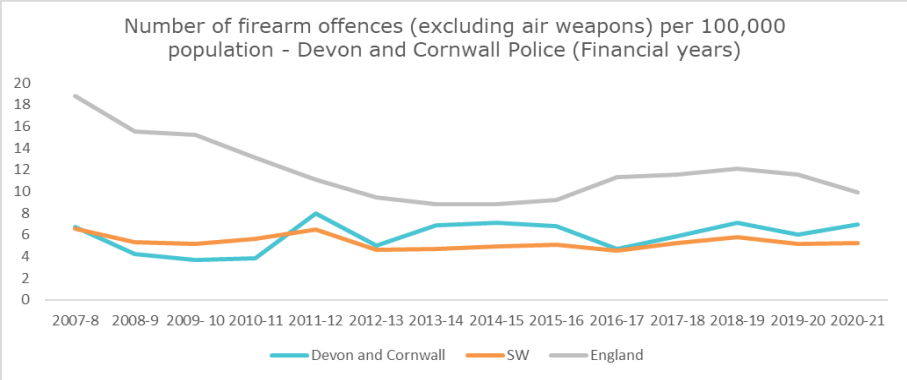
Devon and Cornwall were cited as positive practice within the report, for adding to **training and awareness for staff** through the use of a theatre company, which had been commissioned to **improve understanding about unconscious bias** in a street interaction setting.

Discharge of firearms

The number of offences recorded by the police in which **lethal barrelled and unknown firearms have been fired** is available at police force level, so these figures cover both Cornwall and Devon.

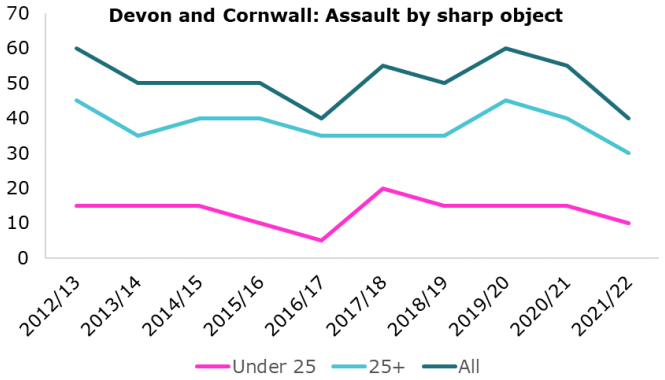


This chart shows the rate per 100,000 population of firearm offences (excluding air weapons) at police force, regional and national level. It shows an **uptick in the rate at force level** (blue line), whilst the national rate is decreasing, and the regional rate remained level.



Assault with a sharp object

Published data from the Office of National Statistics shows that the number of hospital admissions for assault with a sharp object has **fluctuated since 2012** with a **peak in 2019/20**, and a drop in the following two years.



Due to small number suppression[34], the data provided for Cornwall is fairly limited. The Devon and Cornwall police force area data indicates that the majority of people admitted to hospital for injuries caused by a sharp object are **men** and in the **20-29 age group** (which is consistent across the UK). Around 1 in 4 admissions relate to someone under the age of 25.

34 Data is rounded to the nearest 5 admissions and any number below 10 is suppressed.

Drug supply

Drug trafficking is one of the **serious and organised crime themes** identified in the National Security Strategy as a threat to national security, requiring an effective cross-government and law enforcement response.

It is a global trade and covers cultivation, manufacture, distribution, importation and sale of illegal drugs such as heroin, crack cocaine, amphetamines and cannabis. **The marketplace is where demand meets supply**, and clearly represents an opportunity to reduce the supply of illicit drugs.

- It is almost certain **all major drug types have a footprint** and are likely to have a market in the Force area. **Cannabis is the single largest drugs market**.
- The most harmful drugs are opiates and crack. The estimated **societal cost of opiate and crack cocaine use** (£474m) is over **four times the value** of the the opiate and crack market itself.
- Users and suppliers known to the police are predominantly **male, white and in their thirties**. It is almost certain that **fluidity exists between the roles of drug supplier and users** (i.e., user-dealers), and users who encounter the police have **higher rates of drug dependency and vulnerability** than the wider population.
- **47% of drug trafficking offenders/suspects** were linked to **County Lines**, with the majority estimated to originate from outside the Force area. Graft lines are now more likely to be located locally and it is a realistic possibility this reflects **a shift towards a localised 'franchise' model of County Lines**.
- The majority of drugs offending occurs in **urban, predominantly residential locations** and offences are more likely to occur in **deprived areas**. This is true of County Lines, Dangerous Drug Networks and lone dealers.
- A greater proportion of **lone dealers offended in rural locations** than other types - they are best able to service more isolated areas which would not be cost-effective for drug groups to target due to smaller demand. The majority of **lone dealers originate from within the Force area**.
- It is highly likely that the **graft line continues to be dominant method for the sale of heroin and crack cocaine** whilst the recreational drugs market is likely to be dominated by online platforms.
- The use of **online platforms** in drugs criminality almost certainly poses a growing threat in the Force area. Illicit online drug activity is **concentrated among the younger generation**.
- **Some evidence of sexual exploitation** being used to 'repay' drug debts in Devon and Cornwall, but this is **recognised as a knowledge gap**.
- **Increasing numbers of children identified** through operational multi-agency response groups – key themes include multiple vulnerabilities, parental substance use, high levels of homelessness (21%).

Recognising County Lines – Updated Guidance

The 2018 **Home Office Serious Violence Strategy** states the definition of a County Line is: *"… gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas [within the UK], using dedicated mobile phone lines or other form of "deal line". They are likely to exploit children and vulnerable adults to move [and store] the drugs and money and they will often use coercion, intimidation, violence (including sexual violence) and weapons.*"

The **latest guidance from the National County Lines Coordination Centre** explores the above definition in more detail and emphasises that **the distance between the gang and its customers is not relevant**. County Lines can operate between towns, amid counties and even across cities. This is a step away from the traditional concept of a County Line exporting from one area into another.

The key factors used to determine a County Line are therefore:

- Are they a **gang or organised criminal network** supplying drugs?
- Do they use a **dedicated mobile phone line** or other form of "deal line"? This is usually but does not have to be a branded deal line?
- Are they likely to exploit **vulnerable people**?

National drug market

The tables below show key aspects of the drug markets nationally[35].

Heroin	Crack cocaine
In large cities, heroin is supplied by local OCGs or USGs, usually alongside crack. In other areas county lines groups have increasingly taken control of heroin and crack supply. Street dealers consist of user-dealers and junior OCG or USG members. Mainly purchased from street level dealers.	Supply is largely through OCGS and generally controlled by county lines. Some of the stigma associated with crack in the past has gone and younger users now see it as more acceptable. With the changes in price and purity of cocaine, some cocaine users are moving from smoking it (freebasing) to the use of cheaper more ready-to-use crack. Crack increases tend to be outside established urban areas – possibly corresponding with the growth in county lines.

[35] Dame Carole Black's Independent Review of Drugs, 2020.

Powder cocaine	Cannabis
Albanian OCGs dominate the UK cocaine market, with a supply network from source country to towns and cities across the UK, acting as the main wholesaler to powder cocaine retail operations. Many users obtain these drugs for free through social supply, rather than from a dealer. It is often sold in the night-time economy alongside other recreational drugs. The overall prevalence of cocaine use in the last year has increased by around a quarter since 2013/14 with the largest increases in the under 30s, in rural areas and in those with higher incomes. The South West has seen the largest increase in cocaine prevalence since 2013/14.	Cannabis is obtained through a combination of dealers, social supply, and individuals growing cannabis for their own consumption. Increased media attention on medicinal use of cannabis and sale of CBD products in shops. The majority of cannabis users are under 30 with use widespread across the general population and most demographics. Rates of use are higher in the South with the South West and East of England seeing the largest increases in use over the last five years
Synthetics (MDMA, amphetamines and NPS)	
Increases in the number and quantity of ecstasy and MDMA seized across Europe are an indication that production of both substances may be increasing. The strength of ecstasy is also increasing with dose levels in many tablets now very high. The number of new NPS identified in the EU has fallen considerably since 2015, indicating a slowdown in the generation of new substances. The dark web is an important source of supply for synthetics, particularly for NPS outside of synthetic cannabinoids. Little change in the profile of users of MDMA and amphetamines, but whilst NPS use has fallen substantially, prevalence remains very high among rough sleepers and in prisons.	

Local Drug Market and Organised Crime

Key themes emerging from **partners' understanding of changes in the drugs market** were discussed at a themed multi-agency workshop undertaken for the Safer Cornwall Strategic Assessment. This brought together insight from partners working with people accessing drug and alcohol treatment and other services, as well as wider community and criminal justice system impacts.

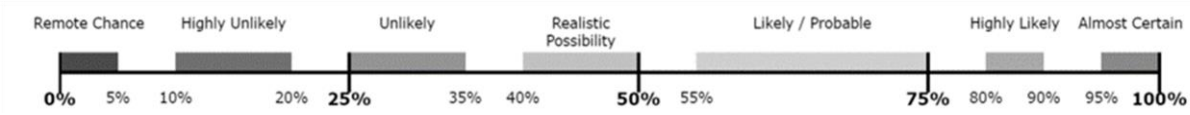
In 2022/23 Devon and Cornwall police developed a **Drug Market Profile** which was shared with local partnerships in April 2023. This is the first time that such a product has been made available at local level. It aims to support partnership working to develop a **system-wide response to tackle drug supply**. Note that the **findings cover Devon, Cornwall and the Isles of Scilly** and this area is referred to throughout this section as the **Force area.**

Police Drug Market Profile

Probability, Uncertainty and Confidence Levels

As a clandestine business model, it is not surprising that **significant knowledge gaps exist** about the nature and extent of the market, with its hard-to-reach suppliers and consumers, and the challenges for data collection associated with the disclosure of illegal behaviours. As estimates are contingent on **variable assumptions, uncertainties and research methods**, the illicit drugs market is difficult to assess with certainty at a local, national and international level.

To account for this uncertainty, **known data limitations are clearly stated** in the Drugs Market Profile and the language of uncertainty as well as **confidence statements are used** where relevant within the findings. Throughout this document, the 'probability yardstick' has been used to ensure consistency across the different threats and themes when assessing probability. The following defines the **probability ranges** considered when language is used:



Where relevant to the findings, estimative probability has been paired with the following analytical confidence levels:

- **High Confidence** - Good quality and/or corroborated evidence exists from a range of different sources. Or situations where it is possible to make a clear judgement.
- **Medium Confidence** - Evidence is open to various interpretations. Or the finding is credible and plausible but lacks corroboration.
- **Low Confidence** - Scant or very fragmented evidence. Or based on sources of suspect reliability

The agreed standard for conveying probability in intelligence analysis in the UK is the Professional Head of Intelligence Assessment 'probability yardstick'. More information about this is on the delivering effective analysis page of the College of Policing website

Devon and Cornwall Drugs Retail Market

- It is almost certain **all major drug types have a footprint** and are likely to have a market in the Force Area.
- An estimated **87,000 people took drugs** in the Force area last year (low confidence), with around **8,000 taking the most harmful drugs** (opiates and/or crack cocaine). **Cannabis is the single largest drugs market** at an estimated 70,500 users (low confidence).
- An estimated **32,000 people were frequent drug users** in the Force area (low confidence), 10,000 of whom took drugs daily.
- To meet the **current user demand** for drugs across the Force area, it is estimated that 526 kg of powder cocaine, 6438 kg of cannabis, 59,402 ecstasy pills, 162 kg of crack and 908 kg of opiates would be required (low confidence).
- Drug users in the Force area **spend approximately £214 million on illicit drugs** annually (low confidence), 50% of which is spent on crack cocaine and opiates alone. The most criminally profitable drugs markets are therefore not necessarily the largest.

- Up to **£506,000 of the proceeds of drugs crime** were subject to confiscation or forfeiture in the Force area from January to October 2022. This is 0.24% of the estimated value of the drugs market in Force.
- The **estimated societal cost of opiate and crack cocaine** in the Force area is **£474 million** (moderate confidence). This is **over four times the value of the opiate and crack market itself**. Up to 50% (approx. £234 million) of the societal cost of the opiate and crack cocaine market can be attributed to crime (low confidence).

Demographic and Criminal Profile

- 3,987 potential drug users and 1,713 potential dealers were identified on Force systems in the year to October 2022. It is almost certain that **fluidity exists between the roles of drug supplier and users** (i.e., user-dealers), with 29% of dealers also being identified as potential users.
- Users and suppliers known to the police are predominantly **male, white and in their thirties** – there is limited difference in the average demographic profile.
- **Drug use and drug dependence is not distributed evenly** across the population. It also differs by recreational or non-recreational drug use.
- The average age of all users known to the police was 31 years old, but the **average age was lower for ketamine and MDMA users** (both 27 years), and **higher for opiate/crack users** (41 years).
- On average, **51% of users known to the police were unemployed** but average unemployment rates were higher for amphetamine, heroin, crack cocaine and opiate/crack users (60%, 72%, 81% and 74%) and lower for MDMA, ketamine, and cocaine users (33%, 35% and 38%).
- It is almost certain that **users who encounter the police have higher rates of drug dependency and vulnerability** than the wider population.
- **47% of drug trafficking offenders/suspects** in the year to October 2022 were linked to **County Lines**, 16% to DDNs, 14% to Lone Dealers and 23% to 'Other' business models. It is likely that **drug groups account for most drug supply-related offending** in the Force area.
- **Limited demographic differences** exist between nominals linked to the main drugs-related criminal business models (County Lines, DDNs, lone dealers) operating in in the Force area.
- Nominals linked to **County Lines and DDNs** are more frequently associated with **Class-A supply offences**, than lone dealers who are most frequently associated to Class-B offences.
- It is likely that **up to 70% of lone dealers originate from the Force area**, compared with 50% of DDNs. The majority (60%) of County Lines are estimated to originate from outside the Force area but graft lines[36] are now more likely to be located within the Force area than a metropolitan source region (56% in 2022).
- It is a realistic possibility this reflects **a shift towards a localised 'franchise' model of County Lines**, as criminals seek to evade police attention amid growing law enforcement awareness of traditional tactics.

Geography of Supply and Demand

- The **majority of drugs offending occurs in urban, predominantly residential locations**. This is true of County Lines, DDNs and lone dealers. A greater proportion of lone dealers (25%) offended in rural locations than

36 A graft line refers to the selling of illegal drugs via a mobile phone line

- suspects/offenders linked to DDNs (14%) and County Lines (9%).
- **Drug offences are more likely to occur in deprived areas** in the Force area, with drug possession offences slightly more likely to occur in more deprived postcodes (77%) than drug trafficking offences (73%).
- It is a realistic possibility that an above Force average proportion of drugs trafficking offenders/suspects in Exeter, East and Mid Devon LPA are linked to County Lines. **East Cornwall** is the only Local Policing Area with **less than half of offenders/suspects linked to County Lines**.
- Heatmapping of possession and trafficking offences in the year to October 2022 by sector indicates that **Newquay and Truro are among the user hotspots** in the Force area (along with Barnstaple), but **not suppliers**.
- It is a realistic possibility that in **West Cornwall**, a smaller number of **entrenched suppliers** are basing themselves in one sector (e.g., Penzance) and travelling out to supply other areas. This is likely due to lower supply
- competition, compared with cities such as Plymouth and Exeter with greater rail and road connections often seen as desirable by gangs like County Lines
- It is likely **lone dealers are capitalising on a niche in the market**. They are best able to service **more isolated areas** which would not be cost-effective for drug groups to target due to smaller demand.
- It is highly likely that **the majority of drug use occurs in private spaces**, most commonly users' own homes. It is a realistic possibility that drug use (in particular, recreational drugs) occurs more frequently in areas associated the ENTE, than drug supply.

Drug Supply Chains

- It is almost certain that **most drug supply comes from outside the Force area** and from the major urban hubs Merseyside, London and the West Midlands.
- It is highly likely that the **most common methods for transporting** drugs into the Force area from the national/regional level is by **car, followed by rail and the postal system**.
- It is almost certain that **cannabis cultivation has an established footprint** in the Force area, dominated by small-scale 'grows' intended for personal use. The small number of large-scale cannabis cultivations in the Force area are frequently linked to the Western Balkan OCGs. It is a realistic possibility that **over half the cannabis sold in the Force area is produced locally**.
- **Crack cocaine is also produced in the Force area**, although the extent of market share remains unknown. It almost certain that **production fluctuates** according to the quality and availability of crack.
- It is highly likely that the **majority of drugs are exchanged face-to-face** in 'open' markets (streets or public spaces). **Drug deliveries** via post, location drop-off and courier are likely to play a **significant, although smaller role**.
- It is likely that **open markets (such as meeting users on the street) still have a footprint in the Force area**, albeit a small one compared to closed markets (like graft phones and the internet).

Method of Sale – Open and Closed Markets

- It is highly likely that the **graft line continues to be dominant method for the sale of heroin and crack cocaine** whilst the recreational drugs market is likely to be dominated by online platforms. This is highly likely to continue to be the case in the near-term, but as younger tech-savvy users get older, and technology improves this is likely to change.

- It is almost certain that **user contact lists are still a valuable asset** for drug suppliers.
- The use of **online platforms** in drugs criminality almost certainly poses a growing threat in the Force area, with intelligence reports increasing by 88% from 2018 to 2021.
- **Illicit online drug activity is concentrated among the younger generation**. The younger cohort is linked in drugs intelligence to Snapchat most frequently and Facebook second or third most, the opposite is true of over 30s.
- It is highly likely that the **dominant method of online drug sales is via the clear web**. Snapchat (45%), Facebook (16%) and Instagram (11%) were the most commonly reported platforms being used in drugs criminality. There has been a **growing trend of Snapchat** being reported in the sale of drugs since 2018.
- The **dark web and encrypted devices present substantial barriers for user and dealer access** (technical competence, access to a device with anonymising software such as a Tor Browser and cryptocurrency). It is highly likely that future growth in this market depends on the ability of dealers and users to overcome these barriers.
- It is likely that the **purity of cocaine and crack in Force has increased slightly** following the end of COVID-19 restrictions during which scarcity and reduced purity were widely reported.

Organised Crime Groups

In the section on Trends in Drug Use, we described how aggressive targeting by **Organised Crime Groups** (OCGs), particularly via County Lines, has resulted in crack cocaine being **readily available** across Devon and Cornwall, with a rapid escalation of use, particularly amongst opiate users.

This brought with it a greater risk profile, including a rise in **violence and exploitation**, and serious health harms, more **drug related deaths**, and increased risks for **vulnerable people targeted by OCGs**, who are using them and their homes to sell drugs and recruit more users.

Pre-pandemic, the local picture also showed **increased poly drug use**, and **illicit use of prescribed medicines** (such as Valium and Clonazepam), particularly amongst young people. Specific concerns were raised about purchases made via the Dark Web.

A review of evidence of **sexual exploitation** linked to OCGs across the Peninsula for the Peninsula Strategic Assessment in 2020 highlighted that **sexual violence was being used as a method of control** in drug trafficking/exploitation, particularly targeting vulnerable women[37] and young people. This indicates significant **hidden harms/risks with victims unlikely to seek help** due to their circumstances.

Over the course of the pandemic, we saw some key changes in **drug prices and supply**, with harmful counterfeit drugs, high strength benzodiazepines and "designer drugs" being sold locally – these drugs were **higher strength** than they

[37] A specific example includes work conducted in Exeter to understand the risks facing people involved in sex work – this found that vulnerable womenwere being coerced into sexual exploitation as part of County Lines exploitation, including as a result of accruing drug debts, with particular concerns about the targeting female rough sleepers

were pre-pandemic and being **marketed at younger people**, appearing in new brightly coloured tablets; the **potential for substantial financial** gain for those producing was recognised.

Spice and Methadone (prescribed and unprescribed) were also noted to be filling a gap left by supply issues with heroin and cocaine. Dealers were seen to be cutting their stock with other substances, with users usually unaware, and this also increased the risk of overdose. There were also heightened concerns about **poly drug use** with interruptions in drug supply causing users to use different combinations of drugs or use contaminated drugs.

Means of supply also changed, with **more drugs being purchased online** and **increased use of social media**, including Snapchat and Instagram particularly being used with young people to obtain and sell substances during the period when COVID restrictions were in place.

Partnership County Lines Threat Assessment (November 2022)

A **Partnership Intelligence Report** on the theme of **County Lines** was shared with partners by the police in November 2022.

This report provides partners with an **overview of County Lines criminality** in Devon and Cornwall, as well as an insight into how partner information submissions have contributed to operational activity and are continuing to work in partnership with the Police.

The report notes that most County Lines operating locally come from **Merseyside, the West Midlands and London** and often maintain long term links to our area. The **new definition** in the latest Home Office guidance, however, has resulted in some **local drugs networks** being categorised as County Lines.

Key Findings:

- **County Lines have resumed 'business as usual'** tactics and levels of activity since COVID restrictions were lifted.
- County Lines are **utilising the Royal Mail postal system** to transport drugs and launder illicit profits into and out of Devon and Cornwall. It is highly likely they are utilising legitimate courier services in a similar way.
- The **majority (80%) of people involved** in County Lines criminality in Devon and Cornwall in 2021 and 2022 were **male**. It is a realistic possibility that a **spike in female involvement** in drugs trafficking crimes in 2020 is attributable to drug networks' **targeting females during COVID-19 lockdowns** under the belief that females were better able to evade law enforcement scrutiny.
- There is some evidence of **sexual exploitation to 'repay' drug debts** being seen in Devon and Cornwall.

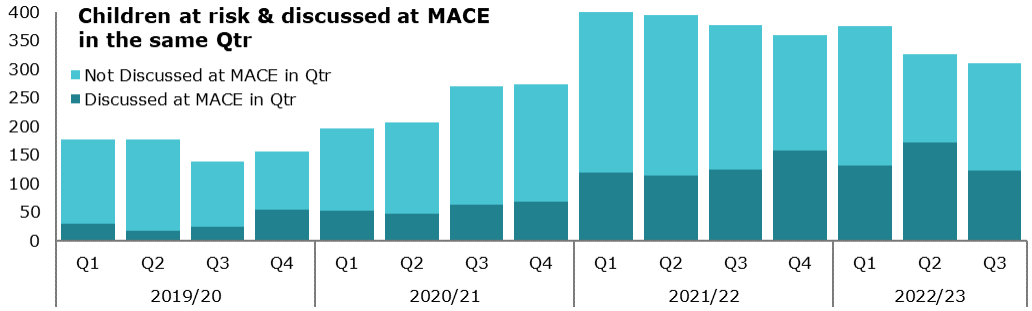
Intelligence Gaps:

- Are **students and young people** in Devon and Cornwall being **targeted as Money Mules** by County Lines via social media?
- How prevalent is the **sexual exploitation of women** within drugs networks?
- Are **'burner phone' apps being utilised** by drugs criminals in Devon and Cornwall to advertise drugs for sale?

Multi-agency responses to safeguard young people at risk

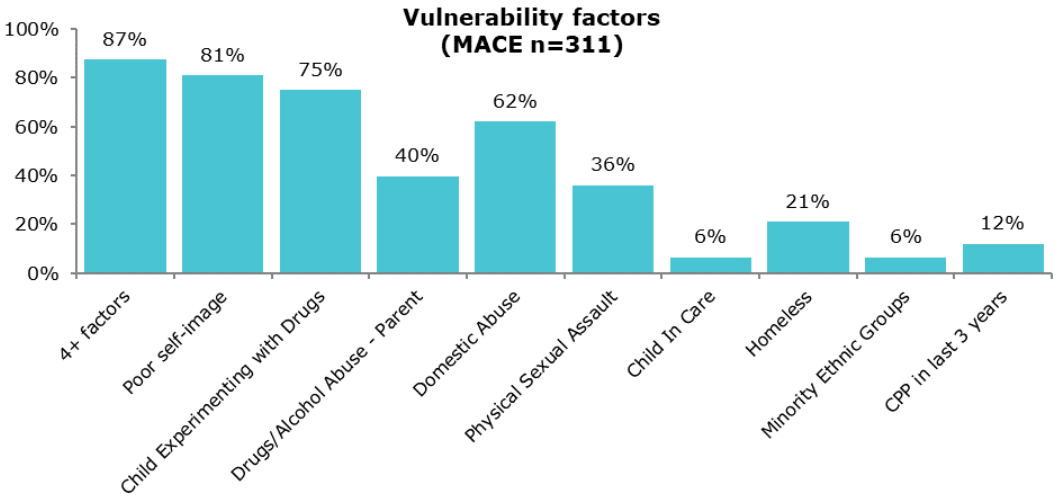
The **Missing and Child Exploitation (MACE) Panel** provides the operational response to all forms of exploitation of children and young adults to the age of 25. The MACE Panel ensures that agencies, partners and commissioned services work together effectively and consistently to identify risk, prevent and disrupt exploitation, reduce the risks faced by those who go missing from home, care or education and identify activities to disrupt exploitation.

- **974 children were identified as at risk of or experiencing exploitation in the 12 month period to December 2022** of which just under 1 in 3 (30%) were discussed at MACE in the quarter that they were flagged. Although the uplift in numbers in 2021/22 was expected due to expanding the definition from just sexual exploitation to all types, **numbers started rising in 2020/21**.



Source: Mosaic, Cornwall Exploitation Strategy Performance Report Q3 2022/23

- 87% of children have **4 or more vulnerability factors**; poor self-image, drugs and domestic abuse are the most common. **Domestic abuse** is present **in the home for 62%** of children. **4 out of every 10 children have parents that use drugs** and/or alcohol.



- At 6% there is an **over-representation of children from minority ethnic groups** – this is largely split between Mixed Ethnic groups and Other White.[38]

[38] 6% (20 children) are from minority ethnic groups and this is higher than the population profile (3.2% from Census 2021). 5 with a mixed ethnic background, 2 Polish, 6 White and Black Caribbean, 1 Black British & 6 recorded as 'Any Other White background'.

- **9% are homeless** – this has dropped back to historical levels in the last quarter having been elevated to twice that level over the last three periods.
- The **number of children referred to MACE who are in care has dropped** – 20 children (6%) were recorded as being in care compared with around 20% over the last year. 12% of children have been subject to a Child Protection Plan in the last 3 years.
- **Sexual identity is now to be recorded within Return Home Conversations** as it is a recognised vulnerability in exploitation and will be included in future reports (2023/24 onwards).

Local Disruption and Support Meetings (LDSMs) are a contextual safeguarding response to any escalation in exploitation risk in a specific geographic area. These are **held whenever and wherever a significant risk is identified**.

- Recent trends from the LDSMs include **education-related challenges**, with most children and young people having been excluded from school and **many are waiting for places in Alternative Provision Academies**.
- We are seeing **increased physical threat** and involvement in anti-social behaviour, with organised fights as a regular feature.
- **Younger children are increasingly being highlighted as at risk**, which includes primary aged children.
- With public transport having got cheaper (with the new £5 all day bus fares), we are seeing **young people travel easily to other towns and networks joining up** and becoming established.

Other themes[39] identified include:

- **Knife** carrying
- **Sharing of information**/intel/portal submissions
- Hidden **adults**
- **Under-reported** missing children
- **Voice** of the child /young person
- Possible parental **disguised compliance**
- **Expensive** clothing/accessories

Concerns raised specifically about drugs and alcohol:

- With You advised generally that the service are seeing more referrals of **young people using alcohol**.
- The substances of concern are primarily **cannabis and alcohol**. Cocaine mentioned in Falmouth/Penryn more recently, speed in Launceston and ketamine and NOS in Bude.
- There is a concern that young people are **not being challenged when shoplifting alcohol** – this has particularly been raised in relation to a specific store in multiple locations (Marks and Spencer).

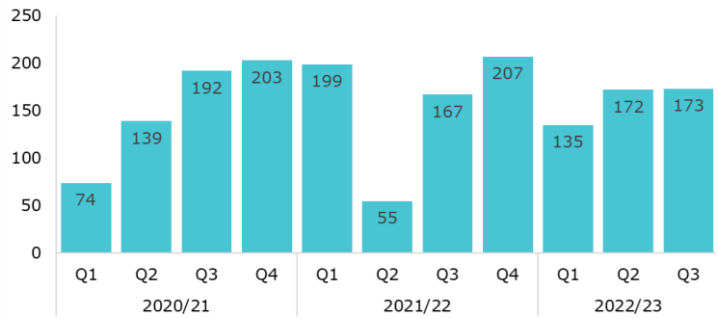
The multi-agency workshop on Youth Issues (undertaken for the Safer Cornwall Strategic Assessment) highlighted that **information sharing needs to improve** – cases being discussed at **MACE** involve people who are or are linked to With You clients, but **With You are not involved** in the discussions – the people concerned may be victims or identified as a person of concern.

[39] Snapshot of 6 LDSMs in Q2 2021/22 - Falmouth/Penryn, Launceston, Truro, Hayle, Bude, Callington

Intelligence submitted to the police by partners

Partner agencies are encouraged to report any non-urgent community intelligence of concern to the police using the on-line community partnership intelligence form.

- **There were 687 community intelligence submissions** in the 12 months to December 2022, with 173 in the most recent period reported. There is considerable fluctuation in the numbers between each quarter.
- Around a **third of submissions were related to drugs and/or exploitation** (54 submissions).



Theme	Number
Safeguarding	27
Violence	25
Drug Taking	20
Anti-Social Behaviour	18
Criminal Exploitation	13
County Lines	12
Dangerous Drugs Networks	9
Domestic Abuse	9
Child Sexual Exploitation	6
Acquisitive Crime	6
Hate Crime	3
Extremism and Radicalisation	2
Cyber Crime	2
Other	21
Total submissions	**173**

Deep Dive exploration of Safeguarding Partnership responses to County lines and Serious Youth Violence: Cornwall and Isles of Scilly report

In 2021 a national study was undertaken by Liverpool John Moores University which aimed to "*consider the response of multi- agency safeguarding arrangements to serious youth violence and county lines exploitation and to identify areas of promising practice, learning and recommendations for all safeguarding partners*".

Cornwall was one of nine local partnership areas that were invited to participate in the study.

This included the key questions of:

- How are the **leadership and structures** of multi-agency safeguarding arrangements configured to respond to serious violence and child criminal exploitation?
- What systems are in place to **collect and share data and intelligence** to get a detailed picture of those at risk?
- How effective are systems to **collectively identify and risk assess children** who are at risk?
- How effective are systems to **collectively manage, review and escalate risk** for cases of county lines and child criminal exploitation?
- What **interventions are put in place to support those at risk** and how effective are these interventions?
- How do safeguarding partners **scrutinise, evaluate and improve multi-agency arrangements** to safeguard children at risk of criminal exploitation?

The research concluded that Cornwall has a **cohesive approach to addressing the whole landscape around county lines** and exploitation. Efforts are made not

just to identify, support and safeguard the person being exploited, but also to assess the wider risk and disrupt the criminal activity of perpetrators.

Partnership working is identified as "*a huge strength in Cornwall*" and it was noted by all participants regardless of agency that a lot has been invested into effective partnership working, including with the VCSE sector. **Strong leadership** in this area and a **coherent multi-agency strategy** were also commended.

The study made **ten recommendations** (the most relevant are highlighted):

Ownership and Awareness of Exploitation	• Building on the success of Cornwall's Exploitation Awareness campaign, it would be helpful to ensure there are visible pathways where anyone can report concerns, share information and access support and advice. There also needs to be consideration of appropriate communication channels such as social media, for communicating with young people and families so that this message visible.
Resource, Early Intervention and Prevention	• It was repeatedly highlighted that there is a chronic lack of funding in order to effectively tackle risk factors related to serious violence and exploitation by county lines. • It was recognised that the agencies within the partnership are hugely underfunded and there was a need for further long-term funding across all areas as well as the need to provide long-term care and support for **neurodiverse conditions**. • There was an overwhelming response that more resources need to be invested into prevention and early intervention; especially pertinent given that exploitation can happen to any child. • It was highlighted that there is a need for detached youth workers and safe places for young people to go and take part in meaningful activities. This requires significant resource, planning and investment to ensure that these activities are desirable, assessable and sustainable
Seeing Young People as Victims	• This was evident amongst the professionals interviewed, this could be developed further across all agencies and it was noted even more could be done to recognise **presenting behaviours of young people who may be at risk** of exploitation. • There should be **consistency in understanding** across all organisations and within society and should ensure that the language used represents this understanding.
Educational Consistency	• Participants expressed a desire for standardisation within education establishments. There is **variability in awareness** raising on county lines and exploitation within PSHE, for example. • Despite exclusions being highlighted as a key critical moment for young people becoming at risk of exploitation, the response to a **child bringing drugs into school** for example, is variable. • There was also **great variation** in how education establishments worked in partnership working with **substance misuse practitioners** and diversionary teams from the police

Consistency in Identifying Risk Factors	• It was noted that different assessments and referral forms can capture different information and that it would be good to learn from other agencies and partnerships and get national consensus regarding which information to record and enable a **standardised risk assessment and checklist** for all agencies
NRM Awareness	• There was a feeling that as partnerships are so strong locally, the immediate need to put in an NRM is not always recognised. • There are steps in place within Cornwall for further training being planned regarding the NRM and this training should clarify the NRM purpose, the process and areas of responsibility. *NB process delays and a clunky system within NRM are a massive barrier. There are very few NRM referrals for young people.*
Contextual Safeguarding	• It was highlighted that contextual safeguarding primarily is led by social care and police and that **health could potentially lead on some contextual areas**, particularly at an earlier stage of risk, including addressing unmet need • There were mixed feelings on implementation of a specific Exploitation Team - however, it was noted that dedicated resource and coordination would be welcome.
Family Partnership Voice	• The Local Authority is looking at how it can support parents further, it could also explore how families who have been supported by the safeguarding partnership, (parents, carers and young people themselves) become involved in **co-production**, providing feedback and contributing to service delivery
Across Area Information Sharing Protocol	• Given that professionals are often working within similar roles across the country and that the nature of county lines is such that it requires collaboration nationwide, participants noted that they wanted to see more of a national consistent response to county lines and this involved sharing information, taking responsibility, awareness and support. • This also included having agreements in place with other areas, such as the MACE-to-MACE protocol which is planned
Quality Staff Support	• There are an array of professionals working to support young people at risk of exploitation and it was noted that working with exploitation can be extremely stressful for staff and that there must be an investment and commitment to providing ongoing, good quality support for staff, due to the risk of vicarious trauma

A **review of progress against these recommendations** was undertaken by Safer Cornwall partners in early 2022 and a number of areas were identified as needing more focus to address effectively.

Training and employment

- Ensuring that the **training offer is joined up** (for example Bystander training) to get the maximum benefit and measuring whether the impact of training continues. Meeting the **changing training needs of housing providers (**increased use of Premier Inn, short term lets, Air BnB), as well as the wider **hospitality sector, taxi drivers and other businesses** – providing common training across Cornwall and all sectors (possibly linked through the Local Enterprise Partnership.

- Young people on apprenticeships and work experience **placements in some trades** (anecdotal information was discussed in relation to the motor trade) were **identified as at risk of exposure to drug use** by older colleagues - some awareness training would be good for these employers.

Prevention

- Improving **opportunities for young people to express concerns at an earlier stage** such as drop-in with youth worker/nurse not attached to the school rather than targeted services. Ownership and comms, YP knowing what is available - e.g., refuge provision to access at the right time
- **Whole family and whole community approach towards prevention**, every agency involved. Child-centred and trauma informed early intervention and prevention. Recognising the importance of **trusted and sustained relationships** for young people, particularly for children living in fear. Link to CJS and developing pathways.
- Improving **opportunities for young people to be heard and disclose** at an earlier stage – more youth activities, safe spaces, community spaces. **Universal services** should be able to identify vulnerabilities, unmet need, contextual risks. Very reliant on verbal disclosure – we should support **professional curiousity** and ensure that the right pathways are there to progress concerns.

Educational settings

- **Parental awareness of exploitation** with messages being delivered consistently across education and all services.
- Currently **schools have an inconsistent approach to drug related behaviours**. Better school engagement on this issue is needed – including recognising **drug use as a sign of exploitation** and delaying/stopping exclusion whilst finding the right pathway. It should be best practice to explore risk and make appropriate referrals as early prevention - need a consistent model for schools and multi-agency working.
- **Educational provision differences on Scilly** due to greater vulnerability of children and young people needing to travel to and from the mainland.

Schools are an important part of any young people's drug strategy, for building resilience, for early prevention, to identify substance misuse and refer into specialist substance misuse services. Being excluded and or suspended from school can have a negative effect on young people and increase their vulnerability to problematic substance misuse.

Reducing reoffending

Drug related needs in the Criminal Justice System

- Offenders in Cornwall are **less likely to reoffend** (21% vs national 25%). Rates have reduced over time but **young adults have seen a recent increase**.
- The aim is for **every offender with an addiction to have a treatment place**. Drug related needs are identified for around a third.
- Comparatively **good engagement rates and outcomes for opiate users** locally coming through the CJS, but continued work is needed to identify, refer and engage non-opiate users.
- **Pathfinder is proven effective** as an early intervention to reduce reoffending. Community Sentence Treatment Requirements for **combined drug and mental health treatment** have been very successful and we have the highest number of orders nationally.
- **Continuity of care** from prison to community services is in line with the national rate at 38%; nationally mandated target to get to 75%
- Gaps – **tailored programs** in prison**, housing support** for prison leavers, support for **people with complex needs** to address underlying issues, use of **screening tools**. We need to test **local barriers**.

Proven reoffending statistics

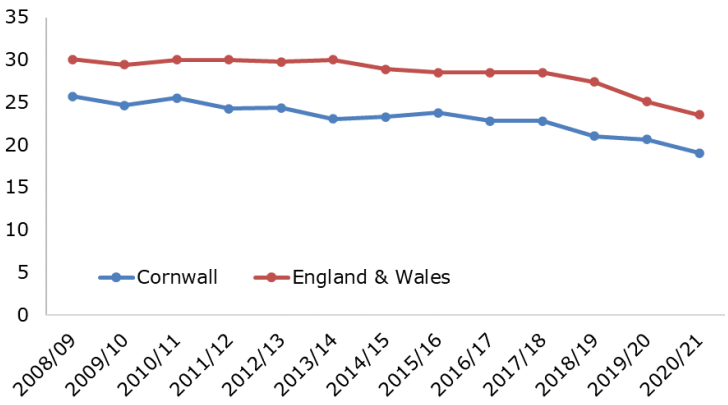
"During this period of volatility, proven reoffending rates are likely to continue oscillating in the short-term before potentially more stable trends are observed as we move further away from the periods of lockdowns"

Nationally, proven **reoffending rates** have steadily fallen over time and the 2020/21 rate was the **lowest rate in the time series** (since 2009).

In the most recent quarter reported (the offender cohort for April to June 2021), adult offenders in England and Wales had a **proven reoffending rate of 24.8%**.[40] Across almost all offender breakdowns we see a similar trend, with reoffending rates down from the same quarter last year, but up from the previous quarter. This highlights the volatility we continue to see due to the effects of the COVID-19 pandemic.

The national statistical release notes **the impacts of the pandemic** on the size of the cohort, likely due to the impact of court closures, and how this has had a pronounced impact on reoffending figures.

In Cornwall, proven reoffending rates for adults in the criminal justice system has **consistently tracked below the national rate**, but the gap has closed slightly in the last two years.



[40] Proven reoffences are measured over a one-year follow-up period and a further six-month waiting period to allow for offences to be proven in court.

- **Adult offenders** had a proven 12-month reoffending rate of 19.1% (vs the national rate of 23.5%). Following the national trend, the rate of **reoffending has steadily reduced over time**.
- The **number of offenders in the system has fallen massively** – the adult cohort is half the size it was ten years ago.
- The index offence type associated with the **highest reoffending rate was thefts** at 41.2% and the second highest was public order offences at 28.6%.
- Offending rates are **highest amongst offenders aged 25-39 years** with the rates dropping off from 40 years of age onwards.
- **18–25 year-olds make up one fifth** of the known offender population. **Reoffending rates for young adults have reduced** in the last 12 months – by 24% for 18-20 year olds and 17% for 21-24 year olds. Reoffending rates for offenders aged 35-44 have increased by around 6% over the same time period.
- **Reoffending rates for women are much lower** than for men and they make up only 17% of the offender population (similar to the national profile, 16%).
- National data shows that reoffending rates are **higher for offenders released from custody** (31.8%), and particularly those who have completed **sentences of less than 12 months** (57.5%).

Support for offenders with drug-related needs

The new National Drugs Strategy includes a goal of ensuring "that **appropriate and high-quality treatment is available to all offenders with an addiction** so that they can work towards drug-free living, and also to ensure that drug treatment, housing and employment support is available for every prisoner subject to probation supervision upon release."

Our local treatment system data indicates comparatively **good engagement rates and outcomes for opiate users** coming through the Criminal Justice System, but **more work is needed** to identify, refer and engage **non-opiate users**.

CJS referrals account for around 12% of new presentations and mostly come via prisons and court-ordered treatment requirements (alcohol, drugs and combined orders with mental health). Probation have advised that an **uplift of around 20% in the offender cohort** is anticipated, which needs to be taken into account in future planning.

Cornwall's **Community Sentence Treatment Requirement** (CSTR) pilot is cited in HM Probation Inspectorate Effective Practice Guide Effective Practice Guide, published in September 2021. Cornwall is very successful with the **highest number of combined orders** in the country and is recognised as a leader in delivering CSTRs.

The strategy states that it intends better outcomes for offenders to be achieved by:

- Mandatory and voluntary **testing regimes in prison**.
- Support for prisoners to engage with community treatment ahead of their release.
- Increasing the use of **intensive drug rehabilitation requirements** for those on community sentences.
- **Expand and improve** the use of **drug testing on arrest** and **details passed to NHS Liaison and Diversion services** to identify offenders with drug treatment and other needs and refer them on.

- **Investing in additional specialist drug workers** to work with police, courts and probation to assess offenders.
- Delivering more **specialist drug treatment staff to work with prisoners as they leave prison** and help them to re-enter the community and start treatment. **This includes people with lived experience**, who are often more able to secure engagement in those vital first few days.
- Investing to **expand the use of video call technology**, enabling prisoners to have **virtual initial meetings with community-based treatment providers before they are released**, to build relationships and make it more likely that the prisoner will want to keep their appointments.

It is expected that the introduction of 50 **Health and Justice Partnership Coordinators** employed by HM Prison and Probation Service will help to achieve some of the outcomes listed above. These 50 roles are part of a broader commitment by the Ministry of Justice and HM Prison and Probation Service for a **coordinator** to be in place **in every probation region in England by 2024/25**.

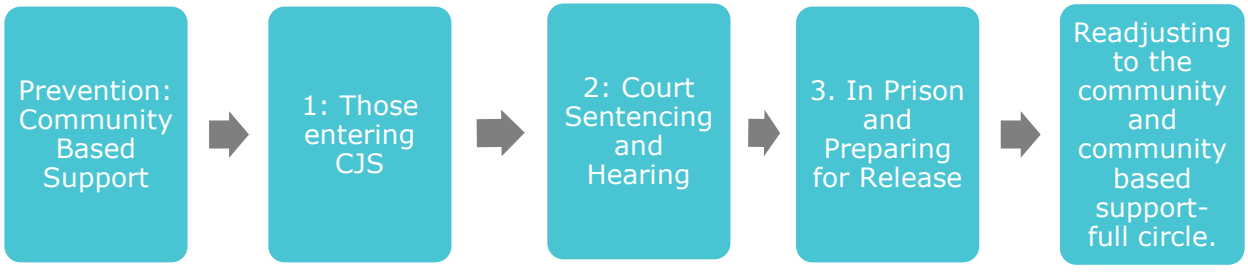
Partnership Co-ordinators will be expected to "lead on **continuity of care** pathways working in tandem **with relevant local partners** and HMPPS colleagues to develop practice related substance misuse and health-related **release planning**. This includes designing and consulting on processes to enable **information sharing**, improving the use of substance misuse and health-related **licence conditions**, and understanding of health and substance misuse **resettlement pathways**.

Probation have recently recruited **three Health and Justice co-ordinators across the South West** to support continuity of care.

Identifying drug-related needs – early intervention

At **every contact point in the criminal justice system** there is an opportunity to identify a drug-related need and engage the person into an appropriate intervention – **early identification** (using accredited screening tools) and intervention will **reduce the risk of further harm**, both to the person themselves and to the wider community, in terms of repeat offending.

The **Intercept Model mapped support** for those affected by **drugs, alcohol, and mental health in the criminal justice system** in Cornwall and the Isles of Scilly and identified the following intervals for prevention and engagement.



The following **gaps** were **identified**

- **Support for individuals in prison** through tailored programs and interventions for problem drinking and drug use and mental health concerns.
- **Ensuring continuity of care for those on discharge** including support to access suitable housing particularly those who are primary carers.

- **Complex needs individuals who identify as female and those transitioning** who may have gone through multiple traumas. In particular those who are high risk and their support throughout the entire model.
- Support for **high-risk serial offenders preparing for and at court**. Missed opportunities to inform sentencing about underlying issues contributing to offending.
- **Screening** for problem drinking and drug use at **community-based level** using validated tools.

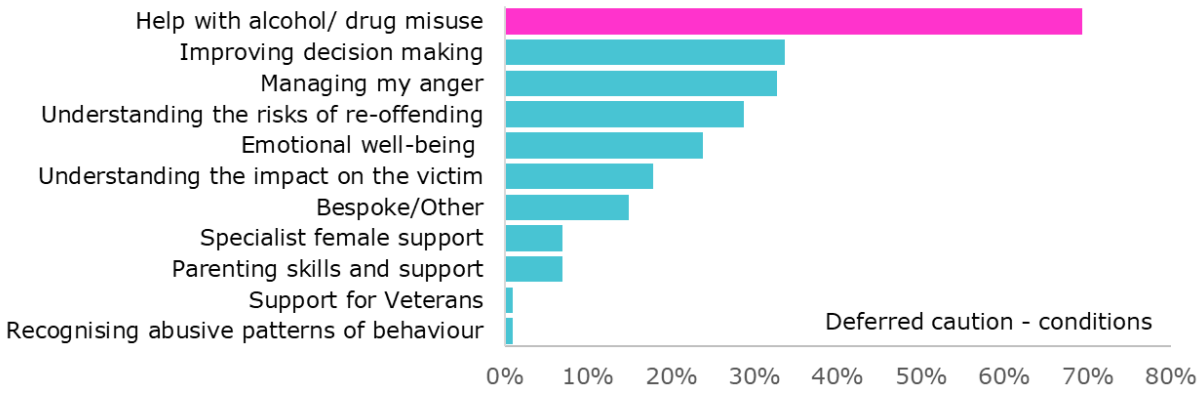
Devon and Cornwall Police's **Pathfinder** scheme is a **voluntary early intervention programme**. It is an evidence-based approach to reducing harm that **holds offenders to account** for their behaviour, whilst **addressing needs** that are directly linked to their offending.

The scheme offers **Deferred Caution** (out of court disposal) and **Deferred Charge** (alternative to court), on condition that a four month 'contract' is successfully complete. The contract is bespoke to the person and will include conditions designed to **support changes in behaviour** and reduce their risk of reoffending. It could also include reparation (for example, paying the victim for any damage caused) or exploring Restorative Justice options, at the victim's request.

The figures for one year for Cornwall show that **3 out of 10 people referred to Pathfinder had committed a drug-related offence**.

Cornwall referrals Jan-Dec 2021	Pathfinder Referrals	Referrals for drug offences	% drug offences	Drug-related need identified[41]	% drug-related need
Deferred Charge	66	21	32%	25	38%
Deferred Caution	142	42	30%	60	42%
Total cases	**208**	**63**	**30%**	**85**	**41%**

For deferred cautions, 'help with alcohol/drug misuse' was the common condition, identified for **70% of people engaged** with the scheme.



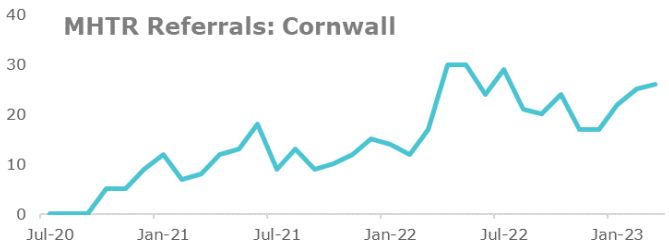
[41] Deferred Charge- identified through keyworker assessment as having a drug or alcohol need; Deferred Caution- those with a condition relating to addressing an issue with substance misuse (note that this is not broken down into drugs and alcohol).

The voluntary engagement rate with Pathfinder is around 50% for deferred caution and 40% for deferred charge – within the year's data that was shared for this assessment, the **majority of people who engaged** in the programme saw a **successful outcome**. Only 5% of the deferred charge cohort and 20% of the deferred caution cohort reoffended or disengaged with the programme.

Mental Health Treatment Requirements

A Mental Health Treatment Requirement (MHTR) can be made as part of a Community Order and is intended for sentencing offenders convicted of an offence (or offences) which is below the threshold for a custodial sentence, where the offender has a mental health problem that does not require secure in-patient treatment. Since October 2020, Magistrates Courts in Cornwall have been able to include MHTRs in addition to the existing Drug Rehabilitation Requirements (DRR) and Alcohol Treatment Requirements (ATR).

A report by The Institute for Public Safety, Crime and Justice from July 2022 indicated that **Cornwall remains amongst the front runners nationally** in terms of referrals for MHTRs.



Local data shows that **referral numbers have continued to increase since early 2022/23**, with the annual total reaching a high of 285 as of March 2023, an average of 24 per month. Overall, 438 individuals have been referred since October 2020.

This increase may suggest that Cornwall takes advantage of a **well-defined and publicised pathway for making referrals**, which is supported and endorsed by the wider criminal justice system at a local level. This may be further demonstrated by the **low proportion of clients that decline an MHTR**, 4% locally versus 11% across the country.

Recent reports of **increasing wait times** between assessment for suitability and sentencing could prove **detrimental to initial engagement** and ultimately, successful outcomes.

As of July 2022, around 16% of individuals fail to complete the intervention, which is in line with the national trend, however a higher proportion of the overall client cohort in Cornwall are **currently receiving the intervention**, possibly a factor of increasing referral numbers and therefore a potential element of pressure on the treatment provider over recent months.

More recent local data would appear to indicate an improving situation with the proportion of clients not completing their intervention appearing to be closer to 12%. Latest local data shows that **72 individuals have so far completed an MHTR intervention**, with a further 151 currently receiving treatment.

The report by The Institute for Public Safety, Crime and Justice indicated a very positive set of results had been achieved by sites offering an MHTR intervention nationally with most individuals, who successfully completed, showing **statistically**

significant positive change using the CORE 34, GAD 7 and PHQ 9 treatment tools for scoring levels of anxiety and depression.

Cornwall was amongst the best performing areas across these measures; however, the report does warn that increases in the volume of clients referred could impact these successes.

Prisons and Probation

Overall, the **proportion of adults in treatment locally** who are (or have been) in contact with the criminal justice system[42] is similar to national rates across all drug groups apart from **non-opiate**, where we have a different split between non-opiate only and non-opiate with alcohol.

DOMES Q4 2022/23	Local		National average
	(%)	(n)	(%)
Opiate	18.1%	241 / 1330	18.7%
Non-opiate	5.7%	17 / 296	13.1%
Alcohol and non-opiate	16.2%	106 / 655	12.9%
All drugs	16.0%	364 / 2281	
Alcohol	8.7%	101 / 1158	7.2%

- **Successful completions** amongst CJS clients are slightly above the wider treatment population currently but the small numbers in each cohort means that the difference is not significant. **Local outcomes for offenders are above the national average** for all drug groups.

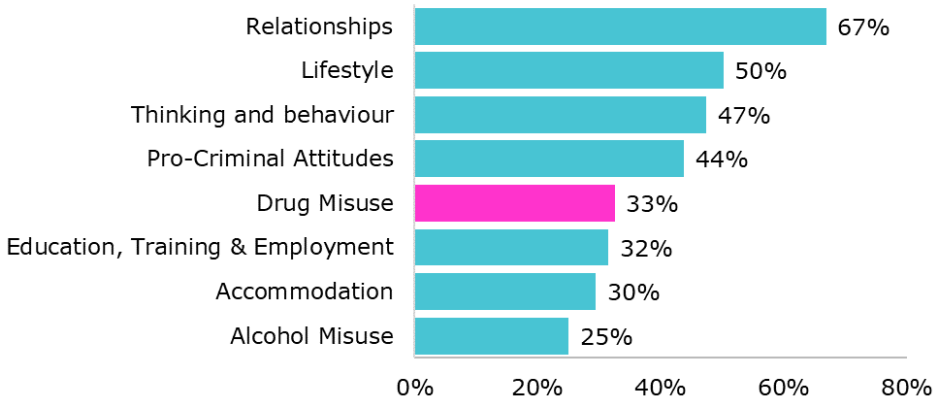
DOMES Q4 2022/23	Local			National average
	CJS (%)	CJS (n)	All (%)	CJS (%)
Opiate	4.1%	10 / 241	5.3%	3.2%
Non-opiate	47.1%	8 / 17	31.8%	28.5%
Alcohol and non-opiate	29.2%	31 / 106	25.8%	27.4%
Alcohol	40.6%	41 / 101	32.8%	35.7%

Routine data provision by Probation services to community safety partners was suspended further to the service delivery changes introduced by the government's Transforming Rehabilitation programme – and this has been recognised as a knowledge gap since 2015.

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

Whilst information sharing arrangements are being refreshed, Probation have provided some headline figures on the **eight criminogenic need areas**[43] from the current caseload.

42 Defined as clients taken onto a CJIT caseload within 42 days of the earliest triage or the first referral source of the treatment journey is a criminal justice referral route
43 Factors that impact on risk of reoffending or risk of serious harm to self or others. Criminogenic needs are recorded in the Offender Assessment System (OASys) - an operational database used to assess risk and need for eligible offenders in prisons and probation services across England and Wales.



- **Family and personal relationships** are most commonly linked to risk of serious harm and/or reoffending (affecting two thirds of adult offenders); historical data indicated high prevalence of domestic abuse in offender relationships (as abuser and person experiencing the abuse).
- At 33%, **problematic drug use is more common than problem drinking** (25%) but about on a par with employment and accommodation support needs. This is a **marked change from our historical data**, where alcohol needs were present in just over half of the offender population. National data shows a similar picture – for both custody and community, **alcohol misuse need was the least prevalent** out of the eight need areas.
- The proportion of adult offenders with a **drug-related need is similar to historical levels** (35% reported in the 2014/15 Needs Assessment).

The 2022 MoRiLE workshop highlighted concerns about the **apparent reduction in assessed level of alcohol need** in Probation caseload – this does not triangulate with alcohol related needs being seen by services and may indicate a need for **training** and re-promotion of drug and alcohol

What else do we know from **past needs assessments**?

- Offenders with a **criminogenic drugs need** are significantly **more likely to reoffend** and have **more complex needs** with three quarters requiring support in 5 or more other areas.
- Short sentence prisoners show **greater use of heroin, non-prescribed methadone, tranquilisers and crack cocaine** in the year prior to custody, and they demonstrate **greater levels of risk-taking** behaviour in terms of drug use, including more injecting.
- Drug use is particularly **problematic amongst female offenders**.

After drug-specific risk factors, **financial problems** present the most increased risk and offenders with drug-related needs are more likely to be **unemployed**. **Mental health problems**, **homelessness** and **domestic abuse** are also more prevalent within this group.

Past drugs needs assessments also identified that only **half of the number** of offenders assessed as having criminogenic drug and/or alcohol needs were being supported in **community treatment services** – with those not receiving support being mostly non-opiate users and problem drinkers. This raised a question

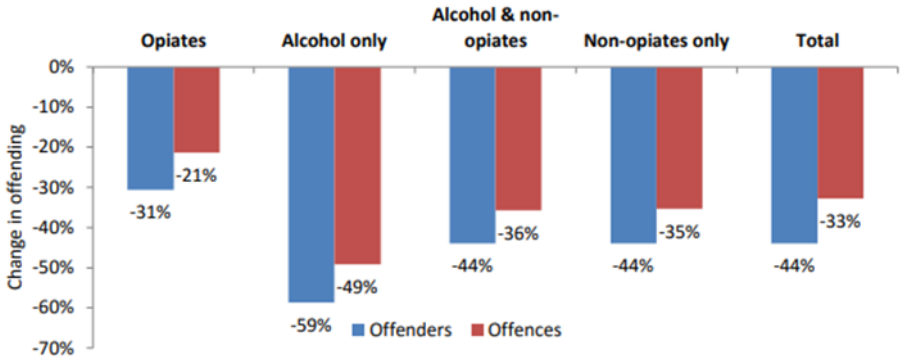
regarding the **skills of offender managers in assessing risk** around substance use and a lack of liaison with community services about specialist assessment.

Analysis carried out by the Ministry of Justice and Public Health England (2017)[44], identified **factors associated with offending** in the years **prior to, and completing community-based drug treatment.**

The analysis found that the following groups were **more at risk** of offending either **before or after their treatment**: men, people from black or minority ethnic groups, homeless and people with a current or lifetime history of injecting drugs.

- Those who were **older**, or in treatment for **drugs other than opiates** were less likely to offend.
- People **more at risk** of offending **during or after their treatment** were those who had been in prison prior to starting treatment or were re-presenting to treatment.
- Those who either **completed** or were **still in treatment** at the end of the analysis period where **less likely** to re-offend.

The chart below shows reoffending changes in the 2 years after starting treatment.



- **Opiate clients had the lowest percentage change** in recorded offenders and offences (31% and 21%, respectively), while the **alcohol only client group saw the greatest reduction** in both offenders and offences (59% and 49%, respectively).

Her Majesty's Inspectorate of Probation[45] published an **evidence base** for substance misuse in 2021. Its primary focus is the **Drug Rehabilitation Order** (DRR) which can be attached to community orders or suspended sentence orders. **Evidence relating to specific interventions** is summarised in the next table.

[44] Impact of community-based drug treatment on re-offending, MoJ and Public Health England (2017)
[45] Her Majesty's Inspectorate of Probation, Evidence Base (2021)

Opioid substitution treatment (OST)	Cognitive Behavioural Therapy
OST can assist with **withdrawal** as well as the **prevention of relapse**. OST has been widely evaluated and there is solid evidence to suggest that this treatment is **effective at suppressing heroin use.** **Crime reduction** has also been observed for those remaining in **continuous treatment**, which often includes access or signposting to a range of additional support services.	While there is some evidence for CBT's effectiveness when compared to no treatment, this has been found to **vary between substances.** This approach can be helpful for those with **comorbid substance misuse and mental health** difficulties.
Building Skills for Recovery	**Online approaches**
Building Skills for Recovery is the accredited **psychosocial substance misuse programme** available both for those in custody and the community. The intervention aims to **reduce reoffending behaviour and problematic substance misuse** with an eventual goal of recovery. An evaluation of an earlier iteration on the programme found that those who **completed** it had **significantly lower rates of reconviction** and **longer-time to reconviction** than non-completers.	Online approaches to treating addiction enable people to access necessary services in a **confidential and anonymous manner.** As such, **digital treatment has the potential to overcome barriers** in seeking assistance for substance misuse, including the stigma associated with more visible, traditional services. Breaking Free Online is a digital treatment which focuses on **strengthening the user's recovery and resilience** from substance misuse through a range of psychological techniques, with versions for both prison and probation settings. An evaluation of the treatment found significant **improvements** in user's **alcohol and drug dependence**, as well as other aspects of **psychosocial functioning.**

The document highlights the need for **better treatment for service users in the community**, and those who have been **recently released from custody** as "**especially vulnerable** to relapse, reoffending, and drug-related deaths".

Ministry of Justice research identified these **barriers for DRR service users**:

- The assessment process
- Staffing issues in treatment agencies
- Waiting times for interventions
- Clashes between probation and treatment appointments
- Travel issues and caring responsibilities.

Service users interviewed felt that "a **lack of consequences** for continual positive drug tests" indicated that staff did not care about their progress. "It has previously been found that **interventions are most successful** where staff are in a position to reliably detect both service users' **accomplishments and infractions**, applying rewards and sanctions where applicable."

Probation staff emphasised the following **barriers to successful treatment**:

- Issues with service users' motivation
- Impact of chronic drug use
- Availability of appropriate services
- Management of breach and compliance.

The importance of a **trauma-informed approach** is highlighted by the evidence base and recognises that many of those with problematic levels of substance use may also have, or still be experiencing trauma.

The weeks immediately after release from prison is recognised as a pivotal time for those using substances. An evidence review undertaken in 2017 (cited in the Dame Carol Black review) identified a number of **weaknesses in the pathway between custody and community:**

- Almost half of the **referrals** made by prison treatment services **were not received** by community treatment service
- Limited opportunities to make referrals with unplanned releases from court and **no joined-up working** with probation services during release planning
- **Low attendance at appointments** or drop-in clinics in the community following release from prison, with limited follow-up on those who did not attend.

"It was also found that service users were much more likely to engage with treatment in the community where treatment services had made contact with them in custody prior to their release."

Continuity of care between prison discharge and engagement in treatment is therefore a fundamental part of reducing reoffending and recidivism. Nationally there is an ambition to ensure that **3 in 4 prison leavers** with a substance misuse issue are **engaging in treatment 3 weeks** after release by the end of 2023.

Currently, both local and national systems are **achieving around half that figure**.

The latest data shows that **148 people in Cornwall left prison** in 2021/22 with a drug related need, around **56 people (38%) engaged successfully** in community treatment within three weeks. This data shows that engagement rates are highest for opiates (52%) and lowest for non-opiates (16%).

A 2022 article from Sky News[46] commentating on this data points to a model in a West Midlands local authority where **62% of prison leavers** are **receiving help**.

- A **whole system approach** has been developed which identifies and **supports offenders** with drug use from the **point of arrest through to release from prison**. The model consists of a diversion scheme for those found in
- possession of drugs, support from drug or alcohol workers for those in police custody and co-ordinated treatment on release from prison.
- Alongside high levels of engagement in community treatment, the area has also reported **low numbers of drug related deaths** with a rate of 2.2 deaths per 100,000 population, less than half of the national rate of 5 deaths per 100,000.

[46] Sky News – Prisoners needing drug treatment on release

Engagement in Treatment

- Currently we have **2,269 people in structured treatment for drugs** (60% opiate and 40% non-opiate) – well above commissioned capacity of 1,600. 2020/21 baseline for the new Grant, including alcohol, is 3,345.
- **Local penetration rate is good** - 62% of the estimated number of Opiate and Crack Users (OCUs) are in treatment (compared with 46% nationally).
- **Caseloads are too high for effectiveness** - 50-80 per worker, much higher than the 40 recommended as best practice. Such high caseloads affect quality of care and treatment effectiveness.
- **Two thirds of people self-refer**, suggesting that other agencies may be unclear about their role in identifying and referring to treatment, which may delay engagement and increase complexity.
- **Abstinence rates in treatment are within the expected range.** Cocaine abstinence has dropped over the last year but the rate of reduction in use has improved, indicating that people using cocaine are **more likely to have reduced their use than stopped altogether**.
- New guidance says that **at least 2% of people should be accessing residential rehab** - we already exceed this with 4%. However, **local waiting times have increased** for this intervention.
- **Additional barriers are identified for minority groups** where different approaches are needed to support engagement with treatment. Further exploration is also needed of **the differences between places**.
- Our **Mutual Aid Programme is highly valued** and has developed significantly since the last assessment, as well as identifying the potential for even more. This to **run concurrently alongside treatment**, building engagement from the start as well as developing local recovery communities to sustain the gains of treatment over the longer term.

A Framework for the Treatment System

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

Tier	Description	What does it include?
Tier 1	Generic services – Health, Social Care, Probation, Citizens Advice, Job Centres, Housing	Screening, identification, referral, delivery of brief interventions in wider non-specialist services
Tier 2	Open Access Services (specialist)	Outreach Telephone help line On-line Drop-in services Needle exchange Aftercare and Recovery

Tier	Description	What does it include?
Tier 3	Structured specialist community treatment	Assessment Stabilisation Care Planned Withdrawal Maintenance Pharmacotherapy (Clinical) Structured psychosocial interventions
Tier 4	Residential specialist services	In-patient Residential rehab

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

All services work with a wide range of people, including those who use drugs and alcohol, but their sole purpose is not drug or alcohol treatment. The role of non-specialist services, includes, as a minimum, **screening for problem drug and alcohol use** using accredited screening tools **and referral** to local treatment.

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

- Allows **generic agencies to identify drug problems** and conduct a basic level assessment (screening)
- Defines a **simple 'map' of local services** and the **processes of referral** into the system

Such professionals need to be sufficiently trained and supported to work with people who use drugs and alcohol **who are often marginalised from, and find difficulty in, accessing generic health and social care services.**

As the majority of referrals continue to be self-referral, this indicates that there remains **a lack of understanding, skills and abilities to identify, screen and refer** by agencies. A lack of identification and referral, and waiting for a person to self-refer, can delay treatment by a significant period during which they may continue to harm themselves and others; this is a priority to improve.

The **DAAT training programme is available to non-specialists** to develop awareness and the ability to identify, screen and refer children, young people and adults. A **training report** that shows the level of delivery and range of professionals who have accessed the training to date is available as part of the separate **supporting documentation** set for this needs assessment.

- Take up amongst Housing, Job Centre Plus and domestic abuse and sexual violence services has been high. Rollout in **Adult social care and children's services teams** has been challenging; **routine screening has yet to be established but should be a priority** for these services. As of January 2023, 88 frontline staff from Adult Social Care had attended Basic Drug Awareness and 55 had attended Alcohol IBA training.

There is a well-established **Pregnancy and Substance Misuse pathway** that was revised and updated in 2015 and 2016 and is being reviewed again now. A similar pathway and process has **yet to be established with health visiting.**

Tier 2: Open Access drug and alcohol treatment services

The aim of the treatment in Tier 2 is to **engage people in treatment who are dependent on drugs and/or alcohol and reduce drug-related harm**. Tier 2 services do not necessarily require a high level of commitment to structured programmes or a complex or lengthy assessment process.

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

People who use drugs have access to the following Tier 2 open-access specialist drug interventions in Cornwall:

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

Recording of activity related to non-structured treatment is not mandated for the National Drug Treatment Monitoring System. OHID **measures treatment system effectiveness based on structured treatment activity** only. Locally, however, we use our case management system to record information about people engaging in non-structured services.

People in non-structured services:

- **2,140 people with a Tier 2 episode** in service during 2021/22
- 1,056 (40%) episodes are dedicated to **Outreach**
- Three quarters of all these clients are **men**, most likely to be aged 30-39
- Of the 1,035 episodes closed in 2021/22, **20% closed successfully** (206 episodes) with the person leaving treatment **drug free or starting a tier 3 programme.**

Tier 3: Structured treatment

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

Community structured services include psychosocial interventions and structured counselling, cognitive behavioural therapy, motivational interventions,

methadone maintenance programmes, community detoxification, or day care provided either as a drug- and alcohol-free programme or as an adjunct to methadone treatment.

- Tier 3 services require a **comprehensive assessment and a care plan** to be agreed between the service provider and person using drugs and alcohol.
- People in community structured services will have a **Recovery Care co-ordinator**, responsible for co-ordination of that individual's care.
- Tier 3 services and mental health services should work closely together to meet the needs of people in drug and alcohol treatment who have a **dual diagnosis** (psychiatric co-morbidity);

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

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

Tier 4 services: Residential services

Residential services are designed for people with the **highest level of presenting need**. Tier 4 treatment covers specialist, medically managed in-patient detoxification and residential rehabilitation interventions.

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

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

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

Numbers in structured treatment

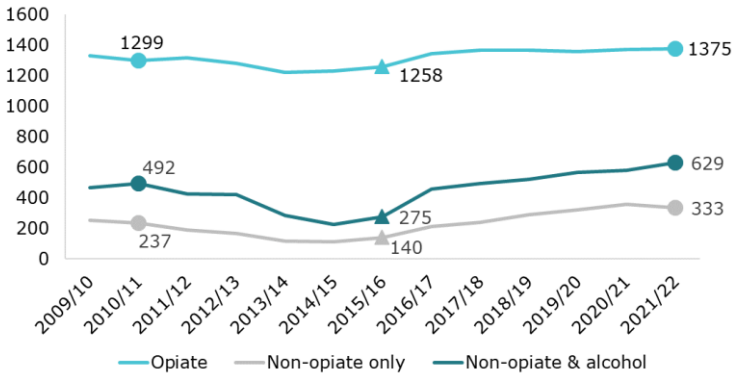
NDTMS data[47] for the 12 month period to March 2022 shows that there are **2,337 people in treatment for drugs** (60% opiate and 40% non-opiate) and this is well above the current commissioned capacity of 1,600. The 2020/21 baseline provided for planning against the Supplemental Substance Misuse Treatment and Recovery Grant (SSMTRG) is **3,345 people**, which includes people in treatment for alcohol only.

There was a steep rise in people entering treatment in 2016/17 and new presentations stayed at this same high level for the next three years.

Recent years have seen a **reducing number of people enter treatment** (but still relatively high). The overall number in treatment continues to increase (indicating that the number leaving the system is less than the numbers of new people coming in).

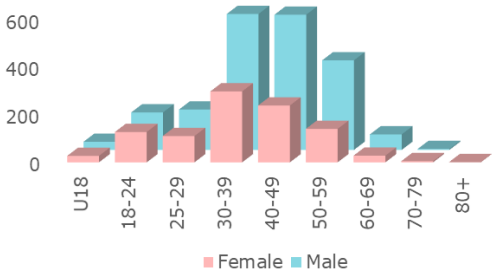
- **Opiate users** in treatment have increased by 9% since the last needs assessment, with most of the rise in 2016/17 and relative stability since then.
- Whilst lower in volume, the increase in **non-opiate users** in treatment has been greater in both number and percentage terms. The number has **more than doubled in the last 5 years** and is continuing to grow.

Source: NDTMS ViewIT



Local People Profile[48]

- The majority of people in treatment are **aged over 30 and male**. Two thirds are men and one third women; **more women** than the national profile (33% vs 29%), and this is reflected across all drug groups.
- Cornwall has a **higher proportion of younger adults** in treatment than the national profile (18-29 years, 21% vs 15%), but lower proportions aged 30-49 years and this is for both men and women.
- 5% of people are identified in the data as being from a **minority ethnic group**, compared with 16% nationally (in line with Cornwall's population).[49]



47 As reported in ViewIT on ndtms.net
48 Source unless stated is the Adult Drug Commissioning Support Pack: 2023/24: Key Data Planning for drug prevention, treatment and recovery in adults (OHID)
49 ONS UK Census 2021; 96.8% of people in Cornwall identify as White

- People from the **Gypsy and Traveller community** are 6 times more likely to be in treatment[50] than the general population – the differential is higher for drugs (6.5 times) than for alcohol (3.7 times).
- People in treatment in Cornwall are **more likely to disclose a disability** (44% vs 29%) with the majority having a behavioural or emotional condition (29%, indicating a 7% rise on 2021/22), just under a fifth having a physical disability (17%) and around one in twenty disclosing a learning disability.
- **4% of people are recorded as being Gay/Lesbian or Bisexual**, marginally higher than national profile.[51] Over one in every ten clients either did not wish to state their sexuality, wasn't sure of their sexuality or didn't have this information on their record.

Substance use

- Our local treatment population **remains predominantly opiate users** (59%) but the proportion of non-opiate users has grown over the last 5 years (from 25% in 2015/16).
- We have a much **lower prevalence of crack cocaine use** than the national profile (16% vs 50%). **Higher use of most other drugs** including alcohol, cocaine, cannabis, benzodiazepines and illicit use of Prescription Only and Over the Counter Medicines (16% vs 9%).
- **Locally people in treatment are less likely to be smoking tobacco** at treatment start (42% vs 62%) and show higher levels of tobacco abstinence at treatment review. It is important to **link this cohort into smoking cessation initiatives** delivered by Public Health.

The Treatment Journey

Routes into treatment

- **The most common route into treatment is self-referral,** as it is nationally, but our local percentage is higher (64% vs 57%). This suggests that **other agencies may be unclear about their role** in identifying and referring to treatment, which may delay engagement and increase complexity.
- **Criminal justice referrals are around the same level as the national rate** (16% vs 17%) – and this has risen from just 9% in 2020/21 – and predominantly come through **Prisons and Rehabilitation Requirements** (Alcohol Tretament Requirements and Drug Rehabilitation Requirements).
- **Other referral routes are broadly in line** with the national picture. This is a change from 2019/20 when we saw higher rates of GP and hospital referrals.
- **Very few people wait** 3 or more weeks before starting their first intervention (<1%) and this is in line with the national figure.
- Rates of **early unplanned exit are lower than the national rate** (13% vs 18% nationally), although do appear to be rising.[52]

50 Local case management system (Halo) data, all people in treatment in 2019-2022.
51 ONS UK Census 2021; 3.2% of the national population identify as LGB+ or 'Other sexual orientation'
52 6% locally in 2020/21

Time in treatment

National data shows that **adults with opiate problems who successfully complete within two years** of first starting treatment have a higher likelihood of achieving sustained recovery.

Adults that have been **in treatment for long periods of time** will usually **find it harder to successfully complete** treatment. For adults with opiate problems, this means six years or over and it's over two years for adults with non-opiate problems.

- **Non-opiate users are engaged in treatment for longer** locally:
  - 13% of non-opiate users and 14% of non-opiate and alcohol users have been in treatment for 2 years or more (compared with 3% and 4% respectively for these groups nationally). This has **increased over the last year** so should be monitored.
- Long term treatment for **opiates (6+ years) is in line with the national profile** at 30% (national 28%). 36% have been in treatment for under 2 years, compared with 42% nationally.

These figures refer to time in treatment for a **person's current journey**, it is worth noting that analysis of people with **one or more open episodes at any point** between April 2018 and March 2022 **substantially increases** the proportion of non-opiate users in treatment for 2 years – for non-opiate users it increases to 17% and for users of non-opiates and alcohol it increases to 21%.

In treatment outcomes

Data from NDTMS suggests that **adults who stop using illicit opiates in the first six months** of treatment are almost **five times more likely to complete successfully** than those who continue to use.

The **Treatment Outcomes Profile** (TOP) tracks the progress drug users make whilst in treatment. TOP data is used to provide information on rates of abstinence from drugs and statistically significant reductions in drug use and injecting.

- **51% of opiate users were abstinent** at the latest reporting period[53] which is around the middle to upper end of the expected range (31%-60%).
- **For both crack and cocaine 50% have stopped using**, and in both cases this figure is towards the upper end of the expected range (14-59% for crack and 26%-58% for cocaine). It is noted that the **crack and cocaine abstinence rates are based on smaller cohorts** and hence more variable.
- The picture for **significant reductions** at six month review shows an increased percentage for opiates and cocaine. 24% had signficantly reduced their opiate use (up from 19%), 11% reduced their cocaine use (up from 7%). Crack is around the same (24% now vs 22% last year).
- **67% of adults are not injecting at the six month review point**, around in the middle of the expected range (43-91%).

53 DOMES Q3 2022/23, Latest period: 01/01/2022 to 31/12/2022.

Focus on Protected characteristics

Women

Drug using communities are often small and with women making up one in three service users,[54] it is common for women to encounter their former partner or abuser in group settings. Better engagement and outcomes for women in treatment are supported by:

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

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

All **best practice guidance** outlines the need for: **multi-agency** working; evidence **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.

Learning disabilities

Those with learning disabilities are **less likely to receive treatment or remain in treatment** for problem substance use.

The number of referrals into services where a Learning Disability is identified has been **slowly increasing in recent years**, accounting for around 6%[55] of all referrals in 2021/22.

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

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

[54] 875 people across commissioned drug and alcohol services, 2021/22

[55] 45 people requiring support with opiates, non-opiates or alcohol and non-opiates

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.

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

- **Screening for learning disabilities** in drug and alcohol services and screening for substance use in learning disability services, as part of initial assessments.
- Training for staff in drug and alcohol services in how to **tailor their approach** to those with learning disabilities. **Training for learning disabilities services** around substance use.
- Information and interventions **tailored to individual's communication and learning needs**. Messaging and topics need to be simplified.
- A **one-to-one approach** rather than group work.
- **Shorter sessions** but a longer time in treatment with maintenance sessions.
- A **patient, flexible, teaching approach** using repetition and fixed goals set over short time frames; incentives, role play, quizzes, pictures and games.
- Widening a person's **social support network**.
- Involving **family/carers** in treatment.
- Access to **other support services** to help people address the reasons they may be using substances e.g. sexual abuse and bereavement.

Our local treatment population contains around **150 individuals with a learning disability**. While the largest group of these (44%) appear within the opiate users' group, it is actually slightly more likely to find an individual with learning disabilities in treatment for non-opiate or alcohol and non-opiate use.

Older adults

Older people have similar barriers to accessing support as people with disabilities – including a lack of awareness about support available, situational vulnerability, social isolation and physical accessibility due to mobility issues.

Age UK[56] also identify **some general barriers experienced by older people** seeking help:

- Not wanting to burden the system
- Unaware of the value of services
- Challenges negotiating institutions
- No/irregular computer/internet access
- Lack of service availability
- Lack of awareness of what is available

The number of older people (55+ years) referred into services in the latest year is low, less than 30 people, however **this number has grown by more than 80% since 2019/20**.

[56] Socially excluded older people and their access to services, 2020

Adults with care and support needs

Substance use may be the main reason for a person's involvement with social care or it may be one of a number of overlapping experiences. Currently, Adult Social Care data is **not able to distinguish between alcohol and/or drugs** as a care and support need with 'substance misuse' recorded instead.

- Of the 7,119 service users open to Adult Social Care in October 2021, 48 had been identified as having a primary or secondary support reason of substance misuse (0.7%).

Referrals from social care into drug treatment account for only **1% of referrals over the last three years**. Whilst numbers are still low, they have increased in the last year (3% of new referrals, similar to the national rate).

The Alcohol Needs Assessment flags that there is a specific **gap in practitioner' knowledge about applying the Mental Capacity Act** (2015) and the Care Act (2014) to those who have a substance misuse problem. This has been highlighted in a local safeguarding case study.

LGBT+ adults

5% of people in treatment are recorded as being Lesbian, Gay or Bisexual, broadly in line with the national rate for people in treatment (6%).[57]

Data on sexual identity is patchy, however - one in every ten clients either did not wish to state their sexuality, weren't sure of their sexuality or didn't have this information on their record.

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

A Stonewall publication[58] about health and LGBT individuals in Britain stated that high proportions of LGBT people have:

- Experienced **inappropriate curiosity** (25%).
- Been **'outed' without their consent** by healthcare staff in front of other staff or patients (10%).
- Experienced a **lack of understanding of specific lesbian, gay and bisexual health needs** by healthcare staff.

People from minority ethnic groups

5% of people in treatment are recorded as being from a minority ethnic group, compared with 10% nationally. Our local population is significantly **less ethnically diverse** than the national profile, but this is in line with the population of Cornwall.

---

[57] Based on national estimates taken from the Annual Population Survey, 3% of the population aged 16-74 identify as LGB (Office for National Statistics, 2020)

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

It is no longer considered good practice to look at the needs of people from ethnic minority groups as a single homogenous group, as this acts as a form of discrimination, not recognising that different groups will have different experiences and needs.

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

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

38 people are from the Gypsy and Traveller community, accounting for about one in every 30 clients in the treatment system.

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

In treatment 2021/22 - stated Ethnicity	No.	%
Asian	6	0.2%
Bangladeshi	<5	
Indian	<5	
Pakistani	<5	
Other Asian	<5	
Black	7	0.3%
African	<5	
Caribbean	<5	
Other Black	<5	
Mixed	34	1.4%
White and Asian	7	
White and Black African	7	
White and Black Caribbean	7	
Other Mixed	16	
White	2,352	95.8%
White British	2,283	93%
White Irish	9	0%
Other White	60	2%
Any Other	6	0.2%
Gypsy and Traveller	*38*	*1.5%*
Not stated	*45*	1.8%

NB any number less than 5 is suppressed

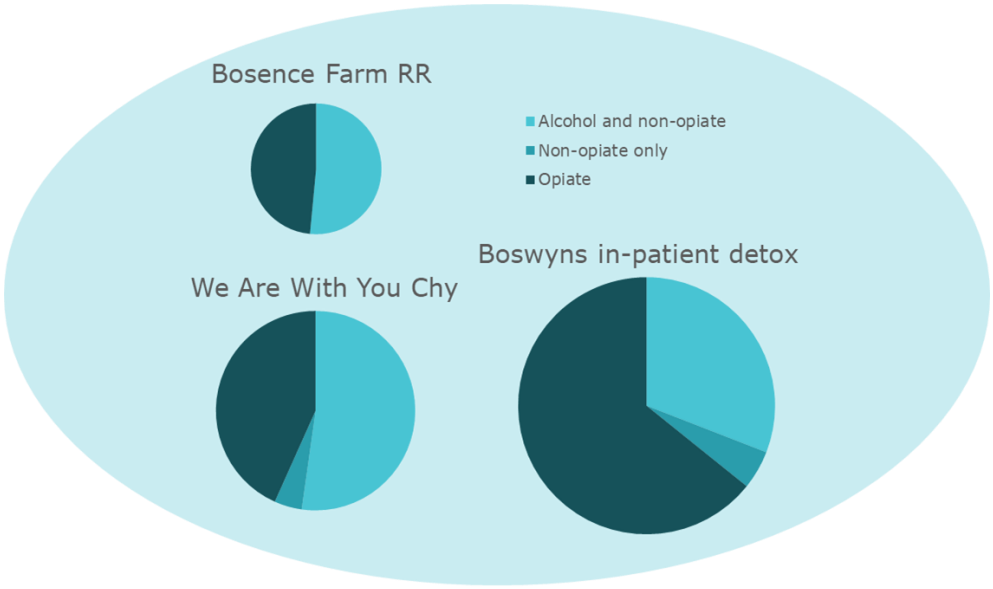
- **Socio-economic factors** – reliance on partner/family
- **Language constraints**, particularly if English is not the first language
- **Immigration** status
- **Social isolation**; fear of being ostracised from the community
- Lack of understanding about welfare benefits and access to help
- Fears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

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

In patient and residential treatment (Tier 4)

Residential rehab provision has been maintained locally, whereas **nationally this has declined**. Responding to this, the national guidance states that at least 2% of people in treatment should be in residential rehab.

- We **already exceed this with 4%.** An additional **10% of people locally are in in-patient interventions** compared with only 3% nationally.



In 2021/22 7% of all clients (192 people) across all drug groups in treatment entered into a Tier 4 episode, 54% of these went into in-patient detox and 46% to residential rehabilitation (based upon at least one episode per setting per client).

The majority of **in-patient detox episodes are for opiate users** while individuals in **residential rehabilitation** are slightly more likely to have an **alcohol and non-opiate treatment need.**

Mutual Aid

Mutual Aid requirements

Mutual Aid is a set of community groups arranged to act as **a support network for those going through recovery**.

They act as peer mentor style support with attendees at **all stages of their recovery** acting as a support network for each other. The benefit of this is that those further along in their recovery journeys can offer advice to those who are new to recovery as well as provide hope for sustained recovery.

Whilst we have a wide range of 12-Step provision locally, it is a requirement of the Community Services contract that **alternatives to the 12-Step programme** are delivered for the much larger population who may not benefit from the 12-Step approach. Further, that all people are offered, made aware of and encouraged to **utilise the full range available**.
The service provider (and commissioners) must keep **up-to-date records of all Mutual Aid groups available** locally and ensure Key Workers offer this as an option and, wherever possible, include in their care plan from the start.

As part of this requirement, service users must have **access to Mutual Aid groups 7 days a week** and have a choice of groups to attend, so that they can pick the one that best suits their needs.

Local Provision

With You have a designated Mutual Aid Lead who liaises with the local Mutual Aid groups to ensure service users have all the relevant and current information. They also bridge the gap between local Mutual Aid groups and Key Workers within the service as well as partner organisations and Cornwall Council.

The Mutual Aid Lead also **supports the commissioning team** in attending local meetings when required, such as obtaining feedback to inform the local Needs Assessment.

Key Workers discuss mutual aid with all service users throughout their treatment journey and where applicable it is included in the service user's care plan.

> "Yes - I highlight MAP groups as an option for clients… If a client wishes to set this as a goal, to attend a MAP group, then yes" [it is included in care planning]
> Key Worker

> "My key worker advised me to try the MAP meetings and they have been an invaluable part of my recovery"
> Service User

Locally there are a range of Mutual Aid groups both internal (provided by the Service Provider) and external:

- Alcoholics Anonymous = 34 (+30 online) with at least 2 meetings a day
- Narcotics Anonymous = 10 (+2 online) with at least 1 meeting a day
- Cocaine Anonymous = 2 (+10 online) only 2 face to face per week
- Drug Addicts Anonymous = 1 (+1 online)
- Marijuana Anonymous = 12 online only as no local provision (includes a newcomer meeting and a LGBTQ meeting)
- Families Anonymous = 1 on a Tuesday (+1 online)
- Al-Anon = 6 (+ WhatsApp group)
- Local Recovery Group (internal Service Provider MAP Groups) = 4 (+4 online) every day apart from Fridays and Sundays

Mutual Aid meetings are **available in sites across Cornwall** through a range of organisations.

The number of **online meetings increased exponentially** due to the pandemic and the need to ensure support groups were still available during this time. For some service users this has made it easier to attend, whilst others have struggled due to issues with technology and the lack of a more personal connection with the group. Therefore, in order to **maximise the reach** of these groups there is now **both online and face to face options** available.

> *"It's so much different now, there are so many elements available that you can access at every step of the way. You can see the way through. It's like a Yellow Brick Road to Recovery"*

Consultation showed that our **Mutual Aid Programme is highly valued** and has developed significantly since the last assessment, as well as identifying the potential for even more.

This to **run concurrently alongside treatment**, building engagement from the start as well as developing local recovery communities to sustain the gains of treatment over the longer term.

What groups are available locally?	Number of meetings						
	Mon	Tue	Wed	Thu	Fri	Sat	Sun
MAP Groups (MAP + 4 online)	x1 online	x1 Bude	x2 Falmouth, Truro Arts & crafts group after Truro meeting x1 online	x1 national Open to all but mainly Cornwall attendees (online)		x1 Truro Recovery cafe afterwards x1 online	
Alcoholics Anonymous[59] + 30 online per week	x5	x6	x5	x3	x8	x2	x5
Narcotics Anonymous[60] +2 online per week	x2	x2	x2	x1	x1	x1	x1
Cocaine Anonymous[61] + 10 Devon and Cornwall online per week (some social)	x1			x1			
Drug Addicts Anonymous[62]	x1				x1 online		
Marijuana Anonymous[63] *Online only as no local in person meetings*	x2	x1 Newcomers meeting	x2	x3 Includes LGBTQ meeting	x1	x1	x2
Families Anonymous + 1 Online Camborne		x1					
Al-anon[64] + WhatsApp Group by Truro AA	x2	x1	x1	x1		x1	

59 Face-to-groups https://www.aa-cornwall.co.uk/about-3 and on-line meetings https://www.aa-cornwall.co.uk/zoom-meetings
60 Search function on their website for face-to-face groups or online
61 https://meetings.cocaineanonymous.org.uk/meetings/?tsml-day=any&tsml-query=cornwall
62 https://www.drugaddictsanonymous.org.uk/meetings/south-west
63 On-line only meetings http://www.marijuana-anonymous.org.uk/meetings.html
64 https://www.al-anonuk.org.uk/find-a-meeting/?county=cornwall

Workforce Development

The aim of the second part of the **Independent Review of Drugs in 2019** was to make sure that vulnerable people with drug and alcohol problems get the support and treatment they need to recover and turn their lives around. As well as considering the level of funding required, it had a **major focus on workforce**.

Recognising the **impact of a decade of disinvestment upon the workforce**, and thereby the quality of commissioning and treatment, the Review recognised that achieving these improvements in treatment and wider recovery "*will require significant rebuilding of capacity, including recruiting many more professionally qualified staff and trained support workers.*"

Amongst the call for urgent additional investment, was a need for expansion in:

- The number of **professionally qualified workers** (psychiatrists, psychologists, nurses and social workers), and development of training to improve the skills of drug workers and peer recovery workers
- Local areas' support for **peer-led grass-roots recovery communities and peer mentoring**, complementing professionally led services

- **Recommendation 9:**
  We recommend that DHSC commission Health Education England (HEE) to devise a comprehensive strategy to increase the number of professionally qualified drug treatment staff (psychiatrists and other doctors, psychologists and other therapists, nurses and social workers), and set occupational standards, competency and training requirements for drug workers and peer recovery workers. Government should also fund HEE to cover the costs of training the workforce.
- **Recommendation 10:**
  We recommend that the Academy of Royal Medical Colleges, working with appropriate other bodies, be commissioned to develop a professional body, a Centre for Addictions, for all members of the substance misuse workforce. DHSC should provide seed funding to enable this.

Rebuilding services: workforce

The **drug treatment and recovery workforce has deteriorated** significantly in quantity, quality and morale in recent years, due to excessive caseloads, decreased training and lack of clinical supervision.

A recent workforce survey 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. **Focus should be on providing high-quality personalised care**, rather than paperwork.

The availability of **training placements for the next generation of specialists has reduced**, and so too has professionals' capacity to train and support drug workers and peer workers.

The only effective treatments for people dependent on non-opioid drugs are **psychosocial interventions** including cognitive behavioural therapy, yet people with **professional skills in these areas are in very short supply**.

Drug workers are not always properly trained or supervised and 10% of them are volunteers. **Similar issues affect peer workers** although people with lived experience, working as peer supporters or mentors, have a critical role to play in any well-developed drug and alcohol treatment service.

The **disruption caused by frequent retendering** of drug treatment services has made recruitment difficult and has caused many to leave.

Job security and access to professional development are not always available. Rebuilding the workforce is going to require sustained focus and financial investment over the medium to longer-term. This requires development of a workforce strategy that complements HEE's workforce strategy for mental health services. Clear **occupational standards for drug workers** and **peer recovery workers** are also needed, including a competency and training framework.

The Government invested an **additional £80m in drug treatment services** in 2021/22. This funding saw the field successfully **recruit around 800 additional staff in 9 months**. Although the recruitment focused predominantly on drug and alcohol workers and peer workers, this demonstrates that the substance misuse sector can use **additional investment to rapidly expand** the workforce.

In July 2021, the Government responded to recommendations in part 2 of Dame Carol Black's review with a **new 10-year drug strategy**: from Harm to Hope and significant new investment, including **an additional £532m for drug and alcohol treatment and recovery services** from 2022/23 to 2024/25.

The new 10-year drug strategy specified that the **additional funding should deliver:**

- **800** more medical, mental health and other professionals
- **950** additional drug and alcohol and criminal justice workers
- **Sufficient commissioning and co-ordinator capacity** in every local authority (LA)

To achieve this, the Government committed to a range of actions to support workforce transformation including:

- Work to implement a **comprehensive strategy to expand the workforce** through effective recruitment and retention
- Work to **define and improve the training and skills** of all sections of the drug treatment workforce, including registered health professionals, drug and alcohol workers and peer supporters

National Programme delivery

Office for Health Improvement and Disparities (OHID), HEE and NHS England are working closely to **engage with a wide range of services and stakeholders** to develop the overall transformation programme. The national programme is focussing upon the following organisation types:

- **Local authority commissioning teams** for drug and alcohol services
- **Local authority commissioned services**, including adult and young people's community services for drug and alcohol treatment and recovery, residential rehabilitation, and inpatient detoxification services, including NHS and third sector providers
- **Lived experience recovery organisations** (LEROs)
- **Services jointly delivered** between NHS and Local Authorities to improve care for people with co-occurring mental health needs and drug and alcohol treatment needs

The programme will also ensure that its outputs, such as the new workforce strategy, **reference and align with NHS workforce strategic planning for other key service types** such as NHS-commissioned substance misuse teams in secure settings, mental health services and alcohol care teams (ACTs), and **locally services are encouraged to plan in partnership with NHS services**. This will ensure better integration of services/roles within Integrated Care Systems (ICSs).

"LAs and NHS partners should collaborate as part of new ICS structures to jointly plan this expansion of workforce and transformation of services. Services will need to work closely together to plan transformation of services for people with co-occurring needs. This work should ensure that provision is made to support people with their drug and alcohol treatment needs, alongside their mental health needs, rather than expecting people to attend different services with no alignment or integration."

Drug and Alcohol Workforce Census 2022

Health Education England (HEE) commissioned **the NHS Benchmarking Network** to conduct a Drug and Alcohol Treatment and Recovery Services National Workforce Census, looking at the workforce as of 30 June 2022.

This is **the first time this information has been gathered on this scale** and subsequent reports are planned for later in 2023 and 2024 respectively.

The report analysed data across the following sectors:

- Local Authority commissioned providers of adult and young people's treatment and recovery services in the NHS, Local Authorities (services directly delivered by the Locla Authority), voluntary, NHS and independent/private sectors.
- Local Authority commissioning workforce
- Lived experience recovery organisations (LEROs)

The findings of this report will **enable Health Education England to work collaboratively with key strategic partners** to inform education and workforce planning and investments for now and in the future. The report and its findings have also informed the, soon to be published, **Drugs and Alcohol Treatment and Recovery Workforce Strategic Framework** and will support the upcoming comprehensive Workforce Strategic Implementation Plan.

Workforce planning guidance

In March 2023, **OHID distributed workforce planning guidance**. This **guidance was developed following extensive sector engagement** including focus groups with staff and people with lived experience, one-to-one conversations with 67 staff and volunteers, and a survey completed by 476 frontline staff and volunteers.

The resulting workforce planning guidance was intended to **support Local Authorities and their delivery partners** in 2023/24 Supplemental Substance Misuse Treatment and Recovery Grant (SSMTRG) planning.

The guidance pack provided key actions for Local Authorities and delivery partners to consider in 2023/24 budgets and plans.

The new national Drug and Alcohol Treatment and Recovery Workforce Transformation Programme for 2022/25

This is the **first phase of the workforce programme** that will run for the duration of the drug strategy 'From Harm to Hope: A 10-year drug plan to cut crime and save lives'.

The Strategic framework for the drug and alcohol treatment and recovery workforce, 2023

4 key areas of focus for workforce development:
1. Recruitment and retention
2. Training and skills development
3. Career progression
4. Supervision and support with a focus on clinical supervision.

Recruitment and Retention

Role-specific Recruitment and Retention:
Develop plans to **recruit more registered roles** (especially in areas who received enhanced money in 2022/23) and to retain and train currently non-registered workforce notably drug and alcohol workers.

Whole workforce recruitment and retention:
- Commissioners must support service providers to ensure they are commissioning for workforce development to **enable caseloads to be regularly reviewed** and active caseload management to be prioritised.
- Consider the importance of **recruiting a diverse workforce** to deliver culturally appropriate services and reflect the national and local populations.

Attending **university and community job/careers fairs** and engaging people who may be interested in exploring **an opportunity to develop new skills** or work in a new sector.

- Contracts of employment should **commit to paying staff in line with market value**. Consideration should be given to the impact of inconsistencies between service providers for pay, contractual rights and working conditions.
- **Consider higher pay** where employee benefits, such as pensions and leave allowances, are unable to be matched and may want to consider **benchmarking against the NHS Agenda for Change** (AfC) for pay and working conditions, including allowing for annual pay increments.
- **Local Authority leads and service providers** should ensure that they are represented on the **Local Enterprise Partnership** (LEP) or equivalent.
- **Employee wellbeing must be a priority** for all employers. Evidence-based guidelines should be used, such as NICE guideline NG212 mental wellbeing at work and the World Health Organization's guidelines on mental health at work, which includes recommendations for health workers. Services must also ensure that they are regularly carrying out the Health and Safety Executive's stress risk assessment to prevent and minimise workplace stress.

Spotlight on student placement opportunities:
This should include (but need not be limited to): pre-registration nurses; social workers; psychologists; occupational therapists; pharmacists; and psychiatrists.

Whole workforce training and skills development

Enable access to regular continuing professional development (CPD). This should include offering or enabling CPD opportunities for registered professional staff in line with the requirements of their regulator.

About CPD:

- This should **include service providers and commissioners working together** to ensure that budgets for CPD are reflected in workforce development.
- **All roles** within the drug and alcohol workforce require **appropriate ongoing training and CPD**, with learning activities tailored to their expertise and role responsibilities being offered.
- This will enable the **whole workforce** to engage in suitable CPD and skill development to **enhance their confidence, competence and abilities** within their role.
- **Employers need to invest in the skills and development of all their employees** and ensure that workforce management allows for protected time for ongoing CPD to be prioritised.

Career progression

Given the **multi-faceted nature of dependence and recovery**, service providers should **consider developing career progression in a "specialism" model** across services for drug and alcohol workers to further develop into, while remaining on the frontline.

This may include **family engagement**, housing, **dual-diagnosis** (co-occurring mental health and drug/alcohol use conditions), **employment**, working with particular populations, **physical health promotion** and training roles.

Services should be **creative and flexible with role development** depending on local needs and offer CPD accordingly. Contracts, employment packages and job titles should recognise this additional clinical responsibility. This would **provide a career journey**, enhanced job satisfaction, improved care and aid the retention of skilled staff in frontline roles.

- Promote **a culture of skills and career development**.
- **Create development opportunities** for registered professionals in the sector.

Whole workforce supervision and support

Services must be led by **team leaders and service managers who are skilled and trained** in managing a wide range of staff exposed to **vicarious trauma.**

- Ensure every staff member delivering treatment to people using the service, regardless of their level of skill and experience, has **access to high-quality clinical supervision**. Service providers must ensure clinical supervisors are appropriately trained to carry out high-quality supervision and should receive regular clinical supervision themselves.
- Ensure **clinical supervisors are appropriately trained** to carry out high-quality supervision and should receive regular clinical supervision themselves.
- **Deploy the skills of registered professionals** to provide high-quality clinical supervision, development and training to staff.
- **Utilise quality-assured external provision** of clinical supervision where there is a temporary shortage or lack of appropriately trained supervisors.
- **Ensure managers and team leaders are appropriately trained** to carry out high-quality management supervision and should receive regular management supervision themselves.

Workforce planning self-assessment criteria

The Commissioning quality standard: alcohol and drug treatment and recovery guidance provides criteria by which the system will know if the workforce is meeting the needs of the people they treat, as well as examples of evidence it should have. This can be used as a self-assessment tool in workforce planning.

You will know you are achieving this standard if you meet the following criteria:

1. Treatment services employ a **multi-disciplinary workforce** who are competent to treat and support the treatment population, including people with co-morbidities.
2. All members of the workforce who provide care and support have a **caseload that is clinically safe and appropriate** to be able to deliver quality treatment.
3. Treatment **service specifications and legal contracts make sure that service providers comply** with treatment workforce standards. This also

includes any mandatory training and development plans for the workforce and the partnership has dedicated funding to support this.
4. **Any gaps in skills are identified** by a training needs analysis.
5. **Entry level roles and opportunities** for trainee posts, including addiction psychiatry posts, are incorporated into workforce strategies and clear career progression routes are available.
6. All members of the treatment workforce receive **regular supervision**, including clinical supervision.
7. The partnership supports **opportunities to exchange staff** between different partner organisations to **promote skill and practice sharing** and to improve communication and collaboration.
8. There is a **long-term local treatment and recovery workforce strategy** to maintain a flexible and sustainable workforce model.

We should have evidence available that you are meeting this standard. This could include the following examples:

1. **Contract monitoring** processes.
2. A **workforce structure chart** which is part of a service's contract.
3. **Workforce skills analysis and training and development plans** for the treatment workforce, which services can prove are routinely monitored and shared with their commissioner.
4. **A record of CPD for each staff member**, which is demonstrated in staff CPD records and in broader workforce consultation and feedback reports.
5. Evidence that service providers have met **local management and clinical supervision standards**.
6. The partnership's **commissioning and delivery plan**.

Workforce planning self-assessment (Cornwall and Isles of Scilly)

Criterion	Evidence	Status
Contract and Contract Monitoring Processes	**Contracts** 'our priority focuses upon increasing the capacity of the workforce and improving quality, with a small increase in capacity in children's treatment. This includes reducing caseload sizes to 40 over the Grant's lifetime. This requires a considerable workforce development programme, given the challenges to recruitment. This will include a 'Ladder to Employment' through Apprenticeships, Volunteering and Peer Mentoring for Experts by Experience as well as a training programme for people with transferable skills and experience who wish to change career. A priority focus for improving outcomes is for non-opiates and alcohol. **Training** The service will complete, prior to commencement, the Training in Assessment, toolkit and interventions, as required and arranged. Subsequently, the service will complete the additional training requirements and updates, as advised. The workforce Training Matrix will be submitted along with the other reporting requirements at Contract Review Meetings for monitoring purposes. **Key Clinical Requirements** The Service will deliver the same Incident reporting, Risk Management, Clinical Governance and Safeguarding procedures as outlined in the Main Contract. All staff will complete the training in the required tools, as directed by the Commissioner and report through the Workforce template for Contracts.	Training programme in progress and caseloads on target to be reduced to 40 by 2024. **Criteria met.**

Criterion	Evidence	Status
Workforce Structure chart	An updated **Workforce structure chart** is required at each Contract Review meeting.	**Met**
Workforce skills analysis and training and development plans which services can prove are routinely monitored and shared with their commissioner.	**Training and development matrix supplied** at Contract Review meetings.	In progress. **Met**.
A record of CPD for each staff member, which is demonstrated in staff CPD records and in broader workforce consultation and feedback reports.	This has not been subject to external review yet and is **planned for 2023/24**.	**Partially met**, in that the Providers undertake and confirm that these are in place, but they have not been externally reviewed.
Evidence that service providers have met local management and clinical supervision standards.	**We do not have externally specified standards**. The providers have internally specified criteria and arrangements, but these have not been subject to external scrutiny.	**Partially met**, but to be externally reviewed.
The partnership's commissioning and delivery plan.	We have a **Workforce Plan and priorities** agreed by the Drugs Partnership. However, it does not specify the supervision and CPD requirements.	**In progress.** Plan to be updated with supervision and CPD requirements.

Summary

A **mapping of the Community Treatment workforce has been carried out**, baseline established and has identified the number and types of staff required to secure a reduction of caseloads to 40 or below, as advised, with the required additional support in terms of medical staff.

The full complement of staff required will be staged over two years, as the 2023/24 allocation is insufficient to support the entirety in that year.

The **ending of the Supporting Families Grant in March 2023 leaves a gap** in parenting and family interventions and services for young people affected by parental alcohol and drug problems, both of which are experiencing increasing demands, referrals and are highly valued by the beneficiaries and producing positive outcomes. **We have therefore included continuation funding for these services.**

Overarching Objectives:

- **Growing our own workforce** – due to the challenges locally of recruiting to Cornwall, and only abutting other LAs on two sides, as well as external recruits being unable to secure accommodation in Cornwall ,due to the declared Housing Crisis.
- **'Ladder to Employment'**- a clear stepped progression for people with lived experience or little/no employment history
- Experts by Experience (11 now, 20 to be in place by year 3)
- **Individual Placement Support Grant scheme** – providing employment for people in treatment as opposed to after completion of treatment
- Caseloads of 40 or less
- **Recovery Communities**/Local Expert Recovery Organisation (LERO) led by Experts by Experience
- Target: **50% of workforce to be people with lived experience.**

Growing our own workforce – A 'Ladder to Employment'

- Increase the capacity for **volunteering opportunities** with the service from current baseline of 200
- Increase opportunities for **Peer Mentors** (from 3 to 12 people) and **Peer Advocates**, including Health Peer Advocates (team of 9)
- Increase the number of **Experts by Experience** (from 11 to 20)
- Sustain and increase **student placements** (e.g. Social Care, medical training and Counselling)
- Increase opportunities for **Sessional and part-time workers**
- Develop more **specialist shadowing and secondment** opportunities
- Increasing the **sustainability of medical and nursing capacity**

Commissioning Team

- **Employ Graduates** from the National Graduate Development Programme (NGDP)
- **Apprenticeships** (at different levels)
- **Shadowing/secondment opportunities** from multi-disciplinary backgrounds

- Train people in **21st Century approaches** such as Human Learning Systems/Co-Production and Strategic and Systems Leadership approaches
- Put all staff through the Institute of Public Care or similar **Commissioning qualifications**
- Increase opportunities for staff to join **commissioning and systems stewardship initiatives** nationally
- **Leaders by Experience programme** for people with lived experience to become commissioners
- Challenge: **stronger linkages required** with European Social Fund, Shared Prosperity Fund and Employment and Skills Board
- **Linkages with wider Health and Social Care Workforce Strategy** to continue to be built upon.

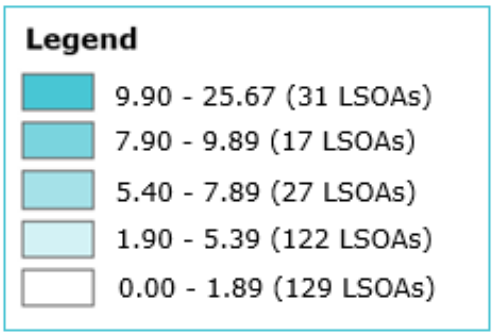
Community Service Capacity Requirements to reach caseloads of 40 and implement quality improvements

Required capacity	2023/24 Planned	2024/25
Total to reach caseload sizes of 40 or less (for specialist roles)	Full capacity cannot be achieved in 2023/24, so will be staged and planned	Aiming to achieve in 2024/25 with inflation built in.
6 Recovery workers		
2 Team Leaders		
4 Advanced Practitioners		
2 Nurses		
1 Doctor		
7 Lifeskills workers		
3 Family Workers		
Sub- total Adults Available	£551,000 available	£780,000
2 YP Outreach	£78,290	
1 Affected Others Worker	£39,195	
Sub Total YP:	£118,115	£120,000
Total	£669,115	£900,000
6 Recovery workers	5	1

Required capacity	2023/24 Planned	2024/25
Total to reach caseload sizes of 40 or less (for specialist roles)	Full capacity cannot be achieved in 2023/24, so will be staged and planned	Aiming to achieve in 2024/25 with inflation built in.
2 Team Leaders	1	1
4 Advanced Practitioners		4
2 Nurses	2	
1 Doctor	1	
7 Lifeskills workers	7	
3 Family Workers	3	
Sub- total Adults	£551,000	£780,000
2 YP Outreach	£78,290	
1 Affected Others Worker	£39,195	
Sub Total YP:	£118,115	£120,000
Total	£669,115	£900,000

People in treatment by location

Opiate and/or crack users



This section examines the **distribution of people in treatment** across Cornwall to identify the main clusters and also the areas where numbers are lower than expected.

The maps show the number of people in treatment per 1,000 resident population aged 15-64 with the **middle band** (5.40 to 7.89) being around the **estimated prevalence** rate of 6.7 per 1,000[65].

- The **darker areas** on the map show the areas where the rate is **above the prevalence estimate** and the lighter areas are lower.
- Data is mapped to **Lower Super Output Area** (LSOA) which is a statistical geographical unit with an average population of 1,500 people or 650 households. There are 326 LSOAs in Cornwall.

Cornwall has a **high penetration rate**, meaning that an above average proportion of people estimated to use opiate and/or crack are receiving help through the treatment system. Currently this sits at around **62% of the estimated prevalence** (well above the national rate of 46%).

Summary

The nature of Cornwall's varied rural landscape interspersed with urban pockets containing small towns and villages of varying sizes, suggests that you would expect to find most service users living in and around these more urban areas. They are **more attractive as places to live** for somebody seeking support as they are more likely to present opportunities such as:

- Being home to a person's friends, family and wider **support network**
- Having better public **transport** links
- Containing **vital services** such as shops and GPs within wallking distance
- Offering **specialist support services**

Rural areas tend to see **lower rates of people in treatment** within their populations, and an absence of the factors above will be a contributory factor. The use of a private car to get to appointments, for example, may be an unmanageable expense.

Key locations of note include:

- **Penzance and St Austell** – containing the LSOAs with the highest rates of people in treatment Cornwall (around three to four times the rate indicated by the prevalence estimate), both towns have a With You base.
- **Liskeard** has two LSOAs inside the ten highest ranked in terms of numbers of people in treatment per 1000 people, similar to nearby **Callington**.

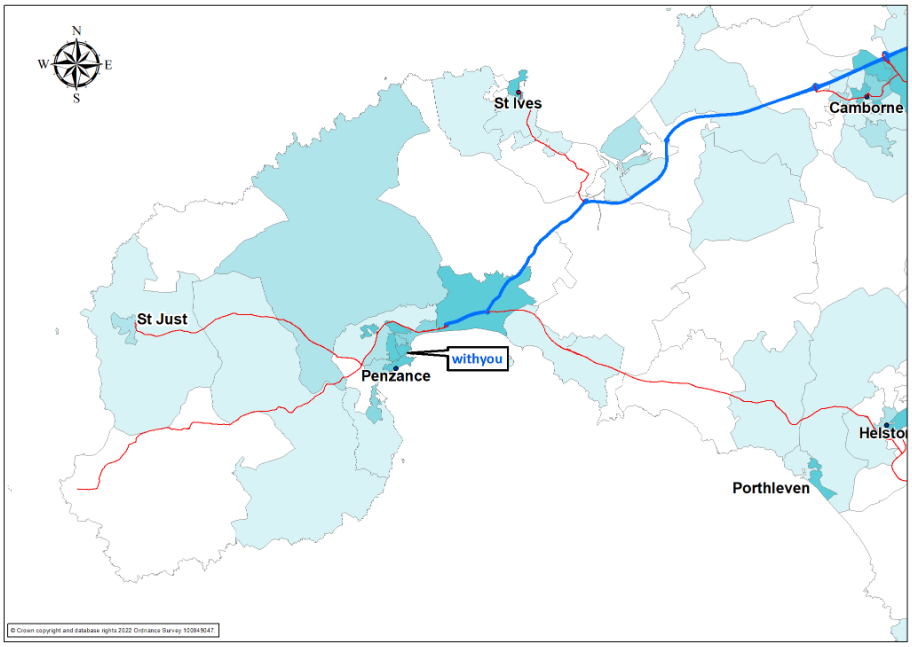
[65] Estimates of opiate and crack cocaine use prevalence: 2016 to 2017, Public Health England (2019)

- **Bodmin** has five LSOAs with above average rates of people in treatment, but none in the 25 areas with the highest rates – there is no With You office in Bodmin.
- Truro, Falmouth and **Newquay** all contain individual areas of very high rates, but these are less clustered.
- By contrast, some more urban areas demonstrate a much lower rate of service users than might be expected, **Saltash** in the far east of the county doesn't contain any LSOA with an average or above average rate of people in treatment – potentially due to its proximity with Plymouth.[66]
- Some **larger villages** show contrasting situations, for instance **Porthleven** has an LSOA with more than **double the average rate** of service users; Porthleven East (13.8 per 1,000 population), which is higher than any of the LSOAs in the nearby town of **Helston**.
- However, other small to medium sized urbanisations such as **St Agnes**, a large village north of Truro, and Charlestown near St Austell, demonstrate **extremely low rates**.

The following section provides some more detailed analysis of locations around Cornwall.

Penzance and St Ives

Penzance and the surrounding area contains 4 of the highest ranked LSOAs in terms of concentrations of people in treatment – these are the area around the town centre, harbour and to the north; the Treneere Estate. There is a **With You Office** in the town centre, but this will struggle to accommodate the extra staff required to bring the caseload sizes down to the desired level, as indicated in the new Drug Strategy. Two areas in Penzance, Penzance St Clare and Town and Penzance Treneere, are ranked in the **most deprived** 10% of LSOAs in England.[67]



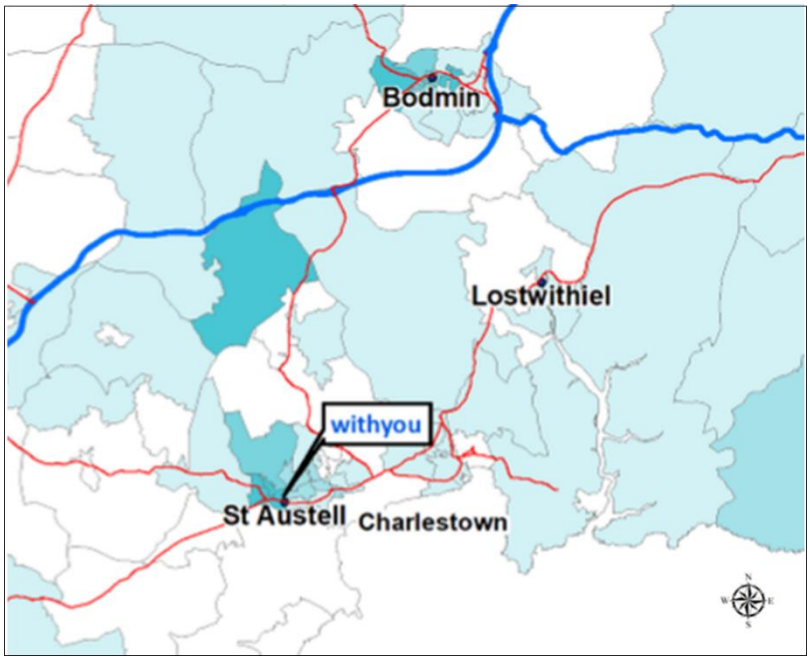
66 Data only available for With You Cornwall service, plus Bosence Farm Ltd. Therefore, any Opiate and crack users utilising services based outside of Cornwall won't be counted
67 Index of Multiple Deprivation (2019)

- Penzance Wharfside and Town LSOA: 21.6 service users per 1000 people
- Further away from the town centre, to the north-east the area containing **Crowlas, Ludgvan and Long Rock** has a rate of 15.4 users per 1000 people, around two and a half times the prevalence rate for Cornwall.
- There is a well-established **community perception of drug use and dealing** being a long-term problem in Penzance.
- The rural areas to the far north-east of the town appear to less populated, as does the area to the west stretching all the way to Lands End, save for a **small pocket around St Just**.
- **St Ives town centre** on the north coast is also in the top ten areas with the most people in Alexandra Road and Porthmeor, an area which has no people currently in treatment at all.

Bodmin and St Austell

The town centre of Bodmin is home to around 13,000 residents and is situated close to Cornwall's main A30 artery with easy access to the A38 road to Plymouth.

The town no longer has an operational railway station with mainline access now only accessible at Bodmin Parkway around 4 miles outside of town. With You do not currently have a service delivery point located in Bodmin.



- As might be expected for a town of its size, Bodmin contains two LSOAs with higher-than-average numbers of OCUs, Bodmin Town Centre (10.5 per 1000) and Berryfields and Bodmin St Lawrences and Dunmere (10.1 per 1000) however, neither of these areas sits inside the top 25 LSOAs in Cornwall

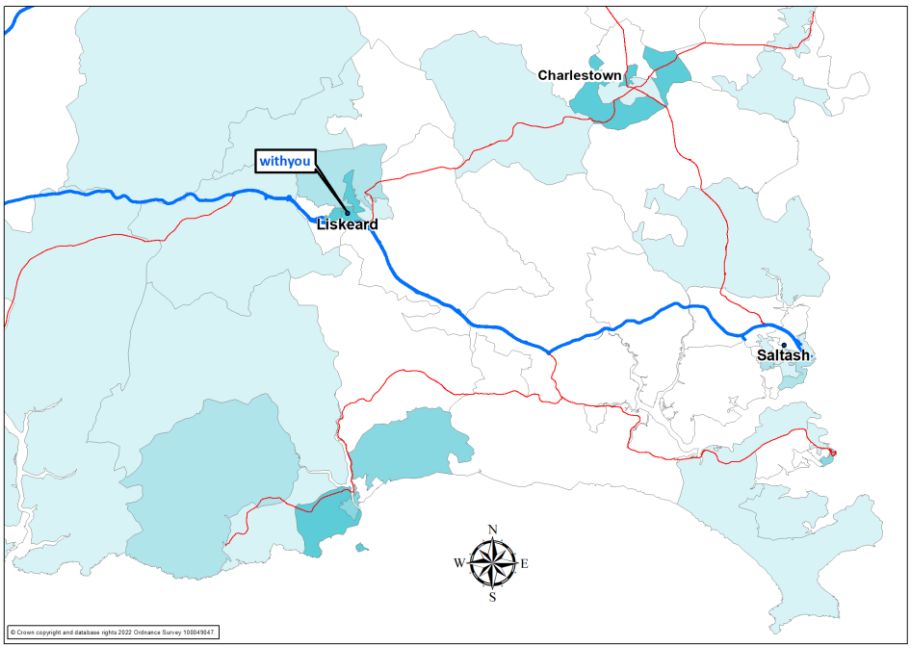
St Austell now has a With You service based in the town along with other services and projects supporting people with **complex needs** including substance misuse, such as Harbour Housing. The town is part of a wider urban area including St Blazey, Par and Charlestown. The town centre LSOA is amongst the **most deprived** 10% of areas in England.

- St Austell has two of the LSOAs within the highest three in Cornwall in terms of clusters of people in treatment, and these are St Austell Penwinnick and Town Centre (25.7 per 1,000 population) St Austell Gover and Edgcumbe (23.0 per 1,000). These areas are located around the **town centre**, to the western side of St Austell.

- The areas immediately to the north and east also have **high numbers of people in treatment** although there appears to be a drop off in numbers in the LSOAs immediately surrounding the conurbation with Duporth, Charlestown, Carlyon Bay and Tregrehan, in particular, being **underrepresented in the data.**
- Further afield; Roche North, containing the settlements of Roche, Victoria and Bugle, has a **higher than average** rate of 10.7 per 1000 people in treatment while the area in and around **Fowey has very few.**

Liskeard and Saltash

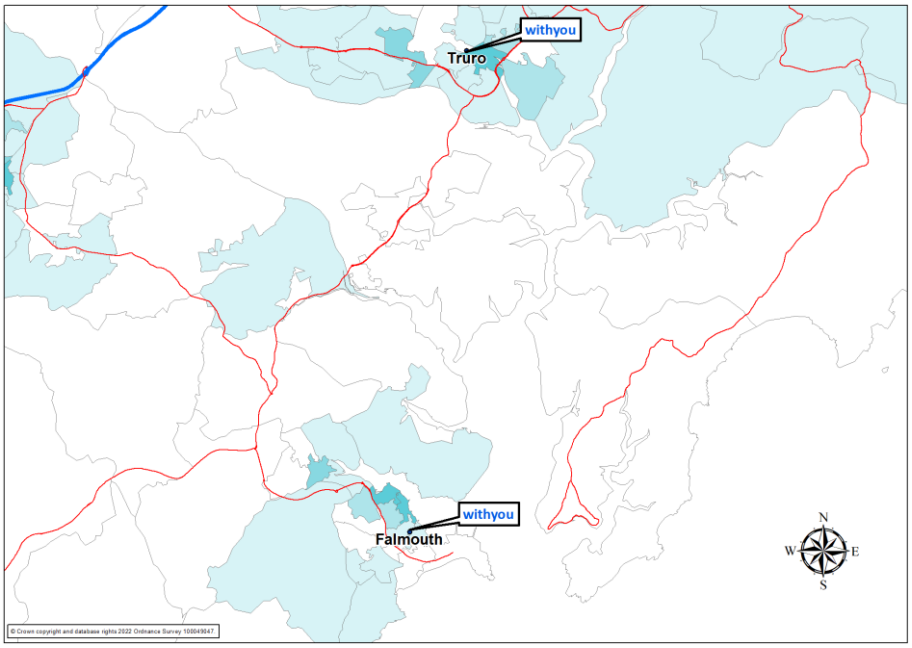
This area has a With You office in **Liskeard**.



- Liskeard's treatment population appear to be **highly concentrated in and around the town centre**, in the area known as Liskeard Town Centre West, Dean Street and Lanchard (20.2 per 1,000 population) and Liskeard Town Centre East, Sungirt and Plymouth Road (15.5 per 1,000), with the railway station situated a short distance to the south.
- Immediately to the south and east are also **areas with low population**, which is reflected in the low numbers in treatment, however continuing south, numbers increase towards the areas surrounding **Looe and Polperro**.
- In the east, the LSOA adjacent to Callington town centre; **Callington West** which has around **double the number of people in treatment** than would be indicated by the prevalence estimate (12.7 per 1,000)
- To the north of the town is Bodmin Moor, an area that is sparsely populated; the numbers of people in treatment in the LSOAs covering this area are around the average rate.
- To the south-east, the areas surrounding and including **Saltash appear to be very much underrepresented**. The close proximity of the Devon border may be a factor, as a proportion of opiate and crack users in this area may be accessing support services in nearby Plymouth.

Truro and Falmouth

Truro has a **With You office in the town centre** and services operate out of **community venues in Falmouth** (however the space available is insufficient to deliver the full range of services to the population in scope).

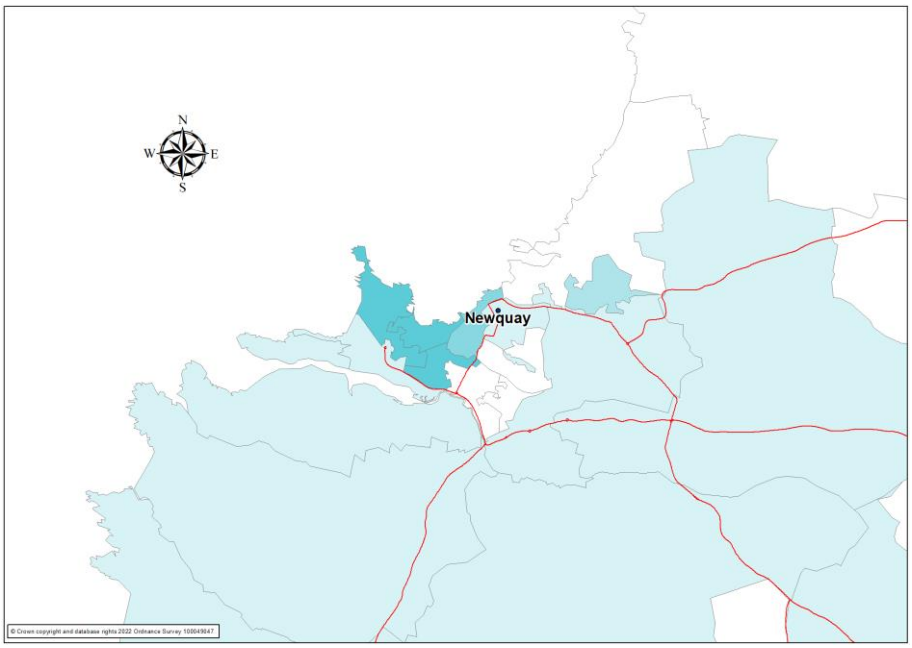


- **Falmouth** has one area within the 20 LSOAs with the highest rates of people in treatment in Cornwall – Falmouth Old Hill (13.5 per 1,000 population) – whilst the area of Falmouth High Street and Trevethan Road sits just outside (10.7 per 1,000). These LSOAs are situated to the north end of the town.
- Slightly further inland, the nearby town of **Penryn** contains one LSOA with an above average service user rate (8.2 per 1,000).
- **Truro** also has one LSOA amongst the 20 areas with the highest rates – Truro City Centre (12.2 per 1,000 population) – with one other LSOA featuring a rate higher than the prevalence estimate, Truro Highertown and Malabar (9.3 per 1,000).
- The rural areas of the **Roseland Peninsula** to the south-east of Truro and the **Lizard Peninsula** west of Falmouth have very few people in treatment, also noting that these areas are more remote and sparsely populated.

Newquay

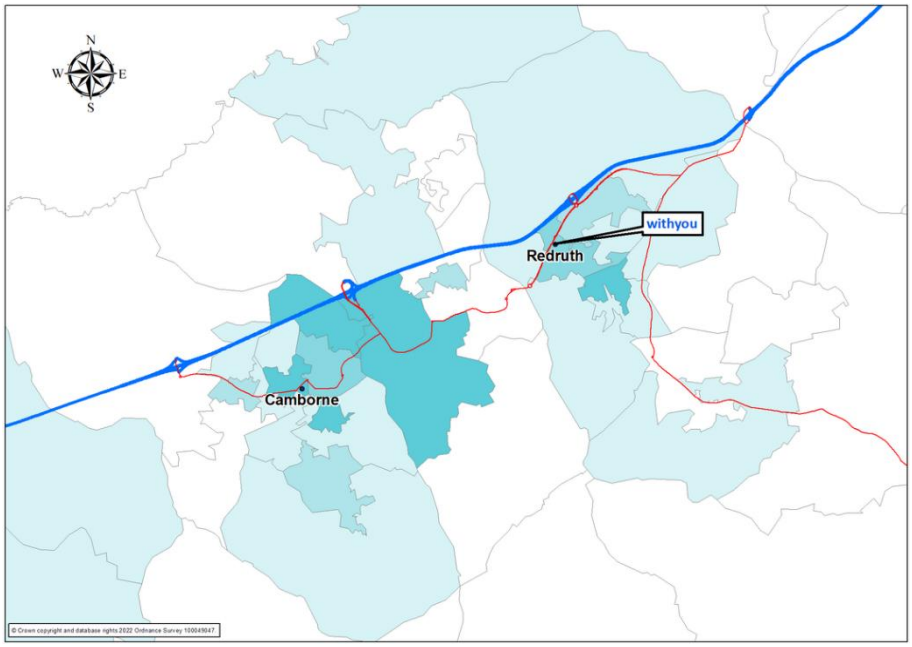
Newquay does not have a With You base. Services are delivered from a community venue but there is a need for a more dedicated delivery point, given the numbers requiring treatment in the area.

- **Newquay** has three **town centre LSOAs** within the 20 areas with the highest rates. The highest rate is in the area of Newquay Trelawney and Chynance Drive, with 17.2 service users per 1000 – over two and half times the estimated prevalence rate for Cornwall. Newquay Narrowcliff also contains a higher rate at 9.2 per 1000 resident population.
- Outside of Newquay town centre the rates drop off, in line with rurality.



Camborne and Redruth

- **Camborne** and the surrounding area contains three LSOAs ranking in the top 20 for the highest proportion of people in treatment within the local population; Camborne North Parade and Rosewarne Gardens (13.1 people per 1,000 population), Camborne Tuckingmill Valley and Roskear Parc (12.2 per 1,0o00) and Pool West and Tregajorran (12.5 per 1,000), each demonstrating **rates around twice those expected** based on the prevalence estimate for Cornwall.

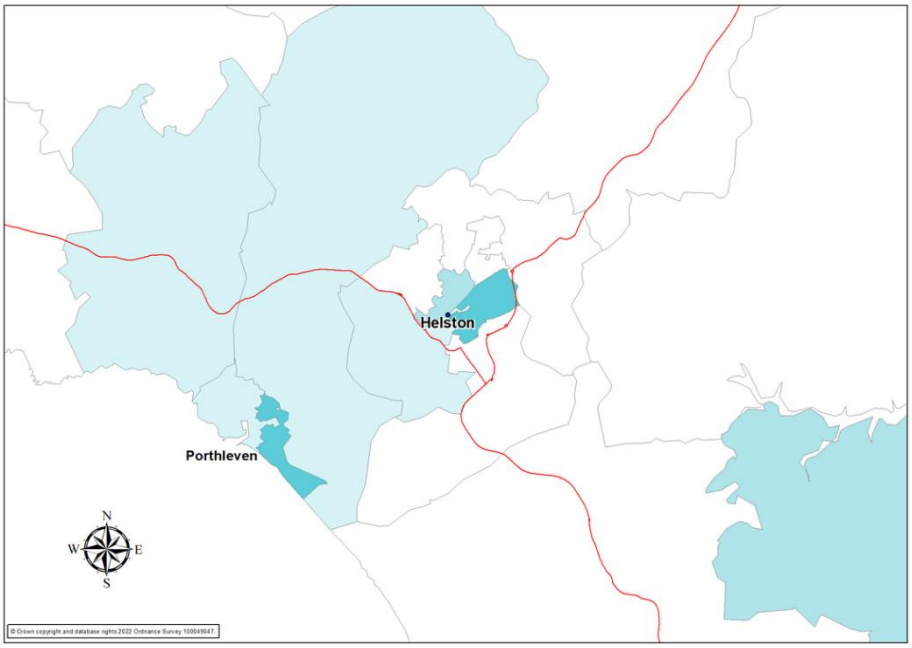


- **Redruth** has two LSOAs containing around one and half times above the expected number, both areas are situated in the **town centre**; Redruth Train Station and Victoria Park (11.0 per 1,000) and Redruth Tolgus Hill and Plain-an-Gwarry (9.6 per 1,000).

- Rates **drop off** in the more rural areas around the towns, which are less densely populated.
- The **treatment service offices were closed to make efficiencies** and savings in the last decade, and these are a priority for increasing access in future years.

Helston

- Helston Trengrouse Way (containing part of the town centre and an area to the east of it) has almost **twice the number of people in treatment estimated** by the prevalence rate for Cornwall.
- In **Porthleven**, on the coast to the west, the rate is more than **double the Cornwall estimate** at 13.8 per 1,000 population.
- To the south-east of the town, beyond Gweek and Mawgan, is the much **more rural** Lizard Peninsula which has much **lower numbers**.



Recovery Outcomes

Successful completions of treatment

- Currently **8% of opiate users and 36% of non-opiate users** complete treatment successfully and do not represent within 6 months – performance is **better than national average**.
- The factors with the **strongest negative impact** on successful completions are **housing** problems, **crack** use, **criminal justice** referral and dual diagnosis.
- For opiates, the **strong positive factors** are being a **young adult** (aged 18-24) and **living with children**.
- Living with children is also a strong positive factor for non-opiate users, but other factors include **no mental health issue** and **not using alcohol**.

Successful completions

Rates of successful completion are comparatively high locally, driven by **good performance for opiate users**. Successful completions for non-opiate users fluctuates around the national average, with users of non-opiates and alcohol seeing the lowest rates of the two non-opiate groups.

- **Opiates** – the number of people in treatment has remained fairly stable, but **new presentations saw a small drop** (meaning that fewer people left). Successful completions remain in the **top quartile** for performance nationally.
- **Non-opiates** – the number of people in treatment increased, including new presentations (non-opiates without adjacent problem alcohol use). Around a third complete successfully and this is **just above the national rate**, having improved slightly over the last year. Representations for users of alcohol and non-opiates have increased (more are coming back) but the numbers involved are small.
- The JSNA data, which provides trends over the longer term, shows **a decline in successful completion performance** since the last needs assessment was undertaken.

Figure 8.25.1 Proportion of all in opiate treatment, who successfully completed treatment and did not re-present within 6 months (PHOF C19a/C19b), for **Cornwall & Isles of Scilly** and **England**, **2017-18 to 2020-21**.

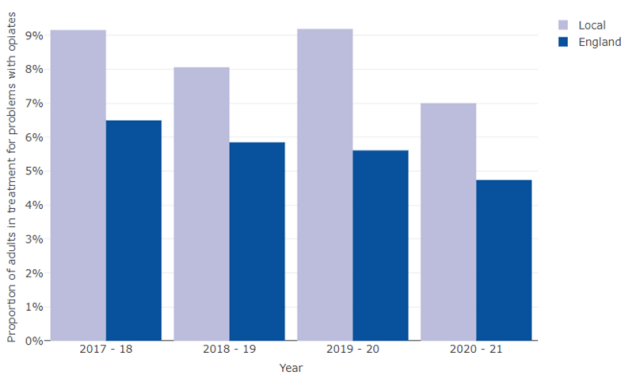
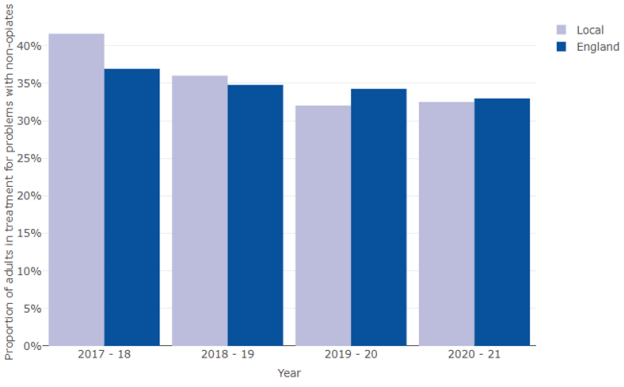


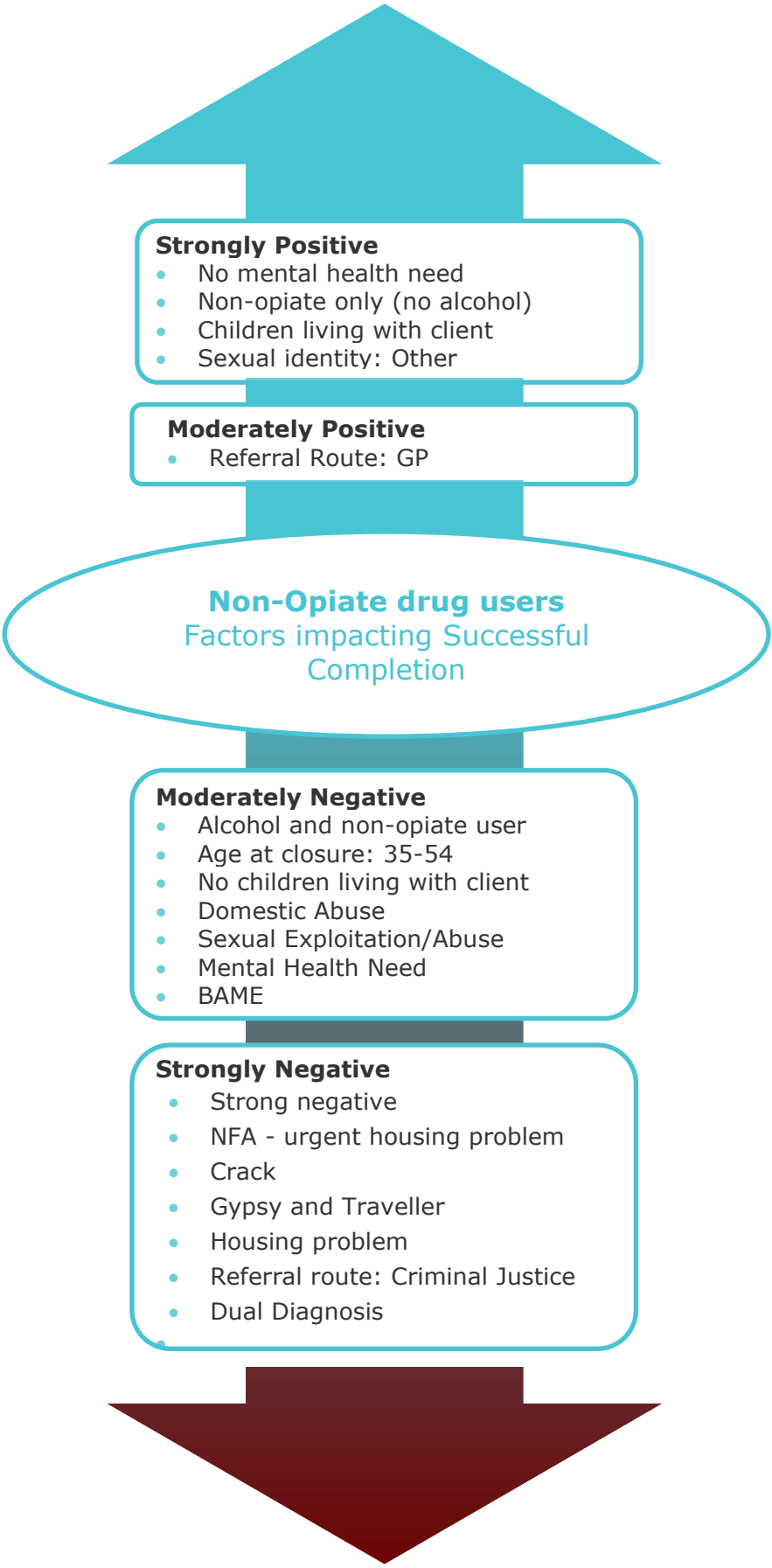
Figure 8.25.2 Proportion of all in non-opiate or alcohol and non-opiate treatment, who successfully completed treatment and did not re-present within 6 months (PHOF C19a/C19b), for **Cornwall & Isles of Scilly** and **England**, **2017-18 to 2020-21**.



Factors in successful completion – non-opiate

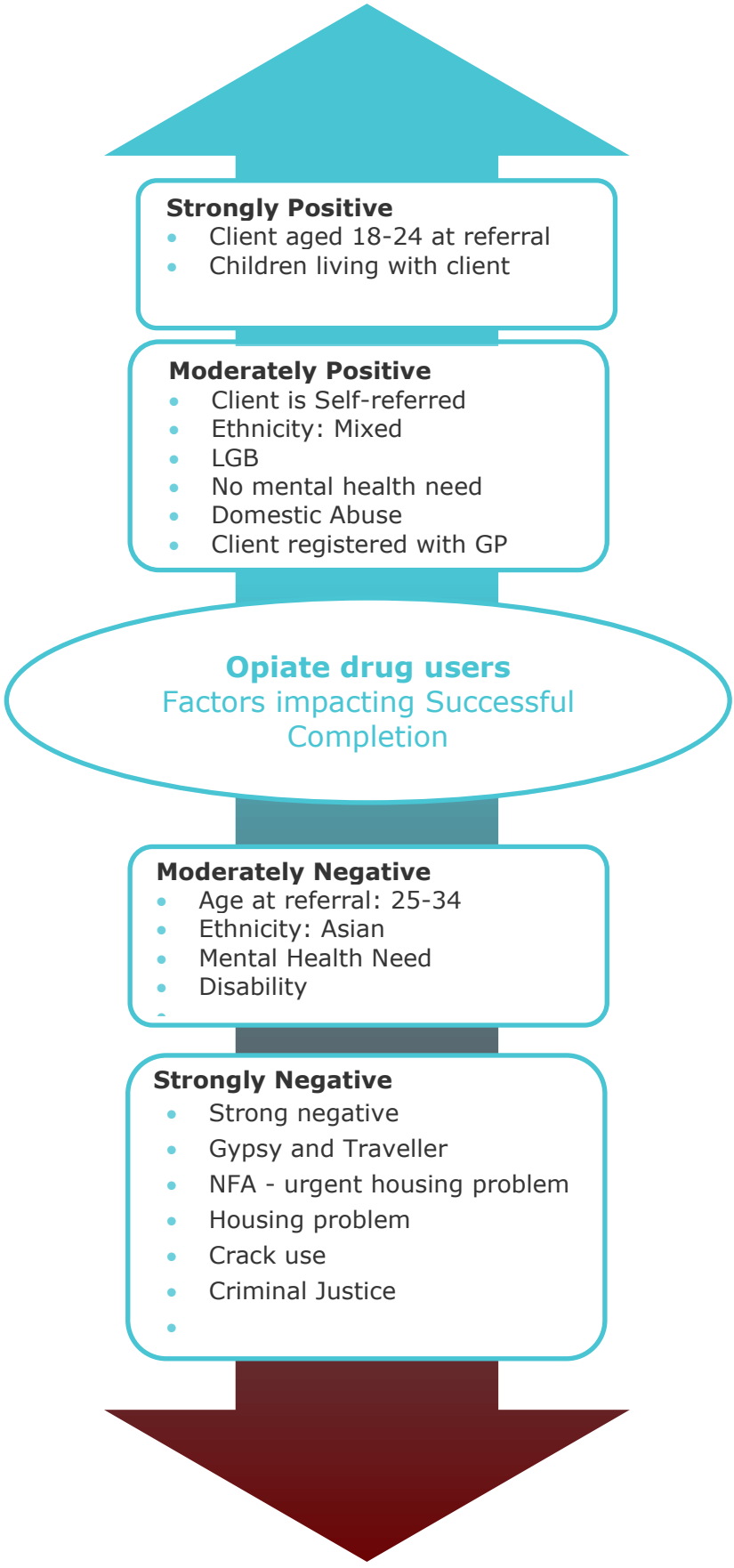
Analysis of successful completion rates over 3 years by different characteristics.

- The factors with the strongest negative impact are **housing** problems, **crack** use, **criminal justice** referral and **dual diagnosis**.
- Moderate negative impacts are discernible amongst those that are **aged between 35-54**, do not have **children** living with them, have a history of **domestic and/or sexual abuse**, present with a **mental health need** or are from an **ethnic minority** background.
- A strong positive impact on successful completion tends to correlate with much of the opposite factors that we observe amongst the negative impacts, including **no mental health issue** and having **children** living with the client. Other positive factors include not using alcohol and not identifying with any specific sexuality.



Factors in successful completion – opiates

- The factors with the strongest negative impact are **housing problems, crack** use and a criminal justice referral.
- Moderate negative impacts are found amongst those **aged between 25-34**, those with a **disability** or specific **mental health need**
- **Strong positive** factors include are young adults **aged between 18-24** and having children living with the client;
- **Moderately positive factors** include self-referring, or having a GP referral, not having a mental health issue at referral. Being a victim of **domestic abuse** appears to impact successful completion in a positive way, further investigation would be required to understand this better, but it may indicate that having a multi-disciplinary professional support network around a client can benefit various aspects of their recovery.
- Likewise sexual identity, specifically **being LGB**, would appear to contribute in a **moderately positive way**, possibly indicating a link between those that are able to overcome barriers to accessing a service and an increased likelihood of a successful outcome. The slightly **younger age profile of LGB clients** accessing the service may also be a factor, numbers are small, however all of the LGB clients in the opiate group are no older than 55 with two thirds of successful completions being amongst those aged 30 or younger.[68]



[68] Age taken at referral date

Deaths in treatment

In 2020/21, there was a **18% increase at a national level** in the number of people recorded as having died while in treatment for drug misuse, with wide local variation. It is likely that changes to drug 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.

- In Cornwall 34 people died whilst in treatment in 2021/22, equating to **1.5% of the treatment population**, mostly opiate users. This is in line with the national rate of 1.3%. The number of people who died whilst in treatment in 2020/21 was lower than the year before but **in 2021/22 this went up by over a third**.

Housing and employment

The **findings under this theme are taken from the Alcohol Needs Assessment** that was completed in 2020/21, where housing and employment outcomes were reviewed for all drug groups together. Where relevant, findings have been re-confirmed with the latest data from OHID.

- The government recognises **housing as critical to successful treatment outcomes** in the new National Drugs Strategy. Affordable, sustainable housing is **challenging for all locally.**
- New **Rough Sleeper Grant** is supporting the most vulnerable. Snapshot – 71% had an alcohol and/or drug need, of which just under half then engaged in treatment.
- Around a third of local supported housing is **alcohol/drug tolerant** which helps engage people in treatment; **drug-free provision is also needed** to support people in their recovery.
- **Progression with employment status** for people in drug treatment appears to have **improved** and this may reflect that a number of good employment initiatives are starting to have an impact, such as the new **Individual Placement and Support Grant**.

Housing and homelessness

The government has recognised **housing as critical to successful treatment outcomes** in the new National Drugs Strategy. 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 of relapse after treatment,** particularly after **leaving prison or residential**

rehabilitation. This review also highlighted a variation in housing access, with **less access in areas of high housing cost and high demand.[69]**

- Our local data indicates that **housing problems are one of the factors with the strongest negative impact on successful completions** – for both opiate and non-opiate drug groups these are being homeless (No Fixed Abode) or having an immediate housing problem, crack use, criminal justice referral and dual diagnosis. These are discussed in more detail under Successful Completions.

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. An estimated 259 deaths of homeless people registered in 2021[70] were related to drug poisoning, accounting for **35% of all estimated deaths**.

- Locally **4 out of 38 people[71]** who died of a drug-related cause in 2021 were homeless at the time of death, and several others had a history of homelessness.

The Drug Related Deaths Annual Report highlights the additional challenges of supporting someone who is homeless, with **frequent disruptions** to contact and prescriptions due to moving from one area to another, and the **additional vulnerabilities** that arose from not being in stable housing, including the development of abusive relationships.

- The structured, systemic approach to service provision simply **does not take into account transience and homelessness** and the difficulties that individuals in these circumstances have in gaining access in a timely manner to the services they require.

In 2020/21, 3,226 households were assessed and **owed a statutory homelessness duty** in Cornwall.[72] The data shows that many people who are homeless or sleeping rough **have multiple vulnerabilities**.

- **7.7% had drug dependency needs** and 7.6% had an alcohol dependency
- **14.5%** of households lost their last settled home due to **Domestic Abuse**
- **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 men**; aged **25-34**; and **unemployed**

69 An evidence Review of the outcomes that can be expected of drug misuse treatment in England, Public Health England (2017)
70 Deaths of homeless people in England and Wales: 2021 registrations, Office for National Statistics, published November 2022
71 Cornwall and Isles of Scilly Drug Related Deaths Annual Report 2021, Safer Cornwall
72 Latest published data for Cornwall – Cornwall did not submit data in 2021/22. Initial assessments of statutory homelessness duties owed, England, April 2020 to March 2021, Department for levelling Up, Housing and Communities (2021)

Accommodation needs in the treatment population

The latest comparator data (2021/22) shows that the **proportion of people presenting to treatment as homeless has increased to 10%**, the proportion with a housing problem is unchanged (15%). Both figures are slightly **above the national average** - a difference of 3% for people who are presenting as homeless and 2% in housing need.

Housing status at treatment start	2019/20	2020/21	2021/22	National 2021/22
NFA - urgent housing problem	11%	8%	10% (76)	7%
Housing problem	13%	15%	15% (118)	13%
No housing problem	77%	78%	68% (530)	76%
Missing	0%	1%	7% (55)	4%

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.

A snapshot of data reviewed for the Alcohol Needs Assessment indicated **high levels of need** amongst this group, and **positive engagement rates** in treatment for both substance use and mental health.

Data snapshot (October to December 2021) - **48 people were sleeping rough with a further 1,837 people at risk** in Cornwall. Of the 241 people assessed:

- 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 prior at the start of engagement
- The majority of rough sleepers and those at risk were **aged 30-34**
- **All rough sleepers were men** and around 1 in 5 of those at risk were women
- Only **28% were registered with a GP**
- **71% had an alcohol and/or drug need** (171 people) of which just under half (72 people) then engaged in treatment
- **62% engaged in mental health treatment** (148 people) after being assessed

HomeChoice

Homechoice is the system for **letting council and housing association homes** to rent in Cornwall where applicants bid for properties. Data provided by Cornwall Housing Lid for the Alcohol Needs Assessment provided a snapshot of the proportion of current live HomeChoice applications with **self-declared alcohol and/or drug dependency.**

This review of live applications did not identify people who were flagged with just drug dependency. We have requested this for future iterations of the needs assessments.

The findings of the review with respect to people flagged with either alcohol only or alcohol and drug dependency are reproduced here for reference.

Out of a total of **20,375 live applications**:

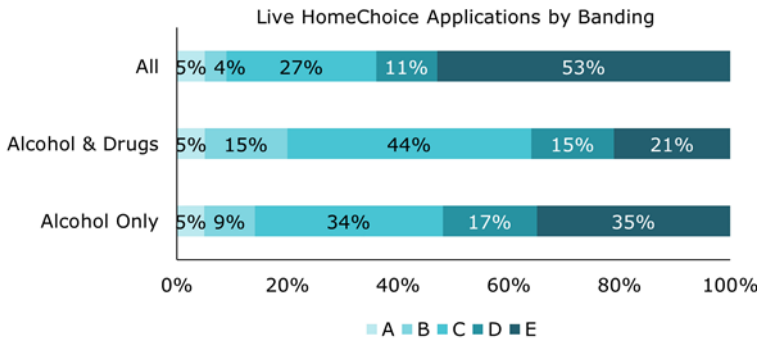
- 303 are flagged for just alcohol dependency (1.5%)
- 100 are flagged for both **alcohol and drug dependency** (0.5%)

Out of the 403 applications with alcohol dependency, 8.7% are classed as Homeless-Statutory (owed a duty) and a further 24% Homeless-Other. Only 2 applicants are recorded as receiving support for alcohol or drugs suggesting very poor data collection of this attribute.

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%).

A greater proportion of those with an alcohol only or alcohol and drug need are banded B compared to all applicants.



Applicants who declare an alcohol dependency only are more likely to be banded D than all applicants and are more likely to receive a lower banding than those who declare a drug dependency alongside alcohol.

There appears to be **little difference in the banding of drug and alcohol clients** compared to all applicants suggesting that **the HomeChoice banding system is challenging for all**.

During consultation with people in treatment, the issue of banding was raised 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 also found that there was little scope to increase banding.

The **Homechoice Housing Register is now managed within the Council** as part of the Housing Options service, on behalf of 13 Registered Providers.

Provision

Over many years the DAAT has worked closely with supported housing commissioners and providers in analysing need and **developing a staged model** of supported accommodation that best meets the needs of those with drug and/or alcohol dependency at various stages of their treatment and recovery journey. These services, although having sustained massive budget cuts in recent years, are **crucial in supporting clients with complex needs** through their treatment journey towards recovery.

The 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 Housing Options.

Cornwall Council's Housing Options now delivers the **statutory housing service**, providing **support for people who are sleeping rough**, administering the **Homechoice Housing Register** on behalf of 13 Registered Provider partners and **assisting households who are at risk of, or are, homeless**.

It also provides dedicated services for people who are sleeping rough in Cornwall, including **assertive outreach**, a **Somewhere Safe to Stay** (rapid assessment) Hub, **tenancy sustainment** and **Housing First**. There is also a small team who procure housing related services and contract manage externally provided housing services.

- The **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.
- The **Housing First initiative** 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.

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 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.

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

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

Rough Sleeping Initiative (RSI) 5

Over the past 4 years Cornwall has been awarded RSI funding. This funding has assisted a range **of accommodation based, outreach and support services** to be commissioned and delivered for **rough sleepers**.

Previously, this funding has been made available year on year giving little opportunity for longer term service planning. However, though **RSI5** the Government has announced a **3-year programme** which has enabled Housing to strategically review and plan for longer term service delivery. Housing have widely consulted with Partners (including drug and alcohol commissioners and service providers) as to what should be included in a future rough sleeping 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 affected the Council's ability to access emergency accommodation and resulted in multiple moves for many households. The **demand profile 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[73], the Council established a number of emergency accommodation provisions for people sleeping rough, of which some are still operational. Despite this additional **high-tolerance accommodation** provision, the **number of rough sleepers has remained at between 20-30, and fluctuates week on week**, reaching as high as 40 at some points. High tolerance accommodation requires high staffing levels to manage behaviours.

The pandemic resulted in a range of accommodation options for rough sleepers, however, who **previously were often excluded from more mainstream housing provision** as a result of their complex needs, challenging behaviour or lack of recourse to public funds.

COVID sites (extra emergency accommodation sites set up during the pandemic) 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 Kerslake Commission's report[74] evaluating Everyone In highlighted the importance of the inclusion of **drug and alcohol workers in assertive outreach teams** for rough sleepers.

[73] 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.

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

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 substance misuse) 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.

The Council has subsequently delivered 2 further emergency accommodation **Bunkabin schemes** to meet ongoing demand and a new purpose-built assessment centre for homeless clients. These are not viewed as long-term options but **emergency provision 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 (**TARRP**) was implemented to address the immediate and urgent pressures created by the number of households who have had to be accommodated in temporary accommodation.

Where preventing homelessness was not possible, efforts increased at **getting to know the rough sleeping cohort** and their **needs and aspirations** through regular multi-agency meetings with all outreach teams. **Protect and Vaccinate funding** then enabled the delivery of bespoke solutions to meet the identified needs of these clients and provide the best opportunity to get rough sleepers off the street.

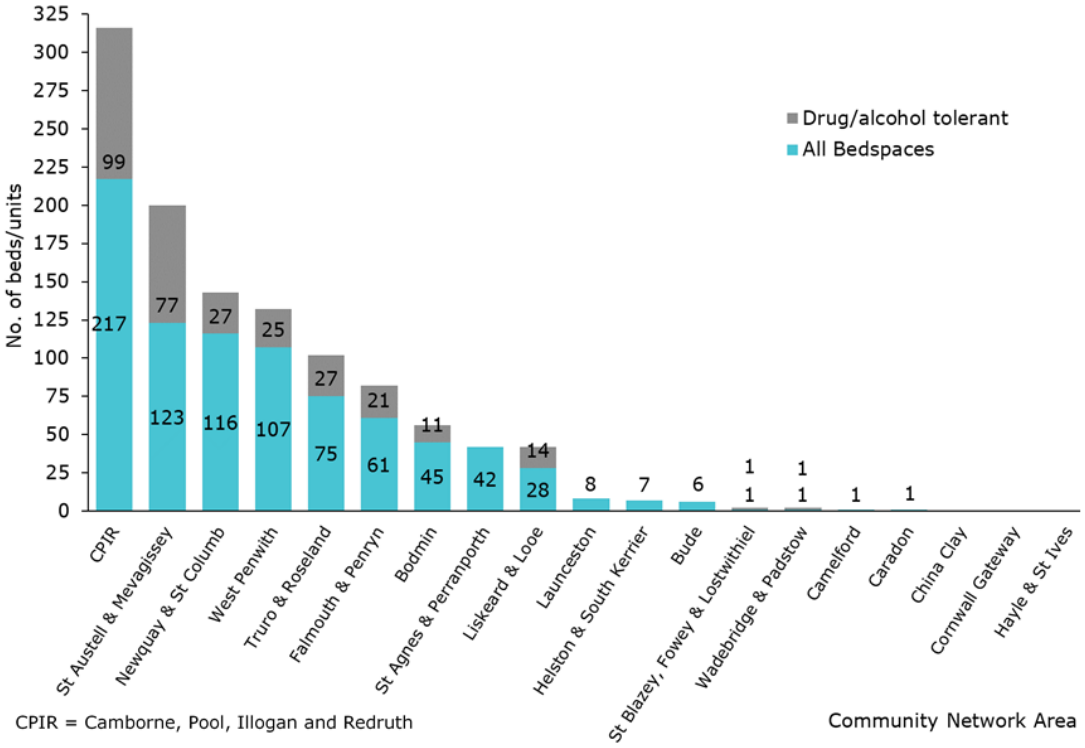
In addition to emergency accommodation, Cornwall was successful in its bid to the **Next Steps Accommodation programme** (NSAP) and the **Rough Sleeping Accommodation Programme** (RSAP). This provision will help the flow through the accommodation system by accommodating those ready to move out of high support accommodation into more independent living, freeing up high support accommodation spaces.

From October 2020 to August 2021, **374 individual rough sleepers were 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**.

A snapshot of the 161 current or former rough sleepers on the database from March to August 2021, showed that just under half **were linked to substance misuse treatment** (75 people) – the database was unable to distinguish between drug and alcohol needs. A cohort of 40 current rough sleepers had been identified at this time to target for solutions and monitor their outcomes.

A snapshot of provision reviewed for the Alcohol Needs Assessment in July 2021, showed that across all commissioned and non-commissioned provision there were 839 units/beds of supported accommodation in Cornwall, of which just over **a third were alcohol/drug tolerant** (so, will take those who are not yet abstinent/in treatment – 303 units or 36%). Of the 303 beds, 286 can accommodate mental health needs and 72 beds are for those fleeing domestic abuse.

The chart below shows the **distribution of supported accommodation** in Cornwall at the time this **snapshot** was taken.



At the time that this snapshot was provided, a further 111 units were under acquisition or in development, of which 54 to be alcohol/drug tolerant.

Feedback from both service users and staff has highlighted the need for appropriate **accommodation post rehab and detox that is alcohol and drug free to support sustained recovery**. Accommodation would also 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 and homelessness.

Employment

Dame Carol Black's 2016 independent review[75] on the impact of substance misuse 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.

Comparator data provided by OHID[76] indicates that:

- Locally we see a **higher proportion of people in employment when they start** treatment (32% vs 24%) but this reflects a lower proportion of people long term sick or disabled (16% vs 20%).
- The percentage of people in **employment on exit from treatment is similar to the national rate** – 35% are in either part- or full-time employment, compared with 34% nationally. This suggests that little progression is being made.
- **Rates of progression from start to exit show similar outcomes** to the national picture, however, with an extra 7% in full-time employment at the point of a planned exit (compared with 5% nationally).

Employment needs of the treatment population

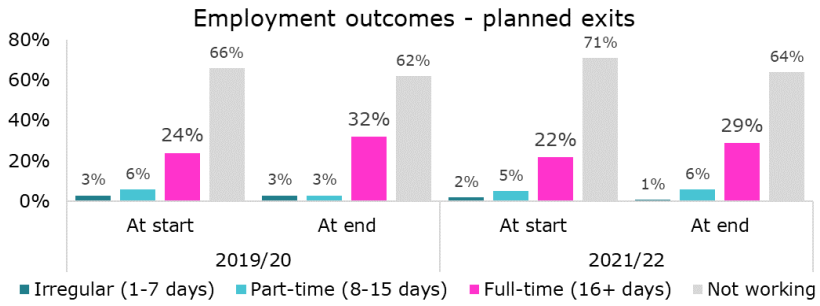
The employment status of people accessing treatment is established during the comprehensive assessment process for new clients and recorded in Halo.

Employment status on presentation	2019/20	2020/21	2021/22	2021/22 National
In regular employment	30%	28%	32%	24%
In education	2%	2%	1%	1%
Unpaid/voluntary	0%	0%	0%	0%
Unemployed/Economically inactive	42%	48%	45%	48%
Long term sick/disabled	19%	15%	16%	20%
Other	6%	2%	1%	1%
Not stated/missing	0%	5%	4%	5%
Not in work	67%	65%	61%	68%

- Around **3 in 5 people were not in work** when they started treatment in 2021/22; this showed a reduction of 4% compared with the previous year.
- The proportion of people starting treatment in **regular employment has increased**, further to a fluctuation in 2020/21, and is **above the national rate** of 24%.
- The proportion assessed as long term sick or disabled is similar to last year but a **higher proportion were unemployed** or economically inactive (+3%).

[75] An independent review into the impact on employment outcomes of drug or alcohol addiction, and obesity, Department for Work and Pensions (2016)
[76] Adult Drug Commissioning Support Pack: 2023-24: Key Data

Data on employment is also captured through **regular Treatment Outcomes Profile (TOP) assessments** completed during a client's treatment journey and on exit from the treatment system.



Our local data has indicated previously that the proportion of people not working on exit from treatment was fairly similar to the start of treatment, which suggested that **treatment has little impact on changing employment status** for people who commence drug treatment as unemployed. There is, however, a **small shift from part-time working to full-time** working, which may reflect the positive impact of employment support initiatives.

The latest data for 2021/22 shows **an improvement of 7% between treatment start and planned exit**, slightly above the national rate of improvement of 5%. This would benefit from continued monitoring and analysis, particularly in the light of the investment in the new **Individual Placement and Support** programme.

The latest quarterly DOMES report[77] for Quarter 4 2022/23 indicates that those exiting drug treatment in Cornwall are **slightly more likely than the national average to meet the target of 10 days paid work in the 28 days before exit** (26.5% vs 25.7% for opiate users and 47.2% vs 38.4% for non-opiate).

Initiatives

Within Jobcentre Plus's 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 drug and alcohol issues are preventing them from getting work are amongst those eligible. Job Centres provide support to help people to identify their **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.

Data looking specifically at those with drug and alcohol dependency is not available. Locally in 2019/20 and 2020/21, 225 referrals were made to WHP for those identified as early access. This group includes Veterans, ex-offenders, carers, those with drug or alcohol dependencies and others. Since the

[77] Diagnostic Outcomes Monitoring Executive Summary or DOMES; a detailed performance report covering the whole treatment system provided by OHID Quarterly

programme began in December 2017, 54 people have achieved employment within 24 months of their start date.

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, advice and guidance, alongside support to enhance health and wellbeing and priority access to local services such as Citizens Advice. They also support people once they have found employment.

The **People Hub** in Cornwall provides free and confidential information, advice and support to people 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 a 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 Big Lottery ESF **Positive People Programme** started in 2017 and will run until June 2023. This is delivered by Pluss in partnership with many Cornish organisations including With You.

Coaches provide people with **bespoke support** and work with them to agree and regularly review an action plan which will target their progression in terms of **training, job search and employment**. Health and wellbeing support is provided in the form of online activities and 1:1 intervention 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 With You clients engaged with the programme** (46% female; 54% male) of which 63 had previous criminal justice experience. 113 participants (50%) achieved **successful outcomes**: 35 in paid employment, 74 in education/training and 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.

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 'fidelity' 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; and
8. Financial planning is provided

The distinguishing feature of IPS is that **employment support is provided alongside clinical treatment**. It works by integrating an employment specialist within treatment as an equal member of the multi-disciplinary team. **This makes employment a key aim of recovery** and integral to the aims of treatment.

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 were recruited in 2021 by the commissioned drug and alcohol service **With You**. A local steering group provides strategic direction and operational oversight. Data is regularly submitted to OHID allowing the effectiveness of the programme to be evaluated and learning captured.

The number of **referrals to IPS has been more than double the targeted level** in the first 12 months of operation.

- In the 12 months to April 2023, IPS received **386 referrals** (the target was 180), of which 185 commenced intervention with IPS.
- The **conversion rate** from referral to programme start was **48%** (target = 60%).
- 45 people have progressed into paid work, **27 people have sustained employment for 13 weeks or more** and 7 have reached 26 weeks of sustainment.

'IPS has developed into one of the most important working relationships within my role as a recovery worker. IPS is great, they listen to where my client is in their recovery and where they want to be in life and make a path they can walk and achieve in the direction the client chooses.

IPS runs alongside recovery for the client, giving them hope for future aspirations whilst supporting them where they are now. When my clients get a job IPS are still there to support them and better yet, if there's a lapse recovery wise, they let me know and we work together to help overcome barriers'
Denys, Team Leader

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 design a plan which helps to 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.

Mental health needs

- Recording of mental health needs and treatment is still **patchy but improving**. NDTMS **business definitions** for mental health fields are felt to be **too ambiguous**, however, and thus not helpful in supporting workers to complete the right information.
- Local analysis across a variety of indicators suggest that Cornwall has a **higher prevalence of mental health conditions** (than the national rate) – frequently co-occurring with other vulnerabilities.
- 71% of people in treatment are recorded as having **a mental health need**, with 30% not receiving any mental health treatment. 15% are recorded as having 'dual diagnosis'.
- People in treatment continue to tell us about **long wait times for support** from the Community Mental Health Team and being turned away from support because their issues are "**not long or severe enough" to meet thresholds.**
- Local improvements have been made through **Dual Diagnosis multi-agency steering group**, implementation plan and escalation process but still some challenges remain around promoting and embedding this approach.

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. [Good] Mental health is more than the absence of mental disorders. It exists on a complex continuum, which is **experienced differently from one person to the next**, with varying degrees of difficulty and distress and potentially very different social and clinical outcomes.[78]

In England **one in four adults experience at least one diagnosable mental health problem** in any given year. In Cornwall, 12.7% of adults has a diagnosis of depression[79] and 0.9% of the population are affected by a serious mental illness[80]. Cornwall had a **higher rate of hospital admissions for intentional self-harm** than average national figures pre-pandemic[81], and a **higher suicide rate** than nationally.

Multiple national studies revealed the **negative affect the pandemic has had on mental health and wellbeing**. Deteriorations in mental health and wellbeing were seen at the start of the pandemic and whilst there were improvements at some points, mental health and wellbeing in Autumn 2021 was still poorer than before the pandemic[82].

Locally, **Healthwatch Cornwall** undertook a detailed exploration[83] of the impacts of the COVID-19 pandemic on mental health.

---

[78] Mental health: strengthening our response, WHO (2018)

[79] Patients with a diagnosis of depression on practice registers in 2021/22. Fingertips, OHID.

[80] Patients with schizophrenia, bipolar affective disorder and other psychoses as recorded on practice disease registers in 2020/21. Fingertips, OHID

[81] Emergency hospital admissions for intentional self-harm 2019/20, Fingertips, OHID

[82] COVID-19 mental health and wellbeing surveillance: report, Important findings, OHID (November 2021)

[83] Cornwall Coronavirus Survey 2020, Full Report, Healthwatch Cornwall (2020)

It was found that:

- 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.
- Experiences of **exclusion, disadvantage and vulnerability were exacerbated** by COVID-19.
- Factors such as loss of income, social isolation, housing insecurity and reduced access to services **contributed to the decline** in mental wellbeing
- The **pandemic has had a lasting impact on people's mental health** despite the lifting of lockdowns
- Many people including carers, people from ethnic minority backgrounds and disabled people report **ongoing anxiety and depression** because of their experiences in the pandemic.

Dual Diagnosis

The terms 'Dual Diagnosis' and 'Comorbidity' are used commonly and interchangeably 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. Many people with a dual diagnosis have **multiple vulnerabilities** which may include:

- One or more **significant physical health problems**
- **High risk** behaviours and mortality
- A history of **early life abuse**
- Experience of **domestic abuse and/or sexual violence**
- **A range of social issues** such as poor housing, low income, unemployment and social isolation

Historically, dual diagnosis guidance has mostly focused only on the needs of those with 'Severe Mental Illness' (for example, psychosis, schizophrenia, bipolar disorder) and drug and alcohol problems 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 and care** for the larger number of people with drug and 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**.

Research shows that it is usual, rather than the exception, to find people with co-occurring mental health and substance use across health and care settings: **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

[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)

condition. **70% of people in drug services and 86% in alcohol services** have a co-occurring mental health issue.[86]

Local data

In local drug and alcohol treatment whether a client has a mental health need, and if they are receiving treatment for this, is recorded[87]. The national dataset does not break 'mental health need' down by specific conditions, however.

The JSNA Commissioning Support Pack provided by OHID indicates that **recording of mental health conditions has improved** – increasing from 55% in 2020/21 (and below the national average, which was counter-intuitive) to **74% in 2021/22 and slightly above the national average** (70%). Where a need is identified, **3 out of 4 people are recorded as receiving help**, with support being provided in a similar range of settings to the national average (predominantly GP – local 54%, national 55%).

A more in-depth analysis of the local referral data for 2021/22 across a wider variety of indicators also suggests that Cornwall and the Isles of Scilly **has a higher prevalence of mental health conditions**, 80% of all new referrals are identified as having a mental health need, with alcohol and non-opiate clients being more likely to be identified in this group than opiate clients.

- **70% of those identified with mental health need are receiving some sort of support** for their mental health – opiate users are less likely than non-opiate and alcohol and non-opiate users to be accessing mental health support already.

In addition, **21% of people in treatment for drugs in 2021/22** were recorded as having **'dual diagnosis.'** Prevalence of dual diagnosis is highest for those in treatment for alcohol and non-opiates (26%) and lowest for opiates (19%). For 25% of the caseload this was not recorded at all.

Of these, **60% were receiving mental health treatment**, predominantly through community mental health services (24%) or GP (30%).

Treatment for mental health	Total	% of people in treatment
Already engaged with the community mental health team/other mental health services	127	24%
Engaged with IAPT	8	2%
Has an identified space in a health-based place of safety for mental health crises	4	1%

[86] Comorbidity of substance misuse and mental illness in community mental health and substance misuse services, Weaver et al. (2003)

[87] 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.

Treatment for mental health	Total	% of people in treatment
Receiving any NICE recommended psychosocial or pharmacological intervention for treatment of a mental health problem in drug or alcohol services	15	3%
Receiving mental health treatment from GP	159	30%
Client declined to commence treatment for their mental health need	4	1%
Treatment need identified but no treatment being received	102	19%
Not completed	106	20%
Total people with Dual Diagnosis	525	

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

People with a dual diagnosis are more likely to **come into contact with a wide range of services**, including Emergency services, Criminal Justice services, Hospital in-patient services, housing, Primary Care, Social Services, Child or Adult Safeguarding services, and Domestic Abuse and Sexual Violence services. Whilst some of these services are well placed to support clients, most have limited capacity to address underlying conditions in the long term. This, in turn, results in high per capita costs to taxpayers.

Despite some **good local examples of effective joint working**, people whose needs straddle multiple service providers may still not receive the support they need due to:

- **Lack of clarity about roles and responsibilities**- no clear consensus on lead provider and poor understanding of their wider needs
- The **absence of clear pathways** to the treatment and care
- Divergent eligibility **thresholds** that may lead to exclusion
- Issues regarding **information sharing**
- **Presenting problems** are symptomatic of other problems
- **Outcomes are not clear** or shared across agencies
- **Lack of targeted resources** for example. crisis intervention, transient populations, carers and families
- A need to inform and **involve important carers and family members** in any treatment or care planning, whenever possible
- Lack of an evidence base to inform and benchmark optimal treatment.

Those with **coexisting mental health issues and drug dependency need to be identified at the earliest opportunity**, then referred and supported to access and engage in appropriate services. The wider voluntary and community sector has a large role to play in prevention and supporting those with low level mental health needs and are a priority for development.

A Mental Health Treatment Requirement (MHTR) can be made as part of a Community Order and is intended for **sentencing offenders** convicted of an offence (or offences) which is below the threshold for a custodial sentence, where the offender has a mental health problem that does not require secure in-patient treatment. Since October 2020, Magistrates Courts in Cornwall have been able to **include MHTRs in addition to the existing Drug Rehabilitation Requirements (DRR) and Alcohol Treatment Requirements (ATR).**

Cornwall was amongst the best performing areas nationally across these measures and has been held up by NHS England as the 'Gold Standard' for delivery of these orders.

National policy and guidance

PHE's **Better care for people with co-occurring mental health & alcohol/drug use conditions**[88] recognised that, despite best efforts, people continued to experience exclusion from services as a result of their dual diagnosis and complex needs. Its aim was to **support local areas to commission timely and effective responses** for people with co-occurring conditions, encouraging commissioners and service providers to work together to improve access to services enabling flexible and effective responses to need, including in crisis.

It includes two key principles:

Everyone's Job: Commissioners and providers of mental health and alcohol and drug use services have a joint responsibility to meet the needs of individuals with co-occurring conditions by working together to reach shared solutions.

No Wrong Door: Providers in alcohol and drug, mental health and other services have an open-door policy for individuals with co-occurring conditions and make every contact count. Treatment for any of the co-occurring conditions is available through every contact point.

NICE has produced two pieces of guidance relating to dual diagnosis. CG120[89] covers assessment and management for those aged 14 and over with coexisting (or suspected) severe mental illness (psychosis) and substance misuse. NG58[90] covers how to improve services for those aged 14 and over who have a diagnosis of severe mental illness and substance misuse. NICE Quality Standard 188[91] outlines that this should be delivered through 4 quality statements:

- **Initial identification of coexisiting substance misue** through asking people as soon as possible when they attend services such as mental health,

[88] Better care for people with co-occurring mental health, and alcohol and drug use conditions, PHE (2017)
[89] NICE Clinical Guidance (CG120) Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings, NICE (2011)
[90] NICE Guideline (NG58) Coexisting severe mental illness and substance misuse: community health and social care services, NICE (2016)
[91] Coexisting severe mental illness and substance misuse, Quality Standard [QS188], National Institute for Health and Care Excellence (2019)

emergency departments, general practice and services within the criminal justice system.
- People with a severe mental health illness and substance misuse 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 (such as primary healthcare, 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**, to help ensure the person remains in contact with services or re-engages quickly. If people are automatically discharged from a service because of non-attendance they can be left without support when they are vulnerable.

The **Improving Access to Psychological Therapies Manual**[92] for all commissioners, providers and clinicians outlines that IAPT and drug/alcohol treatment services should work together to address a person's needs.

Local response

"Futures in Mind", the **Adult Mental Health Strategy** for Cornwall and the Isles of Scilly[93] has six areas of focus including providing easier access to treatment.

This involves a **continued focus on substance use and mental health** to ensure support for people with multiple complex needs; working with people to understand complex needs; and review the care and support available to them. Working with partners to develop a flexible and resilient workforce with additional specialised training is also included.

The Cornwall and Isles of Scilly **Dual Diagnosis Strategy 2019-22** outlined the principles and local commitment for supporting those experiencing these combined issues, based on the national guidance. The **strategy was refreshed in 2022**.

- **Professionals or persons/volunteers** involved with service users who come into contact with them at times of crisis **will know where to get help or advice** and refer people for longer-term help.
- All who come into contact with this group must **respect the knowledge of the person concerned about their own needs** and their perspective on any risks they face. This is linked to the national move towards **personalised care**, which means people have greater choice and control over the care and support they need.
- **Engaging and retaining** this group, in community-based treatment that addresses their wider needs, is likely to **reduce episodes of crisis, reduce risk**, and significantly reduce the relatively high cost of in-patient episodes.
- 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.

---

[92] The Improving Access to Psychological Therapies Manual, NHS (2018)

[93] Futures in Mind, Adult mental health strategy (2019-2024), Cornwall and Isles of Scilly Health and Care Partnership.

The diagram below provides the framework to identify the appropriate **lead agency** for each person with a dual diagnosis. However, the **diversity and complexity of their wider needs, as well as their preferred choice** of setting (where they are most likely to attend for help) should also be considered.

National guidance and evidence are clear that **specific 'dual diagnosis' services should not be created**. However, dedicated co-ordination can impact positively on reducing hand-offs and gaps and improving joint working.

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.

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]

Assessment and treatment interventions from both mental health and drug and 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.

Whilst there are excellent examples of joint working both before the strategy was created and currently, people with mental health problems and drug dependency **report difficulties in accessing the support that they need**.

The most recent focus groups highlighted:

- **Not enough capacity in mental health services** for those with alcohol and/or drug needs – long wait times for support from the Community Mental Health Team.
- A **lack of meaningful counselling** with Outlook South West 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".

A need for "better **dual diagnosis understanding** and more dual diagnosis training" was identified as a key area for improvement.

Services such as drug and alcohol treatment, domestic abuse and sexual violence, Housing and voluntary sector organisations report having to **'hold' extremely complex mental health cases** with little support from secondary mental health services. In addition, there are **delays in assessments** due to a person's drug use.

The **Dual Diagnosis Multi-Agency implementation Group** was formed in Autumn 2021 with representatives from across mental health and substance misuse services. An implementation plan is in progress, supported by an escalation process, where issues cannot be resolved at the practitioner level. The group provides as 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 they 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[94]) 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.

[94] The NHS Long Term Plan (January 2019)

Self-harm and Suicide

Suicide rates for Cornwall and the Isles of Scilly are **significantly higher** than in both England (10.4) and the South West (12.0) at 13.5 per 100,000 people aged 10 years and over (2019-2021). There were **73 deaths by suicide in 2021**. Local rates of emergency hospital admissions for intentional self-harm are also higher than nationally.

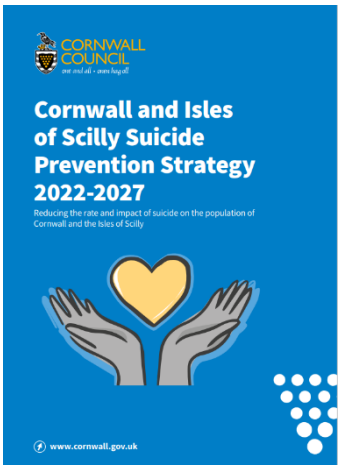
Each death by suicide represents an individual tragedy and a devastating bereavement for family and friends. It is estimated that **every death affects 135 people** who knew the person[95]. This ripple-effect includes family and friends along with co-workers, peers and those in the wider community who knew the person.

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) in place which tracks anonymised data relating to suspected suicide deaths in the county and maps up-to-date information in order to implement postvention support, identify themes, risks and potential clusters. This is necessary due to the time lag between an unexpected death and Coroner conclusion at inquest.

The learning from this system is used to implement suicide prevention in a timelier manner and is reviewed by the Suicide Surveillance Group to inform suicide prevention strategies.

A new 5-year Suicide Prevention Strategy was launched in 2022. The vision is a Cornwall and Isles of Scilly with zero suicides, where people can live healthy, fulfilling and connected lives; and where anybody in need and in crisis is supported by their communities and services that work together to improve wellbeing



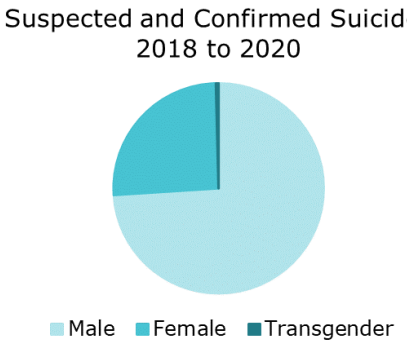
There are four strategic priorities for action to deliver this strategy.

- Strong **local intelligence network** and sharing of best practice
- Promotion of **healthier, more connected and safer** communities
- Targeted suicide **prevention and early intervention**
- **Support for people impacted** by suicide
- Support delivery of the **implementation plans for mental health and suicide prevention strategies**, and the all age prevention concordat for better mental health.

[95] How Many People Are Exposed to Suicide? Not Six, Cerel et al. (2018)

Local data

The Alcohol Needs Assessment reviewed data from the Cornwall and Isles of Scilly RTSS database, which includes both suspected and registered suicides.[96]



- From January 2018 to December 2020 there were 246 suspected or registered deaths by suicide in Cornwall. Both locally and nationally suicide rates for **males are 3 times higher than for females**.
- 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.

Public Health undertake an annual **Suicide Audit** using RTSS data, which is used to identify those at higher risk of death by suicide.

Risk factors for suicide and suicide attempts:

- **Gender**: males are 3 x more likely to take their own life
- **Age**: people aged 30-59 are most at risk
- Mental illness
- Treatment and care **after suicide attempt**
- Previous **self-harming** behaviour
- Physically **disabling or painful illness**
- Alcohol and **drug misuse**
- **Living alone**, social exclusion, or isolation
- Bereavement
- **Family breakdown** and conflict
- **Adverse childhood experiences**, trauma, abuse and sexual violence
- Identifying as **LGBTQ+**
- Leaving **Care**
- Individuals on the **autistic spectrum**
- **Certain occupations** such as agricultural and construction industries
- **Deprivation**, financial insecurity, poor or unemployment and debt

People with a drug dependency are at higher risk of suicide[97] than the general population, with prescribed drugs, notably antidepressants and methadone, influencing this heightened risk.

The **pandemic has had a significant impact on people's mental health and wellbeing**. National suicide rates did rise after the previous recession, and those most affected by the economic downturn were at greatest risk. Therefore, the full long-term impact of the pandemic on mental health and suicide are not yet known, and further research will be needed in this area.

[96] The confirmation and registration of a suicide is a matter for the Coroner and occurs some months after the death. RTSS figures are therefore likely to be an overestimate due to the inclusion of suspected suicides.

[97] Suicide among drug addicts in the UK, The British Journal of Psychiatry, Oyefeso, A., Ghodse, H., Clancy, C., & Corkefy, J. (1999)

What people say about our services

As part of the Needs Assessment development, we held five **focus groups** (online and face-to-face) with a total of 34 people who use the service. A **survey**, on Cornwall Council's online consultation platform Let's Talk, had 73 responses from people who use services, partner organisations, specialist staff and stakeholders. We also held meetings with Specialist Treatment staff and wider 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.

What is working well?

Treatment and support

- **Flexible, holistic** service approach (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 one-to-one support and group programmes. **Good relationships** between staff and service users.
- YZUP provides an **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 them e.g. mental health support, medical appointments, bus passes and activities.
- **Ability to refer people** to initiatives such as Street Kitchen and Breadline [Penzance] providing routine.
- **Links with pharmacy** are supportive and communicative.
- **Shared care** is a benefit.
- **Housing outreach** giving on the spot help.
- **Workers go the 'extra mile'**

Workforce

- The ability to become a **volunteer** [with the service] and the **training scheme** for volunteers.
- Staff **understanding and awareness** as a result of training and development opportunities.
- **Naloxone training** for all frontline staff.
- **Response to needle reports** and rapid information sharing.
- **Staff** from the service are **very well trained**

"Beautiful service" –about With You MAP groups

"MAP provides routine, something to look forward to"

"They usually know what I need before I do" – about their key worker.

"It's like having a diary that talks back to you" – about MAP groups

"Groups in Truro kept me clean" – about activity

"Addiction is a hobby; I need a new hobby to replace it with" – about life skills groups

"Being at Cosgarne normalises my life, don't have to steal or rely on anyone" – about supported housing

"It's so much different now, there are so many elements available that you can access at every step of the way. You can see the way through. It's like a Yellow Brick Road to Recovery"

"Before I used to stay in my room all day, now there are facilities and something to do every day" – Cosgarne resident (supported housing) who was also at Cosgarne 10 years ago.

What is not working well and needs to be improved?

Treatment

- **Long-winded processes** delay support.
- More **flexibility in prescriptions**
- Issues post-recovery e.g. **debt/no money.**
- Lack of and short-term nature of **funding**.
- **Lack of a safe space** (premises/ venues) to see clients.
- **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.
- **Increase in 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.
- **Need more drug and alcohol outreach** to specific hotspot areas known in the town, not just when drug litter is found.
- **Long-term recovery support** is not as good.
- **Needle exchange in some areas** needs to improve.

Residential detox and rehab

- **Not enough provision** – long wait times. Individuals also are not informed of their progress on the waiting list.
- **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.

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 substance misuse services.
- Lack of work to reduce impact of harm on children impacted by complex needs **until safeguarding thresholds** are met.
- Lack of funding to support young people with **drug/alcohol use and County Lines**.

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.

Mental Health

- **Not enough capacity in mental health services** for those with alcohol and/or drug needs – long wait times for support from the Community Mental Health Team.
- A **lack of meaningful counselling** with Outlook South West 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".

Housing and accommodation

- Lack of **housing options**- shortfall in emergency housing and **adapted supported accommodation** with ground floor and wheelchair access.
- People with **complex needs housed in B&Bs**.
- **Funding lost** for tenancy course.
- **No in-between provision** - straight from supported housing to independent living.
- **Relationships between people in supported accommodation and residents** in the community need to improve.

Workforce

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

Multi-agency working

- **Lack of joined-up working** means service users need to retell their story repeatedly to multiple people/organisations. This can lead to re-traumatisation.
- **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.

"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"

If we only change 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 agencies 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,** shorter **wait times** and smoother **transitions** between services
- Better **links with mental health services**.
- **Improved communication** between services and clients.
- **More and sustained funding** to allow for strategic planning in relation to the outcomes of this needs assessment.

- **Increase access to needle exchange** and raise awareness of service locations. Service available more days a week.
- Promote **Naloxone** and provide training for more frontline staff to use it.
- Consideration of **Heroin Assisted Treatment** at various sites in Cornwall, as a measure to reduce drug related deaths.
- **More bases to deliver treatment** from, particularly in Bodmin, Newquay, Falmouth and Helston

Residential detox and rehab

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

Children, young people and families

- Increase in **early intervention** (Affected Other/Child Exploitation/Schools - in particular Alternative Provision Academies).
- **Improved/longer-term transition arrangements** so that young people have consistent support for transition to adulthood.
- Training to include **Safety Planning/Managing Risk** with service users aged 11-25 years.
- **Whole family approach**.

Mental health

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

Housing and accommodation

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

Workforce

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

Multi-agency working

- **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.
- **GPs –** input and awareness, training, health conditions and complex needs awareness, compassion, support with referrals with the Community Mental Health Team.
- **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 on drug and alcohol harm especially drug-related deaths; sharing of relevant data and information.

Prevention

Young people and drugs

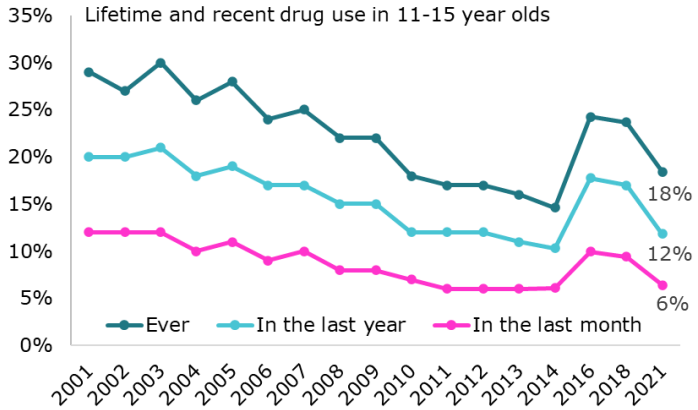
This section provides **key headlines from the Young People's Substance Misuse Needs Assessment** for 2022/23; the full assessment can be downloaded from the Safer Cornwall library.

- There are indicators both locally and nationally of **increased drug use and risk taking behaviours amongst young people** (under 16), with some groups particularly vulnerable post-COVID.
- Higher prevalence of **early onset drug use** amongst young people in Cornwall – implications for development and life skills.
- Complex **mental health issues** and other vulnerabilities;
  - **Involvement in ASB** high for the first time
  - More likely to **use multiple substances**
  - More likely to **self-harm**
  - More likely to be **affected by domestic abuse**
- **Substantial hidden harm** related to parental drug and alcohol use – specific support reaching only a small proportion of the estimated need.
- **Times of transition are challenging** and children can fall through the gaps.
- There are concerns that the **lack of flexibility** from adult services may mean that young people are not getting the ongoing support that they need.
- **Young people are developmentally younger**, due largely to the pandemic, and this makes transition into adult services particularly challenging.

Drug use amongst young people

"Preventing drug misuse is more cost effective and socially desirable than dealing with the consequences of misuse… Local authorities should identify, and provide additional support to, those young people most at risk of being drawn into using illicit substances or involvement in supply." Dame Carol Black Review Part 2

The **NHS Smoking, Drinking and Drug Use (SDD) among Young People** report provides the results of the biennial survey of secondary school pupils in England, mostly aged 11 to 15, focusing on smoking, drinking and drug use. It covers a range of topics including prevalence, habits, attitudes, and wellbeing. Due to the impact of the COVID pandemic, the survey was run in the 2021 school year instead of 2020 as planned.



The 2021 SDD[98] found that there had been a recent **fall in the prevalence of lifetime and recent illicit drug** use amongst young people.

[98] NHS Smoking, Drinking and Drug Use among Young People 2021, NHS Digital (2022)

The chart shows the timeseries for lifetime and recent drug use in 11-15 year olds. Psychoactive substances (NPS) were included from 2016 and so data before then is not comparable. In 2016, even when accounting for the addition of NPS, there was a **large and unexpected rise in overall drug use** prevalence, with increased use of stimulants, volatile substances and psychedelics – a reversal of the previous long-term reducing trend.

- In 2021, **18% of pupils reported they had ever taken drugs** (24% in 2018), 12% had taken drugs in the last year (17% in 2018), and 6% in the last month (9% in 2018). These results are more in line with the averages over the five years pre-2016.

There has been a decrease in the prevalence of smoking cigarettes but **an increase in vaping**.

- Current e-cigarette use (vaping) has increased to 9%, up from 6% in 2018. Around 1 in 5 (21%) 15-year old girls were classified as current e-cigarette users

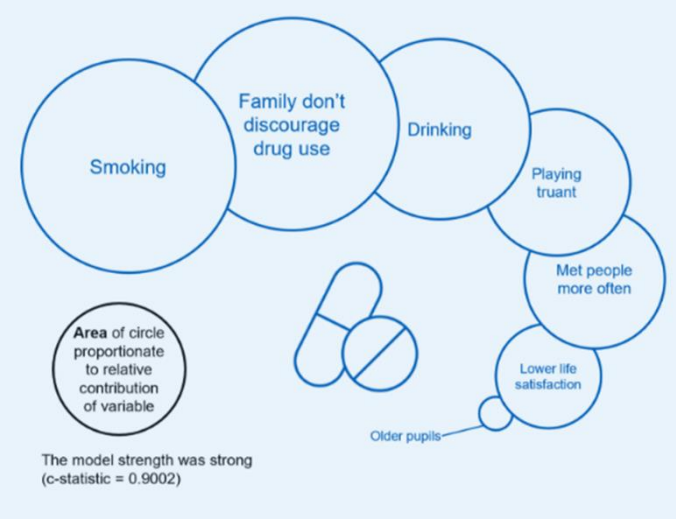
Low wellbeing was more likely amongst pupils who recently smoked, drank and/or have taken drugs. 57% of pupils who had recently[99] smoked, drank alcohol and taken drugs **reported low levels of life satisfaction** compared with 35% of pupils who have only done one of these, and 18% for those who have done none of these.

Pupils who **frequently met up with people outside their school or home**, were more likely to have recently smoked, drunk alcohol or taken drugs

- Of pupils who **met with people every day**, 9% were current smokers, 12% usually drank alcohol once a week, and **19% had taken drugs in the last month**. For pupils who had never met other people in the last four weeks, these proportions fell to 1%, 2%, and 2% respectively.

The 7 factors (explanatory variables) shown below had a significant association with having taken any drugs in the last month. The size of the circles represents an estimate of the relative contribution to the model.

It was estimated that **being a smoker had the strongest association**, followed by having a family who don't discourage drug use, and then drinking alcohol.



[99] Recently refers to smoking in the last week, drinking alcohol in the last week, and taking drugs in the last month

Young people known to treatment

Key statistics[100]

- **99 young people[101]** in community structured treatment in 2021/22
  - ***62%*** *of young people identified as having a* ***mental health treatment need*** *at the start of treatment, compared with 48% nationally*
  - *Young people are* **presenting as more complex** *with increasing use of anti-anxiety and depression medicines*
  - **Cannabis most prevalent drug** *for young people in treatment (86%). Cocaine and ecstasy has a higher prevalence in Cornwall when compared with the previous year.*
- **50 young people being worked with as affected others** - where their parents have an identified substance misuse need.

Nationally there has been a **sustained and significant decrease** in the number of young people receiving specialist interventions for their drug use.

Those who are accessing treatment interventions have more **complex needs**, including poor mental health, self-harm, offending and experience of sexual exploitation.

YZUP, our young people's substance misuse treatment service is also reporting that they are **working with increased complexity** with their young people. This can be in the form of multiple vulnerabilities as well as them being the victims of child exploitation. They are also **working with more young people** than has previously been the case.

YZUP are currently working with 152 young people (as of May 2023) in relation to their drugs and alcohol needs.

- **Cannabis** is still the most frequently used drug, although **class A drugs such as cocaine and ecstasy are now more available (both** crack and powder form).
- Medicated **tranquilizers** (including Valium, Xanax and Diazepam) as well as ketamine are often recorded as secondary and tertiary drugs.
- The use of **prescription drugs tend to be anti-anxiety and depression medicines** that have been obtained from medicine cabinets or via other young people on social media.
- **Alcohol use amongst young service users is comparatively low** when compared with national levels.

Around a third of the young people who have sought specialist help are **young people who are affected by parental alcohol and other drug use** (as well as parental mental health problems and domestic abuse in the family). Due to the hidden nature of young people who are affected others, we believe that there are still many more young people in need.
To get an idea of the scale of **potential unmet need**:

100 Data covers 2021/22, compared with 2020/21
101 Young people substance misuse commissioning support pack 2023/24: Key data. Number of young people in community structured treatment, for under 18s or 18-24 year olds in young people's services. 18-24s in adult substance misuse services are not included. It includes young people in treatment during any part of 2021/22.

- Data from NDTMS indicates that **350 children** were recorded as living with a drug user entering treatment in 2021/22.
- Estimates[102] for the whole population of children affected by parental drug/alcohol dependency suggests that **3,980 children are potentially at risk** of being adversely affected in Cornwall.

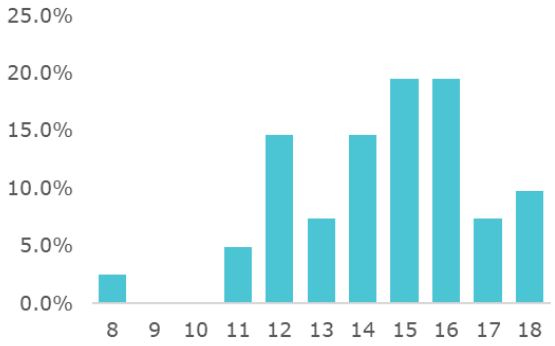
The commissioning pack for young people's services provided by Office of Health Inequalities and Disparities (OHID) indicates that **young people in treatment locally are more complex** than the national profile.

The data for 2021/22 shows that young people in Cornwall are:

- More likely to **involved in anti-social behaviour** (42% vs 20%); in previous years involvement in crime and anti-social behaviour was less likely amongst our local cohort
- More likely to have started **using their problematic substance under the age of 15** (73% locally vs 58% nationally), therefore indicating that young people locally are at **greater risk of early onset impacts**
- More likely to be in **treatment for two or more substances** (55% vs 39% nationally). Historically Cornwall has had high proportions of young people with alcohol and cannabis as secondary / tertiary drugs.
- More likely to **self-harm** (27% vs 20% nationally).
- More likely to be **affected by domestic abuse** or witness domestic abuse in the home (19% vs 15% nationally).
- Less likely to be in **mainstream education** (46% vs 60%), with a greater proportion of young people Not in Education or Employment (NEET).

In the 12 month period ending November 2022 there were 254 adults (aged 18-25) in the adult structured treatment service:

- **72% or 182 of these young adults were not previously known to YZUP.** This therefore indicates that there is an unmet need in the under 18 population;
- When we look at adults aged 18-20 this percentage lowers to 58% or 24 out of 41 young adults.
- The chart to the right shows the **age of first use** for the 254 young adults. We can see that the majority of the cohort began using their primary substance above the age of 15.
- Those young people aged 14 and under are those that would be classified as **early onset users** and are in most cases more complex cases to work with.



Our 2022 Youth Issues workshop highlighted the following issues seen by our front-line workers:

- We are seeing **more vulnerability** for those young people engaged with treatment services, particularly when there are **other substance users in the**

102 Estimating the prevalence of the 'toxic trio', Children's Commissioner's Office (Chowdry, 2018)

home and when **school have excluded** the individual. Young people are also **starting to use their substances and cigarettes at a younger age**.

- The treatment model is based on adolescent development, however COVID has affected this and has impacted massively on self confidence. **Alcohol use has increased in lockdown which is affecting mental health.**
- Some young people have **no structure in their lives** and now struggle in school as a result. There have been family breakdowns due to **financial pressures** as well as reports of **domestic abuse** and drug and alcohol use.
- There is **lack of awareness of risk** and drugs are used as a "blow out". The understanding of what substances do to a young person is less than previous years. Drug use can be self-destructive due to their perceived lack of future and aspirations.
- **Cannabis and alcohol are mainly used**. We are seeing reductions in the use of tranquilizers although prescriptions are now bought from dealers – these are **particularly harmful when mixed with alcohol**. We are seeing increases in Ketamine and Cocaine, which are much easier to acquire and more popular than MDMA. The latter is no longer as expensive although the quality of the product is unknown.
- **Affected others cohort** - approximately 40% of these young people are not using substances but their family members are. Services need to understand more about this cohort as **their behaviour is a result of their home lives** and the trauma they are witnessing.
- Some young people are **using substances daily in order to self-medicate**, which has now become normalised.
- **Public concern** about young people's drug use tends to be focussed on visible impacts such as drug litter and the deaths of young people due to "party drugs" and unknown substances attract significant media attention.

Drug-related exclusions

In England in the 2020/21 academic year, 8% of permanent exclusions and 3% of suspensions were related to drugs and alcohol.

In Cornwall there were 50 permanent exclusions and 3,575 suspensions during the 2020/21 academic year, with 6 permanent (12%) and 149 suspensions (4%), linked to drugs and alcohol, slightly above the national rates. The **majority of exclusions and suspensions come from secondary schools** but there are incidents where they have been suspensions from primary schools.

Our Youth Issues workshop highlighted the following issues with respect to schools:

- Currently **schools in Cornwall have an inconsistent approach to drug related behaviours**. Better school engagement on this issue is needed – including recognising **drug use as a sign of exploitation** and delaying/stopping exclusion whilst finding the right pathway. It should be best practice to explore risk and make appropriate referrals as early prevention - need a consistent model for schools and multi-agency working.
- **Parental awareness of exploitation** needs to improve, with messages being delivered consistently across education and all services.
- **Educational provision differences on Scilly** due to greater vulnerability of children and young people needing to travel to and from the mainland.
- Information from the Local Disruption and Support Meetings highlight that most children and young people have been excluded from school and **many are waiting for places in Alternative Provision Academies**.

Transition to adult services

Times of transition are challenging, and children can fall through the gaps – from child to adult services and also from school to college. Biological age determines which service when **developmental age may be much younger** (particularly post-COVID). In further education safeguarding policies must cover both adults and children and balance the right to autonomy vs risk of exploitation.

Partners are highlighting that transition is **more challenging now than it has ever been previously**, with the situation having been **exacerbated by the pandemic** and greater complexity of needs for our young people.

- Young people often **struggle with the transition between school and college**. There can be a lack of engagement when the timetable is not full time. Services may not be able to see young people during **school holidays**, meaning that young people may struggle without the ongoing support.
- Some young people who are currently engaged with young people's services are finding that, on reaching adulthood, there may not be the right provision to meet their needs. **Adult services are also more structured** and may be less able to flex to support young people who have complex issues.
- **Working with 17/18 year old victims of exploitation** requires flaxibility of approach when transitioning to adult services, to keep them engaged.
- **Young people are developmentally younger**, due largely to the pandemic, and this makes transition into adult services particularly challenging. Adult services have a less flexible approach and a reduced level of support. There is a need to work with adult services to support them in understanding young people's needs.

Feedback from YZUP regarding working with adult services shows that they often encounter problems, especially where young people are engaged in different services. This can be due to a **lack of transparency or explanation** as to why a young person cannot be transitioned to adult services for mental health or social care.

Adult services may **not be willing to share information** about the young person even when explicit consent has been given.

Transition discussions about young people's needs and service thresholds are not timely, often not taking place ahead of the young person's eighteenth birthday. **This should be routine** even if in some cases it is to explain why someone won't be supported.

The chaotic lifestyle of a young person with complex needs is often **considered as non-engagement.** If focus shifted to the barriers of engagement, then transition into adult services will become much smoother.

Drugs prevention – what works (young people)

Public Health Commissioning Guidance

Invest in provision from schools to treating young people's substance use

There should be effective pathways between specialist services and **children's social care**

Clear pathways needed between targeted and specialist young people's services, supported by **joint working protocols and good communication**

Universal and targeted services: help **build resilience** and provide substance misuse **advice and support** at earliest opportunity

Specialist services: for those whose use has **escalated and/or is causing harm**

Specialist services must deliver **age-appropriate interventions** and promote **safeguarding and welfare**

Every effort should be made to **assess the** risk of children and young people **interacting with older service users**

Services available need to be **tailored to the specific needs** of girls and boys within these services and ensure that young people with **multiple vulnerabilities** or a high risk of substance use-related harm get **extra support** with clear referral pathways and joint working protocols.

Services for Children and Young People

Build **resilience and confidence** amongst young people to prevent a range of risks including substance use

Outcomes of effective specialist substance misuse interventions include:

- Improved **health and wellbeing**
- Better educational **attainment**
- Reduction in **NEET** numbers
- Reduction in **risk taking** behaviour

Young people have better outcomes when they receive a **range of interventions** as part of their package

Young people generally spend less time in specialist interventions than adults. However, **those with care needs often require support for longer**

If young people **re-present to treatment**, this is not necessarily a failure and should be **rapidly re-assessed**

Sources:
Community-based interventions for the reduction of substance misuse among vulnerable and disadvantaged young people, National Collaborating Centre Drug Prevention (2006)
'What Works' in Drug Education and Prevention, Scottish Government (2016)
School-based alcohol and drug education and prevention – what works?, Mentor Adepis (2017)

Peer educators should be involved, although not necessarily lead drug education but trained teachers and health professionals can be effective

The rationale for this approach is that young people learn from each other and have greater credibility, sensitivity and understanding than adults when discussing health behaviour, and can act as positive role models to reinforce these messages.

Integrated information – children and young people cannot make the healthy, pro-social decisions, without accurate information. But information on its own is insufficient to enable (young) people to make informed decisions

Drug education programmes which are **multi-component** in nature and/or which target young people's environment (e.g. school, community) are possibly more effective than those which are single-component in nature and which primarily target the individual (moderate evidence). Multi-sectoral programmes with multiple components (**including school and community**) are effective in reducing illegal drug use.

Correcting the 'myth-understandings' which need to be **based on local data** including the results of **anonymous in-school questionnaires** and then to be followed up with teaching **practical refusal skills.**

There is evidence from local services to suggest that there are better outcomes when young people can **access mental health/ pastoral support in schools**, both for their own or a family member's use

Interactive drug education programmes are nearly always **more effective than non-interactive programmes** and those which incorporate active learning and pupil-to-pupil interaction, are more likely to reduce drug use. Some **social influence programmes** can produce short-term reductions in cannabis use, particularly in low-risk populations.

Social competence approaches offering information but also allow pupils to model and practice giving feedback and positive reinforcement. These approaches teach personal and social skills such as generic self-management, target-setting, problem-solving and decision-making, as well as cognitive skills to be able to resist media and interpersonal influences. They also increase assertiveness skills and competence and to interact with others.

"There should also be a focus on preventing the risk factors and enhancing the **protective factors**, increasing young people's **resilience capability**, helping with strategies for refusal and hence supporting young people's resilience."

Drug education programmes adopting **life skills, social influences, resistance skills** or normative approaches are more effective.

Drug and alcohol screening and early intervention

To prevent or reduce the harm of drug use in children, young people and adults who are most likely to start using drugs or who are already experimenting or using drugs occasionally, NICE guidance recommends:

- **Skills training for children and young people** who are vulnerable to drug use
- **Information to adults** who are vulnerable to drug use
- Information about drug use **in targeted settings** that people who use drugs or are at risk of using drugs may attend

Other: High risk, vulnerable individuals

NICE guidance highlights **vulnerable and disadvantaged children and young people aged under 25** as at particular risk of using substances including:

> "those who are - or who have been - looked after by local authorities, fostered or homeless, or who move frequently, those whose parents or other family members misuse substances, those from marginalised and disadvantaged communities, including some black and minority ethnic groups, those with behavioural conduct disorders and/or mental health problems, those excluded from school and truants, young offenders (including those who are incarcerated), those involved in commercial sex work, those with other health, education or social problems at home, school and elsewhere and those who are already misusing substances".[103]

There is a case for **maintaining drug-specific prevention interventions for those young people most at risk of harm**, or already misusing drugs.

NICE, as highlighted above, provide guidance on substance misuse interventions for under 25s and has recently consulted on draft guidelines for this group for 2017. However, the evidence also suggests that young people considered at greater risk will also benefit from universal approaches, and so tailored approaches may not always be required (Spoth et al., 2006, in ACMD, 2015).[104]

Other: The following factors are identified as being "likely to be beneficial" or "mixed evidence" of success

- **Pre-school, family-based programmes** in producing long-term reductions in the prevalence of lifetime or current tobacco use, and lifetime cannabis use.[104]
- **Motivational interviewing** in producing short-term reductions in multiple substance use.[104]
- **Whole school approaches** that aim to change the school environment on use of multiple substances.[104]
- **Parental programmes** for parents designed to reduce use of multiple substances by young people. Where effective, programmes included **active parental involvement**, or aimed to develop skills in social competence, self-regulation, and parenting skills.[104]
- Drug education needs to be **deployed early enough to be preventative** (before young people begin to experiment) but also to be **relevant and age-appropriate**.[105]

---

[103] Community-based interventions for the reduction of substance misuse among vulnerable and disadvantaged young people, National Collaborating Centre Drug Prevention (2006)

[104] 'What Works' in Drug Education and Prevention, Scottish Government (2016)

[105] School-based alcohol and drug education and prevention – what works?, Mentor Adepis (2017)

The use of **'sniffer dogs' in schools**. Policy should not create a climate of fear and mistrust

Programmes relying on **scare tactics** to prevent children and adolescents from engaging in risky behaviours are not only ineffective, but may have damaging effects

Alcohol and drug testing in schools can give high levels of false positives; non-invasive tests are unlikely to be admissible in a court case and testing can only be conducted with explicit and informed parental consent for under 16s.

Targeted support for individuals as part of a broader treatment programme may be considered as a voluntary collaboration to manage risk and support a vulnerable young person to re-enter school as part of a broader treatment programme.

'Health terrorism' (including 'Scared Straight' approaches). Petrosino, Turpin-Petrosino and Finckenauer (2000) found these well-meaning programmes **can have harmful effects**. Scared Straight and other prison or parole programmes which bring together prisoners and students have **resulted in higher rates of re-arrest** and offending behaviour than youths not involved in the intervention.

Mass media programmes targeting illegal drug use

Mentoring programmes have no short or long-term preventative effects on illegal drug use

Focusing only on the building of self-esteem and emotional education. **Addressing only ethical/moral decision making or values**

Interventions which do not take into account the situation and vulnerability of a target group. (ACMD 2015)

One-time assemblies, events or testimonials. Former users engaged as visiting speakers are likely to have a **negative impact** on the beliefs, attitudes and behaviour of young people and children **if not used in the context of a broader curriculum** and within a **life skills-based approach** to education.

Standalone school-based curricula **relying solely on facts** about illegal drugs and their dangers, designed only to increase knowledge

Utilising **non-interactive methods**, such as lecturing, as a primary delivery strategy; information-giving alone, particularly fear arousal

A **'zero tolerance' approach** to substance misuse. If young people know school policy includes a punitive approach to disclosure it will prevent the creation of an environment which is conducive to discussion.

Recreational/diversionary activities, and theatre/drama based education to prevent illegal drug use. Experience from local services indicates, however, that this can be beneficial when combined with a programme of reduction and as a way of distraction to experience natural lifting of mood, and new friends with more positive attitudes to free time.

Drugs prevention – what works (adults)

The pyramid chart on the next page gives a breakdown of the **known effectiveness** of prevention activities at **primary, secondary and tertiary levels**. This relates to prevention for adults but there may be some crossover with prevention activity for young people.

A brief summary is provided below with definitions taken from DrugWise[106]

- **Primary**: trying to stop people using drugs before they have started using them

There is very little evidence about what prevention activities may prevent people from taking drugs on a recreational basis. NICE recommends that **adults vulnerable to drug use** should be given **information about drugs and signposted** to local services. Those with **multiple vulnerabilities**, including drug use, should receive a **joint approach** from agencies and organisations working in partnership.

- **Secondary**: trying to stop or reduce harm that people do to themselves or others while they are using drugs – in other words changing to safer and less damaging ways of using drugs

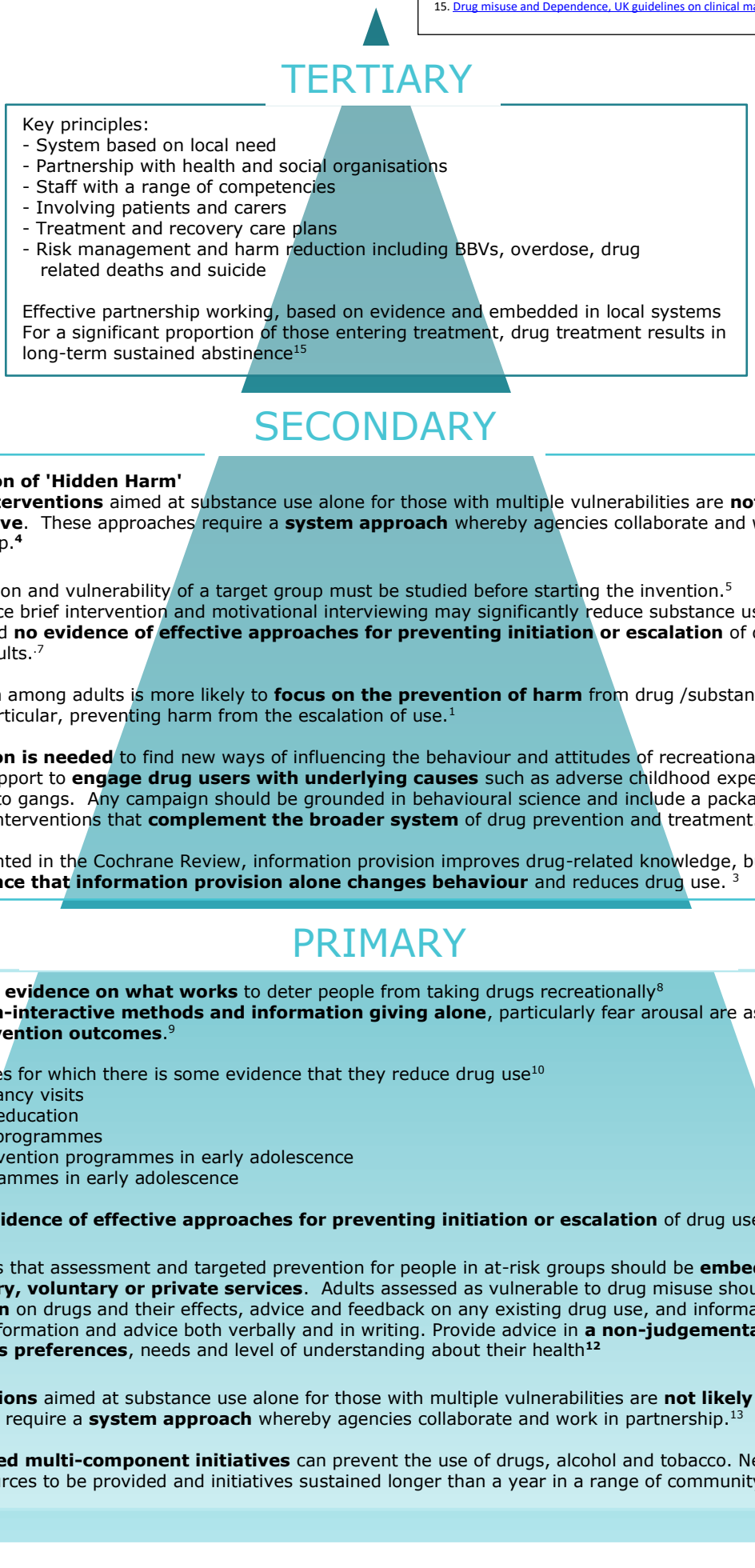
The Advisory Council on the Misuse of Drugs (ACMD) state that there is also a shortage of evidence about what works to reduce a person's existing drug use. Prevention for adults at this level relates to **prevention of harms** (including those that may be 'hidden'). **Face to face brief interventions** can be effective in reducing drug use and **multi-agency approaches** are recommended for those with multiple vulnerabilities.

- **Tertiary**: providing support and treatment for people who are using drugs, often dependently to give up drug use

Drug treatment results in long-term sustained abstinence for many at this level of drug prevention. Services need to incorporate effective partnership working with the **involvement of the person using drugs and carers**, and treatment and recovery care plans. Risk management and harm reduction relating to **blood-borne viruses** (BBVs), **overdose**, **drug related deaths and suicide** are integral.

[106] DrugWise – Prevention (Accessed November 2022)

1,4,5,7,11,13.ACMD Drug Misuse Prevention Review (2022)
2&8.Dame Carol Black, Review of drugs Part 2 (2021)
3.Stead and Angus (2004) referenced in What works in drug education and prevention (2016)
6,9,10,14. UNODC and WHO International Standards on Drug Use Prevention (2018)
12.NICE Drug misuse prevention: targeted interventions (2017)
15. Drug misuse and Dependence, UK guidelines on clinical management (2017)



TERTIARY

Key principles:
- System based on local need
- Partnership with health and social organisations
- Staff with a range of competencies
- Involving patients and carers
- Treatment and recovery care plans
- Risk management and harm reduction including BBVs, overdose, drug related deaths and suicide

Effective partnership working, based on evidence and embedded in local systems
For a significant proportion of those entering treatment, drug treatment results in long-term sustained abstinence[15]

SECONDARY

Prevention of 'Hidden Harm'
Single interventions aimed at substance use alone for those with multiple vulnerabilities are **not likely to be effective**. These approaches require a **system approach** whereby agencies collaborate and work in partnership.[4]

The situation and vulnerability of a target group must be studied before starting the invention.[5]
Face to face brief intervention and motivational interviewing may significantly reduce substance use. [6]
NICE found **no evidence of effective approaches for preventing initiation or escalation** of drug use among adults.[7]

Prevention among adults is more likely to **focus on the prevention of harm** from drug /substance use and, in particular, preventing harm from the escalation of use.[1]

Innovation is needed to find new ways of influencing the behaviour and attitudes of recreational drug users. Support to **engage drug users with underlying causes** such as adverse childhood experiences or exposure to gangs. Any campaign should be grounded in behavioural science and include a package of targeted interventions that **complement the broader system** of drug prevention and treatment. [2]

As highlighted in the Cochrane Review, information provision improves drug-related knowledge, but there is **no evidence that information provision alone changes behaviour** and reduces drug use. [3]

PRIMARY

There is a **lack of evidence on what works** to deter people from taking drugs recreationally[8]
Lecturing and **non-interactive methods and information giving alone**, particularly fear arousal are associated with **no or negative prevention outcomes**.[9]

Selective processes for which there is some evidence that they reduce drug use[10]
- Prenatal and infancy visits
- Early childhood education
- Parenting skills programmes
- Skills-based prevention programmes in early adolescence
- Mentoring programmes in early adolescence

NICE found **no evidence of effective approaches for preventing initiation or escalation** of drug use among adults.[11]

NICE recommends that assessment and targeted prevention for people in at-risk groups should be **embedded in existing statutory, voluntary or private services**. Adults assessed as vulnerable to drug misuse should be given **clear information** on drugs and their effects, advice and feedback on any existing drug use, and information on local services. Offer information and advice both verbally and in writing. Provide advice in **a non-judgemental** way and **tailor it to the person's preferences**, needs and level of understanding about their health[12]

Single interventions aimed at substance use alone for those with multiple vulnerabilities are **not likely to be effective**. These approaches require a **system approach** whereby agencies collaborate and work in partnership.[13]

Community-based multi-component initiatives can prevent the use of drugs, alcohol and tobacco. Needs adequate training and resources to be provided and initiatives sustained longer than a year in a range of community settings[14]

Appendices

A: Safer Cornwall Partnership Plan 2022-2025

Local delivery of national Drug and Alcohol Strategy priorities

A **systems approach to reduce the harms of drug and alcohol use** and promote recovery - to include education and earlier identification, workforce development, commissioning of community and residential services, criminal justice interventions and reducing alcohol and other drug-related deaths.

Where we want to be in 2025

- We have **increased our Prevention activity** - all health, social care and criminal justice services are able to screen, identify and provide brief interventions in alcohol and drugs, including through Making Every Contact Count and Health Checks
- We are **committed to reducing caseload sizes to 40 or less**, as recommended in the Independent Review of Drug Treatment, through increasing the workforce within treatment services
- We have **improved the quality of treatment** by reducing caseloads to advised levels and increasing the structured psychosocial interventions available
- People can **access treatment at every stage of the criminal justice system** through increased integration and improved care pathways between the criminal justice settings, and treatment
- We have **reduced alcohol-related hospital admissions and attendances** for the most frequent attenders
- We have **turned the tide of drug related deaths locally** and reduced numbers dying from a drug-related death
- We have sufficient capacity for **alcohol and drug detoxification** and residential rehabilitation
- We have improved the numbers **successfully completing treatment** and not returning and improved the level of aftercare available
- We have improved our approach to supporting people with **co-occurring health, alcohol and drugs problems** (including Dual Diagnosis - mental health problems alongside drug/alcohol dependency), sexual and reproductive health, blood born viruses (vaccination, screening, testing and treatment) and harm reduction

Community services to reduce the harms of drugs and alcohol

Priorities to deliver in 2023/24

- Publish **comprehensive drug and alcohol needs assessments and commissioning priorities**
- Develop and implement a **3 month Aftercare programme** to sustain the gains made in treatment
- Provide **3 additional Alcohol detox beds** within supported accommodation to enable people to detox where they live
- Deliver **Individual Placement Support** to increase the number of people in treatment who are employed
- Increase the numbers in treatment of people who are **rough sleeping or in insecure accommodation**
- Increase the number of people in **parenting and family interventions**
- Ensure that everyone in treatment experiencing depression and anxiety has access to **evidence-based interventions**

- Deliver **Community Sentencing Treatment Requirement orders** for people in the criminal justice system with combined alcohol, drug and mental health problems
- Improve the **co-ordination of care** for people with combined alcohol, drug and mental health problems (Dual Diagnosis)
- **Improve end of life care** for people with alcohol and drug problems, ensuring that they receive the compassionate care experienced by others
- Work with partners to ensure that **people with alcohol-related brain damage receive care closer to home** and have the opportunities to improve

Other relevant activities in the next year

Reducing hospital admissions

Work together to meet the needs of some of our **most vulnerable residents** to **improve their health and wellbeing** and quality of life; reducing hospital attendances and admissions, length of stay and ambulance call-outs through proactive work with the most **frequent hospital attenders**.

Safe and Well Hubs

Town-based hubs co-locating a range of services for people with **multiple vulnerabilities** - including services for alcohol, drugs, domestic abuse and sexual violence, mental health, offender support and other services. In 2023/24 the hubs established in Truro and most recently Penzance will continue to develop, alongside new hubs in St Austell and Camborne (and potentially Redruth). Spokes will be set up in Callington, Saltash and Launceston.

Upskill the workforce to work with common vulnerabilities

A transformational workforce development programme that **builds capacity in frontline services** to work more effectively with people with multiple needs and vulnerabilities – increases opportunities for early identification and intervention, prevents escalation of harm, improves individual experience and recovery journey, reduces demand on acute services.

Training and accredited tools are available in: Domestic Abuse & Sexual Violence, Trauma informed approaches, Drugs, Alcohol, Suicide, Mental health, County Lines and Exploitation.

Develop the Trauma Informed Network for Cornwall (TINC)

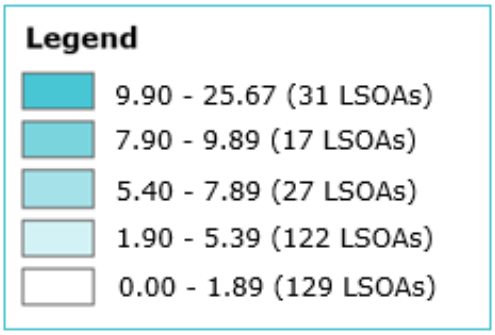
Trauma Informed Network Cornwall (TINC) provides **a place where professionals learn from each other**, share and evolve best practice in improving outcomes for our most vulnerable people. TINC's multi-agency membership comes from **commissioned and non-commissioned service providers** across adult and children services working with individuals with complex and multiple needs who meet and discuss the challenges and success connected to this work.

Priorities include securing funding for a **Trauma Informed Co-ordinator post**, developing a **Trauma Informed Charter** and Trauma Network **website** and supporting the **South West Peninsula Trauma Informed Network**.

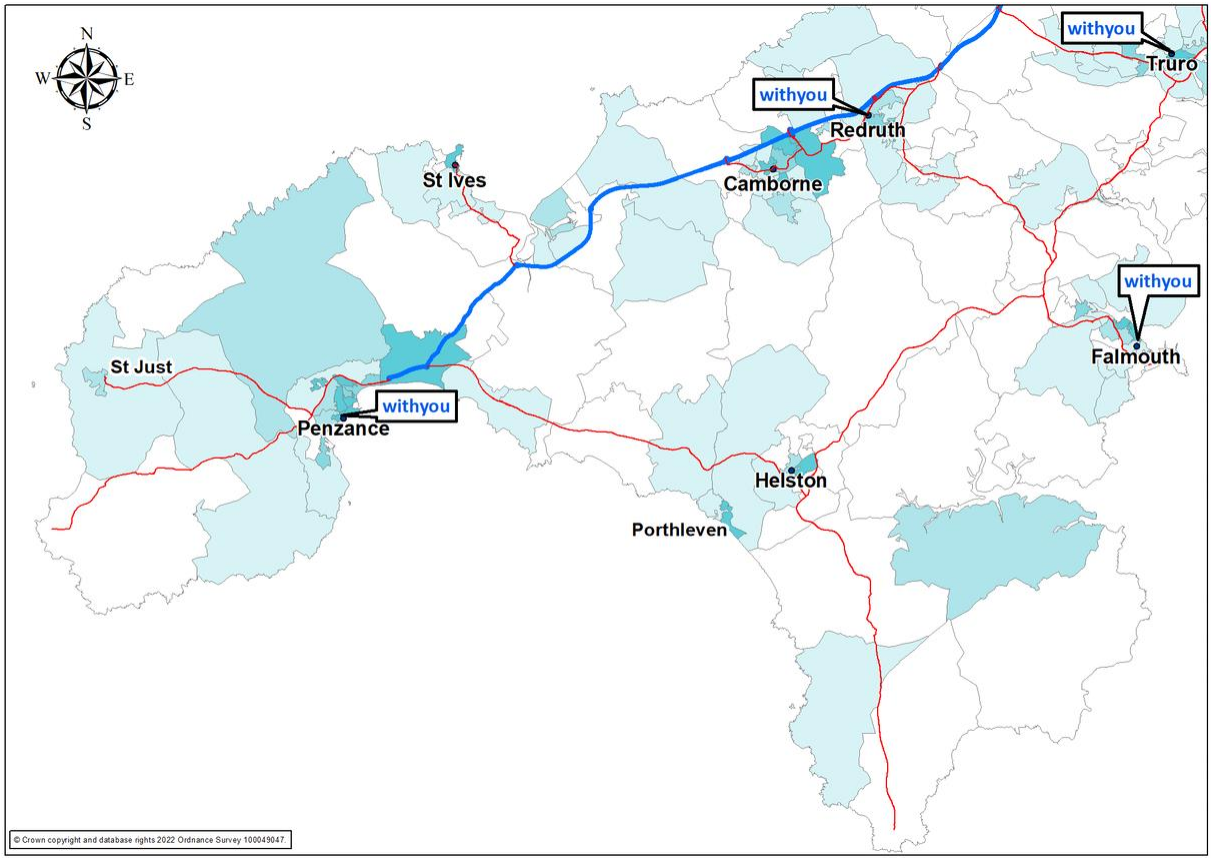
B: Prevalence and treatment maps

Opiate and/or crack use

The following maps show the number of people in treatment per 1,000 resident population with the **middle band** (5.40 to 7.89) being around the **estimated prevalence** rate of 6.7 per 1,000[107]. These are the full maps for West, Mid and East Cornwall (rather than zoomed into individual conurbations).

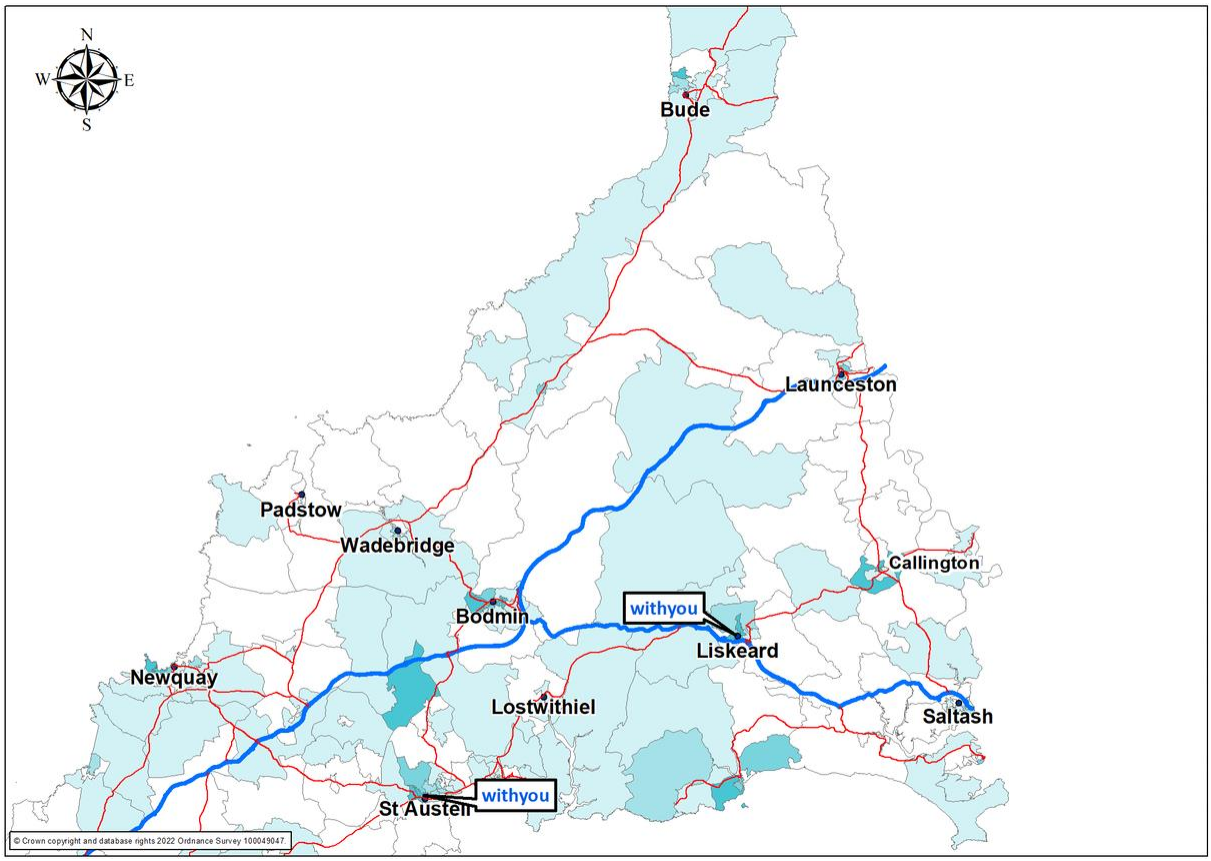


West Cornwall

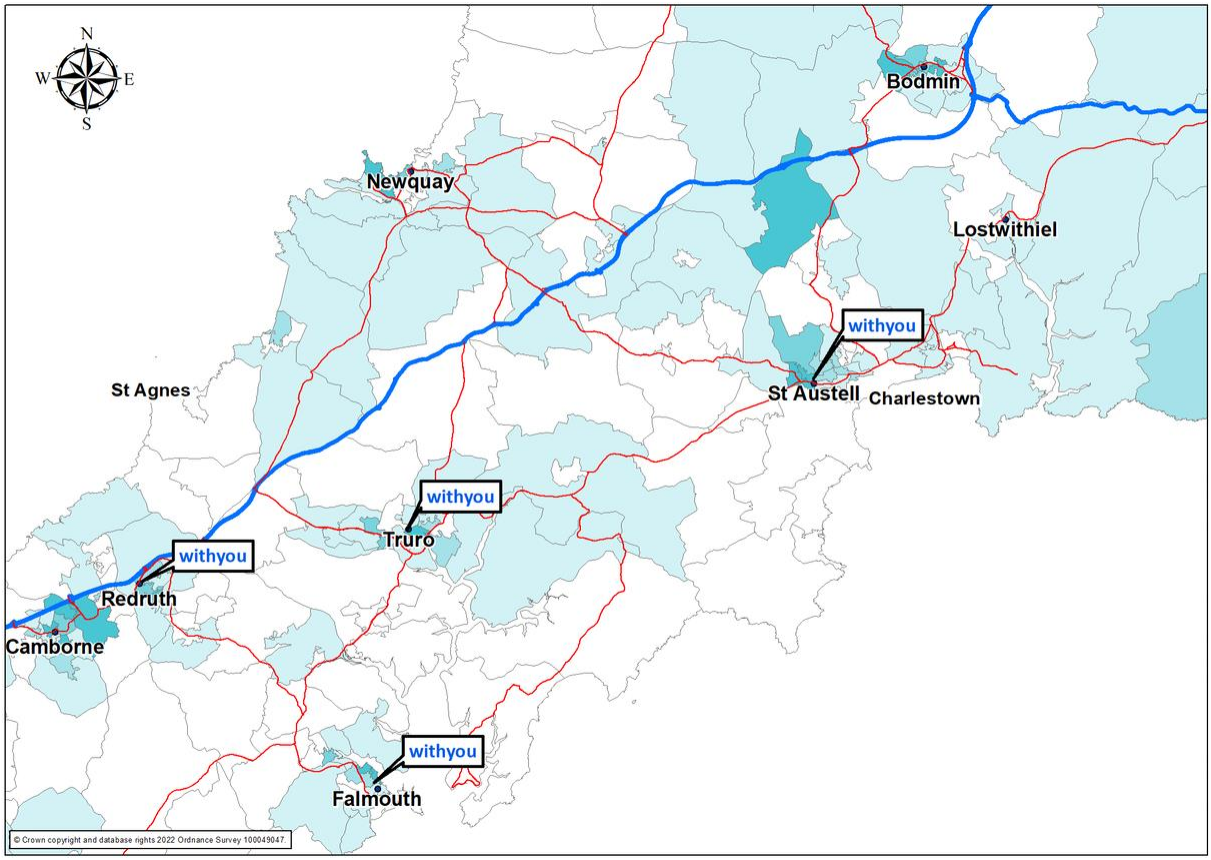


[107] Estimates of opiate and crack cocaine use prevalence: 2016 to 2017, Public Health England (2019)

Mid Cornwall



East Cornwall



C: Further reading

The **Amethyst Community Safety Intelligence Team** specialises in data analysis and research relating to crime, anti-social behaviour, problem use of alcohol and other drugs, reoffending and other issues affecting community safety in Cornwall.

Based within Cornwall Council's Community Services, **Amethyst supports evidence-based delivery** in all aspects of community safety business for Safer Cornwall and the Council.

Key assessments, strategies and information sources are available from the Safer Cornwall website in our library of publications.

These assessments provide the evidence that underpins all of our various strategies and commissioning activity, including the over-arching Safer Cornwall Partnership Plan as well as all of the individual thematic work.

You will find the latest versions of:

- Safer Cornwall Strategic Assessment
- Safer Towns Profiles
- Peninsula Strategic Assessment
- Drugs Needs Assessment
- Alcohol Needs Assessment
- Young People's Substance Use Needs Assessment
- Domestic Abuse and Sexual Violence Needs Assessment
- Safe Accommodation Needs Assessment

The following Organised Crime Local Profiles have been developed with partners and can be provided on request from the Serious and Organised Crime Sub-group:

- Child Sexual Abuse and Exploitation
- Modern Slavery
- Cyber Crime and Fraud (including Counterfeit Goods)
- Serious Acquisitive Crime
- Trafficking of People, Drugs and Weapons

Other evidence sources for Community Safety risk

The Community Risk Profile is produced each year to provide Cornwall Fire and Rescue Service with a comprehensive understanding of risks relating to fire, rescue and road safety.

Additional information about road safety is contained within the Cornwall Transport Plan 2030 – specifically with respect to objectives around supporting community safety and individual wellbeing. Our local strategy is linked into the South West Peninsula Road Safety Partnership.

All of these assessments form part of the evidence bank and online resource library of assessments and focus papers included in the Joint Strategic Needs Assessment.

If you would like this information in another format, please contact:

Community Services, Cornwall Council

Telephone: 0300 1234 100
email: mail@safercornwall.co.uk

www.safercornwall.co.uk